Applying the National Norms: Integration of Misoprostol into Postabortion Care

The Mexico City Experience

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Context of postabortion care

- 20+ million inhabitants in Mexico City and surrounding metropolitan area
- >6,200 abortion patients treated in SSDF network in 2012 (15+ general & maternal-infant hospitals)
- Patients present and are treated predominantly in secondary level of care
- Standard of care: PAC patients hospitalized, D&C or MVA with general anesthesia

Strategy for introduction

- Integrate misoprostol for incomplete abortion as **first-line treatment** in emergency rooms
- Protocol follows international recommendations – **single dose 400 mcg sublingual miso**
- **Ambulatory treatment,** misoprostol taken at hospital or at home

Activities and time frame of implementation

Educational materials and data capture forms developed
(Oct 2008 – Feb 2009)

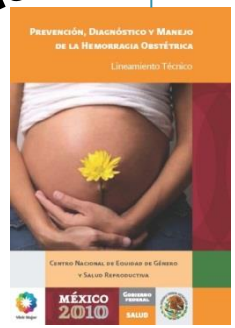
Inclusion in WHO Essential Medicines List
(Apr 2009)

Organización Mundial de la Salud

Support, documentation, monitoring and evaluation
(continual)

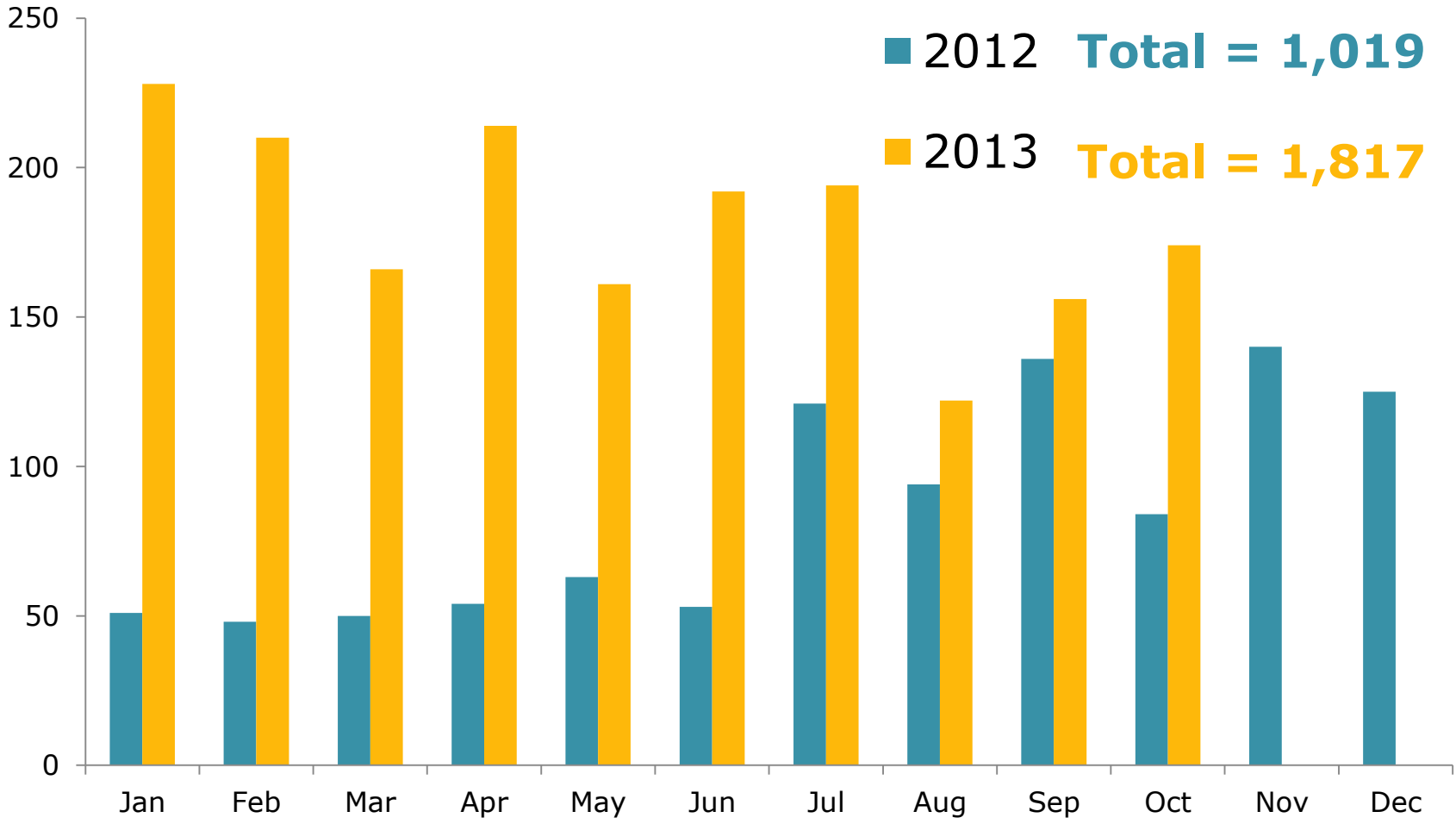
Training of providers 14 hospitals
(Mar 2009)

Misoprostol included in national guidelines
(end of 2009)



Refresher training of 14 hospitals + 9 more
(Jun 2012)

Women treated with misoprostol 2012-2013



Experience cont.

- 73% of initial hospitals trained offering method regularly (2013 data)
- 24% uptake of postabortion contraception in misoprostol patients
- Consistent reduction in hospitalizations since 2009 attributed in part to miso offered as ambulatory treatment
- At least 1 primary care clinic offering service

Successes

Reduction in costs to the health system:

- Use of beds, operating theater, personnel time, anesthesia, sterilization and maintenance of surgical equipment

Integration of misoprostol into national clinical guidelines and registries:

- Instrumental to garner support of clinical providers in Mexico City and nationally
- Initiated and achieved improved registration system in 2012; new codes created for miso as PAC treatment

Creation of local expertise and contribution to expansion efforts:

- Experienced health care providers serve as expert trainers in state-level expansion; 5 states have introduced protocol since 2010

Key challenges

- Resistance to new method by clinical providers
  - Association of miso with abortion
  - Initially not included in WHO EML nor national guidelines; not convinced by data alone
- Slow uptake and limited integration across shifts
- Acquisition and management of misoprostol at the hospital level
- Accurate documentation difficult initially as not contemplated as treatment option in national registries; ambulatory procedure

Strategies to address challenges

Key challenge	Strategies
Provider resistance	- Updated evidence-based guidelines disseminated - Patient information (banners) placed in waiting rooms to increase demand
Slow uptake and limited integration	- Continuous monitoring/ evaluation to ensure use in all hospitals that receive abortion pts - Ongoing training to increase capacity and offer miso on all shifts and as first-line tx
Acquisition & management of misoprostol	- Stock and placement monitored regularly to ensure drug available where needed
Accurate documentation	- Updated registration codes disseminated and data capture personnel trained

Future plans

- Continue to focus on secondary level hospitals; most patients present at this level for care
- Ensure adequate contraceptive supply for all postabortion patients that desire them
- Disseminate experience and lessons learned in Mexico, LAC and internationally