Women's Health USA 2010

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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, in part, 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 2010*, the ninth 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 vision and hearing loss, home health and hospice care, sleep disorders, and women veterans are a few of the new topics included in this edition. There is also a new section on women and aging, with data on population character-

istics and labor force participation among older women, as well as age-specific information on activity limitations, osteoporosis, injury, and abuse.

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, estimates with a relative standard error of 30 percent or greater were considered unreliable and were not reported.

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 2010* is 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 various 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 during 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 2010 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 2009* were not included in this year's edition because new data were not available or preference was given to an emerging issue in women's health. For coverage of these issues, please refer to *Women's Health USA 2009*, 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.healthstatus2010.com/owh. Data are available at the State and county levels, by age, race and ethnicity, and sex.

 Please provide feedback on this publication to the HRSA Information Center which offers single copies of the data book at no charge:

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INTRODUCTION

In 2008, females comprised 50.7 percent of the 304 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 9.0 and 6.8 percent of the female population aged 65 years and older, respectively, but they represented 14.1 and 22.4 percent of females under 15 years of age. Non-Hispanic Whites accounted for 79.9 percent of women aged 65 years and older, but only 55.2 percent of those under 15 years of age. Hispanic women now comprise a greater proportion of the female population than in 2000, when they made up 17.5 percent of the population under age 15 and 4.9 percent of those 65 years and older.

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 2008, 63.4 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 48.1 percent of Hispanic women and 48.4 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 2008, rates of new HIV cases were highest among Black and Hispanic females (56.0 and 13.3 per 100,000 females, respectively). In 2008, 36.0 percent of non-Hispanic White women had ever been tested for HIV, compared to 57.0 percent of non-Hispanic Black and 50.6 percent of Hispanic women.

Hypertension, or high blood pressure, was also more prevalent among non-Hispanic Black women than women of other races. In 2005–2008, 21.3 percent of non-Hispanic Black women were found to have high blood pressure, compared to 16.3 percent of non-Hispanic White, 10.6 percent of Mexican American, and 12.4 percent of other 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 and older adults. Among women with diabetes, however, non-Hispanic Black women were most likely to have been diagnosed with the condition by a health professional (63.7 percent), compared to only 49.1 percent of non-Hispanic White 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 with no spouse present (25.7 percent). Poverty rates were also high among non-Hispanic Black, non-Hispanic American Indian/Alaska Native, and Hispanic women (23.2, 22.7, and 22.3 percent, respectively). Women in these racial and ethnic groups were also more likely to be heads of households than their non-Hispanic White and non-Hispanic Asian/Pacific Islander counterparts.

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. In 2008, non-Hispanic American Indian/Alaska Native and non-Hispanic women of multiple races were more likely than women of other races and ethnicities to report ever having had depression (40.0 percent each), followed by non-Hispanic White women (36.5 percent). Women in these racial and ethnic groups were also more likely than other women to report ever having had generalized anxiety.

Some conditions and health risks are more closely linked to family income than to race and ethnicity, including asthma. Rates of asthma decline as income increases, and women with higher incomes are more likely to effectively manage their asthma. Nearly 14 percent of women with household incomes of less than 100 percent of poverty had asthma in 2008, compared to 8.4 percent of women with incomes of 200-399 percent of poverty and 7.2 percent of women with higher incomes.

Severe headaches and migraines were also more common among women with lower household incomes and were more likely to affect women than men. In 2008, 24.9 percent of women with household incomes below 100 percent of poverty had experienced severe headaches or migraines in the previous 3 months, compared to 16.7 percent of women with incomes of 200 percent or more of poverty.

Receipt of oral health care and oral health status among women also varies dramatically with household income. In 2005–2008, women with incomes of 300 percent or more of poverty were more likely to have had a dental restoration (89.9 percent) and significantly less likely to have untreated dental decay (10.3 percent) than their lower-income counterparts. Fewer than 69 percent of women with incomes below 100 percent of poverty had had a tooth restored, while 30.3 percent were found to have untreated dental decay.

Among older adults, physical disabilities are more prevalent among women than men. 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, 68.4 percent of women and 54.4 percent of men aged 65 years and older reported having an activity limitation in 2008.

However, men bear a disproportionate burden of some health conditions, such as HIV/AIDS, high blood pressure, and coronary heart disease. In 2008, for instance, the rate of newly reported HIV cases among adolescent and adult males was more than 3 times the rate among females (35.9 versus 11.5 per 100,000, respectively). Despite the greater risk, a smaller proportion of men had ever been tested for HIV than women (37.6 versus 40.9 percent, respectively).

Certain health risks, such as cigarette use and illicit drug use, occur more commonly among men than women. In 2008, 23.1 percent of men smoked cigarettes, compared to 18.3 percent of women. Similarly, 29.1 percent of men consumed 4 or more drinks per week in the past year, compared to only 13.3 percent of women. In addition, men were more likely than women to lack health insurance.

Many diseases and health conditions, including some of those mentioned above, can be avoided or minimized through good nutrition, regular physical activity, and preventive health care. In 2008, 76.3 percent of women aged 40 and older reported having had a mammogram in the previous 2 years. In 2005–2008, 72.5 percent of women aged 20 and older reported having had a cholesterol screening in the previous 5 years. More than 68 percent of women aged 65 years and older also reported receiving flu vaccine; however, this percentage ranged from 60.2 percent of women with incomes below 100 percent of poverty to 70.5 percent of women with incomes of 200 percent or more of poverty.

There are many ways women (and men) can promote health and help prevent disease and disability. Regular physical activity is one of these. In 2008, 14.9 percent of women participated in at least 2.5 hours of moderate intensity physical activity per week or 1.25 hours of vigorous-intensity activity per week, in addition to muscle-strengthening activities on 2 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 contribute to maintaining long-term health and preventing disease. In 2005–2008, however, only 24.5 percent of women met or exceeded the recommended Adequate Intake of calcium, which is critical in reducing the risk of osteoporosis and preventing bone loss.

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 2008, 58.2 percent of women reported any alcohol use in the past year, but relatively few women (8.3 percent) reported moderate drinking (more than three and up to seven drinks per week) and even fewer (5.0 percent) reported heavy drinking (more than seven drinks per week). In the same year, 11.5 percent of women used illicit drugs, including marijuana, cocaine, hallucinogens, inhalants, and prescription-type drugs for nonmedical 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 22 States and reporting areas, 10.4 percent of pregnant women reported smoking during pregnancy in 2007. This rate was highest among non-Hispanic American Indian/Alaska Native women (24.4 percent) and lowest among non-Hispanic Asian/Pacific Islander women (1.5 percent).

Women's Health USA 2010 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 and men throughout the United States.

POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were more than 154 million females in the United States in 2008, 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 to better serve the needs of women at higher risk for certain conditions.

This section presents data on population characteristics that may 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, labor force participation, and participation in Federal programs. The characteristics of women veterans and rural and urban women are also reviewed and analyzed.

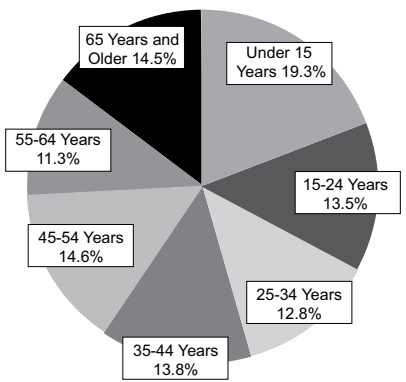
U.S. POPULATION

In 2008, the U.S. population was more than 304 million, with females comprising 50.7 percent of that total. Females younger than 35 years of age accounted for 45.6 percent of the female population, those aged 35–64 years accounted for 39.7 percent, and females aged 65 years and older accounted for 14.5 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 years and older, 57.7 percent were women.

U.S. Female Population,* by Age, 2008

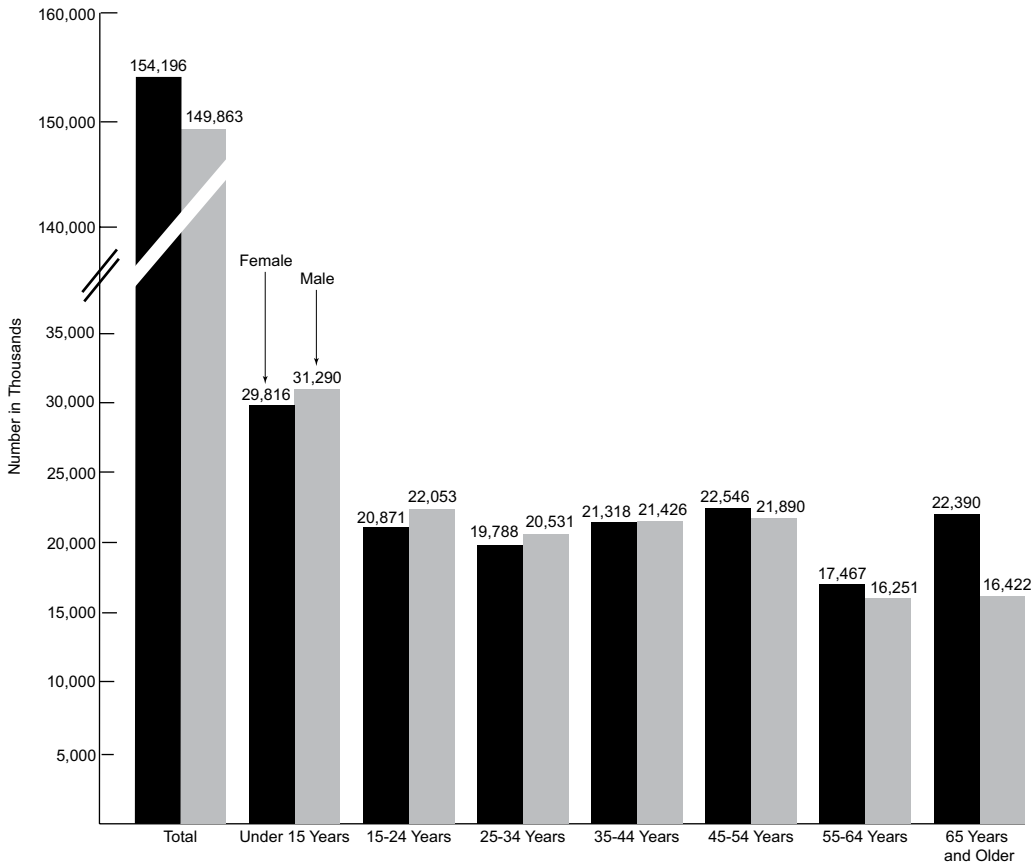
Source I.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing (e.g. dormitories, institutions). Percentages do not add to 100 due to rounding.

U.S. Population,* by Age and Sex, 2008

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



*Includes only non-institutionalized population not living in group housing (e.g. dormitories, institutions).

U.S. FEMALE POPULATION

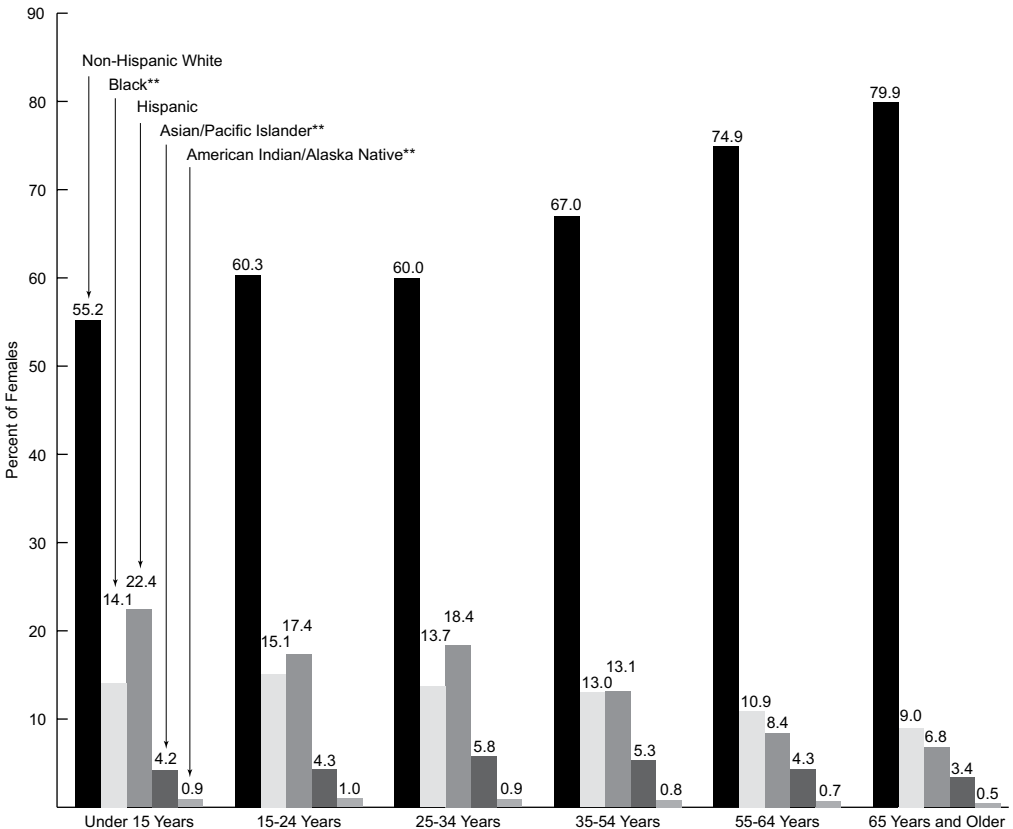
The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. The younger female population (under 15 years) is significantly more diverse than the older female population. In 2008, 55.2 percent of females under 15 years of age were non-Hispanic White, while 22.4 percent of that group were Hispanic. In contrast, among women aged 65 years and older, 79.9 percent were non-Hispanic White and only 6.8 percent were Hispanic. The distribution of the Black population was more consistent across age groups, ranging from 14.1 percent of females under 15 years of age to 9.0 percent of women aged 65 years and older.

The racial distribution of females has shifted dramatically since 2000, when non-Hispanic Whites accounted for 60.2 percent of females under 15 years of age and 83.3 percent of those aged 65 years and older. Hispanic females accounted for 17.5 percent of those under 15 years and 4.9 percent of those aged 65 and older (data not shown).[1]

Evidence indicates that the prevalence of health conditions varies among women of different racial and ethnic backgrounds. 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 U.S. population.[2]

U.S. Female Population,* by Age and Race/Ethnicity, 2008

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



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

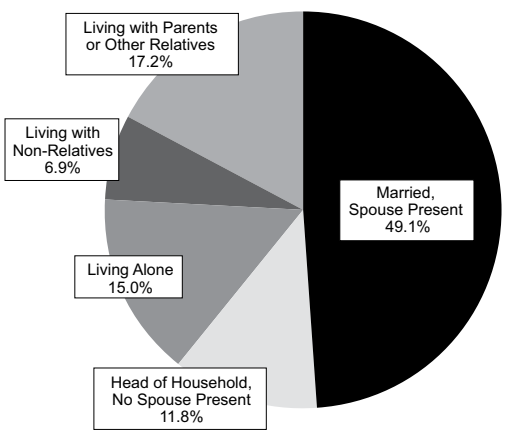
HOUSEHOLD COMPOSITION

In 2008, 49.1 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. Nearly 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. More than 17 percent of women lived with parents or other relatives, 15.0 percent lived alone and 6.9 percent lived with non-relatives.

Women in families 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 2008, non-Hispanic Black women were most likely to be single heads of households with family members present (28.1 percent), while non-Hispanic Asian/Pacific Islander and non-Hispanic White women were least likely (7.9 and 9.0 percent, respectively). Nearly 14 percent of non-Hispanic women of multiple races and 17.0 percent each of Hispanic and non-Hispanic American Indian/Alaska Native women were single heads of households that included other family members.

Women Aged 18 and Older,* by Household Composition, 2008

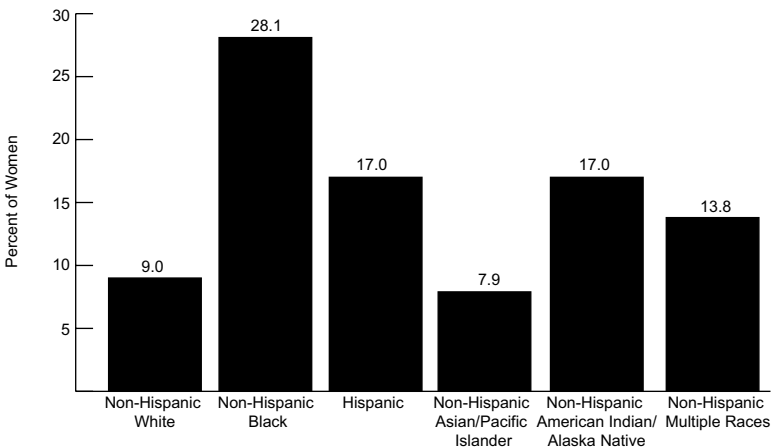
Source I.2: U.S. Census Bureau, Current Population Survey



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

Women Aged 18 and Older Who Are Heads of Households with Family Members,* by Race/Ethnicity, 2008

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



*Includes only non-institutionalized population not living in group housing; includes those who are heads of households and have children or other family members, but no spouse, living in a house that they own or rent.

WOMEN AND POVERTY

In 2008, nearly 40 million people in the United States lived with incomes below the poverty level.[3] More than 15 million of those were women aged 18 and older, accounting for 13.0 percent of the adult female population. In comparison, 9.6 percent of adult men lived in poverty (data not shown). With regard to race and ethnicity, non-Hispanic White women were least likely to experience poverty (9.4 percent), followed by non-Hispanic Asian/Pacific Islanders (12.0 percent). In contrast, more than 22 percent of Hispanic, non-Hispanic Black, and non-Hispanic American Indian/Alaska Native women lived in poverty.

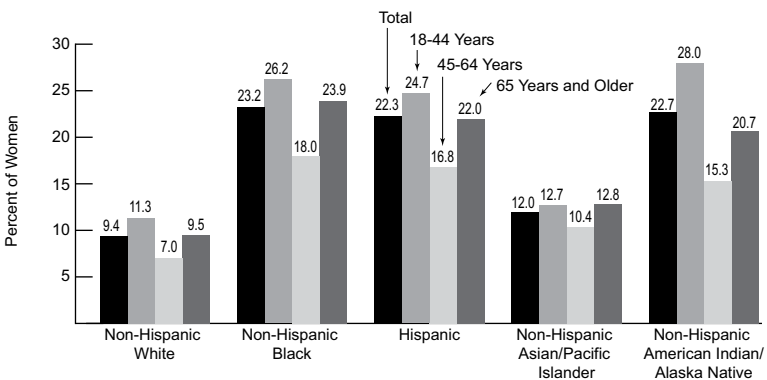
Poverty status varies with age. Among women of each race and ethnicity, those aged 45–64 years were less likely to experience poverty than those aged 18–44 and 65 years and older. For instance, 18.0 percent of non-Hispanic Black women aged 45–64 were living in poverty in 2008, compared to 26.2 percent of non-Hispanic Black women aged 18–44 and 23.9 percent of those aged 65 years and older.

Poverty status also varies with educational attainment. Among women aged 25 years and older, 30.4 percent of those without a high school diploma were living in poverty, compared to 13.1 percent of those with a high school diploma or equivalent, 9.8 percent of those with some college and 4.2 percent of those with a Bachelor's degree or higher (data not shown).

In 2008, women in families—a group of at least two people related by birth, marriage, or adoption and residing together—experienced higher rates of poverty than men in families (10.1 versus 6.9 percent, respectively). Men in families with no spouse present were considerably less likely to have household incomes below the poverty level than women in families with no spouse present (11.9 versus 25.7 percent, respectively).

Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity and Age, 2008

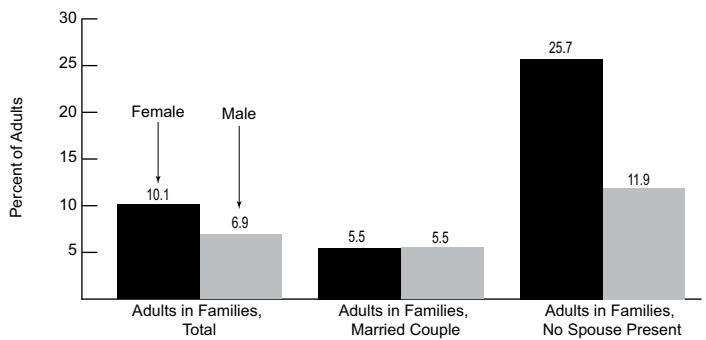
Source I.4: U.S. Census Bureau, Current Population Survey



Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

Adults in Families* Living Below the Poverty Level,** by Household Type and Sex, 2008

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 $22,025 for a family of four in 2008.*

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 survey 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.

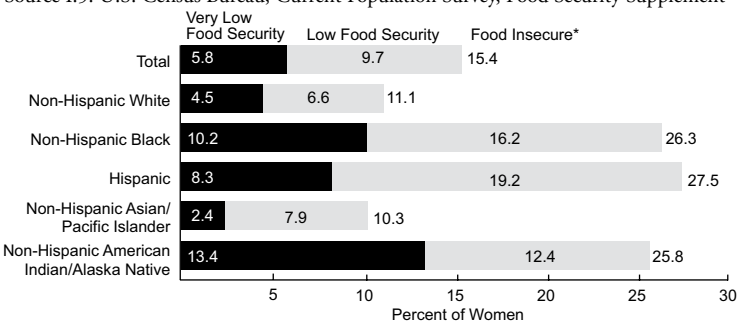
In 2008, an estimated 49.1 million people lived in households that were classified as food-insecure.[1] Households or persons experiencing food insecurity may be categorized as experiencing "low food security" or "very low food security". Low food security generally indicates multiple food access issues, 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.

Overall, 15.4 percent of women experienced household food insecurity in 2008; this varies, however, by race and ethnicity. Non-Hispanic Asian/Pacific Islander and non-Hispanic White women were least likely to be food insecure (10.3 and 11.1 percent, respectively), compared to more than one-quarter of Hispanic, non-Hispanic Black, and non-Hispanic American Indian/Alaska Native women. Non-Hispanic American Indian/Alaska Native and non-Hispanic Black women were also more likely to have very low food security (13.4 and 10.2 percent, respectively).

Food security status also varies by household composition. While adult men and women living alone had similar rates of food insecurity in 2008, female-headed households with no spouse present were more likely than male-headed households with no spouse present to experience food insecurity (37.2 versus 27.6 percent, respectively). Among adults with no spouse present, females were also more likely than males to experience very low food security (13.3 versus 7.2 percent, respectively).

Women Aged 18 and Older Experiencing Household Food Insecurity, by Race/Ethnicity, 2008

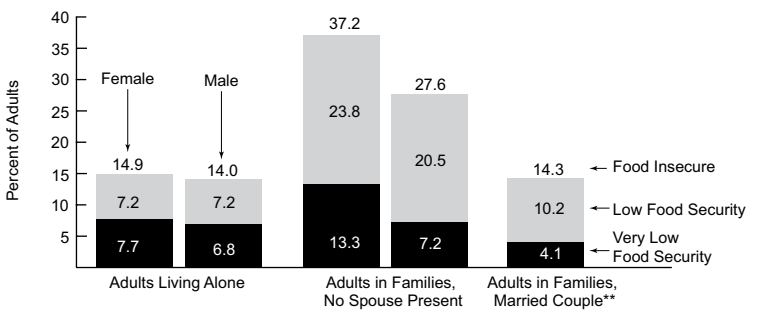
Source I.5: U.S. Census Bureau, Current Population Survey, Food Security Supplement



**Food insecure includes very low and low food security. Percentages may not add to totals due to rounding.*

Food Security Status Among Adults Aged 18 and Older, by Household Composition and Sex, 2008

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



**Food insecure includes very low and low food security. Percentages may not add to totals due to rounding.*
***Data were reported for persons in married couples overall and not by sex.*

WOMEN AND FEDERAL NUTRITION PROGRAMS

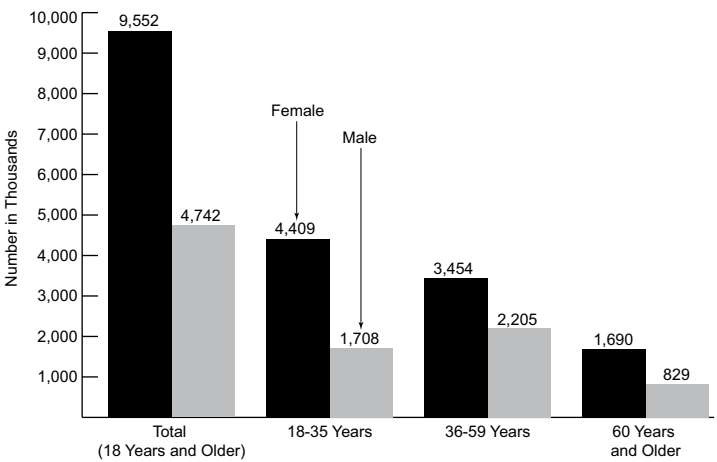
Federal programs can provide essential help to low-income women and their families in obtaining food and income support. The Supplemental Nutrition Assistance Program (SNAP), formerly the Federal Food Stamp Program, helps low-income individuals and families purchase food. In 2008, nearly 14.3 million adults participated in SNAP; of these, more than 9.5 million (66.8 percent) were women. Among participating women, 4.4 million (46.2 percent) were in the 18- to 35-year-old age group.

Female-headed households with children made up 29.4 percent of households that relied on food stamps, and represented 57.7 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. In 2009, more than three-quarters of all individuals receiving WIC benefits were infants and children (76.1 percent); however, the program also served nearly 2.2 million pregnant women and mothers, representing 23.9 percent of WIC participants. During the years 1992–2009, the number of women participating in WIC increased by 77.9 percent.

Adult Recipients of the Supplemental Nutrition Assistance Program,* by Age and Sex, 2008**

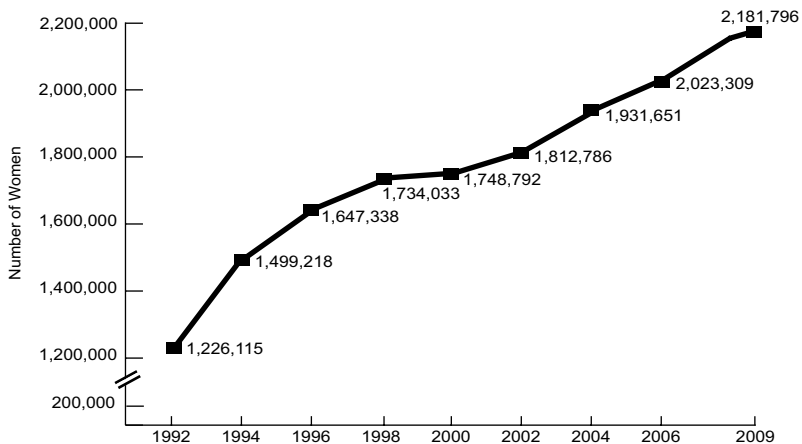
Source I.7: U.S. Department of Agriculture, Food Stamp Quality Control Sample



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

Women Participating in WIC,* 1992–2009**

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); 2009 data are preliminary.

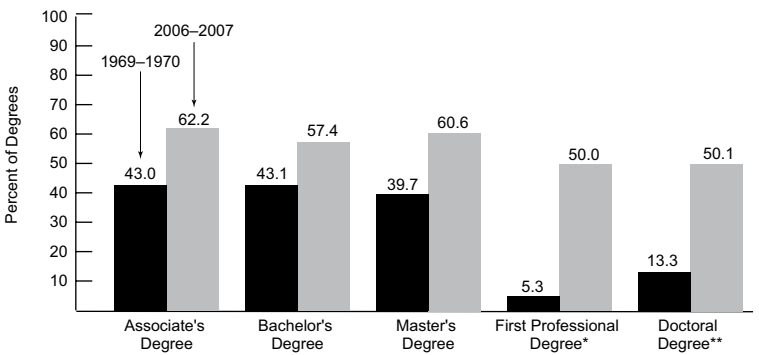
EDUCATIONAL DEGREES AND HEALTH PROFESSION SCHOOLS

The number of post-secondary educational degrees awarded to women rose from slightly more than half a million in the 1969–1970 academic year to nearly 1.8 million in 2006–2007. 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 2006–2007, women earned more than half of all associate's, bachelor's, master's, and doctoral degrees, and half of all first professional 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 50.0 percent in 2006–2007. The total number of women earning their first professional degree in 2006–2007 (45,032) was 24 times greater than in 1969–1970 (1,841).

While the sex disparity in degrees awarded has disappeared or reversed, a racial and ethnic disparity remains among women enrolled in schools for health professions. Non-Hispanic White women accounted for more than half of all women enrolled in schools of allopathic and osteopathic medicine, dentistry, 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 these schools. In comparison, non-Hispanic Asian/Pacific Islander women were overrepresented relative to their representation within the population, accounting for 30.9 percent of female students of optometry, 28.4 percent of female students of dentistry, and 22.9 percent of female pharmacy students.

Degrees Awarded to Women, by Type, 1969–1970 and 2006–2007

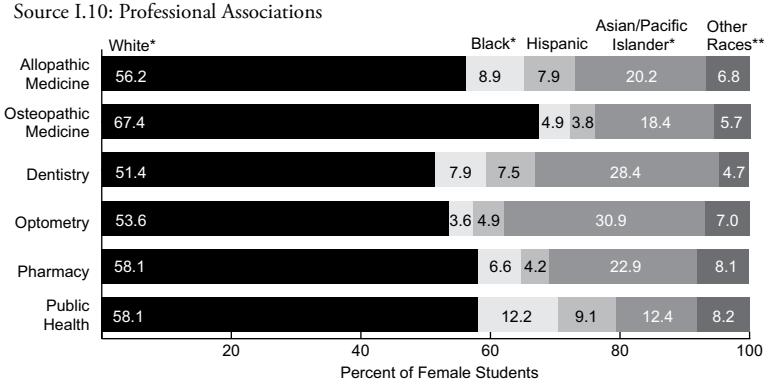
Source I.9: U.S. Department of Education, Digest of Education Statistics



*Includes fields of dentistry, medicine, optometry, osteopathic medicine, pharmacy, podiatry, veterinary medicine, chiropractic, public health, 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, 2008–2009

Source I.10: Professional Associations



*Non-Hispanic. **Includes non-Hispanic American Indian/Alaska Natives, students of other races, foreign students, and students whose race is unknown; data for allopathic medicine do not include foreign students.

WOMEN IN THE LABOR FORCE

In 2008, 59.5 percent of women aged 16 and older were in the labor force (either employed or not employed and actively seeking employment). This represents a 28.5 percent increase over the 46.3 percent of women who were in the labor force in 1975. During the same period, the percentage of men in the labor force decreased slightly (from 77.9 percent to 73.0 percent).

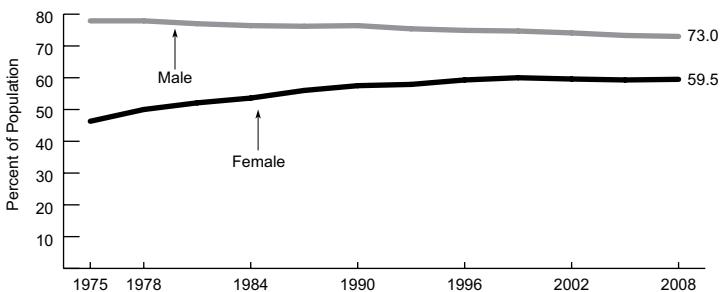
Women and men aged 18 and older experience similar rates of unemployment (not employed and actively seeking employment). In 2008, 5.2 percent of women and 5.8 percent of men in the labor force were unemployed. Unemployment among both men and women decreases as age increases. Among women, those aged 18–24 years were most likely to experience unemployment (10.0 percent), followed by 25- to 34-year-olds (5.5 percent). Women aged 45–64 and 65 years and older had the lowest proportion of unemployed workers (3.8 and 3.9 percent, respectively).

Labor force participation rates among mothers vary with the age of their child. Among women with at least one child under 6 years of age, 64.0 percent were in the labor force in 2008. In comparison, more than 77 percent of mothers of older children (aged 6–17 years) were in the labor force (data not shown).[5]

Labor force participation among mothers of children under age 18 also varies by race and ethnicity. Among women with children under 6 years of age, non-Hispanic Black women were most likely to be in the labor force (72.7 percent), followed by non-Hispanic American Indian/Alaska Native and non-Hispanic White women (67.3 and 66.3 percent, respectively). Hispanic mothers of children under age 6 were least likely to be in the labor force (52.3 percent), followed by non-Hispanic Asian/Pacific Islanders (62.8 percent). Similarly, nearly 80 percent of non-Hispanic Black and non-Hispanic White mothers of older children (aged 6–17 years) were in the labor force in 2008, compared to 70.0 percent of Hispanic and 71.2 percent of non-Hispanic American Indian/Alaska Native women (data not shown).[6]

Labor Force Participation* Among Persons Aged 16 and Older, by Sex, 1975–2008**

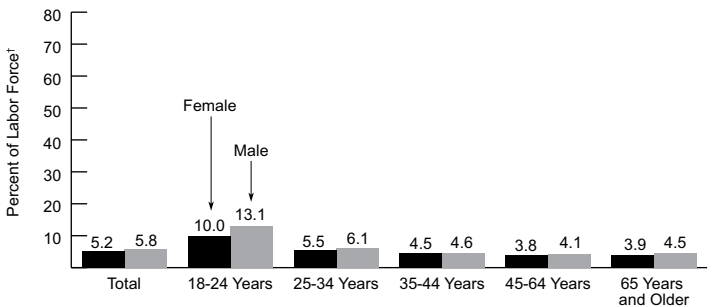
Source I.11: U.S. Census Bureau, Current Population Survey



*Includes persons employed or not employed and actively seeking employment. **Due to changes in data collection methodology, estimates may not be strictly comparable over years.

Unemployed* Persons Aged 18 and Older, by Age and Sex, 2008**

Source I.11: U.S. Census Bureau, Current Population Survey



*Includes persons not employed and actively seeking employment. **Includes only non-institutionalized population not living in group housing; based on annual averages. †Includes persons employed or not employed and actively seeking employment.

WOMEN VETERANS

As of September 2009, more than 1.8 million living women veterans had served in the U.S. military. This number is projected to rise to 1.9 million by 2016. 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 9.0 percent of the veteran population by 2013.

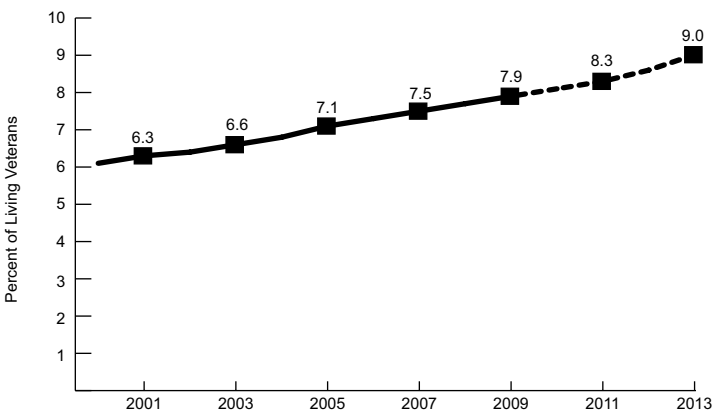
Female veterans are eligible for the same Department of Veterans Affairs (VA) benefits as male veterans. Comprehensive health services are available to all women veterans including primary care, gynecology and maternity care, mental health care, and specialty health care services. Full-time Women Veterans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

Of the 7.8 million veterans who are enrolled in the VA for health care, women account for more than 487,000 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 of previous eras.

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 16 and 40 years of age, (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, 2000–2013*

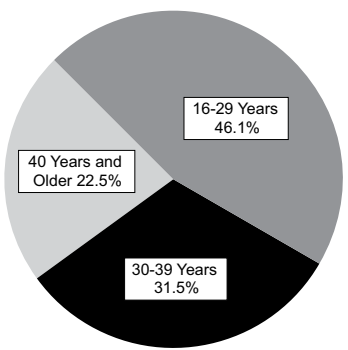
Source I.12: Department of Veteran Affairs, Office of Policy and Planning



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

Women Veterans of Operations Enduring Freedom and Iraqi Freedom, by Age, 2002–2009*

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



*Percentages may not add to 100 due to rounding.

RURAL AND URBAN WOMEN

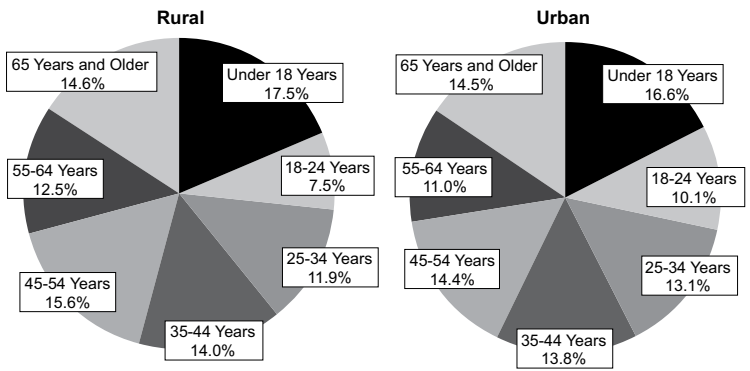
In 2008, an estimated 35.1 million women and girls, representing 22.7 percent of the female population, lived in rural areas. Residents of rural areas tend to have completed fewer years of education, have public insurance or no health insurance, and live farther from health care resources than their urban counterparts. Rural areas also have fewer physicians and dentists per capita than urban areas.[7]

In 2008, a greater proportion of urban females were aged 18–34 years than in rural areas, while the proportion of rural females was greater among 35- to 64-year-olds. More than 10 percent of females in urban areas were 18–24 years of age, compared to 7.5 percent of those in rural areas. Similarly, 13.1 percent of females in urban areas were 25–34 years of age, compared to 11.9 percent of females in rural areas. Among females in rural areas, 12.5 percent were 55–64 years of age and 15.6 percent were aged 45–54 years; this was slightly higher than in urban areas where 11.0 percent of females were 55–64 years and 14.4 percent were 45–54 years of age.

The percentage of women living with household incomes below 100 percent of poverty varies by rural/urban residence and age. Women in urban areas were more likely to be living in poverty than their rural counterparts (13.9 versus 11.5 percent, respectively); this was true for most age groups. Among women in both urban and rural areas, those aged 18–34 years were most likely to have incomes below 100 percent of poverty: 20.7 percent of women aged 18–34 years in urban areas and 16.3 percent of those in rural areas did so. Women aged 45–64 years in both urban and rural areas were least likely to be living below the poverty level (9.8 and 8.6 percent, respectively).

U.S. Female Population, by Rural/Urban Residence* and Age, 2008

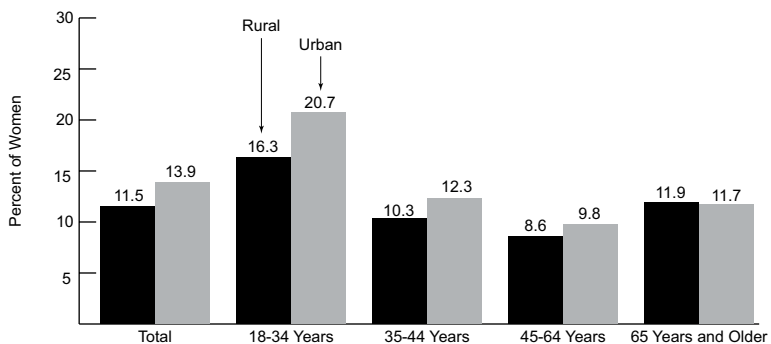
Source I.1: U.S. Census Bureau, American Community Survey



**U.S. Census Bureau defines urban as all territory, population, and housing units located within an urbanized area or urban cluster which encompass core census blocks/block groups with at least 1,000 people per square mile, and surrounding census blocks with at least 500 people per square mile; all other areas are categorized as rural.*

Women Aged 18 and Older Living Below the Poverty Level,* by Age and Rural/Urban Residence,** 2008

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



Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.U.S. Census Bureau defines urban as all territory, population, and housing units located within an urbanized area or urban cluster which encompass core census blocks/block groups with at least 1,000 people per square mile, and surrounding census blocks with at least 500 people per square mile; all other areas are categorized as rural.*

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. Studying trends in health status can 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 hearing and vision loss and violence against women. A new subsection on women and aging also provides data on the population characteristics, labor force participation, and household composition of older women, as well as age-specific information on activity limitations, osteoporosis, and injury and abuse. 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.[1] 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, plus muscle-strengthening activities on at least 2 days per week. Additional health benefits are gained by engaging in physical activity beyond this amount.[2]

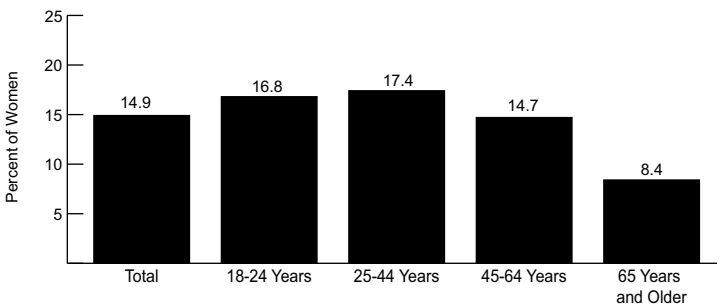
In 2008, fewer than 15 percent of women met the recommendations for adequate physical activity. The percentage of women reporting adequate physical activity generally decreases as age increases. Women aged 18–24 and 25–44 years were most likely to have engaged in adequate physical activity (16.8 and 17.4 percent, respectively). Women aged 65 years and older were least likely to engage in adequate amounts of physical activity (8.4 percent).

The proportion of women engaging in the recommended amount of physical activity also varies by race and ethnicity and poverty status. Overall, non-Hispanic White women were more likely to have reported adequate physical activity (16.9 percent) than non-Hispanic Black or Hispanic women (9.7 and 9.6 percent, respectively).

Among each of these racial and ethnic groups, the proportion of women engaging in adequate physical activity was highest among those with household incomes of 200 percent or more of poverty. Among Hispanic women, however, almost twice as many women with incomes below 100 percent of poverty engaged in adequate physical activity as compared to those with incomes between 100–199 percent of poverty (8.2 versus 4.4 percent, respectively). Non-Hispanic White women with incomes below 100 percent of poverty and 100–199 percent of poverty had comparable rates of adequate physical activity (10.4 and 9.3 percent, respectively).

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Age, 2008

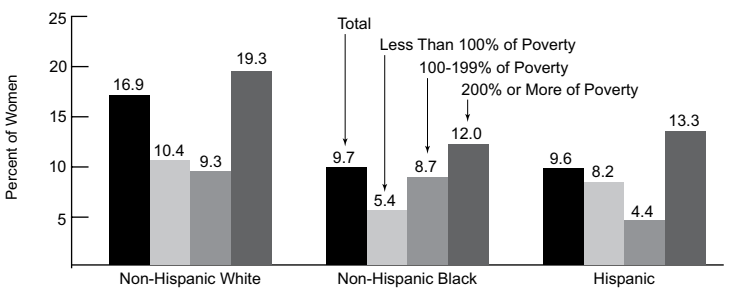
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Adequate physical activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous-intensity activity, or an equivalent combination of both, plus muscle-strengthening activities on 2 or more days per week.*

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Race/Ethnicity** and Poverty Status,† 2008

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



**Adequate physical activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous-intensity activity, or an equivalent combination of both, plus muscle-strengthening activities on 2 or more days per week. **The sample of American Indian/Alaska Natives, Asians, Native Hawaiian/Pacific Islanders, and persons of multiple races was too small to produce reliable results. †Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.*

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.[1]

Folate is 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 2005–2008, only 32.0 percent of women consumed the Recommended Dietary Allowance (RDA) for folate (400 mcg/day). This varied by race and ethnicity, as well as poverty status.

Fewer than 22 percent of non-Hispanic Black women consumed the recommended amount of folate, compared to more than 30 percent of Mexican American and other Hispanic women, and 34.0 percent of non-Hispanic White women.

Women with household incomes of 300 percent or more of poverty were more likely than women with lower incomes to have met the RDA for folate (35.8 percent), while women with incomes below 100 percent of poverty were least likely to have done so (23.4 percent).

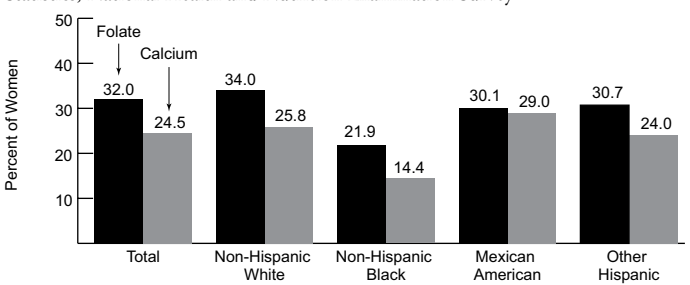
Inadequate calcium consumption can lead to lower bone density, bone loss, and increased risk of osteoporosis. The recommended Adequate Intake (AI) for calcium is 1,000 mg/day for women aged 19–50 and 1,200 mg/day for women aged 51 years and older. In 2005–2008, fewer than one-quarter of women (24.5 percent) met or exceeded this recommendation.

Non-Hispanic Black women were less likely than women of other races and ethnicities to have met the recommendations for calcium in 2005–2008 (14.4 percent).

Women with incomes of 300 percent or more of poverty were more likely than those with household incomes of less than 100 percent of poverty to have met the recommended AI for calcium (26.8 versus 19.9 percent, respectively).

Women Meeting the Recommended Daily Intake of Folate and Calcium,* by Race/Ethnicity,** 2005–2008

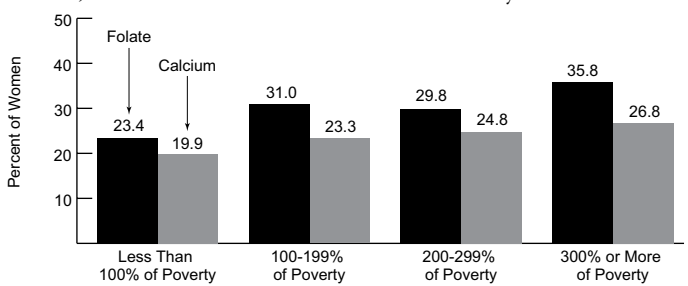
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**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.*
***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.*

Women Meeting the Recommended Daily Intake of Folate and Calcium,* by Poverty Status, 2005–2008

Source II.2: 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.*

SLEEP DISORDERS

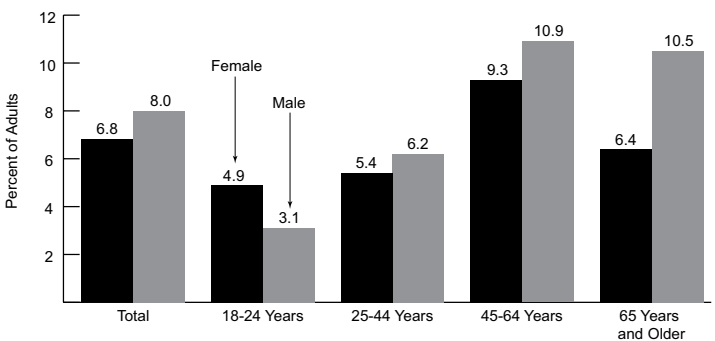
In 2005–2008, 7.4 percent of adults reported that they had ever been told by a health professional that they had a sleep disorder. Sleep disorders can take many forms and have serious health effects in addition to their effects on productivity and quality of life.[3] Insomnia is a sleep disorder characterized by a person's inability to fall or stay asleep, while narcolepsy is characterized by excessive daytime sleepiness, or "sleep attacks," and sudden muscle weakness. Some sleep disorders affect an individual during sleep. Sleep apnea, which is sometimes confused with snoring, is marked by gasping or snorting and can momentarily disrupt an individual's sleep cycle or constrict the airway.

Overall, sleep disorders are slightly more common among men than women (8.0 versus 6.8 percent, respectively), and vary with age among both sexes. Among women, 45- to 64-year-olds were more likely than women of other age groups to have been told by a health professional that they had a sleep disorder (9.3 percent). Women aged 65 years and older were also more likely than those aged 18–24 years to have had a sleep disorder (6.4 versus 4.9 percent, respectively). Among men, those aged 45–64 and 65 years and older were more likely than younger men to have had a sleep disorder (10.9 and 10.5 percent, respectively).

Sleep disorders among women also vary by poverty status. Women with household incomes below 100 percent of poverty are more likely than women with higher incomes to have reported a sleep disorder (10.1 percent). Women with incomes of 100–199 percent of poverty were also more likely than women with incomes of 300 percent or more to have ever been told by a health professional that they had a sleep disorder (7.2 versus 5.3 percent, respectively).

Sleep Disorders* Among Adults Aged 18 and Older, by Age and Sex, 2005–2008

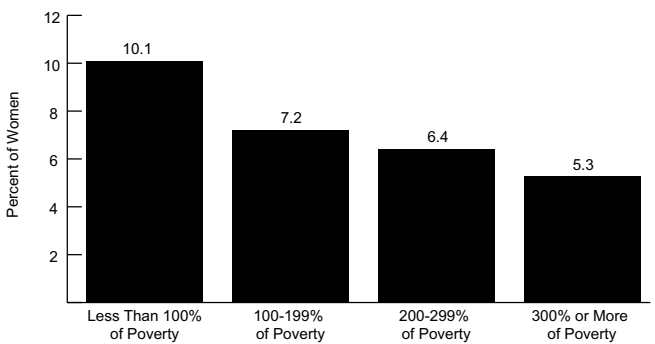
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported that a health professional has ever told them they have a sleep disorder; this may include insomnia, restless legs, sleep apnea and other conditions.

Sleep Disorders* Among Women Aged 18 and Older, by Poverty Status,** 2005–2008

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



*Reported that a health professional has ever told them they have a sleep disorder: this may include insomnia, restless legs, sleep apnea and other conditions. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

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.[4] 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 and depression.

In 2008, 63.1 percent of adults aged 18 years and older were current drinkers (had at least one alcoholic drink in the past year; data not shown). This varies, however, by sex. Overall, women were less likely than men to have consumed any alcohol in the past year (57.3 versus 69.2 percent, respectively).

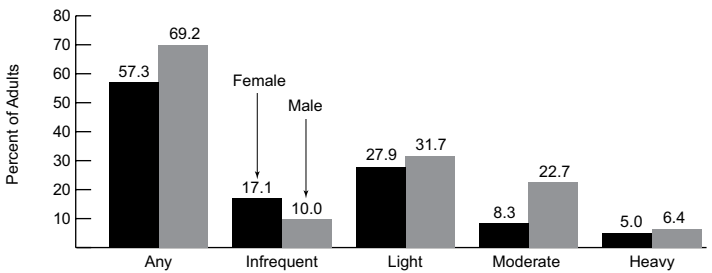
While more than half of women had consumed alcohol in the past year, most of them reported infrequent or light drinking. Fewer than 28 percent of women reported light drinking (3 or fewer drinks per week), and 17.1 percent reported infrequent drinking (1–11 drinks total in the past year).

The frequency of alcohol consumption among women varies by age. Women aged 65 and older were most likely not to have consumed alcohol in the past year (62.5 percent), followed by women aged 18–24 and 45–64 years (42.0 and 38.9 percent, respectively). Women aged 18–24 years were, however, more likely than women of other ages to be heavy drinkers (8.2 percent), while women aged 25–44 years were most likely to have reported light drinking (35.1 percent).

While the rate of arrests for driving under the influence has decreased slightly from 1999 to 2008 (from 5.4 to 4.8 per 1,000 people, respectively, among reporting agencies), the proportion of females arrested for this crime has increased during that time. In 2008, females accounted for 21.4 percent of arrests reported for driving under the influence, compared to 15.8 percent in 1999 (data not shown).[5]

Current Drinking* Among Adults Aged 18 and Older, by Level of Alcohol Consumption** and Sex, 2008

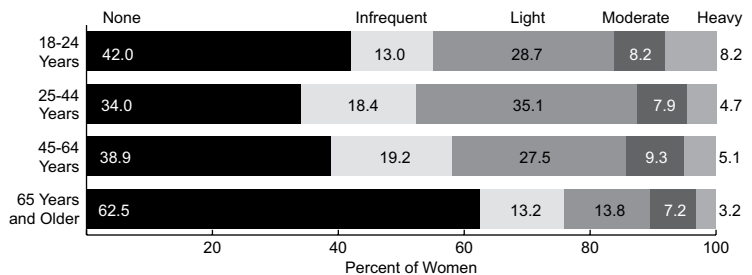
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Had at least 1 drink in the past year. **Infrequent indicates 1-11 drinks consumed in the past year; light indicates 3 or fewer drinks per week in the past year; moderate indicates 4 to 7 (for females) or 4 to 14 (for males) drinks per week; heavy indicates more than 7 (for females) or more than 14 (for males) drinks per week.

Level of Alcohol Consumption* Among Women Aged 18 and Older, by Age, 2008

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



*Infrequent indicates 1-11 drinks consumed in the past year; light indicates 3 or fewer drinks per week in the past year; moderate indicates 4 to 7 drinks per week; heavy indicates more than 7 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, impair genes that control the growth of cells, and bind 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.[6]

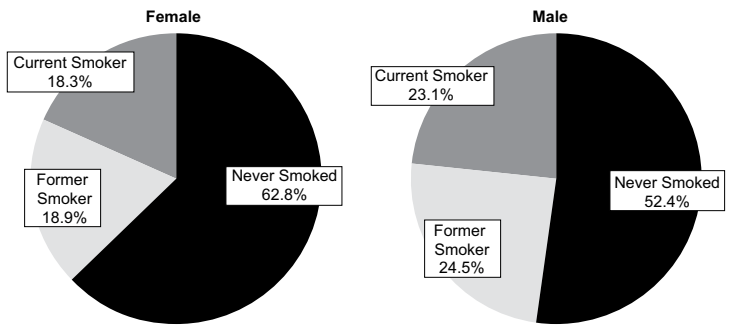
In 2008, women aged 18 and older were more likely than men never to have smoked cigarettes in their lifetime (62.8 versus 52.4 percent, respectively). Women were just as likely to be current cigarette smokers as former smokers (18.3 and 18.9 percent, respectively). Similarly, among men, 23.1 percent were current smokers and 24.5 percent were former smokers.

The proportion of women who have never smoked cigarettes was greater among those with higher incomes. Women with household incomes of 400 percent or more of poverty or 200–399 percent of poverty (65.1 and 62.7 percent, respectively) were more likely than women with household incomes below 100 percent of poverty to have never smoked cigarettes (57.9 percent).

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[1] In 2008, more than 48 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 years were most likely to have attempted to quit smoking (51.5 percent), compared to women aged 45–64 years (45.8 percent) and 65 years and older (42.0 percent; data not shown).

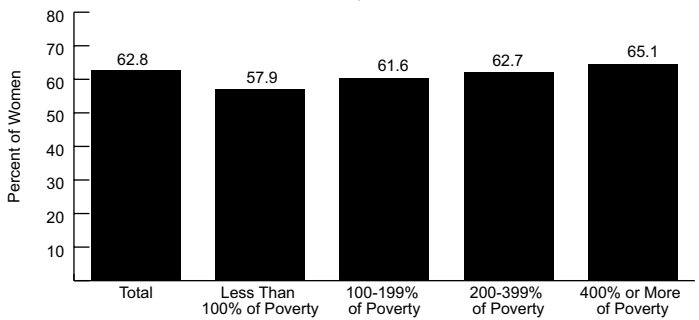
Current Cigarette Smoking Among Adults Aged 18 and Older, by Sex, 2008

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



Women Aged 18 and Older Who Never Smoked Cigarettes, by Poverty Status,* 2008

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 $22,025 for a family of four in 2008.*

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.[7] Illicit drugs include marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes. In 2008, nearly 13.4 million women aged 18 years and older reported using an illicit drug within the past year, representing 11.5 percent of adult women. In comparison, 17.4 million men, representing 16.1 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 (29.9 percent), followed by females aged 12–17 years (18.9 percent); past-year use was lowest among women aged 26 years and older (8.5 percent).

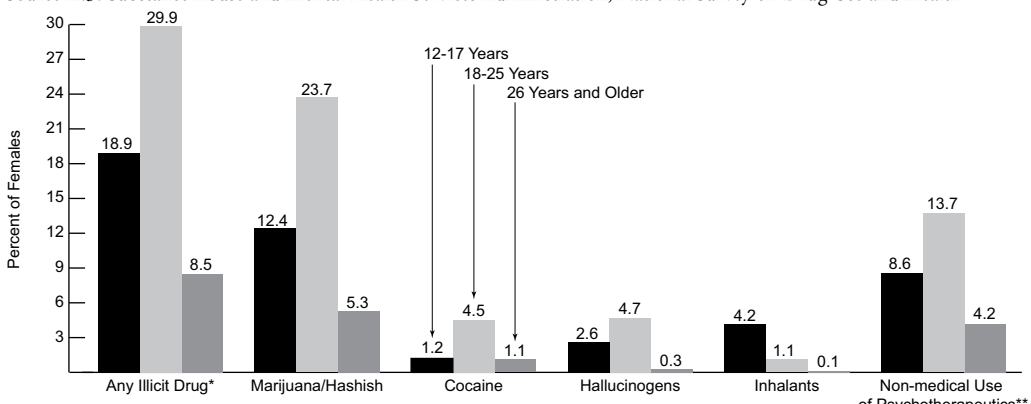
Use of all drug types, except inhalants, was highest among females aged 18–25 years, with 23.7 percent reporting past-year marijuana use and 13.7 percent reporting non-medical use of prescription-type psychotherapeutic drugs (including prescription pain relievers, tranquilizers, stimulants, and sedatives). Use of inhalants in the past year was highest among females aged 12–17 (4.2 percent), compared to 1.1 percent of 18- to 25-year-olds and 0.1 percent of those aged 26 years and older.

Marijuana was the most commonly used illicit drug among females of all ages, followed by the non-medical use of psychotherapeutics. Short-term effects of marijuana use can include difficulty thinking and solving problems, memory and learning problems, and distorted perception. Long-term use of psychotherapeutic 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. Prescription drugs commonly used or abused for non-medical purposes include opioids, central nervous system depressants, and stimulants.[7]

The percentage of women reporting non-medical use of psychotherapeutics varies by race and ethnicity. Among women aged 18 and older, non-Hispanic White women were more likely than women of other races and ethnicities to report the use of psychotherapeutics in the past year (6.3 percent). Four percent of non-Hispanic Black women also reported the non-medical use of psychotherapeutics, as did 3.5 percent of non-Hispanic American Indian/Alaska Native and Hispanic women (data not shown).

Past Year Use of Illicit Drugs Among Females Aged 12 and Older, by Age and Drug Type, 2008

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

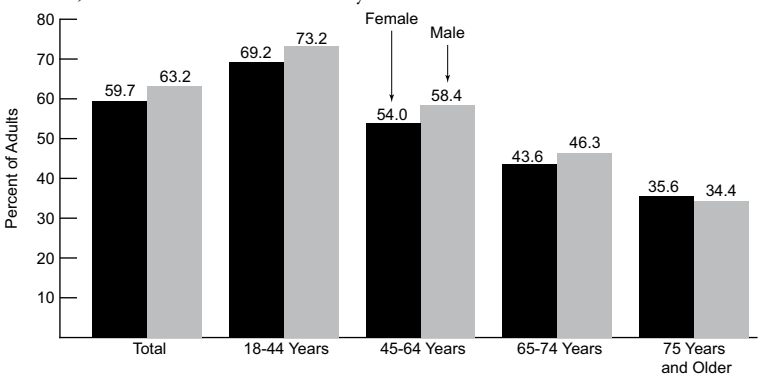
In 2008, 61.4 percent of adults reported being in excellent or very good health; this did not vary significantly by sex (data not shown). Among both sexes, self-reported health status declines with age. Women and men aged 75 years and older were least likely to report excellent or very good health (35.6 and 34.4 percent, respectively), compared to 69.2 percent of women and 73.2 percent of men aged 18–44 years.

The proportion of women reporting excellent or very good health also varies with race and ethnicity. Non-Hispanic Asian and non-Hispanic White women were most likely to report excellent or very good health in 2008 (65.8 and 63.4 percent, respectively). In comparison, 43.0 percent of non-Hispanic women of multiple races, and slightly more than 48 percent of non-Hispanic Black and Hispanic women reported excellent or very good health. Approximately 1 in 5 non-Hispanic Black, non-Hispanic American Indian/Alaska Native, Hispanic, and non-Hispanic women of multiple races reported fair or poor health status.

Self-reported health status among women improves as household income increases. Women with household incomes below the poverty level were least likely to report excellent or very good health (35.2 percent), followed by women with incomes of 100–199 percent of poverty (45.7 percent). Women with higher household incomes were significantly more likely to report being in excellent or very good health; 60.2 percent of women with household incomes of 200–399 percent of poverty and 72.8 percent of those with incomes of 400 percent or more of poverty reported excellent or very good health (data not shown).

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Age and Sex, 2008*

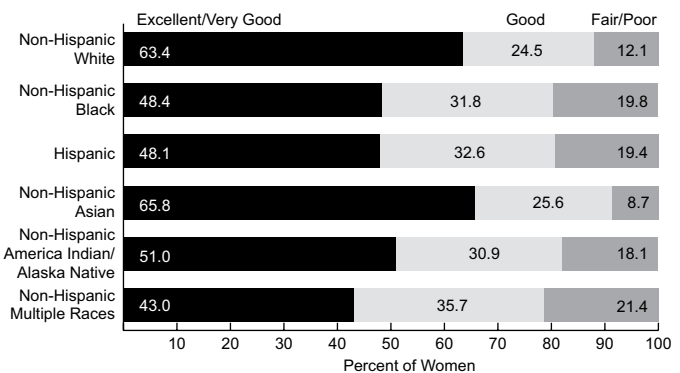
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Rates reported are age-adjusted.

Self-Reported Health Status of Women Aged 18 and Older, by Race/Ethnicity, 2008*

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



*Rates reported are age-adjusted. Percentages may not add to 100 due to rounding.

LIFE EXPECTANCY

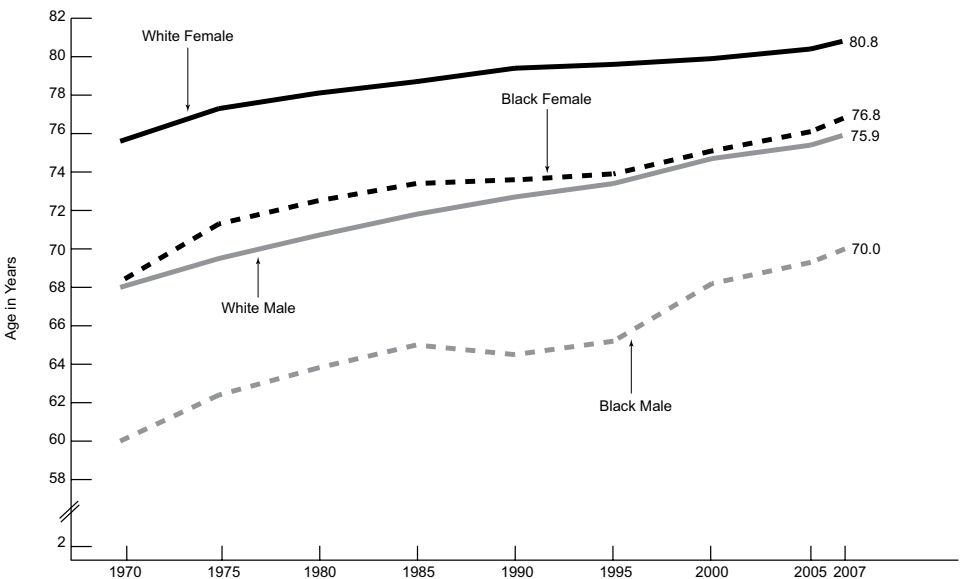
The overall life expectancy of a baby born in 2007 was 77.9 years (data not shown); this varied, however, by sex and race. A baby girl born in the United States in 2007 could expect to live 80.4 years, 5.0 years longer than a male baby, whose life expectancy would be 75.4 years (data not shown). The differential between male and female life expectancy was greater among Blacks than Whites. Black males born in 2007 could expect to live 70.0 years, 6.8 years fewer than Black females (76.8 years). The difference between White males and females was 4.9 years, with life expectancies at birth of 75.9 and 80.8 years, respectively. White females could expect to live 4.0 years longer than Black females. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates, as well as higher mortality rates throughout the lifespan.[8]

Life expectancy has increased since 1970 for males and females in both racial groups. Between 1970 and 2007, White males' life expectancy increased from 68.0 to 75.9 years (11.6 percent), while White females' life expectancy increased from 75.6 to 80.8 years (6.9 percent). During the same period, the life expectancy for Black males increased from 60.0 to 70.0 years (16.7 percent), while life expectancy increased from 68.3 to 76.8 years (12.4 percent) for Black females.

While life expectancy estimates have not historically been calculated and reported for the Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native populations, the U.S. Census Bureau has calculated projected life expectancies for these groups. An American Indian/Alaska Native female born in 2010 is expected to live 81.5 years, while a male is expected to live 76.6 years. Among Hispanics born in 2010, females are expected to have a life expectancy of 83.7 years and males 78.4 years. Asian females born in that year are expected to live 81.1 years, while life expectancy for Asian males is 76.3 years. In comparison, non-Hispanic White females and males born in 2010 are projected to live 81.1 and 76.3 years, respectively (data not shown).[9]

Life Expectancy at Birth, by Race* and Sex, 1970–2007

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



*Both racial categories include Hispanics.

LEADING CAUSES OF DEATH

In 2007, there were 1,200,336 deaths of women aged 18 and older in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), which were responsible for 25.5 and 22.4 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 6.8 percent of deaths, and chronic lower respiratory disease, which accounted for 5.5 percent.

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 women, 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 seventh leading cause of death among non-Hispanic White women, while it was the fourth among all other racial and ethnic groups. Similarly, chronic lower respiratory disease was the fourth and fifth leading causes of death among non-Hispanic White and non-Hispanic American Indian/Alaska Native women, respectively, while it ranked seventh among other racial and ethnic groups. Nephritis, or kidney inflamation, was the fifth leading cause of death among non-Hispanic Black women, but ranked eighth and ninth among women of other races and ethnicities.

Hypertension was the tenth leading cause among non-Hispanic Black and non-Hispanic Asian/Pacific Islander women, accounting for 2.0 and 1.6 percent of deaths, respectively (data not shown). Also noteworthy is that non-Hispanic American Indian/Alaska Native women experienced a higher proportion of deaths due to unintentional injury (8.2 percent) and liver disease (4.8 percent; seventh leading cause of death) than women of other racial and ethnic groups. Liver disease was also the tenth leading cause of death among Hispanic women, accounting for 2.0 percent of deaths (data not shown).

Ten Leading Causes of Death Among Women Aged 18 and Older, by Race/Ethnicity, 2007

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	25.5 **(1)**	25.6 **(1)**	26.0 **(1)**	23.8 **(1)**	22.9 **(2)**	18.2 **(2)**
Malignant Neoplasms (cancer)	22.4 **(2)**	22.3 **(2)**	22.7 **(2)**	23.2 **(2)**	27.9 **(1)**	19.6 **(1)**
Cerebrovascular Diseases (stroke)	6.8 **(3)**	6.7 **(3)**	7.0 **(3)**	6.7 **(3)**	9.5 **(3)**	5.0 **(6)**
Chronic Lower Respiratory Disease	5.5 **(4)**	6.2 **(4)**	2.7 **(7)**	2.9 **(7)**	2.5 **(7)**	5.0 **(5)**
Alzheimer's Disease	4.4 **(5)**	4.8 **(5)**	2.6 **(8)**	3.0 **(6)**	2.4 **(8)**	N/A
Unintentional Injury	3.4 **(6)**	3.4 **(6)**	2.7 **(6)**	4.3 **(5)**	3.6 **(5)**	8.2 **(3)**
Diabetes Mellitus	3.0 **(7)**	2.5 **(7)**	5.1 **(4)**	5.8 **(4)**	4.2 **(4)**	6.7 **(4)**
Influenza and Pneumonia	2.4 **(8)**	2.4 **(8)**	N/A	2.4 **(8)**	3.0 **(6)**	2.1 **(9)**
Nephritis (kidney inflammation)	2.0 **(9)**	1.8 **(9)**	3.4 **(5)**	2.3 **(9)**	1.9 **(9)**	2.7 **(8)**
Septicemia (blood poisoning)	1.6 **(10)**	1.4 **(10)**	2.5 **(9)**	N/A	N/A	2.0 **(10)**

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

ARTHRITIS

Arthritis, the most common cause of disability among American adults, comprises more than 100 different diseases that affect areas in or around the joints.[10] 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.[11] 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.[11]

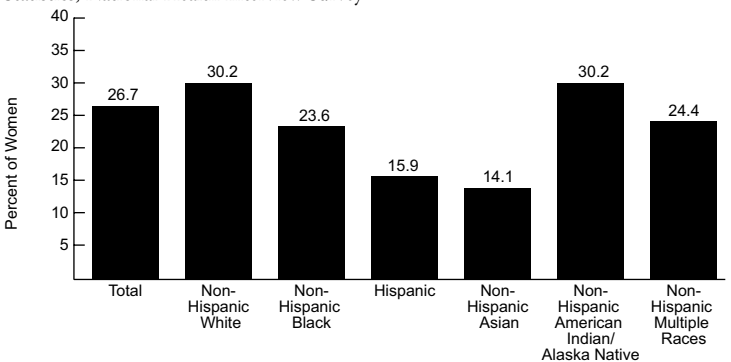
In 2008, nearly 23 percent of adults in the United States reported that they had ever been diagnosed with arthritis; this represents more than 51 million adults (data not shown). Arthritis was more common among women than men (26.7 versus 18.5 percent, respectively). The proportion of adults with arthritis increases dramatically with age for both sexes. Fewer than 9 percent of women aged 18–44 years had ever been diagnosed with arthritis, compared to 55.1 percent of women aged 65–74 years, and 59.8 percent of women aged 75 years and older (data not shown).

The proportion of women with arthritis varies by race and ethnicity. In 2008, arthritis was most common among non-Hispanic White women (30.2 percent), followed by non-Hispanic Black women (23.6 percent). Non-Hispanic Asian and Hispanic women were least likely to report having ever been told that they have arthritis (14.1 and 15.9 percent, respectively). Other observed differences were not statistically significant.

Among women with arthritis in 2008 who reported a specific condition, 11.6 percent reported that a health professional had told them they have rheumatoid arthritis, while 8.1 percent reported that they have fibromyalgia. Two percent of women with arthritis reported that they had lupus arthritis, 2.9 percent had gout, and 5.7 percent reported some other joint condition.

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity, 2008

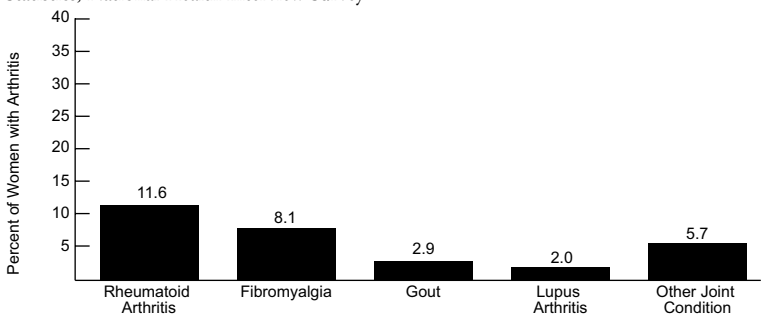
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Selected Types of Arthritis* Among Women Aged 18 and Older with Arthritis, 2008

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 any of these conditions; respondents could report more than one type of arthritis.

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, poor housing, 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.

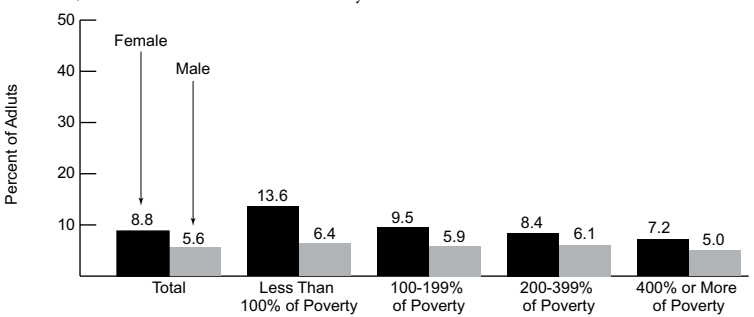
In 2008, women were more likely to have asthma than men (8.8 versus 5.6 percent, respectively); this was true for all income levels. Among women, those with household incomes below 100 percent of poverty were most likely to have asthma (13.6 percent). In comparison, 8.4 percent of women with incomes of 200–399 percent of poverty and 7.2 percent of those with incomes of 400 percent or more of poverty had asthma.

A visit to the emergency room due to an asthma attack may indicate that asthma is not being effectively controlled or treated. In 2008, 22.1 percent of women with an asthma attack in the past year sought care from an emergency room for their condition. The proportion of women suffering an asthma attack who visit the emergency room varies by race and ethnicity. Non-Hispanic Black women were most likely to have visited an emergency room (38.6 percent), compared to 21.4 percent of Hispanic women and 17.7 percent of non-Hispanic White women.

Women with asthma can effectively manage their condition by creating an asthma management plan with their doctor and knowing about and avoiding asthma triggers.[12] Consistent access to and use of medication can reduce the likelihood of an asthma attack, as well as the use of hospital and emergency room care for people with asthma.[13]

Adults Aged 18 and Older with Asthma,* by Poverty Status** and Sex, 2008

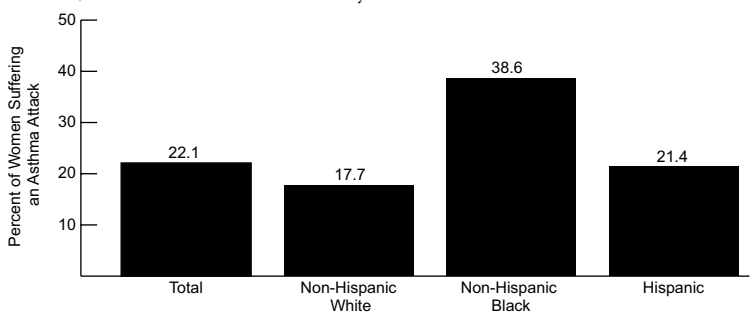
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

Women Aged 18 and Older with an Emergency Room Visit Due to Asthma in the Past Year, by Race/Ethnicity,* 2008

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



*The sample of American Indian/Alaska Natives, Asians, Native Hawaiian/Pacific Islanders, and persons of multiple races was too small to produce reliable results.

CANCER

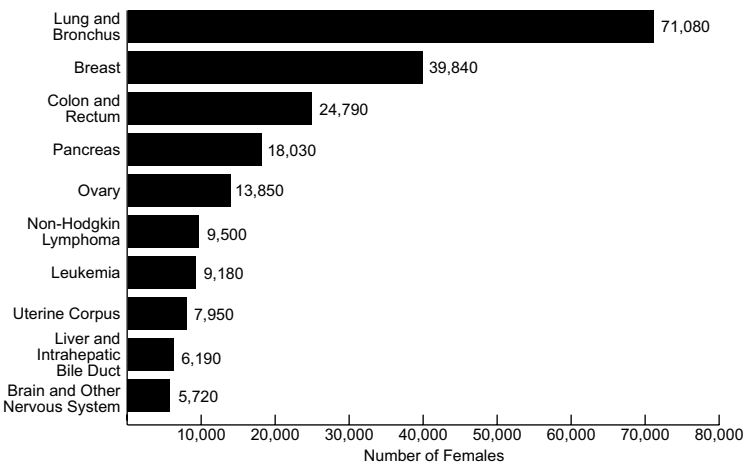
It is estimated that 739,940 new cancer cases will be diagnosed among females, and more than 270,000 females will die of cancer in 2010. Lung and bronchus cancer is expected to be the leading cause of cancer death among females, accounting for 71,080 deaths, or 26 percent of all cancer deaths, followed by breast cancer, which will be responsible for 39,840, 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 56,670 deaths combined.

Due to the varying survival rates for different types of cancer, the most common causes of death from cancer are not always the most common types of cancer. For instance, although lung and bronchus cancer causes the greatest number of deaths among females, breast cancer is more commonly diagnosed. In 2006, invasive breast cancer occurred among 119.3 per 100,000 females, whereas lung and bronchus cancer occurred in only 55.0 per 100,000. Other types of cancer that are more likely to be diagnosed but are not among the top 10 causes of cancer deaths include thyroid, melanoma, and cervical cancer, occurring in 16.0, 15.0, and 8.0 per 100,000 females, respectively.

Regular screening can help prevent or detect cervical cancer in the early stages. Cervical cancer screenings are recommended at least every 3 years beginning within 3 years of sexual activity or by age 21. A vaccine for genital human papillomavirus (HPV; the leading cause of cervical cancer) was approved for use by the Food and Drug Administration in 2006 and is recommended for adolescents and young women aged 9–26 years.[14] In 2006–2007, 10 percent

Leading Causes of Cancer Deaths Among Females (All Ages), by Site, 2010 Estimates

Source II.6: American Cancer Society



Invasive Cancer Rates per 100,000 Females (All Ages), by Site and Race/Ethnicity, 2006*

Source II.7: Centers for Disease Control and Prevention and National Cancer Institute

	Total	White**	Black**	Hispanic†	Asian/Pacific Islander**†	American Indian/ Alaska Native**†
Breast	119.3	120.4	113.2	89.0	80.3	61.0
Lung and Bronchus	55.0	56.7	49.8	25.5	27.2	36.9
Colon and Rectum	41.1	39.9	49.2	33.2	31.7	26.7
Thyroid	16.0	16.7	9.6	15.0	16.5	8.6
Non-Hodgkin Lymphoma	15.7	16.2	11.0	14.2	9.4	10.2
Melanoma	15.0	16.9	1.0	3.9	1.1	3.9
Cervix	8.0	7.7	9.9	11.6	7.4	6.3

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

of women aged 18-26 years had been vaccinated for HPV (data not shown).[15] There is also a vaccine available for adolescent and young men to protect against HPV.

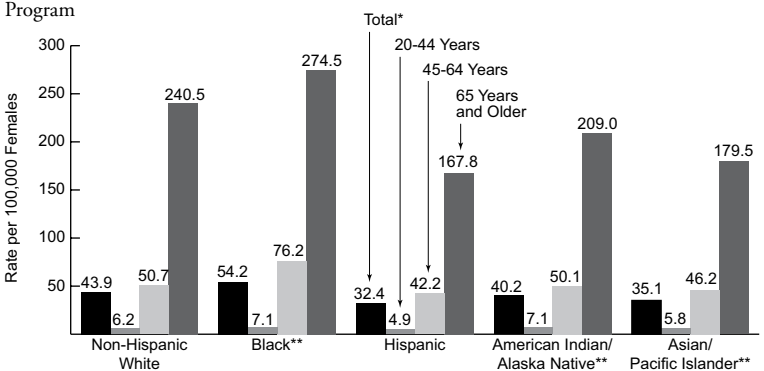
Despite preventive measures, cervical cancer incidence varies by race and ethnicity. In 2006, Hispanic and Black females were most likely to have been diagnosed with invasive cervical cancer (11.6 and 9.9 per 100,000, respectively), compared to 7.7 per 100,000 White females.

In 2000–2007, Black females were more likely than women of other races and ethnicities to be diagnosed with colon and rectum cancer (54.2 per 100,000). Overall, Black and non-Hispanic White women aged 65 years and older were most likely to have developed this type of cancer (274.5 and 240.5 per 100,000 women, respectively), followed by American Indian/Alaska Native women of the same age group (209.0 per 100,000). Among women of all ages, Hispanic women were least likely to have colon and rectum cancer.

Cancer survival rates vary depending on how early the cancer is discovered. For females diagnosed with lung and bronchus cancer in 1999–2006, 18.3 percent could expect to live 5 years or more; however, this varied by race and the stage of the cancer. White women were more likely than Black women to live at least 5 years when the cancer was diagnosed in the localized stage (57.8 versus 49.0 percent, respectively). Fewer than 27 percent of White females and 22.3 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 4.2 percent of White females and 3.4 percent of Black females could expect to live 5 more years.

Colon and Rectum Cancer Incidence Among Females, by Race/Ethnicity and Age, 2000–2007

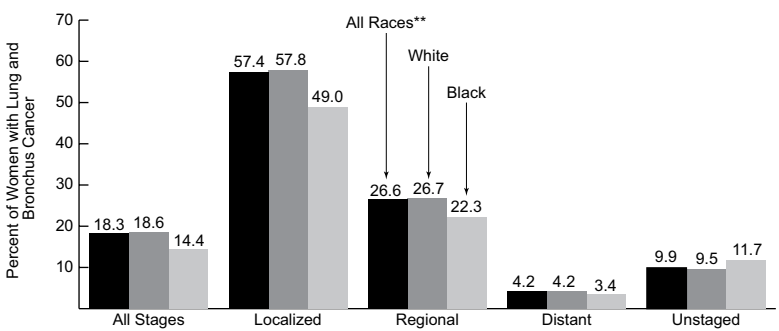
Source II.8: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



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

Five-year Period Survival Rates for Lung and Bronchus Cancer Among Females, by Race and Stage,* 1999–2006

Source II.8: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*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. **Includes races and ethnicities other than white and black.

DIABETES

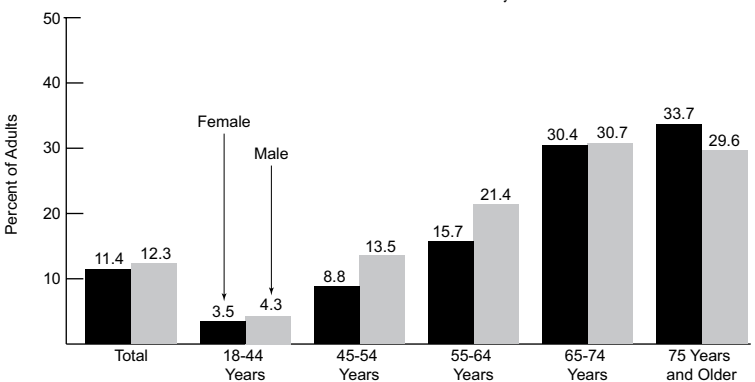
Diabetes mellitus is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. The main types of diabetes are Type 1, Type 2, and gestational (diabetes occurring or first recognized 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 prevalence has been increasing among children and adolescents as well. Risk factors for Type 2 diabetes include obesity, physical inactivity, a family history of the disease, and gestational diabetes.

In 2005–2008, 11.8 percent of adults were found to have diabetes (tested positive for the condition on a fasting plasma glucose test, glycohemoglobin A1C test, or 2-hour oral glucose test; data not shown). Diabetes prevalence did not vary by sex and generally increased with age for both men and women. Women aged 65 years and older were significantly more likely than younger women to have diabetes. More than 30 percent of women aged 65–74 years and 33.7 percent of those aged 75 years and older had diabetes, compared to 15.7 percent of 55- to 64-year-olds and 8.8 percent of those aged 45–54 years.

Among women aged 18 years and older who were found to have diabetes , only 54.9 percent reported that they had been told by a health professional that they have diabetes. Non-Hispanic Black women were more likely than non-Hispanic White women to have ever been told by a health professional that they have diabetes (63.7 versus 49.1 percent, respectively). Other observed differences were not statistically significant.

Adults Aged 18 and Older Who Have Diabetes,* by Age and Sex, 2005–2008

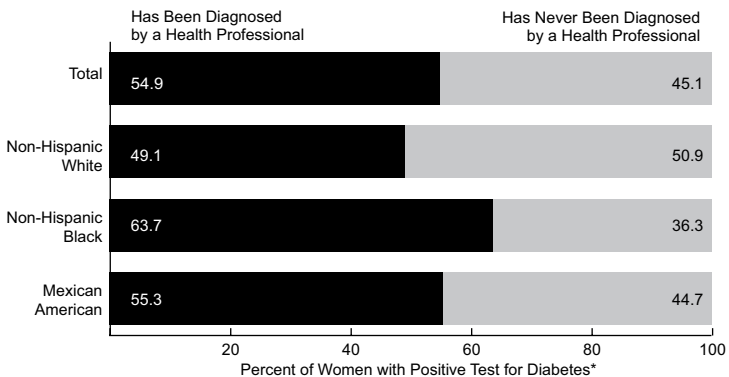
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test.

Women Aged 18 and Older Who Have Diabetes,* by Race/Ethnicity and Diagnosis Status,** 2005–2008

Source II.2: 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, glycohemoglobin A1C test, or 2-hour oral glucose test. Rates are not age-adjusted. **Reported a health professional has ever told them they have diabetes.

OVERWEIGHT AND OBESITY

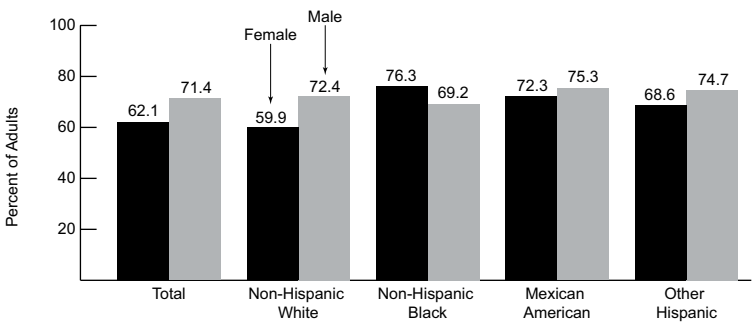
Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke, arthritis, certain types of cancer, and reproductive health risks.[16] Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2005–2008, two-thirds of adults were overweight (66.6 percent; BMI of 25.0 or more); this includes the 33.4 percent of adults who were classified as obese (BMI of 30.0 or more; data not shown).

In 2005–2008, men had higher rates of overweight than women overall (71.4 versus 62.1 percent, respectively); this was only true, however, for non-Hispanic Whites and Hispanics other than Mexican Americans. Non-Hispanic Black women were more likely than non-Hispanic Black men to be overweight (76.3 versus 69.2 percent, respectively), while overweight among Mexican American women and men were not significantly different (72.3 and 75.3 percent, respectively). Non-Hispanic White women were least likely to be overweight (59.9 percent), compared to Hispanic, Mexican American and non-Hispanic Black women.

Overall, 36.1 percent of women aged 25 and older were obese in 2005–2008; this includes 7.4 percent of women who were severely obese (BMI of 40.0 or more). Rates of obesity and severe obesity vary with level of education. Among women aged 25 and older, those with a 4-year degree or more were least likely to be obese (24.1 percent), compared to about 40 percent of women who had not attained that level of education. Similarly, women with a 4-year degree or more were less likely to be severely obese (5.1 percent), than women with a high school diploma or GED and those who attended some college (8.8 and 8.9 percent, respectively).

Overweight* Among Adults Aged 18 and Older, by Race/Ethnicity** and Sex, 2005–2008

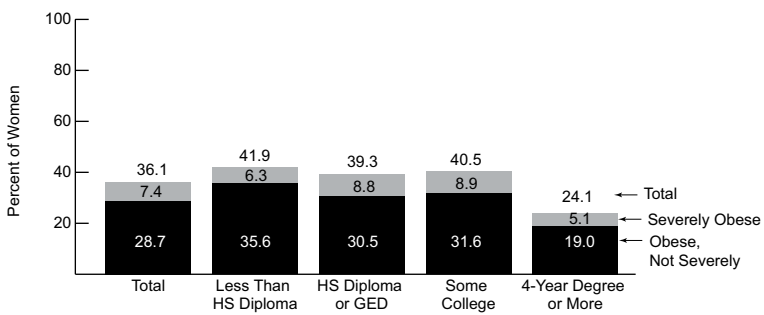
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Defined as having a Body Mass Index (BMI) of 25.0 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.

Obesity and Severe Obesity* Among Women Aged 25 and Older, by Level of Education, 2005–2008

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



*Obesity is defined as having a Body Mass Index (BMI) of 30.0 or more; severe obesity is defined as having a BMI of 40.0 or more.

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.[17]

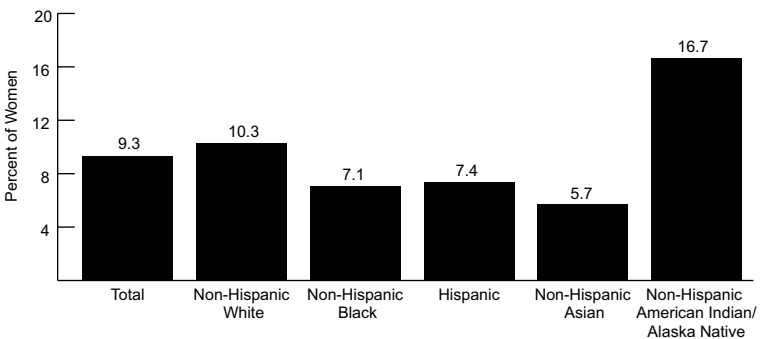
While recent data are not readily available on the prevalence of many of these diseases by race and ethnicity or sex, it is estimated that 8.5 million people in the United States are affected by hemorrhoids each year; 2.1 million people are affected by irritable bowel syndrome; and gallstones affect 20.5 million people (data not shown).[17]

Peptic ulcers are most commonly caused by a bacterium called *Helicobacter pylori (H. pylori). H. pylori* weaken the mucous coating of the stomach and duodenum, allowing acids to irritate the sensitive lining beneath. In 2008, 8.6 percent of adults reported that they had ever been told by a health professional that they have an ulcer (data not shown). Among women, non-Hispanic American Indian/Alaska Native women were most likely to report having had an ulcer (16.7 percent), followed by non-Hispanic White (10.3 percent) and Hispanic women (7.4 percent). Asian women were least likely to report ever having had an ulcer (5.7 percent).

In 2007, physicians reported that digestive disorders were the primary diagnosis in 2.9 percent of all visits made by women aged 18 and older, accounting for more than 14 million physician visits. The most common digestive disorder diagnosis was esophageal reflux (21.1 percent of physician's visits for digestive disorders), followed by abdominal hernia (8.8 percent). Irritable bowel syndrome was the primary diagnosis in 6.6 percent of visits for digestive disorders, while constipation accounted for 5.1 percent of visits.

Women Aged 18 and Older Who Have Ever Had an Ulcer,* by Race/Ethnicity, 2008

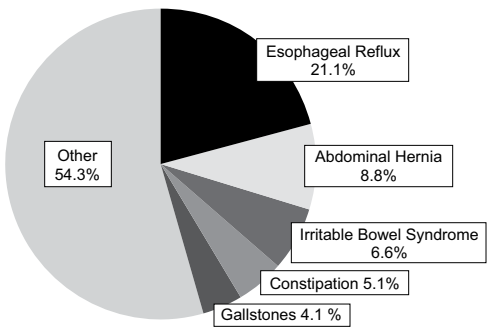
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Physician Visits for Selected Digestive Disorders Among Women Aged 18 and Older, 2007*

Source II.9: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



Based on ICD-9-CM codes: esophageal reflux (530.81); hernia (550-553); irritable bowel syndrome (564.1); constipation (564.00, 564.01, 564.09); gallstones (560.31); 'other' includes remaining codes (520-579).

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).

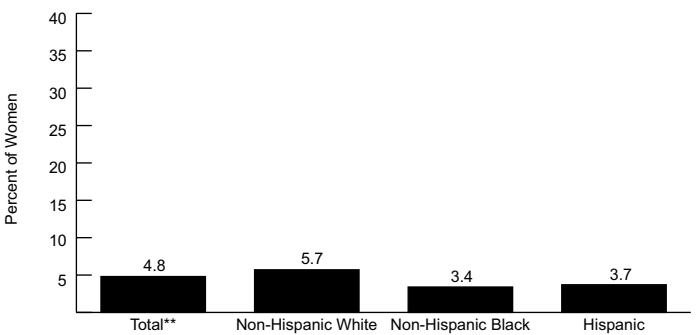
Some problems can affect the proper functioning of the reproductive system and may affect a woman's ability to get pregnant. One example, polycystic ovary syndrome, occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. Another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

In 2006–2008, 4.8 percent of women aged 15–44 years reported that they had ever been told by a health professional that they have endometriosis. Overall, non-Hispanic White women were slightly more likely than Hispanic and non-Hispanic Black women to report having been diagnosed with endometriosis (5.7 versus 3.7 and 3.4 percent, respectively).

If endometriosis is not treated by medication or surgery, or if a woman is affected by other gynecological or reproductive disorders such as ovarian, uterine, or cervical cancer, she may undergo a hysterectomy. This is a surgical procedure during which the uterus, and in some cases the ovaries and fallopian tubes, is removed. In 2007, the rate of hospital discharges for hysterectomies was 33.7 per 10,000 discharges. The procedure was most commonly performed for women aged 45–54 years (72.2 per 10,000 discharges).

Endometriosis Among Women Aged 15–44, by Race/Ethnicity,* 2006–2008

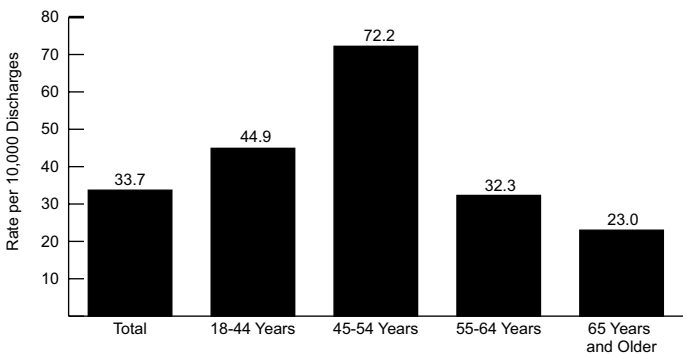
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



**The sample of American Indian/Alaska Natives, Asian/Pacific Islanders, persons of multiple races, and persons of other races was too small to produce reliable results. **Total includes persons of all races/ethnicities.*

Rates of Hospital Discharge due to Hysterectomy, 2007

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge 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. While the most common symptom of a heart attack is chest pain or discomfort, women are more likely than men to have other symptoms, such as shortness of breath, nausea and vomiting, and back or jaw pain.[18]

In 2008, nearly 12 percent of adults reported that a health professional had ever told them they have a heart condition or heart disease and 4.1 percent reported that they had had coronary heart disease (data not shown). While overall, men were more likely than women to have had coronary heart disease (5.4 versus 3.0 percent, respectively), this was only true for non-Hispanic Whites (6.7 versus 3.3 percent, respectively). There were no differences between non-Hispanic Black and Hispanic men and women.

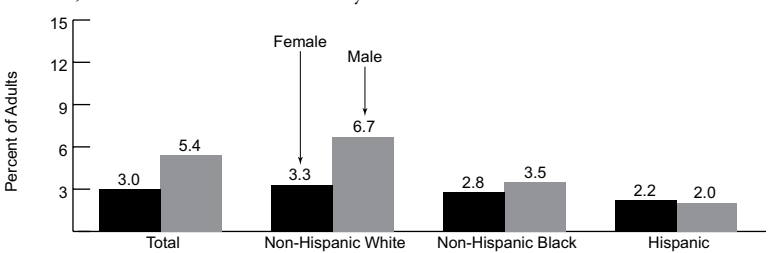
Stroke is a type of cardiovascular disease that affects blood flow to the brain. Warning signs are sudden and can include facial, arm, or leg numbness, especially on one side of the body; severe headache; trouble walking; dizziness; a loss of balance or coordination; or trouble seeing in one or both eyes.[18]

In 2008, 2.9 percent of adults reported that they had ever been diagnosed with a stroke (data not shown). This rate did not vary by sex. Among both men and women, however, the proportion of persons ever having had a stroke increases with age. Among women, those aged 75 and older were significantly more likely to have suffered a stroke (13.0 percent), than women aged 65–74 or 45–64 years of age (5.8 and 2.6 percent, respectively).

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.[19] 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.[20]

Adults Aged 18 and Older with Coronary Heart Disease,* by Race/Ethnicity** and Sex, 2008

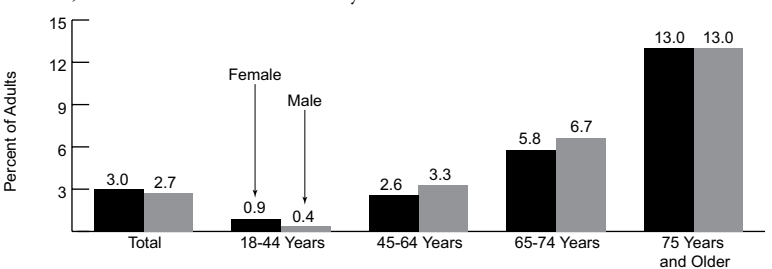
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them that they had coronary heart disease. **The sample of American Indian/Alaska Natives, Asians, Native Hawaiian/Pacific Islanders, and persons of multiple races was too small to produce reliable results.

Adults Aged 18 and Older Who Have Had a Stroke,* by Age and Sex, 2008

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 that they had a stroke.

HIGH BLOOD PRESSURE

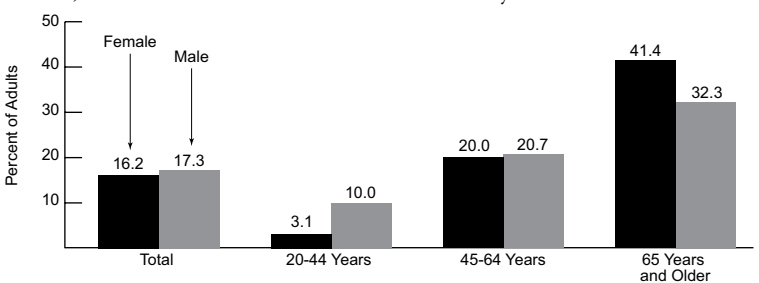
High blood pressure is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic blood pressure (during heartbeats) of 140 mmHg or higher, and/or a diastolic blood pressure (between heartbeats) of 90 mmHg or higher. In 2005–2008, 16.7 percent of adults were identified with high blood pressure (not including those whose blood pressure is controlled by taking antihypertensive medication; data not shown). This did not vary significantly overall by sex, but did vary with age. Among adults aged 65 years and older, women were more likely than men to have high blood pressure (41.4 versus 32.3 percent, respectively), while men aged 20–44 years were more likely than women to have high blood pressure (10.0 versus 3.1 percent, respectively).

Rates of high blood pressure among women vary by race and ethnicity. Non-Hispanic Black women were most likely to have high blood pressure (21.3 percent), followed by non-Hispanic White women (16.3 percent). Nearly 11 percent of Mexican American and 12.4 percent of other Hispanic women also had high blood pressure (data not shown).

Among women identified with high blood pressure in 2005–2008, 54.5 percent had been previously diagnosed by a health professional and were taking medication for the condition. Nearly 12 percent of women identified with high blood pressure had been previously diagnosed by a health professional, but were not taking medication, and 33.5 percent had never been diagnosed. Diagnosis status among women with high blood pressure varies, however, with race and ethnicity. Mexican American women with uncontrolled high blood pressure were most likely to be undiagnosed (45.6 percent), while non-Hispanic Black women were most likely to have been diagnosed and taking medication (61.7 percent).

Adults Aged 20 and Older with High Blood Pressure,* by Age and Sex, 2005–2008

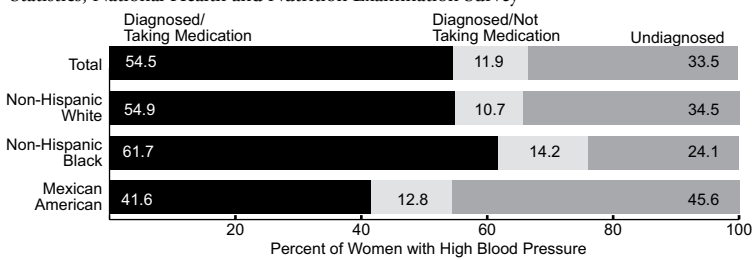
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*At the time of examination had a systolic blood pressure (during heartbeats) of 140mmHg or higher, and/or a diastolic blood pressure (between heartbeats) of 90mmHg or higher; does not include persons taking antihypertensive medication whose blood pressure is controlled.

Women Aged 20 and Older with Uncontrolled High Blood Pressure,* by Race/Ethnicity** and Diagnosis Status,† 2005–2008

Source II.2: 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 blood pressure (during heartbeats) of 140mmHg or higher, and/or a diastolic blood pressure (between heartbeats) of 90mmHg or higher; does not include persons taking antihypertensive medication whose blood pressure is controlled. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, other Hispanics, persons of more than one race, and persons of other races was too small to produce reliable results. †Reported whether they had ever been told by a health professional that they have high blood pressure and whether they were taking antihypertensive medication.

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 difficulty fighting infections.[21] While HIV and AIDS disproportionately affect men, a growing number of women are also affected; in 2008, an estimated 39.5 new cases of HIV per 100,000 males (data not shown) and 11.5 per 100,000 females aged 13 and older were reported in the United States.

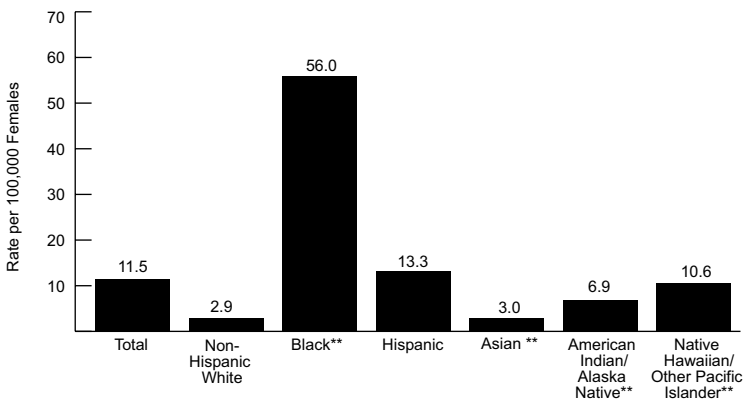
Rates of new cases among adolescent and adult females vary dramatically by race and ethnicity. HIV disproportionately affects Black females (56.0 cases per 100,000 females). Non-Hispanic White and Asian females had the lowest rates of new cases of HIV (2.9 and 3.0 cases per 100,000 females, respectively).

A newly released study indicates that low-income individuals may be at greater risk for HIV. In low-income urban areas, HIV prevalence among heterosexuals was estimated to be 2.4 percent among those with incomes below 100 percent of poverty and 1.2 percent among those with higher incomes. In comparison, national prevalence is .45 percent (data not shown).[22]

Early detection of HIV infection is critical in preventing transmission of the virus to others, and persons aware of their HIV infection can benefit from advances in medicine that may significantly prolong their lives. Despite these individual and societal benefits, a large proportion of people identified as HIV-positive progress rapidly toward an AIDS diagnosis. In 2007, 30% of HIV-positive females received an AIDS diagnosis within 12 months of their HIV diagnosis. Females were just as likely as males to have had an AIDS diagnosis within 12 months of an HIV diagnosis (data not shown).

Estimated Rates of New HIV Cases Reported Among Adolescent and Adult Females, by Race/Ethnicity, 2008*

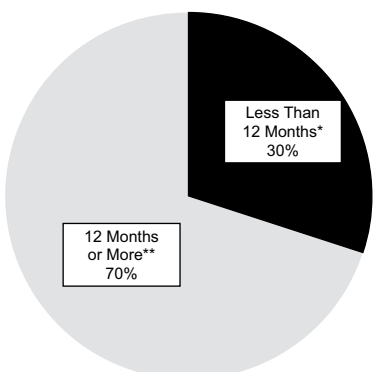
Source II.12: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Data collected from 37 states with confidential name-based HIV infection reporting.
**May include Hispanics.

Time to an AIDS Diagnosis After a Diagnosis of HIV Infection Among Females, 2007

Source II.12: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Includes persons whose diagnosis of HIV infection and AIDS were made at the same time.
**Includes persons in whom AIDS has not developed.

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 2008, 3,275.8 cases of chlamydia and 636.8 cases of gonorrhea were reported per 100,000 females aged 15–19 years, compared to 30.9 and 11.2 reported cases per 100,000 women aged 45–54 years, respectively. Syphilis was also more common among younger women in 2008, occurring among 3.0, 5.1, and 3.9 per 100,000 females aged 15–19, 20–24, and 25–29 years, respectively (data not shown).

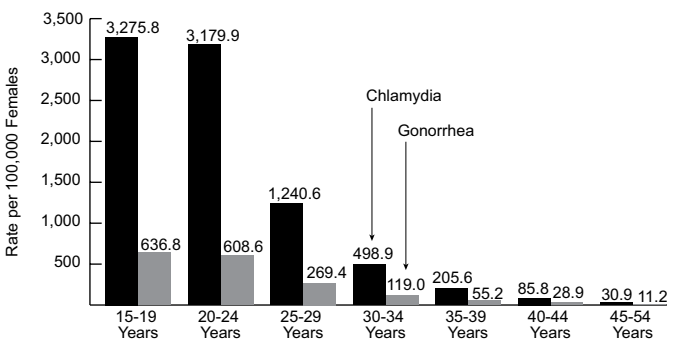
Although chlamydia, gonorrhea, and syphilis can be cured with appropriate antibiotics, left untreated they can have serious health consequences. Active infections can increase the likelihood of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility,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

Some STIs cannot be cured with antibiotics. Herpes Simplex Virus Type 2 (HSV-2) is an infection that causes genital herpes and can lead to blindness, neonatal infections, and increased risk for HIV. Herpes Simplex Virus Type 1 (HSV-1) can also cause genital herpes, but it is more commonly associated with sores around the mouth, and recurring symptoms are less common than with HSV-2. Overall, 59.1 percent of women tested positive for HSV-1 and 23.5 percent tested positive for HSV-2 in 2005–2008.

The prevalence of both HSV-1 and HSV-2 varies by race and ethnicity. Non-Hispanic Black (54.2 percent) and Hispanic women other than Mexican American (40.8 percent) were more likely to have tested positive for HSV-2 than non-Hispanic White and Mexican American women (18.0 and 14.7 percent, respectively). Despite the relatively low proportion of Mexican American women with HSV-2, they were more likely to have tested positive for HSV-1 than non-Hispanic Whites and non-Hispanic Blacks (83.8 versus 52.7 and 63.4 percent, respectively).

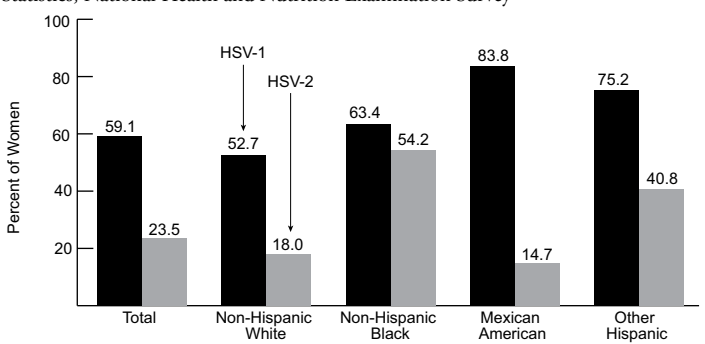
Rates of Chlamydia and Gonorrhea in the United States Among Females aged 15–54, by Age, 2008

Source II.13: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



HSV-1 and HSV-2 Infection Among Women Aged 18 and Older, by Race/Ethnicity,* 2005–2008**

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



**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. **Rates reported are not age-adjusted. Results are based on a positive lab test for either infection.*

INJURY

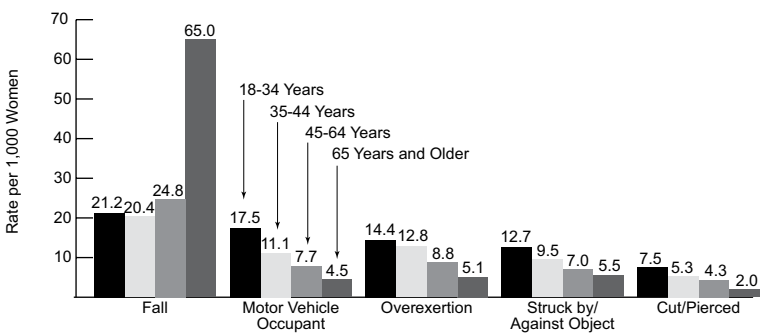
Injuries can often be controlled through education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples include the design, oversight, and use of child safety seats, seatbelts, and passenger airbags, workplace regulations regarding safety practices, and tax incentives for fitting home pools with fences.

In 2008, unintentional falls were the leading cause of nonfatal injury treated in U.S. hospital emergency departments among women of all ages, and rates generally increased with age. Women aged 65 years and older had the highest rate of injury due to unintentional falls (65.0 per 1,000 women), compared to 21.2 per 1,000 women aged 18–34 and 20.4 per 1,000 women aged 35–44 years. However, women aged 65 years and older had the lowest rates of each of the other four leading causes of nonfatal injuries, while women aged 18–34 years had the highest rates. Unintentional injuries sustained by motor vehicle occupants were the second leading cause of injury among 18- to 34-year-olds (17.5 per 1,000 women), while unintentional overexertion—which can be due to strenuous or repetitive motions such as lifting—was the second leading cause of injury among women aged 35–44 and 45–64 years (12.8 and 8.8 per 1,000 women, respectively).

In 2008, there were nearly 1.1 million nonfatal occupational injuries and illnesses in the United States. While males have higher overall rates of occupational injury than females (124.8 versus 97.3 per 10,000 workers, respectively; data not shown), the distribution of injuries by sex varies by occupational sector. In 2008, females accounted for 68.2 percent of injuries occurring in management, professional, and related occupations, despite making up only 51.7 percent of the workforce in that sector. Conversely, females were somewhat underrepresented in injuries to workers in production, transportation, and material moving and farming, fishing, and forestry.

Leading Causes of Nonfatal Injury* Among Women Aged 18 and Older, by Age, 2008

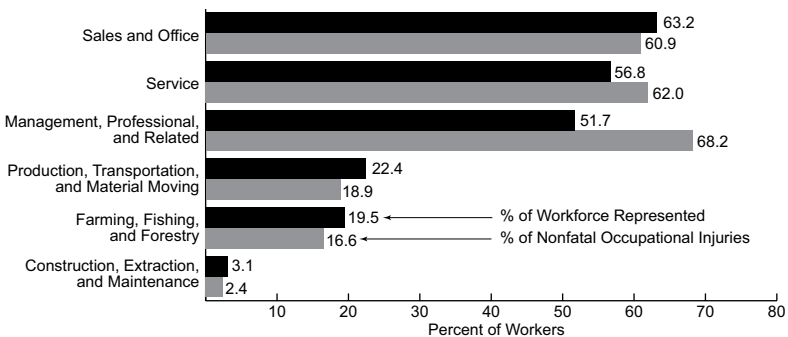
Source II.14: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Consumer Product Safety Commission, NEISS-AIP



All of the leading causes of injury in 2008 were unintentional; estimates provided are for injuries treated in U.S. hospital emergency departments.

Female Workforce Representation and Nonfatal Occupational Injuries and Illnesses, by Occupational Sector, 2008

Source I.1, II.15: U.S. Census Bureau, American Community Survey; U.S. Department of Labor, Bureau of Labor Statistics*



Workforce representation statistics are from the U.S. Census Bureau; nonfatal occupational injury statistics are from the U.S. Department of Labor.

VIOLENCE

In 2008, an estimated 4.9 million nonfatal violent crimes were committed in the United States. Males were more likely than females to experience nonfatal violent crime victimization overall (21.3 versus 17.3 per 1,000 persons aged 12 and older; data not shown),[23] however, females were more likely to report nonfatal intimate partner violence than males (4.3 versus 0.8 per 1,000 persons aged 12 and older).

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.

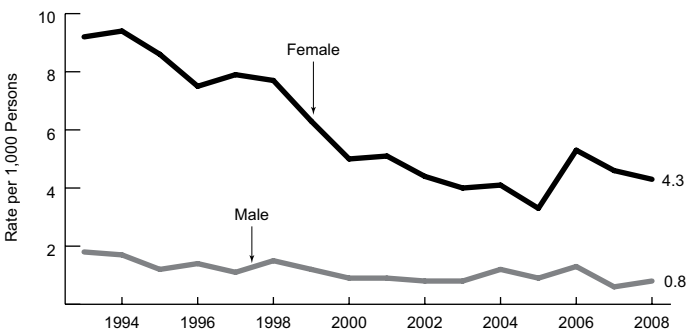
According to the National Crime Victimization Survey, which collects data on victimization based on household and individual surveys, the rate of nonfatal intimate partner violence has decreased dramatically among both males and females since the early 1990's. Among females aged 12 and older, nonfatal IPV has decreased 53 percent from 9.2 per 1,000 females in 1993 to 4.3 per 1,000 females in 2008.

In 2007, females with disabilities reported higher rates of violent crime victimization than females without disabilities. Nearly 35 per 1,000 females aged 12 and older with disabilities (age-adjusted) experienced violent crime victimization; this was nearly twice the rate of females without disabilities (18.9 per 1,000; data not shown).[24]

Among female victims of violent crimes, the relationship of the victim to the offender varied by disability status. For instance, more than one-quarter of nonfatal violent crimes committed against females without disabilities were by an intimate partner, compared to 16.1 percent of crimes against females with disabilities. Females with disabilities were more likely to be victims of crimes committed by strangers than females without disabilities (33.5 versus 24.2 percent, respectively), and by non-intimate relatives, such as parents, siblings or cousins (12.5 versus 8.7 percent, respectively).

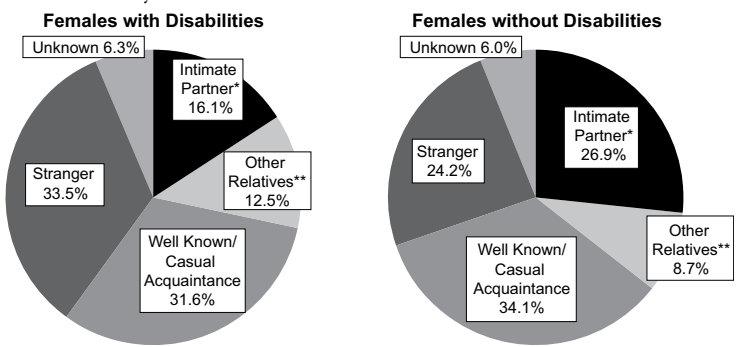
Nonfatal Intimate Partner Violence Perpetrated Against Persons Aged 12 and Older, by Sex, 1993–2008

Source II.16: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



Violence Experienced by Females Aged 12 and Older, by Disability Status and Relationship to Perpetrator, 2007

Source II.17: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



*Current or former spouses, boyfriends, or girlfriends. **Parents, siblings, or cousins.

MENTAL ILLNESS

Mental illness affects both sexes, although many types of mental disorders are more prevalent among women.[25] For instance, in 2008, 33.7 percent of women and 22.4 percent of men reported ever having had depression. Similarly, 23.0 percent of women reported ever experiencing generalized anxiety, compared to 15.3 percent of men. Women were also nearly twice as likely as men to report ever having had panic disorder (10.3 versus 5.5 percent, respectively; data not shown).

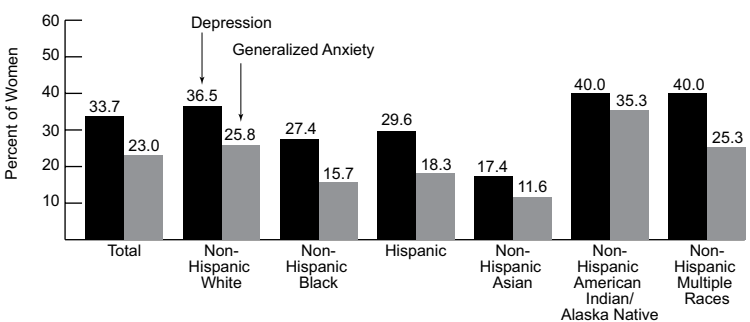
Among women, lifetime prevalence of depression and generalized anxiety varies with race and ethnicity. Non-Hispanic American Indian/Alaska Native women and non-Hispanic women of multiple races were most likely to report having experienced depression (40.0 percent each), followed by non-Hispanic White women (36.5 percent). Non-Hispanic Asian women were least likely to have experienced depression (17.4 percent).

Non-Hispanic American Indian/Alaska Native women were also most likely to report having had generalized anxiety (35.3 percent), followed by non-Hispanic White and non-Hispanic women of multiple races (25.8 and 25.3 percent, respectively). Non-Hispanic Asian and non-Hispanic Black women were least likely to report having experienced generalized anxiety (11.6 and 15.7 percent, respectively).

Women who have experienced depression and generalized anxiety are more likely than women without those conditions to be limited in their activities – such as walking or climbing, relaxing, or attending social events – and to engage in health risk behaviors such as cigarette smoking and heavy alcohol use. More than half of women who reported having had depression or anxiety also reported current activity limitations, compared to about 30 percent of women who hadn't experienced these conditions. Similarly, more than 27 percent of women who experienced depression and anxiety were current smokers, nearly twice the proportion of women who had never experienced these conditions.

Depression and Generalized Anxiety* Among Women Aged 18 and Older, by Race/Ethnicity, 2008

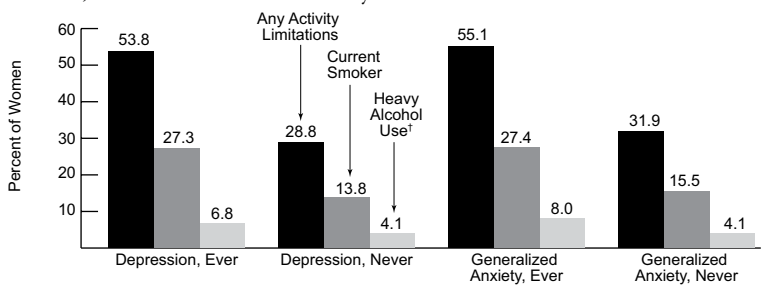
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had ever had these conditions.

Activity Limitations* and Health Risk Behaviors Among Women Aged 18 and Older, by Experience of Depression and Generalized Anxiety,** 2008

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 such as walking or lifting, relaxing, and attending social events. **Reported that they ever had these conditions. †Consumed more than 7 drinks per week in the past year.

ORAL HEALTH

Poor oral health can cause chronic pain of the mouth and face and can impair the ability to eat normally. To prevent caries (tooth decay) and periodontal (gum) disease, the American Dental Association recommends brushing at least twice a day and flossing at least once per day, and receiving regular dental checkups.[26]

In 2005–2008, 39.1 percent of women reported that their teeth were in excellent or very good condition. This varied, however, by race and ethnicity; fewer than one-quarter of Mexican American women (22.5 percent) and 25.4 percent of non-Hispanic Black women reported their teeth to be in excellent or very good condition, compared to 44.5 percent of non-Hispanic White women. Nearly 50 percent of Mexican American women and more than 40 percent of other Hispanic and non-Hispanic Black women reported fair or poor oral health.

Dental restoration, such as fillings or crowns, can be used to treat cavities caused by caries. In 2005–2008, 81.6 percent of women had had at least one tooth restored, while 17.7 percent of women had untreated tooth decay. The likelihood of dental restoration among women increases as income increases, while prevalence of untreated tooth decay decreases with increasing income. Women with incomes of 300 percent or more of poverty were most likely to have had at least one tooth restored (89.9 percent), compared to 72.3 percent of women with incomes of 100–199 percent of poverty and 68.3 percent of women living in poverty. Conversely, 30.3 percent of women with household incomes below 100 percent of poverty and 25.2 percent of women with incomes of 100–199 percent of poverty had untreated tooth decay, compared to 10.3 percent of women with incomes of 300 percent or more of poverty.

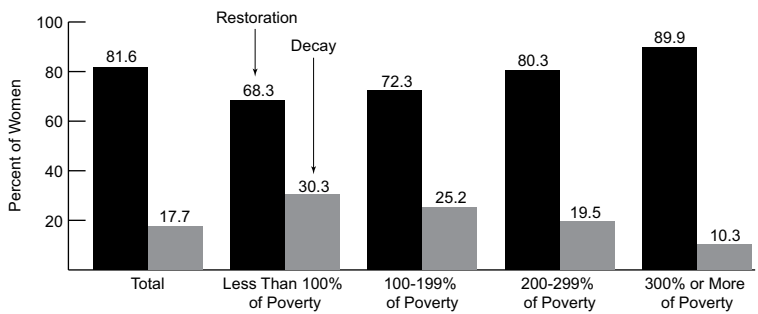
Self-Reported Oral Health Status of Women Aged 18 and Older, by Race/Ethnicity,* 2005–2008

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

**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.*

Presence of Tooth Decay and Restoration Among Women Aged 18 and Older, by Poverty Status,* 2005–2008

Source II.2: 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 $22,025 for a family of four in 2008.*

SEVERE HEADACHES AND MIGRAINES

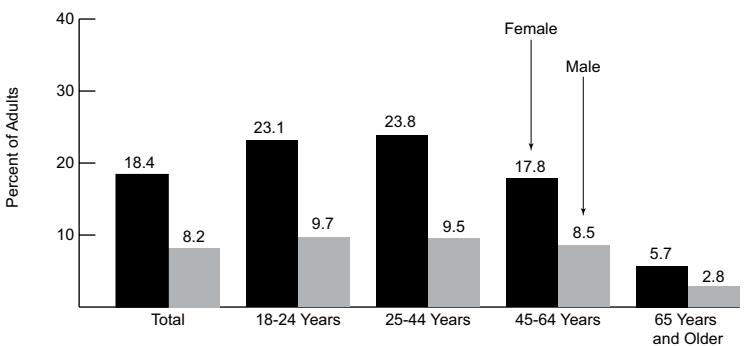
Severe headaches of any kind can be debilitating. Symptoms of severe headache include intense pain, usually on both sides of the head. Migraine, in addition to severe pain on only one side of the head, may be accompanied by neurological symptoms such as distorted vision, nausea, vomiting, and sensitivity to light or sound. In 2008, 13.5 percent of adults reported experiencing a severe headache or migraine in the past 3 months (data not shown). Severe headaches and migraines were more than twice as common among women as men (18.4 versus 8.2 percent, respectively). The proportion of women with severe headaches and migraines is highest among the younger age groups and decreases with age. Among women, only 5.7 percent of those aged 65 years and older reported severe headaches or migraines in the past 3 months, compared to more than 23 percent of women aged 18–24 and 25–44 years.

The percentage of women experiencing severe headaches and migraines also varies by race and ethnicity. Non-Hispanic women of multiple races and non-Hispanic American Indian/Alaska Native women were most likely to report a severe headache or migraine in the past 3 months (29.0 and 25.6 percent, respectively). Non-Hispanic Asian and non-Hispanic Black women were less likely than women of other races and ethnicities to report a severe headache or migraine (11.0 and 16.7 percent, respectively).

The proportion of women with severe headaches or migraines generally decreases as income increases. Women with household incomes below 100 percent of poverty were most likely to have had a severe headache or migraine (24.9 percent), followed by women with incomes of 100–199 percent of poverty (20.0 percent). In comparison, 16.7 percent of women with incomes of 200 percent or more of poverty had experienced severe headaches or migraines in the past 3 months (data not shown).

Adults Aged 18 and Older With Severe Headaches or Migraines,* by Age and Sex, 2008

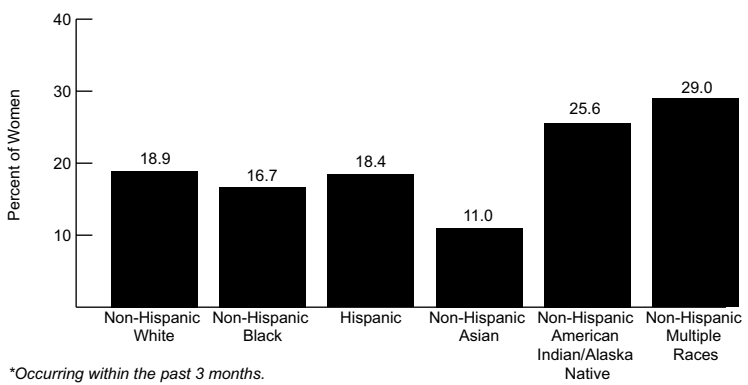
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Occurring within the past 3 months.

Women Aged 18 and Older with Severe Headaches or Migraines,* by Race/Ethnicity, 2008

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



*Occurring within the past 3 months.

UROLOGIC DISORDERS

Urologic disorders encompass illnesses and diseases of the genitourinary tract. Some examples of such disorders include urinary incontinence, urinary tract infection, bladder prolapse, urolithiasis (kidney stones), and kidney and bladder cancer. Many of these disorders affect a large number of adult women; annual medical expenditures for urinary incontinence and urinary tract infections among adult women total more than $458 million and $2.5 billion, respectively. These same illnesses accounted for $10.3 million and $1 billion in expenditures, respectively, for adult men.[27]

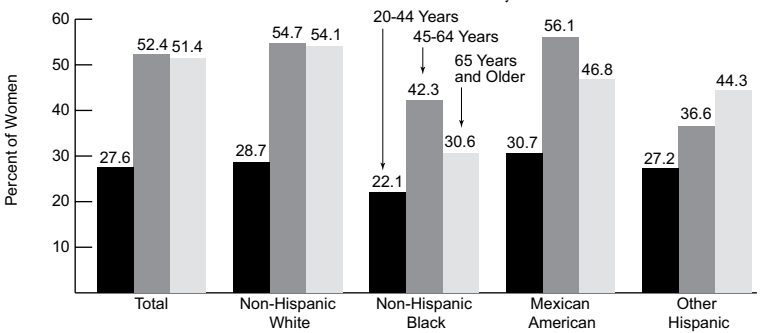
Urinary incontinence is one of the most prevalent chronic diseases in the United States and is generally more common among women than men.[27] In 2005–2008, 40.7 percent of women and 12.5 percent of men aged 20 years and older reported that they ever had urinary leakage (data not shown).

The prevalence of urinary incontinence among women varies by race and ethnicity, as well as age. More than 43 percent of non-Hispanic White women and 39.0 percent of Mexican American women reported urinary leakage in 2005–2008, compared to 30.6 percent of non-Hispanic Black and 31.6 percent of Hispanic women other than Mexican American (data not shown). Among Mexican American and non-Hispanic Black women, those aged 45–64 years were most likely to report urinary leakage (56.1 and 42.3 percent, respectively). Among non-Hispanic White women, more than 54 percent of those aged 45–64 and 65 years and older also reported urinary leakage.

Among women with urinary leakage, 39.2 percent reported that it occurred less than once a month, while 29.4 percent reported occurrence a few times a month. More than 16 percent of those with urinary leakage reported that it occurred every day or night, and 15.0 percent experienced leakage a few times a week.

Women Aged 20 and Older Reporting Urinary Leakage, by Race/Ethnicity* and Age, 2005–2008

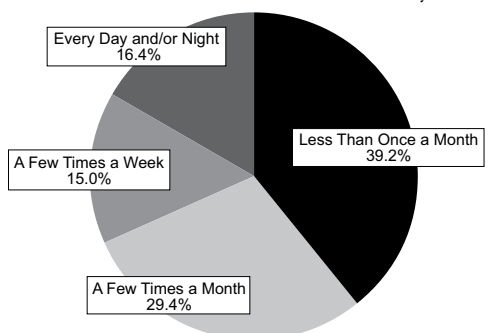
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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.

Frequency of Urinary Leakage Among Women Aged 20 and Older Reporting Any Leakage, 2005–2008

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



VISION AND HEARING LOSS

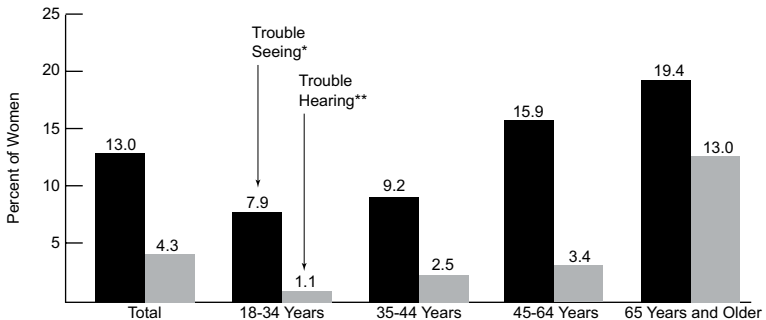
In 2008, an estimated 25.2 million adults had trouble seeing even with eyeglasses or contact lenses, while 1.2 million adults reported moderate or a lot of trouble hearing without a hearing aid. The proportion of adults reporting trouble seeing or hearing varies with sex and age. Women were more likely than men to report trouble seeing without an aid (13.0 versus 9.3 percent, respectively), while men were more likely than women to report moderate or a lot of trouble hearing without an aid or being deaf (6.8 versus 4.3 percent, respectively; data not shown).

Among women, the proportion of those who have trouble seeing and hearing increases with age. Women aged 65 years and older were most likely to have trouble seeing (19.4 percent) and hearing (13.0 percent), followed by women aged 45–64 years (15.9 and 3.4 percent, respectively). Fewer than 8 percent of women aged 18–34 years had trouble seeing and only 1.1 percent had trouble hearing.

Vision and hearing loss caused activity limitations among more than 3 million adults in 2008. Persons with activity limitations may have trouble participating in social activities, going shopping, or attending sporting events without assistance. Among all adults with activity limitations, 3.6 percent reported that the limitation was due to vision problems, while 1.5 percent of those with limitations reported that hearing loss was the reason for the limitation. Overall, 4.4 percent of adults with any activity limitations reported the limitation due to hearing or vision loss. This did not vary significantly by sex.

Women Aged 18 and Older with Trouble Seeing and Hearing, by Age, 2008

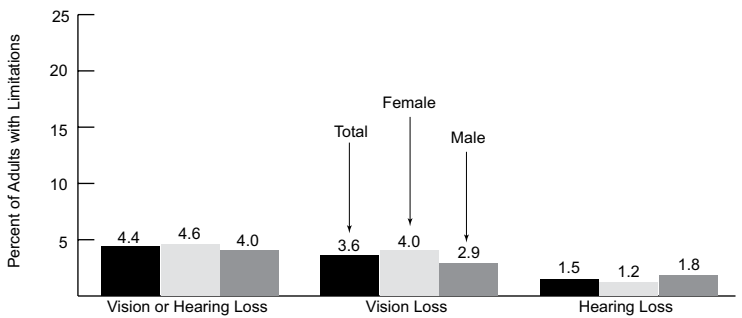
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had trouble seeing without eyeglasses, contact lenses, or other aids. **Reported they had moderate or a lot of trouble hearing without a hearing aid, or are deaf.

Adults Aged 18 and Older with Any Activity Limitations* Due to Vision or Hearing Loss, by Sex, 2008

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.

LIVE BIRTHS

According to preliminary data, there were nearly 4.3 million live births in the United States in 2008, a decrease of 2 percent from the previous year. Overall, the crude birth rate was 14.0 births per 1,000 total population (data not shown). Hispanic women continued to have the highest birth rate in 2008 (98.6 per 1,000 women), followed by Asian/Pacific Islander and non-Hispanic Black women (71.4 and 71.2 per 1,000 women, respectively) despite decreases in the number of births within each of those groups. Non-Hispanic White women had the lowest birth rate (59.6 per 1,000 women).

With regard to age, overall birth rates were highest among mothers aged 25–29 years (115.1 live births per 1,000 women), followed by those aged 20–24 years (103.1 births per 1,000 women). The birth rate for non-Hispanic White women was highest among 25- to 29-year-olds (106.2 per 1,000), while the birth rates for non-Hispanic Blacks, Hispanics, and American Indian/Alaska Natives were highest among 20- to 24-year-olds (130.8, 170.4, and 115.6 per 1,000 women, respectively). The birth rate among Asian/Pacific Islanders was highest among 30- to 34-year-olds (126.8 per 1,000 women).

The proportion of births delivered by cesarean section has steadily increased since 1996. Among all births in 2007 (the latest year for which data are available), nearly one-third (31.8 percent) were delivered by cesarean section, a 53 percent increase since 1996, when only about one-fifth of births were delivered in this manner (20.7 percent). Additionally, induction of labor has increased more than 135 percent since 1990, from 9.5 percent in 1990 to 22.8 percent in 2007.

Live Births per 1,000 Women, by Age and Race/Ethnicity, 2008*

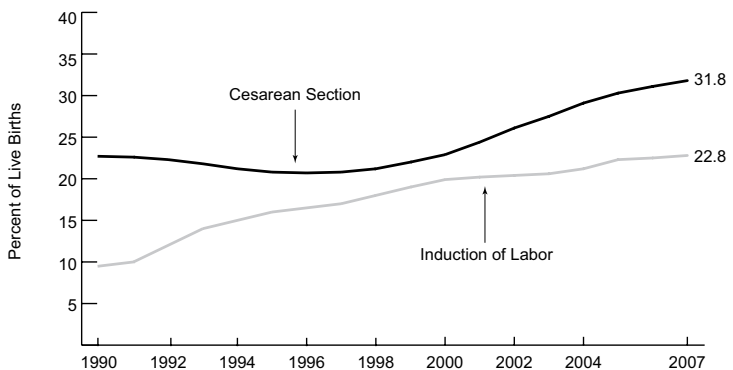
Source II.18: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaska Native**	Asian/Pacific Islander**
Total	68.7	59.6	71.2	98.6	64.6	71.4
15-19 Years	41.5	26.7	62.9	77.4	58.4	16.2
20-24 Years	103.1	80.8	130.8	170.4	115.6	64.5
25-29 Years	115.1	106.2	105.8	152.3	94.4	120.3
30-34 Years	99.3	98.9	75.1	109.3	63.8	126.8
35-39 Years	46.9	44.8	36.7	55.9	28.8	66.8
40-44 Years	9.9	8.8	8.8	13.7	6.4	15.2

**Data are preliminary. **Includes Hispanics.*

Births Involving Cesarean Section and Induction of Labor Among Women, 1990–2007

Source II.19, II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



BREASTFEEDING

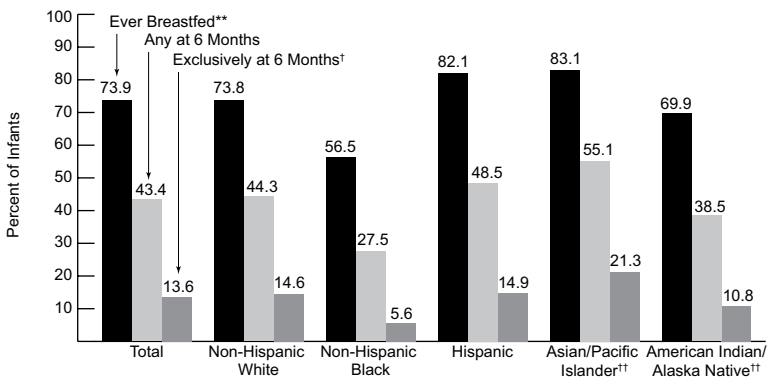
Breast milk benefits the health, growth, immunity, and development of infants, and mothers who breastfeed may have a decreased risk of breast and ovarian cancers.[28] Among infants born in 2006, 73.9 percent were reported to have ever been breastfed, representing a significant increase over the 68.3 percent of infants ever breastfed in 1999. Non-Hispanic Black infants were the least likely to ever be breastfed (56.5 percent), while Asian/Pacific Islanders and Hispanics were the most likely (83.1 and 82.1 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, 33.1 percent of infants born in 2006 were exclusively breastfed through 3 months (data not shown), and 13.6 percent were exclusively breastfed through 6 months. Breastfeeding practices vary considerably by a number of factors, including maternal age—infants born to mothers aged 30 years and older were most likely to have ever been breastfed (78.0 percent), while infants born to mothers under 20 years of age were least likely (55.6 percent). Slightly more than 69 percent of infants born in 2006 to mothers aged 20–29 years were ever breastfed.

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.[29] In 2007–2008, 51.4 percent of mothers with children under 1 year of age were employed, and 70.2 percent of those mothers were employed full-time (data not shown).[30]

Infants* Who Are Breastfed, by Race/Ethnicity and Duration, 2006

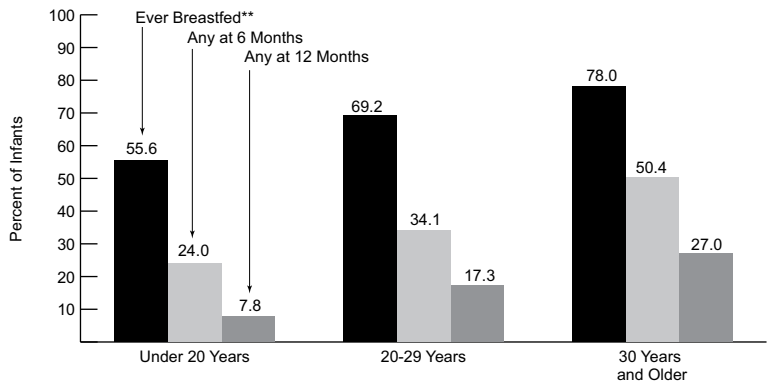
Source II.21: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2006; 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 Age and Duration, 2006

Source II.21: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2006; 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—some of the leading causes of infant mortality.[31] Maternal cigarette use data are 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 which is assessed with the unrevised birth certificate. As of 2007, the 1989 Standard Certificate of Live Birth (unrevised) was used in 24 States, New York City, and Washington, DC, while 22 States used the revised birth certificate.[32]

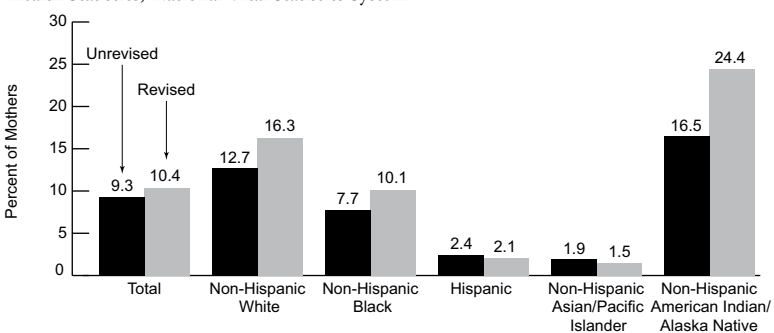
The areas using the revised birth certificate reported slightly higher rates of smoking during pregnancy than those using the unrevised certificate (10.4 versus 9.3 percent, respectively). The proportion of pregnant women who smoked cigarettes varied by maternal race and ethnicity. Among women in areas using the revised birth certificate, non-Hispanic American Indian/Alaska Native mothers (24.4 percent) and non-Hispanic White mothers (16.3 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 (16.5 percent), followed by non-Hispanic White women (12.7 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 2007. Among women in the revised reporting areas, women under 20 years of age (14.0 percent) and those aged 20–29 years (12.9 percent) were more likely than older women to have smoked cigarettes during pregnancy. Similarly, 12.4 percent of women under 20 years of age and 11.5 percent of women aged 20–29 years in the unrevised reporting areas smoked during pregnancy.

Cigarette Smoking During Pregnancy, by Maternal Race/Ethnicity and Birth Certificate Type,* 2007

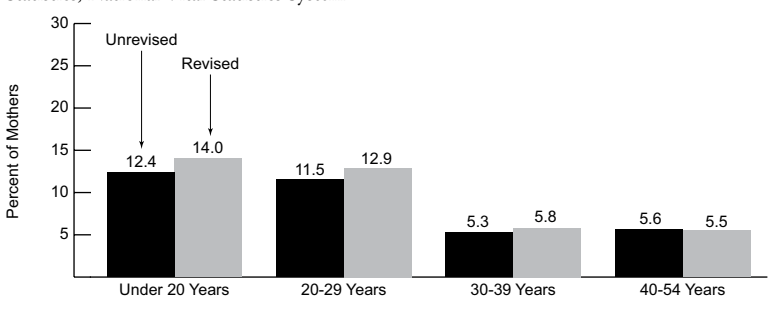
Source II.19, II.22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



**The 1989 Standard Certificate of Live Birth (unrevised) was used in 26 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 22 reporting areas.*

Cigarette Smoking During Pregnancy, by Maternal Age and Birth Certificate Type,* 2007

Source II.19: 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 26 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 22 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 a woman and her baby. Women with gestational diabetes are at increased risk for developing diabetes later in life.[33] In 2007, diabetes of any type during pregnancy occurred at a rate of 44.8 per 1,000 live births. This varied by race and ethnicity; Hispanic mothers were more likely to have had diabetes (46.1 per 1,000 live births) than non-Hispanic Whites and non-Hispanic Blacks (42.3 and 38.9 per 1,000, respectively).

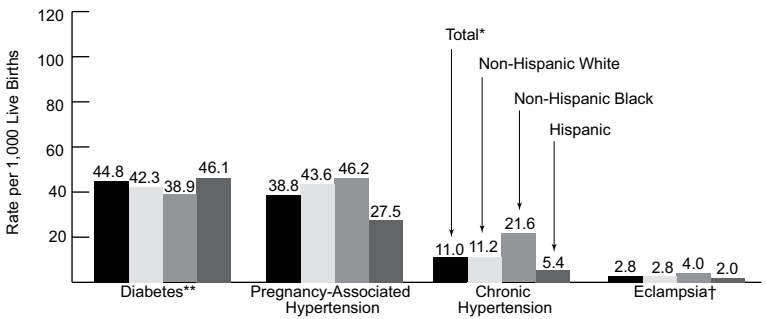
Hypertension during pregnancy can also be either chronic in nature or gestational. Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, premature birth, placental abruption, and stillbirth.[34] Chronic hypertension was present in 11.0 per 1,000 live births in 2007 and occurred most often among non-Hispanic Black women (21.6 per 1,000). The rate of pregnancy-associated hypertension was 38.8 per 1,000 live births and was more common among non-Hispanic Black and non-Hispanic White women (46.2 and 43.6 per 1,000 births) than among Hispanic women (27.5 per 1,000 births).

Eclampsia, which involves seizures and is usually preceded by a diagnosis of preeclampsia, is a life-threatening complication of pregnancy. In 2007, eclampsia occurred among 2.8 women per 1,000 live births.

Rates of maternal morbidities and risk factors also varied by maternal age. In 2007, women aged 40–54 years were at highest risk of diabetes during pregnancy (100.5 per 1,000 live births), pregnancy-associated hypertension (50.1 per 1,000), chronic hypertension (32.2 per 1,000), and eclampsia (4.3 per 1,000). Women under 20 years of age were least likely to have diabetes during pregnancy or chronic hypertension (14.0 and 3.9 per 1,000, respectively).

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Race/Ethnicity, 2007

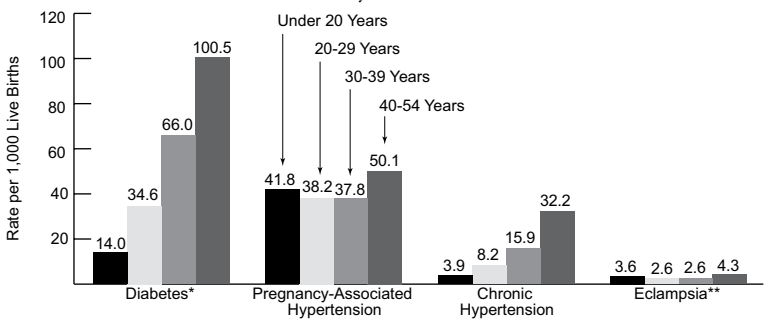
Source II.19, II.22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Total includes all births to U.S. residents. **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. Eclampsia is reported in 15 reporting areas.*

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Age, 2007

Source II.19, II.22: 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. Eclampsia is reported in 15 reporting areas.*

MATERNAL MORTALITY

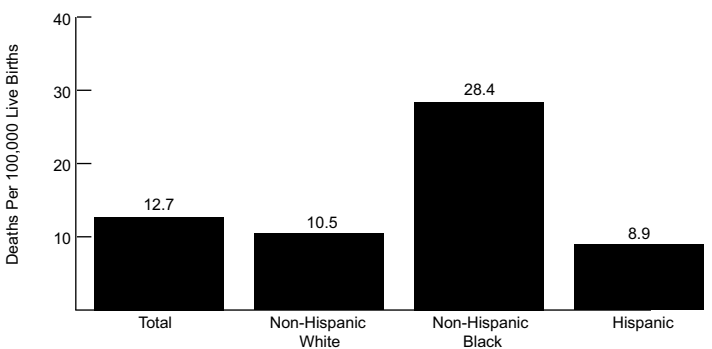
Maternal deaths are those reported on the death certificate to be related to or aggravated by pregnancy or pregnancy management and which occur during or within 42 days after the end of the pregnancy. The maternal mortality rate has declined dramatically since 1950, when the rate was 83.3 deaths per 100,000 live births; however, the maternal mortality rate in 2007 (12.7 per 100,000 live births) was 55 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.[35]

In 2007, there were a total of 548 maternal deaths. This does not include 221 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 2007, the maternal mortality rate among non-Hispanic Black women (28.4 per 100,000 live births) was roughly 3 times the rates among non-Hispanic White and Hispanic women (10.5 and 8.9 per 100,000, respectively).

The risk of maternal death increases with age for women of all races and ethnicities. In 2007, the maternal mortality rate was highest among women aged 35 years and older (32.3 per 100,000 live births), compared to 7.1 per 100,000 live births to women under 20 years of age and 8.1 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,* 2007

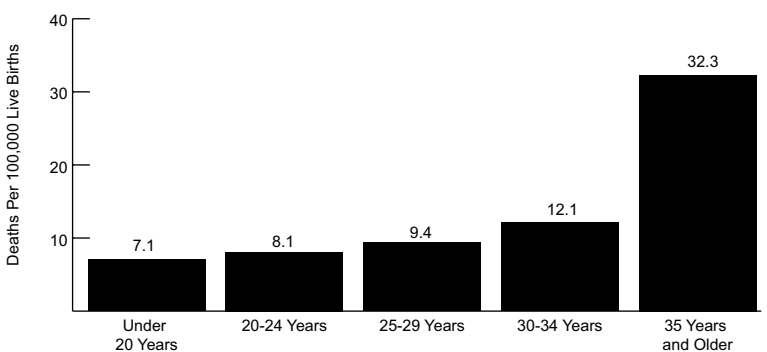
Source II.19: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



**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, 2007

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



POPULATION CHARACTERISTICS

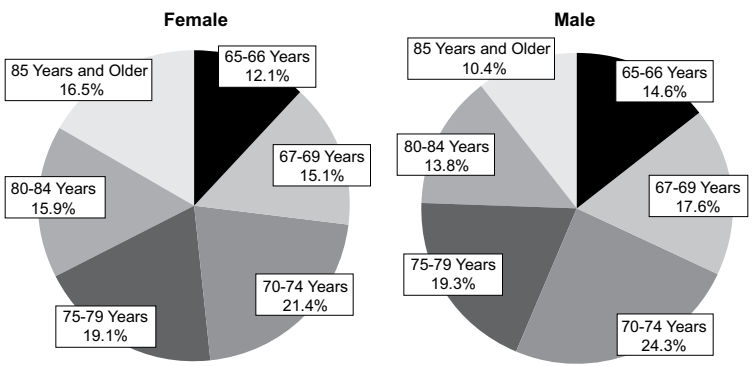
In 2008, there were nearly 39 million non-institutionalized adults aged 65 years and older in the United States. Women accounted for nearly 22.5 million or 57.7 percent of the older population. The age distribution of older adults varies by sex. More than 16 percent of older women were aged 85 years and older, compared to only 10.4 percent of the older male population. Similarly, 27.2 percent of older women were 65–69 years of age, compared to 32.2 percent of older men.

The distribution of the older female population varies by race and ethnicity and age. In 2008, non-Hispanic White women accounted for the majority of women aged 65 and older (79.9 percent), followed by Black and Hispanic women (9.0 and 6.8 percent, respectively). As age increases, non-Hispanic White women account for a greater percentage of the female population, while each of the other racial and ethnic groups account for a lower percentage. Non-Hispanic White women accounted for 77.3 percent of women aged 65–74 years, and 84.8 percent of women aged 85 years and older. In comparison, Hispanic women accounted for 7.6 percent of 65- to 74-year-olds and only 4.7 percent of those aged 85 years and older.

In the year 2011, the oldest members of the baby boom cohort will turn 65 years of age. Over the next two decades, the population of older Americans will grow dramatically as this generation ages.

U.S. Population* Aged 65 and Older, by Sex and Age, 2008

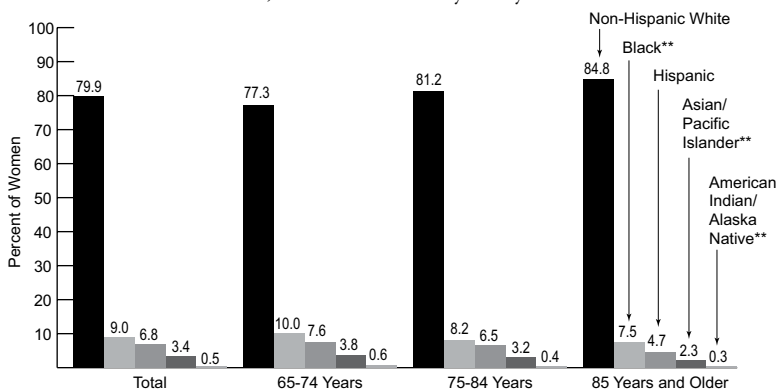
Source I.1: U.S. Census Bureau, American Community Survey



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

U.S. Female Population* Aged 65 and Older, by Race/Ethnicity and Age, 2008

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



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

LABOR FORCE PARTICIPATION

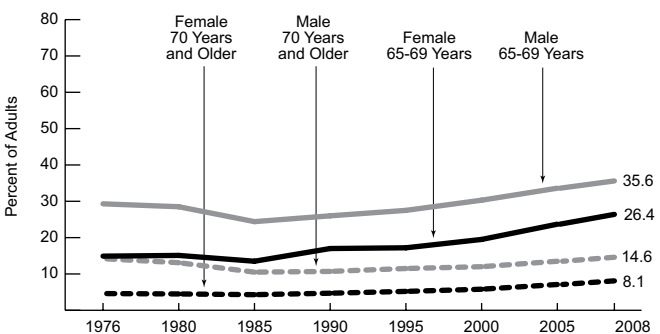
In 2008, 13.3 percent of women and 21.5 percent of men aged 65 years and older were in the labor force (employed or not employed and actively seeking employment; data not shown). Among older women, labor force participation rates have increased substantially since the 1970's. Between 1976 and 2008, labor force participation among women aged 65–69 years increased 77.2 percent, from 14.9 to 26.4 percent of the civilian, non-institutionalized population. Labor force participation among women aged 70 years and older has shown an even greater increase (85.4 percent) from 4.6 percent in 1976 to 8.1 percent in 2008. In comparison, men aged 65–69 years saw a 21.5 percent increase in labor force participation from 1976 to 2008, while men aged 70 years and older saw an increase of less than 3 percent.

As labor force participation among women has risen over the past 3 decades, the proportion of women receiving Social Security retired worker benefits has increased, as well. In 2006, 67.6 percent of women aged 65–69 years were receiving Social Security benefits for retired workers (as opposed to benefits for spouses of retired workers), an increase of 21.6 percent over the 55.6 percent of women receiving those benefits in 1990. Among women aged 70 years and older, 61.9 percent received retired worker benefits in 2006, compared to 55.9 percent in 1990; this represents an increase of 10.7 percent during that time period.

In 2006, 28.1 percent of women aged 65 and older received employer pensions or retirement savings. This is virtually unchanged since 1990, when 28.3 percent of women were receiving pensions or retirement savings. During this time, however, the proportion of men receiving retirement income from these sources decreased from 49.2 percent to 43.6 percent, possibly due in part to the decreasing reliance on traditional pension plans (data not shown).

Labor Force Participation* Among Adults Aged 65 and Older, by Age and Sex, 1976–2008

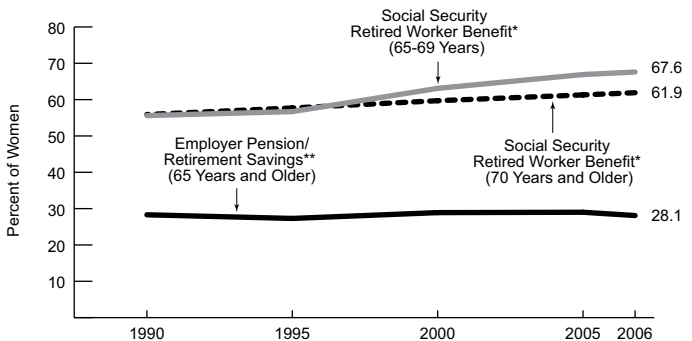
Source II.24, I.11: U.S. Department of Labor, Bureau of Labor Statistics



*Percent of the civilian, non-institutionalized population employed or not employed and looking for work.

Women Aged 65 and Older Receiving Retirement Income, by Type of Benefit and Selected Age Group, 1990–2006

Source II.25: U.S. Department of Labor, Current Population Survey and the Social Security Administration (as published by the Congressional Research Service)



*Includes women who are receiving the retired worker benefit based on their own employment; does not include women receiving a benefit as the spouse of a retired worker. **Includes traditional pensions, retirement savings plans, or both.

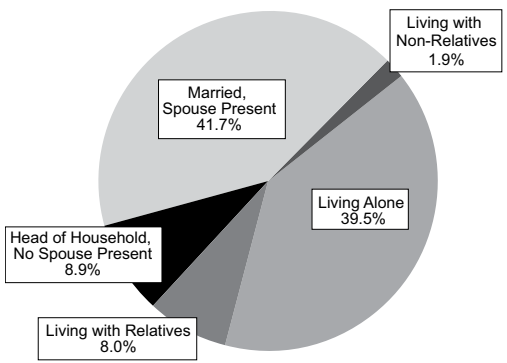
POVERTY AND HOUSEHOLD COMPOSITION

In 2008, 41.7 percent of women aged 65 years and older who did not reside in an institution were married and living with a spouse, while another 39.5 percent lived alone. Nearly 9 percent of older women were heads of their household, with no spouse present, meaning that they had 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.[36]

Nearly 12 percent of women aged 65 years and older lived in poverty in 2008, while 29.9 percent had household incomes of 100–199 percent of poverty. Only one-quarter of older women had incomes of 400 percent or more of poverty. Among women aged 65 and older, income decreases as age increases. For instance, women aged 75 years and older were most likely to have incomes of 100–199 percent of poverty and less than 100 percent of poverty (36.1 and 13.3 percent, respectively). In comparison, 9.5 percent of women aged 65–69 years lived in poverty, and 21.6 percent had incomes of 100–199 percent of poverty. Women aged 75 and older were also least likely to have incomes of 400 percent or more of poverty (18.4 percent), compared to 26.2 percent of women aged 70–74 years and 36.6 percent of women aged 65–69 years.

Women Aged 65 and Older*, by Household Composition, 2008

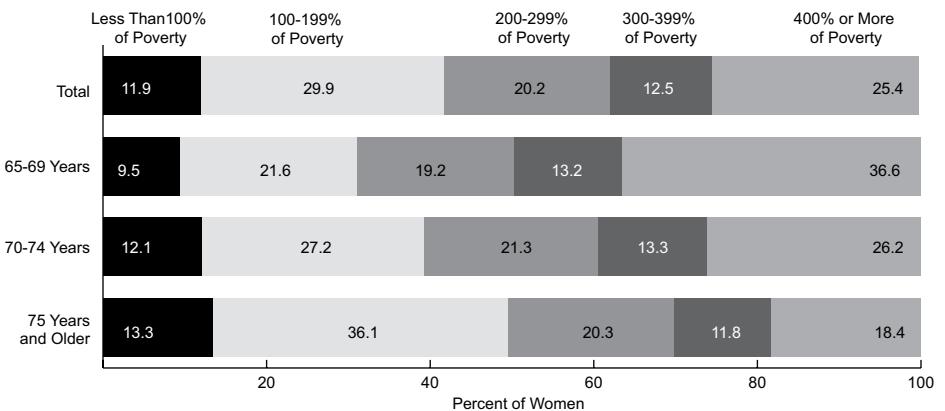
Source I.2: U.S. Census Bureau, Current Population Survey



*Civilian, non-institutionalized population.

Women Aged 65 and Older, by Poverty Status* and Age, 2008**

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



*Poverty level, defined by the U.S. Census Bureau, was about $10,991 for an individual or $22,025 for a family of four in 2008.
**Percentages may not add to 100 due to rounding.

ACTIVITY LIMITATIONS

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. While women and men of all ages may be limited in their ability to perform some of these activities, the proportion of adults with activity limitations increases with age. In 2008, more than 62 percent of adults aged 65 years and older reported having a condition that limited their ability to perform one or more of these common activities (data not shown). Women of this age were more likely than men to report being limited in their activities (68.4 versus 54.4 percent, respectively; data not shown).

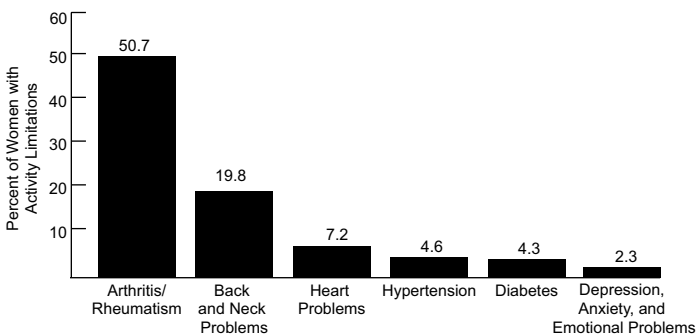
The most common causes of activity limitations among women aged 65 years and older were arthritis (reported by 50.7 percent of women with limitations) and back and neck problems (19.8 percent). Heart problems were the next most common condition, reported among 7.2 percent of women with activity limitations.

The percentage of women aged 65 and older reporting at least one activity limitation varies with race and ethnicity. Non-Hispanic Black women (71.9 percent) were more likely than Hispanic and non-Hispanic White women (69.6 and 68.2 percent, respectively) to report any activity limitations (data not shown).

Dementia is characterized by loss of memory and a decline in cognitive functioning. In 2002, an estimated 3.4 million adults aged 71 years and older had dementia, 2.4 million of whom had Alzheimer's disease (data not shown). Overall, women were more likely than men to have dementia (15.7 versus 11.1 percent, respectively); however this varied with age. For both men and women, the prevalence of dementia increases as age increases. Women and men aged 90 years and older were most likely to have dementia (34.7 and 44.6 percent, respectively) while those aged 71–79 years were least likely (4.8 and 5.3 percent, respectively).

Most Common Conditions Causing Activity Limitations* Among Women Aged 65 and Older, 2008

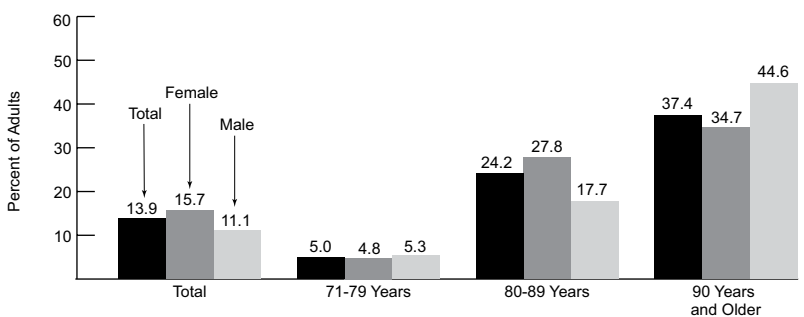
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Dementia Prevalence* Among Adults Aged 71 and Older, by Age and Sex, 2002

Source II.26: National Institute on Aging, Aging, Demographics and Memory Study, as published in Plassman, et al, 2007



**Includes all types of dementia, such as Alzheimer's disease, vascular dementia, dementia of undetermined etiology, Parkinson's dementia, alcoholic dementia, traumatic brain injury, and Lewy body dementia.*

OSTEOPOROSIS

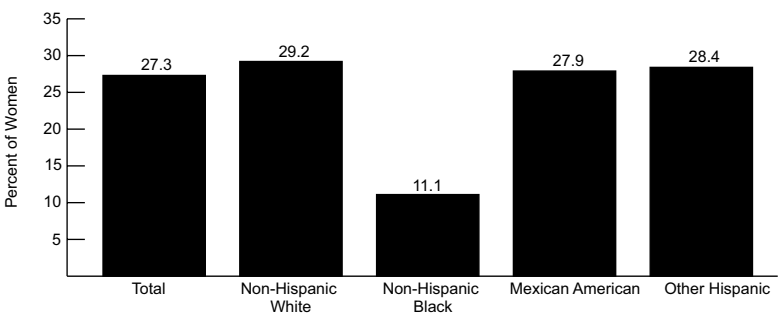
Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even among individuals who have already suffered a fracture. In 2005–2008, an estimated 6.3 million Americans aged 65 years and older had osteoporosis, nearly 90 percent of whom were women. Among adults in this age group, 27.3 percent of women and 4.2 percent of men reported having ever been told by a health professional that they have osteoporosis. Estimates of osteoporosis prevalence among women varied significantly by race and ethnicity. Non-Hispanic Black women were least likely to have osteoporosis (11.1 percent), compared to about 28 percent of Mexican American and other Hispanic women, and 29.2 percent of non-Hispanic White women.

Each year more than 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks occurring 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.[37] In 2007, there were 208,000 hospital discharges due to hip fractures among women aged 18 and older, nearly half of which occurred among women aged 85 and older. Hospital discharge rates due to hip fractures were 271.8 per 10,000 women aged 85 and older, and 83.7 per 10,000 women aged 75–84 years.

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (such as walking), and by taking prescription medication when appropriate. Bone density tests are now recommended for women aged 65 and older, men aged 70 and older, any man or woman who suffers a fracture after age 50, and any postmenopausal women who have a risk factor, including low weight, smoking, heavy alcohol consumption, and family history of a broken hip.[38]

Women Aged 65 and Older with Diagnosed Osteoporosis,* by Race/Ethnicity,** 2005–2008

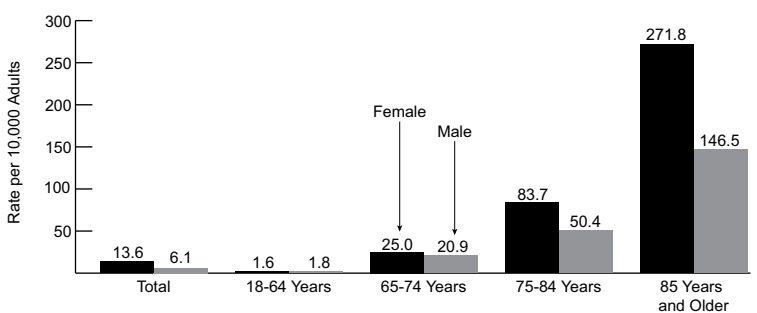
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they had 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.

Hospital Discharges Due to Hip Fractures* Among Adults, by Age and Sex, 2007

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: 820.0-820.9).

INJURY AND ABUSE

The consequences of injuries can often be controlled by either preventing or lessening the impact of an injurious event. This can occur through education, enactment and enforcement of policies and laws, and improvements in emergency care. Some examples of efforts to prevent injury and falls among older Americans include home-modification interventions, community-based exercise interventions, and guidelines recommending that physicians ask about falls as part of a patient's routine physical exam.[39]

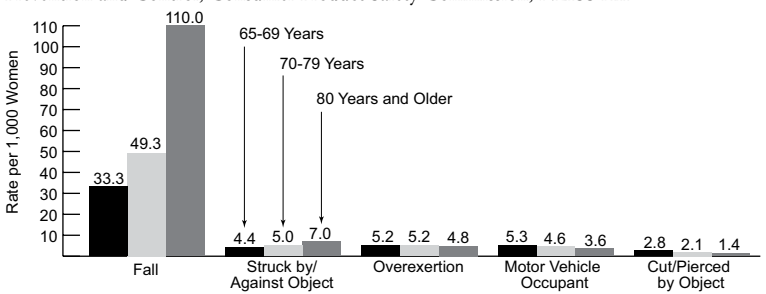
Despite efforts to prevent injuries among older adults, the rate of unintentional injury treated in hospital emergency departments has increased by 12.1 percent among women aged 65 years and older, from 82.9 per 1,000 women in 2001 to 92.9 per 1,000 women in 2008 (data not shown). Falls were the most commonly reported cause of injury reported by older women, followed by being struck by or against an object. Rates of fall-related injuries and being struck by or against an object increase as age increases, while rates of injuries sustained as a motor vehicle occupant and being cut or pierced by an object decrease with age. Women aged 80 years and older were most likely to have suffered a fall-related injury (110.0 per 1,000 women), compared to 49.3 per 1,000 women aged 70–79 years and 33.3 per 1,000 women aged 65–69 years.

Statistics regarding the criminal victimization and abuse of older adults have not been uniformly and consistently collected and reported. In 2006, rates of violent crimes for adults aged 65 and older were 2.1 per 1,000 women and 5.0 per 1,000 men.[40] Despite these low rates, it is estimated that 2–10 percent of older adults may be victims of elder abuse, and that only 1 in 14 incidents are reported to authorities (data not shown).[41] Elder abuse takes many forms, including physical abuse; neglect; emotional or psychological abuse; financial exploitation; and sexual abuse.

A survey of State Adult Protective Services agencies found that, in 2004, women were more likely to be victims of reported elder abuse (65.7 percent; 15 states reporting; data not shown), and that the most common forms of substantiated abuse for all adults were self-neglect (37.2 percent) and caregiver neglect (20.4 percent; 19 states reporting). Nearly 15 percent of cases each were for financial exploitation and emotional, psychological, or verbal abuse.

Leading Causes of Nonfatal Unintentional Injury* Among Women Aged 65 and Older, by Age, 2008

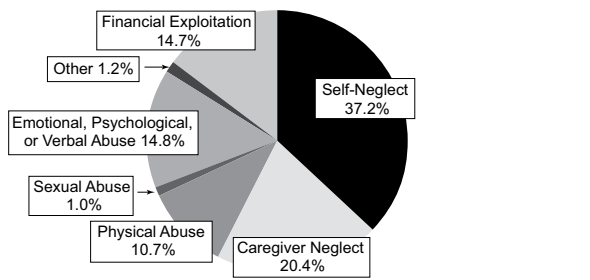
Source II.14: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Consumer Product Safety Commission, NEISS-AIP



*Treated in hospital emergency departments.

Substantiated Reports of Elder Abuse Among Adults Aged 60 and Older, by Category of Abuse, 2004*

Source II.27: National Protective Services Association, Survey of State Adult Protective Services



*Based on 19 State agencies reporting; includes all adults (data were not reported by sex).

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, limited financial resources, lack of insurance, and limited access to a range of health services, preventive treatment and rehabilitation can be critical in preventing disease and improving the quality of women's lives.

This section presents data on women's use of health services, 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 home health and hospice care.

USUAL SOURCE OF CARE

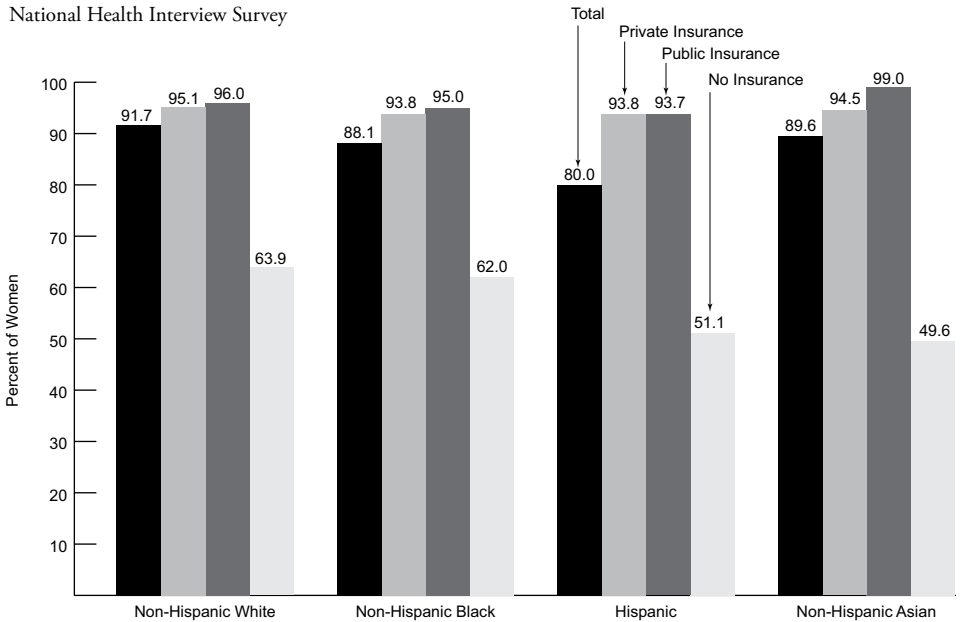
Women who have a usual source of care (a place they usually go when they are sick, such as a physician's office or health center) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2008, 89.6 percent of women reported having a usual source of care (data not shown); this varied, however, by race and ethnicity and health insurance status.

Non-Hispanic White women were more likely than any women of other races and ethnicities to report a usual source of care (91.7 percent), while Hispanic women were least likely to do so (80.0 percent). Nearly 90 percent of non-Hispanic Asian women and 88.1 percent of non-Hispanic Black women also reported having a usual source of care.

The proportion of women of different races and ethnicities who have a usual source of care varied with health insurance status. Among all women, more than 93 percent of those with private or public health insurance reported having a usual source of care; this did not vary significantly by race and ethnicity. Women lacking health insurance were least likely to have a usual source of care (59.0 percent; data not shown). Among women without health insurance, non-Hispanic Whites were more likely than Hispanic and non-Hispanic Asian women to have a usual source of care (63.9 versus 51.1 and 49.6 percent, respectively).

Women Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity* and Health Insurance Status,** 2008

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 races was too small to produce reliable results. Rates reported are not age-adjusted. **Respondents could have private or public health insurance or both; items are not mutually exclusive.*

HEALTH INSURANCE

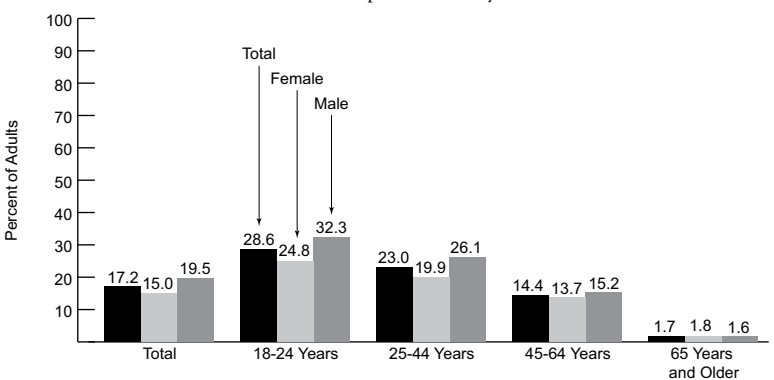
People who are uninsured are less likely than those with insurance to seek health care, which may result in poor health outcomes and higher health care costs.[4] In 2008, 39.0 million adults (17.2 percent) were uninsured. Adults aged 18–64 accounted for 38.3 million of those uninsured, representing 20.3 percent of that population (data not shown).[5] The percentage of people who are uninsured varies considerably across a number of factors, including age, sex, marital status, race and ethnicity, and education.

Among adults in 2008, those aged 18–24 years were most likely to lack health insurance. Men aged 18–64 years were more likely than women of the same age to be uninsured. The highest rate of uninsurance occurred among 18- to 24-year-old men (32.3 percent), which was significantly higher than the percentage of women of the same age (24.8 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest rate was found among women and men aged 45–64 (13.7 and 15.2 percent, respectively); the sex disparity in this age group was less pronounced than in the younger age groups.

Among women aged 18–64 years in 2008, 70.5 percent had private insurance, 15.8 percent had public insurance, and 18.0 percent were uninsured. This distribution varied by marital status: women who were married and whose spouse was present were most likely to have private insurance coverage (80.4 percent), while women who were widowed or separated from their spouses were least likely (52.5 and 49.7 percent, respectively). Women who were widowed were also more likely than women of other marital statuses to have public insurance (31.7 percent). Women separated from their spouses were most likely to lack insurance (28.7 percent), followed by women who had never married (25.1 percent). [Respondents could report more than one type of coverage.]

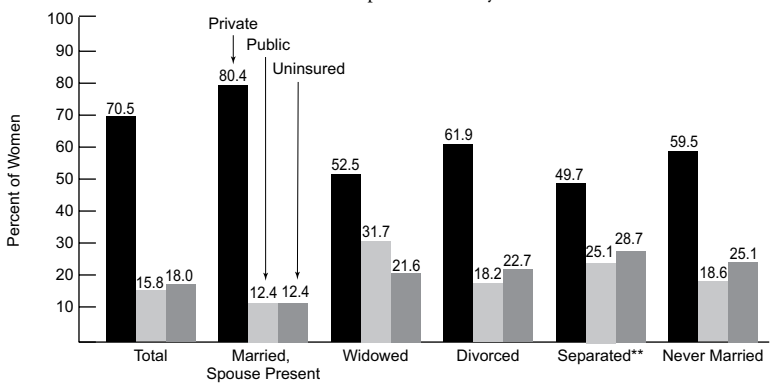
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2008

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



Health Insurance Coverage of Women Aged 18–64, by Marital Status and Type of Coverage,* 2008

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



*Percentages may add to more than 100 because it was possible to report more than one type of coverage.
**Includes respondents reporting that they are married but their spouse is absent.

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 coverage through private insurers; and Part D allows for coverage of prescription drugs through private insurers.

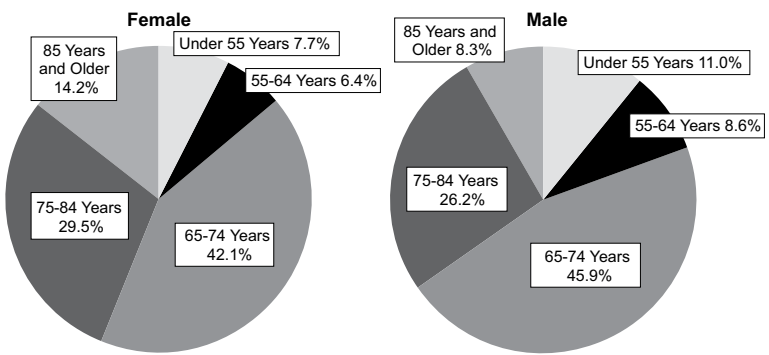
In 2008, 55.5 percent of Medicare's 45.4 million enrollees were female (data not shown). Among both women and men, those in older age groups accounted for a greater proportion of overall enrollment; however, men had greater representation than women in the younger age groups. For instance, 19.6 percent of male enrollees were under 65 years of age, compared to 14.1 percent of female enrollees. In contrast, adults aged 75 years and older accounted for 43.7 percent of female enrollees, compared to 34.5 percent of male enrollees.

Medicaid, jointly funded by Federal and State governments, provides coverage for low-income people and people with disabilities. In 2007, 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 (29.3 million), and women accounted for 69.3 percent of all adult enrollees (data not shown). 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 (74.5 and 80.1 percent, respectively).

Nearly 12.6 million women, representing 61.6 percent of adult female Medicaid enrollees, were of childbearing age in 2007 (data not shown). In order to expand family planning services to those most in need, States are able to apply for a waiver to cover women after childbirth, when their coverage would otherwise expire. As of November 2009, 27 States had secured a waiver for expanded family planning services; 11 of those states limited this benefit to adults aged 19 years or older.[6]

Medicare Enrollees, by Sex and Age, 2008*

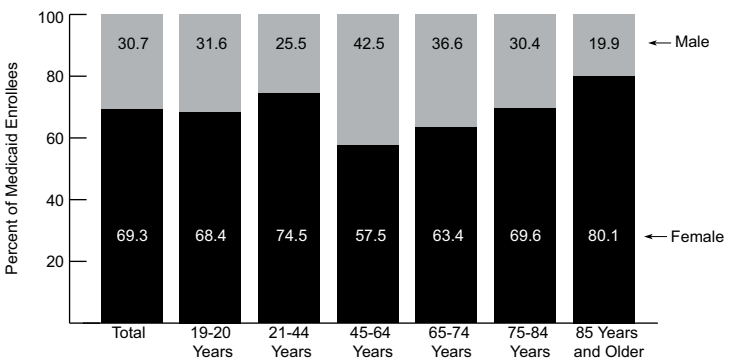
Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2008.

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

Source III.1: Centers for Medicare and Medicaid Services



PREVENTIVE CARE

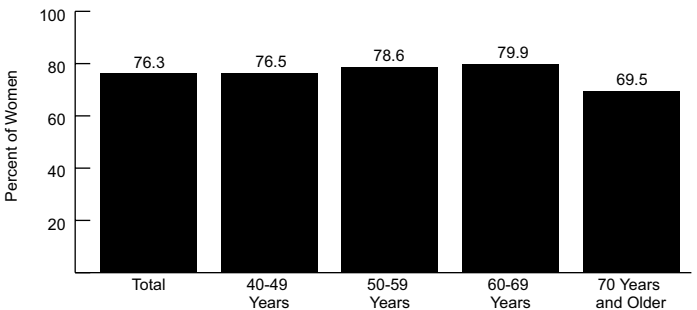
Preventive health care, including counseling, education, and screening, can help prevent or minimize the effects of many serious health conditions. In 2006, females of all ages made 533 million physician office visits. Of these visits, 21.5 percent were for preventive care, including prenatal care, health screening, and insurance examinations (data not shown).[7]

Biennial breast cancer screenings are recommended for every woman aged 50–74 years and for women aged 40–49 years depending on their individual circumstances.[8] The Healthy People 2010 goal is to increase the proportion of women aged 40 years and older who received a mammogram in the previous 2 years to 70 percent.[9] In 2008, 76.3 percent of women aged 40 years and older reported receiving a mammogram within the past 2 years, representing a dramatic increase since 1998 when 67 percent of women did so. Women aged 60–69 years were most likely to have received a mammogram in the past 2 years (79.9 percent), followed by women aged 50–59 years (78.6 percent). Nearly 70 percent of women aged 70 years and older had also received a mammogram in the past 2 years. There were no differences in receipt of a mammogram in the past 2 years among women of different races and ethnicities.

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.[9] In 2005–2008, 72.5 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 72.4 percent, respectively), than Mexican American and other Hispanic women (50.3 and 65.5 percent, respectively).

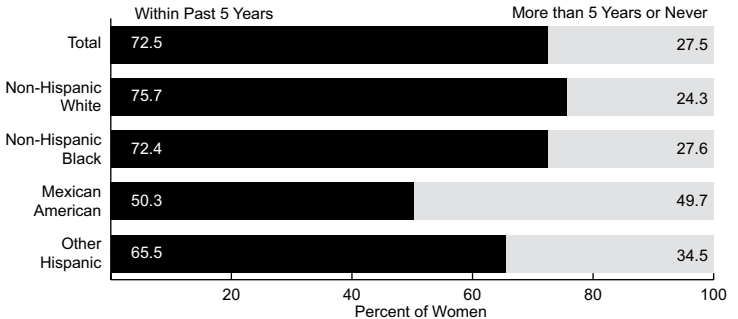
Women Aged 40 and Older Who Received a Mammogram in the Past 2 Years, by Age, 2008

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



Receipt of Cholesterol Screening Among Women Aged 20 and Older, by Race/Ethnicity,* 2005–2008

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



**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. Total includes all races/ethnicities.*

VACCINATION

Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for children aged 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.[10] In 2008, 47.5 percent of women aged 55–64 years and 68.1 percent of women aged 65 years and older reported receiving a flu vaccine in the past year; rates of vaccination vary, however, by poverty status. Among women aged 65 years and older, women with family incomes of 200 percent or more of poverty were most likely to have had a flu vaccine (70.6 percent), compared to 61.5 percent of women with incomes below 100 percent of poverty.

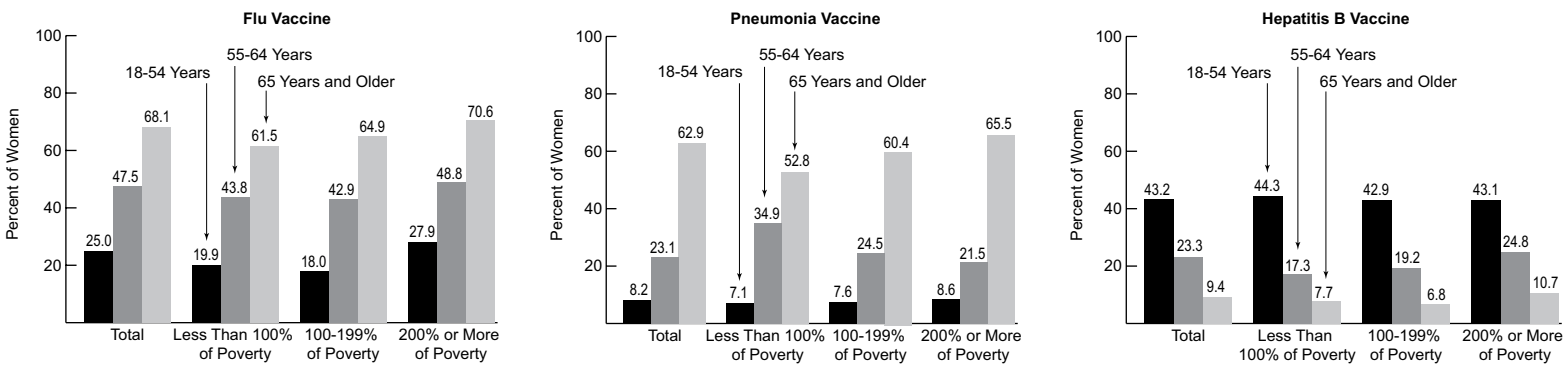
Pneumonia (pneumococcal) vaccine is recommended for adults aged 65 years and older, people with certain health conditions (such as asthma), and those who smoke cigarettes. In 2008, 62.9 percent of women aged 65 and older reported ever receiving the vaccine. In this age group, 52.8 percent of women with household incomes below 100 percent of poverty received the vaccination, compared to 65.5 percent of women with household incomes of 200 percent or more of poverty.

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.[11] In 2008, hepatitis B vaccination varied by poverty level, as well as age. Younger women were more likely than women of other ages to have received at least one of the three recommended doses.

In 2009, a new strain of the influenza virus, 2009 H1N1, emerged worldwide. The strain appears to affect younger people more severely than the seasonal flu, and can cause severe illness and death in pregnant and postpartum women.[12] The H1N1 vaccine is recommended for pregnant women, people aged 6 months to 24 years, those caring for children under 6 months, and those aged 25–64 who have certain medical conditions.[13]

Receipt of Selected Vaccinations* Among Women Aged 18 and Older, by Poverty Status** and Age, 2008

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. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

HEALTH CARE EXPENDITURES

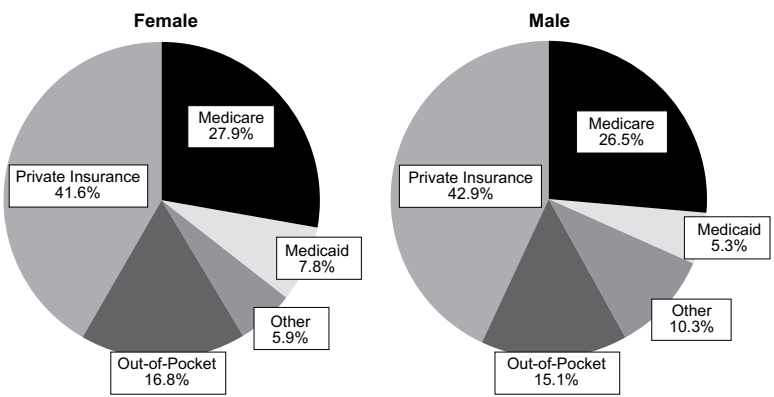
In 2007, the majority of health care expenses of both women and men were covered by public or private health insurance. Among women, one-third of expenses were covered by either Medicare or Medicaid, while 41.6 percent of expenses were covered by private insurance. Although the percentage of expenditures 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 (7.8 versus 5.3 percent, respectively).

In 2007, 90.2 percent of women had at least one health care expenditure, compared to 78.8 percent of men (data not shown). Among adults 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 slightly higher for women ($5,519) than for men ($5,076). However, men's average expenditures exceeded women's for hospital inpatient services ($21,175 versus $13,626, respectively), hospital outpatient services ($2,549 versus $1,965), and home health services ($5,769 versus $4,912). Women's expenditures exceeded men's in the categories of office-based medical services ($1,529 versus $1,411, respectively) and dental services ($694 versus $639). Despite health care expenses by individual category generally being lower for women than men, the overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 11.1 percent of women had hospital inpatient services, compared to 6.6 percent of men, which contributes to a higher mean expenditure overall.

Overall per capita health care expenditures have increased substantially in the past decade. In 2007, the annual mean health care expenses for women and men were 68.1 and 77.0 percent higher, respectively, than in 1999 (data not shown).

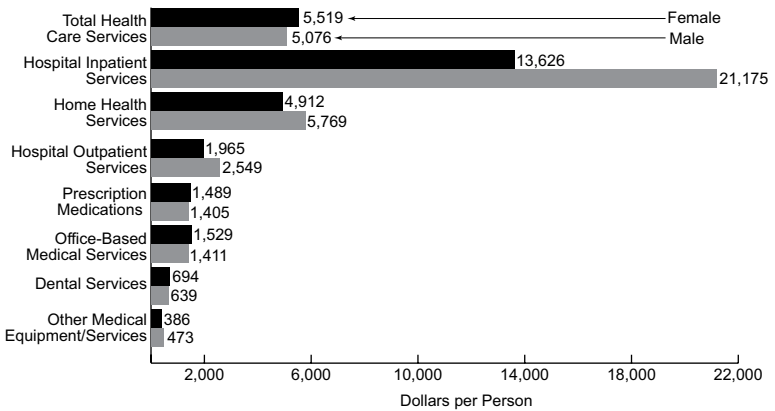
Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment, 2007

Source III.2: U.S. 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, 2007

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



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.[14] In addition, the CDC recommends that all health care providers include HIV testing as part of their patients' routine health care and that all pregnant women be tested during their pregnancy.

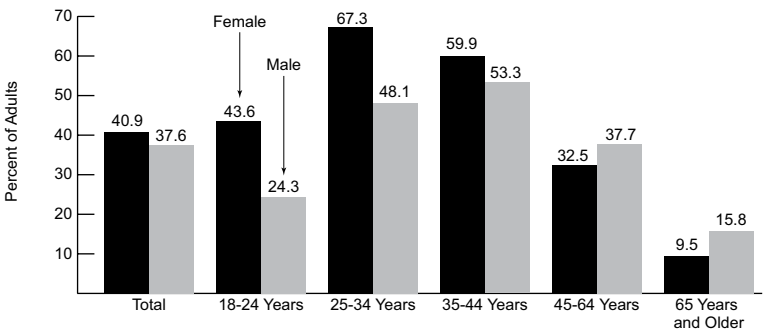
In 2008, more than 39 percent of adults in the United States had ever been tested for HIV (data not shown). Overall, women were slightly more likely than men to have been tested (40.9 versus 37.6 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, while men were more likely to have been tested at older ages (45 years and older).

Among women in 2008, non-Hispanic women of multiple races were most likely to have ever been tested (63.7 percent), followed by non-Hispanic Black women (57.0 percent) and Hispanic women (50.6 percent). Non-Hispanic White and Asian women were much less likely to have reported ever being tested (36.0 and 36.2 percent, respectively).

Among women who had not been tested, 79.3 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 18.8 percent reported that there was no particular reason they had not done so (data not shown).

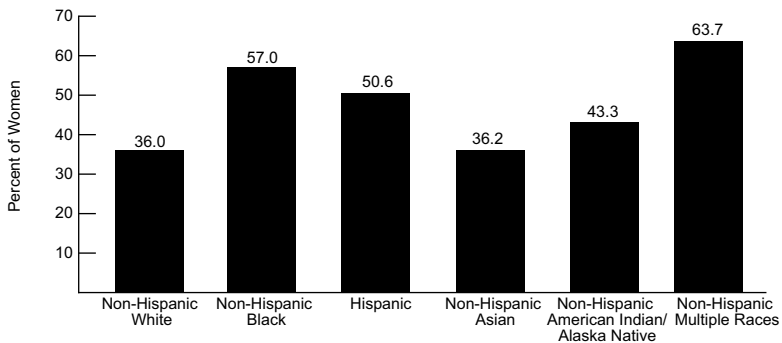
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2008

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, 2008*

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



**Rates reported are not age-adjusted.*

HOME HEALTH AND HOSPICE CARE

In 2006, approximately 6.1 million people began receiving home health care services, while nearly 940,000 were admitted to a hospice care facility (an agency providing end-of-life care). Overall, women account for a greater proportion of users of home health and hospice services than men; in 2007, 64.8 percent of current home health care patients (aged 18 and older) were women, while 55.1 percent of patients discharged from hospice care were women. While women accounted for a greater proportion than men of home health care patients within all age groups, the proportion of hospice patients who were women varied by age group.

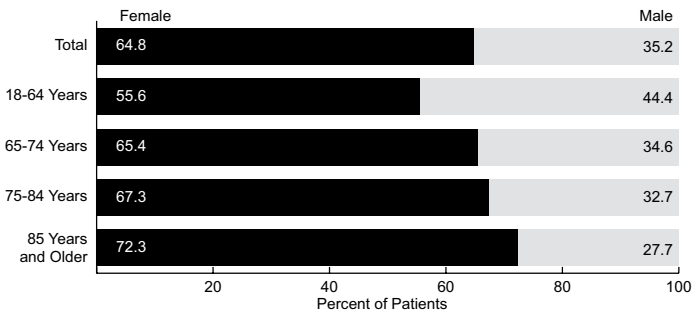
Among adults under 65 years of age, men accounted for a greater percentage of hospice discharges (including those released from the facility for any reason, such as death, or moved to another facility, residential, or home care) in 2007 than women (53.7 versus 46.3 percent, respectively), while men and women made up about equal proportions of discharges for those aged 65–84 years. In comparison, 65.3 percent of hospice patients aged 85 and older were women. This is likely due, at least in part, to the longer life expectancy among women than men.

In 2007, the large majority of both home health care patients and patients discharged from hospice care were non-Hispanic White (76.2 and 87.6 percent, respectively; age-adjusted). Non-Hispanic Black women accounted for an additional 12.9 percent of home health care patients, while 8.4 percent were Hispanic. Non-Hispanic Black and Hispanic women made up a substantially smaller proportion of hospice care patients discharged in 2007: 5.9 percent were non-Hispanic Black and 5.2 percent were Hispanic (data not shown).

As the U.S. population ages, there will be a greater reliance on home health care and on those providing care in the home. Research has found that the burden of caregiving may have numerous physical and emotional health consequences including increased likelihood of chronic disease, fatigue and loss of sleep, stress or anxiety, pain, depression, and headaches.[15] As such, the health needs of female caregivers will also need to be addressed.

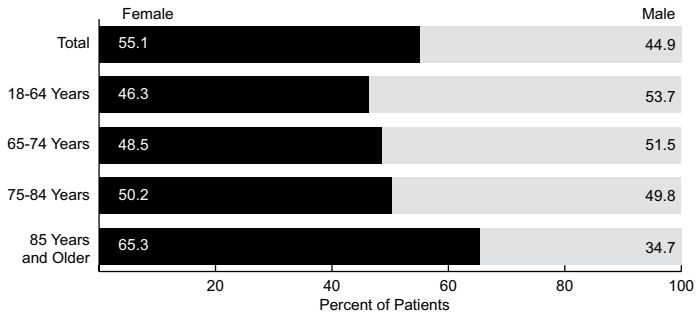
Current Home Health Patients, by Age and Sex, 2007

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Home Health and Hospice Care Survey



Patients Discharged from Hospice Care,* by Age and Sex, 2007

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Home Health and Hospice Care Survey



*Includes patients released from the facility for any reason, such as death, moved to another facility, or discharged to residential or home care.

MENTAL HEALTH CARE UTILIZATION

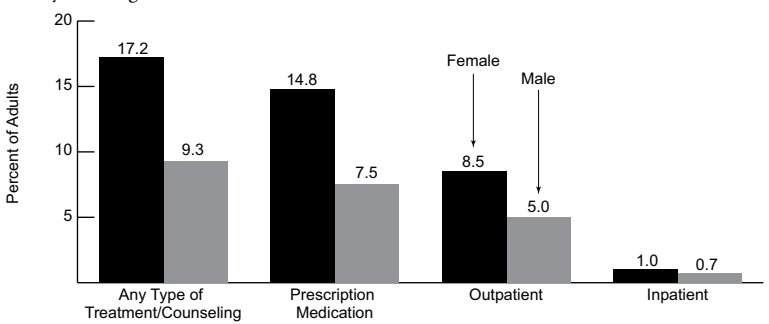
In 2008, more than 30 million adults in the United States reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services, including inpatient and outpatient care and prescription medications. More than 17 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.8 percent of women aged 18 and older, almost twice the rate among men (7.5 percent). Outpatient treatment was reported by 8.5 percent of women, and inpatient treatment was reported by 1.0 percent of women.

In 2008, mental health services were needed, but not received, by an estimated 10.6 million adults in the United States. Women were twice as likely as men to have an unmet need for mental health treatment or counseling in the past year (6.3 versus 3.0 percent, respectively). Among women, unmet need for treatment varies with age; 9.9 percent of women aged 18–34 years and 8.0 percent of 35- to 49-year-olds reported an unmet need. Slightly more than 4 percent of women aged 50–64 years also reported an unmet need for mental health treatment (data not shown).

Among women aged 18–64 years, reasons for not receiving needed mental health treatment vary by age. Cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services among all age groups. Women aged 35–49 years with unmet mental health treatment needs were most likely to cite this reason, followed by 48.1 percent of those aged 18–34 years, and 42.6 percent of 50- to 64-year-olds. Nearly one-third of women aged 18–34 and 50–64 with an unmet treatment need reported that they could handle their problems on their own, compared to 25.2 percent of 35- to 49-year-olds. Fear of stigma—such as concerns about confidentiality, the opinions of others, or the potential effect on employment—and not knowing where to go for services were reported by 23.7 and 20.7 percent, respectively, of 18- to 34-year-olds.

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Type and Sex, 2008

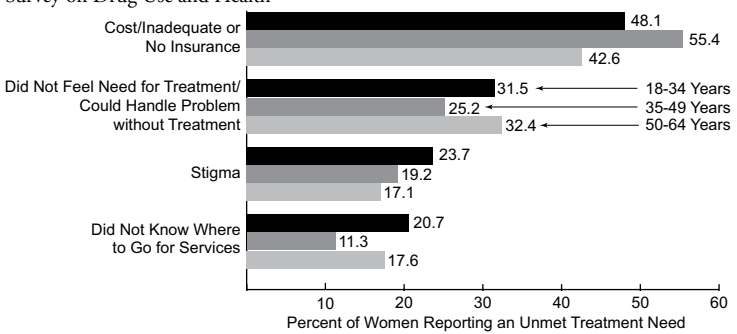
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



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

Reasons for Unmet Need for Mental Health Treatment* Among Women Aged 18-64, by Age,** 2008

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. **The sample of women aged 65 years and older not receiving needed treatment was too small to produce reliable results.

ORGAN TRANSPLANTATION

Since 1988, there have been more than 475,000 organ transplants in the United States. More than 28,000 of those transplants occurred in 2009, when nearly 15,000 people donated organs. Overall distribution of organ donation by sex was nearly even (7,347 male and 7,284 female organ donors), though females were more likely than males to be living donors (60.4 percent of living donors were female), while males accounted for a greater proportion of deceased donors (58.9 percent; data not shown).

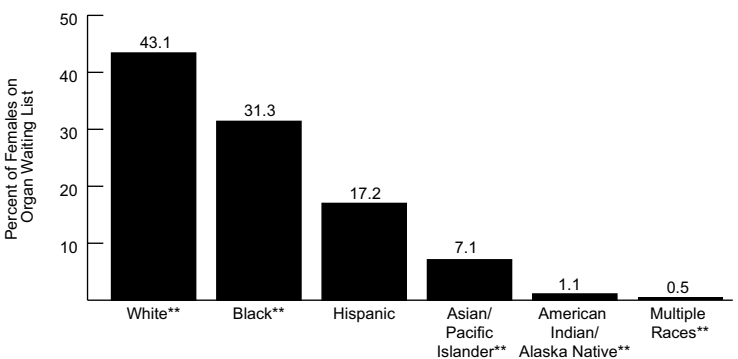
The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of July 23, 2010, there were 107,960 people awaiting a life-saving organ transplant. Females accounted for 41.0 percent of those patients but made up only 37.9 percent of those who received a transplant in 2009 (data not shown). Among females waiting for an organ transplant, 43.4 percent were White, 31.4 percent were Black, and 17.0 percent were Hispanic.

In 2009, there were 10,774 organ transplants performed for females in the United States. The most commonly transplanted organ was the kidney (6,678 transplanted), followed by the liver (2,158). The kidney and liver were also the most donated organs, with 6,851 females donating kidneys and 2,865 donating liver in 2009.

In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donations. From 2003 to 2009, organ donation by deceased donors increased by an unprecedented 24 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 limited understanding of donation and funeral arrangements.[16]

Females on Organ Waiting Lists,* by Race/Ethnicity, 2010

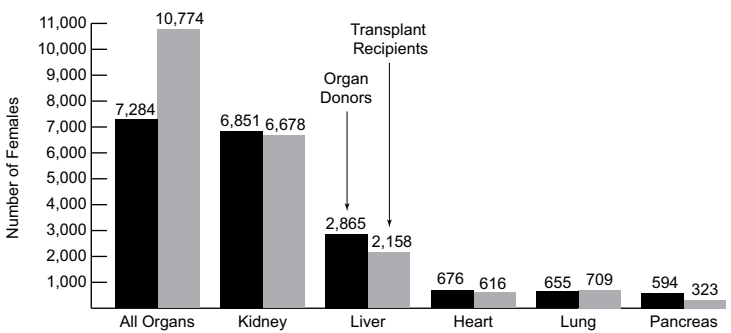
Source III.5: Organ Procurement and Transplantation Network



*As of July 23, 2010. Percentages may not add to 100 because respondents could select more than one race and ethnicity. **May include Hispanics.

Female Organ Donors and Transplant Recipients, 2009*

Source III.5: Organ Procurement and Transplantation Network



*Data subject to change based on future submission or correction; based on OPTN data as of July 23, 2010.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, and timeliness of women's health services. While there are numerous ways to measure quality of care, some common indicators used to monitor women's health care in managed care plans include screening for chlamydia, screening for cervical cancer, and the receipt of timely prenatal and postpartum care.

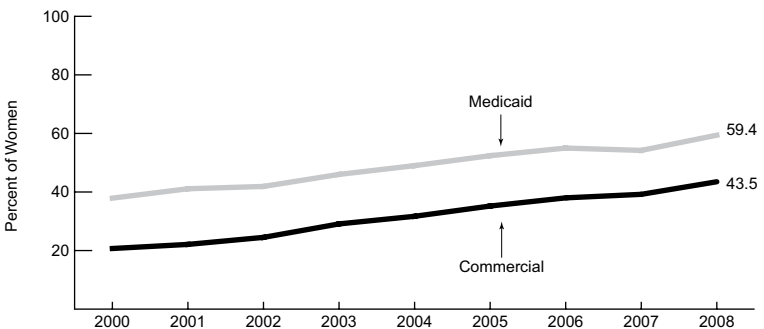
In 2008, women aged 21–24 years enrolled in Medicaid were more likely than those enrolled in commercial plans to have had a chlamydia screening (59.4 versus 43.5 percent, respectively). Since 2000, the percentage of sexually active females screened for chlamydia has increased by 110 percent among those in commercial plans and 56.7 percent among Medicaid participants.

Cervical cancer screenings appeared to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 18–64 years, cervical cancer screenings were received at least once during the previous 3 years by 80.8 percent of commercially-insured women and 66.0 percent of those covered by Medicaid (data not shown).

In 2008, women with commercial insurance coverage were more likely than those with Medicaid to have received timely prenatal and postpartum care. More than 92 percent of commercially-insured women received prenatal care in either their first trimester or within 42 days of enrollment, compared to 81.9 percent of those covered by Medicaid. Similarly, 82.8 percent of women with commercial coverage had a postpartum visit between 21 and 56 days after delivery, compared to 62.7 percent of women participating in Medicaid. Since 2003, the percentage of postpartum women receiving timely care increased 13.4 percent among Medicaid participants and 3.1 percent among commercially-insured women.

HEDIS®* Chlamydia** Screening Among Women Aged 21–24 Years, by Payer, 2000–2008

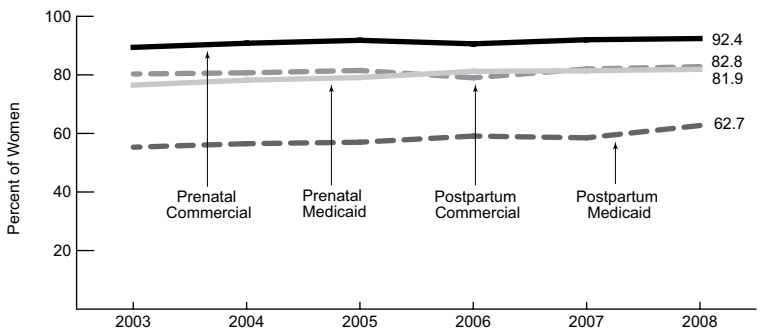
Source III.6: National Committee for Quality Assurance



*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®* Timeliness of Prenatal** and Postpartum Care,† by Payer, 2003–2008

Source III.6: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of pregnant women who received a prenatal care visit in either the first trimester or within 42 days of enrollment. †The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.

SATISFACTION WITH HEALTH CARE

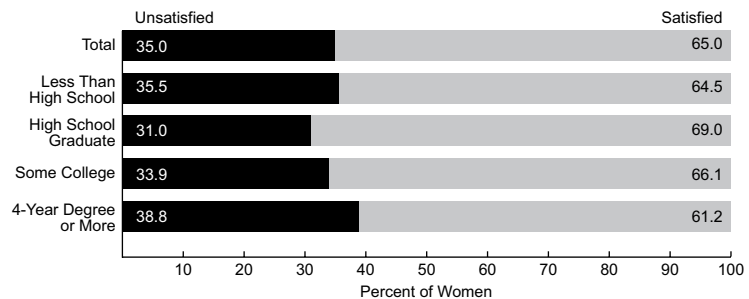
Patients' use of health care is affected by the quality of care; those who are not satisfied with their providers may be less likely to continue with treatment or seek further services.[17] Some aspects of patients' experience of care that may contribute to better outcomes are patients' perceptions of how well their doctors communicate with them and individuals' experiences with their health plans.

In 2008, 35.0 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 varies by education level. Women with at least a 4-year college degree were most likely to be dissatisfied (38.8 percent), followed by women with less than a high school diploma (35.5 percent). In comparison, 31.0 percent of female high school graduates were dissatisfied with aspects of their health plan's customer service.

Overall, 15.4 percent of women were dissatisfied with how well their doctors communicate including perceptions of how carefully doctors listened to them, whether doctors explained things in a way that was easy to understand, and whether doctors spent enough time with them. This varied, however, with race and ethnicity. Non-Hispanic White women were least likely to be dissatisfied with how well their doctors communicate (13.5 percent), followed by non-Hispanic American Indian/Alaska Native women (17.8 percent). Nearly one-quarter of non-Hispanic Asian women were dissatisfied with communication with their doctors (24.4 percent), as were 20 percent of Hispanic and non-Hispanic Black women.

Women's Satisfaction with Experiences Related to Health Plan Customer Service,* by Level of Education, 2008

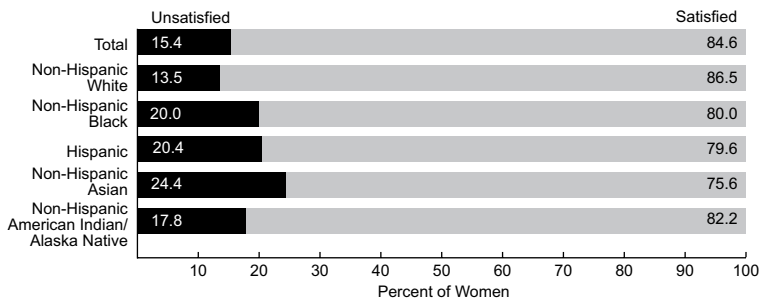
Source III.7: U.S. Agency for Healthcare Research and Quality, National CAHPS Benchmarking Database®



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

Women's Satisfaction with How Well Doctors Communicate,* by Race/Ethnicity, 2008

Source III.7: 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).

HRSA PROGRAMS RELATED TO WOMEN'S HEALTH

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) is the Federal agency responsible for providing access to high-quality, culturally competent health care for uninsured, underserved, and special needs populations. A systems approach is at the core of HRSA's efforts to promote access to health care. Systems of care provide integrated and coordinated community-based services, including primary and preventive care, and involve the consumer in health care decision-making.

HRSA's Office of Women's Health (OWH) addresses women's health issues across the lifespan. The Bright Futures for Women's Health and Wellness Initiative (BFWHW) provides materials on topics such as physical activity and healthy eating, emotional wellness, and maternal wellness. Spanish versions of all materials will be completed in 2010. BFWHW tools, data books, and reports can be found on the OWH Web site at www.hrsa.gov/womenshealth.

The HIV/AIDS Bureau (HAB) provides resources and services for women living with HIV/AIDS through the Ryan White Program, specifically Part D, which addresses the needs of women, infants, children, youth, and their families. As of the end of 2009, HAB supported systems of care for women living with HIV/AIDS through 98 Part D grantees. In 2009, HAB also funded a new Special Project of National Significance under Part F of the Ryan White Program, entitled *"Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color."* Grantees will develop and test innovative, gender-specific strategies to keep affected women in continuous care.

The Bureau of Primary Health Care (BPHC) funds a national network of over 1,080 grantees through the Health Center Program. In 2008, BPHC-funded health centers offered primary health services to over 6.5 million uninsured Americans for a sliding-scale fee. Women comprised 59.2 percent of health center users, over 900,000 of whom were aged 25–29 years.[18] Systems of care models are central to BPHC's work. Many health centers operate within a network which includes several health centers. Some community health center networks provide a system of care for the homeless, including primary health care, substance abuse treatment, mental health services, and oral health care. Public housing primary care programs are located in or near public housing developments and provide comprehensive services to residents. Community health centers often provide translation services, transportation, and patient education programs in order to ensure access and continuity of care.

The Bureau of Health Professions (BHPr) works to address the shortage of health professionals and clinicians, especially in underserved rural and urban areas. Programs such as the Children's Hospital Graduate Medical Education Payment Program; the Nurse Education, Practice, and Retention Program; the Health Careers Opportunity Program; and various scholarship programs are designed to promote the recruitment, placement, and training of diverse health care professionals.

HRSA's Maternal and Child Health Bureau (MCHB) supports the Title V MCH Block Grant. Through a Federal-State partnership, MCHB aims to provide a comprehensive system of perinatal care for women. In addition, the Healthy Start Program works to improve the quality of and access to local systems of care in order to improve health outcomes for pregnant women and women in the interconceptional period. The Healthy Start system of care includes:

- Direct health care services, such as prenatal care, family planning services, well-woman care, and postpartum care;
- Enabling services, such as translation, transportation, home visitation and education;
- Population-based services such as immunization and public information; and
- Infrastructure building services, such as training of women's health care providers.

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 2009

Bleeding Disorders
Complementary and Alternative Medicine
Endocrine and Metabolic Disorders
Healthy People 2010 Update
Hospitalizations
State Data on Cigarette Smoking, Leading Causes of Death, and Overweight and Obesity
Supplement on U.S.—Mexico Border Health

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
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

Title V Abstinence Education Programs
Title X Family Planning Services
Vitamin and Mineral Supplement Use

ENDNOTES

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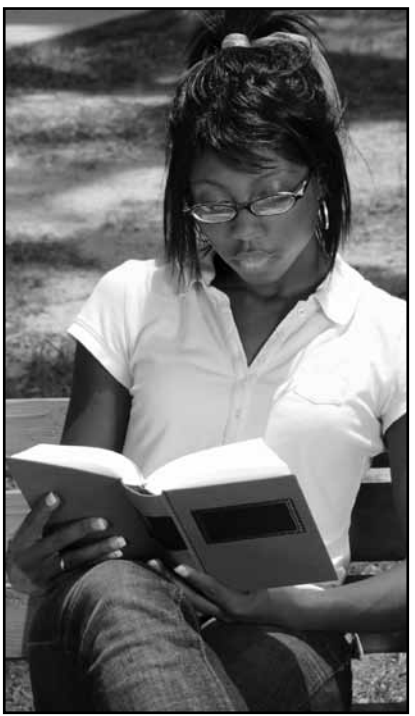

CONTRIBUTORS

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