



San Francisco Department of Public Health
Women's Health Plan

Partnering in Wellness With
Women and Girls in San Francisco
2003 – 2006

May 2003
San Francisco Department of Public Health's Office of Women's Health

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This report can be found online at the SFDPH website: www.dph.sf.ca.us

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Executive Summary

- **Preface**

The Office of Women's Health (OWH), in issuing this report, invites you to share our vision: Health-seeking women and girls collaborating with the Department of Public Health (DPH) to create and maintain wellness in all the communities that make up San Francisco. We must strive to implement this vision by creatively surmounting the challenges of our current reality: a national economic downturn and rising unemployment levels, state and county shrinking budgets, the lack of universal health care coverage, social inequity contributing to widespread health disparities, bio-terrorism preparedness requirements, and threats to our reproductive and civil rights. These new factors are added to the ongoing public health mandate to provide health education, prevent injury and disease, and heal the sick. To achieve women and girl's health, all City departments, community based organizations and the people of San Francisco must be active partners.

- **Purpose of the Plan**

The Women's Health Plan: Partnering in Wellness with Women and Girls in San Francisco 2003-2006 is a local perspective on women's health and wellness. It was created by members of the DPH Women and Girl's Health Advisory Committee and the OWH to guide the San Francisco Department of Public Health in its efforts to safeguard, promote and improve the health and well being of the women and girls of San Francisco. The Plan outlines six core recommendations and encourages a series of DPH programmatic strategies. Progress made on implementing strategies and achieving recommendations will be regularly monitored and formally evaluated in 2007.

- **Framework for the Plan: Nine Guiding Principles**

1. Women's health is defined primarily as the achievement and maintenance of wellness, and is shaped by women's needs, strengths, responsibilities, roles and relationships.
2. Women's health encompasses the lifespan and changes over time reflecting physiological changes and needs.
3. Health conditions may affect women solely, predominantly, or differently than men.
4. A holistic approach to women's health care is preferred which takes into account that women's health is influenced by the economic, political, environmental and social contexts of her daily life.
5. Women's wellness is nurtured and sustained by environments and communities that are healthy, non-violent and inclusive.
6. Access to health care is a human right along with the right to food, shelter, and the right to live free of violence.
7. Women should be involved as partners in the design and evaluation of health care programs serving them and in the achievement and maintenance of their wellness.
8. Health services for women should be gender-specific, culturally competent, accessible, cost-effective and science-based.
9. Women's wellness will be encouraged by assisting women in becoming educated healthcare consumers, by promoting healthy lifestyles and by placing emphasis on prevention and treatment of disease and injury.

- **Challenges to Women’s Health and Well-being**

A woman’s health is the sum of her own biology and her socioeconomic environment, including cultural and physical conditions both at home and at work. Although women live longer than men, women tend to be more affected by long-term and chronic illness, which significantly affects the quality of their lives. The health of women and girls is jeopardized by preventable illness, poverty, lack of access to health insurance coverage, violence, social inequity, environmental and occupational hazards, chronic illness, inadequate access to health care, insufficient research data and unhealthy lifestyles. Women’s health and the health of families and communities are inextricably entwined due to the multiple pivotal roles women fulfill: breadwinners, mothers, wives/partners, health care decision makers, caregivers and housekeepers. Women tend to put their own health last on the list of priorities and do not tend to access preventive care in a timely fashion. And yet, it is impossible to assure the overall health of our communities without assuring the health of women – women are the caregivers for the young, the elderly and sick family and community members.

- **A Profile of the Women and Girls of San Francisco**

Women (ages 20+):

1. 49.2% of the population of San Francisco (381,905 of 776,733)
2. 49.7% White, 30.8% Asian, 14.1% Latina, 7.8% Black/African American, 6.5% Other race, 4.3% Multiracial, <1% N. Hawaiian/Pacific Islander, <1% American Indian
3. 52.3% of DPH Primary Care clients
4. 75,000 San Francisco women lack health insurance coverage (approximate figure)
5. 13% have disabilities; Unipolar Depressive Disorder is leading cause of disability
6. 6% of persons living with AIDS
7. 1,936 were homeless (October 2002)
8. Heart Disease and Cancer are the leading causes of death (in US, 2000)
9. 2/3 of women victims of homicide were killed by an intimate partner (1997)

Young Women/Girls (ages 10-19):

1. 49% of San Francisco youth – 15,000 girls ages 10-14 and 16,310 young women ages 15-19
2. 38% Asian, 22% White, 21% Latina, 12% Black/African American, 5% Multiracial, 1% N. Hawaiian/Pacific Islander, <1% American Indian
3. Have the highest rate of STD cases in SF
4. 29% of youth in the criminal justice system
5. Unintentional injuries and homicide are leading causes of death (ages 15-19 in US, 2000)
6. Reality of sexual, physical and emotional abuse for many

- **Six Core Recommendations for Safeguarding, Promoting and Improving Health for Women and Girls**

The six core recommendations were developed through a collaborative effort between DPH staff, community members and other city agency/department staff to help DPH serve the needs of women and girls in San Francisco. These recommendations reflect current best practices for women and girls’ health. The full report provides a complete listing of specific strategies suggested for the achievement of the recommendations.

Those strategies that will be new are followed by the letter **N** and the suggested year for implementation (example: **N '04**); those ongoing and already in place are followed by the letter **O**.

1. Promote wellness and provide excellence in health care to women and girls in a gender-specific context.

Women, by virtue of their sex, present particular physiological health concerns and exhibit gender based health disparities. In order to provide health care services that best meet the needs of women and girls, a gender-conscious perspective that takes into consideration women's specific needs across their life span should be utilized in program and policy design and implementation.

- a. Utilize the Office of Women's Health to develop, promote and monitor gender-sensitive health care policies. (O)
- b. Increase intra-DPH communication, collaboration and coordination by creating an internal DPH Women and Girls' Services Coordinating Council. (N '03)
- c. Provide gender focused cultural competency training for staff and contractors. (N '04)
- d. Ensure DPH provides gender-specific care. (O)
- e. Regularly evaluate women and girls' services. (N '06)
- f. Standardize DPH utilization of data by gender. (N '04)

2. Reduce mortality and disability rates among women through concerted prevention efforts.

The main determinants of health are social, economic, cultural, environmental, health services and personal health practices. In order to encourage improvement in health outcomes in populations of women, a broad range of targeted prevention strategies must be implemented by DPH in partnership with public, private and nonprofit organizations.

- a. Ensure gender-perspective in design, promotion and implementation of all DPH prevention campaigns and in creation of DPH Prevention Framework strategic plan. (N '04)
- b. Target reduction of unipolar major depression, alcohol dependence and drug abuse among older women. (N '05)
- c. Encourage healthy lifestyles and assure access to health education. (O)

3. Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families.

Violence has become a major public health challenge for women and may be a hidden cause of maternal mortality. In addition to injuries sustained during violent episodes, physical and psychological abuse are linked to a number of adverse physical health effects. Intimate partner violence, sexual assault and gun-related violence continue to negatively affect women, girls and their families.

- a. Implement the DPH Intimate Partner Violence Screening Policy Protocol. (N '04)
- b. Collaborate to develop and implement a DPH Intimate Partner Violence Prevention Strategic Plan. (O)

- c. Assist in design and implementation of a healthy relationship curriculum in SF schools. (N '05)
- d. Encourage community collaboration in prevention and crisis intervention for sexual assault. (O)
- e. Reduce firearm violence through prevention strategy development and implementation. (N '06)

4. Expand screening and treatment services and encourage prevention efforts to reduce cancer rates among women.

Cancer is the second leading killer of American women. Over the past 10 years, the mortality rate from lung cancer has declined in men but has continued to rise in women; much of this is due to increased rates of cigarette smoking in women. Breast cancer is the second leading cancer killer among women and the incidence and death rates from this type of cancer increase with age. Early detection through screening has contributed to a decline in cervical cancer rates.

- a. Ensure access to timely cervical and mammography screening services. (O)
- b. Ensure access to support services and system navigators for cancer patients. (O)
- c. Participate in community collaborations to eliminate environmental and social determinants of breast cancer. (O)
- d. Encourage prevention through tobacco cessation efforts focused on women. (N '05)

5. Eliminate health disparities based on race and ethnicity, disabilities and sexual orientation among women.

Notwithstanding modern improvements in medical technology, access to health services and public health practices, notable disparities in health outcomes among different social groups persist. Disproportionate rates of incidence of disease, disability and death exists among certain populations including women in general, people of color, lesbian, bisexual and transgender women, and women with disabilities. The need exists to improve health outcomes by impacting social determinants such as social inequity, improving access to care and promoting individual behavior change.

- a. Design and implement prevention campaigns to influence nutrition, physical activity and tobacco consumption among women of color. (N '04)
- b. Participate in community collaborations to impact root causes of social determinants such as racism, able-ism and heterosexism. (N '04)
- c. Continue to provide comprehensive cultural competency training to DPH staff and contractors. (O)
- d. Ensure access to health services and programs. (O)

6. Ensure the health of vulnerable populations of women by enhancing access to health services.

Among women there are specific vulnerable populations that experience disproportionate stressors to their health. Focus on these populations must be present in health care services design and provision. (O and N – see Pages 44 - 51 for details)

- a. Younger Women

- b. Older Women
- c. Homeless Women
- d. Poor and Uninsured Women
- e. Immigrant Newcomer Women
- f. Incarcerated Women

- **Next Steps for DPH**

1. The Office of Women's Health (OWH) will disseminate the Women's Health Plan throughout DPH and will make it available to the general public in hard copy and on the DPH website.
2. The OWH will work with DPH Directors and the newly created DPH Women and Girls' Services Coordinating Council to coordinate the implementation of the Plan.
3. The OWH will provide assistance as needed to all sections during the implementation of the Plan.
4. Annual progress reports on the achievement of the Plan will be issued.
5. An evaluation of the Women's Health Plan will be conducted in 2007.

Section One

Introduction

Preface

The Office of Women's Health (OWH), in issuing this report, invites you to share our vision: Health-seeking women and girls collaborating with the Department of Public Health (DPH) to create and maintain wellness in all the communities that make up San Francisco. We must strive to implement this vision creatively surmounting the challenges of our current reality: a national economic downturn and rising unemployment levels, state and county shrinking budgets, the lack of universal health care coverage, social inequity contributing to widespread health disparities, bio-terrorism preparedness requirements, and threats to our reproductive and civil rights. These new factors are added to the ongoing public health mandate to provide health education, prevent injury and disease, and heal the sick. To achieve women and girl's health, all City departments, community based organizations and the people of San Francisco must be active partners.

Purpose of The Plan

The Women's Health Plan: Partnering in Wellness with Women and Girls in San Francisco 2003-2006 is a local perspective on women's health and wellness. It was written to guide the San Francisco Department of Public Health in its efforts to safeguard, promote and improve the health and well being of the women and girls of San Francisco.

In addition to providing a San Francisco-specific perspective, the Plan takes into account a variety of Federal and State strategies, issues and problems. The Plan outlines six core recommendations and encourages a series of DPH programmatic strategies – the achievement of which will be shared by DPH, City departments, State and Federal agencies, community organizations and the women and girls of San Francisco.

Progress made on implementing strategies and achieving recommendations will be regularly monitored and formally evaluated in 2007.

Developers of The Plan

Office of Women's Health

The Office of Women's Health (OWH) reports to the Director of Community Programs and assists DPH in setting policy concerning the health care needs of women and girls in San Francisco. Hired in October of 2001, the Coordinator of the OWH serves as a liaison between DPH, advisory groups, and other City departments on issues pertaining to women and girls, including:

- DPH Cultural Competency Task Force
- DPH Intimate Partner Violence Prevention Work Group
- DPH Prevention Framework Work Group
- DPH Patient Education Committee of the Avon Women's Imaging Center and Mammography Program
- Delinquency Prevention Commission Continuum of Care for Girls in SF Task Force
- Executive Committee of the Lesbian Health Research Center
- SF Board of Supervisor's End the Exploitation of Youth Task Force

As a direct provider of services, the OWH Coordinator continues a thirteen-year tradition of providing health education and prevention services to young women in detention at the San Francisco Youth Guidance Center through DPH's Special Programs for Youth Section.

The development and publication of a strategic Women's Health Plan for the SFDPH continues to be a priority for the OWH. In June 2002, a student with the San Jose State University Master's in Public Health program became an intern with the OWH and chose the creation of the Women's Health Plan as her project.

Women And Girl's Health Advisory Committee

The Women and Girl's Health Advisory Committee (WAGHAC) was originally created in 1991 to advise the San Francisco Health Commission and the Department of Public Health (DPH) and serves as an expert review body on women's health care initiatives and issues. It also identifies and prioritizes needs and service gaps as part of the Department's budget process. WAGHAC members represent diverse communities and include advocates and individuals from community-based organizations who provide health-related services to women and girls. The Committee is a vital link between DPH and San Francisco women and girls' health care providers and consumers. The Committee meets monthly and is staffed by the Coordinator of the DPH Office of Women's Health. The members of the WAGHAC provided invaluable guidance to the OWH in the development of the Women's Health Plan and strong support for the Guiding Principles and Six Core Recommendations at the heart of the Plan.

The Framework for The Plan

Nine Guiding Principles

The Women's Health Plan is formulated with the following principles:

1. Women's health is defined primarily as the achievement and maintenance of wellness, and is shaped by women's needs, strengths, responsibilities, roles and relationships.
2. Women's health encompasses the lifespan and changes over time reflecting physiological changes and needs.
3. Health conditions may affect women solely, predominantly, or differently than men.
4. A holistic approach to women's health care is preferred which takes into account that women's health is influenced by the economic, political, environmental and social contexts of her daily life.
5. Women's wellness is nurtured and sustained by environments and communities that are healthy, non-violent and inclusive.
6. Access to health care is a human right along with the right to food, shelter, and the right to live free of violence.
7. Women should be involved as partners in the design and evaluation of health care programs serving them and in the achievement and maintenance of their wellness.
8. Health services for women should be gender-specific, culturally competent, accessible, cost-effective and science-based.
9. Women's wellness will be encouraged by assisting women in becoming educated healthcare consumers, by promoting healthy lifestyles and by placing emphasis on prevention and treatment of disease and injury.

Essence of The Plan – Six Core Recommendations

1. Promote wellness and provide excellence in health care to women and girls in a gender-specific context.
2. Reduce mortality and disability rates among women through concerted prevention efforts.
3. Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families.
4. Expand screening and treatment services and encourage prevention efforts to reduce cancer rates among women.
5. Eliminate health disparities based on race and ethnicity, disabilities and sexual orientation among women.
6. Ensure the health of vulnerable populations of women by enhancing access to health services

Foundation for The Plan

“From Voices to Action: Conceiving a Model for Women’s Wellness”

In October 1996, the San Francisco Women’s Health Advisory Committee (predecessor to the current Women and Girls Health Advisory Committee) defined an ideal system for women’s health care delivery: “It must be a system of coordinated effort to increase and maintain the wellness of an individual woman, her family, and her community. We must expand the definition of health care to include more than medical services. Women need a care coordination approach that incorporates case management, personal health services, prevention, and health promotion principles into a health delivery structure.”¹ Their model was structured to “improve and preserve the health of women.” It stated that San Francisco would achieve this by²:

1. Making plans and developing policies for women’s current and future health and by making women integral to that process
2. Regularly evaluating women’s health services against agreed upon standards and by making women integral to the development, implementation and evaluation of those standards
3. Providing high quality, accessible, comprehensive and coordinated health services that are integrated into one system and into the broader community
4. Inviting women, and their providers, to work as partners to prevent disease and promote wellness
5. Helping practitioners recognize, and incorporate into their practices, the diverse issues that affect women and their health

This model served as a foundation for the development of this Women’s Health Plan.

“Leading the Way to a Healthier Community 2000”

In 2000, the San Francisco Department of Public Health issued its Strategic Plan. It stated four major strategic goals:

¹ Voices to Action: Conceiving a Model for Women’s Wellness, San Francisco City and County Department of Public Health, Women’s Health Advisory Committee, October 1996.

² Ibid.

1. San Franciscans have access to the health services they need, while the Department emphasizes services to its target populations
2. Disease and injury are prevented
3. Services, programs and facilities are cost-efficient and resources are maximized
4. Partnerships with communities are created and sustained to assess, develop, implement and advocate for health funding, policies, programs and services³

The Women's Health Plan reflects these priorities by emphasizing prevention, community partnerships, facilitating access and targeting of certain populations.

"Healthy People 2010: A Systematic Approach to Health Improvement"

In 2000, the U.S. Department of Health and Human Services issued an analysis of the nation's health and strategic plans for the future.⁴ It outlined the health goals over the next ten years and is intended to serve as a guidepost for local community program planning. Their report also defined ten Leading Health Indicators as major health issues for the nation; these include physical activity, overweight and obesity, tobacco use, substance use, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization and access to health care. The two overarching goals for Healthy People 2010 are:

1. Increase quality and years of healthy life.
2. Eliminate health disparities.⁵

The Women's Health Plan also places a focus on impacting health disparities related to ethnicity, race, sexual orientation and disability and on encouraging reduction of Disability Adjusted Life Years (DALY)⁶ rates by influencing health indicators.

The Federal Office of Women's Health is focusing the majority of its resources to address the following priority women's health areas in FY 2003: cancer, cardiovascular disease, diabetes/obesity, and HIV/AIDS.⁷

³ Leading The Way to a Healthier Community 2000: San Francisco Department of Public Health Strategic Plan, www.dph.sf.ca.us/stratplan

⁴ Healthy People 2010: A Systematic Approach to Health Improvement. http://www.health.gov/healthypeople/Document/html/uih/uih_2.htm

⁵ Ibid.

⁶ Disability Adjusted Life Years (DALYs) are a measure of the overall burden of disease and injury in a population. DALYs were developed by the World Health Organization and are a combination of years lost to premature mortality and the number of years lived with a disabling condition. The measure allows health evidence to be used to estimate the largest contributors to reduced years of healthy life due to disease, injury, disability, and death. (Overview of Health in San Francisco 2002, San Francisco Department of Public Health, page 39).

⁷ According to Kay Strawder, Coordinator of Region IX Federal Office of Women's Health. No overarching Women's Health Strategic Plan has been issued at this time.

Section Two

Challenges to Women's Health and Well-Being

Condition of Women's Health

A woman's health is the sum of her own biology and her socioeconomic environment, including cultural and physical conditions both at home and at work.⁸ Although women live longer than men, women tend to be more affected by long-term and chronic illness, which significantly affects the quality of their lives.⁹ A higher percentage of women report their health as 'fair' or 'poor' compared to men.¹⁰ "Sadly, the health of the Nation's girls and women is severely jeopardized by preventable illness, poverty, domestic violence, chronic illness, inadequate access to health care, and numerous other factors."¹¹

A report issued in 2001 identified unresolved problems negatively impacting the health of California women and girls. These included: lack of data constitutes a significant barrier to meaningful policy planning, a piecemeal approach to filling gaps in health care and coverage that is not working, and the pressing need to reduce environmental and occupational hazards in order to significantly improve the status of health among women and girls.¹²

Women's health and the health of families and communities are inextricably entwined due to the multiple pivotal roles women fulfill: breadwinners, mothers, wives/partners, health care decision makers, caregivers and housekeepers. Women tend to put their own health last on the list of priorities and do not tend to access preventive care in a timely fashion. And yet, it is impossible to assure the overall health of our communities without assuring the health of women – women are the caregivers for the young, the elderly and sick family and community members.

Poverty

Women are more likely to live in poverty, particularly women who are single parents. Nearly a third of single mothers live in poverty and 71% of the adult Medicaid population is female.¹³ Female heads of households also are significantly more prone to experience the stress of chronic, unmitigated, and persistent poverty.¹⁴ Researchers have consistently found that poverty and exposure to unrelenting stress are two factors that precipitate the onset of mental health problems.¹⁵ Low-income women (particularly women of color) face more frequent threatening and uncontrollable life events than do other populations. These events include crime, violence, discrimination, and the loss of a child or a partner to

⁸ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

⁹ Women, Health and Development Program Fact Sheet. Pan American Health Organization. <http://www.paho.org/genderandhealth>

¹⁰ Healthy People 2010.

¹¹ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

¹² Nearly A Failing Grade: A Report Card on the Health Status of Women and Girls in California. The Women's Foundation with the Los Angeles Women's Foundation, Women's Health Leadership, California Black Women's Health Project, Latino Issues Forum, and Asian and Pacific Islander American Health Forum, January 2001.

¹³ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

¹⁴ Dailard, JD, C., Gender-Specific Approaches to Mental Health Policy, 1999, The Journal of Gender-Specific Medicine, Vol. 2, Number 3, May/June.

¹⁵ Russo, Nancy F., Women's Mental Health: Research Agenda for the Twenty-first Century, in Mental Health, Racism and Sexism (Charles V. Willie et al. Eds. 1995), 378-380.

violence, imprisonment, or disease.¹⁶ Some of the concerns for women in California include hunger and food insecurity, a lack of affordable and reliable childcare, and a crisis in affordable housing.¹⁷

Inadequate Access to Health Insurance Coverage

Health insurance, which is correlated with income and employment, is a primary indicator of access to health care services. Having health insurance improves the ability of individuals to obtain preventative medical services such as vaccinations, prenatal care and cancer screening, and to seek medical care when illness occurs. Thus, health insurance can lead to improvement in health status.¹⁸ Preliminary findings from the California Women's Health Survey point to the connection between low socio-economic status, lack of access to primary and preventive health services and poorer health outcomes.¹⁹

A national survey conducted in May 2001 found persistent problems with health care access and satisfaction among the most vulnerable segments of women—those with health problems, those with low incomes, women of color, and the uninsured. The survey reported that the cost of prescription drugs and the quality of their medical care were significant concerns of many women.²⁰ A study done in December 2001 assessed the overall health of women in California and concluded that inadequate health insurance coverage seriously compromised women's access to health care services. This study also found that more research into women's health, better data collection and data systems, and greater focus on emerging issues affecting women's health and well being are needed.²¹

An estimated 42 million Americans are uninsured.²² Nationwide, more women than men go without health care or prescription drugs due to cost.²³ California has an estimated 7 million people who lack health insurance, a higher figure than any other state in the nation.²⁴ California has the fourth highest percentage of uninsured women when compared to other states, exceeded only by Texas, Arizona and New Mexico.²⁵ In California, 23.8% of all

¹⁶ Belle, Deborah, *Inequality and Mental Health: Low Income and Minority Women*, in *Women and Mental Health Policy* (Lenore Walker ed. 1994), 135, 138.

¹⁶ The Women's Foundation and Co-Releasers, *Failing to Make Ends Meet: A Report on the Economic Status of Women in California – Summary of Findings and Recommendations*, May 2002.

¹⁸ Public Policy Institute of California, Belinda I. Reyes, ed., *A Portrait of Race and Ethnicity in California: An Assessment of Social and Economic Well-being*, 2001, page 71.

¹⁹ California Women's Health Survey, CA OWH (?)

²⁰ *Women's Health in the United States: Health Coverage and Access to Care – Kaiser Women's Health Survey*. The Henry J. Kaiser Family Foundation and UCLA Center for Health Policy Research, May 2002.

²¹ *Making The Grade on Women's Health: A National and State-by-State Report Card*. National Women's Law Center, FOCUS on Health & Leadership for Women, Center for Clinical Epidemiology and Biostatistics at the University of Pennsylvania School of Medicine, and Oregon Health & Science University, 2001

²² UCSF Center for Health and Community News, February 15, 2002.

²³ Henry J. Kaiser Family Foundation Survey, May 2002.

²⁴ California HealthCare Foundation and the Field Research Corporation, *To Buy or Not to Buy: A Profile of California's Non-Poor Uninsured*, 1999, page 2.

²⁵ The Women's Foundation with the Los Angeles Women's Foundation, Women's Health Leadership, California Black Women's Health Project, Latino Issues Forum, and Asian and Pacific Islander American Health Forum, *Nearly a*

women between 18 and 64 are uninsured and 42.7% of low-income women do not have health insurance.²⁶ Thirty-five percent of Latinas, 28% of Asian and Pacific Islander women, and 25% of Black women are uninsured.²⁷ In California, women often experience a lack of access to key services that include pap smears, pregnancy termination services, contraceptive services, mental health care, drug and alcohol treatment and culturally appropriate care.²⁸

An estimated 75,000 women in San Francisco are uninsured.²⁹ Public coverage offered in programs such as Medi-Cal, transitional Medi-Cal and Healthy Families is inadequate and underutilized. Nearly three in ten uninsured women (28%) reported a delay in care due to cost concerns.³⁰ Fifty percent of uninsured people have not visited a doctor in the past year and 70% of the uninsured have no regular health care provider.³¹ The possibility of establishing a single-payer system of health care coverage in California holds out great promise for the improvement of the health of women and girls.

Social Inequity

Sex and gender are crucial variables to take into consideration when designing systems of health care provision for women. "Gender refers to the ways in which roles, attitudes, values and relationships regarding women and men are constructed in all communities and cultures. Therefore, while the sex of a person only describes being female or male, the gender of that person is socially constructed. In our society, the role of gender functions in a way that subordinates and discriminates against women to the detriment of their full enjoyment of all human rights. This discrimination is not only reflected in individual relationships, but also permeates all institutions."³²

Unjust disparities exist in the levels of physical, psychological, social and emotional well being enjoyed by different social groups. These disparities, defined as inequities, result from historical differences in treatment and access to resources according to gender, socio-economic class, ethnicity, race, age, disability, geographic region and sexual orientation. Achieving equity in health implies the elimination of inequalities that are unnecessary, avoidable and unjust. This allows all social groups the same opportunity to enjoy living conditions and services that enable them to be in good health, without becoming ill, disabled or dying by causes of inequality. For example, gender equity in health achieves balance in the areas between health risks and opportunities to enjoy health, between health

Failing Grade: A Report Card on the Health Status of Women and Girls in California, January 2001, Factual Corrections insert.

²⁶ Ibid

²⁷ Ibid.

²⁸ The Women's Foundation, page 10.

²⁹ Rebecca Vesely, Women's eNEWS, 9/22/02, (according to U.S. Census figures).

³⁰ The Women's Foundation, page 10.

³¹ San Francisco Community Clinic Consortium, Health and Insurance in San Francisco: The Facts, 2001, Health Status Report 2001, April 2001, San Francisco Department of Public Health, page 24.

³² WILD, CEDAW gender equity fact sheet.

needs and access to resources, and between responsibilities and power in health work.³³ In 1979, the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which affirmed for women the right to access adequate health care, including resources adequate to ensure mental and physical well-being, not just absence of disease. In 1998, although not ratified by the US, the City and County of San Francisco enacted an ordinance implementing the principles underlying CEDAW. The local health care principles of the San Francisco CEDAW Ordinance state:

1. It shall be the goal of the City to take all appropriate measures to eliminate discrimination against women and girls in the field of health care in order to ensure, on a basis of equity, information about and access to adequate health care facilities and services, according to the needs of all communities, regardless of race, ethnicity, culture, language, and sexual orientation, including information, counseling and services in family planning.
2. It shall be the goal of the City to ensure that women and girls receive appropriate services in connection with prenatal care, delivery, and the post-natal period, granting free services where possible, as well as adequate nutrition during pregnancy and lactation.³⁴

The need for gender-specific research on women and their changing needs over the course of the life span was an overarching theme of a National Institute of Health task force convened in 1998. "Slowly, we are correcting our male models of normal human function and of the pathophysiology of disease. It is now undeniable that there are significant differences between men and women in virtually every system of the body and, equally important, that the experience of disease is not homogeneous, but has unique features depending on whether the patient is male or female. As a result, our ideas about how to diagnose and treat illness are increasingly more accurate and effective."³⁵

There are significant biological differences between men and women in many areas, including bone, the brain, cardiovascular disease, drug metabolism, immunology, and intestinal motility.³⁶ Differences between men and women account for a number of striking differences in health outcomes:

- The differences in drug metabolism explain women's vulnerability to medications that have been tested primarily in men. For example, one study reports that the treatment of mild to moderate hypertension in white women increased the all-cause death rate by 26% while lowering all-cause mortality in men by 15%.³⁷

³³ Women, Health and Development Fact Sheet. Pan-American Health Organization, <http://www.paho.org/genderandhealth>

³⁴ San Francisco Commission on the Status of Women, http://www.sfgov.org/site/cosw_page.asp?id=10849

³⁵ Legato, MD, FACP, Marianne J., Report of the Task Force on Research on Women's Health for the 21st Century: A Personal Overview. The Journal of Gender-Specific Medicine 1998, Volume 1, Number 1, September.

³⁶ Legato, MD, FACP, Marianne J., Is There a Role For Gender-Specific Medicine in Today's Health Care System?, 2000, The Journal of Gender-Specific Medicine, Vol. 3, Issue 3 – Special Issue, April.

³⁷ Anastos K., Charney P., Charon RA, et al. Hypertension in women: What is really known. Ann Intern Med. 1991; 115:287-293.

- Gender-specific differences in levels of neurotransmitters have also been used to explain the difference in the incidence of depression, which is twice as high in women as in men in virtually every country in the world.³⁸
- Women are more likely than men to report recent episodes of depression and anxiety disorders, and to seek treatment for mental health problems. Yet, women with mental disorders remain significantly underserved, with only one-quarter receiving any form of treatment.³⁹
- Women receive two-thirds of all prescriptions for psychotropic drugs.⁴⁰
- Women are also more prone than men to become addicted to prescription antidepressants and sedatives and to combine them with alcohol as a coping mechanism.⁴¹
- Type 2 diabetes is more prevalent among women than men; knowledge of lifespan issues from adolescence through menopause is crucial to the management of women with diabetes.⁴²
- In Alzheimer's disease, gender differences are reported in patient behavior, clinical course and symptoms, treatment decisions made by health care workers, predictors of mortality, and duration of illness.⁴³

³⁸ Weissman MM, Klerman GL. Sex differences in the epidemiology of depression. *Arch Gen Psychiatry* 1977; 34:98-111.

³⁹ Kessler, Ronald C., Sex Differences in DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey, 53(4), *J. Am. Med. Women's Association*. 1998, 148-149.

⁴⁰ Cafferata, GL, and Meyers, SM, Pathways to Psychotropic Drugs, 1990, 28 *Med Care*, 285.

⁴¹ Horton, JA, ed., *The Women's Health Data Book: A Profile of Women in the United States*, 1992, The Jacob's Institute of Women's Health, 79.

⁴² Campaigne, PhD, BN, and Wishner, PhD, MD, KL, Gender-Specific Health Care in Diabetes Mellitus, 2000, *The Journal of Gender-Specific Medicine*, Vol. 3, Issue 1, Jan/Feb.

⁴³ McCannJJ, Herbert LE, Bennett DA, et al. Why Alzheimer's disease is a women's health issue. *J Am Med Women's Association* 1997; 52: 132-137.

Section Three

A Profile of the Women and Girls of San Francisco 2003

Demographics

Adults

According to the U.S. Census Bureau, the total population of San Francisco County in the year 2000 was 776,733 persons; 381,905 of these were female (49.2%).⁴⁴ An estimated 4,000 individuals living in San Francisco self-identify as transgendered; of these, 75% are male-to-female.⁴⁵

The ethnic/racial composition of the San Francisco County population in 2000 was:⁴⁶

White	49.7%
Asian.....	30.8%
Hispanic/Latino	14.1%
Black/African American.....	7.8%
Other race	6.5%
Two or more races.....	4.3%
N. Hawaiian/Pacific Islander	0.5%
American Indian/Alaska Native.	0.4%

Youth

The population of San Francisco County in 2000 included 64,147 youth ages 10-19 (8.3% of total population).⁴⁷ Girls ages 10-14 years constituted 3.9% (15,000) and young women ages 15-19 years constituted 4.3% (16,310).⁴⁸

The ethnic/racial composition of females ages 10-19 years in San Francisco County was:⁴⁹

Asian.....	38%
White	22%
Hispanic/Latino	21%
Black/African American.....	12%
Multiracial.....	5%
N. Hawaiian/Pacific Islander	1%
American Indian/Alaska Native.	<1%
Other race.....	<1%

Disabilities

U.S. Census figures estimated that in 1999, 13% of Females ages 21 to 64 had disabilities. In San Francisco, the U.S. Census 2000 found that 8.1% of all residents ages 5 to 20 and 17.9% of all residents ages 21 to 64 had a disability.⁵⁰

⁴⁴ U.S. Census Bureau, Census 2000

⁴⁵ 2001 San Francisco HIV Prevention Plan, San Francisco Department of Public Health, AIDS Office, page 46.

⁴⁶ U.S. Census Bureau, Census 2000

⁴⁷ U.S. Census Bureau, Census 2000

⁴⁸ U.S. Census Bureau, Census 2000 Summary File 1, Matrices P13 and PCT12

⁴⁹ U.S. Census Bureau, Census 2000 of Population and Housing, Summary File1, California State Census Data Center

⁵⁰ U.S. Census Bureau, Census 2000.

In 2001, 6% of persons living with AIDS in San Francisco were female.⁵¹ Women of color in general make up a higher proportion of female living AIDS cases at 68%; of these 46% are African American women.⁵²

Fertility Rates

In 2000 there were 189,498 women of childbearing age (15-44) in San Francisco. During 2000 there were 8,691 births in San Francisco⁵³ and 58 fetal deaths for a rate of 6.7 per 1,000.⁵⁴

The most commonly used contraceptive for women in the United States is female sterilization (18% of women), followed by oral contraceptives (17% of women).⁵⁵

Socioeconomic Status

San Francisco has one of the highest costs of living in the United States. It is estimated that it costs at least 20% more to subsist at a 'modest standard of living' (MSOL) in the Bay Area than it does in the rest of California. This level is probably underestimated for San Francisco because of the higher market rates for apartment rentals.⁵⁶

It is estimated that about a quarter of our population is uninsured. When compared to other large metropolitan areas, San Francisco has a higher proportion of uninsured residents and a higher proportion of low-income people who are uninsured.⁵⁷ Female-headed households with no husband present make up 51.6% of families living in poverty in San Francisco.⁵⁸

Housing

Compared to California as a whole, San Francisco has almost twice the number of non-family households and larger numbers of persons living alone.

The Mayor's Office on Homelessness counted 1,936 homeless women in San Francisco in October 2002; this included those living on the street, in shelters, and in crisis or traditional substance abuse or mental health treatment programs.

⁵¹ HIV/AIDS Epidemiology Annual Report 2001, San Francisco Department of Public Health, page 40.

⁵² 2001 San Francisco HIV Prevention Plan, page 65.

⁵³ California County Profile Report 2000, Demography
<http://datamch.berkeley.edu/ccpr/2000/075/demography.html#demog1>

⁵⁴ San Francisco Department of Public Health, "Women of Childbearing Age, Health Report Card 2000"

⁵⁵ Source:<http://www.4woman.gov/media/statistics.htm>.

⁵⁶ San Francisco Department of Public Health, 2002 Overview of Health, citing the California Budget Project – Sept. 2001, p.12.

⁵⁷ San Francisco Department of Public Health, 2002 Overview of Health, p. 30.

⁵⁸ San Francisco Department of Public Health, 2002 Overview of Health, p.10.

Health Status

The life expectancy for women in the United States is 79.5 years; this is 7 years longer than men's.⁵⁹

Mortality and Disability

In San Francisco, approximately 50% of deaths each year are premature and preventable.⁶⁰ The top ten leading causes of death for American women in general in 2000 were:⁶¹

- Heart Disease
- Cancer
- Cerebrovascular Diseases (includes stroke)
- Chronic Obstructive Pulmonary Diseases (includes chronic bronchitis, emphysema and asthmatic bronchitis)
- Pneumonia and Influenza
- Diabetes Mellitus
- Unintentional Injuries
- Alzheimer's Disease
- Nephritis, Nephritic Syndrome, and Nephritis
- Septicemia

However these leading causes of death do differ among women by age group, and by race and ethnicity (See Page 37). For females ages 10-14 in the United States, the top six leading causes of death in 2000 were:⁶²

- Accidents (unintentional injuries) 34.2%
- Malignant neoplasms 14.0%
- Congenital malformations, deformations
and chromosomal abnormalities..... 6.2%
- Assault (homicide) 5.0%
- Diseases of heart 4.1%
- Intentional self-harm (suicide) 3.9%

For females ages 15-19 in the United States, the top five leading causes of death in 2000 were:⁶³

- Accidents (unintentional injuries) 51.7%
- Assaults (homicides) 7.8%
- Malignant neoplasms 7.7%
- Intentional self-harm (suicide) 7.0%
- Diseases of heart 4.0%
- Congenital malformations, deformations
and chromosomal abnormalities..... 2.3%

⁵⁹ The National Women's Health Information Center; 4woman.gov

⁶⁰ San Francisco Community Clinic Consortium, Health and Insurance in San Francisco: The Facts, 2001, from the 2001 State of the City Public Health Address given April 9, 2001 by Mitchell H. Katz, MD, Director of Health, San Francisco Department of Public Health, page 3.

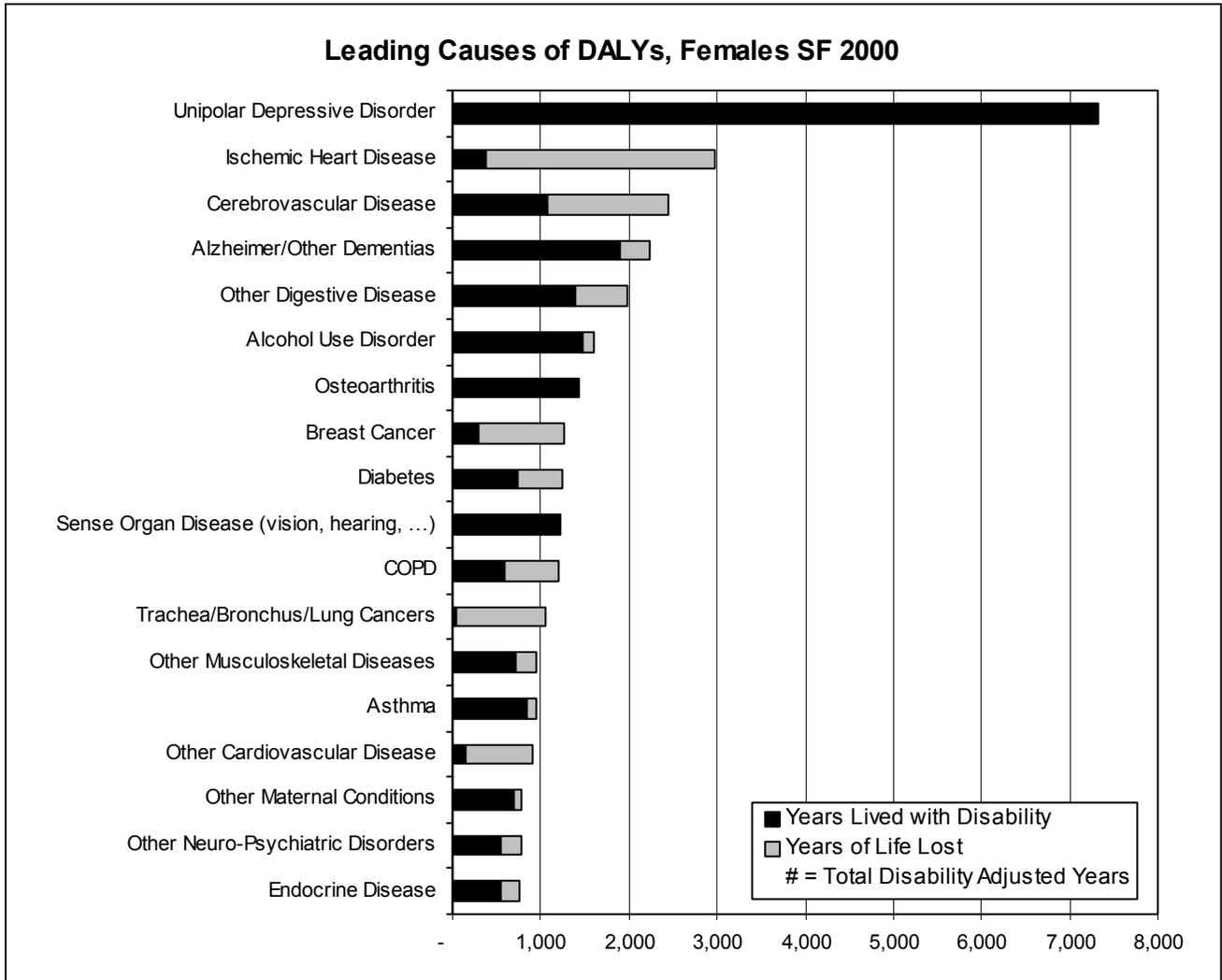
⁶¹ Women's Health Statistical Information, CDC, 2000

⁶² National Vital Statistics Report, Vol. 50, No. 16, September 16, 2002, Table 1.

⁶³ Ibid.

For the period from 1995 to 1999, among females, invasive breast cancer had almost triple the incidence of lung and colorectal cancers, but the death rate from lung cancer was twice that of colorectal cancer, and a third higher than breast cancer.⁶⁴

The top five leading causes of Disability Adjusted Life Years (DALYs – a combination of years lost to premature mortality and years lived with a disabling condition) among women in San Francisco in 2000 were:⁶⁵



For young people age 5-14 in San Francisco between 1989 and 1998, the leading mechanism of injury death was motor vehicle traffic crashes and the leading mechanism of non-fatal injury hospitalization was falls. For young people ages 15-24 in San Francisco between 1989 and 1998, the leading mechanism of injury death was firearms and the leading mechanism of non-fatal injury hospitalization was motor vehicle traffic crashes.⁶⁶

⁶⁴ San Francisco Department of Public Health, 2002 Overview of Health, p. 43, citing NCCC, *Cancer Incidence & Mortality in the SF Bay Area, 1988-1999*. December 2001

⁶⁵ San Francisco Department of Public Health, Community Health Epidemiology

⁶⁶ Profile of Injury, The San Francisco Injury Center, San Francisco Department of Public Health, July 2001, pages 97-98.

Femicide

The Commission on the Status of Women reported in 2000 that two thirds of the women murdered in San Francisco in 1997 were killed by their spouse, partner or ex-partner.⁶⁷

Reasons Women Seek Health Care Services

The DPH Primary Care division includes 19 primary care clinics and numerous satellite clinics and community sites located throughout San Francisco. About 73,193 unduplicated clients visited a DPH Primary Care clinic one or more times in FY 2000-2001 (does not include Laguna Honda Hospital and Jail Health Services); 52.3% of these clients were female, 22% were children (age 0-17) and 8% were elderly (age 65 and above).⁶⁸

Primary Care users:

- Tend to live disproportionately in low-income neighborhoods; 58.4% live in Bayview – Hunters Point, Chinatown, Mission/Potrero Hill, Outer Mission, South of Market, Tenderloin, and Visitation Valley.
- Include homeless people – 9.8% were homeless at some time during the year
- Are disproportionately people of color; 26.9% are Latino, 24.2% are African American and 19.9% are Asian Pacific Islanders.
- Are disproportionately immigrants and non-English speakers compared with the general population; only 54.5% list English as their primary language. Other languages most frequently listed include Spanish (11.6%), Cantonese (7.3%), Russian (1.6%), Vietnamese (1.0%), Mandarin (0.7%), and Tagalog (0.5%).
- Are predominantly publicly insured or uninsured – 56.3% were uninsured at some time during the year, 32.7% had MediCal insurance, 9.9% had Medicare coverage and 17.1 were enrolled in a managed care plan.⁶⁹

Patients visit Primary Care clinics for chronic and urgent conditions and for health care maintenance and prevention. Many of the urgent complaints are actually acute exacerbations of chronic illness. Most frequent disease diagnoses include hypertension, HIV disease, upper respiratory infections, cellulites/abscess, drug dependence, diabetes, depression, hyperlipidemia, and alcohol abuse. Most frequent health-care-maintenance diagnoses include well child exams, vaccinations, pregnancy, and TB screening. Most frequent psychosocial diagnoses include lack of housing, unspecified psychosocial circumstances, counseling, and psychological stress.⁷⁰

The most common major surgery that women in the U.S. have is cesarean section delivery; the second most common surgery is hysterectomy.⁷¹ The most frequent primary discharge

⁶⁷ “Violence Against Women and Girls in San Francisco: Meeting the Needs of Survivors”, 2000, Commission on the Status of Women, http://www.sfgov.org/site/uploaded_files/cosw/vawrpt2000/index.htm#executive

⁶⁸ Primary Care Division Annual Report Fiscal Year 2000-2001, San Francisco Department of Public Health.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Source; http://www.cdc.gov/nccdphp/drh/wh_hysterec.htm and <http://www.ahrq.gov/research/hysterec.htm>

diagnosis for women for inpatient services at San Francisco General Hospital in FY 2001-2002 were:

- Normal delivery (childbirth)
- Psychosis
- Schizophrenia
- Pneumonia
- Chest Pain
- Exam/Clinical Research
- Perineal Laceration
- Delivery by C-section (childbirth)
- Congestive Heart Failure
- Depressive Disorder
- Neurotic Disorder
- Cellulitis & Abscess of Leg
- HIV Disease

Section Four

Six Core Recommendations for Safeguarding, Promoting and Improving Health for Women and Girls in San Francisco

Recommendation One:

Promote wellness and provide excellence
in health care to women and girls
in San Francisco
in a gender-specific context.

Recommendation One:

Promote wellness and provide excellence in health care to women and girls in San Francisco in a gender-specific context.

Background

Women, by virtue of their sex, present particular physiological health concerns and exhibit gender based health disparities. In order to provide health care services that best meet the needs of women and girls, a gender conscious perspective that takes into consideration women's specific needs across their life span should be utilized in program and policy design and implementation. "Diagnosis and treatment that is appropriate to gender can and should be the focus of the health care delivery system."⁷²

**** San Francisco Healthy Highlight ****

The Women's Community Clinic, in partnership with DPH, is the only free women's health clinic in SF, provides quality healthcare for women by women to over 2,000 women per year; 90% of their clients are uninsured.

Women's reproductive health requires attention be paid to lifespan issues, conditions and interventions which include menstruation, PMS, contraception, STD's, fertility, pregnancy, childbirth, abortion, menopause and hysterectomies. Over 80 percent of all American women have had a child by the age of 45.

About 75 percent of autoimmune diseases occur in women, most frequently during the childbearing years. Grouped together, autoimmune diseases represent the fourth largest cause of disability among women in the United States. Examples include:

- Systemic lupus erythematosus (SLE or Lupus) – 9 of 10 cases occur in women.
- Sjogren's Syndrome – 9 out of 10 cases occur in women.
- Rheumatoid arthritis – occurs in women two to three times as often as in men.
- Scleroderma (systemic sclerosis) – approximately 80% of those afflicted are women in their prime.
- Multiple sclerosis (MS) – affects women more often than men, perhaps two to three times more often.
- Chronic fatigue syndrome (CFS) – more women than men are diagnosed with CFS.
- Hashimoto's thyroiditis – most common cause of hypothyroidism, which occurs 5 times more often in women than in men.
- Graves' disease – most common cause for hyperthyroidism, which targets women four to eight times as often as men.⁷³

Incidence and prevalence rates for Alzheimer's disease are higher in women than in men. Alzheimer's disease is a problem for more women than for men – as both patients and caregivers.⁷⁴

⁷² Wilson, A., Flyer, K., and McSpendon, C., The Evolution of Women's Health Resources, The Journal of Gender-Specific Medicine 1998, Volume 1, Number 2, November.

⁷³ The National Women's Health Information Center, <http://www.4woman.gov/media/statistics.html>

⁷⁴ McCann JJ, Herbert LE, Bennett DA, et al. Why Alzheimer's disease is a women's health issue. J Am Med Womens Assoc 1997; 52:132-137.

Recommendation One:

Promote wellness and provide excellence in health care to women and girls in San Francisco in a gender-specific context.

Women are twice as likely as men to experience depression, and two to three times as likely to experience anxiety disorders, such as panic, phobias, and posttraumatic stress. Women are also far more likely to experience anorexia and bulimia.⁷⁵

Osteoporosis is a major public health threat for more than 28 million Americans. Eighty percent of those affected by this disease are women. It accounts for 70% of all the fractures occurring annually in people over age 45 and is a major cause of admission to nursing homes.⁷⁶

Arthritis is the leading cause of disability in the United States. Arthritis is the most common and disabling condition reported by women; it is also the leading chronic condition among women. Women aged 15 years and older account for 60% of arthritis cases.⁷⁷

More than 13 million people in the United States experience urinary incontinence. Women experience incontinence two times more often than men do; pregnancy and childbirth, menopause, and the structure of the female urinary tract account for this difference.⁷⁸

Heart disease is the leading cause of death for women and a major contributor to their morbidity and disability. More women than men die each year from heart disease, and among those who survive a heart attack, nearly twice as many women as men die within the following year.⁷⁹

Women account for 61 percent of deaths due to stroke each year. Women who smoke or who have high blood pressure, heart disease, or diabetes are at greater risk of having a stroke. Hormonal changes with pregnancy, childbirth, and menopause are also linked to an increased risk of stroke.⁸⁰

DPH Strategies

- 1-a) Continue to utilize the Office of Women's Health to develop, promote and monitor gender-sensitive policies concerning the health care needs of women and girls at local, state and federal levels in collaboration with community advocacy organizations. (Ongoing: O)

⁷⁵ Dailard, JD, Cynthia , Gender-Specific Approaches to Mental Health Policy, The Journal of Gender-Specific Medicine 1999; Vol. 2, Number 3, May/June.

⁷⁶ The National Women's Health Information Center, <http://www.4woman.gov/media/statistics.html>.

⁷⁷ Source: <http://www.cdc.gov/nccdphp/arthritis/index.htm>

⁷⁸ Source: <http://www.niddk.nih.gov/health/urolog/pubs/uiwomen/uiwomen.htm>

⁷⁹ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

⁸⁰ Source: http://www.stroke.org/pages/brain_women.cfm; http://www.4woman.gov/owh/pub/heart_disease/index.htm

Recommendation One:

Promote wellness and provide excellence in health care to women and girls in San Francisco in a gender-specific context.

- 1-b) Ensure programmatic suggestions and recommendations emerging from the Women and Girl's Health Advisory Committee are reviewed and that feedback is provided. (O)
- 1-c) Increase intra-DPH communication, collaboration and coordination in utilization of resources and in planning and provision of health care services to women and girls by creating an internal DPH Women and Girl's Services Coordinating Council composed of representatives from all programs, departments and primary care settings serving these populations. (New: N '03) ** First meeting of this group will be held July 2003 **
- 1-d) Increase personnel sensitivity and knowledge by providing cultural competency training with focus on gender issues to all DPH divisions, contractors and providers through the DPH Office of Equal Employment Opportunity, Affirmative Action and Cultural Competency (N '04)
- 1-e) Implement a monitoring plan to encourage achievement of gender sensitive cultural competency throughout DPH (N '06)
- 1-f) Ensure that DPH programs provide gender-specific services and pay particular attention to health conditions and diseases affecting women exclusively or disproportionately such as lupus, thyroid disease, menopause, osteoporosis, Alzheimer's disease, and breast, cervical, uterine and ovarian cancer (N '05)
- 1-g) Through the leadership of the Office of Women's Health, collaborate with service providers and community advocacy groups to organize campaigns and events such as Women's Health Fairs in different San Francisco neighborhoods and the annual observance of National Women's Health Week (O)
- 1-h) Standardize DPH data utilization by ensuring that all DPH sections, departments and programs (including contracted services), maintain and submit client health status, provision of health care services and demographic data by gender to the appropriate DPH data bank. (N '04)
- 1-i) All DPH periodic updates and annual reports such as the Overview of Health to list data by gender (N '04)
- 1-j) Through the leadership of the Office of Women's Health, develop evaluation process for DPH women and girl's health services involving the Women's Health Services Coordinating Council and the Office of Adolescent Health (N '06)
- 1-k) Periodically review evaluation of DPH women and girl's services with representatives of other City departments including the Commission on Aging and the Mayor's Office on Disability (N '06)

Recommendation One:

Promote wellness and provide excellence in health care to women and girls in San Francisco in a gender-specific context.

- 1-l) Periodically undertake evaluation processes for all DPH women's health services and programs including the use of quality control monitoring mechanisms, and client and provider satisfaction surveys (N '06)

Recommendation Two:

Reduce mortality and disability rates
among women through
concerted prevention efforts.

Recommendation Two:

Reduce mortality and disability rates among women through concerted prevention efforts.

Background

The main determinants of health are social, economic, cultural, environmental, health services and personal health practices. In order to encourage improvement in health outcomes in populations of women, a broad range of targeted prevention strategies must be implemented by DPH in partnership with public, private and nonprofit organizations.

DPH can be a catalyst for change in the lives of women and girls by encouraging healthy changes in individual lifestyle choices and practices. About half of all women aged 20 to 74 are overweight or obese. The percentages of obese women among African American, Native American and Mexican American women are even higher.⁸¹

Current cigarette smoking estimates for the United States are that about 22 million women (22%) are smokers, putting them at increased risk of heart attack and stroke.⁸² Over the past 10 years, the mortality rate from lung cancer has declined in men but has continued to rise in women; this trend is due almost exclusively to increased rates of cigarette smoking in women.⁸³ Smoking during pregnancy is estimated to account for 20 to 30 percent of low-birth weight babies, up to 14 percent of pre-term deliveries, and some 10 percent of all infant deaths.⁸⁴ A higher percentage of women stop smoking during pregnancy, both spontaneously and with assistance, than at other times in their lives. Using pregnancy-specific programs can increase smoking cessation rates, which benefits infant health and is cost effective.⁸⁵

Of women who use illicit drugs, about half are in the childbearing age group of 15 to 44. Women who abuse alcohol or drugs are also at higher risk for HIV/AIDS, tuberculosis, oral and pharyngeal cancer, injury, and sexually transmitted diseases.⁸⁶

In San Francisco since 1997, chlamydia rates have increased by 20% in women although between 2000 and 2001 there was a 5% decline in reported cases.⁸⁷ Notwithstanding, the chlamydia rate for San Francisco has remained higher than the rate for New York City and Los Angeles as well as the overall rates for the United States and for California through 2000.⁸⁸ Chlamydia rates are higher for women and the rates for the southeastern sector of San Francisco (West Hunters Point, Sunnydale, and Potrero Hill) are much higher than other

⁸¹ Source: Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001: <http://www.surgeongeneral.gov/topics/obesity/default.htm>

⁸² Source: <http://www.americanheart.org/statistics/biostats/biowo.htm>

⁸³ Source: American Cancer Society, Cancer Facts and Figures 2002: <http://www.cancer.org/downloads/STT/CFF2002.pdf>

⁸⁴ Source: http://www.lungusa.org/tobacco/pregnancy_factsheet99.html

⁸⁵ Source: Surgeon General's Report, At a Glance: http://www.cdc.gov/tobacco/sgr/sgr_forwomen/ataglance.htm

⁸⁶ The Women's Health Information Center: Substance Abuse: <http://www.4woman.gov/media/statistics.htm>

⁸⁷ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July, 2002.

⁸⁸ Sexually Transmitted Disease Surveillance, 2000, Division of STD Prevention of the US Department of Health and Human Services, November 2001.

Recommendation Two:

Reduce mortality and disability rates among women through concerted prevention efforts.

neighborhoods.⁸⁹ Part of the difference by gender for chlamydia is likely to be an artifact of testing: screening programs have targeted women because of adverse reproductive outcomes of untreated infections such as pelvic inflammatory disease, chronic pelvic pain, and infertility. Some of the difference also is due to physiological differences that make women more susceptible to chlamydia infection.⁹⁰

About 16 million adults ages 40 to 74 have pre-diabetes (Impaired Glucose Tolerance) which puts them at 50 percent higher risk of having a heart attack or stroke. The Diabetes Prevention Program clinical trial demonstrated that moderate changes in diet and exercise could delay and possibly prevent type 2 diabetes in this population, particularly in those people ages 60 and older.⁹¹

DPH Strategies

- 2-a) The Office of Women's Health (OWH) in cooperation with Community Behavioral Health Services will work with ongoing prevention programs and treatment services to reduce the prevalence of unipolar major depression, alcohol dependence and drug abuse among older women. (New: N '05)
- 2-b) The OWH and Community Health Promotion and Prevention (CHPP) to ensure the DPH Prevention Framework strategic plan specifically takes into account the health of women and girl populations. (N '04)
- 2-c) The OWH and CHPP to ensure gender-perspective informs the design, promotion and implementation of prevention campaigns among DPH sections and community stakeholders. (N '04)

⁸⁹ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July 2002.

⁹⁰ Ibid., page 18.

⁹¹ Source: <http://ndep.nih.gov/get-info/dpc.htm>

Recommendation Three:

Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families in San Francisco.

Recommendation Three:

Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families in San Francisco.

Background

Violence has become a major public health challenge for women, who are six times more likely than men to be victimized by an intimate partner, especially in low-income families. In addition to injuries sustained during violent episodes, physical and psychological abuse are linked to a number of adverse physical health effects including arthritis, chronic neck or back pain, migraine and other frequent headaches, stammering, problems seeing, sexually transmitted infections, chronic pelvic pain, stomach ulcers, spastic colon, and frequent indigestion, diarrhea, or constipation.⁹²

Violence may be a hidden cause of maternal mortality, as it is estimated that up to 17% of pregnant women are physically abused.⁹³ One study found that pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause.⁹⁴ One out of four American women report having been raped and/or physically assaulted by a current or former spouse, live-in partner, or date at some time in their life. While men are more likely to be victims of violent crime, women are between 5 to 8 times more likely to be victimized by an intimate partner. An estimated 4 million women are physically abused by their partners each year, and about one of every four women seeking care in emergency rooms has injuries resulting from domestic violence.⁹⁵

Women age 16-24 experience the highest per capita rates of intimate violence.⁹⁶ It is estimated that 10 to 20 percent or 1 out of 10 young women are the victims of sexual abuse.⁹⁷ A history of abuse may influence sexual risk taking later in life among women.⁹⁸ A history of childhood sexual abuse is a salient factor for all women in terms of HIV risk later in life.⁹⁹

Sexual assault exists as a continuum of violence that includes the exploitation of women and girls; sexual harassment; molestation; incest; rape of children; and rape by dates, acquaintances, spouses, significant others, and strangers.¹⁰⁰ Sexual assault has demonstrated links to other forms of violence such as gang violence, domestic violence and

⁹² Coker, A., Smith, P., Bethea, L., King, M., McKeown, R., "Physical Health Consequences of Physical and Psychological Intimate Partner Violence," Archives of Family Medicine, Vol. 9, May 2000.

⁹³ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

⁹⁴ Horon, I., & Cheng, D., (2001). Enhanced Surveillance for Pregnancy-Associated Mortality – Maryland 1993-1998. The Journal of the American Medical Association, 285, No. 11, March 21, 2001.

⁹⁵ The National Women's Health Information Center, Source: <http://www.ahrq.gov/research/womenh2.htm#domvio>

⁹⁶ The National Women's health Information Center, Source: <http://www.ojp.usdoj.gov/bjs/pub/ascii/vi/txt>

⁹⁷ The National Women's Health Information Center, Source: <http://www.cdc.gov/ncipc/dvp/dvp.htm>

⁹⁸ 2001 San Francisco HIV Prevention Plan, pp. 88-89.

⁹⁹ Ibid, page 34.

¹⁰⁰ California Coalition Against Sexual Assault, CALCASA Strategic Forum Report: A Vision to End Sexual Assault, 2000, page i.

Recommendation Three:

Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families in San Francisco.

violence related to drug and alcohol use.¹⁰¹ An estimated 302,100 women and 92,700 are forcibly raped each year in the United States.¹⁰²

While the same high rate of lifetime physical, sexual and/or emotional abuse was found among women with physical disabilities and non-disabled women, women with disabilities were more likely to experience abuse by health care providers and personal assistants, both formal and informal, family members, intimate partners, friends or professionals and for longer periods of time.¹⁰³ In addition, women with disabilities are at risk for experiencing abuse that is specifically related to their disability support needs, such as medication abuse, refusing to provide essential care, and disabling of equipment.¹⁰⁴

**** San Francisco Healthy Highlight ****

The DPH Community Health Education Section is currently producing a five-year strategic plan for primary prevention of intimate partner violence. This work has been made possible by a grant from the State Department of Health Services' Epidemiology and Injury Control Section and the plan will be made public in the summer of 2003.

African American women in abusive relationships were found to be less likely to use condoms than other racial/ethnic groups and more likely to experience verbal abuse or the threat of physical abuse when they used condoms.¹⁰⁵

DPH Strategies

- 3-a) Through involvement of Office of Women's Health (OWH), assure DPH implementation, monitoring and evaluation of the DPH Intimate Partner Violence Screening Policy Protocol (New: N '04)
- 3-b) Through OWH, collaborate with DPH Community Health Promotion and Prevention and community violence prevention coalitions to develop and implement a DPH Intimate Partner Violence Prevention Strategic Plan (Ongoing: O)

¹⁰¹ Ibid.

¹⁰² *2000 Sexual Assault Awareness Month: Rape and Sexual Assault Statistics Compilation*, Oakland, California: California Coalition Against Sexual Assault, April 2000, p. 18, citing Patricia Tjaden and Nancy Thoennes, *Prevalence, Incidence and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey*, Washington, D.C.: National Institute of Justice, U.S. Department of Justice, November 1998, p.4.

¹⁰³ Nosek MA, Howland CA, Rintala DH, Young ME and Chanpong GF. National Study of Women with Physical Disabilities: Final Report. Center for Women with Disabilities, Houston, TX, page 5.

¹⁰⁴ Family Violence Prevention Fund, End Abuse Health Alert: Strengthening the Health Care System's Response to Domestic Violence, Volume 8, No. 1, Winter 2002, page 2.

¹⁰⁵ 2001 San Francisco HIV Prevention Plan, page 34.

Recommendation Three:

Reduce mortality, injury and negative effects on the quality of life due to violence confronted by women, girls and their families in San Francisco.

- 3-c) Collaborate with other City departments, such as the Department on the Status of Women and the SFPD, to create and implement strategies to reduce women's mortality and injury rates and family vulnerability to firearm violence (N '06)
- 3-d) Through OWH, ensure collaboration with Office of Adolescent Health and San Francisco Unified School District to design and implement a healthy relationships curriculum (N '05)
- 3-e) The OWH, in collaboration with the San Francisco Adult Sexual Assault Task Force and CASARC will encourage coordinated community collaborative efforts to prevent sexual assault and ensure provision of comprehensive crisis services for individuals and families (O)

Recommendation Four:

Expand screening and treatment services and encourage prevention efforts to reduce cancer rates among women.

Recommendation Four:

Expand screening and treatment services and encourage prevention efforts to reduce cancer rates among women.

Background

Cancer is the second leading killer of American women. Since 1987, lung cancer has been the top cancer killer among American women, with an estimated 65,700 deaths in 2002. Over the past 10 years, the mortality rate from lung cancer has declined in men but has continued to rise in women. These alarming trends are under recognized by women and are due almost exclusively to increased rates of cigarette smoking in women.¹⁰⁶

Breast cancer is the second leading cancer killer among women. However, although lung cancer kills more women each year than breast cancer does, there are more new cases of breast cancer every year than lung cancer.¹⁰⁷ The incidence and death rates from breast cancer increase with age. About 80 percent of breast cancers occur in women age 50 or older.¹⁰⁸ In California in 2000, only 39% of women 40 years and older surveyed reported having had a mammogram in the last year.¹⁰⁹

**** San Francisco Healthy Highlight ****

Breast Cancer Town Hall Meetings (a collaborative effort between community groups, such as Breast Cancer Action, and DPH) have been held successfully for the past three years in communities such as Bayview/Hunter's Point, Western Addition and the Mission.

**** San Francisco Healthy Highlight ****

In 2000, a Mammogram/PAP task force of the CHN Primary Care QI Committee developed and implemented new systems for primary care patients. The systems combine reminder letters and calls to patients, and annual lists of patients needing PAPs or mammograms to primary care sites. As a result, CHN Primary Care's:

- Mammogram Rate improved from 63% in Jul-00 to 71% in Dec-02
- PAP Rate improved from 67% in Feb-01 to 70% in Dec-02.

Colorectal cancer is the third leading cause of cancer deaths in American women. Regular screening, exercise and a healthy diet can prevent many cases. Cervical cancer rates have shown dramatic declines due to early detection and prevention through the use of Pap smears.¹¹⁰

African American women have a higher death rate from breast cancer despite having a mammography-screening rate that is nearly the same as the rate for white women.

¹⁰⁶ The National Women's Health Information Center, Source: American Cancer Society, Cancer Facts and Figures 2002: <http://www.cancer.org/downloads/STT/CF2002.pdf>

¹⁰⁷ Ibid.

¹⁰⁸ The National Women's Health Information Center, Source: Breast Cancer Facts and Figures 2001-2002, American Cancer Society. <http://www.cancer.org/downloads/STT/BrCaFF2001.pdf>

¹⁰⁹ California Women's Health Survey, California Department of Health Services, Office of Women's Health, 1999-2000, No.20; <http://www.dhs.ca.gov/director/owh/htm/whs/19992000DataPoints.htm>

¹¹⁰ The National Women's Health Information Center, Source: American Cancer Society, Cancer Facts and figures 2002.

Recommendation Four:

Expand screening and treatment services and encourage prevention efforts to reduce cancer rates among women.

Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women.¹¹¹

DPH Strategies

- 4-a) The Office of Women's Health (OWH) will continue development and improvement of collaboration between SFGH and UCSF through the Avon Women's Imaging Center and Mammography Program (Ongoing: O)
- 4-b) The OWH and Community Health Promotion and Prevention (CHPP) to collaborate with community advocacy groups in prevention efforts focused on identifying and reducing or eliminating environmental and social determinants of breast cancer. (O)
- 4-c) The OWH, in collaboration with the Breast and Cervical Cancer Screening Services Program and Jail Health Services, will review and support the provision of screening to all women in San Francisco County jails. (New: N '04)
- 4-d) The Office of Women's Health in collaboration with SFGH, Laguna Honda Hospital and Rehabilitation Center and UCSF will ensure availability of mammography services for older and disabled women (N '04)
- 4-e) Ensure that immigrant women breast and cervical cancer patients have access to comprehensive support services and navigator (O)
- 4-f) The OWH in collaboration with Breast and Cervical Cancer Screening Services will continue emphasis on ensuring access to timely cervical and mammography screening services for diverse women's communities in San Francisco. (O)
- 4-g) The OWH, Community Health Promotion & Prevention and community advocates will focus tobacco cessation efforts on women. (N'05)

¹¹¹ Healthy People 2010

Recommendation Five:

Eliminate health disparities
among women in San Francisco, including:

- Race and Ethnicity
- Sexual Orientation
 - Disability

Recommendation Five:

Eliminate health disparities among women in San Francisco.

Race and Ethnicity Disparities – Background

Notwithstanding modern improvements in medical technology, access to health services and public health practices, notable disparities in health outcomes among different racial and ethnic groups persist. Access to care, individual behaviors, socioeconomic status and immigrant status are all factors that influence disparity in health outcomes.

For example, the disparities can be viewed as both a cause and a result of the socioeconomic differences among Californians. Poverty and poor education can lead to a lack of access to health care and poor information about health behaviors. At the same time, poor health reduces educational and economic opportunities.¹¹² Other studies point to gender and racial bias in medical treatment providers as a source of disparate treatment for heart disease.¹¹³

In terms of health outcomes, African Americans fare worse than other racial and ethnic groups, both nationally and in California.¹¹⁴ African Americans in San Francisco have the lowest levels of life expectancy at birth and the highest levels of mortality for each sex. Asian/Pacific Islanders and Hispanic/Latinos in San Francisco have the lowest mortality rates.

In San Francisco, African American women (and men) have the highest rates of chlamydia, gonorrhea, and syphilis, three times the rate of women with the next highest rates.¹¹⁵ African American female youth under 20 are even more disproportionately affected, with chlamydia and gonorrhea rates over 3.5 times the average rate for the City as a whole, and six to eight times the rates for the ethnic group with the next highest rates. These issues may point to African American women and female adolescents as an emerging population at risk for

**** San Francisco Healthy Highlight ****

The DPH African-American Health Initiative, in partnership with the African American Coalition for Health Improvement and Empowerment (AACHIE), the San Francisco Housing Authority and the Sheriff's Department helped create the Community Empowerment Center.

The CEP targets violence prevention and provides services in health outreach and information, family planning, mentorship and internship programs, and self-help support groups for girls and substance abuse.

disparities in health among African Americans by developing successful interventions through community partnerships using culturally appropriate methods.

¹¹² Public Policy Institute of California, Reyes, Belinda I., ed., A Portrait of Race and Ethnicity in California: An Assessment of Social and Economic Well-Being, 2001, page 73.

¹¹³ Oppenheimer, DB and Shultz, MM, Gender and Race Bias in Medical Treatment, The Journal of Gender-Specific Medicine, 1999, Vol. 2, Number 4, July/August.

¹¹⁴ Public Policy Institute of California, Reyes, Belinda I., ed., A portrait of Race and Ethnicity in California: An Assessment of Social and Economic Well-Being, 2001, page ix.

¹¹⁵ 2001 San Francisco HIV Prevention Plan, pp. 33-34.

Recommendation Five:

Eliminate health disparities among women in San Francisco.

increasing rates of HIV infection, although more research and surveillance is needed.”¹¹⁶ Rates for gonorrhea for African-American adolescents are eight times the rate for whites, and chlamydia rates are twelve times greater.¹¹⁷ Gonorrhea cases increased among African-American adolescents during 2001, but were relatively stable among other racial and ethnic groups.¹¹⁸

African American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (77%) of AIDS cases reported to date among women in our country.¹¹⁹ Overall mortality rates due to cancer were significantly higher for African American women.

African American women tend to develop lupus three times more often than white women, develop it at a younger age, develop more serious complications, and have a higher mortality rate from the disease than do white women.¹²⁰

Hispanics often have less access to health care and lower health status than whites, whereas health indicators for Asians are similar to-and sometimes better than those for whites. These broad generalizations about the health of Hispanics and Asians do not highlight important differences in the health of different Hispanic and Asian subgroups. Although people of Japanese, Chinese, and Korean ancestry tend to enjoy better health than whites, people of Southeast Asian and Filipino ancestry have comparatively poor health outcomes. Although Mexicans have poorer access to health services such as prenatal care, they have better birth outcomes than other Hispanic groups.¹²¹

Differences exist when the leading causes of death among women are examined by race and ethnicity: for African American women HIV/AIDS is 10th, for Asian/Pacific Islander women suicide is 8th, for Hispanic/Latinas conditions originating in the perinatal period is 8th, and for Native Americans/Alaskans chronic liver disease and cirrhosis is 7th.¹²² None of these diseases and conditions appears in the top ten causes of death for American women in general. (See Page 15)

Women of color receive fewer preventive health interventions than white women. Fifty-five percent of Asian American women, 43 percent of Hispanic women and 37 percent of African American women did not have a Pap test within the past year. Seventy-four percent of

¹¹⁶ 2001 San Francisco HIV Prevention Plan, p. 34.

¹¹⁷ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July, 2002, page 47.

¹¹⁸ Ibid.

¹¹⁹ Source: <http://www.cdc.gov/hiv/pubs/facts/women.htm>

¹²⁰ The National Women's Health Information Center, Source: <http://www.niams.nih.gov/hi/topics/lupus/slehandout/index.htm>
<http://www.niams.nih.gov/hi/topics/lupus/lupusguide/chp2.htm>

¹²¹ Public Policy Institute of California, Reyes, Belinda I., ed., A portrait of race and Ethnicity in California: An Assessment of Social and Economic Well-being, 2001, page ix.

¹²² Women's Health Statistical Information, CDC, 2000.

Recommendation Five:

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Hispanic women and 73 percent of Asian American women did not have a blood pressure screening within the past year.¹²³

Stroke occurs at a higher rate among African American and Hispanic women compared with white women.¹²⁴ African American women have a higher risk of disability and death from stroke than white women do.¹²⁵ Among women in San Francisco in 2000, African Americans had the highest rate of ischemic heart disease and stroke, followed by Whites. Hispanic/Latinas had the lowest rate for both diseases.

Type 2 Diabetes is more prevalent in people of color, including African American and Hispanic populations. Women of African American and Hispanic descent, as well as some with Native American ancestry, are at additional risk for obesity and the development of Type 2 Diabetes. Women from these populations need to be monitored closely and counseled on the prevention and early management of these chronic diseases.¹²⁶ Screening for diabetes is crucial because, left untreated, it can lead to heart disease, stroke, kidney disease, severe vision loss, and lower limb amputation.¹²⁷

Race and Ethnicity Disparities – DPH Strategies

- 5-a) The OWH to participate in community efforts to document and address social determinants of health disparities due to ethnicity and race in SF (New: N '04)
- 5-b) Include gender and racial/ethnic specific strategies in the development and implementation of the DPH Prevention Framework (Ongoing: O)
- 5-c) In coordination with the DPH Prevention Framework, identify and implement strategies to increase screening and influence nutrition, physical activity and tobacco consumption habits among Latinas, African American and Asian/Pacific Islander women as part of efforts to prevent and decrease mortality and disability rates due to obesity, cerebrovascular disease, heart disease, lung cancer and arthritis. (N '04)
- 5-e) Support current programmatic efforts being coordinated through Maternal Child Health and DPH Prevention (O)
- 5-f) The OWH in collaboration with Maternal Child Health will further reduce incidence of low birth weight babies by expanding access to prenatal care for Latinas, African American and Asian women. (N '04)

¹²³ The National Women's Health Information Center, Source: <http://www.cdc.gov/nchs/data/hus/huscht95.pdf>

¹²⁴ Ibid.

¹²⁵ Source: http://www.4woman.gov/owh/pub/heart_disease/index.htm

¹²⁶ Campaigne, PhD, BN, and Wishner, PhD, KL, Gender-Specific Health Care in Diabetes Mellitus, The Journal of Gender-Specific Medicine, 2000, Vol. 3, Issue 1, Jan/Feb.

¹²⁷ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

Recommendation Five:

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- 5-g) The OWH, the African American Health Initiative and the African American Coalition for Health Improvement and Empowerment to collaborate in ensuring DPH programs and services effectively serve women of African descent living in San Francisco. (O)
-

Sexual Orientation Disparities – Background

Lesbian, bisexual and transgender (LBT) women face challenges in accessing health care that include less availability of spousal benefits of health insurance for domestic partners, prejudice and lack of cultural competence among service providers, and inadequate risk assessment and medical screenings due to unwillingness to disclose sexual orientation, gender identity and sexual practices for fear of discrimination. LBT women are also at increased risk of stress-related mental health problems and substance abuse.¹²⁸

**** San Francisco Healthy Highlight ****

Dimensions Clinic, a weekly clinic held at the DPH Castro Mission Health Center, is the only one of its kind in San Francisco specifically focused on providing culturally appropriate comprehensive health services for lesbian, bisexual, gay, transgender and queer youth. The clinic has become a national model for successfully serving these populations.

Rates of ovarian and breast cancer are higher among women who have not had children or used oral contraceptives. Many lesbians fall into this category and may have an increased risk for ovarian and breast cancer. Lesbians access gynecological care less frequently than heterosexual women, which can result in later diagnosis of cervical, ovarian or breast cancer.¹²⁹

Some evidence suggests lesbians have higher rates of smoking, overweight, alcohol abuse, and stress than heterosexual women.¹³⁰ Many lesbians experience barriers to accessing healthcare throughout their lives that result in delay, avoidance, and mismanagement. The cumulative effect of this experience can have an impact on health status for lesbians later in life.¹³¹ Few agencies tailor services to the needs of lesbian seniors. The combination of this lack of social support in conjunction with the barriers to access that lesbians already experience from the healthcare system puts lesbian seniors at increased risk.¹³²

¹²⁸ Mind, Body, Spirit: Our Community, Our Health. National Coalition for LGBT Health. http://www.lgbthealth.net/health_care.html

¹²⁹ Ibid.

¹³⁰ Healthy People 2010.

¹³¹ Healthy People 2010, p. 52.

¹³² Behney, R. The aging network's response to gay and lesbian issues. Outword, Newsletter of the Lesbian and gay Aging Issues Network of the American Society on Aging, Winter 1994.

Recommendation Five:

Eliminate health disparities among women in San Francisco.

Sexual Orientation Disparities – DPH Action Needed

- 5-h) Continue to provide culturally competent health care and facilitate access to such care to lesbian, bisexual and transgender women (Ongoing: O)
- 5-i) The OWH in collaboration with DPH Office of EEO, Affirmative Action and Cultural Competency will incorporate the “Community Standards of Practice for the Provision of Quality Health Care and Social Services for Gay, Lesbian, Bisexual and Transgender Individuals and Their Families” into the DPH policy on Contractor’s Compliance with Nondiscrimination and Cultural Competency by expanding the existing requirements, including evaluation criteria for measuring compliance with these standards and establishing an implementation timeline (New: N ’04)
- 5-j) Design and provide, through the DPH Office of EEO, Affirmative Action and Cultural Competency, cultural competency training on sexual orientation issues (N ’03)
- 5-k) Access and disseminate throughout DPH current information concerning emerging health concerns, state and national policy initiatives and new treatment modalities for lesbian, bisexual and transgender women (O)
- 5-l) Through the Office of Women’s Health, maintain communication with health advocacy networks such as the Gay and Lesbian Medical Association and the Lesbian and Gay Health Association (O)
- 5-m) Collaborate with community partners such as the Lesbian Health Research Center in encouraging research efforts focused on assessment of health conditions and development of prevention and treatment modalities tailored to lesbian, bisexual and transgender women. Note: The OWH Coordinator is currently a member of the Executive Committee and Advisory Council of the LHRC (O)

Disability Disparities – Background

Women with disabilities must deal with physical barriers getting to health care as well as health provider biases or mistaken assumptions in obtaining care. Also, many women face obstacles in getting programs like MediCal and Medicare to pay for needed medical equipment, services and supplies. The Center for Research on Women with Disabilities (CROWD) found that women with physical disabilities are more likely to use every major category of healthcare provider and facility (including public health clinics and emergency rooms) within a given year, and that 91% see one or more specialists during that time.¹³³ Disabled women report more chronic conditions and at younger ages than women without

¹³³ Family Violence Prevention Fund, End Abuse Health Alert: Strengthening the Health Care System’s Response to Domestic Violence, Volume 8, No. 1, Winter 2002.

Recommendation Five:

Eliminate health disparities among women in San Francisco.

disabilities.¹³⁴ Women have a higher rate of disability than men and report a higher number of conditions that limit their activity. In 1997, nationally 20.7% of women had a disability in comparison to 18.6% of men.¹³⁵

In the United States and other developed countries, 4 of the 10 leading causes of disability are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Nearly twice as many women as men are affected by a depressive disorder each year.¹³⁶ Women are more likely than men to have an anxiety disorder such as panic disorder, post-traumatic stress disorder, generalized anxiety disorder, agoraphobia and specific phobia.¹³⁷

People with disabilities also have other disparities including lower rates of physical activity and higher rates of obesity.¹³⁸

Disability Disparities – DPH Action Needed

- 5-n) DPH will continue to provide culturally competent accessible health care services to women with disabilities in compliance with the American Disability Act requirements (Ongoing: O)
- 5-o) The Office of Women’s Health in collaboration with the DPH Office of EEO, Affirmative Action and Cultural Competency, the Mayor’s Office on Disability and disability advocates will periodically evaluate ADA guideline compliance of all DPH facilities and contract sites (New: N ‘05)
- 5-p) Continue offering training through the DPH Office of EEO, Affirmative Action and Cultural Competency to all DPH personnel, contractors and providers on cultural competency concerning disability (O)
- 5-q) Centralize available internally generated data, encourage expanded data collection efforts in all DPH divisions and access data maintained by CBOs serving the blind, deaf and hard of hearing, developmentally disabled and physically/mobility impaired for inclusion in an expanded section on Disability in the DPH annual Overview of Health (N ‘05)
- 5-r) DPH to collaborate with other City departments and CBOs serving disabled women in assessing and documenting the incidence of women with disabilities who are uninsured and those who although insured or accessing Medicare, do not qualify for

¹³⁴ Source: <http://www.hrsa.gov/WomensHealth/wh21cen.htm>

¹³⁵ Women’s Health USA 2002, Maternal and Child Health Bureau, p. 28; <http://www.mchb.hrsa.gov/data/women.htm>

¹³⁶ Source: <http://www.nimh.nih.gov/publicat/numbers.cfm>

¹³⁷ Ibid.

¹³⁸ Healthy People 20210

Recommendation Five:

Eliminate health disparities among women in San Francisco.

coverage of all the health services and equipment they need as part of efforts to improve the quality of life of disabled women. (N '06)

- 5-s) Recruit and include women with disabilities in DPH:
- ADA compliance monitoring efforts
 - Advisory committees when possible
 - Trainers in EEO/Cultural Competency trainings on disability (O)

Recommendation Six:

Ensure the health of vulnerable populations of women by expanding access to health services, including:

- Younger Women
- Older Women
- Homeless Women
- Poor and Uninsured Women
- Immigrant Newcomer Women
 - Incarcerated Women

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

Young Women – Background

“Adolescents are one of the most medically underserved populations, frequently lacking health insurance coverage, access to basic health care or adolescent health specialists. Legal, parental, and societal barriers may prevent adolescents from seeking and receiving health services independent of their guardians.”¹³⁹

For young women in the U.S. in 2000 ages 10-19, the leading cause of death was unintentional injuries. Assault (homicide) is the second leading cause of death among young women ages 15-19 and the fourth cause among ages 10-14. Intentional self-harm (suicide) is the fourth leading cause of death among ages 15-19 and the sixth cause among ages 10-14.¹⁴⁰

A study conducted by the National Center on Addiction and Substance Abuse at Columbia University based on a nationwide survey of females ages 8 to 22 found the following:

- Girls and young women are more easily addicted to drugs and alcohol
- They have different reasons than boys for abusing substances (i.e. a desire to reduce stress and alleviate depression)
- Girls are more likely to abuse substances if they reach puberty early, have eating disorders or are ever physically or sexually abused
- They may need single-sex treatment programs and female-targeted prevention programs¹⁴¹

Teenage girls often start to smoke to avoid weight gain. They also seek to identify themselves as independent and glamorous, which reflect images projected by tobacco ads. In 1999, 34.9 % of high school girls were current smokers and 15.6% were frequent smokers.¹⁴²

Younger women are particularly at risk for reproductive health problems associated with sexually transmitted diseases. Two-thirds of all STD cases occur among individuals younger than 25 years, and 1 in 4 teenagers contracts an STD each year.¹⁴³ In San Francisco the highest STD rates are seen

**** San Francisco Healthy Highlight ****

Solutions is a DPH Special Programs for Youth program for young women detained at Youth Guidance Center in collaboration with BRAVA for Women in the Arts. It provides weekly group sessions providing a curriculum encouraging self-empowerment through health education, creative expression and group dynamics. The young women regularly publish their writings and artwork in teen magazines and have assembled a touring multimedia public art show called ‘Girls in the Hall.’

¹³⁹ Source: Meeting the Needs of Youth at Risk: Adolescent Health Programs. Bureau of Primary Health Care, 1996.

¹⁴⁰ National Vital Statistics Report, Vol. 50, No. 16, Sept. 16, 20-02, Table 1.

¹⁴¹ San Francisco Chronicle, February 6, 2003.

¹⁴² Source: http://www.lungusa.org/tobacco/women_factsheet99.html

¹⁴³ Source: <http://www.niaid.nih.gov/factsheets/stdinfo.htm>

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

among women 20 years old or younger; rates for gonorrhea and chlamydia are higher for female adolescents than for males.¹⁴⁴ In 2001, the rate for chlamydia was highest for women 15 to 19 years old and fell sharply in older age groups. Gonorrhea rates have increased since 2000 among females younger than 25 years and peak among women 15 to 19 years old.¹⁴⁵

Younger Women – DPH Strategies

- 6-a) Ensure consideration of gender-specific needs in implementation of DPH Adolescent Health Report 2003-2005 through collaboration between the Office of Women's Health and the Office of Adolescent Health (New: N '03)
- 6-b) The OWH to collaborate with other City departments, CBOs and community advocates in addressing health and wellness issues of sexually exploited young women (Ongoing: O)
- 6-c) Review and identify specific recommendations made by the Ending the Exploitation of Youth Task Force of the SF Board of Supervisors that relate to the DPH; work with DPH staff to assist in implementation efforts (O)
- 6-d) Ensure that sexually exploited young women are identified for DPH services through Special Programs for Youth and Children's Mental Health Services (O)
- 6-e) Participate in San Francisco collaboration to develop a plan of action to reduce rates of STDs, HIV/AIDS and Hepatitis among young women involved with the Juvenile Justice system (N ` 04)
- 6-f) OWH in collaboration with DPH Prevention, the AIDS Office and the Office of Adolescent Health will prioritize screening and prevention campaigns focused on African Americans, Latinas and other young women in order to reduce rates of STDs, HIV/AIDS and Hepatitis (N ` 04)
- 6-g) Increase participation of young women in Women and Girls' Health Advisory Committee and in all other DPH advisory groups (O)
- 6-h) Focus efforts of Behavioral Health planning to ensure availability of treatment services for Unipolar major depression, Post Traumatic Stress Disorder and substance abuse for young women, including pregnant young women and young women with children (O)

¹⁴⁴ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July 2002.

¹⁴⁵ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July 2002.

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

- 6-i) OWH, Office of Adolescent Health, Youth Commission and community groups including LYRIC to collaborate in ensuring access to appropriate DPH health programs and services for lesbian, bisexual, transgender and queer youth (O)
 - 6-j) OWH, Office of Adolescent Health and Youth Commission will develop plan to reduce mortality among young women due to motor vehicle traffic crashes. (N '05)
-

Older Women – Background

Today, 1 in 8 Americans is over 65. In the United States women make up 58% of the population over 60 and 70% of the population over 85.¹⁴⁶ Many elderly women encounter obstacles to accessing economic security, community services, and health and long-term care. In comparison to men, older women are three times as likely to live alone and spend more years and a larger percentage of their lifetime disabled. Older women are also nearly twice as likely as men to reside in a nursing home.¹⁴⁷ The poverty rate among persons 65 years and older is 13% and nearly three-fourths of the nation's elderly poor are women. For women ages 45-64 years the leading causes of death are unintentional injuries, cancer and heart disease (in varying order). For ages 65 years and older, the third leading cause of death is stroke.¹⁴⁸ One in four women over age 65 has some form of heart disease.¹⁴⁹ Many older women mistakenly believe that after menopause, regular gynecological exams are no longer necessary, but they are at that point at higher risk for cancers of the reproductive system, and other gynecological problems such as uterine prolapse.¹⁵⁰ In 1997, almost 16 percent of AIDS cases reported to the Centers for Disease Control and Prevention were in women over the age of 50.

The prevalence of osteoporosis increases with age and, according to the World Health Organization, up to 70 percent of women over age 80 years have osteoporosis.¹⁵¹ Women can lose up to 20% of their bone mass in the 5-7 years following menopause, making them more susceptible to osteoporosis. This chronic disabling condition accounts for 70 percent of all the fractures occurring annually in people over age 45.¹⁵²

¹⁴⁶ U.S. Administration on Aging, "Meeting the Needs of Older Women: A Diverse and Growing Population" <http://www.aoa.gov/factsheets/ow.html>

¹⁴⁷ Ibid.

¹⁴⁸ 1997, Healthy People 2010.

¹⁴⁹ Source: <http://www.4woman.gov/owh/pub/womhealthissues/index.htm>;
<http://www.cdc.gov/nchs/data/has/has99ncb.pdf>

¹⁵⁰ Source: <http://www.4woman.gov/media/statistics.htm>

¹⁵¹ Source: Osteoporosis in Postmenopausal Women: Diagnosis and Monitoring.
<http://www.ahcpr.gov/clinic/epcsums/osteosum.htm>

¹⁵² Source: <http://www.osteoporosis.org/docs/18.916325301.html>

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

One in 10 persons over 65 – and nearly half of those over 85 – have Alzheimer’s disease. It is the most common cause of dementia for individuals over age 65. The disease usually begins after age 60, and the risk goes up with age.¹⁵³

One in 4 women ages 30 to 59 and half of all elderly people experience episodes of urinary incontinence. Incontinence is treatable in most cases, but many people who experience this problem do not discuss it with a health care professional.¹⁵⁴

Rates of arthritis are higher among women, older persons, rural populations, and those with low education or low income.¹⁵⁵

Older Women – DPH Action Needed

- 6-k) The OWH, the Department on the Status of Women, the Mayor’s Office on Aging, other City departments and community advocacy groups to collaborate to ensure access to appropriate DPH health services and programs. (Ongoing: O)
- 6-l) The OWH, DPH Prevention and other DPH section will collaborate in increasing health screening promotion and chronic illness management knowledge and skills targeting older women. (New: N ’05)

Homeless Women – Background

“Homeless women face significant barriers to accessible health care, such as lack of transportation, limited service hours, poverty, discrimination, and lack of health insurance. A large percentage of homeless women suffer from mental health and substance abuse problems, and many have experienced significant violent abuse or trauma. As a result, homeless women become disengaged from mainstream society and are frequently distrustful of traditional health care and social service systems. Serious illness occurs at much higher rates among homeless people than housed people. Homeless women

**** San Francisco Healthy Highlight ****

The all-female staff at **Tom Waddell Health Center Women’s Clinic** provides medical care, nursing services and psychosocial services to homeless and marginally housed women.

The all-woman environment of care assures a non-threatening situation for

m

and street violence.

and two shelters: A Woman’s Place and th

During FY 99/00, the clinic served 693 unduplicated clients.

¹⁵³ Source: <http://www.alzheimers.org/pubs/adfact.html>

¹⁵⁴ Source: <http://www.niddk.nih.gov/health/urolog/pubs/uiwomen/uiwomen.htm>

¹⁵⁵ Source: <http://www.cdc.gov/nccdphp/arthritis/index.htm>

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

commonly suffer from chronic skin ailments, hypertension, dental and vision problems, poor nutrition, upper respiratory infections, and post-traumatic stress. In addition, communicable diseases such as TB and HIV/AIDS are common among the homeless, compared with the U.S. population in general.¹⁵⁶

Homeless Women – DPH Action Needed

- 6-m) The OWH in collaboration with DPH Housing and Urban Health will ensure the continuation of the provision of gender appropriate housing services to women. (Ongoing: O)
- 6-n) The OWH in collaboration with the Tom Waddell Health Center Women’s Clinic will ensure provision of health care services targeting homeless women. (O)
- 6-o) The OWH will collaborate with other City departments and community homeless advocacy groups in efforts to improve the health and well-being of homeless women. (New: N '04)

Poor and Uninsured Women – Background

In California, 15% of women have incomes below the poverty level, and 18% are considered near-poor (family incomes between 100-199% of the federal poverty level). Also, very-low-income women (family incomes below 100% of poverty level) in California are particularly likely to be uninsured. Forty-eight percent of California women ages 18-64 with incomes at this level are uninsured, as are four out of ten near-poor women.¹⁵⁷ Thirty percent of women with incomes below poverty have Medi-Cal coverage, as do 17% of near-poor women. Among very-low-income women only 17% have job-based coverage.¹⁵⁸ Approximately one in four women living in San Francisco/San Mateo/Marin counties are

**** San Francisco Healthy Highlight ****

FamilyPACT Program – All California residents with incomes at or below 200 percent of the Federal Poverty Level with no other source of family planning health care coverage will have access to comprehensive family planning services during childbearing years up to age 55. These services include: contraception, pregnancy testing, sexually transmitted infections testing and treatment, HIV testing, sterilization, Hepatitis B vaccination, cervical cancer screening, and reproductive health education and counseling. Services are reimbursed to providers at Medi-Cal rates. The number of state of California FamilyPACT female users increased from 665,997 in FY 2001 to 869,666 in FY 2002.

¹⁵⁶ Pathways to Wellness: Women Centered Primary Health Care. HRSA, Bureau of Primary Health Care, Office of Minority and Women’s Health, September 2001.

¹⁵⁷ Data Brief: Health Insurance Coverage of Women Ages 18-64 in California, 1998, California Alliance for Women’s Health Leadership

¹⁵⁸ Ibid.

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

uninsured.¹⁵⁹

Poor and Uninsured Women – DPH Action Needed

- 6-o) The OWH in collaboration with other DPH sections will explore methods to increase number of uninsured women and girls accessing and utilizing existing DPH healthcare services (Ongoing: O)
- 6-p) The OWH in collaboration with Maternal and Child Health will increase enrollment of eligible DPH clients for FamilyPACT Program coverage (New: N ` 04)
- 6-p) Ensure access to housing, food, childcare, employment and transportation as essential complementary components of health services provided by DPH to women and their families by linking clients to available City and community services. (O)
- 6-q) Support DPH SSI Advocacy initiatives currently in progress (O)

Immigrant Newcomer Women – Background

Immigrants and refugees present specific challenges to the provision of competent health care services: lack of familiarity with the English language and with American culture, inability to navigate the health care system unassisted, fear of deportation, medical health problems such as drug resistant tuberculosis and parasitic infestations, and lack of health insurance. Many refugees have had a traumatic escape process in which they have witnessed or experienced torture and rape, war, separation between families, refugee camps, malnourishment and prolonged exposure to stress. Other newcomer women end up in San Francisco as abused victims of trafficking forced to labor under debt bondage as prostitutes, domestic servants or sweatshop workers, threats of deportation, physical and psychological cruelty, and imprisonment. During the period of January-December 2002 the Newcomer Clinic at San Francisco General Hospital saw 188 patients who were refugees or persons who had been granted asylum; 92 of these were female.¹⁶⁰

¹⁵⁹ Ibid; March 1998 and 1999 Current Population Surveys.

¹⁶⁰ According to Samira Causevic, Clinical Coordinator of Newcomer Clinic, SFGH, San Francisco Department of Public Health, 3/20/03.

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

Immigrant Newcomer Women – DPH Action Needed

- 6-r) The OWH and the Newcomer Clinic at SFGH will collaborate to assure access to appropriate health care services for immigrant newcomer women. (Ongoing: O)

- 6-s) The OWH will work in conjunction with the Bay Area Anti-Trafficking Taskforce to raise community awareness concerning the needs of women and girls who are victims of international trafficking in San Francisco. (New: N '04)

**** San Francisco Healthy Highlight ****

Citywide Families in SROs Collaborative Project

The SFDPH-funded project was composed of eight community-based agencies who

conditions of families with children residing in single room occupancy hotels in 2001 in San Francisco. The multi-lingual outreach workers who conducted the interviews were SRO residents who received peer outreach and advocacy training.

Over 450 families and 769 children were found to live in SROs; with the vast majority being immigrants of color who spoke a primary language other than English. The Collaborative recommended increasing low-income housing options, improving the conditions of SROs, minimizing health and safety risks to families residing in SROs, building community among SRO residents and increasing accessibility to health and social services.

Recommendation Six: Ensure the health of vulnerable populations of women by expanding access to health services

Incarcerated Women - Background

Over the past 15 years the number of incarcerated women has increased dramatically nationally, in California and in San Francisco. Women in the criminal justice system have extensive health care problems that are frequently the result of poverty and lack of access to health care.¹⁶¹ In a needs assessment of the health care status of female inmates in San Francisco jails done in 1996, 73% of respondents reported having no health insurance. Of those inmates who had seen a health care practitioner in the last year, 47.5% reported receiving this care at San Francisco General Hospital. Additionally, 71% reported use of illicit drugs and 62% reported daily drug use. Fifty-six percent of respondents reported a history of sexual abuse and 60% reported a history of physical abuse.¹⁶²

During 2001, the jails detected the greatest number of cases of chlamydia and gonorrhea in males and females for any clinic or screening site in San Francisco other than City Clinic. Youth Guidance Center had the highest prevalence of infection among women screened at any site in the city.¹⁶³ Since more than 90% of persons in detention with chlamydia and/or gonorrhea had no symptoms and thus would not have sought medical services for their infections, screening is critical to reducing the burden of these infections.¹⁶⁴

Incarcerated Women – DPH Action Needed

- 6-s) The Office of Women's Health (OWH), through the Community Programs involvement in the Criminal Justice Health Committee will work in collaboration to ensure coordination with Primary Care, Jail Health Services and community partners of post release health services to incarcerated women and their families (Ongoing: O)
- 6-t) Through Jail Health Services, assure the provision, when appropriate, of family planning services to women prior to leaving the jails (New: N '04)
- 6-u) The OWH and Jail Health Services to design and implement gender-specific health services which will include the establishment of a Women's Health Specialty Team and the creation of individual gender-focused comprehensive plans for women in the county jails (N '05)

¹⁶¹ Report on the Health Care Status of Incarcerated Women, 1996. (? Get complete footnote)

¹⁶² Ibid.

¹⁶³ STD Control Section. San Francisco Sexually Transmitted Disease Annual Summary, 2001. San Francisco Department of Public Health, San Francisco, California. July 2002.

¹⁶⁴ Ibid, pages 75 and 83.

Section Five

Next Steps for DPH

Next Steps for DPH

In the previous sections, the Women's Health Plan lists suggested strategies to implement with sound strategies that are already being implemented. Those strategies that will be new are followed by the letter **N** and the suggested year for implementation (example: **N 04**); those ongoing and already in place are followed by the letter **O**.

The range of suggested strategies is designed to allow flexibility and adaptation to fluctuations in staffing patterns, program budget allocations, community input and emerging issues.

1. The Office of Women's Health will disseminate the Women's Health Plan throughout DPH and will make it available to the general public on the DPH website (<http://www.dph.sf.ca.us>).
2. The OWH will work with DPH Directors and the soon to be created DPH Women and Girls' Services Coordinating Council to coordinate the implementation of the Plan.
3. The OWH will provide assistance as needed to all sections during the implementation of the Plan.
4. Annual progress reports on the achievement of the Plan will be issued.
5. An evaluation of the Women's Health Plan will be conducted in 2007.

Appendix One

DPH Women-Focused Programs

DPH Women-Focused Programs

The San Francisco Department of Public Health provides health care services to women and girls through all of our divisions and departments. Our Primary Care division of Community Programs is comprised of 17 primary care programs, 19 primary care clinics and numerous satellite clinics and community sites located throughout the City and County of San Francisco. DPH provides many health care services, in particular those related to substance abuse, mental health and HIV/AIDS, through our contracted community-based agency partners. Health care for women and girls is also provided through our eight partners in the Safety Net primary care network of San Francisco, the San Francisco Community Clinic Consortium clinics. Lyon-Martin Women's Health Services is one of the Consortium clinics.

The following DPH programs are targeted to serve women and girls in a more gender-specific manner:

- A. AIDS Office** – Contracted partners such as the Women's Integrated Delivery Service (collaboration between Lyon-Martin Women's Health Services and UCSF Women's Services), and Smith-Ryan House (Haight Ashbury program providing substance abuse detox services for HIV+ women)

- B. Behavioral Health Section** – Contracted partners such as IRIS Center: Women's Counseling and Recovery Services; CalWORKs Integrated Behavioral Health Programs, including Westside CalWORKs Outpatient Counseling Services and Jelani Rites of Passage Residential Treatment Program.

- C. Breast and Cervical Cancer Services** – Provides enhanced breast and cervical screening, diagnostic, treatment, tracking and support services including case management, education and multilingual Women's Care Navigators

- D. Housing and Urban Health**
 - a. SafeHouse (San Francisco Network Ministries Housing Corporation) – Transitional housing for homeless adult women sex workers wishing to leave this profession
 - b. Restoration House (Ark of Refuge) – Transitional housing for African-American HIV+ women with no or low income who desire residential substance abuse treatment
 - c. De Paul House and MIA House (Lutheran Social Services) – Transitional housing for women in recovery from alcohol and/or drug abuse who are survivors of domestic violence and have dependent children, particularly if homeless and/or in flight

- E. Maternal Child Health**
 - a. Comprehensive Perinatal Services
 - b. Family Planning Program
 - c. Perinatal Outreach and Education
 - d. Women Infant & Children (WIC) Supplemental Nutrition Program

- F. Newcomers Health Program** (DPH in collaboration with International Institute of SF and Bay Area Community Resources)
- a. Bosnian Women’s Support Group
 - b. Russian Women’s Support Group
 - c. Multi-lingual domestic violence education for women
 - d. Women’s health services (provided through SFGH Refugee Medical Clinic and Ocean Park Health Center; includes perinatal care and mammograms)
- G. Office of Women’s Health**
- a. Women and Girls’ Health Advisory Committee
- H. Primary Care**
- a. Women’s Health Center at San Francisco General Hospital – Provides obstetrics and gynecology care for women including primary care and specialty care
 - i. Mamatoto – Substance Abuse services for pregnant women
 - ii. Group Prenatal Care – for Spanish-speaking women
 - iii. Women’s Options Center – Provides medical abortions
 - b. Women’s Cancer Support Group at Chinatown Public Health Center – Therapeutic support group for monolingual Chinese women; also includes ‘Dr. Play’ art therapy support group for children of the women in the WC Support Group
 - c. Women’s Healthcare Taskforce of the Primary Care Quality Improvement Committee
 - d. Women’s Clinic at Tom Waddell Health Center – Multidisciplinary health care for homeless women provided by all-women staff
- I. Special Programs for Youth**
- a. Solutions Program – gender specific comprehensive expressive arts program for young women/girls detained at the Youth Guidance Center and in the community (collaboration with Brava for Women in the Arts)
- J. STD Prevention and Control**
- a. Sentinel Surveillance Screening Sites for Women – allows trends in prevalence of diseases to be monitored over time; includes City Clinic, Youth Guidance Center, Cole Street Youth Clinic, Ocean Park Health Center and Southeast Health Center
 - b. Screening Program – Provides laboratory support and clinical technical assistance to over 25 programs screening women of childbearing age for gonorrhea and/or chlamydia

Appendix Two

Acknowledgements

Acknowledgements

On behalf of the Office of Women's Health and the women and girls of San Francisco, profound gratitude goes to the following for contributions made to this report.

Community Agencies / Entities

- | | | |
|---|--|--|
| 1. Breast Cancer Action | 6. Lesbian Health Research Center | 10. Planned Parenthood Golden Gate |
| 2. California Women's Health Care Partnership | 7. Lyon-Martin Women's Health Services | 11. Region IX Federal Office of Women's Health |
| 3. Commission on the Status of Women | 8. Mission Neighborhood Health Center | 12. San Francisco Youth Commission |
| 4. End the Exploitation of Youth Task Force - SF Board of Supervisors | 9. Office of Women's Health - California Department of Health Services | 13. UCSF National Center of Excellence in Women's Health |
| 5. Health Initiatives for Youth | | 14. Women's Community Clinic |

San Francisco Department of Public Health Programs

- | | | |
|---|--|--|
| 1. AIDS Office | 6. Housing and Urban Health Section | 11. SFGH Women's Health Center |
| 2. Breast and Cervical Screening Services | 7. Laguna Honda Hospital | 12. SFGH Women's Options Center |
| 3. Community Behavioral Health Services Section | 8. Maternal, Child and Adolescent Health Section | 13. Special Programs for Youth |
| 4. Community Health Education Section | 9. Office of Adolescent Health | 14. Tom Waddell Health Center's Women's Clinic |
| 5. Health Prevention and Promotion Section | 10. SFGH Patient Education Resource Center | 15. Women and Girl's Health Advisory Committee |

San Francisco Department of Public Health Staff

- | | | |
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Women And Girl's Health Advisory Committee

- | | | |
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