Improving Women’s Access to Mobile Family Planning Services

By Luk Van Wassenhove , INSEAD

Cash-strapped NGOs could reach more clients in rural areas – at no extra cost – by basing their visit frequency on data instead of habits.

Put yourself in the shoes of Maïly, a fictitious community outreach manager working for an NGO. In charge of running mobile family planning clinics in Kenya, she can deploy 12 medical teams. Each of them can only set up about one mobile clinic per (working) day since the villages are often far apart and difficult to reach. In certain locales, all it takes to attract a crowd is a driver with a megaphone announcing that the team is on site. In others, filling the clinic requires more advance marketing through radio spots or posters.

Maïly’s problem is: Which villages should her teams visit and at what frequency, considering their diverse needs? With limited resources, it could be tempting to just stick to the busy locales. But over time, frequent visits to the same sites could become less fruitful, as family planning needs might be met. Also, out of equity concerns, she cannot neglect the other villages. If clinic visits become too far and few in between, patients will stop trusting the

NGO – or simply turn to other solutions. In addition, it would be unethical to deny patients the opportunity of regular follow-ups after certain medical procedures, such as the implantation of an intra-uterine device.

To study this problem of optimal resource allocation, **Harwin de Vries**, **Lisa Swinkels** and I partnered with Marie Stopes International (MSI, renamed MSI Reproductive Choices in 2020), an NGO that gave us access to a large dataset of mobile family planning visits in Madagascar, Uganda and Zimbabwe. This allowed us to model the relationship between the number of patients seen during a team visit and the time elapsed since the last visit. We were able to develop simple frequency policies that showed a potential increase in patient numbers of between 7 and 10 percent. In the context of MSI's work, an increase of only 7 percent would mean more than 175,000 additional families to whom family planning services could be provided globally, per year.

This is important because access to family planning plays a crucial role in achieving many of the UN Sustainable Development Goals (SDGs). Aside from reducing unintended pregnancies, universal access to contraception is estimated to reduce maternal deaths by 25 percent and infant mortality by 10 percent. By allowing women to postpone the birth of their first child, it also helps them advance their education. In all, family planning supports four UN SDGs: good health and well-being (3), no poverty (1), quality education (4) and gender equality (5). Sadly, in many rural areas of the world, access to such services is limited or non-existent. In a context of shrinking funding, optimising the reach of the NGOs that do provide these services is critical.

Simple policies can go a long way

Often, NGOs grow organically. They start with a few outposts, perhaps based on the founders' networks. As they grow, their leaders are reluctant to impose policies because of a culture that favours decentralised decisions. There are indeed several factors that support this decentralisation. Who better than those on the ground to know about weather and road conditions, market days and other local variables? But over time, this can lead to spaghetti-like growth. Decisions can become based on sheer force of habit, more than on logic.

The great news is that, according to our research, simple rules are good enough. We found that merely splitting visit sites into two different categories (based on historical visit data) and assigning a specific visit

frequency to each category would increase the number of patients served by up to 10 percent. In most cases, moving from two to three categories – and thus complexifying the frequency rules – would improve reach by a mere additional 1 percent. Simple rules fit the organisational culture of NGOs, which values flexibility and local staff empowerment.

While our study looked at a family planning NGO operating in Africa, our findings apply to mobile health access initiatives in general. Whether the health needs are related to Covid, tuberculosis or dengue for example, and whether the mobile health teams are acting in Africa, Asia or South America, designing simple rules to streamline outreach efforts could yield profound results.

Impact is often difficult to measure. It is far from being a number-only game. Reaching fewer people can be meaningful if these people couldn't otherwise dream of accessing health services. But whatever the aims of an NGO might be, it is important to start with some data, such as the number of clients or patients served and the number of visits.

Leaders of outreach teams like Maïly should receive basic analytics training. Outreach frequency matters and it must be reviewed periodically, with a critical eye. However, just as importantly, leaders should know how to incentivise their teams to adhere to simple policies. There may be valid reasons for them to deviate from the recommended visit frequency – such as weather, accessibility or security – but overall, simple rules, when followed, can help scale up access without additional investments.

Find article at
https://knowledge.insead.edu/operations/improving-womens-access-mobile-family-planning-services

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About the research

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