



MARIE STOPES
INTERNATIONAL

Time to Act: Achieving a world where no woman dies from unsafe abortion



The world cannot sit and wait for more women to die.

I have seen women's dreams, aspirations and hopes for a better future for themselves and their family be taken out of their hands because of lack of access to modern contraception.

I have watched women feel powerless because they didn't have choice over how and when to give birth.

I have witnessed the destruction unsafe abortion wreaks on families and communities.

I have been screamed at by a woman who was angry at me because our services came too late.

Women cannot wait any longer.

Faustina Fynn-Nyame
Country Director, Marie Stopes Kenya.



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The world today

Counterfeit drugs, quack 'doctors', tea-leaves, knitting needles, even small bottles filled with explosives inserted into the uterus – these are just some of the things that girls and women turn to – nearly 22 million times a year – in a desperate attempt to end their unintended pregnancies.

The world today

- 222 million women who don't want to get pregnant but aren't able to do anything about it.¹
- 21.6 million unsafe abortions each year.²
- 8 million women who suffer disability or complications from unsafe abortions.
- 3 million of those don't get the care they need.³
- 47,000 women die every year.⁴

Throughout history, in every country, women find themselves faced with a pregnancy they didn't intend. Some will have been unable to get contraception, some unable to negotiate using contraception with their partners. For others, their method may have failed. There can be many reasons both within and outside of a woman's control. Whatever the reason, the consequences of not being able to control her fertility can be dire.

Some women are fortunate enough to find a supportive way forward, keeping plans on course, and dreams alive. For many others, like Jane, they see no solution that does not bring shame, desperation or risk to their lives.

"I was young - I didn't know how to take care of a baby. I was confused. But I came to my final decision to have an abortion."

Jane drank concentrated tea-leaves, an abortion method suggested to her by friends, along with detergent and boiled Coca-Cola.

"Immediately after I drank the tea I started vomiting, even vomiting blood... After thirty minutes I started to bleed heavily from my vagina... I was feeling dizzy, whenever I tried to stand up I fell down."

"One of my friends came and gave me something, some medicine that she got from the quack doctor and then the bleeding stopped, and then I went to the hospital."

"I was unconscious for two days. After two days, that's when I knew where I was."

Counterfeit drugs, quack 'doctors', tea-leaves, knitting needles, even small bottles filled with explosives inserted into the uterus – these are just some of the things that girls and women turn to – nearly 22 million times a year – in a desperate attempt to end their unintended pregnancies. Some, like Jane, are fortunate, and live to tell their stories. Many others do not – one woman dies every 11 minutes of every day from having to resort to unsafe abortion.

And even more shameful: we know how to prevent these deaths. We know how to save thousands of lives every year, how to empower women to avoid unintended pregnancies in the first place.

How? By making contraception available to every woman who wants it; by improving access to safe abortion services, where legal, and making sure that where they are not legal, life-saving post-abortion care services are readily available. This continuum of services can make deaths from unsafe abortion a thing of the past.

But we – service providers, national governments, advocates – are not doing enough.

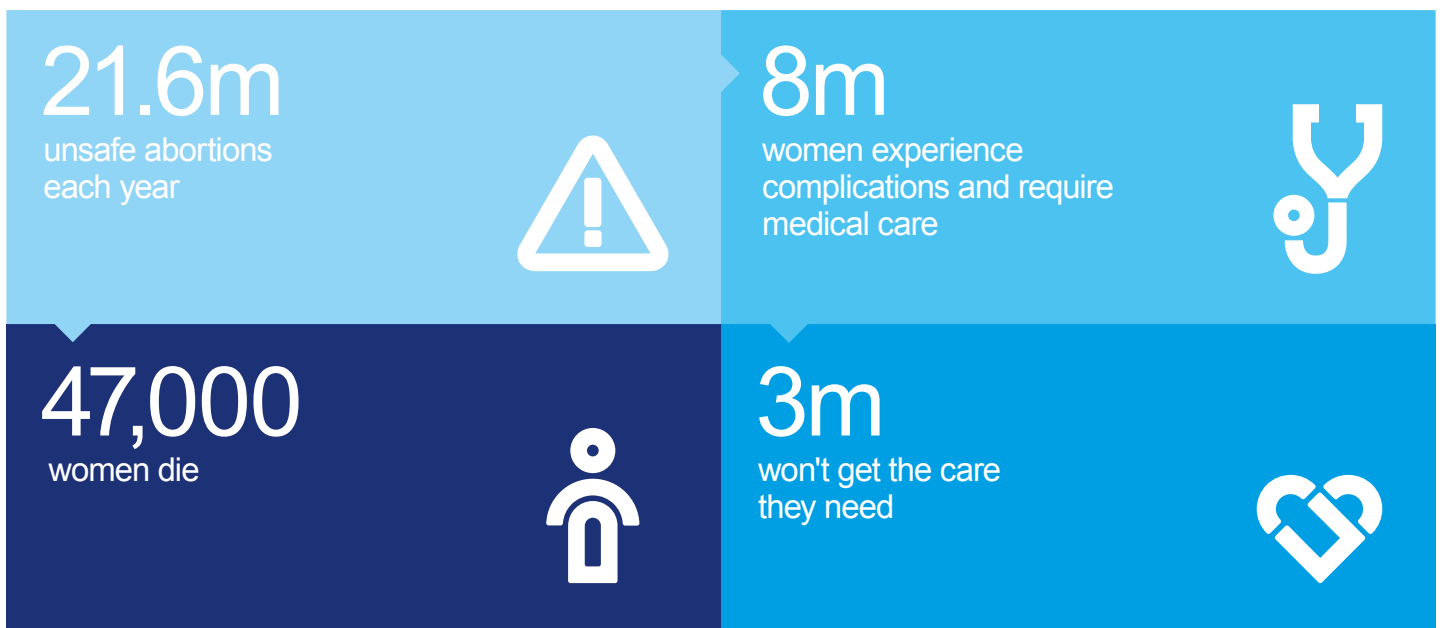
Why? Because by 2020 there will be more women of reproductive age than ever before, demanding contraception and sexual and reproductive health services. At current projected rates of growth in our ability to offer services, we simply will not be able to meet their needs. This will have tragic and widespread consequences for individual women, their families and their communities.

Without appreciating the scale of the challenge, and changing in order to meet it, the international community will fail women and girls.

But at Marie Stopes International, we believe that, with renewed effort, it is possible, within this generation, to create a world where no woman or girl ever again dies from unsafe abortion.

Here's how.

Unsafe abortion: The figures



¹Singh et al, Adding it up: Costs and benefits of contraceptive services - estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund, June 2012.

²WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. WHO, 2011.

³Singh et al, Adding it up: Costs and benefits of contraceptive services - estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund, June 2012.

⁴WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. WHO, 2011.

The challenge



177 million

To maintain current levels of contraceptive prevalence across the developing world in 2020, the resources will need to be found to serve, on average, 177 million women every year until the end of the decade.

1.63 billion

By 2020, there will be 1.63 billion women of reproductive age, in the less developed regions of the world.

The world is already a much safer place for women than it was even 15 years ago. Maternal mortality has reduced by nearly half since 1990, and more investment in sexual and reproductive health services across the world has brought huge benefits. Getting more contraception to more women who want it, wherever they live has meant that millions of women have avoided resorting to unsafe abortion, through preventing unintended pregnancy in the first place. And in many countries such as Nepal and Ethiopia, revisions to abortion legislation have increased access to life-saving safe abortion and post-abortion care services.

Despite these gains, the statistics today are shocking and indeed, one in eight maternal deaths worldwide are the result of unsafe abortion.⁵

The reasons are clear: in addition to the problems with access, poorly formulated policies and untrained healthcare providers, there is also the lack of knowledge amongst women about the services and entitlements that do exist, as well as multiple levels of discrimination, exclusion and stigmatisation.

We know how to address many of these challenges. Organisations like Marie Stopes International and our partners work every day to ensure women have the power to make their own choices about whether and when to have children. Our health workers in Pakistan travel for three weeks at a time to address stigma and misconceptions around contraception amongst remote hill tribes in Punjab. In South Africa, health extension workers educate women about the legality of abortion in their country, along with providing sexual and reproductive health information and services.

When all this fails, and women still turn to desperate measures, obstetric teams in Zambia train their surgeons to deal with the horrific consequences of botched abortions, through providing expert post-abortion care.

But though these solutions exist, and are an integral part of efforts to combat the dire consequences of unsafe abortion, they are not reaching women and girls fast enough.

To put the scale of the challenge into perspective, just to maintain current levels of contraceptive prevalence in the developing world up to 2020, the resources will need to be found to provide services for an estimated 177 million women every year, on average, until the end of the decade.⁶

On top of that, by 2020, there will be more women of reproductive age in the developing world than now, driven by the largest ever cohort of women and girls aged 15 – 24.⁷

So our current pledges to meet the needs of a certain number of women by a certain date are critical in focusing global efforts. But if we do not take account of the fact that the number of women in need of reproductive healthcare is growing, the global effort will fall short of adequately addressing the problems of the enormous future demand for contraception, and the ongoing threat of unsafe abortion.

Investment in family planning and in comprehensive abortion and post-abortion care is critical.

If we do not take account of the fact that the number of women in need of reproductive healthcare is growing, the global effort will fall short of addressing the future demand for contraception.

⁵WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. WHO, 2011.

⁶Based on current method mix across the developing world (UN contraceptive use wallchart, 2012), re-supplying all current

users of contraception with their method, and reaching new women to keep CPR levels constant in the context of population growth.

⁷UN population prospects projection (2012 revision).

The figures



In just six years, there will be 71 million more women of reproductive age in the less developed regions of the world.

Across the less developed regions of the world, there will be around 1.63 billion women of reproductive age by 2020, a 5% increase from today.⁸ Most of this growth will come from sub-Saharan Africa. In just six years, there will be 71 million more women of reproductive age in the less developed regions of the world than there are today, with 40.7 million more women aged 15-49 in sub-Saharan Africa alone.⁹

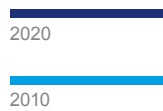
To make serious inroads in the fight against unsafe abortion, we must invest

to meet the growth in demand for contraception and sexual and reproductive health services that we expect to see in the near future, ensuring our efforts make services available to women, regardless of age, location, marital status, income or level of education.

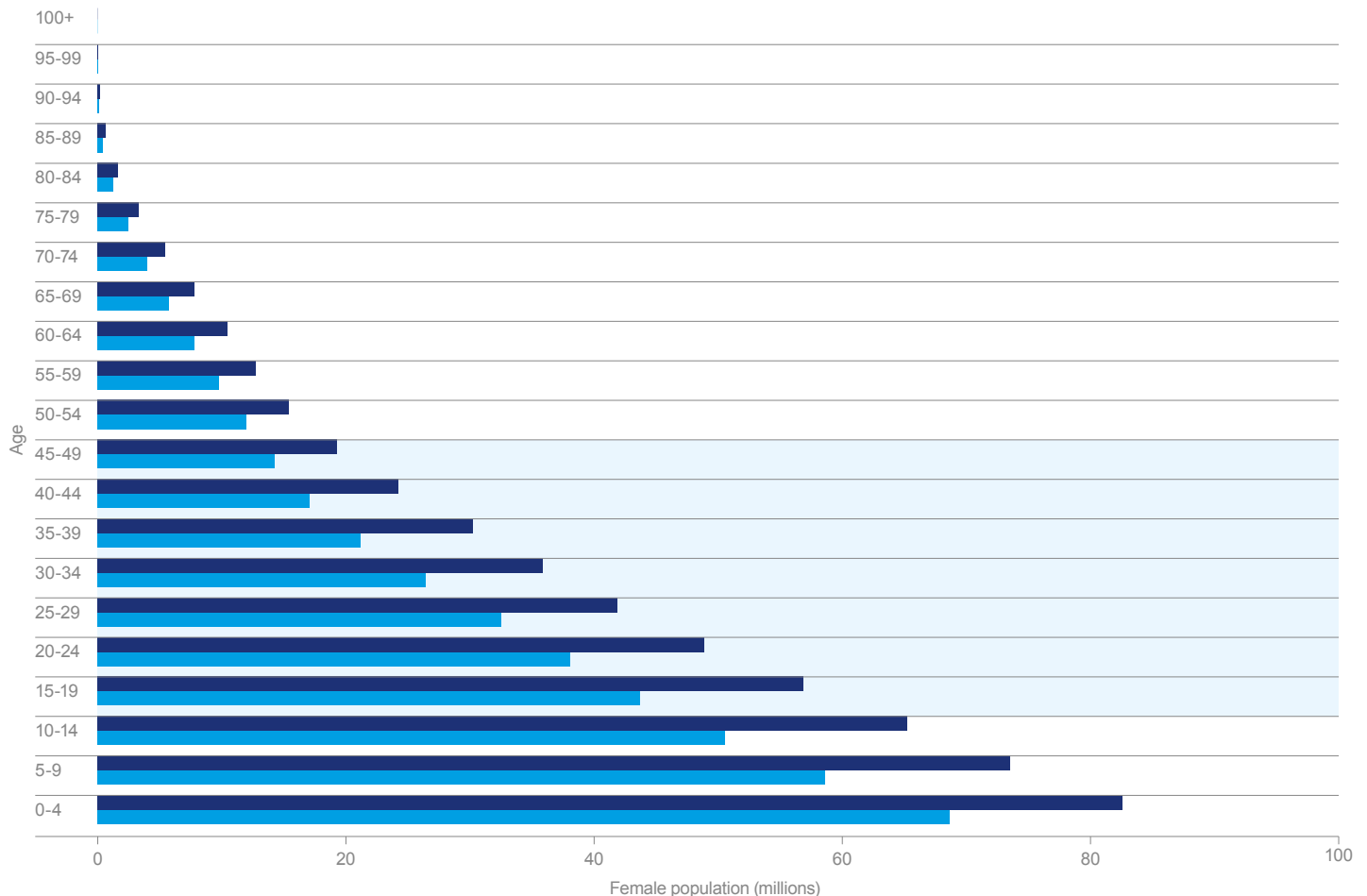
In short, without consciously deciding, now, to face the scale of the challenge, unsafe abortion will continue to destroy the gains that have been won by women, their families, and their societies.

Without deciding now to face the scale of the challenge, unsafe abortion will continue to destroy the gains that have been won by women, their families, and their societies.

Age structure chart for sub-Saharan Africa, with reproductive years highlighted.



Women of reproductive age
2010: 194 million
2020: 254 million



⁸Ibid.

⁹Ibid.



In Zambia, we use drama to educate communities about the risks of unsafe abortion and where they can access safe services.



2

The world we
are working for

By making
commitments now,
we can ensure no
woman dies from
unsafe abortion

A future where no woman dies from unsafe abortion

Unless we change what we are doing, and how we are doing it, unsafe abortion will continue to be the immense human rights and public health crisis that it is today. Below is a snapshot of where unsafe abortions will be happening in 2020, based on current projections. The heaviest burden ranges from the poorest states to middle income countries.

In those countries with the highest maternal mortality rate, women seeking out unsafe abortions face the greatest risk of dying. Therefore, as we look to 2020, we must address both those countries with the largest burden of unsafe abortions in absolute terms

(for example in India or Nigeria), but also those places where women are most likely to face severe risks (for example in Sierra Leone or South Sudan).

But this future is not inevitable.

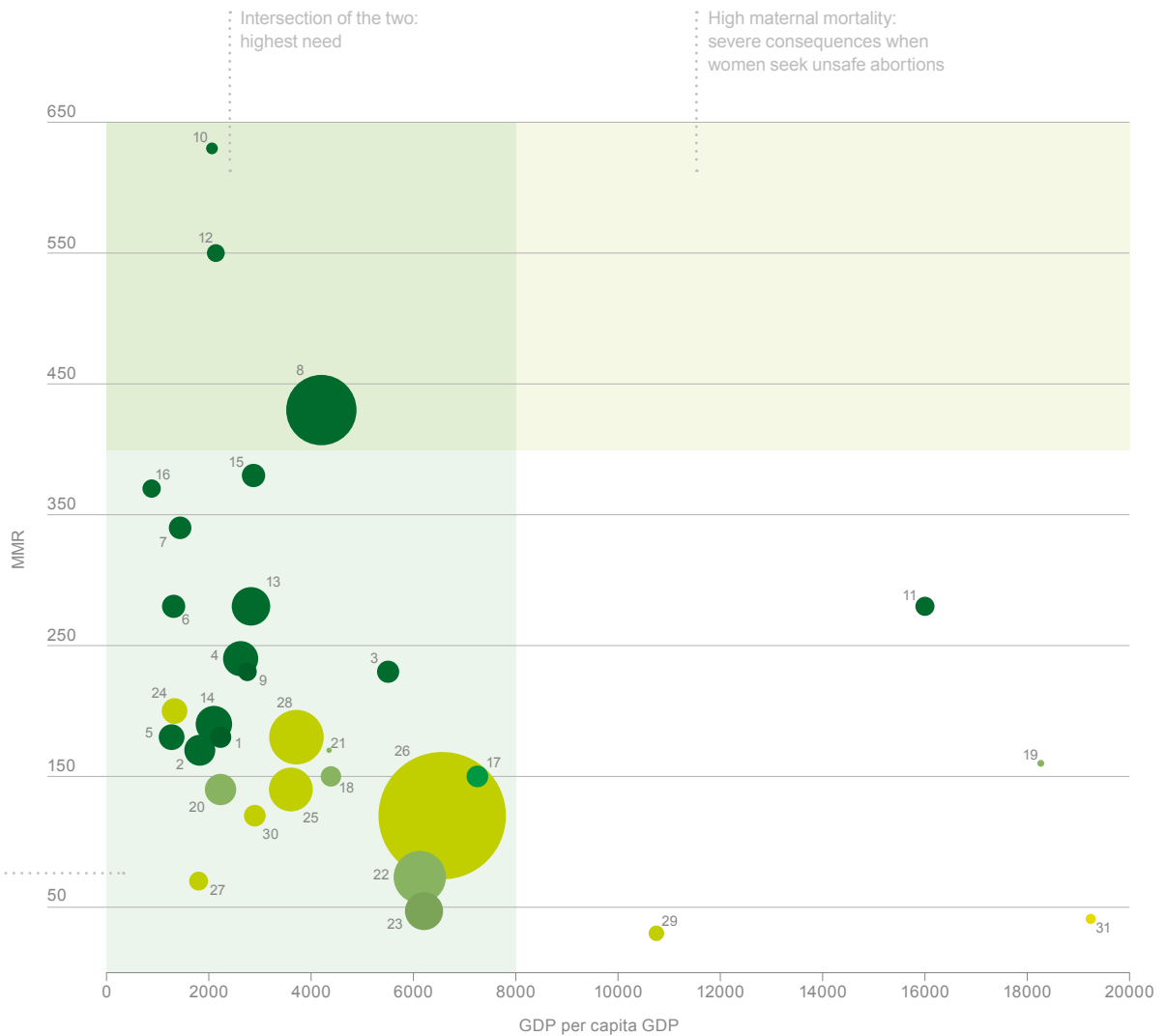
Our experience as health providers shows that we can change the trajectory even in a short space of time. By making commitments now, we can ensure no woman dies from unsafe abortion.

What does this graph show?

The size of the country bubbles relate to the number of unsafe abortions we project will take place in 2020 based on current trends, ranging from 7,300 in Papua New Guinea, to 4.36 million in India.

The bubbles are plotted against each country's projected maternal mortality ratio (per 100,000 live births), and Gross Domestic Product (GDP) per capita.

Low GDP / capita: higher levels of poverty, health systems may be less likely to provide for women in need



Africa

1. Burkina Faso
2. Ethiopia
3. Ghana
4. Kenya
5. Madagascar
6. Malawi
7. Mali
8. Nigeria
9. Senegal
10. Sierra Leone
11. South Africa
12. South Sudan

Latin America

13. Tanzania
14. Uganda
15. Zambia
16. Zimbabwe
17. Bolivia

Pacific Asia

18. Cambodia
19. Timor-Leste
20. Myanmar
21. Papua New Guinea
22. Philippines
23. Viet Nam

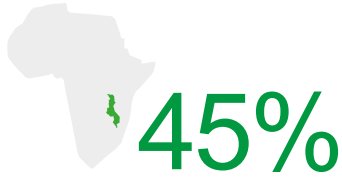
South Asia

24. Afghanistan
25. Bangladesh
26. India
27. Nepal
28. Pakistan
29. Sri Lanka
30. Yemen

Europe

31. Romania

The best solution of all: give women choice, when and where they want it



In Malawi, modern contraceptive use increased by 45% between 2004 and 2010, with Marie Stopes International contributing over 20% of the growth.

81,000

81,000 lives would be saved if, by 2020, we were reaching all women around the world with an unmet need for contraception.

Supporting those in need: increasing access to safe abortion and post-abortion care

Maternal deaths averted if current unmet need met, safe abortion provided where legal, and post-abortion care delivered to all who need it, 2020.

Maternal deaths averted by contraception

Maternal deaths averted by safe abortion / post-abortion care

Giving women and girls access to a full range of contraception – when they want it, where they want it from, and at a cost they can afford – is one of the single most important steps to eradicating unsafe abortion. Fully informed and affordable choice, and the maximum possible range of choice of methods, is vital. Just as important is tackling the barriers that prevent many women and girls from making these choices at all: stigma, discrimination, early marriage, and gender-based violence.

When women make this choice themselves, or with their partners, the evidence indicates that they will be more likely to continue using a method that best suits them. This means fewer women stop using their method abruptly, fewer unintended pregnancies, and so fewer unsafe abortions.

Choice does not come without its challenges. Full support for women who need long acting and reversible methods removed (such as implants and IUDs), and adequate supplies in remote areas are desperately

needed to make full contraceptive choice a reality.

But we can do it. In Malawi for example, modern contraceptive use increased by 45% between 2004 and 2010, with Marie Stopes International contributing over 20% of the growth.¹⁰ Marie Stopes International, with our partners, has succeeded in dramatically expanding access to long acting and permanent methods of contraception in many countries across the world.

So we can and must do more.

In many parts of the world, one in three women who don't want to be pregnant are not using contraception.¹¹ Unless we make significant changes to our commitments, this figure will barely change at all.

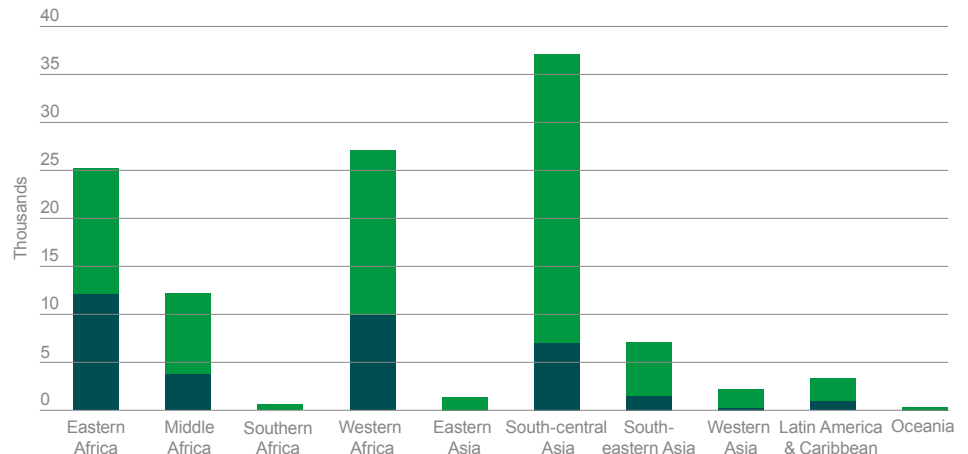
Addressing this challenge is not an insurmountable task. If, by 2020, unmet need for contraception was met, Marie Stopes International estimates that around the world around 81,000 lives would be saved.¹²

We know that even if contraceptive choice is a reality globally, there will continue to be risks due to unsafe abortion. Women will still seek out abortion services. Some, because they are not using contraception and get pregnant when they do not want to. Others, because contraception isn't 100% effective, and their method may have failed.

So there is always a need to ensure women can access safe abortion services where legal, and post-abortion care services globally, to deal with the consequences of an unsafe abortion.

By Marie Stopes International's estimates, if there was full access to safe abortion where legal, along with full access to post-abortion care where needed, this could save an additional 31,000 lives. This means offering this full continuum of services (contraception, safe abortion and post-abortion care) could result in 112,000 women's lives saved in 2020 around the developing world.¹³

Here's what that looks like by region:



¹⁰Based on figures for modern contraceptive prevalence among all women in Malawi, 2004 and 2010, and estimated contribution of Marie Stopes International to this growth, calculated using our contraceptive service delivery numbers, client profile data, and Impact 2.

¹¹UN Population Division, Estimates and Projections of Family Planning Indicators 2014.

¹²Estimated using Impact 2, based on the impact of meeting current unmet need. See 'MSI analysis' in annex at www.makewomenmatter.org/timetoact for more details.

¹³Estimated using Impact 2, based on the impact of meeting current unmet need, and preventing all mortality associated with unsafe abortions. See 'MSI analysis' in annex at www.makewomenmatter.org/timetoact for more details.



Case study: How can we ensure women have access to the services they are entitled to?

Increasing the legal grounds for abortion does not automatically lead to improved access for women. Time and time again – even in less restricted settings – we hear of lives lost and destroyed because women cannot access a safe service. Sometimes this is because they are not available or affordable, and other times it's because of a lack of information or confusion about the legal status.

Liberalisation in Nepal

In 2002, restrictions on abortion in Nepal were removed to allow abortion during the first 12 weeks of pregnancy or up to 18 weeks in specific cases. Following this policy change, the government worked with NGOs such as Marie Stopes International to make safe services available to women by training providers and ensuring access in clinics countrywide. As a result maternal mortality has fallen by almost 50%.

Despite this impressive progress, a recent survey showed that only 39% of women of reproductive age knew the legal status of abortion, and that knowledge was particularly low among poor and illiterate women. Even today – 12 years on – there are providers who are unaware of the law and women who do not know where to access safe abortion services.

To address some of the remaining barriers to access, Marie Stopes International has been working with the Midwives Society of Nepal to scale up training and provider knowledge. We also work closely with local communities to ensure women know their rights and where to access services, particularly in remote parts of the country.

What's working?

- Educating women and providers so that they understand the legal situation.
- Increasing the availability of abortion, and expanding geographic coverage so women in the most remote communities are not excluded from services.





3

What do we
need to do?

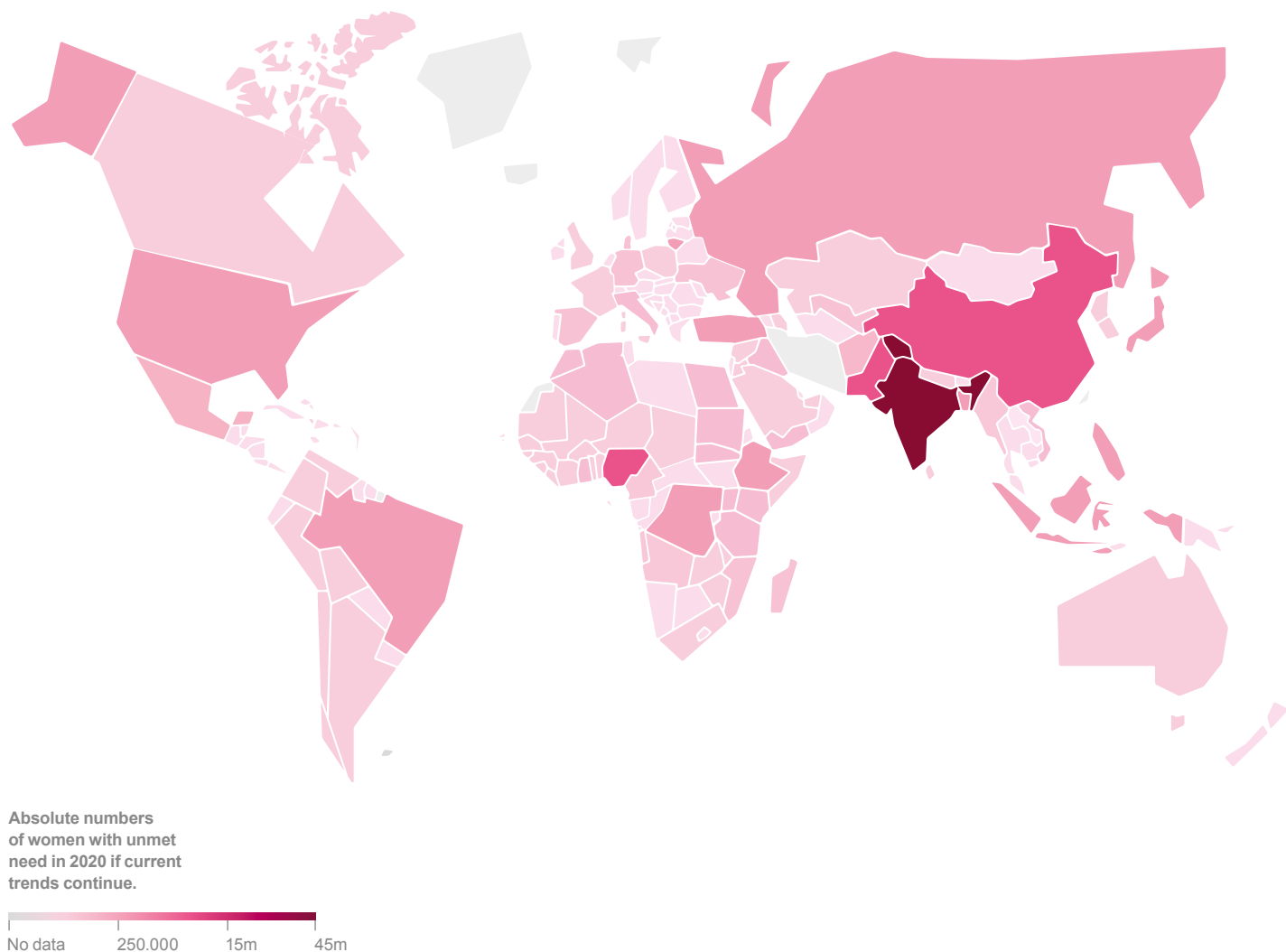


We can and
must do more.

Understanding where the need is

International aid to so called 'middle-income' countries is declining. Despite this, in absolute terms, many middle income countries will still have the largest populations of women living in extreme poverty in 2020, and women

who don't want to get pregnant, but are not using contraception. So we have a problem. Where will resources come from to meet the needs of women in middle income countries? Let's examine the numbers.



By 2020, in India alone there will be more than 45 million women of reproductive age¹⁴ with an unmet need for contraception – more than all the women of this age in the UK, France and Germany combined.¹⁵ While overall contraceptive prevalence is expected to grow in many countries, it will remain crucial to look beyond this growth, to identify the large pockets of unmet need that will still exist.

These huge increases in unmet need are in addition to keeping those women currently using contraception supplied with the method of their choice.

In countries like India and Nigeria, where millions more girls will be entering their reproductive years and will want access to contraception, maintaining current rates of use will require intense focus. These countries represent a huge proportion of the women and girls across the developing world who have a right to continue choosing the contraception of their choice. Getting it right will improve the prospects of future prosperity for these countries.

¹⁴Based on unmet need figures for married women and MSI analysis from UN Population Division. See annex at www.makewomenmatter.org/timetoact for more information.

¹⁵UN population prospects projection (2012 revision).

Understanding where poverty is

A nation becoming wealthier does not mean all its citizens become wealthy as well. In India alone, an emerging 'middle income' economy, there will be an estimated 322 million people living in extreme poverty by 2020¹⁶, well over a third of the global total.¹⁷ Women in extreme poverty simply do not have the same access to contraception. They have far more limited access to quality sexual and reproductive health services, and often face more severe health consequences if they become pregnant. To fully realise a world where no woman dies from unsafe abortion, reaching these women is critical.

Simple, clear data such as these are crucial for identifying need wherever it is, regardless of the relative wealth of the country in question.

If we are serious about reducing the number of women who will be faced with the stark possibility of dealing with an unsafe abortion, we must explore new and innovative ways of funding our services. Donor funding may be limited in many affected countries, so now is the time to begin investigating financial models such as insurance, private sector partnerships, franchising to private health providers and cross-subsidising services.

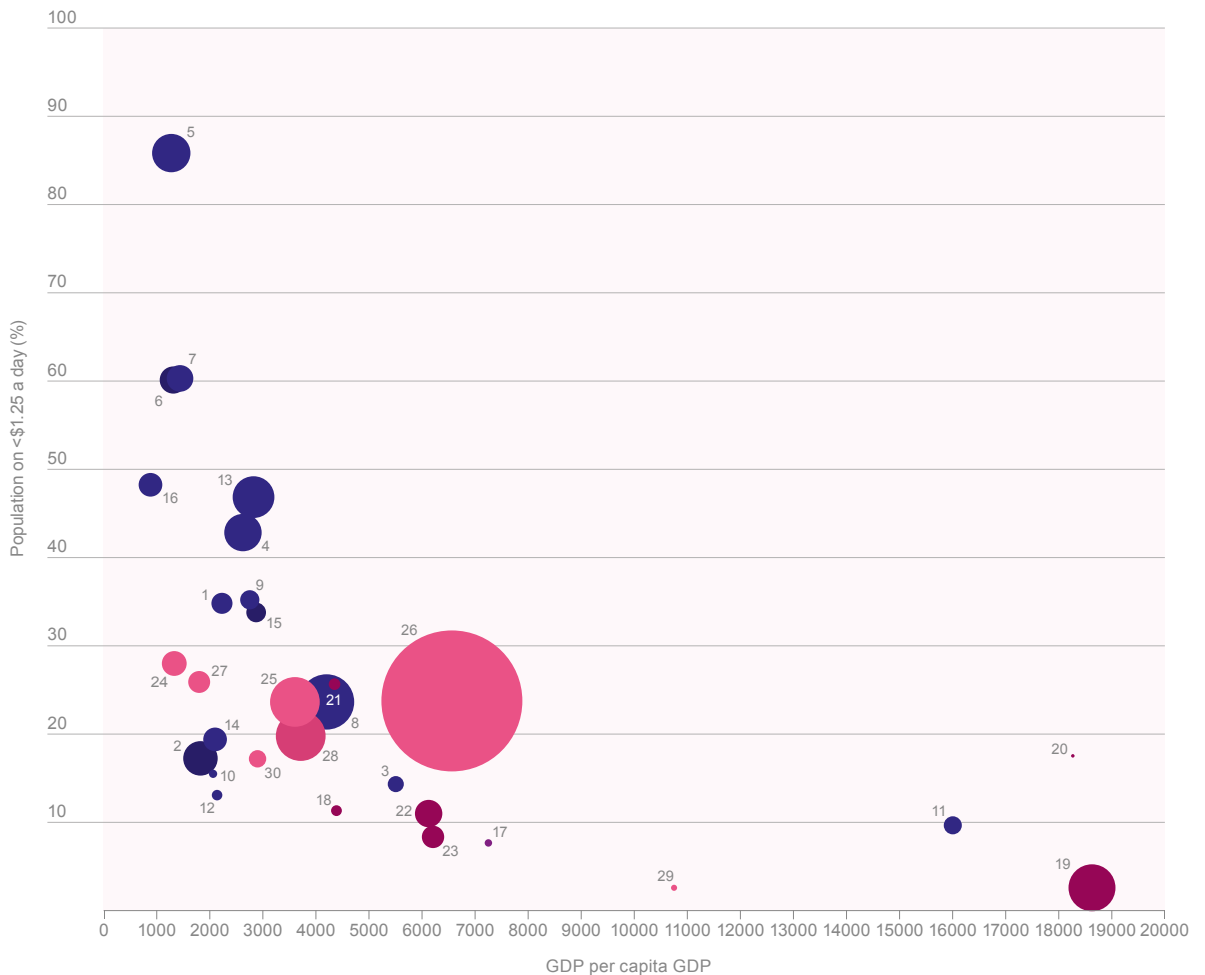
Below is a visual representation of the number of people living in extreme poverty in the countries Marie Stopes International works in.

What does this graph show?

The size of the country bubbles in the chart correspond to the projected numbers of people living on less than \$1.25 a day in 2020, from around 225,000 in Timor-Leste, to 322 million in India.

The bubbles are plotted against the proportion of the country's population living on less than \$1.25 a day, and its GDP per capita.

Countries with the lowest GDP per capita, mainly in Africa, have higher proportions of people living on less than \$1.25 a day, but in terms of absolute numbers of people living in extreme poverty, India dwarfs all other countries, despite its lower overall poverty rates and slightly higher GDP per capita.



- Africa**
- Burkina Faso
 - Ethiopia
 - Ghana
 - Kenya
 - Madagascar
 - Malawi
 - Mali
 - Nigeria
 - Senegal
 - Sierra Leone
 - South Africa
 - South Sudan

- Tanzania
 - Uganda
 - Zambia
 - Zimbabwe
- Latin America**
- Bolivia

- Pacific Asia**
- Cambodia
 - China
 - Timor-Leste
 - Papua New Guinea
 - Philippines
 - Viet Nam

- South Asia**
- Afghanistan
 - Bangladesh
 - India
 - Nepal
 - Pakistan
 - Sri Lanka
 - Yemen

¹⁶People living on less than \$1.25 of income a day.

¹⁷International Futures Long Term Forecasting model (www.ifs.du.edu)



Case study:

How can we ensure that the poorest people in middle income countries are not forgotten?

The largest groups of people living in extreme poverty no longer live in the poorest countries. India is a case in point. Here we are partnering with state governments and linking in with government health financing to improve quality, provide services to underserved groups, and find funding to replace dwindling donor funds.

Partnering with the government of Rajasthan

In Rajasthan, the government is the largest provider of family planning services. But to increase its capacity and reach, it partners with Marie Stopes India. We currently offer two models of support. Through the first, we provide logistics and demand generation to the government's clinical teams, ensuring women are aware of the services on offer and that they receive comprehensive counselling and quality care. Through the second model, we provide the services at government health facilities.

We cover the cost of services up front but are reimbursed by the government for an agreed cost per client. By combining a fixed pot

of donor funds with state and national funding, we have been able to significantly increase our health impact.

What's working?

- Engaging with national and state governments to prioritise investment in family planning – it's one of the most cost-effective health interventions.
- Operating as a business to find new ways to supplement donor income.



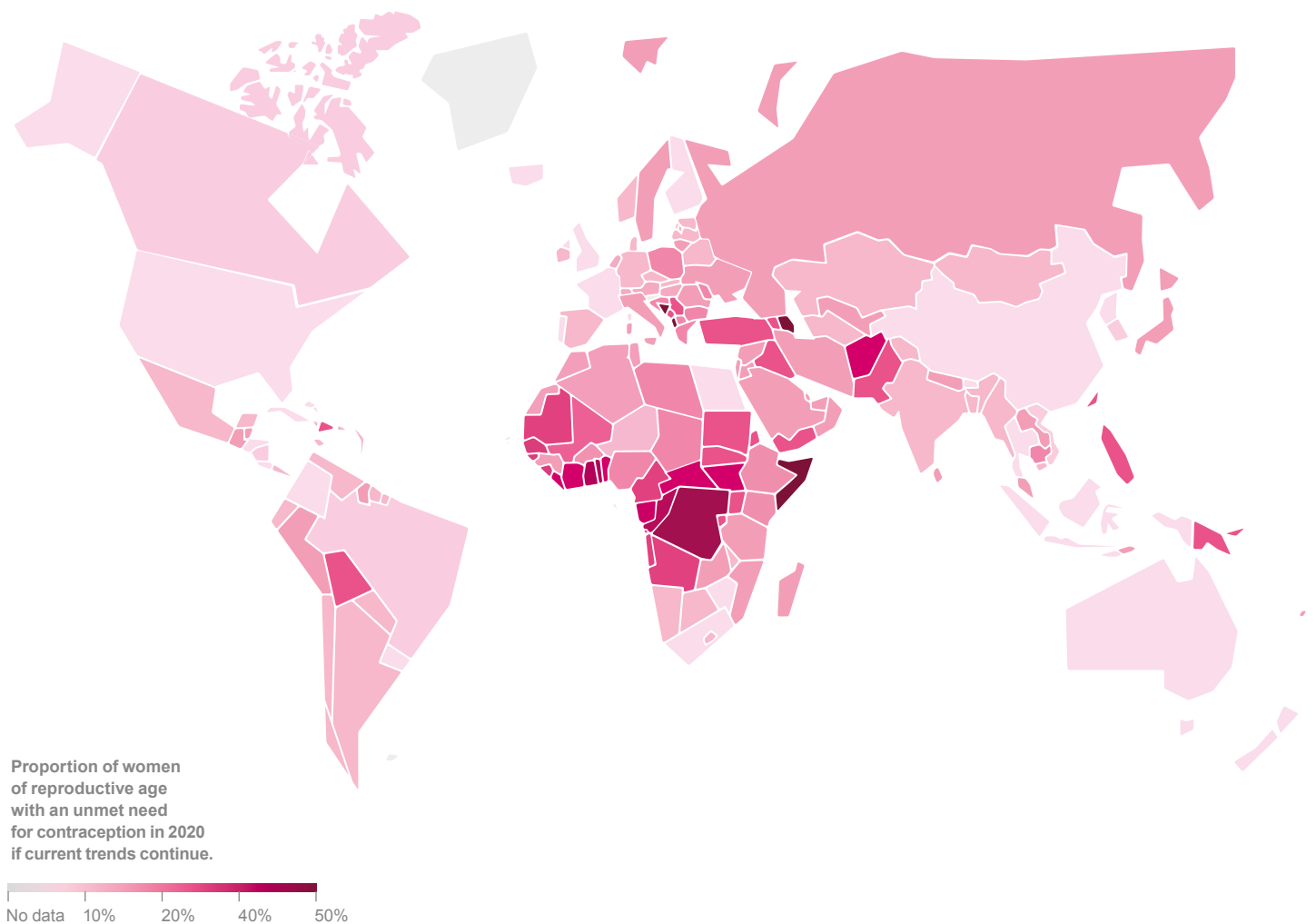
Going where women need us

As we see all too evidently today, many of the poorest women will also be in 'fragile' states, meaning sexual and reproductive health services will have to overcome enormous challenges. While, the largest numbers of women living in extreme poverty – and with an unmet need for contraception – might be concentrated in countries like India, Pakistan and Nigeria, we cannot forget about the many others, particularly in west and middle Africa. They will be particularly vulnerable without access to even basic health services, let alone sexual and reproductive health services.

If progress is to be made towards a world where no woman faces the awful prospect of dying from an unsafe abortion, these countries must not be left behind.

If we do not wake up and take action, sub-Saharan Africa will continue to bear the heaviest burden. While just about every woman who doesn't want to get pregnant in the UK can access contraception, in sub-Saharan Africa, more than one in three will not be able to use contraception, despite not wanting to be pregnant.¹⁸

Here's what this looks like compared with the rest of the world:



The poorest women in the world are currently the least able to access healthcare, and in this case, even the least aware that contraceptive options exist or that they have a right to reproductive choice. This can improve with economic and educational change, but given current trends

shaping poverty and inequality, eliminating extreme poverty in many countries may not be feasible in the next five to ten years. This makes the expansion of accessible voluntary family planning and reproductive health services in these countries fundamental to reducing unsafe abortion.

¹⁸UN Population Division, Estimates and Projections of Family Planning Indicators 2014.

Case study: How can we bring contraceptive choices to countries left behind?

West Africa has some of the lowest contraceptive prevalence rates and highest maternal mortality rates in the world. The potential for impact in the region is considerable and Marie Stopes International is exploring ways that we can take quality services to the women who need them, at low cost and at scale.

Marie Stopes Ladies

One approach that we believe has promise is our 'Marie Stopes Ladies' model, which we are piloting in Burkina Faso, Madagascar, Mali and the Philippines.

MS Ladies are clinical providers who are typically drawn from midwife, nurse, and nurse aide cadres, who work with us to accelerate access to long acting reversible

contraceptive methods through community and door-to-door outreach. They cover specific catchment areas and visit clients in their homes, places of work and at health or community centres offering counselling, referral, services and follow-up care on the spot.

What's working?

Evaluations in Madagascar and Burkina Faso show that our MS Ladies are delivering more services than comparable channels at considerably lower cost. We believe they offer a low cost way of scaling up contraceptive access, particularly in resource-poor settings with very rural populations. And they have huge potential to combat unmet need in some of the most underserved regions of the world.



The economic benefits of contraception

Widespread and accessible contraception not only improves maternal health and reduces the number of unsafe abortions, it has a transformative effect on whole societies, promoting economic development and gender equality.¹⁹

- A woman's individual ability to control her fertility helps to change the social and economic position of women across society. Women have more opportunities to enter further education and employment.
- Access to contraception can reduce fertility rates of a country. National fertility declines are associated with improvements to women's health, their earnings, and their participation in education and paid work.

- The children of women that have access to family planning are healthier and better educated than the children of women who don't have access to it. These children have greater prospects for the future, generating long term economic benefits when they eventually enter the workforce.

- Reductions in fertility rates and child mortality lead to an increased proportion of working age people within the population. This can have a positive impact on economic growth, known as a 'demographic dividend'.

Marie Stopes International will explore more of these benefits in future publications.

¹⁹Canning, D & Schultz, T.P. (2012), 'The economic consequences of reproductive health and family planning', *The Lancet*, Vol, 380. Issue, 9837.

Girls and young women are most at risk

By 2020 there will be 40.7 million more women of reproductive age just in sub-Saharan Africa alone. Nearly 40% of these women will be younger than 25, and 22% aged 19 or younger.²⁰ And we know the biggest single killer of girls aged 15-19 is pregnancy and complications arising from it, including unsafe abortion.²¹ Younger women and girls in these countries often simply have no way to access reproductive health services, and many pay with their lives.

Why focus on sub-Saharan Africa?

Because here, unsafe abortion is particularly lethal. The risk of dying from an unsafe abortion is 15 times higher for a woman living in sub-Saharan Africa, than a woman living in Latin America. Just in this region, there will be almost a fifth more women

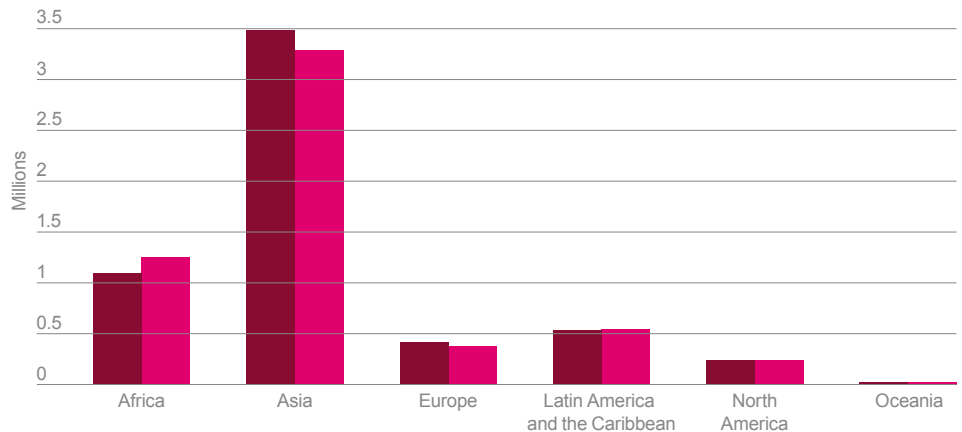
of reproductive age in 2020 than there are today, including 57 million girls aged 15-19. We must find effective ways to reach these girls with the services they want – for many, it will be the difference between life and death.

And, unlike many regions of the world where the numbers of young women (15-24) are on the decline, due to reductions in fertility rates, sub-Saharan Africa will continue to see larger and larger cohorts of young people in the coming years. In fact, there will be 15.4 million more young women by 2020 than there are today.²²

To make serious inroads in the fight against unsafe abortion, sexual and reproductive health services must be accessible and appropriate for younger women.

Young women of reproductive age (15-24) today, and in 2020.

2014
2020



Case study: How can we reach growing youth populations?

The youth population in the least developed countries will rise to 103 million by 2020. Addressing the need among this age group is critical. We will make no headway if we do not find effective ways to reach them.

In a number of our programmes we are seeing success from approaches targeting young people. In Madagascar, an m-voucher pilot aimed at increasing adolescent uptake of contraception through our social franchising network is showing particular promise.

The Madagascar pilot

Marie Stopes International is learning that supply-side interventions have stronger results when matched with a demand-side component. In this instance, community based educators were trained to raise awareness of contraception and promote vouchers to adolescents, while our social franchising providers were trained on the delivery of services to young people.

Vouchers removed the financial barriers to access, generated demand among adolescents, and increased provider confidence in delivering services to this group due to the increased volume of clients.

Around 3,000 adolescents are using the vouchers to receive services each month – that's a huge uplift in the number of young people coming to our franchised providers.

What's working?

- Respecting young people's privacy.
- Educating providers so they are not a barrier to service delivery.
- Removing financial obstacles for young people.
- Offering integrated packages of services so all their sexual and reproductive health needs can be met in one place.



Staying ahead of the curve

To make rapid progress in our fight against unsafe abortion, we must capitalise on these emerging trends in order to scale up services and reach the women who so desperately want the choices that so many of us take for granted.

Our commitment to the rights and health of women must not be considered in isolation. The data we've examined here tells us much about, first, where the women we will need to serve will be and, second, the resources and commitment that will be needed to prepare for the future. But also for consideration are other emerging trends.

The way women find out about and want to use contraception is changing

Today there are many different methods of modern contraception, and the trend is emerging for ever more of these to be controlled by the user herself. Can we not imagine a world where a range of methods are available and affordable from every pharmacist without a prescription? A world where a woman can truly choose for herself the method she wants to use? At a cost she can afford?

The pace of the information revolution in the developing world will change how we work

Where before entire communities were isolated, we now see information exchanged almost instantaneously across great distances via mobile phone networks. This means, too, that women's – particularly young women and girls' – sophistication in knowledge of, and demand for services has increased exponentially. In future, more women will be telling us what they want in more informed and certain terms.

Advances in the education of girls is making a difference

Over time the increased number of girls in education is leading to changes in women's preferences on whether and when to have children, what method they feel is most appropriate, and a huge upswing in the demand for contraception.

The national and local settings are changing

The increased availability of life-saving misoprostol and mifepristone drugs, where they are registered for use in safe abortion and post-abortion care mean that millions more women now have a better chance of avoiding the consequences of an unsafe abortion. More women are better informed about how to use these drugs properly in these settings, as more private providers, pharmacists and midwives are educated on when and how to use them correctly. We expect more women to be aware of their choices, for any stage of their reproductive health, than ever before.

Even where policies are formulated to protect women, challenges remain. In Ethiopia, where changes in the legislation governing abortion resulted in a growth in safe services, women and girls still resort to unsafe abortion.²³ From our own experiences of providing services there, we see that lack of awareness, misinformation and continued stigma can cause many women and girls to resort to dangerous unsafe procedures, because they don't know their rights nor what is available to them locally.

Similarly, a milestone ruling by the Government of Uganda to allow clinical officers to perform voluntary female sterilisations will require significant resources to become a reality, in order for more women to have access to these services.

To make rapid progress in our fight against unsafe abortion, we must capitalise on these emerging trends in order to scale up services and reach the women who so desperately want the choices that so many of us take for granted. But we can't do it alone.



²⁰UN population prospects, 2012 revision.

²¹Unicef - Progress for Children: A report card on adolescents, 2012.

²²UN population prospects, 2012 revision.

²³Singh et al, The Estimated Incidence of Induced Abortion In Ethiopia, 2008, International Perspectives on Sexual and Reproductive Health, Volume 36, Number 1, March 2010.

A call to action

Not so long ago, a woman had limited reproductive choice. But with the advent of a small, easily taken, contraceptive pill, the world changed and a 'contraception revolution' began. At the same time, governments across the world recognised the horrific consequences of unsafe abortion, and many acted to mitigate the devastation that it wrought on their citizens.

Because of this millions of women are now able to make a choice, without coercion, about whether and when to have children.

We must recognise, however, that the revolution has not extended to the benefit of all. Without greater commitment, we will find ourselves in a situation where the more affluent have every choice, while those who are poor, or those living somewhere by an accident of geography, are simply left behind.

1. Invest specifically in delivering contraception and sexual and reproductive healthcare for women and girls.

That investment pays enormous social and economic dividends, but funding for contraception made up only around 1% of overseas development aid from OECD donor countries in 2012.²⁴ Even an increase of 1% would have a profound effect on outcomes. Governments and non-governmental organisations must put investment in health and rights on a par with investments in education, clean water and infrastructure.

2. Leave no woman behind.

Those of us working to deliver health and rights to women must ensure that every woman remains the focus of our efforts. The millennium development goals and our pledges in 2012 were just a start. If we want a world where no more women have to tell stories like Jane's then we must redouble our efforts and invest in the sexual and reproductive health and rights of women and girls.

If we make these commitments, we can stop women dying from unsafe abortion in our lifetime. If we truly challenge ourselves, and increase our efforts, perhaps we can even imagine the eradication of unsafe abortion altogether.

Even the enormously important pledges made at the 2012 London Summit on Family Planning to give access to 120 million more women by 2020 are simply a first step in fulfilling every woman's fundamental right to have children by choice, not chance.

As this report has shown, if women are going to be able to get the services they need in the coming decade, we are not doing enough. The world's pledges to the women of the future, including our own here at Marie Stopes International, are not sufficient.

We know what must be done.

3. Hold ourselves to account.

Over the next 12 months national governments will debate where to focus attention in the next set of development goals. Sexual and reproductive health must feature in them, with clear targets that encourage investment, can illustrate progress, and document successes. The 'sustainable development goals' must have agreed indicators on access to, delivery of, and follow-up on the full continuum of sexual and reproductive health services.

4. Direct more resources to national level.

While advocacy at a global level is important, preventing the needless deaths from unsafe abortion is a local challenge. Resources must go increasingly to organisations on the ground to help governments around the world prepare for the enormous number of women who will want and need contraception and sexual and reproductive health services.

As we do this, we make a promise to every girl today of a life free of the fear of a pregnancy that was never intended.

The women of the future will expect us to deliver.

²⁴See 'MSI analysis' in annex at www.makewomenmatter.org/timetoact.



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