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CLINICAL ARTICLE

Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania

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ABSTRACT

Objective: To explore the feasibility of educating communities about gynecologic uses for misoprostol at the community level through community-based organizations in countries with restrictive abortion laws. *Methods:* In 2012, the Public Health Institute and Ipas conducted an operations research study, providing small grants to 28 community-based organizations in Kenya and Tanzania to disseminate information on the correct use of misoprostol for both abortion and postpartum hemorrhage. These groups were connected to pharmacies selling misoprostol. The primary outcomes of the intervention were reports from the community-based organizations regarding the health education strategies that they had developed and implemented to educate their communities. *Results:* The groups developed numerous creative strategies to reach diverse audiences and ensure access to misoprostol pills. Given the restrictive environment, the groups attributed their success to having addressed the use of misoprostol for both indications (abortion and postpartum hemorrhage) and to using a harm reduction approach to frame the advocacy. *Conclusion:* This initiative proves that, even where abortion is legally restricted and socially stigmatized, community-based organizations can publicly and openly share information about misoprostol and refer it to women by using innovative and effective strategies, without political backlash. Furthermore, it shows that communities are eager for this information.

1. Introduction

Misoprostol, a drug sold around the world to treat gastric ulcers, has proven to be very effective in preventing 2 of the leading causes of maternal mortality—postpartum hemorrhage (PPH) and unsafe abortion [1,2]. Since the 1980s, when women in Brazil discovered that misoprostol could help them safely end unwanted pregnancies, women have been passing on this knowledge by word of mouth, woman to woman. We now have global evidence that misoprostol is being used by women in many countries with restrictive abortion laws to end unwanted pregnancies, without talking to or seeing a healthcare provider [3–5]. In addition, community-based studies have shown that women can also use this lifesaving drug to prevent hemorrhaging at birth—safely, by themselves, in their own homes [6–8].

Unfortunately, despite the tremendous potential of this relatively inexpensive and widely available drug, knowledge about its various indications is extremely sparse, particularly in countries where abortion continues to be restricted [9–11]. Public policies; legal, regulatory, and administrative barriers; and general discomfort with abortion have combined to keep misoprostol a best-kept secret [12,13]. Believing that women everywhere have the right to information about and access to this lifesaving drug, the Public Health Institute and Ipas conducted an operations research study to explore strategies for introducing misoprostol for gynecologic uses at the community level through community-based organizations in countries with restrictive abortion laws.

2. Materials and methods

The present study was conducted in early 2012 in Kenya and Tanzania—2 countries where abortion is restricted and stigmatized, and where maternal mortality is still relatively high. In partnership with 4 local organizations—the Center for the Study of Adolescence (Kenya), KMET (Kenya), Ifakara Health Institute (Tanzania), and the Women's Promotion Centre (Tanzania)—we trained community groups on gynecologic uses of misoprostol and provided them with funding to improve access to misoprostol in their communities. Small grants (averaging US $2000 per group) were awarded to 28 community-based organizations: 9 based in Kigoma, Tanzania; 7 in Nairobi, Kenya;

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and 11 in Kisumu, Kenya. By supporting strategies that emerged from local groups that work directly with women and adolescents, we hoped to strengthen communities' understanding of the multiple uses of misoprostol, create a favorable community context in which misoprostol and abortion could openly be discussed, increase the buy-in and commitment for access to safe abortion within a diverse array of community organizations, and help build women's skills to manage their reproductive lives.

The initiative set out to test whether groups could, in a restrictive environment, talk openly about misoprostol for both indications: abortion and prevention of postpartum hemorrhage. Abortion is legally restricted in both countries but access to medical information is not prohibited; in fact, the constitutions of both countries guarantee the right to information for consumers of services: Article 46 (b) of the Kenyan Bill of Rights and Article 18 (b) of the Tanzanian Constitution. Discussing misoprostol freely is, therefore, lawful and the initiative set out to test the feasibility of sharing this information at the community level.

Before implementing the program, we met with national and international organizations working in the 2 countries and identified local community-based organizations interested in partnering. These organizations helped us disseminate the open call for proposals and participated in both the review of the proposals and the follow-up of the ones awarded grants. The request for proposals entailed a very simple process: requesting ideas that could be implemented in a 9-month timeframe and for a maximum of the local equivalent of $2000. The proposals were judged according to creativity, feasibility, and replicability. Following the implementation of the activities for which they received funding, the community-based organizations submitted reports, which were then analyzed; phone interviews were conducted when needed to clarify the reports further. Because this was strictly a funding initiative that involved disseminating information to communities, informed consent and ethics approval were not required.

3. Results

The groups that received funding were extremely varied and served diverse constituencies, including women with disabilities, youth, business groups, religious leaders, and assorted health professionals. With the exception of 1 group—a medical student organization in Nairobi, which met resistance from anti-choice students—all found that the initiative greatly assisted them in their advocacy work. For example, some reported that the approach gave women and youth opportunities to speak their views on abortion and maternal deaths, and helped break silence and taboos surrounding abortion and safe motherhood by sharing very sensitive testimonies about unsafe abortion and its effects. Others said that the initiative cleared misconceptions and myths around abortion, challenging religious fundamentalism, and created awareness that women can perform abortions safely and prevent PPH themselves, using medical back-up only if needed. Still others reported increased empathy and support from local leaders and various stakeholders for the campaign on reducing maternal deaths and the creation of a network of like-minded advocacy groups that drew synergy from each other.

The strategies that the groups implemented were diverse and reached many different audiences in creative ways. For example, an organization that was uncomfortable addressing abortion directly did not specifically mention the word, instead using phrases on flyers such as "Have you missed your period? Are you worried? Come talk to us, we can help."

Many grantees developed materials that could be used by the community groups to increase information on managing expected effects, prevention of PPH, and signs and symptoms of incomplete abortion. Young people from the slum areas of Nairobi relied on social media platforms to educate each other and create linkages to increase access to the drug. In Kigoma, a group printed and disseminated handkerchiefs with pictorial indications on the use of misoprostol for both safe abortion and PPH prevention to convey the information. Another group in Kigoma distributed simple information cards with a message to encourage girls to seek support and guidance from trained teachers and peer educators in schools. In Kisumu, messages written inside the reusable sanitary towel packages distributed by the Kenyan Medical Educational Trust in rural communities included what to do if worried about a missed period and the number of a helpline to call.

Others came up with innovative and effective strategies to ensure access to the drug—a particular challenge for women living in rural communities. The use of community pharmacies and traditional birth attendants to distribute the drug proved to be effective approaches that attracted no backlash but increased coverage and drug availability at the community level. For example, 14 traditional birth attendants and herbalists in Kisumu asked KMET to train them to provide misoprostol directly to women. KMET contracted with matatu (public transport) drivers to deliver misoprostol to women in rural communities in which pharmacists either had not stocked the drug or were unwilling to dispense it without a doctor's prescription. The community-based organizer or the woman in need calls the KMET helpline to ask for misoprostol, waits for the matatu driver to deliver the drug, and confirms receipt via text message. The partnership with matatu drivers—which facilitated same-day deliveries—greatly improved access to misoprostol.

In Kigoma, because no pharmacies were selling misoprostol in the rural community, a grantee organization decided to provide the drug directly. Using its own resources, the organization trained staff to provide counseling and support, formed an alliance with like-minded doctors to help women with any complications, and established a small pharmacy as an alternate model for supporting women's access to safe pregnancy and family planning. The competition that resulted from the organization's lower prices has driven down the cost from other private drug sellers, making these medicines more affordable for women who need them.

Overall, we found that most groups felt emboldened to advocate for the prevention of maternal deaths in their communities. They showed courage in reaching out and vocalizing the needless deaths and suffering of women in their communities from unwanted pregnancies, and did this in spite of a difficult legal and social environment. As one of the groups reported, women and mothers are dying because of a lack of information; the group was thankful for the initiative because, in their words, knowledge is power. Another group expressed outrage at not having been given this information earlier, saying that women continued to die in their communities while this "magic drug" was being kept a secret; the group urged those in authority to disseminate this good news to all women in rural communities in order to save lives.

4. Discussion

The misoprostol initiative in Kenya and Tanzania provides practice-based evidence that local community-based groups operating under social and legal sanctions or restrictive abortion laws and policies can openly and publicly disseminate information about misoprostol to prevent both unsafe abortion and PPH. The groups we funded in Kenya and Tanzania showed that, with very small sums (approximately $2000), they could simply and effectively (and without political backlash) inform their communities that misoprostol is available; that women can be empowered to use it safely, on their own, without going to a provider; and that it can prevent maternal deaths. They also showed that, while diversified strategies are needed to reach diverse audiences, information on the correct use of misoprostol can be spread very effectively and inexpensively by community groups.

One of the biggest barriers to the introduction of misoprostol for use at the community level is its association with abortion [13]. Most of the international non-governmental organizations we met with when we first introduced the initiative in Kenya and Tanzania were wary, warning us that—because of the sensitivity of abortion in these 2

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countries—we might not be able to openly discuss the use of misoprostol to end pregnancy. Some warned us that we might be "endangering" the groups by funding them. Yet, when we approached national and local organizations, we found that we had no shortage of interested partners. In both countries, we easily found organizations willing to work with us, to help spread information about the initiative, and to distribute our request for proposals. In all 3 locations we decided to focus on—Nairobi, Kisumu, and Kigoma—we received many more proposals than we were able to fund.

The funding model proved to be key; each group/organization decided how much political risk it could or would undertake. And, because the groups were so well networked and had legitimacy in their communities, they managed the political risk. As the director of a community-based organization confirmed, "political risk management is something we do all the time."

Why were so many groups able to accomplish what many feared could not be done: that is, publicly disseminate information about a drug that can be used to terminate a pregnancy in countries where abortion is restricted? Our partners pointed to 2 strategies that they felt made this "emboldened advocacy" possible. The first, and most important, strategy was that they addressed the use of misoprostol for both indications—abortion and the prevention of PPH; the second was that they used a harm reduction framework to introduce the work.

Focusing on several indications at once was the sole requirement we had when we announced the request for proposals. Given that we were focusing on community mobilization, we thought it best to impart information about both of the indications for which women can safely and effectively use misoprostol without having to go to a facility. We knew that there was already interest at the community level about a drug for abortion and thought it best not to skirt around that fact, but rather share the complete knowledge with the women and the communities. Talking about both uses had additional benefits: it gave cover for the work on abortion for those who needed it; more players became involved because it included organizations that focused on maternal health as well as those that tackled the problem of unsafe abortion; and, because misoprostol can reduce maternal deaths in several ways, it provided a very effective advocacy message. Maternal mortality as a public health issue is receiving a tremendous amount of attention in both countries, and the fact that a single inexpensive and available drug can significantly prevent 2 of the major causes of maternal mortality is a powerful advocacy message. In addition, the fact that misoprostol is used for prevention—of unsafe abortion and hemorrhaging at birth—was compelling for community-based organizations that do not normally see themselves as health providers but as educators.

Using a harm reduction framework to introduce the lifesaving qualities of misoprostol shifted the conversation about abortion from its legal status to protecting women's health. Harm reduction is an evidence-based public health and human rights framework that prioritizes strategies to reduce harm and preserve health in situations in which policies and practices prohibit, stigmatize, and drive common human activities underground [14,15]. In this context, the harm reduction framework enabled discussions about how reducing the harms associated with unsafe abortion and home delivery could promote the rights to health, life, information, empowerment, and participation, in addition to women's human rights in general. In Kenya and Tanzania, where abortion is legally and socially restricted, the framework freed the community groups from the political and legal constraints they usually operate under and allowed them to devise ways to help prevent women in their communities dying from unsafe abortion and from hemorrhage during home deliveries. Once it was understood that the harms associated with both activities could be significantly reduced with the dissemination of accurate information on misoprostol use as well as access to the drug, many eagerly submitted proposals to improve both information about and access to misoprostol. Most of the groups came to view the sharing of information about the multiple uses of misoprostol as their obligation because the drug can significantly reduce harms and save lives.

A particular strength of the initiative was joint accountability; we partnered with the organizations by providing financial support, and trusted them to develop their approaches and to implement the programs. The strategies the groups developed emanated from lived experience and were concrete, doable, and creative. Furthermore, because the groups embedded these strategies into their ongoing work and existing networks, the approaches were inexpensive and will, hopefully, be sustainable.

What really matters to the people closest to the communities is that women are dying. They will do what they need to do in order to meet their communities' needs. The funded organizations viewed misoprostol as a right to information and understood that women need to know about its potentially lifesaving properties and be empowered to obtain and use it correctly. Indeed, the simplicity and effectiveness of misoprostol produced outrage in several communities over the fact that they had not been informed about this "good news pill" sooner.

For most, direct access to misoprostol was about a woman's agency and her ability to help herself by preventing possible hemorrhage while giving birth or by safely ending an unwanted pregnancy of her own accord. The misoprostol initiative grew into the beginnings of a movement—one in which women help themselves and then help others by sharing information. By putting access to misoprostol in the hands of women in their communities, these groups are breaking the silence that so often surrounds abortion and are assisting women in becoming the shapers and users of this promising technology.

Conflict of interest

The authors have no conflicts of interest.

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