HEALTH STATUS

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

In this section, health status indicators related to morbidity, mortality, health behaviors, and maternal health are presented. New topics include chronic fatigue syndrome, eye health, digestive disorders, endocrine and metabolic disorders, occupational injury, attention deficit hyperactivity disorder, intimate partner violence, urologic disorders, and maternal mortality, as well as a discussion of genetics and women's health. The data are displayed by sex, age, race and ethnicity, and income, where feasible.

PHYSICAL ACTIVITY

Regular physical activity promotes health, psychological well-being, and a healthy body weight; enhances independent living; and improves one's quality of life. To reduce the risk of chronic disease, the *Dietary Guidelines for Americans, 2005,* recommended that adults engage in at least 30 minutes of moderate-intensity physical activity, above usual activity at work or home on most, or preferably all, days of the week.[1] For most people, greater health benefits can be obtained by engaging in more vigorous or longer periods of physical activity. The Healthy People 2010 objectives include increasing the percentage of adults participating in regular moderate or vigorous physical activity.[2]

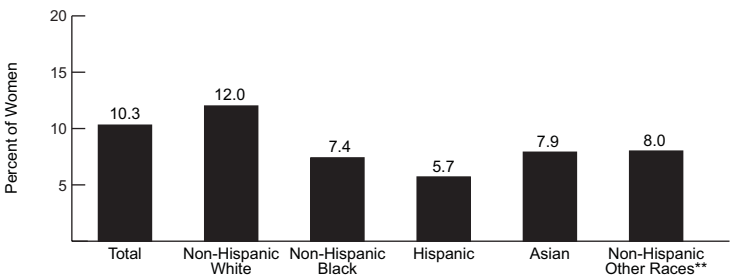
In 2006, only 10.3 percent of women reported participating in adequate physical activity (defined as engaging in moderate-intensity physical activity for at least 30 minutes per day on a minimum of 5 days per week or vigorous-intensity activity for at least 20 minutes per day for a minimum of 3 days per week). While there was little variation between women and men engaging in adequate physical activity, the percentage of women reporting regular physical activity varied by race/ethnicity, age, and income.

In 2006, non-Hispanic White women were more likely than women of other races/ethnicities to report adequate physical activity (12.0 percent). Hispanic women were least likely to report adequate physical activity (5.7 percent).

Among women in all income groups, rates of adequate physical activity peak during the ages of 25–44 years and decline as women grow older. In addition, among women in most age groups, those with higher income levels are more likely to engage in adequate physical activity. The women most likely to do so are those aged 25–44 years with incomes of 200 percent or more of poverty (19.2 percent), compared to 13.4 percent of women in the same age group with incomes of 100–199 percent of poverty and 12.7 percent of women in the same age group with incomes less than 100 percent of poverty.

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Race/Ethnicity, 2006

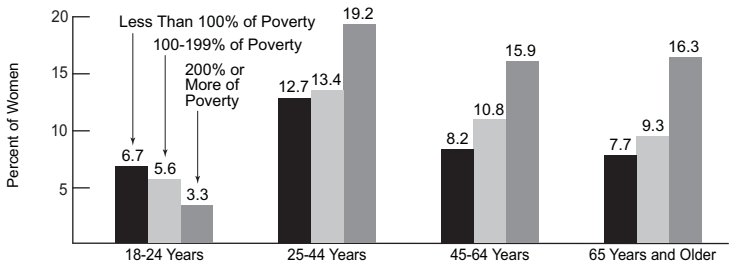
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Adequate physical activity is defined as 30 minutes per day or more of moderate-intensity activity on 5 or more days per week or 20 minutes per day of vigorous-intensity activity on 3 or more days per week.*
***Includes American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.*

Women Aged 18 and Older Engaging in Adequate* Physical Activity, by Age and Poverty Status,** 2006

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



**Adequate physical activity is defined as 30 minutes per day or more of moderate-intensity activity on 5 or more days per week or 20 minutes per day of vigorous-intensity activity on 3 or more days per week.*
***Poverty level, defined by the U.S. Census Bureau, was $20,444 for a family of four in 2006.*

NUTRITION

The *Dietary Guidelines for Americans, 2005* recommends eating a variety of nutrient-dense foods while not exceeding caloric needs. For most people, this means eating a daily assortment of fruits and vegetables, whole grains, lean meats and beans, and low-fat or fat-free milk products while limiting added sugar, sodium, saturated and *trans* fats, and cholesterol.[1]

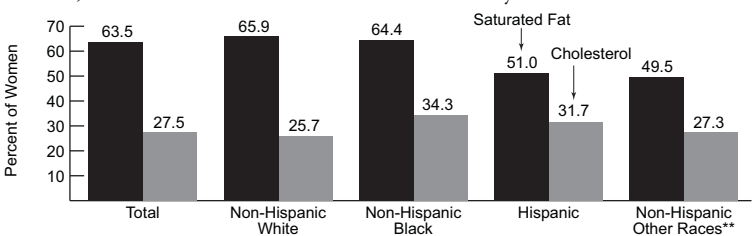
Some fats, mostly those that come from sources of polyunsaturated or monounsaturated fatty acids, such as fish, nuts, and vegetable oils, are an important part of a healthy diet. However, high intake of saturated fats, *trans* fats, and cholesterol may increase the risk of coronary heart disease. Most Americans should consume fewer than 10 percent of calories from saturated fats, less than 300 mg/day of cholesterol, and keep *trans* fatty acid consumption to a minimum. In 2003–2004, 63.5 percent of women exceeded the recommended maximum daily intake of saturated fat—most commonly non-Hispanic White women and non-Hispanic Black women (65.9 and 64.4 percent, respectively).

Salt, or sodium chloride, also plays an important role in heart health, as high salt intake can contribute to high blood pressure. In 2003–2004, nearly 70 percent of women exceeded the recommended maximum intake of less than 2,300 mg/day of sodium, or about 1 teaspoon of salt (data not shown).

Calcium is important for strengthening bones and teeth, and inadequate calcium consumption can lead to lower bone density, bone loss, and increased risk of osteoporosis. The recommended intake of calcium is 1,000 mg/day for women aged 19–50 and 1,200 mg/day for women aged 51 years and older. In 2003–2004, 20.2 percent of women met or exceeded the recommended daily intake. Folate is also an important part of a healthy diet, especially among women of childbearing age, since it can help reduce the risk of neural tube defects early in pregnancy. In 2003–2004, fewer than 30 percent of women consumed the recommended daily intake of folate (400 µg/day). Fewer than 20 percent of non-Hispanic Black women consumed the recommended amount of folate, compared to more than 30 percent each of non-Hispanic White and Hispanic women.

Women Exceeding the Recommended Daily Intake of Saturated Fat and Cholesterol,* by Race/Ethnicity, 2003–2004

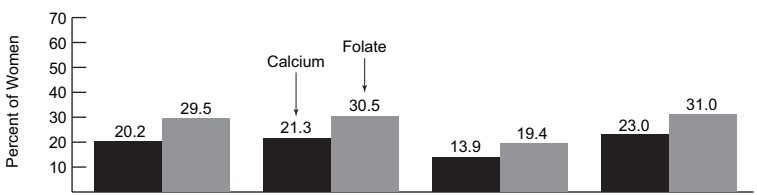
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Recommended maximum daily intake of saturated fat is 10 percent of daily caloric intake or less; recommended maximum daily intake of cholesterol is less than 300mg/day. **Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of other races not specified.

Women Meeting the Recommended Daily Intake of Calcium and Folate,* by Race/Ethnicity,** 2003–2004

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



*Recommended daily intake of calcium is 1,000 mg/day for women aged 19–50 and 1,200 mg/day for women aged 51 years and older; recommended folate intake is 400 µg/day. **The sample of American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of other races not specified was too small to produce reliable results.

ALCOHOL USE

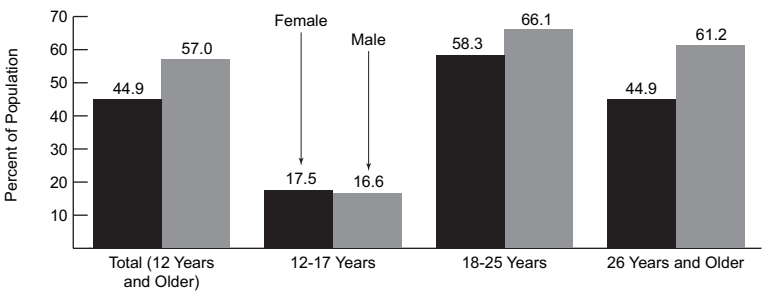
In 2006, 50.8 percent of the total U.S. population aged 12 and older reported using alcohol in the past month; among those aged 18 and older, the rate was 54.7 percent (data not shown). According to the Centers for Disease Control and Prevention (CDC), alcohol is a central nervous system depressant that, in small amounts, can have a relaxing effect. Although there is some debate over the health benefits of small amounts of alcohol consumed regularly, the negative health effects of excessive alcohol use and abuse are well established.[3] Short-term effects can include increased risk of motor vehicle injuries, falls, domestic violence, and child abuse. Long-term effects can include pancreatitis, high blood pressure, liver cirrhosis, various cancers, and psychological disorders, including alcohol dependency.

Overall, males are more likely to drink alcohol than females, with past-month alcohol use reported by 57.0 percent of males and 44.9 percent of females aged 12 years and older. This is true across all age groups with the exception of 12- to 17-year-olds; in that group, 17.5 percent of females and 16.6 percent of males reported past-month use.

Alcohol use, and the frequency of use, also vary by race and ethnicity. Among women aged 18 and older, non-Hispanic White women were most likely to report any alcohol use in the past month (53.5 percent), while Asian/Pacific Islander women were least likely (28.4 percent), followed by American Indian/Alaska Native women (31.1 percent). American Indian/Alaska Native women were more likely than women of other races and ethnicities to engage in binge drinking, which is defined as drinking five or more drinks on the same occasion at least once in the past month (19.6 percent), and heavy drinking, which is defined as five or more drinks on the same occasion at least five times in the past month (6.9 percent). Non-Hispanic White women reported the next highest percentages of binge drinking and heavy drinking (16.8 and 4.1 percent, respectively).

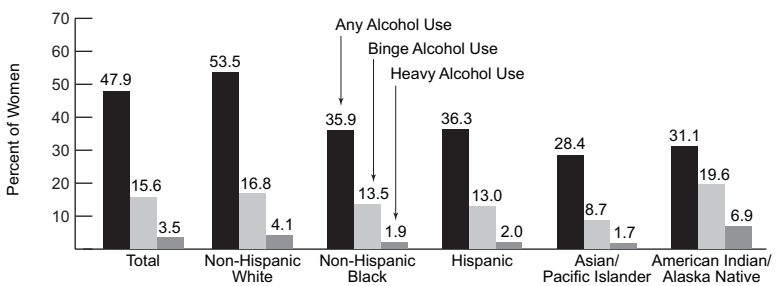
Past Month Alcohol Use, by Sex and Age, 2006

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



Past Month Alcohol Use Among Women Aged 18 and Older, by Type* and Race/Ethnicity, 2006

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



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

CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body. Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impairs genes that control the growth of cells, and binds to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[4]

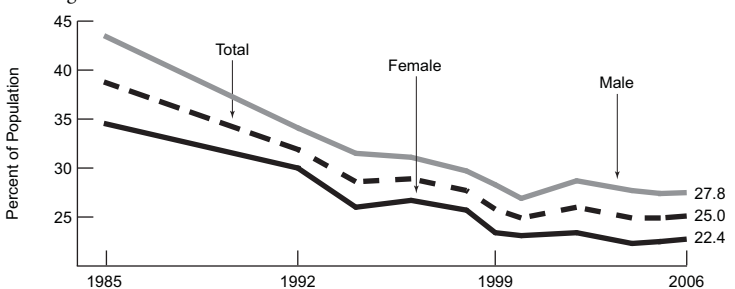
In 2006, more than 61.5 million people in the United States aged 12 and older smoked cigarettes within the past month. Smoking was less common among females aged 12 and older (22.4 percent) than among males of the same age group (27.8 percent). Cigarette use has declined over the past several decades among both sexes, though it has leveled off in recent years. In 1985, the rate among males was 43.4 percent while the rate among females was 34.5 percent.

Among women, the rate of smoking varied by race and ethnicity in 2006. American Indian/Alaska Native women were most likely to have smoked cigarettes in the past month (39.1 percent), followed by non-Hispanic White women (24.9 percent). Asian/Pacific Islander women were least likely to have smoked cigarettes (9.7 percent).

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[3] In 2006, nearly 46 percent of female smokers aged 18 and older reported trying to quit at least once in the past year; however, this varied by age. Women aged 18–44 were most likely to have attempted quitting (49.3 percent), followed by women aged 45–64 years (44.3 percent). Fewer than 30 percent of female smokers aged 65 years and older attempted to quit smoking in 2006 (data not shown).[5] Research indicates that smoking cessation programs, including behavioral therapy, telephone support, and pharmacotherapy, may increase the likelihood of quitting smoking,[6] although participation rates in such programs are unknown.

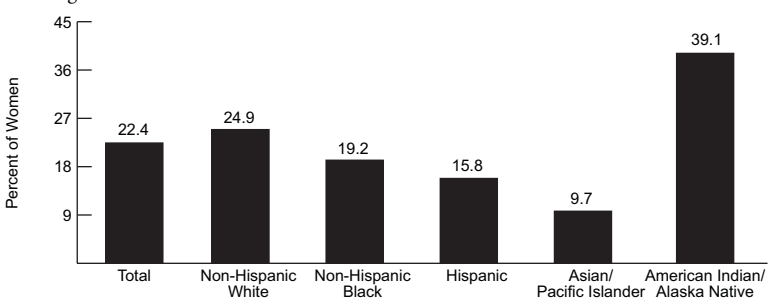
Past Month Cigarette Use Among Persons Aged 12 and Older, by Sex, 1985–2006

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



Past Month Cigarette Use Among Women Aged 18 and Older, by Race/Ethnicity, 2006

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



ILLICIT DRUG USE

Illicit drug use is associated with serious health and social consequences, such as impaired cognitive functioning, kidney and liver damage, drug addition, and decreased worker productivity.[7] Illicit drugs include marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes. In 2006, nearly 12.6 million women aged 18 years and older reported using an illicit drug within the past year; this represents 11.0 percent of women. In comparison, 18.2 million men, representing 17.1 percent of the adult male population, used at least one illicit drug in the past year. Past-year illicit drug use was significantly higher among women aged 18–25 years than among women 26 years and older (30.3 versus 7.8 percent). Among adolescent females aged 12–17 years, 19.7 percent used at least one illicit drug in the past year.

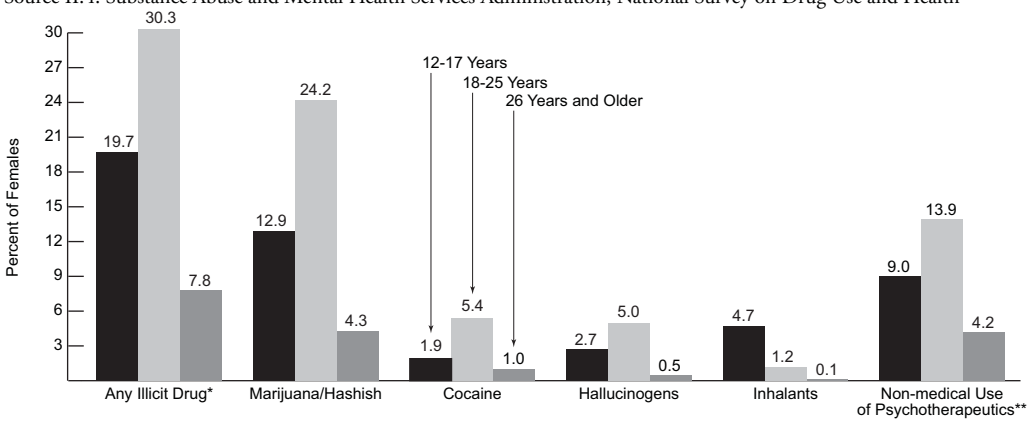
In 2006, marijuana was the most commonly used illicit drug among females in each age group, followed by the non-medical use of prescription-type psychotherapeutic drugs. Short-term effects of marijuana use can include difficulty thinking and solving problems, memory and learning problems, and distorted perception. Prescription drugs commonly used or abused for non-medical purposes include opioids, central nervous system depressants, and stimulants. Long-term use of these drugs can lead to physical dependence and addiction. In addition, when taken in large doses, stimulant use can lead to compulsivity, paranoia, dangerously high body temperature, and an irregular heartbeat.[7]

Use of all drug types, except inhalants, was highest among females aged 18–25 years, with 24.2 percent reporting past-year marijuana use and 13.9 percent reporting non-medical use of prescription-type psychotherapeutic drugs. Use of inhalants in the past-year was highest among females aged 12–17 (4.7 percent), compared to 1.2 percent of those aged 18–25 and 0.1 percent of those aged 26 years and older.

Methamphetamine is a stimulant with a high potential for abuse, and use can result in decreased appetite, increased respiration and blood pressure, rapid heart rate, irregular heartbeat, and hyperthermia. Long-term effects can include paranoia, delusions, hallucinations, and stroke.[7] The Monitoring the Future Survey estimates that, in 2006, 1.8 percent of women aged 19–30 years used methamphetamine and 1.3 percent used crystal methamphetamine. Use of crystal methamphetamine was more common among females than males in this age group, while there was no difference in the use of methamphetamine (data not shown).[8]

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2006

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



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes. **Includes prescription-type pain relievers, tranquilizers, stimulants, and sedatives, but not over-the-counter drugs.

SELF-REPORTED HEALTH STATUS

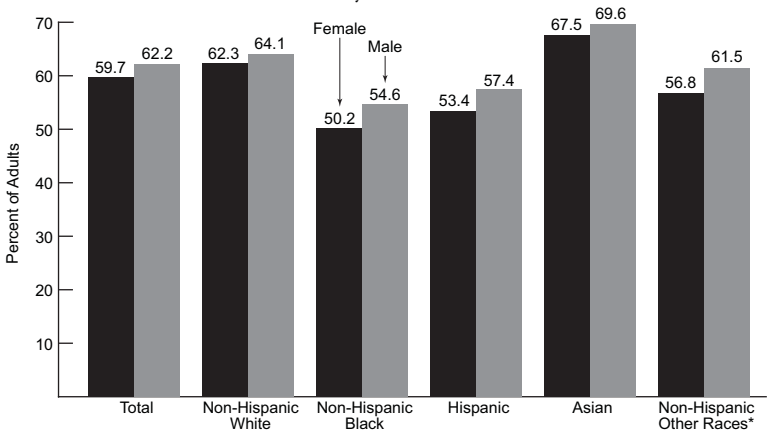
In 2006, men were more likely than women to report being in excellent or very good health (62.2 versus 59.7 percent); this was true in every racial and ethnic group. Among both sexes, Asians most often reported that they were in excellent or very good health, followed by non-Hispanic Whites; non-Hispanic Blacks were the least likely to report being in excellent or very good health.

Self-reported health status declines with age: 70.8 percent of women aged 18–44 years reported excellent or very good health status, compared to 54.5 percent of those aged 45–64 years, 42.4 percent of those aged 65–74 years, and 35.9 percent of those aged 75 years and older. Among those in the oldest age group, 27.0 percent reported fair or poor health, compared to only 6.2 percent of those in the youngest age group.

The rate of women reporting excellent or very good health also varies with income (data not shown). Women with family incomes of 300 percent or more of poverty were most likely to report excellent or very good health (71.1 percent), followed by 58.2 percent of women with family incomes of 200–299 percent of poverty. Only 42.5 percent of women whose family incomes were below 100 percent of poverty reported excellent or very good health.

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Sex and Race/Ethnicity, 2006

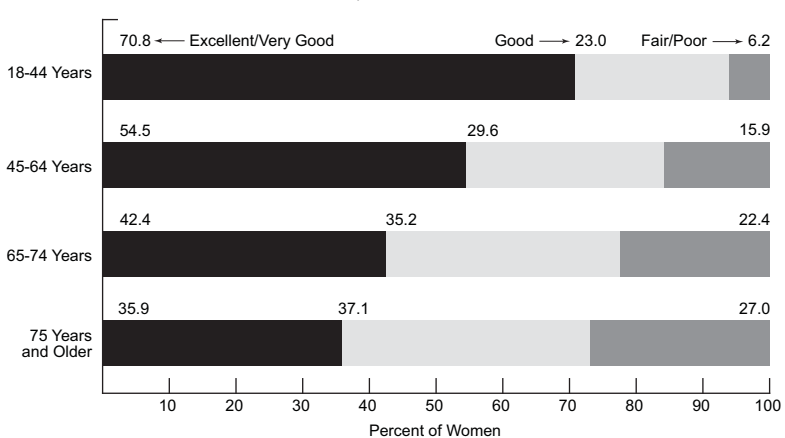
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Includes American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.*

Self-Reported Health Status of Women Aged 18 and Older, by Age, 2006

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



LIFE EXPECTANCY

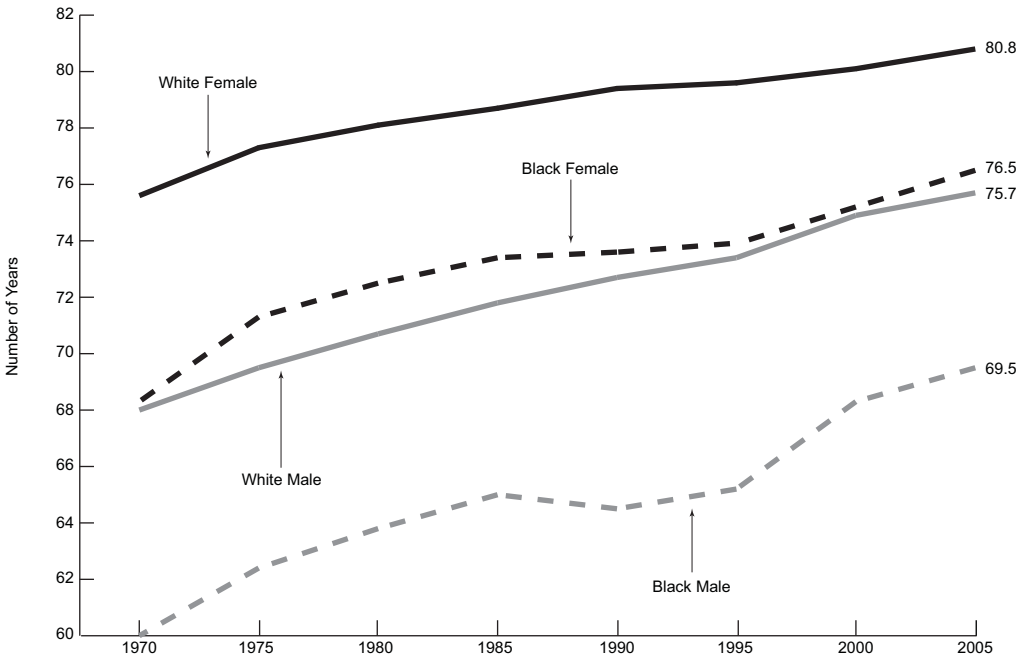
A baby girl born in the United States in 2005 could expect to live 80.4 years, 5.2 years longer than a male baby, whose life expectancy would be 75.2 years. The differential between male and female life expectancy was greater among Blacks than Whites. Black males could expect to live 69.5 years, 7 years fewer than Black females (76.5 years). The difference between White males and females was 5.1 years, with a life expectancy at birth for White females of 80.8 years and 75.7 years for White males. White females could expect to live 4.3 years longer than Black females. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates.

Life expectancy has steadily increased since 1970 for males and females in both racial groups. Between 1970 and 2005, White males' life expectancy increased from 68.0 to 75.7 years (11.3 percent), while White females' life expectancy increased from 75.6 to 80.8 years (6.9 percent). During the same period, the life expectancy for Black males increased from 60.0 to 69.5 years (15.8 percent), while life expectancy increased from 68.3 to 76.5 years (11.7 percent) for Black females.

Life expectancy data have not been uniformly calculated and reported for the Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native populations. However, estimated life expectancy is generally lower for these groups. An American Indian/Alaska Native born in 1999–2001 could expect to live 74.5 years; this is a 17.1 percent increase over the life expectancy in 1972–1974 (63.6 years).[9] The U.S. Census Bureau estimated that Hispanics born in 1999 would have a life expectancy of 83.7 years for females and 77.2 years for males. Asian males born in 1999 had a life expectancy of 80.9 years, while life expectancy for Asian females born in that year was 86.5 years (data not shown).[10]

Life Expectancy at Birth, by Race* and Sex, 1970–2005

Source II.5: Centers for Disease Control and Prevention, National Center for Health Statistics



*Both racial categories include Hispanics.

LEADING CAUSES OF DEATH

In 2005, there were 1,240,342 female deaths in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), responsible for 26.5 and 21.7 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 7.0 percent of deaths, followed by chronic lower respiratory disease, which accounted for 5.5 percent. Among both males and females under 44 years of age, unintentional injury was the leading cause of death (data not shown).

Heart disease was the leading cause of death for women in almost every racial and ethnic group; the exception was Asian/Pacific Islander females, for whom the leading cause of death was cancer. One of the most noticeable differences in leading causes of death by race and ethnicity is that diabetes mellitus was the eighth leading cause of death among non-Hispanic White females, while it was the fourth among all other racial and ethnic groups. Similarly, chronic lower respiratory disease was the fourth leading cause of death among non-Hispanic White females while it ranked sixth or seventh among other racial and ethnic groups. Death in the perinatal period was the ninth leading cause of death among Hispanic females, and hypertension was the tenth leading cause among Asian/Pacific Islander females (data not shown). Also noteworthy is that American Indian/Alaska Native females experienced a higher proportion of deaths due to unintentional injury (8.0 percent) and liver disease (4.0 percent; seventh leading cause of death) than females of other racial and ethnic groups.

Ten Leading Causes of Death Among Females (All Ages), by Race/Ethnicity, 2005

Source II.6: Centers for Disease Control and Prevention, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Asian/Pacific Islander	American Indian/ Alaska Native
Cause of Death	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**
Heart Disease	26.5 **(1)**	26.8 **(1)**	26.3 **(1)**	23.8 **(1)**	23.4 **(2)**	19.0 **(1)**
Malignant Neoplasms (cancer)	21.7 **(2)**	21.7 **(2)**	21.2 **(2)**	21.4 **(2)**	27.7 **(1)**	18.6 **(2)**
Cerebrovascular Diseases (stroke)	7.0 **(3)**	7.0 **(3)**	7.0 **(3)**	6.3 **(3)**	9.5 **(3)**	6.0 **(5)**
Chronic Lower Respiratory Disease	5.5 **(4)**	6.2 **(4)**	2.6 **(7)**	2.8 **(6)**	2.4 **(7)**	4.1 **(6)**
Alzheimer's Disease	4.1 **(5)**	4.5 **(5)**	2.3 **(9)**	2.5 **(8)**	1.9 **(8)**	2.0 **(10)**
Unintentional Injury	3.3 **(6)**	3.3 **(6)**	3.0 **(6)**	5.0 **(5)**	3.9 **(5)**	8.0 **(3)**
Diabetes Mellitus	3.1 **(7)**	2.6 **(8)**	5.0 **(4)**	5.9 **(4)**	4.0 **(4)**	6.3 **(4)**
Influenza and Pneumonia	2.8 **(8)**	2.9 **(7)**	2.1 **(10)**	2.8 **(7)**	3.0 **(6)**	2.8 **(8)**
Nephritis (kidney inflammation)	1.8 **(9)**	1.6 **(9)**	3.1 **(5)**	2.0 **(10)**	1.8 **(9)**	2.6 **(9)**
Septicemia (blood poisoning)	1.5 **(10)**	1.4 **(10)**	2.4 **(8)**	N/A	N/A	N/A

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

ACTIVITY LIMITATIONS AND DISABILITIES

Although there are many different ways to define a disability, one common guideline is whether a person is able to perform common activities—such as walking up stairs, standing or sitting for several hours at a time, grasping small objects, or carrying items such as groceries—without assistance. In 2006, nearly 14 percent of adults reported having at least one condition that limited their ability to perform one or more of these common activities. Women were more likely to report being limited in their activities than men (15.0 versus 12.6 percent).

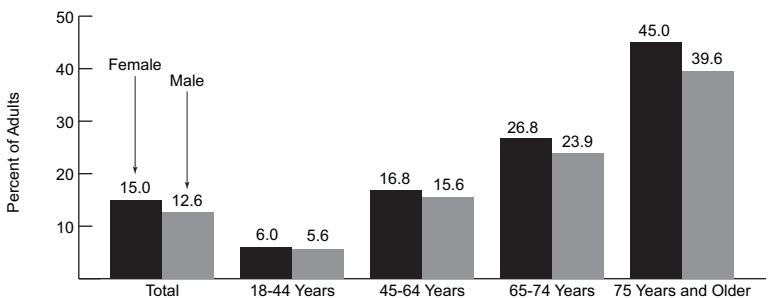
The percentage of adults reporting at least one activity limitation varied with age among both men and women. Only 6.0 percent of women aged 18–44 years reported any activity limitation, compared to nearly 27 percent of women aged 65–74 years and 45.0 percent of women aged 75 years or older.

The percentage of women reporting that a vision or hearing problem causes activity limitations also increased with age. Overall, 7.6 percent of women with a limitation reported a vision problem, and 3.7 percent reported that a hearing problem caused their activity limitation. Only 4.0 percent of women aged 18–44 years reported vision problems compared to 13.0 percent of women aged 75 years and older. Similarly, 3.0 percent of 18- to 44-year-old women reported a hearing problem, compared to 7.4 percent of women aged 75 years and older.

In 2006, the percentage of women reporting at least one activity limitation varied by race and ethnicity (data not shown). Non-Hispanic Black women were most likely to report at least one limitation (16.5 percent), followed by non-Hispanic White women (16.0 percent). Asian women were least likely to report any activity limitation (7.0 percent). More than 9.5 percent of Hispanic women also reported an activity limitation.

Adults Aged 18 and Older with at Least One Activity Limitation,* by Age and Sex, 2006

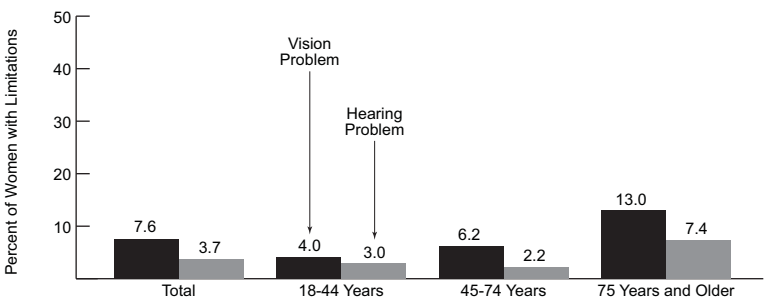
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Vision or Hearing Problems Causing Activity Limitations,* by Age, 2006

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



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

ARTHRITIS

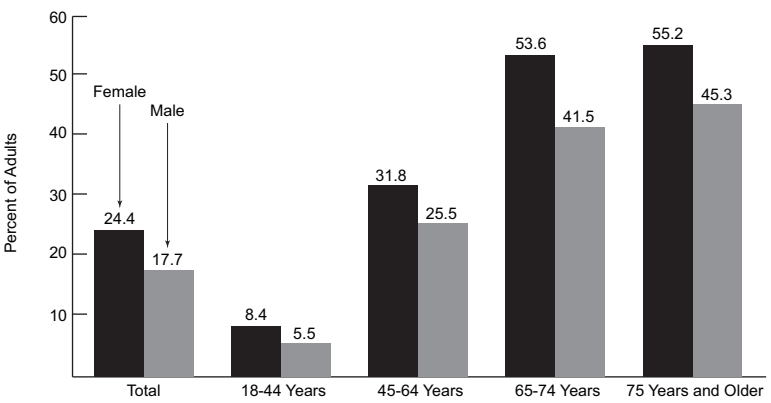
Arthritis, the leading cause of disability among Americans over 15 years of age, comprises more than 100 different diseases that affect areas in or around the joints. The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement due to deterioration in the cartilage covering the ends of bones in the joints. Types of arthritis that primarily affect women include lupus arthritis, fibromyalgia, and rheumatoid arthritis, which is the most serious and disabling type of arthritis.[11]

In 2006, more than 21 percent of adults in the United States reported that they had ever been diagnosed with arthritis. Arthritis was more common among women than men (24.4 versus 17.7 percent), and rates of arthritis increased dramatically with age for both sexes. Fewer than 10 percent of women aged 18–44 years had been diagnosed with arthritis, compared to 53.6 percent of women aged 65–74 years, and almost 55.2 percent of women aged 75 years and older.

In 2006, the rate of arthritis among women varied by race and ethnicity. Arthritis was most common among non-Hispanic White women (27.2 percent), followed by non-Hispanic Black women (23.5 percent). Asian and Hispanic women were least likely to report having ever been told that they have arthritis (11.5 and 14.3 percent, respectively).

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2006

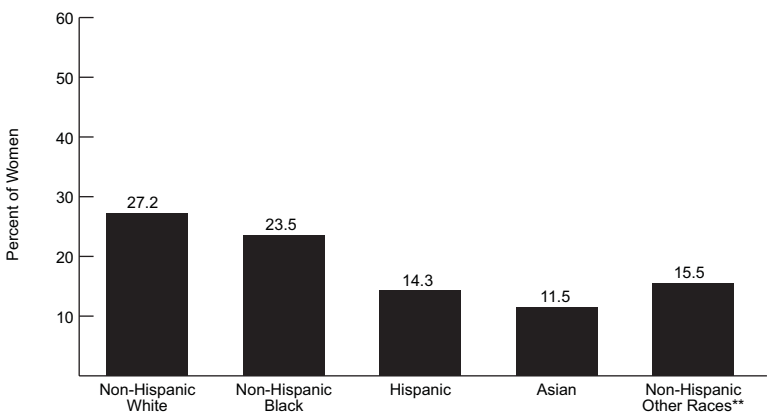
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity, 2006

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



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

ASTHMA

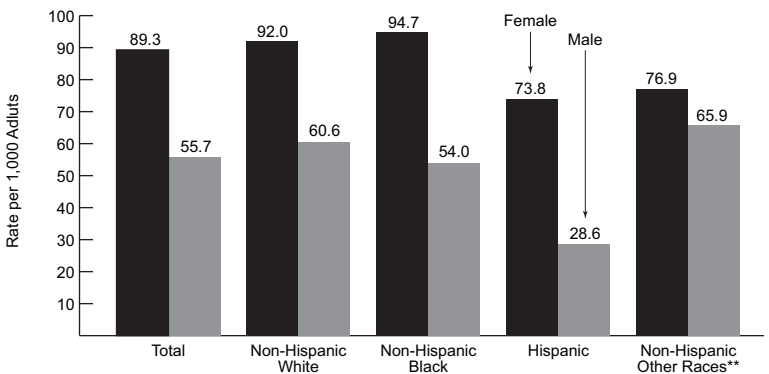
Asthma is a chronic inflammatory disorder of the airway characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. However, by taking certain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

In 2006, women had higher rates of asthma than men (89.3 per 1,000 women versus 55.7 per 1,000 men); this was true in every racial and ethnic group. Among women, non-Hispanic Black women had the highest asthma rate (94.7 per 1,000 women), followed by non-Hispanic White women (92.0 per 1,000); Hispanic women had the lowest asthma rate (73.8 per 1,000).

A visit to the emergency room due to asthma may be an indication that the asthma is not effectively controlled or treated. In 2006, asthmatic women with family incomes below poverty were more likely than women with higher family incomes to have an emergency room visit due to asthma. Among women with family incomes less than 100 percent of poverty, 35.9 percent of those with asthma had visited the emergency room in the past year, compared to 24.8 percent of asthmatic women with family incomes of 300 percent or more of poverty. Consistent use of medication can reduce the use of hospital and emergency room care for people with asthma.[12]

Adults Aged 18 and Older with Asthma,* by Race/Ethnicity and Sex, 2006

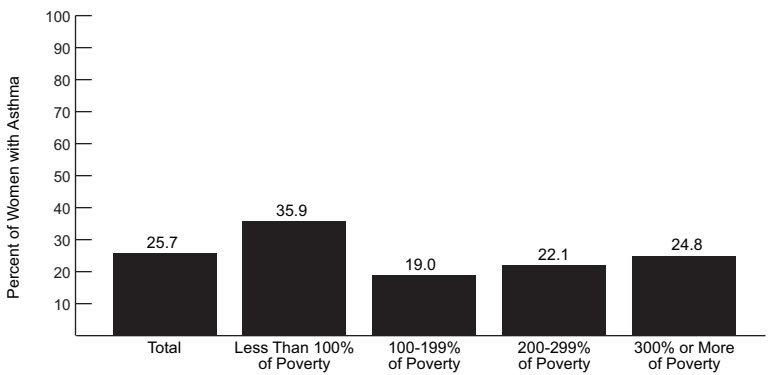
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that (1) a health professional has ever told them that they have asthma, and (2) they still have asthma. Rates reported are not age-adjusted. **Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.

Women Aged 18 and Older with an Emergency Room Visit Due to Asthma in the Past Year, by Poverty Status,* 2006

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



*Poverty level, defined by the U.S. Census Bureau, was $20,444 for a family of four in 2006.

CHRONIC FATIGUE SYNDROME

While research indicates that any person may develop chronic fatigue syndrome, women are four times more likely to experience the disorder than men. Chronic fatigue syndrome is characterized by extreme, sometimes disabling, fatigue that does not improve with bed rest and may be worsened by physical or mental activity. Since there are no known causes of chronic fatigue syndrome and no diagnostic laboratory tests to identify the disorder, researchers have set strict guidelines for diagnosing chronic fatigue syndrome. Patients must have experienced severe chronic fatigue lasting 6 months or longer (with other known medical conditions excluded), and at least four of the following symptoms: impairment in short-term memory or concentration; sore throat; tender lymph nodes; muscle pain; multi-joint pain (without swelling or redness); headaches; unrefreshing sleep; and post-exertional malaise lasting more than 24 hours. In addition, these symptoms must have occurred prior to the onset of the fatigue and have persisted during at least 6 months of illness.[13]

While national population-based studies of chronic fatigue syndrome prevalence have not been conducted, research on the disorder has been underway for over 20 years. The CDC estimates that more than one million people in the United States are affected by chronic fatigue syndrome, while millions more experience symptoms but do not meet the strict criteria described above. A recent study conducted in the State of Georgia estimated that approximately 2.5 percent of adults aged 18–59 years may have chronic fatigue syndrome.[14] Chronic fatigue syndrome is more common among people in their 40s and 50s than among other age groups.[13] In addition, it appears that fewer than 20 percent of persons with chronic fatigue syndrome have ever received a diagnosis and treatment for the illness.[15]

CANCER

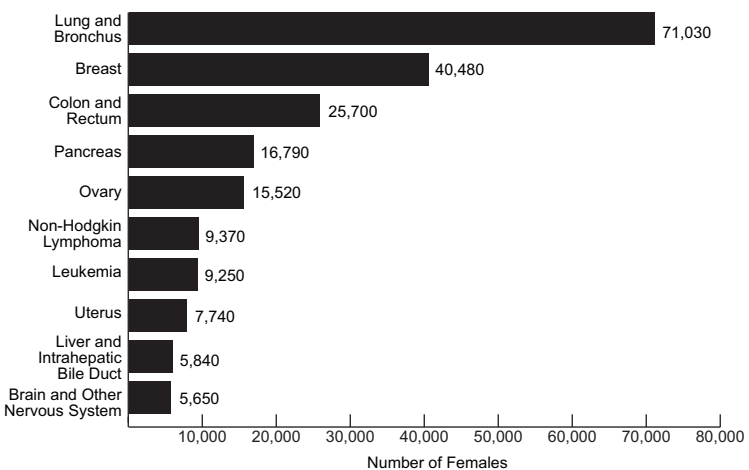
It is estimated that 692,000 new cancer cases will be diagnosed among females, and more than 271,000 females will die of cancer in 2008. Lung and bronchus cancer is expected to be the leading cause of cancer death among females with 71,030 deaths, accounting for 26 percent of all cancer deaths, followed by breast cancer, which will be responsible for 40,480, or 15 percent of deaths. Colon and rectal cancer, pancreatic cancer, and ovarian cancer will also be significant causes of cancer deaths among females.

Due to the varying survival rates for different types of cancer, the most common causes of cancer death are not always the most common types of cancer. For instance, although lung and bronchus cancers cause the greatest number of deaths, breast cancer is more commonly diagnosed among women; there will be an estimated 182,460 new breast cancer cases in 2008 versus 100,330 lung and bronchus cancer cases. Other types of cancer that are commonly diagnosed among females but are not among the top 10 causes of cancer deaths include melanoma, thyroid cancer, cancer of the kidney and renal pelvis, and basal and sqamous cell skin cancer.

Cervical cancer screenings are recommended at least every 3 years beginning within 3 years of sexual activity or by age 21. In addition, a vaccination for genital human papillomavirus (the leading cause of cervical cancer) was approved for use by the FDA in 2006 and is recommended for adolescents and young women aged 9–26 years.[16] Cervical cancer rates increase with age and vary by race and ethnicity. In 2000–2004, Hispanic women aged 20–44 and

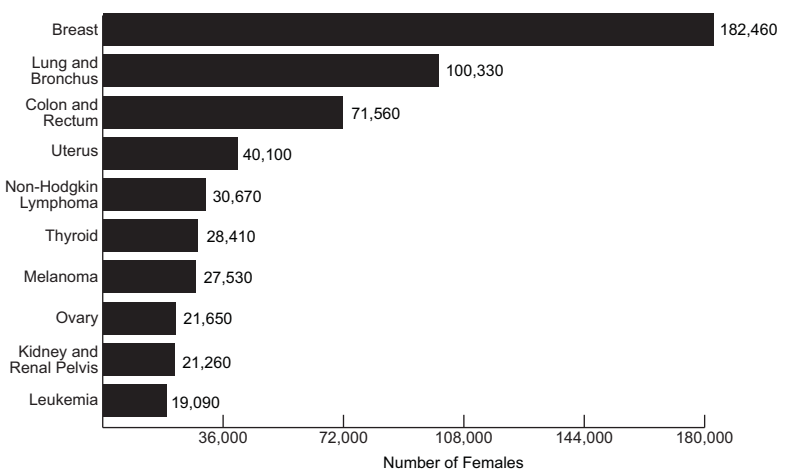
Leading Causes of Cancer Deaths Among Females, by Site, 2008 Estimates

Source II.7: American Cancer Society



New Cancer Cases Among Females, by Site, 2008 Estimates

Source II.7: American Cancer Society

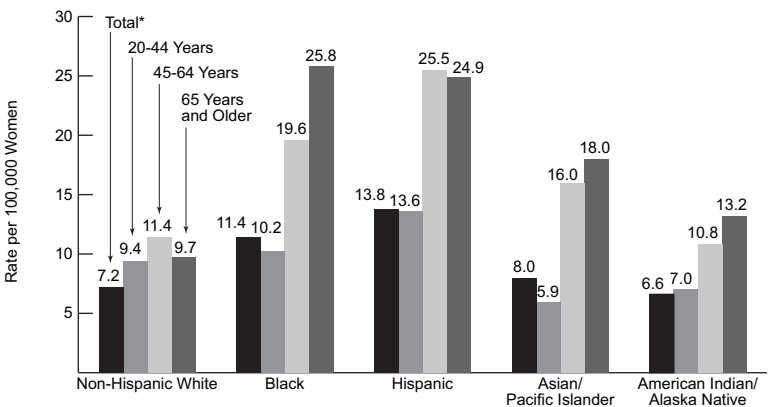


45–64 years were more likely than women of other races and ethnicities of the same age groups to be diagnosed with cervical cancer (13.6 and 25.5 per 100,000 women, respectively). Black and Hispanic women aged 65 years and older were also more likely to be diagnosed with this type of cancer (25.8 and 24.9 per 100,000, respectively). Asian/Pacific Islander women aged 20–44 years were least likely to be diagnosed with cervical cancer (5.9 per 100,000).

Survival rates for ovarian cancer vary depending on how early it is discovered. For women diagnosed with ovarian cancer in 1996–2003, 45.0 percent could expect to live 5 years or more; however, this varied by race and the stage of the cancer. More than 92 percent of women of all races with cancer localized in the ovaries could expect to live at least 5 years. Comparatively, 71.1 percent of White women and 49.8 percent of Black women could expect the same when cancer is in the regional stage (spread beyond the primary site). Among women at the distant stage (spread to distant organs or lymph nodes), only 30.0 percent of White women and 22.5 percent of Black women could expect to live 5 more years.

Cervical Cancer Incidence, by Race/Ethnicity and Age, 2000–2004

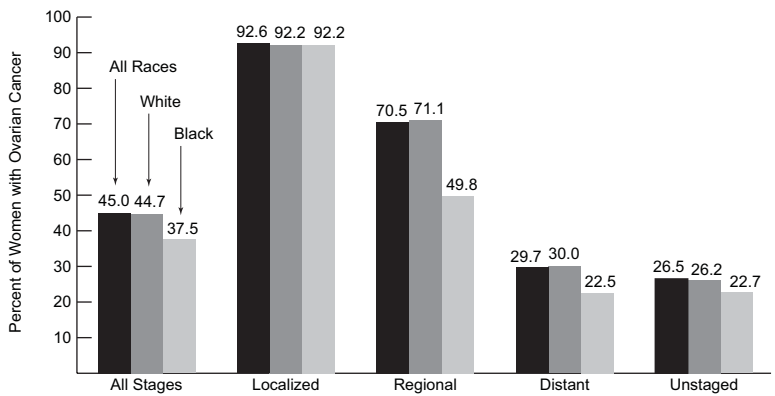
Source II.8: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*Includes all ages.

Five-year Period Survival Rates for Ovarian Cancer, by Race* and Stage,** 1996–2003

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



*All Races includes American Indian/Alaska Natives, Asian/Pacific Islanders, Hispanics, persons of more than one race, and persons of unspecified race. **Localized cancer is limited to the organ in which it began (no evidence of spread); regional cancer has spread beyond the primary site; distant cancer has spread to distant organs or lymph nodes; and unstaged indicates that there is not enough information to determine a stage.

DIABETES

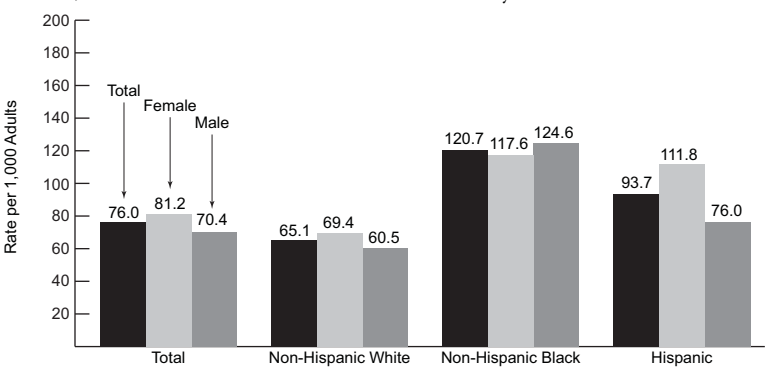
Diabetes mellitus is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. Diabetes is becoming increasingly common among children and young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

In 2005–2006, 76.0 per 1,000 adults reported that they had been told by a health professional that they have diabetes. Women were more likely than men to have diabetes overall (81.2 versus 70.4 per 1,000 adults) and in most racial and ethnic groups. Among women, non-Hispanic Blacks and Hispanics had higher rates of diabetes (117.6 and 111.8 per 1,000, respectively) than non-Hispanic Whites (69.4 per 1,000).

Diabetes prevalence generally increases with age. In 2005–2006, among women aged 45 and older, the highest rate of diabetes occurred among women aged 65–74 years (197.5 per 1,000 women). In other words, nearly one in five women in this age group have diabetes. Women aged 55–64 and 75 years and older also had relatively high rates of diabetes (155.5 and 153.4 per 1,000, respectively).

Adults Aged 18 and Older with Diabetes,* by Race/Ethnicity** and Sex, 2005–2006

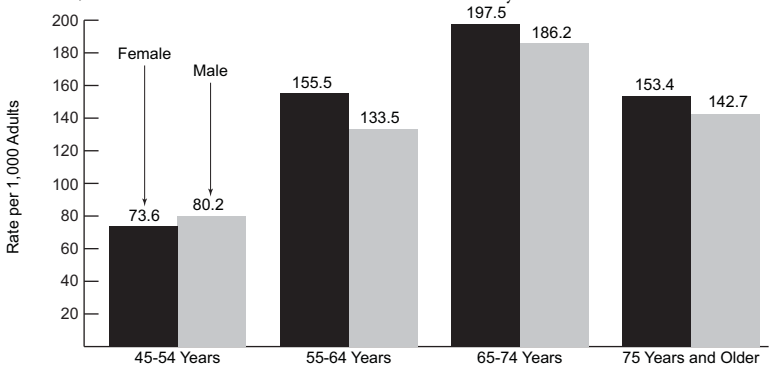
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional has ever told them they have diabetes. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of multiple races, and persons of other races unspecified was too small to produce reliable results.

Adults Aged 45 and Older with Diabetes,* by Age and Sex, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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

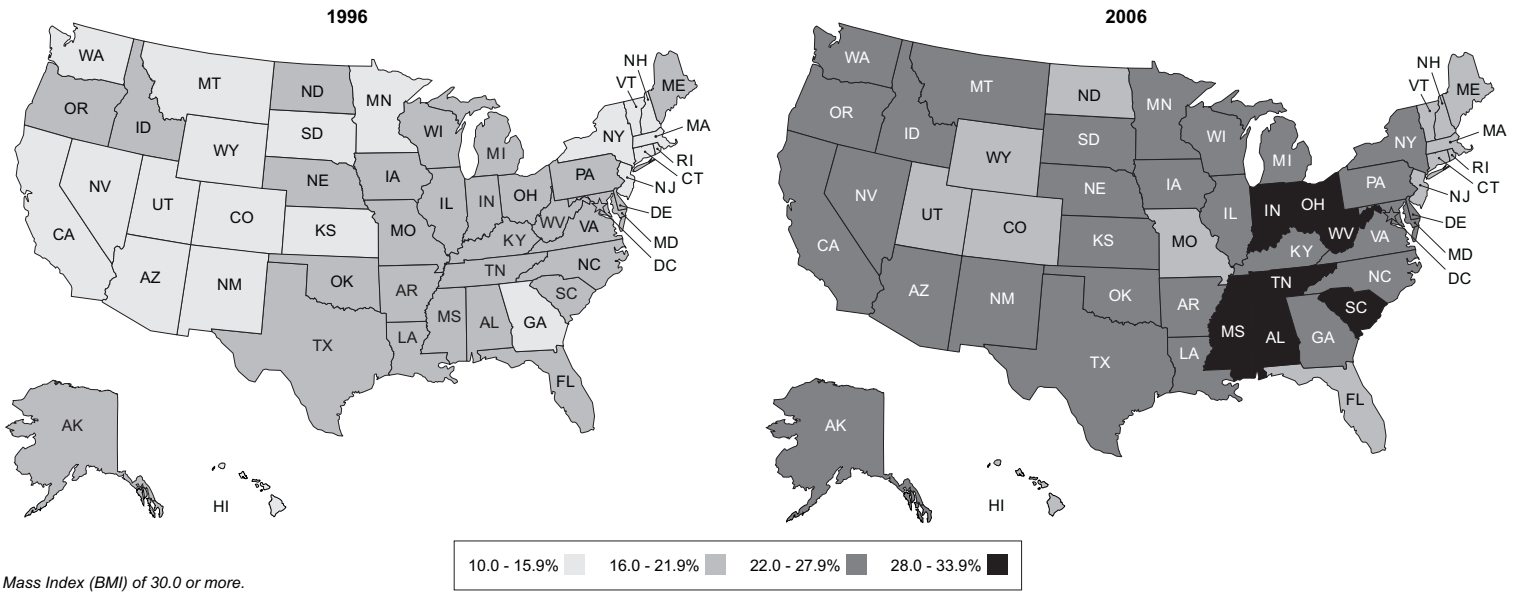
OVERWEIGHT AND OBESITY

Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, type 2 diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health.[17] In 2006, 29.4 percent of women in the United States were overweight and an additional 24.4 percent were obese. Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. Overweight is defined as a BMI of 25.0–29.9, and obese is defined as a BMI of 30.0 or more; a BMI of 18.5–24.9 is considered normal, while a BMI below 18.5 is considered underweight.

In the past decade, obesity among women has increased nearly 50 percent: in 1996, only 16.7 percent of women were obese, and obesity rates among women ranged from 10.7 percent in Colorado to 21.4 percent in Louisiana. By 2006, in 39 States and Washington, DC, more than 21.4 percent of women were obese and State rates ranged from 17.6 percent in Colorado to 33.5 percent in Mississippi.

Women Aged 18 and Older Who Are Obese,* by State, 1996 and 2006

Source II.9: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System



*Body Mass Index (BMI) of 30.0 or more.

HEART DISEASE AND STROKE

In 2005, heart disease was the leading cause of death among women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common type of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow to the heart muscle. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age. While the most common symptom of a heart attack is chest pain or discomfort, women are more likely than men to have symptoms such as shortness of breath, nausea and vomiting, and back or jaw pain.[18]

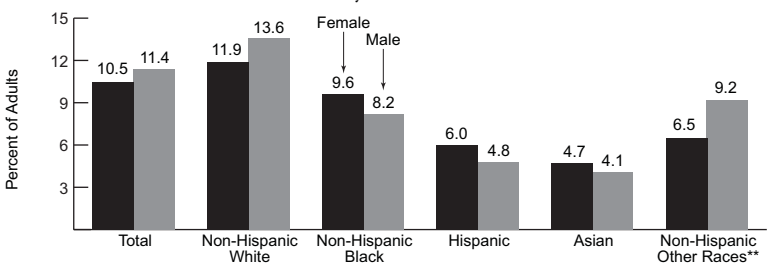
Stroke is a type of heart disease that affects blood flow. Warning signs are sudden and can include facial, arm, or leg numbness, especially on one side of the body; severe headache; trouble walking; dizziness; a loss of balance or coordination; or trouble seeing in one or both eyes.[18]

In 2006, adult women were slightly less likely than men to have ever been told by a health professional that they have a heart condition or heart disease (10.5 versus 11.4 percent). This varied by race and ethnicity. Among non-Hispanic Whites and non-Hispanic other races, men were more likely than women to have heart disease. Among non-Hispanic Black, Hispanic, and Asian adults, however, women were more likely than men to have heart disease. Among women, non-Hispanic Whites were most likely to have heart disease (11.9 percent), compared to 9.6 percent of non-Hispanic Blacks, 6.0 percent of Hispanics, and 4.7 percent of Asians. While heart disease rates are highest among non-Hispanic White women, the death rate from heart disease is highest among non-Hispanic Black women.

Hospital discharges due to heart disease varied by sex and age. Overall, men experienced a higher rate of hospital discharges compared to women (206.0 versus 174.8 hospital discharges per 10,000 adults). Rates of hospital discharge also increased with age; for instance, the hospital discharge rate for women aged 75 years and older was 905.5 per 10,000 women, compared to 119.8 hospital discharges per 10,000 women aged 45–64 years.

Adults Aged 18 and Older with Heart Disease,* by Race/Ethnicity and Sex, 2006

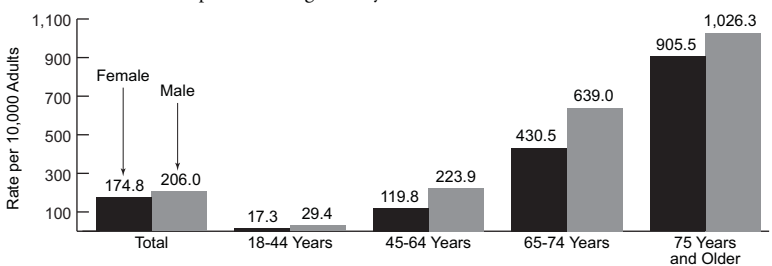
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them they have a heart condition or heart disease. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of other races not specified.

Discharges Due to Heart Disease* from Non-Federal, Short-Stay Hospitals, by Age and Sex, 2005

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



*First-listed diagnosis of heart disease (includes ICD-9-CM codes 391-392.0, 393-398, 402, 404, 410-416, 420-429).

HYPERTENSION

Hypertension, also known as high blood pressure, is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. A study in 2005–2006 tested adults' blood pressure and found that men had higher overall rates of hypertension than women (165.8 versus 152.7 per 1,000 population).

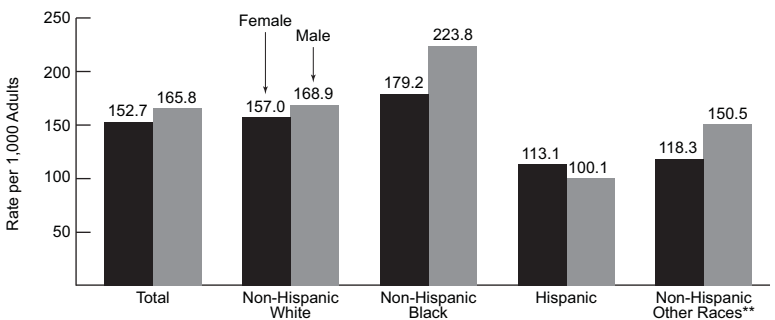
Rates of hypertension among women varied significantly by race and ethnicity. For instance, rates of hypertension were highest among non-Hispanic Black women (179.2 per 1,000 women) and non-Hispanic White women (157.0 per 1,000). The rates of hypertension among Hispanic women and non-Hispanic women of other races were fewer than 120 per 1,000 women.

Rates of hypertension increase substantially with age and are highest among those aged 75 years and older, which demonstrates the chronic nature of the disease. Nearly 25 per 1,000 women aged 18–44 years had hypertension in 2005–2006, compared to 374.7 per 1,000 women aged 65–74 years and 462.7 per 1,000 women aged 75 years and older. Nearly 200 per 1,000 women aged 45–64 years had hypertension (data not shown).

Among adults aged 45 years and older, 16.3 percent of women and 15.2 percent of men who were found to have hypertension had never been told by a health professional that they have hypertension, or were undiagnosed at the time of the examination. Undiagnosed hypertension also increased with age among both women and men. While more than 10 percent of women aged 45–64 years with hypertension had never been diagnosed, 23.8 percent of women aged 65–74 years and 42.6 percent of women aged 75 years and older had never been diagnosed.

Adults Aged 18 and Older with Hypertension,* by Race/Ethnicity and Sex, 2005–2006

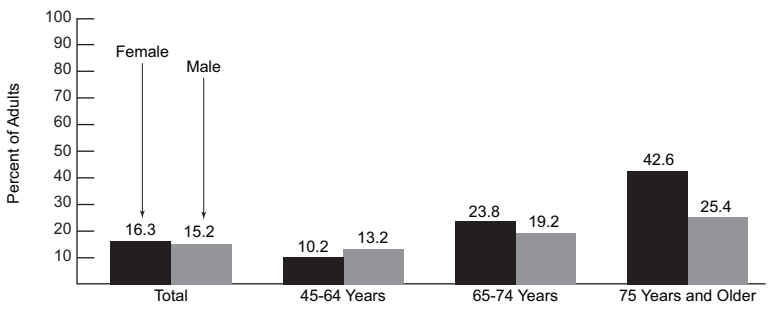
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. Rates are not age-adjusted. **Includes Asian/Pacific Islander, American Indian/Alaska Native, persons of more than one race, and persons of other races not specified.*

Adults Aged 45 and Older with Undiagnosed Hypertension,* by Age and Sex, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher AND had never been told by a health professional that they had hypertension.

ORAL HEALTH AND DENTAL CARE

Oral health conditions can cause chronic pain of the mouth and face and can impair the ability to eat normally. Regular dental care is particularly important for women because there is some evidence of an association between periodontal disease and certain birth outcomes, such as increased risk of preterm birth and low birth weight.[19] To prevent caries (tooth decay) and periodontal (gum) disease, the American Dental Association recommends maintaining a healthy diet with plenty of water, and limiting eating and drinking between meals.[20] Other important preventive measures include daily brushing and flossing, regular dental cleanings to remove plaque, and checkups to examine for caries or other potential problems.[21]

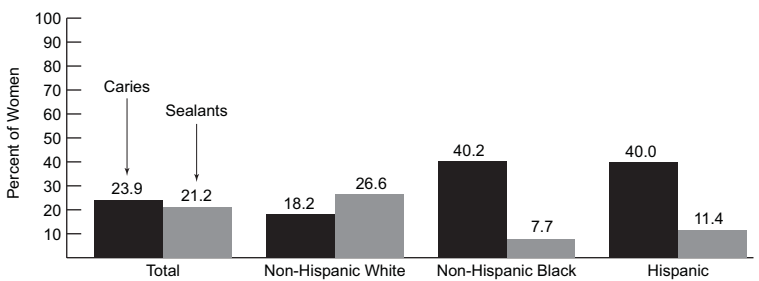
In 2003–2004, women were less likely than men to have untreated dental caries (23.9 versus 30.5 percent). Among women, non-Hispanic Black and Hispanic women were most likely to have untreated caries. Sealants—a hard, clear substance applied to the surfaces of teeth— may help to prevent caries, but only 21.2 percent of women had sealants. Non-Hispanic Black and Hispanic women were the least likely to have sealants (7.7 and 11.4 percent, respectively).

The presence of untreated caries also varied by poverty status. Women with household incomes below 200 percent of the poverty level were more than twice as likely as women with higher incomes to have untreated dental caries (36.8 versus 15.6 percent, respectively; data not shown).

Poverty status may also influence how often women see a dentist. In 2003–2004, women with incomes of 100–199 percent of the poverty level were least likely to have seen a dentist in the past year (44.9 percent), followed by women with incomes of less than 100 percent of the poverty level (51.4 percent). In comparison, nearly 75 percent of women with incomes of 300 percent or more of poverty had seen a dentist in the past year.

Untreated Dental Caries and Presence of Sealants Among Women,* by Race/Ethnicity,** 2003–2004

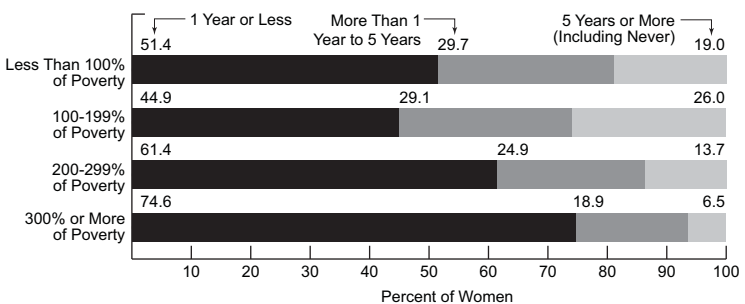
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Caries are among women aged 18 years and older; sealants are among women aged 18–34. **The sample of Asian/Pacific Islanders, Native American/Alaska Natives, persons of more than one race, and persons of other races not specified was too small to produce reliable results.

Time Since Last Seen a Dentist Among Women Aged 18 and Older, by Poverty Status,* 2003–2004

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



*Poverty level, defined by the U.S. Census Bureau, was $19,307 for a family of four in 2004.

EYE HEALTH

Vision is important to maintaining independence and quality of life throughout a woman's life. A number of eye conditions and diseases disproportionately affect older women, including glaucoma, cataracts, and macular degeneration.

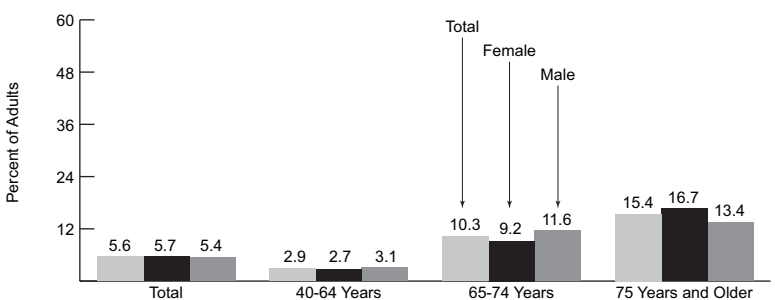
Glaucoma can damage the optic nerve and result in vision loss or blindness.[22] It is estimated to affect 5.6 percent of adults over 40 years of age, but this varies by sex, age, and race and ethnicity. Among adults aged 65–74 years, men were slightly more likely than females to have glaucoma (11.6 versus 9.2 percent), while among adults aged 75 and older, glaucoma was more common in women than men (16.7 versus 13.4 percent). Among women, non-Hispanic Black women were most likely to have had glaucoma (9.4 percent), compared to non-Hispanic White and Hispanic women (5.7 and 2.0 percent, respectively; data not shown).

A cataract occurs when protein builds up in the lens and causes clouding. Surgery to replace the lens has proven to be an effective treatment for cataracts when blurring becomes severe enough to limit vision.[22] In 2005–2006, among adults aged 65 years and older, 35.8 percent of women and 25.7 percent of men reported ever having had cataract surgery. Older adults were more likely to have had the surgery; 57.3 percent of women aged 75 years and older had the surgery compared to 17.4 percent of women aged 65–74 years.

Macular degeneration is a disease that affects the macula (which allows one to see in fine detail) usually resulting in partial vision loss. While there is no known cure for macular degeneration, early detection and treatment can slow its effects.[22] In 2005–2006, 4.3 percent of women aged 40 years and older reported having been told by a health professional that they have macular degeneration. This disease was more common among older women. Fewer than 2 percent of women aged 40–64 years had macular degeneration compared to 3.8 and 16.9 percent of women aged 65–74 and 75 years and older, respectively (data not shown).

Glaucoma Among Adults* Aged 40 and Older, by Age and Sex, 2005–2006

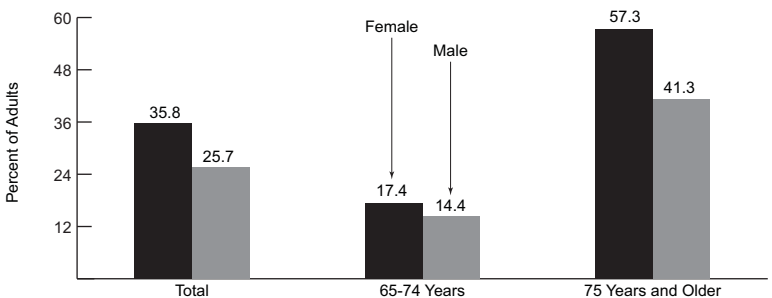
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported that a health professional had ever told them they have glaucoma.

Cataract Surgery Among Adults* Aged 65 and Older, by Age and Sex, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported that they had ever had cataract surgery.

OSTEOPOROSIS

Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even among individuals who have already suffered a fracture. An estimated 10 million Americans now have osteoporosis, while another 34 million have low bone mass and are at risk for developing osteoporosis; 80 percent of them are women. Each year more than 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks in the wrist, spine, and hip. Fractures can have devastating consequences. For example, hip fractures are associated with an increased risk of mortality, and nearly 1 in 5 hip fracture patients ends up in a nursing home within a year. Direct care for osteoporotic fractures costs $18 billion yearly.[23]

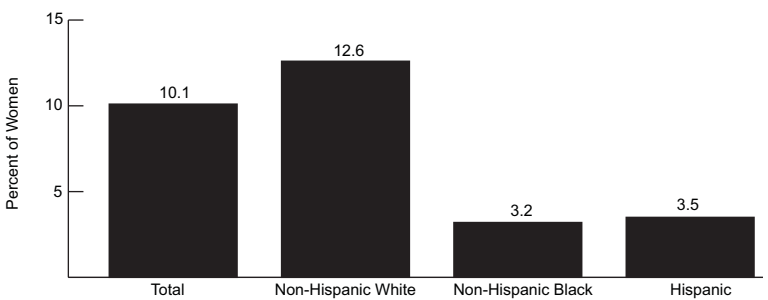
In 2003–2004, women aged 18 years and older were more likely than men to report having been told by a health professional that they have osteoporosis (10.0 versus 1.7 percent, respectively.) The rate of osteoporosis among women varied significantly with race and ethnicity. Non-Hispanic White women were most likely to have osteoporosis (12.6 percent), compared to 3.2 percent of non-Hispanic Black women and 3.5 percent of Hispanic women.

In 2005 there were 215,000 hospital discharges due to hip fractures among women aged 18 and older, a rate of 18.8 per 10,000 women. Rates of hospital discharges due to hip fractures varied by age. Women aged 75 and older had 149.4 discharges per 10,000 women, compared to 29.6 discharges per 10,000 women aged 65–74 years.

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (i.e. walking), and by taking prescription medication when appropriate. Bone density tests are recommended for women over 65 years and for any man or woman who suffers a fracture after age 50. Treatment for osteoporosis has been shown to reduce the risk of subsequent fractures by 30–65 percent.[23]

Women Aged 18 and Older with Osteoporosis, by Race/Ethnicity,* 2003–2004

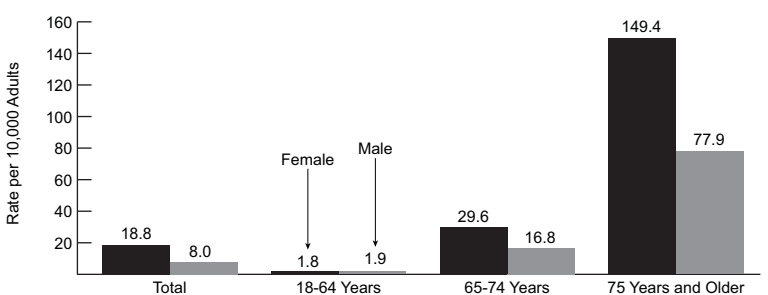
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



The sample of Asian/Pacific Islanders, Native American/Alaska Natives, persons of more than one race, and persons of other races not specified was too small to produce reliable results.

Hospital Discharges Due to Hip Fractures* Among Adults Aged 18 and Older, by Age and Sex, 2005

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



First-listed diagnosis of hip fracture (ICD-9CM code: 820).

DIGESTIVE DISORDERS

Digestive disorders, or gastrointestinal diseases, include a number of conditions that affect the digestive system, including heartburn; constipation; hemorrhoids; irritable bowel syndrome; ulcers; gallstones; celiac disease (a genetic disorder in which consumption of gluten damages the intestines); and inflammatory bowel diseases, including Crohn's disease (which causes ulcers to form in the gastrointestinal tract). Digestive disorders are estimated to affect 60–70 million people in the United States.[24]

While recent data are not readily available on the prevalence of many of these diseases by race and ethnicity or sex, it is estimated that 8.5 million people in the United States are affected by hemorrhoids each year; 2.1 million people are affected by irritable bowel syndrome; and gallstones affect 20.5 million people.[24]

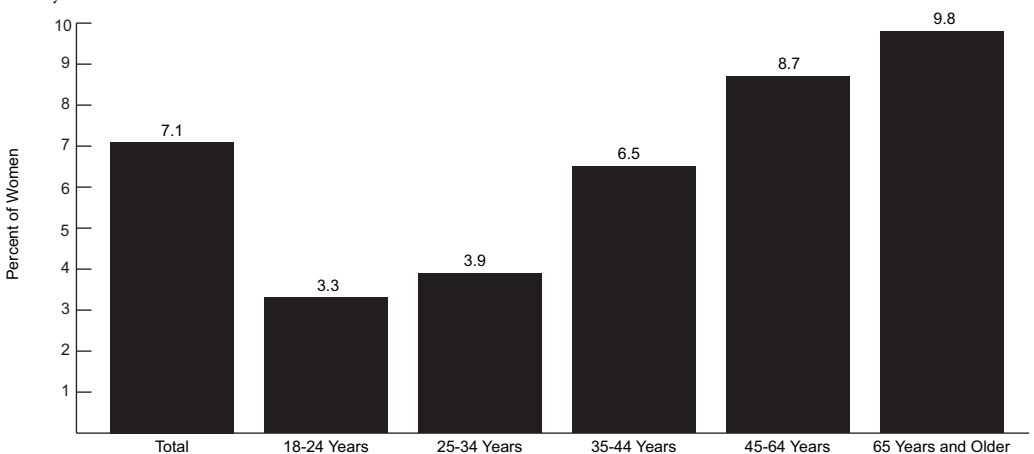
Peptic ulcers are most commonly caused by a bacterium called *Helicobacter pylori (H. pylori). H. pylori* weakens the mucous coating of the stomach and duodenum, allowing acids to irritate the sensitive lining beneath. In 2006, 7.0 percent of adults reported that they had ever been told by a health professional that they have an ulcer. This did not vary by sex, but did vary by age. Among women, those aged 65 years and older were most likely to have reported ever having had an ulcer (9.8 percent), followed by women aged 45–64 years (8.7 percent). Fewer than 4 percent of women aged 18–24 and 25–34 years had ever had an ulcer. Among adults who have ever had an ulcer, 19.5 percent of men and 27.9 percent of women reported that they had an ulcer in the past year (data not shown).

There was little variation among women reporting having ever had an ulcer by race and ethnicity. Non-Hispanic White women were most likely to report having had an ulcer (7.7 percent), followed by non-Hispanic Black women (6.2 percent), and Hispanic women (5.8 percent). Women of other races, including Asian/Pacific Islanders, American Indian/Alaska Natives, and women of multiple races, were least likely to report ever having had an ulcer (3.3 percent; data not shown).

According to the CDC, digestive system symptoms accounted for 33.3 million visits to doctor's offices and 3.6 million visits to hospital outpatient departments in 2005. In addition, 15.7 million visits to emergency departments were attributed to a digestive system diagnosis that year (data not shown).[25]

Women Aged 18 and Older Who Have Ever Had an Ulcer,* by Age, 2006

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



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

ENDOCRINE AND METABOLIC DISORDERS

Endocrine disorders involve the body's over- or under-production of certain hormones, while metabolic disorders affect the body's ability to process certain nutrients and vitamins. Endocrine disorders include hyperthyroidism and hypothyroidism, congenital adrenal hyperplasia, diseases of the parathyroid gland, diabetes mellitus, diseases of the adrenal glands (including Cushing's syndrome and Addison's disease), and ovarian dysfunction (including polycystic ovarian syndrome), among others. Some examples of metabolic disorders include cystic fibrosis, phenylketonuria (PKU), hyperlipidemia, gout, and rickets.

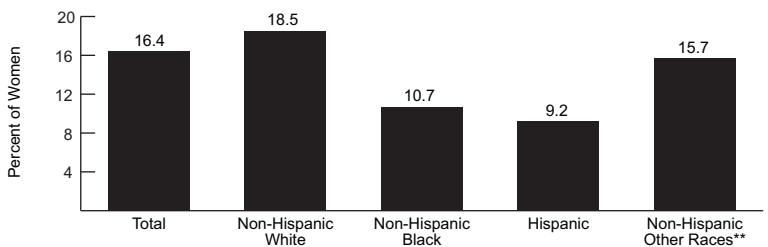
Polycystic ovary syndrome (PCOS) is one of the most common endocrine disorders among women of reproductive age. PCOS is the most common cause of endocrine-related female infertility in the United States. An estimated 1 in 10 women of childbearing age has PCOS, and it can occur in females as young as 11 years of age. In addition, PCOS may put women at risk for other health conditions, including high blood pressure, heart disease, and diabetes.[26]

Hyperthyroidism and hypothyroidism are also common endocrine disorders. In 2005–2006, women were more likely than men to report having ever been told by a health professional that they have a thyroid problem (16.4 versus 3.4 percent). Among women, rates varied by race and ethnicity. Non-Hispanic Whites were most likely to report a thyroid problem (18.5 percent), compared to non-Hispanic Blacks (10.7 percent), and Hispanics (9.2 percent).

In 2005, the rate of physician visits due to endocrine and metabolic disorders varied by sex. Nearly 4 per 100 physician visits made by men were for a disorder of an endocrine gland other than the thyroid gland, compared to 3.1 per 100 visits made by women. Similarly, 2.9 per 100 visits made by men were due to a metabolic disorder, versus 2.0 per 100 visits among women. Women, however, had twice the rate of visits due to disorders of the thyroid gland than men (1.5 versus 0.7 per 100 visits).

Thyroid Problems* Among Women Aged 18 and Older, by Race/Ethnicity, 2005–2006

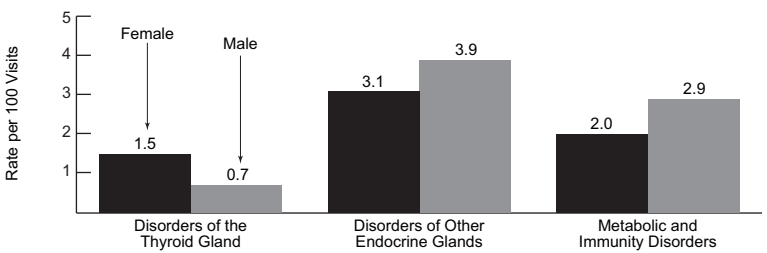
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional has ever told them they have a thyroid problem; includes hyperthyroidism and hypothyroidism **Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of all other races not specified.

Physician Visits by Adults Aged 18 and Older Due to Endocrine and Metabolic Disorders,* by Sex, 2005

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



*Based on ICD-9-CM codes for disorders of the thyroid gland: 240-246; disorders of other endocrine glands: 250-259; other metabolic and immunity disorders: 270-279.

GENETICS AND WOMEN'S HEALTH

Genes may play a role in the risk of many of the most common causes of morbidity and mortality among women, including cancer, cardiovascular disease, and diabetes. The most reliable way to identify those at risk for an inherited susceptibility to chronic disease is through their family health histories.

Breast cancer affects 1 in 8 women over their lifetime, and colon cancer affects 1 in 15 women. Approximately 10 percent of breast, ovarian, and colon cancer cases are due to inherited mutations in specific genes that can be passed down from either parent (mother or father) and greatly increase the risk of cancer. The genetics of all cancer is complex, and even those individuals in whom single gene mutations cannot be identified may still have an elevated risk for cancer, emphasizing the importance of knowing one's family history.

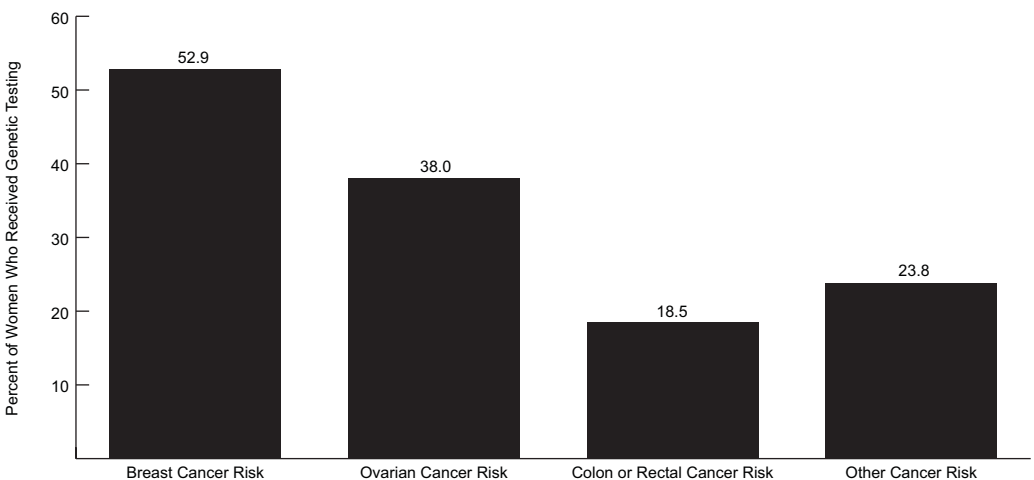
Coronary heart disease is the leading cause of death for women in the United States. Although there are significant modifiable lifestyle risk factors such as smoking, hypertension, and obesity, genetics is important in identifying women and men at risk for heart disease and other chronic conditions. Having a male first-degree relative (parent or sibling) who had a heart attack or stroke before age 65 or a female relative who had a heart attack before age 55 is a risk factor for heart disease.

Type 2 diabetes is also a major cause of morbidity in women. Although obesity and reduced physical activity are the most important risk factors for type 2 diabetes, the greater the number of relatives affected with diabetes the higher the risk to family members.

Genetic testing is one way to identify the subset of high-risk women who have inherited a susceptibility to cancer. In 2005, 1.5 percent of women reported having a genetic test for cancer risk. Among these women, breast cancer risk was most commonly tested (52.9 percent), followed by ovarian cancer risk (38.0 percent) and colon or rectal cancer risk (18.5 percent). Additionally, nearly 24 percent had a genetic test for some other cancer risk. [Respondents could report more than one type of genetic test.]

Genetic Tests for Cancer Risk Among Women Aged 18 and Older Who Received Any Genetic Test, by Cancer Site,* 2005

Source II.12: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Percentages do not add to 100 because respondents could report more than one type of genetic test.

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the final stage of the human immunodeficiency virus (HIV), which destroys or disables the cells that are responsible for fighting infection. AIDS is diagnosed when HIV has weakened the immune system enough that the body has a difficult time fighting infections.[27] In 2006, there were an estimated 10,537 new AIDS cases reported among adolescent and adult females aged 13 and older, compared to 28,378 new cases among males of the same age group.

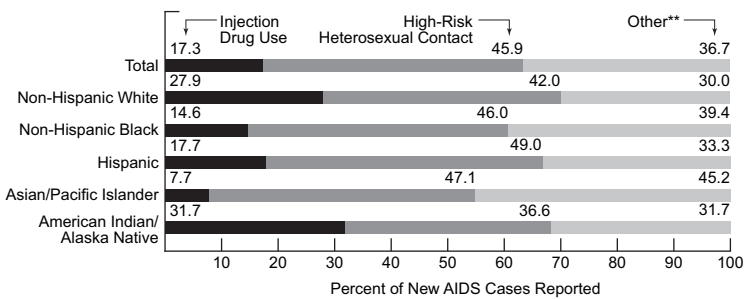
In 2006, high-risk heterosexual contact (including sex with an injection drug user, sex with men who have sex with men, and sex with an HIV-infected person) accounted for 45.9 percent of new AIDS cases among adolescent and adult females, followed by injection drug use (17.3 percent). In 36.0 percent of cases, the transmission category was not reported or identified, and an additional 0.6 percent of cases were due to blood transfusions or receipt of blood components or tissue. High-risk heterosexual contact was the most often cited transmission category for AIDS cases, particularly among Hispanic females (49.0 percent) and Asian/Pacific Islander females (47.1 percent). Injection drug use accounted for 31.7 percent of new AIDS cases among American Indian/Alaska Native females, and 27.9 percent of cases among non-Hispanic White females.

In 2006, an estimated 131,195 adolescent and adult females were living with HIV/AIDS.[28] Nearly 84,000 non-Hispanic Black females were living with HIV/AIDS in 2006, accounting for 63.9 percent of cases. Non-Hispanic White and Hispanic females accounted for 25,050 and 20,004 cases, respectively.

HIV/AIDS disproportionately affects minorities. While being of a particular race or ethnicity does not increase the likelihood of contracting HIV, certain challenges exist for non-Hispanic Black and Hispanic females putting them at greater risk for infection: socioeconomic factors such as limited access to quality health care; language and cultural barriers, particularly for Hispanics, which can affect the quality of health care; high rates of STIs, which increase the risk of HIV infection; and substance abuse.[29]

Reported New AIDS Cases Among Adolescent and Adult Females, by Race/Ethnicity and Transmission Category, 2006*

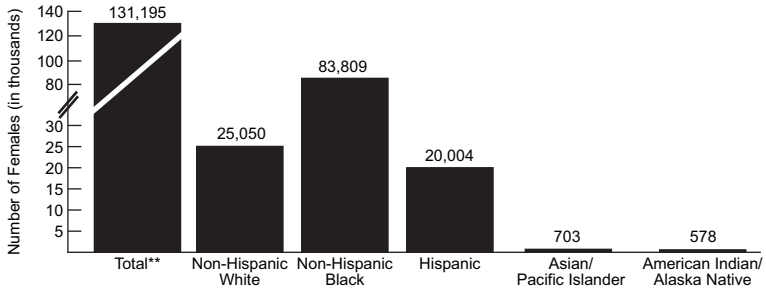
Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Percentages may not add to 100 percent due to rounding. **"Other" includes risk factors not reported or not identified, blood transfusion, hemophilia/coagulation disorder, and perinatal exposure.

Adolescent and Adult Females Living with HIV/AIDS,* by Race/Ethnicity, 2006

Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS, in 33 States. Data do not reflect improved estimates of HIV incidence released in August 2008. **Includes 1,051 females of unknown race/ethnicity.

SEXUALLY TRANSMITTED INFECTIONS

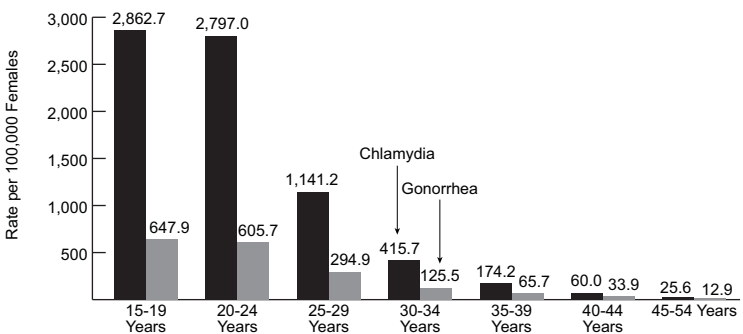
Reported rates of sexually transmitted infections (STIs) among females vary by a number of factors, including age and race/ethnicity. Rates of chlamydia, gonorrhea, and syphilis are highest among adolescents and young adults. In 2006, there were 2,862.7 reported cases of chlamydia and 647.9 cases of gonorrhea per 100,000 females aged 15–19 years, compared to 25.6 and 12.9 reported cases, respectively, per 100,000 females aged 45–54 years. Syphilis was also most common among young women, occurring at a rate of 2.9 per 100,000 females aged 20–24 years; 2.5 per 100,000 females aged 25–29 years, and 2.3 per 100,000 females aged 15–19 years (data not shown).

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

Another STI, genital human papillomavirus (HPV), has been estimated to affect at least 50 percent of the sexually active population at some point in their lives.[16] In 2003–2004, 27.5 percent of females aged 18–59 years were found to have HPV. This varied by race and ethnicity. Non-Hispanic Black women were most likely to have HPV (39.6 percent), compared to non-Hispanic White and Hispanic women (25.0 and 28.3 percent, respectively). There are many different types of HPV, and some, which are referred to as "high-risk," can cause cancer. In 2006, the Food and Drug Administration approved a vaccine that protects women from four strains of HPV that can be the source of cervical cancer, precancerous lesions, and genital warts.[16] Since 2006, 10 percent of women aged 18–26 years have received this vaccine.[30]

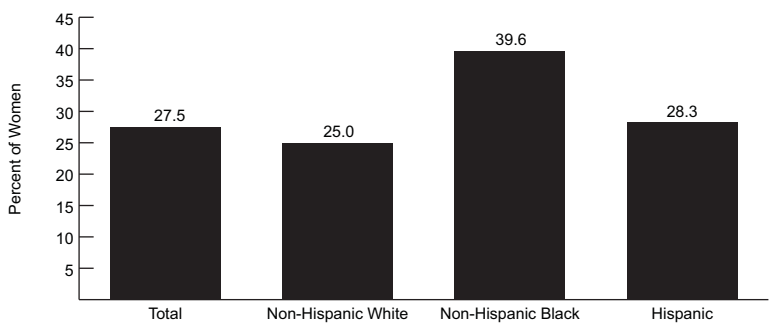
Rates of Chlamydia and Gonorrhea Among Females Aged 15–54, by Age, 2006

Source II.14: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Genital Human Pappillomavirus (HPV) Infection Among Women Aged 18–59, by Race/Ethnicity,* 2003–2004

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



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

INJURY

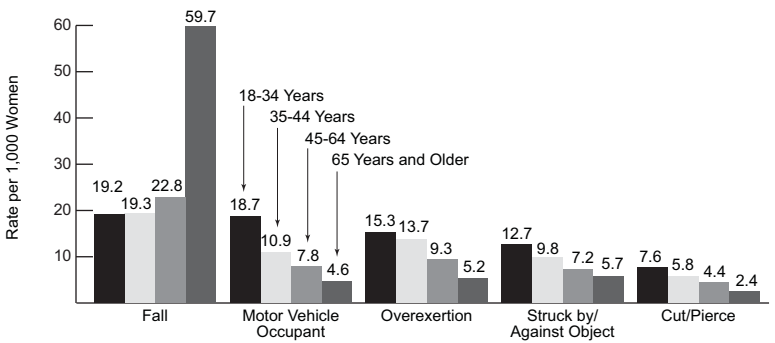
Often, injuries can be controlled by either preventing an event (such as a car crash) or lessening its impact. This can occur through education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples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

In 2006, unintentional falls were the leading cause of nonfatal injury among women of every age group, and rates generally increased with age. Women aged 65 years and older had the highest rate of injury due to unintentional falls (59.7 per 1,000 women), while slightly more than 19 per 1,000 women aged 18–34 and 35–44 years experienced fall-related injuries. Unintentional injuries sustained as motor vehicle occupants were the second leading cause of injury among 18- to 34-year-olds (18.7 per 1,000), while unintentional overexertion was the second leading cause of injury among women aged 35–44 and 45–64 years (13.7 and 9.3 per 1,000, respectively). Among women aged 65 years and older, being unintentionally struck by or against an object was the second leading cause of injury (5.7 per 1,000).

Unintentional and intentional injuries each represented a higher proportion of emergency department (ED) visits for men than women in 2005. Among women and men aged 18 years and older, unintentional injuries accounted for 19.9 and 27.5 percent of ED visits, respectively, while intentional injuries, or assault, represented 1.4 and 2.7 percent of visits, respectively. Among both women and men, unintentional injury accounted for a higher percentage of ED visits among those living in non-metropolitan areas, while adults living in metropolitan areas had a slightly higher percentage of ED visits due to intentional injury.

Leading Causes of Injury* Among Women Aged 18 and Older, by Age, 2006

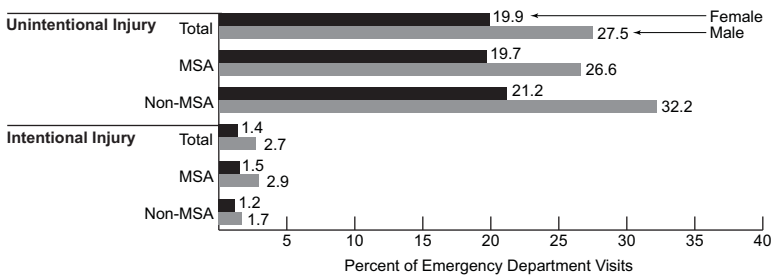
Source II.15: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control



*All of the leading causes of injury in 2006 were unintentional.

Injury-Related Emergency Department Visits Among Adults Aged 18 and Older, by Area of Residence* and Sex, 2005

Source II.16: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



*Metropolitan Statistical Areas (MSA) include at least: one city with 50,000 or more inhabitants, or an urbanized area of at least 50,000 inhabitants and a total metropolitan population of at least 100,000 (75,000 in New England).

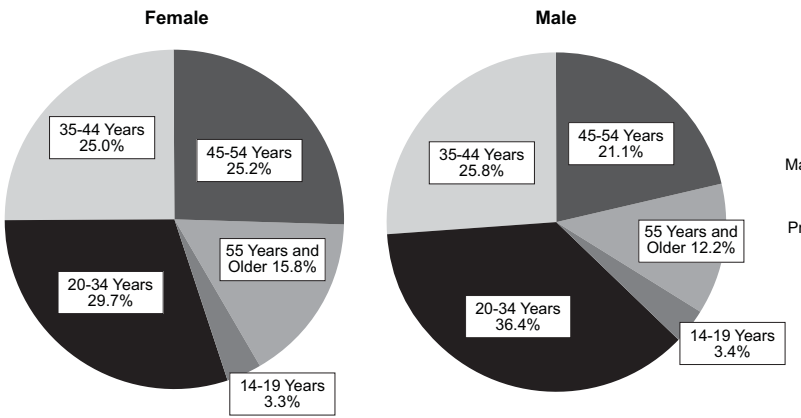
OCCUPATIONAL INJURY

In 2006, there were nearly 1.2 million nonfatal occupational injuries in the United States that resulted in at least 1 day absent from work. Of those, more than 34 percent of injuries occurred among females aged 14 and older. While males account for the majority of total injuries, the distribution of injuries by age differs between males and females. More than 36 percent of males with occupational injuries were aged 20–34 years, compared to 29.7 percent of females in the same age group. In comparison, nearly 16 percent of injuries among females occurred among women aged 55 years and older, while males of this age group accounted for 12.2 percent of injuries.

The distribution of nonfatal occupational injuries by sex varies by occupational sector. In 2006, females accounted for 66.7 percent of injuries occurring in management, professional, and related occupations, despite making up only 51.1 percent of the workforce in that sector. Similarly, females represented 56.5 percent of the service workforce, but accounted for 61.9 percent of injuries in that sector. Conversely, males were somewhat overrepresented in injuries to sales and office workers; males made up 36.9 percent of that workforce, but accounted for 40.9 percent of injuries in that sector. Injuries occurring among males and females in the farming, fishing, and forestry sector, as well as the construction, extraction, and maintenance sector were approximately proportionate to their workforce representation. (See page 18, "Women in the Labor Force," for data on workforce representation by occupational sector and sex.)

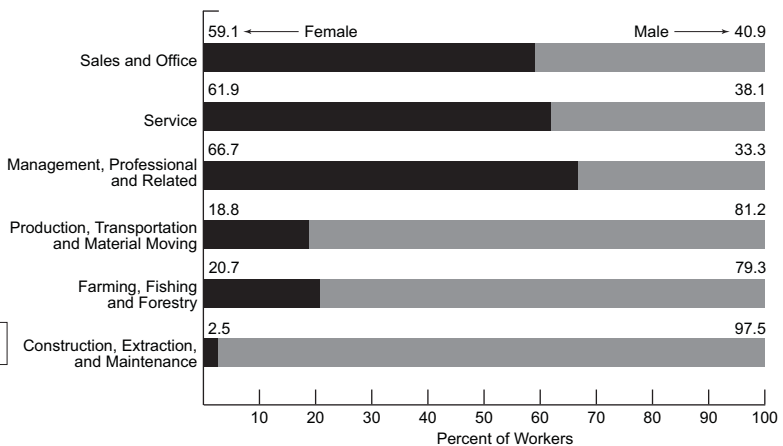
Nonfatal Occupational Injuries and Illnesses of Workers Aged 14 and Older, by Sex and Age,* 2006

Source II.17: U.S. Department of Labor, Bureau of Labor Statistics



Nonfatal Occupational Injuries and Illnesses, by Occupational Sector and Sex, 2006

Source II.17: U.S. Department of Labor, Bureau of Labor Statistics



Percentages do not equal 100 because age was not reported in 1.1 percent of cases and rounding.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention deficit hyperactivity disorder (ADHD) is a neurobehavioral, or psychiatric, disorder that commonly appears in childhood and often persists into adulthood. ADHD is characterized by chronic inattention and/or impulsive hyperactivity severe enough to interfere with daily functioning. While professionals began to use the term "attention deficit disorder" to describe these characteristics in the 1970s, the causes of the disorder are still unknown. It is estimated that as many as half of those with ADHD have other mental disorders, making it more difficult to diagnose and presenting more challenges for those affected.[31,32]

The best estimate of ADHD prevalence among adults is from a 2001–2003 study which found that 3.2 percent of women and 5.4 percent of men had ADHD.[33] Symptoms of ADHD in adulthood can include distractibility, disorganization, forgetfulness, procrastination, chronic boredom, chronic lateness, and employment problems.[34] Anxiety, depression, low self-esteem, mood swings, and restlessness are other symptoms that may easily mask ADHD, making it more likely that affected individuals will be diagnosed with depression. Many women with ADHD may also feel disorganized, overwhelmed, ashamed, inadequate, and out of control.[32]

Adults with ADHD may face particular problems in the workplace, finding time management, problem solving, and environmental distractions extremely challenging. An estimated 35 days of work are lost annually among adults with ADHD due to their condition.[33]

While there is no cure for ADHD, diagnosing the disorder in adults has many benefits. Interventions and treatment can improve work performance and skills and educational achievement, as well as self-esteem. Treatments may include patient and family education, educational or employment accommodations, medication, and counseling. While medications are often used to help individuals manage their symptoms, those with resulting social problems may choose to work with a therapist or coach to set goals to learn and apply new social skills. In addition, some adults with ADHD may choose to work with a career counselor to address workplace issues that arise as a result of their condition.

Common Adulthood Symptoms of ADHD

Source II.18: Children and Adults with Attention Deficit Hyperactivity Disorder, National Resource Center on ADHD

- Poor attention; excessive distractibility
- Physical restlessness or hyperactivity
- Excessive forgetfulness
- Excessive impulsivity; saying or doing things without thinking
- Excessive and chronic procrastination
- Difficulty getting started on tasks
- Difficulty completing tasks
- Frequently losing things
- Poor organization, planning, and time management skills

MENTAL ILLNESS AND SUICIDE

Mental illness affects both sexes, although many types of mental disorders are more prevalent among women.[35] For instance, in 2006, 13.5 percent of women and 8.7 percent of men had experienced serious psychological distress in the past year. Similarly, 8.7 percent of women experienced a major depressive episode, compared to 5.2 percent of men.

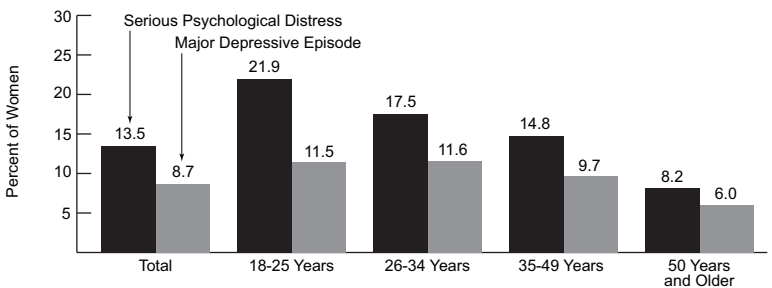
Among women, the rate of serious psychological distress and major depressive episodes decreases with age. Serious psychological distress occurs among almost 21.9 percent of women aged 18–25 years, compared to 17.5 percent of women aged 26–34 years and 14.8 percent of women aged 35–49 years. Similarly, approximately 11.5 and 11.6 percent of women aged 18–25 and 26–34 years, respectively, experienced a major depressive episode, but that rate decreased as age increased.

Serious psychological distress and major depressive episodes among women also vary by race and ethnicity. In 2006, American Indian/Alaska Native women were most likely to have experienced both disorders (26.8 and 16.6 percent, respectively). Asian/Pacific Islanders were least likely to have experienced serious psychological distress (9.8 percent) and major depressive episodes (3.6 percent) in the past year.

Although most people who suffer from mental illness do not commit suicide, mental illness is a major risk factor. In 2005, 5.7 per 100,000 women aged 18 and older committed suicide. American Indian/Alaska Native and non-Hispanic White women had the highest suicide rates (7.0 and 6.9 per 100,000, respectively). Hispanic and non-Hispanic Black women had the lowest suicide rates among all racial and ethnic groups (2.3 and 2.4 per 100,000, respectively; data not shown).[36]

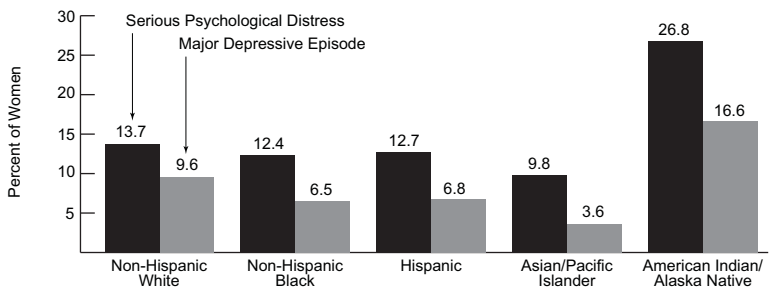
Serious Psychological Distress and Major Depressive Episode* Among Women Aged 18 and Older, by Age, 2006

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



Serious Psychological Distress and Major Depressive Episode* Among Women Aged 18 and Older, by Race/Ethnicity, 2006

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



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

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) refers to any physical, sexual, or emotional abuse, or threats occurring between two people in a relationship. Intimate partners include current or former spouses, boyfriends, or girlfriends. According to the National Crime Victimization Survey, which estimates victimization rates based on household and individual surveys, 4.2 per 1,000 females aged 12 and older were victims of nonfatal IPV between 2001 and 2005; this rate represents 21.5 percent of all nonfatal violent victimizations committed against females, which include rape, sexual assault, robbery, aggravated assault, and simple assault. Additionally, between 1976 and 2005, intimate partners committed 30.1 percent of homicides against females. IPV varies with a number of factors including age, race/ ethnicity, income, and marital status.

In 2001–2005, women aged 20–24 years had the highest rate of IPV (11.3 per 1,000), followed by women aged 25–34 years (8.1 per 1,000). Women aged 50–64 years and 12–15 years were least likely to have reported IPV (1.3 and 1.6 per 1,000, respectively).

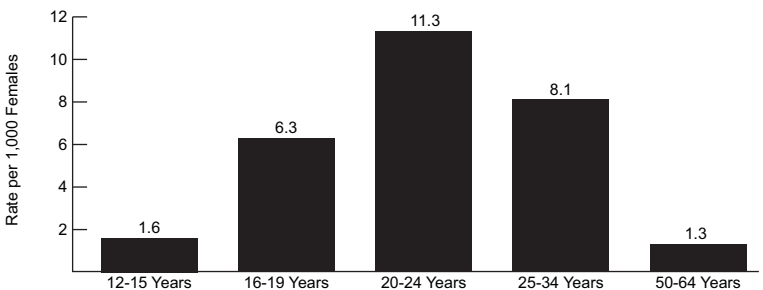
American Indian/Alaska Native females experienced the highest rate of intimate partner victimization (11.1 per 1,000 females). The second highest rate occurred among Black females (5.0 per 1,000), while Asian females were least likely to be victims of IPV (1.4 per 1,000).

During this same time period, females in households with annual incomes below $7,500 had the highest rate of intimate partner victimization (12.7 per 1,000), while those in households with annual incomes of $50,000 or more were least likely to have reported IPV (2.0 per 1,000; data not shown).

IPV may have negative effects on the health and well-being of children whose mothers experience violence. Children whose mothers experience IPV are significantly more likely than other children to visit the emergency department[37] and three times more likely to receive mental health services after cessation of the violence.[38] In 2001–2005, children were present in 216,490 (35.2 percent) households experiencing IPV (data not shown).

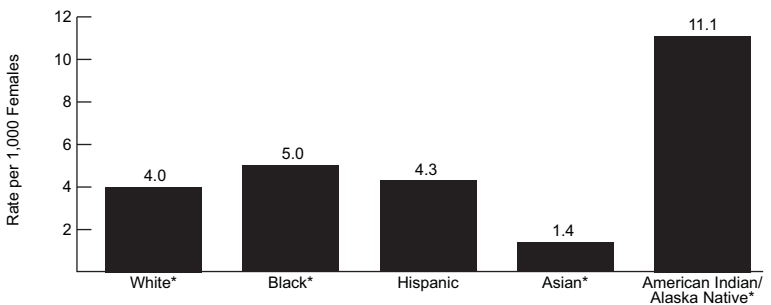
Intimate Partner Violence Among Females Aged 12–64, by Age, 2001–2005

Source II.19: U.S. Department of Justice, Bureau of Justice Statistics



Intimate Partner Violence Among Females Aged 12 and Older, by Race/Ethnicity, 2001–2005

Source II.19: U.S. Department of Justice, Bureau of Justice Statistics



*May include Hispanics.

UROLOGIC DISORDERS

Urologic disorders encompass illnesses and diseases of the genitourinary tract. Some examples include urinary incontinence, urinary tract infection, sexually transmitted diseases, urolithiasis (kidney stones), and kidney and bladder cancer. Many of these disorders affect a large number of adult women; annual Medicaid expenditures for urinary incontinence and urinary tract infections among adult women total more than $234 million and $956 million, respectively. These same illnesses accounted for $39 million and $480 million in expenditures, respectively, for adult men.[39]

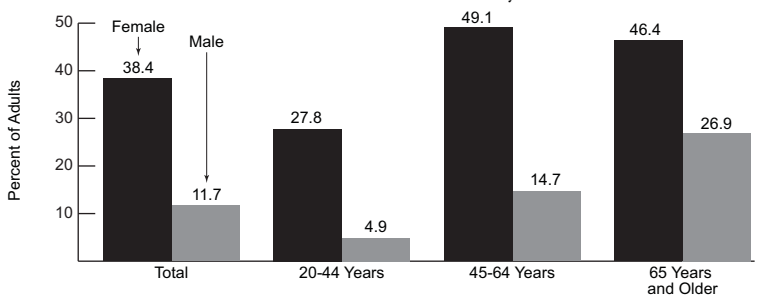
Urinary incontinence is one of the most prevalent chronic diseases in the United States and is generally more common among women than men.[39] In 2005–2006, 38.4 percent of women and 11.7 percent of men aged 20 years and older reported that they had ever had urinary leakage. Among women, urinary leakage was most common among women aged 45–64 and 65 years and older (49.1 and 46.4 percent, respectively), compared to 27.8 percent of women aged 20–44 years. In addition, 21.6 percent of women with urinary leakage reported that it affects their daily activities at least a little, compared to 14.5 percent of men (data not shown).

Among women with urinary leakage, 38.7 percent reported that it occurred less than once a month, while 28.3 percent reported occurrence a few times a month. Nearly 16 percent of those with urinary leakage reported that it occurred a few times a week and 17.2 percent experienced leakage every day and/or night.

Urinary incontinence also varied by race and ethnicity. More than 40 percent of non-Hispanic White women reported urinary leakage, followed by 36.6 percent of Hispanic women. Non-Hispanic Black women were least likely to report any leakage (29.4 percent; data not shown). Among women with urinary leakage, the frequency of occurrence and effects on daily activities did not vary by race and ethnicity, indicating that the impact of the condition is universal.

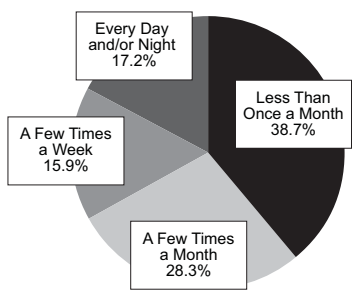
Adults Aged 20 and Older Reporting Urinary Leakage, by Age and Sex, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Frequency of Urinary Leakage Among Women Aged 20 and Older Reporting Any Leakage,* 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Percentages do not equal 100 because of rounding.

GYNECOLOGICAL AND REPRODUCTIVE DISORDERS

Gynecological disorders affect the internal and external organs in a woman's pelvic and abdominal areas and may affect a woman's fertility. These disorders include vulvodynia—unexplained chronic discomfort or pain of the vulva—and chronic pelvic pain—a consistent and severe pain occurring mostly in the lower abdomen for at least 6 months. While the causes of vulvodynia are unknown, recent evidence suggests that it may occur in up to 16 percent of women, usually beginning before age 25, and that Hispanic women are at greater risk for this disorder.[40] Chronic pelvic pain may be symptomatic of an infection or indicate a problem with one of the organs in the pelvic area.[41]

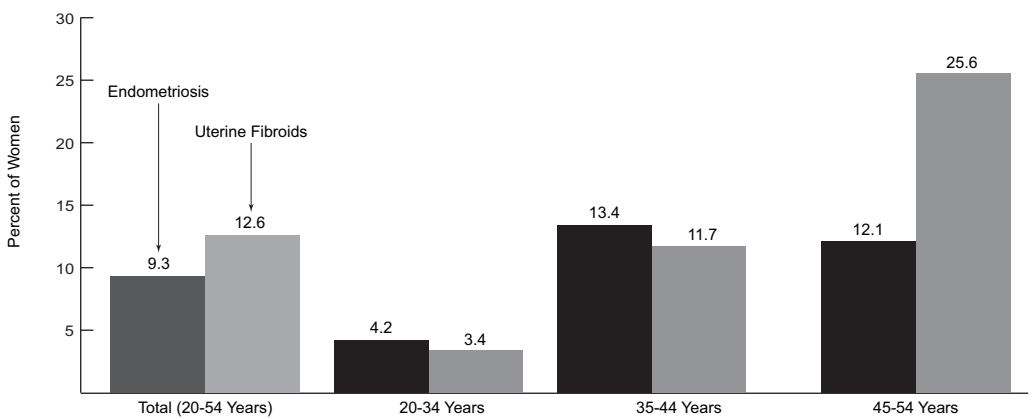
Reproductive disorders may affect a woman's ability to get pregnant. Examples of these disorders include polycystic ovary syndrome (PCOS), endometriosis, and uterine fibroids. PCOS occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. In most cases, the failure of the follicles to release the eggs results in a woman's inability to become pregnant. An estimated 1 in 10 women in the United States are affected by PCOS.[41] Endometriosis occurs when tissue resembling that of the uterine lining grows outside of the uterus. Uterine fibroids are non-cancerous tumors that grow underneath the lining, between the muscles, or on the outside of the uterus.

In 2005–2006, 9.3 percent of women aged 20–54 years had endometriosis and 12.6 percent had uterine fibroids, but the prevalence of both disorders varied with age. Of women aged 20–54 years, endometriosis was most common among 35- to 44-year-olds (13.4 percent), while uterine fibroids were most common among 45- to 54-year-olds (25.6 percent). Women aged 20–34 years were least likely to have either disorder (4.2 and 3.4 percent, respectively).

A hysterectomy—abdominal surgery to remove the uterus—is one option to treat certain conditions including chronic pelvic pain, uterine fibroids, and endometriosis when symptoms are severe.[41] In 2005–2006, nearly 40 percent of women aged 45–54 reported having had a hysterectomy, though it is not clear how many of these hysterectomies were to treat gynecological or reproductive disorders (data not shown).

Endometriosis and Uterine Fibroids Among Women Aged 20–54, by Age, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



LIVE BIRTHS

According to preliminary data, there were 4.3 million births in the United States in 2006, which represents an increase of 3 percent from the previous year, the largest single-year increase since 1989. The number of births rose in every racial and ethnic group, most noticeably among non-Hispanic Black women and American Indian/Alaska Native women. Overall, the birth rate was 14.2 per 1,000 population.

With regard to age, overall birth rates were highest among those aged 25–29 years (116.8 per 1,000), followed by those aged 20–24 years (105.9 per 1,000). The birth rate for non-Hispanic Whites was highest in the 25–29 age group (109.2 per 1,000), while the rates for non-Hispanic Blacks, Hispanics, and American Indian/Alaska Natives were highest in the 20–24 age group (133.1, 177.0, and 114.9 per 1,000, respectively). The birth rate among Asian/Pacific Islanders was highest among 30- to 34-year-olds (116.5 per 1,000).

The percentage of births with a cesarean delivery has been increasing steadily since 1996, while vaginal births after a previous cesarean (VBAC) have been decreasing. Among all births in 2005, more than 30 percent were delivered by cesarean, representing a 46 percent increase since 1996. Only 7.9 percent of women with a previous cesarean delivery had a vaginal birth in 2005, compared to a high of 28.3 percent in 1996, a decrease of 72 percent. This trend is maintained even when considering only low-risk women.[42] Additionally, induction of labor has increased substantially since 1990. Nearly 23 percent of singleton births were induced in 2005, which is nearly 2.5 times the percentage in 1990 (9.6 percent).

In 2005, 83.9 percent of women received prenatal care during the first trimester of pregnancy, while 3.5 percent of women received care in the third trimester or not at all.[43]

Live Births per 1,000 Women, by Age and Race/Ethnicity, 2006*

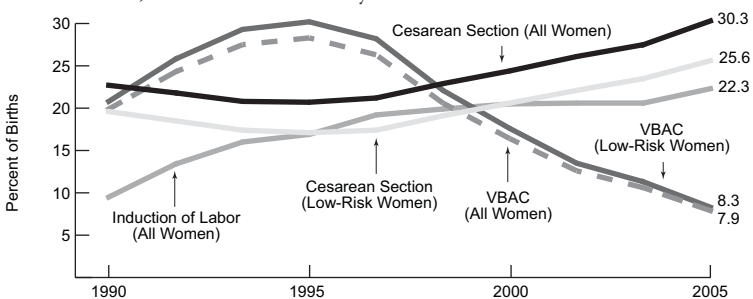
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaska Native	Asian/ Pacific Islander
15-19 Years	41.9	26.6	63.7	83.0	54.7	16.7
20-24 Years	105.9	83.4	133.1	177.0	114.9	62.5
25-29 Years	116.8	109.2	107.1	152.4	97.2	107.8
30-34 Years	97.7	98.1	72.6	108.4	61.5	116.5
35-39 Years	47.3	46.3	36.0	55.6	28.2	62.8
40-44 Years	9.4	8.4	8.3	13.3	6.1	14.1

*Data are preliminary.

Births Involving Cesarean Section, VBAC, and Induction of Labor, by Maternal Risk Status,* 1990–2005**

Source II.21, 22, 23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*A low-risk woman is defined as one with a full-term (at least 37 completed weeks of gestation), singleton (not a multiple pregnancy), and vertex fetus (head facing in a downward position in the birth canal). **Data after 2003 for C-sections and VBACs are from the 37 reporting areas using the 1989 Standard Certificate of Live Birth (unrevised) to maintain comparability with previous years' data.

BREASTFEEDING

Breastmilk benefits the health, growth, immunity, and development of infants, and mothers who breastfeed may have a decreased risk of breast and ovarian cancers.[44] Among infants born in 2004, 73.8 percent were reported to have ever been breastfed. Non-Hispanic Black infants were the least likely to ever be breastfed (56.2 percent), while Asian/Pacific Islanders and Hispanics were the most likely (81.7 and 81.0 percent, respectively).

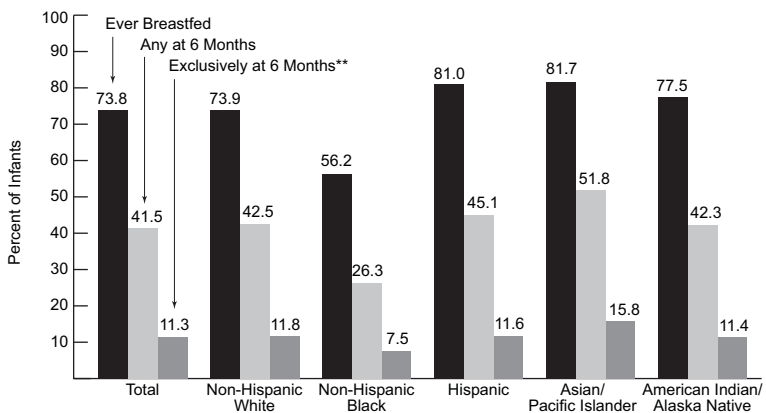
The American Academy of Pediatrics recommends that infants be exclusively breastfed—without supplemental solids or liquids—for the first 6 months of life; however, only 11.3 percent of infants born in 2004 were exclusively breastfed at 6 months, and only 41.5 percent of infants were fed any breastmilk at 6 months.

Breastfeeding practices vary considerably by maternal age, educational attainment, and marital status. For instance, infants born to college graduates were most likely to have ever been breastfed (85.3 percent), while infants born to mothers with a high school education or less were least likely (65.7 and 67.7 percent, respectively.)

Research indicates that maternal employment can also affect whether and for how long an infant is breastfed; for instance, mothers working full time are less likely to be breastfeeding at 6 months than those working part time or not at all.[45] In 2005, 49.5 percent of mothers with children under 1 year of age were employed, and more than two-thirds were employed full-time (data not shown).[46]

Infants* Who Are Breastfed, by Race/Ethnicity and Duration, 2004–2006

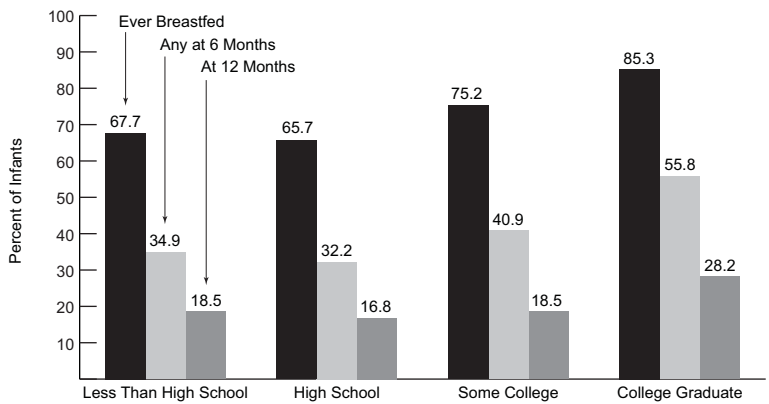
Source II.24: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2004. **Exclusive breastfeeding is defined as only breastmilk—no solids, water, or other liquids; data are not comparable to previous years' data due to changes in data collection methods.

Infants* Who Are Breastfed, by Maternal Education and Duration, 2004–2006

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



*Includes only infants born in 2004.

SMOKING DURING PREGNANCY

Smoking during pregnancy can have a negative impact on the health of infants and children by increasing the risk of complications during pregnancy, premature delivery, and low birth weight—a leading cause of infant mortality.[47] Maternal cigarette use data is captured on birth certificates; however, data collection methods vary due to revisions to the birth certificate in 2003. As of 2005, the 1989 Standard Certificate of Live Birth (unrevised) was used in 36 States, New York City and Washington, DC, while 11 States used the revised birth certificate.[48]

In 2005, 10.7 percent of all pregnant women giving birth in areas using the unrevised birth certificate smoked cigarettes during their pregnancy. This varied by maternal race and ethnicity.

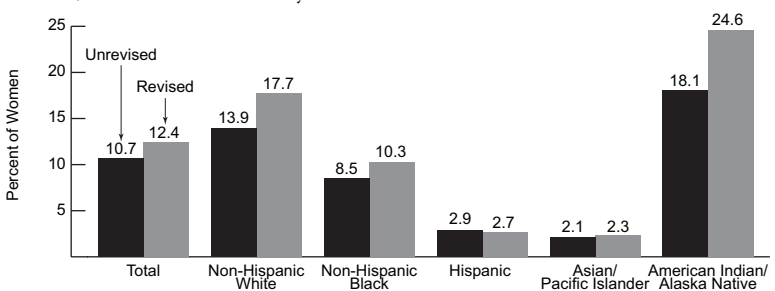
Among women in the unrevised reporting areas, American Indian/Alaska Native mothers were most likely to have smoked during pregnancy (18.1 percent), followed by non-Hispanic White women (13.9 percent). Smoking during pregnancy was higher among pregnant women in areas using the revised birth certificate (12.4 percent). Smoking was also most common among American Indian/Alaska Native mothers in these areas (24.6 percent). Asian/Pacific Islanders and Hispanic women were least likely to have smoked during pregnancy in both reporting areas.

Cigarette use also varied by maternal age in 2005. Among women in the unrevised reporting areas, women under 20 years of age were most likely to have smoked cigarettes during pregnancy (15.1 percent), followed by 13.0 percent of women aged 20–29 years. Similarly, 16.4 percent of women under 20 years of age in the revised reporting areas smoked during pregnancy, followed by 15.0 percent of women aged 20–29.

Smoking during the postpartum period has negative consequences for the mother and infant. In 2004, 17.9 percent of mothers smoked postpartum (data not shown). Women at highest risk were young mothers (under 20 years), White mothers, and mothers whose pregnancy was unintended.[49]

Cigarette Smoking During Pregnancy, by Maternal Race/Ethnicity and Birth Certificate Type,* 2005

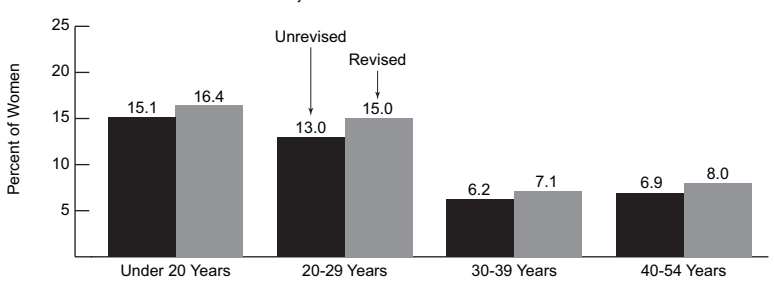
Source II.23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*The 1989 Standard Certificate of Live Birth (unrevised) was used in 36 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 11 reporting areas.

Cigarette Smoking During Pregnancy, by Maternal Age and Birth Certificate Type,* 2005

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



*The 1989 Standard Certificate of Live Birth (unrevised) was used in 36 reporting areas including New York City and Washington, DC; the 2003 revised birth certificate was used in 11 reporting areas.

MATERNAL MORBIDITY AND RISK FACTORS IN PREGNANCY

Since 1989, diabetes and hypertension have been the most commonly reported health conditions among pregnant women. Diabetes, both chronic and gestational (developing only during pregnancy), may pose health risks to the mother and infant. Women with gestational diabetes are at increased risk for developing diabetes later in life.[50] In 2005, diabetes during pregnancy occurred at a rate of 38.5 per 1,000 live births and was similar across all racial and ethnic groups (data not shown).

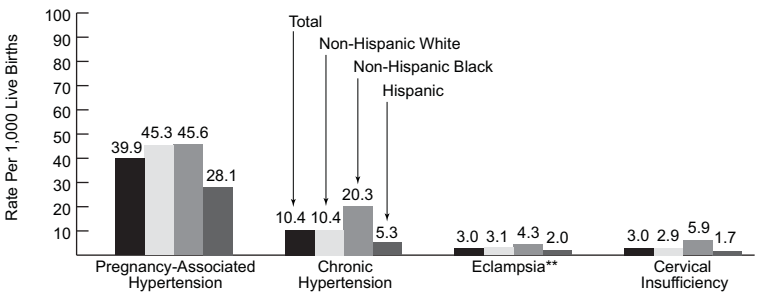
Hypertension during pregnancy can also be either chronic in nature or limited to the duration of pregnancy. Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, premature birth, placental abruption, and stillbirth.[51] Chronic hypertension was present in 10.4 per 1,000 live births in 2005. The rate of pregnancy-associated hypertension was even higher, occurring in 39.9 of every 1,000 live births.

Other illnesses or risk factors during pregnancy can include eclampsia, which involves seizures (usually preceded by a diagnosis of preeclampsia), and cervical insufficiency, which occurs when the cervix opens or dilates before the fetus is full term. All of these conditions are more common among non-Hispanic Black than non-Hispanic White and Hispanic women, and among older mothers.

Excessive or insufficient weight gain during pregnancy can also influence birth outcomes. In 2005, 10.7 percent of infants born to mothers who gained less than 16 pounds were low birth weight, compared to 5.9 percent of infants born to women gaining 36 to 40 pounds. Excessive weight gain (40 or more pounds) may elevate the risk of gestational diabetes, preeclampsia, and large-for-gestational-age babies; more than 20 percent of pregnant women gained more than 40 pounds in 2005 (data not shown).

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Race/Ethnicity,* 2005

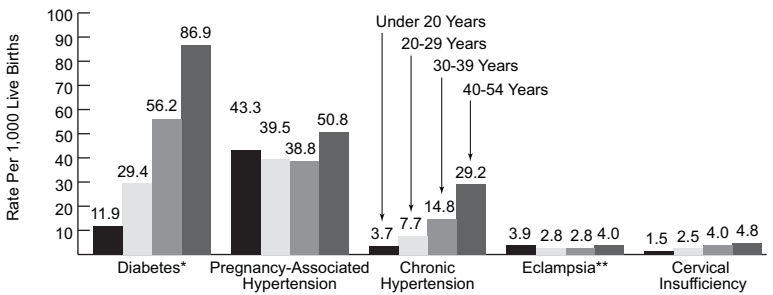
Source II.21, 22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data not reported for American Indian/Alaska Natives, Asian/Pacific Islanders, and persons of more than one race. **Eclampsia is characterized by seizures and generally follows preeclampsia, which is marked by high blood pressure, weight gain, and protein in the urine.

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Age, 2005

Source II.21, 22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Includes gestational and chronic diabetes. **Eclampsia is characterized by seizures and generally follows preeclampsia, which is marked by high blood pressure, weight gain, and protein in the urine.

MATERNAL MORTALITY

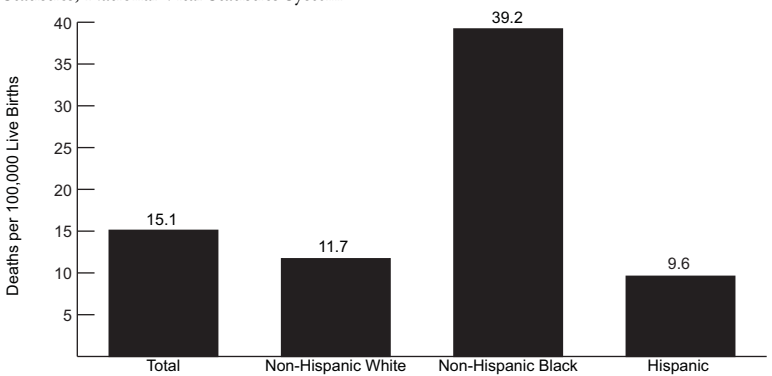
Maternal deaths are those reported on the death certificate to be related to or aggravated by pregnancy or pregnancy management that occur within 42 days after the end of the pregnancy. The maternal mortality rate has declined dramatically since 1950 when the rate was 83.3 deaths per 100,000 live births; however, the maternal mortality rate in 2005 (15.1 per 100,000 live births) was 84 percent higher than the rate reported in 1990 (8.2 per 100,000). According to the National Center for Health Statistics, this increase may largely be due to changes in how pregnancy status is recorded on death certificates; beginning in 1999, the cause of death was coded according to International Classification of Diseases, 10th Revision (ICD-10). Other methodological changes in reporting and data processing have been responsible for apparent increases in more recent years.[52]

In 2005, there were a total of 623 maternal deaths. This does not include the 137 deaths of women due to complications during pregnancy or childbirth after 42 days postpartum or the deaths of pregnant women due to external causes such as unintentional injury, homicide, or suicide. In 2005, the maternal mortality rate among non-Hispanic Black women (39.2 per 100,000 live births) was more than 3 times the rate among non-Hispanic White women (11.7 per 100,000) and more than 4 times the rate among Hispanic women (9.6 per 100,000).

The risk of maternal death increases with age for women of all races and ethnicities. In 2005, the maternal mortality rate was highest among women aged 35 years and older (38.0 per 100,000 live births), compared to 7.4 per 100,000 live births to women under 20 years of age and 10.7 per 100,000 live births among women aged 20–24 years.

Maternal Mortality Rates, by Race/Ethnicity,* 2005

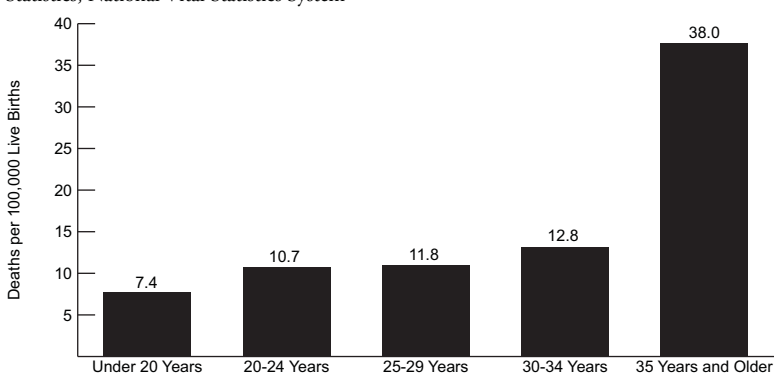
Source II.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



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

Maternal Mortality Rates, by Age, 2005

Source II.25: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



OLDER WOMEN

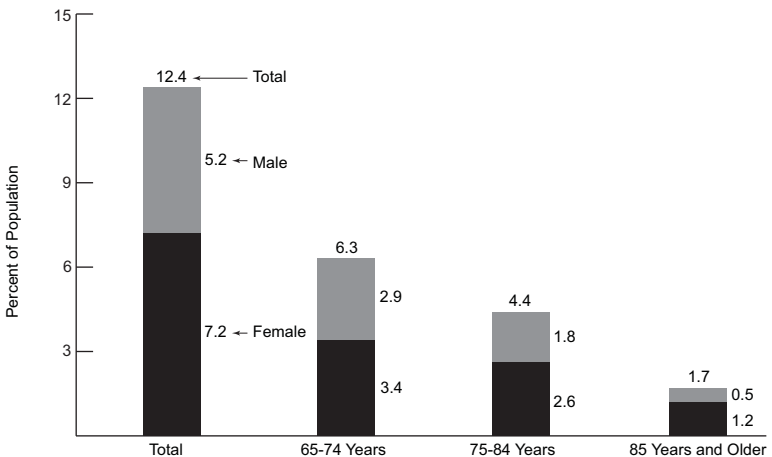
In 2006, there were 37.2 million adults aged 65 and older in the United States, representing 12.4 percent of the total population. According to the U.S. Census Bureau, the older population is expected to grow to 72 million by 2030, representing approximately 20 percent of the population, due to the aging of the baby boom generation. In 2006, older women composed 7.2 percent of the total population while men accounted for 5.2 percent. Women represented a larger proportion of the elderly population than men within every age group.

More than 40 percent of women aged 65 or older were married and living with a spouse in 2006, while another 38.4 percent lived alone. Research has suggested that older adults who live alone are more likely to live in poverty, which has numerous health implications. Another 8.8 percent of older women were heads of their household (with no spouse present), while 8.6 percent were living with relatives.

Employment plays a significant role in the lives of many older Americans. In 2006, more than 2.2 million women aged 65 years and older were working, accounting for 10.3 percent of women in this age group. Nearly 18 percent of women aged 65–74 years were employed during 2006, while only 3.5 percent of women aged 75 and older were employed. Less than 0.5 percent of women aged 65 and older were unemployed and looking for work (data not shown).

Representation of Adults Aged 65 and Older in the U.S. Population,* by Age and Sex, 2006

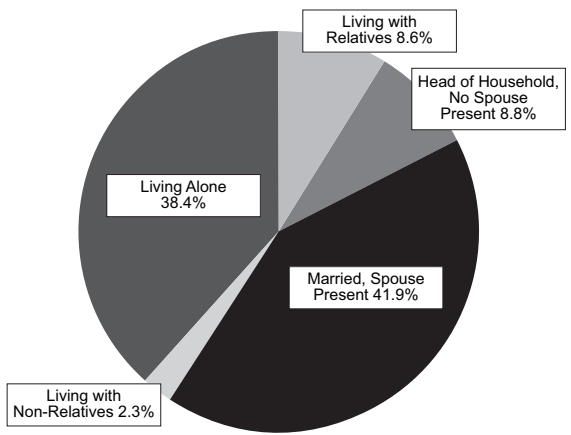
Source I.1: U.S. Census Bureau, American Community Survey



*Civilian, non-institutionalized population.

Women Aged 65 and Older,* by Household Composition, 2006

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



*Civilian, non-institutionalized population.

RURAL AND URBAN WOMEN

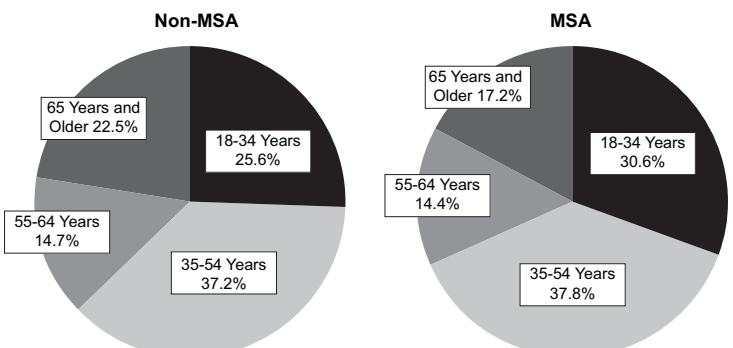
In 2005, more than 48 million people, or 16.6 percent of the population, lived in areas considered to be non-metropolitan. The number of areas defined as metropolitan changes frequently as the population grows and people move. Residents of non-metropolitan areas tend to be older, complete fewer years of education, have public insurance or no health insurance, and live farther from health care resources than their metropolitan counterparts.

In 2005, 22.5 percent of women in non-metropolitan areas were aged 65 years and older, while only 17.2 percent of women in metropolitan areas were in the same age group. Fewer than 26 percent of women in non-metropolitan areas were aged 18–34 years, compared to 30.6 percent in metropolitan areas. Women aged 35–54 years and 55–64 years accounted for approximately the same percentage of the female population in non-metropolitan and metropolitan areas.

In 2004–2006, the percentage of women experiencing activity limitations due to a chronic condition was higher in non-metropolitan areas (17.0 percent) than in metropolitan areas (13.4 percent), regardless of age. For instance, 30.2 percent of women aged 65–74 years living in non-metropolitan areas had an activity limitation due to a chronic condition, compared to 25.0 percent of women of the same age group in metropolitan areas. As age increases, however, the discrepancy narrows; among women aged 85 years and older, 63.3 percent in non-metropolitan areas experienced an activity limitation, as did 61.9 percent in metropolitan areas.

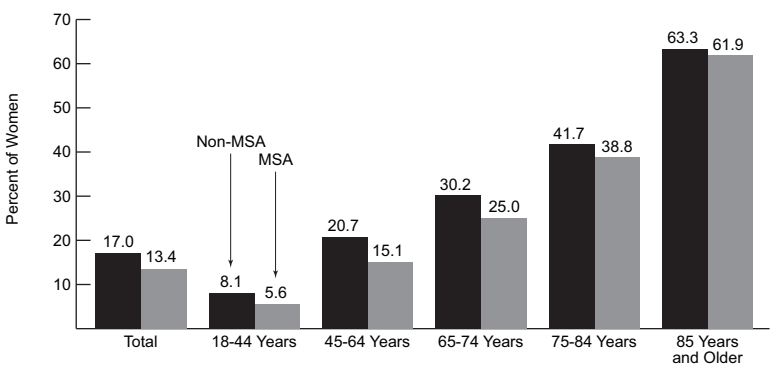
Women Aged 18 and Older, by Area of Residence* and Age, 2005

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



Activity Limitations Due to a Chronic Condition Among Women Aged 18 and Older, by Age and Area of Residence,* 2004–2006

Source II.27: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



A metropolitan statistical area (MSA) is defined as a core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core. All counties within a metropolitan statistical area are classified as metropolitan. Counties not within a metropolitan statistical area are considered non-metropolitan.