Taking Family Planning Services To Hard-to-Reach Populations

By Patricia Donovan

In a 1995 survey of the nation’s 3,119 family planning agencies, three-quarters of those questioned reported that they provide contraceptive services to such hard-to-reach populations as substance abusers, incarcerated men and women, the disabled, the homeless and non–English-speaking minorities. However, the survey results left unclear the scope of these services, and did not indicate whether agencies specifically target these populations through outreach, education and specialized services, or simply provide standard services to individuals from these groups when they seek care.

Recent interviews with roughly 100 administrators, program supervisors and clinicians in family planning agencies that make special efforts to serve hard-to-reach groups provide insight into the range of services offered. Some of these efforts are large, collaborative undertakings involving several agencies and substantial public funding, while others are small programs that may reach no more than 10–15 people a year and receive little or no outside support. Some programs are multiyear demonstration projects, others are short-term or even one-time events. Organizations may target education and counseling or provide direct medical services. Some agencies provide services at their clinics, while others conduct outreach and provide education and family planning services in substance-abuse treatment centers, homeless shelters, prisons and other nontraditional sites where hard-to-reach populations live or congregate.

Family planning providers generally agree that these hard-to-reach populations are desperately in need of services. Many report that it is not uncommon for homeless, incarcerated or substance-abusing women to have gone 10 years or more without a Pap test; some have never had a pelvic examination. Kay Armstrong, research director at the Family Planning Council of Southeastern Pennsylvania in Philadelphia notes that “many [drug abusers] don’t have homes, they’re constantly changing relationships, they don’t have money. Health care is often at the bottom of their priority list.”

Karen Andrade, director of community services at Planned Parenthood Association of the Mercer Area, Trenton, N. J., which has special programs for Hispanic women and homeless women, agrees: “There are so many issues in the lives [of these women] that health care for themselves is not a priority.” Consequently, many women who are homeless or drug-involved have more health problems, and more serious ones, than clients usually seen by family planning providers.

This article provides a sampling of the kinds of programs family planning agencies offer for hard-to-reach populations and examines some of the problems that agencies encounter in their efforts to serve these groups. The contacted agencies were selected in a variety of ways: Some were respondents to the 1995 survey; some were identified by state or regional health department officials; and others were suggested by fellow providers of services for hard-to-reach groups. The interviews on which the article is based were conducted between December 1995 and March 1996.

**Special Programs**

**Substance Abusers**

According to the 1995 survey, family planning agencies are somewhat more likely to target substance abusers than other hard-to-reach groups. The link between illegal drug use and infection with human immunodeficiency virus (HIV), the virus that causes AIDS, and the availability of federal and state funding for programs designed to prevent HIV infection among high-risk groups are probably the primary reasons why programs for drug and alcohol abusers are relatively common. Some of these programs focus almost exclusively on HIV prevention, but others offer comprehensive family planning services and related education and counseling.

Michigan launched a major initiative to link substance abusers with family planning services and other primary health care about four years ago at the direction of the state legislature. Concerned about the effects of drug use during pregnancy, lawmakers have earmarked funds since 1992 to support pregnancy prevention programs among women who abuse drugs. The funding—$1,004,100 in 1996—supports five demonstration projects operated by different types of family planning providers under the direction of the state health department.

One of the participating agencies is Hutzel Hospital, a large public hospital in Detroit. Nurses from the hospital’s family planning clinic teach a 14-week course for women in 12 substance abuse rehabilitation centers in the city, including residential treatment centers, outpatient facilities and halfway houses. Among the topics covered are sexually transmitted diseases (STDs), birth control, communication skills, conflict resolution, coping with the fear of violence and self-esteem. Nurses also offer pregnancy testing and distribute condoms on site. Women are referred to the hospital’s family planning clinic for medical services and prescription contraceptives. If necessary, the hospital assists with transportation expenses.

Nancy Hauff, director of community outreach for the hospital, estimates that several thousand women in the various rehabilitation centers attend the education sessions each year and that 500–1,000 women seek services at the clinic. As a Title
X recipient, the hospital’s family planning clinic uses a sliding-fee scale to determine charges for its services. According to Hauff, most of the women from the rehabilitation centers have incomes below the poverty level and therefore do not pay any fees.

The family planning office of the Saginaw County Department of Public Health is another participant in the Michigan program. Twice a month, a nurse educator from the family planning office provides information on birth control, STDs, HIV and AIDS, and other reproductive health issues to men and women in two residential substance abuse centers. The agency also provides on-site clinical services, including Pap tests, HIV testing, STD screening, treatment and follow-up, and the full range of contraceptive methods. “We pull out privacy screens from a corner and transform the [conference] room into a clinic for a day,” reports Joyce Howey, a nurse educator at the health department who oversees the program.

The Planned Parenthood affiliate in Grand Rapids also participates in the state’s program for substance abusers. Initially, the agency conducted education and counseling sessions on STDs and HIV, contraception, sexual assault and fetal development in two residential treatment centers and one outpatient facility. It has since expanded to more than a dozen sites, including a homeless shelter, a county jail and a juvenile detention facility. Women who complete the education sessions and those released from the treatment centers or from prison are referred to Planned Parenthood for medical services.

In 1994–1995, some 5,000 women took part in Planned Parenthood’s education sessions; more than 250 women went to the clinic for medical services during that time. Jan Lunquist, the agency’s vice president of education and professional development, notes that for some of these women, “we’re the only health care they’ve ever had.”

The outreach educator serves as the women’s case manager, making clinic appointments and greeting them when they arrive. “Many...have shared how important it was for them to see the same face and know that I would take a special interest in their health concerns,” adds educator Kim Duursma.

The Family Planning Council of Southwestern Pennsylvania has funding from the Centers for Disease Control and Prevention (CDC) to operate full-service Title X family planning clinics in five drug treatment centers. The clinics, which are open 2–3 days a week, served 365 men and women in 1995. The project, which began in 1991, is funded through September 1997.

Planned Parenthood of the Rocky Mountains in Denver also provides comprehensive family planning services in treatment centers for substance abusers. Initiated and funded by the Colorado health department, the program (“Go Where You’re Needed”) delivers family planning counseling, medical services and contraceptives, including the hormonal implant and the injectable, via weekly nurse practitioner visits to six centers. The program has served 550 patients since its inception in 1994.

The Family Planning Council of Western Massachusetts operates several programs for substance abusers, all funded by state HIV-prevention funds. It received $20,000 late in 1995 to initiate a needle-exchange program for intravenous drug users in the town of Northampton, the only city in the western part of the state where such exchanges are legal. Beyond supplying clean needles, other HIV prevention services and family planning information, the program strives “to link these individuals to appropriate health services that they are ready to take advantage of,” says Timothy Purington, director of the council’s HIV Risk Reduction Project. “The key is [not to] push any services, but to create an environment where it is safe to talk about a person’s needs at this time.” The council hopes to eventually integrate the needle-exchange program into its regular family planning clinic.

The council is also working to incorporate needle exchange into its traditional street-outreach program, which began about two years ago and receives about $84,000 a year in state HIV funds. Outreach workers visit parks, bars, sex abuse treatment programs, housing projects and other settings where intravenous drug users might be found to try to recruit them into a basic AIDS education session held in the community. They also offer HIV counseling and testing on site. When appropriate, council staff members refer drug users for other health services and arrange transportation.

**Prison Inmates**

Programs for incarcerated men and women range from basic sex education classes to comprehensive reproductive health care. Some focus heavily on HIV prevention, reflecting the fact that many of the inmates are incarcerated for drug-related offenses.

Planned Parenthood of Central Texas in Waco offers a sex education course at a state prison for women. Between 30 and 35 inmates attend sessions that cover reproductive anatomy, common gynecological problems, contraception, STDs and HIV, and parenting skills. (Nearly all of the inmates have children, and many are coping with long-distance parenting.) The agency receives no support from the prison system for its program, which began about five years ago; the roughly $5,000 in annual staff and travel costs are absorbed by the agency’s education budget.

Planned Parenthood of the Southern Tier, near Elmira, New York, teaches two classes at a medium-security prison for men who are about to go through the parole process. The sessions cover safer-sex practices, STDs, reproductive anatomy, pregnancy and contraceptive methods. “The participants are very receptive,” reports Margaret Stumpf, the agency’s director of education and counseling. At first, “it seems strange to them to have a middle-class lady come out of nowhere to talk to [them] about sex...[but] they get over it.”

The Family Planning Council of Western Massachusetts has programs in three county jails. As part of its contract with the state, it provides voluntary HIV counseling and testing at one of these sites. At the others, it conducts HIV and AIDS risk-reduction education classes as well as classes on birth control, STDs, sexual decision-making and parenting skills. The council’s courses go “beyond [providing] basic information. [They explore] how inmates can apply information to their lives [and]...what changes they need to make in their behavior to protect [themselves],” explains Timothy Blake, a community health educator at the council.

The Family Planning Council of Southeastern Pennsylvania has a three-year, $150,000 matching grant from a local non-profit agency to conduct group parenting education, followed by individual counseling in three correctional facilities for women. A total of 50–60 women participate in the program at any given time. Most of the inmates have children, and the 12-week course, aimed at reducing child abuse and neglect, focuses on issues related to their separation from their children. The course also covers child growth and development, prenatal care, well-baby and well-child care, and child immunization and safety, as well as a variety of women’s health issues.

Individual counseling continues every 1–2 weeks, from the end of the course until an inmate’s release. Both in the course and in the individual sessions, the council’s educators try to help the women address feelings of guilt and anxiety about the long separation from their children, as well as...
to help them prepare for “reacquaintance” visits with their children during their incarceration. The women are followed for 3–4 months after their release to ensure that they are receiving necessary services, such as drug and alcohol treatment, family planning services, ongoing parenting support and Medicaid coverage.

Nonetheless, program director Dottie Shell reports that there is a lot of recidivism: “The lives they lead, the places they go back to, are so tangled, it is hard” for the women to meet their parole rules and stay out of trouble.10

In Saginaw, Michigan, the health department’s family planning office provides gynecologic services as well as education to women in the county jail, most of whom are incarcerated for drug-related crimes. The program is part of a state-funded project to provide services to substance abusers. Women go through the education session first and then have the option of scheduling appointments for pelvic exams, STD screening and contraceptive services.

Family planning agencies may also provide services to juvenile offenders. Planned Parenthood of East Tennessee, in Oak Ridge, conducts a sex education class at three group homes for boys who range in age from 12 to 18. Roughly 12 boys attend sessions that cover birth control, pregnancy, choices for resolving an unplanned pregnancy and STDs and AIDS. Planned Parenthood receives no direct support for the program; however, contributions to the agency’s general education program from the United Way and a grant from a local foundation to encourage male responsibility help cover the program’s costs.

“This is really important work,” observes Judy Roitman, the agency’s education outreach coordinator, who conducts the classes. “These kids are really high-risk. They act out sexually, they’re involved with drugs. It is an important group to reach.”

In Pittsburgh, the Department of Adolescent Medicine at Children’s Hospital, which provides family planning and other reproductive health services at the hospital, delivers many of the same services to every young person who is admitted to a local juvenile detention center. Within 48 hours of their admission, a clinician meets with the teenager to, among other things, discuss his or her sexual and childbearing history, screen for STDs, discuss birth control, if appropriate, and provide HIV prevention education. The services at the detention center are funded under a contract between the adolescent medicine department and the county.

### The Homeless

Family planning providers use a variety of approaches to reach homeless women. While some agencies offer services directly at homeless shelters, others use outreach workers to recruit women from the streets and from other settings into traditional family planning clinics. Some agencies provide care at nontraditional sites that offer services to the homeless and other hard-to-reach groups.

The Family Planning Council of Southwestern Pennsylvania, in addition to its programs in drug treatment centers, operates full-service Title X clinics in three homeless shelters in Philadelphia. Services are available 2–3 days a week to shelter residents only. More than 200 men and women used the shelter clinics in 1995.

In Trenton, New Jersey, the Planned Parenthood affiliate sends outreach workers to shelters, soup kitchens, city welfare offices and even street corners in an effort to identify homeless women and encourage them to come to the clinic for free family planning services. The program, known as “Get Safe,” is funded by a three-year, $250,000 HIV-prevention grant from the state; it is part of a collaborative effort with two other community-based organizations to target HIV risk-reduction education and services and case management to populations at greatest risk of HIV infection.

In addition to homeless women, Planned Parenthood targets women who trade sex for drugs and those who live in shelters for battered women. The other agencies involved in the collaborative effort provide services to men who have sex with men, as well as to juvenile offenders and runaway youths.

The San Francisco health department operates a clinic exclusively for homeless women and men. On one day a week, it offers free gynecological care and medical referrals. The clinic, located in a part of the city where, according to family planning coordinator Stephen Purser, “there are lots of doorways to sleep in,” is frequented by a large number of transients. The health department also provides contraceptive and other reproductive health care to homeless and other high-risk women in such nontraditional sites as a drug rehabilitation clinic and a clinic housed in a church. “The idea,” says Purser, is to offer services “where high-risk women are already going for other services.”

### Disabled Persons

A 1993 survey of federally funded family planning clinics found that only a “negligible” number of disabled women were served in these sites.11 To the extent that family planning agencies do reach out to disabled women and men, they are more likely to target services to individuals with developmental disabilities than to those with physical impairments. Moreover, some agencies direct their programs to professionals who work with the disabled, rather than to disabled individuals themselves.

Planned Parenthood Association of Cincinnati, however, does both. It provides training on sexuality issues for professionals—such as case-workers, teachers, and group-home representatives—who work with developmentally disabled men and women or with individuals who suffer from mental illness; it also runs workshops for individuals with physical disabilities. In addition, the agency’s director of education and training teaches a mandatory sexuality education course for all first-year students at the University of Cincinnati medical school; the course includes a segment on sex and disability. Beyond its extensive educational activities, the agency provides annual gynecological exams for women in a group home for the developmentally disabled near one of its sites.

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Many professionals who work with the disabled have difficulty addressing, or even recognizing, their clients’ sexual needs. To that end, Planned Parenthood of Southern Arizona in Tucson receives $3,000 a year from the state to develop expertise through a “human sexuality education cadre.” This group of experts then works with home health-care providers, teachers, group-home employees and others to provide training and technical assistance in managing the sexual and reproductive needs of the developmentally disabled.

Planned Parenthood of Southeast Iowa operates a small sexuality education program at a local agency serving individuals with developmental disabilities. The agency sought Planned Parenthood’s assistance because its own staff felt uncomfortable dealing with sexuality issues. The weekly classes cover issues such as human reproduction, birth control and STDs, as well as...
social relationships, dating, marriage, parenting and sexual abuse. “Most of the men and women are incredibly embarrassed at the beginning,” reports education director Debbie Leoni. “For many, it is the first time anyone has ever talked to them about [these] subjects.”15 Planned Parenthood receives $10 an hour for its services.

The family planning clinic at the University of California at Los Angeles (UCLA) Medical Center conducts outreach and education at four organizations serving the developmentally disabled and at one community mental health center. In individual and group sessions of no more than three people, the program provides information about reproduction, birth control and STDs. Individuals are referred to UCLA or a more convenient clinic for medical family planning services. “This is not like any other health education people normally do in our field,” notes Janice Amar, who runs the UCLA program. “It takes a lot of planning and tailoring [to run] these sessions...You have to go very slowly [and] use a lot of repetition.”

The program’s Title X funding was unexpectedly cut in December, and the agency is currently looking for another source of support. Amar believes the program is critical, especially for men: “[These] men really have no [other] access to reproductive health information.”16

Agencies making special efforts to serve the physically disabled are especially rare; in interviews with 100 family planning agency officials, only five mentioned any efforts to accommodate physically disabled women, and most of those were extremely modest. Barbara Faye Waxman, director of the Americans with Disabilities Act (ADA) and Reproductive Health Project in Los Angeles, says health care providers are often uncomfortable serving women who are physically disabled, and may have difficulty accepting them as sexual beings. She also believes many providers are reluctant to reach out to disabled women because they would then be forced to remodel their facilities to make them accessible to these women.

Waxman argues that family planning clinics supported by Title X are the appropriate reproductive health care provider for disabled women. “It makes sense economically and geographically,” she contends. “Because of...discrimination...a lot of disabled women...are not employed or are underemployed. So they rely on Medicaid and Medicare for health services. [But] since so many private doctors do not accept [Medicaid] anymore, it makes sense for Title X clinics to be prepared to serve this community.” Waxman contends, however, that most family planning providers are not prepared to serve disabled women.17

To remedy this situation, Waxman’s project, which operates as part of the Los Angeles Regional Family Planning Council (LARFPC), provides technical assistance to family planning clinics seeking to improve their accessibility to women with physical disabilities and trying to meet the requirements of the ADA. The project suggests, for example, that information be put onto audio tapes or provided in large-print Braille so that it is accessible to visually impaired clients; that clinics hire staff who can use sign language to converse with hearing-impaired clients; and that clinics purchase a special examination table that can be lowered to wheelchair height to facilitate use by women with impaired mobility.

The project also suggests that clinics either rent space on the ground floor if the clinic itself is not wheelchair-accessible or, if structural changes are not feasible, refer women to an accessible physician who charges comparable fees. In addition, LARFPC has developed a directory of Los Angeles family planning clinics that indicates each clinic’s ability to accommodate women with disabilities.

The UCLA family planning clinic is one of those identified in the LARFPC directory as accessible to physically disabled women. Although the clinic does not do extensive outreach to the physically disabled, it is wheelchair-accessible. The clinic has a hydraulic table and special stirrups for women who are paralyzed and provides patient information and consent forms on audio tapes. The site also has access to the hospital’s sign-language interpreters.

Planned Parenthood of Pasadena has equipped an examination room with a hydraulic table, has installed a phone for the deaf and has a person on staff who can use sign language. In rural areas where its clinic is not wheelchair-accessible, Planned Parenthood of the Rocky Mountains has arranged for disabled patients to see a physician in the community who has a ground-floor office.

Non-English Speakers

Some family planning agencies have special programs and outreach activities targeted to non-English speaking minorities or migrant workers. The Multnomah County Health Department in Portland, Oregon, for example, has teamed up with Planned Parenthood of Columbia/Willamette to operate a program designed to increase knowledge and use of family planning among local Hispanic women. Outreach workers encourage women to come to the health department’s La Clinica de Buena Salud or to Planned Parenthood for counseling and medical services. Women who have children and are at risk of becoming homeless are referred to the department’s clinic. Others are given a voucher for family planning services at Planned Parenthood.

The program, which began in 1994, has funding for three years as a Title X National Priority Project. Originally, the project was intended to increase Hispanic men’s involvement in family planning and STD prevention. However, program officials found men to be unresponsive to their outreach efforts and redirected the program to focus on women instead.

Hispanic women are also the focus of “Take Care!” an HIV prevention and education program operated by Planned Parenthood in Trenton, N.J., where 35–40% of the population is Spanish-speaking; many are recent immigrants from Central and South America. The “Clinica Latina” staff are Spanish-speaking, and they share cultural similarities with the target group. Many of the women do not have Medicaid coverage or other health insurance, but the clinic does not turn away those who are unable to pay.

According to community services director Karen Andrade, about 900–1,000 Hispanic women have used the clinic for medical services since the program’s inception in January 1993. The program, funded by a three-year, $300,000 grant from the state, is also designed to meet the general health care needs of this community. Agency officials plan to continue the program when the grant ends in December 1996; they are currently looking for other sources of support.

In Seattle, the International District Clinic, a community and migrant health center that serves the city’s Asian community, receives Title X funds to provide reproductive health care to refugees from Cambodia, China, Laos, Thailand, Vietnam and elsewhere in Southeast Asia. According to Kimo Hirayama, the clinic’s family planning supervisor, a large majority of the women are first-generation immigrants who speak little or no English.

The clinic logs about 1,000 family planning visits annually. The prenatal and postpartum care that the clinic offers is especially important, notes Hirayama, because the period during pregnancy and immediately following birth “is the one time a lot of our patients will even listen to us about family planning.”18 The clinic does not engage in
extensive outreach activities, but maintains booths at ethnic festivals and other public events to draw attention to its services. A few of the providers contacted for this article reported efforts to reach out to migrant workers, but these programs appear to be extremely modest. Planned Parenthood of the Rocky Mountains, for example, tries to offer clinic hours that accommodate migrants’ work schedules. It has also worked with migrant groups in an effort to build trust and to inform them of available services.

In Pennsylvania, in an effort to inform women from the nearby migrant camps about family planning, an educator from the Planned Parenthood affiliate near Allentown works one day a month in a migrant health program run by a local medical center. Until the departure of its Spanish-speaking staff member, the agency had conducted outreach to migrants working on local mushroom farms. The affiliate recently sponsored a conference, supported by grants from the Robert Wood Johnson and Kaiser Foundations, for medical providers, social workers, teachers and school nurses across the state to address barriers to providing health care to the Hispanic community.

In Idaho, the state family planning program periodically visits migrant camps to provide family planning information and services. Agency officials feel, however, that services need to be provided more frequently, and are looking for ways to finance services at the camps on a regular basis.

Other Groups
Family planning agencies may also target other hard-to-reach groups in addition to those already mentioned. Women living in housing projects and shelters for battered women, welfare applicants and sex workers are among the groups identified as needing specialized services.

Planned Parenthood Center of El Paso, for example, provides gynecologic care to women in the city’s 23 housing projects, as well as in a shelter for battered women. Women are brought to one of the agency’s clinics in small groups (usually 5–10 at a time). Services are funded by a $250,000 community development block grant. The city turned to Planned Parenthood when it became clear that the local health department could not handle the demand for general gynecologic care, yet even with both providers, says executive director Betty Hoover, “we cannot meet everyone’s need.”

The Family Planning Council of Southeastern Pennsylvania operates comprehensive family planning clinics in the projects themselves. The same six-year CDC-funded project grant that supports family planning services in homeless shelters and drug treatment centers supports full-service clinics in two large housing projects. According to research director Kay Armstrong, preliminary data indicate that of the three targeted groups, women in the housing projects are the most likely to take advantage of the clinical services; 350 project residents used the clinics in 1995.

The health department in Seattle–King County, meanwhile, places public health nurses in each of the county’s 10 welfare offices to provide information on family planning and STD services to women applying for public assistance. When women come to the office, they are given condoms, materials about family planning and information on how to receive other health services. They can also obtain a pregnancy test. The health department spends about $250,000 a year on this program.

Issues in Providing Services
Almost without exception, family planning providers report that their services are welcomed by the agencies—drug treatment centers, homeless shelters and group homes, among others—that enlist their help, and are well used and appreciated by many people in the special groups they target. "The reception…has been overwhelmingly positive," comments Jan Lunquist of Planned Parenthood in Grand Rapids. Agency officials relate how prison inmates shake their hands in appreciation. Inmates shake their hands in appreciation, and argue among themselves to gain admission to a filled class. Men and women in substance-abuse treatment are described as "hungry" for information and anxious to apply what they have learned to their own lives. Disabled individuals are grateful that their sexuality is recognized.

Even so, convincing some of the individuals in these groups to take advantage of family planning services is often difficult. Many are wary of government programs and organized health care. Thus, providers have to work hard to establish trust. In addition, some groups present language and cultural barriers that must be overcome if they are to benefit from family planning messages and services. Cost is also a major concern, since it is generally more expensive to provide services to these populations than to traditional family planning clients, and adequate funding is often difficult to obtain.

Establishing Trust
Creating trust is key to serving hard-to-reach populations. For example, as Timothy Purington, of the Family Planning Council of Western Massachusetts, points out, providers who want to work with intravenous drug users must persuade them that their program "is not a sting operation." A nonjudgmental atmosphere is crucial, he adds. Frieda Saraga, a health educator with Planned Parenthood of Northeast Florida in Jacksonville who works with female inmates in a county jail, concurs: "I let them know that whoever they are, whatever their situation is, it's okay. I make sure they know I am not judging them.

Being accepted doesn't happen overnight. "It took at least a year," reports Joyce Howey, of the Saginaw Health Department who works with substance abusers. "It is hard to be taken seriously and to have credibility and respect [with this population]. We have to make people realize...we're here for them,...that there are no tricks involved." As Kay Armstrong of the Family Planning Council of Southeastern Pennsylvania notes, "many people with drug-related backgrounds have been treated pretty shabbily by...health care providers...so there is a lot of mistrust about going to a clinic and revealing [personal] information." That mistrust may explain why some providers have had greater success attracting target groups in nontraditional settings than in their traditional family planning sites.

In San Francisco, for example, the health department began offering services in clinics located in churches and drug rehabilitation centers when it became evident that the women it was trying to reach would not use its traditional family planning clinics. Some providers have sought to foster trust by having outreach workers serve as case managers, making clinic appointments and greeting women at the clinic when they arrive for services. Moreover, since it is more difficult to recruit individuals who utilize outpatient services than it is to serve women who are incarcerated or in a residential rehabilita-

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Language and Cultural Differences

Language and cultural differences are significant barriers to serving some hard-to-reach populations. "It is almost a requirement now, at least in the West, to have a bilingual staff," observes Kathy Nichols, regional manager at Planned Parenthood of the Rocky Mountains in Denver. At the International District Clinic in Seattle, for example, where clients speak numerous Asian languages, 75–80% of visits involve the use of an interpreter.

Providers report that they often have difficulty finding bilingual staff members with the necessary training and background. "Not only is language an issue, but [so are] cultural factors," observes Karen Andrade, of Planned Parenthood in Trenton. "There are a lot of different Spanish-speaking groups, and they all have different cultural norms. We need people who can relate on a cultural level, not just speak Spanish."26

Moreover, people of some ethnic backgrounds are uncomfortable talking to a stranger about such intimate topics as sex and birth control. "The concept of going to a medical provider for something as personal as a gynecological exam" is extremely uncomfortable for many Hispanics, reports Susan Ault, Idaho’s state family planning manager.27 Asians, meanwhile, "don’t see a doctor for preventive health care. They go when they are sick," notes Kimo Hirayama, of the International District Clinic. Additionally, he says, "people...are very passive about family planning issues. ...It is hard to get them to come in."28

Costs and Funding

Providing outreach, education and clinical services to hard-to-reach populations is expensive. They are often poor and may have neither health insurance nor Medicaid. They frequently have more health problems than typical family planning clinic clients. Reaching these groups can also be time-consuming. According to Kay Armstrong, although the Family Planning Council of Southeastern Pennsylvania serves "far fewer women" in clinics located in substance abuse centers, homeless shelters and housing projects than in its regular Title X clinics, "these women have more health problems...[and] we need to allow for additional counseling and care."29

Extra staff time is also needed in work with disabled individuals, especially those with developmental disabilities. Not only is the process a lot slower, but, as UCLA’s Amar points out, careful follow-up is essential for these clients. Otherwise, she notes, "they may have difficulties with contraceptive compliance, or with side effects that go unnoticed until [the problem] gets serious."30

Stephen Purser, the San Francisco health department’s family planning coordinator, reports that it costs twice as much to serve homeless women who use alternative clinics as women utilizing the traditional family planning clinics. The difference, Purser says, reflects the fact that women using the alternative clinics are at such high risk of various gynecologic problems that they must undergo a pelvic exam and basic diagnostic tests on every visit. "It is not just a pill refill and a blood pressure check," Purser explains.31 Instead of a 15–20-minute check-up, each visit takes 20–60 minutes of a clinician’s time.

Meeting the needs of physically disabled women, and the requirements of the ADA, can entail considerable expense to make the structural changes and acquire the equipment that will make the clinic accessible to women whose mobility, hearing or vision is compromised. For example, an examination table that allows wheelchair-bound women to transfer easily—rather than needing the help of several staff members—can cost up to $4,000.32

Some providers say they simply do not have the resources to implement programs for hard-to-serve groups. Others who already run programs would like to do more, but don’t have the money. Since state and federal HIV-prevention funds are a critical source of support for agencies attempting to serve hard-to-reach groups, family planning agencies that have tapped into these funds have generally mounted the most comprehensive programs and served the largest number of people.

However, many of these programs are funded for a set number of years and whether funding will be renewed or whether other sources of support can be found remains to be seen. "It is the million-dollar question" declares Kay Armstrong. "It is a great concern to us."33

Some providers use their Title X funds to support outreach and services to special groups. However, their ability to do so has been limited by the decline that has occurred in Title X funding. Between 1980 and 1992, Title X funding declined 72% (after accounting for inflation).34 In response to that decline, many family planning providers were forced to cut back on their services; outreach efforts were particularly hard hit. Although Title X funding has increased slightly since 1992, the increase has not been nearly enough to make up for the earlier declines. Other sources of support tend to be random, such as small grants from local foundations.

The extra time, effort and expense required to reach hard-to-serve groups undoubtedly discourages some family planning agencies from implementing special programs for these populations. Moreover, with public funding unlikely to significantly increase in the near future, it will be hard for providers who have developed special programs to reach large numbers of men and women in need of services. In fact, limited financial resources make it difficult for some agencies to adequately serve their traditional family planning clients. While some agencies have successfully implemented programs to meet the needs of the underserved, without additional resources, efforts to offer programs to hard-to-serve groups will probably remain spotty, leaving many people in need of basic reproductive health care.

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