# WISCONSIN'S STATEWIDE FRAMEWORK FOR IMPROVING WOMEN'S HEALTH

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*The Wisconsin Healthiest Women Initiative is a public and private partnership convened by the State of Wisconsin Department of Health Services and co-led by:*

- *The Wisconsin Women's Health Foundation*
- *The Wisconsin Association for Perinatal Care*
- *The Wisconsin Alliance for Women's Health*
- *Health Care Education and Training*
- *Wisconsin, March of Dimes*

## INTRODUCTION

The Wisconsin Healthiest Women Initiative was formed to promote the health of women by bringing together partners and stakeholders in women's health around the state to create a collective *Wisconsin Statewide Framework for Improving Women's Health* and to build on previous efforts to improve birth outcomes. The health of Wisconsin's women is closely tied to the health of Wisconsin's infants, children, and families. Therefore, it is especially important to understand and improve the health of women of reproductive age and across the entire life span. Working together we have the potential to ensure that each of us – the women who are our mothers, sisters, daughters, partners, neighbors, or friends - is living in a healthy environment, has the opportunity and knowledge needed to make healthy choices, and has access to affordable and quality health care.

The goals of the Wisconsin Healthiest Women Initiative are threefold:

Goal 1: Build and strengthen community capacity
Goal 2: Expand access to and affordability of high quality services
Goal 3: Improve accountability: identify and monitor relevant information

This report will provide the background, supporting data and literature references, and the Framework for Action strategies that will help us focus on what we can do to improve the health of Wisconsin women across the lifespan.

## BACKGROUND

### Why Focus on Women?

There are approximately 2,864,586 women and girls living in Wisconsin according to the U.S. Census Bureau, making up more than half of the state's total population.[1] As such, their health is an important marker of the overall health of the state population. In addition to women's social role as caregiver in families (both formal and informal), a woman's health before and during a pregnancy is closely intertwined with, and an important influence on, the health of her child. Children spend nine months being nurtured and developed within a woman's body and continue to receive sustenance through breast milk. Her health – before, during, and after pregnancy – helps to determine the quality of the developmental environment. This unique

[1] A. S. D. Website Services & Coordination Staff, "2010 Demographic Profile", http://www.census.gov/popfinder/.

relationship highlights how women's health has an impact on overall population health. For that reason, we often examine the status of adult women of reproductive age as an indicator of the health of our future generations, as well as of our population as a whole.

Women are key consumers of health care with unique health needs that present across the lifespan. Women are usually the primary health care decision makers for themselves and their families – choosing health care providers for their children, taking children to appointments, and ensuring follow-up care is received as well as taking on the role of primary caregiver for aging parents.[2] Women across the country are more likely than men to live in poverty and earn, on average, less than men,[3] which may make them particularly vulnerable to the rising costs of health care and other necessities.

In Wisconsin, women make up 48 percent of those in the labor force, and about 10 percent of all households are headed by a female with no husband present.[4] Among Wisconsin women of reproductive age (defined here as ages 18-44 years), 28 percent live below 200 percent of the Federal Poverty Level, which is $38,180 for a family of 3.[5] Women experience many hurdles when attempting to access quality health care; one of these barriers is money. A report by the Commonwealth Fund found that "(i)n 2010, 48 percent of working-age women in the U.S.—an estimated 45 million women—reported that because of cost they did not fill a prescription; skipped a recommended test, treatment, or follow-up; had a medical problem for which they did not visit the doctor; or did not see a specialist when needed—an increase from 34 percent in 2001."[6] To ease the financial burden, many women make tradeoffs in order to afford health care for themselves and their families. While many women report that they spent less on other basic needs in the past year to have enough money for health care, women who are uninsured (25 percent), on Medicaid (26 percent) or low-income (27 percent; defined here as under 200 percent of poverty) experienced this burden at double the rates of women with private insurance (12 percent) and women above 200 percent of the poverty level (11 percent).[2] In addition, women are almost twice as likely as men to receive health insurance as a "dependent" rather than as the primary wage-earner (25 percent are insurance "dependents" compared to 13 percent of men), resulting in greater vulnerability if a woman wants or needs to leave a relationship.[7]

More than one-third of women (35 percent) have a chronic condition that requires ongoing medical attention, such as diabetes or hypertension.[2] Even among younger women, approximately one in 10 women of reproductive age (18 to 44 years) say they have been diagnosed with arthritis (9 percent), hypertension (11 percent), or high cholesterol (9 percent), and by the time women reach their middle years (45 to 64 years), these rates triple to

[2] Usha Ranji and Alina Salganico, *Women's Health Care Chartbook Key Findings from the MAY 2011 Kaiser Women's Health Survey* (Kaiser Family Foundation, May 2011), http://www.kff.org/womenshealth/upload/8164.pdf .

[3] *Women in America: Indicators of Social and Economic Well-being.* Prepared by the U.S. Department of Commerce, Economics and Statistics Administration and the Executive Office of the President, Office of Management and Budget for the White House Council on Women and Girls. March 2011. http://www.whitehouse.gov/sites/default/files/rss_viewer/Women_in_America.pdf.

[4] U.S. Census Bureau, "American FactFinder - Results", http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1.

[5] Demographic Internet Staff US Census Bureau, "Current Population Survey (CPS), CPS Table Creator", August 12, 2011, http://www.census.gov/cps/data/cpstablecreator.html.

[6] Ruth Robertson and Sara R. Collins. *Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help* (The Commonwealth Fund, May 2011), http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/May/Women-at-Risk.aspx

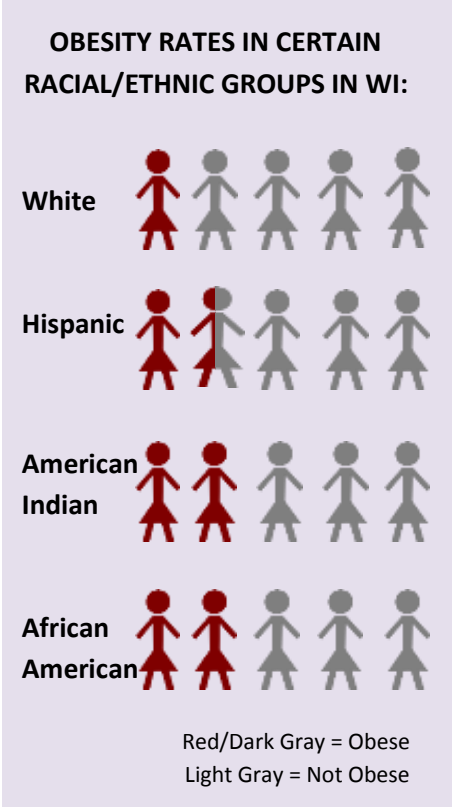
[7] "Women's Health Insurance Fact Sheet" (Kaiser Family Foundation, October 2009), http://www.kff.org/womenshealth/upload/6000-08.pdf.

39 percent, 36 percent, and 34 percent respectively.[2] Women, along with their chronic health needs, make up a larger proportion of the older adult population (57 percent) in Wisconsin compared to the younger population (49 percent);[8] therefore, addressing these chronic conditions and their risks in women of reproductive age can also reduce the health and financial burdens on the overall population as women age.

The fact that this document focuses primarily on women does not imply that men are without health challenges or that their health is in any way less important. The health of men in terms of behavioral health, chronic disease, and exposure to social and environmental stressors will also have an impact on their reproductive health and the health of future children. Improving the health of women in Wisconsin and their partners would not only improve their own quality of life and reduce their health care costs, but it also has the potential to positively impact their entire family.

**What is the Current State of Health for Women of Reproductive Age?**

The health of Wisconsin women ages 18-44 as a whole is comparable to the health of all U.S. women of reproductive age when reviewing a number of health indicators: 23 percent are obese, 23 percent smoke, and 12 percent report poor mental health[9] (see Appendix A for data spreadsheet). For factors relating to pregnancy, 35 percent of pregnancies were unintended, 33 percent of women took a multivitamin with folic acid daily in the month prior to conceiving, and 14 percent experienced postpartum depressive symptoms.[10] Although Wisconsin appears similar to other states, these indicators still represent challenges to Wisconsin women and mothers' ability to reach optimal health and improved maternal and infant outcomes.[11]




Additionally, significant disparities exist by race and ethnicity for many of these indicators. The rates of poor mental health, obesity, sexually transmitted infections and physical abuse were among the indicators to reveal the largest degree of inequity. Hispanic, American Indian, and African American women of reproductive age are about twice as likely to report poor mental health for at least half of the days in the last month. Similarly, the rates of obesity for certain racial and ethnic groups of women of reproductive age were significantly higher than White women: 23 percent of White women are obese, compared to about 40 percent of both African American and American Indian women and 29 percent of Hispanic women.

[8] U.S. Census Bureau Factfinder. http://factfinder2.census.gov/bkmk/table/1.0/en/DEC/10_DP/DPDP1/0400000US55

[9] "WI BRFSS 2007-2009" (WI Department of Health Services, March 2, 2011).

[10] "WI PRAMS 2007 –2008" (WI Department of Health Services, March 2, 2011).

[11] Lindsay Womack and William M. Sappenfield, *Preconception Health: An Issue for Every Woman of Childbearing Age in Florida* (Florida Department of Health Division of Family Health Services Bureau of Family and Community Health, June 2010), http://everywomanfl.com/Pages/Healthcare_Providers/Preconception_Health_Indicator_Report.aspx.

Sexually transmitted infections represent one of the highest health disparities among women in Wisconsin. White women of reproductive age in Wisconsin are diagnosed with STIs at a rate of 542 per 100,000. In contrast, Hispanic women are diagnosed at over two times that rate (1,223 per 100,000), American Indian women are diagnosed with STIs at about four times the rate of White women, and African American women are diagnosed with STIs at a rate of about 11 times that of White women in the state.[12]

African American mothers in Wisconsin suffer physical abuse prior to pregnancy at a rate of 14.2 percent.[10] This means that almost one out of every six African American mothers in Wisconsin report being physically abused prior to pregnancy. Hispanic women also report higher rates of physical abuse: Almost one in every 10 Hispanic women (9.3 percent) in Wisconsin reports being physically abused prior to pregnancy. These disparities in women's health are only a sample of the many disparities that exist for women, including many of the differences outlined in *Healthiest Wisconsin 2020* and *Healthiest Wisconsin 2010*, such as differences by age, sexual identity and orientation, gender identity, educational attainment, socioeconomic status, disability, and geography, and for racial and ethnic groups for which adequate data is often unavailable.

There is one health indicator in particular for which Wisconsin women overall are falling behind the national average: binge drinking. The rate of binge drinking among women aged 18-44 years is higher for Wisconsin than the overall national rate for women in this same age group. While 14 percent of U.S. women ages 18-44 years binge drink,[11] 25 percent in this age group in Wisconsin reported binge drinking.[9] This indicator also shows disparities by race and ethnicity, with White women and American Indian women reporting the highest rates at 24 percent and 26 percent, respectively.

**What is the Life-Course Perspective? How Does it Relate to Women's Health?**

The life-course perspective[13,14] was introduced to Wisconsin, nearly a decade ago by Dr. Michael Lu. He detailed why good prenatal care during the nine months of pregnancy may not be enough to assure a healthy birth outcome. The life-course approach suggests that health outcomes across the life span are influenced by a complex interplay of biological, behavioral, psychological, and social protective and risk factors.[13] A risk factor is something that carries with it the possibility of harm,[15] in this instance, to one's health or pregnancy, e.g., psychosocial stress or perinatal infections.[13] Protective factors, e.g., good nutrition, access to good medical care, and family and community support, potentially keep one from harm.[13]

Cutting edge research is also beginning to uncover the origins of chronic disease, which may include poor health during the fetal and early infancy periods that can lead to diseases such as

[12] "Wisconsin STD Program 2010" (WI Department of Health Services, March 2, 2011).

[13] Neal Halfon and Miles Hochstein, "Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research," *The Milbank Quarterly* 80, no. 3 (2002): 433–479, http://www.healthychild.ucla.edu/DropDownMenu/StaffDirectory/Halfon%20Files/LCHD.pdf.

[14] Michael C. Lu, MD, MPH and Neal Halfon, MD, MPH, "Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective," *Maternal and Child Health Journal* 7, no. 1 (March 2003): 13–30, http://mchb.hrsa.gov/infantmortalitysummit/disparitieslifecourse.pdf.

[15] "The American Heritage Dictionary Entry: Risk Factor", n.d., http://www.ahdictionary.com/word/search.html?q=risk+factor&submit.x=0&submit.y=0.

obesity, hypertension, diabetes, cardiovascular disease, and even mental illness.[16,17] Consider the following:

- Babies born at a low birth weight are more likely to have heart disease, hypertension and diabetes in later life.[14]
- A study of Adverse Childhood Experiences (called the ACE Study) found that the more problems in childhood, the more likely an individual is to have heart disease and depression when he or she is older. (See Appendix D for a link to this resource.)
- The publication *From Neurons to Neighborhoods*[18] identifies that positive environments and relationships in the life of a child serve as protective factors to support development and provide a strong foundation for all future learning, behavior, and health.

The life-course approach helps explain health and disease patterns over time and health disparities across populations with the following key concepts:[19]

**Timeline:** Today's experiences and exposures influence tomorrow's health. Health develops over a lifetime, with health improving or diminishing based in part on exposure to risk and protective factors.

**Timing:** Health pathways are particularly affected during critical or sensitive periods. Exposure to protective and risk factors have a significant impact on health when they occur early in life and during sensitive periods.

**Environment:** The broader community environment – biologic, physical and social - strongly affects the capacity to be healthy. There is a cumulative effect of chronic exposure to risk factors.

**Equity:** Inequity in health reflects more than genetics and personal choice. Differential exposures to risk and protective factors contribute to disparities in health outcomes.

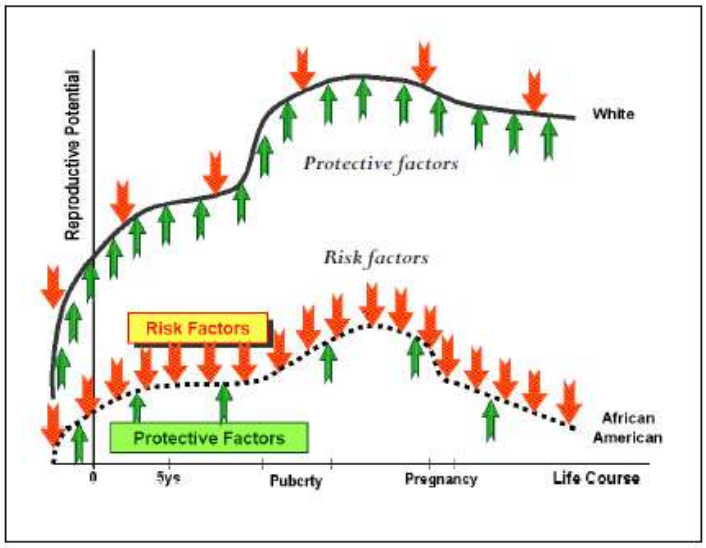
The following graphic illustrates the key concepts of the life-course approach with a reproductive health example. For White and African American women, differences in risk factors (downward arrows) and protective factors (upward arrows) over the life course affect the health and development of individuals and population groups and contribute to racial and ethnic disparities in birth outcomes.

[16] Janet L. Collins, et al., "Ties That Bind: Maternal and Child Health and Chronic Disease Prevention at the Centers for Disease Control and Prevention," *Preventing Chronic Disease* 6, no. 1 (January 2009), http://www.cdc.gov/pcd/issues/2009/jan/08_0233.htm.

[17] Annie Murphy Paul, "How the First Nine Months Shape the Rest of Your Life," *TIME Magazine*, September 22, 2010, http://www.time.com/time/magazine/article/0,9171,2021065,00.html.

[18] Jack P. Shonkoff and Deborah A. Phillips, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington DC: Institute of Medicine, 2000), http://www.nap.edu/openbook.php?isbn=0309069882.

[19] *Rethinking MCH: The Life Course Model as an Organizing Framework*, Version 1.1 (U.S. Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau, November 2010), http://mchb.hrsa.gov/lifecourse/rethinkingmchlifecourse.pdf.




**Examples of Protective & Risk Factors**

- Socioeconomic status
- Race and racism
- Health care
- Disease status
- Stress
- Nutrition
- Weight status
- Birth weight
- Various health behaviors

*(See Footnote 14 for citation; Used with permission)*

Related to women's health, the life-course approach identifies factors that influence the capacity of women to reach their full potential for health and well-being and helps to explain why disparities in women's health persist across population groups.

Socioeconomic status; strength of family support, marriage, and other personal relationships; race and racism; health care; disease status; stress; nutrition; weight status; birth weight; community level of poverty; living conditions; and a range of behaviors are some of the key factors that may affect health, including reproductive health. These factors, in both the past and present, may affect women of various racial/ethnic groups differently. The life-course approach suggests that the disparities persist due to differences in protective and risk factors between groups of women over the course of their lives.

The life-course approach suggests prenatal care alone is not sufficient to prevent poor birth outcomes.

(Halfon and Hochstein, Lu and

These risk factors can put the health of women of childbearing age and the health of their unborn children at risk. It was previously thought that disparities in birth outcomes, such as low birth weight and infant mortality, could be decreased simply by improving the quality and frequency of prenatal care. However, the life-course approach suggests prenatal care alone is not sufficient to prevent these birth outcomes. Recognizing that prenatal interventions are necessary but not sufficient to reduce the risk factors that can result in poor birth outcomes, it is important to optimize women's health prior to pregnancy. Through interventions including preventive measures (multivitamins with folic acid, immunizations), managing health conditions (diabetes, hypertension, infections), and supporting healthy behaviors (smoking cessation, physical activity), the risk for preterm and low birth-weight births, fetal loss and birth defects can be reduced. Many of the risk behaviors and exposures that can affect fetal development and subsequent birth outcomes have their greatest effect during days 17 to 56 of pregnancy, before many women enter prenatal care.[20]

[20] Hani Atrash et al., "Where Is the 'W'oman in MCH?," *American Journal of Obstetrics & Gynecology* Supplement to DECEMBER 2008 (August 29, 2008): S259–S265.

**Intergenerational Nature of Health Disparities and Poor Birth Outcomes**

The life-course approach on health provides a long-term perspective on the importance of the intergenerational health of women, and how this affects their own health, and that of future generations. Understanding the life-course approach can assist in identifying opportunities to build upon protective factors and reduce risk factors. Our work needs to ensure that the array of biological, behavioral, psychological, and social protective and risk factors are addressed in an integrated, coordinated, and comprehensive manner. We know that "place matters"[21] and public health programs and healthy public policy should focus on creating the social, economic, and overall environmental conditions in which children, women, families, and communities can be healthy and thrive. An improvement in the health of Wisconsin women and girls will go a long way toward improving the health of the entire state.

The protective factors or risk factors, such as the stress of racial discrimination, access to neighborhood grocery stores with fresh food, and coping behaviors related to stress, may all impact the mothers' health and the health of her children. For women of color, regardless of their socioeconomic condition, or for women with low educational attainment who live in poor neighborhoods, this can mean their infants may also experience poor health. Prematurity and low birth weight are the main contributors to poor birth outcomes and infant deaths. In 2010, infants born to non-Hispanic African American women, teenage girls, women who smoke, single women, and women who did not complete high school were more likely to be premature. Women who received no prenatal care, non-Hispanic African American women, women who smoke, women who are unmarried, and women who did not complete high school were also more likely to have a low birth weight baby.[22]

In 2010, infants born to African American women were nearly 3 times more likely to die (13.9 per 1,000 live births) before their first birthday than infants born to white women (4.9 per 1,000 live births) in Wisconsin. In the past two decades, the rate of African American infant deaths reached over four times the rate of white infant deaths. This disparity continues to persist regardless of age, education, prenatal care, or smoking status. Based on 2008-2010 rates, infants born to Hispanic/Latina women (5.7 per 1,000 live births) have a similar risk to white infants of dying during the first year (5.2), and infants born to American Indian women have slightly higher rates (7.3 per 1,000 live births).[22]

These are only a few of the indicators demonstrating the extent of the effects of race, place, and poverty on women and the health and well-being of their babies. Although there have been many improvements in access to and quality of prenatal care, these disparities in birth outcomes persist, requiring a broader examination of how the social, economic, and environmental determinants of health, including racism, affect birth outcomes.

[21] PBS, *Unnatural Causes: Place Matters*, http://www.unnaturalcauses.org/about_the_series.php.
[22] "Wisconsin Births and Infant Deaths 2010" (WI Department of Health Services, January 2012).

*"The nation's approach to women's health care may well be at the tipping point of redefining the perinatal period to include women's wellness across the reproductive life span as an appropriate and favored approach to impacting reducing poor pregnancy outcomes."* [23]

**The Momentum for the Wisconsin Healthiest Women Initiative**

In 2003, Dr. Michael Lu (now Associate Administrator of Maternal and Child Health of the Health Resources and Services Administration) first introduced the life-course perspective to Wisconsin at a summit sponsored by the Maternal and Child Health (MCH) Program of the Wisconsin Department of Health Services (DHS), along with state and local MCH advocates.[24] He energized state and local efforts to incorporate the life-course perspective to improve maternal and child health, and address the persistent racial and ethnic disparities present in Wisconsin. Since that time, Wisconsin's MCH Program has embraced the life-course approach in its work on eliminating racial and ethnic disparities in birth outcomes, women's health, early childhood systems, and children and youth with special health care needs.

During the years from 2003 to 2008, the state assumed a leadership role in raising awareness, and established a statewide advisory committee. The *Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes* developed three goals to improve equity in birth outcomes: build and strengthen community capacity, expand access to and the availability of high quality services for women, and improve the use of data and accountability. In 2008, new state, federal, and foundation funding sponsored the following efforts: focus groups of African American mothers, fathers, and grandmothers on factors that lead to or prevent healthy births; a community-driven social marketing campaign that integrates a life-course approach and addresses the negative effects of stress; a Milwaukee collaborative addressing the relationships of fatherhood, racism, and infant mortality; and home visiting programs in the central cities of Milwaukee and Racine. (For more information about these initiatives, go to www.dhs.wisconsin.gov/healthybirths/.)

The Wisconsin Pregnancy Risk Assessment Monitoring System (called PRAMS) began data collection in 2007 and confirmed racial and ethnic disparities in income levels, depression, chronic disease, and stressful life events experienced by women. In 2009, the University of Wisconsin School of Medicine and Public Health announced its multi-year, $10 million commitment to reduce African American infant mortality in Beloit, Kenosha, Milwaukee, and Racine, and Wisconsin's Medicaid program established a managed care pilot program to improve birth outcomes in southeastern Wisconsin. The next step seemed clear: join with statewide and local partners, to focus on Wisconsin women, prioritize those with the highest needs and focus on their health and well-being, and thus improve the health of their families and communities.

[23] Margaret Comerford Freda, Merry-K. Moos, and Michele Curtis, "The History of Preconception Care: Evolving Guidelines and Standards," *Maternal and Child Health Journal* 10, no. Suppl 1 (September 2006): 43–52, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1592152/.

[24] Murray L. Katcher, et al., "Healthy Babies in Wisconsin: A Call to Action Summary of the Wisconsin Perinatal Summit General Plenary Sessions, July 15, 2003, Wisconsin Rapids, Wis," *Wisconsin Medical Journal* 102, no. 5 (2003): 48–50.

**Wisconsin Healthiest Women Initiative's Collaborative Process to Develop a Framework for Action**

Over the years, Wisconsin's Title V Maternal and Child Health (MCH) Program has provided funding to statewide women's health partners to lead initiatives focused on preconception health, including the Women's Health Now and Beyond Pregnancy pilot project, promoting improved spacing between pregnancies and increased folic acid use. These initiatives were successful in increasing awareness among individual health providers of the need for a focus on preconception health. It became increasingly clear, however, that it is time for Wisconsin to develop a greater statewide focus on improving the health of all women of childbearing age. With a small technical assistance grant from the federal Maternal and Child Health Bureau, the MCH Program launched an initiative to bring together individuals and organizations to develop a statewide framework to improve women's health.

In 2011 a leadership workgroup was formed to help guide this new Wisconsin Healthiest Women Initiative. The leadership workgroup is composed of representatives from statewide women's health organizations in Wisconsin (the March of Dimes, the Wisconsin Women's Health Foundation, the Wisconsin Alliance for Women's Health, the Wisconsin Association for Perinatal Care, and Health Care Education and Training), a community representative, Division of Public Health staff, and a national consultant on preconception care from North Carolina. The *Core State Preconception Health Indicators: A Voluntary, Multi-State Selection Process*[25] and corresponding health indicators were used to narrow the focus of this initiative. The five priority focus areas selected were: social and economic determinants; sexual health and pregnancy planning; substance use; overweight/obesity; and mental health. Each focus area has two to four corresponding health indicators with data sources available to measure these indicators. For example, the corresponding health indicators for the Social and Economic Determinants of Health focus area are the rates of: poverty (<200 percent FPL), physical abuse prior to pregnancy, and less than high school education. These data sources allow progress on each health indicator to be tracked systematically. For each of the health indicators in the five focus areas, Division of Public Health (DPH) staff worked to compile data on the rates of each indicator for women of reproductive age in the nation as a whole and in Wisconsin (Available in Appendix A). In addition, whenever possible, the data were further stratified to reveal the difference in rates across different racial and ethnic groups including White, African American, American Indian, Hispanic and Other non-Hispanic. The health indicator data were collected from various sources including the U.S. Census (CPS), preconception work done by other states (Florida), WI PRAMS, and WI BRFSS, among others.

**INITIAL FOCUS AREAS:**

- *Social & Economic Determinants of Health**
- *Sexual Health & Pregnancy Planning**
- Substance Use
- Overweight/Obesity
- Mental Health

** Of the five initial focus areas, forum participants elected to prioritize these two for the first phase of the Initiative*

[25] Danielle L Broussard et al., "Core State Preconception Health Indicators: a Voluntary, Multi-state Selection Process," *Maternal and Child Health Journal* 15, no. 2 (February 2011): 158–168, http://www.ncbi.nlm.nih.gov/pubmed/20225127.

A series of three forums then followed: June 8 in Madison; September 8 in Beloit; and December 8 in Madison. More than 100 individuals around the state were invited, representing women's health organizations, clinics, health systems, infant mortality reduction coalitions, non-profit agencies, community-based organizations, public education, institutes of higher learning, and other local public health and human services agencies; 60 to 90 partners participated at each forum.

Forum participants examined the data available on the health and well-being of Wisconsin women and the efforts currently underway to improve women's health across the state. Although participants felt all five focus areas were important, it was determined that this initiative would be most successful by concentrating efforts on two initial focus areas. The two focus areas chosen by nominal group process were 1) Sexual Health and Pregnancy Planning, and, 2) Socioeconomic and Environmental Determinants of Health.

Two workgroups were formed to narrow the list of possible intervention strategies and potential partners to address the socioeconomic and environmental determinants and issues related to sexual health and pregnancy planning that will ultimately help to improve Wisconsin women's health and reduce poor birth outcomes.

**Why the Need for a Statewide Framework for Action?**

Both the national Healthy People 2020 and Healthiest Wisconsin 2020 (HW 2020) discuss the importance of women's health, sexual health, preconception health and the value of reducing health disparities by improving social determinants of health.

Healthy People 2020, the national strategic plan for improving the health of the country, states:
*"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The objectives of the Maternal, Infant, and Child Health topic area address a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families."*

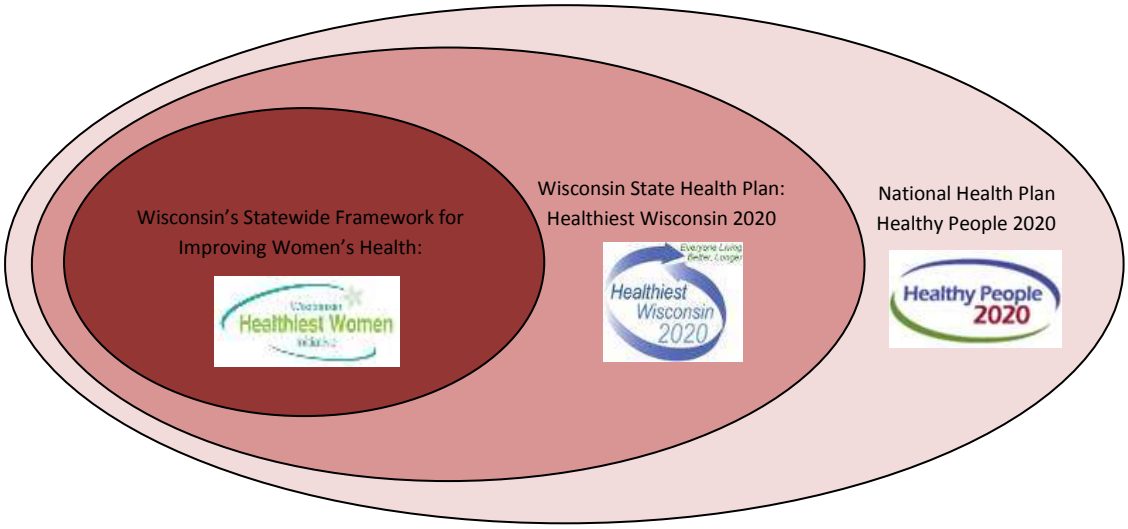
Healthiest Wisconsin 2020, the statewide framework for improving the health of Wisconsinites, states:
*"To maintain reproductive and sexual health, individuals must have access to reproductive and sexual health education, and medical services from a health care provider of their choice…. [However,] Health outcomes are not driven by individual behavior alone. Supportive community attitudes toward healthy sexuality, positive social and economic environments, and constructive public policies are as important as access to education and services in fostering reproductive and sexual health."*

*"Another group of health determinants described as social, economic and educational factors…. Research show a particularly strong association of both individual and community levels of health with these factors."*

*"Disparities in health outcomes between Wisconsin racial and ethnic groups and certain other populations are especially severe…. Thus improvement is needed to maintain Wisconsin's healthy advantages, and particularly to address systematic inequities and health disparities. Such systemic and across-the-board health disparities also strongly suggest the need for systemic, as opposed to individual-level, remedies."*

These two documents offer a starting point and foundation for state partners to further define how the objectives of these broader documents are applied to women's health, including before, during, and after pregnancy. This *women-specific* Framework for Action builds on these efforts and proposes strategies for improving *women's* health and the health of Wisconsin families. Moreover, creating a separate and more specific strategic framework elevates and prioritizes the importance of women's health and furthers the work of HW2020 to implement the Healthy Growth and Development objective to *provide pre-conception and inter-conception care to Wisconsin women in population groups disproportionately affected by poor birth outcomes*. This framework's strategies can provide guidance to the work and funding priorities of agencies and organizations when applying for grants; creating, implementing and evaluating programs and policies; and determining data resources.

Wisconsin has much to gain by improving the health of all women. This framework takes Wisconsin one step closer to achieving healthy women, healthy partners, healthy babies, healthy families, and healthy communities.



## OVERARCHING GOALS

**The participants in the Wisconsin Healthiest Women Initiative agreed to build on the three goals of the *Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes* by expanding these goals to connect women's health, and that of men, during the childbearing years to infant health. The next several pages highlight those key strategies that participants identified to achieve the Wisconsin Healthiest Women Initiative's goals. The strategies listed in this document are to encourage alignment and collaboration with a statewide systems approach to women's health.**

### Goal #1: Build and Strengthen Community Capacity

For most Wisconsinites, the life-course perspective, or the notion that health is cumulative and experiential is unfamiliar. Many women, partners and even health care providers don't consider how youth and adolescent health and well-being can impact a woman's health in the long-term. And yet, more than half of all Wisconsin pregnancies are unplanned, meaning that many women may not have the opportunity to improve their health prior to conceiving a baby. Therefore, it is necessary to increase community awareness about the need for women and men to be healthy throughout the life-course including the time prior to and between pregnancies. Therefore we aim to **ensure that consumers, communities, providers of health care and other services, and leaders understand the causes and determinants of the health of women and men during the childbearing years and the link to healthy birth outcomes.**

### Goal #2: Expand Access to and Affordability of High Quality Services

In order to provide health care services across the life span, women need to be connected to a healthcare provider and a clinic. This becomes more challenging when coverage for services is limited or unaffordable, the locations of clinics are not readily accessible, and when women are seeing multiple providers and systems for various services. Shifting the focus from management during pregnancy to prevention and health promotion at every opportunity is necessary in order to reduce chronic disease and improve birth outcomes.[19] We aim to achieve this by **expanding access to and the availability and affordability of effective and appropriate health care interventions and psychosocial and socioeconomic supports for those women and men of childbearing age who are at risk for poor health and poor birth outcomes.**

### Goal #3: Improve Accountability: Identify and Monitor Relevant Information

This is an opportunity to further decrease disparities in women's health and birth outcomes. Improved data capacity and the ability to use data effectively at both the system and community level is an essential first step toward improving health outcomes. Similarly, it is important to closely monitor program performance of interventions and to increase accountability for all partners to work together to improve women's health and eliminate disparities. With an increased focus on women's health in general, especially prior to and between pregnancies, this initiative works to **identify and monitor relevant information regarding progress toward improving the health of women and men of childbearing age and closing the gap in birth outcomes.**

**Focus Area: SOCIOECONOMIC & ENVIRONMENTAL DETERMINANTS OF HEALTH**

**GOALS & STRATEGIES**

**The following is a list of strategies for improving the socioeconomic and environmental determinants of health as suggested by the Wisconsin Healthiest Women Initiative Forum participants. This list of strategies is certainly not comprehensive but it does provide some valuable suggestions for how system and community-level partners can work to improve women's health.**

## Goal #1: Build and Strengthen Community Capacity

a) Improve community awareness of social and economic determinants of health and knowledge about community resources available to address them.

b) Integrate the life-course perspective into programs and policies to emphasize the importance of all ages and stages of life for men, women, and children.

c) Increase awareness and education to reduce racism and improve the health of the African American community and other communities of color.

d) Promote public policies that address social, economic and environmental determinants of health.

e) Ensure that memberships of boards and organizational bodies that affect social, economic and environmental determinants of health are representative of the communities that they serve (across the spectrum of sex, race, culture, language, etc).

## Goal #2: Expand Access to and Affordability of High Quality Services

a) Improve health care providers' understanding and screening of social, economic and environmental determinants of health, and cultural humility.[26]

b) Identify effective approaches that focus on the importance of interconception care.

c) Expand health education and health literacy efforts.

d) Expand faith-based community efforts in public health.

e) Expand the medical home model in order to improve access and accountability.

f) Expand comprehensive home visiting and include screening for social and economic issues and initiating referrals as needed.

## Goal #3: Improve Accountability: Identify and Monitor Relevant Information

a) Improve the quality and quantity of health indicator data.

b) Increase access to data.

c) Increase translational value of data (moving from data to action).

d) Engage communities by increasing transparency of data and decision-making.

[26] "Cultural humility is a lifelong process of self-reflection, self-critique and commitment to understanding and respecting different points of view, and engaging with others humbly, authentically and from a place of learning (Tervalon & Murray-Garcia, 1998). Tervalon and Murray-Garcia developed this concept while addressing disparities and institutional inequities in the field of public healthcare." Joseph R. Betancourt et al., "Defining Cultural Competence: a Practical Framework for Addressing Racial/ethnic Disparities in Health and Health Care.," *Public Health Reports* 118, no. 4 (August 2003): 293, /pmc/articles/PMC1497553/?report=abstract.

**Focus Area: SEXUAL HEALTH & PREGNANCY PLANNING**

**GOALS & STRATEGIES**

**The following is a list of strategies for improving the sexual health and pregnancy planning of Wisconsin women as suggested by the Wisconsin Healthiest Women Initiative Forum participants. This list of strategies is certainly not comprehensive but it does provide some valuable suggestions for how system and community-level partners can work to improve women's health.**

## Goal #1: Build and Strengthen Community Capacity

a) Engage new and existing collaboratives, partnerships and initiatives to bring communities together around the topic of sexual health across the life-course.

b) Increase local ownership by empowering formal and informal community leaders.

c) Increase quality education and information about sexuality in all settings and use better and consistent terms to normalize the conversation around sexual health.

## Goal #2: Expand Access to and Affordability of High Quality Services

a) Increase access to coordinated care and collaborative wellness models (such as medical homes).

b) Improve access and affordability of health services to men.

c) Train providers in cultural and community humility, particularly as it relates to sexual health (competency and humility should relate to cultures, socioeconomic status, languages, physical environments, etc.).

d) Support healthcare reform.

## Goal #3: Improve Accountability: Identify and Monitor Relevant Information

a) Improve accountability by normalizing reproductive health standards of care (such as those of the American College of Obstetricians and Gynecologists) and reporting on the implementation of these standards.

b) Improve data collection.

c) Educate consumers, providers and leaders to encourage meaningful policy and program formation and implementation.

## WHAT *WE* CAN DO: Call to Action

*"Public health agencies alone cannot assure the nation's health."* [27]

It will take all of the system-level partners and grassroots communities to improve the health and well-being of all women and girls in Wisconsin.

As we move forward with a unified commitment to the health and wellbeing of women and girls, the challenge is to think about the following questions as a personal and professional "call to action":

- What is your community doing to improve women's health?
- What additional efforts might your organization or community undertake?
- What organizations or other partners might you collaborate with in order to improve the health and well-being of women in your community?

### Here are some examples of ongoing women's health efforts from system & community partners related to the three goals of the Wisconsin Healthiest Women Initiative:

**GOAL 1: *Efforts to Strengthen Communities***: Increasing awareness of the importance of health across the lifespan is a mutual goal for the Wisconsin Alliance for Women's Health (WAWH), Wisconsin March of Dimes, and the Wisconsin Women's Health Foundation (WWHF). Both Wisconsin March of Dimes and the WWHF are investing in evidence-based innovative models of care that are culturally diverse and address the socioeconomic and environmental determinants of health. The Centering Pregnancy® and First Breath programs strive to build on the existing strengths of women and promote a community-centered approach to pregnancy and child-rearing. The WAWH developed the Adolescent Health Care Communication Program to bridge the communication gap between adolescents and their health providers. WAWH trains and empowers local teens to become health care educators for other teens and health care providers in order to improve honest communication with health providers and thus to improve the delivery of sexual and reproductive health care to all young people in our community.

**GOAL 2: *Efforts to Improve Access:*** In 2011, the Wisconsin Association for Perinatal Care (WAPC) and Health Care Education and Training (HCET) began working with healthcare clinics and systems to integrate preconception services into existing women's health services. WAPC, in partnership with Children's Community Health Plan, Women's Outpatient and Family Care Centers at St. Joseph's Hospital of Milwaukee, and Community Connect Health Plan began a pilot project to streamline systems of care to assure pre/interconception health care was engrained in the existing care frameworks. Working with providers, WAPC created both a paper chart and electronic reminders. With these tools, providers were able to increase the frequency and quality of pre/interconception health services to women by nearly 100 percent. In a similar effort, HCET, in partnership with four women's health clinics around the state, is working to enhance Prenatal Care Coordination (PNCC), by incorporating pre/interconception health through active referrals and health education messaging for all PNCC clients and create a seamless transition from prenatal care to routine women's healthcare for all women.

**GOAL 3: *Efforts to Improve Accountability:*** The Wisconsin Department of Health Services (DHS), the Wisconsin March of Dimes (MOD), and the Wisconsin Alliance for Women's Health (WAWH) support access to consumer education and quality data to inform the decisions made by individuals, systems, and leaders that affect the health of women and girls, as well as track the impact of these decisions over time. DHS assesses the health of Wisconsin women through the Pregnancy Risk Assessment Monitoring

[27] "The Future of the Public's Health in the 21st Century - Institute of Medicine", http://iom.edu/Reports/2002/The-Future-of-the-Publics-Health-in-the-21st-Century.aspx.

System (PRAMS) Survey and the Behavioral Risk Factor Surveillance System (BRFSS) Survey and continues to work to make this information accessible and relevant to partners. MOD monitors and shares relevant data through their website and is a key national partner on initiatives to partner with states and providers to improve accountability, such as *Healthy Babies are Worth the Wait* and the *Healthy Babies Challenge*. WAWH convenes consumers and statewide women's health partners annually to discuss women's health issues in Wisconsin.

## APPENDIX A: Health Focus Areas for Wisconsin Women of Reproductive Age (18-44 years)

| Focus Areas | Indicators | WI Women Ages 18-44 (percent) | US Women Ages 18-44* (percent) | White** (percent) | Black** (percent) | American Indian** (percent) | Hispanic (percent) | Other non-Hispanic (percent) |
|---|---|---|---|---|---|---|---|---|
| **Social/Economic Determinants** | Poverty (<200 percent Federal Poverty Level) | 28 | 37 | 25 | 57 | n/a | n/a | n/a |
| | Physical abuse prior to pregnancy | 5.8 | 5.0 (median) | 4.2 | 14.2 | † | 9.3 | 5.9† |
| | Less than a high school education | 7 | 11 | 5 | 15 | n/a | 26 | n/a |
| **Sexual Health and Pregnancy Planning** | Unintended pregnancy | 35 | 40 (median) | 30 | 61 | † | 45 | 44† |
| | Sexually transmitted infections (rate per 100,000 women age 18-44) | 1624 | 2023 | 542 | 6015 | 2302 | 1223 | 1164 |
| | Inter-pregnancy interval < 18 months (percent of repeat live births) | 33 | n/a | 33 | 35 | 37 | 29 | 38 |
| | Folic acid / multi-vitamin every day in month prior to pregnancy | 33 | 30 (median) | 37 | 23 | † | 20 | 26 |
| **Substance Use** | Current smokers | 23 | 19 | 23 | 28 | 37 | 26 | 19 |
| | Binge drinking | 25 | 14 | 24 | 17 | 26 | 21 | 11 |
| **Overweight/Obesity** | Obese (BMI ≥30) | 23 | 24 | 20 | 42 | 40 | 29 | 22 |
| | Consume at least 5 fruit/vegetable servings per day | 26 | 27 | 25 | 21 | n/a | n/a | n/a |
| | Meet guidelines for moderate / vigorous physical activity | 59 | 51 | 59 | 54 | n/a | n/a | n/a |
| | Any exercise (other than regular job) | 84 | n/a | 85 | 67 | 77 | 74 | 72 |
| **Mental Health** | Postpartum depressive symptoms | 14 | 13 (median) | 11 | 26 | † | 18 | 21† |
| | Mental health not good for 14+ days in last month | 12 | 13 | 11 | 20 | 23 | 25 | 15 |

Notes: All indicators are percentages unless otherwise noted. PRAMS data represent women who recently gave birth (all ages). Birth certificate data (all ages) exclude first births. Most indicators are a selection of those recommended by the Core State Preconception Health Indicators Working Group. Broussard DL, Sappenfield WB, Fussman C, Kroelinger CD, Grigorescu V. Core State Preconception Health Indicators: A Voluntary, Multi-state Selection Process. *Maternal and Child Health Journal.* 2011; 15(2):158-168. Some Wisconsin BRFSS indicators provided courtesy of Anne Ziege, PhD.

*As reported in Florida's report, Preconception Health: An Issue for *Every Woman* of Childbearing Age in Florida, June 2010.
http://everywomanfl.com/Pages/Healthcare_Providers/Preconception_Health_Indicator_Report.aspx

**Non-Hispanic

†"Other non-Hispanic" group includes American Indians for these indicators.

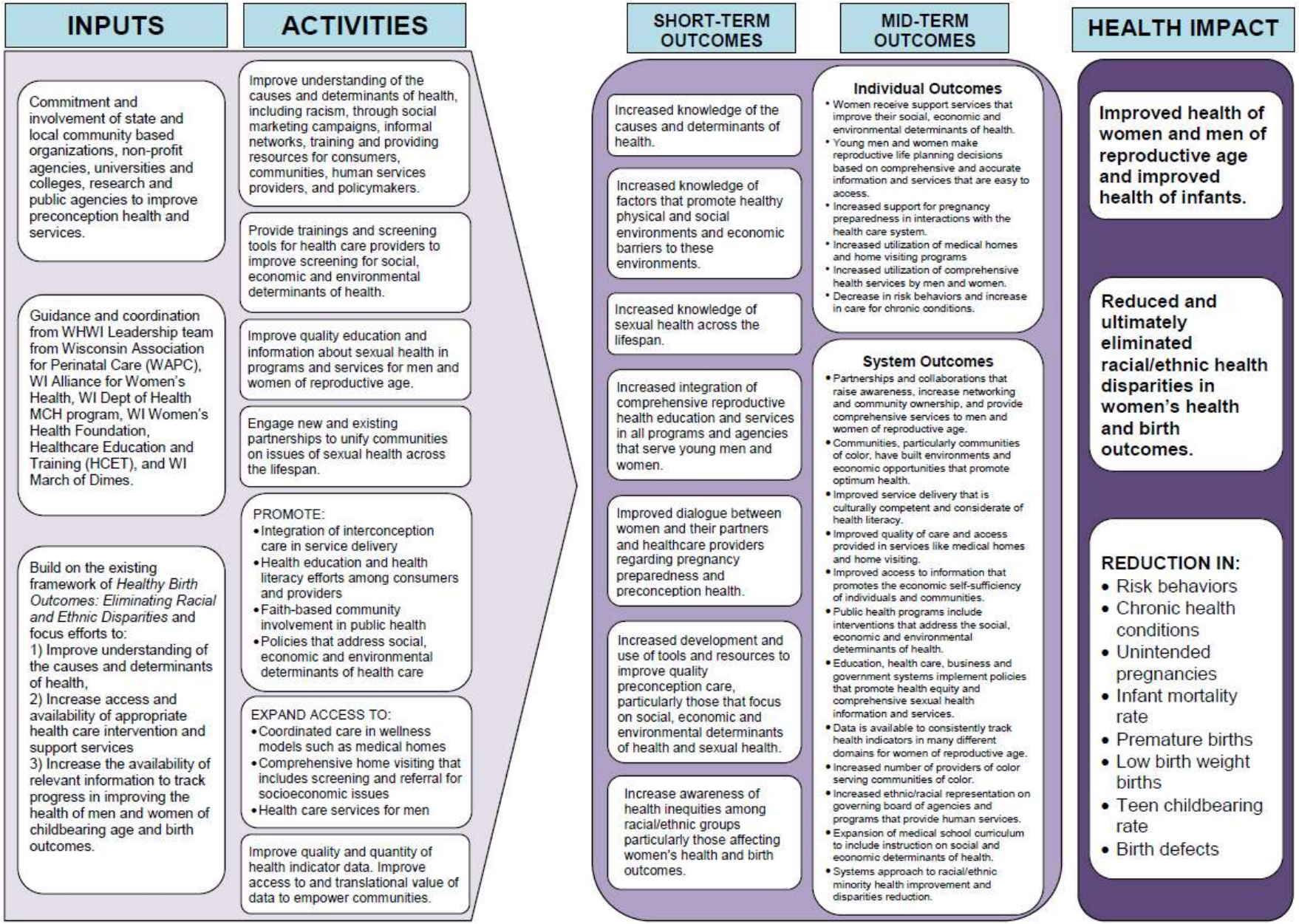
n/a: Reliable, comparable estimate not readily available.

Bolded boxes indicate a risk value that is approximately twice (ratio of 1.75+) the U.S. rate for the state rate or approx. twice the white rate for racial ethnic groups.

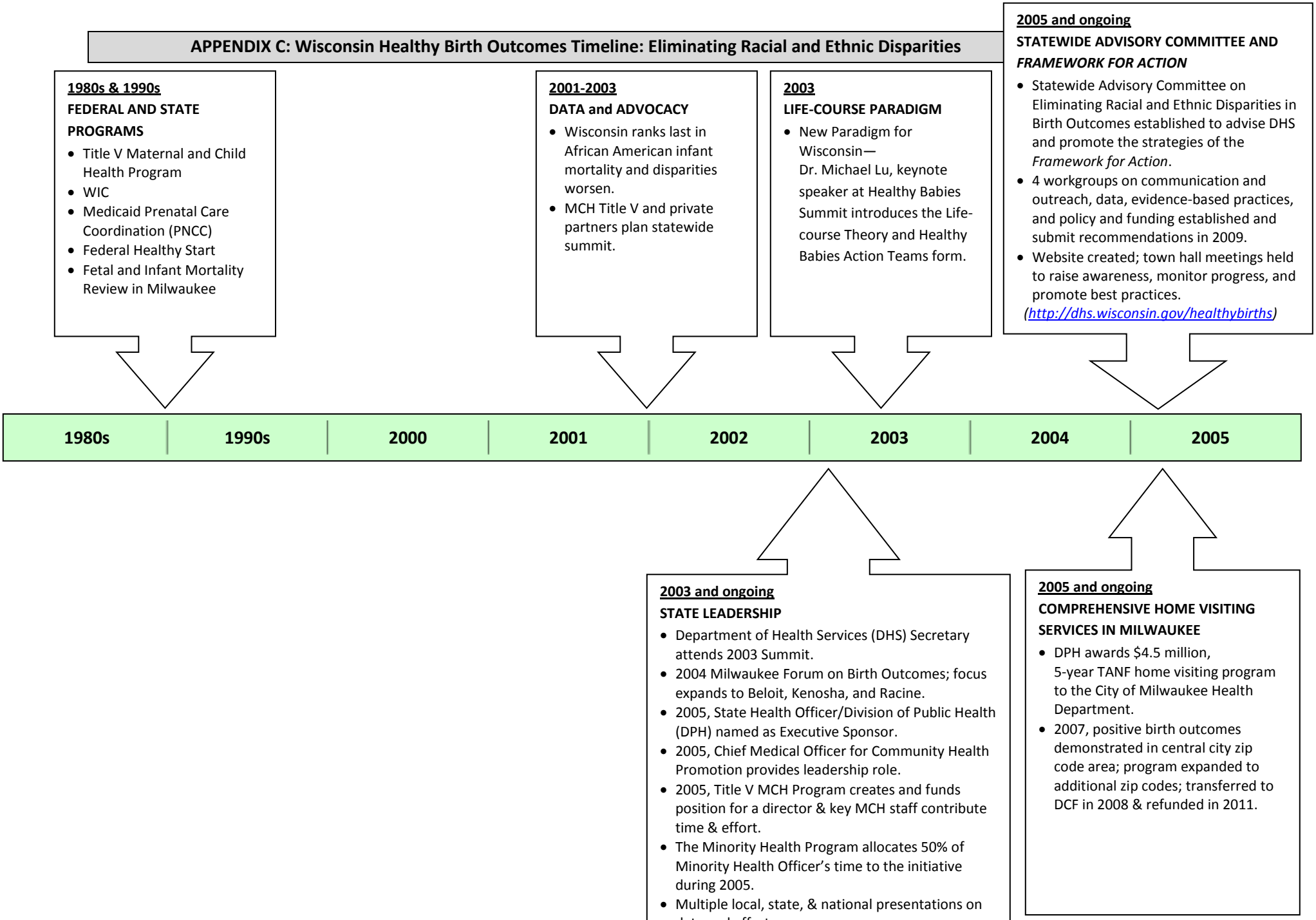
**Health indicator details**

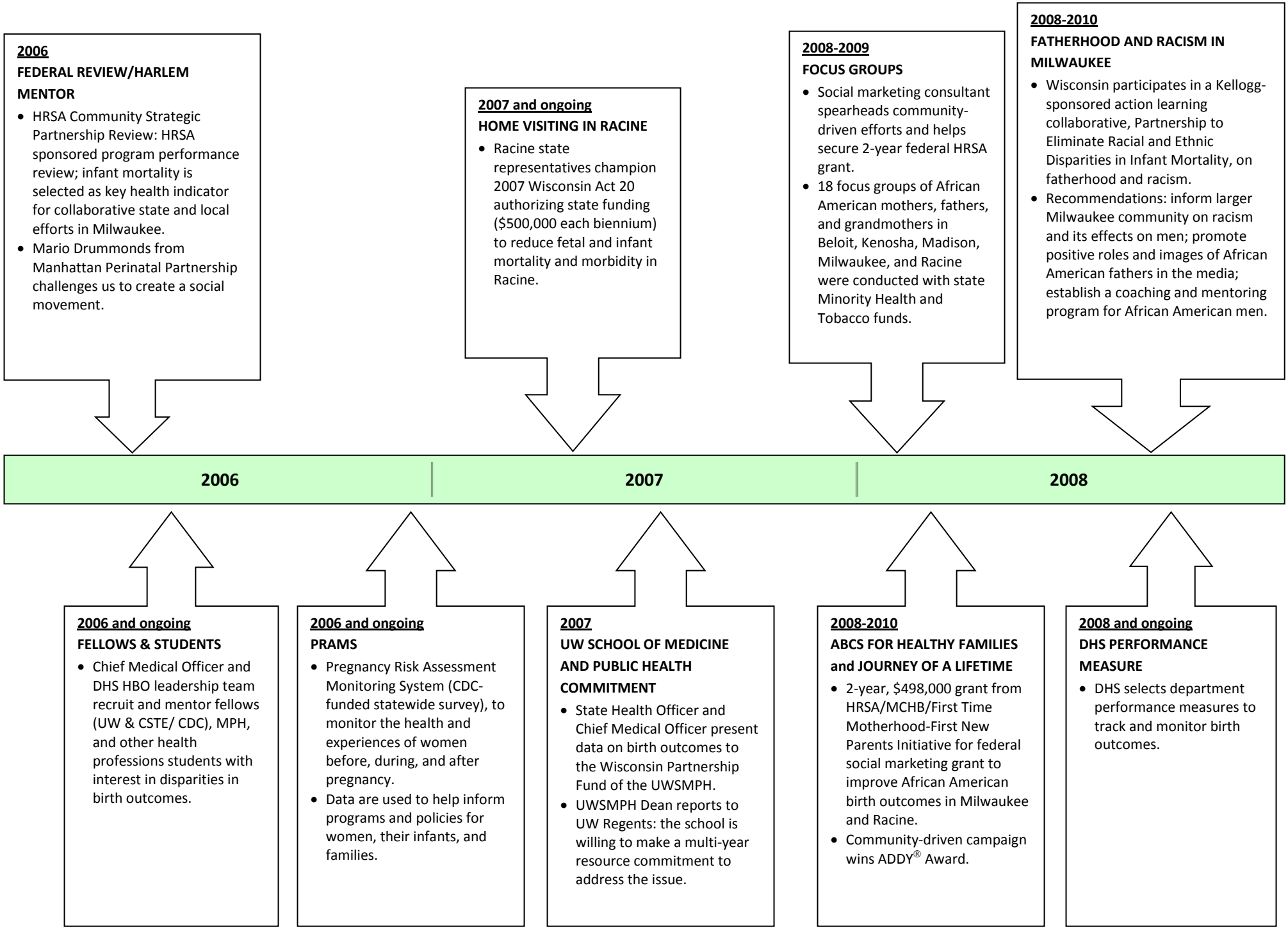
| Indicator | Data source, years – WI | Data source, years – US | Data notes |
|---|---|---|---|
| Poverty (<200 percent Federal Poverty Level) | U.S. Census (CPS); 2008-10 | U.S. Census (CPS); 2010 | |
| Physical abuse prior to pregnancy (partner/ex) | WI PRAMS; 2007-2008 | CDC PRAMS; 2008 | |
| Less than a high school education | WI BRFSS; 2005-2010 | Florida report; 2008 | Value for Hispanics may not be reliable due to small sample size |
| Unintended pregnancy | WI PRAMS; 2007-2008 | Florida report; 2008 | |
| Sexually transmitted infections (cases of chlamydia, gonorrhea, syphilis per 100,000 | WI STD Program; 2010 | Florida report; 2008 | WI rates adjusted to account for underreporting of race/ethnicity |
| Inter-pregnancy interval < 18 months (percent of live repeat births) | WI Birth certificates (WISH); 2007-09 | n/a | Racial/ethnic group data for years 2005-09<br>*Note: WIC data from Pregnancy Nutrition Surveillance System: 38.5 percent (WI); 38.7 percent (US) |
| Folic acid / multi-vitamin every day in month prior to pregnancy | WI PRAMS; 2007-2008 | Florida report; 2008 | |
| Current smokers | WI BRFSS (WISH); 2007-09 | Florida report; 2008 | Racial/ethnic group data for years 2004-09 |
| Binge drinking | WI BRFSS (WISH); 2007-09 | Florida report; 2008 | Racial/ethnic group data for years 2004-09 |
| Obese | WI BRFSS (WISH); 2007-09 | Florida report; 2008 | Racial/ethnic group data for years 2004-09 |
| 5+ fruit/vegetable servings per day | WI BRFSS; 2005-2010 | Florida report; 2008 | Insufficient data for some racial/ethnic groups |
| Meet guidelines for physical activity | WI BRFSS; 2005-2010 | Florida report; 2008 | Insufficient data for some racial/ethnic groups |
| Any exercise (other than regular job) | WI BRFSS; 2005-2010 | n/a | Value for American Indians may not be reliable due to small sample size (CI ±14 percent) |
| Postpartum depressive symptoms | WI PRAMS; 2007-2008 | CDC's CPONDER; 2008 | |
| Mental health not good for 14+ days in last month | WI BRFSS; 2005-2010 | Florida report; 2008 | Value for American Indians may not be reliable due to small sample size (CI ±14 percent) |

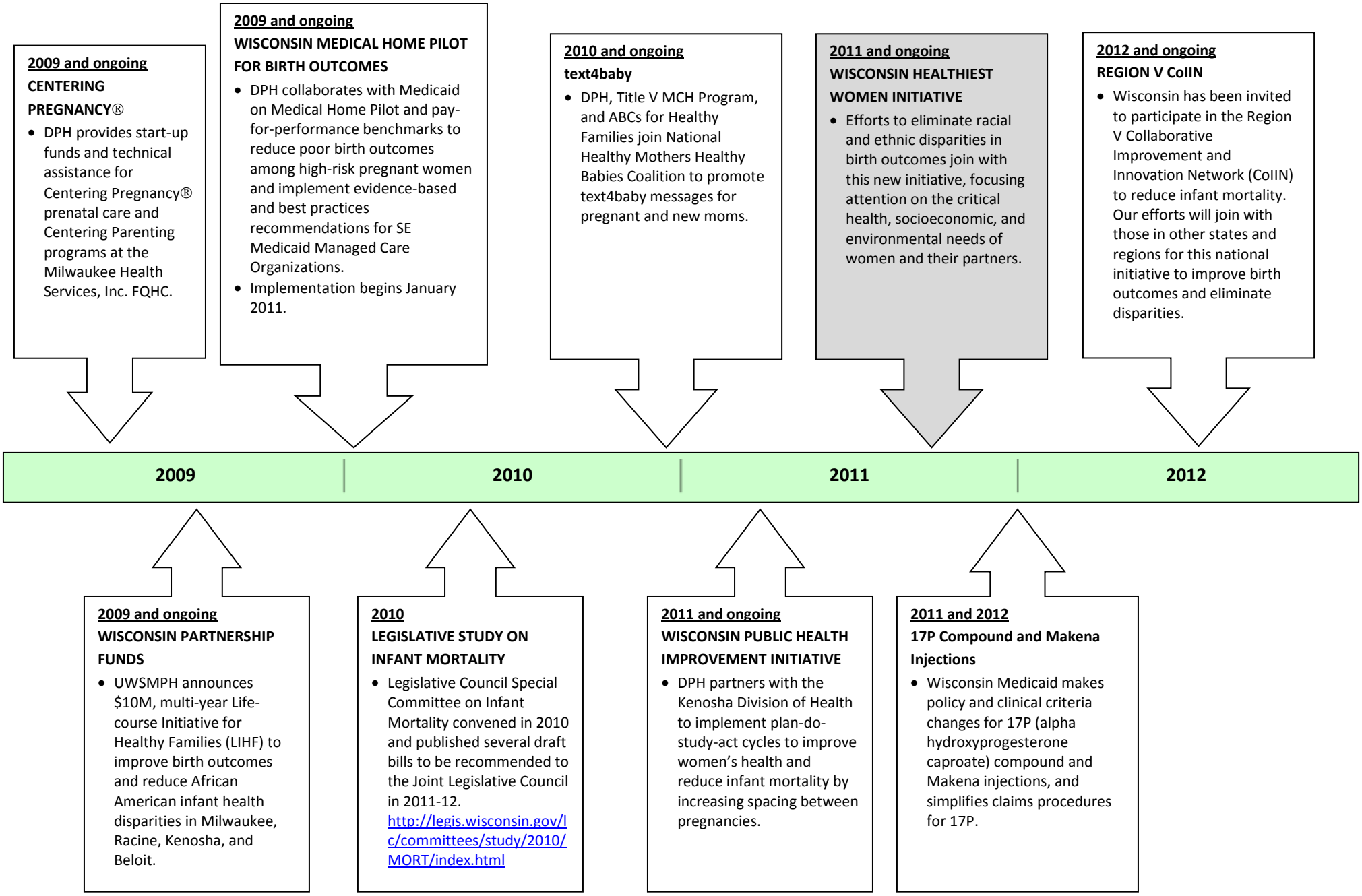
## APPENDIX B: Logic Model for Wisconsin Healthiest Women Initiative



## APPENDIX C: Wisconsin Healthy Birth Outcomes Timeline: Eliminating Racial and Ethnic Disparities




2006
FEDERAL REVIEW/HARLEM MENTOR
• HRSA Community Strategic Partnership Review: HRSA sponsored program performance review; infant mortality is selected as key health indicator for collaborative state and local efforts in Milwaukee.
• Mario Drummonds from Manhattan Perinatal Partnership challenges us to create a social movement.
2007 and ongoing
HOME VISITING IN RACINE
• Racine state representatives champion 2007 Wisconsin Act 20 authorizing state funding ($500,000 each biennium) to reduce fetal and infant mortality and morbidity in Racine.
2008-2009
FOCUS GROUPS
• Social marketing consultant spearheads community-driven efforts and helps secure 2-year federal HRSA grant.
• 18 focus groups of African American mothers, fathers, and grandmothers in Beloit, Kenosha, Madison, Milwaukee, and Racine were conducted with state Minority Health and Tobacco funds.
2008-2010
FATHERHOOD AND RACISM IN MILWAUKEE
• Wisconsin participates in a Kellogg-sponsored action learning collaborative, Partnership to Eliminate Racial and Ethnic Disparities in Infant Mortality, on fatherhood and racism.
• Recommendations: inform larger Milwaukee community on racism and its effects on men; promote positive roles and images of African American fathers in the media; establish a coaching and mentoring program for African American men.
2006
2007
2008
2006 and ongoing
FELLOWS & STUDENTS
• Chief Medical Officer and DHS HBO leadership team recruit and mentor fellows (UW & CSTE/ CDC), MPH, and other health professions students with interest in disparities in birth outcomes.
2006 and ongoing
PRAMS
• Pregnancy Risk Assessment Monitoring System (CDC-funded statewide survey), to monitor the health and experiences of women before, during, and after pregnancy.
• Data are used to help inform programs and policies for women, their infants, and families.
2007
UW SCHOOL OF MEDICINE AND PUBLIC HEALTH COMMITMENT
• State Health Officer and Chief Medical Officer present data on birth outcomes to the Wisconsin Partnership Fund of the UWSMPH.
• UWSMPH Dean reports to UW Regents: the school is willing to make a multi-year resource commitment to address the issue.
2008-2010
ABCS FOR HEALTHY FAMILIES and JOURNEY OF A LIFETIME
• 2-year, $498,000 grant from HRSA/MCHB/First Time Motherhood-First New Parents Initiative for federal social marketing grant to improve African American birth outcomes in Milwaukee and Racine.
• Community-driven campaign wins ADDY® Award.
2008 and ongoing
DHS PERFORMANCE MEASURE
• DHS selects department performance measures to track and monitor birth outcomes.


2009 and ongoing
CENTERING PREGNANCY®
• DPH provides start-up funds and technical assistance for Centering Pregnancy® prenatal care and Centering Parenting programs at the Milwaukee Health Services, Inc. FQHC.
2009 and ongoing
WISCONSIN MEDICAL HOME PILOT FOR BIRTH OUTCOMES
• DPH collaborates with Medicaid on Medical Home Pilot and pay-for-performance benchmarks to reduce poor birth outcomes among high-risk pregnant women and implement evidence-based and best practices recommendations for SE Medicaid Managed Care Organizations.
• Implementation begins January 2011.
2010 and ongoing
text4baby
• DPH, Title V MCH Program, and ABCs for Healthy Families join National Healthy Mothers Healthy Babies Coalition to promote text4baby messages for pregnant and new moms.
2011 and ongoing
WISCONSIN HEALTHIEST WOMEN INITIATIVE
• Efforts to eliminate racial and ethnic disparities in birth outcomes join with this new initiative, focusing attention on the critical health, socioeconomic, and environmental needs of women and their partners.
2012 and ongoing
REGION V CoIIN
• Wisconsin has been invited to participate in the Region V Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. Our efforts will join with those in other states and regions for this national initiative to improve birth outcomes and eliminate disparities.
2009
2010
2011
2012
2009 and ongoing
WISCONSIN PARTNERSHIP FUNDS
• UWSMPH announces $10M, multi-year Life-course Initiative for Healthy Families (LIHF) to improve birth outcomes and reduce African American infant health disparities in Milwaukee, Racine, Kenosha, and Beloit.
2010
LEGISLATIVE STUDY ON INFANT MORTALITY
• Legislative Council Special Committee on Infant Mortality convened in 2010 and published several draft bills to be recommended to the Joint Legislative Council in 2011-12. http://legis.wisconsin.gov/lc/committees/study/2010/MORT/index.html
2011 and ongoing
WISCONSIN PUBLIC HEALTH IMPROVEMENT INITIATIVE
• DPH partners with the Kenosha Division of Health to implement plan-do-study-act cycles to improve women's health and reduce infant mortality by increasing spacing between pregnancies.
2011 and 2012
17P Compound and Makena Injections
• Wisconsin Medicaid makes policy and clinical criteria changes for 17P (alpha hydroxyprogesterone caproate) compound and Makena injections, and simplifies claims procedures for 17P.

## APPENDIX D: Additional Resources

**A Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes Wisconsin 2008-2011**

- WI Department of Health and Human Services, Division of Public Health
  http://www.dhs.wisconsin.gov/healthybirths/pdf/framework20082011.pdf

**Adverse Childhood Experiences (ACE) Study**

- Centers for Disease Control and Prevention
  http://www.cdc.gov/ace/about.htm
- Children's Trust fund and the Child Abuse Prevention Fund
  http://wichildrenstrustfund.org/files/WisconsinACEs.pdf

**Annual report (2010) about births and infant deaths**

- WI Department of Health and Human Services, Division of Public Health
  http://www.dhs.wisconsin.gov/publications/P4/P45364-10.pdf

**Healthiest Wisconsin 2020**

- WI Department of Health and Human Services, Division of Public Health
  http://www.dhs.wisconsin.gov/hw2020/

**Healthy People 2020**

- U.S. Department of Health and Human Services
  http://www.healthypeople.gov/2020/default.aspx

**Realizing Health Reform's Potential - Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help**

- The Commonwealth Fund, May 2011
  http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/May/Women-at-Risk.aspx

**Report: Core State Preconception Health Indicators: A Voluntary, Multi-State Selection Process**

- U.S. Centers for Disease Control and Prevention
  http://www.ncbi.nlm.nih.gov/pubmed/20225127

**State-by-State Women's Insurance analysis**

- Kaiser Family Foundation, Dec 2011
  http://www.kff.org/womenshealth/upload/1613-11.pdf

**The Report to Congress from the U.S. Department of Health and Human Services (Report on Activities Related to "Improving Women's Health" as Required by the Affordable Care Act**

- U.S. Department of Health and Human Services
  http://www.healthcare.gov/law/resources/reports/women03252011a.pdf

**Women's Health Care Chartbook**

- Kaiser Family Foundation, May 2011:
  http://www.kff.org/womenshealth/upload/8164.pdf

**"Unnatural Causes" Documentary Series exploring racial and socioeconomic inequalities in health-PBS**

- www.unnaturalcauses.org

P-00535 (09/2013)
Division of Public Health
Wisconsin Department of Health Services