October 15, 2008

The Secretary,
17th Expert Committee on the Selection and Use of Essential Medicines
Medicine Access and Rational Use (MAR)
Department of Essential Medicines and Pharmaceutical Policies (EMP)
World Health Organization (WHO)
20 Avenue Appia
CH-1221 Geneva 27
Switzerland

Dear Sir/Madam,

A Letter of Support for the Inclusion of Misoprostol in the WHO List of Essential Medicines for its PPH Prevention Indication

On behalf of the Women's Health and Action Research Centre (WHARC), I write to support the inclusion of misoprostol into the Model list of Essential Medicines of the World Health Organization (WHO) for its postpartum haemorrhage (PPH) indication. WHARC is a non-profit, non-governmental organization, whose mission is to promote the health and social wellbeing of women, through research, documentation, advocacy and service delivery on women’s health in sub-Saharan Africa.

Available statistics show that ninety nine percent of maternal deaths occur in low-income countries. African women carry most of this burden, and PPH is the leading cause. In Nigeria, as in much of Africa, the situation of women at delivery is dire and deteriorating where PPH accounts for about a quarter of the 55,000 annual maternal deaths.

The national average maternal mortality ratio (MMR) is 800-900 per 100,000 live births. Many women do not reach health facilities until it is almost too late, and the MMR in hospitals is often higher than the national average. Doctors and nurses are stretched to the limit and unable to provide sufficient care in rural areas. However, those working in hospitals and clinics see only a small percentage of the total number of PPH deaths, because most maternal deaths occur when a mother delivers at home alone or in the presence of a traditional birth attendant (TBA).

Even, the Nigerian Federal Ministry of Health recognized this growing problem: “failure to factor population figures in earlier planning...has led to the provision of inadequate facilities for the teeming and increasing population”.

Thus, providing skilled attendance to all births, though an optimal solution, might take decades of training providers, placing them, and retaining them in rural areas where most of the Nigerian population resides. In the meantime, programs to decrease maternal mortality attributed to PPH can be in place, and in this way, significant progress can
be made to achieve Millennium Development Goal 5. Therefore, misoprostol has been discovered to be a proven, evidence-based treatment that reduces postpartum blood loss. Moreover, it is safe; as demonstrated by the reports of nearly 600 published studies on the use of misoprostol in obstetrics and gynaecology that have involved more than 30,000 women. Also, its ease of administration and high effectiveness in controlling PPH offers an alternative to other standard treatments, including injective oxytocin and ergometrine, both of which require a cold chain and skilled administration that are not always sustainable and/or available in low resource countries.

Misoprostol is inexpensive, and so offers a low-cost, low-tech, but safe and effective means of preventing PPH that can be offered by providers at all levels of the health care system.

At present, some Ministries of Health are yet to provide misoprostol for PPH prevention because the product is not listed on the World Health Organization Essential Medicines List for this important women’s health indication. Similarly, UN agencies active in emergency situations are frequently unable to offer this medication because of its absence from the Essential Medicines List. Listing misoprostol for its PPH prevention indication will break down this barrier and facilitate easier access to misoprostol for postpartum haemorrhage prevention. Therefore, in recognition of a well-established efficacy of misoprostol for the prevention of postpartum haemorrhage, I propose that misoprostol be specifically listed for its PPH indication in section 22.01.00.00 “Oxytocics” of the WHO Essential Medicines List (EML). And use of misoprostol for PPH prevention should be recommended particularly in places where traditional injectible uterotonics are not available and/or feasible.

Thank you, as I look forward to your early consideration and approval of this application.

Yours Sincerely,

Professor F E Okonofua MbChB, PhD (Sweden), FMCOG, FWACS, FRCOG ad eundem (UK) Executive Director