IMPROVING CONTRACEPTIVE HEALTH CARE IN HOMELESS WOMEN

By

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Abstract

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Purpose: To answer the question: What are the characteristics of contraceptive use and need among homeless women? Also included in the article, is an overview of contraceptive choices available today and guidelines for the nurse practitioner regarding contraceptive problems.

Data Sources: PubMed, ProQuest, CINAHL, and OVID.

Conclusions: Information regarding the characteristics of homeless women’s contraceptive use and need has received little focus or research. This lack of focus represents a significant gap in the literature. Understanding this problem and also assuring that homeless women’s contraceptive needs are met is a fundamental responsibility of health care providers and policy makers. Investing in contraception for homeless women yields benefits to both women and to society that go beyond decreasing or eliminating unintended pregnancies.

Key Words: homeless women, birth control, contraception and Williams model.

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Improving Contraceptive Health Care in Homeless Women

Introduction

Access to contraceptive services and supplies are fundamental to the well being of women during their reproductive years. Within the homeless population, this fundamental concern holds true, but is often neglected by both health care providers and the health care system. Homeless women do not have their reproductive care needs met for several reasons, including factors related to individual circumstances, socioeconomic status (SES) and the health care system (Killion, 1998). Current literature highlights individual characteristics and behaviors, suggesting that these factors are the primary determinants of contraceptive outcomes for homeless women. Recommendations for improving contraceptive and reproductive health for homeless women often focus on changing individual behavior and on changing the medical care system.

Resources such as public health clinics, non-profit organizations, Medicaid programs and Title X funded clinics designated to provide contraceptives to poor women, are not enough to meet homeless women’s contraceptive needs. More needs to be done in terms of understanding individual behavior, increasing access to medical care, and understanding SES factors that influence reproductive decisions. The purpose of this manuscript is to answer the question: What are the characteristics of use and need among homeless women? The manuscript also provides an overview of contraceptive choices available today and the role of the nurse practitioner in guiding contraceptive use.

Model for Analysis

Williams model (Figure 1) describes the relationship between socioeconomic status (SES) and health outcome. The model is comprised of three major components: Psychosocial
Factors, Medical Care and Health Outcomes. The premise of this model is that SES influences Health Outcomes via the other two major components of the model, Psychosocial Factors and Medical Care. Williams incorporates two other factors into his model that exert less influence on Health Outcomes. These factors are: biomedical factors (early environment, genetic endowment, and constitution) and demographic factors (e.g., age, race, sex). The two explanatory variables of Psychosocial Factors and Medical Care are viewed as reciprocal and have influence on each other. For example, Psychosocial Factors can influence health care utilization and Medical Care can impact health practices (Williams, 1990).

Psychosocial factors are defined as health practices (contraceptive use), social ties, perceptions of control, and stress (family, occupational, residential), which are defined as “prime candidates for a central role in explaining socioeconomic disparities in health” and “are not viewed as individual characteristics, but as the patterned response of social groups to the realities and constraints of the external environment” (Williams, 1990, pgs. 81 & 82). Medical Care encompasses all health care services and health professionals (Williams, 1990).

A literature search was conducted through PubMed, ProQuest, CINAHL and OVID databases. Seventeen research studies were identified that focused on contraception and healthcare of homeless women and were used in this manuscript. The key words used in the search were homeless women, contraception, birth control, family planning, reproduction, sexual violence and healthcare.

Definitions of Homelessness

Depending on the source, “homeless” has been broadly defined. Nyamathi, Leake, & Gelberg, 2000, define homeless as “a woman who had spent the previous night in a shelter,
hotel, motel, or home of a relative or friend, and was uncertain as to her residence in the next 60 days or who stated that she did not have a home or house of her own in which to reside”, pg. 569. For the purpose of this manuscript, Nyamathi and colleagues definition of “homeless” was used.

**Demography of Homeless Women**

Over the past two decades, the number of homeless women either single, or with children has increased (U.S. Conference of Mayors, 2003). The 1999 survey by the Urban Institute, estimates that 32% of the homeless are women. Of those, 14% are single and live primarily in urban areas and the rest are families living in urban, as well as rural communities (National Coalition of the Homeless, 2004). The fastest growing segment of the homeless population is families with children. Among these families, women head 84% of the households with 26% having one child, 28% having two children and 30% having three or more children. Families with children, single mothers, and children make up the largest group of homeless people in rural communities (National Law Center on Homelessness and Poverty, 2004). The U.S. Conference of Mayors reported in their 2003 survey of 25 American cities that 40% of the homeless populations were families, an increase from 38 % in 1999.

**Healthcare and Homeless Women**

Homeless women have health care needs that have largely gone unaddressed by health care providers and the health care system (Lewis et al., 2003, Nyamathis et al., 2000, & Luck et al., 2002). Lewis and colleagues (2003) found that 37% of women reported an unmet health care need during a 60-day period. Nyamath and colegues found that 60% of participates reported fair or poor health compared to only 10% of the general population reporting fair or poor health. These studies also documented that homeless women have more health problems, than women in the general population and, as such, have mortality rates 10 times higher than women in the
general population (Cheung & Hwang, 2004). Nyamathi et al. (2000) found that homeless women, specifically those who live unsheltered have significant health care problems. Most of their problems are related to physical or mental health issues, drug and alcohol abuse, and exposure to violence (Nyamathi et al., 2000). Other studies (Wilson, 2005, & Wei et al, 2002) have documented health care needs related to hypertension, arthritis, diabetes, and sexually transmitted infections. Over 50% of homeless women were current smokers, as compared to 22.6% of adult women in the general population and 56% of homeless women were exposed to rape, as compared to 16% in the general population (Silver & Panares, 2000, Bureau of Justice Statistics, 2005).

Intensifying the problem of increased health risks are homeless women’s social and economic circumstances. Homeless women do not have consistent and reliable access to a source of health care, health insurance, or stable income (Nyamathi et al., 2000). Other social and economic concerns are: inconsistent transportation, lack of child care, competing needs of finding and maintaining shelter and employment, making and keeping health care appointments, and having a regular health care provider (Lewis et al., 2003).

Lewis and colleagues addressed all three major components of Williams model. Psychosocial Factors of stress (lack of housing), health practices (alcohol and drug use, history of rape), and Medical Care (not have a regular source of care or a “medical home”) were included in the study and then related to Health Outcomes. The Health Care Outcome identified was that 37% of respondents reported an unmet health care need, compared to 21% in the general population. Recommendations of the study were directed at changing individual behavior through education and improving access to care for homeless.
Contraceptive Use In Homeless Women

The pregnancy rate of homeless women is 11%, compared to 5% of the general population (Wright, Weber-Burdin, Knight, & Lam, 1987). Over 80% of homeless women are sexually active and of those, 65% do not use birth control (Institute for Children and Poverty, 2003). The rate of unintended pregnancy is approximately 50%, similar to the rate of unintended pregnancy in the general population (Shuler, et al., 1995). In a report by the Institute for Children and Poverty, approximately 50% of homeless women did not believe that birth control was important, 37% did not know how to obtain it and 42% were unclear on how to use it. Wenzel and colleagues (2001), found the same social and economic circumstances that affect homeless women's general health, also impact their ability to have consistent, reliable and effective contraception.

Wenzel et al, (2001) studied the characteristics, utilization, and access to birth control for homeless women and found that those women with a regular source of medical care and case management were more likely to use birth control services. A sample size of 974 homeless women was interviewed in shelters and meal programs in Los Angeles County. Of the 633 women sampled who met study inclusion criteria, only 33% wanted birth control services. The authors found that the women who wanted birth control services shared similar characteristics. They spent less time homeless during the previous 60 days and were less likely to have been homeless for more than 12 months. Other characteristics of women who sought birth control services included: decreased drug and alcohol dependence, having at least one previous unintended pregnancy, having a history of using birth control consistently. Finally, the study found that 66% of those who visited a doctor for birth control services also had their children...
living with them. This was compared to those who did not visit a doctor for birth control services, finding only 47% had their children living with them.

The study fills a gap in the literature by investigating homeless women’s access to birth control services. The study also reviews the characteristics of homeless women who want birth control services and provides direction for practice and health policy. Limitations of this study are: findings determined through subject self-report may be impaired by recall or other factors and the subjects were only asked about visiting a doctor, as compared to visiting a nurse practitioner or physician assistant in the last year.

This study incorporated the Williams model by examining Psychosocial Factors in several domains. These factors included birth control use, alcohol and drug practices, mental health problems, and stress being defined as homelessness. Medical Care was addressed as not having a regular source of care, limited clinic hours, and inequities in access to obtaining birth control services. Finally, Health Outcomes was defined as the rate of unintended pregnancy. Recommendations were similar to those found in other studies, with the focus on changing individual behaviors, improving access to care and increasing the availability of medical services.

There are very few studies of the homeless female population that describe contraception use, preferred choice, patterns across the reproductive life span, and deterrents to use. In a study published in 2001, Gelberg et al, sampled 1200 non-sterilized, homeless women (ages 14-44) in Los Angeles.

The use of oral contraceptives in homeless women was found to be comparable to the use of oral contraceptives in non-homeless women. In their sample, 66% of the women used oral contraception at some point in their lives or were current users. Approximately, 14% used
hormonal injectables, 11.7% used intrauterine device (IUD) and 2.7% used implants (Gelberg et al., 2001). In the general population, 5.3% use hormonal injectables, 2% use IUD, and 1.2% use implants (Guttmacher, 2005).

In the domain of nonhormonal contraceptives, Gelberg et al., (2001) found condoms to be the contraception of choice among the sampled women regardless of a higher failure rate, than hormonal contraceptives. Eighty-five percent used condoms for their contraceptive needs at some point in their reproductive years, while in the general population 18% use condoms (Guttmacher, 2005). Gelberg and colleagues attribute high condom use to availability of condoms without prescription, easier access for use and knowledge regarding sexually transmitted disease protection. Foam/gel/cream were the next most commonly used at 29.8%, followed by suppository at 16.7% and diaphragm at 11.9%. In the general population, 0.3% use diaphragms and 0.9% use other types of contraceptives (Guttmacher, 2005).

Similarly, Gelberg et al., (2000) found that fear of side effects of contraceptives, costs and partner dislike were deterrents to contraceptive use. Thus making contraceptive use an unfavorable practice.

The literature is enhanced in these quantitative studies by describing contraceptive use, determinants to use and patterns of use across the reproductive lifespan of homeless women. However, the limitations of the studies were that data was taken from subjects self-report. Additionally, the information was collected in a region of the country that may not be generalized to the rest of the homeless women population.

Williams model as it applied to this study included use of Psychosocial Factors. The Medical Care explanatory variable was not addressed, but was speculated. Health Care Outcomes and Demographic Factors were assessed.
In an anthropological qualitative study of 15 homeless women over a one-year period, Killion (1998) found that certain circumstances such as timing, place and choice of partner played a significant role in their ability to control their reproduction. Other factors such as being a victim, economic survival through sex, inability to access contraception and overall poverty were found to influence pregnancy and contraception for homeless women in this study. Killion found one factor that has not been addressed in other studies: the desire of some of the subjects to engage in unprotected sex out of a need for intimacy and a baby which represented hope for the future (1998).

A primary strength of this study is that it provided an intimate snapshot into the lives of fifteen homeless women over a one-year period. The author had the opportunity to know her subjects from a closer and personal perspective. Since the study focused on contraception over a one-year time frame, it allowed the researcher the chance to follow women through parts of their pregnancies, as well as through the course of one pregnancy. The author noted that all areas of pregnancy and childbearing were examined. The focus of this particular paper was on the circumstances surrounding conception.

The findings of this study cannot be generalized to the overall population of homeless women. This study provides a poignant glimpse into the lives of these women and their issues related to contraception.

Psychosocial Factors were related to nutrition, fertility, stress of living on the streets, coping with shelter living and uncertainty regarding employment, and difficulty with interpersonal relationships. Health Outcomes were pregnancy, unintended pregnancy and contraceptive practices.
Rape And Homeless Women

An understanding of the lives of homeless women and characteristics of their health care use and needs would not be complete without mention of violence that impacts their day to day lives. The literature documents sexual violence as a common and significant crime perpetrated against homeless women. Wenzel and colleagues documented in one study that 13% of subjects reported rape in a one-year period and some had been raped more than one time (2000). This exemplifies Williams model by analyzing the pathway from homelessness (SES) to Medical Care and their inability to access care and concluding with the Health Outcome of rape. These women were less likely to access health care for their reproductive and other health care needs, despite reporting two or more gynecologic symptoms and conditions, and two or more serious physical health symptoms. Although 53% of rape victim subjects reported the need to see a health care provider, they did not seek care as compared to 35% of non-rape victims, who also did not seek care. Alcohol and drug abuse or dependence and depression were health concerns commonly reported by raped women. Of those women, 20% were not able to obtain treatment, as compared to 6% of non-raped women. This quantitative study yielded valuable information regarding rape and subsequent health outcomes of a sample of 974 homeless women. This study examined several pathways proposed by Williams model. The authors’ primary aim of determining rape rates among homeless women was examined through Psychosocial Factors, Medical Care, and Health Outcomes.

In 2000, Ensign studied 20 homeless adolescent females using qualitative methods. The sample ranged in age from 15-23 years. The aim of the study was to gather information regarding perspectives on the topics of health issues, self-care, fertility control and the experience of homelessness. In this study, participants described their personal experience with
sexual exploitation, survival sex and rape. A major finding of this study was that all participants had experience with sexual violence or knew of someone who had.

Ensigns' qualitative study enhances the literature by adding the voices, perspectives and priorities of individual participants. Limitations of the study were sample size, the sample represented homeless adolescent females from one region of the country, and most of the participants were in the upper age range of adolescents. Psychosocial Factors were related to problems with sexual identity, exhaustion, malnutrition and concern about friends, Medical Care was addressed as limited access to care, and experience with health providers that were judgmental. Finally, Health Outcomes was identified as self induced abortions, unintended pregnancy, rape and gynecological disorders.

Current Contraceptive Practices

Contraceptive choice is not simple. Not only are there distinct advantages and disadvantages to each method, there are also considerations related to age, education, socioeconomic status, relationship status, number of partners, culture and values (Freeman, 2005). Homeless women and their health care practitioners face challenges in finding the birth control method that will be most effective, easiest to obtain and use, and one that a woman can stay with. Homeless women most often rely on public health clinics, Title X funded clinics, non-profit clinics and Medicaid programs for obtaining their contraceptives (Killion, 1998).

The wide varieties of hormonal choices (Table 1), afford women the opportunity to select a birth control method that best fits individual needs. The wide variety of choices is an advantage given that women’s reproductive years span three decades, and during this time most women will use several different methods to meet their needs (Guttmacher, 2005).
Contraceptive choices can be divided into two major categories: hormonal and non-hormonal. In the early years of hormonal contraception the “pill” was the only available option. In recent years, the choices of hormonal contraceptives have expanded. Current hormonal contraceptives (Table 1) are available as transdermal, intravaginal, intrauterine, and implantable or injectable and emergency contraception. (Archer, 2001)

Non-hormonal contraception (Table 1) includes: coitus interruptus, lactational amenorrhea, natural family planning, male and female condoms, diaphragm, cervical cap, and spermidicidal agents (Omnia, 2004). Permanent sterilization is also an option. For a female, it is bilateral tubal ligation (BTL) and for a male, it is vasectomy (Wheeler, 2002).

Finally, religious beliefs can be a limiting factor in a woman’s contraceptive choice. For example, some religious beliefs forbid “artificial” methods such as hormonal or barrier methods, but may accept “natural” methods, such as coitus interruptus or natural family planning. This issue can be addressed with the medical history (Patient UK, 2005).

There are differences in effectiveness, costs, delivery system, and ease of use. Condoms are the only method that protect against sexually transmitted infections (Freeman, 2005). Hormonal methods when used consistently and correctly offer the best contraceptive effectiveness, safety and number of delivery systems. The most significant difference between hormonal and non-hormonal methods is effectiveness rates. In general, the failure rate of non-hormonal contraceptives is higher, than the rates for hormonal contraceptives, even when they are used consistently and correctly. For example, condoms can break, spermidicidal agents alone, vary in effectiveness from 20-50%, and barrier devices can be difficult to insert and need to be left in the vagina for several hours after intercourse. If barrier devices are removed too soon, there is an increased risk of pregnancy occurring (Omnia, 2004).
For many women even those with optimal life conditions, management of reproductive goals can be fraught with challenges. For homeless women, managing health care is more difficult (Killion, 1998; Wei et al., 2002; Wenzel et al., 2001).

Guidelines for Nurse Practitioners

Nurse practitioners can take the opportunity to include instruction about contraceptives and family planning during primary care visits. The literature reports that most homeless women use health care services for acute problems, as compared to regular ongoing health maintenance (Wei et al., 2002). The primary reasons for this are attributed to lack of insurance, lack of income, lack of transportation and availability of health care clinics that serve low-income people (Lewis et al., 2003). Therefore, the acute visit may be one of the few opportunities for the NP to address contraceptive needs with homeless or low-income clients.

The plan of care crafted for homeless women will most likely not be the same, as the one developed for housed clients. For example, because of the documented high incidence of sexual/physical assault born by homeless women, the NP could defer a pelvic exam until a later time. While the standard of care is a yearly Pap and check for STIs, some research supports forgoing this exam depending on the contraceptive method chosen. The NP may need to dispense contraception at the time of the visit, since the woman may not have the means or access to obtaining contraception, when she leaves the clinic (Bonin et al., 2004).

The Health Care for the Homeless Clinicians' Network published a comprehensive guideline regarding reproductive health care for homeless patients that covers a wide variety of considerations for treating homeless people. This valuable guide is available with no restrictions regarding copyright at http://www.nhche.org.
Selecting Contraception

The process of finding a good contraceptive match begins with informing the woman of her choices and then providing counseling to find a contraceptive that best fits her needs. Certain information must be obtained and conveyed to the client in order to meet the criteria for providing essential up-to-date information (Table 2) (WHO, 2004). Obtaining a complete and thorough medical history is also necessary in selecting the appropriate contraceptive (Table 3). The NP will need to consider other points that are relevant to practice when working with the homeless client (Table 4).

Providing quality, appropriate and meaningful contraceptive care to homeless women involves recognizing and knowing your clients psychosocial and living circumstances and understanding variables that make up the content of her life (Killion, 1998). These steps in developing a plan of care incorporate the Williams model by focusing on Psychosocial Factors specifically health practices, social ties, and stress, Medical Care, and Biomedical Factors (complete medical history). Using the Williams model in this way assists the NP in predicting Health Outcomes.

These Nurse Practitioner Guidelines are by no means exhaustive and some of the suggestions require extra funding. For example, giving out condoms, handouts, and hygiene kits will require additional funding. There are also several sources in the literature and via health care advocacy groups for the poor that offer numerous examples of interventions and suggestions on how to assist homeless people with their health care needs.

Implications for Practice

For the individual NP, caring for the homeless client is not an easy task. Homeless clients come into care with poor health and a social and economic life history, which require a
great deal of care and compassion on the part of the health care practitioner. A major role of the NP is to provide an atmosphere of trust and compassion for the client, while simultaneously addressing psychosocial needs. Nurse practitioners must be willing to be strong advocates, as well as care providers for this population and be aware of contraceptive concerns and needs specific to these clients.

**Summary**

This manuscript describes general characteristics of contraceptive use and need among homeless women. These findings could pave the way for direction for practice, specifically for interventions geared toward individual psychosocial factors and health care services. These studies also highlight the lack of effort on the part of health care providers, the health care system and the community in providing services that will meet the contraceptive needs of homeless women. There needs to be much more effort put forth to address contraceptive needs of homeless women.

Additionally, poverty and SES factors, which foster homelessness, traditionally have not been the focus of studies on contraceptive use among homeless women. The lack of SES studies is also of fundamental importance in addressing the contraceptive needs of homeless women. The 11% pregnancy rate for homeless women as compared to 5% for housed women cannot be solely explained by individual behaviors (Bonin et al., 2003). Unavailable and affordable housing, low or no income, and eroding social services perpetuate women’s homelessness and without a doubt warrant further research. If research studies only focus on individual characteristics of homeless women and the health care system relating to contraceptive need, then it is easy to conclude that the burden of contraception falls on the shoulders of impoverished
women and a struggling health care system. For these reasons, it is important to step back and see a broader view that considers socioeconomic status factors.

The paucity of research on contraceptive use and reproductive health among homeless women is alarming, yet not surprising. Health care research has a history of being grounded in the experiences of men and then applying these findings to women (Heart Healthy Women, 2005). Since reproduction and contraception is viewed primarily as the responsibility of women, then it follows that contraception would not be considered an important research topic.
References


<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Contraceptives</td>
<td>0.1%</td>
<td>Regulates menstrual cycle, ectopic pregnancy decreased, decreased breast disease, pelvic inflammatory disease, functional cysts, ovarian and endometrial cancers.</td>
<td>Nausea, breast tenderness, weight gain, breakthrough bleeding, amenorrhea, headaches, depression, anxiety, decreased libido.</td>
</tr>
<tr>
<td>Combination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patch</td>
<td>0.3%</td>
<td>Decreased nausea and vomiting.</td>
<td>Skin irritation.</td>
</tr>
<tr>
<td>Vaginal Ring</td>
<td>&gt; 1%</td>
<td>Highly reversible and effective</td>
<td>Headaches, vaginal irritation, can slip out during intercourse.</td>
</tr>
<tr>
<td>Emergency Contraception</td>
<td>80% decrease in risk of pregnancy for a single act of unprotected sex.</td>
<td>Fertility &amp; menses returns with next cycle.</td>
<td>Nausea, vomiting, pain, fatigue, headache. Must be taken within 72 hours of unprotected sex.</td>
</tr>
<tr>
<td>(Plan B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td>0.3%</td>
<td>Decreased Dysmenorrhea &amp; Endometrial &amp; Ovarian Cancer</td>
<td>Amenorrhea 50% of women, Irregular bleeding, weight gain, delayed onset of fertility.</td>
</tr>
<tr>
<td>Intrauterine Device</td>
<td>0.1%</td>
<td>Can stay in place for 5 years</td>
<td>Cramps, bleeding, pelvic inflammatory disease, infertility, perforation of uterus.</td>
</tr>
<tr>
<td>Mirena</td>
<td></td>
<td></td>
<td>Skin irritation, interruption of sex, breakage &amp; spillage.</td>
</tr>
<tr>
<td>Male Condom</td>
<td>11%</td>
<td>Over the counter, protection from STDs,</td>
<td>Skin irritation, can be difficult to place.</td>
</tr>
<tr>
<td>Female Condom</td>
<td>15%</td>
<td>Can be inserted up to 8 hours before</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Effectiveness (%)</td>
<td>Description</td>
<td></td>
</tr>
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<td>-------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>Spermicidal alone</td>
<td>18% to 29%</td>
<td>SomeSTD protection, intercourse, someSTD protection, over the counter. Over the counter.</td>
<td></td>
</tr>
<tr>
<td>Diaphragm with spermicidal</td>
<td>6.0%</td>
<td>Can be inserted up to 6 hours before intercourse and left in place for 24 hours after intercourse. Skin irritation, allergic reaction, increased risk for urinary tract infection.</td>
<td></td>
</tr>
<tr>
<td>Natural Family Planning</td>
<td>25%</td>
<td>Good for people with religious or cultural limitations.</td>
<td></td>
</tr>
<tr>
<td>Cervical Cap with spermicidal</td>
<td>9% nulliparous, 20% parous women</td>
<td>Can be inserted 8 hours before sex and left in place for 48 hours after intercourse. No use of hormones, can remain in place regardless of number of intercourse acts.</td>
<td></td>
</tr>
<tr>
<td>IUD Copper T380</td>
<td>0.6%</td>
<td>Can remain in place for up to 10 years. Cramps, bleeding, pelvic inflammatory disease, infertility, perforation of uterus.</td>
<td></td>
</tr>
<tr>
<td>No method</td>
<td>85.0%</td>
<td>No interference with religious beliefs. No protection from STIs, high failure rate.</td>
<td></td>
</tr>
<tr>
<td>Coitus Interruptus</td>
<td>4-19%</td>
<td>Immediate availability, no costs, no devices, no chemical involvement. Room for incorrect or inconsistent use resulting in failure.</td>
<td></td>
</tr>
<tr>
<td>Lactational amenorrhea</td>
<td>2% within 6 months postpartum</td>
<td>Menses suppressed immediately following childbirth. Return to fertility uncertain.</td>
<td></td>
</tr>
<tr>
<td>Bilateral Tubal Ligation</td>
<td>0.8% to 3.7%</td>
<td>No hormones involved. Possibility of regret, risks of surgery.</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Rate</td>
<td>Description</td>
<td></td>
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<tr>
<td>-----------</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Vasectomy</td>
<td>0.1%</td>
<td>Permanent, same day procedure. No hormones, permanent, outpatient procedure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Possibility of regret, short-term discomfort.</td>
<td></td>
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Table 2

Essential Birth Control Information

Correct use of method, how it works, and effectiveness.
Common side effects with associated advantages and disadvantages.
Contraindications.
Non-contraceptive benefits.
Signs and symptoms indicating that the client should return to clinic.
Access, availability and medical follow up required.
When fertility is expected to return after discontinuing use of contraception.
Protection against sexually transmitted disease.


Table 3

Medical History

| Medical History with religious considerations. |
| Reproductive history. |
| Previous contraceptive use. |
| Personal or partner sexual behavior. |
| Future reproductive goals. |
| Smoking history. |
| Fears or concerns regarding contraceptives. |
| Ability to comply with the requirements of birth control chosen. |


Points to Practice

Remain realistic with your plan of care.
Be alert to signs of mental illness, substance abuse and interpersonal violence. Know how to treat these problems and know the experts in your community who do.
Know community resources and how to help your clients tap into them.
Provide hygiene packets for clients that do not have any resources that include toothbrushes, toothpaste, soap, condoms, and emergency contraception with simple instructions.
Have basic handouts that cover contraceptive choices.
Incorporate increased flexibility in terms of appointment schedules and encounter times.
Remember clients have other pressing needs such as housing, income, and food assistance that may interfere with keeping appointments.
Provide bus vouchers.
Offer clients who have been raped the option of emergency contraception, longer-term contraception and counseling.

Figure 1