Women's Health USA 2009

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PREFACE AND READER'S GUIDE

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports healthy women building healthy communities. HRSA is charged with ensuring access to quality health care through a network of community-based health centers, maternal and child health programs, and community HIV/AIDS programs throughout the States and U.S. jurisdictions. In addition, HRSA's mission includes supporting individuals pursuing careers in medicine, nursing, and many other health disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely, topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA is pleased to present *Women's Health USA 2009*, the eighth edition of the *Women's Health USA* data book. To reflect the ever-changing, increasingly diverse population and its characteristics, *Women's Health USA* selectively highlights emerging issues and trends in women's health. Data and information on women veterans, bleeding disorders, hearing problems, and severe headaches and migraines are a few of the new topics included in this edition. There is also a new section providing State-specific data on leading causes of death, overweight and

obesity, and smoking among women. A special supplement on women's health along the U.S.–Mexico border is also new this year and covers a range of topics including population characteristics, health insurance coverage, and reproductive health.

Racial and ethnic, sex, and socioeconomic disparities are highlighted throughout the document where possible. Where race and ethnicity data are reported, every effort was made to ensure that groups are mutually exclusive. In some instances, it was not possible to provide data for all races due to the design of the original data source or the size of the sample population; therefore, data with a relative standard error of 30 percent or greater were considered unreliable and were not reported. For estimates relying on the 2005–2006 National Health and Nutrition Examination Survey, data presented for the Hispanic population should be interpreted with caution. Due to the sampling design of the survey, the data may not be representative of the entire U.S. Hispanic population.

The data book was developed by HRSA to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. *Women's Health USA 2009* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal government, including the U.S. Department of Health and Human Services, U.S. Department of Agriculture, U.S. Department of Labor, and U.S. Department of Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years. It is important to note that the data included are generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races and ethnicities. Without age adjustment, it is difficult to know how much of the difference in incidence rates between groups can be attributed to differences in the groups' age distributions.

Women's Health USA 2009 is available online through the HRSA Maternal and Child Health Bureau (MCHB), Office of Women's Health Web site at http://hrsa.gov/womenshealth or the MCHB Office of Data and Program Development's Web site at www.mchb.hrsa.gov/data. Some of the topics covered in *Women's Health USA 2008* were not included in this year's edition because either new data were not available or because preference was given to an emerging issue in women's health. For coverage of these issues, please refer to *Women's Health USA 2008*, also available online. The National Women's Health Information Center, located online at www.womenshealth.gov, has detailed women's and minority health data and maps. These data are available through Quick Health Data Online at www.4woman.gov/quickhealthdata. Data are available at the State and county levels, by age, race and ethnicity, and sex.

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INTRODUCTION

In 2007, women represented 50.7 percent of the 302 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people aged 65 years and older; within this age group, women represented 58 percent of the population. The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. Black and Hispanic women accounted for 8.9 and 6.5 percent of the female population aged 65 years and older, respectively, but they represented 14.6 and 21.5 percent of females under 15 years of age. Non-Hispanic Whites accounted for 80.2 percent of women aged 65 years and older, but only 55.9 percent of those under 15 years of age.

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in health status and the use of health care services. In 2007, 62.1 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 53.1 percent of Hispanic women and 51.0 percent of non-Hispanic Black women. Minority women are disproportionately affected by a number of diseases and health conditions, including HIV/AIDS, sexually transmitted infections, diabetes, and asthma. For instance, in 2006, HIV incidence was highest among Black (55.7 per 100,000 females) and Hispanic females (14.4 per 100,000 females). One-third of non-Hispanic White women had ever been tested for HIV, compared to 55.5 percent of non-Hispanic Black women and 48.8 percent of Hispanic women.

Hypertension, or high blood pressure, was also more prevalent among non-Hispanic Black women than women of other races. In 2005–2006, this condition occurred at a rate of 199.2 per 1,000 non-Hispanic Black women,

compared with 163.0 per 1,000 non-Hispanic White women and 117.0 per 1,000 Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and is especially prevalent among minority populations. Among women with any disability or condition limiting their activity, 11.4 percent cited diabetes as the cause of the activity limitation. In 2007, non-Hispanic Black women and Hispanic women were much more likely to suffer limitations due to diabetes (20.6 and 18.0 percent of women with any activity limitation) than non-Hispanic White women (8.9 percent).

Some conditions, such as arthritis and heart disease, disproportionately affect non-Hispanic White women. For instance, in 2007, more than 27 percent of non-Hispanic White women had arthritis, compared to 22.2 percent of non-Hispanic Black women and 15.4 percent of Hispanic women.

In addition to race and ethnicity, income and education are important factors that contribute to women's health and access to health care. Regardless of family structure, women are more likely than men to live in poverty. Poverty rates were highest among women who were heads of their households (24.9 percent). Poverty rates were also highest among non-Hispanic American Indian/Alaska Native women (23.4 percent), followed by non-Hispanic Black and Hispanic women (23.3 and 20.8 percent, respectively). Non-Hispanic Black and Hispanic women were also more likely to be heads of households than their non-Hispanic White and non-Hispanic Asian counterparts.

Some conditions and health risks are more closely linked to family income than to race and ethnicity, such as asthma. Rates of asthma decline as income increases and women with higher incomes are more likely to effectively manage their asthma. Among women with asthma whose incomes were below 100 percent of poverty, 32.4 percent had an asthma-related emergency room visit in the past year, compared to 14.5 percent of women with family incomes of 300 percent or more of poverty.

Mental health is another important aspect of women's overall health. A range of mental health problems including depression, anxiety, phobias, and post-traumatic stress disorder, disproportionately affect women. Women with lower incomes were significantly more likely than those with higher incomes to report frequent depression and anxiety in 2007.

Severe headaches and migraines were also more common among women than men, and were more common among women with lower family incomes. In 2007, nearly one-quarter of women with family incomes below 100 percent of poverty experienced severe headaches or migraines, compared to 14.8 percent of women with incomes of 400 percent or more of poverty.

Physical disabilities are more prevalent among women as well. Disability can be defined as impairment of the ability to perform common activities like walking up stairs, sitting or standing for 2 hours or more, grasping small objects, or carrying items like groceries. Therefore, the terms "activity limitations" and "disabilities" are used interchangeably throughout this book. Overall, 15.6 percent of women and 13.0 percent of men reported having activity limitations in 2007.

Men, however, bear a disproportionate burden of some health conditions, such as HIV/AIDS, hypertension, and heart disease. In 2006, for instance, the rate of newly reported HIV cases for adolescent and adult males was more than 3 times the rate for females (34.3 versus 11.9 per 100,000, respectively). Despite the greater risk, though, a smaller proportion of men had ever been tested for HIV than women (34.3 versus 38.8 percent, respectively).

Certain health risks, such as cigarette use, illicit drug use, and injury, occur more commonly among men than women. In 2007, 22.3 percent of men smoked cigarettes, compared to

17.4 percent of women. Among men, 28.1 percent of emergency department visits were injury-related, while only 20.4 percent of women's visits were due to injury. In addition, men were more likely than women to lack health insurance.

Many diseases and health conditions, such as those mentioned above, can be avoided or minimized through good nutrition, regular physical activity, and preventive health care. In 2006, 21.5 percent of women's visits to physicians were for preventive care, including prenatal care, preventive screenings, and immunizations. In 2007, 66.3 percent women aged 65 years and older reported receiving a flu shot; however, this percentage ranged from 54.0 percent of Hispanic women to 68.4 percent of non-Hispanic White women.

In addition to preventive health care, preventive dental care is also important to prevent dental caries and gum disease. In 2006, 65.7 percent of women reported receiving annual dental checkups; however, this was more common among women in metropolitan areas than in non-metropolitan areas (67.3 versus 57.7 percent, respectively).

There are many ways women (and men) can promote health and help prevent disease and disability. Regular physical activity is one of these. In 2007, 10.0 percent of women participated in at least 30 minutes of moderate-intensity physical activity on most days of the week or 20 minutes of vigorous-intensity activity on 3 or more days per week. Non-Hispanic White women and women with higher incomes were most likely to meet this level of physical activity.

Healthy eating habits can also be a major contributor to long-term health and prevention of chronic disease. In 2005–2006, however, more than half of all women had diets that included more than the recommended amount of saturated fat and sodium and less than the recommended amount of folate and calcium. Overall, 63.0 percent of women exceeded the maximum recommended daily intake of saturated fat, and 68.0 percent exceeded the maximum recommended amount of sodium.

While some behaviors have a positive effect on health, a number of others, such as smoking, illicit drug use, and excessive alcohol use can have a negative effect. In 2007, 39.6 percent of women reported any alcohol use in the past year, but of those women, relatively few (13.4 percent) reported moderate drinking (more than three, up to seven drinks per week) and even fewer (7.7 percent) reported heavy drinking (more than seven drinks per week). In the same year, 12.6 percent of women used illicit drugs, including marijuana, cocaine, hallucinogens, inhalants, and prescription-type drugs for non-medical purposes.

Cigarette, alcohol, and illicit drug use is particularly harmful during pregnancy. The use of tobacco during pregnancy has declined steadily since 1989. Based on data from 32 States and 2 reporting areas, 9.9 percent of pregnant women reported smoking during pregnancy in 2006. This rate was highest among non-Hispanic American Indian/Alaska Native women (16.9 percent) and lowest among non-Hispanic Asian/Pacific Islander women (2.0 percent).

Women's Health USA 2009 can be an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women throughout the United States.

POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were nearly 153 million females in the United States in 2007, representing slightly more than half of the population.

Examining data by demographic factors such as sex, age, and race and ethnicity can serve a number of purposes for policymakers and program planners. For instance, these comparisons can be used to tailor the development and evaluation of policies and programs serving women.

This section presents data on population characteristics that affect women's physical, social, and mental health. Some of these characteristics include the age and racial and ethnic distribution of the population, household composition, education, income, occupation, and participation in Federal programs.

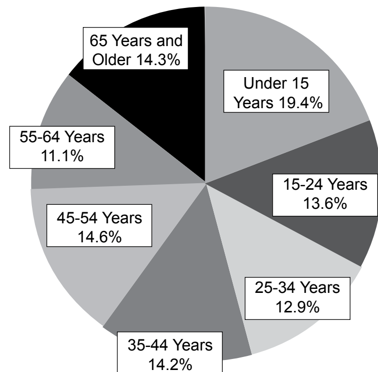
U.S. POPULATION

In 2007, the total U.S. population was nearly 302 million, with females comprising 50.7 percent of that total. Females younger than 35 years of age accounted for 45.9 percent of the female population, those aged 35–64 years accounted for 39.9 percent, and females aged 65 years and older accounted for 14.3 percent.

The distribution of the population by sex was fairly even across younger age groups; however, women accounted for a greater percentage of the older population than men. Of those aged 65 and older, 57.9 percent were women.

U.S. Female Population,* by Age, 2007

Source I.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing. Percentages do not add to 100 due to rounding.

U.S. Population,* by Age and Sex, 2007

Source I.1: U.S. Census Bureau, American Community Survey

Number in Thousands

	Female	Male
Total	152,982	148,639
Under 15 Years	29,717	31,180
15-24 Years	20,763	22,069
25-34 Years	19,680	20,307
35-44 Years	21,675	21,736
45-54 Years	22,291	21,634
55-64 Years	16,952	15,777
65 Years and Older	21,903	15,937

*Includes only non-institutionalized population not living in group housing.

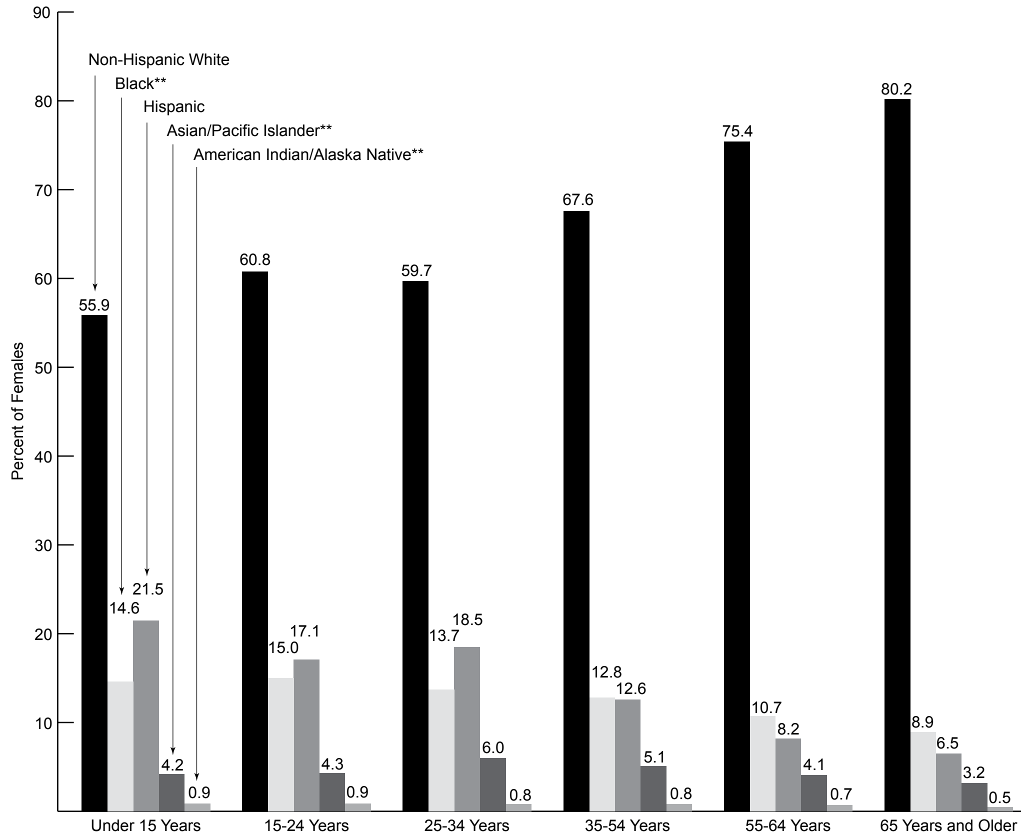
U.S. FEMALE POPULATION

The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. The younger female population (under 15 years) is significantly more diverse than the older female population. In 2007, 55.9 percent of females under 15 years were non-Hispanic White, while 21.5 percent of that group were Hispanic. In contrast, among women aged 65 years and older, 80.2 percent were non-Hispanic White and only 6.5 percent were Hispanic. The distribution of the Black population was more consistent across age groups, ranging from 14.6 percent of females under 15 years of age to 8.9 percent of women aged 65 years and older.

Evidence indicates that race and ethnicity represent important factors related to health disparities, that is, variations in rates of health conditions and chronic diseases in persons of different races and ethnicities. Coupled with the increasing diversity of the U.S. population, these health disparities make culturally-appropriate, community-driven programs critical to improving the health of the entire U.S. population.[1]

U.S. Female Population,* by Age and Race/Ethnicity, 2007

Source I.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing. Percentages do not equal 100 because data are not shown for persons of other races or more than one race. **May include Hispanics.

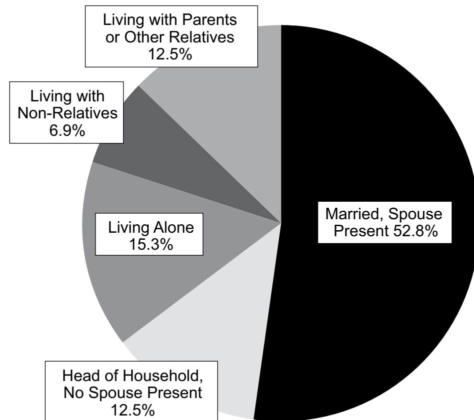
HOUSEHOLD COMPOSITION

In 2007, 52.8 percent of women aged 18 years and older were married and living with a spouse; this includes married couples living with other people, such as parents. More than 12 percent of women over age 18 were the heads of their households, meaning that they have children or other family members, but no spouse, living with them in a housing unit that they own or rent. Housing units may include houses, apartments, groups of rooms or a single room that is intended to be used as separate living quarters. Women who are heads of households include single mothers, single women with a parent or other close relative living in their home, and women with other household compositions. The remaining women lived alone (15.3 percent), with parents or other relatives (12.5 percent), or with non-relatives (6.9 percent).

Women in households with no spouse present are more likely than women in married-couple families to have incomes below poverty (see "Women and Poverty" on the next page). In 2007, non-Hispanic Black women were most likely to be single heads of households (36.1 percent), while non-Hispanic Asian/Pacific Islander women were least likely (8.0 percent). Hispanic women (19.0 percent) and non-Hispanic women of other races (25.9 percent) were also more likely than non-Hispanic White women to be heads of households (12.0 percent).

Adult Women,* by Household Composition, 2007

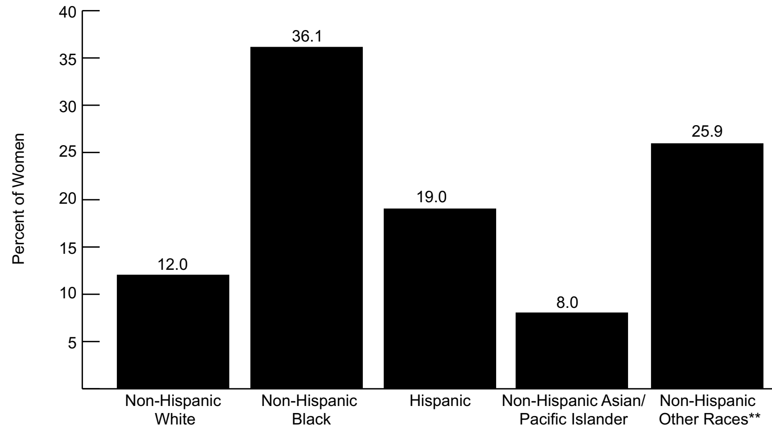
Source I.2: U.S. Census Bureau, Current Population Survey



*Civilian, non-institutionalized population aged 18 years and older.

Women Who Are Heads of Households,* by Race/Ethnicity, 2007

Source I.3: U.S. Census Bureau, Current Population Survey



*Civilian, non-institutionalized population aged 18 years and older; includes women who have children or other family members, but no spouse, living in a house that they own or rent. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of all other races.

WOMEN AND POVERTY

In 2007, nearly 37.3 million people in the United States lived with incomes below the poverty level.[2] More than 12 percent of women aged 18 years and older (14.4 million) lived in poverty, compared to 8.8 percent of men. With regard to race and ethnicity, non-Hispanic White women were least likely to experience poverty (9.0 percent), while non-Hispanic American Indian/Alaska Native women were most likely (23.4 percent), followed closely by non-Hispanic Black women (23.3 percent) and Hispanic women (20.8 percent).

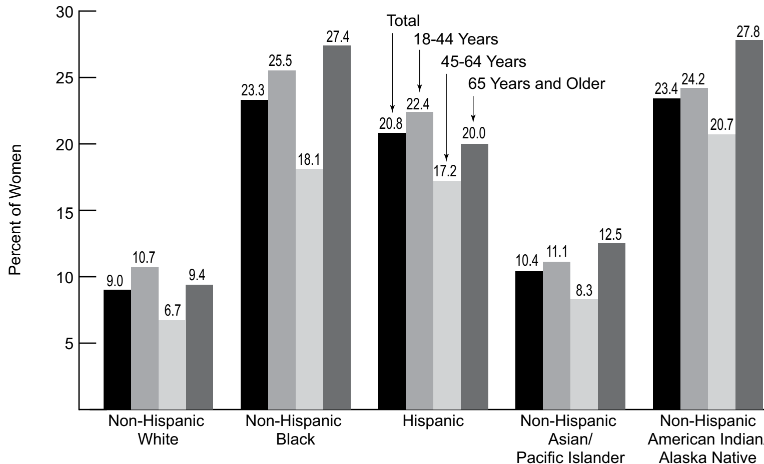
Poverty status varies with age. Among women of each race and ethnicity, those aged 45–64 years were less likely to experience poverty than those aged 18–44 and 65 years and older. For instance, 18.1 percent of non-Hispanic Black women aged 45–64 were in poverty in 2007, compared to 25.5 percent of non-Hispanic Black women aged 18–44 and 27.4 percent of those aged 65 years and older.

Women in families—a group of at least two people related by birth, marriage, or adoption and residing together—experience higher rates of poverty than men in families (9.5 versus 6.2 percent, respectively). Men in families with no spouse present were considerably less likely to have family incomes below the poverty level than women in families with no spouse present (11.8 versus 24.9 percent, respectively).

Female-headed households may also be more likely to experience homelessness than male-headed households. In a study of 16 cities, 65 percent of households with children experiencing homelessness were female-headed.[3]

Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity and Age, 2007

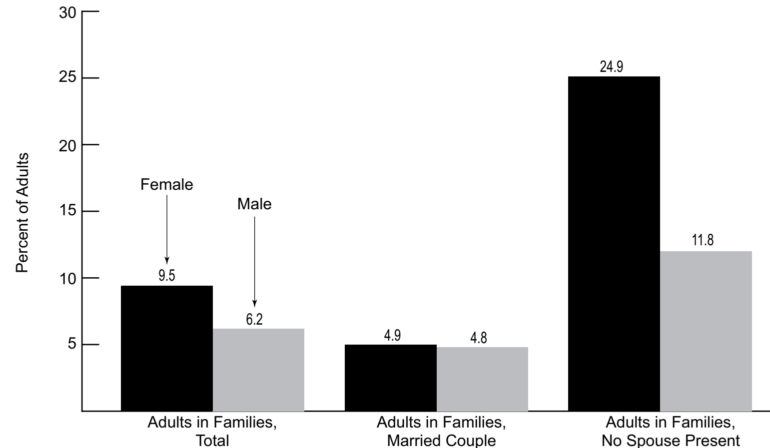
Source I.4: U.S. Census Bureau, Current Population Survey



*Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

Adults in Families* Living Below the Poverty Level,** by Household Type and Sex, 2007

Source I.4: U.S. Census Bureau, Current Population Survey



*Families are groups of at least two people related by birth, marriage, or adoption and residing together.
**Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

FOOD SECURITY

Food security is defined as having access at all times to enough nutritionally adequate and safe foods to lead a healthy, active lifestyle.[4] Food security status is assessed through a series of questions such as whether people worried that food would run out before there would be money to buy more; whether an individual or his/her family cut the size of meals or skipped meals because there was not enough money for food; and whether an individual or his/her family had ever gone a whole day without eating because there was not enough food.

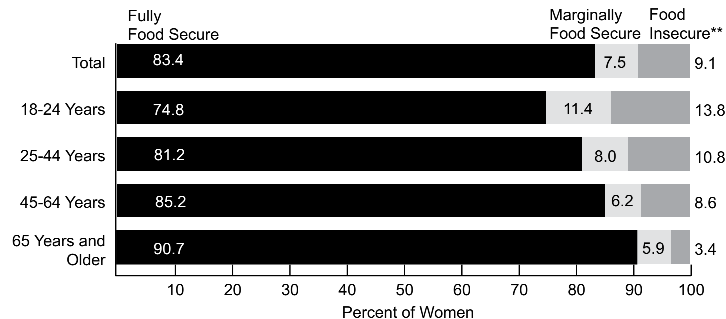
In 2007, an estimated 36.2 million people lived in households that were classified as not fully food secure.[4] Households or persons experiencing food insecurity may be categorized as experiencing low food security or very low food security (formerly referred to as "food insecurity with hunger"). Low food security generally indicates multiple food access issues, while very low food security indicates reduced food intake and disrupted eating patterns due to inadequate resources for food. Periods of low or very low food security may be occasional or episodic, placing the members of a household at greater nutritional risk due to insufficient access to nutritionally adequate and safe foods. Marginal food security indicates some problems accessing food, but not enough to qualify as food insecure.

In 2005–2006, nearly 17 percent of women lived in households that were not fully food secure, and this percentage varied by age. The proportion of women who were fully food secure increased as age increased. Women aged 65 years and older were most likely to be fully food secure (90.7 percent), while 18- to 24-year-olds were least likely (74.8 percent).

Food security status also varies by household composition. While adult men and women living alone had similar rates of food insecurity in 2007, female-headed households with no spouse present were more likely than male-headed households with no spouse present to experience food insecurity (30.2 versus 18.0 percent, respectively).

Food Security Status of Women Aged 18 and Older,* by Age, 2005–2006

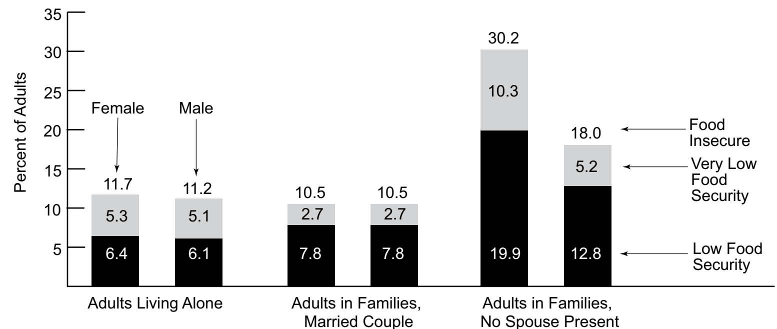
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Based on household food security status. **Includes "low" and "very low" food security.

Food Security Status Among Adults Aged 18 and Older, by Household Composition* and Sex, 2007

Source I.6: U.S. Department of Agriculture, Economic Research Service



*Percentages may not add to totals due to rounding.

WOMEN AND FEDERAL NUTRITION PROGRAMS

Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Supplemental Nutrition Assistance Program (SNAP), formerly the Federal Food Stamp Program, helps low-income individuals purchase food. In 2007, more than 13 million adults participated in SNAP; of these, nearly 9 million (67.8 percent) were women. Among participating women, nearly 4.1 million (45.7 percent) were in the 18- to 35-year-old age group.

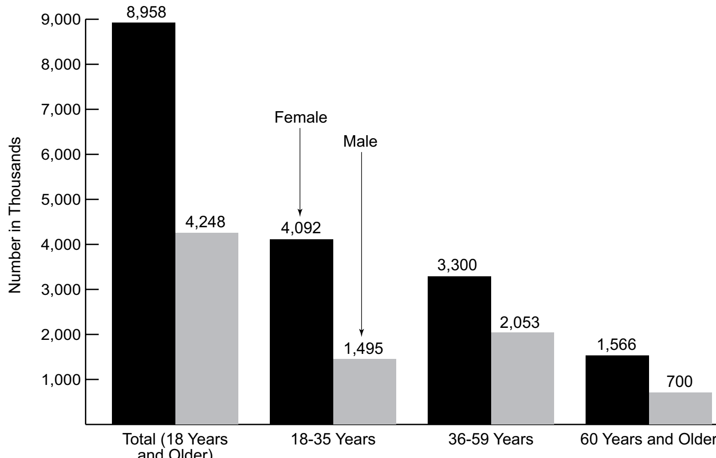
The number of people participating in SNAP increased significantly in 2008 due to the economic downturn resulting in an addition of nearly 4 million people of all ages from January through September 2008 alone.[5]

Female-headed households with children make up 30.5 percent of households that rely on food stamps, and represent nearly 60 percent of food stamp households with children (data not shown).

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) also plays an important role in serving women and families by providing supplementary nutrition during pregnancy, the postpartum period, and while breastfeeding. More than three-quarters of all WIC participants are infants and children (75.3 percent); however, the program also serves more than 2 million pregnant women and mothers, representing 24.7 percent of WIC participants in 2008. During the years 1992–2008, the number of women participating in WIC increased by 75.6 percent, and it continues to rise.

Adult Recipients of the Supplemental Nutrition Assistance Program,* by Age and Sex, 2007**

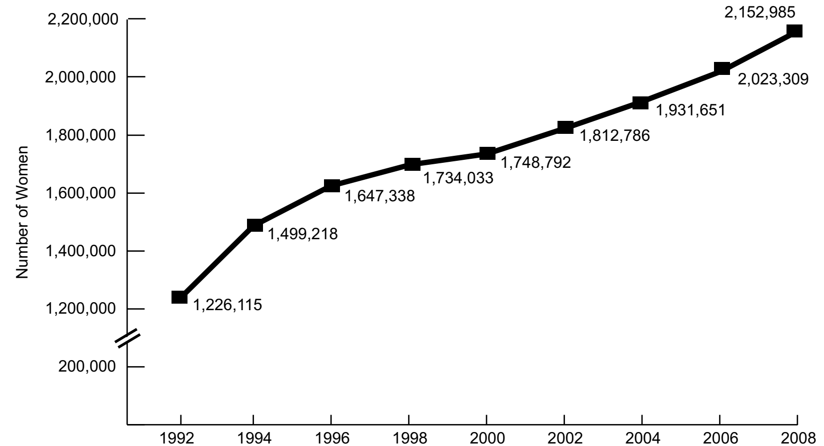
Source I.7: U.S. Department of Agriculture, Food Stamp Quality Control Sample



** Formerly the Food Stamp Program. **Based on Federal Fiscal Year (October-September).*

Women Participating in WIC,* 1992–2008**

Source I.8: U.S. Department of Agriculture, WIC Program Participation Data



**Participants are classified as women, infants, or children based on nutritional-risk status; data reported include all pregnant women and mothers regardless of age. **Based on Federal Fiscal Year (October-September).*

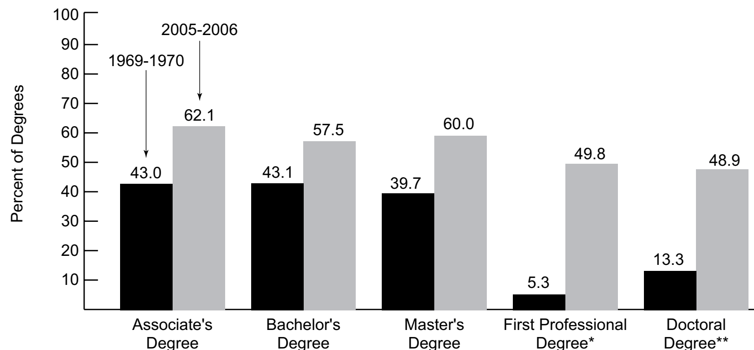
EDUCATIONAL DEGREES AND HEALTH PROFESSION SCHOOLS

The number of post-secondary educational degrees awarded to women rose from just over half a million in the 1969–1970 academic year to more than 1.7 million in 2005–2006. Although the number of degrees earned by men has also increased, the rate of growth among women has been much faster; therefore, the proportion of degrees earned by women has risen dramatically. In 1969–1970, men earned a majority of every type of post-secondary degree, while in 2005–2006, women earned more than half of all associate's, bachelor's, and master's degrees and nearly half of all first professional and doctoral degrees. The most significant increase has been in the proportion of first professional degree earners who are women, which jumped from 5.3 percent in 1969–1970 to 49.8 percent in 2005–2006. The total number of women earning their first professional degree in 2005–2006 (43,617) was 24 times greater than in 1969–1970 (1,841).

While the sex disparity in degrees awarded has decreased, a racial/ethnic disparity remains among women enrolled in schools for health professions. During the 2007–2008 academic year, non-Hispanic White women accounted for more than half of all women enrolled in schools of medicine, optometry, pharmacy, and public health, while fewer than 10 percent of women enrolled in these schools were Hispanic. Non-Hispanic Black women were also underrepresented among female students enrolled in schools of medicine, pharmacy, and optometry (9.0, 7.0, and 3.6 percent, respectively). In comparison, non-Hispanic Asian/Pacific Islander women were overrepresented relative to their representation within the population, accounting for 30.3 percent of female students of optometry, 20.3 percent of female students of medicine, and 21.3 percent of female pharmacy students.

Degrees Awarded to Women, by Type, 1969–1970 and 2005–2006

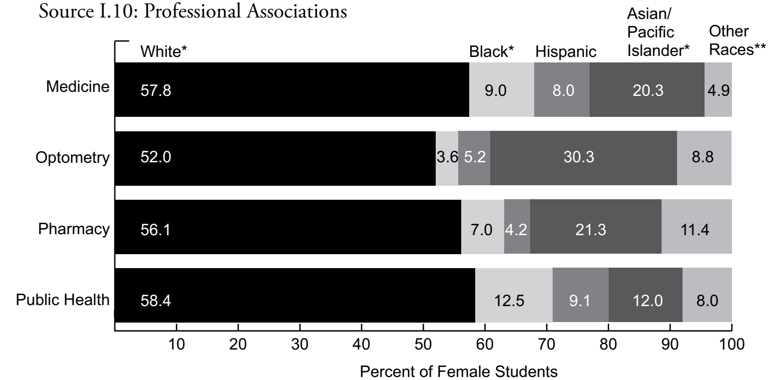
Source I.9: U.S. Department of Education, Digest of Education Statistics



*Includes fields of dentistry, medicine, optometry, osteopathic medicine, pharmacy, podiatry, veterinary medicine, chiropractic, law, and theological professions. **Includes Doctor of Philosophy degree and degrees awarded for fulfilling specialized requirements in professional fields such as education, musical arts, and engineering. Does not include first professional degrees.*

Women in Selected Schools for Health Professions, by Race/Ethnicity, 2007–2008

Source I.10: Professional Associations



*Non-Hispanic. **Includes non-Hispanic American Indian/Alaska Natives, persons of other races not specified, foreign students, and students whose race is unknown; medical school enrollment data do not include foreign students.*

WOMEN IN THE LABOR FORCE

In 2007, 58.6 percent of women aged 16 and older were in the labor force (either employed or not employed and actively seeking employment). This represents a 35 percent increase from the 43.3 percent of women who were in the labor force in 1970.[6] In 2007, females accounted for 46.6 percent of workers, while males accounted for 53.4 percent (data not shown).

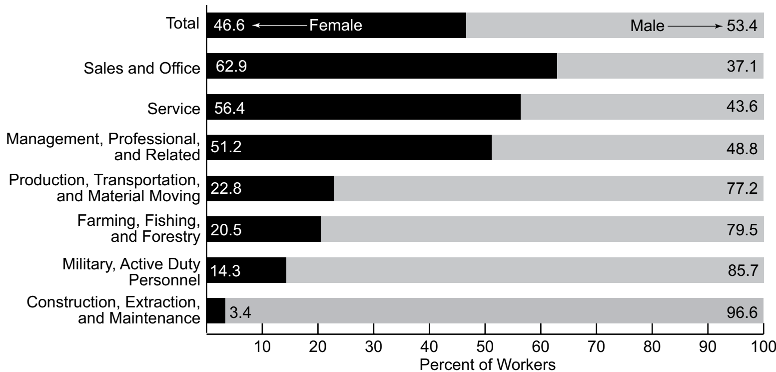
The representation of females in the labor force varies greatly by occupational sector. In 2007, women accounted for 62.9 percent of sales and office workers, but only 3.4 percent of construction, extraction, and maintenance workers. Other positions which were more commonly held by women than men included service jobs (56.4 percent) and management, professional, and related jobs (51.2 percent). Women were the minority in production, transportation, and material moving (22.8 percent); farming, fishing, and forestry (20.5 percent); and in the military (14.3 percent). In 2007, a total of 200,337 women were on active duty in the armed services.

Overall, in 2007 there was a large discrepancy between the annual median earnings of women and men working full-time ($34,103 versus $44,250, respectively), and this discrepancy existed within each occupational sector. Men's median earnings were approximately 40 percent higher than women's in management and professional; service; and production, transportation, and material moving occupations. The smallest disparity was evident in the construction, extraction, and maintenance occupational sector: men's median earnings were only 7.4 percent higher than women's.

The percentage of women working full-time has steadily increased in recent years. In 2007, 75.3 percent of employed women were working full-time, compared to 74.4 percent in 2003 (data not shown).[7]

Workforce Representation, by Occupational Sector and Sex, 2007

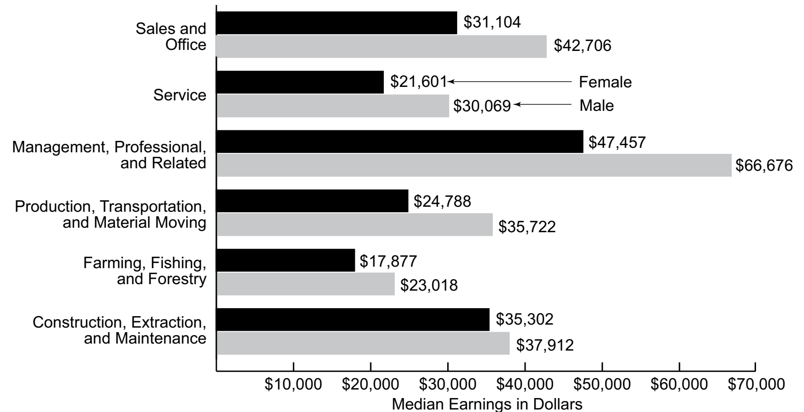
Sources I.1, I.11: U.S. Census Bureau, American Community Survey; U.S. Department of Defense*



*Military enlistment data are from the U.S. Department of Defense; all other from the U.S. Census Bureau.

Median Earnings,* by Occupational Sector and Sex, 2007

Source I.1: U.S. Census Bureau, American Community Survey



*In 2007 inflation-adjusted dollars for full-time, year-round, civilian employed population 16 years and over.

WOMEN VETERANS

As of September 2008, nearly 1.8 million living women veterans had served in the military on behalf of the United States. This number is projected to rise to 1.9 million by 2013. The percentage of veterans who are female has increased by more than 25 percent in recent years. In 2000, 6.1 percent of all living veterans were women, while women accounted for 7.7 percent of living veterans in 2008. Women are expected to account for 8.8 percent of the veteran population by 2013.

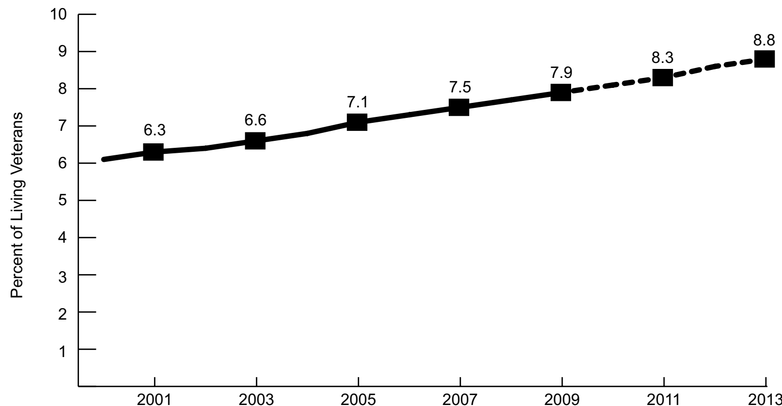
Female veterans are eligible for the same Department of Veterans Affairs (VA) benefits as male veterans. Comprehensive health services are available to all women veterans including primary care, gynecology and maternity care, mental health care, and specialty health care services. Full-time Women Veterans Program Managers are available at all VA facilities to help women veterans seeking treatment and benefits. For more information, visit http://www.va.gov/womenshealth/.

Of the 7.8 million veterans who are enrolled in the VA for health care, women account for more than 500,000 enrollees. The proportion of VA enrollees who are women is expected to increase to 1 in 7 over the next 10 years. The majority of new female veterans—from Operations Enduring Freedom and Iraqi Freedom (OEF/OIF)—are more likely to obtain their health care from VA facilities than previous female veterans.

Women are changing the landscape of care in the VA and not by their numbers alone. Women veterans of OEF/OIF are younger than women veterans of the past; more than three-quarters of OEF/OIF women veterans who are enrolled in VA health care are between 20 and 40 years old (i.e., of child-bearing age). These women are likely to be balancing work, motherhood, and transition to civilian life and will rely on the VA to provide high-quality, age-appropriate, and woman-specific care.

Living Women Veteran Population, 2003–2013*

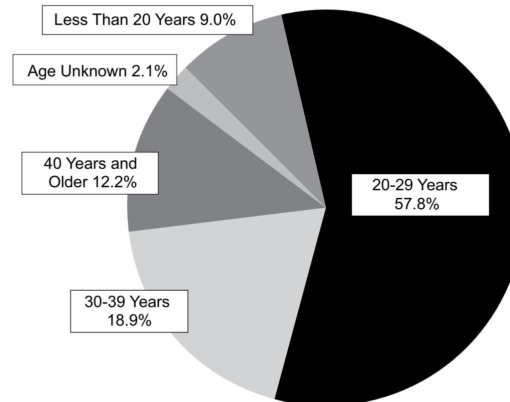
Source I.12: Department of Veteran Affairs, Office of Policy and Planning



*Historical data from 2000-2008; projected for 2009-2013

Women Veterans of Operations Enduring Freedom and Iraqi Freedom, by Age, 2002–2008

Source I.13: Department of Veteran Affairs, Office of Public Health and Environmental Hazards



HEALTH STATUS

Analysis of women's health status enables health professionals and policymakers to determine the impact of past and current health interventions and the need for new programs. Trends in health status help to identify new issues as they emerge.

In this section, health status indicators related to morbidity, mortality, health behaviors, and maternal health are presented. New topics include bleeding disorders and hearing problems, as well as severe headaches and migraines. In addition, a new section provides State-by-State data on the leading causes of death, smoking, and obesity among women. The data throughout this section are displayed by sex, age, race and ethnicity, and income, where feasible.

PHYSICAL ACTIVITY

Regular physical activity promotes health, psychological well-being, and a healthy body weight; enhances independent living; and improves one's quality of life. The 2008 Physical Activity Guidelines for Americans states that for substantial health benefits, women should engage in at least 2½ hours per week of moderate-intensity or 1¼ hours per week of vigorous-intensity aerobic physical activity, or an equivalent combination of both. Additional health benefits are gained by engaging in physical activity beyond this amount.[1] Prior to these guidelines, the *Dietary Guidelines for Americans, 2005,* recommended that adults engage in at least 30 minutes of moderate-intensity physical activity, above usual activity at work or home on most, or preferably all, days of the week.[2]

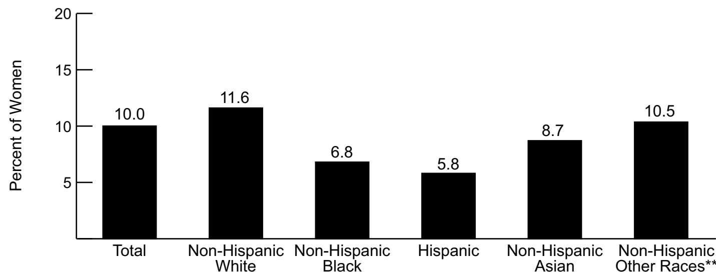
In 2007, only 10.0 percent of women reported participating in adequate physical activity (defined as engaging in physical activity of moderate intensity for at least 30 minutes per day on a minimum of 5 days per week or vigorous-intensity activity for at least 20 minutes per day for a minimum of 3 days per week). The percentage of women reporting regular physical activity varied by race/ethnicity, age, and income.

In 2007, non-Hispanic White women were more likely than women of other races and ethnicities to report adequate physical activity (11.6 percent). Hispanic women were least likely to report adequate physical activity (5.8 percent).

Among women in all income groups, rates of adequate physical activity peak during the ages of 25–44 years and decline as women grow older. In addition, among women aged 25 years and older, those with higher incomes are more likely to engage in adequate physical activity than those with lower incomes. In 2007, the women most likely to do so were those aged 25–44 years with incomes of 200 percent or more of poverty (17.4 percent), compared to 13.8 percent of women in the same age group with incomes of 100–199 percent of poverty and 11.4 percent of those with incomes less than 100 percent of poverty.

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Race/Ethnicity, 2007

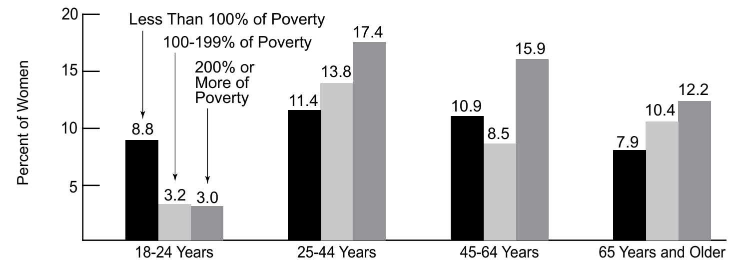
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Adequate physical activity is defined as 30 minutes per day or more of moderate-intensity activity on 5 or more days per week or 20 minutes per day of vigorous-intensity activity on 3 or more days per week.
**Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Age and Poverty Status,** 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Adequate physical activity is defined as 30 minutes per day or more of moderate-intensity activity on 5 or more days per week or 20 minutes per day of vigorous-intensity activity on 3 or more days per week.
**Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

NUTRITION

The *Dietary Guidelines for Americans, 2005* recommends eating a variety of nutrient-dense foods while not exceeding caloric needs. For most people, this means eating a daily assortment of fruits and vegetables, whole grains, lean meats and beans, and low-fat or fat-free milk products while limiting added sugar, sodium, saturated and *trans* fats, and cholesterol.[2]

Fats that come from sources of polyunsaturated or monounsaturated fatty acids, such as fish, nuts, and vegetable oils, are an important part of a healthy diet. However, high intake of saturated fats, *trans* fats, and cholesterol may increase the risk of coronary heart disease. Most Americans should consume fewer than 10 percent of calories from saturated fats, less than 300 mg/day of cholesterol, and keep *trans* fatty acid consumption to a minimum. In 2005–2006, 63.0 percent of women exceeded the recommended maximum daily intake of saturated fat—particularly non-Hispanic White and non-Hispanic Black women (65.7 and 59.4 percent, respectively).

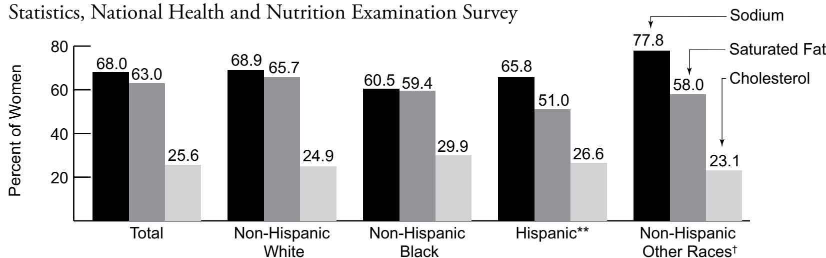
Salt also plays an important role in heart health, as high salt intake can contribute to high blood pressure. In 2005–2006, 68.0 percent of women exceeded the recommended maximum intake of less than 2,300 mg/day of sodium, or about 1 teaspoon of salt.

Inadequate calcium consumption can lead to lower bone density, bone loss, and increased risk of osteoporosis. The recommended Adequate Intake (AI) for calcium is 1,000 mg/day for women aged 19–50 and 1,200 mg/day for women aged 51 years and older. In 2005–2006, fewer than one-quarter of women met or exceeded the recommended AI for calcium.

Folate is also an important part of a healthy diet, especially among women of childbearing age, since it can help reduce the risk of neural tube defects early in pregnancy. In 2005–2006, only 32.8 percent of women consumed the Recommended Dietary Allowance (RDA) for folate (400 mcg/day). Fewer than one-quarter of non-Hispanic Black women consumed the RDA for folate, compared to slightly more than one-third of non-Hispanic White and Hispanic women.

Women Exceeding the Recommended Daily Intake of Sodium, Saturated Fat, and Cholesterol* by Race/Ethnicity, 2005–2006

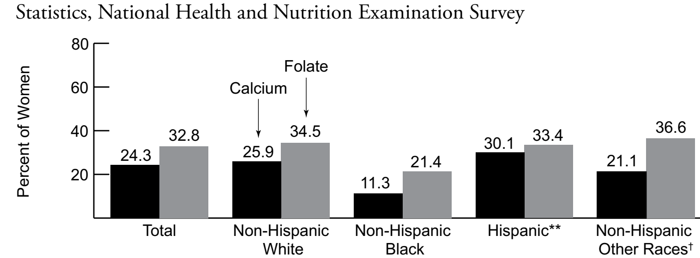
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Maximum recommended daily intake of sodium is less than 2300 mg/day; recommended intake of saturated fat is 10 percent of daily caloric intake or less; recommended daily intake of cholesterol is less than 300 mg/day. **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. †Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of other races.

Women Meeting the Recommended Daily Intake of Calcium and Folate,* by Race/Ethnicity, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Adequate Intake (AI) for calcium is 1,000 mg/day for women aged 19–50 and 1,200 mg/day for women aged 50 years and older; Recommended Dietary Allowance (RDA) for folate intake is 400 mcg/day. **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. †Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of other races.

ALCOHOL USE

According to the Centers for Disease Control and Prevention (CDC), alcohol is a central nervous system depressant that, in small amounts, can have a relaxing effect. Although there is some debate over the health benefits of small amounts of alcohol consumed regularly, the negative health effects of excessive alcohol use and abuse are well established.[3] Short-term effects can include increased risk of motor vehicle injuries, falls, intimate partner violence, and child abuse. Long-term effects can include pancreatitis, high blood pressure, liver cirrhosis, various cancers, and psychological disorders, including alcohol dependency. In 2007, 39.6 percent of women aged 18 years and older were current drinkers (had at least one alcoholic drink in the past year; data not shown).

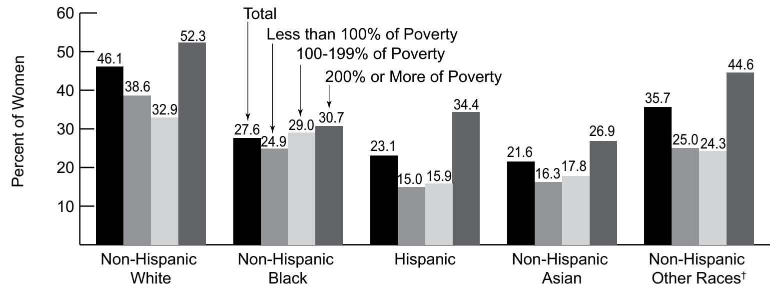
Non-Hispanic White women were most likely to be current drinkers (46.1 percent), followed by non-Hispanic women of other races (35.7 percent) and non-Hispanic Black women (27.6 percent). Women with higher household incomes were more likely than women with lower incomes to be current drinkers, and this was true for every racial and ethnic group. For instance, 34.4 percent of Hispanic women with incomes of 200 percent or more of poverty were current drinkers, compared to 15.0 percent of those with incomes below 100 percent of poverty.

Among current drinkers, the level of alcohol consumption varies by sex. In 2007, women were more likely than men to have consumed alcohol infrequently (1–11 drinks in the past year) or to have engaged in light alcohol consumption (3 or fewer drinks per week). More than half of women who drank in the past year were considered light drinkers (50.8 percent), compared to 45.2 percent of men. Men, however, were much more likely than women to be moderate drinkers (between 4 and 7 drinks for women or between 4 and 14 drinks for men): 32.0 percent of men and 13.4 percent of women were moderate drinkers.

The average number of drinks consumed by current drinkers in the past year also varied by sex. On average, men consumed more drinks on days when they drank at all than women (3.0 versus 2.0 drinks, respectively; data not shown).

Current Drinking* Among Women Aged 18 and Older, by Race/Ethnicity and Poverty Status,** 2007

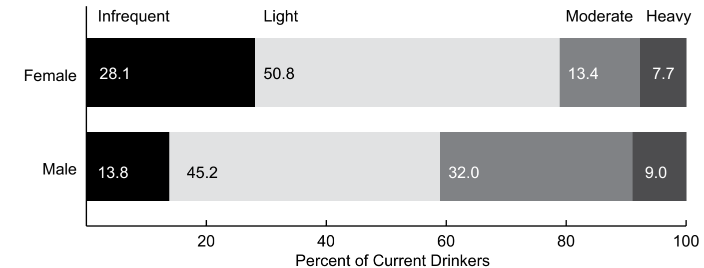
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Had at least one drink in the past year. **Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007. †Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

Level of Alcohol Consumption* Among Current Drinkers Aged 18 and Older, by Sex, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Infrequent drinking indicates 1-11 drinks consumed in the past year; light drinking indicates 3 or fewer drinks per week in the past year; moderate indicates 3 to 7 (females) or 14 (males) drinks per week; heavy indicates more than 7 (females) or 14 (males) drinks per week.

CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body. Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impairs genes that control the growth of cells, and binds to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[4]

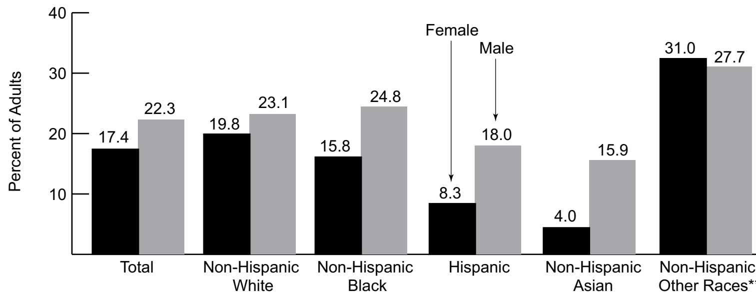
In 2007, 19.8 percent of adults aged 18 and older smoked cigarettes some days or every day. Current cigarette smoking varied by sex and race/ethnicity. Men were more likely to smoke cigarettes than women overall (22.3 versus 17.4 percent, respectively), and in most racial and ethnic groups. Among women, non-Hispanic women of other races were most likely to be current cigarette smokers (31.0 percent), followed by non-Hispanic White women (19.8 percent). Non-Hispanic Asian women were least likely to smoke cigarettes (4.0 percent).

The likelihood of being a current cigarette smoker declines as a person's level of education increases. In 2006, women aged 25 years and older with less than a high school diploma were most likely to smoke cigarettes (26.0 percent), while only 7.2 percent of those with a college degree or higher did so. Cigarette smoking among women of every education level has declined in the past decade.

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[4] In 2007, more than 44 percent of current female smokers aged 18 and older reported trying to quit at least once in the past year; however, this varied by age. Women aged 18–44 were most likely to have attempted quitting smoking (48.6 percent), followed by women aged 45–64 years (41.3 percent). Fewer than 30 percent of female cigarette smokers aged 65 years and older attempted to do so (data not shown).

Current Cigarette Smoking Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2007

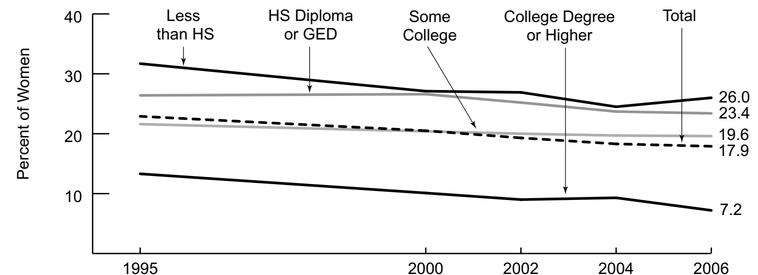
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Estimates are not age-adjusted. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

Current Cigarette Smoking Among Women Aged 25 and Older, by Education Level, 1995–2006*

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Estimates are age-adjusted.

ILLICIT DRUG USE

Illicit drug use is associated with serious health and social consequences, such as impaired cognitive functioning, kidney and liver damage, drug addiction, and decreased worker productivity.[5] Illicit drugs include marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes. In 2007, nearly 12.6 million women aged 18 years and older reported using an illicit drug within the past year, representing 10.9 percent of this population. In comparison, 18.4 million men, representing 17.1 percent of the adult male population, used at least one illicit drug in the past year (data not shown). Past-year illicit drug use was highest among females aged 18–25 years (29.1 percent), followed by females aged 12–17 years (18.0 percent); past-year use was lowest among women aged 26 years and older (7.9 percent).

Use of all drug types, except inhalants, was highest among females aged 18–25 years, with 23.1 percent reporting past-year marijuana use and 13.7 percent reporting non-medical use of prescription-type psychotherapeutic drugs. Use of inhalants in the past year was highest among females aged 12–17 (4.0 percent), compared to 0.9 percent of those aged 18–25 and 0.1 percent of those aged 26 years and older.

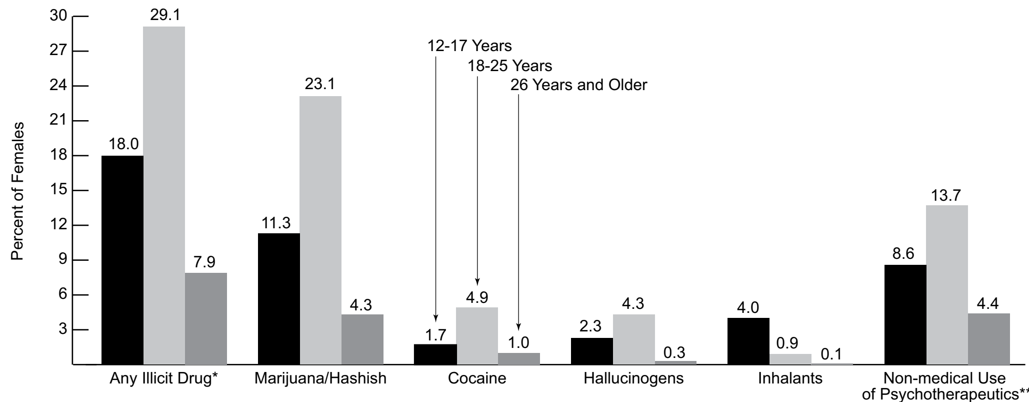
Marijuana was the most commonly used illicit drug among females aged 12–17 and 18–25 years, and was the second most commonly used drug among women 26 years and older. Short-term effects of marijuana use can include difficulty thinking and solving problems, memory and learning problems, and distorted perception.

Non-medical use of psychotherapeutics was the most commonly used drug among women aged 26 years and older and was the second most commonly used drug among younger females. Prescription drugs commonly used or abused for non-medical purposes include opioids, central nervous system depressants, and stimulants. Long-term use of these drugs can lead to physical dependence and addiction. In addition, when taken in large doses, stimulant use can lead to compulsivity, paranoia, dangerously high body temperature, and an irregular heartbeat.[5]

The percentage of women reporting non-medical use of psychotherapeutics varied by race and ethnicity. Among women aged 18 and older, American Indian/Alaska Natives were most likely to report the use of psychotherapeutics in the past year (8.5 percent), followed by non-Hispanic women of multiple races (7.6 percent), and non-Hispanic White women (6.1 percent). Slightly more than 4 percent of non-Hispanic Black women and 5.0 percent of Hispanic women also reported non-medical use of psychotherapeutics.

Past Year Use of Illicit Drugs Among Females, by Age and Drug Type, 2007

Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes. **Includes prescription-type pain relievers, tranquilizers, stimulants, and sedatives, but not over-the-counter drugs.*

SELF-REPORTED HEALTH STATUS

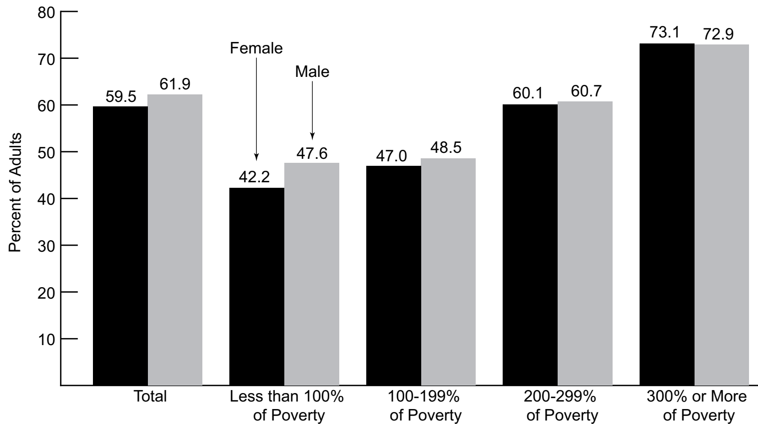
In 2007, men were slightly more likely than women to report being in excellent or very good health (61.9 versus 59.5 percent, respectively). Among both sexes, self-reported health status improves with income. Women and men with incomes less than 100 percent of poverty were least likely to report excellent or very good health (42.2 and 47.6 percent, respectively), compared to about 60 percent of men and women with incomes of 200–299 percent of poverty and 73 percent of those with incomes of 300 percent or more of poverty.

Self-reported health status declines with increasing age: 70.3 percent of women aged 18–44 years reported excellent or very good health, compared to 55.6 percent of those aged 45–64 years, 42.8 percent of those aged 65–74 years, and 32.8 percent of those aged 75 years and older. Among women in the oldest age group, 30.9 percent reported fair or poor health, compared to only 6.5 percent of those in the youngest age group.

The rate of women reporting excellent or very good health also varies with race and ethnicity. Non-Hispanic Asian women were most likely to report excellent or very good health (64.0 percent), compared to 53.1 percent of Hispanic and 51.0 percent of non-Hispanic Black women. More than 62 percent of non-Hispanic White women reported being in excellent or very good health (data not shown).

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Sex and Poverty Status,* 2007

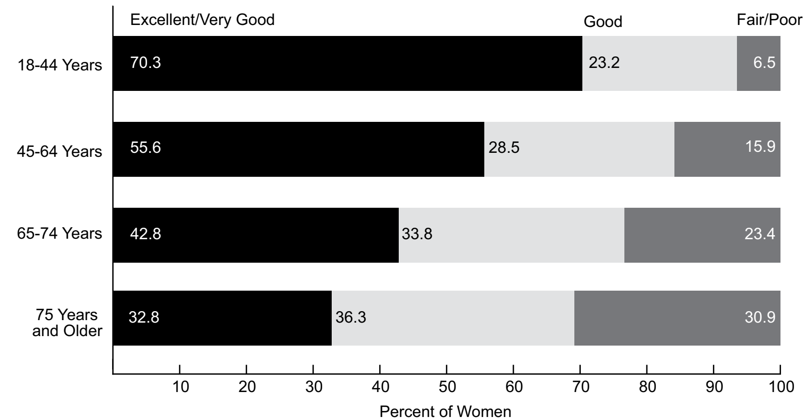
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Poverty, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

Self-Reported Health Status of Women Aged 18 and Older, by Age, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



LIFE EXPECTANCY

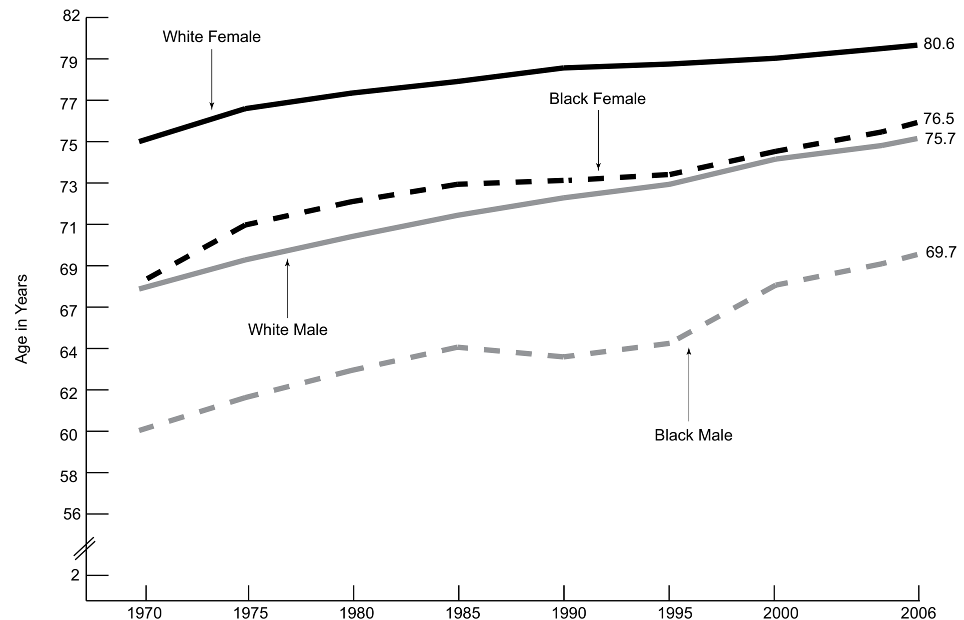
The overall life expectancy of a baby born in 2006 was 77.7 years (data not shown); this varied, however, by age, sex, and race/ethnicity. A baby girl born in the United States in 2006 could expect to live 80.2 years, 5.1 years longer than a male baby, whose life expectancy would be 75.1 years (data not shown). The differential between male and female life expectancy was greater among Blacks than Whites. Black males could expect to live 69.7 years, 6.8 years fewer than Black females (76.5 years). The difference between White males and females was 4.9 years, with a life expectancy at birth for White females of 80.6 years and 75.7 years for White males. White females could expect to live 4.1 years longer than Black females. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates.

Life expectancy has steadily increased since 1970 for males and females in both racial groups. Between 1970 and 2006, White males' life expectancy increased from 68.0 to 75.7 years (11.3 percent), while White females' life expectancy increased from 75.6 to 80.6 years (6.6 percent). During the same period, the life expectancy for Black males increased from 60.0 to 69.7 years (16.2 percent), while life expectancy increased from 68.3 to 76.5 years (11.7 percent) for Black females.

Life expectancy data have not been uniformly calculated and reported for the Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native populations. According to the most recent estimates available, an American Indian/Alaska Native born in 1999–2001 could expect to live 74.5 years; this represents a 17.1 percent increase over the life expectancy in 1972–1974 (63.6 years).[6] The U.S. Census Bureau estimated that Hispanics born in 1999 would have a life expectancy of 83.7 years for females and 77.2 years for males. Asian males born in 1999 had a life expectancy of 80.9 years, while life expectancy for Asian females born in that year was 86.5 years (data not shown).[7]

Life Expectancy at Birth, by Race* and Sex, 1970–2006

Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics



*Both racial categories include Hispanics.

LEADING CAUSES OF DEATH

In 2006, there were 1,224,322 deaths of females in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), responsible for 25.8 and 22.0 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 6.7 percent of deaths, and chronic lower respiratory disease, which accounted for 5.3 percent. Among females aged 1–34 years of age, unintentional injury was the leading cause of death (data not shown).

Heart disease was the leading cause of death for women in most racial and ethnic groups; the exceptions were non-Hispanic Asian/Pacific Islander and non-Hispanic American Indian/Alaska Native females, for whom the leading cause of death was cancer. One of the most noticeable differences in leading causes of death by race and ethnicity is that diabetes mellitus was the eighth leading cause of death among non-Hispanic White females, while it was the fourth among all other racial and ethnic groups. Similarly, chronic lower respiratory disease was the fourth leading cause of death among non-Hispanic White females while it ranked sixth or seventh among other racial and ethnic groups. Death in the perinatal period was the ninth leading cause of death among Hispanic females, accounting for 2.1 percent of deaths, and hypertension was the tenth leading cause among non-Hispanic Asian/Pacific Islander females, accounting for 1.6 percent of deaths (data not shown). Also noteworthy is that non-Hispanic American Indian/Alaska Native females experienced a higher proportion of deaths due to unintentional injury (8.2 percent) and liver disease (4.1 percent; seventh leading cause of death) than females of other racial and ethnic groups.

Ten Leading Causes of Death Among Females (All Ages), by Race/Ethnicity, 2006

Source II.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian/Pacific Islander	Non-Hispanic American Indian/ Alaska Native
Cause of Death	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**
Heart Disease	25.8 **(1)**	26.1 **(1)**	25.5 **(1)**	22.8 **(1)**	22.7 **(2)**	18.8 **(2)**
Malignant Neoplasms (cancer)	22.0 **(2)**	22.0 **(2)**	21.6 **(2)**	21.7 **(2)**	27.3 **(1)**	19.3 **(1)**
Cerebrovascular Diseases (stroke)	6.7 **(3)**	6.7 **(3)**	6.8 **(3)**	6.4 **(3)**	9.4 **(3)**	4.8 **(5)**
Chronic Lower Respiratory Disease	5.3 **(4)**	5.9 **(4)**	2.5 **(7)**	2.7 **(6)**	2.4 **(7)**	4.3 **(6)**
Alzheimer's Disease	4.2 **(5)**	4.6 **(5)**	2.3 **(9)**	2.7 **(7)**	2.2 **(8)**	N/A
Unintentional Injury	3.5 **(6)**	3.4 **(6)**	3.0 **(6)**	5.0 **(5)**	3.8 **(5)**	8.2 **(3)**
Diabetes Mellitus	3.0 **(7)**	2.5 **(8)**	5.0 **(4)**	5.4 **(4)**	3.8 **(4)**	7.1 **(4)**
Influenza and Pneumonia	2.5 **(8)**	2.6 **(7)**	2.0 **(10)**	2.6 **(8)**	2.9 **(6)**	2.1 **(9)**
Nephritis (kidney inflammation)	1.9 **(9)**	1.7 **(9)**	3.3 **(5)**	2.2 **(9)**	2.0 **(9)**	2.3 **(8)**
Septicemia (blood poisoning)	1.5 **(10)**	1.4 **(10)**	2.4 **(8)**	N/A	N/A	1.7 **(10)**

N/A = not in the top 10 leading causes of death for this racial/ethnic group.

ACTIVITY LIMITATIONS AND DISABILITIES

Although disability may be defined in many different ways, one common guideline is whether a person is able to perform common activities—such as walking up stairs, standing or sitting for several hours at a time, grasping small objects, or carrying items such as groceries—without assistance. In 2007, nearly 14.4 percent of adults reported having at least one condition that limited their ability to perform one or more of these common activities (data not shown). Women were more likely than men to report being limited in their activities (15.6 versus 13.0 percent, respectively).

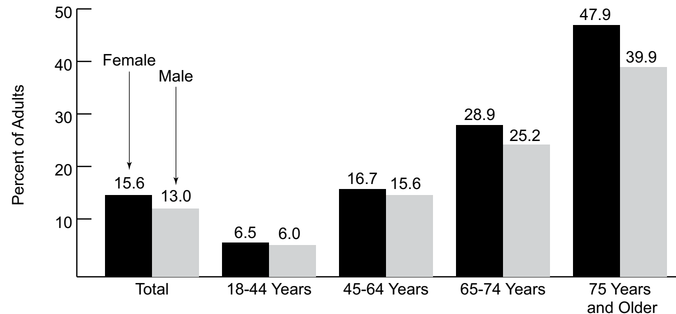
The percentage of adults reporting at least one activity limitation varied with age among both men and women. Only 6.5 percent of women aged 18–44 years reported any activity limitation, compared to 28.9 percent of women aged 65–74 years and 47.9 percent of women aged 75 years or older.

In 2007, the percentage of women reporting at least one activity limitation varied by race and ethnicity. Non-Hispanic Black women were most likely to report at least one limitation (18.4 percent), followed by non-Hispanic White women (16.5 percent). Asian women were least likely to report any activity limitation (7.1 percent). More than 10 percent of Hispanic women also reported an activity limitation (data not shown).

Among women with any activity limitations, the causes of these limitations also varied by race and ethnicity. For instance, 30.1 percent of non-Hispanic Black women who were limited in some way cited arthritis or rheumatism as the condition limiting their activity, compared to 26.5 percent of non-Hispanic White and 25.5 percent of Hispanic women. Depression, anxiety, and emotional problems were the cause of activity limitation among 16.8 percent of Hispanic women, 12.4 percent of non-Hispanic White and 9.7 percent of non-Hispanic Black women.

Adults Aged 18 and Older with at Least One Activity Limitation,* by Age and Sex, 2007

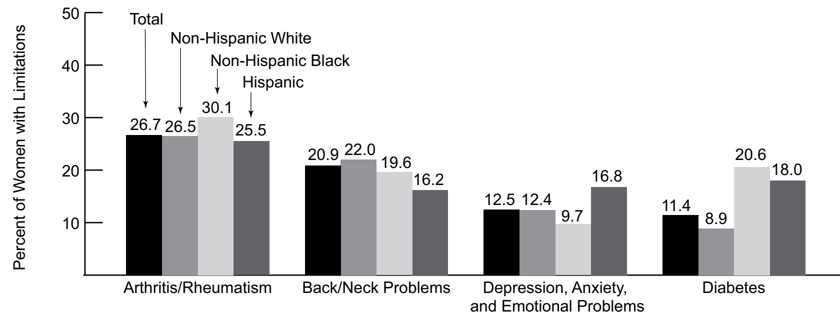
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as conditions that cause difficulty performing certain physical, leisure, and social activities.

Women Aged 18 and Older with Activity Limitations,* by Selected Condition and Race/Ethnicity,** 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as conditions that cause difficulty performing certain physical, leisure, and social activities.
**The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other or unspecified races was too small to produce reliable results.

ARTHRITIS

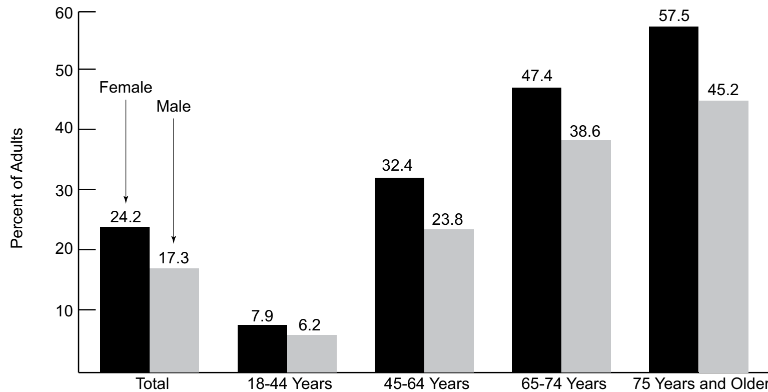
Arthritis, the leading cause of disability among Americans over 15 years of age, comprises more than 100 different diseases that affect areas in or around the joints. Arthritis is the second most common cause of work disability and restricts daily activities such as walking, dressing, and bathing for more than seven million Americans.[8] The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement due to deterioration in the cartilage covering the ends of bones in the joints. Types of arthritis that primarily affect women include lupus arthritis, fibromyalgia, and rheumatoid arthritis, which is the most serious and disabling type of arthritis.[8]

In 2007, nearly 21 percent of adults in the United States reported that they had ever been diagnosed with arthritis; this represents more than 46 million adults (data not shown). Arthritis was more common among women than men (24.2 versus 17.3 percent, respectively), and rates of arthritis increased dramatically with age for both sexes. Fewer than 8 percent of women aged 18–44 years had been diagnosed with arthritis, compared to 47.4 percent of women aged 65–74 years, and 57.5 percent of women aged 75 years and older.

In 2007, the rate of arthritis among women varied by race and ethnicity. Arthritis was most common among non-Hispanic White women (27.2 percent), followed by non-Hispanic women of other races (23.2 percent) and non-Hispanic Black women (22.2 percent). Non-Hispanic Asian and Hispanic women were least likely to report having ever been told that they have arthritis (8.9 and 15.4 percent, respectively).

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2007

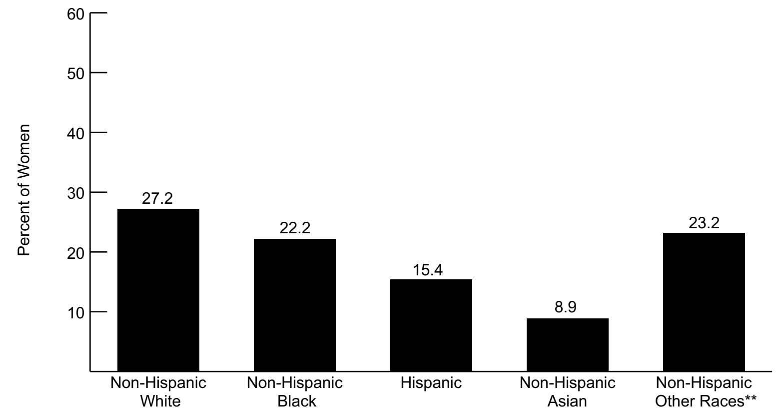
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have arthritis.

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have arthritis. Rates reported are not age-adjusted.
**Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.

ASTHMA

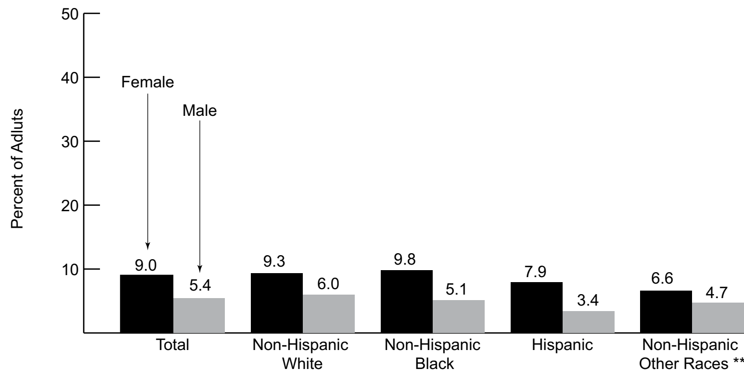
Asthma is a chronic inflammatory disorder of the airways characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. However, by taking certain precautions, persons with asthma may be able to effectively manage this disorder and participate in daily activities.

In 2007, women were more likely to have asthma than men (9.0 versus 5.4 percent, respectively); this was true in every racial and ethnic group. Among women, non-Hispanic Black women were most likely to have asthma (9.8 percent), followed by non-Hispanic White women (9.3 percent). Non-Hispanic women of other races and Hispanic women were least likely to have asthma (6.6 and 7.9 percent, respectively).

A visit to the emergency room due to asthma may be an indication that the asthma is not effectively controlled or treated. In 2007, asthmatic women with family incomes below poverty were more likely than women with higher family incomes to have an emergency room visit due to asthma. Among women with family incomes less than 100 percent of poverty, 32.4 percent of those with asthma had visited the emergency room in the past year, compared to 14.5 percent of asthmatic women with family incomes of 300 percent or more of poverty. Consistent access to and use of medication can reduce the use of hospital and emergency room care for people with asthma.[9]

Adults Aged 18 and Older with Asthma,* by Race/Ethnicity and Sex, 2007

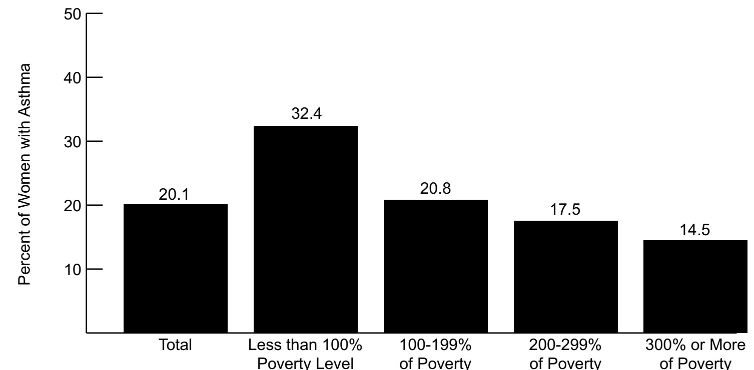
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Reported that (1) a health professional has ever told them that they have asthma, and (2) they still have asthma. Rates reported are not age-adjusted. **Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

Women Aged 18 and Older with an Emergency Room Visit Due to Asthma in the Past Year, by Poverty Status,* 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.*

BLEEDING DISORDERS

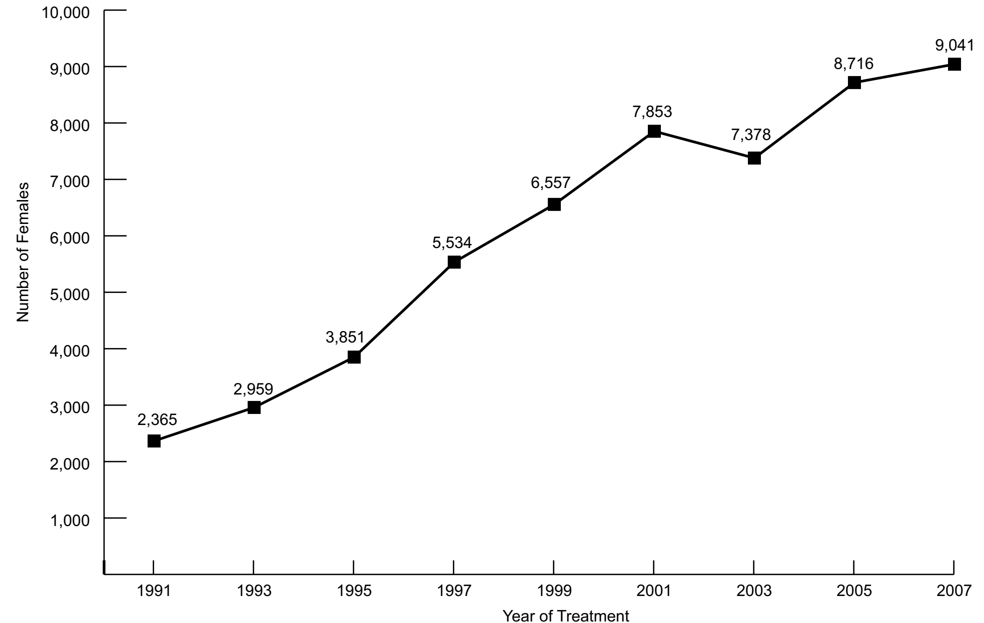
Bleeding disorders occur when components in the blood, called "factors," are missing or do not work correctly. This hinders blood clotting and makes it harder for the body to stop bleeding. One widely recognized bleeding disorder, hemophilia, sometimes occurs in females; more often, however, females carry the gene that causes the disorder. The most common bleeding disorder among females is von Willebrand Disease (VWD). Up to 3 million Americans, half of whom are female, have VWD. Typical symptoms of VWD and other bleeding disorders for females include heavy menstrual periods, easy bruising, frequent nosebleeds, and prolonged bleeding after minor injuries, surgery, childbirth, or dental work. Of the approximately 12 percent of menstruating girls and women who have heavy menstrual bleeding (menorrhagia),[10] 13 percent may have an inherited bleeding disorder.[11] Unfortunately, most of these disorders go undiagnosed.

The U.S. Department of Health and Human Service's National Institutes of Health recently published guidelines about diagnosing, evaluating, and treating VWD. Diagnosing a bleeding disorder requires taking a personal medical history, a family medical history, and conducting special laboratory tests. Fortunately, many of these disorders can be treated, allowing affected women to live a normal life. The guidelines can be found at www.nhlbi.nih.gov/guidelines/vwd/.

Experts in diagnosing and treating bleeding disorders can be found throughout the United States and its jurisdictions at more than 130 federally-funded hemophilia treatment centers (HTC). HTC treat a wide range of bleeding disorders, primarily inherited bleeding and clotting disorders. From 1991 to 2007, the number of female HTC patients grew nearly 300 percent, from 2,365 to 9,041. To locate an HTC, visit http://www.cdc.gov/ncbddd/hbd/htc_list.htm. For more information about bleeding disorders, call the National Hemophilia Foundation at 1-800-42-HANDI or visit www.hemophilia.org.

Females Treated for Bleeding Disorders at Hemophilia Treatment Centers, 1991–2007

Source II.6: Centers for Disease Control and Prevention and Health Resources and Services Administration



CANCER

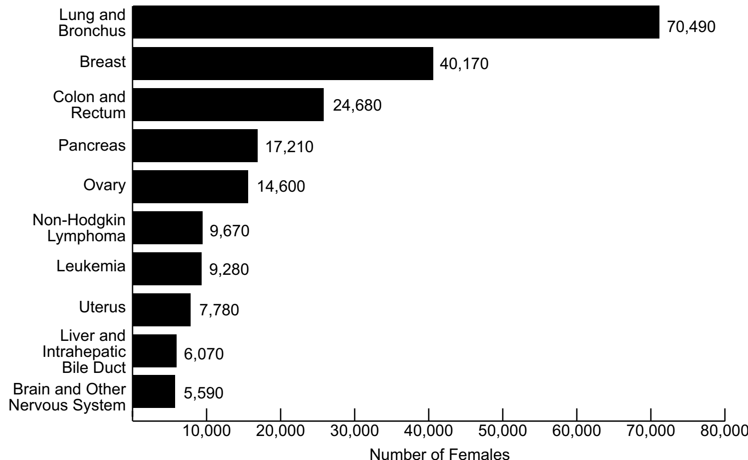
It is estimated that 713,220 new cancer cases will be diagnosed among females, and more than 269,000 females will die of cancer in 2009. Lung and bronchus cancer is expected to be the leading cause of cancer death among females, accounting for 70,490 deaths, or 26 percent of all cancer deaths, followed by breast cancer, which will be responsible for 40,170, or 15 percent of deaths. Colon and rectal cancer, pancreatic cancer, and ovarian cancer will also be significant causes of cancer deaths among females, accounting for an additional 56,490 deaths combined.

Due to the varying survival rates for different types of cancer, the most common causes of cancer death are not always the most common types of cancer. For instance, although lung and bronchus cancers cause the greatest number of deaths, breast cancer is more commonly diagnosed among women. In 2005, invasive breast cancer occurred among 117.7 per 100,000 women whereas lung and bronchus cancers occurred in only 55.2 per 100,000 women. Other types of cancer that are commonly diagnosed among females but are not among the top 10 causes of cancer deaths include melanoma, thyroid, and cervical cancer, occurring in 15.1, 14.9, and 8.1 per 100,000 women, respectively.

Cervical cancer incidence varies by race and ethnicity; in 2005, Hispanic and Black females were most likely to have been diagnosed with invasive cervical cancer (12.4 and 10.3 per 100,000, respectively), compared to 7.7 per 100,000 White females. Cervical cancer screenings are recommended at least every 3 years beginning within 3 years of sexual activity or by age 21. In addition, a vaccine for genital human papillomavirus (the leading cause of cervical cancer) was approved for use by the Food and Drug Administration in

Leading Causes of Cancer Deaths Among Females, by Site, 2009 Estimates

Source II.7: American Cancer Society



Invasive Cancer Rates per 100,000 Females, by Site and Race/Ethnicity, 2005*

Source II.8: Centers for Disease Control and Prevention and National Cancer Institute

	Total	White**	Black**	Hispanic	Asian/Pacific Islander†	American Indian/ Alaska Native†
Breast	117.7	119.1	110.2	89.8	78.8	59.4
Lung and Bronchus	55.2	56.6	50.9	25.2	26.9	24.5
Colon and Rectum	41.9	40.8	49.4	33.9	32.2	37.6
Non-Hodgkin Lymphoma	15.9	16.3	10.9	15.1	9.9	8.5
Melanoma	15.1	17.0	0.9	4.2	1.3	3.6
Thyroid	14.9	15.5	9.7	14.7	14.9	6.6
Cervix	8.1	7.7	10.3	12.4	7.4	6.2

*All rates are age-adjusted. **Includes Hispanics. †Results should be interpreted with caution; includes Hispanics.*

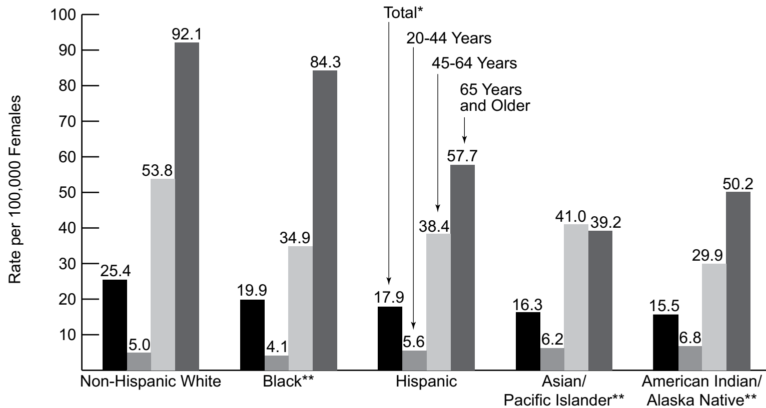
2006 and is recommended for adolescents and young women aged 9–26 years.[12] In 2006–2007, 10 percent of women aged 18–26 years had been vaccinated for HPV (data not shown).[13]

In 2000–2005, non-Hispanic White females were more likely than women of other races and ethnicities to be diagnosed with endometrial or uterine cancer (25.4 per 100,000). Overall, non-Hispanic White and Black women aged 65 years and older were most likely to have this type of cancer (92.1 and 84.3 per 100,000 women, respectively), followed by Hispanic women of the same age group (57.7 per 100,000). Among 45- to 64-year-olds, American Indian/Alaska Native women were least likely to have endometrial or uterine cancer (29.9 per 100,000), while Black women were least likely among those aged 20–44 years (4.1 per 100,000).

Survival rates for ovarian cancer vary depending on how early it is discovered. For females diagnosed with ovarian cancer in 1996–2004, 45.6 percent could expect to live 5 years or more; however, this varied by race and the stage of the cancer. Black women were slightly more likely than White women to live at least 5 years when the cancer was diagnosed in the localized stage (94.3 versus 92.1 percent, respectively). Comparatively, 71.3 percent of White females and 50.7 percent of Black females could expect the same when the cancer is in the regional stage (spread beyond the primary site). Among those whose cancer is diagnosed at the distant stage (spread to distant organs or lymph nodes), only 30.7 percent of White females and 22.6 percent of Black females could expect to live 5 more years.

Endometrial and Uterine Cancer Incidence, by Race/Ethnicity and Age, 2000–2005

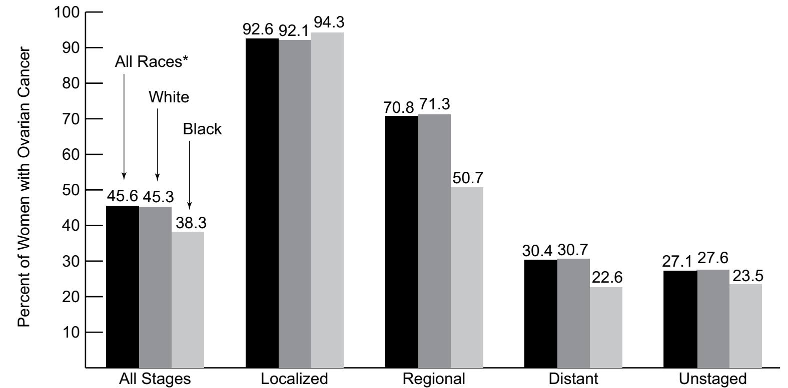
Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*Totals include females of all ages. **May include Hispanics.

Five-year Period Survival Rates for Ovarian Cancer, by Race and Stage,** 1996–2004

Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*Includes races and ethnicities other than White and Black. **Localized cancer is limited to the organ in which it began (no evidence of spread); regional cancer has spread beyond the primary site; distant cancer has spread to distant organs or lymph nodes; and unstaged indicates that there was not enough information to determine a stage.

DIABETES

Diabetes mellitus is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. Diabetes is becoming increasingly common among children and young adults. The main types of diabetes are Type 1, Type 2, and gestational (occurring only during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults, but may occur at any age. Type 2 diabetes is the most common; it is often diagnosed among adults but has increased among children. Risk factors for Type 2 diabetes include obesity, physical inactivity, and a family history of the disease.

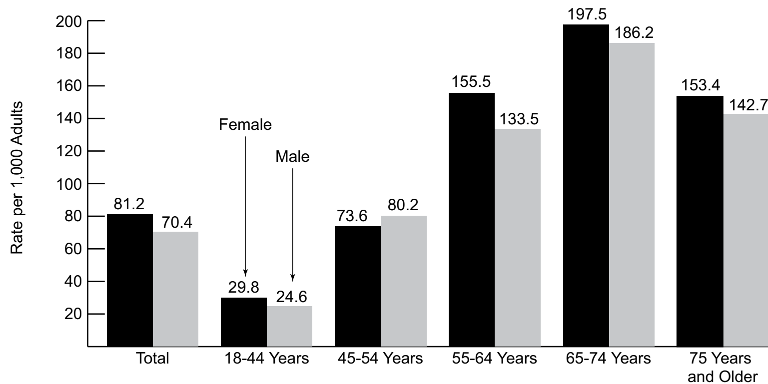
In 2005–2006, 76.0 per 1,000 adults reported that they had been told by a health professional that they have diabetes (data not shown). Women were slightly more likely than men to have diabetes overall (81.2 versus 70.4 per 1,000 adults, respectively) and in most age groups.

Diabetes prevalence generally increases with age. Fewer than 30 per 1,000 women aged 18–44 years had diabetes, compared to 197.5 per 1,000 women aged 65–74 years. Women aged 55–64 and 75 years and older also had relatively high rates of diabetes (155.5 and 153.4 per 1,000 women, respectively).

Among adults aged 18 years and older who were found to have diabetes (based on the results of a Fasting Plasma Glucose test), 33.2 percent had never been told by a health professional that they have diabetes. Women who tested positive were less likely than men to have reported never being diagnosed by a health professional (24.1 versus 45.2 percent, respectively).

Adults Aged 18 and Older Who Have Been Diagnosed With Diabetes,* by Age and Sex, 2005–2006

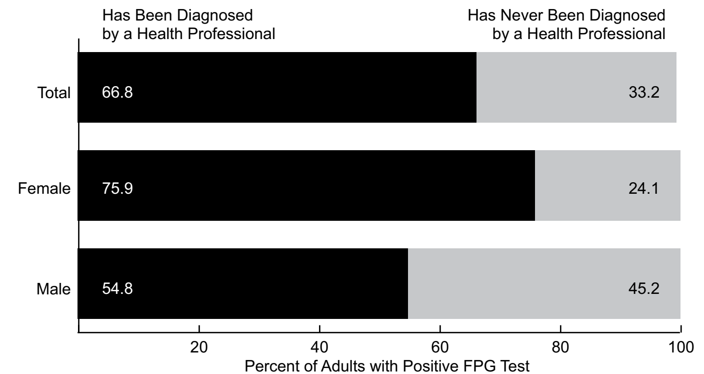
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Reported a health professional has ever told them they have diabetes; does not include gestational diabetes. Rates are not age-adjusted.

Adults Aged 18 and Older Who Tested Positive for Diabetes,* by Sex and Diagnosis Status, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Tested positive on a Fasting Plasma Glucose (FPG) test; does not include people with diabetes whose blood glucose is controlled. Rates are not age-adjusted.

OVERWEIGHT AND OBESITY

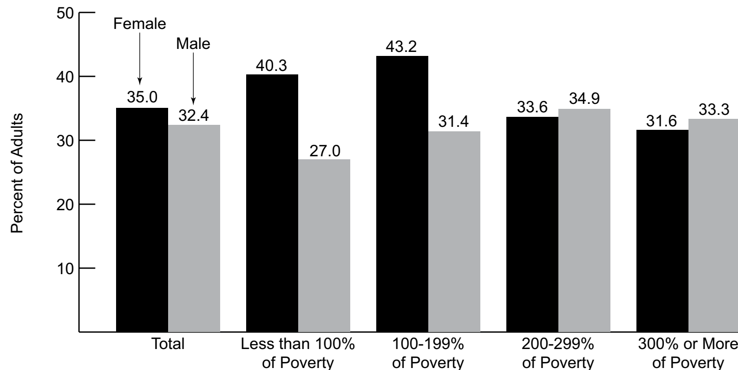
Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke, arthritis, certain types of cancer, and reproductive health risks.[14] Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2005–2006, 32.4 percent of adults were overweight (BMI of 25.0-29.9), while an additional 33.8 percent were obese (BMI of 30.0 or more; data not shown).

While women and men had similar rates of obesity in 2005–2006 (35.0 and 32.4 percent, respectively), rates among women varied by poverty status. Among women, obesity was lowest among those with higher incomes. More than 40 percent of women with household incomes below 200 percent of the poverty level were obese, compared to 31.6 percent of women with incomes of 300 percent or more of poverty and 33.6 percent of those with incomes of 200–299 percent of poverty. Among men, however, obesity rates did not vary significantly with poverty status.

Women were more likely than men to be severely obese, defined as having a BMI of 40.0 or more (7.3 versus 4.1 percent, respectively). Non-Hispanic Black women were more likely than non-Hispanic White and Hispanic women to be severely obese (13.7 versus 6.6 and 5.4 percent, respectively).

Obesity* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2005–2006

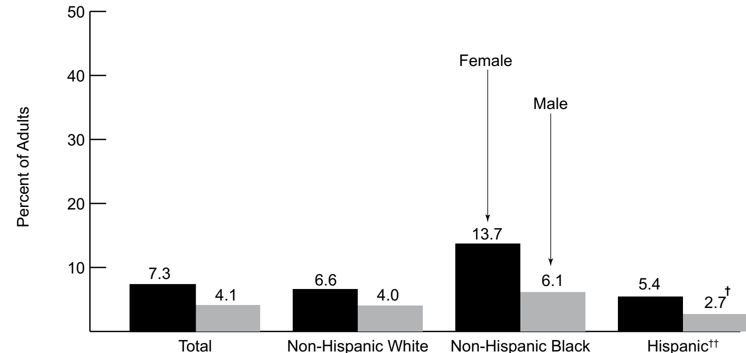
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Defined as having a Body Mass Index (BMI) of 30.0 or more. Rates are not age-adjusted.
**Poverty, defined by the U.S. Census Bureau, was $20,444 for a family of four in 2006.

Severe Obesity* Among Adults Aged 18 and Older, by Race/Ethnicity** and Sex, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Defined as having a Body Mass Index (BMI) of 40.0 or more. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of multiple races, and persons of other races was too small to produce reliable results. †This result should be interpreted with caution; the relative standard error was greater than 30 percent. ††Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population.

DIGESTIVE DISORDERS

Digestive disorders, or gastrointestinal diseases, include a number of conditions that affect the digestive system, including heartburn; constipation; hemorrhoids; irritable bowel syndrome; ulcers; gallstones; celiac disease (a genetic disorder in which consumption of gluten damages the intestines); and inflammatory bowel diseases, including Crohn's disease (which causes ulcers to form in the gastrointestinal tract). Digestive disorders are estimated to affect 60–70 million people in the United States.[15]

While recent data are not readily available on the prevalence of many of these diseases by race and ethnicity or sex, it is estimated that 8.5 million people in the United States are affected by hemorrhoids each year; 2.1 million people are affected by irritable bowel syndrome; and gallstones affect 20.5 million people.[15]

Peptic ulcers are most commonly caused by a bacterium called *Helicobacter pylori (H. pylori). H. pylori* weakens the mucous coating of the stomach and duodenum, allowing acids to irritate the sensitive lining beneath. In 2007, 7.1 percent of adults reported that they had ever been told by a health professional that they have an ulcer (data not shown). Among women, the likelihood of having ever had an ulcer increased with age. Women aged 65 years and older were most likely to have reported ever having had an ulcer (11.1 percent), followed by women aged 45–64 years (8.6 percent). In comparison, fewer than 4 percent of women aged 18–24 years had ever had an ulcer.

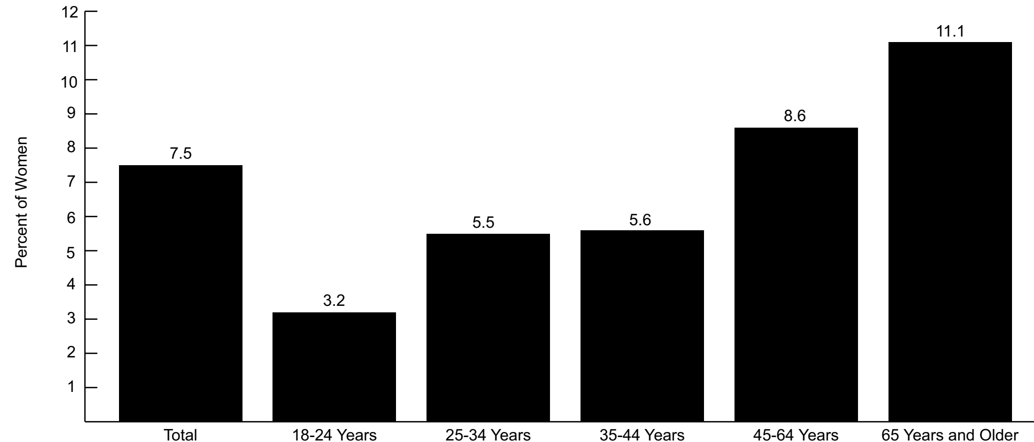
There was also some variation among women reporting having ever had an ulcer by race and ethnicity. Non-Hispanic White women were most likely to report having had an ulcer (8.3 percent), followed by non-Hispanic Black (5.6 percent) and Hispanic women (5.3 percent). Asian women were least likely to report ever having had an ulcer (3.5 percent; data not shown).

Women with family incomes below 200 percent of the poverty line were also more likely than women with incomes above that threshold to have ever had an ulcer (9.8 versus 6.8 percent, respectively; data not shown).

In 2006, digestive system symptoms accounted for 35.9 million visits to doctor's offices and 3.2 million visits to hospital outpatient departments, while an additional 7.2 million visits to emergency departments were attributed to a digestive system diagnosis.[16]

Women Aged 18 and Older Who Have Ever Had an Ulcer,* by Age, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Reported a health professional has ever told them they have an ulcer.*

ENDOCRINE AND METABOLIC DISORDERS

Endocrine disorders involve the body's over- or under-production of certain hormones, while metabolic disorders affect the body's ability to process certain nutrients and vitamins. Endocrine disorders include hypothyroidism, congenital adrenal hyperplasia, diseases of the parathyroid gland, diabetes mellitus, diseases of the adrenal glands (including Cushing's syndrome and Addison's disease), and ovarian dysfunction (including polycystic ovary syndrome), among others. Some examples of metabolic disorders include cystic fibrosis, phenylketonuria (PKU), hyperlipidemia, gout, and rickets.

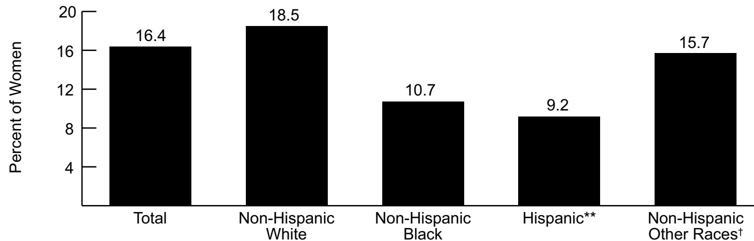
Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders among women of reproductive age, and is the most common cause of endocrine-related female infertility in the United States. An estimated 1 in 10 women of childbearing age has PCOS, and it can occur in females as young as 11 years of age. In addition, PCOS may put women at risk for other health conditions, including high blood pressure, heart disease, and diabetes.[17]

Hyperthyroidism and hypothyroidism are also common endocrine disorders. In 2005–2006, women were nearly five times more likely than men to report having ever been told by a health professional that they have a thyroid problem (16.4 versus 3.4 percent, respectively; data not shown). Among women, rates varied by race and ethnicity. Non-Hispanic White women were most likely to report a thyroid problem (18.5 percent), while Hispanic women were least likely (9.2 percent).

In 2006, the rate of physician visits due to endocrine and metabolic disorders varied by sex: 4.0 percent of physician visits made by men were for disorders of endocrine glands other than the thyroid, compared to 3.1 percent of visits made by women. The rate of visits due to metabolic and immunity disorders was also higher among men than women (2.7 versus 1.9 percent of visits, respectively). However, the rate of visits for thyroid disorders was higher among women than men (0.8 versus 0.3 percent of visits, respectively).

Thyroid Problems* Among Women Aged 20 and Older, by Race/Ethnicity, 2005–2006

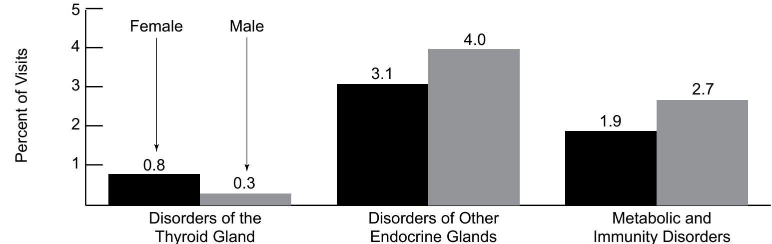
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional has ever told them they have a thyroid problem; includes hyperthyroidism and hypothyroidism **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. †Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of all other races.

Physician Visits by Adults Aged 18 and Older Due to Endocrine and Metabolic Disorders,* by Sex, 2006

Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Based on ICD-9-CM codes for disorders of the thyroid gland (240-246); disorders of other endocrine glands (250-259); other metabolic and immunity disorders (270-279).

GYNECOLOGICAL AND REPRODUCTIVE DISORDERS

Gynecological disorders affect the internal and external organs in the female pelvic and abdominal areas. These disorders include dysmenorrhea (pain associated with menstruation), vulvodynia (unexplained chronic discomfort or pain of the vulva), and chronic pelvic pain (a persistent and severe pain occurring primarily in the lower abdomen for at least 6 months).

Some problems can affect the proper functioning of the reproductive system and may affect a woman's ability to get pregnant. One example, polycystic ovary syndrome, occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. Another reproductive disorder, endometriosis, occurs when the type of tissue that lines the uterus grows elsewhere, such as on the ovaries or other abdominal organs. Uterine fibroids are non-cancerous tumors that grow in the uterine cavity, within the wall of the uterus, or on the outside of the uterus.

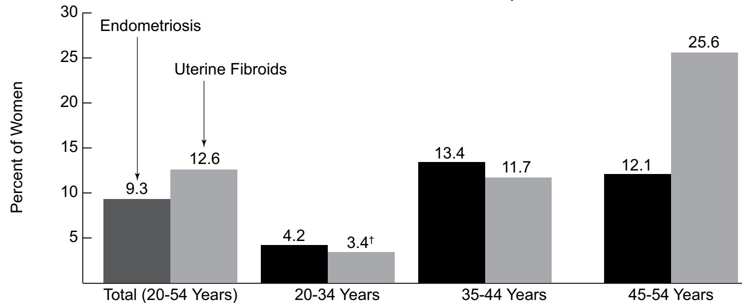
In 2005–2006, 9.3 percent of women aged 20–54 years had ever been told by a health professional that they have endometriosis and 12.6 percent had been told that they have uterine fibroids. Overall, endometriosis was most common among those aged 35–44 years (13.4 percent), while uterine fibroids were most common among those aged 45–54 years (25.6 percent).

In 2006, 34.1 per 1,000 physician visits among women aged 18 years and older were for gynecological or reproductive problems. Women aged 18–24 years were most likely to visit a physician for gynecological or reproductive disorders (57.8 per 1,000 visits), while women aged 65 years and older were least likely (16.7 per 1,000).

Some women take supplemental hormones for gynecological or other health problems, sometimes to reduce the symptoms of menopause. In 2005–2006, 27.0 percent of females reported ever having taken female hormones (not including birth control or fertility medications). Non-Hispanic White women (31.8 percent) were more likely than non-Hispanic Black and Hispanic women to report having ever taken hormones (17.2 and 11.6 percent, respectively; data not shown).[18]

Endometriosis and Uterine Fibroids Among Women Aged 20–54,* by Age, 2005–2006

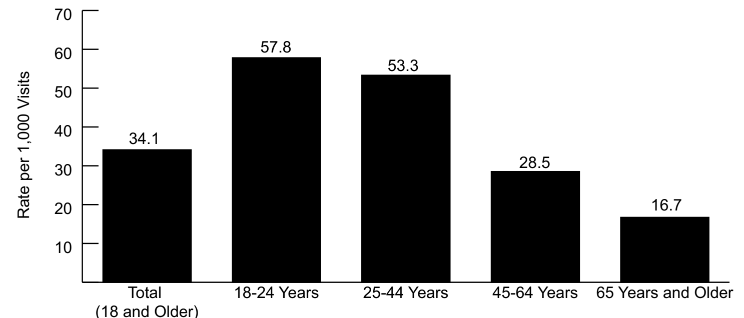
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they have endometriosis or uterine fibroids.
†This result should be interpreted with caution; the relative standard error was greater than 30 percent.

Physician Visits by Women Aged 18 and Older Due to Gynecological and Reproductive Problems,* by Age, 2006

Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Based on ICD-9-CM codes: 179-184, 221, 256, 614-616, 617-629, and 752.

HEARING PROBLEMS

Hearing problems can significantly and adversely affect a person's quality of life, making it difficult to understand a doctor's advice, hear alarms, and communicate with friends and family members. In 2007, 85.1 percent of adults reported excellent or good hearing without the use of an aid, while 14.7 percent reported at least some trouble hearing and 0.2 percent were deaf (data not shown). Women were less likely than men to have reported trouble hearing overall (11.9 versus 17.7 percent, respectively), and in every age group. For instance, among adults aged 75 years and older, 37.6 percent of women had trouble hearing compared to 53.1 percent of men.

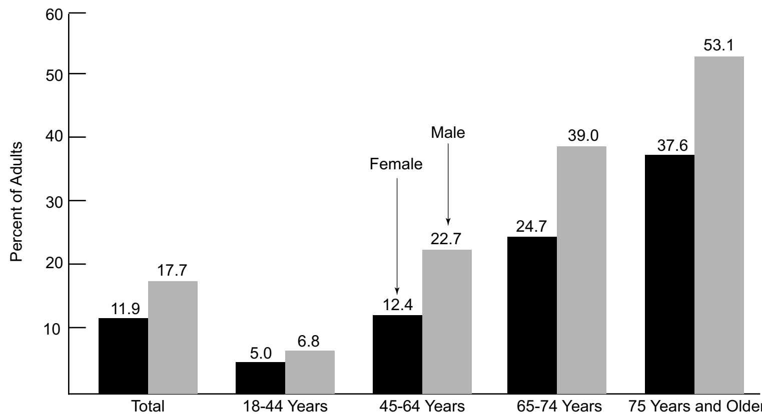
The percentage of adults who reported trouble hearing increased with age for both men and women. Among women, 5.0 percent of 18- to 44-year-olds reported trouble hearing without the use of an aid, compared to 12.4 percent of those aged 45–64 years and 24.7 percent of those aged 65–74.

The use of hearing aids also increases with age. Among women, 13.8 percent of those aged 75 and older reported using a hearing aid, while only 3.8 percent of 65- to 74-year-olds and fewer than 1 percent of those aged 45–64 years did so.

Tinnitus is the term used for a persistent ringing, buzzing, or roaring sound in the ears or head. In 2007, 8.8 percent of women reported symptoms congruent with tinnitus. This varied, however, by race and ethnicity. Non-Hispanic White women were more likely than non-Hispanic Black and Hispanic women to have tinnitus (9.6 versus 7.6 and 6.6 percent, respectively). Non-Hispanic Asian women were least likely to have reported experiencing tinnitus (4.1 percent; data not shown).

Adults Aged 18 and Older Reporting Trouble Hearing,* by Age and Sex, 2007

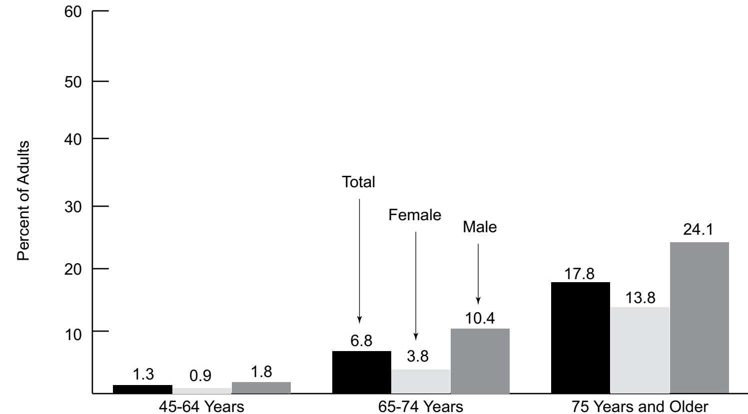
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported "a little," "moderate," or "a lot of" trouble hearing; does not include those reporting "deaf."

Use of Hearing Aids Among Adults Aged 45 and Older, by Age and Sex, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



HEART DISEASE AND STROKE

In 2006, heart disease was the leading cause of death among both men and women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common type of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow to the heart muscle. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age. While the most common symptom of a heart attack is chest pain or discomfort, women are more likely than men to have symptoms such as shortness of breath, nausea and vomiting, and back or jaw pain.[19]

Stroke is a type of cardiovascular disease that affects blood flow to the brain. Warning signs are sudden and can include facial, arm, or leg numbness, especially on one side of the body; severe headache; trouble walking; dizziness; a loss of balance or coordination; or trouble seeing in one or both eyes.[19]

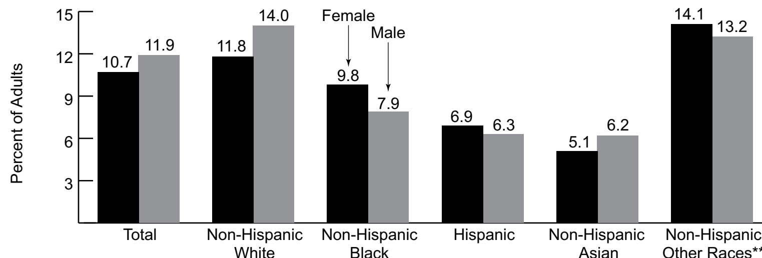
In 2007, women were slightly less likely than men to have ever been told by a health professional that they have heart disease (10.7 versus 11.9 percent, respectively). Among women, non-Hispanic Asians and Hispanics were least likely to be diagnosed with heart disease (5.1 and 6.9 percent, respectively).

In 2006, there were nearly 2 million hospital discharges due to heart disease among women aged 18 years and older, resulting in a rate of 171.2 discharges per 10,000 women. Rates of hospital discharges due to heart disease increased with age: the rate among women aged 45–64 years was 125.4 per 10,000, compared to 874.4 per 10,000 women aged 75 years and older.

There is evidence that women diagnosed with acute myocardial infarction (AMI), or heart attack, are less likely than men with AMI to receive certain treatments that have been reported to improve outcomes.[20] Research also suggests that physicians are less likely to counsel women about modifiable risk factors, such as diet and exercise, and that after a first heart attack, women are less likely than men to receive cardiac rehabilitation, though the reasons for these sex disparities are unclear.[21]

Adults Aged 18 and Older with Heart Disease,* by Race/Ethnicity and Sex, 2007

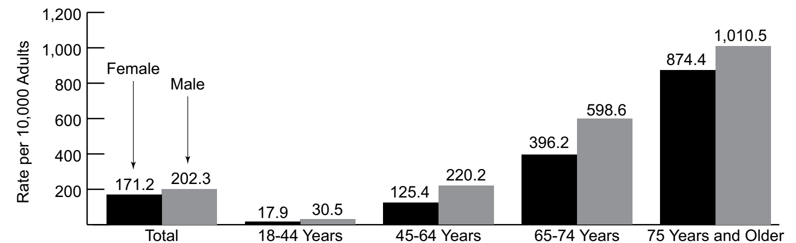
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them they have a heart condition or heart disease. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

Discharges Due to Heart Disease* from Non-Federal, Short-Stay Hospitals, by Age and Sex, 2006

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



First-listed diagnosis of heart disease (includes ICD-9-CM codes 391-392.0, 393-398, 402, 404, 410-416, 420-429).

HIGH BLOOD PRESSURE

High blood pressure is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. An examination of adults' blood pressure in 2005–2006 showed that men had higher overall rates of high blood pressure than women (17.3 versus 16.0 percent, respectively).

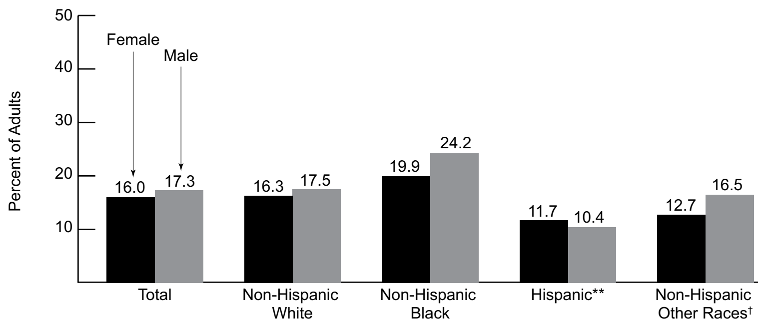
Rates of high blood pressure among women varied by race and ethnicity. Non-Hispanic Black and non-Hispanic White women were most likely to have high blood pressure (19.9 and 16.3 percent, respectively), while Hispanic women were least likely (11.7 percent).

The prevalence of high blood pressure among both men and women increases with age. Among women in 2003–2006, those aged 65 years and older were most likely to have high blood pressure (47.4 percent), compared to 23.4 percent of women aged 45–64 years. Women aged 20–44 years were least likely to have high blood pressure (3.1 percent).

Antihypertensive drugs work to lower the body's blood pressure. The proportion of adults with high blood pressure who were not taking medication for the condition varied by sex, as well as race and ethnicity. In 2005–2006, 62.6 percent of men and 42.4 percent of women found to have high blood pressure were not taking antihypertensive medication. Among women with high blood pressure, Hispanics were least likely to be taking medication: 64.4 percent reported not taking antihypertensive medication. Nearly one-third of non-Hispanic Black and 41.1 percent of non-Hispanic White women had high blood pressure but were not taking medication for the condition (data not shown).

Adults Aged 18 and Older with High Blood Pressure,* by Race/Ethnicity and Sex, 2005–2006

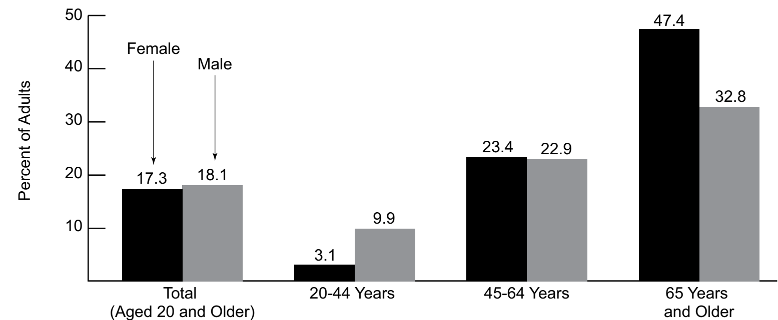
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. Rates are not age-adjusted. **Estimates for Hispanics should be interpreted with caution; they may not be repressentative of the entire Hispanic population. †Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races.

Adults Aged 20 and Older with High Blood Pressure,* by Age and Sex, 2003–2006

Source II.12: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher.

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the final stage of infection with the human immunodeficiency virus (HIV), which destroys or disables the cells that are responsible for fighting infection. AIDS is diagnosed when HIV has weakened the immune system enough that the body has a difficult time fighting infections.[22] While HIV and AIDS disproportionately affect men, a growing number of women are also affected; in 2006, there were an estimated 11.9 new cases of HIV per 100,000 females aged 13 and older in the United States.

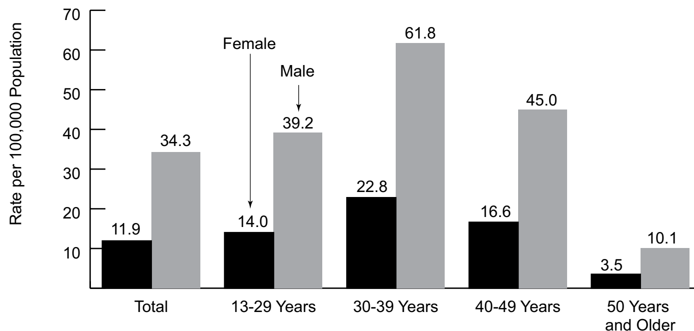
Rates of HIV incidence vary by sex, age, and race/ethnicity. Among both males and females, rates of new HIV infections increase with age until age 40, then decrease. Among females, those aged 30–39 years had the highest HIV incidence rate (22.8 per 100,000), followed by females aged 40–49 and 13–29 years (16.6 and 14.0 per 100,000, respectively). Women aged 50 years and older had the lowest HIV incidence rate in 2006 (3.5 per 100,000).

Among females aged 13 and older, Black women had the highest incidence rates (55.7 per 100,000), followed by Hispanic and American Indian/Alaska Native women (14.4 and 12.8 per 100,000, respectively). While being of a particular race or ethnicity does not increase the likelihood of contracting HIV, certain challenges exist for non-Hispanic Black and Hispanic females putting them at greater risk for infection: socioeconomic factors such as limited access to quality health care; language and cultural barriers, particularly for Hispanics, which can affect the quality of health care; high rates of sexually transmitted infections, which increase the risk of HIV infection; and substance abuse.[23]

In 2007, high-risk heterosexual contact (including sex with an injection drug user, sex with men who have sex with men, and sex with an HIV-infected person) accounted for 45.9 percent of new cases of HIV infection among adolescent and adult females, while injection drug use accounted for an additional 14.3 percent. In 39.2 percent of new cases, the transmission category was not reported or identified, and 0.5 percent of new cases were due to blood transfusions or receipt of blood components or tissue (data not shown).

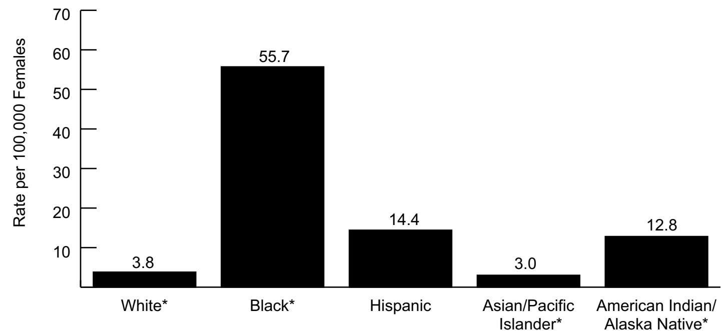
Estimated HIV Incidence Among Persons Aged 13 and Older, by Age and Sex, 2006

Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



Estimated HIV Incidence Among Females Aged 13 and Older, by Race/Ethnicity, 2006

Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



Includes Hispanics.

SEXUALLY TRANSMITTED INFECTIONS

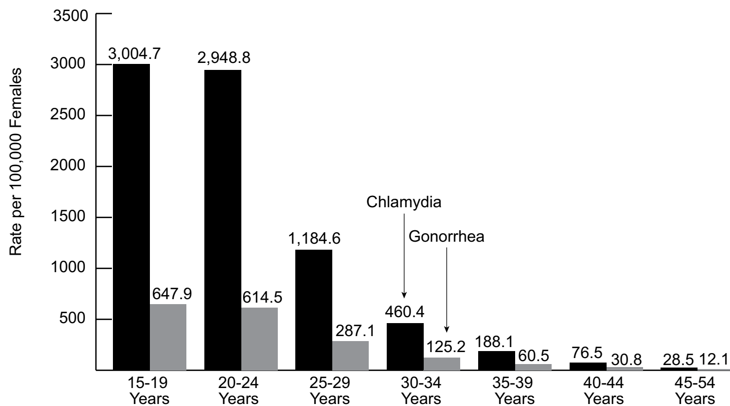
Reported rates of sexually transmitted infections (STIs) among females vary by age. Rates of chlamydia, gonorrhea, and syphilis are highest among adolescents and young adults. In 2007, there were 3,004.7 reported cases of chlamydia and 647.9 reported cases of gonorrhea per 100,000 females aged 15–19 years, compared to 28.5 and 12.1 reported cases per 100,000 women aged 45–54 years, respectively. Syphilis was also more common among young women in 2007, occurring among 2.4, 3.5, and 2.6 per 100,000 females aged 15–19, 20–24, and 25–29 years, respectively (data not shown).

Although chlamydia, gonorrhea, and syphilis can be cured with appropriate antibiotics, left untreated they can have serious health consequences. Active infections can increase the likelihood of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes.

Some STIs cannot be cured with antibiotics but can only be treated to improve symptoms. Herpes Simplex Virus Type 2 (HSV-2) is an untreatable viral infection that can cause neonatal infections and increase risk for contracting HIV. HSV-2 is one of two viral infections that cause genital herpes. The prevalence of HSV-2 varies by age and sex. In 1999–2004, females were more likely than males to have HSV-2 (22.8 versus 11.2 percent, respectively). This was true for every age category. Women aged 40–49 years were most likely to have HSV-2 (33.9 percent), compared to 15.6 percent of females aged 20–29 and 2.3 percent of those aged 14–19 years.

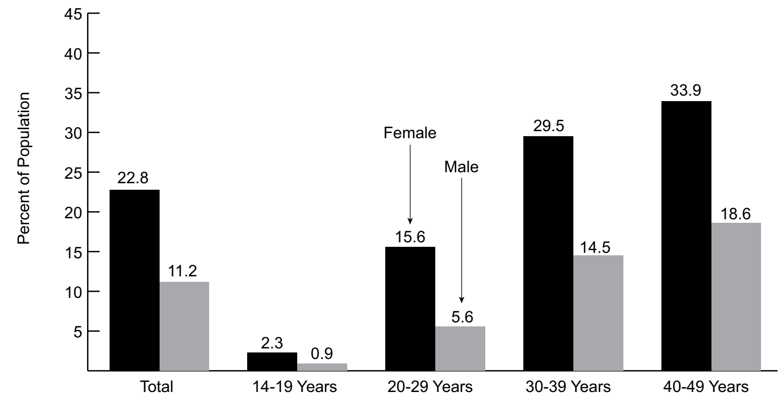
Rates of Chlamydia and Gonorrhea Among Females Aged 15–54, by Age, 2007

Source II.14: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Evidence of Herpes Simplex Virus Type 2 (HSV-2) Infection Among Persons Aged 14–49, by Age and Sex, 1999–2004

Source II.15: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, as published in Xu, F., et al, 2006



INJURY

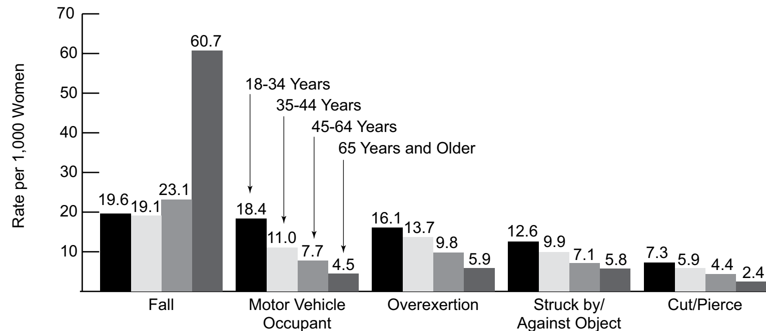
Injuries can often be controlled by either preventing an event (such as a car crash) or lessening its impact. This can occur through education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples include the design, oversight, and use of child safety seats and seatbelts, workplace regulations regarding safety practices, and tax incentives for fitting home pools with fences.

In 2007, unintentional falls were the leading cause of nonfatal injury among women of every age group, and rates generally increased with age. Women aged 65 years and older had the highest rate of injury due to unintentional falls (60.7 per 1,000 women), while fewer than 20 per 1,000 women aged 18–34 and 35–44 years experienced fall-related injuries. Unintentional injuries sustained as motor vehicle occupants were the second leading cause of injury among 18- to 34-year-olds (18.4 per 1,000 women), while unintentional overexertion was the second leading cause of injury among women of all other age groups; 13.7 per 1,000 women aged 35–44 years experienced injury due to overexertion, as did 9.8 per 1,000 women aged 45–64, and 5.9 per 1,000 women aged 65 years and older.

Unintentional and intentional injuries each represented a higher proportion of emergency department (ED) visits for men than women in 2006. Among women and men aged 18 years and older, unintentional injuries accounted for 18.7 and 25.1 percent of ED visits, respectively, while intentional injuries, or assault, represented 1.7 and 3.0 percent of visits, respectively. Among both women and men, unintentional injury accounted for a higher percentage of ED visits among those living in non-metropolitan areas, while adults living in metropolitan areas had a slightly higher percentage of ED visits due to intentional injury.

Leading Causes of Nonfatal Injury* Among Women Aged 18 and Older, by Age, 2007

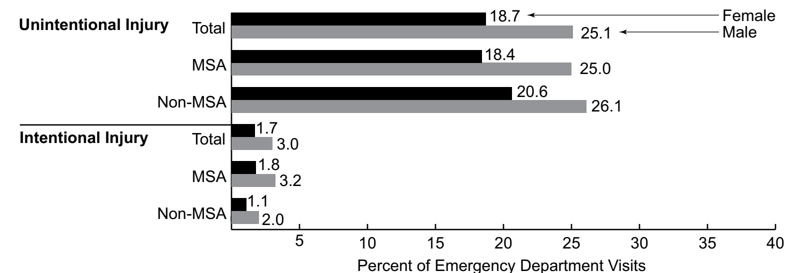
Source II.16: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control



*All of the leading causes of injury in 2007 were unintentional.

Injury-Related Emergency Department Visits Among Adults Aged 18 and Older, by Area of Residence* and Sex, 2006

Source II.17: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



*A metropolitan statistical area (MSA) is defined as a core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core. All counties within a metropolitan statistical area are classified as metropolitan. Counties not within a metropolitan statistical area are considered non-metropolitan.

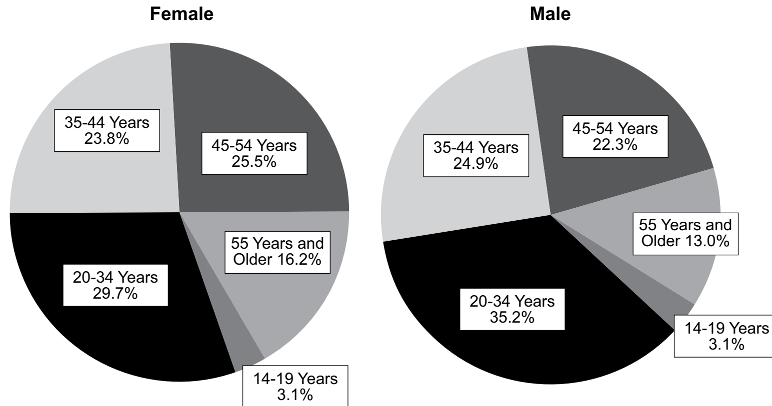
OCCUPATIONAL INJURY

In 2007, there were nearly 1.2 million nonfatal occupational injuries in the United States that resulted in at least 1 day of absence from work. Of those injuries, more than 35 percent occurred among females aged 14 and older. While males account for the majority of total injuries, the distribution of injuries by age differs between males and females. More than 35 percent of males with occupational injuries were aged 20–34 years, compared to 29.7 percent of females in the same age group. In comparison, 16.2 percent of injuries among females occurred among women aged 55 years and older, while males of this age group accounted for 13.0 percent of injuries.

The distribution of nonfatal occupational injuries by sex varies by occupational sector. In 2007, females accounted for 68.4 percent of injuries occurring in management, professional, and related occupations, despite making up only 51.2 percent of the workforce in that sector. Similarly, females represented 56.4 percent of the service workforce, but accounted for 61.1 percent of injuries in that sector. Conversely, males were somewhat overrepresented in injuries to sales and office workers: males made up 37.1 percent of that workforce, but accounted for 39.3 percent of the injuries. Injuries occurring among males and females in the farming, fishing, and forestry sector, as well as the construction, extraction, and maintenance sector were approximately proportionate to their workforce representation. (See page 17, "Women in the Labor Force," for data on workforce representation by occupational sector and sex.)

Nonfatal Occupational Injuries and Illnesses of Workers Aged 14 and Older, by Sex and Age,* 2007

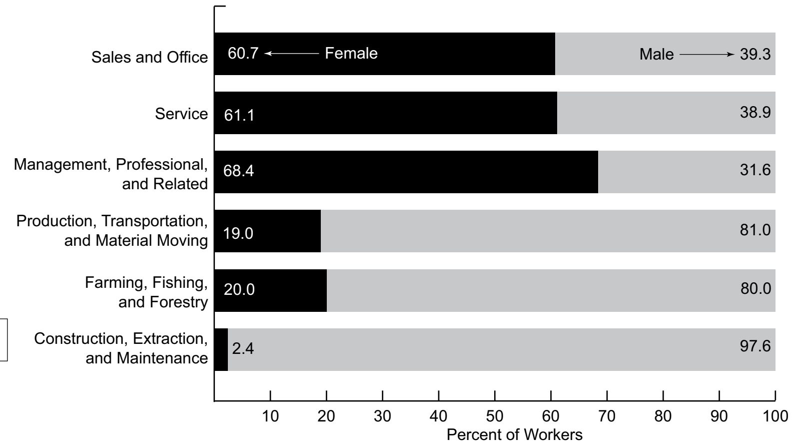
Source II.18: U.S. Department of Labor, Bureau of Labor Statistics



*Percentages do not equal 100 due to rounding and age not being reported in 2.0 percent of cases.

Nonfatal Occupational Injuries and Illnesses, by Occupational Sector and Sex, 2007

Source II.18: U.S. Department of Labor, Bureau of Labor Statistics



INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) refers to any physical, sexual, or psychological harm by a current or former partner or spouse. IPV can take on many forms and vary in frequency and severity, ranging from threats of abuse to chronic, severe battering. IPV often is underreported, especially with regard to sexual and psychological violence.

According to the National Crime Victimization Survey, which collects data on victimization based on household and individual surveys, 5.7 per 1,000 women aged 18 and older were victims of nonfatal IPV in 2006. Additionally, between 1976 and 2005, 30.0 percent of homicides against females were committed by intimate partners.[24] Rates of IPV vary with a number of factors including age, race and ethnicity, income, and marital status.

Rates of women who report experiencing IPV decline with age. In 2006, women aged 18–34 years were most likely to have reported experiencing IPV (12.6 per 1,000 women), compared to 6.4 per 1,000 women aged 35–44 years, and 2.0 per 1,000 women aged 45–64 years.

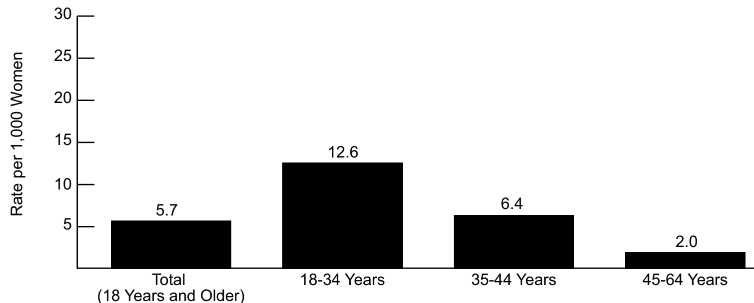
Similarly, reportes of IPV decline as annual household income increases. Women in households with incomes below $15,000 per year were most likely to have reported IPV (15.9 per 1,000 women), followed by women with incomes of $15,000-29,999 annually (8.6 per 1,000). Women with annual incomes of $50,000 or more were least likely to have reported IPV (2.8 per 1,000).

Non-Hispanic White and Hispanic women were less likely to have reported IPV (5.0 and 5.6 per 1,000, respectively) than non-Hispanic Black women (7.4 per 1,000; data not shown).

Human trafficking is another crime that disproportionately affects women and girls. In 2007–2008, 1,229 alleged human trafficking incidents were reported by task forces in the United States, involving 1,442 victims. In cases where victims' characteristics were reported, women and girls accounted for 92.1 percent of victims. The proportion of sex trafficking victims who were female was even greater: 98.9 percent (data not shown).[25]

Nonfatal Intimate Partner Violence Among Women Aged 18 and Older,* by Age, 2006

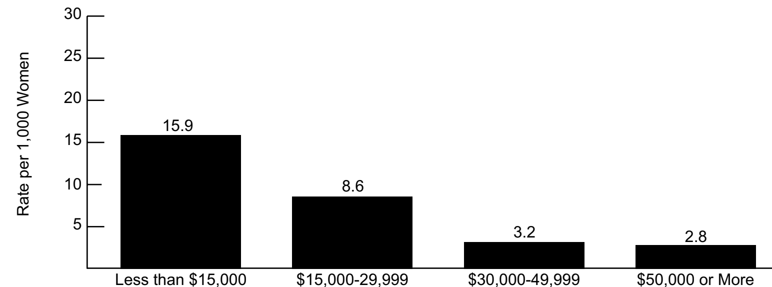
Source II.19: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



Due to the small sample size, the estimate for the 65 and older age group was not reliable.

Nonfatal Intimate Partner Violence Among Women Aged 18 and Older, by Annual Income, 2006

Source II.19: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



MENTAL ILLNESS

Mental illness affects both sexes, although many types of mental disorders are more prevalent among women.[26] For instance, in 2007, 13.3 percent of women and 8.1 percent of men reported experiencing frequent depression in the past year. Similarly, 13.0 percent of women reported experiencing frequent anxiety, compared to 8.6 percent of men (data not shown).

Among women, rates of frequent depression and anxiety increase with age up to age 64, but then decrease. More than 15 percent of women aged 45–64 years experienced frequent depression, compared to 12.8 percent of those aged 25–44 years and 9.6 percent of those aged 18–24. Similarly, women aged 45–64 years were more likely than women of other ages to experience frequent anxiety (14.7 percent).

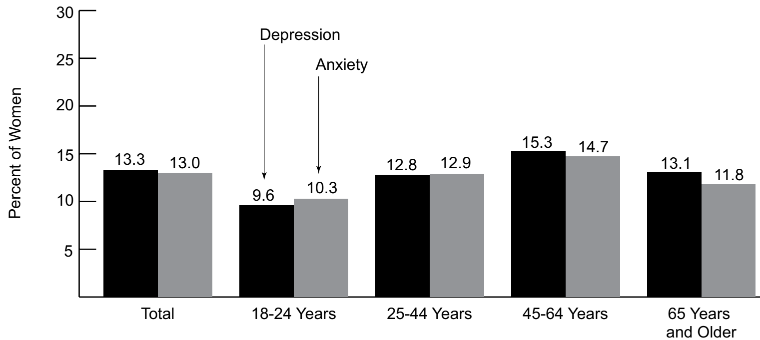
Frequent depression and anxiety among women decrease as household income increases. In 2007, women with incomes of less than 100 percent of the poverty level were most likely to have experienced frequent depression or anxiety (25.1 and 22.4 percent, respectively), followed by women with incomes of 100–199 percent of poverty (18.3 and 17.9 percent, respectively). Women with incomes of 400 percent or more of poverty were least likely to have reported experiencing frequent depression or anxiety in the past year (7.8 and 9.2 percent, respectively).

Although most people who suffer from mental illness do not intentionally injure themselves, mental illness is a major risk factor for self-inflicted injury. In 2003–2005, 13.7 per 10,000 emergency department (ED) visits were for self-inflicted injuries. The rate of emergency department visits due to self-inflicted injury was higher for females than males (16.2 versus 11.3 per 10,000 ED visits, respectively; data not shown).[27]

Research suggests that women suffering from chronic diseases such as heart disease may be more likely than men to suffer major depression, increasing the risk of mortality and morbidity.[28]

Frequent Depression and Anxiety* Within the Past Year Among Women Aged 18 and Older, by Age, 2007

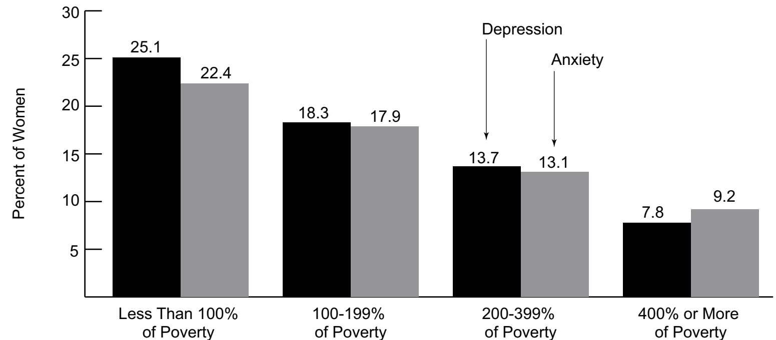
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had been frequently depressed or anxious during the past 12 months.

Frequent Depression and Anxiety* Within the Past Year Among Women Aged 18 and Older, by Poverty Status,** 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had been frequently depressed or anxious during the past 12 months.**Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

ORAL HEALTH

Oral health conditions can cause chronic pain of the mouth and face and can impair the ability to eat normally. Regular dental care is particularly important for women because there is some evidence of an association between periodontal disease and certain birth outcomes, such as increased risk of preterm birth and low birth weight.[29] To prevent caries (tooth decay) and periodontal (gum) disease, the American Dental Association recommends maintaining a healthy diet with plenty of water, and limiting eating and drinking between meals.[30]

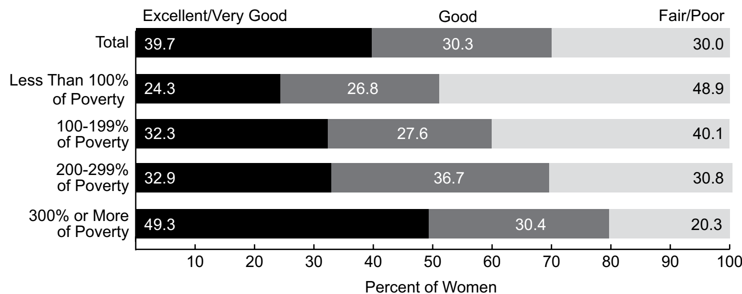
In 2005–2006, 39.7 percent of women reported that their teeth were in excellent or very good condition. This varied, however, by poverty status; nearly half of women with household incomes below 100 percent of the poverty level reported their teeth to be in fair or poor condition, while fewer than one-quarter reported excellent or very good oral health. In comparison, nearly half of women with incomes of 300 percent or more of poverty reported that their teeth were in excellent or very good condition.

Dental restoration is used to treat cavities caused by caries. In 2005–2006, 82.7 percent of women had had at least one tooth restored, while 19.1 percent of women had untreated tooth decay. Prevalence of dental restoration and untreated tooth decay among women varied with age. Women aged 45–64 years were most likely to have had at least one tooth restored (89.5 percent), compared to 87.3 percent of women aged 25–44 years and 72.0 percent of women aged 18–24 years. Women aged 25–44 years were more likely than women of other ages to have untreated tooth decay (22.8 percent), followed by women aged 18–24 years (21.0 percent).

Since many physical injuries resulting from intimate partner violence (IPV) involve the head, neck, and mouth, dental professionals have a unique opportunity to assess, educate, and refer women experiencing or at risk of IPV to appropriate services. Physical symptoms of IPV that may be observed during a dental visit include trauma in the head and neck region, multiple or old injuries, and untreated rampant caries.[31]

Self-Reported Oral Health Status of Women Aged 18 and Older, by Poverty Status,* 2005–2006

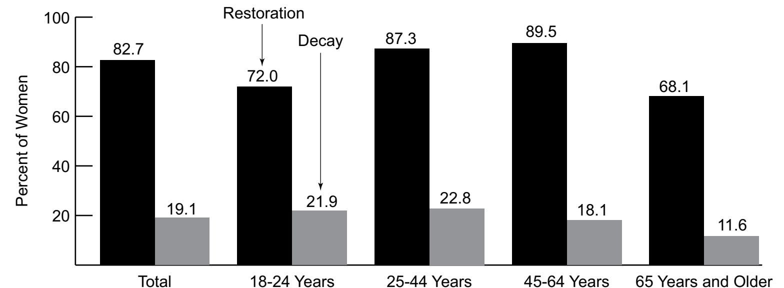
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Poverty level, defined by the U.S. Census Bureau, was $20,444 for a family of four in 2006.

Presence of Tooth Decay and Restoration Among Women Aged 18 and Older, by Age, 2005–2006*

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Beginning in 2005–2006, data collection methods changed, making estimates not comparable to those reported in previous years.

OSTEOPOROSIS

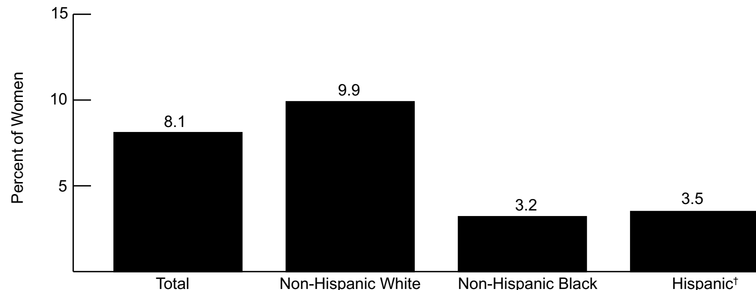
Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even among individuals who have already suffered a fracture. In 2005–2006, an estimated 10.5 million Americans over the age of 20 had osteoporosis, 84 percent of whom were women. Among adults aged 20 years and older, 8.1 percent of women and 1.7 percent of men reported having ever been told by a health professional that they have osteoporosis. The rate of osteoporosis among women varied significantly with race and ethnicity. Non-Hispanic White women were most likely to have osteoporosis (9.9 percent), compared to non-Hispanic Black and Hispanic women (3.2 and 3.5 percent, respectively).

Each year more than 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks in the wrist, spine, and hip. Fractures can have devastating consequences. For example, hip fractures are associated with an increased risk of mortality, and nearly 1 in 5 hip fracture patients is admitted to a nursing home within a year.[32] In 2006, there were 237,000 hospital discharges due to hip fractures among women aged 18 and older, a rate of 20.5 per 10,000 women. Rates of hospital discharges due to hip fractures were highest among women aged 75 years and older (169.9 discharges per 10,000 women), followed by women aged 65–74 years (28.3 per 10,000 women).

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (i.e. walking), and by taking prescription medication when appropriate. Bone density tests are recommended for women over 65 years and for any man or woman who suffers a fracture after age 50. Treatment for osteoporosis has been shown to reduce the risk of subsequent fractures by 30–65 percent.[32] Among women who had been told by a health professional that they have osteoporosis, 76.1 percent reported having been treated for the condition (data not shown).

Women Aged 20 and Older with Diagnosed Osteoporosis,* by Race/Ethnicity,** 2005–2006

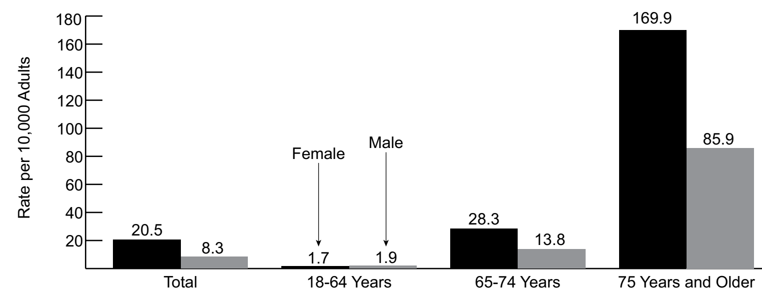
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they have osteoporosis. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races was too small to produce reliable results. †Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population.

Hospital Discharges Due to Hip Fractures* Among Adults Aged 18 and Older, by Age and Sex, 2006

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*First-listed diagnosis of hip fracture (ICD-9-CM code: 820).

SEVERE HEADACHES AND MIGRAINES

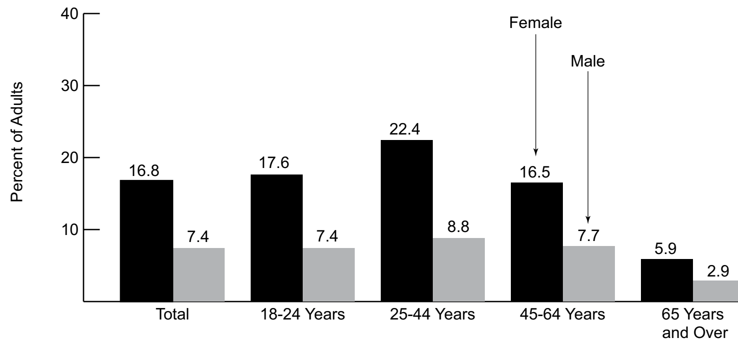
Severe headaches of any kind can be debilitating. Symptoms of severe headache include intense pain, usually on both sides of the head. Migraine, in addition to severe pain on only one side of the head, may be accompanied by neurological symptoms such as distorted vision, nausea, vomiting, and sensitivity to light or sound. In 2007, 12.3 percent of adults reported experiencing a severe headache or migraine in the past 3 months (data not shown). Severe headaches and migraines are more than twice as common among women as men (16.8 versus 7.4 percent, respectively). For both sexes, the rate of severe headaches and migraines is highest among those aged 25–44 years and decreases with age. Among women aged 65 years and older, only 5.9 percent reported severe headaches or migraines in the past 3 months, compared to 22.4 percent of women aged 25–44 years.

The percentage of women experiencing severe headaches and migraines decreases as household income increases. In 2007, 24.1 percent of women with household incomes below 100 percent of poverty reported experiencing a severe headache or migraine in the past 3 months, compared to 17.9 percent of women with household incomes of 200–399 percent of poverty and 14.8 percent of women with incomes of 400 percent or more of poverty.

The percentage of women reporting severe headaches or migraines varied by race and ethnicity: 17.9 percent of Hispanic women reported experiencing a severe headache or migraine in the past 3 months, compared to 16.8 percent of non-Hispanic White and 15.7 percent of non-Hispanic Black women. Non-Hispanic Asian women were least likely to report a severe headache or migraine (13.3 percent). Nearly 30 percent of non-Hispanic women of other races reported experiencing a severe headache or migraine (data not shown).

Adults Aged 18 and Older With Severe Headaches or Migraines,* by Age and Sex, 2007

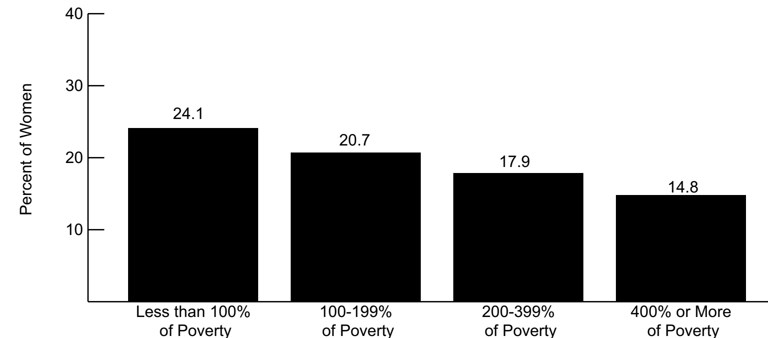
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Occurring within the past 3 months.

Women Aged 18 and Older with Severe Headaches or Migraines,* by Poverty Status,** 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Occurring within the past 3 months. **Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

UROLOGIC DISORDERS

Urologic disorders encompass illnesses and diseases of the genitourinary tract. Some examples include urinary incontinence, urinary tract infection, sexually transmitted diseases, urolithiasis (kidney stones), and kidney and bladder cancer. Many of these disorders affect a large number of adult women; annual Medicaid expenditures for urinary incontinence and urinary tract infections among adult women total more than $234 million and $956 million, respectively. These same illnesses accounted for $39 million and $480 million in expenditures, respectively, for adult men.[33]

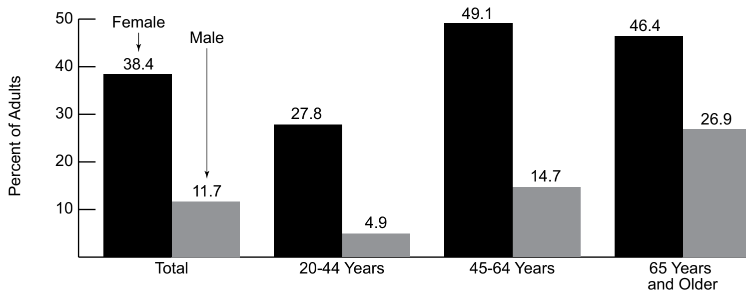
Urinary incontinence is one of the most prevalent chronic diseases in the United States and is generally more common among women than men.[33] In 2005–2006, 38.4 percent of women and 11.7 percent of men aged 20 years and older reported that they had urinary leakage less than once a month or more frequently. Among women, urinary leakage was most common among those aged 45–64 and 65 years and older (49.1 and 46.4 percent, respectively), compared to 27.8 percent of women aged 20–44 years. In addition, 21.6 percent of women with urinary leakage reported that it affects their daily activities at least a little, compared to 14.5 percent of men (data not shown).

Among women with urinary leakage, 38.7 percent reported that it occurred less than once a month, while 28.3 percent reported occurrence a few times a month. Nearly 16 percent of those with urinary leakage reported that it occurred a few times a week and 17.2 percent experienced leakage every day and/or night.

Urinary incontinence also varied by race and ethnicity. More than 40 percent of non-Hispanic White women reported urinary leakage, followed by 36.6 percent of Hispanic women. Non-Hispanic Black women were least likely to report any leakage (29.4 percent; data not shown). Among women with urinary leakage, the frequency of occurrence and effects on daily activities did not vary by race and ethnicity, indicating that the impact of the condition is universal.

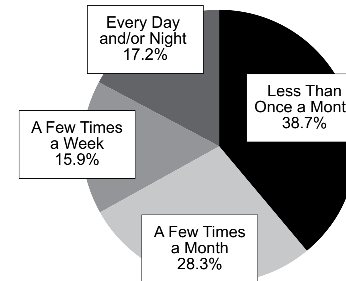
Adults Aged 20 and Older Reporting Urinary Leakage, by Age and Sex, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Frequency of Urinary Leakage Among Women Aged 20 and Older Reporting Any Leakage,* 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Percentages do not equal 100 because of rounding.*

LIVE BIRTHS

According to preliminary data, there were more than 4.3 million live births in the United States in 2007, an increase of 1 percent from the previous year. The number of births rose in every racial and ethnic group, most noticeably among Asian/Pacific Islander women (6 percent). Overall, the crude birth rate was 14.3 births per 1,000 total population (data not shown). Hispanic women continued to have the highest birth rate in 2007 (102.1 per 1,000 women), followed by non-Hispanic Black women (71.6 per 1,000 women). Non-Hispanic White women had the lowest birth rate (60.1 per 1,000 women).

With regard to age, overall birth rates were highest among mothers aged 25–29 years (117.5 live births per 1,000 women), followed by those aged 20–24 years (106.4 births per 1,000 women). The birth rate for non-Hispanic Whites was highest among 25- to 29-year-olds (108.8 per 1,000), while the rates for non-Hispanic Blacks, Hispanics, and American Indian/Alaska Natives were highest among 20- to 24-year-olds (133.6, 178.5, and 116.3 per 1,000 women, respectively). The birth rate among Asian/Pacific Islanders was highest among 30- to 34-year-olds (125.1 per 1,000 women).

The percentage of births delivered by cesarean has steadily increased since 1996. Among all births in 2006 (the latest year for which data are available), nearly one-third (31.1 percent) were delivered by cesarean, a 50 percent increase since 1996. Additionally, induction of labor increased more than 130 percent since 1990, from 9.6 percent in 1990 to 22.5 percent in 2006. In contrast, rates of vaginal births after a previous cesarean (VBAC) continued to decrease from 2005 to 2006 (from 7.9 to 7.6 percent; data not shown).[34]

In 2006, 83.2 percent of women received prenatal care during the first trimester of pregnancy, while 3.6 percent of women received care in the third trimester or not at all (data not shown).[34]

Live Births per 1,000 Women, by Age and Race/Ethnicity, 2007*

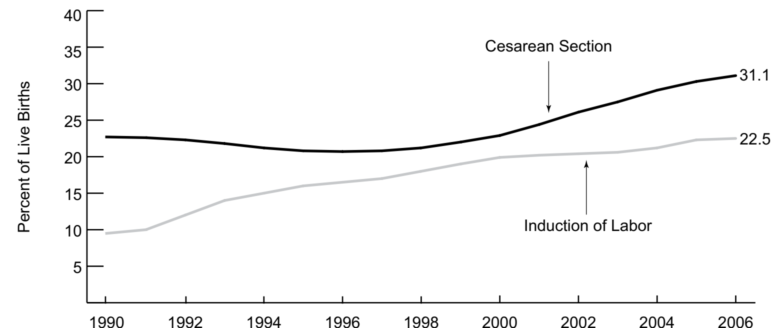
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaska Native**	Asian/Pacific Islander**
Total	69.5	60.1	71.6	102.1	64.7	71.4
15-19 Years	42.5	27.2	64.3	81.7	59.0	17.3
20-24 Years	106.4	83.3	133.6	178.5	116.3	66.2
25-29 Years	117.5	108.8	107.5	155.6	96.4	117.9
30-34 Years	99.9	99.7	74.4	110.8	63.7	125.1
35-39 Years	47.5	45.8	36.4	56.4	29.4	66.3
40-44 Years	9.5	8.6	8.6	13.4	6.1	14.5

*Data are preliminary. **Includes Hispanics.

Births Involving Cesarean Section and Induction of Labor Among Women, 1990–2006

Source II.21, 22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



BREASTFEEDING

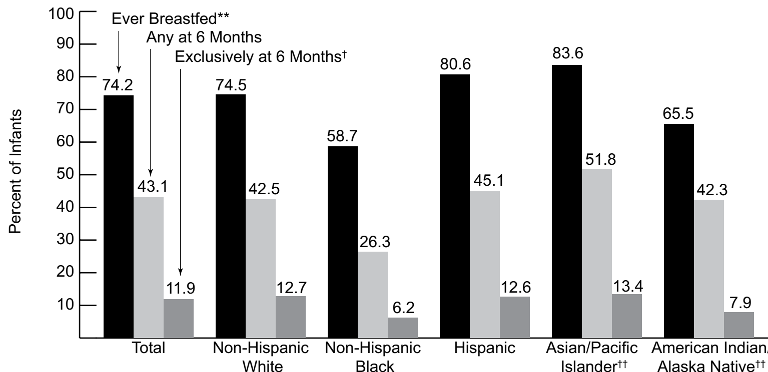
Breastmilk benefits the health, growth, immunity, and development of infants, and mothers who breastfeed may have a decreased risk of breast and ovarian cancers.[35] The Healthy People 2010 objectives for breastfeeding are to increase the percentage of women ever breastfeeding to 75 percent and those breastfeeding at 6 months to 50 percent.[36] Among infants born in 2005, 74.2 percent were reported to have ever been breastfed, representing a significant increase over the 68.3 percent of children ever breastfed in 1999. Other estimates of breastfeeding initiation yield percentages that exceed the HP 2010 goal.[37] Non-Hispanic Black infants were the least likely to ever be breastfed (58.7 percent), while Asian/Pacific Islanders and Hispanics were the most likely (83.6 and 80.6 percent, respectively).

The American Academy of Pediatrics recommends that infants be exclusively breastfed—without supplemental solids or liquids—for the first 6 months of life; however, 11.9 percent of infants born in 2005 were exclusively breastfed through 6 months, and 43.1 percent of infants were fed any breastmilk at 6 months. Breastfeeding practices vary considerably by a number of factors, including educational attainment—infants born to college graduates were most likely to have ever been breastfed (85.9 percent), while infants born to mothers with no high school diploma were least likely (65.7 percent).

Maternal employment can also affect whether and for how long an infant is breastfed; mothers working full-time are less likely to breastfeed at 6 months than those working part-time or not at all.[38] In 2006, 51.9 percent of mothers with children under 1 year of age were employed, and nearly 70 percent of those mothers were employed full-time (data not shown).[39]

Infants* Who Are Breastfed, by Race/Ethnicity and Duration, 2005–2007

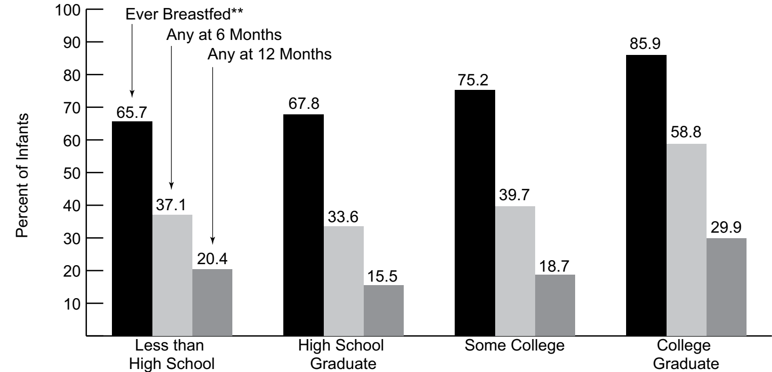
Source II.23: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2005; data are provisional. **Reported that child was ever breastfed or fed human breastmilk. †Exclusive breastfeeding is defined as only human breastmilk—no solids, water, or other liquids. ††Includes Hispanics.

Infants* Who Are Breastfed, by Maternal Education and Duration, 2005–2007

Source II.23: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2005; data are provisional. **Reported that child was ever breastfed or fed human breastmilk.

SMOKING DURING PREGNANCY

Smoking during pregnancy can have a negative impact on the health of women, infants, and children by increasing the risk of complications during pregnancy, premature delivery, and low birth weight—leading causes of infant mortality.[4] Maternal cigarette use data is captured on birth certificates; however, a revised birth certificate was introduced in 2003 that captures smoking during pregnancy by trimester, as opposed to any time during pregnancy as is assessed with the unrevised birth certificate. As of 2006, the 1989 Standard Certificate of Live Birth (unrevised) was used in 32 States, New York City, and Washington, DC, while 19 States used the revised birth certificate.[40]

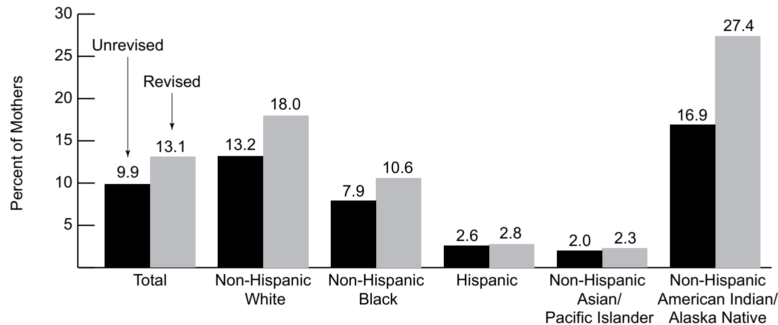
The areas using the revised birth certificate reported higher rates of smoking in pregnancy than those using the unrevised certificate (13.1 versus 9.9 percent, respectively). The proportion of mothers who smoked varied by maternal race and ethnicity. Among women in areas using the revised birth certificate, non-Hispanic American Indian/Alaska Native mothers (27.4 percent) and non-Hispanic White mothers (18.0 percent) were most likely to report having smoked during pregnancy.

Similarly, among women in the unrevised reporting areas, non-Hispanic American Indian/Alaska Native mothers were most likely to have smoked during pregnancy (16.9 percent), followed by non-Hispanic White women (13.2 percent). Non-Hispanic Asian/Pacific Islander and Hispanic mothers were least likely to have smoked during pregnancy in both reporting areas.

Cigarette use also varied by maternal age in 2006. Among women in the revised reporting areas, women under 20 years of age were most likely to have smoked cigarettes during pregnancy (17.3 percent), followed by women aged 20–29 years (15.9 percent). Similarly, 13.5 percent of women under 20 years of age in the unrevised reporting areas smoked during pregnancy, followed by 12.2 percent of women aged 20–29 years.

Cigarette Smoking During Pregnancy, by Maternal Race/Ethnicity and Birth Certificate Type,* 2006

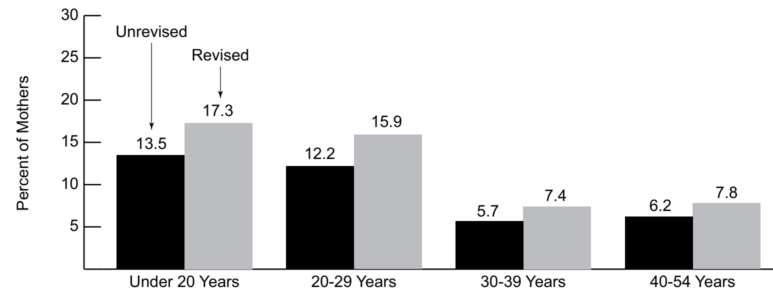
Source II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*The 1989 Standard Certificate of Live Birth (unrevised) was used in 34 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 19 reporting areas.

Cigarette Smoking During Pregnancy, by Maternal Age and Birth Certificate Type,* 2006

Source II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*The 1989 Standard Certificate of Live Birth (unrevised) was used in 34 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 19 reporting areas.

MATERNAL MORBIDITY AND RISK FACTORS IN PREGNANCY

Since 1989, diabetes and hypertension have been the most commonly reported health conditions among pregnant women. Diabetes, both chronic and gestational (developing only during pregnancy), may pose health risks to both a woman and her baby. Women with gestational diabetes are at increased risk for developing diabetes later in life.[41] In 2006, diabetes of any type during pregnancy occurred at a rate of 42.3 per 1,000 live births. This varied by race/ethnicity; Hispanic mothers were more likely to have had diabetes (43.0 per 1,000 live births) than non-Hispanic Whites and non-Hispanic Blacks (40.1 and 37.1 per 1,000, respectively).

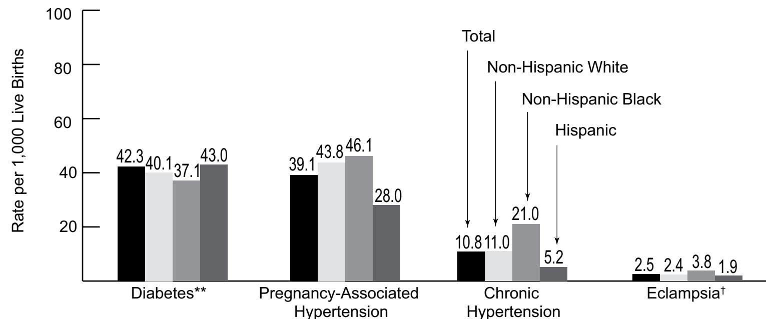
Hypertension during pregnancy can also be either chronic in nature or gestational. Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, premature birth, placental abruption, and stillbirth.[42] Chronic hypertension was present in 10.8 per 1,000 live births in 2006, and most common among non-Hispanic Black women (21.0 per 1,000). The rate of pregnancy-associated hypertension was 39.1 per 1,000 live births and was more common among non-Hispanic Black and non-Hispanic White women (46.1 and 43.8 per 1,000 births) than among Hispanic women (28.0 per 1,000).

Eclampsia, which involves seizures and is usually preceded by a diagnosis of preeclampsia, is a life-threatening complication of pregnancy. In 2006, eclampsia occurred among 2.5 women per 1,000 live births.

Rates of maternal morbidities and risk factors also varied by maternal age. In 2006, women aged 40–54 years were at highest risk of diabetes during pregnancy (94.3 per 1,000 live births), pregnancy-associated hypertension (50.5 per 1,000) and chronic hypertension (30.4 per 1,000). Women under 20 years of age were least likely to have diabetes during pregnancy or chronic hypertension (13.3 and 3.9 per 1,000, respectively). Rates of pregnancy-associated hypertension did not vary significantly between age groups for women under 40 years of age.

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Race/Ethnicity,* 2006

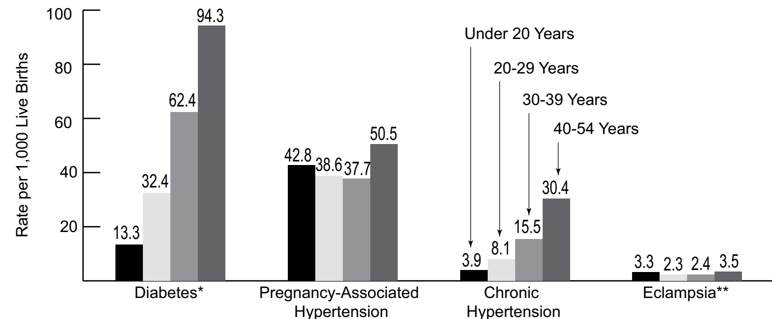
Source II.21, II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data not reported for American Indian/Alaska Natives, Asian/Pacific Islanders, and persons of more than one race. **Includes gestational and chronic diabetes. †Eclampsia is characterized by seizures and generally follows preeclampsia, which is marked by high blood pressure, weight gain, and protein in the urine.

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Age, 2006

Source II.21, II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Includes gestational and chronic diabetes. **Eclampsia is characterized by seizures and generally follows preeclampsia, which is marked by high blood pressure, weight gain, and protein in the urine.

MATERNAL MORTALITY

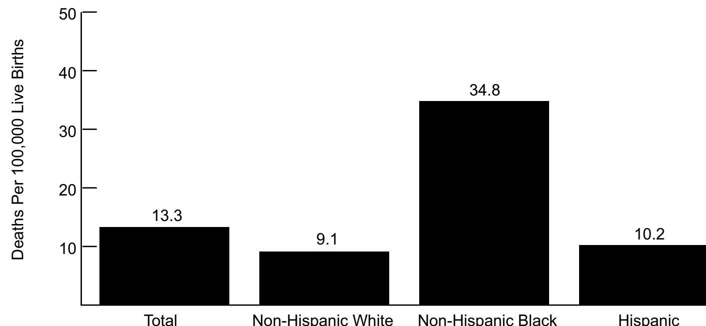
Maternal deaths are those reported on the death certificate to be related to or aggravated by pregnancy or pregnancy management that occur during or within 42 days after the end of the pregnancy. The maternal mortality rate has declined dramatically since 1950 when the rate was 83.3 deaths per 100,000 live births; however, the maternal mortality rate in 2006 (13.3 per 100,000 live births) was 62 percent higher than the rate reported in 1990 (8.2 per 100,000). According to the National Center for Health Statistics, this increase may largely be due to changes in how pregnancy status is recorded on death certificates; beginning in 1999, the cause of death was coded according to International Classification of Diseases, 10th Revision (ICD-10). Other methodological changes in reporting and data processing have been responsible for apparent increases in more recent years, including question formatting and revisions to the U.S. Standard Certificate of Death.[43]

In 2006, there were a total of 569 maternal deaths. This does not include 191 deaths of women that were due to complications during pregnancy or childbirth and that occurred after 42 days postpartum or the deaths of pregnant women due to external causes such as unintentional injury, homicide, or suicide. In 2006, the maternal mortality rate among non-Hispanic Black women (34.8 per 100,000 live births) was more than 3 times the rates among non-Hispanic White and Hispanic women (9.1 and 10.2 per 100,000, respectively).

The risk of maternal death increases with age for women of all races and ethnicities. In 2006, the maternal mortality rate was highest among women aged 35 years and older (29.3 per 100,000 live births), compared to 5.0 per 100,000 live births to women under 20 years of age and 10.2 per 100,000 live births among women aged 20–24 years. There was little variation in maternal mortality rates by age group among women aged 20–34 years.

Maternal Mortality Rates, by Race/Ethnicity,* 2006

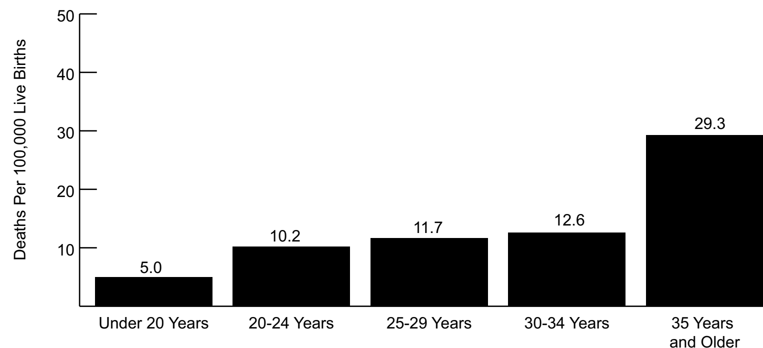
Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



**Data not reported for Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races not specified.*

Maternal Mortality Rates, by Age, 2006

Source II.25: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



OLDER WOMEN

In 2007, there were 37.9 million adults aged 65 years and older in the United States, representing 12.6 percent of the total population. According to the U.S. Census Bureau, the older population is expected to grow to 72 million by 2030, representing approximately 20 percent of the population. In 2007, older women composed 7.3 percent of the total population while men accounted for 5.3 percent. Women represented a larger proportion of the population than men within every older age group.

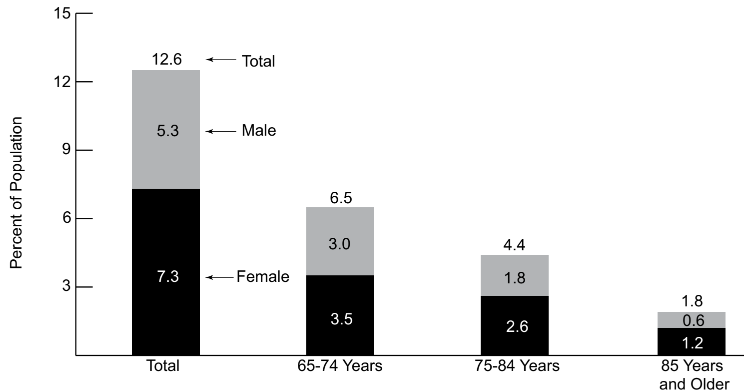
Among women aged 65 years and older and not living in an institution, 42.2 percent were married and living with a spouse in 2007, while another 38.6 percent lived alone. Nearly 9 percent of older women were heads of their household, with no spouse present, meaning that they have children or other family members, but no spouse, living with them in a housing unit that they own or rent. Research has suggested that older adults who live alone are more likely to live in poverty, which has numerous implications including increased risk of food insecurity, decreased access to health care facilities due to lack of transportation, and inability to pay utility bills. [44]

Employment plays a significant role in the lives of many older Americans. In 2007, more than 2.4 million women aged 65 years and older were working, accounting for 10.8 percent of women in this age group. Nearly 19 percent of women aged 65–74 years were employed during 2007, while only 3.5 percent of those aged 75 and older were employed (data not shown).

In 2004, an estimated 1.5 million adults resided in nursing homes. Women aged 65 years and older accounted for 65.7 percent of the nursing home resident population. Some nursing home facilities offer end-of-life or palliative care for their residents; in 2004, 17.2 percent of facilities reported participating in at least one end-of-life program, while 16.7 percent also reported having trained staff for providing palliative and end-of-life care (data not shown).[45]

Representation of Adults Aged 65 and Older in the U.S. Population,* by Age and Sex, 2007

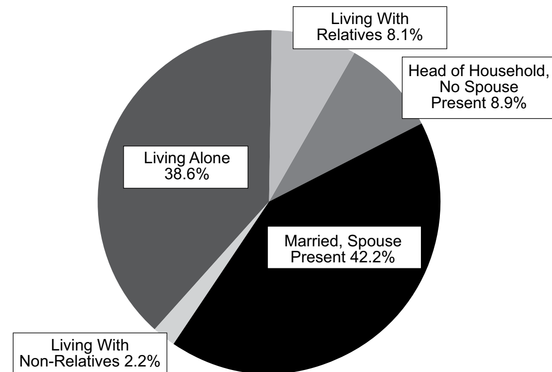
Source I.1: U.S. Census Bureau, American Community Survey



*Civilian, non-institutionalized population.

Women Aged 65 and Older,* by Household Composition, 2007

Source I.2: U.S. Census Bureau, Current Population Survey



*Civilian, non-institutionalized population.

RURAL AND URBAN WOMEN

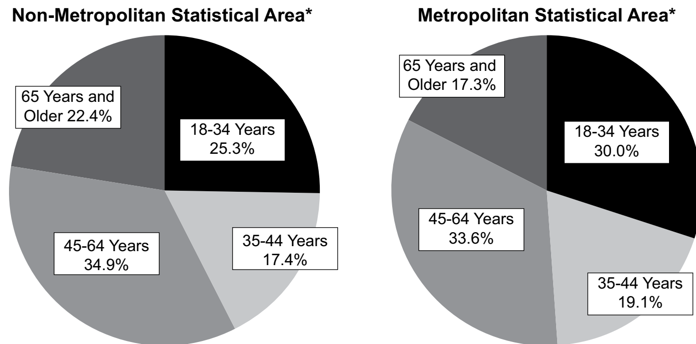
In 2006, more than 48 million people, or 16.4 percent of the population, lived in areas considered to be non-metropolitan. The number of areas defined as metropolitan changes frequently as the population grows and people move. Residents of non-metropolitan areas tend to be older, complete fewer years of education, have public insurance or no health insurance, and live farther from health care resources than their metropolitan counterparts.

In 2006, 22.4 percent of women in non-metropolitan areas were aged 65 years and older, while only 17.3 percent of women in metropolitan areas were in the same age group. One-quarter of women in non-metropolitan areas were aged 18–34 years, compared to 30.0 percent in metropolitan areas. Women aged 35–44 years and 45–64 years accounted for approximately the same percentage of the female population in non-metropolitan and metropolitan areas.

Nearly 66 percent of women reported receiving dental care once a year or more frequently in 2006. Annual dental care was more common among women of all ages in metropolitan areas than in non-metropolitan areas (67.3 versus 57.7 percent, respectively). Among women in non-metropolitan areas, those aged 35–44 years were most likely to receive dental care at least once a year (64.2 percent), followed by women aged 18–34 and 45–64 years (59.1 and 59.7 percent, respectively). Fewer than half of non-metropolitan women aged 65 years and older reported receiving dental care at least once a year.

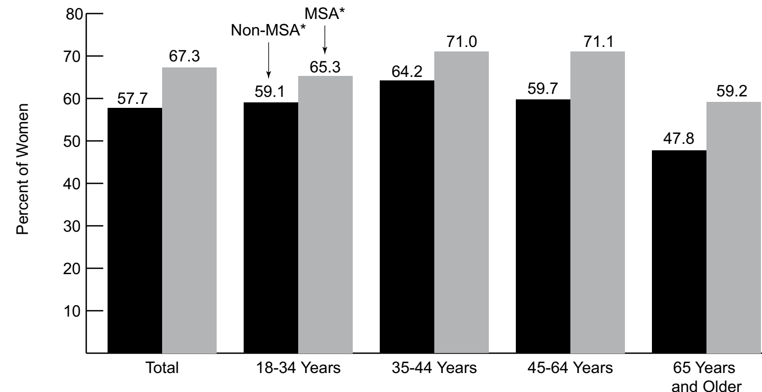
Women Aged 18 and Older, by Area of Residence and Age, 2006

Source II.26: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Women Aged 18 and Older Who Receive Dental Care Once a Year or More, by Age and Area of Residence, 2006

Source II.26: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



A metropolitan statistical area (MSA) is defined as a core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core. All counties within a metropolitan statistical area are classified as metropolitan. Counties not within a metropolitan statistical area are considered non-metropolitan.

Percent of Women Aged 18 and Older Who Are Current Smokers, by State and Age, 2007

Source II.27: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System

STATE	Total	18-34 Years	35-44 Years	45-64 Years	65 Years and Older
Alabama	19.7	23.1	23.5	21.2	9.0
Alaska	19.7	21.7	20.7	20.8	7.9
Arizona	16.3	19.0	15.4	17.8	10.7
Arkansas	20.2	20.9	24.6	24.0	9.9
California	10.6	10.7	11.5	11.6	7.6
Colorado	17.7	21.5	17.1	18.1	9.7
Connecticut	14.5	18.5	14.5	16.2	6.8
Delaware	20.3	23.9	21.2	22.5	10.5
District of Columbia	15.7	16.6	15.1	19.5	9.1
Florida	17.5	18.6	21.3	20.3	9.7
Georgia	17.5	20.2	18.4	19.0	8.5
Hawaii	14.3	19.0	14.7	14.5	7.8
Idaho	17.4	20.1	18.2	19.5	7.8
Illinois	18.4	21.9	20.1	19.7	8.6
Indiana	22.4	27.6	25.3	23.4	9.9
Iowa	18.3	24.6	21.9	17.9	8.0
Kansas	17.1	19.3	20.6	18.3	8.8
Kentucky	27.8	36.9	30.6	28.1	11.1
Louisiana	19.1	19.6	23.5	21.2	8.6
Maine	19.3	29.1	22.7	17.1	8.4
Maryland	16.0	19.7	16.4	16.7	8.2
Massachusetts	15.5	20.1	17.6	15.7	7.7
Michigan	19.0	25.2	22.4	18.1	7.8
Minnesota	14.7	17.6	15.4	15.7	7.5
Mississippi	20.5	22.3	23.9	22.9	10.1
Missouri	23.3	27.1	27.7	25.6	9.8

STATE	Total	18-34 Years	35-44 Years	45-64 Years	65 Years and Older
Montana	19.3	25.2	23.2	18.9	9.1
Nebraska	16.8	19.5	19.6	18.5	7.5
Nevada	19.6	19.2	18.1	23.0	15.4
New Hampshire	18.6	22.3	21.0	18.9	10.1
New Jersey	15.2	16.9	17.3	16.4	9.0
New Mexico	18.1	20.2	16.6	21.7	9.3
New York	16.5	18.6	16.6	18.8	9.4
North Carolina	20.7	23.3	25.4	21.7	10.1
North Dakota	19.8	26.5	20.3	21.1	8.6
Ohio	22.1	29.6	24.1	22.3	9.4
Oklahoma	23.8	26.5	26.3	28.7	9.7
Oregon	14.9	17.8	15.5	16.3	7.7
Pennsylvania	21.1	27.3	26.9	21.8	8.6
Rhode Island	16.3	18.7	19.3	16.7	9.7
South Carolina	18.8	21.9	21.4	20.1	9.0
South Dakota	19.5	24.9	22.5	20.5	8.4
Tennessee	22.9	27.3	25.8	26.1	8.3
Texas	16.9	19.0	17.2	18.8	9.2
Utah	8.0	9.1	9.9	6.9	4.3
Vermont	15.9	21.8	19.4	15.0	6.2
Virginia	16.9	21.0	15.8	18.5	8.0
Washington	15.7	20.3	16.9	15.1	7.4
West Virginia	25.5	31.6	34.3	25.4	11.8
Wisconsin	19.5	25.3	21.7	20.2	8.0
Wyoming	21.4	24.3	28.6	21.7	9.7

Leading Causes of Death Among Women,* by State, 2005

Source II.28: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

STATE	All Causes		Heart Disease		Malignant Neoplasm (Cancer)		Cerebrovascular Disease (Stroke)		Chronic Lower Respiratory Disease		Unintentional Injury	
	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000
Alabama	23,932	820.7	6,679	222.0	4,599	163.0	1,819	60.5	1,149	39.3	798	31.3
Alaska	1,363	635.8	237	122.6	328	145.5	96	51.6	79	38.3	93	30.9
Arizona	21,818	631.5	5,064	142.2	4,559	136.4	1,397	39.1	1,502	43.3	1,136	36.0
Arkansas	13,926	754.7	3,771	194.7	2,853	164.3	1,123	57.6	740	40.7	454	29.1
California	117,342	609.4	32,204	162.4	26,828	145.9	9,299	47.2	7,053	37.3	3,656	19.8
Colorado	14,729	638.1	3,012	129.5	3,182	140.7	941	40.4	935	42.2	689	29.4
Connecticut	15,617	617.7	4,024	147.8	3,529	153.9	914	34.1	828	33.3	402	18.4
Delaware	3,763	712.4	1,044	190.7	861	167.9	218	40.1	223	42.3	94	19.7
District of Columbia	2,681	731.0	801	206.7	543	155.0	136	35.9	69	18.1	74	21.9
Florida	82,641	606.3	22,265	149.8	18,606	146.7	5,359	36.7	4,942	35.3	2,907	27.6
Georgia	33,646	743.5	8,374	184.8	6,739	151.0	2,328	51.6	1,762	40.0	1,295	28.0
Hawaii	4,147	499.8	1,016	118.4	980	124.0	367	42.0	124	14.8	137	17.8
Idaho	5,163	656.7	1,162	143.8	1,087	145.3	425	52.1	339	45.3	210	28.0
Illinois	54,076	684.8	14,419	174.4	12,009	164.0	3,839	46.3	2,768	36.0	1,436	20.1
Indiana	28,621	733.4	7,413	182.5	6,126	166.9	2,030	50.0	1,820	47.8	897	25.2
Iowa	14,516	628.9	3,801	152.6	3,058	153.0	1,169	46.0	838	39.0	478	24.6
Kansas	12,771	686.5	3,005	149.8	2,618	159.1	964	47.9	778	44.1	427	26.8
Kentucky	20,213	785.9	5,474	206.9	4,392	176.7	1,347	50.5	1,319	52.0	789	34.6
Louisiana	22,152	850.2	5,444	204.0	4,345	172.0	1,507	56.9	933	36.1	1,089	44.1
Maine	6,582	698.5	1,471	148.7	1,526	171.3	431	42.9	428	46.3	207	25.5
Maryland	22,339	694.0	5,934	180.8	5,081	162.2	1,499	45.4	1,121	35.0	422	13.8
Massachusetts	28,738	624.0	6,961	140.8	6,603	159.3	1,881	38.0	1,523	34.1	720	18.1
Michigan	44,629	716.7	12,837	197.7	9,784	165.4	3,082	47.4	2,392	39.1	1,265	22.3
Minnesota	19,420	585.1	3,802	107.9	4,360	146.8	1,475	41.9	1,018	32.7	757	24.1
Mississippi	14,550	822.9	4,475	243.8	2,773	164.1	898	49.2	686	39.2	679	42.7

STATE	All Causes		Heart Disease		Malignant Neoplasm (Cancer)		Cerebrovascular Disease (Stroke)		Chronic Lower Respiratory Disease		Unintentional Injury	
	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000	Number of Deaths	Rate per 100,000
Missouri	27,922	722.2	7,677	187.8	5,889	164.4	2,091	51.0	1,548	41.1	1,029	30.6
Montana	4,203	678.9	857	130.6	933	161.7	314	47.2	289	48.1	184	33.2
Nebraska	7,723	628.9	1,857	138.5	1,619	148.2	578	43.3	474	40.6	302	28.1
Nevada	8,595	749.3	2,158	189.9	1,972	165.8	506	45.1	644	56.4	345	29.7
New Hampshire	5,280	646.5	1,273	148.2	1,253	162.6	330	38.5	358	45.5	159	21.1
New Jersey	37,798	654.1	10,967	179.2	8,719	160.9	2,191	36.5	1,777	31.1	928	18.4
New Mexico	7,085	652.9	1,628	146.3	1,501	140.7	449	40.4	421	38.8	434	42.5
New York	80,468	622.9	28,593	208.6	18,110	150.6	4,051	30.1	3,784	29.8	1,644	14.0
North Carolina	38,098	736.0	8,849	167.0	7,916	157.2	2,954	55.5	2,079	40.6	1,507	31.6
North Dakota	2,883	583.1	747	135.3	634	150.5	221	39.8	126	28.0	104	25.0
Ohio	56,247	736.7	14,766	184.7	11,858	165.0	3,900	48.5	3,481	46.2	1,742	25.9
Oklahoma	18,310	810.3	5,122	215.7	3,467	162.4	1,384	58.5	1,185	53.8	728	37.4
Oregon	15,803	678.2	3,290	133.8	3,503	160.3	1,406	57.4	992	44.4	543	25.4
Pennsylvania	67,848	701.4	19,001	182.6	14,458	164.5	4,767	45.9	3,272	33.8	1,979	25.7
Rhode Island	5,404	661.3	1,663	186.6	1,127	156.9	321	36.6	296	37.2	133	17.4
South Carolina	19,077	741.5	4,468	170.3	3,938	155.5	1,450	55.2	983	38.4	737	31.7
South Dakota	3,512	619.6	855	137.9	745	150.4	308	49.5	193	36.1	143	29.3
Tennessee	28,784	789.0	7,523	200.2	6,082	171.8	2,247	59.6	1,634	45.4	1,156	35.5
Texas	77,260	683.4	19,695	172.8	16,011	145.8	5,622	49.3	4,065	37.2	2,952	25.8
Utah	6,675	634.7	1,449	137.5	1,172	115.9	473	45.3	257	25.6	257	22.4
Vermont	2,611	629.8	624	143.1	589	150.8	149	33.4	189	46.8	112	30.3
Virginia	29,624	690.6	7,086	162.4	6,665	158.7	2,288	52.3	1,560	37.0	939	22.9
Washington	23,242	642.7	5,234	139.3	5,414	157.5	1,762	47.0	1,464	41.9	902	26.1
West Virginia	10,553	808.4	2,797	202.7	2,188	175.7	736	53.2	687	52.6	323	29.9
Wisconsin	23,999	647.5	5,931	149.8	5,322	157.7	1,811	45.9	1,230	34.7	962	29.1
Wyoming	1,963	678.5	451	153.0	436	154.7	140	47.0	141	49.4	79	29.6

**All rates are age-adjusted.*

Percent of Women Aged 18 and Older Who Are Overweight and Obese,* by State, 1996 and 2007

Source II.27: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System

STATE	Overweight		Obese	
	1996	2007	1996	2007
Alabama	25.9	29.9	20.3	31.8
Alaska	25.2	28.2	19.2	29.6
Arizona	25.5	32.1	13.1	21.8
Arkansas	26.6	30.2	17.9	27.5
California	27.1	28.8	15.0	22.4
Colorado	24.2	27.2	10.7	18.9
Connecticut	25.8	28.5	12.0	20.0
Delaware	27.6	30.9	19.1	26.0
District of Columbia	28.4	28.6	19.6	25.3
Florida	27.0	30.2	16.8	23.1
Georgia	28.3	29.9	11.7	28.7
Hawaii	25.2	26.6	11.8	19.4
Idaho	26.5	29.4	16.2	26.4
Illinois	27.3	30.4	18.6	25.0
Indiana	26.6	27.8	19.6	27.7
Iowa	27.8	31.6	18.1	25.9
Kansas	25.0	29.9	14.5	26.6
Kentucky	27.8	30.1	19.1	28.5
Louisiana	27.4	29.3	21.4	29.4
Maine	27.9	31.1	17.6	23.7
Maryland	25.6	29.7	18.7	27.3
Massachusetts	26.8	29.0	12.0	20.1
Michigan	28.9	30.5	18.6	27.8
Minnesota	26.9	31.0	14.1	22.3
Mississippi	28.9	29.2	21.1	33.8
Missouri	27.5	28.8	20.7	27.9
Montana	28.1	31.4	14.1	22.0
Nebraska	27.3	28.5	16.4	25.7
Nevada	22.9	31.4	13.6	23.4
New Hampshire	27.2	30.5	11.2	23.5
New Jersey	26.2	31.6	13.6	22.9
New Mexico	28.8	29.4	15.4	26.6
New York	28.2	29.5	15.2	24.6
North Carolina	27.6	29.4	17.8	29.4
North Dakota	30.3	31.3	17.2	23.4
Ohio	28.3	29.1	19.2	26.9
Oklahoma	26.0	30.4	16.8	28.6
Oregon	26.0	28.8	16.7	25.9
Pennsylvania	28.1	28.7	18.2	27.2
Rhode Island	27.5	29.1	14.1	21.5
South Carolina	27.9	29.6	19.2	29.8
South Dakota	30.9	30.5	14.1	26.5
Tennessee	24.2	31.5	18.2	28.8
Texas	26.9	31.3	18.2	28.6
Utah	24.6	28.6	13.2	20.5
Vermont	25.6	28.5	14.6	20.8
Virginia	23.8	29.6	16.8	24.6
Washington	25.7	29.8	15.8	25.6
West Virginia	30.8	31.3	19.9	29.8
Wisconsin	25.5	29.0	18.8	23.5
Wyoming	24.9	30.8	13.8	24.3

Overweight is defined as a Body Mass Index (BMI) of 25.0 to 29.9, and obesity is defined as a BMI of 30.0 or more.

HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affects all aspects of women's health. For women who have poor health status, disabilities, poverty, lack of insurance, and limited access to a range of health services, preventive treatment and rehabilitation can be critical in preventing disease and improving quality of life.

This section presents data on women's health services utilization, including data on women's insurance coverage, usual source of care, satisfaction with care, and use of various services, such as preventive care, HIV testing, hospitalization, and mental health services. A new addition to this section describes the use of alternative and complementary medicine among women.

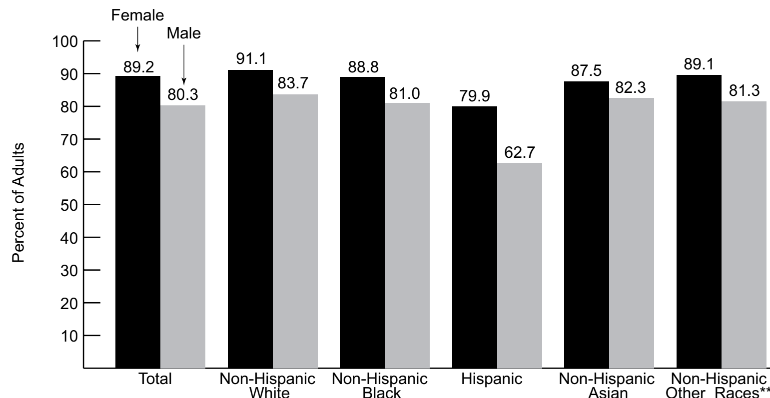
USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2007, 89.2 percent of women reported having a usual source of care. Within every racial and ethnic group, women were more likely than men to have a usual source of care. Non-Hispanic White women were most likely to report a usual source of care (91.1 percent), followed by non-Hispanic women of other races not specified (89.1 percent) and non-Hispanic Black women (88.8 percent). Among both women and men, Hispanics were least likely to report a usual source of care (79.9 and 62.7 percent, respectively).

In 2007, the percentage of women with a usual source of care varied by geographic region and poverty level. Among women with household incomes of 200 percent or more of the poverty level, there was little variation in having a usual source of care by geographic region. Among women with lower incomes, however, having a usual source of care varied noticeably by geographic region. Among women with incomes of less than 200 percent of poverty, those in the South and West were least likely to have a usual source of care (77.0 and 81.7 percent, respectively), while those in the Northeast were most likely to have a usual source of care (90.8 percent).

Adults Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity and Sex, 2007*

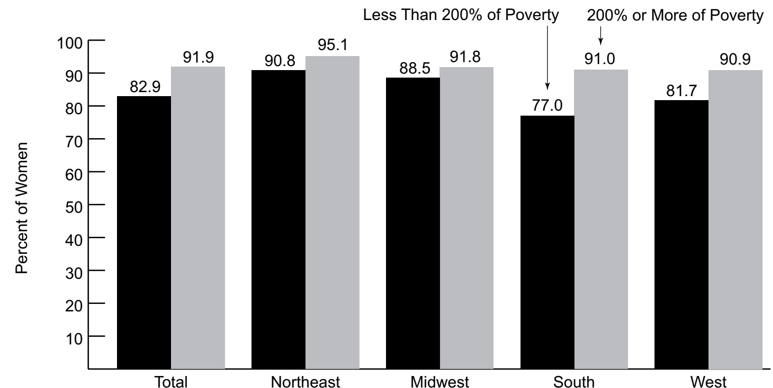
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Rates reported are not age-adjusted. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

Women Aged 18 and Older with a Usual Source of Care, by Geographic Region and Poverty Status,* 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007. Rates reported are not age-adjusted.*

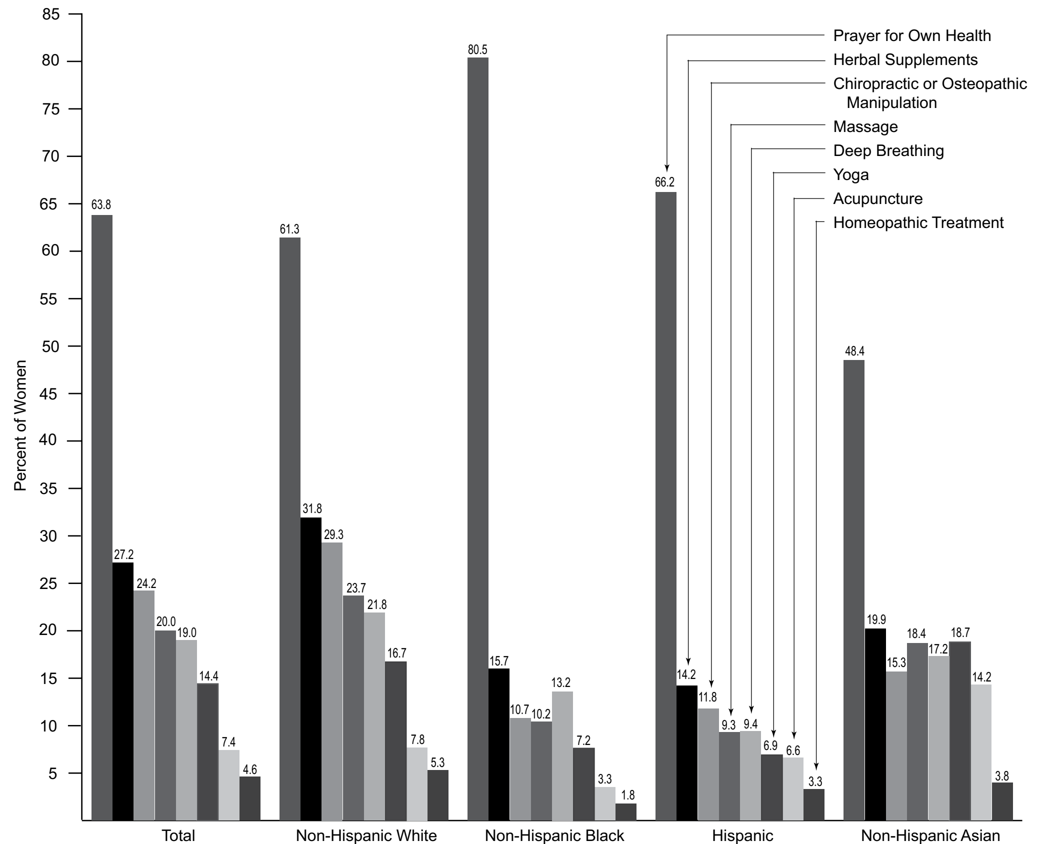
COMPLEMENTARY AND ALTERNATIVE MEDICINE

Complementary and alternative medicine (CAM) describes a wide range of health care practices, therapies, and products that are not considered to be part of conventional Western medicine. Complementary interventions are used together with conventional treatments, while alternative interventions are used in place of those treatments. Both can be used to improve health and well-being, to relieve symptoms associated with illness, and to relieve side effects from conventional treatments.

In 2007, 63.8 percent of women reported having ever prayed for their own health. The second most commonly reported CAM therapy was the use of herbal supplements (27.2 percent), followed by chiropractic or osteopathic manipulation (24.2 percent) and massage (20.0 percent). Use of CAM therapies varied by race and ethnicity: non-Hispanic Black women were more likely than women of other races to have ever prayed for their own health (80.5 percent), while non-Hispanic White women were the most likely to utilize massage (23.7 percent), deep breathing (21.8 percent), and homeopathic treatment (5.3 percent). Non-Hispanic Asian women were most likely to have used yoga (18.7 percent) and acupuncture (14.2 percent) as a complementary or alternative treatment.

Selected Complementary and Alternative Medicines Ever Used by Women Aged 18 and Older, by Race/Ethnicity* and Treatment Type, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



The sample of Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other and unspecified races was too small to produce reliable results. Data are not age-adjusted.

HEALTH INSURANCE

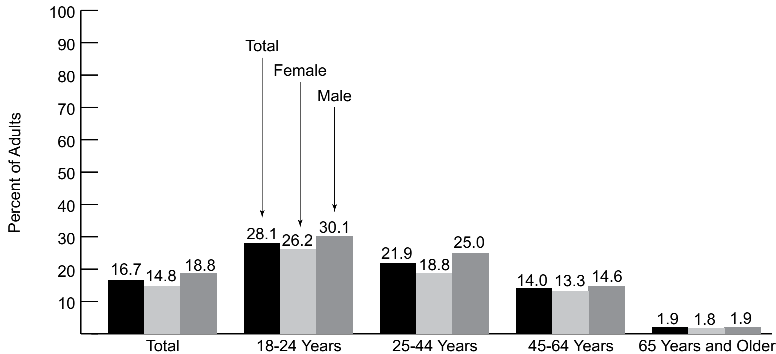
People who are uninsured are less likely than those with insurance to seek health care, which can result in poor health outcomes and higher health care costs. In 2007, 37.5 million adults (16.7 percent) were uninsured. Adults aged 18-64 accounted for 36.8 million of those uninsured, representing 19.6 percent of that population (data not shown).[4] The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race and ethnicity, income, and education.

Among adults in 2007, those aged 18–24 years were most likely to lack health insurance. Men were more likely than women to be uninsured in every age group. The highest rate of uninsurance occurred among 18- to 24-year-old men (30.1 percent), which was substantially higher than the percentage for women of the same age group (26.2 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest percentage of uninsured occurred among women and men aged 45–64 (13.3 and 14.6 percent, respectively); the sex disparity in this age group was less pronounced than in the younger age groups.

Among women aged 18–64 in 2007, 71.5 percent had private insurance, 15.0 percent had public insurance, and 17.6 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (78.9 percent), followed by Asian/Pacific Islander women (72.6 percent). American Indian/Alaska Native females had the highest rate of public insurance coverage (23.9 percent) followed closely by non-Hispanic Black women (23.3 percent). Hispanic females had the highest rate of uninsurance (36.6 percent), followed by American Indian/Alaska Native women (30.7 percent). [Respondents were able to report more than one type of coverage.]

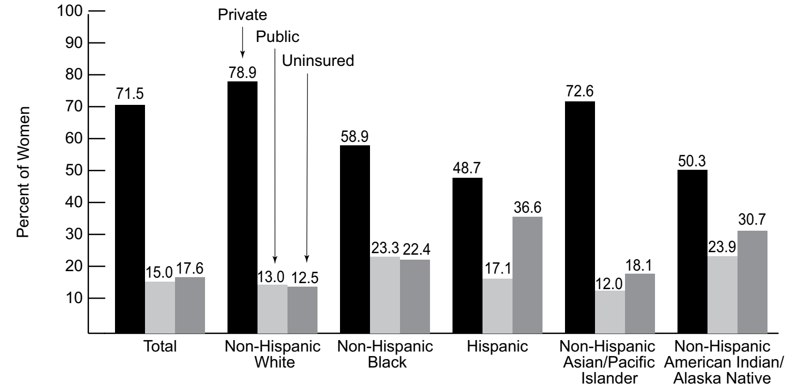
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2007

Source I.4: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Race/Ethnicity and Type of Coverage,* 2007

Source I.4: U.S. Census Bureau, Current Population Survey



Percentages may equal more than 100 because it was possible to report more than one type of coverage.

MEDICARE AND MEDICAID

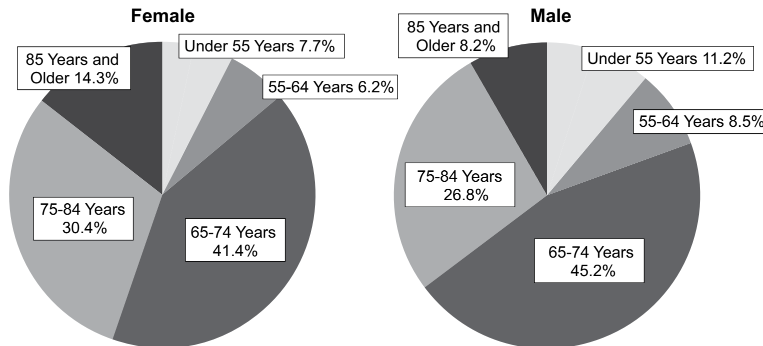
Medicare is the Nation's health insurance program for people aged 65 years and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase additional insurance coverage through private insurers; and Part D allows coverage for prescription drugs through private insurers.

In 2007, 60.2 percent of Medicare's 44.3 million enrollees were female. Among both women and men, those in older age groups accounted for a greater proportion of overall enrollment; however, men were more likely to have greater representation than women in the younger age groups. For instance, 8.5 percent of male enrollees were aged 55–64 years, compared to 6.2 percent of female enrollees. Similarly, adults aged 65–74 years accounted for 45.2 percent of male enrollees, compared to 41.4 percent of female enrollees. In contrast, adults aged 75 years and older accounted for 44.7 percent of female enrollees, compared to 35.0 percent of male enrollees.

Medicaid, jointly funded by Federal and State governments, provides coverage for low-income people and people with disabilities. In 2006, Medicaid covered 59.4 million people including children; the aged, blind, and disabled; and adults who are eligible for cash assistance programs. Adults aged 19 and older accounted for nearly half of Medicaid enrollees (29.4 million), and women accounted for 69.4 percent of adult enrollees. Women accounted for a greater proportion of adult Medicaid enrollees than men in every age group, most noticeably among 21- to 44-year-olds and those aged 85 years and older (74.3 and 80.4 percent, respectively).

Medicare Enrollees,* by Sex and Age, 2007

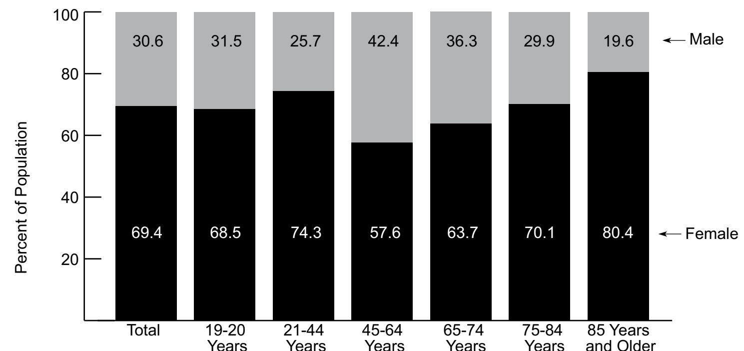
Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2007.

Adult Medicaid Enrollees Aged 19 and Older, by Age and Sex, 2007

Source III.1: Centers for Medicare and Medicaid Services



PREVENTIVE CARE

Preventive health care, including counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2006, females of all ages made 533 million physician office visits. Of these visits, 21.5 percent were for preventive care, including prenatal care, health screening, and insurance examinations (data not shown).[5]

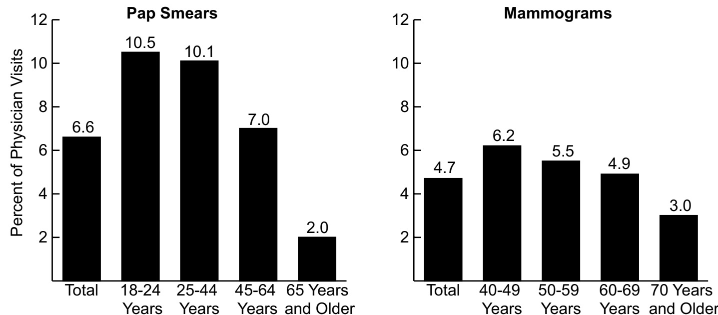
Routine Pap smears, which detect the early signs of cervical cancer, are recommended at least every 3 years beginning within 3 years of initiation of sexual activity, or by age 21.[6] In 2006, 6.6 percent of physician office visits made by women aged 18 and older included a Pap smear. This rate was higher among younger women and decreased with age, most likely due to higher rates of physician office visits among older women for non-preventive care. Among women aged 18–24 years, 10.5 percent of physician visits included a Pap smear, compared to 7.0 percent of visits made by women aged 45–64 years and 2.0 percent of visits among those aged 65 years and older.

Among women aged 40 and older, 4.7 percent of physician visits included a mammogram, which is recommended every 1–2 years to screen for breast cancer among this age group.[6] The rate of office visits including a mammogram was highest among the younger age groups. Among women aged 40–49 years, 6.2 percent of visits included a mammogram, compared to 3.0 percent of visits made by women aged 70 years and older.

High cholesterol is a risk factor for heart disease. The Healthy People 2010 goal is to increase the percentage of adults aged 20 and over who receive a cholesterol screening at least every 5 years to 80 percent.[7] In 2005–2006, 72.1 percent of women aged 20 years and older had received a cholesterol test within the previous 5 years. Non-Hispanic White and non-Hispanic Black women were more likely to have had the test (75.7 and 71.3 percent, respectively), compared to Hispanic women and non-Hispanic women of other races (53.5 and 64.7 percent, respectively).

Physician Office Visits Involving Pap Smears* and Mammograms,** by Selected Age Group, 2006†

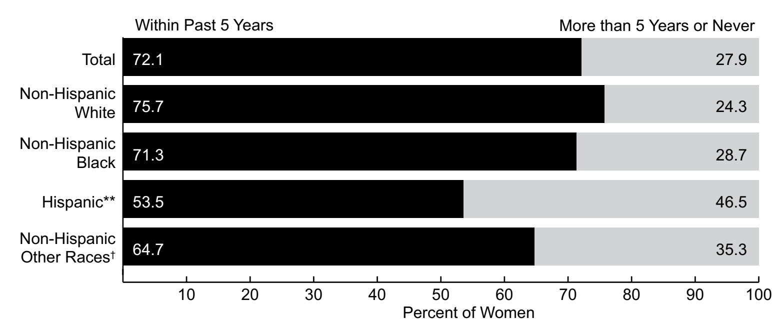
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Among women aged 18 and older. **Among women aged 40 and older. †Results should be interpreted with caution; older women visit physician's offices more frequently for non-preventive care.

Receipt of Cholesterol Screening Among Women Aged 20 and Older, by Race/Ethnicity, 2005–2006*

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Estimates are not age-adjusted. **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. †Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races.

VACCINATION

Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for young children 6 months through 18 years of age, adults aged 50 years and older, pregnant women or women who will be pregnant during flu season, persons with certain chronic medical conditions, persons in long-term care facilities, and health care workers and other persons in close contact with those at high risk.[8] In 2007, 44.8 percent of women aged 55–64 years and 66.3 percent of women aged 65 years and older reported receiving a flu vaccine in the past year; this varied, however, by race and ethnicity. Non-Hispanic White women were more likely than women of other races and ethnicities to have received the flu vaccine: 47.0 percent of 55- to 64-year-olds and 68.4 percent of those aged 65 years and older did so. Fewer than 57 percent of non-Hispanic Black and Hispanic women aged 65 years and older received the flu vaccine.

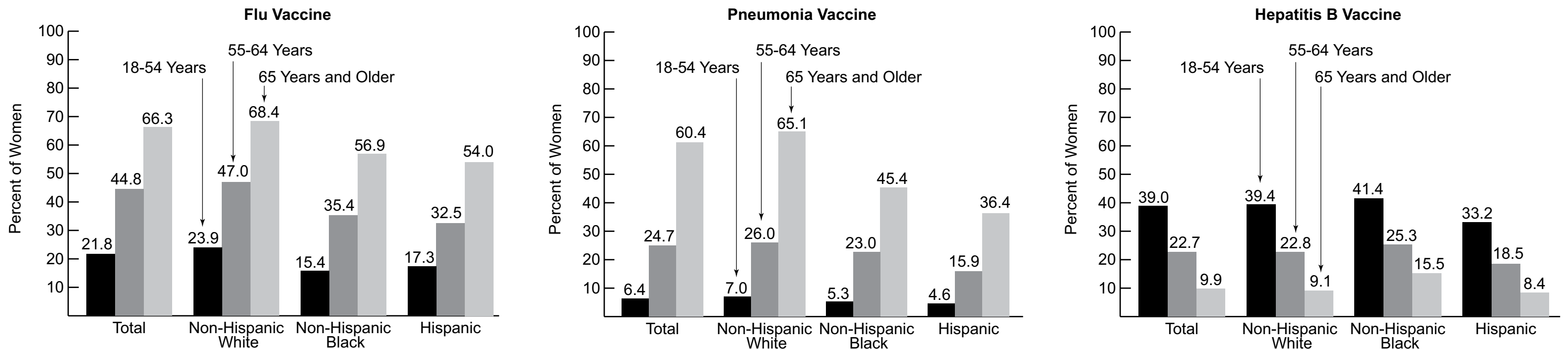
Pneumonia (pneumococcal) vaccine is recommended for adults aged 65 years and older and for people with certain health conditions. In 2007, 60.4 percent of women aged 65 and older reported ever receiving the vaccine. In this age group, 65.1 percent of non-Hispanic White women had ever received the pneumonia vaccine, compared to 45.4 percent of non-Hispanic Black women and 36.4 percent of Hispanic women.

Hepatitis B vaccine is recommended to reduce the spread of hepatitis B, which may result in cirrhosis of the liver, liver cancer, liver failure, and even death.[9] Hepatitis B vaccination also varied by race and ethnicity, as well as age. Younger women were most likely to have received at least one of the three recommended doses, and non-Hispanic White and non-Hispanic Black women in every age group were more likely than Hispanic women to have received the vaccine.

Genital human papillomavirus (HPV) can cause cervical cancer and other diseases in women. In 2006, the HPV vaccine was recommended for adolescent females and young women aged 9–26 years.[10] In 2006–2007, 10 percent of women aged 18–26 had been vaccinated for HPV (data not shown).[11]

Receipt of Selected Vaccinations* Among Women Aged 18 and Older, by Race/Ethnicity** and Selected Age Group, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Having received the flu vaccine in the past 12 months; having ever received the pneumonia vaccine; and having ever received at least one dose of the three-dose hepatitis B vaccine. **Sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of all other and unspecified races was too small to produce reliable results. Totals include all races/ethnicities.

HEALTH CARE EXPENDITURES

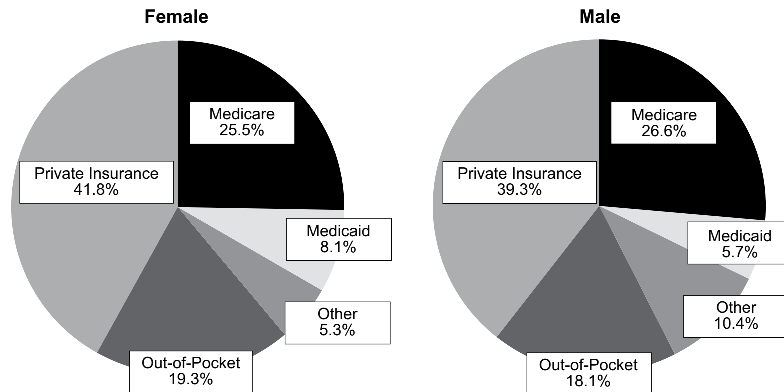
In 2006, the majority of health care expenses of both women and men were covered by public or private health insurance. Among women, one-third of expenses were covered by either Medicare or Medicaid, while 41.8 percent of expenses were covered by private insurance. Although the percentage of expenditures paid through private insurance was similar for both sexes, health care costs of women were more likely than those of men to be paid by Medicaid (8.1 versus 5.7 percent, respectively).

In 2006, 90.5 percent of women had at least one health care expenditure, compared to 77.9 percent of men (data not shown). Among those who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was higher for women ($5,219) than for men ($4,546). However, men's average expenditures exceeded women's for hospital inpatient services ($17,531 versus $13,104, respectively), hospital outpatient services ($2,369 versus $1,871), and home health services ($5,450 versus $5,286). Women's expenditures exceeded men's in the categories of office-based medical services ($1,426 versus $1,253, respectively) and dental services ($622 versus $595). Despite women's mean health care expenses by category generally being lower than men's, the overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, more women had hospital inpatient services than men, which contributes to a higher mean expenditure overall.

Overall per capita health care expenditures have increased substantially in the past decade for both men and women. In 2006, the annual mean health care expenses for both men and women were nearly 59 percent higher than in 1999 (data not shown).

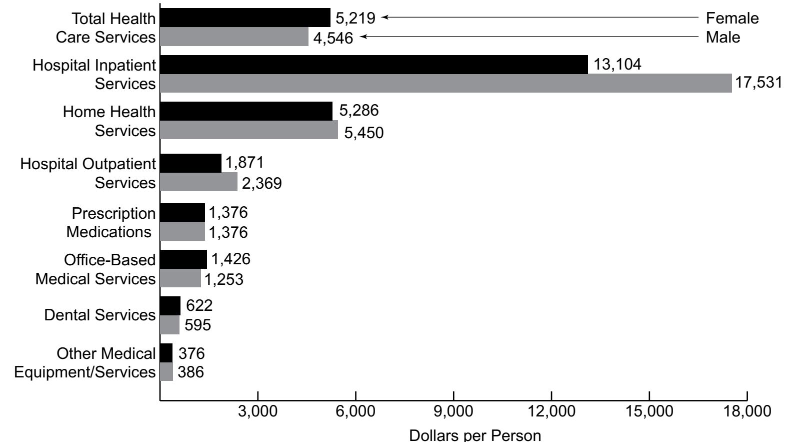
Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment, 2006

Source III.2: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2006

Source III.2: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



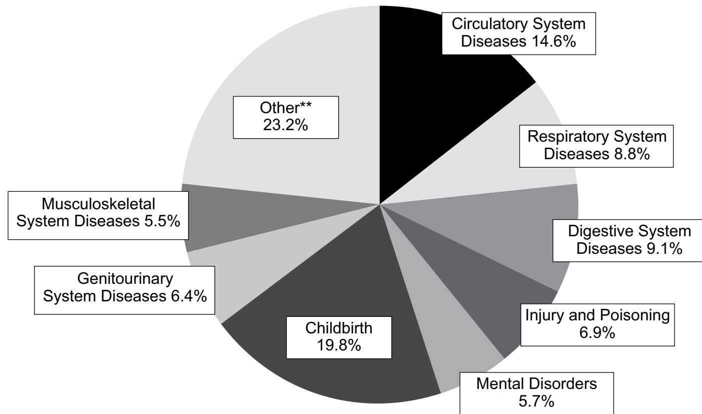
HOSPITALIZATIONS

Females represented 59.9 percent of the 34.9 million short-stay hospital discharges in 2006. Nearly 20 percent of hospital stays for all females were due to childbirth, while 14.6 percent were due to diseases of the circulatory system. Other common reasons for hospitalization included diseases of the respiratory, digestive, and genitourinary systems; injury and poisoning; and mental disorders. Overall, females had a higher hospital discharge rate than males in 2006 (1,375.3 versus 954.9 per 10,000 population; data not shown).

The types of procedures conducted during short hospital stays also vary by sex. Overall procedure rates were 1,811.5 procedures per 10,000 females (this includes 466.4 obstetrical procedures per 10,000 females) and 1,261.5 procedures per 10,000 males. Several of the procedures more common among females included operations on the digestive system (207.0 per 10,000 females versus 166.0 per 10,000 males) and operations on the genital organs, including hysterectomy for women (129.0 versus 17.1 per 10,000, respectively). Males had a higher rate than females for operations on the cardiovascular system (280.9 versus 205.6 per 10,000, respectively). Among females, the highest rate of procedures for discharges from short-stay hospitals was obstetrical procedures (466.4 per 10,000).

Discharges from Non-Federal, Short-Stay Hospitals Among Females of All Ages,* by Diagnosis, 2006

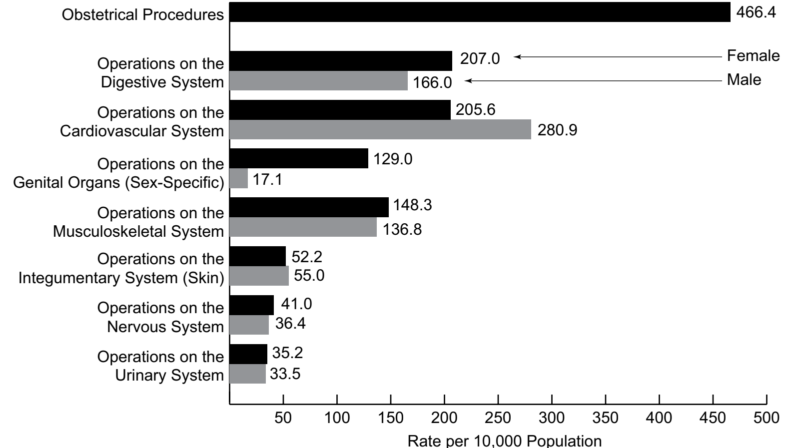
Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants. **Includes all other diagnoses, including neoplasms; infectious and parasitic diseases; endrocrine, nutritional, and metabolic diseases; skin and subcutaneous tissue diseases; nervous system and sense organ diseases; and diseases of the blood and blood-forming organs.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Procedure Category, All Ages,* 2006

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

HIV TESTING

People aware of and receiving appropriate care for positive HIV serostatus may be able to live longer and healthier lives because of newly available, effective treatments. It is recommended that people who meet any of the following criteria be tested at least annually for HIV: those who have injected drugs or steroids, or shared drug use equipment (such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of these criteria.[12] In addition, the CDC recommends that all pregnant women be tested for HIV during their pregnancy. In 2006, CDC guidelines recommended that all health care providers include HIV testing as part of their patients' routine health care.

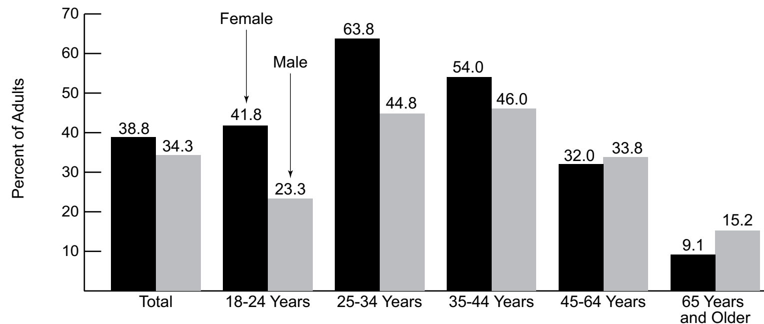
In 2007, nearly 37 percent of adults in the United States had ever been tested for HIV. Overall, women were slightly more likely than men to have been tested (38.8 versus 34.3 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, while men were more likely to have been tested at older ages (45 years and older).

Among women in 2007, non-Hispanic Blacks were most likely to have ever been tested (55.5 percent), while non-Hispanic White women were least likely (33.9 percent).

Of women who had not been tested, 78.0 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 19.9 percent reported that there was no particular reason they had not done so (data not shown).

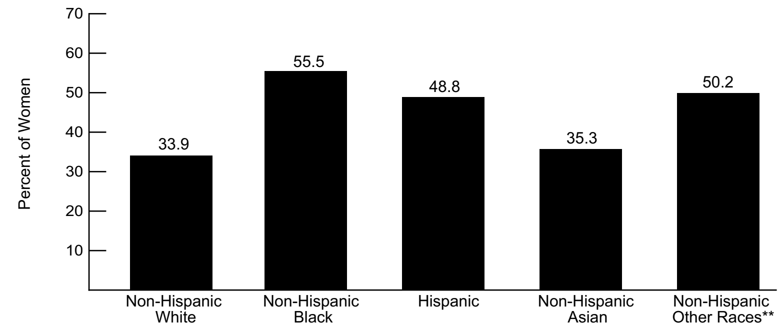
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2007*

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Rates reported are not age-adjusted. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

MENTAL HEALTH CARE UTILIZATION

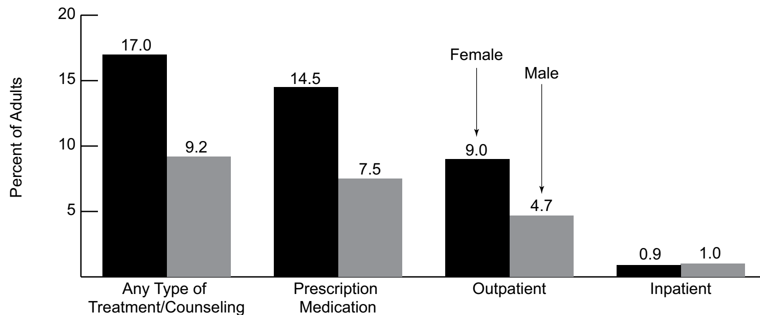
In 2007, more than 29 million adults in the United States reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services, including inpatient and outpatient care and prescription medications. Nearly 17 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.5 percent of women aged 18 and older, almost twice the rate among men (7.5 percent). Outpatient treatment was reported by 9.0 percent of women, and inpatient treatment was reported by 0.9 percent of women.

In 2007, mental health services were needed, but not received, by an estimated 11 million adults in the United States. Nearly 7 percent of women and 3.1 percent of men reported an unmet need for mental health treatment or counseling in the past year. Cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services, reported by 50.7 percent of women and 47.5 percent of men with unmet mental health treatment needs. The next most commonly reported reasons among women were feeling that they could handle their problems without treatment (29.5 percent) and fear of stigma, including concerns about confidentiality or the opinions of others, or the potential effect on employment (21.5 percent). Not knowing where to go for services prevented 13.6 percent of women from receiving needed treatment.

Among women, unmet need for treatment varied by race and ethnicity. Non-Hispanic women of multiple races were most likely to report an unmet need for treatment (13.9 percent), followed by non-Hispanic White and non-Hispanic American Indian/Alaska Native women (7.4 and 6.6 percent, respectively). Additionally, 5.9 percent of non-Hispanic Black women and 5.2 percent of Hispanic women had an unmet need for treatment. Non-Hispanic Asian/Pacific Islander women were least likely to report an unmet need for mental health treatment (3.2 percent; data not shown).

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Type and Sex, 2007

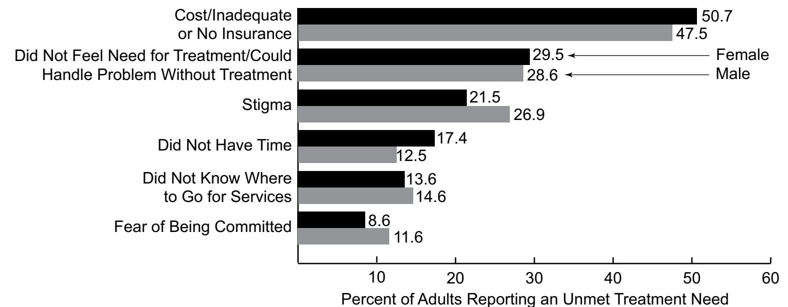
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use. Respondents could report more than one type of treatment.

Reasons for Unmet Mental Health Treatment* Needs Among Adults Aged 18 and Older, by Sex, 2007

Source III.4: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use. Respondents could report more than one reason.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services. Indicators used to monitor women's health care in managed care plans include screening for chlamydia, screening for cervical cancer, and receipt of mammograms.

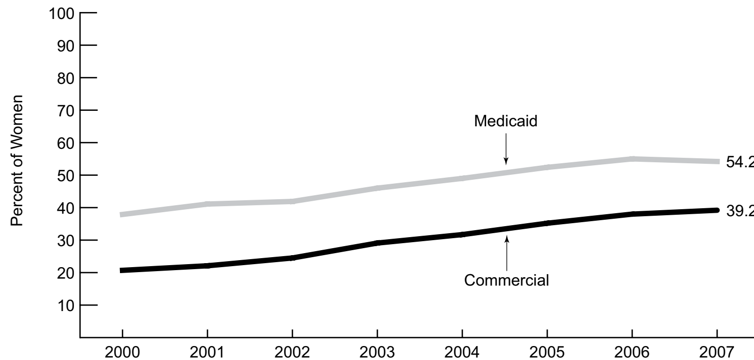
Despite a slight decline in chlamydia screenings for women aged 21–25 years enrolled in Medicaid from 2006 to 2007, females with Medicaid coverage were more likely to have received a chlamydia screening than those with private coverage (54.2 versus 39.2 percent, respectively). Since 2000, the percentage of sexually active females screened for chlamydia has increased by 89 percent among those in commercial plans and 43 percent among Medicaid participants.

In 2007, receipt of mammograms for women aged 40–69 years was approximately the same for women with private coverage and those covered through Medicare (69.1 and 67.3 percent, respectively). However, women enrolled in Medicaid were considerably less likely to have received a mammogram at least once during the previous 2 years (49.9 percent).

Cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 21–64 years, cervical cancer screenings were received at least once during the previous 3 years by 81.7 percent of commercially-insured women and 64.7 percent of those covered by Medicaid.

HEDIS®* Chlamydia** Screening Among Women Aged 21–25 Years, by Payer, 2000–2007

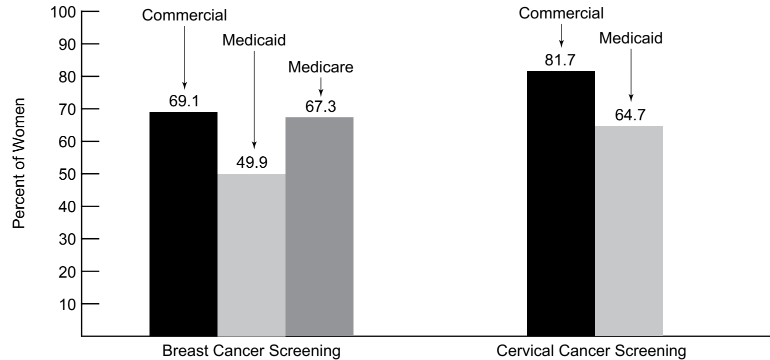
Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active females who had at least one test for chlamydia in the past year.

HEDIS®* Breast** and Cervical Cancer Screening,† by Payer, 2007

Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 40–69 years who had at least one mammogram in the past 2 years. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years; Medicare data were not available.

SATISFACTION WITH HEALTH CARE

Patients' utilization of health care is influenced by the quality of care; those who are not satisfied with their providers may be less likely to continue with treatment or seek further services.[13] Some aspects of patients' experience of care that may contribute to better outcomes are patients' perceptions of how well their doctors communicate with them and individuals' experiences with their health plans.

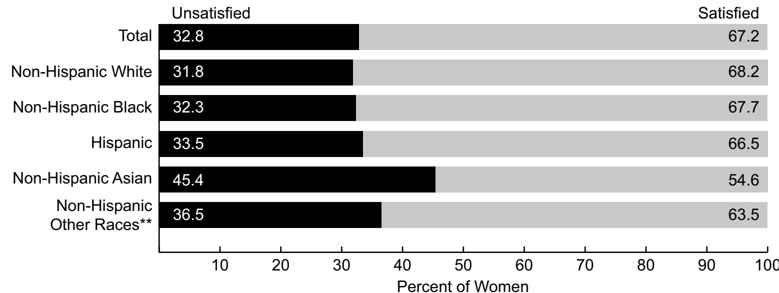
In 2007, 32.8 percent of women were not satisfied with their experiences related to their health plan's customer service, including receiving needed information or help and being treated with courtesy and respect. This varied by race and ethnicity. Non-Hispanic Asian women were most likely to be dissatisfied (45.4 percent), while non-Hispanic White women were least likely (31.8 percent). About one-third of non-Hispanic Black and Hispanic women were dissatisfied with their experiences related to their health plans.

Satisfaction with how well doctors communicate varies by education level; women with higher levels of education are more likely to be satisfied. In 2007, women who had at least a 4-year college degree were most likely to be satisfied with how well their doctors communicate (84.7 percent), followed closely by those completing at least some college (83.2 percent). In contrast, fewer than three-quarters of women with less than a high school diploma were satisfied with communications with their doctors.

More than 24 percent of women were not satisfied with their experiences in getting the care they needed when they needed it, including seeing specialists and getting necessary care, tests, or treatment. The percentage of women reporting dissatisfaction was greatest among non-Hispanic Asian women (32.4 percent). More than 29 percent of Hispanic women, 28.9 percent of non-Hispanic Black and 22.3 percent of non-Hispanic White women were also not satisfied with getting the care they needed (data not shown).

Women's Satisfaction with Experiences Related to Health Plans,* by Race/Ethnicity, 2007

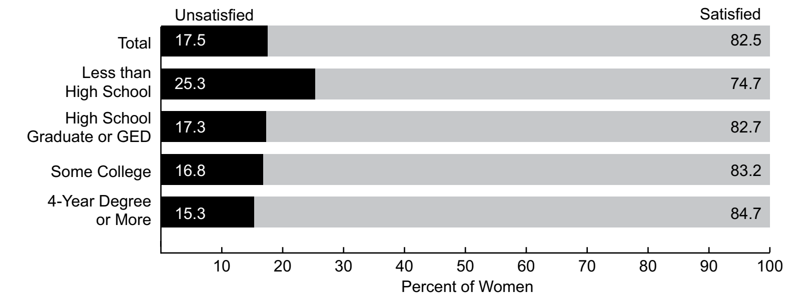
Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



*Based on questions related to respondents' experiences with their health plans in the past 6 months (Medicaid respondents) or 12 months (commercial health plan respondents). **Includes American Indian/Alaska Natives, persons of more than one race, and persons of other and unspecified races.

Women's Satisfaction with How Well Doctors Communicate,* by Level of Education, 2007

Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



*Based on questions related to respondents' experiences with their doctors in the past 6 months (Medicaid respondents) or 12 months (commercial health plan respondents).

ORGAN TRANSPLANTATION

Since 1988, there have been 447,518 organ transplants in the United States. More than 25,600 of those transplants occurred between January 1 and November 30, 2008. In 2008, nearly 13,000 people donated organs in the U.S. Overall distribution of organ donation by sex was nearly even (6,574 males and 6,357 females), though 60.3 percent of organs donated by living people were from females, and 59.4 percent of organs from deceased donors were from males.

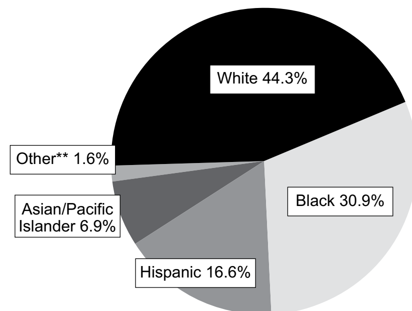
The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 13, 2009, there were 100,774 people awaiting a life-saving organ transplant. Females accounted for 41.6 percent of those patients but made up only 37.2 percent of those who received a transplant in 2008.[14] Among females waiting for an organ transplant, 44.3 percent were White, 30.9 percent were Black, and 16.6 percent were Hispanic. The kidney was the organ in highest demand, with 32,810 females awaiting this organ as of February 13, 2009.

The number of organs donated annually has increased significantly since 1988, from 5,909 to a total of 14,400 in 2007. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. From 2003 to 2007, organ donation by deceased donors increased by an unprecedented 25.2 percent. One of the challenges of organ donation is obtaining consent from the donor's family or legal surrogate. Consent rates may vary due to religious beliefs, communication issues between health care providers and grieving families, perceived inequities in the allocation system, lack of knowledge of the wishes of the deceased, and lack of understanding concerning donation and funeral arrangements.[15]

The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are managed by HRSA's Healthcare Systems Bureau (HSB). Other HSB programs include: the National Marrow Donor Program, the National Vaccine Injury Compensation Program, and the C.W. Bill Young Cell Transplantation Program.

Females on Organ Waiting Lists,* by Race/Ethnicity, 2009

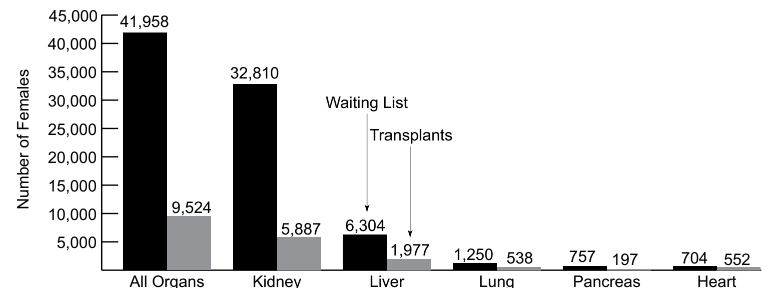
Source III.7: Organ Procurement and Transplantation Network



*As of February 13, 2009. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of unspecified race.*

Females on Organ Waiting Lists,* 2009, and Female Transplant Recipients,** 2008, by Organ

Source III.7: Organ Procurement and Transplantation Network



*As of February 13, 2009. **Transplants occurring between January 1–November 30, 2008, as of February 13, 2009.*

BORDER HEALTH

Women living along the U.S.–Mexico border face different challenges and barriers to care and health risks than women in the general U.S. population. High rates of poverty and uninsurance among women in the U.S. border region contribute to barriers in accessing care. This special border health supplement to *Women's Health USA* is intended to provide policymakers and women's health advocates with a snapshot of women's health in the border region.

The U.S.–Mexico border region refers to an area encompassing 100 kilometers (62 miles) north and south of the U.S.–Mexico border. This area includes 80 *municipios* in 6 Mexican states and 48 counties in 4 U.S. States. The Healthy Border 2010 initiative of the U.S.–Mexico Border Health Commission limits this region to 44 U.S. border counties, excluding Maricopa, Pinal, and La Paz counties in Arizona and Riverside County in California. The "Border Region" referred to in this supplement also refers to those 44 U.S. counties in Arizona, California, New Mexico, and Texas.

Technical Note: While every effort has been made to cite the most recent and reliable data available for the border region, in some cases estimates are presented that represent only a portion of border counties. This is the case for estimates based on the U.S. Census Bureau's Current Population Survey and the Centers for Disease Control and Prevention's Local Area Behavioral Risk Factor Surveillance System, each of which includes 9 border counties and represents 89.9 and 89.1 percent of the entire border population, respectively. It is acknowledged that the population residing in the counties included in these analyses may differ substantially from the population of those living in the remaining 35 border counties, who only account for about 10 percent of the border population.

U.S.–MEXICO BORDER POPULATION

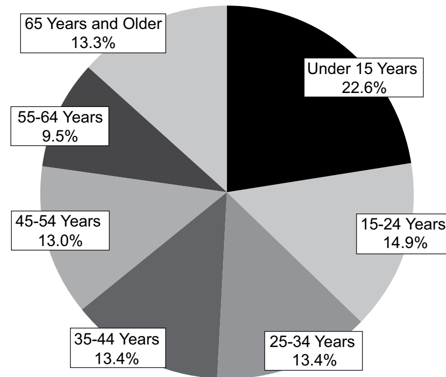
In 2007, there were more than 7.2 million people in the United States living on the U.S.–Mexico border, with females comprising 50.6 percent of that total. Females younger than 35 years of age accounted for 50.9 percent of the female population, while those aged 35–64 years accounted for 35.9 percent, and women aged 65 years and older accounted for 13.3 percent.

The female population living on the U.S.–Mexico border is younger than the overall U.S. population. Nearly 23 percent of females in the U.S. border region were under 15 years of age compared to 19.4 percent of those in the entire United States. Similarly, females aged 45 years and older accounted for 35.8 percent of females in the border region, compared to 40.0 percent of females in the total U.S. population.

The distribution of the population by sex was fairly even across all age groups with the exception of those aged 65 years and older. Within that age group, women accounted for the majority of the population (56.8 percent).

U.S. Female Border Population,* by Age, 2007

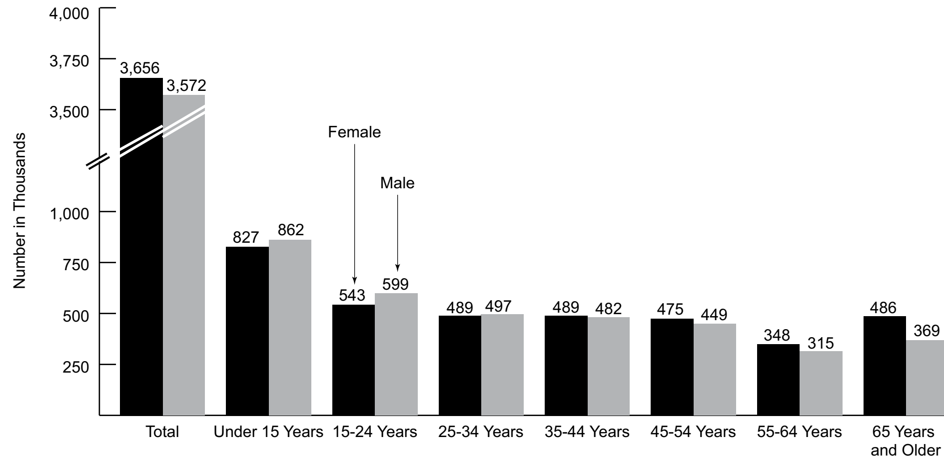
Source IV.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing. Percentages do not add to 100 due to rounding.

U.S. Border Population,* by Age and Sex, 2007

Source IV.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing.

POVERTY STATUS

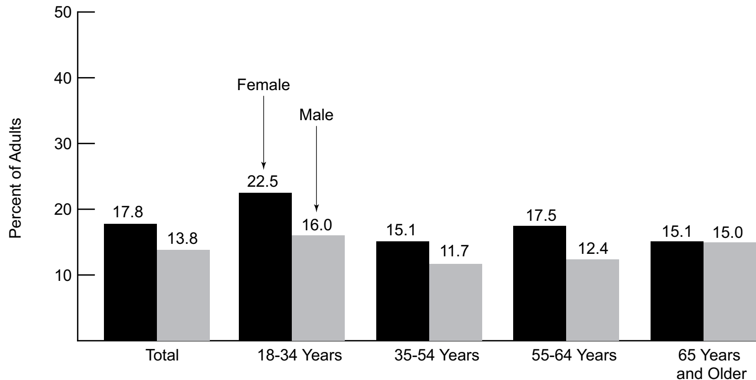
In 2007, an estimated 15.8 percent of adults aged 18 and older in the U.S. border region were living below the poverty level.[1] Nearly 18 percent of women in the border region had household incomes below 100 percent of poverty, which was more than twice the percentage of women living in poverty in the U.S. population overall (8.8 percent; data not shown).

In the U.S. border region, poverty status varied with age and sex. Women were significantly more likely than men to be living in poverty overall (17.8 versus 13.8 percent, respectively), and in every age group below 65 years of age. About 15 percent of men and women aged 65 years and older had household incomes below the poverty level. Among women, those aged 18–34 years were most likely to have household incomes below 100 percent of poverty (22.5 percent), followed by women aged 55–64 years (17.5 percent).

Poverty status also varies with household type. In 2007, women and men in the U.S. border region who were in married-couple families[2] were least likely to have household incomes below 100 percent of poverty (11.8 percent). Women who were heads of households with no spouse present were most likely to be living below the poverty level (31.4 percent). This was significantly more than among men who were heads of households with no spouse present (23.0 percent). Nearly one-quarter of women living alone or with non-relatives also lived in poverty in 2007, as did 19.4 percent of women living with parents or other relatives.

Adults Aged 18 and Older Living Below the Poverty Level, by Age and Sex, 2007*

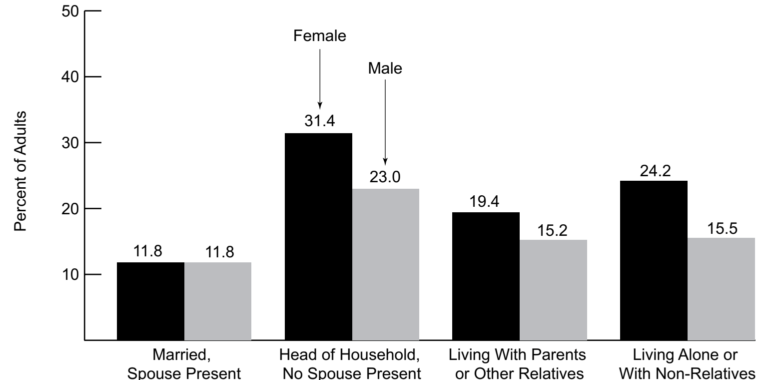
Source IV.2: U.S. Census Bureau, Current Population Survey



Based on survey responses from 9 border counties representing 89.9 percent of the border population. Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

Adults Aged 18 and Older Living Below the Poverty Level, by Household Type and Sex, 2007*

Source IV.2: U.S. Census Bureau, Current Population Survey



Based on survey responses from 9 border counties representing 89.9 percent of the border population. Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007.

OVERWEIGHT AND OBESITY

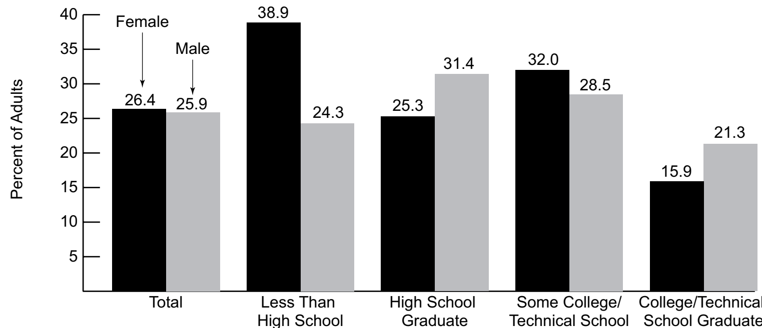
Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke, arthritis, certain types of cancer, and reproductive health risks.[3] Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2007, 36.9 percent of adults in the U.S. border region reported themselves to be overweight (BMI of 25.0–29.9), while an additional 26.1 percent reported themselves to be obese (BMI of 30.0 or more). These rates were similar to those of the total U.S. population; 36.6 percent of adults reported themselves to be overweight, while 26.3 percent reported themselves to be obese (data not shown).[4]

Overall, women and men in the U.S. border region had similar rates of obesity (26.4 and 25.8 percent, respectively), but men were more likely than women to be overweight (45.3 versus 28.5 percent, respectively; data not shown). Obesity among women varied by level of education. In 2007, women with less than a high school diploma were most likely to be obese (38.9 percent) followed by women with some college or technical school training (32.0 percent). Women who were college or technical school graduates were least likely to report being obese (15.9 percent).

Rates of obesity among women in the U.S. border region also varied by race and ethnicity. Among women in 2007, Hispanics were more likely to be obese (31.6 percent) than non-Hispanic White women (23.3 percent) and non-Hispanic women of other races (17.2 percent). Rates of overweight did not vary significantly among women by race and ethnicity.

Obesity* Among Adults Aged 18 and Older, by Level of Education and Sex, 2007

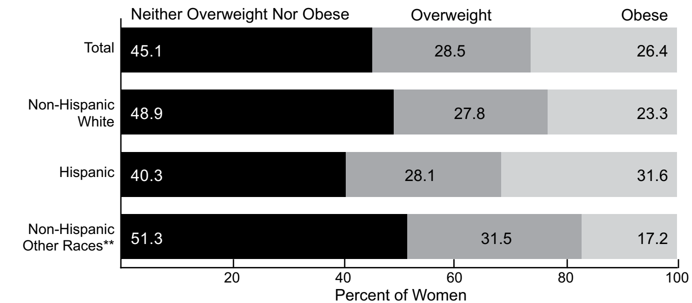
Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Defined as having a Body Mass Index (BMI) of 30.0 or more. Results are based on survey responses from 9 counties representing 89.1 percent of the border population.

Overweight and Obesity* Among Women Aged 18 and Older, by Race/Ethnicity, 2007

Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Overweight is defined as having a Body Mass Index (BMI) of 25.0-29.9; obesity is defined as having a BMI of 30.0 or more. Results are based on survey responses from 9 counties representing 89.1 percent of the border population. **Includes non-Hispanic Blacks, Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races not specified.

DIABETES

Diabetes mellitus is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. The main types of diabetes are Type 1, Type 2, and gestational (occuring only during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults, but may occur at any age. Type 2 diabetes is the most common; it is often diagnosed among adults but has increased among children. Risk factors for Type 2 diabetes include obesity, physical inactivity, and a family history of the disease.

In 2007, 9.5 percent of adults in the U.S. border region reported having ever been told by a health professional that they have chronic diabetes. This was slightly higher than among the overall U.S. adult population (8.0 percent).

Diabetes prevalence in the U.S. border region varied among women by race and ethnicity, as well as age. Non-Hispanic White women were less likely to report having ever been told that they have diabetes (6.4 percent), than Hispanic and non-Hispanic women of other races (11.0 and 13.6 percent, respectively).

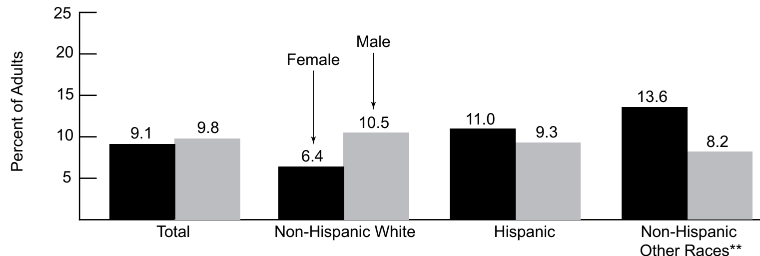
Diabetes prevalence increased with age among women in the U.S. border region in 2007. Those aged 65 years and older were most likely to report having ever been told by a health professional that they have diabetes (21.6 percent), followed by women aged 45–64 years (12.2 percent), and those aged 35–44 years (4.2 percent).

Among women, diabetes prevalence also increased with Body Mass Index. Nearly 18 percent of women in the border region who were obese had ever been diagnosed with diabetes, compared to 7.8 percent of women who were overweight but not obese, and only 4.4 percent of women who were at a healthy weight (data not shown).

One objective in Healthy Border 2010 was to reduce the rate of deaths due to diabetes by 10 percent from 26.9 deaths per 100,000 people in 2000 to 24.2 per 100,000 in 2010. Limited progress has been made to date on this objective, however. The overall mortality rate due to diabetes was 26.8 in 2005.[5]

Adults Aged 18 and Older with Diabetes,* by Race/Ethnicity, 2007

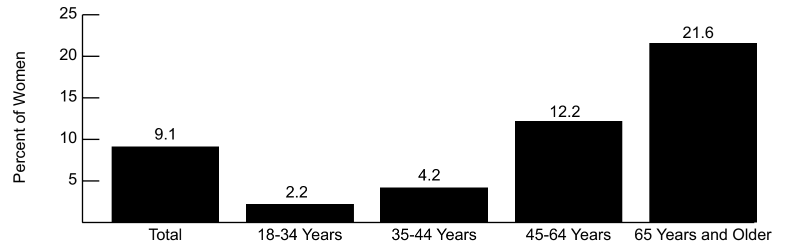
Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Reported that they have ever been told by a health professional that they have diabetes; does not include gestational diabetes. Results are based on survey responses from 9 counties representing 89.1 percent of the border population. **Includes non-Hispanic Blacks, Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races.*

Women Aged 18 and Older with Diabetes,* by Age, 2007

Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



Reported that they have ever been told by a health professional that they have diabetes; does not include gestational diabetes. Results are based on survey responses from 9 counties representing 89.1 percent of the border population.

HEALTH RISK BEHAVIORS

A number of behaviors, such as cigarette smoking and alcohol abuse can have negative long-term consequences for an individual's health. In 2007, 16.2 percent of adults in the U.S. border region were current cigarette smokers (smoked some days or every day). This was slightly lower than in the U.S. population overall (19.8 percent; data not shown).

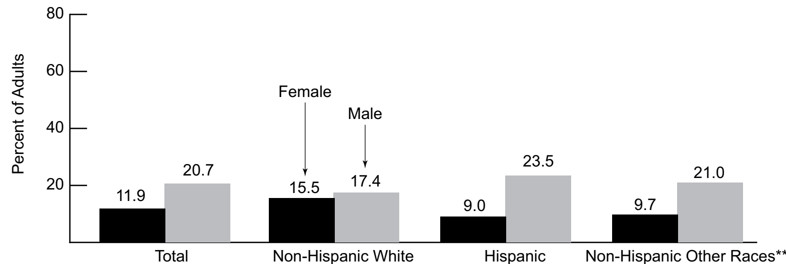
Rates of cigarette smoking in the U.S. border region varied by sex; men were significantly more likely than women to be cigarette smokers (20.7 versus 11.9 percent, respectively). Among women in the border region, cigarette smoking varied by race and ethnicity. Non-Hispanic White women were most likely to be current cigarette smokers (15.5 percent), compared to 9.0 percent of Hispanic women and 9.7 percent of non-Hispanic women of other races.

Men aged 21 and older in the U.S. border region were also more likely than women to have consumed alcohol in the past month (64.1 versus 44.9 percent, respectively). Among men and women aged 21 and older, past-month alcohol consumption increased as level of education increased. Among women in the U.S. border region, those with a college or technical school degree were most likely to have consumed alcohol in the past month (59.2 percent), compared to 36.8 percent of high school graduates, and 16.9 percent of those who did not graduate from high school.

While behaviors such as these can contribute to negative health outcomes, other behaviors, such as regular leisure-time physical activity, can help reduce health risks. In 2007, 25.0 percent of adults in the U.S. border region reported that they did not engage in any leisure-time physical activity in the previous 30 days. Overall, women were more likely than men to have reported being physically inactive (28.0 versus 21.8 percent, respectively). Among women, those with higher levels of education were more likely to have engaged in physical activity in the past month. Nearly 50 percent of women without a high school diploma did not engage in any leisure-time physical activity, compared to 30.2 percent of women who attended college or technical school, and 14.1 percent of women with a college or technical school diploma (data not shown).

Current Cigarette Smoking Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2007*

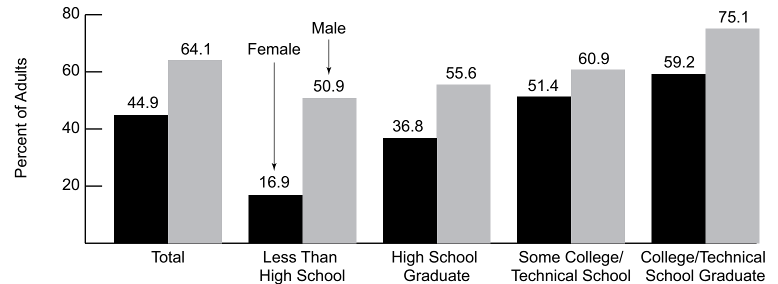
Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Results are based on survey responses from 9 counties representing 89.1 percent of the border population.
**Includes non-Hispanic Blacks, Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races not specified.

Past Month Alcohol Consumption Among Adults Aged 21 and Older, by Level of Education and Sex, 2007*

Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Results are based on survey responses from 9 counties representing 89.1 percent of the border population.

REPRODUCTIVE HEALTH

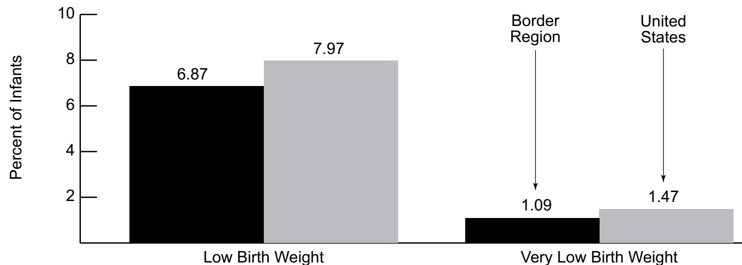
From 2002 to 2004, there were an average of 123,116 live births per year in the U.S. border region. These births accounted for about 3.1 percent of total U.S. births during this period. The percentage of infants born at low and very low birth weight was lower in the U.S. border region than in the United States as a whole. Nearly 6.9 percent of infants born in the border region in 2002–2004 had a low birth weight (less than 2,500 grams), compared to 7.97 percent of infants born in the United States. Similarly, 1.09 percent of infants in the border region were born at a very low birth weight (less than 1,500 grams), compared to 1.47 percent of infants in the United States.

The percentage of live births delivered by cesarean section in 2002–2004 was slightly higher in the border region than in the United States overall (29.8 versus 27.4 percent, respectively). The percentage of births to teen mothers was also higher in the border region than in the United States as a whole (5.01 versus 3.45 percent, respectively; data not shown).

Gestational diabetes (occurring only during pregnancy) can pose health risks to a mother and her baby and women with the condition are at increased risk for developing diabetes later in life.[6] In 2002, women giving birth in the U.S. border region were less likely to have had gestational diabetes than women in the U.S. population (2.44 versus 3.31 percent, respectively). Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, premature birth, placental abruption, and stillbirth.[7] In 2002, women giving birth in the border region were also less likely to have pregnancy-induced hypertension than women in the United States as a whole (2.05 versus 3.83 percent, respectively).

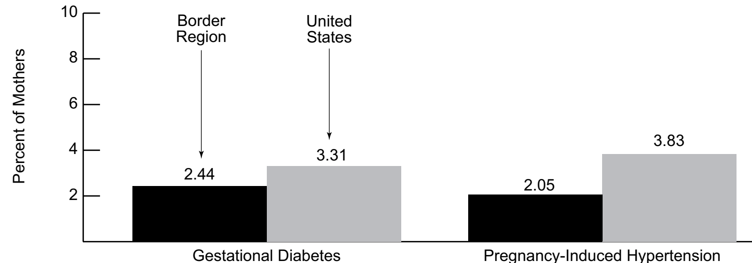
Low and Very Low Birth Weight Infants, by Location, 2002–2004

Source IV.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Maternal Morbidity and Risk Factors During Pregnancy, by Location, 2002

Source IV.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



LEADING CAUSES OF DEATH

In 2005, there were 47,386 deaths recorded in the U.S. border region. Females accounted for 22,637, or 47.8 percent, of these deaths. Overall, the death rate among this population was 849.7 per 100,000 males and 587.6 per 100,000 females, which is lower than that of the overall U.S. population (951.1 and 677.6 per 100,000, respectively; data not shown).

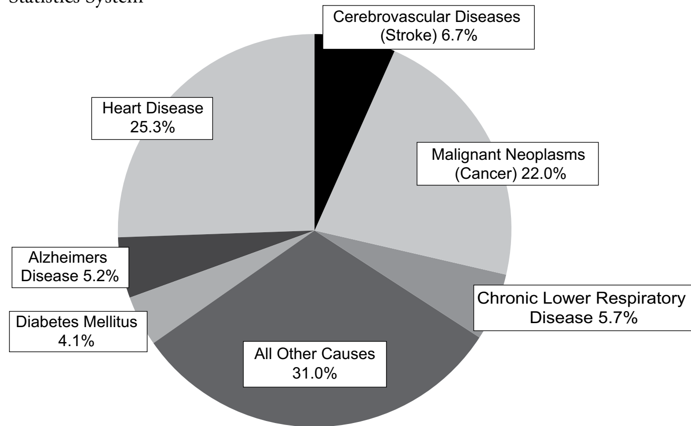
The top 10 leading causes of death for females accounted for 81.6 percent of all deaths (data not shown). Among females, heart disease accounted for 25.3 percent of deaths, followed by malignant neoplasms, or cancer (22.0 percent), and cerebrovascular diseases or stroke (6.7 percent).

The leading cause of death among both females and males was heart disease, which was the cause of death for 145.2 and 229.4 per 100,000 people, respectively, followed by cancer (135.0 and 194.7 per 100,000, respectively). Males had higher mortality rates than females for all of the leading causes of death except for Alzheimers disease, which was the cause of death for 28.3 per 100,000 females and 21.1 per 100,000 males.

The leading causes of death among females in the U.S. border region were similar to that of the U.S. female population overall. In general, mortality rates due to the top 10 leading causes were lower among those in the border region, with the exception of Alzheimers disease and diabetes mellitus. Alzheimers disease accounted for 28.3 deaths per 100,000 females in the border region, compared to 25.1 deaths per 100,000 females in the U.S. population overall. Similarly, diabetes mellitus was the cause of death for 24.8 per 100,000 females in the border region, compared to 21.6 per 100,000 females among the general population (data not shown).

Leading Causes of Death Among Females, 2005*

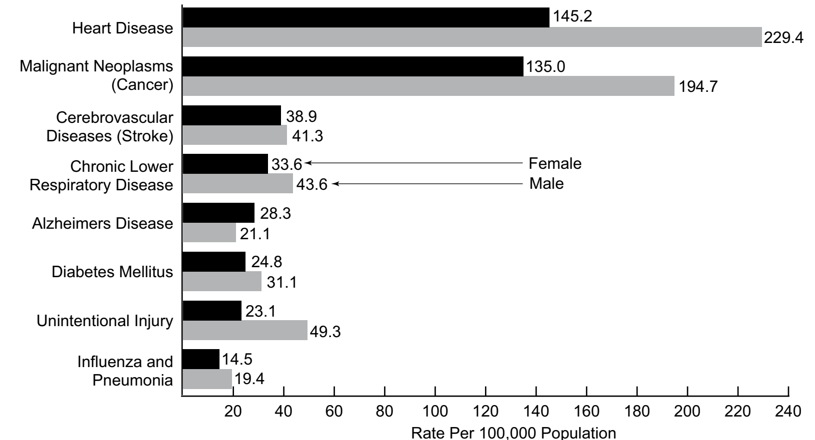
Source IV.5: Centers for Disease Control and Prevention, National Vital Statistics System



*Includes females of all ages in the 44 counties constituting the U.S.-Mexico border region.

Leading Causes of Death (All Ages), by Sex, 2005*

Source IV.5: Centers for Disease Control and Prevention, National Vital Statistics System



*Includes people of all ages in the 44 counties constituting the U.S.-Mexico border region; rates are age-adjusted.

CERVICAL CANCER MORTALITY

Regular cervical cancer screening can decrease the likelihood of death due to cervical cancer by detecting and treating precancerous lesions and invasive cancer before it has spread. Research suggests that high rates of cervical cancer mortality may be indicative of reduced access to health care, a lack of culturally competent communication, and a deficiency in patient/provider education.[8] In 2003–2005, women in the U.S. border region had a greater mortality rate due to cervical cancer than the overall U.S. female population (2.7 versus 2.4 deaths per 100,000 women, respectively).

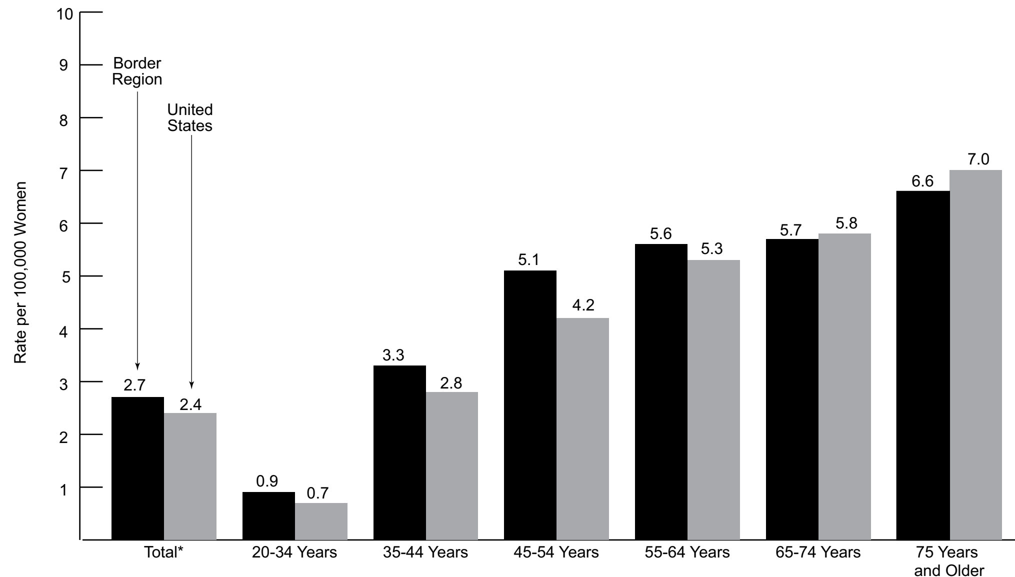
Cervical cancer mortality rates vary by age. Younger women in the U.S. border region had higher mortality rates than the population as a whole; however, older women in the general population had higher mortality rates than those in the U.S. border region. For instance, among women aged 35–44 years, 3.3 deaths per 100,000 women in the border region were due to cervical cancer, compared to 2.8 deaths per 100,000 women in the United States. However, among women aged 75 years and older, cervical cancer was the cause of 6.6 deaths per 100,000 women in the U.S. border region, compared to 7.0 deaths per 100,000 women in the United States.

One objective in Healthy Border 2010 was to reduce the cervical cancer death rate by 30 percent, from 3.7 deaths per 100,000 women in 2000 to 2.6 per 100,000 by 2010. Significant progress has been made in achieving that goal with a cervical cancer mortality rate of 2.7 per 100,000 women in 2003–2005.[5]

Cervical cancer screening is recommended at least every 3 years beginning within 3 years of sexual activity or by age 21. A vaccine for genital human papillomavirus, the leading cause of cervical cancer, was approved by the Food and Drug Administration in 2006 and is recommended for female adolescents and women aged 9–26 years.[9]

Cervical Cancer Mortality Among Women, by Age and Residence, 2003-2005

Source IV.5: Centers for Disease Control and Prevention, National Vital Statistics System



*Age-adjusted.

ACCESS TO CARE

People living on the U.S.–Mexico border face numerous barriers to accessing health care, including high rates of uninsurance and limited access to health care facilities. People who are uninsured are less likely than those with insurance to seek health care, which can result in poor health outcomes and higher health care costs. In 2007, more than one-quarter of adults in the U.S. border region lacked health insurance (26.7 percent), compared to 16.7 percent of adults in the total U.S. population. When considering only adults aged 18–64 years, 31.2 percent of those in the U.S. border region lacked health insurance, compared to 19.6 percent of those in the general U.S. population (data not shown).

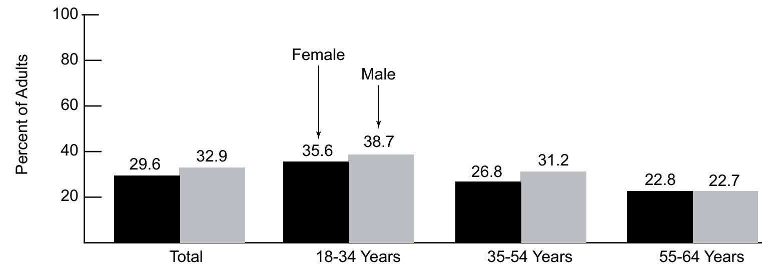
Among adults aged 18–64 years in the U.S. border region, men were more likely than women to lack health insurance overall (32.9 versus 29.6 percent, respectively) and in most age groups. Among both men and women, rates of uninsurance decreased as age increased. Among women, 35.6 percent of 18-to 34-year-olds lacked health insurance, compared to 26.8 percent of those aged 35–54 years, and 22.8 percent of 55- to 64-year-olds.

Among women aged 18–64 years, just more than half reported having private health insurance in 2007, while 13.4 percent had public insurance, and 6.2 percent had both private and public insurance (data not shown).

Another indicator of access to health care is the rate at which adults receive preventive screenings and recommended tests. Cholesterol screenings are recommended at least every 5 years to detect high cholesterol, a risk factor for heart disease. In 2007, 69.1 percent of adults in the U.S. border region reported receiving a cholesterol screening within the previous 5 years, slightly less than the U.S. population overall (74.8 percent; data not shown). Cholesterol screening increased with age among both men and women. Among women in the U.S. border region, those aged 65 years and older were most likely to have received the screening in the past 5 years (91.6 percent) followed by 45- to 64-year-olds (84.0 percent), while those aged 18–34 years were least likely to have been screened (50.8 percent).

Adults Aged 18-64 Without Health Insurance,* by Age** and Sex, 2007

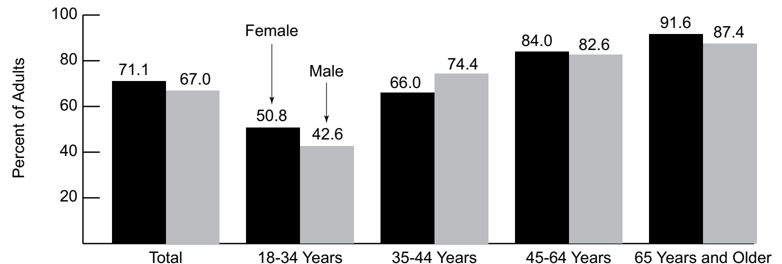
Source IV.2: U.S. Census Bureau, Current Population Survey



***Based on survey responses from 9 border counties representing 89.9 percent of the border population.*
***Due to the small number of uninsured adults aged 65 and older, a reliable estimate could not be produced.*

Receipt of Recommended Cholesterol Screening Among Adults Aged 18 and Older, by Age and Sex, 2007*

Source IV.3: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



**Screening received within the past 5 years. Results are based on survey responses from 9 border counties representing 89.1 percent of the border population.*

HRSA PROGRAMS ON THE BORDER

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) supports programs that promote access to health care services for underserved and vulnerable populations, including individuals living along the U.S.–Mexico border.

Healthy Border 2010 aims to improve the quality of life, increase the number of years of healthy life, and eliminate health disparities. Four objectives focusing on the health and wellness of women are to:

- Reduce the female breast cancer mortality rate by 20 percent;
- Reduce the cervical cancer mortality rate by 30 percent;
- Increase the proportion of mothers receiving prenatal care in the first trimester to 85 percent; and
- Reduce the adolescent (15–17 years of age) pregnancy rate by 33 percent.

HRSA's Office of Rural Health Policy (ORHP) manages the HRSA Border Health Initiative. ORHP assists rural communities in strengthening health care services by supporting programs that aim to improve the recruitment and retention of health professionals and eliminate health disparities. In a collaborative effort, ORHP, the University of North Dakota Center for Rural Health, and the Rural Policy Research Institute developed the Rural Assistance Center (RAC; www.raconline.org). The RAC is a Web-based resource that assists residents along the U.S.–Mexico border in locating and competing for funding opportunities that address the health care needs and challenges of their communities. ORHP's Border Health Initiative also works closely with the U.S.–Mexico Border Health Commission (BHC), which is composed of the U.S. and Mexican secretaries of health, the chief health officers of the 10 border States, and prominent community health professionals from both nations. The mission of the BHC is to provide international leadership to optimize health and quality of life along the U.S.–Mexico border. Information on the BHC can be found at www.borderhealth.org.

HRSA's Maternal and Child Health Bureau (MCHB) currently funds six Healthy Start grantees along the U.S.–Mexico border. Healthy Start programs work to bring women into prenatal care early in their pregnancies, reducing infant mortality rates and low birth weights, while working to eliminate health disparities related to pregnancies. The six grantees are located in each of the four U.S. border States and utilize *promotoras* to provide support and guidance to the community; this model has been shown to work particularly well in border projects where program participants and the communities at large are faced with a variety of unique challenges and barriers. The HRSA Office of Women's Health has also translated several of its preventive health publications under the Bright Futures for Women's Health and Wellness Initiative to reach more Spanish speaking women (www.hrsa.gov/womenshealth).

Other HRSA Offices and Bureaus contribute to accomplishing the mission and vision of HRSA on the U.S.–Mexico border through a myriad of programs and initiatives. The Bureau of Health Professions (BHPr) supports Area Health Education Centers and Centers of Excellence, including the U.S.–Mexico Border Health Centers of Excellence Consortium. The Bureau of Primary Health Care (BPHC) delivers primary care services through a variety of Community Health Centers and Migrant Health Centers. The HIV/AIDS Bureau (HAB) funds Ryan White Parts A–F including Special Programs of National Significance, AIDS Education and Training Centers, Dental Programs, and the Minority AIDS Initiative.

HEALTHY PEOPLE 2010 UPDATE

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the 21st century. Created by scientists both inside and outside of government, it identifies a wide range of public health priorities and specific, measurable objectives to guide the development of programs to improve public health.

Healthy People 2010: Selected Focus Areas and Objectives For Females

Source V.1: Centers for Disease Control and Prevention, National Center for Health Statistics; Substance Abuse and Mental Health Services Administration; U.S. Department of Justice, Bureau of Justice Statistics; U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards

Focus Area	Objective	Baseline	Most recent	Target
Access to Health Care	16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care	74%	75% +	90%
	1-4. Increase in Persons With Specific Source of Ongoing Care (all ages)	91%	90% -	96%
Environmental Health	8-1g. Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for harmful air pollutants: Number of people exposed to any harmful air pollutants (all ages; in thousands)	69,937	58,794 +	0
Immunization and Infectious Disease	14-29a. Increase the proportion of adults who are vaccinated annually against influenza (aged 65 and older)	63%	64% +	90%
	14-29b. Increase the proportion of adults who are ever vaccinated against pneumococcal disease (aged 65 and older)	46%	59% +	90%
Injury and Violence	15-28. Reduce hip fractures among older adults (per 100,000)	1,055.8	868.0 +	416.0
	15-34. Reduce the rate of physical assault by current or former intimate partners (aged 12 and older; per 1,000)	7.2	3.3 +	3.3
Mental Health	18-1. Reduce the suicide rate (all ages; per 100,000)	4.0	4.4 -	4.8
Overweight and Obesity	19-1. Increase the proportion of adults who are at a healthy weight (aged 20 and older)	45%	37% -	60%
	19-17. Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition (aged 20 and older)	39%	35% -	75%
Physical Activity	22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate or vigorous physical activity (aged 18 and older)	29%	29% •	50%
Substance Abuse	26-3. Reduce drug-induced deaths (all ages; per 100,000)	4.4	8.1 -	1.2
	26-18b Reduce the treatment gap for illicit drugs in the general population: Treatment for alcohol and/or drugs (aged 12 and older)	11%	11% •	16%
Tobacco Use	27-1. Reduce tobacco use by adults (aged 18 and older)	22%	18% +	12%
	27-5. Increase smoking cessation attempts by adult smokers (aged 18 and older)	42%	44% +	75%

\+ *Indicates improvement since baseline.*
\- *Indicates worsening since baseline.*
• *Indicates no change.*

INDICATORS IN PREVIOUS EDITIONS

Each edition of Women's Health USA contains the most current available data on health issues important to women. If no updated data are available, indicators may be replaced to make room for information on new indicators. For more information on the indicators listed here, please reference previous editions of Women's Health USA which can be accessed online at either of these Web sites:

www.hrsa.gov/womenshealth
www.mchb.hrsa.gov/data

Women's Health USA 2008

Attention Deficit Hyperactivity Disorder
Chronic Fatigue Syndrome
Eye Health
Genetics and Women's Health
Medication Use

Women's Health USA 2007

Autoimmune Diseases
HIV in Pregnancy
Obstetrical Procedures and Complications of Labor and Delivery
Sleep Disorders
Violence and Abuse
Weight Gain During Pregnancy

Women's Health USA 2006

American Indian/Alaska Native Women
Contraception
Infertility Services
Postpartum Depression
Women and Crime

Women's Health USA 2005

Adolescent Pregnancy
Immigrant Health
Maternity Leave
Prenatal Care

Women's Health USA 2004

Eating Disorders
Services for Homeless Women
Women in NIH-Funded Clinical Research

Women's Health USA 2003

Home Health and Hospice Care
Title V Abstinence Education Programs
Title X Family Planning Services
Vitamin and Mineral Supplement Uses

Women's Health USA 2002

Lupus
Non-Medical Use of Prescription Drugs
Nursing Home Care Utilization
Unintended Pregnancies

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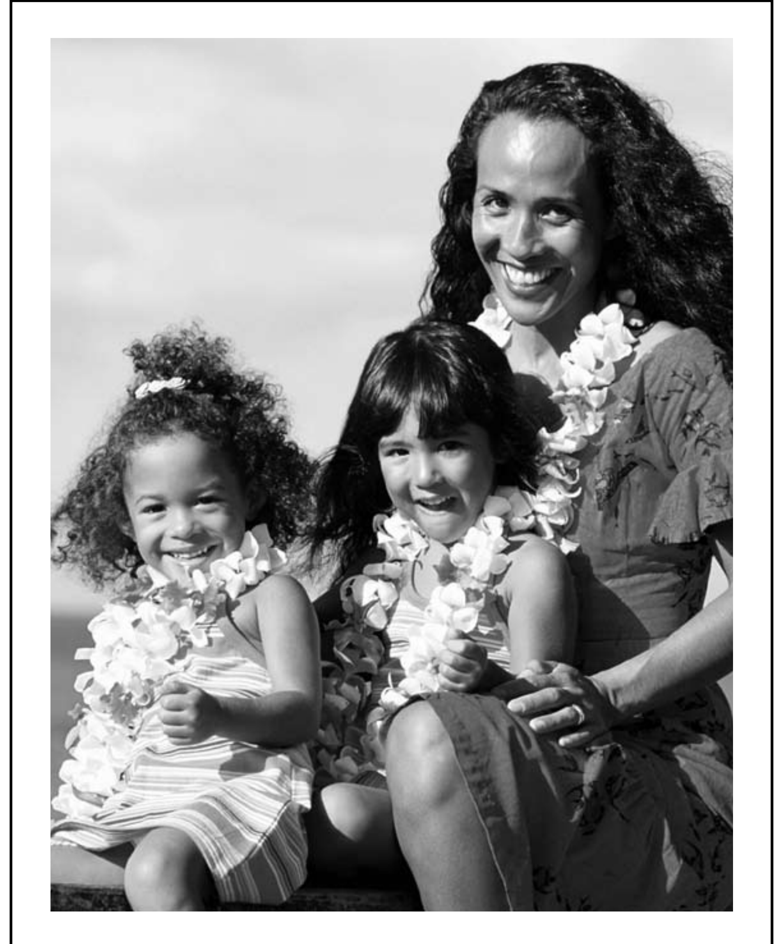

CONTRIBUTORS

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Federal Contributors within the U.S. Department of Health and Human Services

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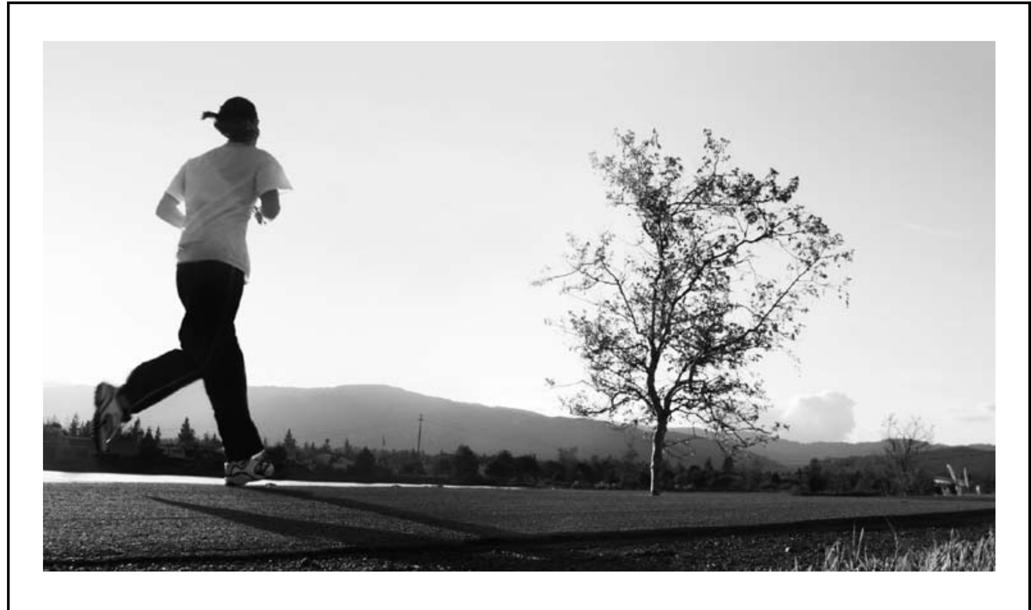

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