

Listening to Emerging Women's Health Leaders in California: *The Second Year*

A Report of the
California Alliance for
Women's Health
Leadership

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Women's Health
Leadership



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■ INTRODUCTION

THIS REPORT PRESENTS THE RESULTS of the second annual survey by the California Alliance for Women's Health Leadership of emerging women's health leaders in California.

The California Alliance for Women's Health Leadership was initiated in 1998 to enhance and expand upon the scope and depth of women's and girls' leadership in order to create more effective programs addressing women's health. It specifically seeks to increase access to health information and to affordable, quality health care for underserved women and their communities.

Four partner organizations work in concert toward the Alliance's goals: the Los Angeles Women's Foundation (LAWF), The Women's Foundation of San Francisco (TWF), the Women's Health Leadership (WHL) Program, and the Women's Health Collaborative (WHC). The Women's Health Leadership Program provides a year-long training program in women's health that builds leadership skills in the areas of program development, community advocacy, management, communications, and policy.

Each of the Alliance partners contributes to the planning, education and outreach to WHL program alumnae and other women's health leaders in communities throughout California. The two prominent women's foundations from northern and southern California provide grant-making capability and technical assistance, while the WHL program provides an infrastructure, technical support, and a continuing stream of community women's health leaders. The Women's Health Collaborative serves to convene and coordinate activities in support of the Alliance's mission.

The purpose of this report is to present data that can be used to inform the grantmaking decisions of the Alliance, enhance the technical assistance and support program for the WHL alumnae, and convey the program ideas of the women's health leaders. Unlike the first survey, this questionnaire went not only to women who were graduates of the Women's Health Leadership program but also to women who received grants from the Alliance's granting institutions but were not part of the WHL program. Comparisons between these two groups are drawn in the report.

THE REPORT IS DIVIDED INTO SIX SECTIONS:

- A. Profile of the Women's Health Leaders
 - B. Priority Issues in Women's Health
 - C. CAWHL Grantmaking Experience
 - D. Use of WHL Resources
 - E. Policy Activities
 - F. Funding Priorities
- Conclusions and Recommendations

■ METHODS

A SELF-ADMINISTERED SURVEY in English and Spanish was mailed to 234 women's health leaders in California. These included Women's Health Leadership alumnae (1995 through 1998) who were grantees and non-grantees of the Alliance and grantees of the Alliance's partner foundations who were not graduates of the Women's Health Leadership Program. To assure an adequate response rate, a copy of the survey questionnaire was sent to non-respondents, twice if necessary, and a reminder call was made between the second and third mailings. One hundred twenty-six WHL alumnae and 25 non-WHL grantees completed and returned a survey. The overall response rate was 67%. (The response rate in 1999 was 65%.) The data from the questionnaires were entered and frequencies calculated using the Statistical Analysis System data analysis program.

A. PROFILE OF THE WOMEN'S HEALTH LEADERS

Data were collected to describe the survey respondents in terms of age, educational attainment, ethnicity, primary language, employment status, and access to health insurance.

AGE GROUP

The majority of respondents (67%) are between the ages of 36 and 54. A quarter (24%) are 21 to 35, and 9% are 55 or older.

TABLE A-1: AGE GROUP

	Number	Percent
21-35	36	24%
36-45	54	36%
46-54	47	31%
55 and above	14	9%
TOTAL	151	100%

EDUCATIONAL ATTAINMENT

More than one-third (37%) of the survey respondents have received an undergraduate college degree. Another third (34%) have received a Master's degree, and 4% have a doctoral level degree. One in five respondents' schooling (20%) ended with a two-year college degree (AA) or less.

TABLE A-2: HIGHEST DEGREE

	Number	Percent
Less than high school	1	1%
High school	12	8%
AA	18	12%
BA/BS	56	37%
MA/MS/MPH	51	34%
PHD/MD/JD	6	4%
Certification	5	3%
No response	2	1%

ETHNICITY

The survey respondents are a diverse group: 36% are Caucasian, 21% are black, 20% are Latina, and 10% are Asian. Approximately 13% of respondents reported other ethnicities, including Native American, bi-racial, and Pacific Islander.

TABLE A-3: ETHNICITY

	Number	Percent
Caucasian	54	36%
Black	32	21%
Latina	30	20%
Asian	15	10%
Bi-racial	6	4%
Native American	6	4%
Pacific Islander	3	2%
Other ethnicity	5	3%

PRIMARY LANGUAGE

Nearly all (91%) survey respondents are most comfortable speaking English. Five percent consider Spanish their primary language. Other primary languages included Vietnamese (1%) and Hmong (1%).

TABLE A-4: LANGUAGE MOST COMFORTABLE SPEAKING

	Number	Percent
English	137	91%
Spanish	7	5%
Hmong	2	1%
Vietnamese	2	1%
Other	3	2%

EMPLOYMENT STATUS

Only two respondents (1%) reported being unemployed.

TABLE A-5: EMPLOYMENT STATUS

	Number	Percent
Employed	148	98%
Not employed	2	1%
No response	1	1%

May not total 100% due to rounding

HEALTH INSURANCE

Most of the survey respondents have health insurance (86%); 14% do not have health insurance or did not answer the question. Since 98% of respondents are employed, these data suggest that for 14%, their employment does not provide health insurance benefits.

TABLE A-6: HEALTH INSURANCE

	Number	Percent
Yes	130	86%
No	20	13%
No response	1	1%

TYPE OF EMPLOYER

Survey respondents were asked to describe the organization in which they work. Most work for non-profit organizations (55%); others work in government agencies (17%), for-profit agencies (7%), academic institutions (9%), or are self-employed (8%).

**TABLE A-7: TYPE OF EMPLOYER
(RESPONDENTS SELECTED ONE CATEGORY)**

	Number	Percent
Non-profit agency	83	55%
Government agency	26	17%
Academic institution	13	9%
Self-employed	12	8%
For-profit agency	10	7%
Other	1	1%
Missing/not employed	6	4%

CURRENT OCCUPATION

Survey respondents reported a variety of occupations within the health care field. Many are in managerial positions, such as program administrator (25%) or project coordinator (20%). Others are working as health educators (9%), social workers (6%), or therapists (3%).

**TABLE A-8: CURRENT OCCUPATION
(RESPONDENTS SELECTED ONE CATEGORY)**

	Number	Percent
Administrator	37	25%
Project coordinator	30	20%
Health educator	14	9%
Social worker	9	6%
Consultant	8	5%
Nurse	8	5%
Community outreach	7	5%
Advocate	6	4%
Therapist	5	3%
Teacher	4	3%
Midwife	3	2%
Administrative assistant	3	4%
Program officer	2	1.3%
Clergy	1	0.7%
Nurse practitioner	1	0.7%
Project assistant	1	0.7%
Trainer	1	0.7%
Other	9	5.9%
No response	1	0.7%

EMPLOYER ORGANIZATION FOCUS

Nearly two-thirds (65%) of survey respondents are working for organizations that provide direct services; 27% are working for advocacy/policy agencies; 24% work for organizations that provide technical assistance.

TABLE A-9: WHAT DOES YOUR EMPLOYER ORGANIZATION DO?
(RESPONDENTS SELECTED ONE CATEGORY)

	Number	Percent
Direct services	97	65 %
Advocacy/Policy	40	27 %
Technical assistance	20	24 %
Research	4	5 %
Other	12	14 %

INVOLVEMENT IN ADDITIONAL HEALTH ACTIVITIES

Survey respondents view their work in women’s health as more than a job. Sixty-two percent of the respondents reported being involved in health activities in addition to their primary employment.

A-10: OTHER HEALTH ACTIVITIES

	Number	Percent
Yes	94	62 %
No	46	30 %
No response	11	7 %

May not total 100% due to rounding

B. PRIORITY ISSUES IN WOMEN’S HEALTH

PRIORITIES REMAIN THE SAME

The women’s health issues prioritized by women’s health leaders in the previous survey remain of greatest importance: mental health (92%), domestic partner violence (91%), health education, and access to preventive care (91%), reproductive health (89%), health insurance and access to health care (89%). Additional priority areas are poverty (34%), culturally competent care (32%), and violence in society (29%).

TABLE B-1: PRIORITY ISSUES IN WOMEN’S HEALTH
(RESPONDENTS SELECTED ALL THAT APPLY)

	Number	Percent
Mental health (including substance abuse, stress and depression)	139	92 %
Domestic partner violence	138	91 %
Health education/access to preventive services	137	91 %
Health insurance/access to health care	134	89 %
Reproductive health (including teen pregnancy, family planning, STDs and breast cancer)	134	89 %
New Priority Areas:		
Poverty	52	34 %
Culturally competent care	48	32 %
Violence in society	44	29 %

CREATING AND DIRECTING WOMEN’S HEALTH PROGRAMS

The leadership roles of the survey respondents are clearly illustrated by the fact that two-thirds (67%) of them have created a program in women’s health and 69% are currently working in a program they created. Moreover, two-thirds (66%) have directed a program in women’s health and, of these, 75% are currently directing the program in which they work.

TABLE B-2: CREATING WOMEN’S HEALTH PROGRAMS

<i>Have you created a program in women’s health?</i>		
	Number	Percent
Yes	101	67 %
No	49	32 %
Missing	1	1 %
<i>Are you currently working in a program you created?</i>		
Yes	70	69 %
No	29	29 %
No response	2	1 %

TABLE B-3: DIRECTING WOMEN'S HEALTH PROGRAMS

<i>Have you directed a program in women's health?</i>		
	Number	Percent
Yes	100	66%
No	48	32%
No response	3	2%
<i>Are you currently directing a program in women's health?</i>		
Yes	75	75%
No	24	24%
No response	1	1%

SELF-ASSESSMENT OF LEADERSHIP

When queried as to their self-perception as leaders, the overwhelming majority of survey respondents (87%) reported considering themselves leaders.

TABLE B-4: DO YOU SEE YOURSELF AS A LEADER IN WOMEN'S HEALTH?

	Number	Percent
Yes	132	87%
No	17	11%
No response	2	1%

WHAT MAKES A LEADER

Survey respondents were asked to describe all the ways they are a leader in women's health. More than three-fourths (78%) describe themselves as organizers and advocates, 74% as health promoters, 70% as facilitators, and 50% as decision makers.

TABLE B-5: IN WHAT WAYS ARE YOU A LEADER? (RESPONDENTS SELECTED ALL THAT APPLY)

	Number	Percent
Organizer and advocate	103	78%
Health promoter	98	74%
Facilitator	93	70%
Decision maker	66	50%
Other	17	13%

SKILLS USED IN LEADERSHIP ROLE

When asked about the skills they use in their leadership role, respondents most often cited their ability to access resources (83%), advocacy (79%), outreach (67%), coalition-building and collaboration (66%), networking (64%), and public speaking (64%).

TABLE B-6: WHICH OF THE FOLLOWING SKILLS DO YOU USE IN YOUR LEADERSHIP ROLE? (RESPONDENTS SELECTED ALL THAT APPLY)

	Number	Percent
Ability to access resources	109	83%
Advocacy	104	79%
Outreach	88	67%
Coalition building/ Collaboration	87	66%
Networking	84	64%
Public speaking	85	64%
Program planning	83	63%
Community organization	77	58%
Consciousness raising	72	55%
Ability to influence women's health	71	54%
Group process/facilitation	70	53%
Program management	69	52%
Communications	67	51%
Proposal writing	63	48%
Representing communities	57	43%
Social support	54	41%
Program evaluation	52	39%
Computer/Internet skills	42	32%
Strategic alliance building	39	30%
Community health assessment	38	29%
Fiscal management/Budgeting	34	26%
Media advocacy/Relations	35	26%
Time management	34	26%
Marketing	31	24%
Conflict resolution	30	23%
Public policy	25	19%
Economic development	16	12%
Other	5	4%

POPULATIONS CURRENTLY SERVED

Survey respondents were asked to describe the populations they serve in their current work. The variety of populations described represents the broad spectrum of work in women’s health. While respondents most frequently cited serving families (50%), other groups they mentioned are girls (28%), the disabled (18%), the uninsured (16%), rural (13%) and homeless women (11%), and immigrants (10%).

**TABLE B-7: POPULATIONS CURRENTLY SERVED
(RESPONDENTS SELECTED UP TO TWO CATEGORIES)**

	Number	Percent
Families	76	50%
Girls	43	28%
Disabled	28	18%
Uninsured/Underinsured	24	16%
Rural communities	20	13%
Homeless	16	11%
Immigrants	15	10%
Monolingual communities	10	7%
Low literacy	7	5%
Lesbians & bisexual women	5	3%
Migrant workers	5	3%
Refugees	3	2%
Other	19	13%

ETHNIC GROUPS CURRENTLY REACHED

The majority of respondents work with the general population and are involved with various ethnic groups in their women’s health work. Fifty-six percent work with Latinas, 50% with blacks, 48% with whites, 40% with Asians, 21% with American Indian, and 19% with Pacific Islanders. See Table B-8, top, right.

STRATEGIES TO MEET THE NEEDS OF SPECIFIC POPULATIONS

Survey respondents utilize a number of strategies in tailoring their programs to meet the needs of the specific ethnic and cultural groups they serve. The most frequently reported strategy was community outreach (62%), 50% utilize community- and coalition-building, 48% provide counseling and social support, and 42% use peer education. See Table B-9, at right.

**TABLE B-8: ETHNIC GROUPS CURRENTLY REACHED
(RESPONDENTS SELECTED ALL THAT APPLY)**

	Number	Percent
Latina	85	56%
Black	76	50%
General population	74	49%
Caucasian	73	48%
Asian	61	40%
Bi-racial	40	26%
American Indian	32	21%
Pacific Islander	29	19%
Other	15	10%

**TABLE B-9: STRATEGIES TO MEET SPECIFIC
POPULATION GROUP NEEDS
(RESPONDENTS SELECTED ALL THAT APPLY)**

	Number	Percent
Community outreach	94	62%
Community/Coalition building	76	50%
Counseling & social support	72	48%
Peer education	64	42%
Group process and facilitation	61	40%
Hire staff that reflect client’s culture	60	40%
Technical assistance and/or training	51	34%
Translate materials into other languages	50	33%
Media, advocacy, and policy work	43	28%
Adult mentoring	36	24%
Institute faith-based approaches	25	17%
Other	12	8.0%

STRATEGIES FOR ADDRESSING PRIORITY ISSUES

While leaders address their priority issues and social problems through multiple methods, the most widely used method is the development and dissemination of educational and health promotion materials (64%).

Other methods they employ are community organizing and community development (47%), community health outreach and provision of direct health services (39%), coalition building (40%), self-help and mutual support groups (42%). A few respondents added fundraising, volunteer efforts, and direct care.

**TABLE B-10: STRATEGIES FOR ADDRESSING PRIORITY ISSUES
(RESPONDENTS SELECTED ALL THAT APPLY)**

	Number	Percent
Health education/ Promotion materials	96	64%
Community organizing and development	71	47%
Self help support groups	64	42%
Coalition building	61	40%
Health care delivery and outreach	59	39%
Cultural competency	47	31%
Technical assistance and training	45	30%
Lobbying/ Advocacy on legislation	32	21%
Media, marketing and communications	28	18%
Research and policy analysis	22	15%
Other	10	7%

C. CAWHL GRANTMAKING EXPERIENCE

The CAWHL partner foundations — the Los Angeles Women’s Foundation (LAWF) and The Women’s Foundation, San Francisco (TWF) — developed a grant-making process for funding women’s health projects that was open to all of the respondents to this survey. At the time of this survey, 58 grants had been awarded by the two women’s foundations during the first funding cycle. A total of 63 grants were awarded at the end of this funding cycle. Of these, 43 were to non-WHL alumnae and 20 were to WHL alumnae.

Of the WHL alumnae responding to this survey, 38 (30%) said they had applied for funding with the CAWHL foundation partners; 18 WHL alumnae said they received funding. By definition, all 25 of non-WHL respondents were grantees.

The majority of grantees agreed with the funding priorities set by LAWF and TWF, which support increasing access to health care for underserved women and girls and developing women’s leadership in health care in ethnically diverse communities. One respondent mentioned that the priorities were not comprehensive enough and did not include the top health concerns of black women: obesity, heart disease and stroke.

Respondents who had applied for a grant were asked if they thought CAWHL funding levels were sufficient to carry out the proposed work. Grant applicants who were waiting to hear if they had been awarded a grant, in the second year of the grant cycle, could not answer the question. Of those who had received grants, several reported that CAWHL awards were not sufficient and that considerable time and energy had to be devoted to seeking additional financial support. One grantee felt that the CAWHL funding was sufficient to start her project, but that additional funds were needed for full project implementation. A small number of grantee respondents were satisfied with the amount of money received from their CAWHL grant. One grantee reported that the CAWHL monies allowed her program to expand and to pay stipends to community health workers.

Some respondents valued the technical assistance in seeking grants they have already received, others would like more time between the Alliance’s request for proposals and the application deadline. Future technical assistance needs to help apply for a CAWHL grant include grantwriting workshops, meetings with funders, individual mentoring, pre-review of proposals (review of a proposal by a foundation staff person before formal submission), and technical support on writing, establishing 501(c)(3) status, and evaluation.

When asked if they would apply for funding again, the majority of survey respondents (79%) stated they plan to apply again. Those who apply for and receive grant funds are more likely to participate in networking events, workshops and one-to-one consultations.

In the opinion of survey respondents, the development of women’s health leaders in California can be supported by changes in CAWHL’s grantmaking strategy. A primary change involves creating additional categories of funding, such as operational and administrative support, program expansion grants, preplanning grants, equipment grants, grants to individuals, and seed or start-up funding.

IMPORTANCE OF EXPANDING APPLICANT AND GRANTMAKING POOL

The findings from the current survey provide information on the applicant pool and grantees of the Alliance grantmaking program. Forty-three of those who responded to this survey had received funding from Alliance granting institutions. There were some notable findings about those who were awarded grants that may help to inform future grantmaking programs.

Taken as a whole, grantees—both WHL alumnae and non-WHL grantees—currently work primarily as administrators (35%) or project coordinators (26%). Most (63%) work for non-profit organizations; 19% work for government agencies. About one-third of the grantees have a Bachelor's degree and another third have a Master's degree; one grantee has a Doctorate degree. The grantees are ethnically diverse, representing whites (42%), Latinas (19%) and African Americans (12%).

The inclusion of WHL alumnae seems to broaden the pool of applicants for and recipients of women's health leadership grants under the Alliance grantmaking program. The WHL alumnae respondents are more diverse ethnically than the non-WHL grantees, with blacks and Latinas prominent among WHL alumnae (25% and 21%, respectively) and barely represented among the non-WHL grantees (0% and 12%).

WHL alumnae overall are more active in their communities, being more than twice as likely to be involved in health-related activities outside of work (68%) as the non-WHL grantees (32%). Further, more WHL alumnae participated in policy-related activities: 63% of WHL alumnae participated in a policy-related activity, such as meeting with an elected official to discuss women's health issues, compared with 44% of non-WHL grantees.

There were some notable differences in the profiles of the WHL alumnae who received grants compared with the 108 WHL alumnae responding to the survey who were not grantees of the women's foundations:

- ❖ The WHL grantees have more formal education than their WHL peers, with 75% obtaining a BA degree or higher, compared with 61% of non-grantee alumnae.
- ❖ The WHL grantees were more likely to work for a non-profit agency (44%) or a government agency (44%) than WHL alumnae not receiving grants.

- ❖ The WHL grantees are more likely than the non-grantee WHL alumnae to have created (89% versus 64%) or directed (78% versus 65%) a program in women's health, and they are more likely to identify themselves as health outreach workers (11% compared with 5%).
- ❖ The WHL grantees are more likely to be involved in women's health outside of work (89% compared with 65% of non-grantee WHL alumnae).
- ❖ WHL grantees are more likely to have contacted an elected official (89% compared with 66% of non-grantee WHL alumnae).

D. USE OF CAWHL RESOURCES

WHL ALUMNAE NETWORK

Of the survey respondents who participated in the WHL program over the last four years, 56% participated in WHL Alumnae Network activities. Most of these women attended regional meetings in order to network with others (57%). About one-third of the women participated in focus groups (31%), used the network for resource and referral (26%), and attended strategic planning workshops (26%). Other alumnae used the network to review job opportunities, attend logic modeling workshops, participate in policy days in Sacramento, and receive technical assistance. Alumnae who have not received grants through the Alliance partners were slightly less likely to participate in alumnae network activities.

Most WHL alumnae would like the alumnae network to sponsor an annual conference (65%). Roughly one-third of the alumnae endorsed other suggestions, including regional meetings, a Web page, policy workshops, and an alumnae newsletter. Other ideas that generated support among the alumnae are advocacy in Sacramento, an e-mail network, monthly mailings, media/communications training, mentoring, and a toll-free information line. The non-grantee WHL alumnae were more interested in receiving one-on-one mentoring than the WHL grantees (25% vs. 17%), and more likely to participate in a media/communications training (25% vs. 17%). Additional suggestions for alumnae network activities include posting employment opportunities; holding workshops on non-profit management, fundraising, and board development; providing support for travel to alumnae events; and publishing funding alerts.

RESOURCES USED

Survey respondents were most likely to report having used WHC/CAWHL materials, including *Listening to Emerging Women Health Leaders* (21%), *Women at Risk in California* (24%), and the policy tracking guide, *Women's Health Policy in the California Legislature* (19%). Respondents would like access to resource information in the following formats: Web sites (53% would use), newsletters (55%), booklets or pamphlets (38%), journal articles (34%), presentations (30%). The types of women's health data or information respondents would like access to cover a wide range of topics, some of which fall into the following categories: disease-specific population data broken down by ethnicity and geography; policy data relevant to legislation affecting women's health; legal data linking crime statistics to domestic violence and sexual assault, and information on mental health, welfare reform, including poverty and housing, and leadership development.

TECHNICAL ASSISTANCE REQUESTS

Survey respondents who applied for a CAWHL grant indicated that workshops and technical assistance (44%), communication with funders (40%), and pre-review of proposals (22%) were the most useful types of technical assistance when applying for a grant. Regarding future applications for funds, they would welcome assistance with grantwriting (42%), help identifying funding opportunities (36%), and arranged meetings with funders (33%).

Responding grantees were also asked about the types of technical assistance they received from their funders. Seventy-two percent indicated they have received assistance. Of those grantees, 14% mentioned logic modeling training, 12% received one-to-one consultation, and 9% had assistance with strategic planning. When they were asked what types of assistance they would like to receive from the funder, responding grantees identified strategic planning (33%), one-to-one consultation (23%), fundraising (26%), and public relations (19%).

E. POLICY ACTIVITIES

The majority of women surveyed (79%) reported that they use their women's health leadership skills in advocacy, reflecting women interested and active in the policy arena. Most of those surveyed (67%) report having contacted an elected official, with slightly fewer (60%) having met with an official. More than half the women

(56%) reported that they had attended a policy training, advocacy day, or lobby day. Most (63%) of the training activities were not sponsored by CAWHL, showing a clear interest in policy and connections to other community-based agencies among those surveyed. Twenty-seven percent of those responding had taken action on legislation in the 1999 California State Legislative Session.

Women who had participated in WHL were most likely to have contacted (phoned, written, or e-mailed) an elected official. In this survey, 66% of WHL alumnae respondents and 89% of WHL CAWHL grantees (compared with 60% of non-CAWHL grantees) have contacted an elected official. WHL participants were also more likely than non-WHL participants to have met with an elected official: 63% of all WHL alumnae have done so compared with 44% of non-alumnae grantees.

Those who had taken action on legislation had advocated for needle exchange, safe sex education, mental health care reform, access to care, funding for breast cancer treatment, contraceptive equality, funding for rural clinics, microbicide research, nicotine control, disbursement of tobacco settlement funds, partner notification, action on youth violence, safety of school portables, licensing of medicines, and measures on domestic violence. Showing the breadth of interest of those surveyed, some also listed acting on legislation not pertaining to health, such as advocating for park bonds and against logging of old-growth forests.

Involvement in community leadership activity is high, as 91% of women surveyed reported having served on a non-profit board of directors, committee, grants review committee for a foundation, PTA/community group, school board, or a women's committee or special task force. Civic involvement in these types of activities should allow for increased involvement in public policy, and would infuse the public policy arena with women who are involved in their own communities.

When asked what technical assistance would be helpful to expand their policy work, respondents cited alerts and updates on legislation (44%), help forming grassroots groups (13%), and intensive training in policy actions (13%). Brief trainings, technical assistance in setting up meetings with elected officials, and internships with health organizations or elected officials were identified as second and third priorities. Of those whose top priority was intensive training, all were WHL participants (19%).

Public policy issues that some respondents noted they would like to work on reflect a broadened women's health agenda that is not yet covered in current legislation. In frequency order, those issues are access to health care, reproductive rights, health education, domestic violence, breast cancer, substance abuse, mental health, research/data, elder health, Native American health, and environmental health. Other issues identified by at least one woman surveyed are racism, child care, homelessness, cultural competence, international health, and employment.

F. FUNDING PRIORITIES

In order to create long-term change in the enhancement of women and girls' health, leaders would like CAWHL to designate funding in four categories:

- 1) Preventing violence
- 2) Programs for girls and young women
- 3) Community development
- 4) Education of consumers and providers on health issues

In these four areas, leaders provided details and insight on the nature of the problems to be addressed and some funding suggestions.

1. Violence Prevention Programs should include the following:

- ❖ Education and training for those who provide services to victims of domestic violence
- ❖ Expanded awareness of dating violence
- ❖ Understanding of the effects of violence on girls
- ❖ Advocacy for victims of domestic violence and sexual assault
- ❖ Shelter for victims of domestic violence
- ❖ Sexual assault response teams
- ❖ Training in anger management

2. Programs for Girls and Young Women should include:

- ❖ Computer training
- ❖ Prenatal and parenting training for teen moms
- ❖ Employment and job-retention training
- ❖ Group homes for displaced girls

- ❖ Clinics for youth / adolescent health
- ❖ Services for rural youth
- ❖ Replicating the WHL model for young women
- ❖ Programs for girls with special needs
- ❖ Leadership programs

3. The following types of Community Development efforts should be supported:

- ❖ Extracurricular activities in the arts and music in local schools
- ❖ Peer tutors
- ❖ Community capacity building
- ❖ Community coalitions that link organizations
- ❖ WHL alumnae building
- ❖ Community-based advocacy and organizing
- ❖ Leadership programs for community health workers

4. Education programs for consumers and providers should include the following:

- ❖ Training of health care providers on selected topics
- ❖ Expanded education of community health workers on perinatal health, lesbian and bisexual health, language skills, and use of media
- ❖ Education of health care consumers with specific needs, e.g., breast cancer, infectious diseases/HIV-AIDS, mental health, tobacco cessation, diabetes, and substance abuse

■ CONCLUSIONS AND RECOMMENDATIONS

Women's health leaders represent an ethnically diverse group, with varying educational backgrounds and professional involvement. Many are directing women's health programs and reaching underserved populations that have the greatest health disparities. While most of these women are employed, 14% do not have health insurance. (Though this figure is disturbing, in California only 59% of all women have job-based coverage and only 75% have any health insurance, according to the Data Brief, "Health Insurance Coverage of Women Ages 18-64 in California, 1998," published by the California Alliance for Women's Health Leadership.)

The WHL alumnae have served to broaden the pool of applicants and grantees seeking funding and receiving grants from the Women's Foundations participating in the Alliance. The WHL alumnae are more ethnically diverse than non-WHL grantees of the Alliance partner granting institutions; in addition, they are more often working in traditionally underserved communities, reflect a grassroots perspective in their work, and have been involved with health issues outside of the workplace, including political advocacy.

The grantmaking process instituted by the Los Angeles Women's Foundation and the Women's Foundation, San Francisco, was sufficient to acquaint grassroots women's health leaders with the grantwriting and proposal submission process. However, the women request more technical assistance with preparing for and executing grantwriting activities. Furthermore, the funding levels offered may not have been enough to provide grantee organizations with stability or the ability to carry out new programs.

About one-third of WHL alumnae utilize WHL networking opportunities and resources. Many of the women would like more information, particularly in the form of newsletters. They would also like particular types of information related to their work, including disease-specific, policy-related and legal data.

Women's health leaders have a clear idea of the areas needing programs to create long-term change in the health of the women and girls they serve, and articulated a number of specific program ideas in the following priority areas: 1) preventing violence, 2) programs for girls and young women, 3) community development, and 4) education.

Three major conclusions can be drawn from the 1998 and 1999 surveys of emerging leaders in women's health in California:

- ❖ Women with ethnically and professionally diverse backgrounds who have a keen sense of the needs of underserved women and girls in California are taking leadership roles in programs that serve a wide segment of this population.
- ❖ These emerging leaders are as yet making limited use of the funding opportunities provided through the Alliance grantmaking partners and need additional support in locating and responding to granting opportunities.

- ❖ The Women's Health Leadership alumnae have broadened the pool of applicants and grantees seeking funding from the two women's foundations in California.

RECOMMENDATIONS

A number of recommendations for funders and WHL program developers have been drawn from the 1999 survey of emerging women's health leaders. If enacted, these recommendations will enable these women to achieve greater success in reaching underserved women and girls.

- ❖ Funding should continue for WHL alumnae to reach underserved populations with greater health disparities so that they can meet the needs of these populations using non-traditional and responsive approaches.
- ❖ A range of technical assistance is needed — from proposal development through program implementation — to enable women's health leaders to bring their projects into the funding process and achieve their program goals.
- ❖ Funders should facilitate the grant application process to assure success of the proposals of women's health leaders.
- ❖ Future funding efforts need to assist grantees to reach a level in which program activities are sustainable and fully implemented.
- ❖ Funders should develop granting opportunities that are responsive to the priority health concerns of women's health leaders.
- ❖ Women's health leaders need specific, policy-related technical assistance and training to be able to engage in creating and influencing public policy that builds healthy societies rather than simply reacting to unhealthy ones.

