

# Women's Health Trends in Los Angeles County 1997-2007



Los Angeles County  
Department of Public Health  
**Office of Women's Health**



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## Foreword

On the occasion of their 10<sup>th</sup> anniversary, the Los Angeles County Department of Public Health, Office of Women's Health has compiled this data report looking at the health of women in Los Angeles County over the last decade. Trends in key health indicators are presented with a focus on highlighting disparities among racial/ethnic groups. Comparisons to state and national data allow a comprehensive look at how women in Los Angeles County fare in relation to women in California and in the United States.

In addition, the report presents data on two important programs from the Office of Women's Health *Prevention Matters!* Campaign. The Mobile Clinic Outreach Program and the Heart Disease Risk Assessment represent key components of a campaign directed at reducing health disparities and the burden of chronic disease among low-income, uninsured women.

The information provided in this report reveals the persistent health disparities that affect our communities. This report is intended to serve as a stimulus to develop collaborative efforts and multi-faceted strategies to reduce disparities and improve the health status of all women in Los Angeles County.

The Office of Women's Health joins each of you in working toward the elimination of disparities in health delivery and health outcomes and building true health equity among our diverse Los Angeles County population.

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## Office Of Women’s Health – *Prevention Matters!* Campaigns & Programs

One of the key campaigns that the Office of Women’s Health has developed in the last ten years is *Prevention Matters!* This multi-cultural, multi-lingual campaign focuses on reducing health disparities and the burden of chronic disease among low-income, uninsured women by addressing prevention, education, screening and access. The campaign consists of several components including a 7 language hotline, a Community Partners network, community dialogues, a speaker’s bureau and multi-lingual educational materials. Two key components of the campaign, the Women’s Health Mobile Clinic Outreach Program and the Heart Disease Risk Assessment, are further described below.

### Women’s Health Mobile Clinic Outreach Program

The Women’s Health Mobile Clinic Outreach program was launched in May 2002, in response to a 1999 report that found significant disparities in the health of women in Los Angeles County<sup>1</sup>. The primary goal of the program is to improve the health of underserved women in Los Angeles County by eliminating barriers to health care, increasing utilization of preventive services and establishing a regular source of medical care for those with identified disease. The program provides preventive care via a mobile van to underserved women in Los Angeles County in partnership with community based organizations. Medical and non-medical staff provide services in a culturally and linguistically appropriate manner. Low-income, uninsured women from African American, Armenian, Chinese, Latina and Korean communities are targeted for the program.

In addition to health screenings for hypertension, diabetes, high cholesterol, smoking, obesity, and cervical and breast cancer, tailored health education and counseling is provided by experienced nursing staff in the women’s primary language. All results of screening tests are reviewed by program staff and follow-up appointments in community and county clinics are provided for women with abnormal lab or clinical findings. Data are collected from clients via a questionnaire that includes information on demographics and access to health care.

In the most recent analysis of the data from the program for participants seen through December 2007, 4,122 women were screened at 206 events. Over 90% were women of color and 86% were born outside of the US. Approximately 95% of women were low-income and uninsured. Access to previous care was low among the women, with over 35% not seen by a physician in the last two years and one third not meeting guidelines for cervical cancer screening (Table below).

Demographics for Mobile Clinic Clients	
	%
<b><u>Demographics</u></b>	
Born outside the US	85.7
Preferred language other than English	78.8
Race/Ethnicity	
African American	10.2
Armenian	6.8
Asian/Pacific Islander	33.8
Latina	46.2
White	2.5
<b><u>Access to Care</u></b>	
Federal Poverty Level (FPL) ≤ 200%	94.4
No Health insurance	95.4
No Regular source of care	81.1
Last physician visit > 2 yrs	35.5
Last Pap Smear ≥ 3yrs	33.3

High rates of chronic diseases were found among the women screened. African American women had the highest rates of high blood pressure (29%) and diabetes (18%), and Armenian women had the highest rates of high cholesterol (38%). Central American women had significant disease (18% with diabetes, 28% with high cholesterol, 8% abnormal Pap test). Rates of overweight/obesity were 80% among Mexican women and 81% among Central American women.

The success of the Women’s Health Mobile Clinic Program in increasing access to medical care and providing important preventive health care to ‘at risk’ communities in Los Angeles County is readily apparent. With the partnership of community based organizations and the multi-cultural, multi-lingual program staff, the Office of Women’s Health is committed to reaching the women most in need and playing a role in improving the health of women in Los Angeles County.

### Heart Disease Risk Assessment

Almost half a million women die of heart disease in the US each year, making it the leading cause of death for women nationally and in Los Angeles County.<sup>2</sup> However, heart disease is mostly a preventable condition, with ninety percent of the risk associated with having an initial heart attack accounted for by 9 modifiable risk factors: cigarette smoking, high cholesterol, hypertension, diabetes, abdominal obesity, lack of physical activity, low daily intake of fruits and vegetables, alcohol consumption and poor psychosocial index (includes measures of stress related to work, home, finances, life events, depression and the perceived ability to control life circumstances).<sup>3</sup>

A study conducted by the American Heart Association found that large disparities exist in heart disease awareness and perception.<sup>4</sup> Only 29% of Hispanic women and 31% of African American women, versus 68% of white women identified cardiovascular disease as the leading cause of death among women. Studies have documented that increasing awareness of heart disease leads to preventive action and healthy lifestyle changes.

In March of 2007, the Office of Women’s Health launched a multi-lingual Heart Disease Risk Assessment targeting low-income, uninsured women aimed at increasing heart disease risk factor awareness and reducing the rate of heart disease among women in Los Angeles County. The assessment, administered over the phone by operators speaking seven languages, consists of 11 questions evaluating the women’s risk factors. Health education tailored to the responses and healthy lifestyle promotion are provided to the women in their preferred language, both verbally and with written materials.

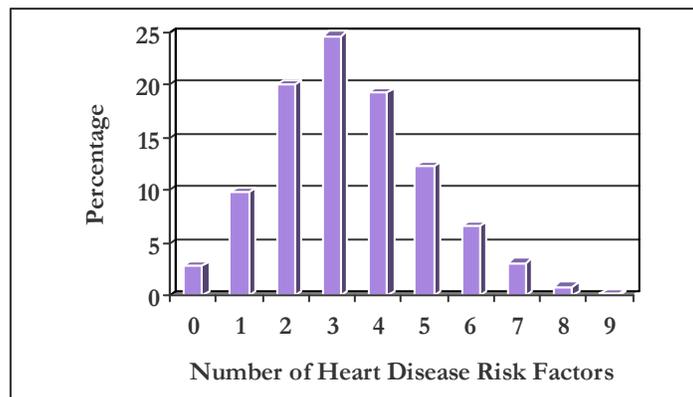
From March 2007 to January 2008, 1,365 questionnaires were completed. The mean age of participants was 48.1 years. Over 75% were born outside of the US, and 73% preferred a language other than English. Nearly 96% of the clients were living at less than 200% of the Federal Poverty Level (FPL). Over 95% of women reported having no health insurance and 84% reported having no regular source of care. Latinas comprised 50% of the participants, while 30% identified as Asian/Pacific Islander, 12% as African American and 5% as white.

Results from a baseline questionnaire found that only 39% of women knew that cardiovascular disease (CVD) causes more deaths than breast cancer and only 67% knew that CVD is preventable. However, 92% correctly identified stress as a factor that increases the risk for CVD and 87% reported that losing weight will lower the risk for CVD.

Almost 25% of the women had five or more risk factors for heart disease (Graph below). The most prevalent risk factors identified among program participants were modifiable, such as lack of physical activity (65%), overweight/obesity (58%), and low daily consumption of fruits and vegetables (54%).

The Heart Disease Risk Assessment is a powerful tool that addresses the significant disparities among women of color with regard to the leading cause of death. Ultimately, through its multi-lingual education and counseling, the program aims to increase awareness and decrease heart disease mortality in Los Angeles County.

Heart Disease Risk Factors



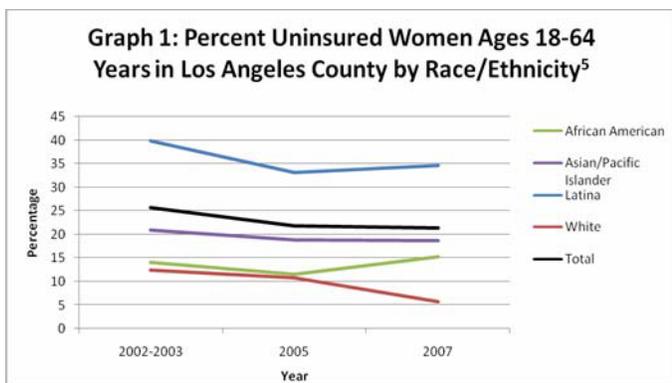
## Women's Health Trends

In Los Angeles County, health disparities exist for women across all ethnicities. To better understand these disparities and the factors that contribute to them, the Office of Women's Health examines data on access to care, health risks and behaviors, health status and health outcomes. Identifying trends in these key indicators allows a framework for assessing performance of current Public Health programs, and identifying existing gaps that need to be addressed.

Presented below are data trends over the last decade that represent some of the most pressing issues for women in Los Angeles County. The focus is on highlighting disparities among racial/ethnic groups, and when available, comparisons are made to state and national data, and Healthy People 2010 goals.

In the graphs, "Total" (represented by a black line), consists of all race/ethnicities, including American Indian/Alaskan Native and mixed/other.

### Access to Care

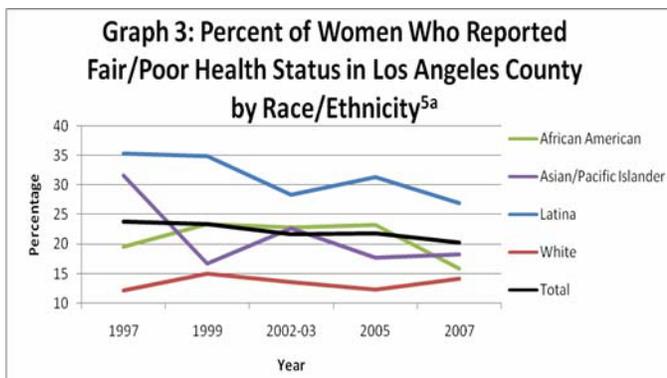
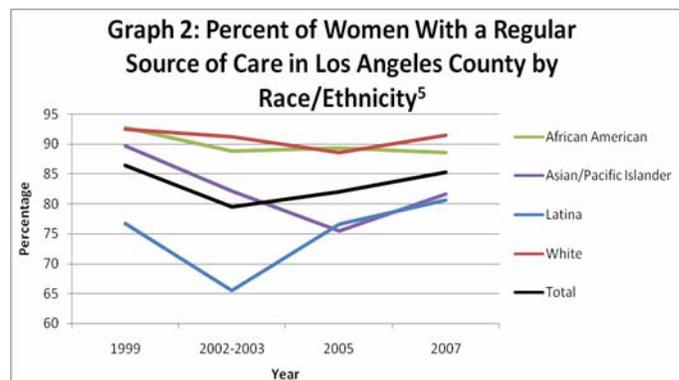


#### Health Insurance Coverage<sup>5</sup> (Graph 1)

- From 2002 to 2007, the percentage of uninsured women declined from 25.7% to 21.3% in Los Angeles County. While the percent of uninsured decreased 5.2% and 6.7% among Latina and white women respectively, uninsured rates among African American women increased 1.2%.
- Latinas consistently had the highest rates of uninsurance.

#### Regular Source of Care<sup>5</sup> (Graph 2)

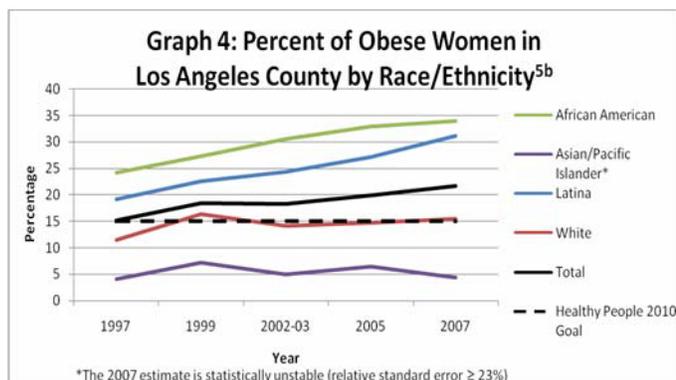
- The percent of women with a regular source of care (RSC) slightly decreased from 86.5% in 1999 to 85.3% in 2007.
- Although fewer Latinas reported having a RSC (except in 2005), they showed the most improvement in this indicator. Only 65.5% had a RSC in 2002-03 compared to 80.6% in 2007.
- While the percent of Asian/Pacific Islander women with a RSC, declined from 89.7% in 1999 to 75.5% in 2005, it increased to 81.7% in 2007.



#### Health Status<sup>5a</sup> (Graph 3)

- From 1997 to 2007, the percentage of women who reported fair/poor health status has steadily declined from 23.8% to 20.3%.
- While the percent of fair/poor self-perceived health status decreased over the past 10 years across most ethnicities, for white women it increased slightly.
- The percent of Asian/Pacific Islander women that reported their health status as fair/poor decreased 13.4% from 1997 to 2007.

## Lifestyle Factors

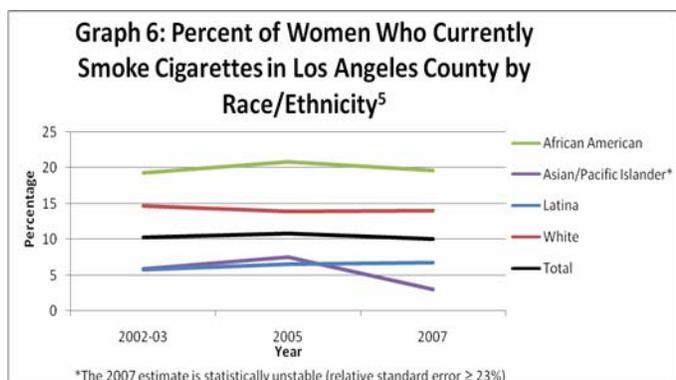
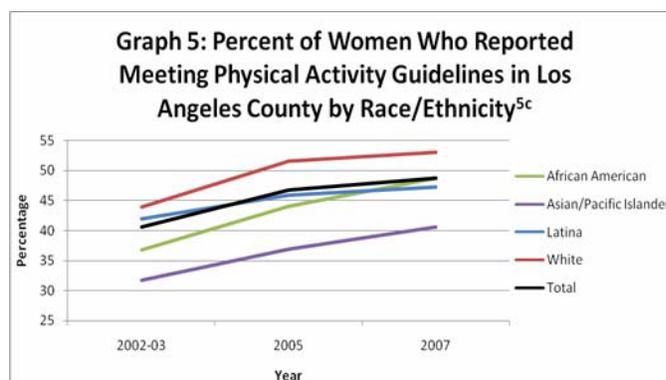


### Obesity<sup>5b</sup> (Graph 4)

- Obesity remains a growing epidemic for Los Angeles County. The obesity rates for women increased 6.5% in the past ten years, with African American women consistently demonstrating the highest rates.
- Latinas saw the greatest increase at 12.2%, followed by African American women at 9.8% and white women at 4.0%. Only Asian/Pacific Islander women have obesity rates well below the Healthy People 2010 goal of 15%.
- In 2007, nearly half of all women in Los Angeles County were obese (21.7%) or overweight (27.2%).
- In California, African American women had the highest obesity rates compared to all other ethnicities.<sup>6</sup>

### Physical Activity Level<sup>5c</sup> (Graph 5)

- Physical activity is associated with a lower risk of many chronic diseases and in the past 5 years, women were increasingly meeting the recommended guidelines for physical activity.
- From 2002 to 2007, a lower percentage of Asian/Pacific Islander women reported meeting physical activity guidelines compared to other ethnicities.

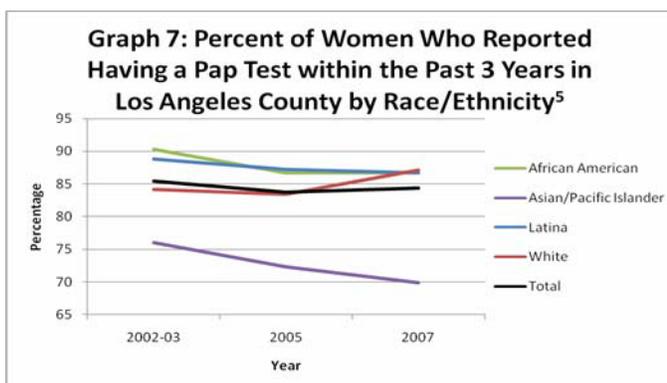


### Cigarette Smoking<sup>5</sup> (Graph 6)

- In 2007, more African American and white women smoked cigarettes (19.6% and 14.0%, respectively) compared to Latinas (6.8%) and Asian/Pacific Islander women (3.0%\*).
- Similarly, in California, African American and white women smoke at higher rates compared to Latinas and Asian/Pacific Islander women.<sup>6</sup>

## Screening and Incidence

**Graph 7: Percent of Women Who Reported Having a Pap Test within the Past 3 Years in Los Angeles County by Race/Ethnicity<sup>5</sup>**



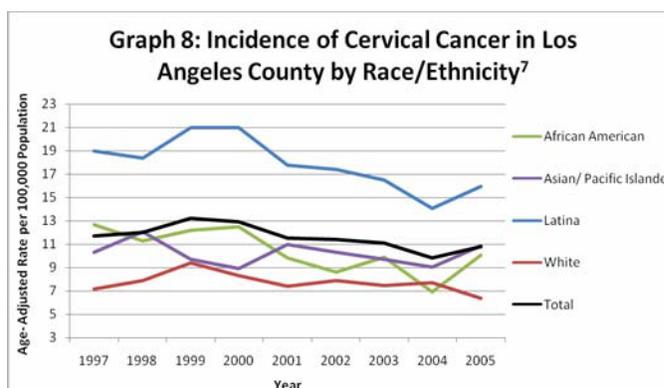
### **Cervical Cancer Screening (Pap test)<sup>5</sup> (Graph 7)**

- Rates of cervical cancer screening have remained relatively stable from 2002-03 to 2007.
- Asian/Pacific Islander women have lower screening rates compared to other ethnicities in Los Angeles County and in California.<sup>6</sup>

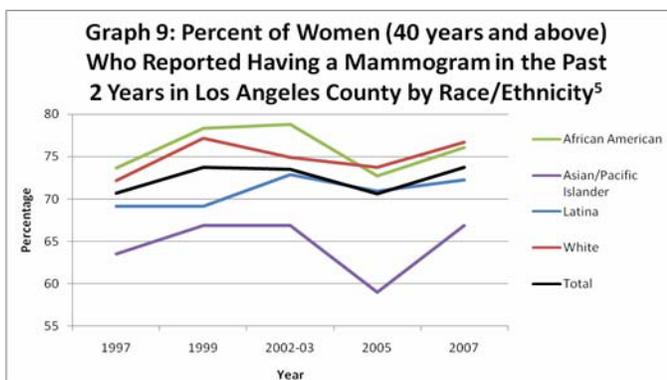
### **Cervical Cancer Incidence<sup>7</sup> (Graph 8)**

- From 1997 to 2005, cervical cancer incidence has gradually declined for most women.
- The incidence of cervical cancer remains the highest among Latinas.

**Graph 8: Incidence of Cervical Cancer in Los Angeles County by Race/Ethnicity<sup>7</sup>**



**Graph 9: Percent of Women (40 years and above) Who Reported Having a Mammogram in the Past 2 Years in Los Angeles County by Race/Ethnicity<sup>5</sup>**



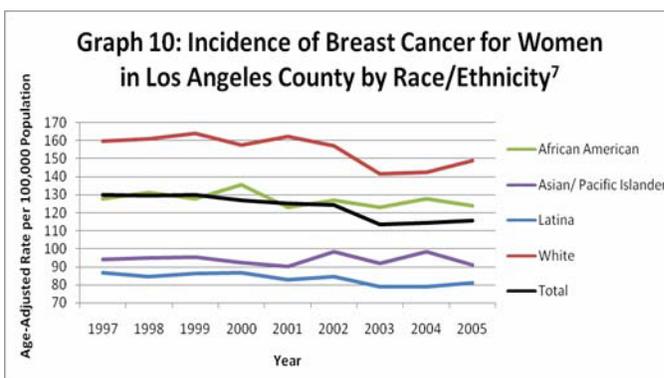
### **Mammogram Usage<sup>5</sup> (Graph 9)**

- Over the past 10 years, the percentage of all women ages 40 and above who reported having a mammogram within the last two years has remained relatively stable from 70.7% in 1997 to 73.7% in 2007.
- Asian/Pacific Islander women were consistently less likely to have had a mammogram in the past 2 years (followed by Latinas) compared to other ethnicities.
- In 2005, in California, Latinas and Asian/Pacific Islander women had lower screening rates than African American and white women.<sup>6</sup>

### **Breast Cancer Incidence<sup>7</sup> (Graph 10)**

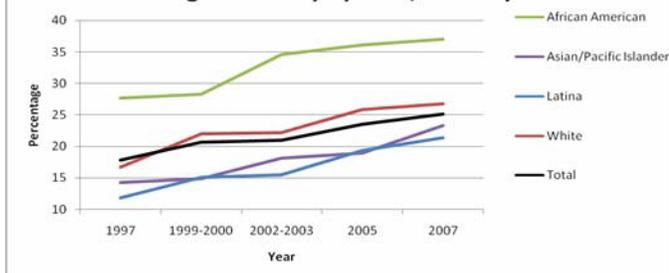
- From 1997 to 2005, invasive breast cancer incidence declined for all ethnicities.
- White women have the highest rates of breast cancer followed by African American women.

**Graph 10: Incidence of Breast Cancer for Women in Los Angeles County by Race/Ethnicity<sup>7</sup>**



## Chronic Disease Prevalence

**Graph 11: Percent of Women Who Reported Being Diagnosed with High Blood Pressure in Los Angeles County by Race/Ethnicity<sup>5</sup>**



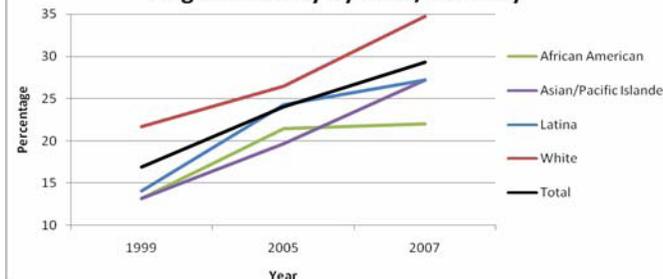
### **Hypertension (High Blood Pressure)<sup>5</sup> (Graph 11)**

- The percentage of women diagnosed with hypertension steadily increased across all ethnicities over the past ten years.
- In 2007, African American women have dramatically higher rates of hypertension (37.0%), followed by whites (26.8%), Asians/Pacific Islanders (23.3%), and Latinas (21.4%).

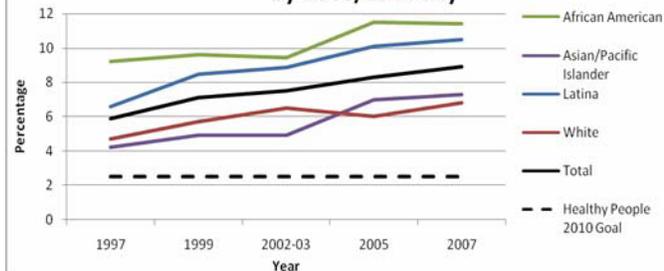
### **High Cholesterol<sup>5</sup> (Graph 12)**

- The total percentage of women diagnosed with high cholesterol has increased from 16.9% in 1999 to 29.3% in 2007.
- In 2007, more white women reported having been diagnosed with high cholesterol (34.7%), followed by Latinas and Asians/Pacific Islanders (27.2% each), and African Americans (22.0%).

**Graph 12: Percent of Women Who Reported Being Diagnosed with High Cholesterol in Los Angeles County by Race/Ethnicity<sup>5</sup>**



**Graph 13: Percent of Women Reported Being Diagnosed with Diabetes in Los Angeles County by Race/Ethnicity<sup>5</sup>**



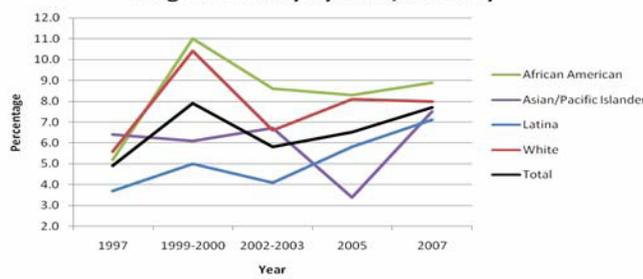
### **Diabetes<sup>5</sup> (Graph 13)**

- For all women, diabetes rates have steadily increased over the ten year period: from 5.9% in 1997 to 8.9% in 2007.
- In 2007, African American women and Latinas have higher rates of diabetes (11.4% and 10.5%, respectively), compared to Asian/Pacific Islander women (7.3%), and white women (6.8%).

### **Heart Disease<sup>5</sup> (Graph 14)**

- In 2007, more African American and white women (8.9% and 8.0% respectively), reported being diagnosed with heart disease compared to Asian/Pacific Islander women (7.5%), and Latinas (7.1%).

**Graph 14: Percent of Women Who Reported Being Diagnosed with Heart Disease in Los Angeles County by Race/Ethnicity<sup>5</sup>**



**Table 1: Leading Causes of Death for Women in Los Angeles County by Race/Ethnicity, 2005<sup>8</sup>**

Race/ethnicity Number of deaths Age-adjusted death rate	#1 cause Number of deaths Age-adjusted death rate	#2 cause Number of deaths Age-adjusted death rate	#3 cause Number of deaths Age-adjusted death rate	#4 cause Number of deaths Age-adjusted death rate	#5 cause Number of deaths Age-adjusted death rate
<b>White</b> 16,765 617 per 100,000	Coronary heart disease 4,591 153 per 100,000	Stroke 1,192 40 per 100,000	Emphysema/COPD 1,017 37 per 100,000	Lung cancer 909 38 per 100,000	Alzheimer's disease 819 25 per 100,000
<b>Hispanic</b> 6,057 486 per 100,000	Coronary heart disease 1,901 113 per 100,000	Stroke 422 35 per 100,000	Diabetes 383 31 per 100,000	Pneumonia/influenza 240 21 per 100,000	Breast cancer 223 15 per 100,000
<b>Black</b> 4,092 826 per 100,000	Coronary heart disease 1,001 202 per 100,000	Stroke 324 65 per 100,000	Lung cancer 214 43 per 100,000	Diabetes 208 42 per 100,000	Breast cancer 181 36 per 100,000
<b>Asian/Pacific Islander</b> 2,808 397 per 100,000	Coronary heart disease 627 91 per 100,000	Stroke 273 39 per 100,000	Lung cancer 140 19 per 100,000	Pneumonia/influenza 139 20 per 100,000	Breast cancer 152 17 per 100,000
<b>All females</b> 29,897 572 per 100,000	Coronary heart disease 7,541 141 per 100,000	Stroke 2,221 42 per 100,000	Lung cancer 1,428 29 per 100,000	Emphysema/COPD 1,422 28 per 100,000	Pneumonia/influenza 1,278 24 per 100,000

Reproduced from Los Angeles County Department of Public Health, Office of Health Assessment & Epidemiology. Mortality in Los Angeles County 2005: Leading causes of death and premature death. Jul 2008

**Leading Causes of Death<sup>8</sup>**

- In 2005, for women across all ethnicities in Los Angeles County, Coronary Heart Disease (CHD) remained the leading cause of death, with African American women experiencing an age-adjusted death rate close to 1.5 times higher than other ethnicities. Stroke is the second leading cause of death when all cancers are assessed separately.
- Differences among ethnicities were more visible with the third cause of death. COPD is the third cause of death for white women, diabetes for Latinas, and lung cancer for African American and Asian/Pacific Islander women.

**Table 2: Leading Causes of Premature\* Death for Women in Los Angeles County by Race/Ethnicity, 2005<sup>8</sup>**

Race/ethnicity	#1 cause	#2 cause	#3 cause	#4 cause	#5 cause
<b>White</b>	Coronary heart disease	Breast cancer	Lung cancer	Suicide	Drug overdose
<b>Hispanic</b>	Motor vehicle crash	Coronary heart disease	Breast cancer	Diabetes	Stroke
<b>Black</b>	Coronary heart disease	Breast cancer	Stroke	Diabetes	Homicide
<b>Asian/Pacific Islander</b>	Breast cancer	Coronary heart disease	Stroke	Lung cancer	Motor vehicle crash
<b>All females</b>	Coronary heart disease	Breast cancer	Motor vehicle crash	Lung cancer	Stroke

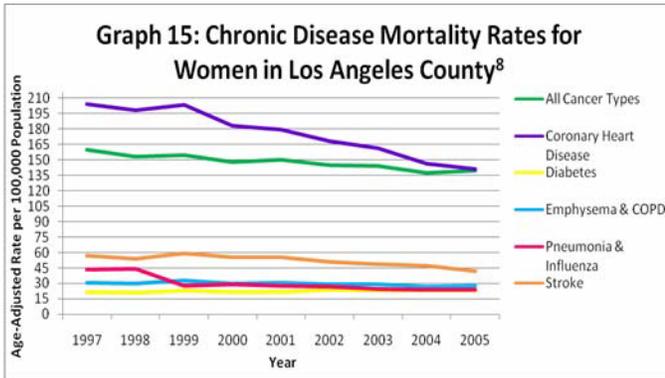
\*Death before age 75 years

Reproduced from Los Angeles County Department of Public Health, Office of Health Assessment & Epidemiology. Mortality in Los Angeles County 2005: Leading causes of death and premature death. Jul 2008

**Leading Causes of Premature Death<sup>8</sup>**

- In 2005, 45% of people who died in Los Angeles County, were less than 75 years old.
- When looking at the 5 leading causes of premature death for women, differences among ethnicities are again evident. Coronary heart disease remained the leading cause of premature death for white and African American women, motor vehicle crashes for Latinas and breast cancer for Asian/Pacific Islander women.

## Mortality Rates

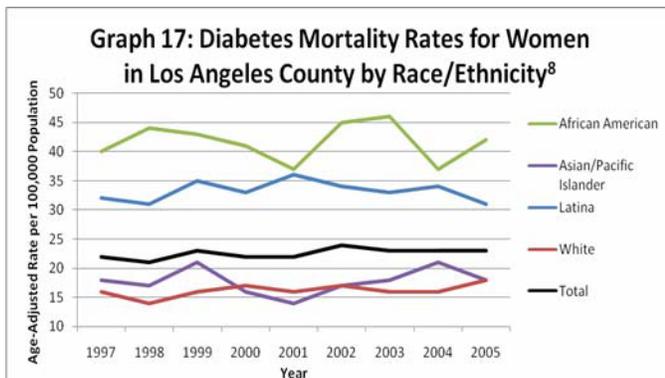
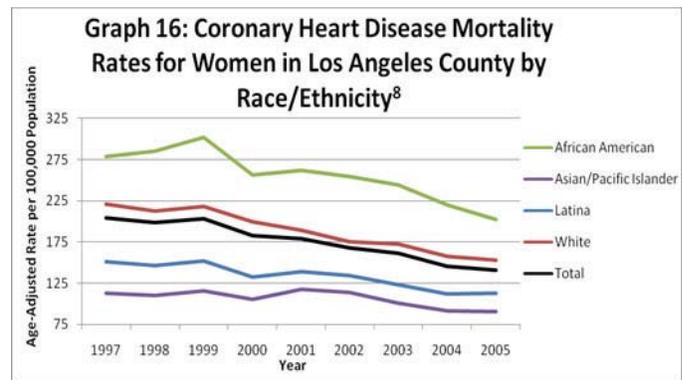


### Chronic Disease Mortality<sup>8</sup> (Graph 15)

- Coronary Heart Disease (CHD) and cancers (all types) have been by far the leading causes of death for women in Los Angeles County.
- Nationwide, CHD mortality rates decreased, however this decrease is reaching a plateau, particularly for women aged 35-54 years.<sup>9</sup> This re-emphasizes the importance of healthy lifestyles to prevent heart disease.

### Coronary Heart Disease Mortality<sup>8</sup> (Graph 16)

- From 1997-2005, across all ethnicities, CHD mortality rates have decreased from 204 to 141/100,000, a 30.8% decrease.
- African American women had the highest mortality rates of CHD followed by white women.

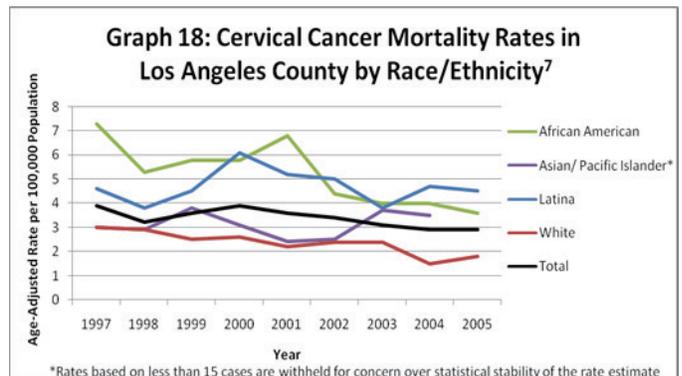


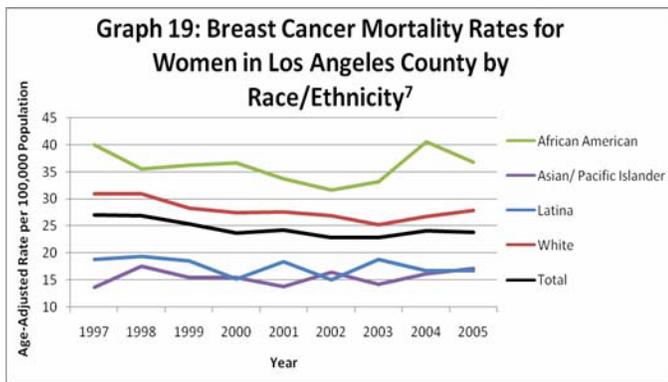
### Diabetes Mortality<sup>8</sup> (Graph 17)

- From 1997-2005 diabetes mortality rates for African American women and Latinas were the highest compared to other ethnicities.
- Despite steady increases in diabetes incidence rates, mortality rates among women overall, have only slightly increased.

### Cervical Cancer Mortality<sup>7</sup> (Graph 18)

- Cervical cancer mortality rates, for all women have slightly decreased in the past 8 years.
- African American and white women showed a decline in mortality since 1997, with African American women having the greatest decline.
- In 2005, at the local and state level, Latinas have the highest incidence and mortality rates for cervical cancer.<sup>10</sup>





### Breast Cancer Mortality<sup>7</sup> (Graph 19)

- Breast cancer mortality rates declined slightly for all women during 1997 to 2005.
- In 2005, at the local and state level, African American women followed by white women had the highest rates of breast cancer mortality.<sup>10</sup>

The health disparities identified in this report can most effectively be addressed with collaborative efforts and multi-faceted strategies. Funders are encouraged to support both evidence-based programs as well as innovative and promising practices that address these inequities.

### Data Sources and Notes

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  - b. Adult Overweight and Obesity: National Institutes of Health, National Heart, Lung, and Blood Institute; Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obese Adults [Executive Summary]. Obesity defined as a self-reported Body Mass Index [BMI] greater than 30 and overweight defined as a self-reported BMI of greater than 25 but less than 30.
  - c. Adult Physical Activity: To meet guidelines one of the following criteria must be fulfilled: 1) vigorous physical activity causing heavy sweating, large increases in breathing and heart rate for  $\geq 20$  minutes,  $\geq 3$  days/week, 2) moderate physical activity causing light sweating, slight increase in breathing and heart rate for  $\geq 30$  minutes,  $\geq 5$  days/week, or 3) a combination of moderate/vigorous activity  $\geq 5$  days/week. <http://www.cdc.gov/nccdphp/dnpa/physical/recommendations/index.htm>.
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8. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Data Collection and Analysis Unit, 2005 data. All mortality estimates are based on death certificate reporting of underlying causes of death. Death rates presented are age-adjusted to the 2000 U.S. Standard Population using age-specific rates. Premature death is calculated from years of life lost (YLL) for each death before age 75 years and adding the total YLL for each cause of death. Infants less than 1 year of age are excluded from YLL.
9. Ford ES, Capewell S. Coronary heart disease mortality among young adults in the US from 1980 through 2002. *J Am Coll Cardiol* 2007; 50: 2128-32.
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Zev Yaroslavsky, Third District  
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