

ADAPTING YOUR PRACTICE

*Treatment and Recommendations
on Reproductive Health Care
for Homeless Patients*

Reproductive Health Care



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Health Care for the Homeless
Clinicians' Network

2003

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.

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Bonin E, Brammer S, Brehove T, Hale A, Hines L, Kline S, Kopydlowski MA, Misgen M, Obias ME, Olivet J, O'Sullivan A, Post P, Rabiner M, Reller C, Schulz B, Sherman P, Strehlow AJ, & Yungman J. *Adapting Your Practice: Treatment and Recommendations on Reproductive Health Care for Homeless Patients*, 22 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2003.

PREFACE

Clinicians practicing in Health Care for the Homeless (HCH) projects* 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 Network Steering Committee and other primary health care providers, representing HCH projects across the United States, devoted several months during 2002–03 to developing special recommendations on 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.

Patricia A. Post, MPA
HCH Clinicians' Network

* Health Care for the Homeless projects are funded by the Bureau of Primary Health Care in the Health Resources and Services Administration of the U.S. Department of Health and Human Services under Section 330(h) of the Public Health Services Act.

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ACKNOWLEDGEMENTS

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The Advisory Committee appreciates the skillful facilitation of this project by Adele O'Sullivan, MD, Medical Director of the Maricopa County Department of Public Health's Health Care for the Homeless Project in Phoenix, Arizona.

For their help in recording and facilitating discussion among the clinicians who developed these recommendations, we also extend special thanks to John Lozier, MSSW, Executive Director of the National Health Care for the Homeless Council; to Brenda Proffitt, MHA, Director of the HCH Clinicians' Network; and to the National Council's Clinician Specialist, Ken Kraybill, MSW. We are also grateful for comments contributed by Amy Taylor, MD, MHS, Deputy Chief, Health Care for the Homeless Branch, Bureau of Primary Health Care, Health Resources and Services Administration.

Finally, the Advisory Committee expresses its gratitude to the clinicians who reviewed and commented on the draft recommendations prior to publication: Sue Ellen Abdalian, MD, Associate Professor of Clinical Pediatrics, Clinical Associate Professor of Medicine, and Head, Section of Adolescent Medicine, Tulane University Health Sciences Center, New Orleans, Louisiana; Edward R. Hills, MD, Chairperson and Associate Professor, Department of Obstetrics and Gynecology, Meharry Medical College, Nashville, Tennessee; and Roseanna Means, MD, MSc, President and Medical Director, Women of Means, Inc., a nonprofit organization that provides health care to women who are homeless or marginally housed in Boston, Massachusetts.

Adapting Your Practice: Treatment and Recommendations on Reproductive Health Care for Homeless Patients was supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services.

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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 times more prevalent among homeless people (3.4%) than in the general population (1%) (Allen, 1994). Negative attitudes toward condom use are among the documented risk factors for transmission of HIV in both homeless men and women (Somlai, 1998). High risk for viral hepatitis (HBV, HCV) is also reported among homeless adults and youth, particularly those involved in intravenous drug use and unprotected sex (Garfein et al., 1998; Busen and Beech, 1997; Morey and Friedman, 1993; Wang, 1991).

Risky sexual behaviors and sexually transmitted diseases in homeless adolescents and youth are frequently linked to childhood sexual abuse (Noell, 2001; Tyler, 2000). A recent 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 and 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 (Nyamathi, 1993), yet 65 percent do not use birth control (Institute for Children and Poverty, 1996). 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). 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).

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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 et al., 1988). This is alarming, given that 23 percent of homeless family planning clinic users had an abnormal Pap smear (Shuler, 1991). Based on studies of homeless women's obstetrical history, 74 percent have had children (Burnam, 1989; Shuler, 1994), and 54 percent are currently at risk for unintended pregnancy (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* (March 2000), 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 ADOLESCENT

The patient, a 19-year-old white female with mental illness, presents at the clinic with a complaint of side effects from Depo Provera (bleeding and undesired weight gain).

Social History: Her mother died in a car accident shortly after she was born. She was raised by her father and did not attend school. (Compulsory education was not enforced in the rural area of Alabama where she grew up.) At age 15, she was brought to a shelter in Birmingham following the death of her father, as an alternative to juvenile detention. There were no social services in her hometown. She has lived on the streets for the past three years, often feeding from dumpsters. Limited social skills and low literacy present serious barriers to employment. Currently she has no income and engages in sex work to support herself, which she describes as “taking up with somebody” so she has a place to stay. Initially engaged by the Mobile County Mental Health Outreach team, the patient was almost 19 when she was first seen by mental health services.

Medical history: The first time she was brought to the clinic, the patient was diagnosed as low functioning with schizophrenia and multiple sexually transmitted diseases (trichomonas, gonorrhea and syphilis). No significant health problems were identified other than mental illness and her developmental disability. She had no disability benefits and no other health insurance, but did qualify for family planning services under the State's Medicaid program.

Contraceptive history: Acknowledging her life style, the provider talked to the patient about birth control, and she agreed to try Depo Provera. She returned to the clinic because of concern about bleeding, a known side effect that is usually temporary. Despite attempts to reassure the patient, she was unable to understand that the bleeding probably would not persist longer than three months. She was immensely frightened by the bleeding and worried also about weight gain following her first Depo injection. Birth control pills combined with condom use were offered as an alternative, to protect against pregnancy and sexually transmitted diseases.

Physical examination: Routine, including complete breast, thyroid, heart, abdomen, and pelvic exam.

Labs: hematocrit, hemoglobin, STD screening (HIV, VDRL, culture for gonorrhea, chlamydia, wet prep), Pap smear, urinalysis, blood sugar.

Medications: Prolixin, IM; Cogentin; Orthonovum 7-7-7.

Follow-up: The patient frequently encounters HCH staff on the street to report lost pills. When given 3-4 months' supply of birth control pills at a time, she would constantly lose them. When the prescription was limited to one pill pack per month, she seemed to appreciate coming by the clinic more frequently for the social interaction, sometimes to talk, other times just to get the pills, which are kept in a special place for her.

Current assessment: family planning, history of mental illness

Plan: Continue on Orthonovum 7-7-7; dispense only one pill pack per month. Follow up with mental health services to assure that the patient is addressing her mental health problems. Work with case manager to help patient apply for disability assistance and find permanent housing.

Reproductive Health Care

Diagnosis and Evaluation

HISTORY

- **Living conditions** Ask where patient lives; assess for residential stability, access to drinking water and food (particularly when needed to take medications), bathing facilities, a safe place to keep medications (including those requiring refrigeration) and hygiene items.
- **Sexual history** Ask about sexual identity, orientation, behaviors, partners, pregnancies, and sexually transmitted diseases including hepatitis B. Assess STD risk in considering IUD use.
- **Desire for contraception** Assess patient's need and desire for contraceptive services. Ask about history of contraceptive use. Offer reproductive health services to all patients, regardless of gender.
- **Substance abuse/ mental health** Assess patient's ability to take pills daily or remember to return for follow-up.
- **Medical history** Elicit best possible history of ongoing medical problems, or prior history of significant 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.
- **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 patient about medications she 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 patient has been vaccinated against measles-mumps-rubella (MMR) and hepatitis. Women of childbearing age should receive MMR vaccine if not pregnant. Patients engaging in high-risk sexual behaviors may be at risk for hepatitis B and should be vaccinated as necessary. Men who have sex with men (MSM) are at risk for hepatitis A and should be vaccinated.
- **Menstrual history** If history of irregular 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, sometimes seen in substance abusers).

- **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. This may be one of few opportunities patient has to talk about these issues without partner present.
- **Insurance status/ resources** Assess 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). Do not tell patient that 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 patient with a history of sexual abuse, who may be reluctant to have a pelvic exam. 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, according to standard clinical guidelines. Also do breast exam to address preventive care needs. Provider should be extremely sensitive to patient with a history of sexual abuse. See patient with clothes on first; carefully explain genital exam; ask permission to examine; never leave female patient alone in stirrups.
- **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 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 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 possibility of infection of multiple orifices in men and women, considering sexual practices.

- **Pregnancy test** urine pregnancy test (UCG)
- **Routine health care maintenance** For female: annual Pap smear if age 17 or older (younger if sexually active), mammogram if indicated (baseline mammogram between ages 35–40; every 1–2 years ages 40–49; and every year, age 50 and above). For male: monthly testicular self-examination, 15 and older; annually per clinician; prostate examination: both digital rectal exam and prostate specific antigen (PSA) test annually, age 50 and older (age 40 and older for African American men and men with family history of prostate cancer) (AHRQ, 1998).
- **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 client in finding ways 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; take into account primary language, literacy, and possible cognitive deficit. Give simple instructions for 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 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 method. Provide information on availability of male and female barrier methods, either on site or elsewhere. Provide information about vaginal creams, gels, and suppositories containing spermicides 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 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 use or other serious drug use, offer referral to substance abuse treatment and for access to clean needles when available.

- **Smoking cessation** Use opportunity to encourage smoking cessation; assess readiness to change smoking behavior in female who prefers birth control pills.
- **Partner education** If possible, include partner in discussion of contraceptive alternatives.
- **Preconception counseling** Discuss nutrition, mental health and substance abuse nonjudgmentally. Explain risks of pregnancy for 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 client desiring pregnancy about advantages of and contraindications to breast feeding.
- **Health care maintenance** Encourage monthly breast/testicular self-exam and teach client how to perform exam.
- **Storage/expiration of condoms, birth control pills** Educate patient about proper storage of condoms and birth control pills; advise not to use beyond expiration date.
- **Co-existing medical conditions** Educate patient about possible effects of pregnancy on chronic medical conditions (e.g., diabetes, asthma, seizures, psychiatric disorders). This information will help male or female patient in decisions regarding family planning or contraceptive use.

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. For 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 patient cannot adhere to daily regimen (for birth control pills), especially if risks associated with pregnancy are high. If pregnancy test is negative and likelihood of pregnancy before next visit is high, consider initiating injection beyond five-day onset of menses. Counsel patient regarding theoretic and very small risk to fetus if 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 number of pill packs to prescribe at one time based on patient's access to medications and ability to adhere to prescribed regimen. Make calendar for patient to use. For patients with mental health problems, consider prescribing only one pill pack at a time.

- **Transdermal methods** offer the advantage of convenience for some homeless clients, but may be expensive. Provider should also consider patient's occupation when prescribing contraceptive patches. Conspicuous forms of birth control (such as contraceptive patches, implants, etc.) may present an occupational disadvantage to some individuals (e.g., 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.
- **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 fetus). Vitamins are usually appealing to homeless women, who have inadequate diets. Recommend calcium supplement (e.g., Tums) to patient 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 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 discussion issue of deleterious side effects of epileptic medications in pregnancy.

ASSOCIATED PROBLEMS/COMPLICATIONS

- **Pregnancy** Counsel 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 of loss of other children to state custody, belief that partner will be more faithful if patient is pregnant, to get sympathy/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 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, 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 prescribed contraceptive method. Mention reproductive health to patient at each visit. Make plan to ensure return one month after initial visit.
- **Reminders** Appointment cards kept in pouches, worn around neck, are useful to remind patient when to return to clinic for next prescription or injection. Use of voicemail reminders and outreach workers can also facilitate follow-up care.
- **Positive reinforcement** Thank 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 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** 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.

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SUGGESTED RESOURCES

- Kraybill K. *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*. National Health Care for the Homeless Council, June 2002: www.nhchc.org/Publications/.
- McMurray-Avila M. *Organizing Health Services for Homeless People*. ISBN: 0971165092; 2nd Edition. Nashville: National Health Care for the Homeless Council, Inc., 2001.
- Miller WR and Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. ISBN: 1572305630; 2nd Edition. New York: Guildford Press, 2002.
- National Health Care for the Homeless Council. *Health Care for the Homeless: An Introduction*. 22 minute video and user's guide. June, 2001. To order: www.nhchc.org/Publications/.
- National Health Care for the Homeless Council. *Health Care for the Homeless: Outreach*. 21 minute video. June, 2001. To order: www.nhchc.org/Publications/.

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.