



Misoprostol: A Key Resource for Maternal Health Programs

Women are dying in childbirth—and overwhelmingly due to excessive bleeding after childbirth, or postpartum hemorrhage (PPH). Effective maternal health programs must address this life-threatening condition. Misoprostol is a heat-stable tablet that is taken after the birth of the newborn to effectively control PPH. Three tablets are taken orally to prevent PPH or five tablets are taken rectally to treat PPH once it occurs.

Misoprostol should be considered a key intervention to curb maternal mortality.

Why misoprostol?

- ✓ **Excellent safety profile:** extensive research has shown misoprostol is safe for the prevention and treatment of PPH (blood loss greater than 500ml)¹ and there is no reasonable fear of overdose when using misoprostol to control PPH.
- ✓ **Extremely effective:** misoprostol stops PPH within minutes.^{2,3} Misoprostol is a prostaglandin-E1 analogue and stops bleeding after delivery by causing the uterus to contract.
- ✓ **Minimal, if any symptoms:** symptoms associated with its use occasionally include shivering, increased body temperature, nausea, vomiting and/or diarrhea. These symptoms are not life-threatening, and can be managed at the household level.
- ✓ **Ideal prophylaxis and treatment** because it is:
 - **Inexpensive:** misoprostol is an off-patent, generic drug
 - **Heat stable:** misoprostol can be stored at room temperature for three years⁴
 - **Easily administered:** misoprostol tablets can be taken orally or rectally
- ✓ **Key policy endorsements:** leading international health experts recommend misoprostol in precisely the settings where maternal health programs are needed most: poor, often rural communities where women deliver at home, out of reach of the healthcare system.^{5,6}

“...in home births without a skilled attendant, misoprostol may be the only technology available to control PPH.”

International Confederation of
Gynecology and Obstetrics
Joint Statement
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“In the absence of active management of the third stage of labor, a uterotonic drug (oxytocin or misoprostol) should be offered by a health worker trained in its use for prevention of PPH.”

The World Health Organization (WHO)
Recommendation #7
October 2006

Who can provide misoprostol?

- Research has shown that misoprostol can be safely administered by traditional birth attendants and the mother herself.^{7,8}
- In community settings in Tanzania⁹ and Zambia, an everyday cloth (kanga or chitenge) is a culturally appropriate tool for measuring blood loss. Community providers know that two soaked cloths is too much blood loss.
- WHO defines “a trained health worker” broadly and acknowledges that depending upon the setting, “healthcare providers such as auxiliary nurse-midwives, community midwives, village midwives, and health visitors may have also acquired appropriate skills [for the administration of misoprostol], if they have been specially trained.”⁵

Note: VSI facilitates the registration and distribution of misoprostol because of its tremendous potential to save lives, and makes no money from its sale.

References

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