

Prenatal Health



Medicaid Coverage

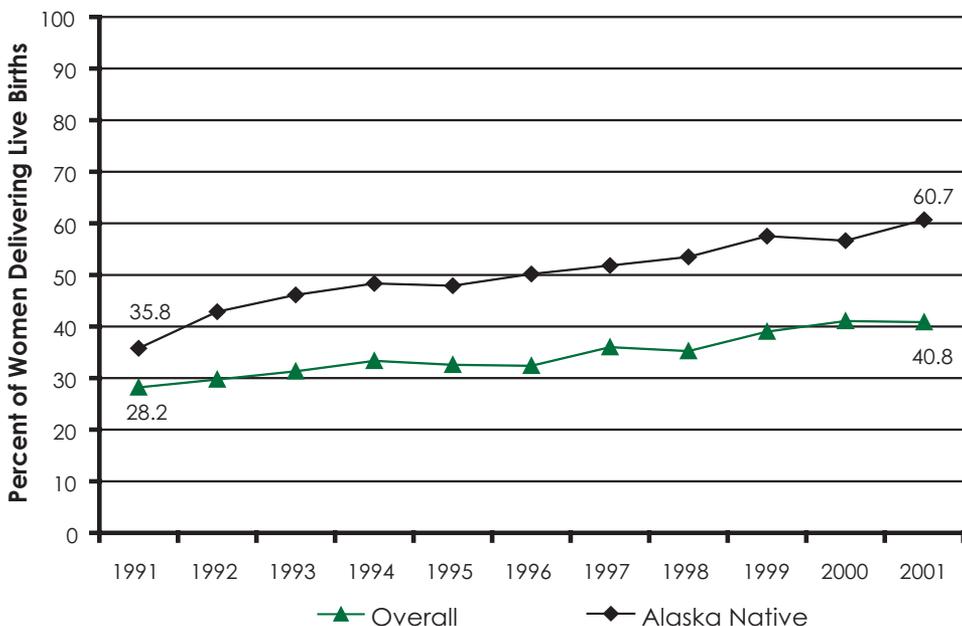
Medicaid is the health insurance program for the poor in the United States. During the 1980s, the U.S. Congress authorized states to expand Medicaid to include pregnant women who were formerly ineligible for Medicaid Services. The Children's Health Insurance Program for the State of Alaska, Denali KidCare, was implemented on March 1, 1999 and represented the biggest expansion of the Medicaid program in Alaska. In addition to expanding eligibility for children's health services, Denali KidCare expanded coverage to pregnant women. These changes resulted in a state health insurance program that covered not only low income – but moderate income – women in an effort to improve prenatal care and ultimately, adverse pregnancy outcomes.

- Medicaid coverage of prenatal care in Alaska has been steadily increasing over the past decade. Almost 41% of women who delivered a live birth in 2001 indicated that Medicaid had paid for at least some of their prenatal care.
- Between 1993 and 1999, Alaska was the only PRAMS state to demonstrate a statistically significant increase in the proportion of women who delivered a live birth who received Medicaid coverage during their pregnancy.¹ During the same time period, six states showed a statistically significant decrease in prenatal Medicaid coverage.
- Between 1991 and 2001, the prevalence of Medicaid coverage for prenatal care was consistently higher for Alaska Native women than for Alaskan women overall.
- Reported prenatal Medicaid coverage does not appear to be correlated geographically with the prevalence of pregnancy risk factors. For example, between the two regions with consistently higher prevalences of pregnancy risk behaviors, the Southwest had the highest (68.8%), and the Northern region had the second lowest prevalence (36.4%) of Medicaid coverage for pregnancy and childbirth.

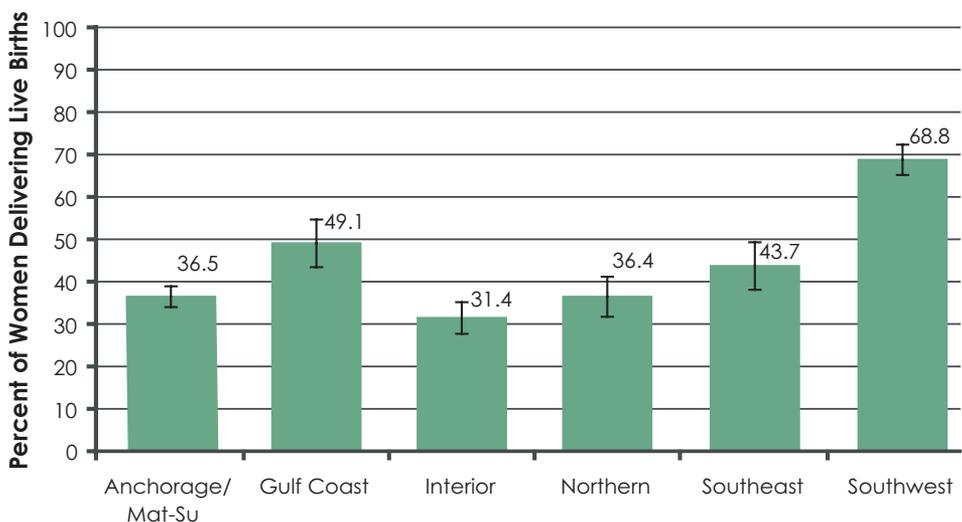
¹ PRAMS 1999 Surveillance Report. (See References for full citation)

Prenatal Health: Protective Behaviors

Medicaid Coverage for Prenatal Care by Race and Year
Alaska, 1991-2001



Medicaid Coverage for Prenatal Care by Region
Alaska, 1999-2001



Medicaid Coverage

An important outcome of the Medicaid expansion effort has been a reduction of the number of uninsured deliveries in the United States. Improvement in important indicators of prenatal health, such as early entry into prenatal care, participation in support services, and the number of providers serving low income women, have also been documented.¹ Across the country, state budget cutting policies implemented in 2003-2004 have resulted in reduced expenditures in Medicaid and other health insurance programs, including the State Children's Health Insurance Program (Alaska's Denali KidCare). Effective in 2004, Alaska reduced the eligibility limit from 200% of the poverty level to 175% and removed the inflation adjustment in the income limit. The result is that the eligibility level will fall below 175% of the poverty line in the future. Comparison of annual PRAMS data will help Alaska define impacts of Medicaid budget cuts to pregnant women.

- Alaska Natives were the most likely race group to use Medicaid to help pay for the medical costs of pregnancy (60.7%). White women were the least likely race group to use Medicaid, but Medicaid usage is still high in this group with over one-third of white women who delivered a live birth reporting that they used Medicaid to pay for at least some of the costs of their most recent pregnancy.
- The youngest Alaskan mothers were the most likely to use Medicaid, with well over half (67.2%) of teenagers and 49.3% of 20-24 year olds relying on Medicaid to help pay for their prenatal care and delivery. Almost one quarter of older mothers (ages 35 or older) used Medicaid as their insurance.
- Over one quarter (25.5%) of Alaskan women with more than a high school education used Medicaid to help pay for their prenatal care and delivery.

¹ PRAMS 1999 Surveillance Report. (See References for full citation)

Prenatal Health: Protective Behaviors

Prevalence of Medicaid Coverage for Prenatal Care by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	33.0	1999	1.9	(29.3 - 36.8)
Alaska Native	60.7	1420	1.7	(57.3 - 64.0)
Black	42.8 *	183	8.1	(27.0 - 58.6)
Asian or Pacific Islander	36.8	196	6.7	(23.7 - 49.9)
Maternal Ethnicity				
Hispanic	41.4	231	6.5	(28.8 - 54.0)
Non-Hispanic	39.5	3216	1.5	(36.5 - 42.5)
Maternal Age				
15-19 years	67.2	626	3.9	(59.5 - 74.9)
20-24 years	49.3	1311	2.8	(43.9 - 54.7)
25-34 years	35.0	1666	2.0	(31.1 - 38.8)
35 years or older	23.5	266	3.3	(17.1 - 30.0)
Maternal Education				
<12 years	72.3	771	3.2	(66.0 - 78.6)
12 years	46.7	1900	2.2	(42.5 - 51.0)
>12 years	25.5	1026	2.1	(21.4 - 29.5)
OVERALL	40.8	3877	1.4	(38.1 - 43.6)

% Missing = 0.4

Core; Q21

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

WIC Participation

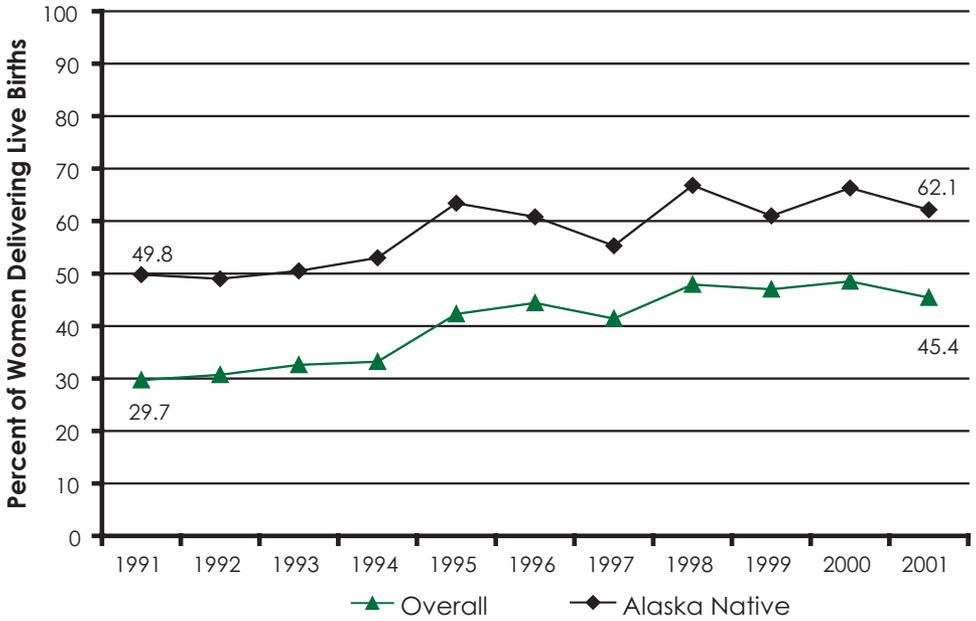
Many low-income families in the State of Alaska receive nutritional support through the Supplemental Nutrition Program for Women, Infants and Children (WIC). WIC provides nutrition counseling, monthly dietary supplementation, food vouchers, growth assessments, and referrals to eligible women and children from birth to 5 years of age. Low income pregnant, postpartum and lactating women are eligible for WIC and qualifying women make up about a quarter of WIC participants nationally.

- Forty-five percent of Alaskan women who had a baby during 2001 indicated that they used WIC services prenatally. While generally showing an increasing trend since 1991, prenatal WIC participation in Alaska appears to have leveled off since 1998 when participation reached 47.9%.
- Between 1993 and 1999, Alaska was one of two PRAMS states to show a statistically significant increase in prenatal WIC participation. In 1999, Alaska's prevalence of prenatal WIC participation (47.0%) ranked at the median level among 17 PRAMS states (range: 29.8% - 58.3%).¹
- A majority (62.1%) of Alaska Native women who delivered in 2001 participated in prenatal WIC nutritional services. Alaska Natives have consistently shown higher levels of prenatal WIC participation.
- A slightly larger proportion of Alaskan women who had recently had a baby used WIC during their pregnancy than used Medicaid. Unlike Medicaid coverage for prenatal care, prenatal WIC participation appears to correlate geographically with a higher regional prevalence of pregnancy risk factors (as seen in the Northern and Southwest regions).
- Women from the Southeast region were least likely to participate in WIC prenatally, yet the participation level was still high – almost 40% of Southeast resident women who delivered a baby between 1999 and 2001.

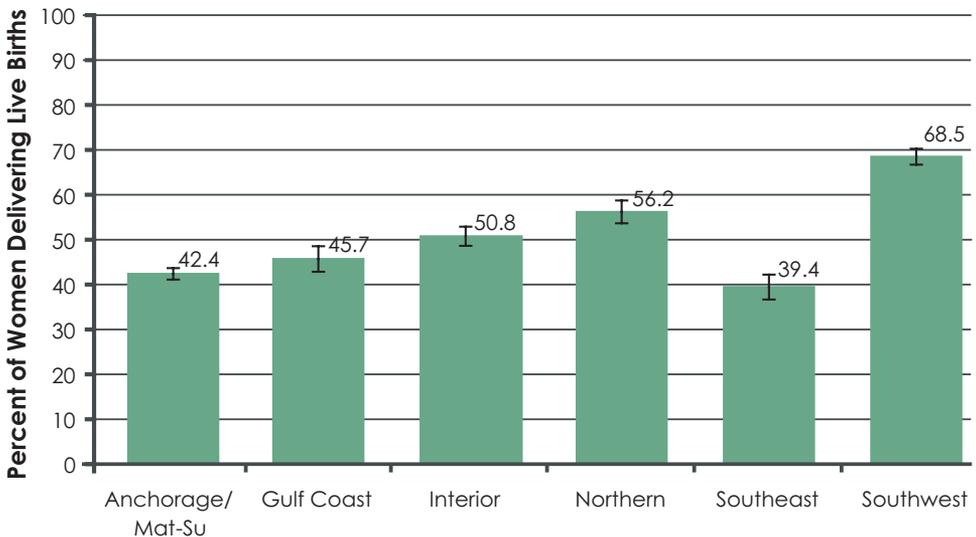
¹ PRAMS 1999 Surveillance Report. (See References for full citation)

Prenatal Health: Protective Behaviors

Prenatal WIC Participation by Race and Year
Alaska, 1991-2001



Prenatal WIC Participation by Region
Alaska, 1999-2001



WIC Participation

WIC promotes breastfeeding, immunization and good nutrition, and refers women to appropriate medical and social services. PRAMS data may be helpful in examining the characteristics of WIC participants, identifying target groups for educational interventions and for looking at the prevalence of important behaviors and pregnancy risks by prenatal WIC participation status.

- The majority of Alaska Native and black women who delivered a live birth in 2001 participated in WIC during their pregnancy (62.1% and 69.1%, respectively). Over one-third of white women and Asian or Pacific Islander women who delivered a live birth in 2001 participated in WIC. More Hispanic women than non-Hispanics participated in WIC prenatally.
- Younger mothers were far more likely than older mothers to participate in WIC during pregnancy. Teenage mothers were 3 times as likely to use WIC services than mothers ages 35 or older and nearly twice as likely to use WIC services as mothers ages 25 or older.
- WIC is an important source of prenatal assistance for Alaskan mothers. In 2001, almost three-quarters of Alaskan mothers with less than 12 years of education participated in WIC prenatally. While prenatal WIC participation declined as education levels increased, almost one-third of women with more than 12 years of education participated in WIC prenatally.
- Over one-quarter of mothers who did not use Medicaid to help pay for their prenatal care in 2001 participated in WIC during their pregnancy.

Prenatal Health: Protective Behaviors

Prevalence of Prenatal WIC Participation by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	37.7	2278	2.0	(33.8 - 41.6)
Alaska Native	62.1	1476	1.7	(58.8 - 65.4)
Black	69.1 *	295	7.5	(54.5 - 83.7)
Asian or Pacific Islander	37.5	210	6.5	(24.7 - 50.3)
Maternal Ethnicity				
Hispanic	53.1	292	6.6	(40.1 - 66.1)
Non-Hispanic	44.2	3612	1.6	(41.1 - 47.2)
Maternal Age				
15-19 years	65.6	622	4.0	(57.7 - 73.4)
20-24 years	63.2	1681	2.7	(58.0 - 68.4)
25-34 years	37.1	1765	2.0	(33.1 - 41.0)
35 years or older	22.0	256	3.1	(15.9 - 28.0)
Maternal Education				
<12 years	73.3	775	3.0	(67.4 - 79.2)
12 years	52.6	2159	2.2	(48.3 - 56.8)
>12 years	30.6	1236	2.2	(26.3 - 35.0)
Prenatal Medicaid Status				
Medicaid	73.4	2830	1.9	(69.6 - 77.1)
Non-Medicaid	26.5	1472	1.7	(23.1 - 29.8)
OVERALL	45.4	4333	1.4	(42.6 - 48.2)

% Missing = 0.9

Core; Q24

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

Folic Acid Knowledge

The B vitamin folic acid plays an important role in the prevention of serious birth defects that affect the developing infant's spine and nervous system. Research has shown that 50% to 70% of these neural tube birth defects (NTDs) could be prevented if all women of childbearing age consumed adequate amounts of folic acid. In 1992 the U.S. Centers for Disease Control and Prevention issued the recommendation that all women consume at least 400 micrograms of folic acid daily.¹ Since then, numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation. Alaska's Folic Acid Coalition² has promoted folic acid awareness through the "Folic Acid for a Healthy Return" campaign since 1999. During 1996 through 2000, an average of nine Alaskan babies were born annually with NTDs that might have been prevented by taking folic acid.³

- Folic acid knowledge among Alaskan mothers is increasing. The proportion of women who indicated that they knew about the benefits of folic acid increased from 63.0% in 1996 to 80.5% in 2001.
- The proportion of Alaska Native mothers who knew about the benefits of folic acid increased by 60% between 1996 and 2001. While the prevalence of folic acid knowledge among Alaska Native mothers of newborns was still substantially lower than overall levels, the gap in knowledge between Alaska Natives and Alaskan mothers overall appears to be closing.
- Women in the Northern and Southwest regions of Alaska were the least likely to know about the benefits of folic acid; however, folic acid knowledge was high in other regions of the state. Among women who had a baby in 2001, over 80% of women in Anchorage/Mat-Su, the Gulf Coast, Interior and Southeast regions knew about folic acid benefits.

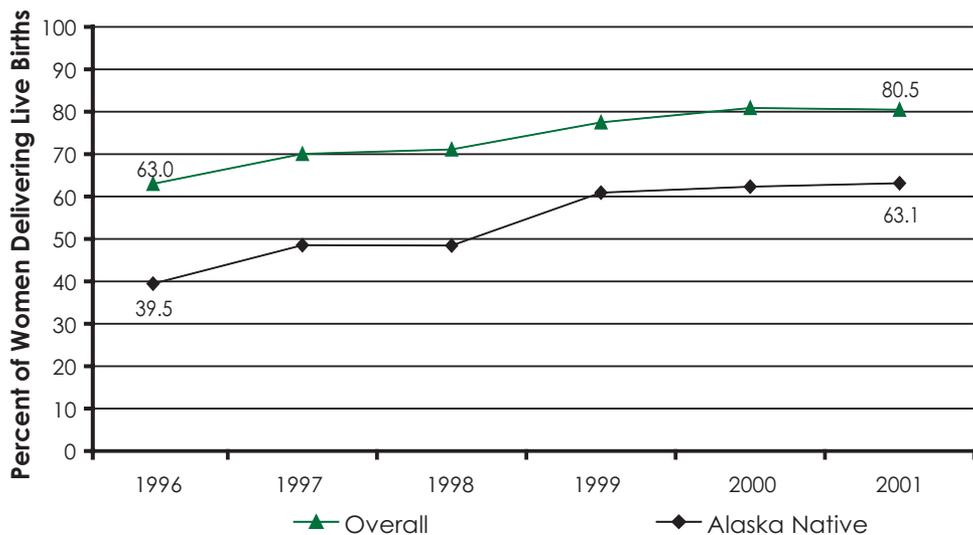
¹ Acuna J, Yoon P, Ericson D. The Prevention of Neural Tube Defects with Folic Acid. Centers for Disease Control and Prevention and Pan American Health Organization. Sep 2003. <http://www.cdc.gov/doc.do/id/0900f3ec8001946f>.

² March of Dimes, Alaska Chapter. Folic Acid for a Healthy Return. http://www.modimes.org/alaska/4908_8520.asp. (10/2004).

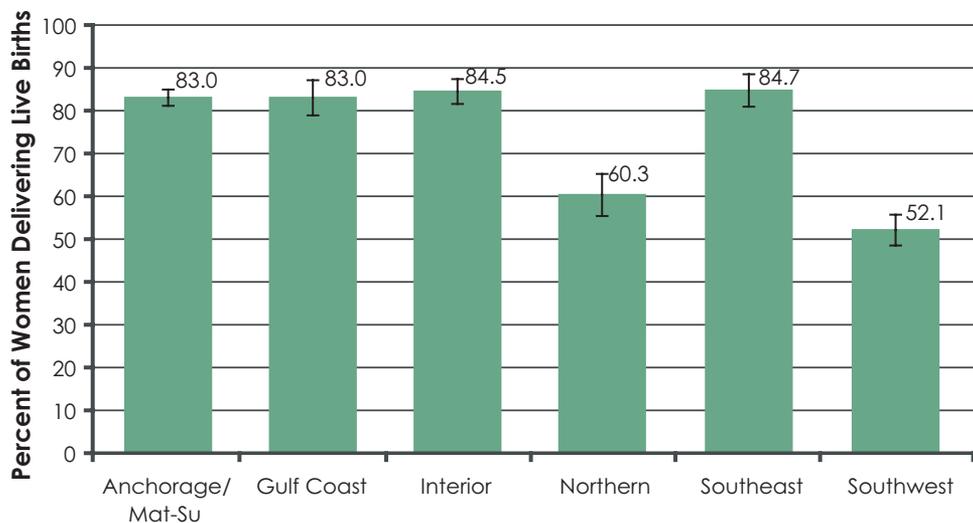
³ State of Alaska, Department of Health and Social Services, Division of Public Health. MCH Epidemiology Website. Healthy Alaskans 2010. Objectives for Maternal and Child Health. Reduce the Occurrence of Spina Bifida and Other Neural Tube Defects. <http://www.epi.hss.state.ak.us/mchepi/indicators/ha2010/mch/update/obj11615.htm>. (10/2004).

Prenatal Health: Protective Behaviors

Knowledge of Folic Acid Benefits by Race and Year Alaska, 1996-2001



Knowledge of Folic Acid Benefits by Region Alaska, 1999-2001



Folic Acid Knowledge

Because the developing infant's spine and brain are already formed by the time most women realize they are pregnant, folic acid is most protective if women have adequate amounts in their systems before becoming pregnant. For this reason, and because up to half of pregnancies in the U.S. are not planned, women should take multivitamins even if they are not planning to become pregnant. In 1998, mandatory fortification of cereal products was implemented in the United States. Studies have shown a subsequent decline in the annual number of births affected by neural tube defects (NTDs). To reduce further the number of NTD-affected pregnancies, all women capable of becoming pregnant should follow the U.S. Public Health Service recommendation to consume 400 micrograms of folic acid daily.¹

- In 2001, knowledge about the benefits of folic acid was highest among white mothers (89.9%) and lowest among Asian or Pacific Islander mothers (59.6%). Just over 63% of Alaska Native mothers were knowledgeable about folic acid benefits.
- The older the mother, the more likely she was to know about the benefits of folic acid. Over 80% of mothers over age 25 knew about folic acid benefits compared to just over half of teenage mothers.
- Alaskan mothers with more than a high school education and women who used non-Medicaid sources to pay for their pregnancy costs were more likely to know about the benefits of folic acid.
- According to a survey conducted by the Alaska Birth Defects Registry, 41% of Alaskan women hear about folic acid from their doctor or other health care provider, but more women (70%) report hearing about folic acid benefits from a newspaper or magazine.²
- National data shows that although 88% of women report that they would take a multivitamin if it were recommended by their health care provider, only 37% report that their current health care provider made this recommendation to them.¹

¹ Center for Disease Control and Prevention. Spina Bifida and Anencephaly Before and After Folic Acid Mandate – United States, 1995-1996 and 1999-2000. MMWR; 53(17): 362-365. May 2004. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5317a3.htm>.

² State of Alaska, Department of Health and Social Services, Maternal and Child Health Epidemiology. Folic Acid Knowledge and Use in Alaska. Alaska MCH Facts: Women's Health 1(2). Aug 2002. <http://www.epi.alaska.gov/mchepi/MCHFacts/Vol1No2.pdf>.

Prenatal Health: Protective Behaviors

Prevalence of Knowledge of Folic Acid Benefits by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	89.9	5399	1.2	(87.5 - 92.3)
Alaska Native	63.1	1477	1.7	(59.8 - 66.4)
Black	67.4 *	286	7.7	(52.3 - 82.4)
Asian or Pacific Islander	59.6	311	6.9	(46.0 - 73.1)
Maternal Ethnicity				
Hispanic	76.7	419	5.6	(65.8 - 87.6)
Non-Hispanic	81.5	6585	1.2	(79.3 - 83.8)
Maternal Age				
15-19 years	55.7	519	4.1	(47.6 - 63.8)
20-24 years	77.2	2038	2.2	(72.9 - 81.5)
25-34 years	85.9	4056	1.3	(83.2 - 88.5)
35 years or older	86.0	970	2.5	(81.0 - 90.9)
Maternal Education				
<12 years	55.3	585	3.6	(48.3 - 62.4)
12 years	76.2	3081	1.7	(72.8 - 79.6)
>12 years	91.8	3659	1.3	(89.2 - 94.3)
Prenatal Medicaid Status				
Medicaid	73.9	2816	1.8	(70.3 - 77.4)
Non-Medicaid	85.7	4720	1.3	(83.1 - 88.2)
OVERALL	80.5	7592	1.1	(78.4 - 82.6)

% Missing = 2.0

State-specific; Q23

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

Physical Abuse by Husband/Partner

Domestic violence is a serious public health concern for Alaskans. The relevance of PRAMS data on intimate partner abuse during pregnancy is emphasized by a 2004 report published by the Violence Policy Center that puts Alaska ahead of all other states in the rate at which men kill women.¹ Current or former intimate partners committed over half of these homicides. Among 17 states who participated in PRAMS in 1999, the prevalence of prenatal physical abuse by a husband or partner ranged from 2.1% to 6.3%. No significant trends were noted for any of the reporting states between 1991 and 1999.²

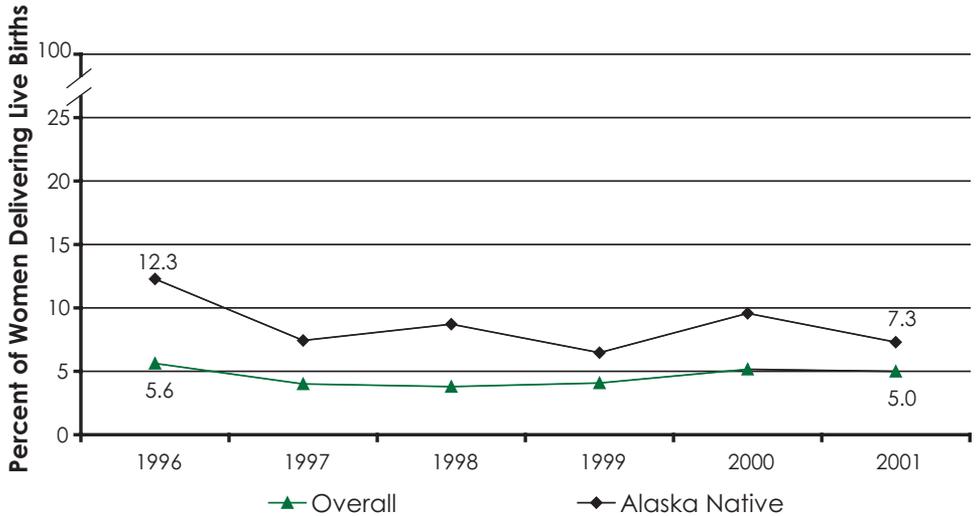
- Overall, 5.0% of Alaskan women reported physical abuse by an intimate partner during their most recent pregnancy in 2001. While the overall prevalence has remained relatively stable since 1996, prenatal physical abuse declined by 41% for Alaska Natives between 1996 and 2001.
- Women were more likely to have reported prenatal physical abuse by a husband or partner if they were from the Northern or Southwest regions. The Interior region reported the lowest prevalence (3.8%).
- Based on PRAMS data, intimate partner physical abuse against pregnant women appears to be far less common than pre-pregnancy abuse. The proportion of Alaskan women who experienced physical abuse by anyone in the 12 months prior to pregnancy was 80% higher than the proportion of new mothers who reported prenatal intimate partner abuse in 2001.

¹ Anchorage Daily News. State No. 1 in Rate of Women Killed by Men. Front page. October 5, 2004.

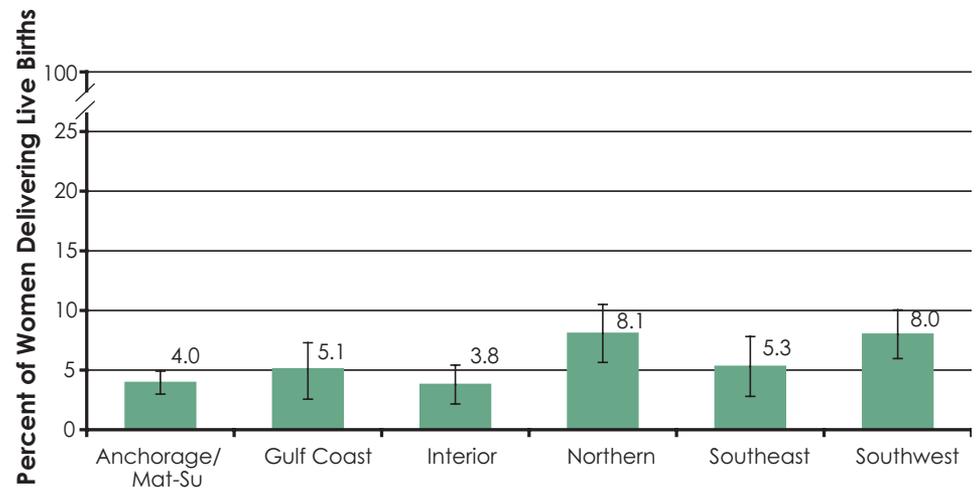
² PRAMS 1999 Surveillance Report. (See References for full citation)

Prenatal Health: Risk Behaviors

Prenatal Physical Abuse by Husband/Partner by Race and Year, Alaska, 1996-2001



Prenatal Physical Abuse by Husband/Partner by Region Alaska, 1999-2001



Physical Abuse by Husband/Partner

Physical abuse during pregnancy puts women at risk for fetal loss and injury, early onset of labor, preterm delivery, having a low birth weight infant, maternal antepartum hemorrhage, and rupture of the uterus. Prenatal abuse has also been associated with late entry into prenatal care and other risk behaviors such as smoking and substance abuse during pregnancy.^{1,2} Prevention of intimate partner violence may depend on effective screening and referral by a broad-based coalition of health, social and law enforcement services as well as improved accessibility and availability of specialized treatment.

- All race groups were at risk for experiencing physical abuse by an intimate partner during pregnancy, but blacks and Alaska Natives appeared to be at higher risk than whites or Asian or Pacific Islanders.
- Many studies have addressed the higher risk of prenatal physical abuse for teenage mothers.² In 2001, the prevalence of intimate partner prenatal physical abuse for Alaskan teenage mothers was 2 times that of 25-34 year olds and 4 times that of mothers ages 35 or older.
- Although physical abuse occurs in all economic classes, indicators of lower socio-economic status are associated with higher rates of physical violence.¹ In Alaska, both maternal education and prenatal Medicaid status were associated with prenatal abuse.
- In 2001, the prevalence of prenatal physical abuse among women who used Medicaid to help pay for their pregnancies was 3 times that of non-Medicaid recipients.

¹ PRAMS 1999 Surveillance Report. (See References for full citation)

² Gessner BD, Perham Hester KA. Experience of Violence Among Teenage Mothers in Alaska. *Journal of Adolescent Health*; 22(5):383-388. May 1998.

Prenatal Health: Risk Behaviors

Prevalence of Prenatal Physical Abuse by Husband/Partner by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	3.2	194	0.7	(1.8 - 4.6)
Alaska Native	7.3	172	0.9	(5.5 - 9.1)
Black	19.1*	81	6.5	(6.3 - 31.8)
Asian or Pacific Islander	2.6	15	2.2	(0.0 - 7.0)
Maternal Ethnicity				
Hispanic	7.5	41	3.8	(0.0 - 15.0)
Non-Hispanic	4.9	398	0.7	(3.6 - 6.2)
Maternal Age				
15-19 years	8.2	76	2.4	(3.4 - 13.0)
20-24 years	7.0	187	1.4	(4.3 - 9.6)
25-34 years	4.0	193	0.8	(2.4 - 5.6)
35 years or older	1.8	20	1.0	(0.0 - 3.8)
Maternal Education				
<12 years	7.6	81	2.1	(3.5 - 11.8)
12 years	5.8	237	1.0	(3.8 - 7.7)
>12 years	3.5	143	0.9	(1.8 - 5.2)
Prenatal Medicaid Status				
Medicaid	8.4	323	1.3	(5.9 - 10.9)
Non-Medicaid	2.7	150	0.6	(1.6 - 3.8)
OVERALL	5.0	477	0.6	(3.8 - 6.2)

% Missing = 0.7

Core; Q36a

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

Prenatal Alcohol Use

According to a recent national survey, 9.1% of pregnant women in the United States drank alcohol in the past month and 5.3% drank during the last trimester of pregnancy.¹ In 2001, the overall prevalence in Alaska was not significantly different from the nation – with 5.2% of Alaskan women drinking during the last three months of their most recent pregnancy. From 1993-1999, Alaska was one of seven PRAMS states to experience a significant decline in prenatal alcohol use.² For the Alaska PRAMS data presented here, prenatal alcohol use is limited to the last three months of pregnancy.

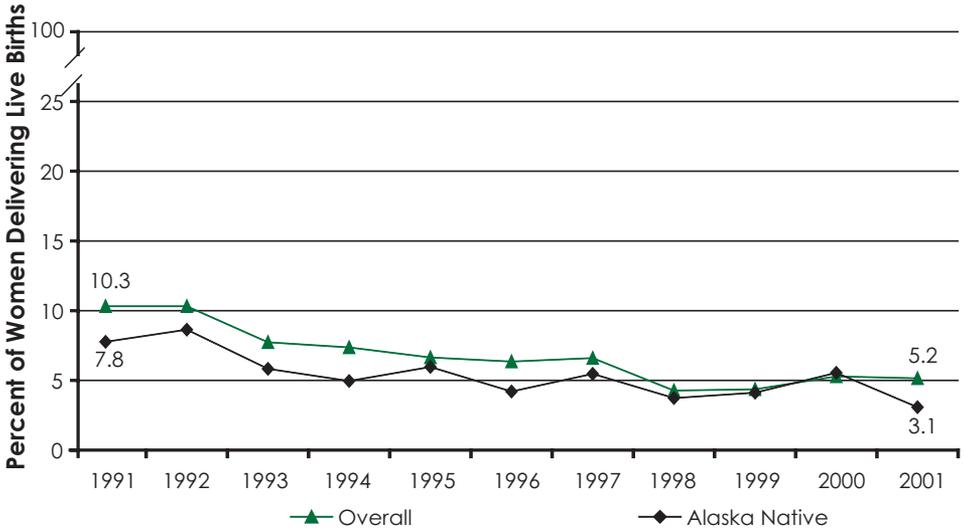
- Over the last decade, there has been a significant decline in prenatal alcohol use in Alaska. Since 1998, prenatal alcohol use in Alaska has remained lower than the Healthy People 2010 target of reducing prenatal alcohol use to less than 6%. The overall prevalence of prenatal alcohol use in Alaska has not yet met the Healthy Alaskan 2010 target of 3.5%, however, Alaska Native mothers achieved this goal in 2001.
- The prevalence of prenatal alcohol use among Alaska Native mothers has significantly declined over the last decade – a decrease of more than 60% from 1991 to 2001 (7.8% to 3.1%, respectively).
- Analysis of regional data for 1999-2001 showed that there was no statistically significant difference in the prevalence of prenatal alcohol use between any of the Alaskan regions.
- The Southeast region had the lowest prevalence of prenatal alcohol use (2.5%) and the Northern region had the highest. At 5.9%, the prevalence of prenatal alcohol use in the Northern region still met the Healthy People 2010 target of 6%.

¹ National Survey on Drug Use and Health. (See References for full citation)

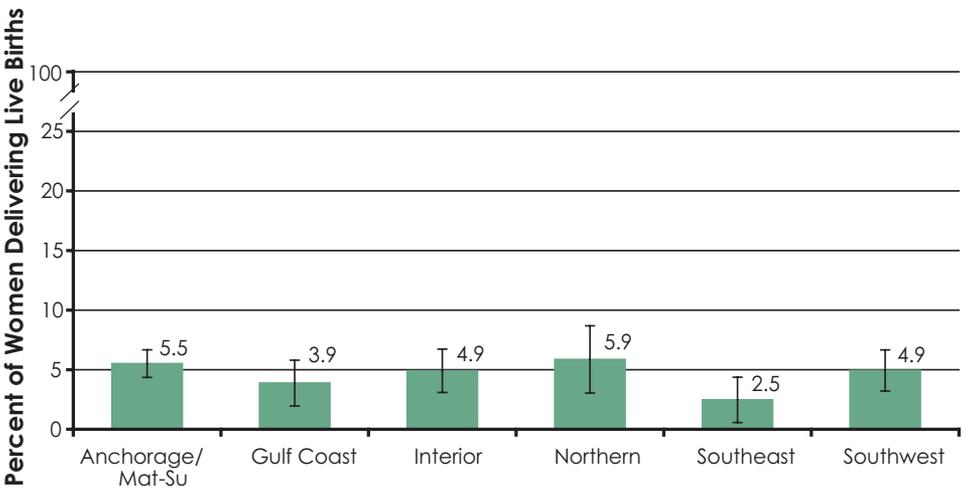
² PRAMS 1999 Surveillance Report. (See References for full citation)

Prenatal Health: Risk Behaviors

Any Prenatal Alcohol Use (last 3 months) by Race and Year, Alaska, 1991-2001



Any Prenatal Alcohol Use (last 3 months) by Region, Alaska, 1999-2001



Prenatal Alcohol Use

Prenatal alcohol use is linked to fetal death, low birth weight, growth abnormalities, developmental delays in children, and fetal alcohol syndrome (FAS).^{1,2} It is also the leading preventable cause of birth defects and mental retardation. PRAMS data can be used to better understand significant risk factors associated with prenatal alcohol use in Alaska and target prevention measures toward high-risk groups.

- In 2001, the prevalence of prenatal alcohol use during the last three months of pregnancy was 6.7% among white mothers in Alaska – more than 20% higher than the State average.
- White mothers were significantly more likely than any other race group to drink alcohol during the last three months of pregnancy – more than twice as likely as Alaska Native mothers.
- Although it appeared that the prevalence of prenatal alcohol use increased with maternal age and education level, the differences were not significant.
- Analysis of prenatal binge drinking during 1996-2000 showed that although any prenatal drinking was highest among white women (any drinking can be as little as “less than one drink a week”), Alaska Native women had the highest prevalence of prenatal binge drinking.³

¹ Healthy People 2010. (See References for full citation)

² Stratton K, Howe C, Battaglia F, eds. Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment. Washington, DC: National Academy Press. 1996.

³ Alaska MCH Data Book 2003, pp 50-51. (See References for full citation)

Prenatal Health: Risk Behaviors

Prevalence of Any Prenatal Alcohol Use (last 3 months) by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	6.7	400	1.0	(4.7 - 8.7)
Alaska Native	3.1	71	0.6	(2.0 - 4.2)
Black	0.5 *	2	0.3	(0.0 - 1.2)
Asian or Pacific Islander	0.0 ^	0	--	--
Maternal Ethnicity				
Hispanic	5.4	29	3.3	(0.0 - 11.8)
Non-Hispanic	5.2	419	0.7	(3.7 - 6.6)
Maternal Age				
15-19 years	2.9	27	1.6	(0.0 - 6.0)
20-24 years	2.8	74	1.0	(0.9 - 4.7)
25-34 years	5.8	276	1.0	(3.9 - 7.8)
35 years or older	9.4	109	2.5	(4.4 - 14.4)
Maternal Education				
<12 years	3.0	32	1.2	(0.7 - 5.3)
12 years	4.4	180	0.9	(2.6 - 6.2)
>12 years	6.4	253	1.2	(4.0 - 8.7)
Prenatal Medicaid Status				
Medicaid	4.0	152	0.9	(2.3 - 5.7)
Non-Medicaid	5.9	326	1.0	(4.0 - 7.8)
OVERALL	5.2	485	0.7	(3.8 - 6.5)

% Missing = 2.1

Core; Q33a

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

^ No respondents reported this indicator.

Prenatal Tobacco Use

Accounting for 20-30% of all low birth weight births in the United States, prenatal cigarette smoking is the greatest known risk factor for low birth weight births.^{1,2} Smoking during pregnancy is associated with infant mortality, miscarriages, preterm delivery, Sudden Infant Death Syndrome (SIDS), and respiratory problems in newborns.³ For the information presented here, prenatal tobacco use is limited to the last three months of pregnancy.

- Over the last decade, the trend in prenatal tobacco use has significantly declined in Alaska. Compared to 1991, the prevalence in 2001 has decreased nearly 40% for the State and 12% for Alaska Natives.
- Although the trend for maternal smoking among Alaska Natives has significantly declined, the prevalence has consistently remained nearly 2 times that of the overall prevalence.
- Alaskan women living in the Northern region were significantly more likely to smoke prenatally (41.1%) than any other region – they were 2 times as likely as women from the Southwest (20.4%) and approximately 4 times more likely than women from the Interior (11.2%) regions to smoke during their pregnancy.
- Among women who reported prenatal tobacco use in 2000, approximately 62% smoked less than half a pack a day – 50% smoked 1-9 cigarettes a day – during the last three months of their pregnancy, while 14% smoked a pack or more a day.⁴

¹ Healthy People 2010. (See References for full citation)

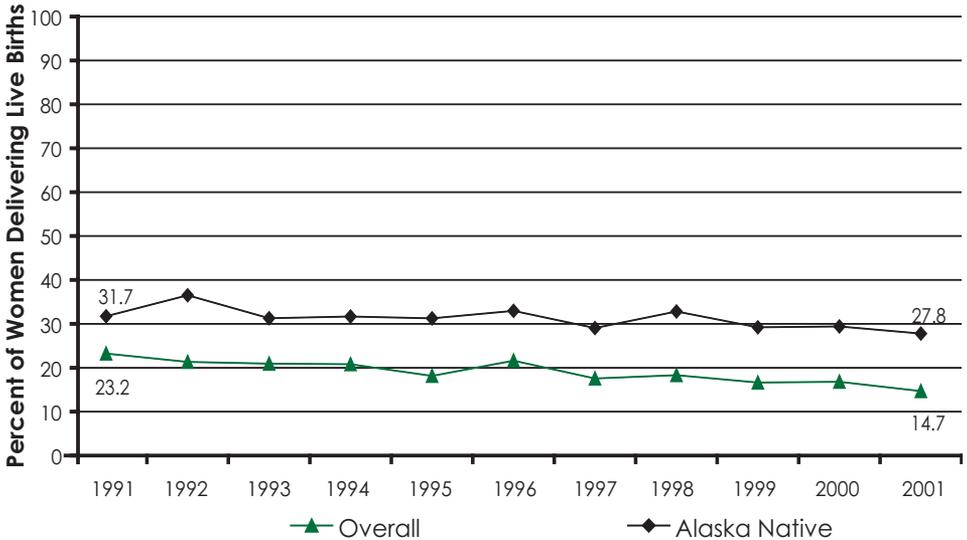
² The Health Consequences of Smoking. (See References for full citation)

³ The Health Consequences of Smoking. (See References for full citation)

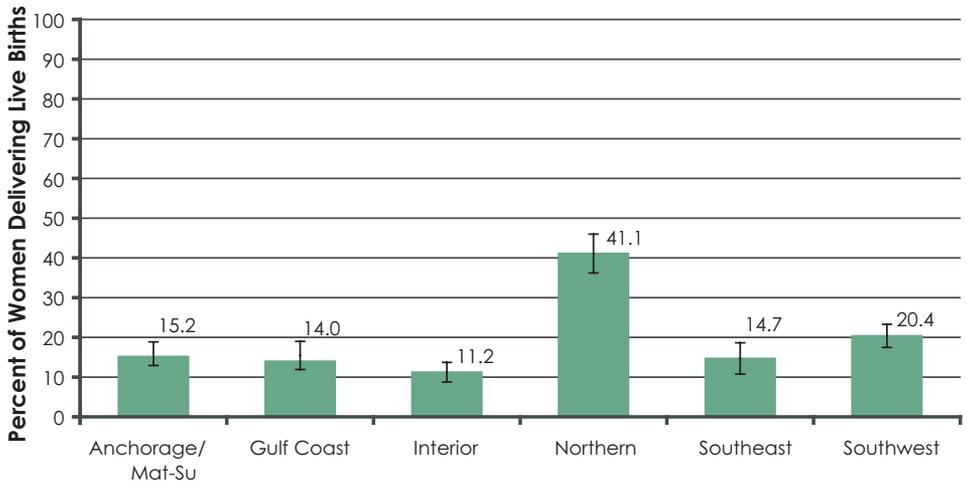
⁴ Alaska MCH Data Book 2003, pp 52-53. (See References for full citation)

Prenatal Health: Risk Behaviors

Prenatal Tobacco Use (last 3 months) by Race and Year
Alaska, 1991-2001



Prenatal Tobacco Use (last 3 months) by Region
Alaska, 1999-2001



Prenatal Tobacco Use

According to the 2004 Surgeon General’s Report, eliminating maternal smoking may lead to a 10% reduction in all sudden infant deaths and a 12% reduction in deaths from perinatal conditions.¹

- Alaska Native mothers had the highest prevalence of prenatal tobacco use (27.8%) of any race group – nearly 2.5 times that of white mothers (11.7%) and 14 times that of Asian or Pacific Islander mothers (2.0%).
- Young mothers, ages less than 25 years, were at greater risk of prenatal tobacco use than mothers 25 and older. Women in their early twenties were 1.6 times more likely to report prenatal tobacco use than women in the 25-34 age group.
- Teen mothers were twice as likely to report prenatal tobacco use as older mothers. While teen mothers had the highest prevalence of prenatal tobacco use (23.4%) in Alaska, recent national data indicate that they also had a significantly higher prevalence than their cohorts nationally (17.5% of teen mothers in the U.S. smoked prenatally in 2001).²
- Education level was significantly associated with the prevalence of prenatal tobacco use – as education level increased, the risk of maternal smoking decreased.
- Women with less than a high school education were 2 times as likely as women that completed high school and nearly 6 times as likely as women with at least some college to smoke tobacco prenatally.
- Alaskan women that had at least some prenatal care services paid by Medicaid were significantly more likely to smoke tobacco during the last three months of pregnancy than women that did not use Medicaid to pay for prenatal care.

¹ The Health Consequences of Smoking. (See References for full citation)

² The Health Consequences of Smoking. (See References for full citation)

Prenatal Health: Risk Behaviors

Prevalence of Prenatal Tobacco Use (last 3 months) by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	11.7	697	1.3	(9.2 - 14.3)
Alaska Native	27.8	645	1.6	(24.7 - 30.9)
Black	0.6 *	2	0.4	(0.0 - 1.3)
Asian or Pacific Islander	2.0	11	1.9	(0.0 - 5.8)
Maternal Ethnicity				
Hispanic	6.5	35	2.7	(1.1 - 11.9)
Non-Hispanic	15.7	1254	1.1	(13.6 - 17.7)
Maternal Age				
15-19 years	23.4	221	3.1	(17.3 - 29.5)
20-24 years	18.3	474	2.0	(14.4 - 22.1)
25-34 years	11.7	541	1.3	(9.1 - 14.2)
35 years or older	11.2	129	2.4	(6.5 - 16.0)
Maternal Education				
<12 years	36.2	363	3.5	(29.4 - 42.9)
12 years	17.5	706	1.5	(14.5 - 20.5)
>12 years	6.3	247	1.1	(4.0 - 8.5)
Prenatal Medicaid Status				
Medicaid	21.2	794	1.7	(17.9 - 24.6)
Non-Medicaid	10.1	550	1.1	(8.0 - 12.1)
OVERALL	14.7	1370	0.9	(12.8 - 16.5)

% Missing = 3.0

Core; Q29

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

Prenatal Marijuana Use

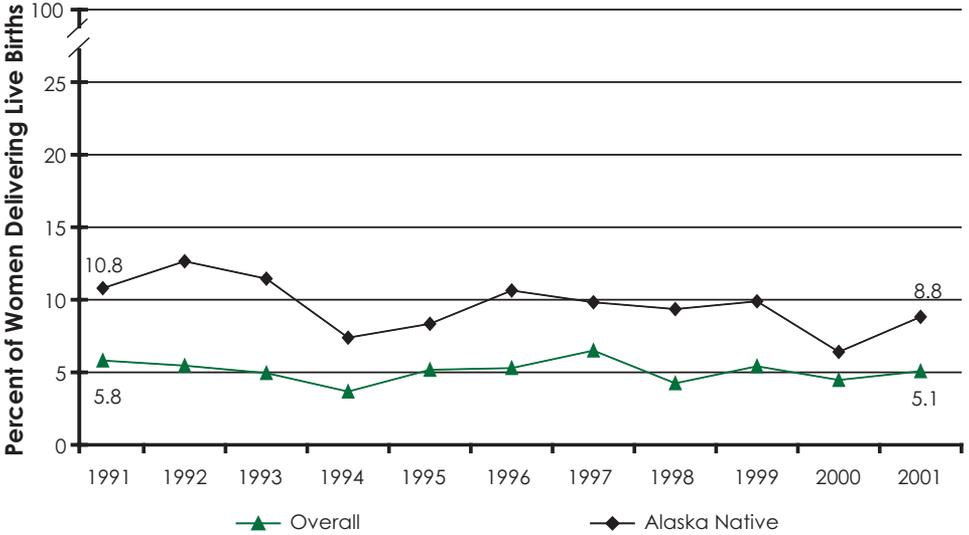
The Healthy People 2010 objective is to eliminate illicit drug use among pregnant women by the year 2010. The Healthy Alaskans 2010 objective is to reduce prenatal marijuana use among pregnant women to less than 3.5%.

- Over the last decade, there has been no significant decline in the trend for overall prenatal marijuana use in Alaska. Compared to data from a national survey, Alaskan women were more likely to report prenatal marijuana use than women in the United States overall (5.1% and 2.9%, respectively).¹
- The prevalence of prenatal marijuana use among Alaska Native mothers has been significantly higher than the overall state prevalence over the last decade – nearly twice that of the State average in 2001.
- During 1999-2001, the Northern region had the highest prevalence of prenatal marijuana use (13.8%). Compared to all other regions, women from the Northern region were significantly more likely to report prenatal marijuana use – approximately 2 to 4.5 times that of other regions. The Interior region had the lowest prevalence of prenatal marijuana use (3.0%).

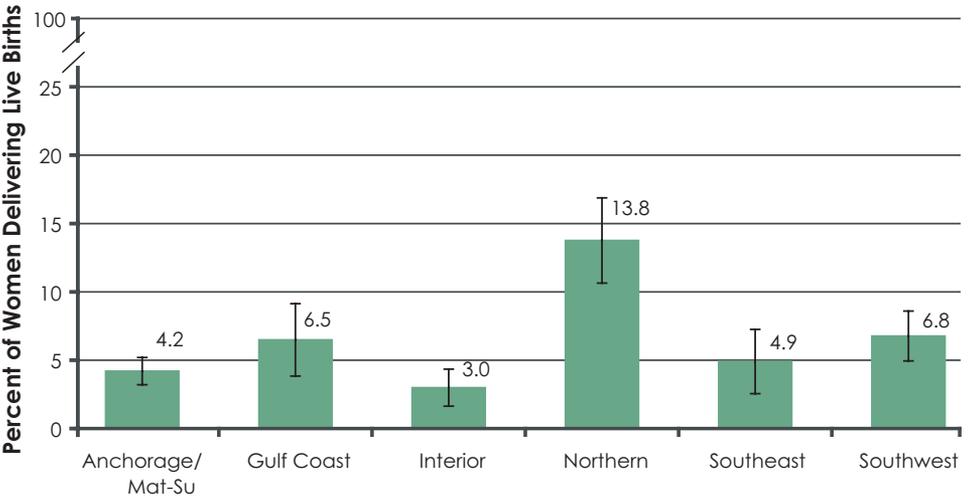
¹ National Survey on Drug Use and Health. (See References for full citation)

Prenatal Health: Risk Behaviors

Prenatal Marijuana Use by Race and Year
Alaska, 1991-2001



Prenatal Marijuana Use by Region
Alaska, 1999-2001



Prenatal Marijuana Use

Although the Alaska prevalence of prenatal marijuana use is higher than the national prevalence (5.1% and 2.9%, respectively), marijuana was not illegal in Alaska until after March 31, 1991. In 2001, prenatal use of marijuana was similar to the prevalence of prenatal alcohol use, but significantly lower than prenatal tobacco use.

- Alaska Native mothers were significantly more likely to report prenatal marijuana use than white mothers. The prevalence was more than twice as high among Alaska Natives compared to white and Asian or Pacific Islander mothers.
- Teen mothers had a significantly increased risk of prenatal marijuana use – they reported use at a rate 3.5 to 5 times that of other age groups.
- Alaskan women were significantly less likely to report prenatal marijuana use as education level increased. Women that had not completed high school were more than 2.5 times more likely to use marijuana prenatally than those that had completed high school and 4 times more likely than those with at least some college.
- The prevalence of prenatal marijuana use among Alaskan women that had prenatal care paid by Medicaid (7.5%) was significantly higher than among women that did not use Medicaid to pay for prenatal care (3.2%) – nearly 2.5 times higher.

Prenatal Health: Risk Behaviors

Prevalence of Prenatal Marijuana Use by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	4.0	244	0.8	(2.5 - 5.6)
Alaska Native	8.9	207	1.0	(6.9 - 10.8)
Black	0.0 *^	0	--	--
Asian or Pacific Islander	4.4	24	2.9	(0.0 - 10.2)
Maternal Ethnicity				
Hispanic	3.8	21	2.3	(0.0 - 8.3)
Non-Hispanic	5.4	439	0.7	(4.1 - 6.7)
Maternal Age				
15-19 years	14.9	139	3.1	(8.7 - 21.0)
20-24 years	3.9	103	0.9	(2.2 - 5.6)
25-34 years	4.3	204	0.8	(2.7 - 5.9)
35 years or older	3.1	35	1.1	(0.9 - 5.3)
Maternal Education				
<12 years	13.1	139	2.5	(8.3 - 17.9)
12 years	5.1	208	0.9	(3.3 - 6.8)
>12 years	3.2	130	0.8	(1.6 - 4.8)
Prenatal Medicaid Status				
Medicaid	7.5	285	1.1	(5.3 - 9.6)
Non-Medicaid	3.2	177	0.6	(2.0 - 4.4)
OVERALL	5.1	483	0.6	(3.9 - 6.2)

% Missing = 1.1

State-specific; Q70b

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

^ No respondents reported this indicator.

Prenatal Smokeless Tobacco Use

The effects of smokeless tobacco during pregnancy have been largely unstudied. At present, one study analyzing Swedish birth registry data indicates that prenatal smokeless tobacco use may be associated with increased risk of preterm delivery and pre-eclampsia.¹ According to the Surgeon General, smokeless tobacco use is associated with oral cancer and oral leukoplakia. Studies have shown that it also increases the risk of tooth loss and periodontal disease.

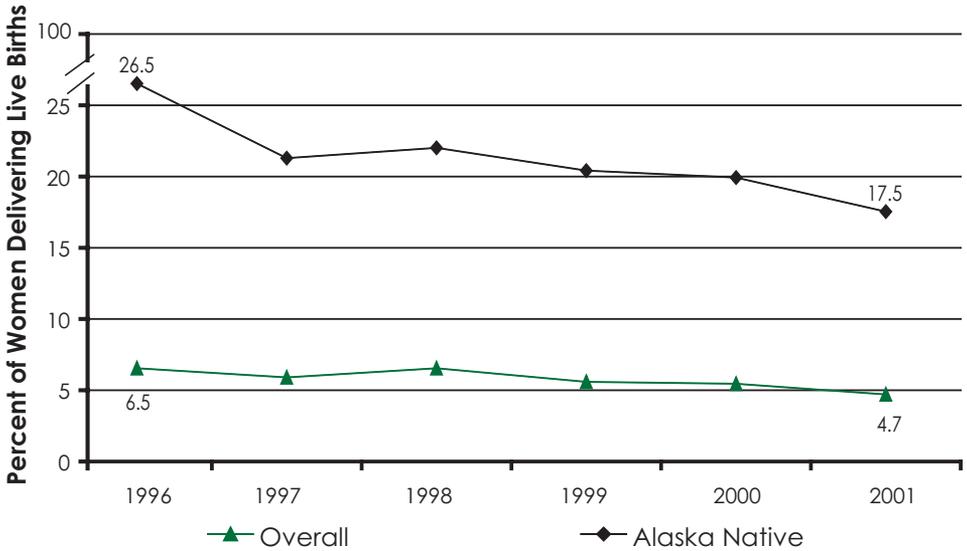
- From 1996-2001, there has been a significant decline in prenatal smokeless tobacco use in Alaska. Overall, the prevalence has declined nearly 30% since 1996. Compared to data from a national survey, Alaskan women were much more likely to report prenatal smokeless tobacco use than women in the United States (4.7% and 0.4%, respectively).²
- Prenatal smokeless tobacco use among Alaska Natives has been reduced more than one-third since 1996. Although the trend among Alaska Natives has significantly declined over the last six years, it is still nearly 4 times that of the State average (17.5% and 4.7%, respectively for 2001).
- The Southwest region had the highest prevalence of prenatal smokeless tobacco use (43.9%). Compared to all other regions, women from the Southwest region were significantly more likely to use smokeless tobacco while they were pregnant – nearly 8 times that of women from the Northern region (6.1%) and more than 30 times that of women from the Interior, Anchorage/Mat-Su, Southeast, and Gulf Coast regions (from 1.2% to 1.5%).

¹ Centers for Disease Control and Prevention. Safe Motherhood: Promoting Health for Women Before, During, and After Pregnancy. U.S. Department of Health and Human Services. 2004.

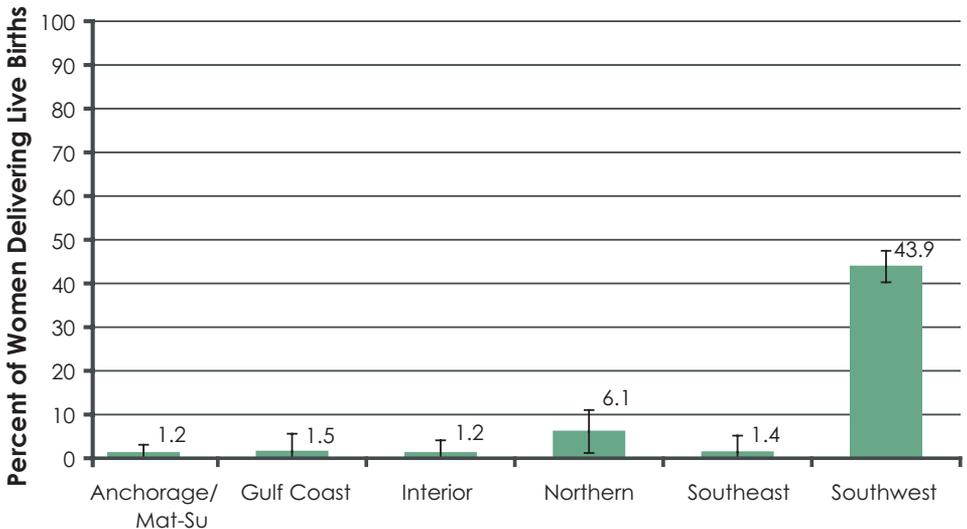
² National Survey on Drug Use and Health. (See References for full citation)

Prenatal Health: Risk Behaviors

Prenatal Smokeless Tobacco Use by Race and Year
Alaska, 1996-2001



Prenatal Smokeless Tobacco Use by Region
Alaska, 1999-2001



Prenatal Smokeless Tobacco Use

Smokeless tobacco use is a growing public health concern. Some people incorrectly perceive that using smokeless tobacco is safer than smoking cigarettes. Few states other than Alaska collect information on the use of smokeless tobacco during pregnancy.

- Alaska Native mothers were significantly more likely to report using smokeless tobacco while they were pregnant than white mothers – the prevalence was more than 40 times higher (17.5% and 0.4%, respectively).
- Although prenatal smokeless tobacco use appeared to decrease with maternal age, the differences between age groups were not statistically significant.
- The prevalence of smokeless tobacco use during pregnancy among Alaskan women significantly decreased as maternal education level increased. Women that had not completed high school (11.9%) were nearly 2 times as likely to use smokeless tobacco as those that had completed high school (6.7%) and 40 times more likely than those with at least some college (0.3%).
- Smokeless tobacco use among Alaskan women that had prenatal care paid by Medicaid (9.2%) was significantly higher than women that did not use Medicaid to pay for prenatal services (1.4%) – more than 6.5 times higher.

Prenatal Health: Risk Behaviors

Prevalence of Prenatal Smokeless Tobacco Use by Selected Demographics Alaska, 2001

	Percent	Weighted n	Standard Error	95% CI
Maternal Race				
White	0.4	27	0.3	(0.0 - 0.9)
Alaska Native	17.5	412	1.3	(15.0 - 20.1)
Black	0.0 *^	0	--	--
Asian or Pacific Islander	0.0 ^	0	--	--
Maternal Ethnicity				
Hispanic	0.7	4	0.6	(0.0 - 2.0)
Non-Hispanic	3.1	249	0.3	(2.4 - 3.7)
Maternal Age				
15-19 years	7.3	70	1.5	(4.5 - 10.2)
20-24 years	5.0	132	0.9	(3.3 - 6.6)
25-34 years	4.3	202	0.5	(3.3 - 5.2)
35 years or older	3.7	42	0.9	(1.9 - 5.5)
Maternal Education				
<12 years	11.9	127	1.9	(8.2 - 15.6)
12 years	6.7	274	0.7	(5.4 - 8.1)
>12 years	0.3	11	0.1	(0.0 - 0.5)
Prenatal Medicaid Status				
Medicaid	9.2	354	0.9	(7.6 - 10.9)
Non-Medicaid	1.4	77	0.3	(0.9 - 1.9)
OVERALL	4.7	447	0.4	(4.0 - 5.4)

% Missing = 1.4

State-specific; Q78b

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

^ No respondents reported this indicator.