CASE STUDY

SOMALILAND

PREVENTION & TREATMENT OF POST-PARTUM HEMORRHAGE IN SOMALILAND:
NAVIGATING A COMPLEX COURSE TO GREATER HEALTH IMPACT
**SOMALILAND SITUATION ANALYSIS**

Somalia is ranked 161 out of 163 states in UNDP’s 2001 global human development index, with maternal, newborn and child mortality and morbidity rates among the highest in the world. The northwestern part of the country, known as the Republic of Somaliland, declared independence from the rest of Somalia in 1991; however, it has not yet received recognition from the international community. Although more stable than some areas of Somalia, Somaliland remains a fragile state with low capacity to offer health services. The services which are available are fragmented, poorly financed and have inadequate infrastructure and staffing, making it difficult to provide more than the most basic health services to the majority of the population.

Somali women are particularly vulnerable; Somaliland’s maternal mortality rate is estimated at 1,013 per 100,000 live births – one of the highest in the world. Post-partum hemorrhage (PPH) is the leading cause of maternal mortality worldwide, accounting for 34 percent of maternal deaths in Africa. In Somaliland, modern CPR is low at 4.6 percent of women aged 15-49 with a high total fertility rate of 5.9 births per woman. The high fertility rate means that women are repeatedly exposed to the risks associated with childbirth over their lifetime.

In addition, in Somaliland cultural and religious beliefs strongly influence social norms and values. Large family size is praised and encouraged in Somali society, while discussion of sexual and reproductive health is generally taboo, leading to significant gaps in knowledge on healthy behaviors. Low levels of education and literacy, especially among women and the largely rural population, combined with harmful traditional practices – an estimated 94 percent of women have undergone female genital cutting – only exacerbate the problem. Implementing a program to address sexual and reproductive health issues in this context is beset with potential landmines and must be navigated with caution and sensitivity.

With support from the Dutch Government under the Strategic Alliance with International Non-Governmental Organisations (SALIN), PSI/Somaliland is working to reduce the high maternal mortality rate through the distribution of the uterotonic drug misoprostol for the prevention and treatment of post-partum haemorrhage, complemented by a targeted behavioural change communications (BCC) program promoting safe motherhood practices.

**MISOPROSTOL FOR THE PREVENTION AND TREATMENT OF PPH**

Misoprostol is a safe and effective uterotonic drug that can be used to prevent and treat PPH when oxytocin is not available. When used for prevention, the recommended dose is 600 mcg (3 tablets) administered orally immediately after delivery. This has been shown to significantly reduce the incidence of PPH. Unlike other options for preventing and treating PPH, misoprostol is simple to administer, easy to store, does not require refrigeration and has a long shelf life. Other uterotonic drugs such as oxytocin require a cold chain, as well as a skilled provider who can administer an injection, both of which are limited outside of hospitals and larger public health facilities in Somaliland.

Together with Venture Strategies Innovations (VSI), an organization that supports the use of misoprostol in more than 10 countries, PSI/Somaliland developed its misoprostol brand, distribution and communication strategy. Given sensitivities around the alternative use of misoprostol as an abortifacient, approval to import the drug and authorization to distribute were achieved through sustained advocacy efforts by the partners over several months. PSI/Somaliland was able to gain support for the project from the government of Somaliland and key players in the medical community. The Somaliland Ministry of Health (MoH) approved and signed an agreement outlining the misoprostol program which has been included as an addendum to PSI/Somaliland’s Memorandum of Understanding with the Government. PSI/Somaliland is distributing misoprostol under the local brand name *Ummul-gargaar*, which translates to “new mother helper.”

**DESIGNING THE PROGRAM STRATEGY**

Based on information gathered from the reproductive health community and taking into consideration the realities of the current health system and its available resources, PSI/Somaliland and Venture Strategies designed an initial strategy focused on distribution of the drug through public maternal and child health (MCH) clinics, the lowest level in the public health system with delivery services, and to health posts (HPs) where the drug would be made available to the many traditional birth attendants (TBAs) and midwives affiliated with these health facilities. Due to the considerable number of home deliveries and reliance on TBAs, the strategy aimed to reach women at the household level, training TBAs to correctly and safely administer misoprostol for the prevention and treatment of PPH for deliveries occurring at home.

PSI/Somaliland proposed this distribution strategy in consideration of the weak health infrastructure in Somaliland which, at least in the short term, needs significant investment to increase the rate of births at health facilities. Yet there were fears among the local RH community and within the MoH that empowering TBAs could have negative consequences, such as encouraging women to continue to deliver at home, unattended by a skilled professional. Another concern was that allowing TBAs access to the drug could result in the use...
of misoprostol for abortion, while in Somaliland abortion is illegal. Although some women do seek to terminate their pregnancy, abortion is deeply frowned upon and services are primarily performed by unskilled providers using unsafe methods.

In response to the political situation and a subsequent request from the MoH, PSI/Somaliland revised its implementation plan to refocus distribution of misoprostol to trained health professionals only – doctors, nurses and midwives – and only make misoprostol available to women during facility-based deliveries. In a pilot intervention, misoprostol was distributed through maternity hospitals for use during deliveries when oxytocin is unavailable. This initial step was taken in order to demonstrate the effectiveness of the project's control systems over the distribution chain, the safety and acceptability of misoprostol use among providers and the health impact of the drug in preventing and treating PPH in the Somaliland context. The initial phase was followed by distribution to maternal and child health clinics in the Maroodi-Jeex region. Pending MoH guidance following this phase, distribution will be expanded to MCHs in all six regions of Somaliland.

### TARGETED COMMUNICATIONS

To address the reduction in potential access to the drug resulting from the inability to distribute through TBAs at the community level, PSI/Somaliland expanded its communications strategy by adding an extensive Interpersonal Communication (IPC) component promoting safe motherhood practices and encouraging women to deliver in health facilities, especially those with oxytocin or misoprostol. While this strategy does not address the immediate need for misoprostol in home delivery settings, it is designed to increase demand for health facility-based deliveries and, indirectly, for uterotonic drugs, namely oxytocin and misoprostol.

A Safe Motherhood IPC toolkit was developed taking into account the shift in the PPH project strategy. In addition to increasing demand for uterotonics, other aspects of safe delivery and safe motherhood have been added to the scope of the BCC program. Key objectives of the IPC program are first to increase the number of married women of reproductive age who utilize the MCH clinics for ante-natal, delivery and post-natal services, and second, to increase knowledge, awareness and demand for modern birth spacing methods. The IPC strategy links PSI/Somaliland’s PPH and birth spacing program objectives, creating a broader campaign addressing multiple reproductive health issues. The IPC agent activities support and connect women to safe motherhood services and products available in their community. Agents work to motivate women to seek birth spacing and safe delivery services at hospitals and MCHs, and thereby receive oxytocin or misoprostol, as well as access birth spacing products at nearby pharmacies. The IPC project aims to address the larger issue of maternal mortality beyond PPH, resulting in more comprehensive programs and greater health impact at the goal level.

### CHALLENGES ENCOUNTERED

In December 2009 a local newspaper published an article accusing the MoH and PSI/Somaliland of breaking the law by promoting an abortion pill. The article presented a serious threat to the program and reappeared on several Somali language news websites. PSI/Somaliland worked closely with the Minister of Health to prevent opposition towards misoprostol from rising. The Minister issued a press release clarifying that the sole indication of misoprostol in Somaliland is for the prevention and treatment of PPH, and emphasizing its significance as a life-saving drug for Somali women. The press release was carried by several newspapers as well as broadcast by television and radio news programs. In addition, PSI/Somaliland asked a prominent Somali gynecologist to speak on the radio in support of misoprostol as an important life-saving drug. No further opposition was raised following these crisis management efforts. However, these types of incidences remain a risk to the project due to cultural sensitivities around sexual and reproductive health in Somaliland.

### ALLAYING THE FEARS

In order to garner support for the program and to dispel the myth that the drug would be used for alternative purposes in Somaliland, PSI/Somaliland took several steps to ensure close monitoring of the program. Health facilities that perform deliveries on-site and have received PSI/Somaliland training are eligible to receive *Ummul-gargaar*, in accordance with the phased roll-out plan. Each facility is required to sign an agreement with PSI/Somaliland, which is approved by the Regional Health Office and the central Ministry. The agreement includes the terms of distribution, roles and responsibilities of each partner, and penalties for violations, including discontinuance of distribution for severe or repeated infringement of the agreement. In order to ensure quality, PSI/Somaliland trained 33 doctors and 644 nurses and midwives nationwide, reinforcing their knowledge about PPH, skills around the active management of the third stage of labor and the correct use of misoprostol in the absence of oxytocin. Prior to distribution, key staff at each facility are trained in sales and record keeping by PSI/Somaliland. During the first three months of the program, PSI/Somaliland visited each facility bi-weekly with a member of the Regional Health Office. Distribution records and current stock are closely monitored during supervisory visits to ensure quality standards. As an additional control measure to ensure a tight distribution chain, a coding system was developed so that each blister pack can be traced back to the original facility that received it.
CONTROLLED EXPANSION

In April 2010, PSI/Somaliland launched misoprostol at five hospitals in the Maroodi Jeex region. Due to the sensitivities around the drug, PSI/Somaliland opted for a low-profile launch and aims to build the reputation of Ummul-gargaar through targeted communications and demonstrated effectiveness of the drug. The project will need to develop slowly so that PSI/Somaliland can ensure a quality intervention and demonstrate control over drug distribution. PSI/Somaliland will expand the program as appropriate to all regions over the coming six months. To date, Ummul-gargaar misoprostol has been given to 2,100 women for prevention of PPH and 113 women for treatment of PPH through nine health facilities in four regions of Somaliland.

LESSONS LEARNED

While PSI/Somaliland was able to secure strong support among the wider health community early on, political support proved to be a critical component to the project’s success. Some doctors and MoH officials were concerned that the lack of a strong regulatory environment and low capacity for monitoring activities at the government level would lead to non-indicated use of misoprostol. PSI/Somaliland worked carefully to overcome this challenge by continuing a dialogue with all parties, emphasizing training for health professionals, creating a strong monitoring system and designing a stringent distribution chain that could identify sources of leakage.

Although the MoH was involved in the program design and development process, PSI/Somaliland could have worked closer and at an earlier stage with proponents within the MoH to do advocacy around the use of misoprostol and address common misunderstandings. During the implementation of the program it became apparent that a health intervention that touches on highly sensitive issues necessitates building broader understanding and support amongst health professionals. The PSI/Somaliland experience has shown that misoprostol distribution requires an advocacy intensive approach at the political level.

Moreover, a more comprehensive approach to address the subject of safe motherhood would have faced fewer risks. The original design envisioned bringing misoprostol directly to women for home-based deliveries. This design would have had a larger impact on the reduction of maternal mortality in Somaliland. The revised design requires women to seek out uterotonics at health facilities which does not address the immediate needs of women who deliver at home. If at the onset PSI/Somaliland had launched a more comprehensive safe motherhood campaign, including family planning, antenatal care and warnings about the risks of home deliveries, the programme may have faced fewer set-backs and delays. More targeted interventions like promoting the use of misoprostol and addressing the health risks related to unsafe abortions could have been implemented at a later stage.

Finally, a clear and concise public relations plan that addresses existing concerns and reservations needs to be in place. A quick response to any such situation is imperative to ensure that correct information is being distributed from the MoH and PSI/Somaliland, but just as importantly, from outside sources that support the program.

NEXT STEPS

Follow-on funding has been secured from DFID to provide continued support for the prevention and treatment of PPH program. The funds will allow PSI/Somaliland and the MoH to maintain communications regarding safe deliveries beyond the implementation period of the SALIN programme. Additionally, the DFID program will work to strengthen the health system and to improve access to quality health services in the public sector, addressing some of the barriers preventing women from seeking reproductive health care. The project will aim to address health facility human resource and staff capacity gaps, as well as inadequate access to delivery services.

PSI supports reproductive health and family planning programs in over 30 countries. To learn more about PSI/Somaliland and our reproductive health programs, visit http://www.psi.org/our-work/healthy-lives/reproductive-health.

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