Women's, Children's, & Family Health

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Contraception: Access and Use in Alaska

According to a national study, a woman spends three-fourths of her reproductive life trying not to become pregnant.[1] Although 9 in 10 women who are at risk of an unintended pregnancy use a method of contraception, over half of all unintended pregnancies in the U.S. occur to women who were using contraceptives during the month they become pregnant.[2]

In the U.S., a large proportion of women, often poor, low-income, or teenage, rely on subsidized services for their family planning care. Many rely on publicly funded family planning clinics for free or low-cost contraceptives.[2] According to the 2001 and 2002 Current Population Survey, 10% of Alaskan women between the ages of 15-44 have incomes below the federal poverty level and 19% do not have private health insurance or Medicaid.

In addition to preventing unintended pregnancy, the non-contraceptive benefits of oral contraceptive pills are important and are prescribed to many women for the prevention and treatment of endometriosis, hormonal imbalance disorders, acne, and menorrhagia.[3,4] Oral contraceptives may provide protection against benign breast disease, ovarian cysts, and pelvic inflammatory disease.[4] Research has shown that compared to non-users, women that use oral contraceptives are 50% less likely to develop endometrial cancer; women that use oral contraceptives for 12 or more years are 80% less likely to develop ovarian cancer.[4]

Seriousness

Healthy People 2010 Targets and National Data

Indicator	Alaska	National	Healthy People 2010 Goal*
Proportion of females at risk of an unintended pregnancy who use contraception	70% (1998)¥	89.3% (2002)^	100%
Proportion of females experiencing pregnancy despite the use of a reversible contraceptive	25.6% (2002)†	13.0% (1995)^^	<7%

The HP2010 goal is to reduce the proportion of all females experiencing pregnancy despite the use of a reversible contraceptive. The estimate for Alaska is limited to only those pregnancies that resulted in a live-birth.

- Although current data is not available for Alaska, data from 1998 suggests that when comparing women at risk of an unintended pregnancy, Alaskan women are less likely to use contraception compared to women in the U.S. as a whole.
- In Alaska, the prevalence of pregnancy despite the use of a reversible contraceptive is nearly 4 times higher than the Healthy People 2010 (HP2010) goal. The estimate for Alaska is only for those pregnancies that resulted in a live-birth, therefore, it is a conservative estimate since it does not include women whose pregnancy resulted in fetal death, spontaneous abortion, or termination.

Increasing access to emergency contraception (EC) is a HP2010 objective. Alaska is currently 1 of 6 states that allow pharmacists to dispense EC without a prescription. In Alaska, pharmacists may dispense any prescription drug, including EC, under collaborative practice agreement.

Severity

Inadequate access to contraception and improper or inconsistent use of contraception can have serious consequences. Adverse outcomes may include unintended pregnancy, abortion, and greater risk of sexually transmitted diseases. More than one-fourth of all live births in Alaska are conceived despite the use of birth control.† The majority of unintended pregnancies among contraceptive users result from inconsistent or incorrect use.[5]

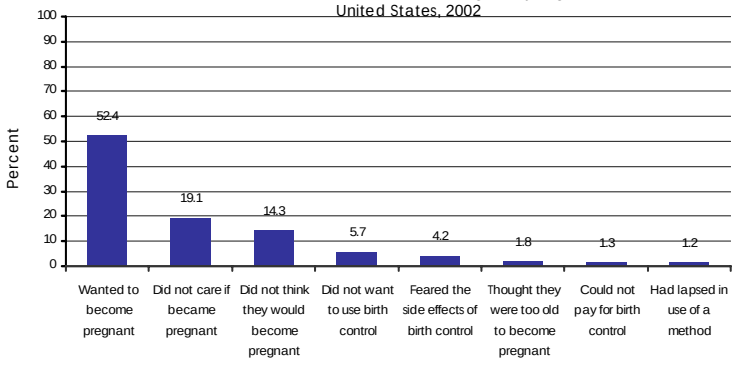
Nationally, approximately half of all unintended pregnancies end in abortion. When the pregnancy is carried to term, the child of an unintended pregnancy is at higher risk of negative outcomes such as low birth weight, dying in the first year of life, not receiving the resources necessary for healthy development, and being neglected or abused. The mother is at greater risk of depression, physical abuse, and not achieving her educational, financial, and career goals. Relationships among couples that have an unintended pregnancy are at three times the risk of dissolution.[6]

Urgency

In 2001, approximately half of the population of Alaskan women ages 15-44 were estimated to be in need of contraceptive services and supplies – of these, 45% were in need of publicly supported contraceptive services.[2]

A recent analysis of the 2002 Behavioral Risk Factor Surveillance System (BRFSS) estimated that of women at risk of pregnancy and not using birth control in the U.S., only half wanted a pregnancy. Among the reasons for not using birth control, nearly 1 in 5 did not care whether pregnancy occurred and 1 in 77 could not pay for birth control.[7] (Figure 1)

Figure 1



Data Source: Behavioral Risk Factor Surveillance System

- Alaska PRAMS data indicated that among Alaskan women delivering a live-born infant, 1 in 4 were using some form of birth control when they became pregnant and 8 in 10 (80.2%) were using birth control when surveyed at approximately three months postpartum.†

- In 2002, data from Alaska PRAMS showed that 86.0% of mothers reported that a health care worker talked to them about postpartum birth control use during their prenatal care.†

Disparities

According to the 2002 National Survey of Family Growth, age, education, race, and marital status were significantly associated with contraceptive use among women of childbearing age.[8] Alaska PRAMS data indicated that race, age, and Medicaid status were significantly associated with having a live birth despite use of birth control.‡

- In Alaska, black mothers were most at risk of having a live birth despite use of birth control. Nearly half (47.4%) of black women that delivered a live-born infant in 2001 were using some form of birth control when they got pregnant – twice the overall rate for the state (26.7%).‡

- Younger mothers were significantly more likely to have a live birth despite use of birth control. In 2002, Alaskan teenagers (15-19 years) and women in their early twenties (20-24 years) had a higher prevalence than all other age groups of having a live birth despite use of birth control. (Figure 2)

- Teen mothers were 70% more likely than mothers 25 years or older to have a live birth despite use of birth control.‡ Nationally, teenagers are less likely than older women to practice contraception without interruption over the course of a year, and more likely to practice contraception sporadically or not at all.[9]

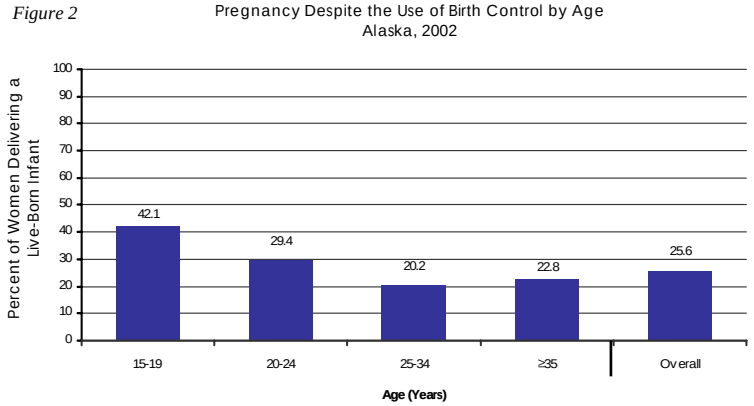
- Alaskan women whose prenatal care was at least partially paid for by Medicaid were significantly more likely to have a live birth despite use of birth control compared to women who did not use Medicaid as payment source for their prenatal care, 33.1% and 22.3%, respectively.‡

Economic Loss

Compared to an unintended pregnancy, the costs to society and individuals for contraceptive services and supplies are small. It is estimated that every public dollar spent on family planning services saves $3 in Medicaid costs for prenatal and newborn care.[2]

Research suggests that by reducing the direct and indirect costs associated with unintended pregnancy (e.g., abortion, prenatal care, delivery, newborn care, pregnancy-related sick leave, etc.) contraceptive coverage would save employers money. Thus, not covering contraceptives in employee health plans could cost employers an estimated 15% to 17% more than the cost of providing coverage.[2]

Figure 2



Data Source: Alaska PRAMS

Interventions & Recommendations

Contraceptive use drastically reduces the chances of unintended pregnancy. Over the course of a year, only 8% of women using the pill will become pregnant, compared with 85% of sexually active women not using contraceptives. It is estimated that 7% of U.S. women are at risk of unintended pregnancy and do not practice contraception – they account for almost half of the country's unintended pregnancies.[10]

Lack of contraceptive coverage by private health insurance was cited among the reasons for high rates of unintended pregnancy in the United States by the Institute of Medicine. The report noted that many privately insured females who need contraceptive care either pay for it themselves, use over-the-counter methods that may be less effective, or not use any method at all when their insurance company does not cover contraceptive use. The Institute of Medicine recommended increasing the proportion of health insurance policies that cover contraceptive services and supplies.[6]

Healthy People 2010 identified increasing access to contraceptive services and supplies for the Nation as a developmental indicator.

Intervention Effectiveness

Recent research has shown that an estimated 24,530 Alaskan women were served by family planning clinics for contraceptive services and supplies in 2001.[11]

Increasing awareness and access to emergency contraception can reduce unwanted and mistimed pregnancy. When used within 72 hours after unprotected sexual intercourse, emergency contraception reduces pregnancy by 75%.[3]

Capacity

Propriety

Promoting behaviors that reduce the rate of unintended pregnancy, improve women's health, and improving birth outcomes falls within the overall mission of the Women's, Children's, and Family Health Section. Family planning is an important issue among the maternal and child health population – national initiatives have been set forth to address increasing contraceptive use and decreasing pregnancy as a result of contraceptive failure, as well as a developmental indicator to increase access to contraceptive services and supplies (HP2010).

Economic Feasibility

Economic feasibility was not evaluated.

Acceptability

Acceptability was not evaluated.

Resources

Data: Alaska PRAMS and Alaska BRFSS can be used to provide data to monitor trends in contraceptive use, barriers to access to contraception, and risk factors associated with access to contraception, and attitudes of contraceptive use.

Title X: The Division of Health Care Services receives federal funding awarded by the Office of Population Affairs (OPA) to administer the Title X Family Planning Services grant in Alaska. Two clinical service providers, located in areas of the state with high numbers of unintended pregnancies, provide confidential, clinical family planning and reproductive health services to high-risk, low-income women and men. In addition to clinical services, the two sites also provide education and referral to other local agencies regarding infant adoption, abstinence education and other risk-reduction counseling.

Title V: Currently the Title V MCH Block Grant funds contracts for nurse practitioners to provide family planning services at three public health centers in addition to the two Title X family planning delegate sites. The MCH block grant also pays for contraceptive pharmaceuticals and laboratory testing services in support of this program.

Legality

Not an issue.

References

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Data Sources

¥ Alaska Behavioral Risk Factor Surveillance System (BRFSS), 1998 Data: State of Alaska, DHSS, DPH.

† Alaska Pregnancy Risk Assessment Monitoring System (PRAMS), 2002 Data: State of Alaska, DHSS, DPH.

^ National Survey of Family Growth, 1995 in; Kost K, Landry DJ, Darroch JE. Predicting Maternal Behaviors During Pregnancy: Does Intention Status Matter? Family Planning Perspectives 30(2): 79-88. 1998.

^^ National Survey of Family Growth, 2002 Data in: Mosher WD, Martinez GM, Chandra A., et al. Use of Contraception and Use of Family Planning Services in the United States, 1982-2002. Advance Data from Vital and Health Statistics; no 350. Hyattsville, MD: National Center for Health Statistics. 2004.

* Healthy People 2010. U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With understanding and improving health and objectives for improving health. 2 Vols. Washington, DC: U.S. Government Printing Office. 2000.

‡ Alaska Pregnancy Risk Assessment Monitoring System (PRAMS), 2001 Data: State of Alaska, DHSS, DPH. Alaska Maternal and Child Health Data Book 2004: PRAMS Edition (in prep).

Notes

Alaska PRAMS estimates of pregnancy despite the use of birth control are limited to women who delivered a live-born infant. In the PRAMS survey, "birth control" is not necessarily defined as a reversible contraceptive. Data are derived from a question that lists the following: "not having sex at certain times [rhythm], and using birth control methods such as the pill, Norplant®, shots [Depo-Provera®], condoms, diaphragm, foam, IUD, having their tubes tied, or their partner having a vasectomy."