ADAPTING YOUR PRACTICE

Treatment and Recommendations on Reproductive Health Care for Homeless Patients

Reproductive Health Care

NETWORK HCH CLINICIANS' NETWORK

ADAPTING YOUR PRACTICE:

Treatment and Recommendations on Reproductive Health Care for Homeless Patients

Health Care for the Homeless
Clinicians' Network
2008 Second Edition

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DISCLAIMER

The information and opinions expressed in this document are those of the Advisory Committee for the Adaptation of Clinical Guidelines on Reproductive Health Care for Homeless Patients, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

PREFACE TO THE SECOND EDITION

Clinicians practicing in Health Care for the Homeless (HCH) projects[1] and others who provide primary care to people who are homeless or at risk of homelessness routinely adapt their medical practice to foster better outcomes for these patients.

Standard clinical practice guidelines often fail to take into consideration the unique challenges faced by homeless patients that may limit their ability to adhere to a plan of care. Recognizing the gap between standard clinical guidelines and clinical practices used by health care providers experienced in the care of individuals who are homeless, the HCH Clinicians' Network has made the adaptation of clinical practice guidelines for homeless patients one of its top priorities.

The original copy of these guidelines was developed in 2003 by primary health care providers, representing HCH projects across the United States. These 2008 guidelines reflect their original work and include revisions that suggest updates in standards of practice in reproductive health care for patients who lack stable housing. These recommendations reflect their collective experience in serving homeless adults and adolescents.

We hope these recommendations offer helpful guidance to primary care providers serving patients who are homeless or at risk of homelessness, and that they will contribute to improvements in the sexual and reproductive health of homeless individuals.

Sharon Morrison, RN, MAT
Health Care for the Homeless Clinicians' Network

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This work is enhanced by the collective contributions of these individuals.

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DIAGNOSIS AND EVALUATION

History

- **Living conditions** Ask where patient lives; assess for residential stability, access to food and water.
- **Sexual history** Ask about sexual identity, orientation, behaviors, number of partners, pregnancies, and sexually transmitted diseases.
- **Desire for contraception** Assess patient's need and desire for contraceptive services. Ask about history of contraceptive use.
- **Desire for Pregnancy** Assess patient's plan for future pregnancies.
- **Substance abuse/ mental health** Assess patient's ability to take pills daily or remember to return for follow-up.
- **Medical history** Elicit history of ongoing medical problems, or prior history of significant conditions such as hypertension, liver disease, or thromboembolic events.
- **Contraceptive history** If patient has a history of IVDU, assess exposure to hepatitis C and tailor physical evaluation and laboratory evaluation toward assessing liver function status (albumin, prothrombin time, and bilirubin).
- **Smoking history** Weigh risk factors for using estrogen-containing methods with risk of pregnancy.
- **Medications** Ask female patient about medications she may be taking which may require careful regulation if taken in conjunction with birth control pills.
- **Immunizations** Ask whether patient has been vaccinated against measles-mumps-rubella (MMR) and hepatitis. All persons engaging in high-risk sexual behaviors may be at risk for hepatitis A and B and should be vaccinated as necessary.
- **Menstrual history** If history of irregular cycles, obtain additional information such as relationship to weight gain or loss, substance use, and galactorrhea.
- **Spiritual/ cultural history** Ask about spiritual and cultural beliefs, values and practices of patient and partner affecting their use of contraception.
- **Domestic/ interpersonal violence** Ask explicitly about history of physical/sexual abuse.
- **Insurance status/ resources** Assess patient's ability to pay for various contraceptive methods.

Physical examination

- **May be postponed** Communicate willingness to initiate contraception without a physical exam. Include a blood pressure evaluation even if the pelvic examination has been deferred.
- **Sexual abuse** Be sensitive to concerns, fears and safety needs of patient with a history of sexual abuse. Understand the paradigm of traumatic experience. Respect patient's physical space; ask permission to touch and to perform each exam.
- **Genital exam** recommended as part of reproductive health care for males and females. Provider should be extremely sensitive to patient with a history of sexual abuse.
- **Oral Health Care** Oral health care should be coordinated among prenatal and oral health care providers. Delay in necessary treatment could result in significant risk to the mother and indirectly to the fetus.
- **Nonjudgmental attitude** Make every effort to convey openness to patient decisions regarding sexual behavior, desire to use contraception, and plans regarding present or future childbearing.

Diagnostic tests

- **STD screening** Concurrently assess for and treat sexually transmitted diseases. Test for gonorrhea, chlamydia, syphilis, HIV (following local regulations regarding patient consent), hepatitis B antigen, trichomonas, bacterial vaginosis, and monilia. Don't neglect possibility of infection of multiple orifices in men and women, considering sexual practices. For patients with a history of Hepatitis C or chronic Hepatitis B infections, include CBC with differentials, liver function and bilirubin testing.
- **Pregnancy test** urine pregnancy test (UCG)
- **Routine health care maintenance** For female: annual Pap smear with reflex HPV testing beginning within three years of sexual debut **or** at age 21 or older. Mammogram if indicated. For male: periodic testicular self-examination and instruction and clinician examination as appropriate; discussion on prostate cancer screening.
- **Tests for other concurrent conditions** Anemia screening if at risk, urinalysis if symptomatic.

PLAN AND MANAGEMENT

Education, self- management

- **Hygiene** Assist client with how to keep clean, given limited access to bathing facilities, menstrual hygiene items, and/or clean underwear.
- **Contraceptive methods** Describe each method in a way that is understandable to patient. Give simple instructions for contraceptive method selected. Ask if there is any barrier to complying with the plan of care and if anything about it is unclear.
- **Side effects** During every visit reinforce education about medication/ contraceptive side effects.
- **STD protection** Explain that many contraceptives (including birth control pills) do not protect against sexually transmitted diseases. Recommend condom use even with other contraceptive method.
- **Risk reduction** Counsel at-risk clients to adopt safer sexual behaviors. Use interactive counseling that focuses on preventing unwanted pregnancy and transmission of disease.
- **Smoking cessation** Use opportunity to encourage smoking cessation; assess readiness to change.
- **Partner education** If possible, include partner in discussion of contraceptive alternatives.
- **Preconception counseling** Discuss nutrition, mental health and substance abuse. Explain risks of pregnancy to patient and fetus related to alcohol, drug, and nicotine use. Encourage folate-containing vitamin supplements. Educate client desiring pregnancy about advantages of and contraindications to breast feeding.
- **Health care maintenance** Encourage regular breast/testicular self-exam.
- **Storage/expiration of condoms, birth control pills** Educate patient about proper storage of condoms and birth control pills.
- **Co-existing medical conditions** Educate patient about possible effects of pregnancy on chronic medical conditions.

Medications/ contraceptive devices

- **Dispense on site** If possible, instead of giving patient a prescription or referring elsewhere. Recommend contraceptive methods that are easiest to use.
- **Injections** Consider injectable contraception if patient cannot adhere to daily regimen.
- **Birth control pills** Determine number of pill packs to prescribe at one time based on patient's access to medications and ability to adhere to prescribed regimen.
- **Transdermal methods** offer the advantage of convenience for some homeless clients. Consider patient's occupation when prescribing contraceptive patches.
- **Female condom** Easy to use and as effective as the male condom, this method may offer homeless clients another alternative for birth control.
- **IUD** Intrauterine Devices provide a contraception option for women unable to use hormonal options in the presence of an elevated liver function status. WHO guidelines should be followed.
- **Implanon** is an easy method of long term birth control which can be inserted in a clinic or medical van.
- **NuvaRing** The NuvaRing is a one month method of birth control that is inserted vaginally and remains for the month.
- **Emergency contraception** Emergency contraception available under the brand name, Plan B, can be administered up to five days after unprotected intercourse to prevent pregnancy. Plan B or alternate method of emergency contraception should be offered to women with a history of rape or unprotected intercourse within the last five days.
- **Initiation of contraception** After discussion of contraceptive alternatives, patient may wish to sign consent and begin contraceptive method immediately.
- **Vitamins** Prescribe folate supplement to all women of childbearing age. Recommend calcium supplement.
- **Contraindications** Estrogen-containing methods are not recommended for women 35 years of age or older who smoke. IUDs are contraindicated for women with high STD risk.
- **Anti-seizure medication** Careful regulation of anti-seizure medication required if taken in conjunction with birth control pills. IUD should be considered as a safe contraceptive option for women taking anti-seizure medications if all other contraindications are absent.

Reproductive Health Care for Homeless Patients: Summary of Recommended Practice Adaptations

Associated problems/ complications

- **Pregnancy** Counsel patient on medical and personal risks of pregnancy. Help patient to understand risks of pregnancy related to irregular menses, drug and alcohol abuse.
- **Housing problems** Recognize that lack of housing may be even more of a problem once client becomes pregnant.
- **PTSD** Recognize that many homeless women and men are survivors of physical/sexual assault, with associated risks of psychological trauma and sexually transmitted disease.
- **Financial barriers** Limited resources for medications and lack of affordable health insurance for impoverished adults unaccompanied by children may present barriers to reproductive health care for both women and men.
- **Lack of safe storage place** Store contraceptive devices and medications for patient and provide ready access to them.

Follow-up

- **Frequent follow-up** is recommended to deal with any side effects of prescribed contraceptive method.
- **Reminders** Appointment cards are useful to remind patient when to return to clinic for next prescription or injection.
- **Positive reinforcement** Thank patient for showing up, even if late, and for any attempt to follow plan of care.
- **Contact information** Re-confirm at every visit where patient is staying, address, phone number, cell phone, emergency contact number(s) where message can be left, case manager's name (if seen in clinic), clinic numbers (if seen in shelter).
- **Drop-in policy** Encourage appointments but allow walk-ins, to promote better follow-up care and increase access to reproductive health services.
- **Educate staff, co-workers** to increase their knowledge of contraceptive options and comfort level with homeless patients.
- **Nursing Protocols** clinics should consider the establishment of protocols that allow nursing staff to administer walk in quick start and emergency contraception prior to a provider visit.

INTRODUCTION

Reproductive health care can be especially challenging for clinicians serving individuals who are homeless, many of whom engage in risky sexual behaviors without appropriate contraceptive protection, increasing the likelihood of undesired pregnancy and sexually transmitted disease. Underlying mental health and/or substance abuse problems, often precipitated by a history of sexual abuse, may complicate these risks, as the following research findings illustrate:

Unprotected sex is associated with high rates of sexually transmitted disease among homeless adults and youth, regardless of gender. HIV infection has been reported to be at least three to nine times more prevalent among homeless people (Menchaca, 2008). Negative attitudes toward condom use, inadequate access to condoms, receptive anal intercourse and engaging in sex work are among the documented risk factors for transmission of HIV in both homeless men and women (Badiage, 2008; Somlai, 1998). High risk for both HIV and viral hepatitis (HBV, HCV) is also reported among homeless adults and youth, particularly those involved in intravenous drug use and unprotected sex (Badiage, 2008; Garfein, 1998; Busen & Beech, 1997; Morey & Friedman, 1993; Wang, 1991).

Risky sexual behaviors and sexually transmitted diseases in homeless adolescents and youth, and subsequently a much higher rate of STIs (Solorio, 2006) is frequently linked to childhood sexual abuse (Johnson, 2006; Noell, 2001; Tyler, 2000). One study found that over half of homeless men and women aged 16–20 years reported a history of sexual abuse, and nearly one in four had been treated for gonorrhea (Rew, 2002). Another study found that 92% of homeless women surveyed had experienced severe physical and/or sexual assault at some time in their lives (60% before the age of 12), and 39% suffered from posttraumatic stress disorder (Browne & Bassuk, 1997). Homeless individuals who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to victimization, and less likely or able to seek help (Wenzel, 2001; Burroughs, 1990).

Ninety-five percent of homeless women are sexually active (Solorio, 2006; Nyamathi, 1993), yet 65 percent do not use birth control (Institute for Children and Poverty, 2008). Less than one percent of homeless women currently use condoms, despite lifestyles that place them at great risk for HIV and other sexually transmitted diseases (Gelberg, 1985; Shuler, 1994; Burroughs, 1990). Problems with hygiene, sexual assault or exploitation, and survival sex increase their risk for negative health outcomes including early unplanned pregnancy and sexually transmitted diseases (Ensign, 2001; Burroughs, 1990). Homeless women have twice the national rate for unplanned pregnancy (Donohoe, 2004). Of surveyed family planning clinic users, 60 percent had a history of a sexually transmitted disease, and 28 percent had a history of pelvic inflammatory disease (Shuler, 1994). The most commonly cited deterrents to contraceptive use by homeless women are side effects, fear of potential health risks, partner's dislike of contraception, and cost (Gelberg, 2002). Age-related factors and ethno-cultural perceptions may deter some homeless women from using particular contraceptive methods. For example, 73 percent of homeless teens but only 38 percent of all surveyed homeless women are willing to consider female condom use; implants are rejected by 80 percent of surveyed African American women; and Native Americans report low use of all contraceptive methods (Gelberg, 2001).

More than one-fifth of homeless women using family planning services have not had a Pap smear in the past five years (Gelberg, 1985), compared to less than 9 percent of women in the general population (Hayward, 1988). This is alarming, given that 23 percent of homeless family planning clinic users had an abnormal Pap smear (Shuler, 1991; increased abnormal paps in the adolescent homeless population also supported by Quinlivan, 2004). Based on studies of homeless women's obstetrical history, 74 percent have had children (Burnam, 1989; Shuler, 1994), and greater than 54 percent are currently at risk for unintended pregnancy (Gelberg, 2008; Shuler, 1994). Homeless women are more likely to be pregnant (11 percent of homeless women aged 20 and over, and 24 percent of 16–19-year-old homeless youth) than their poor but housed peers (five percent). In addition, they are more likely to receive inadequate prenatal care than poor but housed women (56 percent versus 15 percent) (Chavkin, 1987).

Despite their increased risk for sexually transmitted diseases and sexual abuse and their shared responsibility for undesired pregnancies, few homeless males of any age receive reproductive health services or sexual counseling unassociated with treatment for acute medical problems. Like women, men need to prevent unintended pregnancies, protect themselves and their partners against acquiring STDs including HIV, and they need to be screened and treated, if necessary, for such diseases. In addition to medical attention, they need counseling to develop self-esteem and self-awareness, learn how to avoid violent or coercive relationships, and engage sexually in ways that are respectful of themselves and their partners (Sonfield, 2002).

Clinical practice guidelines for the care of people who are homeless are fundamentally the same as for those who are housed. Nevertheless, primary care providers who routinely serve homeless people recognize the need to take living situation and co-occurring disorders into consideration when developing a plan of care with their patients. It is our expectation that these simple adaptations of established guidelines will improve the reproductive health of homeless individuals regardless of gender.

The recommendations in this guide were compiled to assist clinicians who provide reproductive health care and family planning services for homeless individuals. The World Health Organization's *Medical Eligibility Criteria for Contraceptive Use* (2004), the American College of Obstetrics and Gynecology's *Guidelines for Women's Health Care*, 2nd edition (2002), and the Guttmacher Institute's *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men* (March 2002) are the primary source documents for these adaptations. Recommendations found in these guidelines are not restated in this document except to clarify a particular adaptation.

CASE STUDY: REPRODUCTIVE HEALTH CARE FOR A HOMELESS ADULT

The patient, a 27-year-old female, G2, P0, with a history of using condoms and oral contraceptives, presents for a well woman exam as part of her residential recovery program.

Social History: A rural town high school graduate, she has a history of sexual and physical abuse in her childhood and moved to a large city to become a dancer. She began using alcohol and cocaine as "coping" mechanism which gradually moved into smoking crack cocaine. She recently began using heroin. Her addiction led to becoming homeless. At this visit she is 30 days clean for the first time since she was 18 and is stable in residential treatment.

Medical history: Patient has received annual pap exams through Planned Parenthood until 2 years ago. Her PMH is significant for Pelvic Inflammatory Disease. She has had two therapeutic abortions. She has been diagnosed with Post Traumatic Stress Disorder resulting from a history of both childhood and adult sexual trauma that began at the age of six year old. She currently participates in a trauma informed women's recovery group where she received counseling for PTSD.

Physical examination: Routine including pelvic exam, pap and STD screening.

Labs: Hepatitis panel, Comprehensive metabolic panel, CBC with differential, pap, Gonorrhea, Chlamydia, HIV and RPR.

Lab Results: Hepatitis C positive, Hepatitis B immune, HIV negative, GC/CT negative. CBC with differentials normal, CMP normal with slightly elevated AST (43).Bilirubin (.01)

Medications: Trazadone, Suboxone, multi-vitamin

Follow-up: Patient returned 5 months later to discuss contraception, as she has plans to leave residential treatment in a month or two, and she is considering treatment for her Hepatitis C. She is expecting to see the Clinic Hepatitis C provider in a few weeks to get a genotype and viral load, in preparation for treatment.

Current Assessment: Patient desires pregnancy in the future, when asked she says "a couple of years". She reports sporadic success with oral contraceptives acknowledging that she frequently forgot to take the pills. She has been taking vitamins daily, and feels confident that she could now remember to take the pills, but would like to know other methods that would work for her.

***IUD*:** She has a negative GC/CT on file and has been abstinent since the time of culture. She has a PMH of PID but no current infections that could place her at increased risk. She has a history of light periods, so the paraguard (copper T) would be a possibility, as would the Mirena IUD. ***Implanon*:** No contraindications. ***Combined oral contraceptive pills*:** Pt has Hepatitis C, but no evidence of active liver disease at this time. This method of birth control would work as well, and 12 months of packs could be dispensed, as she has taken them in the past, and she knows she tolerates them. ***Nuva Ring*:** No contraindications as they are the same as combined oral contraception. ***Condoms*:** No contraindications.

Plan: Patient agreed to try Implanon, she like the idea of a two year method of birth control that coincided with her plans for a pregnancy. Implanon was reviewed including probability of abnormal bleeding patterns, consent signed and Implanon was inserted. The visit took less than 45 minutes, including 15 minutes of nursing education while the provider saw another patient.

Follow up: Patient seen by Hepatitis C specialist where she reported no problems with the Implanon. Her treatment for Hepatitis C is scheduled to begin in a few weeks.

Reproductive Health Care

Diagnosis and Evaluation

HISTORY

- **Living conditions** Ask where the patient lives; assess for residential stability, access to drinking water and food (particularly where needed to take medications), bathing facilities, a safe place to keep medications (including medications requiring refrigeration) and hygiene items.
- **Sexual history** Ask about sexual identity, orientation, behaviors, number of partners, pregnancies, and sexually transmitted diseases including hepatitis B and C. Assess STD risk in considering IUD use.
- **Desire for contraception** Assess the patient's need and desire for contraceptive services. Ask about history of contraceptive use. Offer reproductive health services to all patients, regardless of gender.
- **Desire for pregnancy** Assess the patient's plan for future pregnancies. If the patient plans pregnancy within a short period of time, elicit past pregnancy history as well as social history regarding previous children. If the patient is experiencing social or medical instability, validate her desire for pregnancy and elicit what conditions she desires to have present in her life for the birth of her baby. Many women desire pregnancy and children. Within the context of pregnancy planning, it is helpful to elicit the patient's thoughts about what preparations she has already made, what needs she has, what resources she knows, and what barriers she perceives that could hinder her ability to have a healthy baby.
- **Substance abuse/ mental health** Assess the patient's ability to take pills daily or remember to return for follow-up.
- **Medical history** Elicit the best possible history of ongoing medical problems and significant prior conditions such as hypertension, liver disease, or thromboembolic events. This can be difficult in homeless patients who seek medical care from multiple providers in multiple sites.
- **Contraceptive history** If the patient has a history of IVDU, assess exposure to hepatitis C and tailor physical evaluation and laboratory evaluation toward assessing liver function status. If liver function is compromised, consider progesterone only hormonal contraception or IUD. Oral contraceptives are contraindicated in patients with acute viral hepatitis (patients with increased bilirubin, etc.) as well as in advanced chronic liver disease such as cirrhosis. In chronic hepatitis B or C, if the liver functions tests are normal (albumin, prothrombin time, and bilirubin) and there is no thrombocytopenia or other clinical evidence of cirrhosis, oral contraceptives can be considered.

- **Smoking history** Given higher incidence of smoking in homeless population**,** weigh risk factors for using estrogen-containing methods with risk of pregnancy.

- **Medications** Ask female patients about medications they may be taking, especially psychiatric and anti-seizure drugs, which may require careful regulation if taken in conjunction with birth control pills.

- **Immunizations** Ask whether the patient has been vaccinated against measles-mumps-rubella (MMR) and hepatitis. Women of childbearing age should receive MMR vaccine if not pregnant. All persons engaging in high-risk sexual behaviors may be at risk for hepatitis A and B and should be vaccinated as necessary.

- **Menstrual history** If there is a history of irregular menstrual cycles, obtain additional information such as relationship to weight gain or loss, substance use, and galactorrhea (abnormal milk production, a common side effect of some psychiatric medications and sometimes seen in substance abusers).

- **Spiritual/ cultural history** Ask about spiritual and cultural beliefs, values and practices of the patient and partner affecting their use of contraception.

- **Domestic/ interpersonal violence** Ask explicitly about a history of physical/sexual abuse. This may be one of few opportunities the patient has to talk about these issues without a partner present.

- **Insurance status/ resources** Assess the patient's ability to pay for various contraceptive methods.

PHYSICAL EXAMINATION

- **May be postponed** Communicate willingness to initiate contraception (e.g., birth control pills or injectable contraception) without a physical exam (see Stewart et al, 2001). Include a blood pressure evaluation even if the pelvic examination has been deferred. Do not tell the patient that an exam is prerequisite to beginning contraceptive method, unless IUD, unexplained bleeding or other pelvic symptoms warrant immediate evaluation.

- **Sexual abuse** Be sensitive to concerns, fears and safety needs of patients with a history of sexual abuse, who may be reluctant to have a pelvic exam. Understand the paradigm of traumatic experience. Respect the patient's physical space; ask permission to touch and to perform each exam.

- **Genital exam** recommended as part of reproductive health care for males and females, according to standard clinical guidelines. Also do a breast exam to address preventive care needs. The provider should be extremely sensitive to patients with a history of sexual abuse. See the patient with clothes on first; carefully explain the genital exam; ask permission to examine; and explain each step of the examination prior to initiating that step; never leave a female patient alone in stirrups.

- **Oral Health Care** Pregnant women are at higher risk for developing tooth decay, gum disease and chronic bacterial disease that affects both gums and bone structure. These risks increase in women who smoke, experience nutritional deficiencies or have less frequent visits to a dentist. Oral health care should be coordinated among prenatal and oral health care providers. First trimester diagnosis and treatment, including needed dental x-rays, can be undertaken safely to diagnose potential disease processes. Delay in necessary treatment could result in significant risk to the mother and indirectly to the fetus.

- **Nonjudgmental attitude** Make every effort to convey openness to patient decisions regarding sexual behavior, desire to use contraception, and plans regarding present or future childbearing. When a patient is currently experiencing homelessness and trying to achieve pregnancy, this can be particularly challenging.

DIAGNOSTIC TESTS

- **STD screening** Concurrently assess for and treat sexually transmitted diseases, recognizing higher incidence and need for more frequent screening if engaging in risky sexual behaviors. Sexually active homeless women should receive the same priority for STD screening as an initial prenatal patient. Test for gonorrhea, chlamydia, syphilis, HIV (following local regulations regarding patient consent), hepatitis B antigen, trichomonas, bacterial vaginosis, and monilia. When a pelvic examination is refused, urine gonorrhea and chlamydia screening combined with self-administered vaginal swab for saline and KOH preparations may be useful screening tools. Don't neglect the possibility of infection of multiple orifices in men and women, considering sexual practices. For patients with a history of Hepatitis C or chronic Hepatitis B infections, include CBC with differentials, liver function and bilirubin testing.

- **Pregnancy test** urine pregnancy test (UCG)

- **Routine health care maintenance** For female: annual Pap smear with reflex HPV testing beginning within three years of sexual debut **or** at age 21 or older. If results are abnormal consult latest guidelines for current recommendations. Mammogram if indicated (baseline mammogram between age of 35-40, every 1-2 years age 40-49, and every year age 50 and above). For male: periodic testicular self-examination and instruction and clinician examination as appropriate; discussion on prostate cancer screening with patients age 50 and older; 40 and older for African American men and men with family history of prostate cancer (AHRQ, 2007).

- **Tests for other concurrent conditions** – e.g., anemia screening if at risk, urinalysis if symptomatic.

Plan and Management

EDUCATION, SELF- MANAGEMENT

- **Hygiene** Discourage use of harsh cleansing products, bath water additives, vaginal perfumes and douches. Assist the client with how to keep clean, given limited access to bathing facilities, menstrual hygiene items, and/or clean underwear.

- **Contraceptive methods** Describe each method in a way that is understandable to the patient; take into account primary language, literacy, and possible cognitive deficit. Give simple instructions for the contraceptive method selected. Always ask if there is any barrier to complying with the plan of care and if anything about it is unclear. Supplement your discussion with simple and effective brochures (multilingual if possible).

- **Side effects** During every visit reinforce education about medication/contraceptive side effects (e.g., irregular bleeding with depo-medroxyprogesterone acetate). Discuss what to report to the health care provider and when to seek medical evaluation.

- **STD protection** Explain that many contraceptives (including birth control pills) do not protect against sexually transmitted diseases. Recommend condom use even with other contraceptive methods. Provide information on the availability of male and female barrier methods, either on-site or elsewhere. Provide information about vaginal creams, gels, and suppositories containing spermacides that will prevent pregnancy and may decrease risk of some STDs.

- **Risk reduction** Counsel at-risk clients to adopt safer sexual behaviors. Use interactive counseling that focuses on preventing unwanted pregnancy and transmission of disease, including description of risky behaviors and preventive methods. Counseling should be nonjudgmental, client-centered, and appropriate to the client's age, sex, sexual orientation, and developmental level. Promote abstinence, reduction in numbers of sexual partners, and use of condoms, but use a risk reduction approach. For patients involved in injection drug and/or other drug use, offer referral to substance abuse treatment and for access to clean needles when available.

- **Smoking cessation** Use the opportunity to encourage smoking cessation; assess readiness to change smoking behavior in a female who prefers birth control pills.

- **Partner education** If possible, include the patient's partner in discussion of contraceptive alternatives.

- **Preconception counseling** Discuss nutrition, mental health and substance abuse nonjudgmentally. Explain risks of pregnancy to the patient and fetus related to alcohol, drug, and nicotine use. Also explain risks of psychiatric medications or other prescribed medications during pregnancy. Encourage folate-containing vitamin supplements in women of childbearing age. Educate clients desiring pregnancy about advantages of and contraindications to breast

feeding. Within the context of pregnancy planning it is helpful to elicit the patient's thoughts about undertaken preparations, current resources and perceived barriers that influence pregnancy, childbirth and child rearing.

- **Health care maintenance** Encourage regular breast/testicular self-exam and teach the client how to do it.

- **Storage/expiration of condoms, birth control pills** Educate the patient about proper storage of condoms and birth control pills; advise not to use beyond the expiration date.

- **Co-existing medical conditions** Educate the patient about possible effects of pregnancy on chronic medical conditions (e.g., diabetes, asthma, seizures, and psychiatric disorders). This information may help male or female patients in decisions regarding family planning or contraceptive use.

MEDICATIONS/ CONTRACEPTIVE DEVICES

- **Dispense on site** if possible, instead of giving the patient a prescription or referring elsewhere. Recommend contraceptive methods that are easiest to use. For a patient desiring contraception, initiate some contraceptive method immediately. Consider patient preference for dosage form (injection versus pills or patch) and encourage dual use of barrier and hormonal method.

- **Injections** Consider injectable contraception if the patient cannot adhere to a daily regimen (for birth control pills), especially if risks associated with pregnancy are high. If the pregnancy test is negative and likelihood of pregnancy before the next visit is high, consider initiating injection beyond five-day onset of menses. Counsel the patient regarding theoretic and very small risk to the fetus if a hormonal method is given inadvertently in early pregnancy. It may be desirable in some cultural or social situations for the female to have access to a contraceptive method of which her partner is not aware. Injections offer some benefit in these situations.

- **Birth control pills** Determine the number of pill packs to prescribe at one time based on the patient's access to medications and ability to adhere to the prescribed regimen. Make a calendar for the patient to use. For patients with mental health problems, consider prescribing only one pill pack at a time.

- **Transdermal methods** Transdermal contraception methods offer the advantage of convenience for some homeless clients, but may be expensive. The provider should also consider the patient's occupation when prescribing contraceptive patches. Recognize that conspicuous forms of birth control (such as contraceptive patches, implants, etc.) may present an occupational disadvantage to some individuals (such as dancers in clubs — a common source of employment for homeless people in some areas).

- **Female condom** Easy to use and as effective as the male condom in preventing pregnancy and protecting against sexually transmitted disease, this method may offer homeless clients another alternative for birth control. It is inexpensive and sold over the counter, but not always available.

- **IUD** Intrauterine Devices provide a contraception option for women unable to use hormonal options in the presence of an elevated liver function status. IUDs are safe, effective, long-term methods of birth control that provide women experiencing homelessness an option that does not require regular visits to a clinic.

  WHO guidelines should be followed, and an IUD should only be inserted if a woman is free from infection at the time of insertion. She should have a negative GC/CT on file within the last three months, and upon insertion she should not have any objective evidence of infection. Women have an increased risk of PID if they have an infection at the time of insertion but there is no increased risk for PID with an IUD after the period immediately following insertion. There are two types of IUDs available in the US, the Copper T 380A and Mirena IUD.

- **Implanon** Implanon is an easy method of long-term birth control which can be inserted in a clinic or medical van. It is a progesterone only contraceptive device that lasts two years and takes less than 15 minutes to prep and insert. Implanon has very few contraindications, and has similar side effects to progesterone only oral contraceptives, including abnormal menstrual bleeding, which clients need to be aware of prior to insertion.

- **NuvaRing** Many women prefer a method of contraception that they do not have to remember on a daily basis. The NuvaRing is a one-month method of birth control that is inserted vaginally and remains for the month (three weeks in, one week out (for withdrawal bleeding/menses)). It can only be dispensed in three-month increments from a pharmacy as it becomes unstable and expires after being removed from temperature controlled refrigeration. While the patient does not need to keep them refrigerated, they must be kept away from direct sunlight and temperatures above 86^0F. (30^0C). NuvaRing currently has the same FDA contraindications as the combined oral contraceptive pill.

- **Emergency contraception** Emergency contraception is available under the brand name, Plan B. Plan B can be administered up to five days after unprotected intercourse to prevent pregnancy. The earlier it is administered, the more effective it is. Plan B or an alternate method of emergency contraception (see resources) should be offered to women with a history of rape or unprotected intercourse within the last five days. Plan B causes nausea, and could be dispensed with an anti-nausea medication. A regular method of birth control can be started immediately with Plan B to prevent future pregnancies.

- **Initiation of contraception** After discussion of contraceptive alternatives, patient may wish to sign consent and begin contraceptive method immediately. Plans for voluntary surgical sterilization may also be initiated, but a temporary method should be considered until this can be accomplished.

- **Vitamins** Prescribe folate supplement to all women of childbearing age (to prevent neural tube defects in the fetus). Vitamins are usually appealing to homeless women, who have inadequate diets. Recommend calcium supplement (e.g., Tums) to patients on metroxyprogesterone acetate to counteract demineralization of bone caused by progesterone-only method.

- **Contraindications** Estrogen-containing methods are not recommended for women 35 years of age or older who smoke. (Higher prevalence of smoking has been documented among homeless adults than in the general population.) IUDs are contraindicated for women with high STD risk (true of many homeless women).

- **Anti-seizure medication** Careful regulation of anti-seizure medication is required if taken in conjunction with birth control pills. Women with seizure disorders may require an additional contraceptive method or a higher dose of oral contraceptive pills than women who are not on anti-seizure medications. This is especially important to avoid an unintended pregnancy while taking a seizure medicine that may be teratogenic. Include in the discussion the issue of deleterious side effects of epileptic medications in pregnancy. IUD should be considered as a safe contraceptive option for women taking anti-seizure medications if all other contraindications are absent.

ASSOCIATED PROBLEMS/ COMPLICATIONS

- **Pregnancy** Counsel the patient on medical and personal risks of pregnancy. May encounter refusal of birth control, desire for pregnancy at a very unstable time of life (e.g., because loss of other children to state custody, belief that the patient's partner will be more faithful if she is pregnant, to get sympathy and benefits). Some females try to achieve pregnancy while actively using drugs and alcohol. Many drug users don't have regular menses and consider birth control unnecessary. Help the patient to understand risks of pregnancy related to irregular menses, drug and alcohol abuse.

- **Housing problems** Recognize that lack of housing may be even more of a problem once a client becomes pregnant.

- **PTSD** Recognize that many homeless women and men are survivors of physical/sexual assault, with associated risks of psychological trauma and sexually transmitted disease, which both complicate and enhance their need for reproductive health services.

- **Financial barriers** Limited resources for medications and lack of affordable health insurance for impoverished adults unaccompanied by children may present barriers to reproductive health care for both women and men.

- **Lack of safe storage place** Many homeless people don't have a safe place to store condoms, barrier devices, or medications. Store contraceptive devices and medications for patient and provide ready access to them.

FOLLOW-UP

- **Frequent follow-up** is recommended to deal with any side effects of the prescribed contraceptive method. Mention reproductive health to the patient at each visit. Make a plan to ensure return one month after the initial visit.
- **Reminders** Appointment cards kept in pouches, worn around the neck, are useful to remind the patient when to return to the clinic for the next prescription or injection. Use of voicemail reminders and outreach workers can also facilitate follow-up care.
- **Positive reinforcement** Thank the patient for showing up, even if late, and for any attempt to follow plan of care. Don't scold.
- **Contact information** Re-confirm at every visit where the patient is staying, address, phone number, cell phone, emergency contact number(s) where a message can be left, the case manager's name (if seen in clinic), and clinic numbers (if seen in shelter).
- **Drop-in policy** Be flexible. Encourage appointments but allow walk-ins, to promote better follow-up care and increase access to reproductive health services.
- **Educate staff, co-workers** to increase their knowledge of contraceptive options and comfort level with homeless patients.
- **Nursing protocols** Clinics should consider the establishment of protocols that allow nursing staff to administer walk-in, quick start and emergency contraception (up to three months of contraception prior to a provider visit).

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WEBSITES

World Health Organization	www.who.int.org
American College of Obstetrics and Gynecology	www.acog.org
Health Disparities Collaboratives	www.healthdisparities.net
National Guideline Clearinghouse	www.guideline.gov
National Health Care for the Homeless Council & Health Care for the Homeless Clinicians' Network	www.nhchc.org

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council, and our efforts are supported by the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and member dues. The Network is governed by a Steering Committee representing diverse community and professional interests.

To become a member or order Network materials, call 615 226-2292 or write network@nhchc.org. Please visit our Web site at www.nhchc.org.