



PRECONCEPTION HEALTH: SELECTED MEASURES, CALIFORNIA, 2005



Maternal, Child and Adolescent
Health Program
Center for Family Health
California Department of
Public Health

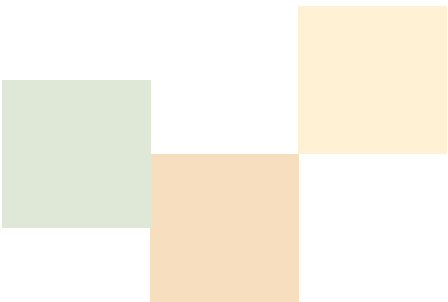
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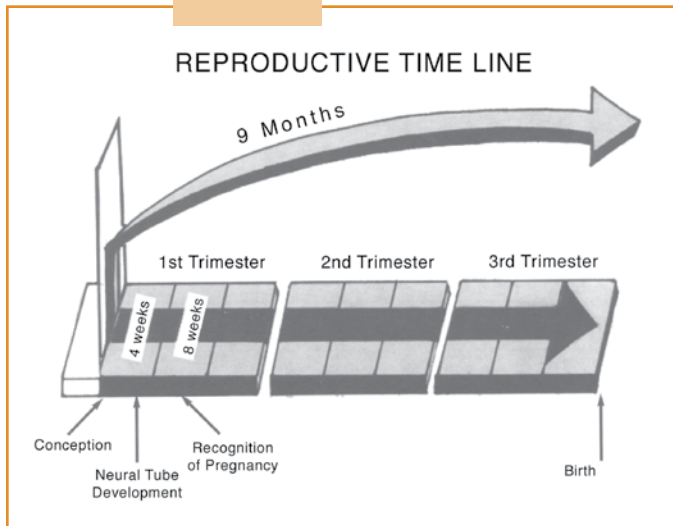
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ACKNOWLEDGMENTS	i
INTRODUCTION	2
UNINTENDED PREGNANCY	4
SMOKING	5
ALCOHOL CONSUMPTION	6
FOLIC ACID CONSUMPTION	7
MENTAL HEALTH	8
INTIMATE PARTNER PHYSICAL VIOLENCE	9
OVERWEIGHT AND OBESITY	10
DIABETES	11
CALIFORNIA AT A GLANCE	12

INTRODUCTION

The most critical periods of fetal development occur in the earliest weeks following conception, before many women even know they are pregnant (see figure). Since prenatal care usually begins at week 11 or 12, it is often too late to prevent a number of adverse maternal and infant health outcomes. In addition, because so many pregnancies are unplanned (41% among 18-44 year old women giving birth in California in 2005), women frequently conceive while in less than optimal health or while engaging in behaviors that can harm a pregnancy. A healthy pregnancy outcome is influenced by a woman's medical history and preconception health status.¹



Reproductive Time Line⁵

Even though 84% to 87% of California mothers received prenatal care in the first trimester during 2000-2005, birth outcomes have not improved. In 2005, 11.2% of infants were born preterm, 6.9% were born with low birthweight, and during the past several years, the infant mortality rate has remained fairly stable at about 5.3 deaths per 1000 live births. The pregnancy-related maternal mortality rate has demonstrated an upward trend since 1999, with the 2004 rate at 13.6 per 100,000 live births.² African-American infants in California are over two-and-a-half times more likely than White infants to die before their first birthday, and African-American mothers have a pregnancy-related mortality rate three times higher than that of Whites.²

Early prenatal care is not enough and, in many cases, may be too late. Several proven interventions recommended during pregnancy are more effective and beneficial if implemented before conception. Moreover, women of reproductive age may suffer from a variety of chronic conditions that could potentially contribute to poor pregnancy outcomes if untreated. For example, in 2005, California women aged 18-44 were found to have hypertension (9.3%), cardiac disease (1.6%) and asthma (13%).³

Beginning in 2003, the Centers for Disease Control and Prevention (CDC) and several partner organizations initiated the development of an agenda for preconception care, resulting in the 2005 National Summit on Preconception Care and the creation of the Select Panel on Preconception Care. In April 2006, this panel and the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Preconception Care Work Group published the Recommendations to Improve Preconception Health and Health Care.⁴ This Morbidity and Mortality Weekly Report (MMWR) publication outlines the action steps that state and local organizations may take to improve the accessibility and effectiveness of preconception care in their communities.

Building on the impetus set by CDC and with its expert support, the Preconception Care Council of California (PCCC) was convened in May 2006 with the leadership and collaboration of the Maternal, Child and Adolescent Health Program of the California Department of Public Health and the California Chapter of the March of Dimes. Composed of representatives from diverse organizations that are important stakeholders in the development of

preconception care services, PCCC serves as a forum for statewide planning and decision-making on issues and programs related to preconception care.

The concept of preconception care is not new. Rather, this health initiative proposes a paradigm that raises the level of awareness of health care professionals and other individuals interested in maternal, child and adolescent health, and reproductive life planning. Preconception care aims to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that may affect future pregnancies.⁴

The following fact sheets describe the status of preconception health in California in 2005, as indicated by the prevalence of pertinent health risks and conditions for California women of reproductive age. Due to the age limitation of the California Women's Health Survey, reproductive age is defined as 18-44 years for these fact sheets. The indicators included are unintended pregnancy, smoking, alcohol consumption, folic acid consumption, mental health, intimate partner physical violence, overweight and obesity, and diabetes.

Methodology Notes:

The topics that follow report data from the 2005 California Women's Health Survey (CWHs), an annual, population-based, telephone survey of California women 18 years and older. Since the questions pertaining to diabetes were not asked in CWHs in 2005, the fact sheet on this topic cites 2004 data. Unintended pregnancy data were obtained from the 2005 Maternal and Infant Health Assessment (MIHA) survey, an annual, population-based mail survey (with telephone follow-up to non-respondents) of California women who recently gave birth.

Demographic groups were included in the discussion of the specified condition only if there were at least two subgroups that differed from each other by a magnitude of at least 1.5 times. Some topics, therefore, reported only on differences among age and/or household federal poverty levels, while others included only race/ethnicity and/or education. A minimum sample size of 30 was required for any identification of subgroups.

¹ Anderson JE, Ebrahim S, Floyd L, Atrash H. Prevalence of risk factors for adverse pregnancy outcomes during pregnancy and the preconception period—United States, 2002-2004. *Matern Child Health J* 2006; 10:S101-S106.

² State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1991-2005. Maternal mortality is defined as deaths \leq 42 days postpartum; pregnancy-related mortality is defined as deaths \leq 365 days postpartum. Produced by California Department of Public Health, Maternal, Child and Adolescent Health Program, August 2007.

³ California Health Interview Survey, 2005. The California Health Interview Survey is a biennial survey using a two-stage, geographically stratified random-digit-dial (RDD) design to produce a sample that is representative of the California population.

⁴ Johnson K, Posner SF, Biermann MS, Cordero JF, Atrash HK, Parker CS, Boulet S, Curtis MG. Recommendations to improve preconception health and health care—United States. A report of the CDC/ATSDR preconception care work group and the select panel on preconception care. *MMWR Recommendations and Reports* 2006; 55(RR06): 1-23.

⁵ Centers for Disease Control and Prevention. Preventing Neural Tube Birth Defects: A Prevention Model and Resource Guide. Available at: http://www.cdc.gov/Images/_Video_and_Audio/Images/Folic_Acid/Preventing_Neural_DefectsFinal2002_2003.pdf. Accessed October 15, 2007.

UNINTENDED PREGNANCY

AMONG CALIFORNIA WOMEN 18-44 YEARS OLD
WITH A RECENT LIVE BIRTH, 2005

Women with unintended pregnancy often have elevated risk behaviors that result in poor pregnancy outcomes.¹ The California Maternal and Infant Health Assessment (MIHA) survey assesses some of these, including the following 2005 findings:

- Folic acid use prior to pregnancy, every day or almost every day
 - 40% of women with an intended pregnancy took a folic acid supplement or a multivitamin containing folic acid
 - 18% of women with unintended pregnancy took folic acid
- Obtained timely (first trimester) prenatal care
 - Intended pregnancy – 90%
 - Unintended pregnancy – 80%
- Alcohol use during first trimester
 - Intended pregnancy – 11%
 - Unintended pregnancy – 17%

How common is unintended pregnancy among California women with a recent live birth?

- The frequency of unintended pregnancy was 41%, down from 47% in 1999
- California had the eighth lowest percent of unintended pregnancy among women with live births among the 20 states using the postpartum Pregnancy Risk Assessment Monitoring System (PRAMS)² survey or MIHA (California only) in 2003

Which women are more likely to experience unintended pregnancy?

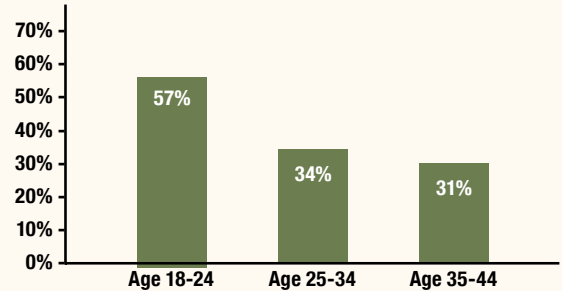
- Younger women (18-24) were more likely than older women
- Non-Hispanic African-American women were more likely than non-Hispanic White or Hispanic women
- Women whose household incomes were within 200% of the federal poverty level (FPL) were more likely than those with household incomes over 200% of the FPL
- Women with less than a college degree were more likely than women who had graduated from college

Source: The 2005 Maternal and Infant Health Assessment (MIHA) survey, an annual survey of a representative sample of women who recently gave birth in California.

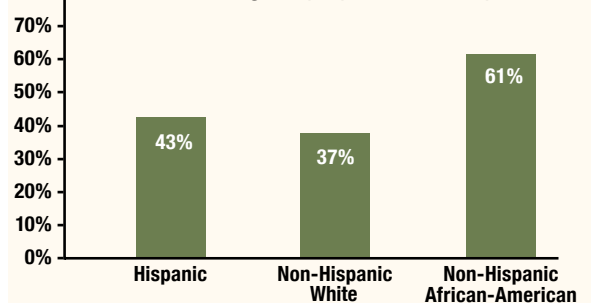
¹ Hellerstedt WL, Pirie PL, Lando HA, Curry SJ, McBride CM, Grothaus LC, Nelson JC. Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *Am J Public Health* 1998;88:663-666.

² Suellentrop K, Morrow B, Williams L, D'Angelo D. Monitoring progress toward achieving maternal and infant *Healthy People 2010* objectives—19 states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000-2003. *MMWR Surveillance Summaries* October 6, 2006;55(SS09):1-11.

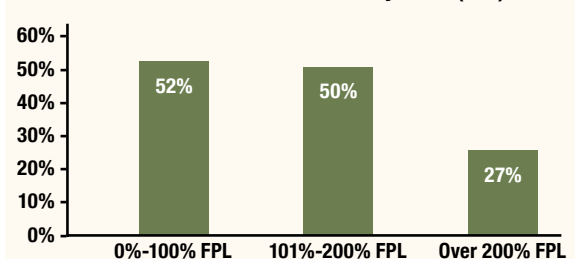
Percentage of Women, Aged 18-44, with a Live Birth & Unintended Pregnancy, by Age at Delivery



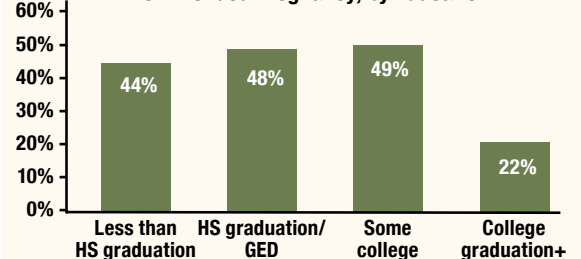
Percentage of Women, Aged 18-44, with a Live Birth & Unintended Pregnancy, by Race/Ethnicity



Percentage of Women, Aged 18-44, with a Live Birth & Unintended Pregnancy, by Family Income as a Percent of Federal Poverty Level (FPL)



Percentage of Women, Aged 18-44, with a Live Birth & Unintended Pregnancy, by Education



HS = High School
GED = General Education Development Test

SMOKING

AMONG NON-PREGNANT CALIFORNIA WOMEN 18-44 YEARS OLD, 2005

Women who quit smoking before or early in pregnancy significantly reduce their risk for adverse pregnancy outcomes. Smoking during pregnancy increases the likelihood of:¹

- Preterm birth
- Low birthweight
- Stillbirth
- Infant mortality
- Placenta previa
- Placental abruption
- Sudden Infant Death Syndrome (SIDS)

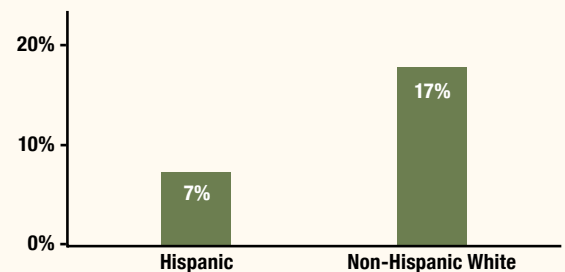
How common is smoking among non-pregnant California women of reproductive age?

- 14% smoked
 - Decreased from 18% in 1997
 - Less than the national average of 20.6% for women (pregnant and non-pregnant) aged 18-44 in 2006²

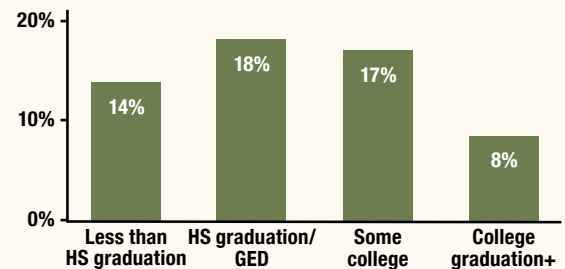
Which women are more likely to smoke?

- Non-Hispanic White women were more likely than Hispanic women
- Women without a college degree were more likely than college graduates

Percentage of Non-pregnant Women, Aged 18-44, Currently Smoking, by Race/Ethnicity



Percentage of Non-pregnant Women, Aged 18-44, Currently Smoking, by Education



HS = High School
GED = General Education Development Test

Source: All California numbers, unless otherwise specified, are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ U.S. Department of Health and Human Services. Smoking among adults in the U.S.: Reproductive Health. In The Health Consequences of Smoking: A Report of the Surgeon General (525-602). Rockville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics, 2004.

² Centers for Disease Control and Prevention. National Health Interview Survey 2006, Released 6/2007. Available at: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease200706.pdf>. Accessed September 20, 2007.

ALCOHOL CONSUMPTION

AMONG NON-PREGNANT CALIFORNIA WOMEN
18-44 YEARS OLD, 2005

There is no known safe amount of alcohol use in pregnancy. The U.S. Surgeon General urges women who are pregnant or may become pregnant to abstain from alcohol.¹ Since damage to the fetus can occur at any time after conception, health professionals are advised to ask women of childbearing age about alcohol consumption and to inform them of its adverse effects.

Alcohol consumption during pregnancy increases the likelihood of having a baby with birth defects that manifest as:¹

- Impaired intellectual development
- Behavioral disorders
- Central nervous system impairment
- Facial abnormalities
- Growth deficiencies

How common is alcohol consumption among non-pregnant California women of reproductive age?

- 55% had at least one alcoholic drink in the past month
 - The median for all 50 states was 50.2% for women aged 18-44 (pregnant and non-pregnant) in 2005²
- 12.5% engaged in binge drinking (consumed 5+ alcoholic drinks on at least one occasion) in the past month

Which women are more likely to have had an alcoholic drink at least once in the past month?

- Non-Hispanic White women were more likely than Hispanic women or non-Hispanic African-American women
- Women with household incomes greater than 200% of the federal poverty level were more likely than women with lower household incomes
- Women with a college degree were more likely than women with less education

Which women are more likely to have engaged in binge drinking in the past month?

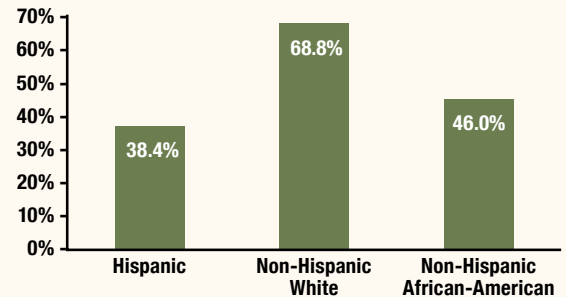
- Younger women (18-24 years old) were more likely than older women

Source: All California numbers, unless otherwise specified, are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

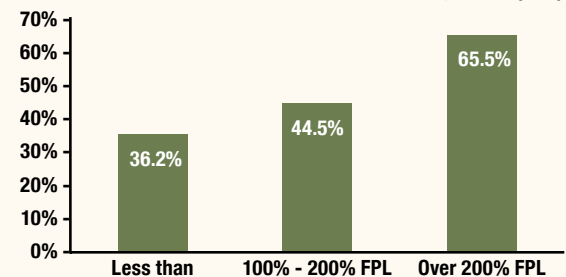
¹ Surgeon General's Advisory on Alcohol Use in Pregnancy (2005, February 21). Available at: <http://www.surgeongeneral.gov/pressreleases/sg02222005.html>. Accessed January 24, 2007.

² Centers for Disease Control and Prevention. Fetal Alcohol Spectrum Disorders. Available at: http://www.cdc.gov/ncbddd/fas/monitor_table.htm. Accessed September 20, 2007.

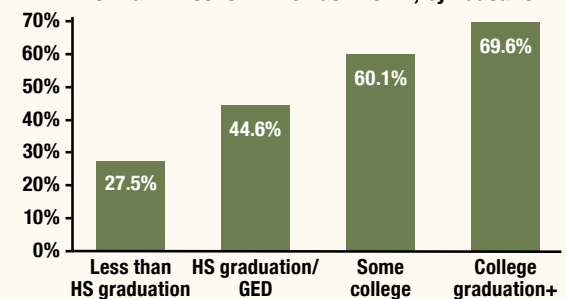
Percentage of Non-pregnant Women, Aged 18-44, Who Drank Alcohol in the Past Month, by Race/Ethnicity



Percentage of Non-pregnant Women, Aged 18-44, Who Drank Alcohol in the Past Month, by Household Income as a Percent of the Federal Poverty Level (FPL)

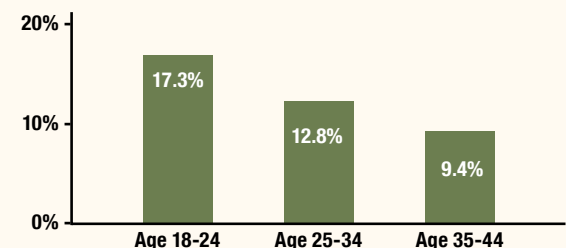


Percentage of Non-pregnant Women, Aged 18-44, Who Drank Alcohol in the Past Month, by Education



HS = High School
GED = General Education Development Test

Percentage of Non-pregnant Women, Aged 18-44, Who Drank 5 or More Alcoholic Drinks on One Occasion In the Past Month, by Age



FOLIC ACID CONSUMPTION

AMONG NON-PREGNANT CALIFORNIA WOMEN
18-44 YEARS OLD, 2005

Consuming 400 μ g of folic acid daily prior to conception has been found to reduce the risk of pregnancies affected by neural tube defects (NTDs), such as spina bifida and anencephaly, by as much as 80%.¹ Women can ensure that they are consuming the recommended amount of folic acid by eating one serving of breakfast cereal fortified with 100% of the recommended daily value of folic acid or by taking a 400 μ g folic acid-containing supplement daily.²

NTDs affect 1 in every 1,480 pregnancies in California.³ They are more frequent in pregnancies of women in the following groups:⁴⁻⁶

- Hispanic ethnicity
- Young
- Obese
- Poor diet quality

Even among high risk populations, daily folic acid consumption prior to conception may successfully decrease NTD-affected pregnancies.⁷

The Healthy People 2010 national objective for consumption of at least 400 μ g of folic acid daily is 80% of 15- to 44-year-old women.

How common is daily folic acid consumption among non-pregnant California women of reproductive age?

- 34% took a folic acid-containing supplement daily

Which women are less likely to consume a folic acid-containing supplement?

- Younger women were less likely than older women
- Hispanic women were less likely than non-Hispanic African-American or non-Hispanic White women
- Women with household incomes below 100% of the federal poverty level were less likely than women with higher household incomes
- Women who had less education were less likely than women who had more education

Source: All California numbers, unless otherwise specified, are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ Berry RJ, Li Z, Erickson JD, Li S, Moore CA, Wang H, Mulinare J, Zhao P, Wong LY, Gindler J, Hong SX, Correa A. Prevention of neural tube defects with folic acid in China. *N Engl J Med* 1999; 341(2):1485-1490.

² Burke B, Lyon Daniel K, Latimer A, Mersereau P, Moran K, Mulinare J, Prue C, Steen J, Watkins M. Preventing Neural Tube Defects: A Prevention Model and Resource Guide. Centers for Disease Control and Prevention;1998.

³ California Birth Defects Monitoring Program. Available at: http://www.cbddmp.org/bd_neural.htm. Accessed September 11, 2007.

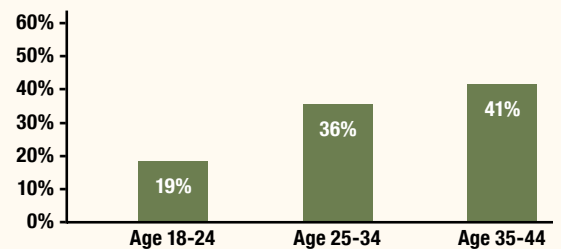
⁴ Shaw GM, Velie EM, Schaffer D. Risk of neural tube defect-affected pregnancies among obese women. *JAMA* 1996;275(14):1093-1096.

⁵ Carmichael SL, Shaw GM, Selvin S, Schaffer DM. Diet quality and risk of neural tube defects. *Med Hypotheses* 2003; 60(3):351-355.

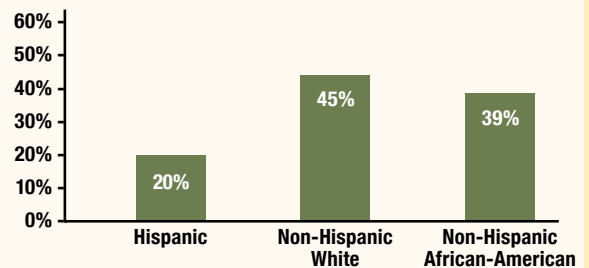
⁶ Shaw GM, Velie EM, Wasserman CR. Risk for neural tube defect-affected pregnancies among women of Mexican descent and White women in California. *Am J Public Health* 1997;87(9):1467-1471.

⁷ Centers for Disease Control and Prevention. Neural tube defect surveillance and folic acid intervention—Texas-Mexico Border, 1993-1998. *MMWR* 2000;49(1):1-4.

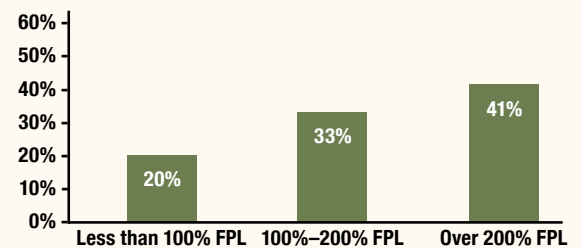
Percentage of Non-pregnant Women, Aged 18-44, Taking Daily Folic Acid, by Age



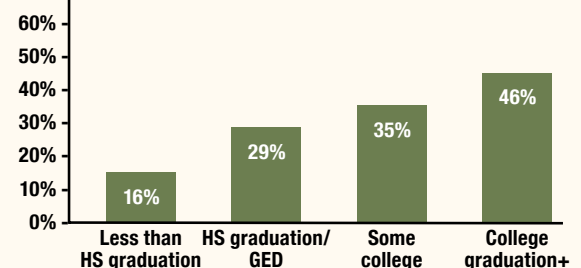
Percentage of Non-pregnant Women, Aged 18-44, Taking Daily Folic Acid, by Race/Ethnicity



Percentage of Non-pregnant Women, Aged 18-44, Taking Daily Folic Acid, by Household Income as a Percent of the Federal Poverty Level (FPL)



Percentage of Non-pregnant Women, Aged 18-44, Taking Daily Folic Acid, by Education



HS = High School
GED = General Education Development Test

MENTAL HEALTH

AMONG NON-PREGNANT CALIFORNIA WOMEN
18-44 YEARS OLD, 2005

Women with poor mental health before pregnancy, often manifested as depression, are more likely to have poor mental health during pregnancy and to experience postpartum depression.¹ Maternal-infant bonding is affected by a woman's mental health status. Children of women with postpartum depression have an increased likelihood of experiencing the following health and developmental problems:

- Injury²
- Compromised social and emotional development³
- Compromised cognitive development³

Depression can negatively influence behaviors in women such as substance use and seeking prenatal care.⁴ Treatment for depression before pregnancy may lower the risk of relapse during pregnancy⁵ and better prepares a woman and her family to anticipate and recognize perinatal recurrences.⁴

How common is “frequent mental distress” among non-pregnant California women of reproductive age?

- 13% reported “frequent mental distress” (defined as 14 or more “not good” mental health days, which includes stress, depression, and problems with emotions, in the past 30 days⁶)

Which women are more likely to experience frequent mental distress?

- Women without a college degree were more likely than college graduates

Source: All California numbers, unless otherwise specified, are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ Stowe ZN, Nemeroff CB. Women at risk for postpartum-onset major depression. *Am J Obstet Gynecol* 1995;173(2):639-45.

² McLearn KT, Minkovitz CS, Strobino DM, Marks E, Hou W. The timing of maternal depressive symptoms and mothers' parenting practices with young children: implications for pediatric practice. *Pediatrics* 2006;118(1):e174-e182.

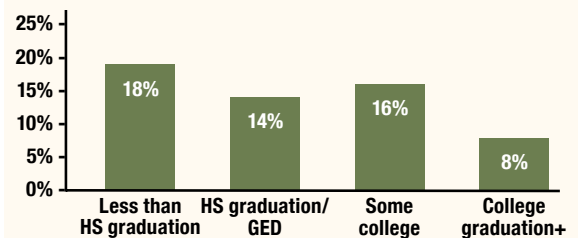
³ Epperson CN. Postpartum major depression: detection and treatment. *American Family Physician* 1999;59(8):1-11. <http://www.aafp.org/afp/990415ap/2247.html>.

⁴ Wilen JM, Mounts, KO. Woman with depression: you can't tell by looking. *Matern Child Health J* 2006; 10(5): S183-186.

⁵ Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC, Suri R, Burt VK, Hendrick V, Remnick AM, Loughhead A, Vitonis AF, Stowe, ZN. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA* 2006; 295(5):499-507.

⁶ Zahran HS, Kobau R, Moriarty DG, Zack MM, Giles WH, Lando J. Self-reported frequent mental distress among adults—United States, 1993-2001. *MMWR* 2004;53(41):963-966.

Percentage of Non-pregnant Women, Aged 18-44, with Frequent Mental Distress in Past Month, by Education



HS = High School

GED = General Education Development Test

INTIMATE PARTNER PHYSICAL VIOLENCE

AMONG NON-PREGNANT CALIFORNIA WOMEN
18-44 YEARS OLD, 2005

Women with a history of intimate partner physical violence (IPPV) are more likely to experience health problems and to display risky health behaviors.¹

Women who experience IPPV before conception have an increased likelihood of maternal complications, including:²

- High blood pressure
- Vaginal bleeding
- Placental problems
- Diabetes
- Kidney or urinary tract infection
- Premature rupture of membranes

Even the reported experience of IPPV in the year prior to, but not during, pregnancy increases the likelihood of having a preterm delivery or a baby in need of neonatal intensive care.²

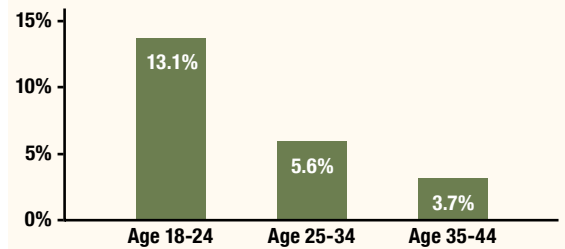
How common is IPPV among non-pregnant California women of reproductive age?

- 6.5% of women reported experiencing IPPV in the past 12 months

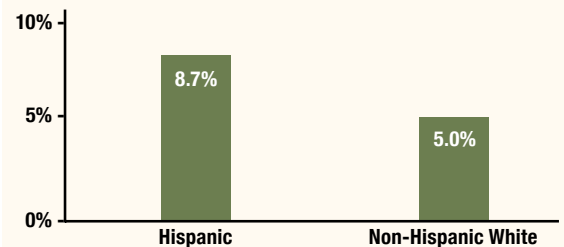
Which women are more likely to report IPPV?

- Younger women (especially between 18 and 24 years of age) were more likely than older women to report IPPV
- Hispanic women were more likely to report IPPV than non-Hispanic White women
- Women whose household incomes were below the federal poverty level (FPL) were more likely to report IPPV than women with household incomes over 200% FPL

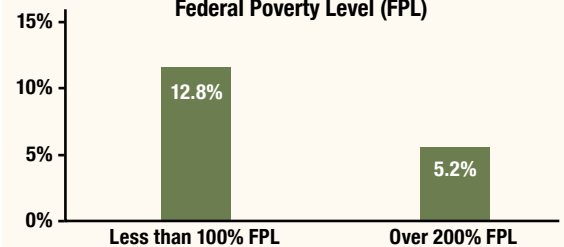
Percentage of Non-pregnant Women, Aged 18-44, Reporting Intimate Partner Physical Violence in Past Year, by Age



Percentage of Non-pregnant Women, Aged 18-44, Reporting Intimate Partner Physical Violence in Past Year, by Race/Ethnicity



Percentage of Non-pregnant Women, Aged 18-44, Reporting Intimate Partner Physical Violence in Past Year, by Household Income as a Percent of the Federal Poverty Level (FPL)



Source: All California numbers unless otherwise specified are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ Coker AL, Davis KE, Arias I, Desai S, Sanderson S, Brandt HM, Smith PH. Physical and mental health effects of intimate partner violence for men and women. Am J Prev Med 2002;23(4):260-268.

² Silverman JG, Decker MR, Reed E, Raj A. Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: associations with maternal and neonatal health. Am J Obstet Gynecol 2006;195(1):140-148.

OVERWEIGHT AND OBESITY

AMONG NON-PREGNANT CALIFORNIA WOMEN

18-44 YEARS OLD, 2005

Women who are overweight (Body Mass Index [BMI] of 25-29.9 kg/m²) or obese (BMI ≥ 30) before conception have an increased likelihood of:¹

- Infertility
- Diabetes
- Chronic hypertension and eclampsia
- Thromboembolic disease
- Labor induction
- Cesarean section
- Poor lactational outcomes
- Excess postpartum weight retention

Complications for the fetus/neonate of an overweight or obese mother include:

- Fetal/neonatal death
- Macrosomia (abnormally large baby)
- Birth defects, including heart defects, spina bifida and omphalocele
- Prematurity and/or small for gestational age
- Childhood obesity

How common are overweight and obesity among non-pregnant California women of reproductive age?

- 25% were overweight and an additional 20% were obese

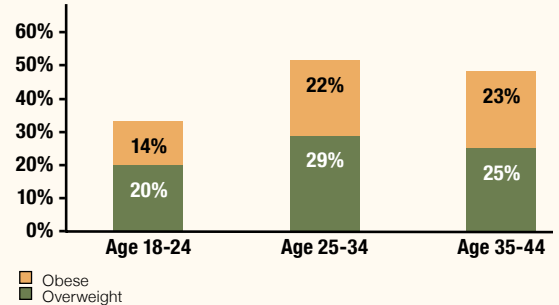
Which women are more likely to be overweight or obese?

- Women over 24 years old were more likely to be overweight or obese than younger women (18 to 24 years)
- Non-Hispanic African-American women and Hispanic women were more likely to be overweight or obese than non-Hispanic White women
- Women with household incomes within 200% of the federal poverty level (FPL) were more likely to be overweight or obese than women with household incomes over 200% of the FPL
- Women with less education were more likely to be overweight or obese than women with more education

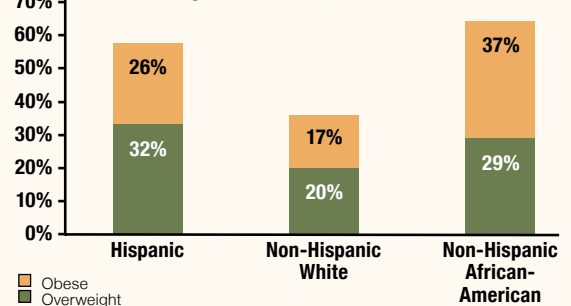
Source: All California numbers, unless otherwise specified, are taken from the 2005 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ Association of Maternal and Child Health Programs (AMCHP)/CityMatCH Women's Health Partnership. Promoting Healthy Weight among Women of Reproductive Age, January 2006.

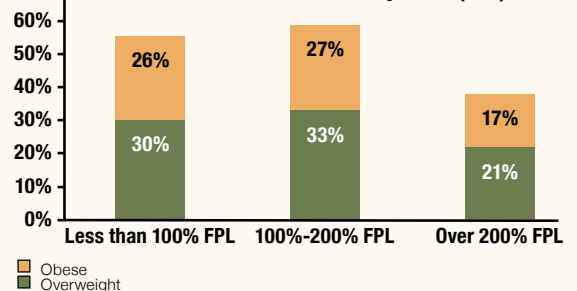
Percentage of Non-pregnant Women, Aged 18-44, Overweight or Obese, by Age



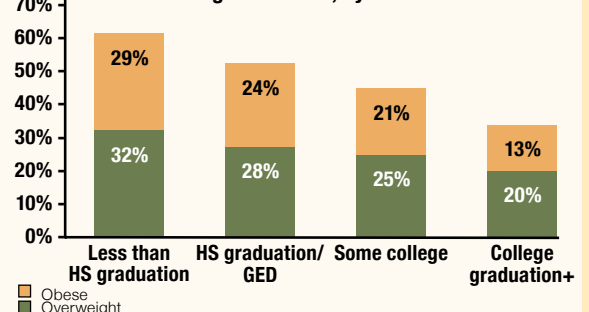
Percentage of Non-pregnant Women, Aged 18-44, Overweight or Obese, by Race/Ethnicity



Percentage of Non-pregnant Women, Aged 18-44, Overweight or Obese, by Household Income as a Percent of the Federal Poverty Level (FPL)



Percentage of Non-pregnant Women, Aged 18-44, Overweight or Obese, by Education



DIABETES

AMONG NON-PREGNANT CALIFORNIA WOMEN
18-44 YEARS OLD, 2004

Adverse maternal and infant outcomes may result from uncontrolled diabetes during pregnancy. These poor outcomes have a direct correlation with a woman's degree of glucose intolerance.¹ Diagnosis and management of diabetes prior to conception and throughout pregnancy reduce the likelihood of:²

- Miscarriage
- Stillbirth
- Macrosomia (abnormally large baby)
- Obstetric and neonatal complications
- Intrauterine developmental and growth abnormalities
- Birth defects

Women with previous gestational diabetes mellitus (GDM) are at a significantly increased risk for developing either diabetes mellitus or future GDM.³

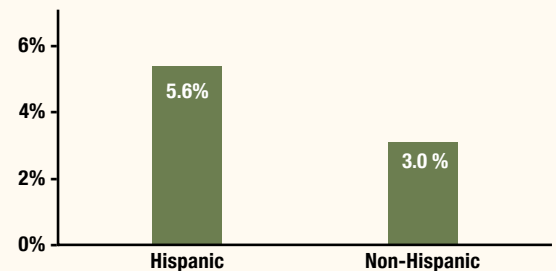
How common is the diagnosis of diabetes among non-pregnant California women of reproductive age?

- 3.9% reported having ever been diagnosed with diabetes or GDM

Which women are more likely to have diabetes?

- Hispanic women were more likely than non-Hispanic women

Percentage of Non-pregnant Women, Aged 18-44, with Previous Diabetes Diagnosis, by Ethnicity



Source: All California numbers, unless otherwise specified, are taken from the 2004 California Women's Health Survey, an annual, population-based, random-digit-dialed survey of California women.

¹ Berkus MD, Langer O. Glucose tolerance test: degree of glucose abnormality correlates with neonatal outcome. *Obstet Gynecol* 1993;81(3):344-348.

² Owens MD, Kieffer EC, Chowdhury FM. Preconception care and women with or at risk for diabetes: implications for community intervention. *Matern Child Health J* 2006;10:S137-S141.

³ Damm P. Gestational diabetes mellitus and subsequent development of overt diabetes mellitus. *Dan Med Bull* 1998;45(5):495-509.

CALIFORNIA AT A GLANCE, 2005

	Number	Proportion of Total Population
■ State Projected Total Population ¹	36.8 M	
– Hispanic	13.2 M	(36%)
– Non-Hispanic	23.6 M	(64%)
White	15.9 M	(43%)
Asian/Pacific Islander	4.2 M	(11%)
African American	2.5 M	(7%)
Multi-Race	0.7 M	(2%)
American Indian	0.3 M	(1%)
■ California Women Aged 15-44 ¹	7.8 M	
■ California Women Aged 18-44 ¹	7.0 M	
■ California Women Aged 15-19 ¹	1.3 M	
■ Births to California Residents ²	549,000	
– 13.3% of US Births ³		(more than 1 out of every 8)
■ Births to Resident Hispanic Women ²	52% of total births	
■ Paid by Medi-Cal (California's Medicaid) ²		
– Prenatal Care	46% of total births	
– Delivery	46% of total births	
■ Percent Unintended Births to California Women (aged 18-44) Who Had a Live Birth ⁴	41%	



¹ California Department of Finance 2000-2050 Population Projections.

² State of California, Department of Health Services, 2005 Birth Statistical Master File.

³ National Vital Statistics Reports, Vol. 55, No. 1, September 29, 2006, Table 11.

⁴ Maternal and Infant Health Assessment (MIHA) Survey, 2005

