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

# Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## RISK FOR HUNGER AMONG WOMEN IN HOUSEHOLDS WITH YOUNG CHILDREN, CALIFORNIA, 1998

**Office of Women's Health**

**Maternal and Child Health Branch**

California has established a number of far-reaching programs to increase access for all Californians to a secure supply of healthy foods. However, to better serve those who remain at risk of hunger, the California Women's Health Survey (CWHS) examines the association between women who live in a household with young children and the risk for hunger among women of different age groups. In households with a limited supply of food, scarce food supplies may be provided to young children at the expense of adults in the household.[1] Thus, women living in households with young children may be more likely to be at risk for hunger than those living in households without young children. In addition, many children in California are raised by grandparents rather than parents. The effects of living with children may be different among women of different age groups. The 1997 CWHS determined that in general, women of childbearing age were more likely to be at risk for hunger than were older women.[2]

The 1998 CWHS was used to determine characteristics of women most likely to be at risk for hunger. Women who answered "yes" to the question**: "In the last 12 months, did you ever eat less than you felt you should have because there wasn't enough money to buy food?"** were considered to be at risk for hunger.

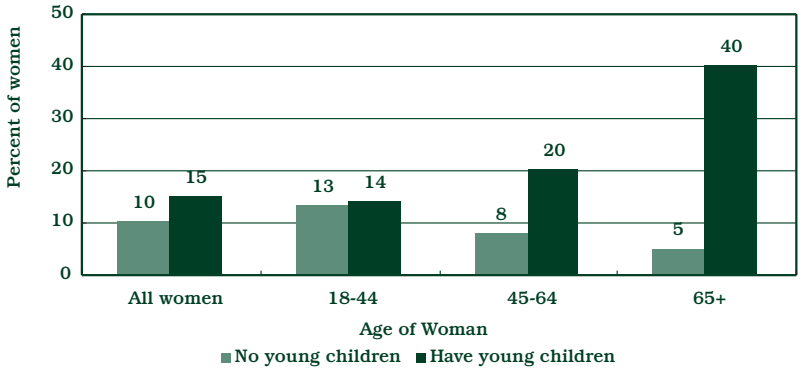
Demographic information collected included race, ethnicity, and the ages and number of children living in the household. Women living with at least one child under age six were classified as living in a household with young children.

- Among all California women, 11% reported having insufficient food at some time in the previous year.
- Women living in households with young children are more likely than those in households without young children to be at risk for hunger. Among women living with young children, 15% were at risk for hunger compared to 10% of those in households without young children.
- Of all women in California at risk for hunger, 33% live in households with children under the age of six.
- Among women living in households without young children, younger women are more likely than older women to be at risk for hunger. In contrast, among women living with young children, older women are more likely than younger women to be at risk for hunger.

[1] Rose D, "Economic determinants and dietary consequences of food insecurity in the United States." (1999) J Nutr 129 (2S Suppl): 517S-520S

[2] Data Points, Issue 1 (13). (1998) "Risk for Hunger Among Women, by Age; California, 1997.

**Risk for Hunger Among Women in Households With and Without Young Children by Age of Woman California, 1998**

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# Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## *RISK FOR HUNGER AMONG CALIFORNIA WOMEN, BY EDUCATIONAL ATTAINMENT, 1998*

**Office of Women's Health**

**Maternal and Child Health Branch**

California has established a number of programs to increase access for all Californians to a secure supply of healthy foods. These include the Women, Infants and Children (WIC) Supplemental Nutrition Program, as well as programs to support development of Farmers' Markets and to encourage small local food stores to carry fruits, vegetables and other healthy foods. However, the 1997 California Women's Health Survey determined that one in nine California women still do not have a secure food supply.[1,2] To better serve these women, it is important to understand the characteristics of women likely to be at risk for hunger.

The 1998 California Women's Health Survey (CWHS) was used to determine characteristics of women most likely to be at risk. Women who answered "yes" to the question: **"In the last 12 months, did you ever eat less than you felt you should have because there wasn't enough money to buy food?"** were considered to be at risk for hunger. Demographic information collected included race, ethnicity, and level of educational attainment.

Among all California women, 11% reported having insufficient food at some time in the previous year.

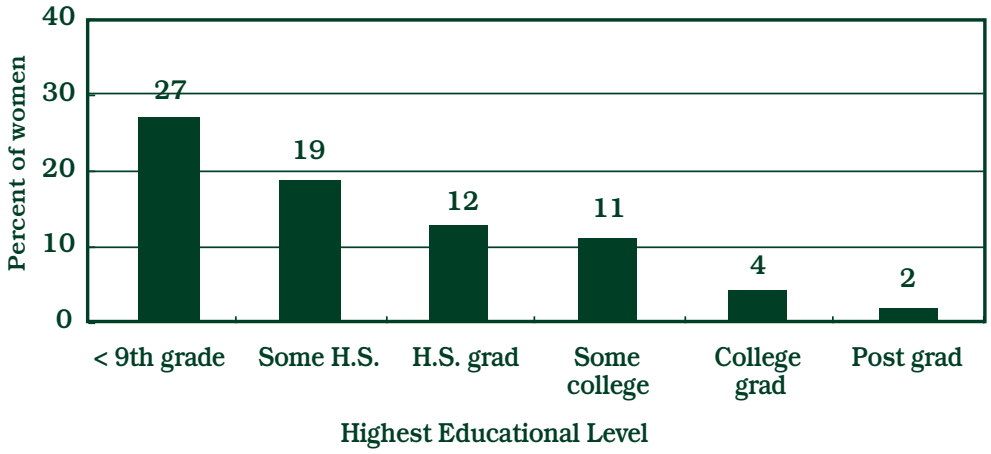
A woman's risk for hunger decreases as her educational level increases:

- Among women with a 9th grade education or less, 27% are at risk for hunger.
- Among women who graduate from college, only 4% are at risk for hunger.

[1] Data Points, Issue 1 (13). (1998) "Risk for Hunger Among Women, by Age; California, 1997".

[2] Data Points, Issue 1 (14). (1998) "Risk for Hunger Among Women, by Race/Ethnicity; California, 1997".

**Educational Attainment and Women's Risk of Hunger**
**California, 1998**

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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

## *RISK FOR HUNGER AND GENERAL HEALTH STATUS AMONG CALIFORNIA WOMEN, 1998*

**Office of Women's Health**

**Maternal and Child Health Branch**

California has established a number of far-reaching programs to increase access to a secure supply of healthy foods. However, the 1997 California Women's Health Survey determined that one in nine California women remains at risk for hunger.[1] To better serve these women, it is important to understand the association between a woman's self-evaluation of her health status and her risk for hunger.

The 1998 California Women's Health Survey (CWHS) was used to explore health status among women who are at risk for hunger. The 1998 CWHS asked women: **"In the last 12 months, did you ever eat less than you felt you should have because there wasn't enough money to buy food?"** Women who answered "yes" to this question were considered to be at risk for hunger. To assess women's perception of their own general health, women were also asked: **"Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"** Demographic information collected included age and race/ethnicity.

- In 1998, 11% of California women had insufficient food at some time during the last year.
- As women's self-assessed health status becomes worse, the likelihood increases that they are at risk for hunger.

[1] Data Points, Issue 1 (14). (1998) "Risk for Hunger Among Women, by Age; California, 1997".

### Risk for Hunger Among California Women by Self-Assessed General Health Status, 1998


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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## RISK FOR HUNGER AMONG U.S. BORN AND IMMIGRANT HISPANIC WOMEN, CALIFORNIA, 1998

**Office of Women's Health**

**Maternal and Child Health Branch**

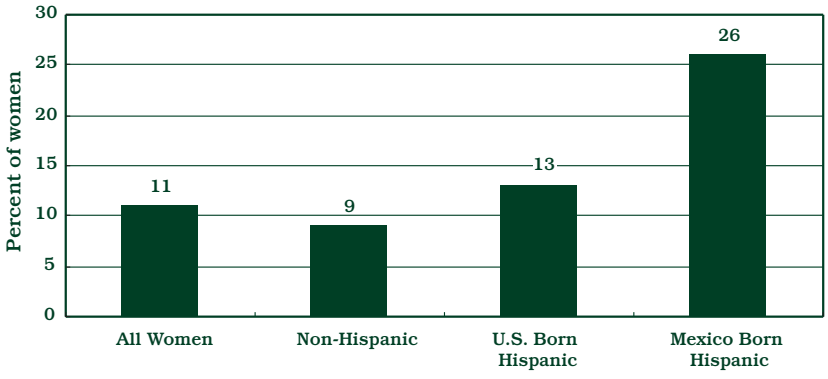
California has established several programs to increase access of all Californians to a secure supply of healthy food. These include the Women, Infants and Children (WIC) Supplemental Nutrition Program, as well as programs to support development of Farmers' Markets and to encourage small local food stores to carry fruits, vegetables, and other healthful foods. Interventions such as these work best when they reach women most likely to be at risk for hunger. However, limited information is available about these women in California. The 1997 California Women's Health Survey[1] found that Hispanic women are highly likely to be at risk for hunger. Data from the 1998 California Women's Health Survey (CWHS) were used to determine characteristics of California Latinas most likely to be at risk for hunger.

The 1998 CWHS assessed women's risk for hunger by asking: **"In the last 12 months, did you ever eat less than you felt you should have because there wasn't enough money to buy food?"** Women who answered "yes" were considered to be at risk for hunger. Demographic information collected included race, ethnicity, and country of birth.

- Among Hispanic women, 20% were at risk for hunger.
- Among Hispanic women interviewed in the CWHS, 47% were born in Mexico and 41% in the United States. Among Hispanic women, 47% were interviewed in Spanish.
- Of all California women at risk for hunger in 1998, 38% were Hispanic, 22% were born in Mexico, and 24% were interviewed in Spanish.
- Spanish speaking Hispanic women are more likely than English speaking Hispanic women to be at risk for hunger. Among Hispanic women interviewed in Spanish, 27% reported going without sufficient food compared to 14% of those interviewed in English.
- Hispanic women born in Mexico are more likely to be at risk for hunger than Hispanic women born in the U.S. Among U.S.-born Hispanic women, 13% were at risk for hunger compared to 26% of Hispanic women born in Mexico.

[1] Data Points, Issue 1 (14). (1998) "Risk for Hunger Among Women, by Race/Ethnicity; California, 1997".

**Percent of California Women at Risk for Hunger by Ethnicity and Birthplace, 1998**

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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

## ACTIVITY LIMITATION AMONG CALIFORNIA WOMEN, 1998

**CMRI (California Medical Review, Inc.)**

Limitation in the ability to perform usual activities can occur due to disease, physical impairment or mental illness. Temporary activity limitation is usually due to conditions of limited duration, to short-lived situations that limit available time for activity, or to the occurrence of a major life event such as birth of a child or death in the family. As women grow older, activity limitation occurs more often or becomes permanent and is more often due to health conditions. Although most adapt well to these changes, limitation in the ability to perform basic activities such as bathing, dressing, or eating can threaten a woman's ability to live independently.

The 1998 California Women's Health Survey asked women about six types of activity limitation: **"During the last four weeks, has your health limited: vigorous activities (e.g., lifting heavy objects, strenuous sports); moderate activities (e.g., moving a table, carrying groceries); the ability to walk up a hill or climb several flights of stairs; bending, lifting, or stooping; walking one block; eating, dressing, bathing, or using the toilet?"** Limitation in any of the first three activities were categorized as minor limitation. Limitation in the latter three activities, which are essential to independent living, were categorized as a major limitation. Women were also asked the most important reason for their activity limitation.

Overall, 32% of the women in the survey reported one or more limited activities. Activity limitation was more common among women of older ages. The main reasons for activity limitations were back or neck problems (22%), pregnancy (8%), arthritis (6%), broken bones (5%), and the flu (5%).

For each of the six activities, older women (ages 65+) reported the most limitation, followed by middle-aged women (ages 45-64) and younger women (ages 18-44). Virtually all younger women with recent limitation in the ability to walk one block or to eat, bathe, or dress reported pregnancy or back/neck problems as the reason.

Percentage of Women Who have Limitations by Age and by Type of Limitation, California, 1998

| | Older (65+) | Middle Age (45-64) | Younger (18-44) |
|---|---|---|---|
| Vigorous activities | 41% | 31% | 23% |
| Moderate activities | 56% | 57% | 45% |
| Walk up hill or stairs | 46% | 46% | 30% |
| Bend, lift or stoop | 25% | 17% | 13% |
| Walk one block | 13% | 9% | 4% |
| Eat, dress, bathe | 6% | 5% | 4% |

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## *ACTIVITY LIMITATION AND PHYSICAL HEALTH AMONG WOMEN AGES 55 AND OLDER, CALIFORNIA, 1998*

**CMRI (California Medical Review, Inc.)**

Limitation in the ability to perform usual activities can occur due to disease, physical impairment or mental illness. Activity limitation is often temporary and is due to conditions of limited duration, such as surgery or a broken limb. As women grow older, activity limitation occurs more often or becomes permanent and is frequently due to health conditions such as arthritis, stroke, chronic pain, and urinary incontinence. Limitation in the ability to perform basic activities such as bathing, dressing, or walking a short distance threaten a woman's ability to live independently. Most women have adapted well to living with limitations. However, when unable to perform these activities, it may be necessary for a woman to move to an assisted living facility, hire help within the home, or rely on family and friends for assistance. Limitation in activity can be exacerbated by smoking, excessive alcohol consumption, and being overweight.

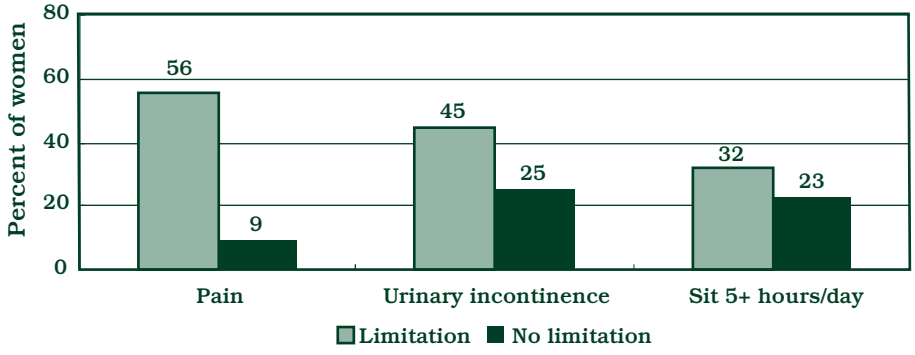
The 1998 California Women's Health Survey asked women about six types of activity limitation: **"During the last four weeks, has your health limited: vigorous activities (e.g., lift heavy objects, strenuous sports); moderate activities (e.g., move table, carry groceries); the ability to walk up a hill or climb several flights of stairs; bending, lifting, or stooping; walking one block; eating, dressing, bathing, or using the toilet?"** Other questions asked the most important reason for their activity limitation and about smoking, alcohol use, weight, number of days activity was limited due to physical health, frequent pain, and urinary incontinence.

Overall, 43% of women ages 55 and older reported one or more limited activities. The oldest women (ages 75+) were most likely to report limitation (53%), followed by women ages 65-74 (41%) and women ages 55-64 (38%). The main reasons for activity limitation were back or neck problems (19%), arthritis (13%), "getting old" (11%), lung/breathing problems (7%) and cardiovascular problems (6%).

Among those ages 55 and older, women who reported limitation were more likely than women without limitation to smoke (17% vs. 13%), be overweight (40% vs. 29%), report their health status as fair or poor (44% vs. 10%), and indicate that due to physical health activity was limited daily (22% vs. 1%).

Among women ages 55 and older, those who reported limitation in usual activities were more likely to report pain, urinary incontinence, and sitting for five or more hours a day than those without limitation.

**Pain, Urinary Incontinence and Sitting 5+ Hours per Day Among Women Ages 55 and Older by Activity Limitation, California, 1998**

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

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# Data Points

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## *ACTIVITY LIMITATION AND MENTAL HEALTH AMONG WOMEN AGES 55 AND OLDER, CALIFORNIA, 1998*

**CMRI (California Medical Review, Inc.)**

Limitation in the ability to perform usual activities, which may be temporary or permanent, can occur due to disease, physical impairment or mental illness. As women grow older, activity limitation occurs more often. While the majority of older women adapt well to having limitations, there are some older women who are depressed or have impaired mental health and may not be able to fully participate in usual activities. In addition, women who are limited in their activities due to physical health may become depressed or anxious, which can result in even further limitation. Limitation in the ability to perform basic activities may necessitate a change in living arrangements, such as moving to an assisted living facility or hiring help within the home.

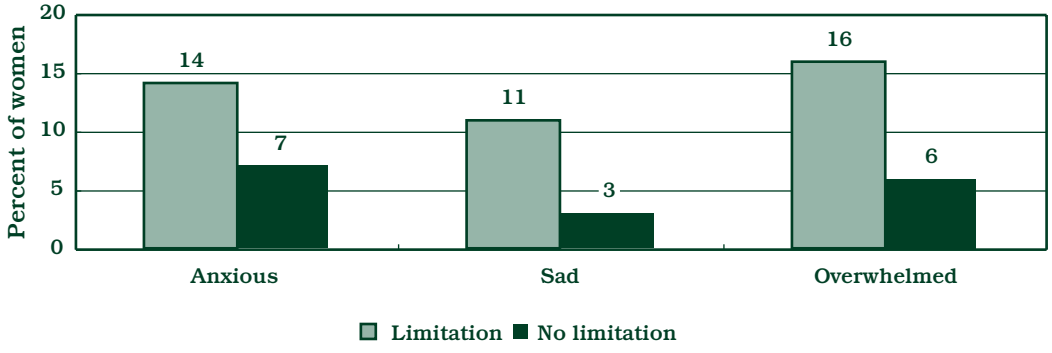
The 1998 California Women's Health Survey asked women about six types of activity limitation: **"During the last four weeks, has your health limited: vigorous activities (e.g., lifting heavy objects, strenuous sports); moderate activities (e.g., moving a table, carrying groceries); the ability to walk up a hill or climb several flights of stairs; bending, lifting, or stooping; walking one block; eating, dressing, bathing, or using the toilet?"** Other questions asked about feeling overwhelmed by problems that were piled up so high they could not be overcome, number of days of limited activity due to mental health, number of days in past month felt anxious or sad, and how often mood limited ability to work and do usual activities. This report focuses on women in the survey who are age 55 and older.

Overall, 43% of older women ages 55 and older reported one or more limited activities. Women aged 75+ were most likely to report limitation (53%), followed by women aged 65-74 (41%) and women ages 55-64 (38%).

Among women 55 and older, those who reported limitation were more likely than those without limitation to feel overwhelmed (16% vs. 6%), have more activity-limited days due to mental health (37% vs. 19%), indicate mood limited activity (10% vs. 4%), and wanted mental health help in the past year (16% vs. 8%)

Older women (ages 55+) who were limited in activities were more likely to report feeling anxious or sad daily or feeling overwhelmed over the past month than older women who were not activity limited.

**Percent of Women Ages 55 and Older Feeling Anxious or Sad Daily or Overwhelmed in the Past Month by Activity Limitation, California, 1998**

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# Data Points

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## PAIN AND ACTIVITY AMONG CALIFORNIA WOMEN, 1998

**CMRI (California Medical Review, Inc.)**

Pain may be acute or chronic. Acute pain, which is severe and lasts a short time, is generally caused by injury or a temporary condition such as a broken bone, childbirth, or migraine headache. Chronic or persistent pain, which recurs or persists over time and interferes with functioning, is frequently due to chronic health problems such as arthritis, back problems, fibromyalgia, or shingles. However, pain often has no tangible diagnosis or identifiable cause. Pain can make a woman feel confused or afraid, so much so that she curtails normal daily activities or spends her time sitting or in bed. It is estimated that about 15% of the adult population is partially or completely disabled due to pain. There are strategies that can help control pain, including medication, stretching and exercise, weight control, using correct posture, acupuncture, and decreasing anxiety. It is also important to understand the characteristics of women who live with pain to improve their quality of life.

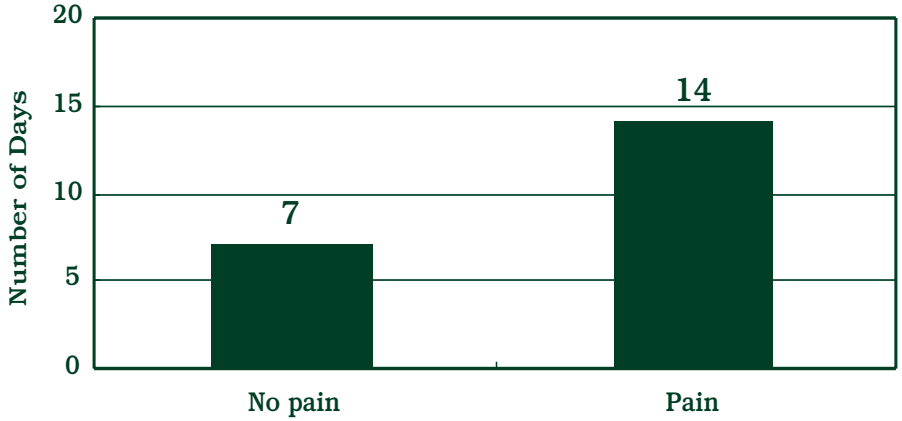
The 1998 California Women's Health Survey asked women: **"During the last 12 months, has pain often kept you from doing things you wanted to do?"** Other questions asked about smoking, alcohol use, weight, number of days of limited activity due to physical health and to overall poor health, self-rating of health, and limitation in six usual activities.

Overall, 22% of the women reported that pain often limited their activities. Limited activity was more common among older women: 30% of women ages 55 and older reported pain, 24% of women ages 35-54 and 16% ages 18-34. About 25% of Black, White, and Hispanic women reported pain, while 17% of Asian women reported pain.

Women who reported pain were more likely than women without pain to smoke (28% vs. 21%), be overweight (31% vs. 19%), indicate poor/fair health status (34% vs. 9%) and report activity limitation (75% vs. 20%).

Major activity limitation - difficulty in ability to bend or lift; walk one block; or eat, bathe or dress oneself - was reported by 56% of women who reported pain and only 9% of those who did not report pain. Less severe activity limitation - ability to do vigorous or moderate activity or climb several flights of stairs - was reported by 66% who reported pain and 17% of those who did not report pain.

Average Number of Days per Year Women Limited Their Activity Due to Physical Health by Pain Status, California, 1998

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## PAIN AND SOCIAL SUPPORT AMONG CALIFORNIA WOMEN, 1998

**CMRI (California Medical Review, Inc.)**

Pain is a common problem that can interfere with daily life and impact relationships. Whether pain is acute (severe and lasts a short time) or chronic (recurs or persists over time and interferes with functioning), it can seem to take over large parts of a woman's life. Pain can create feelings of confusion, anger, guilt, and uncertainty. Feelings and suffering from the pain can affect both the woman in pain and others in her support system, including family, friends, and co-workers. A woman living with pain may find her social interaction and support diminish over time as much of her daily activities and personal relationships are controlled by her pain. There are a number of things that can assist in pain control and in managing pain, including medication, exercise, weight control, stretching, using correct posture, and decreasing anxiety. There are also support groups available for both pain sufferers and their family and friends.

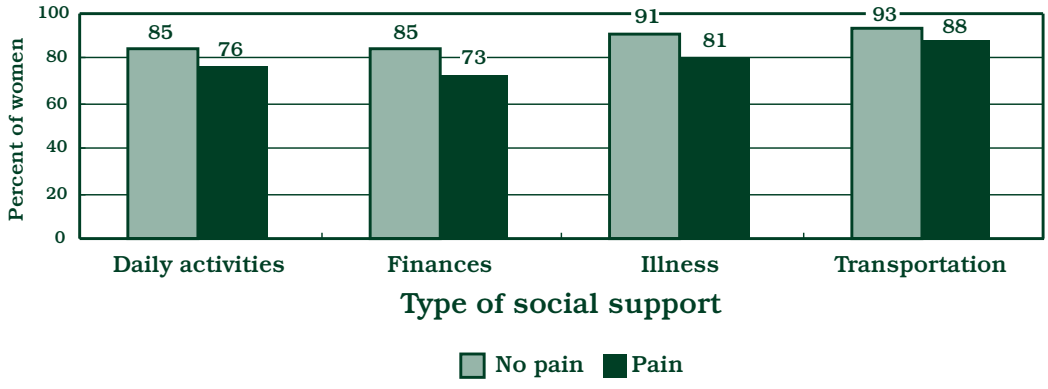
The 1998 California Women's Health Survey asked women: **"During the last 12 months, has pain often kept you from doing things you wanted to do?"** Other questions asked about feeling overwhelmed by problems that were piled up so high they could not be overcome, number of days in the past month they felt anxious, caregiving, and perception of social support (did a woman have someone she could count on if she needed help with every-day activities, was in financial difficulty, was sick or injured and needed to stay in bed for a few days, or needed a ride to an appointment).

Of women who reported pain, 22% reported that pain limited their activities. Pain was more common among older women: 30% of women ages 55 and older, 24% of women ages 35-54, and 16% ages 18-34 reported pain. About 25% of Black, White, and Hispanic women reported pain, while 17% of Asian women reported pain.

Compared to women who did not report pain, women in pain were more likely to feel overwhelmed (25% vs. 9%), have more anxiety (14 days vs. 9 days in the past month), and more often be caregivers (31% vs. 23%).

Over 80% of women who reported no pain had support with daily activities, finances, illness and transportation, and over 70% of women who reported pain had support in these same areas.

**Types of Social Support Available To Women With and Without Pain, California, 1998**

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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

## *CAREGIVING AMONG CALIFORNIA WOMEN, 1997*[1]

**CMRI (California Medical Review, Inc.)**

Caregiving for chronically ill or incapacitated individuals in our society is often provided by informal sources rather than organizations or institutions. The overwhelming majority of such care is provided by women, usually a family member. It is becoming more common for women to care for an ill spouse or elderly parent while raising children. This provides different challenges for women at different ages. Younger women (ages 18-44) may be raising young children, working, and providing care for aging parents. Women in middle age (ages 45-64) may find themselves in a particular bind, raising young or teenage children, pursuing careers, and caring for an aging parent or ill spouse, sometimes both. Older women (ages 65 and older), with their own health challenges, may provide care for an impaired spouse. A growing number of older women are also caring for elderly parents or grandchildren. Providing care for someone, while potentially gratifying, can strain a woman's own health and well-being.

The 1997[1] California Women's Health Survey asked women: **"During the past 12 months, not counting work duties or normal child care, have you provided frequent care to someone?"** Other questions identified the person who was given care, the reason, and length of time care was given.

Overall, 25% of the women in the survey reported being caregivers. Middle-aged women were most likely to be caregivers (32%), followed by older women (28%) and younger women (21%).

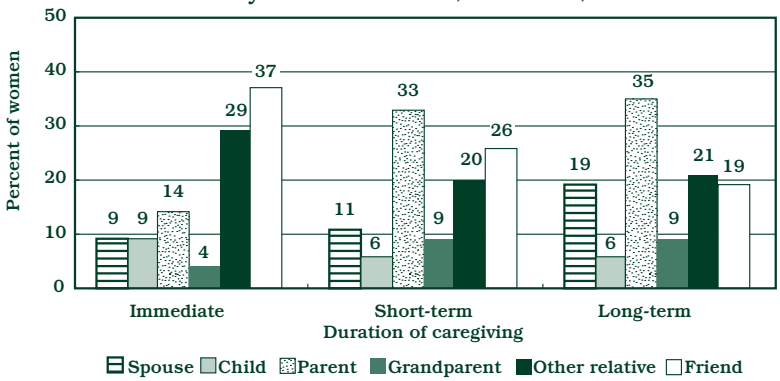
Reasons for providing care were similar for of all ages; 33% of care was for recovery from surgery or major illness, 36% of care was to handle a physical illness or disability, 6% was to handle a mental problem, 32% of both middle-aged and older women provided care for 'other reasons'.

Among caregivers, older women were more likely to provide care for a spouse (29%) than for other relatives or friends; younger women were more likely to provide care for a friend or relative other than a spouse, parent, or child (71%); and middle-aged women were more likely to provide care for a parent (41%) or for friends or family other than a parent, spouse or child (40%).

Caregiving can be immediate (less than two weeks), short term (less than a year) or long term (one or more years). Among caregivers: 23% reported providing immediate care; 33% reported providing care of short duration, for an average of 2.5 months; 44% reported providing care for a period of years (the median number of years was 4.6 among young women, 6.9 among middle-aged women, and 9.0 among older women).

[1] Information on caregiving from the 1997 California Women's Health survey is presented here. These questions were not analyzed for inclusion in Issue #1 of Data Points and were not repeated in the 1998 survey.

**Percent of Women Providing Care by Relationship and by Duration of Care, California, 1997**

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# Data Points

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## *CAREGIVING AND HEALTH AMONG CALIFORNIA WOMEN, 1997*[1]

**CMRI (California Medical Review, Inc.)**

Providing care for someone who is chronically ill or incapacitated can be very stressful. In our society, caregiving is often provided by a family member, and the overwhelming majority of caregivers are women. Whether young (ages 18-44), middle-aged (ages 45-64), or older (ages 65+), women may find themselves providing care for aging parents or an impaired spouse (or both) while raising their own children or grandchildren, holding a job, and managing a household. This leaves little room for a woman to maintain her own health; indeed, the strain that accompanies caregiving can result in poorer mental and physical fitness for a woman, threatening her health and well-being.

The 1997[1] California Women's Health Survey asked women: **"During the past 12 months, not counting work duties or normal child care, have you provided frequent care to someone?"** Other questions asked about smoking, alcohol use, weight, employment, trouble sleeping, wanting to seek help from a mental health professional, and availability of help with everyday tasks, finances, personal illness, or transportation.

Overall, 25% of the women in the survey reported being caregivers. Middle-aged women were most likely to be caregivers (32%), followed by older women (28%) and younger women (21%). A majority of young and middle-aged caregivers were employed (59% and 63%, respectively) as were 14% of older caregivers.

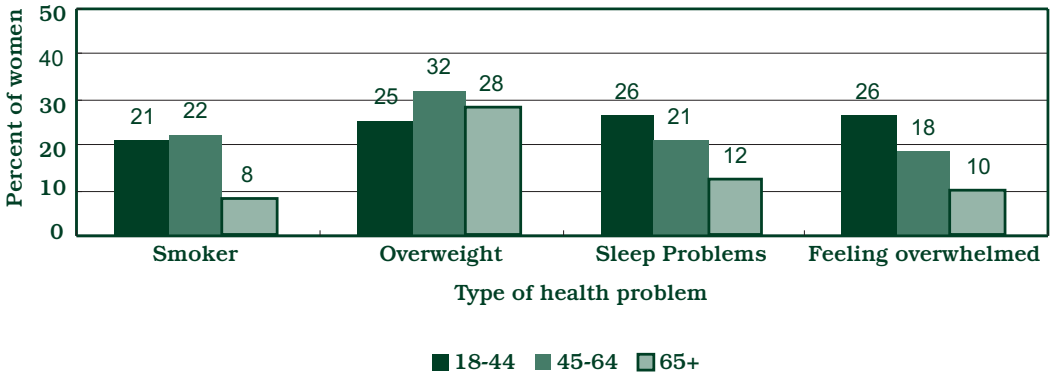
Compared with non-caregivers, caregivers of all ages smoked more (19% vs. 15%) and were more likely to be overweight, especially among older women (28% vs. 23%). Fewer caregivers (43%) had young children at home than non-caregivers (49%).

More caregivers than non-caregivers of all ages reported trouble sleeping (44% vs. 38%), feeling overwhelmed (20% vs. 15%), and wanting to seek help for personal or family problems (24% vs. 20%).

On the positive side, more caregivers than non-caregivers of all ages reported the availability of support with everyday tasks (88% vs. 83%), finances (85% vs. 82%), personal illness (93% vs. 90%), and transportation (96% vs. 93%). Similar levels of support were available for women in each age group.

[1] Information on caregiving from the 1997 California Women's Health survey is presented here. These questions were not analyzed for inclusion in Issue #1 of Data Points and were not repeated in the 1998 survey.

**Health Problems Among Female Caregivers by Age, California, 1997**

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## AGE DISPARITIES IN HEALTH INSURANCE STATUS AMONG CALIFORNIA WOMEN, 1998

**Maternal and Child Health Branch**

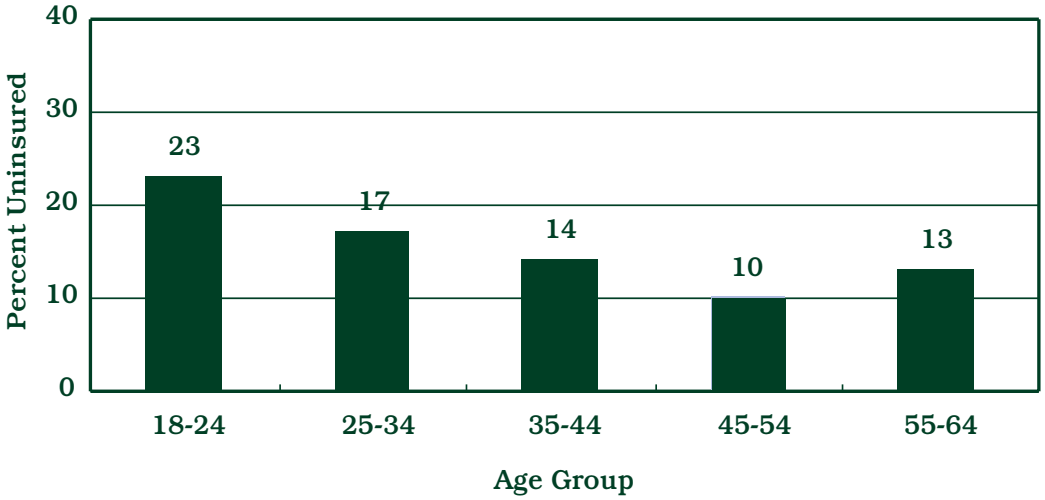
During the last decade, the proportion of women without health insurance coverage has increased annually.[1] Without health insurance, a woman may delay seeking health care when it is needed or may not receive preventive medical services in a timely manner. Several successful initiatives have been implemented to increase access to health insurance and to increase the types of coverage available (e.g., expanding Medi-Cal eligibility by raising the percent poverty test to cover the working poor), yet many Californians remain uninsured or underinsured.

The 1998 California Women's Health Survey asked women aged 18 years and older a series of questions to ascertain health insurance coverage at the time of the interview. Each respondent was asked if she had health insurance coverage through her or her spouse's employment. Further, each woman was asked about the type of coverage: an individual plan, a group plan, Medicare, or other type of government-sponsored coverage.

- Women between the ages of 18 and 24 were most likely to report not having any health insurance coverage.
- Only one percent (1%) of women over 65 years of age reported not having any health insurance coverage.

[1] Health Insurance Coverage: 1998, P60-208, U.S. Census Bureau; Health Insurance Coverage: 1997, P60-202, U.S. Census Bureau; Health Insurance Coverage: 1996, P60-199, U.S. Census Bureau; Health Insurance Coverage: 1995, P60-195, U.S. Census Bureau; Health Insurance Coverage: 1994, P60-190, U.S. Census Bureau

**Lack of Health Insurance Coverage Among Women Under Age 65, California, 1998**

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**STATE OF CALIFORNIA**
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**DEPARTMENT OF HEALTH SERVICES**
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# Data Points

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## RACIAL/ETHNIC DISPARITIES IN HEALTH INSURANCE STATUS AMONG CALIFORNIA WOMEN, 1998

**Maternal and Child Health Branch**

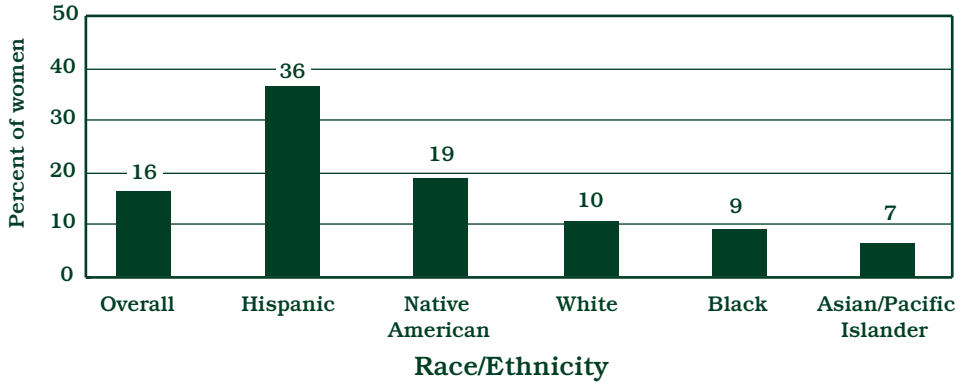
A significant barrier to receiving health care is a lack of health insurance. During the last decade, the proportion of women without health insurance has increased annually.[1] To address this problem, various federal and state programs have initiated reforms to increase access to health insurance and to increase the types of coverage available (e.g., expanding Medi-Cal eligibility by raising the percent poverty test to cover the working poor). However, many women remain uninsured or underinsured which contributes significantly to disparities in access to health care services.

The 1998 California Women's Health Survey asked women aged 18 years and older a series of questions to ascertain health insurance coverage at the time of the interview. Each respondent was asked if she had health insurance coverage through her or her spouse's employment. Further, each woman was asked about the type of coverage: an individual plan, a group plan, Medicare, or other type of government-sponsored coverage.

- Sixteen percent of women under age 65 reported not having health insurance.
- Hispanic women were most likely to report not having any health insurance coverage (36%).
- Among women who completed the interview in Spanish, nearly 50% reported being without health insurance.
- Among Native American women, 19% reported having no health insurance.
- Among White women, 10% reported having no health insurance.
- Among African American women, 9% reported having no health insurance.
- Asian/Pacific Islander women were least likely to report being uninsured (7%).

[1] Health Insurance Coverage: 1998, P60-208, U.S. Census Bureau; Health Insurance Coverage: 1997, P60-202, U.S. Census Bureau; Health Insurance Coverage: 1996, P60-199, U.S. Census Bureau; Health Insurance Coverage: 1995, P60-195, U.S. Census Bureau; Health Insurance Coverage: 1994, P60-190, U.S. Census Bureau

**Lack of Health Insurance Coverage Among Women Under Age 65 by Race/Ethnicity California, 1998**

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## ACCESS TO FAMILY PLANNING SERVICES AMONG CALIFORNIA WOMEN AT RISK OF UNINTENDED PREGNANCY, 1998

Office of Family Planning

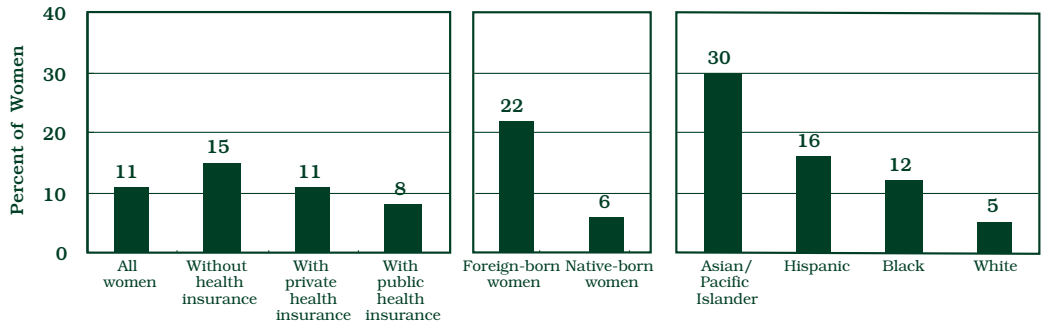
Nationwide, nearly half of unintended pregnancies occur to the 10% of women who report that they do not use birth control[1]. Unintended pregnancies are a serious public health problem in California. Since expanding access to family planning services may reduce the number of unintended pregnancies, California has made a commitment to provide these services, e.g., the Family Planning, Access, Care and Treatment (Family PACT) program for low-income women who have no other source of health care coverage.

The 1998 California Women's Health Survey (CWHS) assessed women's access to family planning services by asking the question: **"When did you last have a visit with a health care provider to talk about or receive birth control?"** We examined access among women ages 18-44 who were at risk of unintended pregnancy (women who had a sexual partner in the previous year who were not infertile nor sterilized, and were neither pregnant nor trying to get pregnant).

- One in ten women have never visited a health care provider to talk about family planning or to receive contraceptive services.
- Six out of ten women reported having visited a health care provider to talk about family planning or to receive contraceptives within the last year.
- Women aged 18-24 and never married women were more likely to report a visit in the past year with a health care provider to talk about or receive contraceptives than were other groups of women. Seventy-two percent of young women and 70% of never married women reported a recent visit compared with 62% of all women.
- Asian/Pacific Islander and foreign-born women were more likely to report that they have never visited a health care provider to discuss family planning services than were all women in general. Thirty percent of Asian/Pacific Islander women and 22% of foreign-born women reported they have never visited a family planning provider compared with 10% of all women.
- Women without public or private health care insurance coverage were more likely to report that they have never visited a health care provider to discuss family planning services than were women with public or private health insurance coverage. Fifteen percent of women without health insurance reported never having visited a family planning provider compared with 8% of women with public insurance and 11% of women with private insurance.

[1] Allan Guttmacher Institute, Facts in Brief: Contraception Counts. New York: AGI 1998.

**Percent of Women Who Have Never Visited a Health Care Provider to Discuss Family Planning or Receive Contraceptives Among Women at Risk of Unintended Pregnancy, California, 1998**

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## CONTRACEPTIVE UTILIZATION AMONG CALIFORNIA WOMEN, 1998

Office of Family Planning

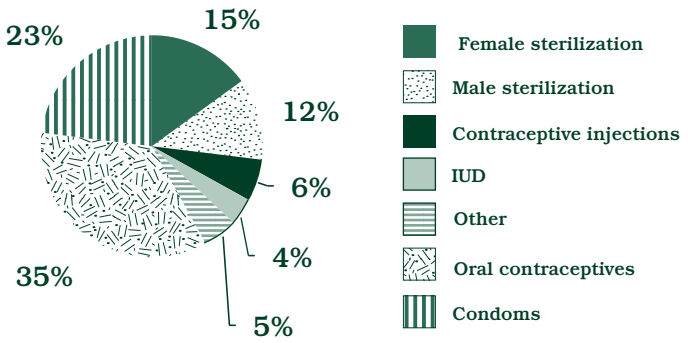
Sexually active women of reproductive age who wish to limit or postpone childbearing rely on contraception to prevent unintended pregnancy.[1] Public health programs designed to maintain and improve women's reproductive health need reliable data about contraceptive utilization to design and evaluate interventions.

The following two questions in the 1998 California Women's Health Survey (CWHS) provided information about contraceptive utilization: **"Are you or your male sexual partner using a birth control method to prevent pregnancy?" and "Which birth control method or methods are you using?"**

- About 55% of California women were reportedly at risk of unintended pregnancy—of these, 78% were using some method of contraception and 22% were not using any method to protect against an unintended pregnancy.
- Among women who use contraceptives, the most popular methods were oral contraceptives (35%) and condoms (23%)
- Oral contraceptives were the most commonly used method by women aged 18-24 (53%). Women aged 35-44 were the largest group most likely to report sterilization as their method of choice (28% rely on female sterilization and 24% rely on male sterilization).
- In general, contraceptive injections, intrauterine devices (IUDs) and contraceptive implants were not widely used. Contraceptive injections were more popular among women aged 18-24 (13%), Hispanic women (11%), and low-income women (11%) than were women as a whole (6%).

[1] Women are considered to be at risk of unintended pregnancy if they have had a partner in the past year who was not infertile, and were neither pregnant nor trying to become pregnant.

**Methods Used by Contracepting Women Ages 18-44, California, 1998**




**Note**: Other includes: natural family planning, 2.3%; diaphragm, 0.7%; contraceptive implant, 0.6%; foam/jelly, 0.5%; withdrawal, 0.48; cervical cap, 0.12%, other, 0.25%.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## BARRIERS TO OBTAINING CONTRACEPTIVE SERVICES AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY, CALIFORNIA, 1998

Office of Family Planning

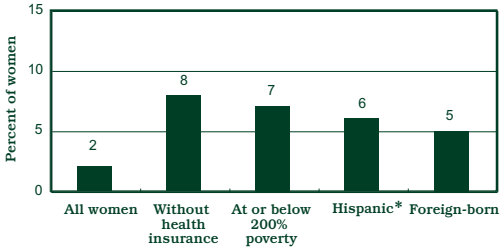
California has a long history of providing family planning services to low-income women and men, including the new Family Planning, Access, Care and Treatment (Family PACT) program which provides contraceptive methods, and screening for sexually transmitted diseases and breast and cervical cancer. Yet, there are still many women who do not utilize family planning services. Understanding the barriers women face is necessary to design programs to improve access to services.

To assess barriers that women at risk of unintended pregnancy[1] encounter in obtaining contraceptive services, the 1998 California Women's Health Survey (CWHS) asked women: **(1) "In the past year, have you gone without birth control supplies because you could not afford them?" (2) "In the past year, have you gone without birth control because you did not know where to get services or supplies?" (3) "In the past year, have you gone without birth control because you could not get an appointment or it was inconvenient to go to the appointment?"**

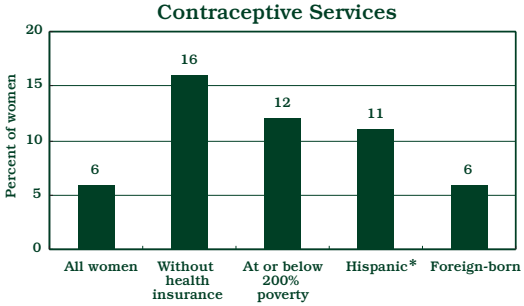
- Overall, more women at risk of unintended pregnancy reported having gone without contraceptives in the past year due to lack of money (6%) than due to difficulty in getting an appointment (5%) or due to a lack of information about where to get family planning services/supplies (2%).
- Four subgroups of women were more likely to report barriers to obtaining family planning services. These include those without health insurance, low-income women, foreign-born women; among racial/ethnic groups, Hispanic women were more likely to report barriers to obtaining services.
- Women without public or private health insurance coverage were more than twice as likely to report that they had difficulty obtaining contraceptive services/supplies in the past year due to lack of money (16%) than were women in the population as a whole (6%).

1 Women are considered to be at risk of unintended pregnancy if they have had a partner in the past year who was not infertile, and were neither pregnant nor trying to become pregnant.

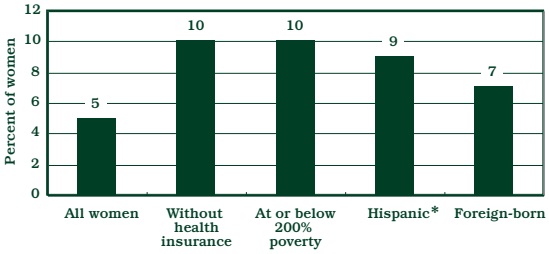
**Not Knowing Where to Get Services/Supplies as a Barrier to Obtaining Contraceptive Servies**




**Lack of Money as a Barrier to Obtaining Contraceptive Services**




**Difficulty in Getting Appointment as a Barrier to Obtaining Contraceptive Services**




* Among racial/ethnic groups, Hispanic women were more likely to report barriers to obtaining services.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## REQUEST FOR CHLAMYDIA TESTING FROM HEALTH PROVIDER AMONG CALIFORNIA WOMEN, 1998

**Sexually Transmitted Disease Control Branch**

*Chlamydia trachomatis*, a sexually transmitted infection is the most commonly reported communicable disease in California. Untreated infections in women are associated with an increased risk of adverse reproductive health outcomes such as pelvic inflammatory disease and infertility. Risk factors for chlamydia infection include: age less than 25 years, more than one sexual partner, and a new sexual partner. In 1998, the Centers for Disease Control Sexually Transmitted Disease Treatment Guidelines recommended that all sexually active adolescent girls should be tested for chlamydia annually. In addition, it was recommended that women aged 20-24 years old with multiple partners or new partners be tested. Because most women with chlamydia have no symptoms or noticeable signs of infection, testing is necessary to identify these infections for timely treatment. There is also a need to increase the number of women who are aware of the need for chlamydia testing.

To address this problem, the California Department of Health Services initiated the Chlamydia Awareness and Prevention Program to enhance local capacity for awareness of chlamydia. This program is designed to prevent individuals from ever becoming infected with chlamydia and to increase testing among those who may have been exposed.

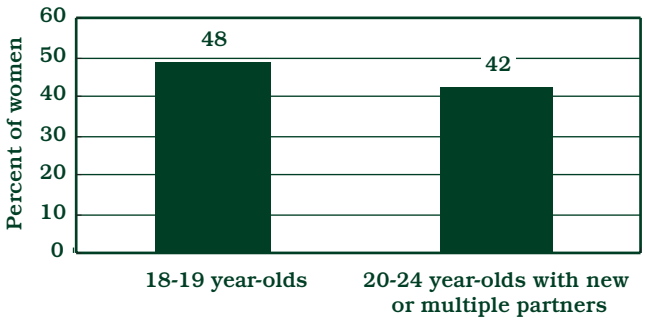
To obtain baseline data to inform these programs, in 1998 the California Women's Health Survey asked women aged 18-24 years old: **During the next year, how likely is it that you will ask your doctor to test you for chlamydia?** Women were also asked about insurance status, use of medical services, and sexual behavior.

- Approximately half (48%) of adolescent girls (18-19) and 42% of women 20-24 with more than one partner or a new partner in the last year reported that they were likely to request a chlamydia test in the next 12 months.

Factors associated with being unlikely to request a chlamydia test in the next 12 months among women 18 to 24 years old were:

- Fifty-five percent of women without health insurance indicated that they were unlikely to request testing as compared to 71% of women with health insurance.
- Women who reported having discussed their sexual behavior with a medical provider in the previous year were more likely to request future testing (38%) than women who had not had this discussion (25%).

**Percent of Women Likely to Request Chlamydia Testing in the Next 12 Months, California, 1998**

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

## ADULT FEMALE VICTIMS OF INTIMATE PARTNER PHYSICAL DOMESTIC VIOLENCE (IPP-DV) CALIFORNIA, 1998

**Maternal and Child Health Branch, Domestic Violence Section**

Domestic violence is the leading cause of injury to women aged 15-44 in the U.S. Annually, about 30% of murdered women are killed by their intimates. In California, 196,832 incidents of domestic violence were reported to law enforcement, and 56,892 domestic violence arrests were made in 1998[1]. Since 1994, a number of California laws have been passed to protect and assist women who are victims of intimate partner abuse. For example, the Battered Women's Shelter Program was established in 1994 as a result of legislative action, and funds direct shelter services for abused women and their children and community prevention activities. In 1996, the Domestic Violence Training and Education Program was implemented to provide related training and technical assistance to probation departments, health and social service providers, court system personnel and others statewide.

The 1998 California Women's Health Survey asked women aged 18 years and older a number of questions about their relationships with their intimate partners in the previous 12 months. A "Yes" response to any question asking whether the respondent was: **pushed, had objects thrown at her, was slapped, was hit with an object, was kicked or hit, was choked, was beaten up, or was threatened with a gun or a knife** by her intimate partner in the previous 12 months was considered an indicator of IPP-DV. Women who responded that their intimate partners victimized them were then asked whether they sought medical care and where they received it.

- About 6% of California adult women (approximately 697,000 women) reported that they were victims of IPP-DV in the previous 12 months. This figure is considerably higher than the national figure: The Commonwealth Fund's "1998 Survey of Women's Health" indicated that 3% of U.S. women reported experiencing intimate partner domestic abuse in the previous year.

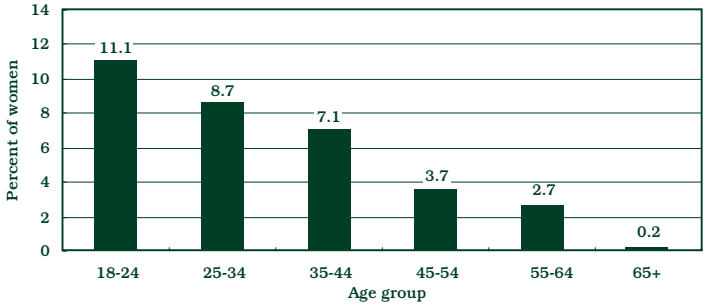
- Only 11% of IPP-DV victims said that they sought medical care for treatment of IPP-DV, in one or more instances in the previous 12 months. Of these instances, most got help at a doctor's office (94%), followed by emergency room visits (76%), mental health care (47%) and overnight hospital stays (18%).

- About 75% of IPP-DV victims have children under 18 at home compared to 46% of the women who are not victims of IPP-DV. Victims had a substantially higher proportion of children under age 6 in their households (47%) compared to women who were not victims of IPP-DV (23%).

- Survey results suggest a strong relationship between the age of the victim and IPP-DV: younger women were more likely to report being victims than older women.

[1] California Department of Justice, 1998 Criminal Justice Statistics

**Adult Female Victims of Intimate Partner Physical Domestic Violence (IPP-DV) by Age Group California, 1998**

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**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 policy-makers. Data are collected through a computer-assisted telephone survey of randomly selected California women. The CWHS is led by the California Department of Health Services (CDHS) with participation from other public and private institutions. The CDHS Office of Women's Health coordinates and facilitates the project, with collaborators listed below working together to develop the survey instrument, analyze data, and distribute findings. Funding for the survey interviews was provided by these collaborators.

The Survey Research Group, Public Health Institute, 1700 Tribute Road, Suite 100, Sacramento, CA 95815-4402, administer the interviews for the CWHS. Each year, approximately 4,000 randomly selected women are interviewed anonymously by women interviewers in either English or Spanish. The age and racial/ethnic distribution of the sample does not completely match that of the California population of women. Therefore, data are weighted in analysis by age and race/ethnicity to reflect the 1990 California female population. Women without telephones in their homes, institutionalized women, and women who do not speak English or Spanish are missing from the sample. Findings are not generalizable to women missing from the sample. Because many Asian women speak neither English nor Spanish, findings should not be generalized to non-English speaking Asian women. Data indicating race/ethnicity are collected according to standards set by the CDHS Center for Health Statistics. During data collection, women are classified as follows: White (non-Hispanic), Black (non-Hispanic), Hispanic, Native American, Asian/Pacific Islander, or Other. For weighting purposes, categories established by the Demographic Research and Census Data Center of the California Department of Finance are used. These categories are White (non-Hispanic), Black (non-Hispanic), Hispanic, and Other. Poverty status is calculated from responses to questions about household income and size as "At or Below 100% of Poverty", "Between 100% and 200% of Poverty" or "Above 200% of Poverty" (Federal Register, February 9, 1995, rounded to nearest $100). Some subgroups used in the analysis, particularly racial/ethnic categories with small numbers, may be represented in such low numbers that meaningful comparisons are not possible. For presentation purposes, percentages are rounded to whole numbers and normalized to total to 100%.

**California Women's Health Survey collaborators include:**

California Department of Health Services:

Cancer Control Branch, 601 North Seventh Street, Sacramento, CA 95814, (916) 322-4787

Genetic Disease Branch, 2151 Berkeley Way, Annex 4, Berkeley, CA 94704, (510) 540-2534

Maternal and Child Health Branch, 714 P Street, Room 750, Sacramento, CA 95814, (916) 657-1347

Office of Family Planning, 714 P Street, Room 440, Sacramento, CA 95814, (916) 654-0357

Office of Women's Health, 714 P Street, Room 792, Sacramento, CA 95814, (916) 653-3330

Sexually Transmitted Disease Control Branch, 1947 Center Street, Suite 201, Berkeley, CA 94704, (510) 540-2657

Women, Infants, and Children (WIC) Supplemental Nutrition Branch, 3901 Lennane Drive, Sacramento, CA 95834, (916) 928-8600

California Department of Mental Health, Systems of Care Division, 1600 Ninth Street, Sacramento, CA 95814, (916) 654-3551

California Department of Alcohol and Drug Programs, Office of Perinatal Substance Abuse and Special Projects, 1700 K Street, Sacramento, CA 95814-4037, (916) 323-4445

CMRI (California Medical Review, Inc.) Citicorp Center, One Sansome Street, Suite 600, San Francisco, CA 94104-4448, (415) 677-2000. CMRI is a non-profit organization dedicated to improving the quality and integrity of health care and is the Quality Improvement Organization for the Medicare program in California.

Editor: Nikki Baumrind, Office of Women's Health

Editorial Board: Joan Chow, Sexually Transmitted Disease Control Branch; Joseph Courtney, Childhood Lead Poisoning Prevention Branch; Bob Currier, Genetic Disease Branch; Diana Greene, Office of Family Planning; Susan Merrill, CMRI.

Additional copies of the 1997 and 1998 Data Points may be requested by fax (916) 653-3535 or by phone (916) 653-3330 or copies may be downloaded from the Office of Women's Health web site at www.dhs.ca.gov/director/owh.

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# Data Points

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

*Issue 2, Spring 2001*

## 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% between 1990 and 1998).[1] These improvements can be attributed, in a large part, 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 provide information to policy-makers and health professionals about women's health, and to serve as a catalyst for innovative solutions that positively impact the health of women and girls in California. Conducted annually, the Survey is led by the California Department of Health Services in partnership with other public and private institutions. Data are collected through a computer-assisted telephone survey in which some 200 questions are answered by approximately 4,000 women who were randomly selected to participate. The information is then analyzed and disseminated in a publication entitled *Data Points.* Although the survey is anonymous and is conducted in English and Spanish, it has several limitations. Findings are not generalizable to women missing from the sample (e.g., with no home telephone, who are institutionalized or who do not speak English or Spanish). Some subgroups used in the analyses, particularly racial/ethnic categories with small numbers, may be represented in such low numbers that meaningful comparisons are not possible.

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[1]California Department of Health Services, Vital Statistics of California, 1998

8. **Pain and Activity Among California Women, 1998.** Susan S. Merrill, CMRI (California Medical Review, Inc.)
*Many strategies are available to help control chronic pain. Yet among California women, 22% experience pain that limits their ability to do what they want to do.*

9. **Pain and Social Support Among California Women, 1998.** Susan S. Merrill, CMRI (California Medical Review, Inc.)
*Compared to women who do not report pain, women who report pain are more likely to report feeling overwhelmed (25% versus 9%), have more anxiety (14 days versus 9 days in the past month), and be caregivers (31% versus 23%). They are also somewhat less likely to have support with daily activities, finances, illness, or transportation.*

10. **Caregiving Among California Women, 1997.** Susan S. Merrill, CMRI (California Medical Review, Inc.)
*Overall, 25% of the women in the survey reported being caregivers. Middle-aged women are most likely to be caregivers (32%), followed by older women (28%) and younger women (21%).*

11. **Caregiving and Health Among California Women, 1997.** Susan S. Merrill, CMRI (California Medical Review, Inc.)
*Compared with non-caregivers, caregivers of all ages smoke more (19% versus 15%) and are more likely to be overweight, especially among older women (28% versus 23%). They are also more likely to report having trouble sleeping (44% versus 38%), feeling overwhelmed (20% versus 15%), and wanting help from a mental health professional for personal or family problems (24% versus 20%).*

12. **Age Disparities In Health Insurance Status Among California Women, 1998.** Edward E. Graham, Maternal and Child Health Branch
*Older women are more likely than younger women to have health insurance coverage. While only 1% of women ages 65 or older are without either public or private insurance, 23% of women ages 18-24 lack any type of health insurance.*

13. **Racial/Ethnic Disparities in Health Insurance Status Among California Women, 1998.** Edward E. Graham, Maternal and Child Health Branch
*Among California women under age 65, 16% are without either public or private health insurance. Rates vary substantially by race/ethnicity, with 36% of Hispanics, 19% of Native Americans, 10% of Whites, 9% of Blacks and 7% of Asian/Pacific Islanders being uninsured.*

14. **Access to Family Planning Services Among California Women at Risk of Unintended Pregnancy, 1998.** M. Chabot, D. Greene, J. Treat, A. Ramirez, Office of Family Planning
*Among California women ages 18-44, Asian/Pacific Islanders, foreign-born women, and women without health insurance are more likely than other women to have never visited a health care provider to talk about family planning or receive contraceptives.*

15. **Contraceptive Utilization Among California Women, 1998.** M. Chabot, D. Greene, J. Treat, A. Ramirez, Office of Family Planning
*Twenty-two percent of California women who are at risk of an unintended pregnancy do not use any method of contraception.*

16. **Barriers to Obtaining Contraceptive Services Among California Women at Risk of Unintended Pregnancy, 1998.** M. Chabot, D. Greene, J. Treat, A. Ramirez, Office of Family Planning
*Women without health insurance, low-income women, foreign-born women, and Hispanic women are more likely than other women to report barriers obtaining family planning services.*

17. **Request for Chlamydia Testing from Health Providers Among California Women, 1998.** Joan M. Chow, Wei Ho, Gail Bolan, Sexually Transmitted Disease Control Branch
*Untreated Chlamydia Trachomatis (CT) infections in women are associated with an increased risk of adverse reproductive health outcomes such as pelvic inflammatory disease and infertility. Because most chlamydial infections are asymptomatic, screening is necessary to identify cases for timely treatment. However, at least half of California women with risk factors for CT infection indicate that they are unlikely to request a CT test in the next 12 months.*

18. **Adult Female Victims of Intimate Partner Physical Domestic Violence (IPP-DV), California, 1998.** Zipora Weinbaum, Terri Stratton, Carol Motylewski-Link, Maternal and Child Health Branch, Domestic Violence Section
*About 6% of the women surveyed reported having been victims of IPP-DV in the previous 12 months. Of these, only 11% sought medical care.*