Getting a Step Ahead

Using a Public Health Framework to Guide FASD Prevention

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Summary of FASD in Canada

- US FASD prevalence – **2 to 5%** (May et al. 2009)
- Canada – No established rate, estimated at **1%**
  - Forms basis of FASD cost estimates - **$5.3 billion/yr**
  - **I**ncludes **$2.1 billion** in health services (Stade et al., 2009; Clarren et al., 2011)

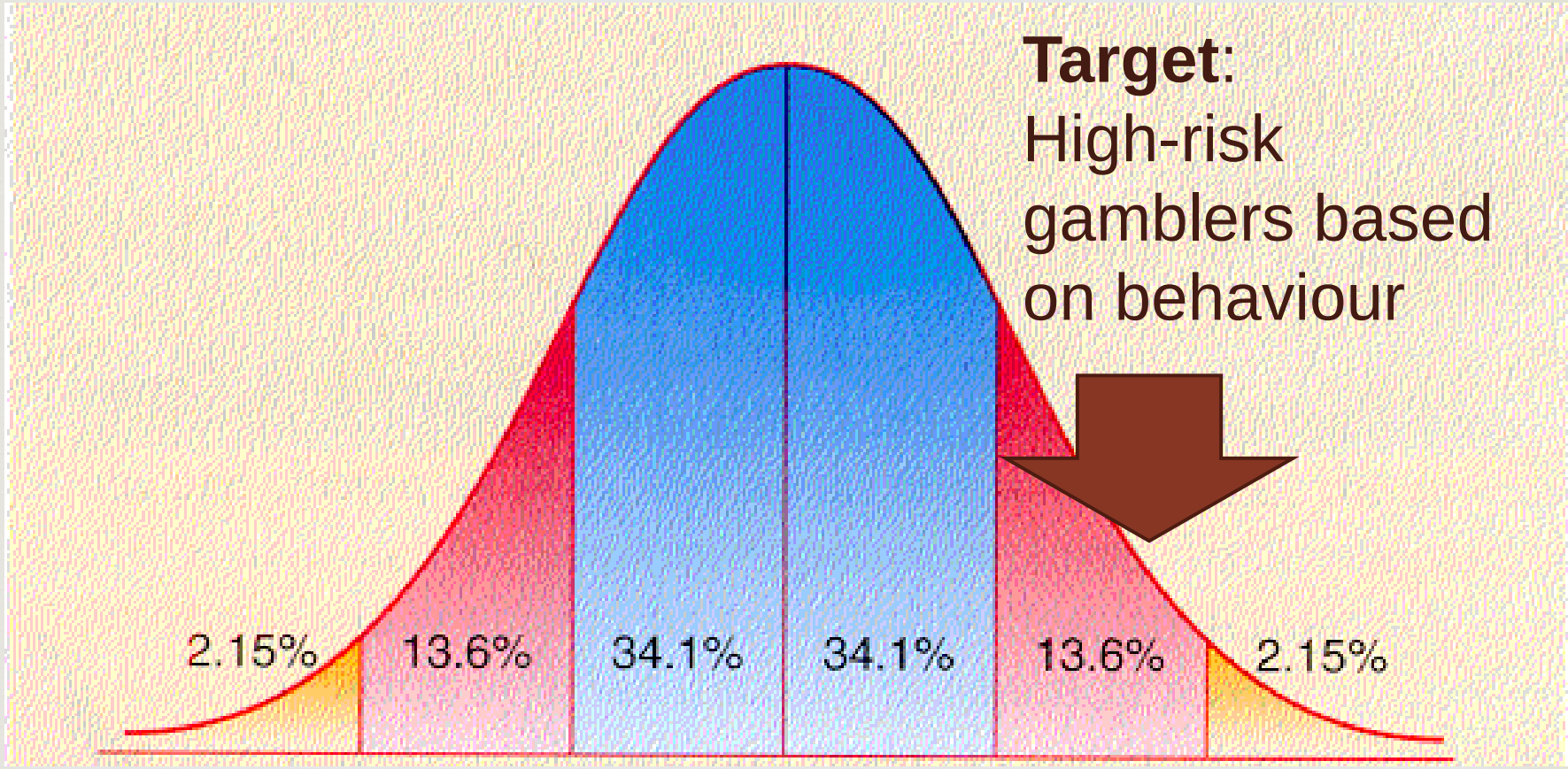
Preventing Alcohol Exposed Pregnancies (AEP)

- Primary prevention
- Downstream vs Upstream
- Upstream to where?
  - The point of pregnancy

Lalonde At-Risk Approach

- Public health interventions focus on populations marked by a health risk behaviour (i.e. alcohol over-consumption) or biological indicators (i.e. pregnancy)

High-Risk Population Focus



Many FASD prevention efforts use an at-risk approach

- Targeting a biological indicator and/or risk behaviour :
  - Women who are pregnant (most common)
  - Women who may become pregnant who drink alcohol
- Applies to Selective, Indicated, and many Universal prevention efforts

Further Upstream

- Project CHOICES (Canada & US)
  - Provide counselling sessions and contraception consultation
  - Targeted women at high risk for alcohol who may become pregnant

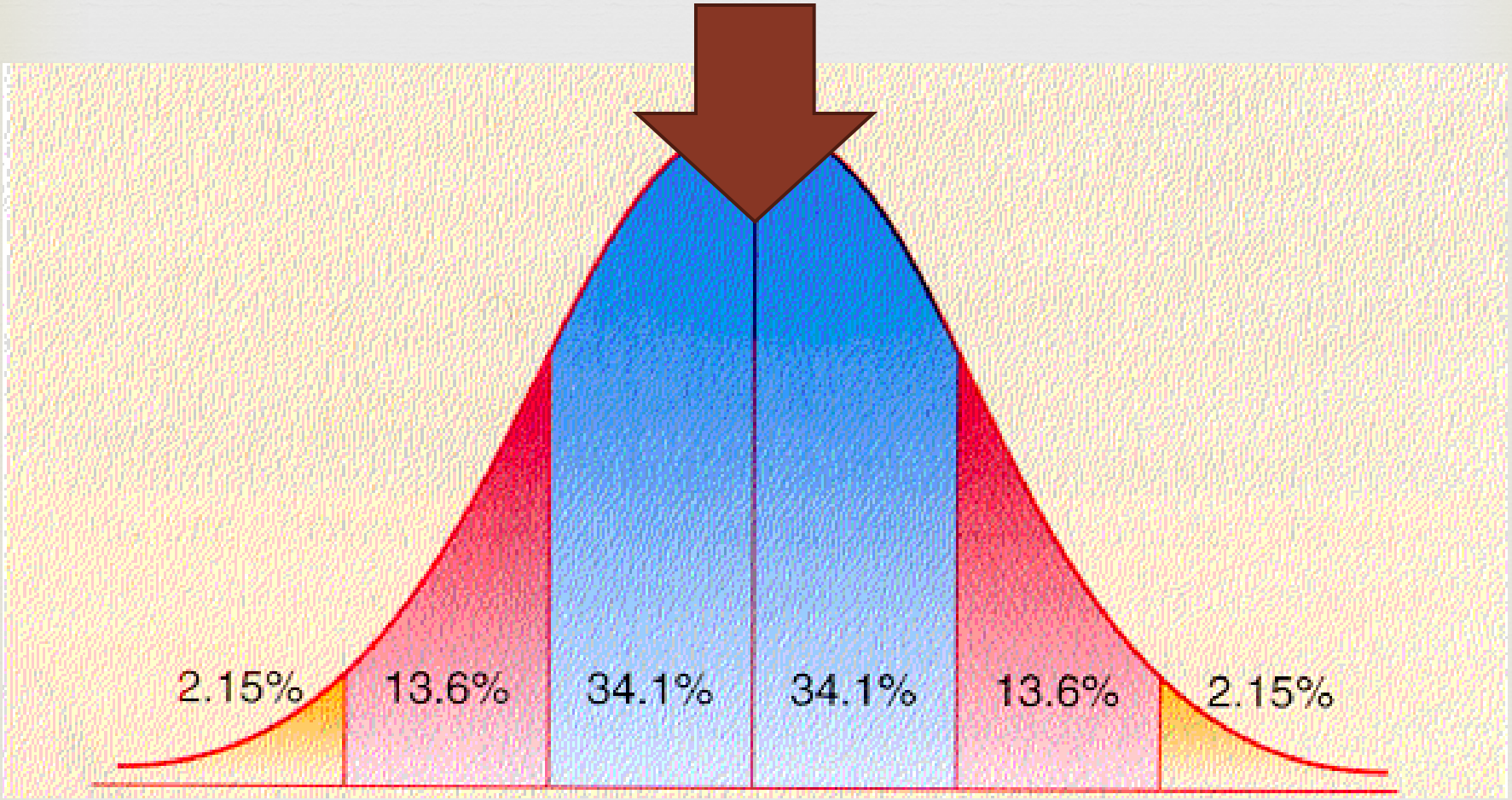
Key limitation of the Lalonde approach

- Behavioural risk and biological factors are often based on behaviours that are considered self-induced
- This can result in blaming, stigmatization, and marginalization

Geoffrey Rose
Whole Population Approach

- Public health interventions focus on the **whole population**, not only those who present with specific health or biological risk - e.g., smokers.
- Goal is to shift the whole population to a lower risk state (lower **average** blood pressure in population) rather than focusing on just those who already have high BP.
- Focus is preventing **new cases of disease** (address the causes of incidence), rather than waiting until people have high BP before giving assistance.

Whole Population Focus



Average BP in population

High BP

Examples of FASD prevention efforts that use a whole population approach

- Some Universal prevention efforts:
  - Awareness campaigns (i.e. FASD day)
  - Advertisement not specifically targeting pregnant women
- Enforcement/prosecution

Vulnerable Population Focus (Frohlich & Potvin, 2008)

- Those with higher SES **derive more benefit** from a whole population focus.
- **UNDERLYING MECHANISMS** in society that lead to health inequities across social groups not addressed.
- **Vulnerable Population Focus**: Focus on those vulnerable to alcohol-exposed pregnancies due to their social circumstances – not whether they are currently pregnant.

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Short reports

What types of interventions generate inequalities? Evidence from systematic reviews

Theo Lorenc[1], Mark Petticrew[1], Vivian Welch[2], Peter Tugwell[2]

Abstract

Background Some effective public health interventions may increase inequalities by disproportionately benefiting less disadvantaged groups ('intervention-generated inequalities' or IGIs). There is a need to understand which types of interventions are likely to produce IGIs, and which can reduce inequalities.

Methods We conducted a rapid overview of systematic reviews to identify evidence on IGIs by socioeconomic status. We included any review of non-healthcare interventions in high-income countries presenting data on differential intervention effects on any health status or health behaviour outcome. Results were synthesised narratively.

Results The following intervention types show some evidence of increasing inequalities (IGIs) between socioeconomic status groups: media campaigns; and workplace smoking bans. However, for many intervention types, data on potential IGIs are lacking. By contrast, the following show some evidence of reducing health inequalities: structural workplace interventions; provision of resources; and fiscal interventions, such as tobacco pricing.

Conclusion Our findings are consistent with the idea that 'downstream' preventive interventions are more likely to increase health inequalities than 'upstream' interventions. More consistent reporting of differential intervention effectiveness is required to help build the evidence base on IGIs.

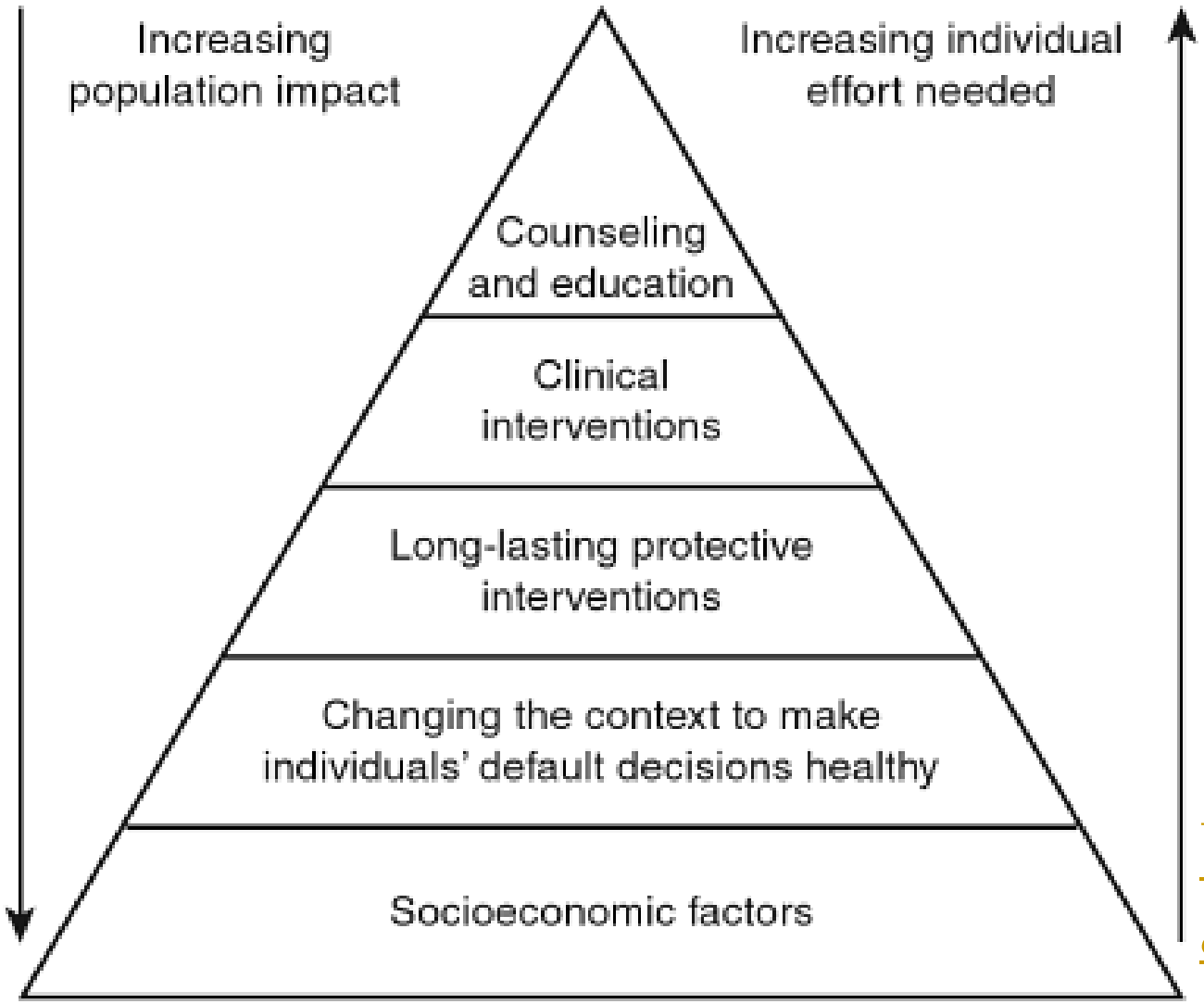
How Can We Prevent Alcohol-Exposed Pregnancies in Vulnerable Groups?

Educational approaches to health promotion have proved disappointingly ineffective. (Gillam et al. 2012).

What are the problems with a focus on educating people?

1. Educating people on ‘how to behave better’ is often **not that effective** in eliciting lasting behaviour change.

2. **New people** will also continue to enter the population at an unaffected rate, who then have to be educated on “how to behave better”. (Syme, 2008)



Link to article

FIGURE 1.5 The Health Impact Pyramid. From Frieden, T. R. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health*, 100, 591.

Alcohol and Pregnancy in Canada

- About half of all pregnancies in North America are unintended (Singh, Sedgh, & Hussain, 2010)
- An unwanted pregnancy is associated with alcohol exposure during pregnancy (Walker et al., 2011)

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Original Research

Preventing Unintended Pregnancies by Providing No-Cost Contraception

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Clinical ObGyn

Abstract

OBJECTIVE: To promote the use of long-acting reversible contraceptive (LARC) methods (intrauterine devices [IUDs] and implants) and provide contraception at no cost to a large cohort of participants in an effort to reduce unintended pregnancies in our region.

METHODS: We enrolled 9,256 adolescents and women at risk for unintended pregnancy into the Contraceptive CHOICE Project, a prospective cohort study of adolescents and women desiring reversible contraceptive methods. Participants were recruited from the two abortion facilities in the St. Louis region and through provider referral, advertisements, and word of mouth. Contraceptive counseling included all reversible methods but emphasized the superior effectiveness of LARC methods (IUDs and implants). All participants received the reversible contraceptive method of their choice at no cost. We analyzed abortion rates, the percentage of abortions that were repeat abortions, and teenage births.

RESULTS: We observed a significant reduction in the percentage of abortions that were repeat abortions in the St. Louis region compared with Kansas City and nonmetropolitan Missouri ($P<.001$). Abortion rates in the CHOICE cohort were less than half the regional and national rates ($P<.001$). The rate of teenage birth within the CHOICE cohort was 6.3 per 1,000, compared with the U.S. rate of 34.3 per 1,000.

CONCLUSION: We noted a clinically and statistically significant reduction in abortion rates, repeat abortions, and teenage birth rates. Unintended pregnancies may be reduced by providing no-cost contraception and promoting the most effective contraceptive methods.

LEVEL OF EVIDENCE: II

Another Method to Reduce FASD

Remove barriers for women to prevent unintended pregnancy:

- Address accessibility & affordability of contraception
- Address access to various methods of contraception (i.e. IUD, oral contraception)
- Respecting women's rights and working with women to better address their needs