Office on Women's Health
U.S. Department of Health and Human Services

THE HEALTH OF MINORITY WOMEN

Of the 281.4 million persons living in the United States in 2002, 143.4 million (50.9%) are female, and 29.5% of all U.S. citizens are of racial or ethnic minority groups. Of the 143.4 million females, 42.1 million females (or 29.3%) are members of racial and ethnic minority groups. Although these women experience many of the same health problems as White women, as a group, they are in poorer health, they use fewer health services, and they continue to suffer disproportionately from premature death, disease, and disabilities. Many also face tremendous social, economic, cultural, and other barriers to achieving optimal health.

Women of color in the United States represent many diverse populations. They encompass five major groups, which are listed in descending order of the size of their populations: African American/Black, Hispanic/Latino, Asian American, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander. The 2000 census (newly revised) now distinguishes between race and ethnicity by collecting data on **race** for African American/Black, Asian, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander women, and **ethnicity** by counting people as either "Hispanic or Latino" or "Not Hispanic or Latino." This separation is made because people of Hispanic ethnicity can be of any race. The 2000 census defines race according to the race or races with which they most closely identify – for example, either (or a combination of):

- African American/Black
- American Indian/Alaska Native
- Asian American, or
- Native Hawaiian/Other Pacific Islander.

Ethnicity, on the other hand, can be either:

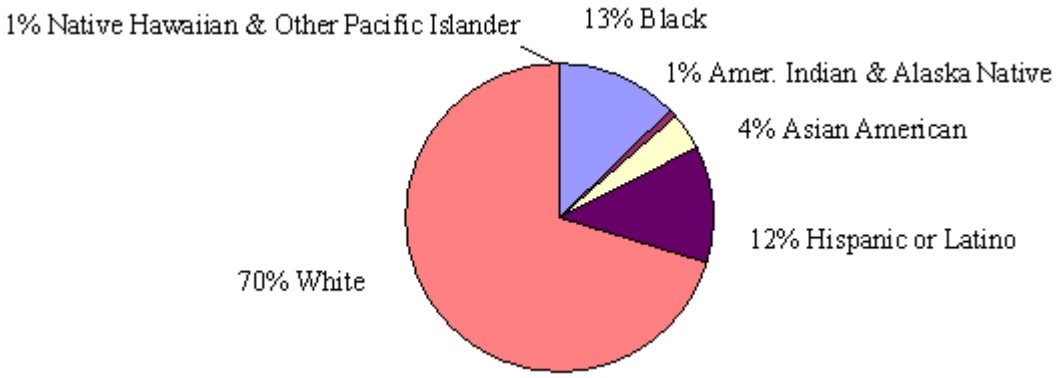
- Hispanic or Latino, or
- Not Hispanic or Latino

These are two separate concepts – race and ethnicity. For example, a person may consider her or himself Black race, but also of Latino ethnicity. Hispanic or Latino, and not Hispanic or Latino, may be of any race.

The population known as the *majority* or *Caucasian population* is referred to as *White* throughout this document. Approximately, 107.7 million, or 75.1%, of American females are White, not of Hispanic origin. For details on the census categories and methodology, please see www.census.gov.

Each group of minority women is made up of subgroups, which have diverse languages, cultures, degrees of acculturation, and histories.

Racial and Ethnic Breakdown of Women in the United States:



- **African American or Black women** have a common African heritage. They may also have roots in the United States, Great Britain, the Caribbean, or other countries. In 2000, slightly more than 18 million (18,193,005), or 12.7%, of all females living in the United States were African American, not of Hispanic origin.

- **Hispanic women**, or **Latinas**, are a multiracial ethnic group, which means persons of Hispanic origin can be of any race. Many Hispanic or Latina women are recent immigrants. Most Hispanics or Latinas in the United States are of Mexican, Puerto Rican, Cuban, Dominican Republic, Central American, or South American descent. In 2000, Hispanic females of any race—numbering more than 17 million (17,114,023) — comprised approximately 12.5% of the U.S. female population.

- **AsianAmerican women** are women with origins in the Far East, including Southeast Asia, or the Indian subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Laos, and Vietnam. The 5.3 million females (5,294,257) in this population group who are not of Hispanic origin comprised 3.7% of all U.S. females in 2000. Asian American women account for 12.6% of all women of color.

- **Native Hawaiian/Pacific Islander women** can originate from any one of 22 islands and may speak as many as 1,000 languages. In the 2000 census, more than 196,000 women in the United States identified themselves as Native Hawaiian/Pacific Islander alone. When the census included Native Hawaiian/Pacific Islander in combination with another racial group, the number rose to almost 435,000 women.

- **American Indian/Alaska Native women** are identified as being members of any of more than 556 federally recognized tribes as well as individuals from state-recognized or unrecognized tribal organizations. Major subgroups of this population are American Indians, Eskimos, and Aleuts. Slightly more than 1 million females (1,241,974), or .87%, of all U.S. females belonged to this population group in 2000. (Note: Percentages of these populations may not equal 100% due to the rounding of numbers.)

Because of this diversity, minority women's access to health care, their health behaviors, and their health status can vary widely between and within these groups. For example, minority women who have recently immigrated to America face *more* obstacles to accessing health care than other minority women in their group. The health status of women *within* the five major minority groups may also differ significantly, depending on income, education, and acculturation.

When minority women are influenced by, and subsequently adopt, the behaviors of a different culture—in this case, Anglo-American culture—they are considered to be *more* acculturated. A greater degree of acculturation has both positive and negative effects on the health risks and health outcomes of these women.

- For example, U.S.-born Hispanic women have a higher risk of developing cancer than foreign-born Hispanics who have immigrated to this country. However, since *more* acculturated Hispanic women tend to have less body fat than their less acculturated peers, their risk for diabetes and heart disease is lower.

  In contrast, less acculturated, first-generation Mexican American women have a lower incidence of low birth-weight infants than more acculturated, second-generation Mexican American women. Immigrants from Mexico also have a lower prevalence of alcohol abuse, major depression, phobias, and drug abuse than U.S.-born Mexican Americans.

I. BARRIERS LIMITING ACCESS TO HEALTH CARE

A. The Health Care System Itself

The current state of *medical practice, medical education, medical research,* and *medical leadership* in the United States creates its own obstacles for minority women. These four areas of medicine have traditionally ignored the health of both women and minorities.

1) **Medical practice**. Obstacles for minority women include inadequate numbers of primary care physicians, the tendency of physicians not to practice in either rural or urban low-income areas in which many minority women live, the absence of nearby health care facilities, and the communication barriers presented by physicians who do not speak or understand the native language of their patients.

Minority women who live in poverty face additional problems. Most receive care in community health centers, hospital outpatient clinics, or other facilities that have high-volume practices. Consequently, physicians in these settings spend less time with patients and provide less preventive care counseling than is common in other medical practices.

2) **Medical education**. Medical education offers little training in cultural competence. Ultimately, cultural competence—more than gender, race, or ethnicity—fosters an environment in which patients of diverse backgrounds will be understood, appropriately diagnosed, and appropriately treated. Only recently has medical education promoted community-based training and increased its focus on primary care, which is desperately needed by minority women in underserved communities.

3) **Medical research.** Few minority women participate in research studies, which results in inadequate or inaccurate data on these populations. Many research studies and data collection efforts misreport the race and ethnicity of minority women. Moreover, data are typically gathered from a limited number of subgroups, and then the conclusions are erroneously applied to the entire minority group.

4) **Medical leadership**. In addition, too few women and minorities serve as physicians, administrators, researchers, medical faculty, nurses, dentists, or other health care providers. Many health care professionals and facilities are, consequently, insensitive to the needs and preferences of minority women. Inadequate communication between patients and health care providers commonly occurs, often as a result of stereotyping, language barriers, and health care materials that are written at inappropriate literacy levels. Health care services that are relevant to the social concerns, cultural attitudes, health needs, and health practices of minority women do not typically exist.

B. Economic Barriers

1) **Income levels**. While minority women are found in all socioeconomic levels, they are more likely to have lower incomes and to live in poverty than are White women. Despite more than 30 years of progress in this society, minority women continue to have less formal education than White women. Even minority women who have similar levels of education as their White counterparts earn less money and have fewer assets. Minority women also hold a disproportionate share of low-wage jobs, and they experience higher unemployment rates.

Low income, in particular, is strongly associated with the decreased use of health services and poor health outcomes. The tendency of economically disadvantaged women to delay seeking treatment—often until the advanced stages of disease—points to the need for early prevention efforts.

2) **Health insurance.** More minority women than White women are uninsured or rely on public, rather than private, health insurance. Since 1965, the federal government's Medicare and Medicaid programs have helped increase minority women's access to health care. Program benefits are limited, however, and frequently do not meet all of these women's health care needs. Unfortunately, the gaps in socioeconomic status and health insurance coverage between White and minority women appear to be growing.

3) **Social and cultural barriers**. Several other factors limit the access of minority women to the U.S. health care system. They include social disadvantages, cultural values, discrimination, lack of culturally appropriate services, inadequate childcare, and transportation, among many others.

Substantial numbers of minority women

- distrust the health care system, which is perceived by many to be hostile and insensitive;
- are single parents;
- have cultural values about health that lead to seeking traditional, ancestral, or spiritual healing first and seeking Western medicine only when other interventions fail;
- experience racial, ethnic, gender, and other forms of discrimination, which can interfere with appropriate diagnosis and treatment;
- are dissatisfied with their health care plans and service providers; and
- experience language barriers and religious differences when being treated by healthcare providers.

II. MINORITY WOMEN'S USE OF PREVENTIVE HEALTH SERVICES:

VACCINATIONS AND SCREENINGS

These systemic, economic, social, and cultural barriers reduce the use of health care services by minority women. Women of every racial/ethnic group, including White women, have low immunization rates for pneumonia and influenza. Women of color often do not get preventive health tests such as screening for cervical cancer (Pap tests), mammograms, or blood pressure screenings. Moreover, the likelihood that minority women will get these preventive tests declines with their age. For all women, being married and having at least a high school education are associated with higher screening rates.

A. Pneumococcal and Influenza Vaccinations

The U.S. Preventative Task Force recommends a single-dose pneumococcal vaccine for all adults 65 years of age and over. The vaccine provides protection against the adverse consequences of pneumonia. In 2000, only 54% of women age 65 and older reported ever having received a pneumococcal vaccination. Rates of pneumococcal vaccines are similar for men and women – but vary greatly between races. Among adults 65 years of age and older, 39% of African American/Black, non-Hispanic adults and 42% of Hispanic or Latino adults reported ever having received a pneumococcal vaccine, compared to 64% of White adults of the same age group.

An annual influenza vaccination is also recommended for all persons 65 years of age and over. It offers substantial protection against complications from the influenza virus. In 2000, 63% of women over the age of 65 had received an influenza vaccine during the past 12 months. Among adults 65 years of age and older, 48% of African American/Black, non-Hispanic adults and 55% of Hispanic or Latino adults, compared to 67% of White adults of the same age group, reported having received a flu vaccine within the past 12 months.

B. Cervical Cancer Screenings

Large percentages of minority women reported that they had *not* been screened for cervical cancer within the past year: 51% of Asian American women, 37% of Hispanic women, and 27% of African American women. (Of White women, 36% did not have a Pap smear during that period of time.) Use of preventive services by all women also differs significantly depending on their insured status. In 1997, 62% of women with health insurance had a Pap test in the past year, while only 48% of women without health insurance had a Pap test.

More African American women (73%) *had* a cervical cancer screening than any other group of females, including White women. Asian American women were the least likely to have had a Pap test of all women, as less than one-half had reported being screened.

C. Breast Cancer Screenings

In 1997, many minority women aged 40 and over had not had a mammogram in the past two years: 27.5% of Asian/Pacific Islander women, 27.1% of African American women, and 33% of Hispanic women. Among American Indian/Alaskan Native women aged 40 and over, 40.1% had not had a mammogram in the last 2 years. (Among White women aged 40 and over, 28.6% had not had a mammogram in the past 2 years.)

Among all women age 40 and over, more White women reported having had a mammogram (72.9%) than did minority populations. Among minority women age 40 and over, more than half in each racial/ethnic group reported having had a mammogram during the past two years.

D. Blood Pressure Screenings

Among all women, American Indian/Alaskan Native women were the least likely to have had a blood pressure screening, with only 27% reporting that they *have* had such a test within the past 12 months - A larger proportion of African American women (82%) had a blood pressure screening in the past year compared to any other group of women.

Of Hispanic and Asian American women, approximately 26% and 27% had not had a blood pressure screening in the past 12 months. In contrast, 20% of White women and 18% of African American women reported that they have not had a blood pressure screening. A staggering 73% of American Indian/Alaskan Native women have not had a blood pressure screening in the past 12 months.

III. MINORITY WOMEN'S HEALTH STATUS

Some groups of minority women are more likely to die from heart disease, stroke, and cancer than are White women. Other health problems—including obesity, diabetes, and hypertension—occur more frequently among most populations of minority women than among White women. Although these important disparities have been identified, we do not know all the reasons why women's disease risks and mortality rates vary by race and ethnicity.

We do know that higher poverty rates coupled with barriers to health education, preventive services, and medical care result in disparities between White and minority women in several areas:

- the likelihood of premature death (mortality),
- life expectancy,
- the risk factors for developing major diseases, and
- the extent and severity of illnesses (morbidity).

[Note: Unless otherwise specified, information on the leading causes of death and mortality rates was obtained from *Table 1, Leading Causes of Death for Females of All Ages in the United States, by Race and Ethnic Origin (2000)* , and *Table 2, Mortality Rates for Selected Major Causes of Death for Females of All Ages, Age-Adjusted, by Race/Ethnicity, United States (2000)* . These two tables can also be found at the end of this document.]

A. Mortality Rates

(Note: *Mortality rate* is defined as the number of deaths in a given year per 100,000 persons in the population.)

1) **African American women**. The four leading causes of death among African American women are, in order of prevalence: heart disease; all malignant neoplasms (cancer) combined; cerebrovascular diseases, including stroke; and diabetes. These women have higher mortality rates from a number of diseases than do White women, including heart disease, stroke, and most cancers.

2) **American Indian/Alaska Native women**. The four leading causes of death among American Indian/Alaskan Native women are, in order of prevalence: heart disease; all cancers combined; unintentional injuries; and diabetes. These women have lower death rates from most major diseases than do White women, including cancer, stroke, and chronic obstructive pulmonary diseases. However, their mortality rates from motor vehicle-related injuries , diabetes , chronic liver disease (cirrhosis) , and homicide are higher than those for White women.

3) **Asian American/Pacific Islander women**. The four leading causes of death for Asian American/Pacific Islander women are, in order of prevalence: all cancers combined; heart disease; cerebrovascular disease, including stroke; and unintentional injuries. These women have lower death rates from most major diseases than do White women, including heart disease, stroke, and AIDS. However, heart disease accounts for more than one-fourth (25%) of deaths. Their mortality rate from breast cancer and all cancers combined was the lowest of all population groups in 2000.

4) **Hispanic women**. The four leading causes of death among Hispanic women are the same as for African American women: heart disease; all cancers combined; cerebrovascular diseases; and diabetes. Among Hispanic women, mortality rates from several diseases are lower than those of White women, including stroke, chronic obstructive pulmonary disease, and cancers of the respiratory system and breasts. Mortality rates from AIDS and homicide, however, are significantly higher for Hispanic women than White women.

B. Life Expectancy

U.S. vital statistics data in 2001 show that the average life expectancy at birth for men and women of all races was 77.2 years, in contrast to 70.8 years in 1970. Life expectancy varies by race, sex, and family income level. At birth, the life expectancy for women is 79.8 years compared to 74.3 years for men. Women have a longer life expectancy than men by an average of 5.5 years, and Whites have a longer life expectancy than African Americans by almost 6 years. In 2001, life expectancy at birth for Asian Americans (both men and women) was 81.5 years and for White women, 79.9 years; Hispanic women, 83.0 years; American Indian/Alaska Native women, 74.7 years; and African American women, 74.7 years.

C. Risk Factors for Disease

Chronic diseases are the leading cause of death and disability among all Americans and account for 70% of all deaths in this country. More than 90 million Americans live with chronic diseases. The risk behaviors most often leading to premature death and disability are tobacco use, alcohol and drug use, poor diet, and physical inactivity. Many of these risk factors are serious issues for minority women.

1) **Tobacco use**. Smoking is the single most preventable cause of death and disease in the United States. As of 1998, roughly 22% of all adult women reported smoking, and in 2000, almost 30% of female high school seniors reported smoking within the past month. Among women, the use of tobacco has been shown to increase the risk of cancer, heart and respiratory diseases, and reproductive disorders. Researchers have identified more than 250 chemicals in tobacco smoke that are toxic or cause cancer in humans and animals. In 1999, approximately 165,000 women died prematurely from smoking-related diseases, such as cancer and heart disease. The proportion of women age 18 and older who report currently smoking cigarettes range from less than 10% (Asian and Pacific Islander) to a high of almost 32% (American Indian/Alaska Native).

Nearly all women who smoke started as teenagers, usually before graduation, and smoking rates among women with less than a high school education are three times higher than for college graduates. The earlier a young woman begins to use tobacco, the more heavily she is likely to use it as an adult. Among high school seniors between 1990 and 1994, 39% of American Indian/Alaska Native females, 33% of White females, 19% of Hispanic or Latino females, 14% of Asian American/Pacific Islander females, and 9% of African Americans females were found to be current smokers. In addition, 39% of White, 32% of Hispanic, and 18% of African American female high school students reported they were current smokers in 1999.

- **American Indian/Alaska Native women** ages 18 and over were the most likely to smoke cigarettes (37.3%) compared to all women. However, 54% of American Indian women living on reservations have never smoked. In addition, smoking prevalence varies by reservation.

- **African American women** had the third highest percentage of current smokers (20.6%), after White women (22.3%). Sixty-four percent of African American women, however, have never tried smoking.

- Of **Hispanic women,** 12.4% reported current cigarette smoking, in contrast to 22.3% of White women. Hispanic women smoke less on a daily basis than do White women or African American women. Among Hispanic women, foreign-born women have much lower rates of smoking than U.S.-born Hispanic women.

- **Asian American/Pacific Islander women** are the least likely population to smoke (10.2%). In 1998, less than 17% reported having ever smoked at all. The prevalence of smoking among Asian American female subpopulations, however, ranged from a low of less than 1% among Vietnamese American women to a high of 19% among Japanese American women.

2) **Body Weight**. The National Institutes of Health (NIH) defines the term *overweight* as an excess amount of body weight for height—which includes muscle, bone, fat, and water—as determined by weight-for-height tables. *Obesity* is defined as the excess accumulation of body fat. Doctors and scientists generally agree that women with more than 30% body fat are obese.

Body-mass index measures (BMI), which do not measure body fat, are used to determine if a person is at a desirable body weight. (BMI is found by dividing a person's weight in kilograms by height in meters squared.) When a woman's BMI exceeds 25 to 29.9 kg/m2, that person is considered *overweight*. Defining overweight as a BMI of greater or equal to 25 is consistent with the recommendations of the World Health Organization. The degree of obesity associated with a particular BMI varies, but the NIH identifies *obesity* as a BMI greater than or equal to 30. These guidelines are based on an increase of adverse health effects in people whose BMI is greater or equal to 25. An estimated 54.9% (97.1 million) of the entire American population over the age of 20 has a BMI greater than or equal to 25.

In 1999-2000, 62.0% of all women between the ages of 20 and 74 were defined as overweight, and 34% of these women were considered obese. Since 1980, the number of obese women in this country has more than doubled (17.1% in 1980 to 34.0% on 2000). Overweight women are at increased risk for hypertension, heart disease, diabetes, osteoarthritis, and some types of cancer. Risk factors include poor nutrition, physical inactivity, environmental factors (such as education and income level), and genetics. The high incidence of adult-onset diabetes is a major problem for women of color, especially Native American, Mexican American, and African American women, in part because of obesity.

- More than three-quarters (78.0%) of **African American women** between the ages of 20 and 74 were classified as overweight in 1999-2000 and 50.8% were classified as obese. In contrast, over half (57.5%) of White women were overweight and almost one-third (30.6%) were obese.

- According to the Indian Health Service, 60% of all **American Indian women** living on reservations and 63% of urban American Indian women are obese.

- Among subpopulations of **Hispanic women**, *Mexican American women* have the highest rate of overweight (71.8%) and obesity (40.1%). Hispanic immigrants who have lived in this country for less than 15 years are less likely to be obese (25%) than more acculturated immigrants (35%).

- **Asian American women**, in general, have the lowest rates of obesity. However, among subpopulations, the percentage of women who are obese ranges from 26% of Filipino American women to 13% of Chinese American women.

3) **Alcohol and Illicit Drug Use.** Heavy and chronic use of alcohol and other drugs have numerous harmful effects on the body. Recent studies have indicated that gender differences in the absorption and metabolism of alcohol place women at higher risk than men for adverse effects of alcohol consumption. Alcohol is a serious health concern for women and adolescent females of all races and ethnic backgrounds. Thousands of women die each year from chronic liver disease or cirrhosis, both of which were the results of sustained alcohol abuse. In cirrhosis of the liver, scar tissue replaces healthy tissue and prevents it from working as it should. Other adverse effects include liver disease, hepatitis and damage to the heart and brain. Heavy alcohol consumption during pregnancy can cause Fetal Alcohol Syndrome (FAS), the leading cause of physical and mental birth defects. FAS is one of the most common known causes of mental retardation, and it is entirely preventable.

Death rates from drug-induced causes—including motor vehicle crashes, unintentional injuries, homicides, and suicides—are significant among minority populations (see Table 2). The use of marijuana and other illicit substances is also linked to sexually transmitted diseases (including HIV/AIDS), poor maternal and infant health, and violence, all of which are experienced disproportionately by minority females.

1) **Alcohol Use**. In 1998, 113 million Americans age 12 and older reported currently using alcohol, that is, that they had used alcohol at least once during the previous 30 days. Roughly 33 million of this group engaged in *binge drinking*, meaning they drank 5 or more drinks on one occasion during that 30-day period. An estimated 12 million were *heavy drinkers*, meaning they had 5 or more drinks on one occasion on 5 or more days during the past 30 days.

Although the consumption of alcoholic beverages is illegal for those under 21 years of age, 10.5 million current drinkers (of the reported 113 million) were between the ages of 12 and 20 in 1998. Of this group, 5.1 million engaged in binge drinking, including 2.3 million who would also be classified as heavy drinkers. The rates of heavy drinking (consuming five or more drinks at one time) are highest among Hispanic (27%) and White (32%) female adolescents, in contrast to 15% of young African American females and 14% of American Indian/Alaska Native female adolescents. More than 37% of Hispanic, 35% of African American, and 32% of White female adolescents reported riding in a vehicle with someone who had recently consumed alcohol. Ten percent of Hispanic, 5% of African American, and 8% of White female adolescents have driven an automobile under the influence of alcohol.

Eighty-three percent of White women, 68% of African American women, and 58% of Hispanic women have used alcohol at some point in their lives. In 2000, 37.7% of women ages 18 and over reported they were regular drinkers (12 or more drinks during the past year), a decrease from 38.9% in 1997. The highest rate of drinking among women occurs between the ages of 25-44, in which 64.1% of women reported being current drinkers.

While the majority of adult women are not problem drinkers, a small proportion drink either frequently or heavily. Rates of alcohol consumption, reported symptoms of alcoholism, and mortality rates vary greatly among minority populations and within the same group. Chronic liver disease and cirrhosis are two conditions often related to the consumption of excessive amounts of alcohol. Between 1995 and 1997, 18 American Indian/Alaska Native women per 100,000 died from liver disease and cirrhosis, compared to 6 deaths per 100,000 for both Hispanics and black non-Hispanic females; 4 deaths per 100,000 white, non-Hispanic females; and 2 deaths per 100,000 for Asian and Pacific Islanders.

- Among **American Indian/Alaska Native women** and White women, 2-3% consumed at least 60 drinks within 30 days. The alcoholism death rate among the American Indian/Alaska Native population is 7 times higher than the national rate for persons of all racial/ethnic groups. American Indian/Alaska Native women have the highest mortality rates related to alcoholism of all American women. A sharp increase in alcohol-related deaths among American Indian/Alaska Native women occurs with increasing age. Among 15- to 24-year-old women, 2.1 per 100,000 die from alcohol-related causes compared to 87.6 per 100,000 for the 44-to-54 age group. Contributing factors to the high mortality rates from drinking include distance to care and reduced availability of services.

- Among **African American women,** 2-3% consume at least 60 drinks within a month. The alcohol-induced death rate for African American women was very small in 1997 (4 per 100,000), slightly higher than that of *White women* (3 per 100,000). Deaths directly and indirectly caused by alcohol occurred at higher rates for African American than White women, 29 per 100,000 women and 16 per 100,000 women, respectively.

- Forty-nine percent of **Hispanic women** abstain from using alcohol. Women of Hispanic origins other than Mexican, Puerto Rican, and Cuban are most likely to abstain from alcohol consumption. However, they are also the most likely to be heavy drinkers (4%), consuming five or more drinks at one sitting at least once a week.

- **Asian American women** are more likely to abstain from alcohol (61%) than other minority populations. Less than 1% are heavy drinkers and consume 60 drinks within one month. Among subpopulations, considerable variation exists between drinking alcohol and reporting symptoms of alcoholism. Larger proportions of Japanese American women reported being heavy drinkers (12%) than Korean American women (0.8%). No Chinese American women reported heavy drinking. In addition, more than one-quarter of Japanese American women, half of Chinese American women, and three-quarters of Korean American women reported abstaining from alcohol.

2) **Illicit drug use**. In 1998, more White women (33%) and African American women (26%) reported having used illicit drugs at some point in their lives than did Hispanic women (20%). White women have also used a greater number of illicit substances than have African American and Hispanic women.

Marijuana is the most common illicit substance used by women, with almost one-third of White women (31%), almost one-fourth of African American women (24%), and one-sixth (17%) of Hispanic women using marijuana at least once in their lives. Other illicit substances include inhalants, hallucinogens, tranquilizers, sedatives, and analgesics (a medication capable of reducing or eliminating pain). In 1998, approximately 6% of Latino and African American women reporting having ingested cocaine at least once in their lifetimes; 9% of White women have used this drug. When asked if they had used cocaine within the last year, 1.3% of Latino, African American, and White women reported use within the last year.

Drug use among American youth remained high during the 1990s. In 1998, 46% of Hispanic, 43% of African American and 42% of White females reported using marijuana. A study in 1993 found that of American Indian high school students (both sexes), 56% surveyed had used marijuana in their lifetimes and 40% reported use within the past month. Significantly more Hispanic female adolescents used cocaine in 1999 (5.4%) than either young White females (2.8%) or African American high school females (1.1%). High school-age Hispanic females had the highest lifetime use of cocaine, glue (for sniffing), and other illegal substances, such as heroin and LSD, than either their African American and White class-mates. Among female high school students, African American students have a lower prevalence of substance use than either Hispanic or White female youth.

- Although **African American women** comprise only 12.7% of the female population, they accounted for 26.4% of drug-related deaths among women in 1999. Among the African American women who died due to drug use that year, 57% were between 26 and 44 years of age at the time of their deaths.

- **Hispanic women** accounted for 7.2% of drug-related deaths among women in 1999. Among the Hispanic women who died due to drug use that year, 53% were between 26 and 44 years old at the time of their deaths. Among young women between the ages of 18 and 25, 11% of Latina, compared to 8% of White and 5% of African Americans, died from drug-related causes.

- **Asian American/Pacific Islander women** represented 1.1% of drug-related deaths among women in 1999.

- **American Indian/Alaska Native women** accounted for 0.6% of all drug-induced deaths in 1999. American Indian/Alaska Native women have a mortality rate from illicit drug use ranging from under 0.5% per 100,000 women for those ages 15 to 24 and 55 to 64, to 8 per 100,000 women for those ages 25 to 34 and 45 to 54.

Among all American women who died from drug-induced causes in 1999, 64.6% were White women of non-Hispanic origin. Of this population, half (50%) were between 26 and 44 years of age at the time of their deaths.

4) **Physical Inactivity.** Research has shown that physical activity has many benefits for health. It can reduce the risk of chronic diseases, helps control weight, appears to relieve symptoms of depression, helps to maintain independent living, and enhances overall quality of life. Conversely, the lack of exercise can negatively affect one's health, contributing to such diseases as coronary heart disease, colon cancer, hip fractures, high blood pressure, and adult onset diabetes.

Regular exercise is important to obtain substantial health benefits. The Surgeon General recommends light to moderate physical activity 30 minutes a day on most days of the week. Light and moderate activities include walking for exercise, gardening, and stretching. More challenging forms of exercise include stair climbing, swimming, aerobics, cycling, jogging, and weightlifting. More men engage in physical activity than do women.

More than 60% of women in the United States do not engage in the recommended amount of physical activity. Among White women, 39% did not exercise. Of the 61% who did report engaging in physical activity, 26% of them engaged in moderate physical activity.

- In 1997, 57% of **Hispanic female immigrants** over 18 years of age were sedentary (not engaging in any physical activity). According to a national youth survey of high school girls, 50% of Hispanic girls engaged in vigorous activity (physical activities that produced hard breathing at least three times a week for more than 20 minutes), and 17% engaged in moderate physical activity (walking or bicycling no fewer than 5 days a week for a half an hour each day).

- Among **African American women,** 57% of African American women reported leading a sedentary lifestyle. In 1999, 47% of African American girls engaged in vigorous physical activity several times a week and an additional 18% engaged in moderate activity.

- Among **Asian American women**, 49% reported that they did not engage in exercise.

Adult women in both urban and rural areas exercised much less than their younger counterparts. Women over age 40 were less likely to exercise if they lived in urban areas than women in rural areas. For women age 40 and older living in urban areas, *only* 12% of Latinas and White, 8% of African American, and 8% of American Indian/Alaska Native women were regularly active. For women ages 40 and older living in rural areas, 21% of Latina, 5% of African American, and 8% of American Indian/Alaska and White women were active.

Overall, half of women ages 40 and over are sedentary, and African American women in rural areas are the most likely to be sedentary (60%).

D. Morbidity

Two overall measures of morbidity are commonly used to reflect one's health status:

1. The percent of women (and men) who are limited in their daily activities due to a chronic condition; and

2. The percent of women (and men) who report fair or poor health status.

Limited activity is measured by asking people questions on their limitations in their ability to perform usual activities for their age group – such as limitations in *daily living*, or in *instrumental activities* of daily living, play, school, and work. People are considered limited if one of more of these activities is hindered because of their health.

These measures (as do mortality rates) continue to reflect the disparities between minority and White populations. For example, a higher proportion of African Americans (14.3%), in comparison to Whites (11.5%), reported some limitation in their activity as a result of chronic conditions in 2000. Almost twenty percent (19.2%) of African Americans reported that they needed help performing "instrumental" activities such as shopping, everyday household chores, and other routine needs, in contrast to 12.1% of Whites. For daily activities such as eating, bathing, and getting around the home, 10.2% of African Americans in comparison to 5.8% of Whites had limitations.

A higher proportion of minority populations report being in fair or poor health than do Whites. Based on self-assessments in 2000, 17.2% of American Indian/Alaska Natives reported fair or poor health, as did 14.6% of African Americans of non-Hispanic origin, and 7.4% of Asian Americans. (Among Whites of non-Hispanic origin, 8.2% reported fair or poor health status.)

A greater number of poor (those whose family income is below the poverty threshold) than non-poor families reported fair or poor health in 2000 (20.9% and 6.3% respectively). Across ethnicities, poverty is associated with health: the lower the income level, the higher percentage of people who reported fair or poor health. Among poor or near poor minority groups, 44.7% of African Americans and 35.6% of Hispanics reported only fair or poor health. (Among poor and near poor Whites of non-Hispanic origin, 34.8% reported fair or poor health.)

IV MINORITY WOMEN'S HEALTH CONCERNS

A. Heart Disease

Heart disease is the *leading cause of death* in African American, Latino, American Indian/Alaska native and White populations. More than 61 million Americans have some type of heart disease, including high blood pressure, coronary heart disease, stroke, congestive heart failure, and other related conditions. More than 950,000 Americans die each year of heart disease, or one person every 33 seconds.

In 1999, more women in the United States died of heart disease and stroke (373,483) compared to all forms of cancer (267,237). Of these women, 11% were African American, 3% were of Hispanic origin (who may be of any race), 88% were White, 1% were Asian American/Pacific Islander women, and less then 1% were American Indian/Alaska native women. Several risk factors contribute to the likelihood of women getting heart disease: smoking, high blood pressure (hypertension), high blood cholesterol, obesity, physical inactivity, and a family history of the disease. Age-adjusted death rates from heart disease among females in minority populations vary greatly, from a low of 113.8 per 100,000 persons (Asian American or Pacific Islanders) to a high of 284.1 (African Americans).

Although the term *heart disease* can refer to any heart ailment, it is usually associated with coronary heart disease. Blocked arteries in the heart severely restrict the amount of blood that can flow to the heart. In turn, this insufficient blood flow deprives the heart muscle of much-needed oxygen and nutrients. When the blood supply is interrupted, the muscle cells of the heart suffer irreversible injury and die. This condition is known as a *heart attack*.

- **African American women** have the highest mortality rate from heart disease (284.1 per 100,000) of all American women. Of this minority population, 36.4% have elevated blood pressure, in contrast to 19.7% of White women. In addition, 21.4% of African American women 18 years of age and over reported currently smoking cigarettes in 1997-1999, whereas 24.0% of White women in this age group smoke. A significant contributing factor for heart disease in African American women is weight. More than one-half (50.8%)of women in this minority group are obese -- defined as having a Body Mass Index (BMI) greater than or equal to 30 -- in contrast to slightly less than one-third (30.6%) of their White counterparts.

- **American Indian/Alaska Native women** have significantly lower death rates from heart disease (129.4 per 100,000) than do White women (210.4 per 100,000). However, when the data age-adjusted to compensate for the miscoding of Indian race on death certificates, **American Indian/Alaska Native women** have a *higher* mortality rate than White women, reports the Indian Health Service, an agency within the U.S. Department of Health and Human Services. (Persons identified as American Indian, Asian, or Hispanic are sometimes misreported as White or non-Hispanic on the death certificate, causing death rates to be underestimated by 21% for American Indians, roughly 11% for Asians, and about 2% for persons of Hispanic origin.) Almost one-third (31.7%) of American Indian/Alaska Native women smoke.

- **Hispanic women** have lower death rates from heart disease (137.1 per 100,000) than do White women. Yet Hispanic women, especially those in certain subgroups, have significantly high rates of obesity, physical inactivity, elevated blood pressure, and high blood cholesterol. In addition, 13.1% of Hispanic women smoke, which increases their risk of heart disease.

- **Asian American/Pacific Islander women** have the lowest mortality rate from heart disease of all population groups (113.8 per 100,000). Only 10.2% of Asian American/Pacific Islander smoke. However, heart disease ranks as the number one cause of death among these minority women. One-fourth (25.7%) of these women's deaths can be attributed to heart disease.

In 1999, almost one-third of deaths of African American women (29.4%), over one-quarter of deaths of Hispanic or Latina women (26.9%) and Asian American/Pacific Islander women (25.7%), and one-fifth of deaths of American Indian/Alaska Native women (21.1%) were attributed to heart disease. (Thirty-one percent of White women died from heart disease in 1999, the largest percentage of any group of women.)

B. Stroke

Each year in the United States, approximately 700,000 people experience a new stroke or repeat strokes, and about 4.7 million people are stroke survivors. In 2000, 61.7% of those who died from stroke were females. Stroke and other cerebrovascular diseases were the third leading cause of death for minority women in the United States (excluding American Indian/Alaska Native women). With cerebrovascular diseases, an obstruction, rupture, or other disorder in the blood vessels leading to the brain restricts the supply of oxygen to the brain. Insufficient oxygen to the brain usually results in a stroke. Cerebrovascular diseases can result in weakness, paralysis of some parts of the body, difficulties with speech, loss of consciousness, or death. Major risk factors for stroke are similar to those for heart disease, including smoking, high blood pressure, and high blood cholesterol.

- **African American women** have the highest death rate from stroke of all women, at 78.1 deaths per 100,000 (in contrast to 57.8 for White women).
- **Asian American/Pacific Islander women** have a mortality rate from stroke of 48.6 per 100,000 women.
- **American Indian/Alaska Native women** have the second lowest mortality rate from stroke, at 39.1 deaths per 100,000.
- **Hispanic women** have the lowest death rate from stroke (36.4 deaths per 100,000 persons).

C. Cancers

All cancers combined is the leading cause of death for Asian American/Pacific Islander women, and the second leading cause of death among other American women of color. Cancers occur when specific cells in the body malfunction and begin to divide uncontrollably; the resulting mass of cells forms a tumor. If the tumor continues to grow unchecked, it begins to invade the normally functioning cells of vital organs and can then become life threatening. For all cancers combined in 1999, death rates for African American women were highest of all women (200 deaths per 100,000). White women were a close second (169 per 100,000), followed by American Indian/Alaska Native women (109 per 100,000); Asian American/Pacific Islander (104 per 100,000); and Latino women, who had the fewest deaths from all cancers combined (101 per 100,000).

1) **Lung cancer**. The incidence of lung cancer, the leading cancer killer of women, is on the rise. This increase can be attributed primarily to the increase in smoking among women. Between 1960 and 1990, female deaths from lung cancer increased by more than 400%, exceeding that of breast cancer deaths in the mid-1980s. In addition, an estimated 3,000 adults die each year from lung cancer attributed to secondhand smoke.

- **African American women** have the highest mortality rate from lung cancer (40.2 per 100,000) among all minority groups, but this rate is slightly lower than that of White women (42.8 per 100,000 persons).
- **American Indian/Alaska Native women** have a mortality rate from lung cancer of 25.6 per 100,000 persons, the second highest rate among all minority women.
- **Asian American/Pacific Islander women** and Hispanic women have the lowest death rates from lung cancer among all minority women, 18.8 and 13.1 per 100,000 persons, respectively.

2) **Breast cancer**. The second leading cause of cancer death among all American women is breast cancer. The *incidence rate* of breast cancer—defined as the number of new cases in a given year per 100,000 persons—rose dramatically in the years between 1940 and 1990. Between 1990 and 1997, White women reported the highest incidence of breast cancer (114 per 100,000) and African American women reported the second highest incidence rate (100 per 100,000). For most American women, the mortality rate of breast cancer has steadily declined. However, for older African American women—those 75 years of age and above—the mortality rate has increased since 1990.

- **African American women** have the highest mortality rate from breast cancer of all population groups (34.9 per 100,000), which is higher than that of White women (26.6 per 100,000). Researchers are trying to find out why African American women are more likely than White women to die of breast cancer. Some reasons may be that tumors are found at a later (more advanced) stage so there are less treatment options, or patients do not follow up after getting abnormal test results. Other reasons might include problems seeing breast lumps due to being overweight, or other potential barriers to care such as access to mammography facilities and transportation. African American women (except those who are 20-24 years of age) are more likely than White women to get breast cancer before age 40. However, they are less likely than White women to get breast cancer *after* age 40.

- **Hispanic women** have the second highest mortality rate from breast cancer of minority populations (15.8 per 100,000), but that rate is less than half that of African American women. One study found that more Hispanic women tend to be diagnosed in the advanced stages of breast cancer than do White women. Therefore, although *incidence rates* of breast cancer are lower in Hispanic women than in White women, Hispanic women diagnosed with breast cancer are more likely to die from the disease.

- **American Indian/Alaskan Native women** have high mortality rates from breast cancer (14.7 per 100,000), second only to lung cancer. American Indian/Alaskan Native women have a lower incidence of breast cancer between 1990 and 1997 (33.0 per 100,000).

- And between 1990 and 1997, **Asian American/Pacific Islander women** have consistently reported the lowest mortality rates from breast cancer (12.7 per 100,000, respectively). However, their reported incidence of breast cancer is 77 per 100,000.

D. Maternal and Infant Health

1) **Maternal mortality**. Maternal mortality rates are based on the number of maternal deaths due to complications from pregnancy, childbirth, and the puerperium (the time immediately following the delivery of a child) per 100,000 live births. According to *Health, United States, 2002,* rates have not been calculated for American Indian/Alaska Native mothers and Asian American/Pacific Islander mothers because mortality rates based on fewer than 20 deaths are unreliable.

- In 2000, **African American women** of all ages had a maternal mortality rate of 20.1 per 100,000 live births, which was more than three times higher than that of White women (6.2 per 100,00 live births). While the maternal mortality rate of African American women has decreased significantly over the last four decades, the striking disparity between these women and White women remains. For example, in 1960, African American women of all ages had a maternal mortality rate of 92.0, compared with 22.4 for White women. Furthermore, African American women aged 35 years and over had a maternal mortality rate of 299.5 that same year, in contrast to 73.9 for White women.

- **Hispanic women** of all ages had a maternal mortality rate of 9.0 per 100,000 live births in 2000, which was higher than that of White women, but more than 50% lower than that of African American women. (Note: Data for Hispanic women does not include data from states lacking a Hispanic-origin item on their death and birth certificates. Consequently, the rates could be higher than reflected.)

2) **Infant mortality rates**. Infant mortality, defined as the death of a child before age one, is related to the underlying health of the mother and the availability and use of prenatal and perinatal services. This important indicator of the health of infants and pregnant women is closely related to factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices. The likelihood of death in infancy is directly related to the mother's education. A higher level of maternal education has been associated with a decrease in the infant mortality rate. All of these factors disproportionately affect some groups of minority women.

Maternal risk factors can severely complicate pregnancy and result in poor birth outcomes, such as infant mortality, low birth weight, and negative consequences for child health and development. These risk factors—including pregnancy-associated hypertension, diabetes, tobacco and alcohol use during pregnancy, and anemia—often differ widely by maternal age and by race/ethnicity.

- **African American women** have the highest infant mortality rate (14.1 per 1,000 births), while the mortality rate of infants born to White mothers was 5.7.

- **Native/Part Hawaiian women** have the second highest infant mortality rate (9.6), followed by **American Indian/Alaska Native women** (9.3).

- **Hispanic women** have an overall infant mortality rate of 5.8. Within this group of women, **Cuban** women have the lowest infant mortality rate (3.6).

- **Asian American/Pacific Islander women** have an infant mortality rate of 5.6, the lowest of all ethnic groups. Within this group, women of **Japanese** origin have the lowest infant mortality rate (3.8).

Smoking and Pregnancy: A Critical Risk Factor for Pregnant Females

Babies born to mothers who smoke during pregnancy are at greatly elevated risk of having low birth-weight. In 2000, two-thirds more low-birth-weight babies were born to smokers than non-smokers. Even light smokers (1 to 5 cigarettes a day) have a higher risk of having low-birth weight babies than do non-smokers. Maternal smoking has declined between 1990 and 1999 by women of all ages and in all racial/ethnic groups. On average, fewer than 5% of mothers-to-be reported smoking while pregnant.

Of all women, however, the rate of maternal smoking among 18-19 year olds is consistently the highest (19.2%). The percentage of these teens who smoked during pregnancy includes 24.1% American Indian/Alaskan native teens, 15.9% of Hawaiian teens, and 8.2% of African American teens. Among pregnant White teenagers, 30.8% reported smoking during pregnancy, which is more than 3.5 times that of African American teenagers.

3) **Low-birth-weight live births**. Low-birth-weight infants are born weighing less than 2,500 grams, or roughly less than 5.5 pounds. These infants are less likely to survive, and they have a higher risk of disability if they live. The incidence of low-birth-weight infants varies considerably by the race/ethnicity of the mothers of these infants, with non-Hispanic African American women having the highest incidence (13%). Mothers of Chinese descent have the lowest percentage of low-birth-weight babies.

- In 2000, **African American women** had the highest incidence of low-birth-weight babies of any racial or ethnic group. Almost 13% of these infants were low-birth weight, compared with almost 7% of White infants. This factor contributes to the high infant mortality rate of African American infants, which is more than 2 times that of White infants.

- Of **Hispanic/Latina women**, 6.4% of all babies born to these mothers were-low birth-weight babies. Among this population, the highest percentage of low-birth-weight babies were born to mothers of Puerto Rican descent (9.3%), while women of Mexican descent had the lowest percentage of low-birth-weight babies of all Hispanic/Latina women (6.1%).

- Of **Asian American/Pacific Islander women,** 7.3% of all babies are of low-birth-weight. **Chinese** women have the lowest percentage of low-birth-weight babies of all women (5.10). However, 8.5% of babies born to **Filipino** women are low-birth-weight babies.

- In 2000, 6.8% of infants born to **American Indian/Alaska Native women** were low-birth-weight.

E. HIV/AIDS

Currently, an estimated 800,000 to 900,000 people are living with HIV, Human Immunodeficiency Virus, in the United States, and approximately 40,000 new infections will occur every year. In addition, 774,467 cases of AIDS, Acquired Immunodeficiency Syndrome (the advanced stages of HIV) have been reported in the United States, including 134,441 cases among women. Approximately a half million people have died from AIDS in this country since the epidemic has been reported.

Long considered a man's disease, HIV/AIDS is a rapidly growing public health problem among women, particularly minority women. Since 1985, the proportion of AIDS cases among adolescent and adult women has more than tripled, from 7% in 1985 to 25% in 1999. One-fourth of all American women are African American and Hispanic/Latina, but more than three-fourths of all AIDS cases in the United States occur in African American and Hispanic/Latina women. In 2000, 80% of new AIDS cases in women occurred among African American and Hispanic/Latina females.

Among women, two major forms of HIV transmission include intravenous (IV) drug use and heterosexual contact. In 2000, 38% of women with AIDS were infected through heterosexual exposure to HIV, and 25% said they had contracted it through IV drug use. Many women report that they did not know they were at risk for HIV/AIDS when they contracted the disease.

- **African American women** accounted for 58% of all AIDS cases among women reported through December 2000, although African American women make up only 13% of the U.S. female population. This year, the death rate from AIDS in African American women was the highest of any group of American women, at 13 per 100,000. In contrast, the mortality rate from AIDS for White, non-Hispanic females were less than one death (0.7) per 100,000.

- **Hispanic/Latina women** are at least 3 times more likely to die from HIV/AIDS than are White women, and have the second highest mortality rate from AIDS (3 per 100,000). HIV/AIDS is the fourth leading cause of death for Latina women aged 25-44.

- **American Indian/Alaska Native women** had 426 cases of AIDS between 1985 and present.

- HIV/AIDS rates in **Asian American/Pacific Islander women** are less than 20 deaths per 100,000, and are therefore not listed as a death rate. In 2000, 0.5% of all AIDS cases, and 0.4% of all HIV infections were attributed to this population.

F. Other Sexually Transmitted Diseases

In the United States, more than 65 million people are currently living with an incurable sexually transmitted disease (STD). An additional 15 million people become infected with one or more STDs each year. Many people underestimate the prevalence of STDs and know little about the facts, the warning signs, and their risk of contracting one or more STDs.

In addition, the health impact of STDs is severe for women, particularly for minority women. Because the infections often cause few or no symptoms and may go untreated, women are at risk for complications from STDs, including ectopic (tubal) pregnancy, infertility, chronic pelvic pain, and poor pregnancy outcomes. These diseases include chlamydia, pelvic inflammatory disease, gonorrhea, human immunodeficiency virus (HIV), herpes simplex virus, human papillomavirus (HPV), and syphilis. Latex condoms, when used consistently and correctly, are effective in decreasing one's chances of contracting many, but not all, of these diseases.

Teenagers are the age group that has the highest risk of contracting STDs. Each year an estimated 3 million teenagers contract one or more STDs. They are more likely to engage in high-risk behaviors that increase their chances of contracting STDs, such as multiple partners, unprotected sex, and for young women, choosing sexual partners older than themselves. In addition, teenage girls have a higher chance of contracting some STDs (such as chlaymdia, gonorrhea, and HIV) than do teenage males because of the biological makeup of female bodies.

1) **Chlamydia.** Chlamydia is the most commonly reported bacterial STD in the United States. It is very dangerous because three-quarters of women and one-half of infected men have *no symptoms*. It is transmitted during vaginal, anal, and oral sex and causes an estimated 3 million infections annually, primarily among adolescents and young adults. Seventy-five percent of individuals who reported having chlamydia were under age 25. By age 30, it is estimated that 50% of sexually active women may have had chlamydia at some point in their lives. Without treatment, as many as 40% of women with chlamydia may develop pelvic inflammatory disease (PID).

2) **Pelvic inflammatory disease (PID).** PID refers to an upper reproductive tract infection in women, which often develops when STDs go untreated or are inadequately treated. Each year, PID and its complications affect more than 1 million women. Untreated gonorrhea and chlamydia can lead to PID. One potentially fatal complication of PID is ectopic pregnancy, an abnormal condition that occurs when a fertilized egg implants itself in a location other than inside a woman's uterus, often in a fallopian tube. If left untreated PID infections can progress to involve the upper reproductive tracts and may result in serious complications.

- Minority women reported one-third of all PID cases. Among **African American women**, the incidence of ectopic pregnancy is 1.5 times higher than that of all other women of color.

3) **Gonorrhea and Syphilis**. Gonorrhea and syphilis are common bacterial infections that can be treated with antibiotics. Gonorrhea and syphilis are spread through vaginal, oral, and anal sex. Syphilis spreads by contact with syphilis sore, and sores are mainly found on the external genitals and anus, or within the vagina and rectum. Syphilis rates have decreased greatly in recent years. Current rates of syphilis are highest among young women of all ethnicities between the ages 20 and 29. However, the rate of syphilis in all African Americans is almost 30 times that of Whites.

Many women who contract gonorrhea do not show symptoms, and sometimes symptoms are so mild that they are mistaken for a bladder or vaginal infection. Gonorrhea infections that occur in the throat usually do not have symptoms and often go undetected. Adolescent females between the ages of 15 and 19 have the highest rates of gonorrhea.

Gonorrhea:

- In 1999, 75% of reported gonorrhea cases occurred among **African American women**, 19% of cases were reported by White women, and 7% by Hispanic/Latina women. Rates of gonorrhea for African American women, 764 cases per 100,000 in 1999, are considerably greater than among other groups of women. The rate of gonorrhea among African American women between ages 35 to 39 (332 per 100,000) was more than 15 times the rate among White women (22 per 100,000) in the same age group.

- One percent of **American Indian/Alaska Native women** and **Asian American/Pacific Islander women** between the ages of 20 and 44 had reported a case of gonorrhea, a distant second to the rate among African American women.

- Seven percent of **Hispanic women** in this age group contracted gonorrhea. The rate of gonorrhea was 77 per 100,000 people, considerably lower than that of African American women, but more than double that of White women.

Syphilis:

- Syphilis rates were the lowest among White non-Hispanic women (less than one per 100,000) in 1999.

- Between 1991 and 1994, the rates of syphilis declined in **Hispanic women** by two-thirds and dropped by approximately one-half among **African American, American Indian/Alaska Native, Asian American**, and White women.

- The overall rate of syphilis among minority women in 1999 was highest among **African American women** (more than 12 reported cases among 100,000 persons).

- Almost one per 100,000 **Hispanic/Latina women** contracted syphilis in 1999.

4) **Genital Herpes**. Genital herpes is caused by the herpes simplex virus (HSV), a highly contagious STD. Once HSV is in the body, it never fully goes away, and it can reoccur at any time. Two types of HSV can occur. HSV type 1 most commonly causes sores on the lips (known as *fever blisters* or *cold sores*), but it can also infect the genital area. HSV type 2 most commonly causes genital sores, but it can also infect the mouth. Both types are transmitted sexually. A person who has sexual contact with someone with HSV type 2, even if no sores are present, will usually contract the disease. A person who is exposed to the saliva of a person with a "cold sore" will probably contract the disease – and this is true for both oral-to-oral contact and oral to genital contact.

In the United States, 1 out of 5 (or 45 million people) ages 12 and over have genital herpes (HSV type 2). Of these people, almost 46% are of **African American** descent, compared to 18% of White Americans. **African American women** are **three** times more likely than White women to be infected with genital herpes (HSV type 2).

Most of the people infected with HSV never recognize the symptoms of genital herpes, so they do not know they are infected. Among women, HSV is frequently more severe in individuals with weakened immune systems, including those infected with HIV. Though there are treatments for genital herpes, it has no cure.

5) **Human papillomavirus (HPV).** HPV refers to a group of more than 100 different viruses, some of which cause genital warts. In many cases, HPV infects women without causing noticeable symptoms because there is no pain and the warts can be small. Genital warts are spread easily during vaginal, anal, and oral sex. Some types of HPV are considered "high-risk," meaning they may carry risks associated with cervical cancer, which causes 4,500 deaths among women each year. Approximately 50-75% of sexually active men and women will get HPV at some point during their lives. Seventy-five percent of people with HPV are asymptomatic, and therefore most people who have the disease do not know are carriers. Topical treatments from a health care provider may help with HPV, but it is a virus with no current cure.

G. Diabetes Mellitus

Diabetes mellitus ranks among the top 10 causes of death among all women. More than one-half of all Americans with diabetes are women. From 1990 to 1998, diabetes rates increased 70% for women between the ages of 30 and 39. It is much more prevalent among minority females than among their White counterparts.

In 2000, this disease was the fourth most common cause of death for African American, American Indian/Alaskan Native, and Hispanic females. (Among White women, diabetes was the seventh leading cause of death in 2000, responsible for 2.8% of deaths from all causes.) Although a cure for diabetes does not yet exist, this disease is treatable.

Type I Diabetes

Type I diabetes, in which the body stops producing insulin, requires insulin injections. Type I diabetes was previously called *juvenile-onset diabetes* or *insulin-dependent diabetes*. In Type 1 diabetes, the body destroys the cells that produce insulin. Autoimmune, genetic, and environmental factors are involved in the development of this type of diabetes. Type 1 diabetes may account for 5-10% of all diagnosed cases of diabetes.

Type II Diabetes

In Type II diabetes, formerly known as *adult-onset diabetes* or *non-insulin-dependent diabetes*, the body produces insulin, but in insufficient quantities. Type II diabetes may account for 90-95% of all diagnosed cases. Risk factors include older age, obesity, physical inactivity, and race/ethnicity. Minority women are 2-3 times more likely than non-Hispanic, white women to have Type II diabetes.

Gestational Diabetes

Gestational diabetes is a type of diabetes which develops during pregnancy. The body becomes intolerant towards sugar. During pregnancy, treatment is needed to normalize the mother's blood to avoid complications with the infant. Gestational diabetes is common among obese women and those with a family history of diabetes.

- In **American Indian/Alaska Native women**, diabetes was the fourth leading cause of death in 2000, responsible for 341 deaths, or 6.6% of deaths from all causes. Variations exist among ethnic groups: One study stated 41% of Navajo women ages 45-64 have diabetes. Among Pima Indian women ages 45-64, one study found as many as 70% have diabetes.

- Among all **Hispanic women**, diabetes was the fourth most common cause of death in 2000, responsible for 2,821 deaths, or 6.0% of deaths from all causes. Older **Mexican American women** are the second most likely racial/ethnic group to have diabetes (after American Indian/Alaska Native women). They have the highest incidence rate of this disease among all Hispanic women. Almost one-third (30%) of these women suffer from the disorder. For this subpopulation, however, with greater acculturation comes reduced obesity and a lower prevalence of diabetes.

- Among **African American women**, diabetes was the fourth leading cause of death in 2000, responsible for 7,250 deaths, or 5.2% of deaths from all causes. The health outcomes of African American women who have diabetes are far worse than those of White women who have this disease. These minority women are more likely to be blinded, become amputees, develop end-stage renal impairment, and die from diabetes than are their White counterparts.

- For **Asian American/Pacific Islander women,** diabetes was the fifth most common cause of death in 2000, responsible for 621 deaths, or 3.5% of deaths from all causes.

H. Tuberculosis

Tuberculosis is the single leading cause of worldwide deaths among women of reproductive age. Long considered a disease of the old, tuberculosis (TB) accounts for 750,000 deaths worldwide among women ages 15-44.

Bacteria called *Mycobacterium tuberculosis* cause TB. TB can attack the body in a number of places, but it usually attacks the lungs. Only individuals who are sick with TB of the lungs are infectious. Like the common cold, tuberculosis spreads through the air when a patient with untreated TB disease coughs, sneezes, or spits. Common symptoms of TB disease include a cough that persists for weeks or months, chest pain, fever (particularly at night), weight loss, and loss of appetite. In 2002,15,078 cases of TB were reported to the Centers for Disease Control and Prevention in the United States.

- United States-born **African Americans** have the highest rates of TB in this country. Of people who have TB who were born in the United States, almost 50% of the cases occur in people of African American descent (46.7%). African Americans have TB rates 7.5 times higher than that of Whites and 2.1 times higher than that of Hispanics.

- Foreign-born Americans have much higher TB rates. Black, non-Hispanic foreign-born Americans have TB rates (49.9 per 100,000 persons) 5 times that of Black, non-Hispanic Americans born in the United States (9.8 per 100,000), and more than 37 times that of White Americans (1.3 per 100,000) born in this county. Foreign-born Asian Americans/Pacific Islanders have the second highest rates of TB, 41.3 per 100,000.

- Among females with TB, 81% of reported cases occurred in minority populations. Of these cases of TB, almost 30% occurred among **African American women**, 26% among **Asian/Pacific Islander women**, and 24% among **Hispanic** females (compared to 19% among White women).

I. Psychiatric Disorders

Psychiatric diseases and conditions can be the result of a behavioral, psychological, or biological (physical) dysfunction. About 22-23% of the United States adult population—or 44 million people — have psychiatric disorders that would be diagnosable if they had visited a mental health provider. Only about 1 in 4 actually receive the care they need. In the United States, mental disorders collectively account for more than 15% of the overall burden of disease (measured in lost years of healthy life) from *all* causes and slightly more than the burden associated with all forms of cancer.

Nearly 12.4 million women (12.0%) in this country are affected by a depressive disorder each year. Depressive disorders include major depression, dysthymic disorder (a less severe but more chronic form of depression), and bipolar disorder (manic-depressive illness). Depressive disorders can increase the risk of suicide. Although men are 4 times more likely than women to die by suicide, women report *attempting* suicide about 2 to 3 times as often as do men. Major depression, for example, afflicts an estimated 5% of Americans. However, nearly twice as many women suffer from major depression than do men (6.5% verses 3.3%). Among minority women, depression may be worsened by factors such as low education and income levels, lack of employment, acculturation difficulties for immigrants, marital and family problems, racism, and single parenthood.

Several psychiatric disorders, including anxiety disorders and mood disorders, disproportionately strike females. Approximately twice as many females as males suffer from these disorders. However, men and women are equally affected by social phobias (overwhelming anxiety in everyday social situations) and obsessive-compulsive disorder.

In addition, more than 90% of those afflicted with eating disorders are women, and 86% report the onset of these disorder by the time they are 20. , Eating disorders—anorexia nervosa, bulimia nervosa, and binge eating disorder—are often perceived to be an affliction of White girls and young women in middle and upper socio-economic classes. However, women and girls (and increasingly, men) of all ethnic groups are susceptible. A recent study has shown that **African American women** were more likely to binge eat more often, and they reported fasting, laxative abuse, or diuretic abuse more often than did their White counterparts.

Eating disorders among ethnically and culturally diverse girls may be underreported due to the lack of population-based studies that include representatives from these groups. The mistaken perception that non-White females are at decreased risk for eating disorders may also contribute to the lack of detection.

Depression

- **Hispanic/Latino women** have the highest lifetime prevalence of depression (24%) among all women. Nearly twice as many Hispanic women reported being depressed (11%) as African American women (6%) and White women (5%). A 1993 survey found that Hispanic women were more likely to report having suffered from severe depression within the past week (53%) than White women (37%).

- **African American women** are less likely to have this disorder (16%) than White women (22%). However, of those suffering from depression, almost half (47%) of African American women are afflicted with severe depression.

- Among **American Indian/Alaska Native female adolescents,** one study found 14% were characterized as extremely sad and hopeless, and 6% displayed signs of serious emotional stress.

Suicide

- In 2000, **American Indian/Alaska Native women** of all ages (except women 65 years and older) had the highest mortality rate from suicide (4.6) of the other three minority populations. Of all women and within all age groups, the highest suicide rate occurred among American Indian/Alaskan Native women between the ages of 25 and 44 (9.1 per 100,000).

- In 2000, **Asian American/Pacific Islander women** of all ages had the second highest mortality rate from suicide (3.0) among minority women. Among all women over 65 years of age, Asian American/Pacific Islander women had the highest mortality rate from suicide (5.4) in 2000.

- That same year, **African American women** of all ages had a mortality rate from suicide of 1.8. Among all women over 65 years of age, African American women had one of the lowest mortality rates from suicide (1.3) of all women in 2000.

- Only **American Indian/Alaska Native women** in this age group had a lower mortality rate, which was not calculated because it was fewer than 20 deaths.

- **Hispanic women** had a mortality rate from suicide of 1.8 (as did African American women) in 2000. However, Hispanic teenagers were twice as likely (19%) to attempt suicide than either African American (8%) or White (9%) girls. Suicide rates for young women ages 15 to 24 are lowest among Hispanic and African American (both 2 per 100,000) compared to White young females of the same age (5 per 100,000). (White, non-Hispanic women have the highest mortality rate (4.7) from suicide of all women.)

J. Violence Against Women

Violent crimes against women are a major public health problem in our country. These acts include homicide, rapes, sexual assaults, robberies, and both aggravated and simple assaults. In a 1996 survey, at least half of all women reported having been physically assaulted at some point in their lifetime. Each year, about 1 million women are stalked in this country, and about 4 million women are physically abused by their spouses or live-in partners.

Persons who are known to the victims commit 6 out of 10 of all rapes and sexual assaults against women. In 1998, an estimated 900,000 women reported acts of non-lethal violence by intimate partners: current or former spouses, boyfriends, or girlfriends (whether heterosexual or same-sex partners). The consequences of non-lethal physical or sexual violence, whether actual or threatened, and of psychological/emotional abuse, can include post-traumatic stress disorder, clinical depression, substance abuse, disassociative disorders, and suicide attempts; and physical consequences may include fractured and broken bones, scarring, bruising, lacerations, organ damage, and miscarriages. In 2001, intimate partner violence made up 20% of all nonfatal cases of violent crime experienced by women.

Women living in households with an annual household income of less than $10,000 experience intimate partner violence at significantly higher rates than women in households with annual incomes of $10,000 or more. Violence is not linked specifically to racial or ethnic factors. However, it *is* linked to socioeconomic status.

- Fifty-two percent of **African American women** are subject to physical assault at some point in their lifetimes, compared to 53% of Hispanic/Latino women, and 51% of White women.

- Among **American Indians/Alaska Native women** of all ages, 61% stated they had been victims of a physical assault. This group of women had the highest percentage, 34%, of rapes. This rate was almost twice that found among White (18%) and African American women (19%).

- Among all women, **Hispanic women** are the least likely group to be victims of rape. Hispanic women (53%) were more likely than non-Hispanic women (52%) to be victims of physical assault.

- **Asian American/Pacific Islander women** are the least likely group to be victims of physical assault during their lifetimes (50%) among all women. They are the least likely to be victims of stalking (5%) or rape (7%).

Activities of the Department of Health and Human Services to Promote the Health of Minority Women

As part of its overall mission to promote and protect the nation's health and to provide essential human services, the **U.S. Department of Health and Human Services (HHS)** is pursuing a comprehensive agenda for improving women's health. HHS is promoting access to a full range of culturally sensitive health care services for women of all ages, all racial and ethnic backgrounds, and all socioeconomic and education levels. HHS has designed several initiatives specifically targeted to minority women, including research on racial and ethnic differences in disease prevalence and outcomes, outreach programs for women who speak little English, recruitment strategies to encourage minority women to work in health professions, and health care and health education programs on cultural competence for healthcare professionals.

President Clinton's *Initiative on Race* in 1998 committed the nation to an ambitious goal: By the year 2010, eliminate the disparities in access to health care services and in health outcomes experienced by racial and ethnic minority populations, while continuing to improve the overall health of Americans. HHS is leading this effort, known as *The Initiative to Eliminate Racial and Ethnic Disparities in Health*. Activities focus on six areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection, and child and adult immunizations.

Through its agencies, offices, and programs, the **Office of Public Health and Science (OPHS)** is addressing health conditions that are more prevalent or more serious in minority women than in Caucasian women.

New initiatives are underway to reach the nation's diverse population of minority women. PHS agencies and offices are addressing language and cultural issues. They are also disseminating health education messages that are targeted to this population. In addition, PHS is conducting research on chronic illnesses, designing culturally appropriate health care interventions, and working to increase minority women's access to health care services and preventive interventions.

The Office on Women's Health (OWH), within the Office of the Secretary of HHS, is the focal point for women's health research, service delivery, and education programs within the Department of Health and Human Services.

Through its Federal Coordinating Committee on Women's Health, OWH advances and coordinates a comprehensive women's health agenda across the federal agencies and offices of PHS, including the PHS Office of Minority Health (OMH), the PHS Office of HIV/AIDS Policy, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). OWH also works with other government agencies, consumer groups, associations, and health care professionals to advance women's health.

OWH and the Federal Coordinating Committee, which it chairs, have the following goals:

- To promote access to gender-appropriate, culturally sensitive, and comprehensive health care services for women of all ages, races, ethnic backgrounds, sexual orientations, and socioeconomic and educational levels.

- To encourage research on diseases, disorders, and conditions affecting women.
- To educate and inform women about women's health issues and programs.
- To support the training of health care professionals in the diagnosis, management and prevention of health conditions in women.
- To foster the recruitment, retention and promotion of women in the health professions and in scientific careers.

Among the steps taken to achieve these goals was the 1993 appointment of the country's first Deputy Assistant Secretary for Women's Health at HHS. Working through OWH, the Deputy Assistant Secretary provides leadership and direction for the federal government's health agenda for women.

OWH Programs

- The Minority Women's Health Panel of Experts develops strategies that help HHS address the diversity of America's health care needs and variations in health care delivery. The panel consists of 31 experts from the African American, Native American, Asian and Pacific Islander, and Hispanic communities.
- The National Women's Health Information Center (NWHIC), a national information clearinghouse on women's health, links women to thousands of public and private resources with health information. NWHIC can be accessed through a toll-free telephone call to 1-800-994-WOMAN (TDD at 1-888-220-5446) or through the Internet at http://www.4woman.gov. Customized sections for several special groups, including women of color, Spanish-speaking women, women with disabilities, and men, are available on-line.
- An education campaign is being developed to encourage positive health choices among women of color.
- OWH has developed outreach efforts targeted to minority media outlets, including community-based publications. Health care information will be provided to audiences who may not otherwise notice or read these messages.
- To help eliminate disparities in health care among racial and ethnic minorities, OWH established National Centers of Excellence in Women's Health (COEs) in 13 states and Puerto Rico. These national models were established in 1996 to integrate women's health research, medical training, public health education, and clinical services into community-based institutions that can be replicated around the country. Six of the 17 COEs were chosen specifically for their plan to meet the health needs of minority populations. All of the COEs must, by contract, actively reach out to women in the community to improve access to health care.

The Office of Minority Health (OMH) works to improve the health status of minority and low-income persons and to reduce disparities in the incidence of premature death, chronic diseases and injuries. OMH is collaborating with **HHS' Health Resources and Services Administration (HRSA),** state agencies, and other federal agencies to increase access to health care services for persons having limited facility with English. This federal and state team supports projects that identify effective practices in bilingual/bicultural health services. Plans are also underway to address culturally competent and linguistically appropriate care in areas such as maternal and child health, nutrition, and psychiatric and addictive disorders.

OMH administers the Minority Community Health Coalition Demonstration Grant Program. This program fosters community coalition-building; it also develops and implements programs that reduce the health risks to minority populations. A number of these activities focus on the unique health issues of minority women. Other critical health priorities include cancer, cardiovascular disease, hypertension, HIV/AIDS, diabetes, and substance abuse. In addition, the OMH sponsors the **Minority Health Resource Center**, accessible through a toll-free telephone call to 1-800-444-6472.

The **PHS Office of Population Affairs (OPA)** has overall policy and management responsibility for the Office of Family Planning and the Office of Adolescent Pregnancy Programs. That oversight function includes the Title X Family Planning Program, which provides reproductive health and family planning services to 4 million women each year. Approximately 85% of these women have low incomes and 30% are adolescents. The Title X program also supports nurse practitioner training for minority students or students who will provide services in high-need areas.

The **PHS Office of HIV/AIDS Policy (OHAP)** serves as the coordinating office for HHS-wide activities that implement PHS guidelines for HIV counseling, testing of pregnant women and infants, and therapies to reduce HIV transmission. These activities include developing consumer materials to inform women of the benefits of HIV counseling and testing as well as sponsoring a conference on new microbicides.

OHAP is working to develop standards of care and quality assurance systems for the treatment of HIV/AIDS, with a particular focus on state Medicaid programs. Women and minorities are especially vulnerable to declines in publicly financed health care, and OHAP is working with all relevant parties to prevent reduced access to appropriate care. Furthermore, costly new drug regimens could exacerbate the inequities in access and availability of care among underserved populations. OHAP is working to meet these challenges, so women and minorities can benefit from these new treatments.

The **Agency for Healthcare Research and Quality (AHRQ)**—formerly known as the Agency for Health Care Policy and Research (AHCPR)—enhances the quality, appropriateness, and effectiveness of health care services for women by (1) conducting health services research and (2) developing materials for health care professionals and consumers on such topics as maternal and infant health, breast and cervical cancer screening, depression, and HIV infection.

AHRQ supports studies related to accessibility of health care for minority women, low-income women, and women with disabilities. The agency has published a series of papers on the use of health services by Hispanics and American Indian/Alaskan Natives. AHRQ also supports the Medical Treatment Effectiveness Program Research Centers on Minority Populations. These centers conduct research on mortality and morbidity patterns of minority populations and determine the cost-benefit and cost-effectiveness of health programs that are targeted to minorities.

As the nation's prevention agency, the **Centers for Disease Control and Prevention (CDC)** actively protects America's health and safety, enhances health decisions through credible information, and promotes health through strong partnerships. CDC strives to achieve its vision—*Healthy People in a Healthy World: Through Prevention*—by promoting health and quality of life and preventing disease, injury and disability. As a cornerstone of the nation's public health system, CDC collaborates with partners throughout the nation and the world to better understand factors that influence the health and safety of minority women's health and to promote healthful behaviors and practices across all the stages of a woman's life. Numerous health promotion, disease prevention and research activities relating to minority women are supported by CDC.

Additional CDC Activities

- Published *Chronic Disease in Minority Populations*, a comprehensive set of health indicators on chronic disease in minority populations.
- Examined how race, ethnicity, and socioeconomic status affect women's health and supported culturally appropriate interventions to reduce morbidity and mortality from breast cancer and cervical cancer.
- Expanded the delivery of HIV/AIDS-prevention services and other sexually transmitted disease (STD)-prevention services in minority communities, paying special attention to the needs of minority women.
- Helped develop, support and evaluate community-based interventions for preventing violence, including family and intimate violence.
- Developed health promotion programs for African Americans and Hispanics at risk for diabetes.
- Developed and implemented a Fetal Alcohol Syndrome surveillance system in conjunction with several states and the Indian Health Service.
- Administers the National Breast and Cervical Cancer Early Detection Program, which provides free or low-cost mammograms and Pap tests to medically underserved women who do not have the resources to seek screening services.
- Evaluated novel, more sensitive diagnostic methods for the early detection of cervical cancer among underserved Hispanic women living on both sides of the U.S.-Mexico border.
- Evaluated rapid methods of bedside diagnosis for bacterial vaginosis—a condition linked to premature births—in underserved African American women attending prenatal care classes.
- Evaluated the relationship between preterm birth and maternal carriage of Group B streptococcus in women living in inner-city areas.
- Evaluated more sensitive, non-invasive methods of diagnosing human papillomavirus infection—a cause of cervical cancer—and other STDs in adolescent African American women who are sexually active and who live in inner-city areas.

The **Food and Drug Administration (FDA)** has jurisdiction over the safety and efficacy of drugs, medical devices, vaccines, blood and tissue products, foods and cosmetics on which American consumers depend. FDA focuses on issues such as the participation of women and minority populations in clinical trials for drugs and medical devices; the need for contraceptive products that protect against STDs, including HIV/AIDS; and the safety and effectiveness of high-quality mammograms. FDA also distributes consumer information on women's health issues.

- FDA's Office of Women's Health designed a health education campaign called *Women's Health: Take Time to Care* and has partnered with more than 80 other organizations on this effort. Its purpose is to raise awareness among mid-life and older women, particularly the underserved, about the safe use of medicine. Materials can be accessed on FDA's web site (http://www.fda.gov/womens/tttc.html) by clicking on My Medicines. These documents are available in a dozen languages, including Spanish, Japanese, Chinese, and Vietnamese.

- In conjunction with FDA field staff members, FDA has sponsored projects to encourage the use of screening tests such as Pap smears and mammograms among Asian American and Pacific Islander women;

- pink-ribbon Sundays in African American churches in the Washington, DC, and Houston, Texas, areas to raise awareness of breast cancer; and

- health empowerment workshops geared toward providing minority women with important health information.

- FDA's Offices of Women's Health, Special Health Issues, Consumer Affairs, and FDA's Centers have developed valuable health education materials, some in languages other than English. These documents can be accessed through the web site of OWH's National Women's Health Information Center (http://www.4woman.gov).

The **Health Resources and Services Administration (HRSA)** assures access to high-quality health care to medically underserved, vulnerable, and special needs individuals and families. The Office of the Senior Advisor for Women's Health provides leadership in HRSA's response to women's health issues from a lifespan perspective and coordinates cross-cutting women's health programs across each of HRSA's four bureaus: the Bureau of Health Professions, the Bureau of Primary Health Care, the HIV/AIDS Bureau, and the Maternal and Child Health Bureau.

Through its Bureau of Health Professions, HRSA promotes the training of health professionals, so they can provide primary care and public health services where needed most.. HRSA's Bureau of Primary Health Care ensures access to primary and preventive care for underserved, minority, and elderly women at community health and migrant health centers, and also provides services for residents of public housing and homeless programs. HRSA is responsible for overseeing the National Health Service Corps, which provides many of these community-based primary care and mental health services.

In addition, the Maternal and Child Health Bureau's state block grants support community-based services for women, including minority women and their children. HRSA also supports African American, Hispanic, American Indian/Alaskan Native, and multicultural Centers of Excellence at medical and dental schools across the country. HIV/AIDS primary care and support services for women and children, as well as health provider training, is provided under the Ryan White CARE Act programs managed by HRSA's HIV/AIDS Bureau.

The **Indian Health Service (IHS)** provides health care services to almost 1.5 million American Indians and Alaska Natives of 557 federally recognized tribes. HIS provides these minority women with health care services that focus on reproductive health, cancer, diabetes, maternal and infant health, alcohol and other drug abuse, psychosocial issues, family violence, and healthy aging. Specific initiatives include expanding the availability of preventive health services such as Pap smears and mammograms in HIS clinics, an injury prevention program, violence education programs, and the appointment of an Indian Women's Health Advisory Committee to further women's health promotion projects.

The **National Institutes of Health (NIH)** is the world's premier medical research organization, supporting roughly 35,000 research projects in diseases such as cancer, diabetes, arthritis, heart disease, and HIV/AIDS. NIH provides national leadership and support for biomedical, behavioral, and epidemiological research on women's health. All NIH institutes, centers, and offices are involved in efforts to improve the health of minority women.

- The **NIH Women's Health Initiative (WHI)** addresses the most common causes of death, disability, and frailty in women, especially in minority women. This 15-year, multimillion-dollar endeavor is one of the largest prevention studies of its kind in the United States. Areas of study include how diet affects the development of disease, how hormone replacement therapy and vitamins affect disease in women, and if behavioral characteristics can help prevent disease in older women.

- The **NIH Office of Research on Women's Health (ORWH)** encourages research on health conditions affecting women, ensures that the research conducted and supported by NIH adequately addresses women's health issues, verifies that women are represented in NIH-supported studies, and develops opportunities for recruiting and advancing women in biomedical careers. ORWH supports research involving the prevalence of risk factors for disease in women of different racial, ethnic, and economic groups. ORWH published the *Women of Color Health Data Book*, a report that focuses on many of the factors that contribute to the health status of minority women.

- The **NIH Office of Research on Minority Health (ORMH)** promotes and supports biomedical and behavioral research aimed at improving the health status of minority Americans across the lifespan and programs designed to expand the participation of underrepresented minorities in all aspects of biomedical and behavioral research. To accomplish this mission, the ORMH collaborates with Institutes and Centers at NIH, other federal agencies, and outside organizations to implement the Minority Health Initiative.

  This multiyear biomedical and behavioral research and research training program supports

  - interventions to improve prenatal health and reduce infant mortality;
  - studies of childhood and adolescent lead poisoning, HIV infection and AIDS, asthma, and alcohol and drug use;
  - research in adult populations focused on cancer, diabetes, obesity, kidney disease, hypertension, cardiovascular diseases, sickle cell disease, mental disorders, visual impairments, and alcohol abuse; and
  - training for faculty and students at all states of the educational pipeline: from precollege and undergraduate studies through graduate and postdoctoral studies.

ORMH supports a number of research initiatives focused on improving the health of minority women and their children:

- ORMH, the **National Institute of Child Health and Human Development (NICHD),** and the **National Institute of Nursing Research (NINR)** co-sponsor infant mortality initiatives that study the causes of, and interventions for, reducing infant mortality and low birthweight.
- ORMH and the **National Institute of Alcohol Abuse and Alcoholism (NIAAA)** are collaborating with clinicians and scientists from Howard University, Drew University, the University of New Mexico, and Indiana University to study fetal alcohol syndrome (FAS). FAS is the most preventable cause of mental retardation. It is characterized by pre- and postnatal growth deficits, morphological anomalies, and cognitive and behavioral dysfunction. This research study is focused on metabolic and genetic risk factors; developmental impairments; and potential ameliorative measures in Native Americans from the Plains Culture, in urban African Americans, and in women of African heritage who live in the Western Cape of South Africa, an area with the highest rate of FAS in the world.
- ORMH and NICHD are co-sponsoring an early childhood longitudinal study whose purpose is to track the health, development, care, and education of a national representative sample of 12,000 children from infancy until the time they enter school. The study will help researchers identify differences in health development and parenting behaviors, so they can increase their understanding of the protective factors that can improve health outcomes for children.
- ORMH and the **National Cancer Institute (NCI)** are identifying genetic predictors of breast cancer disease risk in a population of more than 50,000 geographically diverse African American women.
- ORMH and the **National Institute of Environmental Health Science (NIEHS)** are conducting the first population-based epidemiologic study in the United States of systemic lupus erythematosis, a chronic, disabling disease that disproportionately affects women in general and occurs more frequently in African American and Hispanic women than in Caucasian women. The study will examine occupational and environmental risk factors in a previously understudied population in order to elucidate etiologic pathways and develop targeted preventive measures.
- ORMH and the **National Heart, Lung and Blood Institute (NHLBI)** are conducting the Women's Estrogen/Progestin and Lipid Lowering Hormone Atherosclerosis Regression Trial. This randomized clinical trial will test whether the progression of coronary artery disease in post-menopausal women can be slowed or prevented by adding oral estradiol with or without progestin to standard cholesterol-lowering treatment. There are 226 women in the trial, of which 70 are from diverse racial and ethnic minority groups.
- ORMH and the **National Institute of Arthritis and Musculosketal and Skin Diseases (NIAMSD)** are studying the effects of exogenous female hormones on disease activity and severity in women with systemic lupus erythematosis.

The **National Institute of Child Health and Human Development** conducts the following activities:

- Research on the prevention of HIV transmission among culturally diverse, at-risk couples and between HIV-infected mothers and their babies
- Studies investigating factors associated with the high rates of high-risk pregnancies, poor perinatal outcomes, and increased maternal and infant mortality observed among African American and Hispanic women
- Studies to identify the causes of, and prevention strategies for, unintended pregnancy in culturally diverse, high-risk adolescent girls
- Support of research centers and treatment facilities that actively recruit women and minority adolescents who are HIV-positive or have AIDS into innovative clinical trials to test new forms of treatment
- Research to develop and implement an outreach component of the *Back To Sleep* campaign that will target African American and Hispanic women whose babies are at increased risk of Sudden Infant Death Syndrome.

Additional NIH-sponsored Studies and Activities on Minority Women's Health Issues

- Research on African American mother-infant patient populations in inner cities and health outcomes for pregnant minority women and their infants
- An initiative on improving pregnancy outcomes for Native Hawaiian, American Indian/Alaskan Native, and Hispanic women living in rural areas
- The development of a Spanish-language brochure on pregnancy that covers topics such as nutrition and weight gain, birth defects, fetal alcohol syndrome, and substance abuse
- Studies on osteoporosis in Mexican American women
- An awareness campaign on *lupus*, an autoimmune disease that disproportionately affects African American women
- Research on chronic and debilitating health problems, including obesity, lupus, and kidney diseases
- A program for obese inner-city African American women that helps them modify their diets and begin exercise regimens
- HIV prevention investigations among minority women, including a study that measures sources of stress in the lives of minority women at risk for HIV infection
- Studies investigating hypertension and obesity in African American women; nutrition in Hispanic women; strokes in African American, Caucasian American, and Hispanic men and women; and culturally sensitive interventions in the areas of smoking cessation and barriers to screening for cervical and breast cancers
- A study to assess the mental health and social functioning of rural and urban African American women who are caregivers

- A project to study the influence on children of treating maternal depression among Hispanic, African American, and Caucasian women
- Research to address the prevention of pregnancy-associated obesity in African American women
- Study the effectiveness of physician intervention with low-income African American women for weight loss and subsequent prevention of weight gain
- Study to examine the neuromuscular injury and recovery after vaginal delivery among African American, Hispanic, and Caucasian women
- Cross-sectional and longitudinal studies on the progression of menopause in African American, Hispanic, Chinese, Japanese, and Caucasian women
- Prospective study of the mental health of African American women
- An investigation to examine the development of conduct disorder in inner-city, prepubertal girls who are most African American
- Research to gain knowledge about eating disorders in young adult African American and Caucasian women
- Funding for the Diabetes Prevention Program to compare different intervention methods in high-risk populations. This study will examine the differences in disease risk and outcome among African American, Hispanic, and Caucasian women.
- A prospective study of Chinese women to assess the effects of lead exposure on endocrine dysfunction and later adverse outcomes
- A study of Laotian women who have been exposed to chlorinated pesticides to see if they experience alterations in their ovarian function
- Investigate the effects of in-utero exposure to polychlorinated biphenyls on cognitive and behavioral deficits in offspring among the Alaska Native Inuit population
- Study the effect of low-dose hormones on Systemic Lupus Erythematosus among African American women
- Investigate scleroderma in the Oklahoma Choctaw Native American population
- A study of the differences in skeletal muscle tissue function among African American, Hispanic, Asian, and Caucasian populations

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** identifies the need for substance abuse and mental health services for women, recommends policy, and promotes collaboration among its three centers: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. SAMHSA also works to ensure that the needs of minority women are addressed. It has identified six priority issue areas for women: physical and sexual abuse, women as mothers and caregivers, HIV/AIDS, aging women, women in the criminal justice system, and multiple diagnosis (multiple mental health and substance abuse problems).

Additional SAMHSA Activities

- Providing grants to states and communities that work with minority and migrant women who are substance abusers
- Funding demonstration projects for treatment programs and treatment system enhancements geared to racial and ethnic populations
- Establishing programs to provide comprehensive substance abuse treatment for incarcerated women and for women and their children in residential settings
- Co-funding a study of strategies that would help prevent the transmission of HIV/AIDS among Hispanic women
- Developing HIV/AIDS outreach programs for young women and others at high risk.

Contacts within the Department of Health and Human Services to Promote the Health of Minority Women

As part of its overall mission to promote and protect the nation's health and to provide essential human services, the **U.S. Department of Health and Human Services (HHS)** is pursuing a comprehensive agenda for improving women's health. HHS is promoting access to a full range of culturally sensitive health care services for women of all ages, all racial and ethnic backgrounds, and all socioeconomic and education levels.

Office on Women's Health (OWH) within the Office of the Secretary of HHS, is the focal point for women's health research, service delivery, and education programs within the Department of Health and Human Services.

Office on Women's Health (OWH)
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W., Rm 730B
Washington, D.C. 20201
Phone (202) 690-7650
Fax (202) 690-7172
http://www.4woman.gov/owh/

National Women's Health Information Center (NWHIC)
1-800-994-WOMAN (1-800-994-9662)
TDD: 1-888-220-5446
http://www.4woman.gov/
http://www.4girls.gov/

Office of Minority Health (OMH) works to improve the health status of minority and low-income persons and to reduce disparities in the incidence of premature death, chronic diseases and injuries.

Office of Minority Health
Division of Information and Education
Department of Health and Human Services
OMH Resource Center
P.O. Box 37337
Washington, DC 20013-7337
Phone (800) 444-6472
TDD: (301) 230-7199
Fax (301) 443-8280

Minority Health Resource Center (OMH) is accessible through a toll-free telephone call to 1-800-444-6472. http://www.omhrc.gov/

Health Resources and Services Administration (HRSA) assures access to high-quality health care to medically underserved, vulnerable, and special needs individuals and families.

Office of Women's Health
Health Resources and Services Administration (HRSA)
Department of Health and Human Services
Parklawn Building, Room 14-25
5600 Fishers Lane
Rockville, MD 20857-0001
Phone (301) 443-8695
Fax (301) 443-8587
http://www.hrsa..gov/WomensHealth/

Public Health Services (PHS) Office of Population Affairs (OPA) has overall policy and management responsibility for the Office of Family Planning and the Office of Adolescent Pregnancy Programs.

Office of Population Affairs (OPA)
Office of the Secretary
Department of Health and Human Services
1101 Wootton Parkway – Suite 700
Rockville, MD 20852
Phone (301) 594-4000
Fax (301) 594-5980
http://www.opa.osophs.dhhs.gov/index.html

The PHS Office of HIV/AIDS Policy (OHAP) serves as the coordinating office for HHS-wide activities that implement PHS guidelines for HIV counseling, testing of pregnant women and infants, and therapies to reduce HIV transmission.

Office of HIV/AIDS Policy
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, SW, Room 736E
Washington, DC 20201
Phone (202) 690-5560
Fax (202) 690-7560
http://www.surgeongeneral.gov/aids/ohaphome.html

Agency for Healthcare Research and Quality (AHRQ) enhances the quality, appropriateness, and effectiveness of health care services for women.

Agency for Healthcare Research and Quality (AHRQ)
New Executive Office Building
2101 E. Jefferson St., Suite 501
Rockville, MD 20852
Phone (301) 594-1364
http://www.ahcpr.gov

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547
Phone (800) 358-9295
TDD: 888-586-6340

Centers for Disease Control and Prevention (CDC) actively protects America's health and safety, enhances health decisions through credible information, and promotes health through strong partnerships.

Office of Women's Health
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Mail Stop D-51
Atlanta, GA 30033
Phone (404) 639-7230
Fax (404) 639-7331
http://www.cdc.gov/od/spotlight/nwhw/default.htm

Food and Drug Administration (FDA) has jurisdiction over the safety and efficacy of drugs, medical devices, vaccines, blood and tissue products, foods, and cosmetics on which American consumers depend.

Office of Women's Health
U.S. Food and Drug Administration (FDA)
Parklawn Building
5600 Fishers Lane, Room 16-65
Rockville, MD 20857
Phone (301) 827-0350
Fax (301) 857-0926
http://www.fda.gov/womens

The **Indian Health Service (IHS)** provides health care services to almost 1.5 million American Indians and Alaska Natives of 557 federally recognized tribes.

Indian Health Service
Department of Health and Human Services
The Reyes Building
801 Thompson Ave., Suite 400
Rockville, MD 20852-1627
Phone (301) 443-1083
http://www.ihs.gov

The **National Institutes of Health (NIH)** is the world's premier medical research organization, supporting roughly 35,000 research projects in diseases such as cancer, diabetes, arthritis, heart disease, and HIV/AIDS.

National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892
(301) 496-4000
http://www.nih.gov/

Office of Research on Women's Health (ORWH) encourages research on health conditions affecting women, ensures that the research conducted and supported by NIH adequately addresses women's health issues, verifies that women are represented in NIH-supported studies, and develops opportunities for recruiting and advancing women in biomedical careers.

Office of Research on Women's Health (ORWH)
National Institute of Health
Building 1, Room 201
9000 Rockville Pike
Bethesda, MD 20892-0161
Phone: (301)402-1770
FAX: (301)402-1798
http://www4.od.nih.gov/orwh/

National Center on Minority Health and Health Disparities (Formerly the NIH Office of Research on Minority Health) promotes and supports biomedical and behavioral research aimed at improving the health status of minority Americans across the lifespan and programs designed to expand the participation of underrepresented minorities in all aspects of biomedical and behavioral research.

National Center on Minority Health and Health Disparities
National Institutes of Health
6707 Democracy Blvd., Suite 800
MSC-5465
Bethesda, MD 20892-5465
Phone (301) 402-1366
Fax (301) 480-4049
http://ncmhd.nih.gov/

National Institute of Child Health and Human Development (NICHD) conducts and supports research and professional training opportunities with the goal of ensuring that every person is born healthy and wanted, that women suffer no harmful effects from the reproductive process, and that all children have the chance to fulfill their potential for a healthy and productive life

National Institute of Child Health and Human Development (NICHD)
National Institutes of Health
Building 31, Room 2A32, MSC 2425
31 Center Drive
Bethesda, MD 20892-2425
Phone: 1-800-370-2943
Fax: 301-984-1473
http://www.nichd.nih.gov/

National Institute of Nursing Research (NINR) supports clinical and basic research to establish a scientific basis for the care of individuals across the life span.

National Institute of Nursing Research
National Institutes of Health
31 Center Drive, Room 5B-10
Bethesda, MD 20892-2178
(301) 496-8230
http://www.nih.gov/ninr/

National Institute of Alcohol Abuse and Alcoholism (NIAAA) are collaborating with clinicians and scientists from Howard University, Drew University, the University of New Mexico, and Indiana University to study fetal alcohol syndrome (FAS).

National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
6000 Executive Blvd. – Willco Building
Bethesda, MD 20892-7003
http://www.niaaa.nih.gov/

National Cancer Institute (NCI) coordinates and supports research, training, health information dissemination, and other programs with respect to the cause, diagnosis, prevention, and treatment of cancer, rehabilitation from cancer, and the continuing care of cancer patients and the families of cancer patients.

National Cancer Institute
National Institutes of Health
Suite 3036A
6116 Executive Blvd., MSC8322
Bethesda, MD 20892-8322
1-800-4-CANCER (1-800-422-6237)
TDD: 1-800-332-8615
www.nci.nih.gov/

National Institute of Environmental Health Science (NIEHS) seeks to reduce the burden of human illness and dysfunction from environmental causes by understanding each of these elements and how they interrelate.

National Institute of Environmental Health Science
National Institutes of Health
Mailing: P.O. Box 12233
Research Triangle Park, NC 27709
Street: 111 Alexander Dr.
Research Triangle Park, NC 27709
Phone (919) 541-3345
TDD: (919) 541-0731
http://www.niehs.nih.gov/

National Heart, Lung and Blood Institute (NHLBI) are conducting the Women's Estrogen/Progestin and Lipid Lowering Hormone Atherosclerosis Regression Trial.

National Heart, Lung and Blood Institute
National Institutes of Health
Building 31, Rm 5A52
31 Center Dr. MSC 2486
Bethesda, MD 20892
(301) 592-8573
TDD: (240) 629-3255
Fax: (301) 592-8563
http://www.nhlbi.nih.gov/

National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMSD) are studying the effects of exogenous female hormones on disease activity and severity in women with systemic lupus erythematosis.

National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institutes of Health
1 AMS Circle
Bethesda, MD 20892-3675
(301) 495-4484
or 877-22-NIAMS (toll free)
TDD: (301) 718-6366
http://www.niams.nih.gov/

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies the need for substance abuse and mental health services for women, recommends policy, and promotes collaboration among its three centers: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Parklawn Building, Room 12-105
5600 Fishers Lane
Rockville, MD 20857
Phone (301) 443-8956
Fax (301) 443-9050
http://www.samhsa.gov

SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI)
Phone (800) 729-6686
Fax (301) 468-6433
http://www.health.org/about

Prepared by DHHS/OWH 6/03

Table 1. Leading Causes of Death and Numbers of Deaths for Females in the United States, by Race and Ethnic Origin, 2000

White American Females

	Cause of Death	Number of Deaths
	All Causes	1,064,096
1.	Diseases of the Heart	320,168
2.	Malignant Neoplasms (Cancers)	232,608
3.	Cerebrovascular Diseases (including Stroke)	89,642
4.	Chronic Lower Respiratory Diseases	58,024
5.	Alzheimer's Disease	32,936
6.	Influenza and Pneumonia	32,912
7.	Diabetes Mellitus	29,552
8.	Unintentional Injuries	29,263
9.	Nephritis, Nephrotic Syndrome and, Nephrosis	15,213
10.	Septicemia	14,088

Table 1. (Continued)
Leading Causes of Death and Numbers of Deaths for Females in the United States, by Race and Ethnic Origin, 2000

African American/Black Females

	Cause of Death	Number of Deaths
	All Causes	140,642
1.	Diseases of the Heart	40,783
2.	Malignant Neoplasms (Cancers)	29,128
3.	Cerebrovascular Diseases (including Stroke)	11,195
4.	Diabetes Mellitus	7,250
5.	Nephritis, Nephrotic Syndrome, and Nephrosis	3,837
6.	Unintentional Injuries	3,746
7.	Chronic Lower Respiratory Diseases	3,369
8.	Septicemia	3,341
9.	Influenza and Pneumonia	3,075
10.	Human Immunodeficiency Virus (HIV) Disease	2,448

Table 1. (Continued)
Leading Causes of Death and Numbers of Deaths for Females in the United States, by Race and Ethnic Origin, 2000

American Indian/Alaska Native Females

	Cause of Death	Number of Deaths
	All Causes	5,178
1.	Diseases of the Heart	1,076
2.	Malignant Neoplasms (Cancers)	917
3.	Unintentional Injuries	453
4.	Diabetes Mellitus	341
5.	Cerebrovascular Diseases (including Stroke)	322
6.	Chronic Liver Disease and Cirrhosis	236
7.	Chronic Lower Respiratory Diseases	201
8.	Influenza and Pneumonia	140
9.	Nephritis, Nephrotic Syndrome, and Nephrosis	117
10.	Septicemia	88

Table 1. (Continued)
Leading Causes of Death and Numbers of Deaths for Females in the United States, by Race and Ethnic Origin, 2000

Asian/Pacific Islander Females

	Cause of Death	Number of Deaths
	All Causes	15,857
1.	Malignant Neoplasms (Cancers)	4,356
2.	Diseases of the Heart	3,926
3.	Cerebrovascular Diseases (including Stroke)	1,733
4.	Unintentional Injuries	621
5.	Diabetes Mellitus	556
6.	Influenza and Pneumonia	528
7.	Chronic Lower Respiratory Diseases	411
8.	Nephritis, Nephrotic Syndrome, and Nephrosis	273
9.	Essential (primary) Hypertension and Hypertensive Renal Disease	179
10.	Septicemia	170

Table 1. (Continued)
Leading Causes of Death and Numbers of Deaths for Females in the United States, by Race and Ethnic Origin, 2000

Hispanic Females

	Cause of Death	Number of Deaths
	All Causes	47,082
1.	Diseases of the Heart	12,253
2.	Malignant Neoplasms (Cancers)	10,022
3.	Cerebrovascular Diseases (including Stroke)	3,322
4.	Diabetes Mellitus	2,821
5.	Unintentional Injuries	2,134
6.	Influenza and Pneumonia	1,322
7.	Chronic Lower Respiratory Diseases	1,238
8.	Certain Conditions Originating in the Perinatal Blood	951
9.	Chronic Liver Disease and Cirrhosis	875
10.	Nephritis, Nephrotic Syndrome, and Nephrosis	841

Source of 2000 Figures: Health, United States, 2002, Table 32. U.S. Department of Health and Human Services Centers for Disease Control and Prevention, National Center for Health Statistics.

Table 2. Mortality Rates* for Selected Major Causes of Death for Females of All Ages, Age-Adjusted, by Race/Ethnicity, United States (2000)+

Cause of Death	White	African American/ Black	American Indian/ Alaska Native	Asian American/ Pacific Islander	Hispanic	White, non-Hispanic
All Causes	722.2	947.9	586.4	415.2	475.7	732.6
Diseases of the Heart	207.5	284.1	129.4	113.8	137.1	210.4
Cerebrovascular Diseases (including stroke)	57.8	78.1	39.1	48.6	36.4	58.6
Malignant Neoplasms(Cancer)	168.7	196.6	109.1	103.0	100.6	172.5
Chronic lower respiratory diseases	40.0	23.1	24.9	11.5	13.8	41.5
HIV	1.0	13.4	NA	NA	3.0	0.7
Maternal Mortality	6.2	20.1	a	a	9.0	5.5
Homicide/Legal Intervention	2.1	7.2	3.7	1.8	3.0	1.9
Suicide	4.4	1.8	4.6	3.0	1.8	4.7

Key:

***** Number of deaths in a given year per 100,000 persons in the population.

+ Average annual death rate.

NA Number of deaths too statistically small to calculate (< 0).

Source: Health, United States, 2002, Tables 36-47. U.S. Department of Health and Human Services Centers for Disease Control and Prevention, National Center for Health Statistics.

July 2003