Lessons learned: Scale-up of active management of the third stage of labor and challenges for misoprostol

Deborah Armbruster

PATH

USAID
FROM THE AMERICAN PEOPLE

POPPHI
Prevention of Postpartum Hemorrhage Initiative

Lesson learned: Definition of scale-up

Scaling-up =

Efforts to bring more quality benefits to more people over a wider geographical area more quickly , more equitably, and more lastingly.*

**International Institute for Rural Reconstruction"*

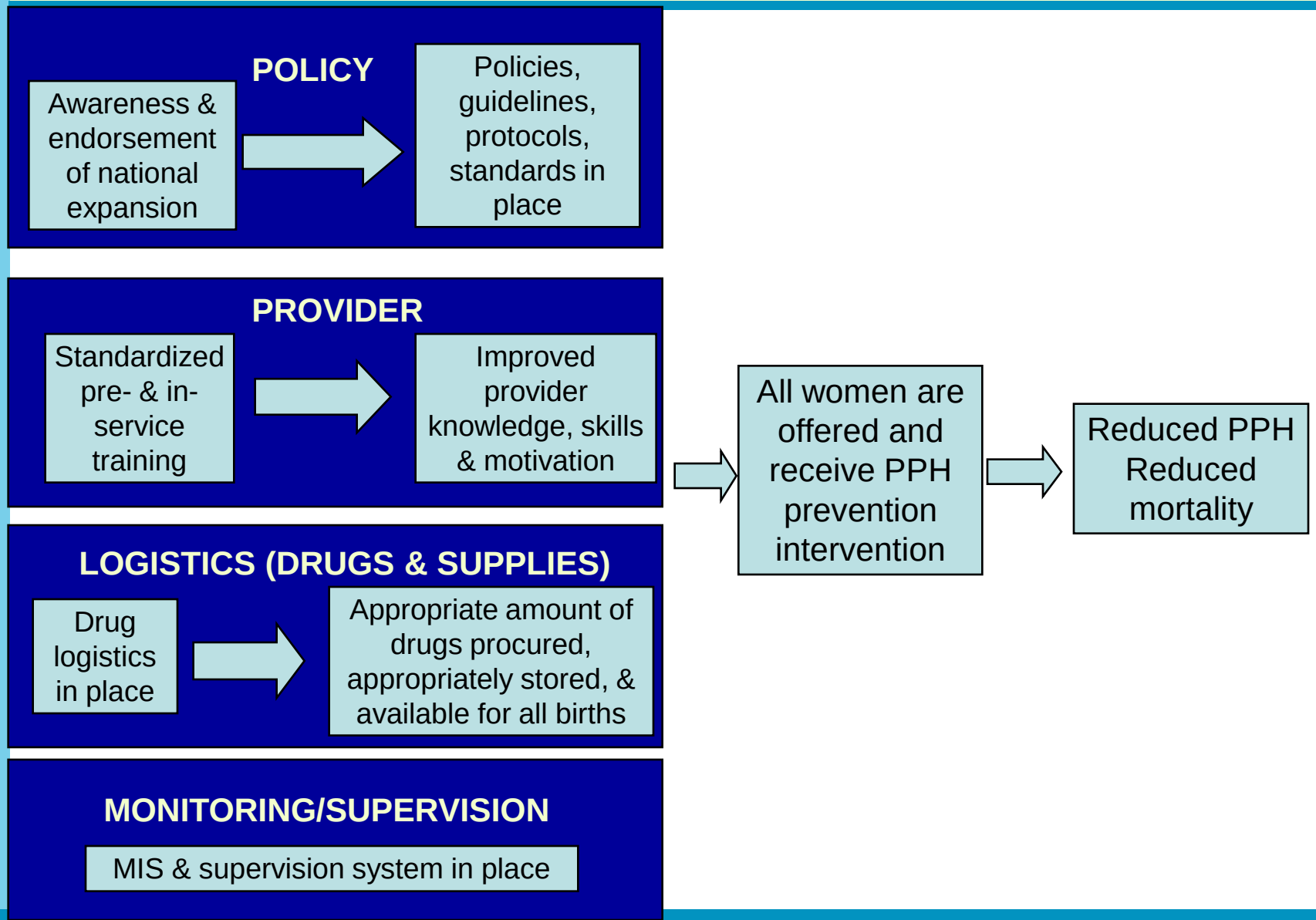
Lesson learned: Strategies to achieve scale-up

- Quantitative scale-up strategy
  - **Increasing number of beneficiaries**
- Functional scale-up strategy
  - **Expanding the number and types of technical interventions**
- Political scale-up strategy
  - **Addressing national level barriers through influence, policy change, etc.**
- Organizational scale-up strategy
  - **Improving its own or another organizations' ability to support an initiative**

Factors influencing success of “scaling-up”

- Predictable, adequate **funding** comes from both international and local sources for **at least 10 years**
- **Political leadership** and champions ensure visible high-level of commitment and maintain vision of “scale”
- **Existing systems** are used/ adapted to introduce project technologies at a **sustainable price**
- **Technical consensus** about the appropriate biomedical or public health approach exists
- **Good management** on the ground is in place to maintain **quality** of the project
- **Effective use of information** for action.

Critical elements for expansion of AMTSL



Lessons learned: AMTSL

- Sufficient time is needed
  - USAID has provided 6-7 yrs. of funding to date
- There is commitment from leadership: global, country, program, providers, logistics
- Identify the champions; support them and work with them

Lessons learned: AMTSL

- Involve and partner with multiple and varied groups (MOH, professional associations, private sector, NGOs, pharmacists/ drug distributors as all have a role to play)
- Identify barriers to the use and scale-up of AMTSL and address them

Lessons learned: AMTSL

- Motivation of providers is an issue

  - Why should they be bothered

  - Are there role models who provide quality care and routinely practice AMTSL

  - Do providers understand that AMTSL decreases PPH significantly and can save lives

Lessons learned: AMTSL

- Need to create win-win situations to encourage partners to work together. e.g.
  - Strengthening Pharmaceutical Systems project/ MSH
  - Health Tech for health technologies
  - Gynuity and Ventures Strategies
  - ACCESS

Lessons learned: AMTSL

- Struggle within midwifery related to philosophy of natural birth
- Should have a PPH prevention strategy that includes all necessary components: oxytocin for AMTSL and miso for community based care

Challenge for misoprostol scale-up in hospital settings (for PPH prevention)

- Oxytocin is available
  - **when would you need it?**
- Cost is significantly higher - $ 0.13 vs $.40
  - **why would you use it?**
- A logistics system that cannot get oxytocin out to facilities is not going to get misoprostol out to facilities
  - **why would you try to include it (use it or switch)?**

Challenge for misoprostol scale-up in hospital settings (for PPH prevention)

- WHO does not recommend misoprostol for AMTSL
  - **why would you recommend it?**
- It would be recommended for very peripheral clinics where there is no refrigeration and very irregular distribution of supplies – twice a year or so.

Challenge for misoprostol scale-up in hospital settings (for PPH prevention)

- If can deliver drugs quarterly, then can be creative and keep oxytocin in cool boxes or cool (as possible) spots.
- Use oxytocin in Uniject with TTI – would be no more costly than miso and may be less expensive in countries

Challenge for misoprostol scale-up in hospital settings (for PPH prevention)

- Oxytocin has recently been labeled as a “high alert” drug by the Institute for Safe Medications.
  - one of only 11 drugs to be identified this way
  - “bearing heightened risk of harm when they are used in error” and may “require special safeguards to reduce the risk of error”
- Miso is likely to follow as it becomes commonly used.

Challenge for misoprostol scale-up in hospital settings (for PPH prevention)

- There can be multiple agendas for use and the lack of transparency about the real use is problematic. Can create lack of trust on part of policy-makers.
- While PPH prevention may be the stated reason for use, when Marie Stopes (FP, STI and abortion services) requested the CD-ROM for PPH prevention, the agenda for use was quite clear.

Scale-up criteria: AMTSL & Misoprostol

Scale-up criteria	AMTSL	Misoprostol
Long term funding	yes	yes
Political leadership/ Champions in country	Global; prioritized in many countries but often missing the passion… except Mali	Global; passionate advocates; passionate foes; multiple agendas for use
Use existing systems at sustainable price	Yes – oxytocin available in system; including training in pre-service	Creating special systems but working to include in routine systems. Drug subsidized and distributed
Technical consensus	yes	no
Good management on ground/ quality	Sometimes but often needs improvement	Don't know
Effective use of information	Needs work	Absolutely

Challenge for misoprostol scale-up in hospital settings

Need to be more comprehensive in our look/ review of misoprostol:

- Need recognition that there are many uses for misoprostol:
  - **prevention, treatment, induction, augmentation, abortion**
- While use of miso for *prevention* of PPH in hospitals is not likely to be recommended or cost effective, misoprostol is a recommended alternative *treatment* for PPH.

Challenge for misoprostol scale-up in hospital settings

- Misoprostol may well be a safer *induction* modality when used at the very low doses and monitoring is minimal (no pumps, fetal heart monitors or adequate staffing)
  - WHO's current work on guidelines for induction (and hopefully augmentation) in low resource settings is very timely and needed

Challenge for misoprostol scale-up in hospital settings

- Do we have adequate data on the clinical use of oxytocin and miso and how to account for variations in use, dose and combinations?
  - Drug actions in the body (how effective is oxytocin when woman has been on an oxytocin drip for 24 hours and then she has a PPH?)
  - Should miso be recommended when a woman has been induced with oxytocin? Do we have evidence pro or con?
  - How best to combine the drugs to meet clinical demands?

Challenge for misoprostol scale-up in hospital settings

- Recognition that individual clinicians and others using these drugs may have only a small piece of the picture of how these drugs work and don't know or understand the multiple uses and the different doses for each use.
- The difficulty of obtaining miso in the correct dose for an important indication – induction – is of particular importance
  - the current practice of breaking up 200 mcg. tablets to get a 25 mcg. dose for induction is dangerous.

In Summary…

- Clear guidance on the use of misoprostol for all indications is necessary… in fact, is critical for the safety of women globally.
- This requires consensus from the experts on its use.
- Scale-up of misoprostol use in hospitals will be about *induction* and as an alternative for *treatment*…not *prevention.*
- The lack of transparency about use is likely to continue to impede efforts to make the drug available for its multiple uses.

THANK YOU