

Alaska Maternal and Child Health Data Book 2018: PRAMS Edition



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Alaska Maternal and Child Health Data Book 2018: PRAMS Edition

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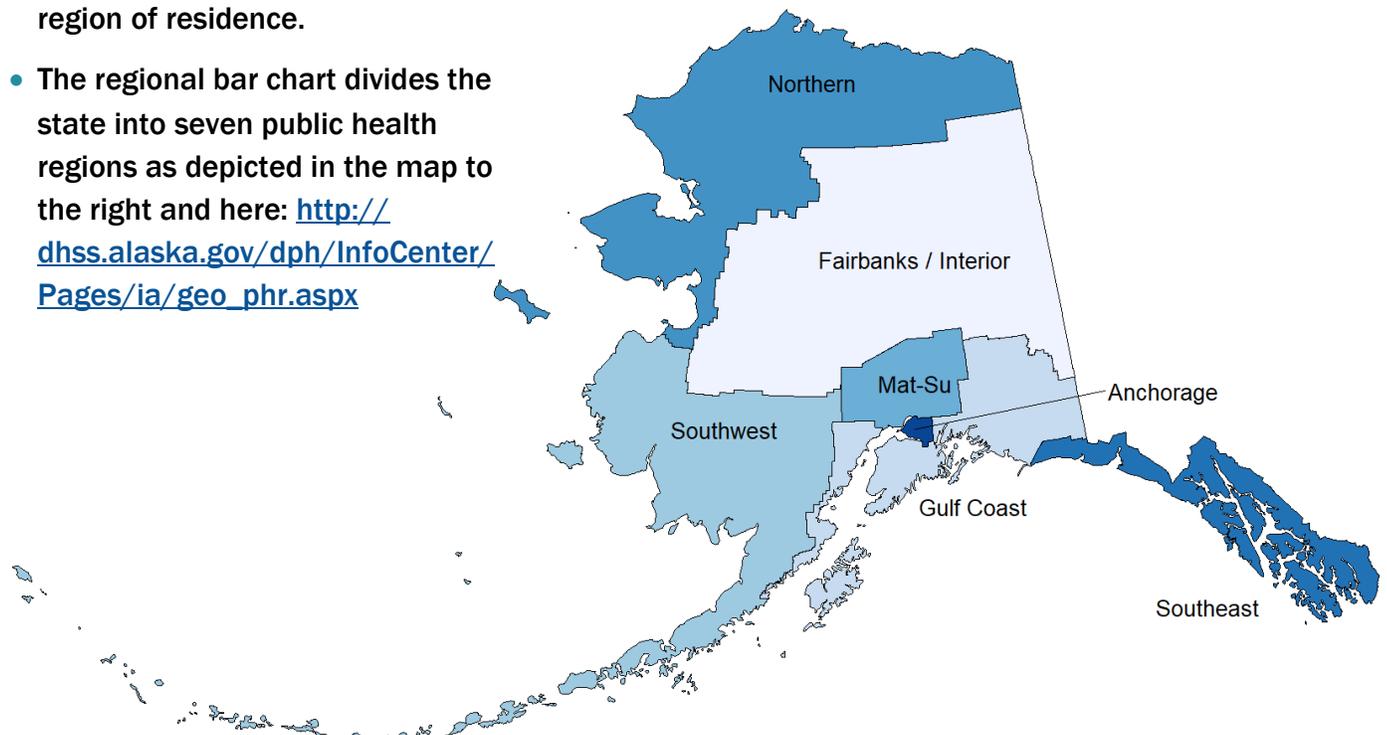
Introduction

We are pleased to present the *Alaska Maternal and Child Health Data Book 2018: PRAMS Edition*, sharing detailed analyses from the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). This book is the eighth in our series of reference books on the epidemiology of maternal, child and family health in Alaska. PRAMS data provides a wealth of population-based information for the State of Alaska on maternal and infant health. This book incorporates newer data visualization techniques, includes topics that have not been reported on in prior data books, and reports on indicators by federal poverty level for the first time. In addition, this is the first book to incorporate comments from women who responded to PRAMS to provide a more personal window into the Alaskan maternal experience. We hope the *Alaska Maternal and Child Health Data Book 2018: PRAMS Edition* will be a helpful reference for all Alaskans concerned with improving the health and well-being of Alaskan families!

How to Use This Book

Alaska PRAMS has collected data on many topics over the last two and half decades. The indicators selected for this data book include the most requested PRAMS topic areas as well as topic areas that have not been previously published.

- Where a trend is given, it always covers the most recent eight years of data available for analysis (2009-2016) and shows the statewide trend and trends by maternal age. Detailed tables showing the individual year data points along with p-values for statistical significance can be found in the Appendix.
- The bar charts show the most recent year(s) of data available for the overall population estimate and estimates for groups based on maternal race, age, federal poverty level, and region of residence.
- The regional bar chart divides the state into seven public health regions as depicted in the map to the right and here: http://dhss.alaska.gov/dph/InfoCenter/Pages/ia/geo_phr.aspx



Introduction

Special Note on Maternal Race

Race refers only to the race of the mother as reported on the birth certificate.

For the purposes of this data book:

- “Alaska Native” refers to women who identify as Alaska Native or American Indian, either alone or in combination with other races.
- “White” refers to women who identify as White alone.
- “Other” refers to women who identify as any race other than Alaska Native (alone or in combination) or White (alone).

Special Note on Comments

Comments selected were edited only for spelling and readability and are shown in colored call-out boxes. The Table of Contents indicates their placement in the Data Book. They are from PRAMS respondents who delivered a baby during 2012 through 2016 and represent the personal opinions and experiences of the Alaskan mothers who shared them.

For More Information

Questions about the analysis methodology, survey question wording, or other specifics regarding the data in this book can be emailed to mch-epi@alaska.gov.

“Having my baby girl has been the best thing that has ever happened to me and she has completely changed how I look at the world. She will be a tough & beautiful Alaskan grown lady. I wish that all babies born would be healthy and loved. That would make the world a much better place.”

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In their own words...comments from PRAMS respondents are shared.



Region-specific data are shared in a bar chart. See introduction for a map of Alaska depicting the regions.



Comparable data for U.S. (available at <https://www.cdc.gov/prams/prams-data/mch-indicators.html>) are included with figure.



Eight-year trends (2009–2016) are shared.

Overview of PRAMS

Background

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences that occur before and during a woman's pregnancy and during the early infancy of her child. PRAMS was developed by the Centers for Disease Control and Prevention (CDC) Division of Reproductive Health in 1987 as part of an initiative to reduce infant mortality and low birth weight. The Alaska PRAMS Project was initiated by the State of Alaska, Division of Public Health, Section of Maternal, Child and Family Health in 1990.

PRAMS was designed to supplement data from vital records and to generate data for planning and assessing perinatal health programs in participating states. Because PRAMS data are population-based, findings from data analyses can be generalized to an entire state's population of women having a live birth. PRAMS is designed not only to generate state-specific data, but also to allow comparisons among states through the use of standardized data collection methods.

Currently PRAMS operates in 51 project sites* and surveillance covers approximately 83% of all U.S. births. Each site utilizes the same core questions and adds a limited number of its own state-specific questions. Topics covered include preconception health; prenatal care; use of tobacco and alcohol and other substances; insurance coverage; breastfeeding; intimate partner violence; infant sleep environment, and life stressors such as illness, job loss, debt; plus many other topics. Current and all prior questionnaires used for specified birth years for Alaska can be found on the Alaska PRAMS website under "Data Collected" <http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/prams>.

Sample Design

All PRAMS programs utilize a sampling technique called "stratified random sampling." Stratified random sampling provides a means to collect more meaningful information about high-risk population groups. For example, because a relatively small percentage of the total population of mothers have a low birth weight infant, a simple random sample may not yield sufficient numbers of responses from these women to tell us about their lifestyles and behaviors as a group.

Alaska stratifies by mother's race and birth weight of the infant (as reported on the birth certificate) to create four strata used for sampling: Alaska Native women with a low birth weight (LBW) infant (i.e., <2500 grams), Alaska Native women with a normal birth weight (NBW) infant

*Forty-seven states, New York City, Puerto Rico, the District of Columbia and the Great Plains Tribal Chairmen's Health Board currently participate in PRAMS. The three states not participating in PRAMS are California, Idaho, and Ohio.

Overview of PRAMS

(i.e., ≥ 2500 grams), non-Native women with a LBW infant, and non-Native women with a NBW infant. A random sample is then drawn from each of these groups to select PRAMS participants each month. A weighting process is used to recombine the resulting responses to reflect the total population of Alaskan mothers of newborns in a specific time period.

Mode of Surveillance

PRAMS is a mixed-mode surveillance system. The primary data collection method is by mail. Up to three self-administered surveys are mailed to sampled women. Phone interviews are attempted on women who do not respond by mail.

Inclusion Criteria

Alaska-resident women of any age who deliver a live birth in Alaska make up the population base for PRAMS. Birth records are eligible for sampling when a minimum of two months (and a maximum of six months) has passed since the date of birth. Women whose infant has died are still included; letters specific for grieving mothers are mailed out in these situations. When the birth is multiple, one infant is randomly selected for the mother to answer infant-specific questions such as breastfeeding or infant sleeping environment. Pending adoptions are included as long as the biological mother is still identified on the birth record.

Sample Size

There are approximately 11,000 live births per year in Alaska, or about 917 live births per month. PRAMS mails out an average of 150 questionnaires per month to mothers who have had a recent live birth. Approximately one of every six mothers of newborns is selected for PRAMS.

Limitations of PRAMS Data

Self-reporting: Some bias is expected from any survey based on self-reported information. The potential for under-reporting as well as over-reporting bias must be kept in mind when interpreting results.

Population sampled: PRAMS samples mothers who have recently had a live birth – pregnancies resulting in abortions, miscarriages, or stillbirths are not sampled. As such, data do not represent women who became pregnant in the time frame specified, only those who delivered a live-born infant.

Recall bias: Some PRAMS questions ask the respondent to remember events or behaviors up to 12 months before they got pregnant. On average, the infant is 19 weeks (about 4.5 months) old at the time the mother responds. Mothers who respond to the survey when their infant is younger

Overview of PRAMS

may recall events more accurately than mothers who respond when their infant is older.

Response rates: Survey response rates may also affect the potential for bias in the data. The overall weighted response rate for 2015 was 66% and for 2016 was 61%.

Reliability: The reliability of a prevalence estimate depends on the actual, unweighted number of respondents in a category (not a weighted number). Interpreting and reporting weighted numbers that are based on a small, unweighted number of respondents can be misleading. The degree of precision increases if the sample size is larger and decreases if the sample size is smaller.

PRAMS-eligible Population

The PRAMS-eligible population is defined as state residents who gave birth in-state during the year specified. PRAMS data are representative of women whose pregnancies resulted in a live birth and are not generalizable to all pregnant women. In the table on the next page, figures for population size and percent are compiled from state birth certificate data. All other figures are estimated from the PRAMS sample.

“Thank you for allowing me to help with this survey. My pregnancy changed my life for the greater. On how I should be eating to what my mother went through with my sisters and I. I am grateful to have my little girl, I am excited to watch her grow into a beautiful woman.”

Characteristics of PRAMS-Eligible Population, Alaska 2016

	Population Size (N)	Percent	Respondents (n)	Estimated Percent
Maternal Race/Ethnicity				
White Non-Hispanic	5,596	51.6	431	52.9
Black Non-Hispanic	299	2.8	27	1.8
Hispanic	796	7.3	120	7.8
Asian or Pacific Islander	918	8.5	75	7.8
Other/ Mixed	383	3.5	24	2.8
Alaska Native	2,848	26.3	476	26.9
Maternal Age				
< 20 years	578	5.3	75	5.3
20-24 years	2,516	23.1	256	20.7
25-34 years	6,304	57.9	663	60.4
35 years or older	1,481	13.6	180	13.6
Maternal Education				
<12 years	1,098	10.3	145	10.6
12 years	3,268	30.5	389	31.8
>12 years	6,340	59.2	616	57.6
Marital Status				
Married	6,936	63.8	689	63.3
Unmarried	3,932	36.2	482	36.7
Birthweight				
Low (< 2500 grams)	564	5.2	335	5.2
Normal (≥ 2500 grams)	10,307	94.8	835	94.8
Parity				
1st birth	3,820	35.2	424	35.0
2nd or later	7,040	64.8	750	65.0
Annual household income				
Less than \$20,000	**	**	290	22.2
\$20,001 to \$50,000	**	**	337	30.6
\$50,001 to \$107,000	**	**	301	33.3
\$107,001 or more	**	**	138	13.9
OVERALL	10,879	100.0	1,174	100.0



Chapter 1: Preconception Health

Preconception Health

Why is this important?

Optimal child, family, and community health is influenced by events and experiences that occur throughout a lifetime. Some periods are particularly critical, including the preconception period before and around the time a woman becomes pregnant. This chapter focuses on things a woman can do or experience prior to becoming pregnant or very early in pregnancy before she knows she is pregnant that can impact the outcome of the pregnancy and even the health of her child later in life.¹

An annual well-woman visit is a preventive care visit for reproductive-aged women. A well-woman visit provides a critical opportunity for women to talk with their health care provider, ask questions, and receive health education on a variety of topics such as family planning. In addition, she can receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women.² Screening and management of chronic conditions, such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be conducted within a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.²

“I feel that most OBs and doctors are not discussing food and nutrition with pregnant women enough. No one ever talked to me about that...”

A pregnancy is considered unintended if the mother did not want to be pregnant at that time or never wanted to be pregnant. For the information presented in this data book,

unintended pregnancies are limited to those that resulted in a live-born infant. Reducing unintended pregnancies is a national public health goal.³ Unintended pregnancies can have negative health consequences for the mother and the baby. Unintended pregnancies are associated with delayed prenatal care; adverse birth outcomes such as preterm delivery, birth defects and low birth weight; and a lower likelihood of breastfeeding.³ Children from unintended pregnancies have poorer mental and physical health during childhood, and are more likely to experience lower educational attainment and behavioral issues as teenagers.³ Using contraception consistently and correctly lowers the risk of a woman having an unintended pregnancy.⁴

Excessive or chronic alcohol use and binge drinking can lead to increased risk of health problems such as injuries, violence, liver diseases, and cancer. Because sexually active women may unintentionally expose a developing fetus to alcohol with an unintended pregnancy, the U.S. Centers for Disease Control and Prevention recommends that women should not drink alcohol if they are planning to become pregnant or are sexually active and do not use effective birth control.⁵

The Alaska PRAMS survey asks women who recently delivered a live birth about a variety

Preconception Health

of stressful life events that may have happened to them during the 12 months before their new baby was born. A woman's historical and current life experiences can directly impact the health and well-being of her children and family. The impacts of life experiences can also be transmitted to subsequent generations. Reducing the frequency of stressful life events experienced by women and their families could potentially result in improved overall health and development of children and families. Some studies have indicated that experiencing certain stressful life events is associated with poor health overall as well as birth outcomes such as preterm birth and low birth weight.⁶

“In general I think there is a challenge in getting people well informed about the aspects of a healthy pregnancy—i.e. drinking and doing drugs during pregnancy. I work with children in mental health, so I see a lot of that. But personally, I had a great experience.”

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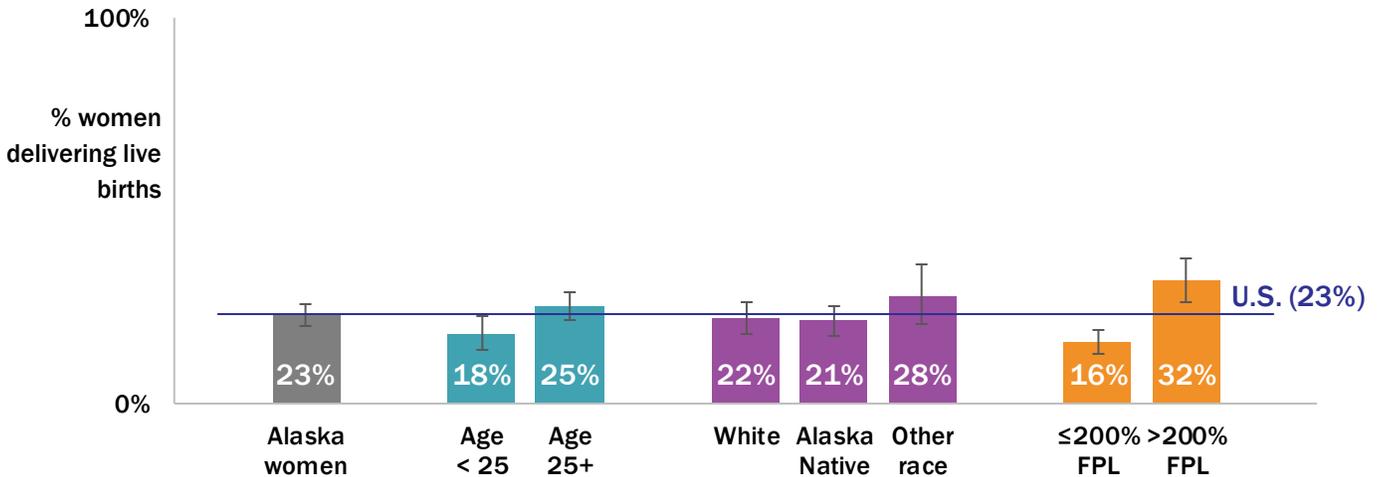
Data Highlights

- In 2015, 23% of Alaska women stated that a health care worker talked with them before they got pregnant about how to improve their health. This was similar to the prevalence overall for the U.S.
- Less than half of Alaska women reported talking with a health care worker during the 12 months before pregnancy about any of the individual health topics examined for this data book. The most commonly reported discussions were being asked whether someone was hurting them emotionally or physically (43%) and if they were feeling down or depressed (43%), while only 19% talked with a provider about sexually transmitted infections.
- Compared with 52% of women not in poverty, only 18% of Alaska women in poverty ($\leq 200\%$ federal poverty level [FPL]) in 2016 were talked to by a health care provider during the 12 months before getting pregnant about their desire to have or not have children.
- Younger women (26%) and Alaska Native women (23%) were more likely than older and White women, respectively, to report being talked to about sexually transmitted infections.
- White women were significantly more likely to be asked whether someone was hurting them emotionally or physically (48%), compared to either Alaska Native women (37%) or women of other races (34%).
- White women were significantly more likely to be asked 12 months before getting pregnant about whether they were feeling down or depressed (46%) than Alaska Native women (38%).

“...The providers did not really talk to me about risk factors, probably because they knew I was well educated...”

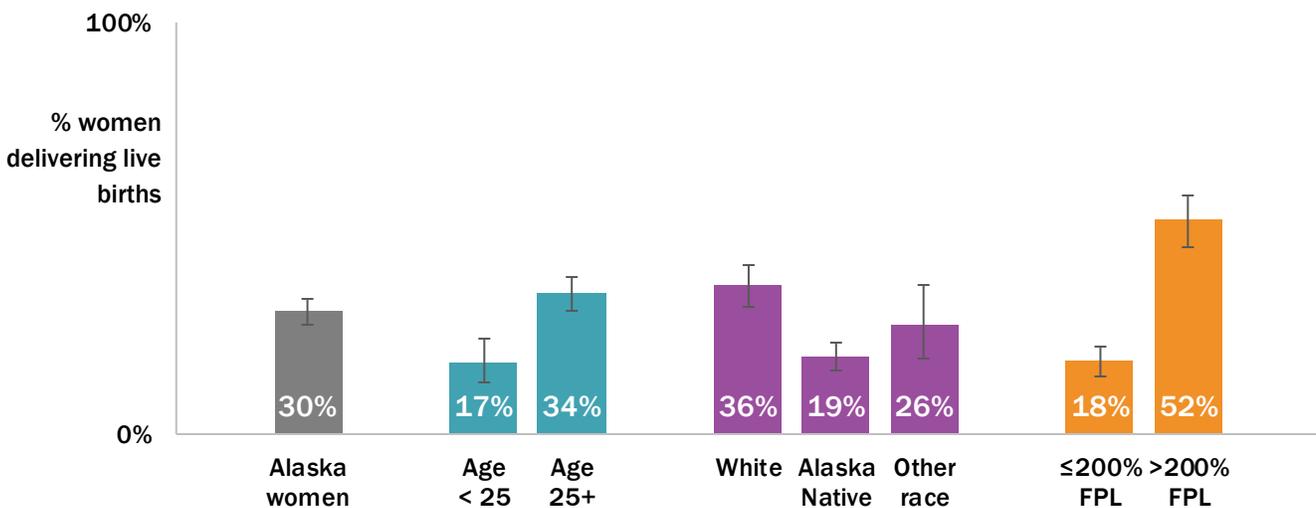
Preconception Health | Discussions with a Health Care Provider

Figure 1. Provider talked to me pre-pregnancy about how I could improve my health, 2015



Source: Alaska PRAMS
 FPL = Federal Poverty Level
 Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

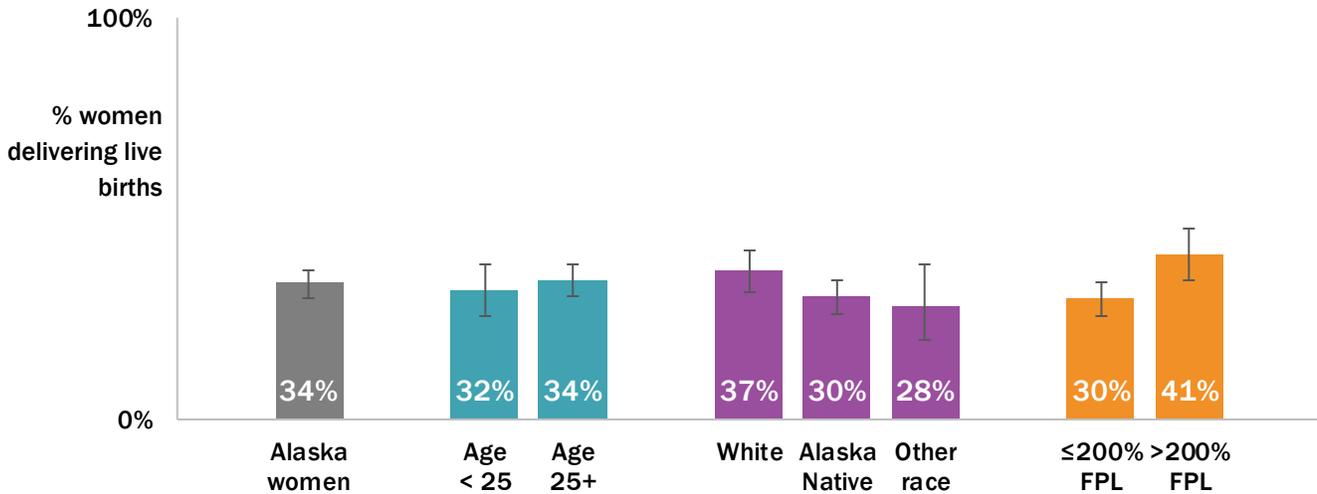
Figure 2. Provider talked to me 12 months pre-pregnancy about my desire to have children, 2016



Source: Alaska PRAMS
 FPL = Federal Poverty Level

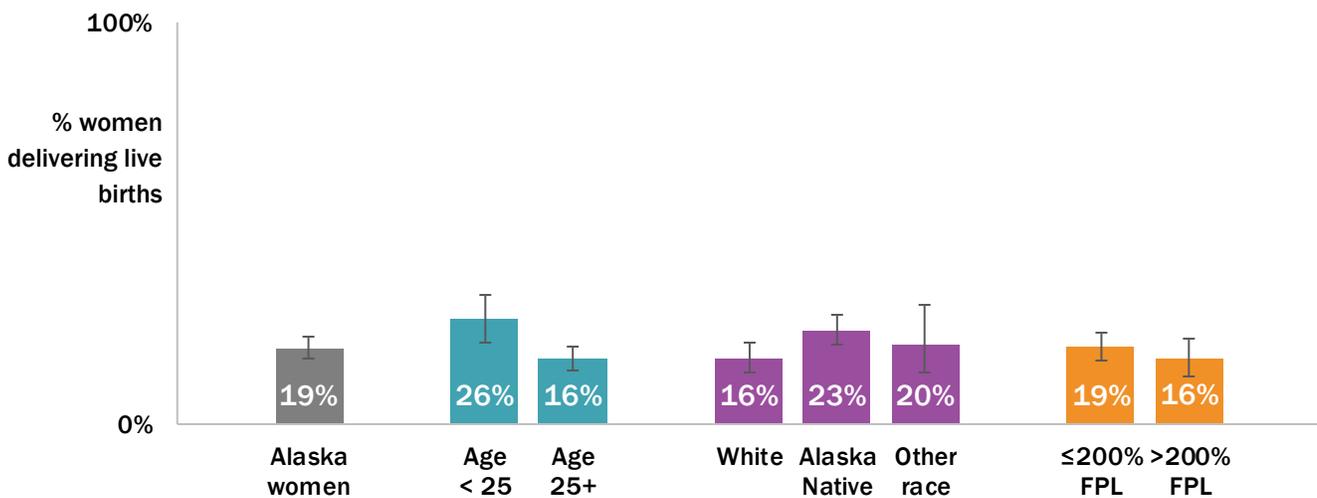
Preconception Health | Discussions with a Health Care Provider

Figure 3. Provider talked to me 12 months pre-pregnancy about using birth control, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

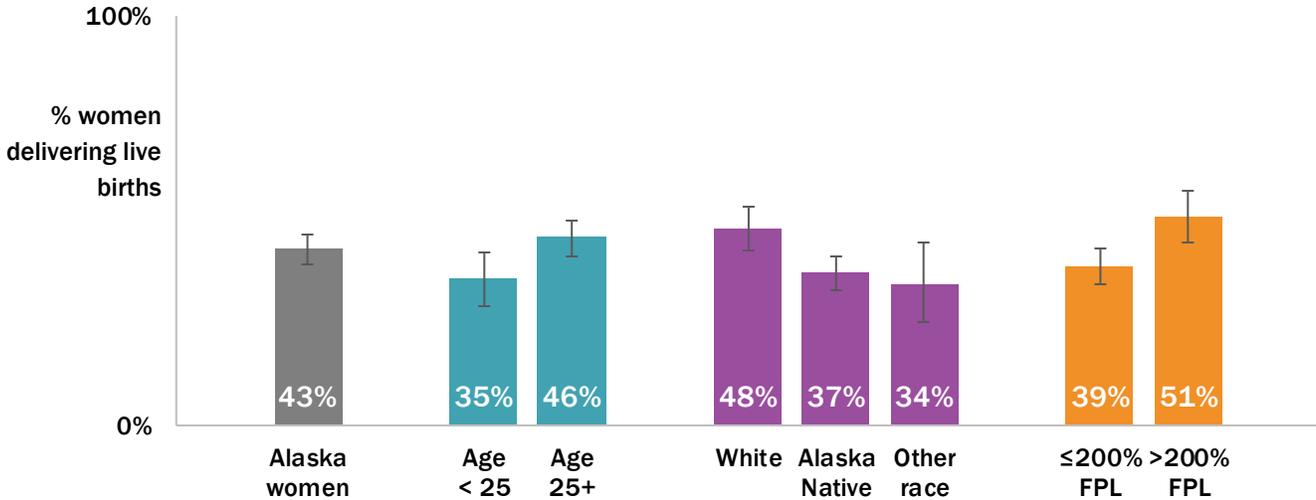
Figure 4. Provider talked to me 12 months pre-pregnancy about sexually transmitted infections, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

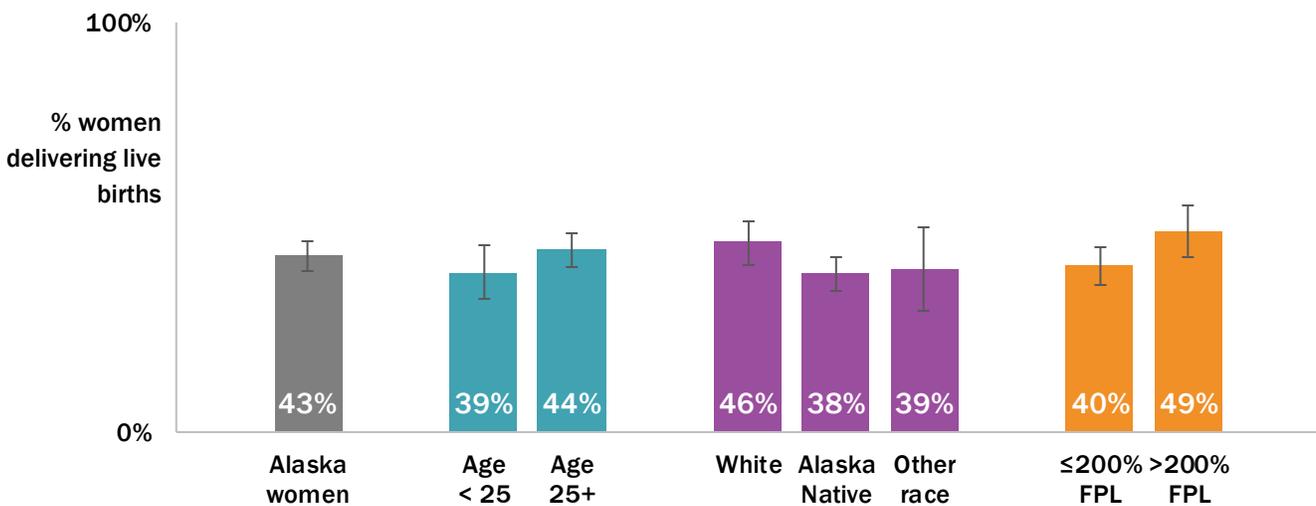
Preconception Health | Discussions with a Health Care Provider

Figure 5. Provider asked me 12 months pre-pregnancy if someone was hurting me emotionally or physically, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 6. Provider asked me 12 months pre-pregnancy if I was feeling down or depressed, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

Data Highlights

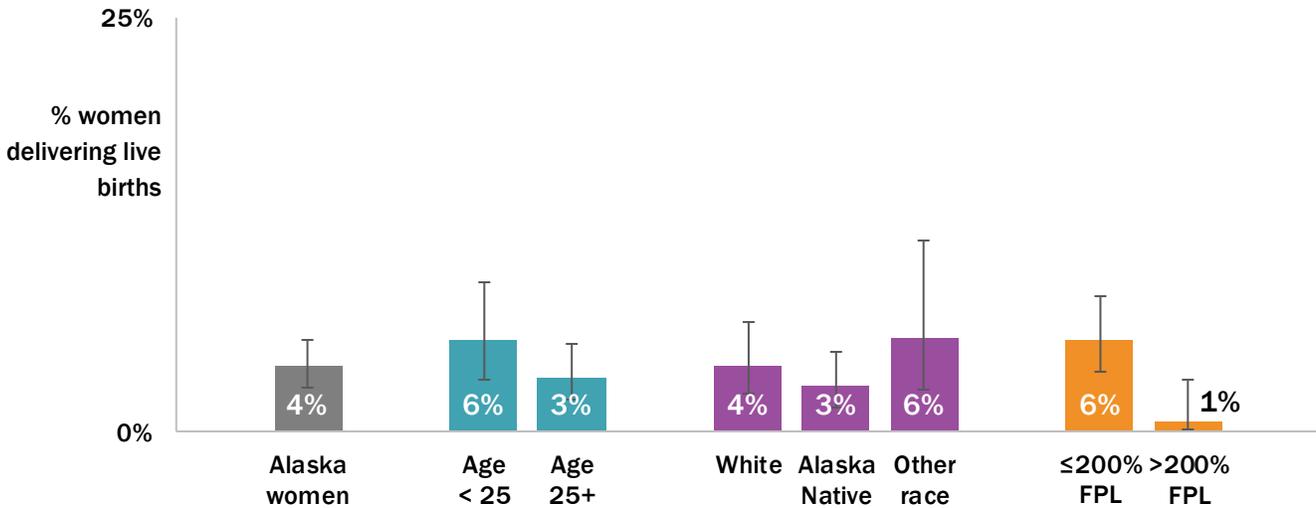
- Alaska women who were younger, of a race other than White or Alaska Native, or who were in poverty were more likely to not know where to go to get birth control and to not have enough money or insurance to get birth control during the 12 months before getting pregnant.
- In 2015, 3% of Alaska women did not feel comfortable asking their local health care provider for birth control during the 12 months before getting pregnant. This was less common among older women, White women, and women not in poverty.
- In 2016, 26% of Alaska women who delivered a live birth said their pregnancy was mistimed or unwanted. This was lower than the prevalence of 34% for women in the U.S. overall.
- By region of residence, the prevalence of a mistimed or unwanted pregnancy ranged from 15% in the Southeast to 40% in the Southwest.
- While 17% of all Alaska women who delivered a live birth in 2016 reported being unsure about whether they wanted their pregnancy, 27% of Alaska Native women were unsure about their pregnancy.

“I wasn't educated about the mini pill & breastfeeding enough to know if you stop breastfeeding & use that pill you'll get pregnant which is the result of my most recent pregnancy. Being better educated would have prevented my pregnancy.”

Data Note on Pregnancy Intention

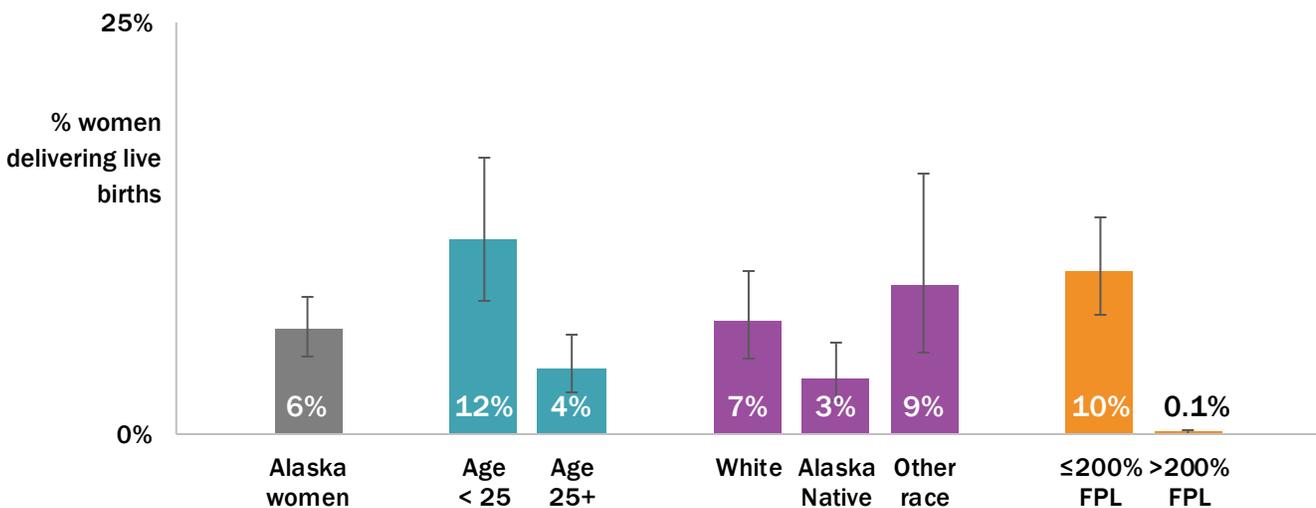
In the past, Alaska Maternal and Child Health Data Books have reported on “Unintended Pregnancy” using the PRAMS question “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?”. “Unintended pregnancy” was previously defined as a mistimed (“I wanted to be pregnant later”) or unwanted (“I didn’t want to be pregnant then or at any time in the future”) response. Starting with 2012 births, the response options for this question added “I wasn’t sure what I wanted” which makes the current “mistimed or unwanted” prevalence incomparable to unintended estimates reported in years prior to 2012.

Figure 7. Problems getting birth control: I didn't know where to go, 2015



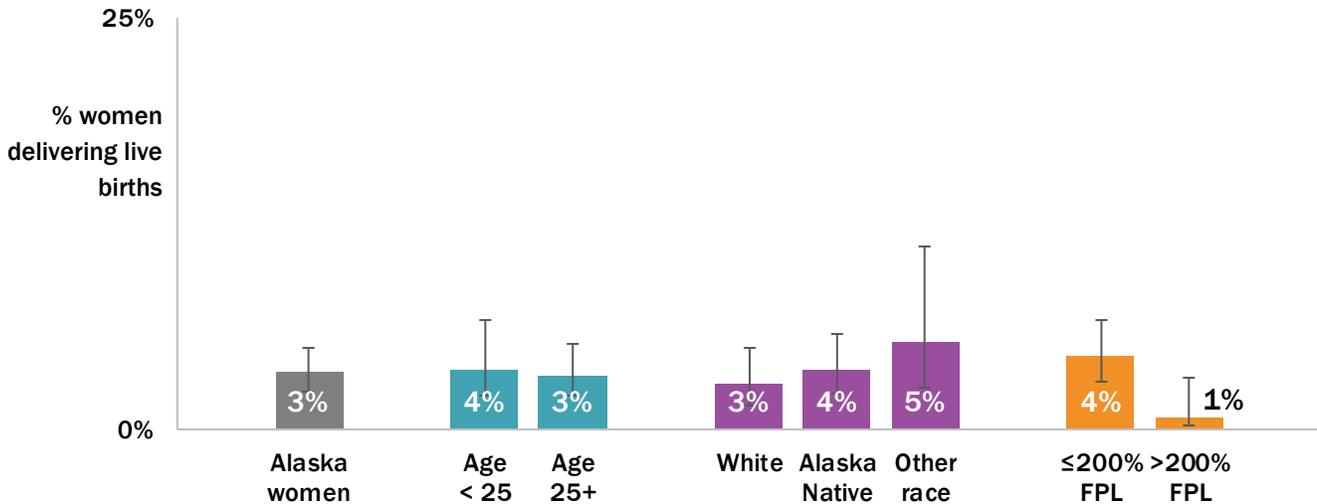
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 8. Problems getting birth control: I didn't have enough money or insurance to pay, 2015



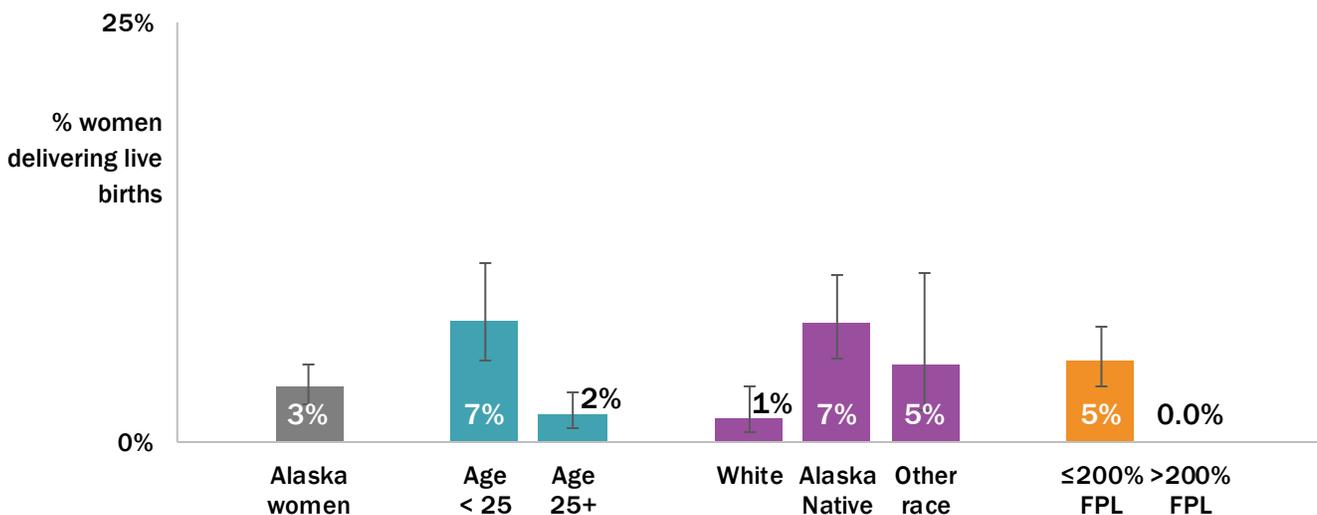
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 9. Problems getting birth control: My husband or partner wouldn't let me use birth control, 2015



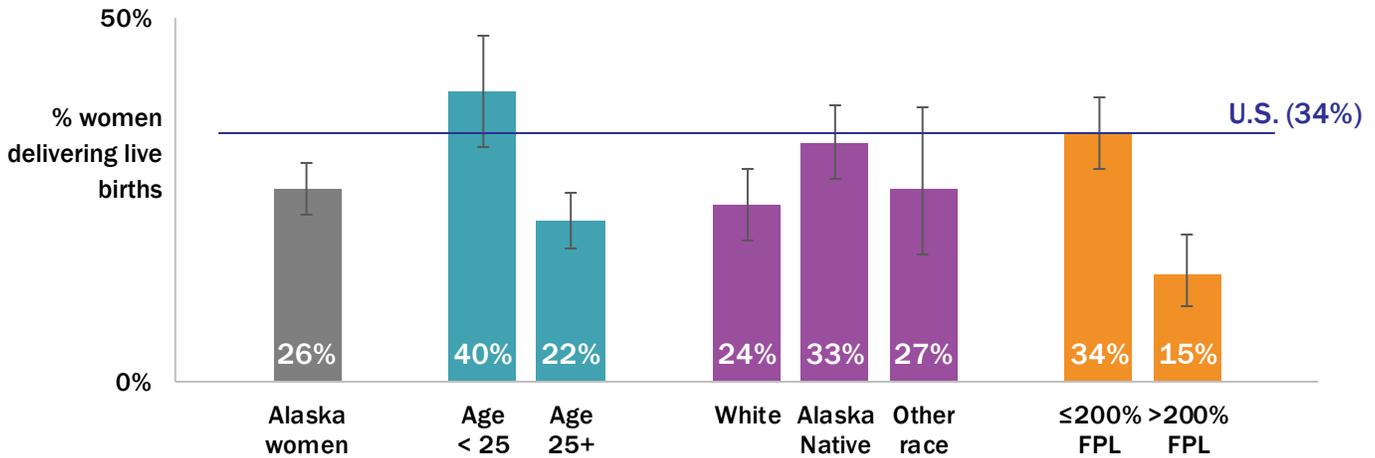
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 10. Problems getting birth control: I didn't feel comfortable asking my local health care provider, 2015



Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 11. Pregnancy Intention[^]: Mistimed or unwanted, 2016



Source: Alaska PRAMS

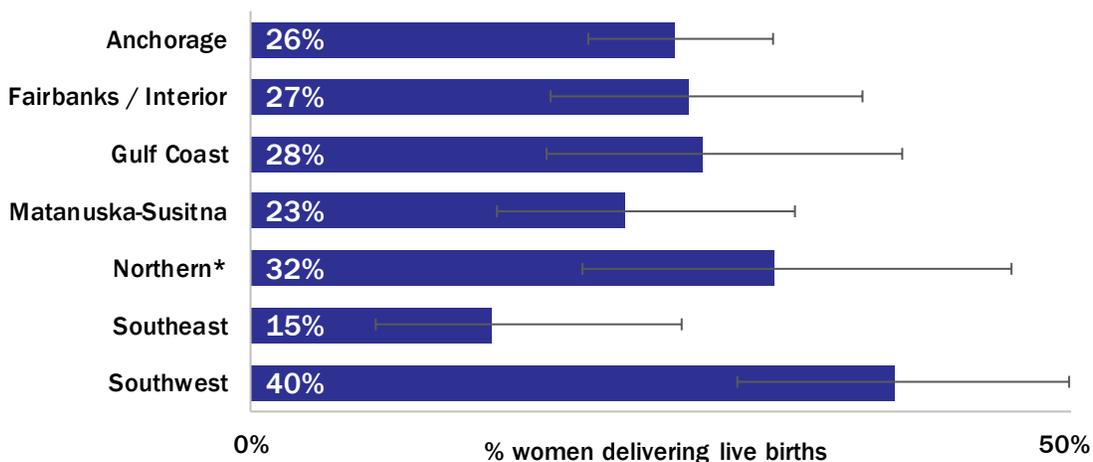
FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

[^] See Data Note on page 12.

“... We had tried actively to get pregnant for a few years but because of PCOS [polycystic ovarian syndrome], it did not happen. At the time I got pregnant we were not trying or preventing. It was a surprise since we did not think I could get pregnant .”

Figure 12. Pregnancy Intention[^]: Mistimed or unwanted by region, 2016

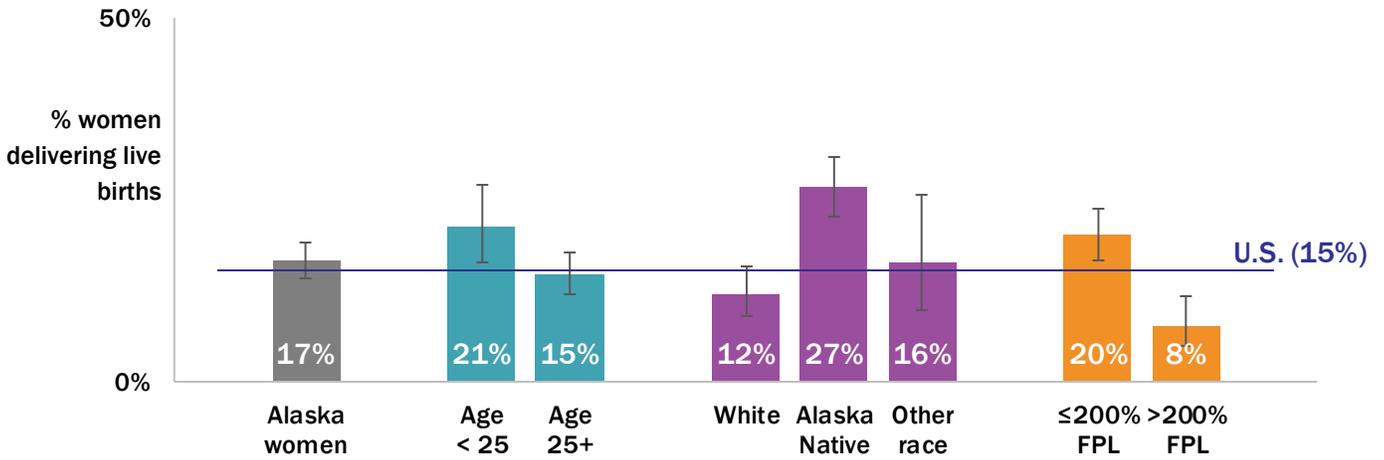


Source: Alaska PRAMS

* Data may be unreliable. Number of respondents was at least 30 but less than 60.

[^] See Data Note on page 12.

Figure 13. Pregnancy Intention[^]: Unsure about pregnancy, 2016



Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

[^] See Data Note on page 12.

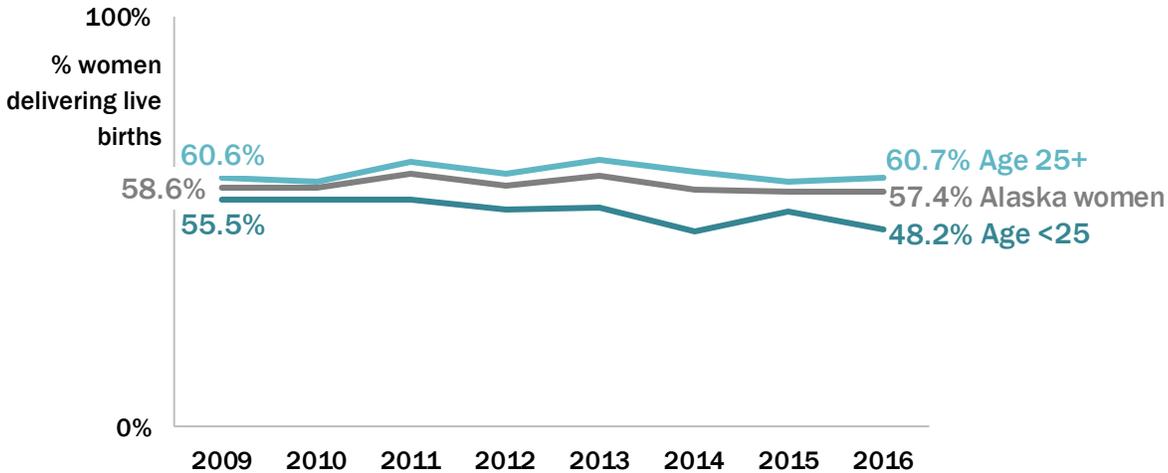
Data Highlights

- Though there was no significant overall trend during 2009-2016 for women drinking any amount of alcohol during the 3 months before getting pregnant, the trend for women less than 25 years of age significantly declined from 55.5% in 2009 to 48.2% in 2016.
- Women who were older, White and not in poverty were more likely to report drinking alcohol pre-pregnancy.
- Binge drinking (drinking 4 alcoholic drinks or more in a 2 hour time span) during the 3 months before pregnancy significantly declined overall as well as among older and younger women during 2009-2016.
- Binge drinking was significantly more common among residents of the Southeast region (28%) compared to residents of the Matanuska-Susitna region (14%).

“I was a heavy drinker before I got pregnant, so I did have some social drinks before I found out, & then quit immediately...”

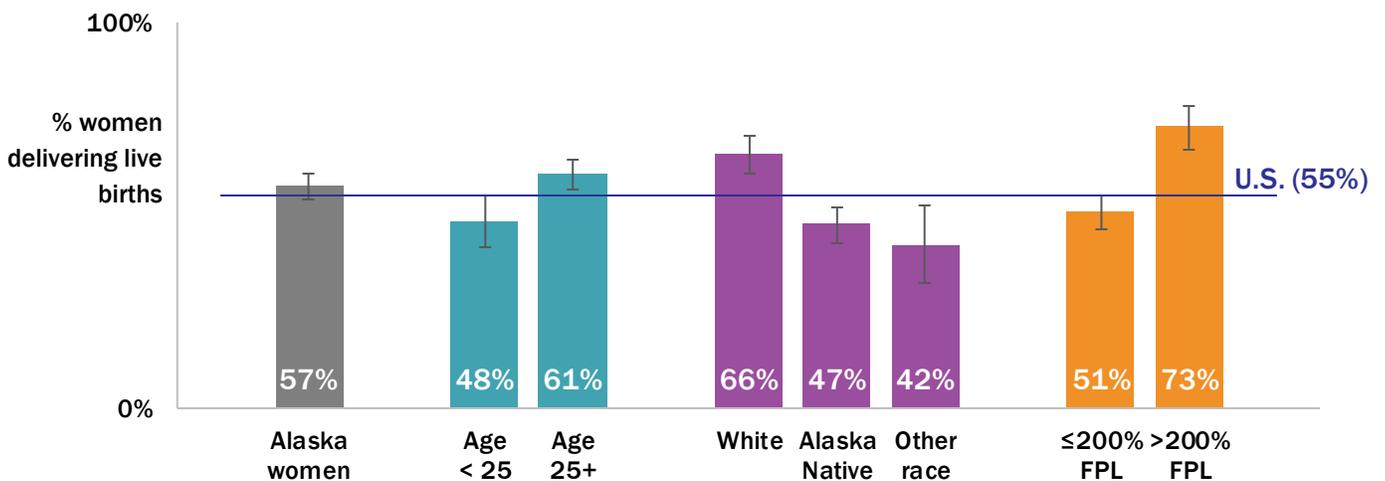
Preconception Health | Pre-pregnancy Alcohol Use

Figure 14. Any alcohol use in the 3 months before getting pregnant by maternal age, 2009-2016



Source: Alaska PRAMS

Figure 15. Any alcohol use in the 3 months before getting pregnant, 2016



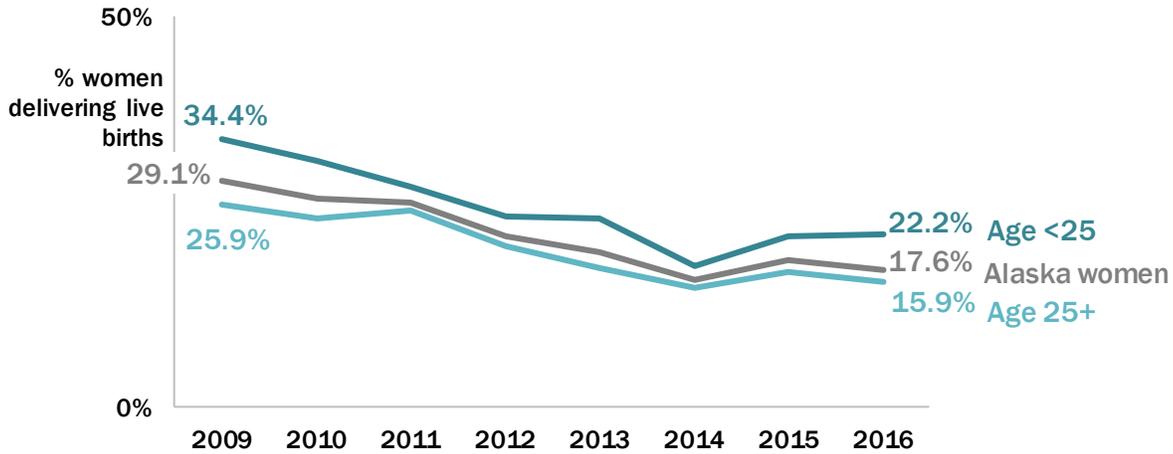
Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

Preconception Health | Pre-pregnancy Alcohol Use

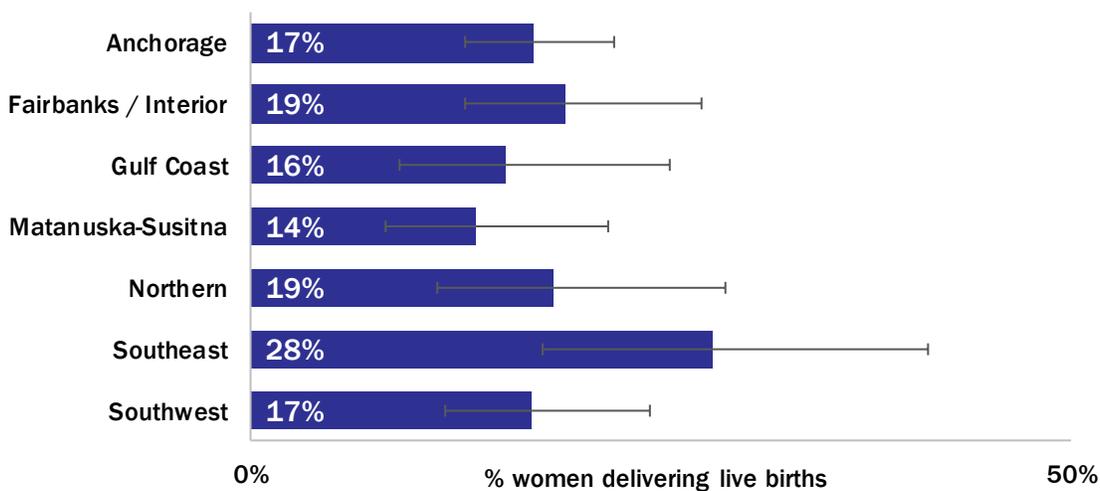
Figure 16. Any binge drinking in the 3 months before getting pregnant by maternal age, 2009-2016



Source: Alaska PRAMS

Note: Binge drinking is defined as consuming 4 or more alcoholic drinks in a 2 hour time span.

Figure 17. Any binge drinking in the 3 months before getting pregnant by region, 2016



Source: Alaska PRAMS

Note: Binge drinking is defined as consuming 4 or more alcoholic drinks in a 2 hour time span.

Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Data Note on Stressful Life Events

Women reported whether they experienced any of 14 particular life events during the 12 months before their baby was born. All 14 are listed in descending order of overall prevalence starting with Figure 20 through Figure 33. Note that the timeframe asked about includes time just before their pregnancy and throughout their entire pregnancy.

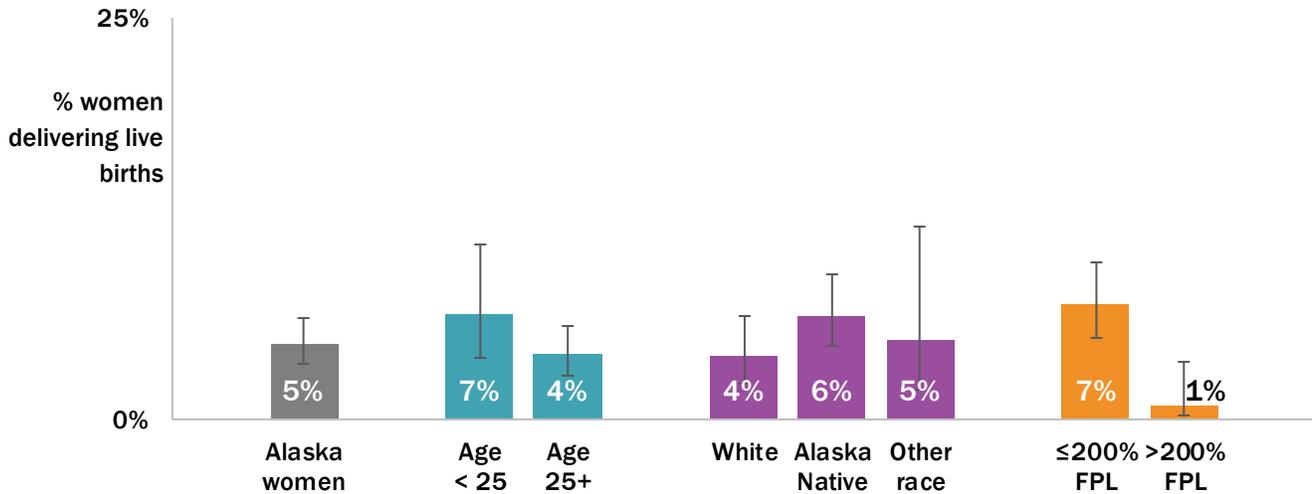
Data Highlights

- Experience of 6 or more stressful life events varied widely by region, from 1% among residents of the Northern and Southwest regions to 7% among residents of the Fairbanks/Interior region.
- During 2009-2016, there was no significant trend in the percent of women moving to a new address during the 12 months before the baby was born. Approximately 38% of women move during this time.
- The most common stressful life events experienced during the 12 months before the baby was born were arguing with husband or partner more than usual (18%), close family member very sick and had to be hospitalized (18%), husband, partner, or self had a cut in work hours or pay (15%), and someone close had a problem with drinking or drugs (15%).
- The least common stressful life events experienced during the 12 months before the baby was born were homelessness (3%), husband, partner, or self went to jail (4%), and husband or partner said they didn't want the pregnancy (5%).
- Women in poverty were more likely to have experienced job loss during the 12 months before the baby was born compared to women not in poverty. Overall, 8% of Alaska women who delivered a baby in 2016 indicated their husband or partner had recently lost their job and 7% indicated they lost their job even though they wanted to go on working.
- White women, older women and those not in poverty were more likely to experience being apart from their husband or partner due to military deployment or extended work-related travel during the 12 months before the baby was born.

“During my pregnancy, I did not smoke, use drugs, or drink. However, it was a very stressful time for me. I experienced a lot of anxiety and emotional distress. This caused a lot of tension in my relationship with my partner. We never fought physically in any way, but there were some occasions where we yelled at each other. My partner lost his job and I was separated and on bad terms with my family who disowned me after I got pregnant, and wanted me to terminate the pregnancy. Overall, it was a very stressful time for me, and I often felt alone and helpless. ... Things are much better now, my partner got a stable job, and I've made peace with my family, who even sent gifts for baby!...”

Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

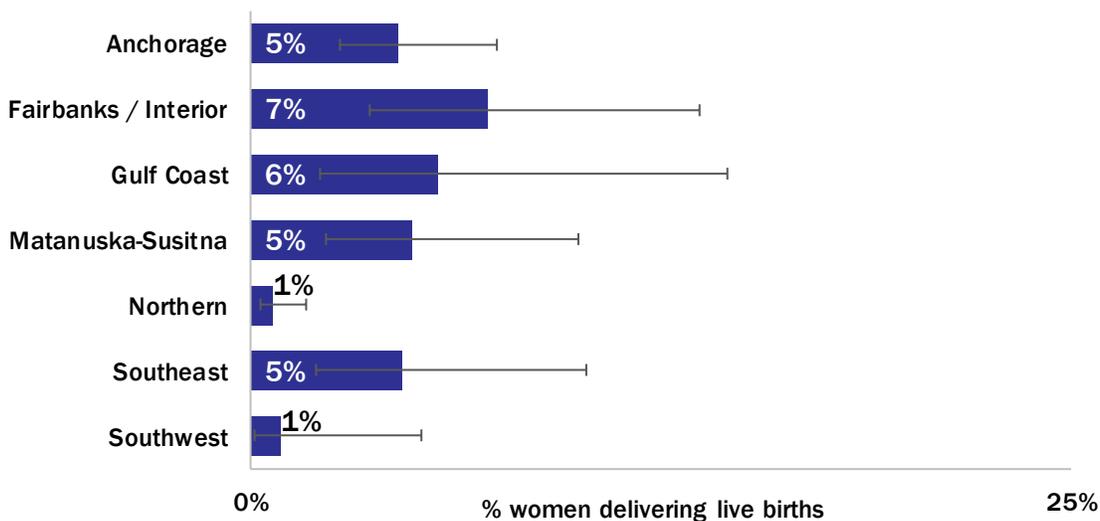
Figure 18. Experienced 6 or more stressful life events, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

“Me and my husband have been going through some very difficult times these last couple of years. My husband lost his mother to cancer. There are also other family issues that have required us to move several times leading to a very stressful time. ... To be frank I was and still am a bit exhausted from the last few years and my 2 children under 2 years.”

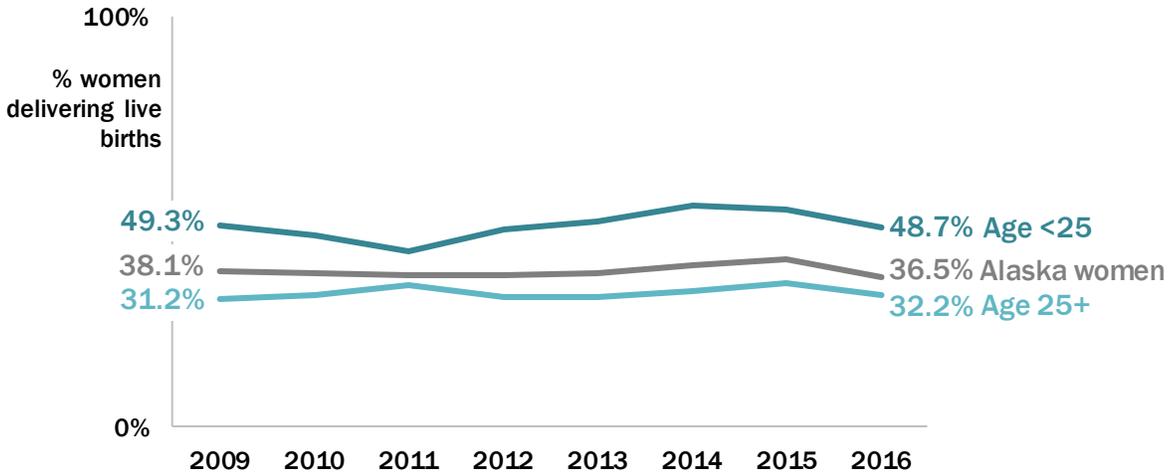
Figure 19. Experienced 6 or more stressful life events by region, 2016



Source: Alaska PRAMS

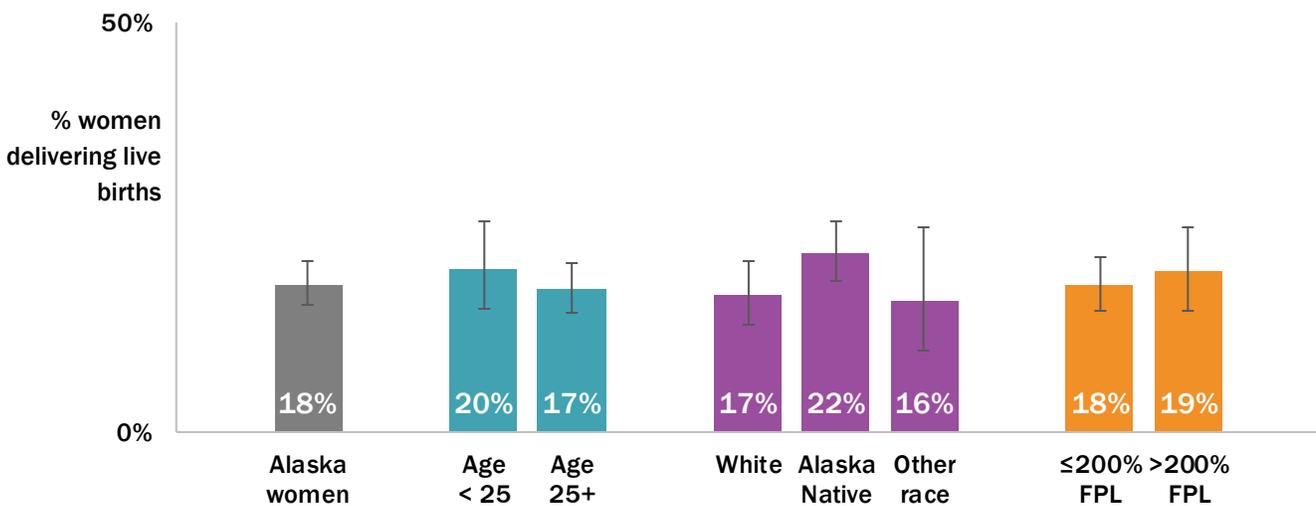
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 20. Moved to a new address by maternal age, 2009-2016



Source: Alaska PRAMS

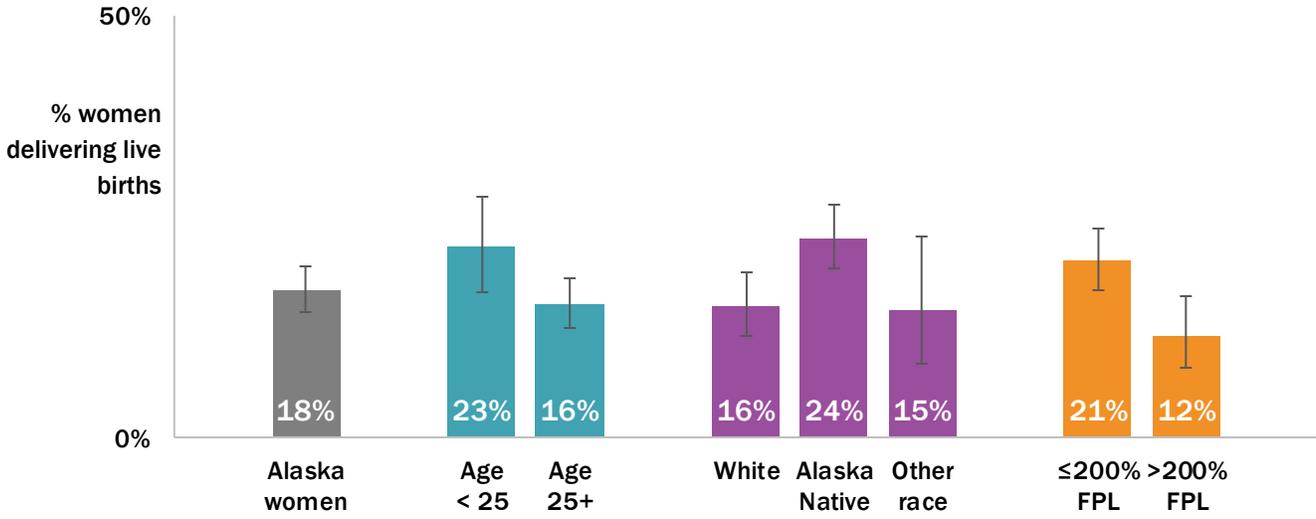
Figure 21. Close family member was very sick and had to be hospitalized, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

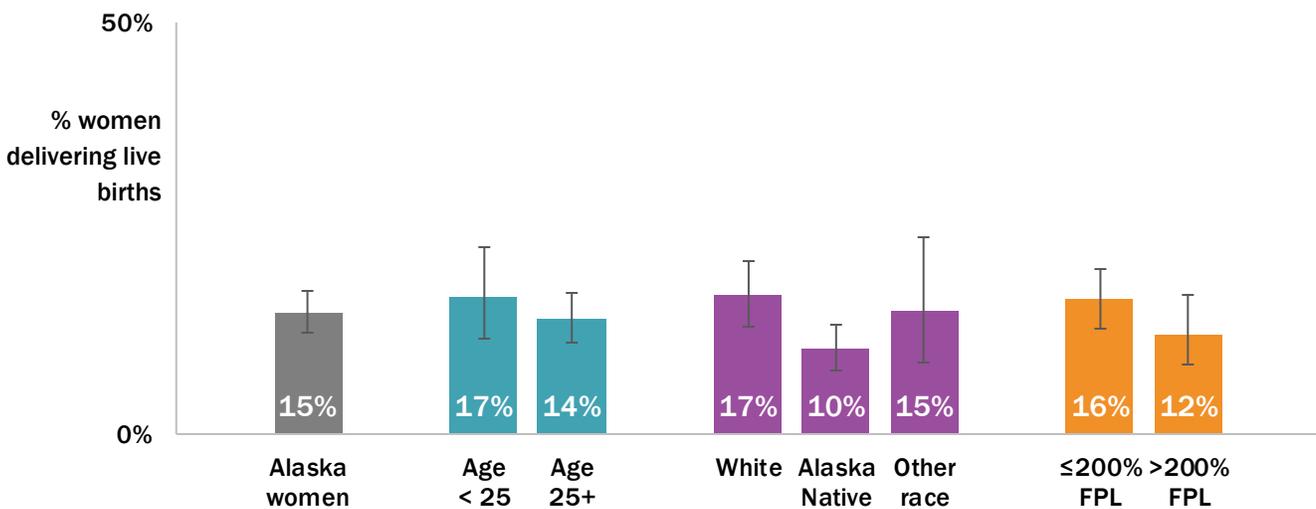
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 22. I argued with my husband or partner more than usual, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

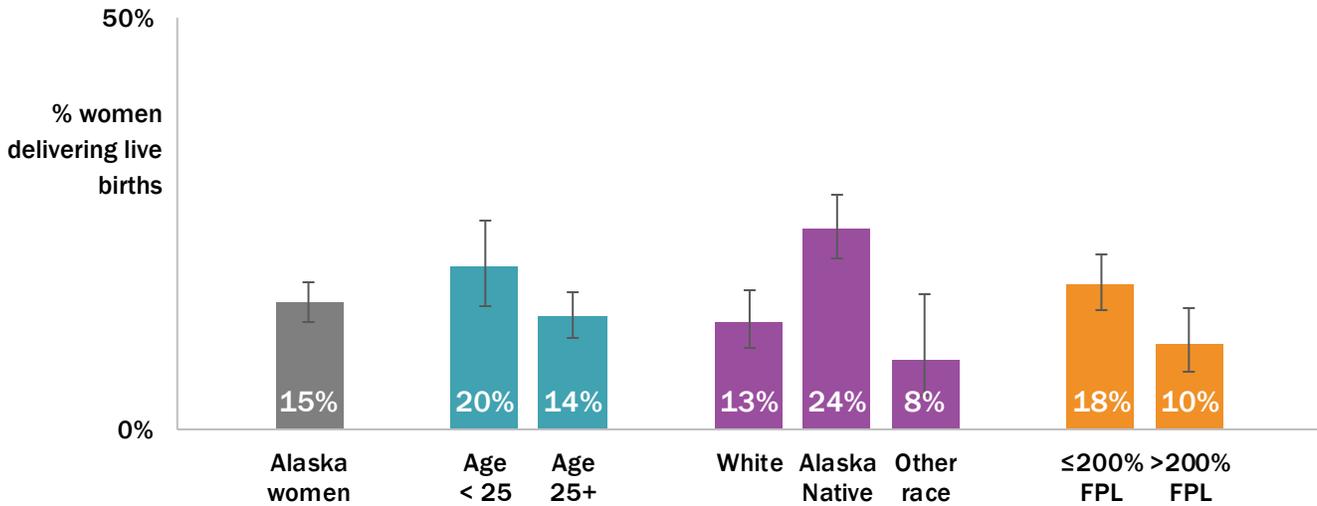
Figure 23. My husband, partner, or I had a cut in work hours or pay, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

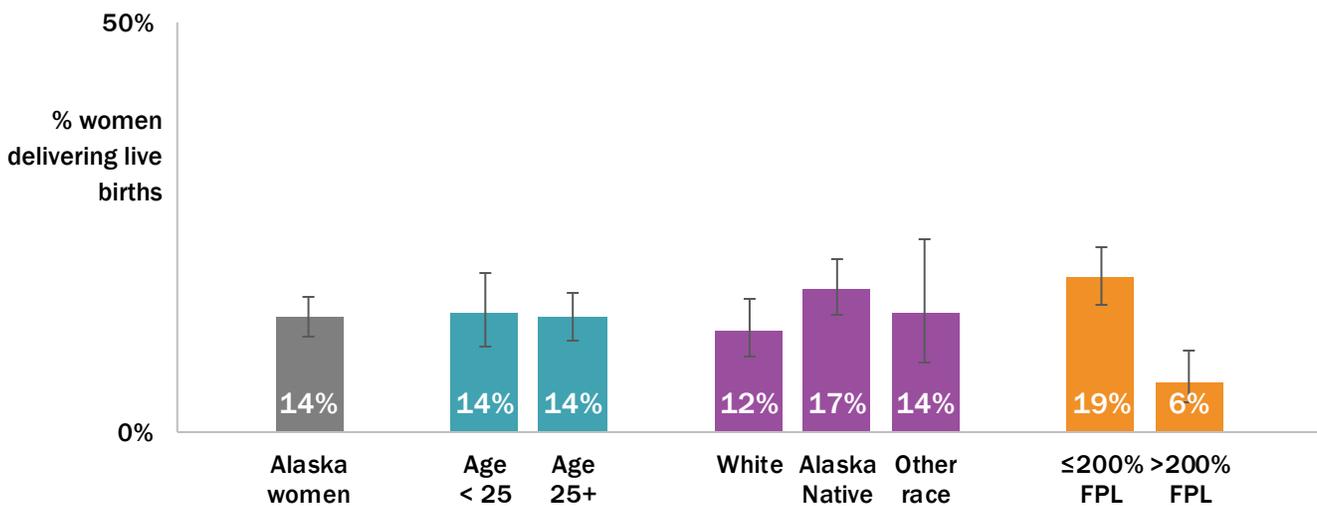
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 24. Someone very close to me had a problem with drinking or drugs, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

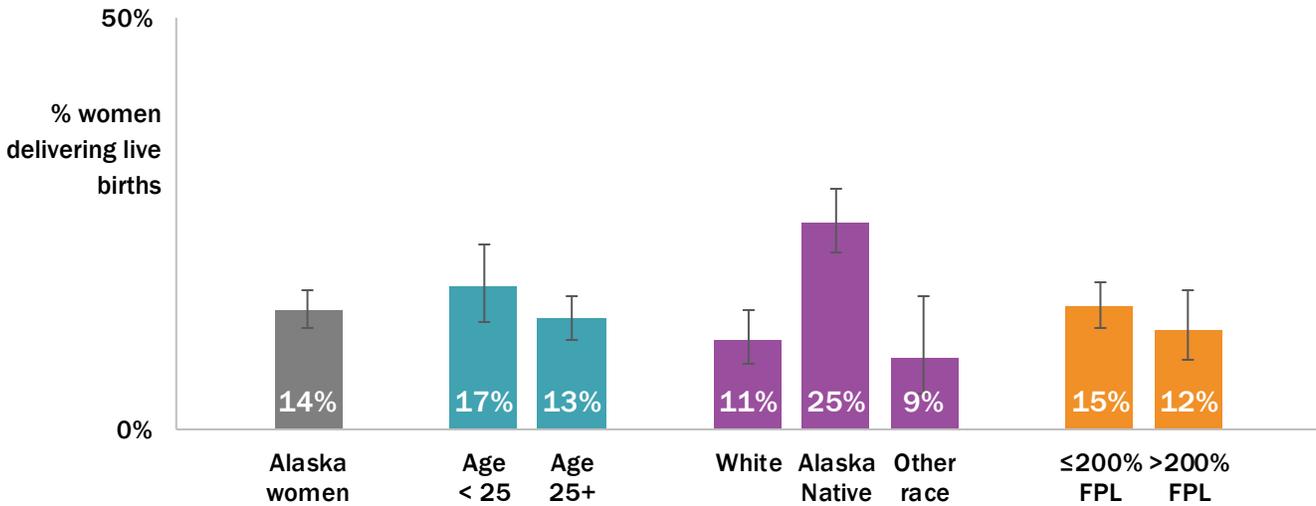
Figure 25. I had problems paying the rent, mortgage, or other bills, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

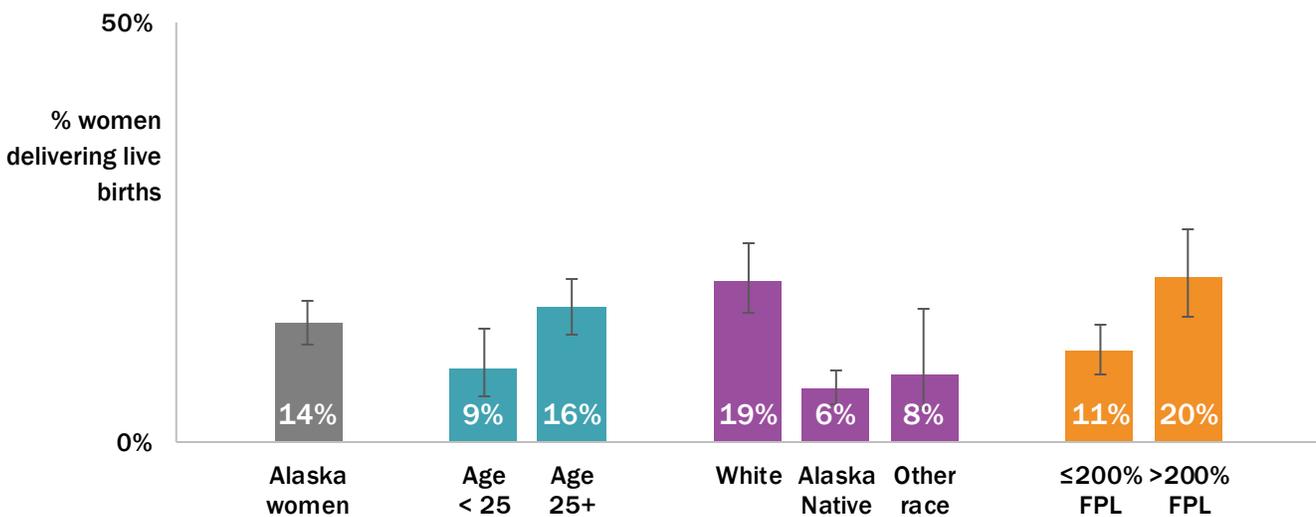
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 26. Someone very close to me died, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level

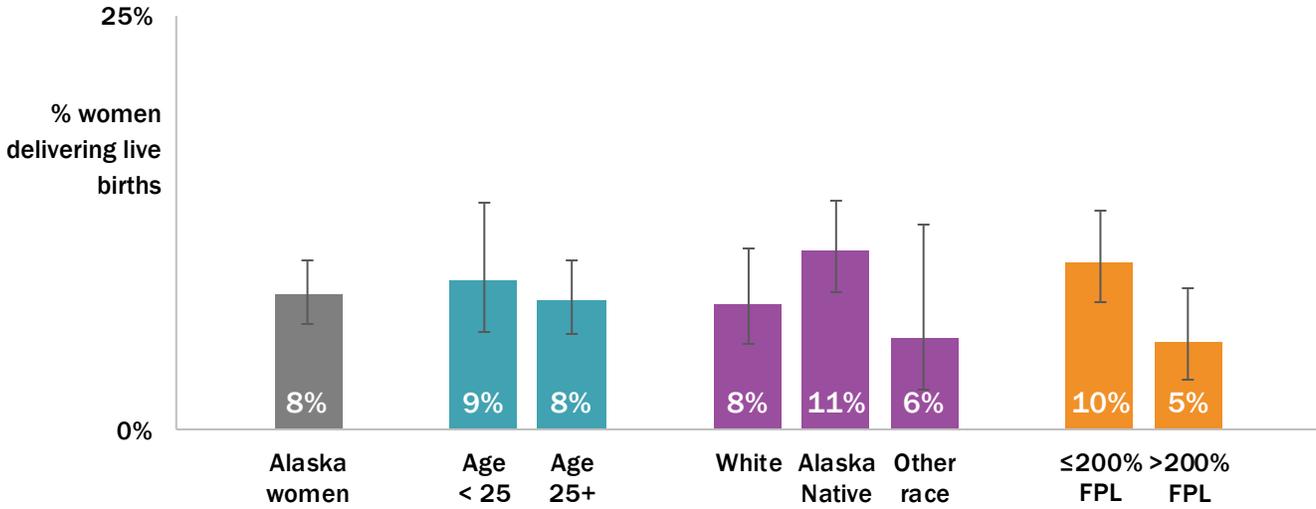
Figure 27. I was apart from my husband or partner due to a military deployment or extended work-related travel, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level

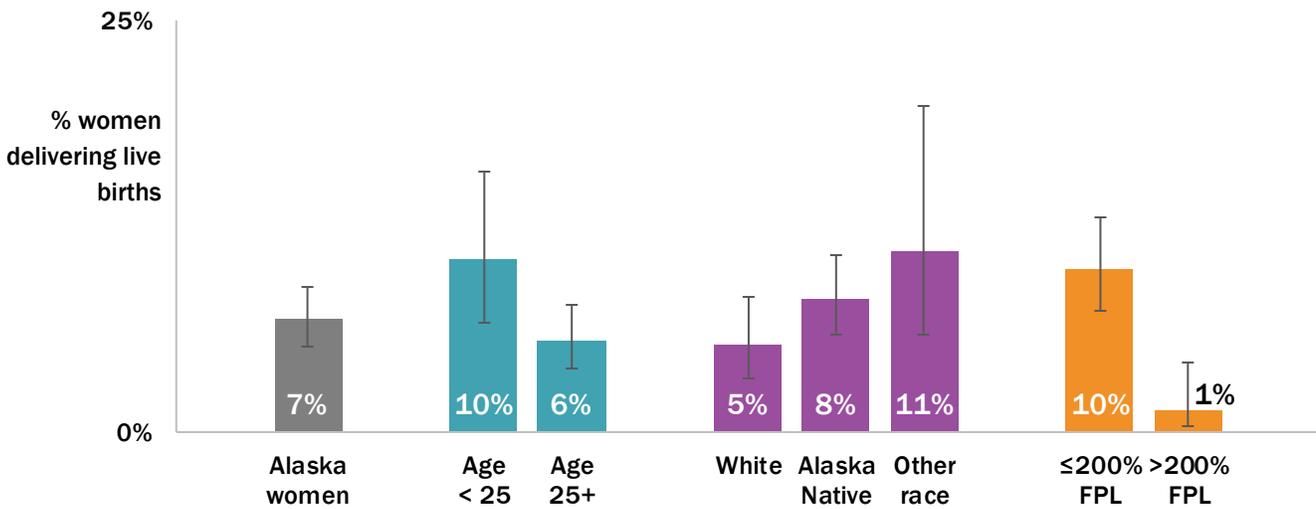
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 28. My husband or partner lost their job, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

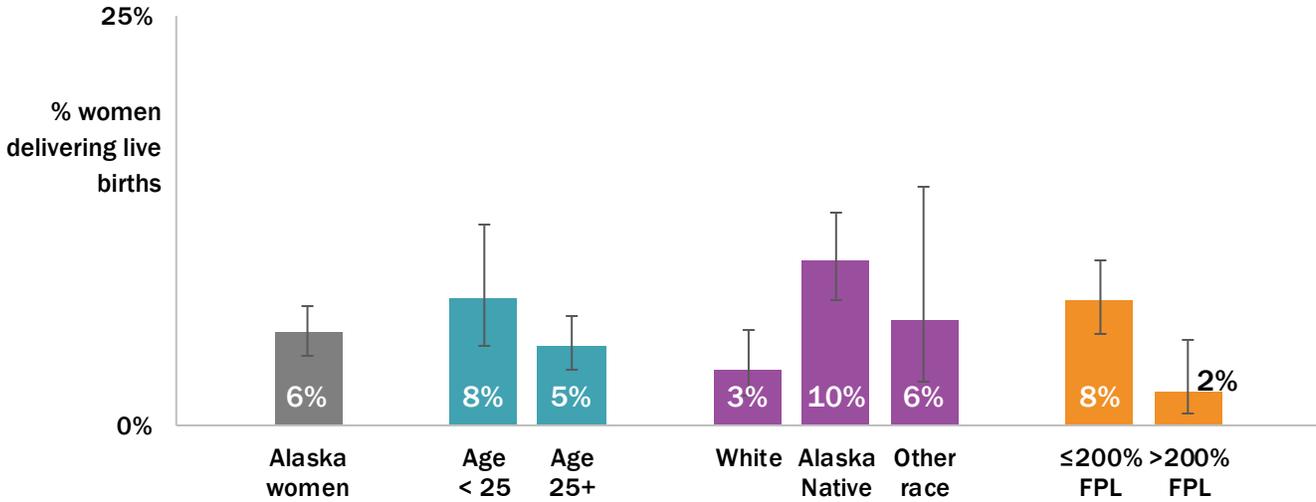
Figure 29. I lost my job even though I wanted to go on working, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

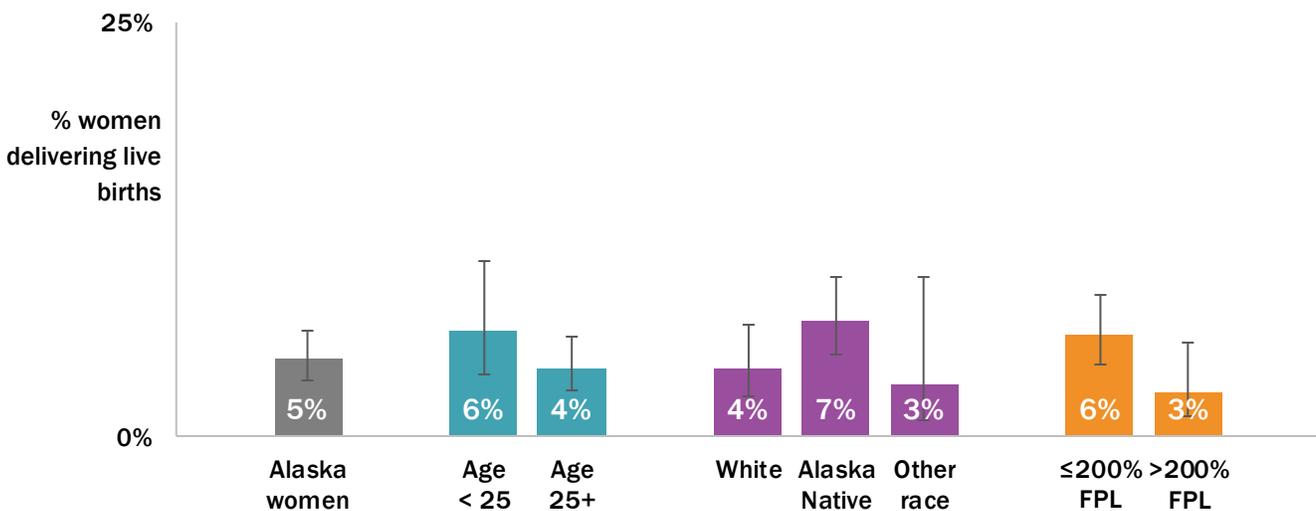
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 30. I was separated or divorced from my husband or partner, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level

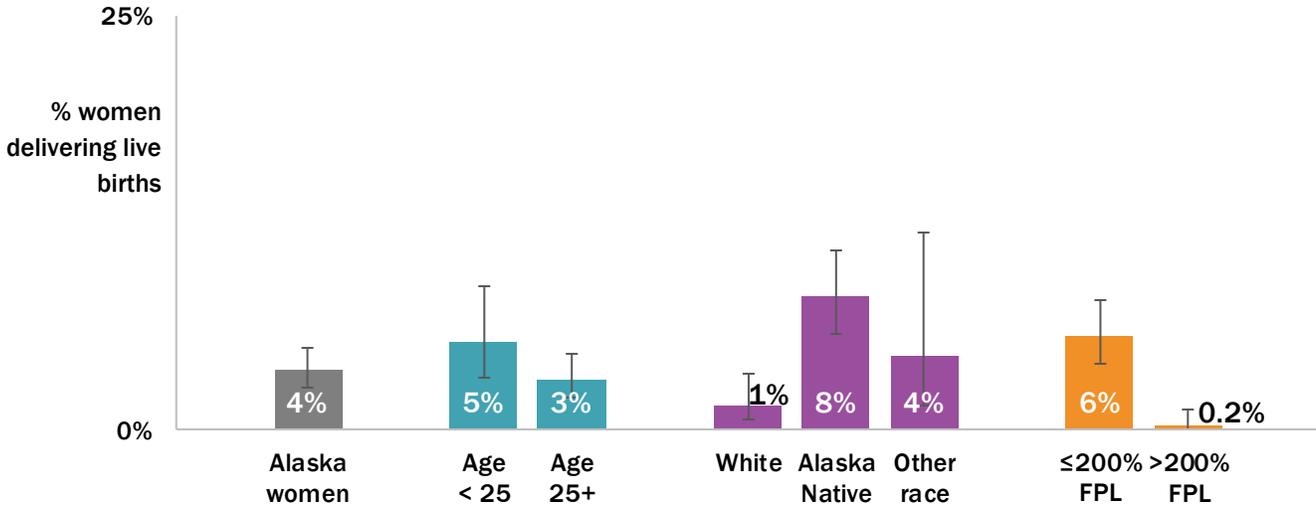
Figure 31. My husband or partner said they didn't want me to be pregnant, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level

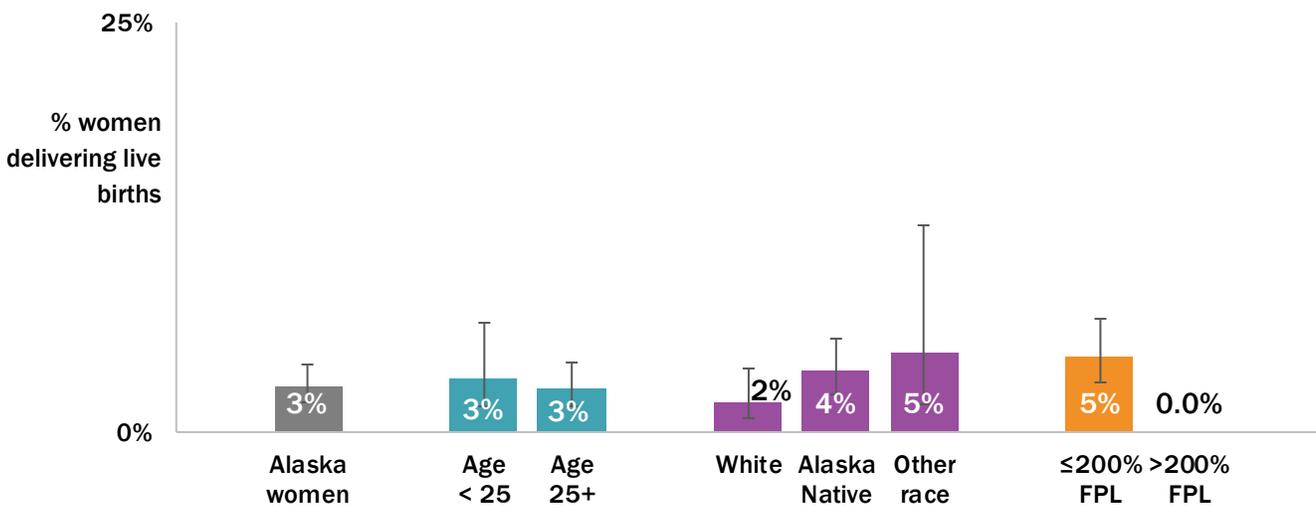
Preconception Health | Stressful Life Events During the 12 Months Before Baby Was Born

Figure 32. My husband, partner, or I went to jail, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level

Figure 33. I was homeless or had to sleep outside, in a car, or in a shelter, 2016



Source: Alaska PRAMS
FPL= Federal Poverty Level



Chapter 2: Prenatal Health

Why is this important?

There are many actions a woman can take while she is pregnant to help ensure a healthy pregnancy and healthy baby. This chapter focuses on behaviors or experiences that might occur during the prenatal period that increase the risk of poor outcomes for the mother and her baby, as well as those that are protective.

Increased risk

Smoking cigarettes or using smokeless tobacco during pregnancy exposes the fetus to dangerous chemicals, increasing the risk for infant low birth weight, prematurity, some birth defects, and stillbirth, as well as damaging a developing baby's brain and lungs.¹ Prenatal smoking also increases the risk of postnatal events such as Sudden Unexpected Infant Death (SUID).¹ Although the aerosol of e-cigarettes generally has fewer harmful substances than cigarette smoke, e-cigarettes are also not safe to use during pregnancy. In addition to nicotine, some of the flavorings used in e-cigarettes may be harmful to a developing baby.²

Prenatal alcohol use is linked to fetal death, low birth weight, growth abnormalities, developmental delays and fetal alcohol spectrum disorders. It is also the leading preventable known cause of birth defects. Adverse birth outcomes related to prenatal alcohol use are 100% preventable. There is no known safe amount of alcohol or time to drink during pregnancy.³

The active compound of marijuana, THC, passes freely through the placental barrier. Growing evidence indicates that prenatal marijuana exposure is associated with an increased risk of neurobehavioral problems in offspring, including issues with attention, memory, and problem solving.⁴⁻⁶ The timing and duration of the exposure, as well as the

cannabis potency, likely impacts the extent of the effects and long-term consequences for the developing fetus.

Intimate partner violence is a serious, preventable public health problem that has been experienced by one-fourth (25.4%) of Alaskan adults according to the Behavioral Risk Factor Surveillance System.⁷ Physical abuse during pregnancy can lead to miscarriage and vaginal bleeding, as well as preterm delivery and low infant birth weight.⁸ Children of mothers who experienced abuse during their pregnancy are also more likely to be reported to child protective services later in life.⁹

Protective factors

Early and regular prenatal care visits are important for ensuring a healthy pregnancy. The American College of Obstetricians and Gynecologists (ACOG) recommends that women have their first prenatal visit at 8-10 weeks of pregnancy. During prenatal care visits, doctors can provide health screenings, education, and treatment for problems that may arise, and also talk with women about things they can do to provide a healthy start to their baby's life.

Proper nutrition promotes the optimal growth and development of children and continues to be important throughout the life course. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), is a nutrition program that helps pregnant and

breastfeeding women, mothers of newborns (6 months old or younger) and young children (less than 5 years old) eat well, learn about good nutrition and stay healthy. WIC provides participants with vouchers that can be used to purchase foods such as milk, juice, eggs, cheese, and cereal. WIC provides nutrition counseling, support and information about breastfeeding, and links mothers to health care and community services. To participate in WIC, a woman must have a nutritional need and meet WIC income eligibility criteria. Income eligibility is set by states, but cannot be more than 185% of the Federal Poverty Level (FPL).

Pregnant women should get at least 150 minutes of moderate-intensity aerobic activity every week.¹⁰ Regular exercise during pregnancy can have many benefits for the mother and baby, including promoting healthy weight gain, strengthening heart and blood vessels, and helping the mother lose weight after the baby is born. Exercise may also reduce the risk of gestational diabetes, preeclampsia, and cesarean delivery.¹¹

Attending childbirth education classes may help women cope with labor pains and reduce the need for medical interventions during labor and birth.¹² One study found that attending prenatal education classes was associated with higher rates of vaginal births among women in the study sample.¹³

Receiving oral health care and education during pregnancy is important both for women's health and for their children's oral health. Women have a higher risk for tooth decay during pregnancy due to increased acidity levels in their mouth. Pregnant

women may develop gingivitis, where their gums swell and bleed easily. If left untreated, gingivitis may lead to more severe gum disease. The bacteria can be transmitted to the fetus, and has been associated with poor birth outcomes such as preeclampsia, preterm birth and low birth weight.¹³ Most dental work is safe during pregnancy (e.g. teeth cleaning, dental x-rays, filling of a decayed tooth), and regular teeth cleanings before and during pregnancy can help protect against gum disease.¹⁴ Untreated maternal dental disease nearly doubles the odds of their child having untreated and more severe dental caries.¹⁵

"Babies are not delivered in my town. However the clinic also does not provide any birth classes or a lactation consultant so you have to educate yourself."

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Data Highlights

Cigarette smoking

- Cigarette smoking during the last 3 months of pregnancy significantly declined between 2009 and 2016 overall (dropping to 11.0% from 15.3%) and by maternal age.
- Although overall prenatal smoking has declined, Alaska's 2016 prenatal smoking prevalence of 11.0% is higher than the 2015 U.S. aggregate value of 8.8%.
- Cigarette smoking during pregnancy was more common among women less than 25 years old compared to older women throughout the 8-year period 2009-2016.
- Younger women, Alaska Native women, and those at $\leq 200\%$ of the federal poverty level (FPL) had higher prevalences of cigarette smoking during pregnancy in 2016.
- In 2016, women residing in the Northern region had a reported prevalence of prenatal smoking (42.2%) that was significantly higher than women in any other region.

E-cigarette use

- Only 1.1% of Alaska women who delivered a baby in 2016 reported using e-cigarettes during the last 3 months of pregnancy.

Smokeless tobacco use

- During 2009-2016, a stable prevalence of approximately 5% of Alaska women indicated using smokeless tobacco products during pregnancy.
- Alaska Native women were significantly more likely to use smokeless tobacco

during pregnancy (15%) than women of other races (1% each for White and other races) in 2016.

Alcohol consumption

- In 2016, 4% of Alaska women reported drinking any alcohol during the last 3 months of pregnancy, less than the U.S. aggregate prevalence of 8% in 2015. This prevalence did not differ by maternal race.
- Drinking alcohol during the last 3 months of pregnancy was more common among Alaska women 25 years or older compared to younger women throughout the 8-year period 2009-2016.

"I quit smoking cigarettes about a month before I got pregnant, but I did smoke marijuana occasionally for about a month after I got pregnant. I also had 1 or 2 alcoholic drinks a handful of times, and one night I drank about 10 drinks, before I was one month pregnant. I am breastfeeding, and plan on continuing to not consume alcohol, marijuana, nicotine, or any other drugs."

Marijuana use

- During 2009-2016, approximately 7% of Alaska women used marijuana during pregnancy. There was no significant trend in prenatal marijuana use either overall or by maternal age groups.
- Younger women, Alaska Native women, and those living in poverty had higher prevalences of marijuana use during pregnancy in 2016.

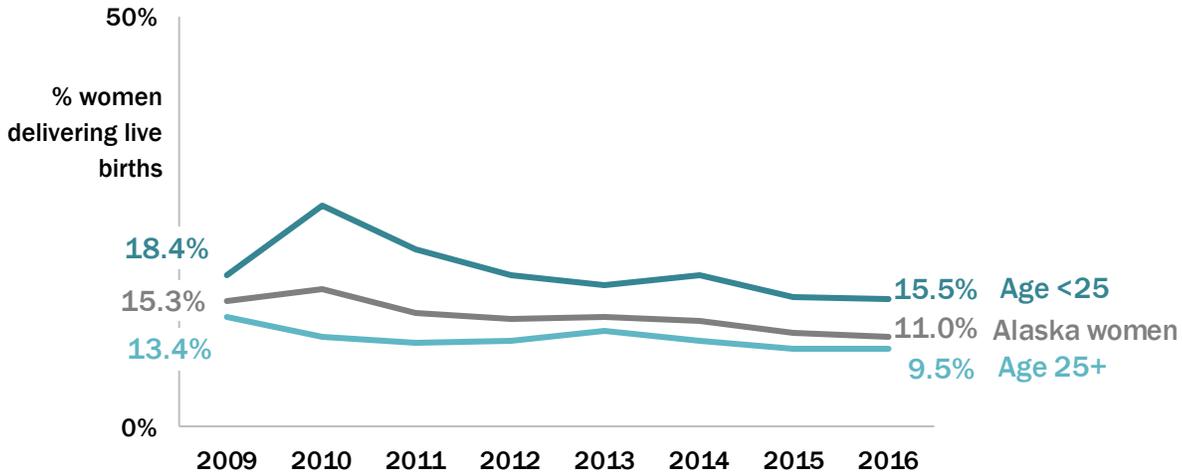
Data Highlights

- In 2016, residents of the Southwest and Northern regions had significantly higher prevalences of prenatal marijuana use compared to residents of other regions, at 12.3% and 15.3%, respectively.

Intimate partner violence

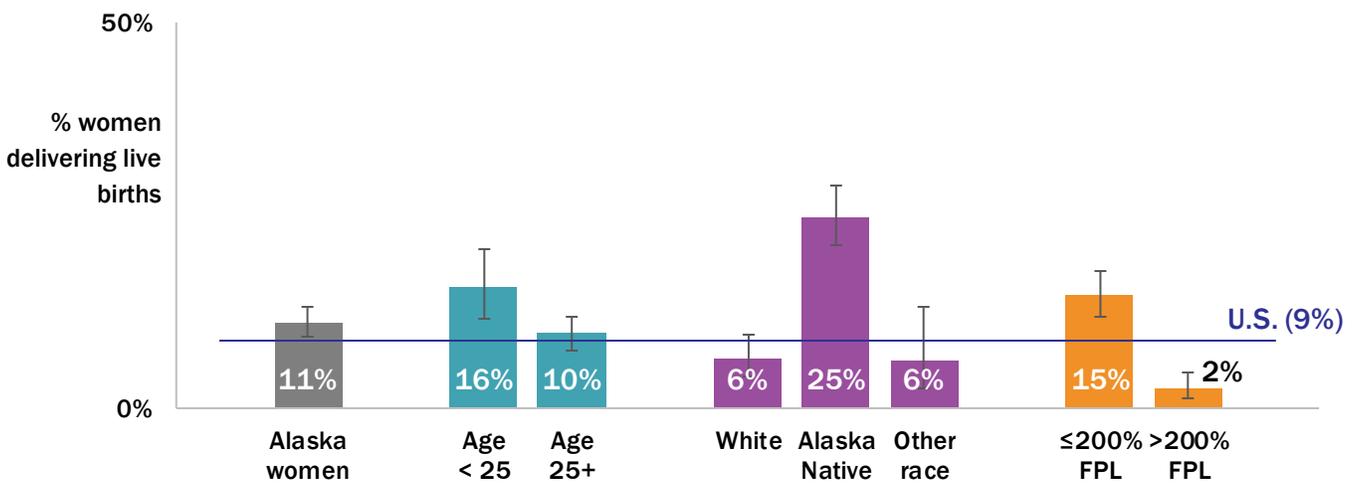
- Alaska's 2016 prevalence of intimate partner violence (IPV) during pregnancy was 2.2%. Younger women, Alaska Native women, and those living in poverty reported higher prevalences of IPV compared to older women, women of other races and those not living in poverty.
- In 2016, residents of the Southwest region of Alaska reported a significantly higher prevalence of intimate partner violence during pregnancy at 7.1% compared to residents of all other regions of the state (range = 1.2% to 3.4%).

Figure 34. Cigarette smoking in last 3 months of pregnancy by maternal age, 2009-2016



Source: Alaska PRAMS

Figure 35. Cigarette smoking in last 3 months of pregnancy, 2016

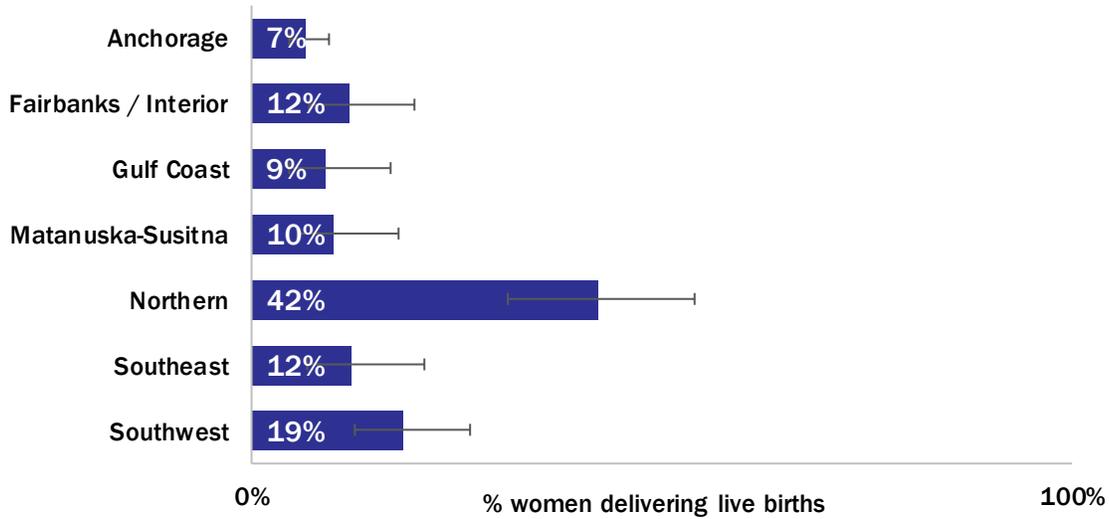


Source: Alaska PRAMS

FPL = Federal Poverty Level

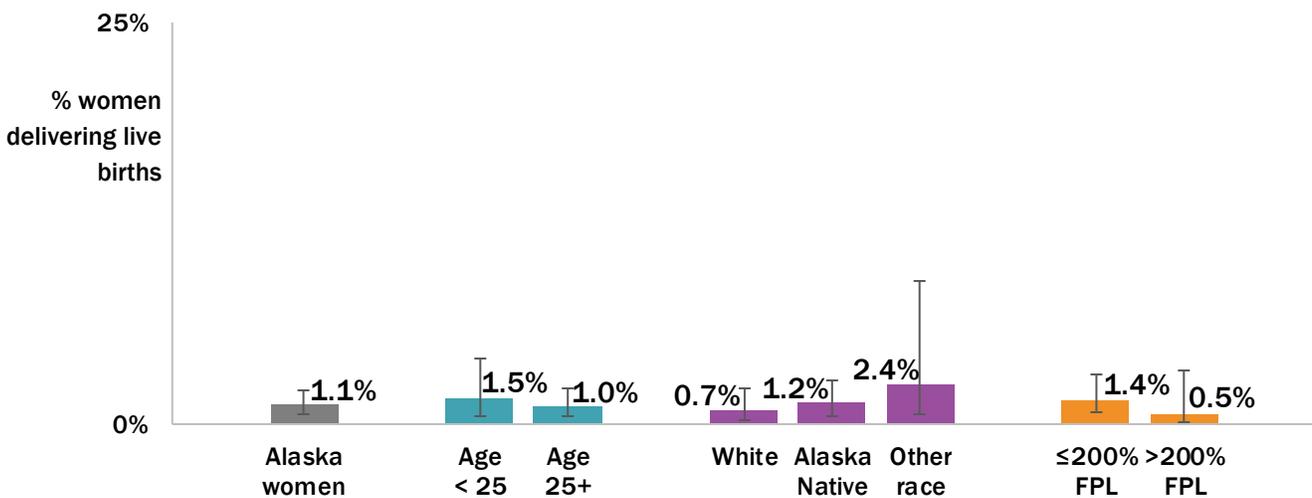
Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

Figure 36. Cigarette smoking in last 3 months of pregnancy by region, 2016



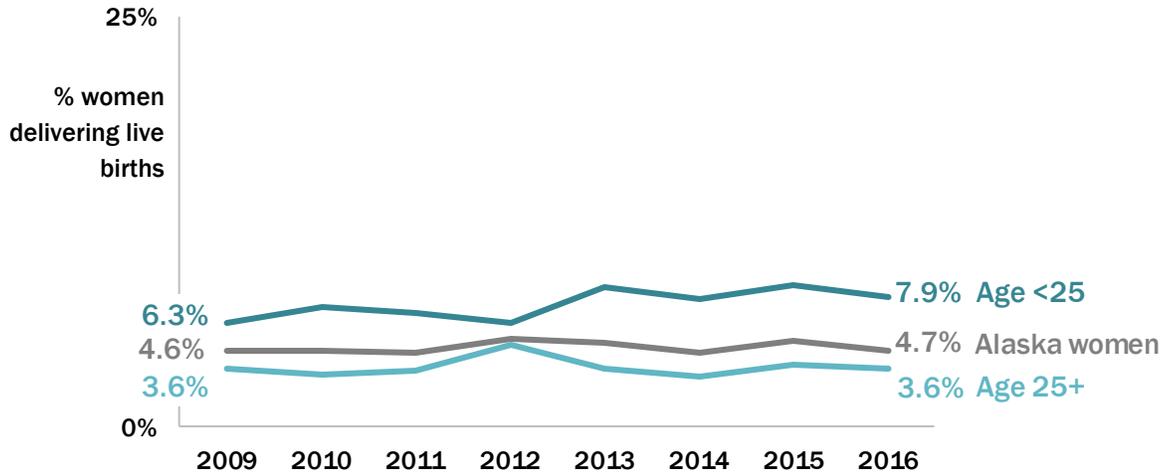
Source: Alaska PRAMS

Figure 37. E-cigarette use in last 3 months of pregnancy, 2016



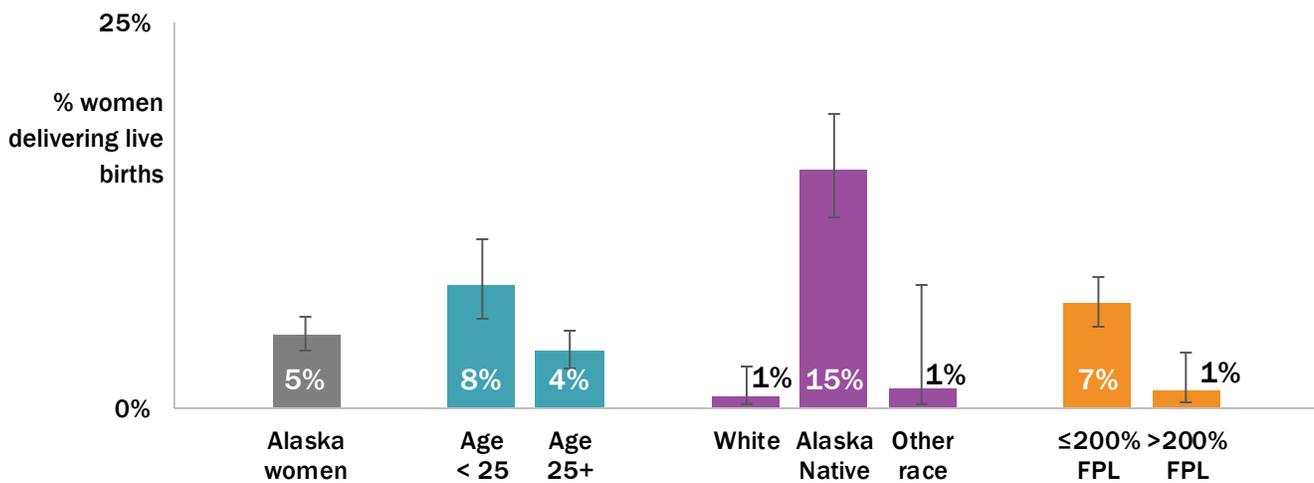
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 38. Smokeless tobacco use during pregnancy by maternal age, 2009-2016



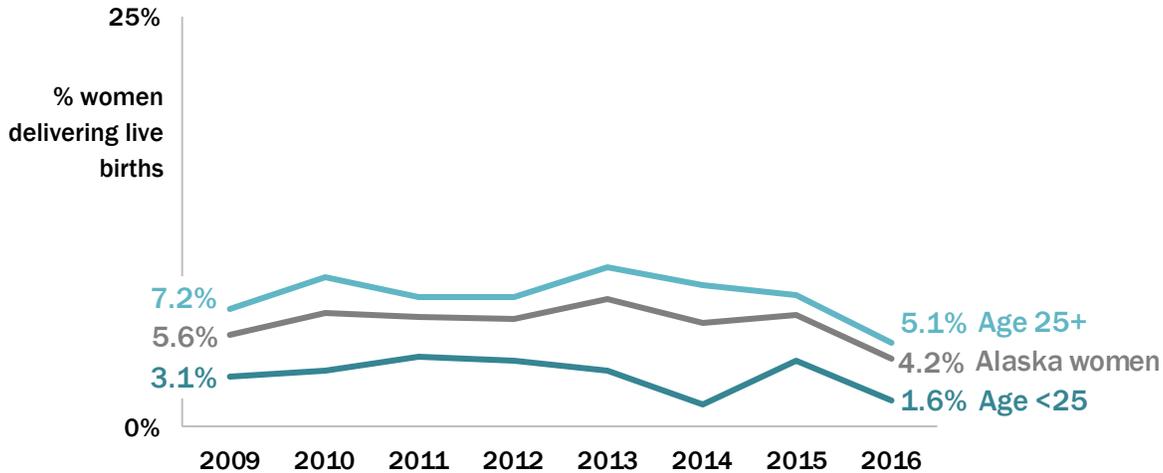
Source: Alaska PRAMS

Figure 39. Smokeless tobacco use during pregnancy, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

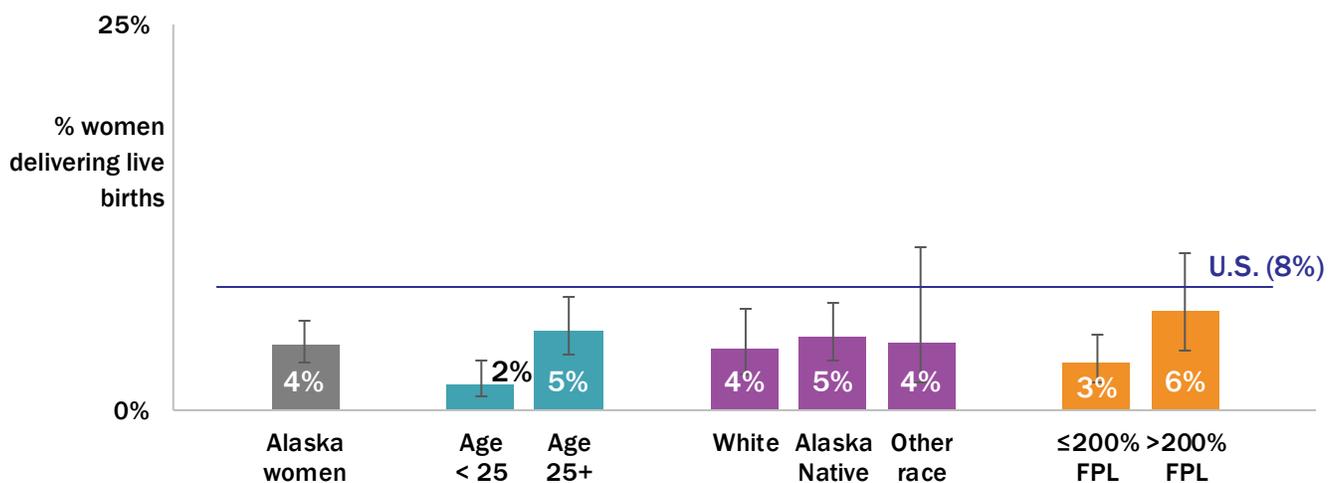
Figure 40. Any alcohol use in the last 3 months of pregnancy by maternal age, 2009-2016



Source: Alaska PRAMS

"...There is a mother in my community who is pregnant and drinking every weekend and she just doesn't care to protect the baby."

Figure 41. Any alcohol use in the last 3 months of pregnancy, 2016

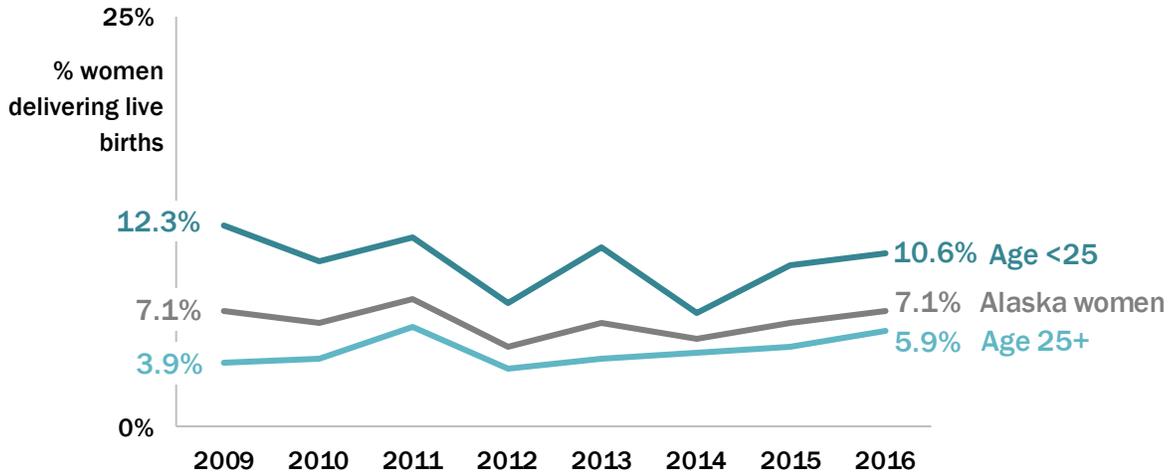


Source: Alaska PRAMS

FPL = Federal Poverty Level

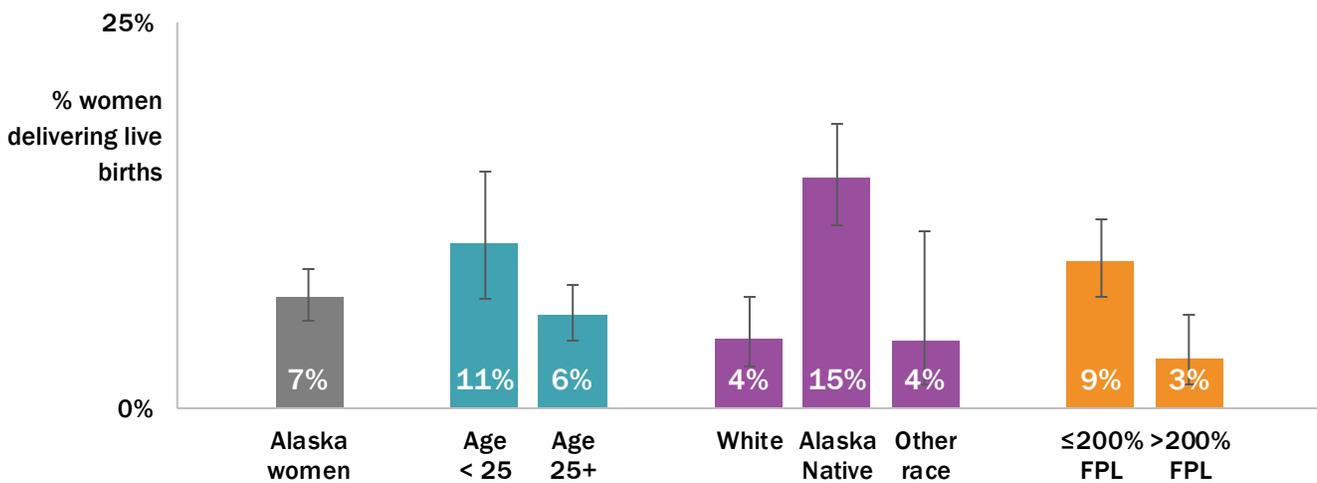
Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

Figure 42. Marijuana use during pregnancy by maternal age, 2009-2016



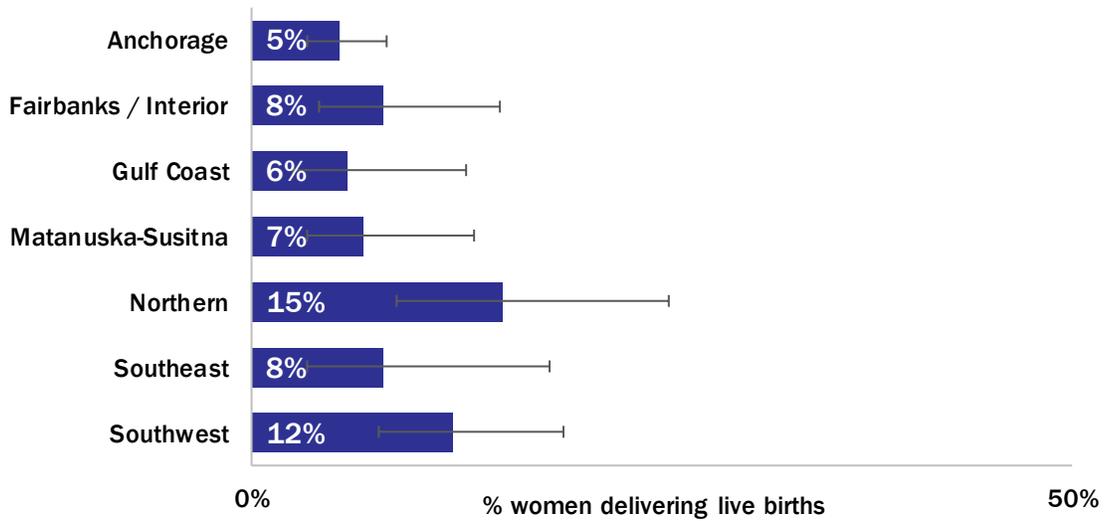
Source: Alaska PRAMS

Figure 43. Marijuana use during pregnancy, 2016



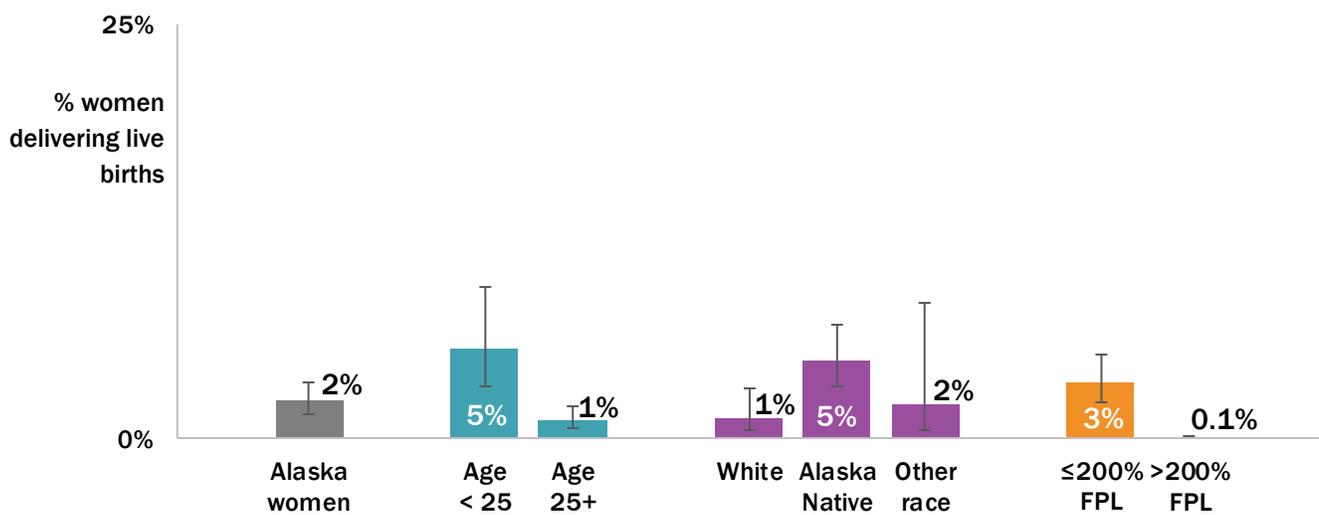
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 44. Marijuana use during pregnancy by region, 2016



Source: Alaska PRAMS

Figure 45. Experienced intimate partner violence during pregnancy, 2016

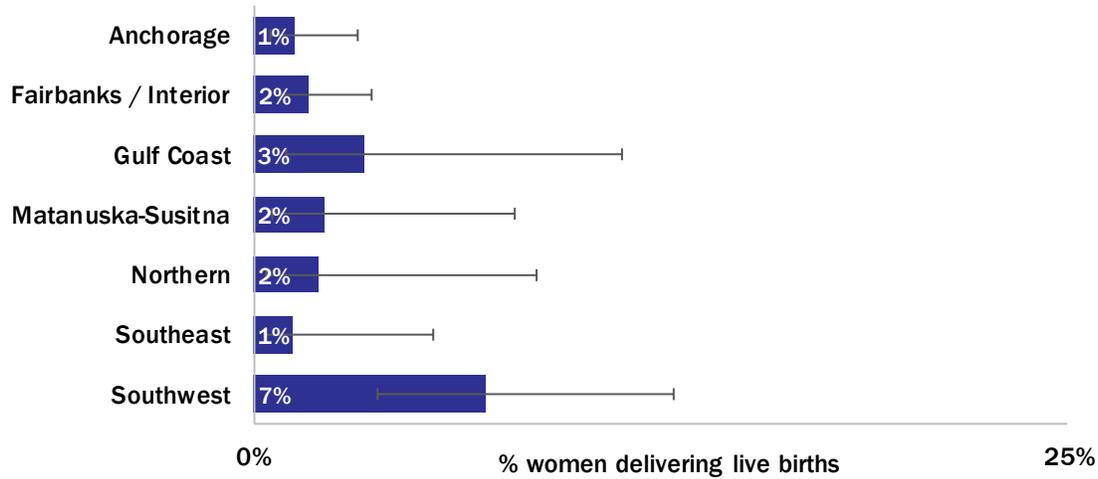


Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: Husband or partner or ex-husband or ex-partner pushed, hit, slapped, kicked, choked, or physically hurt them.

Figure 46. Experienced intimate partner violence during pregnancy by region, 2016



Source: Alaska PRAMS

Note: Husband or partner or ex-husband or ex-partner pushed, hit, slapped, kicked, choked, or physically hurt them.

“Don’t isolate yourself and be willing to speak out about abuse. I was quiet about abuse because I wanted to protect myself from the fear of the unknown. I was scared about how they could help.”

Data Highlights

Barriers to prenatal care

- Overall 7.3% of Alaska women in 2016 did not get prenatal care as early in their pregnancy as they wanted because they didn't know they were pregnant and 1.7% didn't want anyone else to know they were pregnant.
- Not having enough money or insurance to pay for prenatal care visits did not differ significantly by maternal age but this was a significant barrier to getting prenatal care for women of a race other than White or Alaska Native and those at $\leq 200\%$ FPL.
- Women of other races experienced a transportation barrier to getting prenatal care nearly 4 times that of Alaska Native women and 11 times that of White women in 2016.

Alcohol advisement

- The prevalence of Alaska women who were advised not to drink alcohol while they were pregnant significantly increased from 79.5% in 2009 to 90.0% in 2016.

WIC enrollment

- Prenatal WIC enrollment significantly declined overall from 48.2% in 2009 to 37.7% in 2016.
- In 2016, 30.4% of Alaska women 25+ years of age were enrolled in WIC prenatally compared with 58.4% of women less than 25 years of age.

Exercise

- Overall 17% of Alaska women who delivered a baby in 2015 reported they exercised five or more days per week during the last 3 months of their pregnancy.
- The prevalence of frequent exercise during pregnancy was significantly higher for Alaska Native women (24%) compared with White women (16%) and women of other races (10%).

Childbirth class attendance

- Nearly 1 in 4 Alaska women who delivered a baby in 2015 reported attending a childbirth class during their pregnancy.
- Women at $>200\%$ FPL, White women, and women of other races were more likely to attend childbirth classes than women at $\leq 200\%$ FPL and Alaska Native women.

"I did not take a birthing class because I had attended one in the past with a family member. After having my child something I think I would have utilized would have been a class on breastfeeding. I am still breastfeeding my child today, however it took 2 ½ to 3 months to regulate & really figure it all out. I think a class would have been really helpful & possibly made it easier."

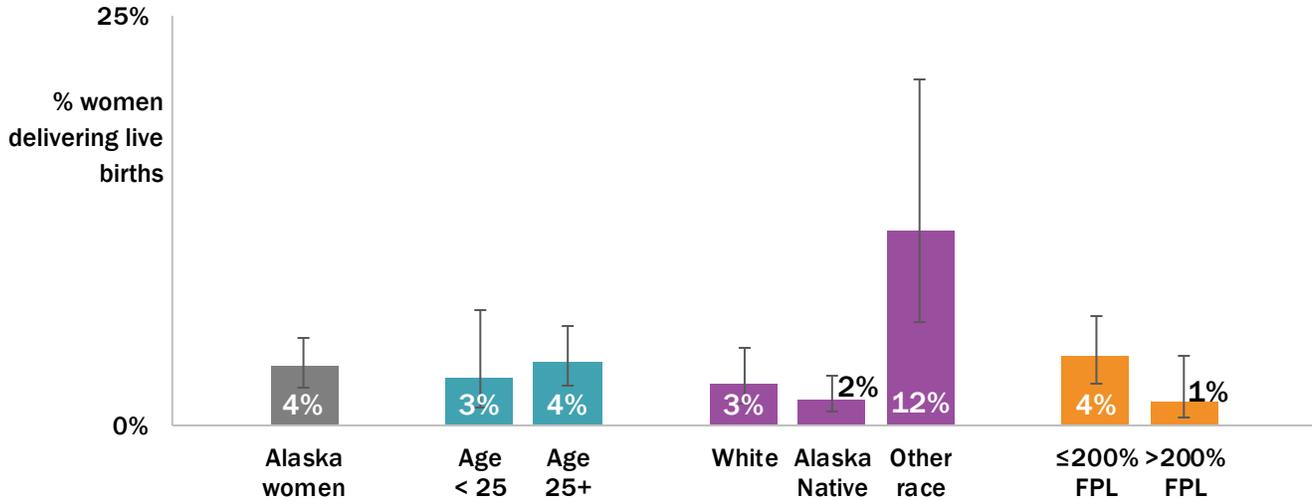
Data Highlights

Dental care

- Nearly 50% of Alaska women who delivered a baby in 2016 had their teeth cleaned during their pregnancy.
- Older women, women at >200% FPL, White women, and women of other races were more likely to have their teeth cleaned during their pregnancy.
- Residents of the Southeast region reported the highest prevalence of prenatal teeth cleaning at 60%, whereas residents of the Southwest region reported the lowest prevalence at 34%.

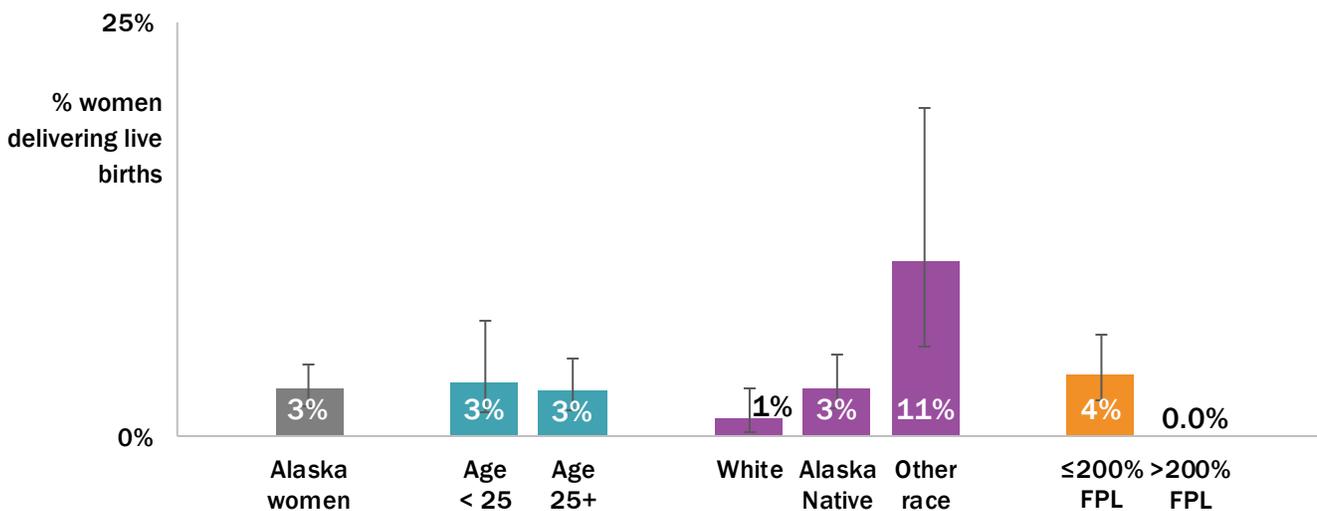
“Just want to add that while I had the option of going to the dentist for cleaning during the pregnancy I opted not to, not because I couldn't, but because I had a bad dentist experience a few years back and was dreading going back. It's my only regret during the pregnancy since I know & know that it could have been bad for my baby. Fortunately, she is doing really great at almost 5 months...”

Figure 47. Barriers to prenatal care: Not enough money or insurance to pay for visit, 2016



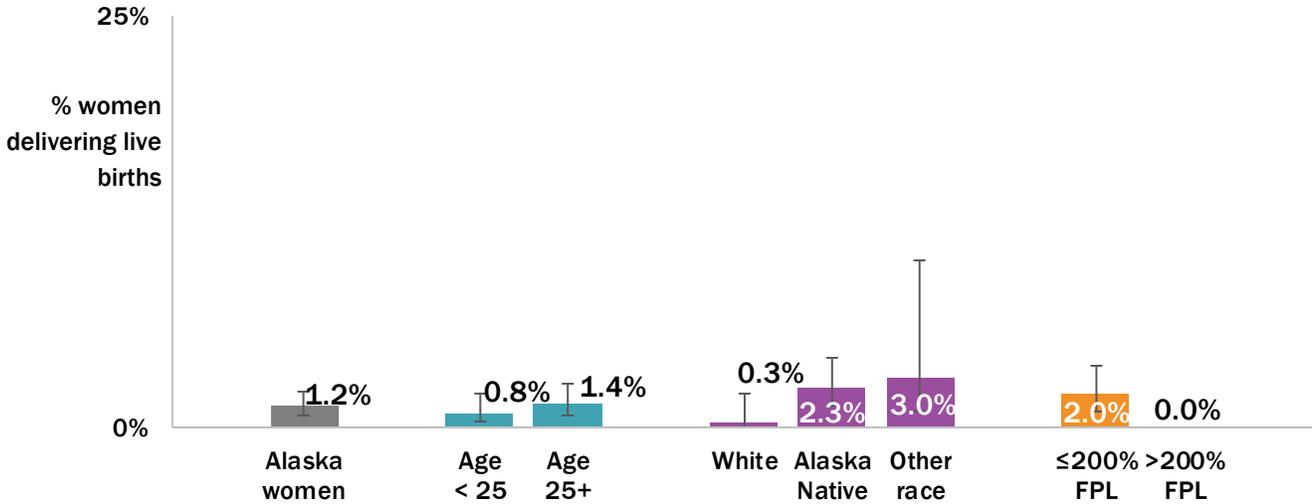
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 48. Barriers to prenatal care: No transportation to get to the clinic or doctor's office, 2016



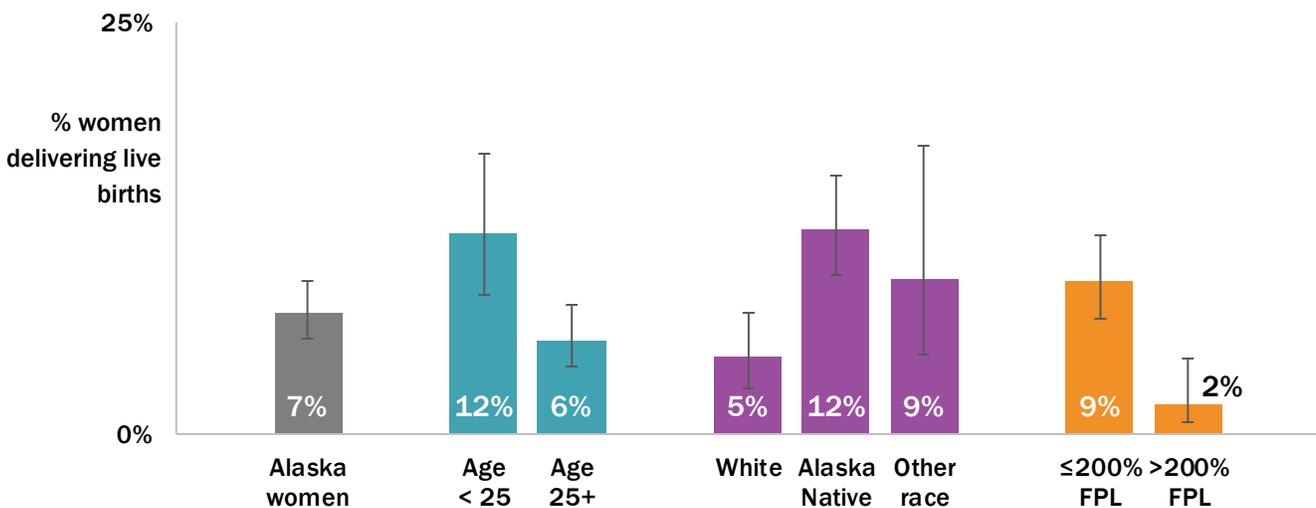
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 49. Barriers to prenatal care: Could not take time off from work or school, 2016



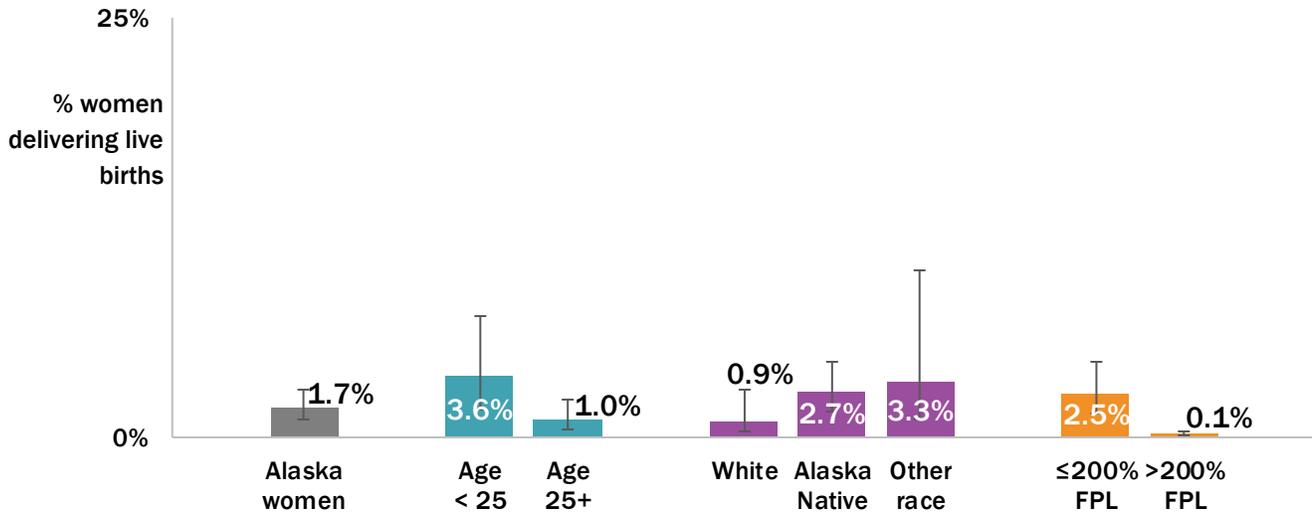
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 50. Barriers to prenatal care: I didn't know that I was pregnant, 2016



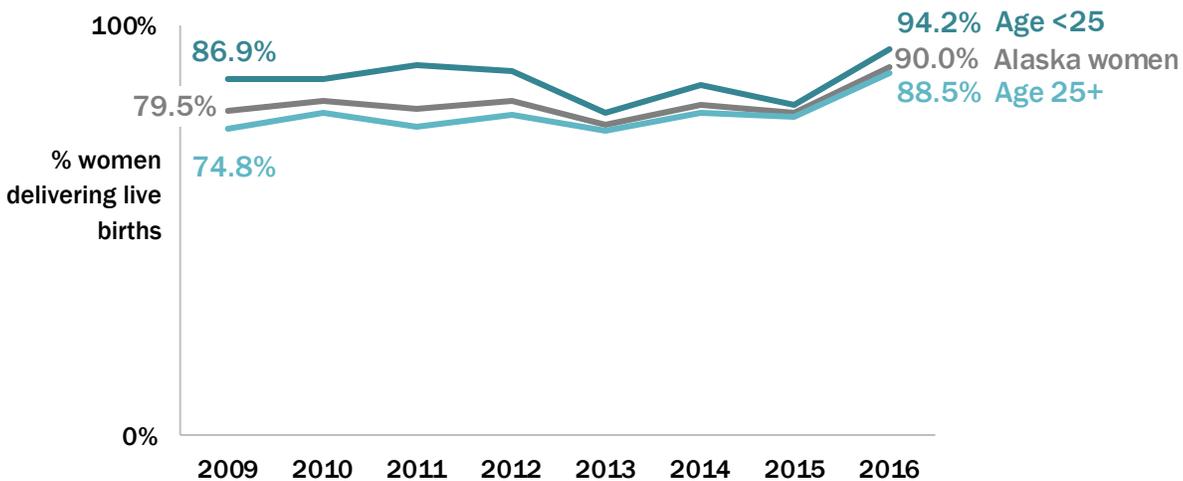
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 51. Barriers to prenatal care: I didn't want anyone to know that I was pregnant, 2016



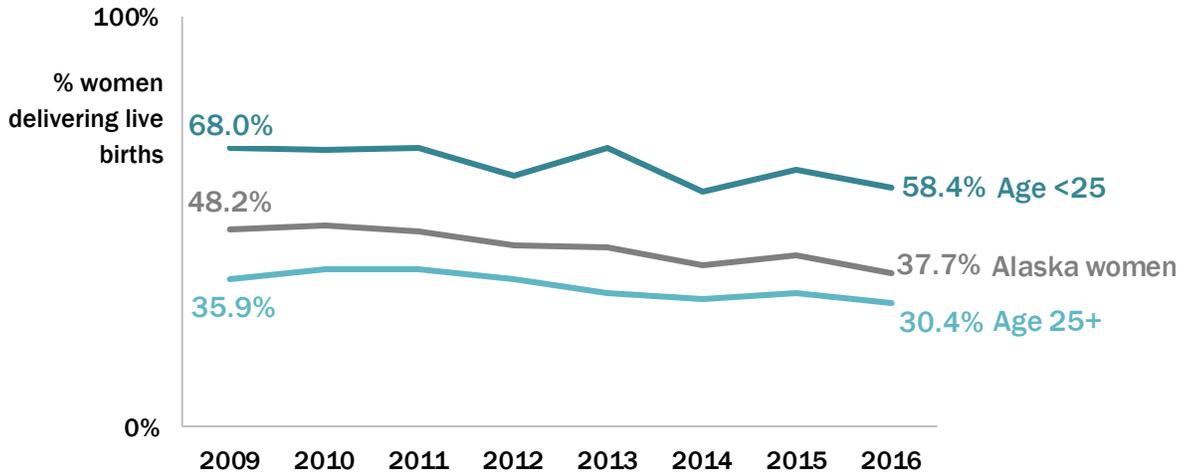
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 52. Prenatal health care worker advised me not to drink alcohol while pregnant by maternal age, 2009-2016



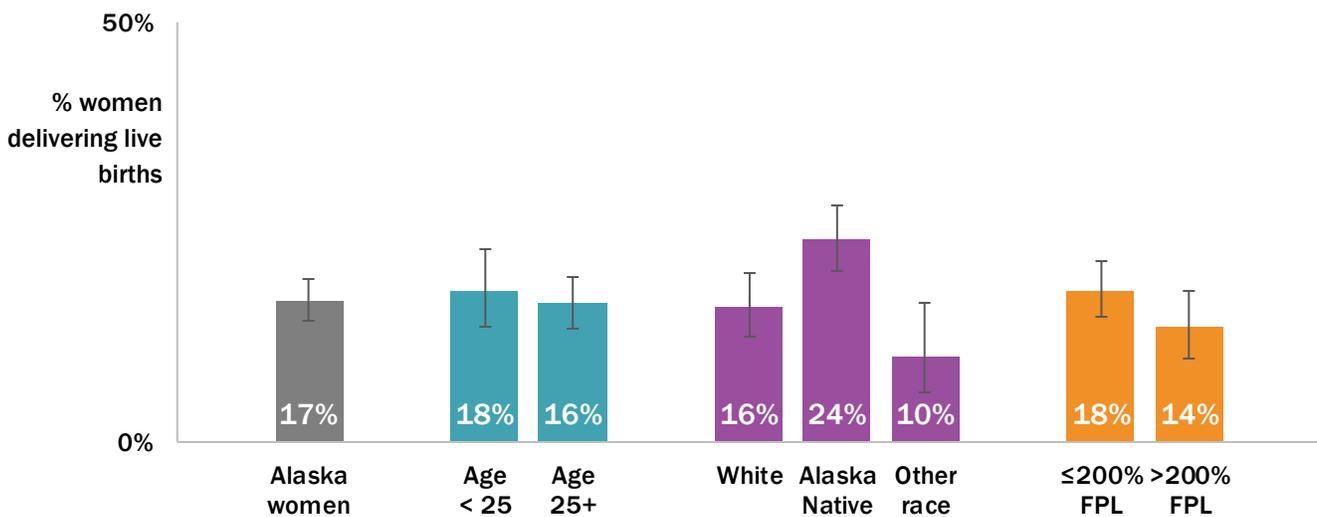
Source: Alaska PRAMS

Figure 53. Enrollment in WIC during pregnancy by maternal age, 2009-2016



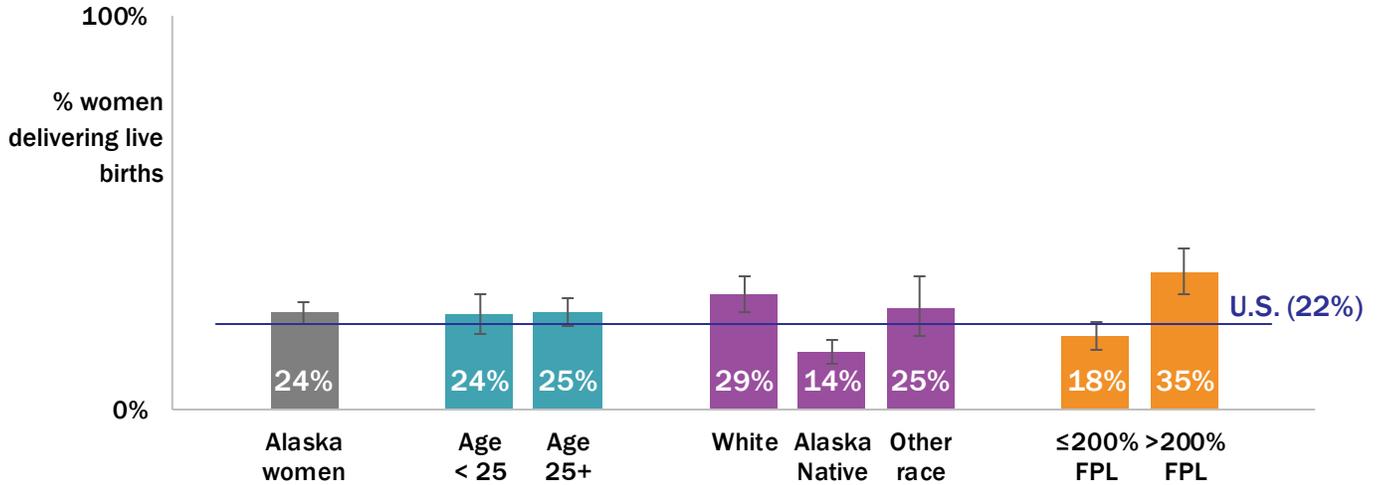
Source: Alaska PRAMS

Figure 54. Exercised five or more days during the last 3 months of pregnancy, 2015



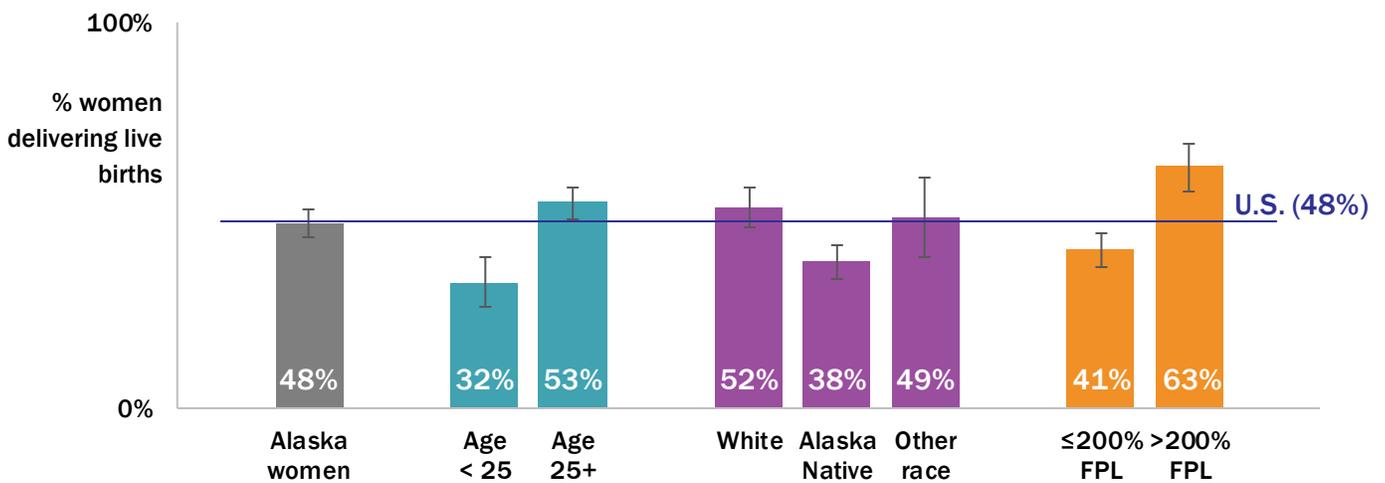
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 55. Took childbirth classes, 2015



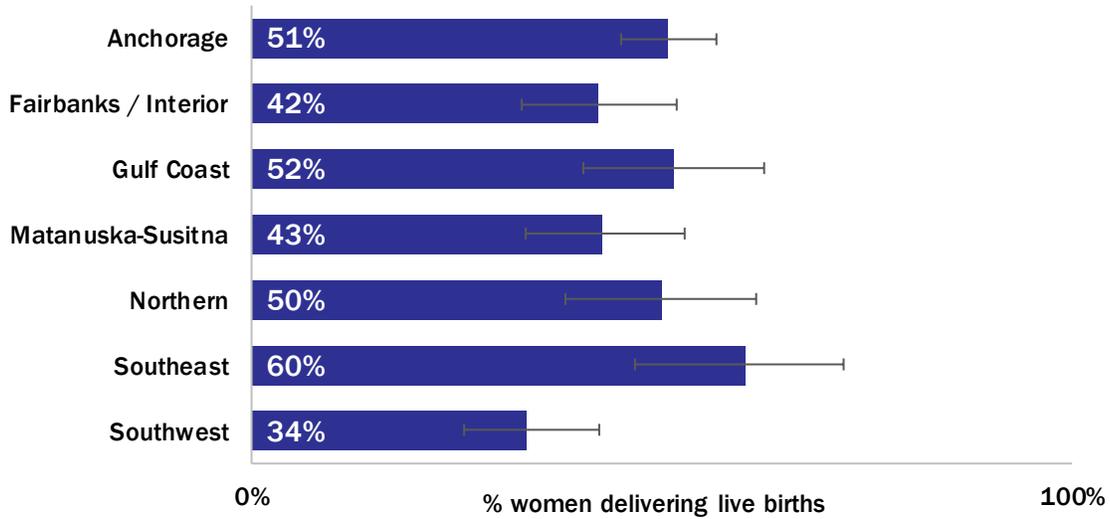
Source: Alaska PRAMS
 FPL = Federal Poverty Level
 Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

Figure 56. Teeth cleaned during pregnancy, 2016



Source: Alaska PRAMS
 FPL = Federal Poverty Level
 Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

Figure 57. Teeth cleaned during pregnancy by region, 2016



Source: Alaska PRAMS

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Chapter 3: Maternal Health

Maternal Health

Why is this important?

The immediate postpartum time period is a critical window for influencing future health of the mother and her baby. Women respond to Alaska PRAMS on average 4.5 months after delivery, and answer questions about their postpartum care and experiences. A mother's physical and mental health and well-being during this time impacts the health and quality of life of her children and family. While traditional factors that influence health—such as access to high quality care—are important, so are many social determinants. Social determinants of health include support networks, economic opportunity, the physical environment, safety, and the availability of resources to meet daily needs. Social determinants of health have been linked to health disparities associated with race and ethnicity, socioeconomic status, geographic location, and other factors.

A social support network can include friends, family and peers. Support networks reduce isolation and loneliness, improve the ability to cope with stress and adverse life events, and provide physical and emotional comfort. Social support can reduce a new mother's risk for postpartum depression and increase successful breastfeeding.^{1,2} PRAMS asks mothers whose baby is living with them whether they would have each of five kinds of help from another person if they needed it since delivering their new baby.

Parental time off from work after having a baby has been associated with decreased infant mortality, increased breastfeeding, and improved overall health of mothers and babies.^{3,4} The two most important determinants of whether parents take leave are if the leave is paid and job-protected.³ Mothers who have job-protected paid leave take more time off from work than mothers without paid leave, and they are more likely to take their infant to the doctor for well child check-ups and immunizations.³

Postpartum visits with a health care provider offer an opportunity for clinicians to discuss pregnancy spacing and contraception

options, provide screening and resources for postpartum depression, manage a patient's chronic illnesses, and provide education regarding overall health and wellness. The American College of Obstetricians and Gynecologists (ACOG) recommends a first postpartum visit for women within 3 weeks of delivery, with a follow-up visit within 12 weeks.⁵

Smoking has many known adverse health effects on the individual who smokes. Exposure to secondhand smoke from a parent can contribute to numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections and related hospital admissions during infancy, ear infections, and sudden unexpected infant death (SUID). Making a plan to quit smoking can make quitting easier.

Postpartum depression is depression that occurs after having a baby. Some consequences of postpartum depression include higher incidence of intimate partner violence, child abuse and neglect, and delayed cognitive, social-emotional, and behavior development of children.⁶ Alaska

PRAMS asks women how often they felt down, depressed or hopeless since their new baby was born and how often they had little interest or little pleasure in doing things they usually enjoyed since their new baby was born. Responses of always or often to either question were counted as experiencing postpartum depressive symptoms.

Intimate partner violence (IPV) includes physical, sexual, or psychological harm by a current or former partner or spouse. Children who are exposed to IPV can experience harm similar to being abused or neglected, including increased emotional and behavioral problems. Alaska PRAMS defines a controlling partner as one who threatened her, limited her activities against her will, or made her feel unsafe in any other way.

Using effective contraception provides women the opportunity to plan when and how many children they have. Contraception plays an important role during the postpartum period to prevent pregnancies that are too close together. Birth-to-pregnancy intervals of less than 18 months increase the risk of low birth weight and preterm birth.⁷

"I've seen a lot of young, unprepared mothers. That can be overwhelming with being needed all the time & not ready emotionally. I wanted & planned for my kiddos & even then becoming a new mom was a big change. Never wanted anything else but I lean on a lot of friends, family & talk through breastfeeding issues & get support & offer it to other new moms. It helps when moms help each other & give honest feedback!"

References

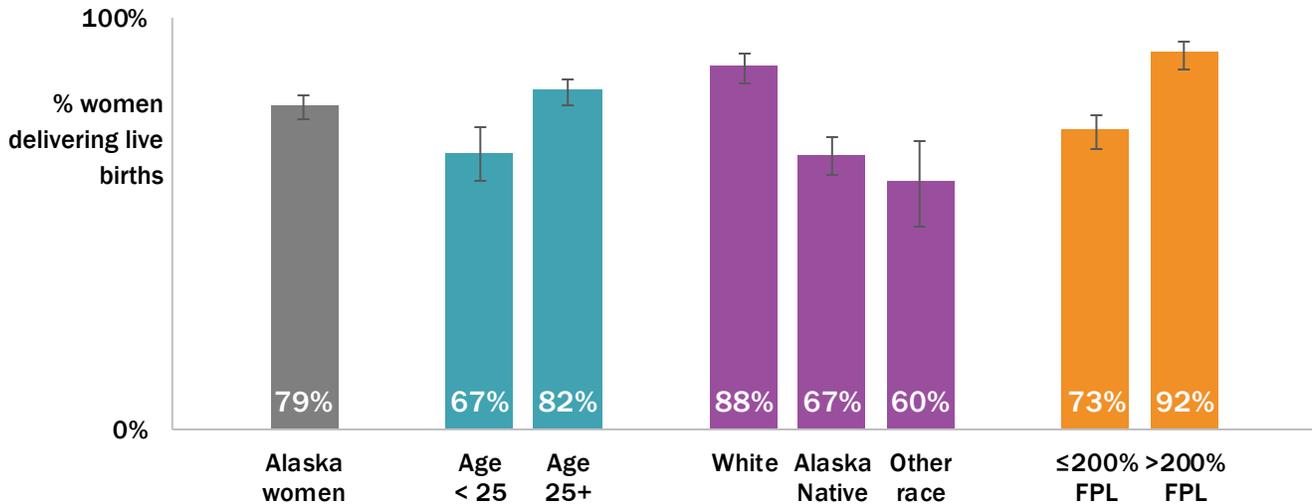
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4. Rossin M. The effects of maternity leave on children's birth and infant health outcomes in the United States. *J Health Econ*. 2011 Mar;30(2):221-39.
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7. March of Dimes. How long should you wait before getting pregnant again? December 2015. Available online at <https://www.marchofdimes.org/pregnancy/how-long-should-i-wait-before-getting-pregnant-again.aspx#>. Accessed October 30, 2018.

Data Highlights

- Most Alaska women reported having at least one type of social support since delivering their new baby. Among five types of social support asked about, the prevalence of individual types ranged from 79% of women who reported having someone to loan her \$50, to 89% who reported having someone to help her if she were tired and feeling frustrated with her new baby.
- The prevalence of all five types of social support was higher among White women and women not in poverty compared to women of other races and women in poverty, respectively. Only financial support (someone to loan me \$50) varied significantly by maternal age, and was higher among older women (82% vs. 67%).
- Residents of the Southwest region reported a lower percentage of having someone to help if she were tired and feeling frustrated with her new baby compared to residents of other regions.

“Mothers are getting younger & younger. I am a young mother myself & just wish there was some way to educate mothers to give skillsets on parenting in an appropriate way once they've chose to go that path. It's hard to reach-out & say 'I don't know what I'm doing or where to go from here.' It would be awesome to see some support or peer support group or get information about one if one is already established. Thank you for your efforts!!!”

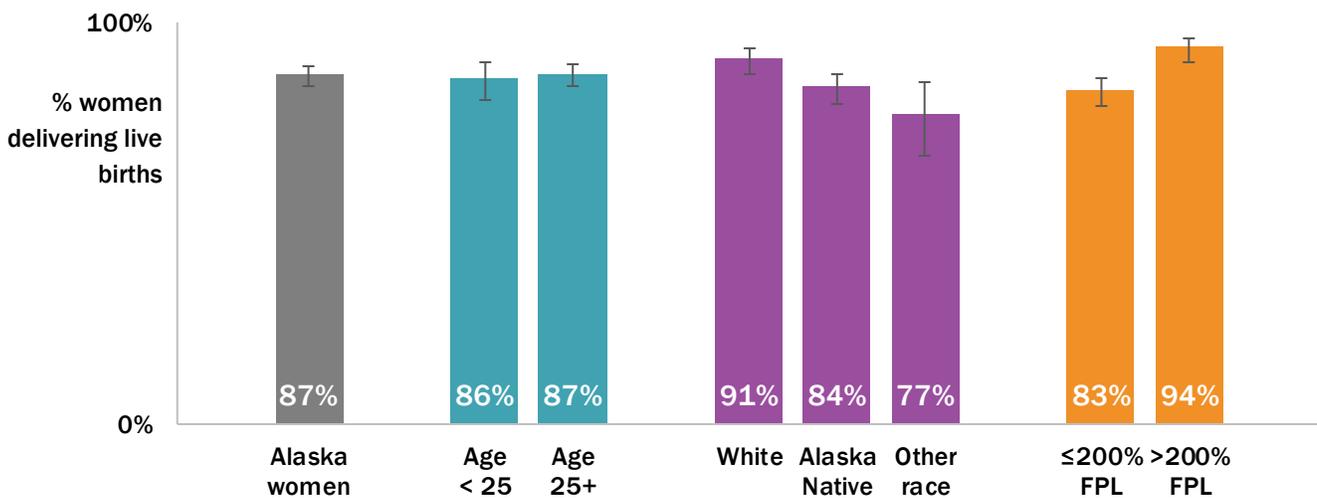
Figure 58. Help from others if I needed it: Someone to loan me \$50, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

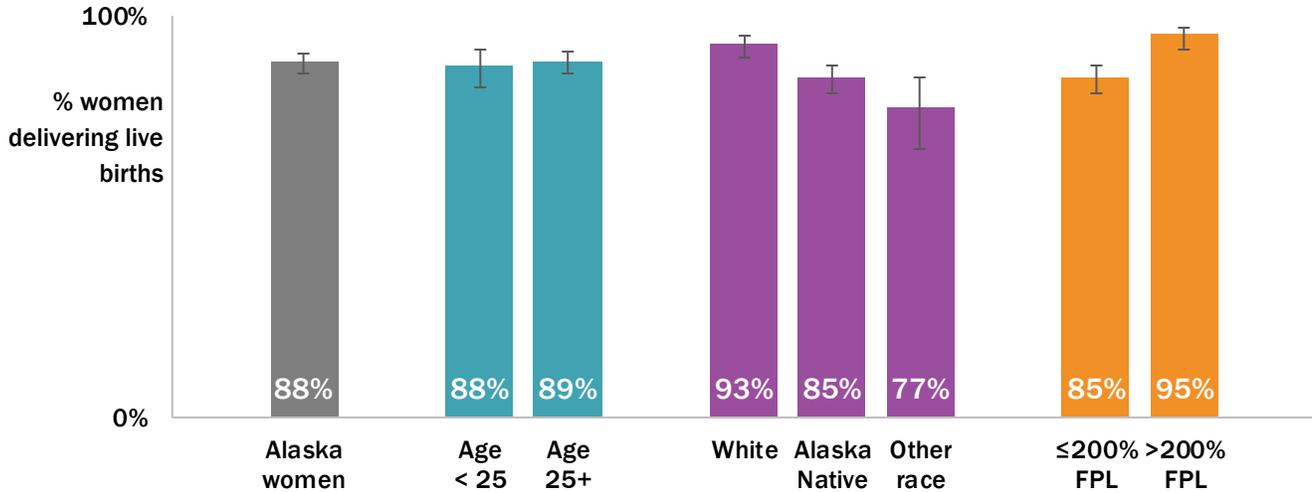
“My husband does slope work. While home I have support but when he's away I don't have a great support system. My family lives in the lower 48 & I'm new to the area.”

Figure 59. Help from others if I needed it: Someone to help me if I were sick and needed to be in bed, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

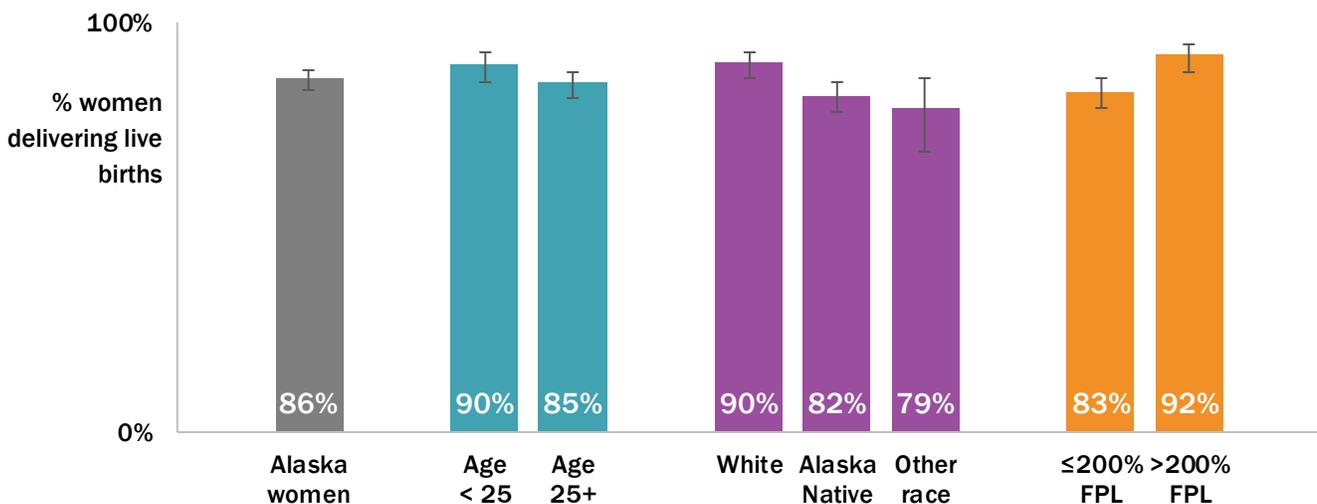
Figure 60. Help from others if I needed it: Someone to talk with about my problems, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

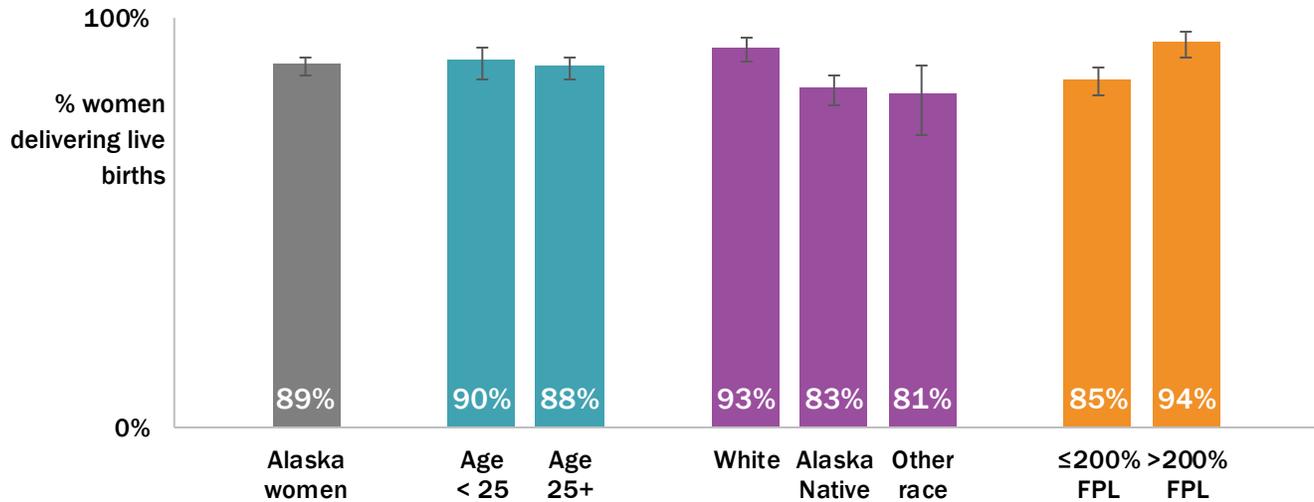
"I have lots of support and I'm still exhausted. I can't imagine how difficult it is for the mothers out there who don't have support."

Figure 61. Help from others if I needed it: Someone to take care of my baby, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

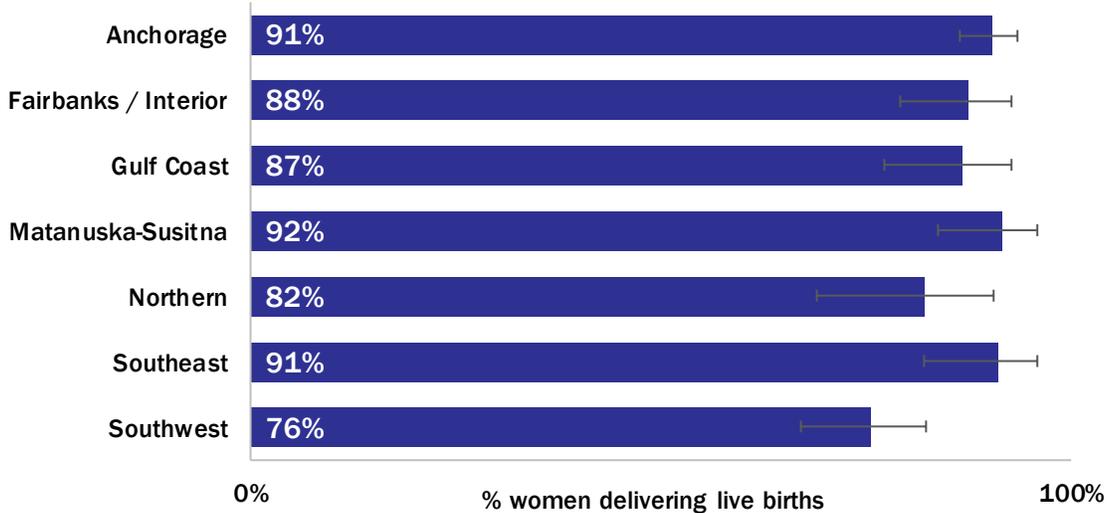
Figure 62. Help from others if I needed it: Someone to help me if I were tired and feeling frustrated with my new baby, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

“Very supported by my community. Alaskans were very supportive. Good spirit of generosity with new babies.”

Figure 63. Help from others if I needed it: Someone to help me if I were tired and feeling frustrated with my new baby by region, 2016



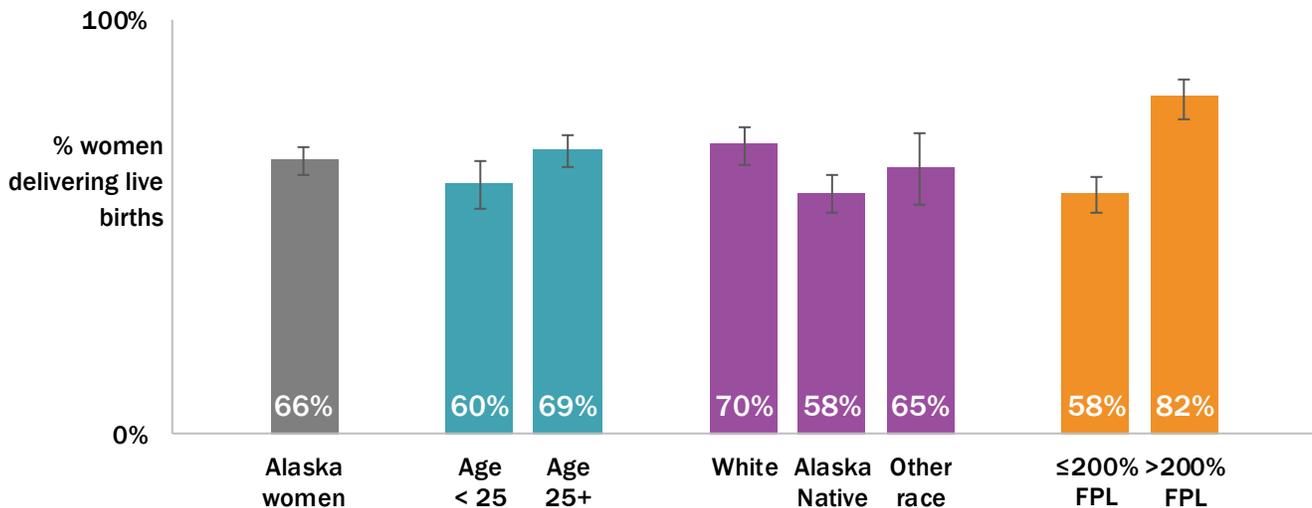
Source: Alaska PRAMS

Data Highlights

- Overall, 66% of Alaska women who delivered a live birth in 2015 worked at a job for pay at some time during their pregnancy. Employment during pregnancy varied significantly by maternal age, race, poverty status, and region.
- Among all women who worked at some point during their pregnancy, 32% had not returned to the job they had during their pregnancy and did not plan to return at the time they responded to PRAMS.
- Among women who had returned to work or planned to return, 45% indicated that they took (or were taking) at least some paid leave after their new baby was born.
- The percent of women not in poverty who took at least some paid leave after their baby was born was greater than the percent of women in poverty who took paid leave (55% vs. 33%). Older women and White women were also more likely to report taking paid leave after their baby was born compared to younger women and women in other racial groups.
- During 2013-2015, paid leave after pregnancy varied by maternal region of residence, with around half of women in the Southeast regions and Fairbanks/Interior regions taking paid leave compared to approximately 20% in the Gulf Coast and Southwest regions.

“...I felt like I did not have enough time to bond with my baby because the lack of paid or unpaid maternity leave. 12 weeks of FMLA is not long enough. Going back to work so early makes continuing breastfeeding a challenge. Despite having 2 'good' private insurance plans, I had to pay a significant amount of money out-of-pocket for my pregnancy which was surprising and financially burdensome. I feel like the entire 'system' lacks support for pregnancy and childbirth and it discourages women from having children, or forces us to choose between that and a career...”

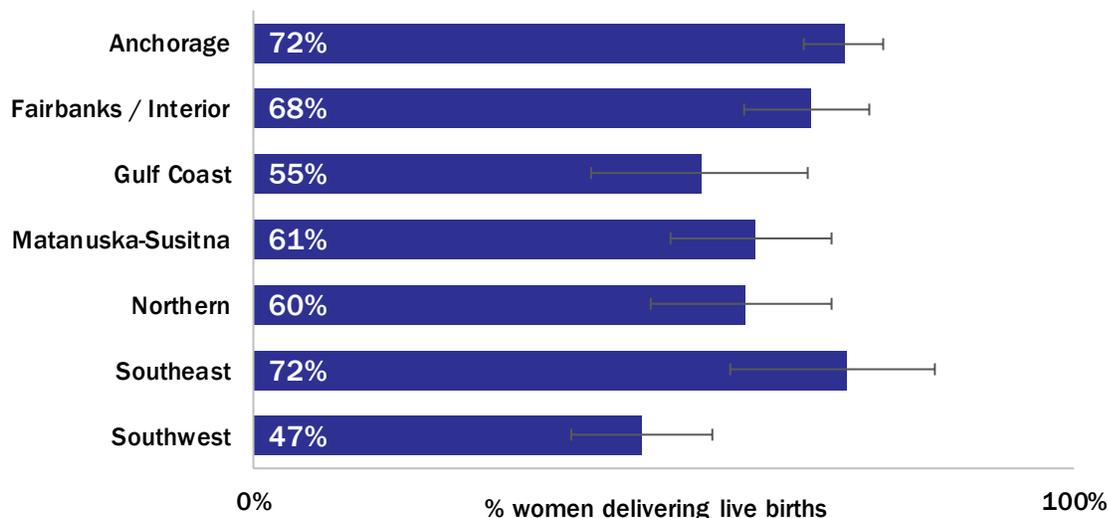
Figure 64. Employed during pregnancy, 2015



Source: Alaska PRAMS
FPL = Federal Poverty Level

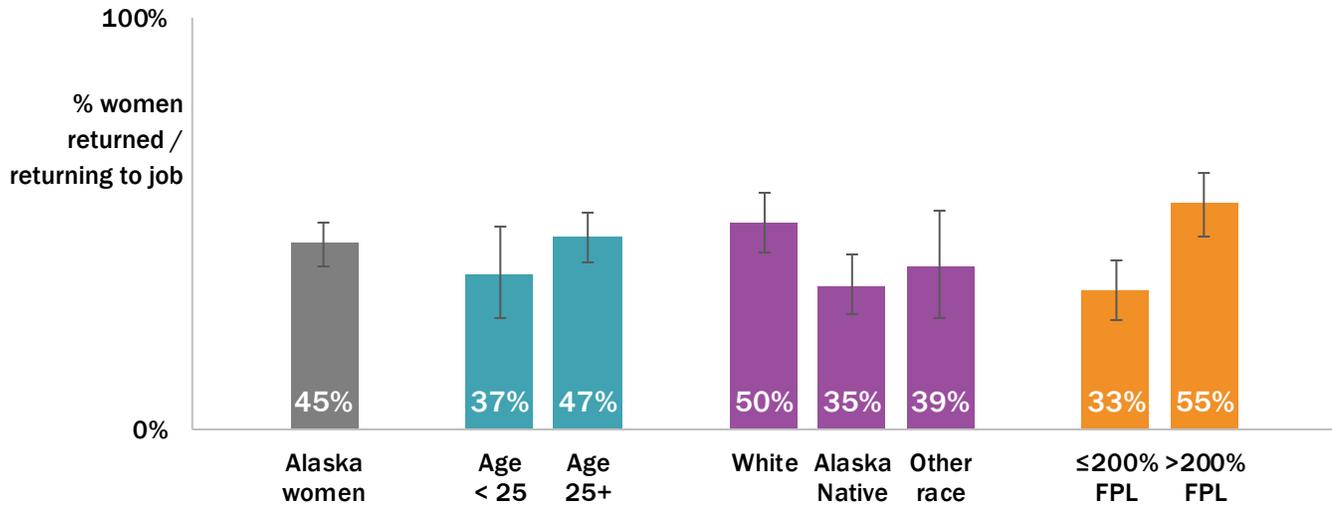
“Upon returning to work I feel that there is very little support for new mothers. Once I was healthy enough to drive (~6 wks after birth due to episiotomy) I attended a new mom meet-up at [the hospital]... Unfortunately when I returned to work (~8 wks) there is no support as I am unable to attend those groups as they are all during normal working hours. It is extremely stressful at times being a working mom who is pumping during the day (3x) and still sore from delivery 4 months after. The only Saturday meet-ups I have found are for dads which is stereotypical and unfair to working mothers. I would like to see more support. ... Thank you.”

Figure 65. Employed during pregnancy by region, 2015



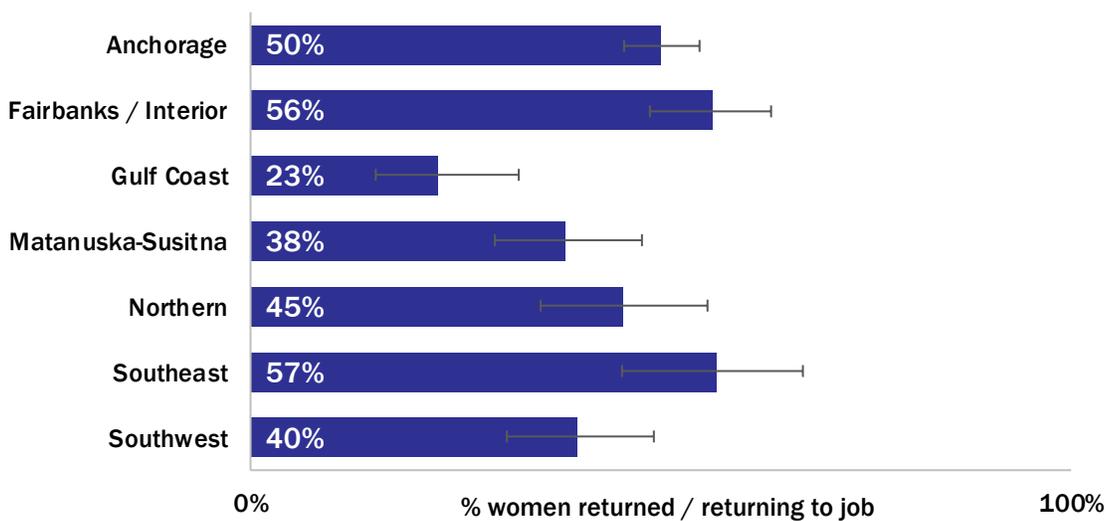
Source: Alaska PRAMS

Figure 66. Took paid leave after baby was born, 2015



Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 67. Took paid leave after baby was born by region, 2013-2015



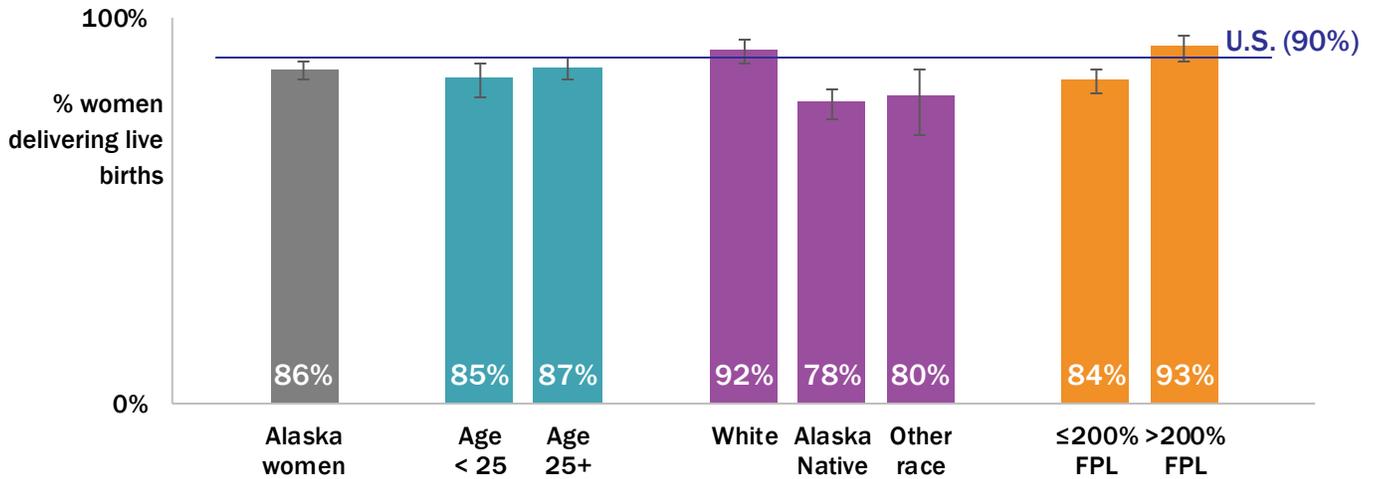
Source: Alaska PRAMS

Data Highlights

- Overall, 86% of Alaska women who delivered a live birth had a postpartum checkup about 4-6 weeks after giving birth, compared to 90% of all U.S. women.
- In 2016, 50% of women indicated their provider talked with them during a postpartum checkup about how long to wait before getting pregnant again and 78% reported that their provider talked with them about birth control methods they can use after giving birth.
- About a third of women (36%) said their provider gave or prescribed her a contraceptive method and 22% said their provider inserted an intrauterine device (IUD) or contraceptive implant at a postpartum visit.
- Depression screening (provider asked if she was feeling down or depressed) during a postpartum visit was reported by 80% of women, and was more commonly reported by White women and women not in poverty compared to women of other races and women in poverty.
- Among the 15% of Alaska women in 2014-2016 who reported current smoking during the postpartum period, 74% were planning to stop smoking. Planning to quit was significantly higher among White women (82%) versus Alaska Native women (67%).
- While 89% of residents of the Matanuska-Susitna region who smoked in the postpartum period were planning to quit, only 60% of residents of the Northern region were planning to quit.
- The percent of Alaska women who recently delivered a live birth and reported postpartum depressive symptoms (14%) was similar to the percent of all U.S. women (13%).
- Reporting a controlling partner since their baby was born was significantly higher among women in poverty compared to women not in poverty (4% vs. 2%).
- Among women who are sexually active and not currently seeking another pregnancy, use of a most or moderately effective contraceptive method ranged from 54.3% in the Southeast region to 70.0% in the Fairbanks/Interior region. None of the differences between regions were significant, however.

“...I have a history of depression and still did not find or have offered any prenatal resources that were useful, even though I expressed my history to my health care providers. In my experience, it seems even the providers have a lack of experience, info. or understanding themselves. Thank you for your work in this survey taking!”

Figure 68. Had a postpartum checkup, 2016

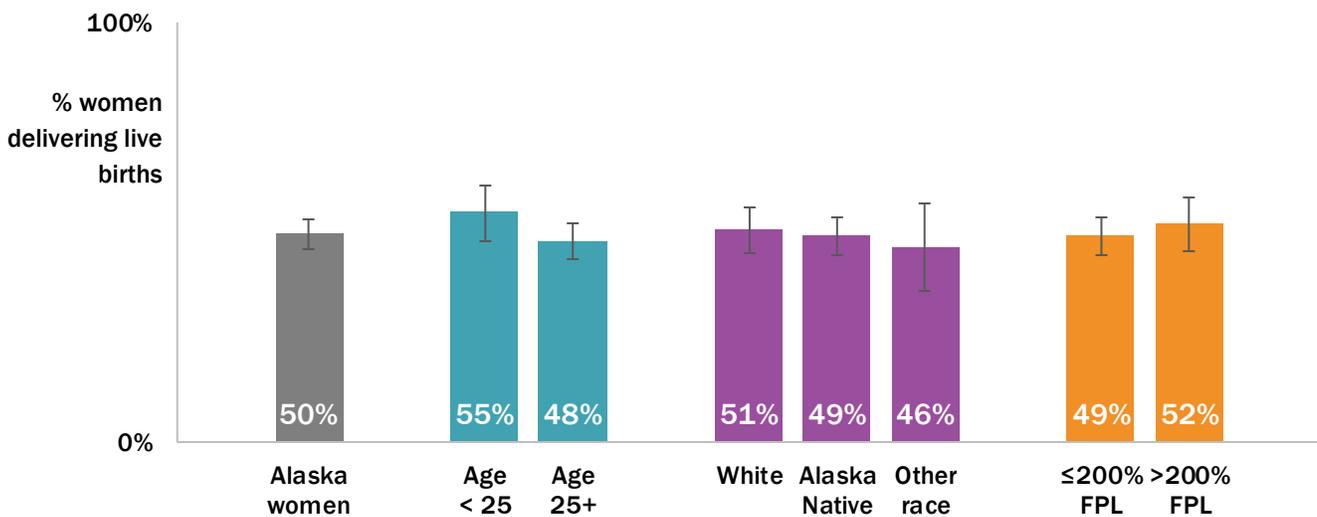


Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

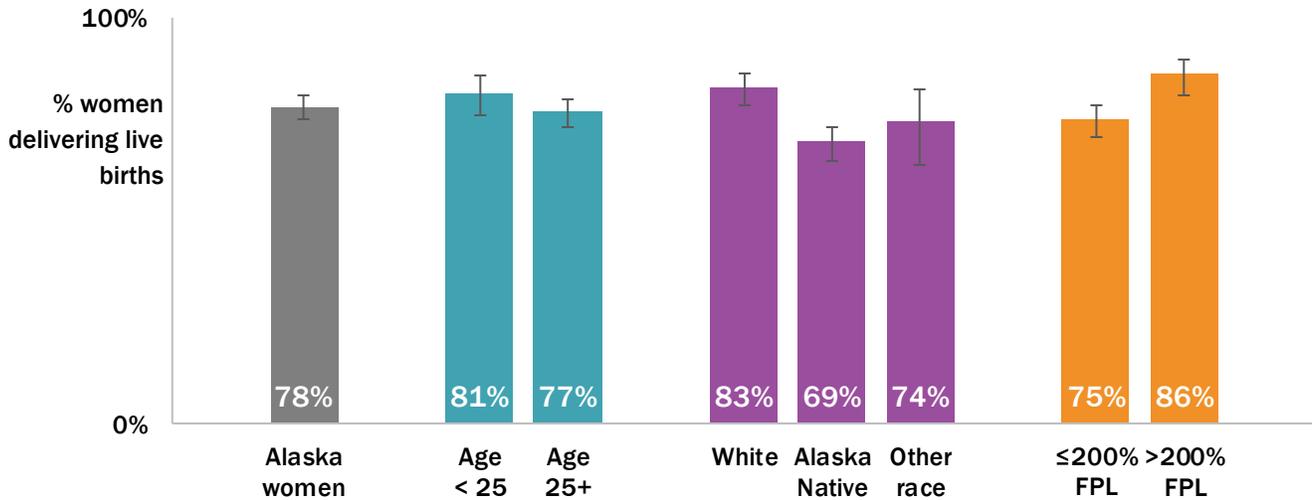
Figure 69. Postpartum checkup provider talked with me about how long to wait before getting pregnant again, 2016



Source: Alaska PRAMS

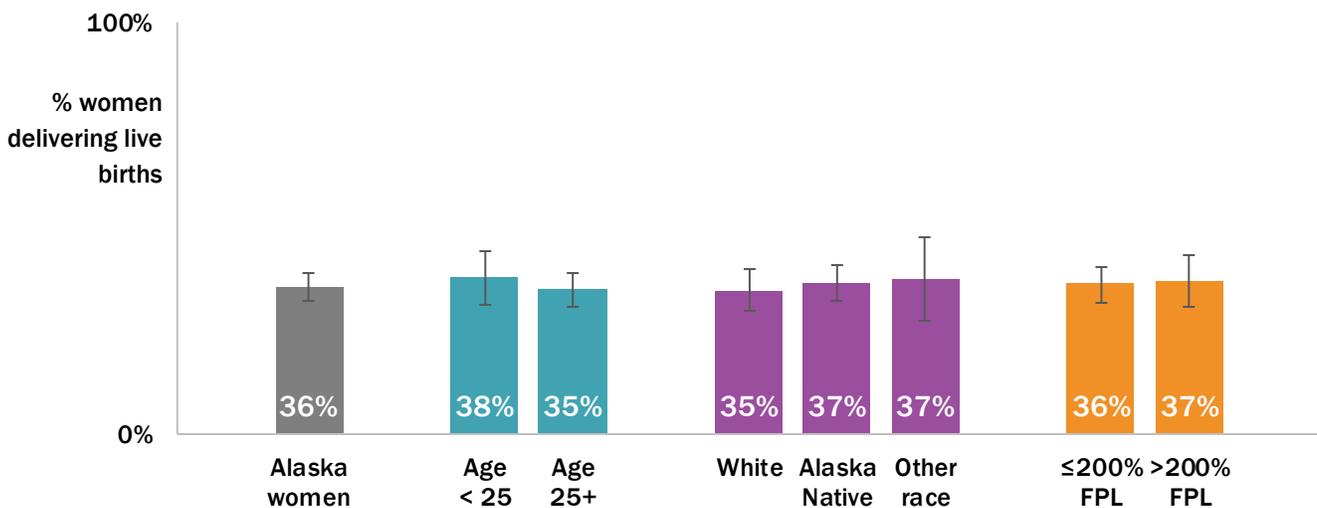
FPL = Federal Poverty Level

Figure 70. Postpartum checkup provider talked with me about birth control methods I can use, 2016



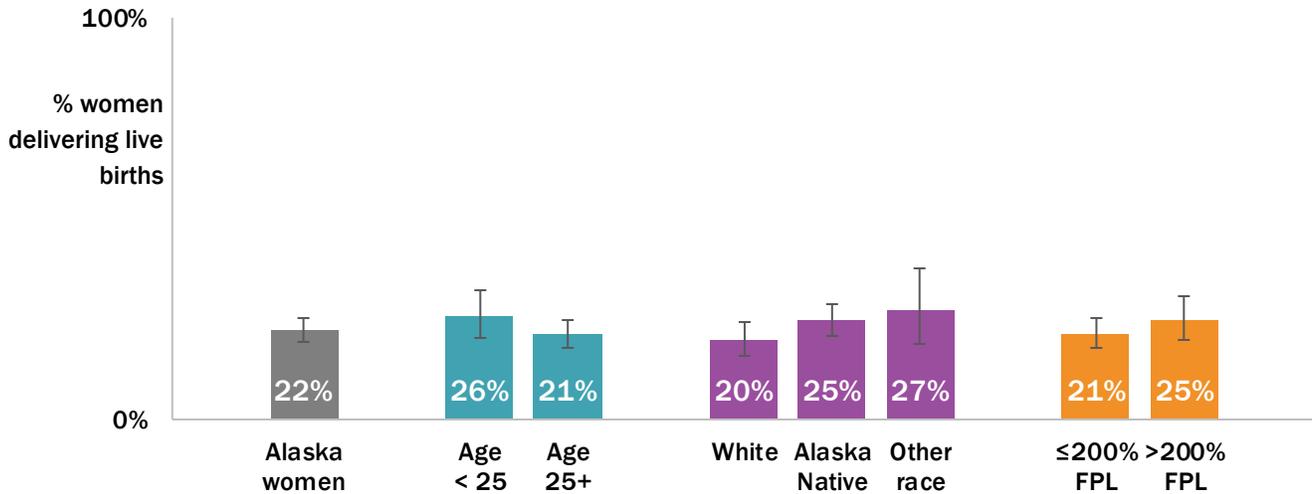
Source: Alaska PRAMS
FPL= Federal Poverty Level

Figure 71. Postpartum checkup provider gave or prescribed me a contraceptive method, 2016



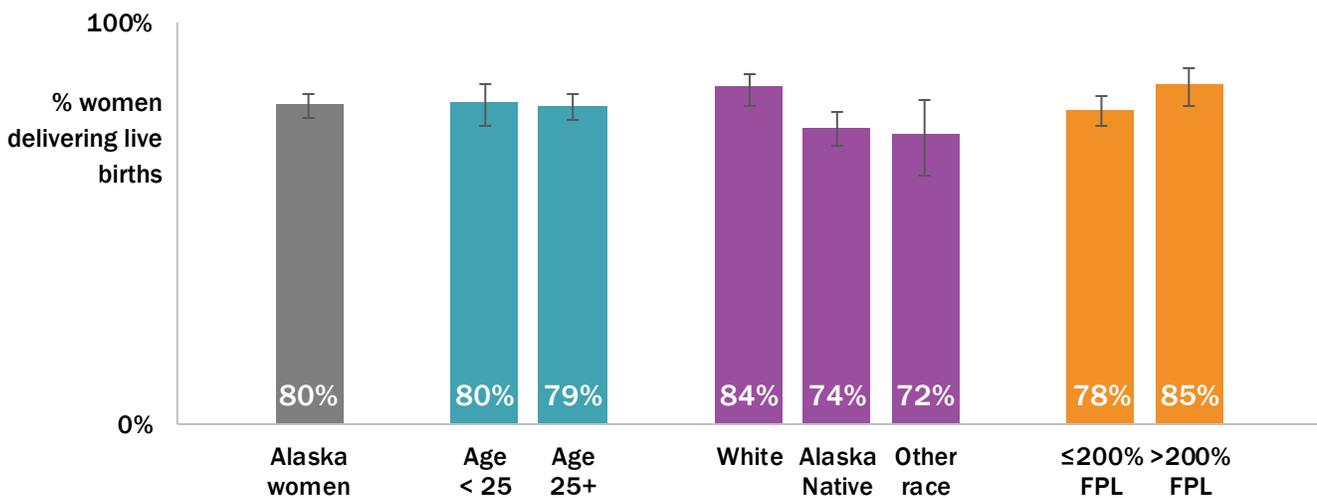
Source: Alaska PRAMS
FPL= Federal Poverty Level

Figure 72. Postpartum checkup provider inserted an IUD or implant, 2016



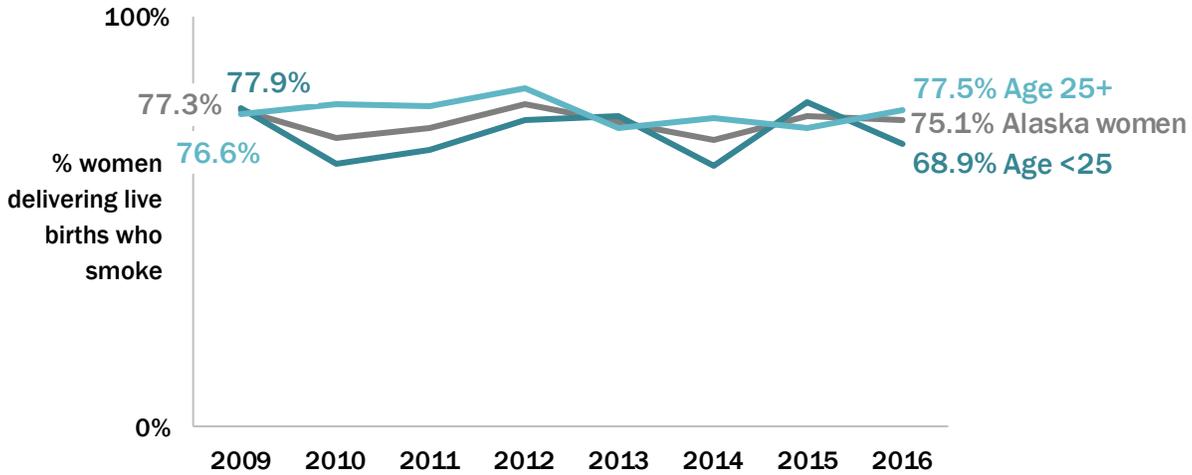
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 73. Postpartum checkup provider asked me if I was feeling down or depressed, 2016



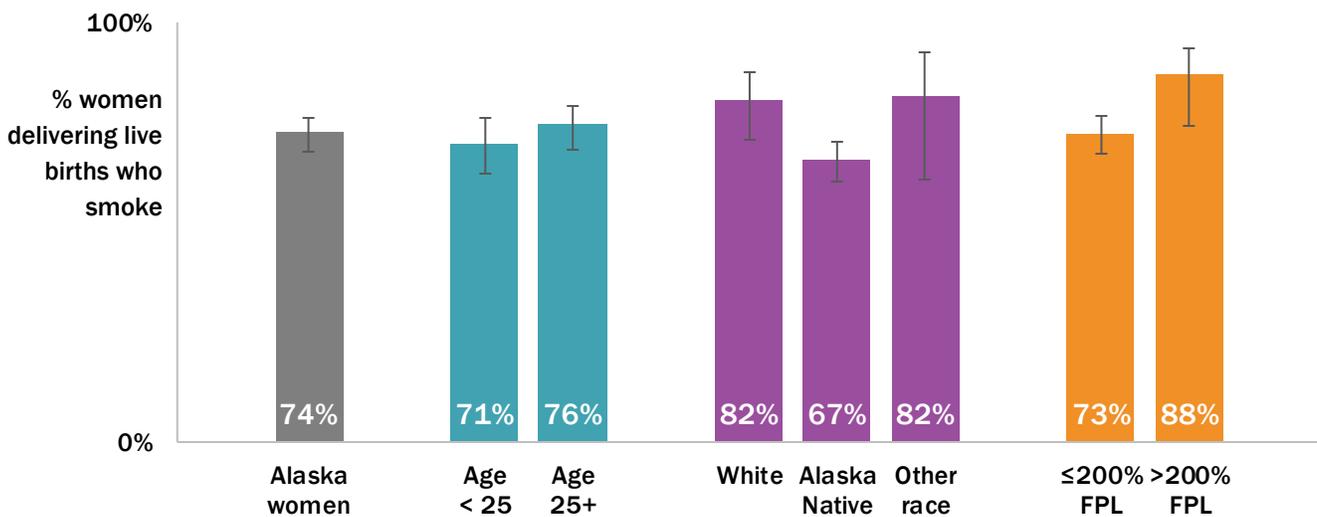
Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 74. Current smokers with plans to stop smoking cigarettes by maternal age, 2009-2016



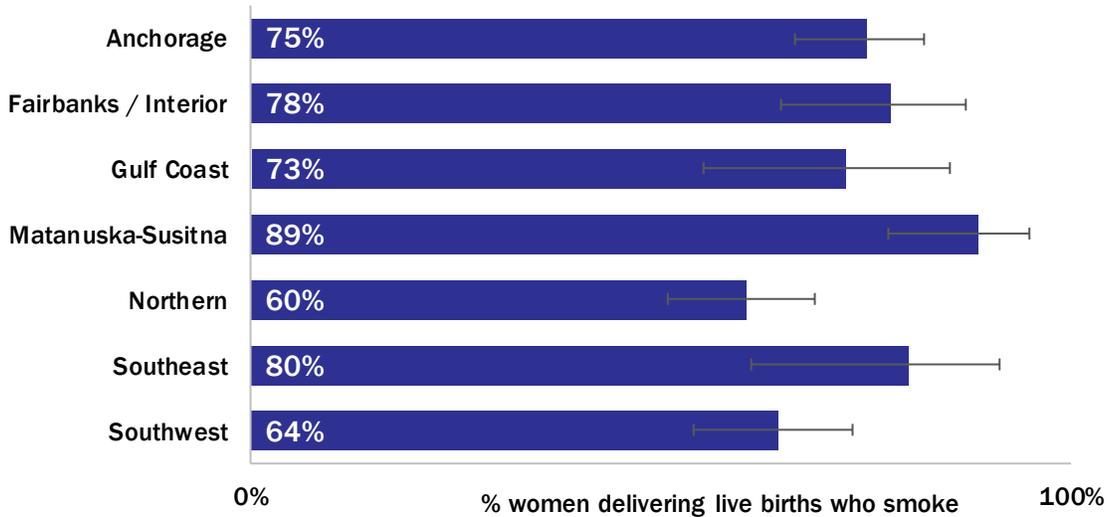
Source: Alaska PRAMS

Figure 75. Current smokers with plans to stop smoking cigarettes, 2014-2016



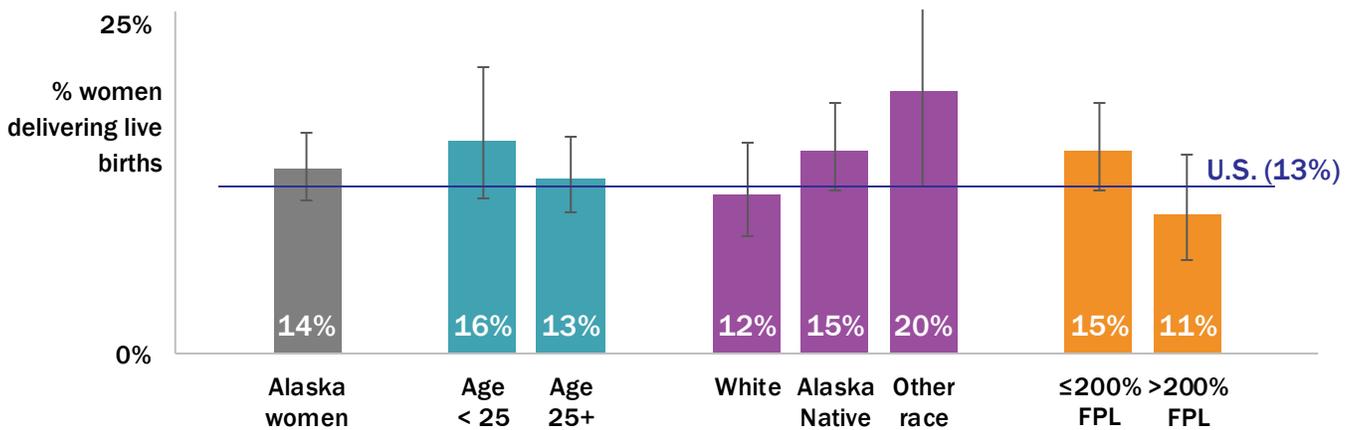
Source: Alaska PRAMS
FPL= Federal Poverty Level

Figure 76. Current smokers with plans to stop smoking cigarettes by region, 2014-2016



Source: Alaska PRAMS

Figure 77. Self-reported postpartum depressive symptoms[^], 2016



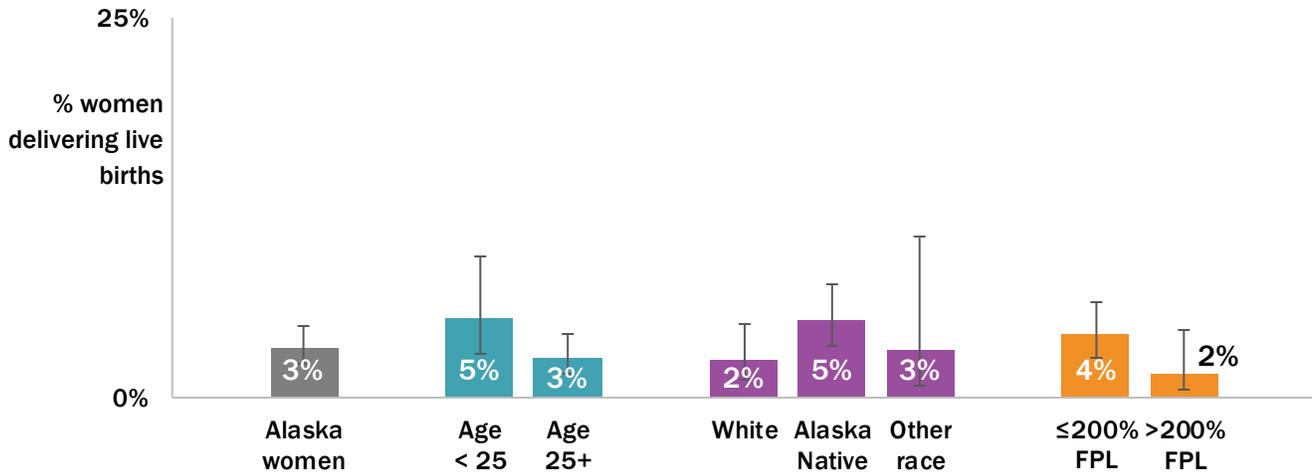
Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

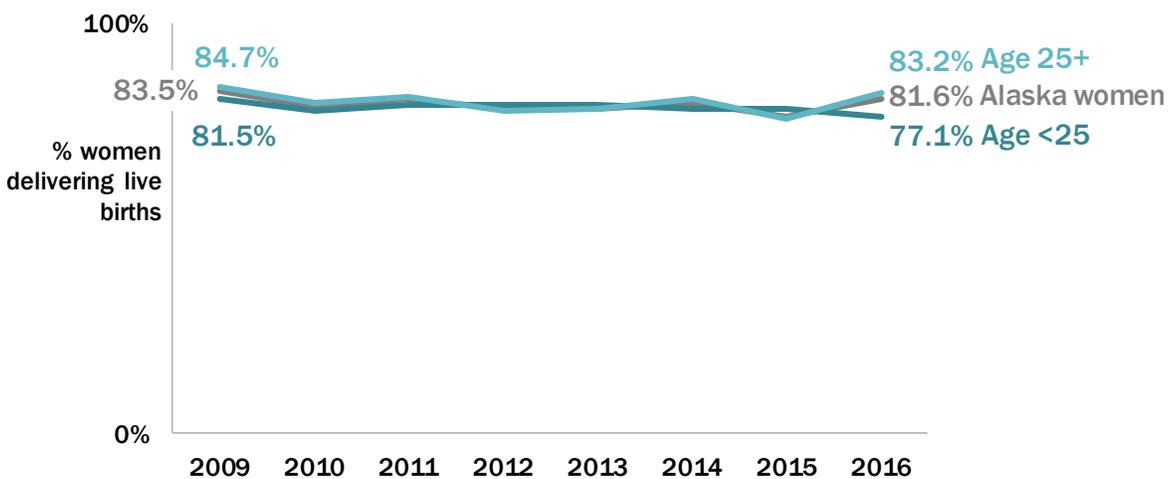
[^] Note: See page 53 for definition.

Figure 78. Husband or partner is controlling or threatening[^] since baby was born, 2016



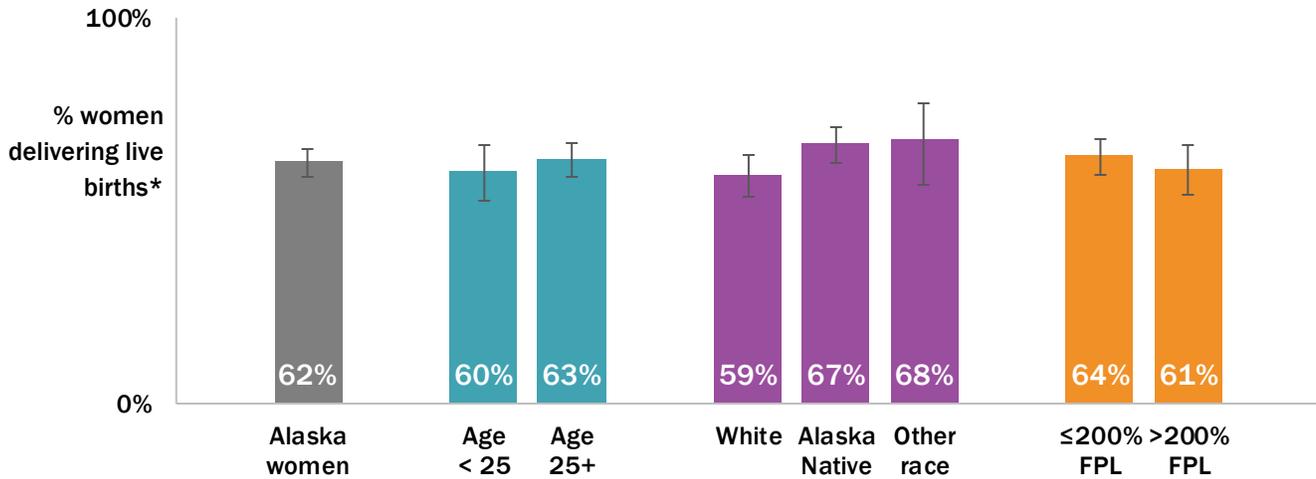
Source: Alaska PRAMS
 FPL = Federal Poverty Level
[^] Note: See page 53 for definition.

Figure 79. Postpartum contraceptive use by maternal age, 2009-2016



Source: Alaska PRAMS

Figure 80. Postpartum use of a most or moderately effective contraceptive method, 2016

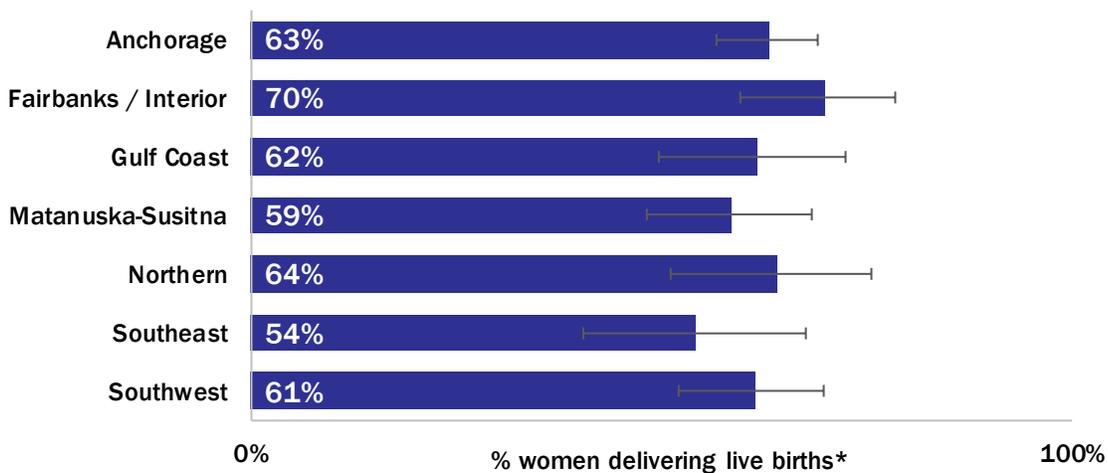


Source: Alaska PRAMS

FPL = Federal Poverty Level

* Note: Non-pregnant women excluding those who indicated they wanted to get pregnant and those who reported not being sexually active. Methods considered "most or moderately effective" are sterilization, implant, IUD, Depo-Provera, pills, or patch/ring.

Figure 81. Postpartum use of a most or moderately effective contraceptive method by region, 2016



Source: Alaska PRAMS

* Note: Non-pregnant women excluding those who indicated they wanted to get pregnant and those who reported not being sexually active. Methods considered "most or moderately effective" are sterilization, implant, IUD, Depo-Provera, pills, or patch/ring.

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Chapter 4: Infant Care

Why is this important?

During the first few weeks of life, infants spend the majority of their time either sleeping and eating. This chapter focuses on PRAMS data related to these activities and infant caretaker behaviors that can help to keep the baby healthy and safe.

Most infants are raised by and are living with their biological mother. Sometimes a woman will give their baby up for adoption. At other times, circumstances may prevent the child from living with her. These situations may be indicative of external stressors affecting the environment that the woman finds herself in postpartum. PRAMS data about women whose baby is not living with her provide insight into a population that may be unrecognized by programs and services that focus on mother-baby dyads.

Research has shown that breastfeeding is recognized as the best source of nutrition for most infants. Infants who are not breastfed experience more episodes of diarrhea, ear infections, and lower respiratory tract infections and are at higher risk of sudden infant death syndrome (SIDS), diabetes, and obesity.¹

Benefits of breastfeeding also extend to the mother. Women who breastfeed have a lower risk of type 2 diabetes, breast and ovarian cancer, and postpartum depression.² For the mother, breastfeeding is convenient, can save money, and increases mother-infant bonding. Longer and more exclusive breastfeeding is associated with better health outcomes. The World Health Organization and the American Academy of Pediatrics recommend exclusive breastfeeding through six months of age.

There have been dramatic improvements in reducing baby deaths during sleep since the 1990s, when recommendations were introduced to place babies on their back for sleep. However, since the late 1990s, declines have slowed. Other recommended safe sleep practices today include eliminating hazards, such as keeping blankets, pillows, bumper pads, and soft toys out of the sleep area. Recommendations also include room sharing but not bed sharing. These practices can help lower the risk of sleep-related infant deaths, including SIDS, accidental suffocation, and deaths from unknown causes.³

“My baby was born perfectly healthy at 39 weeks. ...We exclusively breastfeed. ... New moms should be told during pregnancy that breastfeeding is not easy at first. It took 5 weeks of issues before my baby and I figured out how to do it correctly. It was awful. It was painful. She wouldn't latch correctly. I had oversupply. She had thrush. It was miserable. I wanted to quit but I felt guilty about wanting to quit. I had a lot of support. I talked to a lactation consultant. It got better. Now we have it figured out and are doing great, but in the beginning I almost quit. I'm glad I didn't.”

References

1. Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies. Atlanta: U.S. Department of Health and Human Services; 2013. Available online at <https://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF>. Accessed November 8, 2018.
2. U.S. Department of Health and Human Services. Your Guide to Breastfeeding. Office on Women's Health, 2011.
3. Centers for Disease Control and Prevention. Safe Sleep for Babies. Updated January 2018. Available online at <https://www.cdc.gov/vitalsigns/safesleep/index.html>. Accessed November 8, 2018.

Infant Care

Data Highlights

- Less than 2% of Alaska women who deliver a newborn are not living with the infant they gave birth to. This did not differ significantly by maternal age.
- The percent of all Alaska women initiating breastfeeding had a small but significant increase from 92.9% in 2009 to 95.5% in 2016. The increasing trend was statistically significant among women 25 years or older but only neared significance among women less than 25 years old.
- Alaska's 8-week breastfeeding rate of 83% far exceeds the U.S. comparison at 66%. Even the demographic groups that have lower rates in Alaska (<25 years, Alaska Native or races other than White, or lower FPL) all exceed the overall U.S. value.
- Nearly two-thirds (64%) of Alaska women breastfed exclusively at 8 weeks postpartum in 2016.
- 79% of Alaska women most often placed their infant on his or her back to sleep. This differed significantly by maternal age, race and FPL status. Older women, White women and those not in poverty reported higher prevalences of this behavior.

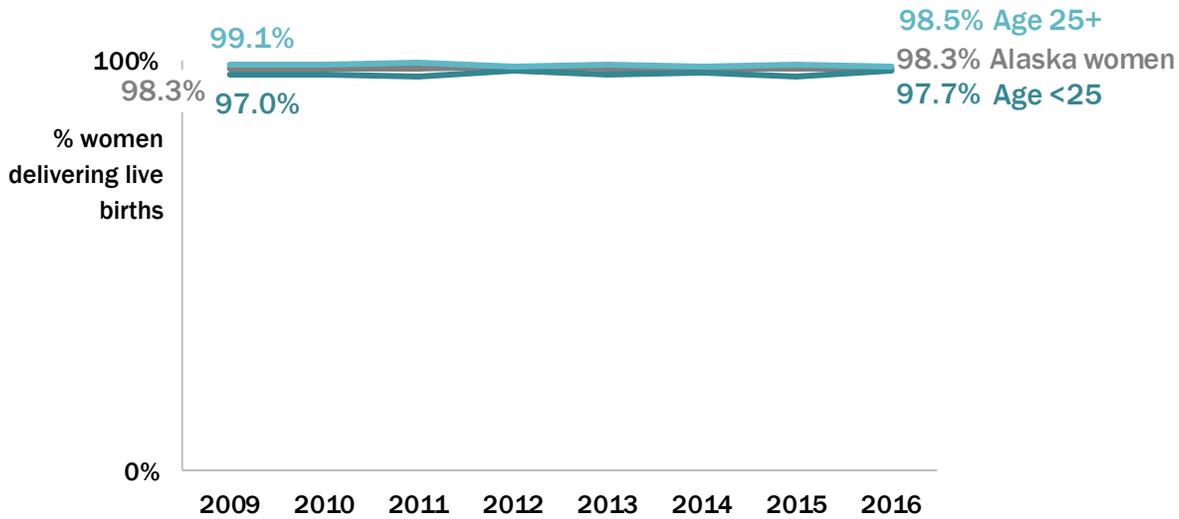
"I feel cosleeping is valuable, but parents should be taught to cosleep safely. This could be an important part of early infancy/parenting education."

"While breastfeeding is important in terms of nutritional benefit and even psychologically via connection between mother & child - there are other ways. I exclusively pump for our baby because of continuous latch issues. I'm a stay at home mom and pump 4-5 times a day to make sure my baby gets the benefits of breastmilk. I was only educated/pushed at times to breastfeed. I feel if more drs./lactation specialist educated/supported moms who have a pump right away - the breastmilk fed babies stats would increase..."

- In Alaska, 20% of infants born in 2016 slept alone in their own crib or bed (in the past 2 weeks). This ranged from 13% among residents of the Southwest region to 27% of residents of the Southeast region.

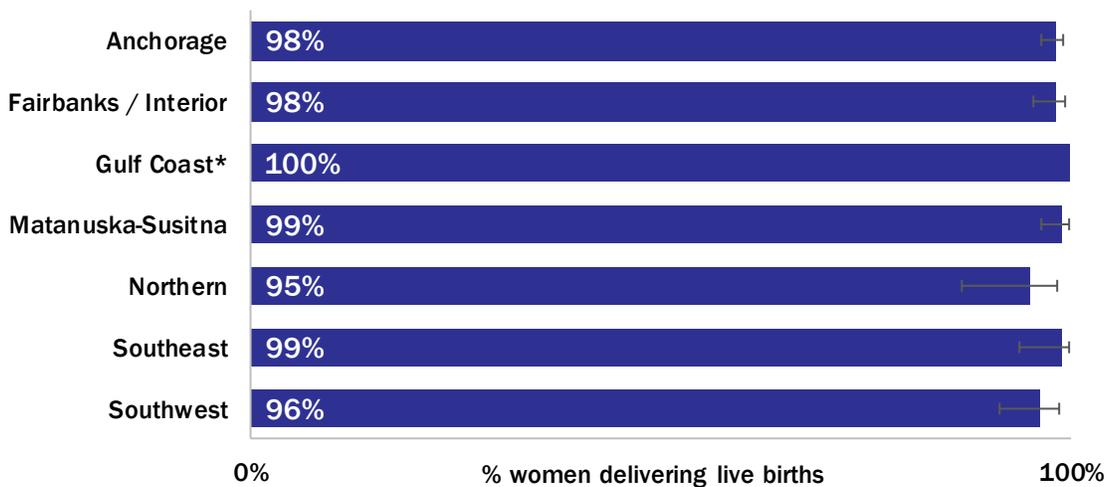
Infant Care

Figure 82. Infant living with the mother by maternal age, 2009-2016



Source: Alaska PRAMS

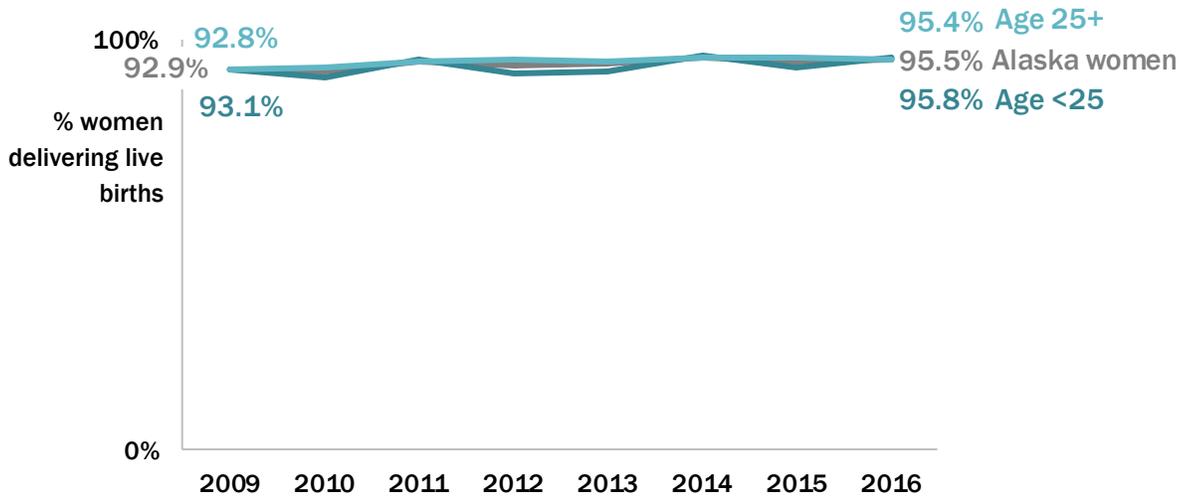
Figure 83. Infant living with the mother, by region, 2016



Source: Alaska PRAMS

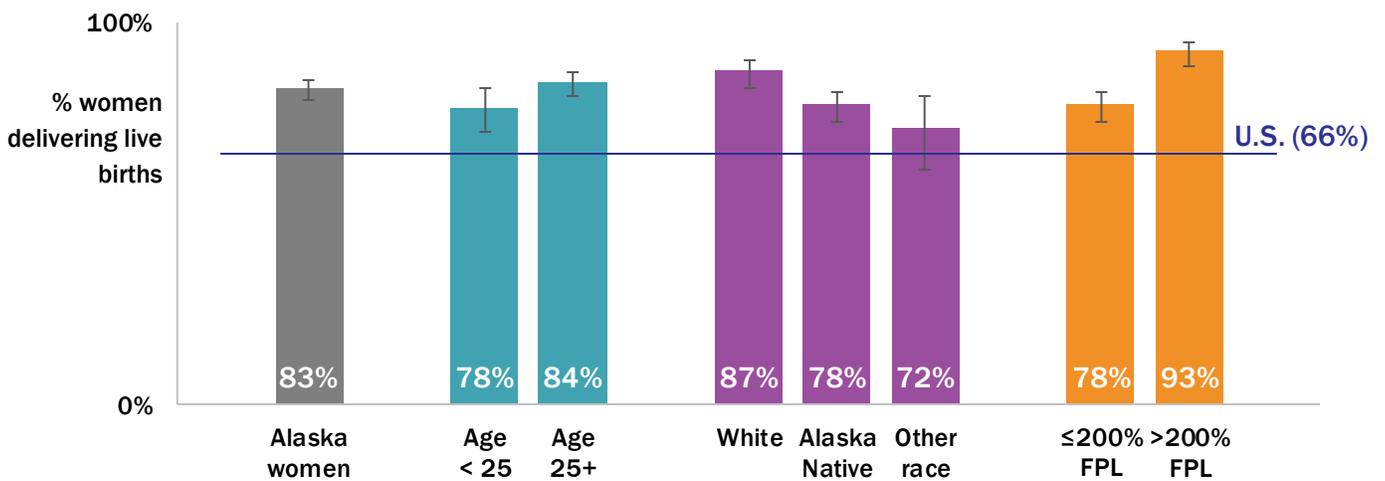
* Note: Confidence interval for Gulf Coast estimate could not be calculated due to sample distribution

Figure 84. Ever breastfed by maternal age, 2009-2016



Source: Alaska PRAMS

Figure 85. Any breastfeeding at 8 weeks, 2016



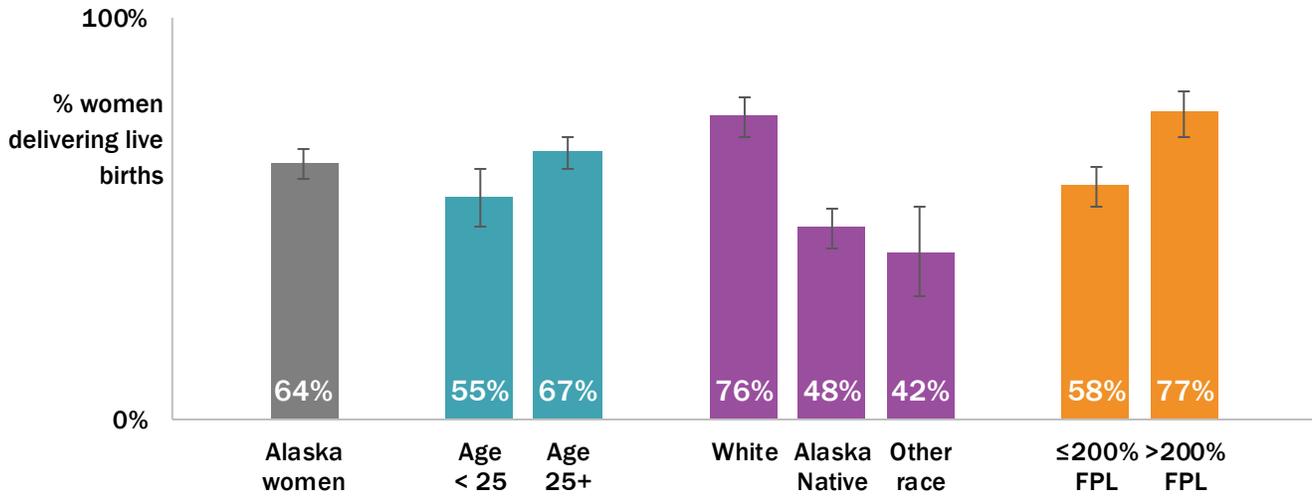
Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.

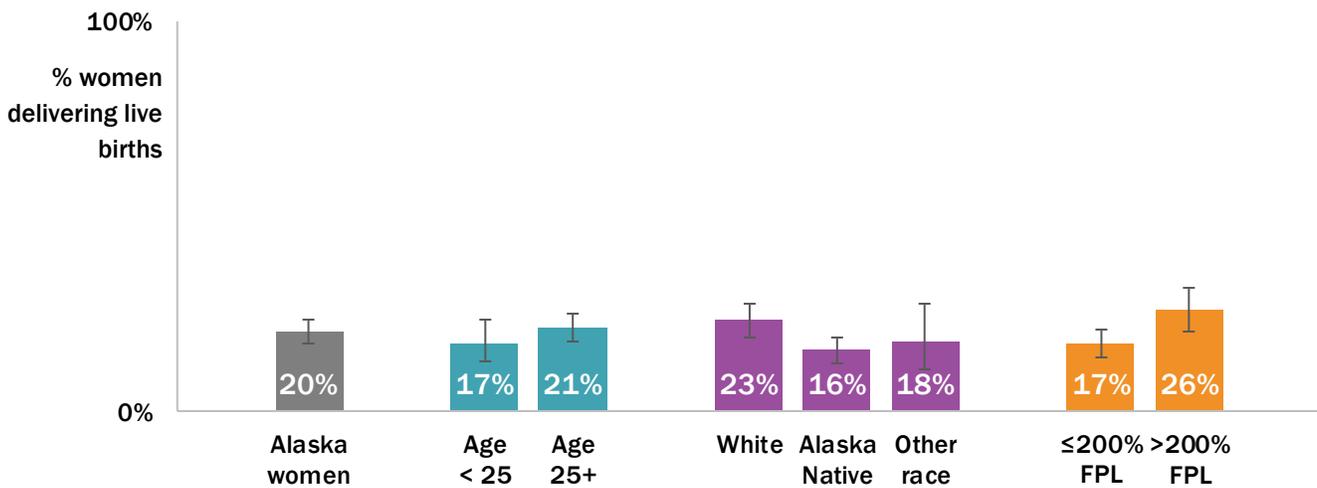
Infant Care

Figure 86. Exclusive breastfeeding at 8 weeks, 2016



Source: Alaska PRAMS
FPL = Federal Poverty Level

Figure 87. Infant always or often slept alone in the past 2 weeks in his or her own crib or bed*, 2016

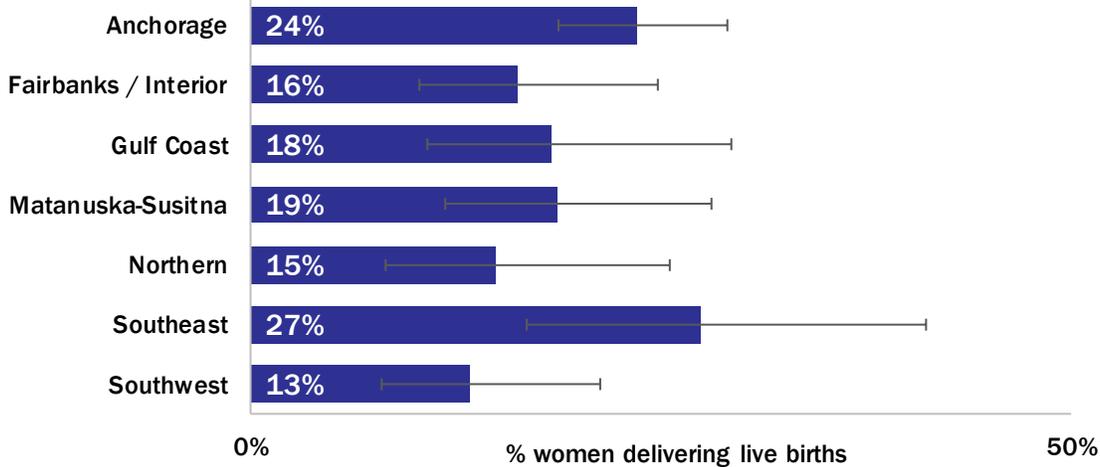


Source: Alaska PRAMS
FPL = Federal Poverty Level

* Defined as a 'Separate approved sleepsurface' that is not an adult mattress, couch, or car seat, for example.

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Figure 88. Infant always or often slept alone in the past 2 weeks in his or her own crib or bed*, by region, 2016

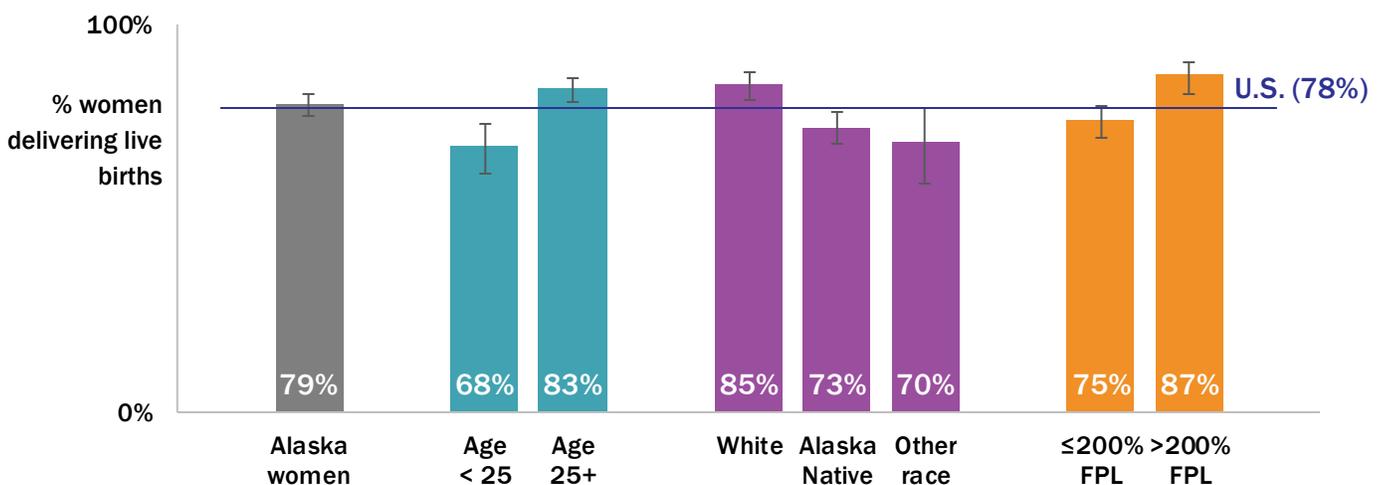


Source: Alaska PRAMS

* Defined as a 'Separate approved sleep surface' that is not an adult mattress, couch, or car seat, for example.

"...My baby and I co-sleep within a twin sized bed. I often carry my baby in a front carrier on my body. She often takes at least one nap in it per day..."

Figure 89. Infant most often placed on back to sleep, 2016



Source: Alaska PRAMS

FPL = Federal Poverty Level

Note: U.S. value is from 2015 and based on weighted mean % of 35 participating PRAMS programs meeting required response rate threshold set by CDC.



Appendix: Detailed Trend Data

Appendix

Chapter 1: Preconception Health

Any alcohol use the 3 months before getting pregnant

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	58.6	58.2	61.9	58.9	61.4	57.7	57.5	57.4	0.341	
% Age < 25	55.5	55.6	55.3	53.0	53.7	47.5	52.5	48.2	0.031 *	
% Age 25+	60.6	59.7	64.9	61.8	65.0	62.3	59.7	60.7	0.827	

Any binge drinking in the 3 months before getting pregnant

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	29.1	26.8	26.1	21.9	19.8	16.2	18.8	17.6	< 0.001 **	
% Age < 25	34.4	31.6	28.3	24.5	24.2	18.1	21.9	22.2	< 0.001 **	
% Age 25+	25.9	24.1	25.1	20.6	17.8	15.3	17.4	15.9	< 0.001 **	

Moved to a new address

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	38.1	37.5	37.2	37.0	37.7	39.5	40.8	36.5	0.581	
% Age < 25	49.3	46.9	42.8	48.2	50.3	53.8	53.2	48.7	0.125	
% Age 25+	31.2	32.1	34.7	31.5	31.9	33.0	35.3	32.2	0.526	

Chapter 2: Prenatal Health

Cigarette smoking in last 3 months of pregnancy

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	15.3	16.8	13.8	13.1	13.4	13.0	11.4	11.0	< 0.001 **	
% Age < 25	18.4	26.9	21.7	18.4	17.2	18.4	15.8	15.5	0.004 **	
% Age 25+	13.4	10.9	10.3	10.6	11.6	10.5	9.5	9.5	0.036 *	

Smokeless tobacco use during pregnancy

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	4.6	4.7	4.5	5.4	5.1	4.5	5.3	4.7	0.611	
% Age < 25	6.3	7.3	6.9	6.3	8.5	7.8	8.7	7.9	0.125	
% Age 25+	3.6	3.2	3.4	5.0	3.6	3.1	3.8	3.6	0.961	

* p value for trend is statistically significant at the 0.05 level

** p value for trend is statistically significant at the 0.01 level

Appendix

Any alcohol use in the last 3 months of pregnancy

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	5.6	7.0	6.7	6.6	7.8	6.4	6.8	4.2	0.330	
% Age < 25	3.1	3.4	4.3	4.0	3.4	1.4	4.0	1.6	0.237	
% Age 25+	7.2	9.1	7.9	7.9	9.8	8.6	8.0	5.1	0.246	

Marijuana use during pregnancy

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	7.1	6.3	7.8	4.9	6.3	5.4	6.4	7.1	0.647	
% Age < 25	12.3	10.1	11.6	7.6	10.9	7.0	9.9	10.6	0.281	
% Age 25+	3.9	4.1	6.1	3.5	4.2	4.5	4.9	5.9	0.206	

Prenatal health care worker advised me not to drink alcohol while pregnant

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	79.5	81.8	79.9	81.9	76.0	80.8	78.8	90.0	0.002 **	
% Age < 25	86.9	87.2	90.4	89.2	79.0	85.6	80.7	94.2	0.572	
% Age 25+	74.8	78.7	75.2	78.3	74.6	78.6	78.0	88.5	< 0.001 **	

Enrollment in WIC during pregnancy

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	48.2	49.2	47.7	44.5	43.8	39.4	41.7	37.7	< 0.001 **	
% Age < 25	68.0	67.5	68.2	61.5	67.9	57.2	62.6	58.4	0.003 **	
% Age 25+	35.9	38.7	38.4	36.1	32.9	31.4	32.5	30.4	< 0.001 **	

Chapter 3: Maternal Health

Current smokers with plans to stop smoking cigarettes

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	77.3	70.6	73.2	78.7	74.3	70.0	75.8	75.1	0.972	
% Age < 25	77.9	64.1	67.5	74.9	76.1	63.9	79.3	68.9 [^]	0.830	
% Age 25+	76.6	79.0	78.5	82.8	72.8	75.4	73.1	77.5	0.471	

[^] Data may be unreliable. Number of respondents was at least 30 but less than 60.

* p value for trend is statistically significant at the 0.05 level

** p value for trend is statistically significant at the 0.01 level

Appendix

Postpartum contraceptive use

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	83.5	79.8	81.8	79.3	79.5	80.9	77.5	81.6	0.127	
% Age < 25	81.5	78.6	80.2	80.1	80.3	79.4	79.2	77.1	0.388	
% Age 25+	84.7	80.5	82.4	78.9	79.2	81.6	76.8	83.2	0.173	

Chapter 4: Infant Care

Infant currently living with mother

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	98.3	98.3	98.4	98.5	98.4	98.0	98.2	98.3	0.639	
% Age < 25	97.0	97.0	96.2	97.8	97.0	97.1	96.2	97.7	0.828	
% Age 25+	99.1	99.1	99.5	98.8	99.1	98.6	99.0	98.5	0.094	

Ever breastfed

	2009	2010	2011	2012	2013	2014	2015	2016	p-value for trend	Sparkline
% Alaska women	92.9	92.6	94.8	94.0	94.2	96.0	95.0	95.5	0.003 **	
% Age < 25	93.1	91.0	95.2	91.7	92.6	96.5	93.6	95.8	0.079	
% Age 25+	92.8	93.5	94.7	95.2	94.8	95.7	95.7	95.4	0.024 *	

Data Note on Trend Analyses

Tests for linear trend for each indicator were completed using logistic regression. We utilized "svy: logistic" in Stata version 15 to test for linear trend at the 95% confidence level. P values $\leq .05$ are considered to be statistically significant.

* p value for trend is statistically significant at the 0.05 level

** p value for trend is statistically significant at the 0.01 level

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