Letters to the Editor

Applying Harm Reduction Principles to Reproductive Health

To the Editor: As clinicians working with individuals with substance use disorders (SUD), we appreciate Drs. Frank and Morrison's coverage of this important topic.[1] We found the inclusion of reproductive health as part of the harm reduction framework to be a strength of the article. Although we agree that long-acting reversible contraceptives (LARCs) should be easily accessible for patients who do not desire pregnancy, we recommend facilitating accessibility of all forms of contraception, including emergency contraception, during SUD treatment.

Physicians may advocate for LARCs with the intention of decreasing unintended pregnancies; however, overemphasis of using a LARC can contribute to patient dissatisfaction, alter patient perceptions of clinical recommendations, and disrupt patient–physician communication.[2] A trauma-informed framework is best suited for conversations about sexual health in patients with SUD; these patients often have a history of interpersonal trauma, including intimate partner violence and reproductive coercion, and potential historical trauma associated with forced contraception and sterilization imposed on communities of color.[3,4] This framework is also appropriate for people who thought they could not become pregnant (e.g., those prescribed medications for opioid use disorder who experience amenorrhea). Comprehensive contraceptive counseling and reproductive health education should be part of the harm-reduction model, and all forms of contraception, including barrier methods and emergency contraception, should be accessible.

People with SUD have higher rates of unintended pregnancy, pregnancy-related mortality, and lower rates of contraceptive use compared with the general population.[3,4] This highlights the importance of ready access to contraception and emergency contraception.[3,4] Prescribing appropriate emergency contraception can fit seamlessly into other harm reduction conversations, including naloxone, pre-exposure prophylaxis (PrEP), and needle exchange services. *Table 1* highlights forms of emergency contraception.[5,6]

Family physicians are positioned to offer a harm-reduction model that integrates SUD treatment and reproductive health care by providing access to contraceptive options. Expanding

TABLE 1

Emergency Contraception

Type	Effectiveness	Timing after sexual intercourse	Body mass index	Dose	Over the counter
Copper intrauterine system (Paragard)	99%	Up to 5 days	All	Not applicable	No
Levonorgestrel-releasing intrauterine system	99%	Up to 5 days	All	52-mg intrauterine system	No
Levonorgestrel (Plan B)	52% to 100%	Up to 3 days	Up to 26 kg per m^2	1.5 mg orally	Yes
Ulipristal (Ella)	62% to 85%	Up to 5 days	Up to 30 kg per m^2	30 mg orally	No

Information from references 5 and 6.

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programs such as Title X and Medicaid programs would increase access to contraception and SUD treatment options in this population, specifically in marginalized populations.

Editor's Note: This letter was sent to the author of "Harm Reduction for Patients With Substance Use Disorders" [Curbside Consultation], who declined to reply but thanked the author for continuing the discussion about harm reduction and reproductive justice.

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