MSI REPRODUCTIVE CHOICES

Delivering Cost Effective Impact: An Investment in Reproductive Health in Nigeria

An MSI provider counsels a group of women and girls in Adobe, Kurmi Local Government Area of Taraba State, Nigeria

Submitted by MSI Reproductive Choices

September 11, 2025

MSI Reproductive Choices (MSI), is pleased to submit this $3.3 million, 36-month proposal on behalf of MSI Nigeria (MSIN). The funding will support two new outreach teams to deliver family planning (FP) services to more than 151,000 underserved women and girls in Enugu and Kwara states in South-East and South-West regions of Nigeria. Through support of these outreach teams, using MSI's Impact 2.6 Estimator tool[1], we estimate that the services provided will generate the following impact:

Impact Metric	Impact Delivered	Cost per Impact to GiveWell	Cost per Impact with value of all commodities[2]
Couple Years of Protection (CYP)	544,858	$6.07	$6.48
Disability-Adjusted Life Years (DALY)	590,540	$5.60	$5.97
Unintended pregnancies	270,098	$12.24	$13.06
Maternal deaths averted	1,331	$2,484.95	$2,651.11
This project will also save $19.2 million in direct healthcare costs.			

Investing in sexual and reproductive health (SRH) services saves lives, empowers young women to pursue their education, and supports them in caring for their families—creating lasting benefits for individuals, families, and entire communities.

Please find below details of our proposed project.

Background/Problem Statement

In Nigeria, while knowledge of contraceptive methods is high (92.7% of all women in Nigeria), modern contraceptive prevalence rates (mCPR) remains one of the lowest in the world, at 15% nationally[3]. Given that Nigeria is projected to be the third most populous country in the world by 2050, the need for FP is exceptionally high:

- 10.9 million people have an unmet need for family planning[4]
- 33% of Nigerians live below the poverty line, and 18% live in extreme poverty[5]
- The maternal mortality rate is among the highest in the world at an estimated 1,100 maternal deaths for every 100,000 live births[6], 157 times higher than in the UK, for example.

Enugu and Kwara states were selected due to their low rates of modern contraceptive use at 11.2% in Enugu and 9.9% in Kwara as well as high unmet need for FP at 23.6% and 27.1%, respectively. Between 2018 and 2023, both states experienced significant declines in mCPR: 42% in Kwara and 36% in Enugu. This significant decline in mCPR has been exacerbated by the declining funding for FP interventions in

[1] We recognize that GiveWell is developing their own FP modelling tool that results in different impact estimates than MSI's Impact2.

[2] $3.3m is the direct cost to GiveWell for this project. The total value of the program is $3.5m including the value of donated commodities.

[3] The DHS Program. (2024). *Nigeria Demographic and Health Survey 2023–24*

[4] United Nations. (2025). Population Division Data Portal. https://population.un.org/dataportal/data/indicators/12/locations/566/start/1990/end/2025/table/pivotbylocation?df=5bd5303a-a7a8-4544-afe4-37561129f988

[5] Global MPI 2024 | OPHI. (2024). Ophi.org.uk. https://ophi.org.uk/global-mpi/2024

[6] Sedgh, G., Bankole, A., Okonofua, F., Imarhiagbe, C., Hussain, R., & Wulf, D. (2009). Barriers to Safe Motherhood in Nigeria. Www.guttmacher.org. https://www.guttmacher.org/report/barriers-safe-motherhood-nigeria

these states and has led to the two states being in the lowest 15 out of 37 states (FCT included) for mCPR in Nigeria. We also selected these states because they are not included in new programs beginning this year with support from the Children's Investment Fund Foundation (CIFF) and the Gates Foundation, leaving them comparatively underfunded. Both states also face high poverty levels and limited access to contraceptive options.

About MSIN

MSIN was founded in 2009 and is one of the largest providers of contraception and other reproductive health services in Nigeria. MSIN has a national reach, supporting service delivery across all 36 states including the Federal Capital Territory, in Nigeria through multiple service delivery channels including Mobile Outreach.

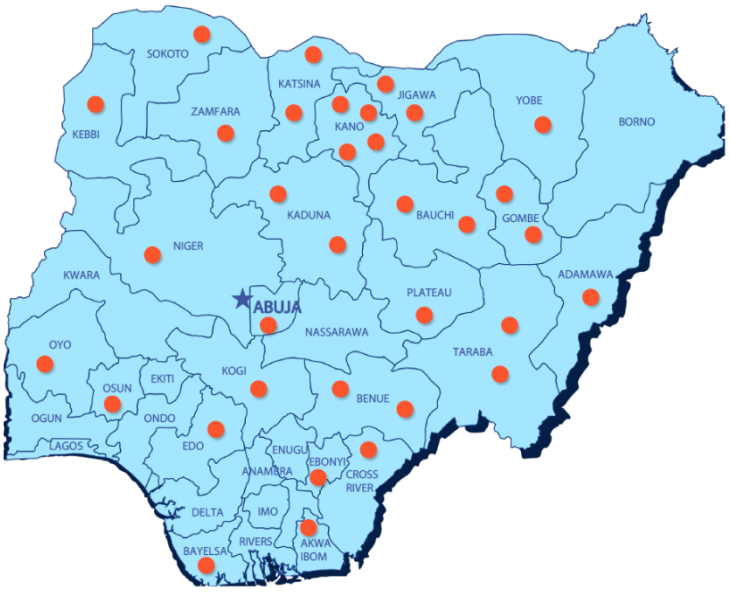
MSIN is committed to upholding women's fundamental right to decide the number and spacing of their children without coercion. In partnership with the Government of Nigeria and other key stakeholders, MSIN works to ensure that the poorest and hardest to reach communities have access to a broader range of reproductive health care services tailored to meet their needs.

Through its national reach, MSIN delivers high-quality reproductive healthcare to over 3 million people annually. Over the past 10 years, more than 25 million individuals have accessed high-quality SRH services through MSIN supported services. As a result, we estimate that 40% of women in Nigeria have had their contraceptive needs met through MSI-supported service delivery.

Technical Approach

MSIN's outreach service channel is comprised of 34 mobile outreach teams that go the last mile to deliver services in under-served communities-including rural, poor communities, displaced communities, and those affected by climate change-expanding access at scale. Every hour of the work week, 228 women are receiving high-quality reproductive health services from our outreach teams across Nigeria. In 2024, 95% of MSIN outreach clients were high-impact:

- 63% did not know of any other provider to get the service they received by the outreach team;
- 82% were FP adopters (clients who had not used a modern method of contraception in the past three months);
- 33% were adolescents (under 20 years of age);
- 36% were living in severe multidimensional poverty.

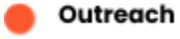


In 2024, outreach teams in Nigeria covered such a large portion of impoverished regions that 25% of all those in extreme poverty would have had access to high quality, free FP services less than 5km away.

Last year, MSI Nigeria's outreach teams reached 526,159 clients, generating 1,935,115 CYPs at an average cost per CYP of $5.2.

Of the total clients served, 95% chose a long-acting reversible contraceptive method. We ensure that all clients are offered a choice, with women typically

being consulted on an average of five methods. In Nigeria, 88% of women come to our Outreach site already having a method in mind and of those, 97% received the method they wanted[7].



Outreach team model: Outreach teams in Nigeria are made up of two clinical providers and a driver who also serves as an administrative assistant. The teams provide free, quality, short-term (STM), long acting and permanent FP methods (LAPM) to rural communities across Nigeria (see map above). Using the infrastructure of public health centers, other community structures, or outreach tents which will be introduced in 2026 through the teams included in this proposal, mobile outreach teams have proven extremely successful in reaching the poorest and hardest to reach women and girls with voluntary SRH services they want. This is because of their ability to go where women and girls are underserved by the current healthcare system, combined with effective community mobilization strategies.

The outreach service model operates using a mobile clinic strategy where teams travel to underserved and hard-to-access locations to provide SRH services. To ensure the teams serve as many clients as possible, MSIN often uses an operational strategy called “splitting” where an outreach team splits into two teams of three staff to maximize their reach with each local government area (LGA). Locum providers (health providers hired on a short-term or ad hoc basis) or government support split outreach teams to maximize reach while not sacrificing quality of care. Locum providers are also trained in MSI clinical quality and client-centered care standards.

MSIN leverages public sector providers to also support outreach events. Outreach teams routinely engage public sector providers to provide direct service delivery in cases where a public sector provider is available for support and has the capacity to do so while ensuring they are not disrupting services in the provider’s primary facility. Depending on the site and the type of outreach, there could be anywhere from 1-3 public providers supporting an outreach day. This is done increasingly as part of MSIN’s capacity-building efforts to strengthen the cadre of providers in the public sector that can provide the full range of FP services.

In addition to leveraging public sector providers, MSIN historically sources approximately 60% of outreach FP commodities from health facilities, while the remaining 40% are supplied directly by outreach teams. The Nigerian Ministry of Health distributes commodities to all 36 states via the Last Mile Distribution (LMD) mechanism, but the availability at the state level and last-mile consistency varies. In cases where commodities are unavailable, MSIN has buffer stock that can be used. Given the drastic shift in the commodities landscape over the last six months due to the closure of USAID, we anticipate that moving forward, in the short-term at least, MSIN may need to procure up to 70% of commodities.

Site Selection

Site selection is a standardized process in Nigeria and conducted annually to review each outreach teams’ planned footprint to confirm that we reach communities with limited access to FP, and to explore potential areas for expansion. The process begins with a 2-day work planning meeting in collaboration with each state government. Meetings are attended by MSIN, state-level directors of health, state family planning coordinators, the state reproductive health coordinator, the local government area, reproductive health coordinator(s), the state health promotion team, and the state M&E officer. Guided by state level mCPR and FP demand data and information from local stakeholders, outreach team schedules are determined annually alongside the local government reproductive health and state FP coordinators.

During these meetings, a review of available data is done to determine areas where there are limited options for services, and communities that have been underserved. Data sources and other information/factors considered include:

[7] This data comes from MSI’s Client Exit Interviews.

- The data from MSIN-generated heat maps, developed from secondary data sources to understand the geographic distribution of different marginalized populations (most notably, people living in poverty), to ensure the program is driving equity in access.
- National Health Management Information System (NHMIS) and relevant demographic surveys (NDHS).
- Contextual knowledge of the communities and wards provided by the state and LGA government officials including communities without alternative access to LARC services and communities that can be reached without safety concerns.

MSIN Outreach teams will typically visit each site 3-4 times a year, however, there may be some instances where sites are visited less frequently, for example, if a site has very low turn-out after multiple visits we may decrease the visit frequency. We will work with local leadership to ensure women at these locations know where to go if they decide they want a method or need a method removed.

Demand generation and counselling

Marketing, demand generation, education and counselling is a multi-step process for mobile outreach. Advance demand generation activities help raise awareness about upcoming MSIN service delivery days and increases the likelihood that all potential clients who want to take up a modern method of contraception are aware of where and when the outreach team will be visiting and the services that will be offered. Providing information in advance enables women and girls to consider the FP methods available to them, what meets their reproductive needs, and discuss them with their partners as may be needed.

MSIN's outreach teams are supported through a network of community-based mobilizers (CBMs) to reach as many people as possible with information. Each team is supported by a Social Behavior Change Communication Officer (SBCCO) who works with local community health workers (CHWs), faith-based organizations and village leaders to share information about the SRH services the outreach teams provide, where and when they will be available. In Nigeria the Ward represents the lowest political organizational unit, with most wards having a ward development committee (WDC) that serve as accountability platforms and local institution to support development initiatives. The SBCC and CBM engage with the leadership and members of the WDC and through them strengthen acceptance for SRH/FP thus improving ownership and sustainability of demand.

CHWs are responsible for generating demand several weeks ahead of an outreach visit as well as actively mobilizing and directing clients to the outreach sites on service delivery days. During demand generation, the SBCCO also plays an important role in determining available space for the outreach team to work from, such as a public health facility, or other designated community buildings in areas where no PHC exist or where the PHC's infrastructure is inadequate. Community-based demand generation strategies include:

- Liaising with local authorities to **distribute information** via local media, word of mouth, loudspeaker announcements and informational materials in the weeks leading up to the outreach day as well as on the day.
- **Home visits by CBMs** to conduct door-to-door visits which aim to engage not only females, but male partners, and mothers-in-law present in the home.
- **Compound Meetings.** CBMs will facilitate meetings in compounds to generate demand for a wider range of primary health services, using a range of information, education and communication materials. MSIN's SBCC Officers will support CBMs with FP IEC materials, which provide information around different FP methods and address common myths and misconceptions.
- **Community dialogues with religious and community leaders.** MSIN SBCCs will engage trusted community structures such as traditional leadership structures in communities including the Ward Development Committees (WDCs), and work with them to integrate demand generation for SRH services in their community dialogues. MSIN has had considerable success partnering

with WDCs and community leaders at community level to promote FP acceptance and connect community leaders with government facilities.

This multi-pronged approach enables us to reach as many people as possible in a setting convenient for them. Our data shows us that 31% of clients hear about us through community meetings while 24% hear about MSI outreach through loudspeaker announcements. The data also shows that community-based mobilizers are key, referring 42% of clients that come to outreach. Public sector partnerships also contribute significantly, with 26% of outreach clients referred by public providers.

Each outreach day begins with **group education sessions** led by an MSIN outreach provider. The provider usually starts each session talking about the general benefits of contraception, followed by an overview of the available methods and the basics of how they work – including demonstrations, such as condom use. Providers generally use the MSI FP flipchart and/or Choice Kit so that people can see and interact with the methods.

Figure 1 A provider conducting group counselling

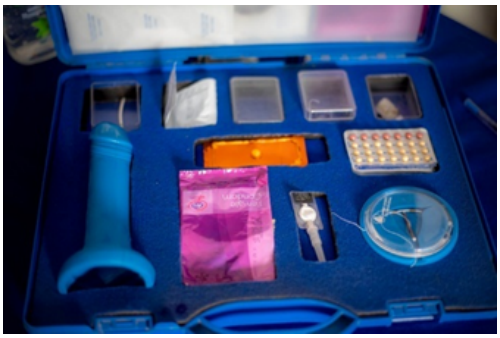


Figure 2 MSI's Choice Kit showing different methods

In addition to the guidelines, providers use counselling flip charts and the MSI Choice Kit during counselling to support conversations. These flipcharts and the Choice Kit provide visual aids to guide group and 1:1 counselling and conversation

Following the group education session, clients receive **individual counselling in a private area** with a trained provider. During this conversation, a client's fertility needs, medical eligibility, side-effect tolerance and personal preferences are reviewed against available FP methods that meet her unique needs. The client will have an opportunity to ask any questions or voice concerns, following which she will select a method of her choosing. If at any time a client decides not to take up a method of contraception, she is free to leave.

Alongside operational excellence, marketing and demand generation are critical to ensuring that all people are able to make fully informed decisions about their sexual and reproductive health. MSI provides accurate, comprehensive information and addresses key barriers around a broad range of contraceptive methods using communication techniques that are relevant to specific client groups, such as adolescents.

As reflected in MSI's 2024 Client Exit Interview survey, 88% of outreach clients in Nigeria already had a method of choice in mind before they came to the outreach, and 63.6% of all outreach clients knew of no other option for the service they received from the outreach team. These findings indicate that we are increasing access to wanted contraception. The women and girls we serve actively seek out our services because they want to take control of their fertility and their lives. Many have already had multiple touchpoints in their community (with a CHW, or community dialogue or some other community-based activity) or have heard about MSIN's services from a friend or family member, they have come to an outreach event with a method of choice already in mind. Then, through group counselling, she is introduced to a full range of options and learns about benefits, side effects, and considerations. Individual

counselling then gives her the space to reflect on her personal circumstances—such as fertility goals, medical history, and tolerance for potential side effects—allowing her to make an informed and wanted choice that best fits her needs and lifestyle.

MSIN outreach teams are filling a critical gap in access to family planning services – reaching clients who would otherwise have limited to no options. Our data shows that we are reaching new users and adopters of modern contraception methods. In 2024, 82% of all MSIN outreach clients were FP adopters.

Monitoring and Clinical Quality Assurance

Throughout the year, MSI implements various measures to ensure continued compliance with best clinical and data practices and to ensure our services are client-centered and high quality. These include:

- Supportive supervision visits to operational outreach sites by the clinical and operations teams take place monthly. Clinical and operations colleagues check in and provide support to service delivery teams in order to maintain the highest level of clinical competency, Level 1, and/or attain proficiency after the initial training and competency assessment.
- Every provider's competency is assessed in each service they provide at least once a year and based on the outcome, the relevant support provided to them.
- Data Quality Audits (DQAs) are conducted quarterly for each outreach team to evaluate levels of data compliance.
- Quarterly Spot Checks: County programs' operations, and clinical teams perform quarterly spot checks across each outreach team and report findings from the visits. The outreach teams are evaluated for quality service delivery including counselling, effective data practices, and adherence to best clinical practices.

MSIN's outreach channel also conducts an annual 5-day clinical refresher training and operations review meeting for outreach service providers. This training serves as a platform to train, re-assess competency, introduce new updates, and refresh providers on MSI's policies, guidelines, standard operating procedures, and general expectations.

MSI's *Client Centered Care Strategy* further articulates the organization's philosophy of care that puts the client's interests first. It means respecting clients as active partners in their own care, and caring about who they are, what happens to them, and how they feel before, during, and after they receive a service from us. This reflects our commitment to rigorous clinical quality assurance standards, and to employing the mechanisms and tools that MSIN has in place to monitor and improve the quality of client-centered care.

MSI's data collection systems are designed to provide quick, high-quality data to support adaptive management, financial management, donor and internal reporting, and robust evidence generation for advocacy and impact measurement purposes. These systems are not designed as parallel systems to national health management information system (HMIS). Rather, insights gathered from these systems are used to feed into and strengthen national data systems, provide government M&E officers with data they might be missing, as well as to gather robust project data when there are gaps in national data systems. MSIN's M&E tools and applications include:

- **Client Level Information Centre (CLIC+):** This is the core service delivery application used by the outreach teams for recording client visits. Data from each outreach team's laptop syncs with a central server daily. This data management platform enables MSIN to generate real-time insights regarding service uptake, method selection, client demographics, and geographic location. Data from CLIC+ is used by MSIN to analyze service delivery trends, which helps MSIN's program and business planning processes.
- **Application for Monitoring Outreach Sites (AMOS):** A mobile application designed by MSI Nigeria to track outreach daily operations by providing information to monitor performance and track other operational parameters. AMOS assists MSIN in collecting geo-coordinates of outreach sites, as well as determining the duration and exact location of each site visit. Data gathered from

AMOS aids MSIN in planning future outreach visits, enhancing community engagement, and ensuring accountability and operational efficiency for outreach teams.

- **Client Exit Interviews (CEI):** This is an annual survey with the primary purpose of determining client experience during service delivery and better understanding who our clients are. Information from the CEI supports MSIN teams in improving client experiences and advancing the continuum of care.
- **Mystery Client Visits:** Data from mystery client visits helps MSIN understand service provider performance and quality of service from a client's perspective and identify hidden quality gaps. MSIN utilizes MCS data to make real-time decisions to mitigate identified risk(s). Under this grant each team will get at least one to two mystery client visits a year.
- **Quality Technical Assurance (QTA):** MSIN utilizes QTA reports and recommendations to improve clinical quality in line with MSI global standards. MSI's approach to QTA is anchored in a dual system of internal and external clinical audits designed to uphold and enhance service quality across its global programs. Internally, QTAs are conducted annually by MSIN's in-country clinical quality teams at each service point, using standardized checklists to assess clinical governance, service delivery, and client safety through direct observation and process reviews. These audits inform site-specific quality improvement plans and are often paired with immediate technical assistance to resolve issues on the spot. Externally, MSIN deploys Clinical Audio-Visual Assessments (CAVAs), a remote-friendly audit framework which enables MSI's Medical Development Team (MDT)-trained assessors to evaluate a sample of sites annually using visual indicators and checklists. This layered system ensures that both internal teams and external reviewers contribute to a robust quality assurance process, with findings disseminated across operational and program staff to guide decision-making and maintain high standards of care.

MSIN also employs a tracking system (Tracpoint), to monitor the movement, mileage, and fuel consumption of each outreach vehicle. Additionally, there is an internal system in place to monitor fuel consumption by each team, with fuel allocations based on their geographical locations, helping to analyze usage patterns.

Impact

We measure the success and impact of our mobile outreach teams through performance management, fleet management, data collection and analysis which enables impact assessments and resource optimization, as well as adaptation to changing needs. We monitor progress against key performance indicators using MSI's bespoke data management tools like CLIC+ and InforBI. To gather client feedback on satisfaction with, and quality of, services, MSIN conducts annual CEIs. We assess the impact of our programs to ensure positive outcomes, optimize resources to maximize impact, and adapt strategies to meet changing community needs.

With an estimated budget of $3.3 million over 36 months, supporting two outreach teams in Enugu and Kwara states, we anticipate reaching more than 151,000 clients and delivering the following impact:

Service Estimates	**2026 (Jan-Dec)**	**2027 (Jan-Dec)**	**2028 (Jan- Dec)**	**Total (Jan 2026- Dec 2028)**
Clients reached	41,682	51,491	58,066	151,239
Adolescent clients (estimated at least 20% of all clients reached)	8,336	10,298	11,613	30,248
CYPs generated	150,054	185,369	209,037	544,858

Impact Metric	Impact Delivered		Cost per Impact to GiveWell	Cost per Impact with value of all commodities[8]
Couple Years of Protection (CYP)	544,858		$6.07	$6.48
Disability-Adjusted Life Years (DALY)	590,540		$5.60	$5.97
Unintended pregnancies	270,098		$12.24	$13.06
Maternal deaths	1,331		$2,484.95	$2,651.11
This project will also save $19.2 million in direct healthcare costs.				

[8] $3.3m is the direct cost to GiveWell for this project. The total value of the program is $3.5m including the value of donated commodities.