Reproductive Planning for Women who use drugs

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Women who use drugs have high-risk pregnancies with increased mortality and morbidity among mothers and babies. Adverse outcomes include increased rates of prematurity, low birth weight and intrauterine growth restriction. The drugs used, whether prescribed or illicit, may cause neonatal withdrawal symptoms and the use of drugs and tobacco together with the disadvantaged backgrounds of most of the women who use drugs, increases the risk of sudden infant death. Furthermore, poorly controlled drug use together with chaotic lifestyles can compromise parenting abilities and lead to adverse social outcomes.

Women who use drugs often have unplanned but not necessarily unintended or unwanted pregnancies. However, the timing of their pregnancies is often inappropriate. Addressing the problems related to drug use when a woman is already pregnant is stressful and the scope for improving outcomes is limited; many of the adverse medical and/or social outcomes of pregnancy experienced by women who use drugs could be avoided or minimised by appropriate planning and management of their drug use and related problems before conception.

The concept of pre-pregnancy counseling and treatment is not new. While it is envisaged as valuable for all women its routine introduction has proved impossible since many women have unplanned pregnancies and the scope for improved outcomes among low risk women is limited. However, the benefits for women with major medical problems have been recognised for some conditions, for example the provision of pre-pregnancy advice to young diabetic women is now widespread. Recognition of the potential benefits of pre-pregnancy care is largely limited to women with medical conditions that can increase mortality and morbidity for the mother and/or baby. The potential benefits for women with problems caused or exacerbated by social circumstances that increase the risk of poor social outcomes is less widely recognised. The failure to provide pre-pregnancy care for women who use drugs is one such striking example.

There is a harsh public perception of women who use drugs, who are widely perceived as irresponsible individuals who are unfit to have children. The underlying problems that lead to drug use are inadequately recognised and many women who use drugs lose custody of their children, often with justification but sometimes because there are inadequate services to support such women and help them develop adequate parenting skills.

Given the adverse social outcomes and potentially long lasting effects on the children, it is sometimes argued that women who use drugs should not have children, the ultimate expression of this view manifest in the campaign offering women money in return for undergoing sterilisation. This view is not expressed with regard to other women with high risk pregnancies, even when lifestyle contributes to poor outcomes as in the case of obesity. Women who use drugs do not differ from other women in their aspirations to have children and it is important to recognise that many of the poor outcomes are caused by poverty directly or indirectly and are merely exacerbated by their drug use. Denying women who use drugs the right to have children is therefore simply punishing them for being disadvantaged! Management of women with high-risk pregnancies should be similar whether the risk is of medical or social aetiology. The aim should be to address problems before conception and to help women to have pregnancies that are wanted, planned and timed to ensure optimal medical and social outcomes.

Provision of multiagency addictions care is now well established in the UK and primary care services have made and continue to make a major contribution in this field. While service content, design and delivery varies, it is now the case that most women who use drugs who attend for maternity care in the UK are already in contact with services, medical and/or social that provide addiction care. *Disappointingly the opportunity to discuss reproductive plans afforded by this contact is often squandered and pregnancies occur to the surprise of both women and services!* This is of particular concern given that any treatment of addiction whether pharmacological or psychosocial may increase fertility either directly or indirectly so, apart from the obvious social benefits, from a purely medico-legal point of view any addictions treatment should be accompanied by information and advice about contraception. While many addiction services now offer contraceptive advice this is often perceived as an optional extra aimed at pregnancy prevention rather than pregnancy deferment until relevant problems have been addressed.

Services working with women who use drugs should make reproductive healthcare, including both contraception and family planning, an integral part of the care provided to both men and women who use drugs but especially to women. In this vulnerable group of often hard to reach women this contact affords an opportunity to ensure cervical screening is up to date and to undertake screening for sexually transmitted infections, HIV and hepatitis as appropriate. As for all women, treatment with folic acid to reduce the risk of neural tube defects should be commenced 3 months prior to conception and continued until 12 weeks gestation. For women who use drugs contemplating pregnancy, stability of drug use is a priority. Opioid substitute medication where prescribed should be appropriate for pregnancy and both methadone and buprenorphine are acceptable although switching from Suboxone to buprenorphine would be advisable. Offering nicotine replacement therapy to women who smoke is worthwhile. The need to reduce and if possible stop using other drugs such as benzodiazepines and cocaine for which there are no safe and effective substitutes should also be discussed. The additional benefits of breast-feeding for babies of women who use drugs should be explained and starting the dialogue before conception will improve breast-feeding rates. The opportunity should also be taken to address social issues that could compromise parenting and lead to poor social outcomes. All women except those who are HIV positive should be encouraged to breast-feed.

Instead of trying to prevent women who use drugs from having children (which will be almost invariably unsuccessful) a more profitable approach would be to help women to address their problems, to explore their aspirations with regard to having children and to ensure any pregnancies they do have are intended and optimally timed for the best possible medical and social outcomes. Primary care services are ideally placed to play a leading role in this area with enormous potential for reducing the impact of drug use on the children of mothers who use drugs and reducing the intergenerational effects of health inequalities. It is an opportunity, which should not be missed.