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 health-related quality of life, secondhand tobacco smoke exposure, Alzheimer's disease and dementia, preconception health, unintended pregnancy, postpartum depressive symptoms, and maternity leave. In addition, special pages are devoted to summarizing the health of lesbian and bisexual women, as well as the indigenous populations of American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander women. The data throughout this section are displayed by various characteristics including sex, age, race and ethnicity, education, and income.

PHYSICAL ACTIVITY

Regular physical activity is critical for people of all ages to achieve and maintain a healthy body weight, prevent chronic disease, and promote psychological well-being. In older adults, physical activity also helps to prevent falls and improve cognitive functioning.[1] The 2008 Physical Activity Guidelines for Americans state that for substantial health benefits, adults should engage in at least 2½ hours per week of moderate intensity (e.g. brisk walking or gardening) or 1¼ hours per week of vigorous-intensity aerobic physical activity (e.g. jogging or kick-boxing), 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.[1]

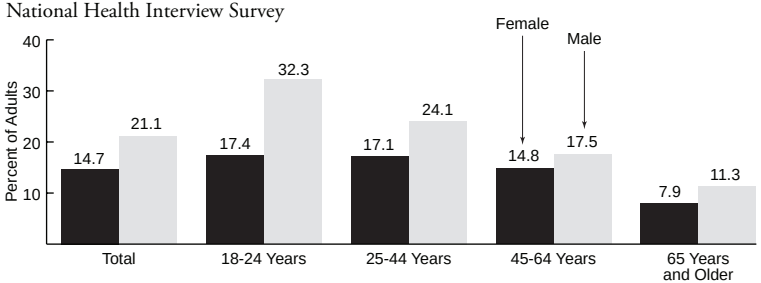
In 2007–2009, 14.7 percent of women met the recommendations for adequate physical activity, compared to 21.1 percent of men. In every age group, women were less likely than men to meet the recommendations for adequate physical activity. For both men and women, the percentage reporting adequate physical activity generally decreased as age increased.

Adequate physical activity also varied by poverty status and race and ethnicity. Overall, women with household incomes of 200 percent or more of poverty were more than twice as likely to report adequate physical activity than those with incomes below 200 percent of poverty (18.8 versus 8.6 percent, respectively; data not shown). This income difference was observed within each racial and ethnic group.

Overall, non-Hispanic White, non-Hispanic women of multiple races, and non-Hispanic American Indian/Alaska Native women reported the highest levels of adequate physical activity (16.9, 16.0, and 14.9 percent, respectively). Fewer non-Hispanic Black, Hispanic, and non-Hispanic Asian women reported engaging in adequate physical activity (9.4, 9.5, and 10.3 percent, respectively). These racial and ethnic differences occurred within both income groups.

Adults Aged 18 and Older Engaging in Adequate* Physical Activity by Age and Sex, 2007–2009

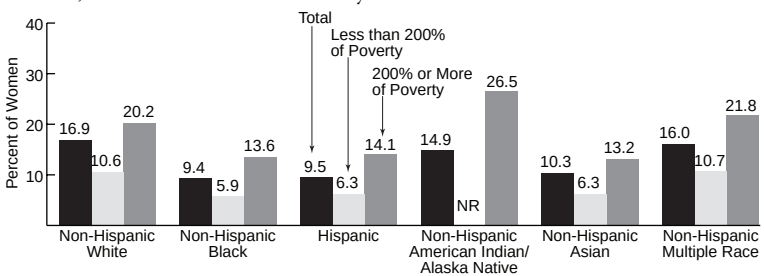
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**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,† 2007–2009

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



*NR = Estimate does not meet the standards of reliability or precision. *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 Native Hawaiian/Pacific Islanders was too small to produce reliable results. †Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.*

NUTRITION

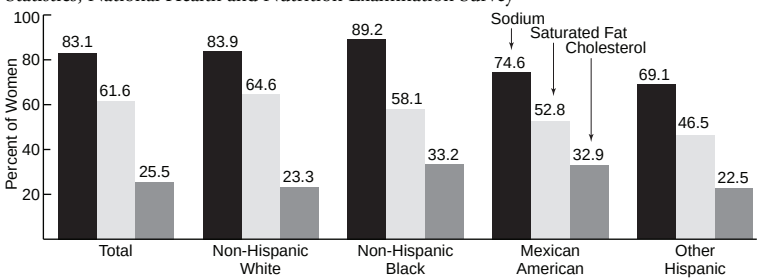
The *2010 Dietary Guidelines for Americans* recommends eating a variety of nutrient-dense foods while not exceeding caloric needs. For most people, this means eating a daily assortment of fruits and vegetables, whole grains, lean meats, seafood and beans, and reduced fat milk products while limiting added sugar, sodium, saturated and *trans* fats, and cholesterol.[2] Balancing a healthy diet with physical activity can help to prevent obesity and numerous chronic conditions, including heart disease, diabetes, and cancer, which are leading causes of death in the U.S.

High salt intake can contribute to high blood pressure—a major risk factor for cardiovascular and kidney disease. The *2010 Dietary Guidelines* recommends restriction of daily sodium intake to less than 2300 mg/day or further reduction to less than 1500 mg/day for persons who are aged 51 and older, Black, or have hypertension, diabetes, or chronic kidney disease. In 2005–2008, 83.1 percent of women exceeded the recommended maximum sodium intake—particularly non-Hispanic White and non-Hispanic Black women (89.2 and 83.9 percent, respectively), as well as those with higher household incomes (200 percent or more of poverty).

Fats that come from sources of polyunsaturated or monounsaturated fatty acids, such as fish, nuts, and vegetable oils, are an important part of a healthy diet. However, high intake of saturated fats and cholesterol, found mainly in animal-based foods, may increase the risk of cardiovascular disease. Most Americans should consume fewer than 10 percent of calories from saturated fats and less than 300 mg/day of cholesterol. *Trans* fat intake should also be kept to a minimum. In 2005–2008, 61.6 percent of women exceeded the recommended maximum daily intake of saturated fat—particularly non-Hispanic White and non-Hispanic Black women (64.6 and 58.1 percent, respectively). About 25 percent of women exceeded the recommended daily limit of cholesterol intake—particularly non-Hispanic Black and Mexican American women (33.2 and 32.9 percent, respectively). Differences in saturated fat and cholesterol intake by poverty status were not significant.

Women Exceeding the Recommended Daily Intake of Sodium, Saturated Fat, and Cholesterol,* by Race/Ethnicity, 2005–2008**

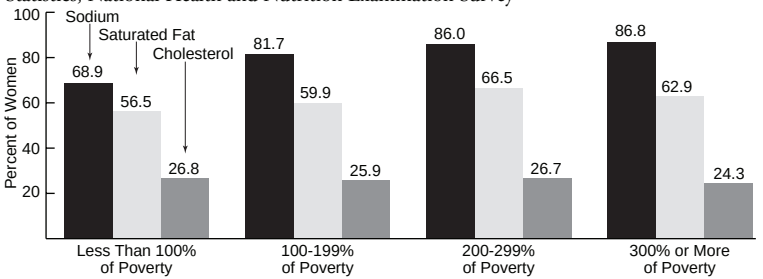
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Maximum recommended daily intake of sodium is less than 2300 mg/day or less than 1500 mg/day for persons who are aged 51 and older, Black, or have hypertension, diabetes, or chronic kidney disease (definition used here does not include lower threshold for chronic kidney disease due to lack of condition assessment); recommended intake of saturated fat is 10 percent of daily caloric intake or less; recommended daily intake of cholesterol is less than 300 mg/day. **The samples of American Indian/Alaska Native, Asian, and Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.*

Women Exceeding the Recommended Daily Intake of Sodium, Saturated Fat, and Cholesterol,* 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



**Maximum recommended daily intake of sodium is less than 2300 mg/day or less than 1500 mg/day for persons who are aged 51 and older, Black, or have hypertension, diabetes, or chronic kidney disease (definition used here does not include lower threshold for chronic kidney disease due to lack of condition assessment); recommended intake of saturated fat is 10 percent of daily caloric intake or less; recommended daily intake of cholesterol is less than 300 mg/day. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.*

ALCOHOL USE

Alcohol is a central nervous system depressant that, in small amounts, can have a relaxing effect. According to the *2010 Dietary Guidelines for Americans*, when alcohol is consumed it should be in moderation and limited to no more than one drink per day for women and two drinks per day for men.[2] While moderate alcohol consumption may have some health benefits primarily related to reducing risk of cardiovascular disease,[3] excessive drinking can lead to many adverse health and social consequences including injury, violence, risky sexual behavior, alcoholism, unemployment, liver diseases, and various cancers.[4]

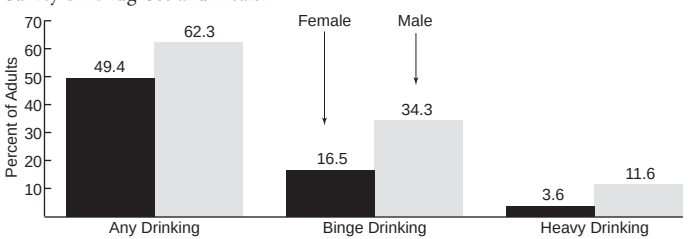
Excessive drinking includes binge drinking and heavy drinking. The National Survey on Drug Use and Health defines binge drinking as having five or more drinks on one occasion (at the same time or within a couple of hours of each other). Heavy drinking is defined as binge drinking on 5 or more of the past 30 days. Thus, binge drinking includes heavy drinking. While not presented here, the CDC has also defined heavy drinking as consuming more than one drink per day on average for women and two drinks per day on average for men.[4]

In 2007–2009, a greater percentage of men than women aged 18 and older reported past month alcohol use (62.3 versus 49.4 percent, respectively). Men were also more likely than women to report binge drinking (34.3 versus 16.5 percent, respectively) and heavy drinking (11.6 versus 3.6 percent, respectively). Despite being less likely to binge drink or drink heavily, women tend to face alcohol-related problems at a lower drinking level than men due to differences in body size and other biological factors.[5]

Binge and heavy drinking among women varies significantly by age and race and ethnicity. Younger women aged 18–25 years were more likely than women of other age groups to report binge and heavy drinking in the past month (33.8 and 9.1 percent, respectively; data not shown). With respect to race and ethnicity, binge drinking was highest among non-Hispanic Native Hawaiian/Other Pacific Islanders and non-Hispanic American Indian/Alaska Native women (27.7 and 21.3 percent, respectively). However, heavy drinking was most common among non-Hispanic White women and non-Hispanic women of multiple races, as well as non-Hispanic American Indian/Alaska Native women (4.1, 4.3, and 4.4 percent, respectively). Non-Hispanic Asian women were least likely to report binge and heavy drinking.

Past Month Alcohol Use Among Adults Aged 18 and Older, by Level of Drinking* and Sex, 2007–2009

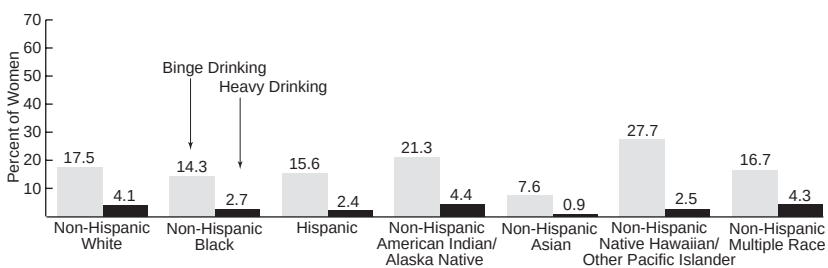
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



**Any drinking indicates at least 1 drink in past month; binge drinking indicates 5 or more drinks on the same occasion in the past month; heavy drinking indicates 5 or more drinks on the same occasion for 5 or more days in the past month.*

Binge and Heavy Alcohol Consumption* in the Past Month Among Women Aged 18 and Older, by Race/Ethnicity, 2007–2009

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



**Binge drinking indicates 5 or more drinks on the same occasion in the past month; heavy drinking indicates 5 or more drinks on the same occasion on 5 or more days in the past month.*

CIGARETTE SMOKING

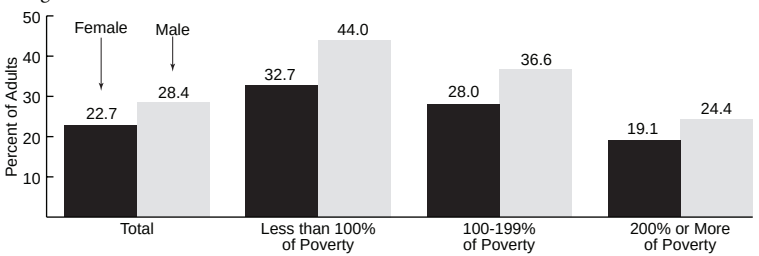
According to the U.S. Surgeon General, smoking damages every organ in the human body.[6] Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impair genes that control the growth of cells, and bind to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[6] Due to its high prevalence and wide-ranging health consequences, smoking is the single largest cause of preventable death and disease for both men and women in the United States. Cigarettes are responsible for 443,000 deaths, or 1 in 5 deaths, annually.[6]

In 2007–2009, women aged 18 and older were less likely than men to report smoking in the past month (22.7 versus 28.4 percent, respectively). For both men and women, smoking was more common among those with lower incomes. For example, 32.7 percent of women with household incomes below 100 percent of poverty smoked in the past month, compared to 19.1 percent of women with incomes of 200 percent or more of poverty. Smoking was significantly lower among women than men in every poverty category, but the difference was greater at lower income levels. Smoking also varied greatly by race and ethnicity. Among women, smoking ranged from 8.3 percent among non-Hispanic Asians to 41.8 percent among non-Hispanic American Indian/Alaska Natives (data not shown).

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[6] In 2007–2009, about 8 percent of women and men who had ever smoked daily and smoked in the previous 3 years had not smoked in the past year. The proportion of adults who quit smoking varied by poverty level for both women and men. For example, women with household incomes of 200 percent or more of poverty were more than twice as likely to have quit smoking as women with household incomes of less than 100 percent of poverty (9.9 versus 3.9 percent, respectively). There were no significant differences in quitting smoking by sex overall or by poverty level. In 2009, five states reported covering all recommended treatments for tobacco dependence in their Medicaid programs.[7]

Past Month Cigarette Smoking Among Adults Aged 18 and Older, by Poverty Status* and Sex, 2007–2009

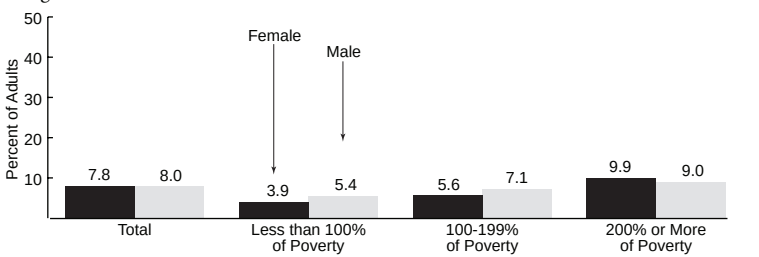
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

Recent Smoking Cessation* Among Adults Aged 18 and Older, by Poverty Status and Sex, 2007–2009**

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



*Defined as the proportion of adults who did not smoke in the past year among those who ever smoked daily at some point in their lives and smoked in the past 3 years; excludes adults who started smoking in the past year. **Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

ILLICIT DRUG USE

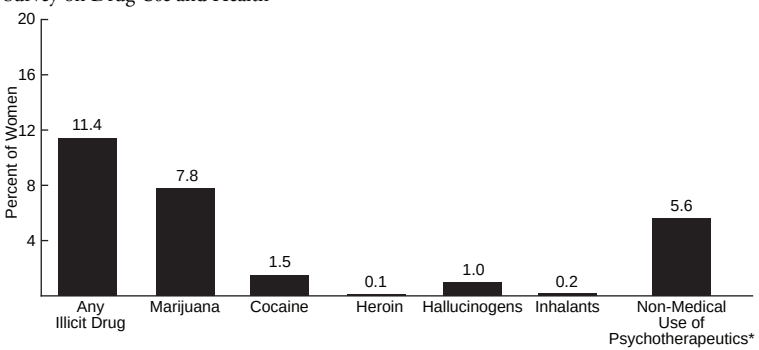
Illicit drug use is associated with serious health and social consequences, including addiction and drug-induced death, impaired cognitive functioning, kidney and liver damage, decreased productivity, and family disintegration.[8,9] Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type psychotherapeutic drugs, such as pain relievers, stimulants, and sedatives. Methamphetamine is a type of psychotherapeutic drug that has limited medical use for narcolepsy and attention deficit disorder, and is now manufactured and distributed illegally.[8]

In 2007–2009, 11.4 percent of adult women aged 18 years and older reported using an illicit drug within the past year, compared to 17.0 percent of adult men (data not shown). Illicit drug use was highest among younger adults; almost one-third (30.4 percent) of adult women aged 18–25 reported past-year illicit drug use (data not shown). Marijuana was the most commonly used illicit drug among women aged 18 and older (7.8 percent), followed by the non-medical use of psychotherapeutics (5.6 percent).

Illicit drug use varies by race and ethnicity. Among women, the use of any illicit drug was highest among non-Hispanic American Indian/Alaska Native, non-Hispanic Native Hawaiian/Other Pacific Islander and non-Hispanic women of multiple races (17.5, 17.6, and 17.7 percent, respectively) and lowest among non-Hispanic Asian women (5.4 percent). Racial and ethnic differences for specific types of illicit drugs are generally similar to differences for any illicit drug use. However, non-Hispanic White and Hispanic women had among the highest rates of reported cocaine use (1.7 and 1.4 percent, respectively), while non-Hispanic Black and non-Hispanic Asian women were least likely to report cocaine use (0.9 and 0.4 percent, respectively). Non-Hispanic White women were also among the most likely to have used psychotherapeutic drugs for non-medical use (6.3 percent; data not shown).

Past Year Use of Illicit Drugs Among Women Aged 18 and Older, by Drug Type, 2007–2009

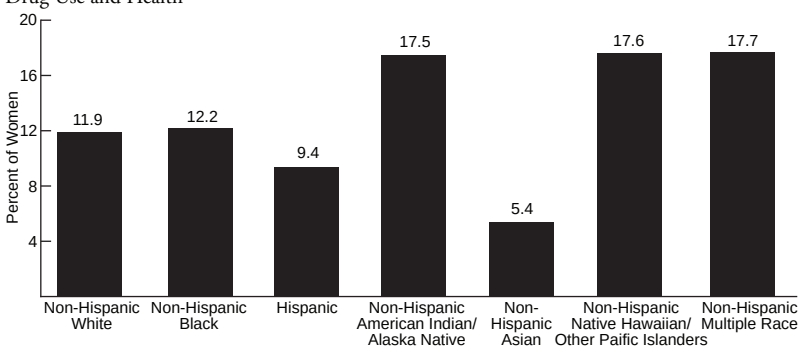
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Includes prescription-type pain relievers, tranquilizers, stimulants, and sedatives, but not over-the-counter drugs

Past Year Use of Any Illicit Drug* Among Women Aged 18 and Older, by Race/Ethnicity, 2007–2009

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.