MSI REPRODUCTIVE CHOICES

NOVEMBER 2025

The Effects of ODA Cuts on Access to Sexual and Reproductive Health and Rights

The dismantling of USAID, the world's previously largest bilateral funder of health and family planning, alongside other cuts to ODA throughout 2025 continue to cause chaos and confusion across health systems, forcing many programmes to close, and leaving gaps in services, with a devastating impact on access.

Development assistance for health declined by 21% between 2024 and 2025, driven largely by a 67% drop – over $9 billion – in financing from the US government. Alongside the UK cutting by 39% ($796.1 million), France by 33% ($555.1 million), Germany by 12% ($304.5 million) and Finland by 11% ($14.9 million).

- Most low-income countries lack the fiscal capacity to immediately replace this support. Supply chain disruptions have already been reported with the collapse of distribution networks, and the impact on service delivery and maternal health projected to peak in 2026.
- Nigeria has lost the most development assistance in absolute terms, more than $400 million, and Malawi has been hit hardest relative to their small budget, with reductions in total health spending of up to 16.5%.
- NGOs that relied on U.S. grants have seen a 23% loss in funding overall, leading to the closure or downsizing of many health and advocacy organisations. This has impacted many of MSI's implementing global, national and local partners.
- UNFPA has lost $377 million in USAID funding, particularly affecting maternal care in crisis zones such as Sudan, Gaza, Ukraine, and Afghanistan.

As the impact cascades through the health system and into communities, it is the poorest and most marginalised people that are most affected, particularly those living in conflict and humanitarian settings. The Lancet (Oct 2025) projected consequences of the cessation of US global health funding between 2025 and 2030, which include:

- 15 – 20 million additional abortions, of which 12 – 16 million are likely to be unsafe
- Loss of 73 – 100 million contraceptive users across 41 countries
- 40 – 55 million additional unintended pregnancies across 51 countries, with the largest estimated impacts in Tanzania, DRC, Uganda, and Mozambique
- In 2025 alone, 17.1 million more unintended pregnancies (including 7.6 million unplanned births and 5.2 million unsafe abortions)
- 4.1 million additional AIDS-related deaths across 55 countries
- 2.5 million additional child deaths from other causes across 24 countries
- 140,000 additional maternal deaths due to a shortage of health-care services

MSI is on the frontline of providing lifesaving SRHR services in 36 countries. As we continue to navigate and respond to these seismic shifts, and in an already limited funding environment here we share insights into current disruptions, priorities, and risks across the building blocks of the health system, recognising that while the immediate hurdles of 2025 are being addressed, the medium to longer term impacts and solutions are still unclear.

This crisis is a critical moment to rethink global health, development, and SRHR financing, and to build an infrastructure that is more resilient, country led and progressive in its inclusion of abortion. Whilst we welcome, and are part of, current and long overdue conversations around what a more sustainably and locally driven approach to aid and development could look like, this document focuses on the shorter-term impacts on the health system as we recommit our efforts to support the ever increasing demand for contraception and abortion and to supporting our service providers that are on the frontline.

86% of MSI country programmes have reported significant to very significant impact on their national health system and SRHR access.

Just over half of MSI country programmes (15) have been asked to take on new roles, primarily by ministries of health. For example:

- in Uganda we have been working with UNFPA to fill gaps
- in Malawi we have been asked to support more public sector sites
- in Zambia we have been asked to source FP commodities, support last mile distribution, assist with provincial and district review meetings, and train additional providers

As governments are forced to transition quickly from donor dependency, domestic, and alternative financing models are being prioritised and fast tracked, learning from countries which are further along in this transition.

> In Nigeria the Federal Government has increased their 2025 health budget by approximately $200 million, announced a $1.7 billion multi-year investment for broader health sector reforms, co-financed by the World Bank and other partners. They have begun absorbing around 28,000 health workers previously supported by USAID into the public payroll.

> Addressing the recent International Conference on Family Planning, Zambia's Minister of Health, Elijah Julaki Muchima, announced an increase in family planning funding from $4.5m (£3.4m) in 2025 to $7.5m (£5.7m) in 2026. "Today, we take a historic step in cementing Zambia's commitment. It is the single most strategic investment in our nation's human capital. This is not just a programme, it is a service to the country."

> Zimbabwe's Minister of Health and Childcare, Douglas Mombeshora, announced his government will spend an additional $2.25m (£1.7m) a year on contraceptives in 2026 and 2027. The Zimbabwean government expects to raise an extra $2m (£1.5m) annually through taxes on products such as alcohol and tobacco to strengthen family planning services.

> The DRC is moving from no budget for contraceptives to $5m (£3.8m) a year over the next four years.

Some governments are investing in the local regional manufacturing of commodities, reviewing health insurance benefits packages to expand coverage, and restructuring health and human resources to rebuild capacity and resilience.

USAID's previous support for FP programmes and systems included:

- **staffing** – salaries for healthcare workers and pharmacists, secondments to MoH
- **technical assistance** – trainings, curriculum development, programme design, implementation support, market assessments, contracting, supporting technical working groups
- **community engagement** – changing harmful social norms to support women and girls' empowerment and active participation in community development
- **infrastructure** – facility improvements, vehicles, computers
- **data collection** – Health Management Information Systems, Demographic and Health Surveys, warehouse management, census data, forecasting
- **in-country supply chain operations** – warehousing and inventory management, distribution, commodity forecasting and quantification, customs clearance
- **product procurement and freight** – product and packaging, freight costs

The WHO Health System Framework

System building blocks

- Improved health (level and equity)
- Responsiveness
- Financial risk protection
- Improved efficiency

Access coverage ↓ **Quality safety**

- Leadership/governance
- Health care financing
- Medical products, technologies
- Information and research
- Health workforce
- Service delivery

Goals/outcomes

> **"The true impact of the USAID pull out is yet to be felt. What we are experiencing now are immediate disruptions in the FP commodity distribution and the absence of many NGOs in the SRHR space. We expect Zambia to experience serious FP commodity shortages between Q3 and Q4 of 2025. Given limited resources the Ministry of Health might prioritise curative medicines including ARVs."**
> **– MSI Zambia**

Impacts on MSI Programmes

Uganda

Marie Stopes Uganda (MSUG) was a sub awardee on the USAID Universal Health Activity programme 2022-2027 led by University Research Co. The project was working with the government to ensure that people – especially underserved communities – across 76 districts and cities in seven regions can access inclusive, respectful and people-centred care. The project was also building the capacity of the health workforce to improve maternal, child health, HIV/ AIDS and contraception services. The 5 year $140m activity was terminated this year which led to an immediate end in supporting public sector sites and the estimated funding loss for MSUG is $2 million.

Ethiopia

MSI Ethiopia (MSIE) advances access to SRHR across nine of Ethiopia's 12 regional states, including to IDP settlements in Afar, Amhara, Oromia, and Tigray. USAID funding was supporting our team to strengthen private sector facilities and restore health services in conflict-affected areas which has now come to an end. UNFPA funding of outreach teams and support to 40 public facilities in conflict and underserved areas of Tigray, Afar, Amhara, and Oromia is also at risk.

Zimbabwe

In 2023 MSI's local affiliate in Zimbabwe, Population Services Zimbabwe (PSZ), was awarded $9 million by USAID to deliver a five-year programme. ShaSha supported outreach teams to travel to the most remote parts of Zimbabwe providing free contraceptive services to women who have little or no other options, and supported 100 public and 120 private sector facilities to strengthen access to quality care. The programme included expanding access for people with disabilities, working with church organisations to dispel myths and misconceptions, and increasing access to services and information for youth and adolescents. The speed at which this programme ended meant that we were not able to give communities and clients any warning that the services they rely on were at risk. In communities where many women have to negotiate with families and partners to access contraception, this has resulted in a betrayal of the trust that our teams have built over many years. Over $6 million of the $9 million awarded has now been lost, equating to over 41% of PSZ's donor funding. Vehicles have had to be returned, and staff contracts ended. If additional funding is not secured approximately 1.3 million women will lose access to SRHR services, leading to 461,200 unintended pregnancies and 1,400 maternal deaths.

1 Collapse of supply chain and commodity shortages

USAID provided 35% of the stock within global FP supply chains, and supplied commodities through missions to 23 countries. **17 out of 28 MSI country programmes have reported that contraceptive supply chains/access to commodities have been the most impacted aspect of their health system.** With fewer implementing partners and reduced public capacity there are concerns about maintaining current pricing. If demand dips this could compromise the system because manufacturers will increase their prices or prioritise production of other products.

An estimated $10 million worth of USAID-procured contraceptives are currently being stored in a warehouse in Geel, Belgium, with the U.S. administration proposing to destroy them. 77% of these essential supplies were earmarked for the DRC, Kenya, Tanzania, Zambia, and Mali.

Of the KES 80.5 billion required for Kenya's national health programmes, approximately KES 24.9 billion was provided by USAID to procure, warehouse, and distribute essential commodities. Given no waiver has been granted to continue distributing USAID supported commodities the current supply of contraceptive commodities is less than five months, well below the required 16-month minimum.

In Tanzania 1,031,400 injectable contraceptives and 365,100 implants will no longer distributed. These products represented over 50% of USAID's annual support to Tanzania's health system and a 28% of the total annual need of the country. In response, the government has established a resource mobilisation taskforce and has allocated $1.3 million for commodities.

In Zambia, USAID funded 60% of the financing for FP commodities. The government is currently fast-tracking $4.7 million in FP commodity procurement to leverage match funding and strengthen domestic ownership.

In Burkina Faso, there is a significant risk of stockouts given previous USAID provision of commodities.

Whilst government led distribution and transportation systems are collapsing some governments have policies that are prohibiting NGOs from moving government stock. MSI have negotiated a work around in Sierra Leone, where we provide the vehicle and driver and the MoH provides a person to load and unload commodities.

In Nepal, cuts have affected government supplies of injectables, with other commodities likely to be impacted soon. MSI in Nepal has stocks of implants which are projected to last until the end of 2025, but despite close co-ordination with the government and UNFPA there is no certainty over future supply.

> **"MSI has been asked to cover previous programmes of partners who have been defunded in Uganda, Zambia and Tanzania and to try and find commodities in warehouses and distribute them. Supplies are diminishing and there is great anxiety looking ahead. With the absence of implants MSI is seeing gradual shifts in method mix as IUDs are still available as they were not previously prioritised or preferred but are now getting used. IUDs now constitute 22% of our method mix in Tanzania, 32% in Madagascar, and 24% in Uganda. However, global popularity of implants and injectables has remained strong." – Carol Sekimpi, Senior Africa Director, MSI**

2 Leadership and co-ordination of technical working groups

USAID had a longstanding commitment to enhancing health systems through the leadership and co-ordination of technical working groups (TWGs) which are instrumental in strengthening health systems, developing policies, setting standards and implementing initiatives. For example, USAID supported TWGs in Ethiopia, Ghana, Kenya, Malawi, Nigeria, Senegal, Sierra Leone, Uganda, Zambia, Afghanistan, Bangladesh, Nepal and Pakistan.

TWGs are responsible for convening monthly or quarterly meetings where issues relating to commodities are discussed and resolved collectively. In some countries meetings have been postponed, delayed, or not occurred. This is a key area where UNFPA, implementers and donors, working with ministries have needed to step in and co-ordinate. USAID were also funding some country based UNFPA staff who played a crucial role in data analysis and support.

3 Shortage of public health providers

USAID significantly contributed to strengthening the health workforce in many low-income countries to address provider shortages, with a particular focus on nurses and midwives who constitute approximately 50% of the global health workforce. USAID supported both the quality and accessibility of care through training workers and expanding coverage. USAID funded extensive training of providers in how to provide contraceptive services and of pharmacists in supply chain management. Some ministries of health have had to halt activities, contracts and payments related to employees hired with USAID support, with many health workers across hospitals, health facilities, administration, and research institutes affected.

In Kenya, Nigeria and Ethiopia outreach services for young people, remote communities and key populations have been paused or scaled back. Some health facilities have had to switch from individual counselling sessions to group counselling. Clinics are now operating at reduced hours or closing on certain days of the week, or not opening on weekends or after hours which will disproportionately affect more vulnerable people. In Ethiopia, there are widespread reports of SRHR services for sexual violence survivors and HIV-positive women being halted.

There is disruption across health systems with increasing unreliability in there being enough providers at the required time and place. The Ethiopian Government has terminated 5,000 provider contracts with similar reports of disruption from the public sites where we previously supported and trained providers in Zambia and Mali.

Over 2,000 health workers have lost their jobs in Uganda, with the Uganda Medical Association warning that the number of unemployed health workers could rise to 5,000. SRHR services for key populations (e.g., LGBTQI+ people) have been suspended. This, along with the loss of other critical resources such as vehicles and fuel will affect the capacity of district health teams to receive training and deliver essential health services at the facility level.

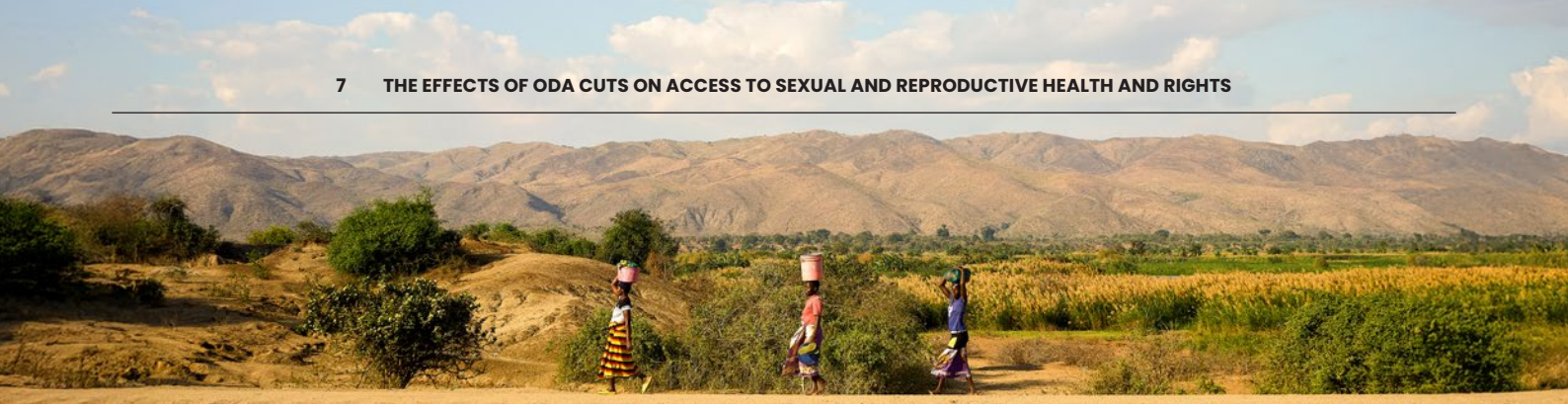
In Zambia we are working with community mobilisers who were trained through USAID funded projects to raise awareness about family planning through community level awareness campaigns and education, and who provide services in remote areas. As turnover happens there will be fewer trained mobilisers and a lack of follow-up training.

According to an assessment by the Senegalese Government, the suspension of USAID bi-lateral funding mechanisms and major RMNCH, nutrition and HSS projects will result in reduced mobile services and community health units, weakened provider capacity, and potential contraceptive shortages.

In Kenya up to 54,000 health workers have been affected, including doctors, nurses, midwives, lab technicians, and community health workers with clinics reporting longer waiting times, stock outs and reduced services available.

> **"There is a dispensary in a small rural village that had been staffed by two nurses supported by USAID funding. They were providing basic care, vaccinations, and maternal health services. Following the cuts, they had to reduce to 1 service provider, suspend outreach programmes, and now only offer short-term methods. The remaining staff member is feeling overworked and has said she may look for a better-paying job in the city. Funding cuts are not just about numbers – they affected real people and have quietly eroded hope in places that needed it most." – MSI Kenya**

> **"In the DRC the Director of the MOH Reproductive Health National Programme has had to reduce provider training and supportive supervision at the national and lower levels and has asked MSI to cover the gaps to ensure that regional/ provincial officers can still support SRHR programme implementation." – MSI DRC**



4 Data and impact

The Demographic and Health Surveys (DHS) is a global initiative that collects and disseminates data on population, health, and other key indicators in low- and middle-income countries. It provides critical data for planning and monitoring and was primarily funded by USAID. The DHS website has lost functionality, with key datasets no longer available, and DHS surveys that were underway (e.g., in Ethiopia) have been paused. The Gates Foundation are funding a three-year grant to stabilise the DHS, but lack of DHS data will severely limit the SRHR community's ability to track national and global progress on mCPR, contraceptive access and equity, and resources to address major gaps.

> Critical vulnerabilities have been exposed in Kenya's health data systems. Key platforms are now grappling with maintenance and technology shortages. These disruptions impair timely data reporting and hinder effective disease surveillance, limiting capacity to monitor public health trends and respond to emerging crises.

> Ethiopia's Health Management Information System (HMIS) has been severely affected as 10,000 MOH data clerks who were responsible for entering data into the system have had their contracts terminated as their salaries were supported by USAID.

> In Uganda, due to the expected reduction in MOH workforce and capacity gaps, the quality and quantity of data captured in the HMIS is expected to decline, weakening knowledge management, commodity tracking, and potentially leading to stock shortages.

> In Tanzania the impact of USAID's closure is being felt at district and regional levels, particularly where USAID partners collaborated on logistics such as printing of stationery. The lack of USAID support has made it difficult for MSI Tanzania to cover printing needs for all facilities. This has been exacerbated given this year has seen the rollout of updated registers, and the monthly summary now requires disaggregated data that differs from the old format so many facilities still do not have the new registers.

5 Reversal of mCPR progress in countries who were most dependent on USAID FP funding

Over the past decade many countries have seen significant progress in increasing choice and access, including Kenya, Ethiopia, and Uganda. Evidence shows that mCPR reduced in Ghana by between 10-15% under the Bush Junior administration with rural communities most affected. We are concerned that mCPR progress will be reversed in countries whose health systems were most heavily reliant on USAID, and where we have taken incremental progress for granted, particularly those countries currently between 30-50% mCPR that are in a particularly vulnerable 'danger zone' for backsliding.

Illustrative Examples of concern	U.S. Funding for Family Planning & Reproductive Health 2023 (US$million)	mCPR[2]
Bangladesh	17,500,000	45.9
Madagascar	11,500,000	35.8
Malawi	5,500,000	48.6
Nepal	14,000,000	35.2
Nigeria	43,500,000	15.5
Tanzania	24,000,000	35.6
Uganda	24,000,000	26.9
Zambia	11,000,000	36.3

6 Diversion of funding to other sectors

We are likely to see a diversion of SRHR funding – both from donors and within government budgets – to humanitarian and other sectors. At a time when the Sustainable Development Goals are already off track, we expect the diversion of funds to have devastating and far-reaching effects, including restricting access to lifesaving health services, and jeopardising hard-won progress on access to SRHR, bodily autonomy, gender equality, and LGBTQI+ rights.

> In Nepal our programme has reported that the Ministry of Health and Population has instructed the Family Welfare Division to reduce their budget by 20% which will impact the delivery of SRHR services and put additional pressure on CSOs.

> If governments reduce expenditure on procuring quality contraceptive products this also decreases the amount of additional funding they would leverage from the UNFPA Match Fund. For example, if they reduce budget lines to the point that they do not finance at least 10% of family planning need, they risk having a reduction in the direct commodity support received from UNFPA Supplies'. UNFPA supplies ability to maintaining support at current levels is severely at risk given recent and likely future cuts.

> Ethiopia was the biggest recipient of US assistance in sub-Saharan Africa and USAID provided significant health funding, including £15.8 million a year for family planning, and £380 million (over 40%) of all humanitarian funding. Ethiopia is a major host country for refugees in Africa and activities such as SGBV counselling, mental health services and hygiene promotion are now on hold.

> In Afghanistan WHO supported health facilities have been closed (over 200 health facilities) and government health facilities have closed in 28 of 24 provinces, leaving over 1.84 million people without access to health services. UNFPA estimates that more than 9 million women and girls could lose access to services and forecasts that between 2025 and 2028 the absence of U.S. support will result in an additional 1,200 maternal deaths and 109,000 unintended pregnancies in Afghanistan.

7 A more hostile operating environment due to the erosion of global norms and frameworks

With explicit attacks against SRHR, renewed focus and expansion of the Geneva 'Consensus Declaration' which has just secured its 40th new member and expanded Global Gag Rule which seeks to implement the Geneva Consensus Declaration, we are seeing an emboldened anti-rights movement at country level.

We have seen the removal of SRHR language and lack of consensus at CSW and CPD with the risk of backsliding on agreed norms and gains made since the Beijing Declaration and Cairo Platform of Action. Whilst we recognise that donors and governments will have to navigate a range of difficult choices and pressures, in the context of a destabilised development and multilateral system, we need long term champions of SRHR and gender equality to continue to centre these issues within the development and foreign policy agenda at both the global and national level.

> For example since Trump's inauguration, in Ethiopia we have seen an increase in abuse, harassment and attacks on social media against our providers and Country Director from Family Watch International. Anti-choice protesters, funded by Heartbeat International have stepped up their activities outside clinics in Addis.

MSI's Initial Mitigation Strategies

- Launch of a Choice Emergency Fund, which has already raised $5.6 million, to maintain access. For example to support our Madagascar team where UNFPA had to terminate grant contracts for MSI outreach teams who go to communities beyond the reach of the health system, and to support our Zambia and Zimbabwe teams to purchase commodities.
- Working closely with governments and donors to find ways to continue to find creative ways to continue to deliver essential services and health system support, and to share costs and resources.
- Taking a more proactive stance to ensure we are better organised to meet this moment, taking a more intentional convening role to facilitate global political and financial support to SRHR, and refocusing our national advocacy where MSI needs to play a different role. For example, acting as caretakers, playing a more proactive and intentional convening role, or focussing more on health systems strengthening to triage and bridge gaps. With a more hostile anti-rights environment, we are recalibrating our ambitions and tactics to ensure we are holding the line and will not lose the progressive policies that allow us to operate.

Our asks to donors

The decimation of USAID and rollback of foreign aid has underscored the fragility of SRHR funding. It has never been more important to protect and support resources to maintain service delivery infrastructure (including commodities, data, in-country leadership and co-ordination) and to draw upon the resilience, creativity and support of our community. In this time of crisis, we ask our donors to continue to:

- ensure that political leadership is underpinned by financial support – particularly in funding last mile programmes
- play a convening and co-ordination role and proactively share knowledge and intel on who is funding what and where, and what the immediate gaps are
- continue to support multilateral institutions such as the WHO, UNFPA, GFF and to work with ministries of health to maintain and prioritise support for SRHR
- support grassroots organisations to hold their governments to account in ensuring SRHR is still prioritised
- push for greater transparency of data relating to commodity procurement and distribution

Additional Resources

- IPPF Global Research Exposes Devastating Impact of the Trump Administration – Over Half of Partners and $85 Million Affected – IPPF
- Which Countries Are Most Exposed to US Aid Cuts; And What Other Providers Can Do – Centre for Global Development
- The politics of health justice: Power, precarity and the fight for gender equality and SRHR – PLOS Global Public Health
- Three countries boost family planning funding in 'powerful shift from dependency' in Africa after aid cuts – The Guardian
- Global aid crisis: 13 countries most affected by international aid cuts – International Rescue Committee
- Understanding the Impact of Foreign Aid Disruptions on International Family Planning and Reproductive Health CSOs – FP20230
- FP2030's collection of information and resources on the impact of family planning funding cuts

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