



MARIE STOPES
INTERNATIONAL

Global Impact Report 2010

Expanding choices and
access for women globally

**Marie Stopes
International delivers
quality family planning
and reproductive
healthcare to millions
of the world's poorest
and most vulnerable
women.**

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

Our mission:
**children by choice
not chance.**

Our core values:

Mission-driven:

we go to work every day to enable more women to have children by choice, not chance.

Customer-focused:

we meet the needs and exceed the expectations of all our customers: service users, donors, host governments and fellow team members.

Results-oriented:

we achieve high quality, measurable outcomes, rather than focusing on inputs or processes.

Pioneering:

we remain at the forefront of family planning, safe abortion and reproductive healthcare globally by learning, innovating and taking risks.

Sustainable:

we build effective programmes and change behaviours that will have a lasting impact for individuals, their communities and their countries.

People-centred:

we know that our continued success depends on the creativity, commitment and courage of MSI team members worldwide.

Foreword

Welcome to the Global Impact Report 2010 for Marie Stopes International (MSI). This report summarises progress during 2010 towards our global mission – “children by choice, not chance”.

215 million women around the world have an unmet need for family planning.¹ A woman dies every 11 minutes in developing countries from complications arising from unsafe abortion – an entirely preventable cause.² MSI exists to reach the underserved, by providing them with the fullest possible range of reproductive health choices, including modern contraception, safe abortion services (where legally permitted) and post-abortion care.

MSI values evidence-informed decision making and transparency and is committed to monitoring and evaluating the public health impact that we are making across the globe. As MSI strives to deliver high quality services to millions through its innovative health service delivery models, we place great importance on understanding whether MSI is reaching those women and couples with the greatest need, and whether MSI is having an impact on a national, regional and global scale.

The data in this report are derived from routinely collected service statistics from all of MSI’s country programmes, clinical quality assessments, outreach evaluations and standardised client exit interviews, along with other research findings. These data are analysed and compared with externally validated third party data, such as Demographic and Health Surveys (DHS), using various analysis methods and models such as MSI’s Impact Estimator and REACH Calculator.

We hope that this report serves as a valuable source of information to track our progress towards achieving the shared global goal of providing accessible and affordable modern contraception and safe abortion services.

I am grateful for the dedication of MSI’s 8,000 team members who strive every day to ensure women across the globe have the power to make informed choices about their reproductive rights and family size, their fertility and their futures.



Dana Hovig
Chief Executive Officer

Acknowledgements

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Referencing

Throughout the document superscript numbers⁽¹⁾ denote bibliography references and superscript letters^(A) denote sidenotes.

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Executive summary

Increasing choices and changing lives

Approximately 215 million couples have an unmet need for family planning,¹ and some 358,000 women die each year in delivery and pregnancy worldwide.³ An estimated 94,000 maternal deaths would be averted and \$1.5 billion saved on maternal and newborn health services if this unmet need were met.⁴ 21.6 million women undergo unsafe abortions every year, resulting in 47,000 maternal deaths.² Marie Stopes International operates in 40 countries, seeking to expand choice in voluntary family planning and reduce the harm caused by unsafe abortion through the provision of safe abortion (where permitted) and post-abortion care services.

By the end of 2010, an estimated 7 million couples⁵ or more were using a family planning method provided by MSI. Users of MSI contraceptives tended to choose a wider or different variety of methods than the general populations in their countries, indicating that MSI enriched the method mix and provided its clients with an expanded choice of contraceptives (see section 2.2 for more detail).

Unsafe abortion remains a major global public health concern and a human rights imperative. Reducing unsafe abortion is a key priority for MSI. In addition to the 7 million women that were using voluntary family planning as a result of MSI during 2010,^A an estimated 1 million or more women accessed MSI services for a safe abortion (where legally permitted) or for treatment of complications relating to an unsafe abortion.

These figures translate into 21 million couple years of protection (CYPs) across the globe.

MSI's success in delivering services to so many women and men is attributable to the use of innovative and diverse service delivery approaches, such as:

- a strong clinical base of 629 MSI centres, which form the backbone of MSI's service delivery infrastructure
- mobile clinical outreach to rural communities, providing free or subsidised voluntary family planning
- financing schemes, such as insurance and vouchers, which lower financial barriers to access
- public-private partnerships to expand distribution networks with social franchising and social marketing
- partnerships with government to provide services in and out of their facilities
- community-based health workers and mobilisers and
- task shifting (delivery of services by mid-level providers rather than physicians).

A: From MSI's REACH Calculator, excluding MSI users of short-acting methods of contraception.

As a result of the services provided by MSI in 2010, it is estimated that 4.8 million unintended pregnancies, 13,000 maternal deaths and 1.3 million unsafe abortions will be prevented⁶. It is projected that the health impact of MSI's reproductive health work alone will save families and healthcare systems in 36 developing countries over £400 million.^B

B: From MSI's Impact Estimator.

Central to expanding choices is MSI's strategy of reaching underserved groups - the poor, the young and those with an unmet need for family planning. In 2010, approximately one in five of MSI's clients were living below the extreme poverty line (less than \$1.25 per day). One in three clients had not completed primary education. One in three clients was under 25 years old. An estimated 40% of MSI's family planning clients reported that they had never used family planning before coming to MSI. However, there is still much work to be done to reach the underserved, in particular to ensure that the poorest of the poor have equitable access to modern voluntary family planning services.

While serving large numbers of people in need, MSI programmes were able to maintain consistently high quality and client-focused services. Quality technical assessments found that 82% of country programmes were satisfying MSI's global clinical standards. Discontinuation studies from MSI's clinical outreach services revealed that the percentages of MSI clients discontinuing use of IUDs in countries such as Bangladesh and Viet Nam were far lower than the national average, suggesting high quality counselling and clinical services. Client exit interview data suggests that over 90% of clients from all service delivery channels were satisfied with MSI's services, reporting that they would recommend MSI services to a friend and that they would return to MSI for future services. This reflects the emphasis MSI places on putting clients' needs at the centre of our service provision. An evaluation of MSI's mobile clinical outreach services shows similarly high quality and client satisfaction scores, even in challenging remote environments.

MSI's success in 2010 improved public health outcomes, particularly maternal health, and reduced the burden for health system spending in developing countries. MSI programmes were able to reach a large number of extremely poor and less educated people.

There is still much to be done in addressing the huge unmet need for family planning and eradicating unsafe abortion in developing countries. MSI has recently completed its 2011-2015 strategic plan, which sets out how MSI will contribute to finally completing the family planning revolution started 40 years ago, so that every woman in every country can choose:

- the number of children she desires
- the spacing of their births
- her preferred contraceptive method, if any
- from her preferred provider.

Chapter 1: About Marie Stopes International

To address the huge unmet need for family planning that exists globally, and to reduce the harm caused by unsafe abortion, Marie Stopes International (MSI) provides women and men with access to comprehensive voluntary family planning services. Over the past 35 years, MSI has delivered high quality services through innovative service delivery models that serve the underserved and reach the unreached. These service delivery channels include MSI centres, mobile clinical outreach programmes, social franchising clinic networks, social marketing programmes and community-based delivery.

Marie Stopes International's structure

Founded in 1976, MSI has grown from a single centre in London to become one of the largest global providers of voluntary family planning with operations in 40 countries spread across Africa, Asia, Europe and Latin America.

MSI's 629 centres form the backbone of the organisation's service delivery infrastructure. MSI centres are designed to be comfortable, non-intimidating environments where women, men and adolescents receive information about their reproductive choices and access vital services. They are often referred to as the gold standard in reproductive health service delivery in their countries, demonstrating to host governments and other providers what is possible in terms of quality, safety, productivity, confidentiality and customer focus.

Extending from these centres are MSI clinical outreach teams, which provide services to hard to reach populations in around 6,000 rural locations and urban slums. MSI outreach teams bring family planning choices to women and men in rural and remote areas who otherwise would have access to only short term methods or no family planning at all. MSI's outreach approach transforms government facilities, community buildings and even workplaces into sterile surgical environments to deliver intrauterine devices (IUDs), implants, female sterilisations, vasectomies, short term contraception and other reproductive health services when needed.

To expand clients' choice of provider, MSI also works with public, private and other non governmental organisation (NGO) health providers to broaden access to voluntary family planning and safe abortion services. As an organisation that always seeks new ways to deliver services, MSI uses the following innovative approaches:

- social franchising - MSI's franchise networks now comprise more than 1,300 private, public, faith-based and NGO healthcare providers that deliver a range of high quality family planning, safe abortion (where legally permitted) and post-abortion care choices to low income women in their communities
- demand side financing - MSI reimburses accredited private or NGO healthcare providers for providing sexual and reproductive health services, often through voucher schemes that transfer purchasing power to the poor and vulnerable
- community-based distribution - MSI brings contraceptive commodities directly to hard to reach populations by providing training and supplies to community health workers and members of the community
- social marketing - MSI increases access to affordable condoms, contraceptive pills and emergency contraception through pharmacies and non-clinical settings.

Service delivery is complemented with marketing and behaviour change communication campaigns that improve health-seeking behaviour and build social support for sexual and reproductive health within communities. MSI country programmes receive programme, technical, financial and human resource technical assistance from MSI support offices in London, Melbourne and other regional offices in Nairobi and New Delhi.

Public-private partnerships

MSI strengthens national health systems by training and working in partnership with public and private sector providers, through franchise networks, government contracting out to MSI, participation in social insurance schemes and increasingly through demand side financing initiatives which allow women to choose reproductive health services from accredited public and private providers. MSI also assists partners and host governments by developing and distributing high quality and low-cost medical supplies and equipment, and disseminating research findings, best practice and innovations. MSI ensures that sexual and reproductive health (SRH) remains high on the agenda and works with key decision makers, such as national health and population ministries and donors to overcome the key policy and social barriers to greater provision and uptake of SRH services.

Funding

In 2010, MSI spent £83.3 million on activities in developing countries. MSI operates as a social enterprise, which means that surpluses generated by income-generating parts of the organisation are used to subsidise services for women who cannot afford to pay, such as poor and rural clients accessing MSI's mobile outreach sites. Income from MSI centres in better off urban areas of developing countries covers about 27% of country programme costs, with a further 7% contributed from MSI's own reserves.

Institutional donations from bilateral and multilateral donors and a number of private trusts and foundations in the UK and the US have grown in recent years, and now represent two thirds of MSI's funding for developing country operations.

Figure 1: MSI's sources of income for developing country programmes in 2010





Case study Tigist's story

It is nine in the morning and Tigist has just finished feeding her two youngest children. She steps out of the house in her blue uniform, carrying her bag filled with leaflets, contraceptive supplies and the notebook with her appointments. Tigist is a community-based distributor for Marie Stopes International in the Merkato area of Ethiopia's capital Addis Ababa. She lives and works in Merkato, travelling around the community to ensure that women in her area can access family planning and other vital sexual and reproductive health services.

First on her list of appointments is Saada. After having twins, Saada decided with her husband that two children are enough, for the moment. "It's so expensive here in Addis" she tells Tigist, "and I have to send money back to my family in Walisso". After talking with Tigist about all the options available she decides to carry on taking the pill, but Tigist will go back and see her regularly to make sure that she has the option to switch to another method of contraception if she chooses to.

Next on her round is Zeitu, a frail looking 30 year old mother of four children. She gave birth to her first child at just 14, having been sold into marriage in her village in Wollo in the Amhara region two years earlier. "Four children are enough," Zeitu tells Tigist, "I'm tired and the little money I make as a seamstress just isn't enough to feed us." Tigist visits her regularly and makes sure that she is able to access the family planning method that suits her and helps achieve her reproductive choice of not falling pregnant again.

Tigist visits women like these each and every day, making sure that they can access and choose the contraceptive that is right for them. She is typical of the 8,000 men and women that work for Marie Stopes International, delivering life changing services in some of the most underserved and hard to reach communities in the world. It is their commitment that allows Marie Stopes International to deliver the impact that it does, and it is their effort and dedication that sits behind each of the numbers in this report.

"Four children are enough... I'm tired and the little money I make as a seamstress just isn't enough to feed us."

Photo: Marie Stopes International / Guy Calaf

Chapter 2: Expanding choice in family planning

This chapter explores the extent to which MSI expanded choices in family planning methods in 2010. It outlines the channels through which women and men are accessing MSI services, as well as the contributions MSI has made to national contraceptive use in the countries in which it works.

215 million	women globally have unmet need for family planning ¹
75 million	unintended pregnancies occur every year ¹
358,000	women die every year in delivery and pregnancy, almost all in developing countries ³
94,000	maternal deaths could be prevented each year if all women had access to family planning services ⁴

Table 1: Key global facts: unmet need for family planning

Overview

Voluntary family planning is essential to help women achieve gender equity, engage politically and contribute to economic growth. It is also one of the most cost effective of all public health interventions.⁷ MSI believes that it is a woman's right to make informed choices about the timing of her pregnancies and the number of children she has.

Providing family planning choices to underserved women and men is key to MSI's mission - "children by choice, not chance". Through its comprehensive family planning programmes, MSI expands choices in the following ways:

- choice of whether to use contraception - ensuring all women and couples, irrespective of education, residence or wealth, can access affordable modern services
- choice of method - ensuring women and couples can choose the most appropriate method to meet their circumstances. Short-acting contraceptive methods such as pills and condoms are often the only method available, and supplies can be intermittent. MSI focuses on expanding the method mix to include implants, intrauterine devices (IUDs), female sterilisation and vasectomy. These are effective and reliable options that are rarely available to women in developing countries
- choice of quality provider - public, NGO and private - making sure all clients can reach services from a provider they trust within easy distance from home
- choice regardless of ability to pay - ensuring all couples can afford services, whether they are free, subsidised, targeted through vouchers, full cost or paid through health or social insurance schemes.

Table 2 (p.16) shows the number of each method of contraception MSI provided during 2010 across 40 countries.

Data sources

In Chapter 2, two different measurements are used: couple years of protection (CYPs) and family planning users.

User figures are the numbers of people who were using an MSI family planning method during 2010. A user may have been provided with a long-acting or permanent method in a previous year and may continue to use it in 2010.

CYPs illustrate the scale of services delivered by MSI during 2010. One CYP is the equivalent of one year of contraceptive protection for one couple. Some of the 2010 CYPs will actually be "used" over future years, because they come from long-acting and permanent methods. For instance, an IUD is equivalent to about five couple years of protection.

The limitations associated with CYP figures are that the evidence base for the conversion factors is limited and out of date, and consequent updates

have led to differing factors within different organisations. USAID is currently working to update and standardise CYP conversion factors.

MSI user numbers are estimated using MSI's REACH Calculator⁵, a tool that uses mathematical models to convert the number of services MSI has provided over the years into the number of users of MSI contraceptives there were in each country in a given year. At present MSI is excluding MSI users of short-acting methods, due to methodological difficulties in creating accurate estimates of current user numbers from number of pill cycles, condoms and injections delivered by MSI each year. Therefore all MSI user figures presented in this report are underestimates.

Table 2: Number of services provided by MSI globally in 2010

Service	Number
Male condom	155,409,777
Female condom	415,809
Oral contraceptive pill cycle	11,973,761
Injectable	1,546,870
IUD	1,047,389
Implant	316,825
Female sterilisation	575,465
Vasectomy	127,876
Emergency contraception	435,134

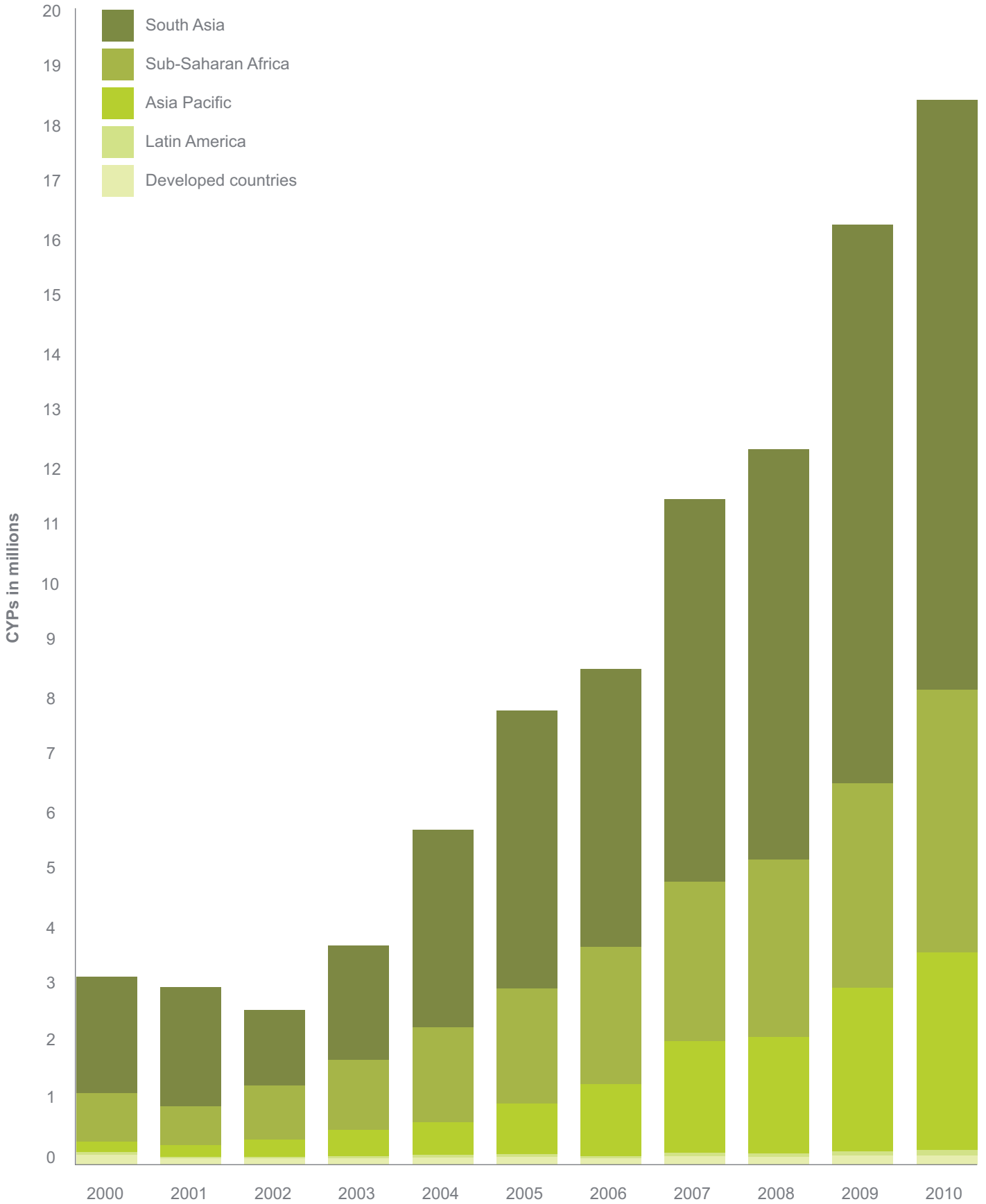
Family planning CYP trends

In the past eight years, the number of CYPs provided by MSI each year through voluntary family planning services has increased dramatically (Figure 2). Of MSI's family planning CYPs delivered in 2010, 56% were generated by country programmes in south Asia^c, 24% came from programmes in sub-Saharan Africa, 17% from Asia Pacific, 1% from Latin America (Mexico and Bolivia), and 2% from developed countries (Australia, Austria, Ireland and the UK).

Figure 2 shows that MSI's family planning service provision has expanded in all regions. The most dramatic overall increases were seen in south Asia, while Africa and Asia Pacific have also seen strong growth. Notably in 2010, MSI's programmes in sub-Saharan Africa witnessed the strongest CYP growth between 2009 and 2010. MSI's programmes in Latin America are relatively small, but are growing rapidly, with a 43% increase in CYPs between 2009 and 2010.

^c: The region 'south Asia' referred to in this document includes Yemen.

Figure 2: Trends in MSI's family planning CYP provision, 2000–2010



Choice of contraceptive methods

D: Estimates generated by MSI's REACH Calculator⁵. As mentioned previously, this is an underestimate - millions of MSI's short term method users are not included here, due to methodological difficulties in creating an accurate estimate.

In 2010, over 7 million couples^D were using long-acting or permanent contraception as a result of MSI services. This includes a proportion of clients from previous years who are estimated to still be using their IUD, implant or sterilisation in 2010. Almost half of these users were in south Asia and over a quarter were in sub-Saharan Africa. Figure 3 shows the global increase in MSI contraceptive users over the past five years, along with the variety in the methods they were using.

Figure 3 shows that users of MSI LAPMs have tripled in the last five years. These increases were spread across all method types. While introducing and expanding access to LAPMs is important for MSI programmes, short term methods are offered in parallel. MSI counsels clients about the full range of short term, long-acting and permanent methods available to them, in order that they can make informed choices about which method is most suitable to them. Short term methods are often available through government or other providers in the areas where MSI works, while there is huge unmet demand for more effective and long-acting methods, due to a lack of supplies and trained staff. This approach results in a more diverse method mix that better reflects the varied desires and needs of clients.

Expanding access to LAPMs to meet women's needs is particularly important in sub-Saharan Africa and south Asia, where a full range of methods is rarely available and where family planning uptake is often motivated by women's desire to limit the number of births. For women in areas with poor supply chains, LAPMs also offer a more reliable option.

The distribution of users by contraceptive method differs according to the region. Figures 4 to 7 show differences in contraceptive preferences among MSI 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. MSI needs to work in other regions to ensure that people are properly informed about and have access to this option
- the only region where MSI's implants are widely used is in Africa, although they are also becoming more common in Latin America. This may be due to cost - there has so far been limited registration of the new affordable generic implant, Sino II.

Figures 4 to 7 also compare methods chosen by MSI clients with methods used nationally in the regions in which MSI does most of its work - sub-Saharan Africa, south Asia and Asia Pacific. These figures demonstrate that MSI is expanding access to a wider choice of methods. The source of the regional general population method mixes is the REACH Calculator, which uses data from the most recent DHS or national family planning surveys available for those countries.

Figure 3: Number of MSI LAPM users, by method, 2006–2010

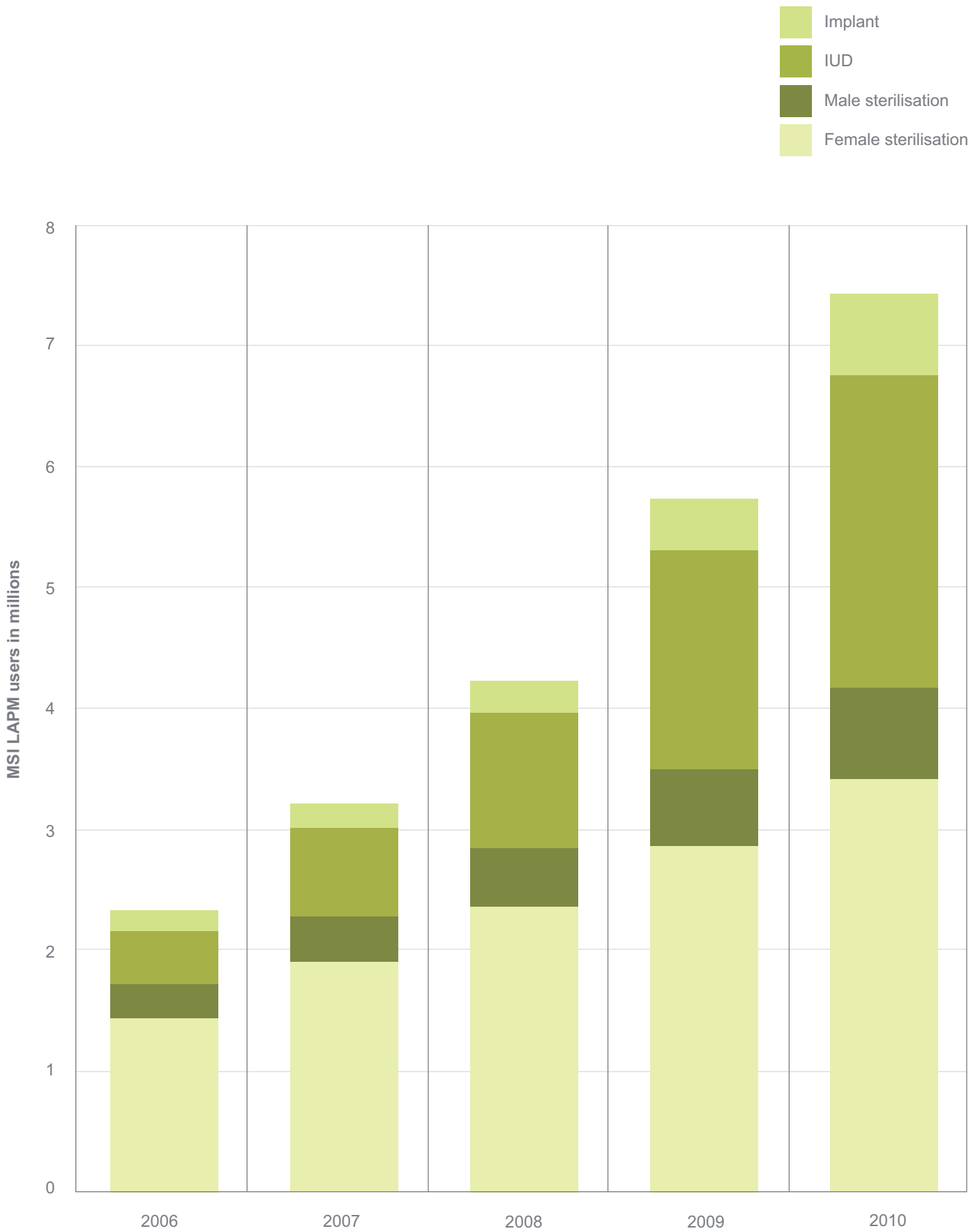
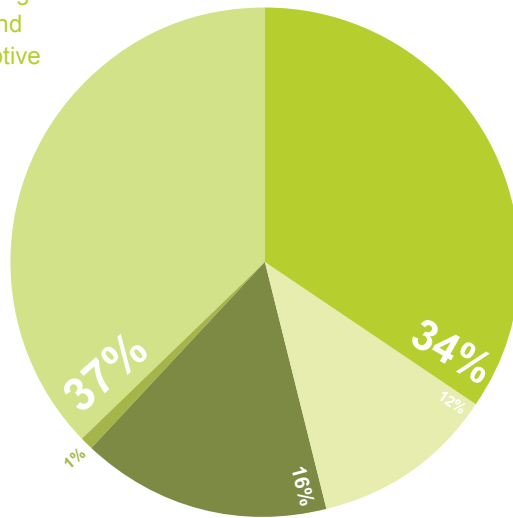
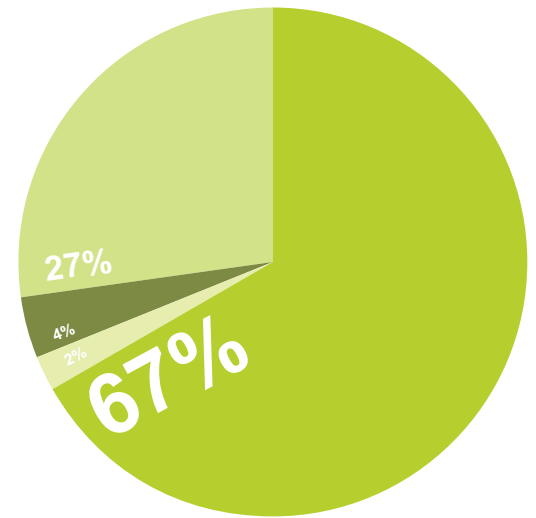


Figure 4: Method mix among MSI contraceptive users and national modern contraceptive users in south Asia

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

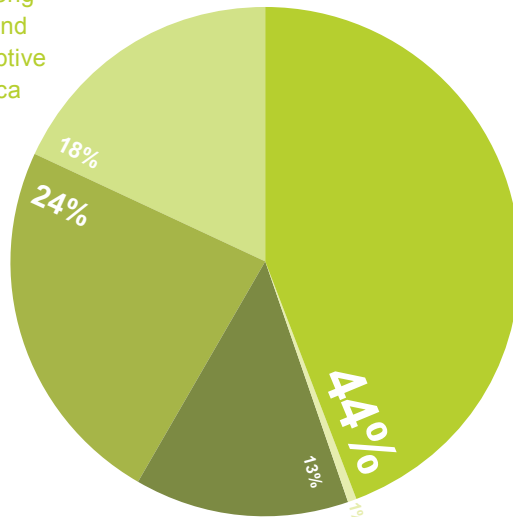


MSI users

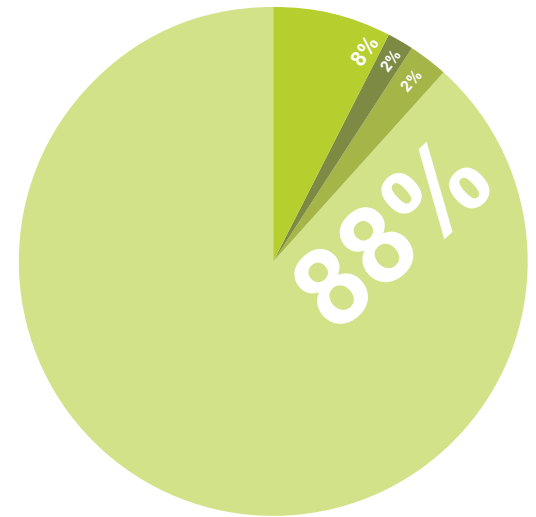


General population

Figure 5: Method mix among MSI contraceptive users and national modern contraceptive users in sub-Saharan Africa

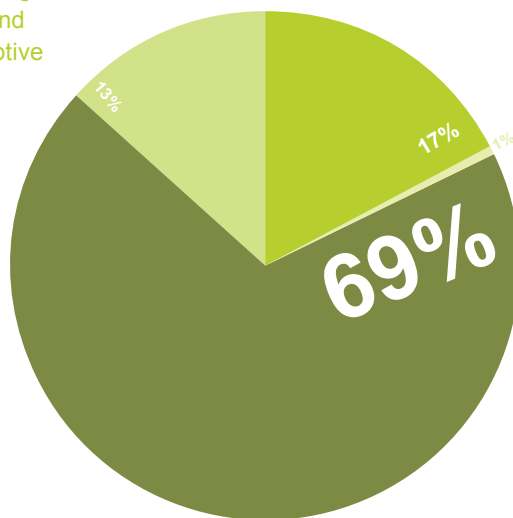


MSI users

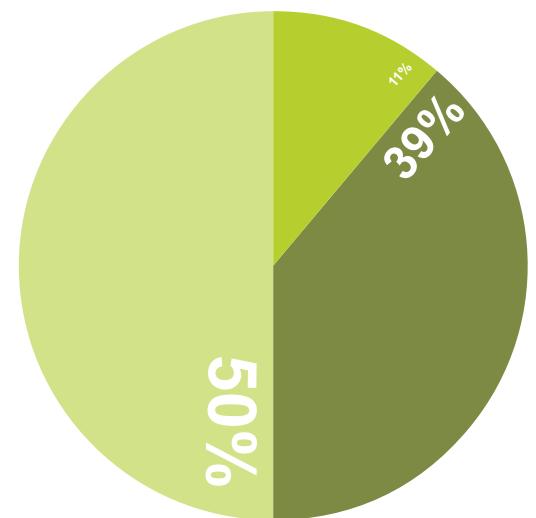


General population

Figure 6: Method mix among MSI contraceptive users and national modern contraceptive users in Asia Pacific (not including China)



MSI users



General population

In the countries of south Asia in which 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. MSI expects to see increasing interest among our clients in contraceptive implants in future years, as the cheaper generic Sino II implant is registered in more countries in the region.

In the sub-Saharan African countries in which MSI works, the vast majority of modern method users rely on short term methods. Meanwhile, among MSI users, a far wider variety of methods were chosen, especially implants, IUDs and voluntary female sterilisations, suggesting high levels of unmet demand for LAPMs in the region. The large number of MSI clients that chose to use IUDs represents an important achievement in expanding choice. IUDs have historically been unpopular, accounting for just 2% of contraceptive use in sub-Saharan Africa.⁸ This is despite the IUD being a particularly effective and affordable form of contraception, well suited to women wishing to space and time their next birth.

In the Asia Pacific^E countries in which MSI works, more than half of modern contraception users rely on short term family planning methods, with most of the remainder using largely IUD 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 MSI clients chose an IUD over short term methods, which may reflect widespread unmet demand for more long-acting reversible methods. These methods are important to allow women to choose the timing and spacing of births. Expanding access to implants is a priority over the coming years in this region, so that a fuller range of choices is available.

^E: China is excluded from these figures since the population is large enough to distort the general population method mix, while the MSI programme there is relatively small.

Data sources

In figures 4 to 7, the general population refers only to the population in the countries where MSI works. The number of users of MSI short term methods in 2010 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. These approximate estimates are

included here solely to enable comparison with national populations. MSI does not consider these estimates to be robust because the evidence base behind the CYP conversion factors is limited, and because this method cannot distinguish between one woman using four injections for 12 months of protection, or four different women using one injection each, lasting just three months.

Choice of service provider

As well as expanding people's choices in contraceptive methods, MSI increased choice in the types of providers from which women and men can access voluntary family planning services. This is vital to ensure that people in all areas have convenient geographical access to quality services from a provider that they trust. Figure 7 shows the distribution of MSI CYPs provided through different service delivery channels. Of all CYPs generated through the provision of contraceptives in 2010, 60% were delivered through mobile clinical outreach programmes, 18% through MSI centres, 17% through social marketing sales and 5% through social franchise clinical networks.

The delivery channels vary in numbers of CYPs delivered as well as the distribution of services types provided. For example, MSI mobile outreach services focus on long-acting and permanent methods (LAPMs), to complement existing supply of short term methods from government or other providers in the hard to reach areas MSI teams visit. Social marketing is better suited to providing short term methods, which do not require a health professional's presence. Figures 8 and 9 investigate in more detail which delivery channels are best suited to which different types of family planning methods.

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 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 onto the national essential drugs list.

By reducing the number of unwanted pregnancies, effective methods of contraception such as Sino-II contribute to lower levels of maternal morbidity and mortality, in turn reducing pressure on healthcare provision. Sino-II has particular potential to positively impact the lives of millions of women around the world seeking to achieve healthy birth spacing and timing.

The fact that it is supplied with a disposable trocar (syringe) eliminates the need to sterilise equipment in an autoclave, therefore reducing the potential for infection. This is particularly applicable to MSI mobile clinical outreach teams which regularly work in challenging remote, rural areas.

Figure 7: CYPs by delivery channel in 2010

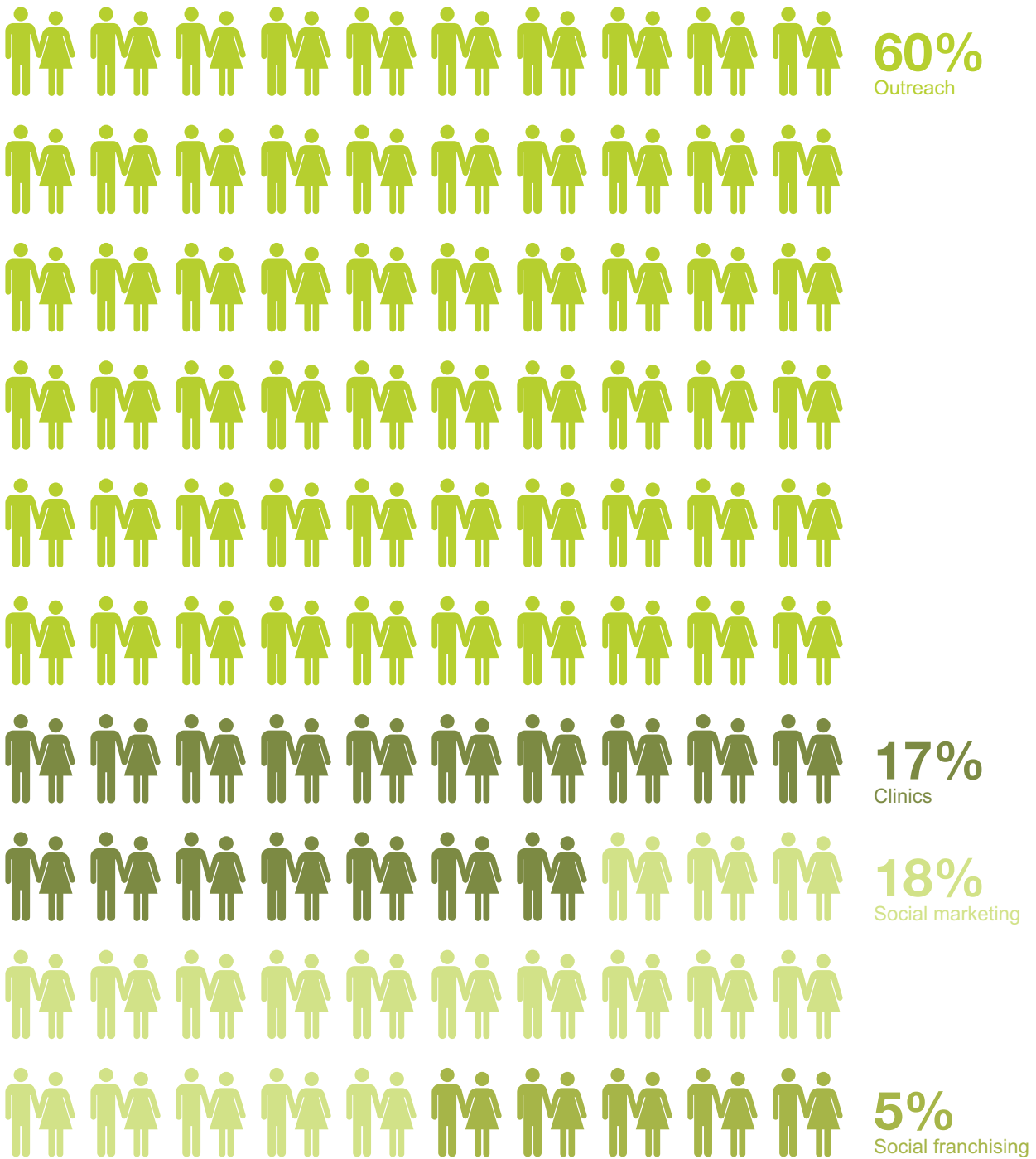


Figure 8: CYPs delivered through MSI centres, by method

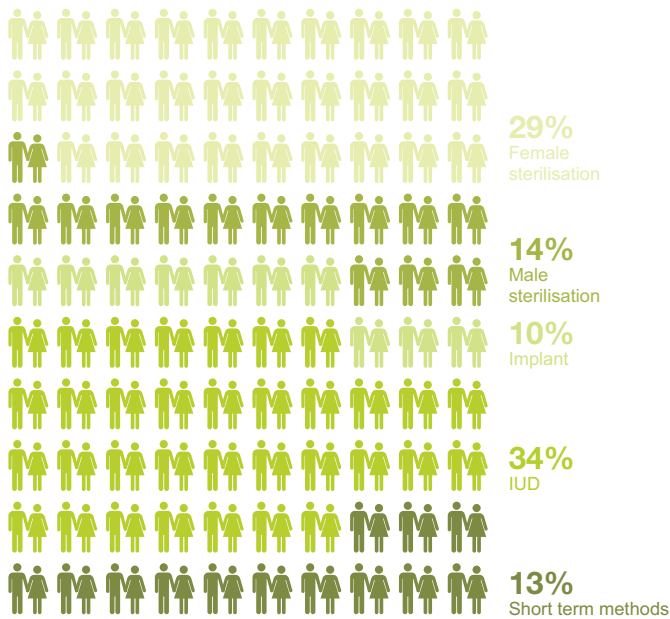
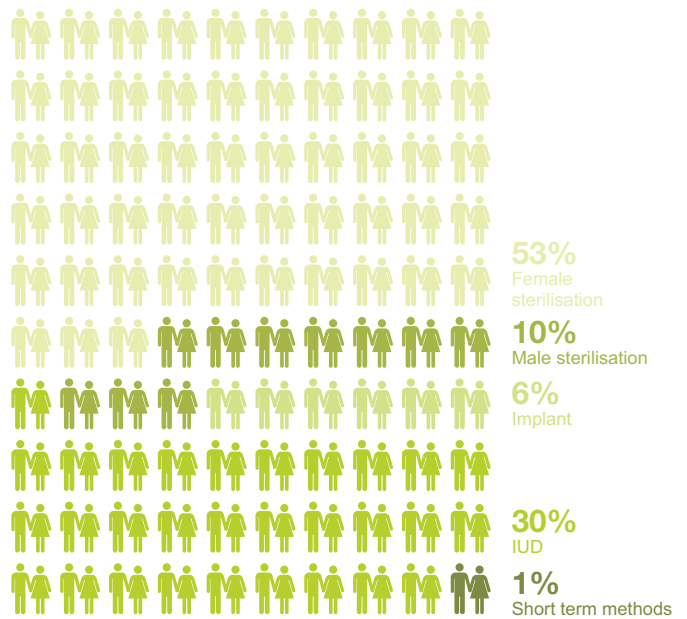


Figure 9: CYPs delivered through MSI clinical outreach services, by method



Centres

Marie Stopes International (MSI) started as a clinic-based organisation, expanding from one centre in London to a global network of 629 centres in 2010. These are client-centred, demedicalised environments where women and men can access, as demonstrated above, a full range of voluntary family planning services, together with other sexual and reproductive health services, and in many centres, basic primary healthcare such as child vaccinations and malaria treatment, and often a general laboratory testing facility or dispensary. The clinic network now serves as a vital base for training and logistics to support mobile clinical outreach teams, community based distributors and social franchisees. In many countries, MSI centres also act as gold standard demonstration sites to host governments and other providers interested in adopting a client-focused approach, or learning about MSI's approach to confidentiality, service quality or safety. Centres are often based in cities, and those in wealthier areas aim to generate income to subsidise centres in urban slums and outreach to poorer clients.

Clinical outreach

MSI's clinical outreach model uses mobile clinical teams, which typically set out in a 4x4 vehicle early in the morning from an MSI centre, to conduct one day or longer visits to areas where women and men cannot easily access a range of family planning options. Community health workers and local healthcare providers let local people know about the visit in the days and weeks beforehand. The team is based at a host facility, usually a rural health centre, but sometimes a school, workplace or even a tent. They have often been contracted by the host government, at national or district level, to provide this service. Typically, the regular healthcare provider in that area offers only short term methods such as pills and sometimes injectables. Therefore the emphasis is to work in partnership with the existing provider to give clients a full range of family planning options, with MSI staff delivering the clinical services.

The day typically starts with a waiting room full of women, and interactive group education by the two nurses about a wide range of family planning options, while the driver / assistant sets up the procedure room and makes arrangements for client comfort and infection prevention. A nurse then takes clients one by one for counselling and IUD and implant insertions, while the other nurse supports the surgical provider with counselling, informed consent and surgical procedures - tubal ligation and vasectomy. The team also makes arrangements with local healthcare providers for follow up care for any clients experiencing problems after the team has left.

Figure 10: MSI CYPs delivered through social marketing, by method

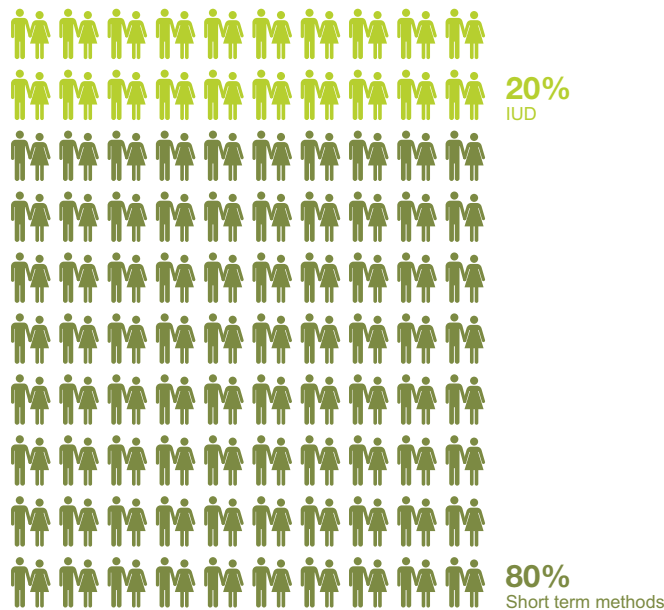
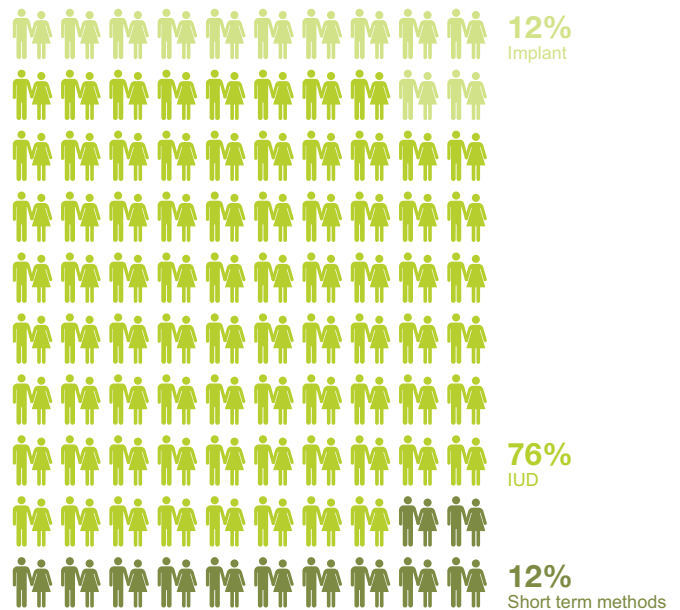


Figure 11: MSI CYPs delivered through social franchises, by method



Social marketing

MSI's social marketing programme markets and distributes low cost and free condoms, oral contraceptive pills, emergency contraception and other contraceptive and health products through pharmacies, community-based distributors and other private providers. Social marketing aims to bring short term methods closer to the client, and to provide an opportunity to offer information and referrals to outreach or clinic facilities for clients who may be interested in longer-acting or permanent methods. The short term methods have branding and advertising tailored to appeal to a particular target market, such as the Snake brand of condoms targeted at aboriginal youth in Australia, or Aramish ("peace") condoms which are targeted at married couples in Afghanistan. IUDs are sold to private, trained, clinical providers where there is a shortage of cost-effective options available commercially.

Social franchising

Social franchising allows MSI to scale up access to high quality clinical family planning and sexual and reproductive health services rapidly, through partnership with existing private and sometimes public healthcare providers. These partnerships allow women in urban slums, smaller towns and villages to have convenient access to a range of choices. MSI's social franchising model contracts these providers and trains them in a range of SRH services, infection prevention, counselling and client focus. Franchisees are provided with branded signboards and materials bearing a recognisable brand name and logo, and franchisees also receive reduced cost supplies and clinic improvements in some instances. Providers must commit to franchising membership standards, including adhering to regular quality assurance monitoring and reporting. Many franchisees already offer a range of short term family planning before joining the network. MSI's focus is to introduce a client-centred approach, with better counselling and follow up, and to ensure clients have access to a wider range of family planning choices including long-acting reversible methods, as well as post-abortion care, safe abortion services where permitted and other SRH services.

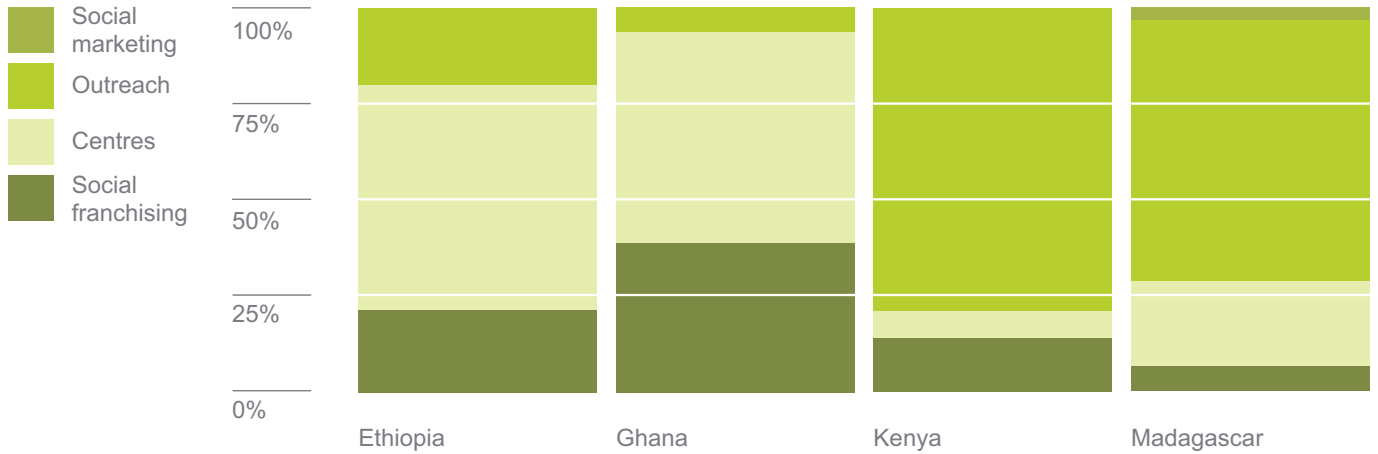
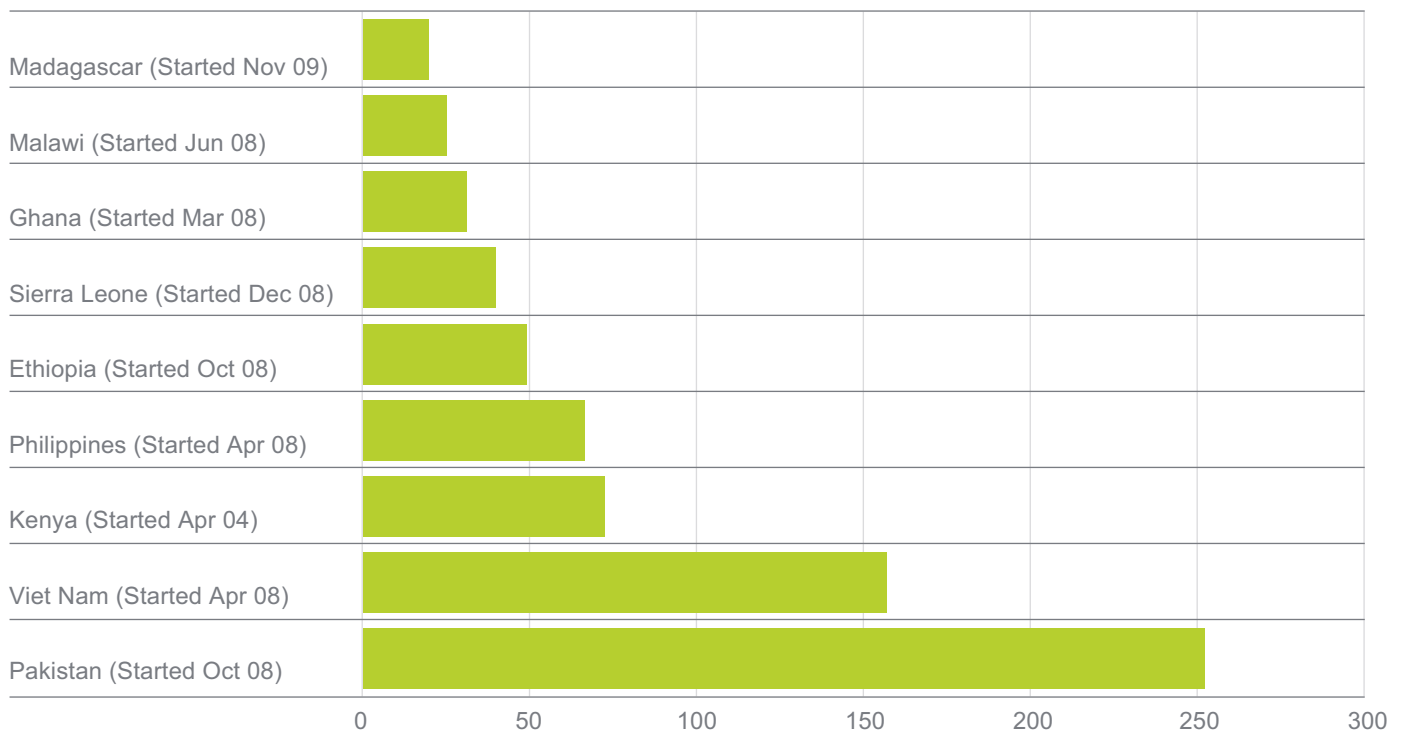
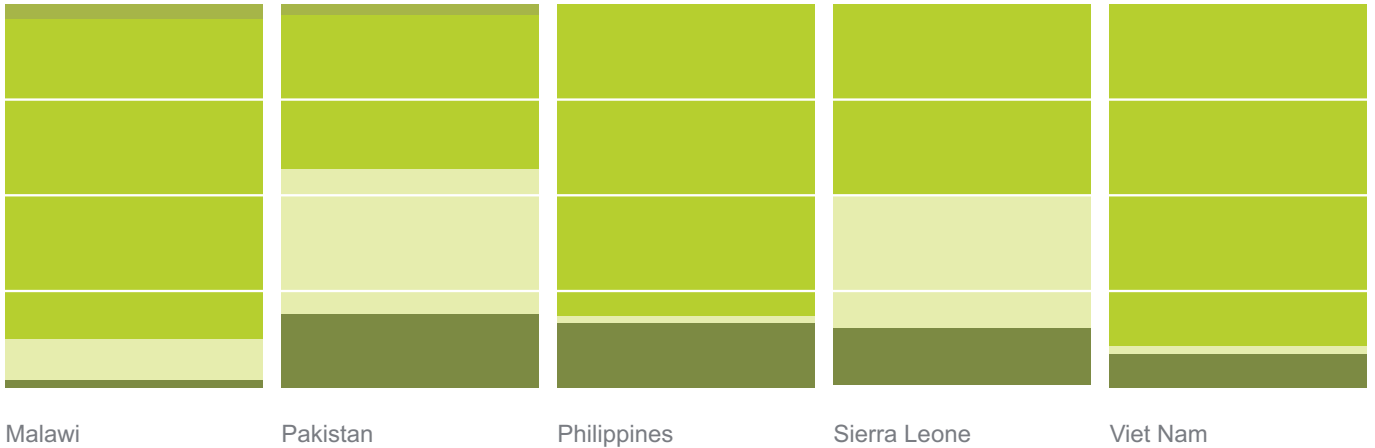


Figure 12: The percentage of MSI CYPs delivered through each channel, for countries with social franchises in 2010

The volume of clients per franchisee varies widely by country. Figure 13 shows the variation in the average number of CYPs provided per franchisee per month across 2010 in each country with a social franchising programme. This is an indicator of the overall networks' effectiveness and often also reflects the type of provider chosen and the age of the franchising programme - new programmes take time to generate increased client loads. For example, the social franchising programme in Madagascar only started in October 2009, and productivity improved rapidly between the beginning and end of the year.

Figure 13: Average number of CYPs delivered per MSI franchisee per month in 2010





Contribution to national contraceptive use

This section explores MSI's contribution to overall contraceptive use in 2010. It looks at MSI users as a proportion of all women currently using modern methods. The data, represented as dark green bars in figure 14 (p.28), suggest that in many countries, MSI's activities are of sufficient scale to significantly contribute to increasing contraceptive prevalence nationally.

However, while it is important to look at MSI's contribution to the modern contraceptive market, it is more important to consider the bigger picture. The bright green bars in figure 14 show MSI users as a share of the potential market, comprising both women who are currently using a modern method, and also those who want to space or limit births but currently rely on traditional methods or practice no family planning at all. The difference between the bright green and dark green bars demonstrates that despite MSI's considerable scale in many countries, there is much work still to be done to reach all of the women and men in need.

Data sources

Data in this section is again taken from MSI's REACH Calculator,⁵ which compares MSI user numbers with data on the national population as a whole.

The REACH Calculator provides two different indicators of the extent MSI is contributing to contraceptive use in a country:

1. MSI users as a proportion of all women currently using modern contraception - MSI's share of the existing modern market.
2. MSI users as a proportion of all women with a need for modern family planning (both met and unmet) - MSI's share of the larger potential family planning market.

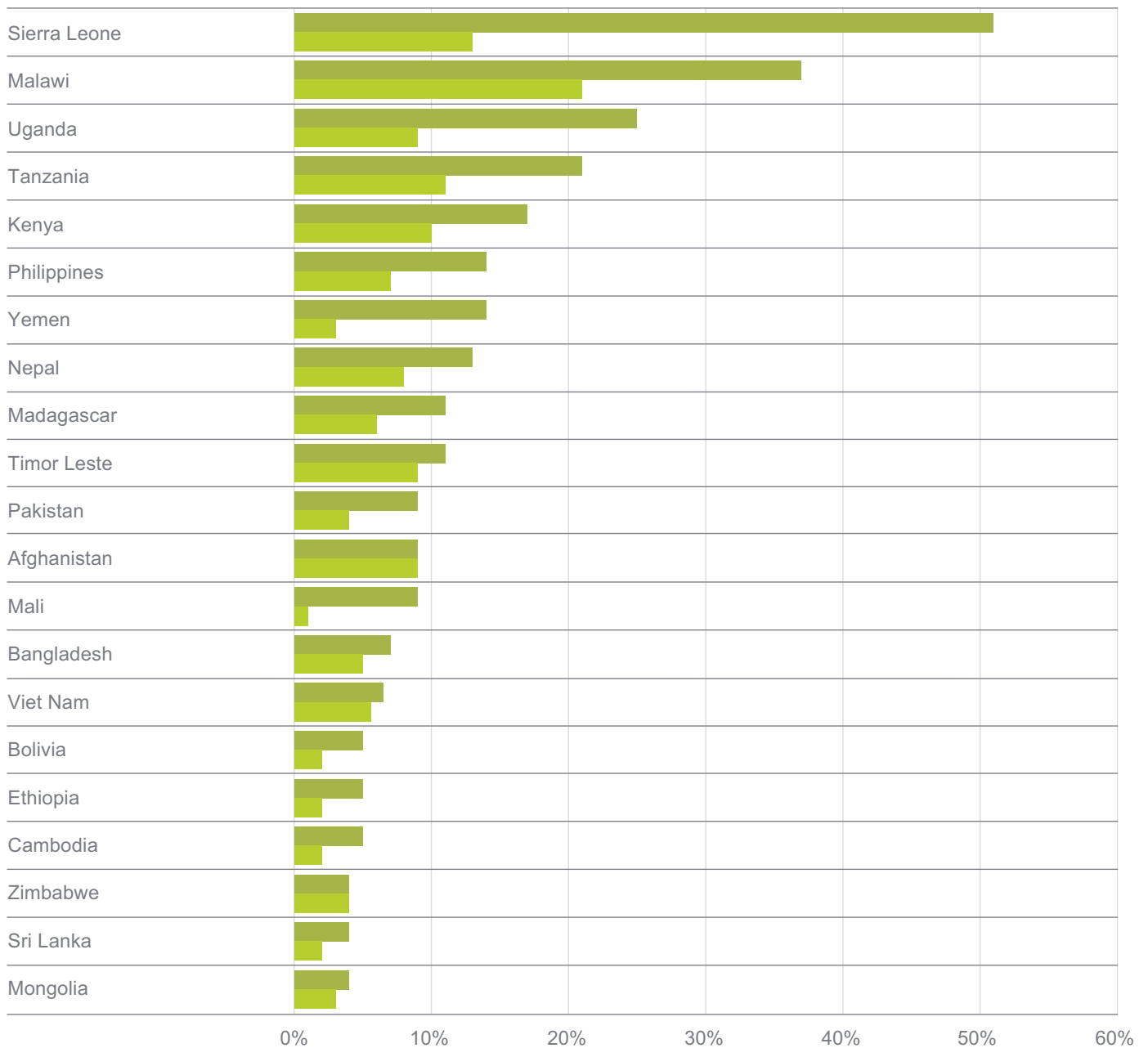
The second indicator is more useful when assessing national context, because it shows the progress towards reducing unmet need and reducing reliance on traditional methods of family planning. Women with an unmet

need for modern family planning are those that are using traditional methods or no family planning at all, who want to delay or limit future births.

As mentioned above, these are conservative underestimates because MSI's short term method users are not included here due to methodological difficulties.

Figures for current national contraceptive use are based on available survey data such as DHS, combined with UNPD population predictions. For years in which such data is not available, an estimate is made assuming a linear trend in contraceptive use. In some cases, contraceptive use does not change linearly. For example, contraceptive use may increase dramatically in a year since the latest survey - something which cannot be predicted by the REACH Calculator. In these cases, MSI's contribution to contraceptive use may be over-estimated.

Figure 14: MSI's share of the modern and potential family planning markets in selected countries in 2010



MSI LAMP users as % of all modern method users

MSI LAMP users as % of all women who currently use or express an unmet need for contraception

MSI's contribution towards the national need for modern family planning in all countries has grown steadily in the past five years, with the Sierra Leone and Afghanistan programmes showing particularly rapid growth during 2010.

The 15 countries where MSI has made greatest progress towards meeting total national need are: Afghanistan (8.8%), Bangladesh (4.8%), Kenya (10.2%), Madagascar (5.8%), Malawi (21.4%), Mongolia (3.3%), Nepal (8.4%), Pakistan (4.0%), Philippines (6.5%), Sierra Leone (12.9%), Tanzania (10.7%), Timor Leste (8.7%), Uganda (9.1%), Viet Nam (5.6%) and Zimbabwe (3.7%).

F: MSI projection based on UNPD World Contraceptive Use database and UNPD population forecasts.

Of approximately 20-25 million modern method users in all of sub-Saharan Africa^{F,8} an estimated two million received their services through MSI.



Case study

Zainabu's story

Zainabu lives in Sierra Leone with her husband and nine children. They're proud of their large family and until recently, they were among the 80%⁹ of couples in this country who'd never used a modern method of contraception. Large families are common, but the risks are high. One in eight women in Sierra Leone dies during pregnancy and childbirth.

Women like Zainabu are all too aware of the dangers. "I want to stop. Giving birth can be dangerous" she told us. News of the death of a local woman in childbirth worried her. This concern for her health, together with the financial pressures of a large family, led Zainabu to find out about family planning for the first time. "By stopping having children, we'll be able to give all our attention to the ones we have."

Two thirds of the population of Sierra Leone live in rural areas, where access to even basic health services can be limited. Zainabu is fortunate though; each month a Marie Stopes Sierra Leone outreach team visits her village to provide access to life-changing family planning services.

On one of these visits, Zainabu approached the team and they counselled her on a range of modern family planning methods, including condoms, the pill and long-acting and permanent methods. With this knowledge, she made a life-changing decision and chose a tubal ligation.

The procedure took just 25 minutes and was performed under a local anaesthetic. After the procedure, she shared her relief: "I'm very happy it's done. It's over now. I didn't feel it. I'm very happy. I'm going to be fine now."

Zainabu is one of the lucky ones. Millions of women still do not have access to modern contraception and continue to die unnecessarily as a result of pregnancy and childbirth.

"By stopping having children, we'll be able to give all our attention to the ones we have."

Photo: Marie Stopes International / Richard Lord



Viet Nam A voice from the franchise network

“So many clients are recommending this clinic that numbers have nearly doubled”

This is Pham Thi Thanh Can, a nurse who runs a local public health centre in Khanh Hoa Province, Viet Nam. About two years ago, she decided to join Marie Stopes Viet Nam’s network of social franchises, which is branded as Tinh Chi Em, meaning sisterhood.

“Tinh Chi Em is like a fishing rod to help my clinic get more fish. Thanks so much to the Marie Stopes Viet Nam team for training us to have a client focus. It has transformed our clinic. We used to have pictures of leprosy and diseases on the walls, now the clinic looks cheerful with pictures of flowers, and our staff are friendly and welcoming. So many clients are recommending this clinic to friends and relatives that client numbers have nearly doubled”

As well as increasing the number of clients coming to her clinic, Pham has increased the range of family planning services she offers. Before joining the Tinh Chi Em network, Pham was only able to offer IUDs to her clients and the local community she serves. She is now able to offer a much greater choice of short and long-acting methods of family planning and has helped to increase access to these vital services.

Photo: Marie Stopes International / Kristen Hopkins

Contribution to national contraceptive use in Uganda

This illustrated example from Uganda explains the figures in more detail by providing a visual representation of the total potential contraceptive market in the country. The diagram shows that MSI is providing a significant proportion (25%) of all current modern contraceptive use nationally. However, the largest segment of the potential contraceptive market is still those who want to space or limit births but currently rely on traditional methods or have no family planning at all.

Figure 15: Uganda's potential family planning market in 2010, by family planning status



Case study

Farari's story



Farari is a 29 year old woman, living in rural Zimbabwe. She has two children and doesn't want any more right now. So she's been using the pill and condoms to prevent herself from falling pregnant again. But after experiencing side effects from taking the pill she decided to stop taking it and to try and find a different contraceptive that would suit her better. But with local clinics and shops only offering condoms or pills, her choice was limited and she was at risk of another pregnancy that she can ill afford.

MSI's programme in Zimbabwe understands that being able to choose a method of contraception that works best for her is just as important for Farari as it is for any other woman around the world. When one of Farari's friends told her about the range of different types of contraception that MSI's outreach team had on offer when they last visited her village, she decided to find out if there was an option that would suit her better. Farari saw a poster advertising another visit by the outreach team to her village and decided to attend their information session. As part of the session a trained health educator led a discussion about all the contraceptive session options available and distributed free male and female condoms for HIV prevention.

After discussing all the options available to her and being counselled on the benefits and drawbacks of each option, Farari decided that she wanted to have a contraceptive implant. Despite being certain that the implant was right for her, she was afraid that it might hurt when the implant was inserted. Seeing that Farari was anxious the outreach nurse tried to calm her fears by explaining what would happen and showing her all of the supplies that would be used. Another member of the outreach team put her at ease by asking about her children and family. Before she realised it, the procedure was over. "Is that it?" Farari exclaimed, "I thought I would be on this table for an hour!"

After being given information about what to do in case of side effects and when the team would be back in the village to offer follow-up assistance, Farari left with a single expression: "great!"

Photo: Marie Stopes International / Nomi Fuchs-Montgomery



In 2010 over 7 million couples used long-acting or permanent contraception as a result of our services.

Photo: Marie Stopes International / Peter Barker

Chapter 3: Prevention of unsafe abortion: a harm reduction approach

Unsafe abortion remains a major global public health concern and a human rights imperative. Among the 208 million women who become pregnant each year worldwide,¹⁰ about 72 million pregnancies¹⁰ (35%) end in stillbirth, spontaneous, or induced abortion. The WHO estimates that 21.6 million women worldwide undergo unsafe abortion procedures annually; 98% occur in resource-limited settings.² Approximately 4.2 million unsafe abortion procedures are performed in Africa, 10.5 million in Asia, and 3.8 million in Latin America and the Caribbean each year.²

208 million	pregnancies worldwide each year ¹⁰
72 million	pregnancies end in stillbirth, spontaneous or induced abortion ¹⁰
21.6 million	unsafe abortions worldwide annually, almost all of which occur in developing countries ²
8.5 million	women require medical treatment (post-abortion care) annually ⁴
47,000	maternal deaths due to unsafe abortion complications ²

Table 3: Key global facts: unsafe abortion

Overview

Globally, deaths related to unsafe abortion constitute at least 13% of maternal mortality.²⁻³ It is estimated that 47,000 women died from complications due to unsafe abortion in 2008,² and an additional 8.5 million⁴ women required medical treatment (post-abortion care).

In response to this urgent situation, MSI takes 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 health, social and economic harms to individuals, communities and society. MSI recognises that, in all societies, no matter what the legal context and no matter what access to contraception, some women will seek to end unwanted pregnancies, safely or otherwise.

MSI strives 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
- providing training to mid-level providers in medical abortion and manual vacuum aspiration techniques
- increasing access to both surgical and medical abortion where permitted
- providing post-abortion family planning
- fostering an enabling policy environment that respects women's health and safety and ability to make informed reproductive decisions.

Unsafe abortion

Across the world our team members see the devastation that unsafe abortion can cause. Like the woman who asked friends to 'help her' by beating her stomach with rocks while she stood against a wall, inducing haemorrhage. And the young woman who came to one of our centres in agony from an infection caused by a stick that had been forced into her uterus to induce an abortion. She was taken to hospital but later died of the infection, leaving behind three young children.

One of the best ways to reduce unsafe abortion is by preventing unplanned pregnancies in the first place, so we're committed to providing access and choice in family planning. But unplanned pregnancies happen and we want to prevent the harm to women, families and communities that unsafe abortions cause. So wherever it is permitted to do so, we provide access to safe abortion services.

Trends in MSI abortion and post-abortion care services

In order to reduce unsafe abortion and its consequences, MSI has been increasing access to safe abortion and safe post-abortion care (PAC) around the world. In 2010 alone, MSI provided safe abortion and post-abortion care services to over one million women across the globe. Key statistics from MSI's effort in the provision of safe abortion and post-abortion care include:

- the global number of safe abortions and PAC provided by MSI has increased by 54% from 2009 to 2010
- most of this growth came from increases in medical abortions outside-of-centre which grew by 127% from 2009 to 2010 and now represents 53% of all MSI's safe abortions and PAC
- 51% of total safe abortion and PAC services were provided in south Asia.

Data sources

Where misoprostol and mifepristone were sold through trade channels, rather than MSI and partners providing a service directly to a client, the total number of abortions has been estimated using conservative conversion formulae.

Figure 16: Number of abortions and post-abortion care services provided in centres and outside of centre facilities, by method, 2000–2010

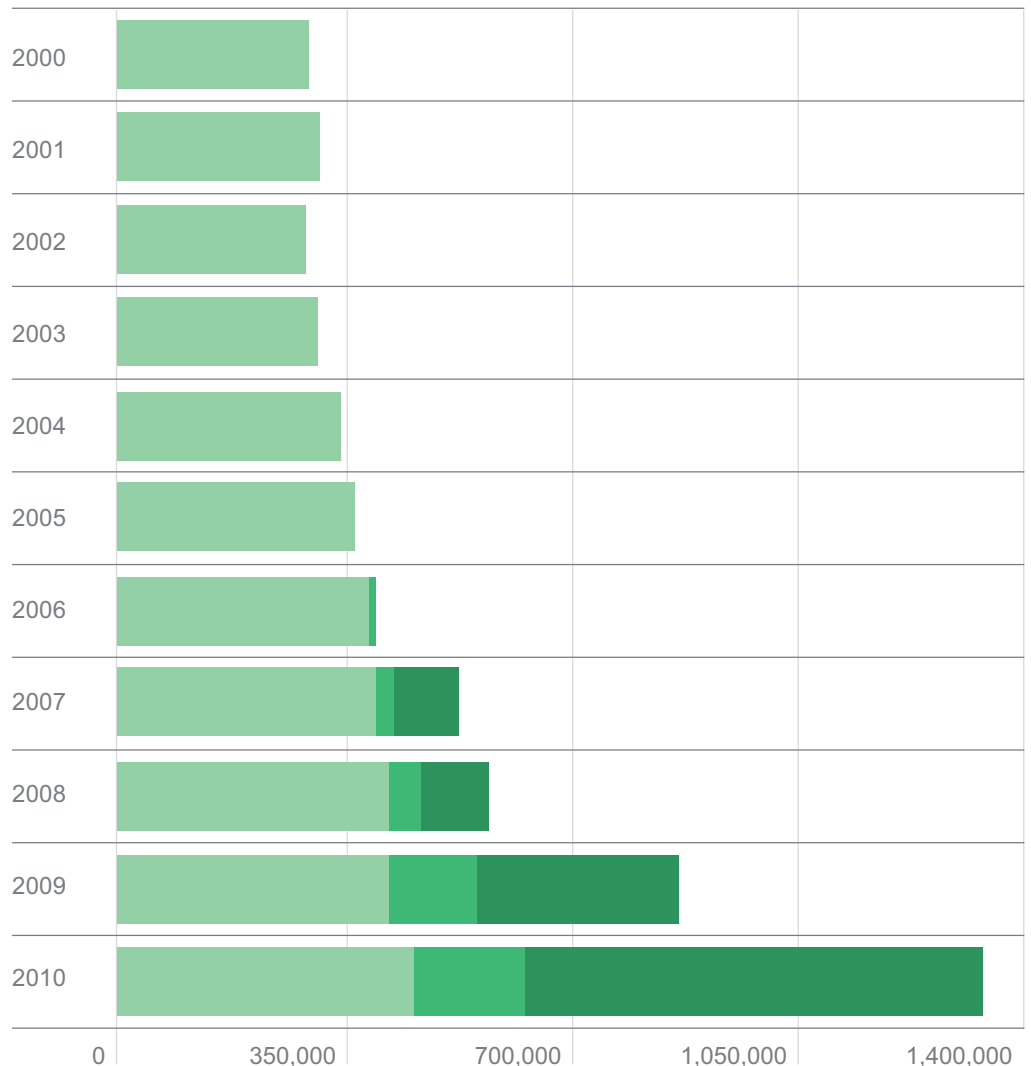
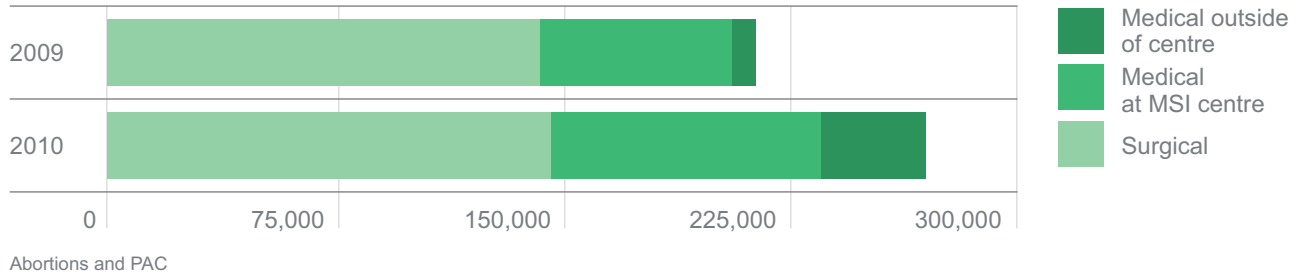
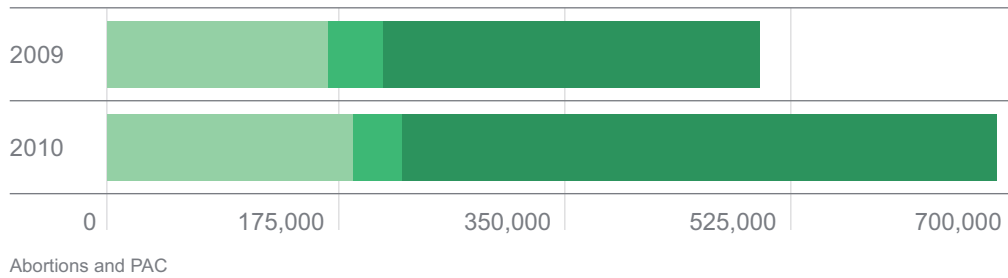


Figure 17: Regional trends in safe abortion and post-abortion care provision

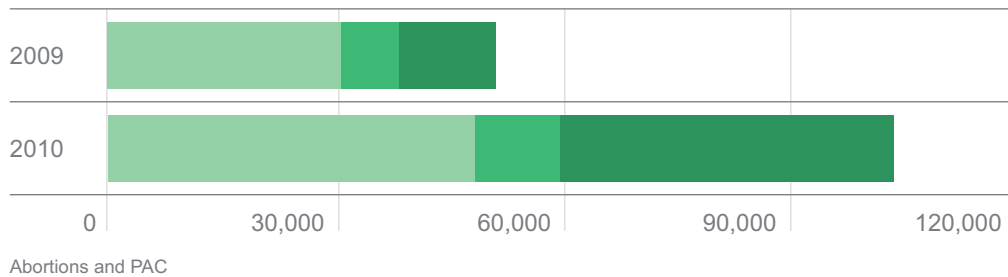
Sub-Saharan Africa



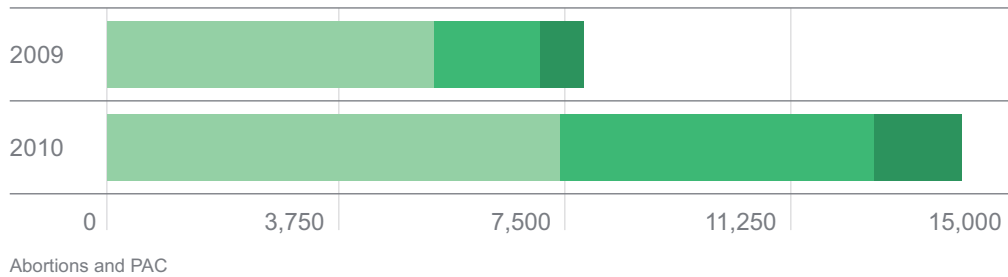
South Asia



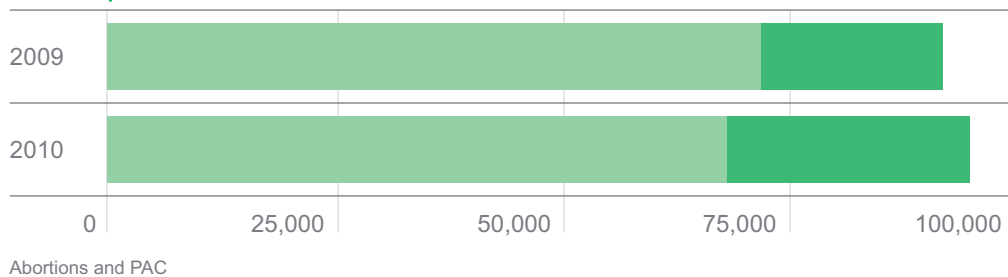
Asia Pacific



Latin America



Developed countries

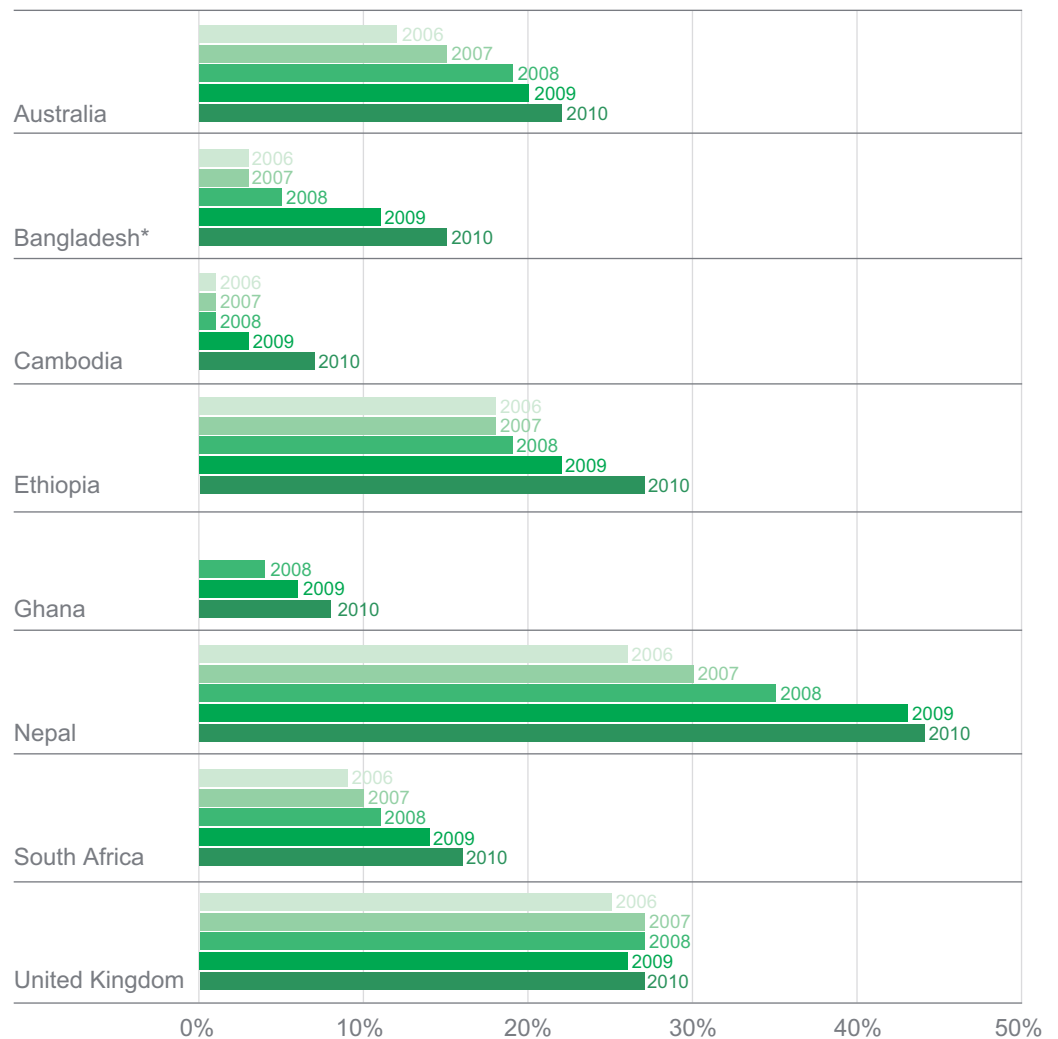


Regional trends in MSI's abortion and PAC services

In 2010, MSI saw particularly dramatic growth in safe abortion and post-abortion care services in Asia Pacific - an increase of 103% from 2009. The greatest absolute growth was in south Asia, with over 180,000 more services provided in 2010 than 2009. Most of the growth was in Asia, where mifepristone and/or misoprostol is provided outside of 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 also becoming more popular choices among women using clinic-based facilities in Latin America and the developed world (Figure 17).

Figure 18: The percentage of all abortions and menstrual regulation provided by MSI in selected countries, 2006–2010

*Menstrual regulation



The REACH Calculator⁵ allows MSI to estimate what proportion of total abortions in each country is provided by MSI. 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. Figure 18 illustrates MSI's progress among eight selected countries in which abortion or menstrual regulation is permitted.

For instance, MSI provided 93,000 safe abortions in 2010 in Nepal; about 45% of all abortions nationally. Despite the liberalisation of abortion law in 2002, unsafe abortion remains high in Nepal due to persisting lack of awareness, embarrassment to seek proper services and inadequate access to safe providers. MSI's increasing contribution to safe abortion services in Nepal is a useful indicator that MSI's harm reduction approach is working and women are turning away from unsafe providers.

Medical abortion - home-based care

The advent of mifepristone and misoprostol over the past decade has revolutionised both abortion and post-abortion care. These drugs provide an alternative to surgical interventions, giving women more choice of method and also expanded choice of location in which to receive care. Studies have shown that medical abortions occurring outside of health facilities are effective, safe and acceptable to women living in numerous resource-limited settings.¹¹

Scaling up the availability of medical abortion, particularly for home-based care, is a priority for MSI. In all countries where legally permitted, MSI centres now offer clients the choice of medical or surgical abortion. Beyond MSI centres, the organisation is making medical abortion available (where permitted) through MSI's networks of social franchises and other providers such as pharmacists and community health workers. Many women now choose to access medical abortion drugs through these providers for home-based care.

MSI places strong emphasis on the quality of information provided to the woman, and on providing adequate support. Follow up is also vital in home-based settings. MSI establishes referral networks and call centres, in order to link clients with MSI clinical or other tertiary services, in the rare cases where there are complications.

Chapter 4: MSI's global impact

This chapter provides estimates for health, demographic, economic and environmental impacts resulting from the family planning and safe abortion services MSI provided globally in 2010. The impacts of family planning programmes are estimated using MSI's Impact Estimator, version 1.2.⁶ This tool is a mathematical model that converts MSI's service figures into estimates of their health, demographic, economic and environmental impacts.



Figure 19: The number of maternal deaths averted in the countries where MSI worked

Health and demographic impacts

Using MSI's Impact Estimator, we estimate that the services provided in 2010 by MSI will prevent approximately:

- 4.8 million unintended pregnancies
- 13,600 maternal deaths
- 1.3 million unsafe abortions
- 3.1 million disability-adjusted life years (DALYs).

Economic impact

Family planning is a preventative healthcare intervention which offers excellent cost-effectiveness compared with nearly every other health intervention. In 2010, the total cost to donors of MSI's programming in developing countries was £61 million. The savings to healthcare systems resulting from MSI's 2010 service provision will be approximately £428 million, through reductions in maternal and infant morbidity and mortality and unsafe abortion.^G

In other words, for every £1 of donor money spent by MSI programmes, £7 will be saved by health systems in developing countries. The costs-to-savings ratios vary by region, for various reasons including economies of scale in MSI's larger programmes and the relative cost of skilled labour and commodities.^H

- in Africa, for every £1 spent, £7.64 will be saved
- in Asia Pacific, for every £1 spent, £9.53 will be saved
- in south Asia, for every £1 spent, £13.00 will be saved
- in Latin America, for every £1 spent, £2.06 will be saved.

G: Note that there are also 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.

H: Note that costs of support from the UK support office are not included in these regional figures.

Data sources

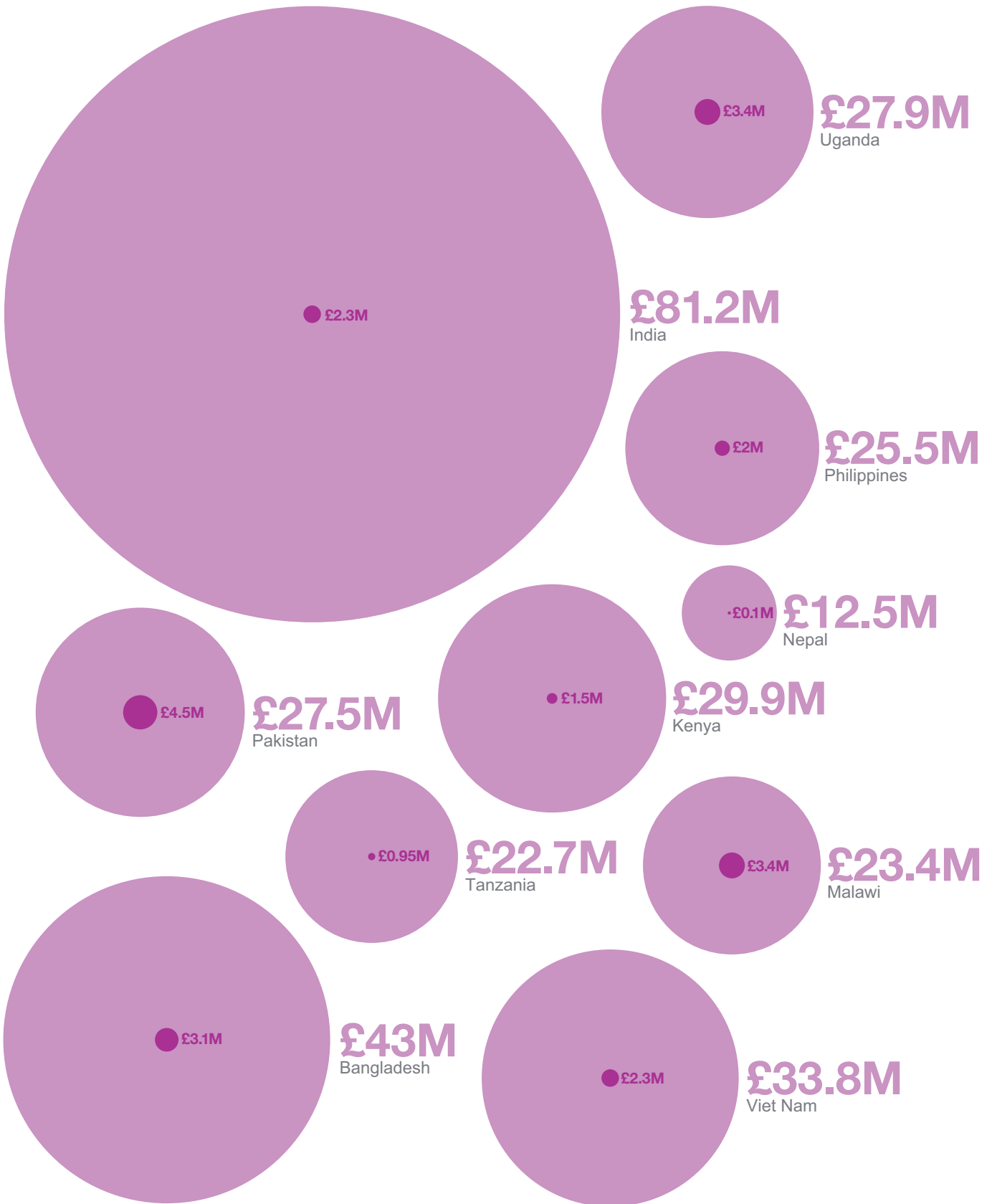
The Impact Estimator[®] was developed in collaboration with experts from Population Services International (PSI) and the Guttmacher Institute, and has been peer reviewed by experts at the Guttmacher Institute, PSI, the United Nations Population Fund (UNFPA), Population Council, EngenderHealth and Futures Institute. The model uses externally validated data sources such as DHS data and UN statistics. To download the model or for information on the methodology and data behind the Impact Estimator, its limitations and recent updates, please visit www.maristopes.org/impact-estimator

Like all mathematical models, the Impact Estimator suffers from some limitations. The greatest is that many of the data items used in the model are not available at national level. It is therefore necessary to apply regional estimates nationally. This results in inaccuracies, particularly for countries that are very different from others in the same region. This is a particular concern for abortion and unsafe abortion ratios and for cost-saving estimates. A second limitation is that the model cannot make annual impact estimates. The model relies on couple years of protection (CYPs) for converting different

family planning methods into a single comparable unit. This means that, for long-acting and permanent family methods (LAPMs), the CYPs and the corresponding impacts are spread over future years, and annual impacts cannot be calculated. MSI is currently developing a new model that will overcome this limitation by estimating the number of people who are actually using each method during the current year. The CYP conversion factors also are based on limited and out-of-date evidence, with many organisations now diverging to use slightly different factors. Updated conversion factors from USAID are expected during 2011, which will strengthen the model.

In February 2011, various parameters within the model were updated as new and improved data were published. The updates have resulted in estimates for the impacts of MSI's services being revised downwards, compared to figures produced by the previous version of the Impact Estimator. Thus, while MSI provided more services in 2010 compared to 2009, the impact figures reported here are lower than those reported in MSI's 2009 Global Impact Report.

Figure 20: Programme costs and savings - MSI's 10 largest country programmes



Total 2010 MSI programme cost
 Total cost savings to healthcare system resulting from MSI services provided in 2010

Figure 20 (previous page) shows the costs of MSI's 10 largest programmes in terms of family planning service delivery, compared to the cost savings resulting from their 2010 activities. In all countries, the savings far outweighed the costs. This is one indication of the value for money achieved in MSI's programmes.

For instance, in the Philippines, for every £1 spent by MSI, £12.51 will be saved in healthcare costs alone because MSI contributed to the prevention of unintended pregnancies, which protected families and healthcare systems from dealing with maternal and infant illness and deaths and post-abortion care.

Table 4 gives the cost of averting a DALY through different types of health intervention. The cost to donors per DALY averted through MSI's programming in 2010 in developing countries was £19.60. 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 (£19.60) was less than that of tuberculosis vaccination, and similar to that of malaria prevention for pregnant women.¹

I: Converted from 2008 US dollars (original text) to 2010 UK pounds

Intervention	Cost per DALY averted, £ (2010) ¹
MSI 2010 programming	19.6
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

Table 4: Cost per DALY of MSI 2010 programming compared with other health interventions

Climate change impact

The family planning services MSI provided in developing countries in 2010 will result in a reduced carbon burden of approximately 780,000 global hectares. In other words, an area of land and sea the size of Gambia will no longer be required to absorb the carbon emissions that would have been produced by additional population if MSI had not helped women to avoid unwanted pregnancies in 2010.

However, MSI recognises that most carbon emissions are generated by people living in rich countries, where people consume far more energy per head. As such, MSI's climate change impact in developing countries is not so much in reducing carbon emissions, but in helping people adapt to cope with climate change. A study led by MSI in 2010 found that a large majority of governments of developing countries receiving international support to cope with new environmental challenges are concerned about how rapid population growth is impeding their ability to adapt to climate change¹²⁻¹³. By meeting women's own desires to plan and space their births, MSI supports individuals, families, communities and countries to adapt so that they can better respond to the challenges presented by climate change, including fresh water scarcity, soil erosion, migration and deforestation.



The services we provided in
2010 will prevent 4.8 million
unintended pregnancies

Photo: Marie Stopes International

Chapter 5: Reaching the underserved

This chapter explores the extent to which MSI is reaching the underserved. MSI is committed to providing services to underserved communities. In particular, MSI uses its innovative models of service delivery to reach individuals with an unmet need for family planning, young people and the poor. Consequently, 99% of MSI's health impact is in developing countries, and 60% of CYPs are delivered for free or heavily subsidised prices through its mobile clinical outreach programmes to hard to reach communities in rural areas and urban slums, which have traditionally had very limited access to modern family planning methods.

Overview

MSI's service provision to underserved communities includes delivery of family planning, post-abortion care and other sexual and reproductive health services to refugees, displaced people or those affected by conflict or natural disaster. These services are delivered directly by MSI staff through centres and outreach, and also in partnership with humanitarian agencies. MSI has enabled these humanitarian agencies, working in crises and emergency contexts, to provide reproductive health services as part of a basic health care package. This has been achieved through capacity building, technical assistance and provision of logistics support to partners in country, as well as technical advice for improving reproductive health in the humanitarian response. In crisis or emergency situations, provision of these basic health services is often interrupted, or does not exist, and the resulting circumstances leave women particularly ill-equipped to deal with or prevent an unintended pregnancy.

In under four years MSI, through its role with the RAISE Initiative, has contributed to the dramatic increase in family planning provision from under 3,000 women per year to over 140,000 women per year, across 11 supported programmes in six conflict-affected countries.

Meeting unmet need

The Demographic and Health Survey (DHS) defines unmet need as any woman who wishes to limit or space her births but is not currently using a method of family planning. These women have inadequate family planning services and choices available to them. It is by reaching these women that national contraceptive use will increase. As a proxy measure for unmet need, MSI collects data on whether a client had ever used modern family planning methods before. Women that come for family planning services who have never used modern family planning before are likely to have had unmet need for family planning.

There are some limitations to this proxy measure. Some first time adopters do not have unmet need - they are simply young women requiring contraception for the first time. Conversely, there is also unmet need among people that have used modern contraception in the past, and even among those currently using contraception. For example, users of short term family planning methods may wish to use LAPMs but not have access to them. This also constitutes a form of unmet need which is currently hard to quantify and is not addressed in DHS.

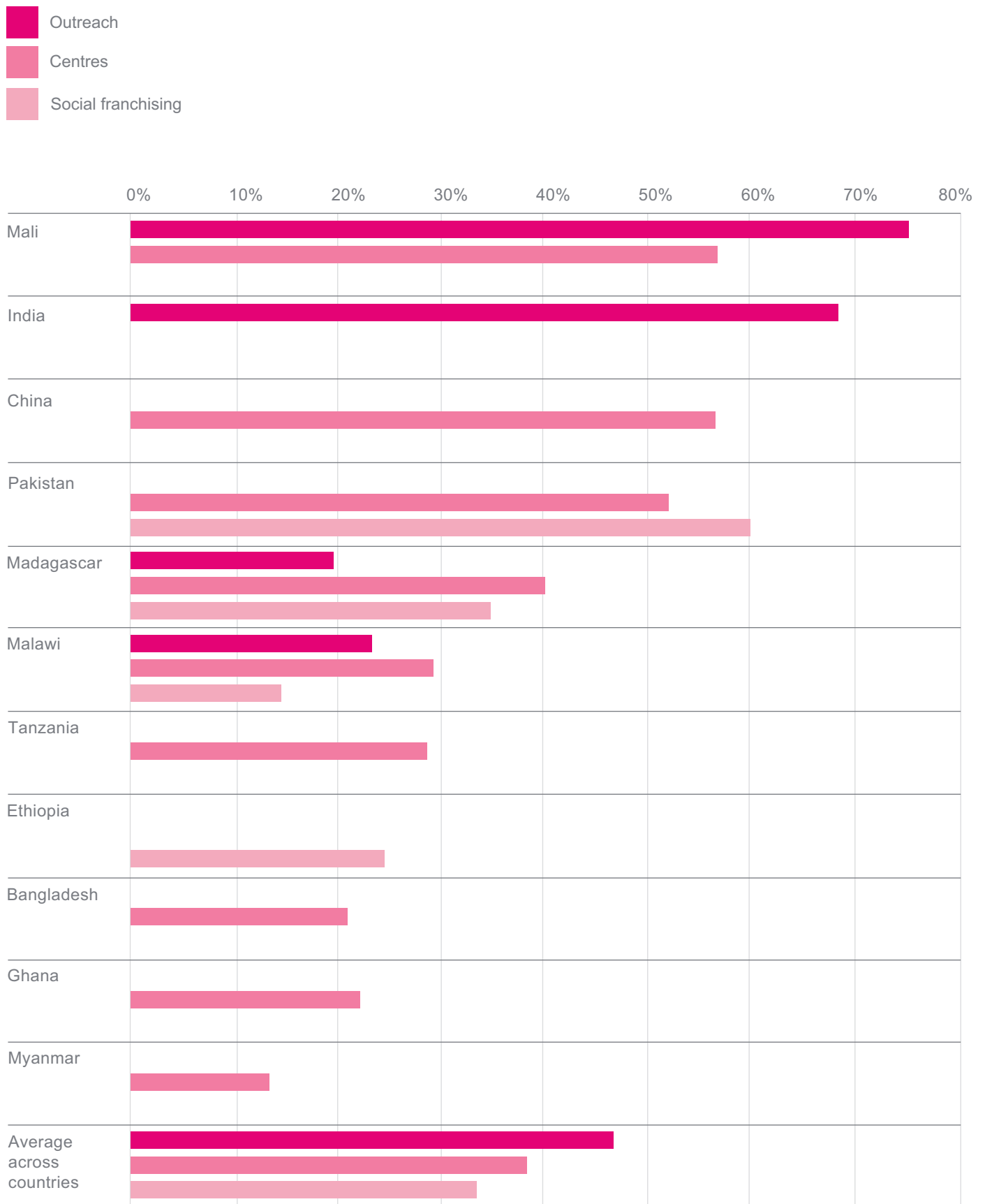
Figure 21 (p.48) shows that all MSI delivery channels served people that had not used family planning before to similar degrees, with outreach being the most successful in reaching the underserved. However, there was a lot of variation between countries. More than half of centre clients in Mali and Pakistan were first time family planning users compared to just a fifth in Bangladesh and Ghana.

Data sources

Data in this chapter are taken from standardised client exit interviews, which have to date been conducted in 12 countries, and from outreach evaluations in six countries. Note that data is only presented for the countries and delivery channels for which data is available. MSI aims to interview a representative sample of clients, with a minimum of 100 clients from each delivery channel. However in some cases randomised sampling was not feasible due to practical constraints, so purposive sampling was used instead. This sampling method and sample size may be inadequate to yield a precise representation of MSI's clients overall.

Data on the prior use of family planning, education level and age of MSI clients come from exit interviews and outreach evaluations. Education and age data for the national population of women aged 15-49 using modern contraception are taken from the most recent DHS for each country.

Poverty figures were estimated using ten poverty assessment questions in exit interviews, based on the Progress out of Poverty Index™ (PPI™) developed by Mark Schreiner of Microfinance Risk Management, L.L.C.¹⁴ and commissioned by the Grameen Foundation¹⁵. 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.

Figure 21: The percentage of MSI family planning clients who are first-time users of modern family planning



Case study Marciana's story

Marciana is 38 and has eight children. She lives in a remote mountain village in Timor Leste, about six hours drive from the capital Dili and the nearest hospital. After miscarrying her ninth child she worried about what might happen if she fell pregnant again.

Marciana had never had access to family planning, so when she heard that one of the outreach teams run by MSI's Timor Leste programme was coming to the village of Atsabe near her home she decided to find out what options were available to her. The outreach team had recently begun working in the area with the support of SUCO (the Ministry of Health) and one of the team explained all of the options available to her. Marciana decided to have an IUD inserted.

However, when Fernanda, one of the outreach team, examined Marciana she immediately realised that the miscarriage wasn't complete. The foetus was stuck in Marciana's cervix and she was bleeding heavily, Marciana hadn't realised this because all the blood was blocked from escaping by the stuck foetus. If this had not been treated immediately infection would have set in and Marciana would almost certainly have died.

Fernanda immediately gave Marciana an injection to help stop the bleeding and delivered the foetus. Once she was clean and comfortable, Fernanda safely inserted the IUD and gave Marciana antibiotics to take home with her. The outreach team then drove Marciana home; otherwise she would have had to walk several miles.

Every day MSI teams around the world are providing life saving services to women like Marciana. Without their assistance Marciana would have died, leaving a family without a mother.

Photo: Marie Stopes International / Susan Schulman

Every day MSI teams around the world are providing life saving services to women like Marciana.

Further data on current contraceptive use is available from outreach evaluations in a number of MSI country programmes. These studies found that the majority of clients taking a long-acting or permanent method at MSI's outreach facilities had previously been using a short term method of family planning, or no family planning at all.

Among Bangladesh tubal ligation clients, more than a third of clients (37%) used no modern contraceptive method prior to choosing voluntary sterilisation and 59% used a short term method.

Among Sierra Leone IUD clients, three quarters used no method of family planning before IUD insertion, and 16% were using a short term method.

Family planning method used prior to receiving service at MSI	Implant clients		IUD clients				Vasectomy clients	Tubal ligation clients
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam	Bangladesh	Bangladesh
None	18%	62%	76%	25%	53%	45%	54%	37%
IUD/implant	1%	2%	0%	1%	1%	0%	1%	3%
Short term method	81%	31%	16%	74%	39%	32%	44%	59%
Other	0%	5%	9%	0%	7%	23%	1%	0%

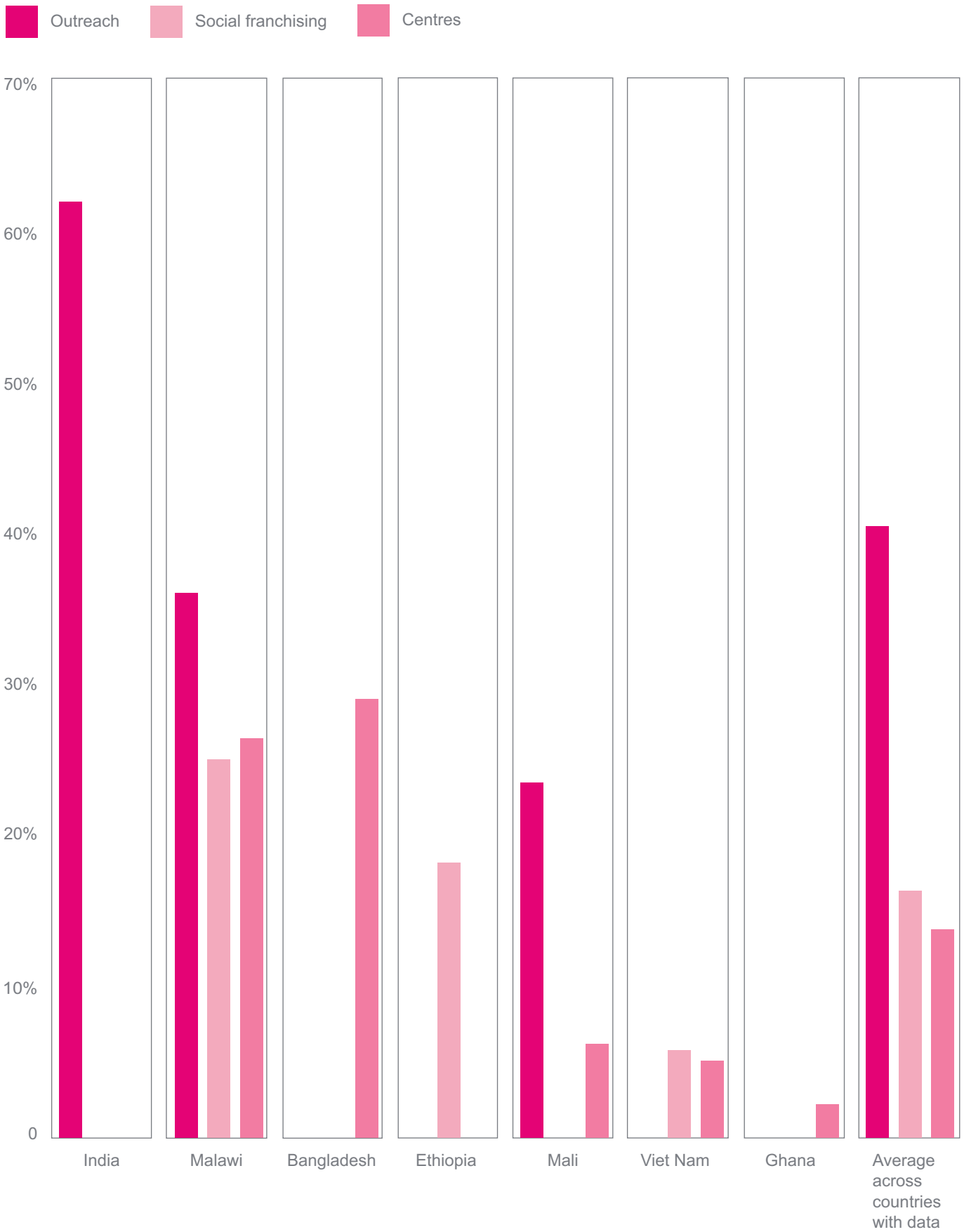
Table 5: Methods used by outreach clients prior to receiving an LAPM from MSI

Reaching the poor

Poverty is a known barrier to accessing modern family planning. MSI aims to ensure that no client is turned away because she or he cannot pay. Some MSI centres are established in middle class urban areas, and usually charge full or subsidised prices for services unless a client demonstrates particular poverty. However, many MSI centres are also nested in urban slums. Social franchises are generally located in less wealthy catchment areas such as urban slums or smaller towns and villages, providing a mix of full price and subsidised services.

Outreach teams geographically target the poorest, offering free or heavily subsidised services in urban slums or rural areas. Pilot voucher schemes and social insurance schemes are starting to blur these divisions, by entitling poor women to access free or heavily subsidised services through any of these outlets and through other non-MSI providers.

Figure 22: The percentage of MSI clients who live in extreme poverty (less than \$1.25 per day)



Reaching the young

The consequences of unmet need for contraception are disproportionately devastating for the health and wellbeing of young women. Pregnancy is the leading cause of death among teenage girls in developing countries, with girls aged 15-19 twice as likely to die from pregnancy-related complications than women in their twenties.¹⁰ Early pregnancy also leads girls to drop out of education earlier. Most sexually active teenage girls in sub-Saharan Africa do not use contraception; in some countries this figure can be as high as 70%. Women aged 24 or younger account for approximately 46% of the 47,000 unsafe abortion-related annual maternal deaths globally.¹⁰ The need to address unwanted pregnancy in young people is growing, fuelled by the largest youth population ever in history now entering their child-bearing years. Young people are often considered harder to reach through traditional service delivery mechanisms, a problem that MSI is striving to address through youth friendly targeted services.

Figure 24 below compares the age of MSI clients with the age of the national population of modern contraceptive users. It shows that MSI's programmes generally perform well in reaching women aged under 25, particularly through centres and social franchises, where MSI clients are younger than the average modern family planning users in the national population (above the line).

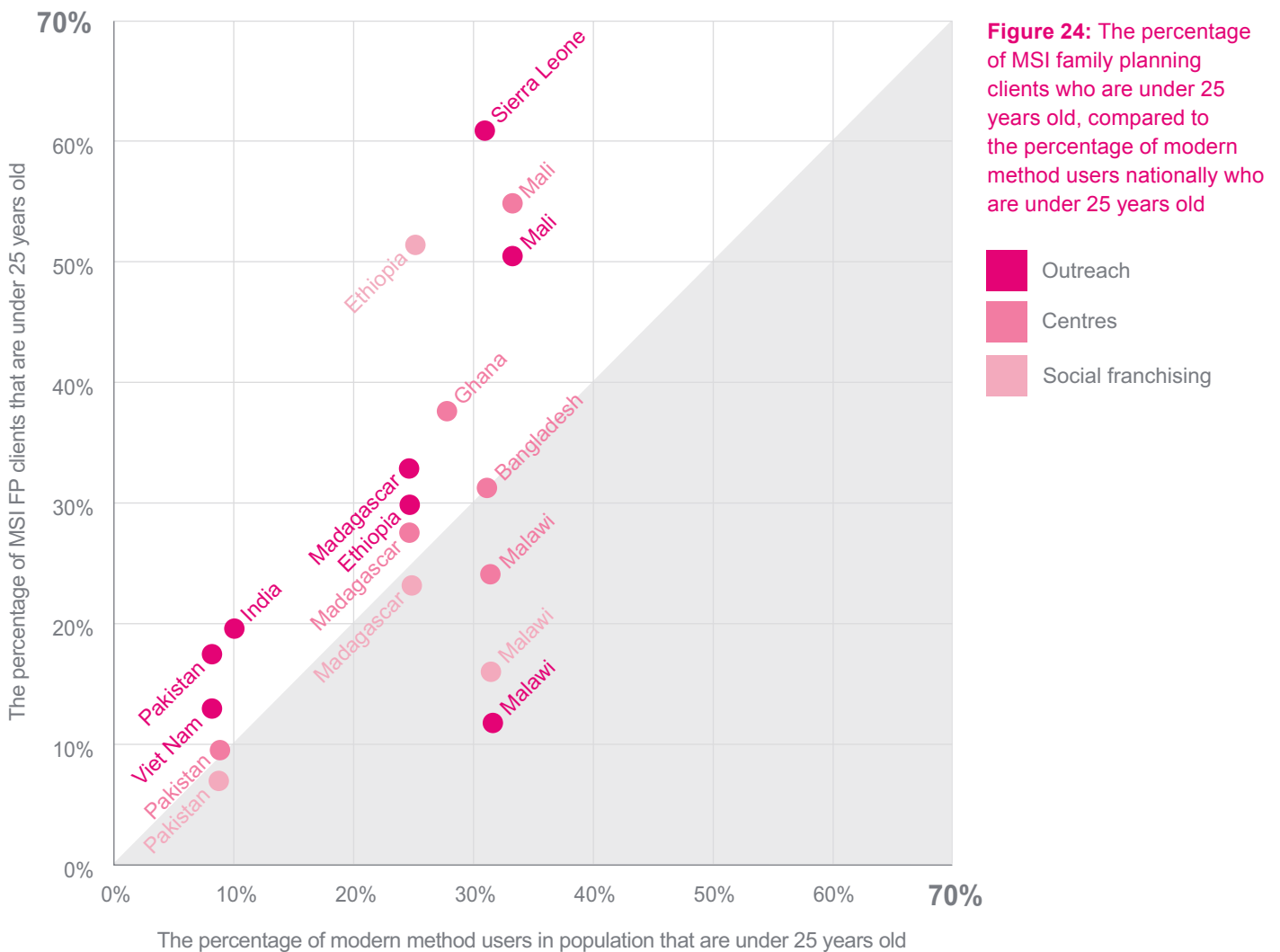


Figure 24: The percentage of MSI family planning clients who are under 25 years old, compared to the percentage of modern method users nationally who are under 25 years old

- Outreach
- Centres
- Social franchising

Chapter 6: Achieving excellence in clinical quality

This chapter looks at the quality of the services MSI provided in 2010. MSI strives to provide high quality, clinically safe services that exceed the expectations of all clients. Data is given for four measures of excellence:

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

Clinical quality assessment scores

The data in this section was collected through international quality technical assistance (QTA) visits to 28 MSI country programmes during 2010. Clinical standards are set centrally by MSI's global clinical leadership. QTA is an ongoing process of on the job training, mentoring and assessment against the global standards, by national MSI quality assurance teams, supported by annual visits from MSI's international quality assurance team. This results in continuous monitoring and improvement of the quality of our clinical services, in MSI centres, outreach sites and social franchises. Providers are given scores for various aspects of their services using a standardised assessment tool, and support is provided to solve any issues identified during the assessments.

A score of >90% is considered excellent, 75–89% satisfactory but in need of attention in specific areas, and <75% in need of extensive support to reach the necessary standard.

Overall, MSI clinical standards are very high:

- excellent scores were achieved in 13 of the 28 countries visited (46.4%)
- satisfactory scores were achieved in 10 countries (35.7%), with attention needed in a few specific areas
- the average QTA score in 2010 was 86%.

The QTA tool assesses all areas of MSI's service delivery, providing disaggregated scores for each area of service provision. The table (p.56) shows the scores for each component of the QTA:

- very high scores were obtained in all countries for tubal ligations, and for surgical and medical abortions (where applicable) and post-abortion care
- areas in need of improvement in certain countries include: clinical governance, managing medical emergencies, and equipment and supplies.

Data sources

Client feedback - exit interviews incorporate a variety of questions designed to determine the satisfaction of clients. Clients were asked to rate different aspects of the service in terms of their satisfaction along with other proxy measures of satisfaction.

IUD/implant discontinuation - during outreach evaluations, clients that received implants and IUDs were followed up after different time periods to determine whether they had continued to use the contraceptive. Low rates of discontinuation are indicative of high quality counselling and service provision. Questions were also asked relating to follow up care.

Post-abortion family planning: the number of abortion and post-abortion care clients that received voluntary post-abortion family planning is recorded in many of MSI's country programmes through the routine Management Information System. It is challenging to collect using paper based client registers, and therefore numbers presented here may be underestimates. Abortion and PAC clients are likely to have a need for family planning, which high quality programmes will be able to meet.

Indicator	Centres	Outreach	Social franchising	Overall
Client focus	88%	84%	77%	86%
Family planning	87%	79%	84%	84%
Tubal ligation (female sterilisation)	94%*	93%	No data/not applicable	93%
Vasectomy (male sterilisation)	92%*	93%	No data/not applicable	92%
Sexually transmitted infection (STI)	80%	No data/not applicable	93%*	80%
Medical abortion or medical post-abortion care	97%	No data/not applicable	No data/not applicable	97%
Surgical abortion or surgical post-abortion care	95%	No data/not applicable	No data/not applicable	95%
Infection prevention	91%	93%	90%	91%
Medical emergency management	80%	73%	69%	78%
Clinical governance	78%	No data/not applicable	48%	74%
Equipment and supplies	86%	No data/not applicable	62%*	85%
Overall score	88%	86%	75%	86%

Table 6: Global clinical quality score (QTA) by component and service delivery channel
* based on scores from fewer than four countries

In 2010, MSI programmes were able to maintain a similar level of quality compared with 2009 scores. Satisfactory scores were achieved in all areas in most countries. Sterilisation procedures, surgical and medical abortion, post-abortion care and infection prevention were performed to excellent standards, while medical emergency management and clinical governance saw slightly lower scores. Social franchising tended to score lower than outreach and centres, though they did well in key areas such as infection prevention and family planning. These results have led to a renewed focus on quality among franchisees, including development of new standard operating procedures and franchisee ranking tools, to help MSI programmes make improvements and prioritise support where it is most needed.

Client feedback on quality

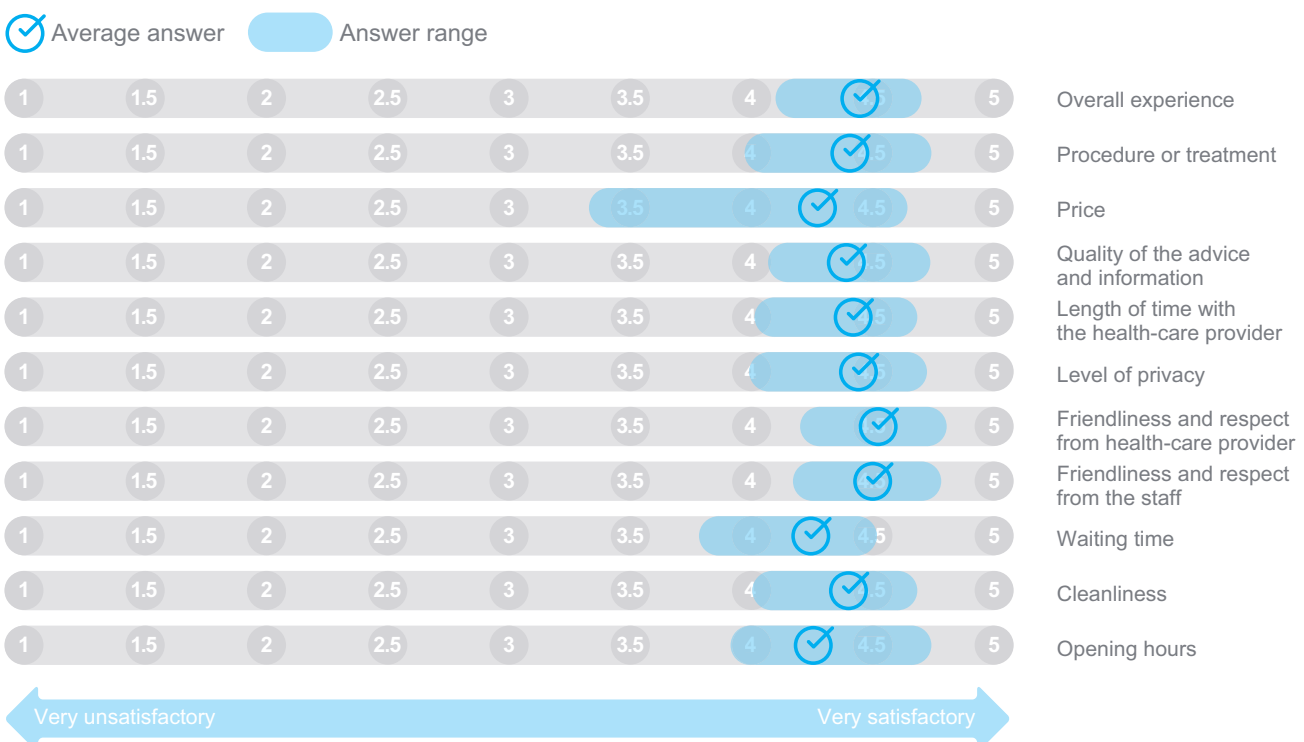
MSI takes pride in making the client the focus of services, and tailoring the services, environment and overall experience to best meet clients' needs and wishes. Client feedback is therefore an important indicator of MSI's success in this area. Figure 25 shows the average satisfaction scores reported by clients from the 12 countries and all delivery channels with exit interview data. The ranges show the lowest and highest scores for each aspect of care.

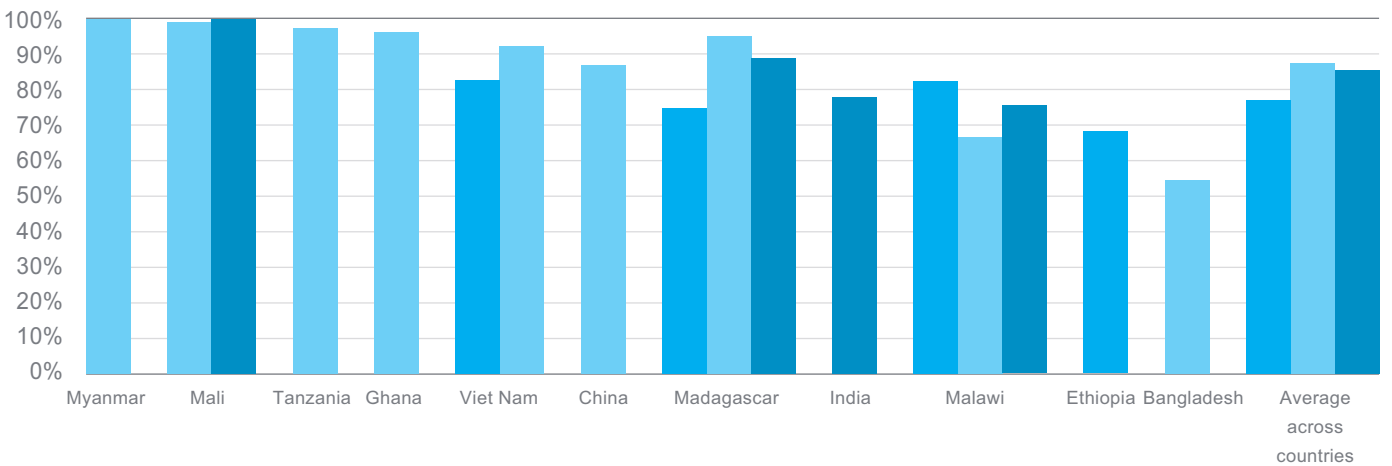
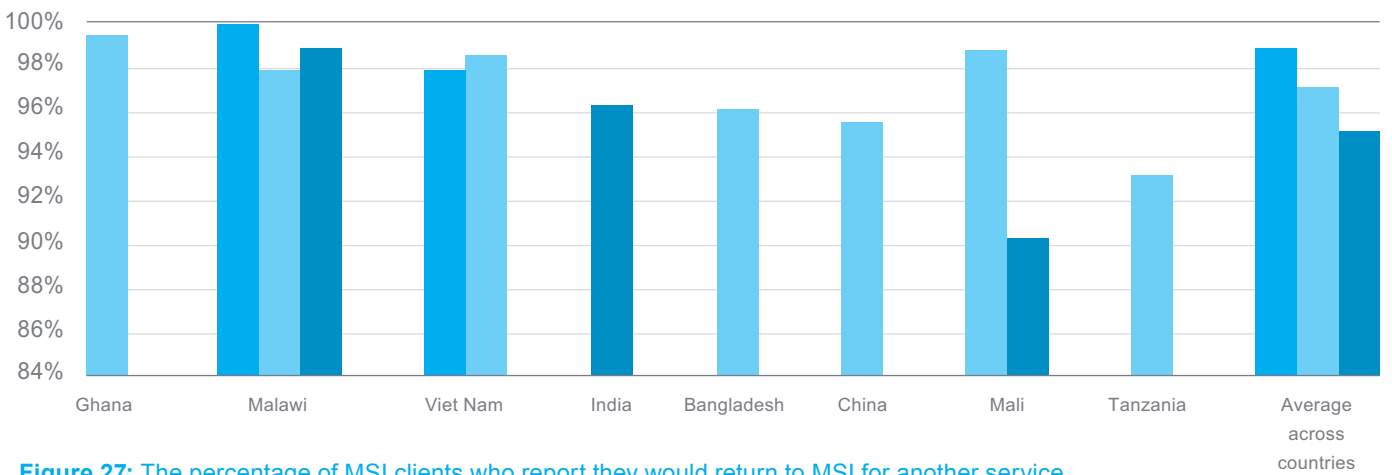
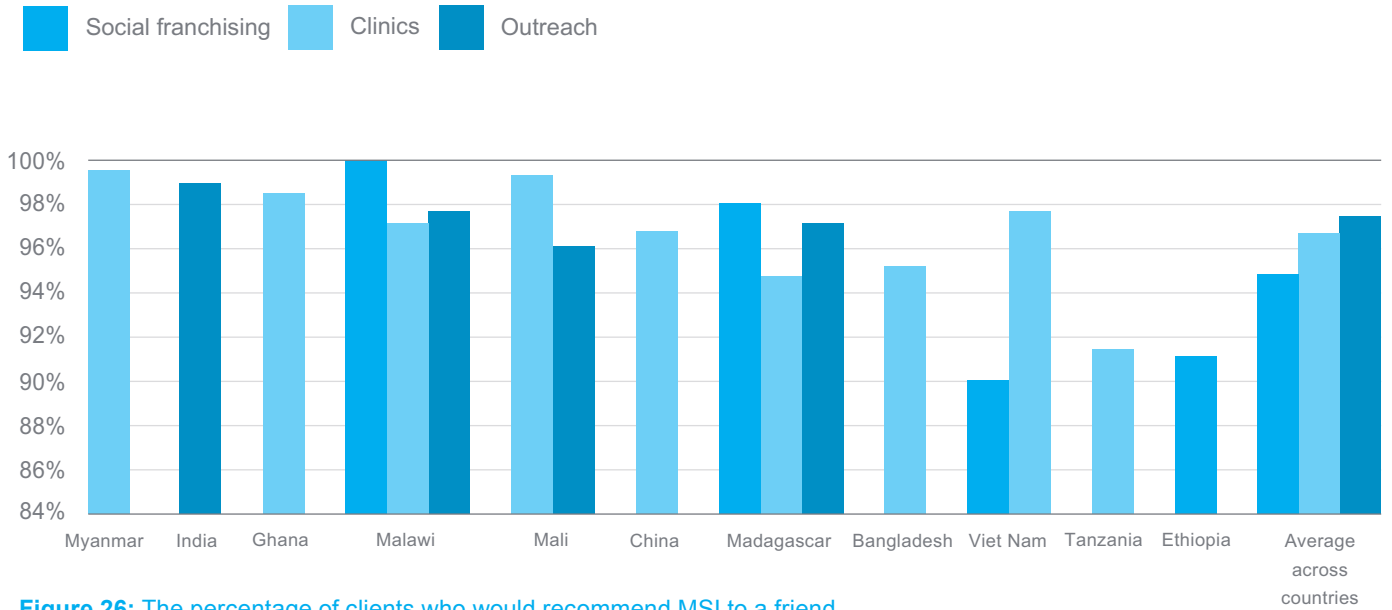
For all areas of care, the average scores across countries and delivery channels with exit interview data were between 'satisfactory' and 'very satisfactory'. This reflects MSI's commitment to client focus and high quality services in all countries and provider types. Scores lower than four (satisfactory) were only given for: price in Tanzania centres; Viet Nam centres and Viet Nam social franchises; procedure/treatment in Viet Nam social franchises; waiting time and level of privacy in India MSI outreach. Work is underway in each of these programmes to improve these areas.

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 for which data were available were satisfied with MSI's services.

An important aspect of quality care is to ensure clients are properly informed of what to do and where to go if they suffer a complication following the service. Figure 28 (p.58) shows the percentage of clients that reported that they were told where to go and what to do if they suffer complications from the service they received. Around 80% of clients reported being properly informed about follow-up care in all delivery channels, with variation by country and delivery channel. MSI has identified this as an area of service provision which needs to be improved.

Figure 25: Average client satisfaction by aspect of care across countries with exit interviews





IUD and implant discontinuation

Whilst some level of early discontinuation is expected among women choosing IUDs or implants, high levels of early discontinuation are a potential sign of poor counselling or poor clinical delivery. For instance, women may be ill prepared for the usual side effects, may have chosen an inappropriate method to meet their fertility needs or may suffer infection.

During outreach evaluations in Ethiopia, Sierra Leone, Myanmar, Pakistan, Viet Nam, Bangladesh and Uganda clients were followed up at different stages after receiving an IUD or implant to determine if they were still using the method.

Relatively high rates of discontinuation were seen among IUD clients in Sierra Leone, Myanmar and Pakistan. Meanwhile, IUD clients in Viet Nam and implant clients in Ethiopia and Sierra Leone were less likely to discontinue.

According to DHS data, 12.5% of IUD users in Viet Nam and 37.3% of users in Bangladesh nationally discontinue after 12 months of use. Discontinuation among MSI clients in Viet Nam (2.3%) and Bangladesh (5.6%) was far lower than the broader population indicating a high standard of counselling and service provision in these programmes. There is scope for improvement in the Sierra Leone, Myanmar and Pakistan programmes, though it should be noted that these discontinuation figures are in a similar range to national discontinuation rates seen elsewhere. In the 14 countries with sufficient DHS data, the percentage of IUD users discontinuing after 12 months ranged from 9.6% to 37.3%.¹⁶

Discontinuation prevalence	Implant			IUD					
	Ethiopia	Uganda	Sierra Leone	Uganda	Sierra Leone	Myanmar	Pakistan	Bangladesh	Viet Nam
at 3 months	0.4%	2.7%	0.7%	10.1%	4.6%	4.8%	3.1%		0.6%
at 6 months	0.7%		3%		13%	9.7%	7.7%		1%
at 8 months +	5.7%		6.2%		16.9%	20.9%	18.9%	5.6%	2.3%

Table 7: Discontinuation prevalence after 3, 6 and 8 months+

Among those women who had had their IUD/implant removed, the top three reasons for discontinuation were: experience from side effects (33.3%–81.1%); followed by expulsion (6.2%–44.7%); and the desire to become pregnant (3.7%–17.4%).

The findings from these evaluations resulted in improved training and other strategies to help ensure that women served through outreach are provided with adequate counselling. In Myanmar, for example, the most common reason for discontinuation reported by clients was side effects and bleeding. This finding led to the country programme focusing efforts on improving counselling skills relating to side effects and bleeding.

Of women who had not had their IUD/implant removed, the vast majority (79%–99%) knew when it should be removed. Similarly, the vast majority of women also knew where to go to have their implant/IUD removed.

Figure 29: Travel times to access removal services reported by outreach clients

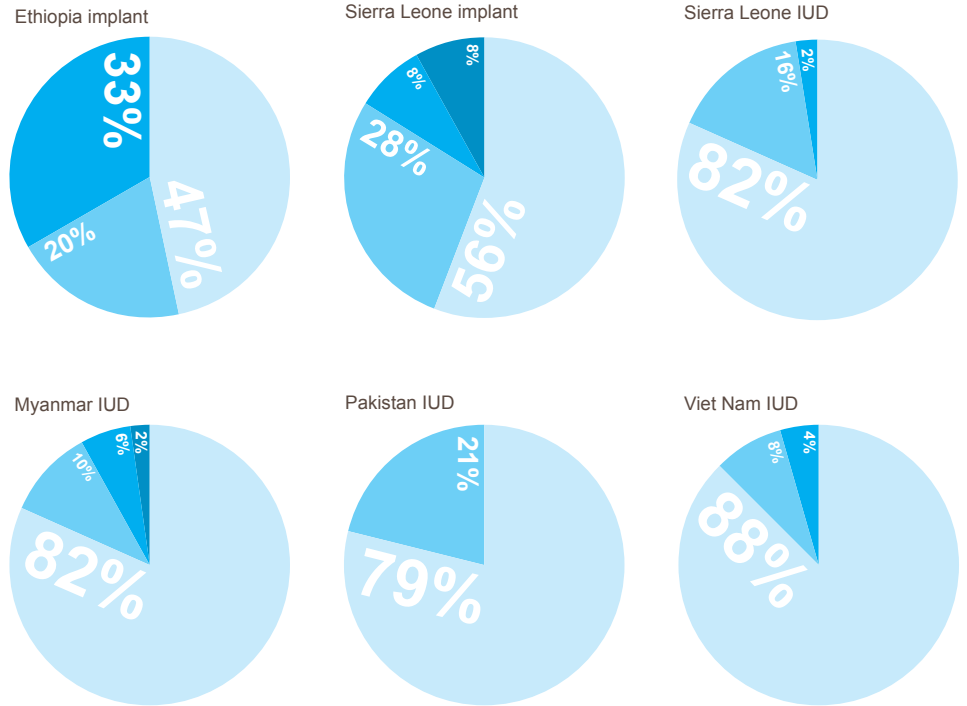
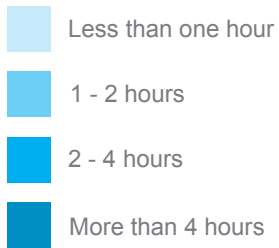
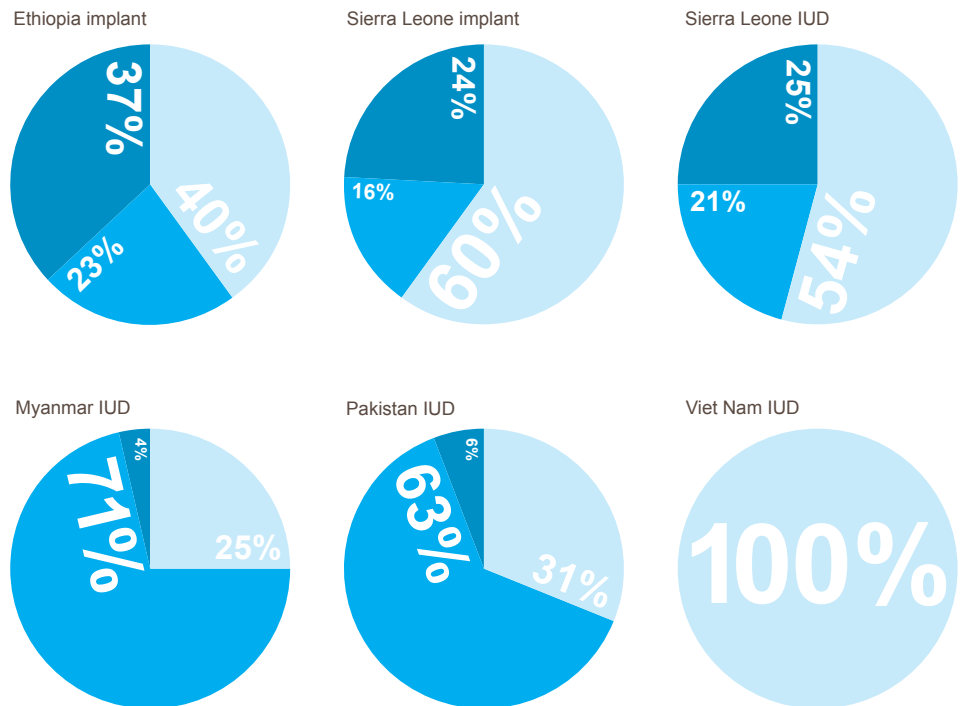
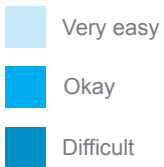


Figure 30: Ease of finding removal services reported by outreach clients



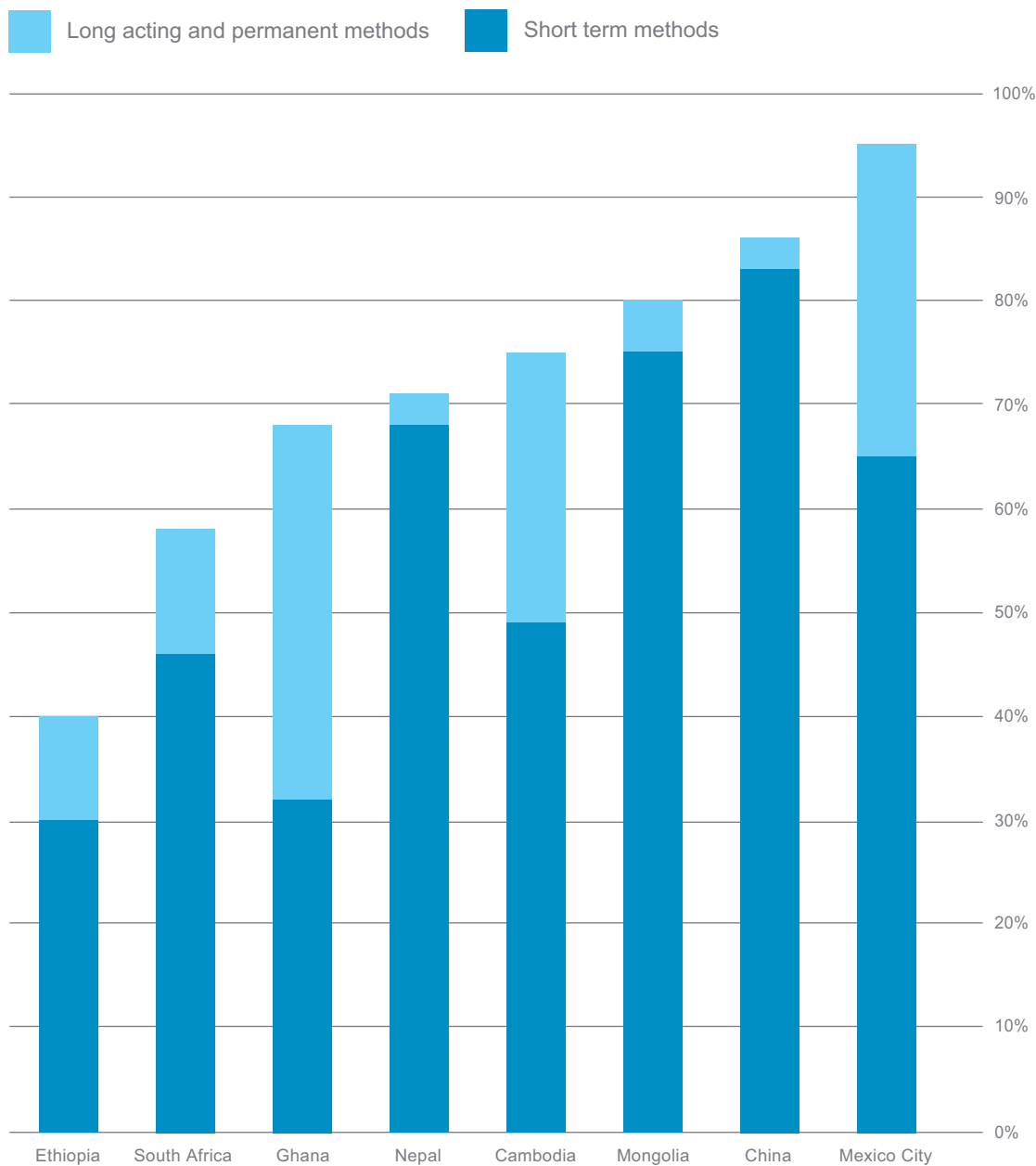
Women seeking removals services in the two African countries tended to have to travel further and were more likely to report that it was difficult. This may relate to less developed health infrastructures making it relatively difficult for women to access care in remote areas in Sierra Leone and Ethiopia. The MSI programmes in these countries are now considering how best to ensure all outreach clients have easier access to help should they need it.

Post-abortion family planning

Women seeking an abortion are likely to have unmet need for effective family planning. By providing abortion and post-abortion care (PAC) clients with family planning counselling and services, MSI seeks to reduce future unintended pregnancies and the rate of repeat or unsafe abortions. Figure 31 shows that for most countries for which data was available in 2010, the majority of MSI abortion and PAC clients received a family planning method. This is an important indicator of the quality of MSI's abortion and PAC counselling services, and one in which MSI seeks continuous improvement.^J

J: Due to client flows and data capture systems in clinics, this data is 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 31: The percentage of abortion or PAC clients receiving family planning



Conclusion

Over the course of this report, you've read the stories of Saada and Zeitu in Ethiopia, Zainabu in Sierra Leone, Farari in Zimbabwe and Marciana in Timor Leste. These are just a few of the millions of women whose lives have been changed by gaining access to reproductive health choices. These individuals must remain at the heart of MSI's work if we are to achieve our vision of a world where all births are wanted and all women can exercise their fundamental right to choose the size of their family.

The number of men and women using MSI contraceptives in 2010 exceeded seven million. Comparisons of the method mix among MSI clients and those in national populations indicated that MSI is succeeding in providing a variety of methods to our clients that better met their diverse needs. In many countries, MSI has reached significant percentages of all the women in need with family planning services. However, much work remains to be done in many countries, as unmet need remains high in many of the countries in which MSI works.

Similarly, MSI was able to do more to prevent the harm caused by unsafe abortion than ever before, through the provision of safe abortion or post-abortion care.

As a result of MSI's work in 2010, over four million unintended pregnancies and over 13,000 maternal deaths will be prevented.

In 2010, MSI demonstrated that more of its services are reaching the underserved than before. MSI services successfully reached young people, with a greater proportion of its clients being under 25 than the national population of modern method users in most countries. An estimated one in three of its family planning clients were first time users of contraception, and approximately one in five of its clients live below the extreme poverty line of \$1.25 a day, and one in three have less than a primary level of education.

Alongside an increase in service numbers, MSI has rigorously maintained a high quality of service. Discontinuation rates among IUD and implant users were below or similar to national averages. Client satisfaction levels were high. Post-abortion family planning was successfully being provided in most countries.

Despite these results, there are millions more women and men who still do not have access to quality SRH information and services. To address this need and increase the delivery of family planning and safe abortion services, MSI works in partnership with in-country governments, NGO partners and donors to leverage the impact of organisational experience, best practice and innovation.

In 2010, MSI launched its Power of Ten strategic plan for 2011-2015. This strategy calls for the acceleration of family planning closest to the client, the evolution of MSI's centres and catalytic innovation to increase quality and choice. In the coming period, MSI will maintain its focus on clinical quality and operational excellence supported by a strong evidence-base. MSI 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.

Throughout 2011, MSI will continue to develop and refine data collection tools, in order to provide a growing body of high quality evidence to assess and improve the impact of MSI's global family planning and safe abortion service delivery.



As a result of MSI's work in 2010, over four million unintended pregnancies and over 13,000 maternal deaths will be prevented.

Photo: Marie Stopes International / Susan Schulman

Annex 1:

Key MSI and national data in 2010

	Couple years of protection (CYPs) delivered by MSI in 2010	Women using modern contraception in 2010*	Women with unmet need for modern contraception in 2010 (this is unmet need + traditional method users)	Women using modern contraception in 2010 provided by MSI ^L	MSI's contribution towards the potential market (women using or in need of modern contraception) in 2010	Maternal deaths that will be averted due to MSI's 2010 services ^M	Unsafe abortions that will be averted due to MSI's 2010 services	Total number of unsafe abortions in country in 2010
Burkina Faso	49,013	620,019	866,383	13,369	0.90%	42	1,199	105,056
Ethiopia	573,288	2,893,422	4,450,083	137,971	1.88%	863	77,262	267,392
Ghana	66,843	783,799	1,620,325	15,600	0.65%	61	14,164	169,601
Kenya	1,065,263	2,783,786	1,874,625	472,473	10.14%	1,409	72,961	382,280
Madagascar	408,508	1,169,921	1,094,766	131,051	5.79%	461	34,903	187,611
Malawi	745,031	994,139	742,071	371,803	21.41%	948	50,927	137,744
Mali	47,974	181,837	887,755	15,728	1.47%	63	1,570	90,595
Nigeria	22,497	3,705,110	7,740,013	7,393	0.06%	29	510	1,047,910
Sierra Leone	226,280	114,992	337,057	58,377	12.91%	391	15,477	40,757
South Africa	171,528	7,083,887		16,584	0.21%	248	41,578	245,211
Sudan	5,525	402,847	1,973,773	669	0.03%	13	1,254	234,554
Swaziland	1,942	131,561	37,688	547	0.32%	2	89	5,572
Tanzania	636,106	2,310,877	2,143,611	477,570	10.72%	1,226	34,653	400,552
Uganda	864,654	1,254,528	2,197,305	313,879	9.09%	922	55,692	286,456
Zambia	30,796	661,480	796,245	9,463	0.65%	37	2,534	114,656
Zimbabwe	158,163	1,343,091	256,927	59,101	3.69%	305	8,730	126,610
Africa	5,073,411	26,435,297	27,018,627	2,101,576		7,020	413,503	3,842,559
Bolivia	71,454	609,391	769,703	30,152	2.19%	24	6,676	83,444
Mexico	51,492	14,202,645	3,340,621	10,158	0.03%	13	13,539	764,828
Latin America	122,946	14,812,036	4,110,324	40,310		37	20,215	848,272
Cambodia	200,525	906,432	1,151,210	41,136	2.00%	111	15,121	96,073
China	4,708	264,035,446	6,467,322	492	0.00%	1	0	0
Timor Leste	14,241	32,072	8,367	3,516	8.69%	9	689	5,910
Fiji & Pacific Islands	8,473	0	N/A	1,181	D/Q	0	120	646
Mongolia	118,469	469,361	41,345	17,029	3.33%	14	0	0
Myanmar	229,634	3,275,242	1,538,251	60,513	1.26%	94	12,586	332,438

K: Regional subtotals include only countries where MSI is currently operating.

L: From MSI's REACH Calculator, which is based on estimated number of users of MSI LAPMs in 2010 rather than service numbers. Excludes MSI's short term method users.

M: These impacts are not annual - they will be realised over a number of years. Eg. for every sterilisation provided by MSI in Pakistan in 2009, the woman will be protected from unsafe abortion and maternal death for the next 17 years on average. These two columns thus quantify the protective effect of MSI's LAPM services into the future.

	Couple years of protection (CYPs) delivered by MSI in 2010	Women using modern contraception in 2010 ^K	Women with unmet need for modern contraception in 2010 (this is unmet need + traditional method users)	Women using modern contraception in 2009 provided by MSI ^L	MSI's contribution towards the potential market (women using or in need of modern contraception) in 2010	Maternal deaths that will be averted due to MSI's 2010 services ^M	Unsafe abortions that will be averted due to MSI's 2010 services	Total number of unsafe abortions in country in 2010
Papua New Guinea	10,628	337,798	N/A	1,690	0.38%	4	161	5,170
Philippines	1,276,241	5,257,355	6,177,222	747,840	6.54%	197	63,246	559,293
Viet Nam	1,758,224	11,836,128	2,005,537	769,622	5.56%	198	120,739	582,475
Asia Pacific	3,621,143	286,149,834	17,389,254	1,643,018		628	212,661	1,582,006
Afghanistan	242,907	1,093,371	N/A	95,765	8.76%	509	7,778	114,840
Bangladesh	3,195,707	16,603,909	8,036,434	1,184,372	4.81%	1,897	189,893	816,987
India (Hyderabad)	4,339,783	125,492,258	46,545,332	891,363	0.52%	1,856	311,551	5,591,239
India (Delhi)	1,053,245	125,492,258	46,545,332	123,189	0.07%	356	30,861	5,591,239
Nepal	709,290	3,163,166	1,676,033	404,840	8.37%	583	74,596	140,585
Pakistan	1,584,019	6,918,715	9,609,030	656,167	3.97%	656	67,734	823,316
Sri Lanka	137,639	1,628,370	963,650	60,384	2.33%	9	7,077	95,857
Yemen	302,605	778,394	2,926,359	109,891	2.97%	78	4,044	46,103
South Asia	11,565,195	281,170,440	116,302,170	3,525,971		5,944	693,535	13,220,166
Australia	89,027	3,123,723	N/A	17,792	0.51%	2	0	0
Austria	11,124	953,065	98,638	7,823	0.74%	0	0	0
Ireland	2,937	928,648	N/A	1,645	0.15%	0	0	0
Romania	6,395	2,475,148	1,715,444	405	0.01%	1	351	26,546
United Kingdom	233,546	11,180,830	N/A	83,249	0.69%	9	0	0
Developed countries	343,029	18,661,414	1,814,083	110,913		12	351	26,546
Global sales	353,099							
Developing Countries	20,735,794	608,567,608	164,820,375	7,310,874		13,628	1,339,913	19,493,003
MSI TOTAL	21,078,823	627,229,022	166,634,457	7,421,787		13,640	1,340,265	19,519,549

Annex 2:

Glossary

Contraceptive prevalence rate (CPR)

This is the percentage of women of reproductive age (15-49) in a 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)

CYPs are used to compare different family planning methods according to the length of time over which they protect a couple from pregnancy. For instance, the average pill cycle protects for nearly a month, and the average intrauterine device (IUD) protects for about five years. The CYP conversion factor reflects typical-use method effectiveness, user discontinuation and age specific fertility differences.¹⁷ For latest conversion factors, visit the USAID website at www.usaid.gov

Disability-adjusted life year (DALY)

A DALY is a year of life, which is adjusted down in the case of impaired productivity due to sickness or disability. Health interventions can be compared according to the productive years that they add to a person's life. Health problems can be compared according to the number of productive 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.

Management information system (MIS)

The MIS refers to data about clients, services and finances that is routinely collected at an MSI centre, franchise or outreach facility and analysed at an MSI support office, in order to inform management decisions.

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.

Neonatal death

A neonatal death is the death of a live-born infant during the first 28 days after birth. Neonatal deaths account for a large proportion of child deaths.

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.

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. MSI aims to undertake QTA visits of all country programmes at least once a year.

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

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Where we worked in 2010

Africa

Burkina Faso
Ethiopia
Ghana
Kenya
Madagascar
Malawi
Mali
Nigeria

Senegal

Sierra Leone
South Africa
Sudan
Swaziland
Tanzania
Uganda
Zambia
Zimbabwe

Asia Pacific

Australia
Cambodia
China
Fiji & Pacific Islands
Mongolia
Myanmar
Papua New Guinea
Philippines
Timor Leste
Viet Nam

Europe

Austria
Ireland
Romania
United Kingdom

South Asia

Afghanistan
Bangladesh
India
Nepal
Pakistan
Sri Lanka

Arab World

Yemen

Latin America

Bolivia
Mexico