Interpretation of National Policy Regarding Community-Based Use of Misoprostol for Postpartum Hemorrhage Prevention in Ethiopia: A Tale of Two Regions

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INTRODUCTION

Women of reproductive age in developing world settings continue to suffer tremendously from pregnancy- and childbirth-related complications. In sub-Saharan Africa, the estimated ratio for maternal mortality is 500 deaths per 100,000 live births, down from 850 in 1990.1 Despite the gains that have been made, progress toward Millennium Development Goal 5 has been slow. Between 1990 and 2005, maternal mortality in sub-Saharan Africa has decreased at 2.6% per year, a rate well below the 5.5% annual decline needed to achieve a three-fourths reduction in maternal mortality.1

Because most life-threatening complications occur during or near birth, access to a skilled attendant (a health professional proficient in midwifery skills, such as a doctor, nurse-midwife, or nurse) and to emergency obstetric care are widely regarded as essential solutions.2,3 However, despite the necessity of these strategies, local conditions in many countries limit the extent to which this care can be made available to every woman who needs it. Lack of coverage, poor quality of care, and delayed care-seeking behavior all contribute to a situation in which many women do not receive care from a skilled attendant and are not likely to receive this care in the near future. The result of this reality is that local policy makers and program officers must often make critical decisions regarding the role of targeted, community-based interventions in efforts to improve maternal health.

Community and community-based refer to homes and small health facilities that are nonsurgical, nonphysician, and geographically remote.

Of great importance is the use of misoprostol (Cytotec) for postpartum hemorrhage (PPH) prevention in community settings with low coverage of higher-level, facility-based services. This intervention consists of 600 mcg of misoprostol given orally immediately after the birth of the newborn.4,5

To be clear, community-based use of misoprostol for PPH prevention should not be considered as a replacement for skilled attendants or emergency obstetric care, but rather as a supplementary intervention for women served by health systems that are not yet able to make more comprehensive services widely accessible. Nonetheless, officials tasked with developing maternal health policy in these countries may face challenges in reconciling priorities involving facility-based
services (eg, quality, quantity, and demand) with widespread implementation of a more targeted, community-based intervention. In response to early findings from the Maternal and Newborn Health in Ethiopia Partnership (MaNHEP) project, the purpose of this study was to examine understandings of national policy for community-based use of misoprostol to prevent PPH in 2 regions of Ethiopia: Amhara and Oromiya. After providing some background on PPH prevention in Ethiopia and on the MaNHEP project, we present a qualitative analysis of how national policy for this intervention was differently understood and implemented across and within these regions. We then discuss implications of our findings in relation to the wider global health policy arena and decision making for maternal health.

Prevention of Postpartum Hemorrhage in Ethiopia

Obstetric hemorrhage accounts for about 34% of maternal deaths in sub-Saharan Africa, making it the leading cause of maternal mortality in the region. Although it is difficult to determine precisely what proportion of obstetric hemorrhage is attributable to postpartum uterine atony versus antenatal complications or intrapartum lacerations, PPH is the most common type of obstetric hemorrhage and uterine atony is the most common cause of PPH. The most effective intervention for PPH prevention is active management of third-stage labor, which has been shown to reduce the risk of PPH by more than 60%. This intervention initially included administration of a uterotonic drug within one minute of birth, controlled cord traction, early cord clamping, and uterine massage after placental delivery. However, current research indicates that cord traction, early cord clamping, and uterine massage are not likely to contribute significantly to reducing the risk of PPH. These components aside, what is clear in the literature is that uterotonic drugs can safely and effectively prevent PPH.

The relative safety, efficacy, and effectiveness of misoprostol to reduce the incidence of PPH as compared to oxytocin, ergometrine, and placebo have been demonstrated in both health facilities and community contexts. In settings where active management of the third stage cannot be provided by a skilled attendant, the World Health Organization (WHO) and other global health organizations recommend that oral administration of misoprostol be offered to women by a trained community health worker for PPH prevention. A recent systematic review of community-based programs distributing misoprostol for home birth showed that these programs achieved high coverage with correct administration. Because misoprostol is heat stable and does not require injection, its administration and storage costs at the community level are substantially lower than those of other uterotonic drugs that depend on a cold chain or parenteral administration.

In Ethiopia, a great majority of the population resides in rural areas and about 90% of births occur at home without a skilled attendant. In 2010, the Drug Administration and Control Authority approved use of misoprostol tablets for oral administration to prevent PPH. In 2011, the Federal Ministry of Health aimed to ensure community-based implementation of this intervention as part of a core package of health services delivered through the existing Health Extension Program. Through this program, a guideline was developed for health extension workers to administer 600 mcg of oral misoprostol to women immediately after birth. These professionals are government-regulated, public health auxiliaries who provide basic services to rural communities, including birth attendance in homes and health posts. To improve self-care and uptake of health services, the federal government also initiated the Community Health Development Army—a program of volunteer agents responsible for educating fellow villagers on health-related matters and facilitating access to the services provided by health extension workers. This volunteer program is especially relevant to maternal health because health extension workers are estimated to attend fewer than 1% of births in the country. For reasons that likely include an insufficient numbers of trainees, conflicting job responsibilities, lack of confidence in skills, and women’s preferences for family members and traditional birth attendants (TBAs).

It is important to note that, although the federal government stipulates the overall responsibilities of health worker cadres, specific duties are often determined at regional and even district levels. Such local control is not uncommon in sub-Saharan Africa, where many countries are striving for decentralization in provision of public goods and services. With respect to the community-based use of misoprostol for PPH prevention, the main policy documents appear to be those related to the Health Extension Program. No policy that we could find specifies whether community health development agents, TBAs, or other laypersons can handle and administer misoprostol. In districts where the MaNHEP

Quick Points

- This study examined regional differences in health officials’ understandings and implementation of policy regarding community-based use of misoprostol (Cytotec) for postpartum hemorrhage (PPH) prevention in Ethiopia’s Amhara and Oromiya regions.
- Substantial differences were found between regions in the interpretation of national policy regarding PPH prevention and preferences for misoprostol administration.
- Systematic dissemination of national policy for community-based PPH prevention throughout the health system may facilitate expanded and increased coverage of this intervention across the country.
To achieve these aims, MaNHEP trained health extension workers, community health development agents, and TBAs to collaboratively provide a package of focused CMNH care and to educate pregnant women and family caregivers on this care. This training included the use of misoprostol for PPH prevention (dose, route, timing, and side effects) and was consistent for all of the health worker cadres. However, implementation (distribution and administration) took place in accordance with the regional regulations. The MaNHEP project purchased and supplied misoprostol to the district health offices in both regions.

Early in the implementation of MaNHEP, quality improvement data indicated a large discrepancy between regions with respect to use of misoprostol for PPH prevention. To better understand this difference, we examined regional trends from MaNHEP’s monthly quality improvement database (March 2011–October 2012) and from its endline survey of 1019 women who gave birth during the previous year (May 2012–July 2012). In both regions, the use of misoprostol increased rapidly at the start of the project and then stabilized for over 20 months in both regions; however, regional differences were persistent and large. Compared to Amhara, women in Oromiya were significantly more likely to be aware of and to receive this drug during pregnancy. Most notably, women in Oromiya were more than 9 times more likely to have used misoprostol at birth than those in Amhara (95% confidence interval [CI], 6.78-13.24), even when controlling for age, parity, education, and other factors.31

From this finding, we concluded that the multiple distribution channels available for misoprostol in Oromiya significantly increased access to this drug in this region. It was possible for women in Oromiya to attain misoprostol from a variety of health workers, either at birth or during pregnancy. In Amhara, the only community-based option that women had to receive this drug was from health extension workers immediately after giving birth. However, what still could not be explained was why these discrepancies in practice existed. We therefore conducted a qualitative study to explore how national policy for maternal health and PPH prevention was understood and implemented differently in the 2 regions.

**Prevention of Postpartum Hemorrhage in the MaNHEP Project**

From 2010 to 2013, MaNHEP partnered with the Ethiopia Federal Ministry of Health to improve implementation of community maternal and newborn health (CMNH) services, increase demand for these services, and improve self-care behaviors in 6 rural districts in the Amhara and Oromiya regions.30 To achieve these aims, MaNHEP trained health extension workers, community health development agents, and TBAs to collaboratively provide a package of focused CMNH care and to educate pregnant women and family caregivers on this care. This training included the use of misoprostol for PPH prevention (dose, route, timing, and side effects) and was consistent for all of the health worker cadres. However, implementation (distribution and administration) took place in accordance with the regional regulations. The MaNHEP project purchased and supplied misoprostol to the district health offices in both regions.

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**Methods**

To examine the policy context of community-based use of misoprostol for PPH prevention in the MaNHEP study setting, we interviewed 42 government officials between April and August of 2012. These officials were purposely selected for their involvement with maternal health policy or programs at different levels of administration, including the Federal Ministry of Health, the Amhara and Oromiya Regional Health Bureaus, zonal (subregional) health departments, and district (subzonal) health offices and health centers. To understand the views of representatives in nongovernmental organizations likely to influence relevant policy in Ethiopia, we also interviewed 9 local officials at institutions such as WHO, the United Nations International Emergency Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA), DKT Ethiopia, and professional organizations (obstetrics and midwifery). Table 1 provides a summary of the study participants.

Prior to the conduct of interviews, a semistructured interview guide was developed, pretested, and refined. The final interview guide consisted of 12 open-ended questions and probes designed to elicit participants’ understandings and views on 3 general categories: 1) national priorities regarding maternal health and national policy for PPH prevention, 2) the safety and effectiveness of community-based misoprostol for PPH prevention, and 3) preferences for administration of misoprostol for PPH prevention. The Emory University institutional review board, the Ethiopia Federal Ministry of Health, and the Amhara and Oromiya Regional Health Bureaus provided ethical approval for this project.

After conducting an informed consent process that specified the participant’s right to review and amend the transcript once completed, an experienced qualitative interviewer proceeded with the interview in a private setting. Individual interviews lasted an average of 45 minutes and were conducted in Amharic, Afan Oromo, or English. All officials invited for an interview agreed to participate, and 6 participants took the opportunity to review their transcript prior to analysis (making no substantive amendments). Audio recordings were transcribed and translated as needed, and then approximately 20% of the data were randomly checked against the original recording to verify accuracy. Final transcripts were entered into MAXQDA qualitative data analysis software32 and coded for key concepts by a single researcher using a
constant comparative method. Transcripts were first coded by administrative group (see Table 1). Predominant group responses and unique themes (as broader conceptual categories) were then identified within these groups. Finally, the newly identified responses and themes were correlated and contrasted across different groups and especially between the 2 regions.

RESULTS

The study results are presented according to 3 main groups representing the main administrative bodies of interest: federal and nongovernmental officials, Amhara officials, and Oromiya officials. The 3 topical categories just described were explored within each of these groups, as well as within administrative subgroups (regional, zonal, and district) for each region. Specific titles and administrative levels are not given for the selected quotations to protect participants’ identities.

National Maternal Health Priorities and Policy Regarding Postpartum Hemorrhage Prevention

Federal and Nongovernmental Officials

Predominant responses to questions regarding national maternal health priorities were as follows: maternal health is indeed a high national priority; PPH is a major contributor to maternal mortality; and PPH prevention is essential for saving lives. These officials frequently cited Millennium Development Goal 5 as well as the slogan, “No woman should die giving life.” However, despite acknowledging the critical role of PPH prevention in reducing maternal mortality, an overriding theme was a preference for a broader health system approach rather than implementing PPH prevention as a stand-alone or vertical intervention. Diverse strategies discussed as components of this broad approach included emergency obstetric care; antenatal and postnatal care; transport and referral mechanisms; nutritional supplements; family planning; and most commonly, increasing the number of births taking place in a health facility.

It is impossible to solve the problem by giving focus to misoprostol alone. Other services—antenatal care, postnatal care, and basic and comprehensive emergency obstetric care at health facilities—must also be given focus. It is only when we integrate all of these things that we will be able to reduce maternal mortality.

Confusion or ambivalence regarding the existence of an official policy for community-based use of misoprostol to prevent PPH was another theme that emerged from this group. Some officials referred to the 2011 Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality, while others said that the policy is implied in the drug’s national approval and registration. Despite the current guideline for health extension workers, most of these officials were uncertain as to whether any official policy had been approved, and some expressed a need for a more specific policy guideline.

There is a general policy that guides us. But how should misoprostol be given? Who should it be given to? How it should be implemented? A document that includes all of these things should be compiled. I think there is much that has not been done.

Finally, these officials felt that federal policy should be uniform across and within different administrative levels, but due to allowances for regions to adopt their own implementation strategies, practice of this policy can vary. Other reasons suggested for regional differences included systematic inconsistencies in drug supply, training, and professional (or personal) commitment among lower-level officials and health workers. Most officials conceded that, without more specific guidelines, consistent implementation across regions, zones, and districts is unlikely.

“You only have one country; everything generates from there. But specific implementation procedures could vary from region to region because we don’t set all of these (procedures). There is no question about that.”

Amhara Officials

In terms of national priorities for maternal health, the Amhara officials placed great emphasis on increasing the number of women giving birth in health facilities—so much so that the preference for this strategy became its own theme among this group. Community-based interventions were considered to be a less preferable strategy, which should be veered away from if possible. Confusion or lack of awareness about the existence of a specific policy for PPH prevention was also apparent, with many officials expressing concerns about the use of misoprostol outside of a health facility. The district officials were especially cautious, often voicing fears about potentially encouraging home birth with community-based misoprostol—and thus deviating away from the strategy to increase use of facilities for birth.

Priority is given to create access for mothers and to expand health facilities and professionals. If a mother goes to a health facility, the problem of PPH can be prevented.

I think the government permits health extension workers to give misoprostol to mothers immediately after birth. I participated in a meeting on this issue. But it was said that this drug encourages home birth and reduces birth in facilities.

Oromiya Officials

Regarding national maternal health priorities, Oromiya officials responded similarly to officials at the federal level and in Amhara. However, these officials stressed the broader goal to reduce maternal mortality while acknowledging but downplaying the strategy to increase the number of facility-based births as a means of accomplishing this goal. None were aware of an existing federal policy specific to community-based PPH prevention, but most indicated that misoprostol was currently being used at births in homes and health posts and could describe this practice in detail.

I have never heard of a policy that specifies use of this drug. But clearly there is a policy that says no mother should die giving birth. That means not from PPH, one of the main
causes of maternal death. Misoprostol is one of the best ways to prevent it.

A unique theme emerging from this group involved empowerment in terms of raising community awareness, education, and responsibility for maternal health. In other words, pregnant women and their families need to know how to protect themselves and what resources are available to them, including misoprostol to prevent PPH. In response to the strategy to increase the number of facility-based births, describing a birth as "unexpected," "accidental," or "an emergency" often justified use of misoprostol in homes.

The main thing in preventing PPH is for a woman to give birth at a health facility. But we also want her to know about her own health and to get information. If she unexpectedly gives birth at home, there is a new drug known as misoprostol that can help.

Perceived Safety and Effectiveness of Using Community-Based Misoprostol for Postpartum Hemorrhage Prevention

Federal and Nongovernmental Officials

On the whole, the response of these officials was that misoprostol is highly effective in preventing PPH, if not the most effective drug (which some said is oxytocin). About half were unwilling to commit to the safety of misoprostol, either stating that they personally did not have enough knowledge or indicating a need for more research. Concerns over mishandling by untrained persons and misuse for unsafe abortion was a primary theme. However, despite doubts about safety issues and alongside a caveat that this drug is only a temporary solution until numbers of facility-based births can be increased, these officials indicated that misoprostol is the drug of choice at the community level—both for practical reasons and because there are no better alternatives.

There is no question about misoprostol at the community level ... you have no other choice. For oxytocin you have to move around with a refrigerator to keep the cold chain. In rural communities this is not possible. There is nothing science has yet discovered that matches misoprostol—at the community level.

PPH is not predictable. It can occur at any time. So I feel this drug is fundamental. But I don’t think we should consider it our final solution. In the interim we can use misoprostol as a strategy.

Amhara Officials

Although Amhara officials also viewed misoprostol as being effective in preventing PPH, the theme pertaining to fear of misuse was also apparent. The most commonly cited safety concerns in this group included administration in the event of an undiagnosed twin (leading to a fatal outcome), administration during labor (causing uterine rupture), and use for unsafe abortion. Although these officials generally favored misoprostol in response to the question of what should be the drug of choice for PPH prevention at the community level, many continued to insist that birth should take place in health facilities despite the challenges of serving laboring women in remote areas.

During birth, tissues may tear and need to be stitched together. No one should overestimate misoprostol because many things can cause bleeding. What will happen if the drug is given when the woman is still in labor? Or if there is another baby (twin)? Or perhaps it may be used unsafely for other purposes … A woman can die.

Oromiya Officials

The predominant response among Oromiya officials was that misoprostol is safe, effective, and greatly beneficial as compared to its risks. These officials unequivocally felt that misoprostol should be the first choice for PPH prevention in the community and were confident that this drug could be used feasibly and reliably in cases of unexpected home birth. Like officials in other groups, many discussed the practical value of this intervention and its ease of use for saving women’s lives in conditions lacking basic infrastructure. But unlike the officials in Amhara, these officials repeatedly discussed the demand among pregnant women and family members for obtaining misoprostol to prevent PPH.

You know, if some people in our rural community become aware, they will communicate with their friends and relatives ... what they have taken and how it benefited them. This is happening with misoprostol. That people are coming and demanding it is alone evidence of its safety and effectiveness. What other evidence is necessary?

Preferences for Administration of Misoprostol for Postpartum Hemorrhage Prevention

Federal and Nongovernmental Officials

Despite occasional reservations about promoting home birth, all of these officials indicated that health extension workers are permitted to administer misoprostol in homes and in rural health posts. However, most federal officials did not believe that community health development agents or other community members (including TBAs) should perform this duty and were also against distribution of the drug during pregnancy with training for self-administration. Primary reasons for this opposition again included concerns about misuse, as well as issues related to improper storage and a perception that “rural people” have a limited ability to understand and follow instructions.

“The community volunteers provide ‘simple and consistent messages.’ They inform mothers to immunize children and use antenatal care and give birth in facilities. They are message transmitters only. The health extension workers implement the drug.”

Amhara Officials

As with the federal officials, Amhara officials felt that health extension workers are the “lowest-level” health workers that should be permitted to administer misoprostol. Some were not even in full support of this policy, reiterating the importance of encouraging women to come to health facilities for
birth. It was unanimous among these officials that community health development agents and TBAs should not administer this drug. Besides the above-mentioned fears concerning intrapartum administration, undiagnosed multiple gestation, unsafe abortion, and improper storage, another reason given for this resistance included potential “medication sharing” with family and friends.

The volunteers cannot distinguish one kind of drug from another. Also, in accordance with our tradition, people share medication with each other. They could distribute it for … other purposes. They may not keep it properly or they may even use it after its expiration date.

While the majority of Amhara officials responded in opposition to advance distribution of misoprostol during pregnancy for self-administration (frequently referring to the “stressful” situation of laboring women and the likelihood that they would forget to take the drug), a few were notably open to this idea. These officials compared current practice in Amhara to that of Oromiya and Tigray regions, accepting that this strategy may be effective in saving women’s lives. Nonetheless, the prevailing sentiment related back to a perceived critical need to increase numbers of facility-based births; namely, fear of giving women a drug that may convey a false sense of security for home birth.

The government (Regional Health Bureau) hypothesizes that a mother will not come to a facility if the drug is in her home … that she may be overconfident. But mothers could also die if we don’t allow them to keep this drug at home. I hope no one will hold me to this, but I believe it’s a good idea to give the drug to the woman.

Women and families will feel a false security and will forget that they still need to go to the health facility. Having the medication at home will cause the mother to stay there longer.

**Oromiya Officials**

The Oromiya officials all agreed that health extension workers can and should administer misoprostol. Regional and zonal officials were less confident about community health development agents but were more supportive than their counterparts in Amhara. District officials enthusiastically supported the strategy to train community development agents to administer misoprostol. Many preferred that these volunteers (as well as trained TBAs and family members) administer misoprostol over health extension workers because they are closer to laboring women and can more reliably deliver the drug. The theme emerging from this group with respect to administration was highly pragmatic: So long as they are properly trained, any adult should be able to give misoprostol for PPH prevention.

If things happen accidentally before the mother gets to a health facility, there should be an alternative. The health extension workers cannot cover the whole village. In light of saving her life, I think these volunteers can give the drug to her.

I don’t differentiate between the health extension workers and the trained volunteers or the TBAs or anyone else. As long as they have received the proper training, they are more than capable of administering the drug.

In terms of advance distribution and training pregnant women for self-administration, the regional and zonal officials in Oromiya again expressed mixed views, whereas district officials exhibited clear feelings that mothers in rural areas should be able to prevent PPH on their own. Consistent with the theme of empowerment, a few of these officials seemed to take some personal initiative in implementing PPH prevention strategies. As one district official remarked, “We just thought it would be a good idea in our district to give (the drug) to the mother herself, and so far we’ve seen good results.”

Of course it’s possible. If amoxicillin or some malaria drug is prescribed every 6 hours, it is self-administered. It (misoprostol) is the same thing… Once they have been trained, it is better that the mothers keep it than the health extension workers or volunteers.

In our country we have 2 choices. We can make use of the resources we currently have and accept the risks. Or we can wait until qualified health professionals are available in each locality and lose people. So, we look at the balance and do what we can.

**DISCUSSION**

The qualitative data reveal ambivalence among health officials about the existence and content of a national policy for community-based use of misoprostol for PPH prevention. Despite this general uncertainty, patterns emerged that are consistent with the regional differences found in the MaNHEP quantitative data. With few exceptions, Amhara officials were averse to deviating from what they viewed as the clear national priority for maternal health—to increase the number of facility-based births. At every administrative level, these officials also expressed fear about a range of potential consequences that could result from misuse of misoprostol. Such concerns were reflected in the regional decision to allow only health extension workers to administer the drug at the community level. Although Oromiya officials also recognized that increasing births in health facilities is a national goal, they tended to frame the policy priority in broader terms—to reduce maternal mortality. These officials reasoned that any effective intervention for accomplishing this larger goal was in keeping with national policy. They also incorporated leniency into the strategy involving facility-based birth by labeling home birth as “accidental” and frankly acknowledging local realities. Last, the Oromiya officials seemed to adopt strategies that fostered empowerment, both in terms of permitting a range of trained health workers to administer misoprostol and by encouraging women and families to take charge of their own health and well-being.

This analysis illustrates how national policy to reduce maternal mortality and prevent PPH can be implemented differently in diverse, within-country contexts. These differences were particularly apparent at the district level, which is where
policy plays out as practice on a day-to-day basis. The decentralization of public services, the relative nonspecificity of higher-level policy, and a lack of communication of the policy that does exist left the door open for local interpretation, which appears to play a critical role in how, where, and especially by who misoprostol for PPH prevention is implemented. These results demonstrate a major strength of qualitative research, which is the ability to offer valid insight that addresses the why of observed statistical patterns and associations. The most important limitation of this study involves potential response bias that the in-depth interviews may have been subject to, given the prominent positions of the interviewees. However, the fact that few officials requested to review their own transcript suggests that the interview content was not overly sensitive, and the forthright manner in which most officials responded to the topics lends additional credibility to the validity of the results.

**Implications for Maternal Health Policy in Low-Income Settings**

In the past decade, global health has seen a substantial push toward the strengthening of health systems and something of a move away from vertical, disease-specific interventions. Despite a relatively weak evidence base and questions about sustainability, many highly influential global health organizations have endorsed this approach. However, in some settings, targeted maternal health interventions can still play a critical role alongside more horizontal strategies such as emergency obstetric care. Although the evidence for advance antenatal distribution is inconclusive, the safety and effectiveness of misoprostol for PPH prevention have been well established. The feasibility of implementing this intervention in community settings has also been documented. Finally, misoprostol for PPH prevention has been shown to be extremely cost-effective for saving lives in developing countries as compared to several other maternal health interventions.

Nonetheless, even if a particular intervention is shown to be safe, effective, feasible, and efficient, the question remains as to whether it will be acceptable. As reflected in this study, some policy makers or program officers may be reluctant to promote a community-based maternal health intervention if they feel that home birth could potentially increase as a result. A strategy to make misoprostol widely available at the community level for PPH prevention may also face political barriers from concerns over misuse by providers seen as unqualified or unease about the drug's abortifacient properties. A few key studies shed light on how political priority for maternal health is generated in developing countries and on how knowledge in the form of evidence-based practice translates to policy in these settings. However, far more research is needed regarding complex processes by which specific interventions are enacted as policy in diverse global contexts.

As concluded in our quantitative analysis of MnHEP data, as well as in a recent systematic review, a strategy that permits multiple channels of misoprostol distribution (ie, trained community health workers or advance distribution with trained childbearing women and family caregivers) has great potential to increase PPH prevention coverage and to save women's lives. At the same time, there is not a single solution for all countries, and individual countries need not adopt a singular approach. In this vein, a usable framework is available to assist policy makers in context-driven decision making for community-based PPH prevention by providing a standardized means of employing existing evidence to evaluate how, where, and under what circumstances it makes sense to implement this intervention. Regardless of the particular approach, the objective is to expand a medical advance that improves maternal survival for women who are not likely to reach skilled attendants or emergency obstetric care. The results of this study suggest that a deliberate, clear, and specific national policy that is systematically communicated throughout all levels of a country's health system may be fundamental for achieving this goal.

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**CONFLICT OF INTEREST**

The authors have no conflicts of interest.

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