CHARITY ENTREPRENEURSHIP

Expanding Access to Contraception through Mobile Clinics

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RECOMMENDED

Expanding access to contraception through mobile clinics

Ambitious Impact Research Report

January 2026

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Ambitious Impact (AIM) *exists to enable more effective charities to exist worldwide. We strive to achieve this goal through our extensive research process and Incubator Program. We give talented potential entrepreneurs two months of cost-covered, intensive training designed by founders for founders. Our talented researchers and entrepreneurs identify evidence-based, high-impact interventions and help founders find a co-founder to launch the idea and reach scale.*

Note to readers: *Our research is geared toward AIM decision-makers and program participants. We attempt to find the best ideas for our incubation programs through these reports. Given our commitment to focusing on recommended ideas, reports on those not recommended for incubation can often be less polished.*

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Expanding access to contraception through mobile clinics / Summary

Description

This report focuses on using mobile medical clinics to deliver modern contraceptive methods (mCMs) in areas where access is limited. Mobile clinics are vehicle-based, staffed units that travel to remote or underserved communities to provide same-day contraception services. The approach targets persistent barriers such as long travel distances, stockouts, limited method choice, and unreliable service availability, all of which contribute to high levels of unintended pregnancy.

Counterfactual impact

Mobile outreach is most effective in areas where access to contraception services is limited or unreliable. In many of the settings considered, especially in rural and hard-to-reach populations, use of modern contraception remains low. As a result, mobile clinics are likely to reach people who would not otherwise receive care, rather than shifting clients away from existing providers.

Cost-effectiveness: Modeling across five countries (Burundi, Angola, Nigeria, Uganda, and Zambia) suggests a cost of $7–$15 per additional year of contraceptive use for a charity that operates ten mobile clinics. At a larger scale, costs fall to $4.5–$9.7 per year for a charity operating 50 clinics. These estimates are well below GiveWell's benchmark of $20 per additional year of contraception use.

Scale: A single mobile clinic operating 200 days per year could serve over 10,000 clients annually, providing thousands of people with protection against unintended pregnancies. A charity operating 10 clinics could therefore reach over 100,000 clients per year, while a program with 50 clinics could reach more than half a million people annually.

Potential for success

Evidence base: The evidence supporting mobile outreach for contraceptive delivery is moderately strong. Multi-country program evaluations and observational studies consistently show that mobile services increase uptake and continuation of modern contraceptive methods, including long-acting reversible contraceptives, when delivered by trained providers with reliable supply chains.

Theory of change: This intervention follows a well-established delivery model. A mobile outreach charity would identify underserved regions with limited access to contraception, recruit and train providers, secure reliable commodity supply, and deploy mobile clinics on a regular schedule to deliver same-day contraceptive services with follow-up. Delivered reliably, these inputs would increase access to modern contraception and support continued use, leading to fewer unintended pregnancies.

Neglectedness

Existing activity: Mobile outreach for contraception is not a highly neglected intervention, and this is an important consideration. Large family planning organizations already operate mobile clinics at scale, and funding for this delivery model is substantial. However, unmet need remains high in many settings, particularly in parts of rural sub-Saharan Africa. Gaps persist in areas that are not consistently reached by large implementers, or where access is constrained by conflict,

distance, or frequent shortages. These conditions create pockets of unmet need that are not fully addressed by existing programs, suggesting some room for a new entrant that can operate in underserved locations

Geographic fit: Our geographic assessment prioritized Burundi, Angola, Nigeria, Uganda, and Zambia based on need and potential cost-effectiveness. While mobile outreach is present in all five countries, coverage varies substantially. Uganda and Zambia appear relatively well served, while Burundi, Angola, and parts of Nigeria may offer more scope for a new charity, particularly if it focuses on areas not currently reached by major implementers. Any expansion would need to focus on underserved sub-regions and coordinate closely with existing organizations to avoid duplication and ensure added value.

Relevance

Strategic value to AIM: This idea fits AIM's model of scaling interventions with a strong evidence base and clear pathway to impact. It builds on established delivery models in family planning while targeting settings where access remains uneven. The intervention is cost-effective and complements AIM's existing work in reproductive health.

Fit for the CEIP: This idea is likely to appeal to incubatees with experience in operations, health systems, or service delivery. Implementation would involve managing logistics, staffing, and supply chains, as well as coordinating with existing providers and public systems. While the underlying model is well established, successful delivery would require moderate technical skill and experience in, or an aptitude for, managing complex operations.

Other

Expert views: The experts consulted for this report broadly agreed that mobile clinics can be an effective way to expand access to contraception, particularly for reaching populations with high unmet need. Several emphasized that mobile outreach works best when focused on long-acting methods and when paired with strong community engagement and reliable supply chains.

At the same time, experts highlighted important practical constraints. These included challenges around community trust, security, staffing, and cost, as well as the risk of duplication in settings where large providers already operate. Several noted that setting up a new mobile outreach program can be resource-intensive, and that in some contexts it may be more effective to work through or alongside existing organizations rather than creating a new entity.

Implementation factors: Key implementation challenges include maintaining reliable supply chains, coordination with existing programs, and ensuring continuity and quality of care. Risks are generally low but include service disruptions due to logistics or security constraints, as well as variation in counseling quality if staff are insufficiently trained. Careful planning and local coordination are therefore central to successful implementation.

Increasing access to family planning in underserved communities with mobile clinics / Crucial considerations

Additionality

We have some remaining uncertainty about how much additional impact a new mobile outreach charity would generate. While there are clearly underserved regions where mobile clinics could reach people with limited access to family planning services, it is not always clear why existing providers have not expanded into these areas. There may be constraints related to access, security, or other operational barriers, which could also affect a new organization. Demonstrating additional impact would require close coordination with existing providers and better data collection systems to track potential overlaps in service delivery.

Geographic variation in costs and potential impact

Costs, uptake rates, and infrastructure constraints differ sharply across and within countries, affecting tractability. Supply chains and road access in remote or fragile areas may be unreliable, raising costs and reducing the number of service days per year. Cultural and political resistance in more conservative regions could also limit effectiveness or constrain method mix. These factors make more localized modeling essential. Expanding the cost-effectiveness model to include additional countries or subnational data could further clarify where returns are likely to be highest (see Geographic assessment).

Partnership dynamics

The family-planning sector is dense with major NGOs already running mobile and outreach programs (see Actors driving this intervention). Cooperation is critical but not guaranteed—organizations may be reluctant to share data or collaborate with a perceived competitor for funding or geography. Successful entry will depend on building trusted relationships with health authorities and incumbents to ensure coordination rather than duplication. The extent to which this is achievable remains uncertain and may vary by region.

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1 Background

1.1 Context

Ambitious Impact (AIM) exists to increase the number and quality of effective nonprofits working to improve human and animal wellbeing. AIM connects talented individuals with high-impact ideas. We give potential entrepreneurs intensive training and ongoing support to launch ideas to scale. Our research team focuses on finding impactful opportunities.[1]

As part of our 2025 research agenda, we reviewed several interventions around family planning.[2] In that context, we researched supporting mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives (LARCs) and permanent methods. This report provides an overview of our findings.

1.2 Introduction to the idea and problem

Despite the expansion of modern contraceptive use worldwide, access remains uneven—especially in remote or low-resource settings (Pillai & Nagoshi, 2023; Our World In Data, 2025). In many low- and middle-income countries (LMICs), women who wish to delay or avoid pregnancy still face major barriers including long travel distances to clinics, limited method choice, frequent stock-outs, and interrupted services (Habib, 2022). These gaps lead to unintended pregnancies, higher maternal health risk, and increased strain on health systems (Pillai & Nagoshi, 2023).

This report examines the case for mobile medical clinics delivering a full mix of modern contraceptive methods (mCMs), including short-acting contraceptives,

[1] To read more about our approach to selecting intervention ideas for our program, please see this document.
[2] To read more about this research process, please review our website.

injectables, and LARCs.[3] In the context of this report, a mobile clinic is defined as a vehicle-based, staffed and equipped unit that travels to underserved communities to directly provide family planning counseling and contraceptive services.

The mechanics are straightforward. First, identify areas where access to contraception is limited and unmet need remains high. Second, deploy mobile clinics to that area on a regular schedule, staffed with trained professionals and equipped with contraception supplies, medical materials, and basic outreach support. Third, deliver same-day contraception services, ideally including LARCs, alongside appropriate counseling and follow-up. Over time, increased uptake and continuation of contraception reduce unintended pregnancies and associated health burdens.

The need for this type of intervention is vast. Estimates from 2024 show that, in 128 LMICs, around 214 million women who wanted to avoid pregnancy were not using a modern method. Of these, 78 million were estimated to have *unmet demand*, meaning they wanted to avoid pregnancy and were interested in or open to using contraception, but were not currently doing so (Guttmacher Institute, 2024). This gap is concentrated among rural and low-income populations and contributes to high unintended pregnancy rates, as well as closely spaced births, both of which elevate the risk of negative health and wellbeing outcomes for the mother and her family (Tian, et al., 2025; GiveWell, 2025).

Mobile clinics are not novel. Large NGOs and national programs have successfully deployed them in the past and some continue to use them at a large scale. However, we think that there is potential for further high-impact, cost-effective work through geographic expansion into regions that remain neglected.

[3] Throughout, mCM refers to the mix of modern contraceptive methods that mobile clinics will offer. Because these clinics visit remote locations infrequently, the analysis focuses on LARCs and injectables such as DMPA-SC ("Sayana Press"), which offer the most practical and cost-efficient options in this context, though programs would likely include a wider range of methods in practice.

2 Theories of change

The hypothesis underlying this intervention is that **mobile outreach can directly address some of the core drivers behind low uptake of modern methods of contraception—i.e., distance, cost, stigma, supply gaps, and limited method choice—by bringing trained providers and reliable commodities into underserved communities on a predictable schedule.**

If a charity can accurately identify neglected regions, recruit staff without displacing essential workers, secure dependable supply chains, and operate regularly despite logistical challenges, outreach should yield increased adoption and sustained use of effective contraception in these areas.

The causal pathway is straightforward and supported by numerous studies and real-world results. However, success depends on high-quality counseling, continuity of care, and strong supply reliability.

The counterfactual impact of the intervention relies heavily on targeting. An organization delivering this work must ensure that it is not displacing other actors delivering similar contraceptive services, and that it is targeting areas where individuals are truly facing supply or access challenges.

2.1 Barriers to contraceptive access in LMICs

The main barriers we have identified to accessing mCMs in remote, low-income regions are:

- Travel time, transport cost, limited clinic hours, and provider scarcity in rural and poor regions (Kaur & Lathrop, 2023).
- Stockouts and a narrow method mix at static facilities, as well as unpredictable schedules and limited trained staff where mobile clinics operate (HIP, 2022).
- High costs for mCMs, restricting availability and contributing to stockouts in low-resource settings. eEvidence suggests that price reductions may be helpful in expanding access (Braun & Grever, 2020).

- Conflict and other shocks disrupting static services in remote settings (Edmond et al., 2020).

Less severe, but potentially significant barriers include:

- Stigma, privacy concerns, and worries about side effects, which can suppress demand (Hamon et al., 2020).
- Weather-related disruptions, which can interrupt facility services where these exist (UNFPA Bangladesh, 2024).
- Where access is increased through mobile outreach service programs, weak counseling and follow-up are linked to early discontinuation (Azmat et al., 2013).
- Programs without explicit plans for continuity of care, which can leave service gaps that undermine protection (Christofield & Lacoste, 2016).

2.2 Theory of change for this charity

We decided to focus on the ToC depicted in Figure 1. The core focus of the envisioned organization would be to provide access to mCMs (especially, but not only, LARCs) through the deployment of mobile clinics.

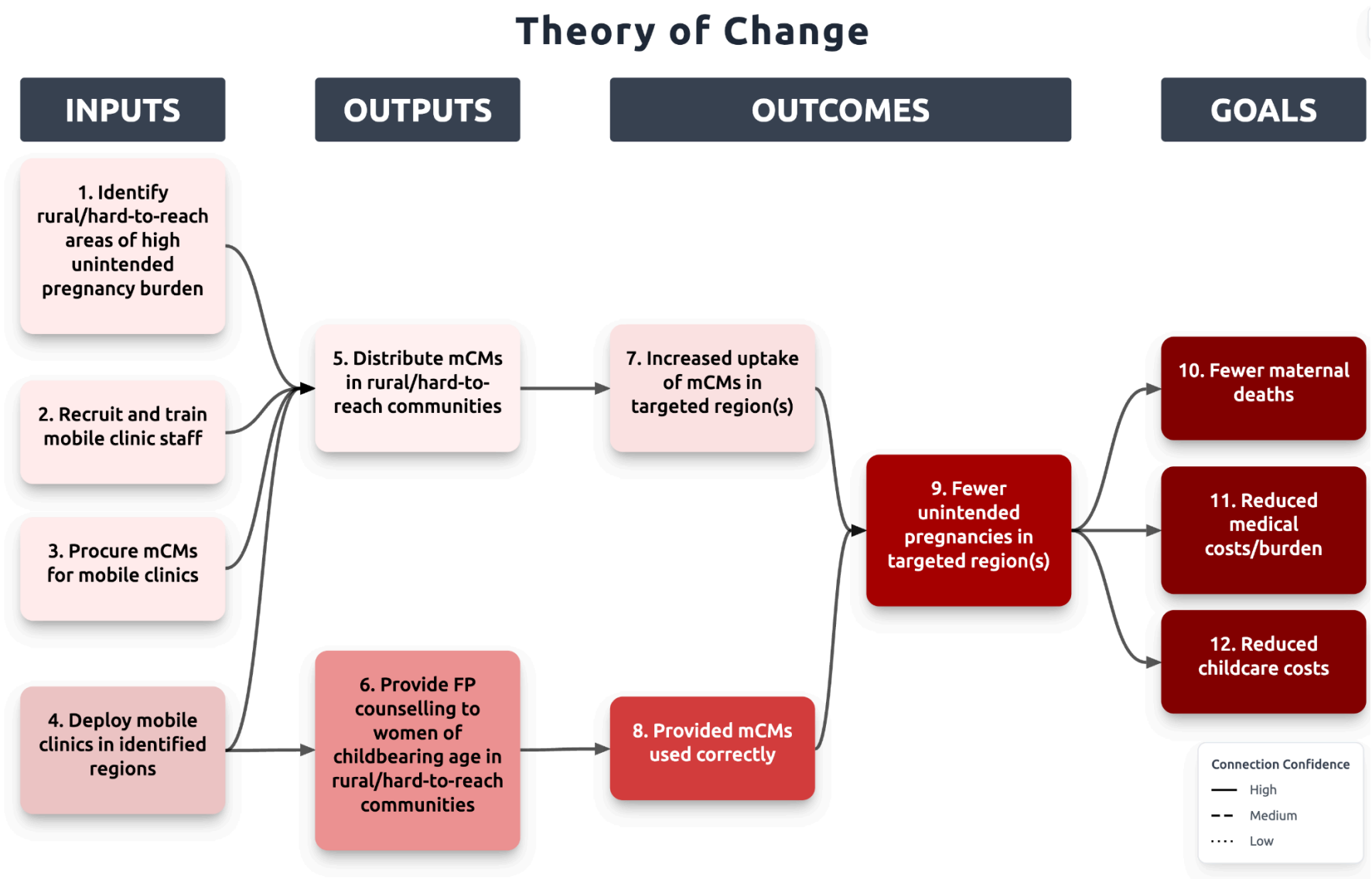

Figure 1: The theory of change for a new charity working on mobile clinics to deliver mCMs.

The table below lists the key assumptions behind the theory of change, together with our subjective confidence rating of each assumption and reasoning behind each rating. We use the following color-coding to indicate levels of confidence: <20%, 20–40%, 40–60%, 60–85%, 85%+.

Table 1: Theory of change assumptions

Assumption (confidence level)	Explanation for confidence level
Assumptions about inputs	
The charity can identify target areas	The charity can use desk research and local consultation to identify rural and hard-to-reach areas with high unintended pregnancy and limited access to mCMs. As this is standard practice in this area, we have high confidence in this being tractable (Kaur & Lathrop, 2023). The charity will need to screen sites to avoid overlap with other family planning services (mobile outreach or others) and to ensure feasibility (e.g., local infrastructure) before deployment.
The charity can recruit and train staff	The charity would need to recruit and train staff to deliver mobile clinic services. Many past AIM-incubated charities have recruited local medical staff, making us highly confident in this step.
The charity can procure commodities and avoid stockouts	Successfully procuring sufficient commodities for all the mobile clinics may be a challenge that this charity will need to focus on, as stockouts of contraceptives are common in LMICs. However, given the positive experiences with procurement of past AIM-incubated charities (Lafiya, AMI), we believe that a focused team can overcome challenges in this space.
The charity can successfully deploy mobile outreach teams	Our confidence is moderately high, since steps like obtaining permissions, vehicles, and forming partnerships with governments may present some challenges.
Inputs → outputs assumptions	
Well-stocked and staffed mobile clinics can distribute mCM to rural and/or hard-to-reach areas	This involves planning routes and service days around road quality, seasonal weather, and local security so services run reliably. Where possible, the charity should aim to maintain access during disruptions (such as due to weather). Our confidence is high, as this has been successful even in highly remote and dangerous locations (Edmond et al., 2020). However, disruptions may still happen.
Well-trained staff will provide clear method counseling	Staff should be able to provide high-quality counseling in local languages, offer switching support where needed, and give simple guidance on what to do if problems arise.

	The existing literature points to some past issues around poor quality of counseling (e.g., Azmat et al., 2013). We believe that this can be overcome with proper staff training and monitoring and evaluation systems in place.
Increased mCM uptake in target areas	Multi-country program evidence shows substantial increases in mCM provision when outreach is introduced under real-world conditions (Ngo et al., 2016; Duvall et al., 2014); therefore, confidence is high.
Clients use mCM correctly and continuously	Following outreach, continuation at 12 months is generally high (above 80%), supporting sustained protection; confidence reflects measured continuation rates in similar real-world programs, at moderately high (Azmat et al., 2013). That said, mobile outreach services have a higher risk of incorrect use and/or discontinuation due to the lower availability of staff contacts. To ensure high satisfaction and low discontinuation rates, the charity should ensure follow-up care is provided at regular visits (HIP, 2022).
Assumptions about outcomes	
Fewer unintended pregnancies in target areas	Increased adoption and continuation of effective mCM translate into fewer unintended pregnancies (GiveWell, 2025).
Outcomes → Goals assumptions	
Fewer maternal deaths	Reductions in unintended pregnancies reduces the risk of pregnancy-related mortality (GiveWell, 2025).
Reduced medical costs and health-system burden	Avoiding pregnancies reduces healthcare utilization and costs of pregnancy-related care (Guttmacher Institute, 2025).
Reduced childcare costs for households	Fewer unintended births reduces household expenditure and time costs for childcare in a way that is measurable and material for the target populations (GiveWell, 2025).

3 Quality of evidence

Our review found a moderate but geographically diverse evidence base indicating that mobile family planning services can expand method choice and increase uptake, especially when delivered by trained providers with reliable supplies. The strongest evidence comes from multi-country observational and programmatic studies in sub-Saharan Africa and South Asia, which consistently report large increases in mCM use and high continuation once access barriers are reduced. Several non-randomized evaluations also support the pattern of large increases in the uptake of contraceptives (especially LARCs) when mobile clinics are present.

However, gaps remain in rigorous causal evaluation—particularly studies with long-term follow-up, standardized outcome measures, or cost-effectiveness data. Much of the current evidence comes from real-world program evaluations with limited control groups and potential selection bias. Despite these limitations, findings are consistent across contexts and supported by clear mechanisms and implementation experience, providing moderate-to-strong confidence that mobile delivery can effectively increase contraceptive access and use in underserved populations.

3.1 Evidence on feasibility

3.1.1 Direct evidence: mobile clinics delivering contraceptive services

A 2023 narrative review concluded that mobile FP programs are effective in increasing knowledge and access to family planning, particularly by increasing the uptake of LARCs and permanent contraception in underserved areas (Kaur & Lathrop, 2023). However, as a narrative rather than systematic review, the evidence presented may not fully represent less effective programs.

A multi-country evaluation in sub-Saharan Africa documented rapid scale-up of mCM provision through routine MSI delivery models, including mobile outreach, demonstrating that high-volume services are achievable under real-world constraints (Ngo et al., 2016). However, the analysis relies on retrospective program data from high-performing implementers, which may overestimate outcomes achievable in weaker or newly established settings.

In Bangladesh, UNFPA recently supported 40,000 women and girls in mobile health camps delivering, among other services, sexual and reproductive health services in climate-affected districts (UNFPA Bangladesh, 2024); they have also deployed nearly 100 mobile clinics since 2023 across several countries and contexts (UNFPA Bangladesh, 2025), indicating that mobile delivery can help maintain access during shocks. However, there is some risk of bias, given that these are self-reported program data without systematic outcome measurement or estimation of counterfactual coverage.

A multi-country outreach scale-up by MSI between 2008 and 2012 increased annual implant insertions in remote areas from just over 80,000 to more than 750,000, which demonstrates that mobile delivery can generate high volumes of effective contraceptive services in real-world conditions (Duvall et al., 2014).

Lastly, an epidemiologic study in Nepal showed that men living in remote regions served by mobile FP teams were more than twice as likely to obtain vasectomy compared with men in similar regions relying only on static services, with an adjusted odds ratio of approximately 1.6 (95% CI 1.21–2.25) (Padmadas et al., 2014).

Overall, this evidence makes us highly confident that contraceptive services can be successfully delivered to underserved populations.

3.1.2 Indirect evidence: mobile clinics delivering other primary-care services

A 2020 population-based study in conflict-affected provinces of Afghanistan (n = 338,796 pregnant women) **found that communities served by scheduled**

mobile health teams had higher coverage of selected maternal and child health services than comparable areas without mobile teams, including ~36% higher coverage of at least one antenatal care visit and ~29% higher first-dose measles vaccination coverage (Edmond et al., 2020). The study found no significant differences in postnatal care use, clinic-level ANC service volume, or several other outcomes. Because the quasi-experimental design compares districts with different baseline conditions, some observed effects may reflect contextual factors rather than the intervention itself. However, the study still provides evidence that mobile delivery can operate effectively and at scale in remote, insecure settings.

A realist evaluation in rural Malawi found that integrating FP counseling into routine outreach immunization improved acceptability among postpartum women by reducing travel barriers and offering more discretion, which suggests that mobile delivery can improve access for populations with cultural barriers to mCM access (Hamon et al., 2020). However, these findings are based on qualitative and small-sample quantitative data, potentially limiting internal and external validity.

3.2 Evidence on effectiveness

3.2.1 Direct evidence: mobile clinics delivering contraceptive services

Evidence reviews by High-Impact Practices find that mobile outreach delivering trained providers and a full range of contraceptive methods increases contraceptive use in settings where travel time, cost, or stigma limit access (HIP, 2022).

An analysis of MSI's delivery of contraceptive implants in sub-Saharan Africa, primarily delivered through mobile outreach, shows near-term increases in the adoption of mCMs, with several-fold increases in implant uptake in areas where mobile services were introduced (Duvall et al., 2014). While the analysis

documents a strong association between MSI's outreach expansion and rising implant uptake, it does not isolate the specific effect of mobile clinics.

A 2018 study in the Democratic Republic of the Congo, Tanzania, and Uganda reported that the "uptake of LARCs is particularly high during mobile outreach and special family planning day events," indicating that these delivery channels are potentially effective, at least in this region (Jarvis et al., 2018).

3.2.2 Indirect evidence: mobile clinics delivering other primary-care services

Program and market evaluations show that method availability, price reductions, and assured supplies are key drivers of increases in mCM use. In practice, mobile outreach is one of the channels that operationalizes these gains by bringing the expanded method mix to hard-to-reach populations (Braun & Grever, 2020; MSI Annual Review, 2023).

International comparative research finds that mCP increases by roughly 4–8% for each additional modern method available, supporting the mechanism that mobile services activate by bringing a broader method mix to underserved populations (Ross & Stover, 2013).

Evidence from outreach in other health domains demonstrates that when access barriers are reduced, usage increases, which strengthens the plausibility that improved access via mobile delivery will lead to higher mCP uptake (Edmond et al., 2020; Hamon et al., 2020).

3.3 Evidence on broader impacts and spillover effects

We have identified several potential positive and negative externalities or second-order effects of mobile outreach programs.

On the positive side, an equity review by Hardee et al. (2019) reported a **much larger share of very low-income clients among mobile-outreach users in**

sub-Saharan Africa, suggesting that mobile delivery might improve distributional equity. A summative evaluation of the Implants Access Program (which aimed to increase access to contraceptive implants for women in low-income countries) reported that implant prices fell by ~50% via volume guarantees, alongside supply-chain and service-delivery investments (including outreach and special service days; Braun & Grever, 2020). Lower prices and reliable supply were associated with large increases in implant availability and use across sub-Saharan Africa.

On the negative side, **we are primarily concerned about the risk of mobile clinics providing long-acting methods without offering guaranteed, timely access to removal services.** Outreach programs must therefore plan and finance removal services or offer mCMs that are not permanent (Christofield & Lacoste, 2016). Similarly, mixed-methods research in Malawi shows that continuity of care and access to removals are crucial to sustain acceptability and ongoing protection (Hamon et al., 2020). In addition, observational evidence from Pakistan indicates that continuation after mobile and outreach-linked IUD insertion is highly sensitive to counseling quality, with most early removals driven by inadequate management of side effects, suggesting that mobile delivery should include structured counseling to maintain contraceptive protection (Azmat et al., 2013).

Lastly, our expert interviews stressed that poor commodity coordination could lead to stockouts during concentrated service days, undermining trust and future uptake (see Expert views).

4 Expert views

As part of our investigation, we consulted four people familiar with this space:

- Miri Muntean, Co-Founder and Co-Executive Director, Access to Medicines Initiative
- Klau Pakos, Co-Founder, Lafiya
- Expert C (anonymized)
- Expert D (anonymized)

Our findings from these conversations influenced our decision-making across the reporting. This section summarizes the key findings from the consultation not mentioned elsewhere.

4.1 Miri Muntean (Access to Medicines Initiative)

Five key areas were discussed with Miri Muntean, summarized below.

1. Geographic Focus

- Nigeria's family planning needs are vast, and no single group fully covers all 36 states.
- Funders like the Gates Foundation and CIFF (Children's Investment Fund Foundation) focus on only a few states, leaving large gaps.
- Rural and northern regions have the highest need.

2. Staffing

- Charities should consider the counterfactual when hiring limited and in-demand local medical staff, as this can increase coverage gaps elsewhere.
- Recruiting from within communities builds trust and lowers security risks.

3. Organizational Landscape

- Many organizations operate in Nigeria, but efforts are fragmented and sometimes duplicative and the need is very large.
- Miri feels positively about new independent mobile clinic programs over expanding existing ones, citing cost and control.
- The loss of USAID funding has disrupted supply chains, with groups like DKT and Gates temporarily filling some of the gaps.

4. Cultural Barriers

- Religious beliefs, male status linked to fertility, and myths about contraception limit uptake.
- Engaging religious and traditional leaders helps counter resistance.
- Despite large desired family sizes, over 30% of pregnancies are unintended, showing clear unmet demand.
- Mobile clinics can address cultural, supply, and access barriers simultaneously.

5. Costs and Method Mix

- Offering several contraceptive options supports choice but raises cost differences.

4.2 Klau Pakos (Lafiya)

The conversation with Klau Pakos touched on three key areas:

1. Value of the intervention

- Mobile clinics are particularly well suited to delivering LARCs, as these methods do not require monthly visits and can be provided safely in controlled, sterile conditions.

2. Neglectedness in Nigeria

- MSI has been doing a lot of work on this, and filling this demand well.

3. Challenges

- Acceptance of LARCs varies widely by context. In some settings, particularly hard-to-reach and rural areas such as parts of northern Nigeria, these methods are not generally accepted, which limits demand despite availability.
- Mobile clinics can face trust barriers in some communities, as they are often perceived as outsiders visiting infrequently. Common concerns include fears of hidden agendas, uncertainty around managing side effects, and doubts about whether follow-up care or subsequent doses will arrive in time.
- Klau also raised concerns about long-term sustainability, particularly at scale, and that fundraising could present a significant challenge.

4.3 Expert C

Our conversation with this expert highlighted several key points:

1. Barriers and enablers

- It's advisable to maintain a network of community organizer who inform local community about upcoming mobile clinic visits.
- It is important to get an agreement from the government and buy-in from local leaders in order to minimize the risk of community backlash.
- Security is a major concern in remote areas of some countries.

2. Mobile clinics' cost-effectiveness

- Mobile clinics are the single most cost-effective intervention when it comes to the impact of contraceptives on women's health. This is because they can

target areas where the need is highest and where there is limited availability of family planning and maternal health services.

3. Views on setting up a new charity

- The expert cautioned that setting up a mobile-outreach operation from scratch is a significant undertaking. It requires investment into logistics, quality assurance, community engagement, follow-up care, etc. New actors should not expect it to be easy.
- High set-up costs mean that cost-effectiveness depends on reaching sufficient scale.

4.4 Expert D

In our conversation, Expert D talked about their experience running a project using mobile clinics for contraceptive expansion in sub-Saharan Africa.

1. How the project was run

- The project used two mobile clinics that visited peri-urban areas, with the primary goal of increasing the uptake of IUDs (while other methods were also offered).
- The project team did not purchase the clinics, but rented them. While this was expensive, it reduced upfront costs.

2. Observations

- Despite minimal demand generation, clinics experienced very long queues of women seeking services.
- Many women were unable to have an IUD inserted on their first visit because they tested positive for an STI. In these cases, the clinic team first provided treatment and then performed the IUD insertion at a subsequent visit.
- Some women learned that they were pregnant via these clinics.

3. Barriers and enablers

- They found that charging women a small fee for the IUDs—around $1—helped build trust in the service and increased demand.
- Establishing a new charity in a new country may be time-consuming and costly. It may be more effective to begin by operating in partnership with an existing NGO that is established in the target country.

5 Existing activity, funding, and geographic assessment

This section outlines our considerations of additionality and reviews where this intervention could be implemented, based on need, feasibility, and potential impact.

5.1 Existing activity and funding

Our research indicates that mobile clinics are *not* a very neglected intervention, with neglectedness having been our key concern for this charity idea. NGOs with a focus on family planning regularly use mobile clinics to deliver mCMs,[4] and funding for this specific intervention is in the $10s of millions (see Attention and Funding, below). In addition, a relatively large number of NGOs are already working in this area (see Actors delivering this intervention).

Nevertheless, rates of unintended pregnancy remain high (see Figure 2), indicating that significant gaps persist despite the large number of actors working in this space. Our expert consultations, both for this report and across related family planning research) suggest that access to contraceptives (particularly LARCs) remains limited in many countries. These gaps are often concentrated in more remote areas that are difficult for existing services to reach, and where mobile clinics may be well suited. **This makes us confident that there is still room for new actors**, though any new charity would need to carefully assess where unmet need is greatest before establishing operations.

[4] See, e.g., MSI's 2024 Impact Report which notes over 10 million kilometers traveled by mobile outreach teams; DKT International noting 13 mobile clinics operating in Mozambique; UNFPA reporting the use of mobile clinics.

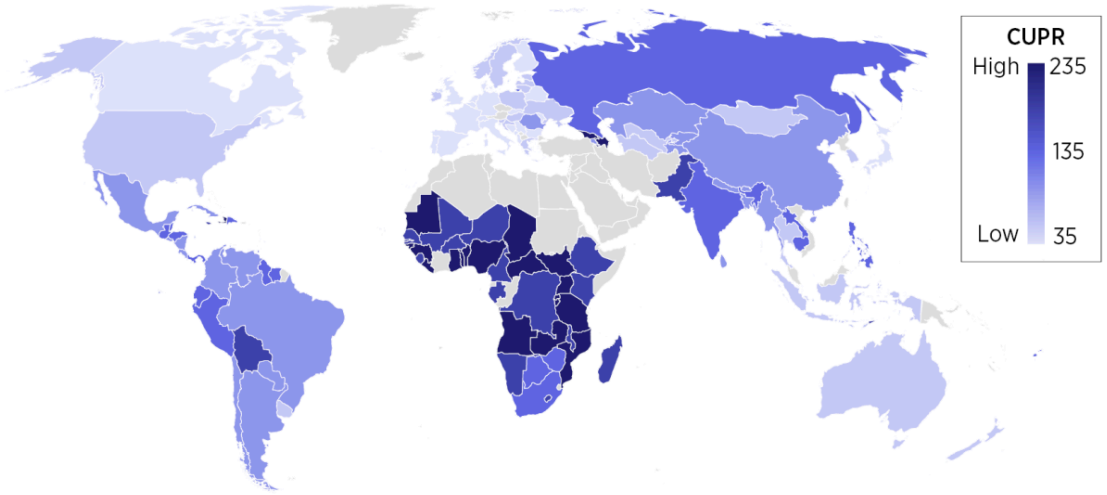

Figure 2: Conditional unintended pregnancy rates, 2015–2019 (Guttmacher, 2025).

Actors delivering this intervention

Some of the largest actors working in this space are listed below. Note that all of these are multi-armed organizations, and mobile clinics are only one of their interventions. Moreover, to our knowledge, only MSI and IPPF operate a large number of mobile clinics dedicated to family planning in non-humanitarian settings. The other listed organizations either run mobile clinics in humanitarian settings (e.g., UNFPA, International Medical Corps, the IRC) or only seem to operate a modest number of mobile clinics.

Table 2: Organizations that operate (/have operated) mobile clinics.

Organization/ Link	Scale/coverage (whole organization, not necessarily mobile clinics)	What they do
MSI Reproductive Choices	Operating over 400 mobile clinics across 36 countries	• Provide contraception and abortion care through fixed clinics and mobile teams. • Work with partner clinics and private providers to expand access and maintain quality. • Offer LARCs, as well as permanent and

Organization/ Link	Scale/coverage (whole organization, not necessarily mobile clinics)	What they do
		short-term contraceptive methods with counseling and follow-up. • Train nurses and midwives to deliver services safely.
United Nations Population Fund (UNFPA)	Operating over 800 mobile clinics	• Supply contraceptives and other reproductive health materials to public health systems. • Help governments plan and manage supply chains to avoid stock-outs. • Support national family planning programs, often in crisis or humanitarian settings. • Provide technical advice and population data to guide policies. • Directly run 100s of mobile clinics, though often not exclusive to family planning, and often with a focus on humanitarian settings.
International Planned Parenthood Federation (IPPF)	145+ countries	• Run programs that provide contraception, pregnancy care, and abortion care. • Advocate for access to reproductive healthcare and individual choice. • Specific country programs may operate mobile clinics
DKT International	100 countries	• Make affordable contraceptives widely available through pharmacies, clinics, and online stores. • Use marketing and outreach to help people learn about and choose contraception. • To our knowledge, they use *some* mobile clinics (e.g., in Mozambique) but not at a large scale
Population Services International (PSI)	Operating in 50+ countries concentrated in LMICs	• Work with governments and private providers to make contraception affordable and easy to access. • Train health workers and support pharmacy and clinic networks. • Use mobile clinics in some context, though often (to our knowledge) on a time-limited, project-based basis.
International Rescue	Operates in 40+ countries; FP	• Deliver healthcare in conflict and crisis zones, including family planning and reproductive

Organization/ Link	Scale/coverage (whole organization, not necessarily mobile clinics)	What they do
Committee (IRC)	(and mCMs) are included but not the primary focus	services. • Combine reproductive health care with mental health and gender-based violence support. • Their mobile clinics focus on humanitarian settings and may not focus exclusively on contraceptives.
IntraHealth International	Operating in 35 LMICs	• Train and support health workers who provide family planning and reproductive healthcare. • Strengthen public health systems and ensure that supplies reach local clinics. • Help governments and partners improve data use and service quality. • Expand access to contraception for young people and new mothers. • Use mobile clinics in some context (e.g., Tanzania), though typically on a project-based basis.
Ipas	Operating in 30+ countries	• Expand safe abortion care where legal and improve care after miscarriage or abortion. • Offer contraceptive options alongside treatment. • Train healthcare providers and support policy change to reduce unsafe abortion. • To our knowledge, operate a limited number of mobile clinics.
International Medical Corps	Currently active in 28 countries; FP is one of many focus areas	• Provide primary and reproductive healthcare in emergencies and conflict areas. • Train local staff and help rebuild damaged health facilities. • Use mobile medical units to reach displaced or remote populations.
Pathfinder International	16 countries, including India, Pakistan, Nigeria, Egypt, and Bangladesh	• Expand access to contraception through clinics, pharmacies, and community health workers. • Focus on youth-friendly and women-centered family planning services. • Strengthen public health systems and supply chains.

Organization/ Link	Scale/coverage (whole organization, not necessarily mobile clinics)	What they do
		• Advocate for sustainable funding and supportive policies.
Engender Health	Operating in 9 sub-Saharan countries and India	• Improve the quality and accessibility of family planning and reproductive healthcare. • Train providers in mCMs and counseling to ensure informed choice. • Support governments to strengthen reproductive health policies and services. • Operate mobile clinics in some settings (e.g., Bangladesh).

Attention and Funding

Provision of mCMs in LMICs has attracted significant funding and attention. UNFPA reported over $1.5 billion in revenue and expenses for 2023 (UNFPA, 2023); DKT International's 2023 expenses exceeded $250m (DKT International, 2024); and IPPF reported income of $116m in 2024 (IPPF, 2025). The Gates Foundation has indicated plans to expand work in this area (Gates Foundation, 2024), with multimillion-dollar funding for mobile clinics dating back more than a decade (Gates Foundation, 2014).

This picture indicates both an appetite for further funding as well as a competitive landscape for NGOs operating in this area. Given the interest of funders, it is plausible that a new charity could attract funding if it could differentiate itself in this crowded field; however, this may prove challenging, and further discussions with recently incubated charities in this space may provide clarity around funding challenges and opportunities.

5.2 Geographic assessment

We conducted a preliminary geographic assessment (GA) to identify which countries to include in our cost-effectiveness analysis.[5] The full model is available here.[6] It is based on three variables, as described in Table 3.

Table 3: Variables and weights used in the geographic assessment

Variable	Data source and manipulations	Strengths/weaknesses	Weight
Price level ratio of PPP conversion factor (GDP) to market exchange rate	World Bank – variable normalized or z-scored.	A proxy for the purchasing power of philanthropic dollars in a country, usually Gross Domestic Product per capita.	30%
Conditional unintended pregnancy rate (per 1000 women of reproductive age)	Bearak et al. (2023) – variable normalized or z-scored.	An indicator of the prevalence of unintended pregnancies. This variable captures how dense or concentrated unintended pregnancies are.	35%
Number of unintended pregnancies per year	Bearak et al. (2023) (as above), multiplied by population figures from the World Health Organization. Variable normalized or z-scored.	This variable additionally captures the total number of unintended pregnancies, so that larger countries – with more space for scaling – are prioritized.	35%

These three factors generated the following initial list (top ten, in ranked order): Burundi, Somalia, Angola, Nigeria, Uganda, the Democratic Republic of the Congo (DRC), Syria, Zambia, Mauritania, and Chad.

[5] Note that we are trialing a new way of carrying out geographic assessments, focusing on fewer—more standardized—variables to order countries based on a rough prioritization. As such, we ask that this GA be read as preliminary, rather than a confident ordering of countries by their promisingness.
[6] Reported as of 23 January 2026. Note that our models are live and may be subject to tweaks or (in rare occasions) large changes that may not be reflected in the text if carried out after publication.

We next removed countries where we thought it may be challenging to operate due to political stability or safety reasons, and selected the top five remaining countries for cost-effectiveness modeling. The results from this model are summarized in Table 4 below (see Cost-effectiveness analysis for more details):

Table 4: Results of CEA, showing the top candidate countries for this work.

Rank	Country	GA score	Purchasing Power Parity	Conditional unintended pregnancy rate (per 1000 WRA[7])	Estimated cost per additional year of mCM use (10 clinics)	Estimated cost per additional year of mCM use (50 clinics)
1	**Burundi**	1.13	0.16	274	$9.3	$6.4
3	**Angola**	1.04	0.25	283	$6.7	$4.5
4	**Nigeria**	0.93	0.13	224	$6.9	$4.6
5	**Uganda**	0.93	0.33	280	$11.4	$7.9
8	**Zambia**	0.78	0.29	240	$14.5	$9.7

Based on our (limited) research, mobile clinics for family planning have been deployed in all of these countries, though to varying extents:

- In **Burundi**, the only active project we have found involves four outreach teams run by IPPF.
- In **Angola**, we have found mentions of limited numbers of mobile clinics being run by UNFPA and by the Ministry of Health.
- In **Nigeria**, MSI operates 24 outreach teams. IPPF also operates some outreach teams in the country, but does not specify their number.
- In **Uganda**, mobile clinics are operated by MSI, IPPF, and UNFPA. Mobile outreach teams also seem to be operated directly by the Government of Uganda
- In **Zambia**, MSI, IPPF, and the Government of Zambia operate mobile clinics.

Based on the above information, our preliminary judgment is that, of these five countries, Uganda and Zambia are *likely non-neglected*, while Burundi, Angola,

[7] WRA = women of reproductive age

and Nigeria *likely have significant space for new charity* focused on running mobile outreach services.

In any case, **we would like to reiterate that coordination with existing NGOs is crucial in order to maximize additionality**.

6 Cost-effectiveness analysis

Link to our model.

The model estimates the **cost per additional year of contraceptive coverage**. We calculated the **cost per protection ("YoP"[8]) against unintended pregnancies** at three scale scenarios (10, 25, and 50 clinics) across the **five countries prioritized in the geographic assessment**.

6.1 Results

Overall, we estimate the intervention costs approximately **$10/YoP at small scale** (10 clinics), **$7.4/YoP at medium scale** (25 clinics), and **$6.6/YoP at large scale** (50 clinics). Table 5 reports country-level cost-effectiveness estimates across these scale assumptions.

Table 5: Country level cost-effectiveness estimates across scale.

Country	$ per CYP assuming 10 clinics	$ per CYP assuming 25 clinics	$ per CYP assuming 50 clinics
Burundi	$9.3	$7.1	$6.4
Angola	$6.7	$5.0	$4.5
Nigeria	$6.9	$5.2	$4.6
Uganda	$11.4	$8.8	$7.9
Zambia	$14.5	$10.9	$9.7

[8] This is the term AIM uses to capture a year of protection, adjusted for (estimated) counterfactual uptake of modern contraceptives or the use of traditional methods. A YoP is closely related to the widely-used concept of a couple-year of protection (CYP). However, a CYP is a metric specifically designed to quantify the *outputs* of family planning programs, not the achieved *outcome*. It is calculated by multiplying the quantity of each contraceptive method distributed to clients, with each method having a defined conversion factor (e.g., 1 IUD = 4.6 CYPs), without adjusting for counterfactuals. As such, we do not use the CYP concept when reporting our results.

Across all countries and scale scenarios, estimated costs per year of protection are well below **GiveWell's benchmark of $20 per counterfactual year of modern contraceptive use** (GiveWell, 2025), clearing this threshold by a substantial margin.

Other models

MSI Reproductive Choices published the results of a cost-effectiveness analysis in 2024, finding an average cost per couple years of protection of $4.88 (Blake, 2024). While the results are very similar to those reached here, the analysis itself is not published, making it difficult to compare the two.

6.2 Modeling choices

Costs

At scale, we assumed fixed costs would be $325,000 per year. This includes core staff salaries (set to $50k per year per staff member for five full-time staff), as well as 15% overhead.

We estimated variable costs to be approximately $58,483per clinic per year. This includes the cost for the vehicle which serves as a mobile clinic (annualized), contraceptive commodities, equipment and consumables, local clinic staff (two medical and one driver), staff training (five days per year, and vehicle fuel and maintenance.

Table 6: Total cost per clinic

Cost component	Annual cost per clinic (USD)
Fixed costs	***$325,000***
Fixed staff	$250,000
Overhead	$75,000
Variable cost	***$58,483***

Outreach and demand generation	$3,762
Cost for contraception and equipment	$31,446
Annualized vehicle cost	$11,508
Staffing Cost for Clinics	$11,767

We envisioned a mobile clinic that would provide a range of contraceptive options, including IUDs, implants, injectables, and pills. We used UNFPA cost data from 2022 for each contraceptive method (UNFPA 2022) and multiplied these by the expected number of each method delivered annually by a mobile clinic (see Reach for details on how service volumes were calculated).

Reach

Reach was estimated using real-world service delivery data from 16 countries. The primary dataset comes from 15 MSI country programs (Duvali, 2014), supplemented with one additional report from Mozambique (DK International, 2024). Combined, these sources cover 1,993,652 family planning clients served by 229 mobile outreach teams.

Across the MSI dataset, mobile outreach teams delivered an average of 2,609 implant insertions per team per year. Because implants were the only method consistently reported across countries, we used implant volume as the anchor for estimating total contraceptive provision per mobile clinic. Full details are provided in the CEA spreadsheet (Reach (data input) tab).

To estimate provision of other modern contraceptive methods, we used three real-world sources reporting method mix in mobile outreach (MSI Annual Report 2020, MSI Zambia 2018, PSI- Mobile outreach, Nigeria 2019). Across these sources, the average method mix was:

- 49.3% implants
- 22.0% IUDs
- 18.4% injectables
- 8.4% pills

Methods contributing less than 1% were excluded. Applying this distribution to the average implant volume implies annual per-clinic provision of:

- 2,630 implants
- 1,173 IUDs
- 983 injectables
- 450 pills

We used this as a baseline and adjusted country-level reach for environmental constraints that may limit operations. Across the 16-country dataset, programs experienced an average of 3.8 rainy months per year (mean precipitation 154 mm/month). The five focal countries experience 5.3 rainy months on average (148 mm/month). We therefore applied an 8% downward adjustment to reflect reduced operating days and access during adverse weather. This adjustment is approximate; more precise approaches incorporating road quality and transport constraints would improve future estimates.

Under these assumptions, we estimate that a mobile clinic provides **approximately 4,833 contraceptives to clients services per year** (range **4,497–5,058**).

Counterfactuals

The primary counterfactual is whether clients reached by the intervention would have obtained modern contraceptive methods (mCMs) through other channels in the absence of the program. Baseline mCM prevalence for each country was drawn from World Bank data, which report data through approximately 2017–2022, depending on the country.

To align these data with the intervention start year, we projected mCM use to 2025 by linearly extrapolating recent country-specific trends. We consider this approach more conservative than relying on older point estimates that may understate current access and uptake at the time a new program begins.

We then assumed that the share of the population already using mCMs in each country represents the proportion of clients who would have counterfactually accessed contraception without the intervention. Estimated impact was therefore

discounted by baseline mCM prevalence in each country. This assumption may be conservative, as the intervention is targeted toward rural and hard-to-reach areas, where mCM use is likely lower than national averages.

Across the countries considered, estimated mCM use ranged from **14% in Angola** to **58% in Zambia**, resulting in corresponding downward adjustments to counterfactual uptake.

Effects

The effect size was calculated by multiplying the estimated number of counterfactual mCM users (see Reach and Counterfactual) by the couple-years of protection (CYP) per user for each method. CYP conversion factors were taken from USAID, which already account for typical use, method failure, discontinuation, and wastage (USAID, 2022).[9]

Table 7 summarizes the estimated number of users of each method and CYPs generated per clinic per year.

Table 7: Breakdown of mCM users and CYPs provided for different methods, per clinic per year.

mCM Type	Total provided per clinic per year	Counterfactual mCM users	CYP per user	CYPs per Year
Implants	2,630	1,640	3.15	5,168
IUDs	1,082	732	4.7	3,438
Injectables	907	613	1.0	613
Pills	415	281	0.9	253

[9] USAID explains how CYP is calculated: "CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized." (USAID, 2022)

Sensitivity Analysis and Considerations

The cost-effectiveness analysis relies on various assumptions, as well as on approximate inputs. We used conservative assumptions—high-end cost estimates and low-end reach or impact figures—which may underestimate reach and overstate costs. However, uncertainty around counterfactuals (how many patients would have accessed contraception elsewhere) and the presence of existing NGO programs could lead to overestimates. Table 8 summarizes the key parameters driving this sensitivity.

Table 8: Factors that could affect cost-effectiveness

Factors that could increase cost-effectiveness	Factors that could reduce cost-effectiveness
• The charity is likely to work in areas where contraceptive use is much lower than the national average, meaning. • Vehicle costs could be substantially lower if used vehicles were purchased. • The charity may be able to co-fund contraceptives with the government • The charity may be able to charge the users a small fee for the service. Anecdotally, this may increase trust and therefore uptake. • The cost of injectable contraceptives may decrease, as they have recently become generic.	• Other NGOs may already be operating mobile clinics in regions where the model is the most cost-effective. • Poor or unreliable infrastructure may make some rural areas inaccessible, or unpredictably accessible, to mobile clinics. • Additional staff training may be needed and could be costly and challenging to source if specialized skills are required. • Setting up a mobile clinic operation in a country may be more costly than we assumed.

7 Implementation considerations

This section discusses implementation factors that we think are of relevance for assessing the tractability of this charity idea and for helping potential founders understand how to take this idea to scale.

7.1 What operating this charity would look like

Figure 3 highlights how we'd characterize this proposed idea along an explore-exploit continuum.[10] Mobile clinics for contraceptive expansion is a well-established intervention, placing it close to the "exploit" end of the spectrum. However, charity founders will still need to find novel ways of implementing and targeting this program, especially in order to reach new areas that are not being served by existing family planning programs.

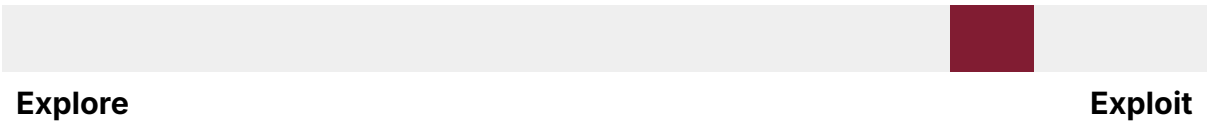

Figure 3: Explore-exploit continuum

After identifying a region where running mobile clinics would be safe, cost-effective, and additional, the charity will need to:

- **Coordinate with existing actors**: Liaise with NGOs and local health authorities to ensure work complements rather than duplicates existing services.
- **Establish supply logistics**: Secure and manage a reliable supply of mCMs and medical consumables. Partner with procurement agencies and other NGOs to strengthen supply chains through pooled purchasing or volume guarantees.
- **Register as a provider of medical services:** As a charity directly employing healthcare providers and providing medical services, this charity will need

[10] Our recommendations can be characterized along a spectrum between exploration and exploitation—ideas closer to exploration require more research and design, and involve riskier bets and wider confidence intervals; ideas closer to the exploit side of things usually have narrower confidence intervals and rely more on replication/expansion of well-developed and concrete interventions.

to ensure it strictly follows any local requirements and regulations for such an operation. We expect this would initially be most feasible through collaboration with an existing, locally registered NGO.

- **Engage communities**: Conduct targeted community outreach and behavior-change communication to build trust, counter misinformation, and maximize uptake. This may be done in low-cost ways via community volunteers/ambassadors, either identified by the charity itself or in collaboration with other NGOs operating in the same geographies.
- **Plan clinic routes and operations**: Create a feasible schedule for mobile clinics, mapping reliable routes that efficiently connect rural and underserved communities. Continuously monitor routes based on demand, terrain, and seasonality, keeping the schedule as reliable and consistent as possible.
- **Recruit and train staff**: Source or design a training program that ensures high-quality counseling, informed consent, and cultural sensitivity. Include protocols for follow-up visits.
- **Coordinate human resources**: Liaise with local health systems and NGOs to avoid drawing critical staff away from existing facilities and to identify opportunities for joint staffing or training.
- **Ensure regulatory compliance and client safety**: Obtain required licenses, adhere to national clinical standards, and implement safeguarding and confidentiality protocols.
- **Monitor and evaluate performance**: Track key metrics such as uptake rates, clients served per day, days of operation per year, method mix, follow-up rates, and quality of counseling. Incorporate client-feedback mechanisms and periodic cost-effectiveness reviews.
- **Plan for sustainability**: Develop a maintenance plan for vehicles and equipment, and explore long-term funding once proof of concept is achieved.

7.2 Key operational factors

This section summarizes our concerns (or lack thereof) about different aspects of a new charity putting this idea into practice.

Table 9: Implementation concerns

Factor	Level of concern
Talent	Low
Access to information	Moderate
Access to relevant stakeholders	Moderate
Feedback loops / monitoring and evaluation	Moderate
Execution difficulty/tractability	Moderate
Complexity of scaling	Low
Risk of harm	Low-moderate

Talent

The following backgrounds or skillsets would likely be useful for at least one of the co-founders (or early hires) of this charity:

- **Complex operations management**: Designing and running mobile service delivery entails planning routes around poor infrastructure, seasonal weather, and security constraints. Strong aptitude for operations management is therefore key.
- **Comfort with operating in low-resource environments**: Part of this work may involve spending days in remote, low-resource areas of very poor parts of the world, requiring a high level of resilience.
- **Skilled at networking and relationship building,** as the charity will need to form positive relationships with governments, local communities, and third-party NGOs who already operate in this space.
- **Experience managing complex supply chains** to ensure uninterrupted supplies of contraceptives and medical consumables, without stockouts, and at low prices.

- **Commitment to maintaining quality of care**: While a key objective is to run this charity in a cost-effective manner, it cannot come at the cost of poor medical care, such as improper sterilization, insufficient counseling on side effects, or a lack of follow-up care and contraceptive removal services

Access

Information

Access to high-quality, disaggregated data on contraceptive use varies dramatically by country. In some contexts, national and subnational data systems publish state- or even district-level indicators on modern contraceptive prevalence, method mix, and unmet need. This allows rapid identification of underserved areas and benchmarking of potential impact. Elsewhere, equivalent data may be scarce, outdated, or aggregated only at the national level, making it difficult to target regions or evaluate outcomes reliably. Irregular survey intervals can widen this information gap. In some regions, a charity will need to rely in part on data from experts or NGOs rather than standardized metrics.

Relevant stakeholders

The family-planning landscape is dense with potential entry points: hundreds of NGOs and local health partners already operate mobile or outreach services. However, **organizations may be cautious about engaging with new actors they perceive as competitors for funding or geographic territory**. This may limit information-sharing and delay partnerships, even when objectives align.

Feedback loops / monitoring and evaluation

Key outputs should include the number of clinic-days delivered, patients served, and additional years of contraceptive coverage generated. These are straightforward to track using standard service-delivery data, making it relatively easy to see whether operations are being delivered as planned. Assessing

outcomes (sustained contraceptive use and improved access among underserved groups) is harder, but feasible through follow-ups or short client surveys.

The main challenge lies in establishing additionality, since overlapping NGO programs can obscure how many clients would have accessed contraception elsewhere. Tracking first-time users and uptake in previously unreached areas offers potentially useful proxies.

Full experimental studies are unlikely to be practical or ethical, but ongoing feedback on service delivery should still provide useful guidance for real-time adjustments and improvements.

Tractability

Overall, we rate this idea as having medium tractability.

In politically stable, safe, and accessible settings, tractability is high, as demonstrated by the extensive experience of other NGOs in this space. However, expansion to less stable or harder-to-reach regions may present a range of challenges that the founders will have to navigate.

Day-to-day operations such as staffing, route planning, vehicle procurement, and supply-chain management are all generally manageable. More significant challenges relate to ensuring reliable supply chains and building effective relationships with local health authorities and NGOs, but should be possible. Greater constraints come from security risks, weather conditions, and especially poor infrastructure, which have the potential to limit operations in some target areas.

Setting up a new mobile clinic operation may prove challenging. Even establishing a single clinic will likely require a substantial upfront investment of time and resources. While this is feasible, it is more difficult than some other charity ideas AIM has explored, particularly those that can be easily piloted at a smaller scale.

Complexity of scaling

While we expect the initial set-up to be somewhat complex, scaling up a charity in this space should be highly feasible. The model's core components (vehicles, trained staff, and steady supply chains) are well established and relatively straightforward to replicate across regions. Ensuring consistent service quality is feasible with centralized oversight, although relying on multiple partner organizations could create coordination and data-reporting challenges. Expansion will be slower than digital programs due to the need for staff training and fleet growth, but once systems are in place, replication can proceed quickly in stable, well-connected areas. Overall, this is a proven, scalable model with moderate logistical demands and relatively low risk of quality loss as it grows.

Risk of harm

Risks of harm are generally low, though not negligible. Staff could face safety risks if clinics operate in insecure regions or areas where contraception is controversial. For beneficiaries, risks include poor counseling that leads to coercion or discontinuation, or potentially substandard infection control. These risks should be manageable with proper training, quality assurance, and community engagement, as well as thorough research of on-the-ground conditions before expanding to any particular area. Overall, risks of harm are limited and well understood, with most mitigations already standard practice in established outreach models.

7.3 Remaining uncertainties

Several uncertainties remain:

- True additionality: in many cases it is likely to remain unclear how many clients would have accessed contraception elsewhere.
- Regional variation: costs, uptake, and reach likely differ sharply across contexts within the same country.

- Reliability of supply chains and road access in remote areas.
- Quality and consistency of counseling across staff and regions.
- Degree of cooperation or competition from existing NGOs.
- Accuracy of modeled cost assumptions.
- The extent of political or cultural resistance in conservative regions.

8 Conclusion

Mobile outreach for contraceptive expansion represents a credible opportunity for a new charity to achieve scalable, cost-effective impact in settings where access to modern contraceptives remains limited. The intervention is supported by a clear and well-supported theory of change, addresses persistent access barriers faced by rural and hard-to-reach populations, and builds on extensive implementation experience across multiple countries.

While the space is not highly neglected, our analysis suggests that meaningful geographic and operational gaps remain. In particular, there is scope for impact in underserved subregions where careful targeting, reliable supply chains, and consistent, high-quality service delivery, including counseling and follow-up, could generate additional impact.

Overall, we are excited about the potential impact of this idea and recommend mobile outreach for contraceptive expansion for incubation through the Charity Entrepreneurship Incubation Program.

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