# SB 198

<TARGET><BILL>SB 198</BILL><SUBJECT>SB 198</SUBJECT><COMM>HHSS30</COMM></TARGET>

# Alaska State Legislature

## Senator Pete Kelly


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**Sponsor Statement – Senate Bill 198**

*"An Act relating to a study of the effectiveness and cost of providing long-acting reversible contraception to women with substance abuse disorders."*

The rising rate of maternal opioid use has resulted in a drastic increase in children born with Neonatal Abstinence Syndrome (NAS). In Alaska, the incidence of children born with NAS has increased over 500% from 2004 to 2015.[1] In addition to the ongoing opioid crisis, Alaska continues to report one of the highest rates of fetal alcohol spectrum disorders (FASD) in the nation. The true rate of FASD in the state is likely to be significantly higher according to recent national prevalence studies.[5]

Through SB 198, the UAA Center for Alcohol and Addiction Studies will evaluate the feasibility and effectiveness of providing Long Acting Reversible Contraception (LARC) to women involved in services such as Alaska Regional Hospital's Neonatal Abstinence Evaluation Support Treatment (NEST) program. The population of women served by the NEST program represent one of the highest risk groups in Alaska for unintended pregnancy and prenatal drug/alcohol exposure. The public health consequences of NAS and FASD addressed by this program highlight the critical importance of providing effective long-term contraception options to women struggling with alcohol and drug addiction challenges.

SB 198 is an important step in eradicating FASD and NAS in Alaska. This study will provide critical data on LARC as an effective tool in reducing the rates of FASD and NAS. Furthermore, the anticipated outcomes can inform future state spending related to LARC as a public health strategy and its utility for reducing pressure on state programs and budgets. Approximately 50% of infants with Neonatal Abstinence Syndrome treated at Alaska Regional Hospital's NEST program were immediately placed into the care of the Office of Children's Services.[1] In Alaska, the Department of Health and Social Services has estimated the average cost of treating an infant with NAS is $88,869, which is predominantly paid by Medicaid.[2] According to the Alaska Department of Health and Social Services, each child born with FASD in Alaska will cost the State of Alaska between $860,000 and $4.2 million dollars from birth to age 18.[5]

SB 198 is a foundational step towards turning the tide on these staggering statistics.

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[1] Alaska Regional Hospital. 2015-2016 NEST factsheet. 2017. Print.
[2] Miller, H. How hospitals are treating babies caught in the crosshairs of Alaska's opioid crisis. Anchorage Daily News. May 18, 2016. Retrieved from: https://www.adn.com/alaska-news/article/how-hospitals-are-treating-babies-caught-crosshairs-alaska-s-opioid-epidemic/2016/05/09/

## Supporting Data

Nearly 50% of all pregnancies in Alaska are unintended while 89% of pregnancies by women with opioid use disorder are unintended.[3]

93% of pregnant women utilizing NEST program services had prenatal drug use identified before delivery.[1]

Alaska has more than 120 children diagnosed with Fetal Alcohol Spectrum Disorders every year.[4]

A newly published national FASD prevalence study funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reports that FASD may be as common as Autism in the United States.[5]

Long acting reversible contraception (LARC) methods such as intrauterine devices (IUDs) and subdermal implants are 20 times more effective than other common forms of contraception.[6]

Postpartum LARC insertion for women with substance abuse disorders in order to prevent unintentional pregnancy and prenatal drug/alcohol exposure has been recommended by the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, and the Centers for Medicare and Medicaid Services.[7]

The National Center for Chronic Disease Prevention and Health Promotion has identified LARCs as a primary prevention method for reducing the incidence of Neonatal Abstinence Syndrome.[8]

The State of Alaska Department of Health and Social Services - Women's, Children's, & Family Health Section reports that if half of the unintended pregnancies in Alaska, or 2,500 births, could be averted or delayed, the potential cost saving to the State of Alaska would be over $44 million per year.[9]

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[3] Heil SH, Jones HE, Arria A, et al. Unintended pregnancy in opioid-abusing women. J Subst Abuse Treat. 2011;40(2):199–202.
[4] Alaska State Legislature. Fetal Alcohol Spectrum Disorders and Alaska. Retrieved from: http://www.legis.state.ak.us/basis/get_documents.asp?session=28&docid=18982
[5] May, P. Chambers, C. Kalberg, W., et. al. Prevalence of Fetal Alcohol Spectrum Disorders in 4 US communities. Journal of American Medical Association. Feb. 6, 2018. Retrieved from: https://jamanetwork.com/journals/jama/article-abstract/2671465?redirect=true
[6] The American College of Obstetricians and Gynecologists. Long acting reversible contraception (LARC): IUD and Implant. FAQ184. July 2014. ACOG Print.
[7] Ray, M., and King, V. Immediate postpartum LARC: An underused contraceptive option. American Academy of Family Physicians. Jan. 1, 2018. Retrieved from: https://www.aafp.org/afp/2018/0101/p9.html
[8] Barfield, W., The problem with Neonatal Abstinence Syndrome. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from: https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016-H.pdf
[9] State of Alaska, Department of Health and Social Services Women's, Children's, & Family Health Section. Unintended pregnancy in Alaska. Special series fact sheet. Dec. 2010. Print.

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**Sectional Analysis – Senate Bill 198**

*"An Act relating to a study of the effectiveness and cost of providing long-acting reversible contraception to women with substance abuse disorders."*

**Section 1:**

(A) Directs the University of Alaska Anchorage Center for Alcohol and Addiction Studies to conduct a study to evaluate the effectiveness of providing long-acting reversible contraception (LARC) to women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure.

The study shall be done in collaboration with hospitals and health care providers in Alaska who treat women with substance abuse disorders and:

(1) Establish an advisory council to assist with designing and implementing the study,
(2) Evaluate best practices for treating women and children when there is a high risk of neonatal abstinence syndrome (NAS) or fetal alcohol spectrum disorders (FASD),
(3) Facilitate a network for sharing of best practices,
(4) Identify women and children to participate in the study on a voluntary basis,
(5) Provide LARC to participants who are at a high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure,
(6) Evaluate the cost and effectiveness of providing LARC to reduce the occurrence of NAS and FASD,
(7) Develop a cohort of women and children who can be evaluated in later studies regarding NAS and FASD,
(8) Provide a data driven framework to establish a comprehensive strategy for using LARC to reduce NAS and FASD in Alaska.

(B) Directs the University to complete two interim reports by June 30 of 2019 and 2020 and a final report by June 30, 2021.

(C) Provides definitions for "fetal alcohol spectrum disorder," "long-acting reversible contraception," and "neonatal abstinence syndrome."

**Section 2:**

Repeals Section 1 on June 30, 2021, which coincides with the date of the final report on the project

# Fiscal Note

State of Alaska
2018 Legislative Session

| | |
|---|---|
| Bill Version: | SB 198 |
| Fiscal Note Number: | 1 |
| (S) Publish Date: | 4/4/2018 |

Identifier: SB198-UA-AC-3-27-18
Title: UAA LONG-ACTING CONTRACEPTION STUDY
Sponsor: KELLY
Requester: Senate Finance

Department: University of Alaska
Appropriation: University of Alaska
Allocation: Anchorage Campus
OMB Component Number: 753

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2019 Appropriation Requested | Included in Governor's FY2019 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2019** | **FY 2019** | **FY 2020** | **FY 2021** | **FY 2022** | **FY 2023** | **FY 2024** |
| Personal Services | 93.1 | | 103.9 | 98.1 | | | |
| Travel | | | | | | | |
| Services | 30.0 | | 60.0 | 60.0 | | | |
| Commodities | 25.0 | | 25.0 | 5.0 | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | **148.1** | **0.0** | **188.9** | **163.1** | **0.0** | **0.0** | **0.0** |
| **Fund Source (Operating Only)** | | | | | | | |
| 1004 Gen Fund (UGF) | 148.1 | | 188.9 | 163.1 | | | |
| **Total** | **148.1** | **0.0** | **188.9** | **163.1** | **0.0** | **0.0** | **0.0** |
| **Positions** | | | | | | | |
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |
| **Change in Revenues** | | | | | | | |
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Estimated SUPPLEMENTAL (FY2018) cost:** 0.0 *(separate supplemental appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2019) cost:** 0.0 *(separate capital appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version/comments:**

This new version of the Fiscal Note makes two changes: 1) it removes revenues, which were incorrectly included in the original version. The bill itself will not result in a change of revenues to UA and 2) changes the fund source to 1004 General Funds. The original version incorrectly listed the fund source as 1037 GF/Mental Health.


Prepared By: Michelle Rizk — Phone: (907)322-9625
Division: University of Alaska — Date: 03/26/2018 02:30 PM
Approved By: Michelle Rizk — Date: 03/26/18
Agency: University of Alaska


REPORTED OUT OF SFC 04/04/2018

# FISCAL NOTE ANALYSIS

**STATE OF ALASKA**
**2018 LEGISLATIVE SESSION**

## Analysis

Through SB 198, the University of Alaska Anchorage Center for Alcohol and Addiction Studies will conduct a study to evaluate the feasibility and effectiveness of providing Long Acting Reversible Contraception (LARC) to women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure. The study will be done in collaboration with hospitals and health care providers in Alaska who treat women with substance abuse disorders.

Project Outcomes:

- Establish a collaborative network of service providers treating women at high risk of Neonatal Abstinence Syndrome (NAS) and/or Fetal Alcohol Spectrum Disorders (FASD)
- Assess the feasibility and utility of providing LARCs to the Neonatal Abstinence Evaluation Support Treatment (NEST) program
- Develop a cohort of women and children receiving NEST services for long term follow-up
- Provide a data-driven framework and foundation for a comprehensive LARC strategy in Alaska
- Provide a full report to the Alaska State Legislature and Key Stakeholders

The study will begin in July 2018 and be conducted in three phases:

**Phase 1:** Development (July 2018 - March 2019)
Establish and convene advisory panels, develop clinical protocols, research procedures
**Phase 2:** Implementation and Evaluation (March 2019 - May 2020)
Implement referral protocols, assemble cohort, data collection, network collaboration
**Phase 3:** Data Analysis and Reporting (April 2019 - June 2021)
Data analysis, strategy development, outcomes, reporting, strategy recommendations

Funding covers personnel costs for time contributed by principal investigator and co-investigators; contracted case management, and medical commodities necessary for the study to include the cost of providing contraception to project participants without health insurance.

Two interim reports will be provided: June 30, 2019 and June 30, 2020, and a final report will be due by June 30, 2021.

alaska children's trust

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alaskachildrenstrust.org



30 YEARS

**26 February 2018**

**Re: SB 198 – UAA Long-Acting Contraception Study**

**Dear Members of the Alaska State Legislature,**

**Alaska Children's Trust (ACT) fully supports SB 198 and the effort to increase access to long-acting reversible contraception (LARC) for women who experience significant risk of unintended pregnancy and prenatal drug and alcohol exposure. As you may be aware, unintended pregnancy is directly correlated with increased incidents of child abuse and neglect in Alaska. In addition, children prenatally exposed to drugs and alcohol often experience significant lifelong health and social challenges. As rates of maternal opioid use continue to skyrocket, the importance of increasing access to substance abuse treatment and long-acting reversible contraception has reached critical mass in Alaska.**

**We believe the project described in SB 198 will have far reaching benefits for improving health outcomes in both children and families in our state. In addition to providing a valuable intervention to women in need, the data derived from SB 198 has the potential to inform policy and health strategy in Alaska for years to come. This project will provide a critical data foundation for developing a comprehensive LARC strategy and understanding the long-term impacts of children born with Neonatal Abstinence Syndrome in Alaska.**

**We look forward to working with our colleagues at the UAA Center for Alcohol and Addiction Studies and other key stakeholders involved with SB 198 in the effort to improve health outcomes in mothers, reduce unintended pregnancy in Alaska, and mitigate the substantial impact of prenatal drug and alcohol exposure in our state. When healthy Alaskan mothers have healthy Alaskan babies, we all win.**

**Sincerely,**

**Trevor J. Storrs**
**Executive Director**

Alaska Dispatch News

Alaska News

# How hospitals are treating babies caught in the crosshairs of Alaska's opioid crisis

Author: **Hope Miller** Updated: May 18, 2016 Published May 8, 2016

A troubling side effect of Alaska's spike in opiod abuse is getting increased attention from health care officials: drug-dependent babies who go through withdrawal in the first days of their lives.

In Anchorage and elsewhere, hospitals are adapting in an effort to better treat these newborns. In late 2014, Alaska Regional Hospital opened a four-bed facility specifically for babies exposed to addictive medications and drugs like heroin while in the womb.

"If ever there was an innocent being, it has to be a baby," said William Trawick, a neonatal nurse practitioner who works for Alaska Neonatology Associates Inc. and led the effort to create the specialized unit at Alaska Regional. "They don't deserve anything like this. They can't understand this."

And at Providence Alaska Medical Center, there are plans in place for a similar setup. In the meantime, the hospital has sought quiet, dimly lit spaces to monitor babies going through withdrawal -- the antithesis of the bright, noisy neonatal intensive care units that were standard in the past.

## Rise in prenatal opioid use

Prenatal exposure to opioids is on the rise nationwide, and Alaska is no exception to the trend. As a result, babies can be born with neonatal abstinence syndrome, or NAS. The withdrawal can be horrific for the infants and the long-term effects aren't well understood, Trawick said.

Symptoms can vary, including but not limited to fever, trouble sleeping, slow weight gain, diarrhea and excessive crying. Seizures are less common but "ominous," Trawick says.

"I was really shocked at how little we knew in terms of the number of babies that were affected by it," he said of when he started his self-motivated "crash education" on babies with NAS. "And then even looking at how little we knew, how many babies that there were."

Since Alaska Regional's Neonatal Abstinence Evaluation Support and Treatment, or NEST, program started in October 2014, 33 babies "who have experienced significant withdrawal" stayed in one of the NEST rooms as of

early April.

From 2014 to 2015, 97 babies admitted to Providence's NICU had NAS, staff say.

"It's a big topic of discussion," said Dr. Mary-Alice Johnson, the NICU medical director at Providence. "Everybody is concerned about the fact that we're seeing more moms exposed and therefore more babies suffering from neonatal abstinence syndrome."

Statewide, the NAS rate saw a fivefold increase from 2001 to 2012 -- "from less than one to more than five for every 1,000 live births," according to a February bulletin from the state Department of Health and Social Services. Cases were pulled from Medicaid claims and a hospital discharge database. Incidence rates were highest in Anchorage and Southeast Alaska, according to hospital discharge data.

***[Juneau's heroin heartbreak]***

Treating these babies can be expensive, too. From 2001 to 2012, the average hospital stay for a NAS baby was 16 days with an average hospitalization charge of $88,869, the DHSS said. Medicaid foots the bill for many of the NAS cases.

**Specialized care**

Alaska Regional's NEST unit is touted as a one-of-a-kind facility for NAS treatment in Alaska. Alaska Regional was the primary funder, but the hospital did get a $75,000 grant from the Alaska Mental Health Trust Authority to get the unit up and running, said Alaska Regional spokeswoman Kjerstin Lastufka.

Sound-dampening ceiling tiles and dim lighting decrease stimulation for the baby. Rocking chairs in the rooms and sleeping accommodations for parents are for baby-parent bonding.

"We're trying to be a little less institutional," Trawick said. A mobile with pink and blue birds hung from a crib near where he stood in one of the NEST rooms during an early April interview. "We try to make it look a little more peaceful and baby-like."

The staff-to-patient ratio is also a key component, said Dianne Gillis, director of women's and children's services at Alaska Regional. A baby with NAS may have her own dedicated nurse, providing almost instant availability should the infant need anything.

"You can't tell these babies, 'Wait a minute,' "Gillis said.

At Providence, staff have identified a couple of large private rooms that could be adapted to house babies with NAS and allow mothers to be near their children 24/7. A business plan has already been written up and it's received support, said Sharon Liska, clinical nurse specialist at Providence.

***[She died in the Anchorage jail detoxing from heroin. Her family wants answers]***

"We've identified work that needs to be done as far as keeping that family unit together," she said. "And part of a special-care nursery we're working on right now is an outreach to the NAS families."

Heroin is one of the most common drugs Providence and Regional see that causes NAS. Methadone, Subutex and other prescription medications -- obtained legally and illegally -- also crop up.

"Nenonatal abstinence syndrome looks the same regardless of the avenue that that opiate got to the kid," said Johnson, noting that some newborns may have painkillers in their system if they underwent surgery.

Hospitals everywhere are grappling with how best to treat babies with NAS. Trawick said he and others recently got back from a trip to Canada where they learned about varying approaches to NAS.

There is an effort to standardize some protocols. Providence, Alaska Regional and four other hospitals in Alaska have a "Center of Excellence in NAS Education and Care" designation through the Vermont Oxford Network, according to Providence spokesman Mike Canfield.

There's also a scoring sheet that quantifies the severity of NAS, but Trawick says it may be overvalued. Pharmacological care, such as morphine, can be used, but Trawick says the fewer drugs prescribed the better. Swaddling, rocking and subdued physical contact between mother and baby shouldn't be overlooked.

**Involving the family**

At the two Anchorage hospitals, staff say shaming the mothers is never OK. The goal is to promote bonding between mother and child and educate the parents.

"You cannot lose sight of the fact that they are human beings and they just had a baby," Trawick said. "And to anyone else, that's a great experience and should be a happy time for them. But for them, it's a very complicated time."

Hospitals are required to report positive drug screens of mothers and children to the Office of Children's Services. What OCS does after that isn't something hospitals control. But a positive screen doesn't necessarily mean a child will be whisked away from the mother.

"The goal is to keep the mom with the baby as much as possible," said Graeme Hopewell, clinical nurse educator at Providence.

Johnson, the NICU medical director at Providence, says a lack of resources for mothers looking to get clean exacerbates Alaska's opioid problem. Recently, the state's two inpatient detox centers suspended new admissions because of changes in federal regulations. The Ernie Turner Center in Anchorage and the Gateway to Recovery Center in Fairbanks have since said they will change their procedures to start admitting new patients for opiate detox.

"Moms come in here and they reach out, they want help and they are put on a waitlist for the whole pregnancy," Johnson said. "The providers before us, the providers after us is a huge component to the success of these families."

**About this Author**

**Hope Miller**

Comments

ELSEVIER

Journal of Substance Abuse Treatment 40 (2011) 199–202

Journal of Substance Abuse Treatment

Brief article

# Unintended pregnancy in opioid-abusing women

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Received 1 July 2010; accepted 25 August 2010

**Abstract**

The aim of this study was to estimate the prevalence of unintended pregnancy and its three subtypes (mistimed, unwanted, and ambivalent) among opioid-abusing women. In the general population, 31%–47% of pregnancies are unintended; data on unintended pregnancy in opioid- and other drug-abusing women are lacking. Pregnant opioid-abusing women ($N$ = 946) screened for possible enrollment in a multisite randomized controlled trial comparing opioid maintenance medications completed a standardized interview assessing sociodemographic characteristics, current and past drug use, and pregnancy intention. Almost 9 of every 10 pregnancies were unintended (86%), with comparable percentages mistimed (34%), unwanted (27%), and ambivalent (26%). Irrespective of pregnancy intention, more than 90% of the total sample had a history of drug abuse treatment, averaging more than three treatment episodes. Interventions are sorely needed to address the extremely high rate of unintended pregnancy among opioid-abusing women. Drug treatment programs are likely to be an important setting for such interventions. 

*Keywords:* Pregnancy; Intention; Family planning; Opioid; Drug abuse

## 1. Introduction

Licit and illicit opioid dependence during pregnancy is often complicated by a multitude of other factors, including low socioeconomic status, poor nutrition, lack of prenatal care, family instability, interpersonal violence, homelessness, psychological problems, and other drug use (Center for Substance Abuse Treatment, 1993). In the perinatal period, these intertwined factors can contribute to a number of adverse maternal and infant outcomes including, but not limited to, premature delivery, low birth weight, and neonatal abstinence syndrome (see Kaltenbach, Berghella, & Finnegan, 1998, for a review). In the longer term, bearing a child in such disadvantaged circumstances has been shown to significantly diminish the future well-being of both the mother and the child (Graham, 2007, 2009; Mishel, Berstein, & Shierholz, 2009).

Further compounding these difficult circumstances, opioid-dependent women become pregnant more often than women in the general population. In a seminal study of the reproductive health of opioid-dependent women, 54%

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0740-5472/10/$ – see front matter 
doi:10.1016/j.jsat.2010.08.011

reported having four or more pregnancies in their lifetime compared with 14% of a nationally representative sample of U.S. women (Armstrong, Kennedy, Kline, & Tunstall, 1999). These authors also observed that almost five times as many opioid-dependent women reported ever having an abortion compared with women in the national sample (57% vs. 12%), suggesting that many pregnancies among opioid-dependent women were not intended.

To our knowledge, there is only one small study estimating unintended pregnancy among opioid-dependent women. The results of this study indicated that 67% (24/36) of pregnant women enrolled in a New York City methadone maintenance program reported that they did not plan the pregnancy (Selwyn et al., 1989). As a first step toward developing interventions to reduce unintended pregnancy among opioid-dependent women, this study sought to estimate the prevalence of unintended pregnancy and its three subtypes (mistimed, unwanted, and ambivalent) in a much larger sample of pregnant women reporting opioid abuse.

## 2. Methods

### 2.1. Participants

Data were obtained from 946 opioid-abusing pregnant women screened for potential enrollment in the MOTHER (Maternal Opioid Treatment: Human Experimental Research) trial. This multisite trial, performed at eight diverse U.S. and international clinical sites and settings, was designed to compare the safety and efficacy of methadone and buprenorphine for the treatment of opioid dependence during pregnancy (Jones et al., 2008).

### 2.2. Screening assessment

Participants who provided informed consent were screened for eligibility either at the time of treatment entry or at the time they considered a change from their established drug treatment program. Interviews were conducted with all potential participants to determine eligibility for the study; at some sites, some information was collected by chart review prior to the interview. Demographic information collected included age, education level, race, and marital status. Drug use and treatment variables assessed included frequency of current opioid and cocaine use and the number and type of prior treatment episodes.

Pregnancy intention of the current pregnancy was assessed by the question "When did you intend to become pregnant?" Response options were "sooner," "now," "later," "never," and "don't know/unsure." Women who responded that they intended to become pregnant "sooner" or "now" were classified as having intended pregnancies. Women who responded "later" were classified a having mistimed pregnancies. Women who responded "never" were classified as having unwanted pregnancies. Women who responded "don't know/unsure" were classified as having ambivalent pregnancies (Mohllajee, Curtis, Morrow, & Marchbanks, 2007).

### 2.3. Data analyses

Two types of analyses were performed to examine between-group differences. First, analyses examined the demographic differences between women with intended pregnancies and women with unintended pregnancies. Statistically significant differences in continuous and dichotomous variables were evaluated using $t$ tests and $z$ tests, respectively. Second, differences in drug use and other factors between groups were evaluated using logistic regression models in which each variable of interest was entered separately into a logit model controlling for age, race, and site location.

## 3. Results

### 3.1. Pregnancy intentions

Of 946 opioid-abusing women screened, 129 (14%) reported having intended pregnancies and 817 (86%) reported having unintended pregnancies. As a percentage of all pregnancies, 323 (34%) were mistimed, 252 (27%) were unwanted, and 242 (26%) were ambivalent pregnancies.

### 3.2. Pregnancy intention and maternal demographic characteristics and drug use

No significant differences were observed on the five maternal demographic characteristics compared between women with intended versus unintended pregnancies (top part of Table 1). Regarding the subtypes of unintended pregnancy, women with mistimed pregnancies were significantly younger compared with women with intended pregnancies, $t(450) = 2.1$, $p < .05$. Women with unwanted pregnancies were significantly older, $t(379) = 4.8$, $p < .001$, and less likely to be White, $t(378) = 2.9$, $p < .01$, compared with women with intended pregnancies. Women with ambivalent pregnancies were significantly older, $t(368) = 3.3$, $p = .001$, and less likely to be White, $t(366) = 2.7$, $p < .01$, and employed, $t(354) = 2.8$, $p < .01$, compared with women with intended pregnancies.

Regarding maternal drug use, women with unintended pregnancies were more likely to have used cocaine in the 30 days prior to screening compared with women with intended pregnancies (adjusted odds ratio = 1.6, $p < .05$). Regarding the subtypes of unintended pregnancy, women with mistimed pregnancies were less likely to have used cocaine in the past 30 days compared with women with intended pregnancies (adjusted odds ratio = 1.8, $p < .05$). Women with ambivalent pregnancies were more likely to report prior

Table 1
Maternal demographic characteristics and drug use by pregnancy intention

| Characteristics | Total, ($N$ = 946)[a] | Intended ($n$ = 129, 14%) | Unintended ($n$ = 817, 86%) | Unintended pregnancy subtypes | | |
|---|---|---|---|---|---|---|
| | | | | Mistimed ($n$ = 323, 34%) | Unwanted ($n$ = 252, 27%) | Ambivalent ($n$ = 242, 26%) |
| Demographic characteristics | | | | | | |
| Age, $M$ ($SD$), years | 27.9 (5.9) | 27.0 (5.4) | 28.1 (5.9) | 25.8 (5.4)[b] | 30.1 (6.1)[b] | 29.0 (5.5)[b] |
| % White | 78 | 82 | 77 | 89 | 69[b] | 70[b] |
| Years of education, $M$ ($SD$) | 11.1 (1.8) | 11.2 (2.1) | 11.1 (1.8) | 11.1 (1.7) | 11.2 (1.9) | 11.1 (1.9) |
| % married | 11 | 13 | 11 | 9 | 11 | 13 |
| % employed | 11 | 15 | 11 | 13 | 12 | 6[b] |
| Drug use[c] | | | | | | |
| % with prior drug treatment | 91 | 91 | 91 | 90 | 90 | 95 |
| % with prior medication-assisted treatment | 88 | 87 | 88 | 84 | 89 | 92[b] |
| Number of times treated for drug abuse in lifetime, $M$ ($SD$) | 3.2 (3.6) | 3.2 (4.0) | 3.2 (3.5) | 2.9 (2.9) | 3.4 (4.2) | 3.3 (3.2) |
| Years of age at first medication-assisted treatment, $M$ ($SD$) | 24.8 (5.5) | 23.8 (5.1) | 25 (5.6) | 22.9 (4.9) | 26.3 (5.8) | 26.2 (5.4) |
| % with daily illicit/nonmedical opioid use in the 30 days prior to screening | 83 | 72 | 85 | 74 | 91 | 93 |
| % with cocaine use in the past 30 days | 40 | 40 | 40[b] | 28[b] | 48 | 49 |

[a] $n$s vary by characteristic due to missing data and range from 726 to 945.
[b] Significantly different ($p < .05$) from intended pregnancy group.
[c] Analyses controlled for age, race, and site.

medication-assisted treatment compared with women with intended pregnancies (adjusted odds ratio = 0.5, $p < .05$).

## 4. Discussion

Unintended pregnancy was highly prevalent in this sample; nearly 9 of every 10 women screened reported that the current pregnancy was unintended. This rate is two to three times the rate observed in the general population (Chandra, Martinez, Mosher, Abma, & Jones, 2005; Mohllajee et al., 2007; Williams et al., 2006). In addition, the occurrence of unintended pregnancy in the current sample was nearly 20% higher than previous estimates in pregnant women with opioid problems (Selwyn et al., 1989).

To our knowledge, this is the first report of the rates of the three subtypes of unintended pregnancy in opioid-abusing pregnant women. The percentage of women reporting mistimed, unwanted, or ambivalent pregnancies in the present sample were fairly comparable, with each representing about one third of the total sample. The percentage of women reporting an unwanted pregnancy was nearly three times higher in this study compared with the general population; and the percentage of women reporting ambivalence, more than four times higher (Mohllajee et al., 2007). These figures dramatically underscore the need to develop interventions to bring contraceptive use in line with conception desires among opioid-abusing women.

Although there were few differences between women with intended versus unintended pregnancies, more differences emerged when women with unintended pregnancies were disaggregated into the three subtypes of unintended pregnancy and compared with women with intended pregnancies. Consistent with the literature on pregnancy intention in the general population, women with mistimed pregnancies were younger (D'Angelo, Gilbert, Rochat, Santelli, & Herold, 2004; Mohllajee et al., 2007). A lower percentage of these women also reported recent cocaine use compared with women with intended pregnancies. In studies of the general population, women with mistimed pregnancies report more smoking but less drinking compared with women with intended pregnancies (D'Angelo et al., 2004; Mohllajee et al., 2007), suggesting some variability in drug use among women with mistimed pregnancies.

Consistent with the literature in the general population, women with unwanted and ambivalent pregnancies were older and less likely to be White compared with women with intended pregnancies (D'Angelo et al., 2004; Mohllajee et al., 2007). Women with ambivalent pregnancies were also more likely to be unemployed, and a higher percentage reported prior medication-assisted treatment. Overall, the greatest number of differences was observed between women with ambivalent versus intended pregnancies. This is in contrast to the general population literature, where women with ambivalent pregnancies tend to be most similar to women with intended pregnancies in terms of demographic characteristics and maternal and infant outcomes (Mohllajee et al., 2007). Additional studies will be needed to replicate this pattern of results and to determine the implications of such differences.

Although there were no differences as a function of pregnancy intention on this variable, it is notable that more than 90% of the total sample had a history of prior drug treatment, averaging more than three episodes. These data

suggest that drug abuse treatment programs may be an important setting for interventions to reduce the very high rate of unintended pregnancy in this population. In the late 1980s, the Centers for Disease Control (CDC) funded several demonstration projects designed to improve access to reproductive health services for women at high risk of unintended pregnancy and HIV infection, including women with substance use disorders (see Armstrong et al., 1999). One strategy for doing so involved integrating free family planning services into drug treatment programs. The limited results reported from these projects suggest that women who received family planning services, including inexpensive referral services, in their drug treatment program were more likely to be using contraception at follow-up than were women who did not (CDC, 1995). These findings suggest that this is a promising model that should be further developed and rigorously tested as part of efforts to reduce unintended pregnancy among drug-abusing women.

This study has notable strengths. The data were systematically collected across eight diverse U.S. and international clinical sites and settings and represent the largest data set to date on the topic of pregnancy intention in pregnant women with substance use disorders. The study also has limitations. The format of the pregnancy intention question differed from the format used in national surveys (e.g., the National Survey on Family Growth and Pregnancy Risk Assessment Monitoring System) and has not been formally validated in women with substance use disorders. In addition, it is possible that women who were screened for potential study participation may not be representative of the larger population of opioid-dependent women. Nevertheless, the results of this study clearly document the extremely high rate of unintended pregnancy among a large sample of opioid-abusing women and underscore the need for a greater scientific attention to this serious problem.

## Acknowledgments

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## References

Armstrong, K. A., Kennedy, M. G., Kline, A., & Tunstall, C. (1999). Reproductive health needs: Comparing women at high, drug-related risk of HIV with a national sample. *Journal of the American Medical Women's Association, 54*, 65–70.

Centers for Disease Control. (1995). What we have learned...1990-1995. Retrieved from http://www.cdc.gov/std/research/older/wwhl-1990-1995/learn0.htm.

Center for Substance Abuse Treatment. (1993). *Improving treatment for drug-exposed infants.* Treatment Improvement Protocol (TIP) Series 5. Rockville, MD.

Chandra, A., Martinez, G. M., Mosher, W. D., Abma, J. C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital and Health Statistics*, 1–160.

D'Angelo, D. V., Gilbert, B. C., Rochat, R. W., Santelli, J. S., & Herold, J. M. (2004). Differences between mistimed and unwanted pregnancies among women who have live births. *Perspectives on Sexual and Reproductive Health, 36*, 192–197.

Graham, H. (2007). *Unequal lives: Health and socioeconomic inequalities.* Berkshire, England: Open University Press.

Graham, H. (2009). Women and smoking: Understanding socioeconomic influences. *Drug and Alcohol Dependence, 104*(Suppl 1), S11–S16.

Jones, H. E., Martin, P. R., Heil, S. H., Kaltenbach, K., Selby, P., Coyle, M. G., et al. (2008). Treatment of opioid dependent pregnant women: Clinical and research issues. *Journal of Substance Abuse Treatment, 35*, 245–259.

Kaltenbach, K., Berghella, V., & Finnegan, L. (1998). Opioid dependence during pregnancy. Effects and management. *Obstetrics and Gynecology Clinics of North America, 25*, 139–151.

Mishel, L. l., Berstein, J., & Shierholz, H. (2009). *The state of working America, 2008/2009.* Ithaca, NY: ILR Press.

Mohllajee, A. P., Curtis, K. M., Morrow, B., & Marchbanks, P. A. (2007). Pregnancy intention and its relationship to birth and maternal outcomes. *Obstetrics and Gynecology, 109*, 678–686.

Selwyn, P. A., Carter, R. J., Schoenbaum, E. E., Robertson, J., Klein, R. S., & Rogers, M. F. (1989). Knowledge of HIV antibody status and decisions to continue or terminate pregnancy among intravenous drug users. *Journal of the American Medical Association, 261*, 3567–3571.

Williams, L., Morrow, B., Shulman, H., Stephens, R., D'Angelo, D., & Fowler, C. I. (2006). PRAMS 2002 surveillance report. Retrieved from http://www.cdc.gov/PRAMS/2002PRAMSSurvReport/Index.htm.

Senate Finance Committee
Alaska State Capitol
Juneau, AK 99801

Re: Testimony on Senate Bill 198

March 26th, 2018

Dear committee members,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to comment on Senate Bill 198.

As the nation's leading provider of sexual and reproductive health care services, Planned Parenthood works every day to ensure that people in Alaska have access to the full range of birth control methods. In 2016 we provided Long Acting Reversible Contraception to more than 1,000 patients in Alaska. We believe that every woman deserves the ability to access the best birth control method that is right for her, whether that be LARC or another method, and we strongly support efforts to address barriers to access to the full range of birth control methods.

We share the legislature's interest in improving the health and wellbeing of women and children in our state. We support efforts to evaluate best practices related to women's health and to facilitate the sharing of these best practices across provider networks, as called for in this legislation. Increasing collaboration across our health care system and implementing evidence-based solutions are important tools to improve women's health across our state.

However, we do have concerns about this bill as written. First is the long history of coercive practices around provider-controlled contraceptive methods such as LARC. Low-income women and women of color, groups that are disproportionately impacted by substance use disorder, have been particularly harmed by this coercion. Because of this history and the potential for ongoing coercion, nobody should be directed towards any particular method solely because it is cost-effective or more effective at preventing pregnancy. Birth control methods are not one-size-fits-all: the best birth control method is that which meets an individual's needs. LARC effectiveness at preventing unintended pregnancy is not the only way a woman might evaluate what would work best for her at any given time in her life.

Women struggling with substance use disorder are just as deserving of the right to make their own reproductive health decisions based on their own unique needs and considerations. Instead of steering women towards certain methods without regard for the woman's own preferences or needs, the state should work to ensure that every person, including women struggling with substance use disorder, receives complete, unbiased information on the full range of birth control methods in order to make the decision that is best for their own personal health and unique circumstances. The attached *LARC Statement of Principles* from SisterSong outlines crucial considerations for any attempt to expand LARC access. We encourage the legislature to take these principles into account in your efforts and to take a multifaceted approach to improving contraceptive access and women's health.

Second, while we strongly support research-driven public policy, the benefits of LARC and contraceptive access generally have already been well documented. It is already well-established that LARC are the most effective methods of contraception in terms of preventing unintended pregnancy, and that there are substantial savings and public health benefits associated with improved access to and funding for family planning services:

- The Centers of Disease Control estimate that typical use of hormonal birth control fails 9 out of 100 times, whereas IUDs have a failure rate of 0.5%.
- Research published in the New England Journal of Medicine found that publicly funded family planning provided at safety-net health centers in Alaska in 2010 helped save over $65 million in public funds.[i]
- An Institute of Medicine Report has identified unintended pregnancy as a risk factor for exposure of the fetus to alcohol and other drugs, as well as a number of other negative outcomes such as inadequate prenatal care and low birth rate.[ii]

In short, we already know that access to family planning services – including LARC and the full range of contraception – reduces unintended pregnancy, saves the state money, and improves maternal and child health.

We are also concerned that this bill requires collaboration with providers who treat women with substance use disorders but does not require similar collaboration with providers who specialize in family planning and contraception, including LARC insertion and removal and unbiased contraceptive counseling. This collaboration is necessary to ensure that study participants receive high-quality, non-coercive care. This is a particularly important consideration given the fact that Alaska has a shortage of providers who are qualified and willing to both insert and remove all types of LARC.[iii] As written, this legislation does not make clear the need for improved access to training on comprehensive, culturally competent contraceptive counseling, and it does not recognize the need to consult with experts in comprehensive family planning care.

Thank you for the opportunity to comment on this legislation. We look forward to working with this committee and the legislature to advance patient-centered, multi-faceted policies that improve maternal and child health in our state.

Sincerely,

Alyson Currey
Legislative Liaison

Attachments: SisterSong "LARC Statement of Principles," Guttmacher "Guarding Against Coercion While Ensuring Access: A Delicate Balance"

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[i] Finer LB and Zolna MR, Declines in unintended pregnancies in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):834–852, http://nejm.org/doi/full/10.1056/NEJMsa1506575.

[ii] Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, D.C.: National Academy Press, 1995. https://www.nap.edu/read/4903/chapter/1

[iii] Health Management Associates. "Defunding Planned Parenthood in Alaska: Rural Women to Face Serious Challenges to Access to Care." June 2017.

Sister Song
Women of Color Reproductive Justice Collective

NATIONAL WOMEN'S HEALTH NETWORK

**Long-Acting Reversible Contraception**
**Statement of Principles**

We believe that people can and do make good decisions about the risks and benefits of drugs and medical devices when they have good information and supportive health care. We strongly support the inclusion of long-acting reversible contraceptive methods (LARCs) as part of a well-balanced mix of options, including barrier methods, oral contraceptives, and other alternatives. We reject efforts to direct women[1] toward any particular method and caution providers and public health officials against making assumptions based on race, ethnicity, age, ability, economic status, sexual orientation, or gender identity and expression. People should be given complete information and be supported in making the best decision for their health and other unique circumstances.

We call on the reproductive health, rights, and justice communities, including clinicians, professional associations, service providers, public health agencies, private funders and others to endorse the following principles.

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**We acknowledge the complex history of the provision of LARCs and seek to ensure that counseling is provided in a consistent and respectful manner that neither denies access nor coerces anyone into using a specific method.**

- Many of the same communities now aggressively targeted by public health officials for LARCs have also been subjected to a long history of sterilization abuse, particularly people of color, low-income and uninsured women, Indigenous women, immigrant women, women with disabilities, and people whose sexual expression was not respected.

**We commit to ensuring that people are provided comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner in order to ensure that each person is supported in identifying the method that best meets their needs.**

- A one-size-fits-all focus on LARCs at the exclusion of a full discussion of other methods ignores the needs of each individual and the benefits that other contraceptive methods provide. A woman seeking care who is preemptively directed to a LARC may be better served by a barrier method that reduces the spread of HIV and other sexually transmitted infections (STIs); a pill, patch, or ring that allows her to control her menstrual cycle; or

[1] While we use "woman" and "women" throughout this statement, we recognize that these terms do not encompass the full range of people who utilize contraception and who may be impacted by coercive practices. We also use the gender-inclusive "their" and "them" as singular pronouns.

any method that she can choose to stop using on her own without the approval of clinician.

- Women—particularly young women, elderly women, women of color, LGBTQ individuals, and low-income women—frequently report that clinicians talk down to them, do not take their questions seriously, and treat them as though they do not have the basic human right to determine what happens with their bodies. Only affordable coverage of all options and a comprehensive, medically accurate, and culturally competent discussion of them will ensure treatment of the whole human being and truly meet the health and life needs of every woman.

**Advocates and the medical community must balance efforts to emphasize contraception as part of a healthy sex life beyond the fear of unintended pregnancy with appropriate counseling and support for people who seek contraception for other health reasons.**

- The current focus on straight, cisgender women limits the health information given to people whose primary need may not be for preventing pregnancy, but for treating endometriosis, ovarian cysts, heavy or painful menstrual cycles, and more. This current focus also reinforces a limited set of public health outcomes that have been historically problematic, rather than respecting the bodily autonomy and rights of all women.

- Health care providers need good information to effectively consult with their patients. We seek to ensure access to training and up-to-date information on the benefits and possible drawbacks or limitations of any given option so that health professionals and clinic staff are able to provide the highest quality counseling for each and every patient.

**The decision to obtain a LARC should be made by each person on the basis of quality counseling that helps them identify what will work best for them. No one should be pressured into using a certain method or denied access based on limitations in health insurance for the insertion or removal of LARC devices.**

- Too often, providers receive biased promotional information from funders and pharmaceutical companies. It is critical that providers receive information that doesn't privilege LARC over other methods.

- Governments, foundations, and providers should reject explicit and implicit targets or goals for total numbers of LARCs inserted, which inappropriately bias the conversation between women and clinicians and can lead to coercion.

- Governments, foundations, and providers should reject incentives that limit patient choice, such as vouchers that can only be redeemed for LARCs.

**The decision to cease using a long-acting method should be made by each individual with support from their health professional without judgment or obstacles.**

- A woman who wants her LARC removed should have her decision respected and her LARC promptly removed, even if her clinician believes that she might ultimately be happy with the device if she were to wait.

- Removal of a LARC can be more demanding than insertion, but many women face significant obstacles when they want their LARC removed. Every clinic that offers a LARC should also have clinicians trained and able to remove LARCs and should offer appointments for removal at that same site. Likewise, providers should make clear that if women are not insured at the time they want their LARC removed, they may have to pay for removal out of pocket.

- When programs are implemented to increase access to LARCs, they should clearly address issues of removal, particularly how the needs of patients will be met if and when a program ends.

**The current enthusiasm for LARCs should not distract from the ongoing need to support other policies and programs that address the full scope of healthy sexuality.**

- Comprehensive sexuality education must be fully funded and supported.

- LARCs are an important addition to the range of options, but they are not the only option. The medical community must not only ensure access to and information about the full range of current methods, but also support continued research to develop new options to continue to improve quality of care and support women and families.

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Women should have the right and the ability to control their own fertility whether planning, preventing or terminating a pregnancy. Marginalized communities, and particularly women of color, have experienced many forms of reproductive oppression, from forced sterilization to restrictions on abortion access to coercive limits on their ability to have children, and they continue to face high rates of maternal mortality.

We believe articulating these principles is necessary to protect the bodily autonomy and to respect the agency, health and dignity of marginalized women so that those who have historically been oppressed or harmed feel safe when making reproductive decisions. This is a critical step forward. This is what reproductive justice looks like.

To sign the statement, please fill out the form found HERE.
For questions, please contact Sarah Christopherson at schristopherson@nwhn.org.

**This statement of principles is endorsed by the following organizations in alphabetical order:**

ACCESS Women's Health Justice
Action for Boston Community Development
Advocates for Youth
AIDS Foundation of Chicago
American Civil Liberties Union
Backline/All-Options
Black Women for Wellness
Black Women's Health Imperative
CAIR Project

California Latinas for Reproductive Justice
Cambridge Health Alliance Sexual and Reproductive Health Program
Center for Reproductive Rights
Center on Reproductive Rights and Justice at University of California, Berkeley
Civil Liberties and Public Policy (CLPP)
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Conceivable Future
Desiree Alliance
Essential Access Health
Forward Together
Harm Reduction Coalition
Healthy Philadelphia
Howard Brown Health Center
Ibis Reproductive Health
If/When/How
Illinois Caucus for Adolescent Health
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Jacobs Institute of Women's Health
Latino Commission on AIDS
Madre Tierra Latina Women Organization
Midwives for Peace & Justice
Mississippi Reproductive Freedom Fund
NARAL Pro-Choice America
NARAL Pro-Choice North Carolina
NARAL Pro-Choice Oregon
NARAL Pro-Choice Virginia
National Asian Pacific American Women's Forum (NAPAWF)
National Birth Equity Collaborative
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association (NFPRHA)
National Female Condom Coalition
National Health Law Program
National Institute for Reproductive Health
National Latina Institute for Reproductive Health
National Network of Abortion Funds
National Organization for Women (NOW)
National Organization for Women of New Jersey
National Organization for Women Northern New Jersey Chapter
National Partnership for Women & Families
National Women's Health Network
National Women's Law Center
New Mexico Perinatal Collaborative
New Voices for Reproductive Justice
New York Latina Advocacy Network
Our Bodies Ourselves
Pandora's Box Productions
Physicians for Reproductive Health
Planned Parenthood Federation of America

Mt. Baker Planned Parenthood
Planned Parenthood Hudson Peconic
Planned Parenthood Minnesota, North Dakota, South Dakota
Planned Parenthood Northern California
Planned Parenthood of Greater Ohio
Planned Parenthood of Middle and East Tennessee
Planned Parenthood of Nassau County
Planned Parenthood of South West and Central Florida
Planned Parenthood of Southern New England
Planned Parenthood of the Great Northwest and the Hawaiian Islands
Planned Parenthood Southeast
Planned Parenthood Southeastern Pennsylvania
Planned Parenthood South Texas
Population & Development Program at Hampshire College
Positive Women's Network
Prison Birth Project
Pro-Choice Alliance for Responsible Research
Program in Woman-Centered Contraception at University of California, San Francisco
Provide Inc.
Rainier Valley Community Clinic
Religious Coalition for Reproductive Choice
Religious Institute
Reproaction
Reproductive Health Access Project
Reproductive Health Technologies Project (RHTP)
Sacramento Sister Circle
Seattle Medical and Wellness Clinic
Sexual Health and Reproductive Equity Program, University of California, Berkeley
Sexuality Information and Education Council of the United States (SIECUS)
SisterLove
SisterReach
SisterSong: National Women of Color Reproductive Justice Collective
Society of Adolescent Health and Medicine (SAHM)
Southwest Women's Law Center
SPARK Reproductive Justice NOW!
St. John's Well Child and Family Center
Tapestry Health
Training in Early Abortion for Comprehensive Healthcare (TEACH)
Unitarian Universalist Association
Unitarian Universalist Pennsylvania Legislative Advocacy Network
URGE: Unite for Reproductive & Gender Equity
Women Engaged
Women with a Vision
Women's Centers
Women's Health Specialists, Feminist Women's Health Centers
Woodhull Freedom Foundation
WV Free
Young Women United
YWCA of Greater Charleston

**This statement of principles is endorsed by the following individuals in order of date signed:**

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# Guarding Against Coercion While Ensuring Access: A Delicate Balance

**By Rachel Benson Gold**

Widespread use of long-acting reversible contraceptive (LARC) methods—IUDs and hormonal implants—may be the next giant step forward for American women and couples seeking to determine whether and when to have children. These highly effective methods—which essentially can be forgotten once started—can dramatically reduce user error. And given that about four in 10 unintended pregnancies occur among women who had been using a contraceptive inconsistently or incorrectly, that is no small deal.[1] In practice, a couple relying on the pill is, on average, 45 times as likely as a couple relying on a hormonal IUD to have an unintended pregnancy in one year.[2]

Because of the potential significance of LARC methods, many family planning advocates are working to promote policies and practices that could reduce barriers to their widespread use. Reducing how much patients pay for these methods is critical: Starting an implant or IUD can cost a month's salary for a woman working full time at minimum wage.[3] And other barriers to LARC use also need to be addressed, including insufficient provider training and experience, the need for improved patient education and the high cost of the devices themselves (which make it difficult for health care providers to have them on hand so they are readily available when women request them).

Yet, reducing these barriers to LARC provision and use would not be sufficient to make good on the promise of enabling women and couples to make childbearing decisions freely and for themselves. Supporters of reproductive rights caution that it is imperative to consider not just method effectiveness but also concerns about side effects, frequency of sexual activity and the ability of individuals to readily obtain the contraceptive method they choose.[4,5] With unintended pregnancy highly concentrated among low-income women and women of color, it is also important to take into account the broader context of individuals' lives, including the range of economic, social and health-related pressures they may be facing.

As advocates of reproductive health and rights consider ways to increase access to and enable greater use of LARCs, they cannot ignore the historical context of coercive practices related to contraception, especially those targeting disadvantaged groups. These practices fall along a spectrum, ranging from extreme, overt and intentional instances of involuntary sterilization to more subtle attempts to influence women's contraceptive decision making by providing financial incentives or taking other steps to unduly encourage choice of a specific method, such as the experience with Norplant in the 1990s.

Understanding and acknowledging this dark history—some of which is recent—is important to today's conversations about increasing the use of LARC methods and, more broadly, to any discussions about individuals' contraceptive options. It should further sensitize providers about the paramount importance of providing care in a way that ensures their patients' choices are fully informed and completely voluntary. This, in turn, can help reassure patients that they are receiving unbiased and comprehensive information and

are empowered to choose freely from among the range of contraceptive options, including highly effective LARC methods.

## Long History of Sterilization Abuse

Because it permanently robs individuals of any control over their future childbearing, coercive sterilization is particularly egregious. Yet, the practice—which was often aimed at women with limited mental capacity and low-income women of color, especially those receiving government benefits or who were dependent on the government for their health care—was distressingly common not too many decades ago.

The case of Mary Alice Relf, age 12, and her 14-year-old sister Minnie—two young African American girls sterilized in Montgomery, Alabama in 1973—is notorious.[6] A nurse who had been administering injectable contraceptives under a program funded through the federal Office of Economic Opportunity brought the girls to a physician's office for their shots. Their mother, who was unable to read, accompanied them and put an "X" on a form, thinking that she was consenting to the contraceptive injections. The girls and their mother were then transferred to a hospital and their mother then escorted home; the girls were sterilized the next morning. According to the family's lawyer, the nurse returned for their 16-year-old sister Katie, but Katie evaded the nurse by locking herself in her room. Neither of the girls' parents knew the operations had taken place until after they were done.

However, what happened to the Relf sisters is hardly unique. In Aiken County Hospital in South Carolina, more than a third of the welfare recipients who gave birth during the first six months of 1973 were sterilized under a policy enforced by the county's three obstetricians.[7] The physicians, who told patients they would refuse to continue to treat them after their third delivery unless they were sterilized, differed on their rationales. According to press accounts, one of the physicians attributed his motivation to cost: "I feel that if I'm paying for them as a taxpayer, I want to put an end to their reproduction." Another said: "It's not a matter of money at all. It's that the individual shouldn't have any more children." Neither the hospital nor the state medical association objected; the hospital administrator described the policy as "well within accepted standards."

North Carolina has an especially long and disturbing history going back to the early decades of the 20th century, including the creation of the state Eugenics Board in 1933. Although the program was designed to provide sterilizations to individuals who were "feebleminded, epileptic and mentally diseased,"[8] the state Department of Public Welfare began promoting increased sterilization in the 1940s as a way to address poverty and childbearing outside of marriage.[9] Public uproar about the program, which was not formally abolished until 1977, led to passage of a 2013 law offering compensation to the estimated 7,600 residents who had been sterilized under the program. The state believes that 40% of the program's victims were nonwhite, and that 2,000 of them were younger than 18, with the youngest only 10 years old.[9,10]

In the mid-1970s, concern about abuse directed toward the Native American community led then-Sen. James G. Abourezk (D-SD) to ask the General Accounting Office to conduct an inquiry in four of the 12 Indian Health Service (IHS) areas across the country.[11] The agency's report, which covered FY 1973–1976, identified 13 violations of the agency's 1974 moratorium on sterilizing individuals younger than age 21. It also concluded that the informed consent procedures in place in the four areas "generally were not in compliance" with IHS regulations in effect at the time.

Allegations of abuse were also at the heart of a case filed by 10 low-income Latinas against Los Angeles County-USC Medical Center in the 1970s, who charged that they had been coerced into being sterilized before or during labor, or immediately after giving birth.[12] According to affidavits in the case, some of the women had not understood that the procedure was permanent. One indicated she had not been informed about the sterilization until a postpartum visit weeks later.[13] Another obtained an IUD from a family planning clinic six weeks after the surgery, and according to her claim, did not find out that she had been sterilized until 1974, two years later.[14]

Although these kinds of blatant human rights abuses are no longer officially tolerated or sanctioned anywhere in the United States, instances of alleged abuse still arise. For example, the California state auditor recently reported that between 2005 and 2013, some inmates in California state prisons had been sterilized unlawfully, and without regard to informed consent procedures.[15]

## The Norplant Controversy

By the 1990s, attention shifted away from sterilization toward Norplant, a contraceptive implant offering up to five year of protection against pregnancy that was approved by the Food and Drug Administration on December 10, 1990. Just two days after the method's approval, however, an editorial in the *Philadelphia Inquirer* argued that although no one should be compelled to use the method, "there could be incentives to do so. What if welfare mothers were offered an increased benefit for agreeing to use this new, safe, long-term contraceptive?"[16]The piece unleashed an immediate firestorm, which led the newspaper to publish a formal apology less than two weeks later: "Great pain, anger and controversy have resulted from that editorial, and we deeply regret our decision to print it....In the previous editorial we said that women on welfare should be encouraged, but not compelled, to use Norplant. We suggested incentives, such as an additional benefit of some kind. Our critics countered that to dangle cash or some other benefit in front of a desperately poor woman is tantamount to coercion. They're right."[17]

These sentiments echoed those of Sheldon Segal, who led the team that created Norplant. He said that the method was developed to enhance reproductive freedom, not restrict it, and that anyone seeking to use it for purposes of coercion would find him "leading the opposition."[18] Responding to a legislative proposal in Kansas, Segal added that "the line between incentive and coercion gets very fuzzy. The $500 bonus can be a heavy government hand on the scales of choice for the poor....When you single out a welfare mother, wave a $500 bill in front of her face and say the government is going to induce you not to have children, you've gotten into a risky area, ethically and morally."[19]

But it was too late. Employing incentives to induce low-income women to accept Norplant had taken on a life of its own.

Between 1991 and 1994, legislators in 13 states introduced measures to provide women receiving public assistance with financial incentives to obtain the implant.[20–23] In 1991 in Texas, for example, legislators proposed an amendment to an appropriations measure that would have offered a woman $300 if she agreed to receive the method and an additional $200 if she retained it for five years. Although none of these measures ever became law, the many public debates they engendered sent a powerful message about where many policymakers wanted to go. And offering incentives was just the start.

During those same years, legislators in seven states introduced bills that actually would have mandated Norplant use for some women. Some of these measures, for example, would have required it for a woman who gave birth to a newborn showing signs of substance abuse during pregnancy. One bill introduced in Washington would have required the woman to keep the method in place until she was drug-free for six months. Another in North Carolina would have mandated the implant for women who had had a publicly funded abortion, unless medically contraindicated. A bill introduced in South Carolina in 1993 would have required a woman with two or more children to have a Norplant inserted as a condition of being able to start receiving welfare benefits, and still others—in Mississippi, Ohio and South Carolina—sought to require the method for women as a condition of continuing to receive benefits for their existing children.

(In the context of the fight over welfare reform in the mid-1990s, this approach paved the way for a debate over so-called family caps, which are policies aimed at limiting welfare payments to families with more than a designated number of children or who have additional children while receiving welfare payments. Family caps remain in effect in several states today.[24] California's family cap policy takes a unique approach—exempting a woman who has an additional birth due to contraceptive failure; specifically, the woman must

provide written verification that she was using a LARC method at the time, or that she or her partner had been sterilized.[25])

Finally, legislators in Colorado and Ohio introduced measures that would have offered women convicted of a crime reduced legal sentences if they obtained the implant or agreed to be sterilized. The question of reduced sentences gained more traction in the courts, however. During the mid-1990s, in states as diverse as California, Florida, Illinois, Nebraska and Texas, judges ruled that a woman must accept implant insertion as a sentencing requirement, usually as a condition of a reduced sentence. In the 1991 California case, *People v. Johnson,* Darlene Johnson was offered

## A Global Challenge

*In nations around the world, policymakers often have sacrificed the reproductive self-determination and human rights of individual women for a variety of reasons, including fears of a population explosion or implosion; the desire for more workers, soldiers or patriots; or to serve religious orthodoxies (see "Governmental Coercion in Reproductive Decision Making: See It Both Ways," Fall 2012). In the latter half of the 20th century, reproductive and human rights activists focused global attention on the violations committed by governments curtailing what they view as "overpopulation." For example, amid anxiety about the impact of high population growth rates on deepening poverty levels, India established population growth targets, condoned mandatory sterilization laws in several states and designed punitive disincentives for large families. Similarly, in the 1990s, under former President Alberto Fujimori's regime, Peru sanctioned coercive and forced sterilizations of close to 350,000 poor and indigenous women, and almost 25,000 men, through intimidation and force.*

*Notably, it has been primarily reproductive rights advocates (as opposed to those simply opposed to government involvement in contraception or abortion altogether) who have condemned equally reprehensible governmental efforts to compel pregnancy and childbirth. The height of such coercion in the modern era occurred under President Nicolae Ceausescu's dictatorship in Romania from 1965 to 1989. Under that repressive regime, the state implemented a radical pronatalist policy that outlawed all forms of contraception and banned abortion, except for women older than 45 who had at least five children who were still minors. The state enforced these policies by carrying out mandatory monthly gynecologic exams and dispatching special state agents to health settings to investigate illegal abortions. This policy led to disastrous consequences. Maternal mortality— mostly the result of unsafe, illegal abortions—skyrocketed, as did infant mortality, while thousands of surviving children were abandoned in orphanages without basic food, health care and attention.*

*Formal U.S. policy governing international assistance efforts has consistently stood fast in opposition to coercion. The earliest U.S. Agency for International Development (USAID) guidelines from the 1960s outlined key principles under which population assistance would be provided. Under the early incarnation of these principles, assistance was conditioned on the voluntary participation of individuals free to choose among available methods that align with their own beliefs, culture and personal desires. In addition, USAID would not promote any specific family planning policies or methods; instead, U.S. funds would support the ability of "people everywhere [to] enjoy the fundamental freedom of controlling their reproduction, health, and welfare as they desire." These tenets were codified in the 1968 Foreign Assistance Act and then refined by USAID in simple and stark terms: "The underlying principles of U.S. assistance for family planning are voluntarism and informed choice."*

*In 1998, Congress weighed in and further elaborated on the standards for voluntary family planning service delivery in all international family planning assistance programs funded by the U.S. government. The provision, known as the Tiahrt amendment, prohibits quotas and numerical targets related to births, clients or particular contraceptive methods. It also forbids using financial incentives to reach targets or to deny benefits or rights when an individual rejects family planning services. Finally, the amendment mandates the provision of comprehensible information on the health benefits and risks of the method chosen. This provision, which is renewed automatically each year as part of the annual appropriations process, remains in effect and stands as an important bulwark in support of voluntarism.*

a reduced sentence for her child abuse conviction if she agreed to receive Norplant.[26] Although she agreed to the condition initially, her lawyers filed for a modification a week later. In denying her request, the judge noted that although the condition impinged on Johnson's right to procreate, that had to be balanced against the state's need to prevent child abuse. The saga came to an end when her probation was ultimately revoked after she tested positive for cocaine use and was sent to prison.

In a similar case, a judge in Illinois reduced the sentence for Lisa Ann Smith—who had pleaded guilty to child abuse in February 1993—with the stipulation that she receive the implant and obtain court approval to have it removed.[27] In rebuffing further motions to reconsider his order, the judge argued that mandating the contraceptive was a responsible option: "Almost anyone can have sex and have a baby, but there are far too many people having children who are not fit to be parents....Our jails are full of the offspring of such unions; our social welfare and health care systems reel under the strain of caring for such children and their eventual progeny." Although Smith subsequently violated the terms of her probation and was sentenced to prison, uproar over the case led to Illinois' 1993 enactment of the only state law to block judges from requiring contraceptive use (specifically, requiring that the defendant be "implanted, injected with or to use any form of birth control") as a condition of sentencing.[28]

Although the tactic of linking reduced sentences to an agreement to use long-acting or permanent contraception receded as the decade wore on, linking sentencing to the ability to procreate has not disappeared entirely. Just this year, a Virginia man facing charges of child endangerment agreed to have a vasectomy as part of a plea deal. The prosecutor who offered the deal described the arrangement as "in the best interest of the Commonwealth."[29]

## Instituting Safeguards

Disclosure of instances of coercion, both domestically and internationally (see box), have led to myriad safeguards that remain in effect today. The rules applying to sterilizations paid for by Medicaid are among the most stringent. Although the program has stipulated since 1972 that family planning services are covered only for individuals "who desire such services and supplies," subsequent regulations put additional specific requirements on Medicaid-funded sterilizations. These rules bar using Medicaid funds to sterilize anyone who is institutionalized or younger than age 21; they also require a 30-day waiting period between the time a woman consents and when the procedure is performed. The regulations lay out specific procedures designed to ensure that patients give their informed consent, including a requirement that they be told that receipt of any other benefits cannot be conditioned on agreeing to be sterilized.

From its inception in 1970, Title X also has incorporated important safeguards aimed at ensuring that all care received under the auspices of the program is obtained voluntarily; indeed, the very statute authorizing the program calls for "voluntary" family planning programs. Funded projects are bound by restrictions on sterilization services similar to those governing Medicaid. In addition, federal regulations require programs to offer services without "any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services." Moreover, Title X regulations articulate the principle that grantees must provide services "in a manner which protects the dignity of the individual."

Along similar lines, Title X regulations require that programs provide clients a choice of a broad range of contraceptive methods. Ensuring that individuals have access to the information they need to make informed choices—including information about the availability of alternatives—has long been a central principle of informed consent (see "State Abortion Counseling Policies and the Fundamental Principles of Informed Consent," Fall 2007). The Institute of Medicine recently underscored the importance of giving patients "the necessary information and opportunity to exercise the degree of control they choose over health care decisions" as part of its effort to foster patient-centered medical care.[30]

## A Question of Balance

Although these safeguards were instrumental in stemming the worst of the abuse and will still clearly have value going forward, some reproductive health advocates are concerned that they can have the unintended effect of impeding people's access to care that they clearly want.[31,32] For example, some argue that Medicaid's flat ban on sterilizations for individuals younger than 21 may block access to services for young people who freely and truly desire to terminate their childbearing ability. Moreover, the 30-day waiting period may have the effect of restricting access for women who want the procedure concurrent with either abortion or childbirth. In addition, some experts contend that the informed consent forms may be overly complex, and the requirement that the signed forms be available at the time of the procedure can be a logistical barrier for a woman wanting a sterilization concurrent with childbirth. Furthermore, it is noteworthy that these protections that apply to publicly funded procedures—or limitations, depending on one's point of view—do not apply to people who rely on private coverage.

The ability to make personal decisions about whether and when to have a child is a basic human right. Making good on that promise for all people—regardless of income, race or ethnicity—requires achieving the delicate balance between protecting unfettered access and preventing abuse, and finding that fine line between encouraging and coercing. Sometimes the line is plain to see. The U.S. history of sterilizing women without their informed consent—or in some cases without their knowledge at all—was clearly coercive. The Norplant controversies of the 1990s were equally stark, and rapidly led to a societal consensus to abandon its forced use. But although it may be less obvious, other cases, such as offering money to a low-income mother trying to provide for her children—or, for that matter, any low-income woman—still cross the fuzzy line between incentive and coercion.

In sharp contrast to events of past decades, today's conversation is motivated primarily by providers and advocates wanting individual women to have unfettered access to the extremely effective methods now available, as opposed to serving some perceived greater social good. The questions on the table now are much more nuanced and complex, and certainly no less important. Given the historical examples of women not having received the information they needed to make free and informed choices, what is the best way for practitioners to convey that some methods are more effective than others, while still ensuring that women are given the full information they need to make decisions about what is most appropriate for them? Because financial incentives have been inappropriately used to influence women's choices in the past, how can payment systems that financially reward providers when more women opt for the most effective methods, such as LARCs, be structured to avoid undermining the quality of the information and range of choices women receive?[33] This is a conversation that the reproductive health field—united as it is in its unshakeable commitment to the basic human right of individuals to make personal choices about childbearing freely and without coercion—should welcome. **www.guttmacher.org**

## REFERENCES


**1.** Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform,* New York: Guttmacher Institute, 2014, <http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf>, accessed Aug. 18, 2014.

**2.** Guttmacher Institute, Contraceptive use in the United States, *Fact Sheet,* Jun. 2014, <http://www.guttmacher.org/pubs/fb_contr_use.pdf>, accessed Aug. 18, 2014.

**3.** Brief of the Guttmacher Institute and Professor Sara Rosenbaum as *Amici Curiae* in Support of the Government, *Kathleen Sebelius v. Hobby Lobby Stores, Inc* and *Conestoga Wood Specialties Corporation v. Kathleen Sebelius,* Nos. 13-354 & 13-356, <http://www.guttmacher.org/media/guttmacher_scotus_amicus_brief.pdf>, accessed Aug. 18, 2014.

**4.** Higgins JA, Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach, *Contraception,* 2014, 89(4):237–241.

**5.** Gomez AM, Fuentes L and Allina A, Women or LARC first? Reproductive autonomy and the promotion of long-active reversible contraceptive methods, *Perspectives on Sexual and Reproductive Health,* 2014, 46(3), <http://onlinelibrary.wiley.com/doi/10.1363/46e1614/pdf>, accessed Aug. 18, 2014.

**6.** Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate, Statement of Joseph Levin, Esq., General Counsel, Southern Poverty Law Center, Montgomery, Ala., accompanied by Mr. and Mrs. Relf, Montgomery, Ala., and Warren M. Hern, M.D., M.P.H., Denver, Colo., Apr. 30, Jun. 28–29 and Jul. 10, 1973, Washington: Government Printing Office, 1973.

**7.** Eichel H, S.C. mothers on welfare sterilized, *Washington Post,* Jul. 22, 1973.

**8.** Eugenics Board of North Carolina, *Sterilization—The North Carolina Program,* Raleigh, NC: Eugenics Board of North Carolina, 1954, <http://digital.ncdcr.gov/cdm/ref/collection/p249901coll37/id/15162>, accessed Aug. 20, 2014.

**9.** N.C. Office of Justice for Sterilization Victims, Questions and answers on eugenics in N.C., 2013, <http://www.sterilizationvictims.nc.gov/documents/JS-brochure.pdf?id=635368017347622836>, accessed Aug. 18, 2014.

**10.** Office of the Speaker Pro Tempore, Rep. Paul Stam, *Eugenics in North Carolina,* 2014, <http://www.nchouserepublicanleader.com/wp-content/uploads/2014/05/Eugenics-in-North-Carolina_Final.pdf>, accessed Aug. 20, 2014.

**11.** Comptroller General of the United States, Letter Report B-164031(5) to Sen. James G. Abourezk, Nov. 4 1976, <http://archive.gao.gov/f0402/100493.pdf>, accessed Aug. 20, 2014.

**12.** Stern AM, Sterilized in the name of public health, *American Journal of Public Health,* 2005, 95(7):1128–1138.

**13.** Hernandez A, Chicanas and the issue of involuntary sterilization: reforms needed to protect informed consent, *Chicana/o - Latina/o Law Review,* 1976, 3(3):3–37.

**14.** Goodman M, 3 women ask $6 million from county in sterilization claim, *Los Angeles Times,* Nov. 21, 1974.

**15.** California State Auditor, *Sterilization of Female Inmates,* Sacramento, CA: California State Auditor, 2014, <http://auditor.ca.gov/reports/summary/2013-120>, accessed Aug. 20, 2014.

**16.** Editorial Board, Poverty and Norplant: can contraception reduce the underclass? *Philadelphia Inquirer,* Dec. 12, 1990, <http://articles.philly.com/1990-12-12/news/25920681_1_black-children-norplant-black-middle-class>, accessed Aug. 18, 2014.

**17.** Editorial Board, An apology: the editorial on 'Norplant and poverty' was misguided and wrongheaded, *Philadelphia Inquirer,* Dec. 23, 1990, <http://articles.philly.com/1990-12-23/news/25922202_1_norplant-poor-women-poverty>, accessed Aug. 18, 2014.

**18.** Sullivan P, Sheldon J. Segal, 83, led team that developed Norplant, *Washington Post,* Oct. 22, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/21/AR2009102104031.html>, accessed Aug. 18, 2014.

**19.** Goodman E, The politics of Norplant, *Washington Post,* Feb. 19, 1991.

**20.** Alan Guttmacher Institute, Legislative proposals and actions, *State Reproductive Health Monitor,* 1991, 2(4):30–43.

**21.** Alan Guttmacher Institute, Legislative proposals and actions, *State Reproductive Health Monitor,* 1992, 3(4):29–47.

**22.** Alan Guttmacher Institute, Legislative proposals and actions, *State Reproductive Health Monitor,* 1993, 4(4):30–50.

**23.** Alan Guttmacher Institute, Legislative proposals and actions, *State Reproductive Health Monitor,* 1994, 5(4):28–49.

**24.** National Conference of State Legislatures, Family cap policies, 2009, <http://www.ncsl.org/research/human-services/welfare-reform-family-cap-policies.aspx>, accessed Aug. 18, 2014.

**25.** California Department of Social Services, Eligibility and Assistance Standards Manual, Chapter 44-314.

**26.** Arthur SL, The Norplant Prescription: birth control, women control or crime control? *UCLA Law Review,* 1992, 40(1):1–101.

**27.** Alan Guttmacher Institute, Norplant: opportunity and perils for low-income women, *Special Report,* 1993, No. 2.

**28.** Alan Guttmacher Institute, Norplant: opportunity and perils for low-income women, *Special Report,* 1994, No. 3.

**29.** Jouvenal J, In an unusual plea deal, Virginia man agrees to a vasectomy, *Washington Post,* Jun. 29, 2014, <http://www.washingtonpost.com/local/crime/in-unusual-plea-deal-virginia-man-agrees-to-a-vasectomy/2014/06/29/7835371c-fe3e-11e3-932c-0a55b81f48ce_story.html>, accessed Aug. 18, 2014.

**30.** Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* Washington, DC: National Academy Press, 2001.

**31.** Borrero S et al., Potential unintended pregnancies averted and cost savings associated with a revised Medicaid sterilization policy, *Contraception,* 2013, 88(6):691–696.

**32.** Krashin JW et al., Prohibiting consent: what are the costs of denying permanent contraception concurrent with abortion care? *American Journal of Obstetrics & Gynecology,* 2014, 211(1):76.e1–76.e10.

**33.** Sonfield AS, Pay-for-performance: making it work for safety-net family planning centers and the clients they serve, *Guttmacher Policy Review,* 2014, 17(2):8–13, <http://www.guttmacher.org/pubs/gpr/17/2/gpr170208.pdf>, accessed Aug. 18, 2014.

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Senate Finance Committee
Alaska State Capitol
Juneau, AK 99801

Re: Testimony on Senate Bill 198

March 26th, 2018

Dear committee members,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to comment on Senate Bill 198.

As the nation's leading provider of sexual and reproductive health care services, Planned Parenthood works every day to ensure that people in Alaska have access to the full range of birth control methods. In 2016 we provided Long Acting Reversible Contraception to more than 1,000 patients in Alaska. We believe that every woman deserves the ability to access the best birth control method that is right for her, whether that be LARC or another method, and we strongly support efforts to address barriers to access to the full range of birth control methods.

We share the legislature's interest in improving the health and wellbeing of women and children in our state. We support efforts to evaluate best practices related to women's health and to facilitate the sharing of these best practices across provider networks, as called for in this legislation. Increasing collaboration across our health care system and implementing evidence-based solutions are important tools to improve women's health across our state.

However, we do have concerns about this bill. First is the long history of coercive practices around provider-controlled contraceptive methods such as LARC. Low-income women and women of color, groups that are disproportionately impacted by substance use disorder, have been particularly harmed by this coercion. Because of this history and the potential for ongoing coercion, nobody should be directed towards any particular method solely because it is cost-effective or more effective at preventing pregnancy. Birth control methods are not one-size-fits-all: the best birth control method is that which meet an individual's needs, and LARC effectiveness at preventing unintended pregnancy is not the only way a woman might evaluate what would work best for her at any given time in her life.

Women struggling with substance use disorder are just as deserving of the right to make their own reproductive health decisions based on their own unique needs and considerations. Instead of steering women towards certain methods without regard for the woman's own preferences or needs, the state should work to ensure that every person, including women struggling with substance use disorder, receives complete, unbiased information on the full range of birth control methods in order to make the decision that is best for their own personal health and unique circumstances. The attached *LARC Statement of Principles* from SisterSong outlines crucial considerations for any attempt to expand LARC access. We encourage the legislature to take these principles into account in your efforts and to take a multifaceted approach to improving contraceptive access and women's health.

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Second, while we strongly support research-driven public policy, the benefits of LARC and contraceptive access generally have already been well documented. It is already well-established that LARC are the most effective methods of contraception in terms of preventing unintended pregnancy, and that there are substantial savings and public health benefits associated with improved access to and funding for family planning services:

- The Centers of Disease Control estimate that typical use of hormonal birth control fails 9 out of 100 times, whereas IUDs have a failure rate of 0.5%.
- Research published in the New England Journal of Medicine found that publicly funded family planning provided at safety-net health centers in Alaska in 2010 helped save over $65 million in public funds.[i]
- An Institute of Medicine Report has identified unintended pregnancy as a risk factor for exposure of the fetus to alcohol and other drugs, as well as a number of other negative outcomes such as inadequate prenatal care and low birth rate.[ii]

In short, we already know that access to family planning services – including LARC and the full range of contraception – reduces unintended pregnancy, saves the state money, and improves maternal and child health.

We are also concerned that this bill requires collaboration with providers who treat women with substance use disorders but does not require similar collaboration with providers who specialize in family planning and contraception, including LARC insertion and removal and unbiased contraceptive counseling. This collaboration is necessary to ensure that study participants receive high-quality, non-coercive care. This is a particularly important consideration given the fact that Alaska has a shortage of providers who are qualified and willing to both insert and remove all types of LARC.[iii] As written, this legislation does not make clear the need for improved access to training on comprehensive, culturally competent contraceptive counseling, and it does not recognize the need to consult with experts in comprehensive family planning care.

Thank you for the opportunity to comment on this legislation. We look forward to working with this committee and the legislature to advance patient-centered, multi-faceted policies that improve maternal and child health in our state.

Sincerely,

Alyson Currey
Regional Field Organizer and Legislative Liaison

Attachments: SisterSong "LARC Statement of Principles," Guttmacher "Guarding Against Coercion While Ensuring Access: A Delicate Balance"

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[i] Finer LB and Zolna MR, Declines in unintended pregnancies in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):834–852, http://nejm.org/doi/full/10.1056/NEJMsa1506575.

[ii] Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, D.C.: National Academy Press, 1995. https://www.nap.edu/read/4903/chapter/1

[iii] Health Management Associates. "Defunding Planned Parenthood in Alaska: Rural Women to Face Serious Challenges to Access to Care." June 2017.

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4/16/18

# AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE TARR

TO: SB 198

Page 1, line 13, following "disorders":

Insert ", including health care providers who provide comprehensive contraception and contraceptive counseling,"

30-LS1393\D.9
Laffen
4/16/18

# AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE TARR

TO: SB 198

Page 2, lines 17 - 18:

Delete "establish a comprehensive strategy for using long-acting reversible contraception to reduce"

Insert "assess the role of comprehensive contraceptive access in reducing"

30-LS1393\D.12
Laffen
4/17/18

# AMENDMENT

OFFERED IN THE HOUSE

TO: SB 198

Page 2, lines 8 - 10:

Delete all material and insert:

"(5) provide comprehensive contraceptive counseling to participants in the study;"

(6) provide to the participants, if long-acting reversible contraception is determined to be the most appropriate method of contraception for participants in the study,

(A) long-acting reversible contraception;

(B) removal of the long-acting reversible contraception;

(C) follow-up care related to the long-acting reversible contraception after the study concludes;"

Renumber the following paragraphs accordingly.

30-LS1393\D.13
Laffen
4/18/18

# AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ZULKOSKY

TO: SB 198

Page 1, lines 1 - 2:

Delete **"relating to a study of the effectiveness and cost of providing long-acting reversible contraception to women with substance abuse disorders"**

Insert **"establishing a pilot project relating to women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure"**

Page 1, line 4, through page 3, line 7:

Delete all material and insert:

"* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

PILOT PROJECT: LONG-ACTING REVERSIBLE CONTRACEPTION. (a) The University of Alaska Anchorage shall establish a pilot project for the purpose of identifying

(1) barriers of access to long-acting reversible contraception by women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure; and

(2) pathways for providing greater support and wraparound services, including the provision of long-acting reversible contraception, for women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure.

(b) The University of Alaska shall complete a final report and two interim reports describing the results of the pilot project. The university shall complete the first interim report not later than June 30, 2019, the second interim report not later than June 30, 2020, and the

final report not later than June 30, 2021, and submit each report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that each report is available.

(c) In this section, "long-acting reversible contraception" means a method of birth control that prevents a woman from becoming pregnant for an extended time without requiring action by the user, but that can be reversed to allow the woman to become pregnant."

30-LS1393\D.14
Laffen
4/19/18

# AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ZULKOSKY

TO: SB 198

Page 1, lines 1 - 2:

Delete **"effectiveness and cost of providing long-acting reversible contraception to"**

Insert **"barriers of access to long-acting reversible contraception for"**

Page 1, line 9:

Delete "effectiveness of providing long-acting reversible contraception to"

Insert "barriers of access to long-acting reversible contraception for"

Page 2, following line 10:

Insert a new paragraph to read:

"(6) identify pathways for providing greater support and wraparound services, including the provision of long-acting reversible contraception, for women with substance abuse disorders who are at high risk for unintended pregnancies that may result in prenatal drug or alcohol exposure;"

Renumber the following paragraphs accordingly.

Page 2, lines 11 - 12:

Delete "and the effectiveness of long-acting reversible contraception in reducing"

Insert "to reduce"

Page 2, lines 21 - 22:

Delete "cost and effectiveness of providing long-acting reversible contraceptives to women in substance abuse treatment programs"

Insert "barriers of access to long-acting reversible contraception for women with substance abuse disorders"

**From:** Niesje Steinkruger
**To:** Rep. Ivy Spohnholz
**Subject:** SB 198 Long Acting Contraception Study comments
**Date:** Thursday, April 19, 2018 11:34:46 AM

Please include in committee packet for SB 198 today. Thank you, Niesje

**Subject: RE: SB 198 Long Acting Contraception**

Hello Alaska Legislature,

My name is Niesje Steinkruger. I am a retired Superior Court Judge from Fairbanks. FASD has been a part of my legal caseload since 1976 when, as a new lawyer, I was appointed as a Guardian ad Litem , by the court to represent a child with FASD. I have also been the lawyer for Moms, for Dads, for Foster Parents, and the Judge, in many cases with FASD children in CINA, Delinquency, Guardianship, Alcohol Commitment, Mental Commitment and Criminal Cases.

Alaska spends billions of dollars treating and providing services to our citizens with FASD. Money is plowed into the budgets of Schools, Medical Care, Foster Care, Mental Health, Law Enforcement, and Corrections. The only way to stem the $$ tide and the human pain is to focus on Prevention, not just treatment.

SB 198 allows us to try giving women with severe substance abuse addictions access to LARC. This option is not a form of abortion. It allows a woman to prevent. The unplanned pregnancy rate believed to be 50% in the general population and 90% in the population this bill would provide access to. We must give these women the option of access to LARC such as an implant in their arm that prevents an unplanned pregnancy with a FASD child.

This is not a moral issue of these women being "stronger" so they don't use alcohol and drugs or have sex. It is an issue of preventing continuing FASD children if the mother so chooses. Australia, Canada and some European countries are in stride with us in offering prevention, not just more treatment.

I urge you to pass SB 198 to allow Alaska to keep working toward FASD prevention options.

Niesje Steinkruger
Retired Faurbanks
Superior Court Judge

SB 198

Thank you Madame Chair my name is Serene Rose O'Hara-Jolley and I live in Fairbanks, I am an adjunct professor at University of Alaska Fairbanks and I am here representing myself.

I am here to voice my concerns with SB 198 and urge the committee to vote to amend. In graduate school I had the privilege of gaining IRB approval. I would like to speak to the IRB process as I have some concerns I hope the committee will take into consideration. The IRB does in fact have stringent ethical standards and all research that is approved by the board must pass rigorous guidelines. However, in the past, all though unintentional the IRB has approved studies that have harmed vulnerable population, and although they have learned from these missteps and taken steps to prevent these oversights from happening again we must remember they are not infallible. We must insure that the IRB is considering all aspects of the potential risk to the health and safety of participants. The IRB only applies their guidelines to the research proposal as it is laid before the board. Aspects that may need to be ethically considered, if not directly laid out in the study, fall out side of the potential purview of the board. To put that in the context of the current study. Right now, the study as written is concerned with the insertion of LARC and its effects on pregnancy rates, currently it layouts no provisions or funding for the removal of LARC. If this is not explicitly part of the study the IRB could potentially not address removal. I personally have reservations about implanting and inserting medical devises that require not only an additional doctors visit but the funds to pay for removal or access to insurance that covers it. LARC removal is expensive and will eventually be necessary for all participants as all LARC has an expiration date. Since this proposal as written does not account for this it potentially leaves an already at risk group of women with another financial responsibility, one that could lead to adverse heath effects if the LARC is not removed when needed. In testimony on Tuesday in front of this committee the PI stated that they would help women to gain insurance to cover costs, however if a participants is not able to obtain insurance one adverse effect could either use all the financial resources of the study or the study could leave that woman to bare the burden of that cost. In addition, retention rates of all participants in studies are small and no provisions are in place if a women leaves Alaska for the removal of the device. I also have concerns that will be addressed by the IRB but I think should also be brought to the attention of the committee as the state is funding this project. This study is potentially coercive if participants financially feel as though they have no other option. In addition, asking women who have just given birth and are potentially not of sound mind from chemical substances self administered or administered by hospital staff calls into question for me personally the ethics of this study. It does not seem that these women will be in a position to give informed consent. We already know that LARC prevents untended pregnancies, we do not need to put a group of women at risk to study something we already know to be fact. I urge the committee to make sure that our state is funding a project that is safe for the women involved and not setting them up for further financial hardship or medical complications. I urge the committee to amend the proposal to address these concerns so that the state does not fund a project that potentially harms women.

Thank you for your time

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Planned Parenthood Votes Northwest and Hawaii

House Health and Social Services Committee
Alaska State Capitol
Juneau, AK 99801

Re: Testimony on Senate Bill 198

April 19, 2018

Dear committee members,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to comment on Senate Bill 198.

As the nation's leading provider of sexual and reproductive health care services, Planned Parenthood works every day to ensure that people in Alaska have access to the full range of birth control methods. In 2016 we provided Long Acting Reversible Contraception (LARC) to more than 1,000 patients in Alaska and also provided nearly 8,000 units of short acting contraception (pills, patches and rings).

We believe that every woman deserves the ability to access the best birth control method that is right for her, whether that be LARC or another method. Planned Parenthood strongly support efforts to address barriers to access to the full range of birth control methods. We reject efforts to direct people to any particular method solely because it is cost-effective or more effective at preventing pregnancy.

We also share the legislature's interest in improving the health and wellbeing of women and children in our state. We support efforts to evaluate best practices related to women's health and to facilitate the sharing of these best practices across provider networks, as called for in this legislation. Increasing collaboration across our health care system and implementing evidence-based solutions are important tools to improve women's health across our state.

However, we do have concerns about this bill. First and foremost is the long history of coercive practices around provider-controlled contraceptive methods such as LARC. Low-income women and women of color, groups that are disproportionately impacted by substance use disorder, have been particularly harmed by this coercion. Because of this history and the potential for ongoing coercion, nobody should be directed towards any particular method solely because it saves the state money or improves public health metrics.

Birth control methods are not one-size-fits-all: the best birth control method is that which meets an individual's needs, and LARC effectiveness at preventing unintended pregnancy is not the only way a woman might evaluate what would work best for her at any given time in her life. Women consider many factors when making decisions about contraception. This includes side effects, personal comfort or discomfort with a method, and other health concerns such as the need to protect against STIs. Any attempt to expand access to LARC must treat women as whole people with complex and unique needs. Women struggling with substance use disorder are no exception.

Women struggling with substance use disorder deserve the right to make their own reproductive health decisions based on their own unique needs and considerations. Instead of steering women towards

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certain methods without regard for the woman's own preferences or needs, the state should work to ensure that every person receives complete, unbiased information on the full range of birth control methods in order to make the decision that is best for them. The attached *LARC Statement of Principles* from SisterSong outlines crucial considerations for any attempt to expand LARC access. We encourage the legislature to take these principles into account in your efforts and to take a multifaceted approach to improving contraceptive access and women's health.

This includes ensuring that study participants have access to LARC removal both during and after the study. Women who cannot continue using LARC, or who would prefer not to, must have access to the follow-up care needed to discontinue use. This legislation does not take this into account and the accompanying fiscal note does not include the funding necessary to put a process in place. If there is no funding to provide removal services and follow-up care, it simply will not be possible to establish a removal process for all participants, including those who remain uninsured. This issue must be addressed before this legislation moves forward.

As written, this bill does not adequately safeguard the reproductive autonomy of study participants. We cannot simply assume that this and other important concerns will be worked out later. To advance our shared goal of preventing reproductive coercion, we must clarify the bill to make sure there is no doubt about the protections that must be in place. If we all agree on this important principle, there is simply no good reason not to put it in writing.

Additionally, while we strongly support research-driven public policy, the benefits of LARC and contraceptive access generally have already been well documented. It is already well-established that LARC are the most effective methods of contraception in terms of preventing unintended pregnancy, and that there are substantial savings and public health benefits associated with improved access to and funding for family planning services:

- The Centers of Disease Control estimate that typical use of hormonal birth control fails 9 out of 100 times, whereas IUDs have a failure rate of 0.5%.
- Research published in the New England Journal of Medicine found that publicly funded family planning provided at safety-net health centers in Alaska in 2010 helped save over $65 million in public funds.[i]
- An Institute of Medicine Report has identified unintended pregnancy as a risk factor for exposure of the fetus to alcohol and other drugs, as well as a number of other negative outcomes such as inadequate prenatal care and low birth rate.[ii]

In short, we already know that access to family planning services – including LARC and the full range of contraception – reduces unintended pregnancy, saves the state money, and improves maternal and child health.

We are also concerned that this bill requires collaboration with providers who treat women with substance use disorders but does not require similar collaboration with providers who specialize in family planning and contraception, including LARC insertion and removal and unbiased contraceptive counseling. This collaboration is necessary to ensure that study participants receive high-quality, non-coercive care. This is a particularly important consideration given the fact that Alaska has a shortage of

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providers who are qualified and willing to both insert and remove all types of LARC.[iii] As written, this legislation does not make clear the need for improved access to training on comprehensive, culturally competent contraceptive counseling, and it does not recognize the need to consult with experts in comprehensive family planning care. Again, we cannot simply assume that this will be addressed later. This requirement must be explicitly added to this legislation to ensure that study participants receive the high-quality contraceptive care they deserve.

We appreciate this committee's thoughtful and careful consideration before moving this bill forward. As written, we cannot support this bill. If it is amended to be clear and explicit about necessary protections for study participants to protect their rights and bodily autonomy, we would need to re-review the bill and decide.

Thank you for the opportunity to comment on this legislation. We look forward to continue working with this committee and the legislature to advance patient-centered, multi-faceted policies that improve maternal and child health in our state.

Sincerely,

Alyson Currey
Alaska Legislative Liaison
Alyson.Currey@ppvnh.org
907.957.8708

Attachments: SisterSong "LARC Statement of Principles," Guttmacher "Guarding Against Coercion While Ensuring Access: A Delicate Balance"

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[i] Finer LB and Zolna MR, Declines in unintended pregnancies in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):834–852, http://nejm.org/doi/full/10.1056/NEJMsa1506575.

[ii] Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, D.C.: National Academy Press, 1995. https://www.nap.edu/read/4903/chapter/1

[iii] Health Management Associates. "Defunding Planned Parenthood in Alaska: Rural Women to Face Serious Challenges to Access to Care." June 2017.