

## A Deeper Look: The future of family planning and reproductive health

April 2021

Patrick Fine, Ann Starrs

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[Music]

*Ann Starrs:* Our new strategy reflects our understanding of what are the key barriers and the key enablers of progress in the global family planning field. It's also focused on where the Foundation can have the greatest impact.

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*Voiceover:* *A Deeper Look.* Exploring what works and what doesn't in development and the changes we can make together to turn ideas into action.

*Patrick Fine:* Hi, I'm Patrick Fine, CEO of FHI 360 and this is *A Deeper Look* podcast. One of the great things about *A Deeper Look* is that I get to talk with some of the great champions working in human development today. In this episode, I have the great pleasure of talking to one of the real champions for women's empowerment, gender equity and reproductive health and rights, Ann Starrs.

Ann is the director at the Bill & Melinda Gates Foundation overseeing their work on family planning, directing the team's overall strategy and coordinating that strategy with other aspects of the Foundation's work. She is a recognized champion in the field of standing up for women, and for women's rights, and for reproductive health.

Prior to joining the Gates Foundation, she was the CEO of the Guttmacher Institute, and prior to that, she was one of the founders and the President of Family Care International. Ann brings a tremendous body of experience to issues around reproductive health and women's rights. Ann, thank you so much for joining me today.

*Ann Starrs:* It's my pleasure, Patrick. Thanks for having me.

*Patrick Fine:* This year, we're taking a deeper look into the disruptions that are shaping human development now and that will continue to shape them in the future.

Can you share with our listeners your journey? How did you come to be such an important voice, such an important actor in the field of reproductive health?

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*Ann Starrs:*

So, I spent most of my childhood outside of the U.S. So, I was always interested in international issues, and I have never really and still don't identify strongly as American. I was mostly in Spanish-speaking countries, in Spain, Guatemala and Mexico.

And then, my interest in reproductive health grew out of my commitment to helping women and girls achieve their full potential. You know this, of course, that being able to choose to decide on the timing and number of pregnancies, being able to go through pregnancy and childbirth safely and in good health is fundamental to that outcome of helping women and girls achieve their full potential. And, that is really at the core of my commitment to working in this space.

My first job out of college was with a foundation. I then worked for the International Planned Parenthood Federation, Western Hemisphere Region; did grad school; lived and worked in Uganda and in eastern and southern Africa for a number of years; and then worked in the NGO sector, as you mentioned in your introduction, for 25 years.

I think I came to the Gates Foundation because of the potential for impact in this field. The Gates Foundation – it's an important funder but it's also an important voice in this space. So, being able to have access to that kind of influence, to be able to take what I have learned over the past 25 to 30 years and apply that in a funding context was just such an amazing opportunity. But, I think the voice comes from the passion and the commitment.

*Patrick Fine:*

Well, the Gates Foundation is a real thought leader and often a first mover on issues of reproductive health and women's empowerment and gender equity. One of the reasons that they are able to be so influential and be a thought leader is because they have people like you who provide the substance to turn those aspirations into a reality. And, there's a lot for us to talk about. We're still in the midst of the global pandemic that has disrupted the entire world, and one of my concerns is how the pandemic is impacting women and adolescent girls' access to modern contraceptives.

And, I wonder if you could share with us your view about how disruptive the pandemic has been to women's access to contraceptives, and more generally, to reproductive health services.

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*Ann Starrs:*

Sure, my pleasure to address that question, Patrick. So, we've seen, from previous disease outbreaks, that these kinds of situations, although of course COVID is unique, but similar situations tend to strain health systems and disrupt access to essential services, including, of course, family planning. And, at the beginning of the pandemic we were really worried about the potential impact that COVID disruptions could have on women's health and on progress we've achieved in the field of family planning and reproductive health.

I think where we are now, knowing that we're still of course not through the pandemic, is that while there has been some significant impacts, and in particular in late spring, April/May, there were measurable impacts on access to and utilization of family planning services, that the numbers, as they're looking now at least, appear not to have been as bad as we were expecting at the beginning.

UNFPA just came out with a report that estimated that 12 million women in 115 low- to middle-income countries, lost access to family planning services at some point during the COVID-19 pandemic. I mean that's not an insignificant number. That's roughly the equivalent of the population of Paris. But, at the beginning, UNFPA was saying that number could be up to 49 to 50 million.

So, we have seen some impact; we have seen an increase in unintended pregnancies as a result of COVID and reduced access to services. But, we've also seen, for example, through some surveys that have been done by one of our grant partners, PMA, in four sub-Saharan African countries, that most women have been able to maintain their access to and use of contraception.

And interestingly, in contrast to the United States and some of the European countries, where we saw significant reductions in desired pregnancy, or intended fertility as a result of COVID, that fertility intentions in most of sub-Saharan Africa weren't really affected by COVID.

My last comment is just to caveat this and say I'm talking here specifically about access to family planning services. We have seen some quite significant data around violence against women, gender-based violence, and women's increased susceptibility to that, which can have ripple effects on access to and utilization of reproductive health services and just women's health and well-

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being overall. We don't have solid numbers on those potential impacts yet.

*Patrick Fine:* In many areas of human development, the pandemic has brought both challenges and it's also brought adaptation. And, we've seen organizations and ministries and institutions adapt their practices so that they can maintain the delivery of services. Have you seen adaptation or innovation that has allowed services to continue to be provided?

*Ann Starrs:* Yes, we have seen some of those changes. We saw a number of countries change policies, in some cases, explicitly on an interim basis, to ease access to contraceptive and other reproductive health services, particularly, for example, increasing the availability of telemedicine, or allowing clinics to provide three months of oral contraceptive; three or four months of oral conceptive packages, or longer, additional packages of DMPA acetate self-injectable contraception in response to COVID so that women wouldn't have to go to clinics as frequently. So, we've seen some changes like that that have been positive effects of COVID; at least there are some.

*Patrick Fine:* Do you think those will have a long-term impact, that those health systems will see that this is an effective way to deliver services, and so they'll keep those practices in place?

*Ann Starrs:* That is the hope and the intention. I think the advocacy community is gearing up to promote the continuation of those kinds of eased policies; the hope is that some of those changes will continue and potentially even be expanded.

*Patrick Fine:* We're talking now about access to modern contraceptives and family planning services. But, one of the things that we've seen is that access to basic health services have been constrained, in part because people don't want to go to health facilities because they perceive that as risky, and in part because health facilities are so focused on pandemic response that they have reduced their other offerings. Are you seeing that having an impact on, say, maternal health or infant health practices?

*Ann Starrs:* Yes. We have seen, although again, it varies quite a bit by geography, but we have seen some reductions in institutional delivery. There was a report just recently in Devex that looked at reductions in the implementation of kangaroo mother care because

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of COVID, more that when health workers were unaware of the COVID status of a postpartum mother, they were reluctant to institute kangaroo mother care so there was a fairly significant reduction in utilization of that particular intervention in this one study. So yes, it's a complicated picture.

We also did see – I don't want to ignore this – we did see some disruptions in supply chain as a result of COVID. And again, I think much of that has eased, but – I'm on the steering committee for the UNFPA supplies partnership – their shipment costs were up significantly this past year because they had to resort to air freight for a significant portion of the distribution of contraceptive products because of COVID.

*Patrick Fine:* That's a really interesting point and one that people may not go to immediately, which is the cost of transporting supplies. I've read that for just regular shipping, through shipping containers, that the cost has doubled over the last year. How do you see governments and health systems adjusting to that sharp increase in costs?

*Ann Starrs:* I think the question will be are those increases in cost sustained. The hope is that as the pandemic rolls out, and as we get a better handle on its impact, particularly in low- and middle-income countries, that some of those increased costs will settle back down to their previous levels. Many countries did have a cushion of contraceptive commodities already in stock. And so, that helped also to cushion the impact. I don't know what the numbers were for other key healthy commodities, but at least in family planning, as I said, most of the disruption that we saw reported on was in that kind of April/May period, when countries were really in lockdown.

*Patrick Fine:* Right. And so now, we're at a point where it sounds like you're saying systems have adjusted, some adaptations have been made, and the service delivery has stabilized. Do you have a sense about whether demand for services increased or decreased during this period?

*Ann Starrs:* That's a great question. We don't have definitive data or we're still getting data from some surveys, but the PMA, the partner that I mentioned earlier did do surveys in four sub-Saharan African countries and had some really interesting findings that there were significant economic disruptions that women reported, significant issues with food insecurity that women reported in their families. So, if you look at the broader economic impacts and to some extent

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social impacts of COVID, that was clearly reflected in the survey findings.

But, we also found that contraceptive use, MCPR, the contraceptive prevalence rate for modern contraceptives, did not go down in most of these countries, and that interestingly, desired fertility, or the desire to have another pregnancy, remained stable or in some countries actually increased marginally.

*Patrick Fine:* Yeah, I wonder if people are locked down together and they're not allowed to go out, their movement, even in their community, is restricted because of fear of transmission of COVID. Wouldn't that suggest that you might get a population boom during this period of pandemic?

*Ann Starrs:* That's a possibility. I think the key intervening factor goes back to this question of contraception. Yes, if people are in lockdown, if say husbands or wives, or partners who normally are away from home working in another setting – in some cases, even another country – are in fact back home, then there is the possibility of that act that we so rarely talk about in the field of family planning, which is sex *[laughter]* taking place with greater frequency. And, if that is happening without the protection of contraceptive use then, yes, we could potentially see a birth boom.

We haven't had – you know how long it takes, Patrick, it's nine months – we haven't had enough time to see whether that is going to be reflected in the data. But as I said, the data that we have, at least from the four countries where this PMA survey was conducted, pretty clearly indicated that women did manage to maintain their access to and use of contraception.

*Patrick Fine:* Right, which is good news. Now, I know that the Gates Foundation has just very recently developed a new strategy for its family planning work. Can you share with us what your strategy is going forward? What are the priorities, and what do you see as the main challenges?

*Ann Starrs:* Great. Love to have that opportunity. Yes, we just got approval of the new strategy from the Foundation's leadership in the middle of January, so we're just in the initial stages of communicating it and rolling it out. It was an 18-month process to develop this strategy and it included some rigorous analysis, assessment and consultation with both internal and external partners. And, our new

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strategy reflects our understanding of what are the key barriers and the key enablers of progress in the global family planning field. It's also focused on where the Foundation can have the greatest impact, building on our comparative advantage and also complementing the priorities of other major donors and partners in the field.

Picking up on your key theme for the podcast on what are disruptors in development, our new family planning strategy is going to focus on, in particular on a few major what we call gamechangers that we think can have a catalytic impact. The first priority is, building on one of the key comparative advantages of the Foundation, is a focus on technology. So, a significant portion of the budget will be going to developing new and improved contraceptive products that better address women's and girls' needs and preferences.

One of the lessons learned, one of the impacts of COVID is that we're leaning in, in particular, on methods that are aligned with the principles of self-care, so methods that women can purchase in a drug shop or pharmacy and use effectively on their own without needing to go back to a health worker on a monthly or even quarterly basis.

*Patrick Fine:* Can you give some examples of what some of those self-care products might be? Are those still hormonal contraceptives? Or, do they go beyond that?

*Ann Starrs:* Thus far, we're still looking at hormonal products. So, the products, of course, that already have been available that fit under that self-care rubric include oral contraceptives, condoms (which are not hormonal-related, of course) then the self-injectable contraceptive. In terms of some future products, we're looking at a longer-term self-injectable, so right now, the product that's available is effective for three months; we're exploring potentially a six-month self-injectable. We're looking at a once-a-month oral contraceptive, and we're looking at microarray patches, a strip that would be put on the arm and then peeled off that would then administer hormonal contraceptive for a set period of time.

*Patrick Fine:* Those micro-needle patches are one of my favorite products on the horizon. And, for our listeners who may not be familiar with this, this is a patch on your arm and then you pull it off. And, the patch has microneedles that deliver the contraception into your body. So,

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it's just like putting a Band-Aid on and then pulling the Band-Aid off and you've administered the contraception. That's cool.

*Ann Starrs:*

It's really exciting. That work on the contraceptive products is shaped by another component of the strategy, which is this in-depth research to understand what we call user insights. So, what are the preferences and priorities of women, and in particular what are the tradeoffs that women and girls make as they're making a decision about whether to use contraception at all, as well as what method to use. Do they care about the duration of impact? Do they care about side effects? Do they care about the ability to use a method covertly without, say a husband or parent knowing about it? And so, understanding these different tradeoffs and these priorities that women have is crucial for us in understanding what are the key characteristics of the products that we want to ask the scientists to develop. Because resource are limited, we want to be able to develop the products that are going to have a maximum user audience and be best received by the potential users.

*Patrick Fine:*

Have you had insights into the user experience?

*Ann Starrs:*

Yes, we have some data that has been collected all along, and we've been analyzing some of that and understanding that. But, it's an area that we need to lean in on I think more moving forward with the strategy and get more rigorous about, and we'll also be looking at how we can make the insights and the data, the findings from that research, more widely available.

One of our intentions with this strategy is also to try and strengthen the R&D ecosystem. It's actually shocking how little is invested by pharmaceutical companies in contraceptive technology R&D, and one of our hopes is that by sharing some of the data and the analysis around the user perspectives and the user priorities, that that might help encourage pharma to come more vigorously into this space.

I think to be perhaps slightly provocative, and potentially unfair, I think that pharma executives sometimes look at this space and they say, "Oh, there's a lot of contraceptive methods already available. The market is saturated. We don't need to develop more." But the fact is – and you probably know this, Patrick – that dissatisfaction with side effects is the most significant reason that women give for not using contraception when they want to avoid pregnancy, and it's also the most common reason women give for discontinuing

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contraceptive methods, once they've actually started using one. So clearly, women aren't happy with the methods that are out there.

*Patrick Fine:* I wonder if the behavior of the pharmaceutical companies is that they just don't see a profitable market, and what we're really seeing is a kind of market failure where there is a product that is necessary for community well-being. But, because there's not a big economic payoff, particularly in poor countries, you just don't see the pharmaceutical companies developing products for those markets.

*Ann Starrs:* I think that is one of the aspects of market failure that is at play here in the contraceptive R&D space. I think another factor is that, in terms of the contraceptive development process, these are products that need to be tested over a relatively long period of time, and they're tested on – essentially on healthy women of reproductive age. So, the bar, in terms of proving and demonstrating safety, is quite high. The event that you're trying to prevent, right, is not death or disability, it's pregnancy, and women's willingness to put themselves sometimes at risk can be constrained, and I think pharmaceutical companies are sometimes worried about the liability issues. There is a history of lawsuits in this space that can also be, shall we say, a disincentive to pharma.

*Patrick Fine:* Right. So, that's a good example of how the Foundation is addressing a market failure in a way that can help those markets mature to the point where then they will become sustainable through private-sector action.

*Ann Starrs:* And, that's a perfect lead-in to another one of the key elements of the new strategy, which is to explore the potential for what I would call nontraditional channels, for making contraceptive products actually available to women. And again, this is another theme that is influenced by the COVID pandemic and the self-care movement that we're hearing so much about in the public health space. So, we're looking at can we strengthen the capacity of the private sector, in particular drug shops, pharmacies, these kiosks that I'm sure you've seen in cities, and even in some cases small towns throughout low- and middle-income countries that sell drugs, malaria treatment, etc., etc., but can also sell these self-care contraceptive methods. Are there interventions that the Foundation can support to ease access to increase profitability while still ensuring affordability of these methods, for example including

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provision of methods through these drug shops and pharmacies in national insurance plans?

*Patrick Fine:* So, in order for the national insurance plans to cover those products through those distribution points, that will require changes in policy in the management of, say, their national insurance plans. Are you planning on really engagement with governments and those private insurers around the policy changes that would be required?

*Ann Starrs:* That's certainly one of the areas that we're exploring. You know the Foundation, Patrick. We always start with the data and analytics. So, that would be our first entry point in this is understanding what are the costs aspects to this, the financing aspects of this; what's the feasibility of this for different countries.

If you look now at what national health insurance plans are in a number of countries, they often either don't cover family planning at all, or they cover only limited methods: IUDs, for example, or implants, the methods that require some level of clinical intervention to provide. We'll be doing the costing analysis around the feasibility of that kind of an approach.

*Patrick Fine:* That would be a gamechanger. I'm really happy to hear that you've included that in your strategy because as you look at the evolution of economies in low-income countries, things like private insurers or national insurance schemes have become more and more important in financing health services. And, if those aren't brought into the picture, then there will be a giant constraint and block to expanding access. I think that is absolutely on target and gamechanger is the right word for policies that do support financing of self-care products that provide for family planning.

*Ann Starrs:* I'm glad to hear you're supportive. Some of the other key elements of the strategy include looking at digital platforms: what's the potential of digital platforms to provide solid information and counseling, ideally in a more interactive way so that when women go into a drug shop or pharmacy or into a family planning or primary health care clinic, that they already know what are the methods that are available to them and have some of the basic information. Direct-to-consumer is another option that we're exploring.

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So, what we'll be looking at there, the Foundation is already doing some exploratory work, not through family planning but through other teams, other strategies. So, we'll be looking at whether some of the innovative approaches that have been tried for other health issues or other products, whether those platforms can be expanded to include at least selective contraceptive methods.

*Patrick Fine:* Other products in the health sector?

*Ann Starrs:* Yes.

*Patrick Fine:* Because we are seeing an adoption of telemedicine and a kind of normalization of the use of telemedicine vastly accelerated by the pandemic and the fact that's the only option for many people or the best option for many people.

*Ann Starrs:* Yes, it could be integration with other health products. There's also the option of that lovely acronym "HBA," which my sister taught me many years ago: health and beauty aids. So, one of the other options is packaging these kinds of contraceptive products with hair care products, beauty products, etc., etc., which could also help with some of the stigma issues.

*Patrick Fine:* When you talked about the small drug shops and general dealers that carry some health products, particularly out in more remote or rural areas, I also thought of the folks who are selling those products in the back of their truck, or in some cases, on a bicycle. So, you really could get to that last mile if you're successful with the self-care strategy and you combine it with things like health and beauty products that are sold over the counter. But that requires getting approval to sell modern contraceptives over the counter. What do you hear from policymakers when you have that conversation?

*Ann Starrs:* I think things are easing up on that front and there's also the reality, to be blunt, that sometimes what's happening on the ground is a little bit ahead of what policy actually allows. Certainly, with oral contraceptives, we see that, for example, that oral contraceptives are pretty widely available over the counter in many low- and middle-income countries. But, even in some countries where it's not authorized, it just happens by default. But yes, I think proving – as with all these things, proving safety is the first bar that we need to surmount, and then demonstrating the feasibility in terms of the potential market and the potential profitability for the sellers.

*Patrick Fine:* So, you've talked about three big prongs. One is the product, so having reliable, safe products that meet the users' needs. Two, you've talked about the policy environment that will support the access and distribution of those with a focus on self-care is really being the game-changing element. And then, three, you've talked about the financing, which will influence the policy, but it's its own thing. So, these products are available at an affordable price through the kind of systemic or institutional channels that countries have in place to provide health services.

*Ann Starrs:* Yes, and I don't want to leave out the demand side. So, the interventions that I've talked about, and that you've just summarized, are mostly on the supply side. We are aware, and many countries say this as well, that demand-side barriers are a significant, in some cases even a more significant, issue in terms of the challenges that we face with addressing unmet need for contraception.

We're looking at some specific approaches, testing some innovative approaches and addressing some of the key questions that we have on the potential of interventions to address some of those demand-side challenges. We know, from exemplars in the family-planning space over decades, that mass media can be a highly-effective intervention for increasing awareness of and informed demand for contraception. So, those traditional media: radio, print, television. I think there are two key questions that I'm really interested in having us explore through the new family planning strategy at the Gates Foundation. One is in a more digital world what is the impact of those traditional media? Are they still as effective in changing norms, in ensuring informed decision making and informed choices on the part of women and girls. And, then the other key question is so what is the potential of digital platforms, of social media? Can they have the same kind of impact that those traditional media did in the past?

*Patrick Fine:* How does the strategy incorporate the youth? There's a youth boom in lower-income countries right now. Does the strategy have an explicit focus, or does it treat youth as a particular group whose needs need to be understood and addressed?

*Ann Starrs:* The way we are approaching the question of adolescence and young people is in essence – for you who have been around for a long time in development, Patrick, will be familiar with this – is a

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mainstreaming approach. So, we are looking in our user insights research; we are of course identifying that 15-to-19, the 20-to-24 age group as a particular audience that may have particular needs.

The guidance I've given to my team is we have these different initiatives, the work on the contraceptive technology R&D, the user insights research, the private sector, the digital platforms, looking at demand-side barriers. Let's look in each one of those areas: Do adolescents and young people have particular needs that wouldn't be met by a more generic or mainstream approach? Let's figure out what those particular needs are and figure out what is feasible, what modifications or what new initiatives, new elements do we need to introduce in order to address the particular needs of young people. So, the digital counseling and direct to consumer approaches, for example, could have a particular focus on reaching young people.

*Patrick Fine:*

I would think that the use case for youth would be different from the use cases for some other groups, such as married men and women, or people in a polygamous relationship. In your user experience research, and as you think about demand creation, are you looking at those types of differentiation?

*Ann Starrs:*

Absolutely, yes. We're still figuring out what we call the user segmentation process. The framing that we use in family planning, which has been around for decades, but I have to say it still makes sense to me, is when we're looking, for example, at the contraceptive technology, the R&D work, the first framing that we look at is: Is our user group looking to delay a first birth, to space pregnancies, or to limit births? And, in particular, there's a difference between what are the product profiles that you want for women who don't want to have any more children versus women who want to delay for six months or a year or two years.

The other key variable – and we talked about this a little bit before – is the frequency of sexual intercourse, because that's a key determinant. I said earlier that the most common reason that women give for not using contraception when they are sexually active but don't want to be pregnant, don't want to have a child, is the concerns about side effects. In many countries and many cultures the second most common reason that women give is infrequent sex.

*Patrick Fine:*

They just don't think they're at that much risk of getting pregnant?

*Ann Starrs:* Right. Exactly, what we call emergency contraception, which is one of the things we're exploring, is potentially repositioning emergency contraception as a – and of course we'll have to come up with better language than this – is a pericoital method. So, it's a method that women would have on hand. The morning after pill is maybe a better term than emergency contraception, because you could actually plan to use this method. That's one of the things we're looking at.

*Patrick Fine:* That's great. That would offer an option that many women need that they currently don't have.

*Ann Starrs:* Yes. There's a couple of other what we call initiatives within this strategy. One is, Patrick, on collaborating with the key global partners – World Bank, Global Financing Facility, UNFPA, WHO, USAID as the key bilateral donor with regional bodies like Ouagadougou Partnership – to promote the adoption and scale-up of new technologies and new interventions that are proven to have an impact. And, we don't have the resources to roll out everything every place, but by working through and with these partners and encouraging them, showing them the data on the potential of new policies and new products to get them to adopt and roll out, as well as of course governments themselves, that's a key part of the strategy as well for getting impact at scale.

*Patrick Fine:* The Foundation has a long track record of building coalitions amongst these major international and multilateral institutions.

*Ann Starrs:* One other thing that I would highlight as a key shift in our strategy is that from 2012, when the FP strategy at the Gates Foundation really got launched or first got a significant uptick in resources, to 2020, the focus was on family planning, primarily as a vertical issue.

I think we now need to build on that but really position family planning as a core element of other frameworks, of primary health care, of universal health coverage, of human capital development, gender equality, sexual and reproductive health and rights. Family planning needs to be a core part of each of these broader frameworks. And in particular, since primary health care is the dominant framework that most countries are now using to shape their health systems and their health strategies, we need to be able to make the case that family planning needs to be there.

When countries use burden of disease as the framework for prioritizing their health budgets and their health interventions, family planning doesn't always rise to the top. So, we need to make the case, really effectively, about why family planning is not just a crucial health intervention but a crucial social and economic and development intervention.

*Patrick Fine:* Right. So, maybe you switch from burden of disease to individual and community well-being. I couldn't agree more with you about the need to see family planning as integral to broader health services and to a healthy life and to a healthy society. At FHI 360, we've put a lot of effort and are big advocates for integrated approaches that don't silo human development interventions, but rather take a more comprehensive and holistic look at things and approach to things. So, it's great to hear that you've built that into your strategy.

*Ann Starrs:* Exactly.

*Patrick Fine:* So, Ann, you've described the new strategy and its major dimensions. You've talked about wanting to have gamechangers that are really going to disrupt practice in a positive way so that more women and adolescent youth have access to reproductive health services, to the information they need, and to modern contraceptives and family planning.

Amongst those game-changing initiatives within your strategy, is there one that stands out to you as having the most potential to really move the needle on current practice?

*Ann Starrs:* Yes, my answer to that would be one of the initiatives we've talked about, which is the contraceptive technology work. Our analysis very clearly showed that women's dissatisfaction, women's unhappiness was side effects, their concerns about a range of aspects of the technology itself as a major barrier to use. It may take a while for us to really get the products right and, coming back to one of the things you mentioned, Patrick, we do have a portion of our budget that's looking at nonhormonal methods, and whether we can get some really new and innovative products in that space that would address some of these concerns. So, it may take 10 or 15 years for these investments to pay off, but that I think is going to be the biggest gamechanger.

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*Patrick Fine:* Ann, it's really inspiring to hear the vision that the Gates Foundation has and that you're leading with respect to looking forward to the future and how to meet unmet demand and unmet need for family planning and for reproductive health services.

In this season of *Deeper Look*, I'm asking each of our guests what advice would you give to the next generation of people who want to work in the field of reproductive health.

*Ann Starrs:* I don't want to sound too nerdy, but my advice would be to always anchor in what the data tells you about the scope and the consequences of a public health problem that you want to address. There are always limitations to data, that numbers alone, they can tell you the what but they can't tell you the why. And, they also can't tell you the how to change, which is what the public health field is all about. But, I think understanding the scope of a problem, understanding what are the options to address that is fundamental to progress in public health. So, I think anchoring to that data and evidence is critical.

And then, what I said at the beginning. Commitment to action is essential, always, always to be asking the question, "What impact am I trying to achieve? What population am I trying to help? And, what do they want? And, how will I assess whether I am making a difference?" That would be my advice.

*Patrick Fine:* That's great advice from a true champion for reproductive health and women's empowerment. Ann, thank you so much for sharing your insights, for sharing what the Foundation is doing, talking about its new strategy.

Ann, you know, good luck in the execution on that strategy. You've got a towering task ahead of you. Thank you so much for being with me today.

*Ann Starrs:* My pleasure, Patrick. I'm really excited about this strategy, as I hope came through in this conversation. It's wonderful for me to be able to share it, and I look forward to continuing to work with you and many of our colleagues in the field to roll this out.

*Patrick Fine:* I also want to thank your listeners for joining us for this terrific conversation. Please share this episode. If you know people who are interested in reproductive health and family planning, this is an episode that they should not miss. Please share comments and

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thoughts on the trends and people that you see disrupting human development. If you have ideas about how to positively disrupt around creating more access to reproductive health services, please share those, and join us next month for another episode of *A Deeper Look*.

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