CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

OVERVIEW

California is making important strides to improve the health status of women as shown by the dramatic decrease in death rates for females (11.2 percent between 1990 and 1998).[1] These improvements may be attributed to the effectiveness of new or expanded programs such as those focused on improving access to health care services, promoting the importance of prenatal care, and increasing breast cancer screening and diagnostic services. However, there is still much to be done, especially in affecting disparities in access to health care.

The California Women's Health Survey (CWHS) was established to collect, analyze, and disseminate information to guide decision-making about women's health by public health professionals and policymakers. Data are collected through a computer-assisted telephone survey of randomly selected California women. The CWHS is a collaborative effort of the California Department of Health Services (CDHS), the California Department of Social Services, the California Department of Alcohol and Drug Programs, and the Public Health Institute's Survey Research Group. The CDHS Office of Women's Health and the Survey Research Group coordinate and facilitate the project, with collaborators working together to develop the survey instrument, analyze data, and distribute findings. Funding for the data collection is provided by the collaborators.

The Survey Research Group, Public Health Institute, 1700 Tribute Road, Suite 100, Sacramento, CA 95815-4402, administers the interviews for the CWHS. Each year, approximately 4,000 randomly selected women are interviewed anonymously in either English or Spanish. Data are weighted in these analyses by age and race/ethnicity to reflect the 2000 California adult female population.

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Special thanks to the Women’s Health Council including Mary Wiberg, California Commission on the Status of Women.

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1 California Department of Health Services, Vital Statistics of California, 1998.

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2. **Women Who Were Food Insecure by Employment Status, 2004.** Nikki Baumrind and Sheila Dumbauld, Research and Evaluation Branch, California Department of Social Services, (916) 654-1327, skl1@cox.net

3. **Food Insecurity Among Women Who Have Children Under Age 18 Living in the Household, 2004.** Nikki Baumrind and Sheila Dumbauld, Research and Evaluation Branch, California Department of Social Services, (916) 654-1327, skl1@cox.net

4. **Risk for Housing Insecurity (HI) Among California Women, 2003.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov; Marta Induni, Survey Research Group, Public Health Institute, (916) 455-2563, Minduni@SurveyResearchGroup.com

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5. **Unhealthy Days Among California Women, 2004.** Ann Webb, Survey Research Group, Public Health Institute, (916) 779-0287, awebb@surveyresearchgroup.com

6. **Women Aged 40 and Above Who Never or Rarely Receive Routine Mammography, California, 2004.** Aldona Herrndorf, Weihong Zhang, Kirsten Knutson, and Farzaneh Tabnak, Cancer Detection Section, California Department of Health Services, (916) 449-5305, Kknutson@dhs.ca.gov

7. **Heart Disease or Stroke Status Among California Women, 2004.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

8. **Diabetes Among California Women, 2004.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

9. **Breast/Reproductive Cancer Diagnosis Among California Women, 2004.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

10. **Asthma Among Adult California Women, 2004.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

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12. **Bone Density Testing and Falls, 2004.** Jennifer Troyan and Gina Nicholson, Chronic Disease Control Branch, California Department of Health Services, (916) 552-9968, gnichols@dhs.ca.gov

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14. **Healthcare Provider Discussion About HIV Risk, California, 2003.** Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

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17. **Contraceptive Use Among California Women Ages 18-44, 2003-2004.** Marina Chabot and Mary Bradsberry, Maternal, Child and Adolescent Health Branch/Office of Family Planning, California Department of Health Services, University of California, San Francisco Bixby Center for Reproductive Health Research & Policy, (916) 650-0467, mchabot@dhs.ca.gov

18. **HIV Testing Among Pregnant California Women, 2003-2004.** Renato Littaua, Eugene Takahashi, and Shabbir Ahmad, Maternal Child and Adolescent Health Branch/Office of Family Planning, California Department of Health Services, (916) 650-0332, rlittaua@dhs.ca.gov; Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

19. **Prenatal HIV Counseling, California, 2003-2004.** Renato Littaua, Eugene Takahashi, and Shabbir Ahmad, Maternal, Child and Adolescent Health Branch/Office of Family Planning, California Department of Health Services, (916) 650-0332, rlittaua@dhs.ca.gov; Zipora Weinbaum and Terri Thorfinnson, Office of Women's Health, California Department of Health Services, (916) 440-7626, zweinbau@dhs.ca.gov

20. **Infertility: Problems Getting Pregnant and Past Infertility Diagnosis Among California Women, 2003.** Joan Chow, Julie Lifshay, and Gail Bolan, Sexually Transmitted Disease Control Branch, California Department of Health Services, (510) 620-3718, jchow@dhs.ca.gov; Ann Webb, Survey Research Group, Public Health Institute, (916) 779-0287, awebb@surveyresearchgroup.com

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21. **Eating Five or More Fruit and Vegetable Servings a Day: Belief Versus Practice of California Women, 2004.** Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, Cancer Prevention and Nutrition Section, California Department of Health Services, (916) 552-9938, BmkNelly@dhs.ca.gov

22. **Healthy Weight Among California Women, 2004.** Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, Cancer Prevention and Nutrition Section, California Department of Health Services, (916) 552-9938, BmkNelly@dhs.ca.gov

23. **Achievement of Recommended Levels of Physical Activity Among California Women, 2004.** Sharon Sugerman, Barbara MkNelly, and Patrick Mitchell, Cancer Prevention and Nutrition Section, California Department of Health Services, (916) 449-5406, Ssugerma@dhs.ca.gov

24. **Belief and Practice to Eat Five or More Fruit and Vegetable Servings per Day Among Low-Income California Women Receiving Nutrition Assistance, 2004.** Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, Cancer Prevention and Nutrition Section, California Department of Health Services, (916) 552-9938, BmkNelly@dhs.ca.gov

25. **Prevalence of Obesity and Disparities in Obesity-Related Factors Among California Women, 2004.** Sharon Sugerman, Barbara MkNelly, and Patrick Mitchell, Cancer Prevention and Nutrition Section, California Department of Health Services, (916) 449-5406, Ssugerma@dhs.ca.gov

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26. **Health Insurance Status of Reproductive Age Women 18-44 in California, 2003-2004.** Marina Chabot, Maternal, Child and Adolescent Health Branch/Office of Family Planning, California Department of Health Services, University of California, San Francisco Bixby Center for Reproductive Health Research & Policy, (916) 650-0467, mchabot@dhs.ca.gov

27. **Women and Long-Term Care Awareness, California, 2003.** Raul Moreno, California Partnership for Long-Term Care, California Department of Health Services. (916) 440-5626, rmoreno@dhs.ca.gov

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29. **Intimate Partner Violence Against Women with Disabilities in California, 2003-2004.** H. Stephen Kaye, Office on Disability & Health, Epidemiology and Prevention for Injury Control Branch, California Department of Health Services and Institute for Health & Aging, University of California, San Francisco, (415) 502-7266, steve.kaye@ucsf.edu

METHODOLOGY

30. **The California Women's Health Survey (CWHS) Methodology.** Marta Induni, Survey Research Group, Public Health Institute, (916) 455-2563, Minduni@SurveyResearchGroup.com

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Trends in Food Security Among California Women, 1999 to 2004

Department of Social Services
Research and Evaluation Branch

The U. S. Department of Agriculture (USDA) defines food security as "having access, at all times, to enough food for an active, healthy life." USDA categorizes food insecurity into two levels: (1) food insecure without hunger and (2) food insecure with hunger.

Food insecurity without hunger means that a woman has limited or uncertain availability of nutritionally adequate and safe food. Food insecurity with hunger means food intake has been reduced to an extent that a woman has experienced the physical sensation of hunger because there wasn't enough money to buy food.[1]

The Healthy People 2010 Goal for food security is to reduce it by half, from 12.0 percent to 6.0 percent.[2]

USDA has developed a standardized methodology for measuring food insecurity and hunger. The California Women's Health Survey (CWHS) has collected information on food security since 1999 from about 4,000 women each year. The CWHS used an abbreviated, validated six-item version of the USDA's 18-item standardized scale to measure the occurrence and severity of food insecurity. The scale consists of six questions about the woman's food supply based on monetary constraints. Each question increases the level of severity of food insecurity. Women who had no responses or answered positively to one question were food secure, those who responded positively to two, three, or four questions were food insecure without hunger. Those responding positively to five or six questions were food insecure with hunger. The CWHS indicates the following trends over the five-year period since 1999:

- Food security has been decreasing among California women, from 78.3 percent in 1999 to 73.4 percent in 2004. The decrease was statistically significant.[3]

- Food insecurity without hunger increased from 14.3 percent in 1999 to 18.4 percent in 2004, although the increase was not statistically significant. Food insecurity with hunger has also increased from 7.4 percent in 1999 to 8.2 percent in 2004, but the increase was not statistically significant.

- Food insecurity (with and without hunger combined) increased significantly for both Black/African American and White women. The food insecurity rate for Black/African American women increased from 15.2 percent in 1999 to 35.1 percent in 2004, and for White women from 11.4 percent in 1999 to 14.7 percent in 2004.

- Food insecurity rates (with and without hunger combined) increased for all age groups, with the largest increase among young women aged 18-24. Their food insecurity rate increased from 28.1 percent in 1999 to 41.1 percent in 2004, although the increase was not statistically significant.

Public Health Message:
Public and private programs that provide healthy food for food insecure women should be aware that food security among California women is decreasing and this trend needs to be reversed in order to have all California women food secure.

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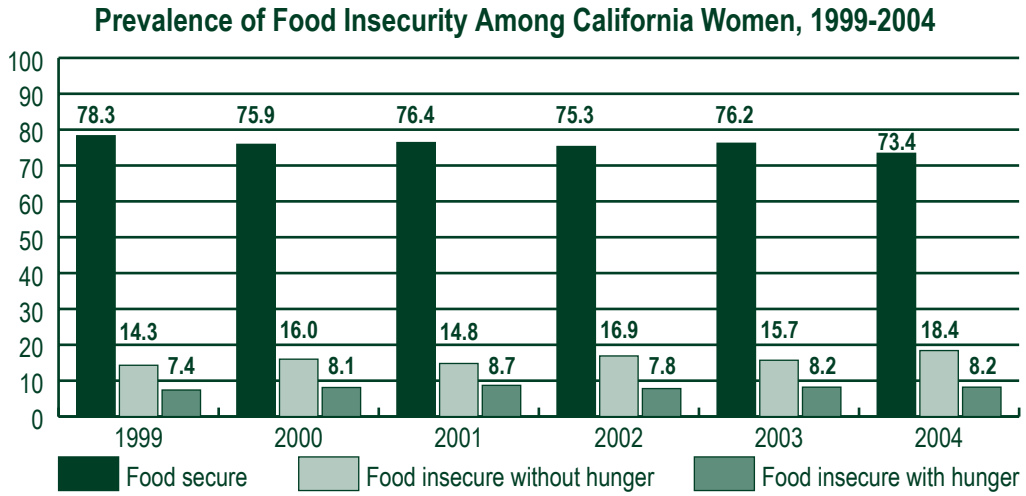
Trends in Food Security Among California Women, 1999 to 2004

Department of Social Services
Research and Evaluation Branch



Source: California Women's Health Survey

1 Bickel G, Nord M, Price C, Hamilton W, Cook J. A Guide to Measuring Household Food Security, Revised 2000. USDA, Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation, March 2000.

2 US Department of Health and Human Services, Healthy People 2010, 2nd ed. With Understanding and Improving Health and Objectives for improving Health, 2 Vols. Washington, D.C., Government Printing Office, Nov. 2000.

3 Trend was statistically significant using Least Squares Regression.

Submitted by: Nikki Baumrind and Sheila Dumbauld, California Department of Social Services, Research and Evaluation Branch, (916) 654-1327, skl1@cox.net

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Access to food and adequate nutrition are keys to an active, healthy life. Women who are food insecure and have limited or uncertain access to enough food to sustain a healthy lifestyle are prone to poor health and related problems. Food insecure women also face emotional stress and anxiety concerning their food supply and often engage in compromising behaviors such as choosing lower cost, less nutritious food or choosing to buy food rather than paying rent or buying medicine.[1]

The California Women's Health Survey (CWHS) asked women aged 18 and older questions regarding their access to food. In addition, the CWHS compiled detailed demographic information on women's employment status. The hunger and access to food module in the CWHS is based on a six-question severity scale that was derived from an 18-item U.S. Department of Agriculture module to produce estimates of food insecurity.

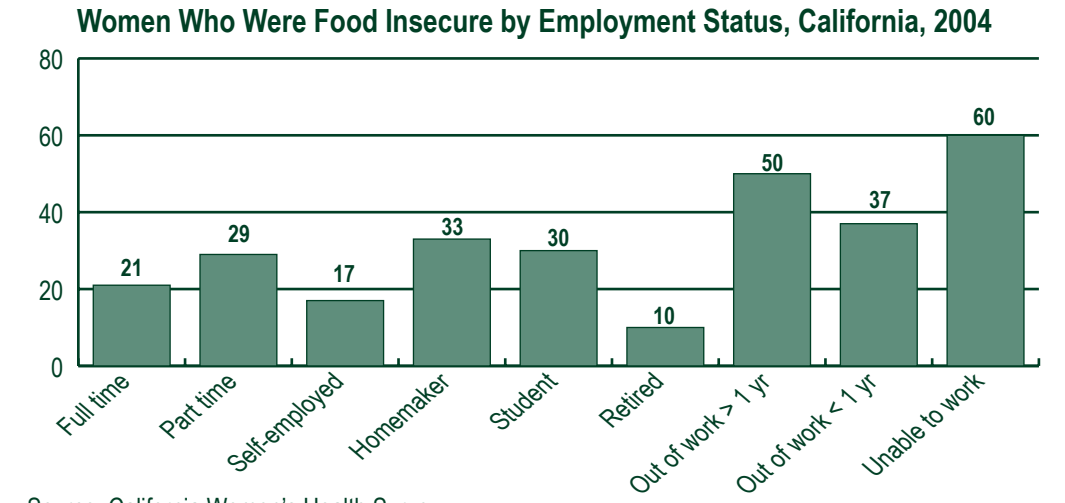
The rate of food insecurity among California women varied widely according to their employment status. The highest rates of food insecurity were among women who were out of work or unable to work. The next highest rates were among homemakers and students, where almost one-third of those women were food insecure. In 2004, the CWHS showed the following:

- The rates of food insecurity among women who were out of work greater than one year was 49.7 percent, out of work less than one year, 36.8 percent, and unable to work, 60.3 percent.
- Homemakers and students had the next highest rates of food insecurity, 33.5 percent and 29.5 percent, respectively.
- Employed women differed in the amount of food insecurity they experienced by type of employment: part-time workers had the highest rate, 29.0 percent, followed by full-time workers, 21.2 percent, and self-employed workers, 16.7 percent.
- Retired women had the lowest rate of food insecurity, 9.7 percent.

Women Who Were Food Insecure by Employment Status, 2004

Department of Social Services
Research and Evaluation Branch

Public Health Message:
Women who were out of work or unable to work are the most likely to be food insecure. However, food supplemental programs need to be aware that homemakers and students, compared with other women, are also more likely to be food insecure.



Source: California Women's Health Survey

Issue 4, Summer 2006, Num. 2

1 Bickel G, Nord M, Price C, Hamilton W, Cook J. A Guide to Measuring Household Food Security, Revised 2000. USDA, Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation, March 2000.

Submitted by: Nikki Baumrind and Sheila Dumbauld, California Department of Social Services, Research and Evaluation Branch, (916) 654-1327, skl1@cox.net

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Food Insecurity Among Women Who Have Children Under Age 18 Living in the Household, 2004

Department of Social Services
Research and Evaluation Branch

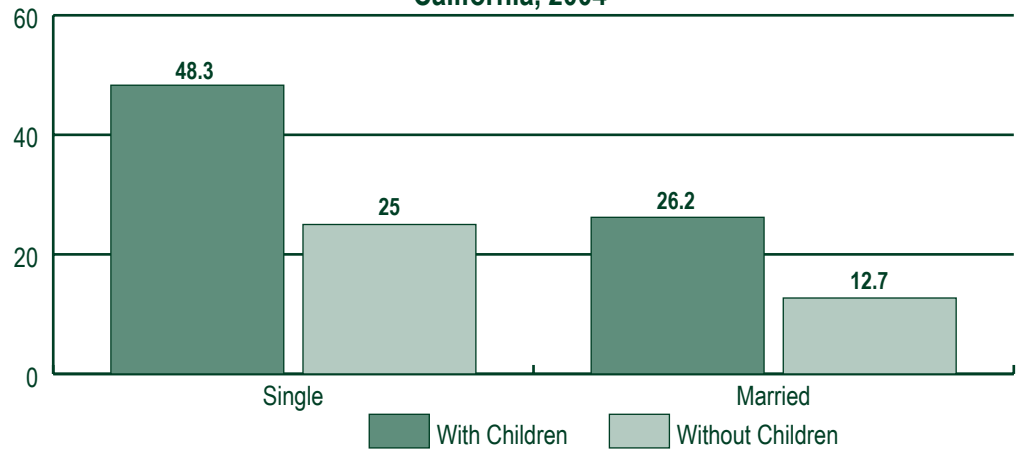
The U.S. Department of Agriculture (USDA) in 2004 defined food security as "the ability of women to have access at all times to enough food for an active, healthy life." Further, the USDA indicates that food insecurity without hunger is evident in a woman's concerns and in adjustments to food management, including reduced quality of diets. Additionally, food insecurity with hunger means that a woman has repeatedly gone without food because there was not enough money to purchase more food.[1] Food insecurity has been shown to be a potential precursor to more serious health and developmental problems.

The California Women's Health Survey (CWHS) collects information on food insecurity annually, in addition to other health-related issues and demographic characteristics. The hunger and access to food module in the CWHS is based on a six-question scale that was derived from an 18-item USDA module to produce estimates of food insecurity. In 2004, the CWHS showed the following:

- Women with children under age 18 living in the home were more likely than women who did not have children under age 18 living in the home to be food insecure, 34.3 percent compared with 19.5 percent, a difference that was statistically significant.
- Food insecurity was substantially higher for women who had children under age 18 living in the household if they were single (48.3 percent) than women who were married (26.2 percent). The difference between these two percentages was statistically significant.

Public Health Message: *Women who have children under age 18 living in the home are more likely than women who do not have minor children living in the home to be food insecure and single women with children even more so. Food supplemental programs need to be aware of the increased likelihood of food insecurity among this group of women.*

Food Insecure Women With and Without Minor Children by Marital Status, California, 2004



Source: California Women's Health Survey

Issue 4, Summer 2006, Num. 3

1 Bickel G, Nord M, Price C, Hamilton W, Cook J. A Guide to Measuring Household Food Security, Revised 2000. USDA, Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation, March 2000.

Submitted by: Nikki Baumrind and Sheila Dumbauld, California Department of Social Services, Research and Evaluation Branch, (916) 654-1327, skl1@cox.net

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

It is difficult to estimate the number of homeless individuals because of the transient nature of this population. California estimates based on continuum of care plans submitted to the U.S. Department of Housing and Urban Development (HUD) indicate that about 361,000 individuals, representing 1.1 percent of the state population, are homeless on any given day. The annual homeless population is estimated to be in excess of one million individuals.[1]

In 2004, the Office of Women's Health sponsored questions in the annual California Women's Health Survey (CWHS) asking respondents about their household living arrangements to estimate their risk for housing insecurity (HI). The HI risk was defined as a "yes" response to any of the following questions: 1) "*In the past 12 months, has your household been more than 30 days late paying rent or mortgage?*" (4.3 percent of the respondents) 2) "*In the past 12 months, have you been without your own housing for any period of time?*" (2.9 percent of the respondents). And a subset of respondents who moved more than once in the past 12 months and said that during that period they: 3) "*…had trouble finding safe, adequate, or affordable housing*" (2.4 percent of the respondents).

Overall, 7.8 percent of the respondents (representing approximately 950,000 California women) were estimated to have experienced HI in 2003. HI affects children: 64.3 percent of women who experienced HI reported having children under the age of 18 in their households. Below are some of the factors that show important differences between women with HI, and women without HI.

- Physical domestic violence: Women with HI were more than five times as likely to report that in the previous 12 months they experienced intimate partner physical domestic violence (partners threw things at them, pushed, grabbed, shoved or slapped, kicked, bit or hit, beat them up or choked, used a knife or fired a gun at them). While 19.5 percent of women with HI experienced intimate partner physical domestic violence, only 3.4 percent of women without HI experienced intimate partner physical domestic violence.[2]

- Young age: Women with HI were more likely to be aged 44 and younger (74.5 percent), compared with women without HI (52.9 percent).[3]

- Health insurance: More women with HI lacked health insurance (24.5 percent), compared with women without HI (11.9 percent).[4]

- Poverty: Almost two-thirds of women with HI had incomes less than 200 percent federal poverty level (63.4 percent), compared with women without HI (30.6 percent).

Women with HI were more likely to say that their health was fair/poor (26.0 percent), compared with women without HI (17.8 percent). They were also more likely to have any unhealthy physical and mental days in the previous 30 days, compared with women without HI (see graph).[5]

Risk for Housing Insecurity (HI) Among California Women, 2003

California Department of Health Services
Office of Women's Health

Survey Research Group

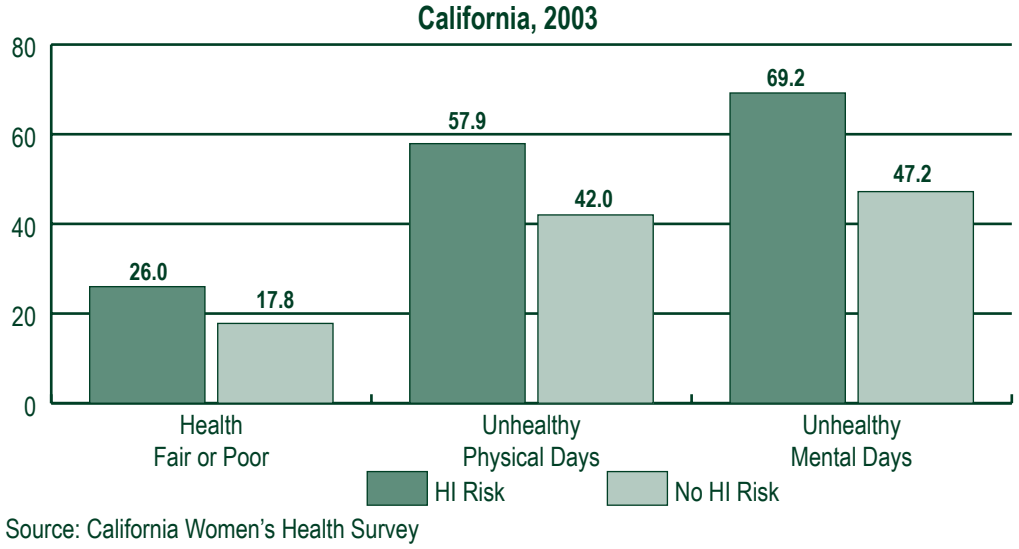
Public Health Message: *Housing insecurity (HI) is a public health issue. The health status of women with HI, and associated conditions (i.e., physical domestic violence, young age, lack of health insurance, and poverty) indicates that these women are also at risk for adverse health outcomes.*

Issue 4, Summer 2006, Num. 4

Risk for Housing Insecurity (HI) Among California Women, 2003

California Department of Health Services
Office of Women's Health

Survey Research Group



1 A Summary Report on California's Programs to Address Homelessness. Prepared for Governor Gray Davis. March 2002.
2 $p < 0.001$.
3 $p < 0.001$.
4 $p < 0.001$.
5 $p < 0.01$.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov; Marta Induni, Survey Research Group, Public Health Institute, (916) 455-2563, Minduni@SurveyResearchGroup.com

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Unhealthy Days Among California Women, 2004

Survey Research Group

Public Health Message: *Unhealthy days are an estimate of health-related quality of life, which is affected by chronic disease and illness. Unhealthy days are a broad measure that health professionals can use to identify and better understand how health behaviors and chronic illness affects a person's well being.*

In public health and in medicine, the concept of health-related quality of life (HRQOL) refers to an individual's perceived physical and mental health over time. HRQOL is often used to measure the effects of health behaviors and chronic illnesses and how these affect a person's day-to-day life. Tracking HRQOL in different populations can identify subgroups with poor physical or mental health and help guide policies and interventions to improve their health.[1]

Unhealthy days are an estimate of HRQOL. In 2004, the California Women's Health Survey (CWHS) asked 4,557[2] California women aged 18 and older, "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" This was followed by, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Unhealthy days are calculated as the overall number of days during the previous 30 days when the respondent felt that either her physical or mental health was not good.

Responses to the two questions above were combined to calculate a summary index of overall unhealthy days, with a logical maximum of 30 unhealthy days. For example, a person who reported 4 physically unhealthy days and 2 mentally unhealthy days was assigned a value of 6 unhealthy days, while someone who reported 30 physically unhealthy days and 30 mentally unhealthy days was assigned the maximum of 30 unhealthy days.[3] Unhealthy days can be related to a number of risk factors. The table shows different risk factors by the mean number of unhealthy days among California women, as well as 95.0 percent confidence intervals.

Overall, more than one-quarter of the past 30 days were unhealthy among California women (7.8 days). California women with a high school education or less had a statistically significant higher mean number of unhealthy days in the past 30 days (9.2 days) than women with some college (7.9 days) or a college education or more (5.9 days).[4] Women who reported being obese[5] had a statistically significant higher mean number of unhealthy days (10.5 days) than those who reported not being obese (7.0 days). Likewise, women who reported being overweight or obese[6] had a statistically significant higher mean number of unhealthy days (9.0 days) than those who reported not being overweight or obese (6.6 days).

All levels of smoking (current smoker, former smoker, and never smoked) were statistically different as well. California women who reported physical, mental, or emotional limitations had a statistically significant higher mean number of unhealthy days (16.1 days) than those who did not (5.9 days). Finally, California women who reported having food insecurity with hunger reported a statistically significant higher mean number of unhealthy days (11.5 days) than women who reported having food security (6.4 days).

1 U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion (November 2000). Measuring Healthy Days. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

2 Don't know and refused responses were omitted, final n=4,519.

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Unhealthy Days Among California Women, 2004

Survey Research Group

Unhealthy Days Among California Women, 2004

TOPICS	VARIABLE	N	Mean # of Unhealthy Days	95 percent CL for Mean	
	Overall	4519	7.8	7.5	8.2
RACE/ETHNICITY	White	2605	7.3	6.9	7.7
	Black/African American	249	8.9	7.5	10.4
	Hispanic	1345	8.7	8.1	9.4
	Other	320	6.7	5.6	7.9
AGE	18-24	359	6.9	5.9	7.9
	25-34	899	6.9	6.3	7.6
	35-44	1030	7.9	7.2	8.6
	45-54	855	8.9	8.0	9.7
	55-64	644	8.3	7.2	9.3
	65+	732	8.3	7.3	9.2
EDUCATION	High School graduate or less	1731	9.2	8.6	9.8
	Some college	1270	7.9	7.3	8.5
	College graduate or more	1518	5.9	5.4	6.3
POVERTY STATUS	Below poverty	620	9.9	8.9	10.9
	100 percent-200 percent	759	10.1	9.2	11.0
	201 percent and above	2753	6.5	6.1	6.9
	Unknown	387	7.5	6.2	8.8
SMOKING STATUS	Current smoker	550	12.0	10.9	13.1
	Former smoker	991	8.1	7.4	8.9
	Never smoked	2973	7.0	6.6	7.4
ACUTE DRINKING[1]	Not at risk	3783	7.9	7.5	8.2
	At risk	302	8.7	7.5	10.0
CHRONIC DRINKING[2]	Not at risk	4067	7.9	6.7	7.7
	At risk	64	10.7	7.6	13.8
GENERAL HEALTH STATUS	Excellent, very good, or good health	3710	5.8	5.5	6.1
	Fair or poor health	809	16.8	15.8	17.7
OBESITY[3]	Obese	1037	10.5	9.7	11.3
	Not obese	3291	7.0	6.6	7.4
OVERWEIGHT OR OBESE[4]	Overweight or obese	2248	9.0	8.5	9.5
	Not overweight or obese	2080	6.6	6.1	7.0
ASTHMA[5]	Yes	627	11.2	10.2	12.2
	No	3613	7.3	6.9	7.7
DIABETES[5]	Yes	306	14.0	12.5	15.6
	No	3883	7.4	7.0	7.8
	Gestational diabetes	49	8.1	5.7	10.5
PHYSICAL, MENTAL, OR EMOTIONAL LIMITATIONS[6]	Yes	910	16.1	15.2	17.0
	No	3604	5.9	5.5	6.2
OSTEOPEROSIS[5]	Yes	422	11.5	10.1	12.9
	No	3795	7.6	7.2	7.9
FOOD INSECURITY[7]	Food insecure	1094	11.4	10.6	12.2
	Food secure	3339	6.4	6.1	6.8

Note: *All don't know or refused responses are set to missing.
*Tukey significance level at .05

1 Acute drinking includes those who had 5+ drinks on one ocassion in the past 30 days.
2 Chronic drinking includes those who had 60+ drinks in the past 30 days.
3 Obesity is defined as a body mass index greater than or equal to 30.
4 Overweight or obese is defined as a body mass index greater than or equal to 25.
5 Respondent reported doctor diagnosis.
6 "Respondent reported having physical, mental, or emotional limitations".
7 Food insecurtiy with hunger (6 question scale defined by California Prevention and Nutrition Section).

Source: 2004 California Women's Health Survey
Weighted to the 2000 CA population

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3 U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion (2005). How is the summary index of unhealthy days calculated? Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (Retrieved 9/14/05), http://www.cdc.gov/hrqol/.
4 Tukey significance testing ($p<0.05$).
5 Obese is defined as a body mass index greater than or equal to 30.
6 Overweight or obese is defined as a body mass index greater than or equal to 25.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Women Aged 40 and Above Who Never or Rarely Receive Routine Mammography, California, 2004

California Department of Health Services
Cancer Detection Section

Breast cancer is the most commonly diagnosed cancer among California women. In 2006, 22,070 women will be diagnosed with breast cancer, and 4,165 women will die of the disease.[1] Every woman is at risk for breast cancer, regardless of her racial/ethnic background. Finding breast cancer early when it is still confined to the breast significantly improves five-year survival rates. For example, 96.0 percent of women diagnosed with a small cancer confined to the breast will be alive five years after their diagnosis compared with only 18.0 percent of women who are diagnosed when the tumor has spread to other parts of the body.[2] The American Cancer Society (ACS) recommends that women ages 40 years and above receive both a mammogram and a clinical breast examination (CBE) annually to improve their chances of finding breast cancer early.

In 2002, nearly 68.0 percent of breast cancers diagnosed in California women were found at an early stage, when cancers are more likely to favorably respond to treatment.[3] Despite the successful efforts by organizations such as ACS and the California Department of Health Services to increase the number of women who receive regular breast cancer screening, women of some racial/ethnic groups still disproportionately receive the recommended annual mammograms and clinical breast examinations.[4, 5]

This report focuses only on mammogram screening rather than screening with both CBE and mammogram due to small sample size. The 2004 California Women's Health Survey (CWHS) asked women if they had ever had a mammogram, and how long it had been since they had their last mammogram. Respondents who had ever had a mammogram could respond that their last mammogram was within the past one, two, three or five years, or more than five years ago. The survey data is weighted to the 2000 California population by the race/ethnicity and age grouping specific to this report. Women who reported being previously diagnosed with breast cancer (n = 79) or had partially completed the survey (n = 310) were not included in the analysis. The final analysis is based on 2,380 women ages 40 years and above.

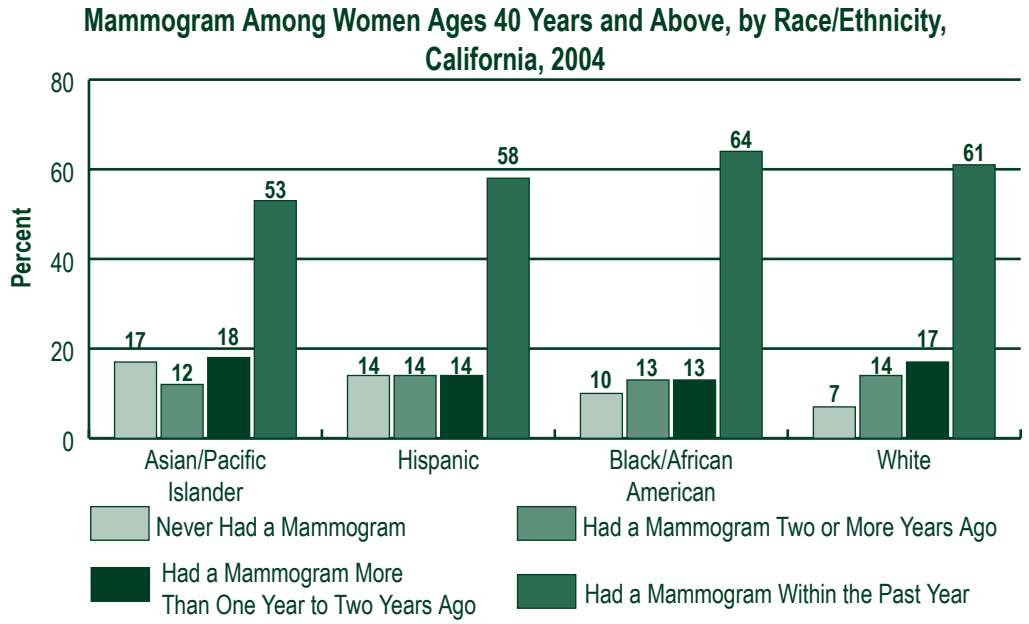
- In 2004, of the California women ages 40 years and above included in the study, 9.7 percent reported never having a mammogram and 14.0 percent reported having their last mammogram more than two years ago.
- 17.3 percent of Asian/Pacific Islander women reported never having a mammogram, compared with 14.2 percent of Hispanic women, 9.6 percent of Black/African American women, and 7.1 percent of White women.
- 14.3 percent of White women, 14.2 percent of Hispanic women, 13.3 percent of Black/African American women, and 12.0 percent of Asian/Pacific Islander women reported having their last mammogram more than two years ago.

Public Health Message: *Both an annual mammogram and clinical breast examination are recommended for women ages 40 years and above to greatly enhance their opportunity for early diagnosis and definitive treatment of breast cancer. Despite the fact that survival is excellent when breast cancer is diagnosed early, it is estimated that nearly 40 percent of California women aged 40 and above do not receive annual mammograms.*

Issue 4, Summer 2006, Num. 6

Women Aged 40 and Above Who Never or Rarely Receive Routine Mammography, California, 2004

California Department of Health Services
Cancer Detection Section



Source: California Women's Health Survey

1 American Cancer Society, California Division and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures, 2006. Oakland, CA: American Cancer Society, California Division, September 2005.

2 American Cancer Society, California Division and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures, 2006. Oakland, CA: American Cancer Society, California Division, September 2005.

3 American Cancer Society, California Division and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures, 2006. Oakland, CA: American Cancer Society, California Division, September 2005.

4 Kagawa-Singer M, Pourat N. Asian American and Pacific Islander breast and cervical carcinoma screening rates and Healthy People 2000 objectives. Cancer. 2000;89:3:696-705.

5 O'Malley MS, Earp JAL, Hawley ST, Schell MJ, Matthews HF, Mitchell J. The association of race/ethnicity, socioeconomic status, and physician recommendation for mammography: who gets the message about breast cancer screening? American Journal of Public Health. 2001;91:49-54.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Heart disease and strokes are among the leading causes of death for women in California, representing about 40.0 percent of all deaths of California women. The age-adjusted rate of heart disease, the leading cause of death in 2002, was 180.5 per 100,000. Stroke deaths, the third leading cause of death in women, occurred at 55.3 per 100,000.[1]

In 2004, the Office of Women's Health sponsored questions in the annual California Women's Health Survey (CWHS) asking 4,281 respondents whether they were told by a health care professional that they had heart disease/stroke. Findings indicate that 5.9 percent of California women (estimated to 690,000 California women) reported that a health care professional had told them that they had heart disease or a stroke. The following comparisons between the subgroups indicate significant differences as tested by chi-square test.

Among the race/ethnicity groups, 8.7 percent of Black/African American, 6.7 percent of White, and 5.3 percent of Hispanic women reported that a health care professional had told them that they had heart disease/stroke.[2] Findings indicated that having heart disease or a stroke was highly related to the age of the respondent with older women reporting higher rates (see figure).[3]

Among women reporting heart disease/stroke:

- About 54.7 percent reported having physical, mental, or emotional limitation (compared with 17.6 percent among women with no heart disease/stroke).[4]
- About 21.0 percent reported having a diagnosis of diabetes (compared with 5.2 percent among women with no heart disease/stroke).[5]
- Approximately 46.8 percent were below 200 percent of the federal poverty level (compared with 33.2 percent among women with no heart disease/stroke).[6]
- Overall about 11.4 percent had no access to health insurance. However, the proportion of women with heart disease/stroke who did not have access to health care was distributed unevenly among the age groups, with 25.9 percent of women younger than 65 lacking access to health insurance (compared with 17.8 percent at this age group among women with no heart disease/stroke).
- Fifteen percent of respondents with heart disease/stroke chose to be surveyed in Spanish. This group comprised 58.6 percent of respondents with heart disease/stroke that self-identified as Hispanic.

Tobacco use was associated with heart disease/stroke. Respondents who said they had never smoked tobacco had lower prevalence of heart disease/stroke (4.8 percent), compared with current smokers (7.0 percent) and former smokers (8.7 percent).[7]

Heart Disease or Stroke Status Among California Women, 2004

California Department of Health Services
Office of Women's Health

Public Health Message: *Consideration of the status of health insurance and of demographics is vital in heart disease/stroke-related prevention, outreach, and treatment. To be effective, culturally appropriate interventions should consider age, physical, mental, or emotional limitation, health status, economic status, and use of languages other than English.*

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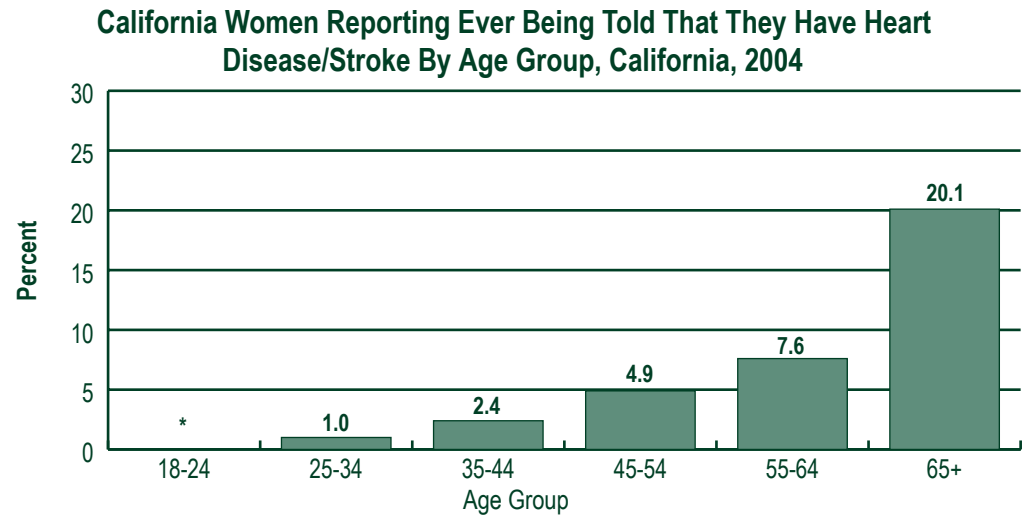
Heart Disease or Stroke Status Among California Women, 2004

California Department of Health Services
Office of Women's Health



* Sample size too small - finding may be unreliable
Source: California Women's Health Survey

1 California Department of Health Services. Vital Statistics of California, 2002. http://www.dhs.ca.gov/hisp/chs/OHIR/Publication/Highlights/VSC2002/VSC2002.pdf.
2 $p < 0.001$.
3 $p < 0.001$.
4 $p < 0.001$.
5 $p < 0.001$.
6 $p < 0.001$.
7 $p < 0.001$.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Diabetes Among California Women, 2004

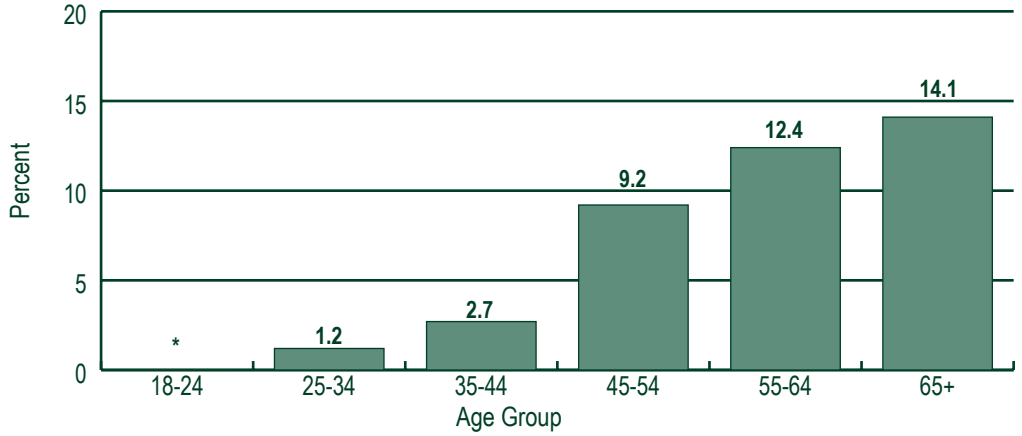
California Department of Health Services
Office of Women's Health

Chronic diseases are leading causes of disability and death in the United States, and they account for more than 70.0 percent of the nation's annual medical care costs.[1] Diabetes, a chronic disease, is indicated by high levels of blood glucose resulting from defects in insulin production, insulin action, or both.[2] In 2004, the Office of Women's Health sponsored questions in the annual California Women's Health Survey (CWHS) asking respondents ages 18 and above whether they had ever been told by a health care professional that they had diabetes.

About 6.1 percent of 4,271 respondents reported that they had been told they had diabetes (excluding pregnancy-related diabetes). Diabetes rates varied significantly by race/ethnicity, age group, activity limitation status, and weight.[3]

- Black/African American women reported highest diabetes rates at 10.5 percent, followed by Hispanic (8.0 percent), White (5.2 percent), and Asian/Other women (3.9 percent).
- A larger proportion of respondents with diabetes said that they had a physical, mental, or other emotional problem resulting in activity limitation (46.7 percent), compared with respondents who did not have diabetes (18.0 percent).
- A larger proportion of respondents with diabetes were classified as obese (assessed by weight and height) (52.2 percent), compared with respondents who did not have diabetes (21.4 percent).
- Overall, proportions of respondents with diabetes increased with age (see graph).
- More than 17.0 percent of respondents with diabetes, who were younger than 65, had no access to health insurance. This proportion was similar to the proportion of all respondents who lacked health insurance.

Proportion of Women Reporting Ever Being Told That They Have Diabetes, By Age Group, California, 2004



* Sample size too small - finding may be unreliable
Source: California Women's Health Survey

Public Health Message: *More than six percent of the respondents indicated a lifetime diagnosis of diabetes. Diabetes was positively related to respondent's age, weight, and limited activity. Among the race/ethnicity groups, Black/African American women reported highest rates of diabetes. Almost one in five California women younger than 65 who had a lifetime diagnosis of diabetes lacked health insurance. Lack of health insurance likely reduces diabetes prevention activities for women at risk, and adversely affects health care for women with diabetes.*

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1 Centers for Disease Control. The burden of chronic diseases and their risk factors: national and state perspectives. Atlanta, GA: US Department of Health and Humans Services, CDC, 2004.
2 http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf.
3 Chi-square test $p < 0.01$.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Breast/Reproductive Cancer Diagnosis Among California Women, 2004

California Department of Health Services
Office of Women's Health

Cancer-related mortality is the second leading cause of death for women in California.[1] In 2000, breast cancer and reproductive cancers were the third and fourth most frequent causes of death following cancers of the lung and digestive systems.[2]

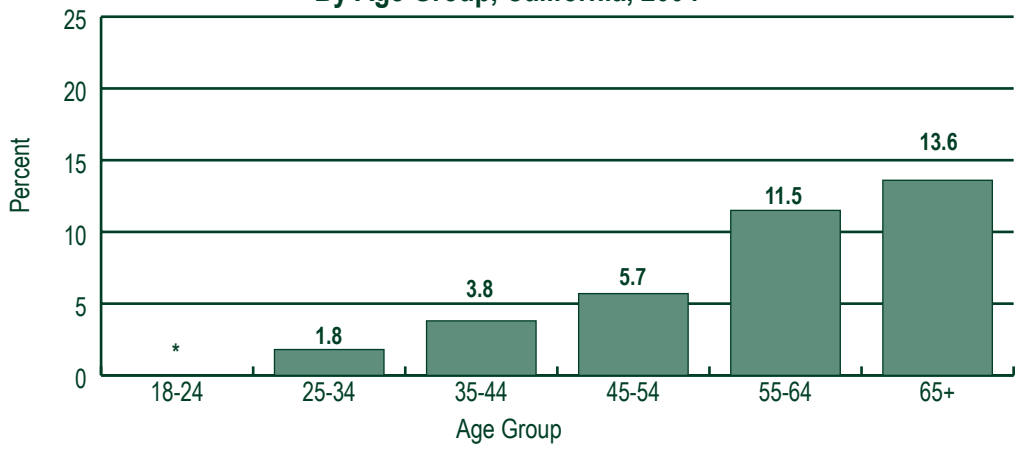
In 2004, the Office of Women's Health sponsored questions in the annual California Women's Health Survey (CWHS) asking respondents whether they were ever told by a doctor that they had breast cancer or cancer of the reproductive system.

Six percent of 4,282 respondents reported a diagnosis of breast/reproductive cancers in their lifetime. Self-reported diagnosis of past breast/reproductive cancers varied significantly by race/ethnicity, age group, activity limitation status, and smoking status.[3]

- Overall, higher proportions of breast/reproductive cancer were reported by respondents older than 55 (see graph).
- A higher proportion of White respondents reported a past diagnosis of breast/reproductive cancer (7.3 percent), compared with Black/African American (6.8 percent), Asian/Other (5.4 percent), and Hispanic women (2.9 percent).
- Past diagnosis of breast/reproductive cancer was more commonly reported by smokers (8.3 percent) than by never smokers (5.0 percent).
- About 32.0 percent of respondents with past diagnosis of breast/reproductive cancer also reported having physical, mental, or other emotional problems compared with 19.0 percent of respondents who did not report a past diagnosis of breast/reproductive cancer.

Public Health Message: *Six percent of the respondents reported a lifetime diagnosis of breast/reproductive cancers. Report of breast/reproductive cancer diagnosis differed by respondent age, race/ethnicity, smoking status, and activity limitation status. This information could help target outreach to groups that are at risk for breast/reproductive cancers. Women who were diagnosed with breast/reproductive cancers may need additional support even after diagnosis and treatment.*

Proportion of Women Reporting That They Were Ever Told by a Doctor That They Had Cancer of The Breast or Reproductive System, By Age Group, California, 2004



* Sample size too small - finding may be unreliable
Source: California Women's Health Survey

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1 http://www.dhs.ca.gov/hisp/chs/OHIR/tables/datafiles/vsofca/0510.pdf.
2 http://www.ccrcal.org/PDF/Min2003.pdf.
3 $p<0.05$.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Chronic diseases are leading causes of disability and death in the United States, and they account for more than 70.0 percent of the nation's annual medical care costs.[1] Asthma is a chronic lung disease that causes wheezing, shortness of breath, coughing, and chest tightness.[2] In 2004, the Office of Women's Health sponsored questions in the annual California Women's Health Survey (CWHS) asking respondents whether they had ever been told by a health care professional that they had asthma, and whether they still had the disease.

Approximately 15.5 percent of 4,269 respondents reported a diagnosis of asthma in their lifetime. Of those, 64.2 percent said that they still had asthma (9.9 percent of all the respondents). Asthma rates varied significantly by race/ethnicity, disability status, and age group.[3] The following is data from respondents who said that they still had asthma:

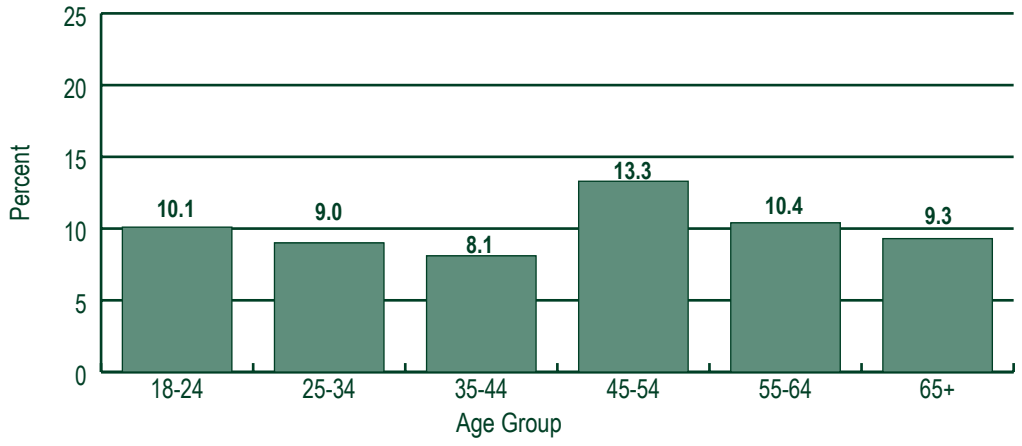
- The highest proportion of asthma diagnosis occurred among Black/African American respondents (14.8 percent), followed by White (11.4 percent), Asian/Other (8.2 percent), and Hispanic respondents (6.6 percent).
- About 42.8 percent of respondents with asthma reported having physical, mental, or other emotional problems, compared with 17.3 percent of respondents who did not have asthma.
- Rates of asthma were higher for smokers (11.7 percent) than for women who had never smoked (9.0 percent).
- Respondents with asthma were distributed among all age groups (see graph).

Asthma Among Adult California Women, 2004

California Department of Health Services
Office of Women's Health

Public Health Message: *Nearly ten percent of California women indicated that they had asthma. Asthma diagnosis was distributed among all age groups. Black/African Americans, tobacco smokers, and respondents with physical, mental, or other emotional problems had higher rates of asthma. These groups could be targeted for outreach and educational efforts about asthma.*

Proportion of Women Reporting That They Have Asthma, By Age Group, California, 2004



Source: California Women's Health Survey

Issue 4, Summer 2006, Num. 10

1 Centers for Disease Control (CDC). The burden of chronic diseases and their risk factors: National and state perspectives. Atlanta, GA: United States Department of Health and Humans Services, CDC, 2004.
2 www.cdc.gov/asthma/faqs.htm.
3 $p<0.05$, chi-square test.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Osteoporosis ("porous bone") is a disease characterized by decreased bone mass and weakened bone tissue, leading to an increased risk of bone fractures. Any bone is susceptible, though fractures most often occur at the hip, spine, and wrist.

Eight million women in the United States are estimated to have osteoporosis, and another 22 million are at risk of osteoporosis due to low bone mass.[1] Though osteoporosis can strike at any age, the risk is highest in post-menopausal women due to loss of estrogen. One in two women over the age of 50 will have an osteoporosis-related fracture in her lifetime.[2] Women can help prevent or delay the onset of osteoporosis through diet, exercise, and use of medications when appropriate.

The 2004 California Women's Health Survey (CWHS) asked 4,557 women ages 18 and older if a doctor had talked with them about osteoporosis prevention and also, when the last time their height was measured by a doctor. There were 2,252 women ages 45 and older asked if they had been told by a doctor that they have osteoporosis.

Overall, 14.0 percent of women ages 45 and older reported having been told by a doctor or other healthcare provider that they had osteoporosis. The number of women reporting osteoporosis increased with age. Women ages 65 and older were most likely to have been told they had osteoporosis (see graph). White women were most likely and Asian/Other women were least likely to have been told they had osteoporosis (see graph).

Among adult women ages 18 and older, 39.0 percent reported having discussed osteoporosis prevention with their doctor. White women were the most likely to have talked with their doctor about osteoporosis (48.0 percent), followed by Asian/Other (39.0 percent), Black/African American (29.0 percent), and Hispanic (25.0 percent). Women ages 45 and older were more likely than younger women to have discussed osteoporosis prevention with their doctor (53.0 percent versus 28.0 percent).

Only 55.0 percent of adult women had their height checked by a healthcare provider in the last year. Fewer women ages 45.0 and older than younger women reported having their height checked in the last year (53.0 percent versus 57.0 percent). Women diagnosed with osteoporosis were more likely to have had their height checked in the last year (65.0 percent).

Osteoporosis Prevalence and Awareness, California, 2004

California Department of Health Services Chronic Disease Control Branch

Public Health Message

Osteoporosis is a treatable and preventable disease. Discussion of osteoporosis with a health provider leads to early diagnosis and treatment. Less than one-third of women surveyed under age 45 have talked to their doctor about osteoporosis prevention. Efforts to raise awareness about osteoporosis prevention among younger women are necessary.

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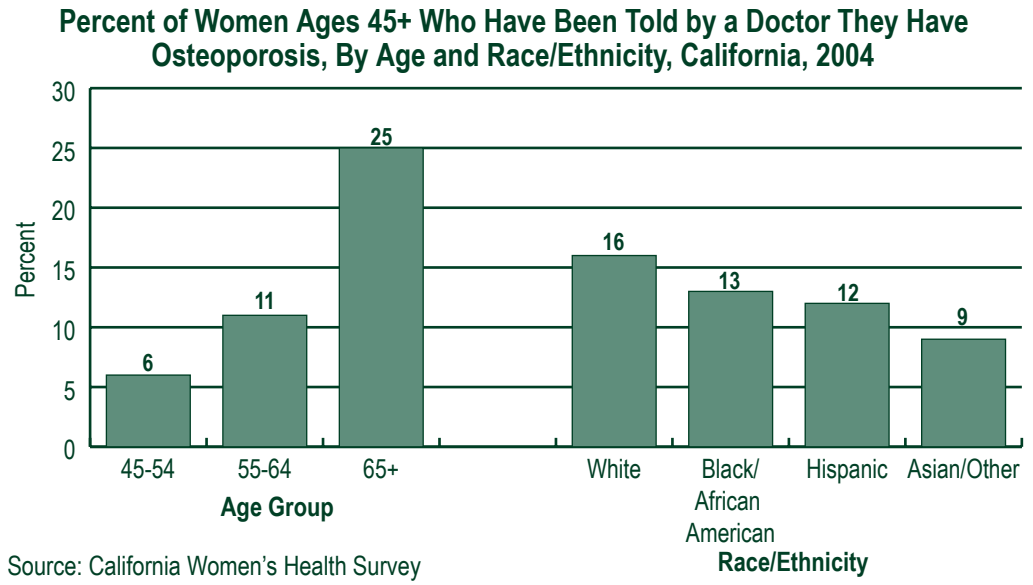
Osteoporosis Prevalence and Awareness, California, 2004

California Department of Health Services Chronic Disease Control Branch



1 National Osteoporosis Foundation. America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation. Washington, DC: National Osteoporosis Foundation, 2002.

2 NIH Osteoporosis and Related Bone Diseases National Resource Center-- Fast Facts on Osteoporosis. Available at www.osteo.org/inetdocs/r106pi.pdf.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Osteoporosis ("porous bone") is a disease characterized by decreased bone mass and weakened bone tissue, leading to an increased risk of bone fractures. Women are four times more likely to develop osteoporosis than men.[1] Postmenopausal women are at highest risk. Other risk factors for osteoporosis include history of fracture, family history, low body weight, increased age, low calcium intake, vitamin D deficiency, smoking, excessive alcohol consumption, and an inactive lifestyle. Bone mineral density tests can detect osteoporosis before a fracture occurs, and is recommended for all women at risk of developing the disease.[2]

The 2004 California Women's Health Survey (CWHS) asked 4,557 women ages 18 and older if they ever: 1) had a bone density test for osteoporosis or bone loss; and 2) had broken a bone as the result of a fall. Women who reported having both a broken bone and a bone density test were asked if they received the bone density test as a result of the fall.

Overall, 21.0 percent of women ages 18 and older reported having had a bone density test for osteoporosis or bone loss. The number of women that reported having a bone density test increased with age. Among women 45 and older, 41.0 percent reported having had a bone density test. Women ages 65 and older were most likely to have had a bone density test (see graph). White women were most likely and Hispanic women were least likely to have had a bone density test (see graph).

Among all adult women, 14.0 percent had broken a bone as the result of a fall during their lifetime. The number of women that reported having ever broken a bone due to a fall increased slightly with age. Women ages 45 and older were more likely than younger women to have broken a bone as the result of a fall (16.0 percent versus 13.0 percent). White women were the most likely to have fallen and broken a bone (19.0 percent), followed by Black/African American (11.0 percent), Asian/Other (10.0 percent), and Hispanic (9.0 percent). The bone broken most often was the wrist (40.0 percent), followed by the ankle (17.0 percent), the foot (17.0 percent), and the elbow (8.0 percent).

Of the 238 adult women who had broken a bone as the result of a fall and had a bone density test, 12.0 percent reported having received the bone density test because of the fall. The majority of those who had a bone density test because of the fall were women ages 45 and older (87.0 percent).

Bone Density Testing and Falls, California, 2004

California Department of Health Services
Chronic Disease Control Branch

Public Health Message

Bone density screening is recommended for women with risk factors for developing osteoporosis. National guidelines recommend routine screening for women over age 65. Efforts to increase screening rates among both elderly and at-risk women should continue.

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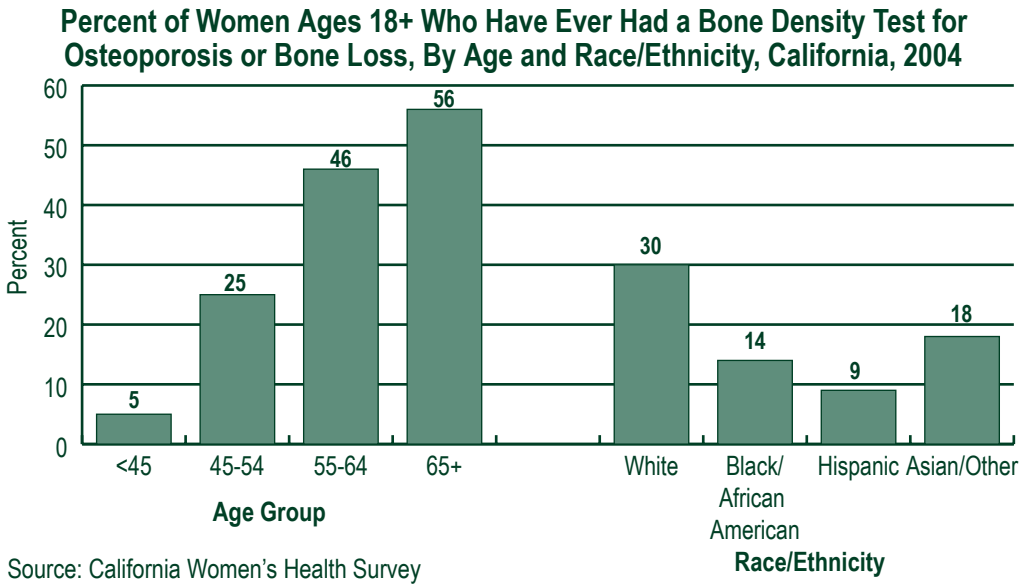
Bone Density Testing and Falls, California, 2004

California Department of Health Services
Chronic Disease Control Branch



1 National Osteoporosis Foundation. America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation. Washington, DC: National Osteoporosis Foundation, 2002.

2 NIH Osteoporosis and Related Bone Diseases National Resource Center - Fast Facts on Osteoporosis. Available at www.osteo.org/inetdocs/r106pi.pdf.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Health and Mental Health Problems Among California Women by Drinking Status: Abstainers, Moderate Drinkers, and Heavier Drinkers

California Department of Alcohol and Drug Programs

National population-based studies indicate that women are less likely than men to drink or to drink heavily, but that the gender gap in alcohol abuse and dependence appears to be narrowing.[1] As a result of gender-related physiological differences, women may experience negative health consequences at lower levels of consumption and with a shorter duration of heavier drinking than men.[2] Heavier alcohol use is associated with a wide array of health-related problems including risk for injury, illness, and alcohol dependence. Women who are heavier drinkers appear to be at risk for a number of health problems including alcohol-related liver disease, injury, neurological problems, hypertension, breast cancer, and violent victimization.[2,3] Alcohol and other drug problems are also highly correlated with mental health problems.[4] Measures of heavier drinking occasions (i.e., five or more drinks on one occasion) are often associated with high levels of alcohol-related risks or problems, even when overall volume of drinking is low.[5]

The 2004 California Women's Health Survey (CWHS) asked all women respondents two questions about indicators of alcohol-related problems in their entire lifetime: 1) "Was there ever a time when you felt your drinking had a harmful effect on your health?" and 2) "Have you ever gone to anyone – a physician, AA, a treatment agency, anyone at all – for a problem related in any way to your drinking?" Other questions were asked about alcohol use in the past 30 days and about whether respondents wanted and received help from a mental health professional.

This report compares responses from women who had abstained from alcohol in the preceding 30 days, moderate drinkers (respondents who consumed alcohol in the past 30 days but did not consume five or more drinks on at least one occasion), and heavier drinkers. Overall, approximately half the respondents in 2004 reported abstaining from alcohol (50.5 percent) and nearly half reported at least some drinking (49.5 percent). Among drinkers, approximately 8.0 percent were heavier drinkers (defined as women who reported drinking five or more drinks on a single occasion once or more in the past month). Findings are summarized below.

- Women who were heavier drinkers were significantly more likely to report past harm to their health from drinking (34 percent), compared with moderate drinkers (17 percent) or abstainers (13 percent).
- Heavier drinking women were also more likely to report having sought help in the past for a drinking problem (7 percent), compared with abstainers (3 percent) or moderate drinkers (2 percent).
- A separate analysis, found that heavier drinking women were more likely to report needing help from a mental health professional in the past year (30 percent), compared with 22 percent among drinkers and 18 percent among abstainers. At the same time, moderate drinkers who wanted help were most likely to get help (64 percent) than heavier drinkers (55 percent).

Public Health Message: *Women who are heavier drinkers were significantly more likely to report harm to their health than moderate drinkers or abstainers. They were also more likely to have sought help in the past for a drinking problem. These findings underscore the importance of screening for heavier drinking and alcohol-related problems in both health and mental health settings. In addition, the findings support the importance of efforts to facilitate collaboration between mental health and substance abuse treatment fields.*

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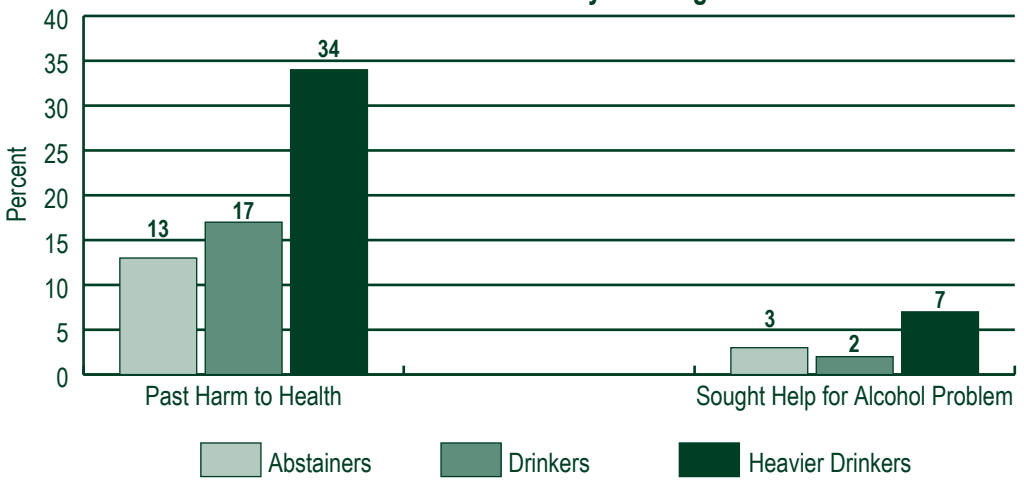
Health and Mental Health Problems Among California Women by Drinking Status: Abstainers, Moderate Drinkers, and Heavier Drinkers

California Department of Alcohol and Drug Programs



Source: California Women's Health Survey

1 Grant BF, Dawson D, Stinson FS, Chou S, Dufour MC, Pickering RP. The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence. Drug and Alcohol Dependence. 2004;17:223-234.

2 National Institute on Alcohol Abuse and Alcoholism (NIAAA). Are women more vulnerable to alcohol's effects? Alcohol Alert No. 46. 1999.

3 Bradley KA, Badrinath S, Bush K, Boyd-Wickizer J, Anawalt B. Medical risks for women who drink alcohol. Journal of General Internal Medicine. 1998;13:627-639.

4 United States Department of Health and Human Services. Overview of findings from the 2003 National Survey on Durg Use and Health. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA). DHHS Publication No. (SMA) 04-3963. 2003.

5 Midanik LT, Tam TW, Greenfield TK, Caetano R. Risk functions for alcohol-related problems in a 1998 US national sample. Addictions. 1996;91:1427-1437.

Submitted by: Laurie Drabble, San Jose State University, School of Social Work, for the California Department of Alcohol and Drug Programs (408) 924-5836, ldrabble@sjsu.edu
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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Healthcare Provider Discussion About HIV Risk, California, 2003

California Department of Health Services
Office of Women's Health

The proportion of all AIDS cases that are women increased from 5.9 percent in 1992 to 11.8 percent in 2004. About 85.0 percent of California women with HIV or AIDS are of childbearing age, but 12.1 percent of newly-diagnosed female HIV/AIDS cases in California in 2004 were women aged 50 and above.[1] Knowledge of HIV serostatus is important to enable initiation of antiretroviral therapy and counseling to prevent further sexual, injection drug use, and perinatal transmission.

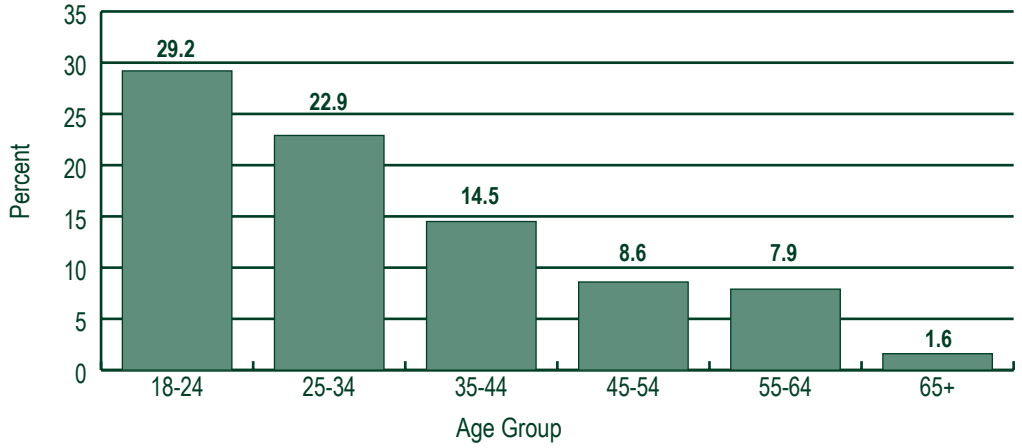
In 2003, the Office of Women's Health (OWH) asked questions relating to doctor or other healthcare provider screening for HIV. All respondents were asked whether in the previous 12 months providers had asked them about their personal risk for HIV.[2]

About 14.0 percent of 4,034 respondents reported that a healthcare provider had talked with them about their personal risk for HIV during the previous 12 months. Respondents reporting HIV discussions varied significantly by age (see graph) and race/ethnicity.[3] Younger respondents, Hispanic (22.3 percent) and Black/African American (18.8 percent) reported higher rates of provider discussion about HIV risk.

- Married women were less likely to report that a healthcare provider had discussed HIV risk with them (10.7 percent) than non-married women (18.2 percent).
- Women with health insurance were less likely to report that a healthcare provider had discussed HIV risk with them (13.4 percent), compared with women who had no health insurance (19.3 percent).
- Women whose income was at or below federal poverty level were most likely to report that a healthcare provider had discussed HIV risk (19.9 percent), compared with women above the poverty level (11.0 percent).

Public Health Message: *Healthcare providers were more likely to discuss HIV in the previous 12 months with women who were at risk for HIV: younger, Hispanic, Black/African American, and uninsured. Providers should consider discussing HIV testing with women older than 50, since they are also at risk for HIV/AIDS.*

Proportion of Women Reporting that a Health Care Provider Discussed HIV Risks With Them During the Past 12 Months, By Age Group, California, 2003



Source: California Women's Health Survey

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1 Office of AIDS, California Department of Health Services. Personal communication. Data presented are as of December 31, 2004.

2 Missing responses and refusals were excluded from the analyses. The questions were asked of all the respondents under an assumption that all the respondents had seen a healthcare provider in the previous 12 months.

3 Chi-square test $p < 0.001$.

Submitted by: Zipora Weinbaum and Terri Thorfinnson, California Department of Health Services, Office of Women's Health, (916) 440-7626, zweinbau@dhs.ca.gov

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Provider Discussion of Sexual Behavior and Chlamydia Testing of California Women with Sexual Risk Behaviors, 2004

California Department of Health Services
Division of Communicable Disease Control, Sexually Transmitted Disease Control Branch

Survey Research Group

Chlamydia infections are the most commonly reported disease in California and untreated infections are associated with infertility and tubal pregnancy.[1] To identify these predominantly asymptomatic infections, national guidelines recommend annual testing for chlamydia for sexually active women age 25 years and younger, and targeted testing of women older than age 25 years with risk factors such as new and/or multiple partners and partners with other sex partners.[2] Health-care providers providing reproductive health care services to women at risk for chlamydia should discuss possible sexual risk behaviors to determine if a test for chlamydia or other sexually transmitted diseases is warranted.

In 2004, 2,412 California Women's Health Survey (CWHS) participants aged 18-49 were asked "During the past 12 months, did a doctor or other healthcare provider talk to you about your personal sexual behavior?" Women who reported that they had a new male sexual partner in the past 12 months, had more than 1 male sexual partner in the past 12 months, or reported that their male sex partner was likely to have other sex partners were categorized in the analysis as having sexual risk behaviors. Responses were stratified by age and race/ethnicity, and were weighted to the 2000 California population.

Overall, 18.2 percent of all women reported having sexual risk behaviors and 16.8 percent of all women reported that their healthcare provider had discussed their sexual behavior with them in the past year. Of the women with sexual risk behaviors, 21.1 percent reported a healthcare provider discussion.

- Younger women aged 18-24 with risk behaviors were more likely (35.0 percent) than older women aged 35 and older (12.0 percent) to report a healthcare provider discussion.
- Black/African American women with risk behaviors were more likely (36.4 percent) than White women (29.5 percent), Hispanic women (11.7 percent), and women of Asian/Pacific Islander and Other race/ethnicity groups (17.3 percent) to report a healthcare provider discussion.

Additionally, 41.3 percent of women with risk behaviors reported a chlamydia test in the past 12 months.

- Younger women aged 18-24 with risk behaviors were more likely (55.8 percent) than women aged 25-34 (48.7 percent) and aged 35-44 (28.7 percent) to have had a chlamydia test in the past year. Overall, 51.0 percent of all young women reported a chlamydia test in the past year.
- White women with risk behaviors (43.7 percent) were more likely than Hispanic women (38.6 percent) to have had a chlamydia test in the past year.[3]

Public Health Message: *Current levels of provider discussion of sexual behavior and chlamydia testing among women with sexual risk behaviors as well as young women in general can be improved. Further efforts are needed to reduce barriers to provider discussion and chlamydia testing of women at high risk for chlamydia infections.*

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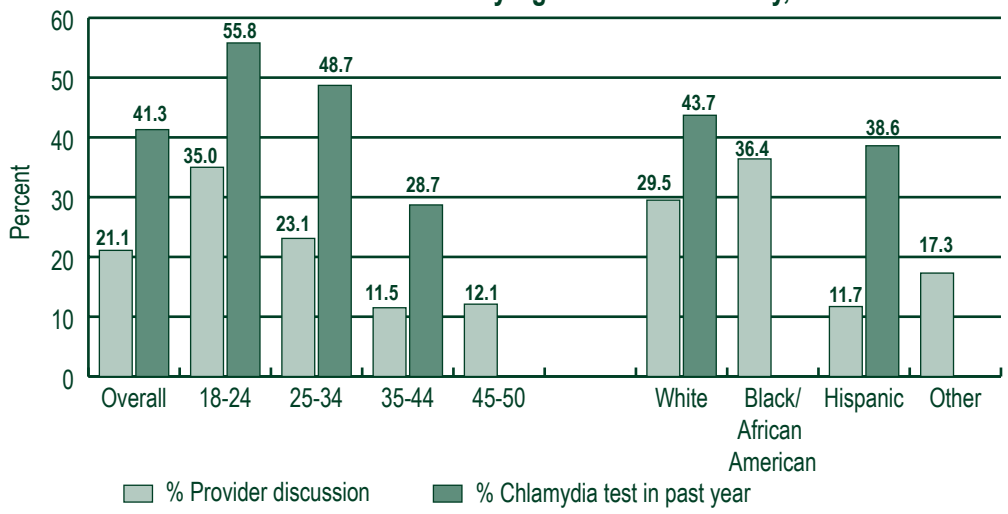
Provider Discussion of Sexual Behavior and Chlamydia Testing of California Women with Sexual Risk Behaviors, 2004

California Department of Health Services
Division of Communicable Disease Control, Sexually Transmitted Disease Control Branch

Survey Research Group



Source: California Women's Health Survey

1 Cates W, Wasserheit JN. Genital chlamydial infections: epidemiology and reproductive sequelae. Am J Obstet Gynecol 1991;164:1771-81.

2 Centers for Disease Control and Prevention. Sexually transmitted disease treatment guidelines 2002. MMWR 2002;51(No. RR-6):1-84.

3 Small numbers of respondents in the Black/African American and Asian/Pacific Islander and Other race/ethnicity categories did not allow for stable estimates of chlamydia testing.

Submitted by: Joan Chow, Julie Lifshay, and Gail Bolan, California Department of Health Services, Sexually Transmitted Disease Control Branch, (510) 620-3718, jchow@dhs.ca.gov; Ann Webb, Survey Research Group, Public Health Institute, (916) 779-0287, awebb@surveyresearchgroup.com

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Access to Methods of Family Planning Among California Women Ages 18-44 Who are at Risk of Unintended Pregnancy, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch

Unintended pregnancy is associated with a host of personal, social, and health consequences for mothers, their children, and the society as a whole.[1] While current contraceptive technology provides couples considerable control over their fertility, one-half of all pregnancies in the United States are unintended.[2] Improved access to family planning services may prevent unplanned pregnancies by enabling women and men to choose effective methods of family planning.

The California Department of Health Services' Office of Family Planning Branch participates in the annual California Women's Health Survey (CWHS) by including questions related to sexual behavior and use of birth control methods. CWHS gathered information about family planning related visits with a healthcare provider to talk about or to receive birth control methods. Responses from the combined 2003 and 2004 CWHS were analyzed to identify women at risk of unintended pregnancy and examine their access to family planning methods. For the purposes of this analysis, women ages 18-44 "at risk of unintended pregnancy" were determined by using several survey items that identified those who were sexually active in the past 12 months and neither pregnant, sterilized, postpartum, seeking pregnancy, nor infertile. A total of 2,064 women at risk of unintended pregnancy were included in the analysis.

- Nearly one in ten women at risk of unintended pregnancy had never had a family planning related visit to talk about or to receive birth control.
- Foreign-born women were more than three times as likely as U.S.-born women (16.1 percent vs. 4.9 percent) to report that they never had a family planning related visit.
- The proportion of women who never had a family planning related visit is over twice as high for women without health insurance coverage as it is for women who reported having health insurance coverage (16.0 percent vs. 7.3 percent).
- A higher proportion (15.6 percent) of women with less than a high school education reported never having a family planning related visit compared with 4.8 percent of women with a college or post-education degree.
- More than half (55.2 percent) of younger women ages 18-24 reported a visit in the past six months; nearly 13.0 percent, however, stated they never had a family planning related visit.

It is likely for a respondent currently using a birth control method to report never having had a family planning related visit with a healthcare provider to discuss or to obtain birth control. More than half (55.0 percent) of those who reported never having a family planning related visit were condom users, suggesting that this method is obtained through over-the-counter access.

- More than nine in ten women currently using oral contraceptives, patch, or ring have had a family planning related visit in the past 12 months.
- Roughly one-quarter (24.8 percent) of those who never had a family planning related visit were both at risk of unintended pregnancy and non-users of any form of contraception.

Public Health Message: *Convenient access is one factor affecting birth control use. CWHS data show that women surveyed in Spanish, foreign-born women, and women lacking health insurance are less likely to have ever had a family planning related visit with a healthcare provider. Family planning services should target these groups.*

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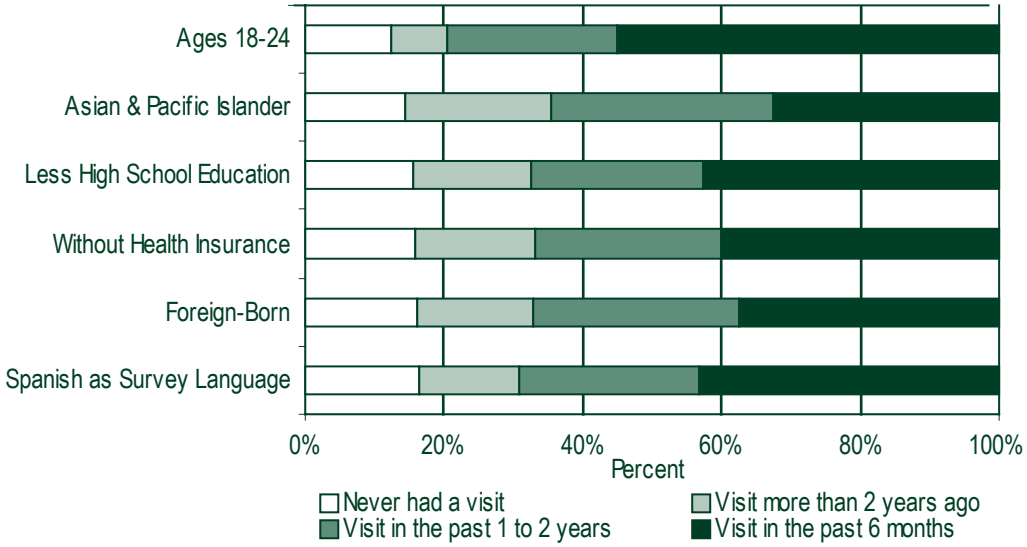
Access to Methods of Family Planning Among California Women Ages 18-44 Who are at Risk of Unintended Pregnancy, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch

Select Demographic Characteristics of Women At Risk of Unintended Pregnancy* By Visit with a Healthcare Provider to Discuss or to Obtain Birth Control Methods, 2003-2004



Source: California Women's Health Survey

* Women ages 18-44 were considered at risk of unintended pregnancy if they were sexually active in the past 12 months and neither pregnant, sterilized, postpartum, seeking pregnancy, nor infertile.

1 Lee LR, Stewart FH. 1995. Failing to prevent unintended pregnancy is costly. American Journal of Public Health. 85(4):479-480. Maynard RA. 1997. Having kids: The economic and social consequence of teen pregnancy. The Cost of Adolescent Childbearing. 10:285-323.

2 Office of Population Affairs and National Center for Health Statistics, U.S. Department of Health and Human Services. 1997. Healthy People 2000 Review. Hyattsville, Maryland: Public Health Service.

Submitted by: Marina Chabot and Mary Bradsberry, California Department of Health Services, Maternal, Child, and Adolescent Health/Office of Family Planning Branch, and University of California, San Francisco Bixby Center for Reproductive Health Research & Policy, (916) 650-0467, mchabot@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Contraceptive Use Among California Women Ages 18-44, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch

Contraceptive use is essential among sexually active women of reproductive age who wish to limit the number of children they have. Contraception is important for those who plan to space their births at healthy intervals or postpone childbearing. Family planning is included as one of the 28 focus areas of Healthy People 2010, a nationwide comprehensive health promotion and disease prevention agenda launched by the U.S. Department of Health and Human Services.[1]

The California Department of Health Services' Office of Family Planning Branch included two contraceptive utilization questions asked of non-pregnant, fertile respondents (i.e. those who reported they haven't had a hysterectomy) in the annual California Women's Health Survey (CWHS): first, *"Are you or your male sex partners currently using a birth control method to prevent pregnancy?"* and second, *"Which birth control method or methods are you using?"* Respondents or their partners who were currently using a contraceptive method were classified by what method they were using; those using multiple methods were classified by the most effective method they were using. A total of 2,595 respondents were current users of contraception in the combined 2003-2004 CWHS.

Nearly half, 48.9 percent of women ages 18-44 were at risk of unintended pregnancy. Of those at risk of unintended pregnancy (sexually active in the past 12 months and neither pregnant, sterilized, postpartum, seeking pregnancy, nor infertile), 13.6 percent were not currently using any contraceptive method and 86.4 percent were currently using some form of birth control. Women who reported sterilization (either male or female) were excluded from this estimate because they are not considered to be at risk of unintended pregnancy.

Below are the highlights describing current contraceptive users and their methods of choice:

- The contraceptive pill was the most popular method with 27.9 percent of contraceptive users; 40.5 percent of women ages 25-29, 39.7 percent of women ages 18-24, 39.1 percent of those who were never married/unmarried couple, and 31.5 percent of White women were oral contraceptives users.
- Approximately one-quarter of women reported using condoms, the second most frequently cited method of contraception; 36.4 percent of Asian/Pacific Islander and 35.6 percent of African American women reported condoms as their primary method.
- Female sterilization was the third leading method with 16.6 percent of users of contraception; 31.8 percent of women who were divorced, widowed, and separated, 31.4 percent of older women ages 40-44, and 26.2 percent of women ages 35-39 reported this method as their leading method of contraception.
- Twelve percent of women currently using contraception relied on male sterilization as their contraceptive method.
- Eleven percent of women reported using long-acting methods such as Depo-Provera®, contraceptive implant, and intrauterine contraception.
- About 5.0 percent of women and their partners were current users of other methods such as diaphragm, cervical cap, natural family planning, and withdrawal.

Public Health Message:
Prevention of mistimed and unplanned pregnancies is possible through consistent use of effective contraception. Although nearly nine in ten women ages 18-44 reported current use of contraceptives, more than one in ten who were at risk of unintended pregnancy were not using any form of contraception.

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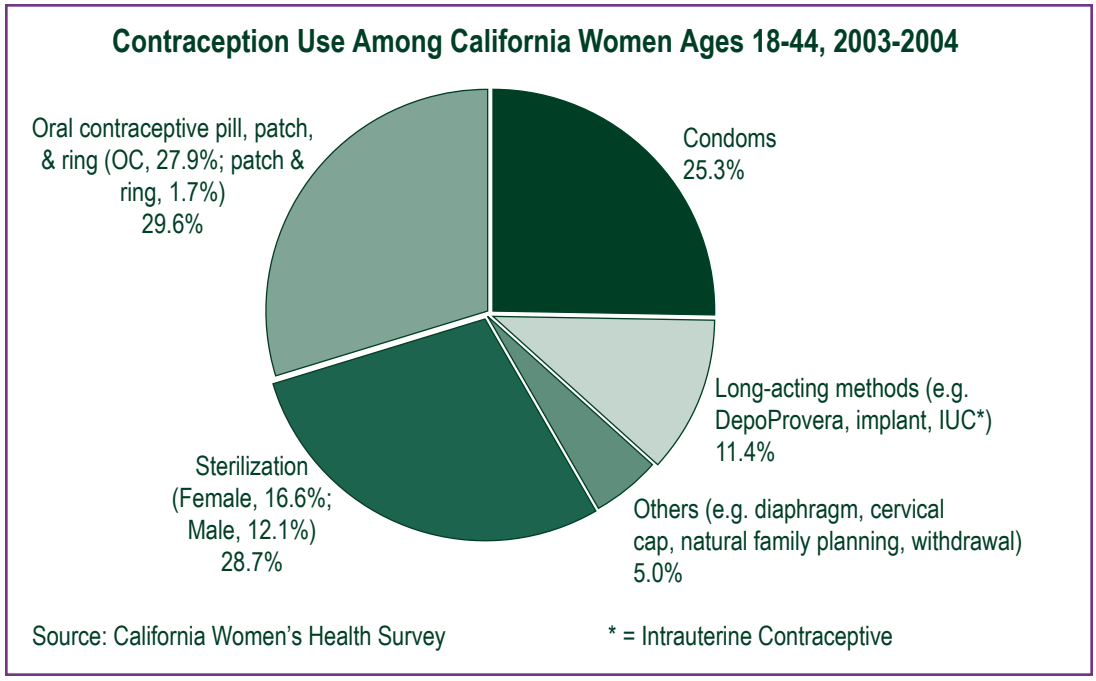
Contraceptive Use Among California Women Ages 18-44, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch



1 United States Department of Health and Human Services. 2000. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: U.S. government Printing Office.

Submitted by: Marina Chabot and Mary Bradsberry, California Department of Health Services, Maternal, Child, and Adolescent Health/Office of Family Planning Branch and University of California, San Francisco Bixby Center for Reproductive Health Research & Policy, (916) 650-0467, mchabot@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

HIV Testing Among Pregnant California Women, 2003-2004

Most infants and children with the human immunodeficiency virus (HIV) infection or the acquired immunodeficiency disease syndrome (AIDS) were exposed before or during birth or through breast-feeding. Despite declines in perinatal HIV transmission, there were 4 pediatric AIDS cases and 24 pediatric HIV cases reported in California in 2005. The U.S. Public Health Service, the Institute of Medicine, and the Centers for Disease Control and Prevention recommend that all pregnant women be tested for HIV. Good prenatal care, use of antiretroviral medications, avoidance of breastfeeding, and elective caesarean section at delivery reduce the risk of perinatal HIV transmission. Moreover, studies have shown that HIV testing is acceptable to over 90.0 percent of pregnant women.

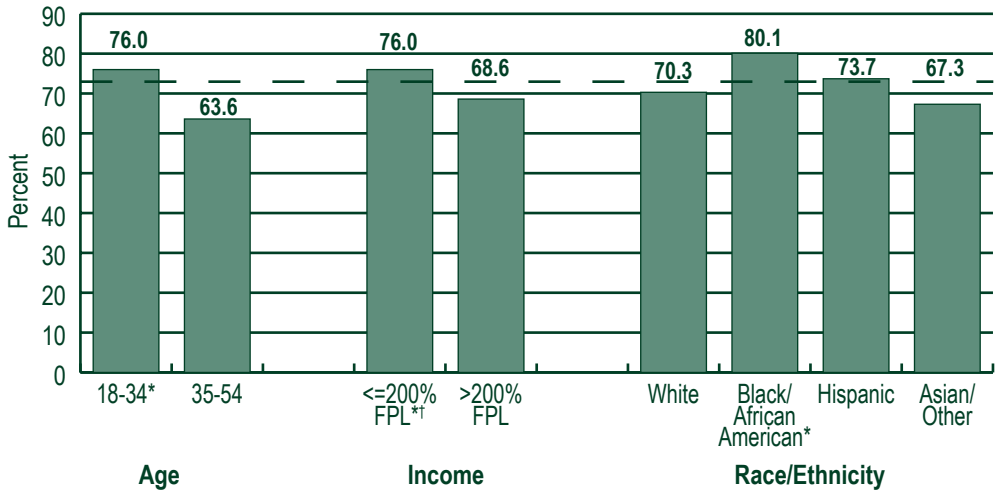
Women who participated in the California Women's Health Survey (CWHS) in 2003 and 2004, and reported being pregnant within the past five years were asked if they had an HIV test during their most recent pregnancy.

Seventy-two percent of women were tested for HIV during a pregnancy in the past five years. Adult women less than 35 years of age were significantly more likely to report being tested for HIV during pregnancy compared with women 35 years of age or older (75.9 percent vs. 63.5 percent, respectively).[1] Women with incomes at 200 percent of the federal poverty level or lower were more likely to report that they had an HIV test compared with pregnant women with higher incomes (76.0 percent vs. 68.6 percent, respectively).[2] A higher proportion of Black/African American women reported being tested for HIV (80.1 percent) compared with Hispanic (73.7 percent), White (70.3 percent), and Asian/Other (67.3 percent) women.

HIV Testing Among Pregnant California Women, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch
Office of Women's Health

Public Health Message:
Targeted interventions are needed to reduce barriers to prenatal HIV testing among women. Increased efforts are needed to educate women about the risks of HIV.



Source: California Women's Health Survey

* Represents groups reporting significantly higher HIV testing rates

† Federal poverty level

— – Dashed line represents the overall percent of women who had an HIV test

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1 $p < .001$.
2 $p < .001$.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Prenatal HIV Counseling, California, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch
Office of Women's Health

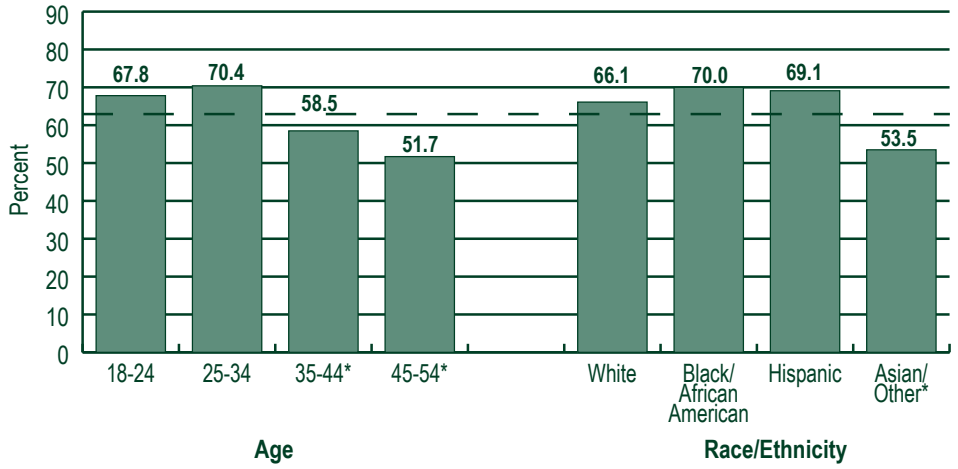
Counseling women about the human immunodeficiency virus (HIV) during pregnancy may help initiate behavior change to prevent HIV infection and assist those already infected with HIV to initiate antiretroviral therapy and obtain further counseling and referrals for additional prevention, medical care and other needed services. HIV counseling also provides the healthcare provider an opportunity to offer HIV testing and get informed consent. In 1995, California required all prenatal care providers to offer HIV information, counseling, and voluntary testing to all pregnant women. In 2003, the state mandate was modified to include HIV testing with consent as part of routine prenatal testing and require the California Department of Health Services to develop culturally sensitive informational material covering HIV testing and counseling.

California Women's Health Survey (CWHS) respondents in 2003 and 2004 who reported being pregnant within the past five years were asked, "During your most recent pregnancy, did a doctor, nurse or healthcare provider talk with you about HIV (the virus that causes AIDS) and about testing your blood for HIV?"

Two-thirds (65.9 percent) of all respondents who were pregnant within the past five years reported that a healthcare provider talked to them about HIV and offered HIV testing during their last pregnancy. Women between 35 and 54 years of age were significantly less likely to report being counseled and offered an HIV test (58.0 percent) compared with younger women (70.0 percent). Asian/Other women were significantly less likely to report being counseled and offered an HIV test (54.0 percent) than White (66.0 percent), Hispanic (69.0 percent), or Black/African American women (70.0 percent).

Public Health Message: *Despite statewide recommendations to provide HIV counseling and offer HIV testing to all pregnant women, one-third of pregnant women had not been counseled for HIV. Efforts to increase access to HIV counseling, specifically to older and Asian/Other pregnant women, are warranted.*

Percent of Women Who Reported that a Healthcare Provider Discussed HIV and HIV Testing during their most recent pregnancy within the past five years



Source: California Women's Health Survey

* Represents groups reporting significantly lower HIV counseling and test offering

— – Dashed line represents the overall percent of women receiving HIV counseling and test offering

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Prenatal HIV Counseling, California, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch
Office of Women's Health

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Infertility: Problems Getting Pregnant and Past Infertility Diagnosis Among California Women, 2003

California Department of Health Services
Division of Communicable Disease Control, Sexually Transmitted Disease Control Branch

Survey Research Group

Public Health Message: *History of infertility diagnosis and problems with getting pregnant varied by age and race/ethnicity. These patterns may be related to differences in timing of child birth and health care-seeking behaviors.*

Infertility is a major public health problem affecting up to 10.0 percent of American couples of reproductive age and is defined as inability to conceive a pregnancy after 12 months of unprotected intercourse.[1] Infertility may be related to hormonal factors and history of upper genital tract infection within couples. Differences in infertility prevalence may exist with respect to income and access to infertility-related services as well as age and race/ethnicity.[2]

In 2003, 2,564 California Women's Health Survey (CWHS) participants ages 18-50 were asked the following questions: "In the past have you ever tried for more than 12 months to get pregnant and weren't successful? and "Have you ever been told by a doctor or other health professional that you were infertile?" Responses were stratified by age, race/ethnicity, and health insurance status, and weighted to the 2000 California population.

Overall, 11.2 percent of California women reported having problems getting pregnant after 12 months of trying to get pregnant.

- Women ages 35-44 and 45-50 were more likely to report problems with getting pregnant (13.1 percent) compared with women ages 18-24 (3.5 percent) and ages 25-34 (11.9 percent).[3]
- White women were more likely to report problems getting pregnant (13.7 percent) compared with women of "Other" race/ethnicity (9.8 percent), Hispanic women (8.3 percent), and Black/African American women (7.0 percent).
- Among women with and without health insurance, 11.0 percent of each reported problems getting pregnant.

Overall, 4.6 percent of California women reported a past history of an infertility diagnosis.

- A higher proportion of women ages 35-44 and 45-50 reported a past diagnosis of infertility (6.3 percent) compared with women ages 18-24 (2.1 percent), and ages 25-34 (3.2 percent).[3]
- Black/African American women were more likely to report a past infertility diagnosis (9.1 percent) compared with White women (5.3 percent), women of Other race/ethnicity (3.0 percent), and Hispanic women (2.9 percent).[3]
- Five percent of women with health insurance reported a past infertility diagnosis.[3]

Eighteen percent of women who had problems getting pregnant also reported a past diagnosis of infertility.

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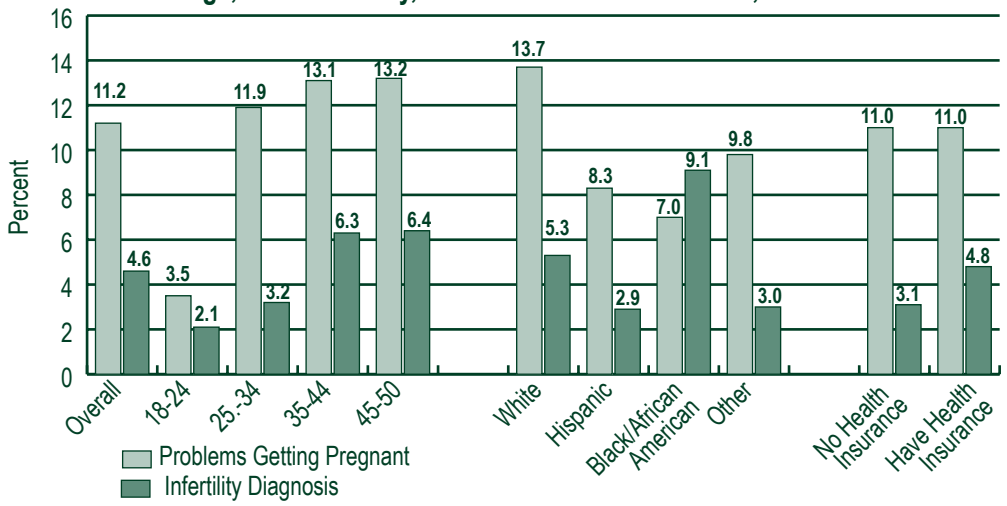
Infertility: Problems Getting Pregnant and Past Infertility Diagnosis Among California Women, 2003

California Department of Health Services
Division of Communicable Disease Control, Sexually Transmitted Disease Control Branch

Survey Research Group

Problems Getting Pregnant and Past Infertility Diagnosis Among California Women by Age, Race/Ethnicity, and Health Insurance Status, 2003



Source: California Women's Health Survey

1 Mosher WD, Pratt WF. Fecundity and infertility in the United States, 1965-88, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1990. (Advance data from vital and health statistics; no. 192).

2 Hirsch MB, Mosher WD. Characteristics of infertile women in the United States and their use of infertility services. Fertil Steril 1987;47:618-25.

3 Small numbers of respondents for women who were age 18-24, Black/African American and Asian/PI and Other race/ethnicity, and uninsured did not allow for comparisons with these groups.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Eating Five or More Fruits and Vegetable Servings a Day: Belief versus Practice of California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Increasing fruit and vegetable consumption is an important healthy behavior that can help prevent heart disease, some cancers, high blood pressure, type 2 diabetes, and the risk of overweight and obesity.[1] In 2004, the Cancer Prevention and Nutrition Section (CPNS) sponsored questions in the California Women's Health Survey (CWHS) to determine women's belief and practice of the prevailing fruit and vegetable dietary recommendations to eat five or more servings per day. In 2005, the U.S. Departments of Health and Human Services and Agriculture released revised Dietary Guidelines for Americans that almost doubled the daily fruit and vegetable recommendations for women.[2]

Overall 61.0 percent of the 4,434 women aged 18 to 97 believe they should eat five or more servings of fruits and vegetables every day for good health ("5 a Day"). (A serving was defined for respondents as being about 1/2 cup of vegetables or fruit, 6 ounces of 100.0 percent fruit or vegetable juice, a medium piece of fruit, or 1 cup of green salad.) However, only 20.7 percent reported that they usually ate five or more servings of fruit/vegetables in an average day. "5 a Day" belief and practice varied significantly by race/ethnicity, income and education level,[3] and age group.[4]

- White women were most likely to report they should eat five or more servings of fruits and vegetables every day (69.9 percent), followed by Black/African American (55.4 percent), Asian/Other (51.8 percent), and Hispanic women (49.9 percent). Similarly, more White women (26.0 percent) reported eating five or more servings on the average day than Asian/Other (17.4 percent), Hispanic (14.3 percent), and Black/African American women (11.6 percent).
- In general, "5 a Day" belief was greater among younger women, with 64.5 percent of respondents 25-34 years of age reporting they should eat five or more servings for good health compared with 56.2 percent of women 65 years of age and older. However, behavior was more positive in the older age group, with one in four women aged 65 and older reporting they ate five or more servings compared with fewer than one in five of women aged 25-34.
- Fewer than half (44.9 percent) of the women with incomes below the federal poverty level thought they should eat five or more servings of fruit and vegetable per day for good health, compared with two-thirds (69.4 percent) of respondents with incomes more than twice the federal poverty level. Only one in ten respondents below the federal poverty level reported eating five or more servings compared with one in four of the respondents whose income was more than twice the federal poverty level (see graph).
- Greater formal education was associated with "5 a Day" belief and practice: 42.6 percent and 13.3 percent, respectively, for women with less than high school education; 52.2 percent and 14.1 percent for those completing high school; 66.9 percent and 21.5 percent for women with some college; and 70.6 percent and 27.8 percent for college graduates.

Public Health Message: *Most California women believe they should eat five or more fruit and vegetable servings each day for good health but only one in five do so. Eating the recommended servings was positively related to respondent's age, income, and education level. Black/African American women were least likely to eat five or more fruit and vegetable servings daily. The new 2005 Dietary Guidelines for Americans further widen the gap between women's belief and their fruit and vegetable consumption. These data are consistent with other California surveys showing the need for additional policy, programmatic, and environmental efforts to improve fruit and vegetable access, availability, opportunity, and incentive for consumption.*

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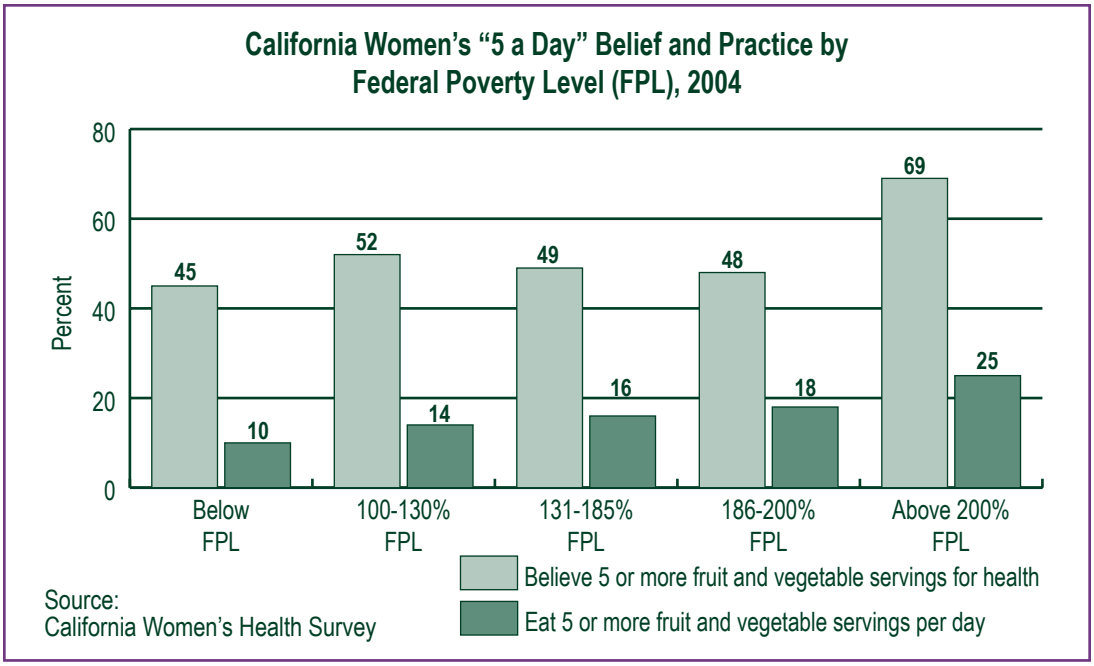
Eating Five or More Fruits and Vegetable Servings a Day: Belief versus Practice of California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section



1 Hyson, D. The health benefits of fruits and vegetables: A scientific overview for health professionals. Produce for Better Health Foundation, 2002.
2 United States Department of Agriculture, United States Department of Health and Human Services. 2005. Dietary guidelines for Americans 2005. Available at: www.healthierus.gov/dietaryguidelines.
3 $p < 0.0001$, chi-square test.
4 $p = .02$, chi-square test.

Submitted by: Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, California Department of Health Services, Cancer Prevention and Nutrition Section, (916) 552-9938, BmkNelly@dhs.ca.gov

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

A great deal of attention has focused on the increase in obesity and its link to greater coronary heart disease, diabetes, hypertension, gall bladder disease, osteoarthritis, and many types of cancer.[1,2] This public health concern can be framed in terms of the relatively low prevalence of healthy weight. Setting healthy weight targets might be a more positive and motivating approach than only emphasizing obesity reduction. The national *Healthy People 2010* target is to increase to 60.0 percent the proportion of adults at a healthy weight.[3]

In the 2004 California Women's Health Survey (CWHS), women self-reported their heights and weights, which were then converted to a Body Mass Index (BMI). For the analysis presented here, women classified as underweight (BMI less than 18.5) or overweight or obese (BMI more than 25) were not considered to be of a "healthy weight."

Women who were pregnant or one-year postpartum were excluded from the analysis for a total sample of 4,032.

- Overall, less than half of the California women (47.8 percent) had a healthy weight.

Healthy weight status varied significantly by race/ethnicity, age group, income, education level, and food security status.[4]

- A greater percentage of Asian/Other women had a healthy weight (64.6 percent), followed by White (50.1 percent), Hispanic (35.8 percent), and Black/African American women (33.9 percent). The prevalence of healthy weight was even higher (69.1 percent) among women identifying themselves as Asian or Pacific Islander and excluding women who are American Indian or Alaska Native.

- Healthy weight prevalence declined with age. The majority of women 18-24 years had a healthy weight (62.5 percent) compared with 50.8 percent of women 25-34 years, 49.7 percent of women 35-44 years, 43.0 percent of women 45-54 years, 36.9 percent of women 55-64 years and 46.1 percent of women 65 years and older.

- Just over one in three (39.4 percent) women with incomes below the federal poverty level had a healthy weight, compared with just over one in two (51.8 percent) respondents with incomes twice the federal poverty level.

- Greater formal education was positively associated with a healthy weight. Only 31.5 percent of women with less than a high school education had a healthy weight, compared with 41.4 percent of high school graduates, 47.2 percent of women with some college, and 59.0 percent of college graduates. (See graph)

- More than half (51.4 percent) of women in food secure households had a healthy weight compared with 39.8 percent of women in food insecure households without hunger, and 31.1 percent of women in food insecure households with hunger.

For women income eligible to receive food stamps (less than130 percent federal poverty level), healthy weight did not differ significantly by participation in the Food Stamp Program (FSP). Healthy weight prevalence was 39.6

Healthy Weight Among California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Public Health Message:
Most California women do not have a healthy weight. Having a healthy weight was positively and significantly related to respondents' income, education level, and food security, negatively and significantly related to age, and not significantly related to participation in the Food Stamp Program. Health disparities undermine California's social and economic well-being. They are likely to persist unless the prevalence of healthy weight increases among California's women and especially low-income women and women of Black/African American and Hispanic race/ethnicity.

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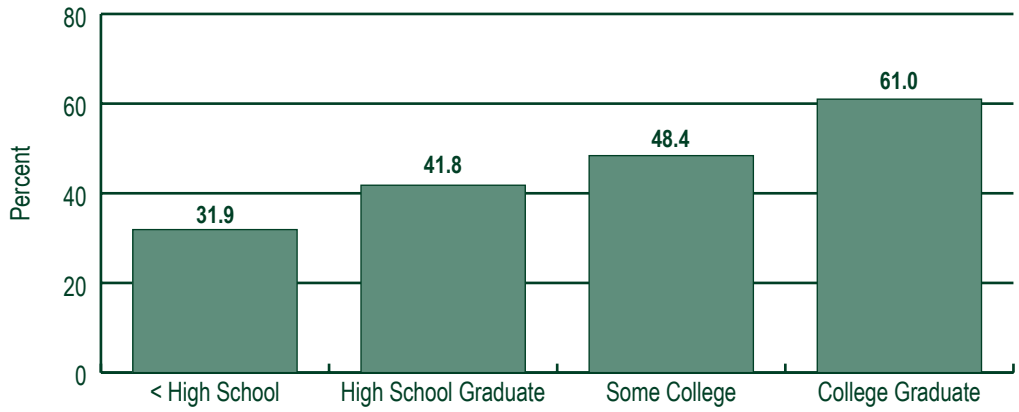

Source: California Women's Health Survey
* Body Mass Index (BMI) is greater than or equal to 18.5 but less than 25, i.e., not underweight, overweight or obese.

percent for food stamp recipients compared with 40.9 percent for women income eligible but not receiving food stamp benefits.

1 Must A, Spadano EH, Coakley AE, Field G, Colditz W, Dietz H. The disease burden associated with overweight and obesity. Journal of American Medical Association. 1999;282(16):1523-1529.
2 Calle EE, Rodriguez C, Walker-Thurmond K, Thun MJ. Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. New England Journal of Medicine. 2003;24(348):1625-1638.
3 United States Department of Health and Human Services. 2000. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, http://www.healthypeople.gov/document/html/volume2/19nutrition.htm.
4 $p < 0.0001$, chi-square test.

Submitted by: Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, California Department of Health Services, Cancer Prevention and Nutrition Section, (916) 552-9938, BmkNelly@dhs.ca.gov.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Achievement of Recommended Levels of Physical Activity Among California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Public Health Message: *Adequate physical activity can substantially reduce the burden of chronic disease and increase healthy years lived. However, for many women it is an elusive goal. Public health efforts are needed to help women better identify and incorporate times and places in their lives for physical activity.*

Physical activity has far-reaching effects on long-term disease and overall health. It is associated with lower mortality for adults of all ages; decreased risk of coronary heart disease, colon cancer, and type 2 diabetes; more controlled blood pressure; healthier weight; improved mood; reduced depression and anxiety; and generally enhanced health-related quality of life.[1] During 2000, physical inactivity was estimated to cost Californians $13.3 billion.[2] Recommended levels of physical activity vary, but federal guidelines call for at least 30 minutes a day of moderate-intensity physical activity most days of the week.[3]

In 2004, the California Department of Health Services' Cancer Prevention and Nutrition Section placed questions on the California Women's Health Survey (CWHS) asking 4,372 women how many days in a usual week and for how much time they do moderate or vigorous activity such as brisk walking, bicycling, vacuuming, gardening, or other activities that cause an increase in breathing or heart rate. Women reporting physical activity of at least 30 minutes five or more times per week were classified as meeting the physical activity recommendation. Women were next asked an open-ended question about their major barrier to getting more exercise. Demographic data, a six-item food insecurity scale, and use of federal food assistance programs were also collected. Self-reported height and weight were used to calculate Body Mass Index (BMI), a measure that identifies obesity. The National Heart, Lung, and Blood Institute defines obesity as a BMI greater than or equal to 30, overweight as a BMI greater than or equal to 25 but less than 30, and "underweight" as a BMI less than 18.5.[4]

In 2004, 39.7 percent of California women reported meeting the physical activity guideline, with no differences by educational level or poverty-related factors. Physical activity varied significantly by race/ethnicity, age group, and BMI.[5]

- White women were most likely to meet recommendations, at 44.1 percent, followed by Hispanic women at 37.4 percent, Black/African American women at 34.5 percent, and Asian/Other women at 29.6 percent (see graph).
- Women who had children younger than age 18 in the household were less likely to meet the activity recommendations (37.8 percent) than women who had no children in the household (51.7 percent). Women of child-bearing age (aged 18 to 44) were less likely to meet activity recommendations than women aged 45 and above, 38.2 percent vs. 41.8 percent, respectively.
- At 31.7 percent, obese women were significantly less likely to achieve recommended physical activity levels than were underweight (37.8 percent), healthy weight (44.0 percent), and overweight (39.3 percent) women.
- In unprompted responses, nearly half of all women (47.5 percent) reported not enough time/too busy or too tired as their main barrier to not being more physically active. The only other reasons reported by more than 10.0 percent of the women were medical conditions (16.4 percent), laziness/no reason (12.4 percent), and already getting enough exercise (12.3 percent). Only four women reported safety concerns as their primary issue.

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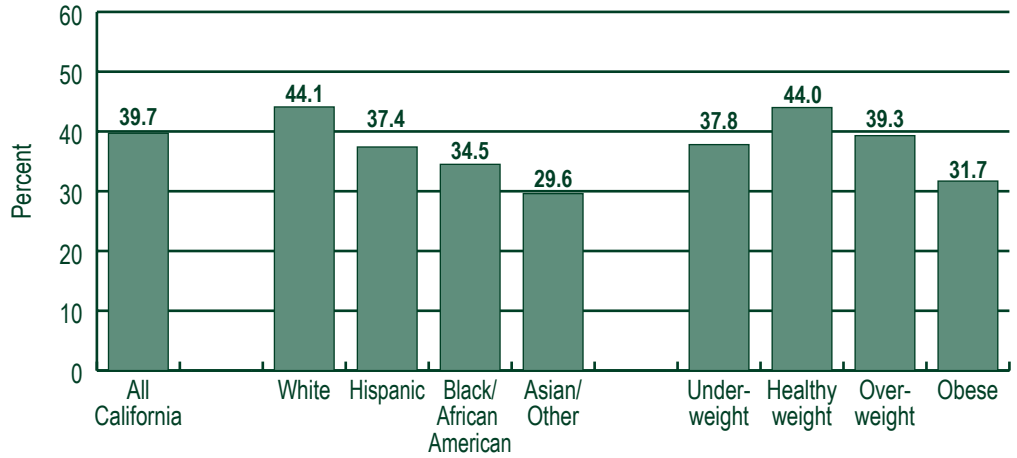
Achievement of Recommended Levels of Physical Activity Among California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section



Source: California Women's Health Survey

- Women of healthy weight status were twice as likely (17.5 percent) as other women (8.2 percent) to report already exercising enough, half as likely to cite health conditions (10.4 percent compared with 21.9 percent), and more likely to report having not enough time/too busy or too tired as their major barrier (51.0 percent and 43.7 percent, respectively).

1 U.S. Department of Health and Human Services. 1996. Physical Activity and Health: A Report of the Surgeon General. Centers for Disease Control and Prevention. Available at: www.cdc.gov/nccdphp/sgr/pdf/sgrfull.pdf.

2 Chenoweth D. 2005. The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults during the Year 2000: A Technical Analysis. California Department of Health Services, Cancer Prevention and Nutrition Section and Epidemiology and Health Promotion Section.

3 U.S. Department of Health and Human Services and U.S. Department of Agriculture, Dietary Guidelines for Americans, 2005, 6th Edition, Washington DC; U.S. Government Printing Office, January 2005.

4 National Institutes of Health. 1998. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: the Evidence Report. NIH Publication No. 98-4083. National Institutes of Health: Washington DC.

5 $p < 0.05$, chi-square test.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Belief and Practice to Eat Five or More Fruit and Vegetable Servings per Day Among Low-Income California Women Receiving Nutrition Assistance, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Federal food and nutrition assistance such as the Food Stamp Program (FSP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) share a goal to "ensure the health of vulnerable Americans by providing access to a nutritionally adequate diet".[1] Daily consumption of the recommended amounts of fruits and vegetables is an important component of a nutritionally adequate diet.

In 2004, the California Department of Health Services' Cancer Prevention and Nutrition Section (CPNS) sponsored the following question in the California Women's Health Survey (CWHS)— *About how many servings of fruits and vegetables do you usually eat or drink on an average day? A serving is about 1/2 cup of vegetables or fruit, 6 ounces of 100 percent fruit or vegetable juice, a medium piece of fruit, or 1 cup of green salad*. Respondents who reported consuming 15 or more servings a day (only 13 observations) were excluded from the analysis for a total sample size of 4,509 with women ranging from 18 to 97 years of age.

The survey collected additional information about participation in food and nutrition assistance programs over the preceding 12 months. Because fruit and vegetable intake tends to increase at higher income levels, the analysis was restricted to the 786 surveyed women who would be income eligible for the FSP by virtue of reporting a gross income less than130 percent of the federal poverty level. In the preceding 12 months, 16.0 percent of these low-income women had participated in the FSP only, 20.4 percent in WIC only, 13.7 percent in both FSP and WIC, and 49.9 percent in neither FSP nor WIC although they were income eligible for the FSP and WIC since they had either had a child under five or were pregnant. A six-item U.S. Department of Agriculture (USDA) food security scale was also used to classify women into three groups: 1) food secure (i.e., having access, at all times, to enough food for an active healthy life), 2) food insecure without hunger, or 3) food insecure with hunger.

- Mean servings of fruits and vegetables varied significantly by women's food security status.[2] The mean number of fruit and vegetable servings on an average day was 3.3 for women who were food secure, 2.9 servings for women who were food insecure without hunger, and 2.7 for women who were food insecure with hunger.

Almost half of the WIC recipients were either pregnant or one-year post-partum, compared with only 27.0 percent of the FSP recipients. Women are often more cognizant of the need for healthy diets when they are pregnant or breastfeeding. WIC recipients were also significantly younger,[3] had more individuals in their household,[4] and were more likely to be married than the FSP sample.[5] Multivariate analysis controlling for these differences was used for the comparisons between food assistance groups.

- The mean number of fruit and vegetable servings on an average day was 2.8 for women who were income eligible for the FSP but who were not receiving food stamps or WIC benefits. Food stamp-only recipients had a mean intake of 2.3 servings compared with 2.9 for WIC-only recipients and 2.6 for women participating in both the FSP and WIC (see graph). However, after controlling for income, age, race/ethnicity, number of children, and pregnancy and post-partum status, low-income women's mean consumption did

Public Health Message: *California women who are food insecure and who are income eligible for federal nutrition assistance, especially women participating in the Food Stamp Program, consume far less than the recommended servings of fruit and vegetables. Limited belief about the recommendation indicates the need for increased educational efforts. However, even women who believe they should consume the recommended amount consume much less, indicating the possible need for additional policy, programmatic, and environmental efforts to improve fruit and vegetable access, availability, opportunity, and incentive for consumption.*

Issue 4, Summer 2006, Num. 24

Belief and Practice to Eat Five or More Fruit and Vegetable Servings per Day Among Low-Income California Women Receiving Nutrition Assistance, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Low Income (<130% FPL*) Women's Fruit and Vegetable Consumption by Food Assistance Status in the Last 12 Months, California, 2004

Source: California Women's Health Survey
* FPL - Federal Poverty Level FSP - Food Stamp Program,
WIC - Women's Infant's and Children's Supplemental Food Program

not differ significantly by food assistance program participation.

- Among women income eligible for the FSP, those who participated both in the FSP and WIC were significantly more likely to believe they should eat five servings or more per day for good health, 59.5 percent compared with 47.1 percent of the WIC-only recipients,[6] 42.0 percent of the FSP-only recipients,[7] and 44.5 percent of women not participating in either program.[8]
- Even among low-income women who believed they should eat five or more fruit and vegetable servings for good health, consumption was only on average 3.4 fruit and vegetables servings in an average day.

1 Fox MK, Hamilton W, Lin BW. 2004. Effects of food assistance and nutrition programs on nutrition and health. Executive Summary of the Literature Review. United States Department of Agriculture, Economic Research Service. Food Assistance and Nutrition Research Report, 4:19-4.
2 ANOVA p<.0001.
3 p<.001.
4 p=.01.
5 chi square, p<.001.
6 chi-square p=.05.
7 chi-square p=.009.
8 chi-square p=007.

Submitted by: Barbara MkNelly, Sharon Sugerman, and Patrick Mitchell, California Department of Health Services, Cancer Prevention and Nutrition Section, (916) 552-9938, BmkNelly@dhs.ca.gov.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Prevalence of Obesity and Disparities in Obesity-Related Factors Among California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section

Steadily increasing obesity has become one of the major public health problems of the past 20 years.[1] Obesity contributes to the development of numerous chronic diseases.[2] It was estimated to cost Californians $6.4 billion in 2000.[3]

Core questions in the 2004 California Women's Healthy Survey (CWHS) asked 4,372 respondents to self-report height and weight, which were used to calculate the Body Mass Index (BMI), a density measure that is a surrogate for obesity. Obesity is defined as a BMI greater than or equal to 30. Demographic data and data on use of food assistance programs were also collected. After eliminating pregnant women and women one year post-partum, 4,032 respondents remained. A six-item U.S. Department of Agriculture (USDA) food security scale was also used to classify women into three groups: food secure, i.e., having access, at all times, to enough food for an active healthy life; food insecure without hunger; or food insecure with hunger.

The Healthy People 2010 goal is to reduce obesity to 15.0 percent.[4] In 2004, the overall rate for obesity among women in the CWHS was 23.2 percent. Obesity prevalence varied significantly by respondents' demographic characteristics, food insecurity, and income,[5] but not by participation in the federal Food Stamp Program (FSP).

- Poverty-related factors were highly associated with obesity. The percentage of obesity among food insecure women with hunger was 40.7 percent, among food insecure women without hunger 31.6 percent, and among food secure women 19.6 percent.
- When household income exceeded 200 percent of the federal poverty level (FPL), obesity significantly decreased, dropping to 20.1 percent.[6] However, there were no significant differences among any of the lower income FPL ratios (see graph).
- There was no significant difference in obesity prevalence between women who participated in the FSP during the prior 12 months compared with women of qualifying income level (less than or equal to 130 percent of the FPL) who did not participate (31.1 vs. 28.4 percent, respectively).
- Prevalence of obesity is negatively associated with education, with obesity among college graduates at 14.2 percent, some college at 25.3 percent, high school graduates at 26.3 percent, and women with less than a high school education at 36.0 percent.
- Asian/Other women reported an obesity rate of 12.0 percent, followed by White women at 21.1 percent. Hispanic and Black/African American women reported 32.2 and 33.1 percent, respectively.
    - When Asian/Pacific Islander (API) women were separated from "Other" women (American Indian or Alaska Native), the API obesity prevalence rate was 7.8 percent.
- Women of child-bearing age (ages 18 to 44) reported significantly lower obesity levels than women aged 45 and over, 20.2 percent vs. 26.2 percent.

Public Health Message: *Education, socio-economic status, and race/ethnicity are associated with obesity. Personal, social normative, environmental, and public policy factors are all contributors to obesity's prevalence. Widespread high levels of obesity among both women of color and White women, as well as among women whose households' earnings were less than 200 percent of the federal poverty level, reinforce the urgency of providing public education, programs, and advocacy to combat this problem. The community, the workplace, and the policy/environmental/economic arenas are all venues where the public health sector can support women's endeavors to reduce levels of obesity.*

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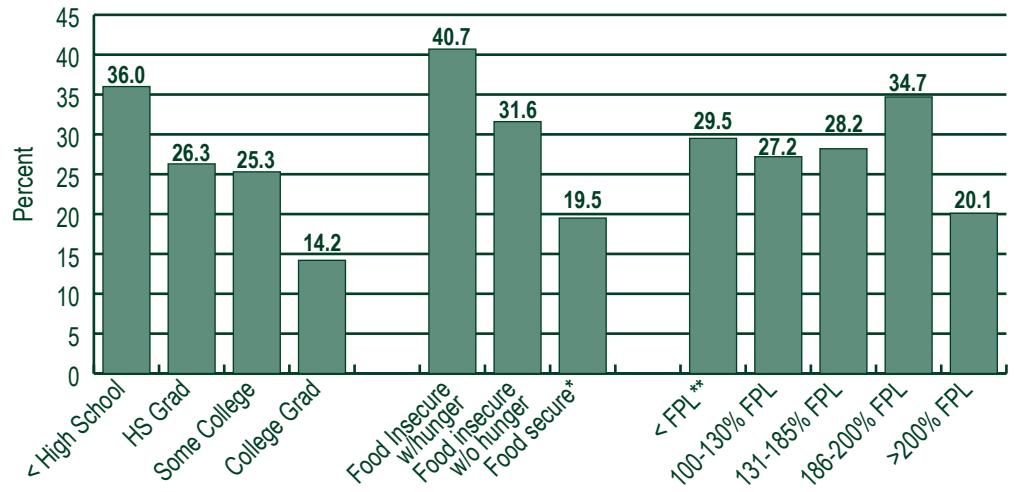
Prevalence of Obesity and Disparities in Obesity-Related Factors Among California Women, 2004

California Department of Health Services
Cancer Prevention and Nutrition Section



* Food secure = having access, at all times, to enough food for an active healthy life.
** FPL = Federal poverty level
Source: California Women's Health Survey

1 U.S. Department of Health and Human Services. 2001. The Surgeon General's call to action to prevent and decrease overweight and obesity. Available at: www.surgeongeneral.gov/library.

2 Must A, Spadano J, Coakley EH, Field AE, Colditz G, Dietz WH. 1999. The disease burden associated with overweight and obesity. JAMA. 282(16):1523-9.

3 Chenoweth D. 2005. The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults during the Year 2000: A Technical Analysis. California Department of Health Services, Cancer Prevention and Nutrition Section and Epidemiology and Health Promotion Section.

4 U.S. Department of Health and Human Services. 2000. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC. Available at: http://www.healthypeople.gov/document/html/volume2/19nutrition.htm.

5 Chi-square $p < .0001$ except for FPL.

6 $p < .05$.

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For additional copies of CWHS 2003-2004 Data Points please contact the Office of Women's Health:

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Women's use of reproductive and preventive health services depends on, among other factors, their insurance status. Uninsured women are less likely to have a usual source of health care and access to pregnancy prevention information and services.

The combined 2003-2004 California Women's Health Survey (CWHS) included 4,537 total respondents of reproductive age. The survey asked multiple health access questions, including questions regarding: 1) access to health care coverage; 2) types of health care coverage; and 3) demographic characteristics of women of childbearing age, i.e., ages 18-44.

Approximately one-fifth of women ages 18-44 reported that they had no health insurance. Among the insured women, 72.7 percent reported they had employment-based coverage, 18.4 percent had government health insurance, and 8.9 percent reported 'other' or self-purchased insurance coverage. The characteristics of uninsured women are examined below:

- The likelihood of being uninsured was highest for women in early adulthood and declined with age; more than one-quarter (26.1 percent) of women aged 18-24 were uninsured compared with 13.9 percent of women aged 40-44.
- Among women who completed the survey in Spanish, 43.6 percent were uninsured compared with 13.2 percent of those who responded to the survey in English.
- Close to one-third (31.7 percent) of women with incomes at or below 200 percent of the federal poverty level (FPL)[1] were uninsured compared with 9.0 percent of women with incomes above 200 percent FPL.
- Thirty-one percent of foreign-born women were uninsured compared with 12.3 percent of U.S.-born women.
- Approximately one-quarter of unmarried, divorced, separated, or widowed women were uninsured compared with 14.6 percent of married women.

Health Insurance Status of Reproductive Age Women 18-44 in California, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch

Public Health Message:
Expanding access to health insurance, in particular among low-income women, is important to ensuring overall reproductive health. CWHS data suggest that some population subgroups, such as those who responded in Spanish language to the survey or women with incomes below 200 percent of the federal poverty level, have a higher likelihood of being uninsured.

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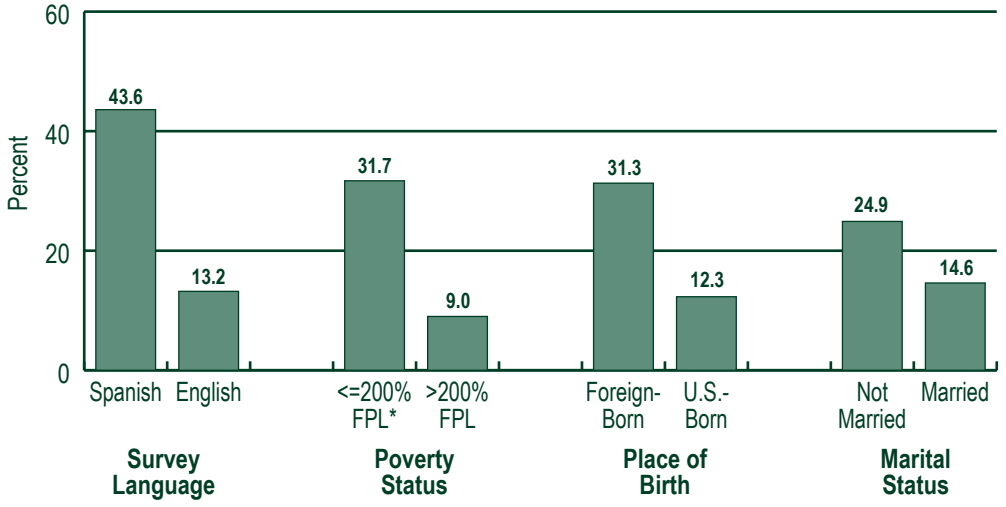
Health Insurance Status of Reproductive Age Women 18-44 in California, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch



Source: California Women's Health Survey

* Federal poverty level

1 Federal poverty levels or poverty guidelines are used for determining income eligibility for certain programs. For example, a woman at or below the 200 percent of Federal Poverty Level, at risk of unintended pregnancy, and without health insurance is eligible to participate in the California's Family PACT Program.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Long-term care is needed when a person is unable to care for himself or herself because of a lengthy illness or disability. It ranges from help with activities of daily living, like eating or dressing, to 24-hour care by skilled medical personnel.

Long-term care is a woman's issue. According to the U.S. Department of Labor,[1] women become primary caregivers for long-term care services and they are the primary recipients of long-term care.

Issues that disproportionately affect California women[2] and their long-term care needs are:

- Women's life expectancy is 4.7 years longer then men.
- After the age of 65, the rate of disability is higher for women (10.3 percent) than for men (6.2 percent).
- After the age of 65, a woman's personal income averages 26.0 percent less than that of a man.
- After the age of 65, 15.3 percent of women are on Medi-Cal compared with 11.3 percent of men. (Medi-Cal is both an indicator of poverty as well as an indicator of medical need.)

The 2003 California Women's Health Survey (CWHS) asked 2,165 California adult women, 45 years of age and older, five questions designed to ascertain the degree to which California women are aware of or have been exposed to long-term care and to determine to what extent they have or will be making plans to address their future long-term care.

The survey results revealed the following:

- 44.0 percent of women surveyed knew someone who had received long-term care;
- 28.0 percent had provided long-term care for someone for more than one month;
- 40.0 percent had discussed their own long-term care needs with their family or friends;
- 29.0 percent had purchased or will purchase long-term care insurance coverage for themselves or family members.

When asked who will care for them when they are unable to care for themselves, only 1.0 percent indicated that their long-term care insurance would care for them, while 74.0 percent expected their family, spouse or partner to care for them.

Women and Long-Term Care Awareness, California, 2003

California Department of Health Services
California Partnership for Long-Term Care

Public Health Message: *Substantial numbers of the women surveyed had been exposed to long-term care in some form. These findings draw attention to the financial and emotional expectations of families and friends regarding their own long-term care. Women can mitigate the financial and emotional stresses of long-term care on family and friends by planning ahead for their future long-term care, including the purchase of long-term care insurance.*

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1 Report of the Working Group on Long-Term Care, November 14, 2000.
2 California Department of Finance, Current Population Survey Report, March 2001 Data, released February 2002.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Frequent Mental Distress and Desire for Help Among California Women Experiencing Intimate Partner Violence, 2003-2004

California Department of Health Services
Maternal, Child and Adolescent Health/Office of Family Planning Branch
Office of Women's Health

Intimate partner violence (IPV), often called domestic violence (DV), adversely affects both the individual and her family. Women who experience IPV are burdened by its impact on their safety, relationships, families, finances, and mental and physical health.[1]

In the 2003-2004 California Women's Health Survey (CWHS), 7,735 women responded to questions about IPV in the past year. Intimate partner physical violence (physical IPV) was defined as a "yes" response to any question about whether an intimate partner threw something at the respondent, pushed, kicked, beat, or used a knife/gun on her. Psychological-only IPV was defined as a "yes" response to any question about whether the respondent was frightened, controlled, or followed by an intimate partner, excluding respondents who also reported physical IPV. The few cases reporting forced sex but no physical IPV were dropped from analysis.[2]

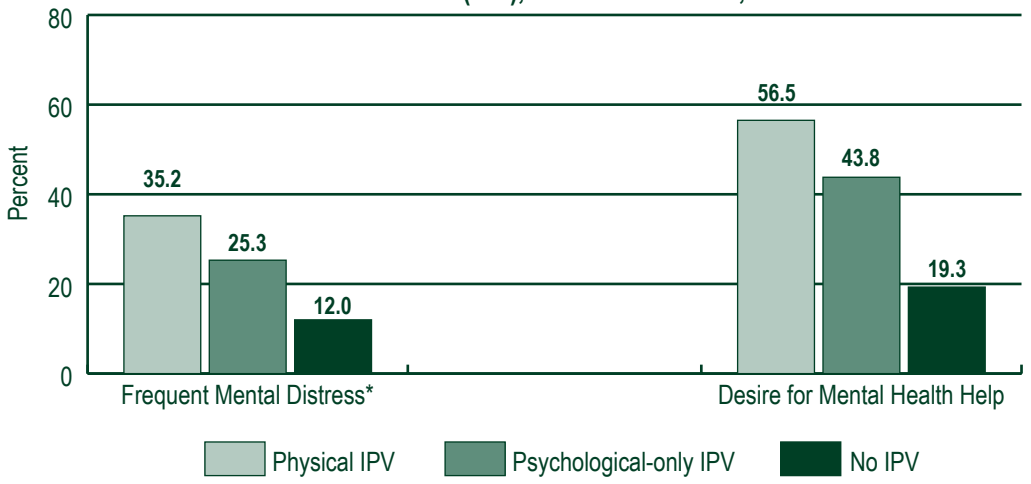
The survey also asked respondents about the number of days in the past month that their mental health was not good, desire for professional help for mental health issues in the past year, and, for those who wanted mental health help, whether they got it. For comparisons between mental health measures and the various categories of IPV, responses of women who did not answer all eight DV questions were dropped.[3]

Of the women who responded to the physical IPV questions, approximately 4.3 percent reported physical IPV in the past year, and an additional 4.5 percent reported psychological-only IPV. About 13.6 percent of all respondents reported frequent mental distress (FMD), and 21.6 percent reported wanting help for mental health issues in the past year.[4, 5]

Both FMD and the desire for mental health help varied significantly among the IPV categories (see graph).[6] More than one-third of women with physical IPV had FMD, and more than half wanted mental health help. Of the women who had both physical IPV and FMD, almost three-quarters (71.5 percent) wanted mental health help, but less than half of this group (46.5 percent) said they got help.

Public Health Message: *About one-third of California women experiencing physical intimate partner violence (physical IPV) had frequent mental distress (FMD). Most women who experienced both IPV and FMD wanted mental health help but less than half of those received it. The IPV population would benefit from provider awareness and attention to their mental health issues.*

Proportion of Frequent Mental Distress* and Desire for Mental Health Help by Type of Intimate Partner Violence (IPV), California Women, 2003-2004



Source: California Women's Health Survey
* 14 or more days with not good mental health in the past month

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1 National Center for Injury Prevention and Control. Costs of intimate partner violence against women in the United States. Atlanta: Centers for Disease Control and Prevention, 2003.
2 n=25 (0.3 percent).
3 n=38 (0.4 percent).
4 Defined as 14 days or more of poor mental health in the past month.
5 Centers for Disease Control. Self-reported frequent mental distress among adults – United States, 1993-1996. MMWR. 1998,47(16):325-331.
6 $p<0.001$.

Submitted by: Moreen Libet, California Department of Health Services, Maternal Child and Adolescent Health/Office of Family Planning Branch, (916) 650-0333, mlibet@dhs.ca.gov; Zipora Weinbaum, California Department of Health Services, Office of Women's Health, (916) 440-7633, zweinbau@dhs.ca.gov.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

Intimate Partner Violence Against Women with Disabilities in California, 2003–2004

California Department of Health Services
Epidemiology and Prevention for Injury Control Branch, Office on Disability and Health

Women with disabilities in California are more likely than women without disabilities to experience intimate partner violence. This finding is derived from self-reported data from the California Women's Health Survey (CWHS), in an analysis performed by the Office on Disability and Health of the California Department of Health Services.

In 2003 and 2004, approximately 8,000 California women, 18 years of age or older, responded fully to a series of questions on their prior-year experiences of intimate partner violence.[1] About one-fifth of survey respondents were identified as having disabilities, having answered affirmatively to a single question asking whether they were limited "in any way in any activities because of a physical, mental, or emotional problem."

Intimate partner violence refers to physical or emotional abuse perpetrated by a spouse or other partner, and includes not only actual physical violence but also threatened violence, sexual abuse, and attempts to exert control over the victim's activities. Questions on physical violence asked whether the partner had thrown something at the respondent; pushed, grabbed, shoved, or slapped her; kicked, bit, or hit her with a fist; beat her up or choked her; or used a knife or fired a gun at her. A question on threatened violence asked whether the respondent had feared for her safety, or that of her family or friends, because of anger or threats. A question on sexual abuse asked whether the partner had forced the respondent to have sex against her will. And questions on physical or emotional control asked about the partner following the respondent, spying on her, or trying to control most of her daily activities.

Comparison of reported levels of intimate partner violence between women with and without disabilities yields the following results:[2]

- 5.2 percent of women with disabilities reported physical violence in the prior year, compared with 3.8 percent of non-disabled women.
- 5.9 percent of women with disabilities reported threatened violence, nearly twice the proportion (3.1 percent) of women without disabilities.
- Among women under 65, those with disabilities were more than twice as likely to have experienced sexual abuse over a 12-month period as their non-disabled counterparts (1.8 percent versus 0.7 percent).[3]
- 7.4 percent of women with disabilities reported that their partners exerted emotional or physical control over them during the prior year, much higher than among women without disabilities (5.0 percent).
- Overall, 11.9 percent of California women with disabilities experienced one or more forms of intimate partner violence in the year prior to the interview, compared with 7.8 percent of women without disabilities.

The observed association between disability and intimate partner violence may imply that having a disability puts women at substantially greater risk of such violence. However, other explanations are also possible. For example, intimate partner violence could be the cause of some respondents' disabilities, or some other factor may put women at risk for both violence and disability. Further research is needed to establish a causal relationship between disability and intimate partner violence.

Public health message: *Women with disabilities experience a high level of intimate partner violence, more than 50 percent greater than that of women without disabilities. These findings highlight the importance of prevention efforts—both those focusing on intimate partner violence and those focusing on health and wellness for people with disabilities—and of improving access to intimate partner violence programs and services for women with disabilities.*

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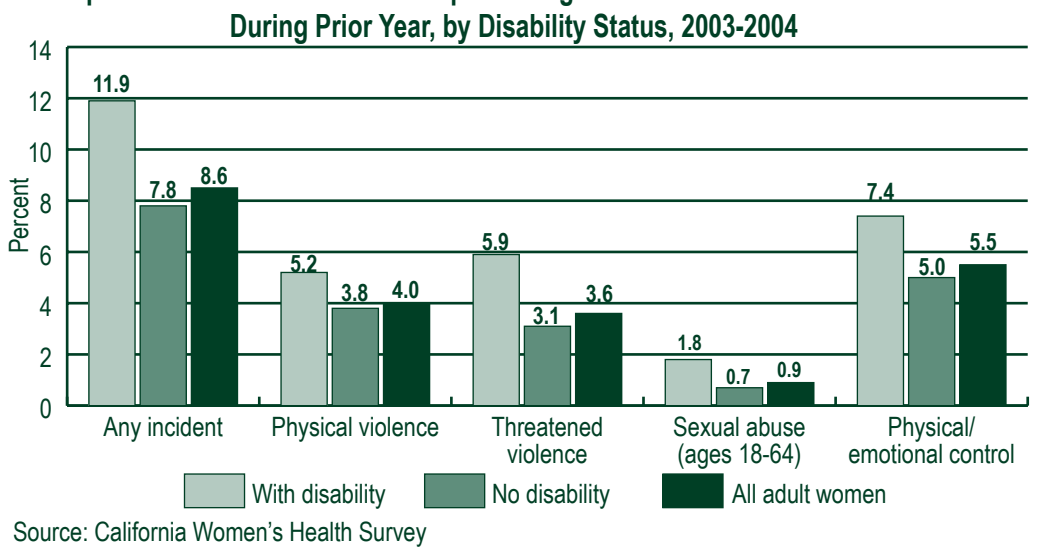
Intimate Partner Violence Against Women with Disabilities in California, 2003–2004

California Department of Health Services
Epidemiology and Prevention for Injury Control Branch, Office on Disability and Health



Source: California Women's Health Survey

1 Respondents answering some but not all of the questions on intimate partner violence have been excluded from the analysis, as were those who skipped the section entirely.
2 All statistically significant at the 95.0 percent confidence level or better. Violence categories are not mutually exclusive.
3 Only one survey respondent over 64 years of age reported an instance of sexual abuse.

Submitted by: H. Stephen Kaye, California Department of Health Services, Epidemiology and Prevention for Injury Control Branch, Office on Disability & Health and Institute for Health & Aging, University of California, San Francisco, (415) 502-7266, steve.kaye@ucsf.edu

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES • OFFICE OF WOMEN'S HEALTH

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

The California Women's Health Survey (CWHS) Methodology

Survey Research Group

The California Women's Health Survey (CWHS) is an annual telephone survey that collects information from a sample of approximately 4,000 randomly selected adult women aged 18 years or older on a wide variety of health indicators and health-related knowledge, behaviors, and attitudes. This survey began in March 1997 as a collaborative effort between the California Departments of Health Services, Mental Health, Alcohol and Drug Programs, and Social Services, and the Public Health Institute (PHI). PHI's Survey Research Group administered the survey while California Medical Review, Inc. (CMRI) provided technical assistance.

The CWHS asks respondents about a wide variety of behaviors related to past and present involvement in healthcare systems, food security status, participation in government nutrition programs, prenatal care, vitamin consumption, alcohol consumption, breastfeeding, sexually transmitted diseases, intimate partner violence, utilization of cancer screening procedures, and other preventative measures. The survey also collects basic demographic information, such as age, race/ethnicity, employment status, and education. Participation in the CWHS is completely voluntary and anonymous. Interviews are conducted by trained interviewers following standardized procedures developed by SRG staff and the Centers for Disease Control and Prevention (CDC). The survey collects data monthly from a random sample of California adult women living in households with telephones. Quality control procedures are rigorous to ensure a high level of accuracy in the data collected.

Using a computer-assisted telephone interviewing (CATI) system, interviewers read questions as they are displayed on a computer screen. Interviewers key responses directly into the computer. Once a household is reached, all women aged 18 years or older living within that household are eligible to participate in the survey. If more than one member of the household is eligible, one person is selected at random (using a computer-generated random selection algorithm) to become the respondent. If the person selected is not available, an appointment is made to conduct the interview at a different time or on another day. Once a respondent is selected, no other household member can be selected, even if it is not possible to obtain an interview from the selected respondent. To maximize the representativeness of the sample, standardized procedures are followed for calling back numbers that ring with no answer or give a busy signal, or for encouraging selected respondents who are reluctant to participate.

Through the sampling process, SRG attempts to collect interviews from a random sample that is representative of California's population. The age and race/ethnicity characteristics of the CWHS sample differ to some extent from the age and race/ethnicity characteristics of the female California population. In addition, the probability of selection within a household varies depending upon the number of telephone numbers and individuals living in the household. Therefore, to obtain meaningful population estimates, all analyses of the survey data are weighted to the age and race/ethnicity of the 2000 California population. No adjustment is made for the observed differences in education or income.

Data from these Data Points should be interpreted with caution. Due to the cross-sectional design of the CWHS, causality can not be established between the variables because

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The California Women's Health Survey (CWHS) Methodology

Survey Research Group

they are measured simultaneously. In addition, the survey is only completed in English and Spanish, which may exclude a portion of the population. Recall bias also may be a problem with this survey. Information recall may be particularly difficult on a telephone survey. Another area of concern is that over-reporting of healthy behaviors and under-reporting of unhealthy behaviors is well documented in behavioral survey research. This study is population-based; the results can only be generalized to non-institutionalized adult women in California living in households with telephones. However, over 95.0 percent of households in California are estimated to have telephones and the effects of non-coverage appear to be small. Each Data Point is meant to "stand alone," with data presented based on program needs and definitions. Therefore, the definitions used in one Data Point may differ from that in another.

More methodological information and a thorough examination of the representativeness of the CWHS sample are available from the most recent *California Women's Health Survey SAS Dataset Documentation and Technical Report*. For a copy of the most recent technical report, please contact the Survey Research Group: srg@surveyresearchgroup.com.

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