

# 2016 Health Assessment: Women of Childbearing Ages



**Erie County Health Department &  
Erie County Community Health Center**









**Erie County Health Department**  
*An Accredited Public Health Department*

**Erie County Community Health Center**  
*A Federally Qualified Health Center*

**Peter T. Schade, MPH, RS**  
*Health Commissioner*



## **Foreword**

Infant Mortality – Two words that should never have to go together. The startling facts of infant mortality within our community have led to numerous stakeholders banding together to reverse the awful percentages of our babies dying in their first year.

Many meetings have been held, many groups are pursuing action ... we feel it is important that we get data directly from our moms and moms-to-be, here in Northwest Ohio ... facts that we can use to identify common areas that are leading to the infant mortality rates that are completely unacceptable.

Now then, we all realize the existence of infant mortality, and all age mortality ... death is a part of life. However, when infant deaths are occurring at historically high numbers ... we know as a community that something is wrong and we need to help reverse the trend.

In 2015, the Erie County Health Department/Erie County Community Health Center received some special funding from the RCHN Community Health Foundation. This funding is being used to pay for this six city/county Infant Mortality Health Assessment. All data herein belongs to all of these individuals who read it and who want to use the information to better the quality of life for all in Northwest Ohio.

The Erie County Health Department/Erie County Community Health Center is committed to turning the percentages of infant deaths back toward levels that equate a healthier community.

Thank you, to all of the respondents who answered the survey. You all are brave, honest, and exceptional citizens who voluntarily shared personal information for the betterment of all.

We will, as a region, continue to work to improve infant mortality, so someday these words will never be tied together.

Peter T. Schade, MPH, RS  
Health Commissioner  
Erie County Health Department/Erie County Community Health Center

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# EXECUTIVE SUMMARY

This executive summary provides an overview of health-related data for women of child-bearing age (ages 18-44 years old) who participated in an assessment survey during fall 2015. The findings are based on self-administered surveys using a structured questionnaire. The questions were modeled after the survey instrument used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS) and the National Survey of Children's Health (NSCH) developed by the Child and Adolescent Health Measurement Initiative. The Hospital Council of Northwest Ohio collected the data, guided the health assessment process and integrated sources of primary and secondary data into the final report.

## Primary Data Collection Methods

### DESIGN

This community health assessment was cross-sectional in nature and included a written survey of women of child-bearing age in the following counties: Allen, Erie, Lucas, Richland, Sandusky, and Wood. These counties are all located in Northwest Ohio and have a significant number of African Americans, one of the predictors of infant mortality.

From the beginning, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the study. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

### INSTRUMENT DEVELOPMENT

One survey instrument for women of child bearing age was designed for this study. As a first step in the design process, health education researchers from the University of Toledo and staff members from the Hospital Council of NW Ohio met to discuss potential sources of valid and reliable survey items that would be appropriate for assessing the health status and health needs of adults and adolescents. The investigators decided to derive the majority of the adult survey items from the BRFSS and NSCH.

The Project Coordinator from the Hospital Council of NW Ohio conducted a series of meetings with the planning committee from Erie County. During these meetings, banks of potential survey questions from the BRFSS survey were reviewed and discussed. Based on input from the Erie County planning committee, the Project Coordinator composed a draft survey containing 33 items for the survey. The draft was reviewed and approved by health education researchers at the University of Toledo.

### SAMPLING

Women ages 18 to 44 years old living in selected counties in Northwest Ohio were used as the sampling frame for the adult survey. Those counties that were selected had a significant African American population. There were 28,691 women of childbearing age (ages 18-44 years old) living in the selected six counties. The investigators conducted a power analysis to determine what sample size was needed to ensure a 95% confidence level with a corresponding margin of error of 5% (i.e., we can be 95% sure that the "true" population responses are within a 5% margin of error of the survey findings.) A sample size of at least 379 women of childbearing age was needed to ensure this level of confidence. The random sample of mailing addresses of women from the selected counties was obtained from Allegra Marketing Services in Louisville, KY.

## PROCEDURE

Prior to mailing the survey, an advance letter was mailed to 879 valid addresses for women in the selected counties in Northwest Ohio. This advance letter was personalized, printed on the Hospital Council of Northwest Ohio stationery and was signed by Peter Schade, Health Commissioner, Erie County Health Department and Jan Ruma, Vice President, Hospital Council of Northwest Ohio and Director, Northwest Ohio Pathways HUB. The letter introduced the project and informed the readers that they may be randomly selected to receive the survey. The letter also explained that the respondents' confidentiality would be protected and encouraged the readers to complete and return the survey promptly if they were selected.

Two weeks following the advance letter, a two-wave mailing procedure was implemented to maximize the survey return rate. The initial mailing included a personalized hand signed cover letter (on Hospital Council of Northwest Ohio stationery) describing the purpose of the study; a questionnaire printed on colored paper; a self-addressed stamped return envelope; and a \$2 incentive. Approximately two weeks after the first mailing, a second wave mailing encouraging them to reply, another copy of the questionnaire on colored paper, and another reply envelope was sent. Surveys returned as undeliverable were not replaced with another potential respondent.

The response rate for the mailing was 34% (n=297; CI=±5.66).

## DATA ANALYSIS

Individual responses were anonymous and confidential. Only group data are available. All data was analyzed by health education researchers at the University of Toledo using SPSS 17.0. Crosstabs were used to calculate descriptive statistics for the data presented in this report.

## LIMITATIONS

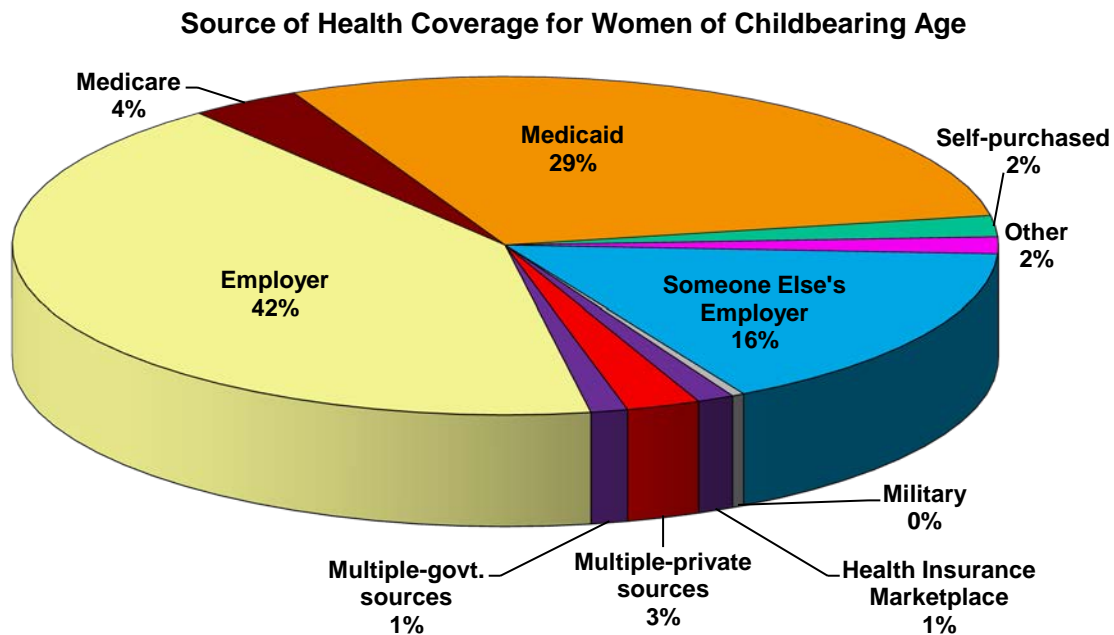
As with all county assessments, it is important to consider the findings in light of all possible limitations. If any important differences existed between the respondents and the non-respondents regarding the questions asked, this would represent a threat to the external validity of the results (the generalizability of the results to the region). If there were little to no differences between respondents and non-respondents, then this would not be a limitation.

Lastly, it is important to note that, although several questions were asked using the same wording as the CDC questionnaires, the data collection method differed. CDC adult data were collected using a set of questions from the total question bank and adults were asked the questions over the telephone rather than as a mail survey.

## Data Summary

### HEALTH CARE COVERAGE & UTILIZATION

The 2015 Health Assessment data has identified that 9% of women were without health care coverage. Those most likely to be uninsured were adults with an income level under \$25,000.



### REPRODUCTIVE HEALTH & SEXUAL BEHAVIOR

In 2015, 93% of women that are currently pregnant understand the ABC's of Safe Sleep. 39% of currently pregnant women understand that taking folic acid lowers their chance for a low birth weight infant.

### SOCIAL CONTEXT

32% of women had three or more adverse childhood experiences. About one-third (34%) of women received assistance for food in the past year.

### PARENTING

83% of parents put their child to sleep on his/her back. Almost one quarter (24%) of women breastfed their child for at least 1 year.



# Women of Childbearing Age | HEALTH CARE COVERAGE & UTILIZATION

## Key Findings

*The 2015 Health Assessment data has identified that 9% of women were without health care coverage. Those most likely to be uninsured were women with an income level under \$25,000.*

## Women of Childbearing Age - General Health Care Coverage

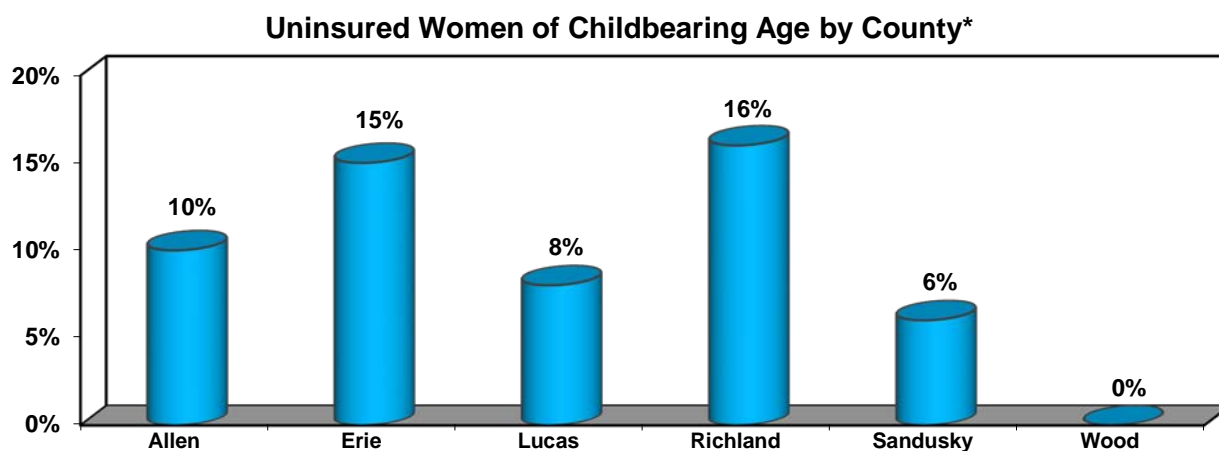
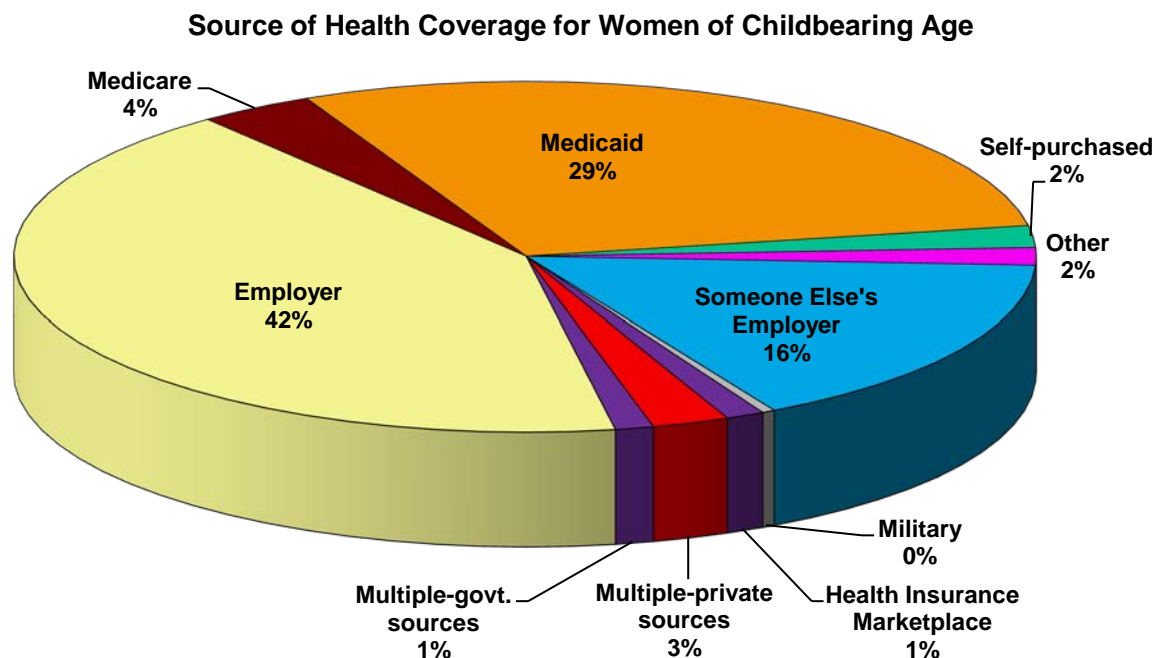
- In 2015, 91% of women had health care coverage, leaving 9% who were uninsured. The 2014 BRFSS reports uninsured female prevalence rates for Ohio (8%).
- In the past year, 9% of women were uninsured, increasing to 12% of those with incomes less than \$25,000.
- The following types of health care coverage were used: employer (42%), Medicaid or medical assistance (29%), someone else's employer (16%), Medicare (4%), self-paid plan (2%), multiple-including private sources (2%), multiple-including government sources (1%), Health Insurance Market place (1%), military or VA (<1%), and other (2%).

*9% of women of childbearing age were uninsured.*

## Women of Childbearing Age - Health Care Access

- 86% of women reported they had one particular place they usually went if they were sick or needed advice about their health.
- Women visited the following places for health care services: doctor's office (85%), urgent care center (10%), hospital emergency room (4%), hospital outpatient department (<1%), and some other kind of place (1%).
- 14% of women indicated they had no usual place for health care services.
- Women had the following transportation issues when they needed health services: could not afford gas (11%), no car (9%), no driver's license (8%), no car insurance (5%), car did not work (3%), limited public transportation available or accessible (2%), disabled (1%), no public transportation available or accessible (1%), no transportation before or after 8:00 a.m.- 4:30 p.m. (<1%), did not feel safe to drive (<1%), and other car issues/expenses (4%).
- Women used the following as their usual source of services for female health concerns: private gynecologist (64%), general or family physician (22%), nurse practitioner/physician assistant (10%), a family planning clinic (i.e., Planned Parenthood) (10%), health department clinic (10%), community health center (5%), midwife (3%), and some other place (1%). (Percentages may exceed 100% as some respondents answered more than one source.)
- 7% of women did not have a usual source of services for female health concerns.

The pie chart shows sources of health care coverage for women of childbearing age. The following graph shows the percentage of uninsured women of childbearing age by county.

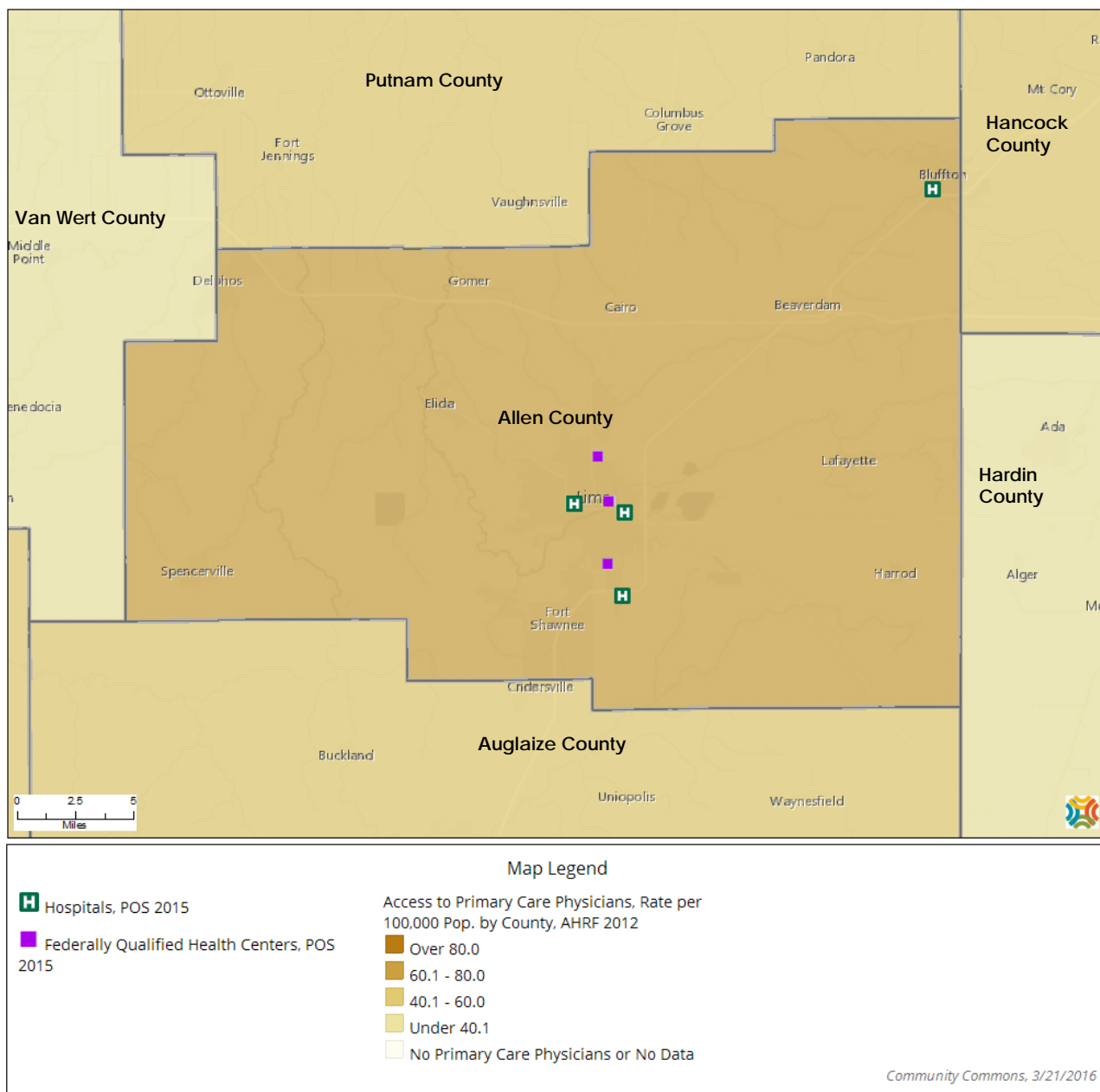


*\* Sample size numbers are small and can not be generalized.*

# HEALTH CARE COVERAGE

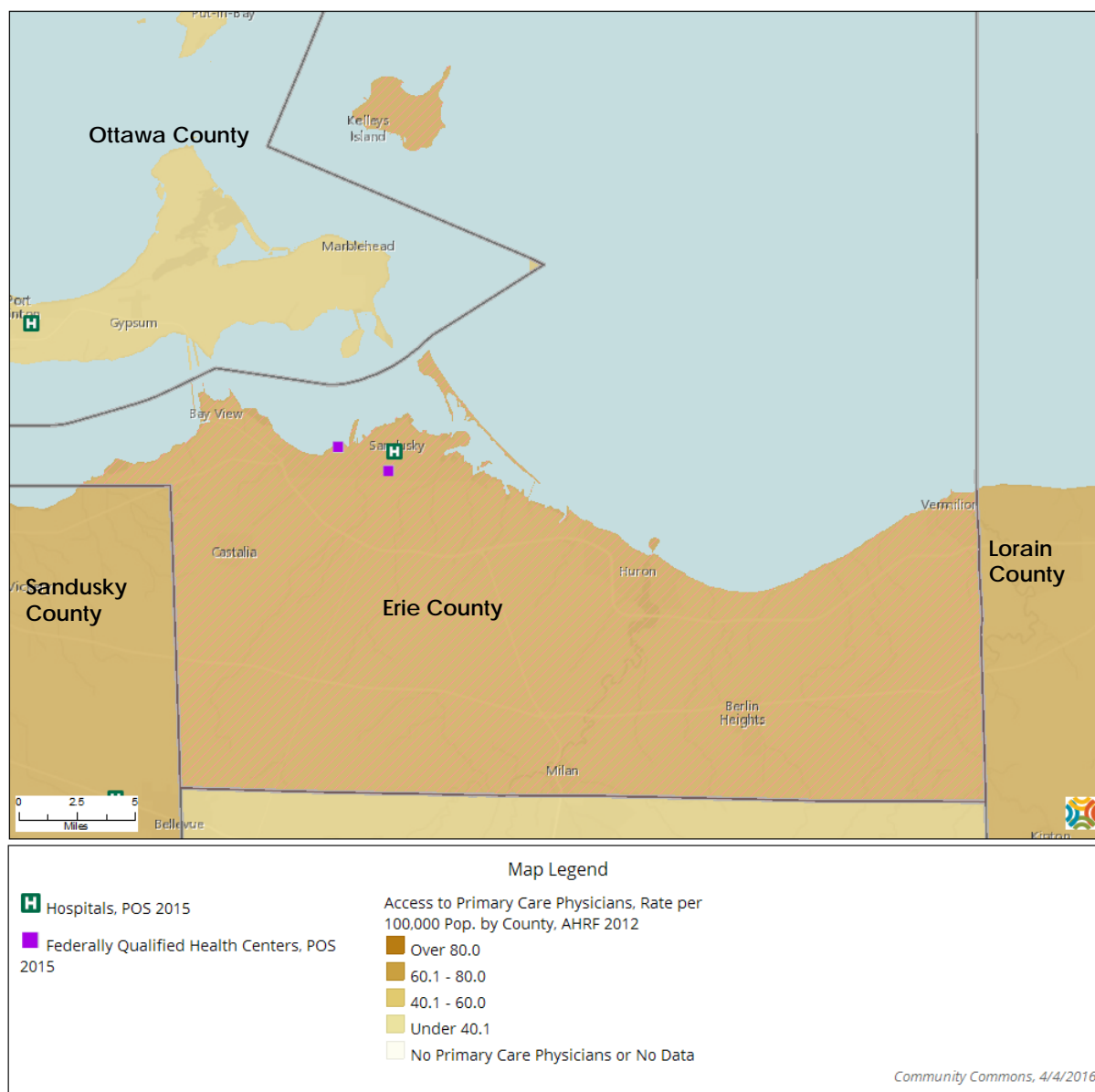


## Allen County Residents Access to Primary Care Physicians, Rate per 100,000 Pop. By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 3/21/2016)

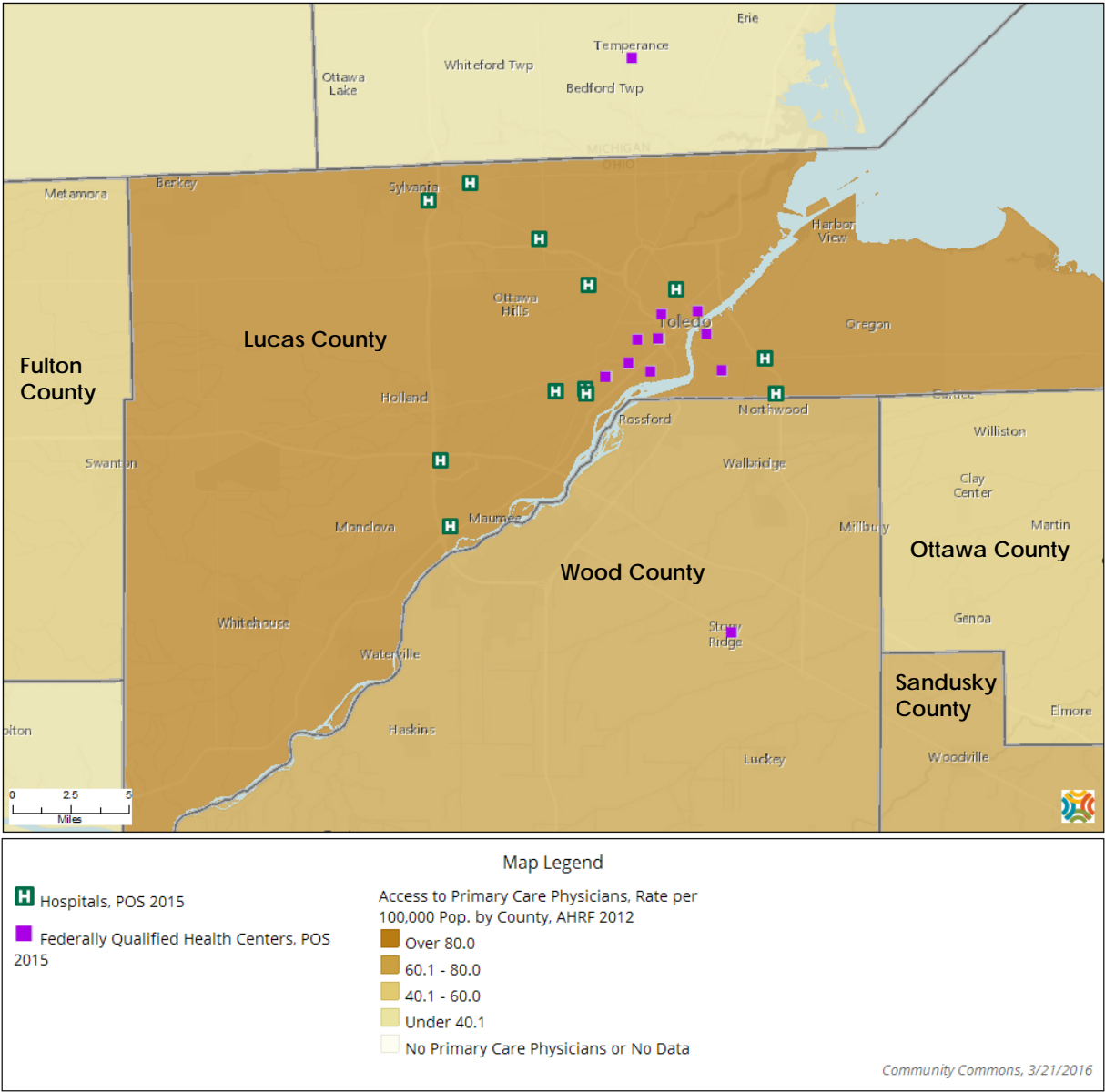
## Erie County Residents Access to Primary Care Physicians, Rate per 100,000 Pop. By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 4/4/2016)

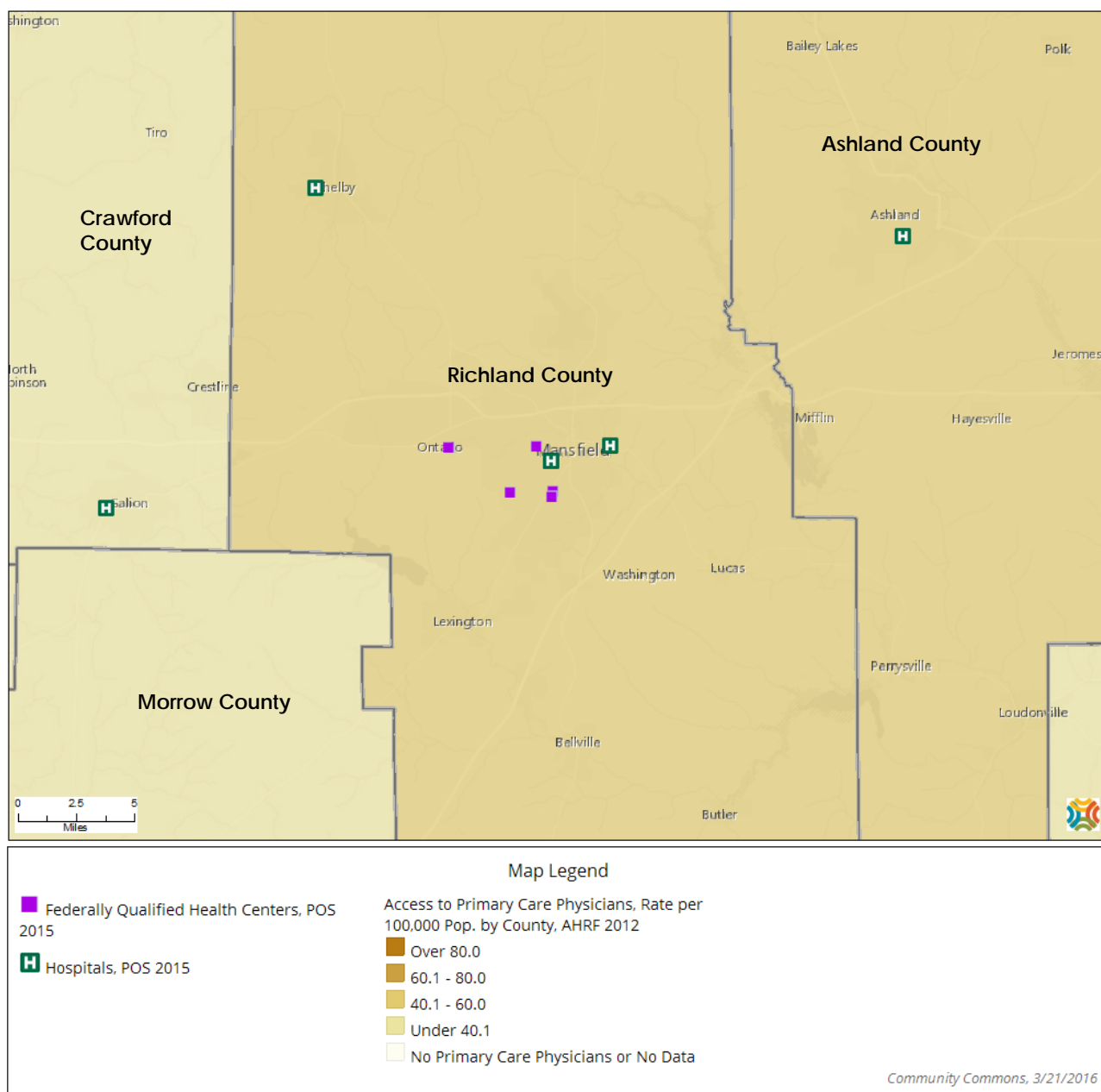


# Lucas County Residents Access to Primary Care Physicians, Rate per 100,000 Pop. By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 3/21/2016)

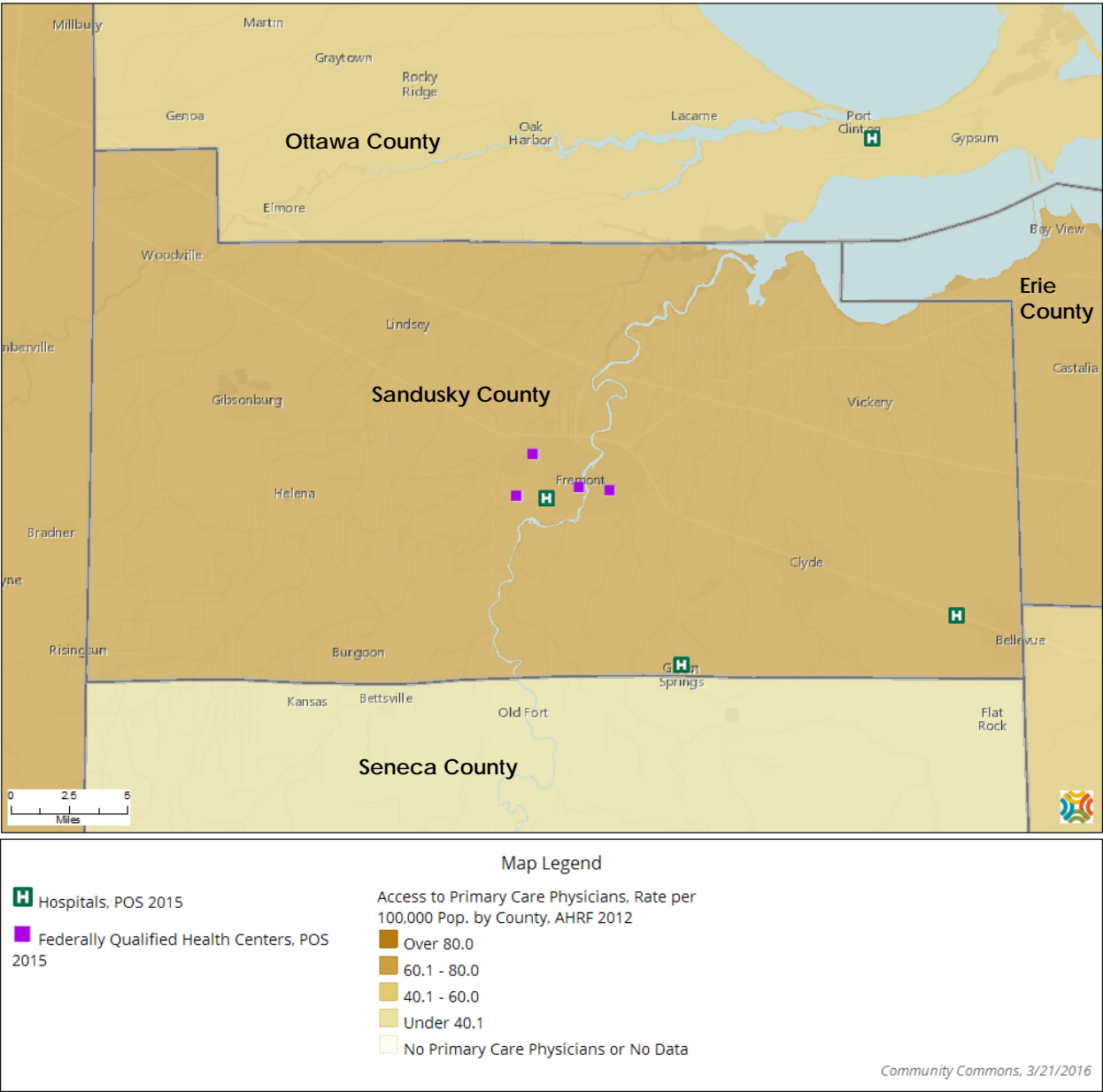
# Richland County Residents Access to Primary Care Physicians, Rate per 100,000 Pop. By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 3/21/2016)

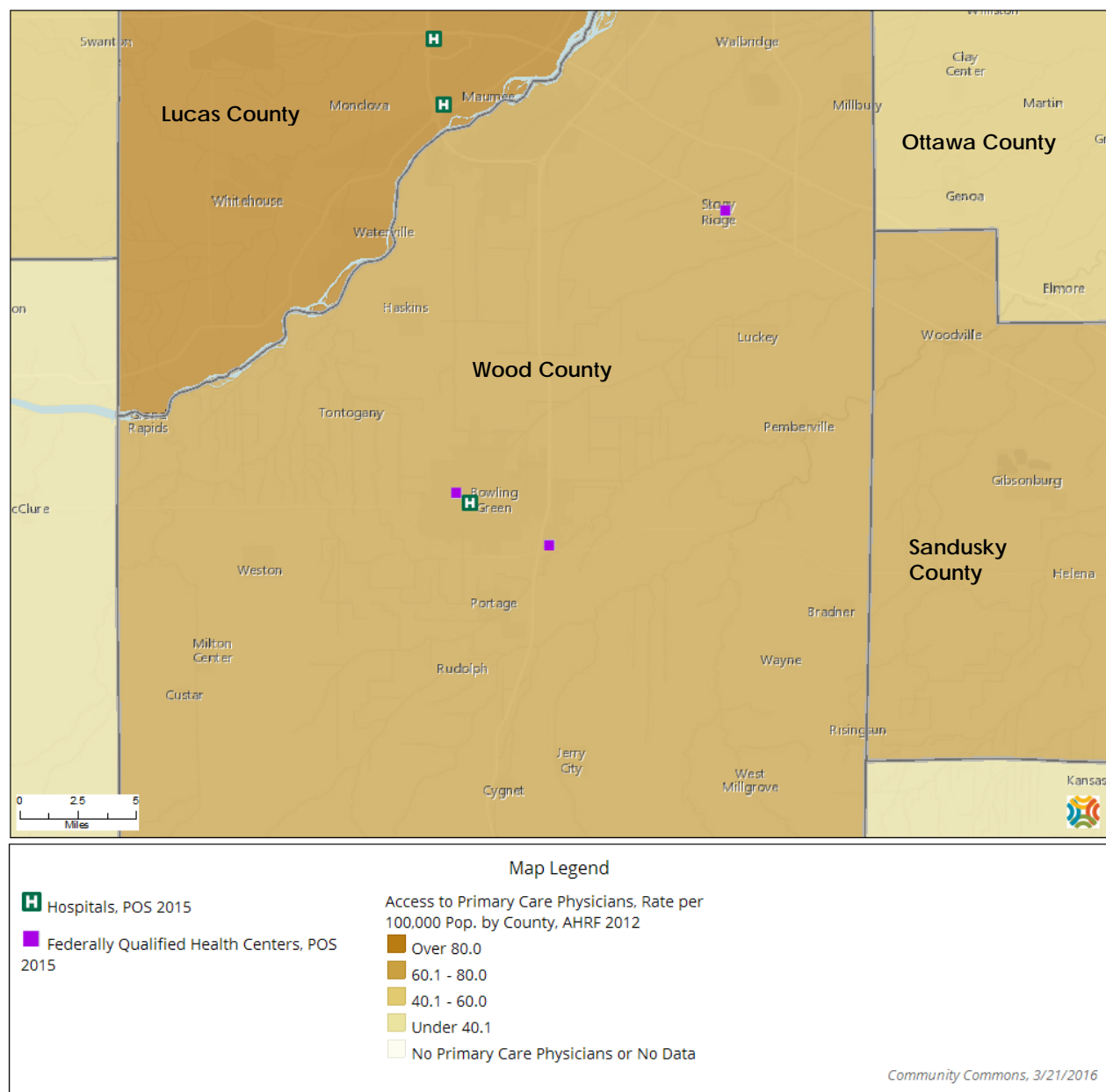
HEALTH CARE COVERAGE

# Sandusky County Residents Access to Primary Care Physicians, Rate per 100,000 Pop. By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 3/21/2016)

Wood County Residents Access to Primary Care Physicians, Rate per 100,000 Pop.  
By County, Area Health Resources Files (AHRF), 2012



(Source: Community Commons, 3/21/2016)

# Women of Childbearing Age |

## REPRODUCTIVE HEALTH & SEXUAL BEHAVIOR

### Key Findings

*In 2015, 93% of women that were currently pregnant understood the ABC's of Safe Sleep. About 2 in 5 (39%) pregnant women understood that taking folic acid lowers their chance for a low birth weight infant.*

### Women of Childbearing Age - Reproductive Health

- 5% of women were currently pregnant at the time of the survey.
- During their current pregnancy, women: got a prenatal appointment in the first 3 months (85%), took a multi-vitamin (77%), took folic acid during pregnancy (50%), smoked cigarettes (21%), and used marijuana (14%).
- Of the women who were currently pregnant, 77% planned to breast feed their child.
- About 2 out of 5 (39%) pregnant women understand that taking folic acid lowers their chance for a low birth weight infant.
- 93% of women that were currently pregnant understood the ABC's of Safe Sleep.

***ABC's of Safe Sleep – Infants should sleep **alone**, on their **back**, and in a **crib**.***

- The remaining bullet points in this section are based on responses from women who had been pregnant in the past 5 years.
- Thinking back to their last pregnancy: 44% of women wanted to be pregnant then, 10% wanted to be pregnant sooner, 19% wanted to be pregnant later, 13% did not want to be pregnant then or any time in the future, and 14% of women did not recall.
- Women were told the following by their healthcare provider: were a high risk pregnancy (69%), were in preterm labor (32%), had pre-eclampsia/eclampsia (high blood pressure) (15%), had gestational diabetes (14%), and had a short cervix (12%).
- 21% of women had a baby delivered before 37 weeks gestation (pre-term).
- 16% of women had a baby that weighed less than 5 lbs., 8 oz. at birth (low birth weight).
- During their last pregnancy in the past 5 years, women: got a prenatal appointment in the first 3 months (76%), took a multi-vitamin (73%), received WIC services (35%), received a dental exam during pregnancy (32%), took folic acid during pregnancy (32%), took folic acid pre-pregnancy (22%), experienced domestic violence (11%), experienced perinatal depression (5%), smoked cigarettes (16%), used other tobacco products (3%), and used marijuana (3%).
- 8% of women felt down, depressed, or hopeless nearly every day in the past 2 weeks.



Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	62%	31%	8%	0%
Feeling down, depressed or hopeless	69%	23%	0%	8%

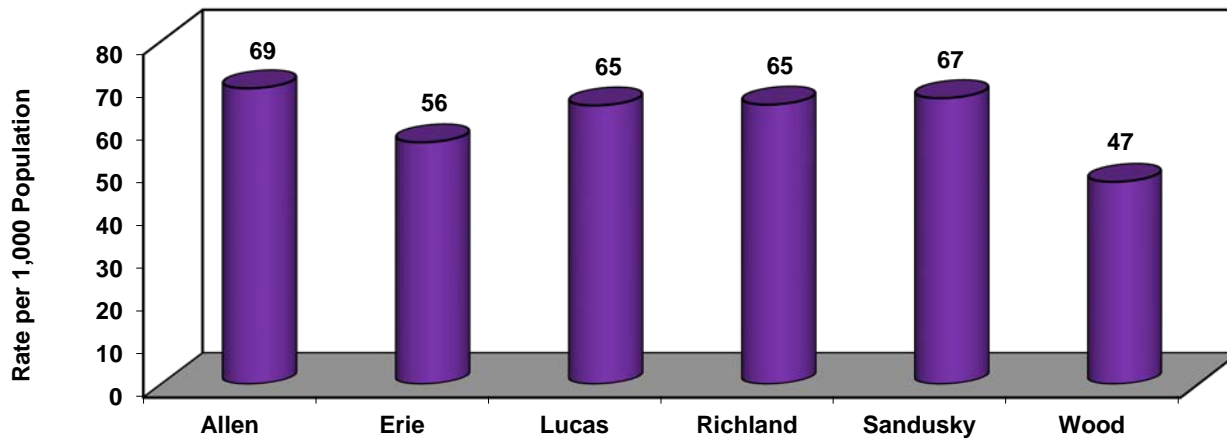
## Women of Childbearing Age - Sexual Behavior

- Women used the following methods of birth control: condoms (22%), birth control pill (17%), tubes tied (17%), abstinence (16%), vasectomy (9%), IUD (8%), rhythm method (6%), withdrawal (5%), hysterectomy (3%), they or their partner were too old (2%), ovaries/testicles removed (2%), shots (1%), contraceptive implants (1%), diaphragm, cervical ring or cap (1%), infertility (1%), contraceptive patch (<1%), emergency contraception (<1%), and other method (foam, jelly, cream, etc.) (2%).
- 15% of women were not using any method of birth control.
- 8% of women were trying to get pregnant.
- 2% of women reported they were gay or a lesbian.
- Women did not use birth control for the following reasons:
  - They or their partner had a hysterectomy/vasectomy/tubes tied (25%)
  - They wanted to get pregnant (14%)
  - They did not want to use birth control (11%)
  - They did not think they could get pregnant (9%)
  - They or their partner did not like birth control/fear of side effects (7%)
  - No partner/not sexually active (5%)
  - They did not care if they got pregnant (5%)
  - They were currently pregnant (4%)
  - Religious preferences (3%)
  - Their partner did not want to use birth control (3%)
  - They had just had a baby/were postpartum (2%)
  - They could not pay for birth control (2%)
  - They had a problem getting birth control when they needed it (2%)
  - They were currently breast feeding (1%)
  - They had a lapse in use of a method (<1%)
  - They were too old (menopausal) (<1%)
  - They did not know (3%)

## Women of Childbearing Age - Pregnancy Outcomes

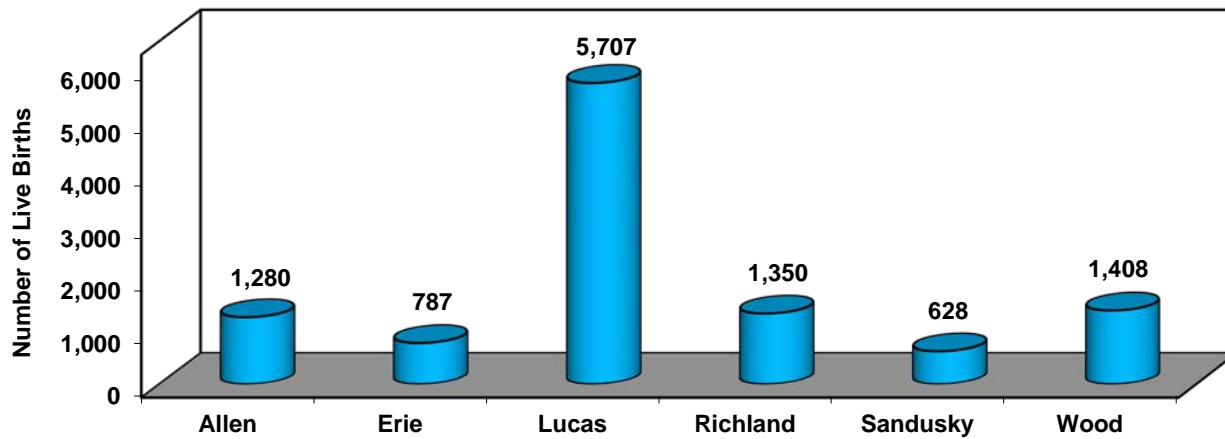
*\*Please note that the pregnancy outcomes data includes all births to adults and adolescents.*

**Women of Childbearing Age Fertility Rates, 2010**



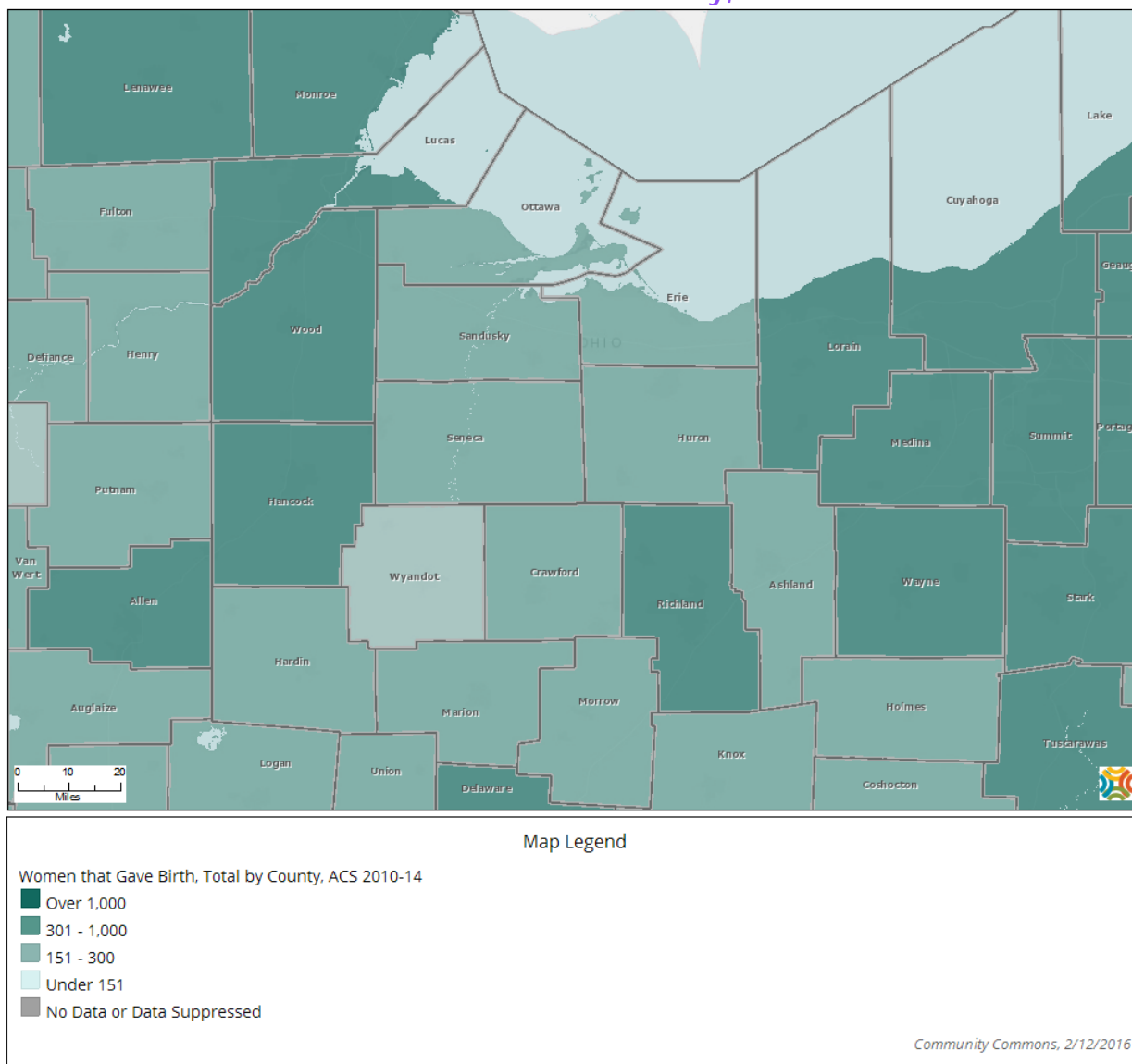
*\*Fertility rates are for women ages 15-44 years.*

**Women of Childbearing Age Total Live Births by Counties, 2014**



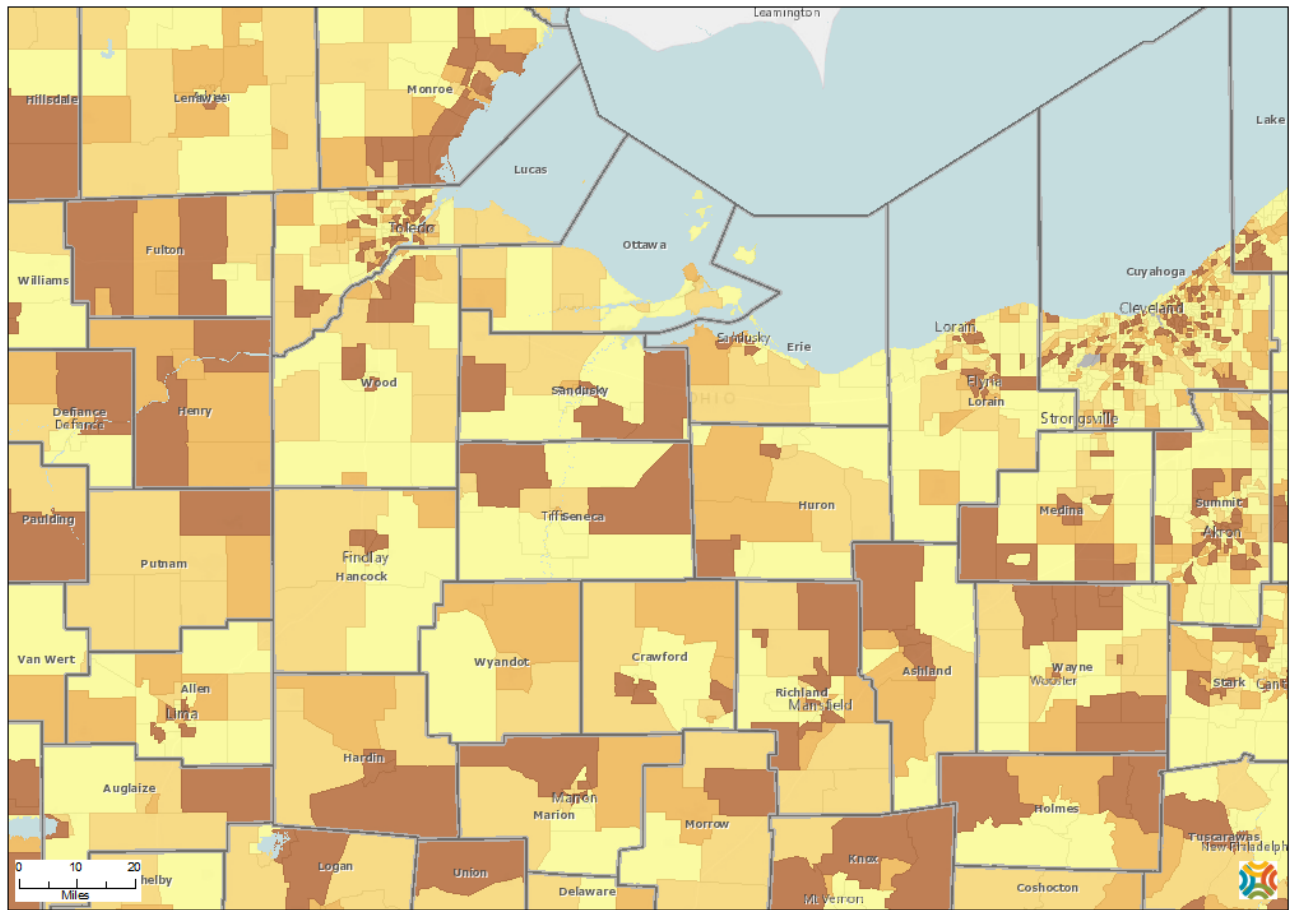
*(Source for graphs: ODH Information Warehouse)*

## Women that Gave Birth, Total Number by Census Tract, American Communities Survey, 2010-2014



(Source: Community Commons, 2/12/2016)

## Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



### Map Legend

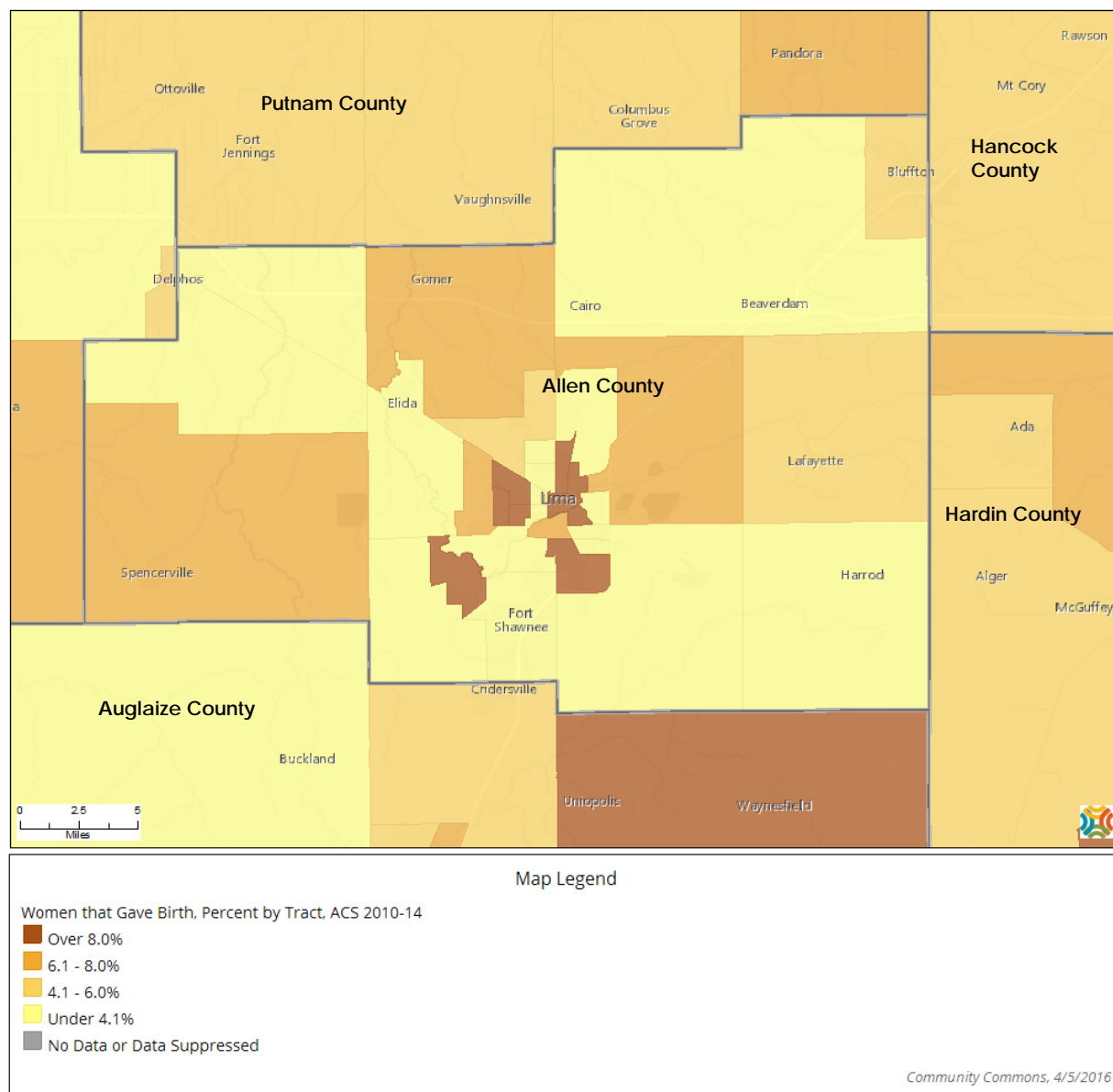
Women that Gave Birth, Percent by Tract, ACS 2010-14

- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed

Community Commons, 2/12/2016

(Source: Community Commons, 2/12/2016)

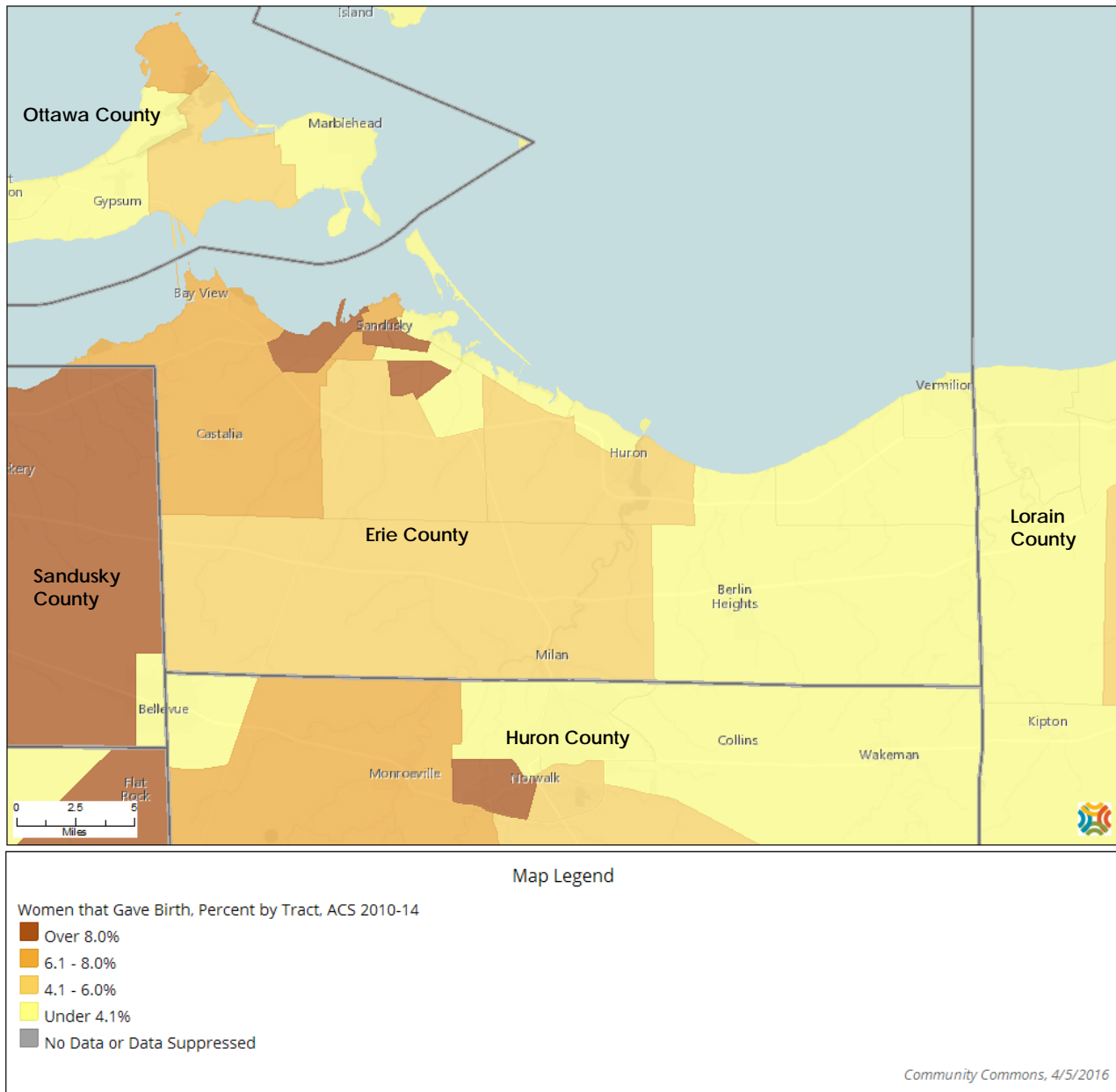
## Allen County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



(Source: Community Commons, 4/5/2016)

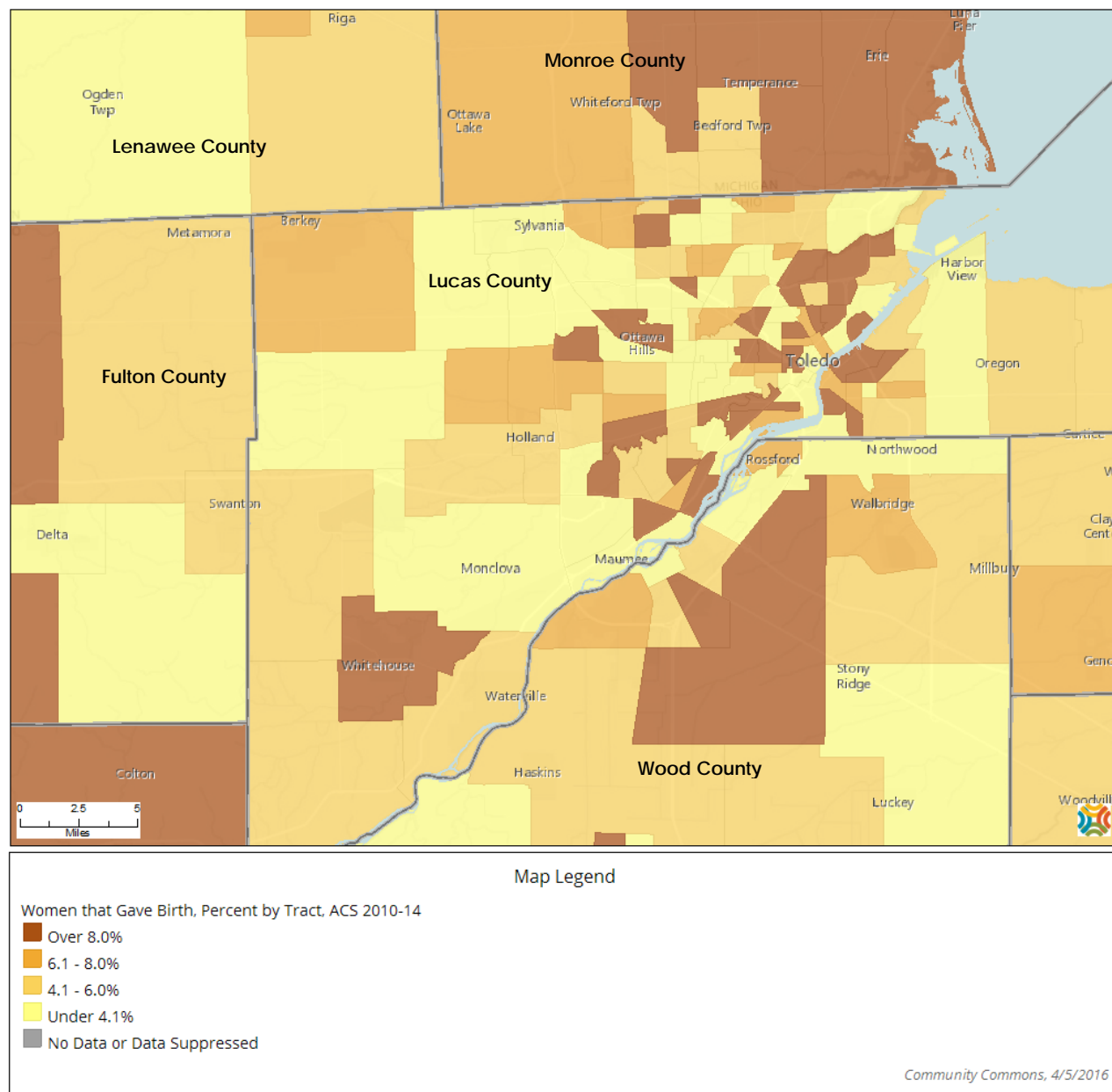


## Erie County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



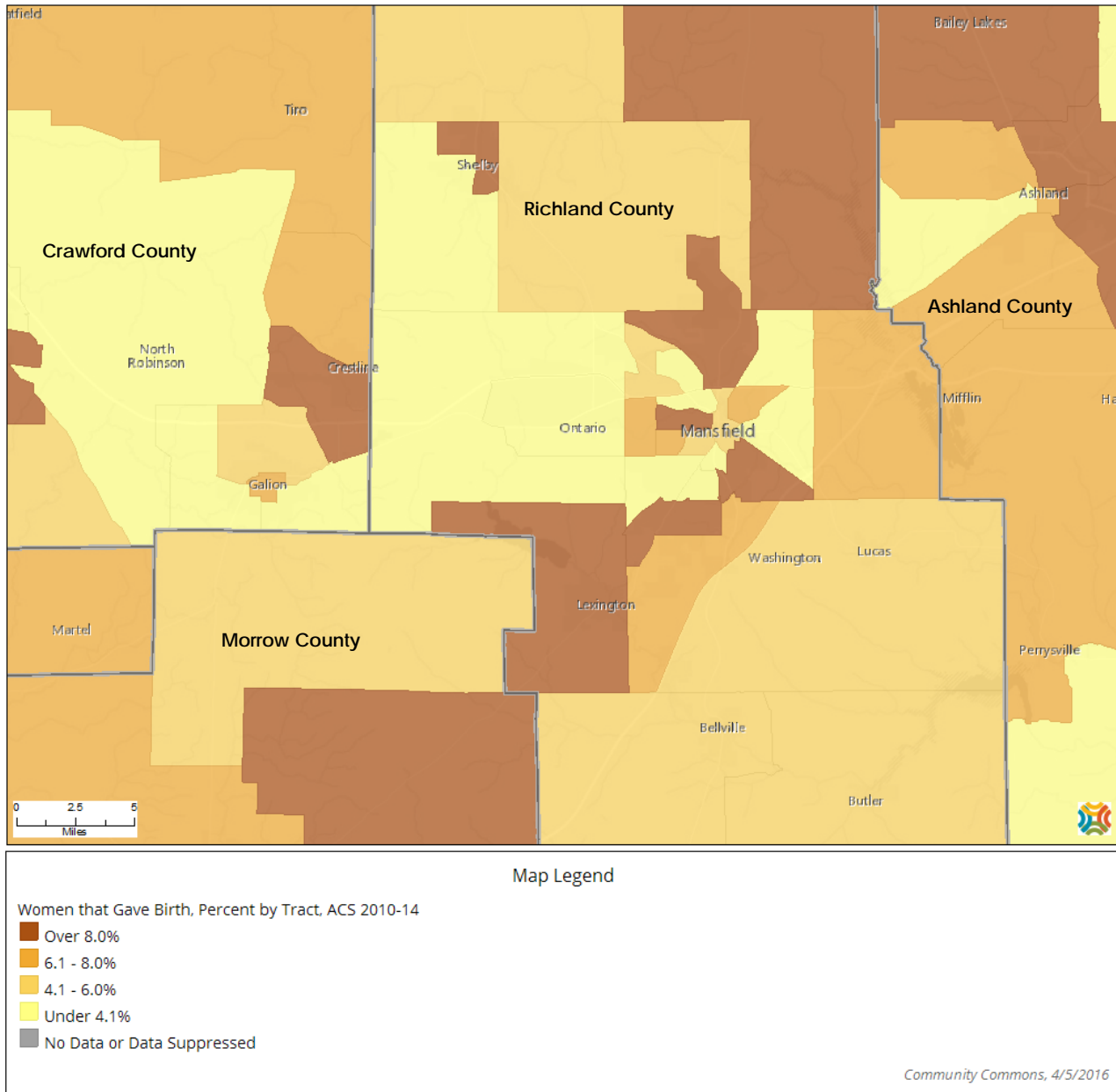
(Source: Community Commons, 4/5/2016)

## Lucas County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



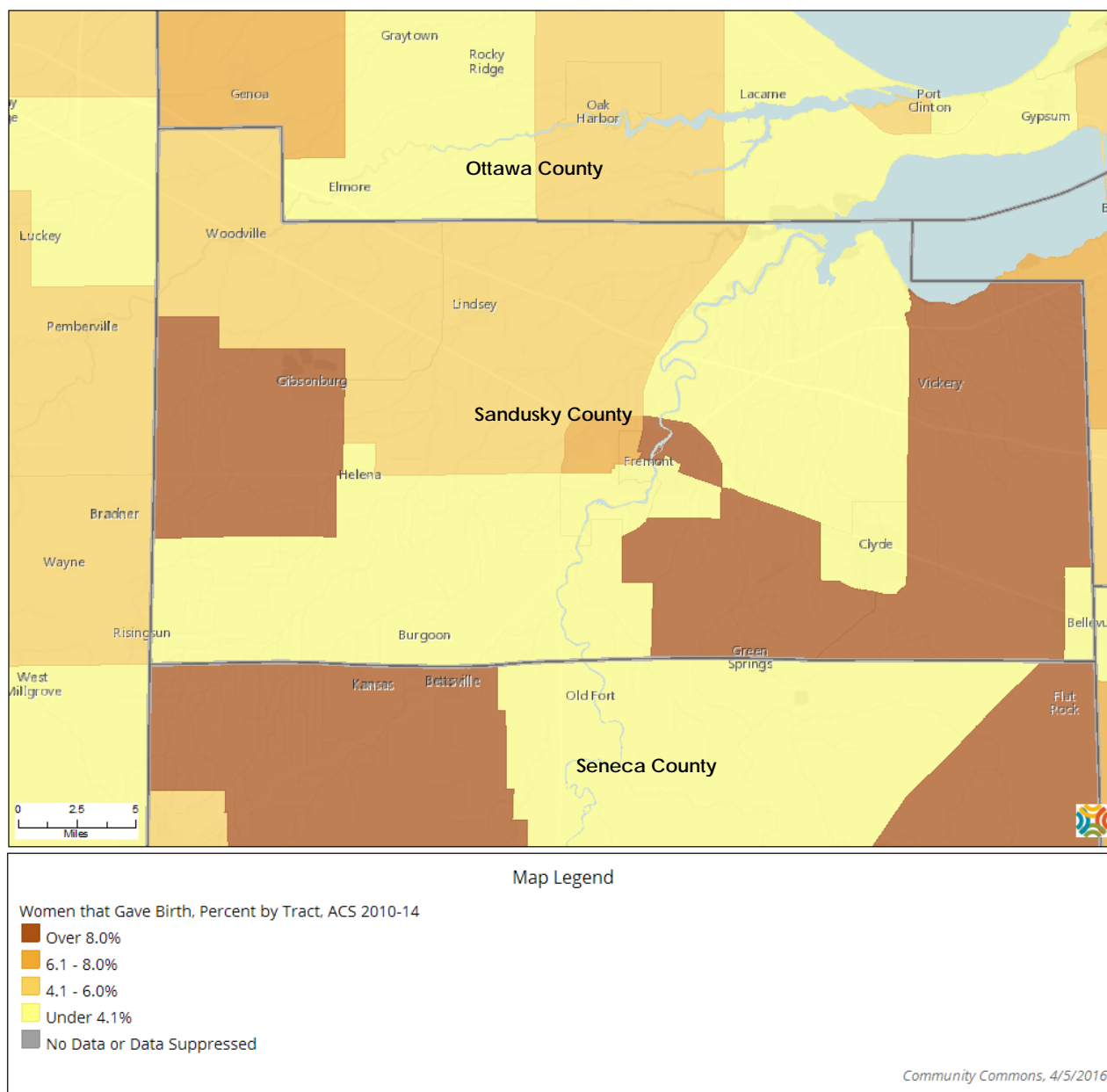
(Source: Community Commons, 4/5/2016)

## Richland County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



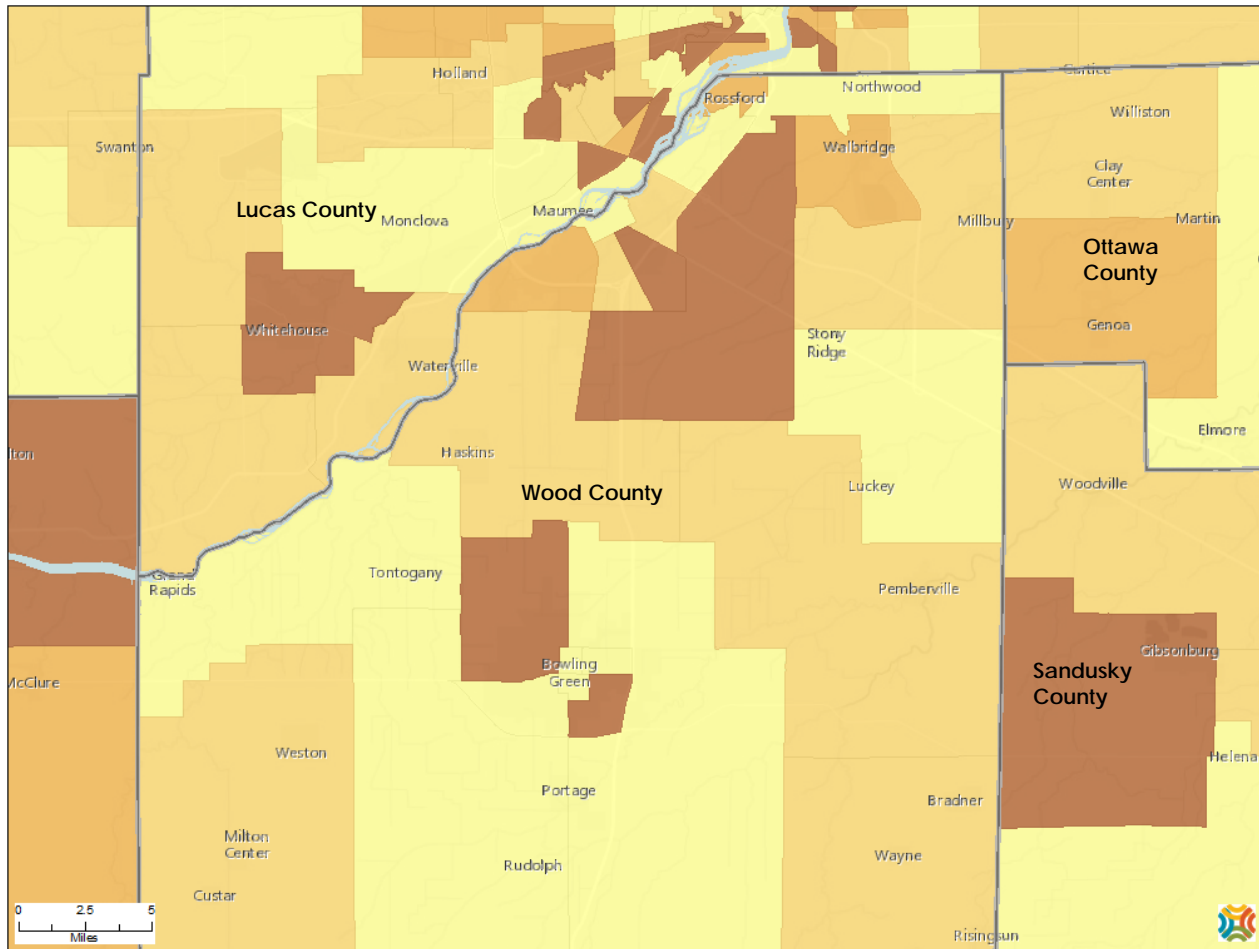
(Source: Community Commons, 4/5/2016)

## Sandusky County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



(Source: Community Commons, 4/5/2016)

## Wood County Women that Gave Birth, Percent by Census Tract, American Communities Survey, 2010-2014



**Map Legend**

Women that Gave Birth, Percent by Tract, ACS 2010-14

- Over 8.0%
- 6.1 - 8.0%
- 4.1 - 6.0%
- Under 4.1%
- No Data or Data Suppressed

*Community Commons, 4/5/2016*

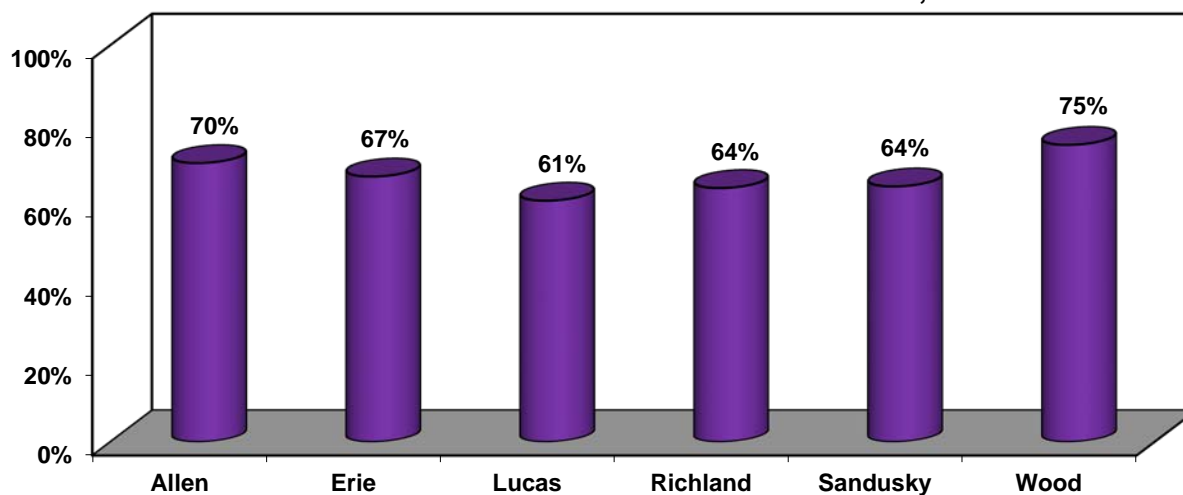
(Source: Community Commons, 4/5/2016)



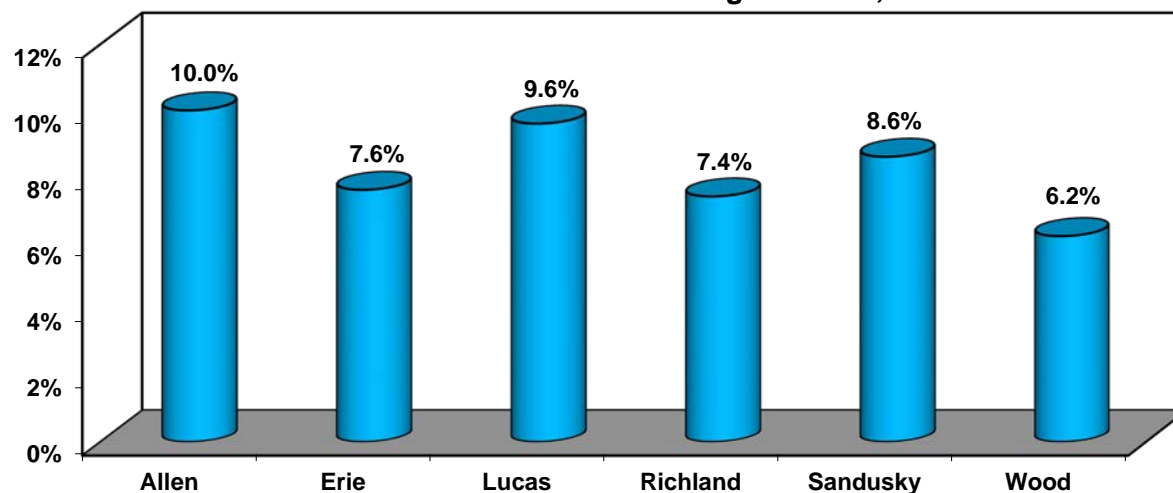
The following graphs show women of childbearing age percentage of births with first trimester prenatal care and low birth weight rates by the Ohio Department of Health. The graphs show:

- In 2014, 75% of Wood County mothers received prenatal care during the first trimester, as compared to only 61% of Lucas County mothers.
- In 2014, 10% of all Allen County live births were low birth weight.

**Northwest Ohio First Trimester Prenatal Care, 2014**



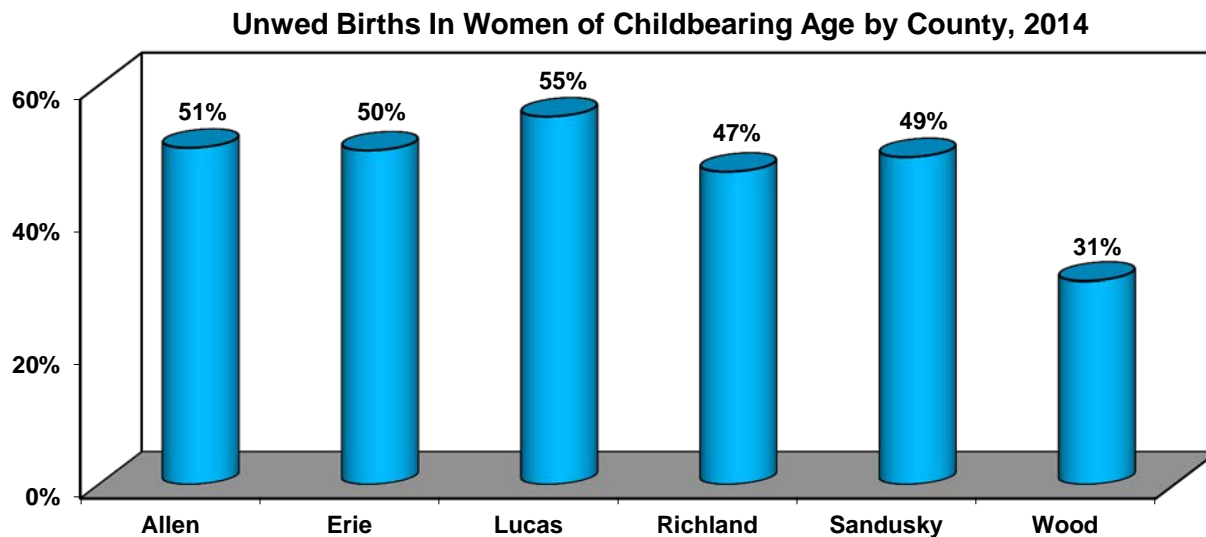
**Northwest Ohio Low Birth Weight Births\*, 2014**



*\*Low Birth Weight is defined as weighing less than 2,500 grams or 5 pounds, 8 ounces.  
(Source for graphs: ODH Information Warehouse)*

The following graph shows women of childbearing age percentage of unwed births by the Ohio Department of Health. The graph shows:

- In 2014, 55% of Lucas County births were to unwed women, compared to 31% of Wood County births.



(Source for graph: ODH Information Warehouse)

### Neonatal, Post-Neonatal and Infant Mortality in 2014

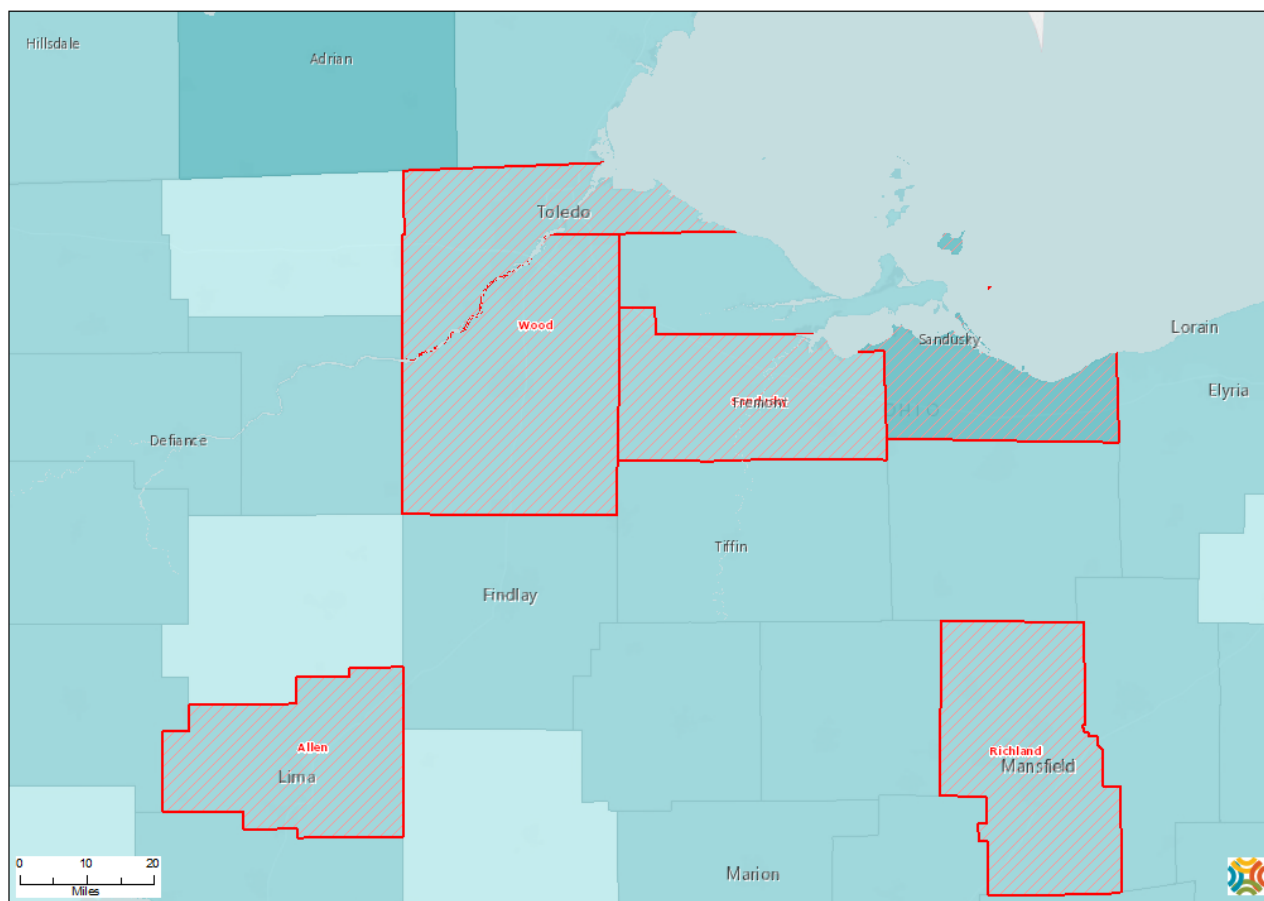
	Number of Neonatal Deaths*	Number of Post-neonatal Deaths**	Total Number of Infant Deaths	Number of Births
Allen	10	1	11	1,280
Erie	8	4	12	787
Lucas	40	13	53	5,707
Richland	3	5	8	1,350
Sandusky	3	0	3	628
Wood	7	1	8	1,408
<b>Ohio</b>	<b>692</b>	<b>263</b>	<b>988</b>	<b>139,518</b>

\*Neonatal death is defined as a death of live born infant during the first 28 days of life.

\*\* Post-neonatal death is defined as a death of an infant between 29 days and 364 days of life.

(Source: Ohio Department of Health, Bureau of Vital Statistics, 2014 Ohio Infant Mortality Data: General Findings, obtained from: <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/2014%20Ohio%20Infant%20Mortality%20Report%20Final.pdf>)

## Infant Mortality, Rate (Per 1,000 Live Births) by County, Area Health Resources Files, 2006-2010



### Map Legend

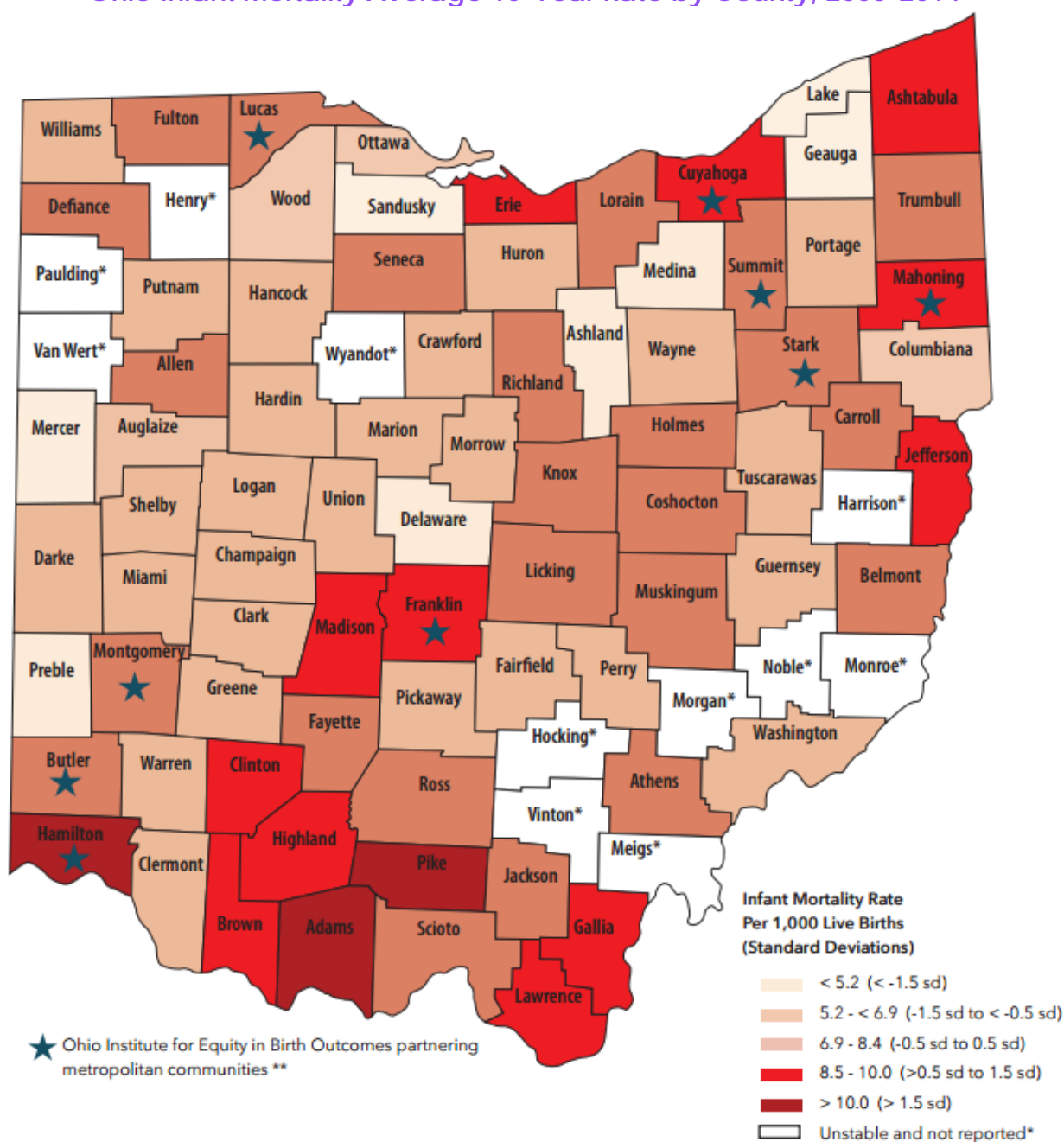
Infant Mortality, Rate (Per 1,000 Live Births)  
by County, AHRF 2006-10

- Over 10.0
- 8.1 - 10.0
- 5.1 - 8.0
- Under 5.1
- No Data or Data Suppressed

Community Commons, 12/17/2015

(Source: Community Commons, 12/17/2015)

## Ohio Infant Mortality Average 10-Year Rate by County, 2005-2014



\* Rates based on fewer than 20 infant deaths are unstable and not reported.

\*\* Ohio Institute for Equity in Birth Outcomes partnering communities seek to improve overall birth outcomes and reduce racial and ethnic disparities in infant mortality.

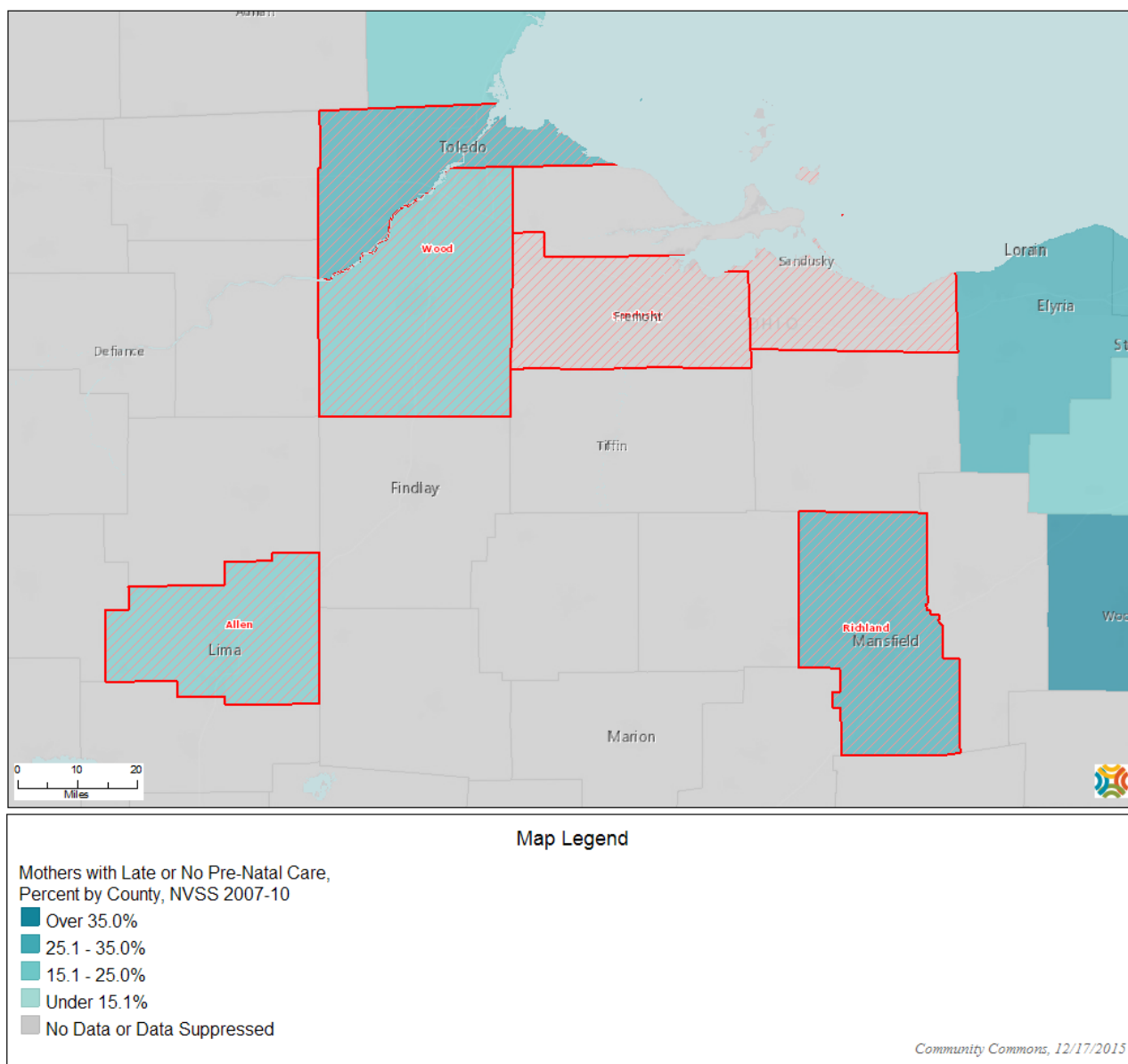
Ohio Overall Infant Mortality Rate 2005-2014: 7.6 infant deaths per 1,000 live births.

Healthy People 2020 Objective: 6.0 infant deaths per 1,000 live births.

Source: Ohio Department of Health, Bureau of Vital Statistics.

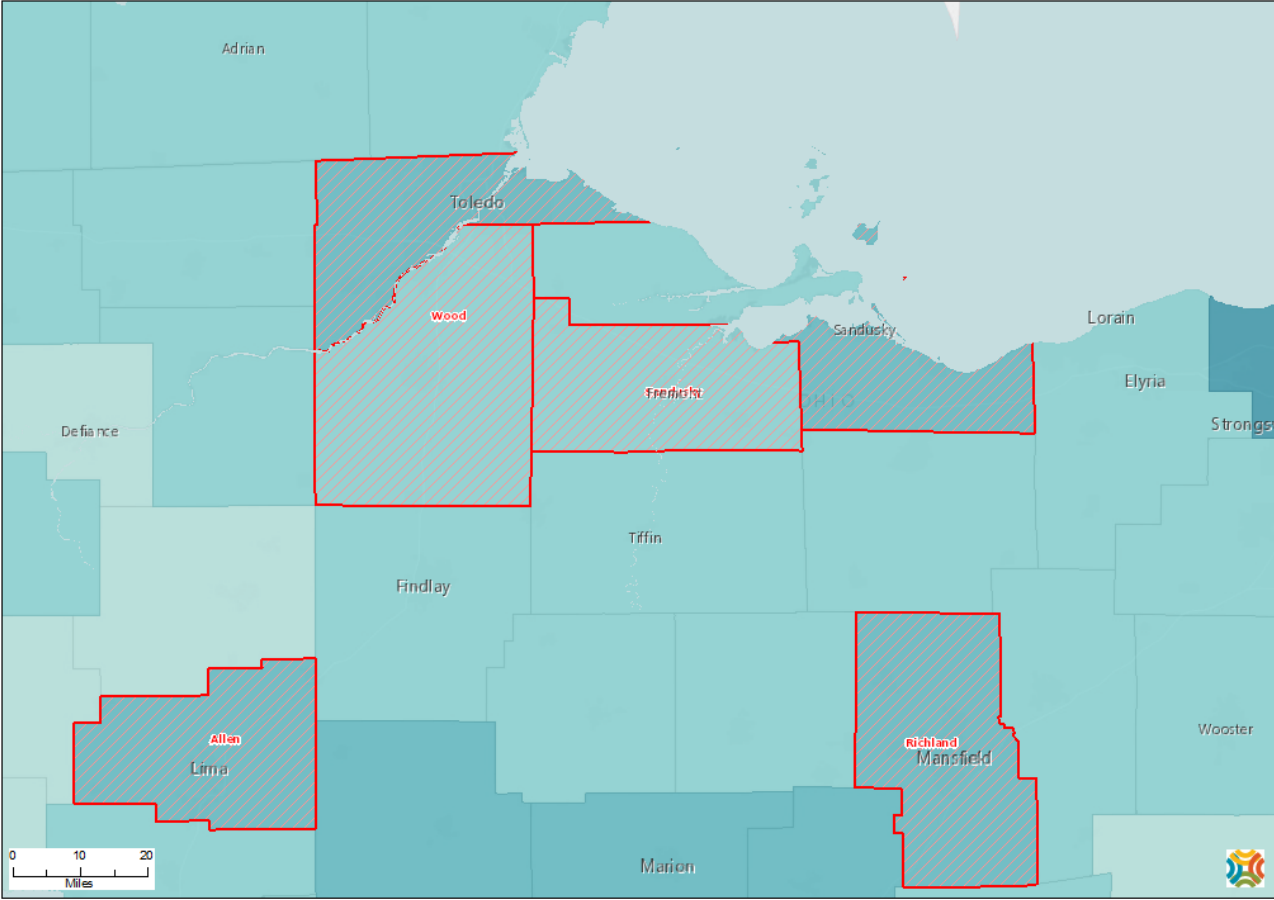
(Source: Ohio Department of Health, Bureau of Vital Statistics, 2014 Ohio Infant Mortality Data: General Findings, obtained from: <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/2014%20Ohio%20Infant%20Mortality%20Report%20Final.pdf>)

## Mothers with Late or No Pre-Natal Care, Percent by County, National Vital Statistics System 2007-2010



(Source: Community Commons, 12/17/2015)

Low Birth Weight, Percent of Live Births by County,  
National Vital Statistics System 2006-2012



Map Legend

Low Birth Weight, Percent of Live Births by  
County, NVSS 2006-12

- Over 10.0%
- 8.1 - 10.0%
- 6.1 - 8.0%
- Under 6.1%
- No Data or Data Suppressed

Community Commons, 12/17/2015

(Source: Community Commons, 12/17/2015)

## Birth Spacing

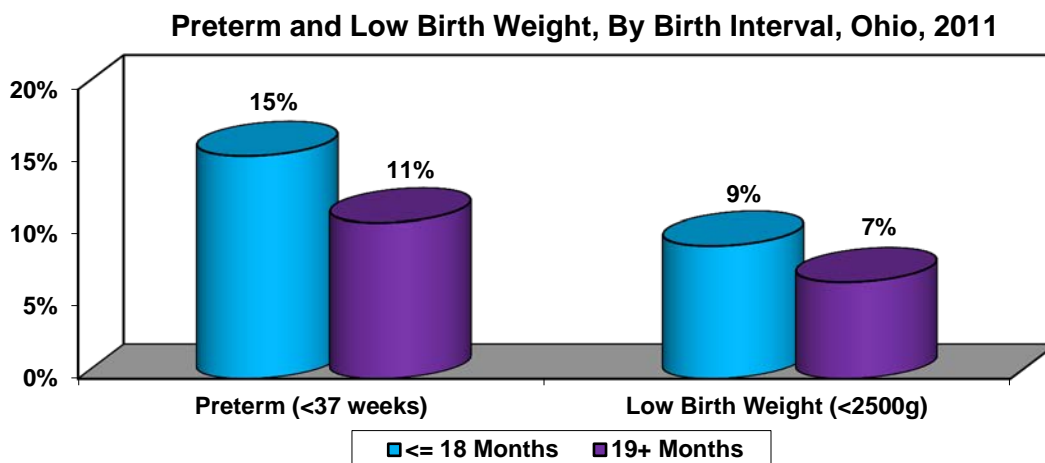
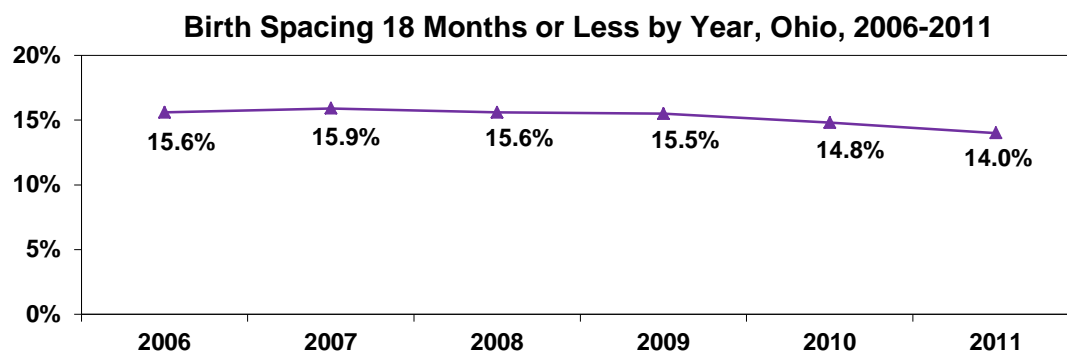
Birth spacing is the time between one live birth and the next. The amount of time between births can impact health of the mother and infant. Birth intervals less than 18 months have been shown to increase the risk of poor birth outcomes. Nationally, non-Hispanic black women and those living in poverty were more likely to have births spaced less than 18 months.

### Why is Adequate Birth Spacing Important?

Birth intervals of at least 18 months reduce the risk of low birth weight, preterm birth, and small gestational age, placental abruption and other poor birth outcomes and maternal morbidities.

### Birth Spacing in Ohio

- In 2011, 14% of live births in Ohio to women with a previous birth had an interval of 18 months or less.
- Mothers less than 20 years of age had a higher percentage of short birth spacing than older mothers.
- The percentage of mothers with birth spacing of 18 months or less has decreased slightly in recent years, from 15.6% in 2006 to 14.0% in 2011.
- In 2011, women with 18 months or fewer since their last live birth had a higher percentage of preterm birth and low birth weight infants.



(Source: ODH, Maternal and Child Health, Woman and Infants Health, 2014, Birth Spacing)



## What is Ohio Doing to Encourage Adequate Birth Spacing?

- The Ohio Connections for Children with Special Needs (OCCSN) is doing spacing education. This program provides mothers with postpartum education that encourages breastfeeding, birth spacing plans, and assistance to address psychosocial issues.
- The Ohio Better Birth Outcomes (OBBO) has a safe spacing program in place to reduce the risk of preterm births.
- Ohio Medicaid is working with managed care plans to identify women who are at risk for poor pregnancy or birth outcomes using vital statistics information. These women are offered enhanced services such as tobacco cessation counseling, specialized care management, and centering (group) care and are encouraged to attend postpartum visits or receive postpartum content in all settings.
- Establishing a Reproductive Life Plan (RLP) in the Reproductive Health and Wellness Program (RHWP) is required and is encouraged in Child and Family Health Services (CFHS) to promote birth spacing. RHWP and the Ohio Infant Mortality Reduction Initiative (OIMRI) provide contraception information utilizing contraceptive teaching kits.
- Exclusive breastfeeding helps ensure adequate birth spacing. Ohio Department of Health (ODH) developed a policy about infant feeding in 2013 to encourage clear, consistent messages about breastfeeding. Many programs with ODH, particularly Women, Infants and Children (WIC), encourage and support breastfeeding.

*(Source: ODH, Maternal and Child Health, Woman and Infants Health, 2014, Birth Spacing)*

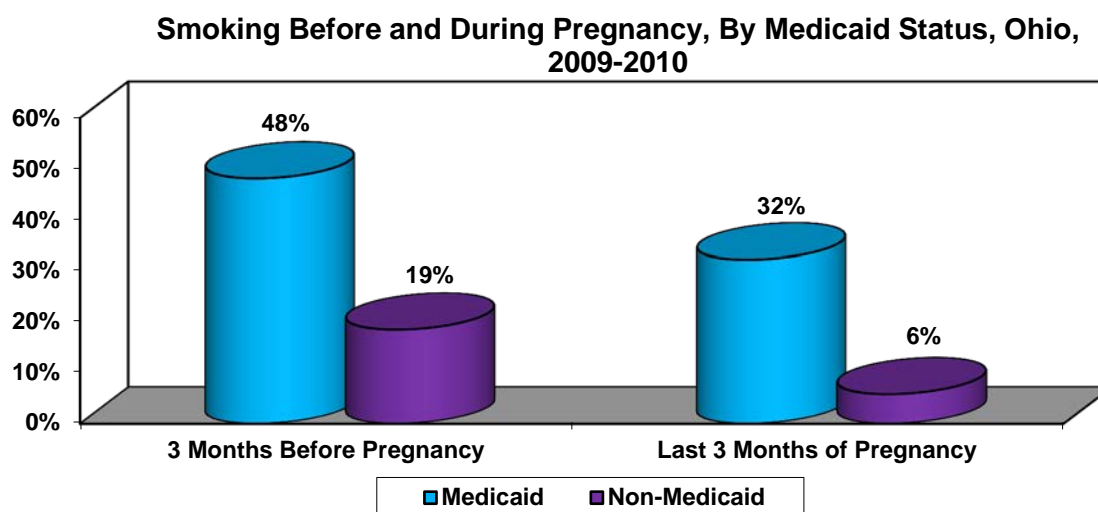
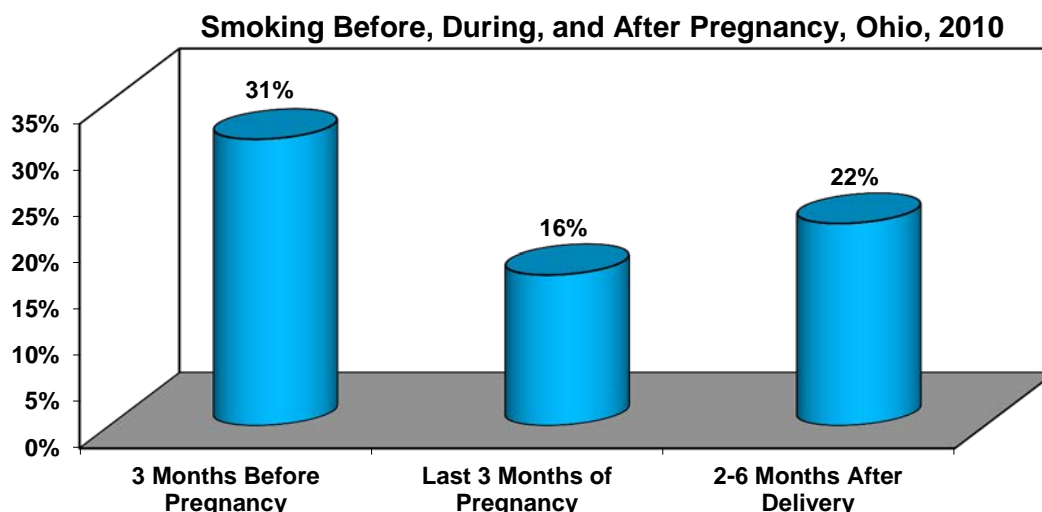
## Perinatal Cigarette Smoking

- Smoking during pregnancy remains one of the most common preventable causes of infant morbidity and mortality.
- Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications including placenta previa, placental abruption, premature rupture of the membrane, preterm delivery, restricted fetal growth, and sudden infant death syndrome (SIDS).
- Smoking around the time of conception has been associated with the development of cleft lip with or without cleft palate.
- In the United States, 5-8% of preterm deliveries, 13-19% of low-birth weight deliveries, 23-34% of SIDS, and 5-7% of preterm-related deaths are attributable to prenatal smoking.

## Cost Impact

- Maternal smoking increased the risk of admission to a neonatal intensive care unit (NICU) by almost 20% and increased the length of stay.
- NICU care for an infant costs over \$3,600 per night.
- Smoking attributable expenses were estimated at \$149 million nationally and \$340 per maternal smoker.

*(Source: ODH, Maternal and Child Health, Woman and Infants Health, 2012, Perinatal Cigarette Smoking)*



(Source: ODH, Maternal and Child Health, Woman and Infants Health, 2012, Perinatal Cigarette Smoking)

## What is Being Done in Ohio for Pregnant Smokers?

- ODH uses the “5 A’s” in 14 Child and Family Health Services Perinatal Direct care clinics and 13 Women, Infant, and Children (WIC) projects.
- The 5 A’s is an evidence-based intervention method that increases smoking cessation among pregnant smokers by 30-70%.
- The 5 A’s method includes: Asking a woman about her tobacco use. Advising her to quit, Assessing willingness to make an attempt to quit, Assisting her with counseling or pharmacotherapy and Arranging a follow-up appointment or referral.

(Source: ODH, Maternal and Child Health, Woman and Infants Health, 2012, Perinatal Cigarette Smoking)

# Women of Childbearing Age |

## SOCIAL CONTEXT

### Key Findings

*About one-third (32%) of women have had three or more adverse childhood experiences. 34% of women received assistance for food in the past year.*

### Women of Childbearing Age - Social Context

- Women experienced the following as a child: their parents became separated or were divorced (38%), a parent or adult in their home swore at, insulted, or put them down (26%), lived with someone who was depressed, mentally ill, or suicidal (24%), lived with someone who was a problem drinker or alcoholic (22%), lived with someone who used illegal stress drugs, or who abused prescription medications (19%), their parents were not married (19%), someone at least 5 years older than them or an adult touched them sexually (17%), their parents or adults in their home slapped, hit, kicked, punched, or beat each other up (15%), lived with someone who served time or was sentenced to serve time in prison, jail or other correctional facility (14%), a parent or adult in their home hit, beat, kicked, or physically hurt them (12%), someone at least 5 years older than them or an adult tried to make them touch them sexually (12%), and someone at least 5 years older than them or an adult forced them to have sex (5%).
- 33% of women have had three or more adverse childhood experiences, which can lead to multitude of health and social problems. See data box in this section for more information.
- Women received assistance for the following in the past year: food (34%), health care (28%), utilities (22%), prescription assistance (19%), mental illness issues (16%), rent/mortgage (11%), transportation (9%), free tax preparation (7%), clothing (7%), affordable childcare (6%), employment (6%), credit counseling (4%), unplanned pregnancy (4%), home repair (4%), alcohol or other substance abuse dependency (3%), abuse or neglect issues (3%), legal aid services (2%), post incarceration issues (1%), homelessness (1%), and emergency shelter (1%).
- Women had the following rules/practices about smoking in their home: never allowed (78%), not allowed when children are present (7%), allowed anywhere (5%), allowed some places or at some times (5%), and there were no rules about smoking in their home (5%).

#### Smoking Rules

- Eighty-one percent of U.S. adults report having smoke-free rules in their homes and 74 percent have smoke-free rules in their vehicles.
- Eighty-nine percent of non-smokers report having smoke-free home rules, while only 48 percent of smokers have them.
- Eighty-five percent of non-smokers report having smoke-free vehicle rules, while only 27 percent of smokers have them.
- Secondhand smoke exposure among nonsmokers in homes and vehicles was greatest among men, younger adults, non-Hispanic blacks, and those with a lower level of education.
- Many of the states with the lowest prevalence of smoke-free rules in homes and vehicles are states with a high prevalence of adult smoking.

*(Source: CDC, Large majority of adults have smoke-free rules in homes, vehicles, May 16, 2013, from: <http://www.cdc.gov/media/releases/2013/p0516-smoke-free-rules.html>)*

## Children and Smoking

- 63% of Ohio children ages 0-5 do not have anyone that smokes in their household. 27% has someone in their household that smokes, but does not smoke inside the child's house. 10% have someone that smokes in their household and smokes inside the child's house.
- 66% of Ohio children ages 6-11 do not have anyone that smokes in their household. 18% have someone that smokes in their household, but doesn't smoke inside the child's home. 16% have someone that smokes in the household, and smokes inside the home of the child.
- For U.S. children ages 0-5, 74% have no one that smokes in their household. 21% have someone that smokes in their household, but does not smoke inside the house. 5% have someone that smokes in the household, and smokes inside the child's home
- For U.S. children ages 6-11, 75% have no one that smokes in their household. 18% have someone that smokes in their household, but does not smoke inside the house. 8% have someone that smokes in the household, and smokes inside the child's house.

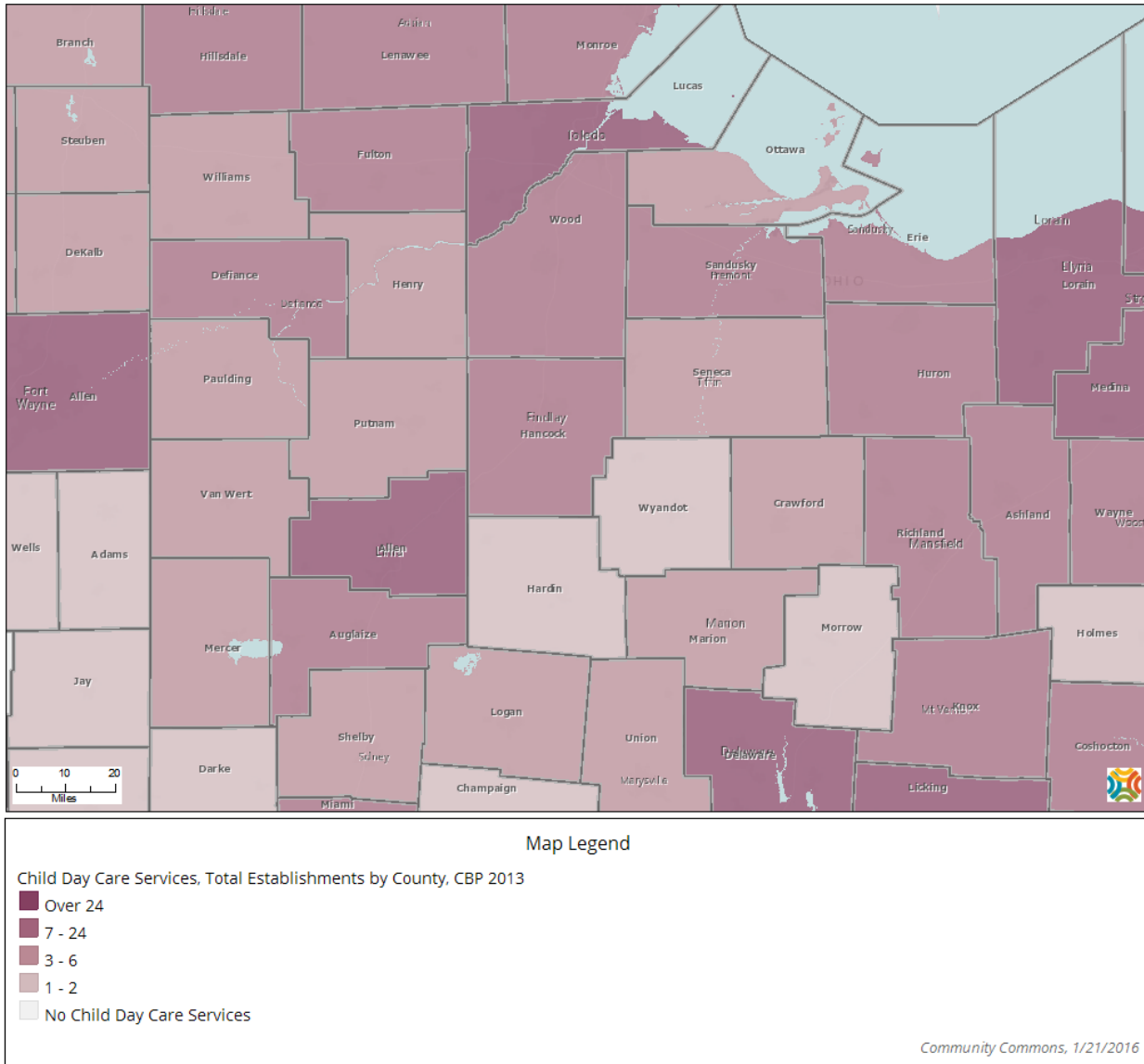
(Source: National Survey of Children's Health, Data Resource Center)

## Adverse Childhood Experiences (ACE)

- Childhood abuse, neglect, and exposure to other traumatic stressors which we term adverse childhood experiences (ACE) are common. The most common are separated or divorced parents, verbal, physical or sexual abuse, witness of domestic violence, and having a family member with depression or mental illness.
- According to the CDC, 59% of people surveyed in 5 states in 2009 reported having had at least one ACE while 9% reported five or more ACEs.
- The short and long-term outcomes of these childhood exposures include a multitude of health and social problems such as:
  - Depression
  - Fetal death
  - Illicit drug use
  - Liver disease
  - STD's
  - Multiple sexual partners
  - Alcoholism and alcohol abuse
  - COPD
  - Unintended pregnancies
  - Suicide attempts
  - Early initiation of smoking
  - Risk for intimate partner violence
- Given the high prevalence of ACEs, additional efforts are needed at the state and local level to reduce and prevent childhood maltreatment and associated family dysfunction in the US.

(Source: CDC, Adverse Childhood Experiences (ACE) Study, May13, 2014, <http://www.cdc.gov/ace/about.htm> & Adverse Childhood Experiences Reported by Adults, Last Reviewed: June 3, 2011, <http://www.cdc.gov/features/dsaces/index.html>)

## Child Day Care Services, Total Number of Establishments, Census Business Patterns, 2013



(Source: Community Commons, Accessed on 1/21/2016)

# Women of Childbearing Age | PARENTING

## Key Findings

83% of mothers put their child to sleep on his/her back. Almost one quarter (24%) of women breastfed their child for at least one year.

## Women of Childbearing Age - Parenting

- When asked how mothers put their child to sleep as an infant, 83% said on their back, 22% said on their side, 12% said in bed with parent or another person, 11% said on their stomach, and 19% said various methods.
- Children were put to sleep in the following places: crib/bassinet without bumper pads, blankets, and toys (68%), pack n' play (28%), in bed with parent or another person (28%), crib/bassinet with bumper pads, blankets, and toys (26%), swing (21%), car seat (16%), couch or chair (6%), floor (2%), and other (4%).
- Almost one-quarter (24%) of women breastfed their child for at least one year.
- Mothers reported their child was not breastfed for one year for the following reasons: they did not produce enough milk (30%), they did not want to (21%), cultural reasons (13%), medical issues with their child (8%), they did not have workplace support (8%), they did not have time (7%), inconvenient (5%), they did not have adequate support (4%), they did not have a breast pump (4%), they did not have adequate education (2%), and some other reason (7%). 20% of parents reported multiple reasons.

### Facts about Breastfeeding

- The percent of infants who were ever breastfed is 65% in Ohio, compared to 77% in the U.S.
- Human milk provides virtually all the protein, sugar, and fat your baby needs to be healthy, and it also contains many substances that benefit your baby's immune system, including antibodies, immune factors, enzymes, and white blood cells. These substances protect your baby against a wide variety of diseases and infections not only while he is breastfeeding but in some cases long after he has weaned. Formula cannot offer this protection.
- With regard to allergy prevention, there is some evidence that breastfeeding protects babies born to families with a history of allergies, compared to those babies who are fed either a standard cow's milk based formula or a soy formula.
- Recent research even indicates that breastfed infants are less likely to be obese in adolescence and adulthood. They are also less vulnerable to developing both type 1 and type 2 diabetes.
- The American Academy of Pediatrics (AAP) recommends that breastfeeding continue for at least 12 months, and thereafter for as long as mother and baby desire. The World Health Organization recommends continued breastfeeding up to 2 years of age or beyond.

(Source: CDC, Breastfeeding, July, 31, 2013, from: <http://www.cdc.gov/breastfeeding/faq/index.htm> & Healthy Children, Breastfeeding Benefits Your Baby's Immune System, 5/11/2013, from: <http://www.healthychildren.org/>)

## Dangers of Bed-sharing

Many people confuse co-sleeping with bed-sharing, but they're not the same. When you sleep close enough to your baby that you can see, hear, touch or smell each other, it's called co-sleeping. Bed-sharing is a kind of co-sleeping. It's when babies and parents sleep together in the same bed. Some studies show that bed-sharing is the most common cause of death in babies, especially babies younger than 3 months old.

Why is bed-sharing dangerous? During bed-sharing, a baby can be hurt by:

- Getting trapped by the bed's frame, headboard or footboard
- Getting stuck between the bed and the wall, furniture or other objects
- Falling off the bed
- Being suffocated by pillows, blankets or quilts or from laying facedown
- Having another person roll on top of him
- SIDS

About half of all SIDS deaths happen when a baby shares a bed, sofa or sofa chair with another person. To help keep your baby safe from SIDS, don't bed-share if:

- Your baby is younger than 4 months old. This is when a baby is at highest risk of SIDS.
- Your partner or other children sleep in your bed.
- You smoke, even if you don't smoke in bed.
- You're very tired.
- You've had alcohol, used street drugs or taken certain prescription medicines, like antidepressants, or over-the-counter (also called OTC) medicines, like allergy or cough medicine that may make you sleepy. Taking these things can make it hard for you to wake up or respond to your baby.

(Source: March of Dimes, Bed-sharing, from: <http://www.marchofdimes.org/baby/co-sleeping.aspx>)

## Sudden Infant Death Syndrome (SIDS)

SIDS is the diagnosis given when an infant under one year of age dies suddenly, and the incident cannot be explained by recent illness, medical history, an autopsy or the death scene itself. Risk factors for SIDS have been identified and include:

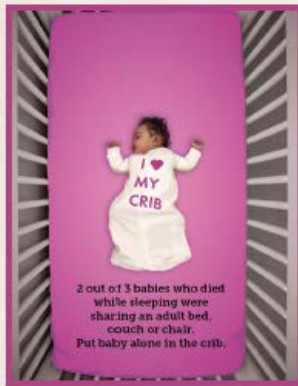
- Sleeping in the prone position (stomach sleeping)
- Soft bedding or unsafe beds (couches, daybeds, waterbeds)
- Loose bedding such as blankets and pillows
- Overheating due to clothing, blankets or room temperature
- Mother's age younger than 20 years
- Mother smoking during pregnancy
- Exposure to secondhand smoke
- Mother receiving late or no prenatal care
- Premature birth or low birth weight

(Source: National Sleep Foundation, Sudden Infant Death Syndrome and Sleep, <http://sleepfoundation.org/sleep-disorders-problems/sudden-infant-death-syndrome-and-sleep>)



## ABCs of Safe Sleep

Every week in Ohio, 3 babies die in unsafe sleep environments.



**Share the room, not the bed.** Always place your baby alone in a crib, bassinet, or play yard with a firm mattress. The safest place for your baby to sleep is in your room (within arm's reach), but not in your bed. This way, you can easily breastfeed and bond with your baby. Never nap on a couch or chair while holding your baby and don't lay your baby down on adult beds, chairs, sofas, waterbeds, air mattresses, pillows, or cushions.

**You should never share the bed with your baby because:**

- You can roll too close to or onto your baby while she sleeps.
- Babies can get stuck between the mattress and the wall, headboard, footboard or other furniture.
- Your baby could fall off the bed and get hurt, or fall onto something on the floor and suffocate.



**Back is best for baby.** Always put your baby to sleep on his back. Healthy babies naturally swallow or cough up their spit up, so your baby will not choke if he's on his back.

**It's also safer for your baby to wake up often during the night on his back.**

If your baby is sleeping on his tummy and needs to take a deep breath, it could be dangerous because:

- He may be unable to move his head.
- His mouth or nose may be blocked and he could suffocate, even in a bare crib.
- The air people breathe out is filled with carbon dioxide, or "bad air," and your baby could keep breathing "bad air" and suffocate.



**Bare is Best.** Many parents believe their baby won't be safe and warm without bumper pads, blankets, pillows, and stuffed animals, but these items can be deadly. Babies can suffocate on any extra item in the crib.

Place your baby to sleep in a safety-approved crib with a firm mattress covered by a fitted sheet. Sleep clothing like fitted, appropriate-sized sleepers and sleep sacks, are safer for baby than blankets!

**If you use a safety-approved crib, baby's hand or foot won't get caught.** Many parents think baby will get hurt if they don't use bumper pads, but this isn't true because:

- Babies don't have enough strength to hurt themselves.
- No babies have seriously hurt themselves by getting stuck between the crib railings.

(Source: Ohio Department of Health, Infant Safe Sleep, from:

<http://www.odh.ohio.gov/features/odhfeatures/SafeSleep/Safe%20Sleep%20Home%20Page.aspx>)

## Sleep-Related Infant Deaths

Sleep-related infant deaths are those that happen suddenly and unexpectedly in a sleep environment. The causes include sudden infant death syndrome (SIDS), unintentional suffocation, positional asphyxia, overlay, and undetermined causes.

### Impact on Infant Mortality

- Sleep-related deaths are the leading cause of death for infants from one month to one year of age.
- More than three Ohio infants' deaths each week are sleep related.
- From 2007 to 2011, 819 Ohio infants died from sleep-related causes. Sleep-related deaths account for 15 percent of the cases reviewed by the Ohio Child Fatality Review, more than any other cause of death except prematurity.
- The national rate for SIDS for African-American infants (99 per 100,000 live births) is nearly twice that of white infants (55 per 100,000 live births).
- The incidence of sleep-related infant deaths (excluding SIDS) has increased in the US since 2005.
- Sleep-related infant deaths outnumber deaths of Ohio children of all ages from car crashes.

(Source: ODH, Maternal and Child Health, Early Childhood, 2014, Sleep-Related Infant Deaths, from: [http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec\\_Sleeprelatedinfant.ashx](http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec_Sleeprelatedinfant.ashx))

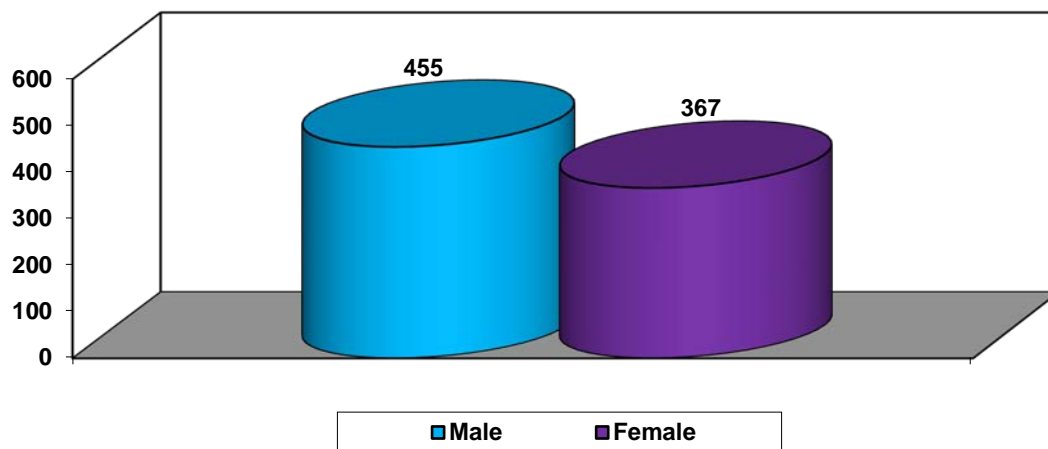
### Sleep-Related Infant Deaths: Who is at Greater Risk?

All infants are at risk for sleep-related deaths, but we know the risks are much greater for:

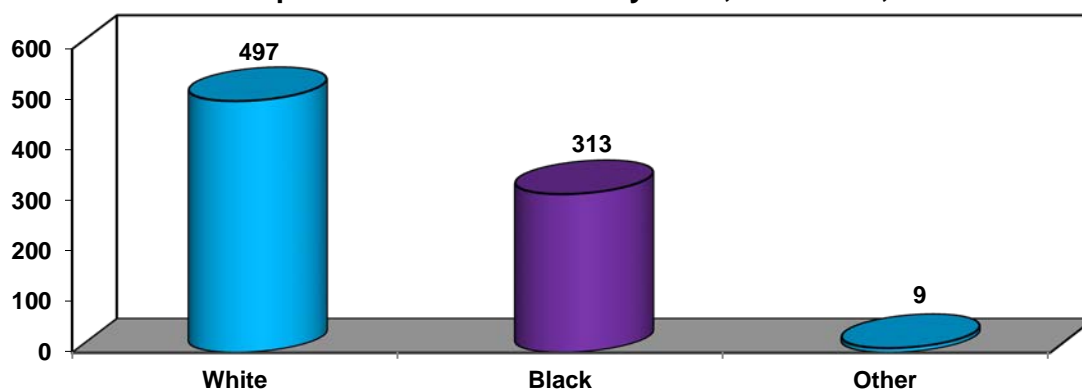
- **Infants who bed share:** Fifty-eight percent of sleep-related deaths occurred while the infant was sharing a sleep surface with another person.
- **Infants not placed to sleep on their backs:** Only 36 percent of sleep-related deaths had been placed to sleep on their backs.
- **Infants not placed to sleep in a crib:** Seventy-one percent of sleep-related deaths occurred when infants were sleeping some place other than a crib or bassinet. Forty-five percent occurred in adult beds.
- **Infants exposed to tobacco smoke:** Forty three percent of sleep-related deaths were to infants exposed to tobacco smoke in utero and/or after birth. It is estimated that one-third of SIDS deaths would be prevented if maternal smoking during pregnancy were eliminated.
- **Younger infants:** Sleep-related deaths decrease substantially after 3 months of age. Eighty-eight percent occurred prior to 6 months of age.
- **African-American infants:** Thirty-eight percent of sleep-related deaths were African-American infants, which is disproportionately higher than their representation in the general infant population (15 percent). Differences in the prevalence of safe-sleep positioning and other environment conditions among races may contribute to this disparity.

(Source: ODH, Maternal and Child Health, Early Childhood, 2014, Sleep-Related Infant Deaths, from: [http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec\\_Sleeprelatedinfant.ashx](http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec_Sleeprelatedinfant.ashx))

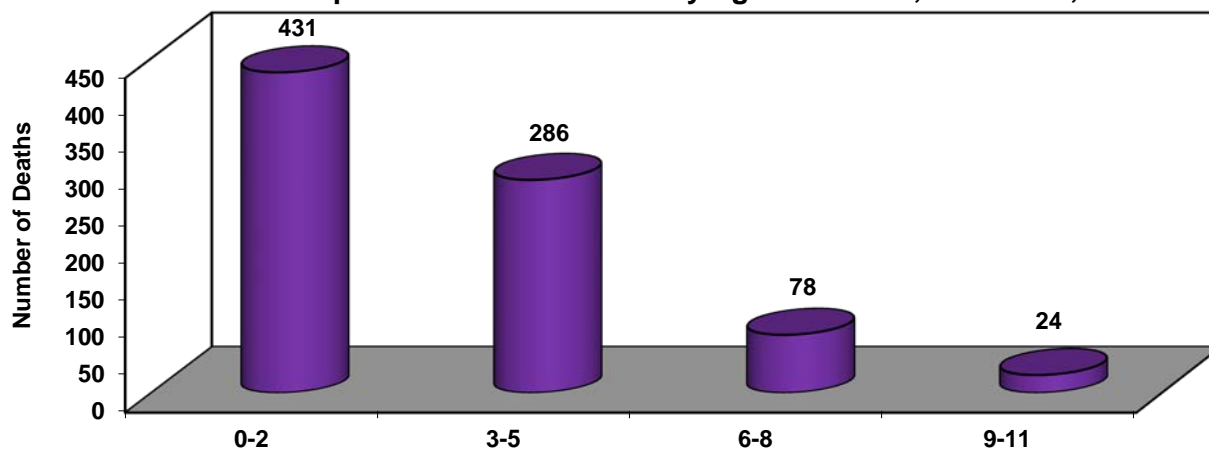
**Sleep-Related Infant Deaths by Gender, 2007-2011, Ohio**



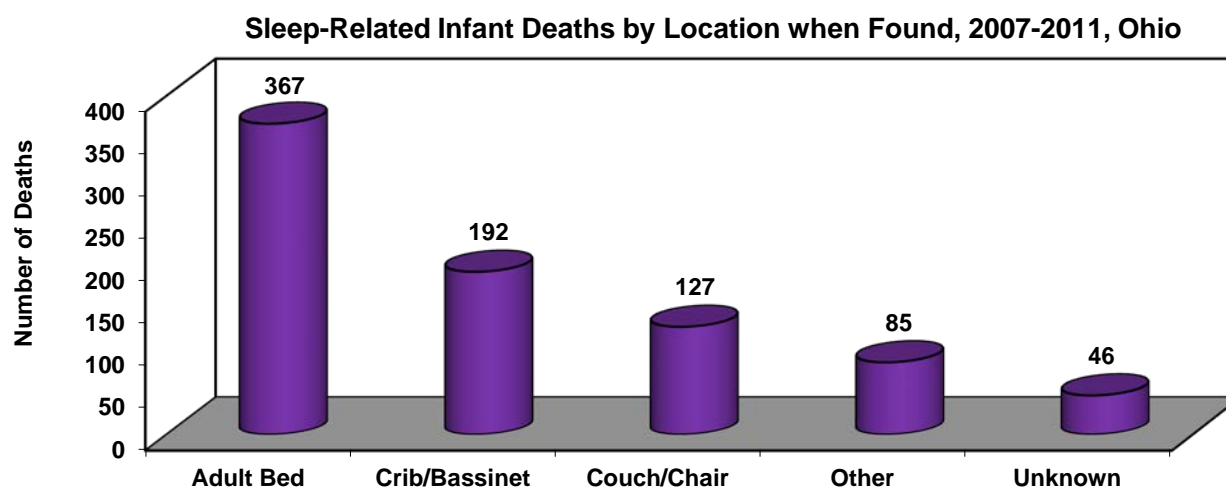
**Sleep-Related Infant Deaths by Race, 2007-2011, Ohio**



**Sleep-Related Infant Deaths by Age in Months, 2007-2011, Ohio**



(Source: ODH, Maternal and Child Health, Early Childhood, 2014, Sleep-Related Infant Deaths)



(Source: ODH, Maternal and Child Health, Early Childhood, 2014, Sleep-Related Infant Deaths)

## What is Being Done in Ohio to Prevent Sleep-Related Infant Deaths?

- ODH adopted an Infant Safe Sleep Policy to establish a consistent safe sleep message across all departments, subgrantee programs and activities. All ODH programs shall adhere to the infant safe sleep standards as endorsed by the American Academy of Pediatrics.
- Through the collaboration of partners from across the state, the ODH Violence and Injury Prevention Program, Child Injury Action Group (CIAG) and the Bureau of Child and Family Health Services will launch a statewide safe sleep social marketing campaign in early 2014. The Infant Safe Sleep subcommittee developed and focus group-tested messages for parents in order to implement the campaign.
- The CIAG Infant Safe Sleep subcommittee has identified several strategies and action steps to reduce sleep-related deaths. The group is currently working on promoting and supporting policies and legislation regarding safe sleep education; partnering with health care providers and retailers to promote safe sleep; and supporting the expansion of Cribs for Kids® partner sites in Ohio.
- The theme of the November 2012 Ohio Infant Mortality Summit was *Turn Up the Volume*. ODH continued to draw attention to safe sleep recommendations by distributing infant onesies printed with "This Side Up" at the Ohio State Fair and hospitals across the state. Infant sleep sacks that eliminate the need for loose blankets in the crib are being distributed through the Child and Family Health Services projects.
- The SID Network of Ohio offers programs and services to parents, professionals, and the community to promote infant safety in an effort to reduce the rate of SIDS and other sleep-related deaths.
- ODH hosted Infant Death Investigation trainings in March 2014.

(Source: ODH, Maternal and Child Health, Early Childhood, 2014, Sleep-Related Infant Deaths, from: [http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec\\_sleeprelatedinfant.ashx](http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/maternal%20and%20child%20health/ec_sleeprelatedinfant.ashx))

# Appendix I | WOMEN OF CHILD BEARING AGE HEALTH ASSESSMENT INFORMATION SOURCES

## APPENDIX I

Source	Data Used	Website
Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Surveillance Branch, Centers for Disease Control	<ul style="list-style-type: none"> <li>2009 - 2013 Adult Ohio and U.S. Correlating Statistics</li> </ul>	<a href="http://www.cdc.gov">www.cdc.gov</a>
Center for Disease Control and Prevention (CDC)	<ul style="list-style-type: none"> <li>Adverse Childhood Experiences (ACE)</li> <li>Breast Feeding</li> </ul>	<a href="http://www.cdc.gov">www.cdc.gov</a>
CDC, Press Release	<ul style="list-style-type: none"> <li>Large Majority of adults have smoke-free rules in homes, vehicles</li> </ul>	<a href="http://www.cdc.gov/media/releases/2013/p0516-smoke-free-rules.html">www.cdc.gov/media/releases/2013/p0516-smoke-free-rules.html</a>
Community Commons	<ul style="list-style-type: none"> <li>Access to Primary Care Physicians</li> <li>Child Day Care Services</li> <li>Infant Mortality Rates</li> <li>Low Birth Weight</li> <li>Mothers with Late or No Prenatal Care</li> <li>Rural vs. Urban Childhood Poverty</li> </ul>	<a href="http://www.communitycommons.org/">www.communitycommons.org/</a>
Healthy People 2020: U.S. Department of Health & Human Services	<ul style="list-style-type: none"> <li>All Healthy People 2020 Target Data Points</li> <li>Some U.S. Baseline Statistics</li> </ul>	<a href="http://www.healthypeople.gov/2020/topics/objectives2020">www.healthypeople.gov/2020/topics/objectives2020</a>
National Sleep Foundation	<ul style="list-style-type: none"> <li>Sudden Infant Death Syndrome</li> </ul>	<a href="http://sleepfoundation.org/sleep-disorders-problems/sudden-infant-death-syndrome-and-sleep">http://sleepfoundation.org/sleep-disorders-problems/sudden-infant-death-syndrome-and-sleep</a>
National Survey of Children, Data Resource Center	<ul style="list-style-type: none"> <li>Children and Smoking</li> </ul>	<a href="http://www.childhealthdata.org/search?k=smoking">www.childhealthdata.org/search?k=smoking</a>
Ohio Department of Health, Bureau of Vital Statistics, 2014 Ohio Infant Mortality Data: General Findings	<ul style="list-style-type: none"> <li>Neonatal, Post-neonatal and Infant Mortality by County</li> <li>Infant Mortality 10 year Average by County</li> </ul>	<a href="http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/2014%20Ohio%20Infant%20Mortality%20Report%20Final.pdf">www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/Infant%20Mortality/2014%20Ohio%20Infant%20Mortality%20Report%20Final.pdf</a>

Source	Data Used	Website
Ohio Department of Health, Information Warehouse	<ul style="list-style-type: none"> <li>Allen, Erie, Lucas, Richland, Sandusky, and Wood County Birth Statistics</li> </ul>	<a href="http://www.odh.ohio.gov">www.odh.ohio.gov</a>
Ohio Development Services Agency, The Ohio Poverty Report, February 2015	<ul style="list-style-type: none"> <li>Poverty in Ohio by Race and Hispanic Status</li> </ul>	<a href="https://development.ohio.gov/files/research/P7005.pdf">https://development.ohio.gov/files/research/P7005.pdf</a>
U. S. Department of Commerce, Census Bureau; Bureau of Economic Analysis	<ul style="list-style-type: none"> <li>Federal Poverty Thresholds, 2014</li> </ul>	<a href="http://www.census.gov">www.census.gov</a>

# Appendix II | WOMEN OF CHILD BEARING AGE SAMPLE DEMOGRAPHIC PROFILE\*

## APPENDIX II

Variable	2015 Survey Sample
<b>Age</b>	
18-24	13.7%
25-34	56.8%
35-44	29.5%
<b>Race/Ethnicity</b>	
White	69.0%
Black or African American	25.9%
American Indian and Alaska Native	0%
Asian	0.3%
Other	5.0%
Hispanic Origin (may be of any race)	3.0%
<b>Marital Status</b>	
Married Couple	42.8%
Never been married/member of an unmarried couple	42.8%
Divorced/Separated	11.2%
Widowed	1.3%
<b>Education</b>	
Less than High School Diploma	6.4%
High School Diploma	20.2%
Some college/ College graduate	73.0%
<b>Income (Families)</b>	
\$14,999 and less	26.6%
\$15,000 to \$24,999	9.4%
\$25,000 to \$49,999	24.9%
\$50,000 to \$74,999	12.8%
\$75,000 or more	19.2%

\* The percents reported are the actual percent within each category who responded to the survey. Percents may not add to 100% due to missing data (non-responses).



# Appendix III | DEMOGRAPHIC INFORMATION

## Federal Poverty Thresholds in 2015 by Size of Family and Number of Related Children Under 18 Years of Age

Size of Family Unit	No Children	One Child	Two Children	Three Children	Four Children	Five Children
1 Person <65 years	\$12,331					
1 Person 65 and >	\$11,367					
2 people Householder < 65 years	\$15,871	\$16,337				
2 People Householder 65 and >	\$14,326	\$16,275				
3 People	\$18,540	\$19,078	\$19,096			
4 People	\$24,447	\$24,847	\$24,036	\$24,120		
5 People	\$29,482	\$29,911	\$28,995	\$28,286	\$27,853	
6 People	\$33,909	\$34,044	\$33,342	\$32,670	\$31,670	\$31,078
7 People	\$39,017	\$39,260	\$38,421	\$37,835	\$36,745	\$35,473
8 People	\$43,637	\$44,023	\$43,230	\$42,536	\$41,551	\$40,300
9 People or >	\$52,493	\$52,747	\$52,046	\$51,457	\$50,490	\$49,159

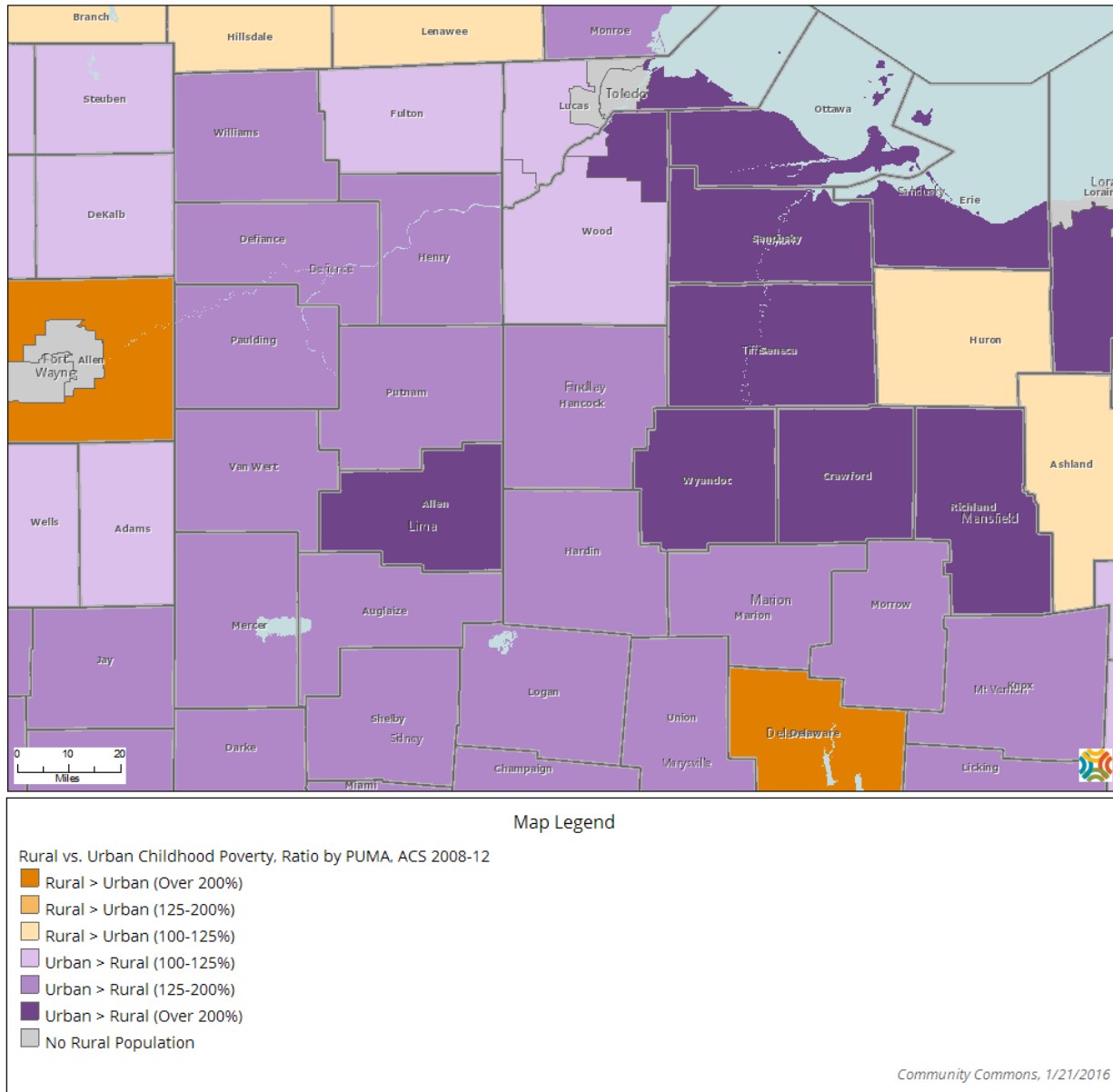
(Source: U. S. Census Bureau, Poverty Thresholds 2015,  
<http://www.census.gov/hhes/www/poverty/data/threshld/index.html>)

## Poverty in Ohio by Race and Hispanic Status

	Persons for Whom Poverty Status Was Determined, 2014 ACS		
	Total	Number	Percent
Total	11,276,403	1,785,780	15.8%
White	9,286,588	1,160,770	12.5%
Black	1,359,798	471,652	34.7%
American Indian/Alaskan Native	22,006	6,835	31.1%
Asian/Pacific Islander	221,110	30,681	13.9%
Other	101,016	27,420	27.1%
Two or More Races	285,885	88,422	30.9%
Hispanics	386,934	108,414	28.0%
White, not Hispanic	9,049,045	1,101,899	12.2%
All Minorities Combined	2,227,358	683,881	30.7%

(Source: Ohio Development Services Agency, The Ohio Poverty Report, February 2016, Table A13: Poverty in Ohio by Race and Hispanic Status for 2014, Obtained from: <https://development.ohio.gov/files/research/P7005.pdf>)

Rural vs. Urban Childhood Poverty, Ratio by Public Use Microdata Area (PUMA),  
American Community Survey, 2008-2012



(Source: Community Commons, 1/21/2016)