Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Implementation Challenges and Pathways for Advance Distribution of Misoprostol for Postpartum Haemorrhage Prevention in Nigeria: A Qualitative Political Economy Analysis

Sylverius Obafemi
sylverius.obafemi@jhpiego.org
Jhpiego
Victor Abiola Adepoju
Jhpiego
Sefunmi Oluwole
Datalead Africa
Bright C. Orji
Jhpiego
Sikiratu Kailani
Jhpiego
Aisha Nana Adamu
Federal University Birnin Kebbi Nigeria
Samuel Oyeniyi
Federal Ministry of Health Nigeria
Adetiloye Oniyire
Jhpiego
Freda Nyaga
Jhpiego
Hannah Tappis
Jhpiego
Elaine Roman
Jhpiego
Pooja Sripad
Jhpiego

Research Article

Keywords: postpartum haemorrhage, misoprostol, community health, maternal health, political economy analysis, Nigeria

Posted Date: November 13th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11158050/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Implementation Challenges and Pathways for Advance Distribution of Misoprostol for Postpartum Haemorrhage Prevention in Nigeria: A Qualitative Political Economy Analysis

Sylverius Obafemi[1*], Victor Abiola Adepoju[1], Sefunmi Oluwole[2], Bright C. Orji[1], Sikiratu Kailani[1], Aisha Nana Adamu[3], Oyeniyi Samuel[4], Adetiloye Oniyire[1], Freda Nyaga[5], Hannah Tappis[6], Elaine Roman[6], and Pooja Sripad[6*]

[1] Jhpiego Nigeria, Abuja, Nigeria
[2] Datalead Africa, Abuja, Nigeria
[3] Federal University Birnin Kebbi, Birnin Kebbi, Nigeria
[4] Federal Ministry of Health, Abuja, Nigeria
[5] Jhpiego Kenya, Nairobi, Kenya
[6] Jhpiego, Baltimore, USA

*Corresponding author: Sylverius Obafemi, Jhpiego Nigeria, Plot 971 Reuben Okoya Crescent, Wuye, Ankuru 900108, Federal Capital Territory, Nigeria. Sylverius.Obafemi@jhpiego.org

Abstract

Background

Postpartum haemorrhage (PPH) is a leading cause of maternal mortality in Nigeria, where the maternal mortality ratio is approximately 993 deaths per 100,000 live births and, in 17 of 36 states, more than half of births occur outside a facility. Advance distribution of misoprostol for use after home birth is recommended by WHO and authorised by Nigeria's National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage (2023) yet is not implemented at scale in any state.

Methods

We examined the structural and behavioural factors shaping this policy-implementation gap at national level (in the Federal Capital Territory) and in three purposively selected states (Sokoto, Niger, and Akwa Ibom) Forty-eight key informant interviews and four stakeholder roundtables conducted between 25 August and 10 September 2025.were analysed thematically using a codebook guided by the Context and Implementation of Complex Interventions framework and the Capability–Opportunity–Motivation–Behaviour model, interpreted through a political economy analysis lens. Reporting follows the Standards for Reporting Qualitative Research.

Results

No participant contested misoprostol's effectiveness; the gap reflected interacting structural and behavioural factors. Structural barriers included regulatory ambiguity, weak federal-to-state translation, fragmented supply, donor dependence, and absent community-level pharmacovigilance. Behavioural readiness differed by state: Sokoto strongest from prior pilot exposure, Niger with latent capacity but no operational pathway, and Akwa Ibom with misoprostol stock at health facilities but low awareness of strategies to extend uterotonic coverage to community births. Stakeholders identified six interrelated pathways to close the policy-implementation gap and promote uptake of advance distribution of misoprostol spanning policy alignment, model adaptation, health-system support, demand creation, financing, and operational learning.

Conclusion

The gap is operational, regulatory, and behavioural. Closing it requires federal regulatory clarification, state-led adaptation of the national guideline through inclusive coordination platforms, and integration of advance distribution of misoprostol into routine financing, supply, workforce, and monitoring systems.

Keywords

postpartum haemorrhage; misoprostol; community health; maternal health; political economy analysis; Nigeria

Background

Maternal mortality remains a major global health challenge and is particularly acute in Africa, where most of the world's maternal deaths occur (1). Postpartum haemorrhage (PPH) is one of the leading direct causes of maternal death globally and in Nigeria, and the risk of severe outcomes is heightened where women deliver outside health facilities, and without skilled health personnel present (2, 3). Nigeria has one of the highest maternal mortality burdens globally, with an estimated 74,559 maternal deaths in 2023, equivalent to a maternal mortality ratio of 993 deaths per 100,000 live births (1). National figures mask deep subnational inequities: in 17 of Nigeria's 36 states, more than 50% of births occur outside health facilities, with markedly higher home birth rates in northern regions where geographic, socio-economic, and socio-cultural barriers constrain access to skilled care (4).

These realities have prompted attention to strategies that extend essential maternal health interventions beyond facilities. Advance distribution of misoprostol provides the medicine to women during antenatal care (ANC) or through community-based platforms before delivery, so that a uterotonic is available for use immediately after childbirth for PPH prevention if a birth occurs outside a facility. This approach ensures that every pregnant woman, regardless of where she gives birth, has access to a quality uterotonic (5). In 2012, the World Health Organization (WHO) recommended that community health workers or lay health workers administer misoprostol in settings where skilled birth attendants are not present (6), and in 2020 recommended that, in settings where a large proportion of women still give birth outside of health facilities, misoprostol can be distributed for women to self-administer immediately after birth, if accompanied by appropriate monitoring and evaluation (7). This recommendation is supported by a robust evidence review concluding that advance distribution of misoprostol can increase health equity and improve birth outcomes in remote and underserved areas and confirming past studies have shown very few reports of incorrect use or adverse events (8). The 2025 WHO-FIGO-ICM *Consolidated guidelines for the prevention, diagnosis and treatment of postpartum haemorrhage* reaffirm recommendations on

advance distribution of misoprostol as a complementary strategy alongside facility-based interventions to prevent maternal morbidity and mortality (9, 10).

Nigeria has a history of advance distribution of misoprostol pilots and a progressively expanding policy framework. Between approximately 2009 and 2015, donor-supported pilots in Sokoto and Kaduna demonstrated feasibility, high correct use of misoprostol for PPH prevention, and low adverse-event rates but did not lead to sustained scale-up (11-14). Misoprostol was added to the *National Essential Medicines List* in 2010 (15), and the *National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage at the community level* were issued in 2011 and revised in 2020 and 2023 (16-18). The 2023 revision is operationally significant: it explicitly authorises three community-level distribution models: (i) ANC-based distribution to pregnant women for self-administration; (ii) distribution by the community health workforce, including Junior Community Health Extension Workers (JCHEWs), Community Health Influencers, Promoters and Services (CHIPS) agents, and faith-based, civil-society, and traditional birth attendants (TBAs); and (iii) distribution through private-sector channels, including Patent and Proprietary Medicine Vendors (PPMVs) and community pharmacies (18). This guidance is reinforced by the *Task Shifting and Task Sharing Policy for essential health care services in Nigeria* (19), the *CHIPS Programme Guidelines* and *CHIPS Facilitators Manual* (20, 21), the *National guidelines on self-care for sexual, reproductive, maternal, newborn, child and adolescent health* (22), and the *Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N) Strategy 2022–2026* (23). Despite this enabling environment, no state implements advance distribution of misoprostol at scale; misoprostol largely remains a facility-based commodity used for PPH management rather than community-based prevention.

Where technical evidence is favourable but a policy is not operationalised, resistance typically lies in the complex interaction of individual interests, incentives, relationships, and regulatory and professional arrangements of the actors involved (24-26). Political economy analysis (PEA) is well suited to understanding such problems, foregrounding how power, mandates, professional norms, and institutions

shape whether policies are translated into practice (27). This study is a descriptive, exploratory PEA of the structural and behavioural factors that have constrained the operationalisation and scale-up of advance distribution of misoprostol for PPH prevention in Nigeria, despite a favourable policy environment.

Methods

Reporting follows the Standards for Reporting Qualitative Research (SRQR) (28).

Study design

This qualitative study used an applied PEA approach to examine the barriers and enablers influencing the operationalisation and scale-up of advance distribution of misoprostol for PPH prevention in Nigeria. Data collection methods included roundtable discussions with policy decision-makers at national and sub-national levels, and key informant interviews with programme implementers enabled exploration of stakeholder perspectives, institutional dynamics, and the contextual factors shaping policy implementation within a complex, decentralised health system. Two complementary frameworks guided analysis that was interpreted through an overarching PEA lens: the Context and Implementation of Complex Interventions (CICI) framework, which organises the structural and contextual conditions surrounding implementation (29), and the Capability–Opportunity–Motivation–Behaviour (COM-B) model, which organises the behavioural drivers of stakeholder action (30). The PEA lens connects these frameworks by asking how interests, incentives, relationships, and power shape the way actors and systems act on advance distribution of misoprostol guidelines.

Study setting

Data collection took place in the Federal Capital Territory (Abuja) and three purposively selected states representing contrasting maternal health and advance distribution of misoprostol implementation contexts, covering a range of epidemiological, geographic, and health-system conditions (***Table 1)***. Sokoto (in the North-West geopolitical zone) has the lowest facility delivery rate of the three states, a community

health workforce in place, and prior experience piloting advance distribution of misoprostol. Niger (in the North-Central geopolitical zone) has low facility delivery rates and a community health workforce in place, but no operational pathway for advance distribution of misoprostol. Akwa Ibom (in the South-South geopolitical zone) has the highest facility delivery rate of the three states, a community health workforce in place, and recent procurement of misoprostol for facility use, but no current community-level distribution.

Table 1. Study settings: maternal health profile, comparative epidemiological, geographic, and contextual conditions, and history of advance distribution of misoprostol implementation

Participant sample

Participants were purposively sampled to capture the actors most relevant to advance distribution of misoprostol policy and implementation. Two stakeholder groups were defined: policy decision-makers, including federal and state government representatives, regulatory agencies, professional association leadership, and the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) technical working group; and programme implementers, including facility-based healthcare providers, community health workers, and implementing-partner staff. In total, 48 key informant interviews (KIIs) spanning both stakeholder groups and four stakeholder roundtables with policy decision-makers were conducted, comprising 94 participants **(*Table 2*)**.

Table 2. Participants by stakeholder type and data collection method

Data collection and management

Data were collected between 25 August and 10 September 2025. KIIs explored individual perspectives across both stakeholder groups, while roundtables elicited collective and institutional perspectives from policy decision-makers and professional association leadership at national and state levels, including views on the current maternal health policy and programming landscape. Topic guides, informed from the

integrated PEA framework and study objectives, covering the structural, behavioural, and pathways of change domains, were reviewed and pretested ***(Supplementary File 1)***. Three guides were used: a national roundtable discussion guide, a state-level roundtable discussion guide, and a key informant interview guide. Each roundtable opened with a level-setting presentation on postpartum haemorrhage, maternal mortality, and the evidence on advance distribution of misoprostol, followed by a facilitated discussion in which participants listed barriers and then ranked the largest and smallest through a participatory tagging exercise. All three guides included a common vignette describing a woman planning a home birth who obtains misoprostol in advance, used to elicit views on feasibility, self-administration, private-sector and community-cadre roles, and oversight requirements. Interviews and roundtables were conducted in English, audio-recorded with consent, and accompanied by field notes. Data collectors had prior qualitative research experience, held at least a bachelor's degree, and participated in a three-day training on the study purpose, design, methods, and research ethics. The training included role-playing, vignettes, and pretesting of tools to ensure consistency and contextual alignment.

All audio recordings were transcribed verbatim by trained transcribers and reviewed for accuracy against the original audio and field notes by the in-country study lead. Transcripts were de-identified during transcription, with personal and institutional identifiers removed or replaced with stakeholder labels (e.g., “Akwa Ibom KII, maternal health stakeholder”), assigned unique alphanumeric codes, and imported into Dedoose Version 10.0.35 for coding. Data integrity was verified through recording-to-transcript checks on a sample of files.

Data analysis

Analysis followed a thematic approach combining deductive and inductive coding (31). An initial codebook was developed deductively from the integrated PEA framework and the topic guides, with parent codes corresponding to the structural CICI domains and the behavioural COM-B domains. This was refined inductively as transcripts were reviewed; adding sub-codes for emergent themes such as

misoprostol's abortion-related stigma, donor dependence and state ownership, performance-indicator pressure, professional role boundaries, PPMV regulatory ambiguity, and inclusive policy formulation. All transcripts were coded by a trained analyst using the finalised codebook.

PEA interpretation was operationalised through analytic memos. For each thematic cluster, the analyst wrote a memo summarising coded data by describing how and by whom a theme was raised, and similarities and differences across stakeholder types, levels, and states; these memos were discussed in regular study-team meetings to test interpretations, surface alternative readings, and reach consensus where interpretations diverged. Summary memos were used to synthesise coded data in three steps: first, structural and behavioural domains were summarised separately for each setting; second, their intersections were examined (for example, how regulatory ambiguity interacted with provider hesitation about role boundaries); third, the PEA lens was applied across this matrix to surface the interests, relationships, and power dynamics shaping decision-making and inaction. The pathways to change reported are stakeholder-identified recommendations and enablers, also embedded through the same PEA lens. A stakeholder mapping summarising actor roles, influence, positions, and interests relative to advance distribution of misoprostol guideline operationalisation was developed to synthesise findings.

Techniques to enhance trustworthiness

Trustworthiness was strengthened through triangulation by design across methods (KIIs and roundtables), stakeholder types (policy decision-makers, and implementers), and levels and settings (national/state and Sokoto, Niger, Akwa Ibom). The iterative team review of memos served as investigator triangulation, with the analyst presenting coded segments and emerging themes to the team for contextual clarity and rigor. An audit trail was maintained through coded reports, and analytic memos. Disconfirming evidence (e.g. provider caution about advance distribution of misoprostol even where pilots had shown safety, and Akwa Ibom's withdrawal of community-level stock) were deliberately retained and analysed. Member-

checking with selected national stakeholders during dissemination engagements verified that thematic interpretations resonated with their experience.

Researcher characteristics and reflexivity

The study team comprised maternal health researchers and implementation specialists with cultural sensitivity and experience working in Nigeria's reproductive health system with in-country collaborators. Data collectors were experienced qualitative interviewers familiar with the policy context. The team's combined clinical, implementation, and policy backgrounds informed both data collection and interpretation; reflexive discussion within the multidisciplinary team was used throughout analysis to surface and challenge assumptions, including assumptions about advance distribution of misoprostol. Team members were affiliated with academic and implementing institutions and some had prior and ongoing engagement with maternal health programmes and policymakers in Nigeria. These positions may have facilitated access to participants and influenced interpretation; to mitigate this, interviewers used a standard interview guide and the team regularly reflected on potential biases during data analysis.

Ethical considerations

Participation was voluntary, and written informed consent was obtained from all participants before data collection. Participants were free to decline any question or withdraw at any time. This study was conducted in accordance with the Declaration of Helsinki and Ethical approval was obtained from the National Health Research Ethics Committee of Nigeria (Approval Number: NHREC/01/01/2007-21/07/2025), and the Johns Hopkins University Institutional Review Board (JHU IRB No: 32982). Transcripts were de-identified, and identifiable data were stored separately and securely on password-protected drives with access limited to authorised study-team members.

Results

Three convergent findings held across all sites. First, no participant in any state contested the clinical effectiveness or relevance of misoprostol for PPH prevention; the advance distribution of misoprostol policy-implementation gap was understood as an operational, regulatory, and behavioural problem, not a question of whether it would improve maternal health outcomes. Second, despite the 2023 guideline authorising three distribution models, none of the study states had a structured advance distribution of misoprostol programme running at scale at the time of data collection; misoprostol use was generally limited to health facilities and oriented to PPH management rather than prevention. Third, awareness of the *National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage* was uneven, most pronounced among national policy decision-makers and Sokoto stakeholders, modest in Niger, and limited in Akwa Ibom.

Factors shaping the policy-implementation gap and perceived pathways to operationalisation of the 2023 guidelines varied across stakeholder type and state. These factors are organised around three thematic areas: structural context (CICI domains), agency and behaviour (COM-B domains), and stakeholder-identified pathways, interpreted throughout through a PEA lens **(Figure 1).** For each sub-theme, illustrative quotations appear inline; additional quotations, organised by sub-theme and labelled by stakeholder type and setting, are provided in ***Supplementary File 2.***

Figure 1. **A political economy analysis framework to understand the advance distribution of misoprostol policy-implementation gap through structural context, agency and behaviour, and stakeholder-identified pathways to change in Abuja, Sokoto, Niger, and Akwa Ibom States, Nigeria.**

Structural context shaping advance distribution of misoprostol policy uptake and operationalisation (CICI domains)

Five interconnected structural domains shaped advance distribution of misoprostol guideline operationalisation (or lack thereof): geographic and epidemiological variability; socio-economic and socio-cultural dynamics; ethical context; legal and regulatory framing; and political and institutional dynamics.

Geographic and epidemiological variability in maternal health service access

Participants across all three states described uneven access to a uterotonic at birth, driven by geography, facility functionality, and workforce availability. Both policy decision-makers and implementers in Sokoto and Niger described limited access to health facilities for childbirth, with long distances, dispersed populations, insecurity in some local government areas, and gaps in primary health care staffing, equipment, and medicines making home births common. In Akwa Ibom, facility delivery rates were higher, though riverine and hard-to-reach communities remained underserved. National policy decision-makers framed advance distribution of misoprostol as a pragmatic interim measure for women whose facility access cannot be expanded quickly.

> *"Some facilities are open, but there is no midwife, no light, and no medicine, so women deliver at home."* – Niger, implementer, KII

This framing was echoed at state level, but with contextual nuances: state policy decision-makers and implementers in Sokoto and Niger concurred with national stakeholders, whereas in Akwa Ibom, where facility deliveries are more common, respondents favoured facility-anchored advance distribution of misoprostol approaches (i.e. distribution to pregnant women during late third-trimester antenatal care visits) and saw community-based advance distribution channels (i.e. distribution through community health workers and/or private pharmacies and medicine vendors) as relevant mainly for defined hard-to-reach pockets. Where favourable views of advance distribution of misoprostol were strongest (Sokoto, Niger), regulatory and supply gaps were identified as the most prominent barriers to implementation; where stakeholders were more hesitant about advance distribution of misoprostol (Akwa Ibom), facility rates were higher and advance distribution of misoprostol was seen as contradicting, rather than complementing, efforts to promote facility births.

Socio-economic and socio-cultural dynamics shaping acceptability

The same poverty and limited-education factors that keep women from attending ANC also challenged operationalisation of advance distribution of misoprostol guidelines: where ANC coverage is low, ANC-based distribution alone will not reach the women most at risk of home delivery, making complementary community-based channels necessary. Both policy decision-makers and implementers described autonomy-constrained household decision-making, in which husbands, mothers-in-law, and senior family members influence whether a woman attends ANC, keeps the medicine at home, and takes it at the correct moment. Cultural and religious norms, and the influence of traditional rulers and religious leaders, could either legitimise or obstruct advance distribution of misoprostol.

> *"A woman won't take any drug unless her husband or mother-in-law agrees. This second delay is a problem."* – Akwa Ibom, implementer, KII

> *"We respect our traditional and religious leaders; when they advise us on what to do, we follow it."* – Sokoto, policy decision-maker, KII

Across all three states, misoprostol's association with abortion was identified as a particularly persistent demand- and supply-side barrier to advance distribution of misoprostol implementation: it discourages women and gatekeepers from accepting the medicine and discourages health workers from counselling confidently, fuelling community misinformation and weakening trust in non-facility channels.

Ethical context: equity against safety, professional control, and accountability

Several policy decision-makers and professional-association members articulated an equity argument for advance distribution of misoprostol: where many births occur outside facilities, withholding a low-cost, heat-stable uterotonic that could prevent death is itself an ethical concern. These arguments were balanced, and sometimes outweighed, by state-level implementer and professional-body concerns about clinical safety, professional responsibility, and unsupervised self-administration in low-literacy settings, including fears of misuse, diversion, and incorrect timing or dosing. National policy decision-makers noted that these concerns coexist with a different reality: misoprostol is already widely available in

private outlets, so the task is to regulate and counsel for safe use rather than restrict access in ways that shift use to unregulated channels.

> *"The drug is already in the open. A woman can easily buy it. So let us work around what we can do to regulate, rather than restrict it."* – Abuja, policy decision-maker, Roundtable

Ethical caution was the strongest barrier to advance distribution of misoprostol policy endorsement where there was no prior structured implementation experience (Akwa Ibom) and where professional gatekeeping was most pronounced; where advance distribution of misoprostol had been previously implemented (Sokoto), the same risks were framed as operationally manageable.

Legal and regulatory framing: guideline and licensing disconnect

The legal and regulatory environment was the structural domain most explicitly linked to the policy-implementation gap. National policy decision-makers described the 2023 guideline as approved and specific about which distribution models are permitted, but inconsistently translated into circulars, directives, or regulatory authorisations. A specific disconnect was raised by participants at both national and state level: although the guideline authorises private-sector distribution including by PPMVs, the Pharmacy Council of Nigeria has not updated its licensing rules to permit PPMVs to stock or dispense misoprostol, leaving states uncertain which cadres or outlets may legally handle the drug.

> *"There is a national guideline for community distribution. It was approved, but implementation success is very low."* – Abuja, policy decision-maker, Roundtable

State policy decision-makers and implementers experienced this as an absence of operational direction. Without a clear circular or directive, central pharmacy officials were reluctant to procure misoprostol or support implementation of advance distribution guidelines. Stakeholders in Sokoto referred to the previous pilots with familiarity despite reporting no current directives, while those in Niger described advance distribution as unauthorised for home use even though PPMVs stocked the drug. In Akwa Ibom, participants frequently expressed uncertainty about whether a community distribution policy existed at all. This ambiguity across agencies and between federal and state levels emerged as the most consistently cited structural barrier to guideline operationalisation, reflecting unresolved institutional and professional questions regarding who may dispense uterotonics outside health facilities.

Political and institutional dynamics

Political leadership and institutional arrangements were decisive across all states. State policy decision-makers and implementers described programme continuity as contingent on the interest of state Commissioners of Health and State Ministry of Health leadership: when interest aligned with maternal-health priorities, coordination worked; when leadership changed, momentum dissipated.

> *"When the Commissioner was interested, everyone came for meetings… but when he leaves, the programme dies."* – Sokoto, policy decision-maker, KII

National policy decision-makers identified the National Council on Health as the highest decision-making body, whose endorsement is binding on states but has not been activated for advance distribution of misoprostol since the 2023 guidelines were published. Both national and state policy decision-makers identified the inclusion or exclusion of professional bodies and regulators in policy formulation as a recurring source of friction; community-based actors who had not been involved in the policy development were described as having low formal but high informal influence. The political-institutional architecture for advance distribution of misoprostol exists in part (***Table 3***) but lacks cohesion needed to serve as a reliable driver of policy implementation (***Table 3***).

Agency and behavioural factors shaping advance distribution of misoprostol policy uptake and operationalisation (COM-B domains)

Behavioural factors influence how individual and institutional actors are positioned to act on advance distribution of misoprostol. State-level differences were most pronounced here.

Capability: workforce, knowledge, and confidence to safely implement advance distribution of misoprostol

Across all states, multiple cadres with potential for advance distribution of misoprostol existed (midwives, nurses, CHEWs, JCHEWs, CHIPS agents, community-based health workers, TBAs, PPMVs); workforce availability was not the binding constraint; readiness was. Sokoto showed the strongest capability from past donor-supported pilots that trained CHIPS agents, community-based health workers, ward development committees, and women's groups, though attrition has reduced the number of trained

staff still in service. Niger's workforce was available but less experienced with community-level use; Akwa Ibom had trained CHIPS agents but withdrew community-level misoprostol stock, leaving CHIPS in referral roles.

> *"There is attrition of healthcare workers across the board… so there will be need for training of new workers and retraining of even the old ones."* – Sokoto, implementer, KII

Psychological capability varied sharply. Sokoto-based policy decision-makers and implementers articulated misoprostol's purpose, correct timing, and clinical precautions clearly; national policy decision-makers contrasted this familiarity with limited capability elsewhere; Akwa Ibom respondents most often reported being unaware that advance distribution of misoprostol was a current policy option, expressing hesitation grounded in unfamiliarity rather than clinical reasoning. Niger policy decision-makers identified an existing and suitable community health workforce for community-based distribution of misoprostol but emphasised the need for training.

> *"Now we have the community-based healthcare workers- the JCHEWs who have gone through the School of Health Technology. Those ones will be able to handle the use of Misoprostol. But they must undergo training first".*- Niger, policy decision maker, Roundtable

> *"Most of us here do not really know what to do with those guidelines. But in places like Sokoto, they will be very familiar with the guidelines."* – Abuja, policy decision-maker, Roundtable

Opportunity: physical and social conditions for advance distribution of misoprostol

Misoprostol was available and used within facility-based services in all three states, but sustained availability was donor-dependent and uneven, with no dedicated budget line in any state for community-level distribution. Sokoto's history of donor-supported programmes produced the most consistent prior supply environment; Niger's supply for facility use was donor-cycle dependent with frequent stockouts, though PPMVs were routinely stocked (de facto community availability through the private sector); in Akwa Ibom, community-level stock had previously been distributed through CHIPS agents but was withdrawn following misuse concerns, and a subsequent UNFPA-supported procurement stabilised supply for facility use. Last-mile distribution and the absence of community-level pharmacovigilance were near-universally identified gaps.

> *"How do you monitor adverse events if the drug is used outside the facility? There is currently no way to track if something goes wrong in communities."* – Abuja, policy decision-maker, KII

Social opportunity was stronger and more uniform: state RMNCAH technical working groups were identified as established platforms for engagement and joint planning, and the natural site for state-level adaptation of national guidance. Yet both implementers and policy decision-makers reported these platforms are underutilised, specifically with regulators (Pharmacy Council of Nigeria, National Agency for Food and Drug Administration and Control) and some professional associations – key stakeholders for planning and implementation of advance distribution of misoprostol - inconsistently present.

> *"We have technical working groups for virtually any intervention. The coming together of stakeholders makes interventions impactful."* – Sokoto, implementer, KII

Motivation: interests, professional identity, and confidence in advance distribution of misoprostol

Across all states, policy decision-makers and implementers voiced strong reflective motivation to reduce maternal mortality and recognised misoprostol as lifesaving; Sokoto implementers, drawing on pilot experience, were most explicit in framing advance distribution of misoprostol as effective and safe. Several dynamics moderated this motivation. Automatic concerns about misuse and stigma were prominent among implementers, and most pronounced in Akwa Ibom, producing ambivalence rather than opposition: implementers described advance distribution of misoprostol as worthwhile in principle while hesitating to endorse distribution beyond facility settings in practice. Institutional incentives mattered: national performance benchmarks for skilled birth attendance and facility delivery, applied across all states, do not capture whether women delivering outside facilities access a uterotonic, rendering advance distribution of misoprostol institutionally invisible.

> *"Some of the indicators at the national level have to do with deliveries being attended by skilled birth attendants. If women start delivering at home, it will affect our ranking."* – Niger, policy decision-maker, Roundtable

Professional identity and role boundaries figured strongly among professional-association members and clinical implementers, who framed administration of uterotonics as a clinical responsibility and viewed

task-sharing or self-administration as a shift in jurisdiction. Stakeholder motivation was often strengthened through exposure to implementation evidence and operational experience. Where stakeholders had seen advance distribution of misoprostol work (Sokoto), confidence that it could be delivered safely and within existing regulatory and professional boundaries was higher; where they had not, both policy decision-makers and implementers called for further evidence of how advance distribution of misoprostol can work within Nigeria's current regulatory environment.

> *"We already have a baseline through the pilot projects. We can evaluate it and use evidence to convince stakeholders. When you bring data and evidence, no one will argue."* – Abuja, policy decision-maker, KII

Stakeholder-identified pathways for context-responsive advance distribution of misoprostol guideline operationalisation

Stakeholders identified six interrelated pathways for guideline operationalisation: policy alignment, model adaptation, health system support (including coordination of human resource capacity, commodity management and information system strengthening), demand creation, financing and operational learning. Policy decision-makers more often emphasised policy and regulatory alignment, coordination, indicator visibility, and financing; Implementers more often emphasised service-delivery approaches, supply and logistics, training and supervision, community engagement, and pharmacovigilance. Both stakeholder types converged on inclusive policy formulation and operational learning as preconditions for legitimacy and confidence.

Policy and regulation alignment with the *National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage* requires translation of national policy into state-level operational direction. Such direction would need to specify the cadres authorised for each distribution model, supply pathways, monitoring and supervision arrangements, and resolution of the Pharmacy Council of Nigeria licensing disconnect. Stakeholders proposed that operational direction be issued through a national circular, followed by state stakeholder meetings and stakeholder-supervised piloting in selected local government areas.

Contextual adaptation of service-delivery models should be encouraged through the policy translation process. Sokoto favoured a hybrid ANC-and-community-based distribution model building on prior pilot experience; Niger proposed community-led models with intensive supervision and regulated PPMV channels; Akwa Ibom preferred facility-anchored ANC distribution with CHIPS agents in referral and follow-up roles. Across settings, non-facility actors were framed as extensions of the health system embedded in counselling, supervision, reporting, and referral, not substitutes for skilled care.

Irrespective of the distribution model selected, common factors were identified as critical to facilitate policy uptake. Health-system support functions requiring attention included training and supportive supervision for authorised cadres; integration of misoprostol in routine primary health care supply chains and differentiation of community stock from facility stock; pharmacovigilance and reporting tools adapted for advance distribution of misoprostol; integration of community births into uterotonic coverage indicators in HMIS/DHIS2; and quality assurance for community-level distribution. In terms of stakeholder engagement and demand creation, collaboration of trusted community actors (traditional and religious leaders, women's groups, ward development committees) was framed as an acceptability strategy, a safeguarding measure, and a way to reduce professional tension by clarifying roles and addressing abortion-related stigma directly. Stakeholders, and state decision-makers in particular, prioritised operational learning on how to implement advance distribution of misoprostol in Nigeria's current environment over further evidence of whether it works. Finally, financing and sustainability planning were highlighted as central to success. Lessons from earlier initiatives showed that where partner funding ended and state ownership had not been institutionalised, implementation ceased. Stakeholders concurred that sustainability depends on integration into routine primary health care financing through dedicated state budget lines, central medical-stores supply flows, and explicit financing for supervision, logistics, and monitoring.

Discussion

This political economy analysis revealed that the advance distribution of misoprostol policy-implementation gap is the result of unresolved disconnects between the distribution models authorised in the national guidelines and Pharmacy Council of Nigeria licensing rules, weak federal-to-state policy translation, fragmented supply and financing, and a behavioural landscape in which capability, opportunity, and motivation to expand access to uterotonic medicine for PPH prevention outside of health facilities are unevenly distributed across states and stakeholder groups. Together, these findings illustrate a pattern well described in health policy and systems scholarship: a favourable policy is not self-executing, and whether it is enacted depends on how interests, incentives, and institutional relationships align around implementation (24-26).

Few countries have moved advance distribution of misoprostol from pilot to routine practice at scale (5, 32). Nigeria, with a national guideline already in place, a large community health workforce, and documented state-level implementation experience, is well positioned to demonstrate how that transition can be made if the barriers to operationalisation of national guidelines identified in this analysis are well addressed. Our findings echo international evidence that the principal obstacles to advance distribution of misoprostol are regulatory ambiguity, supply integration, and stakeholder alignment rather than lack of evidence (32, 33), and resonate with analyses framing misoprostol's contested trajectory as shaped as much by social meaning and institutional control (34, 35).

Stakeholder agency and behaviour varied along a gradient anchored in prior implementation experience. Sokoto, drawing on earlier pilots, demonstrated the most readiness to operationalise national guidelines, Akwa Ibom demonstrated the least readiness, and Niger between the two. This gradient suggests that investments in advancing guideline operationalisation should be contextualized rather than uniform: implementation at scale accompanied by structured operational learning where experience already exists, supervised demonstration of context-adapted implementation models where capacity is present but implementation experience is limited, and guideline familiarisation and stigma-reduction focused stakeholder engagement where awareness is lowest. Two behavioural motivators are critical to consider

across all contexts. First, performance indicators centre on skilled birth attendance and facility delivery and do not capture whether women who deliver at home receive a uterotonic; provider incentive systems consequently reward facility-based services while offering no recognition for community-level protection. Second, professional identity and role boundaries generated resistance to task-sharing and self-administration, framed by some clinical stakeholders as a loss of jurisdiction; a tension national policy decision-makers countered by noting that misoprostol is already widely available and that the realistic task is to regulate access, not restrict it.

In sum, more than a decade of favourable evidence and progressively expanding policy (11-23) has not produced implementation because the political economy of operationalisation, namely jurisdiction, incentives, professional norms, and financing, has not been addressed. The prominence accorded to financing reflected lessons drawn from previous implementation experiences in Nigeria. Participants noted that earlier initiatives frequently weakened or ceased once external funding ended because they lacked institutionalised state ownership. These experiences suggest that sustainability depends on embedding advance distribution of misoprostol within routine primary health care financing arrangements rather than relying on time-limited, vertically funded projects. Evidence from other settings reinforces these findings. For example, sustained advocacy and regulatory engagement were instrumental in advancing misoprostol policy reforms in Pakistan (36). Similarly, systematic reviews of implementation barriers across low- and middle-income countries have demonstrated that successful scale-up depends on coordinated action across regulatory, supply chain, health system, and financing domains rather than the generation of additional efficacy evidence (37).

Operationalising the *National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage* requires acting on multiple levers simultaneously, with the National Council on Health and federal regulators resolving authorisation, and states using existing coordination platforms to adapt and resource delivery. State-level adaptation should concentrate first on the states and local government areas with the highest proportions of births outside facilities, and that all communication about advance

distribution should carry a dual message: advance distribution of misoprostol is a precautionary measure to prevent PPH in births that occur outside a facility, but facility birth with a skilled attendant remains the goal.

Strengths and limitations

This study should be interpreted alongside its strengths and limitations. It is one of the first to apply a PEA lens to understanding the policy-implementation gap around advance distribution of misoprostol for PPH prevention in births outside health facilities. It also drew on reflections of current and previous programming spanning national and frontline perspectives and contrasting epidemiological and implementation contexts across three states. Triangulation across methods, stakeholder types, and settings offers insights on models that may be transferable to comparable decentralised contexts in and outside Nigeria. Further, use of an integrated analytical framework, team-based interpretation, and member checking supports the study's credibility. Limitations include the deliberate focus on policy and implementation stakeholders rather than women and community members, whose perspectives on acceptability warrant dedicated study. The relatively short fieldwork window may have missed perspectives of staff who had been exposed to prior advance distribution of misoprostol pilots and possibility of attenuated/elevated social-desirability effects in discussing a contested intervention. Each roundtable also opened with a level-setting presentation summarising the evidence on advance distribution of misoprostol, which may have shaped the discussion that followed; the observation that stakeholder motivation strengthened with exposure to implementation evidence should therefore be read with the study design in mind. Finally, the focus on three states, while purposively diverse, does not represent the full range of Nigeria's contexts.

Conclusion

Postpartum haemorrhage remains a leading cause of maternal death in Nigeria, and the women at highest risk are those who give birth where neither a skilled attendant nor a uterotonic is available. The policy

foundations for reaching them are already in place; what is missing is operationalisation. Closing the gap will require federal regulatory clarification, state-led contextual adaptation through inclusive coordination platforms, and integration of advance distribution of misoprostol into routine financing, supply, workforce, and monitoring systems, pursued together as a cohesive implementation strategy and grounded in operational learning from Nigeria's own implementation experience.

Tables and Figures

Table 1. **Study settings: maternal health profile, comparative epidemiological, geographic, and contextual conditions, and history of advance distribution of misoprostol implementation**

Location (setting)	Geopolitical zone	ANC from skilled provider*	≥ 4 ANC visits*	Facility delivery*	Salient context for advance distribution of misoprostol operationalisation
Abuja (national)	Federal Capital Territory	-	-	-	Seat of the Federal Ministry of Health, the National Primary Health Care Development Agency, regulatory bodies (Pharmacy Council of Nigeria; National Agency for Food and Drug Administration and Control; Nursing and Midwifery Council of Nigeria; Medical and Dental Council of Nigeria; Community Health Practitioners Registration Board of Nigeria), national professional associations, and the Reproductive, Maternal, Newborn, Child and Adolescent Health technical working group.
Sokoto (state)	North-West	~26%	23%	13%	Site of donor-supported advance distribution of misoprostol pilots (~2009-2015); institutional memory of safe community use; donor-dependent commodity supply; insecurity in some local government areas; very dispersed rural populations.
Niger (state)	North-Central	~40%	35%	30%	No structured advance distribution of misoprostol programme; donor-cycle dependent health commodity supply; misoprostol restricted to facility use; misoprostol widely available through Patent and Proprietary Medicine Vendors in communities; insecurity in some local government areas.
Akwa Ibom (state)	South-South	~81%	66%	39%	Previous advance distribution of misoprostol through CHIPS agents halted following misuse concerns; recent UNFPA-supported procurement has stabilised misoprostol supply for facility use; strong state policy emphasis on facility delivery; riverine hard-to-reach pockets.

* ANC = antenatal care; indicators are drawn from the 2024 NDHS [11]; "-" denotes not applicable at federal level.

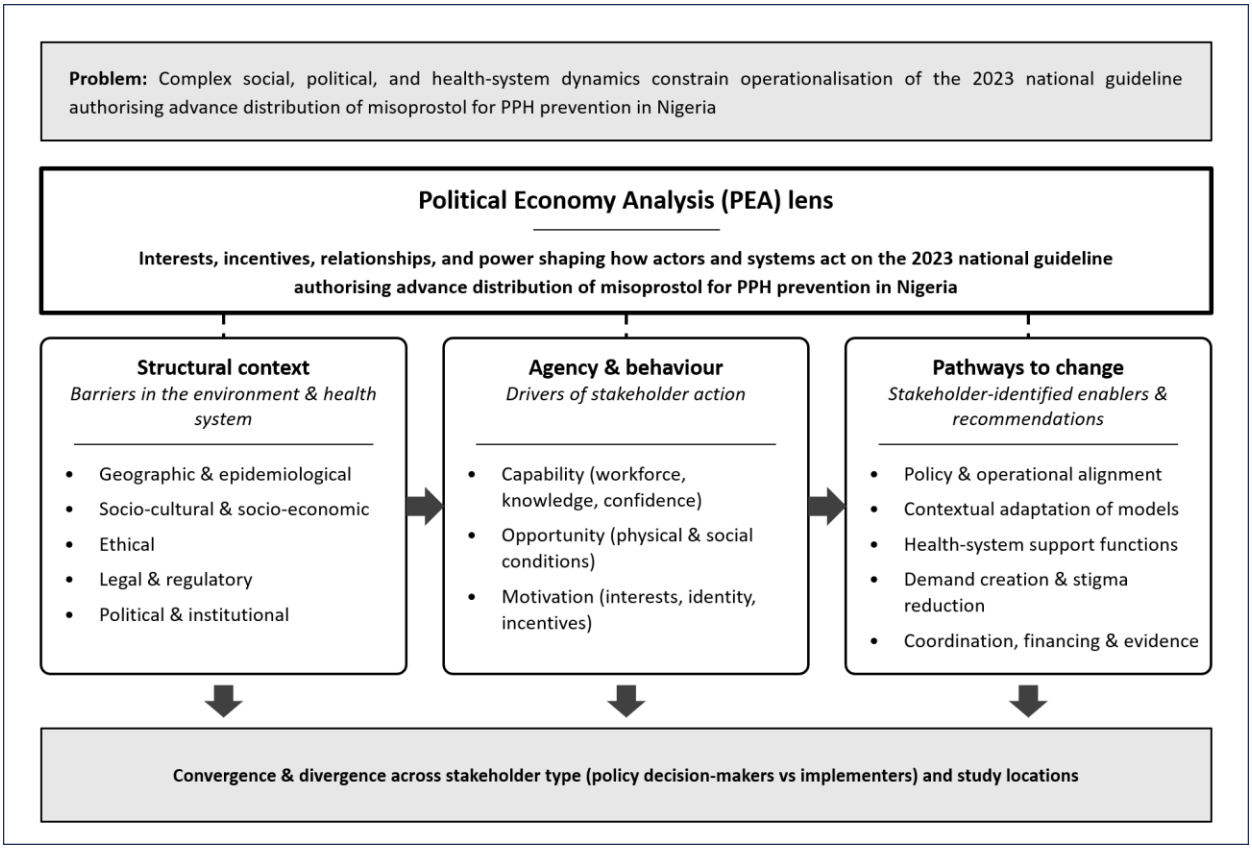
Table 2. **Participants by stakeholder type and data collection method**

Method	Level	Setting	Participants	Stakeholder composition
Key informant interviews	National and state	Abuja, Sokoto, Niger, Akwa Ibom	48	Policy decision-makers (government, regulators, professional bodies) and implementers (healthcare providers, community health workers, implementing partners)
Stakeholder roundtable	National	Abuja	11	Federal government, regulatory agencies, professional-association leadership, development partners
Stakeholder roundtables	State	Sokoto, Niger, Akwa Ibom (11–12 per state)	35	State Ministry of Health officials, state Primary Health Care Development Agency representatives, programme managers, professional-association leadership, community programme actors, implementing partners
		Total	**94**	

Table 3. **Stakeholder mapping for advance distribution of misoprostol operationalisation in Nigeria**

Key actors	Role in advance distribution of misoprostol	Influence	Position	Key interests / incentives
National decision-making authority National Council on Health	Highest policy approval body; decisions binding on states	Very high	Supportive	Maternal health outcomes; system-wide direction
Federal policy actors Federal Ministry of Health; National Primary Health Care Development Agency; Reproductive, Maternal, Newborn, Child and Adolescent Health technical working group	Policy development, technical guidance, coordination	Very high	Supportive	Reducing maternal mortality; alignment with global guidance
Development partners Unitaid; United Nations Population Fund; bilateral donors; international and national non-governmental organisations	Funding, technical support, pilots, evidence generation	High (indirect)	Supportive	Programme impact; evidence; scale-up
Regulatory bodies Pharmacy Council of Nigeria; National Agency for Food and Drug Administration and Control; Nursing and Midwifery Council of Nigeria; Medical and Dental Council of Nigeria	Distribution regulation, licensing, pharmacovigilance	High	Cautious / restrictive	Drug safety; regulatory control; professional standards
Professional associations Society of Obstetrics and Gynaecology of Nigeria; National Association of Nigeria Nurses and Midwives; Nigerian Medical Association; Pharmaceutical Society of Nigeria	Clinical guidance, endorsement, influence over providers	High	Mixed / cautious	Professional standards; role boundaries; authority
State government actors State Ministries of Health; Commissioners for Health; State Primary Health Care Development Agencies	Policy domestication, implementation, resource allocation	High (state)	Variable	Political priorities; performance indicators; leadership interest
Facility-level providers Doctors, nurses, midwives	Service delivery, counselling	Moderate	Mixed	Clinical responsibility; workload; professional identity
Community health workforce Community Health Extension Workers; Junior Community Health Extension Workers; Community Health Influencers, Promoters and Services agents	Community-level delivery, counselling, referral	Moderate (operational)	Supportive	Expanding access; community trust; defined roles
Private-sector actors Patent and Proprietary Medicine Vendors (tier 2/3); community pharmacies	Potential last-mile distribution	Moderate (latent)	Conditional	Business incentives; regulatory approval; training
Community actors Traditional birth attendants; ward development committees; religious and traditional leaders; women's groups	Acceptance, norm shaping, demand creation	Low (formal) / high (informal)	Influential	Community trust; cultural norms; local legitimacy

Figure 1. **A political economy analysis framework to understand the advance distribution of misoprostol policy-implementation gap through structural context, agency and behaviour, and stakeholder-identified pathways to change in Abuja, Sokoto, Niger, and Akwa Ibom States, Nigeria.**



Additional Files

Supplementary File 1. Data collection tools (v1.0, 1 April 2025).

Supplementary File 2. Illustrative quotations by theme and sub-theme (Tables S1–S3).

List of Abbreviations

ANC	antenatal care
CHEW	community health extension worker
CHIPS	community health influencers, promoters and services
CICI	Context and Implementation of Complex Interventions (framework)
COM-B	Capability-Opportunity-Motivation-Beahviour (model)
DHIS2	District Health Information Software 2
HMIS	health management information system
JHU	Johns Hopkins University
KII	key informant interview
NHREC	National Health Research Ethics Committee of Nigeria
PEA	political economy analysis
PPH	postpartum haemorrhage
PPMV	patent and proprietary medicine vendor
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCAEH+N	reproductive, maternal, newborn, child, adolescent and elderly health plus nutrition
SRQR	Standards for Reporting Qualitative Research
TBA	traditional birth attendant
UNFPA	United Nations Population Fund
WHO	World Health Organization

Declarations

Ethics approval and consent to participate

Participation was voluntary, and written informed consent was obtained from all participants before data collection. Ethical approval for the study was obtained from the National Health Research Ethics Committee of Nigeria (Approval Number: NHREC/01/01/2007-21/07/2025) and the Johns Hopkins University Institutional Review Board (JHU IRB No: 32982).

Consent for publication

Not applicable. Quotations are attributed only by stakeholder type and setting, with no individually identifiable participant data.

Availability of data and materials

The de-identified data supporting the findings of this study are available from the corresponding author on reasonable request and signature of a data sharing and use agreement.

Declaration of competing interests

The authors declare that they have no competing interests.

Funding

Work presented in this publication was made possible with support from the *Accelerating Measurable Progress and Leveraging Investments for Postpartum Hemorrhage Impact* project co-funded by Unitaid [2022-48-AMPLI-PPHI] and the European Union's Safe Birth Africa Initiative – a joint Unitaid-UNFPA venture and a Global Gateway Flagship Project [2024-57-AMPLI-PPHI]. The content is the responsibility of the authors and does not represent the views of Unitaid or the European Union.

Author contributions

SO1 contributed to study design, tools development, study implementation including training of data collectors, data collection and analysis, interpretation of findings and manuscript writing. VAA contributed to study design, tools development, interpretation of findings and manuscript writing. SO2 contributed to interpretation of findings and manuscript writing. BCO contributed to study design, tool development, interpretation of findings and manuscript writing. SK coordinated study implementation including training of data collectors and data collection and contributed to interpretation of findings and manuscript writing. ANA contributed to tool development, interpretation of findings and review of manuscript. OS contributed to study design and coordination of study implementation. AO provided technical oversight during study design and implementation. FN contributed to study design, tool development, technical oversight and quality assurance during data collection and critically review of the manuscript. HT contributed to conceptualisation and study design, tool development, technical oversight during data collection, interpretation of findings, and critical review and revision of the manuscript. ER acquired funding and contributed to critical review and revision of the manuscript. PS contributed to conceptualization and study design, technical oversight during study implementation, interpretation of findings and manuscript writing. All authors contributed to the interpretation of the findings, approved the final version of the manuscript, and agree to be accountable for all aspects of the work.

Acknowledgements

We thank Donald Akpena, Endurance Bako, Adamu Umar, Emmanuel Alabi, and Akintayo Taiwo for their contributions to this study. We also thank the study participants and the policy and implementation stakeholders at national and state level in Sokoto, Niger, and Akwa Ibom who generously gave their time to this research.

References

1. Trends in maternal mortality estimates 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division Geneva: World Health Organization; 2025

2. Cresswell JA, Alexander M, Chong MYC, Link HM, Pejchinovska M, Gazeley U, et al. Global and regional causes of maternal deaths 2009-20: a WHO systematic analysis. Lancet Glob Health. 2025;13(4):e626-e34.

3. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health. 2018;6(11):e1196-e252.

4. Federal Ministry of Health and Social Welfare of Nigeria (FMoHSW) NPCNN, and ICF. Nigeria Demographic and Health Survey 2024. Abuja, Nigeria, and Rockville, Maryland, USA: FMoHSW, NPC, and ICF; 2025.

5. Tappis H, Doi N, Bhola C, Bamba Y, Lathrop E. Reducing inequities in access to postpartum hemorrhage prevention: Reframing advance distribution of misoprostol as a test case for health system responsiveness and adaptation. Int J Gynaecol Obstet. 2026;172 Suppl 2(Suppl 2):S26-s33.

6. World Health Organization. WHO recommendations for the prevention and treatment of postpartum haemorrhage Geneva: WHO; 2012

7. World Health Organization. WHO recommendation on advance misoprostol distribution to pregnant women for prevention of postpartum haemorrhage Geneva: WHO; 2020

8. Oladapo OT, Fawole B, Blum J, Abalos E. Advance misoprostol distribution for preventing and treating postpartum haemorrhage. Cochrane Database Syst Rev. 2012(2):CD009336.

9. World Health Organization. Consolidated guidelines for the prevention, diagnosis and treatment of postpartum haemorrhage 2025.

10. Papageorghiou AT, Kihara AB, Dunkley-Bent J, Ahsan S, Begum F, Escobar Vidarte MF, et al. New guidelines for the prevention, diagnosis, and treatment of postpartum haemorrhage: ending the geography of risk. Lancet Glob Health. 2025;13(11):e1796-e8.

11. Ejembi C, Shittu O, Moran M, Adiri F, Oguntunde O, Saadatu B, et al. Community-level distribution of misoprostol to prevent postpartum hemorrhage at home births in northern Nigeria. Afr J Reprod Health. 2014;18(2):166-75.

12. Prata N, Ejembi C, Fraser A, Shittu O, Minkler M. Community mobilization to reduce postpartum hemorrhage in home births in northern Nigeria. Soc Sci Med. 2012;74(8):1288-96.

13. Cannon M, Charyeva Z, Oguntunde O, Sambisa W, Shoretire K, Orobaton N. A case study of community-based distribution and use of Misoprostol and Chlorhexidine in Sokoto State, Nigeria. Glob Public Health. 2017;12(12):1553-67.

14. Orobaton N, Abdulazeez J, Abegunde D, Shoretire K, Maishanu A, Ikoro N, et al. Implementing at-scale, community-based distribution of misoprostol tablets to mothers in the third stage of labor for the prevention of postpartum haemorrhage in Sokoto State, Nigeria: Early results and lessons learned. PLoS One. 2017;12(2):e0170739.

15. Federal Ministry of Health of Nigeria. Essential Medicines List, 5th revision. Abuja: Federal Ministry of Health; 2010.

16. Federal Ministry of Health Nigeria. National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage at the community level. Abuja: Federal Ministry of Health; 2011.

17. Federal Ministry of Health of Nigeria. National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage (revised). Abuja: Federal Ministry of Health; 2020.

18. Federal Ministry of Health of Nigeria. National guidelines for the use of misoprostol for the prevention of postpartum haemorrhage (revised). Abuja: Federal Ministry of Health; 2023.

19. Federal Ministry of Health of Nigeria. Task Shifting and Task Sharing Policy for essential health care services in Nigeria. Abuja: Federal Ministry of Health; 2014.

20. National Primary Health Care Development Agency. CHIPS Programme Guidelines. Abuja: National Primary Health Care Development Agency; 2018.

21. National Primary Health Care Development Agency. CHIPS Facilitators Manual. Abuja: National Primary Health Care Development Agency; 2022.

22. Federal Ministry of Health of Nigeria. National guidelines on self-care for sexual, reproductive, maternal, newborn, child and adolescent health. Abuja: Federal Ministry of Health; 2020.

23. Federal Ministry of Health of Nigeria. Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N) Strategy 2022-2026. Abuja: Federal Ministry of Health; 2022.

24. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy Plan. 1994;9(4):353-70.

25. Sheikh K, Gilson L, Agyepong IA, Hanson K, Ssengooba F, Bennett S. Building the field of health policy and systems research: framing the questions. PLoS Med. 2011;8(8):e1001073.

26. Gilson L, Raphaely N. The terrain of health policy analysis in low and middle income countries: a review of published literature 1994-2007. Health Policy Plan. 2008;23(5):294-307.

27. Karuveettil V, Janakiram C, Ramesh S, Ramachandran A, Mathur M, Varma B, et al. Political economy analysis of health: a scoping review of concepts, definitions, frameworks, outcomes, and applications. Health Policy Plan. 2026;41(Supplement_1):i91-i110.

28. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-51.

29. Pfadenhauer LM, Gerhardus A, Mozygemba K, Lysdahl KB, Booth A, Hofmann B, et al. Making sense of complexity in context and implementation: the Context and Implementation of Complex Interventions (CICI) framework. Implement Sci. 2017;12(1):21.

30. Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. Implement Sci. 2011;6:42.

31. Braun V, Clarke V. What can "thematic analysis" offer health and wellbeing researchers? Int J Qual Stud Health Well-being. 2014;9:26152.

32. Hobday K, Hulme J, Belton S, Homer CS, Prata N. Community-based misoprostol for the prevention of post-partum haemorrhage: A narrative review of the evidence base, challenges and scale-up. Glob Public Health. 2018;13(8):1081-97.

33. Smith HJ, Colvin CJ, Richards E, Roberson J, Sharma G, Thapa K, et al. Programmes for advance distribution of misoprostol to prevent post-partum haemorrhage: a rapid literature review of factors affecting implementation. Health Policy Plan. 2016;31(1):102-13.

34. Suh S. A Stalled Revolution? Misoprostol and the Pharmaceuticalization of Reproductive Health in Francophone Africa. Front Sociol. 2021;6:590556.

35. MacDonald ME. Misoprostol: The Social Life of a Life-saving Drug in Global Maternal Health. Science, Technology, & Human Values. 2021;46(2):376-401.

36. Sarwar Z, Cutherell A, Noor A, Naureen F, Norman J. Analysis of misoprostol and chlorhexidine policy gains in Pakistan: the advocacy experience of Mercy Corps Pakistan. Health Res Policy Syst. 2015;13 Suppl 1(Suppl 1):50.

37. Samnani A, Rizvi N, Ali TS, Abrejo F. Barriers or gaps in implementation of misoprostol use for post-abortion care and post-partum hemorrhage prevention in developing countries: a systematic review. Reprod Health. 2017;14(1):139.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryFile1DataCollectionTools.docx
- SupplementaryFile2IllustrativeQuotations.docx