Family Planning Market Memo:
Country Impacts and Response

NOVEMBER 2025: The past year has tested the resilience of family planning programs across low- and middle-income countries. After the United States Agency for International Development (USAID) ended its reproductive health work in early 2025, governments faced immediate funding gaps and supply chain and service delivery disruptions that extended to the last mile. Other donors (e.g., EU member states and the United Kingdom)[1] have also announced multi-year cuts to Official Development Assistance (ODA) that are likely to impact sexual and reproductive health (SRH) programs.

This memo examines consumption trends and looks at how countries have responded to this new funding landscape to prevent contraceptive shortages, sustain service delivery, and begin planning for more sustainable financing in the years ahead.

CHAI developed this brief based on insights from ministries of health in 11 African countries,[2] logistics management information systems (LMIS) data in a subset of eight countries, and national supply plans in a subset of seven countries.

Although the full impact of these shifts is still unfolding, this memo provides a timely update on how contraceptive access is faring and how governments are responding. In this moment of challenge, governments are showing determination and creativity, coordinating rapidly with partners, identifying local funding sources and solutions, and rethinking how to make family planning programs more resilient for the long term.

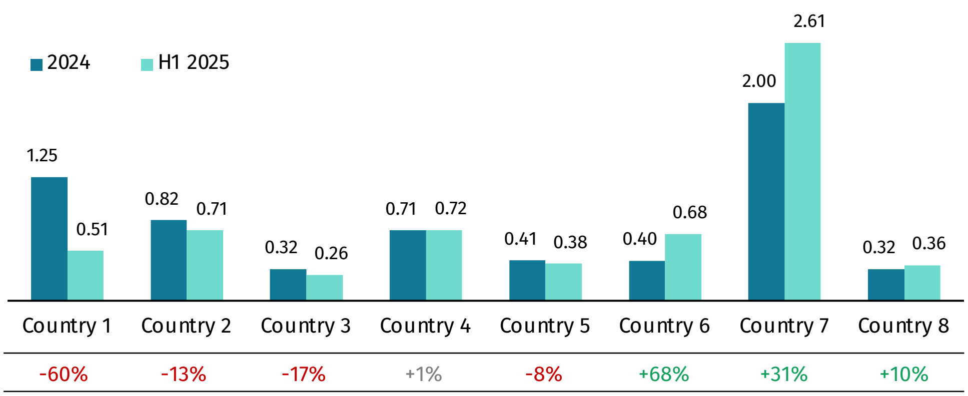
Note: Because of the sensitivity of some data, many findings have been anonymized. However, select country vignettes are included with country permission to highlight national responses.

Impact on Family Planning Uptake

To understand how funding changes have affected access to contraception, CHAI analyzed LMIS data[3] in eight countries (Democratic Republic of the Congo, Ghana, Malawi, Nigeria, Rwanda, Sierra Leone, Uganda, and Zambia) for the first half of 2025 (H1 2025) versus 2024.

The analysis compared the average quarterly consumption in 2024 versus average quarterly consumption in H1 2025 for injectables, pills, copper IUDs, hormonal IUDs, and implants.[4] Data were then converted into couple-years of protection (CYPs) to better enable comparison and aggregation across methods.[5]

Figure 1: Average quarterly consumption (CYPs, M) in 2024 v. H1 2025



4 countries saw a decline, with reductions ranging from 8% to 60% (average decline of 24%); most of these countries were relatively more reliant on USAID support for procurement out of the countries surveyed.

1 country stayed stable.

3 countries saw an increase, ranging from 10% to 68% (average increase of 36%).

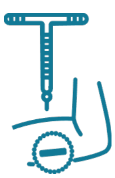
The declines in four countries are potentially concerning early signs of stress in family planning access. However, the fact that some countries managed to maintain or even increase consumption in H1 2025 suggests that government-led rapid actions and ecosystem coordination can help soften the immediate blow of funding cuts.

This early data should be interpreted cautiously. Consumption depends on many factors (e.g., commodity financing, supply chain and distribution systems, service delivery), all of which were placed under different levels of stress across countries throughout 2025. Additionally, some countries may have been able to leverage buffer stock or front-load commodity distribution in 2025 to help cushion the immediate impact of funding cuts. It is likely that the full impact of the USAID withdrawal will therefore continue to unfold throughout 2025 and beyond, underscoring the importance of continued close monitoring of consumption trends.

Breaking down average quarterly CYPs consumed between 2024 and H1 2025 by method reveals further patterns:

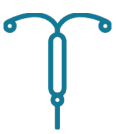
Injectables and Pills

- Declined in 5/8 countries
- Average decline of 33% and 34%, respectively



Copper IUDs and Implants

- Declined in 4/8 countries
- Average decline of 25% and 23%, respectively



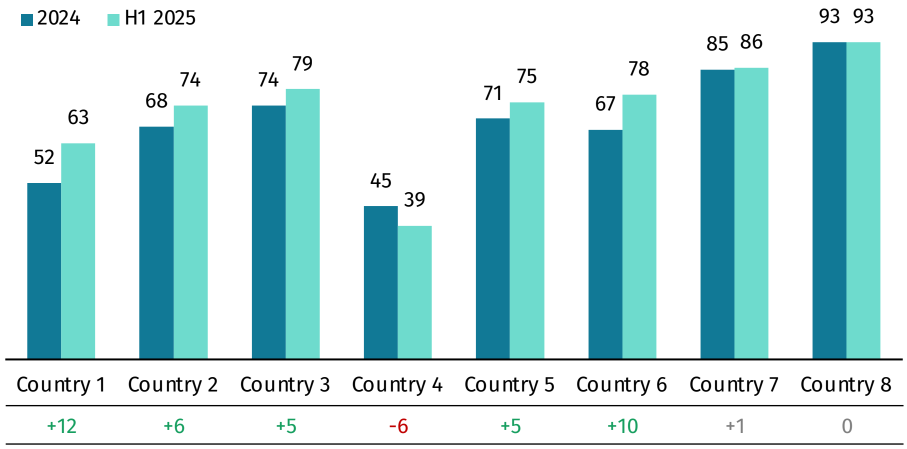
Hormonal IUDs (HIUD)

Declined in 2/6 countries introducing the method

Average decline of 24%

Figure 2 assesses the change in the share of average quarterly CYPs consumed in 2024 v. H1 2025 for long-acting reversible contraceptives (LARCs), i.e., copper IUDs, hormonal IUDs, and implants, versus the in-scope short-term methods, i.e., injectables and pills.

Figure 2: LARC share (%) of average quarterly CYPs consumed, 2024 v. H1 2025



5 out of the 8 countries saw a notable increase in LARC share of average quarterly CYPs consumed in H1 2025 relative to 2024 (5-12 percentage points). In most cases, this increase was driven by higher relative implant consumption and a decline in injectables consumption.

2 of the 8 countries surveyed saw minimal shift in LARC share between H1 2025 v. 2024.

1 country saw LARC share decline in H1 2025 v. 2024 and short-term method share increase proportionally, driven primarily by an increase in injectable consumption and decrease in implant consumption.

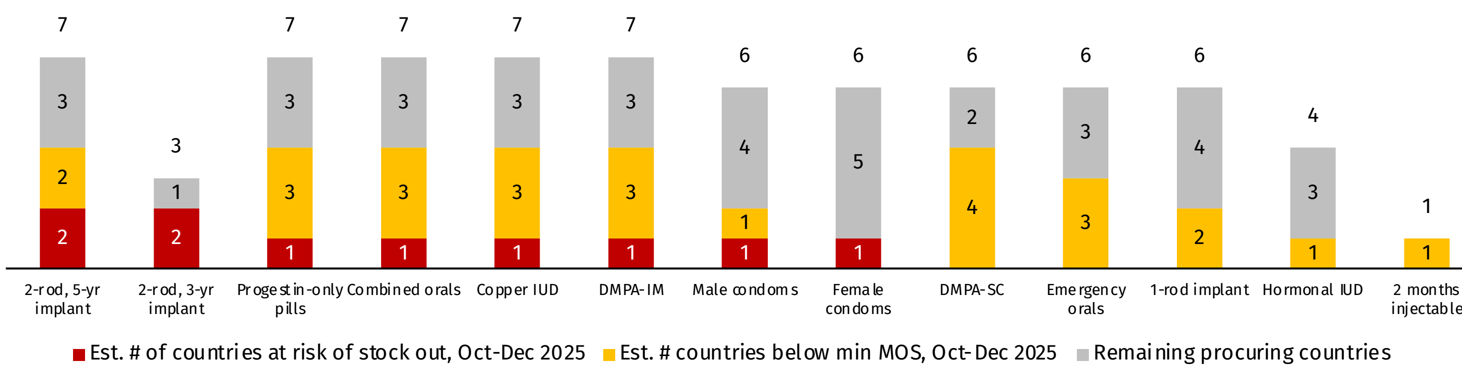
In four countries, LARC methods declined in terms of absolute consumption (measured in CYPs) but now comprise a larger portion of the method mix because relative declines in short-term methods were greater. These early trends may point to a shift toward longer-acting methods, though more data are needed to confirm this pattern. Continued monitoring of method mix trends will help governments understand how contraceptive choice and access is evolving as funding conditions change.

Supply Chain and Service Delivery Disruptions

As family planning programs adjusted to the sudden loss of funding in 2025, many countries faced serious hurdles in keeping contraceptive supplies available and services accessible.[6] Although governments, alongside other country- and global-level stakeholders, have worked to mitigate the impact to clients, stockout risks remain through end of year.

Figure 3 leverages supply plan data and information across seven countries[7] to estimate stockout risks for Oct-Dec 2025. This outlook is a "point in time" estimate based on information currently available in country and may evolve, e.g., as additional orders are confirmed through end of year.

Figure 3: Estimated stockout risks for Oct-Dec 2025 for the 7 countries assessed



2-rod implants are at risk of stockout in two countries.

Progestin-only pills, combined orals, copper IUD, and DMPA-IM are at risk of stockout or falling below minimum months of stock (MOS) on hand in four countries.

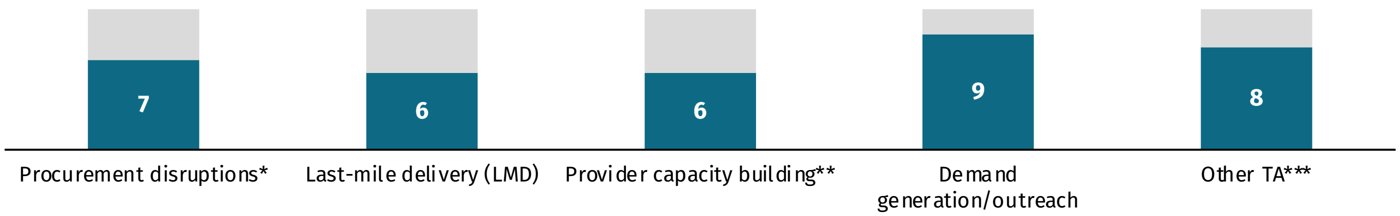
At the country level, **five of the seven countries assessed** are currently projected to face stockouts for at least 1 product in Oct-Dec 2025.

The end of USAID's family planning support caused a ripple effect across nearly every part of the supply chain and service delivery ecosystem. Countries reported a mix of challenges during 2025, including:

- **Procurement and delivery delays:** Countries faced cancelled or postponed orders, customs clearance issues, and loss of U.S.-funded last-mile delivery systems. While notable progress has been made in addressing many near-term gaps, longer-term questions remain about efficiently sustaining last-mile delivery efforts.
- **Reduced technical assistance:** Countries lost USAID-funded technical assistance support for critical activities such as family planning (FP) quantification & forecasting, data management, and warehouse operations.
- **Weakened demand generation & service delivery:** Outreach and community engagement programs were scaled down or suspended, particularly impacting adolescent, rural, and vulnerable populations. USAID-funded provider capacity building and mentorship efforts also ended.

All of the 11 countries surveyed experienced at least one of these disruptions in 2025 (see Figure 4).

Figure 4: Number of countries (out of the 11 countries surveyed) that experienced supply chain and service delivery disruptions in 2025



**Procurement disruptions captures near-term disruptions due to cancelled orders, delays in clearing shipments, and procurement gaps .*

***Provider capacity building captures disruptions related to provider training, mentorship, and service delivery .*

****Other technical assistance captures technical assistance support for activities like forecasting, managing data systems and reporting, and staffing warehouses, which was withdrawn due to the USAID dismantling.*

For women and girls, these disruptions meant their preferred contraceptive methods were sometimes unavailable when they visited clinics. Providers worked hard to minimize the impact by rescheduling appointments, offering substitute methods, and providing counselling to help clients make informed choices but these efforts stretched already overburdened health workers.

Reduced demand generation and community outreach efforts also create longer-term risk to women and girls seeking family planning services. Governments have attempted to sustain demand generation and outreach through other avenues, such as better integrating FP messaging into primary care, expanding digital outreach, and more efficiently leveraging existing platforms (e.g., village health workers) to spread key messages and link women to services. Further assessment of these approaches will help determine their efficacy and sustainability.

Providers described how they worked to offer clients high-quality counselling and alternatives when supplies were limited—though despite their best efforts, some women and girls were turned away.

"We had [a mother]...who chose the IUD during ANC, but when she came back postpartum, we had run out of stock. We immediately contacted the [warehouse] branch, rescheduled her, and made sure she received her preferred method once supplies arrived. In another case, a young woman seeking pills was referred to a nearby facility where stock was available. Even with these challenges, no client went without contraception, because timely referrals, communication, and follow-up kept services going."

—Family Planning Provider, East Africa

"We are trained to support women in making informed choices, but when the preferred method is unavailable, it requires even more patience, empathy, and communication. Sometimes the best we can do is encourage them to come back when supplies are restored."

—Midwife, West Africa

"It is heartbreaking to turn women away when I know they came from far distances just for this service."

—Family Planning Provider, West Africa

Country Case Studies: National Leadership in Action

Despite facing funding cuts and supply chain challenges, several governments acted quickly to protect access to family planning services. The following examples from **Malawi, Uganda,** and **Zambia** illustrate how coordination and leadership helped address supply chain challenges and lessen funding gaps in 2025, while laying the foundation for longer-term reforms. In addition, reflecting on **Ethiopia**'s journey with domestic resource mobilization (DRM) over the past several years offers useful insights on building resilience to funding shocks.

Malawi

Mobilizing resources and moving towards an integrated supply chain

FP Commodity Procurement Funding Gap

$9.6M	$11.4M	-$0.9M	*TBC**
Before funding cuts (FY2025/26)	Immediately after cuts (FY2025/26)	After gov't advocacy/DRM (FY2025/26)	Projected FY2026/27 gap

The Challenge

When the United States withdrew its support, Malawi lost US$1.8 million in expected support for contraceptive supplies. This increased the country's already substantial FP funding gap from US$9.6 million to US$11.4 million.

The Response

The Ministry of Health's Reproductive Health Directorate (RHD) acted swiftly to prevent stockouts, producing a commodity funding gap analysis to mobilize additional support, securing:

- **US$285 thousand** in government funding
- **US$1.5 million** from the United Nations Population Fund (UNFPA)
- **US$6.7 million** from the Health Services Joint Fund (a pooled funding mechanism for the government of Malawi and development partners)

These new resources, along with UNFPA procurement worth US$3.8 million for injectables, implants, orals, and condoms, closed Malawi's FP commodity gap for 2025.

In parallel, with CHAI's support, Malawi's RHD:

- **Fast-tracked the release of reproductive health commodities** from U.S. warehouses to Malawi's Central Medical Stores Trust (CMST).
- Distributed products from CMST to districts to **balance stock levels across regions and prevent shortages.**
- **Conducted quarterly supply plan reviews and developed national stock status reports**, to enhance inventory visibility.

The Outcome

Malawi was hard-hit by funding cuts, but the government's response has helped mitigate impacts. Beyond short-term recovery, the Ministry of Health is working with CHAI and partners to create a **more resilient, integrated supply chain**. This past year demonstrated that siloed, parallel supply chains can be vulnerable and inefficient, prompting efforts to integrate SRH services with programs like HIV/AIDS and tuberculosis to improve value for money.

**To be confirmed pending Q4 quantification & funding analysis.*
Malawi's fiscal year runs from April 1 – March 31.

Uganda

Managing service disruptions and securing domestic funding

FP Commodity Procurement Funding Gap

$12.7M	$16.4M	$13.3M	$16.4M
Before funding cuts (Jan 2025)	Immediately after cuts	After gov't advocacy/ DRM	Projected 2026 gap

The Challenge

In Uganda, the Ministry of Health worked with CHAI to assess service interruptions across a sample of subnational health facilities following the funding cuts. The results showed:

- **73 percent of facilities reported service interruption**; FP services were most affected, followed by adolescent-friendly services.
- **CYPs dispensed dropped 10 percent**, from over one million in Q4 2024 to ~900,000 in Q2 2025.
- Newborn and emergency obstetric care were also impacted, with **interruptions at 37-48 percent of facilities.**

The Response

Providers and facilities worked hard to adapt, reorganizing clinic schedules, integrating services, and using primary healthcare funds to maintain FP outreach. Similarly, districts tried to maintain care by bundling ANC, immunizations, FP, and HIV services together. However, these interventions' impact was uneven and unable to compensate for funding cuts. Uganda's Ministry of Health worked to reduce donor reliance and promote domestic solutions. In 2025, the government approved a US$1.2 million supplementary budget for FP commodities, set for release in October-November 2025. In parallel, Uganda increased its ring- fenced reproductive health commodity budget by 100 percent from FY23/24 to FY25/26 (with a 45 percent increase from FY2024/25 to FY 2025/26). The government has committed to allocating 50 percent of this ~US$10 million budget to FP in FY2025/26.

The Outcome

At the start of 2025, Uganda's funding gap for family planning commodities was US$12.7 million; this rose to US$16.4 million after the U.S. funding cuts. The government's supplementary budget and UNFPA's second tranche of orders reduced the gap to US$13.3 million. However, a US$16.4 million gap is projected for 2026. Recognizing longer-term reforms are needed, the Ministry of Health is exploring including FP in the National Health Insurance Scheme to provide financing stability.

Zambia

Supply chain strengthening and domestic resource mobilization

FP Commodity Procurement Funding Gap

$1.4M	$3.4M	$0	$3.8M
Before funding cuts (Jan 2025)	Immediately after cuts	After gov't advocacy/ DRM	Projected 2026 gap

The Challenge

Zambia lost approximately US$2 million in 2025 funding for FP commodity procurement after USAID was dismantled, roughly 25 percent of Zambia's FP commodity budget. This left a funding gap of US$3.4 million.

In March 2025, Lusaka Province also faced product shortages after losing USAID funding for product distribution, with facility stockout rates reaching up to 83 percent for hormonal IUDs and 34 percent for Jadelle implants.

The Response

To address this crisis:

- The Lusaka District Health Office issued **emergency orders for family planning commodities**. Although the Zambia Medicines and Medical Supplies Agency (ZAMMSA) had available stock, redistribution was challenging without USAID support. The district office coordinated with other facilities to redistribute stock, while other partners like PPAZ and UNFPA supported distribution to facilities.
- CHAI, UNFPA, MSI, and the district office conducted supportive **supervision visits to train facilities on inventory management and ordering practices**

As the Ministry of Health and partners worked to shore up supply chains, the government took urgent action to address funding gaps. The Ministry of Health secured US$2.8 million from donors and US$2 million from the UNFPA Match Fund (requiring US$1 million in domestic contributions).

The Match Fund resources were first used to close the FP commodity funding gap; the remainder then went towards maternal health commodities.

The Outcome

Despite procurement progress, Zambia continues to face distribution challenges. While partners such as UNFPA, CHAI, and others have assisted Ministry of Health, a sustainable long-term solution for the last mile distribution of these commodities is still needed.

Looking ahead to 2026, a US$3.8 million funding gap remains for FP commodities out of a US$15.2 million budget. The government is exploring domestic manufacturing and public-private partnerships to increase sustainability of FP efforts over time.

Ethiopia

Resilience to shocks from domestic resource mobilization

Ethiopia's experience demonstrates how prior investments in sustainable financing created resilience that cushioned the impact of 2025 funding cuts.

Context on Ethiopia's FP Compact

In 2023, the government launched the **Family Planning Multi-Donor Compact**, a co-financing initiative that shared responsibility for funding FP commodities between the government and partners over three years (2023/24-2025/26 in terms of the Ethiopian Fiscal Year).

Prior to the Compact, the Government of Ethiopia allocated roughly US$500,000 to FP commodities annually, leaving the supply chain fragmented and heavily reliant on donor support.[8] The need to transition to a different financing model became clear during the COVID-19 pandemic, when external funding declined, exposing system weaknesses.

The Compact, in contrast, was designed to pool funds and create a "One Financing" approach that reinforced national ownership for FP procurement, warehousing, distribution, and supply chain monitoring. Under the Compact, the government committed to increasing its share of contraceptive funding from 25 percent of total needs in the first year to 50 percent in the second year and 5 percent in the third year.

Outcomes

Over the first two years of the Compact:

- The Ethiopian government contributed US$12.4 million, including US$9.47 million in the second year alone (which represented an eighteen-fold increase in annual spend over pre-compact levels)
- Donors provided an additional US$17.4 million, resulting in a combined investment of nearly US$30 million for FP commodity procurement and distribution.

The U.S. government had been a contributor to this compact, so the dismantling of USAID impacted the Compact's funding pool. USAID's withdrawal created a gap of US$1 million in 2024/2025 and US$1.25 million in 2025/2026. Other donors and the government are mobilizing to fill this gap, and it will be important to monitor how the future funding outlook evolves. While Ethiopia is working to fill these gaps, the recent growth in domestic resource mobilization has cushioned the impact of funding cuts, making Ethiopia's FP program more resilient to global financing shifts.

Looking forward

Even as governments focus on urgent fixes, e.g., filling funding gaps and preventing disruptions to FP services and supply availability, many are also planning for the future. Across the countries surveyed, ministries of health are developing longer-term strategies to make family planning programs more sustainable, locally led, and resilient to external donor financing shifts.

For example, among the countries surveyed for this report:

- **Four countries** are exploring or taking steps to add FP products into **national health insurance schemes.**
- **Four countries** are seeking to strengthen **public-private partnerships** to bring private-sector efficiency, resources, and innovation into public health systems. This will take different forms in each country (e.g., one government is interested to leverage commercial-sector expertise for supply chain management, while another government is leveraging commercial entities to support scale-up of DMPA-SC in the private sector).
- **Three countries** are exploring ways to better integrate FP products into **broader supply chain and service delivery systems** to optimize limited health-sector resources and reduce duplicative efforts. For example, countries are discussing integrating FP services with cervical cancer and HIV screenings, folding FP commodities into national and regional logistics platforms, providing FP information at routine clinic visits, and adding FP to HIV/AIDS and tuberculosis outreach efforts.
- **One country** is actively exploring **local manufacturing of FP products**, with four other countries in earlier stages of exploring broader local manufacturing efforts for SRMNH products and/or other essential medicines

Looking forward, continued government-led collaboration, innovation, and data-driven decision-making are needed to mitigate the impact of global financing cuts and sustain progress in contraceptive access for women and girls.

Photo: Melinda Stanley

References

1. Eleven members of the OECD Development Assistance Committee have publicly announced ODA cuts for the period 2025-2027. Together, these countries comprised almost 75 percent of total ODA in 2024. They include: Austria, Belgium, Finland, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States. Source: "Cuts in official development assistance: OECD projections for 2025 and the near term." OECD Policy Briefs, 26 June 2025. https://www.oecd.org/en/publications/2025/06/cuts-in-official-development-assistance_e161f0c5/full-report.html#endnote4
2. DRC, eSwatini, Ethiopia, Ghana, Lesotho, Malawi, Nigeria, Rwanda, Uganda, Sierra Leone, Zambia.
3. HMIS data was substituted for copper and hormonal IUDs in Malawi, as HMIS data was more complete for these two products.
4. Condoms were excluded from this analysis for simplicity as different funding sources for the method make it challenging to isolate the impact of FP funding cuts specifically.
5. CHAI also assessed consumption patterns in H1 2025 v. H1 2024 but ultimately focused on comparing average quarterly consumption in H1 2025 to average quarterly consumption across full-year 2024 as there wasn't clear seasonality patterns in consumption exhibited across the countries surveyed.
6. Further details can be found here: "Family Planning Market Impact Memo." CHAI and RHSC, June 2025. https://www.clintonhealthaccess.org/report/chai-and-reproductive-health-supplies-coalition-rhsc-release-the-family-planning-market-impact-memo/.
7. eSwatini, Ghana, Malawi, Rwanda, Sierra Leone, Uganda, Zambia
8. Emerging Lessons from Ethiopia's Family Planning Multi-Donor Compact. August 2025. CHAI and the Ethiopian Ministry of Health.