As a service provider, advocate and implementer of the Sustainable Development Goals (SDGs), a partner to governments, donors and the private sector, and an active voice in global and national debates on health, reproductive rights and gender, MSI Reproductive Choices (MSI) welcomes the opportunity to contribute to this critical consultation.

Session 1: Diplomacy and human rights-based response

Question 1: How could we best include the input of marginalized groups in our diplomacy efforts?

Question 2: The Netherlands is often referred to as a 'donor with courage'. If the Netherlands wants to continue being such a donor, which are the (health-related) themes we should focus on?

Question 3: How can the Netherlands best align the national and international efforts regarding Global Health?

Question 4: How can the Netherlands make more effective use of its diplomatic network abroad, including embassies, permanent representations and thematic experts (such as health attachés)?

Question 5: How can the Netherland's position within the UN (and its reputation in the field of international (human) rights) be used to advance global health objectives?

Question 6: How can we systematically link diplomatic efforts in Brussels, Geneva and New York to the benefit of coherence and greater effectiveness?

The Netherlands leadership and expertise on development and human rights is valued across the world, particularly by partner governments, other donor agencies and non-governmental organisations, such as MSI Reproductive Choices. Within the international community the Netherlands is particularly appreciated for its focus on gender, Sexual and Reproductive Health and Rights (SRHR) and sustainability and it has played a unique role in strengthening global norms and development architecture.

As a donor of courage it should continue this focus. Investment in SRHR offers one of the best returns on investment for Dutch taxpayers and is a key driver for poverty reduction, gender equity, and social and economic development. The Netherlands as a donor of courage can continue play a unique and valuable role in this area, maximising their thought-leadership and soft power within the international community through continuing to prioritise these issues in all their diplomatic and development efforts.

As we continue to see roll backs on rights and attacks on hard won rights at global and national level, we recommend that the Netherlands continue to focus and champion the most marginalised issues of SRHR as articulated by the Guttmacher-Lancet SRHR definition, primarily access to safe, legal abortion through supporting mutually reinforcing service delivery and advocacy programmes.

To better align national and international efforts we would recommend the Netherlands support programmes that complement and are grounded in existing national targets and commitments (SDGs, national action plans, FP2030 etc.), and that diplomatic networks engage in a more systematic consultation with partners, so they are informed and equipped to advocate on priority issues as defined by key development partners (e.g. national SRHR coalitions). Support for example to remove the restrictive policies that prevent access to health services (e.g. abortion law reform) would be helpful to close the gap in unmet need for

contraception, eliminate unsafe abortion and ensure universal access to sexual and reproductive health and rights.

Clear and coherent policy priorities would also reduce the potential disconnect between embassies and capitals and ensure greater coherence and impact. We would also recommend that greater co-operation is needed across all ministries particularly foreign, trade, defence and finance to ensure all agendas are actively supporting the objectives of Netherlands development co-operation.

Session 2: Health systems strengthening

Question 7: How can we reach everyone, especially the most marginalized people ('last mile'), to ensure their access to information and medical service?
Question 8: How can we make use of the specific knowledge and experience of all different sectors involved in global health? How can we also involve the private sector in meeting the people in greatest need?
Question 9: How can we promote green and sustainable health systems strengthening?
Question 10: How can we gear health systems strengthening most effectively towards better preparedness?

Addressing poverty, inequality and building economic sustainability cannot be achieved without improving access to SRHR. This includes access to modern contraception and to safe, legal abortion.

50% of people alive today are under 25 and in the coming decades we will have the largest ever cohort ever of women of reproductive age. Business as usual is no longer an option and we need to plan now and at scale to meet these SRHR needs. Young people face specific barriers to accessing services including a lack of information, discrimination and social stigma, provider bias, lack of confidentiality, and policy restrictions.

The younger generation must be at the centre of shaping global socially inclusive and sustainable economic development. It is essential that young people receive the information and services they need and grow up in an environment where their needs and rights are respected.

Investing in the next generation can help to achieve a demographic dividend that brings millions of people out of poverty and unstable living conditions. Only if we engage young people in the dialogue about their health and needs will we identify the right solutions and investing in young people in ways that enable countries to realise their demographic dividends can boost per capita incomes for decades to come.

To make serious inroads, we must invest to meet the growth in demand for sexual and reproductive health services; ensuring efforts make services available to everyone, regardless of age, location, marital status, income, caste, or level of education.

Attached is a report on 'Reproductive choice for all. Leaving no one behind in reproductive health care' prepared by MSI, providing more information on this issue.

Engaging with the private sector

There is growing realisation that a fragmented approach to service delivery that segregates public and private sectors can create redundant systems, inefficiencies and missed opportunities for improved clinical quality. Whether for profit or not-for-profit, formal or informal, the private sector is an important source of health care in the developing world. More and more people of all income levels are turning to the private sector for services. The World Bank estimates that in Africa alone, 50% of women from the bottom wealth quintile currently access healthcare from the private sector.

Government stewardship of the health system is critical to ensuring high quality and pro-poor delivery of healthcare through the private sector. There is great potential for governments, with support from the Netherlands, to work with the private sector to expand the range and reach of services, improve quality and regulation, better integrate with public systems, improve affordability, and ultimately achieve national health and development goals.

We therefore recommend that the Netherlands:

1. Build the capacity of governments to contract and link service delivery to public financing and support governments to transition to a purchaser as well as provider of services. This may include financial and technical assistance for the establishment of mechanisms, such as match-funding arrangements, to facilitate contracting of health services from private health providers. Focusing on contracting capacity is essential to ensuring the long-term stewardship and sustainability of health programmes delivered through the private sector. It also institutionalises the means for public financing to the poor regardless of where the poor access services.

2. Develop the link between health system strengthening and targeted health programmes, especially in the context of universal health coverage (UHC). The path to UHC needs to build systems that will provide adequate incentives for delivering results for high-priority health areas. The Netherlands is in a unique position to ensure that the link between targeted health programmes and UHC is addressed for long-term sustainability.

<u>Session 3: Pandemic prevention, preparedness and response</u>

Question 11: *Which lessons should we learn from our approach in earlier pandemics, and more specifically, what could we do better?*
Question 12: *What are the most pressing gaps in the current global health architecture regarding PPR, and how should/can they be addressed?*
Question 13*: How can we best ensure sustainable financing for PPR?*
Question 14: *To what extent should new international agreements be legally binding?*
Question 15: *To what extent should the Netherlands promote the sharing of IP, knowledge and data in the context of PPR?*
Question 16: *How could we best communicate to a global public audience in order to not only prevent but also respond better to a pandemic?*

Global health security must be considered in a wider context than the international COVID-19 response. A strong health system is the foundation for global health security and for scaling up in the face of any future pandemic or other global health security challenges. It includes preventative care, and a focus on health inequalities to ensure access to the poorest and most marginalised and to end preventable deaths. All of this requires adequate SRHR services and a legal framework that facilitates safe, equitable access to sexual and reproductive health services, including abortion.

SRHR should also be seen as central to any humanitarian climate change response. Climate events disrupt sexual and reproductive health services, often in areas where infrastructure and provision are already fragile, and where affected populations are already underserved.

Preparedness

SRHR is essential to climate change adaptation and resilience. The effects of climate change are gendered - women and girls will be disproportionately affected by the rapid rate of climate change over the next decade (UNFPA 2021). Access to SRHR can help build resilience to the effects of the climate emergency. There is a great need for gender sensitive climate policies and innovative programming that recognise the link between quality SRHR and resilience.

The disruption and uncertainty created by climate change hits women and girls hardest because they are disproportionately affected by poverty, subject to gender discrimination and have poorer access to resources, food and sources of income (UN 2012). In order to effectively respond to events like drought, coastal erosion and desertification they need support to build their resilience. Building resilience or having the capacity to withstand and recover from shocks and stresses can help affected communities adapt to the challenges presented by climate change and mitigate some effects. Ensuring access to sustainable SRHR services and supporting the ability to choose to access services can contribute to resilience (MSI 2021), and this resilience may contribute to improved SRHR (Hardee 2018).

For example, Niger is one of the driest and hottest countries in the Sahel region of Africa and is subject to climate change-related shocks. Climate vulnerability is compounded by the country's high dependence on rain-fed agriculture and its natural resources to support food security and livelihoods. Chronic humanitarian crises due to recurrent drought, flooding, food insecurity, epidemics, and violent conflict exacerbate climate vulnerability Combining SRHR, including family planning and programming with community resilience interventions that improve crop yields or diversify household livelihoods has the potential to support resilience to climate change through female-centred approaches and interventions supporting SRHR and gender equality; health system strengthening improving health and SRHR services; and community resilience interventions diversifying household income.

Attached is a report on 'The impact of the climate crisis on Reproductive Health', prepared by MSI, providing more information on this issue.

Session 4: Products and supply chains

Question 17: *What is necessary to improve local research and production medical supplies, medicines and vaccines?*

Question 19: *How can we facilitate local production?*

Strengthening access to SRH commodities is critical to reducing global health inequalities, however bottlenecks in supply of essential contraceptive methods remains a challenge, despite significant investment in SRH commodities through the UN system. Many countries in Africa and Asia have a small number of burgeoning pharmaceutical manufacturers, who are very willing to expand on a domestic and global scale. Many have undergone Good Manufacture Practice (GMP) assessments from their national regulatory authority (NRA) – however, many of these NRAs are fairly weak and their GMP standards do not always meet the minimum standards for global best practise. These manufacturers are open to support to strengthen quality assurance.

With focused investment, systematic quality assurance activities such as GMP audits, dossier reviews, quality control testing and support to manufacturers with corrective and preventative action plans, can be delivered to bring smaller manufacturer up to an acceptable standard for supplying SRH commodities for domestic or global use, thereby expanding access to contraceptive commodities for women and girls.

In parallel, the market must be sensitised to the risks of substandard products and NRAs strengthened to regulate that risk. WHO has already started work on attributing maturity levels in different areas of pharmaceutical manufacture and distribution to NRAs, and while rollout has been slow, this could be further supported.

Question 18: *How can the private sector contribute to the production and distributions of medical supplies, medicines and vaccines?*

A functioning health system must have uninterrupted supplies of essential health commodities, technologies and medicines and the Netherlands are playing a crucial global leadership and co-ordination role in relation to quality, access and security of health commodities.

In many countries the private sector is the dominant provider of contraception, e.g. in Nigeria where MSI alone provides over 50% of demand met for contraception. Therefore, the Netherlands can use its position in the global governance of programmes such as UNFPA supplies partnership to advocate for sufficient and efficient budgetary allocations expended to accommodate the long lead times of some products such as implants for routine commodity support. The governance of the programme needs to include the role and create space for the voice of the non-government implementing partners, in the national quantification processes to ensure they have access to commodities through all available channels, - direct from the Ministry of Health and via UNFPA country offices (in countries where this channel is still open).

There are untapped opportunities to increase funding for SRH commodity security through leveraging innovative financing such as the Global Financing Facility (GFF) and the International Development Association (IDA). Lack of political will, stigma and in consistent inclusion of civil society all contribute to low levels of funding for SRH commodities. The Netherlands can leverage its position as donor to these entities globally and at country level to advocate for greater attention SRH commodities recognising that reproductive autonomy is the foundation of a range of human rights and social and economic development outcomes.

The private sector has a unique voice as an advocate for SRH commodity security, to advocate for and to hold government to account for commitments made to improve supply side policy and financing. Core support and flexible advocacy funding is critical to enable this.

For production purposes this will have to be a long-term strategy. Donors will need to work with market shaping groups to determine the most significantly worthwhile commodities in the market. i.e. the ones that will have the maximum impact in the locality or indeed, in closely matched regulatory clusters. By making decisions on this information at the outset, the market shaping groups should then work with the regulatory functions of each country to determine viable local manufacturers to work with. Once identified, quality assessments can be undertaken through the likes of SRAs, UNFPA, or WHO to provide a benchmark for the quality improvements or outputs necessary. Those market shaping groups can also link up organisation to handle distribution in the regulatory clusters to determine the strategic match.

Session 5: One health & multisectoral approach

Question 20: *There are noticeable links between global public health and other themes, including climate, food security and nutrition, clean leaving environment (e.g. WASH/clean water and air), animal health, economy, school health (e.g. CSE, ASRHR) and sustainability (social, economic and environment). Which should be the priorities – that are also practically feasible – for the Netherlands in this regard?*

Question 21: *How do we best engage in this intersectional approach of global health?*

Countries will meet neither international nor national commitments, including the SDGs on poverty alleviation, health, and gender equality, unless we invest in reproductive choice for women and girls and capture the opportunities afforded by the demographic dividend, particularly in Africa, over the next five years.

The provision of comprehensive sexuality education (CSE) is essential to increasing access to information and should be further supported by the Netherlands. According to the United Nations Educational Scientific and Cultural Organisation (UNESCO), CSE aims to "help children and young people become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships." Research shows that CSE embedded in a broader "life-skills approach" is often more effective in affecting sustainable behaviour change amongst adolescents than standalone approaches. Increasing access to comprehensive, accurate, rights based, non-judgemental information about sex and relationships is a crucial component in addressing knowledge gaps and misinformation, as well as increasing demand for services amongst youth. Providing young people with knowledge about their rights and responsibilities is critical and will impact their lives for years to come.

Session 6: Sustainable financing

Question 22: *How do we establish sustainable and innovative health financing with the strategy?*

Question 23: *How do we ensure best the blending of public and private funding for the Global Health Strategy?*

Question 24: *How do we ensure sustainable financing for the WHO and the global health architecture at large?*

Sustainable and innovative health financing must include financing for SRH including contraceptive services. While most countries in sub-Saharan Africa have public financing approaches in place for contraception, financing contraception is often focused on the commodity and not the service. In general, midlevel private providers are not accessing those public financing flows at all despite the role they can play to extend UHC and reducing unmet need for contraception. A paper by MSI outlines that UHC financing reforms have to bring together four key elements to make contraception work to address unmet need.

1. The right **People** covered - Coverage designed for including the poor, underserved, marginalized and vulnerable or else it will fail to be the vehicle for reducing unmet need and achieving FP2030 goals. If the poorest and most excluded are covered through specific schemes/exemptions then these are expensive to run and less likely to achieve coverage for all.
2. The right **Package** including contraception and contraceptive choice within the defined UHC benefits package, with careful articulation of methods and how they will be handled under primary health care (and accompanying payments). Otherwise the package risks bias towards short term methods. Contraception should accompany all maternal health packages.
3. The right **Providers** contracted. UHC schemes need to purchase quality services on behalf of the population in appropriate locations and at appropriate, cost-effective levels of the health system. Expansion of provider purchasing is critical. This should extend to midlevel provider operated clinics whose services are accessible to much of the population, and where contraception fits well into the service offer.
4. The right balance in **Payment** approaches that will overcome provider bias in limiting contraceptive choice. That means paying for the service delivery requirements of different contraceptive methods, including appropriate time for counselling. While short-term methods can be efficiently financed through commodity financing, differential case-based payments are best suited to long-acting reversible and permanent methods.

Miscellaneous

Question 25: *Do you have any other thoughts, ideas or comments you would like to share regarding the Global Health Strategy?*

N/a

MSI
REPRODUCTIVE
CHOICES

REPRODUCTIVE CHOICE FOR ALL

LEAVING NO ONE BEHIND IN REPRODUCTIVE HEALTHCARE 2021

REPRODUCTIVE CHOICE FOR ALL

WHAT IS NEEDED TO LEAVE NO ONE BEHIND

Access to reproductive choice can be life changing. It helps keep girls in school, supports women to work outside the home, and saves lives by preventing unsafe abortions and maternal deaths. But for many, reproductive choice – and the opportunities that choice brings – remains out of reach.

That's why, at the heart of our new strategy, MSI 2030, is our commitment to ensuring that no one, whoever they are or wherever they live, is left behind. Over the next 10 years, we commit to providing at least 120 million women and girls with high-quality sexual and reproductive healthcare services. We will scale up and tailor our programmes, strengthen partnerships and innovate to reach the communities who are currently excluded from their health systems.

Through MSI 2030, we will advocate to remove legal and policy barriers and learn from our partners, as well as our evidence and experience to date. We will take three main approaches:

1. **Meeting the immediate need for sexual and reproductive healthcare**, going the last mile to deliver services in underserved communities, including rural, poor communities, displaced communities and those affected by climate change, expanding access at scale.
2. **Delivering client-centred, de-stigmatising care to all**, learning from our adolescent strategy to reach more young people, while working at a facility, community and policy level to ensure all clients, including the most marginalised, can access high-quality, de-stigmatising reproductive healthcare.
3. **Evolving and expanding our public sector partnerships**, to transition from "gap-filling" towards sustainable national ownership of high-quality reproductive healthcare.

THE CHALLENGE

218 MILLION

women and girls in low- and middle-income countries have no access to modern contraception

Today, an estimated

96,000 WOMEN

will risk their lives to undergo an unsafe abortion

ACKNOWLEDGMENTS

We warmly thank our clients who so generously shared their experiences and opinions with us for our client exit interviews between 2016 and 2020, and the donors who made running these interviews possible. We particularly thank the UK's Foreign Commonwealth & Development Office (FCDO), whose support through the WISH (Women's Integrated Sexual Health) programme has been invaluable in shaping MSI's approach to leaving no one behind.

These testimonies and experiences help us to better advocate for access to reproductive healthcare, choices and rights that give us the autonomy over our bodies and our futures, that we all deserve.

There are significant challenges ahead. Over 218 million women and girls in low- and middle-income countries today have no access to modern contraception, with COVID-19 rolling back progress further. Today, an estimated 96,000 women will risk their lives to undergo an unsafe abortion.

OVER THE LAST DECADE, WE LEARNED HOW TO BETTER DELIVER ACCESS TO UNDERSERVED COMMUNITIES AT SCALE.

In 2020, on average, we delivered care to 35,000 clients every day. One in six of these clients were under 20 years old and our 2019 data showed that one in four live on under $1.90 per day. Over the next decade, we aim to work in partnership – with providers, community organisations, civil society organisations, and governments – to further expand reproductive healthcare and rights for the most marginalised. In this report, we share our lessons learned, alongside our plans for the future, as we work towards our vision of client-centred reproductive healthcare for all.

With the evidence and insights that we share in this report, including over 21,000 interviews with MSI clients in 2019, we will continue to refine our programming and expand safe pathways to care. By routinely gathering client feedback, we hear from clients directly about what they value in reproductive healthcare and how we can improve. We hope by sharing these learnings, we can inspire partners, from community-based organisations to governments, to work with us to close the gap.

A NOTE ON LANGUAGE

A key focus of the MSI2030 strategy is to 'leave no one behind'. This involves reaching **underserved people and communities,** by which we mean people who currently have inconsistent or no access to quality, comprehensive care.

This includes people living in rural and remote areas, those in settings affected by conflict or climate change, or those who can only access low quality or limited care. With an explicit focus on these communities, we aim to go where we are most needed, with the ultimate aim of closing any gaps through community and health system strengthening.

Within these underserved communities, we will focus our efforts on reaching the **most marginalised and excluded**: those facing social, economic, or political barriers to care. This would include, for example, those living in extreme poverty, adolescents and girls, people living with disability, displaced people, LGBTQI+ people, Dalit women and sex workers, understanding that clients often face intersecting forms of marginalisation.

Our approach must start with identifying the unique needs of each individual or group, to then ensure our services are client-centred.

70% of MSI's mobile outreach clients in 2019 were living in poverty and 40% were living in extreme poverty

60% of MSI's mobile outreach clients had no alternative access to their chosen contraception

51% of mobile outreach clients were adopters, meaning they were taking up contraception for the first time or after a lapse in use

In 2020, we delivered care to

35,000 CLIENTS EVERY DAY

MEETING THE NEED FOR SEXUAL AND REPRODUCTIVE HEALTHCARE

LESSONS LEARNED ON DELIVERING ACCESS AT SCALE

Across the sub-Saharan Africa region, access to reproductive healthcare is unequal, with data showing that the poorest fifth of women are twice as likely to face an unmet need for contraception as the wealthiest fifth of women[1].

This impacts bodily autonomy and costs lives, leading to more unsafe abortions and more maternal deaths. In Nigeria, for example, the poorest fifth of women are 80% more likely to die from pregnancy-related causes than women in the wealthiest fifth[2].

This inequality is increasing, driven by the power relations that exist within families, communities, and wider societies, and a lack of political will to increase access in the poorest communities. This is despite the fact that expanding access to sexual and reproductive healthcare is one of the smartest, most cost-effective investments that governments and donors can make.

Reproductive choice supports girls to remain in education and women to contribute to the workforce, with the potential of driving a demographic dividend and economic growth, as well we progress towards key Sustainable Development Goals.

Data from MSI's mobile outreach teams illustrates that access can be delivered affordably at scale. It costs just £6 per year – or 2 pence / 3 cents per day – for MSI's outreach teams to protect a girl or young woman from an unintended pregnancy, many of whom live in underserved communities with no alternative access.

An estimated 70% of our mobile outreach clients in 2019 were living in poverty and 40% were living in extreme poverty. 60% had no alternative access to their chosen contraceptive method and 51% were adopters, meaning they were taking up contraception for the first time or after a lapse in use.

PRINCIPLES FOR LAST MILE DELIVERY

Through refining last mile services and learning what works – as well as what does not – we have identified four key focus areas for expanding access to hard-to-reach communities, particularly rural communities and people living in poverty:

Geographic coverage
Providers should operate at scale in rural areas. 85% of people experiencing multidimensional poverty live in rural areas, often underserved by the public sector.

Affordability
Services must be highly subsidised or provided for free.

Client-centred
Activities to build client awareness and shift social norms must be tailored for different audiences and localised.

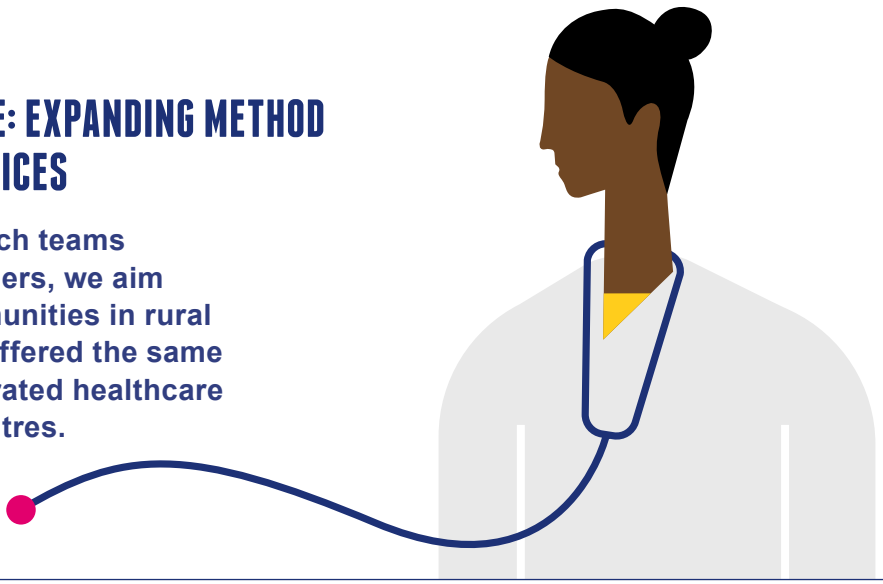
Integrated
Integrating reproductive healthcare with other services, such as immunisation, can build awareness and remove the need for rural clients to travel long distances to access care.

[1] Analysis of the DHS datasets (2010 – 2018) available for the Sub-Saharan African countries that MSI works in, excluding South Africa

[2] Analysis of Nigeria 2018 DHS datasets

PROVIDING CHOICE AT SCALE: EXPANDING METHOD MIX AND INTEGRATING SERVICES

Through MSI's mobile outreach teams and community-based providers, we aim to ensure underserved communities in rural and peri-urban settings are offered the same choice of methods and integrated healthcare services as clients at our centres.



Complementing the health system by expanding choice of methods

Government sites and pharmacies often only provide short-term methods, so we have trained mobile outreach teams and community-based providers to offer a range of long-acting reversible contraceptives. This means clients are counselled on the full range of methods and can choose the right option for them.

To do so, we have tailored training to remove provider barriers. In Zambia, for example, we found that providers lacked confidence in inserting IUDs, and due to the group nature of clinical training, often felt unable to ask for further support. We introduced one-on-one supportive supervision and hired additional female providers and chaperones to ensure clients and providers felt comfortable with gynaecological examinations. This way, we upskilled providers to feel confident in IUD insertions, ensuring full choice of methods for clients.

Our client exit interviews found that globally, our mobile outreach clients were counselled on an average of five modern contraceptive methods. 81% of clients shared that they had a form of contraception in mind before arriving at the outreach site and were able to access that same method during their visit.

Ensuring quality access with integrated reproductive healthcare

Women living in rural communities can face long journeys to access healthcare. To remove this barrier and ensure clients can access multiple services at once, MSI's outreach teams and community-based providers are broadening their offering to cover other essential services, such as post-abortion care, cervical cancer screening, HIV / STI testing, and sexual and gender-based violence first-line care.

By integrating with national activities, such as post-natal care days or immunisation programmes, access can be expanded further, efficiently. In Zimbabwe, for example, by partnering with the national immunisation programme, MSI's WISH-funded outreach teams were able to continue to provide contraception throughout the COVID-19 pandemic.

81% **of clients shared that they had a form of contraception in mind before arriving at the outreach site and were able to access that same method during their visit**

LEAVING NO ONE BEHIND

DELIVERING CLIENT-CENTRED, DE-STIGMATISING CARE TO ALL

While delivering last mile services will help us to reach underserved communities where and when they need us, marginalised communities continue to face multiple and intersecting barriers to healthcare and rights.

Over the next decade, we will forge strong partnerships at a facility, community and policy level. From challenging policy and clinical restrictions that limit who can access reproductive healthcare, to training providers to deliver de-stigmatising care, we will ensure reproductive healthcare is accessible to all.

WHAT WE LEARNED FROM OUR ADOLESCENT STRATEGY ON REACHING MARGINALISED COMMUNITIES

Barriers to reproductive healthcare continue to hold young women and girls back, costing lives.

Research from Population Council across six sub-Saharan African countries found that nearly all adolescent girls who have ever been pregnant are no longer in school, while childbirth complications continue to be the leading cause of death for girls aged 15-19. In Niger, one in two girls will give birth before their 18th birthday, but only one in 100 will finish secondary school.

Young people often face the highest unmet need for contraception, so in 2017, we launched a tailored adolescent strategy expanding access to young women and girls.

Since 2017, we have reached over four million adolescents with services, scaling up investment in three key areas:

1. Building an enabling environment at a policy and community level for equal access
2. Increasing awareness of services and their potential benefits through community engagement
3. Adapting services to ensure facilities and providers are equipped to deliver inclusive care

We learned that simple solutions are often the most effective – building safe, discreet pathways to increase adolescent awareness and referrals, while partnering to achieve longer term goals, with policy change and community support. With this approach, we now aim to expand access to marginalised communities, such as those living in extreme poverty, people living with disabilities, sex workers, and women living with HIV.

We also recognise that every client is individual, facing unique and intersecting forms of marginalisation. That's why, at the core of our leave no one behind approach is our commitment to client-centred care. We will develop an environment that supports all clients to access high quality, de-stigmatising sexual and reproductive healthcare.

"Every girl has her life to live and we are choosing to take our destiny in our hands. My mother dropped out of school at age 19 and my two aunties did the same. The one thing that was common between them was unplanned pregnancy. My ambition is to finish secondary school, gain admission to university and achieve my dream of becoming a lawyer. But I have to protect myself to see my dream come true."

Blessing, MSI Nigeria client, Edo state

TRANSFORMING ACCESS: REMOVING BARRIERS FOR MARGINALISED COMMUNITIES

Reproductive healthcare continues to be over-medicalised and over-regulated. Our role as a service provider is to normalise these lifesaving services, advocating for change, while collaborating with governments to remove needless restrictions that cost lives.

Through our partnerships with government and civil society, we have supported 53 policy, law, regulation, and financing changes between 2016-2020.

These included improvements to young people's eligibility for contraception, safe abortion, and post-abortion care in Zimbabwe's Second National Adolescent SRH Strategy and the inclusion of adolescent sexual and reproductive health and rights in Mali's 2020-2024 strategic reproductive health plan.

RESEARCH ACROSS SIX SUB-SAHARAN AFRICAN COUNTRIES FOUND THAT NEARLY ALL ADOLESCENT GIRLS WHO HAVE EVER BEEN PREGNANT ARE NO LONGER IN SCHOOL

From Zambia and Burkina Faso, where we have used localised data and role play to engage men and community leaders and facilitate joint decision-making between couples, to Sierra Leone where we have allied with disability organisations to develop awareness messaging.

MSI's community engagement work has contributed to shifting social and gender norms, facilitating greater community support for reproductive healthcare and promoting women's roles in decision-making.

"When MSI came to my community, they wanted to see the community leader. I made myself available and they cleared every misconception I had on family planning."

Chief Dayo Olatunji, Chief of Lajoke community, Ondo State, Nigeria

1 IN 2 VS 1 IN 100

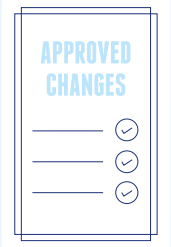
In Niger, one in two girls will give birth before their 18th birthday, but only one in 100 will finish secondary school

GIRLS AGED 15-19

Childbirth complications are the leading cause of death for girls aged 15-19

4M ADOLESCENTS

Since launching our adolescent strategy in 2017, we have reached over four million adolescents with reproductive healthcare services



53 CHANGES

Between 2016-2020, MSI supported 53 policy, legal, regulatory and financial changes

COMMUNITY-LED HEALTHCARE: BUILDING AWARENESS OF REPRODUCTIVE HEALTH AND RIGHTS

Partnering with community hubs and advocates to increase awareness

To build safe referral pathways for marginalised communities, particularly in stigmatised environments, we partner with local advocates and community hubs to build community awareness and help tailor services.

Often the first point of contact for clients, community-based mobilisers (CBMs) are local advocates for reproductive healthcare, who help to build awareness of contraception and support clients with advice and referrals.

WISH is the UK FCDO's flagship women's healthcare programme, delivering reproductive healthcare services across 27 countries in West and Central Africa and Asia. Through WISH, we have partnered with disability-inclusion organisations to train mobilisers with lived experience of marginalisation.

Zainab from Sierra Leone is an MSI community-based mobiliser trained via WISH. As a woman with a disability, she is committed to building awareness of inclusive reproductive healthcare services in her community, challenging harmful social norms. Zainab shared:

> **"People with disabilities in my community now have the confidence to inquire and I can talk to them about our services."**

In 2019, 32% of mobile outreach clients and 28% of clients who accessed services via our community-based providers reported that CBMs were their most important source of information when deciding to come to MSI. 44% of outreach clients and 41% of community-based provider clients reported contact with a mobiliser before their visit.

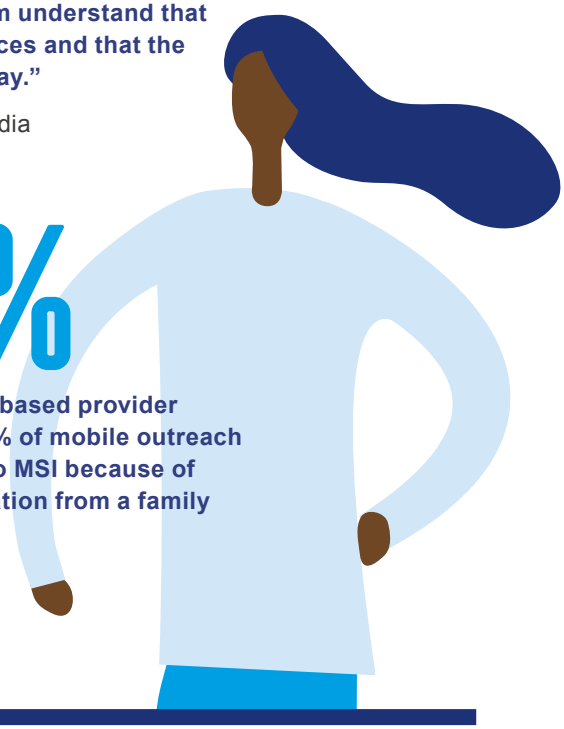
Community hubs, such as youth groups, schools and universities, and community centres, can also provide a safe route for marginalised clients to access inclusive care. In Senegal, for example, our community-based providers partnered with local schools to build awareness of adolescent-friendly contraceptive services, in partnership with the Ministry of Education.

Building safe pathways to care through word of mouth

With prevailing stigma around reproductive healthcare, a recommendation from a friend or family member can be key to finding a safe service, particularly for safe abortion and post-abortion care where personal referrals can drive women to unsafe providers.

In 2019, we found that 33% of clients who sought services with one of MSI's community-based providers did so because of a recommendation from a family member or friend, as did 18% of outreach clients. As we found in our 2018 survey of over 1,900 safe abortion clients, by delivering de-stigmatising, client-centred care, we can increase the likelihood of clients sharing their experiences with their friends and family, building awareness of the safe services available and their benefits.

> **"People don't really talk about abortion here. I think it's important to share my story because it will help other women who are in the same situation. It will help them understand that they have choices and that the choices are okay."**
>
> Johana, Cambodia



33%

of community-based provider clients and 18% of mobile outreach clients came to MSI because of a recommendation from a family or friend

32% OF MOBILE OUTREACH CLIENTS

and 28% of community-based provider clients reported that community-based mobilisers were their most important source of information

44% OF MOBILE OUTREACH CLIENTS

and 41% of community-based provider clients were in contact with a mobiliser before their visit

DELIVERING CLIENT-CENTRED CARE TO ALL: SERVICE ADAPTATIONS

Supporting providers to deliver empathetic, de-stigmatising care to all

Prevailing stigma around who should access sexual and reproductive healthcare continues to exclude certain people or groups, for example, adolescents, unmarried women, sex workers or women with disabilities.

To tackle this, MSI invests in support and training for our providers, including, Providers Share Workshops and Values Clarification and Attitudes Transformation training.

The aim of these training sessions is to support providers in delivering de-stigmatising, empathetic support to all regardless of background or reasons for seeking care.

As we found when delivering cervical cancer screening and preventative therapy to sex workers and women living in slums in Dhaka, Bangladesh, reproductive healthcare must include counselling that is tailored to the client's lifestyle and the unique challenges they face. Certain pathways will need to be entirely bespoke to be inclusive, such as those we have developed for trans men seeking safe abortion care in our UK and Australia programmes. Meanwhile, other pathway adaptations may benefit a range of marginalised groups, for example, separate waiting rooms or queue prioritisation cards.

By ensuring services are empowering and client-centred, providers can help strengthen client agency, particularly for marginalised clients who face systemic barriers to reproductive healthcare and rights.

67%

of our mobile outreach clients have access to a mobile phone.

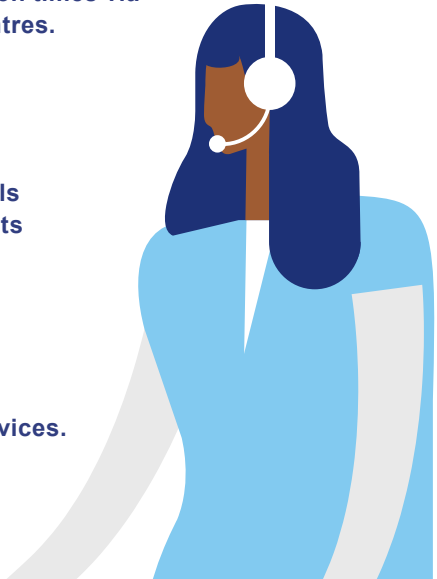
In 2020, we interacted with clients 2.4 million times via our contact centres.

18%

of incoming calls from adolescents

45%

of whom were referred for services.



Inclusive by design – working with marginalised groups to tailor programming

Our client exit interview data indicates that clients from marginalised backgrounds (for example, those living in poverty, adolescents, those living with disability) are just as likely to receive quality care in our outreach services. However, the data also showed that clients in these groups value additional information and space to ask questions during counselling, showing the importance of involving marginalised voices when developing counselling approaches and materials.

Through WISH, MSI Sierra Leone has worked with Leonard Cheshire and the Sierra Leone Union on Disability Issues (SLUDI) to conduct workshops with representatives of disabled peoples' groups, to understand what disability inclusion means to them and design inclusive programming together. By taking a "nothing about us without us" approach, we can meaningfully involve marginalised communities in the development of programmes tailored to their needs.

Ensuring access for marginalised clients with contact centres

Over the past five years, mobile ownership has dramatically increased in the countries that MSI works in. According to our 2019 client exit interviews, 67% of our mobile outreach clients and 77% of community-based provider clients have access to a mobile phone, providing an opportunity to strengthen our continuum of care for clients before, during and after care.

MSI'S NETWORK OF 28 CONTACT CENTRES PROVIDE FREE INFORMATION AND ADVICE VIA THE PHONE, SOCIAL MEDIA AND WHATSAPP, REFERRING CLIENTS TO INCLUSIVE SERVICES.

Our data shows that contact centres are particularly important for marginalised women and girls, who may otherwise feel unable to seek advice due to stigma. In 2020, we interacted with clients over 2.4 million times via messages and calls with our contact centres. 18% of global incoming calls were from adolescents, 45% of whom were referred for services, equating to nearly 100,000 adolescents accessing safe care.

SUSTAINABLE SERVICES

WORKING TOWARDS NATIONAL OWNERSHIP OF SEXUAL AND REPRODUCTIVE HEALTHCARE

As health systems struggle with the impact of COVID-19, and gaps persist in skills, commodities and coverage, MSI's teams will continue to meet immediate healthcare needs. Through MSI2030, we will focus on closing gaps once and for all, partnering with the public sector to build capacity and embed quality assurance mechanisms, working towards national ownership of comprehensive sexual and reproductive healthcare.

CASE STUDY – ETHIOPIA

SUPPORTING THE ETHIOPIAN GOVERNMENT TO DELIVER REPRODUCTIVE CHOICE

In Ethiopia, 82% of family planning services are delivered through the public health sector, but due to commodity shortages, financing challenges and a lack of provider training, providers were often unable to offer a full choice of methods. To change this, MSI Ethiopia partnered with EngenderHealth and Ethiopia's Federal Ministry of Health to deliver the Family Planning by Choice (FPbC) project, funded by the UK's FCDO, to improve the quality, equity and financing of contraception and comprehensive abortion care in Ethiopia.

By building public sector provider capacity, improving facility readiness and working with the government to revise national level policy documents, the project developed 11 Centres of Excellence. These act as training hubs for government providers, who then cascaded the training through the health system.

Through this model, training on delivering client-centred sexual and reproductive healthcare services has been cascaded to 13,000 providers to date, supporting sustainable access to a full range of contraceptive methods across Ethiopia.

Since 2012, MSI has worked directly with the public sector to train over

10,000 PROVIDERS

Across

5,500 PUBLIC SECTOR FACILITIES

Through these facilities, we have partnered with the public sector to serve over

12.6M CLIENTS

and in 2019, 68% of these clients had no alternative access to their chosen contraceptive method.

SUSTAINABLE ACCESS

MSI's public sector strengthening (PSS) work focuses on building public sector provision by tailoring programmes to governmental needs and requests. This varies from hands-on training, quality assurance, and supportive supervision programmes with government providers, to more indirect organisational support, such as training-of-trainers or logistical management of quality assurance.

Regardless of the model, our aim is to close skills and coverage gaps in public sector provision, building sustainable access to a full range of contraceptive methods, as well as safe abortion and post-abortion care.

TRANSITION PLANS FOR THE FUTURE

Where strong existing public sector provision exists, we will begin transitioning MSI operations to national ownership. Over the next decade, we will invest alongside governments to embed the systems, skills, and quality assurance processes needed to facilitate this shift of ownership at scale, building the confidence and political will to ensure stigmatised reproductive healthcare services are not excluded from the package.

Where health systems are struggling to handle the fall out of the pandemic, newer public sector support programmes will run in parallel with MSI's outreach and community-based provision, allowing MSI to protect immediate access to reproductive healthcare, while strengthening capacity in public health systems.

At every step, we will be led by our government partners on where and how we can best support them. Once public sector capacity to provide long-acting reversible contraception, safe abortion and post-abortion care has increased, the need for MSI's outreach services or community-based providers will decrease.

PARTNERING ACROSS THE HEALTH SYSTEM

This transition will require partnership beyond MSI and the public sector. Governments must commit to reproductive healthcare commodities in national budgets and supply chain partnerships are needed to ensure those commodities are secured. Plus, as long as stigma and needless restrictions around reproductive healthcare persist, civil society organisations will be pivotal in shifting attitudes at a community and policy-level.

However, with time, partnership, and joint investment, we hope that national ownership of comprehensive sexual and reproductive healthcare can be achieved.

MSI'S PATHWAY TO QUALITY PUBLIC SECTOR PROVISION AND OWNERSHIP OF REPRODUCTIVE HEALTHCARE

Our pathway for ensuring access to nationally-led services involves creating an enabling environment, while upskilling public providers.

This involves three key phases:

1 MSI service delivery plus public provider coaching

Working at government-selected outreach sites and healthcare facilities, our MSI providers combine direct service delivery with on-the-job coaching of government health care providers, ensuring a full choice of methods for all clients.

2 Public sector provision with MSI support

Public sector providers begin to deliver services directly, with ongoing training, supportive supervision and quality assurance provided by MSI.

3 Indirect public sector support

MSI works with governments to establish quality assurance structures, so that public sector providers can deliver services directly, under clinical supervision and quality assurance from government. Through this final phase, we aim to ultimately hand over service provision and quality assurance activity to government, leading to national ownership.

PATHWAY CASE STUDY – SIERRA LEONE

SUPPORTING THE GOVERNMENT OF SIERRA LEONE TO DELIVER QUALITY REPRODUCTIVE HEALTHCARE

In 2018, the Sierra Leonean government was looking to improve its reproductive, maternal, newborn, child and adolescent health services. To support, MSI's programme in Sierra Leone (MSSL) partnered with seven other NGOs to form the FCDO-funded Saving Lives 2 consortium. This provided a selection of mobile outreach teams, clinical trainers and supervisors to support 90 public sector facilities in delivering high quality, sustainable services.

The programme was co-created with government and involved working with the interreligious council to ensure support at both a national and community level.

In mid-2020, as the clinical quality and community awareness of facilities improved, MSSL began phasing out the support they provided in half of the facilities, with the Ministry of Health taking over responsibility for quality assurance and supportive supervision in those top-performing facilities. This allowed MSSL to pivot support to new facilities, increasing reach and access, whilst moving one step closer to national ownership of high-quality reproductive healthcare services.

SUSTAINABLE SERVICES: FUNDING REPRODUCTIVE HEALTHCARE FOR THE FUTURE

As we look ahead to transitioning services from donor-funded delivery to public sector ownership, national investment in reproductive healthcare will be crucial.

To facilitate this, MSI continues to advocate for the inclusion of contraception, safe abortion, and post-abortion care in the basic health service packages and systems of public health insurance, enabling women to access services without financial barriers.

In Nepal, for example, the government has now included safe abortion care in the Basic Health Services Package, making abortion free of charge at public health facilities. Since the reforms, Nepal has seen a rise in the use of government facilities for abortion care and improved abortion safety.

EXPANDING ACCESS TO SAFE SEXUAL AND REPRODUCTIVE HEALTHCARE CAN RESULT IN SUBSTANTIAL SAVINGS FOR HEALTH SYSTEMS.

Recent estimates show that the average cost of providing a safe abortion in a low and middle-income country is six times lower than the cost of providing post-abortion care following an unsafe abortion. Meanwhile, the Guttmacher Institute found that for each additional dollar spent on contraceptive services, $2.20 would be saved in pregnancy-related care costs. For adolescents, every additional dollar invested would save $3.70, demonstrating the importance of maintaining the focus on the most marginalised.

1/6 OF THE PRICE

The cost of providing a safe abortion is one sixth of the price of providing post-abortion care after an unsafe abortion

$2.20 SAVED

For each additional dollar spent on contraception, the health system is saved $2.20 in pregnancy-related care costs

$3.70 SAVED

For adolescents, every additional dollar spent on contraception saves $3.70

JOIN US IN MAKING REPRODUCTIVE CHOICE FOR ALL A REALITY

By 2030, we aim to support a game-changing shift towards increased national ownership of sexual and reproductive healthcare. This will be a long and gradual journey, but one where we will work closely with our government partners every step of the way.

We know that increased national ownership of reproductive healthcare will build more sustainable access, providing the most coverage for underserved communities.

However, as we increasingly hand over responsibility for service delivery to government, rights-based advocacy, community engagement and accountability for shifting social norms and increasing access for marginalised communities will remain crucial.

HOW TO PARTNER WITH US TO LEAVE NO ONE BEHIND

To partner with MSI to make reproductive choice a reality for all, contact our Partnerships & Philanthropy team via Partnerships&Philanthropy@msichoices.org.

To speak about the evidence and impact shared in this report, reach out to MSI's Evidence & Impact team via evidence@msichoices.org.

To find out more about MSI's services and the countries we work in, visit www.msichoices.org and subscribe to our Spotlight newsletter to receive new evidence and insights straight to your inbox.

PARTNERSHIP WILL BE VITAL: FROM GRASSROOTS WOMEN'S ORGANISATIONS AND COMMUNITY-BASED ADVOCATES, TO NATIONAL NGOS, ADVOCACY PARTNERS, FUNDERS AND GOVERNMENTS, WE WILL WORK TOGETHER TO CONTINUE DISMANTLING BARRIERS FOR THE MOST MARGINALISED, TAILORING PROGRAMMES, AND BUILDING SAFE PATHWAYS TO CARE.

Only by working together, with the expertise and connections of partners, can we ensure that no one is left behind.

Please join us in making reproductive choice a reality for all.

BY 2030, WE AIM TO MAKE REPRODUCTIVE CHOICE A REALITY FOR ALL

NO ABORTION WILL BE UNSAFE AND EVERYONE WHO WANTS ACCESS TO CONTRACEPTION WILL HAVE IT

JOIN US IN MAKING CHOICE POSSIBLE

MSI Reproductive Choices is one of the world's leading providers of contraception and safe abortion care. Working across 37 countries, we support women and girls to determine the path their life takes.

It only costs £6 per year – or 2 pence / 3 cents per day – for MSI to protect a girl or young woman from an unintended pregnancy. This reproductive choice keeps girls in school, supports women to lead, and helps to build more equal and sustainable communities. Join us in making choice possible.

MSI REPRODUCTIVE CHOICES

YOUR BODY,
YOUR CHOICE,
YOUR FUTURE.

For citation purposes: Reproductive Choice for All: Leaving no one behind in reproductive healthcare.
London: MSI Reproductive Choices, 2021.

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MSI REPRODUCTIVE CHOICES

THE IMPACT OF THE CLIMATE CRISIS ON REPRODUCTIVE CHOICE

While navigating the climate crisis, it is essential that women and girls have access to sexual and reproductive health and rights. However, new analysis from MSI Reproductive Choices shows that due to climate-related disruptions, an estimated 14 million women are at risk of losing access to contraception over the next decade.

A GENDERED CRISIS

It is an injustice that the communities that have contributed the least to the climate crisis are suffering the most from its impacts. Water scarcity, rising sea levels, and increasing crop failures and flooding are disproportionately affecting low- and middle-income countries.

Africa, for example, contributes only 2% of the world's carbon dioxide emissions, but is also the continent most vulnerable to the impact of climate change.

Evidence shows that women and girls are hardest hit. Facing gendered discrimination, lower incomes and poorer access to food and other resources, the UN has warned that women and girls will suffer for longer and more severely from climate shocks and disasters.

The World Bank estimates that climate change could displace more than 216 million people by 2050. In humanitarian settings, where one in five women and girls report experiencing sexual violence, the need for sexual and reproductive health and rights become more acute, yet access to quality care is inadequate.

"OUR CHILDREN MIGRATED IN THE HOPE OF A BETTER FUTURE. THE SEA, THEIR ONLY HOPE WITH AGRICULTURE, DOESN'T GENERATE REVENUES ANYMORE. BEFORE WE COULD GET UP TO 100 BASKETS OF FISH. NOW WE BARELY GET 10."

ROKHI, MSI CONTRACEPTIVE CLIENT, JOAL, SENEGAL

14 MILLION WOMEN AT RISK OF LOSING REPRODUCTIVE CHOICE

When facing climate disruptions, like any humanitarian emergency, it is essential that women have access to reproductive choice, enabling them to prevent unintended pregnancies while navigating the crisis. However, analysis from MSI Reproductive Choices across 26 climate impacted countries found that since 2011[1], an estimated 11.5 million women have had their access to contraception disrupted due to climate-related displacement.

MSI's modelling indicates that this will worsen over the next decade, as we estimate that 14 million women are at risk of losing access to contraception due to climate-related displacement.

14M

If access is not protected for these women and their demand is not met, MSI estimates that this would lead to an additional

6.2M unintended pregnancies

2.1M unsafe abortions

5,800 maternal deaths

Pictured left: A woman in Joal, Senegal collects shellfish, which have become harder to harvest due to climate change, with warmer temperatures, rising sea levels and higher water salinity.

[i] Modelling uses data from the Internal Displacement Monitoring Centre (2010-2020), DHS data for 26 of the countries that MSI works in (Afghanistan, Bangladesh, Bolivia, Burkina Faso, DRC, Ethiopia, Ghana, India, Kenya, Madagascar, Mali, Malawi, Myanmar, Nepal, Niger, Nigeria, Pakistan, PNG, Timor-Leste, Senegal, Sierra Leone, Tanzania, Uganda, Yemen, Zambia, and Zimbabwe) and MSI's IMPACT2 tool. Full technical note and methodology available at msichoices.org.

SUPPORTING WOMEN ON THE FRONTLINE OF THE CRISIS TO ADAPT WITH CHOICE

While the global community works to mitigate climate change, we must better support women and communities on the frontline of the crisis to adapt. Access to sexual and reproductive healthcare information and services is foundational to this.

The World Bank has identified sub-Saharan Africa as the region most vulnerable to climate change due to desertification, fragile coastlines, and dependence on agriculture, and this aligns with the experience of MSI's programmes.

For many women accessing healthcare with MSI, the climate crisis is a daily reality. When drought hits, they need to walk further to find water and when harvests fail, they can struggle to feed their families. To support them to adapt to these challenging circumstances, whether that's re-locating or re-entering the workforce, women and girls have made clear that they want reproductive choice.

For example, in Senegal, MSI supported a client who had lost her home due to coastal erosion caused by rising sea levels. Facing homelessness, Fatou* accessed contraception with MSI, providing her with the ability to avoid unintended pregnancy while finding a new home.

WITH AUTONOMY, WOMEN CAN BE PART OF FINDING THE SOLUTIONS

If we are to solve the climate crisis, climate action must acknowledge existing gender inequalities and ensure that women and girls can take part in finding the solutions.

With reproductive choice, girls are better able to finish their education and pursue their careers, providing them with greater economic stability and agency when facing a disaster. With reproductive autonomy, women are also better placed to take on decision-making roles at a community and national level, enabling women to have a seat at the table in finding climate solutions.

* a pseudonym

RECOMMENDATION:

SUPPORT COMMUNITIES TO ADAPT WITH REPRODUCTIVE CHOICE

Around the COP26 climate conference, there is a focus on mobilising $100 billion per year to support low-income countries to respond to climate change. MSI Reproductive Choices is joining 65 partners in calling on governments and donors to integrate sexual and reproductive healthcare and rights into these funding commitments, to support women and girls on the frontline of the crisis to adapt and determine their lives and futures.

For citation purposes: The impact of the climate crisis on reproductive choice.

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