Women's Health USA 2007

U. S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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HRSA Information Center
P.O. Box 2910
Merrifield, VA 22116
1-888-ASK-HRSA or ask@hrsa.gov

The data book is available in limited quantities in CD format.

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 through the States and Territories. In addition, HRSA's mission includes supporting individuals pursuing careers in medicine, nursing, and many other health disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely, topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA is pleased to present *Women's Health USA 2007*, the sixth 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 autoimmune diseases, gynecological and reproductive disorders, and digestive disorders are a few of the new topics included in this edition. Where possible, every effort has been made to highlight racial and ethnic, sex/gender, and socioeconomic dispari-

ties. In some instances, it was not possible to provide data for all races due to the size of the sample population. A cell size of fewer than 20 was deemed too small to produce reliable results.

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 2007* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal government, including the U.S. Department of Health and Human Services, U.S. Department of Agriculture, U.S. Department of Labor, and U.S. Department of Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years. It is important to note that the incidence data included is 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. Also, presentation of racial and ethnic data may appear differently on some pages as a result of the design and limitations of the original data source.

Women's Health USA 2007 is available online through either the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth or the Office of Data and Program Development's Web site at www.mchb.hrsa.gov/data. In an effort to produce a timely document, some of the topics covered in *Women's Health USA 2006* were not included in this year's edition because new data were not available. For coverage of these issues, please refer to *Women's Health USA 2006,* also available online. The National Women's Health Information Center at www.womenshealth.gov also has updated and detailed women's and minority health data and maps through Quick Health Data Online at www.4woman.gov/quickhealthdata. Data are available at the State and county levels, by age, race and ethnicity, and sex/gender.

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HRSA Information Center
P.O. Box 2910
Merrifield, VA 22116
Phone: 703-442-905
Toll-free: 1-888-ASK-HRSA
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Fax: 703-821-2098
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INTRODUCTION

In 2005, women represented 51 percent of the 288 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people 65 years and older; within this age group, women represented over 57 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 and 6.5 percent of the female population aged 65 and older, respectively, but they represented 15.3 and 20.9 percent of females under 15 years of age. Non-Hispanic Whites accounted for nearly 81 percent of women aged 65 years and older, but only 58.6 percent of those under 15 years of age.

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 (25.9 percent). Poverty rates were also higher among Black and Hispanic women (24.2 and 21.7 percent, respectively), who were also more likely to be heads of households than their non-Hispanic White and Asian counterparts.

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 2005, 62.3 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 53.6 percent of Hispanic women and 51.6 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 overweight and obesity. For instance, in 2005, non-Hispanic Black and Hispanic women accounted for more than three-fourths of women living with HIV/AIDS (64.1 and 15.1 percent, respectively). One-third of non-Hispanic White women had ever been tested for the Human Immunodeficiency Virus (HIV), compared to 52.5 percent of non-Hispanic Black women and 47.3 percent of Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and is especially prevalent among non-Hispanic Black women. Among non-Hispanic Black women, diabetes occurred at a rate of 106.8 per 1,000 women, compared to 69.1 per 1,000 non-Hispanic White women. Hypertension, or high blood pressure, was also more prevalent among non-Hispanic Black women than women of other races. This disease occurred at a rate of 353.8 per 1,000 non-Hispanic Black women, compared to 264.5 per 1,000 non-Hispanic White women and 200.2 per 1,000 Hispanic women.

Overweight and obesity are occurring at an increasing rate among Americans of all ages and both sexes. Body Mass Index (BMI) is a measure of the ratio of height to weight, and is often used to determine whether a person's weight is within a healthy range. A BMI of 25–29.9 is considered overweight, and a BMI of 30 or greater is considered obese. In 2003–04, 61.4 percent of women were overweight or obese; rates were highest among non-Hispanic Black (79.9 percent) and Hispanic women (68.4 percent).

Some conditions, such as arthritis and heart disease, disproportionately affect non-Hispanic White women. For instance, in 2005, the rate of arthritis among non-Hispanic White women was 282.1 per 1,000 women, compared to 243.3 per 1,000 non-Hispanic Black women and 144.2 per 1,000 Hispanic women.

Other conditions are more closely linked to family income than to race and ethnicity. Rates of asthma decline as income increases and women with higher incomes are more likely to effectively manage their asthma. Among women with incomes below the Federal poverty level (FPL), more than one-third had an asthma-related emergency room visit in the past year, compared to 19.2 percent of women with family incomes of 300 percent or more of the FPL.

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. Unlike many other health concerns, younger women are more likely than older women to suffer from serious psychological stress and major depressive episodes.

Physical disabilities are more prevalent among women as well. Disability can be defined as impairment of the ability to perform common activities like walking up stairs, sitting or standing for 2 hours or more, grasping small objects, or carrying items like groceries. Therefore, the terms "activity limitations" and "disabilities" are used interchangeably throughout this book. Overall, 15.1 percent of women and 12.5 percent of men reported having activity limitations.

Men, however, bear a disproportionate burden of some health conditions, such as HIV/AIDS, diabetes and heart disease. In 2005, for instance, adolescent and adult males accounted for almost 73 percent of those living with HIV/AIDS, though a smaller proportion of men had ever

been tested for HIV than women (33 versus 38 percent, respectively).

Certain health risks, such as overweight and injury, occurred more commonly among men than women. In 2003–04, 69.6 percent of men were overweight or obese, compared to 61.5 percent of women. Among men, 30.2 percent of emergency department visits were injury related, while only 21.8 percent of women's visits were due to injury. In addition, men were less likely than women to seek preventive care (375 versus 535 million physician office visits), and were more likely to lack health insurance (22.5 versus 18.8 percent uninsured, respectively).

Many diseases and health conditions, such as those mentioned above, can be avoided or minimized through good nutrition, regular physical activity and preventive health care. In 2004, 18.6 percent of women's visits to physicians were for preventive care, including prenatal care, preventive screenings, and immunizations. Overall, 60.5 percent of older women reported receiving a flu shot in 2005; however, this percentage ranges from 38.9 percent among non-Hispanic Black women to 63.8 percent of non-Hispanic White women. In addition to preventive health care, preventive dental care is also important to prevent dental caries and gum disease. In 2003–04, 71.2 percent of women who had health insurance with a dental component saw a dentist in the past year, compared to 58.6 percent of women with health insurance but no dental component, and 38.6 percent of women with no insurance at all.

There are many ways women (and men) can promote health and help prevent disease and disability. Thirty minutes of physical activity on most days of the week may reduce the risk of chronic disease; women who reported participating in any physical activity had an average of 194 minutes of moderate exercise each week in 2005, although only 50 percent of women reported at least 10 minutes of moderate activity.

Healthy eating habits can also be a major contributor to long-term health and prevention of chronic disease. In 1999–2004, however, more than half of all adult women had diets that included more than the recommended amount of saturated fat and sodium and less than the recommended amount of folate. Overall, 63.5 percent of women exceeded the maximum daily intake of saturated fat, and 70 percent exceeded the maximum amount of sodium.

While some behaviors have a positive effect on health, a number of others, such as smoking and alcohol and illicit drug use, can have a negative effect. In 2005, 22.5 percent of women smoked. However, 44.8 percent of female smokers tried to quit at some point in the past year. During the same year, 45.9 percent of women reported any alcohol use in the past month, but relatively few women (15.2 percent) reported binge drinking (five or more drinks on the same occasion) and even fewer (3.1 percent) reported heavy alcohol use (binge drinking on 5 days or more in the past month).

Cigarette, alcohol, and illicit drug use is particularly harmful during pregnancy. While use of illicit drugs is reported by only 3.9 percent of all pregnant women, it is more common among 15- to 17-year-olds who are pregnant — 12.3 percent of them reported drug use in the past month. The use of tobacco during pregnancy has declined steadily since 1989. In 2004–05, 16.6 percent of pregnant women aged 15–44 reported smoking during pregnancy. This rate was highest among non-Hispanic White women (21.5 percent) and lowest among Hispanic women (7.2 percent).

Women's Health USA 2007 can be an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women throughout the United States.

POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were over 146 million women and girls in the United States in 2005, representing slightly more than half of the population.

Comparison of data by factors such as sex, age, and race and ethnicity can be used to tailor the development and evaluation of programs and policies serving women.

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

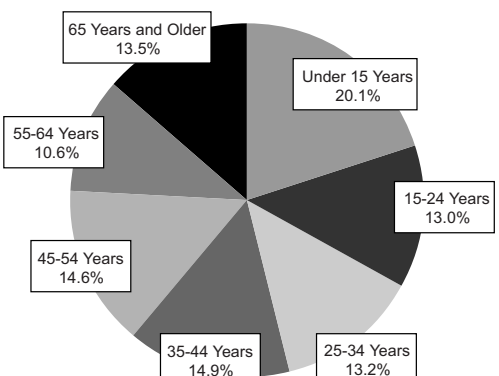
U.S. POPULATION

In 2005, the total U.S. population was over 288 million, with females comprising 51 percent of that total. Females younger than age 35 years accounted for 46.3 percent of the female population, those aged 35–64 years accounted for 40.1 percent, and females age 65 years and older accounted for 13.5 percent.

The distribution by sex was fairly even across younger age groups; however, women accounted for a greater percentage of the older population than men. Of those in the 65 and older age group, 57.3 percent were women.

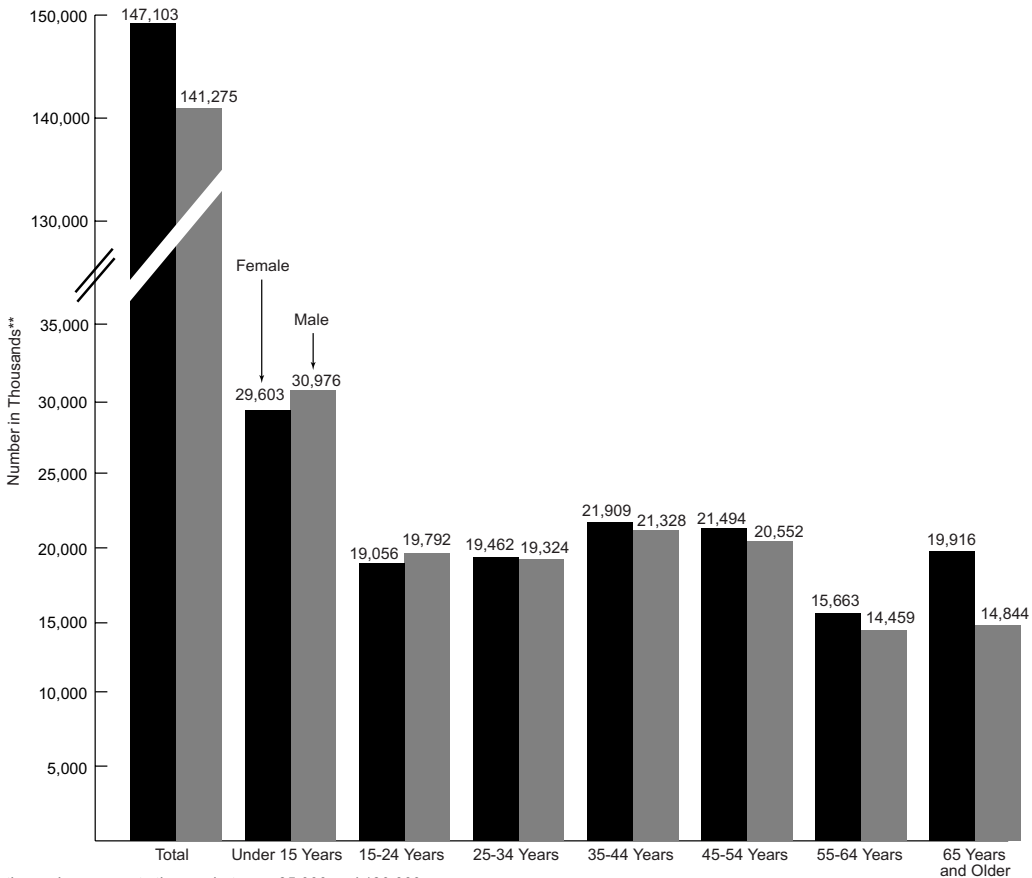
U.S. Female Population,* by Age, 2005

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



U.S. Population, by Age and Sex, in Thousands,* 2005

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



*Non-institutionalized population not living in group housing. **The break in the scale represents the gap between 35,000 and 130,000.

U.S. FEMALE POPULATION BY RACE/ETHNICITY

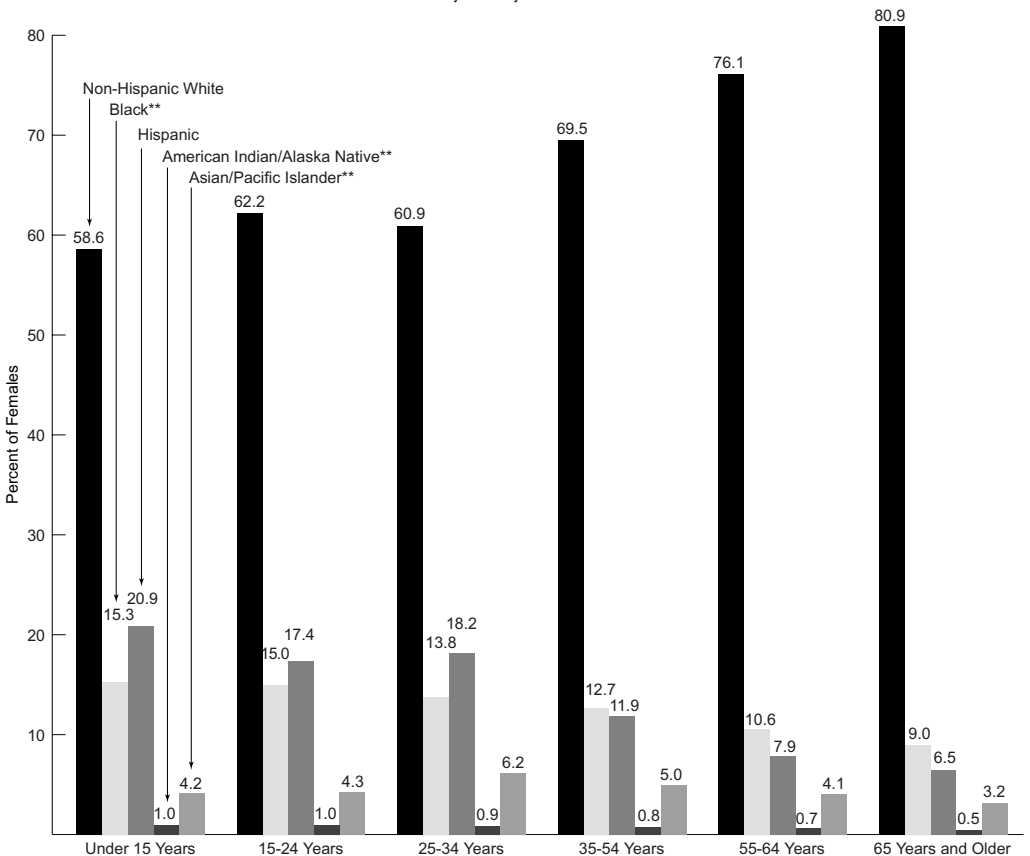
The growing diversity of the U.S. population is reflected by the racial and ethnic distribution of women across age groups. The younger female population (under 15 years) is significantly more diverse than the older female population. In 2005, 58.6 percent of females under 15 years were non-Hispanic White, while 20.9 percent of that group were Hispanic. Among women aged 65 years and older, in contrast, 80.9 percent were non-Hispanic White and only 6.5 percent were Hispanic. The distribution of the Black population was more consistent across age groups, ranging from 15.3 percent of females under 15 years to 9.0 percent of women aged 65 years and older.

Evidence indicates that race and ethnicity correlate with health disparities within the U.S. population. Coupled with the increasing diversity of the U.S. population, these health disparities make culturally-appropriate, community-driven programs critical to improving the health of the entire U.S. population.[1]

1 Centers for Disease Control and Prevention, Office of Minority Health. Disease burden and risk factors. April 4, 2006. http://www.cdc.gov/omh/AMH/dbrf.htm. Viewed 4/16/07.

U.S. Female Population,* by Age and Race/Ethnicity, 2005

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



**Non-institutionalized population not living in group housing; totals may not equal 100 percent—data is not shown for persons selecting "other or more than one race. **May include Hispanics.*

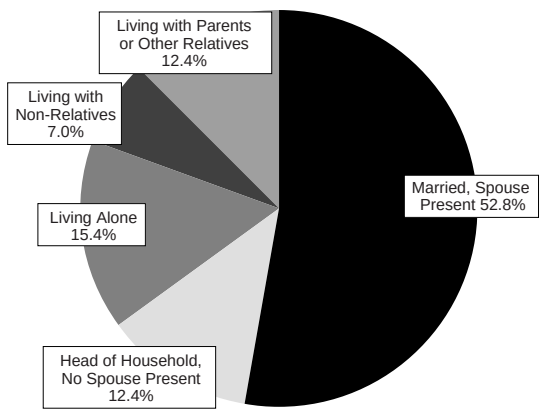
HOUSEHOLD COMPOSITION

In 2005, 52.8 percent of women aged 18 years and older were married and living with a spouse; this includes married couples living with other people, such as parents. Just over 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 house that they own or rent. Women who are heads of households include single mothers, single women with a parent or other close relative in their house, and women with other household compositions. The remaining women lived alone (15.4 percent), with parents or other relatives (12.4 percent), or with non-relatives (7.0 percent).

Women in households with no spouse present are more likely than women in married couple families to have incomes below the poverty level (see "Women and Poverty" on the next page). In 2005, Black women were most likely to be single heads of households (28.5 percent) while Asian women were least likely (7.0 percent). Hispanic women and women of other races were also more likely than non-Hispanic White and Asian women to be heads of households (16.7 and 17.1 percent, respectively).

Adult Women,* by Household Composition, 2005

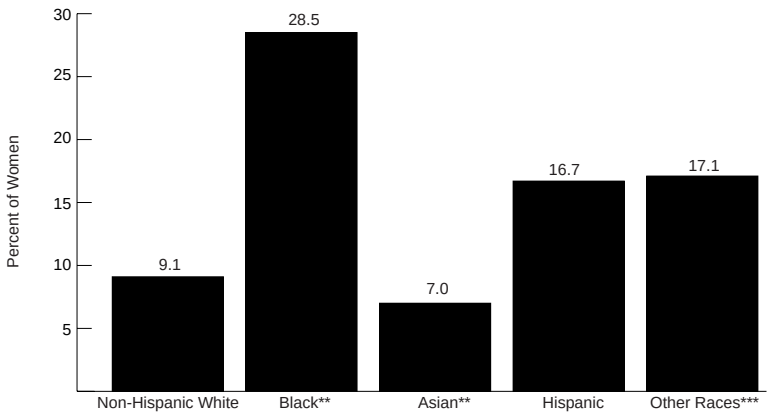
Source I.2: U.S. Census Bureau, Current Population Survey



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

Women Who Are Heads of Households,* by Race/Ethnicity, 2005

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



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

WOMEN AND POVERTY

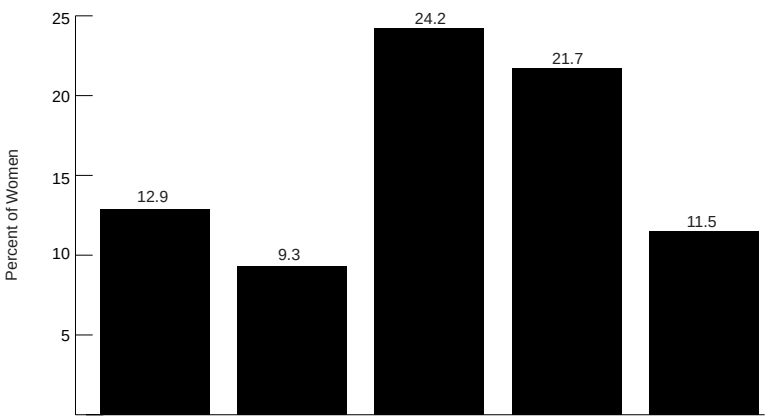
In 2005, nearly 37 million people in the United States lived with incomes below the poverty level.[1] The poverty rate for all women 18 years and older in 2005 was 12.9 percent (14.6 million women), compared to a rate of 8.9 percent for men. With regard to race and ethnicity, non-Hispanic White women were the least likely to experience poverty (9.3 percent), while Black women were the most likely (24.2 percent).

Women in families—a group of at least two people related by birth, marriage, or adoption and residing together—experience higher rates of poverty than men in families (9.6 versus 6.3 percent). Men in families with no spouse present were considerably less likely to be in a family that lived below the poverty level than women in families with no spouse present (11.3 versus 25.9 percent).

1 The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor. Examples of 2005 poverty levels were $9,973 for an individual, $12,755 for a family of two, $15,577 for a family of three, and $19,971 for a family of four. These levels differ from the Federal Poverty Level (FPL) used to determine eligibility for Federal programs.

Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity,** 2005

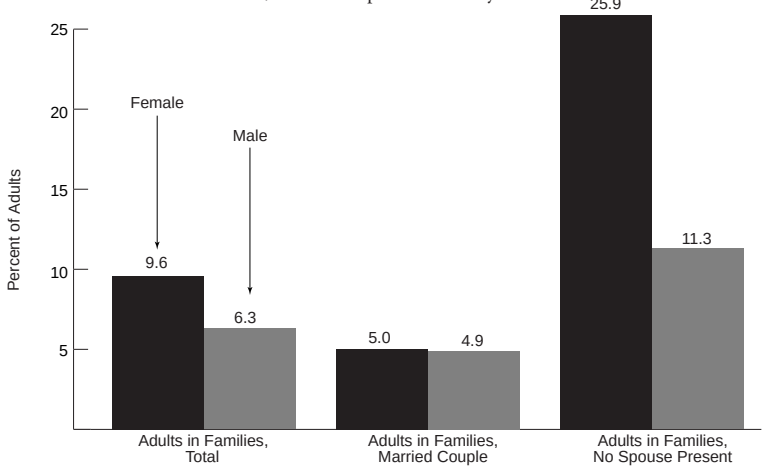
Source I.3: U.S. Census Bureau, Current Population Survey



**Poverty level defined by the U.S. Census Bureau was $19,971 for a family of four in 2005. **Data not reported for American Indian/Alaska Natives, Asian/Pacific Islanders and persons of more than one race. ***May include Hispanics.*

Adults in Families* Living Below the Poverty Level,** by Household Type and Sex, 2005

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



**Families are a group of at least two people related by birth, marriage, or adoption and residing together. **Poverty level defined by the U.S. Census Bureau was $19,971 for a family of four in 2005.*

EDUCATIONAL DEGREES AND INSTRUCTIONAL STAFF

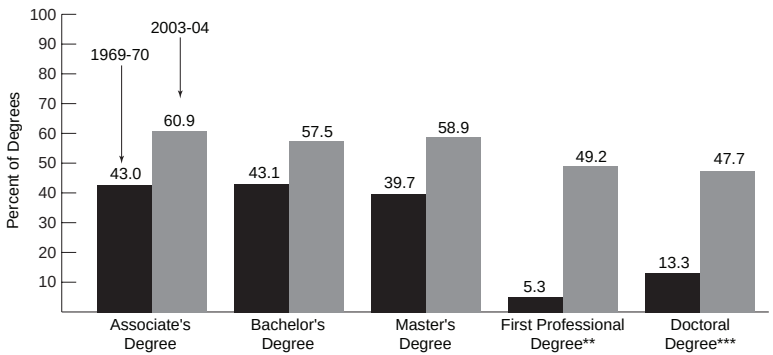
The number of post-secondary educational degrees awarded to women rose from just over half a million in the 1969–70 academic year to more than 1.6 million in 2003–04. Although the number of degrees earned by men has also increased, the rate of growth among women has been much faster; therefore, the proportion of degrees earned by women has risen dramatically. In 1969–70, men earned a majority of every type of postsecondary degree, while in 2003–04, women earned more than half of all associate's, bachelor's, and master's degrees and earned almost half of all first professional and doctoral degrees. The most significant increase has been in the proportion of first professional degree earners who are women, which jumped from 5.3 percent in 1969–70 to 49.2 percent in 2003–04. In 2003–04, the total number of women earning their first professional degree (40,872) was 22 times greater than in 1969–70 (1,841).

Although sex disparities in education have almost disappeared, there is still a disparity among instructional staff in degree-granting institutions. In fall 2003, only 39.4 percent of instructional staff were women.

Among female instructors, a significant racial and ethnic disparity exists as well: 80.1 percent of all female instructional staff were non-Hispanic White. This disparity is even more pronounced among higher-level staff, such as professors, where non-Hispanic White women composed 87.3 percent of full-time female staff, compared to 4.9 percent for non-Hispanic Black women and 2.4 percent for Hispanic women.

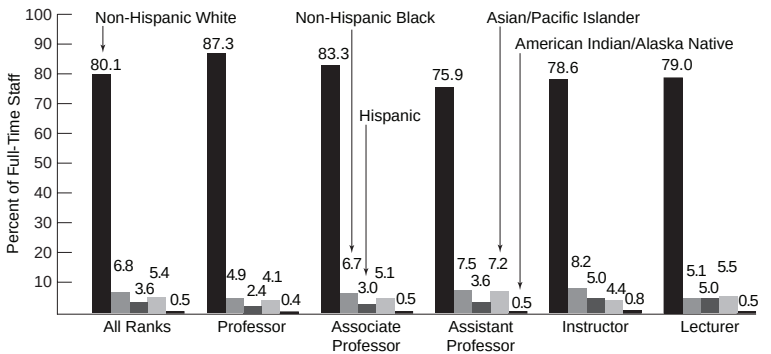
Degrees Awarded to Women,* by Type, 1969-70 and 2003-04

Source I.4: U.S. Department of Education, Digest of Education Statistics



Full-Time Female Instructional Staff in Degree-Granting Institutions, by Academic Rank and Race/Ethnicity, Fall 2003

Source I.4: U.S. Department of Education, Digest of Education Statistics



*Remaining percentage of degrees are those earned by men. **Includes fields of dentistry (D.D.S. or D.M.D.), medicine (M.D.), optometry (O.D.), osteopathic medicine (D.O.), pharmacy (D.Phar.), podiatry (D.P.M.), veterinary medicine (D.V.M.), chiropractic (D.C. or D.C.M.), law (LL.B. or J.D.), and theological professions (M.Div. or M.H.L.) ***Includes Doctor of Philosophy degree (Ph.D.) as well as degrees awarded for fulfilling specialized requirements in professional fields such as education (Ed.D.), musical arts (D.M.A.), business administration (D.B.A.), and engineering (D.Eng. or D.E.S.). First-professional degrees, such as M.D. and D.D.S., are not included under this heading.

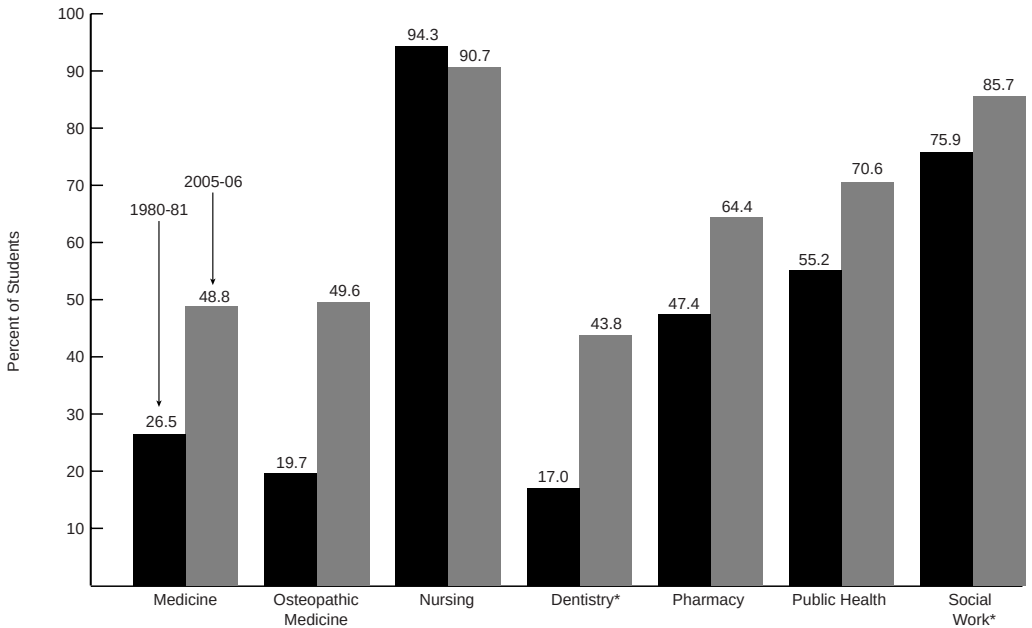
WOMEN IN HEALTH PROFESSION SCHOOLS

The health professions have long been characterized by gender disparities. Some professions, such as medicine and dentistry, have historically been dominated by males, while others, such as nursing, have been predominantly female. Over the past several decades, these gaps have narrowed, and in some cases reversed. In 1980–81, 47.4 percent of pharmacy students were women, while in the fall of 2005, women represented more than 64 percent of pharmacy students. Even in fields where men are still the majority, the representation of female students has grown. In 1980–81, only 26.5 percent of medical students were women compared to nearly one-half (48.8 percent) of students in the fall of 2005. Similar gains have been made in the fields of osteopathic medicine and dentistry, where the most recent data indicate that 49.6 and 43.8 percent of students, respectively, were women compared to only 19.7 and 17.0 percent in 1980–81.

During the 2005–06 academic year, female students represented a growing majority in graduate schools of public health (70.6 percent). Similarly, the most recent data for social work programs indicate that 85.7 percent of enrolled students were female. Nursing, at both the undergraduate and graduate levels, also continues to be dominated by women, although the proportion of students who are female is slowly declining. In the 1980–81 academic year, 94.3 percent of nursing students were female, while in the fall of 2005, females represented 90.7 percent of graduate students in nursing programs. Women also represent a majority of students studying optometry (63.1 percent), physical therapy (73.0 percent in 2004), and dietetics (90.8 percent; data not shown). Comparative data for these programs are not available for the 1980–81 academic year.

Women in Schools for Selected Health Professions, 1980-81 and 2005-06

Source I.5: Professional Associations



*Most recent data for dentistry and social work are from the 2004-05 school year.

WOMEN IN THE LABOR FORCE

In 2006, 59.4 percent of women aged 16 and older were in the labor force (either employed or unemployed and actively seeking employment). This represents a 37 percent increase from the 43.3 percent of women who were in the labor force in 1970. Females aged 16 and older made up 46.3 percent of the total workforce in 2006. Among working females, 75.3 percent worked full-time compared to 89.4 percent of males.[1]

The representation of females in the labor force varies greatly by occupational sector. In 2005, women composed 63 percent of sales and office workers, but only 3.6 percent of construction, extraction, maintenance, and repair workers. Other positions which were more commonly held by women than men include service jobs (56.6 percent) and management, professional, and related jobs (50.7 percent). Women were the minority in production, transportation, and material moving (23.1 percent); farming, fishing, and forestry (20.4 percent); and in the military (14.6 percent).

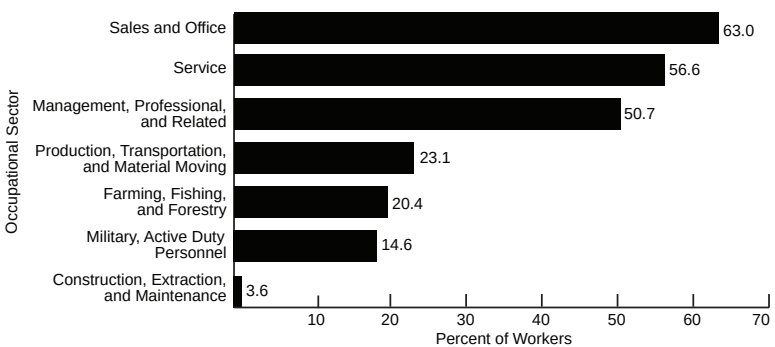
Earnings by women and men also vary greatly. Women represent a majority of earners making less than $25,000 per year. Of earners making less than $2,500 per year, 58.5 percent were women in 2005; however, women represented only 20.2 percent of earners making $100,000 or more per year. The difference between women's and men's earnings is larger among older than younger workers. For instance, women aged 45–54 made 75 cents for every dollar earned by males, while women aged 16–24 earned 93 cents for every dollar earned by males of the same age.[2]

1 U.S. Department of Labor, Bureau of Labor Statistics, Bureau of Labor Statistics Data. http://data.bls.gov. Viewed 4/18/07.

2 U.S. Department of Labor, Bureau of Labor Statistics, Highlights of Women's Earnings in 2005, Report 995, Table 1. Median usual weekly earnings of full-time wage and salary workers by selected characteristics, 2005 annual averages. September 2006. http://www.bls.gov/cps/cpswom2005.pdf. Viewed 4/18/07.

Representation of Females Aged 16 and Older in Occupational Sectors, 2005

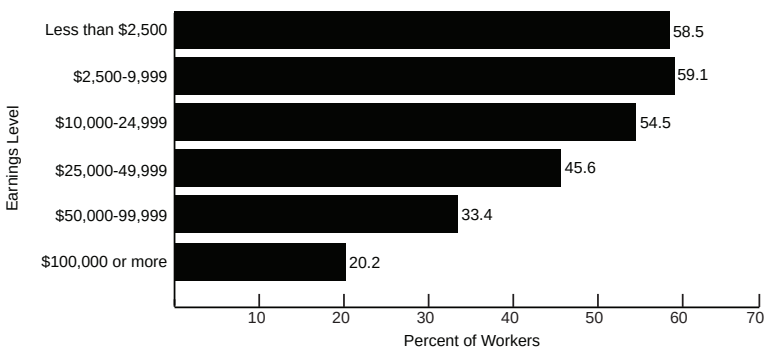
Sources I.1, I.6: U.S. Census Bureau, American Community Survey; U.S. Department of Defense*



**Military enlistment data from U.S. Department of Defense, FY 2005; all other from U.S. Census Bureau.*

Representation of Females Aged 16 and Older in Annual Earnings Levels, 2005

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



FOOD SECURITY

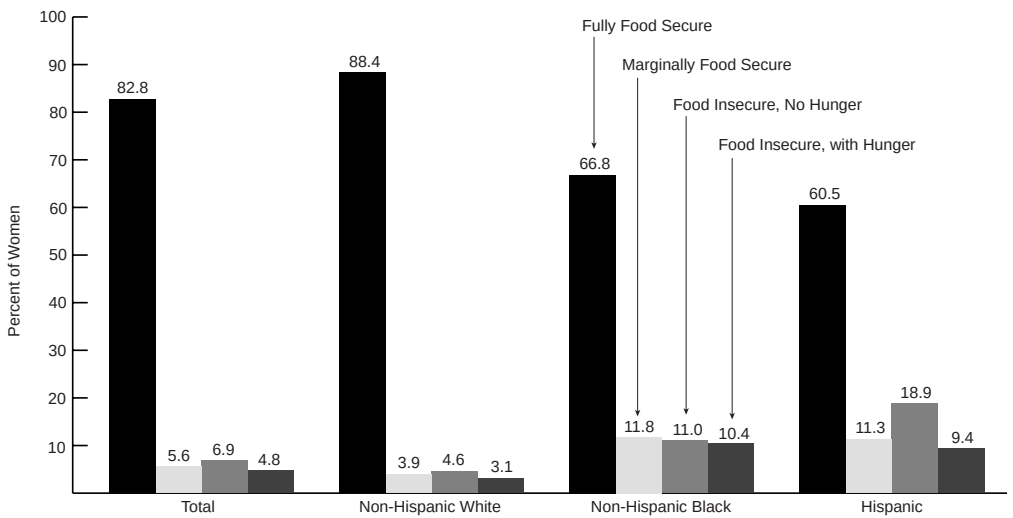
Food security is defined as having access at all times to enough nutritionally adequate and safe foods to lead a healthy, active lifestyle. Food security and hunger are measured in the National Health and Nutrition Examination Survey (NHANES) through a series of questions including whether the respondent worried that food would run out before there would be money to buy more; whether the respondent or his/her family could not afford to eat balanced meals; whether the respondent or his/her family cut the size of meals or skipped meals because there was not enough money for food; and whether the respondent or his/her family ever went for a whole day without eating because there was not enough food. For many of these questions, respondents were asked how often these situations arose. Cases with occasional or episodic food insecurity and/or hunger were more frequently reported than those with chronic situations; however, any degree of food insecurity places the members of a household at greater nutritional risk due to insufficient access to nutritionally adequate and safe foods.

In 2003–04, over 17 percent of women were not fully food secure, and this varied noticeably by race and ethnicity. Among women, non-Hispanic Whites were most likely to be fully food secure (88.4 percent), while Hispanics were least likely (60.5 percent). Hispanic women also had the highest rate of food insecurity without hunger (18.9 percent). Non-Hispanic Black and Hispanic women had similarly high rates of being marginally food secure (11.8 and 11.3 percent) and food insecure with hunger (10.4 and 9.4 percent, respectively).

While nearly 83 percent of women are fully food secure, only 61.5 percent of women with family incomes below the Federal poverty level (FPL) and 71.0 percent of women with incomes of 100–199 percent of the FPL were fully food secure in 2003–04. Comparatively, nearly 99 percent of women with family incomes of 400 percent or more of the FPL were fully food secure (data not shown).

Food Security Among Women 18 Years and Older, by Race/Ethnicity,* 2003-04

Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



The sample of American Indian/Alaska Natives, Asian/Pacific Islanders and persons of more than one race were too small to produce reliable estimates.

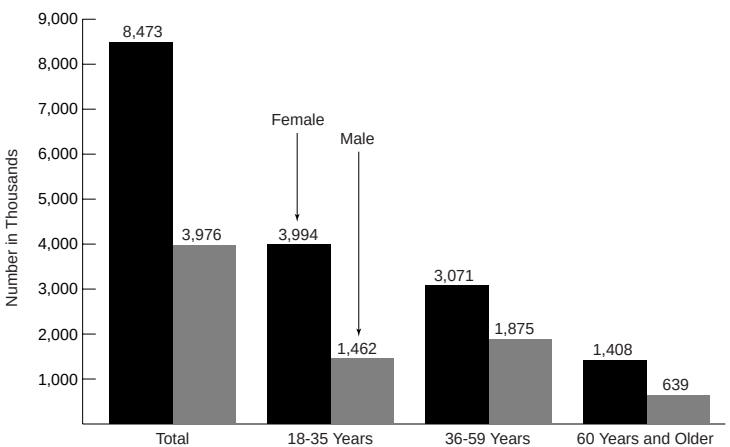
WOMEN AND FEDERAL NUTRITION PROGRAMS

Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Federal Food Stamp Program helps low-income individuals purchase food. In 2005, nearly 12.5 million adults participated in the Food Stamp Program; of these, almost 8.5 million (68 percent) were women. Of these women, nearly 4 million (almost half) were in the 18–35 age group. Female-headed households with children make up nearly one-third of households that rely on food stamps, and represent nearly 60 percent of food stamp households with children (data not shown).

The Supplemental Food 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. Most WIC participants are infants and children (75 percent); however, the program also serves nearly 2 million pregnant women and mothers, representing 25 percent of WIC participants. During the years 1992–2005, the number of women participating in WIC increased by 60 percent, and it continues to rise.

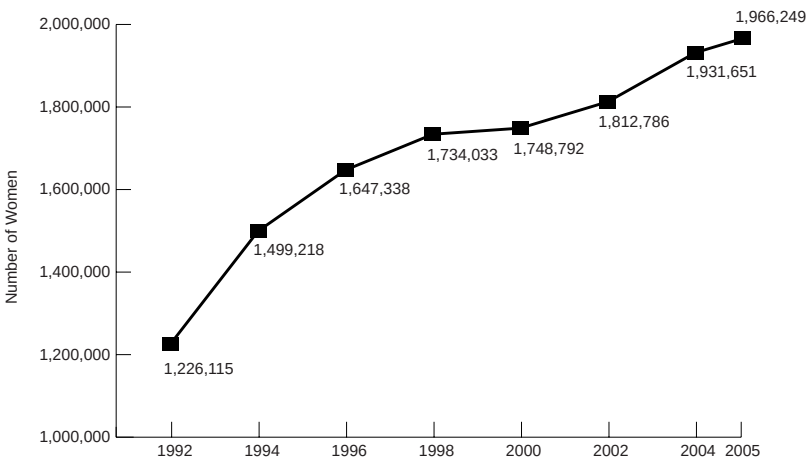
Adult Recipients of Food Stamps, by Age and Sex, 2005

Source I.8: U.S. Department of Agriculture, Food Stamp Quality Control Sample



Women Participating in WIC,* Selected Years, 1992-2005

Source I.9: 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.*

HEALTH STATUS

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

In the following section, health status indicators related to morbidity, mortality, health behaviors, and maternal health are presented. New topics include gynecological and reproductive disorders, sleep disorders, autoimmune diseases, and maternal morbidity. The data are displayed by sex, age, and race and ethnicity, where feasible. Many of the conditions discussed, such as cancer, heart disease, hypertension, and stroke, have an important genetic component. Although the full impact of genetic risk factors on such conditions is still being studied, it is vital for women to be aware of their family history so that their risk for developing such conditions can be properly assessed.

LIFE EXPECTANCY

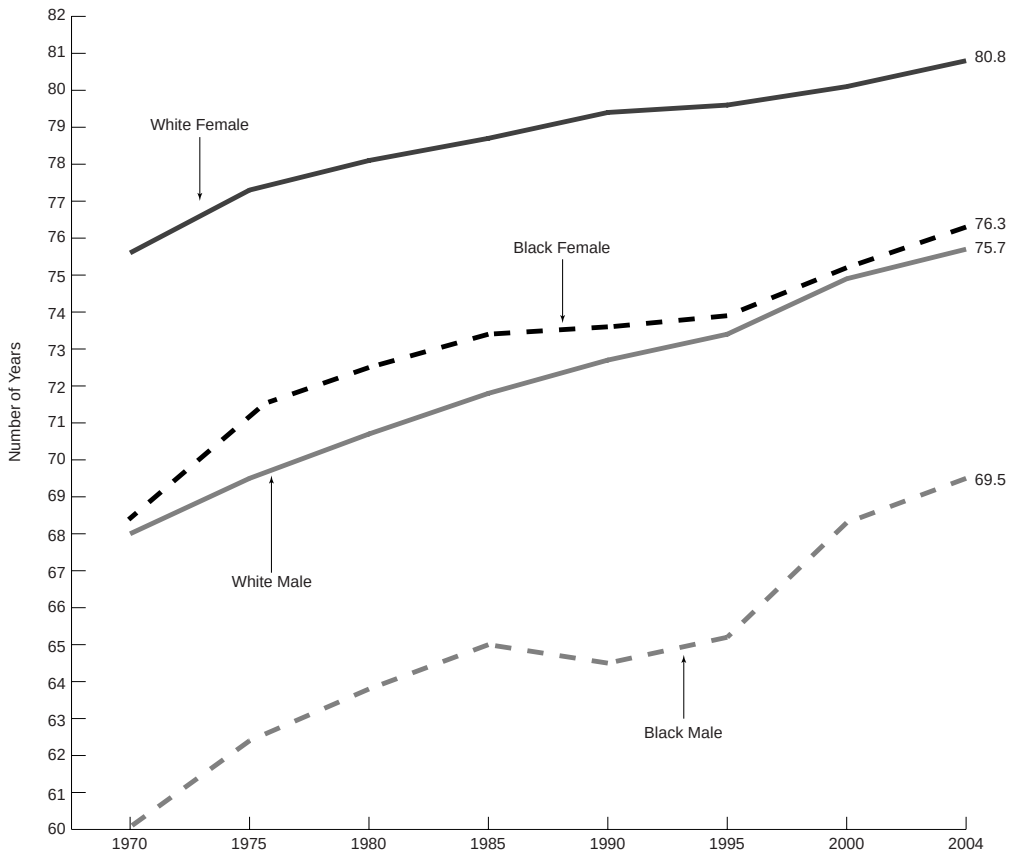
A baby girl born in the United States in 2004 could expect to live 80.4 years, 5.2 years longer than her male counterpart, whose life expectancy would be 75.2 years. The life expectancy at birth for White females was 80.8 years; for Black females, the life expectancy at birth was 76.3 years. The differential between male and female life expectancy was greater among Blacks than Whites; Black males could expect to live 69.5 years, 6.8 years fewer than Black females, while the difference between White males and females was 5.1 years. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates.

Life expectancy has steadily increased since 1970 for males and females in both racial groups. Between 1970 and 2004, White males' life expectancy increased from 68.0 to 75.7 years (11.3 percent), while White females' life expectancy increased from 75.6 to 80.8 years (6.9 percent). Black males' life expectancy increased from 60.0 to 69.5 years (15.8 percent) during the same period, while Black females' life expectancy increased from 68.3 to 76.3 years (11.7 percent).

Life expectancy data have not been reported for American Indian/Alaska Natives, Asian Pacific Islanders, Hispanics alone, and persons of more than one race.

Life Expectancy at Birth, by Race* and Sex, 1970-2004

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



*Data presented may include Hispanics.

PHYSICAL ACTIVITY

Regular physical activity promotes health, psychological well-being, and a healthy body weight. To reduce the risk of chronic disease, the *Dietary Guidelines for Americans, 2005* recommends engaging in at least 30 minutes of moderate-intensity physical activity on most days of the week for adults. To prevent weight gain over time, the Guidelines recommend about 60 minutes of moderate to vigorous physical activity on most days while not exceeding caloric intake requirements.[1]

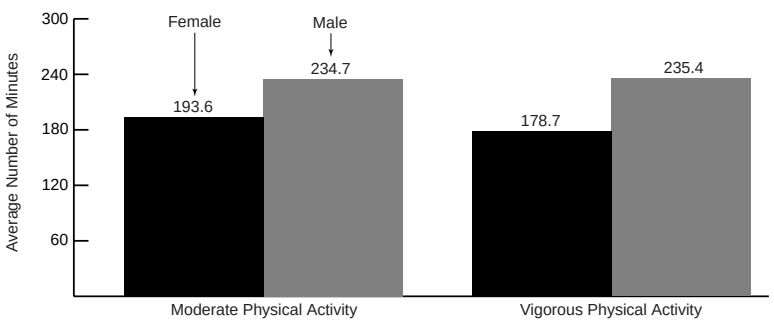
In 2005, only 50.9 percent of women reported engaging in at least 10 minutes of moderate leisure-time physical activity per week, and 32.0 percent reported at least 10 minutes of vigorous activity. Among those reporting any physical activity in the last week, men were more likely to engage in at least 10 minutes of vigorous activity (41.8 percent) and, overall, participated in physical activity for a greater average number of minutes than women. While men reported an average of 235 minutes of moderate or vigorous physical activity per week, women reported spending an average of 194 and 179 minutes, respectively.

The percentage of women reporting at least 10 minutes of physical activity in the past week varied with age. Younger women were much more likely to participate in both moderate and vigorous activity than older women. For instance, more than 50 percent of women under the age of 65 participated in at least 10 minutes of moderate physical activity, compared to only 36 percent of women 75 years and older. The difference is greater when comparing vigorous physical activity: 40.1 percent of women 18–44 versus 8.9 percent of women 75 years and older report at least 10 minutes of vigorous activity.

1 U.S. Department of Health and Human Services; U.S. Department of Agriculture. Dietary Guidelines for Americans 2005. Washington, DC: U.S. Government Printing Office, January 2005.

Average Minutes of Physical Activity per Week Among Adults Aged 18 and Older,* by Sex and Level,** 2005

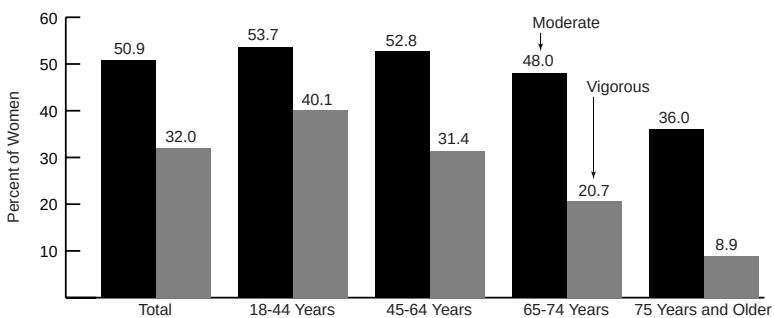
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Among adults who were physically active at least 10 minutes in the week prior to the survey. **Moderate is defined as causing light sweating and/or a slight to moderate increase in breathing or heart rate; vigorous is defined as causing heavy sweating and/or large increases in breathing or heart rate.*

Women Aged 18 and Older Participating in Physical Activity,* by Age and Level,** 2005

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



**Participants reported being physically active at least 10 minutes in the week prior to the survey. **Moderate is defined as causing light sweating and/or a slight to moderate increase in breathing or heart rate; vigorous is defined as causing heavy sweating and/or large increases in breathing or heart rate.*

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]

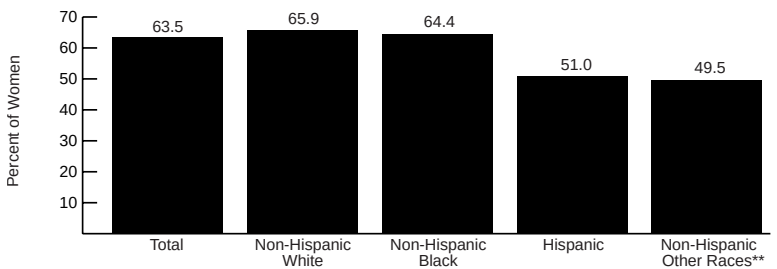
Some fats, mostly those that come from sources of polyunsaturated or monounsaturated fatty acids, such as fish, nuts, and vegetable oils, are an important part of a healthy diet. However, high intake of saturated fats, *trans* fats, and cholesterol may increase the risk of coronary heart disease. Most Americans should consume fewer than 10 percent of calories from saturated fats, less than 300 mg/day of cholesterol, and keep *trans* fatty acid consumption to a minimum. In 2003–04, 63.5 percent of women exceeded the recommended maximum daily intake of saturated fat—most commonly non-Hispanic White women and non-Hispanic Black women (65.9 and 64.4 percent, respectively). Salt, or sodium chloride, also plays an important role in heart health, as high salt intake can contribute to high blood pressure. Almost 70 percent of women exceed the recommended intake of less than 2,300 mg/day of sodium (about 1 teaspoon of salt).

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. The Healthy People 2010 objective for red blood cell (RBC) folate concentration is 220 ng/mL. Non-pregnant women aged 15–44 have met this goal, but average RBC folate levels fell from 260 ng/mL in 2001–02 to 235 ng/mL in 2003–04, representing a decrease of almost 10 percent. The largest decline was among non-Hispanic White women (16 percent), but rates among non-Hispanic Black and Mexican American women also dropped.

1 U.S. Department of Health and Human Services; U.S. Department of Agriculture. Dietary Guidelines for Americans 2005. Washington, DC: U.S. Government Printing Office, January 2005.

Women Exceeding the Recommended Maximum Daily Intake of Saturated Fat,* by Race/Ethnicity, 2003-04

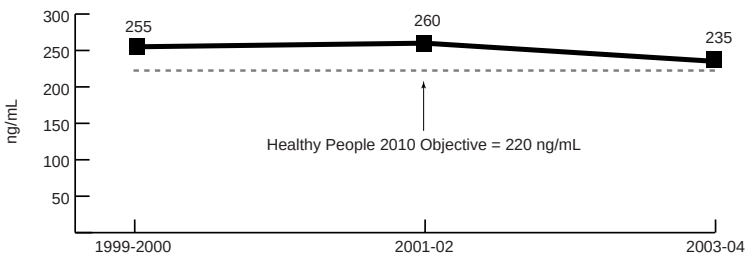
Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Recommended daily intake of saturated fat is 10 percent of daily caloric intake or less. **Includes American Indian/Alaska Natives, Asian/Pacific Islanders, and persons of more than one race.*

Red Blood Cell (RBC) Folate Concentration Among Non-Pregnant Women Aged 15-44, 1999-2004

Source II.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body. Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impairs genes that control the growth of cells, and binds to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[1]

In 2005, over 60 million people in the United States aged 12 and older smoked cigarettes within the past month. Smoking was less common among females aged 12 and older (22.5 percent) than among males of the same age group (27.4 percent). The rate has declined over the past several decades among both sexes. In 1985, the rate among males was 43.4, percent while the rate among females was 34.5 percent.

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[1] In 2005, over 42 percent of smokers reported trying to quit at least once in the past year. Females were more likely than males to try to quit smoking (44.8 versus 40.7 percent). Among both males and females, non-Hispanic Blacks were the most likely to attempt to quit (48.4 and 49.6 percent, respectively).

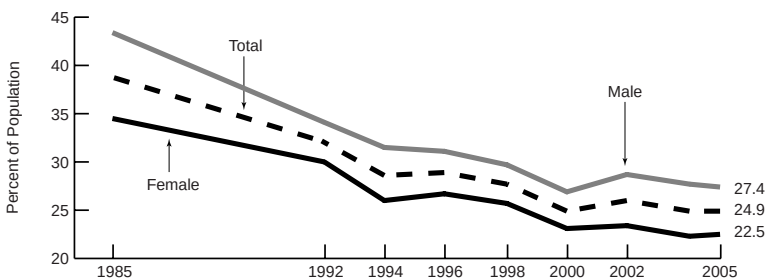
Smoking during pregnancy can have a negative impact on the health of infants and children by increasing the risk of complications during pregnancy, premature delivery, and low birth weight—a leading cause of infant mortality.[1]

According to the National Survey on Drug Use and Health, 16.6 percent of pregnant women aged 15–44 smoked in 2004–05; however, this varied by race and ethnicity. Non-Hispanic White women (21.5 percent) were more likely to smoke during pregnancy than women of other races. Hispanic women were least likely to smoke during pregnancy (7.2 percent), while 15 percent of non-Hispanic Black women did so.

1 U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. 2004.

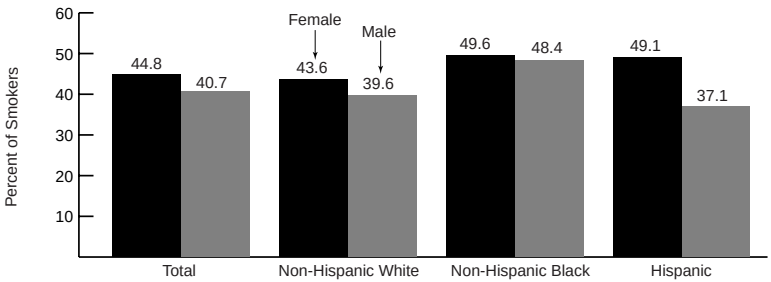
Persons Aged 12 and Older Reporting Past Month Cigarette Use, by Sex, 1985-2005

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



Adults Aged 18 and Older Who Tried to Quit Smoking in the Past Year, by Sex and Race/Ethnicity,* 2005

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



**The sample of American Indian/Alaska Natives, Asian/Pacific Islanders, and persons of more than one race was too small to produce reliable estimates.*

ALCOHOL USE

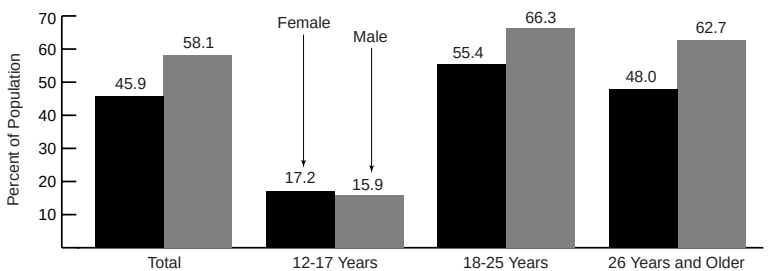
In 2005, 51.8 percent of the total U.S. population aged 12 and older reported using alcohol in the past month; among those aged 18 and older, the rate was 55.9 percent (data not shown). According to the Centers for Disease Control and Prevention, alcohol is a central nervous system depressant that, in 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. Short-term effects can include increased risk of motor vehicle injuries, falls, domestic violence, and child abuse. Long-term effects can include pancreatitis, high blood pressure, liver cirrhosis, various cancers, and psychological disorders including dependency.

Overall, males are more likely to drink alcohol than females with past-month alcohol use reported by 58.1 percent of males and 45.9 percent of females aged 12 years and older. This is true across all age groups with the exception of 12- to 17-year-olds; in that group, 17.2 percent of females and 15.9 percent of males reported past-month use. Males are also more likely than females to engage in binge drinking, which is defined as drinking five or more drinks on the same occasion at least once in the past month (30.5 versus 15.2 percent), and heavy drinking, which is defined as five or more drinks on the same occasion at least five times in the past month (10.3 versus 3.1 percent).

Alcohol use during pregnancy can be a special concern for women of childbearing age. Drinking alcohol during pregnancy can contribute to Fetal Alcohol Syndrome (FAS), low birth weight in infants, and developmental delays. In 2004–05, 12.1 percent of pregnant women reported drinking alcohol in the past month. This was most common in the 15–17 and 26–44 year age groups (13.9 and 13.5 percent, respectively) and least common among those in the 18–25 year age group (9.7 percent; data not shown).

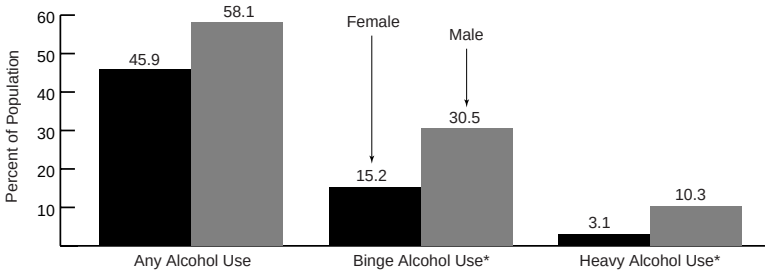
Past Month Alcohol Use, by Sex and Age, 2005

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



Past Month Alcohol Use Among Those Aged 12 and Older, by Type and Sex, 2005

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



**Binge alcohol use is defined as drinking 5 or more drinks on the same occasion on at least 1 day in the past 30 days. Heavy alcohol use is defined as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users.*

ILLICIT DRUG USE

Illicit drugs are associated with serious health and social consequences, such as addiction. Illicit drugs include marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes. In 2005, nearly 12.7 million women aged 18 years and older reported using an illicit drug within the past year; this represents 11.2 percent of women. The past-year illicit drug use rate was significantly higher among women aged 18–25 years than among women 26 years and older (30.1 versus 8.1 percent). Among adolescent females aged 12–17 years, 20.0 percent reported using illicit drugs in the past year.

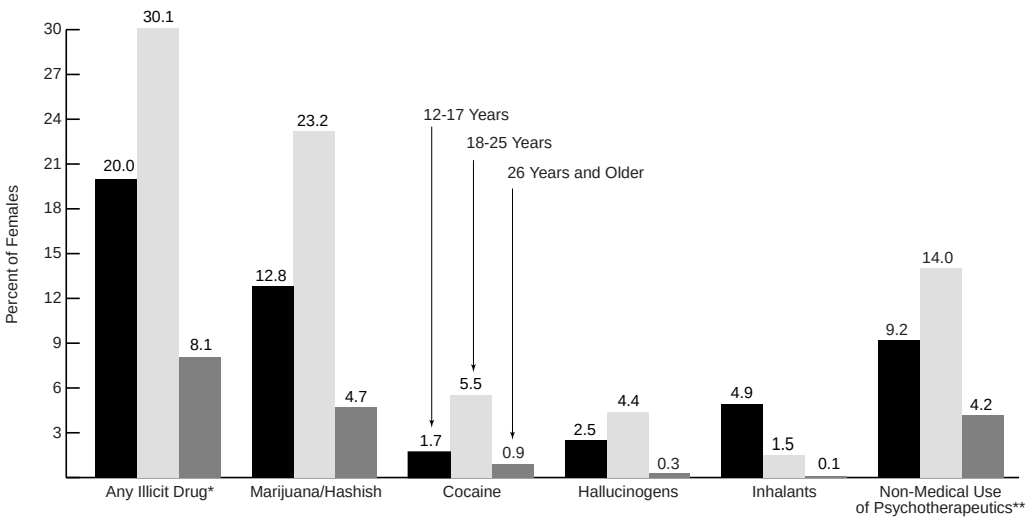
In 2005, marijuana was the most commonly used illicit drug among females in each age group, followed by the non-medical use of prescription-type psychotherapeutic drugs. Use of both categories of drugs was highest among females aged 18–25 (23.2 and 14.0 percent, respectively).

Methamphetamine is a stimulant with a high potential for abuse, and use can result in decreased appetite, increased respiration and blood pressure, rapid heart rate, irregular heartbeat, and hyperthermia. Long-term effects can include paranoia, anorexia, delusions, and hallucinations.[1] While limited data exist on adult methamphetamine use, the Monitoring the Future Survey has tracked use among students since 1999. In 2006, 1.8 percent of 8th and 10th graders and 2.5 percent of 12th graders reported using methamphetamine in the past year (data not shown).[2]

According to the National Survey on Drug Use and Health's 2004–05 estimates, 3.9 percent of pregnant women reported using illicit drugs in the past month. Among pregnant 15- to 17-year-olds, 12.3 percent, or 1 in 8, reported past month illicit drug use. Women 18 and older were less likely to report illicit drug use during pregnancy: the rate was 7.0 percent among 18- to 25-year-olds, and 1.6 percent among those aged 26–44 years (data not shown).

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2005

Source II.4: 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.

1 *National Institutes of Health, National Institute on Drug Abuse. InfoFacts: Methamphetamine. March 2007. www.nida.nih.gov/Infofacts/methamphetamine.html. Viewed 4/18/07.*

2 *Johnston, LD, O'Malley, PM, Bachman, JG, & Schulenberg, JE. Monitoring the Future national results on adolescent drug use: Overview of key findings, 2006. [NIH Publication No. 07-6202] Bethesda, MD: National Institute on Drug Abuse, 2007. http://www.monitoringthefuture.org. Viewed 5/31/07.*

SELF-REPORTED HEALTH STATUS

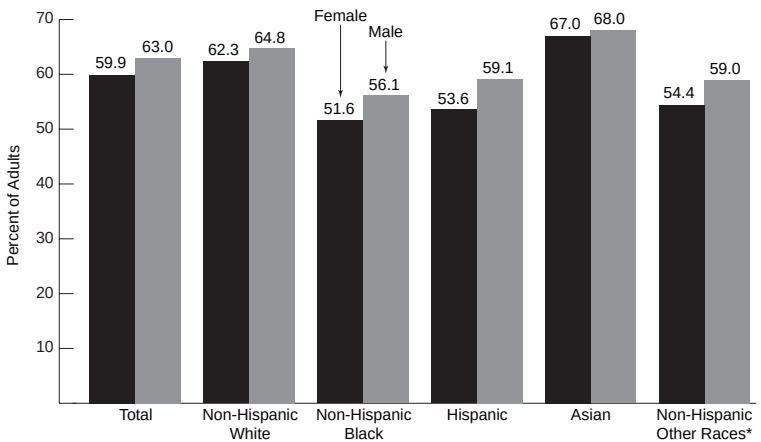
In 2005, men were more likely than women to report being in excellent or very good health (63.0 versus 59.9 percent); this was true in every racial and ethnic group. Among both sexes, Asians most often reported that they were in excellent or very good health, followed by non-Hispanic Whites; non-Hispanic Blacks were the least likely to report themselves to be in excellent or very good health.

Self-reported health status declines with age: 70.9 percent of women aged 18–44 years reported excellent or very good health status, compared to 55.6 percent of those aged 45–64 years, 41.5 percent of those aged 65–74 years, and 32.7 percent of those aged 75 years or more. Among those in the oldest age group, 30.7 percent reported fair or poor health, compared to only 6.2 percent of those in the youngest age group.

The rate of women reporting excellent or very good health also varies with income (data not shown). Among women with family incomes at 300 percent or more of the Federal poverty level (FPL), 73 percent reported excellent or very good health compared to 42 percent of those with family incomes below 100 percent of the FPL.

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Sex and Race/Ethnicity, 2005

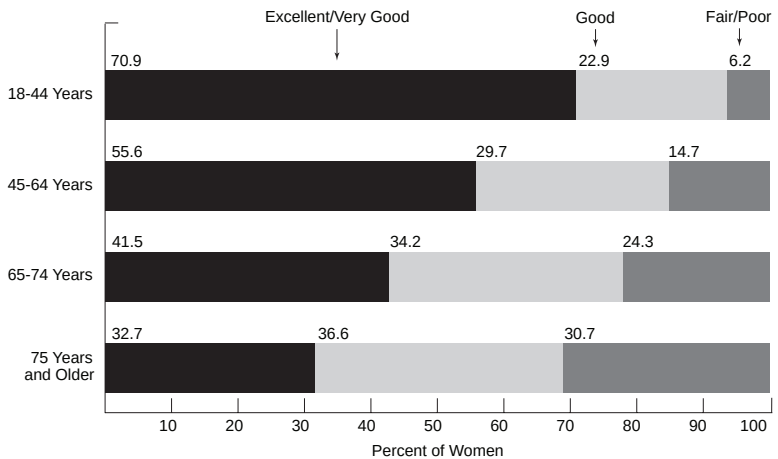
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Includes American Indian/Alaska Natives and persons of more than one race.

Self-Reported Health Status of Women Aged 18 and Older, by Age, 2005

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



HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the final stage of the human immunodeficiency virus (HIV), which destroys or disables the cells that are responsible for fighting infection. AIDS is diagnosed when HIV has weakened the immune system enough that the body has a difficult time fighting infections.[1] In 2005, there were an estimated 10,774 new AIDS cases among adolescent and adult females, compared to 29,766 new cases among males of the same age groups. Men have been disproportionately affected by AIDS, but the rate among women is increasing at a faster pace; since 2001, new AIDS cases have increased by 7.2 percent among females compared to a 6.7 percent increase among males.

In 2005, females accounted for 27.1 percent of all adolescents and adults living with HIV/AIDS[2] and 21.5 percent of enrollees in the AIDS Drug Assistance Program (ADAP), a Federal program providing medications for treatment of HIV disease to those who do not have adequate health insurance or other financial resources. Most are enrolled in ADAP only while they await acceptance into an insurance program such as Medicaid.[3] ADAP is funded through Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program). In December 2006, the Act was reauthorized for 3 years to provide funding for a range of programs serving people with HIV/AIDS.

HIV/AIDS disproportionately affects minorities: in 2005, 64.1 percent of adolescent and adult females living with HIV/AIDS were non-Hispanic Black. In 2004, HIV/AIDS was the leading cause of death among non-Hispanic Black women aged 25–34.[4]

1 Centers for Disease Control and Prevention. HIV/AIDS Basic Information. Available from: http://www.cdc.gov/hiv/topics/basic/index.htm. Viewed 8/15/07.

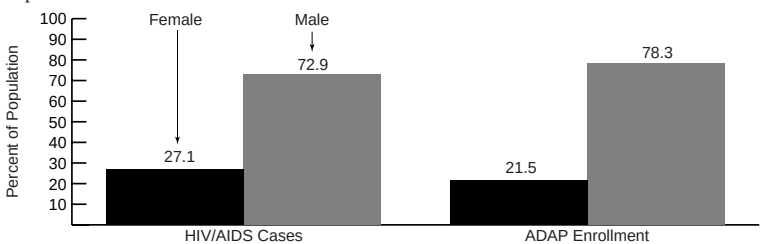
2 Includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS, in 33 States.

3 Health Resources and Services Administration, HIV/AIDS Bureau. ADAP Fact Sheet. Available from: http://hab.hrsa.gov/programs/factsheets/adap1.htm. Viewed 4/18/07.

4 Centers for Disease Control and Prevention. HIV/AIDS Fact Sheet, HIV/AIDS among Women. Rev ed. June 2007. Available from: http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf. Viewed 8/15/07.

Adolescents and Adults Living with HIV/AIDS* and AIDS Drug Assistance Program (ADAP) Enrollment,** by Sex, 2005

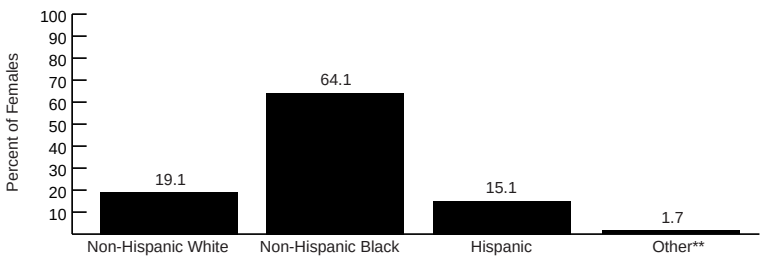
Source II.5, II.6: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report; Health Resources and Services Administration



**Includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS; estimates are based on 33 States with confidential name-based HIV reporting. **Data on HIV/AIDS cases are from CDC; ADAP data are from HRSA.*

Adolescent and Adult Females Living with HIV/AIDS,* by Race/Ethnicity, 2005

Source II.5: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



Includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS; estimates are based on 33 States with confidential name-based HIV reporting. Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and unknown.*

ACTIVITY LIMITATIONS AND DISABILITIES

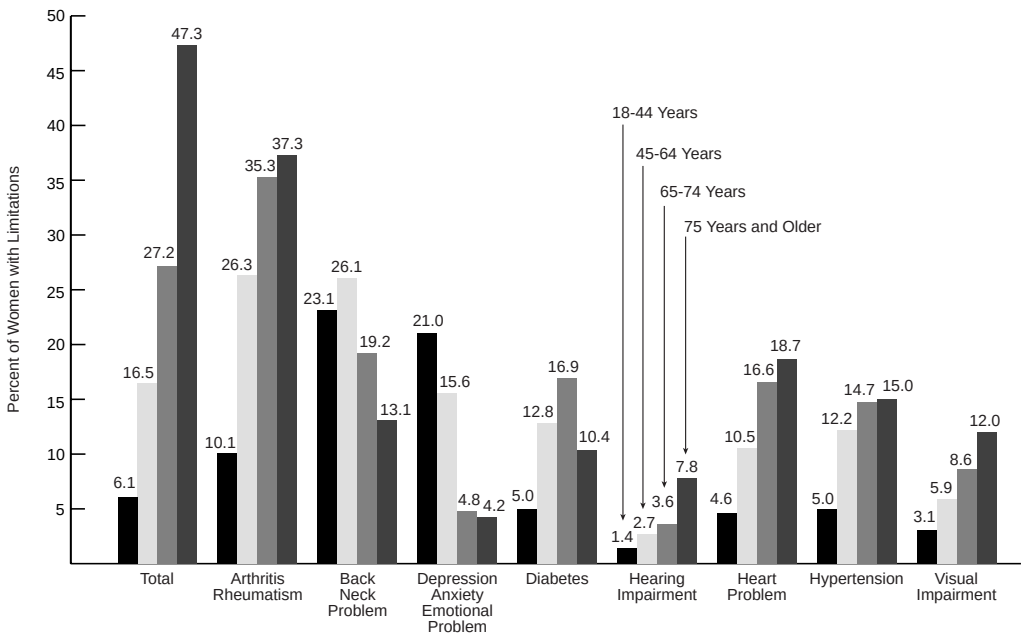
Although there are many different ways to define a disability, one common guideline is whether a person is able to perform common activities—such as walking up stairs, standing or sitting for several hours at a time, grasping small objects, or carrying items such as groceries—without assistance. In 2005, almost 14 percent of the U.S. population reported having at least one condition that limited their ability to perform one or more of these common activities. Women were more likely to report being limited in their activities than men (15.1 versus 12.5 percent).

Among women with at least one activity limitation, the conditions that caused specific activity limitations varied by age. Activity limitations caused by heart problems were most common among women over 75 years (18.7 percent), and least common among women under 45 years (4.6 percent). Older women were also more likely to report limitations due to arthritis: 37.3 percent of women 75 years or older and 35.3 percent of those aged 65–74 years. Conversely, limitations caused by depression, anxiety, or emotional problems were most common among women under 45 years (21.0 percent), and back or neck problems were most common among those aged 45–64 years (26.1 percent) followed by 18- to 44-year-olds (23.1 percent).

In 2005, the percentage of women reporting at least one activity limitation varied by race and ethnicity (data not shown). Non-Hispanic White and non-Hispanic Black women were most likely to report at least one limitation (16.1 percent), while Asians were least likely (4.9 percent). Eleven percent of Hispanic women reported at least one activity limitation.

Selected Conditions Causing Activity Limitations* in Women Aged 18 and Older with at Least One Limitation, by Age, 2005

Source II.2: 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.


uvex

ARTHRITIS

Arthritis, the leading cause of disability among Americans over 15 years of age, comprises more than 100 different diseases that affect areas in or around the joints.[1] 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. Other types of arthritis include rheumatoid arthritis, lupus arthritis, gout, and fibromyalgia.

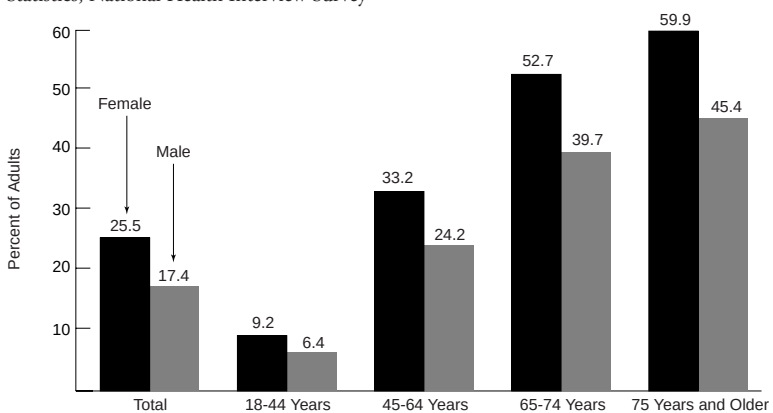
In 2005, over 21 percent of adults in the United States reported that they had ever been diagnosed with arthritis. Arthritis was more common in women than men (25.5 versus 17.4 percent), and rates of arthritis increased dramatically with age for both sexes. Fewer than 10 percent of women in the 18–44 year age group had been diagnosed with arthritis, compared to 52.7 percent among women aged 65–74 years, and almost 60 percent of women 75 years and older.

In 2005, the rate of arthritis among women varied by race and ethnicity. It was most common among non-Hispanic White women (282.1 per 1,000 women), followed by non-Hispanic Black women (243.3 per 1,000). The lowest rates of arthritis were among Asian and Hispanic women (124.4 and 144.2 per 1,000, respectively).

1 Arthritis Foundation. The facts about arthritis. 2004. http://www.arthritis.org. Viewed 4/18/07.

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2005

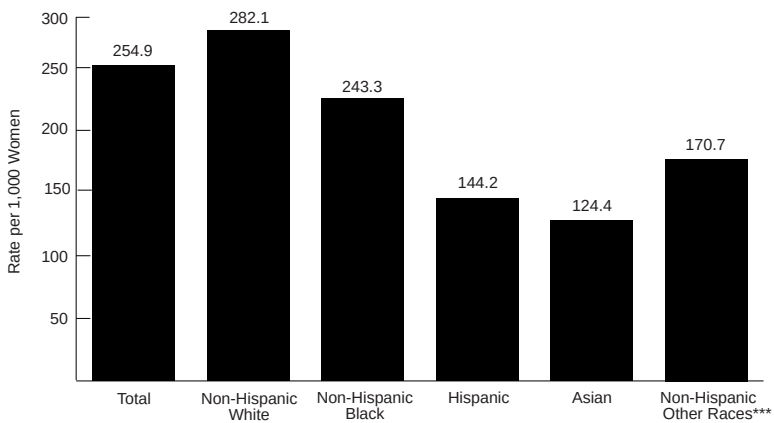
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity,** 2005

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



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

ASTHMA

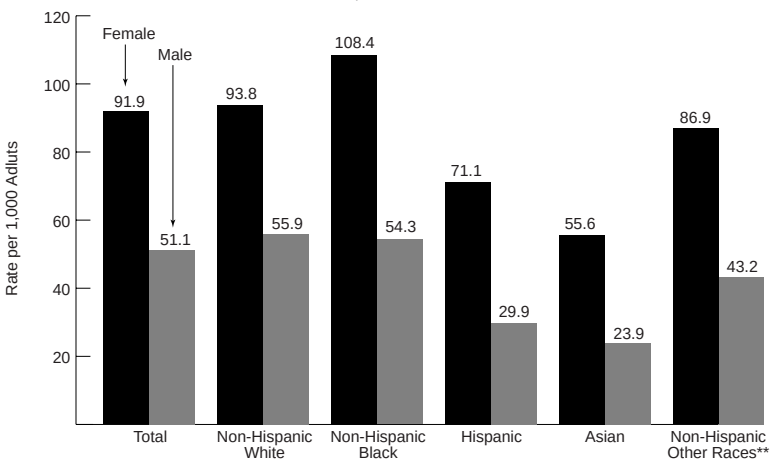
Asthma is a chronic inflammatory disorder of the airway characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. However, by taking certain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

In 2005, women had higher rates of asthma than men (91.9 per 1,000 women versus 51.1 per 1,000 men); this was true in every racial and ethnic group. Among women, non-Hispanic Black women had the highest asthma rate (108.4 per 1,000 women), followed by non-Hispanic White women (93.8 per 1,000); Asian women had the lowest asthma rate (55.6 per 1,000).

A visit to the emergency room due to asthma can be an indication that the asthma is not effectively controlled. In 2005, asthmatic women with lower family incomes were more likely than women with higher family incomes to have an emergency room visit due to asthma. Among women with family incomes below 100 percent of the Federal poverty level (FPL), 34.2 percent of those with asthma had visited the emergency room in the past year, compared to 19.2 percent of asthmatic women with family incomes of 300 percent or more of the FPL.

Adults Aged 18 and Older with Asthma,* by Sex and Race/Ethnicity, 2005

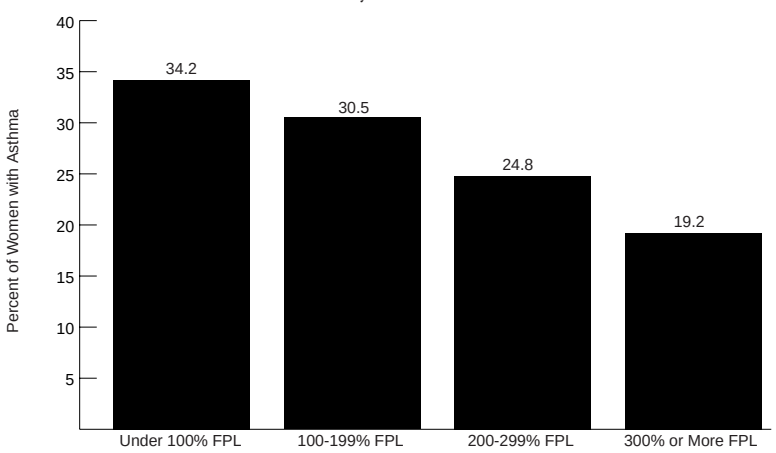
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that a health professional has ever told them they have asthma and report they still have asthma.
**Includes American Indian/Alaska Natives and persons of more than one race.

Women Aged 18 and Older with an Emergency Room Visit Due to Asthma in the Past Year, by Poverty Status,* 2005

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



*Federal poverty level (FPL) was equal to $19,350 for a family of four in 2005; this amount is determined annually by the U.S. Department of Health and Human Services.

AUTOIMMUNE DISEASES

Autoimmune diseases comprise more than 80 serious, chronic illnesses that can involve almost every human organ system. The common thread among these diseases is that the body's own immune system attacks itself. For largely unknown reasons, about 75 percent of autoimmune diseases occur in women, most frequently in women of childbearing age.

The most common autoimmune diseases include thyroid disease and systemic lupus erythematosus. Hashimoto's disease, or hypothyroiditis, is a disease in which the immune system destroys the thyroid, and it occurs in 10 women for every one man. Graves' disease, in which excessive amounts of thyroid hormone are produced, is another thyroid disease that occurs more frequently in women than men.

Lupus is an inflammation of the connective tissues that can affect multiple organ systems; it occurs in nine women for every one man. In addition to lupus, connective tissue diseases include rheumatoid arthritis, a disorder in which the membranes around joints become inflamed; Sjogren's Syndrome, in which patients slowly lose the ability to secrete saliva and tears; and scleroderma, which activates immune cells to produce scar tissue in the skin, internal organs and small blood vessels.

Multiple sclerosis, twice as common in women as in men, is a disease of the central nervous system characterized by numbness, weakness, tingling or paralysis of the limbs, impaired vision, and/or lack of coordination. Myasthenia Gravis also results in gradual muscle weakness. Antiphospholipid syndrome occurs when antibodies attack body tissues and organs and results in the formation of blood clots in arteries or veins. Autoimmune thrombocytopenic purpura is characterized by the failure of blood to clot as it should. Autoimmune hepatitis and primary biliary cirrhosis both cause the liver to become inflamed which can lead to cirrhosis, or scarring, of the liver and liver failure.

Autoimmune diseases are poorly understood and little comprehensive data exist. However, the LUMINA study has provided new data about the relationship between ethnicity and outcomes among patients with lupus. The study found that Black and Hispanic lupus patients have more active disease and more organ system involvement than White patients. Data also showed that Black patients may accrue more renal damage than White patients and more skin damage than either Hispanic or White patients.[1]

1 Alarcon, GS, K Brooks, J Reveille, JR Lisse. Do Patients of Hispanic and African-American Ethnicity with Lupus Experience Worse Outcomes than Patients with Lupus from Other Populations? The LUMINA Study. SLE in Clinical Practice. 1999; 2(3).

Estimated Female-to-Male Ratios of Selected Autoimmune Diseases, 2006

Source II.7: American Autoimmune Related Diseases Association

	Ratio
Hashimoto's Disease/Hypothyroiditis	10:1
Systemic Lupus Erythematosus	9:1
Sjogren's Syndrome	9:1
Antiphospholipid Syndrome: Secondary	9:1
Primary Biliary Cirrhosis	9:1
Autoimmune Hepatitis	8:1
Graves' Disease/Hyperthyroiditis	7:1
Scleroderma	3:1
Rheumatoid Arthritis	2.5:1
Myasthenia Gravis	2:1
Multiple Sclerosis	2:1
Autoimmune Thrombocytopenic Purpura	2:1

DIABETES

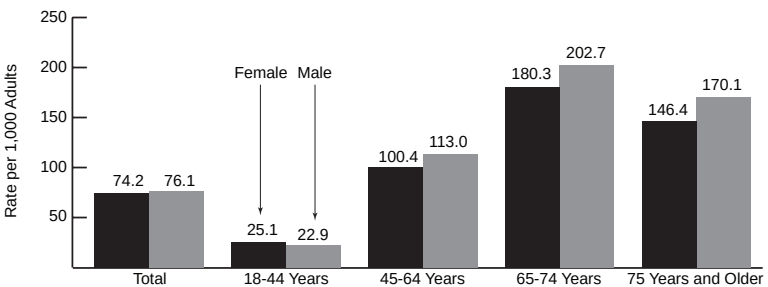
Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. Diabetes is becoming increasingly common among children and young adults. The two main types of diabetes are Type 1 (insulin dependent) and Type 2 (non-insulin dependent). Type 1 diabetes is usually diagnosed in children and young adults, and is commonly referred to as "juvenile diabetes." Type 2 diabetes is more common; it is often diagnosed among adults but is becoming increasingly common among children. Risk factors for Type 2 diabetes include obesity, physical inactivity, and a family history of the disease.

In 2005, women and men reported similar rates of having ever been told they had diabetes, though women under the age of 45 were slightly more likely than men of the same age group. The rate of diabetes increased with age for both sexes; however, older men were more likely to have diabetes than their female counterparts. The rate of diabetes among women under the age of 45 was 25.1 per 1,000 women, compared to 22.9 per 1,000 men of the same age. The rates among women and men 75 years and older were 146.4 and 170.1 per 1,000, respectively.

Non-Hispanic Black women were more likely than women of other racial and ethnic groups to have diabetes: the rate of diabetes among this group was 106.8 per 1,000 in 2005, compared to a rate of 77.1 per 1,000 Hispanic women, 71.6 per 1,000 American Indian/Alaska Natives and women of multiple races, and 69.1 per 1,000 non-Hispanic White women. Asian women had the lowest rate of diabetes (49.7 per 1,000). Most women with diabetes of all racial and ethnic groups do not take insulin, which may indicate that they have Type 2 diabetes. Non-Hispanic White and Hispanic women with diabetes were less likely than non-Hispanic Black women to take insulin in 2005.

Adults Aged 18 and Older with Diabetes,* by Age and Sex, 2005

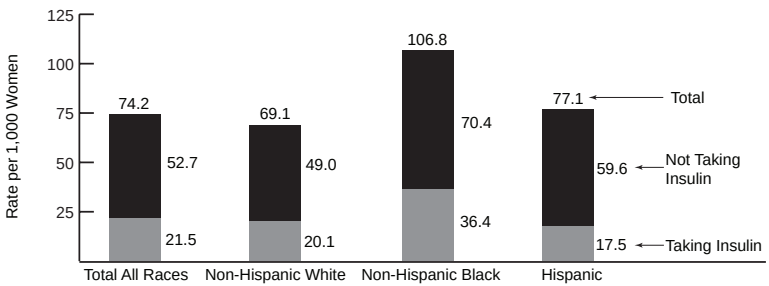
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Current Insulin Use Among Women Aged 18 and Older with Diabetes,* by Race/Ethnicity,** 2005

Source II.2: 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 diabetes. **Rates reported are not age adjusted. The sample of Asian/Pacific Islanders, American Indian/Alaska Natives and persons of more than one race was too small to produce reliable estimates for insulin use.

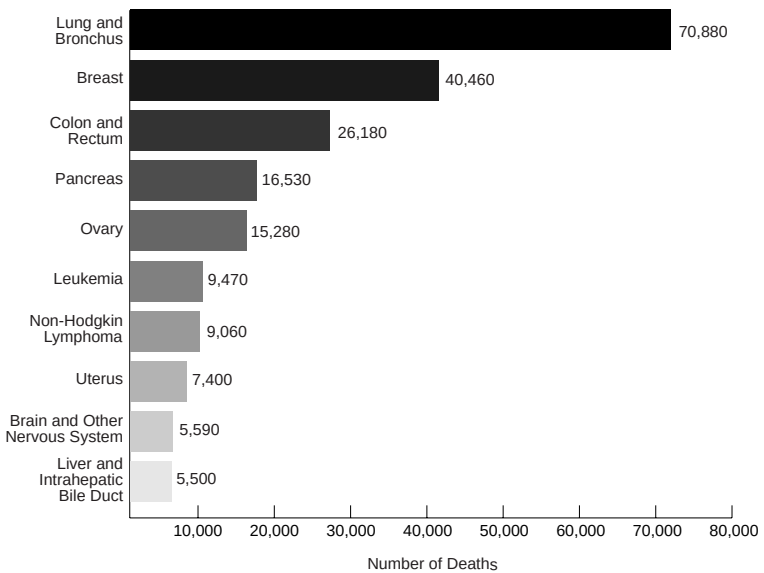
CANCER

It is estimated that just over 270,000 females will die of cancer in 2007. Lung and bronchus cancer is the leading cause of cancer death among females, accounting for 26 percent of cancer deaths, followed by breast cancer, which is responsible for 15 percent of deaths. Colon and rectal cancer, pancreatic cancer, and ovarian cancer are also significant causes of cancer deaths among females. Due to the varying survival rates for different types of cancer, the most common causes of cancer death are not always the most common types of cancer. For instance, although lung and bronchus cancers cause the greatest number of deaths, breast cancer is the most common type of cancer among women. Other types of cancer that are common among females but are not among the top 10 causes of cancer deaths include melanoma, thyroid cancer, and cancer of the kidney and renal pelvis. In addition, other types of cancer, such as some skin cancers, are common but may not lead to death.

There are noticeable differences between the sexes in top causes of cancer mortality. The top 10 causes of cancer deaths among women include breast cancer in addition to 2 sex-specific cancers, ovarian and uterine, while the top 10 causes of

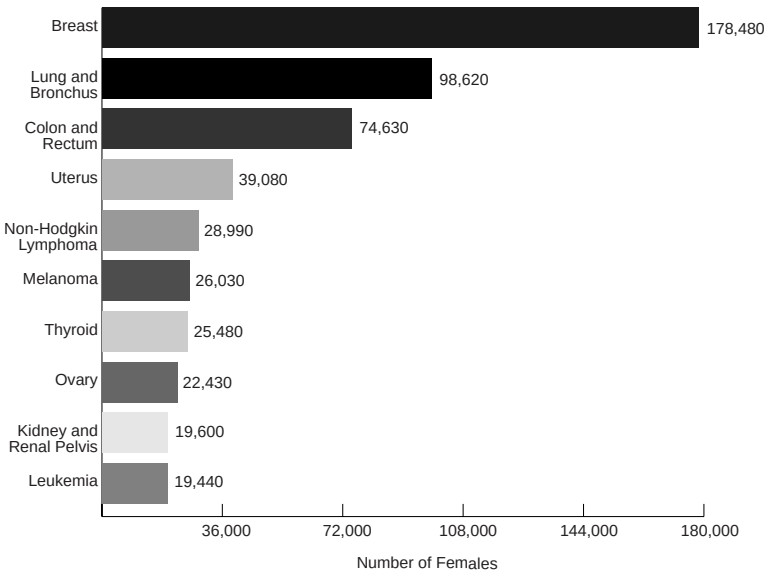
Leading Causes of Cancer Deaths Among Females, by Site, 2007 Estimates

Source II.8: American Cancer Society



New Cancer Cases Among Females, by Site, 2007 Estimates

Source II.8: American Cancer Society

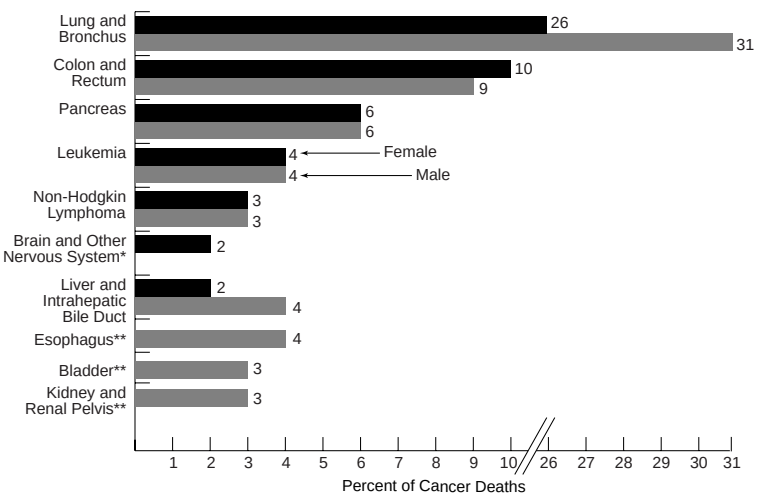


cancer deaths among men include only 1 sex-specific cancer: prostate cancer. Because of differences in the occurrence of sex-specific cancers, several of the top 10 causes of cancer deaths among males do not rank as high among females, including cancers of the bladder and esophagus.

Sex-specific cancers among females have varying survival rates. Breast cancer has the highest 5-year survival rate, with 89.1 percent of females diagnosed with cancer living for at least 5 years after diagnosis. This high survival rate explains why breast cancer is the most common type of cancer among women but not the leading cause of cancer death. Uterine cancer also has a high survival rate (83.0 percent), followed by cervical cancer (71.3 percent). The lowest survival rate for sex-specific cancers among females occurs with ovarian cancer at a rate of 44.9 percent. For each of the sex-specific cancers shown, survival rates are higher for White females than Black females. The two leading causes of death due to non-sex-specific cancers among females are lung and bronchus cancer and colon and rectum cancer, with a 5-year survival rate of 17.7 percent and 64.1 percent respectively (data not shown).

Distribution of Deaths Due to Non-sex Specific Cancers, by Sex, 2007 Estimates

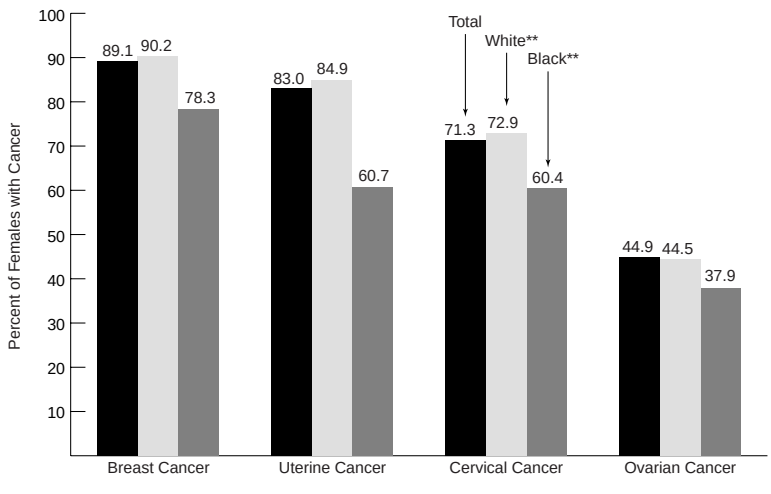
Source II.8: American Cancer Society



*Not one of the top causes of cancer death among males. **Not one of the top causes of cancer death among females.

Five-year Period Survival Rates for Sex-specific Cancers Among Females, by Race/Ethnicity,* 1996-2003

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



*Data not avilable for American Indian/Alaska Natives, Asian/Pacific Islanders, Hispanics and persons of more than one race. **May include Hispanics.

GYNECOLOGICAL AND REPRODUCTIVE DISORDERS

Gynecological disorders affect the internal and external organs in a woman's pelvic and abdominal areas and may affect a woman's fertility. These disorders include vulvodynia—unexplained chronic discomfort or pain of the vulva—and chronic pelvic pain, which is a consistent and severe pain occurring mostly in the lower abdomen for at least 6 months. While the causes of vulvodynia are unknown, recent evidence suggests that it may occur in up to 16 percent of women, usually beginning before age 25, and that Hispanic women are at greater risk for this disorder.[1] Chronic pelvic pain may be symptomatic of an infection or indicate a problem with one of the organs in the pelvic area.[2]

Reproductive disorders may affect a woman's ability to get pregnant. Examples of these disorders include polycystic ovary syndrome (PCOS), endometriosis, and uterine fibroids. PCOS occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. In most cases, the failure of the follicles to release the eggs results in a woman's inability to become pregnant. An estimated 5–10 percent of women in the United States are affected by PCOS. Endometriosis, in which tissue resembling that of the uterine lining grows outside of the uterus, is estimated to affect nearly 5.5 million women in North America. Uterine fibroids are non-cancerous tumors that grow underneath the lining, between the muscles, or on the outside of the uterus. A hysterectomy — abdominal surgery to remove the uterus — is one option to treat certain conditions including chronic pelvic pain, uterine fibroids, PCOS, and endometriosis when symptoms are severe.[2]

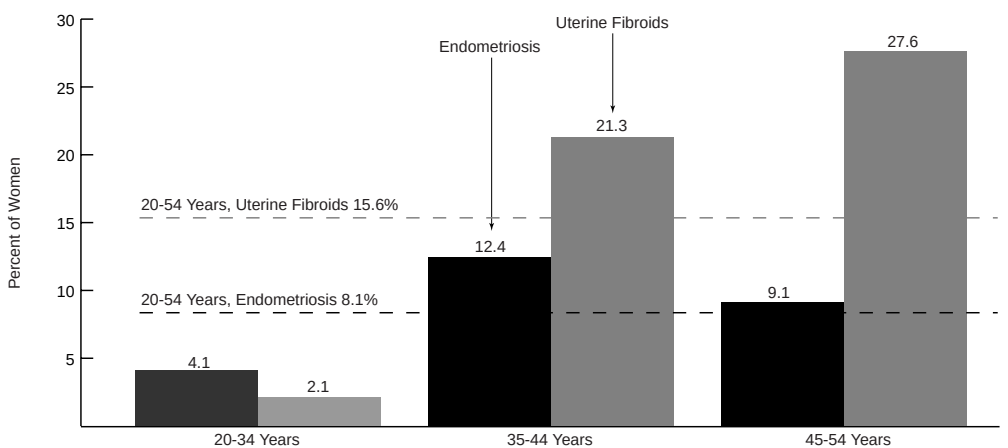
In 2004, 8.1 percent of women aged 20–54 years had endometriosis and 15.6 percent had uterine fibroids, but the prevalence of both disorders varied with age. Of women aged 20–54 years, endometriosis was most common among the 35- to 44-year-old age group (12.4 percent), while uterine fibroids were most common among 45- to 54-year-olds (27.6 percent). Women aged 20–34 years were least likely to have either disorder (4.1 and 2.1 percent, respectively).

1 Harlow et al A Population-Based Assessment of Chronic Unexplained Vulvar Pain: Have we underestimated the prevalence of vulvodynia? JAMWA. 2003; 58: 82-88.

2 National Institutes of Health, National Institute of Child Health and Human Development. www.nichd.nih.gov. Viewed 4/16/07.

Endometriosis and Uterine Fibroids Among Women Aged 20-54, by Age, 2004

Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



INJURY

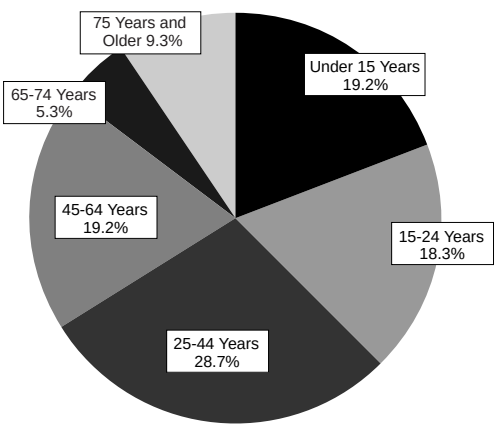
Often, injuries can be controlled by either preventing an event that causes injury or lessening the impact of such an event. This can occur through education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples include the design, oversight, and use of car safety seats and seatbelts, workplace regulations regarding safety practices, vouchers for items such as smoke alarms, and tax incentives for fitting home pools with fences.

There were over 41 million injury-related emergency department (ED) visits in 2004. Among females of all ages, nearly 33 percent of all ED visits were injury-related, compared to 43 percent of all ED visits by males. This represents an annual rate of 13.3 injury-related visits per 100 females compared to 15.4 visits per 100 males (data not shown). Among females, the highest rate of injury-related ED visits occurred among those aged 75 years and older; however, due to the age distribution of the population, they represented only 9.3 percent of all female injury-related ED visits.

Unintentional and intentional injuries represented a higher proportion of ED visits for men than women in 2004. Among women and men aged 18 years and older, unintentional injuries accounted for 20.1 and 27.2 per 100 ED visits, respectively, while intentional injuries represented 1.7 and 3.0 per 100, respectively. Among both women and men, the two most common causes of injury were falls and motor vehicle crashes.

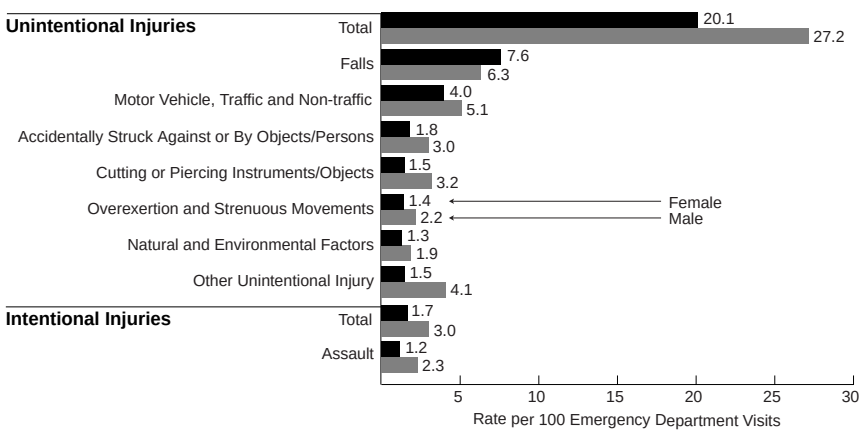
Injury-Related Emergency Department Visits for Females, by Age, 2004

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



Injury-Related Emergency Department Visits Among Adults Aged 18 and Older, by Sex and Mechanism, 2004

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



HEART DISEASE AND STROKE

In 2004, heart disease was the leading cause of death among women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common type of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow to the heart muscle. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age. While the most common symptom of a heart attack is chest pain or discomfort, women are more likely than men to experience other symptoms, such as shortness of breath, nausea and vomiting, and back or jaw pain.[1]

Stroke is a type of heart disease that affects blood flow. 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.[1]

In 2005, adult women under 45 years had a higher rate of heart disease than men of the same age (50.9 versus 35.2 per 1,000 adults, respectively). However, men had a slightly higher overall rate of heart disease than women. Heart disease rates among both sexes increased with age.

In 2004, women were less likely than men to undergo an operation on the cardiovascular system, (202.0 per 10,000 women and 277.7 per 10,000 men). For example, the rate of coronary artery bypass procedures was 8.3 per 10,000 women and 21.1 per 10,000 men.[2]

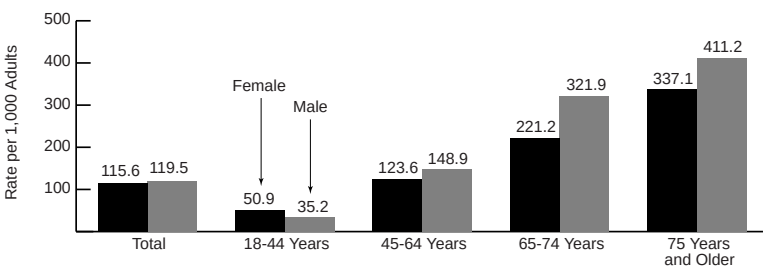
In 2005, the highest rate of heart disease was among non-Hispanic White women (128.7 per 1,000), followed by non-Hispanic Black women (107.1 per 1,000); Asian women had the lowest rate (51.1 per 1,000). Although non-Hispanic White women experience the highest rates of heart disease, deaths from heart disease are highest among non-Hispanic Black women.

1 American Heart Association. Heart Attack, Stroke, and Cardiac Arrest Warning Signs. 2007. www.americanheart.org/presenter.html?identifier=3053#Heart_Attack. Viewed 4/25/07.

2 Kozak LJ, DeFrances CJ, Hall MJ. National Hospital Discharge Survey: 2004 annual summary with detailed diagnosis and procedure data (Table 33). National Center for Health Statistics. Vital Health Stat 13(162). 2006. http://www.cdc.gov/nchs/data/series/sr_13/sr13_162.pdf. Viewed 4/18/07.

Adults Aged 18 and Older with Heart Disease,* by Age and Sex, 2005

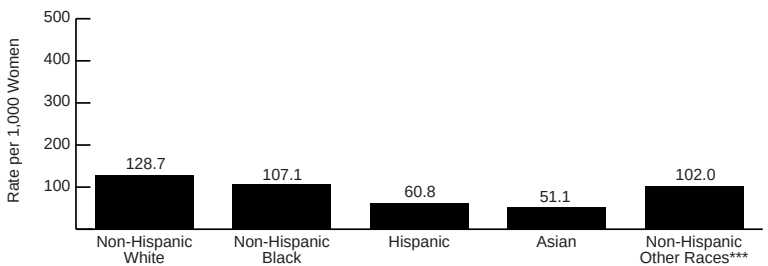
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Reported a health professional has ever told them they have a heart condition or heart disease.*

Women Aged 18 and Older with Heart Disease,* by Race/Ethnicity,** 2005

Source II.2: 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 a heart condition or heart disease. **Rates reported are not age-adjusted. ***Includes American Indian/Alaska Natives and persons of more than one race.*

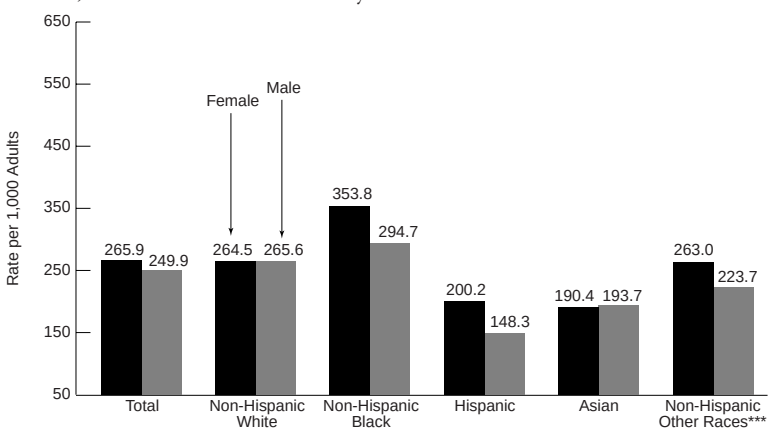
HYPERTENSION

Hypertension, also known as high blood pressure, is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. In 2005, women had higher overall rates of hypertension than men (265.9 versus 249.9 per 1,000 population); however, these rates varied by race and ethnicity. For instance, non-Hispanic Black and Hispanic women had higher rates of hypertension than their male counterparts, while non-Hispanic White and Asian women had rates similar to men. Among women, non-Hispanic Blacks had the highest rate of hypertension (353.8 per 1,000 women), followed by non-Hispanic Whites (264.5 per 1,000); Asian women had the lowest rate (190.4 per 1,000).

Rates of hypertension increase substantially with age and are highest among those 75 years and older, which demonstrates the chronic nature of the disease. The rate among women aged 18–44 years was 90.7 per 1,000 women in 2005, compared to a rate of 345.8 per 1,000 women aged 45–64 years, 570.6 per 1,000 women aged 65–74 years, and 633.0 per 1,000 women aged 75 years and older. This means that almost two-thirds of those in the oldest age group have ever been diagnosed with hypertension.

Adults Aged 18 and Older with Hypertension,* by Sex and Race/Ethnicity,** 2005

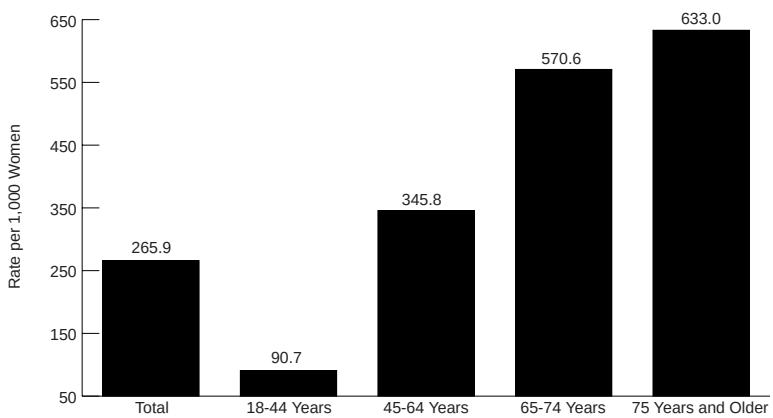
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have hypertension. **Rates reported are not age-adjusted. ***Includes American Indian/Alaska Natives and persons of more than one race.

Women Aged 18 and Older with Hypertension,* by Age, 2005

Source II.2: 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 hypertension.

LEADING CAUSES OF DEATH

In 2004, there were 1,215,947 female deaths in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), responsible for 330,513 and 267,058 deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 7.5 percent of deaths, followed by chronic lower respiratory disease, which accounted for 5.2 percent.

Heart disease was the leading cause of death for women in almost every racial and ethnic group; the exception was Asian/Pacific Islander females, for whom the leading cause of death was cancer. One of the most noticeable differences in leading causes of death by race and ethnicity is that chronic lower respiratory disease was the fourth leading cause of death among non-Hispanic White females while it was the seventh leading cause of death among other racial and ethnic groups. Similarly, diabetes mellitus was the eighth leading cause of death among non-Hispanic White females, while it was the fourth among other racial and ethnic groups. Among Hispanic females, death in the perinatal period was the ninth leading cause of death, and hypertension was the tenth leading cause among Asian/Pacific Islander females. Also noteworthy is that Native American/Alaska Native females experienced a higher proportion of deaths due to unintentional injury (8.5 percent) and liver disease (4.2 percent) than females of other racial and ethnic groups.

Ten Leading Causes of Death Among Females (All Ages), by Race/Ethnicity, 2004

Source II.12: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Rank		Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Asian/ Pacific Islander	American Indian/ Alaska Native
		%	%	%	%	%	%
1	Heart Disease	27.2	27.5	26.9	23.8	23.7	19.4
2	Malignant Neoplasms (cancer)	22.0	22.0	21.3	21.4	26.9	19.2
3	Cerebrovascular Diseases (stroke)	7.5	7.5	7.4	6.6	9.8	5.6
4	Chronic Lower Respiratory Disease	5.2	5.8	2.4	2.7	2.3	4.2
5	Alzheimer's Disease	3.9	4.2	2.2	2.4	1.8	N/A
6	Unintentional Injury	3.3	3.2	2.9	4.8	4.0	8.5
7	Influenza and Pneumonia	3.1	2.8	2.1	2.8	3.4	2.5
8	Diabetes Mellitus	2.7	2.6	5.1	5.8	4.0	6.4
9	Nephritis (kidney inflammation)	1.8	1.6	3.0	2.0	1.7	2.3
10	Septicemia (blood poisoning)	1.5	1.4	2.3	N/A	N/A	1.6

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

ORAL HEALTH AND DENTAL CARE

Oral health conditions can cause chronic pain of the mouth and face, and can impair the ability to eat normally. Regular dental care is particularly important for women because there is some evidence of an association between periodontal disease and certain birth outcomes, such as increased risk of preterm birth and low birth weight.[1] To prevent caries (cavities) and periodontal (gum) disease, the American Dental Association recommends maintaining a healthy diet with plenty of water, and limiting eating and drinking between meals.[2] Other important preventive measures include daily brushing and flossing, regular dental cleanings to remove plaque, and checkups to examine for caries or other potential problems.[3]

In 2003–04, women were less likely than men to have untreated dental caries (23.9 versus 30.5 percent). Among women, non-Hispanic Black and Hispanic women were most likely to have untreated caries. Sealants — a hard, clear substance applied to the surfaces of teeth — may help to prevent caries, but only 21.2 percent of women had sealants. Non-Hispanic Black and Hispanic women were the least likely to have sealants (7.7 and 11.4 percent, respectively).

Having health insurance—particularly dental insurance—influences how often women see a dentist. In 2003–04, 71.2 percent of women who had health insurance with a dental component saw a dentist in the past year, compared to 58.6 percent of women with health insurance but no dental component, and 38.6 percent of women with no health insurance. Uninsured women were the most likely to have not seen a dentist in more than 5 years (24.6 percent).

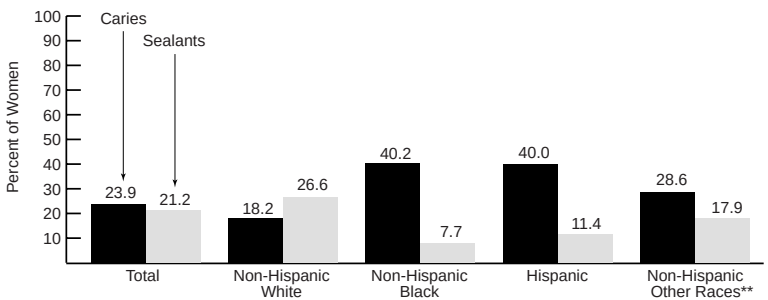
1 Brown A. (2007) Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes: Summary of a Meeting of Maternal, Child, and Oral Health Experts. Washington, DC: National Maternal and Child Oral Health Resource Center.

2 American Dental Association. Diet and oral health: overview. Available from http://www.ada.org/public/topics/diet.asp. Viewed 4/18/07.

3 American Dental Association. Preventing periodontal disease. JADA 2001 Sep;132:1339.

Untreated Dental Caries and Presence of Sealants Among Women,* by Race/Ethnicity, 2003–04

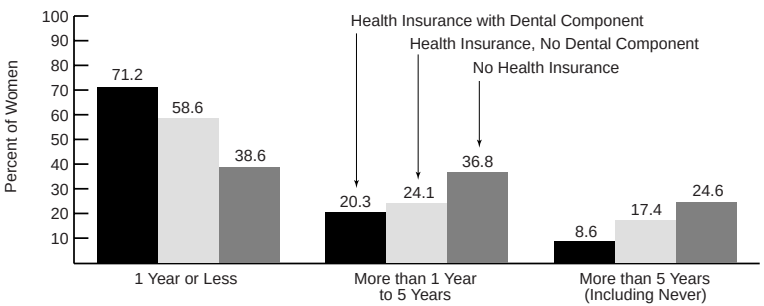
Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Caries are among women aged 18 years and older; sealants are among women aged 18-34 years.*
***Includes Asian/Pacific Islander, Native American/Alaska Native, and persons of more than one race.*

Time Since Last Seen a Dentist Among Women Aged 18 and Older, by Health Insurance, 2003–04

Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



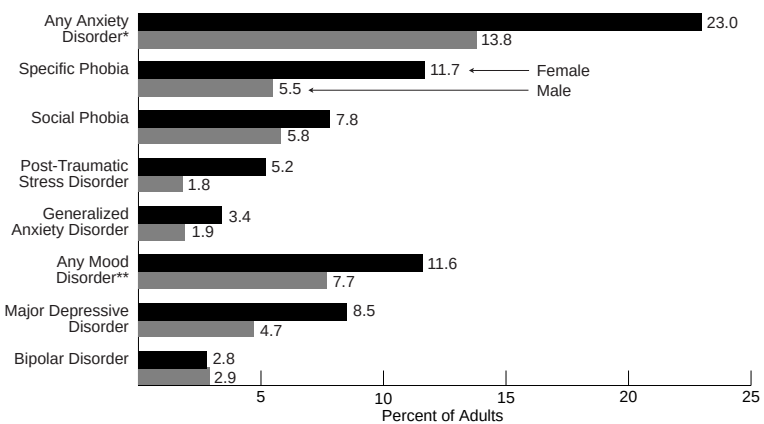
MENTAL ILLNESS AND SUICIDE

Mental illness affects both sexes, although many types of mental disorders are more prevalent among women. Among adults interviewed in 2001–03, 23.0 percent of women had experienced any anxiety disorder in the past year, compared to 13.8 percent of men. Post-traumatic stress disorder (PTSD) is a type of mental disorder that can occur in those who have experienced or witnessed life-threatening events such as natural disasters, serious accidents, terrorist incidents, acts of war, or violent personal assaults such as rape.[1] While PTSD was previously thought of as primarily affecting male war veterans, it is now understood that the disorder affects both sexes and is actually more prevalent in females (5.2 versus 1.8 percent). Other common mental disorders include social phobia, generalized anxiety disorder, and major depressive disorder, all of which are more common among women than men.

Among women, mental disorders are most common among those aged 18–25 years. Serious psychological distress occurs among almost 23 percent of women in this age group, compared to nearly 16 percent of women aged 26–49 years and 9.0 percent of women aged 50 years and older. Major depressive disorder displays a similar pattern, occurring most frequently among those women 18–25 years (12.9 percent), compared to 26- to 49-year-olds and those aged 50 years and older (10.5 and 6.6 percent, respectively).

Selected Mental Disorders Among Adults Aged 18 and Older in the Past Year, by Sex, 2001-03

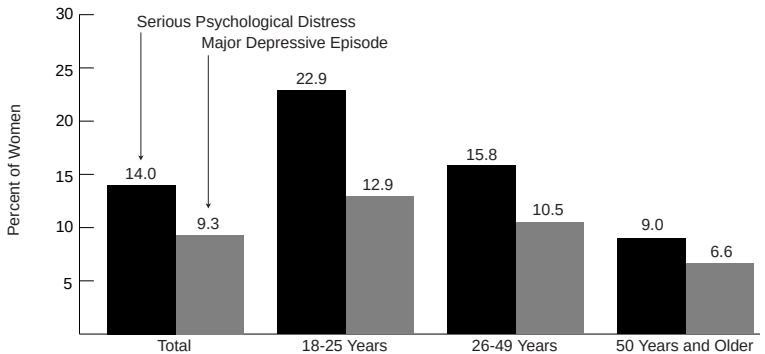
Source II.13: National Comorbidity Survey Replication (NCS-R), as published in Kessler, et al, 2003



*Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, and generalized anxiety disorder. **Mood disorders include major depressive disorder, bipolar disorder, and dysthymia.

Serious Psychological Distress or Major Depressive Episode* Among Women Aged 18 and Older, by Age, 2005**

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



*Serious psychological distress is an overall indicator of past year nonspecific psychological distress that is constructed from the K6 scale, which consists of six questions related to psychological distress. Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the DSM-IV. **Occurring in the past year.

Although most people who suffer from mental illness do not commit suicide, mental illness is a major risk factor. Women attempt suicide three times as often than men, but men are much more likely to die of suicide injury than women.[2] In 2004, the female suicide death rate among those aged 15 years and older was 5.7 per 100,000 females, compared to a rate of 22.4 per 100,000 males. Although mental disorders affect women in younger age groups more often than women in older age groups, women aged 45–54 years have the highest suicide death rate among females (8.6 per 100,000). Among males, the highest suicide death rate occurs in the 65–84 age group (27.2 per 100,000).

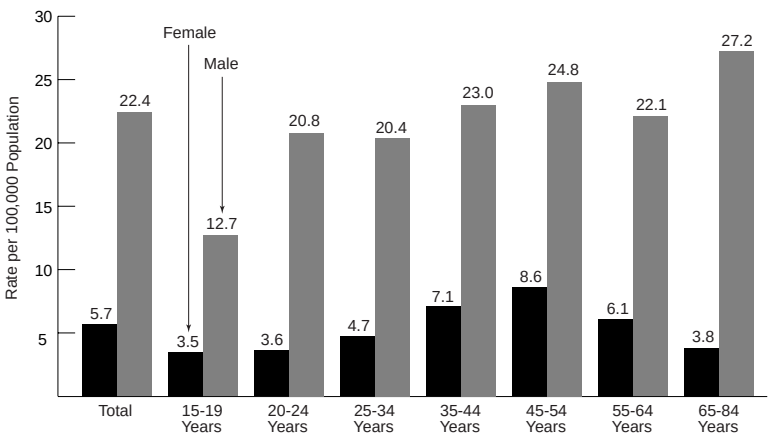
There are also disparities in suicide rates among racial and ethnic groups. Among females aged 15 years and older, American Indian/Alaska Natives have the highest suicide rate (8.0 per 100,000 females), followed by non-Hispanic Whites (6.8 per 100,000). Non-Hispanic Black females have the lowest suicide rates among all racial and ethnic groups (2.3 per 100,000), closely followed by Hispanic females (2.5 per 100,000).

1 American Psychiatric Association. Let's talk facts about Posttraumatic stress disorder. 2006 Nov. http://healthyminds.org/factsheets/LTF-PTSD.pdf. Viewed 4/18/07.

2 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Suicide: Fact Sheet. www.cdc.gov/ncipc. Viewed 4/18/07.

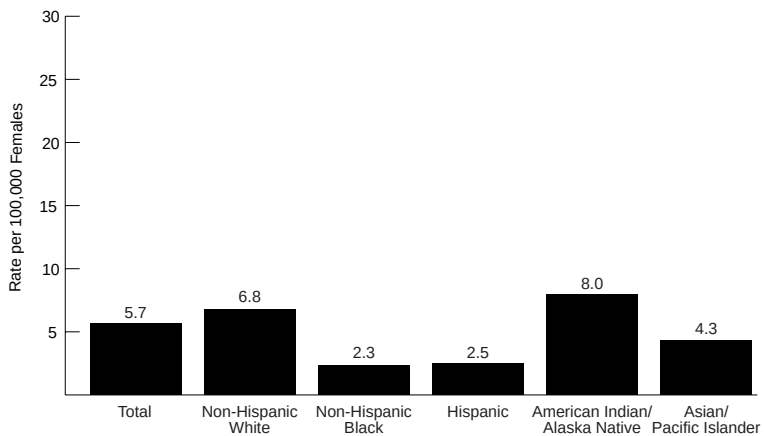
Suicide Death Rates Among Adults Aged 15 and Older, by Age, 2004

Source II.14: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control



Suicide Death Rates Among Females Aged 15 and Older, by Race/Ethnicity, 2004

Source II.14 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control



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. An estimated 10 million Americans now have osteoporosis, while another 34 million have low bone mass and are at risk for developing osteoporosis; 80 percent of them are women. By 2020, an estimated 1 in 2 Americans over age 50 will be at risk for osteoporosis and low bone mass. Each year more than 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks in the wrist, spine and hip. Fractures can have devastating consequences. For example, hip fractures are associated with an increased risk of mortality, and nearly 1 in 5 hip fracture patients ends up in a nursing home within a year. Direct care for osteoporotic fractures costs $18 billion yearly.[1]

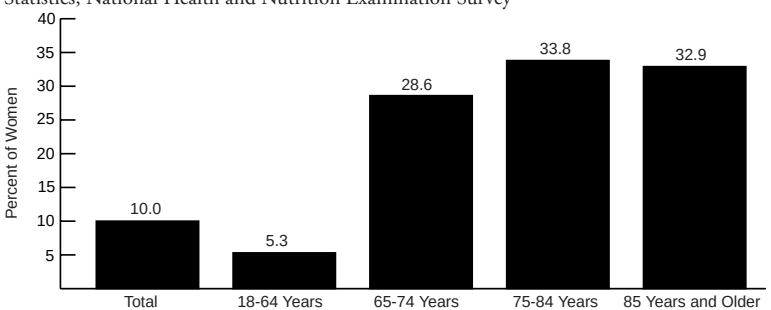
In 2003–04, women aged 18 years and older were more likely than men to report having been told by a health professional that they have osteoporosis (10.0 versus 1.7 percent, respectively.) In addition, 72.4 percent of women with osteoporosis received treatment, compared to 52.1 percent of men. The rate of osteoporosis among women varied significantly with age. While only 5.3 percent aged 18–64 years had osteoporosis in 2003–04, 33.8 percent of women aged 75–84 years and 32.9 percent of those aged 85 years and older reported having osteoporosis.

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (i.e. walking), and by taking prescription medication when appropriate. Bone density tests are recommended for women over 65 years and for any man or woman who suffers a fracture after age 50. Treatment of osteoporosis has been shown to reduce the risk of subsequent fractures by 30–65 percent.[1] Despite these findings, national data in 2005 indicate that only 20.1 percent of female Medicare beneficiaries aged 67 years and older who had a fracture received either a bone mineral density test or a prescription to treat osteoporosis.

1 U.S. Department of Health and Human Services. Bone Health and Osteoporosis: A Report of the Surgeon General. Rockville, MD: Office of the Surgeon General; 2004.

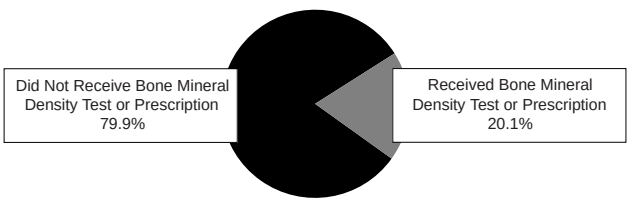
Women Aged 18 and Older with Osteoporosis, by Age, 2003-04

Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



HEDIS®* Measure of Osteoporosis Management in Women Aged 67 and Older Who Had a Fracture, 2005**

Source II.15: National Committee for Quality Assurance



**HEDIS (Health Plan Employer Data and Information Set) is a registered trademark of NCQA. **The HEDIS Osteoporosis Management in Women Who Had a Fracture measure estimates the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density test or a prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture. This measure only applies to Medicare plans.*

OVERWEIGHT AND OBESITY

Being overweight or obese increases the risk for numerous ailments, including high blood pressure, diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health.[1] According to the Centers for Disease Control and Prevention, 61.5 percent of women and 69.6 percent of men were overweight or obese in 2003–04. Measurements of overweight and obesity are based on Body Mass Index (BMI), which is calculated using height and weight. Overweight is defined as a BMI of 25.0–29.9, and obese is defined as a BMI of 30.0 or more; a BMI of 18.5–24.9 is considered normal weight while a BMI below 18.5 is considered underweight.

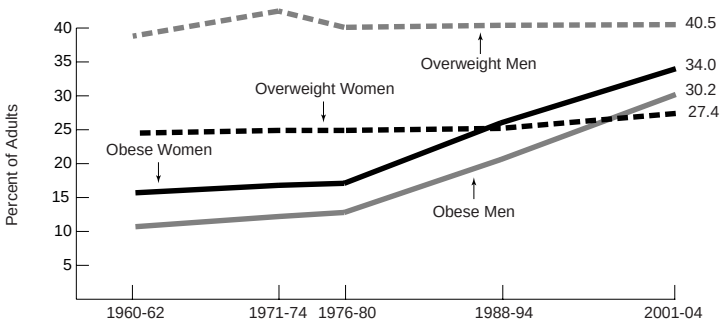
Since 1960, rates of overweight and obesity among men and women have increased dramatically. In 1960–62, 24.5 percent of women were overweight and 15.7 percent were obese, compared to 27.4 and 34.0 percent, respectively, in 2001–04. This marks an 11.8 percent increase in female overweight and a 116.6 percent increase in female obesity over the past 4 decades. Men saw a smaller increase in rates of overweight (4.4 percent), but a larger increase in rates of obesity (182.2 percent). However, men are more likely to be overweight than women, while the reverse is true for obesity.

Rates of overweight and obesity among women vary by race and ethnicity. In 2003–04, Hispanic women (32.1 percent) were more likely than non-Hispanic White and non-Hispanic Black women to be overweight (28.4 and 26.9 percent, respectively). Non-Hispanic Black women were most likely to be obese (53.0 percent), while non-Hispanic White women were least likely to be obese (30.3 percent).

1 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Overweight and obesity. June 2004. www.cdc.gov/nccdphp/dnpa/obesity. Viewed 4/16/07.

Overweight and Obesity* Among Adults Aged 20-74,** by Sex, 1960-2004

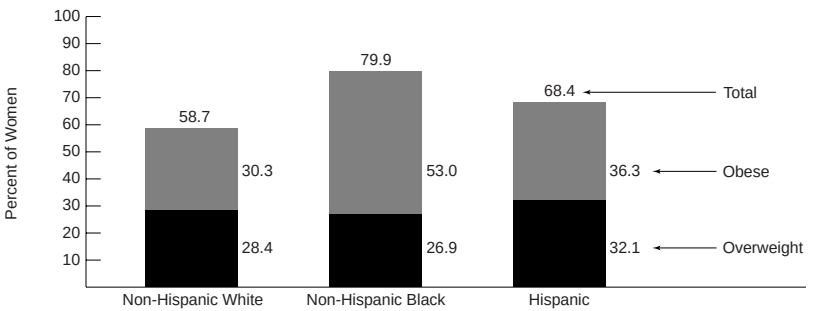
Source II.16: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Overweight represents a BMI of 25.0-29.9 and obesity represents a BMI of 30.0 or more. **Rates are age adjusted.*

Overweight and Obesity* Among Women Aged 18 and Older, by Race/Ethnicity,** 2003-04

Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Overweight represents a BMI of 25.0-29.9 and obesity represents a BMI of 30.0 or more. **The sample of American Indian/Alaska Natives, Asian/Pacific Islanders and persons of more than one race was too small to produce reliable estimates.*

SEXUALLY TRANSMITTED INFECTIONS

Reported rates of sexually transmitted infections (STIs) among females vary by a number of factors, including age and race/ethnicity. Rates are highest among adolescents and young adults, and non-Hispanic Blacks and American Indian/Alaska Natives. In 2005, there were 1,729 cases of chlamydia and 590 cases of gonorrhea per 100,000 non-Hispanic Black females, compared to 237 and 43 cases, respectively, per 100,000 non-Hispanic White females. American Indian/Alaska Native females also have high rates of STIs with 1,778 and 170 cases of chlamydia and gonorrhea, respectively, per 100,000 females.

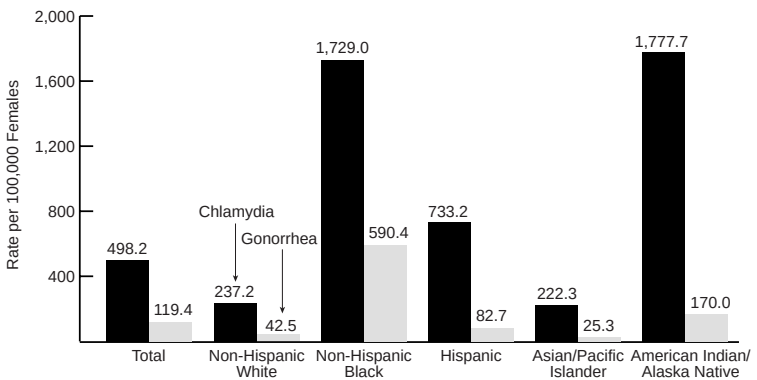
Although these STIs are treatable with antibiotics, they can have serious health consequences. Active infections can increase the odds of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes.

Another STI, genital human papillomavirus (HPV), has been estimated to affect at least 50 percent of the sexually active population. The first study to examine the prevalence of HPV in the United States was recently released, based on data from the National Health and Nutrition Examination Survey. Overall, 26.8 percent of females aged 14–59 years were found to have HPV, with the highest rates occurring among the 20- to 24-year-old age group (44.8 percent). There are many different types of HPV, and some, which are referred to as "high-risk," can cause cancer. In 2006, the Food and Drug Administration approved a vaccine that protects women from four strains of HPV that can be the source of cervical cancer, precancerous lesions, and genital warts.[1]

1 FDA News. FDA Licenses New Vaccine for Prevention of Cervical Cancer and Other Diseases in Females Caused by Human Papillomavirus. June 8, 2006.

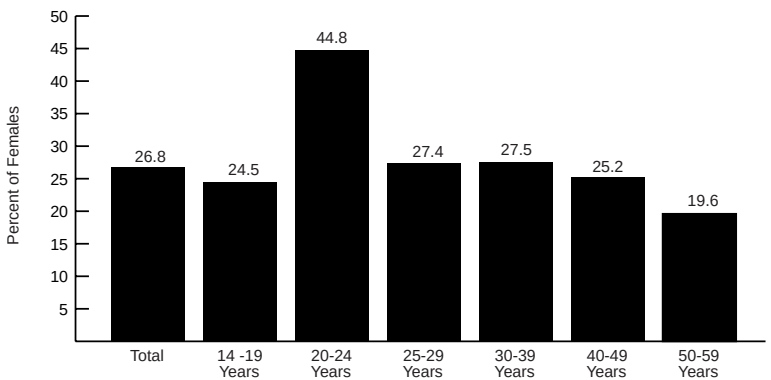
Reported Rates of Chlamydia and Gonorrhea Among Females Aged 10 and Older, by Race/Ethnicity, 2005

Source II.17: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Prevalence of Human Papillomavirus (HPV) Among Females Aged 14-59, by Age, 2003-04

Source II.18: National Health and Nutrition Examination Survey, as published in Dunne et al, 2007



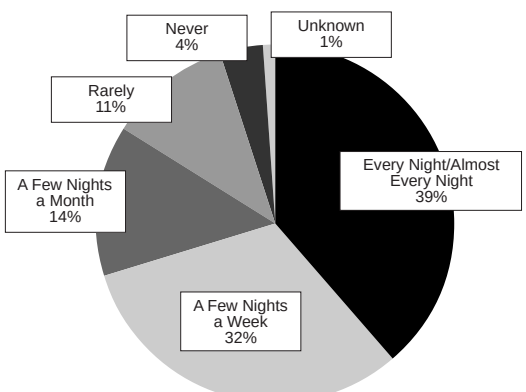
SLEEP DISORDERS

Sleep is a necessity of life; however, in a 2007 poll by the National Sleep Foundation, almost one-third of women reported getting "a good night's sleep" (as defined by respondents) only a few nights a month or less. In the same poll, 39 percent of women reported getting a good night's sleep every night or almost every night, while another 32 percent report getting a good night's sleep a few nights a week. Pregnant and postpartum women were more likely than women overall to report rarely or never getting a good night's sleep (30 and 42 percent versus 15 percent, respectively). Women who reported having a good night's sleep only a few nights a month or less are significantly more likely than those who reported a good night's sleep every night or almost every night to experience certain effects of sleep deprivation, including daytime sleepiness at least a few days a week (43 versus 7 percent) and driving drowsy at least once a month (39 versus 18 percent).

Overall, about two-thirds of women reported experiencing a sleep problem at least a few nights a week within the past month, with 46 percent reporting that this occurred every night or almost every night. The most common sleep problem was waking up feeling unrefreshed, which was reported to occur at least a few nights a week by half of all women. Almost half of women (49 percent) reported being awake a lot during the night at least a few nights a week, 37 percent reported difficulty falling asleep a few nights a week, and just over one-third of women reported waking up too early and not being able to fall back asleep.

Women Reporting That They Had a Good Night's Sleep,* 2007

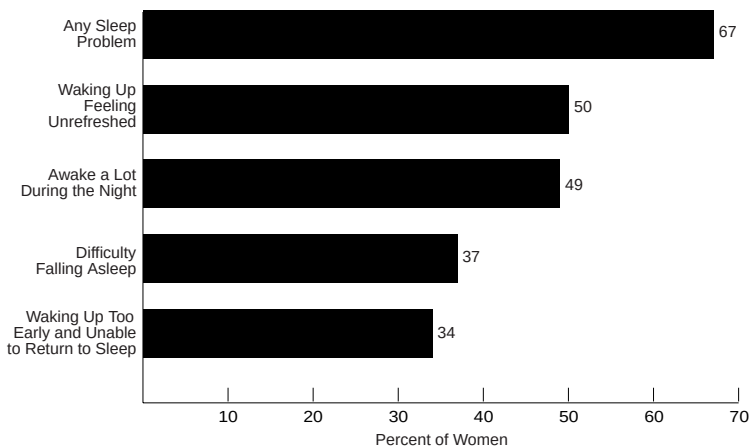
Source II.19: National Sleep Foundation, Sleep in America Poll



*As defined by respondent.

Women Reporting Sleep Problems at Least a Few Nights per Week in the Past Month, 2007

Source II.19: National Sleep Foundation, Sleep in America Poll



VIOLENCE AND ABUSE

According to the National Crime Victimization Survey, which estimates victimization based on household and individual surveys, there were over 2.1 million violent crimes committed against females aged 12 and older in the United States in 2005;[1] these crimes included rape, sexual assault, robbery, aggravated assault, and simple assault. In 1993, the rate of violent victimization among males was 59.8 per 1,000 population and the rate among females was 40.7 per 1,000. Those rates had dropped to 25.5 and 17.1 per 1,000, respectively, in 2005. This follows the downward trend in violent crime victimization rates over the past decade.

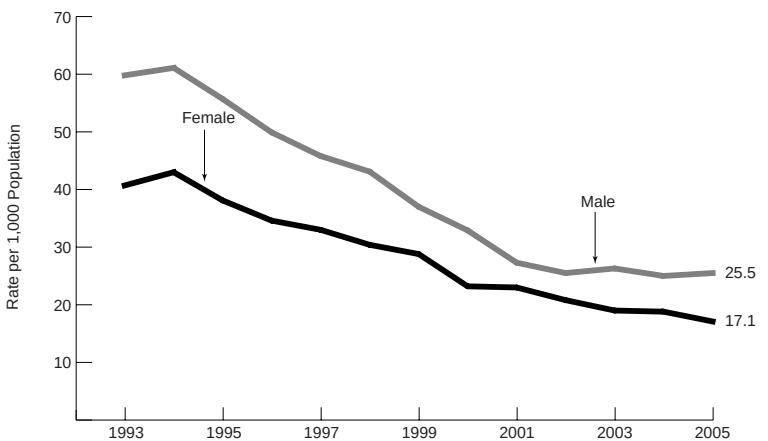
Females are more likely than males to be victims of rape and sexual assault, while males are more likely to be victims of robbery and assault.

For all types of violent crime, women are more likely than men to know the offender. Among all rape and sexual assault cases in 2005, 73 percent of women were attacked by someone that they knew, either an intimate partner (28 percent), other relative (7 percent), or friend/acquaintance (38 percent). Another 26 percent were attacked by a stranger, while the victim/offender relationship in the remaining cases was not determined. Similarly, female victims of 50 percent of robberies, 62 percent of aggravated assaults, and 66 percent of simple assaults knew their assailant.

1 These estimates are based on household and individual surveys that are intended to capture all incidents regardless of whether or not they were reported to law enforcement.

Violent Crime Victimization* Rates Among People Aged 12 and Older, by Sex of Victim, 1993-2005

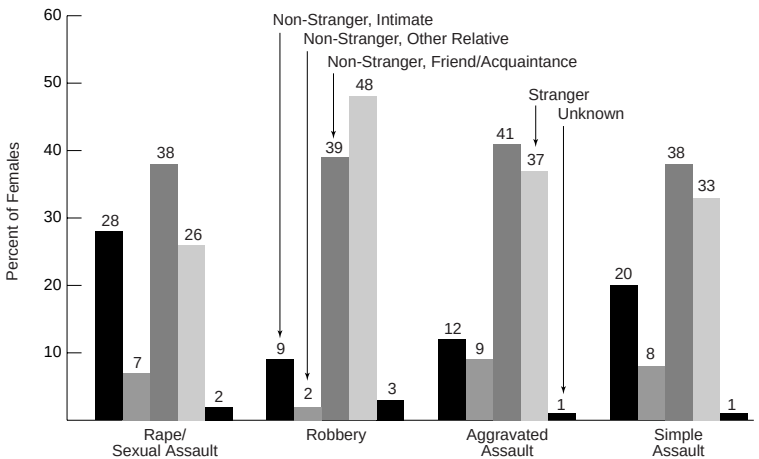
Source II.20: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



**Includes rape/sexual assault, robbery, and assault.*

Victim and Offender Relationship,* Females Aged 12 and Older Who Were Victims of Violent Crime, 2005

Source II.20: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



**Some rates are based on 10 or fewer sample cases.*

HIV IN PREGNANCY

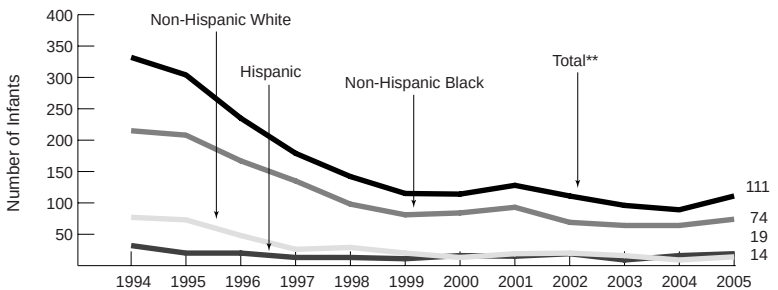
In 2005, 111 infants tested positive for HIV after being born to HIV-infected mothers (126,964 females over age 13 were living with HIV/AIDS in that year). The number of infant HIV/AIDS cases in 2005 was only one-third the number reported in 1994. A major factor in this decline is the increasing use of prophylaxis before, during, and after pregnancy to reduce perinatal transmission of the virus. In 1994, the U.S. Public Health Service began to recommend prophylaxis for all HIV-positive pregnant women; since 1995, HIV counseling and voluntary testing have been recommended for all pregnant women. In 2004, the Centers for Disease Control and Prevention released new and updated materials to further promote universal prenatal HIV testing. It is expected that the perinatal transmission rate will continue to decline with increased use of aggressive interventions and obstetric procedures, such as elective cesarean section.

Although there is a significant racial/ethnic disparity in HIV/AIDS among women, and consequently among infants born to HIV-infected women, the decline over the past decade occurred among each racial and ethnic group. The number of cases of HIV/AIDS among non-Hispanic Black infants declined 65.6 percent, from 215 cases in 1994 to 74 cases in 2005. The decline among Hispanic infants was less marked (40.6 percent), from 32 cases in 1994 to 19 cases in 2005. The most extreme decline in the number of cases was among non-Hispanic White infants (81.8 percent) from 77 cases in 1994 to 14 cases in 2005.

Women can become infected with HIV in a variety of ways. Among infants with HIV/AIDS in 2005, 19 were born to mothers who acquired their HIV through injection drug use, 35 were born to mothers who contracted HIV from sex with an infected partner, and 46 were born to mothers whose risk factor was not specified.

Reported Cases of HIV/AIDS* in Infants Born to HIV-infected Mothers, by Infant Race/Ethnicity, 1994-2005

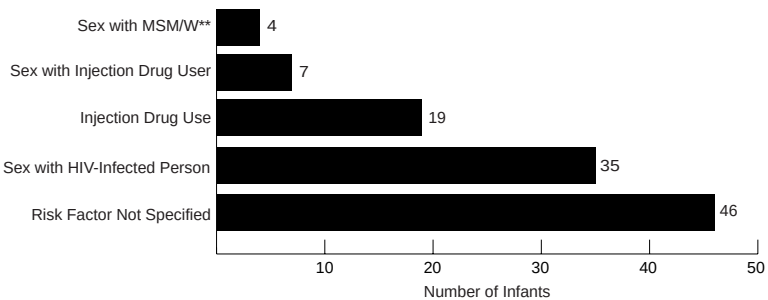
Source II.5: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Includes children with a diagnosis of HIV infection (not AIDS), a diagnosis of AIDS following a prior diagnosis of HIV infection, or concurrent diagnoses of HIV infection and AIDS, in 25 States with confidential name-based HIV reporting. **Includes two Asian/Pacific Islanders and one American Indian/Alaska Native.

Reported Cases of HIV/AIDS* in Infants Born to HIV-infected Mothers, by Perinatal Transmission Categories, 2005

Source II.5: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Includes children with a diagnosis of HIV infection (not AIDS), a diagnosis of AIDS following a prior diagnosis of HIV infection, or concurrent diagnoses of HIV infection and AIDS, in 25 States with confidential name-based HIV reporting. **Men who have sex with men and women.

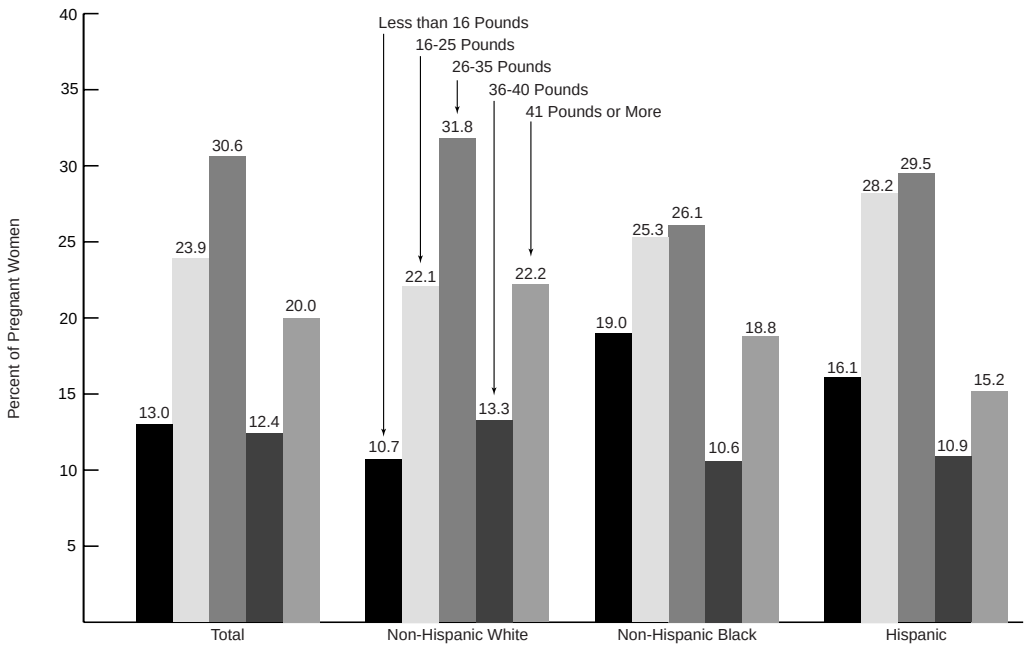
WEIGHT GAIN DURING PREGNANCY

Weight gain during pregnancy is an important factor in pregnancy outcome. Inadequate weight gain has been associated with increased risk of intrauterine growth retardation (IUGR), preterm birth, low birth weight, and perinatal mortality. Excessive weight gain can also have a negative impact on pregnancy outcome, including elevated risk of a large-for-gestational-age infant, cesarean delivery, and long-term maternal weight retention. In 1990, the Institute of Medicine (IOM) developed a set of recommendations for maternal weight gain based on the pre-pregnancy Body Mass Index (BMI) of the mother. The guidelines advise that those with a BMI of less than 19.8 gain 28 to 40 pounds, those with a BMI of 19.8–26.0 gain 25 to 35 pounds, and those with a BMI of 26.1–29.0 gain 15 to 25 pounds. There are currently no recommendations for women who have a BMI of 29.1 or greater. The IOM convened a workshop in 2006 to assess the impact of pregnancy weight on maternal and child health, and a report from that workshop was released in February 2007.

Data from the National Vital Statistics System show that 13.0 percent of women gained fewer than 16 pounds during pregnancy in 2004; this was most common among non-Hispanic Black women (19.0 percent). Another 20.0 percent of all pregnant women gained more than 40 pounds, which was most common among non-Hispanic White women (22.2 percent). These data suggest that approximately one-third of women had weight gain outside the recommended guidelines; however, this does not account for pre-pregnancy BMI or gestational age. Analyses of other national data sets suggest that approximately two-thirds of women experience weight gain outside of the IOM guidelines.

Weight Gain During Pregnancy, by Race/Ethnicity,* 2004

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



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

MATERNAL MORBIDITY AND RISK FACTORS IN PREGNANCY

Maternal morbidity refers to diseases or conditions that arise during pregnancy. Since 1989 (the year these data became available from birth certificates), diabetes and hypertension have been the most commonly reported conditions. Both chronic and gestational (developing only during pregnancy) diabetes may pose health risks to the mother and infant. Babies born to mothers with diabetes can have birth defects. These babies may also be premature or stillborn, or very large at birth.[1] In 2004, diabetes during pregnancy occurred at a rate of 35.8 per 1,000 live births. There was little variation among racial and ethnic groups.

Hypertension during pregnancy can be either chronic in nature or limited to the duration of the pregnancy. Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, premature birth, placental abruption, and stillbirth.[2] Chronic hypertension was present in 9.6 of every 1,000 live births in 2004, and was noticeably more prevalent among non-Hispanic Black women than non-Hispanic White and Hispanic women. The rate of pregnancy-associated hypertension was even higher, occurring in 37.9 of every 1,000 live births. Rates were comparable between non-Hispanic White and non-Hispanic Black women, but were lower among Hispanic women.

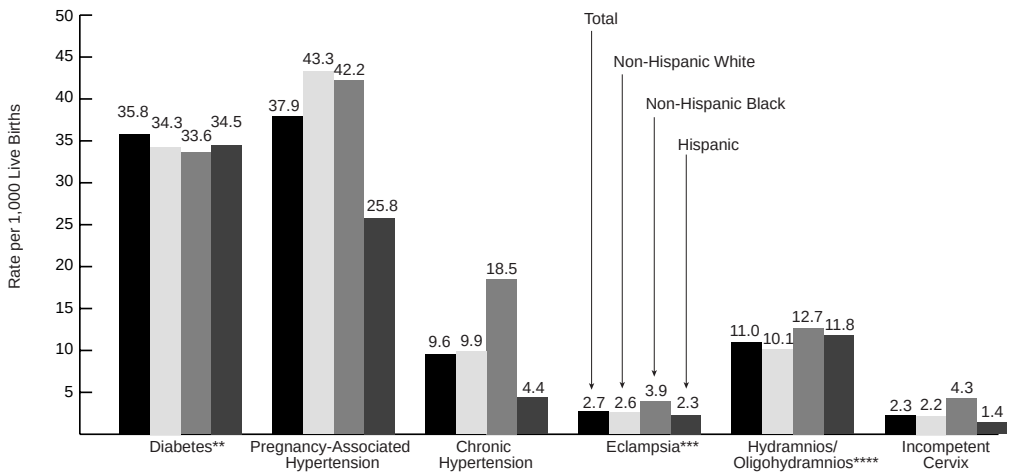
Other illnesses or risk factors during pregnancy can include eclampsia, which involves seizures (usually preceded by a diagnosis of preeclampsia), hydramnios and oligohydramnios, which are too much and too little amniotic fluid, respectively, and incompetent cervix, which can result in preterm birth. All of these conditions are more prevalent among non-Hispanic Black women than non-Hispanic White and Hispanic women.

1 Centers for Disease Control and Prevention. Diabetes and pregnancy FAQs. Available from: http://www.cdc.gov/ncbddd/bd/diabetespregnancyfaqs.htm#whatcanhappentoawoman. Viewed 4/18/07.

2 U.S. Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment Number 14: Management of chronic hypertension during pregnancy. Publication #00E011; 2000 Aug.

Maternal Morbidities and Risk Factors in Pregnancy, by Race/Ethnicity,* 2004

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



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

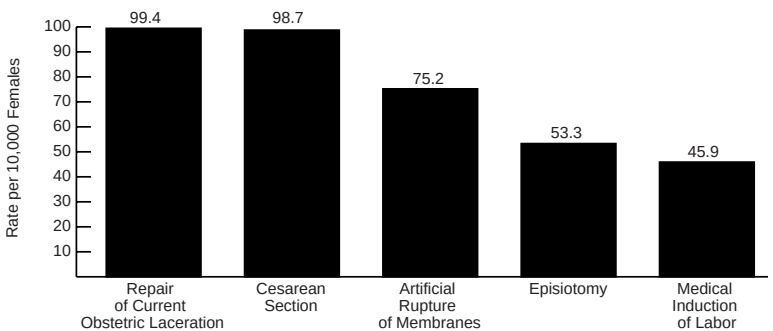
OBSTETRICAL PROCEDURES AND COMPLICATIONS OF LABOR AND DELIVERY

There are a number of complications that can arise and procedures that can occur during labor and delivery. In 2004, repair of a current obstetric laceration and cesarean section were the two most common obstetrical procedures among women aged 15–44 years, according to hospital discharge data (occurring during 99.4 and 98.7 hospital stays per 10,000 women, respectively). Other common procedures were artificial rupture of membranes, also known as "breaking the waters" (75.2 per 10,000), episiotomy, which is a surgical cut to the perineum to enlarge the vaginal opening (53.3 per 10,000), and medical induction of labor (45.9 per 10,000). The rate of induction of labor was twice the 1990 rate, while the cesarean section rate increased 41 percent after a recent low in 1996.

Complications of labor and delivery can include moderate or heavy meconium, which occurs when the baby expels its first stool before being born; breech presentation or malpresentation, which occurs when the baby is in an abnormal position that may interfere with labor; tocolysis, which is the delaying of labor to avoid preterm birth; and precipitous labor, which is labor that takes less than 3 hours from beginning to end. Among childbearing women through age 54, moderate/heavy meconium is most common, occurring at a rate of 48.3 per 1,000 live births, followed by breech/malpresentation (41.6 per 1,000), tocolysis (19.8 per 1,000), and precipitous labor (19.2 per 1,000). There is some racial and ethnic disparity in the occurrence of these complications. Moderate/heavy meconium is most common among births to non-Hispanic Black women and breech/malpresentation occurs most frequently in births to non-Hispanic White women. Both tocolysis and precipitous labor occur less frequently among births to Hispanic women than in births to non-Hispanic White women and non-Hispanic Black women.

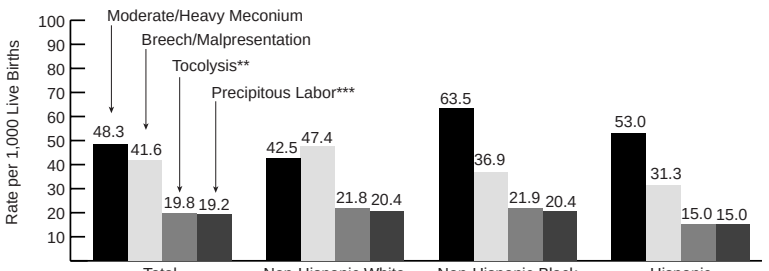
Rate of Discharges for Obstetrical Procedures from Short-Stay Hospitals Among Females Aged 15-44, 2004

Source II.22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



Complications of Labor and Delivery Among Childbearing Women Through Age 54, by Race/Ethnicity,* 2004

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



*Data not reported for American Indian/Alaska Natives, Asian/Pacific Islanders, and persons of more than one race.**Delaying or inhibition of labor, especially to suppress preterm birth.***Labor that is less than 3 hours from beginning of contractions to birth.*

LIVE BIRTHS

According to preliminary data, there were 4.1 million births in the United States in 2005, which was unchanged from 2004. The number of births rose most noticeably among Hispanic women, followed by Asian/Pacific Islander women. Births also rose slightly among American Indian/Alaska Native and non-Hispanic Black women, while they declined slightly among non-Hispanic White women. The birth rate of 14.0 live births per 1,000 population was the same as the rate reported in 2004. Among non-Hispanic White, non-Hispanic Black, and Asian/Pacific Islander populations, birth rates declined, while they rose slightly among the Hispanic and American Indian/Alaska Native populations.

With regard to age, overall birth rates were highest among those aged 25–29 years (115.6 per 1,000), followed by those aged 20–24 years (102.2 per 1,000). The birth rate for non-Hispanic Whites was highest in the 25–29 age group (109.3 per 1,000), while the rates for non-Hispanic Blacks, Hispanics, and American Indian/Alaska Natives were highest in the 20–24 age group (126.7, 169.6, and 109.0 per 1,000, respectively). The birth rate among Asian/Pacific Islanders was highest among 30- to 34-year-olds (115.1 per 1,000).

Overall, 36.8 percent of births were to unmarried mothers. This percentage was the highest among non-Hispanic Black mothers (69.5 percent of all births), followed by American Indian/Alaska Native mothers (63.3 percent). The lowest percentage of births to unmarried mothers was among the Asian/Pacific Islander group (16.2 percent).

Live Births per 1,000 Women, by Age and Race/Ethnicity, 2005*

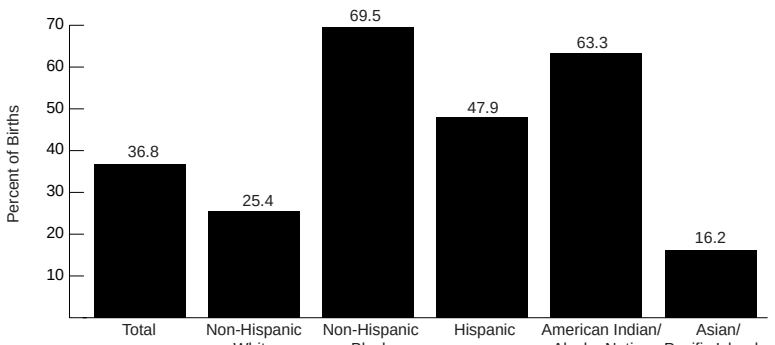
Source II.23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaska Native	Asian/ Pacific Islander
15-19 Years	40.4	26.0	60.9	81.5	52.7	16.9
20-24 Years	102.2	81.5	126.7	169.6	109.0	61.0
25-29 Years	115.6	109.3	103.0	148.8	94.0	108.0
30-34 Years	95.9	97.2	68.5	106.5	59.9	115.1
35-39 Years	46.3	45.7	34.3	54.0	26.9	61.9
40-44 Years	9.1	8.3	8.2	12.9	6.0	13.9

*Data are preliminary.

Births to Unmarried Mothers, by Race/Ethnicity, 2005*

Source II.23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data are preliminary.

BREASTFEEDING

Breastmilk benefits the health, growth, immunity, and development of infants. Mothers who breastfeed may have a decreased risk of breast and ovarian cancers.[1]

In 2005, 72.9 percent of infants were reported to have ever been breastfed. Non-Hispanic Black infants were the least likely to ever be breastfed (55.4 percent), while Asian/Pacific Islanders were the most likely (81.4 percent), followed by Hispanics (79.0 percent). Infants born to younger mothers, mothers with lower educational attainment, mothers with low family income, and mothers receiving WIC program benefits were also less likely to be breastfed.

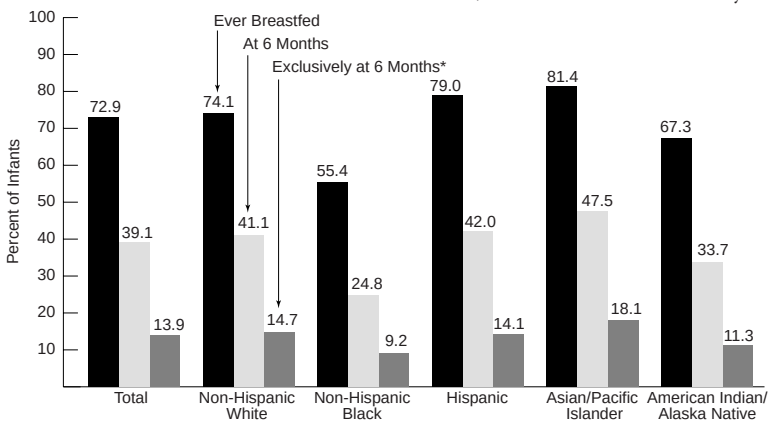
The American Academy of Pediatrics recommends that infants be exclusively breastfed—without supplemental solids or liquids—for the first 6 months of life, based on evidence of reduced risk of upper respiratory and other common infections. However, only 13.9 percent of infants were exclusively breastfed at 6 months in 2005, and only 39.1 percent of infants were fed any breastmilk at 6 months.

Younger mothers were less likely to breastfeed than mothers in older age categories. In 2005, 50.0 percent of infants with mothers under age 20 were ever breastfed, compared to 68.4 percent of infants born to mothers aged 20–29 years, and 77.7 percent of infants born to mothers aged 30 years and older. The percentage of infants who were breastfed at 6 and 12 months also increased with maternal age.

1 Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Evidence Report/Technology Assessment No. 153 (Prepared by Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E0007. Rockville, MD: Agency for Healthcare Research and Quality. April 2007.

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

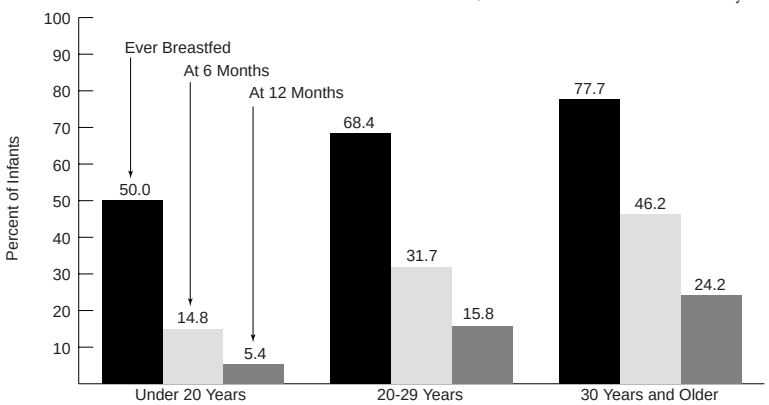
Source II.24: Centers for Disease Control and Prevention, National Immunization Survey



**Exclusive breastfeeding is defined as only breastmilk—no solids, water, or other liquids.*

Infants Who Are Breastfed, by Maternal Age and Duration, 2005

Source II.24: Centers for Disease Control and Prevention, National Immunization Survey



OLDER WOMEN

In 2005, there were 34.8 million adults aged 65 and older in the United States, representing 12 percent of the total population. According to the U.S. Census Bureau, the older population is expected to grow to 72 million by 2030, representing approximately 20 percent of the population, due to the aging of the baby boom generation. In 2005, older women composed 6.9 percent of the total population while men composed 5.2 percent. Older women represented a larger proportion of the elderly population than men within every age group.

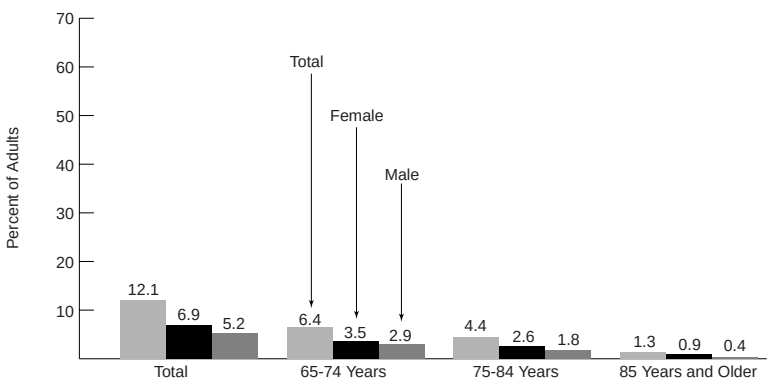
Employment plays a significant role in the lives of many older Americans. In 2006, more than 2.3 million women aged 65 years or older were working, accounting for 11.4 percent of women in this age group. While elderly men are more likely than women to be employed, since 1994 the percentage of employed older adults has increased faster among women than men (data not shown). In 2006, 23.5 percent of 65- to 69-year-old women were employed, compared to 17.3 percent in 1994, an increase of almost 39 percent. Among women aged 70–74, 12.7 percent were employed in 2006, an increase of 53.0 percent since 1994. Likewise, the percentage of women aged 75 and older who worked rose 26.5 percent from 1994 to 2006 (3.4 to 4.3 percent, respectively).

According to a report by the U.S. Census Bureau, those who choose to retire cite a variety of reasons, including being required to do so, poor health, wanting to do other things, and wanting to spend time with family. Very few cited not liking work as a reason for retirement.[1]

1 He W, Sengupta M, Velkoff VA, and DeBarros KA. U.S. Census Bureau, Current Population Reports, P23-209, 65+ in the United States: 2005, U.S. Government Printing Office, Washington, DC, 2005. (Table 4-3)

Representation of Adults Aged 65 and Older in the U.S. Population,* by Age and Sex, 2005

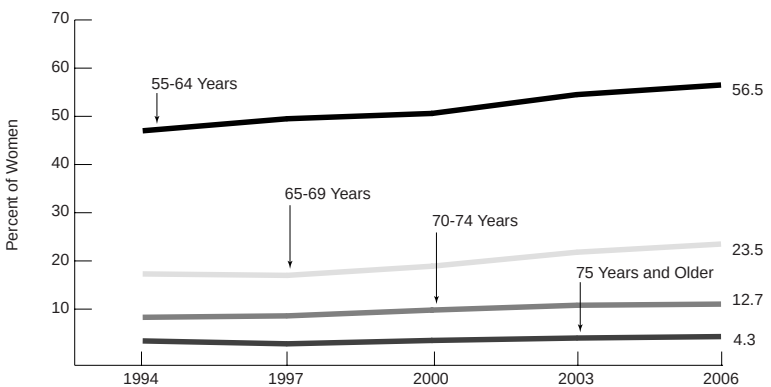
Source I.1: U.S. Census Bureau, American Community Survey



*Civilian, non-institutionalized population.

Employed Women, Aged 55 and Older, by Age, 1994-2006

Source II.25: U.S. Department of Labor, Bureau of Labor Statistics



RURAL AND URBAN WOMEN

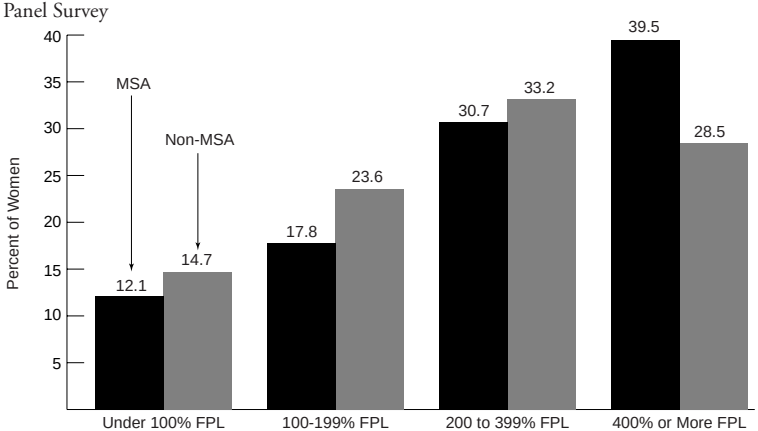
In 2004, almost 51 million people, or 17.3 percent of the population, lived in an area considered to be non-metropolitan. The number of areas defined as metropolitan changes frequently as the population grows and people move. Residents of non-metropolitan areas tend to be older, complete fewer years of education, have public insurance or no health insurance, and live farther from health care resources than their metropolitan counterparts.

Women in metropolitan areas also tend to have higher household incomes. In 2004, 12.1 percent of women in metropolitan areas reported family incomes of less than 100 percent of the Federal poverty level (FPL), compared to 14.7 percent of women in non-metropolitan areas. For women with family incomes of 100–199 percent of the FPL, the rates were 17.8 and 23.6 percent, respectively. Women in metropolitan areas were more likely than women in non-metropolitan areas to report incomes of 400 percent or more of the FPL (39.5 versus 28.5 percent, respectively).

Women in non-metropolitan areas generally have access to fewer health care resources. In addition, they are also less likely to report being in good health. In 2004, 56.7 percent of women in metropolitan areas reported being in excellent or very good health, compared to 51.7 percent of women in non-metropolitan areas. Likewise, metropolitan women were less likely to report having fair or poor health.

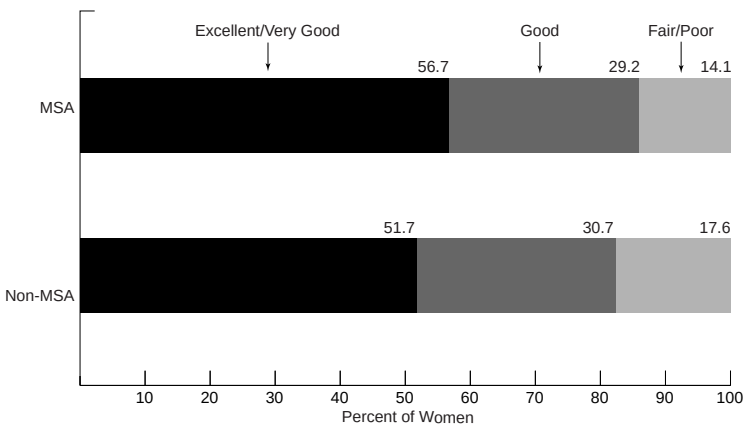
Women Aged 18 and Older, by Area of Residence* and Poverty Status,** 2004

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



Self-Reported Health Status of Women Aged 18 and Older, by Area of Residence,* 2004

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



Metropolitan Statistical Areas (MSA) include at least: one city with 50,000 or more inhabitants, or an urbanized area of at least 50,000 inhabitants and a total metropolitan population of at least 100,000 (75,000 in New England). Additional "outlying counties" are included in the MSA if they meet specified requirements of commuting to the central counties and other selected requirements of metropolitan character. In New England, the MSAs are defined in terms of cities and towns, not counties. Federal Poverty Level (FPL) was equal to $18,850 for a family of four in 2004, as determined by the U.S. Department of Health and Human Services.*

HEALTH SERVICES UTILIZATION

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

The following section presents data on women's health services utilization, including data on insurance coverage, usual source of care, satisfaction with care, use of medication, and use of various services, such as preventive care, HIV testing, and mental health services. The contribution of HRSA to women's health across the country is highlighted, as well.

USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2005, almost 90 percent of women reported having a usual source of care. Women of all racial and ethnic groups were more likely than men to have a usual source of care. Among women, non-Hispanic Whites were most likely to report a usual source of care (91.8 percent), followed by non-Hispanic Blacks (89.9 percent); Hispanic women were least likely to report a usual source of care (78.5 percent).

In 2005, 86.9 percent of women reported an office-based source of care (such as a physician's office), while fewer than 1 percent reported an emergency department was their usual source of care. This varied by family income level. Women with family incomes under 100 percent of the Federal poverty level (FPL) were more likely to report that hospital outpatient departments (1.5 percent) and emergency departments (1.9 percent) were the places they usually go when sick, and were more likely to have no usual source of care (17.1 percent) than those with higher income levels. Only 0.2 percent of women whose family incomes were at 300 percent or more of FPL named emergency departments as the place they usually go when sick, and only 6.1 percent had no usual source of care.

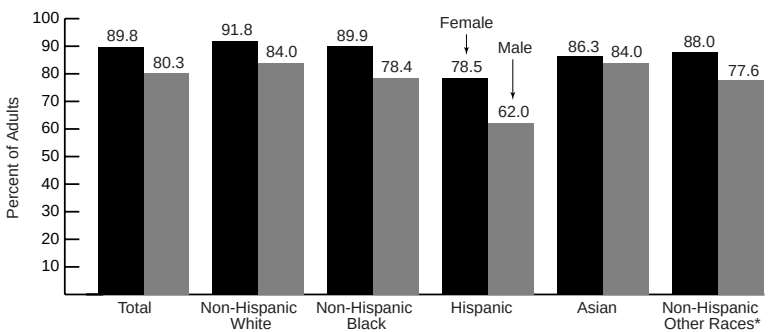
1 Ettner SL. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference? Medical Care 1999;37(6): 647-55.

2 Sox CM, Swartz K, Burstin HR, Brennan TA. Insurance or a regular physician: which is the most powerful predictor of health care? AJPH 1998;88(3):364-70.

3 Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. AJPH 1996;86(12):1742-7.

Adults Aged 18 and Older with a Usual Source of Care, by Sex and Race/Ethnicity, 2005

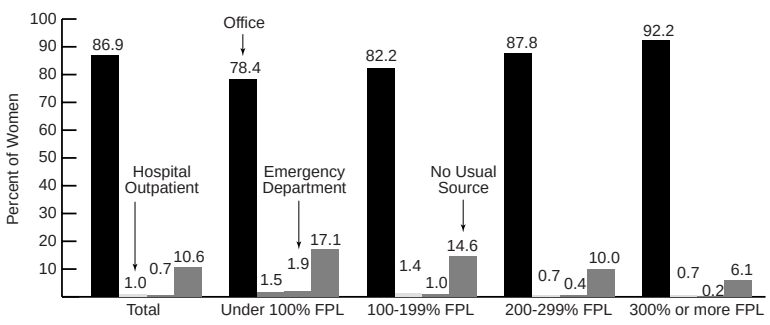
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Includes American Indian/Alaska Natives and persons of more than one race.*

Usual Source of Care Among Women Aged 18 and Older, by Poverty Status,* 2005

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



**Federal poverty level (FPL) was $19,350 for a family of four in 2005; this amount is determined annually by the U.S. Department of Health and Human Services.*

HEALTH INSURANCE

People who are uninsured are less likely than those with insurance to seek preventive care, which can result in poor health outcomes and higher health care costs. In 2005, 44.4 million non-elderly individuals in the United States, representing 17.2 percent of that population, were uninsured.[1] The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race/ethnicity, income, and education.

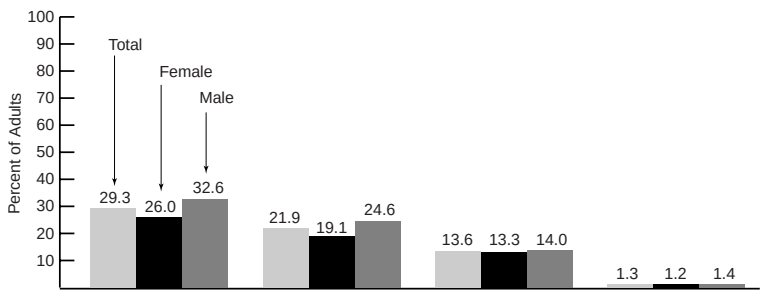
In 2005, among adults aged 18 and older, younger persons were most likely to lack health insurance, and men were more likely than women to be uninsured in every age group. The largest percentage of uninsured persons occurred among 18- to 24-year-old males (32.6 percent), which was significantly higher than the percentage for women of the same age group (26.0 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest rates of uninsured occurred among women and men aged 45–64 (13.3 and 14.0 percent); however, the gender disparity was less pronounced than in the younger age groups.

Among women aged 18–64 in 2005, 71.8 percent had private insurance, 14.6 percent had public insurance, and 17.8 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (79.0 percent), followed by Asian/Pacific Islander women (72.9 percent). Non-Hispanic Black females had the highest rate of public insurance (24.0 percent), and Hispanic females had the highest rate of being uninsured (36.9 percent), followed closely by American Indian/Alaska Native women (33.4 percent). [Respondents were able to report more than one type of coverage.]

1 This statistic does not include adults aged 65 and older because that is the age when people become eligible for Medicare coverage based on age.

Adults Aged 18 and Older Without Health Insurance, by Sex and Age, 2005*

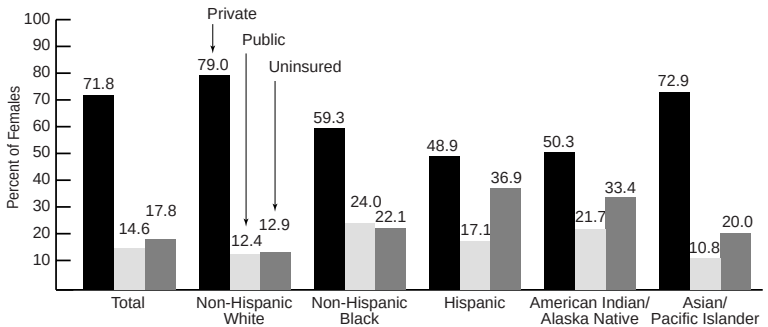
Source III.1: U.S. Census Bureau, Current Population Survey



**These data reflect changes to 2005 estimates that were released on April 10, 2007.*

Health Insurance Coverage of Women Aged 18-64, by Type of Coverage and Race/Ethnicity,* 2005

Source III.1: U.S. Census Bureau, Current Population Survey



**Totals for each race/ethnicity may equal more than 100 percent because it was possible to report more than one type of coverage. These data reflect changes to 2005 estimates that were released on April 10, 2007.*

MEDICARE AND MEDICAID

Medicare is the Nation's health insurance program for people aged 65 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 is a managed care program now known as "Medicare Advantage;" and Part D, added in 2006, covers prescription drugs.

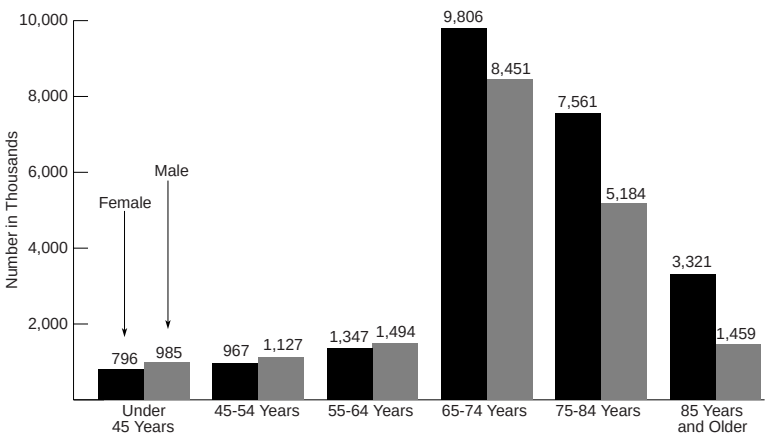
In 2005, 56 percent of Medicare's 42.5 million enrollees, were female. A majority of Medicare enrollees were aged 65 and older; the elderly represented 87 percent of female and 81 percent of male enrollees.

Of the 43 million enrollees eligible for the Medicare Part D prescription drug program in 2006, 55.8 percent were female. Of those who enrolled in stand-alone prescription drug plans, 6.6 million (61 percent) were female. Most women enrolled in Part D are in the 75- to 89-year-old age group with 2.85 million enrollees, followed by the 65- to 74-year-old age group with 2.76 million.

Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income people and people with disabilities. In 2004, Medicaid covered 58 million individuals including children; the aged, blind, and disabled; and adults who are eligible for cash assistance programs. Overall, 59 percent of all Medicaid enrollees were female; of the adults enrolled in Medicaid, 69 percent were women (data not shown).

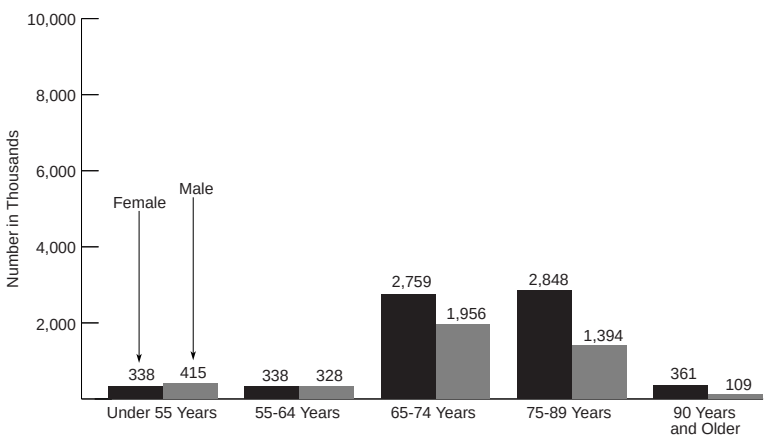
Medicare Enrollees (All Ages), by Age and Sex, 2005

Source III.2: Centers for Medicare and Medicaid Services



Medicare Part D Enrollees* (All Ages), by Age and Sex, 2006

Source III.2: Centers for Medicare and Medicaid Services



Enrollees in stand-alone prescription drug plans only.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services.

Indicators used to monitor women's health care in managed care plans include the timeliness of prenatal care, receipt of postpartum checkups after delivery, screening for chlamydia, screening for cervical cancer, and receipt of mammograms. In 2005, the rate of perinatal services and chlamydia screening increased, while the rate of cervical cancer screening among women in commercial plans rose after a decrease during 2004.

Perinatal services—prenatal care and postpartum checkups—appear to be more accessible in commercial (private) plans than in public-sector plans financed by Medicaid. The same is true of cervical cancer screening, which is received at least once every 3 years by nearly 82 percent of commercially-insured women and 65 percent of women covered by Medicaid.

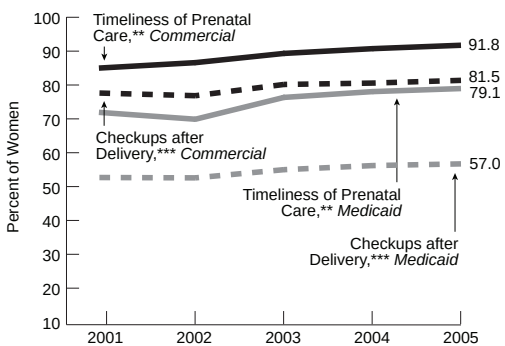
Chlamydia screening is the one screening service that is more common among Medicaid-enrolled women than those with private coverage: 52.4 percent of Medicaid-enrolled women aged 21–25 had a chlamydia screen in the previous year, compared to 35.2 percent of commercially-insured women.

In 2005, the rate of mammograms for women aged 52–69 was approximately the same for women with private coverage and those covered through Medicare. However, Medicaid-enrolled women were considerably less likely to receive a mammogram at least once every 2 years.

Patients' personal experiences of health care also reflect on the quality of care, as those who are not satisfied with their providers may be less likely to

HEDIS®* Measures of Perinatal Care, by Payer, 2001-05

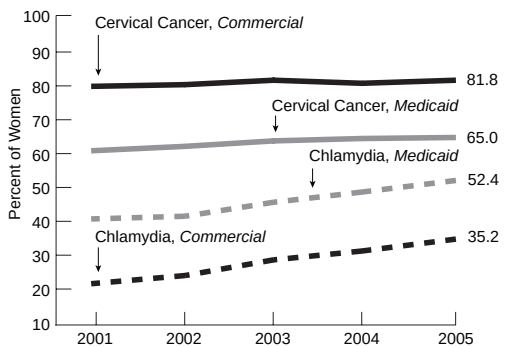
Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The proportion of women beginning prenatal care in the first trimester or within 43 days of enrollment if pregnant at enrollment. ***The proportion of women who had a visit to a health care provider between 21 and 56 days after delivery.*

HEDIS®* Rates of Chlamydia,** Cervical Cancer*** Screening, by Payer, 2001-05

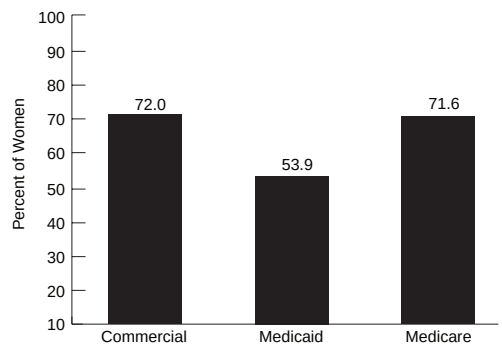
Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active plan members aged 21-25 who had at least one test for chlamydia in the past year. ***The percentage of women aged 21-64 who had at least one Pap test in the past 3 years.*

HEDIS®* Rates of Mammograms,** by Payer, 2005

Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 52-69 years who had at least one mammogram in the past 2 years. Note: Data from 2004 and later cannot be compared to previous years because of changes in the specification of the measure.*

continue with treatments and seek further services.[1] Two aspects that may contribute to better outcomes are patients' perceptions of how well their doctors or other health care providers communicate with them and access to necessary health care services, such as appointments with doctors or specialists, or obtaining necessary tests or treatments. In 2005, women under age 75 were consistently less satisfied than men with their personal experiences of both of these aspects of care.

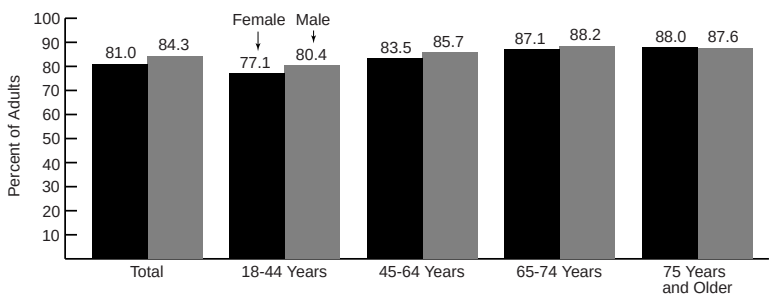
In 2005, fewer females were satisfied with how well their doctors communicated (81.0 percent), compared to males (84.3 percent). However, this varied across age groups. Younger men and women were least likely to be satisfied, and women were less satisfied than men in every age group, except those 75 and older. Among 18- to 44-year-olds, 77.1 percent of women and 80.4 percent of men were satisfied, while 88.0 percent of women and 87.6 percent of men aged 75 and older reported satisfaction with how well doctors communicate. Non-Hispanic White women (83.0 percent) were also more likely than non-Hispanic Black or Hispanic women (76.8 and 76.7 percent, respectively) to be satisfied (data not shown).

In 2005, men were more likely than women (67.0 versus 62.5 percent) to be satisfied with their ability to get necessary care from physicians or specialists—including obtaining treatments or tests—though women aged 75 and older were more likely than their male counterparts (76.9 versus 74.8 percent) to be satisfied. Older men and women were also more likely than their younger counterparts to be satisfied with their access to necessary care. Among females, 60.0 percent of 18- to 44-year-olds were satisfied compared to 72.8 percent of those aged 65–74 and nearly 77 percent of those aged 75 and older.

1 Fan VS, Burman M, McDonnell MB, Fihn SD. Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care. Journal of General Internal Medicine. 2005; 20:226-233.

Satisfaction with How Well Doctors Communicated,* by Sex and Age, 2005

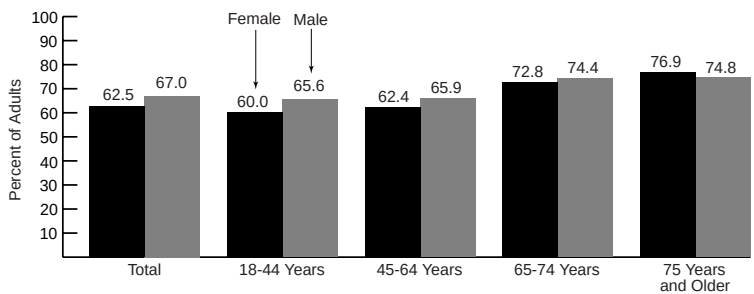
Source III.4: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



**Based on questions related to care received from doctors or other health providers in the past 6 (Medicaid respondents) or 12 months (commercial health plan respondents).*

Satisfaction with Access to Necessary Care,* by Sex and Age, 2005

Source III.4: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



**Based on questions related to receiving regular physician's visits or specialists visits, obtaining necessary treatments or tests, and delays caused by health plan approval in the last 6 (Medicaid respondents) or 12 months (commercial health plan respondents).*

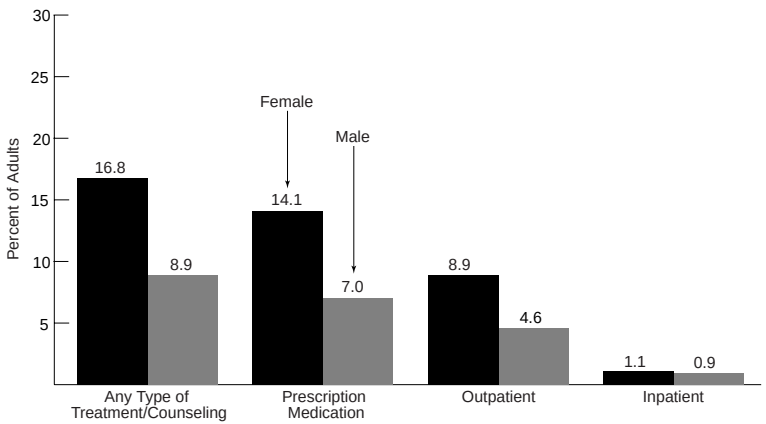
MENTAL HEALTH CARE UTILIZATION

In 2005, over 28 million adults in the United States reported receiving mental health treatment in the past year. Women represented approximately two-thirds of users of mental health services. The most common type of treatment obtained was prescription medication, followed by outpatient treatment. Almost 16 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.1 percent of women aged 18 and older, compared to 7.0 percent of men. Outpatient treatment was reported by 8.9 percent of women, and inpatient treatment was reported by 1.1 percent of women.

Mental health services are needed, but not received, by millions of adults in the United States. In 2005, 3.7 percent of women and 2.3 percent of men reported an unmet need for mental health treatment or counseling. Cost or no insurance was the most commonly reported reason for not receiving needed services, reported by 47.1 percent of women and 51.8 percent of men with unmet mental health treatment needs. Others mentioned feeling that they could handle their problems without treatment (reported by 34.3 percent of women and 28.8 percent of men with unmet needs). In addition, stigma, including concern about the opinions of others, effects on employment, or feelings of shame, embarrassment, or fear prevented 19.6 percent of women and 24.0 percent of men with unmet needs from receiving treatment.

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Sex and Type, 2005

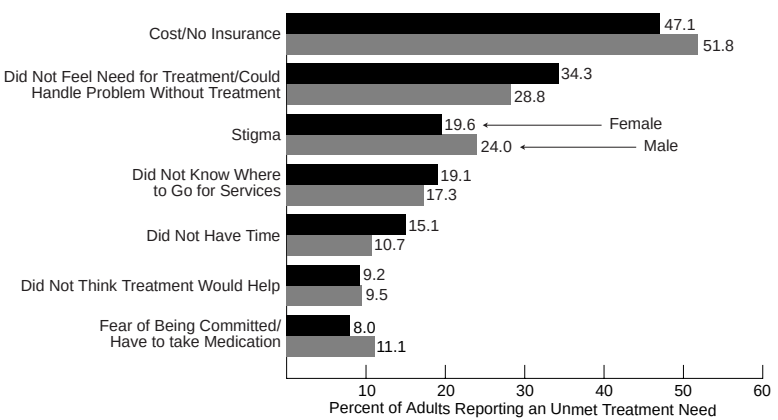
Source II.4: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



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

Reasons for Unmet Mental Health Treatment Needs Among Adults Aged 18 and Older,* by Sex, 2005

Source III.5: 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.

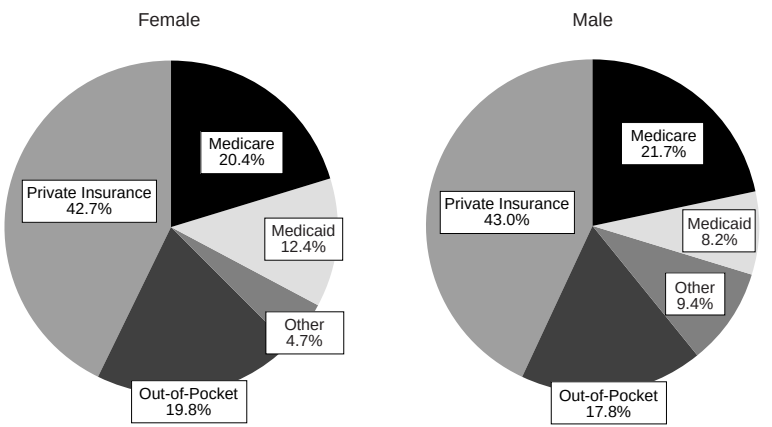
HEALTH CARE EXPENDITURES

In 2004, the majority of health care expenses of both females and males were covered by public or private health insurance. For females, nearly one-third of expenses were covered by either Medicare or Medicaid, while almost 43 percent were covered by private insurance. Although the percentage of expenditures paid through private insurance was approximately equal for both sexes, health care costs of females were more likely than those of males, to be paid by Medicaid or out-of-pocket.

Nearly 90 percent of females had at least one health care expenditure in 2004, compared to 80 percent of males. Among those who had at least one health care expense in 2004, the average per person expenditure including expenses covered by insurance and those paid out-of-pocket, was slightly higher for females ($4,158) than for males ($3,554). However, males' average expenditures exceeded females' for hospital inpatient services ($16,007 compared to $12,292) and hospital outpatient services, while females' expenditures exceeded males' in the categories of home health services, office-based medical services, and prescription drugs. While the gender gap in health care expenditures has narrowed somewhat since 1998, overall per capita health care expenditures have increased substantially among both men and women. Males' expenses have gone up by 67 percent over this period while females' have increased by 53 percent.

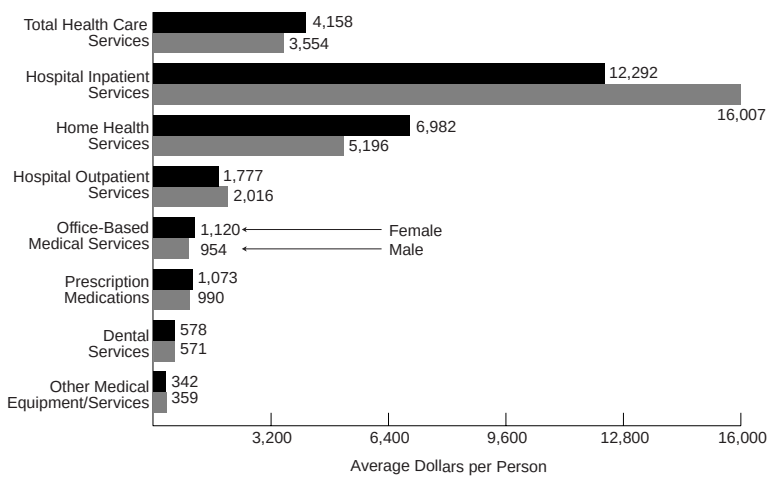
Health Care Expenses, by Source of Payment and Sex (All Ages), 2004

Source III.6: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 2004

Source III.6: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



PREVENTIVE CARE

Counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2004, females of all ages made 535 million physician office visits. Of these visits, 18.6 percent were for preventive care, including prenatal care, screenings, and insurance examinations.[1]

Routine Pap smears, which detect the early signs of cervical cancer, are recommended within 3 years of initiation of sexual activity, or by age 21. In 2004, 5.3 percent of all physician visits made by women aged 18 or older included a Pap smear. This rate was higher among the younger age groups, and occurred in 9.9 percent of office visits made by women aged 18–24 years compared to only 5.2 percent of visits by women aged 45–64 and 1.2 percent of visits made by women aged 65 years and older.

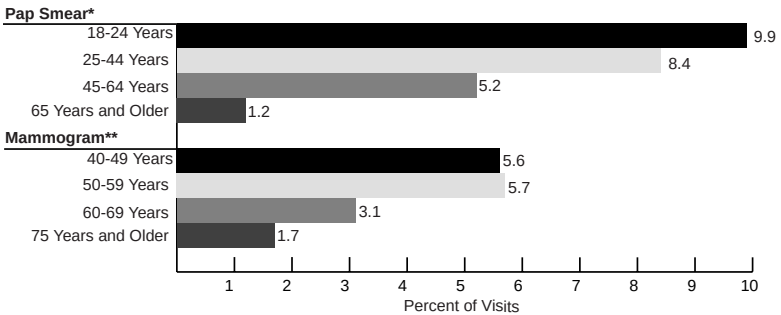
Among women 40 and older, 3.9 percent of all office visits included a mammogram, which is recommended every 1–2 years to screen for breast cancer among this age group. The proportion of office visits including a mammogram was highest among the younger age groups: 5.6 and 5.7 percent of visits, respectively, among women aged 40–49 years and 50–59 years, compared to 1.7 percent among women 75 years and older.

Vaccination is another important preventive measure. Vaccination for influenza is generally recommended for young children, older adults, and adults with chronic health conditions. In 2005, 60.5 percent of women aged 65 and older reported receiving a flu vaccine in the past year. Pneumonia vaccine is also recommended for older adults and people with certain health conditions. In 2005, almost 60 percent of women aged 65 and older reported ever receiving the vaccine. Non-Hispanic White women were most likely to have ever received the pneumonia vaccine (63.2 percent), compared to 28.5 percent of Hispanic and 35.4 percent of Asian women.

1 Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2004 Summary. Advance Data from Vital and Health Statistics, No. 374, June 2006. http://www.cdc.gov/nchs/data/ad/ad374.pdf. Viewed 4/18/07.

Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits, by Age, 2004

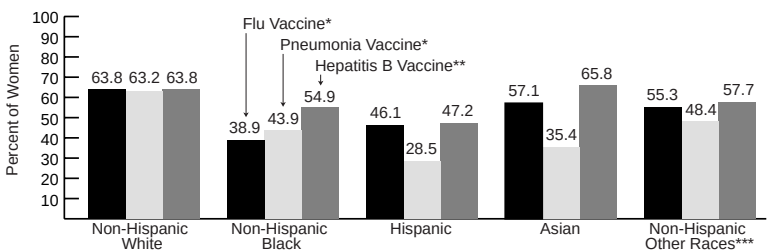
Source III.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



**Among women aged 18 and older. **Among women aged 40 and older.*

Selected Vaccinations Received by Women, by Race/Ethnicity, 2005

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



**Flu vaccine among women aged 65 or older; received either a shot or nasal spray in the last 12 months. Pneumonia vaccine among women aged 65 or older; ever received the vaccine. **Hepatitis B vaccine among women aged 18–24; ever received at least one dose of the vaccine (in a three dose series). ***Includes American Indian/Alaska Natives and persons of more than one race.*

HIV TESTING

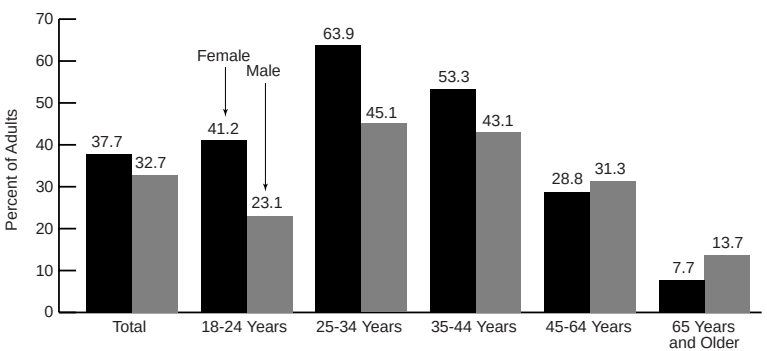
Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek appropriate care. HIV testing requires only a simple blood or saliva test, and it is often offered through confidential or anonymous sources. It is recommended that people who meet any of the following criteria be tested for HIV: have injected drugs or steroids, or shared drug use equipment (such as needles) with others; 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 the previous criteria.[1]

In 2005, just over 35 percent of adults in the United States had ever been tested for HIV. Overall, women were more likely than men to have been tested (37.7 versus 32.7 percent). Women were more likely to have been tested at younger ages, while men were more likely to have been tested at older ages. This difference may be due in part to Centers for Disease Control and Prevention (CDC) guidelines that recommend HIV testing for pregnant women. In 2006, new CDC guidelines were released that recommend all health care providers include HIV testing as part of their patients' routine health care. Among women, in 2005, non-Hispanic Blacks had the highest testing rate (52.5 percent), followed by Hispanics (47.3 percent). Non-Hispanic White women had the lowest rate (33.5 percent).

1 Centers for Disease Control and Prevention, National HIV Testing Resources. Frequently asked questions about HIV and HIV testing. http://www.hivtest.org. Viewed 4/18/07.

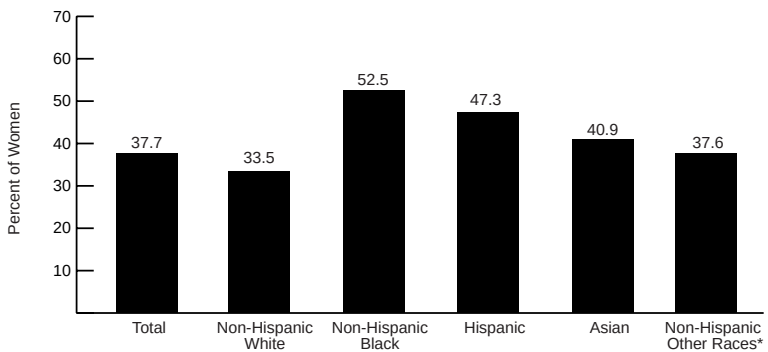
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2005

Source II.2: 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, 2005

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



**Includes American Indian/Alaska Natives and persons of more than one race.*

MEDICATION USE

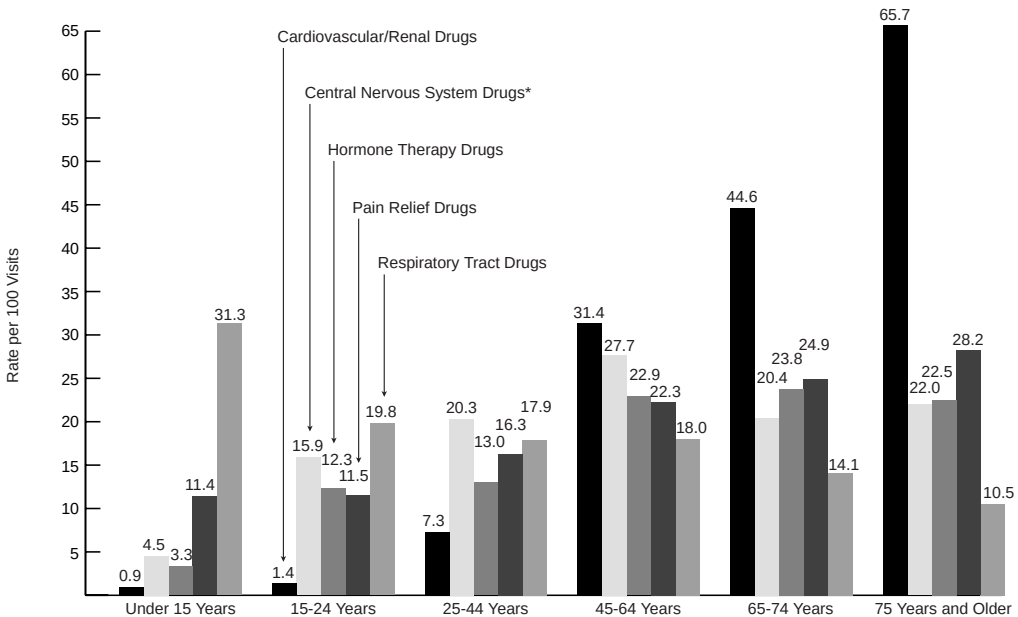
In 2004, medication was prescribed or provided at more than 585 million physician office visits; multiple drug prescriptions were recorded at 38.9 percent of all visits. The percent of visits with one or more drugs prescribed or provided was similar for males and females (64.6 and 64.0 percent). Among females, 36.0 percent of visits did not involve prescribing or providing any drugs, 25.3 percent of visits involved the prescription or provision of one drug, and 14.4 percent of visits involved two drugs.[1]

The prescription or provision of medications among females varies by age and drug type. In 2004, the rate of cardiovascular/renal and pain relief drugs prescribed or provided at physician office visits generally increased with age, while respiratory tract drugs decreased with age. Prescription or provision of nervous system drugs, including mental health medications such as antidepressants, during physician visits were most common among women 45–64 years (27.7 per 100 visits). The highest rate of drug prescription or provision was 65.7 per 100 visits, which was for cardiovascular/renal drugs among women 75 years and older. Among females under 15 years, the lowest rate of drug prescription or provision (0.9 per 100 visits) was for cardiovascular/renal drugs, and the highest rate was for respiratory tract drugs (31.3 per 100 visits).

1 Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2004 summary. Advance Data from Vital and Health Statistics, No. 374; 2006 June.

Medication Use Reported for Females During Physician Office Visits, by Age, 2004

Source III.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



**Includes antidepressants, antipsychotics, sedatives, and anxiety medications.*

ORGAN TRANSPLANTATION

Between January 1 and November 30, 2006, 26,691 organ transplants occurred in the United States. In 2006, the gender distribution of organ donors was nearly even (6,993 males and 6,589 females), though most of the organs donated by living people were from women (58.5 percent). Since 1988, there have been 391,233 transplants.

The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 16, 2007, there were 94,692 people awaiting a life-saving organ transplant. Females were 41.9 percent of those patients, but made up only 37.3 percent of those who received a transplant in 2006.[1] Among women waiting for an organ transplant, 46.5 percent were White, 29.6 percent were Black, and 16.1 percent were Hispanic. The kidney was in highest demand, with 29,437 females awaiting this organ as of February 16, 2007.

The number of organs donated remained roughly static from 1990–2003. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. In 2004, donations increased by an unprecedented 12 percent over the previous year, and in 2005 they increased by another 12 percent; in 2005–06, the number dropped slightly but was still well above 2002 levels. One of the challenges of organ donation is obtaining consent from the donor family or legal surrogate. Consent rates may vary due to religious perceptions, poor communication between health care providers and grieving families, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased.[2]

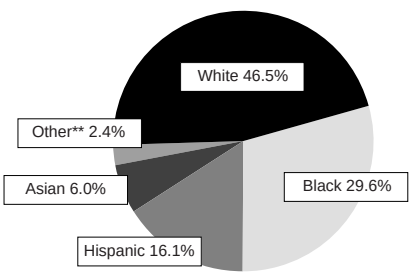
The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are managed by HRSA's Healthcare Systems Bureau (HSB). Other HSB programs include: the National Marrow Donor Program, the National Cord Blood Stem Cell Bank, the National Vaccine Injury Compensation Program, and the Smallpox Emergency Personnel Protection Act Program.

1 2006 Data are from January 1–November 30, 2006.

2 2003 OPTN/SRTR Annual Report: Transplant Data 1992-2002. HHS/HRSA/SPB/DOT; UNOS; URREA.

Distribution of Females on Organ Waiting List,* by Race/Ethnicity, 2007

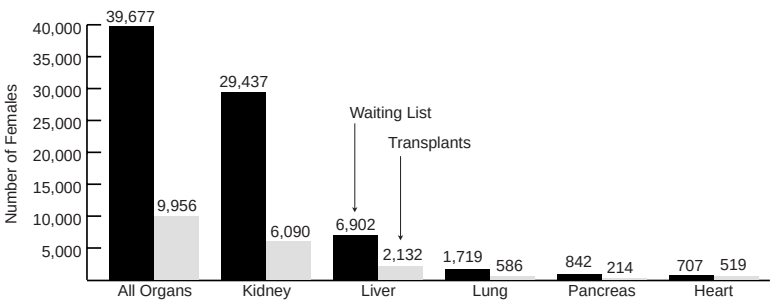
Source III.8: Organ Procurement and Transplantation Network



**As of February 16, 2007. **Includes American Indian/Alaska Natives, Pacific Islanders and persons of more than one race.*

Female Transplant Recipients, 2006, and Females on Transplant Waiting Lists,* 2007, by Organ

Source III.8: Organ Procurement and Transplantation Network



**As of February 16, 2007.*

HRSA PROGRAMS

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports a wide range of programs that increase and promote access to health care for vulnerable populations. **HRSA's Office of Women's Health (OWH)** coordinates many efforts that address women's health across their lifespan. A key project of OWH is the Bright Futures for Women's Health and Wellness (BFWHW) initiative, which provides materials for young women (adolescents) and adult women on topics such as physical activity and healthy eating, emotional wellness, and maternal wellness. These and other consumer-friendly resources, including data books and research reports, can be found on the OWH Web site (www.hrsa.gov/womenshealth).

The HRSA Web site (www.hrsa.gov) provides information about each of HRSA's bureaus and offices, several of which administer programs that directly affect women's health and access to health care. For example, **Maternal and Child Health Bureaus (MCHB)** administers the MCH Block Grant, a Federal-State partnership to improve the health of all mothers and children. MCHB also works to end violence and bullying in schools through the Stop Bullying Now! Campaign online at www.stopbullyingnow.hrsa.gov.

HRSA programs facilitate partnerships to advance women's health. The **Bureau of Health Professions** regularly assesses the health workforce, conducting numerous studies of capacity and diversity in health professions in which women predominate, such as nursing. The **Office of Rural Health Policy** has partnered with OWH to adapt BFWHW Physical Activity and Healthy Eating materials for young women (adolescents) and adult women in rural communities. The **HIV/AIDS Bureau** addresses the needs of women living with HIV/AIDS through all of its programs, especially Part D (formerly Title IV) of the Ryan White Program, which targets services to women, infants, children, youth, and their families. The **Healthcare Systems Bureau** oversees a variety of programs that affect access to lifesaving procedures for women, including the Organ Procurement and Transplantation Network, described on page 74, as well as the 340B Drug Pricing Program, and Hill-Burton Free and Reduced Cost Health Care.

The **Bureau of Primary Health Care** manages the Health Center Program, which funds a national network of more than 1,000 health center grantees at over 3,800 comprehensive, primary health care service delivery sites comprised of community health centers, migrant health centers, health care for the homeless health centers, and public housing primary care health centers. These health centers deliver preventive and primary care services to patients regardless of their ability to pay; charges for health care services are set according to income. Almost 40 percent of the patients treated at health centers have no insurance coverage and others have inadequate coverage.

In 2001, President Bush announced a Health Centers Initiative to increase access to health care in 1,200 communities through new or expanded health center sites. Since then, HRSA has awarded 900 grants to create new health center sites or expand operations at existing centers, and the number of patients has risen from 10.3 million in 2001 to an estimated 14.8 million in 2006.

Finally, HRSA's Health Disparities Collaboratives (HDCs) were developed to transform primary health care practices to improve quality and eliminate health disparities. The HDCs have focused on diabetes, asthma, depression, cardiovascular disease, cancer screening/planned care, finance/redesign, prevention, diabetes prevention, perinatal/patient safety, and oral health. Over 85 percent of health centers have participated in the HDCs as of April 2007.

Health Centers Supported by the Bureau of Primary Health Care

Source: Uniform Data System, Bureau of Primary Health Care, HRSA, HHS, 2005.

Type	*Number*
Community Health Center	851
Migrant Health Center	135
Homeless Health Center	176
School-based Health Center	78
TOTAL	**1,240**

INDICATORS IN PREVIOUS EDITIONS

Each edition of the *Women's Health USA* databook 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 these indicators, 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 2002

Lupus
Non-Medical Use of Prescription Drugs
Nursing Home Care Utilization
Unintended Pregnancies
U.S. Population Growth

Women's Health USA 2003

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

Women's Health USA 2004

Complementary and Alternative Medicine Use
Eating Disorders
Maternal Morbidity and Mortality
Services for Homeless Women
Women in NIH-Funded Clinical Research

Women's Health USA 2005

Adolescent Pregnancy
Border Health
Immigrant Health
Maternity Leave
Prenatal Care

Women's Health USA 2006

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

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I.2 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. America's families and living arrangements. 2005 Mar.

I.3 U.S. Census Bureau, Current Population Survey, Annual Demographic Survey. March supplement. www.census.gov. Viewed 4/18/07.

I.4 U.S. Department of Education, National Center for Education Statistics. Digest of Education Statistics Tables and Figures, 2005. (Tables 227, 246) http://nces.ed.gov. Viewed 4/18/07.

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CONTRIBUTORS

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

Agency for Healthcare Research and Quality
Centers for Disease Control and Prevention
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Other Federal Contributors

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Association of Schools and Colleges of Optometry
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Commission on Accreditation of Dietetics Education
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Employee Benefit Research Institute
National Committee on Quality Assurance
United Network for Organ Sharing