Decreasing Unintended Pregnancy Among Homeless Women

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HEALING HANDS

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Decreasing Unintended Pregnancy among Women Experiencing Homelessness

Nearly half of pregnancies—49 percent—that occur annually in the US are unintended, which translates into about 3.2 million pregnancies being unwanted, unplanned, or mistimed (Guttmacher Institute, 2012a). The rate of unintended pregnancy in the US is significantly higher than the rate in many other developed nations, in spite of the fact that safe and highly effective contraceptives are available. The political and emotional nature of the discussions surrounding reproduction and sexuality impedes progress toward policy and practice changes that will protect the reproductive health of American women and significantly reduce the number of unintended pregnancies (Taylor, 2011).

According to the Guttmacher Institute (2012a), most American families want two children, resulting in the typical woman spending approximately five years pregnant, postpartum, or trying to become pregnant, and about three decades—more than three-quarters of her reproductive years—trying to avoid conception. By the time they reach 45, more than half of American women will have had an unintended pregnancy, with far-reaching health, social, and economic consequences.

For homeless women, a high-risk group for unintended pregnancy, the situation is worse. At any given time about 10 percent of homeless women are pregnant, twice the rate (5 percent) of all US women of reproductive age. One study found that about three-fourths (73 percent) of pregnancies among women experiencing homelessness were unintended at the time of conception (Gelberg, Lu, Leake, Andersen, Morgenstern, & Nyamathi, 2008). It is important to note that pregnancy and recent births are risk factors for becoming or continuing to be homeless (Weinreb, Gelberg, Arangua, & Sullivan, 2004).

Homeless women are more likely to receive inadequate prenatal care than are poor but housed women (39 percent versus 15 percent); consequently, their pregnancy outcomes are worse. The low birthweight rate among homeless women—16.8 percent—is more than twice the national low birthweight rate of 7.4 percent, and 18.5 percent of homeless women give birth pre-term (i.e., before 37 weeks) compared to the national average of 11 percent (Weinreb et al., 2004).

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A PUBLIC HEALTH ISSUE: WHY FAMILY PLANNING IS IMPORTANT

According to the Centers for Disease Control and Prevention (CDC, 1999), family planning is one of the great public health achievements of the 20th century. Government agencies and private-sector experts have long recognized that reproductive health services are a vital and effective component of public health care, resulting in substantial positive consequences for infants, women, families, and society (Sonfield, 2011). In contrast, unintended pregnancy is associated with many negative maternal and child health outcomes (Guttmacher Institute, 2012b; US Department of Health and Human Services [HHS], 2011):

- Delayed prenatal care
- Depression and poor maternal mental health
- Reduced mother-child relationship quality
- Premature birth and poor developmental outcomes for children

Women with unintended pregnancies are more likely to use alcohol and tobacco during pregnancy, and unintended pregnancy that results in a live birth is associated with physical abuse and violence during pregnancy and the 12 months before conception (Santelli et al., 2003). A woman experiencing an unintended pregnancy faces the usual health risks of pregnancy—including maternal death—and closely spaced births are associated with additional health risks for mother and baby. A child from an unplanned conception is at greater risk of low birthweight, of dying in its first year of life, and of being abused (National Research Council, 2004). For these

reasons, the US has set a national public health goal of increasing the proportion of *intended* pregnancies from 51 percent to 56 percent in 2020 (HHS, 2012c).

UNDERSTANDING UNINTENDED PREGNANCY

According to the CDC, an *unintended* pregnancy is one that is mistimed, unplanned, or unwanted at the time of conception. Efforts to decrease unintended pregnancy include finding more effective contraception methods and increasing contraceptive use and adherence. Researchers are also focusing on trying to better understand and more precisely measure pregnancy *intentions*, which should advance efforts to increase contraceptive use, to prevent unintended pregnancies, and to improve health outcomes of women and their children. Pregnancy intendedness—the fertility decision-making process—is a complicated concept, encompassing affective, cognitive, cultural, and contextual dimensions (CDC, 2012; Santelli et al., 2003).

While women of all ages may have unintended pregnancies, these groups are at a higher risk (HHS, 2012c):

- Those who are ages 18 to 24
- Women who are unmarried or cohabiting
- Those whose income is below the federal poverty level
- African-American or Hispanic women
- Those without a high school diploma
- Women who are older than age 40 (Santelli et al., 2003)

Many women do not understand how the reproductive system works, causing them to underestimate their risk of pregnancy. This lack of education, combined with health professionals' unease about discussing sexual topics and limited time for appointments contribute to a system-wide failure to successfully provide contraception services (Taylor, Levi, & Simmonds, 2010). **Karen Zimmerman, MSN, CNM, FNP-BC**, agrees: "By not discussing intimate issues with our patients, we do a disservice to the women in our care." Formerly with Albuquerque Health Care for the Homeless, Zimmerman is now in private practice.

EDITOR'S NOTE

Due to space considerations, we are unable to present the range of contraceptive methods available. Instead, much of this issue focuses on the long-acting reversible methods, which research suggests as being particularly appropriate for homeless women who desire contraception. Please take advantage of the extensive resources featured in the toolkit. There you will find links to the latest clinical information about methods, ranging from abstinence & outercourse to permanent sterilization. Of special interest are the free patient counseling & education tools such as guides to help women select the birth control method that best matches their needs & preferences. In addition, we developed a convenient table of the most effective methods comparing advantages & disadvantages & listing common side effects. Download the free PDF at www.nhchc.org/wp-content/uploads/2012/09/Supplement-to-Fall-2012-Healing-Hands-Contraception.pdf.

TERMS & DEFINITIONS*

Unwanted pregnancy: Occurring when the woman (& her partner) desired no children or no more children

Mistimed pregnancy: Occurring earlier than desired; can occur anytime during the reproductive years but is most common among teens & young adults; unwanted pregnancies tend to have poorer outcomes than those that are mistimed

Intended pregnancy: Occurring at the "right time" or later than desired due to infertility or difficulty conceiving

Unplanned pregnancy: Occurring when the woman was using a contraceptive method or when she did not want to become pregnant, but did not use a method

* These definitions assume that pregnancy is a conscious decision & that women always decide about the desirability of becoming pregnant at the time of sexual intercourse, although this is not always the case.

Sources: HHS, 2011; Santelli et al., 2003

"Because of our culture, it is hard for people—both providers and consumers—to discuss sexuality openly. It is easy to think of our patients as asexual when there are so many other issues going on," says **Deborah Borne, MD, MSW**, clinical coordinator for homeless and community-based programs, with the San Francisco Department of Public Health. "We must help people feel comfortable talking about their bodies, including genitalia. Be respectful. Ask the woman what term she uses for her vagina and use that in your discussion. Delivering reproductive health care in a culturally appropriate way to those experiencing homelessness always requires that we be mindful that our patients are trauma survivors."

PREVENTING UNINTENDED PREGNANCIES

Preventive services offer effective approaches to meeting national health goals (Taylor et al., 2010), and contraception is the quintessential preventive care service and one that is fundamental to the health of families and society. Without using any contraception, 85 percent of couples will have a pregnancy within one year (Cleland, Peipert, Westhoff, Spear, & Trussell, 2011). Although modern contraceptive methods are highly efficacious, no method is 100 percent effective for all users, and some women and men experience undesirable side effects (National Research Council, 2004; Santelli et al., 2003). "We must never lose sight of the fact that being pregnant poses greater risks to a woman's health compared to the risks associated with using most contraceptives," Zimmerman says.

The US Preventive Services Task Force recommends that clinicians use every patient interaction as an opportunity to provide prevention-related and health counseling and education. Successful contraceptive adherence is associated with counseling approaches—such as motivational interviewing—that mobilize a client to clarify her intentions and act on her decisions. Clinicians can also use client interactions to address behavioral aspects such as empowering women to negotiate contraceptive use with their

partner and to recognize and internalize their role in pregnancy planning (Taylor et al., 2010).

"Women need information in order to make informed choices for themselves about their reproductive lives," says **Marji Gold, MD**, professor of family and social medicine and director of the family planning fellowship at Albert Einstein College of Medicine/ Montefiore Medical Center. "The long-lasting methods are easy for homeless women; there are no follow-up visits or anything to carry or remember to use. Encourage patients to use contraception and, if you cannot provide the method they choose, have a referral network in place that can accommodate their needs quickly and without creating additional barriers.

"If the woman is uninterested in an IUD," Gold continues, "discuss other options, such as one of the contraceptive injections. Providers can give the injection in a homeless shelter, for example, and the patient needs it only four times a year. The patch and vaginal ring are other good methods, but they require consistent use to be effective."

"Given the ramifications of an unintended pregnancy, patient-centered family planning counseling is imperative," says Zimmerman. "Ask a woman [of childbearing age] *'Do you want to have a baby this year?'* If the answer is no, this opens the door to discuss contraception. If she responds that she wouldn't mind becoming pregnant, move the conversation to the importance of preparing for a pregnancy, and see that she receives prenatal vitamins, especially folic acid, before she leaves the clinic."

Both Borne and Zimmerman advise that clinicians routinely include LMP (last menstrual period) in the vital signs (VSs). Asking *'When was the first day of your last menstrual period?'* is a prompt to address contraception. "As with other VSs, it's critical to ask for the LMP at each visit," adds Zimmerman, "because we continue and/or start women of childbearing age on medications that are teratogenic, which are unsafe for any woman who is or plans to become pregnant."

> "I prefer seeing a woman provider [for gynecological care] because I'm more relaxed & it's easier to trust another woman when it comes to female matters. Homeless women need safe, women-only places where they can go for family planning & using peer advocates is a great idea."
>
> *— Carol Hall, Consumer Advisory Board Member*
> *North Broward Hospital District Health Care for the Homeless*
> *Fort Lauderdale, Florida*

HOMELESS WOMEN & CONTRACEPTIVE USE

According to national data collected from HCH grantees in 2011, approximately 202,400 women—over half (55 percent)—of all female HCH consumers were of reproductive age, i.e., 13 to 44 years old (HHS, 2012b). Given the challenges that homeless women face in managing the most basic demands of day-to-day life, contraceptives needing storage or routine attention—e.g., pills, patches, injections, the vaginal ring—may have higher failure rates than they or their providers might anticipate. Long-acting reversible contraception—e.g., intrauterine devices and contraceptive implants—may be particularly helpful for homeless women who want contraception, given these methods' independence from user-based failure (Saver, Weinreb, Gelberg, & Zerger, 2012).

A study to investigate the perceived barriers to contraception use among homeless women found the most common deterrents to be side effects, fear of potential health risks, partner's dislike of contraception, and cost. Additional barriers included not knowing how to use contraceptives or which method to use, lack of storage, and discomfort. Understanding these factors is important when designing services that are accessible and acceptable to this population (Gelberg et al., 2002).

HCH BARRIERS TO THE "GET IT & FORGET IT METHODS"

In 2007, the Practice-Based Research Network operated by the National Health Care for the Homeless Council (NHCHC) developed a study in collaboration with researchers interested in learning more about provider-based barriers to contraception among women experiencing homelessness. Recently published in the journal *Women & Health*, the study investigated these issues (Saver et al., 2012):

- Contraception services offered by HCH providers to homeless women
- HCH organizational barriers to providing long-acting, reversible contraception
- Future, practice-based interventions that increase homeless women's access to long-term reversible contraceptive methods

Most of the HCH clinicians responding to the survey provided onsite contraception services to homeless women who wanted them—primarily condoms, oral contraceptive pills, and injectable contraception. Only one-third, however, directly provided two of the most effective, long-term reversible methods, i.e., IUDs and the implant, in spite of their distinct advantages to homeless women. These findings suggest that there is limited access for homeless women in the US to long-acting reversible contraception. The study identified several barriers to providing these methods, most notably the lack of provider training, lack of facilities, and cost.

Lack of provider training. Lack of provider training was a barrier to providing the implant and the IUD at most of the HCH projects participating in the survey, and training would clearly eliminate this barrier (Saver et al., 2012). Before HCH providers can prescribe, order, or administer the birth control implant Nexplanon®, for example, its manufacturer requires completion of a clinical training program on insertion and removal procedures (Merck, 2011).

In particular, increasing provider familiarity with the new implants could help change perceptions based on previous experience or knowledge of older implants such as Norplant® (Saver et al., 2012). According to **Barry Saver, MD, MPH**, "Nexplanon is easily inserted; it's been designed to reduce the risk of insertion errors. HCH projects should already have the needed equipment, and Merck will provide free training onsite." Saver is a family physician in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School in Worcester.

Although some HCH clinicians may be reluctant to provide IUDs to homeless women given the high prevalence of STIs (sexually transmitted infections) in this population, there is little risk of pelvic inflammatory disease (PID) beyond a slight increase around the time of IUD insertion (Farley, Rosenberg, Rowe, Chen, & Meirik, 1992). The incidence of PID among women using IUDs is very low and consistent with estimates of PID incidence in the general population. It seems that bacterial contamination associated with the IUD insertion process is the culprit, not the IUD itself. Furthermore, the Mirena® IUD—in comparison to the ParaGard® IUD—may lower the risk of PID since the progestin levonorgestrel in this IUD is thought to create a protective effect against infection (Stacey, 2011).

Given homeless women's risk of exposure to STIs, however, clinicians should emphasize the importance of STI risk-reduction even when contraception is assured (Saver et al., 2012). Research indicates that women who report using condoms to protect against both disease and pregnancy tend to use condoms more consistently than others do (Santelli et al., 2003), suggesting that clinicians should integrate these prevention messages to strengthen motivation to use condoms consistently.

"The Mirena is very popular," says Zimmerman. "About 20 percent of women using Mirena will cease menstruating after the first year of use; that side effect may be very beneficial to a woman experiencing homelessness. It is important to counsel women, however, that unscheduled bleeding can occur during the first three to six months after insertion.

"With ParaGard, heavy menses and cramping are potential side effects throughout its use, not just during the first few months," continues Zimmerman. "To help reduce the heavier menses and cramping associated with ParaGard, women may use ibuprofen as directed starting one day before menses is expected, and continue around the clock for three days or so." Table 1 provides a sample script that providers can use when offering patients either of these devices.

Lack of facilities. Organizational barriers related to the lack of facilities for long-acting reversible contraception may include lack of a private space suitable for IUD placement when providers are seeing patients in nontraditional settings such as homeless shelters or during street outreach. Given that health centers are required to report on Pap tests, however, providers should be able to refer a woman who requests an IUD to an HCH facility that does have a private exam room. Another reported barrier was the lack of sterile instrument sets (i.e., ring forceps, sound, and tenaculum) needed for insertions.

TABLE 1. Brief Scripted Introduction to Long-Acting Reversible Methods

One of our objectives is to be sure women are aware of all contraceptive options, especially the most effective, reversible, long-acting methods. These methods include intrauterine contraception—the IUD or IUC—and the subdermal implant called Nexplanon.

- IUD or IUC is a completely reversible birth control method that is placed in the womb or uterus. There are two types of IUD. One is hormonal and lasts up to 5 years; this is the Mirena. The other, ParaGard, is non-hormonal, contains copper, and can last up to 10 years. If you wish to become pregnant or want to switch to a new method, either of these IUDs can be removed at any time. They are very safe and have the highest satisfaction and continuation rates of any family planning method.
- Nexplanon is a small, single flexible plastic rod placed under the skin of your upper arm. It is hormonal and lasts up to 3 years. If you wish to become pregnant or decide you would like to use a different method, the implant can also be removed.

Do you have any questions about these methods?

—Adapted from Secura, Allsworth, & Madden, 2010

Researchers suggest addressing this problem by collaborating with an affiliated health center or hospital to get the sets sterilized as needed (Saver et al., 2012).

Cost. Cost-related barriers to providing contraceptive services in the HCH setting included the cost of the method plus coverage for provider time. As discussed in the article that follows, the changes instituted under the Affordable Care Act (ACA) should mitigate the cost barrier for family planning for most women, including those experiencing homelessness. Cost, however, will continue to be a barrier for undocumented women (Saver et al., 2012). Check with Patient Assistance Programs to see which contraceptives may be available free; visit www.rxassist.org for more information.

Studies examining the relationship between contraceptive cost and use suggest that removing the economic barrier to getting the IUD—which can range from $500 to $1,000—will create a surge in demand for the device (Marcotte, 2011; Planned Parenthood Federation of America, 2012). HCH providers should plan now to be able to respond to clients' requests for these long-acting reversible methods, once cost is no longer a barrier.

HCH clinicians have both an opportunity and a responsibility to their clients and communities to help reduce the number of pregnancies that are unintended, and there are compelling reasons to do so. The extremely high rate of unintended pregnancy among homeless women, the link between unintended pregnancy and negative outcomes for maternal and child health, as well as the association of unintended pregnancy with significant costs to the health care system are reasons for HCH clinicians to make unintended pregnancy a high priority. ■

Show Me the Money: Cost-Savings & Family Planning Funds

Funding family planning programs is a wise investment. While contraceptive costs can be a daunting barrier for the individual, even with insurance, public funding for contraceptive services saves money and prevents some 1.3 million unintended pregnancies annually in the US (Santelli et al., 2003; Sonfield, 2011). For example, in 2008, a Medicaid-covered birth was $12,613 (including prenatal care, delivery, postpartum care, and infant care for one year). In comparison, the national cost for contraceptive care was $257 per client (Cleland et al., 2011). An estimated $1.9 billion in expenditures for publicly funded family planning services in 2008 resulted in $7 billion in gross savings from helping women avoid unintended pregnancies and the births that would follow (Guttmacher Institute, 2012a). A 2010 Brookings Institution analysis projected that expanding access to family planning services under Medicaid would save $4.26 for every $1 spent (Sonfield, 2011).

Title X Family Planning Program. Title X is a federal program devoted to providing comprehensive family planning services and related preventive health services:

- Breast and pelvic exams
- Breast and cervical cancer screening
- STI testing and treatment
- HIV testing and counseling
- HPV (human papillomavirus) vaccinations
- Pregnancy diagnosis and counseling

About three-quarters of poor women and women who are uninsured who obtained care from a family planning center considered it to be their usual source of medical care, illustrating the role of publicly funded centers as safety net providers (Guttmacher Institute, 2012a).

Medicaid. According to 2010 data, Title X covers about 10 percent of publicly funded family planning services. The largest source—75 percent—comes from the joint federal-state Medicaid program, and various federal block grants and state appropriations fund the remainder (Guttmacher Institute, 2012a). Almost two-thirds (63 percent) of adult women on Medicaid are in their reproductive years—19 to 44—and for those enrolled, Medicaid covers a range of reproductive health care services. Currently, for a woman to qualify she must meet both income and categorical criteria, meaning that she must fit into a particular *category* such as being pregnant, a mother of a child under age 18, a senior citizen, or having a disability (Salganicoff & Ranji, 2012). Many homeless women—regardless of how poor they are—do not qualify because they do not fall into one of these eligibility categories.

ACA. Beginning in 2014, the ACA will close these gaps in coverage by creating a minimum Medicaid eligibility level. For the first time, Medicaid coverage will extend to many uninsured citizens and legal residents with incomes up to 138 percent of the federal poverty level without categorical requirements (Salganicoff & Ranji, 2012). As a result, homeless women who are currently uninsured will qualify for Medicaid, and HCH clinicians will want to facilitate their enrollment. Family planning is one of the services mandated for Medicaid coverage.

Private insurance plans. Passage of the ACA has brought major reform to insurance coverage. Effective August 1, 2012, ACA requires most insurance plans to cover certain preventive services with no cost-sharing, i.e., copayments or deductibles. For women, this includes FDA-approved contraceptive methods (not including abortifacient drugs), sterilization procedures, and patient education and counseling. Although this coverage will help the expected 47 million women who are eligible for these new preventive services (HHS, 2012a), the law will not help those who are not enrolled, or are ineligible for coverage.

"We put women in a political Catch-22 when we don't give them the resources they need to prevent pregnancy," says **Barbara DiPietro, PhD**, NHCHC's policy director. "Then when they become pregnant, we blame them for having children they can't support and castigate them for turning to safety net programs like TANF, Food Stamps, WIC, Medicaid, and housing assistance—entitlement programs at risk of being cut. As in other aspects of the health care system, we do little cost-effective prevention, and then get angry at the resulting high costs and poor outcomes." ■

PRACTICE PEARLS: TIPS FOR REPRODUCTIVE HEALTH

- "I tell my patients, '*If there is an erect penis within three feet of you, you need to cover it. Put a condom on it*.' This goes for both men and women."

  —Deborah Borne, MD, MSW
  San Francisco Department of Public Health

- "Clinicians worry that if they provide a woman with a non-barrier method, she won't use a condom to prevent STI. These are separate issues. There is high risk for sexual assault among homeless women, and I'd rather she be protected against pregnancy in that event."

  —Barry Saver, MD, MPH
  University of Massachusetts Medical School

- "Yes, unscheduled bleeding from certain contraceptive methods is hard, but having a baby and living on the street is harder."

  —Karen A. Zimmerman, MSN, CNM, FNP-BC
  Women's Specialists of New Mexico, Albuquerque

TOOLKIT OF PRACTICAL RESOURCES TO HELP DECREASE UNINTENDED PREGNANCY

Resources for providers, social workers, case managers, health educators & peer advocates

Association of Reproduction Health Professionals	www.arhp.org
Birth Control | MedlinePlus | National Library of Medicine	www.nlm.nih.gov/medlineplus/birthcontrol.html
Center for Reproductive Health Education in Family Medicine | Montefiore Medical Center	http://rhedi.org/resources.php
Contraception | CDC's Division of Reproductive Health	www.cdc.gov/reproductivehealth/UnintendedPregnancy/Contraception.htm#1
Emergency Contraception (emergency birth control) | HHS Office of Women's Health fact sheet | 2011	http://womenshealth.gov/publications/our-publications/fact-sheet/emergency-contraception.pdf
Unintended Pregnancy Prevention | CDC's Division of Reproductive Health	www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm
Guttmacher Institute	www.guttmacher.org
HHS Office of Women's Health	www.womenshealth.gov
Title X Family Planning | HHS Office of Population Affairs *Enter a ZIP code to find the nearest family planning clinic*	www.hhs.gov/opa
Managing Contraception 2012 – 2014 For Your Pocket	www.managingcontraception.com
HRSA's Maternal & Child Health Bureau	http://mchb.hrsa.gov
Planned Parenthood Federation of America	www.plannedparenthood.org
Family Planning Program Client Education & Pregnancy Counseling Protocols | San Francisco Department of Public Health | 2011	www.gofolic.org/pros/SFDPHHealthEdProtocols.2011November.pdf

Resources for counseling & patient education

Best Method for Me	www.bestmethodforme.com/?id=jki8c41999c58830dfb3c2e3b983a810e1e
Birth Control Guide | FDA Office of Women's Health | Updated August 2012	www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282014.pdf
Birth Control Poster | FDA Office of Women's Health | *Free, put one in every exam room!*	www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282028.pdf
Choose the Right Birth Control | National Health Information Center | 2012	http://healthfinder.gov/prevention/ViewTopic.aspx?topicId=87
Free FDA Publications for Women in English, Spanish & other languages | *Full-color PDF versions to download or order in bulk*	www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/default.htm
Your Birth Control Choices | *Free fact sheets in Word & PDF formats, versions in English & Spanish*	http://rhedi.org/patients.php
My Method | *An online interactive tool to help women pick the right contraceptive given her lifestyle & preferences*	www.plannedparenthood.org/all-access/my-method-26542.htm
Talking with A Partner about Condoms | American Social Health Association | 2012	http://cms.ashastd.org/std-sti-works/condoms/talking-with-a-partner-about-condoms.html

continued on page 7

TOOLKIT OF PRACTICAL RESOURCES TO HELP DECREASE UNINTENDED PREGNANCY, *continued*

Background reading & policy considerations

A Review of the HHS Family Planning Program: Mission, Management & Measurement of Results | Institute of Medicine | 2009	www.nap.edu/catalog.php?record_id=12585
Unintended Pregnancy | Data & Statistics | CDC's Division of Reproductive Health	www.cdc.gov/reproductivehealth/Data_Stats/index.htm#UnintendedPregnancy
Unintended Pregnancy & Contraception | Women's Health USA 2011 | Maternal & Child Health Bureau, HRSA	http://mchb.hrsa.gov/whusa11/hstat/hsrmh/pages/227upc.html
Pregnancy in Homeless Women | August 2012 literature review	www.uptodate.com/contents/pregnancy-in-homeless-women

Guidelines, recommendations & evidence-based practices

Adapting Your Practice: Treatment & Recommendations on Reproductive Health Care for Homeless Patients | HCH Clinicians' Network | 2008	www.nhchc.org/wp-content/uploads/2011/09/ReproductiveHealth.pdf
Healthy People 2020 | Family Planning Objectives	www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13
Clinical Preventive Services for Women: Closing the Gaps | Institute of Medicine consensus report | 2011	www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx
Guidelines for Male Sexual & Reproductive Health Services | 2009	www.cicatelli.org/titlex/downloadable/MaleGuidelines2009.pdf
US Medical Eligibility Criteria for Contraceptive Use, 2010 | MMWR | CDC | *updated in 2011 & 2012*	www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm

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