Santi — Rajasthan, India

We work every day in our programmes to give women, like Santi from Rajasthan, choice: choice over their fertility, their family size and ultimately their future.

But we know there is still much work to be done.

We know that despite India’s prosperity, there are still tens of millions of women and girls in the country who want to choose whether and when to have children, but are unable to get the contraception that would allow them to do so.

We are forging partnerships with the government and the private sector to improve the quality and availability of contraception and safe abortion services so that more women, like Santi, can take control of their lives.
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2013 marked a year of change for Marie Stopes International. We said goodbye to Dana Hovig after seven remarkable years as our CEO. Under Dana’s leadership, Marie Stopes International experienced exceptional growth, and achieved substantial impact, improving the lives of millions of women and girls around the world. I am excited to have joined such a dynamic organisation, and am proud of the significant progress we continued to make with our partners in 2013.
As CEO, I am committed to carrying Marie Stopes International’s momentum forward so that we continue to lead the way in working towards the eradication of unsafe abortion and reducing the unmet need for contraception.

Our momentum is shown by the incredible recent growth in the couple years of protection (CYPs) we have delivered across the world. A CYP is the contraception needed for a couple to prevent pregnancy for one year, and we delivered 24.5 million of them in 2013, an 18% increase on 2012. In this report we share with you the impact that our work – and this growth – had in 2013. And we take a closer look at how we have grown and developed over the past five years (2009-2013) by understanding and responding to women’s family planning and abortion-related needs.

This report is the first in a series over the coming year which will reflect on our recent successes and look to the future at the steps we need to take to remain responsive, sustainable and equitable. Reflecting on where we have come from will help us to forge the future – the focus of our next report.

Our mission is to enable women and girls to have children by choice, not chance. Our expansion of contraceptive, safe abortion, and comprehensive post-abortion care services has helped drive us towards this mission. These services, and their sustainable long term growth, will continue to be our focus in the coming years. We believe that providing women and girls with a full choice of methods, ensuring quality services, and doing everything we can to reach the most excluded groups is critical if we are to protect and promote sexual and reproductive rights.

We are committed to expanding quality services for marginalised women and girls; helping improve their lives, and those of their families and communities. This commitment and expertise helps us to care for our clients, support governments and play a critical role in the achievement of FP2020’s goal: to provide 120 million additional women in 69 of the world’s poorest countries with contraception by the start of the next decade.

In July 2012, Marie Stopes International pledged to provide 6 million additional women in these countries with voluntary family planning services, while helping the 10 million we had already reached continue to use contraception, and offering greater choice of method to a further 4 million women. We are well on our way to meeting this goal; we estimate that by the end of 2013 we had already supported an additional 2.7 million women to access high quality contraceptive services.

Finally, we are committed to maximising the sustainability of the services we provide to ensure that women and girls can count on quality family planning and abortion-related services for generations to come. This will mean further evolving our delivery channels to be responsive to the changing needs and preferences of our clients, positioning our services within the overall health system of countries where we operate, developing long term partnerships with a diverse range of other public and private sector providers and organisations, and investing in world class people and systems to maximise the efficiency and effectiveness of our services.

While this report is a chance for us to look back, we are always thinking about the future. We are learning from where we have been, so that we can continue moving forward, innovating, exploring and identifying new ways of delivering services. In order for our next five years to be even more successful than the last five, we will ensure that our services are sustainable, equitable and tailored to the next generation of clients.

Simon Cooke — CEO
Section 1
Our impact

To achieve our mission of children by choice, not chance, Marie Stopes International is committed to increasing the availability of contraception and reproductive health services in a way that is equitable and which has significant health impact for individuals and the societies in which they live.

Ma Khiin Kywe works in Mandalay, Myanmar, educating communities about sexual and reproductive health. She says one of the main barriers to contraceptive use in her country are the misconceptions that exist.
We know from nearly 40 years of providing high quality services that accessible modern contraception, safe abortion, and post-abortion care (PAC) services are essential if women and girls are to fully enjoy their sexual and reproductive rights. These services are also among the most cost effective public health interventions. They protect women and girls from experiencing unintended pregnancies and from the harm of unsafe abortion and other pregnancy-related complications, while promoting gender equality and economic prosperity.

In 2013, we provided contraception to more people than we ever have before in a single year: 6.1 million. In addition, an estimated 9.5 million women were still using contraception that we provided before 2013. With 15.6 million women around the world using a method of contraception that we supplied, the health impact as a result of our work was enormous.

We have been able to achieve this impact because we have responded to women’s needs, giving more of them access to contraception and – where permitted – safe abortion services. In partnership with others, year on year we have increased our health impact across the world. Indeed, we estimate that our services saved well over twice the number of women’s lives in 2013 as they did four years before, in 2009, and the number of unsafe abortions we prevented had more than tripled compared with what we achieved in 2009.

In 2013, because of the 15.6 million women using a Marie Stopes International supplied contraceptive, and the 3.1 million safe abortion and post-abortion care services we provided

- 6.2 million unintended pregnancies were prevented
- 2.8 million unsafe abortions were prevented
- 14,300 maternal deaths were prevented
Case study: Reaching remote communities by any means

Joe — Papua New Guinea

“Around here, everyone knows a woman who has died in childbirth, and to reduce the chance of falling pregnant again, many husbands and wives don’t sleep in the same bed.

“The isolation of these communities is extreme. People don’t have the money to travel and access healthcare, so we bring it to them, however we can. Most couples here have five children, some as many as 12. Access to birth control is a new opportunity for most.”

Joe is an outreach team leader in Papua New Guinea. These remote, hard-to-reach places that he visits with his team are home to 85% of the population in Papua New Guinea.

Partnering with provincial health authorities to provide clinical services out of government health facilities is a proven model for Marie Stopes Papua New Guinea to bring contraceptive choice to remote communities.

Read more case studies about our work at www.mariestopesimpact.org
We aim to reach three priority groups: those not using contraception, young women, and those living in extreme poverty. We survey representative samples of our clients to help us understand our performance in reaching these groups.

Adopters of contraception

Unmet need for contraception (women who want to space or limit their next pregnancy, but are not using family planning) remains high in many of the regions where we work. Reducing this need is critical to ensuring that women can fulfil their right to choose if and when they have children. We assess our progress in this area by measuring what proportion of our clients are “adopters” – women who were not using contraception before accessing our services. Reaching adopters plays an important role in expanding access, and is critical for countries to make progress towards their FP2020 goals of reaching additional users.

Who we reached in 2013

4 in 10
Across our developing country programmes in 2013, an average of four in 10 (38%) of the clients we served were adopters of family planning.

We are also committed to sustaining services to women who already rely on us; in 2013 37% of our clients were returning to us so that they could continue to use contraception. By sustaining services to our existing clients and reaching out to adopters, we are helping to combat unmet need, and are increasing the prevalence of modern contraceptive choices in the regions we work in.

Women living in extreme poverty

Women living in extreme poverty are less likely to know about and use contraception than those who are more affluent, making them more likely to be affected by unintended pregnancy and its potential consequences, including unsafe abortion. Added to this, the poorest people in developing countries are less likely to have use of health facilities, meaning they have fewer options if they do suffer complications. Making our services available to women living in poverty is critical.

Our clinical outreach services are free or subsidised, and we also provide vouchers for clients to receive subsidised services through our social franchise clinics.

Young women and girls

Young women (here defined as 24 or under) and girls are less likely to be using contraception than older women, and are at greater risk of injury or death if they become pregnant. The biggest killer of 15 to 19 year old girls globally is pregnancy and childbirth, with around 70,000 deaths every year, and the number of women and girls aged 15 to 24 is increasing. By 2020 it is estimated there will be 106 million in sub-Saharan Africa alone; 30% higher than the number in 2010. This makes it critical that young people who are sexually active are able to choose contraception.

Figure 3. Proportion of 2013 clients in our three priority groups

These results are promising, and show we are helping to drive growth in the number of adolescents using contraception in some countries. But with 6% of our clients on a global level aged 19 or under, we know there is much more we need to do. Our investment in understanding who our clients are, and the preferences and unique needs of young women and girls, will be crucial as we strive for greater success in providing them with contraceptive choices.
Section 2
Achieving results by responding to our clients’ needs

The large health impact of our work, and our success in delivering family planning in an equitable way, is rooted in our adaptability and our commitment to responding to the needs of women and girls. We are committed to serving our clients through the delivery channels that work best for them. Because our clients are diverse, we employ a diverse range of service delivery mechanisms (see p.10) each of which is tailored to suit unique local circumstances and to the changing needs of the women, girls and their communities. We also work to improve the environments our clients access services in, to make these more accessible and equitable.

Mary lives in Nasarawa State in Nigeria and has one son. She told us: “When I first learnt about family planning, I got the idea that I would use it and take control of my family and my life. I want to care for this child and to train this one first. When I have done that, then I will have another.”
We are constantly evolving and innovating to be more responsive to those we serve, without ever compromising our quality. And since we know that women’s needs are different around the world, we make sure we adapt our service delivery models to best meet the needs of our clients; from large outreach programmes in sub-Saharan Africa aimed at reaching marginalised women to large social marking programmes in south Asia aimed at providing convenience to lower and middle income women (Figure 4).

Figure 4. Distribution of MSI family planning, post-abortion care and safe abortion services (CYPs) by region and delivery channel in 2013

- Clinics
- Outreach
- Social franchising
- Social marketing
- Community based distributors
- Other

*Within Latin America, we work in Bolivia and Mexico.
In sub-Saharan Africa, the large majority of people in the countries we work in live in rural areas, where family planning is often inaccessible and unaffordable, creating an urgent need for equitable, quality services. We meet this need by using a range of different clinical outreach models. These respond to the needs of women and girls, and the health systems we work within. Donor partner funding, allows us to directly deliver, with our own providers, a full range of contraceptive services, including long acting and permanent methods, where they may otherwise not exist.

In 2013, more than half of the CYPs we delivered in Africa, and significant proportions in the other regions we work in, were provided through outreach. We achieved this through careful prioritisation of marginalised communities with a pressing need for free, high quality family planning.

Responding to the need in marginalised areas

Marie Stopes International clinics
Our clinics remain the backbone for our operations in many countries. They act as a base for training, and a vital logistical hub where outreach teams and community based distributors can re-stock supplies and sterilise equipment. They also consistently deliver around a sixth of our services.

Social franchising
Private healthcare providers are commonly used by people in developing countries, particularly in areas far from state-run facilities. The quality of these providers can be variable however, and governments are often unable to regulate them. Our social franchise network, BlueStar, engages private providers to deliver high quality family planning and safe abortion services.

Social marketing
We run social marketing programmes that market and distribute low cost and free condoms, contraceptive and medical abortion pills, and other health products through pharmacies, community based distributors and other private providers. For men or women who are unlikely to visit a more formal healthcare facility, social marketing provides a vital service.

Mobile clinical outreach
Our outreach teams serve a critical role in the health systems of the countries in which we work. Our teams bring free or subsidised services to rural and urban locations where existing public and private health clinics struggle to meet the needs of women and men, or to offer a full range of contraceptive options. Through partnership with ministries of health and ongoing relationships with hard-to-reach communities, our outreach ensures reliable access to high quality sexual and reproductive health services for those with the greatest need.

Community based distribution
Where health infrastructure is weak, we empower community members to deliver information, counselling and low technology primary healthcare services to other members of the community. We often integrate community based distribution with our other service delivery points to create demand, expand choice, and respond to the needs of underserved populations for family planning services.

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Case study:
A sense of security in insecure times

Mary — Juba, South Sudan
Mary, now 21, became pregnant a few years ago when she was still at school. She had to drop out for a while, but determined to complete her education, she moved to Juba.

Mary came to a Marie Stopes outreach session because she wanted a long lasting method of contraception to stop her worrying about another unplanned pregnancy. After counselling, she chose an IUD which she was able to have fitted free of charge.

Mary earns a living brewing alcohol with other women in her compound, but since the crisis started in December 2013, they've had very few clients and are earning only a dollar or two a day. Some days Mary can't afford to eat so she felt that another child would make her life even more precarious.

Providing choice in a fragile state
In South Sudan, we have been adapting our outreach models, in rural areas and the capital city, to respond to the pressures of a fragile state.

Getting our services to the most remote parts of South Sudan is challenging: the country’s roads are in a state of disrepair, during the seven month rainy season many become impassable, and the risk of violence is high. But by partnering with the UN humanitarian air service, we are able to fly our teams to isolated areas, where women would otherwise be out of reach.

South Sudan’s capital, Juba, can be a difficult city to move around, because of both the infrastructure and the prohibitive cost of transport. So, we’ve set up small mobile teams who travel to its peripheries – where we know residents can’t afford travel or healthcare – to provide services that would otherwise be unavailable in public clinics. Since the crisis in December 2013, the same teams are visiting camps for internally displaced people in the city where they work in partnership with the humanitarian NGOs responsible for general healthcare, ensuring that sexual and reproductive health and rights are integrated into the basic package of care.

Alongside delivering contraception, we provide hands-on training to local health workers. Given the fragility of South Sudan, it’s imperative that we build capacity so that services can still be offered in times of instability.
Responding to the health market by making sexual and reproductive healthcare more convenient

Across the developing world, people’s interactions with the healthcare system are evolving, and many are choosing to access healthcare outside of traditional clinical environments. For example, we know that a third of all women who use contraception in the African countries we work in purchase the commodities from pharmacies or private providers. Among young (24 or under) unmarried women, the figure is over two thirds, which reflects the preference for anonymity among young users of contraception. In this context we are constantly changing to make sure that our services remain relevant, convenient, and accessible.

Our south Asia programmes exemplify this. Just five years ago 71% of our services were delivered through our own static clinics, or mobile outreach teams. Over the last few years we have responded to more people choosing to access basic healthcare in a more convenient manner, through pharmacies and private shops. Our expansion of social marketing in south Asia meant that nearly half (45%) of the CYPs we delivered in 2013 came from this channel, suggesting we are expanding women and girls’ contraceptive choices in the places where they already access healthcare.
We have also tapped into the trend for people to access healthcare in a more convenient manner through social franchising. In 17 countries and across more than 3,000 outlets, we use social franchising to increase the quality of existing clinical providers. These services have grown at an impressive rate in recent years: from 1,070 franchisees in 2009 to 3,190 in 2013. Franchising brings improved quality and contraceptive choice to existing clients, and helps expand access to new ones.

Increasingly, we also link these services to demand-side financing mechanisms like vouchers and insurance, so that poorer clients are able to afford them. The rapid growth in this delivery channel has meant that the number of users of contraception served each year by our franchises has rapidly grown, partly driven by a fourfold increase in implant clients since 2011, and a 55% increase in IUD users in the same period.

In the Philippines, our BlueStar social franchise network is improving the quality and availability of contraceptive services for Laarni, and thousands of other women.

**Figure 6.**
Contraceptive users served each year through social franchising - by method

- **Injectables**
- **Pills**
- **Condoms**
- **IUD**
- **Implant**
- Female/male sterilisation

We found that our clients, on average, had the shortest travel time to get to a social franchise outlet (19 minutes) compared to travel time to clinics or outreach sites.
We believe that it is not enough for a woman to have the choice of whether or not to use contraception. If reproductive rights are to be truly promoted and protected, it is clear that women and girls need fully informed choice, with the opportunity to select from a full range of methods. Marie Stopes International is committed to expanding genuine choice in family planning where it doesn’t exist.

Figure 7 (below) shows the contraceptive methods being used in 2013 by the clients we served and the significant variations in these across different regions. If there are contraceptives that are difficult for women and girls to obtain in a particular area, we focus on expanding access to these, filling the gaps so that they can enjoy genuine choice.

Responding to the need for full choice in family planning

<table>
<thead>
<tr>
<th>Region</th>
<th>Female sterilisation</th>
<th>Male sterilisation</th>
<th>Implant</th>
<th>IUD</th>
<th>Short term methods</th>
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<tbody>
<tr>
<td>Africa</td>
<td>15%</td>
<td>15%</td>
<td>44%</td>
<td>15%</td>
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<tr>
<td>South Asia</td>
<td>21%</td>
<td>29%</td>
<td>36%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Pacific Asia</td>
<td>15%</td>
<td>15%</td>
<td>39%</td>
<td>15%</td>
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</tr>
<tr>
<td>Latin America*</td>
<td>15%</td>
<td>29%</td>
<td>29%</td>
<td>5%</td>
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*Within Latin America, we work in Bolivia and Mexico.
The clearest example of our commitment to expanding choice is from our programmes in sub-Saharan Africa. For many years, the large majority of the women using our contraception there had chosen either a short term method, or a permanent one. In more recent years (see figure 8), we’ve been able to steadily expand access to long acting and reversible contraception; in particular, implants, creating greater choice for women.

Implants are an increasingly popular option for women who want to have children in the future, but find shorter term methods inconvenient. But they are often unavailable to many women in the region, because many health clinics don’t provide them. Implants gained greater availability in 2013 in large part due to partnerships developed between pharmaceutical companies and several influential donors. A price volume guarantee from two of the main implant manufacturers, Merck and Bayer, as well as a global allocation of implants from the UNFPA, helped us secure more implants for our programmes.

By the end of 2013, 40% of the women and girls using contraception that we provided in Africa (over 2 million) were using implants. This has been driven by the strategic expansion of our outreach and social franchising services, which have responded to the lack of contraceptive choice that women and girls in remote areas experience. These channels have been able to expand implant services as a result of stronger supply chains and diverse financing mechanisms, which have combined to reduce costs. Implant removal services across all our delivery channels have also helped to safeguard women’s choices. They ensure we are prepared to serve the growing number of women and girls that require quality implant removal, along with counselling on other forms of contraception.

This increase in implant provision hasn’t just driven a rapid expansion in the number of women in Africa using Marie Stopes International family planning; it has also helped influence national patterns of contraceptive use. In Ethiopia, for example, by the end of 2013 there were 238,000 women using a contraceptive implant that we had provided, which is over a third of all implant users in the country.10

In the countries where we work in south Asia, where approximately two in three women using family planning have had a tubal ligation, and less than one in 20 (4%) are using an IUD, we are also committed to expanding choice. One in five of the women using family planning that we provided in south Asia (1.5 million) now use an IUD, driven by a 50% increase in our IUD users since 2011. With the cost of hormonal IUD products set to lower in the future, we look forward to continuing on this success, and ensuring that our clients in south Asia always have a full range of contraceptive options to choose from.

Figure 8. Users of MSI contraception in Africa by method, 2009-2013

In 2013, one in three (31%) of the outreach clients that we served in sub-Saharan Africa came to us to switch from a short to a long acting or permanent method of contraception. Many of these clients would not otherwise have had access to a full range of methods.
Responding to the consequences of unsafe abortion

Unsafe abortion causes at least 13% of all maternal deaths around the world. And in the regions where we work, every 15 minutes, a woman dies needlessly because of an unsafe procedure.12

One of our central goals is to eradicate unsafe abortion. Making sure women have the option to use contraception is part of the solution - our family planning services prevented 6.2 million unintended pregnancies in 2013 alone. The other part is helping women who do decide to end a pregnancy to fulfil their right to a safe abortion, where legal, or to access post-abortion care (PAC) if they suffer complications from an unsafe procedure.

Medical abortion and medical post-abortion care are a safe13 alternative to surgical services, which can be delivered outside of a healthcare centre, offering more women greater control over what service they receive, who they receive it from, and where they receive it. Our social franchises and social marketing programmes have been instrumental in increasing access to medical abortion and post-abortion care. Ensuring the quality of these services remains our top priority. We train pharmacists and community health workers to advise clients about home based use. We also conduct mystery client surveys with these providers to ensure they are giving accurate advice to clients, and we run call centres, staffed by clinically trained operators. In Bangladesh for example, our call centre receives nearly 4,000 calls every month from clients seeking advice. This enables us to counsel and advise on appropriate use, and address any quality concerns or make referrals when needed.

We are committed to responding to the need for safe services and guaranteeing quality, convenience and confidentiality. Combined, our family planning and safe abortion services prevented an estimated 2.8 million unsafe abortions in 2013. Our ability to offer more clients these options has been driven in recent years through an increase in medical abortion and medical post-abortion care. When we first began to provide access to medical abortion and post-abortion care in 2006 it accounted for just 3% of our safe abortion/PAC services, but by 2013 it made up 84% of these services, with the number of surgical procedures remaining relatively constant.

Figure 9. MSI safe abortion and post-abortion care services, 2009-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1.5</td>
</tr>
<tr>
<td>2011</td>
<td>2</td>
</tr>
<tr>
<td>2012</td>
<td>2.5</td>
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<tr>
<td>2013</td>
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In Bangladesh, our call centre receives nearly 4,000 calls every month from clients seeking advice.

Medical
Surgical
While the majority of our efforts focus on expanding access to contraception, we recognise that many other barriers exist that prevent women from using it. In fact, when married women with an unmet need for modern contraception are asked why they are not using contraception, the majority do not cite cost or convenience as the main reason.\textsuperscript{14} The most common reason given was concern about health, either generally or related to side effects (29%).\textsuperscript{15} Therefore, we know that it is not enough for us to expand our services. We must also partner with community groups, governments, and other organisations to address barriers related to social norms, stigma, and misinformation. Many of these barriers are especially large for young people; and so we are finding new and innovative ways to provide them with contraception. For example, in Senegal we are moving out of the clinic and talking to young people where they are (see p.18). Listening to them, working with them and utilising messaging that resonates is key to expanding services to this important group. With more than half of the world’s population under the age of 25,\textsuperscript{16} we firmly believe that the social and economic potential of young people will not be realised unless they can choose their own futures and access their rights to a full range of sexual and reproductive health services.

**Case study:**
Post-abortion family planning gets a good reception in Cambodia

We know from our programmes that women who seek an abortion often aren’t using effective contraception. So by offering our abortion and post-abortion care clients voluntary family planning counselling and services, we hope to reduce future unintended pregnancies. Our team in Cambodia is trialling a way to increase the uptake of post-abortion family planning using mobile phones.

Interviews with our clients in Cambodia revealed that women often find it difficult to make a decision about contraception right after an abortion. So, in addition to offering services on site, we began working with an interactive voice response system, to use voice messages as a way of reminding women what their options are. A week after the procedure, we send our clients a pre-recorded voice message inviting them to think about contraceptive options.

In Cambodia, a large proportion of the population use mobile phones, and with near total network coverage, it’s an effective channel to deliver messages to the majority of our clients.

**Responding to the need for education**
Stigma and shame about sex is leading to a generation of young people in Senegal who don’t know how to prevent pregnancy and sexually transmitted infections, but with many young people reluctant to go to formal health settings, how can we reach them?

In Senegal, our team has responded to this challenge by taking the information to where they know young people will be: in Dakar, that’s often the beach. Here are some of the insights we received:

“Let me tell you one thing: women don’t get so many babies here because they want to, but because they don’t have a clue about family planning. Senegal is a highly religious country with conservative morals, especially when it comes to sex. How many children people have depends on their wealth and education. The poorer and less educated, the more children. And what future do all these kids have?”

— Pape, Dakar

“Talking about sex is a big taboo here. Sex outside of marriage doesn’t even exist. Officially, that is, because of course it happens. What do you think? Youngsters here want to experiment and live life to the fullest just like people anywhere else.”

— Thiki, Dakar

“Of course we have lovers, girlfriends and boyfriends here, too. The thing is, if you have a girlfriend, you tell it to nobody. Certainly not to your family, but often neither to your best friends. You are always afraid that somebody will find out and make a scandal.

“But what to do? Sex is a natural part of life, I think. However, because it’s so criminalised and secretive here, lots of people lack even the most basic knowledge about stuff like contraception, STIs and so on. That certainly goes for many friends here on the beach.”

— Elhadj, Dakar

Read more case studies about our work at www.mariestopesimpact.org
Not only do we work to improve access and knowledge within communities, but, we also work at a national level to ensure policies help promote equitable access to family planning and reproductive health services. In 2013 we worked to address policy barriers and promote policy change in 15 countries. We take a broad approach when it comes to responding to women’s need for reproductive health services. Our engagement with policy makers across the different countries we work in has helped bring about changes that have made reproductive healthcare easier for women to access.

In Bangladesh, we played a key role in developing new regulations that permit the use of misoprostol for menstrual regulation. This will be crucial in reducing the harm that is caused to women by the indiscriminate and sometimes dangerous use of a range of medical abortion methods.

In Sierra Leone, reproductive health commodities were often going out of stock at delivery points, due to the import duty being charged on them, which caused delays at customs. We convened a committee which investigated the harm that these import duties were causing, and this ultimately resulted in them being removed. This has helped improve the distribution of vital reproductive health commodities across the whole country.

And in Uganda, we were influential in supporting policy change with a group of partners, which has helped expand access to tubal ligation services. As a leading member of the Uganda Family Planning Consortium, we helped obtain formal endorsement from the Ministry of Health for clinical officers to perform tubal ligations. This significantly increased the number of health professionals able to provide the service. We played a key role in providing compelling evidence that this task sharing would not compromise quality standards, through research we undertook with USAID funding.

These examples showcase the breadth of our approach when it comes to responding to women and girls’ reproductive health needs. We will continue to use evidence and analysis to advocate for policy reforms that we can show will advance women’s rights, through making reproductive health services more accessible.

We are committed to better understanding who our clients are, as well as the women we have not yet reached. This helps us to ensure we are reaching the most vulnerable clients, providing equitable services, and using insights to improve our services. For the past few years, we have been conducting annual surveys with representative samples of our clients so we can track how effectively we are reaching particularly important groups, and how clients feel about our services.

While these surveys are useful to give an annual snapshot of our clients, we have realised they are not enough. Therefore, we have been investing in a new client-based information system, which we call CLIC. This system allows us to routinely collect data about our clients so we can track our performance in reaching the most important groups on a daily basis. It also makes it easier for us to arrange follow up visits when clients need their method re-supplying, or may want post-abortion family planning, ensuring high quality standards. In Ghana for example, our call centre has been able to run reports through CLIC alerting them to which clients they need to call to arrange follow up appointments for their family planning.

In addition to CLIC, we are investing in large studies across the countries we work in to gain insights into the women and girls who we have not yet reached. This will lead to a better understanding of who our potential clients are and what we need to do to bring them the choices they want, helping us broaden the reach and sustain the equity of our services.

This focus on improving the way we serve our clients, and crucially gaining insights about them, ensures that as we expand, we remain true to our mission. We will always work to respond to the needs of the women who face the biggest hurdles in choosing contraception.
The future
Staying responsive

Our success in increasing our scale, health impact, and ability to advance women’s rights has been built using our clients’ needs and preferences as our compass. We will only continue to have success in these areas through using evidence and analysis to understand our clients, the women and girls we are yet to reach, and the contexts and communities in which we operate.

In the coming years, the number of women of reproductive age will grow at the fastest rate in history – we must be ready to serve them. Only with a focus on adaptability, quality and equity can we hope to play our part in serving women, girls and their partners for decades to come.

Our planning for the future is well underway. In the next instalment of our Global Impact Report, we will outline the steps that we, and the broader development sector, need to take in the coming years to make reproductive healthcare available to all the women that want it, whoever they are, wherever they may be.
### References


8. Ibid.

9. Marie Stopes International implant user estimate, and proportion of total, based on historic family planning service provision numbers, and Impact 2.

10. Marie Stopes International implant user estimate based on implant service provision and Impact 2. We estimate this is 35% of implant use in Ethiopia, based on UN population prospects data, and growth of implant CPR from the 2011 DHS figure (2.3%) based on the rate of growth between the 2005 DHS figure (0.1%) and 2011.

11. Based on weighted analysis of the most recent DHS datasets from Bangladesh, India, Nepal and Pakistan, which accounted for 89% of our south Asia users in 2013. We also work in Afghanistan, Sri Lanka and Yemen, in the south Asia region.


13. Ngo, T, Park, MH, Shakura. H & Free, C; ‘Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review’ in Bull World Health Organ 2011; 89:5. Research shows that medical abortion is just as safe and effective at home as when it takes place in a clinic).


15. Ibid.


For a breakdown of impacts and CYPs delivered by country and region, visit www.mariestopesimpact.org
Every day, 800 women die from causes related to pregnancy and childbirth.

Worldwide, one woman dies every 11 minutes from an unsafe abortion.

Teenage pregnancy is the number one cause of mortality for girls aged between 15-19.

Millions of lives could be saved if women had access to basic healthcare and contraception. Sign our petition and join us in the worldwide effort to Make Women Matter: www.makewomenmatter.org
Acknowledgments

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

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