

# The Manager

## MANAGEMENT STRATEGIES FOR IMPROVING FAMILY PLANNING AND HEALTH SERVICES

### In this Issue

<i>Understanding the Challenges of Serving the Hard to Reach</i> .....	2
<i>The FRAC Focuses on Serving the Hard to Reach</i> .....	3
<i>Major Underserved Population Groups</i> .....	3
<i>Serving the Hard to Reach</i> .....	4
<i>Choosing a Hard to Reach Group</i> .....	5
<i>Questions to Answer in Choosing a Hard to Reach Group</i> .....	6
<i>Identifying Needs</i> .....	6
<i>Rapid, Low-Cost Methods for Assessing Needs</i> .....	7
<i>Setting Your Objectives</i> .....	8
<i>Setting Objectives for Serving Hard to Reach Groups</i> .....	8
<i>Identifying an Appropriate Strategy</i> .....	9
<i>Identifying an Appropriate Strategy and Point of Contact</i> .....	9-10
<i>Working Solutions—Turkey</i> .....	11-12
<i>Working Solutions—Thailand</i> .....	13
<i>Working Solutions—Haiti</i> .....	15
<i>Managing Your Strategy</i> .....	16
<i>Common Barriers to Bringing Services to Hard to Reach Groups</i> .....	18
<i>Learning Through Experience</i> .....	18
<i>Strengthening Strategies to Reach Underserved Groups</i> .....	19
<i>References</i> .....	20
<i>Checklist for Bringing Services to Hard to Reach Populations</i> .....	22

### Case Scenario

*The Perolimbia Ministry of Health Brings Services to a Hard to Reach Population*

## Bringing Services to Hard to Reach Populations

### Editor's Note

Managers are increasingly focusing on bringing reproductive health services to hard to reach, underserved populations that are geographically, culturally, and economically isolated. By serving the reproductive health needs of these populations, managers will not only increase the use of family planning but also improve the health of mothers and increase child survival rates. In order to effectively plan and design services to reach these population groups, managers need the skills and systems to overcome important constraints and barriers to implementation.

This issue of *The Manager* helps the manager develop solutions to these problems and discusses the kinds of groups that are hard to reach, how to select a group to serve, and methods for determining the group's reproductive health needs. Using several examples of how services have been provided to rural populations, migrants, adolescents, and people with HIV/AIDS, the issue describes successful, cost-effective strategies for reaching these groups and offers guidelines for managing the strategies and integrating them into current programs.

Please note that with this issue we have changed the name of *The Family Planning Manager* to simply, *The Manager*. This change is motivated by the growing acceptance of family planning as a part of the broader area of health services and by this publication's growing emphasis on management concerns that go beyond family planning.

—The Editors

## The Manager

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**Family Planning Management Development  
Management Sciences for Health  
400 Centre Street  
Newton, Massachusetts 02158-2084 USA**

**Phone:** (617) 527-9202

**Fax:** (617) 965-2208

**E-mail:** [fpmdpubs@msh.org](mailto:fpmdpubs@msh.org)

**URL:** <http://www.msh.org>



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# Understanding the Challenges of Serving the Hard to Reach

Even successful reproductive health programs have difficulty reaching certain groups. Geographical barriers such as mountains, forests, rivers, or deserts may limit access to services or hinder the provision of services to people where they live. But hard to reach groups can also be found within the general population when cultural, economic, social, or age-related factors raise barriers to access or to outreach.

The types of hard to reach, underserved groups that managers should consider as potential clients include:

- Remote and nomadic rural populations;
- Adolescents, both rural and urban;
- Migrants;
- Internally displaced persons;
- People who are HIV positive or who are living with AIDS.

These underserved groups are the focus of this issue of *The Manager*. Other groups not discussed in this issue include sex workers, factory workers, handicapped persons, members of some religious communities, and men.

In addressing the challenge of serving the hard to reach, managers first have to differentiate between those who are underserved because access is difficult and those who have access but do not use services. For many underserved groups, the services available may not match their cultural, social, or economic backgrounds, and they may not feel welcome. Some groups may not use services because they lack information about their importance. Others may have multiple needs that are not met by a service that only supplies contraceptives.

This issue of *The Manager* discusses the important strategic decision of choosing an underserved group to reach with services and some of the ways to involve the community in identifying its reproductive health needs. The issue provides suggestions for setting objectives and identifying an appropriate service delivery strategy. It focuses on three effective strategies now used around the world to reach underserved groups—community-based distribution, mobile units, and working through partnerships with governmental and/or non-governmental organizations. And finally, the issue highlights ways to manage strategies to reach the underserved, along with lessons learned in implementing them.

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The guest editors for this issue of *The Manager* are Sylvia Vriesendorp and the members of Le Forum Regional d'Analyse et de Concertation (FRAC). Ms. Vriesendorp is Senior Program Associate for the FPMD Project. In November 1997, Ms. Vriesendorp worked with FRAC members to

explore the topic of reaching underserved groups during the tenth annual FRAC meeting in Port au Prince, Haiti. The editors appreciate their contributions, as well as those from the members of the International Review Board, in the development of this issue.

### **The FRAC Focuses on Serving the Hard to Reach**

The FRAC is a network of senior-level managers of reproductive health programs in Francophone Africa and Haiti. Formed in 1987, a group of these managers meets annually for ten days to study in-depth a topic related to the management of reproductive health programs. Each meeting of the FRAC is organized around an important strategic or management theme, which was selected by the FRAC members during the preceding meeting.

The meeting offers an opportunity to study a successful or innovative approach to the annual theme. In November 1997, the FRAC focused on the challenge of reaching underserved groups, using the experiences especially of Haitian non-governmental organizations as a starting point in their discussions. The major themes in this area focused on:

- reaching adolescents through their peers;
- mobile clinics;
- training of traditional midwives.

The FRAC is now in its tenth year. First funded by USAID through the Family Planning Management Development project, over the last three years the FRAC has launched a successful effort to be self-financed. Now, host country organizing committees solicit funds from a variety of sponsors to cover local administrative costs. A registration fee covers transportation during field visits and other related expenses. All aspects of organizing the FRAC, such as program design and implementation, are the responsibility of FRAC members. A rotating, elected FRAC committee ensures continuity between meetings.

Over the last ten years much has happened—FRAC membership has grown, experimentation with new ways for FRAC members to meet and stay connected has occurred, and many FRAC members have entered the electronic age. As the FRAC has evolved, it has remained true to its original purpose to bring together the minds, the creativity, and the optimism of people who have a common concern for the quality of reproductive health programs and the services they provide to clients in Francophone countries.

## Major Underserved Population Groups

**Remote and nomadic rural populations.** Because of inadequate infrastructure, remote rural populations are frequently the most underserved in terms of all types of health care. Whether fixed or nomadic, they are often indigenous and in many countries constitute a large percentage of a country's population. In many cases, these groups are not aware of the risks of having too many children and having them too closely spaced, though they tend to be receptive to reproductive health services when they become available.

**Adolescents.** In a large number of cultures, social taboos surrounding the discussion of sexuality means that young, unmarried persons do not receive guidance or sexuality education from their parents, other relatives, or teachers. Yet early sexual activity by adolescents throughout the world contributes to high adolescent rates of sexually transmitted infections and pregnancy. Teenage mothers face a higher-than-average risk of maternal death, and their children have higher levels of morbidity and mortality. Young people, both girls and boys, need to be educated about individual responsibility in sexual relations and about risks related to pregnancy and sexually-transmitted infections (STIs), especially HIV.

**Migrants.** Clustered on the periphery of cities, housed in temporary camps, or living in slums, migrants are among the world's most vulnerable people. Local district or municipal governments, whose resources are limited, rarely have adequate resources to address these groups, which can rapidly double the size of the local population. Seasonal migrant labor, particularly men who work on plantations or in mines, may get minimal emergency care but rarely have access to important services such as STI diagnosis and treatment. Women and children may not use services even when available, because they lack information or motivation.

**Internally displaced persons.** More and more countries in the world have internally displaced populations due to civil war, or economic or climatic crisis. Internally displaced persons, forced to live in camps, frequently have access only to minimal health services, which rarely include family planning or other reproductive health services.

**People with HIV/AIDS.** People who are HIV positive or have AIDS are frequently underserved either because services are inappropriate or because providers stigmatize people living with AIDS, or fear them. In many instances pregnant women may be refused maternal and child health (MCH) services if their HIV status is known. Clients who know that they are HIV positive may deliberately avoid seeking out services to avoid such humiliation. There are currently 30 million people living with HIV/AIDS. New HIV infections now number 16,000 every day, and the majority of newly-infected adults are between the age of 15 and 24. Worldwide, of every 100 HIV infections in adults, 75 to 85 have been transmitted through unprotected sexual intercourse.

*Adapted from Population Reports, Volume XXIV, Number 3, November 1996; The State of World Population, 1997; and the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, November 1997*

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## Serving the Hard to Reach

Serving hard to reach populations can be a complex management challenge due to the physical locations, cultural separateness, and social and economic situations in which these groups tend to live. Overcoming these challenges requires commitment on the part of policy makers, a program, and its managers. It also requires decisions about which hard to reach group to serve, how many of the group to reach, and whether to extend coverage using existing services or develop services appropriate to the target population's special needs.

The basic steps for designing and implementing a program to reach underserved groups are:

- Identifying the underserved group(s) you intend to serve;
- Identifying the group's needs for reproductive health services;
- Setting program objectives;
- Identifying a strategy or combination of strategies that will meet those objectives;
- Managing the strategy;
- Monitoring and evaluating the program;
- Integrating these services into broader health services.

The section that follows focuses on identifying principal hard to reach groups, choosing which group(s) to serve, determining the group's needs, and developing strategies or combinations of strategies for bringing services to the group. Finally, we will discuss some of the major challenges in managing an outreach strategy and how to overcome them, and how to integrate your outreach strategy into your current program.

For more information on designing, implementing, monitoring, and evaluating a program, see other issues of *The Manager*, such as "Developing Plans and Proposals for New Initiatives," Volume II, Number 4; "Using Evaluation as a Management Tool," Volume VI, Number 1; and "Using National and Local Data to Guide Reproductive Health Programs," Volume VI, Number 2.

### Choosing a Hard to Reach Group

New circumstances in your region or catchment area, new knowledge about the local health situation, or your own experience may compel you to review your service delivery program and consider expanding your services to reach new clients. Choosing a hard to reach group to include in your services could be one of the most important strategic decisions you will make as a manager. It has important implications for the technical, cost, and managerial components of your current service delivery system. Whenever possible, you should base this choice on reliable demographic and epidemiological data.

As a strategic decision, choosing a new group to serve requires the full participation of a wide variety of groups (e.g., clients, funding sources, and staff.) Asking certain strategic questions can help you and other central- and local-level managers select a group to reach with services. Although not exhaustive, the questions in the following table will guide you as you begin the process. The answers to these questions will undoubtedly prompt many new questions. For further discussion of strategic thinking, please refer to "Learning to Think Strategically," *The Family Planning Manager*, Volume III, Number 1.

## Questions to Answer in Choosing a Hard to Reach Group

Strategic Area	Questions
<b>Demographic</b>	<ul style="list-style-type: none"> <li>• What potential clients now underserved live in the catchment area but are not being covered by current program services or by other health services?</li> <li>• Does the size of this potential population group exceed the capacity of our program's services, given the resources currently available?</li> </ul>
<b>Epidemiological</b>	<ul style="list-style-type: none"> <li>• Does any population subgroup have new or emerging health needs which existing health services are not currently meeting?</li> <li>• Which potential group or groups have health service needs which could readily be met by our program's health services?</li> <li>• Do the special health needs of potential client groups exceed the capacity of the service delivery point even after reasonable efforts to increase capacity have been made?</li> </ul>
<b>Sociological</b>	<ul style="list-style-type: none"> <li>• Are there any potential sources of opposition among current clients which would undermine efforts to extend services to new client groups?</li> <li>• Would current clients make new client groups feel unwelcome?</li> <li>• How much effort would be required to change the attitude of current clients?</li> </ul>
<b>Management</b>	<ul style="list-style-type: none"> <li>• Are there alternative services for reaching these new clients that could adequately address their health needs?</li> <li>• Does providing services to new potential clients fall within the mission of our organization?</li> <li>• Does the catchment area covered by the service delivery point or set of service delivery points officially exclude the participation of particular client groups?</li> <li>• Is there anyone in our organization who might resist efforts to extend services to new client groups?</li> <li>• Do I have sufficient managerial responsibilities and authority to reallocate resources in order to extend services to new groups?</li> </ul>

### Identifying Needs

Working with a hard to reach community to identify its reproductive health needs is one way to promote the eventual use of those services. Involving members of the community in carrying out a needs assessment can help educate them on the importance of those reproductive health services and link services with other perceived needs.

Using rapid, low-cost needs assessment or appraisal methods for identifying health needs will help you gather both qualitative and quantitative information. The table that follows lists four needs assessment methods, suggests an appropriate time to use each method, and lists the circumstances under which the method functions best and some special considerations. The next issue of *The Manager* will focus on rapid assessment methods and have a more complete discussion of them.

### Rapid, Low-Cost Methods for

<b>Assessing Needs</b>			
<b>Method</b>	<b>Use When You Want To . . .</b>	<b>Functions Best When . . .</b>	<b>Special Considerations</b>
<b>Focus Group Discussions (Qualitative)</b>	<ul style="list-style-type: none"> <li>Understand the reasons for specific behaviors or characteristics of a population that emerge from the results of a survey</li> </ul>	<ul style="list-style-type: none"> <li>You use small groups of 6-8 participants</li> <li>You focus on a limited number of key topics</li> <li>The moderator and note taker are experienced</li> </ul>	<ul style="list-style-type: none"> <li>Organizer should choose “typical” members of the community as participants</li> <li>The validity of the results depends on the quality of the interaction among the participants</li> </ul>
<b>Group Interviews (Qualitative)</b>	<ul style="list-style-type: none"> <li>Obtain information about “non-sensitive” issues or about the social context of a problem or behavior</li> </ul>	<ul style="list-style-type: none"> <li>A moderate number of people participate</li> <li>Each participant is asked the same questions</li> </ul>	<ul style="list-style-type: none"> <li>Hidden group dynamics may encourage participants to provide similar “acceptable” answers</li> </ul>
<b>Small Scale Surveys (Quantitative)</b>	<ul style="list-style-type: none"> <li>Establish a limited number of baseline indicators on specific behaviors or characteristics of the underserved population</li> </ul>	<ul style="list-style-type: none"> <li>The questionnaires are field tested</li> <li>The interviewers are trained and supervised</li> </ul>	<ul style="list-style-type: none"> <li>Technical assistance should be available to analyze the results</li> <li>To complete the analysis, compare results with equivalent data from other population groups and other surveys</li> </ul>
<b>Rapid Participatory Assessments (Qualitative)</b>	<ul style="list-style-type: none"> <li>Promote direct participation of the underserved population in designing the service delivery strategy</li> </ul>	<ul style="list-style-type: none"> <li>A variety of participatory qualitative methods are used that stimulate ownership of the process</li> <li>You repeat the assessments whenever problems in implementing the strategy arise</li> </ul>	<ul style="list-style-type: none"> <li>You should immediately follow up the assessment with action, in order to build on the enthusiasm of the participants</li> </ul>

The results of these assessments, combined with data from such sources as Demographic and Health Surveys (DHS), will help you establish service objectives and indicators for monitoring and evaluating your program. The more participatory the assessments, the more likely you and the underserved community will find common objectives and strategies.

Often during a needs assessment, the group identifies key concerns that you are not equipped to

address. Examples of such concerns might include access to potable water, or better housing, roads, and markets. In this case, you may be able to identify other organizations or sectoral programs in education, social services, the environment, or nutrition and coordinate with them in providing services. Coordinating with other sectoral programs requires more time to reach your objectives, but your efforts to help a group meet their perceived needs may make group members more receptive to your message and the services you offer.

## Setting Your Objectives

Setting appropriate, realistic objectives will depend on a number of things, including the results of your needs assessment, the needs you and the underserved community have identified, and your program's or organization's current objectives and strategies.

You may find that your objectives change over time,

depending on the community you are serving and its needs. Rigidly adhering to quantitative objectives may not always be in the best interest of the underserved community. The following table lists some possible objectives for bringing services to hard to reach groups.

### Setting Objectives for Serving Hard to

Reach Groups	
Hard to Reach Group	Possible Service Objectives
<b>Remote and nomadic rural populations</b>	<ul style="list-style-type: none"> <li>• Reduce incidence of unintended pregnancies</li> <li>• Protect children against preventable diseases</li> <li>• Increase access to family planning methods</li> <li>• Improve nutritional status of children aged 0-5 years</li> </ul>
<b>Adolescents</b>	<ul style="list-style-type: none"> <li>• Increase condom use</li> <li>• Reduce incidence of adolescent pregnancy</li> <li>• Increase awareness of risks of unprotected sex</li> <li>• Diagnose, treat, and prevent STIs</li> </ul>
<b>Migrants</b>	<ul style="list-style-type: none"> <li>• Identify, treat, and prevent STIs</li> <li>• Reduce incidence of unintended pregnancies and unsafe abortions</li> <li>• Improve nutritional status of children aged 0-5 years</li> </ul>
<b>Internally displaced persons</b>	<ul style="list-style-type: none"> <li>• Diagnose, treat, and prevent STIs</li> <li>• Increase access to family planning methods</li> <li>• Protect children against preventable diseases</li> <li>• Reduce incidence of unintended pregnancies and unsafe abortions</li> </ul>
<b>People with HIV/AIDS</b>	<ul style="list-style-type: none"> <li>• Provide contraceptives for STI protection and contraception</li> <li>• Provide treatment for opportunistic infection including STIs</li> <li>• Support parents, partners, and families</li> </ul>

## Identifying an Appropriate Strategy

After identifying the needs of the group you plan to reach and setting objectives for your services, you will want to carefully select the strategy or combination of strategies that will make those objectives attainable, given your budget and other resources. A basic strategy for reaching underserved populations is to provide services that are physically accessible to the underserved population at times and in places its members find convenient.

Identifying strategies can be a creative activity. Brainstorm with members of your staff to develop ideas based on their experience. Ask colleagues in other organizations what has worked and not worked in their experience with similar groups. If you have access to the Internet or electronic mail, request suggestions from special forums that address specific or general reproductive health issues or specific underserved groups. One electronic resource is MSH's Electronic Resource Center on the World Wide Web (<http://erc.msh.org>), which offers interactive forums for health and family planning managers to share their experiences and gain access to high-quality, up-to-date management information and tools. You can also refer to some of the resources listed at the end of this issue of *The Manager*.

Financial factors always play a part in identifying a strategy or combination of strategies. When developing a strategy, consider the following questions:

- Do you plan to use your existing human resources, or can you afford to hire additional staff?
- Can you expand existing strategies, or must you create totally new strategies to deliver services?
- Can you afford to budget for regular recurrent costs, such as fuel and maintenance of vehicles if a mobile clinic strategy is required?
- Can the clients in the underserved population make financial or other contributions to help support and maintain the services?
- Can you access donor support, and if so, how long will it last?
- Does your funding source place any restrictions or requirements on the objectives of your program?

The table that follows lists possible service strategies in bringing services to the hard to reach and places where you can make contact with hard to reach groups.

Identifying an Appropriate Strategy and Point of Contact		
Hard to Reach Group	Possible Service Strategies	Points of Contact
<b>Remote and nomadic rural populations</b>	<ul style="list-style-type: none"> <li>• IEC and social marketing programs</li> <li>• Satellite clinics</li> <li>• Depot holders</li> <li>• Mobile units</li> <li>• Use community leaders and women's groups to promote health messages</li> <li>• Train traditional healers and birth attendants to deliver basic MCH services</li> <li>• Train community members to be community-based distribution (CBD) agents</li> <li>• Integrate reproductive health initiatives (RHI) into economic development activities such as agriculture</li> </ul>	<ul style="list-style-type: none"> <li>• Village common areas</li> <li>• Homes</li> <li>• Women's groups</li> </ul>

## Identifying an Appropriate Strategy and Point of Contact

Hard to Reach Group	Possible Service Strategies	Points of Contact
<b>Adolescents</b>	<ul style="list-style-type: none"> <li>• Peer counseling</li> <li>• Plays and dramas dealing with health issues in communities and schools</li> <li>• Radio spots</li> <li>• Disseminate comics, videos, and songs with health messages</li> <li>• Hotline telephone counseling in urban areas</li> <li>• Integrate STI and family planning services</li> <li>• Train adolescent girls in assertiveness</li> <li>• Provide scholarships for adolescent girls to remain in school</li> <li>• Provide rural job opportunities for adolescent girls</li> </ul>	<ul style="list-style-type: none"> <li>• Markets</li> <li>• Schools</li> <li>• Youth centers</li> <li>• City streets</li> <li>• Places of worship</li> <li>• Sport and entertainment events</li> </ul>
<b>Migrants</b>	<ul style="list-style-type: none"> <li>• Community-based distribution programs</li> <li>• Special events</li> <li>• Satellite clinics</li> <li>• Depot holders</li> <li>• IEC and social marketing programs</li> <li>• Integrate STI diagnosis and treatment into family planning services</li> </ul>	<ul style="list-style-type: none"> <li>• Homes</li> <li>• Community centers</li> <li>• Markets</li> <li>• Work sites</li> </ul>
<b>Internally displaced persons</b>	<ul style="list-style-type: none"> <li>• Integrate family planning and STI services into camp health services</li> <li>• Train community members to be CBD agents</li> </ul>	<ul style="list-style-type: none"> <li>• Community centers in displacement camps</li> <li>• Water and food distribution points</li> <li>• Places of worship</li> <li>• Camp health centers</li> </ul>
<b>People with HIV/AIDS</b>	<ul style="list-style-type: none"> <li>• Peer counseling</li> <li>• Outreach activities via advocacy organizations</li> <li>• Educate providers on interacting with people living with HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Service delivery points</li> <li>• Homes</li> </ul>

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Managers do not need to invent new strategies to bring services to the hard to reach. They can adapt existing strategies to reach new groups and provide new services that aren't being provided now. Of the many strategies that managers around the world have found effective in reaching underserved population groups, this issue of *The Manager* discusses three:

- community-based distribution;
- mobile units;
- working through partnerships with governmental and/or non-governmental organizations, such as community-based organizations and the private sector.

Managers have used all three of these strategies successfully to reach clients who are unable to come to fixed clinics for services.

**Community-Based Distribution.** Community-based distribution (CBD) strategies bring reproductive health services to people where they live, work, or meet—often directly to their homes. CBD strategies can use the social structures of the communities. Some CBD strategies provide services through women's groups or labor cooperatives. Some use health workers, traditional birth attendants, or housewives to distribute contraceptive methods, including condoms, spermicides, injectables, and oral contraceptives. In still others, adolescents, men, or people with HIV/AIDS are agents for their peers. CBD strategies generally involve referring clients to clinics for such services as IUD insertions, other medical methods, or STI screening and treatment.

CBD workers make house-to-house visits or hold group meetings to educate and motivate clients and to distribute contraceptives and other commodities. Often the workers are not health professionals, and many may not be able to read or write. Usually they are trained to follow simple medical protocols to match clients and contraceptive methods. They receive several weeks of specialized training, which can include how to motivate family planning clients, recognize medical indications against certain methods, recognize complications, and calculate clients' needs for future contraceptive supplies. Tools such as **ELible COuple** (ELCO) mapping can substantially increase their effectiveness.

For more information on ELCO mapping, please refer to "Using Maps to Improve Services," *The Family Planning Manager*, Volume I, Number 5.

Recently, concerns over the use of such a labor-intensive strategy as CBD have led to setting up depot holders, or community members who maintain and distribute contraceptives from their homes while other CBD agents continue to circulate in the community providing information and motivation. This service delivery strategy is often easier to supervise, although it may diminish the sense of community participation that CBD strategies stimulate.

Usually clinics supervise CBD agents to make sure that they provide safe, reliable services. Research in Asia and Latin America has shown that clients who receive contraceptives, including oral contraceptives, from local workers in community-based programs experience no greater health risks than clients who receive contraceptives from health professionals. More recently, experiments are underway in countries such as Bangladesh to determine whether CBD strategies can also safely include injectables.

Family planning is not the only service for which a CBD strategy can be effective. CBD can be used to provide other primary health care services, including oral rehydration therapy and treatment for malaria and tuberculosis.

**Managing CBD strategies.** It is very important to involve community or group members and leaders in introducing new ideas and technologies, especially in rural areas. However, a CBD strategy's success depends on a regular system of supervision to guarantee that the workers maintain their house-to-house rounds or group meetings and follow necessary reporting procedures. An effective logistics system is also essential to prevent disruption of contraceptive supplies.

Much has been written about community-based distribution strategies and how to manage them. One resource is *Beyond the Clinic Walls: Case Studies in Community-Based Distribution* (Wolff et al., 1990).

### Reaching Underserved Urban Migrants Through CBD

The Safe Motherhood Project of the Human Resources Development Foundation (HRDF), a Turkish non-governmental organization (NGO), helped 10,000 women aged 15–49 in the Istanbul slum area of Alibeykoy understand the basic concepts and terms of reproductive health and gain access to reproductive health services. The women of Alibeykoy are newly arrived migrants with limited education. Before the project, they were isolated from local reproductive health care services due to their limited knowledge both of these services and of over-the-counter contraceptive methods.

The project trained and employed a team of 16 community women as project field workers. HRDF trained each field worker for three weeks on reproductive health and counseling. Being from the community, the field workers could move around easily in neighborhoods without roads, signs, or house numbers. They could speak the same language as the other women of the community and were able to establish trusting relationships with them.

#### Project Implementation

A field worker visited each woman in her home once every three months over a 20-month period. The field workers distributed condoms, spermicides, and oral contraceptive pills free of charge and informed their contacts where they could obtain them. Women who needed special attention or support received more frequent visits. Field workers also accompanied the women who, due to language barriers or shyness, needed assistance visiting a health institution. This gave them confidence to visit the institution alone afterwards.

The project held weekly day-long meetings with the field workers to discuss their problems and find collective solutions. During the 20-month project, HRDF also held two five-day refresher training courses.

The project coordinated a number of meetings among the field workers and local health care institutions in order to acquaint the institutions with the objectives of the project. These meetings helped both groups develop a common language about reproductive health issues to use with the women of the community.

#### Results

Pre- and post-project surveys demonstrate that the use of contraceptive methods among the women of the project area increased from 39 to 71 percent; the use of iron pills by pregnant women increased from 35 to 87 percent; vaccination during pregnancy increased from 12 to 84 percent; routine health control during pregnancy increased from 65 to 93 percent; first-month health control for newborns increased from 49 to 86 percent; and routine health control for babies increased from 49 to 86 percent.

#### Benefits to Field Workers

The field workers say they benefitted from the project by becoming well-known and respected in their neighborhoods and by increasing their status within their families. For most of the workers, this was their first paid job. Many have indicated that they would like to continue working in the future, and some have already found jobs.

## Overcoming Problems

An unexpected obstacle to the success of the project was the confusion among some of the community women and local service providers about the status and skills of the field workers. Some women treated the field workers as nurses or midwives. In turn, some of the nurses and midwives working in local health care institutions felt that the field workers were invading their field of expertise and accused them of giving out wrong or inadequate information. The project overcame this problem through continued contact and coordination with local health care institutions and through efforts to help women in the community better understand the field workers' role.

Another problem was the misunderstanding among some women about the treatment they could expect at health care institutions. The project helped the women understand that they could not expect special treatment at these institutions because of their contact with the project and field workers.

## The Next Steps

HRDF is replicating the project in another slum area in Istanbul. The first project demonstrated that training men as well as women could increase project impact. In the next project, HRDF is training men as CBD workers.

**Providing Access Through Mobile Units.** Mobile service units bring service providers to clients. A mobile unit may be a fully equipped and motorized health center that visits communities on a regular schedule. Units may have film projectors, portable generators, and other audiovisual aids for intensive IEC campaigns. They can be composed of community health workers who offer health information and basic services once a month in different homes. Or they may be set up in village schools, other public buildings, or tents for several days to serve people from a large catchment area.

Mobile units are particularly useful where the health infrastructure is sparse, where the existing infrastructure provides only basic services, or where geographic barriers are extreme (for example, mountainous areas). They can bring services for a fixed period of time to those who want them but will not travel to a facility that provides them. They are also useful in providing surgical services, such as tubal ligation or vasectomy, in areas

where demand is potentially high. Mobile units are most effective when the community is informed and enthusiastic about the services and is actively involved in planning the visit.

The most important obstacle to the use of mobile units is the high cost associated with buying or leasing a vehicle, paying for fuel, and keeping the vehicle in good condition. Because of this, the use of mobile units as a strategy is most effective when the units are used as a temporary means of providing access until the services are integrated into another kind of service delivery strategy.

In Thailand, the use of mobile units is one of the strategies being used to bring HIV/AIDS services to clients in mountainous areas where these services would not otherwise be available. The following Working Solution discusses this experience.

### Using Mobile Units to Reach Remote, Rural Populations

Nine hilltribe groups totaling a population of 600,000 live in the three mountainous provinces of Mae Hong Son, Chiang Rai, and Chiang Mai in northern Thailand. Each group has its own language and culture, and less than 25 percent of their villages can be reached by car. Government health services for this population are insufficient, and research in 1993 found that hilltribe people had a crude birth rate of 56 (versus 21 for the whole country) and a population growth rate of 4.5 percent (versus 1.4 percent for the country) and that less than 20 percent of the population had been immunized.

The Planned Parenthood Association of Thailand (PPAT) has been providing family planning and maternal and child health (FP/MCH) services through the Family Planning Northern Project (FPNP) in Thailand since 1987 in cooperation with provincial health officers and hilltribe volunteers. The project covers 180 main and 430 satellite villages. It provides family planning services to 11,600 acceptors (almost 50 percent of men and women of reproductive age in the project areas) and other health services to more than 10,000 clients per year. FPNP serves approximately 16 percent of the hilltribe population.

Since 1993, FPNP has also been reaching 84 area villages with HIV/AIDS prevention education, counseling, and training services. Hilltribe populations have some of the highest rates of HIV infection and many young people migrate to urban areas unprepared to face high risk situations.

FPNP uses four different strategies for providing FP/MCH and HIV/AIDS prevention services:

- **Community-based services**, through village volunteers in cooperation with the Ministry of Public Health (MOPH) and community leaders. From 1993–1995 FPNP worked in 125 villages. The MOPH is now responsible for those villages, and FPNP has begun community-based services in new villages.
- **Mobile units** that serve remote areas and industrial factories. Medical mobile units make 140 trips per year to villages and 12 trips per year to factories in two provinces. Education, counseling, and training mobile units carry out HIV/AIDS prevention activities in 84 villages in two provinces where the population comes in frequent contact with outsiders and is considered to be at high risk.
- **A static clinic** in Chiang Mai city. The clinic provides FP/MCH and counseling on HIV prevention and care to an average of 20,800 family planning clients and 28,600 MCH and other health service clients per year.
- **A training program.** FPNP has organized training on the counseling and care of HIV/AIDS clients for Buddhist monks, who now conduct HIV/AIDS prevention work with more than 80,500 people in remote, rural areas. The training received financial support from the MOPH.

**Working with Government and Non-Governmental Partners.** Partnering with other government ministries, non-governmental organizations (NGOs), the private sector, mothers' clubs, religious groups, physicians' and nurses' associations, community-based organizations (CBOs), and associations of traditional healers, among others, can be an effective way to extend existing strategies to cover hard to reach groups.

If you manage a government clinic, you may be able to join forces with an NGO that works with an underserved group. If you manage a CBO, you may be able to obtain support from national, provincial, district, or local government programs whose mandate includes outreach, or join with an NGO working in your area. Partnering can offer increased access to funding, training, and other resources that could increase the quality and scope of your service delivery strategies.

Working with partners is challenging. It means sharing resources, information, and decision making. It requires giving up some control over inputs, changing objectives, and getting used to different attitudes and work styles. Successful partnerships depend on the ability to manage problems jointly, on flexibility in adjusting objectives and strategies, and on a willingness to share responsibility for failures as well as for achievements.

CBOs and private sector organizations are two groups with which managers can build successful partnerships.

- **Community-Based Organizations (CBOs).** CBOs first emerged in the 1980s in Africa as a response to the HIV/AIDS epidemic. Their small size gives them the ability to adapt to the changing realities of the population groups with which they work. CBOs often respond to very particular needs of specific communities that, for whatever reason, are not being served by government or NGOs. NGOs such as family planning associations may support CBOs.

- **Private Sector Organizations.** Throughout the world, program managers have found that working with private sector organizations is an effective way to reach underserved groups. In southern Africa, traditional healers participate in delivering family planning methods, diagnosing and treating STIs, and referring patients. In India, where private doctors even in remote, rural areas are the main source of health care for most of the population, they have been trained to deliver oral contraceptives and IUDs, in counseling, and in follow-up services. Indonesia has launched a national program to establish private nurse-midwives in villages to take care of MCH services. In many countries worldwide, social marketing strategies supply condoms to small merchants who market them even in very remote areas.

Clients can also be considered partners in providing services, as the following Working Solution shows. Providing services is a significant challenge for youth programs in developing countries because of the social and cultural barriers that make it hard for sexually active young people to seek family planning or reproductive health services. As a result, a significant number of programs for young people provide sex education and counseling, but not services. In the example below, an NGO in Haiti trained young people who began providing education and counseling in family planning to their peers. Focus group discussions with the counselors and others led to an evolution in the counselors' role—they wanted more responsibility and now provide methods as well as education and counseling. They also refer clients to two clinics that serve young people.

## **Bringing Reproductive Health Education and Services to Youth**

In 1995 the Foundation for Reproductive Health and Family Education (FOSREF), a Haitian NGO, conducted a study of pregnancies

among young people in Haiti that showed that only one in ten sexually active young women were using contraception, that nearly 15 percent of women who had delivered at least one baby were less than 20 years old; and that nearly half the women between the ages of 15 and 24 had had at least one abortion.

This study convinced the education community and the community at large of the need to provide family planning and reproductive health services to youth, the first time anyone in Haiti had focused on this group. FOSREF organized a youth program in the capital city, Port-au-Prince, whose objective is to promote the reproductive and sexual health of young people, and to encourage responsible behavior. The program provides education, motivation, and family planning services to young people between 15 and 24 years of age by training youth facilitators, offering IEC workshops, sponsoring youth clubs, and providing family planning services at two youth centers.

The Youth Program has trained about 3,500 young people as facilitators, and they have conducted educational sessions in more than 100 schools. The youth center provides family planning services to an average of 1,200 young clients each month. More than half the visits are for family planning (one-third new users) and the rest are for psychological counseling and care, diagnosis and treatment of sexually transmitted infections, and other gynecological or reproductive health counseling and services. As the program has expanded, FOSREF has initiated community-based distribution through the recruitment and training of 200 peer counselors between the ages of 18 and 24. FOSREF has been asked to assist other organizations in developing similar youth programs in other urban areas in Haiti.

**Looking Ahead.** The Youth Program staff is asking two key questions as it looks to the future: how to motivate young people to continue volunteering over time, and how to transfer their experience to other organizations in the country.

**Evaluation and Reactions from Young People.** In assessing the Youth Program, FOSREF conducted focus group discussions (FGDs) with youth leaders, students, and young adults who attended sexuality education sessions, and with clients who received services at the youth center. Some recommendations that came out of the evaluation and FGDs include:

- **Involve parents** in the program. FOSREF is now experimenting with ways to target parents for education programs.
- **Treat sexually active clients as a couple** (when appropriate) and teach them how to negotiate and make decisions together. This has strengthened the position of girls in negotiating with their partners.
- **Separate education activities by gender.** This has increased the participation of girls in voicing their opinions and has led to designing new peer counselor activities.
- **Give service delivery responsibilities to the peer counselors.** The focus group discussions indicated that the trained counselors were impatient regarding their role and ready for greater responsibilities. They now provide family planning methods during home visits.
- **Expand clinic-based services.** FOSREF has opened a new youth clinic (Delmas Clinic), which is now serving a significant number of youth.

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## Managing Your Strategy

Once you have decided which strategy or strategies you will use to bring services to your hard to reach group you will need to consider the management implications of the strategy. Added to the tasks you already carry out in managing current health service delivery strategies, you will face some unique challenges in managing those related to serving the hard to reach, especially challenges related to eliminating barriers.

In their discussions, the FRAC members offered a number of recommendations regarding the management of strategies to reach underserved groups. These recommendations are grouped under planning, staffing, logistics, information, and sustainability.

**Planning.** Creating management councils and management committees with members from community groups such as women's groups and farmer's associations, religious leaders, educators, health workers, elected officials, and other interested parties will provide structures for regularly involving community members in the planning process. Input from representatives of these groups will help you do micro-planning at the local level to develop specific and realistic plans. Forming good relations with the community can increase the accuracy and completeness of information from needs assessments.

The community also needs to play an active role in the implementation of your strategy to become fully committed to the objectives and strategy. Regular participation in monitoring and evaluation activities will further reinforce community members' commitment and ownership of the outreach services.

**Staffing.** Provider prejudices can create some of the most important barriers to reaching the underserved. Therefore, providers must develop appropriate skills and attitudes. Supervisory systems that nurture and encourage attitudinal change can make the difference between successful and unsuccessful implementation of the strategy and its ability to meet the needs of the underserved group.

**Logistics.** Guaranteeing the regular availability of essential medicines, contraceptives, and vaccines will be one of the major tasks in reaching remote populations.

Another major task will be procuring the commodities required for the specific groups. *For example, in providing services for adolescents you may need to distribute antibiotics to treat STIs to service delivery sites which are not traditional venues of health care.* You may also have to expand your logistics system for social marketing products such as the t-shirts and other promotional items attractive to adolescents.

**Information.** When implementing strategies to serve hard to reach populations, you will need to be flexible in revising activities, adjusting schedules, and reallocating funding in order to address problems before minor setbacks becomes crises. An effective monitoring and evaluation system will keep you informed about the groups' needs and behaviors and how best to meet their needs using existing strategies and resources. You can accelerate the learning process by using information from many sources, especially by updating indicators from baseline rapid assessments. For further information on appropriate reproductive health indicators and how to calculate them, please refer to "Guide to National and Local Reproductive Health Indicators," a supplement to *The Family Planning Manager*, Volume VI, Number 2.

**Sustainability.** Once you have implemented a strategy for serving hard to reach groups in your catchment area, a new challenge begins—how to integrate these groups on a permanent basis into your ongoing health and family planning program. Sustaining the services will require continuing political will and national and local leadership. National and local plans must make reaching these groups a priority and allocate the resources required to implement and develop service delivery strategies and strengthen institutions. As you integrate hard to reach groups into your target population, you will have to upgrade management skills and systems and introduce new design and implementation approaches to meet the special needs of these groups as well as the needs of your staff.

Cost considerations cannot be avoided. In serving adolescents, for example, it may be necessary to retrain staff and set up services in non-traditional settings where adolescents feel welcome. Providing complementary support services such as sponsoring sports or entertainment events may be necessary to prompt adolescents'

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participation. In reaching remote populations, you will have high logistics costs. Involving the community in support, management, and technical capacity may lower costs in the long term, though your initial investments in recruiting, training, and supervision may be high.

Implementing a referral system will help sustain services by addressing the rising expectations of the hard to reach group once they begin to benefit from your

initial service delivery strategies. With community support in providing transport, accompanying referral clients, and monitoring referral outcomes, you can build client confidence in the services as well as encourage pro-active health-seeking behaviors. An effective referral mechanism will allow you to focus your objectives on meeting the essential needs of the group.

### **Common Barriers to Bringing Services to Hard to Reach Groups**

Cultural, social, political, age, gender, or linguistic differences increase the barriers between the majority of the population and hard to reach, underserved groups. These groups may have different reproductive health concepts and customs, views of women's status and autonomy, and religious beliefs. They may have taboos about discussing family planning, or their members may be unaccustomed to the "medical model" that relies on professional service providers. In some cases, the group members may speak a different language, which can make it difficult for them to ask for what they want or to understand what providers are trying to explain. Traditional decision-making responsibilities in the household may stifle discussion within the family on use of family planning or access to STI detection and treatment services, thus creating a barrier to access for some family members. In other cultures, the practice of seclusion of women can create a barrier.

The prejudices of managers and service providers can be a challenging barrier. The needs of single parents may not be addressed due to social barriers. Adolescents often face prejudice from providers who feel that young people should not begin sexual activity before marriage. Prejudices and lack of knowledge on the part of both providers and clients can result in ill-treatment, poor quality services, or restricted access.

**Overcoming barriers.** Cultural or linguistic barriers can be overcome by hiring staff and using outreach workers who are sensitive to cultural differences or able to speak the language of the group you are trying to reach. You could also provide your existing staff with culturally sensitive training in working with the hard to reach group. For many managers, gaining support first from women's groups, community leaders, and religious leaders in the underserved community has proven to be a helpful bridge between the hard to reach community and new services. Information from sources such as these can also help your staff better understand the underserved community and its health needs.

### **Learning Through Experience**

Developing effective strategies for reaching underserved population groups is an ongoing process. Managers around the world have experienced both

successes and failures. Following are some practical tips provided by managers around the world, based on their experience with the three strategies discussed in this issue.

## Strengthening Strategies to Reach Underserved Groups

Strategy	Lessons Learned
<b>Community-Based Distribution</b>	<ul style="list-style-type: none"> <li>• Employ field workers who are motivated to work with the underserved group.</li> <li>• Establish good relations with the local health care institutions that could be useful referral points.</li> <li>• Develop a common reproductive health terminology for community workers and local service providers. Train community workers and service providers together to foster a similar understanding of objectives and strategies.</li> <li>• Plan the initial training of the CBD workers carefully. Train them how to distribute contraceptives, give information, motivate clients, and limit their counseling to reproductive health.</li> <li>• Put well-organized supervision mechanisms in place to support CBD workers. Include some supervisors from socio-cultural backgrounds similar to those of the underserved groups.</li> <li>• Carefully examine who will be affected by this activity. Some examples might be religious organizations, community leaders, and local service delivery points. Start working with them right away to encourage them to become allies in your efforts.</li> </ul>
<b>Mobile Units</b>	<ul style="list-style-type: none"> <li>• Put one person in charge of preparing and managing each visit.</li> <li>• Prepare the vehicle, fuel, and travel funds in advance and assemble all necessary equipment and medicines at least 24 hours before the mobile unit departs.</li> <li>• Schedule the unit's arrival early enough in the day to set up the site for service delivery before clients arrive.</li> <li>• Before leaving the service site, verify the records and files and leave a copy for the local providers in charge of follow up.</li> <li>• Employ staff who can speak the same language as the groups you are reaching with services and who are sensitive to their culture.</li> <li>• Schedule the unit visits on market days, so women can use the services and do their shopping at the same time.</li> </ul>
<b>Working with Partners</b>	<ul style="list-style-type: none"> <li>• Identify potential partners from every possible segment of the community that might have something to contribute.</li> <li>• Begin your partnership by establishing a common vision, a set of principles, and a plan.</li> <li>• Allow each partner to contribute to the strategy on the basis of its particular strengths and areas of interest.</li> <li>• Maintain open and regular discussion among the partners; acknowledge problems, and seek solutions as promptly as possible.</li> <li>• Provide support and assistance to the partners in the field.</li> </ul>

Launching an initiative to include an underserved group in your health services is a major strategic decision for any program. Whether the group is large or small, reaching it has important management, cost, staffing, and sustainability considerations that you must discuss with your program's or organization's stakeholders before making changes in your service delivery objectives or strategies. Furthermore, the new group you wish to serve must be motivated to use the services you will provide.

The hard to reach groups discussed in this issue of *The Manager* in many cases constitute large segments of the societies in which they live. Yet their physical, cultural, economic, or social separation may make them easy to ignore. Reaching such hard to reach groups as adolescents and migrants with family planning and other health services has implications that reach beyond your clinic walls. Providing them with services will improve their health but may also increase their integration into the broader socio-economic context of the general population.

## Reviewers' Corner

*A forum for discussing additional applications of the concepts and techniques presented in this issue*

**On identifying underserved population groups...** *One reviewer comments, "We have found that doing simple surveys in the slums of our big and middle-size cities has helped us identify pockets of population, usually recent migrants, who are not receiving services."*

**On community-based points of contact...** *Several reviewers write, "The points of contact with underserved groups vary, but hairdressers, barbers, tailors, traditional healers, traditional birth attendants, peer counselors, male counselors, and retired nurses and midwives have all been effective points of contact for us."*

**On setting your objectives...** *Several reviewers say, "It is important to deal openly and honestly with underserved groups and negotiate with them in good faith. If you try to impose your objectives, the group will recognize your aims and reject your services, however beneficial they may be."*

**On defining a strategy...** *One reviewer suggests, "A strategy can be considered a collection of objectives, which include creating an enabling environment, creating demand, providing services (both static and community-based), providing supplies, especially contraceptives, local capacity building, and evaluation."*

**On providing mobile services...** *One reviewer relates, "We have started to hire local drivers who have their own jeeps or vans. Now we do not have to pay maintenance or driver salaries. We have found this new approach much more cost-efficient."*

**On managing outreach strategies...** *One reviewer writes, "Depending on the scale of the problem in a country, it may be advisable for the Ministry of Health to create a separate unit or division which works solely with underserved communities so that it can focus on the particular management challenges facing its service delivery strategies."*

**On sustaining services over the long term...** *One reviewer emphasizes, "Focus on the continuation of the services rather than on the continuation of the organization through which you first begin providing services."*

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## Checklist for Bringing Services to Hard to Reach Populations

- Identify the hard to reach, underserved population groups in your service delivery area, their location, and possible contact points in their communities.
- Choose an underserved group to reach, basing your choice on reliable demographic and epidemiological data whenever possible. Involve a wide variety of groups (e.g., clients, funding sources, and staff) in this selection process.
- Work with community members and community organizations to carry out a rapid low-cost needs assessment and identify the group's health needs.
- Identify potential working partners among the community-based groups, non-governmental organizations, religious leaders, private organizations, development projects, government ministries, and donors already working in the area.
- Work with the community to set qualitative and quantitative objectives for your program.
- Select a strategy or combination of strategies to attain your objectives, given your budget and other resources.
- Identify points of contact.
- Hire staff and use outreach workers who are culturally sensitive to the underserved group and who can speak their language, or train your existing staff in working with the group. Carry out regular motivational activities to keep up staff and worker enthusiasm.
- In managing your strategy, pay particular attention to planning, staffing, logistics, and sustainability.
- Establish a system for receiving accurate and timely information on services, supplies, and activities so that you can identify problems as they arise and address them promptly.
- Integrate your services for underserved groups into your ongoing programs and activities.

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*The Manager*  
Family Planning Management Development  
Management Sciences for Health  
400 Centre Street  
Newton, Massachusetts 02158-2084 USA  
Phone number: (617) 527-9202  
Fax number: (617) 965-2208  
E-mail: [fpmpubs@msh.org](mailto:fpmpubs@msh.org)

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# The Manager

## CASE SCENARIOS FOR TRAINING AND GROUP DISCUSSION

### The Perolimbria Ministry of Health Brings Services to a Hard to Reach Population

“I have good news!” said Dr. Vargas, Deputy Administrator of the Ministry of Health in Perolimbria to Sra. Jimenez and Dra. Lizarraga, his regional office colleagues, as they entered his office. “We will be supporting a new program to reach one of the underserved populations in Sra. Jimenez’ region.”

Sra. Jimenez, Regional Director, nodded and removed her coat. “So, which population are we planning to reach, the mountain tribes, or the river groups?” she said.

“Just the mountain tribes,” said Dr. Vargas. “We have been wanting to get funding to reach those groups for a long time. Let’s talk about what strategies we should consider.”

“Providing services in that region is going to be a real challenge,” said Dra. Lizarraga, Community Health Officer. “Getting around is very difficult what with erosion of the roads, flash floods in the spring, and heavy snow in the winter. And it takes a long time for these groups to accept outsiders. I know some people from the non-governmental group ACOMDE, which started working there five years ago to form women’s groups in the larger villages. They say they still feel like strangers sometimes when they visit.”

“What work do they do with the women’s groups?” asked Dr. Vargas.

“Some literacy programs, nutrition education, and a pre-school program, mostly,” she answered. “They say that attendance at their programs is irregu-

lar. A lot depends on the time of year, and whether the women are busy in their fields or not. The group leader makes a big difference, too. In the villages where the leader is dynamic and respected, the programs are well attended, and ACOMDE is seeing some impact on child survival and child growth rates.”

“What kind of health services do you think these communities would be most open to receiving right away?” asked Sra. Jimenez.

“I think many villagers would be open to services that improve the health of mothers and children,” said Dra. Lizarraga. “Immunizations will be accepted by younger people, though the elders are suspicious of them. Family planning will be accepted by some couples if we hold community information sessions and stress the health advantages. But the men in the community could become resentful if all our services are for women and children. Have you thought of services that would include them, too?”

“The Ministry is interested in providing integrated health services that include family planning and other reproductive health care for men and women, and maternal and child health services,” said Dr. Vargas.

“We won’t be able to decide what services to offer without consulting the communities first,” said Sra. Jimenez. “Why don’t we involve local people in doing some rapid surveys or focus group discussions to help identify their needs?”

## Case Scenario: Bringing Services to a Hard to Reach Population

“I think that’s a good idea,” Dra. Lizarraga, nodding her head. “But do we have enough staff who can speak their language and are sensitive to their culture?”

“Hmmm, that could be a problem,” said Dr. Vargas.

“You might find some administrative-level staff here in your office who are from that region,” said Dra. Lizarraga. “This might be an opportunity for them to both help their own people and grow professionally.”

“There are some people in my department who might be interested,” said Sra. Jimenez. “But they don’t have much experience with outreach services. Do you think we should open stationary clinics?”

Dr. Vargas shook his head. “Not at first,” he said. “I think we would have too much trouble staffing them, at first. And logistics and supervision would be challenging in that area. I think we should consider starting out with either a mobile clinic or a community-based distribution program. Or maybe a combination of the two.”

“Is there enough money for a vehicle and the maintenance, fuel, and staff travel costs required by a mobile program?” asked Sra. Jimenez. “How long is the funding going to last?”

“Well, we have sufficient funding to purchase two vehicles to start,” said Dr. Vargas. “We’ll need those anyway, even for a CBD program, for supervision and logistics. But I am concerned that there might not be enough money to pay community

agents if we decide to go the CBD route. Do you think that women might work with the project as volunteers?”

“Yes, probably,” said Dra. Lizarraga. “The status of being a volunteer might be incentive enough for many women, especially if you are offering training, with certificates.”

“That sounds like a good idea,” said Dr. Vargas. “Especially if we could coordinate the training and travel with another program that could share some of the costs. What other organizations are working in these communities?”

“Well, besides ACOMDE, the Ministry of Agriculture and Forests has some environmental activities,” said Dra. Lizarraga. “And another non-governmental organization has activities that promote cultivation of traditional crops. I have contacts with people in both those organizations.”

Just then Dr. Vargas’ secretary entered to say that his boss, the Administrator, was on the phone. “Well, I think we’ve exchanged some excellent ideas today,” said Dr. Vargas as he reached for the receiver. “Sra. Jimenez, I want you to set up a committee that can begin to develop our strategies. I suggest you include Dra. Lizarraga and identify someone at the Ministry of Agriculture and Forests, the Ministry of Education, and ACOMDE. They may be able to suggest other committee members. Let’s meet again in two weeks, when I’ll have more details on funding.”

### Case Discussion Questions

1. List some of the challenges associated with reaching the underserved group discussed in the case.
2. Identify the three service delivery strategies presented in the case and explain how each strategy would address the challenges you listed in the first question.
3. Discuss some of the management implications that should be considered for each strategy.

## Case Analysis: Bringing Services to a Hard to Reach Population

### 1. List some of the challenges associated with reaching the underserved group discussed in the case.

Some of the challenges associated with reaching this group are related to their location, while others are related to their culture, language, and lifestyle. Their location in a mountainous area poses challenges to travel. The roads become eroded, flooding is a problem, and heavy snows in winter will inhibit access to their villages. Their culture and language pose a challenge to working with them, as it may be difficult to hire or train staff who are sensitive to their culture and speak their language. For any strategy, it will be a challenge to provide services at times that are convenient for the village women. During busy agricultural seasons they will not be as available to participate in information, training, or other kinds of programs.

### 2. Identify the three service delivery strategies presented in the case and explain how each strategy would address the challenges you listed in the first question.

The three strategies presented in the case are a mobile unit, a community-based distribution program, and working with partners.

**Mobile Unit.** A mobile unit would overcome the challenge of location by traveling on a regular basis to visit the underserved population's villages to provide services. In winter and spring, when snow and flooding could impede travel, it would be difficult for the mobile unit to operate, and the schedule would have to work around that. The unit could overcome cultural and language barriers by using staff who know the local culture and speak the local language, or by training existing staff in the culture and language. To overcome the barrier of availability of women, the unit's visits could be timed to coincide with local market days, thus allowing women to combine their visit to the unit with a visit to the market.

**Community-Based Distribution.** A community-based distribution program would overcome the challenge of location by having agents based in the communities themselves. In terms of culture and language, the local agents would have the same culture and language as their neighbors, but the supervisors hired would have to be able to communicate with and understand the culture of the local agents. The agents would also be well-acquainted with the daily, weekly, and seasonal schedules of their neighbors and would be able to help develop a program or a visit schedule that would allow women to participate without requiring them to leave their other responsibilities.

**Working with Partners.** For this strategy, the MOH will form a committee with representatives from the Ministry of Agriculture and Forests, the Ministry of Education, and the NGO ACOMDE to begin to develop strategies. Coordinating with partners could help the MOH make contacts in the local communities more quickly. Coordinating with partners may also help with such challenges as supervision and logistics, if shipment of contraceptives and supplies can be coordinated with the travel schedules of the partners.

## Case Analysis: Bringing Services to a Hard to Reach Population

### 3. Discuss some of the management implications that should be considered for each strategy.

For the mobile unit strategy, management implications include:

- purchasing, leasing, or borrowing vehicles;
- providing regular funding for fuel, a crew, and maintenance;
- coordinating with another ministry or an NGO, or both;
- staffing the unit with culturally sensitive medical and support staff;
- equipping and supplying the unit;
- developing and sticking to a regular visit schedule in the district;
- keeping records and reporting services and expenses;
- assuring medical quality;
- managing complications and follow-up;
- using and perhaps maintaining a site (e.g., a school house or other public facility).

For the CBD strategy, management implications include:

- training the CBD workers;
- supervising the CBD workers;
- hiring culturally sensitive and linguistically able supervisory staff, or providing cultural or linguistic training to existing staff;
- identifying what supplies to provide the CBD workers;
- developing a regular system for re-supplying the CBD workers that would give them enough supplies to last during the months when access could be difficult or impossible;
- keeping records and reporting.

For the strategy of working with partners, management implications include:

- establishing common goals and remaining focused on those throughout;
- creating and maintaining ownership among the various partners;
- managing the flow of information;
- keeping the lines of communication open;
- clarifying accountability and accounting processes and procedures;
- costing of inputs;
- sharing successes and benefits.