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

Data Points

CWHS

RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

(Issue 3, Summer 2002)

Overview

The California Women's Health Survey (CWHS) was established to provide information to policymakers and health professionals about women's health, and to serve as a catalyst for innovative solutions that positively impact the health of women 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 are 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.

Data Points 1999-2000 Table of Contents

9. **Food Insecurity Among Women by Race/Ethnicity and Age, California, 2000.** Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services; Sharon Sugerman, Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services
   Food security varied substantially by race/ethnicity. Hispanic and Black women were more likely than Asian/Other or White women to be food insecure during the preceding 12 months before they were interviewed. Almost one-half of all Hispanic women (48%) were food insecure. Younger women were more likely than older women to be food insecure.

10. **Use of Food Support Systems by Women Classified as Food Insecure, California, 2000.** Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services; Sharon Sugerman, Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services
    With the exception of the WIC program, less than 11% of women who were food insecure were using food supplement programs such as food banks, community kitchens, or senior meals. However, over one-third of food insecure women had used WIC in the preceding 12 months.

11. **Women Who Delayed Medical Treatment or Buying Medicine In Order to Buy Food, by Age, Race/Ethnicity and Family Status, California, 2000.** Sharon Sugerman, Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services; Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services
    While fewer than 8% of women from other racial/ethnic groups reported delaying medical treatment or prescription purchases in order to buy food, 19% of Hispanic women had done so. Women under the age of 55 and women with young children in the house were more likely to have postponed meeting medical needs than were other women.

12. **Women Who Ate Less In Order that Family Members Had Enough Food by Age, Race/Ethnicity and Family Status, California, 2000.** Sharon Sugerman, Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services; Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services
    One in ten California women surveyed reported denying herself food so that others in the family would have enough to eat. This reached nearly two in ten for Hispanic women. Women with children under age 6 were twice as likely to go without food than women who didn't have children under age 6.

13. **Women's Attitudes About and Knowledge of Mental Health Care by Race/Ethnicity and Age, California, 2000.** Paula Agostini, Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services; Jennifer Coronel, Systems of Care, Statistics and Data Analysis, California Department of Mental Health
    While over 90% of all women thought it was a good idea to seek mental health care when confronted with overwhelming problems, those who knew where to obtain that care varied by race/ethnicity. Hispanic women (61%) were the least likely to know where to obtain care followed by Black women (76%), Asian/Other women (77%) and White women (87%).

14. **Desire for and Receipt of Mental Health Care for Women by Poverty Status, California, 2000.** Paula Agostini, Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services; Jennifer Coronel, Systems of Care, Statistics and Data Analysis, California Department of Mental Health.
    Of the 20% of California women surveyed who wanted mental health care in the last 12 months, 53% received care. Women who wanted to obtain mental health care were more likely to receive care if they were above the Federal Poverty Level (55.6%) compared to women who were at or below the Federal Poverty Level (42.6%).

15. **Post Traumatic Stress Disorder Symptoms Among Women, California, 2000.** Paula Agostini, Nikki Baumrind, Research and Evaluation Branch, California Department of Social Services; Rachel Kimerling, Department of Psychiatry, University of California San Francisco; Jennifer Coronel, Systems of Care, Statistics and Data Analysis, California Department of Mental Health
    It has been estimated that about 10% of women will experience PTSD at some point in their lifetime. Of the women surveyed, 9.9% reported having two or more PTSD symptoms in the month preceding the interview.

16. **Women's Use of Folic Acid Supplements and Knowledge of its Importance for Prevention of Birth Defects, California, 2000.** Suzanne Haydu, Rhonda Sarnoff, Marina Chabot, Maternal and Child Health Branch, California Department of Health Services
    Despite the role of folic acid in dramatically reducing the risk of having a pregnancy affected by the birth defects spina bifida and anencepahly, over one-third of Californian women of childbearing age who were surveyed had not heard or read about folic acid or folate, and only one-half were consuming supplements with folic acid at the time of the survey. Latina women were less likely than women of other ethnic or racial groups to report knowledge or use of folic acid.

17. **Chlamydia Testing Among California Women 1998, 1999, and 2000.** Mi-Suk Kang, Sexually Transmitted Disease Control Branch, California Department of Health Services
    Fewer than half of women for whom chlamydia screening was recommended actually reported having had a chlamydia test in the past year.

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

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

PAIN AND ACTIVITY LIMITATION, CALIFORNIA, 1999

CMRI (California Medical Review, Inc.)

Public Health Message:

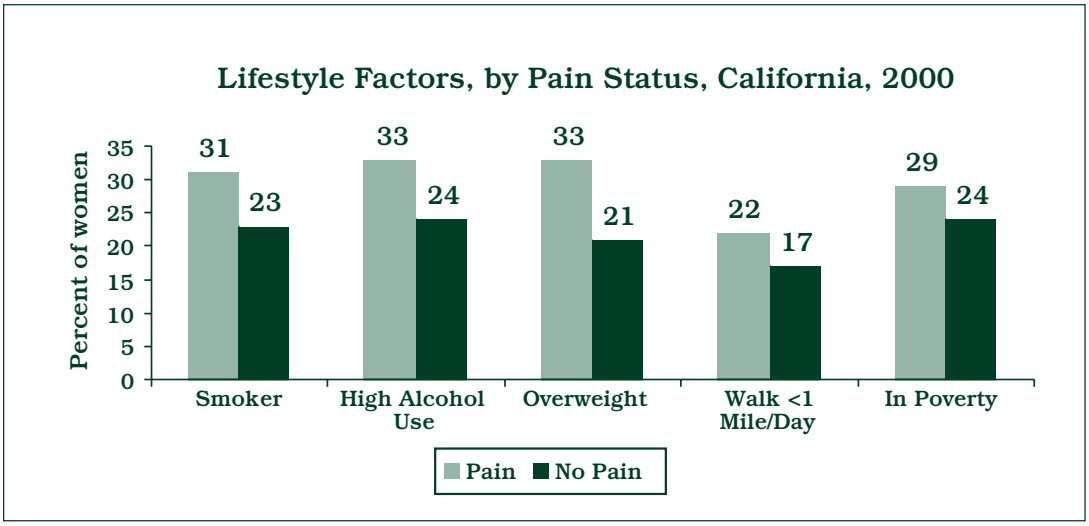
The majority of California women surveyed are not limited by pain. However, chronic pain affects nearly a quarter of women surveyed, limiting their activities and decreasing their quality of life. Pain status is related to other factors, such as smoking and alcohol use, which affect overall health status.

Pain is a common problem affecting 34 million Americans and is the cause of 25% of all sick days. Whether pain is acute (severe and lasts a short time) or chronic (recurs or lasts over a long period of time and reduces the ability to function), it can control a large part of a woman's life. Pain is frequently due to chronic health problems such as arthritis, shingles, or fibromyalgia. However, pain for many women often has no identifiable cause or diagnosis. Unrelieved or under-treated pain can lead to increased stress, delayed healing, impaired immune system functioning, decreased mobility, depression, and problems with appetite and sleep. Women can help to control their pain, with medication, exercise, weight control, stretching, acupuncture, and support groups.

The 1999 California Women's Health Survey asked 4,163 women, ***"During the past 12 months, has pain often kept you from doing things you wanted to do?"*** Other questions asked about race, activity limitations, and reasons for limitation in activity.

Results: Overall, 24% of all women reported that pain has often kept them from doing what they wanted to do. The percent of women reporting pain increased with age: 21% (ages 18-44), 28% (ages 45-64), and 31% (ages 65+).

- Black women were most likely to report pain (30%), followed by White (25%), Hispanic (21%), and Asian (20%) women.
- Among women who reported pain, 75% also reported some type of limitation in specific activities. Older and middle-aged women were more likely to report activity limitation than younger women (87% versus 63%). Black and Hispanic women (80%) were more likely to report activity limitation than Asian (64%) or White (74%) women.
- Among women who reported pain and activity limitation, the health problems that contributed most to the limitations were back or neck problems (24%), arthritis or rheumatism (14%), broken bone or joint problem (7%), recent accident or injury (5%), lung or breathing problems (5%), or recent surgery (4%).
- Women who reported pain were more likely than women without pain to be smokers, use alcohol heavily, be overweight, walk less than one mile/day, and be in poverty (please see graph).



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

COLORECTAL CANCER SCREENING, CALIFORNIA, 2000

CMRI (California Medical Review, Inc.)

Public Health Message:

The majority of women surveyed ages 50 and older have been screened at least once for colorectal cancer. However, less than half of these women have been screened within the past year. Guidelines recommend annual screening for colorectal cancer.

Colorectal cancer, which occurs in the rectum or colon, is the third leading cause of cancer death for women in California.[1] Factors that put women at higher risk for colorectal cancer are older age, family history of cancer, inflammatory bowel disease, having had colorectal cancer or polyps (growths in the colon or rectum), sedentary lifestyle, and a diet low in fiber and high in saturated fat. Colorectal cancer is preventable and, if found early, curable. The most effective prevention measure is regular screening. Women ages 50 and older and younger women at high risk should be screened regularly for polyps and precancerous lesions, which can be removed before becoming cancerous. Few women receive regular colorectal cancer screening, and Hispanic women are least likely to be screened.[2]

The 2000 California Women's Health Survey asked 1,398 women ages 50 and older if and when they had a fecal occult blood test (FOBT), sigmoidoscopy, or colonoscopy to screen for colorectal cancer. Women who had no screening were asked why they have not been screened.

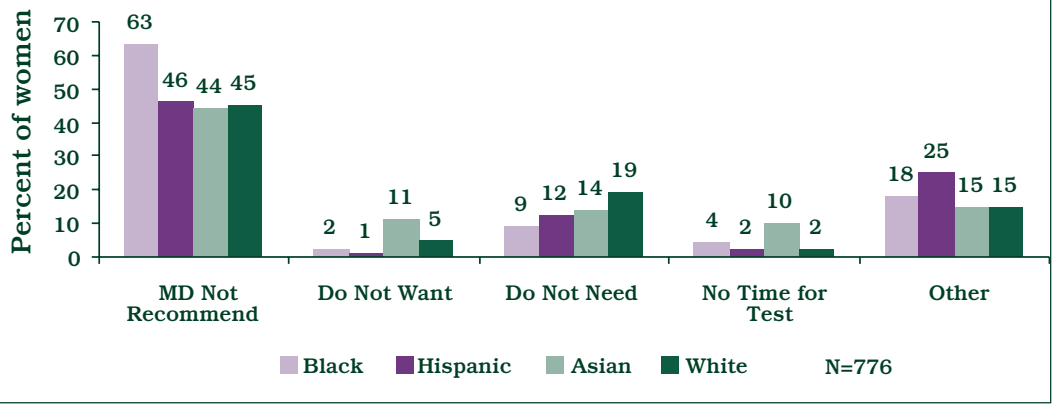
Results: Overall, 75% of women ages 50 and older reported ever having either type of screening test for colorectal cancer.

- More White women reported ever having an FOBT (70%), followed by Asian (69%), Black (57%), and Hispanic (51%) women.
- More Black women reported ever having a sigmoidoscopy or colonoscopy (59%), followed by White (55%), Asian (47%) and Hispanic (40%) women.
- Just 44% of women reported being screened within the past year. White women were most likely to have been recently screened (48%), followed by Asian (43%), Black (42%), and Hispanic (40%) women.
- Women ages 75 and older were less likely to have been screened in the past year than younger women (42% versus 48%).
- The primary reasons for women ages 50+ never having an FOBT or sigmoidoscopy varied by race/ethnicity and included: doctor did not recommend, test was not wanted, test was not needed (low risk), no time to take test, and other – cost, embarrassment, test preparation, fear (see graph).

[1] Kwong SL, et al. Cancer in California: 1988-1998. Sacramento, CA: CA Dept. of Health Services, Cancer Surveillance Section, December 2000.

[2] MMWR. Screening for Colorectal Cancer – U.S. 1997. Feb. 19, 1999; 48(06):116-121.

Primary Reasons Why Women Ages 50+ Have Not Had Colorectal Cancer Screening, by Race/Ethnicity, California, 2000



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OSTEOPOROSIS RISK FACTORS AND BONE DENSITY TESTING, CALIFORNIA, 1999

CMRI (California Medical Review, Inc.)

Public Health Message:

Osteoporosis, which places women at higher risk for bone fractures, can be diagnosed with a bone density test. Women with modifiable risk factors are less likely to have had a bone density test than other women who do not have these risk factors.

Osteoporosis is a disease in which bones become very porous and thin. Low bone mass places women at risk for osteoporosis, and both osteoporosis and low bone mass place women at risk for bone fractures. About 80% of all osteoporosis cases occur among women.[1] Older women and women who have gone through menopause are at higher risk. Other risk factors for osteoporosis include older age, family history, smoking, having a small frame, excessive alcohol use, being underweight, eating a low calcium diet, and having an inactive lifestyle. Bone density testing, a procedure that measures bone mass, is used to diagnose osteoporosis and is recommended for women at risk for the disease.[2]

The 1999 California Women's Health Survey (CWHS) asked 1,642 women ages 50 and older or who had had a hysterectomy, ***"In the past 2 years, have you had a bone density test for osteoporosis or bone loss?"*** Other questions asked about menopausal estrogen use, smoking, alcohol use, weight, and walking.

Results: Overall, 21% of women reported having a bone density test in the past 2 years. About 14% of Black, Hispanic, and Asian women reported having the test, while 23% of White women reported being tested.

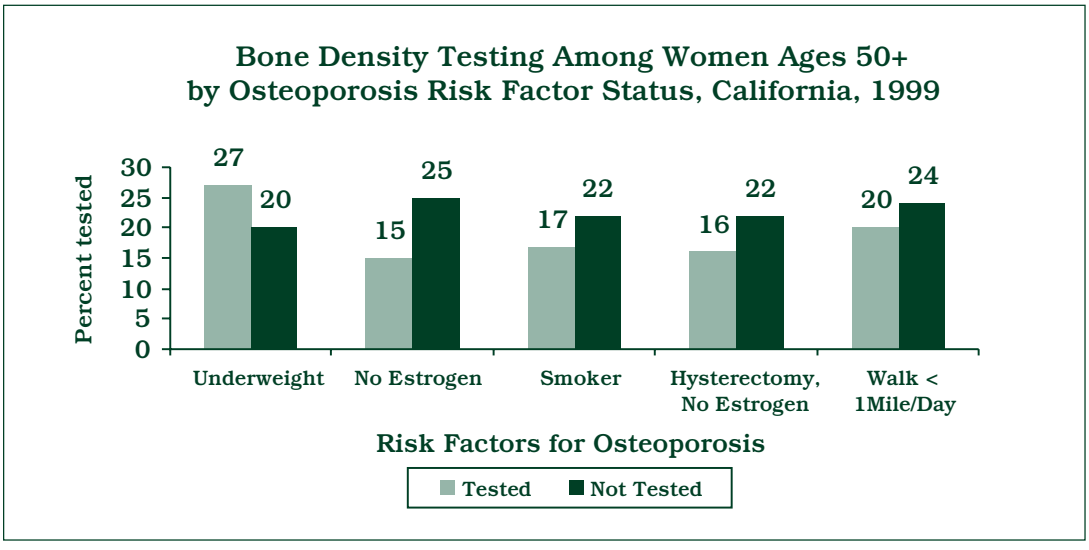
- Risk factors for osteoporosis also varied by race/ethnicity. Hispanic (39%) and Black (43%) women were less likely than Asian (55%) and White (66%) women to have ever used estrogen. Asian (23%) and White (14%) women were more likely to be underweight than Black and Hispanic women (5%).

- More Black (27%) and White (17%) women were smokers than Hispanic (9%) or Asian (2%) women. Fewer Asian women (15%) walked a mile or more per day than Black (26%) and Hispanic and White women (31%). High alcohol use was very low for all women (1%).

- Underweight women were more likely than other women to have had a recent bone density test. However, women with other modifiable risk factors for osteoporosis were less likely to have been screened for osteoporosis in the past two years than women without these risk factors (see graph).

[1] NIH Ostoporosis and Related Bone Diseases: www.osteo.org\osteo.html

[2] National Osteoporosis Foundation: www.nof.org/osteoporosis/stats.htm



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

OSTEOPOROSIS KNOWLEDGE AND AWARENESS, CALIFORNIA, 2000

CMRI (California Medical Review, Inc.)

Public Health Message:

Most women surveyed have heard of osteoporosis and know that it is the loss of bone. Many women ages 50 and older are diagnosed with osteoporosis, yet just one third of women under age 50 report talking to their doctor about osteoporosis prevention.

Osteoporosis, chacterized by thinning bones and weakened bone structure, places women at risk for bone fractures. More than eight million women in the U.S. have osteoporosis, and another 15 million are at risk for osteoporosis due to low bone mass.[1] The condition is more common among older women and women who have gone through menopause; however, osteoporosis can strike at any age. It is estimated that one of two women over age 50 will have an osteoporosis-related fracture in her lifetime.[2] Women can help to prevent or delay osteoporosis by maintaining a healthy lifestyle that includes eating a healthy diet rich in calcium and vitamin D, exercising regularly, and taking medications such as estrogen when appropriate.

The 2000 California Women's Health Survey (CWHS) asked 4,012 women if they had ever heard of osteoporosis, what do they think it is, and whether a doctor had talked with them about preventing osteoporosis. There were 1,398 women ages 50 and older asked if they had ever been told they have osteoporosis.

Results: Overall, 92% of all women reported having heard about osteoporosis. Fewer Hispanic and Asian women (81%) had heard of osteoporosis than Black or White women (96%).

- The majority of women (90%) correctly defined osteoporosis as bone loss while fewer women defined it as joint problems (2%) or other health problems (8%). Fewer Black, Hispanic, and Asian women than White women knew what osteoporosis is (85% versus 93%).

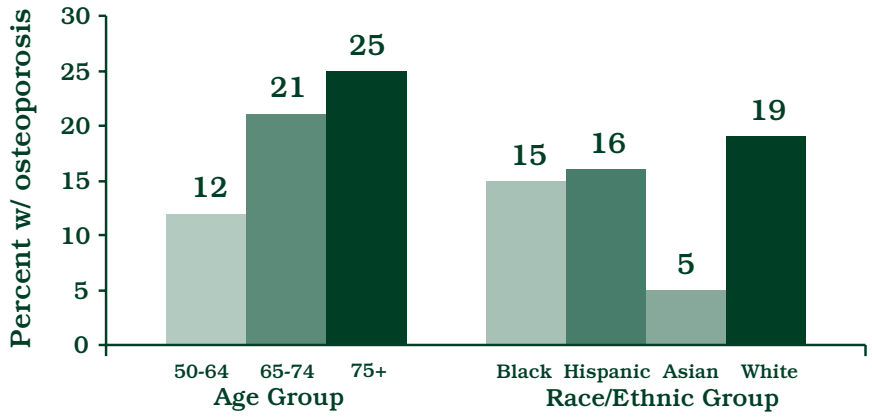
- More women ages 45 and older than younger women reported talking with their doctor about preventing osteoporosis (57% versus 30%). White women were most likely to have talked with their doctor about osteoporosis (48%), followed by Black (33%), Asian (29%), and Hispanic (26%) women.

- Among all women ages 50 and older, women ages 75 and older were most likely and Asian women least likely to have been told they have osteoporosis (see graph).

[1] National Osteoporosis Foundation: www.nof.org/osteoporosis/stats.htm

[2] NIH Ostoporosis and Related Bone Diseases: www.osteo.org/osteofastfact.html

Percent of Women Ages 50+ Who Have Been Told They Have Osteoporosis or Bone Loss, By Age and Race/Ethnicity, California, 2000



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

HELP-SEEKING BEHAVIORS AMONG CALIFORNIA WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, 2000

Domestic Violence Section, Maternal and Child Health Branch, California Department of Health Services

Nearly one-third of American women (31%) report being physically or sexually abused by an intimate partner in their lifetime. The California Battered Women's Shelter Program (BWSP) funds direct shelter services for abused women and their children and community prevention activities.

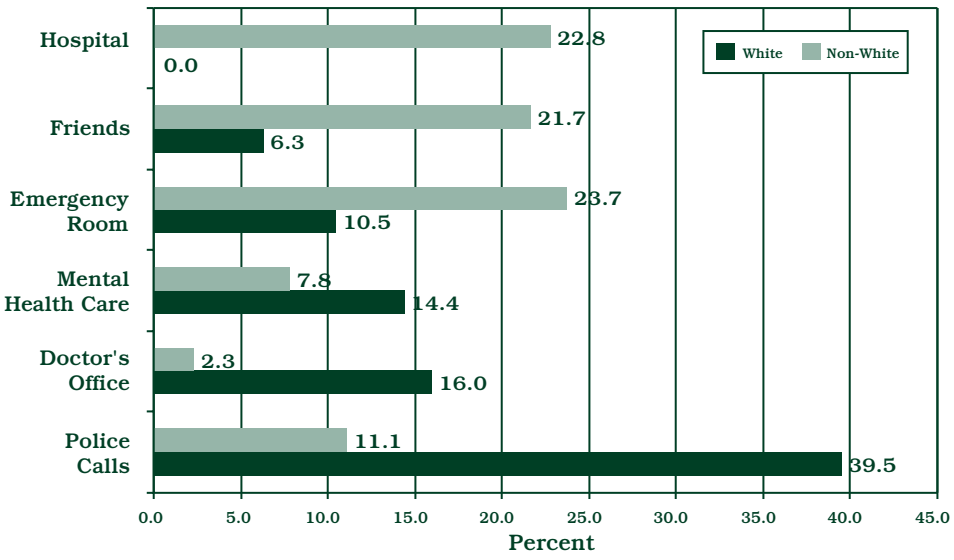
BWSP utilized the California Women's Health Survey (CWHS) to identify domestic violence (DV)-related help-seeking behaviors. Analyses were limited to the 3,878 CWHS respondents who were willing to discuss couple relationships. Of those, 207 or 6% of California women reported that in the previous 12 months their intimate partners either: threw objects at them, hit, kicked, pushed, slapped, choked, beat up, forced them to have sex, or threatened/used a gun or a knife on them. A majority of victims and non-victims alike (68.7%) stated that they had knowledge about DV programs in their communities; however, only 16.9% of all the victims stated that they sought help or medical care for intimate partner violence in the past 12 months. Those seeking help reported using between one and four community resources.

Listed below are characteristics of victims who did or did not seek help:

- About 19.8% of the U.S. born victims sought help for DV, compared with 7.1% of the non-U.S. born victims.
- About 20.4% of the White victims, compared with 11.7% of the non-White victims sought help for DV. None of the "Asian/Pacific Islander/Other" victims stated that they sought help (n=14).
- Only 21.4% of the victims who had knowledge of community DV programs reported that they sought help.
- About 28.8% of the victims neither sought help nor had knowledge about DV programs in their communities.

Among victims who sought help, 30.7% went to the police/sheriff, 14.6% visited the emergency room, and 12.3% sought mental health care. The type of DV assistance resources used varied by race/ethnicity (see table).

Help-Seeking Behaviors Among Female Domestic Violence Victims, California, 2000



Public Health Message:

Most female domestic violence (DV) victims and their children, especially those who are not White and not born in the United States, do not receive assistance to address the abuse they are experiencing. To increase the safety of these victims and provide direct services, cultural, language, and gender appropriate outreach and education activities should be available through a variety of resources and community outlets. Enforcement, health, and social services-related agencies can be appropriate resources in reaching and helping DV victims.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN'S PERCEPTIONS ABOUT THE PURPOSE OF PAP SMEAR TESTING, CALIFORNIA, 2000

Office of Women's Health, California Department of Health Services

Public Health Message:

The majority of California women surveyed were unsure of the purpose of the Pap test. Many women thought the Pap test detects ovarian cancer, which may lead to a false sense of security among these women.

The California Women's Health Survey (CWHS) 2000 showed that 85% of California women had a Pap test within the past three years, however, a majority of these women were unclear about what the Pap test actually detects. The CWHS provided an opportunity to ask women about their knowledge of the Pap test.

Women were asked: ***"Which of the following can be detected with a Pap smear? Would you say ovarian cancer, cervical cancer, both or neither?"***

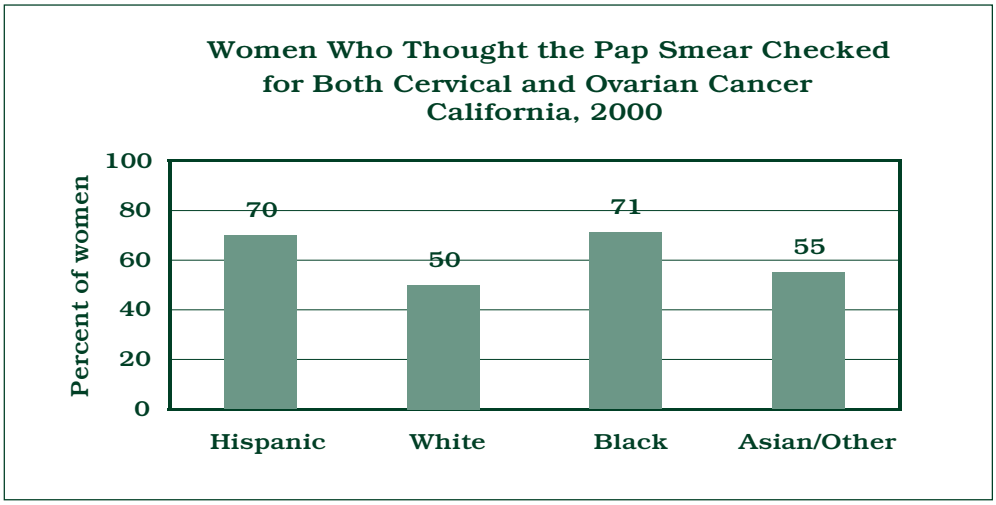
- Over half (56%) of the women said they thought the Pap test checked for both ovarian and cervical cancer, 37% thought it checked for cervical only, 4% for neither and 3% for ovarian cancer only.
- Hispanic (70%) and Black (71%) women were more likely than White (50%) and Asian/other (55%) women to think that the Pap test detected both ovarian and cervical cancer.
- Women ages 34 and younger (65%) were more likely than women over age 34 (50%) to think the Pap test checked for both ovarian and cervical cancer.

Although the Pap test is effective in early detection of cervical cancer, it cannot detect ovarian cancer. While an annual pelvic examination can find some reproductive system cancers at an early stage, most early ovarian tumors are difficult to detect.[1] Only 25% of ovarian cancers are found at an early stage. Early detection improves the chances of successful treatment. Most ovarian cancers occur in women over the age of 50.[2] Certain symptoms may indicate a problem with the ovaries and the need for an examination by a healthcare provider. These include swelling of the abdomen, vaginal bleeding, pelvic pressure, back pain, leg pain, and digestive problems such as gas, bloating, indigestion, or long-term stomach pain.[3]

[1] American Cancer Society, Cancer Resource Center, "Ovarian Cancer, What Is It?"

[2] National Cancer Institute, NIH Publication No 00-561, 2000

[3] American Cancer Society, Cancer Resource Center, "Ovarian Cancer, Can Ovarian Cancer Be Found Early?"



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

PAP TESTING STATUS FOR WOMEN, CALIFORNIA, 2000

Office of Women's Health, California Department of Health Services

Public Health Message:

The Pap test is a highly effective and widely used screening test for cervical cancer. Many California women, particularly Asians, have never had a Pap test or have not had a Pap test in the past three years

Early detection is the most effective way to prevent cervical cancer. Routine, annual pelvic exams and Pap tests can detect pre-cancerous conditions that can often be treated successfully before cancer develops. Nationally, the cervical cancer death rate fell 10% from 1991 to 1996 reflecting continued widespread use of Pap screening.[1] The American Cancer Society (ACS) recommends that women begin annual screening at age 18, or after the onset of sexual activity, whichever occurs first.[2] Despite the recognized benefits of a Pap test, health officials estimate that about 60-80% of American women with newly diagnosed cases of invasive cervical cancer have not had a Pap test within the past five years and many of these have never had a Pap test. These women are more likely to be elderly, African-American, and low income women.[3]

The California Women's Health Survey in 2000 asked women ages 18 and older if they have ever had a Pap test and if they had, how long it has been since their last test.

In 2000, 85% of all women surveyed ages 18 and older reported they had a Pap test within the past three years, 7% within three to five years, and 8% never had a Pap test.

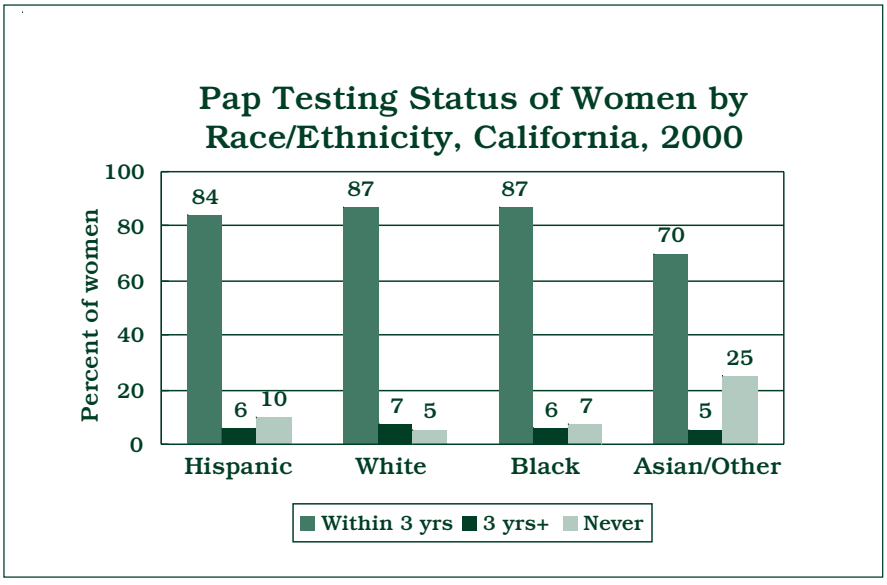
- White (87%), Black (87%), and Hispanic (83%) women were more likely than Asian/Other (70%) women to have a Pap test within the past three years.

- Asian women (25%) were more likely than the other race/ethnic groups to report never having a Pap test compared to White (5%), Black (7%), and Hispanic (10%) women (see graph).

[1] National Cancer Institute, Cancer Facts, 1996

[2] Smith RA, Mettlin CJ, Davis KJ, Eyre H., American Cancer Society Guidelines for the Early Detection of Cancer, CA Cancer J Clin 2000;50:34-49.

[3] American Cancer Society, Cancer Resource Center, Internet Web Page, http://www.cancer.org.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

FOOD INSECURITY AMONG WOMEN BY EDUCATIONAL LEVEL, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services

The terms "food security" and "food insecurity" represent relatively new concepts on the topic of hunger. Food security means that a household has assured access to enough food that is also nutritionally adequate and safe. Food insecurity reflects the emotional stress and anxiety experienced by women due to the lack of available funds to buy food. It also reflects compromising behaviors by women who choose lower cost and less nutritious food, or who choose to buy food instead of paying for medical or other household expenses.[1] Food security is an important dimension of basic individual and family well being, similar to health or housing. On the other hand, food insecurity and hunger are undesirable in their own right and possible precursors to more serious health and developmental problems.[2]

The U.S. Department of Agriculture developed a six-question severity scale that is used to produce estimates of the amount of food insecurity in the nation. This same measure can also be used to estimate food insecurity for each state's population.[1] The California Women's Health Survey asked women these six questions.

- Among California women, 22% were food insecure—that is they did not always have access to enough food to meet basic needs.
- Women with less than a 9th grade education were more likely to be food insecure than women with higher levels of education. As education increased, the percent of women who were food insecure decreased.
- Over 90% of women with less than a ninth grade education were Hispanic.

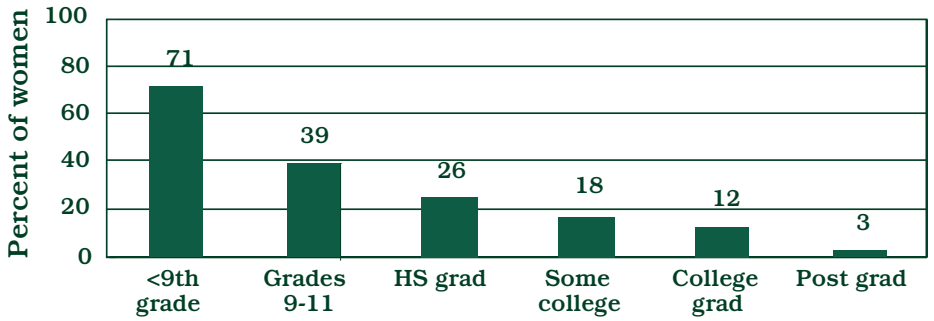
[1] Gary Bickel, Margaret Andrews and Bruce Klein, "Measuring Food Security in the U.S.: A Supplement to the CPS." USDA Food and Consumer Service, Office of Analysis and Evaluation, Alexandria, VA January 1996.

[2] The Rhode Island Food Security Monitoring Project: Assessing the Prevalence of Hunger and Food Insecurity in Rhode Island, Summary Report. The Rhode Island Department of Health, Division of Family Health, November 1999.

Public Health Message:

While 22% of California women surveyed were food insecure, those with less than a 9th grade education were over three times more likely to be food insecure than women with a high school diploma. Outreach efforts to women with less education should be focused on the available food support systems.

Percent of Women Who Were Food Insecure by Educational Level, California, 2000



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

FOOD INSECURITY AMONG WOMEN BY RACE/ ETHNICITY AND AGE, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services

Food security means that a household has assured access to enough food that is nutritionally adequate and safe. Food insecurity means that a household does not have access to enough food. Women who are food insecure must choose between buying lower cost and less nutritious food and/or buying food instead of paying for household expenses or medical costs. The concept of food insecurity also reflects the emotional stress and anxiety experienced by women due to the lack of available funds to buy food.[1]

The 2000 California Women's Health Survey asked women ages 18 and older questions regarding hunger and access to food in their household. The U.S. Department of Agriculture developed a six-question severity scale that is used to produce estimates of the extent of food insecurity in the nation. This measure can also be used by states to produce comparable estimates for each state.[1] The California Women's Health Survey asked women these six questions to determine how many California women were food insecure.

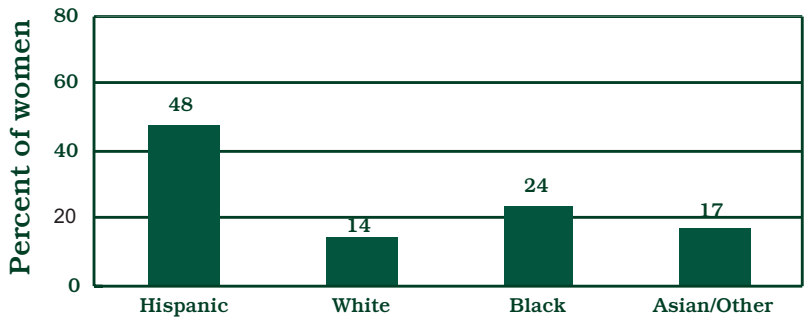
- In 2000, Hispanic (48%) and Black (24%) women were more likely than White (14%) or Asian/Other women (17%) to be food insecure.
- As the age of women increased, the percent who were food insecure decreased. Younger women less than 34 years of age were more likely than women over age 34 to be food insecure, 29% compared to 18%.

[1] Bickel G, Andrews M, and Klein B. "Measuring Food Security in the U.S.: A Supplement to the CPS." USDA Food and Consumer Service, Office of Analysis and Evaluation, Alexandria, VA January 1996.

Public Health Message:

Substantial disparities in food security are present among California women surveyed by race/ ethnicity, and by age. Targeted efforts are needed to assure secure access to food among all California women.

Women Who Were Food Insecure by Race/Ethnicity, California, 2000



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

USE OF FOOD SUPPORT SYSTEMS BY WOMEN CLASSIFIED AS FOOD INSECURE, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services

Women who are food insecure do not have assured access at all times to enough food for an active healthy life. Food insecurity also reflects the emotional stress and anxiety experienced by women due to the lack of money to purchase food.[1] California participates in various federal food assistance programs to help women and their families. These include the Food Stamp program with 2.2 million monthly participants in 1998, the national school lunch program, and the Women, Infants and Children's Supplemental Food Program (WIC), with 1.2 million monthly participants in 1998. Other local sources of food assistance available to women include emergency food banks, community kitchens, senior meals sites, and home delivered meals.

The California Women's Health Survey (CWHS) examined the association between food security and use of food supplement programs. The survey asked women, ***"During the past 12 months, have you received food assistance from any of the following sources—emergency food banks, meals served at a kitchen or community site, Women, Infants and Children's (WIC) vouchers or coupons, or senior meal site or home-delivered meals?"*** In addition, the CWHS asked all women six questions adopted from the U.S. Department of Agriculture scale used to produce estimates of the amount of food security in the nation.

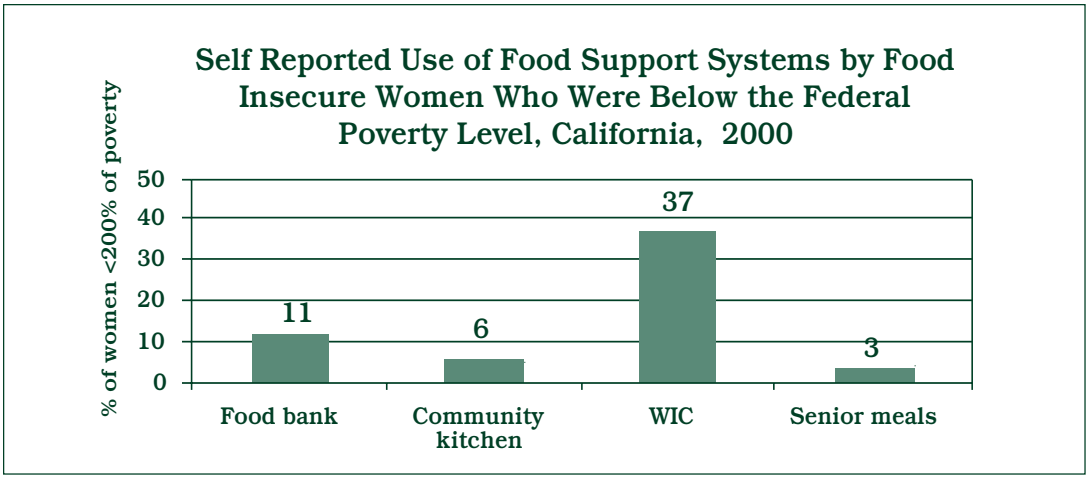
- Less than 11% of women who were classified as food insecure used food support systems such as local food banks, community kitchens, or senior meals programs.
- The Federal WIC program was an exception. In 2000, 37% of women who were food insecure reported having used WIC in the previous 12 months. Findings on Food Stamp participation will be available in the CWHS 2001 survey.

Notes: Estimates for WIC include only women who would meet eligibility requirements, women within 185% of the Federal Poverty Level who are either pregnant or who have children under six years of age. Estimates for Senior Meals include women ages 55 and older that were below the Federal Poverty Level. Food banks and community kitchens include only women who were below the Federal Poverty Level.

[1] Hamilton WL, Cook JT, Thompson WW, et al. "Household Food Security in the United States in 1995: Summary Report of the Food Security Measurement Project". September 1997.

Public Health Message:

Women who are food insecure are not using available food programs optimally. WIC is one potential setting for increased outreach to inform low-income women about other resources available. Federal or state changes in the Food Stamp Program may also provide opportunities to increase benefits and encourage more women to participate.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN WHO DELAYED MEDICAL TREATMENT OR BUYING MEDICINE IN ORDER TO BUY FOOD, BY AGE, RACE/ETHNICITY AND FAMILY STATUS, CALIFORNIA, 2000

Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services; Research and Evaluation Branch, California Department of Social Services

Women who do not have assured access to enough food to meet basic needs are defined as being food insecure. These women may have to use various coping behaviors in order to have enough food for themselves and their families.[1] They may choose from a number of coping behaviors when food is scarce or unavailable, including not paying rent, delaying purchase of medicine, or foregoing other necessities when there is not enough food to meet basic needs.

The 2000 California Women's Health Survey (CWHS) provided an opportunity to examine women's coping behaviors when food was scarce. The CWHS asked women, ***"During the last 12 months, have you or others in your household delayed getting medical treatment or filling prescriptions in order to buy food?"*** Questions on personal characteristics such as age, race/ethnicity, and number of children in the household under age six were also included.

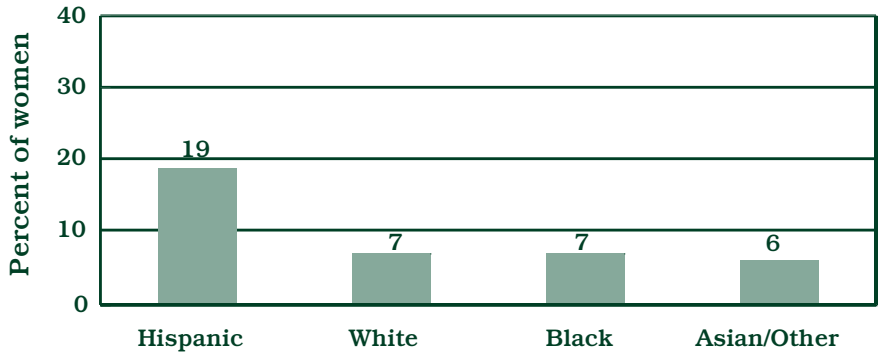
- 10% of all women surveyed responded that they delayed getting treatment or purchasing medicine in order to buy food.
- Hispanic women were more likely than other race/ethnicities to delay medical needs in order to buy food.
- Younger women were more likely than older women to delay medical care in order to buy food:

  12% of women ages 18-24;
  11% of women 25-34;
  12%f women 35-44;
  11% of women 45-54;
  7% of women 55-64;
  3% of women 65 and older.

- Women with children under age 6 were more likely than women without children under age 6 to delay medical treatment or buying medicine in order to buy food, (12% vs. 9%).

[1] Bickel G, Andrews M, and Klein B. "Measuring Food Security in the U.S.: A Supplement to the CPS. USDA Food and Consumer Services, Office of Analysis and Evaluation, Alexandria, VA January 1996.

Women Who Delayed Getting Medicine in Order to Buy Food, California, 2000



Public Health Message:

Many California women are faced with difficult choices between food and medication when allocating household resources. This is especially true for Hispanic women, women ages 18-54 and those with young children in the household. More outreach about supplemental food and medical assistance is needed.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN WHO ATE LESS IN ORDER THAT FAMILY MEMBERS HAD ENOUGH FOOD, BY AGE, RACE/ ETHNICITY AND FAMILY STATUS, CALIFORNIA, 2000

Cancer Prevention and Nutrition Section, Cancer Control Branch, California Department of Health Services; Research and Evaluation Branch, California Department of Social Services

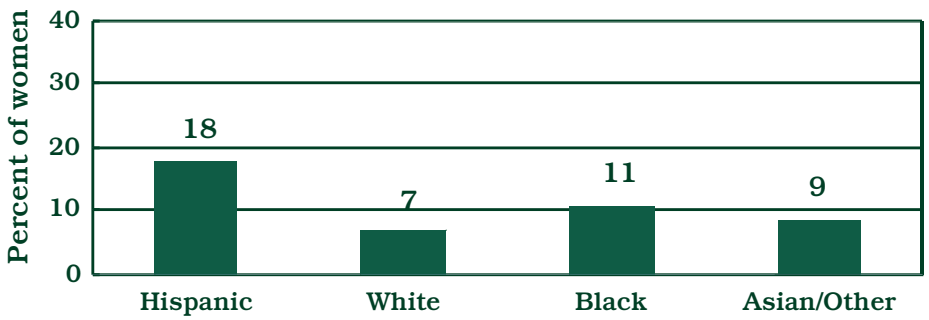
Women who are food secure have assured access to enough food that is nutritious and safe. Women who are food insecure do not have assured access at all times to enough food for an active, healthy life.[1] When food is scarce or unavailable, women may sometimes forego eating in order to provide enough food for their families, consequently compromising their own health.

The 2000 California Women's Health Survey (CWHS) provided an opportunity to examine how women coped with food insecurity. The CWHS asked women, ***"During the last 12 months, did you ever eat less than you wanted or not eat at all so that some other member of your household would have enough to eat?"*** Questions about race/ethnicity and age were also included in the survey.

- Among all women surveyed, 10% responded that they did eat less in order to ensure other family members had enough to eat.
- Black and Hispanic women were more likely than White or Asian/Other women to go without food to ensure other family members had enough to eat.
- Women ages 35-54 (12%) were just as likely as younger women ages 18-34 (13%) to go without food to ensure that other family members had enough to eat.
- Women with children under age 6 were more likely to go without food than women who didn't have children under age 6 (15% vs. 8%).

1 G, Andrews M, Klein B. "Measuring Food Security in the U.S.: A Supplement to the CPS." USDA Food and Consumer Services, Office of Analysis and Evaluation, Alexandria, VA January 1996.

Women Who Ate Less To Ensure Family Members Had Enough to Eat by Race/Ethnicity California, 2000



Public Health Message:

Denying oneself food so that others in the family may eat is a nutritionally risky behavior practiced by many California women, particularly Hispanic women and those with young children living in the household. Efforts are needed to promote increased participation by women in federal nutrition assistance programs, such as Food Stamps.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN'S ATTITUDES ABOUT AND KNOWLEDGE OF MENTAL HEALTH CARE BY RACE/ETHNICITY AND AGE, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Systems of Care, Statistics and Data Analysis, California Department of Mental Health

Most Americans believe that good mental health is just as important as good physical health. Good mental health means having the mental energy to function well at home, work, and play.[1] However, women often place their own physical and mental health as a lower priority than that of others and tend to take care of others in their household first. When non-White women do use mental health services, they are less likely to terminate services if their provider shares their language and culture.[2]

The 2000 California Women's Health Survey (CWHS) provided an opportunity to examine women's attitudes toward seeking mental health care and their knowledge about where to go for help. The survey asked women, ***"Sometimes a person feels problems are piling up so high that she cannot overcome them. When a person feels this way, do you think it is a good idea to seek help from a mental health professional, such as a social worker, psychiatrist, psychologist or counselor?"*** A second question asked women if they knew where to obtain help. Personal characteristics, such as age and race/ethnicity were also included in the survey.

- While over 90% of women in all race/ethnic and age groups thought it was a good idea to seek mental health care, knowledge about where to obtain care varied by race/ethnicity and age.
- Compared to women of other race/ethnicities, Hispanic women were least likely (61%) to report they knew where to obtain mental health care services.
- Younger women ages 18-24 compared to women ages 25 years and older were least likely to know where to obtain mental health care services if they wanted care (72%).

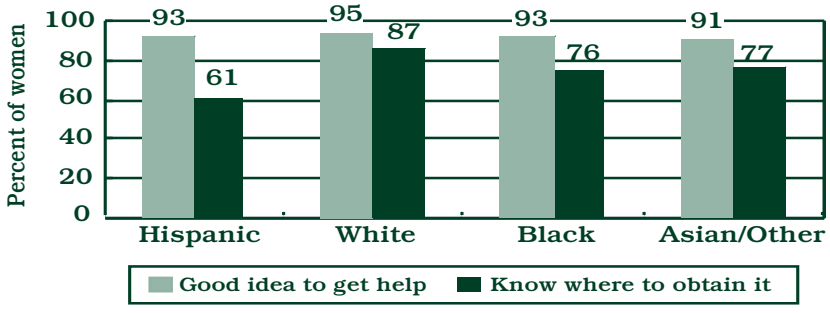
[1] APA Help Center, "Get the Facts: Psychology in Daily Life—How to Achieve Good Mental Health," 1996.

[2] Takeuchi DT, Uehara E and Matamba G. The Sociology of Mental Health, Horowitz A, Scheid T. editors. "Cultural diversity and mental health treatment" New York: Oxford: 550-565, 1999.

Public Health Message:

The majority of women think it is a good idea to seek mental health care when feeling overwhelmed. However, young Hispanic women are least likely to know where to seek out or obtain mental health care. Further study is needed to explore reasons why. Culturally and linguistically appropriate outreach and services may be needed to ensure access to mental health care.

Women Who Reported It Was a Good Idea to Seek Mental Health Care and Who Knew Where to Obtain It by Race/Ethnicity California, 2000



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

DESIRE FOR AND RECEIPT OF MENTAL HEALTH CARE FOR WOMEN BY POVERTY STATUS, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Systems of Care, Statistics and Data Analysis, California Department of Mental Health

Good mental health means having the mental energy to function well at home, work, and play. Good mental health means being able to tend to everyday activities without feeling overly anxious, depressed, or worried. Most Americans believe that good mental health is just as important as good physical health.[1]

Poverty has long been associated with poor physical health status. Limited population-based information is currently available about the association between good mental health and poverty status.

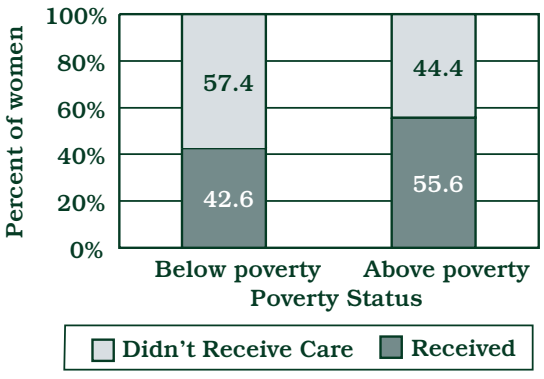
The 2000 California Women's Health Survey provided an opportunity to examine women's desire for mental health care, receipt of mental health care, and poverty status. The survey asked women, ***"In the past 12 months, did you ever want help with personal or family problems from a mental health professional such as a social worker, psychiatrist, psychologist or counselor"*** and ***"In the past 12 months did you visit a mental health professional to talk about personal or family problems?"***

- Of all women surveyed, 20% reported that they wanted to talk with a mental health professional and of these, 53.1% reported they visited a mental health professional within the past 12 months.
- Of those women who reported their annual income and were at or below the Federal Poverty Level, 19% wanted to talk with a mental health professional. For women who were above the Federal Poverty Level, 22% wanted to talk with a mental health professional.
- While approximately the same percentage of women regardless of income level wanted to talk with a mental health professional, women with incomes above the poverty level were more likely than women at or below the poverty level to visit a mental health professional, 55.6% vs. 42.6%.

Note: The Federal Poverty Level is defined as having an annual income of less than $16,984 for a family of four.

[1] APA Help Center, "Get the Facts: Psychology in Daily Life—How to Achieve Good Mental Health," 1996.

Women Who Desired Mental Health Care and Whether or Not They Received It by Poverty Status, California, 2000



Public Health Message:

Of California women surveyed who want mental health care, women in poverty were less likely to receive mental health care if they wanted it. Outreach efforts should be directed toward women in poverty to ensure they have ready access to mental health services.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

POST TRAUMATIC STRESS DISORDER SYMPTOMS AMONG WOMEN, CALIFORNIA, 2000

Research and Evaluation Branch, California Department of Social Services; Department of Psychiatry, University of California, San Francisco; Systems of Care, Statistics and Data Analysis, California Department of Mental Health

The prevalence of problems related to post traumatic stress disorder (PTSD) has been grossly under-recognized.[1] New data suggest that people who experience a trauma may develop significant functional impairment even though their symptoms do not meet the full criteria for a diagnosis of PTSD.

PTSD is an anxiety disorder that may develop after a person has experienced, witnessed, or learned about an extremely traumatic event in which there has been an actual or perceived threat of death, serious injury, or other psychological threat such as an automobile accident, sexual or physical assault, or natural disaster.[1] Symptoms can include intrusive thoughts of the traumatic event, severe insomnia, emotional numbness, or avoidance of anything that serves as a reminder of the event.

Generally, women with PTSD symptoms have more medical problems and poorer functional status than women without PTSD symptoms. National data recently released suggest that 8% of individuals in the United States will experience PTSD symptoms in their lifetime.[1]

The 2000 California Women's Health Survey asked women, ***"Thinking back over your entire lifetime, have you ever had any experience or experiences that were frightening, horrible or upsetting?"*** Women were also asked a set of four questions about symptoms of PTSD in the preceding 12 months. These questions included having nightmares associated with those experiences, avoiding situations that are reminders of the event, being constantly on guard or easily startled, or feeling numb or detached from others or your surroundings.

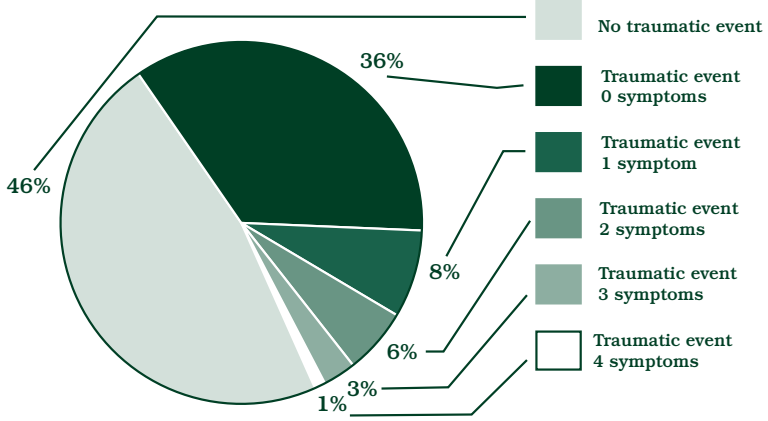
- Over half (54%) of all women reported that they have had a frightening, horrible, or upsetting event at some point in their lifetime.
- Of all women, 36% reported that they have had a traumatic experience in their lifetime but that they did not have any of the four symptoms of PTSD mentioned above.
- Of all women, 8% reported that they have had a traumatic experience in their lifetime and reported having one of the four PTSD symptoms; 6% reported having two symptoms; 3% reported having three symptoms, and 1% reported having all four symptoms.

[1] "The Prevalence of Problems Related to PTSD Grossly Under-Recognized", paper presented at the 154th Annual Meeting of the American Psychiatric Association, May 10, 2001 in New Orleans, LA, by Dr. Randall Marshall, Director of Trauma Studies at the Anxiety Disorders Clinic, New York State Psychiatric Institute and Associate Professor, Columbia University.

Public Health Message:

PTSD is a health problem affecting about 10% of California women surveyed. Because women with PTSD symptoms have more medical problems, primary care providers need to be aware of these PTSD symptoms in their patients so they can be referred to appropriate care.

PTSD Symptoms Among California Women, 2000



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN'S USE OF FOLIC ACID SUPPLEMENTS AND KNOWLEDGE OF ITS IMPORTANCE FOR PREVENTION OF BIRTH DEFECTS, CALIFORNIA, 2000

Maternal and Child Health Branch, California Department of Health Services

Public Health Message:

An appropriate public health campaign may be needed to address the disparities in knowledge and use of folic acid by women of childbearing age, especially Latina women and women with low education levels.

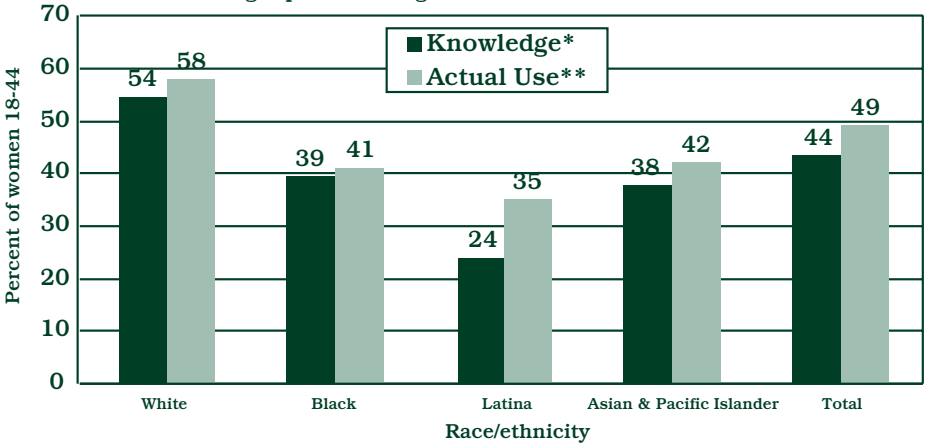
The U.S. Public Health Service recommends that women of childbearing age consume 400 micrograms (0.4 milligram) of synthetic folic acid daily to reduce the risk of having a pregnancy affected by spina bifida or anencephaly. Folic acid may be consumed by taking a vitamin supplement or eating fortified breakfast cereals or other fortified foods. Folic acid, when taken one month before conception and throughout the first trimester of pregnancy, has proven to reduce the risk of a neural tube defect (NTD)-affected pregnancy by 50% to 70%.[1]

Respondents to the 2000 California Women's Health Survey were asked if they had heard or read about folic acid, why folic acid is recommended for women, and whether they were currently taking a prenatal vitamin, multivitamin, or another pill containing the B vitamin folate or folic acid. Responses were analyzed for women of childbearing age (18 through 44 years).

- While 64% of women of childbearing age had heard or read of folic acid or folate, only 44% knew of its importance in reducing birth defects, and 49% were taking supplements with folic acid.
- Higher education was associated with increased awareness and use of folic acid; 35% of women who had not completed high school had heard or read about folic acid compared to 68% of those who completed high school or more. Also, 32% of women who had not completed high school were taking a folic acid supplement compared to 52% of those who completed high school or more.
- Of women who were trying to become pregnant, 59% knew folic acid can prevent birth defects and 53% were taking a folic acid supplement.
- Latina women were least likely to report knowledge (24%) or use of folic acid (35%).

[1] Burke, Beth; Lyon Daniel, Katherine; et al, Preventing Neural Tube Birth Defects: A Prevention Model and Resource Guide, Centers for Disease Control and Prevention, 1998.

Knowledge of the importance of folic acid in birth defects prevention and actual use of multi-vitamins and folic acid supplements among reproductive age women 18-44, California, 2000.



* Respondents who had knowledge of the importance of folic acid in preventing birth defects.

** Use may be higher than knowledge because women may use prenatal/multi-vitamins for other reasons.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

CHLAMYDIA TESTING AMONG CALIFORNIA WOMEN 1998, 1999, AND 2000

Sexually Transmitted Disease Control Branch, California Department of Health Services

Public Health Message:

Fewer than half of women for whom chlamydia screening was recommended actually reported having had a chlamydia test in the past year. Increased public and provider awareness about chlamydia is needed to improve screening rates.

Chlamydia trachomatis, a sexually transmitted infection, is the most commonly reported communicable disease in California.[1] Untreated infections in women are associated with an increased risk of adverse reproductive health outcomes such as pelvic inflammatory disease and infertility.

In 1998, the Centers for Disease Control and Prevention recommended that ***all*** sexually active girls under 20 and women ages 20-24 with multiple sex partners or new sex partners should be tested for chlamydia.

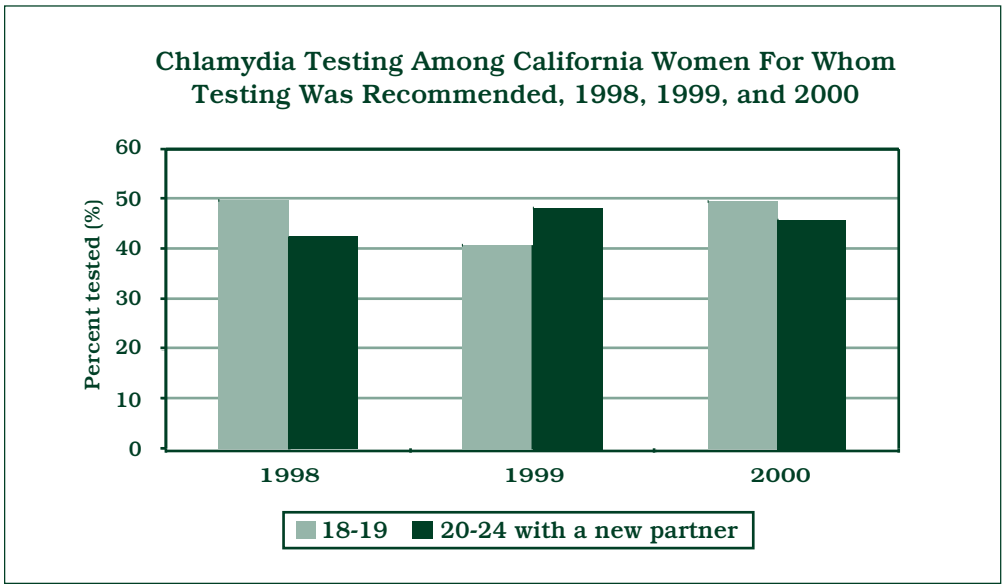
Because most women with chlamydia have no symptoms or noticeable signs of infection, testing is necessary to identify these infections for timely treatment.

From 1998 through 2000, California Women's Health survey participants were asked, ***"Have you been tested for chlamydia during the past 12 months?"*** Women who had had at least one male sexual partner were also asked, ***"During the past 12 months, did you have a new male sexual partner?"***

- In 1998, 50% of sexually active 18 to 19 year olds reported a chlamydia test in the past year. In 1999 and 2000, the percentage of 18 to 19 year olds tested was 41% and 50% respectively.
- In 1998, 22% of women ages 20 to 24 reported having had a new sex partner; in 1999, 20% of 20 to 24 year olds reported a new sex partner; and, in 2000, 28% of 20 to 24 year olds reported a new sex partner.
- In 1998, 42% of women ages 20 to 24 with new sex partners reported having been tested. In 1999 and 2000, these percentages were 48% and 46%, respectively.

The California Department of Health Services Sexually Transmitted Disease Control Branch has initiated the Chlamydia Awareness and Prevention Program and the Get Tested Program. These two programs are designed to increase awareness of chlamydia and to increase testing among those who may have been exposed.

1. Sexually Transmitted Disease in California, 1999. California Department of Health Services, STD Control Branch, July 2001.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

GENITAL HERPES KNOWLEDGE AND DIAGNOSIS AMONG CALIFORNIA WOMEN, 1999

Sexually Transmitted Disease Control Branch,California Department of Health Services

Public Health Message:

Women surveyed were poorly informed about asymptomatic herpes and asymptomatic herpes transmission.

Genital herpes (HSV-2) is one of the most prevalent sexually transmitted diseases in the United States. The third National Health and Nutrition Examination Survey (NHANESIII) found a prevalence of almost 22% for HSV-2 among individuals over 12 years old.[1] The majority of those infected are unaware of their infections, and asymptomatic individuals are able to shed virus and transmit infection to their partners. The California Women's Health Survey asked 2,479 women ages 18 to 44 two questions about genital herpes. These are as follows: ***"True or False: Most genital herpes is spread from a sexual partner when he or she is having a genital herpes outbreak (such as a sore or blister)."*** and ***"True or False: Most people infected with genital herpes know they have it."***

- Overall, 80% of women believed incorrectly that most HSV-2 transmission occurs during an outbreak.
- An additional 47% of women believed incorrectly that most people are aware of their herpes status.

Older women were more likely to have misinformation about genital herpes.

- Of women ages 35 to 44, 87% believed incorrectly that most HSV-2 transmission occurs during an outbreak, compared to 81% of 25 to 34 year olds and 73% of 18 to 24 year olds.
- Of women ages 35 to 44, about 52% mistakenly believed that most people infected with herpes know it. This question was also answered incorrectly by 46% of 25 to 34 year olds and 36% of 18 to 24 year olds.

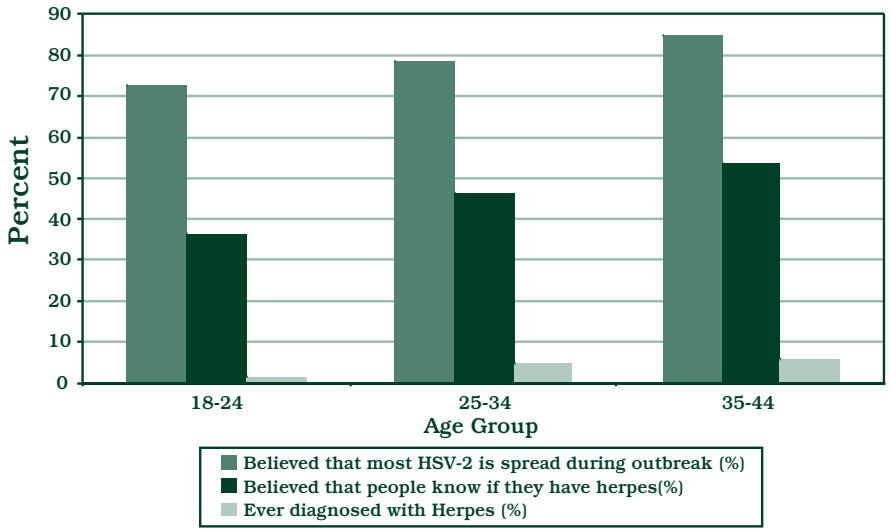
Women participating in the survey were asked if they could remember ever having been diagnosed with genital herpes.

- Of women surveyed, 4.3% reported having had a herpes diagnosis.

Age of first intercourse was also related to herpes diagnosis. The mean age of first intercourse among those reporting a diagnosis was 16 years compared to 18 years among those who did not report a herpes diagnosis.

1. Fleming, D.T., et al., Herpes simplex virus type 2 in the United States, 1976 to 1994. N Engl J Med, 199. 337(16):p. 1105-1

Herpes Knowledge and Diagnoses Among California Women Ages 18 to 44, 1999



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

DOUCHING AMONG CALIFORNIA WOMEN OF REPRODUCTIVE AGE, 2000

Sexually Transmitted Disease Control Branch, California Department of Health Services

Public Health Message:

More than a quarter of the women surveyed reported douching, a health behavior associated with genital infection and poor reproductive health.

Vaginal douching has been associated with a number of reproductive health problems in women. Douching disrupts the vaginal flora and increases the risk for pelvic inflammatory disease, ectopic pregnancy, sexually transmitted infections including HIV, and bacterial vaginosis. Douching may also be associated with infections of the urinary tract.

Women ages 18 to 44 were asked; ***"During the past 12 months, have you douched?"*** Women answering yes were also asked, ***"How often do you douche?"***

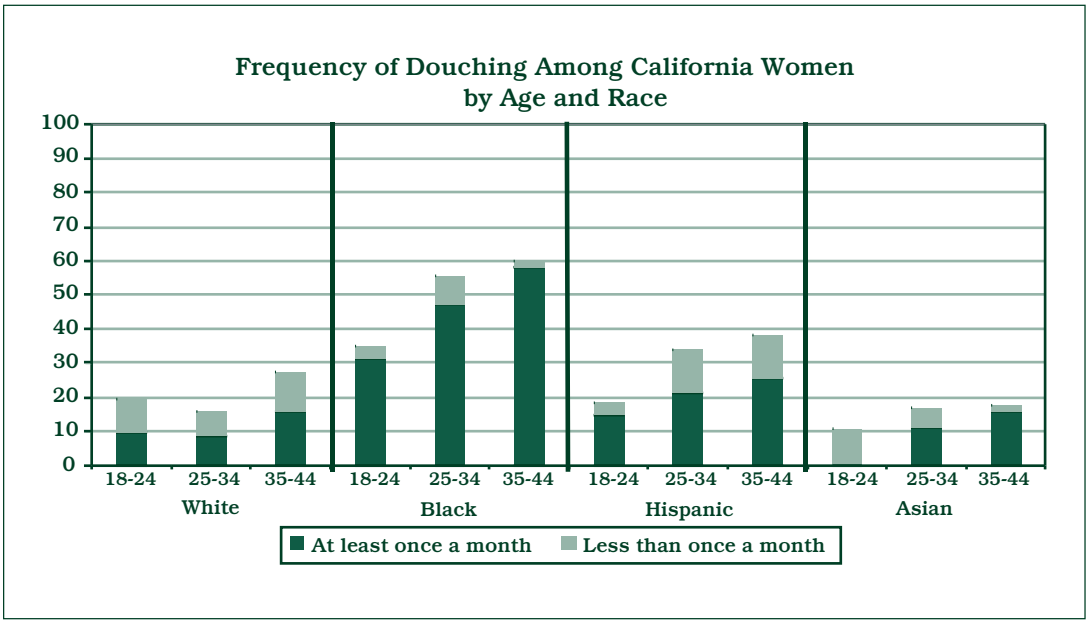
- Of women surveyed, 26% of women had douched at least once during the past 12 months. An additional 17% had douched at least once a month.
- Older women were more likely to report frequent douching than were younger women: 21% of women ages 35 to 44 reported douching at least once a month compared to 12% of women ages 18 to 24.

Ethnicity was related to douching practices.

- African American women were more likely to have douched in the past year than were women of other ethnic groups.
- The proportion of women who reported douching at least once a month varied by ethnic group: 47% of Black/African American women reported this practice compared to 12% of White women, 21% of Hispanic women and 11% of Asian women.

Lower educational status was related to more frequent douching.

- Of women with less than a college education, 34% reported douching compared to only 20% who had at least some college education.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

MAMMOGRAMS AMONG WOMEN AGES 40 AND ABOVE, CALIFORNIA, 1997-2000

Cancer Detection Section, California Department of Health Services

Public Health Message:

Nearly 40% of California women surveyed 40 years and older are not regularly receiving mammograms. Regular screening for breast cancer leads to early diagnosis and can greatly reduce mortality due to breast cancer. It is recommended that women 40 years and older have yearly mammograms and clinical breast exams.

Breast cancer is the second leading cause of deaths due to cancer among California women; only lung cancer accounts for more cancer deaths.[1] Although fewer women are dying from breast cancer today due to better treatment and earlier diagnosis, it is still the most commonly diagnosed cancer among California women.[2]

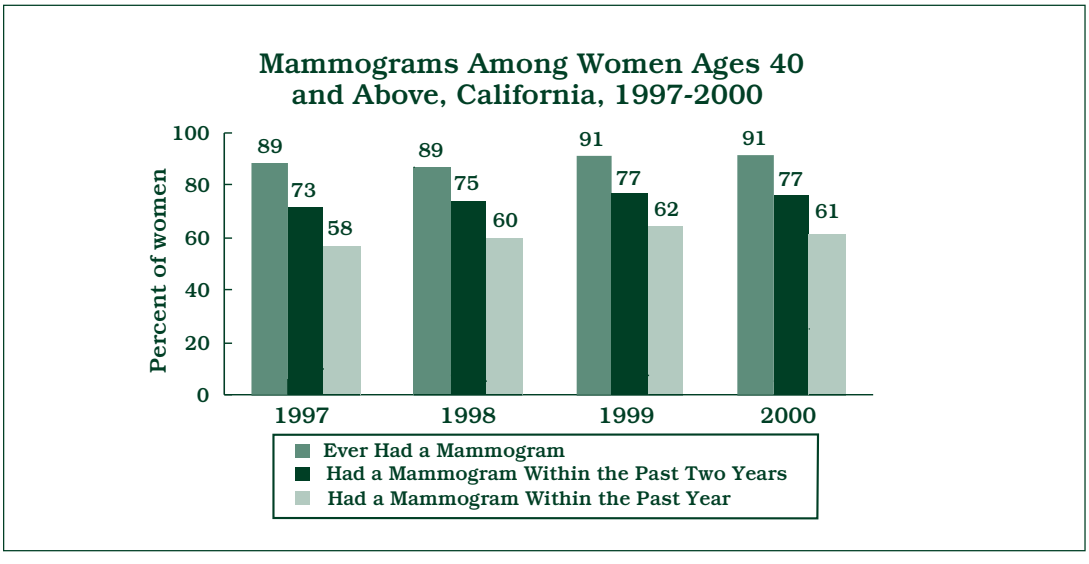
One way to reduce the number of deaths due to breast cancer is to detect the disease at an early and more treatable stage. While mammography is not always 100% accurate, it is an effective early-stage screening method that can detect a cancer up to several years before it can be felt on examination. The American Cancer Society and the California Department of Health Services recommend that women 40 years and older be regularly screened for breast cancer by having a clinical breast exam and a mammogram once a year.

Since 1997, the California Women's Health Survey has asked women if they ever had a mammogram, and how long it had been since they had their last mammogram. Respondents who ever had a mammogram could answer that their last mammogram was within the past one, two, three, or five years, or over five years ago. This analysis is based on 2,331 (1997), 2,142 (1998), 2,343 (1999), and 2,273 (2000) women ages 40 and older participating in the surveys. Women who reported being previously diagnosed with breast cancer (only 5% of all women surveyed who ever had a mammogram) were included.

- Over the last four years, the percent of women reporting having their last mammogram within the past year remained approximately the same, at 58% in 1997, 60% in 1998, 62% in 1999, and 61% in 2000.
- Each year, the majority (67%) of women who reported ever having a mammogram had their last mammogram within the past year (not shown on graph).
- In 2000, 39% of women reported *not* having a mammogram within the past year; an indication that nearly 40% of women are not being regularly screened for breast cancer.

[1] Kwong SL, Perkins CI, Morris CR, Cohen R, Allen M, Schlag R, Wright WE. Cancer in California: 1988-1998. Sacramento, CA: California Department of Health Services, Cancer Surveillance Section, December 2000.

[2] American Cancer Society, California Division, and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures, 2001. Oakland, CA: American Cancer Society, California Division, September 2000.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

MAMMOGRAMS AMONG WOMEN AGES 40 AND ABOVE, BY RACE/ETHNICITY, CALIFORNIA, 2000

Cancer Detection Section, California Department of Health Services

One way to reduce the number of deaths due to breast cancer is to detect the disease at an early, more treatable stage. While mammography is not always 100% accurate, it is an effective early-stage screening method which can detect a cancer up to several years before it can be felt on examination. The American Cancer Society and the California Department of Health Services recommend that women 40 years and older be regularly screened for breast cancer by having a clinical breast exam and a mammogram once a year.

Scientific research has shown that breast cancer mortality varies by race/ethnicity.[1,2] It is therefore important to examine mammography among California women by racial/ethnic group in order to identify populations that need to be addressed by public health programs.

The 2000 California Women's Health Survey asked women if they ever had a mammogram, and how long it had been since they had their last mammogram. Respondents who ever had a mammogram could answer that their last mammogram was within the past one, two, three, or five years, or over five years ago. The analysis is based on 2,273 women ages 40 and older participating in the survey. Women who reported being previously diagnosed with breast cancer (only 5% of all women surveyed who ever had a mammogram) were included.

- Fifty-three percent of Asian/Other women, 58% of Black women, and 59% of Hispanic women reported having a mammogram within the past year, while 63% of White women reported having a mammogram within the past year.

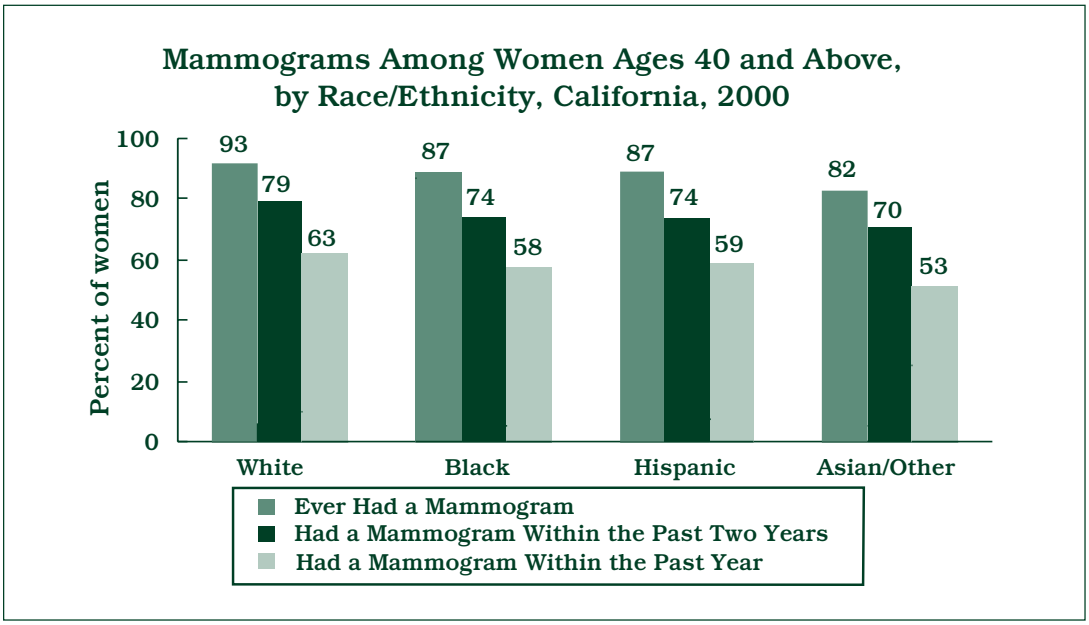
- Of women reporting ever having a mammogram, 65% of Asian/Other women, 67% of Black women, 68% of Hispanic women, and 68% of White women reported having their last mammogram within the past year (not shown in graph).

[1] O'Malley MS, Earp JAL, Hawley ST, Schell MJ, Mathews 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.

[2] American Cancer Society, California Division, and Public Health Institute, California Cancer Registry. California Cancer Facts and Figures, 2001. Oakland, CA: American Cancer Society, California Division, September 2000.

Public Health Message:

Variations in breast cancer mortality by racial/ethnic group are noted in the literature. The data suggest that there are differences in regular mammography by different racial/ethnic groups. Messages for regular mammogram screening should target all women ages 40 years and above, in particular non-White populations.



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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

MAMMOGRAMS AMONG WOMEN AGES 40 AND ABOVE, BY INCOME STATUS, CALIFORNIA, 2000

Cancer Detection Section, California Department of Health Services

One way to reduce the number of deaths due to breast cancer is to detect the disease at an early, more treatable stage. While mammography is not always 100% accurate, it is an effective early-stage screening method which can detect a cancer up to several years before it can be felt on examination. The American Cancer Society and the California Department of Health Services recommend that women 40 years and older be regularly screened for breast cancer by having a clinical breast exam and a mammogram once a year.

Scientific studies have shown that barriers to mammography, such as lack of economic resources, disproportionately affect low income women.[1] It is therefore important to examine mammography among California women by income status in order to identify populations which need to be addressed by public health programs.

The 2000 California Women's Health Survey asked women if they ever had a mammogram, and how long it had been since they had their last mammogram. Respondents who ever had a mammogram could answer that their last mammogram was within the past one, two, three, or five years, or over five years ago. The analysis is based on 2,273 women ages 40 and older participating in the survey. Women who reported being previously diagnosed with breast cancer (only 5% of all women surveyed who ever had a mammogram) were included. Low income is defined as having a household income equal to or less than 200% of the Federal Poverty Level (FPL), and higher income is defined as having a household income greater than 200% of the FPL.

- Of low income women, 86% reported having a mammogram at some point in their lives, compared to 92% of higher income women.
- A greater disparity exists between low and higher income women in reported regular mammography. Of higher income women, 64% reported having their last mammogram within the past year, while 53% of low income women reported having a mammogram within the past year.

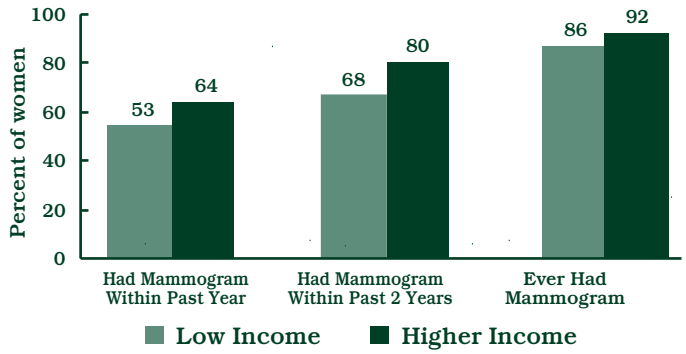
The California Department of Health Services is working to close the economic gap in mammography screening rates. Cancer Detection Section programs such as the Breast Cancer Early Detection Program (BCEDP) and Breast and Cervical Cancer Control Program (BCCCP) provide breast cancer screening and diagnostic services to uninsured and underinsured women of low income.

[1] O'Malley MS, Earp JAL, Hawley ST, Schell MJ, Mathews 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.

Public Health Message:

Messages for regular mammogram screening and access to services should particularly target low income women. Through outreach efforts, low income women 40 years or older who have no or limited health insurance coverage are encouraged to access breast cancer screening and diagnostic services such as that provided by the California Department of Health Services.

Mammograms Among Women Ages 40 and Above, by Income Status, California, 2000



Low Income is defined as having a household income equal to or less than 200% of the Federal Poverty Level (FPL), and Higher Income is defined as having a household income greater that 200% of the FPL.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

WOMEN AGES 40 AND ABOVE WHO HAD A MAMMOGRAM WITHIN THE PAST YEAR, BY AGE AND INCOME STATUS, CALIFORNIA, 2000

Cancer Detection Section, California Department of Health Services

The risk of being diagnosed with breast cancer increases with age; about 18% of breast cancer diagnoses occur in women in their forties[1], while 77% of new cases occur in women 50 years and older.[2] Women over 50 years also have the greatest risk of dying from breast cancer.[3]

One way to reduce the number of deaths due to breast cancer is to detect the disease at an early, more treatable stage. While mammography is not always 100% accurate, it is an effective early-stage screening method which can detect a cancer up to several years before it can be felt on examination. The American Cancer Society and the California Department of Health Services recommend that women 40 years and older be regularly screened for breast cancer by having a clinical breast exam and a mammogram once a year.

The 2000 California Women's Health Survey asked women if they ever had a mammogram, and how long it had been since they had their last mammogram. Respondents who had ever had a mammogram could answer that their last mammogram was within the past one, two, three, or five years, or over five years ago. The analysis is based on 2,067 women ages 40 and older who reported a household income. Women who reported being previously diagnosed with breast cancer (only 3% of women surveyed who reported a household income and who had a mammogram within the past year) were included. Low income is defined as having a household income equal to or less than 200% of the Federal Poverty Level (FPL), and higher income is defined as having a household income greater than 200% of the FPL.

- Income is less of a factor in getting a mammogram within the past year in women under 50 years compared to women 50 years and older. Across all age groups of women 50 years and older, a smaller proportion of low income women reported having a mammogram within the past year compared to higher income women.

- Although women with Medicare have annual mammography coverage[4], only 58% of low income women age 65 and older reported having a mammogram within the past year, compared to 71% of higher income women (not presented in the graph).

The California Department of Health Services is working to close the economic gap in mammography screening rates. Cancer Detection Section programs such as the Breast Cancer Early Detection Program (BCEDP) and Breast and Cervical Cancer Control Program (BCCCP) provide breast cancer screening and diagnostic services to uninsured and underinsured women of low income.

[1] American Cancer Society, Mammography Guidelines for Asymptomatic Women. 2000. www3.cancer.org/cancerinfo.

[2] American Cancer Society, Cancer Resource Center, National Breast Cancer Awareness Month, Fast Facts. www.cancer.org.

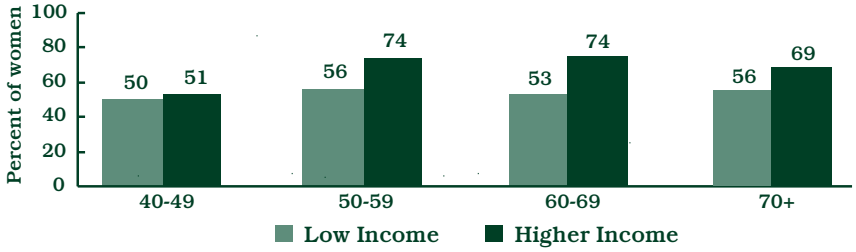
[3] Ibid.

[4] Medicare and You, Your Medicare Benefits, 2000. Health Care Financing Administration. www.hcfa.gov

Public Health Message:

Messages should emphasize the importance of regular breast cancer screening among women ages 40 and over with emphasis on those over 50 years. Outreach efforts should direct low income uninsured or underinsured women ages 40 and over to programs such as California Department of Health Services Breast Cancer Early Detection Program (BCEDP) and Breast and Cervical Cancer Control Program (BCCCP) to receive screening and diagnostic services.

Women Ages 40 and Above Who Had a Mammogram Within the Past Year, by Age and Income Status, California, 2000



Low Income is defined as having a household income equal to or less than 200% of the Federal Poverty Level (FPL), and Higher Income is defined as having a household income greater that 200% of the FPL.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

HEALTH INSURANCE STATUS OF NON-ELDERLY ADULT WOMEN AGES 18 - 64 WITH SELECTED SOCIO-DEMOGRAPHIC CHARACTERISTICS, CALIFORNIA, 2000

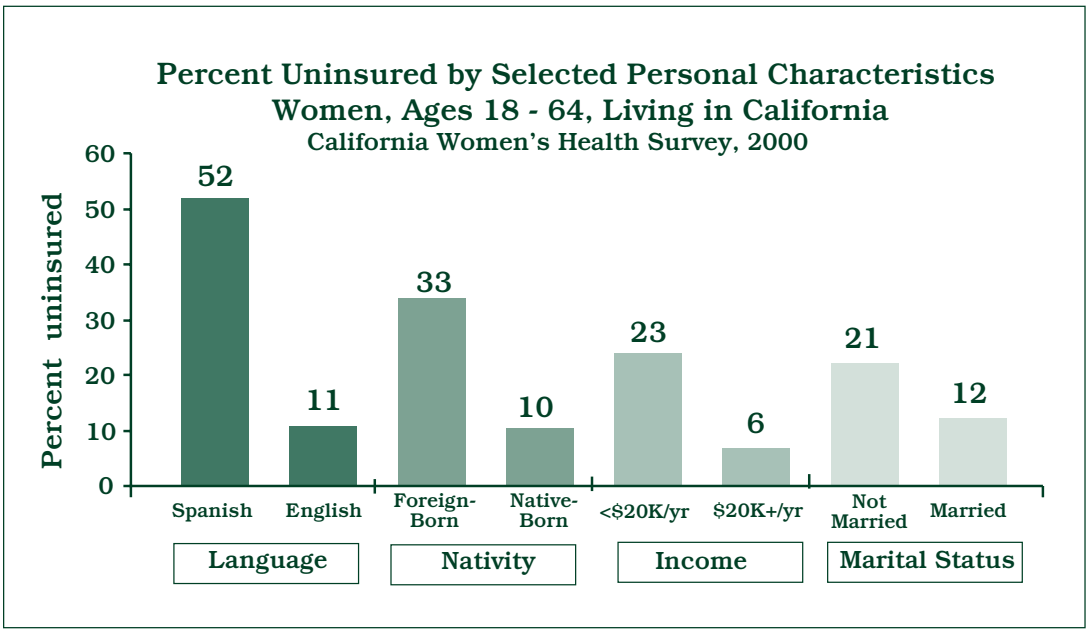
Maternal and Child Health Branch, California Department of Health Services

Health insurance status is a critical determinant of access to health care services. Women who lack health insurance or who have gaps in insurance coverage may not receive needed health and medical care services, including preventive medical services, for chronic conditions and/or episodic illnesses. It is incumbent upon medical and public health professionals to develop a comprehensive understanding of the populations most likely to be without health insurance. Having such an understanding will facilitate programmatic and policy-oriented efforts designed to reduce the burden associated with lack of insurance in California.

The 2000 California Women's Health Survey (CWHS) gathered from each respondent information about her health insurance status, age, nativity, marital status, educational attainment, employment status, personal income, and race/ethnicity. The purpose of this paper is to augment previous work on health insurance coverage status (*Data Points, Issue 2, Numbers 12 and 13*). In the present study, insurance status by sociodemographic characteristics was determined. At the time of the survey:

- Of the women who completed the CWHS in Spanish, 52% were uninsured vs. 11% of those completing the survey in English.
- Of the foreign-born women who completed the CWHS, 33% were uninsured vs. 10% of native-born women.
- Twenty-three percent of women with personal incomes below $20,000 per year were uninsured vs. 6% of those with higher incomes.
- One in five (21%) unmarried women was uninsured vs. one in eight (12%) married women.

Attempts to increase the proportion of California women who have health insurance will need to recognize the contributions marital status and personal income have in influencing one's insurance status. Further, such efforts will need to target Hispanic women with a preference for oral communication in Spanish and women born outside of the United States.



Public Health Message:

Prudent public health efforts are needed not only to identify those California women who lack health insurance coverage but also to enable them to acquire appropriate coverage. In doing so, the burden of uninsuredness on the State of California will be reduced.

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RESULTS FROM THE CALIFORNIA WOMEN'S HEALTH SURVEY

HOW ACCURATE ARE WOMEN IN ASSESSING THEIR PREGNANCY WEIGHT GAINS? CALIFORNIA, 2000

Maternal and Child Health Branch, California Department of Health Services

The amount of weight a woman gains during her pregnancy (gestational weight gain [GWG]), which is related to her pre-pregnancy weight, is clinically important because it is correlated with fetal growth. Accordingly, the National Institute of Medicine (IM) for all Body Mass Index (BMI) groups has established recommended GWGs. (BMI is the ratio of an individual's weight divided by the square of her or his height.)

The 2000 California Women's Health Survey asked women to report their pre-pregnancy weight and height, GWG, and self-assessed appropriateness of GWG (with possible responses of too little, just right, and too much). Using information on pre-pregnancy weight and height, each respondent who had given birth within the prior five years (N = 537) was stratified to the appropriate BMI group. Next, her self-reported GWG during her most recent pregnancy was compared to the IM BMI-specific guideline to ascertain the IM BMI-specific appropriateness of GWG (low, appropriate, and high). This measure was then compared to the respondent's self-assessed appropriateness of GWG. Notably, there was a low level of agreement between women's IM BMI-specific appropriateness of GWG and their self-assessed appropriateness of GWG. Self-assessments by women of what is an appropriate GWG are poor, across all BMI groups.

More than half of women inaccurately self-assessed the appropriateness of their GWGs (not shown in chart).

Nearly nine in ten (87%) women whose GWG was below the IM BMI-specific appropriateness of GWG believed it was either just right or too much, while a similar proportion (88%) of women whose GWG was above the IM BMI-specific appropriateness of GWG believed it was either just right or too little.

Three in ten (31%) women whose GWG was within the IM BMI-specific appropriateness of GWG believed it was either too little or too much.

The National Institute of Child Health and Human Development has identified three maternal factors associated with birthing underdeveloped (i.e., low birthweight) babies, including diet and weight gain during pregnancy. Given that women's self-assessments of the appropriateness of their GWGs are largely at odds with the IM BMI-specific appropriateness of their GWGs, fostering an understanding by pregnant women of the recommended IM BMI-specific guidelines may assist them in modifying their behaviors during pregnancy. In doing so, these women may be more likely to gain adequate weight and give birth to normal birthweight babies.

Public Health Message:

Given that women's self-assessments of their gestational weight gain (GWG) are often at odds with the GWG ranges recommended by the National Institute of Medicine (IM), it is important that pregnant women know their proper pregnancy weight gain ranges and monitor their weight gains during their pregnancies.

How Accurate Are Women In Assessing Their Pregnancy Weight Gains? California 2000

IM BMI-Specific Appropriateness of GWG	Agreement of Self-Assessed Appropriateness of GWG		
	% Women Too Little	% Women Just Right	% Women Too Much
Low GWG	13.3	69.6	17.1
Appropriate GWG	3.2	68.8	28.1
High GWG	25.6	61.9	12.6

Percentages are row percentages and are rounded independently.
Each row of three cells sums to approximately 100.0%, because of rounding.

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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 policymakers. 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, administers 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" (As defined by the preceding year's Federal Register). 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 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

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

Survey Research Group of the Public Health Institute, 1700 Tribute Road, Suite 100, Sacramento, CA 95815, (916) 779-0338

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

California Department of Social Services, 744 P Street, Sacramento, 95814, (916) 654-1327

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.

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Additional copies of the 1999 and 2000 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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