



MARIE STOPES
INTERNATIONAL

Global Impact Report 2012

Reaching the under-served



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Foreword

Dana Hovig
CEO 2006 to May 2013

I have spent the last seven years as CEO here at Marie Stopes International building on the achievements of our founder Tim Black in helping women and families to take control of their reproductive health, their family size and their future.

It is with great pride that I leave Marie Stopes International following one of our most historic years. We reached record numbers of women and couples in under-served areas with our high quality family planning and safe abortion services. At the London Summit on Family Planning in 2012, political leaders and sexual and reproductive health advocates from around the world stood up and made a momentous pledge – a pledge to transform the lives of 120 million people in the developing world by giving them access to something they had repeatedly asked for, and which so many of us take for granted: contraception. MSI will have an important role to play in this – as we strive to double the number of women using our family planning services by 2020.

In 2005, when I joined MSI, we had a committed, passionate group of around 4,000 sexual and reproductive health professionals. Their work had enabled 4 million women to use modern contraception at that time, and they provided around 400,000 safe abortion and post-abortion care services that year.

Today, we have nearly 9,000 team members in 41 countries. Thanks to our focus on our clients' needs, our social business models and our partnership with host governments and donors, we are proud to say that approximately 13.6 million women are using a modern method of contraception as a result of Marie Stopes International's services. And we provided around 2.2 million safe abortion and post-abortion care services in 2012, in some of the most marginalised and under-served communities in the world.

I am proud to have led such a dedicated and talented group of people, whose passion for the rights of our clients ensures we can continue to serve girls and women, even in the most difficult of circumstances.

I am regularly told that MSI now has some of the best leaders in the field of global reproductive health. The choices we provide to under-served women, couples, communities and countries will continue to grow. I look forward to seeing MSI flourish even further in the future, driven by our outstanding team members who work hard every day to fulfil our mission of children by choice, not chance.

Michael Holscher
Interim CEO

2012 was a landmark year for those of us committed to reaching girls, women and couples in need of family planning.

In July we stood up alongside international donors, governments, the private sector and civil society organisations and made a pledge that Marie Stopes International will deliver family planning services to an additional 10 million girls and women by 2020. This is on top of the 10 million we had already reached in the focus countries of the London Summit on Family Planning, as of 2011. Our commitment to reaching these women will drive us and our work for years to come.

In this year's report, we examine our overall impact in 2012, while taking a closer look at who we need to reach to make sure we achieve our 2020 goal: people living in poverty, young people, those not currently using family planning and those not able to choose the methods that are most appropriate to their needs. We also look at our vital work to provide safe abortion services – where legal – and comprehensive post-abortion care, empowering women to fulfil their rights, and protecting them from the harms of unsafe abortion.

In the following pages, we will lay out why we believe it is so important to extend access to these specific groups. We will examine how well we performed in 2012, and we will look at what more we need to

do, as an organisation and as a sector, to ensure women all over the world are able to have children by choice, not chance.

Indeed, as we strive to reach more people, we know that we must also maintain focus on the millions of girls, women and couples currently using a contraceptive method supplied by us. To make an impact on a national and global scale, we must continue to meet the needs of these women, as well as reaching out to those who have not had adequate, if any, choices before.

And while we report on overall global impact, and examine groups we need to reach, we never forget that every woman who comes to one of our service delivery points is an individual with her own unique needs and expectations. Throughout the report, we will share the stories of individual women whose lives have been transformed by the services we provide. Women like Welansa in Ethiopia, Mi Aye in Myanmar, Passipo in Nigeria, Kaushalya in India, and Sophy in Cambodia.

It is the stories of these women that remind me, and all of us at Marie Stopes International, why we must deliver on our 2020 goal. Together with our partners, we are committed in the years ahead to ensuring that more of the most under-served girls and women in the world are able to take control of their futures.

Unmet need for family planning in the developing world - 2012

Across the developing world there are approximately 222 million women who want to use, but can't access, contraception.³ While enabling women to take control of their reproductive health and their futures can be life-changing, the consequences of this lack of access can be devastating.

Every year, there are an estimated 63 million unintended pregnancies that result from a lack of contraception, and 19 million women resort to unsafe abortions to end unintended pregnancies. This causes around 82,000 women to die every year.

222million

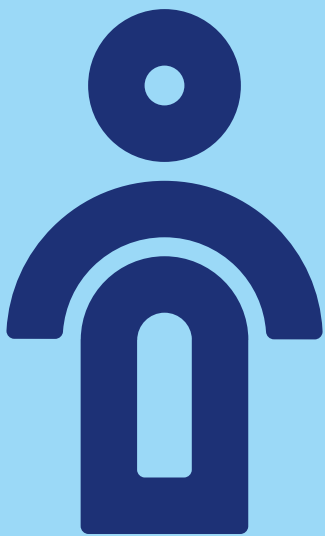
Women in the developing world who want family planning but don't have access to it

The consequences of unmet need

63m
Unintended pregnancies

19m
Unsafe abortions

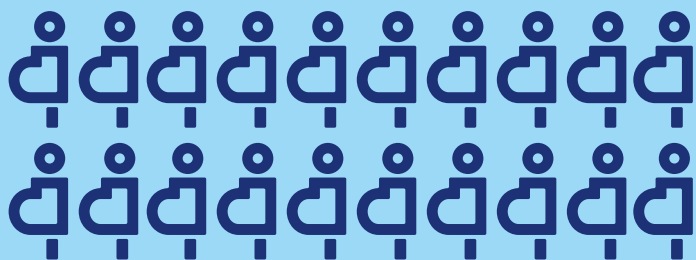
82,000
Maternal deaths



50m
Under 25

14m
Under 20

162m
In poorest countries



Marie Stopes International's 13.6 million users and our impact - 2012

We exist to ensure that women have access to a full range of reproductive health choices including modern contraception, post-abortion care and, where permitted, safe abortion.

In 2012, 13.6 million women were using a method of modern contraception provided

by us, an 18% increase from 2011. We also provided 2.2 million women with safe abortion and post-abortion care services. And as a result we prevented 5.3 million unintended pregnancies, 2.1 million unsafe abortions, and 11,300 maternal deaths.

13.6million

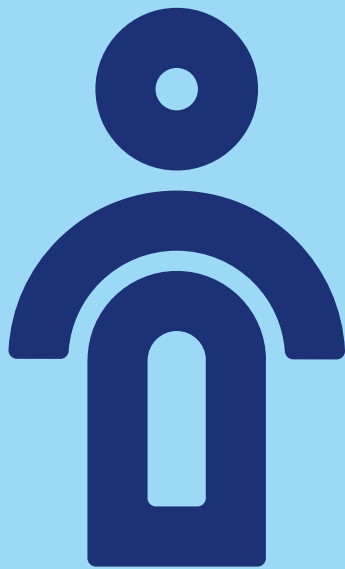
Marie Stopes International family planning users

The impact of our services

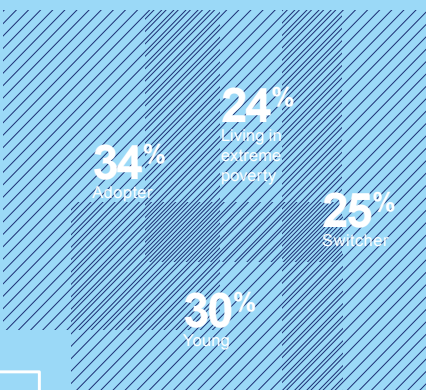
5.3m
Unintended pregnancies prevented

2.1m
Unsafe abortions prevented

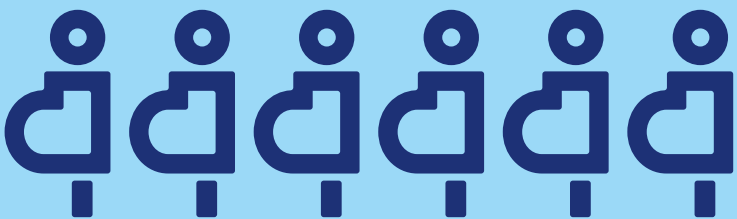
11,300
Maternal deaths prevented



Our 2012 family planning users consist of the following groups.




2.2m
Women receiving safe abortion or post-abortion care services



We have identified four groups of women who we believe we need to reach to expand access to family planning in an equitable way. For each group, we have examined our performance in reaching them in 2012.


34%
Adopters: Globally, 34% of our clients were not previously using a method of family planning

 Like Passipo in Nigeria, whose story you can read on p.6 of the case studies booklet

In many of the regions where we work contraceptive use remains low and unmet need is high. To tackle this, we are working to increase access to contraception in these places. In sub-Saharan Africa, well over one third of the women we served were not previously using family planning, compared to two in 10 women in the general population.

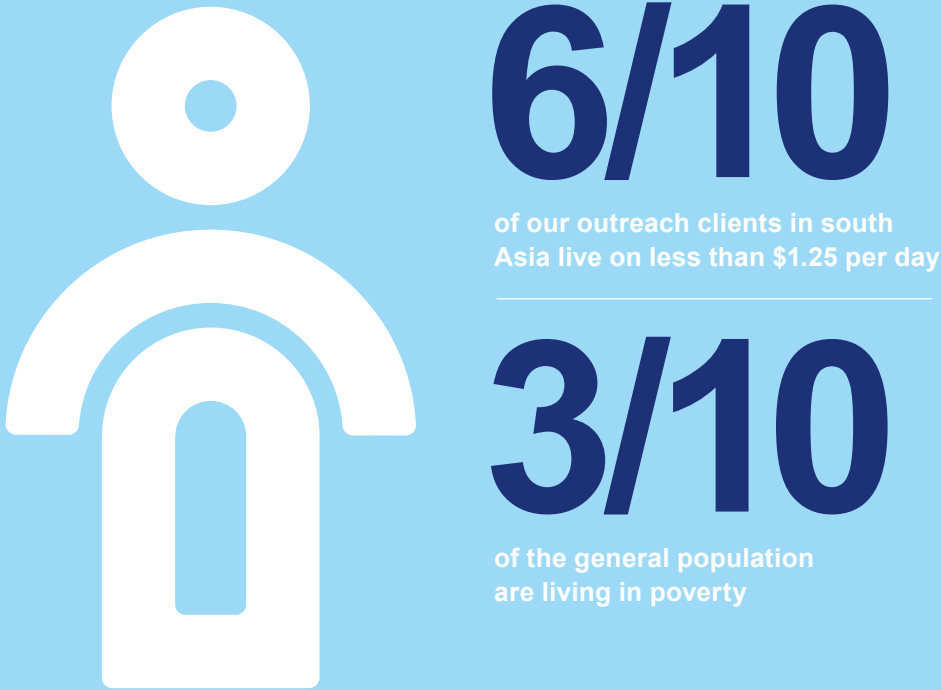


24%
Women living in extreme poverty: Globally, 24% of our clients lived on less than \$1.25 per day

 Like Kaushalya in India, whose story you can read on p.4 of the case studies booklet


Our results show that clients accessing family planning through our clinical outreach services, which are specifically designed to meet the needs of poor people, are either similarly poor or poorer than the regional average.

In south Asia, six in 10 of our outreach clients are poor, compared to three in 10 of the general population.



To reach our FP2020 goals, we must understand more about who our clients - and our potential clients - are, and what tools and approaches work best to deliver a full range of modern family planning choices and services to them.


30%
Young women: Globally, 30% of our clients were under 25

 Like Mi Aye in Myanmar whose story you can read on p.2 of the case studies booklet

In 2012 we reached more young women than ever before. In Pacific Asia, twice as many of our clients are under 25, compared with people using contraception in the general population.

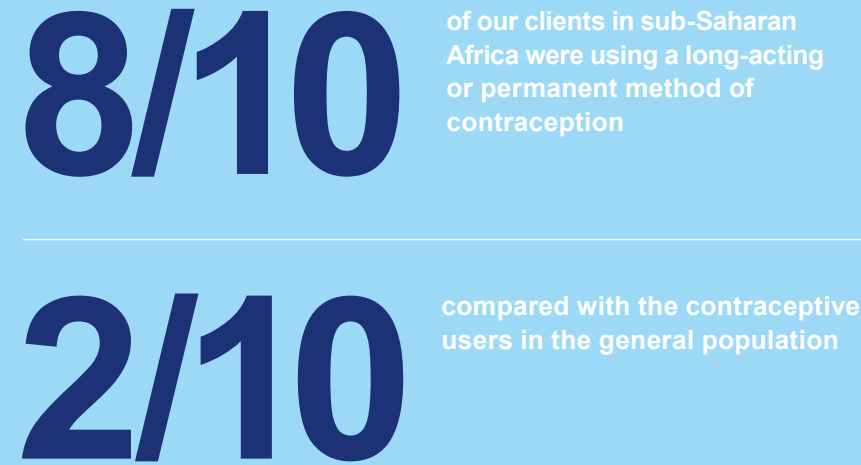


25%
Switchers: Globally, 25% of our clients changed their method of contraception when given the choice

 Like Walasa in Ethiopia, whose story you can read on p. 8 of the case studies booklet

We have expanded choice in family planning by providing contraceptive methods that are not widely available, in the countries where we work. If you look at the method mix of our clients in sub-Saharan Africa, compared with that of the general population, you can see that when women are given choice, many more opt for long term methods.

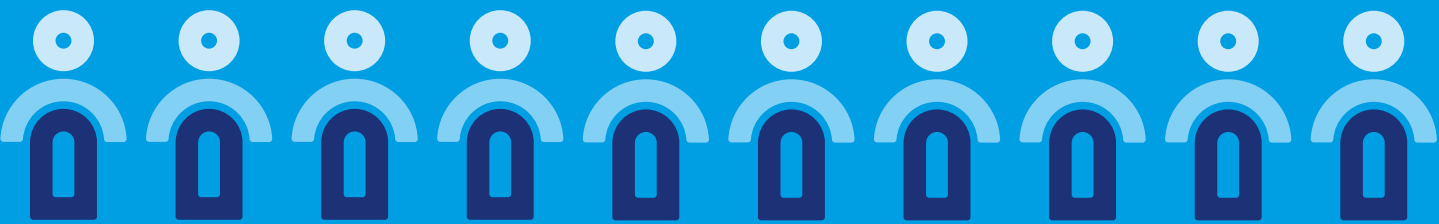
Over eight in 10 of our clients in sub-Saharan Africa were using a long-acting method of contraception, compared to less than two in 10 of the contraceptive users in the general population.



Our impact

In 2012, our services provided choices to more women than ever before. We estimate that there were around 13.6 million women across the globe using a modern method of family planning provided by Marie Stopes International by the end of 2012; more than double the number of women we were serving just four years prior to that, in 2008. This increase in our scale has meant the impact of our work has also grown.

Family planning provided by Marie Stopes International prevented an estimated 5.3 million unintended pregnancies from occurring in 2012, and combined with our safe abortion services, prevented 2.1 million unsafe abortions. This, alongside our post-abortion care services saved the lives of more than 11,000 women last year – that’s the equivalent of more than 30 women every day.



30 Our family planning, safe abortion and post-abortion care services saved the lives of more than 30 women every day.



Section 1

Figure 1. Estimated users of MSI family planning by region, 2001 - 2012 (millions)

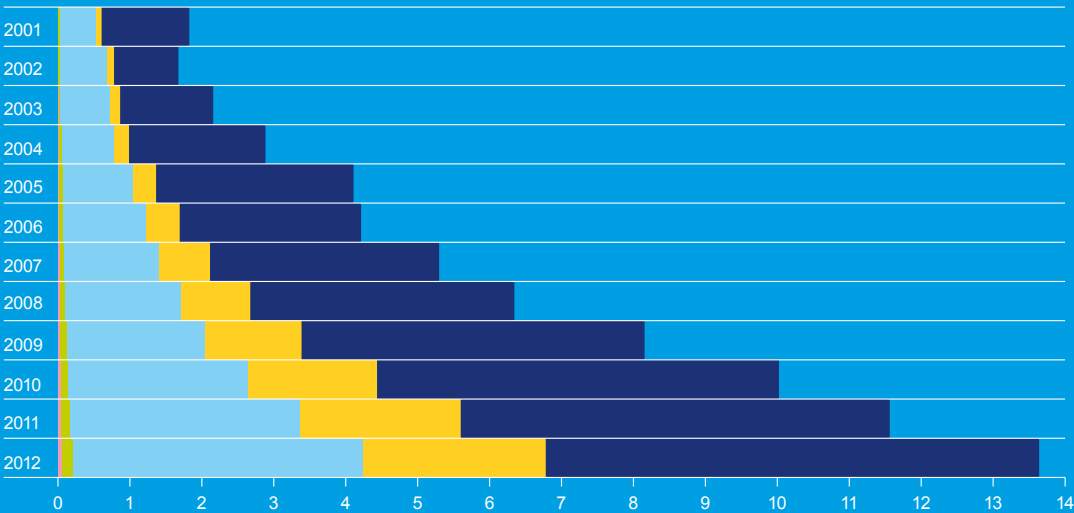
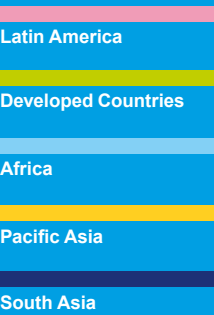
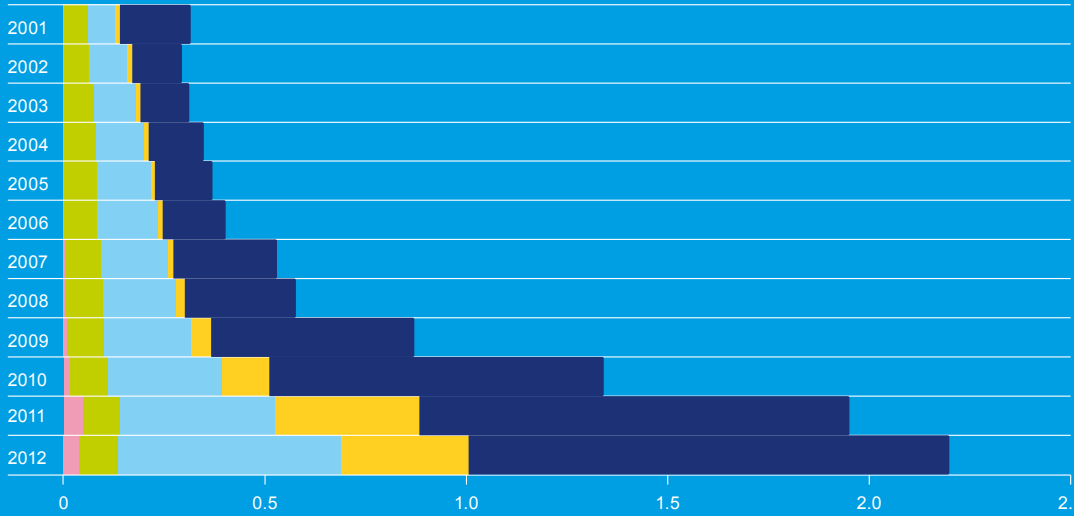
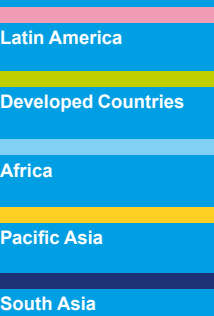


Figure 2. MSI safe abortion and post-abortion care services, by region, 2001 - 2012 (millions)



How do we calculate our impact?

We use Impact 2 - a peer-reviewed model which uses externally validated data from sources including Demographic and Health Surveys (DHS), United Nations Population Prospects, United Nations Maternal and Child Mortality data, among others - to estimate the impact of our family planning and safe abortion / post-abortion care services. Read more about this in Annex C.

Measuring our performance

Couple years of protection

One of the most important ways in which we track the performance of all our country programmes, and the extent to which we are expanding the scale of our services to bring more women choice, is through measuring the couple years of protection (CYPs) that we are delivering each year. One CYP is the contraception that is needed for a couple to prevent pregnancy over the course of a year. Different family planning methods account for different numbers of CYPs, depending on how long they can be used for, and how effectively they prevent pregnancy. Figure 3 shows how the CYPs we have delivered through family planning and safe abortion / post-abortion care services have grown since 2000.

It is, however, essential that we look beyond the volume of services, to ensure that the services we're delivering are equitable. This is why we have adjusted the CYP metric to account for CYPs that go towards: women living in extreme

poverty, adolescents, women not currently using family planning, women choosing to change to a longer acting method from a short term one, and women who are receiving family planning after giving birth or having an abortion. The new metric, which we call the High Impact CYP, was developed based on our goal of reaching those who have the greatest need for improved choice in family planning. Its purpose is to inform decision-making and contribute to real operational improvements, by helping us understand where we are performing well in reaching certain groups of women in need, and where we could perform better. Section 2 of this report explores our performance in reaching these groups of women, and why it is important that we do so.

In 2012, in the 28 programmes where we measured them, 86% of the family planning CYPs that we delivered were High Impact CYPs. These data are being used by these programmes to inform their future strategy, helping us bring choice to more women.

What's in a couple year of protection?

Effectiveness
What is the likelihood that a woman will experience unintended pregnancy using the method?

Duration
How long can the method be used for?

Frequency and consistency
For methods that are only used when couples have sex (e.g. condoms and spermicides), how many do they need in a year, and how often are they used?

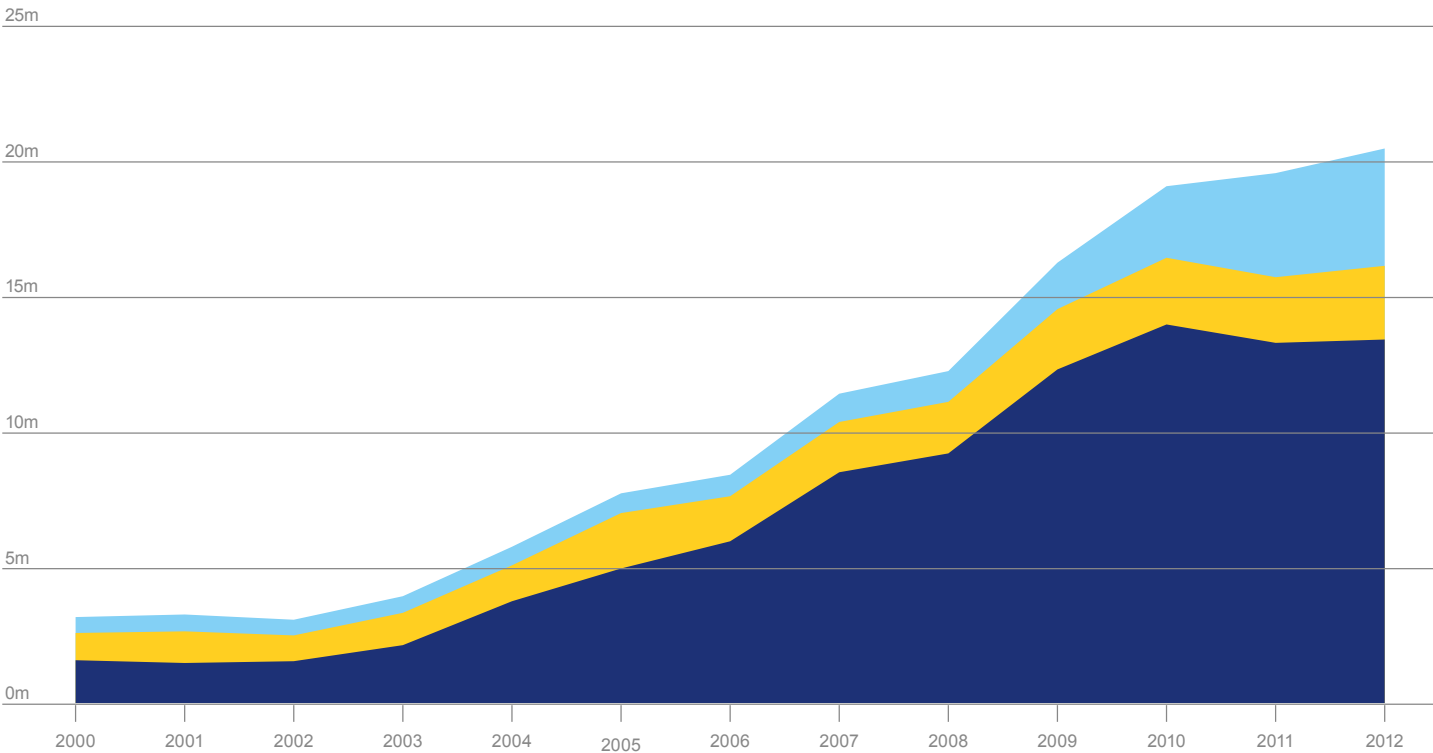
Discontinuation
How long do most women continue to use the method?

Figure 3.
MSI couple years of protection (CYP) growth, 2000 - 2012

Long-acting and permanent method

Short term methods

Safe abortion / post-abortion care



Looking to FP2020



In total, over eight years up to 2020, Marie Stopes International will therefore help prevent some:



What is FP2020?

2012 was a landmark year for family planning. An unprecedented series of national and global pledges were made at the London Summit on Family Planning by donors and developing countries to expand access to a further 120 million women across the developing world by 2020. \$2.6 billion was committed by donors, and over 20 developing countries made bold promises to address policy, financing and delivery barriers that prevent women from accessing their choice of contraception.

This work has the potential to transform the lives of millions of families around the world, and collectively is referred to as Family Planning 2020 (FP2020).

Our FP2020 pledge

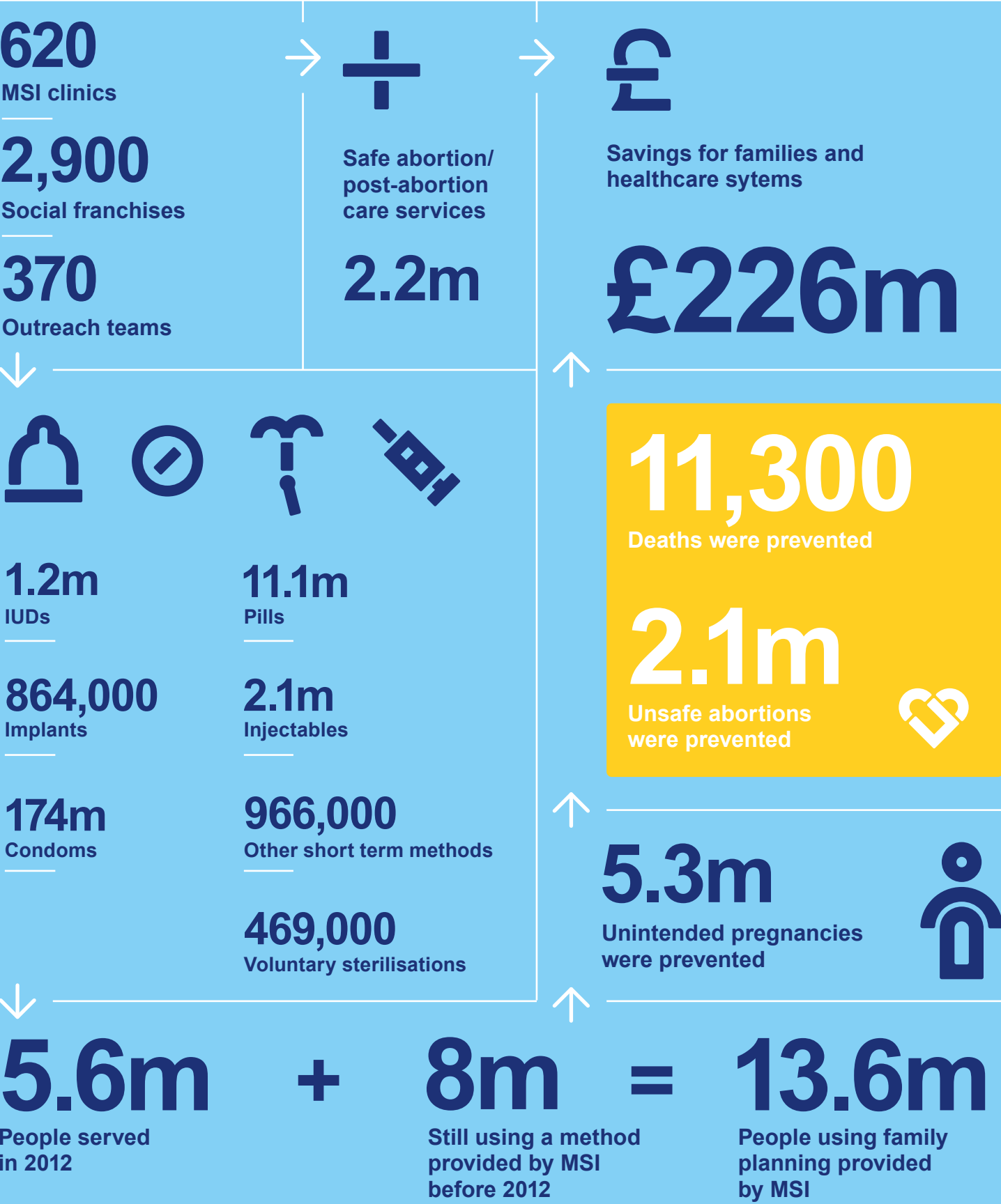
We will have an important role to play in this work. We pledged that, by 2020, 20 million women will be using contraception provided by us – doubling the number of users we had in 2011. Six million of these women will be additional users of family planning, which alone represents five percent of the total FP2020 pledge. We have already gone a long way to achieving this. In 2012, 13.6 million women and couples were using contraceptives supplied by Marie Stopes International.

To reach these women, and achieve these significant impacts, we need to understand who our potential clients are, what their needs are, and what tools and approaches work best to deliver modern family planning choice and services to them. We explore this in more detail in Section 2.

“FP2020 is premised on the power of partnership, innovation and accountability to ensure that women in the developing world have the same access to lifesaving contraceptives and services as those in the developed world. FP2020’s success depends on valued partners like Marie Stopes International who work together with governments, donors and the private sector to increase access to contraceptive information, services and supplies for those who are hardest to reach, without coercion or discrimination.”

Valerie DeFillipo,
Director FP2020

Figure 4.
The estimated impacts
of our work, 2012



In 2012, more women and their families
were able to benefit from the impact of
our services than ever before.



Making a difference: why we are committed to family planning

In Figure 4, we showed the estimated impacts of our work in 2012, and throughout this report we present evidence of how we are expanding access to family planning in an equitable way. The impact of family planning goes far beyond what we can measure, however. We believe that accessible contraception is not only essential if women are to enjoy their sexual and reproductive rights, but it is also a crucial public health intervention, which can promote economic development and gender equality. Widespread and accessible family planning can have a transformative effect across societies.

In areas where access is scarce, women are at greater risk of unintended pregnancy and the complications that can arise from it, including death. Even if women avoid complications when pregnant, the consequences of being unable to control when they have children, and how many

they have, can be stark. The strain placed on families struggling to keep all their children healthy, fed, and schooled can have a severe impact on their standard of living. Women who are struggling to provide for all their children can see their ability to participate in decision making processes undermined, which can perpetuate violence and discrimination. These problems are often compounded by the fact that families living in poverty are less likely to have access to contraception.

When women are given the opportunity to use family planning, based on informed choice, they are able to break away from this cycle and improve their social and economic position. Educational and economic equality is promoted when women are able to freely choose when to have children. Family planning helps them to pursue their education or career, should they wish to. This can create a greater standard of living and improved

prospects for children, families, and their wider communities. On a broad scale, access to family planning can help create economic growth by increasing the ratio of working adults to dependents, which leads to improvements in the health, education and welfare of citizens and their children.

We believe that all women should be able to access a full range of family planning options, enabling them to have children by choice, not chance. Our belief in the massive and wide ranging benefits that result from women and couples being able to choose family planning is what drives our work to expand access, particularly to groups who have traditionally been marginalised.



Our skilled team members ensure all our clients receive high quality counselling, enabling them to make informed choices when accessing contraception.

Reducing harm from unsafe abortion

Unsafe abortion remains a major contributing factor to maternal deaths across the developing world, accounting for at least 13% on a global level.⁴ Across the regions where we work, an estimated four women die every hour as a result of unsafe abortion.⁵ Around the world, approximately eight million women suffer complications from unsafe abortion every year, including anaemia, chronic inflammation and infertility.⁶

Figure 5 shows the proportion and estimated number of maternal deaths that are caused by unsafe abortion in the regions where we work. The figures are a stark reminder of the importance of our work to combat this harm by expanding access to a full range of family planning choices as well as safe abortion services, where permitted, and post-abortion care.

Our family planning protects women from the harm of unsafe abortion, preventing an estimated 5 million unintended pregnancies in 2012 alone; many of these women may have otherwise chosen to resort to an unsafe abortion.

For women who decide to terminate their pregnancy, we help them fulfil their right to a safe abortion, where legal. We also provide women with post-abortion care, if they have suffered complications from an unsafe procedure. As well as safeguarding women's rights, these services help to reduce the harm of unsafe abortion.

Harm reduction is a non coercive, non judgemental philosophy which informs services that reduce health and social harm to individuals, their communities and wider society. In the countries where we work, we see that, regardless of the

legal context, some women will seek to end unintended pregnancies, whether safely or otherwise. This makes our harm reduction work vitally important.

We are committed to providing women with a safe, convenient and confidential service should they decide not to continue with their pregnancy, where it is legal to do so. But we are also dedicated to reducing the chances that women will have an abortion in the future, by providing them with optional post-abortion family planning. Our clients often choose to receive a long-acting or permanent method of family planning after they have opted for a safe abortion, and we keep track of the number of clients who opt for family planning at follow up visits.

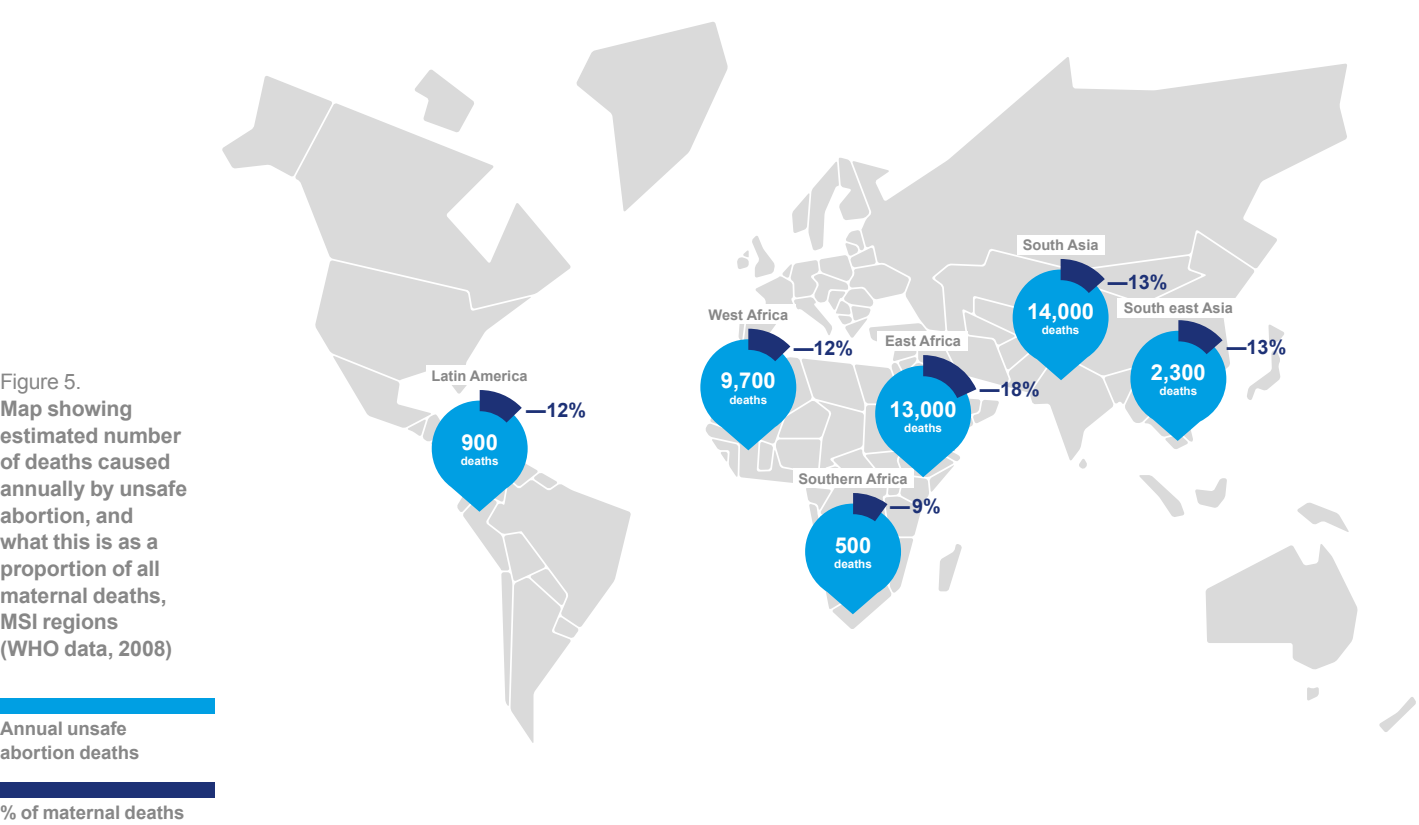
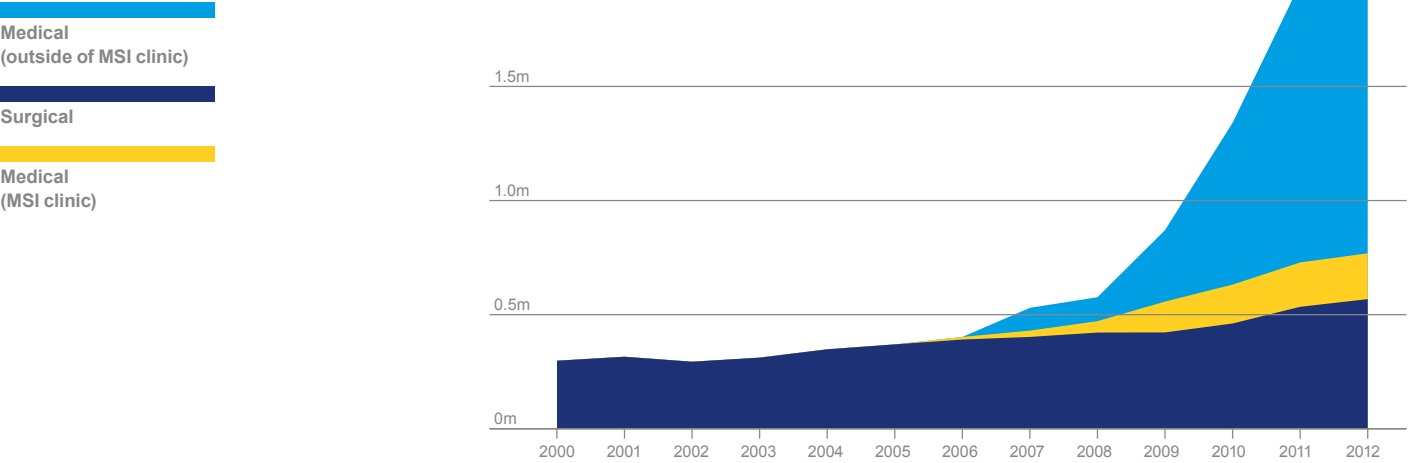


Figure 5. Map showing estimated number of deaths caused annually by unsafe abortion, and what this is as a proportion of all maternal deaths, MSI regions (WHO data, 2008)

Annual unsafe abortion deaths
% of maternal deaths

Figure 6.
Number of MSI abortion
and post-abortion care
services provided, by
method 2000- 2012



Expanding access

In recent years, we have expanded access to medical abortion where we work, wherever it is legal to do so. Medical abortion is a safe, non-invasive alternative to surgical abortion, which crucially can be delivered outside of a healthcare centre. This offers women greater confidentiality and control over the timing of their treatment. We have been able to expand access through our social franchising networks, and pharmacists and community health workers are trained to provide medical abortion and to counsel women about its home-based use.

In addition to giving women more choices in how they access safe abortion services, medical abortion is highly effective. A recent study we conducted in Viet Nam found that it was an acceptable substitute for surgical methods when women used it at home after accessing misoprostol and mifepristone through private providers.⁷ It has also been found that medical abortion that takes place at home is just as safe and effective as when it takes place in a clinic.⁸ The safety and effectiveness of medical abortion allows us to provide a service that maximises the confidentiality and convenience of a woman's treatment, without sacrificing quality.

Another recent study suggested that when 'mid-level' healthcare providers – such as nurses, midwives and non-physicians – carry out surgical and medical abortion procedures, these are just as safe and

effective as procedures carried out by physicians.⁹ We believe that, in regions where a shortage of physicians could put women's health at risk, it is essential that these mid-level providers are trained to provide high quality safe abortion and post-abortion care services.

The approaches outlined by these studies are just a few examples of how we are using innovative approaches to expand access, and safeguard the rights of women to safe abortion and post-abortion care. Figure 6 shows how our provision of these services has grown over the years, driven in large part by an expansion in access to medical abortion. Combined with our family planning services, these services prevented an estimated 2.1 million unsafe abortions across the countries we work in.

Based on the trends in our delivery of safe abortion and post-abortion care, summarised in Figure 6, we believe that more women will choose medical abortion over the coming years, with little growth in surgical abortion. We have been able to expand access to medical abortion through registering MSI branded misoprostol and mifepristone for safe abortion in nine countries. Securing these registrations enhances our ability to offer safe, reliable and inexpensive medical abortion services, where permitted. This enables us to broaden our reach, and expand these services to more of the women who want them.

We estimate that, by 2012, we were providing 13% of all abortion and post-abortion care services in the countries where we work,¹⁰ expanding women's options and enabling them to turn their backs on unsafe providers.

Our commitment to providing women with access to safe abortion services, wherever it is legal and there is a need was demonstrated in October 2012. We opened the first integrated sexual and reproductive health centre in Northern Ireland, offering access to a wide range of family planning and sexual health services under one roof. In addition to offering contraceptive options, emergency contraception, HIV testing, and STI testing and treatment, we became the first provider to offer medical abortion services in Northern Ireland, for pregnancies up to nine weeks in gestation and for women who meet the legal criteria.

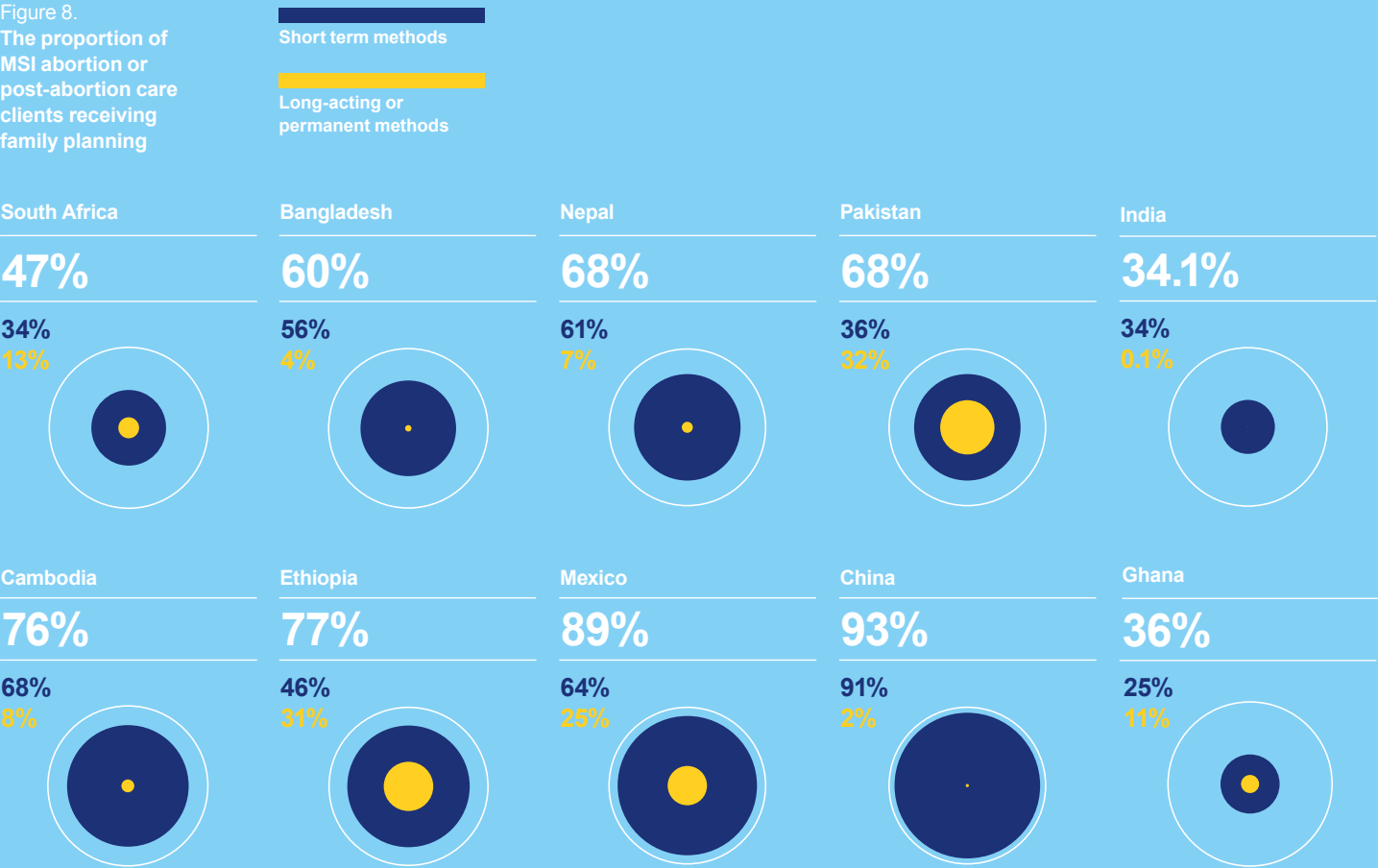
Family planning following safe abortion and post-abortion care

Women who seek an abortion are likely to have an unmet need for effective family planning. By providing abortion and post-abortion care clients with family planning counselling and services, we hope to reduce future unintended pregnancies and the need for repeat or unsafe abortions. Figure 8 shows that in seven of the 10 countries for which data was available, the majority of our abortion and post-abortion care clients received a family planning method.

Figure 7.
Registrations of MSI
branded misoprostol
and mifepristone for
safe abortion services.

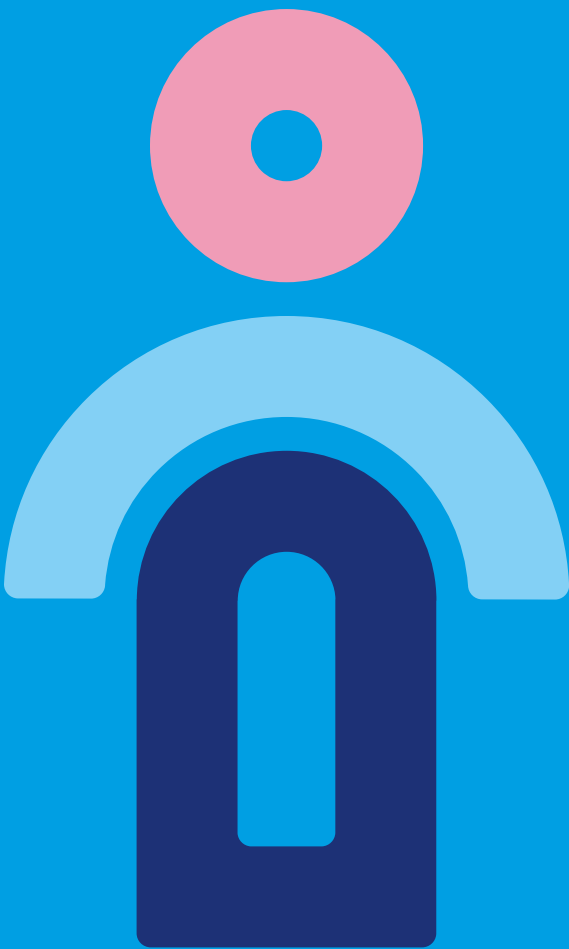


Figure 8.
The proportion of
MSI abortion or
post-abortion care
clients receiving
family planning



The people we served

Across the developing world, there are around 222 million women who want to use contraception but who are not able to access it, the vast majority in countries where we work.¹¹ While enabling women to take control of their reproductive health and their futures can be life-changing, the consequences of a lack of access can be devastating. This is particularly so for some of the most under-served women: women who are living in extreme poverty, who live in rural areas or who are young. Conversely, it's these groups of women who are most likely not to have access to contraception, even though they have a particularly acute need for them.



In this section we explore the four groups of women who we believe it is essential to reach if we are to expand access to family planning in an equitable way:

- 1

Women not currently using a method of contraception
- 2

Women using a method which doesn't best suit their needs
- 3

Women living in poverty, particularly those living on under \$1.25 a day
- 4

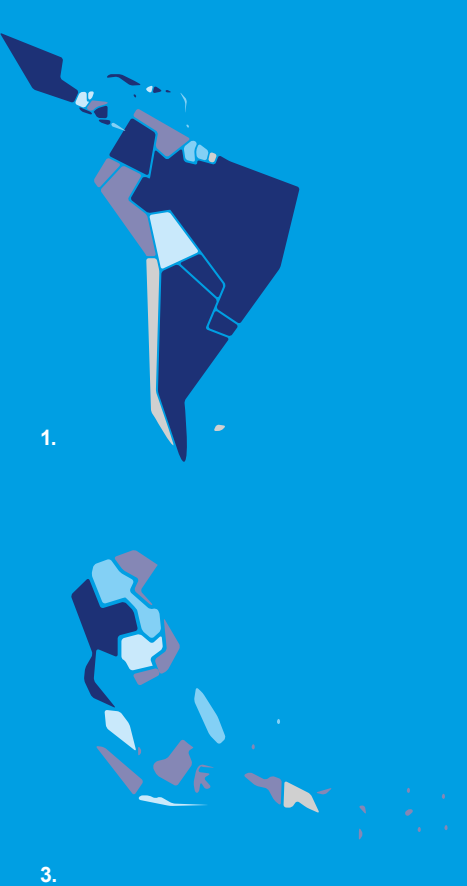
Young women and girls, particularly those under 19

Section 2

In this section we explore the four groups of women we believe it is essential to reach if we are to expand access to family planning in an equitable way. For each of these groups, we look at the broader picture in the regions where we work, analysing current levels of use and knowledge of contraception, to emphasise the importance of ensuring equity of access and choice of method in family planning. We then examine our performance in reaching these groups in 2012.

Across the majority of the countries where we work, we conduct exit surveys with our clients. This helps us understand how many of them are new to family planning, and how many have been able to choose a method more appropriate to their needs with the help of our services.

We also record their levels of poverty, education and age, to make sure we understand how well we are reaching vulnerable groups of women. There are clearly overlaps between these groups, and you can see where these are in the diagrams at the beginning of each chapter of this section. By measuring our performance in reaching these women, we can see how well we are doing at serving those who need us the most.



Looking beyond CPR

The data in this section show the state of contraceptive use in the regions where we work.

Some regions, notably west Africa, have very low rates of modern contraceptive use. We must work in these regions to reach women who are not currently using family planning. But it is equally important that we look beyond overall contraceptive use in a country, and identify inequities and disparities among different groups so we can identify which women may be most in need of our help.

Take India as an example. Approximately 46 million women there cannot access family planning even though they want to, despite India having a contraceptive prevalence rate (CPR) of around 50%.¹² The majority of the women affected by this lack of access are living in poverty.¹³ This is just one example of why it is important to look at different levels of contraceptive use across different groups within a population, in addition to total contraceptive use.

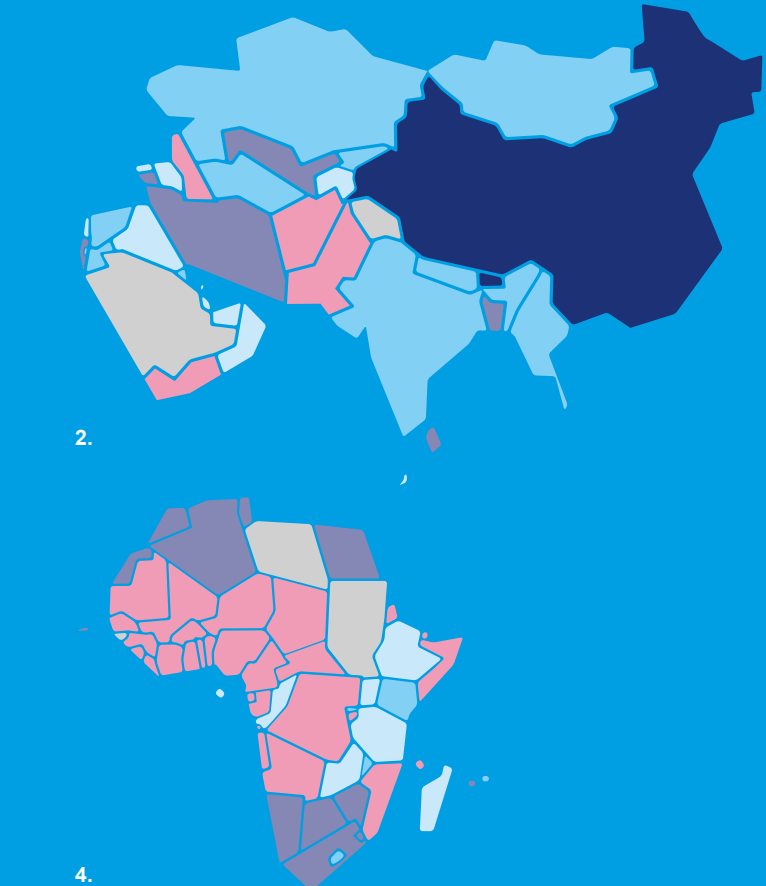


Figure 9. Contraceptive prevalence rates in developing regions



- 1. Latin America
- 2. Asia
- 3. Pacific Asia
- 4. Africa

Reaching adopters of family planning

In many of the regions in which we work, contraceptive use remains low and unmet need is high, despite recent growth (see Figure 9). This means that women’s rights are still not being fulfilled. In order to tackle this problem, we must increase access to contraception in these places. The only way that growth can take place is by providing voluntary family planning to women who need it but are not currently using it, while also ensuring those that are using it are able to carry on doing so.

We consider a woman who comes to us for family planning who was not using contraception before her visit to be a family planning adopter. The tables in Figure 10 show the proportion of our clients across our three main service delivery channels who were adopters in the countries in which we worked in 2012.

32 year old Passipo hasn't been using contraception. Not because she's been trying for a baby, but because the clinics in the town she lives in in Central Nigeria, don't offer it. With a family of four to care for, she doesn't want to have any more children and instead wants to concentrate on keeping herself and her family healthy. Until recently, Passipo was one of over seven million women in Nigeria who want to use family planning but cannot exercise this choice.¹⁴ Read Passipo's full story on page 6 of the case studies booklet.



Our performance in reaching under-served groups, highlighting the proportion who are adopters.

Women living in extreme poverty (< \$1.25 a day)

Women switching from short to long term methods

34%

24%

25%

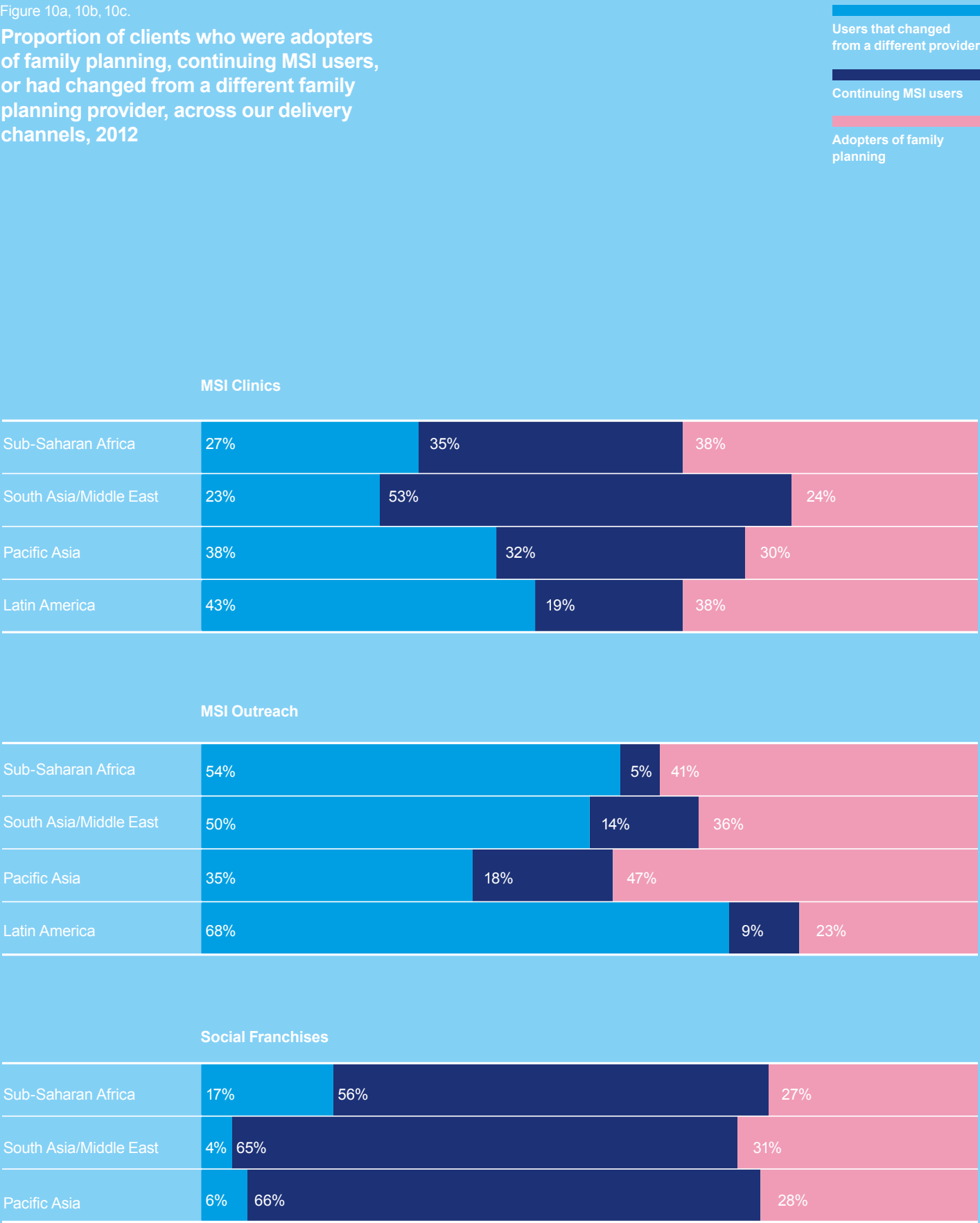
30%

Adopters

Under 25s

Figure 10a, 10b, 10c.

Proportion of clients who were adopters of family planning, continuing MSI users, or had changed from a different family planning provider, across our delivery channels, 2012



Our performance in reaching adopters

In sub-Saharan Africa well over a third of the women served at our clinics and by our outreach teams were not previously using family planning before they came to us. To put these results into perspective, we estimate that around 20% of all family planning users in sub-Saharan Africa were new to family planning in the last year.¹⁵ Achieving results of this magnitude on a large scale is a testament to the skill of our teams in the areas we work, the quality of our clinical services, and our commitment to client-centred care. It also demonstrates the desire of women to take control of their reproductive lives.

This suggests that we are helping contraceptive use to grow, and may be contributing to a reduction of unmet need (the number of women who want family planning but can't access it), on a regional scale. It also means that – over the last

year, and across all the areas where we work – there were many thousands of women like Passipo (page 6 – case study booklet) who were at risk of unintended pregnancy, but who are now using modern contraception and taking control of their reproductive health.

However, it is not enough to ensure that women have access to family planning; we believe they must be able to choose from a range of methods. Different clients will have different needs and desires over time, and certain family planning methods will fit these better than others. The next section tells the story of how we are offering a greater choice of contraceptive methods to women and couples in the areas where we work, by providing short term, long term and permanent forms of contraception, as well as explaining why this is so important.

Our delivery channels

We deliver services across four different service delivery channels:

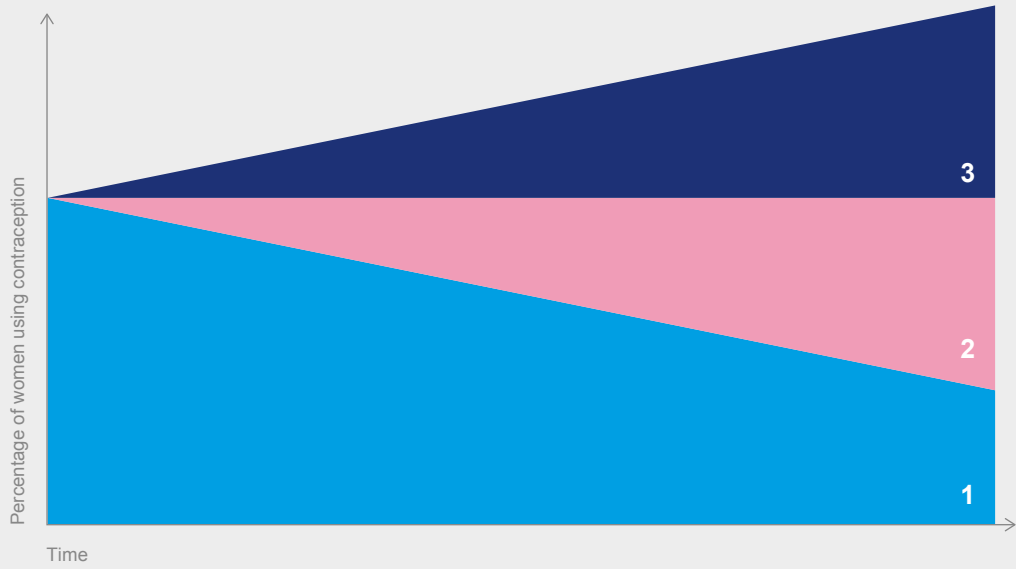
1. Our own clinics, which provide a full range of quality reproductive health services.
2. Mobile outreach teams, which provide family planning choices to women in rural and poor settings who lack access to healthcare.
3. Our BlueStar social franchise network, where we have partnered with a range of private healthcare providers to expand access to high quality family planning and safe abortion services.

4. Our social marketing programme, which distributes low cost and free condoms, pills and other contraceptive and health products through pharmacies, community based distributors and other private providers.

These diverse channels allow us to provide family planning, and safe abortion services, where permitted, to women across a range of different contexts. They also strengthen our partnership with the public health systems of the countries we work in: helping link our services to, and fill gaps within the overall health system, maximising the choices available to women. We survey our clients across the first three of these channels.

How to build contraceptive prevalence

- Providing family planning to additional women who were not previously using it, building contraceptive prevalence
- Providing additional family planning services to support a growing number of women of reproductive age and to keep contraceptive prevalence from falling
- Maintaining the same absolute number of women using contraception



The expansion of our high quality services means that year on year, more women in the areas we work are able to exercise their fundamental right to family planning. In terms of measuring this progress, it is important to understand broader patterns of contraceptive use in these areas, to ensure that our work is addressing the unmet need for family planning overall. If the contraceptive prevalence rate of a country reaches a consistently high level, unmet need will decline.

There are three steps to increasing the contraceptive prevalence rate (CPR) of an area.

1. First, the women who are already choosing to use family planning must be able to continue doing so. This means we must focus as a sector on clinical quality, reducing discontinuation of family planning, and making it easy for women to access follow up appointments when they need them.

2. Second, if the number of women of reproductive age is growing (which is the case in almost all of the countries we work in), access to family planning services must keep being expanded to keep pace with this growing need. Expanding reach to these new groups of women ensures that contraceptive prevalence will not fall.

3. Finally, once both these steps have been taken, overall contraceptive prevalence will grow, if more clients, who were not previously using family planning, decide to start using it after being given the information, counselling, and choice to do so.

The continued growth of contraceptive prevalence is integral to ensuring that no one who wants to use family planning is left without access to it. Making family planning accessible, convenient, and suited to an individual's needs is one of the best ways to ensure that they choose to continue to use it. Our innovative service delivery models help us achieve this, by providing genuine choice in a variety of contexts.

Looking to FP2020

Estimated services needed to sustain current levels of contraceptive use to 2020, in the 69 poorest countries in the world

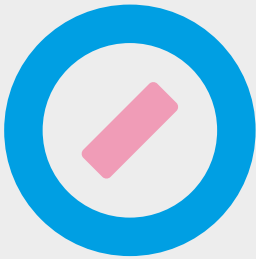
Condoms

14.5 billion



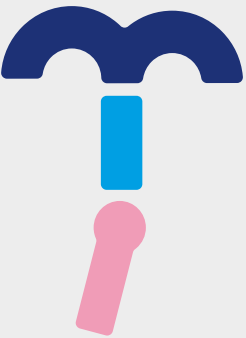
Pills

2.5 billion



IUDs

90 million



Implants

6 million



In 2012, nearly 260 million women were already choosing to use contraceptives across the poorest countries in the world, with the combined efforts of governments, donors, and service providers being largely responsible for building this access. Ensuring that these women have continued access to contraceptives, is of critical importance.

The resources needed to ensure continued access to family planning for these women are significant. For example, we estimate that over the next eight years: 2.5 billion pill cycles, 14.5 billion condoms, 90 million

IUDs and 6 million implants will be needed to ensure the women who were using these methods currently can carry on doing so over the next eight years.

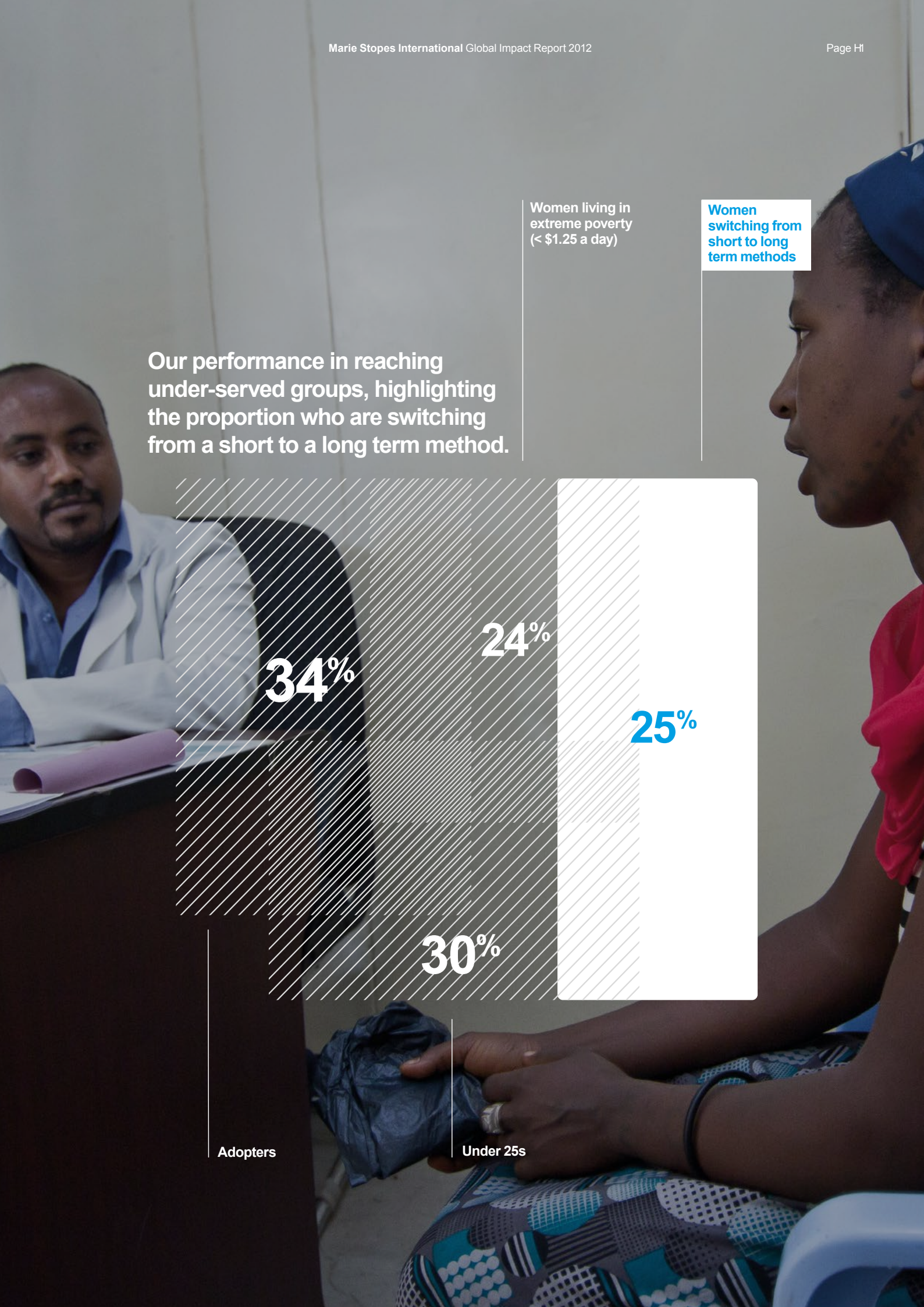
FP2020's focus on expanding access to contraception to women that don't have it is of great importance to meet their needs. But the need to continue to fulfil the right of the 260 million women who already use family planning in these countries to a full range of contraceptive choices should not be forgotten.

Expanding contraceptive choice: reaching switchers

In some of the regions in which we work, trends in family planning use are often skewed towards a certain type of method. This can mean that while women may be using contraception, they may not be able to access the method that best suits their needs. We give our clients the choice of a full range of modern contraceptive methods; short term, long acting and reversible, and permanent. So, if a lack of specialist providers means the vast majority of family planning methods available in a country are short term, for example, we ensure people are able to access long acting or permanent methods should they choose to do so.

Longer acting methods of contraception have lower failure rates and are therefore more reliable than short term methods like condoms or pills.¹⁶ They are often the preferred method of choice for rural women, who wish to avoid having to travel to reach health services. They prevent more unintended pregnancies and the complications that sometimes arise from pregnancy. In a country or region where long-acting or permanent methods only make up a small proportion of contraceptive use, a switch towards a more balanced range of methods could have huge impacts in terms of more unintended pregnancies being prevented, leading to a reduction in unsafe abortions, and preventing the deaths of thousands of women.

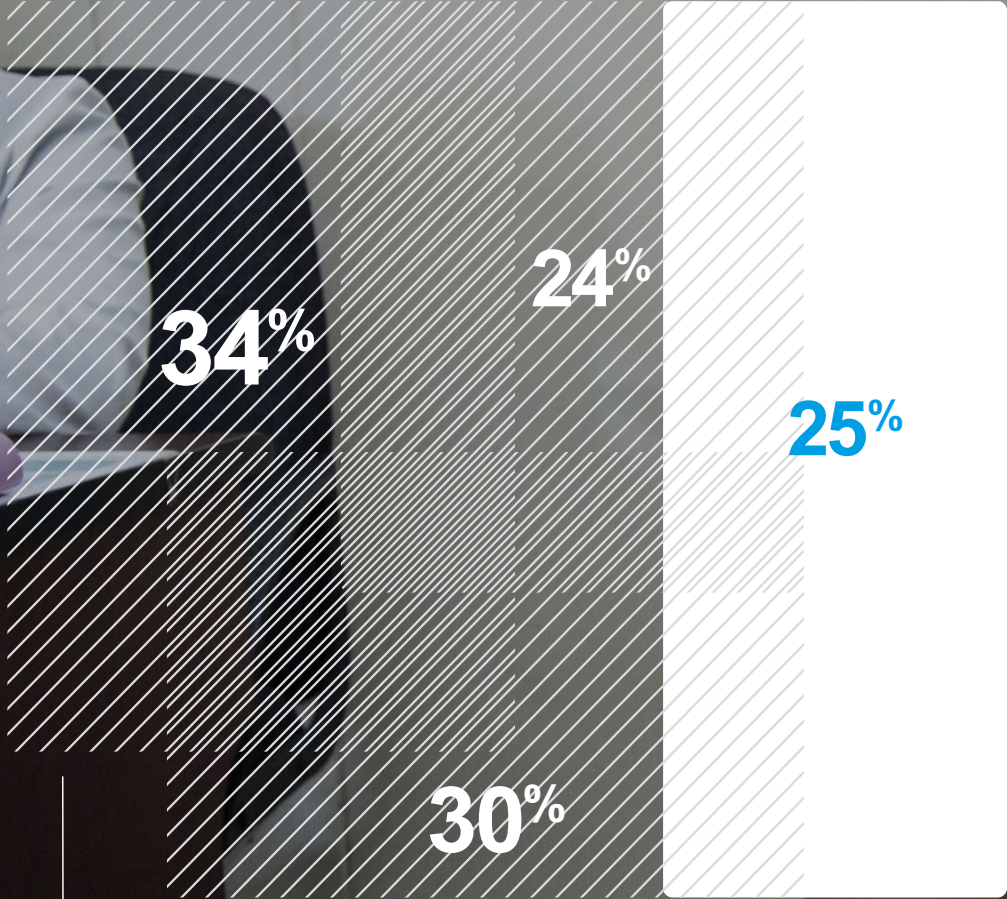
29 year old Welansa has tried a number of contraceptive methods in the past but she hadn't found one that really suited her until she visited her local BlueStar clinic. The wider range of methods on offer meant that she was able to choose an implant for the first time, and she's found that it's much better suited to her personal needs. Read Welansa's full story on page 8 of the case studies booklet.



Our performance in reaching under-served groups, highlighting the proportion who are switching from a short to a long term method.

Women living in extreme poverty (< \$1.25 a day)

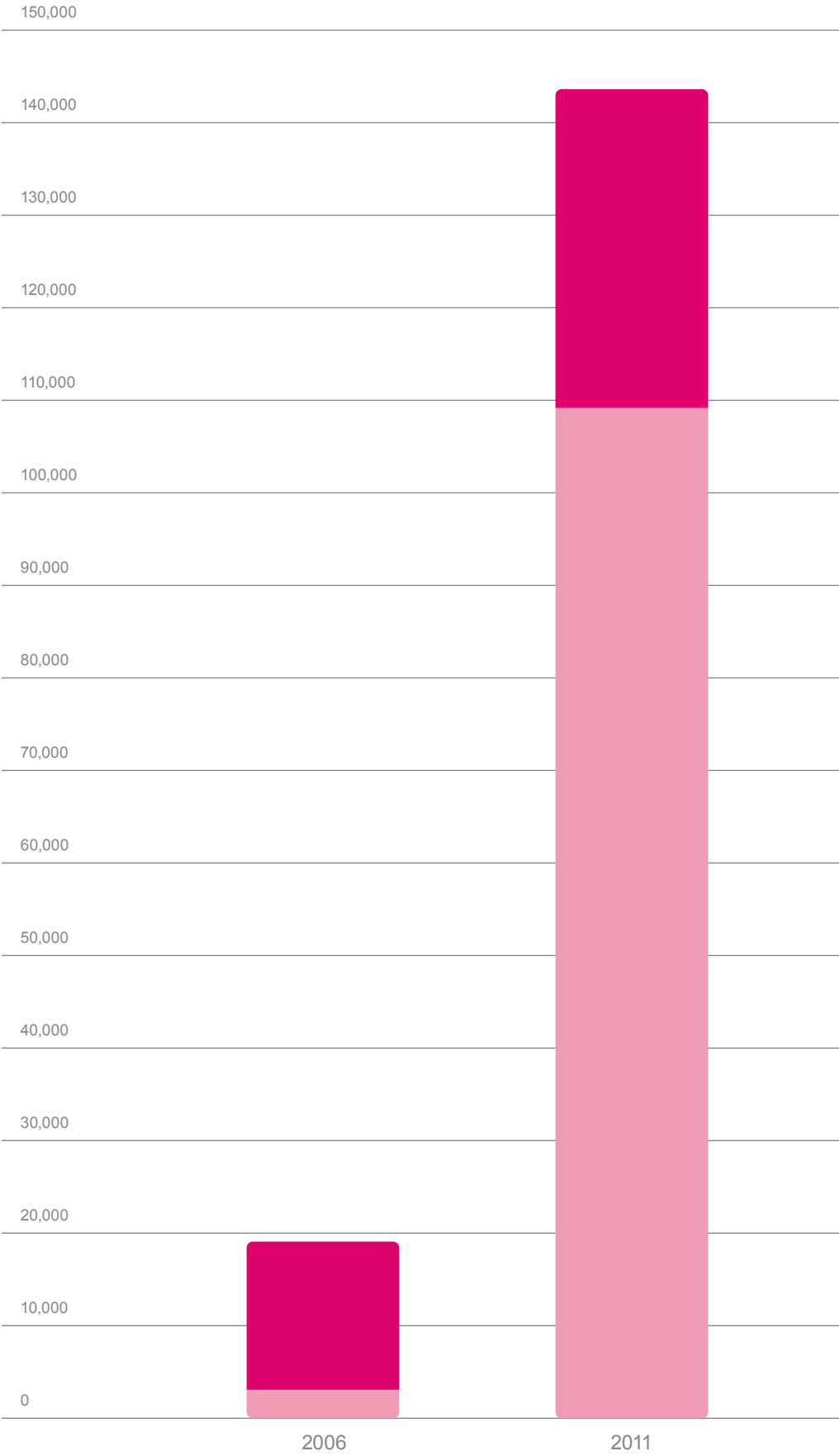
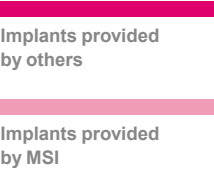
Women switching from short to long term methods



Adopters

Under 25s

Figure 11a.
Growth in implant
users in Uganda,
2006, 2011



What this means
In the five years between 2006 and 2011, there was a notable change in the number of women using implants in Uganda. Marie Stopes Uganda (MSU) had served around two in three of all women choosing implants in Uganda, so our efforts have enabled women to make more informed choices.

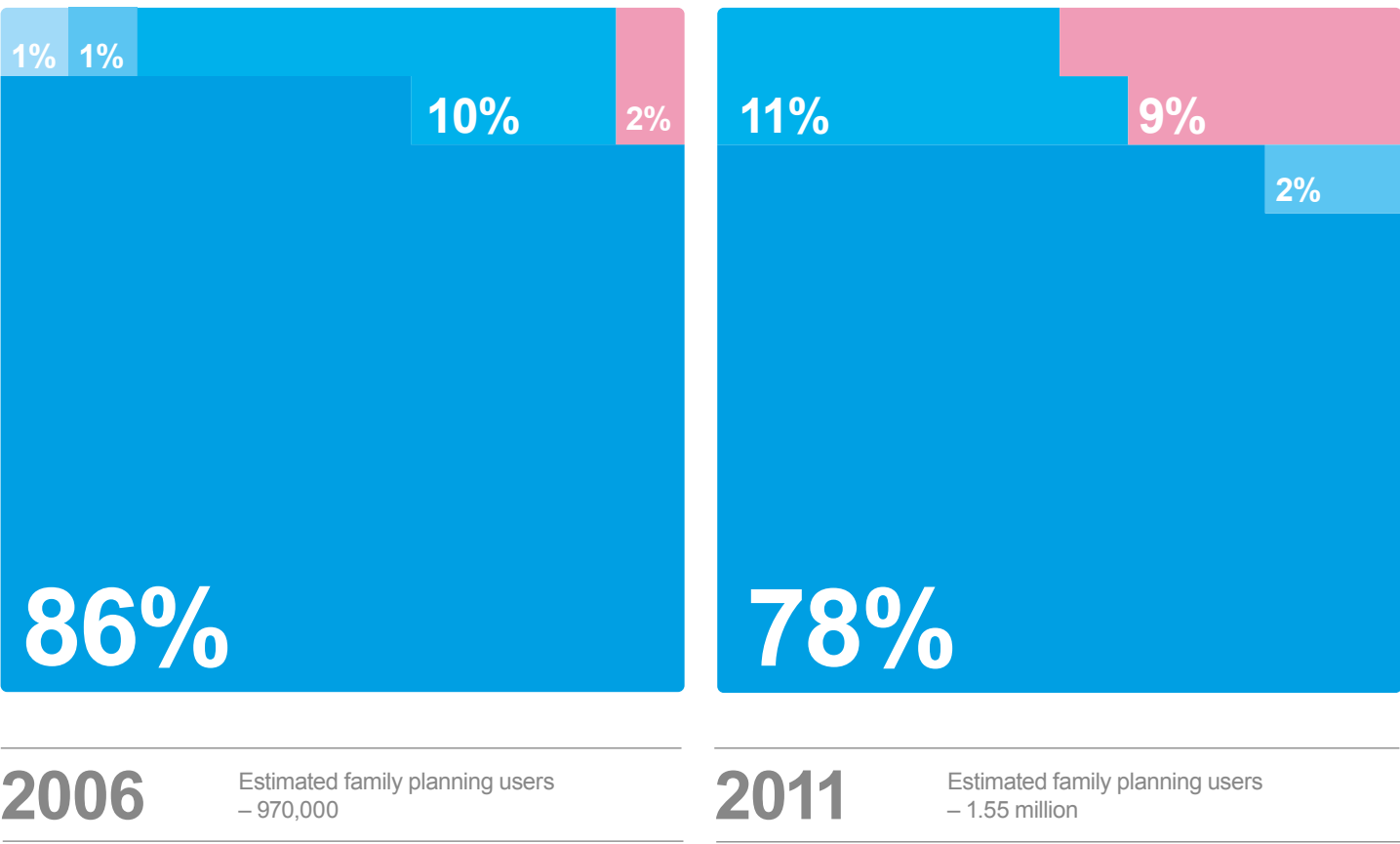
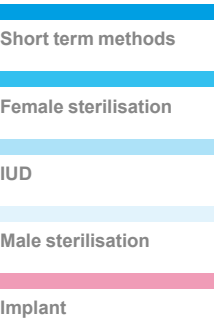


Figure 11b.
The contraceptive
methods used by the
general population of
Uganda, 2006, 2011.



Why is it important to expand choice?

Expanding contraceptive choice maximises the life-changing impact of our work.

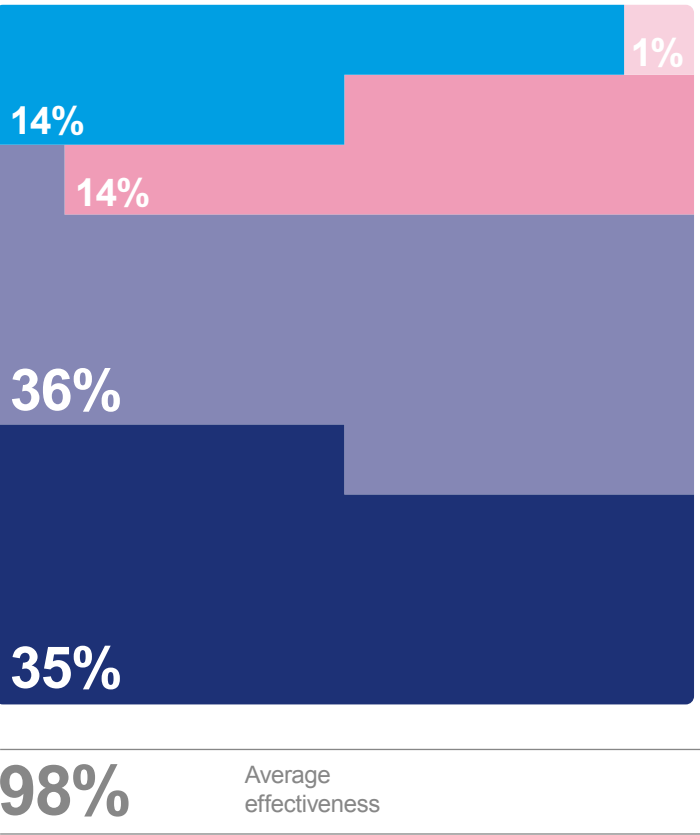
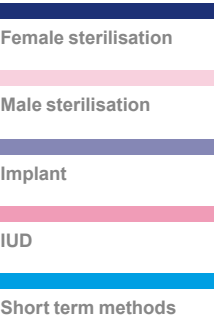
Women can choose to use condoms to protect themselves from sexually transmitted infections while also using another family planning method at the same time. They can choose to use methods that are discrete, long-acting and reversible, and, if they and their partners are sure they do not want any more children, they can choose voluntary sterilisation services which we offer for both men and women.

The scale of our services, reaching millions of women across the world, means that in certain countries, we have been able to influence changes in national patterns of contraceptive use. Figure 11 shows that partly through our work to expand choice in family planning, the proportion of women using

contraception in Uganda who opted for implants rapidly grew between 2006 and 2011. By 2011 60% more women had been able to choose to use family planning than in 2006,¹⁷ and among these women, the proportion choosing an implant had grown from one in 50 to one in 10.¹⁸ We estimate that by 2011, MSI had provided around two thirds of the women choosing to use implants in Uganda with their method,¹⁹ helping create a significant expansion in the family planning choices available to women.

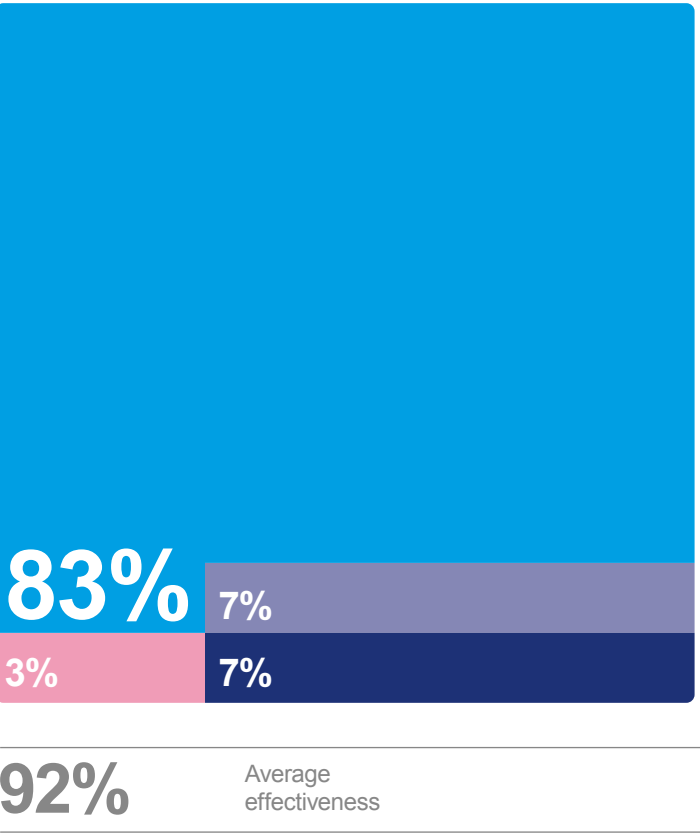
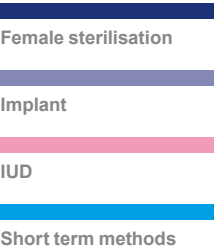
This gives an indication of the appetite among women for access to broader choices in family planning. Making sure that more women have the right to a full range of family planning choices fulfilled is our priority. We believe that women should be empowered, and trusted, to make their own choices regarding family planning, and that the best way to achieve this is through a high quality, client-centred delivery system.

Figure 12.
Methods used by
MSI users in sub-
Saharan Africa,
(MSI countries)
(approximately 4
million users in 2012)



Average effectiveness

Regional average
of methods used in
sub-Saharan Africa,
(MSI countries)
(approximately 30
million family planning
users)



Average effectiveness

What this means
The top chart shows what proportion of women in Africa choosing family planning supplied by Marie Stopes International are currently using each different method. The bottom chart shows the proportion of all family planning users in the countries where we work who are using each method. As more of the women we serve have been able to choose more effective methods than women in Africa as a whole, the average effectiveness of all the methods chosen is noticeably higher than the regional average. The risk of unintended pregnancy is four times lower among our clients.

What ‘contraceptive effectiveness’ means
The effectiveness of contraception depends on the type of method used, and whether it is used correctly. Long acting and permanent methods are more effective than short term methods, largely because there is no need to remember to take or use them. For example, an implant or IUD is over 99% effective at preventing pregnancy, compared with 91% for pills and 82% for condoms (when these are used typically).

This means that, for every 10,000 women that used an implant, only around five would be expected to get pregnant, compared with 1,800 of 10,000 women using condoms typically. In an environment where a lack of contraceptive choice means short term methods are by far the most widely used, expanding choice means women can access methods that are more effective.

Our performance in expanding choice

In the graphs to the left, we highlight how the four million women using family planning provided by us in sub-Saharan Africa (13% of all family planning users in the countries where we work), are using predominantly long acting and permanent methods. When this is compared against the patterns of contraceptive use among all the 30 million family planning users in the same countries, in which short term methods dominate, the importance of our work to expand contraceptive choices becomes apparent.

Above all else, broadening the range of contraceptives available to women is important for them to enjoy fully informed choice, but there are often additional benefits.

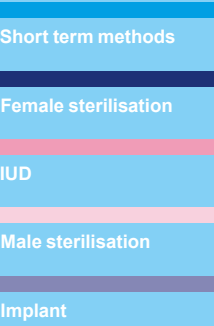
Figure 12 also shows the average effectiveness rates of the family planning methods used by our clients in sub-Saharan Africa, and of the methods used on a national level in the same countries. This highlights the difference that expanding access to long-acting or permanent methods in that context can make. The overall effectiveness of the methods chosen by our clients was 98%, compared with 92% for the methods used by the broader national population of family planning users in the countries where we work in sub-Saharan Africa. This means that, for every 100,000 women using family planning supplied by MSI, around 6,000 fewer would

experience an unintended pregnancy with typical use, when compared with 100,000 women using family planning on a regional level. This comparison is only between modern forms of family planning. If we were to consider traditional methods (which have much higher failure rates), the disparity would be even greater.

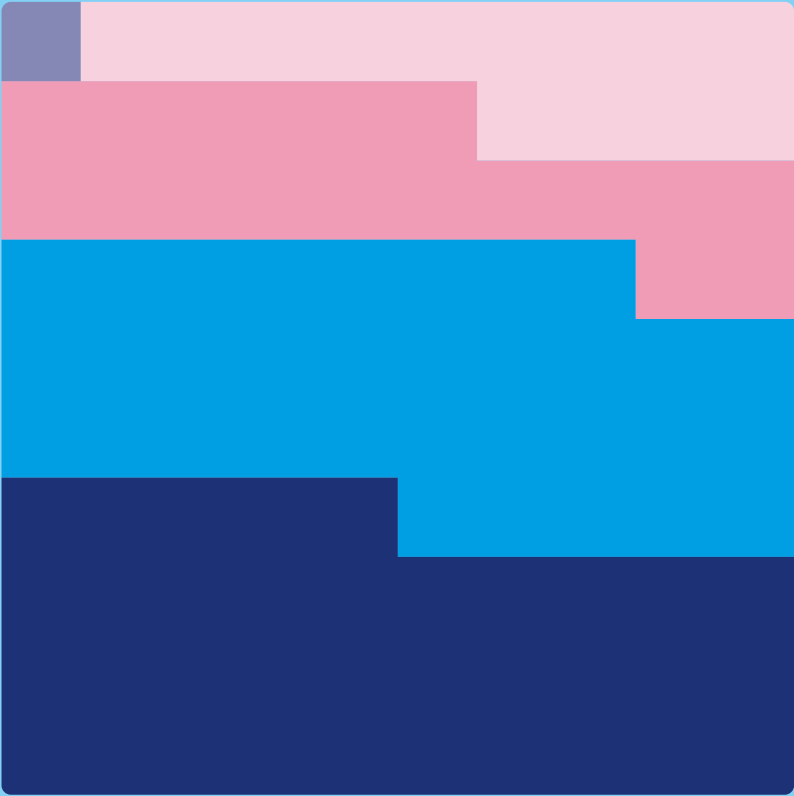
Ensuring our clients have the broadest range of family planning options to choose from is our primary motivation, wherever we work.

In south Asia for example, the methods used by women on average are more effective than those used by women in sub-Saharan Africa, but they still indicate a lack of choice, as two types of method, female sterilisation and short term contraception, dominate (see Figure 13). When given choice, women and couples in south Asia opt for a more balanced range of methods. Our clients in the region favour a range of short term methods, long acting and reversible contraception, mainly IUDs, and voluntary male and female sterilisation. In this way, we are improving the quality of family planning choices that women and couples can make; from the stark choice between voluntary sterilisation and short term methods, to a broader range of options that better suit their needs.

Figure 13.
Methods chosen by
MSI's 6.8 million family
planning users in
south Asia and those
used by the general
population (MSI
countries)



MSI users



General population

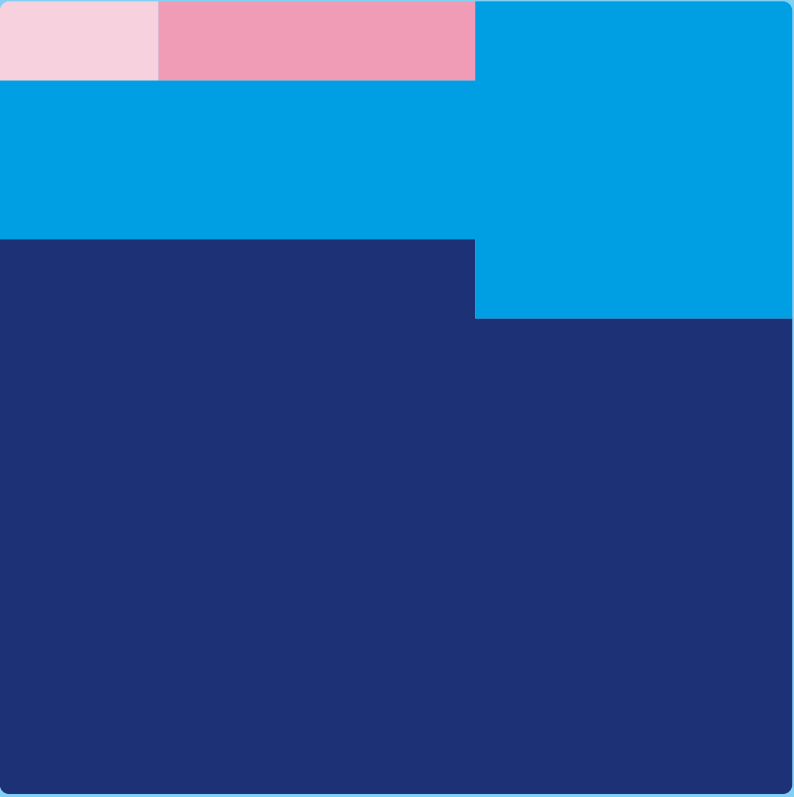
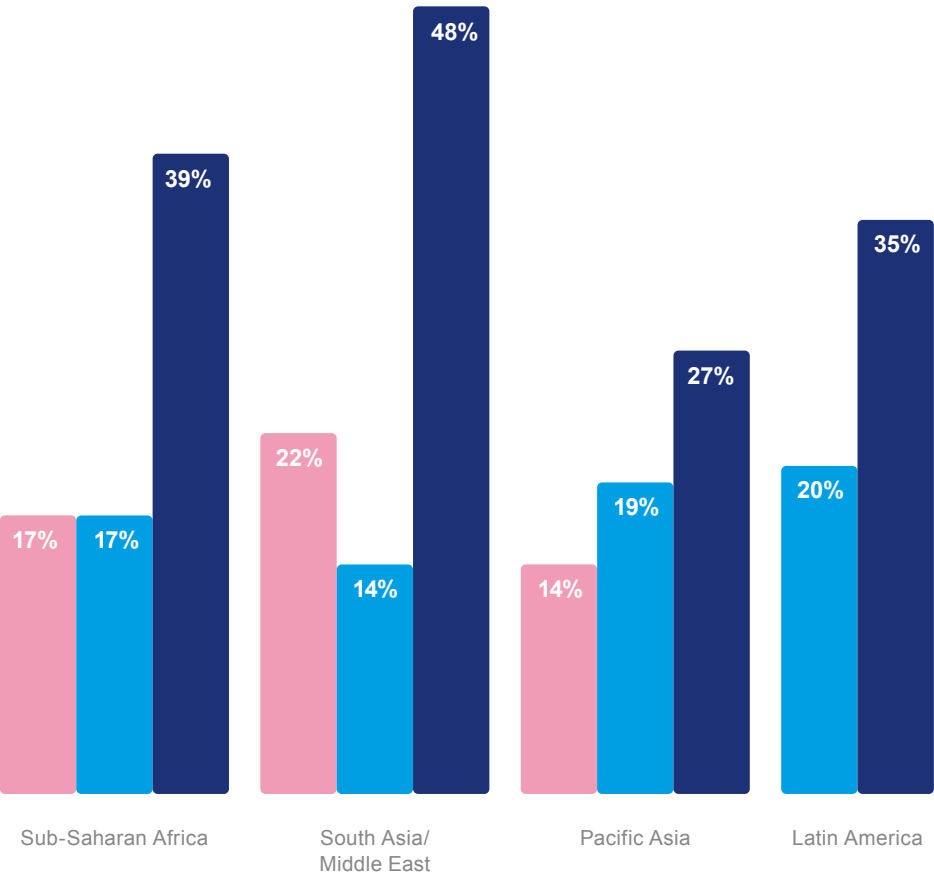
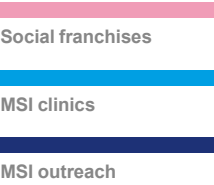


Figure 14.
Proportion of MSI
clients switching
from a short term
to long-acting or
permanent method,
in 2012



We monitor how many of the women we serve are switching from one type of contraceptive method to another, so we can keep track of how well we are expanding choice of all family planning methods. The results in Figure 14 show the proportion of our clients who changed from a short term method to a long-acting or permanent one, across our three main

delivery channels. When considered together with the percentage of our clients that are new users of family planning, it is clear that a significant proportion of the women we serve were either not using family planning previously, or were able to switch to a less expensive, longer-acting method through our services.

Looking to FP2020

The goal of FP2020 is to provide family planning to 120 million additional women by 2020. Imagine that half of the women projected to accept short term methods over the next eight years (based on current patterns of family planning use) are given access to, and choose, more effective long-acting methods (such as IUDs and implants). By providing

more effective methods and reducing method failure, not only would women be able to use the method that best meets their needs, but we estimate that significant impacts could also be achieved. These include the prevention of 28 million more unintended pregnancies, 3.8 million more unsafe abortions and 38,000 more maternal deaths.

Reaching people living in extreme poverty

Across the regions where we work, women with low incomes are consistently less likely to be using family planning than women who are more affluent. The charts overleaf show family planning usage rates for the poorest and most affluent women in sub-Saharan Africa and south Asia (MSI countries). The results are split into wealth quintiles, where all women of reproductive age are split evenly into five groups, from poorest to most affluent, with the contraceptive prevalence rate for each group recorded.

Low levels of knowledge about family planning amongst women living in poverty, as well as problems of access and affordability, contribute to the trends shown in this chapter. The charts overleaf show the proportion of the poorest women who knew about certain methods of family planning, compared with the least poor, in the regions in which we work.

29 year old Kaushalya lives near the small village of Manpur Machedi, in Jaipur, India. Her community is very poor, and while many of the women she knows want to choose if and when they have children, they're not always able to access family planning services.

Kaushalya has four children. And for her and her husband, that's their family complete. While they'd been able to get condoms locally, they hadn't been able to access long-acting methods until recently, when they visited an MSI outreach clinic. Read Kaushalya's full story on page 4 of the case studies booklet.



Our performance in reaching under-served groups, highlighting the proportion who are living in extreme poverty.

Women living in extreme poverty (< \$1.25 a day)

Women switching from short to long term methods

34%

24%

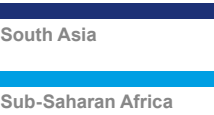
25%

30%

Adopters

Under 25s

Figure 15.
Contraceptive prevalence by wealth quintile in sub-Saharan Africa and south Asia (MSI countries)



Different ways of measuring poverty: wealth quintiles and income levels
This report showcases two different ways of measuring poverty levels. Data on contraceptive use and knowledge amongst the general population is derived from demographic health surveys (DHS), which divide respondents up into five separate wealth quintiles from the poorest to the most affluent within each country. This means the measurement of poverty or affluence is relative to that country (or region, as shown in this report), rather than a comparison with a global standard.

Measurements of our own clients' levels of poverty are based on analysis of questions in surveys of a representative sample of clients, which helps us estimate how many live in extreme poverty (less than \$1.25 a day) and poverty (less than \$2.50 a day). We then compare this information with national averages from the World Bank to determine if our clients are poorer, or less poor than the average.

Low levels of knowledge about family planning among women living in poverty, as well as problems of access and affordability, and cultural and social barriers, contribute to the trends shown in Figure 15. Figures 16a and 16b show the proportion of the poorest women who knew about certain methods of family planning, compared with the most affluent, in the regions where we work.

These statistics reflect a harsh reality: while more women living in poverty are using family planning year on year in the

regions we work in, family planning is still more accessible for the more affluent. This is why we work so hard to ensure that we expand access to reproductive healthcare in an equitable way.

Our interventions, such as free clinical outreach services or vouchers for our social franchising clinics (explained further in Section 3), have helped us ensure that extreme poverty is not a barrier between women and their fundamental right to family planning.

Looking to FP2020

FP2020 aims to reach women in the world's poorest countries. As this section has shown, it is often the poorest women who are most excluded from existing contraceptive services. Therefore, in order for FP2020 to succeed, we need to make a big effort to ensure that services are offered in

ways that reach women who cannot afford them or access them through existing channels. We also need to make sure that we reach them with a full range of contraceptive choices so that poverty doesn't inhibit a woman's right to choose the method most appropriate to her needs.

Figure 16a.
Knowledge of pills, injectables, IUDs and implants among the poorest and most affluent women, sub-Saharan Africa (MSI countries)

Sub-Saharan Africa

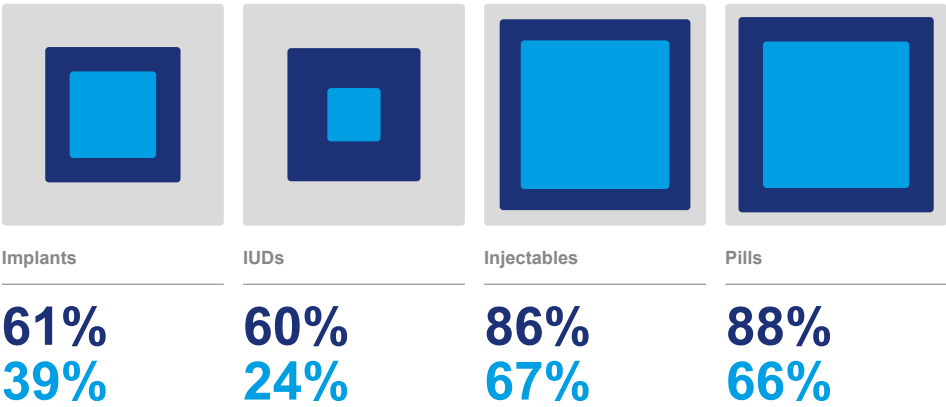
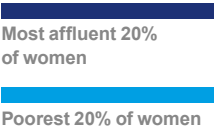
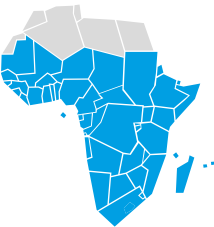


Figure 16b.
Knowledge of pills, injectables, IUDs and implants among the poorest and most affluent women, south Asia (MSI countries)

South Asia

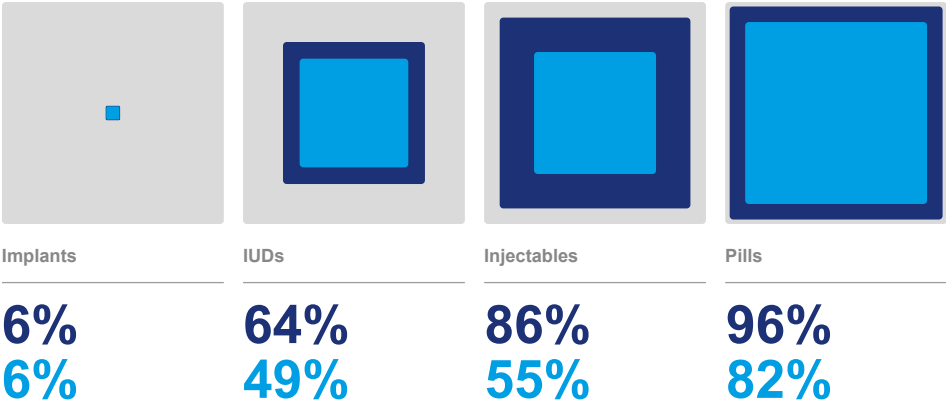
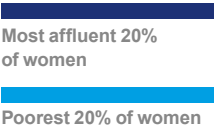
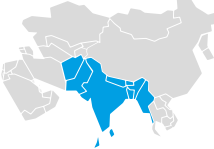
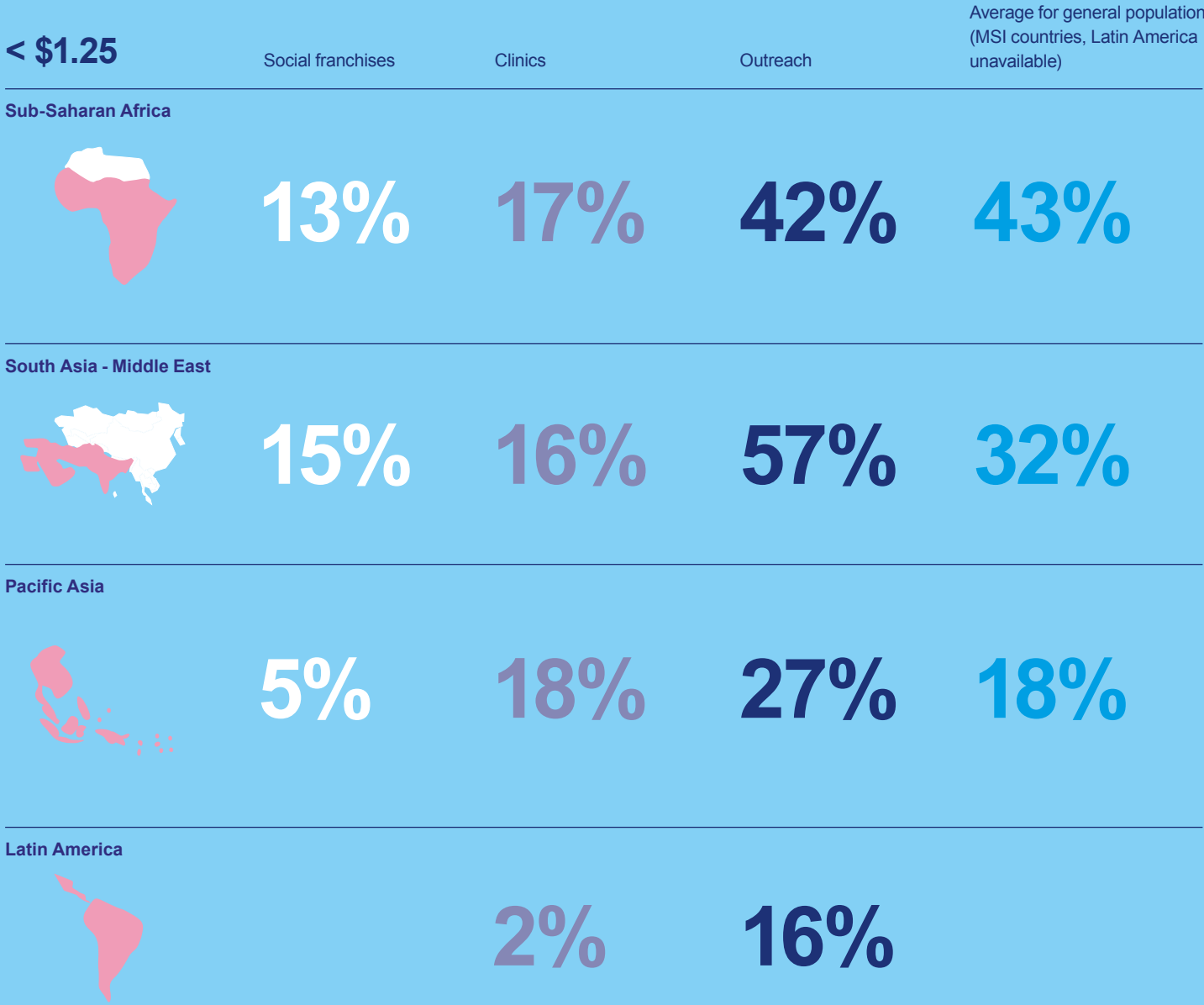


Figure 17a. (below)
Proportion of MSI clients living on less than \$1.25 per day, and average for general population

Figure 17b. (below, r)
Proportion of MSI clients living on less than \$2.50 per day and average for general population

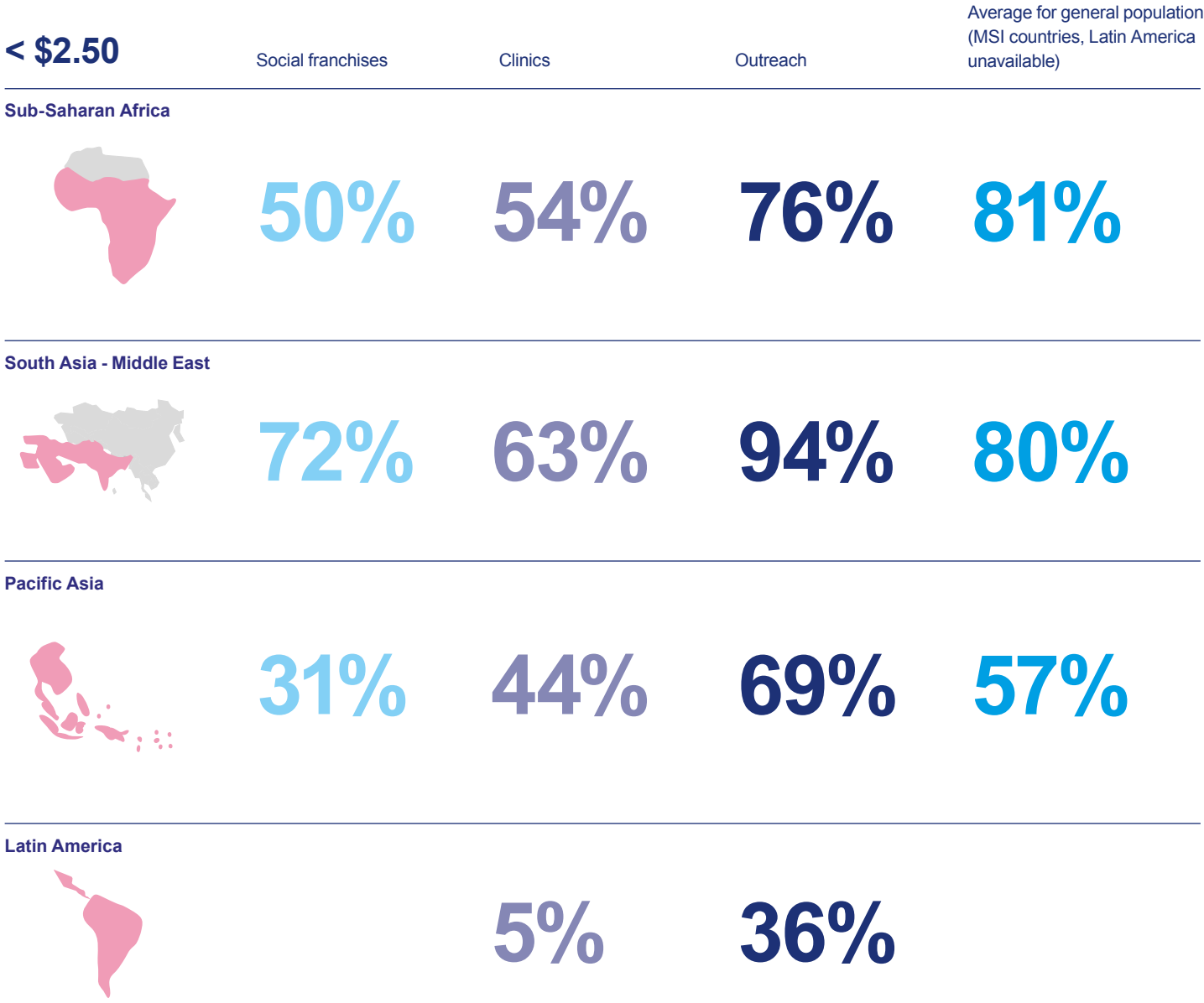


Our performance in reaching poor women

Our 2012 surveys of clients across our programmes allowed us to track our performance in reaching people living in poverty. Figures 17a and 17b compare the proportion of our clients who are living on less than \$1.25 a day, and \$2.50 a day across the regions we work in and our different delivery channels. Weighted regional averages for the population in general have also been included (MSI countries).

The results show that the clients accessing family planning through our clinical outreach services, which are specifically designed to target low income women, are either as poor or poorer than the regional average, when looking at women living in extreme poverty, on less than \$1.25 a day. When we look at women living on less than \$2.50 a day, the proportion living in sub-Saharan Africa as a whole is slightly higher than the proportion of our outreach clients there also living on less than \$2.50 a day. However, in south Asia, almost all of our

outreach clients (94%) are living below this poverty line, with nearly three quarters of our social franchise clients (72%) fitting this description. This compares with a regional average of 80% of people.



Reaching young people

Young people – here defined as under 25 – are an extremely heterogeneous group, and making sure our services are tailored to their differing needs is crucial. Young people, and especially sexually active adolescents, are often affected disproportionately by social and economic inequalities. This is compounded by the fact that, on average, they are less likely to use contraception than older women and are at more risk of death or injury if they do become pregnant.

The number one killer of 15 to 19 year old girls worldwide is pregnancy and childbirth. Every year, 70,000 young women die as a result of pregnancy or childbirth – over 70% of these deaths are preventable. In addition, 2 million more young women suffer morbidity associated with unwanted pregnancies resulting in illness and disabilities that can cause suffering, shame and abandonment. As a result of unintended pregnancy, it is estimated that 2.2 million to 4 million young women resort to unsafe abortions every year.²⁰

Young women aged from 15 to 24 make up 40% of all women of reproductive age in the least developed countries in the world.²¹ Despite making up a greater proportion of women of reproductive age than any other age group, the contribution of women under 25 to total contraceptive use is disproportionately low. Figure 18, overleaf, shows the situation in sub-Saharan Africa, where the median age at which women first have sex is 16.

When Mi Aye married at 13, she had no idea that nine months later she'd be a mother. She'd never been taught about sex. And following the birth at 14, she didn't know who she could talk to about preventing another pregnancy. Read the full story on page 2 of the case studies booklet.



Our performance in reaching under-served groups, highlighting the proportion who are young.

Women living in extreme poverty (< \$1.25 a day)

Women switching from short to long term methods

34%

24%

25%

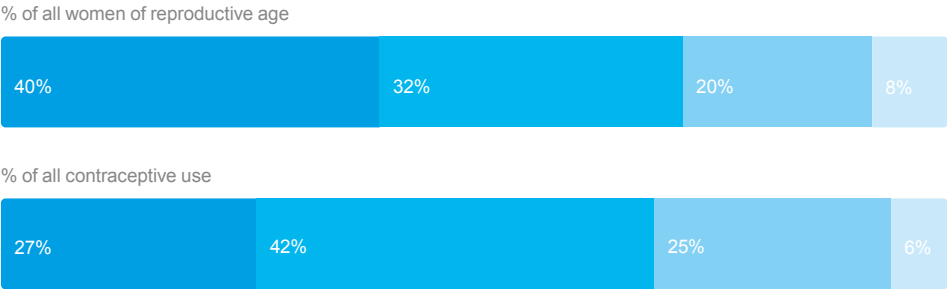
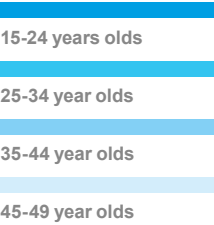
30%

Adopters

Under 25s

Figure 18.
Women of reproductive age, by age group, compared with all contraceptive users by age group, sub-Saharan Africa (MSI countries)

Sub-Saharan Africa



The challenge

Young people often lack access to sexual and reproductive health (SRH) information that is accurate, appropriate, relevant or interesting enough to enable them to make informed decisions that can benefit their health. As a result, young people worldwide are often unaware of the opportunity to address SRH issues that affect them. According to DHS data, young women often have lower than average knowledge of contraceptive methods, which can act as a barrier to making informed choices. As shown in Figures 19a and 19b, the situation can be worse if they are living in poverty and unmarried. These adolescents often feel disempowered to make decisions, or unable to access services, because they are unsure where to go, worried that confidentiality won't be maintained, wary of how they will be received and unaware of their rights.

As well as having lower levels of knowledge, the contraceptives that younger women use are often less diverse than those used by their older counterparts. In countries with a high HIV prevalence, condom use among young people is far higher than any other contraceptive method. One reason may

be that young people may access HIV prevention services as opposed to 'family planning' services, as it may feel more relevant to them. Young people may opt to access contraceptive services through new channels and may not feel welcome in facilities that are traditionally geared to older women who have already begun childbearing. Identification of new ways of reaching young people will be critical in helping adolescents gain access to contraceptive services.

Young people may, at times, not be the main decision makers about contraceptive usage or methods chosen. In cases where they are the decision maker, young people are often influenced by their peers, by myths around long term methods and by their ability to 'hide' a method from a parent or husband. Figure 20 shows the methods used by women aged 15-19 and 20-24, as well as the average in sub-Saharan Africa (MSI countries). Young women aged 15-19 using contraception are 50% more likely to fall pregnant than older women. This is because young people prefer short term methods, which are often harder to adhere to, increasing the risk of unintended pregnancy over the longer term.

Figure 19a.
Knowledge of methods: comparison between poorest, unmarried 15-19 year olds and average for all women, sub-Saharan Africa (MSI countries)

Sub-Saharan Africa

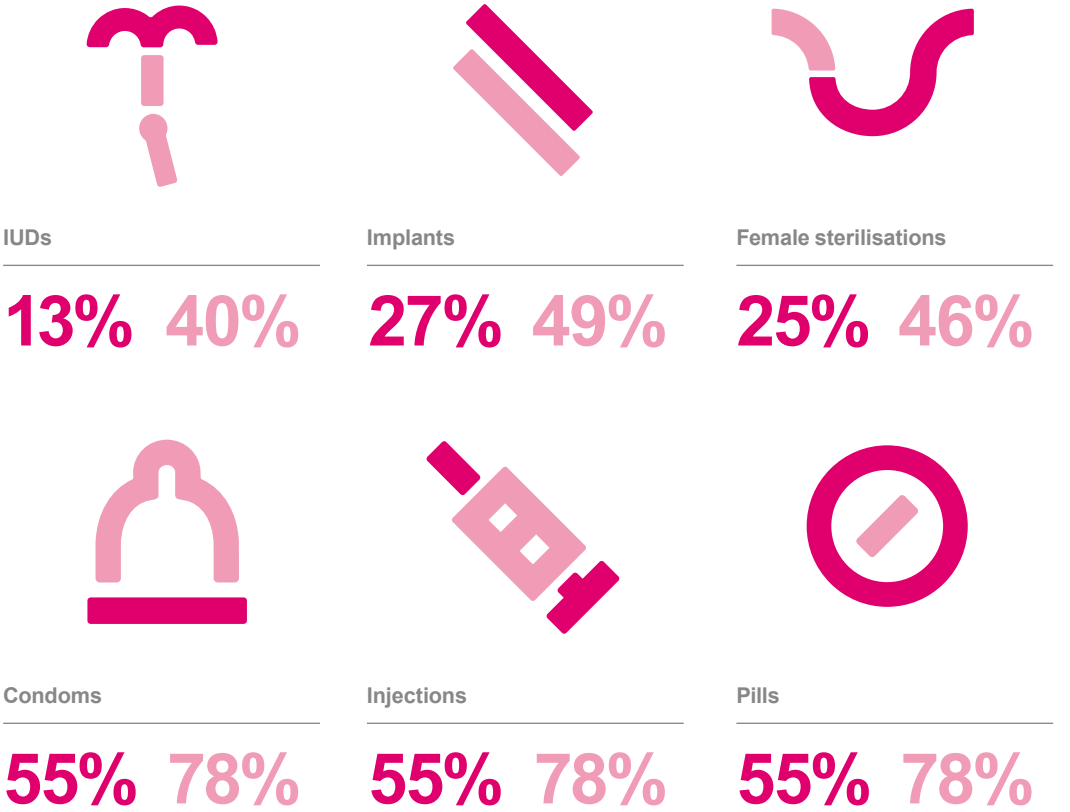
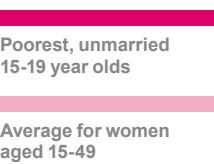
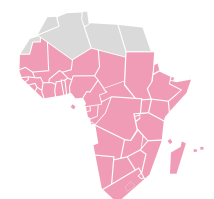


Figure 19b.
Knowledge of methods: comparison between poorest, unmarried 15-19 year olds and average for all women, south Asia (MSI countries)

South Asia

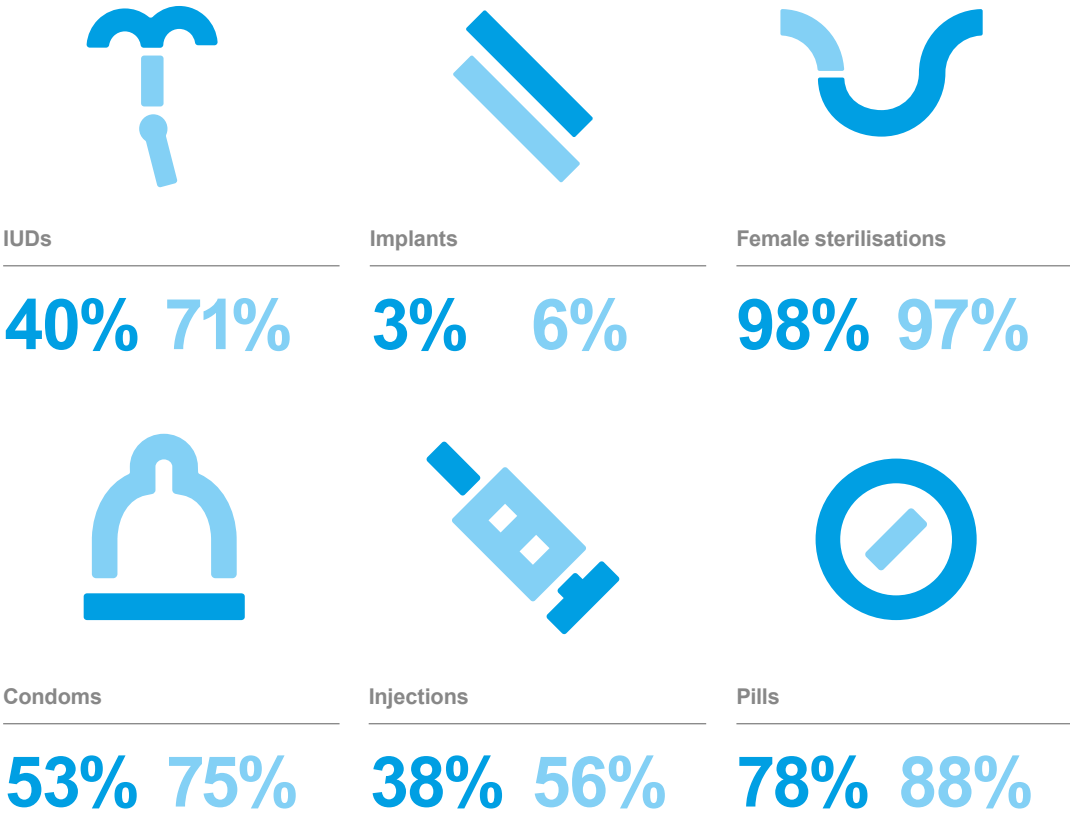
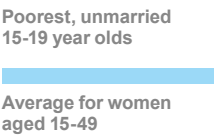
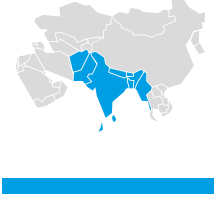
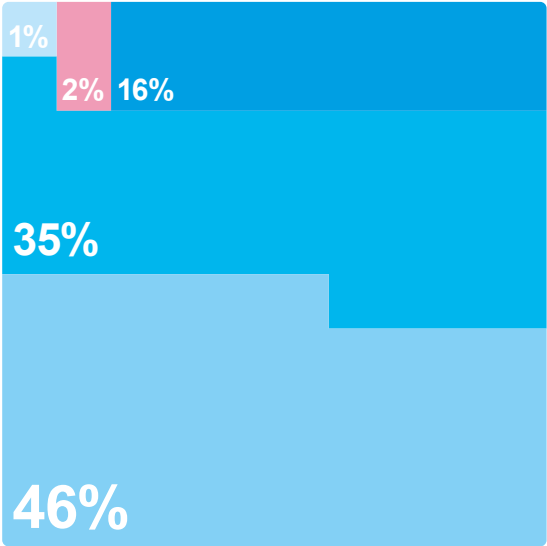
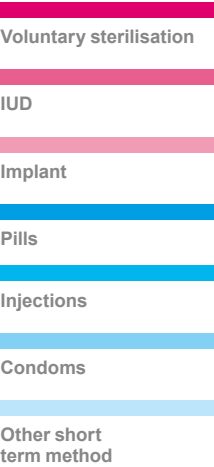


Figure 20.
Methods used by
general population
in sub-Saharan
Africa, by age group
(MSI countries)

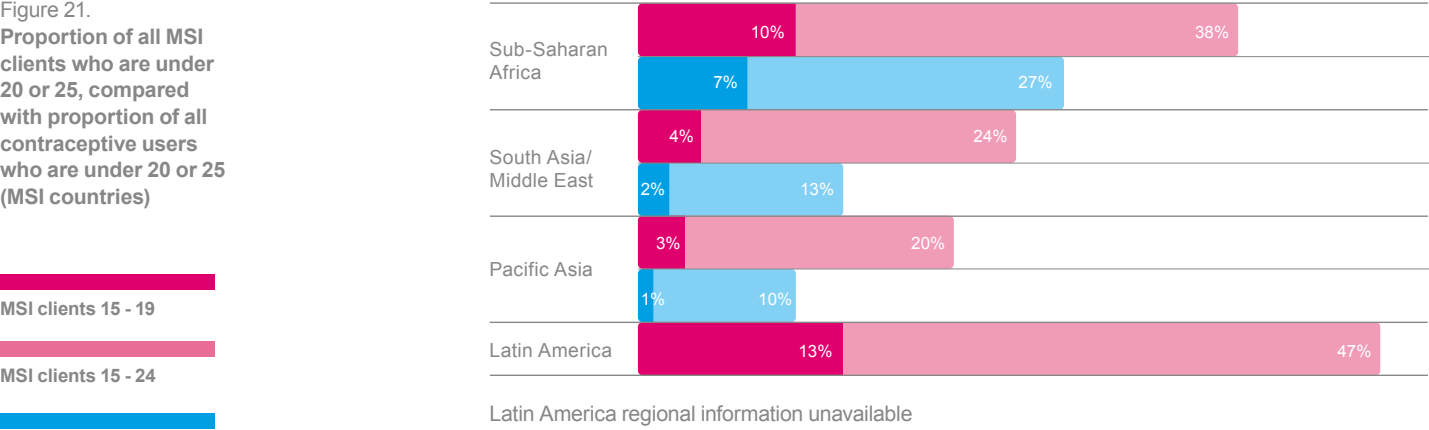
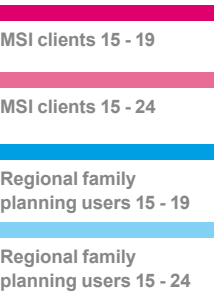


15-19 year olds

88%

Average effectiveness

Figure 21.
Proportion of all MSI
clients who are under
20 or 25, compared
with proportion of all
contraceptive users
who are under 20 or 25
(MSI countries)



Our performance in reaching young people

Of all the clients served by Marie Stopes International across our country programmes, 7% are currently under the age of 20 and 23% are 20-24. While this is a positive start, and a greater proportion of our clients are young than regional averages for contraceptive use (see Figure 21), it shows that there is still much work to be done. It is critical that young women are able to make informed choices about their contraceptive use, and have access to a full range of short and long term methods. Factors such as early marriage, lack of knowledge about contraception and sexual coercion commonly affect young women.²²

Where we focus on youth-orientated behaviour change communication, we have had positive results in engaging young people. In Sierra Leone, strong partnerships with organisations that work with young people, and the inclusion of young behaviour change communication assistants in outreach teams in 2011, contributed to an upsurge in the number of 15-19 year olds who chose to access contraception through Marie Stopes International. A quarter of our clients in

Sierra Leone in 2012 were teenagers, which compares with 12% of all users of contraception in the country.²³

In 2012 we reached more young women than ever before.²⁴ Many of these young women chose contraception, or a long-acting form of contraception, for the first time. Across well over 30 countries, we are empowering women and girls like Mi Aye to take control of their reproductive lives, in a way that removes the stigma from contraception, while respecting their unique needs and enabling individual choices.

Figure 21 shows the proportion of our clients in 2012 who were young, in comparison with the proportion of all users of contraception who were young, in the regions where we work. It shows that we have started to make progress in increasing access to contraceptive choices for young women, although we need to continue to improve how well we serve this important group. A greater proportion of our clients are either adolescent or in their early twenties, compared with the proportion of all family planning users that are in these age groups in the same region.

How we work

In the last two sections, we talked about the impact of our services around the world in 2012 and who we reached. In this final section, we tell you how we did it: by putting the people we serve at the centre of everything we do; by understanding the health systems in which we work and developing services that complement and strengthen what’s already on offer; and by creating an enabling environment for service delivery.

Section 3



Our approach

Support offices

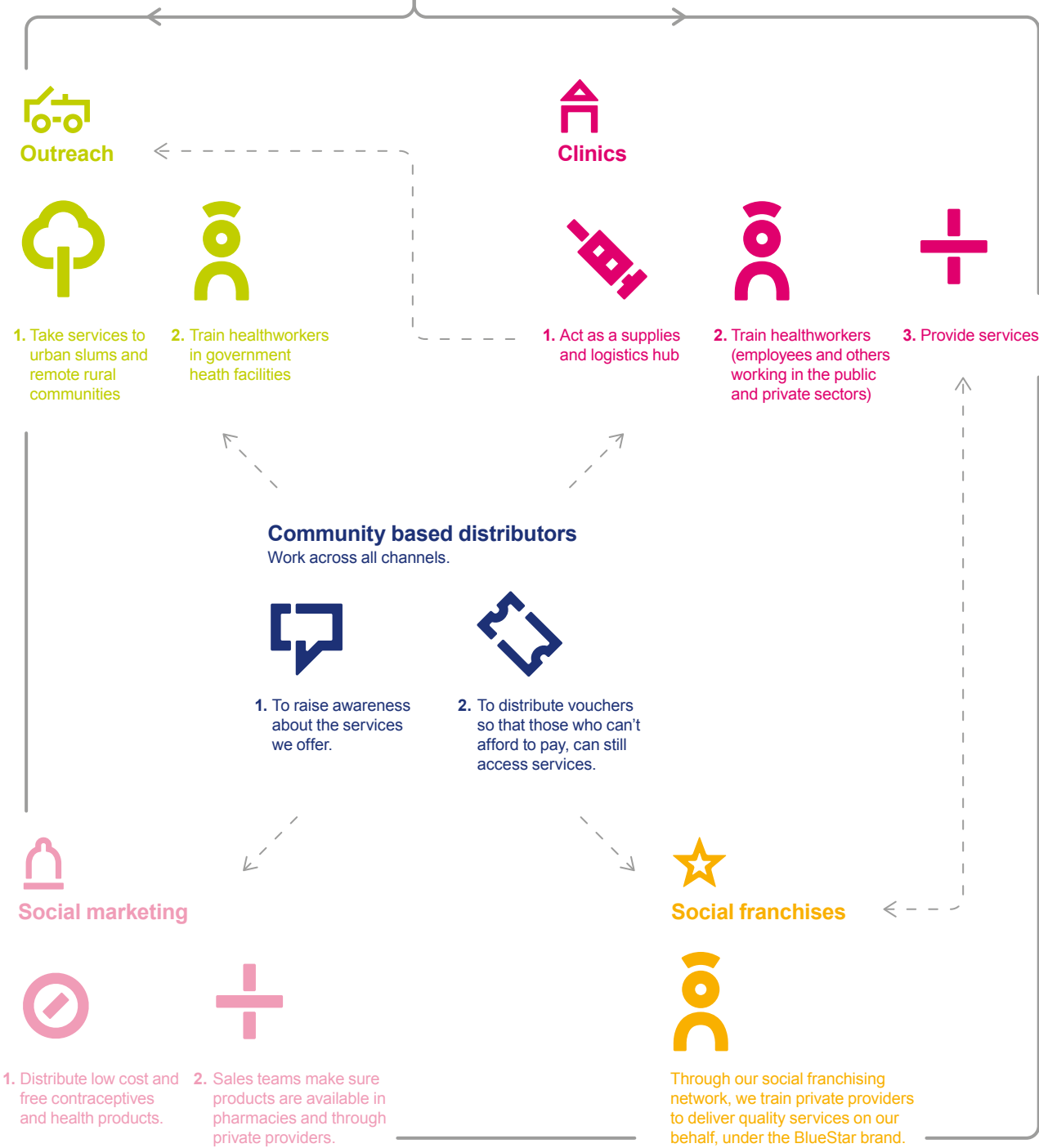
Each of our country programmes has a support office which oversees all the activity in that programme.

- 

1. They monitor the quality of our service delivery through all our channels.
- 

2. They survey our clients and prospective clients to understand their needs and the best ways for us to reach them.
- 

3. And they analyse the health system so that we can integrate our services to fill gaps and complement services that already exist.



Understanding our clients and the health systems we work in



The results we have shared with you in this report were achieved by putting the people who need and use our services at the heart of what we do. By understanding their individual needs and behaviours, we are able to develop services that work for them. And by understanding the family planning needs of a country’s population, we make sure we provide services that complement those that already exist.

For instance, for some women, a lack of knowledge about the full range of family planning methods may prevent them from using contraception that’s most appropriate to their needs. While for others, it can be the availability of methods at their preferred provider that affects their choice. With this in mind, we provide comprehensive counselling for women about the family planning methods that we offer, so they can make informed choices about which method is best suited to their needs. We also work to make sure that this full range of family planning options and safe abortion services (where permitted) are available across a range of service delivery mechanisms. We do this by examining what’s available within

the health system already, across all sectors – public, private and not for profit. And then we develop services and increase community awareness about family planning and service availability, both on our own and in partnership with others, that strengthen existing provision or that plug the gaps. We take a total market approach.

This total market approach expands choice and builds capacity in all areas of a country’s health system, from the training of clinicians working in top public hospitals through to the franchising of rural pharmacists and midwives. Through it, we aim to promote efficiency and equity in what we do, while helping our country programmes to harness opportunities for long term sustainability. We believe it works, and we’ve seen results from countries like the Philippines and Mali, and that’s why we’re focusing on making it the norm in each and every country we work in.

What does this mean?
In Figures 22 and 23, you can see that women in sub-Saharan Africa as a whole are more likely to receive their family planning from a government (public sector) provider. But the story isn’t that simple. Young, unmarried women are more likely than any other group to get their contraception from a friend or private shop, and are much less likely to go to a government provider. Poor women, on the other hand, are much more likely to access family planning through government providers. These characteristics underline the need for a flexible approach to service delivery.

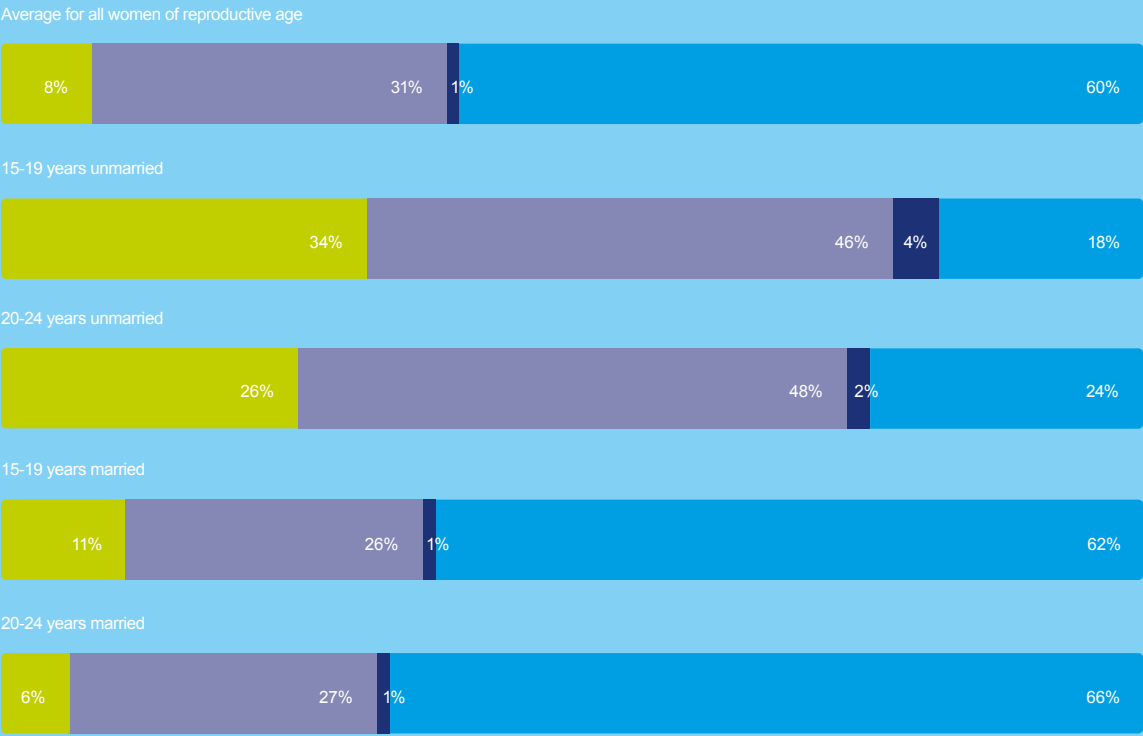


Figure 22. Where young women of reproductive age get their family planning in sub-Saharan Africa (MSI countries) by age category

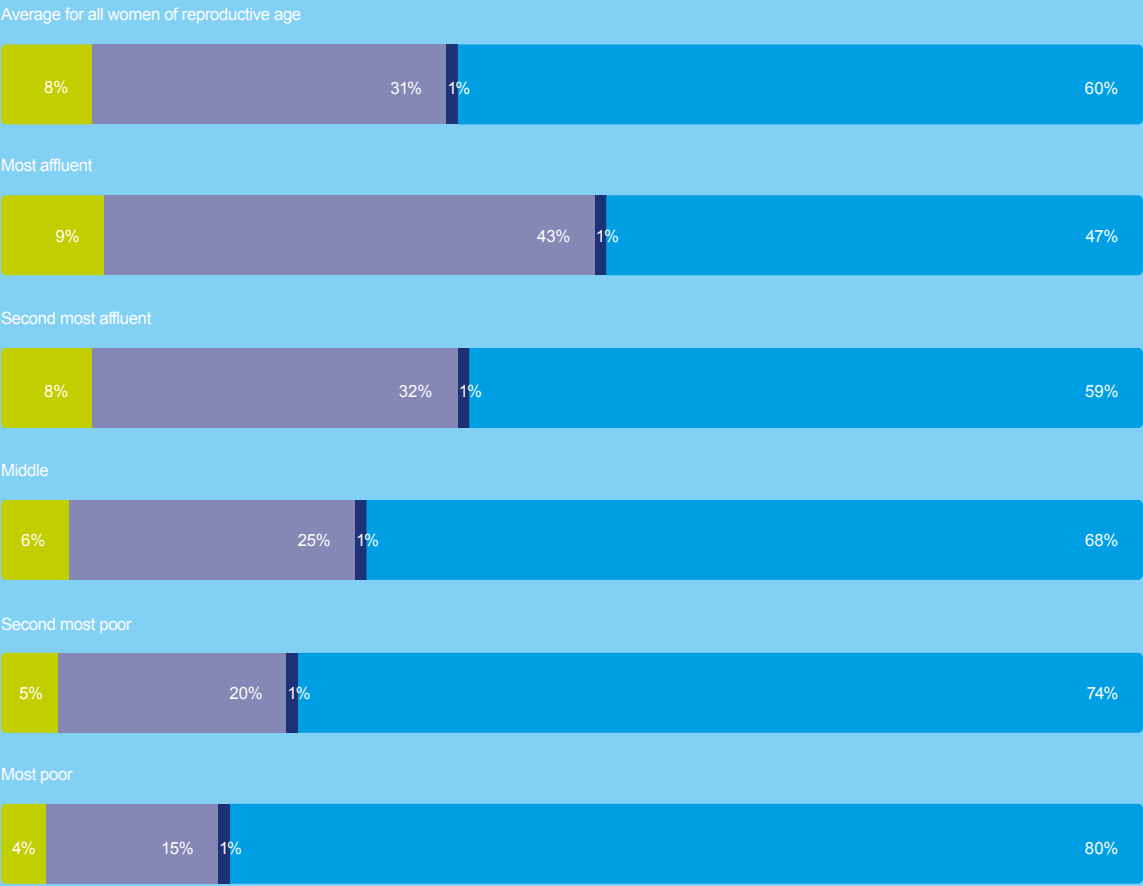


Figure 23. Where young women of reproductive age get their family planning in sub-Saharan Africa (MSI countries) by wealth quintile

Our service delivery channels

Mobile clinical outreach

For many people living in remote areas or urban slums, family planning is neither accessible nor affordable. Through mobile clinical outreach, we're offering choices where health facilities are scarce or are of poor quality due to shortages of staff and equipment, and where short term methods might be sporadically available, but access to longer term methods is almost non-existent.

In 2012:

370	26	30,000
teams	countries	hard-to-reach urban slums and remote rural locations

50,000	1.6 million
days of free or heavily subsidised services	people chose services through outreach

44%
of our CYPs were delivered through outreach



Social franchising

A large proportion of people in developing countries use private healthcare providers, especially those far from state-run health facilities. These providers are often of varying quality and governments have little capacity to regulate them. Social franchise networks, like our BlueStar network, help to organise the private sector by engaging private providers to deliver high quality clinical services that contribute to national and global health goals.

In 2012:

2,900	18	650,000
providers	countries	clients chose family planning services through our social franchises

350,000	13%
women were able to access safe abortion or post-abortion care through our social franchises	of our CYPs were delivered by our social franchises



Centres (MSI clinics)

We started life as a clinic based organisation, and while the majority of our clients now access services through outreach or social franchises, our centres remain the backbone for operations in many countries. They play a crucial role as a base for training and act as a vital logistical hub where our outreach teams and community-based distributors go to sterilise equipment and re-stock on clinical supplies.

In 2012:

620	37	16%
centres	countries	of our CYPs were delivered through our centres

500,000	650,000
women were able to access safe abortion or post-abortion care	clients chose a family planning method at one of our centres



Social marketing

Our social marketing programmes market and distribute low cost and free condoms, pills and other contraceptive and health products through pharmacies, community-based distributors and other private providers. One group who can benefit from social marketing are women and men who, for whatever reason, are unlikely to ever visit a more formal healthcare provider.

In 2012:

23%	2 million
of our CYPs came from our social marketing programmes	people received family planning services through our social marketing channels



Community-based distribution

Community-based distribution (CBD) is a health service delivery mechanism that empowers community members to deliver information, counselling and low technology primary healthcare services directly to other members of the community. Many of our clients live in settings where the health infrastructure is weak, the number of health workers is limited or health service coverage is low. We often integrate CBD with our other service delivery points in order to create demand, extend choice and open up access to SRH services for under-served populations.



Maximising our effectiveness

Delivering for the women and men who need our services is what drives our organisation. But we have to look beyond our delivery channels to make sure we are as effective as possible. This can be about innovation, challenging the status quo and developing new ways of getting our services to those who need them. Or it can be about influencing policy where we work to improve access to services. It’s also about making our services as sustainable as possible, and working in partnership so that we have a lasting impact on the health systems we work in.

Innovation

We work in settings with very few resources, so it’s crucial that we tackle barriers to service delivery with innovative approaches. Here are just two of the ways we’re doing this.

Task sharing: increasing women’s access to family planning

Many of the countries where we work have a shortage of doctors, as well as large numbers of people in rural areas who may find healthcare difficult to access. This means we have to take steps to maximise our reach. One way we do this is through task sharing.

This is where community health workers and ‘mid-level’ healthcare professionals – such as midwives and clinical officers – are trained to carry out procedures that would otherwise be restricted to more senior personnel like doctors. These providers are distributed more evenly across rural and low income areas than doctors, and crucially, are more likely to remain within their communities once they have been trained.

A study we carried out in Ethiopia found that task sharing our voluntary female sterilisation meant we were able to provide services in four times as many locations - the vast majority in rural, under-served communities.

Smart resourcing: using non-pharmacological treatments

In the areas where we work, particularly in sub-Saharan Africa, there are often shortages of analgesics used in minor operations, and when these are available they can be expensive.



We’ve been able to offer female sterilisation services in four times as many locations in Ethiopia through tasksharing.

To ensure we can serve women in these contexts, we use an alternative pain management technique called ‘Vocal Local’. This focuses on reducing anxiety, distraction from pain and avoidance of pain. Anxiety is reduced by performing procedures for women in a demedicalised environment, with trained staff using positive language and breathing exercises to help women manage pain. Our teams use this approach, along with local anaesthetic, for minor surgical procedures.

We carried out a randomised controlled trial and found that there was no noticeable difference in the pain experienced when using this technique than when more powerful analgesics were used. The success of this approach means that our services are not affected by shortages of analgesics, which is crucial in low resource settings.



Afghanistan’s new post-abortion care guidelines, which we helped to develop, will enable women to access lifesaving healthcare.

Focus on policy

The national and global policy environment has a large impact on a woman’s ability to access SRH services. We therefore work to influence policy on a national and global level that will help improve the lives of women.

National policy change to save women’s lives

In 2012, we influenced a range of national policies that will help save women’s lives. For example, in Afghanistan, after engaging the Ministry of Health and discussing the impact of unsafe abortion, we convened a working group of MPs, UN agencies, doctors and donors, to develop guidelines on post-abortion care. The guidelines and their implementation to all provinces and levels of health providers will enable Afghan women suffering complications from miscarriage, incomplete or unsafe abortion to access lifesaving healthcare and family planning.

Global policy change to improve access to family planning

In 2012, MSI’s international experience on task sharing family planning contributed to the development of global guidance. World Health Organisation guidelines were issued in December and reflect MSI best practice, clarifying that mid- and lower-level cadres of health worker can be highly effective in the safe provision of family planning services. We are now working with governments to implement these guidelines, for example in Burkina Faso we played an important role in securing authorisation for nurses and midwives to administer implants and IUDs.

Strengthening health systems: ensuring a lasting impact

It’s important that we develop services in a way that supports and strengthens the health systems we work in, and that ensures people can access services beyond the duration of a specific piece of funding. We achieve this in a number of ways.

Financing

We harness health financing options that ensure people can access services regardless of their income level, and that support the long-term sustainability



Our voucher programmes in Uganda, help women access free or subsidised services through a range of quality outlets.

of our services. Our health voucher programmes and social insurance schemes are enabling women living in poverty to access free or subsidised services through a range of quality outlets. And we are investing in understanding how much our clients and prospective clients are willing and able to pay to address our objectives of reaching the poorest women, while ensuring the sustainability of our services.

Our social enterprise model

Cross subsidising services that focus on reaching the poorest and most under-served people is a core part of our social enterprise model. As well as funding from donors and government contracts, we draw income from our centres and social marketing sales.

Our centres represent the heart of our financial sustainability model. With the exception of those in urban slums, our centres are intended to reach people who can afford to pay, and are competitively priced to serve middle income people and above. The income generated funds outreach programmes that serve the poorest women. This approach is particularly important in middle income countries such as India and Viet Nam, which are transitioning away from aid yet still contain significant levels of poverty and health inequality.

Training

We strengthen the capacity of both private and public providers through training. In many of the countries where we work, our centres are a beacon of best practice and a vital training base for our own staff, those we franchise to, public health sector staff and others.

Partnerships: improving health

Partnership is a cornerstone of our work. We stand the best chance of reaching the people who need our services by teaming up with those who share our goals, and those with complementary goals. We work closely with existing private healthcare providers, with governments and with other aid agencies to deliver family planning and safe abortion services but also to deliver complementary services that will support the health of our clients.

For example, through a partnership with the International HIV/AIDs Alliance we are improving the integration of HIV services into sexual and reproductive health services. We know that poor sexual and reproductive health and HIV infection have common roots in poverty, gender inequality, stigma and cultural norms. It therefore makes sense to wrap these services into a holistic programme that supports progress towards good health as a whole.²⁵

What's next?

- In order for us to achieve the goals of FP2020, we must ensure women who are currently using family planning are able to continue doing so, and then reach adopters of family planning on top of that. Over a third (34%) of the women we served across our programmes in 2012 were adopters, people that were not previously using family planning.
- To enable women to fulfil their right not just to contraception, but to the method that best suits their individual needs, a full range of family planning options should be made available to them. In the countries where we work in sub-Saharan Africa, more than eight in every 10 women using contraception are using short term methods, indicating a lack of choice. A quarter (25%) of all our clients in 2012 chose to switch from a short term method to a long acting or permanent method.
- The lower your income and the younger you are, the less likely it is that you can access family planning, despite having the most acute need for it. To ensure that access to contraception is equitable, and available to those with the greatest need for it, we must reach clients who are young and living in poverty. In 2012, 30% of our clients were aged 24 or under, and 24% lived in extreme poverty (less than \$1.25 a day).
- 162 million women, who want to use contraception but cannot access it, live in the poorest countries in the world. However, we shouldn't just focus our efforts on the poorest countries, but people living in poverty wherever they are. There remain high levels of poverty and health inequality in middle income countries, and it is vital that we reach these women too.
- Ensuring our service delivery mechanisms continue to serve the needs of clients in these groups is essential if we are to expand access to family planning equitably. We must continue to develop our understanding of who our clients are, what barriers some women face in accessing family planning, and how we can better meet the needs of the people we serve.
- The needs of the individual people we serve, and the contexts in which we operate, vary. We must continue to be adaptable to these contexts, providing our services across different delivery channels, and working on our own and in partnership to strengthen the health systems of the countries we work in.



Annexes

Annex A Key Marie Stopes International and national data 2012

	Couple - years of protection (CYPs) delivered by MSI in 2012	Women using modern contraception in 2012 ^[1]	Women using modern contraception in 2012 provided by MSI ^[2]	Estimated unintended pregnancies averted in 2012 due to MSI's services ^[3]	Estimated maternal deaths averted in 2012 due to MSI's services ^[3]	Estimated unsafe abortions averted in 2012 due to MSI's services ^[3]
Burkina Faso	95,125	640,574	44,068	19,451	35	2,530
Ethiopia	829,908	4,073,818	365,119	155,019	800	105,869
Ghana	270,526	845,359	63,297	27,587	450	75,797
Kenya	954,129	3,166,567	735,884	289,927	882	93,754
Madagascar	511,603	1,480,984	301,377	125,514	268	33,732
Malawi	852,087	1,274,019	661,660	216,938	677	53,493
Mali	192,935	247,015	71,802	32,211	167	15,797
Nigeria	202,228	4,508,318	26,125	11,809	445	75,475
Senegal	41,118	268,262	9,874	4,479	13	1,184
Sierra Leone	355,532	Insufficient data	204,140	83,736	559	28,931
South Africa	134,869	6,953,758	37,279	15,281	125	26,179
South Sudan	6,824	20,470	1,968	824	4	573
Tanzania	697,657	2,810,236	610,955	221,746	585	34,250
Uganda	1,136,077	1,695,579	644,678	259,714	686	81,374
Zambia	59,335	931,241	28,282	11,849	62	7,038
Zimbabwe	311,076	1,412,642	232,313	86,787	293	13,959
Africa	6,651,029	30,328,843	4,038,822	1,562,873	6,051	649,933
Bolivia	116,614	629,285	47,841	21,422	25	24,146
Mexico	67,749	15,078,479	16,848	7,389	5	16,936
Latin America	184,363	15,707,764	64,689	28,811	31	41,082
Cambodia	227,575	956,393	70,792	30,503	60	40,590
China	3,721	233,975,490	1,177	370	0	0
Timor Leste	20,190	39,042	12,409	5,195	7	861
Mongolia	151,749	380,144	100,128	33,770	11	0
Myanmar	344,381	3,868,755	340,822	115,203	117	23,433
Papua New Guinea	71,072	399,125	22,939	10,003	14	226
Philippines	1,288,859	5,447,306	1,009,382	420,034	213	72,688
Viet Nam	1,697,176	11,379,271	970,436	427,102	257	247,848
Pacific Asia	3,804,723	256,445,525	2,528,085	1,042,179	680	385,647
Afghanistan	426,011	1,333,269	230,420	97,780	222	15,212
Bangladesh	3,221,127	15,760,128	1,662,088	779,864	1,361	279,867
India PHS	2,867,779	132,670,130	2,636,119	863,855	1,690	481,916
India MSI	517,341	132,670,130	265,219	132,569	141	14,860
Nepal	540,150	3,440,359	528,050	179,659	226	61,439
Pakistan	1,639,282	7,464,490	1,017,825	422,003	812	149,624
Sri Lanka	97,746	1,697,147	119,294	31,633	10	4,966
Yemen	460,533	1,258,091	355,493	133,065	143	16,854
South Asia	9,769,969	296,293,744	6,814,508	2,640,428	4,605	1,024,738
Australia	114,941	3,330,056	31,974	13,202	1	0
Austria	8,492	940,515	8,328	1,726	0	0
Romania	4,410	2,723,427	446	179	0	248
United Kingdom	247,180	10,129,366	114,179	36,689	2	0
Developed Countries	375,023	17,123,365	154,926	51,796	3	248
Developing Countries	20,410,084	598,775,877	13,446,104	5,274,291	11,367	2,101,399
MSI TOTAL	20,785,107	615,899,242	13,601,031	5,326,087	11,370	2,101,647

1. Regional subtotals include only countries where MSI is currently operating. Figures were calculated from Impact 2, based on CPR data and UN population prospects projections

2. From MSI's Impact 2 model. These are estimated numbers of women using a contraceptive method provided by MSI. They include women who received services in 2012, and, who are still using an LAPM received in past years.

3. From MSI's Impact 2 model. These are the estimated numbers of unintended pregnancies, maternal deaths, and unsafe abortions averted in 2012; they include impacts from women who received LAPMs before 2012 who were still using their method of family planning.

Annex B Abbreviations and glossary

Annual impacts

Based on all women using contraception in a given year (including those still using LAPMs received in past years), plus the impact of any post-abortion care or safe abortion services provided that year.

Contraceptive prevalence rate (CPR)

This is the percentage of women of reproductive age (15 to 49) in a given population who are currently using contraception. This report refers to CPR for modern methods of contraception. Some definitions also include traditional and folk methods, and some only include women who are married or in a union.

Couple year of protection (CYP)

One CYP is the equivalent of one year of contraceptive protection for one couple. Some of the CYPs delivered in a specific year will actually be ‘used’ over future years, because they come from long-acting and permanent methods. For instance, an IUD is equivalent to nearly five couple years of protection.

CYPs are different to user numbers. CYPs reflect the scale of service provision in a specific year while ‘users’ are a snapshot of contraceptive use at a specific time.

Long-acting and permanent method of contraception (LAPM)

Long-acting reversible methods of contraception include IUDs and contraceptive implants. Permanent methods include vasectomy and female sterilisation.

Maternal mortality

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Medical abortion (MA)

Medical abortion is the use of pills to terminate a pregnancy. Medical methods using various combinations of mifepristone and misoprostol, or misoprostol alone, for first trimester abortion have been demonstrated to be both safe and effective.

Post-abortion care (PAC)

PAC is an important strategy to reduce maternal mortality by treating complications related to unsafe abortion and spontaneous miscarriage. It includes emptying the uterus of any retained products of conception by using pills or surgical methods, treating infection, pain and injuries, and offering a follow-up choice of modern family planning methods. It also includes identification and treatment or referral for STIs.

Unmet need for family planning

Women who are not using any method of contraception and who want to delay or limit future births.

Unmet need for modern family planning

Women who are using traditional methods or no contraception at all and who want to delay or limit future births.

Unsafe abortion

According to the World Health Organization (WHO), an unsafe abortion is defined as a procedure to terminate an unintended pregnancy performed either by individuals lacking the necessary skills or in an environment that does not meet basic medical standards, or both. Unsafe abortion may be induced by the woman herself or by an unskilled medical practitioner under unhygienic conditions. Common methods include the insertion of a foreign object into the uterus, the ingestion of harmful substances, exertion of external force, or the misuse of modern pharmaceuticals.

Users

The number of people using an MSI contraceptive in a specific year. A user may have been provided with an LAPM in a previous year and continued to use it in 2012. This measure is used in this report, alongside CYPs, to reflect the scale of our service provision. For more information, please see Annex B: Data sources and methodology.

Annex C

Data sources and methodology

This annex gives details of the main data sources used in the report and the main methods of analysis.

Impact 2

Impact 2 was developed by MSI and peer reviewed by experts at: EngenderHealth, Futures Group, Futures Institute, Guttmacher Institute, Ipas, International Planned Parenthood Foundation (IPPF), London School of Hygiene and Tropical Medicine (LSHTM), Population Council, Population Services International (PSI), and the United Nations Population Fund (UNFPA).

Impact 2 uses externally validated data from sources including DHS, UN Population Prospects, UN maternal and child mortality data, WHO Global Burden of Disease and the Guttmacher Institute.

Impact 2 is a model, rather than a measure of real life. As such, the estimates it produces are only as good as the data and assumptions available. While we have used the best available assumptions and data for all developing countries, much of this data is (1) reported infrequently because it is difficult to establish trends over time, and (2) not available at national level – only sub-regional or regional estimates are used.

To download the model, or for more information on the methodology and data behind Impact 2, its limitations, and recent updates, please go to our website (www.mariestopes.org/impact-2).

Impact 2 was used in this report as follows

- The executive summary graphic, figures 1, 4, 11, 12, 13: Estimates of women using a contraceptive method supplied by MSI. Impact 2 applies mortality and discontinuation rates to past LAPM service provision numbers to estimate the total number of users

in a year, rather than the total number of women who received services each year (i.e. clients). In Figures 12 and 13, the general population refers only to countries we work in for where there was recent demographic data available (see Demographic Health Surveys (DHS)). The number of users of MSI short term methods in 2012 is estimated by dividing the number of short term method products distributed by the number of these products needed for one year of coverage. This gives a number that is equivalent to the number of people protected by the short term contraceptives for a full year.

- 'Looking to FP2020' box, page 29 - Estimates of contraceptive commodities required to sustain current levels of use up to 2020. Impact 2 was used to estimate these, based on maintaining the current mix of methods used in less developed regions. This was approximated to be the method mix reported on the UN Contraceptive Use Wallchart (2011) for Less Developed Regions.
- Figure 11: Estimates of women using an implant in Uganda provided by MSI and other providers. National CPR percentages for implant use were taken from the three most recent Uganda DHS surveys, and were applied to UN population projections of women of reproductive age to estimate the number of mplant users in Uganda. The estimated number of MSI implant users was calculated using Impact 2, and then subtracted from this national total to give the estimated number of women using implants who received them from another provider.
- The executive summary graphic, figure 4: Estimates of impacts that took place in 2012 as a result of MSI

services (i.e. unintended pregnancies averted, maternal deaths averted, unsafe abortions averted, costs saved in healthcare spending). Impact 2 models the impacts of our services based on method-specific service provision data.

MSI analysis

To estimate the numbers of women with an unmet need for family planning who were under 25 and under 20 in the executive summary graphic, we used Guttmacher's Adding It Up 2012 report, and the UN population prospects projection 2010. We calculated weighted averages of the proportion of women of reproductive age in these age categories for all the relevant regions in Guttmacher's report, using the UN data. We then applied these percentages to the numbers of women with unmet need in each region that Guttmacher reported, and summed these to get to our estimated total.

To estimate that 20% of users of family planning in sub-Saharan Africa in 2012 were adopters (on the second page of the executive summary and page 27), we first calculated total users by method in sub-Saharan Africa for 2011 and 2012, based on the CPR by method for the region from the UN Contraceptive Wall Chart (2011), and, WRA projections from the UN Population Prospects (2010 Revision). Next, Impact 2 was used to calculate the number of existing LAPM users who would discontinue use of their method, and, it was assumed that 15% of short term method users discontinued use of a method between the two years. Adopters were taken as users replacing this discontinuation, offsetting population growth, and, increasing CPR. Adopter estimates were compared to all users served in 2012 (e.g. adopters + sustaining services to short-term users); we found that between 19% and 24% of users served would be adopters depending on the level of CPR growth from 2011 to 2012.

Demographic Health Surveys (DHS)

DHS are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health and nutrition.

In this report we analysed the most recent DHS datasets that were available from the countries we work in, for information on contraceptive prevalence and knowledge among the general population of women of reproductive age. This enabled us to explore different results by age category and wealth quintile. We then weighted the results to produce regional averages. These results were then used in figures 11-13, 15, 16, and 18-23.

The regional averages used in the report only refer to countries in those regions that MSI works in, and DHS data was available for 22 of the 33 developing countries we have programmes in. The sub-Saharan Africa results were derived from the latest DHS datasets from: Burkina Faso, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Senegal, Nigeria, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe. The south Asia results used the most recent DHS datasets from: Bangladesh, India, Nepal and Pakistan. The Pacific Asia results were based on datasets from: Cambodia, Philippines, Timor-Leste and Viet Nam.

In Figure 19b, Bangladesh was excluded from the poorest 15-19 year old column as the most recent DHS survey results did not include a breakdown of knowledge of contraceptives by wealth quintile. In Figures 22 and 23, Burkina Faso was excluded from the totals showing unmarried women, as the most recent DHS in that country did not have figures on contraceptive use among this group.

UN Wallchart

Data on contraceptive use globally in Figure 9 was based on the UN world contraceptive use wallchart, 2012, which is in turn based on national surveys of contraceptive use such as DHS.

Client surveys

We conducted standardised client surveys of representative samples of our clients, which in 2012 were carried out in 28 countries. These results were then weighted by region and delivery channel where appropriate. When weighting by delivery channel, data were only used from countries where the relevant delivery channel had been surveyed. MSI clinic data came from 25 countries, outreach data came from 21 countries, and social franchise data came from 10 countries. We used random samples designed to result in maximum +/- 10% confidence intervals at the 95% level. The overall results were used to inform the overall profile of our clients served in 2012, which is shown in the Venn diagram in the executive summary graphic, and throughout Section 2 of the report.

- Family planning adopters / continuing users / provider changer data were determined using questions on whether the clients had used a contraceptive in the past three months, where they had received it from, and what method they used. This information was used in the executive summary graphic (to determine that 34% of our clients globally were adopters) and figure 10.
- Figure 14: Data on the proportion of clients switching from a short term to a long acting or permanent method was based on the same questions about their past contraceptive use.

Poverty figures were estimated using ten poverty assessment questions in client surveys, developed by Microfinance Risk Management. These questions can be analysed to determine the proportion of clients that live below the \$1.25 per day extreme poverty line. The tool is not yet available for all countries. The percentages of people in the national population that live in extreme poverty (under \$1.25 a day) and in poverty (under \$2.50 a day) were taken from the World Bank website and used for comparison. These were then

weighted into regional averages for sub-Saharan Africa, south Asia and Pacific Asia. The weighting was done by the population of women of reproductive age in the countries in those regions that had surveyed the poverty levels of their clients. This data was used in the executive summary graphic, and in figures 17a and 17b.

Management information system and MSI service statistics

MSI service numbers and CYP numbers are based on our management information system. This is the reporting system through which our centres, outreach teams, franchisees, social marketing teams and other providers record, use and report the number of services they provided. The data is brought together and used by our country support offices and sent to our London head office for global analysis.

Adding It Up

This report, published by the Guttmacher Institute, presents an analysis on the costs and benefits of investing in family planning. The report includes estimates for the number of women with an unmet need for family planning, and other data that is used in the report. In the executive summary graphic, the data on the number of women in the developing world with an unmet need for family planning, and the consequences of this in terms of unintended pregnancies, unsafe abortions, and maternal deaths, was taken from Adding It Up. For the estimate of 82,000 maternal deaths resulting from unmet need for family planning in the developing world, we took Guttmacher's figure of 104,000 deaths due to unintended pregnancy, and applied their estimated percentage of those pregnancies that were a result of unmet need (79%).

References

1	India Demographic and Health Survey (DHS), 2005-06 and UN population prospects, 2010.	17	Based on estimate of family planning users, calculated using total modern CPR from 2006 and 2011, and UN population prospects (2010) estimate for number of women of reproductive age in those years.
2	Nigeria Demographic and Health Survey (DHS), 2008.	18	Uganda Demographic and Health Survey (DHS), 2006, 2011.
3	Guttmacher Institute, Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012. (2012)	19	Calculated using Uganda Demographic and Health Survey (DHS), 2006 and 2011, UN Population Prospects, 2010, and Impact 2. See Annex C for more information.
4	World Health Organization (WHO). Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. (Sixth Edition, 2011)	20	See http://apps.who.int/rhl/adolescent/cd005215_ramoss_com/en/index.html , 2011
5	Based on 40,400 unsafe abortions in the regions where we work (WHO, 2011) and 8,760 hours in a year.	21	UN Population Prospects, 2010.
6	Guttmacher Institute. Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide, Guttmacher Policy Review 2009; 12:4.	22	United Nations Population Fund (UNFPA), Marrying Too Young: End Child Marriage (2012); Moore, A.M., Awusabo-Asare, K., Madise, M., John-Langba, J. and Kumi-Kyereme, A. Coerced first sex among adolescent girls in sub-Saharan Africa: prevalence and context. African Journal of Reproductive Health, (2007) 11:3; Weighted analysis of most recent DHS surveys from the countries where MSI works consistently showed lower than average levels of knowledge about contraceptives among adolescents.
7	Park, MH; Nguyen, TH ; Dang, ATH ; Ngo, T ‘Medical abortion practices among private providers in Viet Nam’ in International Journal of Gynecology and Obstetrics. (forthcoming)	23	Sierra Leone Demographic and Health Survey (DHS), 2008.
8	Ngo, T, Park, MH, Shakura. H & Free, C; ‘Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review’ in Bull World Health Organ 2011; 89:5.	24	Based on an increase in the number of clients served and no decrease in the proportion of those that were young.
9	Ngo, T, Park, MH, Free C. ‘Safety and effectiveness of termination services performed by doctors versus midlevel providers: a systematic review and analysis’ in International Journal of Women’s Health 2013;5.	25	World Health Organization, United Nations Populations Fund, International Planned Parenthood Federation, Joint United Nations Programme on HIV/AIDS and University of California, San Francisco. Sexual and reproductive health and HIV/AIDS. Linkages: evidence review and recommendations, 2009.
10	Based on MSI safe abortion and post-abortion care service data, and regionalised estimates for annual abortions from WHO, 2011 and Guttmacher Institute, 2009.		
11	Guttmacher Institute, Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012. (2012)		
12	India Demographic and Health Survey (DHS), 2005–06, among married women.		
13	India Demographic and Health Survey (DHS), 2005–06.		
14	Nigeria Demographic and Health Survey (DHS), 2008.		
15	See 'MSI analysis' in Annex C.		
16	Trussell J. Contraceptive Efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D and Policar M (eds). Contraceptive Technology: Twentieth Revised Edition. New York, NY: Ardent Media, 2011.		

Core services

The individual women we serve are our primary focus, and we work to maximise the family planning and safe abortion options available to them so they can make informed choices about what methods suit them best. We offer the following services:

Contraceptive implants
Implants are a highly effective and convenient method of family planning. They are inserted under the skin of the upper arm, and steadily release progesterone, which protects a woman from pregnancy for three, four or five years, depending on the type of implant chosen. They can be removed at any time, and are highly effective, with a 99.9% success rate.

Contraceptive injection
This is an injection of hormones (progesterone) that works to stop ovulation. Injections last between two to three months, depending on the type chosen, and are a reliable alternative to contraceptive pills. They are also highly effective; less than four women in every 1,000 will get pregnant over two years of typical use.

Contraceptive pill
The pill comes in combined form (oestrogen and progesterone) or progesterone only, both of which prevent an egg being released from a woman’s ovary every month. It is convenient, as it can be picked up from pharmacies and shops, and discontinued whenever a woman chooses. When used correctly it is 98% effective.

Female and male sterilisation
If a woman or couple decide that they do not want to have any more children, we offer sterilisation services, with tubal ligations for women, and vasectomies for men. All our clients are given counselling, so they are able to make a fully informed decision about whether or not to proceed with a sterilisation.

Inter uterine device (IUD)
An IUD is a small T-shaped plastic device that is inserted into a woman’s womb. It releases progesterone or copper (depending on the type), which prevents fertilisation of a woman’s egg. IUDs can last for up to 10 years, making them a good option for women who know they will not want to have children for some time. As with implants, they can be removed at any time, and are over 99% effective.

Male and female condoms
We distributed over 170 million condoms in 2012, across all of our delivery channels. We give women access to condoms both for prevention of pregnancy, and to enable them to protect themselves from sexually transmitted infections.

Safe abortion and post abortion care services
Where it is legal, we offer women the option of terminating their pregnancy in a safe, confidential and reassuring environment. We offer both surgical and medical abortion; the large majority of women who access our abortion services choose medical abortion. This is a non-invasive and convenient method, which can be delivered outside of a medical setting. We also provide post-abortion care to women who have had an unsafe abortion from an illegitimate provider. This reduces the harm from unsafe abortion, and helps us save women’s lives across the countries we work in.



Case studies — stories from our clients

Passipo from Nigeria, Welansa from Ethiopia, Kaushalya from India, Mi Aye from Myanmar, and Sophy from Cambodia, share what access to Marie Stopes International's services has meant to them.

A large background image showing a woman with dark hair and a bright smile, looking towards the right. She is wearing a blue top. The background is a solid blue color.

Mi Aye — Bago, Myanmar

16 year old Mi Aye lives in Poner Su, a squatters' quarter in Bago, Myanmar. Married at 13, she had her first child at 14. Here she tells us how a visit from a Marie Stopes health worker has allowed her to take control of her future.



"My family is very poor. My mother is a vendor and my father does odd jobs - he works when there's work and stays at home when there's none. Growing up in a large family, there was never enough in our home and our family couldn't find a way to solve this problem.

"I became a grown up at a very early age because I got married at just 13. To be honest, I'd never thought of the consequences that follow a marriage. Nobody told me about how you have children or how I could avoid getting pregnant, so of course, I got pregnant. I was 'a child giving birth to a child' because I was only 14. And afterwards I was really frightened about getting pregnant again but I didn't know what to do to stop it.

"I must say I'm lucky because health workers from Marie Stopes visited us. I asked them what I could do to stop getting pregnant, and they told me about all these different things I could use. I wanted the contraception that goes in into the uterus to prevent pregnancy for up to 10 years.

"When I said I couldn't pay, they assured me that I could get it for free. It was like being thirsty and falling into a well. I don't have to worry now. I can raise my child properly and do business to get money."

"I think you have to plan properly to have a child. And thanks to Marie Stopes, we've been able to decide that we will only have another when we are ready."

We've been providing integrated sexual and reproductive health services to women in Myanmar since 1998. We work to bring quality family planning to under-served women and with two thirds of the population living in remote areas, we provide extensive clinical outreach across the country to meet their needs.



Kaushalya — Jaipur, India

29 year old Kaushalya lives near the small village of Manpur Machedi, in Jaipur, India. Her community is very poor, and while many of the women she knows want to choose if and when they have children, they're not always able to access family planning services that would allow them to do that.



Kaushalya has four children. And for her and her husband, that's their family complete. While they'd been able to get condoms locally, they hadn't been able to access long-acting methods until recently. That changed when Kaushalya heard about the Marie Stopes India outreach team that was setting up a temporary clinic near her home.

She attended and was told about all the choices available including the five year IUD which she chose.

"What a relief. In five years, I will come back to Marie Stopes for another IUD. It's the only place I can get one and it's the only thing that really stops me from having to worry about getting pregnant."

It's this sense of relief that she's been keen to share with her friends. In her community a lot of her friends and neighbours don't want to have any more children – rather they want to use what money they have to bring up the children they have.

"My husband and I both tell our friends and people in our community about Marie Stopes. Family planning has made such a difference for us and we want to make sure people know what's available to them. I know nine women who have started using family planning after my recommendation."

Visits from the Marie Stopes team mean that women like Kaushalya are able to make choices about the way they live their lives.

But despite the fact that India's economy is booming, there are still large numbers of people living in extreme poverty who aren't able to make these choices. In fact, around 46 million girls and women living in India are unable to access family planning even though they want it.¹

A large background image showing a woman with short dark hair, wearing a light blue shirt, smiling and looking towards the right. In the foreground, the back of another person's head with dark hair is visible, looking towards the same woman. The background is a blue wall.

Passipo — Nasarawa, Nigeria

30 year old Passipo hasn't been using contraception. Not because she's trying for a child, but because the clinics in her town don't offer it. We spoke to her when she visited one of our mobile outreach teams in Nasarawa, Nigeria.



"I have four children, aged eight, five, four and two. I want to be healthy and I want my kids to be healthy but life can be hard and it's a struggle having so many children. That's why I'm here - for now I don't want to have any more."

Our mobile clinical outreach teams bring family planning choices to under-served communities. They visit the same sites regularly and build up relationships with local practitioners and communities in order to provide regular services. And they work with community health workers and local healthcare providers to let people know about the visit in the days and weeks beforehand.

Around 20% of women of reproductive age in Nigeria want to use a method of modern contraception but can't access it.² Since we opened our first clinic in Nigeria in 2009, we have been one of the only providers offering high quality long-acting and permanent methods of family planning. We now have one clinic, five outreach teams providing family planning services in 125 locations, and 92 social franchisees bringing greater choices to women.

In 2012, 26,000 women in Nigeria were using a method of contraception which we supplied, preventing 11,800 unintended pregnancies.

"I found out about Marie Stopes through the town crier. He was telling us all about the work they do and the family planning they offer. We have health clinics in my town but they don't do family planning. It took me and my sister two hours to get here. She wanted family planning too so we shared the motorbike. I know I don't want children for now so I got the five year implant because I want to rest for a long time. I felt no pain in my arm and now, I'm happy."

A large background image showing a woman with short dark hair, wearing a blue top, smiling broadly. In the foreground, the back of another woman's head with dark hair is visible. The background is a blue wall.

Welansa — Mojo, Ethiopia

29 year old Welansa lives in a small village on the outskirts of Mojo, 80 miles from Ethiopia's capital, Addis Ababa. Divorced, with one child, she doesn't want to have any more children at the moment, but may in the future, if she marries again.

Welansa has tried a number of different types of contraception, including the injectable, but she hadn't found one that really suited her until she was able to get an implant at her local BlueStar clinic.

"I'm much happier using the implant - it feels right for me. Before, I was taking the injection every three months. I was menstruating more often and I had to go to the clinic every three months to get my injection which wasn't always easy.


Welansa makes a living selling Tella, a local beer, and her job requires her to travel a lot.

"The implant lasts a lot longer which makes it easier for me and my work. I am happy and confident knowing there is no risk of an unplanned pregnancy for me now."

"I am divorced and I don't want to have more kids right now but I want to keep my options open. If I get married again, I would like to have more but we'll see. I'll probably always use contraception though because I want to be able to space my pregnancies."

BlueStar is our social franchising network, through which we partner with a range of private healthcare providers to expand access to high quality family planning and safe abortion services, where permitted. In 2012, we had 560 BlueStar franchisees in Ethiopia, helping us to bring wider contraceptive choices to women across the country.





Sophy — Battambang, Cambodia

Sophy is 31 and married,
with two children.

Life was tough for Sophy and her husband when they married 11 years ago – they didn't have much money and they worried about what that meant for their future. They decided early on in their marriage that they only wanted to have two children, but they weren't aware of how to make this choice a reality.

So, over the years, Sophy has had three unintended pregnancies, and three abortions. Her story makes clear what can happen when you don't know your family planning options or don't have safe abortion services available to you. And it shows just how important good contraceptive counselling services are, both after an abortion and after birth.

Sophy chose to have her first abortion just a few months after the birth of her first son. She recalls that she “didn't know that you could get pregnant that fast.” The service was provided by a government practitioner who hadn't been trained in abortion care. It left her in a lot of pain and took her weeks to recover. After the abortion, she decided to use an IUD, but had to have it removed as it caused her further pain.

After having their second child, Sophy decided to use the pill, but every now and then would forget to take it and she soon became pregnant again when her daughter was only a few months old. A friend recommended that she try ‘Chinese pills’ - unregulated, over-the-counter abortion drugs. Sophy's experience was very traumatic: “After taking the pills I was in serious pain and losing a lot of blood. The bleeding was so heavy, I was really scared.”

Earlier this year, Sophy became pregnant again and decided that she didn't have the resources to raise another child. Remembering the pain and trauma of her previous abortion experiences, she wanted to find a safe service, and after advice from a neighbour, she visited the Marie Stopes clinic in Battambang.

“The staff at the Marie Stopes clinic were really great. They were professional and caring and made me feel safe and well looked after. They talked me through my contraceptive options too so I could avoid more unintended pregnancies and I am now using the contraceptive injection.

“Our family is doing well now. I have the resources to educate my children and the time to work and help my husband in his business more.”

Marie Stopes International wishes to thank those who support our work around the world. Through the gifts, grants, funding and technical assistance we receive from foundations, institutions and state partnerships - and the incredibly generous support of many individual givers, worldwide - we are able to serve women across the globe, including those most under-served.

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