MARIE STOPES INTERNATIONAL

PROVIDING CHOICES IN REPRODUCTIVE HEALTHCARE

Global Impact Report 2011

Delivering choice and rights for women: past, present and future

Front and back cover:
The number of MSI users by country

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Our vision: a world in which every birth is wanted

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.

Foreword

Acknowledgements

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Welcome to the third Global Impact Report from Marie Stopes International (MSI). Our organisation exists to offer all women access to a full range of reproductive health choices. These include modern contraception, post-abortion care and, where permitted, safe abortion. Our services are critical to ensuring millions of women can exercise their reproductive rights. In this year's report, we look at the past, present and future of the global family planning revolution that is changing lives and opening up opportunities for women. And we examine our contribution towards the shared global goal of providing accessible and affordable modern contraception and safe abortion for all.

The rapid uptake of family planning around the world since the 1960s has allowed billions of people to make informed choices about their reproductive rights and family size. Family planning has had dramatic health impacts – preventing the deaths of approximately 150,000 women in the developing world every year. And there is growing evidence that family planning is helping millions of families escape poverty. Today, there are around 600 million women and couples using family planning in the developing world. This includes 11 million of MSI's own clients. But there are still many people who do not have access to the services they need. An additional 90,000 lives could be saved every year if the current unmet need for family planning could be met. The sexual health and contraceptive needs of young people in particular are largely overlooked.

This report tracks progress during 2011 towards our global mission − 'children by choice, not chance'. We take a detailed look at the quality, scale and impact of our services, and examine to what degree we are reaching under-served groups. We showcase the innovations we are developing to help us expand our future reach, especially to those people who have typically missed out in the past.

We value transparency and decision making informed by hard evidence. This report makes extensive use of various types of data that are now being generated by MSI. We also use external data to help us understand the effects of our work and how we can increase our impact and the support we provide to countries to improve the lives of women.

I am grateful for the dedication of our 8,500 team members who strive every day to ensure women across the globe have the power to make informed choices about their reproductive rights and health, their family size, their fertility and their futures.

Dana Hovig
Chief Executive Officer

Our services have expanded dramatically in the last 10 years – particularly the provision of long-acting and permanent family planning methods (LAPM). In 2011, we provided services that equate to 21.6 million couple years of protection (CYPs), consolidating the enormous growth that had occurred in 2005-2010.[i]

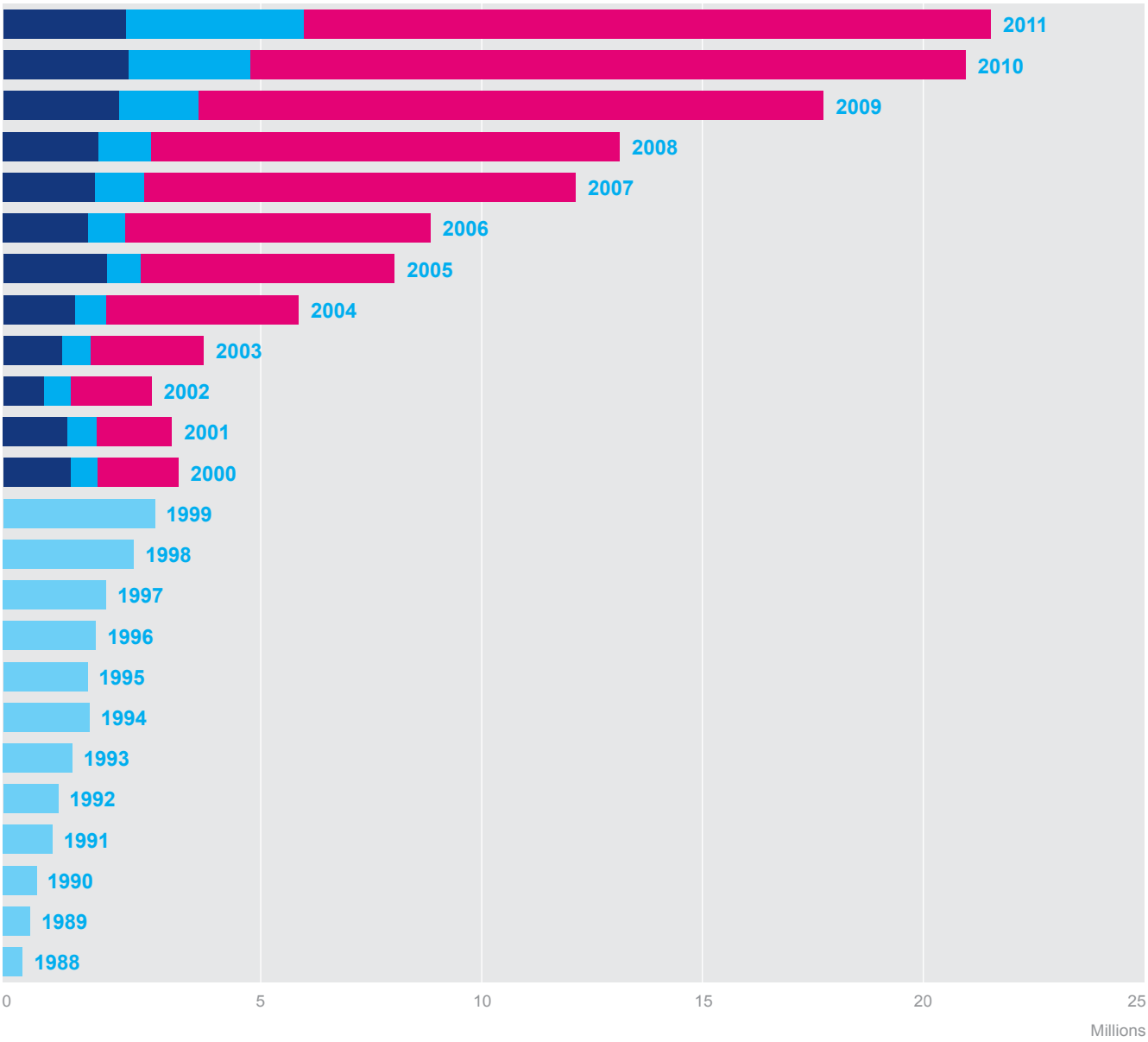


Figure 1:

Number of couple years of protection (CYP) provided by MSI, 1998 - 2011

- LAPM CYPs
- Short term method CYPs
- Safe abortion / PAC CYPs
- 1988-1999 CYPs

i The CYP conversion factors used in this 2011 report were modified versions of those developed by the United States Agency for International Development (USAID) in 2000. We had adjusted them because they had not been updated since 2000. However, USAID has now updated the conversion factors and we will use these new USAID conversion factors in future reports.

2011:

Family planning has achieved massive worldwide growth since the 1960s

The rapid uptake of contraception around the world has helped billions of people choose whether and when to have children.

600,000,000

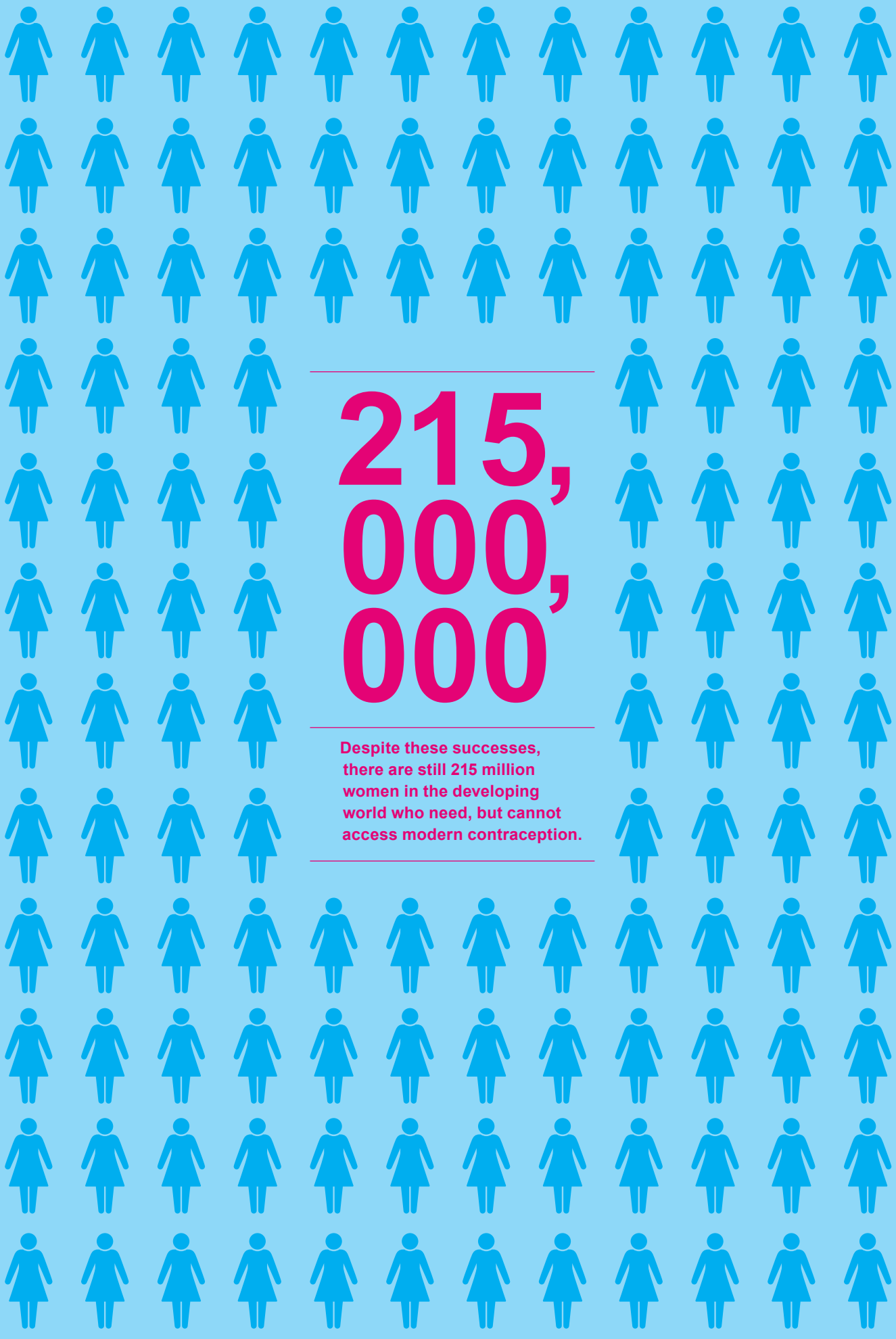
There are 600 million women and couples using family planning in the developing world.

188,000,000

Each year 188 million unintended pregnancies are prevented.

150,000

And 150,000 women's lives are saved as a result.



Despite these successes, there are still 215 million women in the developing world who need, but cannot access modern contraception.

In 2011 we reached more people than ever before

11 million people used an MSI-supplied method of contraception in 2011.

11,000,000

Our services saved the lives of 11,000 women.

11,000

We prevented 1.65 million women from risking their lives by turning to unsafe abortion.

1,650,000

We prevented 4.5 million unintended pregnancies.

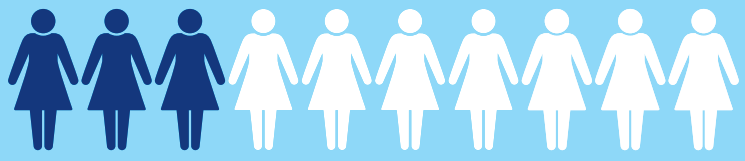
4,500,000

And we saved healthcare systems £188 million.

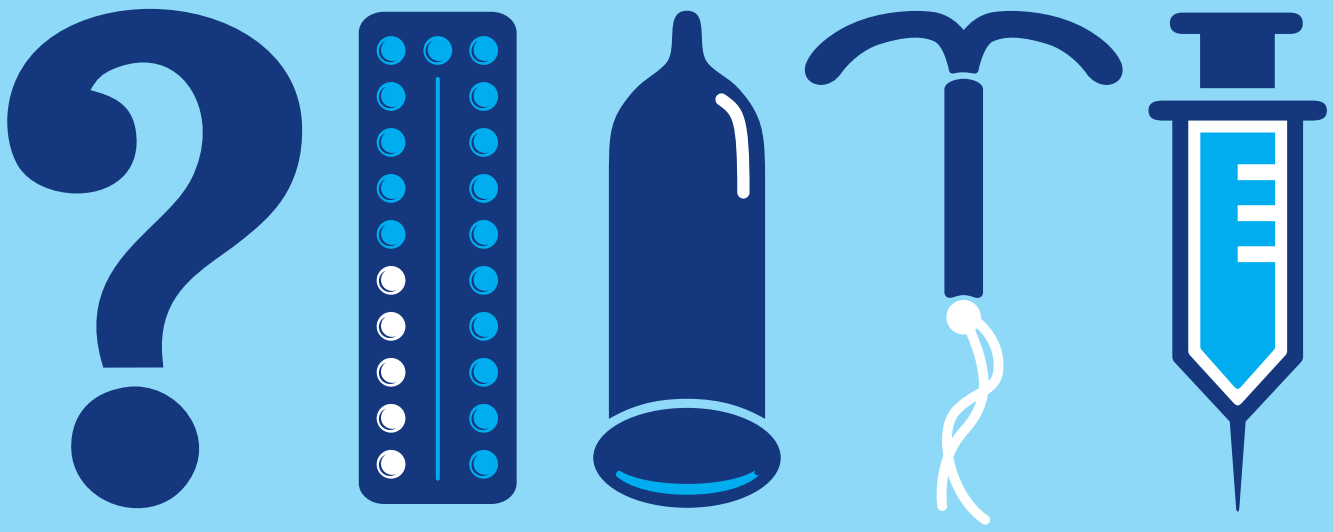
£188,000,000

We reached some of the world's most under-served women

As well as increasing the number of services we provide, we are committed to reaching out to those most in need. In 2011, three in 10 of our clients lived in extreme poverty on less than $1.25 a day and three in 10 were under 25.



We expanded choice



Choice is fundamental to everything we do.

We are working to make sure people have choice over whether they use contraception, choice over the method that they use, and choice over the provider that they receive it from.

4/10

Four in 10 of our users are new adopters of family planning.

3/10

Three in 10 are switching to a long term or permanent method.

We reduced harm

We reduced the potential harm caused by unsafe abortion by providing 1.9 million safe abortion and post-abortion care services.

We improved quality

We take pride in making the client the focus of our service provision, and tailoring our services to best meet our clients' needs and wishes. Over 90% of our clients, in countries with clients survey data, would recommend our services.

We innovated

We are developing a number of innovations around financing, technology and health systems to make sure that we reach those who are unable to access family planning. Read more about our innovations in each chapter of this report.

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Chapter 1
Family planning's past, present and future

"In our day we didn't have family planning. A woman would give birth until she stopped" says Yunia, a great grandmother who estimates her age to be 90. However, attitudes and access to family planning have changed dramatically in her lifetime: something that becomes clear when you speak with the next three generations of her family.

► Full case study on page 22

Family planning worldwide – a success story

The 20th century was a defining era for family planning. Women took control of their fertility in large numbers for the first time, as medical advances and social and cultural changes made family planning readily accessible in many parts of the world. Pioneers set the movement in motion. Marie Stopes herself opened Europe's first family planning clinic in central London in 1921. Then the arrival of the contraceptive pill and the modern intrauterine device (IUD) around 1960 ushered in the modern era of contraception.[1] By 1980, more than 60% of all women aged 15 – 49 were using a modern contraceptive in North America, western Europe, northern Europe and eastern Asia.

Large scale funding for family planning programmes for developing countries began in the 1960s. Over the following two decades, a number of national and international organisations were founded that are still active in the field today. This included Marie Stopes International (MSI), which was established in 1976. The success of family planning programmes experienced in the developed world began to spread through most of the developing world, where a number of national and international governmental and non governmental organisations were working to provide women and couples with options for controlling their fertility. By 2011, parts of Asia and north Africa had achieved high levels of contraceptive use. However, in sub-Saharan Africa, while contraceptive use increased from very low levels, it is still under 20% – far lower than other regions (see Figure 2).

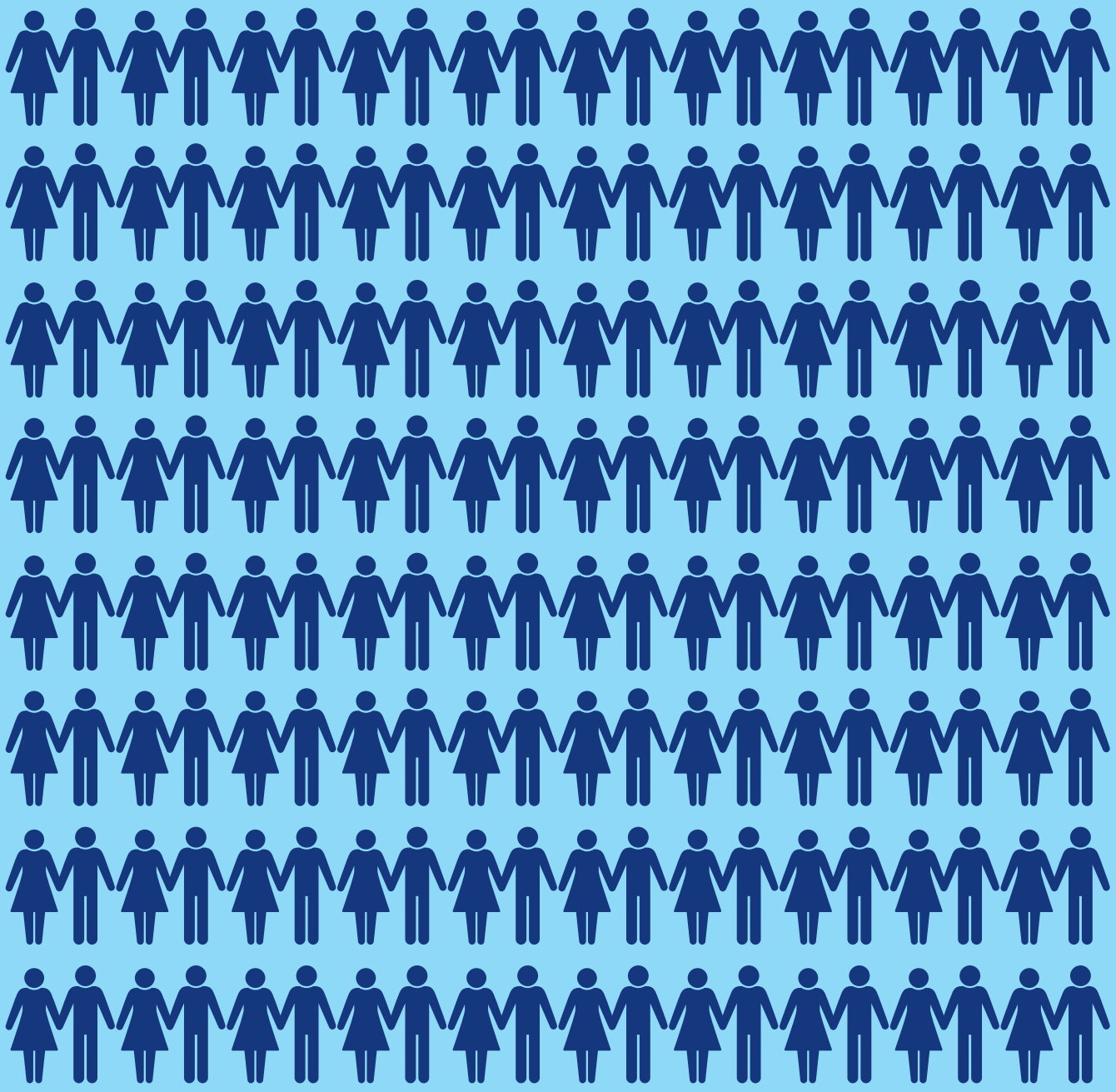
An estimated 600 million people in the developing world currently use a modern method of family planning. This widespread use prevents an estimated 188 million unintended pregnancies, 112 million abortions and 150,000 maternal deaths every year.[2]

MSI has been making significant contributions to this growth. The number of people using an MSI-supplied contraceptive in each region has grown every year, reaching a global total of 11 million in 2011.[ii]

ii There are two measures used in this report that reflect the scale of our service provision:
Couple years 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.
Users: the number of people using an MSI contraceptive in a specific year. A user may have been provided with a long-acting or permanent method in a previous year and may continue to use it in 2011.
For more information, please see Annex 3: Data sources and methods.

Women and couples using family planning in the developing world

600,000,000



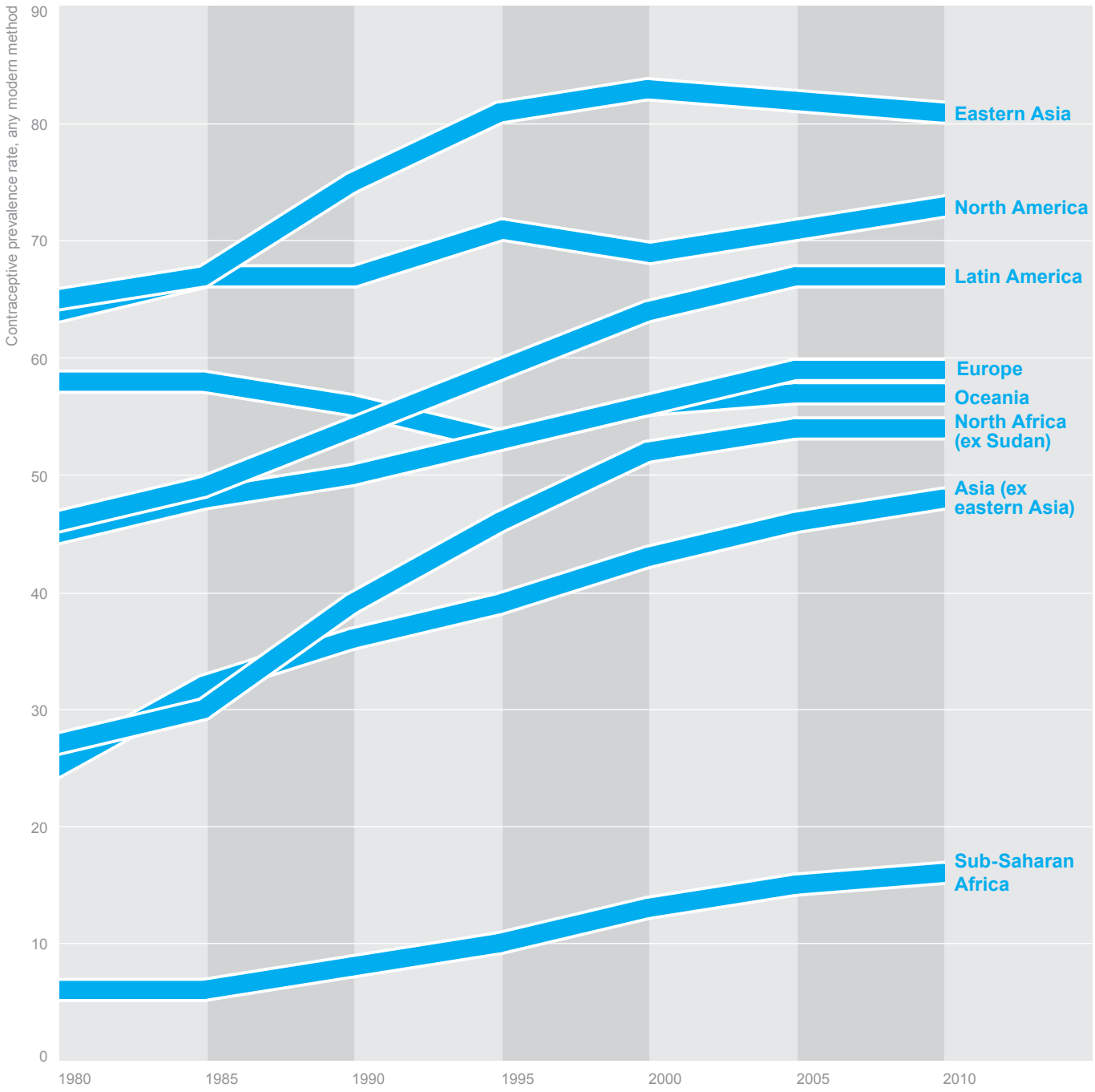


Figure 2:

Contraceptive prevalence rate in selected regions, 1980 to 2010[3]

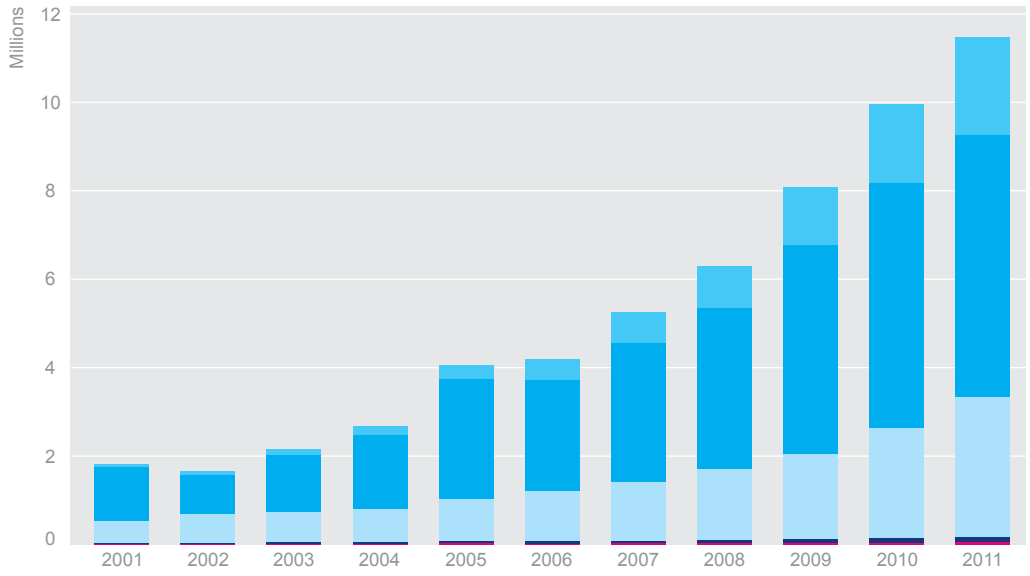


Figure 3:
Estimated number of users of MSI supplied contraceptives by region, 2001 to 2011

Family planning use remains low in some regions

Despite these successes, there is still a long way to go before we achieve universal access to family planning. This can be demonstrated by examining regional variations, and absolute numbers of women with an unmet need for family planning.

Geographical variations in contraceptive use

Figure 2 shows that, while contraceptive use has increased dramatically in Asia, Latin America and developed countries in recent years, it remains low in sub-Saharan Africa, despite recent growth. Within sub-Saharan Africa, there are huge variations between the sub-regions (as shown in Figure 5).

Southern Africa is doing particularly well in terms of expanding access to voluntary family planning, with modern contraceptive use now close to 60%. In contrast, middle and western Africa are both seeing slower progress. We are expanding rapidly to address unmet need for family planning in these regions, with expanding programmes in Burkina Faso, Ghana, Mali, Sierra Leone, Nigeria and a new programme established in Senegal in 2011.

Although uptake is still very low, eastern Africa[iii] has seen a steady increase in contraceptive use since 1980 – from 5.6% in 1980 to 23.7% in 2010.[4] We have made a significant contribution to this. Figure 5 shows the growth in the number of family planning users in eastern Africa and the growth in the number of those that were MSI clients. By 2011, 15% of all modern method users in eastern Africa were MSI clients.

iii Eastern Africa is comprised of: Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mayotte, Mozambique, Réunion, Rwanda, Somalia, Uganda, Tanzania, Zambia and Zimbabwe.

Figure 4:
Family planning timeline: when regions reach 60% – 80% contraceptive use showing 2011 fork in the road.

Developed regions have seen contraceptive use plateau within the range of 60% to 80%. In the following timeline we chart when each sub-region of the world has, or will reach that level.

Pre-1980
North America, northern Europe, eastern Asia, western Europe, Australia and New Zealand
all achieve 60% CPR

Figure 5:
Contraceptive prevalence rate in sub-Saharan Africa by sub-region, 1980 to 2010[5]

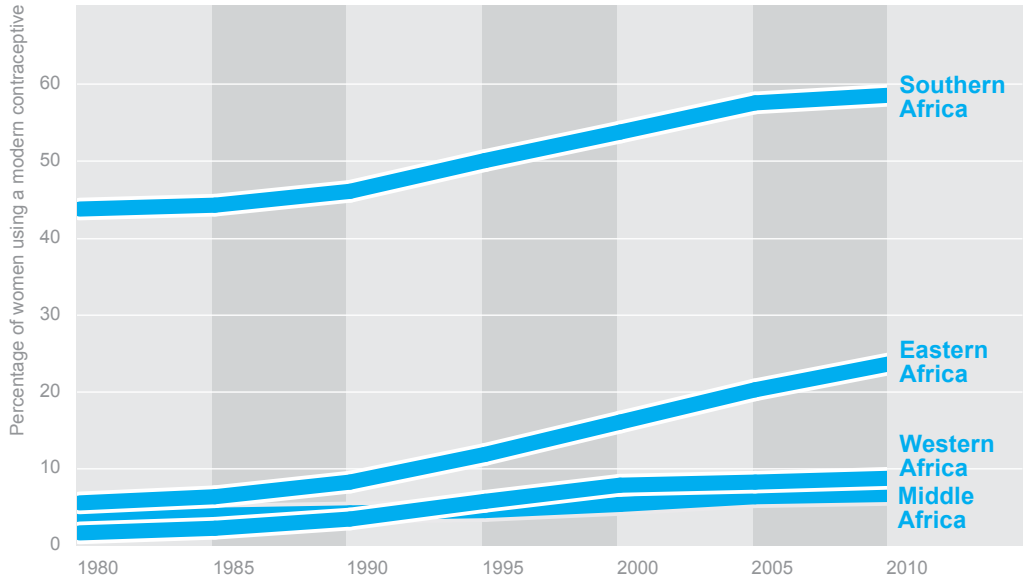
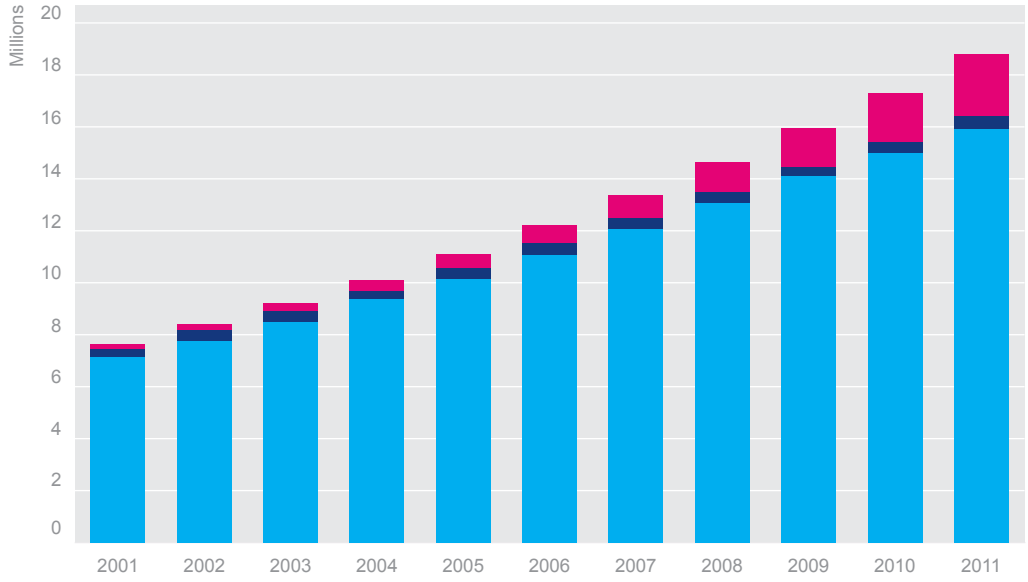
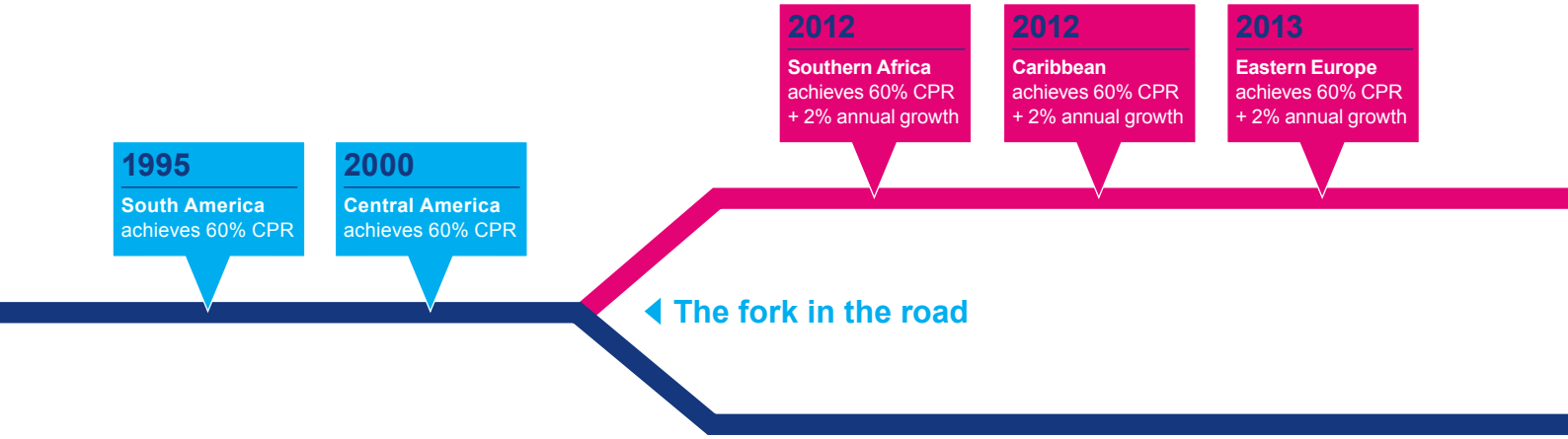


Figure 6:
MSI's contribution to contraceptive use in eastern Africa 2001 to 2011





Women with an unmet need for family planning

While the proportion of women using family planning is increasing in most regions, it is still important to look at the absolute number of women who have an unmet need for modern contraception. We consider a woman to have an unmet need if she wants to limit or space her births but is relying on a less effective traditional method of family planning, or has no method at all. There are an estimated 215 million women in the developing world who currently have an unmet need for family planning.[iv 6] These women make up just one quarter of all the women wishing to avoid a pregnancy. But they account for 82% of the 75 million unintended pregnancies that occur in the developing world every year.[7]

In India, for example, an estimated 54% of women aged between 15 and 49 were using contraception in 2011.[8] However, an estimated 45 million women still had an unmet need for family planning – representing the largest unmet need in any country in the world.[9] Figure 7 shows the absolute number of women with an unmet need in different countries.

This is why we continue to work extensively in south Asia, eastern Africa, western Africa and south east Asia. As Figure 8 shows, the number of people using MSI-supplied contraceptives in 2011 was concentrated in areas with the highest rate of unmet need.

iv **Unmet need:** in this report is defined either as using no family planning method, despite wanting to limit or space births, or using a traditional family planning method.

The future of family planning – a fork in the road

As Figure 2 shows, developed regions have seen contraceptive use plateau within the range of 60% to 80%. If current trends continue, south Asia will not see contraceptive prevalence hit 60% for approximately 20 years, while this will not happen in eastern Africa for 45 years or in middle and western Africa for a startling 500 years. Yet, there's a huge opportunity to change this course. Some countries and regions have seen annual increases in contraceptive use of around two percentage points over the last decade. If we can replicate this growth in those regions with the greatest need, we could see contraceptive prevalence rise to 60% in south Asia within 10 years, while the same could occur in eastern Africa within 20 years and in middle and western Africa within just 25 years.

As an example of the investment required: in sub-Saharan Africa, it would cost somewhere in the region of £300 million to increase contraceptive use by two percentage points per year up until 2015. (This estimate allows for population growth, but assumes that current contraceptive use is maintained by existing investment.) This would result by 2015 in 43,000 additional maternal deaths prevented, £530 million pounds saved for healthcare systems and 1.5 million unsafe abortions averted.[v]

v Impact 2 was used to estimate the service provision needed to reach two CPR goals: (1) 0.6% point increase in CPR from 2013 to 2015 (from current growth rate of 0.2% points a year (UN Department of Economic and Social Affairs. World Contraceptive Use 2011. Wallchart)) and (2) 6% point increase in CPR from 2013 to 2015 (based on growth rate of 2% points a year). The service provision needed to reach each goal was then plugged back into Impact 2 to estimate the resulting impacts from both scenarios.

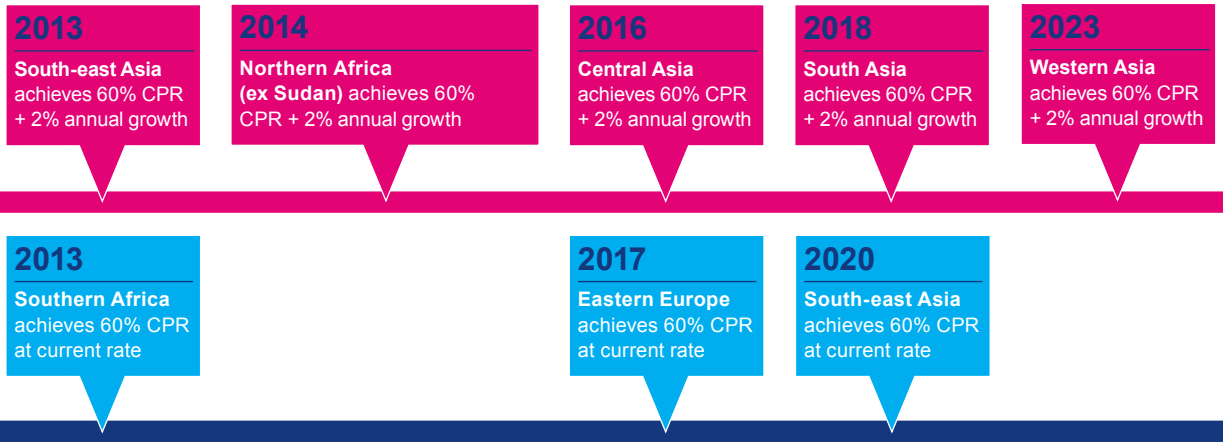


Figure 7:

Number of people with an unmet need for modern family planning in developing regions, by country in 2011[10]

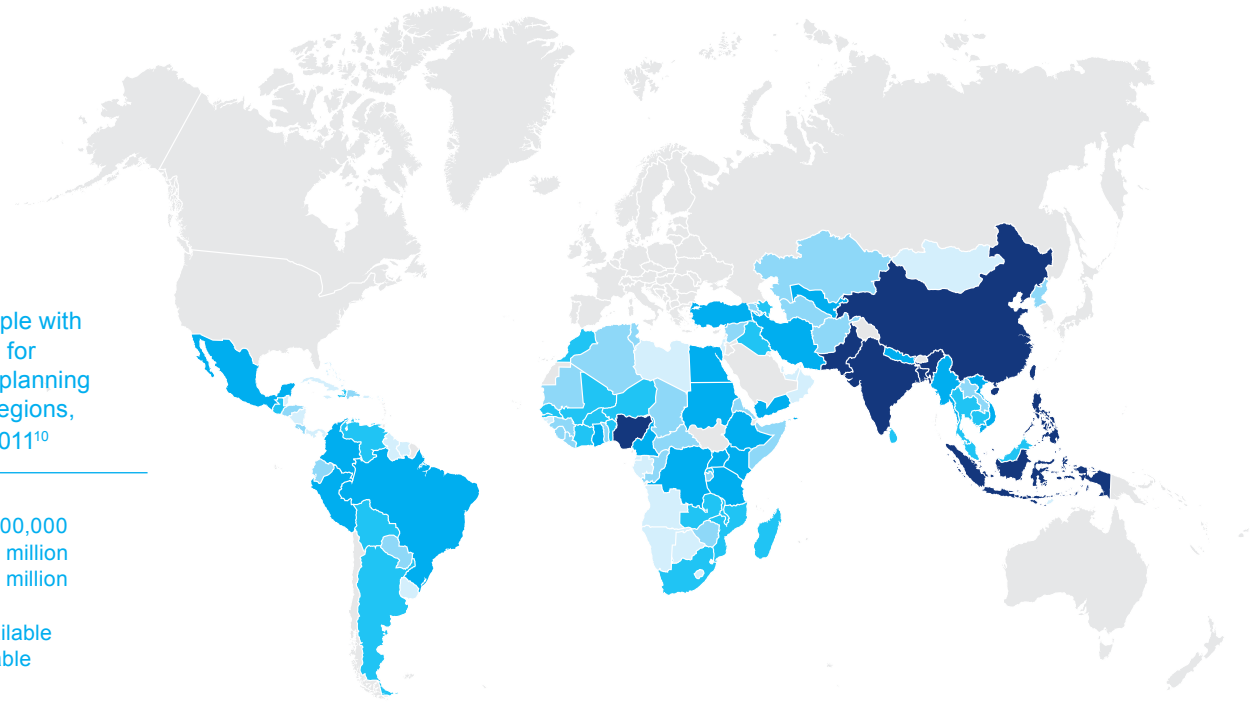
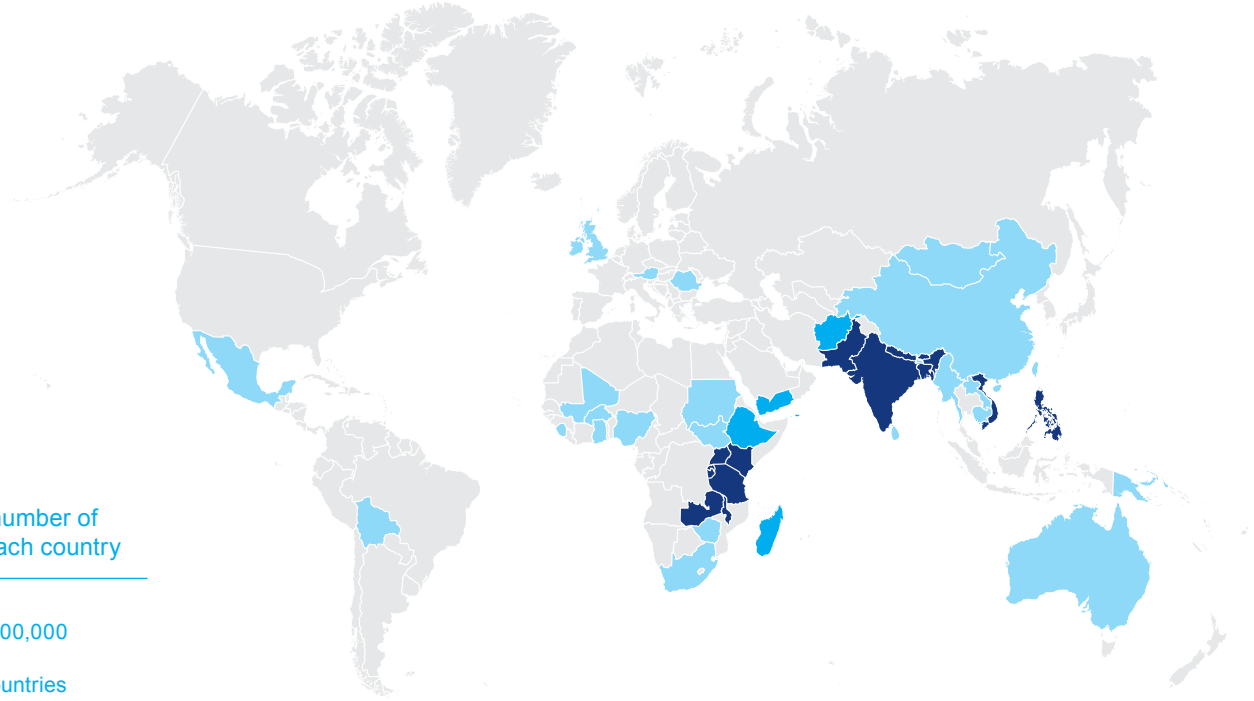


Figure 8:

Map showing number of MSI users in each country



2026
Melanesia, Polynesia, Micronesia achieves 60% CPR + 2% annual growth

2029
Eastern Africa achieves 60% CPR + 2% annual growth

2037
Western Africa achieves 60% CPR + 2% annual growth

2038
Middle Africa achieves 60% CPR + 2% annual growth

2033
South Asia achieves 60% CPR at current rate

2039
Caribbean achieves 60% CPR at current rate

2039
Northern Africa (ex Sudan) achieves 60% CPR at current rate

See Annex 2 for more information about our services

About Marie Stopes International

Millions of the world's poorest and most vulnerable women trust us to provide them with quality family planning and reproductive healthcare. We have been delivering contraception, safe abortion, and mother and baby care for over 30 years. Today, we have offices and operations in 42 countries around the world.

Marie Stopes International started life as a clinic based organisation, expanding from one centre in London to a global network of more than 600 centres across 38 countries. The majority of our clients now access our services through mobile clinical outreach teams or social franchises. However, our centres still offer a backbone for operations in many countries, serving as a vital base for training and logistics to support mobile clinical outreach teams, community based distributors and social franchisees.

We have more than 300 clinical outreach teams working in thousands of hard to reach urban slums and remote rural locations. And through our social franchising network, BlueStar, we've trained, branded and promoted more than 1,700 private healthcare providers in developing countries. We are helping to drive up the quality and choice of family planning services in remote and low income areas.

Our clients are at the centre of everything we do. Through our innovation and partnerships, under-served women and couples are able to access services and make choices about their sexual and reproductive health. By providing high quality services where they are needed most, we prevent unnecessary deaths and make a sustainable impact on the lives of millions of under-served people every year.

Innovation:

Innovating to expand choice and access

Family planning successes have historically always involved finding new ways of getting information and services to clients – whether through a new method, a new model of delivery or a new way of analysing information. The family planning community needs to be creative in order to continue tackling future challenges and to reach those not currently served by existing, traditional service delivery mechanisms. Innovations range from incremental improvements to existing products and services, to a radical shift from the status quo.

Our mobile clinical outreach, social franchise and voucher programmes are innovations in themselves. We continue to innovate to strengthen the impact and reach of these programmes. For example, in Madagascar we used mobile money reimbursements to expand the reach and efficiency of our social franchise network. In Viet Nam, we applied private sector franchising principles to improve sexual and reproductive health services delivered by the public sector.

In each of the chapters in this report we will showcase some of our current innovations.

2055
Eastern Africa achieves 60% CPR at current rate

2057
Western Asia achieves 60% CPR at current rate

2088
Melanesia, Polynesia, Micronesia achieves 60% CPR at current rate

Case study:
Four generations of family planning in Uganda

Yunia, 90 years old

"In our day we didn't have family planning, a woman would give birth until she stopped."

Yunia is a great grandmother who lives in Uganda, "I wanted to have 15 children but I stopped after my eighth child." Of her eight children, five survived into adulthood, and she now lives with them and their families in a compound in Kasese.

Attitudes and access to family planning have changed dramatically in Yunia's lifetime. This becomes clear when you speak with the next three generations of her family. Indeed, Yunia's own attitude to family size has been shaped by the hardships suffered by her offspring.

Pelusi, 47 years old

"I knew about family planning, I just didn't take it up because of all the negative things people kept saying about it."

Yunia's daughter Pelusi has given birth 14 times. She was aware of contraception, but didn't use it because she had heard negative rumours, "they said I'd bleed permanently and my husband would lose interest in me." Like her mother, three of Pelusi's children died in infancy, the last only two years ago, while Pelusi was in labour. This traumatic birth prompted Pelusi to think about using contraception for the first time. And last month she chose to have an intrauterine device (IUD) fitted by the Marie Stopes Uganda outreach team that visits a nearby public health centre.

Chris, 27 years old

"We have ambitious plans for our children's education."

Pelusi's son, and Yunia's grandson, Chris, showed that behaviour can change even earlier in the next generation. "My girlfriend and I conceived when we were in primary seven, and we had to drop straight out of school." The pregnancy was a shock. But Chris and his girlfriend learnt that they could make a choice about the spacing of their future births through family planning and they have been using it ever since. Nine years on, they have three children.

And it's not just contraceptive use that's changing. Access to safe motherhood services is increasing thanks to the healthy baby voucher scheme we introduced in the area. Chris knows from his own family's experiences how important safe delivery services are. So for just under US$1.50 he bought a voucher entitling his wife to antenatal and safe delivery services. They used this for the birth of their third child, Yunia's great-grandson.

Immaculate, 17 years old

"I don't want to have children until I'm 20 years old."

Immaculate is Yunia's great-granddaughter. When asked if she's heard of family planning, she nods her head. She's reluctant to talk about sex in front of her family, but she's clearly learnt from their experiences. With Marie Stopes Uganda visiting her community regularly, she knows where she can access the contraception she'll need to make sure she has a choice about when to start a family.

Family planning has been accepted by Yunia's family. And its use is growing across her community. Myths about different contraceptive methods are still a barrier, but visits from our outreach team are helping to dispel these misconceptions, showing the life-changing impact that family planning can have.

"Times have changed. We used to grow enough food, but these days children go hungry. Women want to have fewer children so they can take care of their family."

Yunia speaks with an MSI team member about how access to family planning has changed through her lifetime.

Photo: Marie Stopes International / Jerry Komagum

2522
Western Africa achieves 60% CPR at current rate

2543
Middle Africa achieves 60% CPR at current rate

Chapter 2
Health, social and economic impacts

'Our country has reduced its maternal mortality rate by 25%, thanks largely to the increase in long term contraception.'

► Full case study on page 32

Saving lives and reducing suffering

Family planning allows women to make choices about their own fertility. It also saves lives and reduces suffering by preventing high risk pregnancies and reducing a woman's likelihood of resorting to unsafe abortions. Family planning prevents an estimated 150,000 maternal deaths in the developing world each year.[11] And if current unmet need were met, family planning services could save a further 90,000 lives. In addition, safe abortion services allow women to avoid resorting to unsafe abortion, while post-abortion care (PAC) reduces the risk of suffering or death due to unsafe abortions. Voluntary family planning is also essential to help women achieve gender equity, engage politically and contribute to economic growth, which makes it an important social end in itself.

Innovation:

Improving decision making with mathematical modelling – Impact 2

We want the decisions we make to have maximum health impact. So we have developed mathematical models that help us to understand the impact of our current work and to plan higher impact future projects. Our latest model is called Impact 2 and replaces our Impact Estimator and REACH calculator.[vi] Impact 2 is a mathematical model that converts family planning services such as condoms, pill cycles and implants into family planning users. From there, it calculates impacts such as expanded contribution to contraceptive prevalence rate (CPR), number of unplanned pregnancies and maternal deaths averted, and even economic cost savings to the healthcare system. The model was developed by our demography experts in collaboration with PSI and the Guttmacher Institute, and has been peer reviewed by experts in the field. It is a user-friendly Excel-based tool that can be accessed via our website (www.mariestopes.org).

vi The Impact Estimator is a model we developed in 2009 to help us estimate the health impacts of our programmes. The REACH Calculator is a model we created to estimate the number of users we had in a given year and compare this to the national context.

Annual maternal deaths in the developing world, including those prevented by family planning and those that could have been prevented by family planning[12]

Maternal deaths prevented due to contraceptive use

150,000

Maternal deaths, which could have been averted if all unmet need were met

90,000

Other maternal deaths, most of which could be prevented by expanded maternal healthcare

260,000

New mortality figures were released in May 2012, but were too late to be used in this report. The mortality figures used here are based on the previous UN mortality figures.

Figure 9:

The estimated lifetime impacts of our 2011 services **globally**[vii]

vii: Two types of impact measure are presented in this report:

Annual impacts the impacts that occur in a specific year from services provided in that year and LAPMs still being used from past years.

Service lifetime impacts the total impact of services provided in a specific year, much of which may occur in future years.

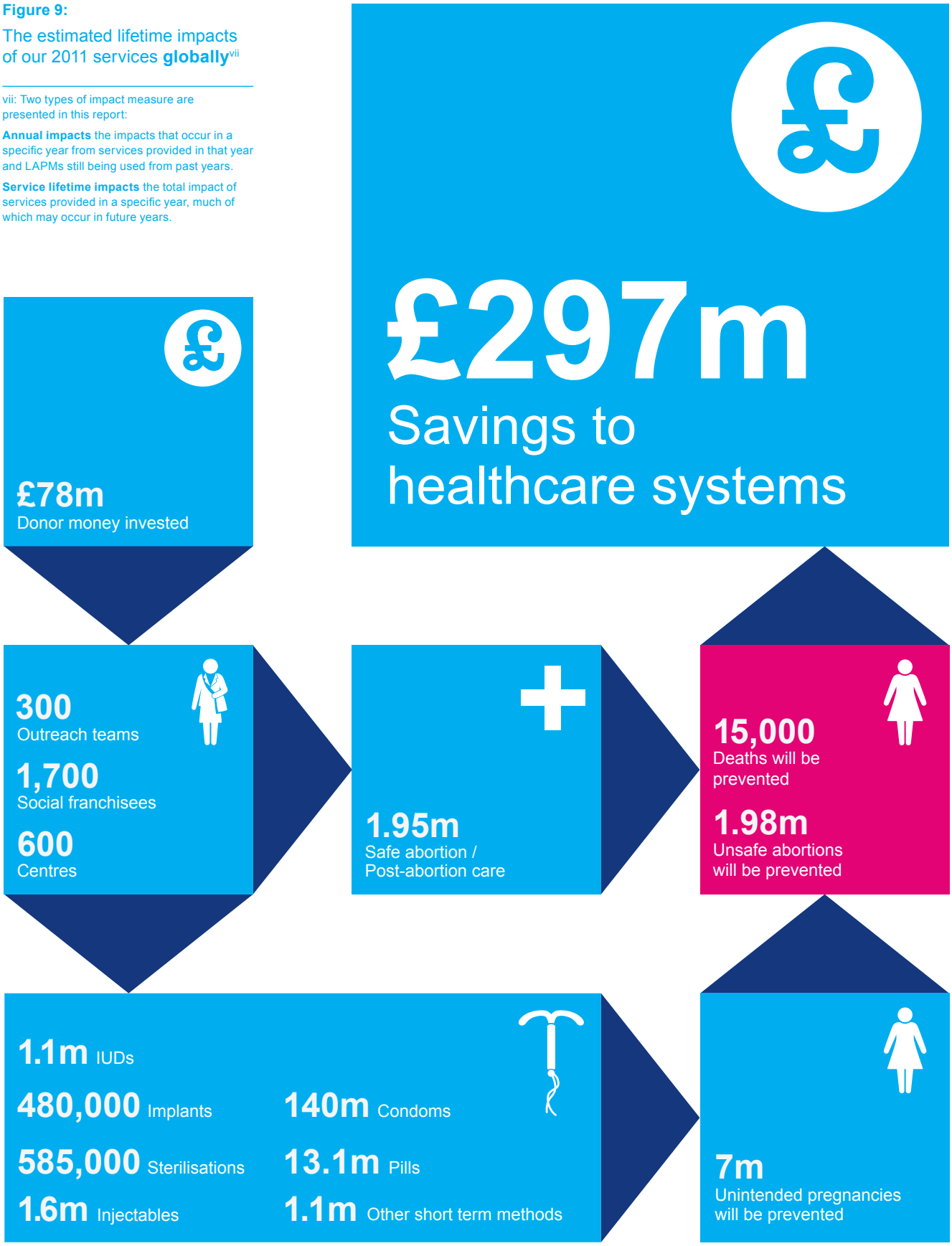


Figure 10:
The estimated lifetime impacts of our 2011 services in **Asia**

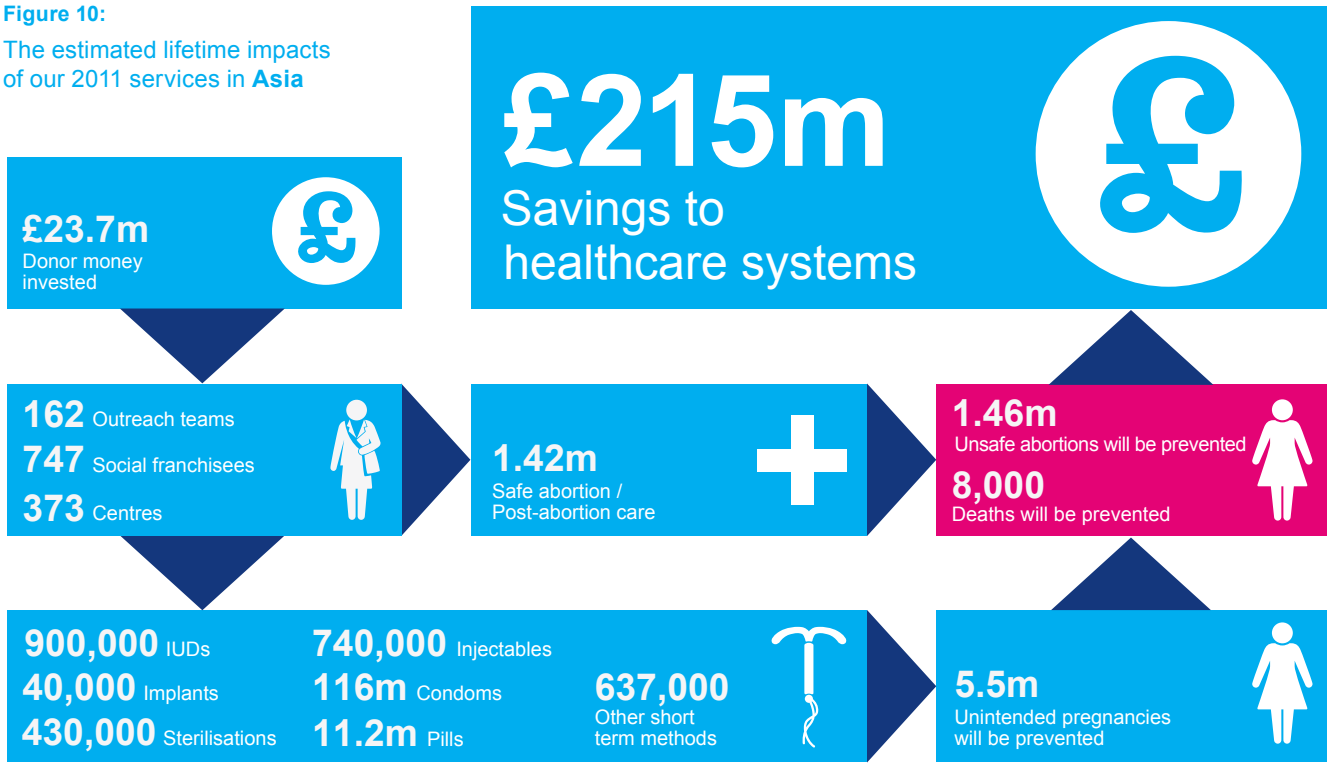
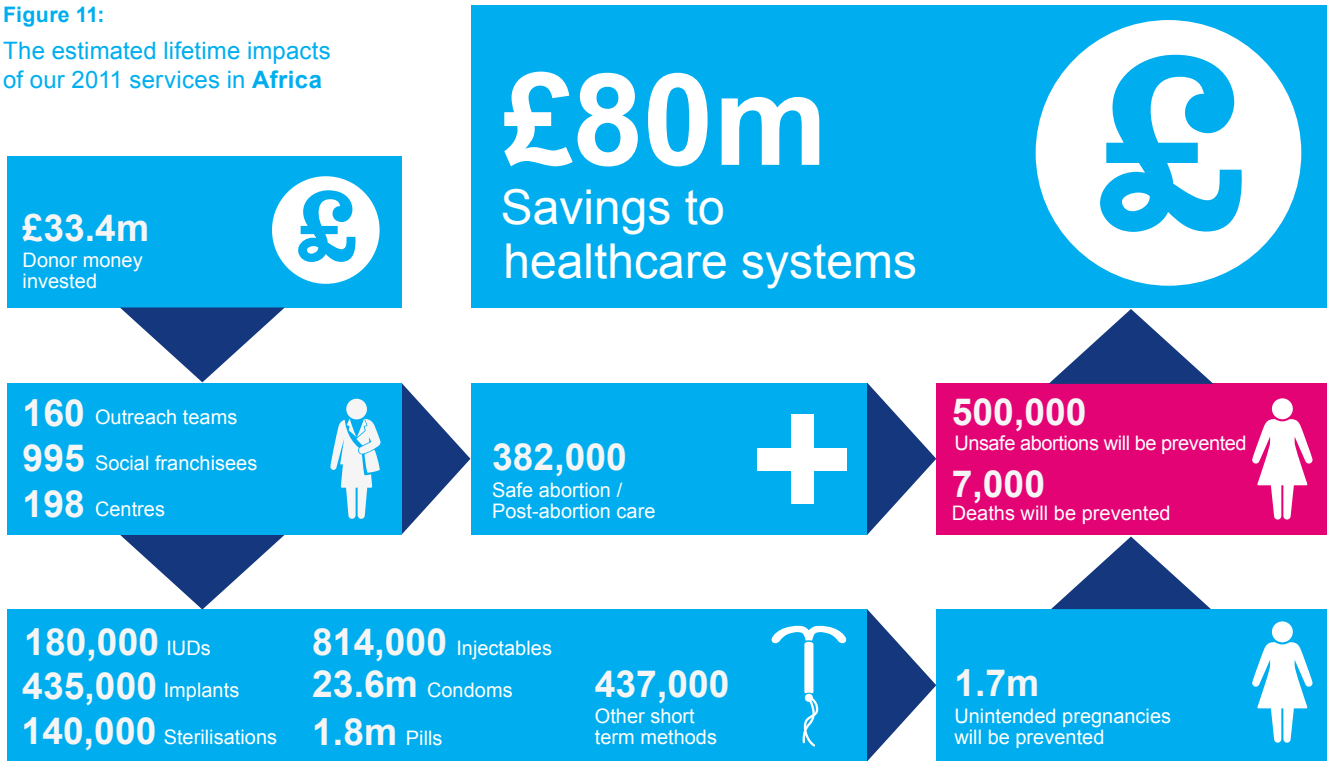


Figure 11:
The estimated lifetime impacts of our 2011 services in **Africa**



Innovation:

Marie Stopes International and performance-based funding

Performance-based funding is about ensuring interests are aligned between funders and health providers or implementers to achieve results for the intended population. As an organisation that has always focused on delivering and quantifying results, MSI is a natural champion of performance-based funding. We demonstrate this commitment in our arrangements with government contractors and donors, in our approach to internally funding our fleet of mobile outreach teams, and in our strategies to engage other private sector providers to deliver services to the poor.

Performance-based payments are generally conditional on measurable actions being undertaken, but different arrangements might be most appropriate in each case. Conditional actions might extend to management of the overall programme or remain more focused on the outputs of individual service providers.

In 2011, we were implementing the following forms of performance-based funding:

- We are contracted by several countries around the world to deliver services on behalf of the government, such as the UK and Tanzania. These contracts clearly state the performance measures that must be met to receive payment.
- With several of our donors, we hold performance contracts whereby we pre-finance an agreed quarterly work plan and are only reimbursed when a mix of management and service delivery measures have been met. In this scenario, we share the financial risk of undertaking programmes with our donors.
- We use performance-based funding internally with our 300 mobile outreach teams that operate across the world. These teams are reimbursed for their outputs in accordance with pre-negotiated rates for each type of service delivered.
- Output-based aid (OBA) is also a sub-group of performance-related funding, and we have been at the forefront of these approaches (whether as an OBA implementer or as an accredited OBA service provider). We implement voucher schemes in Bolivia, Pakistan, Madagascar, Sierra Leone, Cambodia, India and Uganda that target poor and at risk groups with subsidies for underutilised sexual and reproductive health services. In Kenya, we were amongst the first providers accredited into the national OBA programme for reproductive health. These programmes are excellent for achieving equity, facilitating demand and ensuring that providers are only reimbursed for the tangible contribution of services they deliver to the poor.

As a result of our experiences, we have seen first hand that performance-based financing is a powerful mechanism to improve accountability and help us enable more women to have children by choice, not chance.

Increasing choices and changing national contraceptive use

We believe that every woman has a right to decide the number and spacing of her children. To enable every woman to fulfil her family planning goals, many developing countries need to expand access to modern contraception. This is central to our mission. We are already making significant contributions to national contraceptive use in many countries. In 12 countries, more than 15% of modern family planning users were relying on an MSI-supplied contraceptive in 2011 – Malawi (45%), Yemen (20%), Tanzania (20%), Uganda (47%), Philippines (16%), Nepal (15%), Kenya (20%), Madagascar (16%), Mali (14%), Mongolia (28%), Timor Leste (27%), Sierra Leone.[viii]

As illustrated in Figures 12, 13, 14 and 15, this level of contribution can help to increase contraceptive use nationally. This in turn opens up choices for the many women living in those countries who are currently unable to exercise their reproductive rights.

viii The exact figure for Sierra Leone is unknown because we do not have up to date information on the number of women within the population using family planning.

Number of family planning users and non-users by country

Women without a current need for family planning
Women with a potential future need (the number needed to reach 60% CPR)
Women with a current unmet need for modern contraception
Women using contraceptives not supplied by MSI
Women using MSI-supplied contraceptives

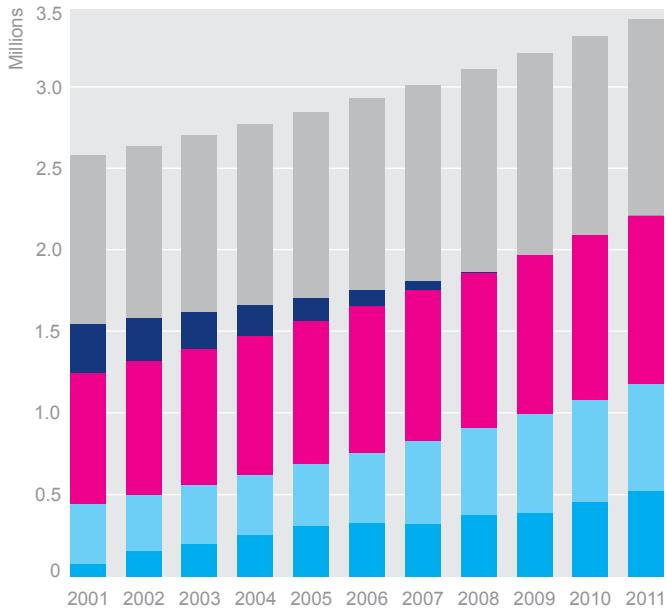


Figure 12: Malawi

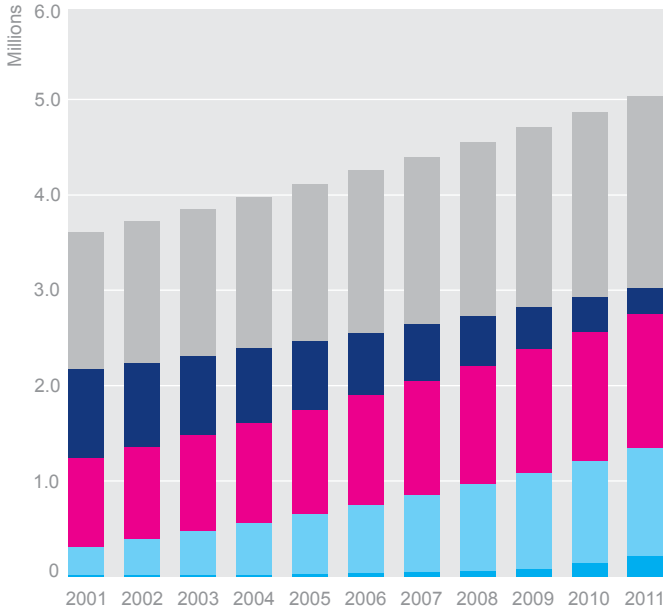


Figure 13: Madagascar

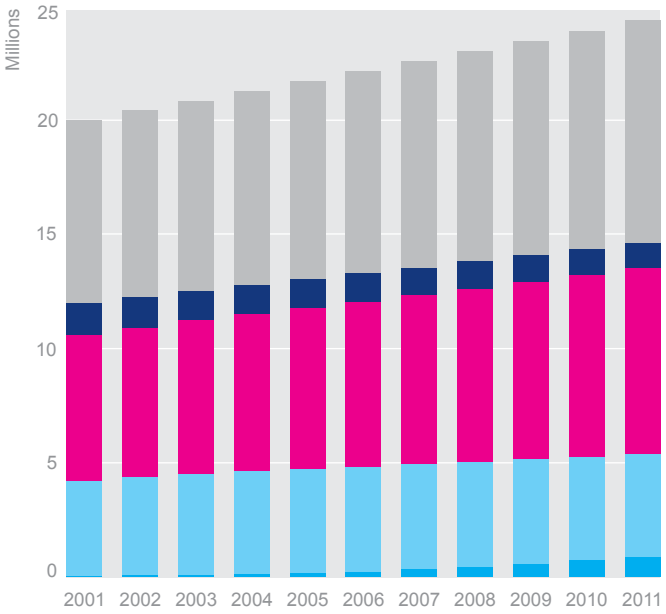


Figure 14: Philippines

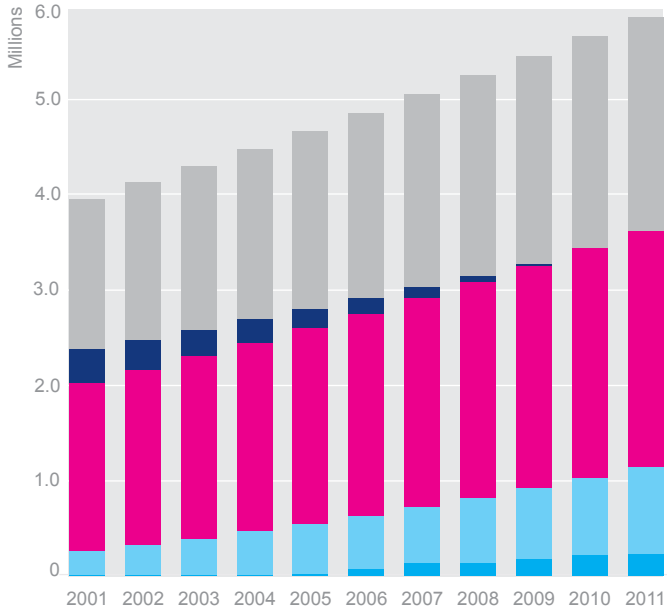


Figure 15: Yemen

Reducing mortality and morbidity

In the last five years, we have prevented an estimated 40,000 maternal deaths.

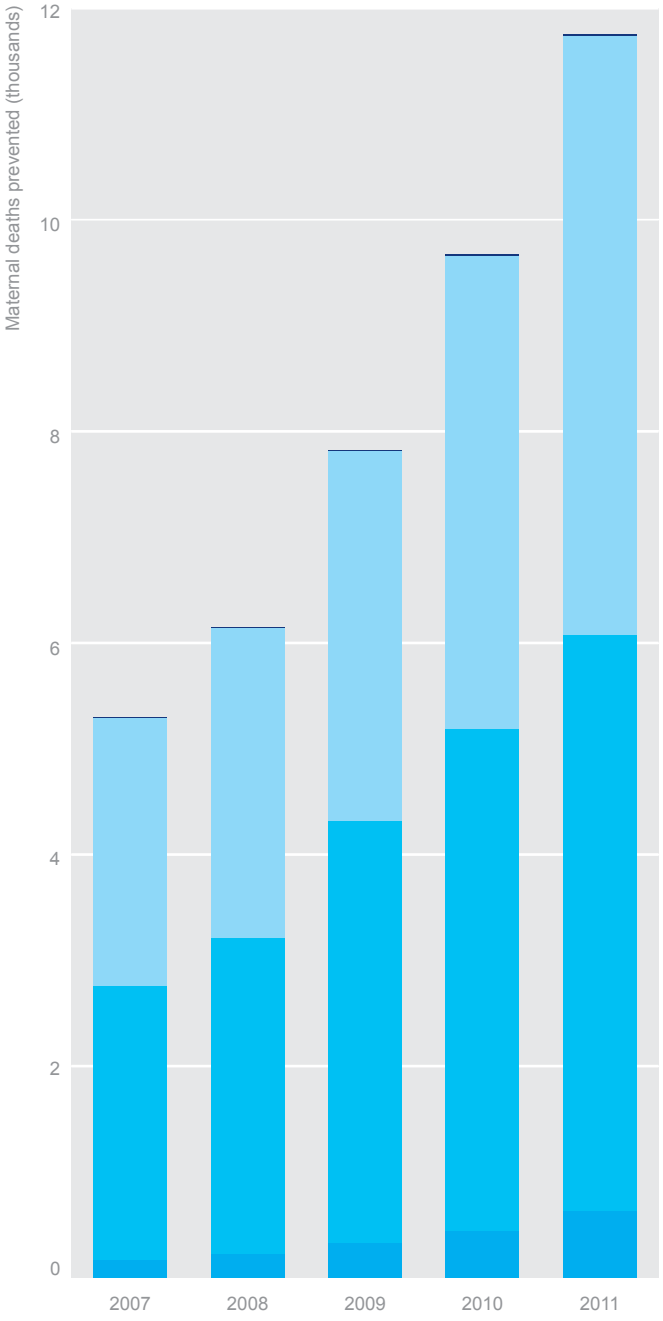


Figure 16:
Maternal deaths averted annually due to MSI's work, 2007 to 2011

Latin America
Developed countries
Africa
South Asia
Pacific Asia

In the last five years, we have prevented an estimated 4.9 million unsafe abortions.

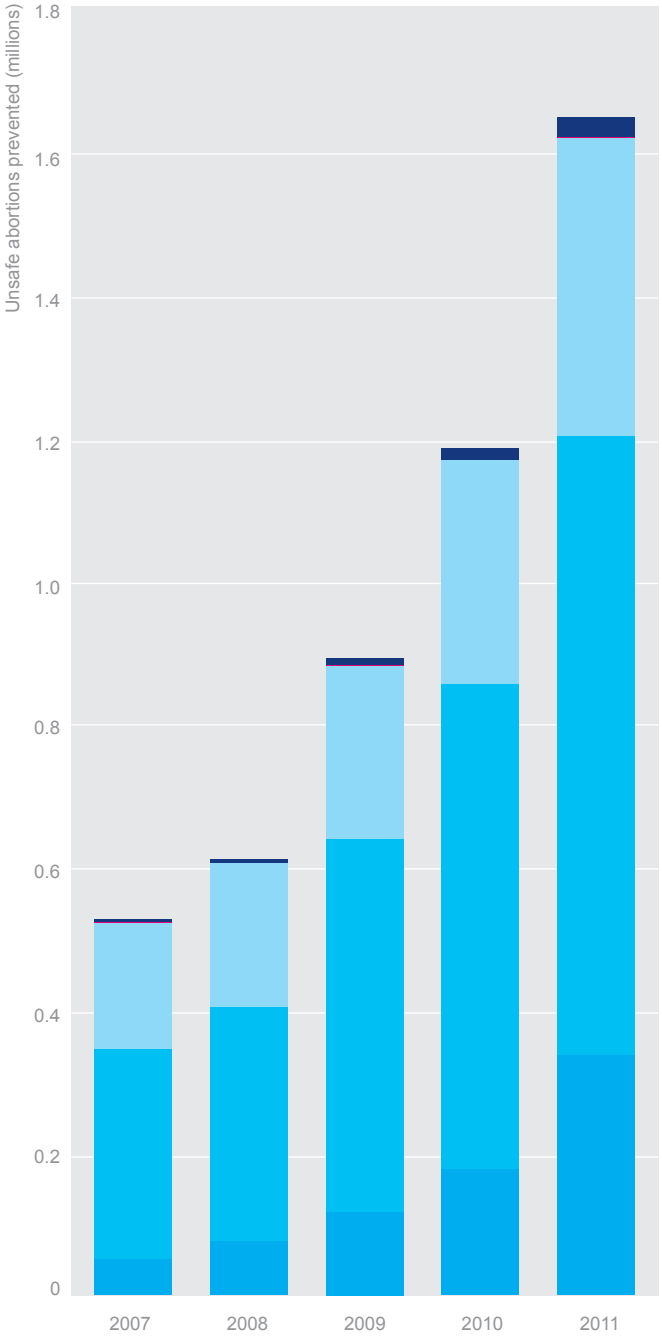


Figure 17:
Unsafe abortions averted annually due to MSI's work, 2007 to 2011

Latin America
Developed countries
Africa
South Asia
Pacific Asia

Economic impact

Family planning is cost-effective compared with nearly every other health intervention. In 2011, the total cost to donors of our programming in developing countries was £78 million. Our overall cost to the donor per CYP was £3.62. Our services will save healthcare systems approximately £297 million, through reductions in maternal and infant morbidity and mortality, as well as reductions in the numbers of unsafe abortions.[ix] For every £1 of donor money spent by MSI programmes, £3.80 will be saved by health systems in developing countries.

Table 1 shows the cost of averting a disability adjusted life year (DALY) through different types of health intervention. Our service provision in 2011 will avert 4.5 million DALYs in developing countries, at a cost to donors per DALY of £13. This compares favourably in terms of cost-effectiveness with other types of public health interventions. For example, the cost to donors per DALY averted through MSI's work (£13) was less than that of tuberculosis vaccination, and similar to that of malaria prevention for pregnant women.[13]

ix This is an estimate of costs saved by families or the public health system in direct healthcare spending (cost of pregnancy and delivery care and treating complications from unsafe abortion) assuming 'full coverage' – ie. all women needing care receive it. Note that there are also other cost savings, not included here, from family planning service provision such as the cost of raising and educating an extra child, and additional infrastructure and utilities needed to support population growth.

Table 1:

Cost per DALY of our 2011 programming compared with other health interventions[14]

Intervention	Cost per DALY averted (GBP)[x]
MSI 2011 programming	13
Insecticide-treated bed nets	9-13
Malaria prevention for pregnant women	19
Tuberculosis treatment (epidemic context)	4-40
HIV antiretroviral therapy (Africa)	167-363
Tuberculosis (BCG) vaccination of children	32-135
Oral rehydration therapy	841
Cholera immunisation	2,331

x Converted from 2008 US dollars (original text) to UK pounds.

Case study: Sierra Leone

"We complement the government's work, particularly in hard to reach communities, helping deliver services to people and build capacity in government health facilities. Where they can't go, we go: what they can't do, we do."

Anna Macauley, or Mama G as she is affectionately known, joined Marie Stopes Sierra Leone in 2000 as an outreach nurse. Rising through the ranks to become outreach coordinator, then national outreach coordinator, she is now the Clinical Services Manager. She explains the situation in her country:

"Sierra Leone was once the worst place to give birth in the world. People didn't use family planning and women were having 11 or 12 children. They gave birth at home and I'm afraid, if there were complications, they often reached the hospital too late. But things are changing. Our country has reduced its maternal mortality rate by 25% since 1990[15] thanks largely to the increase of long term contraception and more recently, the government's ambitious free healthcare initiative for pregnant women, lactating mothers and children under five.

"Marie Stopes Sierra Leone opened in 1986 with a single outreach team of two nurses. We're now working across the whole country with 12 clinics, 12 outreach teams, an obstetrics clinic in the capital and a franchise network of 101 private providers. Our growth has dramatically increased our impact and I am proud to say we now deliver a significant proportion of the country's family planning services, preventing around 60,000 unwanted pregnancies and over 400 maternal deaths every year.

"We complement the government's work, particularly in hard to reach communities, helping to deliver services to people and build capacity in government health facilities. Where they can't go, we go; what they can't do, we do. Before our outreach, many people had no access to contraception and there were lots of myths about family planning – there were rumours it made you sick or stopped you from ever conceiving. We bring information and services right where they're needed, holding educational seminars and sharing information through songs, drama and comedy.

"Working with partners we ensure the mission of reaching the unreached, and serving the under-served is fulfilled. We work with vulnerable groups, including youth, commercial sex workers and the disabled. We have a big problem with teenage pregnancy here. Half of our young girls become pregnant before they turn 20 – and we've been educating teenagers in secondary schools so they know how to protect themselves if they are having sex. Last year, 53% of our clients were under the age of 25 and a lot of young girls go through school without getting pregnant now.

"Innovation has been essential to our impact. In 2009, for example, we registered the Zarin (Sino-II) implant and it's now the most popular choice for women. They prefer it because it is long term and is less embarrassing to have fitted than an IUD. In 2011, we piloted the integration of family planning with child health services at government facilities, and saw a 75% uptake of services. This year, we will bring services to one of the country's most under-served districts by boat, reaching coastal and riverside communities.

"We've changed the lives of women and put a lot of smiles on a lot of faces. Women have choices, they know more about their bodies, and how to plan for their families. Our impact in Sierra Leone is clear but the team is not complacent. By 2015, we hope to have reached 500,000 couple years of protection and, along with partners, help increase our country's contraceptive prevalence rate to 30%."

Women visiting an MSI centre in Sierra Leone: our family planning services prevent around 60,000 unwanted pregnancies and over 400 maternal deaths every year.

Photo: Marie Stopes International / Susan Schulman

Chapter 3
Equity

'The world is reaching its largest ever cohort of young people. For these young people to choose what their future will look like, it's crucial that we reach more young women who are sexually active.'

► Full case study on page 46

Reaching the under-served

As well as increasing the number of services we provide, we also prioritise reaching out to people in particular need. In this chapter, we will explain why providing family planning to the poor and to young people is a priority. We will also examine our performance in reaching out to these sections of the population in 2011.

The data about our clients in this chapter come from our client surveys, the details of which can be found in Annex 3. In 2011, we conducted more client surveys with more scientific rigour than ever before. This effort to determine the target population for our services more effectively is the result of our increasing focus on equity.

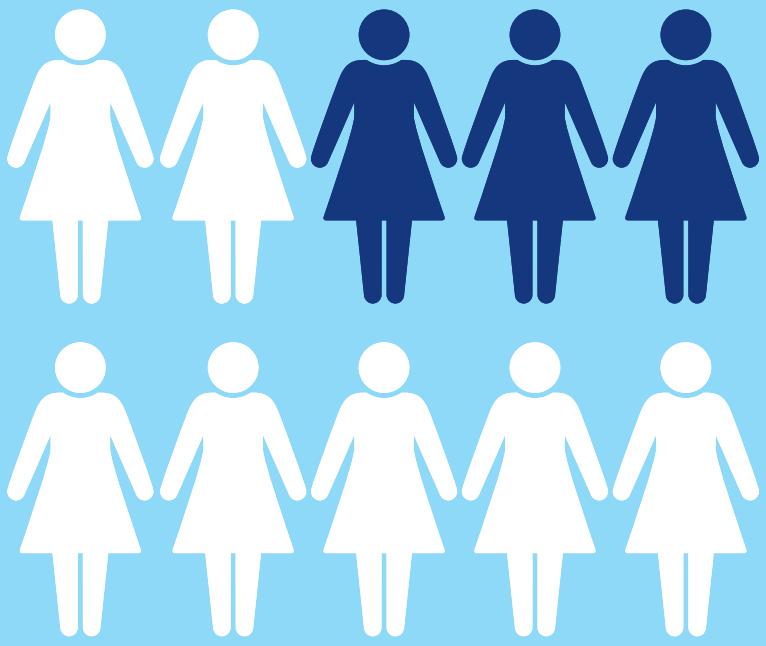
Reaching the poor: the need for targeted services

Around the world, there are vast inequities in sexual and reproductive health status between rich and poor. Poor women and couples receive less family planning care for a variety of reasons, including economic barriers, lack of knowledge and lack of access to services.[16] Subsequently, the poor suffer worse sexual and reproductive health outcomes than wealthier people. There is an urgent need to provide family planning services that overcome these barriers.

There is a clear relationship between contraceptive use and poverty levels in the countries where we work. Figure 18 shows that contraceptive use tends to be lowest in countries with high levels of poverty. There are examples of countries with high contraceptive use despite high levels of poverty, such as India, Bangladesh, Nepal, Malawi, Tanzania and Madagascar (these are all countries with large MSI programmes). These countries prove that purposeful family planning programmes that have a strong political commitment – and that incorporate public, private and NGO actors – can effectively increase contraceptive use, despite high poverty levels.

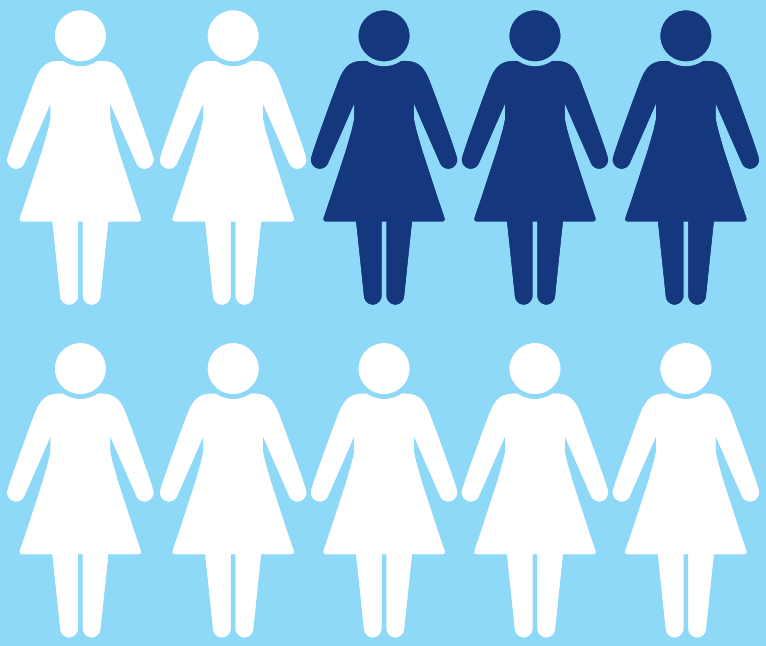
Within each country, contraceptive use is much lower among the relatively poor than among the relatively rich. Figure 19 illustrates the clear correlation between relative wealth and use of a modern contraceptive method. The poorest 20% of the population is less likely to use a modern contraceptive method than the richest 20%. This is despite the fact that the poor are the most likely to suffer adverse health effects if they have an unintended pregnancy. They are the least likely to deliver their baby in a health facility, putting them at greater risk when giving birth. In Africa and Asia, just one in four of the poorest women deliver in health facilities, compared to around three in four of the richest women.[17]

It is crucial that we address this inequity by targeting our services at the poorest groups within each country.



<$1.25

Three in 10 of MSI users live below the $1.25 extreme poverty line.



<25yrs

Three in 10 of MSI users are under 25 years old.

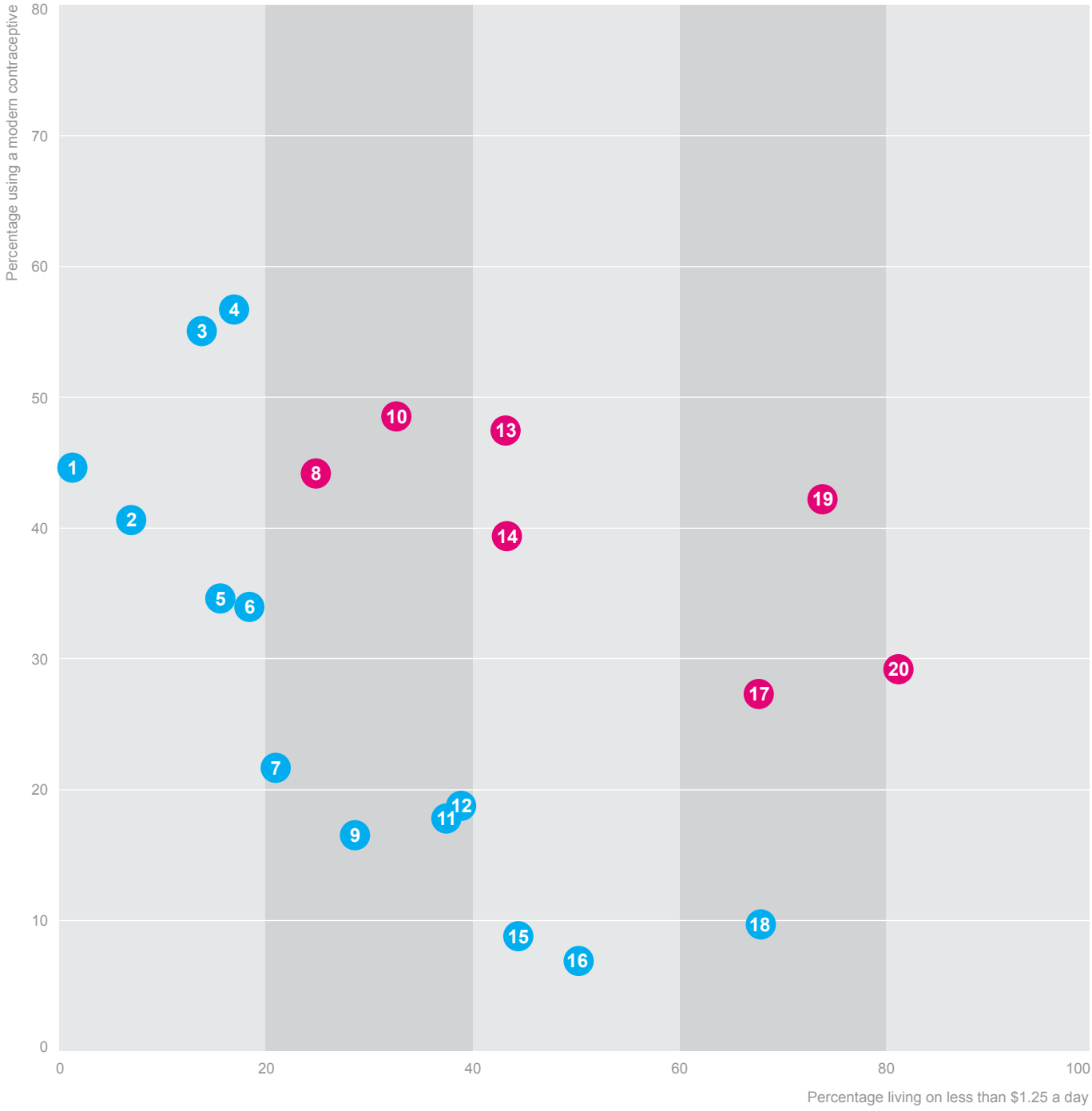


Figure 18:

Use of contraception and poverty levels across MSI countries

Pink is used to highlight countries that have increased CPR, despite high poverty levels, with large family planning programmes.

1. Mexico
2. Sri Lanka
3. South Africa
4. Viet Nam
5. Bolivia
6. Philippines
7. Pakistan
8. Nepal
9. Ghana
10. India
11. Uganda
12. Ethiopia
13. Bangladesh
14. Kenya
15. Burkina Faso
16. Mali
17. Tanzania
18. Nigeria
19. Malawi
20. Madagascar

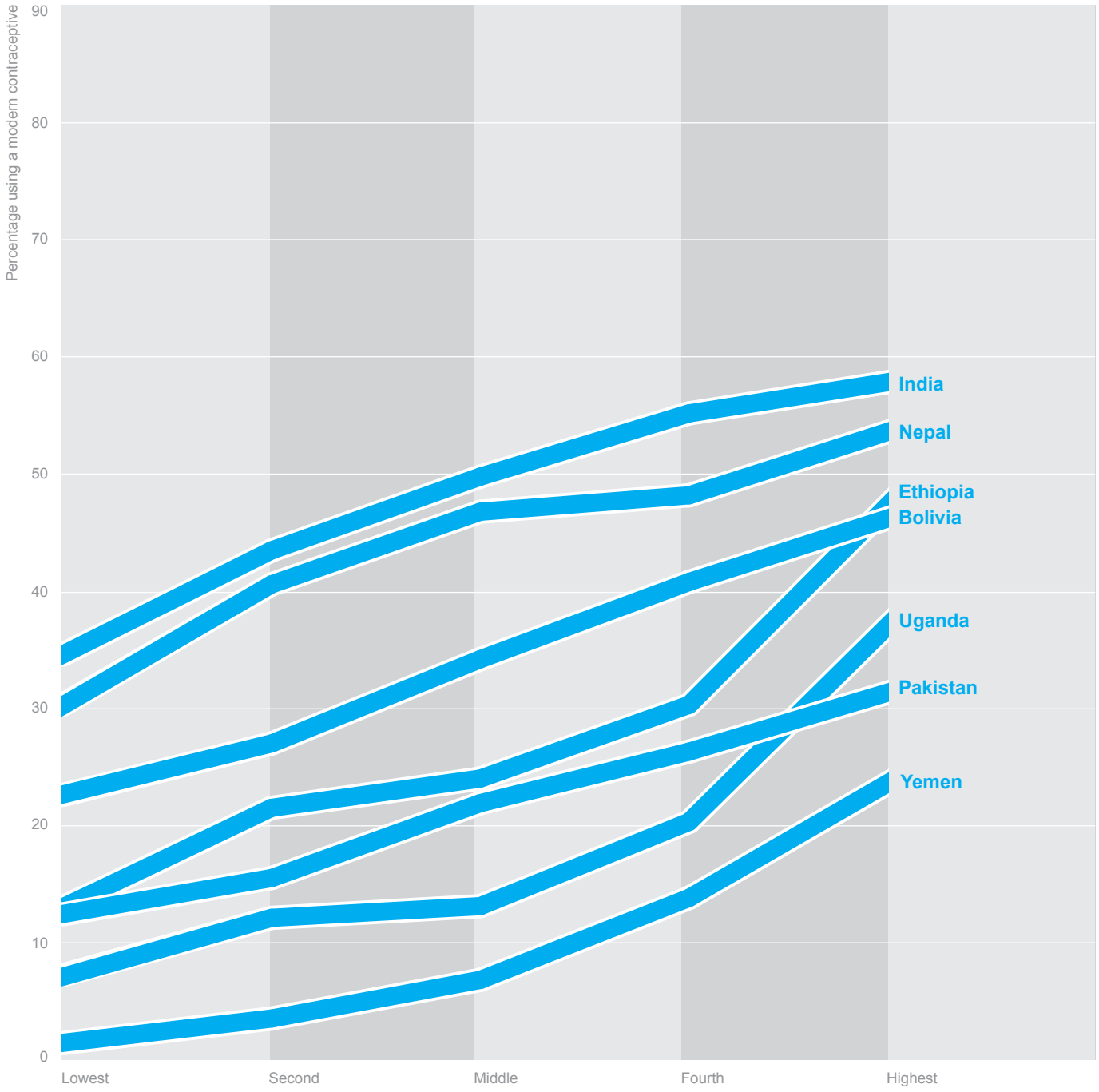


Figure 19:
Percentage of women of reproductive age using a modern method by wealth quintile

Our performance in reaching the poor

We are investing more and more resources so that we can target our services at people living in poverty. For example, 51% of our CYPs in 2011 were delivered free, or at heavily subsidised prices, through mobile clinical outreach programmes that target hard to reach communities in rural areas and urban slums. These are communities that have traditionally had very limited access to modern family planning methods. With the exception of centres in urban slums, MSI centres are intended to reach those who can afford to pay for services and are competitively priced to serve the middle income and above. As such, we have not presented a poverty analysis of our centre clients. Income from our centres is used to subsidise mobile clinical outreach programmes that serve the poorest groups. Our social franchisees are located in urban slums and peri-urban areas and their services are less subsidised. We would therefore expect that they reach poor people, but not necessarily the poorest of the poor.

Figure 20 shows how well we are performing in terms of reaching people living in extreme poverty. We compared the percentage of our outreach clients living in extreme poverty to the percentage of the national population living in extreme poverty. If the circle is pink, the percentage of our clients that are poor is greater than the percentage of the national population that is poor. In other words, our clients are, on average, poorer than the national population and we are successfully targeting the poor within that country. For example, in India, 64% of our clients are poor compared to 42% of the national population.

If the circle is light blue, it means that the percentage of our clients that are poor is approximately the same as the national population (within 10%).

For example, in Tanzania, 72% of our clients are poor and 68% of the national population is poor. If the circle is dark blue, it means that our clients are less poor on average than the national population and improvements need to be made to our targeting strategies. For example, in Ghana just 17% of our clients are poor compared to 30% of the population. If our targeting of the poor in each country is successful the poverty levels of our clients should at least match the national poverty level – ie the circles should be light blue or pink. Our programmes are using these results to identify where we can improve the targeting of our service provision.

We have conducted the same analysis to look at the percentage of our mobile outreach clients living below the $2.50 poverty line for countries where we have this data. The percentages of our clients living below this increased poverty line are of course higher.

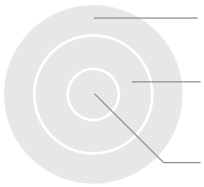
The percentage of our social franchise clients that were poor in most countries with data matched the percentage of national population that was poor in 2011. In other words, our social franchise clients tended to be as poor on average as the broader population.

Figure 20 (opposite):

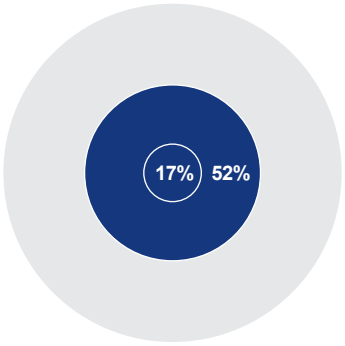
The percentage of MSI **outreach** clients below the $1.25 and the $2.50 poverty lines compared to the percentage of the national population living below the poverty line.[xi]

xi Since the Progress out of Poverty Index is not yet available in Madagascar, we could not collect data on the percentage of our clients living on less than $1.25 a day. As an alternative, we used the Multi-dimensional Poverty Index. The figures in these charts are the percentage of clients in Madagascar that are poor as defined by the Multi-dimensional Poverty Index, which is a similar poverty level to the $1.25 poverty line.

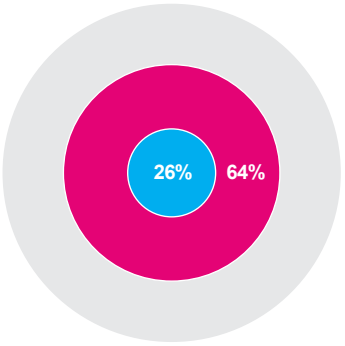
* For these countries, we do not have data for people living below $2.50 a day.



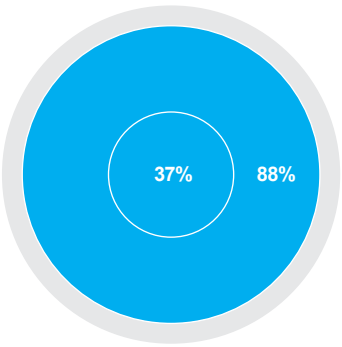
MSI clients are **poorer** on average than the national population
MSI clients are of **similar poverty** level to the national population
MSI clients are **less poor** on average than the national population



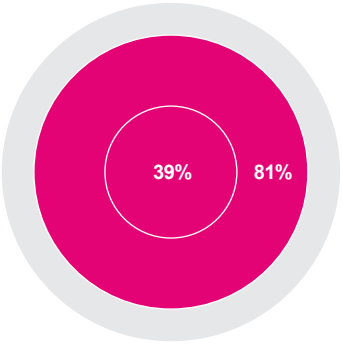
Ghana



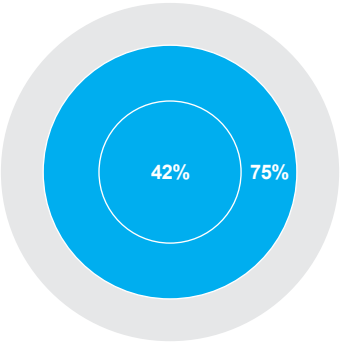
Philippines



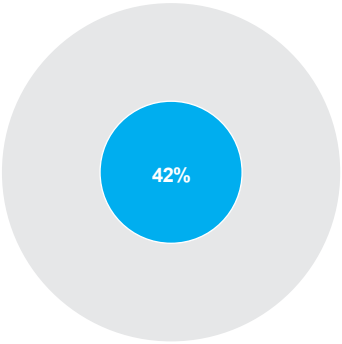
Ethiopia



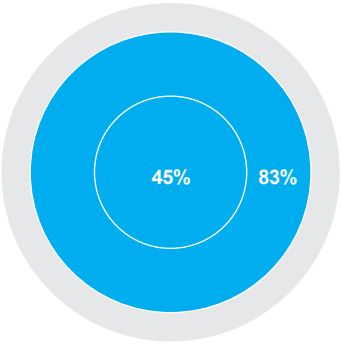
Cambodia



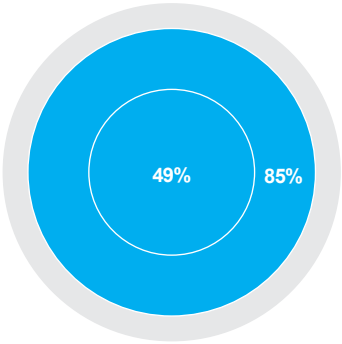
Burkina Faso



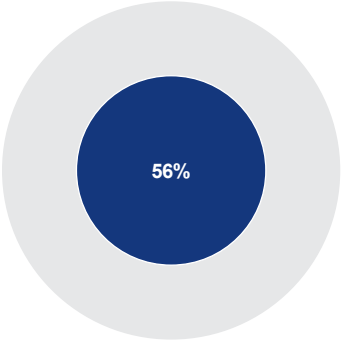
Zimbabwe*



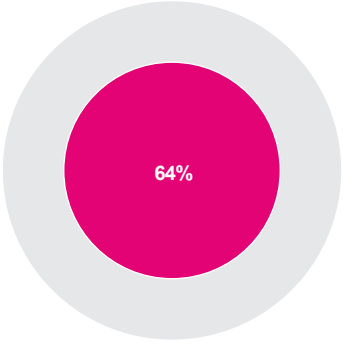
Uganda



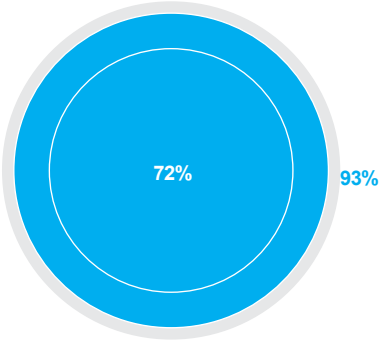
Sierra Leone



Madagascar*

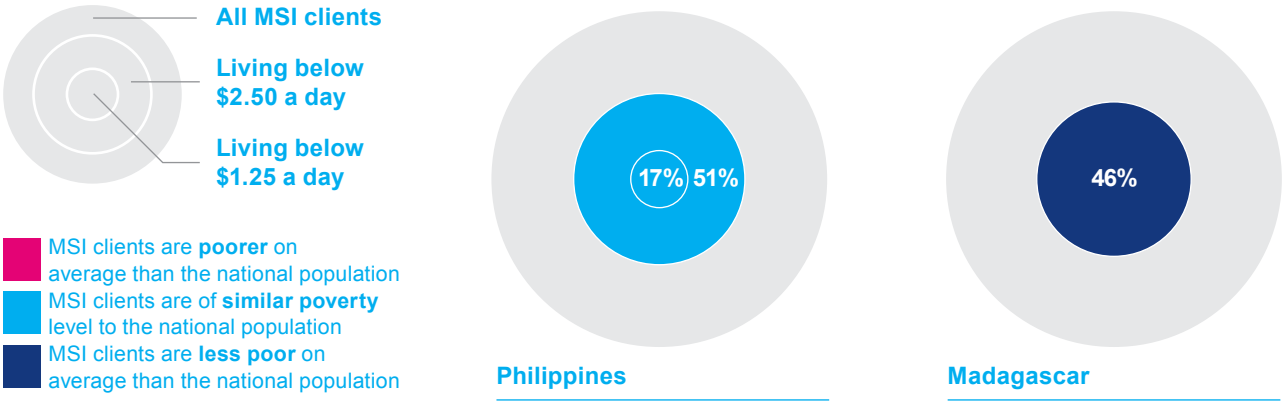


India*



Tanzania

Figure 21:
The percentage of our **social franchise** clients below the $1.25 and the $2.50 poverty lines compared to the percentage of the national population living below the poverty line.



Innovation:

High impact CYPs – measuring where we make the most difference

CYPs have long been our most important global indicator of performance. They allow us to compare country programmes and measure increases in services. However, not every CYP has equally high national impact on our broader goals, such as increased contraceptive use amongst under-served groups, reduced need for abortion and fewer maternal deaths. To achieve these goals, our country programmes must deliver more of the CYPs that have the highest impact. Consequently, from 2012, we will start to use a new metric to measure performance – high impact CYPs.

High impact CYPs will encourage country programmes towards higher national impact by targeting specific groups and contraceptive behaviours.

They are achieved by providing voluntary family planning services to the following groups:

- those that currently do not use modern family planning (adopters)
- those living in extreme poverty
- those under 20 years old
- those living in a very remote area
- those that have just had an abortion
- those choosing to switch from a short term to a long term or permanent method (which are more effective)
- socially excluded groups (to be determined on a country by country basis).

Reaching the young: the need for youth friendly services

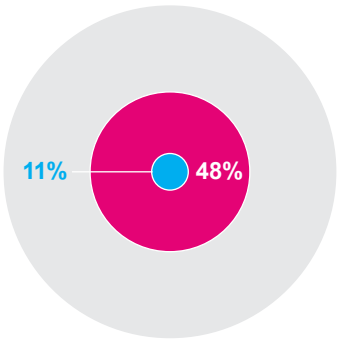
Our increased focus on equitable service provision also means that we need to improve our service provision to young people to better meet their unique needs. More than half of the world's population is younger than 25, and nearly 85% of the youth population lives in developing countries.[18] Young people – particularly those under 20 years old – are often disproportionately affected by social and economic inequities, making them particularly vulnerable to adverse sexual and reproductive health outcomes.[19]

Early marriage, lack of access to information and contraception, and sexual coercion can all lead to unintended adolescent pregnancy – the leading cause of death among teenage girls in developing countries. Girls aged 15–19 are twice as likely to die from pregnancy-related complications than women in their twenties,[20] often because they turn to unsafe abortion. Children who are born to adolescent mothers are likely to have a low birth weight, are at risk of poor development and are at highest risk of infant and child mortality.[21]

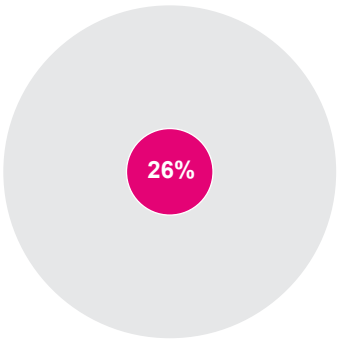
Young people are a diverse group with specific sexual and reproductive health needs dependent on their particular situation. Provision of voluntary family planning and reproductive healthcare services must be acceptable and adaptable to their particular needs. For example, some young people may be unwilling to use conventional health services due to issues of confidentiality, high costs, limited contraceptive choices and negative provider attitudes.[22] In addition, young women may be strongly influenced by the cultural and social norms that prevent them from accessing necessary care. A qualitative study conducted by Marie Stopes Tanzania showed fears of stigma and discrimination from their community far outweighed teenage girls' fears of the risks of undergoing an unsafe abortion. Almost 50% of the study respondents were not using family planning, highlighting the need for youth friendly service provision that meets the needs of young people.[23]

We recognise the importance of meeting the sexual and reproductive health needs of young people. We also recognise that, while the right to adequate reproductive health services is universal, the need – and the best way to meet this need – differs from place to place. As such, we tailor our work with young people based on local contexts. We identify barriers to be removed, find the service delivery channels that are best suited to young people, and work from appropriate venues. For example, in Malawi, we have trained and supported young people as peer counsellors and we have provided education to service providers on youth friendly service provision. This provides a supportive environment for both information sharing and service provision to young people. In Pakistan, our programme works with community leaders and adults who act as gatekeepers, raising awareness of young people's specific reproductive health needs and decreasing social barriers. And our BlueStar social franchise in Sierra Leone has implemented a voucher programme that helps to remove financial barriers for the young and brings services closer to our young clients.

Partnering with other organisations has increased our ability to meet the needs of young people. In Bangladesh, we partner with factories where large numbers of young women work, providing a focused venue for the provision of youth friendly information and services. In China, we work closely with young people, developing youth leaders and ensuring that programmes and messages are effectively designed. And, in Sierra Leone, we partner with other NGOs to reach existing youth groups with key sexual and reproductive health information and services.



Ghana



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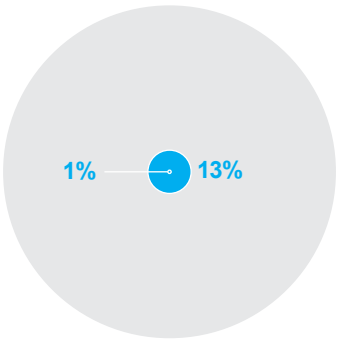

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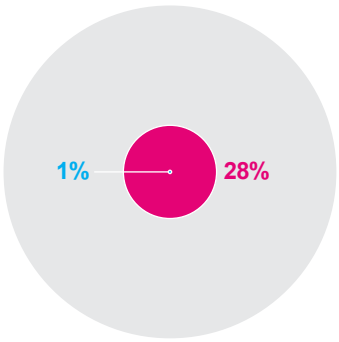

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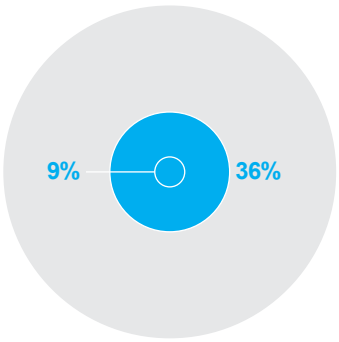

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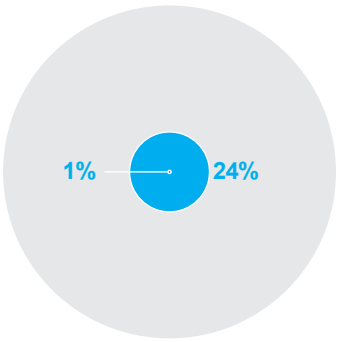

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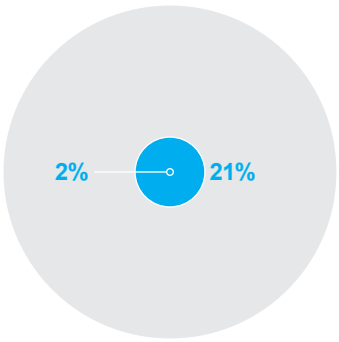

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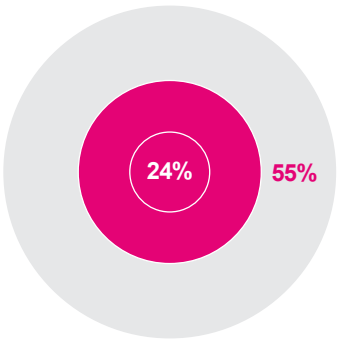

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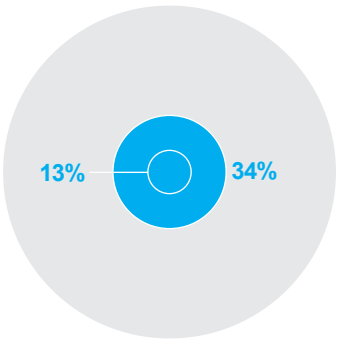
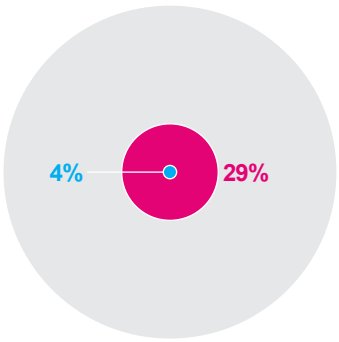


Madagascar



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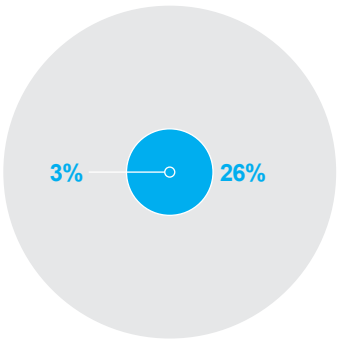
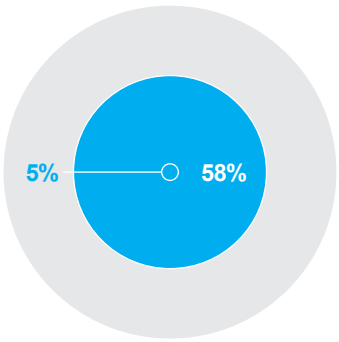
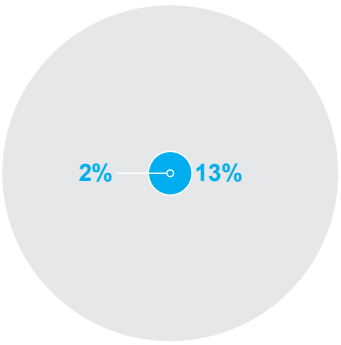


Tanzania



China



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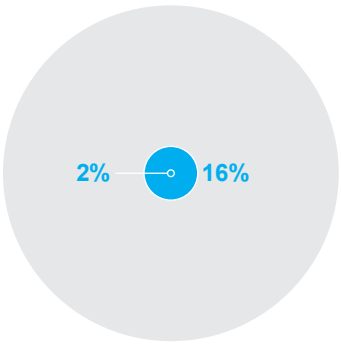

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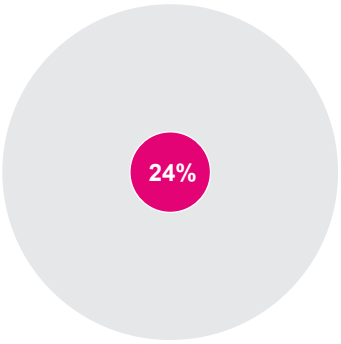
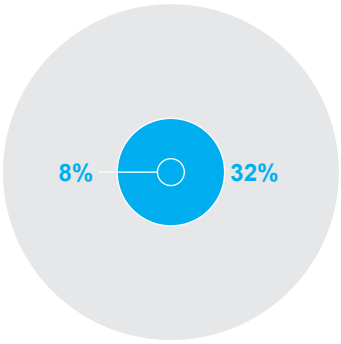


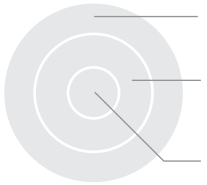
Philippines



Madagascar

Figure 22 (opposite):
The percentage of MSI **centre** clients that are under 25 and under 20 compared to the percentage of the national population of modern method users that are under 25 and under 20.

Figure 23 (this page):
The percentage of MSI **social franchise** clients that are under 25 and under 20 compared to the percentage of the national population of modern method users that are under 25 and under 20.



MSI clients are **younger** than the average modern method user
MSI clients are **of similar age** to the average modern method user
MSI clients are **older** than the average modern method user

Our performance in reaching the young

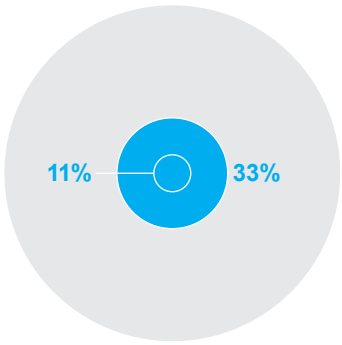
Our performance in reaching the young is shown in Figures 22- 24. Results are shown by country and for each delivery channel where we have data. We compared the percentage of our clients who are under 25 to the proportion of the national population of contraceptive users who are under 25. We also looked at the percentage of clients that are adolescents (aged under 20), to highlight our adolescent friendly service provision.

Where the circles are pink, our clients are younger than the average modern family planning user, showing success in the provision of services that young people are comfortable accessing within that country. If the circle is light blue, the percentage of our clients who are young is approximately the same (within 10%) as the national population of modern method users. Where the circle is dark blue, our clients are, on average, older than the average modern method user, suggesting the need to improve our youth friendly service provision.

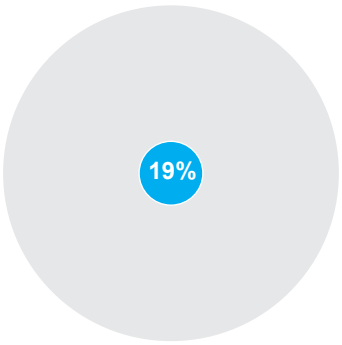
At centres, a greater or similar proportion of our clients were under 25 compared to the national population of modern method users (Figure 22). This shows that our centres performed well in providing youth friendly services to young people.

Similarly, when looking at data from our social franchises, our clients showed a similar age profile to the average modern method user, suggesting that social franchises performed well in meeting the needs of both under 25s and adolescents (Figure 23).

Results from our mobile clinical outreach programmes are displayed in Figure 24 and suggest more varied levels of success between countries in terms of meeting the needs of youth and adolescents. Our clinical outreach programmes often focus on providing LAPMs because short-term methods are already available from other providers in rural settings. LAPM users, especially voluntary sterilisation clients, tend to be older, which may explain the varied success of outreach programmes in reaching the young. Our mobile outreach programme in Sierra Leone performed extremely well in reaching both the under 25s and adolescents – a greater proportion of our clients were younger than the national population of family planning users. Our programme in India also successfully reached out to young people with services through mobile clinical outreach.



Ghana



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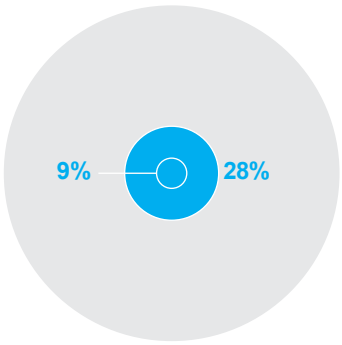

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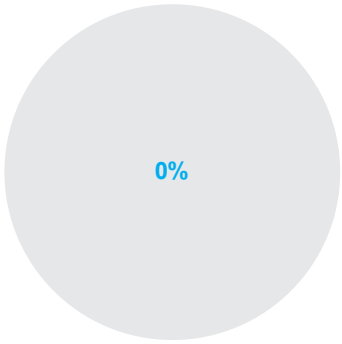

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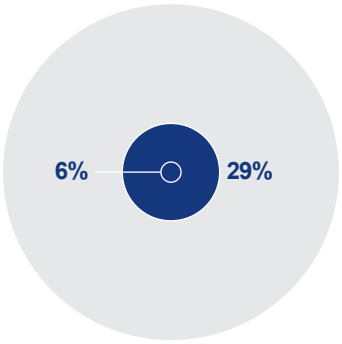
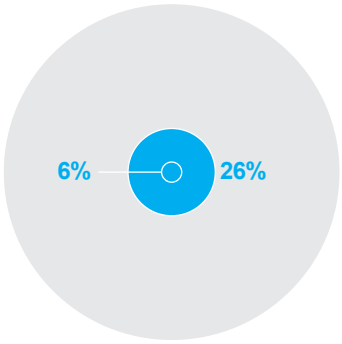
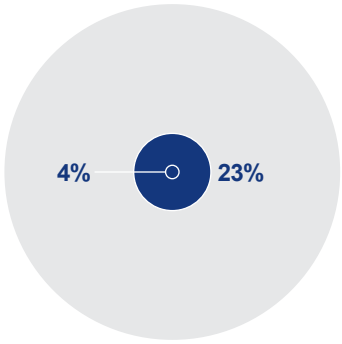


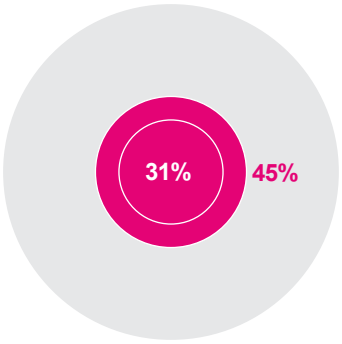
Burkina Faso



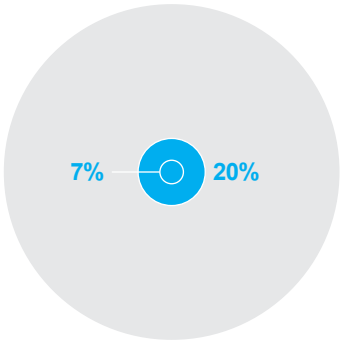
Zimbabwe



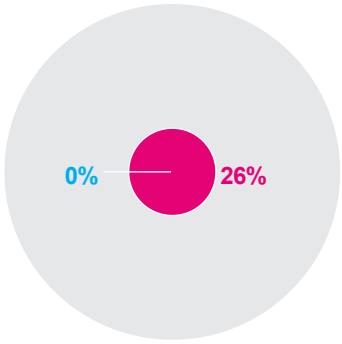
Uganda



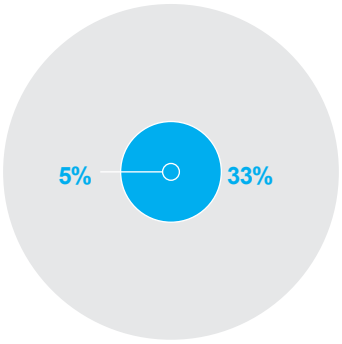
Sierra Leone



Madagascar

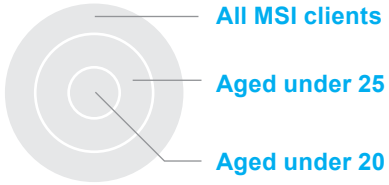


India



Tanzania

Figure 24 (opposite):
The percentage of MSI **outreach** clients who are under 25 and under 20 compared to the percentage of the national population of modern method users who are under 25 and under 20.



MSI clients are **younger** than the average modern method user
MSI clients are **of similar age** to the average modern method user
MSI clients are **older** than the average modern method user

Innovation:

Madagascar – using mobile money to reach the poor

In Madagascar we have been contributing to national maternal health targets through a subsidised voucher programme piloted under the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project. Community health workers distribute vouchers to eligible clients. For approximately US$0.10, clients can buy vouchers to use at one of our social franchise providers in exchange for a voluntary family planning service that would normally cost between US$2 and US$5. Traditionally, we reimburse the franchisee for the service that they delivered via a traditional cash payment.

In remote and resource poor areas, however, there are challenges to implementing this approach. Limited banking facilities outside the capital mean that many franchisees do not have a bank account. Cash payments require staff to travel long distances with considerable sums of money, making this system cost-inefficient, with significant implications for the personal security of our staff. Consequently, we have chosen to incorporate the use of mobile phone SMS money transfer systems to pay the service provider in place of traditional payment methods. Given that all franchisees have mobile phones, this is a simple yet innovative solution. An online control system verifies the voucher codes at our office and we subsequently send the reimbursement to the service provider via SMS. Over a six-month period, we reimbursed all of the unique voucher codes submitted by social franchisees. In total, 35% of the 1,737 claims sent for reimbursement were reimbursed within 48 hours. Data also suggested that use of an SMS money transfer system was easily adopted by the social franchisees.

Data on our voucher clients showed that 76% of clients were poor – a higher proportion than among our other clients and greater than the proportion of the national population living in poverty. The integration of SMS avoids the disadvantages of the traditional cash transfer system in remote areas. In some settings, it has clear operational benefits and can significantly strengthen the reach, efficiency and sustainability of health services. SMS money transfer systems have been introduced in more than 60 countries worldwide; one in 10 of these systems have more than 1 million users. The subsequent potential for large scale replication of this method of reimbursement in other countries is enormous.

Case study:
Creating better futures for young people

"My whole family is at peace now. My husband doesn't have to worry about financing another pregnancy and another child; the children I have are better cared for; and I can take some time to rest."

In the developing world, a young woman's future is often determined by whether she can choose to access contraception or not. Miriam lives in the west African country of Mali. Like many Malian women she married young. In Mali, 65% of women aged 20–24 were married by the age of 18, often for long-established cultural reasons.[24] In many cases, children arrive nine months after the wedding day, and keep on arriving with very little space between them. So mothers don't have enough time to recover, or enough time and money to devote to their existing children.

Up to a point, this is Miriam's story too. She became pregnant again less than a year after giving birth to her first child. At the age of 18, she now has two children under the age of three to look after.

However, at this point Miriam's future took a different turn. One of our team members reached out to her family, and spoke first with her husband about the benefits of birth spacing, advising him that for Miriam and her children to be healthy she should space her births at least two years apart. Concerned for his wife's health, Miriam's husband suggested she visit our centre. Miriam had no knowledge at all about modern family planning methods, so when she came to the centre she spent time with one of our team learning about all the different family planning methods before deciding on an IUD.

Now, six months later, she is still happy with her choice. She says: "My whole family is at peace now. My husband doesn't have to worry about financing another pregnancy and another child; the children I already have are better cared for; and I can take some time to rest."

Our programme in Mali serves a large number of young clients. Salimata Maiga, one of our doctors, says: "We see a lot of young women using our services. They come so they can avoid unwanted pregnancy that would conflict with their educational goals. Others, like Miriam, have children spaced very close together, and seek services to avoid the occurrence again. We help young people by listening to their individual needs, providing counselling; and offering services at a reduced price."

In Mali, just over 30% of modern contraceptive users nationally are under 25. Yet 55% of our centre's clients are under this age, demonstrating the team's ability to reach this critical under-served group. Across all the countries where we work, we are looking for new and innovative ways to make sure that the young people who want to use our services can do so.

At this time in history, the world is seeing its largest ever cohort of young people, and they are now reaching reproductive age. For these young people to choose what their future will look like, it's ever more crucial that we can reach more young people who are just becoming sexually active, and more women like Miriam.

That might mean more online real time counselling, mobile phone results services, and opening hours and locations chosen by young people. What it will definitely mean is young people being able to take charge of their sexual and reproductive health, and deciding for themselves what their future will look like.

An MSI community worker counsels Malian women on the range of family planning methods available to them.

Photo: Marie Stopes International

Chapter 4
Expanding choice in family planning

'Teng and her husband have always been keen to control the size of their family. She realised that she could access a wider range of methods from a Marie Stopes International trained clinic operating in her community.'

► Full case study on page 62

Three types of choice

Choice is the cornerstone of our work. There are three types of choice in family planning that we are working to improve:

1: Choice of whether to use contraception – ensuring that all women and couples, irrespective of education, residence or wealth, can access affordable modern contraceptive services.

2: Choice of provider – public, NGO and private – ensuring that all clients can reach high quality services from a provider they trust within easy distance of their home.

3: Choice of method – ensuring that women and couples can choose the most appropriate method to meet their needs and recognise that these needs may change over the course of their life.

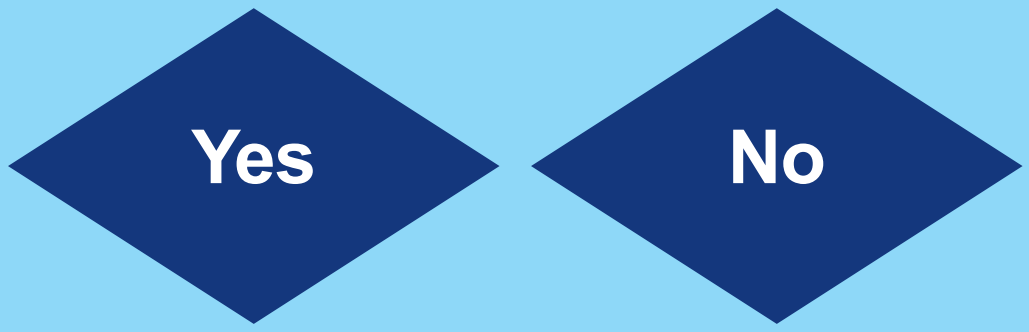
Innovation:

Developing profiles of unmet need to better target services

Our programme in Pakistan recently investigated the factors associated with unmet need among women of reproductive age across 49 districts of Pakistan.[25] Analysis found significantly higher levels of unmet need among certain groups, such as women with low education, the poor and those living in Sindh and Balochistan provinces. We have created similar profiles of women with unmet need in all our countries. This type of data enables us to focus our service delivery on particular under-served groups and in areas with the greatest unmet need, in order to have higher national impact. These findings show the importance of considering the specific country context when identifying those most in need.

1:

Choice of whether to use contraception

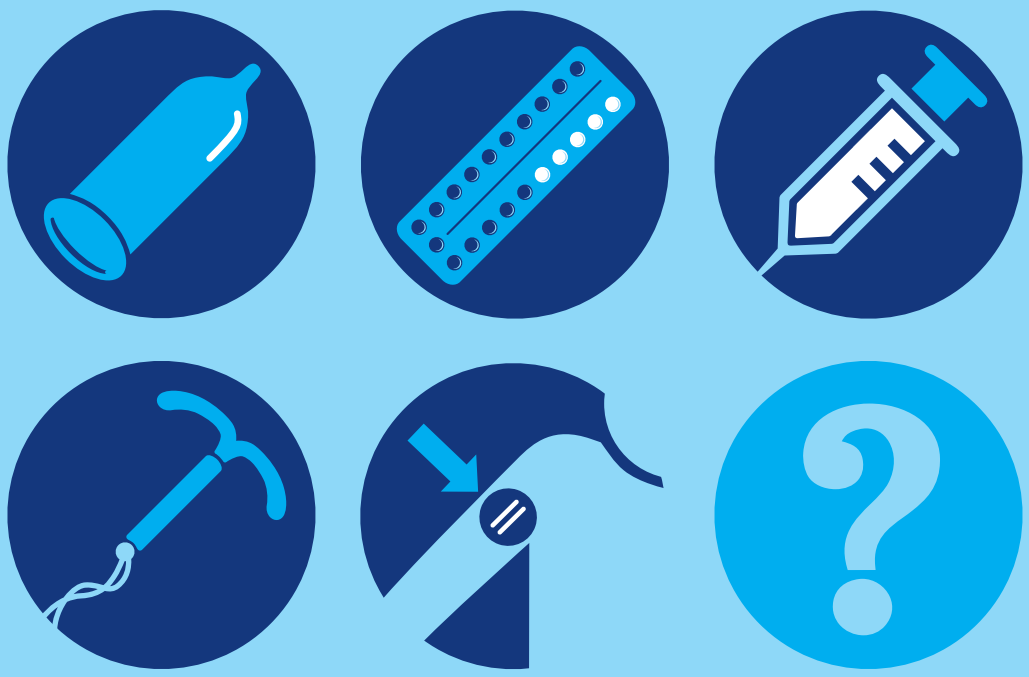


2:

Choice of contraceptive provider

3:

Choice of contraceptive method



Choice of whether to use family planning

As can be seen from the maps in Figures 7 and 8 in Chapter 1, we focus our work in countries where many people have an unmet need for family planning. Therefore it is important that we measure whether we are actually reaching those with an unmet need for family planning in those countries.

To determine our performance in reaching people with an unmet need, we have started to use two proxy measures:

- percentage of clients who are 'adopters' of family planning
- percentage of clients who are 'continuing users' of family planning.

'Adopters' are those taking up family planning that were not previously using any family planning methods. They are new users that are likely to have had an unmet need for family planning. National contraceptive use is increased by reaching these people.

'Continuing users' are those that were using a family planning method that they had received from us. Continuing to serve our existing users is important for sustaining national contraceptive use.

Clients that are not adopters or continuing users are those that were using a family planning method from an alternative provider. This third type of client is thought to be someone that probably could have accessed family planning elsewhere and has switched providers. They do not add to national contraceptive use. One of our goals is to increase the total number of people in a country that have access to family planning, rather than substituting for other providers.

A number of factors determine whether someone is able to access family planning. These factors include geographical remoteness, affordability and social exclusion. The focus on the 'adopter' and 'continuing user' indicators encourages programmes to find people with an unmet need in their country and then to keep them as clients.

In most of our countries, across delivery channels, the majority of our clients are adopters or continuing MSI users. On average, around one in three of our centre and social franchise clients was an adopter and half of our outreach clients were adopters. This shows that outreach is a particularly effective approach in terms of bringing family planning to those that otherwise would not have had access to it.

There are some limitations to the interpretation of these indicators. A person switching providers may be doing so because their previous provider was no longer available or had become unacceptable, and therefore they have had an unmet need for family planning. Most importantly, it may be that they have changed providers because we offered a method they preferred that their previous provider did not offer or a higher quality service. In Madagascar and Zimbabwe, where a high percentage of our mobile clinical outreach clients were provider changers, many had also switched from a short term method to a more effective LAPM. We will explore this further in the next section.

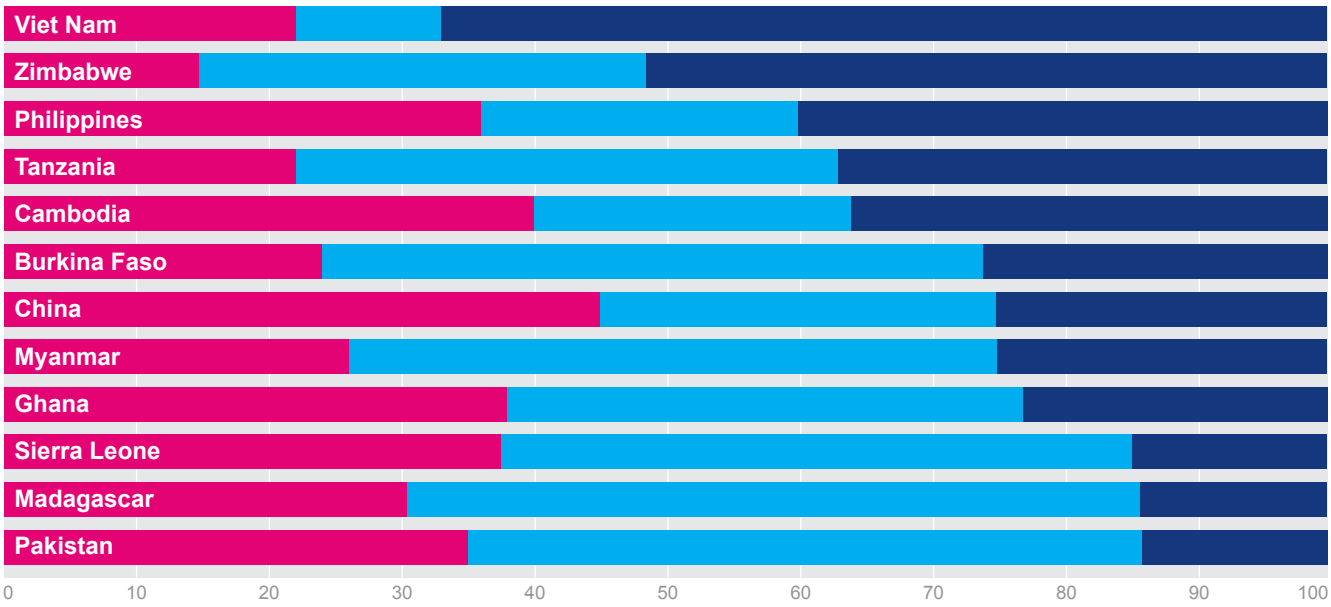


Figure 25:
The percentage of MSI centre clients who were adopters, continuing users and provider changers in 2011

Adopters Continuing MSI users Provider changers

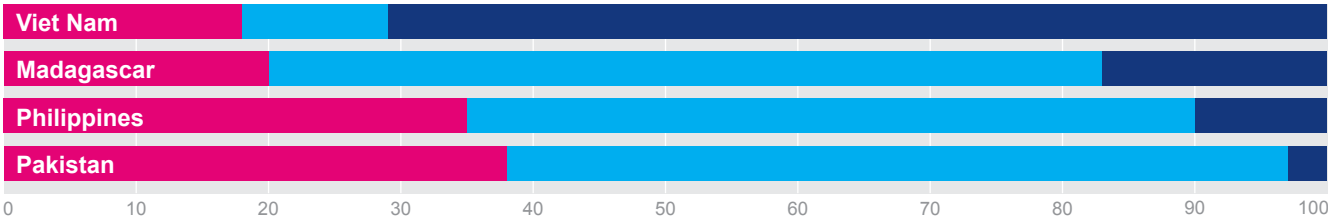


Figure 26:
The percentage of social franchise clients who were adopters, continuing users and provider changers in 2011

Adopters Continuing MSI users Provider changers

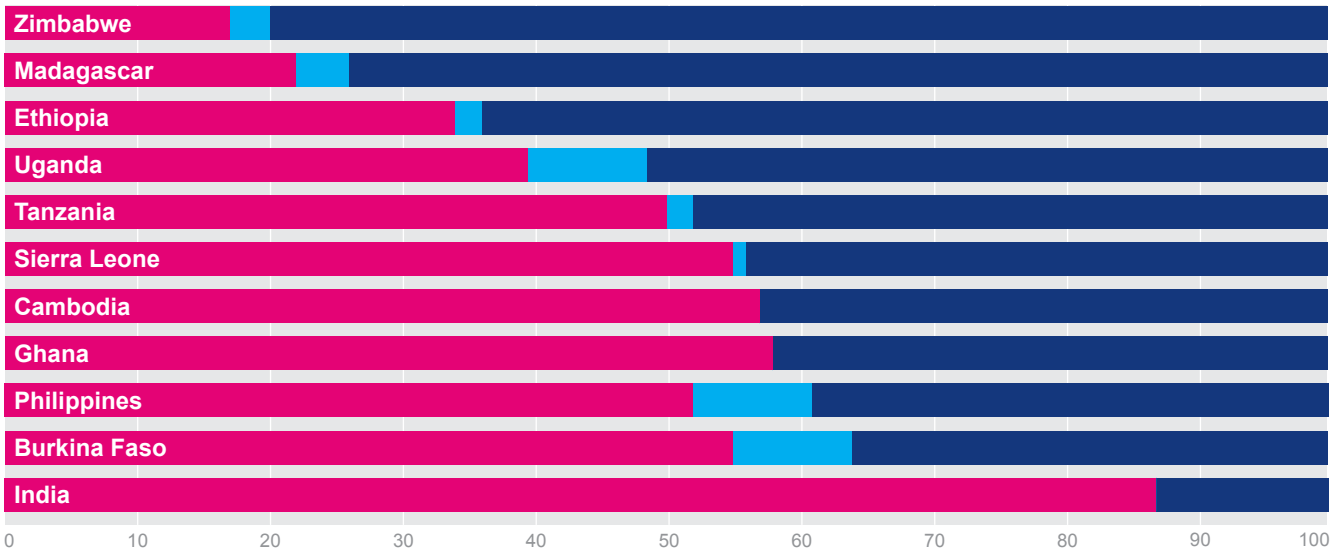


Figure 27:
The percentage of outreach clients who were adopters, continuing users and provider changers in 2011

Adopters Continuing MSI users Provider changers

Choice of method

We believe people have the right to access the most appropriate contraceptive method for their needs. We strive to improve the range of methods that are available in the countries where we work. For example, in sub-Saharan Africa, short term contraceptive methods such as pills and condoms are often the only method available, and supplies can be intermittent. In these countries, we focus on expanding method choice to include long-acting and permanent methods such as implants, IUDs, voluntary female sterilisation and vasectomy. LAPMs are the most effective (99% or greater) methods of contraception available and are safe and convenient. In other areas, we expand access to short term methods, when they are not available to certain groups (for example, if young people who want these types of methods have difficulty accessing them).

We achieve greater health and social impacts by offering a broader range of contraceptive methods. If our LAPM clients had not had the option of using these methods, and used short term methods instead, these women would have experienced more unintended pregnancies, and other potential negative health outcomes. This is illustrated in Table 2 using the example of our service provision in Uganda in 2011 where we provided LAPM services to more than 120,000 women. The first column shows the estimated impacts averted among these women, based on their choice of LAPM. The second column shows the impacts that would have been averted had these women not had access to LAPMs and instead used contraceptive pills. Overall, the one year impact is 32% higher from using LAPMs, rather than short term methods. In other words, by offering women the choice of more effective LAPMs, we are not only expanding contraceptive choice, but we are also saving more lives.

How well have we expanded choice of method?

One way of determining how well we have expanded choices in contraceptive methods is by looking at the extent to which our clients are switching methods. Clients switch methods when they are offered a method that is more appropriate to their current needs than their previous method. For example, users of short term family planning methods in sub-Saharan Africa may have wished to use LAPMs but may not previously have had access to them. From surveys of our clients, we can measure whether this is the case by asking clients what method they had been using. Figures 28 to 30 show the percentages of our clients that were already using family planning in each delivery channel that switched from a short term method to an LAPM.

Table 2:

Estimated first year impacts for LAPM users in Uganda, compared to impacts that would have occurred if they were using the contraceptive pill

Impacts	LAPMs	Pills	Difference
Unintended pregnancies averted	58,757	39,810	-18,947
Maternal deaths averted	151	103	-49
DALYs averted	67,214	45,540	-21,674
Unsafe abortions averted	8,012	5,429	-2,584
Costs saved to the healthcare system (GBP)	2,660,350	1,802,479	-857,871

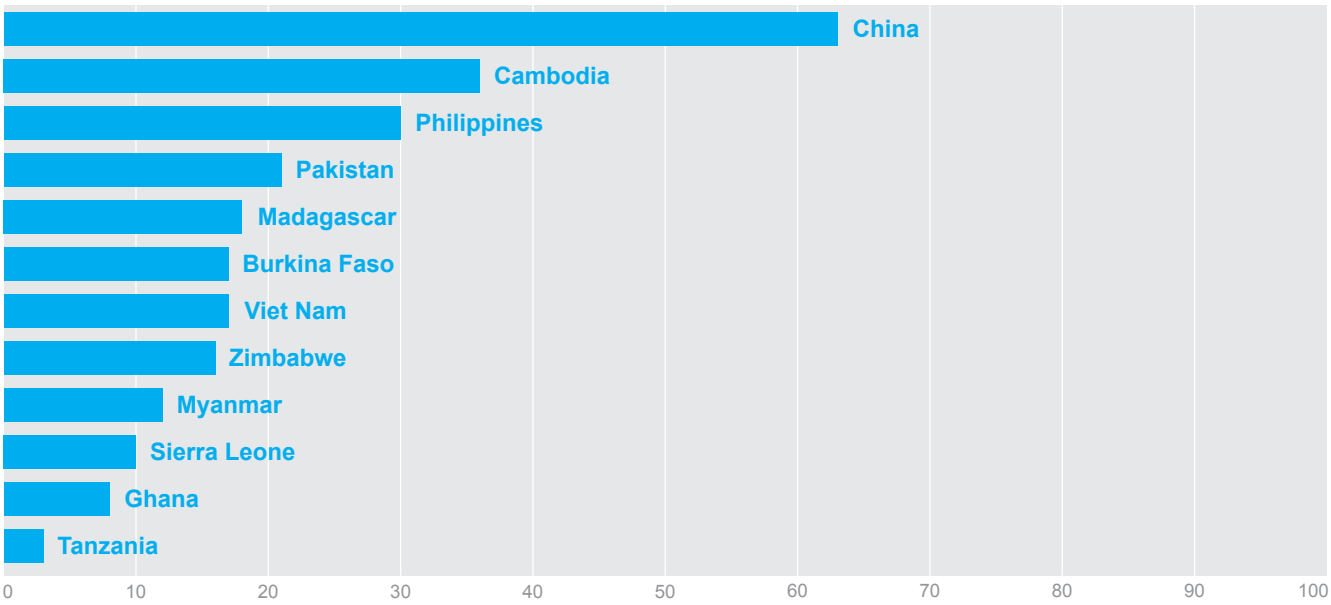


Figure 28:

The percentage of MSI **centre** clients who switched from a short term method to a long term method

Figure 29:

The percentage of MSI **social franchise** clients who switched from a short term method to a long term method

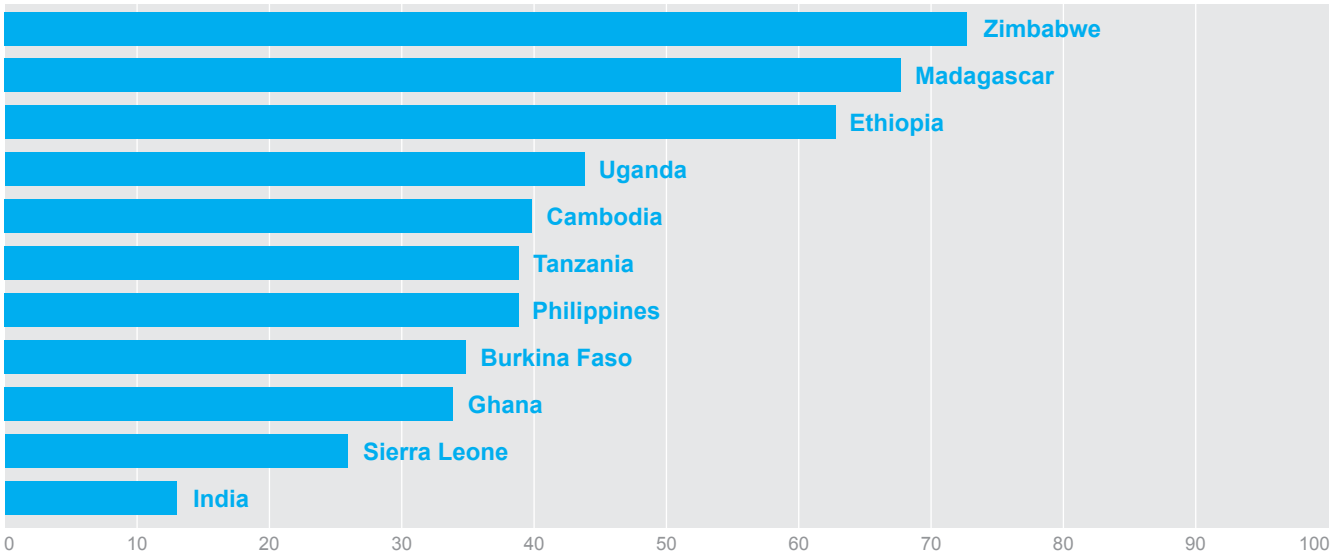


Figure 30:

The percentage of MSI **outreach** clients who switched from a short term method to a long term method

Our method mix versus national method mix

The extent to which we expanded the choice of method can also be seen by looking at the distribution of contraceptive types used nationally and comparing this to the contraceptive types used by our own clients.

The distribution of users by contraceptive method differs according to the region. Figures 31 to 33 show differences in contraceptive preferences among our clients:

- IUDs are commonly chosen in Asia Pacific and Latin America.
- Clients in Africa often choose female sterilisation, IUDs and implants.
- The only region where vasectomy is chosen by a large proportion of clients is south Asia. We need to work in other regions to ensure that people are properly informed about and have access to this option.
- The only region where MSI implants are widely used is in Africa, although they are also becoming more common in Latin America. This may be due to the relatively high cost of implants. The cost is dropping as the new affordable generic implant, Sino-II, is registered around the world. Details can be found in Figure 34.

Figures 31 to 33 also compare methods chosen by MSI clients with methods used nationally in the regions where we do most of our work – sub-Saharan Africa, south Asia and Asia Pacific. These figures demonstrate that we are expanding access to a wider choice of methods. The source of the regional general population method mixes is Impact 2, which uses data from the most recent Demographic and Health Survey (DHS) or national family planning surveys available for those countries.

In the countries of south Asia where MSI works, voluntary female sterilisation is the method used by the majority of modern method users, with the remainder mostly using short term methods. Among MSI users, there is a wider mixture of methods on offer, with more clients choosing vasectomy and IUDs. (See Figure 31).

In sub-Saharan Africa, short term contraceptive methods such as pills and condoms are often the only method available, and supplies can be intermittent. We focus on expanding the method mix to include implants, IUDs, female sterilisation and vasectomy. Among our users, a far wider variety of methods were chosen, compared to the national populations – especially implants, IUDs and voluntary female sterilisations. (See Figure 32). The large number of our clients that chose to use IUDs represents an important achievement in expanding choice. IUDs have historically accounted for just 2% of contraceptive use in sub-Saharan Africa,[26] despite being a particularly effective and affordable form of contraception.

In the Asia Pacific[xii] countries where we work, more than half of modern contraceptive users rely on short term family planning methods (See Figure 33). Most of the remainder opt for IUDs and voluntary female sterilisation. This suggests that a wide variety of methods are already available to current users in the region. Compared with the national populations, many more of our clients choose an IUD over short term methods, which may reflect widespread unmet demand for more LAPMs. These methods are important to allow women to choose the timing and spacing of births. Expanding access to implants is a priority over coming years in this region, so that a fuller range of choices is available.

xii China is excluded from these figures as the population is large enough to distort the general population method mix, while the MSI programme there is relatively small.

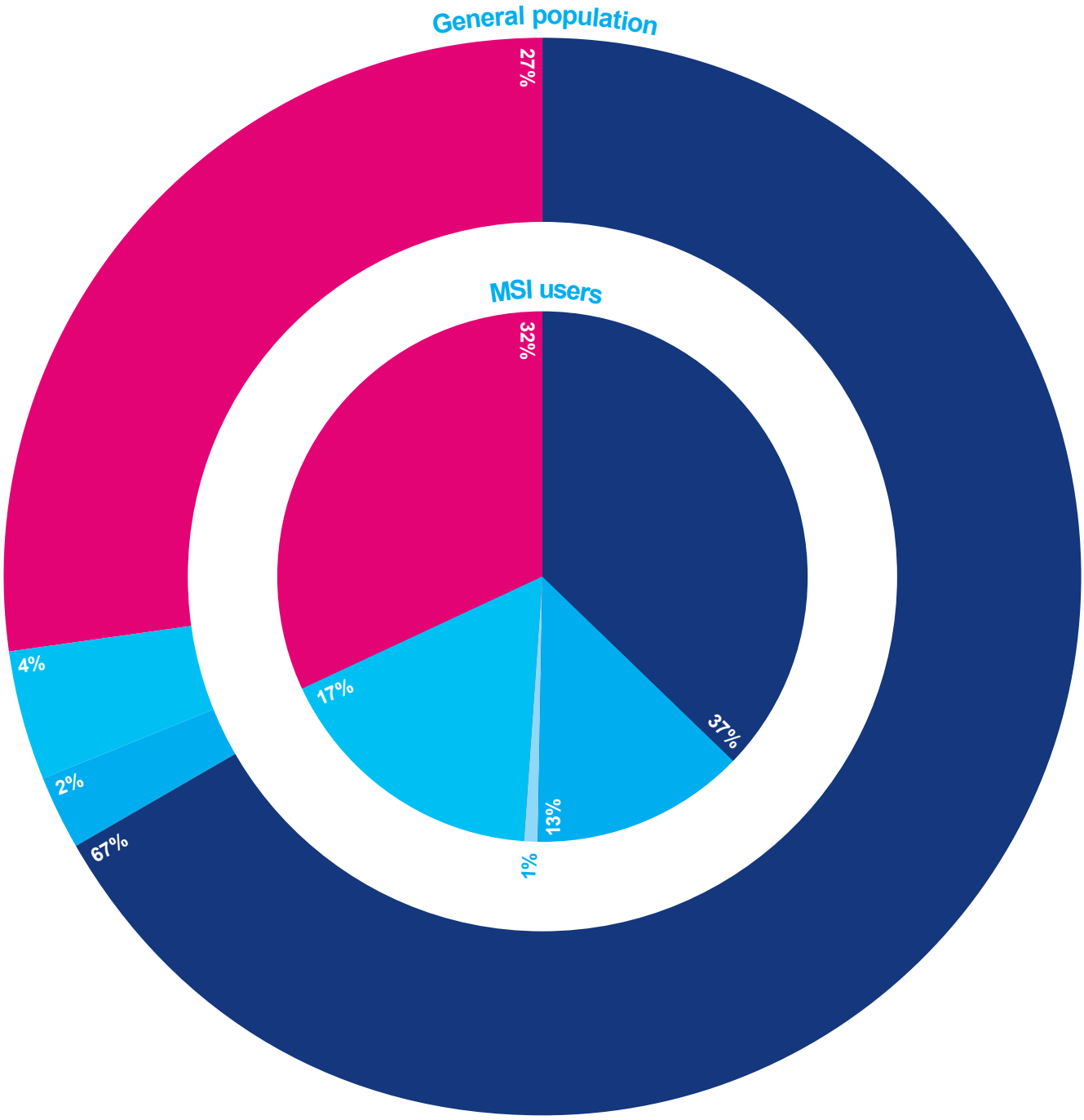


Figure 31:
Method mix among MSI contraceptive users and national modern contraceptive users in **south Asia**

- Female sterilisation
- Male sterilisation
- Implant
- IUD
- Short term method

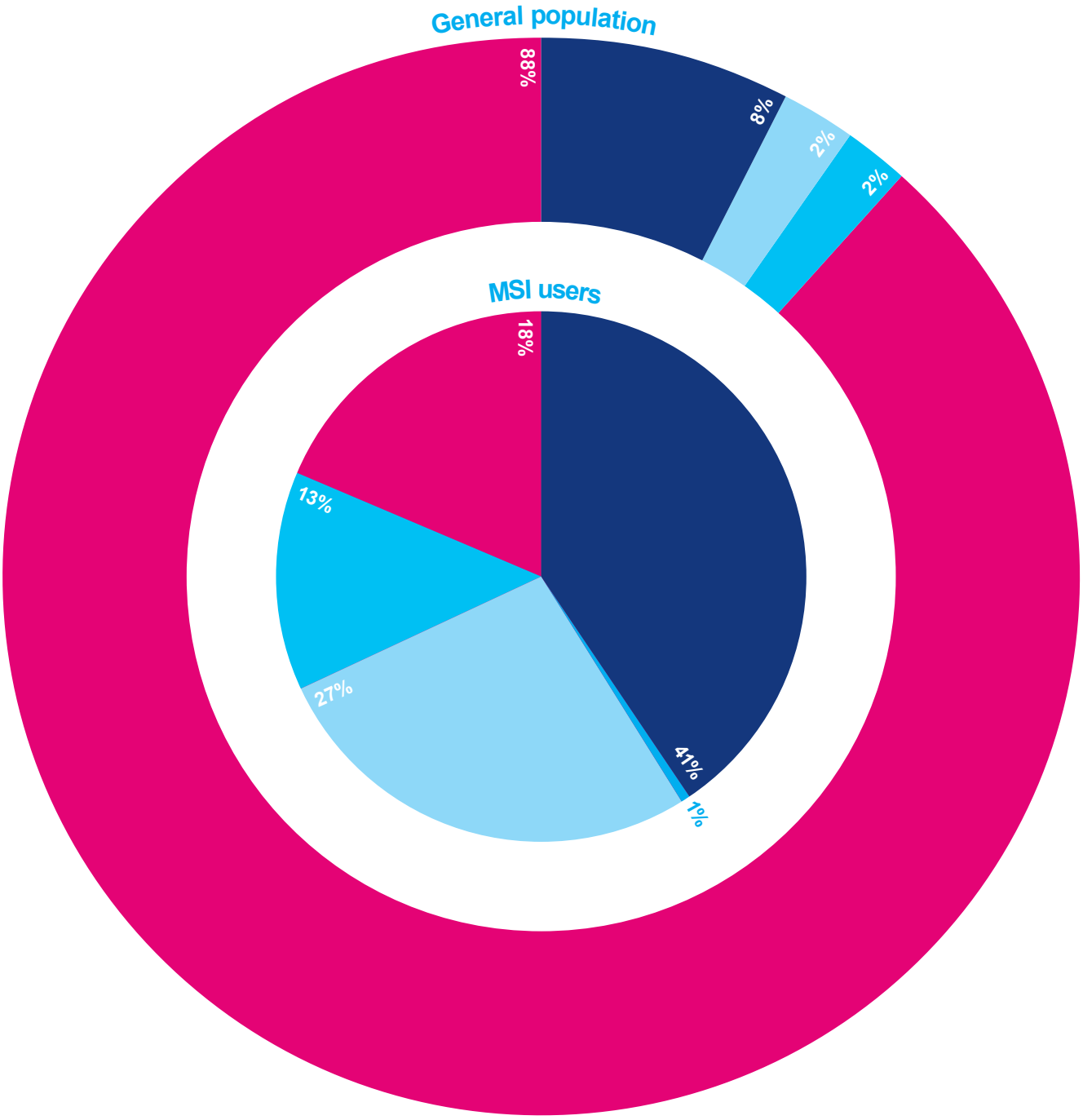


Figure 32:

Method mix among MSI contraceptive users and national modern contraceptive users in **sub-Saharan Africa**

- Female sterilisation
- Male sterilisation
- Implant
- IUD
- Short term method

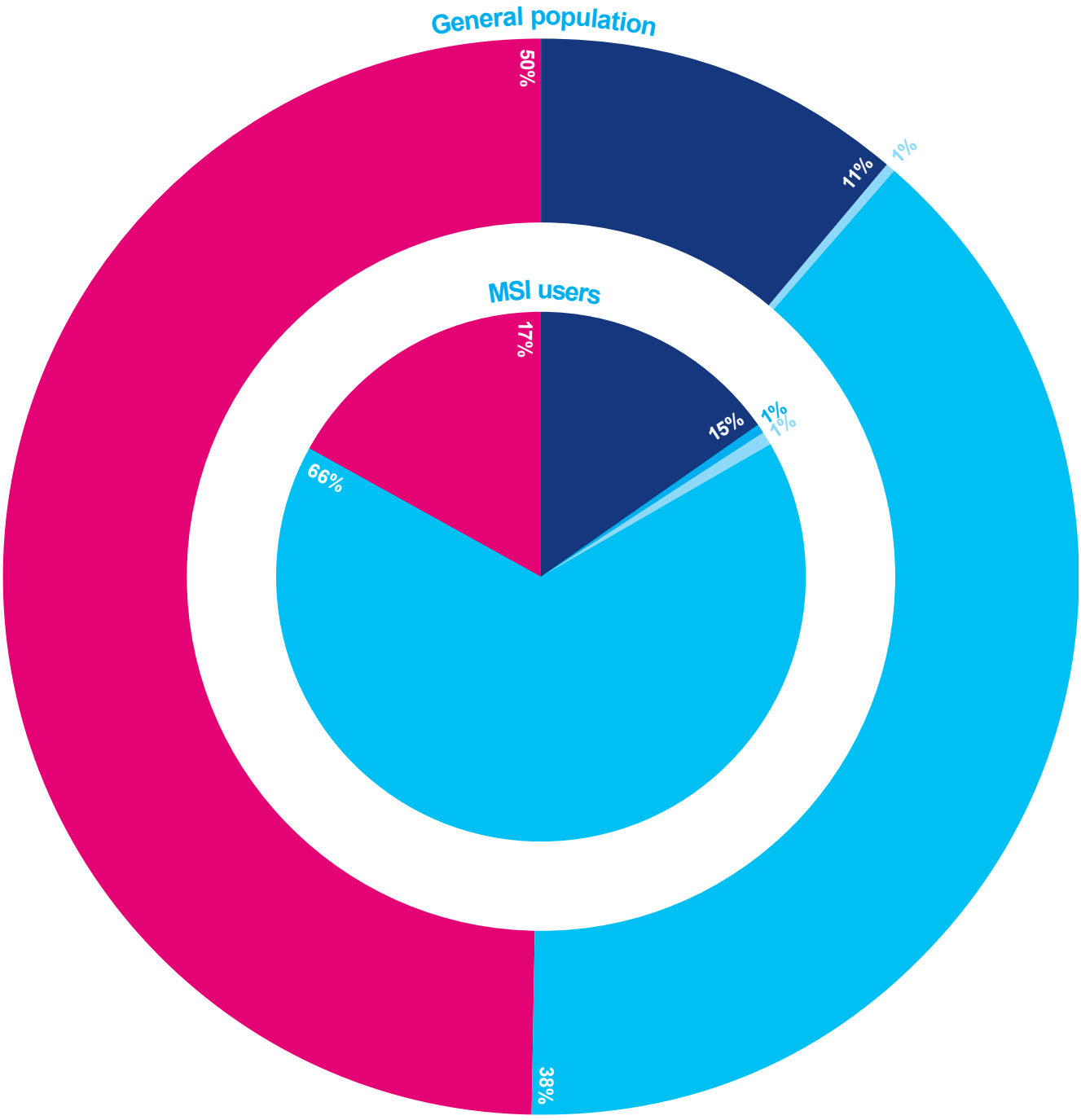


Figure 33:
Method mix among MSI contraceptive users and national modern contraceptive users in **Asia Pacific**

- Female sterilisation
- Male sterilisation
- Implant
- IUD
- Short term method

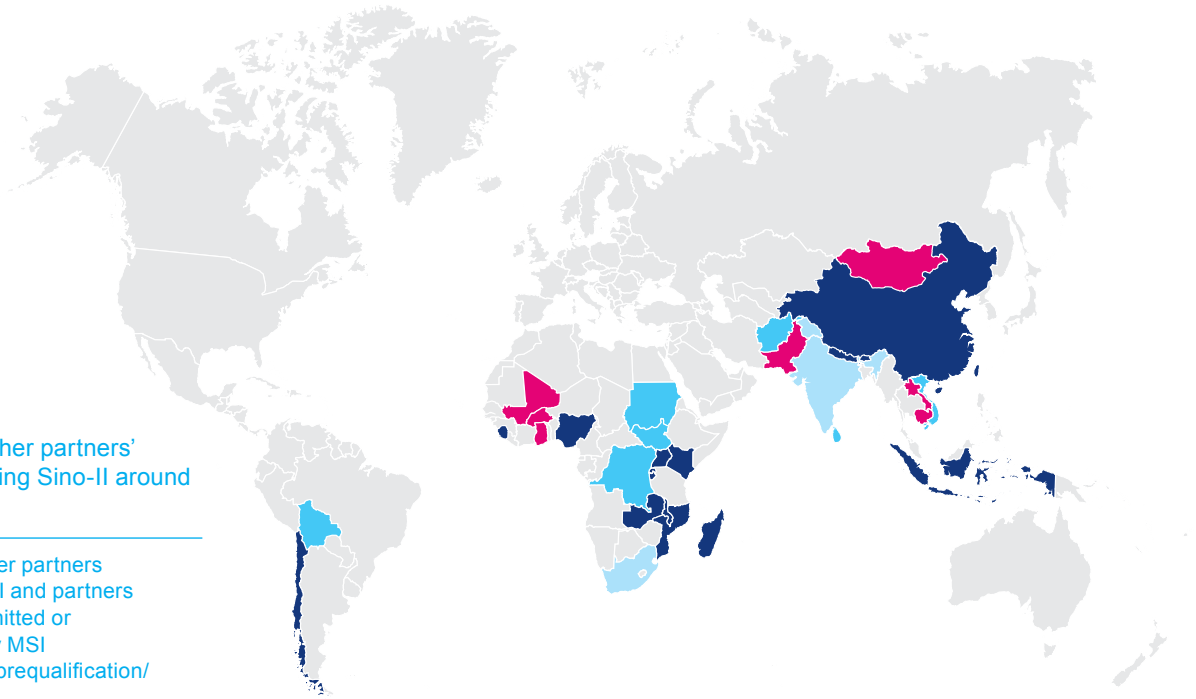


Figure 34:
MSI, FHI 360 and other partners' progress on registering Sino-II around the world

- Registered by other partners
- Registered by MSI and partners
- Applications submitted or being prepared by MSI
- Waiting for WHO prequalification/ clinical trial tests

Sino-II implant registrations

We also expand the range of contraceptive methods available to women by working with partner organisations to register the Sino-II implant. Contraceptive implants are long-acting, reversible and are known to be one of the most effective forms of family planning, with an annual failure rate of less than one percent. Other brands of contraceptive implants (Jadelle and Implanon) are also available. Sino-II, however, is consistently cheaper to supply, at about one third of the price of other brands, making it a viable product for use in large scale, developing country family planning programmes.

The critical steps in getting Sino-II to women in developing countries are to register the contraceptive device with the appropriate national authorities, and to adopt Sino-II on to the national essential drugs list. We have worked with FHI 360 and other partners to expand access to Sino-II across the world, as shown in Figure 34.

How well have we expanded choice of provider?

As well as expanding people's choices in contraceptive methods, it is important to ensure that people in all areas have access to quality services from a provider they trust. In 2011, we continued to broaden the range of provider types for family planning services.

Figure 35 shows the distribution of MSI CYPs provided through different service delivery channels. Of all CYPs generated through the provision of contraceptives in 2011, 51% were delivered through mobile clinical outreach programmes, 17% through MSI centres, 22% through social marketing sales and 10% through social franchise clinical networks. Social franchising has seen the most dramatic growth – from 5% in 2010 to 10% in 2011. Due to the expansion of our social franchising and social marketing programmes, CYPs from mobile clinical outreach dropped from 60% to 51%, though they still represent the majority of our CYPs.

We are increasingly moving beyond delivering services independently towards improving health systems in order to catalyse change. We must engage public and private healthcare providers, as well as consumers, effectively in order to address healthcare quality, coverage and use at scale. We are playing a pioneering role in harnessing the private sector through social franchising and partnering with governments to deliver quality family planning.

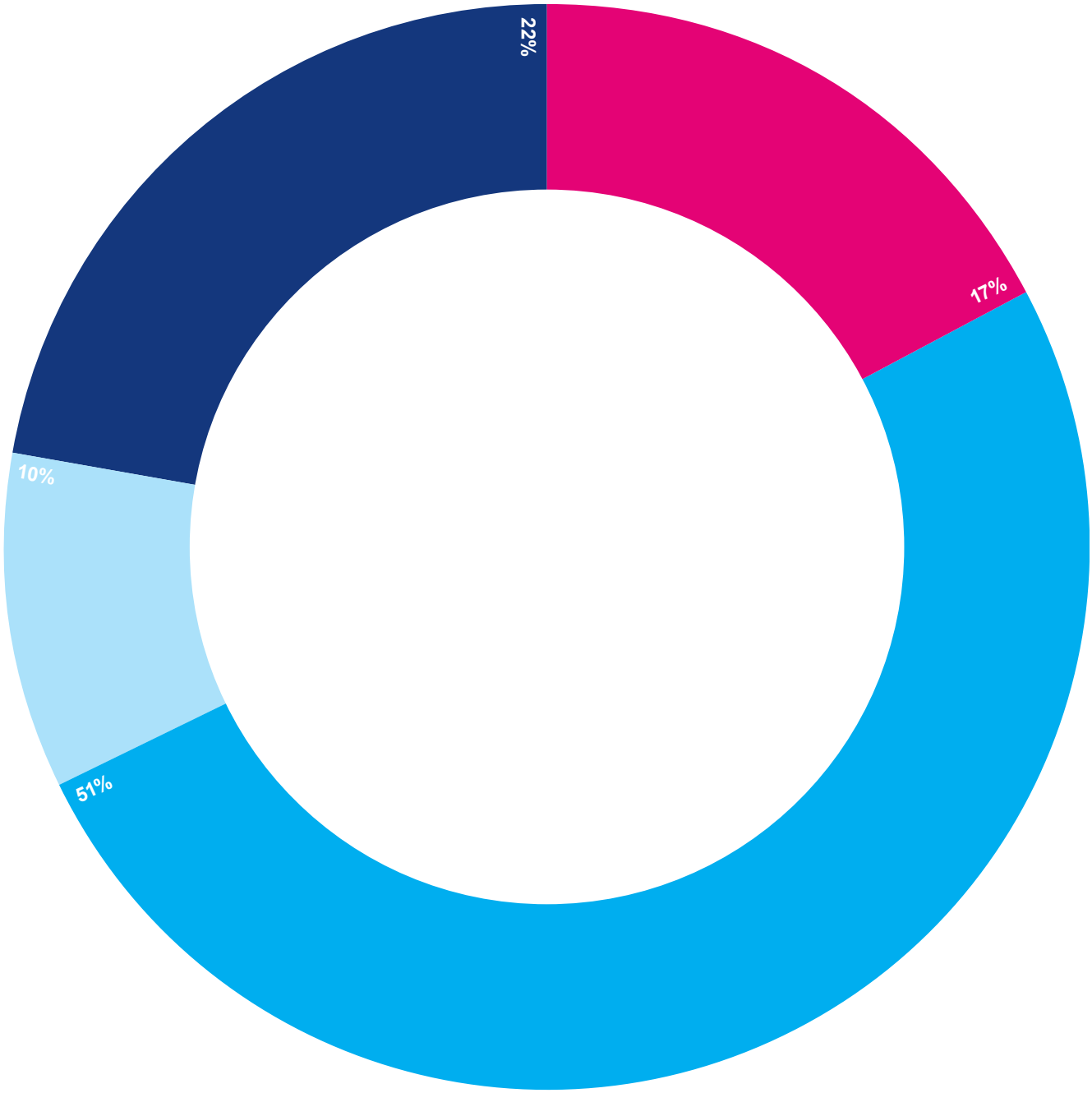


Figure 35:
Couple years of protection
by delivery channel in 2011

- Centres
- Outreach
- Social franchising
- Social marketing

Engaging the private sector through social franchising

Private provider networks, organised through social franchising, can engage otherwise fragmented private providers to deliver high quality clinical services that contribute to global and national public health goals. We are one of the leading social franchisors for family planning in the world.

The role of the private sector in healthcare delivery is increasingly recognised by governments and other stakeholders in developing countries. The private sector, both commercial for profit and not-for-profit, plays a critical and growing role in the provision of healthcare. In many countries, it plays a larger role than the public sector. Even among the poor, the private sector is an important source of healthcare. The World Bank estimates that more than half of women from the poorest wealth quintile in developing countries use private providers for their healthcare needs. Engaging the private sector for preventive and curative service delivery is therefore an important aspect of health reform and an effective way to address the needs of under-served and vulnerable populations.

Despite the potential gains of engaging with the private sector, in most developing country environments the sector remains amorphous, unregulated and fragmented. The private sector encompasses varying levels of providers and capacities. Perverse incentives, a high degree of competition and an uninformed consumer base de-emphasise quality and service value. While many governments recognise the contribution of the private sector to healthcare, ministries of health and professional bodies often have limited capacity to accredit providers, enforce standards and protect consumers. The private sector itself generally has limited access to capital and other sources of financing, limited understanding of the business environment and limited skills to effectively navigate it, and an absence of mechanisms for ensuring a value added supply chain.

Social franchising ensures that private providers are trained, equipped, motivated and certified to implement franchised services. Providers are branded to signal to the client the availability of high-quality services. Local and national marketing for the brand in turn builds demand for franchised services. Social franchising is often complemented by social marketing efforts to provide greater access to products, and community based health workers to provide critical links to low income consumers.

Public sector partnerships and contracting out

The development of public-private partnerships is another area where we are expanding provider choice. Contracting private providers or NGOs, such as MSI, to deliver voluntary family planning or sexual and reproductive health services enables governments to harness the high quality, reputation and efficiency of the private sector to strengthen public sector services and improve client choice. A key motivation for contracting out is to meet the high – and often unmet – demand for quality and affordable sexual and reproductive health services. Contracting private providers may fill gaps in sexual and reproductive health service coverage, especially in areas where government provision is inadequate[27] and in areas populated by predominantly poor or under-served populations.[28]

We have experience of delivering government contracted services in Bangladesh, India, Mali, South Africa, Tanzania, UK and other countries worldwide. In Bangladesh, we are one of 12 service providers contracted by the government to deliver sexual and reproductive health and voluntary family planning services. The government benefits through its increased capacity to meet demand for services and improve service quality. As a result of the partnership, we have been able to increase and improve services to clients living in urban areas, especially the poor. In South Africa, we have agreements with government-run hospitals in two provinces to provide specialised family planning services to referred clients. Given the lack of trained healthcare personnel and the size of the country, the government recognises the need for increased service provision, particularly in remote areas. Here we have increased the availability of services, although it has been difficult to obtain formal government contracts. In India, we provide contracted out services on behalf of the government in four states to meet the needs of under-served populations.

Our experiences of innovative public sector partnerships such as these suggest that, when successfully implemented, contracting out can lead to increased access to and coverage of voluntary family planning services. In so doing, we can be confident that clients receive quality services, contributing to our organisational goals of expanding choice and increasing access to under-served populations.

Innovation:

Task sharing in Ethiopia – training health workers to fill gaps in service provision

In Ethiopia, there is a critical shortage of qualified doctors. Historically this has hindered women's access to permanent methods of contraception. By training mid-level providers (health officers) to deliver tubal ligations via our expanding outreach programme there, we have been able to improve access and choice for women.

We provide thorough training using a competency based curriculum to develop the health officers' skills through safe and supervised practical training until they are proficient in performing tubal ligations. Prior to this initiative, voluntary female sterilisation was exclusively provided by MSI Ethiopia doctors and contracted government doctors at our centres. However, in January 2009, we developed an outreach programme that effectively provides long-acting and permanent methods, including tubal ligations, in order to expand women's choices. By 2011, nine out of 10 outreach teams were led by health officers qualified to deliver tubal ligations. Between January and August 2011 alone, certified health officers were responsible for providing 87% of all tubal ligations delivered by outreach teams. Complication rates were low, with only two major complications reported in 2011.

Our programme of task sharing in Ethiopia demonstrates that tubal ligations can be delivered safely by mid-level providers to expand access to comprehensive voluntary family planning services. Furthermore, task sharing has expanded the number of sites where services can be offered, increasing women's choices, particularly in under-served rural areas.

Task sharing

We have also helped to expand access to quality family planning through task sharing. This is the delegation of tasks from highly qualified providers, who are often in short supply, to less specialised healthcare workers who are able to provide the service to the same standard. Task sharing improves the efficiency and coverage of health services.[29] An example of our approach to task sharing from Ethiopia is given in the box above. We are also reducing restrictions on task sharing in a number of other countries with partner organisations. In Sierra Leone, South Sudan, Tanzania, Uganda and Zambia we are supporting governments to create an enabling policy environment for mid-level provision of tubal ligation. In South Sudan and Malawi we are working with government enabling community based administration of injectable contraceptives. In Timor Leste, we led a protocol review, in association with the Ministry of Health and the United Nations Population Fund (UNFPA), which successfully removed restrictions on provision of implants by nurses.

Case study:
Expanding choice in Cambodia

"I'm very busy every day; I don't have time to visit clinics."

28 year old Teng Chan Tol knows how important it is to be able to choose both your contraceptive method, and your provider. Teng lives with her two sons, her husband and his parents in a two room house on the industrial edge of Phnom Penh, Cambodia. Like many of the city's residents, Teng moved from the countryside to seek new opportunities for her and her family.

She and her husband earn a living by selling and delivering carrier bags to local traders. It's hard work, and the long days mean it can be very difficult for her to access family planning, "I'm very busy every day; I don't have time to visit clinics".

Teng and her husband have always been keen to control the size of their family, to make sure that they have enough money to look after the children that they have. She's tried a number of the family planning methods available to her, including condoms, pills and the contraceptive injection. But she's struggled to find a method that works well for her. That is, until she realised that she could access a wider range of family planning methods from a small clinic operating in her community, right around the corner from her home.

The clinic, run by Dr Peng Seam and his wife, opens up a whole range of family planning choices to the community that it serves. And because of training provided by Marie Stopes International Cambodia, the choices include long-acting and permanent methods, such as the contraceptive implant and IUD, which would otherwise be unavailable to women like Teng.

Under their social partnerships programme, MSI Cambodia has provided nationwide training on family planning choices and comprehensive abortion care to more than 200 health providers, including both government and private health providers.

Dr Seam understands the needs of his clients (many of whom, like Teng, can't get to a clinic during the working day), so he and his wife open the clinic early in the morning (6-7am) and late at night (5-7pm). Because of this, Teng was able to make an appointment at a time that suited her.

After receiving counselling at the clinic on all the methods of family planning available, Teng decided to opt for a contraceptive implant, which means she will be offered protection from unwanted pregnancy for three years. She's now able to concentrate on planning for the future with her husband and two children.

Teng was so delighted with the choices available to her at the clinic, she told her sister about it. And her sister travelled 200 miles from the countryside to be able to access the same range of options.

Teng and one of her sons in their home in Phnom Penh.
Photo: Marie Stopes International / Susan Schulman

Chapter 5
Reducing harm from unsafe abortion

"Unsafe abortion is a major issue here in Zambia. And the consequences are devastating for our young women. The Ministry of Health estimates that it's the cause of nearly one third of maternal deaths in the country, with young women particularly at risk."

► Full case study on page 70

Background

Unsafe abortion remains a major global public health concern and a human rights imperative. Among the 210 million women who become pregnant each year worldwide, about 75 million pregnancies (36%) end in stillbirth, spontaneous or induced abortion.[30] Each year, 21.6 million unsafe abortions occur,[31] which means an estimated one in 10 pregnancies worldwide end in an unsafe abortion. Almost all unsafe abortions (98%) occur in settings with limited resources.[32] Approximately 6.2 million unsafe abortion procedures are performed in Africa, 10.8 million in Asia, and 4.2 million in Latin America and the Caribbean each year.[33]

Globally, deaths related to unsafe abortion constitute an estimated 13% of maternal mortality.[34] It is estimated that 47,000 women died from complications due to unsafe abortion in 2008.[35] An additional 8.5 million women require a medical treatment (post-abortion care).[36]

In response to this urgent situation, we take a harm reduction approach, to reduce suffering and save women's lives. Harm reduction is a non-judgemental and non-coercive philosophy of developing policies, programmes and services that reduce the health, social and economic harms to individuals, communities and society. We recognise that, in all societies, no matter what the legal context and no matter what access to contraception exists, some women will seek to end unintended pregnancies, whether safely or otherwise.

Table 3: Key global facts: unsafe abortion [37, 38, 39]

Worldwide pregnancies each year	210,000,000
Pregnancies ending in stillbirth, spontaneous or induced abortion each year	75,000,000
Unsafe abortions worldwide annually, almost all of which occur in developing countries	21,600,000
Women requiring medical treatment (post-abortion care) annually	8,500,000
Deaths due to unsafe abortion complications annually	47,000
Percentage of maternal deaths due to unsafe abortion or abortion-related complications annually	13%

We strive to reduce the potentially negative consequences to women's health from an unsafe abortion, using the following strategies:

- making contraception accessible and providing counselling on consistent and correct use
- increasing availability and access to both surgical and medical abortion (where permitted)
- providing training to mid-level providers in medical abortion and manual vacuum aspiration techniques (where permitted)
- increasing clients' awareness of where to seek safe abortion services (where permitted) and life-saving post-abortion care to treat the harmful consequences of unsafe abortion
- providing post-abortion care to treat any complications and providing voluntary family planning
- fostering an enabling policy environment that respects women's health and safety and their ability to make informed reproductive decisions.

Another innovative approach to reducing barriers to safe abortion services is our work to scale up the availability of medical abortion, particularly for home-based care, where it is legal to do so. The advent of mifepristone and misoprostol drugs over the past decade provide an alternative to surgical interventions, giving women more choice of method and expanded choice of location in which to receive care. Studies have shown that medical abortions occurring outside health facilities are effective, safe and acceptable to women living in numerous settings with limited resources.[40] Clients appreciate the confidentiality and comfort of being able to undertake this in their own home. This approach gives women greater control over the timing and circumstances of this treatment, while ensuring they have access to sufficient medical support. We endeavour to make medical abortion available (where permitted) through our social franchise networks and other providers such as pharmacists and community health workers who are trained to provide and / or counsel about the safe home-based use of this treatment. We ensure that adequate support and follow up mechanisms are in place for people who need additional information or care and to give clients options for family planning going forward.

Innovation:

Mexico call centre – reducing harm from inadequate access to information

Until 2007, abortion was restricted throughout Mexico. However, approximately 875,000 women had an abortion in 2006. Most of these women had to resort to an unsafe abortion due to the restrictions. Approximately 150,000 women were hospitalised because of complications resulting from these unsafe abortions. These complications were the fifth leading cause of maternal mortality in Mexico. In 2007, abortion became legally available to all women in Mexico City. However, women in the rest of Mexico still suffered from a lack of access to information and safe services.

We set up a call centre, open 24 hours a day, in 2008 in Mexico that has expanded access to sexual and reproductive health advice for men and women in the country, including information about safe abortion and post-abortion care. The call centre is advertised in Mexico City, surrounding states and Chiapas using the media (radio, magazines), outdoor advertising (metro), online sources (Marie Stopes Mexico website, other abortion focused websites), and printed flyers distributed in the street and at community events.

The call centre handles almost 6,000 calls a month and is staffed by up to six call centre operators at a time. Over the next 12 months the call centre is expected to grow by at least 30%.

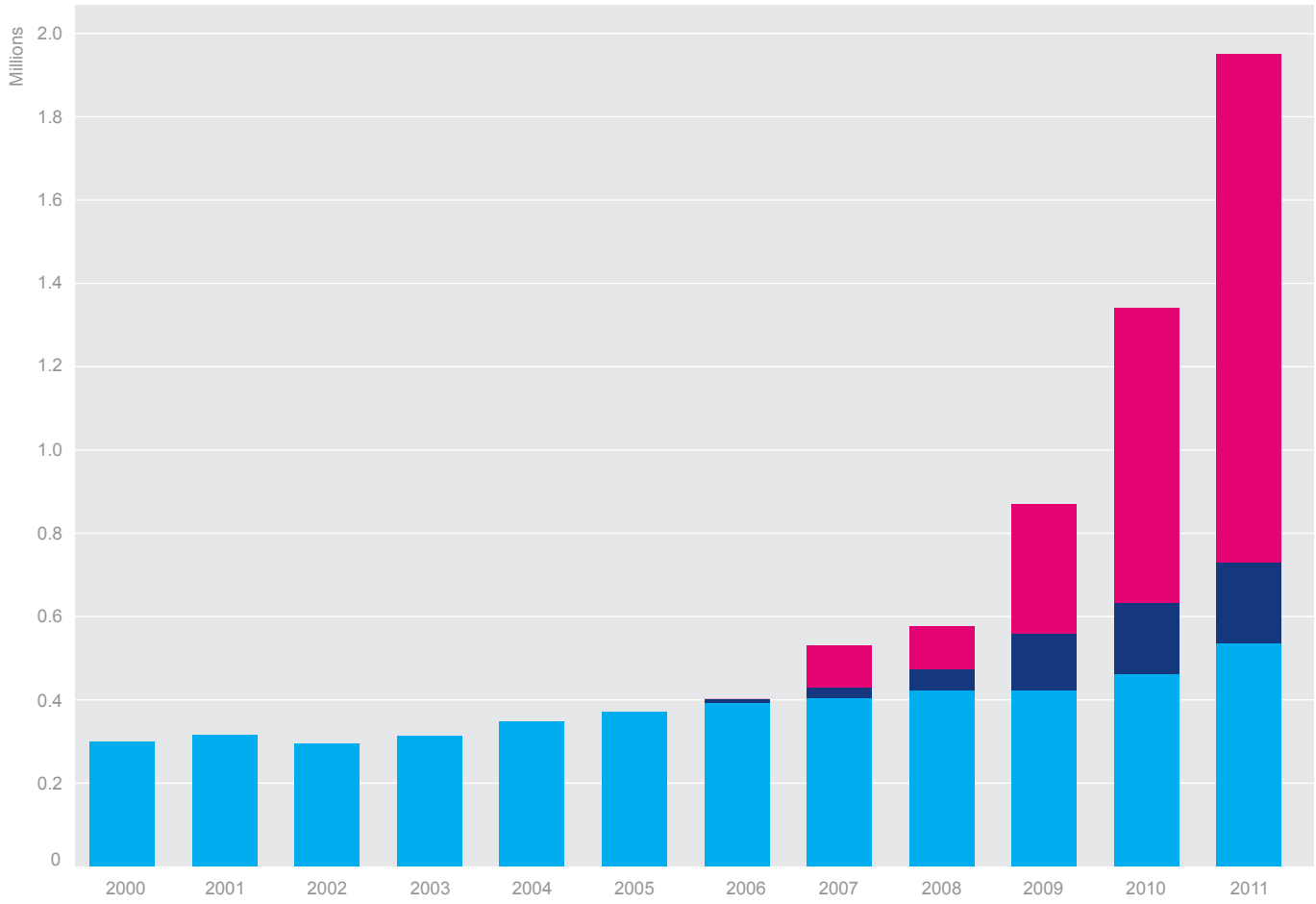


Figure 36:
Number of abortions and post-abortion care services provided by method, 2000 to 2011

Global trends in abortion and post-abortion care services

In order to reduce the negative consequences of unsafe abortion, we increase access to safe abortion and post-abortion care. In 2011 alone, we provided safe abortion and post-abortion care services to nearly 2 million women[xiii] across the globe. Key statistics from our efforts in the provision of safe abortion and post-abortion care include:

- The global number of safe abortions and post-abortion care services that we provided increased by 46% from 2010 to 2011.
- Most of this upward trend came from increases in home-based medical abortions, which rose by 72% from 2010 to 2011 and now represents 63% of all MSI's safe abortions and post-abortion care.
- 55% of total safe abortion and post-abortion care services were provided in south Asia.

We also reduce harm from unsafe abortion by providing our safe abortion and post-abortion care clients with family planning. This is explored further in Chapter 6 in the section 'Family planning following safe abortion and post-abortion care.'

xiii Figures presented in this chapter on safe abortion and post-abortion care numbers are estimates, especially home-based medical abortion numbers.

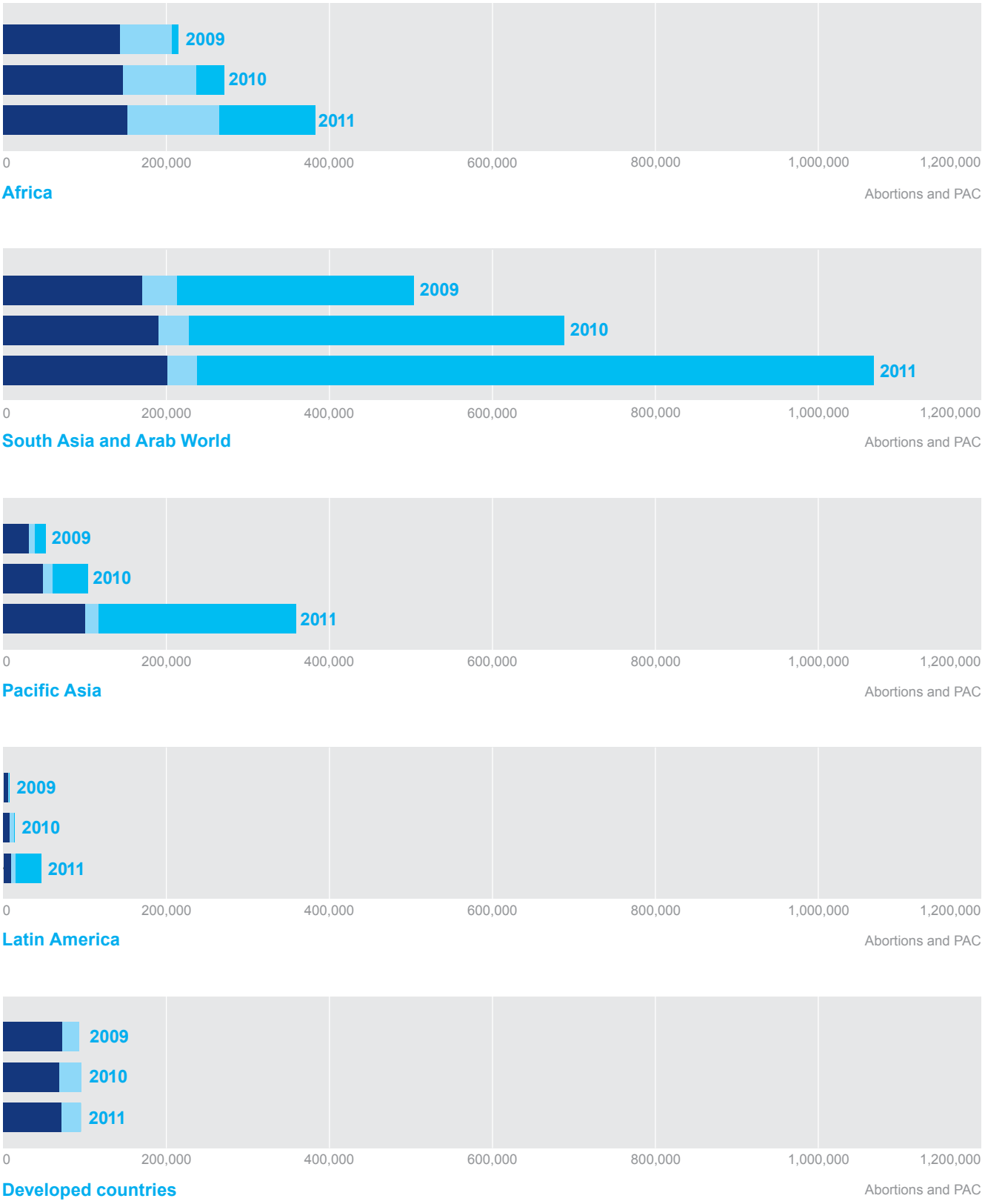


Figure 37:
Regional trends in safe abortion and post-abortion care provision

Surgical | Medical at MSI centre | Medical outside-of-centre

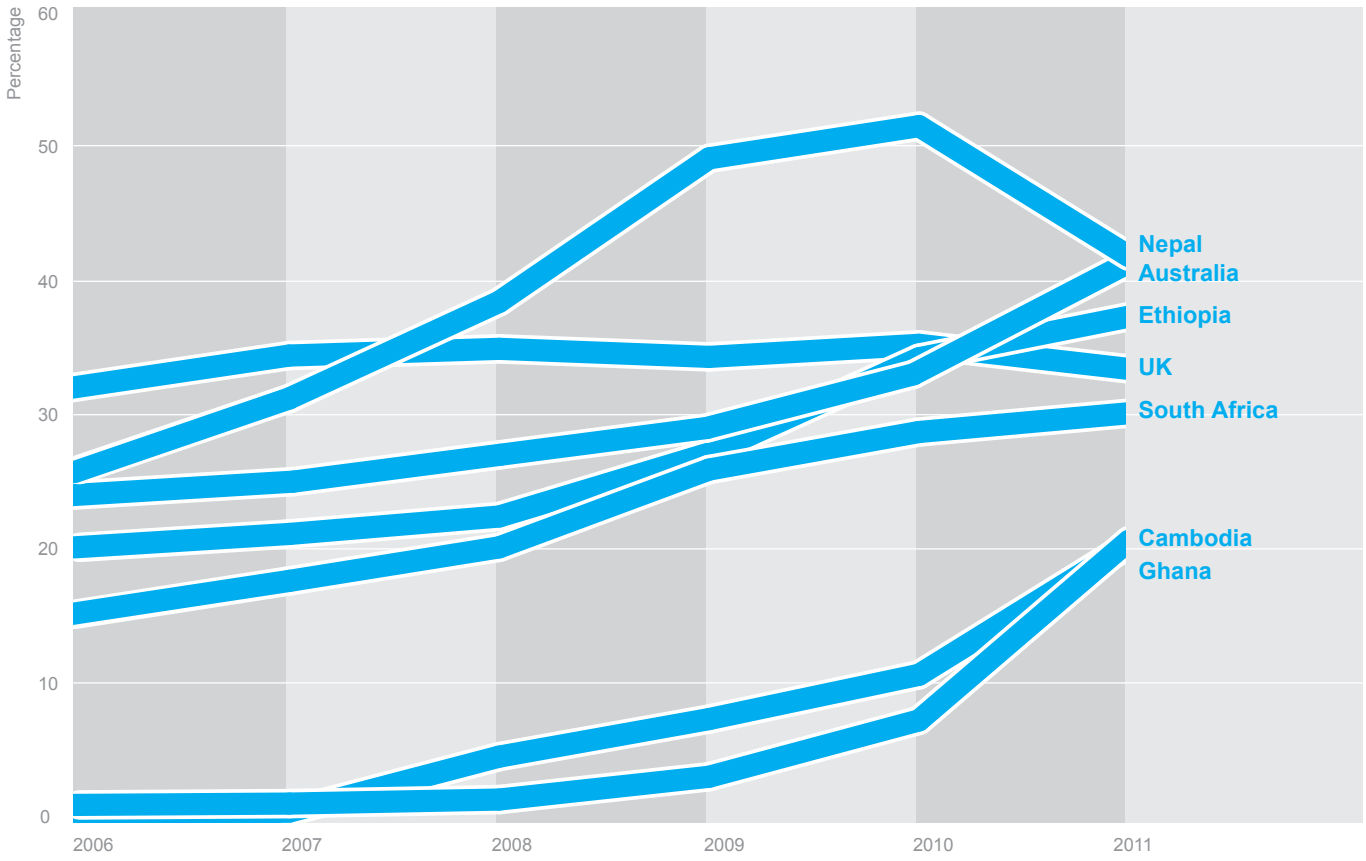


Figure 38:
The percentage of all abortions provided by MSI in selected countries, 2006 to 2011

Regional trends in abortion and post-abortion care services

In 2011, we saw particularly dramatic growth in safe abortion and post-abortion care services in Asia Pacific – an increase of 244% from 2010. The greatest absolute growth was in south Asia, with over 380,000 more services provided in 2011 than 2010. Most of the growth was in Asia, where mifepristone and / or misoprostol are provided outside clinic settings, for home-based care. In Africa, medical abortion (where permitted) and medical post-abortion care also increased. This is an important contribution to reducing the harm caused by unsafe abortion. Medical abortion and medical post-abortion care are increasingly the choice for women using clinic-based facilities in Latin America and the developed world (see Figure 37).

Impact 2 allows us to estimate what proportion of total abortions in each country is provided by us. In countries where unsafe abortion remains high despite its unrestricted status, this data suggests that increasing numbers of women are turning away from unsafe abortion providers. These results are important in tracking the extent to which clients have been able to access effective counselling and safe, confidential services. Expanding access to effective services prevents women from suffering the life-endangering consequences of unsafe abortion. Figure 38 illustrates our progress among seven of the countries where we provide abortion.

For instance, we provided 130,000 safe abortions in 2011 in Ethiopia, which represents about 37% of all abortions nationally. Despite the liberalisation of the abortion law in 2005, unsafe abortion remains high in Ethiopia due to persisting lack of awareness surrounding the law, fear and embarrassment to seek proper services and inadequate access to safe providers. Our increasing contribution to safe abortion services in Ethiopia is a useful indicator that our harm reduction approach is working and women are turning away from unsafe providers.

Case study:
Unsafe abortion in Zambia

"We're educating communities about the voluntary family planning and safe abortion services that we provide. And we're teaming up with youth groups, specifically to reach those most at risk."

"Unsafe abortion is a major issue here in Zambia," says Dr Stephen Mupeta, Clinical Services Manager for our programme in Zambia. "And the consequences are devastating for our young women. The Ministry of Health estimates that it's the cause of nearly one third of maternal deaths in the country, with young women particularly at risk. Yet here in Zambia, we have some of the most liberal abortion laws in sub-Saharan Africa. On the surface, it doesn't make sense.

"Speak to anyone in Zambia, however, and you begin to piece together the complex set of reasons that make so many women risk their lives to end unwanted pregnancies. You hear how many women don't realise the procedure is legal. You hear about providers' prejudices that mean women aren't always offered the services they should be – even women who get the courage to go to a health centre for a safe abortion can be turned away by providers due to personal beliefs. You hear about the limited number of places that women can go to access a safe abortion. And about the shortage of medical staff, which makes getting permission from three physicians, as stated in the Zambian law, nearly impossible.

"You also realise just how widespread the problem is. You find that most people know of a friend, or a friend of a friend who's been injured – or worse still died – as a result of an unsafe abortion. The stories are shocking: cassava roots, sticks and wire hangers forced into women's own uteruses; herbs and poisons ingested; and women who've thrown themselves down stairs or attempted other physical injury. Women, and girls, go to extraordinary lengths in an attempt to end pregnancies in secret. Often they know how risky it might be, but they do it anyway.

"We're working to change this – firstly by preventing unplanned pregnancies from happening, and secondly by tackling barriers that prevent women from accessing safe services. We're educating communities about the voluntary family planning and safe abortion services that we provide using modern, internationally recognised methods that are also recommended by the local ministry of health standards and guidelines. And through our seven outreach teams, we're taking contraception to communities which have previously had no access to it – mainly the rural areas of Zambia and densely populated slum areas of major cities. We offer the full range of contraceptive methods – short term, long term and permanent methods.

"We're also partnering with others who believe that this situation cannot continue. For example, youth groups, specifically to reach those most at risk. Through a partnership with Africa Directions, we've been able to reduce the number of women turning to unsafe abortion in the Mtendere and surrounding compounds in Lusaka. Using sport, drama and group activities as a platform to broach sensitive issues, and counteract the hearsay, we're showing women exactly what their options are."

We use drama to educate communities about the risks of unsafe abortion and to raise awareness about our family planning services.

Photo: Marie Stopes International / Charlie Shoemaker

Chapter 6
Quality

'As a midwife, Anna wanted to help women to plan for their families and to give birth in a safe environment. She joined the BlueStar network of family planning and safe delivery clinics a couple of years ago where she received specialist training in reproductive healthcare.'

► Full case study on page 82

Our four measures of excellence

We strive to provide high-quality, clinically safe services that exceed the expectations of all our clients. This chapter looks at the quality of the services we provided in 2011. Data are given for four measures of excellence:

- IUD / implant continuation rates
- clinical quality assessment scores
- client feedback on quality
- post-abortion family planning uptake.

IUD / implant continuation rates

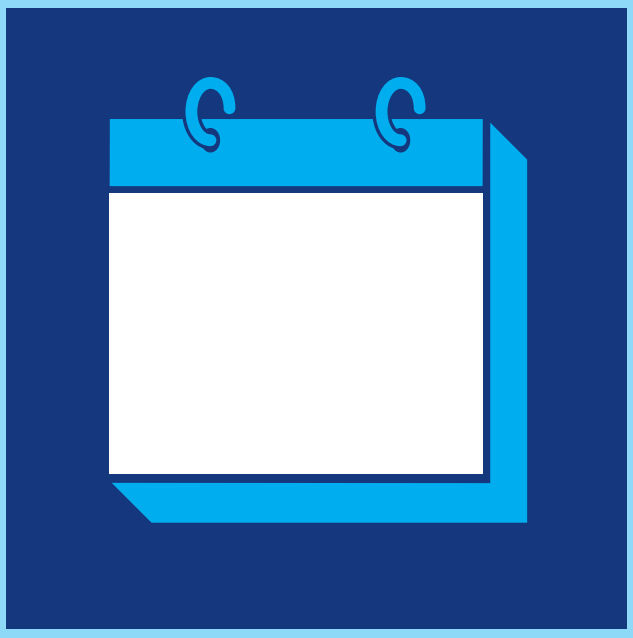
Follow-up evaluations with our clients provide us with useful data regarding the quality of our mobile outreach programmes. Complication rates and levels of method continuation are important indicators of service quality. While some early discontinuation can be expected among women who choose IUDs or implants, high levels may suggest poor counselling or poor clinical delivery.

As can be seen in Figure 39, our programmes have had mixed results. In Myanmar, Pakistan and Sierra Leone in 2010, IUD discontinuation rates were higher than the national / regional discontinuation rates. Since then, we have used this data to improve our counselling quality and other areas of our service provision in these countries, with the aim of reducing discontinuation. In Viet Nam and the Philippines, IUD discontinuation was much lower among our clients compared to the national / regional discontinuation rate, indicating a high quality of service. Implant discontinuation rates were low among our clients in Sierra Leone, Ethiopia and Madagascar, though there was no national or regional data as a comparison.

✓ IUD / implant continuation rates

✓ Clinical quality assessment scores

✓ Client feedback on quality



✓ Post-abortion family planning uptake

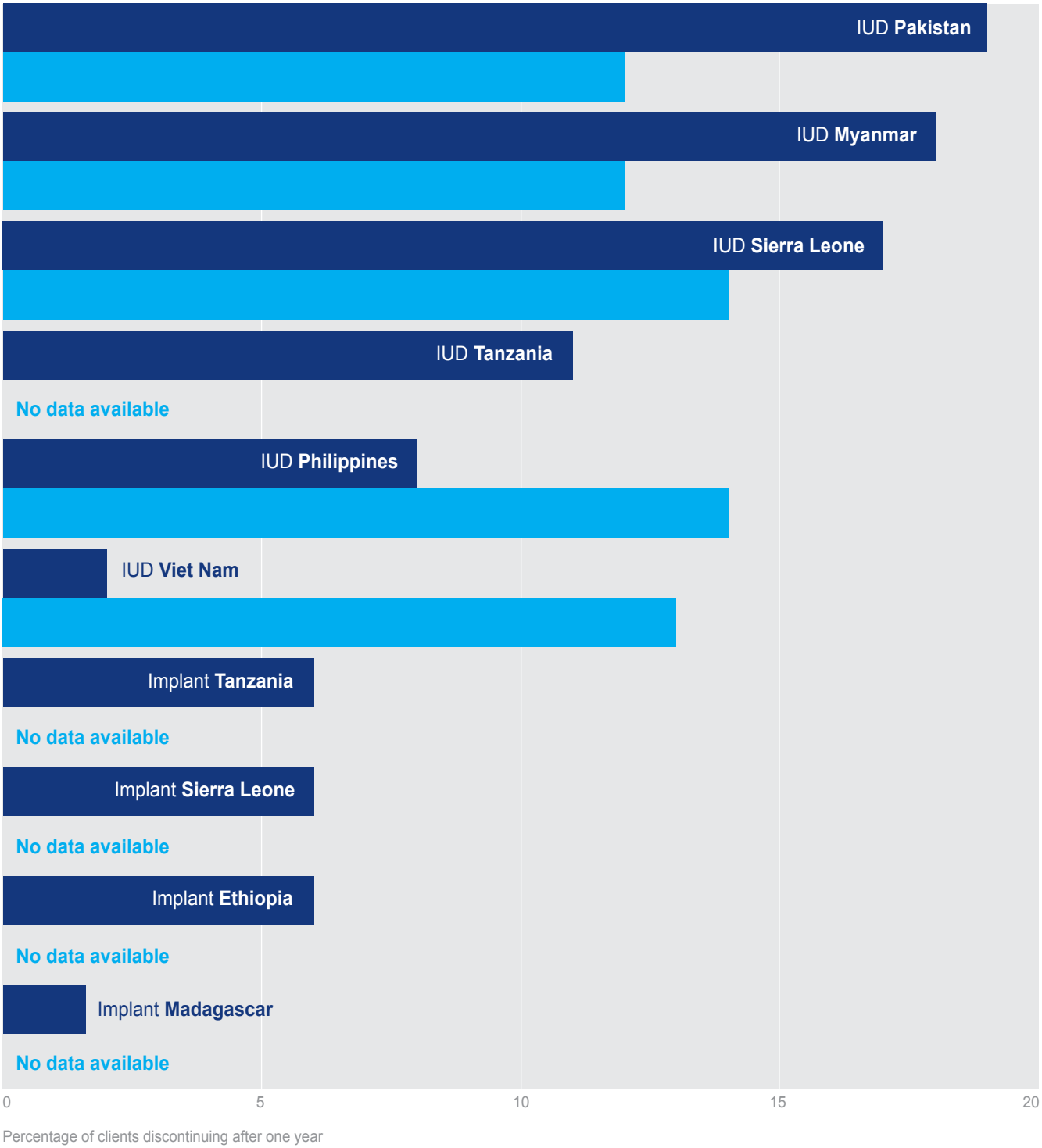


Figure 39:

Discontinuation rates among MSI clients compared to national or regional discontinuation rates[41]

MSI
National / regional

In Tanzania, we found that major complications among IUD, implant and tubal ligation clients at outreach were low (2%) whereas a greater proportion of clients experienced normal or expected side-effects (18%).[xiv] Three-quarters of our clients were well informed and confident about where to seek care in the event of a complication, highlighting the importance of follow-up mechanisms in remote settings. Only 8% of clients discontinued their method of choice after one year (11% IUD; 6% implant) and most client complaints related to normal and minor side-effects. The evaluation resulted in improved strategies to ensure women served at outreach receive adequate counselling about potential side-effects.

Similarly, in Madagascar, we have evaluated the use of the Sino-II implant among our clients. Side-effects were minor and considered acceptable and well tolerated by clients. Less than two percent of women discontinued their implant three months after insertion, which testifies to the quality of our services and client acceptability of Sino-II.

The switching behaviours of women who have discontinued their family planning method are one other important indicator of quality. Following removal, delays in the uptake of a new contraceptive method or switching to an unreliable method can indicate poor quality counselling and a lack of access to alternative methods. In Viet Nam, a recent study showed high levels of IUD discontinuation among women attending government health centres.[42] While only six percent of women removed their IUD because they wanted more children, one-third did not switch to another method. 15% switched to the withdrawal method and 12% waited more than two months before taking up new contraception. These findings highlight the importance of effective counselling, follow-up care and a choice of reliable methods in the provision of quality family planning services.

xiv As per WHO recommendations, this study considered minor and moderate adverse events as normal side-effects and severe adverse events as major or real complications.

Innovation:

Uganda – using mobile phones to improve quality

Use of mobile phones for quality improvement (m4QI) is one example of an innovation we have piloted and evaluated to help us improve quality in Uganda. Use of mobile technologies to achieve health outcomes (m-health) provides promising opportunities to strengthen private sector provision of sexual and reproductive health services. Mobile phones offer an innovative channel through which to provide cost-effective clinical training and support to improve the quality of services.

In 2011, under the Strengthening Health Outcomes through the Private Sector (SHOPS) project, we implemented the m4QI pilot in Uganda, in partnership with Abt Associates and Jhpiego. The pilot involved 34 Marie Stopes Uganda staff at six centres and outreach sites. We provided clinical training using SMS to improve staff knowledge and support quality improvement. For four days a week, over a period of eight weeks, information and quizzes were sent to staff relating to hygiene and infection control. To make it easier to replicate, we used FrontlineSMS as it is a free and open source system, widely used by NGOs to send large numbers of text messages without internet access.

Despite some technical issues, the software application successfully automated the delivery and receipt of text messages to address gaps in provider knowledge. Using data generated from the software, managers were able to make programmatic decisions with regards to supervision and follow-up training, thereby improving provider adherence to recommended quality practices. A subsequent evaluation showed that clinic practices had improved as a result of the intervention.

The promising results of the m4QI pilot have important implications for health programmers elsewhere. The mobile learning platform is well suited for application with larger scale populations in environments with limited resources where training reinforcement is required. It could be scaled up and replicated in other countries where family planning providers have limited access to clinical skills development resources in order to maintain quality standards.

Clinical quality assessment scores

The data in this section was collected through international Quality Technical Assistance (QTA) visits to 31 of our country programmes during 2011. Clinical standards are set centrally by our global clinical leadership. QTA is an annual process of assessment against these global standards, mentoring and technical assistance by our national quality assurance teams, supported by annual visits from our international quality assurance team. This results in continuous monitoring and improvement of the quality of clinical services in our centres, outreach sites and social franchises. Providers are given scores for various aspects of their services using a standardised assessment tool, and focused support is given to countries where key issues of quality or safety are identified by members of the quality assurance teams. Due to the differences in their operation and type of service provision, our clinics and outreach programmes are now analysed differently to social franchises, and are presented separately below.

Centres and outreach

In centres and outreach facilities, scores of more than 90% are considered excellent, 75-89% is satisfactory but in need of attention in specific areas, and less than 75% signifies the need for focused support to reach the necessary standard.

Overall, clinical standards in our clinics and outreach programmes were high in 2011:

- the average QTA score in 2011 was 87%
- excellent scores were achieved for outreach and centres in 18 of the 31 countries visited (58%) – an increase from 46% in 2010
- satisfactory scores were achieved in nine countries (29%)
- scores were below 75% in four countries (13%).

In the four countries scoring below 75%, the programme management teams and our international quality assurance team created action plans to improve clinical quality. The QTA is designed to be a process of improvement and to provide clear action points that can feed into programme plans. In either 2009 or 2010, seven countries scored below 75%. This resulted in a focus from those programme management teams and our clinical quality assurance team to improve on those aspects of care with low scores. Figure 40 shows the improvements in the scores of those countries in 2011. Of the seven countries, four have been able to reach excellent scores and two have achieved satisfactory scores. South Sudan is a new programme that has already made strides in clinical quality in just its first few years of operation.

The QTA tool assesses all areas of our service delivery, providing disaggregated scores for each area of service provision. Table 4 shows the scores for each component of the QTA for centres and outreach:

- Very high scores (over 90%) were obtained at centres in the provision of permanent methods, surgical and medical abortions (where applicable), post-abortion care, sexually transmitted infection (STI) care and infection prevention. On outreach, very high scores were obtained in the provision of permanent methods.
- Areas scoring below 90% in certain countries included medical emergency management at outreach and family planning choice and counselling at both centres and on outreach. Medical emergency management has seen a marked improvement since 2010, increasing from 77% to 85% overall. In 2010 we identified clinical governance as an area for improvement, with a score of 70.5% in 2009 and 77% in 2010. While there is still room for improvement, the 2011 score (82.7%) reflects the considerable progress in clinical governance quality improvement efforts.
- Overall, our mobile outreach programmes achieved similar QTA scores to our centres, an impressive achievement for our outreach teams.

Social franchise members

Members of our social franchises are not owned and operated by MSI, making control of quality more challenging. We have put a lot of work into improving the quality of social franchise members with training, ongoing support and monitoring. Priority areas for social franchising quality are procedures (family planning choice and counselling, voluntary sterilisations, safe abortion and post-abortion care) and infection prevention. Social franchises in 2011 scored highly in most of these priority areas – reflecting the work of our social franchising and clinical teams over the past year to improve these areas. The average score among our franchise programmes increased from 75% in 2010 to 80.5%. Clinical governance and medical emergency management were identified as areas still in need of improvement.

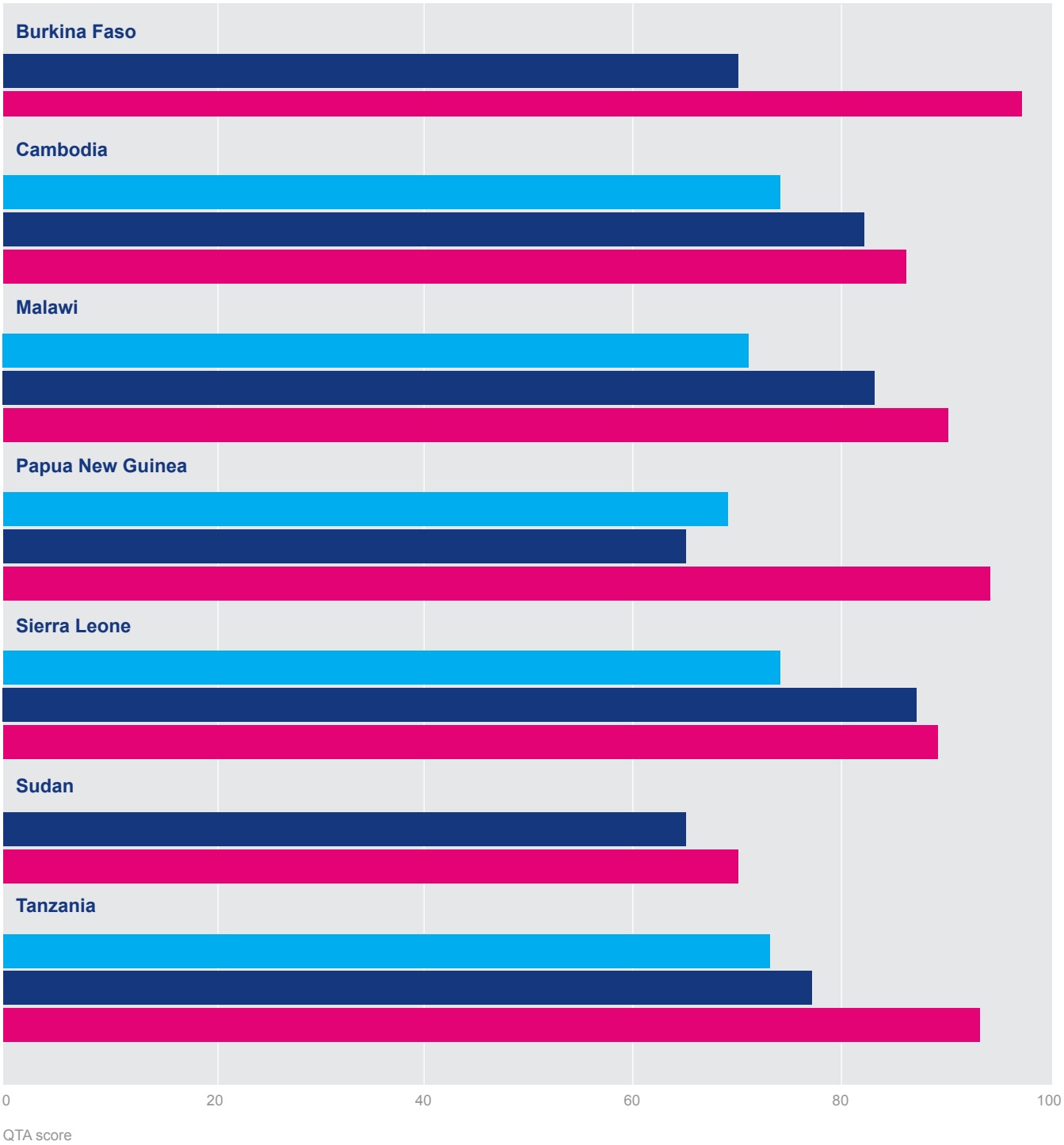


Figure 40:
Trends in QTA scores among programmes that had scores below 75% in 2009 or 2010

Table 4:
Global QTA scores by component and service delivery channel (centres and outreach only)

Indicator	Centres	Outreach
Clinical governance	82.8%	No data / not applicable
Client focus	89.6%	92.4%
Infection prevention	90.9%	89.4%
Medical emergency management	87.3%	82.4%
Family planning choice and counselling	83.6%	78.9%
Sexually transmitted infection (STI)	91.2%	No data / not applicable
Surgical abortion or surgical post-abortion care	92.6%	No data / not applicable
Medical abortion or medical post-abortion care	94.7%	No data / not applicable
Tubal ligation (female sterilisation)	98.7%	92.1%
Vasectomy (male sterilisation)	97.0%	97.3%
Equipment and supplies	85.3%	No data / not applicable
Overall score	90.3%	88.8%

Table 5:
Global QTA scores by component for social franchises

Indicator	Social franchising
Clinical governance	64.5%
Client focus	78.7%
Infection prevention	87.6%
Medical emergency management	70.7%
Family planning choice and counselling	74.3%
Sexually transmitted infection (STI)*	84.4%
Surgical abortion or surgical post-abortion care*	86.0%
Medical abortion or medical post-abortion care*	97.3%
Equipment and supplies	80.8%
Overall score	80.5%

* based on scores from fewer than four countries

Client feedback on quality

We take pride in making the client the focus of our service provision, and tailoring the services, environment and overall experience to best meet our clients' needs and wishes. Client feedback is therefore an important indicator of our success in this area. Figure 41 shows the average satisfaction scores reported by clients from the 15 countries in which we conducted client surveys. The ranges show the lowest and highest scores for each aspect of care.

For all areas of care, the average scores across countries and delivery channels with exit interview data were between 'satisfactory' and 'very satisfactory'. This reflects our commitment to client focus and high quality services in all countries and provider types. Overall, average satisfaction scores were highest for privacy and friendliness and respect from the provider, and lowest for length of waiting time and opening hours, suggesting focus areas for further improvement.

Alternative ways to measure client satisfaction are to ask whether the client would recommend the service to a friend or return to the provider for another service. By both of these measures, over 90% of clients in all countries for all delivery channels with client survey data were satisfied with our services.

Another important aspect of quality care is to ensure that clients are properly informed about what to do and where to go if they suffer a complication following the service. Figures 42 to 44 show the percentage of clients that reported they were told where to go and what to do if they suffered complications from the service they received. This was identified as an area for improvement last year, and this year overall performance was high. Median percentages of clients who were properly informed about follow-up care exceeded 90% for all delivery channels, though the data also helped identify programmes that can improve further. For example, our India MSI programme developed an action plan based on their exit interview findings, including improved counselling training to increase the percentage of their outreach clients that remember being told where to go for follow-up care.

Figure 41:
Average client satisfaction by aspect of care across countries with exit interviews

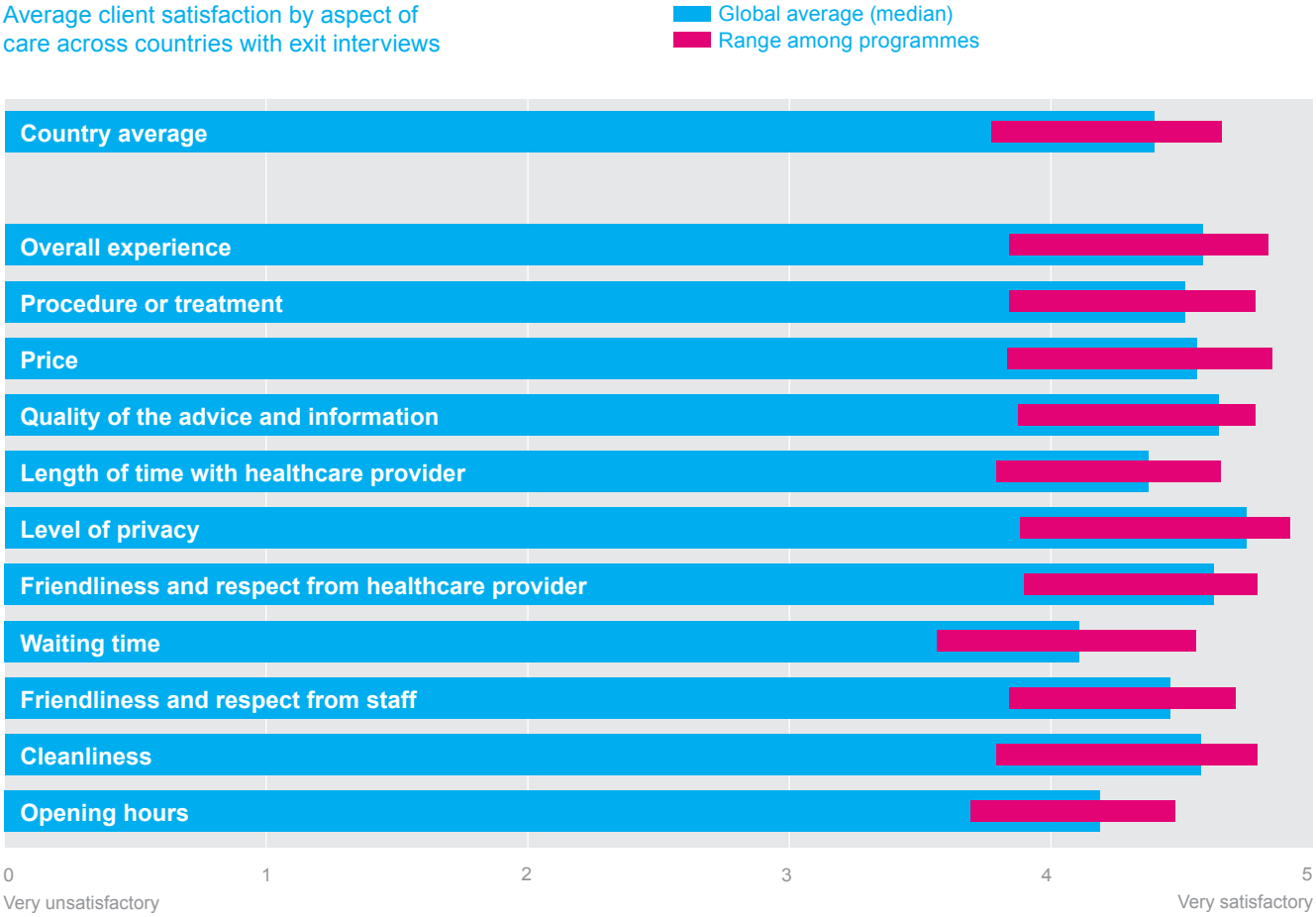


Figure 42:
The percentage of centre clients who remember being told where to go and what to do if they suffered a complication

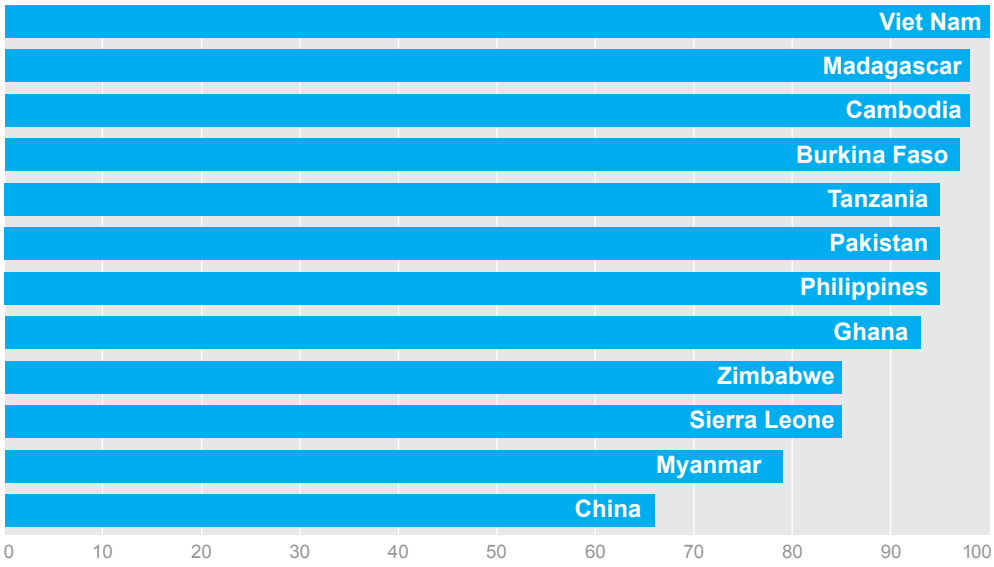


Figure 43:
The percentage of social franchising clients who remember being told where to go and what to do if they suffered a complication

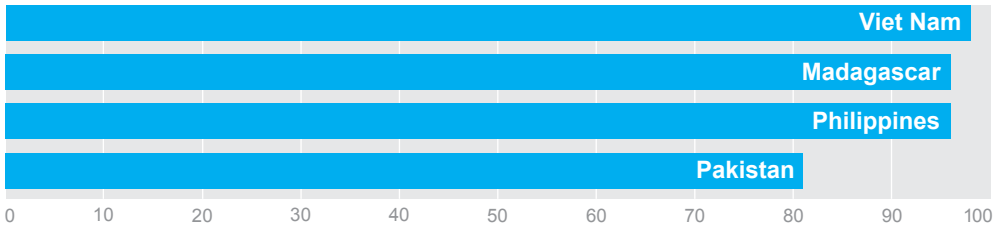
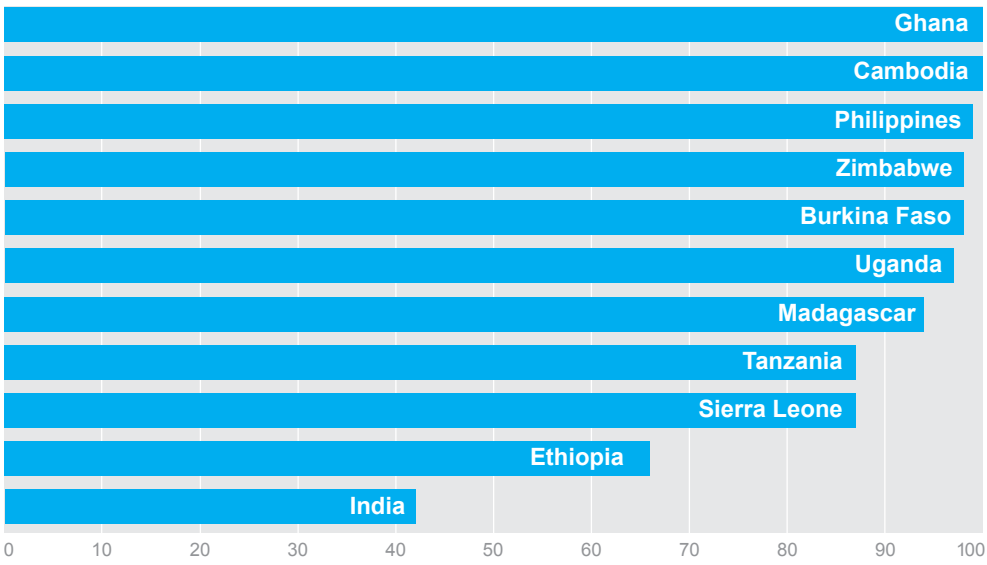


Figure 44:
The percentage of outreach clients who remember being told where to go and what to do if they suffered a complication



Family planning following safe abortion and post-abortion care

Women seeking 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. This is an important indicator of the quality of our abortion and post-abortion care counselling services, and one that we look to continuously improve.[xv] Figure 45 shows that in nine of the 12 countries for which data was available, the majority of our abortion and post-abortion care clients received a family planning method.

However, in most countries, the majority of safe abortion and post-abortion care clients received a short term method and few received an LAPM. Ensuring that after a safe abortion or post-abortion care clients are given proper counselling and receive the method most appropriate to their needs is an area that we are focused on improving.

xv Due to client flows and data capture systems in clinics, these data are challenging to collect accurately without a client-based management information system. Therefore, these may be underestimates for many countries, and at present no clients who return on a different day for family planning are captured.

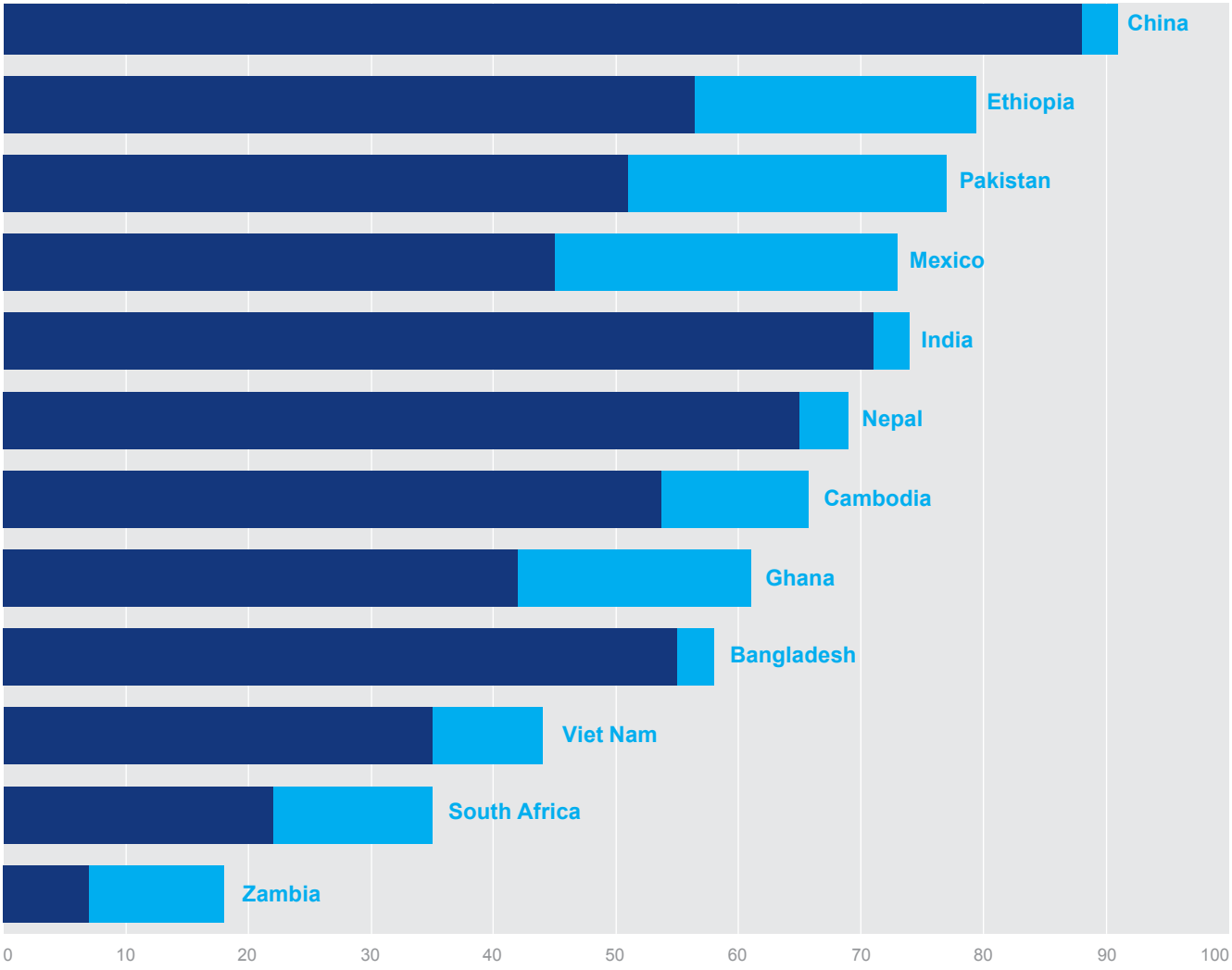


Figure 45:
The percentage of abortion or post-abortion care clients receiving family planning

Short term method
LAPM

Case study:
Driving up quality through social franchising

"Since I've joined the BlueStar network, over 100 women come to my clinic each month. I'm able to help so many more women than before."

"In Paradise Village children beg on the streets because their parents can't afford to look after them. And their mothers keep getting pregnant. I hear about a lot of unwanted pregnancies, but things are improving," says Anna Miranda, a BlueStar midwife who lives and works in Tonsuya in the Philippines.

Paradise Village is a shanty town perched on reclaimed land in Manila, capital city of the Philippines. The optimistic spirit of the community is hard to miss but life is undeniably hard here, "this is a poor area – I have clients who really have nothing".

As a midwife, and resident of Paradise Village, Anna wanted to help women to plan for their families and to give birth in a safe environment. She joined the BlueStar network of family planning and safe delivery clinics a couple of years ago where she received specialist training in reproductive healthcare. Anna's home was then extended and upgraded into a two-storey building to make room for her BlueStar health clinic. Before she joined she described her home as "a cave", a primitive structure prone to flooding. If you see the clean and welcoming BlueStar clinic that now occupies the same space, it's an image that's difficult to reconcile.

And as with her ongoing training, assessments and support, the improvements to the building and branding of the clinic were provided by BlueStar.

BlueStar is a social franchise designed to improve access to quality family planning through a network of private clinics. We launched it in the Philippines in 2008, and now support more than 200 midwives in the country. Prices for clients are affordable, and clinics have an informal sliding scale for cost to ensure no one is turned away.

Access to contraception was limited before Anna's clinic opened and pregnant women relied on traditional health workers, or 'hilots' to deliver their babies at home – a practice with devastating implications when complications arise. Anna is proud of the valuable support she can offer, "since I've joined the BlueStar network, over 100 women come to my clinic each month. I'm able to help so many more women than before."

There are still many barriers to women accessing family planning in the Philippines, but midwives like Anna are making a very real difference, providing quality services to their communities.

Our network of 1,700 BlueStar social franchises is driving up quality and choice of family planning services in remote and challenging areas.

Photo: Marie Stopes International / Veejay Villafranca

Annex 1
Key Marie Stopes International and National Data in 2011

	Couple-years of protection (CYPs) delivered by MSI in 2011	Women using modern contraception in 2011[1]	Women with unmet need for modern contraception in 2011 (this is unmet need + traditional method users)	Women using modern contraception in 2011 provided by MSI[2]	Estimated maternal deaths averted in 2011 due to MSI's services[3]	Estimated unsafe abortions averted in 2011 due to MSI's services[3]
Burkina Faso	70,835	466,241	839,937	26,827	43	1,680
Ethiopia	711,684	3,644,215	3,776,148	257,508	716	82,421
Ghana	138,710	825,544	1,489,660	41,035	176	27,448
Kenya	950,226	2,996,624	1,849,890	599,448	969	68,157
Madagascar	421,809	1,341,113	891,684	218,270	325	27,990
Malawi	696,276	1,175,225	658,964	525,514	611	42,963
Mali	98,129	236,659	809,957	34,020	113	7,447
Nigeria	39,192	4,276,429	6,659,781	12,489	71	8,116
Senegal	2,490	253,473	612,222	610	1	37
Sierra Leone	288,542	Insufficient data	282,447	157,222	470	21,039
South Africa	174,795	6,919,412	671,232	40,948	159	31,712
South Sudan	1,767	19,903	No data	298	1	470
Sudan	5,153	347,408	1,654,749	2,042	4	194
Tanzania	615,795	2,603,120	2,054,927	515,956	949	29,007
Uganda	1,009,104	1,164,094	1,778,976	544,226	675	57,428
Zambia	22,120	869,943	678,096	15,691	25	1,958
Zimbabwe	220,115	1,351,521	268,025	189,258	354	10,740
Africa	**5,466,742**	**28,490,924**	**24,976,695**	**3,181,362**	**5,662**	**418,807**
Bolivia	98,137	616,014	684,740	36,700	18	14,750
Mexico	61,337	14,715,931	2,937,240	14,817	5	13,460
Latin America	**159,474**	**15,331,945**	**3,621,980**	**51,517**	**23**	**28,210**
Cambodia	183,254	900,820	807,880	54,547	49	22,901
China	3,999	234,096,475	7,652,694	1,288	0	0
Timor Leste	14,907	34,449	8,046	9,342	7	626
Mongolia	197,655	371,525	45,300	99,915	10	0
Myanmar	331,635	3,755,867	1,760,738	324,615	147	21,518
Papua New Guinea	23,700	379,666	No data	7,121	4	71
Philippines	1,405,250	5,337,615	5,741,762	863,358	184	64,372
Viet Nam	2,094,012	11,340,550	2,417,064	877,076	231	226,045
Pacific Asia	**4,254,412**	**256,216,967**	**18,433,484**	**2,237,262**	**632**	**335,533**

	Couple-years of protection (CYPs) delivered by MSI in 2011	Women using modern contraception in 2011[1]	Women with unmet need for modern contraception in 2011 (this is unmet need + traditional method users)	Women using modern contraception in 2011 provided by MSI[2]	Estimated maternal deaths averted in 2011 due to MSI's services[3]	Estimated unsafe abortions averted in 2011 due to MSI's services[3]
Afghanistan	390,888	1,181,670	194,446	169,468	587	8,283
Bangladesh	3,159,348	15,497,737	8,555,586	1,451,870	1,631	223,443
India PHS	3,408,584	128,205,651	45,317,734	2,417,504	1,823	439,116
India MSI	1,274,863	128,205,651	45,317,734	232,312	158	12,854
Nepal	647,552	3,246,628	1,544,331	488,715	474	68,066
Pakistan	1,601,773	7,058,718	8,956,850	845,248	644	98,009
Sri Lanka	141,734	1,685,681	779,022	136,486	15	7,330
Yemen	345,346	1,139,847	1,463,580	225,926	103	10,350
South Asia	**10,970,088**	**286,221,583**	**112,129,283**	**5,967,529**	**5,435**	**867,451**
Australia	105,509	3,301,451	145,278	24,637	0	0
Austria	10,547	948,786	44,772	8,030	0	0
Ireland	2,094	834,653	27,216	1,841	0	0
Romania	6,528	2,615,530	1,458,600	368	0	283
United Kingdom	228,819	10,149,401	655,040	93,379	2	0
Developed Countries	**353,497**	**17,849,821**	**2,330,906**	**128,255**	**2**	**283**
Global Sales	432,346					
Developing Countries	**21,283,062**	**586,261,419**	**159,161,442**	**11,437,670**	**11,752**	**1,650,001**
MSI TOTAL	**21,636,559**	**604,111,240**	**161,492,348**	**11,565,925**	**11,754**	**1,650,284**

[1] Regional subtotals include only countries where MSI is currently operating.
[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 2011, and, who are still using a LAPM received in past years.
[3] From MSI's Impact 2 model. These are the estimated numbers of maternal deaths and unsafe abortions averted in 2011; they include impacts from women who received LAPMs before 2011 who were still protected by the method.

Annex 2:
About Marie Stopes International

Our vision: a world in which every birth is wanted.

Some 358,000 women die each year as a result of pregnancy and childbirth. In developing countries, a woman dies every 11 minutes from complications arising from an unsafe abortion. An estimated 215 million couples around the world have no access to modern family planning.

Marie Stopes International exists to help them.

All around the world, women trust us to provide them with a full range of quality reproductive health choices. And we don't just wait for them to come to us. We take our services to the people who want them, bringing voluntary family planning, safe abortion (where permitted), post-abortion care and maternal health support to people in under-served communities who would not otherwise receive them.

In 2011, 11 million people used an MSI supplied method of contraception. We have more than 600 clinics, and more than 300 outreach teams working in hard to reach urban slums and remote rural locations. We will never turn someone away because they can't pay.

Children by choice, not chance

Choice is fundamental to everything we do. We respect the right of women to decide whether and when to have children. For those who choose to prevent a pregnancy, we provide a full range of modern family planning methods, along with counselling about each method. Where it's permitted, we provide safe abortion, as well as a range of maternal health support. It's all about what is most suitable for each individual and for each couple; we give them the information they need to make their own choices.

Preventing unsafe abortion

We recognise that in all societies – whatever the legal situation or the availability of contraception – some women will seek to end unwanted pregnancies. And we know that unsafe abortion remains a major global public health concern. Every year five million women require urgent medical attention as the result of unsafe abortion and 47,000 women worldwide die from complications due to unsafe abortion – representing 13% of all deaths from pregnancy-related causes. But the harm caused by unsafe abortions is preventable, regardless of setting. So we strive every day to reduce the potential harm to women from unsafe abortion, by:

- providing family planning, making contraception accessible and providing counselling on its correct use
- providing training to mid-level medical abortion providers, and increasing access to both surgical and medical abortion (where permitted)
- providing post-abortion care, to treat the harm caused by unsafe abortions
- working towards an enabling policy environment that respects women's health and safety and their ability to make informed decisions about their reproductive health.

Reaching the under-served

We are committed to bringing our services to the most under-served communities via our 600 centres, the 1,700 private providers who belong to our franchise networks and our 300 outreach teams. Together, they work in a wide range of urban slums and remote rural settings – all offering free or heavily subsidised services.

We also deliver family planning, post-abortion care and other sexual and reproductive health services to refugees, displaced people or those affected by conflict or natural disaster. In these situations, basic health services often fall apart, leaving women particularly ill-equipped to prevent or deal with an unintended pregnancy. We have helped humanitarian agencies, working in crises and emergency settings, to provide reproductive health services as part of a basic healthcare package.

Partnership and innovation

We can't do all this on our own, though. Partnership with others is a cornerstone of our work. We work closely with existing private healthcare providers, with governments and with other aid agencies. Together we deliver services, strengthen national health systems, provide training, improve health policies and share expertise. All of this is essential for building sustainable services that will help people to manage their health, their families and their futures as safely as possible. We've pioneered innovative ways to get our services to the people who need them most. Our voucher and social insurance schemes are enabling poor women to access free or subsidised services through a range of quality assured outlets.

Working with the private sector

Studies show that a large proportion of poor people use private healthcare providers for most of their health needs. We've developed a 'social franchise' network called BlueStar that works with existing private healthcare companies in developing countries, in much the same way as a commercial franchising operation. The companies pay us a minimal fee to license as franchisees. In return they receive high quality medicines and other products at a reduced price from us, which they sell to clients according to an agreed pricing structure. In addition, we provide extensive and ongoing training, and monitor the quality of their services, to ensure that they meet our international standards.

Since its inception in 2004, the BlueStar network has trained, branded and promoted more than 1,700 private healthcare providers in developing countries, helping to drive up quality and choice of family planning services in remote and challenging areas.

Our commitment

We are committed to bringing family planning ever closer to those who need it on a worldwide basis. We will evolve our centres to the needs of those who use them, and continue to innovate to increase quality and choice in reproductive health. We will maintain our focus on clinical quality and operational excellence supported by a strong evidence base. We will continue to forge enduring connections with governments and other key organisations to influence policy, funding and practice for family planning and safe abortion at the country level and globally. And we will always be led by the needs of the women and couples who need us most.

Annex 3:
Data sources and methods

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

Impact 2

Impact 2 replaces two previous MSI models, REACH Calculator 1.2 and Impact Estimator 1.2, with improved data sources and methods. The model 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, PSI, and the United Nations Population Fund (UNFPA).

The model 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 was used in this report as follows

- Figures 3, 6, 8, 12, 13, 14, 15, 31, 32, 33: 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 31 to 33, the general population refers only to the population in the countries we work in. The number of users of MSI short term methods in 2011 is estimated by multiplying the number of short term method products distributed by CYP conversion factors. This gives a number that is equivalent to the number of people protected by the short term contraceptives for a full year.
- Figures 6, 12, 31, 32, 33: Estimates of national CPR and national family planning users. Impact 2 creates modified linear trends based on the two most recent CPR estimates; these are applied to UN population projections of women of reproductive age to estimate national users. When available, CPR and user estimates are for all women, not married women.
- Figures 9, 10, 11, 16 and 17: Estimates of both annual and service lifespan impacts (ie unintended pregnancies averted, maternal deaths averted, unsafe abortions averted, costs saved in healthcare spending). Impact 2 models impacts averted based on method-specific service provision data. In some cases, results from multiple scenarios were compared (ie impact if all LAPM clients instead used pills), by entering different combinations of service data.

UN Wallchart

Data on contraceptive use and unmet need globally in Figures 2, 5 and 7 were based on the UN wallchart, which is in turn based on national surveys of contraceptive use such as Demographic and Health Surveys. We used the Guttmacher Institute definition of unmet need, which includes users of traditional family planning methods.

Figure 4: Estimates for the number of years it would take to reach 60% CPR at current trends in different sub-regions were calculated with the following formula: numbers of years = (60% - current CPR) / average annual percentage point growth over the last decade. Estimates for the number of years it would take to reach 60% CPR if we could achieve annual growth of two percentage points was calculated with the following formula: numbers of years = (60% - current CPR) / 2%.

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.

DHS data were used for the contraceptive prevalence rates in Figures 18 and 19, and for the national comparisons in Figures 20 to 24.

Client surveys

Data in Figures 20 to 30 and 41 to 44 were taken from standardised client surveys, which in 2011 were conducted in 17 countries. Note that data is only presented for the countries and delivery channels for which data is available. We improved our sampling strategies in 2011, using random samples designed to result in maximum +/- 10% confidence intervals at the 95% level.

- Figures 20 to 22: Poverty figures were estimated using ten poverty assessment questions in exit interviews, 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) that were used for comparison were taken from the World Bank website.
- Figures 25 to 27: 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.
- Figures 28 to 30: Switcher data were based on the same questions about the client's past contraceptive use.

Outreach evaluations

We conduct periodic evaluations of our outreach programmes, which involve interviews with random samples of our clients after receiving a service and then follow up interviews after specific periods (usually at least three months and one year post-service). Outreach evaluation data was used for Figure 39.

Quality Technical Assistance (QTA)

A QTA visit is a clinical quality assurance visit by an MSI medical advisor that combines assessment with on-the-job training. We aim to undertake QTA visits of all country programmes at least once a year. QTA data is used in Tables 4 and 5.

Management information system and MSI statistics

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, the number of maternal deaths that could be prevented by meeting current unmet need and other data that is used in the report. The report also provided the data used in Table 1 on the costs per DALY of various health interventions.

Annex 4: Glossary

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

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 PAC 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.

Disability adjusted life year (DALY)

One DALY can be thought of as one lost year of "healthy" life due to sickness or disability. Health interventions can be compared according to the healthy years that they add to a person's life and health problems can be compared according to the number of healthy years by which a person's life is reduced.

Intrauterine device (IUD) or intrauterine system (IUS)

IUDs and IUSs are small, T-shaped devices made of flexible plastic. A healthcare provider inserts the device into a woman's uterus to prevent pregnancy. Some use copper and some use the hormone progestin to prevent pregnancy.

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

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 choice of modern family planning methods. It also includes identification and treatment or referral for sexually transmitted infections.

Service lifetime impacts

Based on the services delivered in a given year, but spread over a number of future years for LAPM. This result is the most comparable with CYP-based impacts from older versions of MSI's Impact Estimator.

Total impacts

All impact results shown in this report are total impacts. Total impacts count the full impact of services – ie including impacts to women who were already lowering the national burden because they were already protected by family planning. For example, the total number of maternal deaths averted in 2011 includes maternal deaths that were already being averted previously because some women were already using family planning. This means that impacts are not comparable to national burdens.

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, 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 continue to use it in 2011.

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

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