Making a Difference with Misoprostol: The Case of VSI

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I. INTRODUCTION

Reducing maternal mortality has been one of the most pressing concerns of the global health community since the early 1980s and was prioritized as one of eight Millennium Development Goals (MDGs) agreed to by the United Nations in 2000. In 2013, the World Health Organization (WHO) estimated that 289,000 women died as a result of pregnancy, a decline of 45% since 1990. Postpartum hemorrhage (PPH) and complications of unsafe abortion are responsible for around 35% of those deaths globally, and the burden is highest amongst women who have poor access to health facilities. Between 2008 and 2014, Venture Strategies Innovations (VSI), a non-profit organization based in California, developed a model for creating access to health products in developing countries to address the burden of maternal mortality from these two causes, particularly in this vulnerable group of women.

VSI’s model has three key components: 1) achieving regulatory approval of quality reproductive and maternal health products; 2) evaluating innovative distribution and service delivery strategies to increase access for hard-to-reach populations and incorporating the product’s use into health system policies and practices, and 3) improving product availability. Working with local and national partners, VSI identified and overcame challenges to integrate high-impact medicines and services into the health systems of countries where their use could positively impact poor maternal health outcomes.

VSI’s programs focused on the introduction and integration of misoprostol into health systems for obstetric indications, including the prevention and treatment of PPH and treatment of incomplete abortion and miscarriage, and of misoprostol and mifepristone for the safe termination of pregnancy. The work resulted in national-level success in creating and expanding access to misoprostol and mifepristone and essential maternal health services such as postabortion care (PAC), and also contributed to the revision of national and global policies that support the use of these drugs for reproductive health.

VSI’s initial, pioneering program focused on creating access to misoprostol for PPH prevention and treatment. In developing countries, PPH is a leading cause of maternal deaths, particularly for the many women who deliver outside a health facility. Oxytocin has long been the recommended first line drug to prevent and treat PPH, however, because it requires refrigerated storage and is administered as an injectable; it is not suitable for use outside of a health facility. In the late 1990s, researchers began evaluating whether misoprostol, a synthetic prostaglandin E1 analog,
would be effective for the prevention and treatment\(^1\) of PPH. By the mid-2000s, clinical studies had shown that misoprostol was nearly as effective as oxytocin in managing PPH.\(^3\)\(^4\)\(^5\)\(^6\)\(^7\)\(^8\)\(^9\)\(^10\)

This body of evidence meant that misoprostol, which is formulated as a tablet that does not require refrigeration, has the potential to prevent and treat PPH in women who are not able to deliver in a health facility.

II. THE ORGANIZATION’S BEGINNING

In 2003, following a request from three leading African obstetrician-gynecologists, Venture Strategies for Health and Development (VSHD), VSI’s parent organization, began a program to explore misoprostol availability for the prevention and treatment of PPH. Despite evidence supporting misoprostol’s effectiveness for PPH management, there was limited evidence on how the drug could be distributed and used at the community-level.\(^11\) During this time, from a regulatory standpoint, misoprostol products were only registered for the prevention and treatment of gastric ulcers.

Between 2003 and 2005, VSHD and the Bixby Center for Population Health and Sustainability at the University of California, Berkeley, supported a community-level study in rural Tanzania that demonstrated that traditional birth attendants (TBAs) attending home births could successfully identify women with PPH and safely and effectively treat them using misoprostol.\(^12\) Other community-level studies that were initiated around this time also later documented similar successes for prevention of PPH.\(^10\)\(^13\)\(^14\)

In 2006, following a series of meetings convened by VSHD with government stakeholders and policy makers, professional medical associations, NGOs and regulatory agencies, Nigeria became the first country to grant regulatory approval of misoprostol for PPH prevention and treatment. Tanzania followed suit in 2007.\(^15\)

After these early successes, VSHD recognized that to ensure product availability, there was a need to move beyond simply facilitating regulatory approval of misoprostol. Developing policies for misoprostol use and generating evidence that documented how it could be successfully distributed and used were identified as key to ensuring that it could be integrated into health systems to enable its long-term availability and use.

REACHING WOMEN WHERE THEY ARE

In 2008, VSI was established as an independent organization with a mission to create access to effective and affordable maternal and reproductive health medicines and services that have the potential for large-scale impact. In order to achieve this mission, VSI expanded its approach from product registration to include two new and critical objectives which would help to lay the foundation for the sustained use of misoprostol in countries. The first objective was to develop and revise national policies that guide correct use of the drug. These included national essential

\(^1\) The prevention and treatment of PPH can be collectively referred to as “PPH management.”
medicines lists, clinical norms and protocols, pre-service curricula, and service delivery guidelines. These policy documents dictate the type of services and medicines that can be administered at each level of the health care system, and by which type of provider.

The second objective was to test and recommend innovative distribution strategies that would ensure that women who were unable to deliver at a health facility could access misoprostol. Given the many barriers that women face in accessing health facilities for delivery in low-income countries, particularly in rural areas, community-based distribution strategies were deemed essential to ensuring that all women, regardless of where they gave birth, would be protected from PPH.

**REGISTRATION FOR OBSTETRIC INDICATIONS**

At the time of VSI’s inception, misoprostol availability in most developing countries was limited to Cytotec, the originator product registered for prevention and treatment of gastric and peptic ulcers only. In a few countries, other products were also available, but none were registered for PPH with the exception of products in Nigeria and Tanzania. VSI worked with misoprostol manufacturers to convince them of the importance of registering products for obstetric indications, and then linked interested manufacturers with local pharmaceutical distributors who could import and distribute their products. Registration applications included clinical evidence that documented the safety and effectiveness of misoprostol for PPH management and package inserts that included dosage and administration guidelines. Regulatory approval allows a distributor to import the product and market it for the indications registered. Distributors can target private sector markets through pharmacies and clinics, as well as the public sector through government tenders to supply public sector facilities. This public/private sector approach helps to increase product availability and access for consumers, and became a programmatic strategy employed by VSI.

**POLICY CHANGE FOR INCREASING ACCESS**

Ensuring that national medicines and service delivery policies, clinical guidelines and training materials included correct and up-to-date evidence-based guidelines for the use of misoprostol was considered essential to ensuring its long-term correct use. To advocate for these policy revisions, VSI supported and convened meetings to educate stakeholders about the benefits of misoprostol and its potential to positively impact maternal health outcomes, especially if misoprostol is made available at the lowest levels of the health system where it could be
accessible to the most vulnerable women. Key stakeholders included representatives from Ministries of Health, professional medical, nursing and midwifery associations, and other civil society organizations.

Working with Ministries of Health and professional medical organizations at a series of technical working groups, participants reviewed clinical information, formulated guidelines and decided the level of facility where misoprostol could be used, and what level of provider (ranging from physicians to community health workers) could administer the medicine. These revised policies aimed to ensure that misoprostol was available at primary health care facilities and could be administered by lower-level providers such as primary care nurses to increase the drug’s availability and use.

At the outset of the earliest misoprostol programs, some policy makers were apprehensive that women receiving the drug for PPH prevention at the primary and community levels may misuse the drug – either by taking it at the wrong time or using it for termination of pregnancy. To address these concerns, VSI and partners developed and implemented operations research programs to create access to misoprostol for women delivering outside of facilities that demonstrated that women could safely and correctly use misoprostol for PPH management at the community level. These programs provided evidence to policy makers about correct use, and paved the way for the community-level use of the drug for PPH management in national policies.

Evaluating Distribution Models

Operations research programs were conducted in collaboration with Ministries of Health and local and international partners including professional medical associations and research institutions. Distribution models were designed to test safety, feasibility, acceptability and program effectiveness. Each model trained primary health care workers, community health workers and pregnant women themselves. One model that was evaluated in several countries involved the advanced distribution of misoprostol by health workers to women when they attended antenatal care. A second model utilized community health workers including traditional birth attendants, to either distribute misoprostol to women in advance of their delivery, or to attend the birth and administer misoprostol at the time of birth. All models incorporated an Information, Education and Communication (IEC) campaign aimed at educating women and communities about the importance of delivering in a facility with a skilled birth attendant and the use of misoprostol if giving birth at home. Findings from the operations
research were shared with a diverse group of stakeholders to generate country-level support for these distribution strategies, and provided evidence to support regulatory approval and policy changes.

III. THE FIRST PROGRAM: INTEGRATION OF MISOPROSTOL INTO HEALTH CARE SYSTEMS

PPH programs based on the three-pronged strategy of registration, policy change, and operations research to evaluate distribution models were carried out in nine countries between 2008 and 2014. In 13 other countries, operations research was not required and only registration and/or policy work was undertaken. In these countries, the Ministries of Health felt that given the urgency of the public health problem of PPH, the existing evidence base illustrating the feasibility and effectiveness of integrating misoprostol into health systems was sufficient to introduce the medicine.

Operations research programs using community-level distribution models provided compelling evidence that misoprostol could be safely used at home deliveries. This evidence was used by policy makers and regulators to approve the use of misoprostol, revise national clinical guidelines, and it served as a platform for the creation of national strategies and scale-up plans for expanding access to misoprostol for PPH at the community level.

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<tr>
<th>ACHIEVEMENTS OF MISOPROSTOL FOR POSTPARTUM HEMORRHAGE PROGRAM</th>
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<tr>
<td>Registration</td>
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<td>Operations research</td>
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<td>Clinical guidelines</td>
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<td>Essential medicines list</td>
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Programmatic outcomes in Bangladesh and Zambia illustrated scale-up efforts that are possible after successful operations research. In Bangladesh, for example, the operations research program distributed clean delivery kits (CDK) containing misoprostol to women at antenatal care visits (ANC). Of the 77,337 women who delivered in the program area, 70% received a CDK. Of the 67,611 of mothers who delivered at home and would not otherwise have received a uterotonic, 69% took misoprostol. The program’s success led to the incorporation of misoprostol for PPH into the *Bangladesh Health, Population and Nutrition Sector Development Plan (2011 – 2016)* as a priority intervention, and a phased national scale up of the model began in July 2011. In Zambia, where a model of misoprostol distribution at ANC was evaluated, almost half (49%) of the women delivering at home in intervention areas received misoprostol, whereas only 1% of women delivering at home in control areas (no misoprostol distribution) received a uterotonic drug. Based on this evidence, in 2012 the Zambian Ministry of Health authorized the expansion of misoprostol distribution at ANC for PPH prevention at home deliveries.
COUNTRY CASE STUDY
A SUCCESSFUL COMMUNITY-BASED DISTRIBUTION MODEL IN NIGERIA

While misoprostol had been registered for PPH prevention in Nigeria in 2006, uptake of misoprostol was slow and challenging, especially in areas such as the north of the country where a large proportion of women live in purdah, isolated from health facilities, and where over 92% of women deliver at home.

To address this challenge, in 2008 VSI, the Nigerian Ministry of Health, the Bixby Center for Population, Health and Sustainability at the University of California, Berkeley and Ahmadu Bello University designed and implemented a community-based distribution program that could effectively reach this group of women. In the model, community drug keepers, trusted community members who were selected by their communities, stored and then distributed misoprostol to pregnant women (or their families, if the woman herself could not come to pick up the drug) and traditional birth attendants, and kept records of the distribution. The study, conducted in three communities around the city of Zaria, was the first to leverage community drug keepers as distribution agents.20

The strategy was a great success. The availability of misoprostol protected 83% of women who delivered at home against PPH and who would not otherwise have been protected.21 As a direct result of the evidence generated by the program, the Guidelines for Community Use of Misoprostol for Prevention and Treatment of Postpartum Hemorrhage in Nigeria were approved in 2010, making Nigeria the first country to have in place community-level PPH guidelines for misoprostol.21 Additionally, Nigeria’s Federal Ministry of Health approved the inclusion of misoprostol on the country’s Essential Drug List (EDL) in 2008.22

Following the operations research, community-based distribution programs in Nigeria have continued to grow. The largest of these, the Targeted States High Impact Project (TSHIP) program led by John Snow, Inc. (JSI) uses a similar community drug keeper model in Bauchi and Sokoto states to distribute misoprostol for PPH prevention bundled with chlorhexidine for umbilical cord cleansing.23 Four additional states have set aside funds to start their own programs,24 and three states have submitted proposals for funding.

With policies in place to permit community-level distribution, the expansion of community-level programs occurring throughout the country, and both private- and public-sector procurement of the drug, misoprostol is increasingly available to Nigerian women when and where they need it.
IV. A NEW PROGRAM: INCREASING ACCESS TO ABORTION-RELATED SERVICES

POSTABORTION CARE

By the late 2000s, clinical studies had shown that misoprostol was as effective as manual vacuum aspiration (MVA) to treat incomplete abortion and miscarriage, a key component of postabortion care (PAC) programs.\textsuperscript{25} 26 27 28 29 Building on the success of the PPH work and the increasing global acceptance of misoprostol for maternal health, in 2009, VSI’s programs evolved to include the introduction and use of misoprostol for incomplete abortion and miscarriage. Six operations research projects successfully showed that misoprostol could be safely used for uterine evacuation by primary care providers, ranging from nurse assistants in Angola to primary care nurses in Zimbabwe, at the lowest levels of the health care system.\textsuperscript{30} This enabled the task-shifting of postabortion care services to lower level facilities such as peripheral health centers, which increased access for women, particularly those in rural areas who may face transport and financial challenges in reaching health facilities in urban areas. The findings contributed to success in policy changes and registrations.

<table>
<thead>
<tr>
<th>Achievements of the Misoprostol for Postabortion Care Program</th>
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<tbody>
<tr>
<td>Registration</td>
</tr>
<tr>
<td>15 registrations in 9 countries</td>
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<tr>
<td>Operations research</td>
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<tr>
<td>6 countries</td>
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<tr>
<td>Clinical guidelines</td>
</tr>
<tr>
<td>12 clinical guidelines in 9 countries</td>
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<tr>
<td>Essential medicines list</td>
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<td>5 countries</td>
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COUNTRY CASE STUDY

SCALING UP POSTABORTION CARE WITH MISOPROSTOL IN RWANDA

In 2012 VSI collaborated with the Rwandan Ministry of Health (MOH) to introduce misoprostol for PAC in four districts. With the support of VSI, technical working groups were convened to develop national postabortion care treatment guidelines and protocols and a curriculum for trainers and health providers. In addition, the group developed IEC materials including brochures and posters targeting health providers, women and their communities. As a result of the program, PAC services were integrated into the services of 50 health centers in the four districts, whereas only two facilities offered PAC services prior to the program. The program achieved rapid success, with 83% of PAC cases being treated with misoprostol over eight months of program implementation. Over half of all PAC cases were treated at health centers during the program, and by the end of the program health centers were treating 91% of presenting PAC cases.\textsuperscript{31}

In 2013, VSI expanded the PAC program in one district, training providers to use MVA as a complementary method to misoprostol. Organizations working in Rwanda (including Family Health Project, UNFPA, Chemonics and Partners in Health) have continued to scale up PAC programs
using the standard protocol and training materials developed in 2012. In 2014, scale-up of PAC service delivery was taking place in 21 of the country’s 30 districts.

The use of misoprostol is now fully integrated into the Rwanda Ministry of Health’s PAC training materials and a misoprostol product is widely available for use for both PAC and PPH. The government of Rwanda is firmly committed to expanding access to PAC in rural and underserved areas through the scale up of task-shifting strategies that include the use of primary health care workers to deliver services.

**Medical Abortion**

Of the 44 million abortions that take place each year, about half are unsafe. Almost all (98%) of these unsafe abortions occur in the world’s poorest countries, where they take a devastating toll on the health of women and adolescent girls. In 2008, there were 47,000 deaths from unsafe abortion, and in 2005, over 8.5 million women required medical treatment for complications, some of which can cause serious and permanent injury.

Since the 1990s, clinical evidence had demonstrated that the use of mifepristone and misoprostol for termination of pregnancy is safe and effective, and their use had been endorsed by the WHO first in 2005 and again in 2012. When used in the first trimester, the combination of mifepristone plus misoprostol results in successful abortion in over 95% of cases. Using only misoprostol in the first trimester, the rate of successful abortion is approximately 85%. By the end of 2010, mifepristone and/or the combination of mifepristone and misoprostol had been registered for termination of pregnancy in around 50 countries. Registrations were mostly in high- and middle-income countries and only three were in low-income countries.

In 2011, VSI initiated a program to increase access to safe abortion services using medication abortion. The beginnings of this program were rooted in an operations research program in Ethiopia, conducted by VSI and partners in 2008-2009, that successfully demonstrated that safe abortion services in the first trimester using misoprostol could be task-shifted to health extension workers working at health posts, the lowest formal level of the health system. Further work in a number of countries focused on registration and introduction of mifepristone and/or the combination pack of mifepristone and misoprostol for medical abortion and revising policy documents and training curricula to include their use.

<table>
<thead>
<tr>
<th>Achievements of the Medical Abortion Program</th>
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<tbody>
<tr>
<td>Registration</td>
<td>4 registrations in 3 countries&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Operations Research</td>
<td>2 countries</td>
</tr>
<tr>
<td>Guidelines</td>
<td>5 countries</td>
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<tr>
<td>Essential Medicines List</td>
<td>2 countries</td>
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</table>

<sup>1</sup> Misoprostol alone (1); mifepristone alone (1) mifepristone-misoprostol combination
COUNTRY CASE STUDY
INCREASING ACCESS TO SAFE ABORTION SERVICES IN RWANDA: PUTTING A NEW LAW INTO PRACTICE

In 2012, Rwanda’s penal code was revised to allow legal abortions in cases of rape, incest up to the second degree, forced marriage or when continuation of pregnancy seriously jeopardizes the health of the unborn baby or that of the pregnant woman.43 This change in the law meant that a much larger group of women could now obtain a legal abortion than was previously the case. In 2013, Rwanda’s Ministry of Health invited VSI to develop a program to help operationalize these changes and increase access to safe abortion services. Working with the Ministry of Health, Ministry of Justice, law enforcement and professional medical associations, the program developed and implemented strategies to overcome barriers to implementation of the penal code, which included lack of awareness of the revised penal code’s provisions among women, providers and other key stakeholders; and a lack of training on conducting safe abortion services. The partners jointly developed a guidance document on the processes and protocols that need to be in place in the health system to ensure that eligible women are able to access safe abortion services. The program has also developed clinical protocols and training materials for service delivery, trained 21 health providers to provide medication abortion services, and educated 200 community leaders on the abortion law and how and when to obtain a legal termination. The initial roll-out of services was implemented at eight hospitals across five districts in 2014 and the project results will be disseminated in early 2015.

V. CONTRIBUTIONS TO GLOBAL REPRODUCTIVE HEALTH POLICY

Since VSI was founded there has been a transformation in global attitudes toward the use of misoprostol and an acceptance of its important role in improving women’s reproductive health. VSI has collaborated closely with many organizations involved in this work, and together this group has contributed to successful changes in global maternal and reproductive health policies.

The evidence from clinical and implementation studies on community use of misoprostol for PPH prevention conducted by a wide range of national and international organizations and institutions has resulted in substantial changes in the international health policy arena, and led to a growing global consensus that misoprostol can be safely and effectively used in all settings where women give birth, including at home.44 45 Further, global recognition of the importance of misoprostol for postabortion care, supported by studies that have demonstrated its effectiveness to treat incomplete abortion,46 has resulted in a number of other significant international-level policy changes driven by a multitude of international organizations.
<table>
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<tr>
<th>Year</th>
<th>Source</th>
<th>Description</th>
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<tbody>
<tr>
<td>2006</td>
<td>International Confederation of Midwives (ICM) / International Federation of Gynaecology and Obstetrics (FIGO). Joint Statement.</td>
<td>“In situations where no oxytocin is available or birth attendants’ skills are limited, administering misoprostol soon after birth of the baby reduces the occurrence of hemorrhage”</td>
</tr>
<tr>
<td>2007</td>
<td>WHO Recommendations for the prevention of postpartum haemorrhage.</td>
<td>“In the absence of active management of the third stage of labour, a uterotonic drug (oxytocin or misoprostol) should be offered by a health worker trained in its use for prevention of PPH.”</td>
</tr>
<tr>
<td>2009</td>
<td>WHO guidelines for the management of postpartum haemorrhage and retained placenta.</td>
<td>“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”</td>
</tr>
<tr>
<td>2010</td>
<td>WHO Prequalification of Medicines Programme.</td>
<td>Misoprostol becomes eligible for prequalification.</td>
</tr>
<tr>
<td>2011</td>
<td>WHO Model List of Essential Medicines, 17th Edition.</td>
<td>Misoprostol added for PPH prevention when oxytocin is not available or cannot be safely used.</td>
</tr>
<tr>
<td>2012</td>
<td>WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage.</td>
<td>Guidelines endorse for the first time, the use of misoprostol by community health care workers and lay health workers in settings where skilled birth attendants are not present and oxytocin is unavailable.</td>
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<tr>
<td>2012</td>
<td>UN Commission on Life-Saving Commodities for Women and Children.</td>
<td>Misoprostol for PPH included in a list of 13 commodities that, if made more widely available, could save the lives of 6 million women and children.</td>
</tr>
<tr>
<td>2012</td>
<td>WHO Safe abortion: technical and policy guidelines for safe abortion.</td>
<td>Includes recommendations for the use of misoprostol for incomplete abortion and for termination of pregnancy if mifepristone is not available.</td>
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</table>
Many countries and global organizations are now initiating programs to distribute misoprostol for PPH prevention to women using trained community health workers; and countries are developing policies for its use. A 2012 survey of 37 countries in Africa, Asian and Latin America, revealed that almost half had conducted pilot programs on the use of misoprostol for PPH, and almost 60% had included it on their essential medicines list. Countries including Mozambique, Rwanda, Kenya, Uganda, Senegal, Burkina Faso and Bangladesh have piloted misoprostol for PAC programs and some are now integrating these services into their health systems. There is still much work to do to increase the availability and use of misoprostol, but these programs are helping to increase the numbers of births protected from PPH at home deliveries, raising awareness among women and their families of the importance of a facility delivery and the need to have a skilled birth attendant present when delivering, and bringing PAC services closer to women in need.

VI. KEYS TO SUCCESS

VSI’s programs on PPH and safe abortion involved product registration, policy change and operations research programs to evaluate successful models of distribution to women in need. This approach to product introduction can also be applied to new reproductive health commodities and technologies as they are developed and become available for deployment in the field. The outcomes of VSI’s programs on the introduction of misoprostol and mifepristone for obstetric indications have contributed to the increasingly widespread use of these drugs for obstetric indications. Four areas of activity in VSI’s approach were integral to the success of the organization’s maternal health programs.

First, regulatory approval for obstetric indications ensures that products contain instructions for correct use, which assists providers and helps to make their use acceptable in maternal health programs. Product registration also enables both public and private sector procurement and is considered a critical first step to expanding availability.

Second, in the policy arena, work on clinical and service delivery policies ensures that current best practices that are most suited to a country’s existing health system are incorporated into national guidelines. Important to this work is the identification of product champions in each country who can coordinate stakeholders and drive the agenda. Successes in developing new national policies help to build support for policy changes at the global level.

Third, in the area of service delivery, operations research programs evaluate innovative distribution mechanisms, many involving the task-shifting of services to primary level facilities. These programs generate evidence to help convince governments of the feasibility of integrating new health products into health systems in ways that could effectively bring services closer to women and girls in hard to reach rural areas.

Finally, the training of providers at all levels of the health system, including the community level, increases the capacity and capability of health systems to provide safe and effective maternal health services.
The combination of these activities has helped to introduce misoprostol and mifepristone into country health care systems. Their use in addressing critical maternal health problems including PPH and unsafe abortion can be important cost-effective strategies to improve maternal health outcomes.6 1 62 63 64 65

VII. LOOKING BACK, AND LOOKING FORWARD

The eight years since misoprostol was first registered for PPH prevention and treatment in Nigeria have seen an explosion in global interest around the use of misoprostol and mifepristone. Policies set by global organizations including the WHO, United Nations, the International Federation of Obstetricians and Gynecologists and others now advocate for the use of the drugs to address maternal health concerns. Social marketing organizations globally have taken up the mantle of product registration and introduction and as of late 2014, misoprostol products for obstetric use are registered in over 25 countries. Many of these countries are also revising policies to include the use of misoprostol for PPH management and safe abortion services. And, donor support has continually increased thus elevating the importance of scaling up country programs around the world.

Currently, many countries are not on target to meet the Millennium Development Goals (MDGs), however, as the global development community transitions to focusing on the Sustainable Development Goals (SDGs), reducing maternal mortality and morbidity will continue to be prioritized.66 Service delivery strategies and polices must be in place to reach the most vulnerable women for whom complications of pregnancy and unsafe abortion can have severe consequences. Postpartum and postabortion services must be comprehensive in order to maximize a woman’s interaction with the health system and these services must include family planning counseling and method provision, which is a important strategy for reducing maternal deaths. The work of VSI and others has shown that these essential health services can be effectively and safely task-shifted to the lowest levels of the health system, reaching women where they are. The World Health Organization, the United Nations and the global public health community must continue to prioritize misoprostol and mifepristone as countries strive to reduce their maternal mortality rates. In 2013, almost 250 women died each day from hemorrhage and abortion.2 Bold and expedient steps taken by the global health community to increase access to these two medicines can and will help countries meet the new SDGs of 2030.

ACKNOWLEDGMENTS

In addition to the immensely valuable contributions of VSI team members throughout the years, VSI wishes to acknowledge the valuable contributions of the expert staff and colleagues at partner organizations and government institutions, in particular our parent organization, Venture Strategies for Health and Development; the Bixby Center for Population, Health and Sustainability at the University of California, Berkeley; leaders at the many Ministries of Health with whom VSI has collaborated; medical, nursing, midwifery and civil society organizations, and universities, educational and research institutions that have worked with us to provide evidence and advocate
for improved access to life-saving medicines and services; and VSI’s country champions who have helped advance the goal of reducing maternal mortality. VSI also acknowledges the significant efforts of its field teams in each country who have supported our operations research and programming, including coordinators, supervisors, health management teams, doctors, nurses, midwives, community health workers and traditional birth attendants. Without this group of people, this work could not have been executed, or the women in project districts so skillfully served. VSI recognizes that work to change global health policies and attitudes towards the use of misoprostol has required a large and diverse group of actors including governmental and private donors, national and international nonprofit organizations, universities and civil society organizations around the globe. Their commitment to improving maternal health has been invaluable. Finally and most importantly, VSI is grateful for the participation of the many women and girls and their communities in the districts where we have worked over the years, for whom we hope our work has been of benefit. These “early adopters” have helped pave the way for improved access to medicines and services in communities across Africa and Asia.
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54 Application prepared by VSI and Gynuity Health Projects. Information about the application and the copies of the current Model List are available on the website of the WHO Model List of Essential Medicines http://www.who.int/medicines/publications/essentialmedicines/en/


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