LESBIAN AND BISEXUAL WOMEN

Research suggests that lesbian and bisexual women are at increased risk for adverse health outcomes, including overweight and obesity, poor mental health, substance abuse, violence, and barriers to optimal health care resulting from social and economic inequities.[74,75] Although frequently referred to as part of a larger group of sexual minorities, including gay men and transgender individuals, the health status and needs of lesbians and bisexual women are uniquely shaped by a range of factors including sexual identity and behavior, as well as traditional sociodemographic factors, like age, education, and race and ethnicity. The terms "lesbian" and "bisexual" are used to define women according to their sexual orientation which can reflect sexual identity, behavior, or attraction;[76] however, for the purposes of the data presented on this page, both lesbian and bisexual refer to women's self-reported identity.[77]

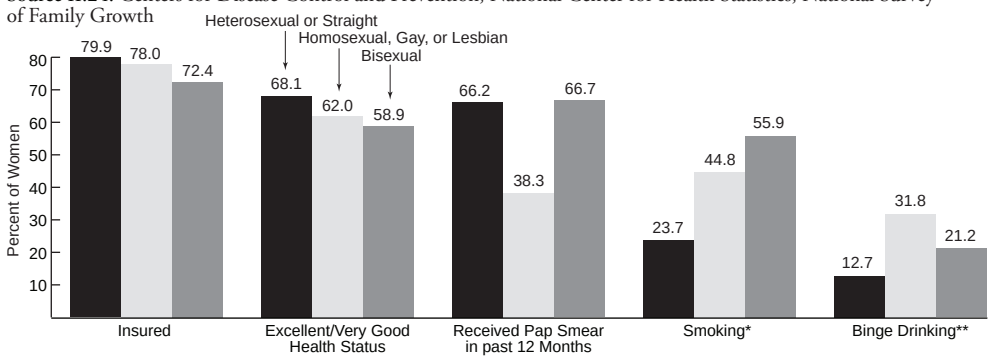
In 2006–2008, 1.1 percent or 590,000 women aged 18–44 years self-identified as homosexual, gay, or lesbian and 3.5 percent or 1.9 million self-identified as bisexual. The proportion of women who reported any same-sex sexual behavior, however, was substantially higher at 12.7 percent, while 16.7 percent of women in this age group reported some degree of same-sex attraction (data not shown).

Among reproductive-aged women in 2006–2008, differences were observed for several health indicators by sexual identity. Bisexual women were less likely than heterosexual women to report having health insurance (72.4 versus 79.9 percent, respectively) and marginally less likely to report being in excellent or very good health (58.9 versus 68.1 percent, respectively); no significant difference was observed between lesbian and heterosexual women for either indicator. Conversely, while approximately 66 percent of heterosexual and bisexual women received a Pap smear in the past 12 months, only 38.3 percent of lesbians reported receiving this service. Both lesbian and bisexual woman, however, were about twice as likely as straight women to report smoking and binge drinking (defined as consuming 5 or more drinks within a couple of hours at least once a month during the past year). Nearly half of lesbian and bisexual women reported smoking, while 31.8 percent and 21.2 percent of lesbians and bisexuals, respectively, reported binge drinking.

A recent report from the Institute of Medicine concluded that to better understand and meet the unique needs of lesbian, gay, bisexual and transgender people, more data are needed in several priority areas: demographics, social influences, health care inequalities, and transgender-specific health needs.[76] The U.S. Department of Health and Human Services is working to increase the number of federally-funded health and demographic surveys that collect and report sexual orientation and gender identity data.[78]

Selected Health Indicators Among Females Aged 18–44 Years, by Sexual Identity, 2006–2008

Source II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



**Smoked at least one cigarette per day on average in the past year. **Defined as consuming 5 or more drinks within a couple of hours at least once a month on average in the past year.*

AMERICAN INDIAN AND ALASKA NATIVE WOMEN

In 2009, 1.5 percent of the U.S. adult female population, or 1.8 million women, identified themselves as American Indian or Alaska Native, either alone or combined with one or more other races.[79] American Indian and Alaska Natives include diverse tribes and cultures distributed throughout the country, but the areas with the largest concentration are in the West, South, and Midwest, particularly Alaska, New Mexico, South Dakota, Montana, Oklahoma, North Dakota, and Arizona.[80] American Indian/Alaska Native communities generally face many challenges as a consequence of displacement and cultural trauma, including high rates of poverty, low rates of educational attainment, and poor health.[81,82]

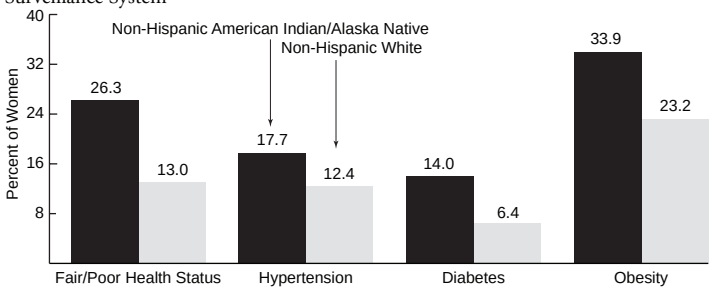
In 2007–2009, non-Hispanic American Indian/Alaska Native women were more than twice as likely to report their health as fair or poor and to report having been diagnosed with diabetes than non-Hispanic White women. They were also more likely to be obese and to have been diagnosed with hypertension. For example, about one-third (33.9 percent) of non-Hispanic American Indian/Alaska Native women were obese, compared to 23.2 percent of non-Hispanic White women. Non-Hispanic American Indian/Alaska Native women also had the highest rate of past-month cigarette smoking (41.8 percent), as well as high rates of binge and heavy drinking and illicit drug use (see *Alcohol Use, Cigarette Smoking*, and *Illicit Drug Use*).

Mirroring higher rates of substance use and chronic conditions, non-Hispanic American Indian/Alaska Native women were also more likely than non-Hispanic White women to die from several specific causes, including unintentional injury, homicide, liver disease, diabetes, and nephritis (kidney inflammation), as well as HIV and hepatitis.

Although many of the health problems afflicting American Indian/Alaska Native women are preventable, geographic, cultural, and financial factors often serve as barriers to accessing quality health care and engaging in healthy behaviors. The Indian Health Service (IHS) helps to provide health care to federally recognized tribes living on or near reservations; yet about 4 in 10 American Indian/Alaska Natives are not served by IHS.[81]

Selected Health Indicators* Among Women Aged 18 and Older, by Race, 2007–2009

Source II.6: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Based on self-reports of health status and doctor-diagnosed health conditions; estimates are age-adjusted.

Deaths per 100,000* Females Aged 15 and Older From Selected Causes, by Race, 2005–2007

Source II.16: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Non-Hispanic American Indian/Alaska Native	Non-Hispanic White
Diabetes	54.8	22.0
Unintentional Injury	50.5	33.4
Chronic Liver Disease and Cirrhosis	28.9	7.4
Nephritis (kidney inflammation)	20.6	13.7
Suicide	7.4	7.0
Homicide	4.9	2.0
Viral Hepatitis	3.2	1.5
HIV	2.3	0.7

*Age-adjusted death rates.

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER WOMEN

In 2009, nearly 300,000 U.S. women (0.24 percent) identified themselves as Native Hawaiian and Other Pacific Islander, either alone or combined with one or more other races.[79] The Native Hawaiian and Other Pacific Islander population includes a diversity of cultures among people native to Hawai'i, Samoa, Guam, Tonga, Fiji or other Pacific Islands. Native Hawaiian/Other Pacific Islanders live throughout the United States, with the largest concentrations in Hawai'i, Alaska, Utah, Nevada, California, Oregon, and Washington.[83] Although this small population has often been grouped with Asians, masking significant health disparities, more specific data is emerging as a consequence of a federal directive to separate these groups.[84]

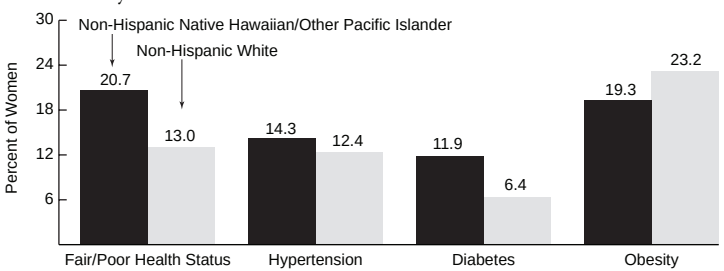
In 2007–2009, non-Hispanic Native Hawaiian/Other Pacific Islander women were more likely than non-Hispanic White women to report their health as fair or poor (20.7 versus 13.0 percent, respectively) and to report having been diagnosed with diabetes (11.9 versus 6.4 percent, respectively). Some studies have also shown higher rates of cardiovascular disease and related risk factors among Native Hawaiian/Other Pacific Islanders.[85] Non-Hispanic Native Hawaiian/Other Pacific Islander women have the highest rates of reported binge drinking and illicit drug use (27.7 and 17.6 percent, respectively; see *Alcohol Use* and *Illicit Drug Use*) and have an HIV diagnosis rate that is 5.5 times higher than non-Hispanic White women (see *HIV/AIDS*).

Cancer is another condition that disproportionately affects Native Hawaiian/Other Pacific Islander women.[86] In 2000–2005, Native Hawaiian women living in Hawaii had higher cancer incidence and mortality rates than their White counterparts both overall and for breast, lung, endometrial, pancreatic, stomach, cervical, and liver cancer. Samoan and Tongan women have also been shown to have high cancer incidence rates.[86]

As indigenous populations, Native Hawaiian/Other Pacific Islanders have endured a similar history of disenfranchisement to American Indian/Alaska Natives and share several health issues like substance abuse, diabetes, and other chronic diseases. The Native Hawaiian Health Care Improvement Act established Papa Ola Lokahi, an advocacy organization, as well as a health care system and scholarships to address the health needs of Native Hawaiians through culturally appropriate outreach, education, and health care.[87]

Selected Health Indicators* Among Women Aged 18 and Older, by Race, 2007–2009

Source II.6: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Based on self-reports of health status and doctor-diagnosed health conditions; estimates are age-adjusted.

Cancer Incidence and Mortality Rates Among Females (All Ages), by Site and Race, 2000–2005*

Source II.25: University of Hawai'i at Mānoa, University of Hawai'i Cancer Center, Hawai'i Tumor Registry

Site	Incidence Rate per 100,000		Mortality Rate per 100,000	
	Native Hawaiian	White	Native Hawaiian	White
All Sites	447.8	413.6	171.0	133.6
Breast	157.5	127.5	27.7	21.1
Lung and Bronchus	61.9	47.9	43.3	32.4
Uterine Corpus	38.5	23.0	6.3	2.5
Pancreas	16.2	9.2	14.0	8.1
Stomach	10.9	4.0	7.4	2.2
Cervix	9.6	7.0	4.5	1.8
Liver	6.3	2.0	5.1	2.7

*Includes only residents of Hawaii; estimates are age-adjusted.