

Women's Health USA 2008



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

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PREFACE AND READER'S GUIDE

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports healthy women building healthy communities. HRSA is charged with ensuring access to quality health care through a network of community-based health centers, maternal and child health programs, and community HIV/AIDS programs throughout the States and Territories. In addition, HRSA's mission includes supporting individuals pursuing careers in medicine, nursing, and many other health disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely, topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA is pleased to present *Women's Health USA 2008*, the seventh edition of the Women's Health USA data book. To reflect the ever-changing, increasingly diverse population and its characteristics, *Women's Health USA* selectively highlights emerging issues and trends in women's health. Data and information on occupational injury, maternal mortality, digestive disorders, oral health, eye health, and urologic disorders are only a few of the new topics included in this edition. Every effort has been made to highlight racial and ethnic, sex/gender, and socioeconomic



disparities where possible. Where race and ethnicity data are reported, every effort was made to ensure that groups are mutually exclusive; when groups of Blacks and Whites exclude Hispanics they are described as non-Hispanic, and Asian/Pacific Islanders and American Indian/Alaska Natives are also generally non-Hispanic. In some instances, it was not possible to provide data for all races due to the design of the original data source or the size of the sample population; therefore, data with a relative standard error of 30 percent or greater were considered unreliable and were not reported.

The data book was developed by HRSA to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. *Women's Health USA 2008* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal government, including the U.S. Department of Health and Human Services, U.S. Department of Agriculture, U.S. Department of Labor, and U.S. Department of Justice. Non-Federal data

sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years. It is important to note that the incidence data included are generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races and ethnicities. Without age adjustment, it is difficult to know how much of the difference in incidence rates between groups can be attributed to differences in the groups' age distributions.

Women's Health USA 2008 is available online through either the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth or the Office of Data and Program Development's Web site at www.mchb.hrsa.gov/data. In an effort to produce a timely document, some of the topics covered in *Women's Health USA 2007* were not included in this year's edition because new data were not available. For coverage of these issues, please refer to *Women's Health USA 2007*, also available online. The National Women's Health Information Center, located online at www.womenshealth.gov, has updated and detailed women's and minority health data and maps. These data are available through Quick Health Data Online at www.4woman.gov/quickhealthdata. Data are available at the State

and county levels, by age, race and ethnicity, and sex/gender.

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INTRODUCTION

In 2006, women represented 50.8 percent of the 299 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people aged 65 years and older; within this age group, women represented 58 percent of the population. The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. Black and Hispanic women accounted for 8.9 and 6.3 percent of the female population aged 65 years and older, respectively, but they represented 14.7 and 21.0 percent of females under 15 years of age. Non-Hispanic Whites accounted for 80.6 percent of women aged 65 years and older, but only 56.4 percent of those under 15 years of age.

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in health status and the use of health care services. In 2006, 62.3 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 53.4 percent of Hispanic women and 50.2 percent of non-Hispanic Black women.

Minority women are disproportionately affected by a number of diseases and health conditions, including HIV/AIDS, sexually transmitted infections, diabetes, and asthma. For



instance, in 2006, non-Hispanic Black and Hispanic women accounted for more than three-fourths of women living with HIV/AIDS (63.9 and 15.2 percent, respectively). One-third of non-Hispanic White women had ever been tested for HIV, compared to 53.7 percent of non-Hispanic Black women and 46.1 percent of Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and is especially prevalent among minority populations. Among non-Hispanic Black and Hispanic women, diabetes occurred at a rate of 117.6 and 111.8 per 1,000 women, respectively, compared to 69.4 per 1,000 non-Hispanic White women. Hypertension, or high blood pressure, was also more prevalent among non-Hispanic Black women than women of other races. In 2005–2006, this condition occurred at a rate of 179.2 per 1,000 non-Hispanic Black women, compared to 157.0 per 1,000 non-Hispanic White women and 113.1 per 1,000 Hispanic women.

Some conditions, such as arthritis and heart disease, disproportionately affect non-Hispanic White women. For instance, in 2006, more than 27 percent of non-Hispanic White women had arthritis, compared to 23.5 percent of non-Hispanic Black women and 14.3 percent of Hispanic women.

In addition to race and ethnicity, income and education are important factors that contribute to women's health and access to health care. Regardless of family structure, women are more likely than men to live in poverty. Poverty rates were highest among women who were heads of their households (25.1 percent). Poverty rates were also highest among American Indian/Alaska Native women (27.6 percent), followed by non-Hispanic Black and Hispanic women (23.4 and 20.2 percent, respectively). Non-Hispanic Black and Hispanic women were also more likely to be heads of households than their non-Hispanic White and Asian counterparts.

Some conditions and health risks are more closely linked to family income than to race and ethnicity, such as asthma. Rates of asthma decline as income increases and women with higher incomes are more likely to effectively manage their asthma. Among women with asthma whose incomes were below 100 percent of poverty, nearly 36 percent had an asthma-related emergency room visit in the past year, compared to 24.8 percent of women with family incomes of 300 percent or more of poverty.

Mental health is another important aspect of women's overall health. A range of mental health problems, including depression, anxiety, phobias, and post-traumatic stress disorder, disproportionately affect women. Unlike many other health

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

Physical disabilities are more prevalent among women as well. Disability can be defined as impairment of the ability to perform common activities like walking up stairs, sitting or standing for 2 hours or more, grasping small objects, or carrying items like groceries. Therefore, the terms "activity limitations" and "disabilities" are used interchangeably throughout this book. Overall, 15.0 percent of women and 12.6 percent of men reported having activity limitations in 2006.

Men, however, bear a disproportionate burden of some health conditions, such as HIV/AIDS, hypertension and heart disease. In 2006, for instance, adolescent and adult males accounted for 72.9 percent of new AIDS cases, though a smaller proportion of men had ever been tested for HIV than women (33.7 versus 37.8 percent, respectively).

Certain health risks, such as cigarette use and injury, occur more commonly among men than women. In 2006, 27.8 percent of males smoked cigarettes, compared to 22.4 percent of females. Among men, 30.2 percent of emergency department visits were injury related, while only 21.3 percent of women's visits were due to injury. In addition, men were more likely than women to lack health insurance.

Many diseases and health conditions, such as those mentioned above, can be avoided or minimized through good nutrition, regular physical activity, and preventive health care. In 2005, 19.7 percent of women's visits to physicians were for preventive care, including prenatal care, preventive screenings, and immunizations. Overall, 64.6 percent of older women reported receiving a flu shot in 2006; however, this percentage ranged from 46.6 percent among Hispanic women to 67.3 percent of non-Hispanic White women.

In addition to preventive health care, preventive dental care is also important to prevent dental caries and gum disease. In 2003–2004, 74.6 percent of women with incomes of 300 percent or more of poverty saw a dentist in the past year, compared to 51.4 percent of women with incomes below 100 percent of poverty, and 44.9 percent of women with incomes of 200–299 percent of poverty.

There are many ways women (and men) can promote health and help prevent disease and disability. Regular physical activity is one of these. In 2006, 10.3 percent of women participated in adequate physical activity—30 minutes of moderate-intensity physical activity on most days of the week or 20 minutes of vigorous-intensity activity on 3 or more days per week. Non-Hispanic White women and women with higher

incomes were most likely to meet the recommended levels of physical activity.

Healthy eating habits can also be a major contributor to long-term health and prevention of chronic disease. In 2003–2004, however, more than half of all adult women had diets that included more than the recommended amount of saturated fat and sodium and less than the recommended amount of folate and calcium. Overall, 63.5 percent of women exceeded the maximum daily intake of saturated fat, and 70 percent exceeded the maximum amount of sodium.

While some behaviors have a positive effect on health, a number of others, such as smoking, illicit drug use, and excessive alcohol use can have a negative effect. In 2006, 22.4 percent of women smoked. However, nearly 46 percent of female smokers tried to quit at some point in the past year. During the same year, 44.9 percent of women reported any alcohol use in the past month, but relatively few women (15.6 percent) reported binge drinking (five or more drinks on the same occasion) and even fewer (3.5 percent) reported heavy alcohol use (binge drinking on 5 days or more in the past month).

Cigarette, alcohol, and illicit drug use is particularly harmful during pregnancy. The use of tobacco during pregnancy has declined steadily since 1989. Based on data from 36 states, 10.5

percent of pregnant women reported smoking during pregnancy in 2005. This rate was highest among American Indian/Alaska Native women (18.1 percent) and lowest among Asian/Pacific Islander women (2.1 percent).

Women's Health USA 2008 can be an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women throughout the United States.





POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were over 151 million females in the United States in 2006, representing slightly more than half of the population.

Examining data by demographic factors such as sex, age, and race/ethnicity can serve a number of purposes for policymakers and program planners. For instance, these comparisons can be used to tailor the development and evaluation of policies and programs serving women.

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

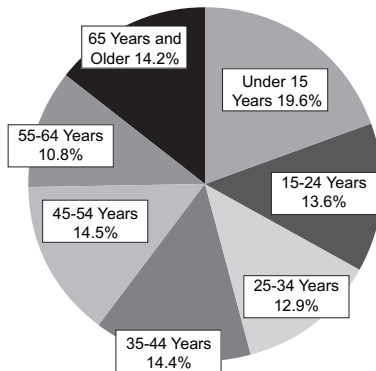
U.S. POPULATION

In 2006, the total U.S. population was over 299 million, with females comprising 50.8 percent of that total. Females younger than 35 years of age accounted for 46.1 percent of the female population, those aged 35–64 years accounted for 39.7 percent, and females aged 65 years and older accounted for 14.2 percent.

The distribution by sex was fairly even across younger age groups; however, women accounted for a greater percentage of the older population than men. Of those aged 65 and older, 58.0 percent were women.

U.S. Female Population,* by Age, 2006

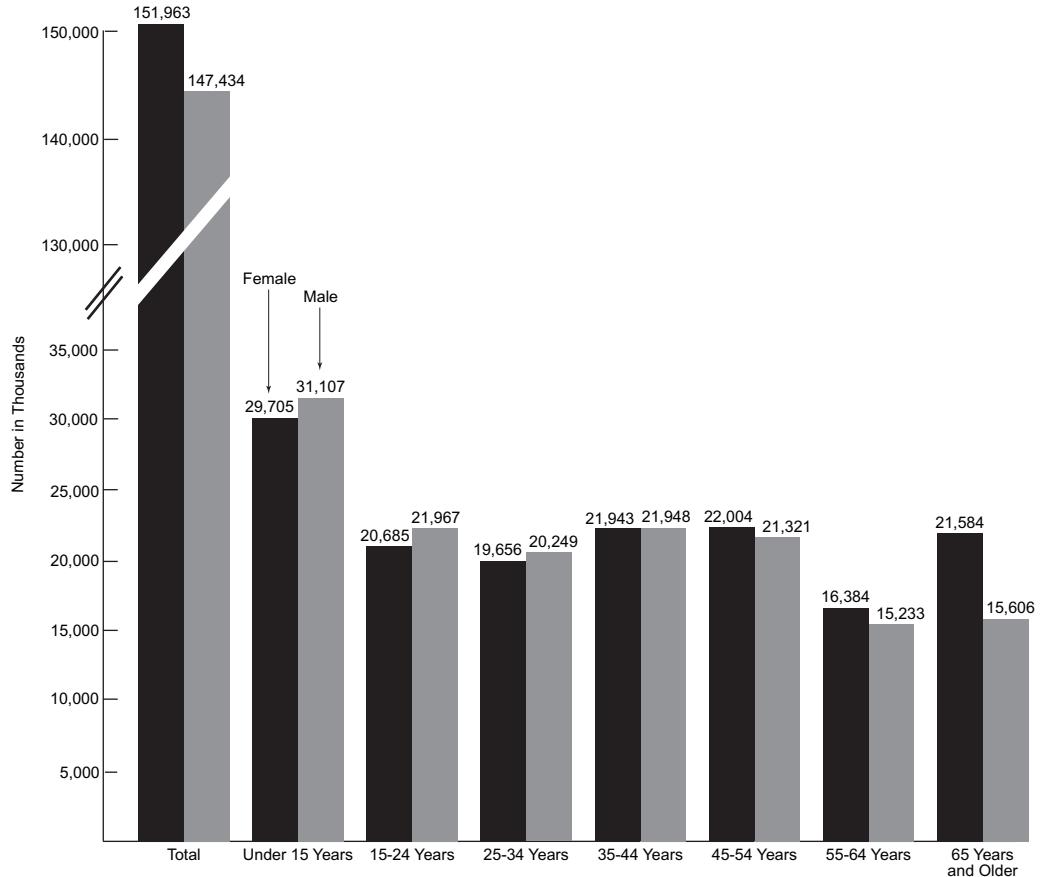
Source I.1: U.S. Census Bureau, American Community Survey



*Includes only non-institutionalized population not living in group housing.

U.S. Population,* by Age and Sex, 2006

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



*Includes only non-institutionalized population not living in group housing.

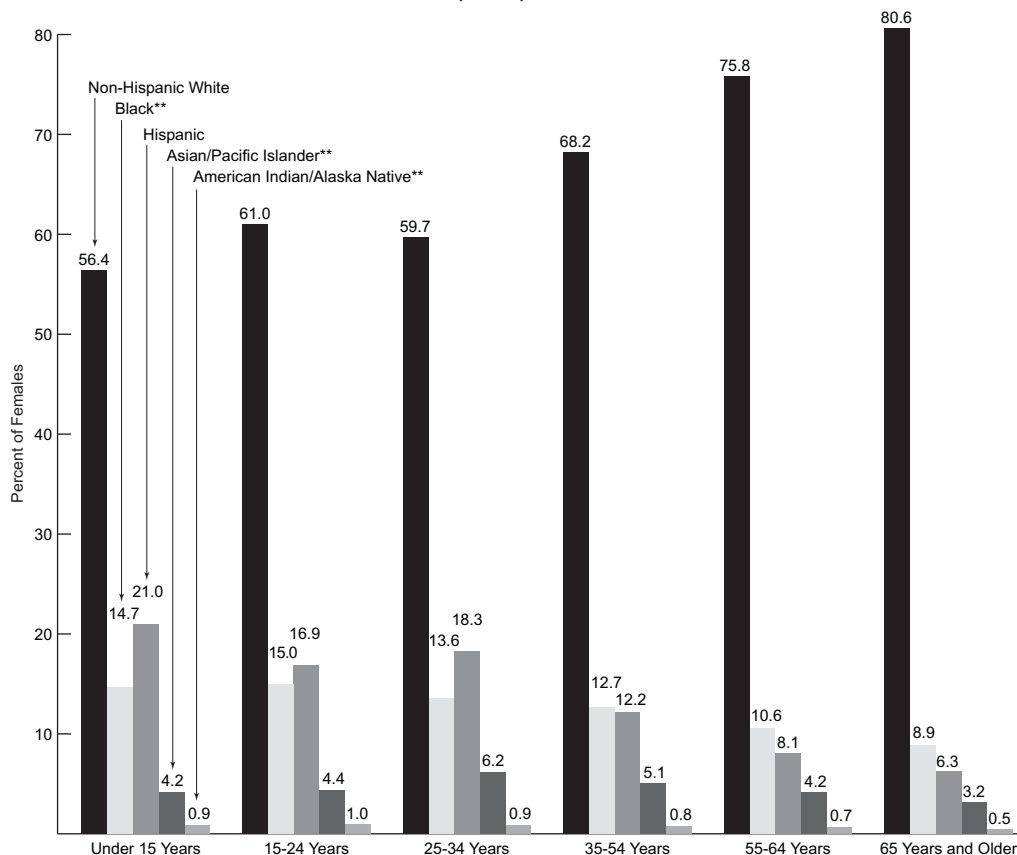
U.S. FEMALE POPULATION

The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. The younger female population (under 15 years) is significantly more diverse than the older female population. In 2006, 56.4 percent of females under 15 years were non-Hispanic White, while 21.0 percent of that group were Hispanic. In contrast, among women aged 65 years and older, 80.6 percent were non-Hispanic White and only 6.3 percent were Hispanic. The distribution of the Black population was more consistent across age groups, ranging from 14.7 percent of females under 15 years of age to 8.9 percent of women aged 65 years and older.

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

U.S. Female Population,* by Age and Race/Ethnicity, 2006

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



*Includes only non-institutionalized population not living in group housing. Percentages do not equal 100 because data are not shown for persons selecting other races or more than one race. **May include Hispanics.

HOUSEHOLD COMPOSITION

In 2006, 52.5 percent of women aged 18 years and older were married and living with a spouse; this includes married couples living with other people, such as parents. Just over 12 percent of women over age 18 were the heads of their households, meaning that they have children or other family members, but no spouse, living with them in a house that they own or rent. Women who are heads of households include single

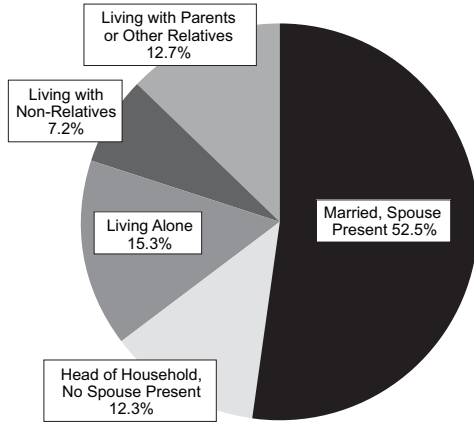
mothers, single women with a parent or other close relative in their house, and women with other household compositions. The remaining women lived alone (15.3 percent), with parents or other relatives (12.7 percent), or with non-relatives (7.2 percent).

Women in households with no spouse present are more likely than women in married couple families to have incomes below poverty (see “Women and Poverty” on the next page). In

2006, Black women were most likely to be single heads of households (28.9 percent) while Asian women were least likely (7.5 percent). Hispanic women and women of other races were also more likely than non-Hispanic White and Asian women to be heads of households (16.2 and 17.7 percent, respectively).

Adult Women,* by Household Composition, 2006

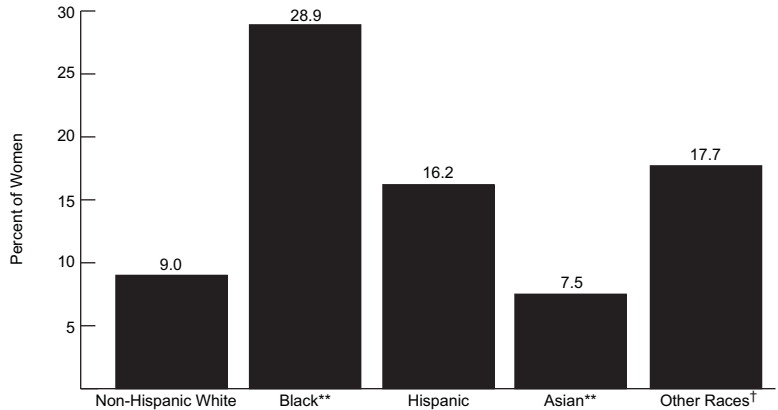
Source I.2: U.S. Census Bureau, Current Population Survey



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

Women Who Are Heads of Households,* by Race/Ethnicity, 2006

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



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

WOMEN AND POVERTY

In 2006, nearly 36.5 million people in the United States lived with incomes below the poverty level.² More than 12 percent of women aged 18 years and older (14.1 million) lived in poverty, compared to 8.8 percent of men. With regard to race and ethnicity, non-Hispanic White women were the least likely to experience poverty (9.0 percent), while American Indian/Alaska Native women were the most likely (27.6 percent), followed closely by non-Hispanic Black

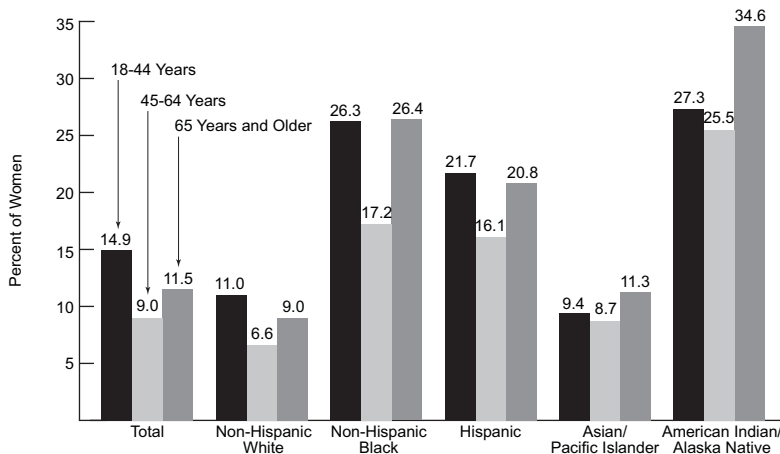
women (23.4 percent) and Hispanic women (20.2 percent; data not shown).

Poverty status varies with age. Among women of each race and ethnicity, those aged 45–64 years were less likely to experience poverty than those aged 18–44 and 65 years and older. For instance, 17.2 percent of non-Hispanic Black women aged 45–64 were in poverty in 2006, compared to more than 26 percent of non-Hispanic Black women aged 18–44 and 65 years and older.

Women in families—a group of at least two people related by birth, marriage, or adoption and residing together—experience higher rates of poverty than men in families (9.4 versus 6.2 percent). Men in families with no spouse present were considerably less likely to have family incomes below the poverty level than women in families with no spouse present (12.0 versus 25.1 percent).

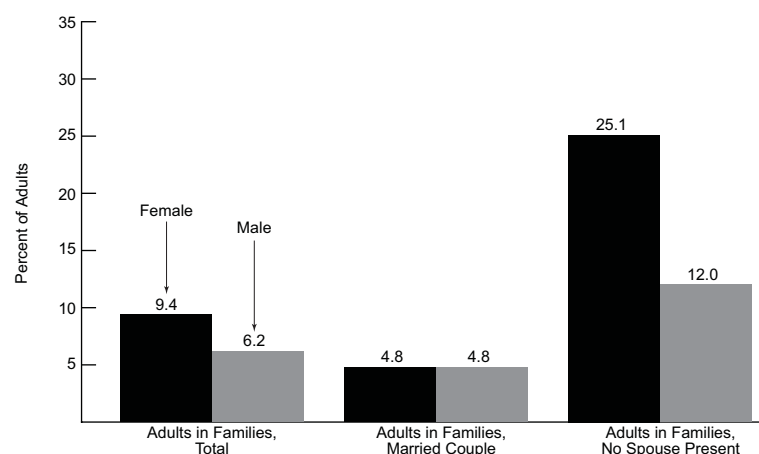
Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity and Age, 2006

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



Adults in Families* Living Below the Poverty Level,** by Household Type and Sex, 2006

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



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

*Families are a group of at least two people related by birth, marriage, or adoption and residing together.
 **Poverty level, defined by the U.S. Census Bureau, was \$20,444 for a family of four in 2006.

FOOD SECURITY

Food security is defined as having access at all times to enough nutritionally adequate and safe foods to lead a healthy, active lifestyle.³ Food security is measured through a series of indicators such as whether people worry that food would run out before there would be money to buy more; whether an individual or his/her family cut the size of meals or skipped meals because there was not enough money for food; and whether an individual or his/her family ever went a whole day without eating as there was not enough food.

In 2006, an estimated 35.5 million people lived in households that were classified as not fully food secure. Households or persons experiencing food insecurity may be categorized as experiencing low

food security or very low food security (formerly referred to as “food insecurity with hunger”). Low food security generally indicates multiple food access issues, while very low food security indicates reduced food intake and disrupted eating patterns due to inadequate resources for food. Periods of low or very low food security may be occasional or episodic, placing the members of a household at greater nutritional risk due to insufficient access to nutritionally adequate and safe foods.

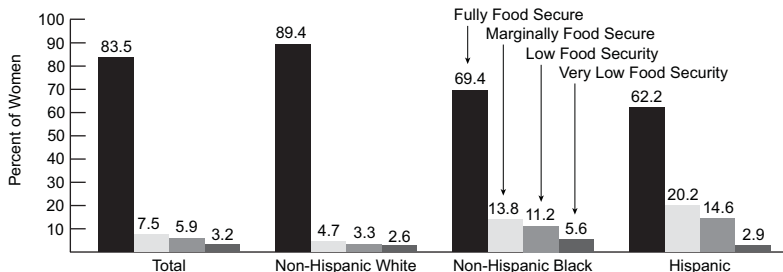
In 2005–2006, nearly 17 percent of women were not fully food secure, and this percentage varied by race and ethnicity. Among women, non-Hispanic Whites were most likely to be fully food secure (89.4 percent), while Hispanics were

least likely (62.2 percent). Non-Hispanic Black women had the highest rate of very low food security (5.6 percent), and Hispanic women had the highest rates of being marginally food secure and having low food security (20.2 and 14.6 percent, respectively).

Food security status also varies by household composition. While adult men and women living alone had similar rates of food insecurity in 2006, female-headed households with no spouse present were more likely than male heads of households with no spouse present to experience food insecurity (30.4 versus 17.0 percent, respectively).

Food Security Status of Women Aged 18 and Older, by Race/Ethnicity,* 2005–2006

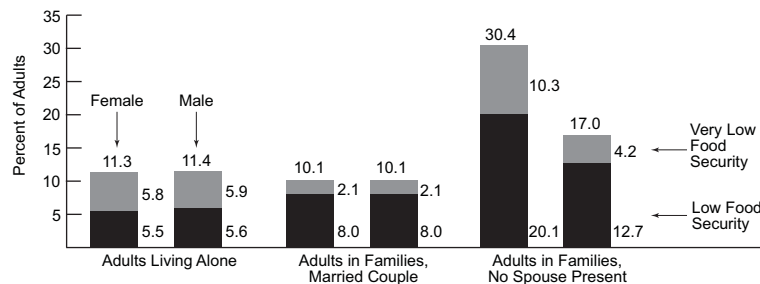
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified were too small to produce reliable estimates.

Food Security Status Among Adults Aged 18 and Older, by Household Composition* and Sex, 2006

Source I.5: U.S. Department of Agriculture, Economic Research Service



*Percentages may not add to totals due to rounding.

WOMEN AND FEDERAL NUTRITION PROGRAMS

Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Federal Food Stamp Program (FSP) helps low-income individuals purchase food. In 2006, nearly 13.0 million adults participated in the FSP; of these, more than 8.8 million (68 percent) were women. Of these women, more than 4 million (almost half) were in the 18- to 35-year-old age group.

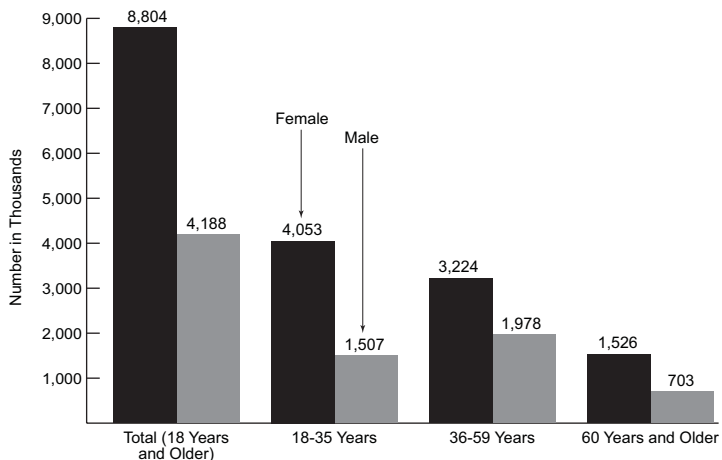
Female-headed households with children make up nearly one-third of households that rely on food stamps, and represent nearly 60 percent of food stamp households with children (data not shown).

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) also plays an important role in serving women and families by providing supplementary nutrition during pregnancy, the postpartum period, and while breastfeeding. Most WIC participants are

infants and children (75.0 percent); however, the program also serves more than 2 million pregnant women and mothers, representing 25.0 percent of WIC participants. During the years 1992–2006, the number of women participating in WIC increased by 65 percent, and it continues to rise.

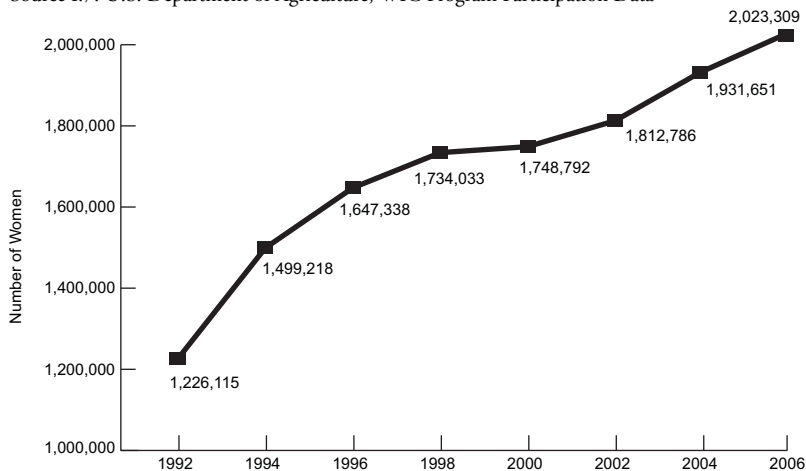
Adult Recipients of Food Stamps, by Age and Sex, 2006

Source I.6: U.S. Department of Agriculture, Food Stamp Quality Control Sample



Women Participating in WIC,* 1992–2006

Source I.7: U.S. Department of Agriculture, WIC Program Participation Data



* Participants are classified as women, infants, or children based on nutritional-risk status; data reported include all pregnant women and mothers regardless of age.

WOMEN IN HEALTH PROFESSION SCHOOLS

The health professions have long been characterized by gender disparities. Some professions, such as medicine and dentistry, have historically been dominated by males, while others, such as

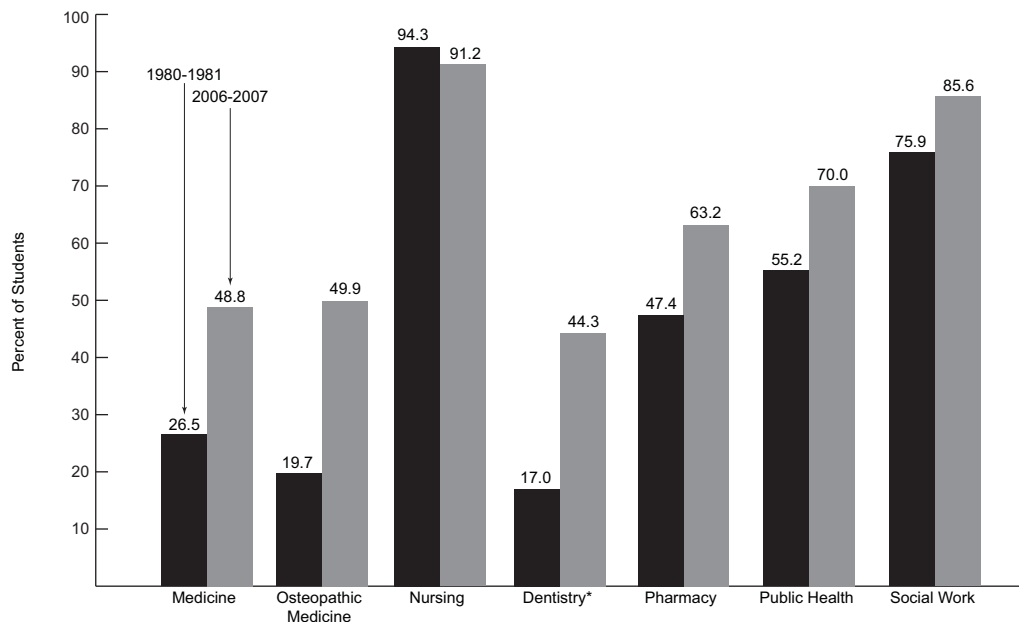
nursing, have been predominantly female. Over the past several decades, these disparities have narrowed, and in some cases reversed. In 1980–1981, 47.4 percent of pharmacy students were women, while in the fall of 2006, women represented more than 63 percent of pharmacy

students. Even in fields where men are still in the majority, the representation of female students has grown. In 1980–1981, only 26.5 percent of medical students were women, compared to nearly one-half (48.8 percent) of students in the fall of 2006. Similar gains have been made in the fields of osteopathic medicine and dentistry, where the most recent data indicate that 49.9 and 44.3 percent of students, respectively, were women, compared to 19.7 and 17.0 percent in 1980–1981.

During the 2006–2007 academic year, female students represented a large majority in graduate public health (70.0 percent) and social work programs (85.6 percent). Nursing, at both the undergraduate and graduate levels, also continues to be dominated by women, although the proportion of students who are female is slowly declining. In the 1980–1981 academic year, 94.3 percent of graduate students in nursing programs were female, while in the fall of 2006, females represented 91.2 percent of graduate students in nursing programs. Women also represent a majority of students studying optometry (64.2 percent) and dietetics (91 percent; data not shown). Comparative data for these programs were not available for the 1980–1981 academic year.

Women in Schools for Selected Health Professions, 1980–1981 and 2006–2007

Source I.8: Professional Associations



*Most recent data for dentistry are from the 2005–2006 school year.

EDUCATIONAL DEGREES AND INSTRUCTIONAL STAFF

The number of post-secondary educational degrees awarded to women rose from just over half a million in the 1969–1970 academic year to nearly 1.7 million in 2004–2005. Although the number of degrees earned by men has also increased, the rate of growth among women has been much faster; therefore, the proportion of degrees earned by women has risen dramatically. In 1969–1970, men earned a majority of every type of post-secondary degree, while in 2004–2005, women earned more than half of all associate's, bachelor's, and master's degrees and

nearly half of all first professional and doctoral degrees. The most significant increase has been in the proportion of first professional degree earners who are women, which jumped from 5.3 percent in 1969–1970 to 49.8 percent in 2004–2005. In 2004–2005, the total number of women earning their first professional degree (43,440) was 23 times greater than in 1969–1970 (1,841).

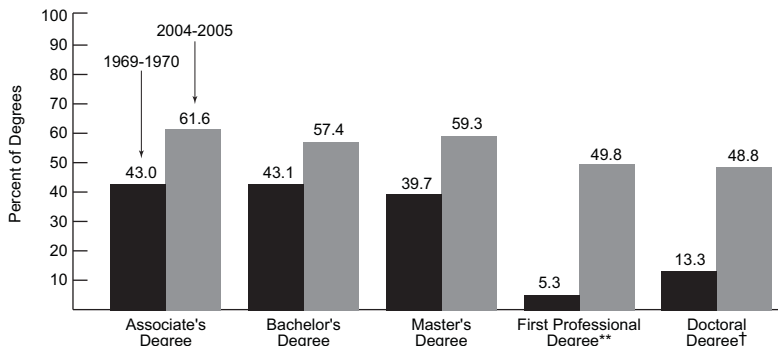
Although sex disparities in education have almost disappeared, there is still a disparity among instructional staff in degree-granting institutions. In fall 2005, only 40.6 percent of full-time instructional faculty were women. While women accounted for more than half of all full-time

instructors and lecturers, they made up only 25.1 percent of professors and less than 39 percent of associate professors.

Among female instructors, a significant racial and ethnic disparity exists as well: 78.1 percent of all female instructional staff were non-Hispanic White. This disparity is even more pronounced among higher-level staff, such as professors, where non-Hispanic White women composed 86.8 percent of full-time female staff, compared to 4.7 percent for non-Hispanic Black women and 2.6 percent for Hispanic women (data not shown).

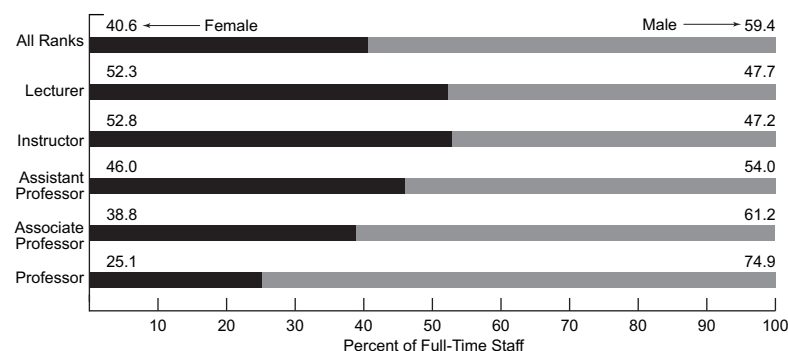
Degrees Awarded to Women,* by Type, 1969–1970 and 2004–2005

Source I.9: U.S. Department of Education, Digest of Education Statistics



Full-Time Instructional Staff in Degree-Granting Institutions, by Academic Rank and Sex, Fall 2005

Source I.9: U.S. Department of Education, Digest of Education Statistics



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

WOMEN IN THE LABOR FORCE

In 2007, 59.4 percent of women aged 16 and older were in the labor force (either employed or unemployed and actively seeking employment). This represents a 37 percent increase from the 43.3 percent of women who were in the labor force in 1970.⁴ In 2006, females accounted for 46.5 percent of workers, while males accounted for 53.5 percent.

The representation of females in the labor force varies greatly by occupational sector. In 2006, women accounted for 63.1 percent of sales and office workers, but only 3.5 percent of construc-

tion, extraction, maintenance, and repair workers. Other positions which were more commonly held by women than men included service jobs (56.5 percent) and management, professional, and related jobs (51.1 percent). Women were the minority in production, transportation, and material moving (23.2 percent); farming, fishing, and forestry (20.3 percent); and in the military (14.6 percent). In 2006, a total of 165,231 women were on active duty in the armed services.

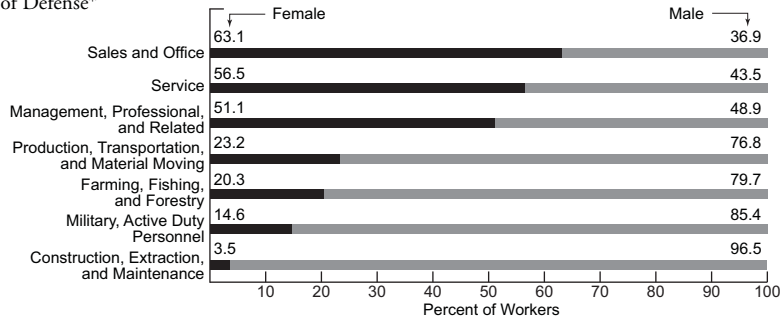
Women are disproportionately represented among lower-income workers. Among workers aged 16 and older, more than 55 percent of those earning less than \$25,000 per year were women,

while 69 percent of those earning more than \$50,000 per year were men (data not shown).

Annual earnings by women aged 16 and older vary greatly by race and ethnicity. In 2006, 24.4 percent of Asian/Pacific Islander women earned more than \$50,000, compared to 8.4 and 8.5 percent of Hispanic and American Indian/ Alaska Native women, respectively. The proportion of female workers earning less than \$25,000 ranged from 68.2 percent of Hispanic women to 47.7 percent of Asian/Pacific Islanders. More than half of Black, non-Hispanic White, and American Indian/Alaska Native women earned less than \$25,000.

Workforce Representation in Selected Occupational Sectors, by Sex, 2006

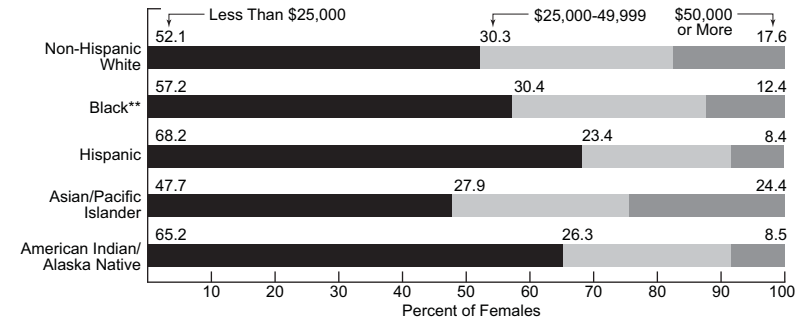
Sources I.1, I.10: U.S. Census Bureau, American Community Survey; U.S. Department of Defense*



*Military enlistment data are from the U.S. Department of Defense; all other from the U.S. Census Bureau.

Annual Earning Levels of Females Aged 16 and Older,* by Race/Ethnicity, 2006

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



*Estimates have not been adjusted for area/region of employment or other factors that may influence earnings levels. **May include Hispanics.

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.

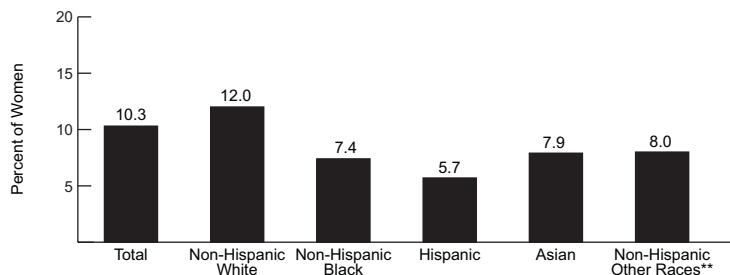
In 2006, non-Hispanic White women were more likely than women of other races/ethnicities to report adequate physical activity (12.0

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

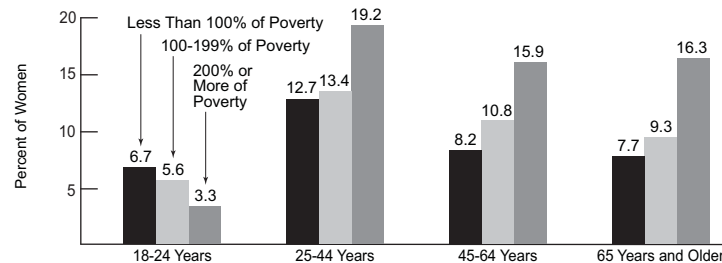


*Adequate physical activity is defined as 30 minutes per day or more of moderate-intensity activity on 5 or more days per week or 20 minutes per day of vigorous-intensity activity on 3 or more days per week.

**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).

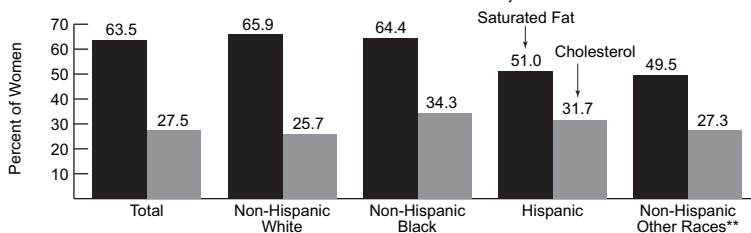
Salt, or sodium chloride, also plays an important role in heart health, as high salt intake can contribute to high blood pressure. In 2003–2004, nearly 70 percent of women exceeded the recommended maximum intake of less than 2,300 mg/day of sodium, or about 1 teaspoon of salt (data not shown).

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

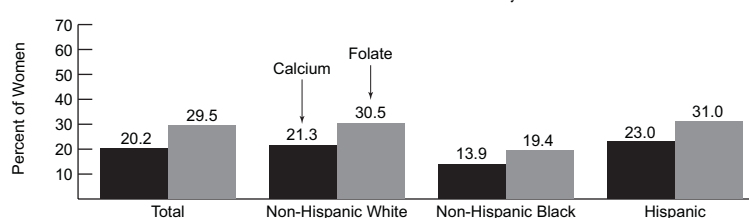
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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.

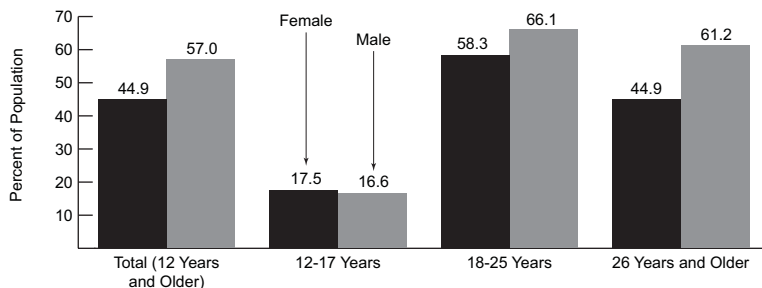
Overall, males are more likely to drink alcohol than females, with past-month alcohol use reported by 57.0 percent of males and 44.9 percent of females aged 12 years and older. This is true across all age groups with the exception of 12- to 17-year-olds; in that group, 17.5 percent of females and 16.6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

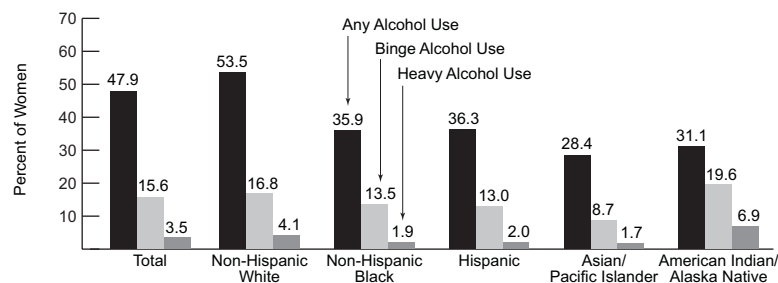
Past Month Alcohol Use, by Sex and Age, 2006

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.

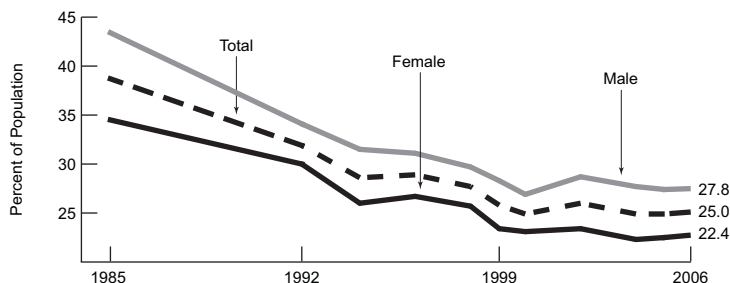
Among women, the rate of smoking varied by race and ethnicity in 2006. American Indian/Alaska Native women were most likely to have smoked cigarettes in the past month (39.1 percent), followed by non-Hispanic White women (24.9 percent). Asian/Pacific Islander women were least likely to have smoked cigarettes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

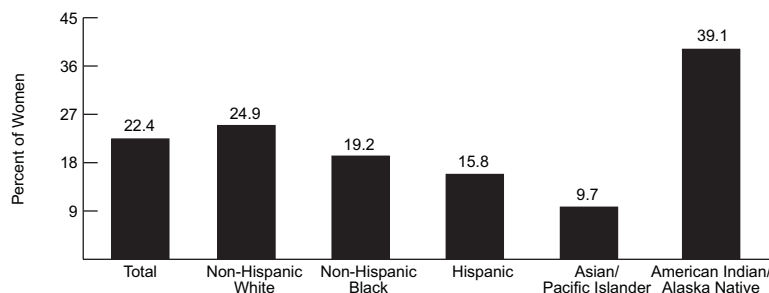
Past Month Cigarette Use Among Persons Aged 12 and Older, by Sex, 1985–2006

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 addiction, 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

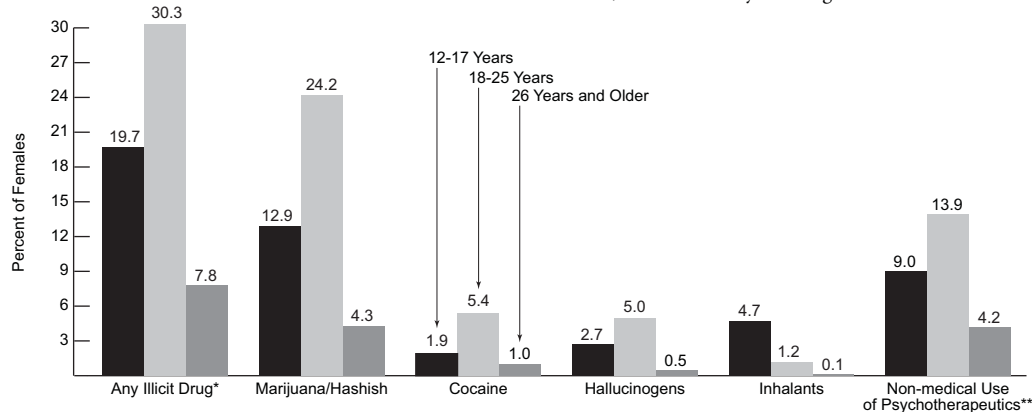
purposes include opioids, central nervous system depressants, and stimulants. Long-term use of these drugs can lead to physical dependence and addiction. In addition, when taken in large doses, stimulant use can lead to compulsivity, paranoia, dangerously high body temperature, and an irregular heartbeat.⁷

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

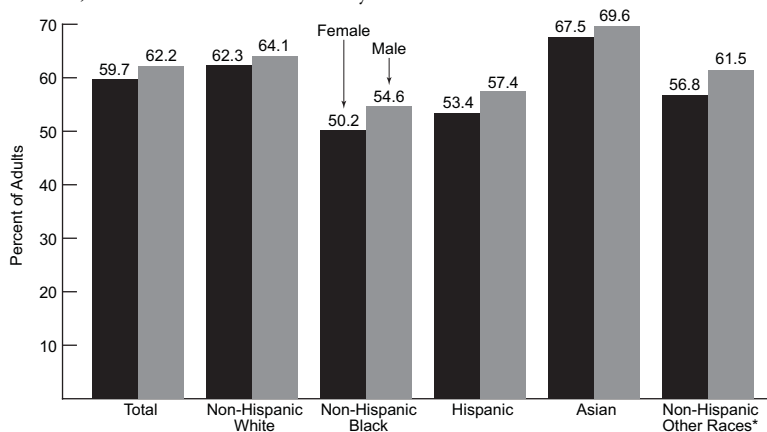
In 2006, men were more likely than women to report being in excellent or very good health (62.2 versus 59.7 percent); this was true in every racial and ethnic group. Among both sexes, Asians most often reported that they were in excellent or very good health, followed by non-Hispanic Whites; non-Hispanic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

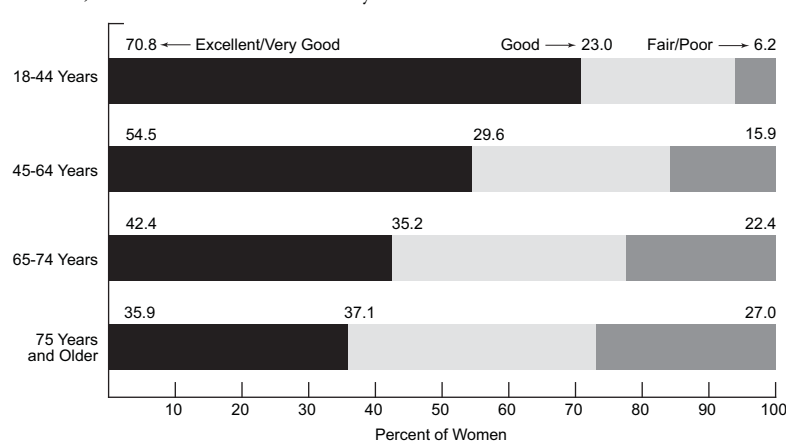
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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.

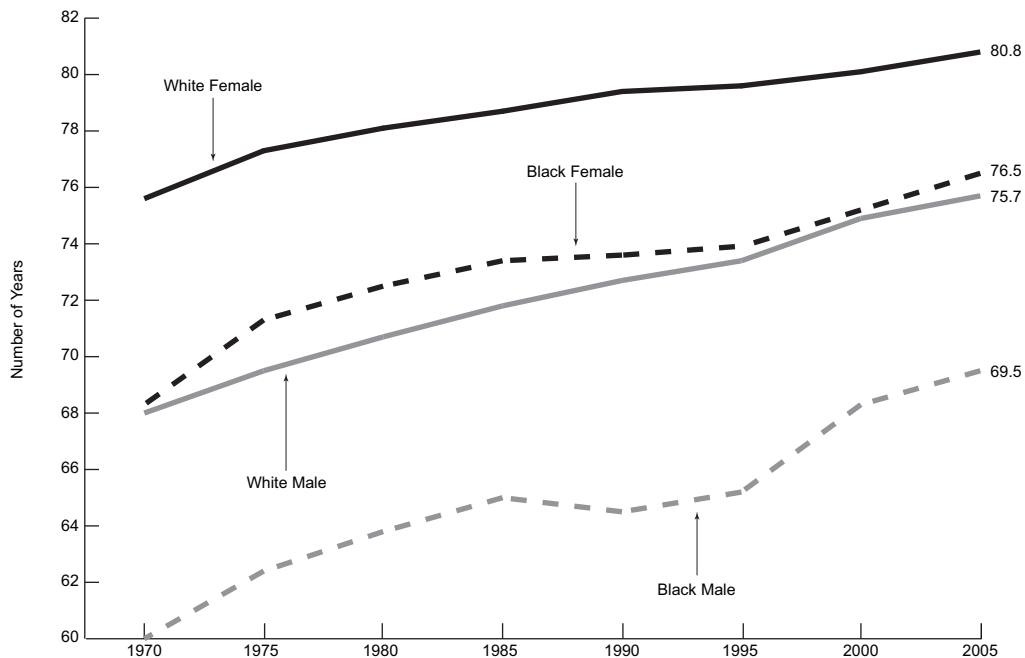
Life expectancy data have not been uniformly calculated and reported for the Hispanic, Asian/Pacific Islander, and American Indian/

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

Cause of Death	Total % (Rank)	Non-Hispanic White % (Rank)	Non-Hispanic Black % (Rank)	Hispanic % (Rank)	Asian/Pacific Islander % (Rank)	American Indian/ Alaska Native % (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.

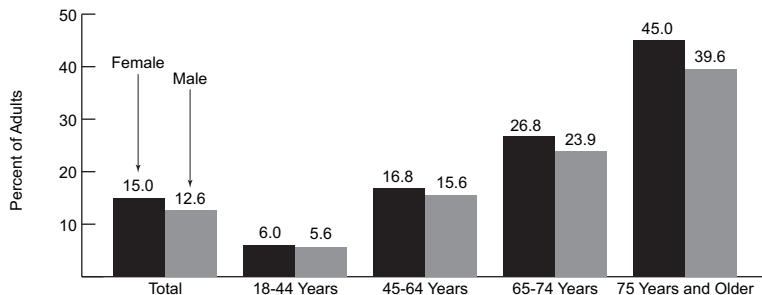
The percentage of women reporting that a vision or hearing problem causes activity limitations also increased with age. Overall, 7.6 percent of women with a limitation reported a vision problem, and 3.7 percent reported that a hearing problem caused their activity limitation. Only 4.0 percent of women 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

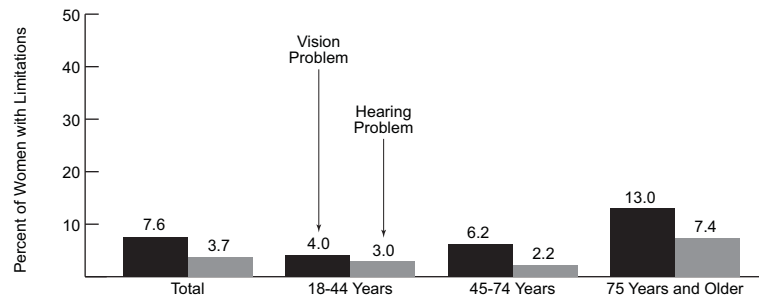
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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

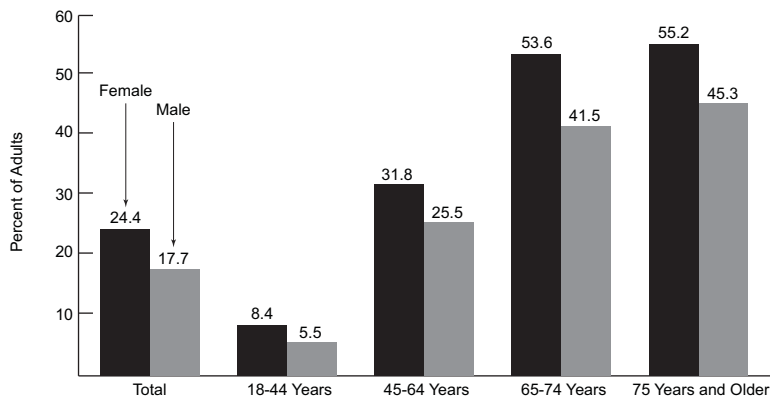
In 2006, more than 21 percent of adults in the United States reported that they had ever been diagnosed with arthritis. Arthritis was more common among women than men (24.4 versus 17.7 percent), and rates of arthritis increased dramatically with age for both sexes. Fewer than 10 percent of women aged 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).

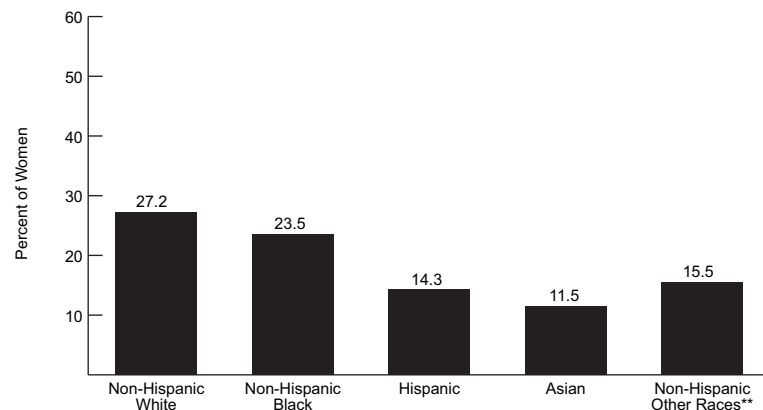
Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2006

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



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.

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

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

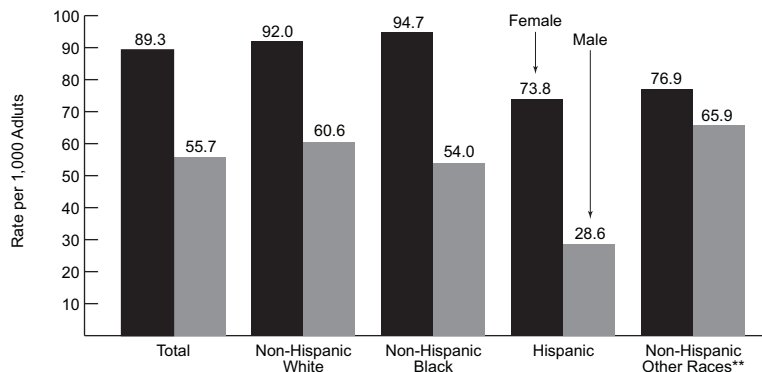
1,000 men); this was true in every racial and ethnic group. Among women, non-Hispanic Black women had the highest asthma rate (94.7 per 1,000 women), followed by non-Hispanic White women (92.0 per 1,000); Hispanic women had the lowest asthma rate (73.8 per 1,000).

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

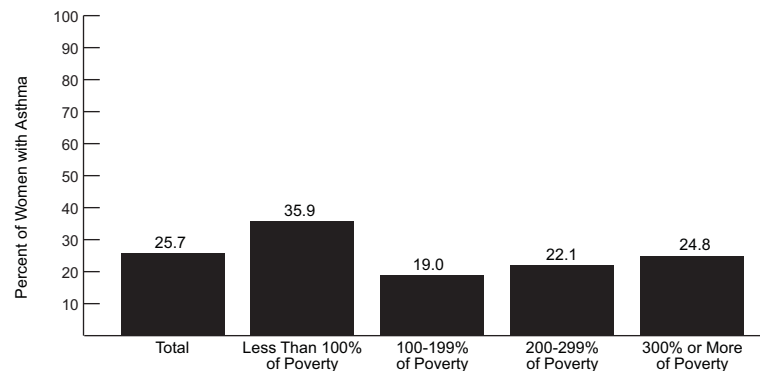
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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.

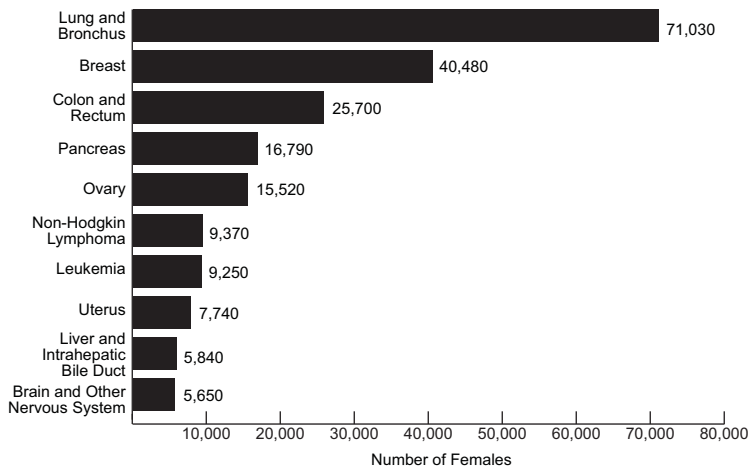
Due to the varying survival rates for different types of cancer, the most common causes of cancer death are not always the most common types of cancer. For instance, although lung and bronchus cancers cause the greatest number of deaths, breast cancer is more commonly diagnosed among women; there will 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 squamous 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

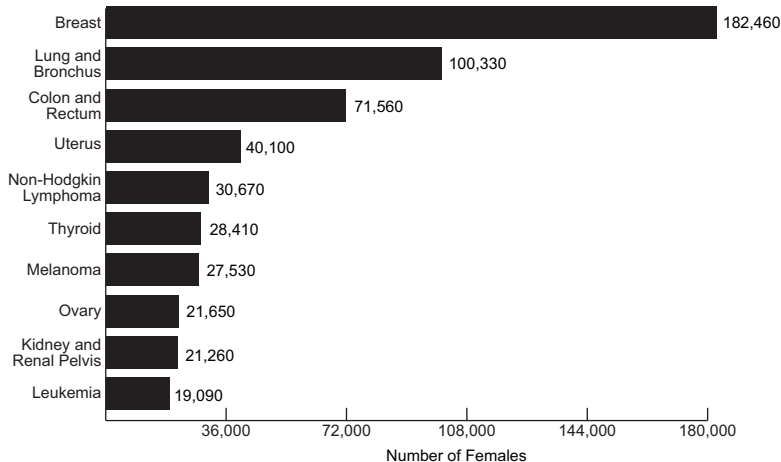
Leading Causes of Cancer Deaths Among Females, by Site, 2008 Estimates

Source II.7: American Cancer Society



New Cancer Cases Among Females, by Site, 2008 Estimates

Source II.7: American Cancer Society



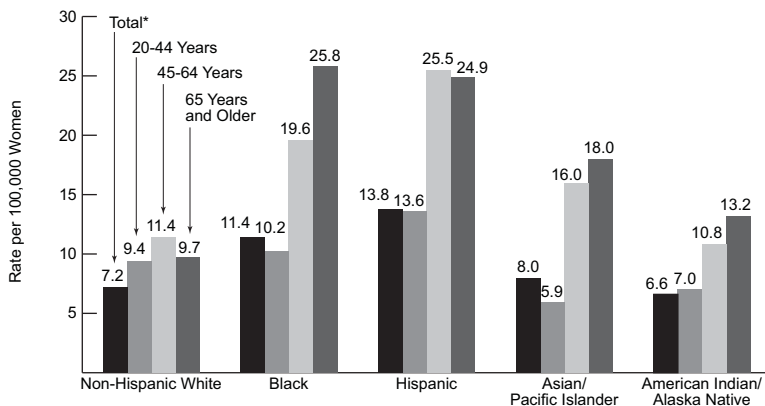
45–64 years were more likely than women of other races and ethnicities of the same age groups to be diagnosed with cervical cancer (13.6 and 25.5 per 100,000 women, respectively). Black and Hispanic women aged 65 years and older were also more likely to be diagnosed with this type of cancer (25.8 and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

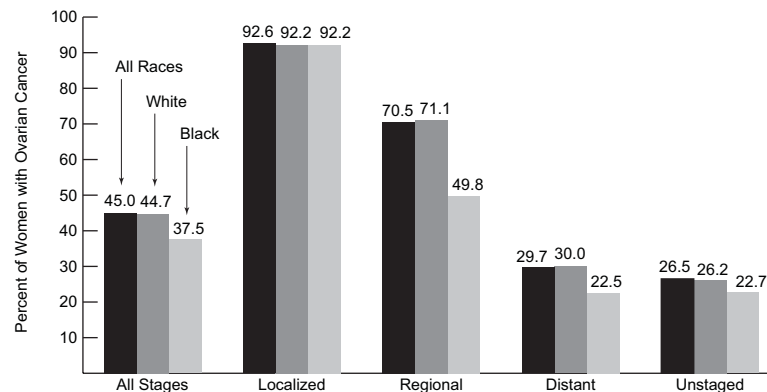
Source II.8: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*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.

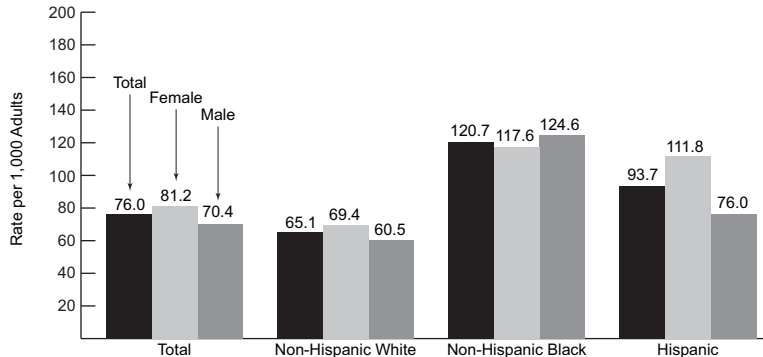
In 2005–2006, 76.0 per 1,000 adults reported that they had been told by a health professional that they have diabetes. Women were more likely than men to have diabetes overall (81.2 versus 70.4 per 1,000 adults) and in most racial and ethnic groups. Among women, non-Hispanic

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

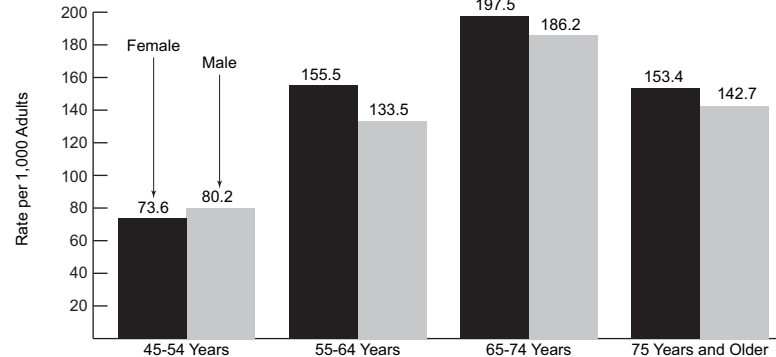
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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

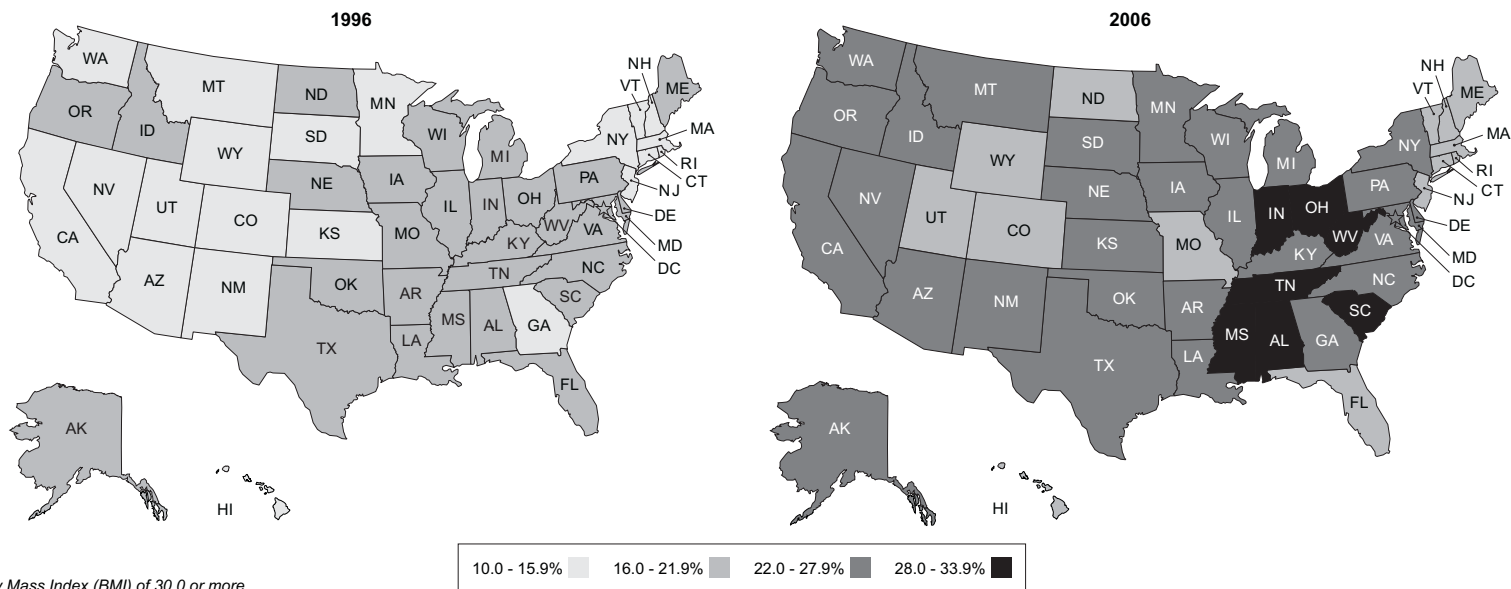
are based on Body Mass Index (BMI), which is a ratio of weight to height. Overweight is defined as a BMI of 25.0–29.9, and obese is defined as a BMI of 30.0 or more; a BMI of 18.5–24.9 is considered normal, while a BMI below 18.5 is considered underweight.

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

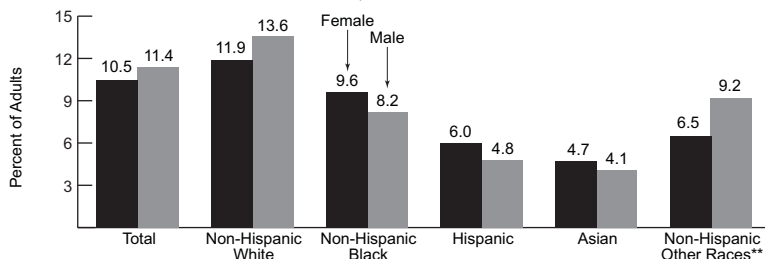
In 2006, adult women were slightly less likely than men to have ever been told by a health professional that they have a heart condition or heart disease (10.5 versus 11.4 percent). This varied by race and ethnicity. Among non-Hispanic Whites and non-Hispanic other races, men were more likely than women 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

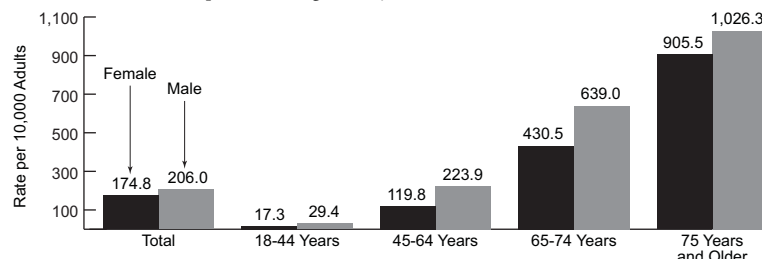
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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.

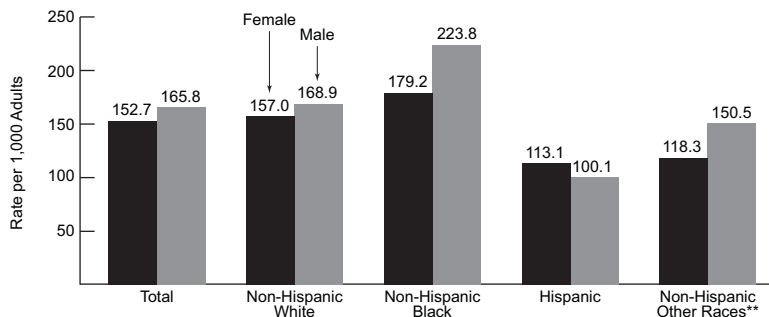
Rates of hypertension increase substantially with age and are highest among those aged 75 years and older, which demonstrates the chronic nature of the disease. Nearly 25 per 1,000 women aged 18–44 years had hypertension in 2005–2006, compared to 374.7 per 1,000 women aged 65–74 years and 462.7 per 1,000 women aged 75 years and older. Nearly 20 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

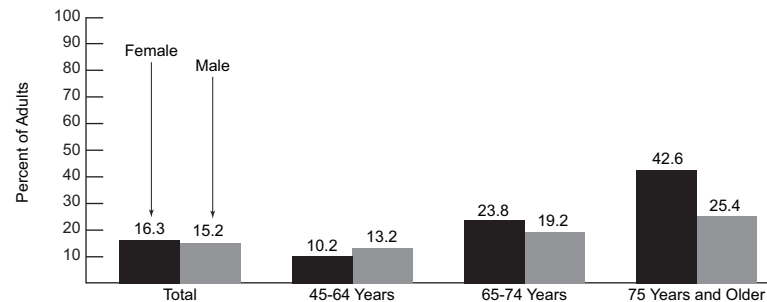
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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).

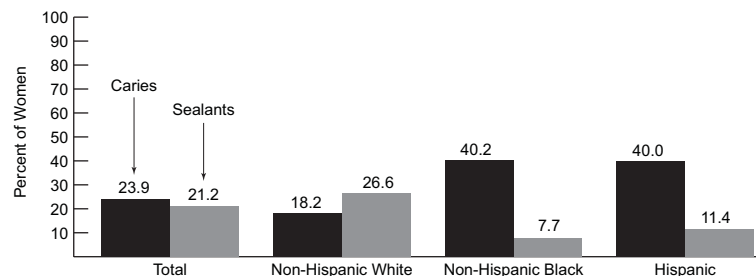
The presence of untreated caries also varied by poverty status. Women with household incomes

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

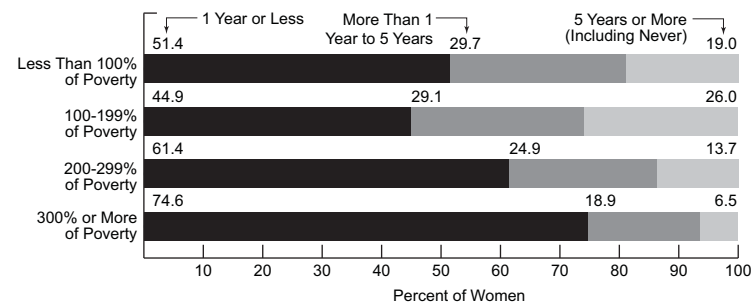
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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

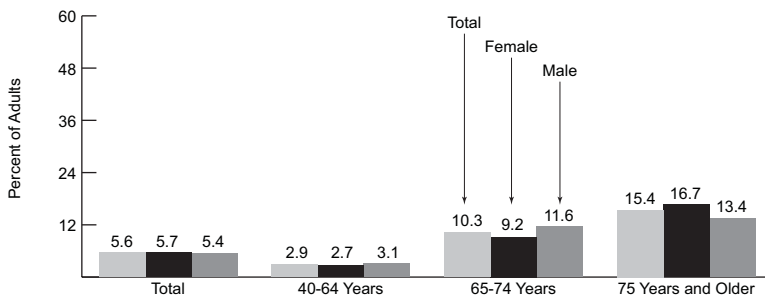
women were most likely to have had glaucoma (9.4 percent), compared to non-Hispanic White and Hispanic women (5.7 and 2.0 percent, respectively; data not shown).

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

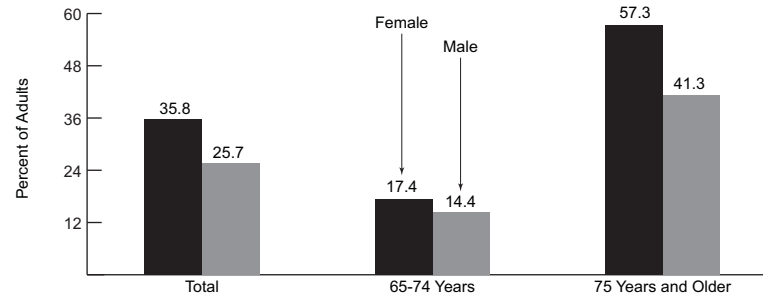
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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.

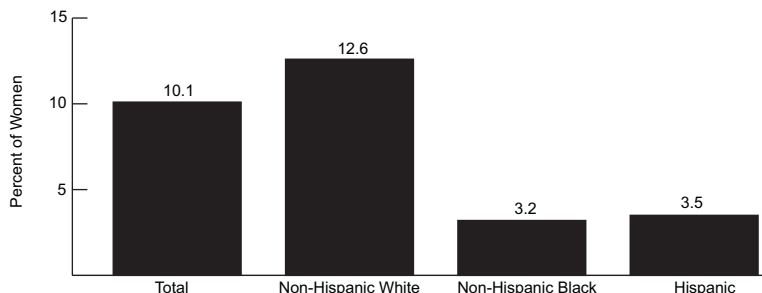
In 2005 there were 215,000 hospital discharges due to hip fractures among women aged 18 and

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

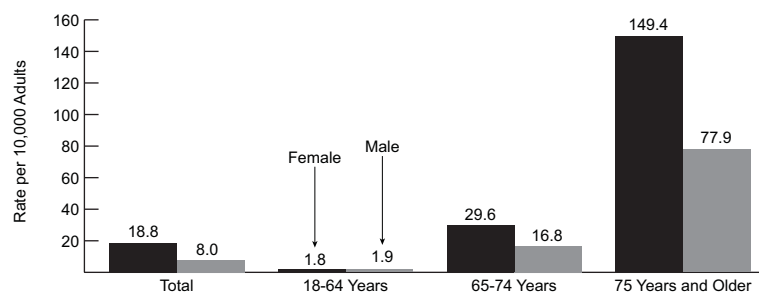
Source IL.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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 IL.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).

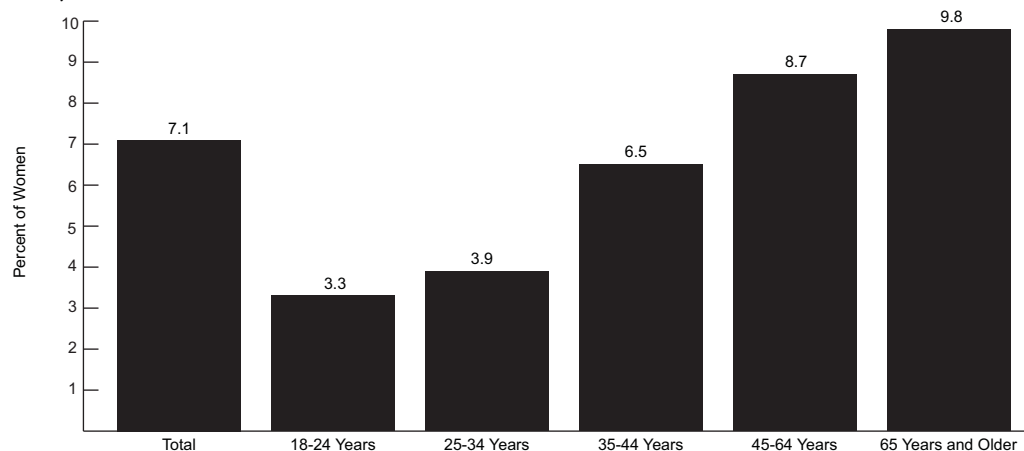
There was little variation among women reporting having ever had an ulcer by race and ethnicity. Non-Hispanic White women were most likely to report having had an ulcer (7.7 percent), followed by non-Hispanic Black women (6.2 percent), and Hispanic women (5.8

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

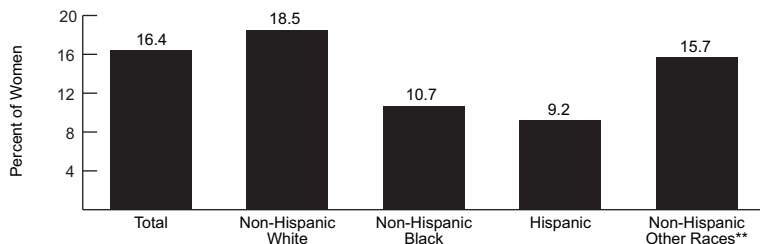
Hyperthyroidism and hypothyroidism are also common endocrine disorders. In 2005–2006, women were more likely than men to report having ever been told by a health professional that they have a thyroid problem (16.4 versus 3.4 percent). Among women, rates varied by race and

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

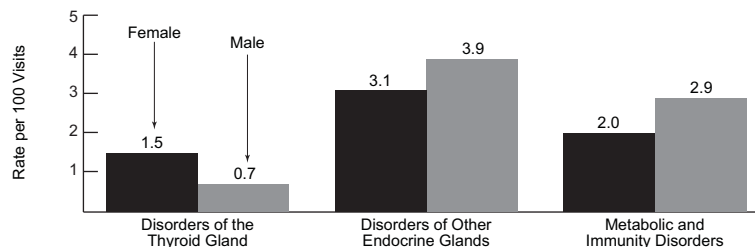
Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*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.

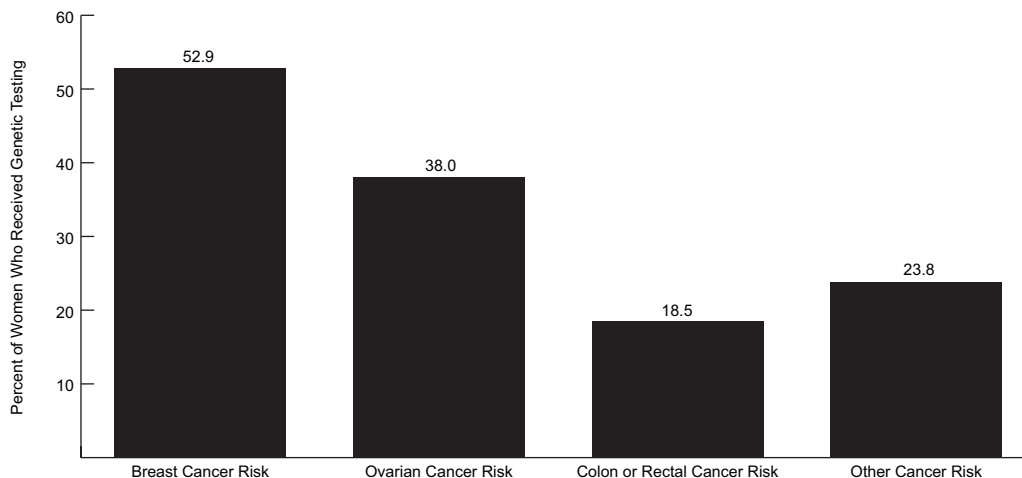
Type 2 diabetes is also a major cause of morbidity in women. Although obesity and reduced physical activity are the most important risk factors for type 2 diabetes, the greater the number of relatives affected with diabetes the higher the risk to family members.

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.

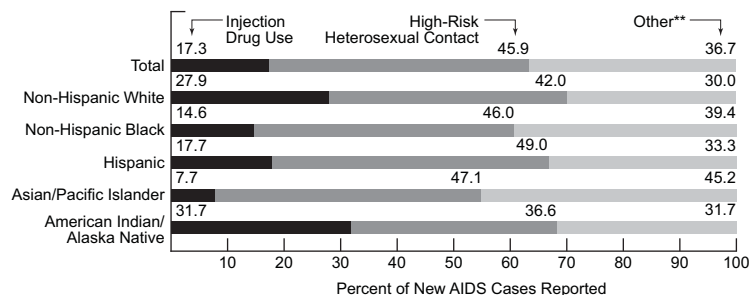
In 2006, an estimated 131,195 adolescent and adult females were living with HIV/AIDS.²⁸

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*

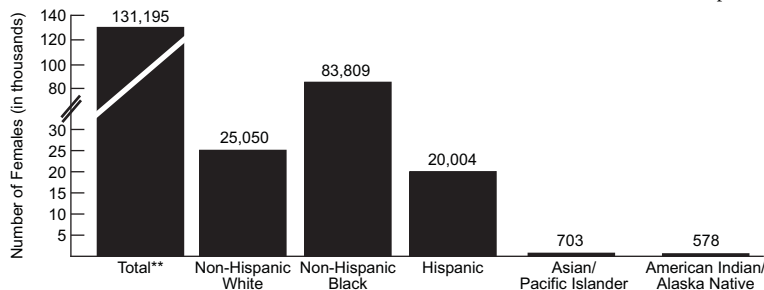
Source II.13: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*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).

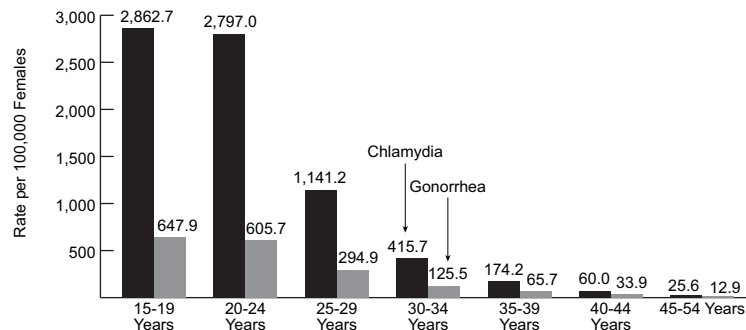
Although these STIs are treatable with antibiotics, they can have serious health consequences. Active infections can increase the likelihood of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes.

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

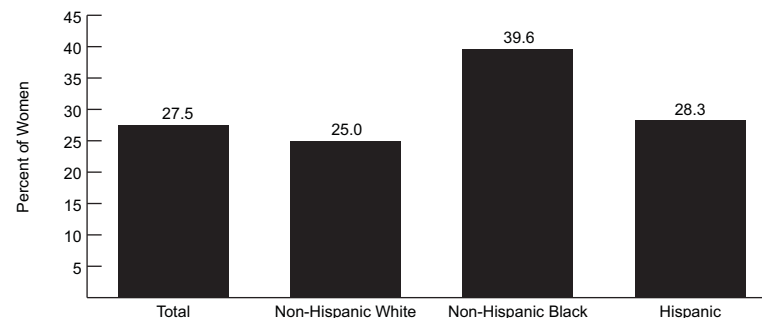
Rates of Chlamydia and Gonorrhea Among Females Aged 15–54, by Age, 2006

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



Genital Human Papillomavirus (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

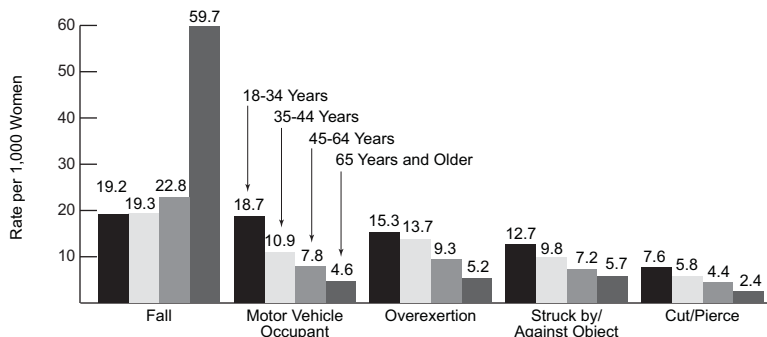
Often, injuries can be controlled by either preventing an event (such as a car crash) or lessening its impact. This can occur through education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples 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).

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

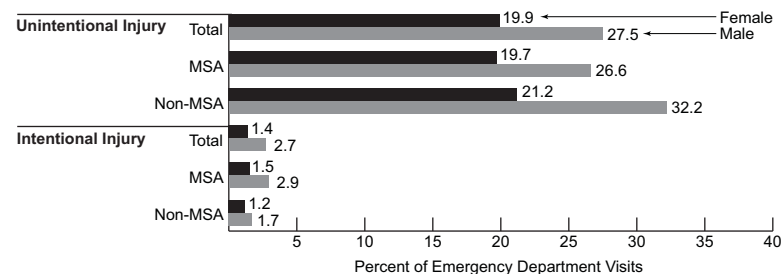


*All of the leading causes of injury in 2006 were unintentional.

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.

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

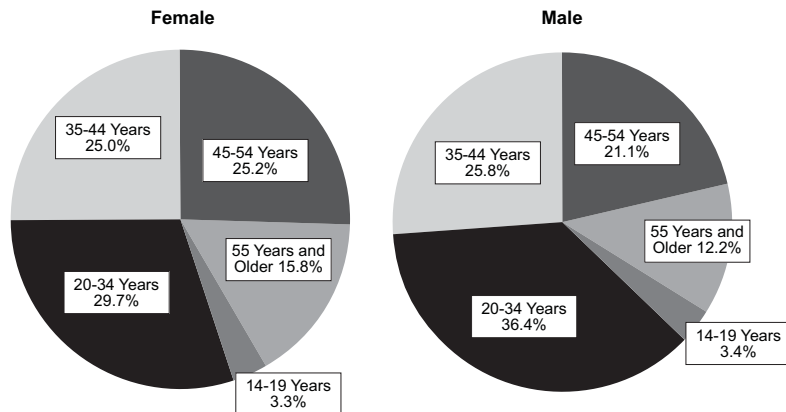
injuries among females occurred among women aged 55 years and older, while males of this age group accounted for 12.2 percent of injuries.

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.)

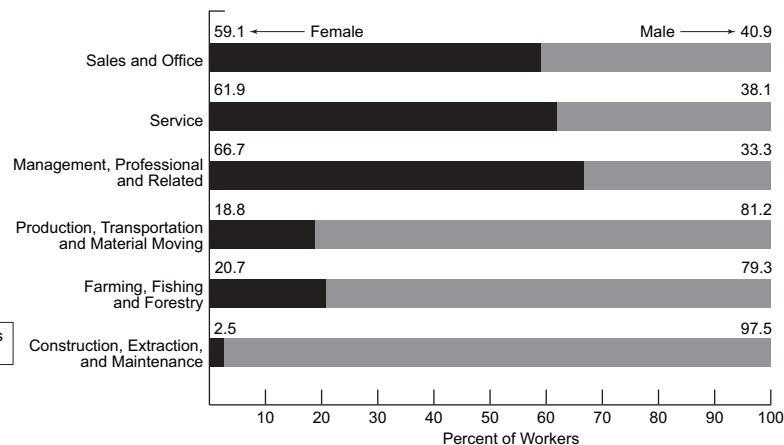
Nonfatal Occupational Injuries and Illnesses of Workers Aged 14 and Older, by Sex and Age,* 2006

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.

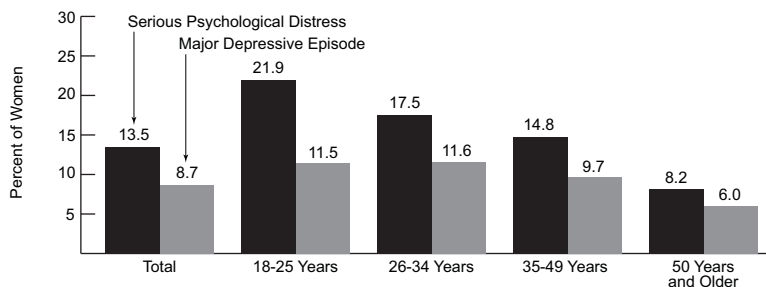
Serious psychological distress and major depressive episodes among women also vary by race and ethnicity. In 2006, American Indian/Alaska Native women were most likely to have experienced both disorders (26.8 and 16.6 percent, respectively). Asian/Pacific Islanders were least likely to have experienced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

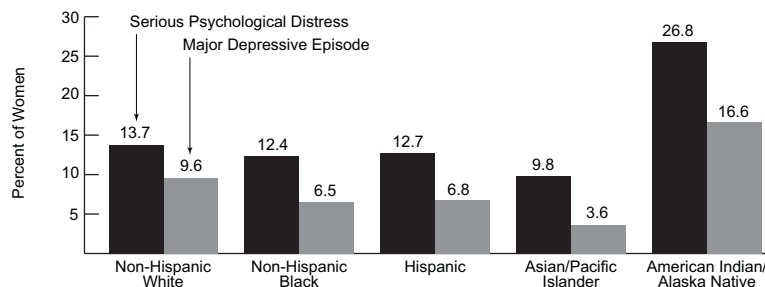
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Serious psychological distress 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.

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



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).

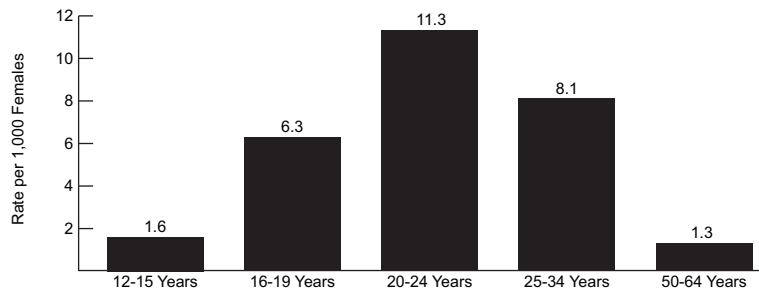
During this same time period, females in households with annual incomes below \$7,500

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 department³⁷ 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).

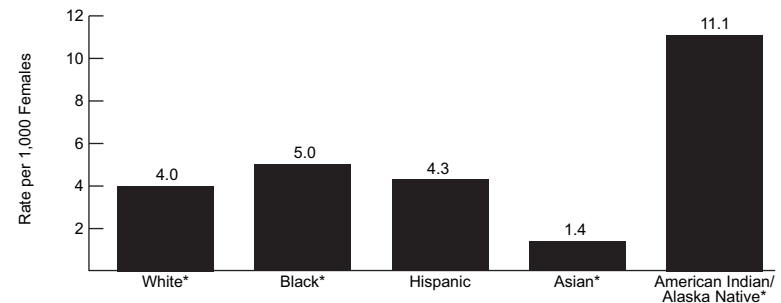
Intimate Partner Violence Among Females Aged 12–64, by Age, 2001–2005

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).

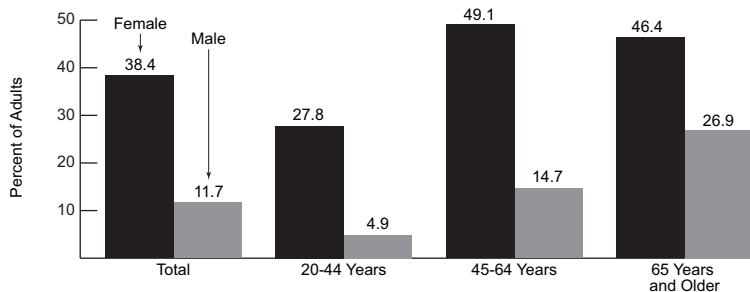
Among women with urinary leakage, 38.7 percent reported that it occurred less than once a month, while 28.3 percent reported occurrence a few times a month. Nearly 16 percent of those

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.

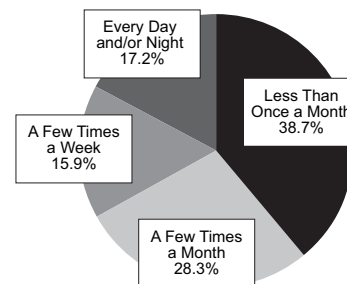
Adults Aged 20 and Older Reporting Urinary Leakage, by Age and Sex, 2005–2006

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

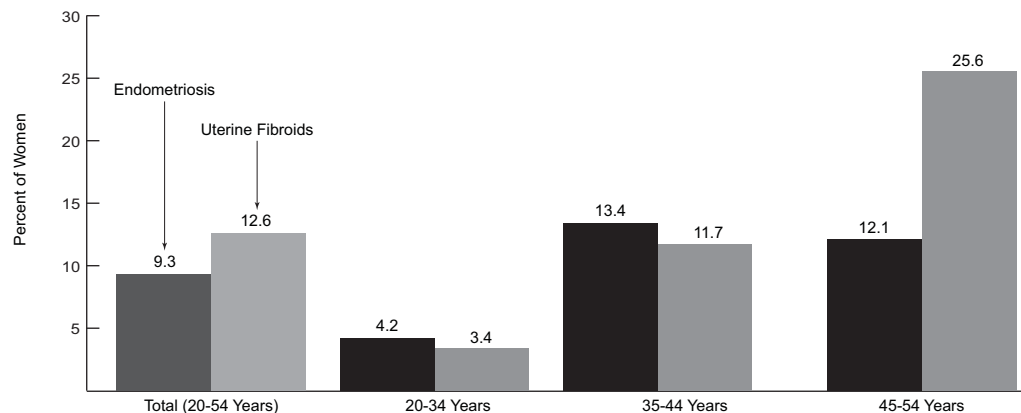
Reproductive disorders may affect a woman's ability to get pregnant. Examples of these disorders include polycystic ovary syndrome (PCOS), endometriosis, and uterine fibroids. PCOS occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. 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).

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



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).

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*

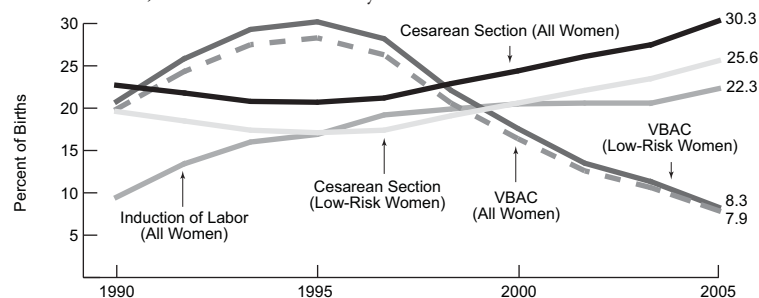
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	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.

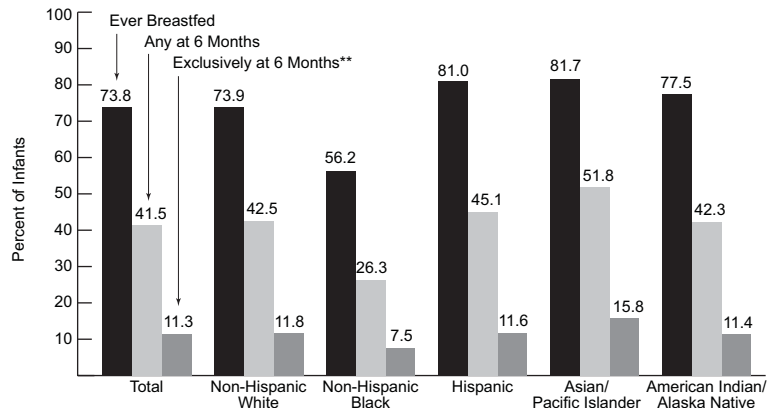
Breastfeeding practices vary considerably by maternal age, educational attainment, and marital status. For instance, infants born to college graduates were most likely to have ever been breastfed (85.3 percent), while infants born to

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

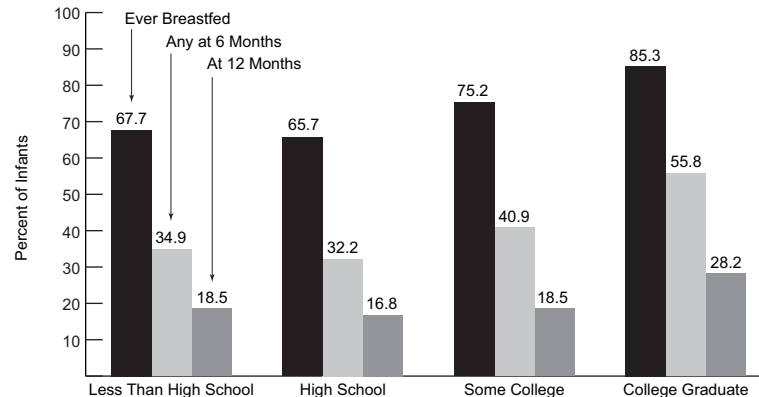
Source II.24: Centers for Disease Control and Prevention, National Immunization Survey



*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.

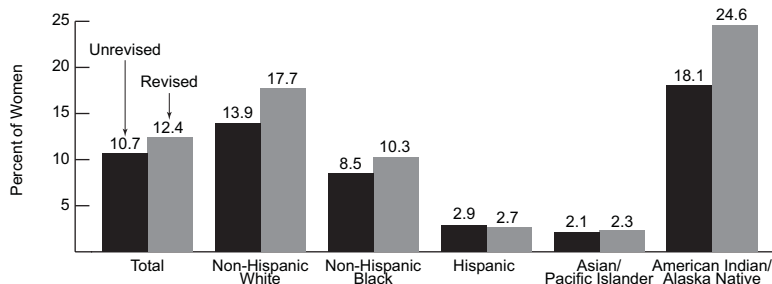
Among women in the unrevised reporting areas, American Indian/Alaska Native mothers were most likely to have smoked during pregnancy (18.1 percent), followed by non-Hispanic White women (13.9 percent). Smoking during pregnancy was higher among pregnant women in areas using the revised birth certificate (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

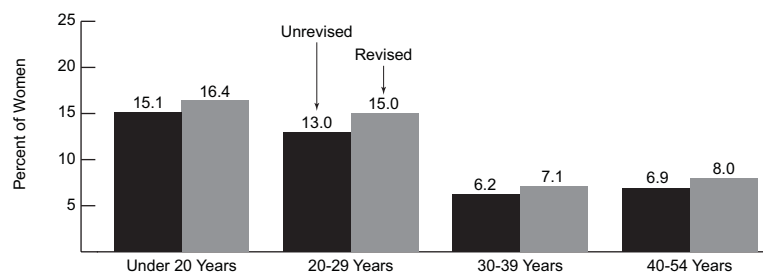
Source II.23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*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.

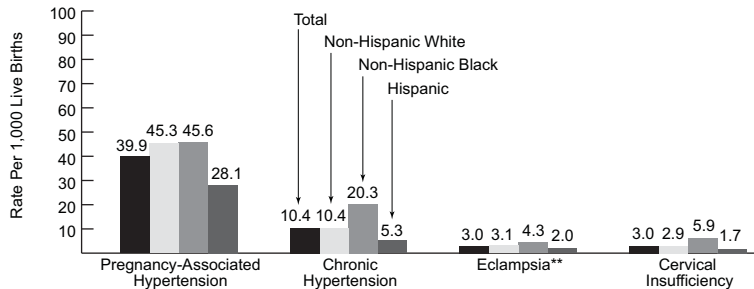
Other illnesses or risk factors during pregnancy can include eclampsia, which involves seizures (usually preceded by a diagnosis of preeclampsia), and cervical insufficiency, which occurs when the cervix opens or dilates before the fetus is full term.

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

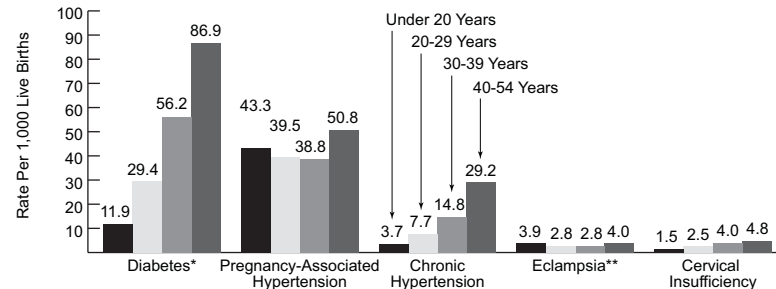
Source II.21, 22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*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

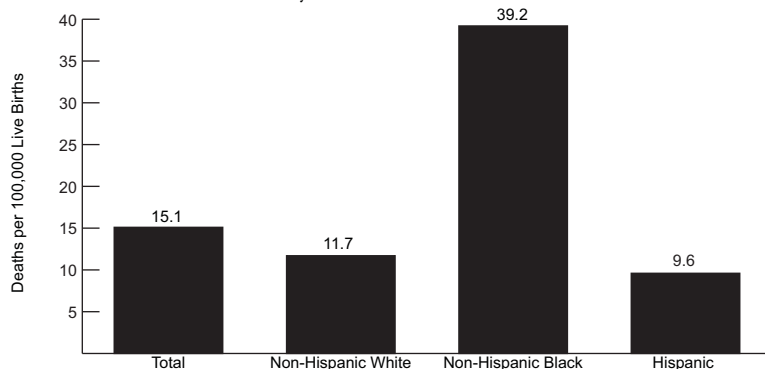
In 2005, there were a total of 623 maternal deaths. This does not include the 137 deaths of women due to complications during pregnancy or childbirth after 42 days postpartum or the deaths of pregnant women due to external causes such as unintentional injury, homicide, or suicide. In 2005, the maternal 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

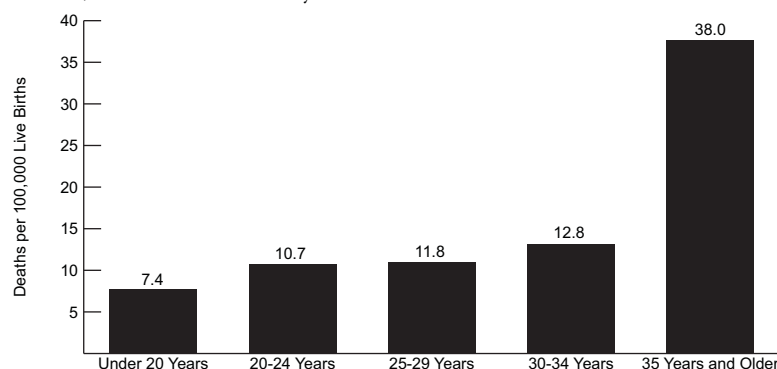
Source II.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*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

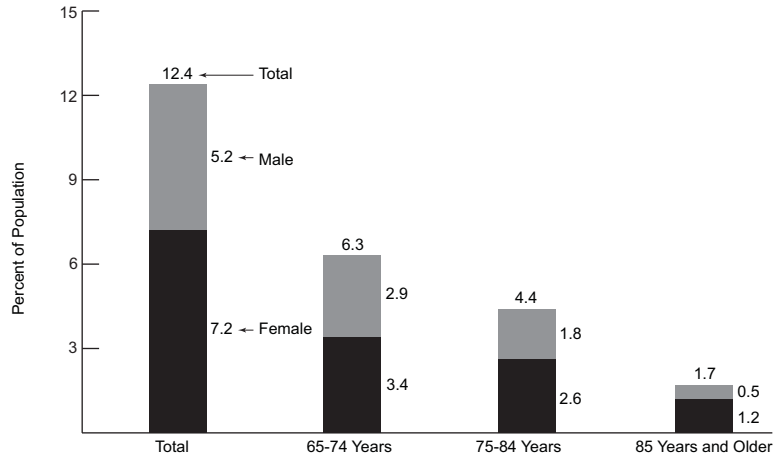
larger proportion of the elderly population than men within every age group.

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

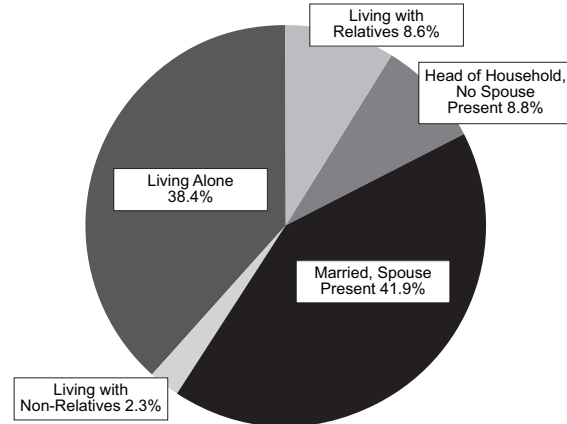
Source I.1: U.S. Census Bureau, American Community Survey



*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.

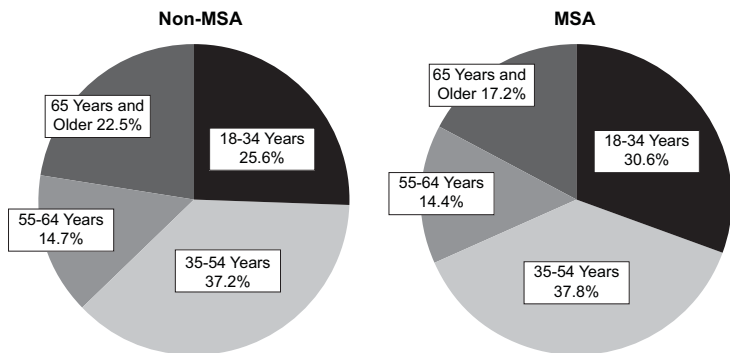
In 2005, 22.5 percent of women in non-metropolitan areas were aged 65 years and older, while only 17.2 percent of women in metropolitan areas were in the same age group. Fewer than 26 percent of women in non-metropolitan areas were aged 18–34 years, compared to 30.6 percent in metropolitan areas. Women 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.

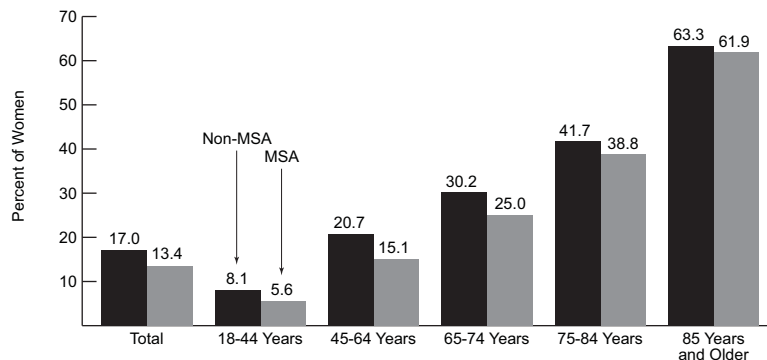
Women Aged 18 and Older, by Area of Residence* and Age, 2005

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.

HEALTH SERVICES UTILIZATION

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

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



USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,¹ to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),² to receive continuous care, and to have lower rates of hospitalization and lower health care costs.³ In 2006, 89.1 percent of women reported having a usual source of care. Women of all racial and ethnic groups were more likely than men to have a usual source of care. Non-Hispanic

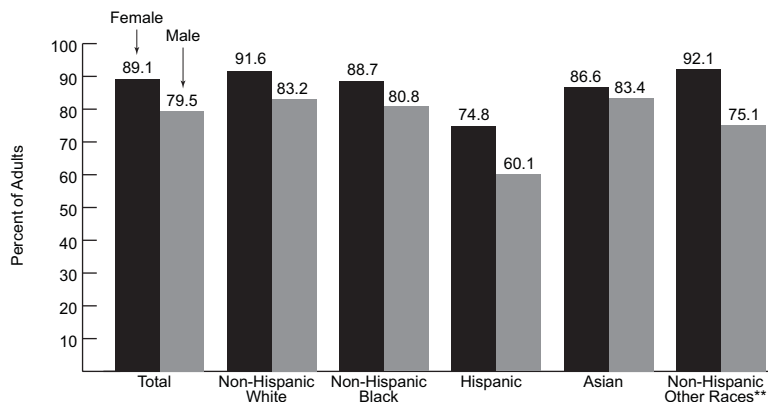
women of other races and non-Hispanic White women were most likely to report a usual source of care (92.1 and 91.6 percent, respectively). Among women, Hispanics were least likely to report a usual source of care (74.8 percent).

In 2006, the percentage of women with a usual source of care varied by geographic region and poverty level. Among women with household incomes of 200 percent or more of poverty, there was little variation in having a usual source of care by geographic region. Among women with lower incomes, however, having a usual source of care

varied significantly by geographic region. Women with incomes of less than 200 percent of poverty in the South and West were least likely to have a usual source of care (77.3 and 80.0 percent, respectively), while low-income women in the Northeast were most likely to have a usual source of care (91.3 percent).

Adults Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity and Sex, 2006*

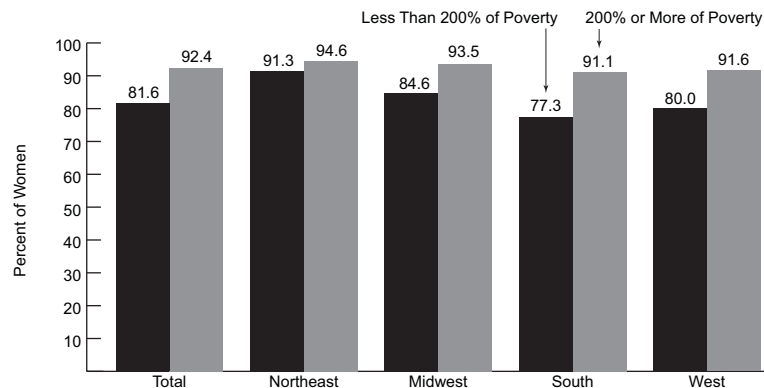
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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.

Women Aged 18 and Older with a Usual Source of Care, by Geographic Region and Poverty Level,* 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. Rates reported are not age-adjusted.

HEALTH INSURANCE

People who are uninsured are less likely than those with insurance to seek health care, which can result in poor health outcomes and higher health care costs. In 2006, 37.8 million adults aged 18–64 years in the United States, representing 20.2 percent of that population, were uninsured (data not shown).⁴ The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race/ethnicity, income, and education.

In 2006, among adults aged 18 and older, younger persons were most likely to lack health insurance, and men were more likely than women

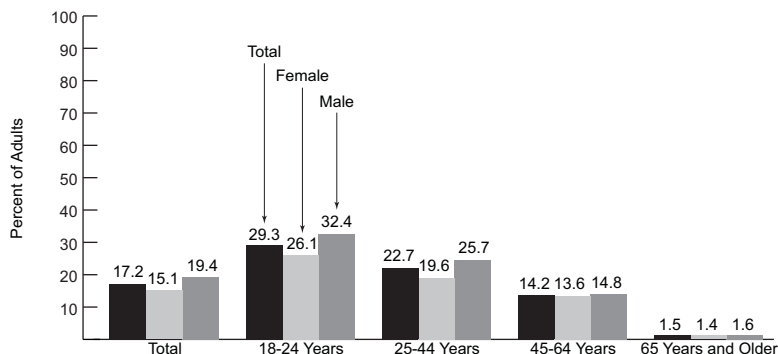
to be uninsured in every age group. The largest percentage of uninsured persons occurred among 18- to 24-year-old males (32.4 percent), which was significantly higher than the percentage for women of the same age group (26.1 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest percentage of uninsured occurred among women and men aged 45–64 (13.6 and 14.8 percent, respectively); the sex disparity in this age group was less pronounced than in the younger age groups.

Among women aged 18–64 in 2006, 71.5 percent had private insurance, 14.4 percent had

public insurance, and 18.1 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (78.9 percent), followed by Asian/Pacific Islander women (74.8 percent). Non-Hispanic Black females had the highest rate of public insurance (22.1 percent) followed closely by American Indian/Alaska Native women (21.2 percent). Hispanic females had the highest rate of uninsurance (38.7 percent), followed by American Indian/Alaska Native women (36.0 percent). [Respondents were able to report more than one type of coverage.]

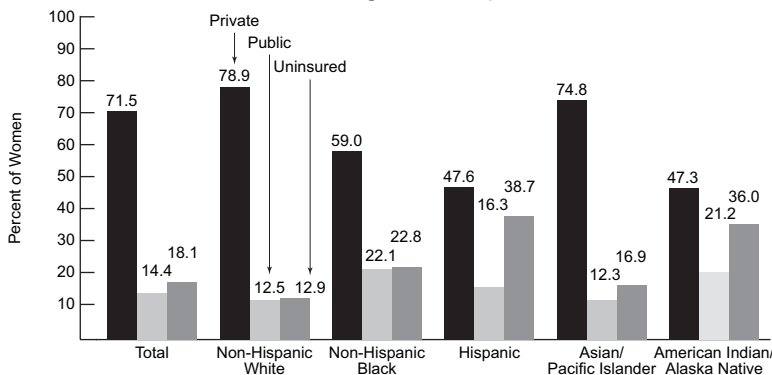
Adults Aged 18 and Older Without Health Insurance, by Sex and Age, 2006

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



Health Insurance Coverage of Women Aged 18–64, by Type of Coverage and Race/Ethnicity,* 2006

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



*Percentages may equal more than 100 because it was possible to report more than one type of coverage.

MEDICARE AND MEDICAID

Medicare is the Nation's health insurance program for people aged 65 and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase additional insurance coverage through private insurers, and Part D allows coverage for prescription drugs through private insurers.

In 2006, 55.8 percent of Medicare's 43.3 million enrollees were female. As age increases the proportion of female enrollees increases while the proportion of male enrollees decreases. For instance, among Medicare enrollees under 45 years of age, 45.2 percent were female while 54.8 percent were male. Among adults aged 85 years and older, however, females accounted for 69.0 percent of enrollees, and males accounted for 31.0 percent.

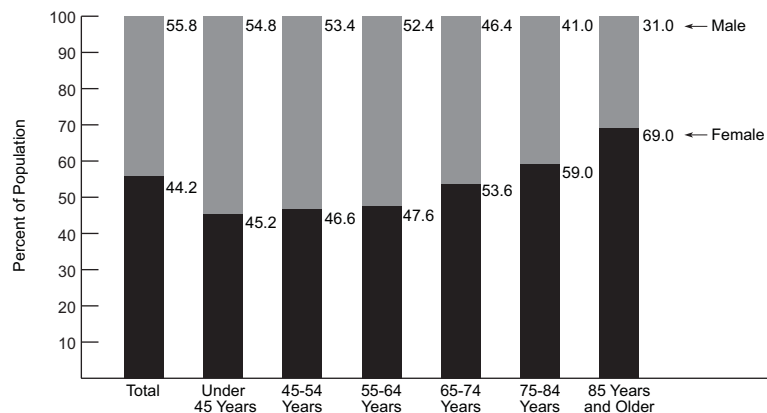
Of the 16.7 million enrollees in the Medicare Part D stand-alone prescription drug program in 2007, 61.5 percent were female. Females accounted for a larger proportion of Part D

enrollees in every age group, excluding those under 55 years, in which 46.5 percent were female and 53.5 percent were male. Among enrollees aged 75–89 years, 68.8 percent, or 4.0 million, were women.

Medicaid, jointly funded by Federal and State governments, provides coverage for low-income people and people with disabilities. In 2005, Medicaid covered 58.7 million including children; the aged, blind, and disabled; and adults who were eligible for cash assistance programs. Overall, 59.4 percent of all Medicaid enrollees were female; of adults enrolled in Medicaid, 69.4 percent were women (data not shown).

Medicare Enrollees,* by Age and Sex, 2006

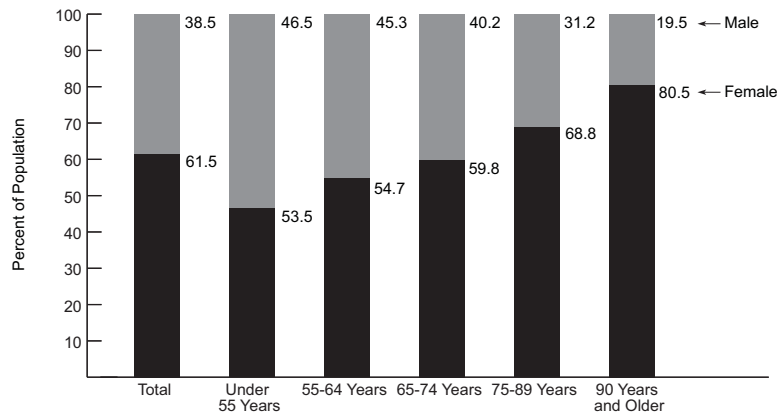
Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2006.

Medicare Part D Enrollees,* by Age and Sex, 2007

Source III.1: Centers for Medicare and Medicaid Services



*Enrollees in stand-alone prescription drug plans only, as of July 1, 2007.

PREVENTIVE CARE

Counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2005, females of all ages made 560 million physician office visits. Of these visits, 19.7 percent were for preventive care, including prenatal care, health screening, and insurance examinations (data not shown).⁵ Routine Pap smears, which detect the early signs of cervical cancer, are recommended at least every 3 years beginning within 3 years of initiation of sexual activity, or by age 21.⁶ Among women aged 21 years and older in 2005, 51.8 percent received a Pap smear in the past 3 years, while another 12.1 percent had received a Pap smear more than

3 but less than 5 years ago. More than 36 percent of women aged 21 years and older had no Pap smear within the past 5 years.

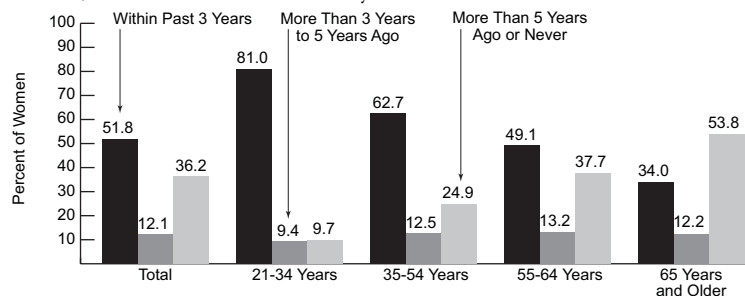
The percentage of women receiving a Pap smear within the recommended timeframe decreases with age. In 2005, women aged 21–34 years were most likely to have had a Pap smear in the previous 3 years (81.0 percent), and were least likely to have not had a Pap test in the previous 5 years (9.7 percent). Women aged 65 years and older were least likely to have received a Pap test in the past 3 years (34.0 percent) and most likely to have not had one in the past 5 years (53.8 percent). Nearly 25 percent of women aged 35–54 and 37.7 percent of women aged 55–64

had not had a Pap test in the previous 5 years.

High cholesterol is a risk factor for heart disease. The Healthy People 2010 goal is to increase the percentage of adults aged 20 and over who receive a cholesterol screening at least every 5 years.⁷ In 2005, 72.1 percent of women aged 20 years and older had received a cholesterol test within the previous 5 years. Non-Hispanic White and non-Hispanic Black women were more likely to have had the test (75.7 and 71.3 percent, respectively), compared to Hispanic women and non-Hispanic women of other races (53.5 and 64.7 percent, respectively).

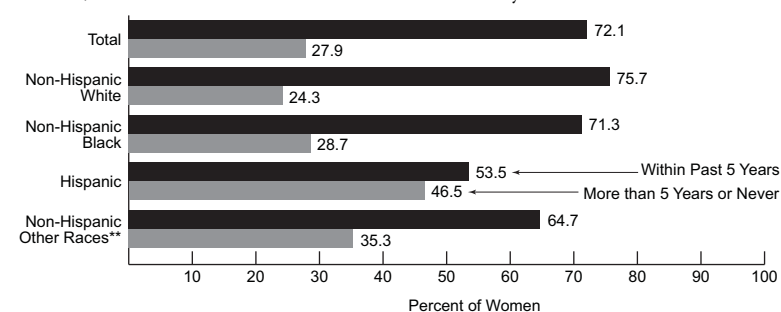
Receipt of Pap Smears Among Women Aged 21 and Older, by Age and Time Since Last Test, 2005

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



Receipt of Cholesterol Screening Among Women,* by Race/Ethnicity and Time Since Last Test, 2005–2006

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



*Women aged 20 and older only. **Includes Asian/Pacific Islander, American Indian/Alaska Native, persons of more than one race, and persons of all other races unspecified.

VACCINATION

Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for young children, pregnant women, persons with certain chronic medical conditions, and adults aged 50 years or older.⁸ In 2006, nearly 40 percent of women aged 55–64 years and 64.6 percent of women aged 65 years and older reported receiving a flu vaccine in the past year; this varied, however, by race and ethnicity. Non-Hispanic White women were more likely than women of other races and ethnicities to have received the flu vaccine; 41.6 percent of 55- to 64-year-olds and 67.3 percent of those aged 65 years and older did so. Fewer than 48 percent of

non-Hispanic Black and Hispanic women aged 65 years and older received the flu vaccine.

Pneumonia vaccine is recommended for adults aged 65 years and older and for people with certain health conditions. In 2006, 60.0 percent of women aged 65 and older reported ever receiving the vaccine. In this age group, Non-Hispanic White women were most likely to have ever received the pneumonia vaccine (64.0 percent), compared to 34.4 percent of Hispanic women and 42.2 percent of non-Hispanic Black women.

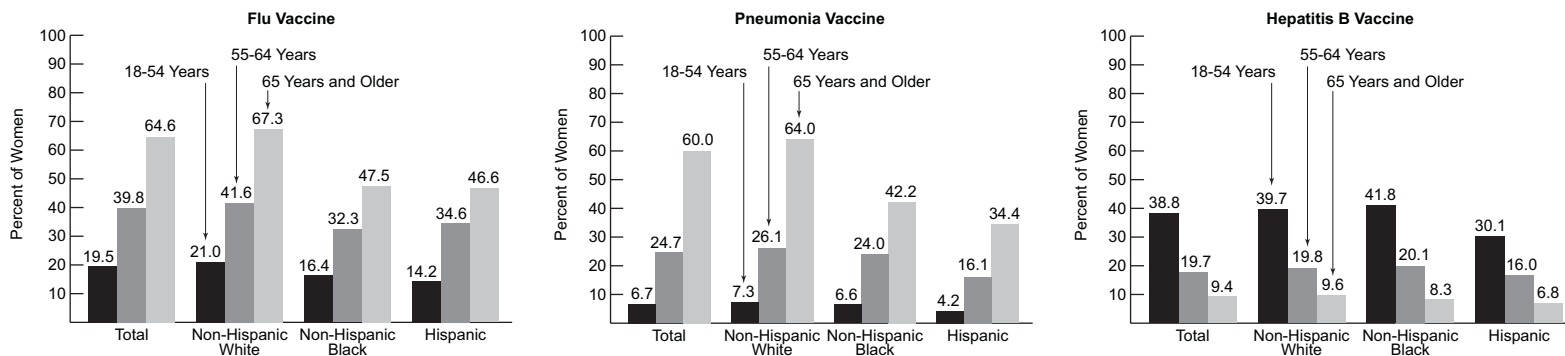
Hepatitis B vaccine is recommended to reduce the spread of hepatitis B, which may result in cirrhosis of the liver, liver cancer, liver failure, and even death.⁹ Hepatitis B vaccination also varied

by race/ethnicity and age. Younger women were most likely to have received at least one of the three recommended doses, and non-Hispanic White and non-Hispanic Black women in every age group were more likely than Hispanic women to have received the vaccine.

Genital human papillomavirus (HPV) can cause cervical cancer and other diseases in women. In 2006, the HPV vaccine was recommended for adolescent females and young women aged 9–26 years;¹⁰ since 2006, 10 percent of women aged 18–26 years have been vaccinated for HPV (data not shown).¹¹

Receipt of Selected Vaccinations* Among Women Aged 18 and Older, by Race/Ethnicity** and Selected Age Group, 2006

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



*Having received the flu vaccine in the past 12 months; having ever received the pneumonia vaccine; and having ever received at least one dose of the three-dose hepatitis B vaccine. **Sample sizes for Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified were too small to produce reliable results. Totals include all races/ethnicities.

HOSPITALIZATIONS

Females represented 59.9 percent of the 34.7 million short-stay hospital discharges in 2005. More than 19 percent of hospital stays for all females were due to childbirth, while 14.6 percent were due to diseases of the circulatory system. Other common reasons for hospitalization included diseases of the respiratory, digestive, and genitourinary systems; injury and poisoning; and mental disorders. Overall, females had a higher hospital discharge rate than males in 2005

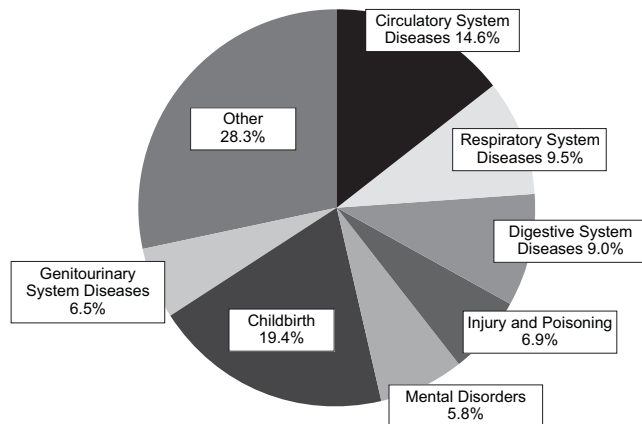
(1,382.2 versus 959.0 per 10,000 population; data not shown).

Males and females also had different rates of procedures for discharges from short-stay hospitals. Overall procedure rates were 1,794.5 procedures per 10,000 females (this includes 456.5 obstetrical procedures per 10,000 females) and 1,241.1 procedures per 10,000 males. Several of the procedures for which females had a higher hospital discharge rate than males included operations on the digestive system (210.7 versus

166.5 per 10,000) and operations on the reproductive organs, including hysterectomy (130.9 versus 16.1 per 10,000). Males had a higher rate than females for operations on the cardiovascular system (280.2 versus 194.8 per 10,000). Among females, the highest rate of procedures for discharges from short-stay hospitals was obstetrical procedures (456.5 per 10,000).

Discharges from Non-Federal, Short-Stay Hospitals Among Females of All Ages,* by Diagnosis, 2005

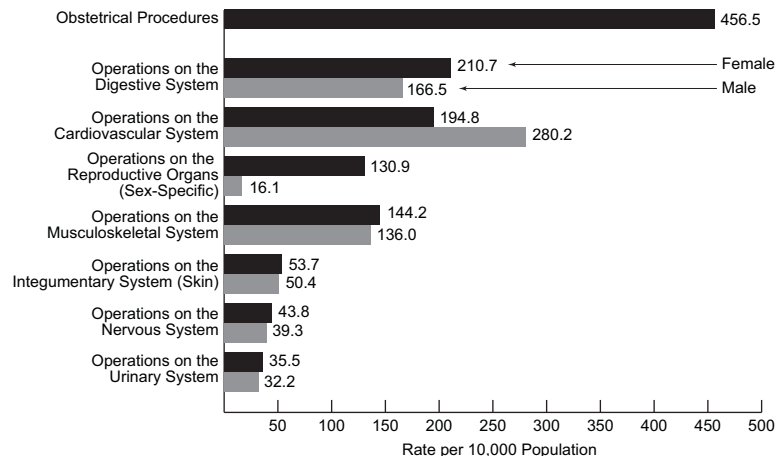
Source III.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Procedure Category, All Ages,* 2005

Source III.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

HEALTH CARE EXPENDITURES

In 2005, the majority of health care expenses of both women and men were covered by public or private health insurance. Among women, more than one-third of expenses were covered by either Medicare or Medicaid, while 40.3 percent of expenses were covered by private insurance. Although the percentage of expenditures paid through private insurance was similar for both sexes, health care costs of women were more likely

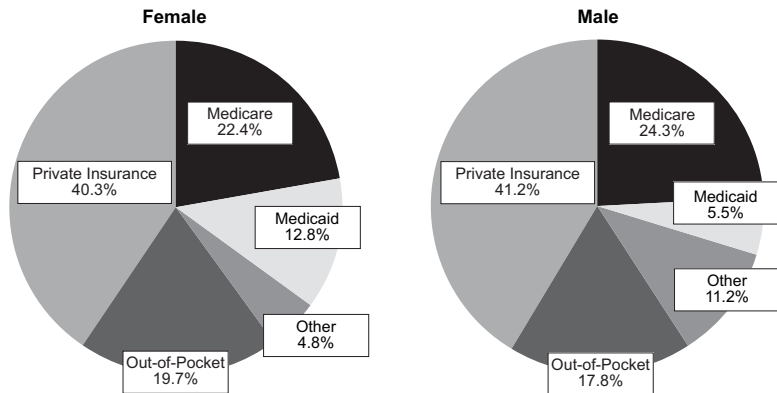
than those of men to be paid by Medicaid or out-of-pocket.

In 2005, 91.0 percent of women had at least one health care expenditure, compared to 77.7 percent of men. Among those who had at least one health care expense in 2005, the average per person expenditure, including expenses covered by insurance and those paid out-of-pocket, was higher for women (\$5,211) than for men (\$4,514). However, men's average expenditures exceeded women's for hospital inpatient services

(\$17,401 versus \$12,556, respectively) and hospital outpatient services (\$2,440 versus \$1,909). Women's expenditures exceeded men's in the categories of home health services, office-based medical services, and prescription drugs. Overall per capita health care expenditures have increased substantially and at about the same rate for both men and women since the 1990's. In 2005, the annual mean health care expenses for both men and women were approximately 58 percent higher than in 1999.

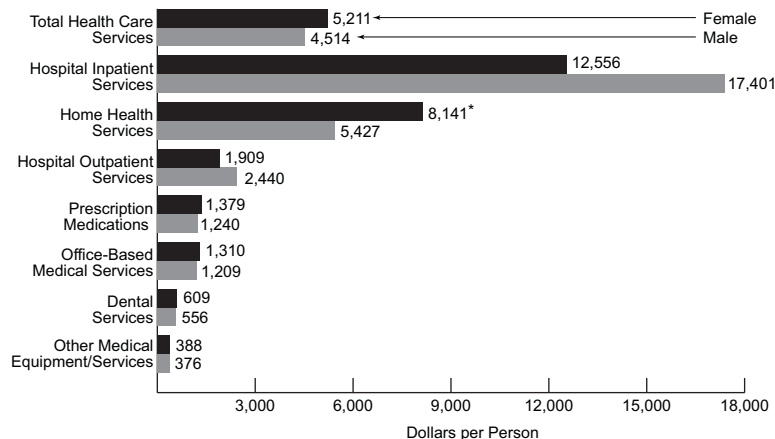
Health Care Expenses of Adults Aged 18 and Older, by Source of Payment and Sex, 2005

Source III.3: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Sex and Category of Service, 2005

Source III.3: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*This statistic should be interpreted with caution; the relative standard error is greater than 30 percent.

MEDICATION USE

In 2005, medication was prescribed or provided by a physician at nearly 680 million, or 70.5 percent of, physician office visits; multiple drug prescriptions were recorded at 45.9 percent of all visits. The percent of visits with one or more drugs prescribed or provided was similar for males and females (70.9 and 69.9 percent, respectively). Among females of all ages, 29.1 percent of visits did not involve prescribing or providing any drugs, 24.9 percent of visits involved the prescription or provision of one drug, and 14.0 percent of visits involved two drugs. An additional 32.1 percent of visits involved the prescription or provision of 3 or more drugs.¹²

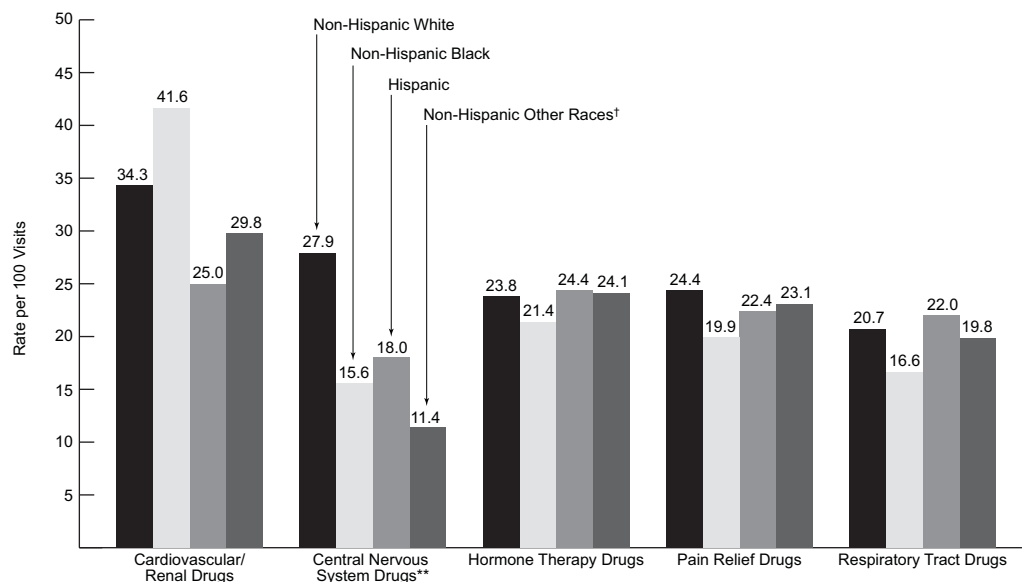
The prescription and provision of medications to females varies by race/ethnicity and drug type. In 2005, the rate of cardiovascular/renal drugs prescribed or provided at physician office visits was highest among non-Hispanic Black females (41.6 per 100 office visits), while non-Hispanic white females were most likely to receive central nervous system drugs (anti-depressants, antipsychotics, sedatives, and anxiety medications; 27.9 per 100 visits). Hispanic females were the most likely to have respiratory tract drugs provided or prescribed (22.0 per 100 visits). There was little variation between females of different races and ethnicities in the use of hormone therapy drugs.

The rate of medications provided and prescribed to females during physician office visits also varies by age. For instance, women aged 45–64 years were the most likely to have central nervous system drugs prescribed or provided (34.1 per 100 visits), while women aged 75 and

older were most likely to receive cardiovascular/renal drugs (85.9 per 100 visits) and pain relief drugs (34.6 per 100 visits). Respiratory drugs were most likely to be prescribed or provided to girls under 15 years of age (25.9 per 100 visits, data not shown).

Medications Reported* During Physician Office Visits Among Females (All Ages), by Race/Ethnicity, 2005

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



*Medications that were prescribed, provided, or continued. **Includes antidepressants, antipsychotics, sedatives, and anxiety medications.

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

MENTAL HEALTH CARE UTILIZATION

In 2006, more than 28 million adults in the United States reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services, including inpatient and outpatient care and prescription medications. More than 16 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.2 percent of women aged 18 and older, compared to 7.2 percent of men. Outpatient treatment was reported by 8.4 percent of women, and inpatient treatment was reported by 0.7 percent of women.

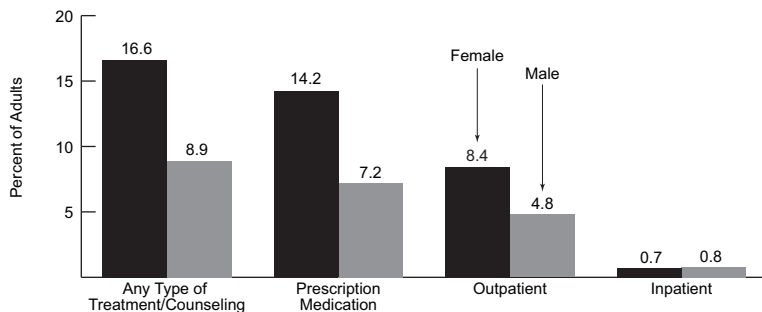
Mental health services were needed, but not received, by an estimated 10 million adults in the United States. In 2006, 5.9 percent of women and 3.2 percent of men reported an unmet need for mental health treatment or counseling. Cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services, reported by 50.1 percent of women and 43.7 percent of men with unmet mental health treatment needs. Others mentioned feeling that they could handle their problems without treatment (reported by 28.5 percent of women and 33.3 percent of men with unmet needs). In addition, stigma, including concern about confidentiality or the opinions of

others, or the potential effect on employment, prevented 20.4 percent of women and 29.6 percent of men with unmet needs from receiving treatment.

Among women, unmet need for treatment varied by race and ethnicity. Non-Hispanic American Indian/Alaska Native women were most likely to report an unmet need for treatment (8.2 percent), followed by non-Hispanic White women (6.4 percent). Additionally, 4.7 percent of non-Hispanic Black women, and 4.1 percent of Hispanic women had an unmet need for treatment. Asian/Pacific Islander women were least likely to report an unmet need for mental health treatment (3.6 percent; data not shown).

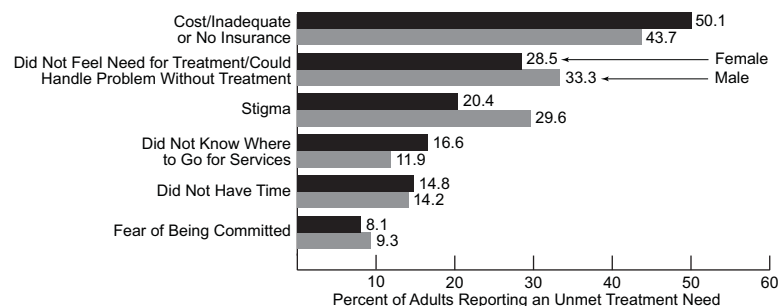
Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Sex and Type, 2006

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



Reasons for Unmet Mental Health Treatment* Needs Among Adults Aged 18 and Older, by Sex, 2006

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



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

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

HIV TESTING

Today, people aware of and receiving appropriate care for their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek care and prevent the spread of HIV. HIV testing requires only a simple blood or saliva test, and it is often offered confidentially or anonymously. It is recommended that people who meet any of the following criteria be tested periodically for HIV: those who have injected drugs or steroids, or shared drug use equipment

(such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of these criteria.¹³ In addition, the CDC recommends that all pregnant women be tested for HIV during their pregnancy. In 2006, new CDC guidelines were released that recommend all health care providers include HIV testing as part of their patients' routine health care. Counseling patients on ways to prevent HIV

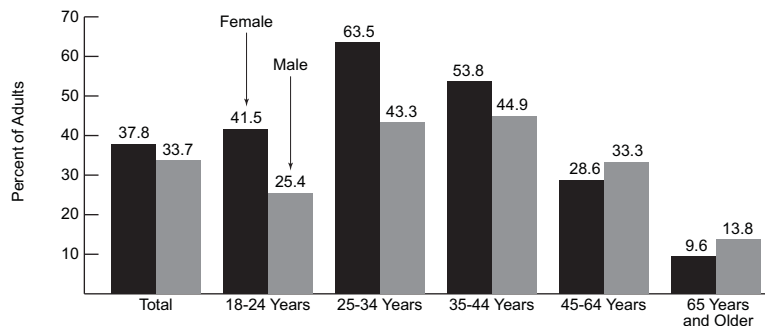
infection or spreading the virus is part of good primary care practice.

In 2006, nearly 36 percent of adults in the United States had ever been tested for HIV. Overall, women were more likely than men to have been tested (37.8 versus 33.7 percent). Women were more likely to have been tested at younger ages, while men were more likely to have been tested at older ages.

Among women, in 2006, non-Hispanic Blacks were most likely to have ever been tested (53.7 percent), followed by Hispanics (46.1 percent), while non-Hispanic White women were least likely (33.5 percent).

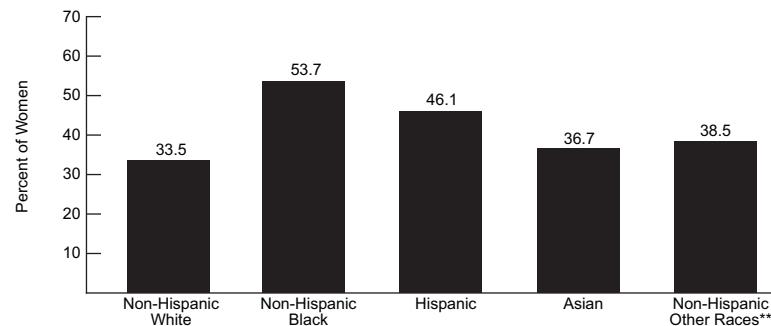
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2006

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



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2006*

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



*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.

ORGAN TRANSPLANTATION

Between January 1 and November 30, 2007, 26,021 organ transplants occurred in the United States. In 2007, the sex distribution of organ donors was nearly even (6,939 males and 6,284 females), though 57.8 percent of organs donated by living people were from women, and 60.5 percent of organs from deceased donors were from men. Since 1988, there have been 419,520 transplants.

The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 1, 2008, there were 97,686 people awaiting a life-saving organ transplant. Females accounted for 41.9 percent of those patients but made up only 36.8 percent of

those who received a transplant in 2007.¹⁴ Among women waiting for an organ transplant, 45.2 percent were White, 30.4 percent were Black, and 16.2 percent were Hispanic. The kidney was in highest demand, with 31,323 females awaiting this organ as of February 1, 2008.

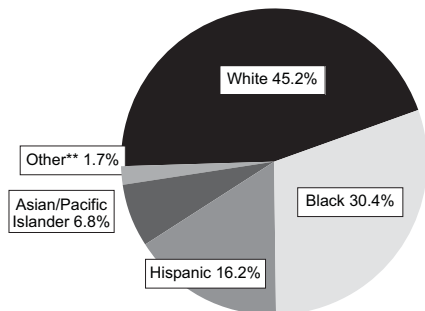
The number of organs donated has increased significantly since 1988, from 5,909 to 14,756 at year's end 2006. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. From 2003 to 2006, organ donation among deceased donors increased by an unprecedented 24.3 percent. One of the challenges of organ

donation is obtaining consent from the donor's family or legal surrogate. Consent rates may vary due to religious beliefs, poor communication between health care providers and grieving families, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased.¹⁵

The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are managed by HRSA's Healthcare Systems Bureau (HSB). Other HSB programs include: the National Marrow Donor Program, the National Vaccine Injury Compensation Program, and the C.W. Bill Young Cell Transplantation Program.

Females on Organ Waiting List,* by Race/Ethnicity, 2008

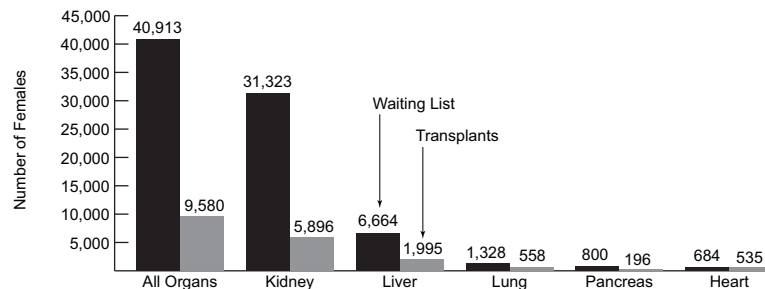
Source III.4: Organ Procurement and Transplantation Network



*As of February 1, 2008. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of unspecified race.

Female Transplant Recipients,* 2007, and Females on Organ Waiting Lists,** 2008, by Organ

Source III.4: Organ Procurement and Transplantation Network



*Transplants occurring between January 1, 2007 and November 30, 2007, as of January 25, 2008.

**As of February 1, 2008.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services. Indicators used to monitor women's health care in managed care plans include screening for chlamydia, screening for cervical cancer, and receipt of mammograms.

In 2006, chlamydia screenings increased for women aged 21–25 years enrolled in commercial (private) health care plans or Medicaid. As in

previous years, females with Medicaid coverage were more likely to have received a chlamydia screening in the previous year than those with private coverage (55.0 versus 38.0 percent, respectively). Since 2000, the percentage of sexually active females screened for chlamydia has increased by nearly 84 percent among those in commercial plans and 45 percent among Medicaid enrollees.

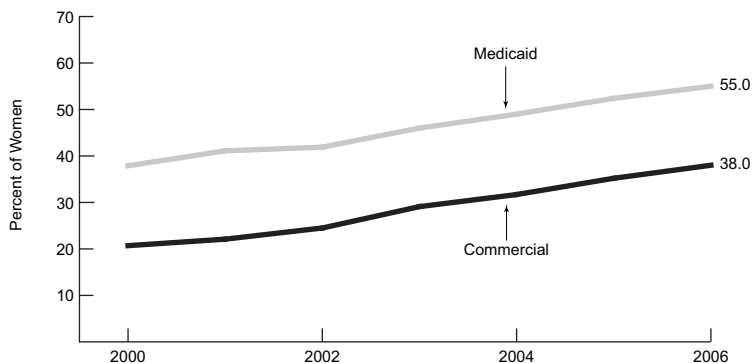
In 2006, receipt of mammograms for women aged 40–69 was approximately the same for women with private coverage and those covered through Medicaid (68.9 and 69.5 percent, respec-

tively). However, Medicare-enrolled women were considerably less likely to have received a mammogram at least once during the previous 2 years (49.1 percent).

Cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Cervical cancer screenings were received at least once every 3 years by nearly 81.0 percent of commercially-insured women and 65.7 percent of women covered by Medicaid.

HEDIS[®]* Chlamydia** Screening Among Women Aged 21–25 Years, by Payer, 2000–2006

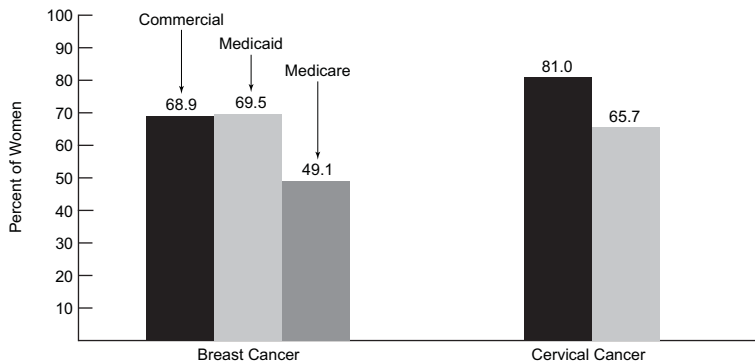
Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active females who had at least one test for chlamydia in the past year.

HEDIS[®]* Breast** and Cervical Cancer Screening,[†] by Payer, 2006

Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 40–69 years who had at least one mammogram in the past 2 years. [†]The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years; Medicare data was not available. Note: Data cannot be compared to previous years due to changes in the age range presented.

SATISFACTION WITH HEALTH CARE

Patients' utilization of health care is influenced by the quality of care; those who are not satisfied with their providers may be less likely to continue with treatment or seek further services.¹⁶ Some aspects of patients' experience of care that may contribute to better outcomes are patients' perceptions of how well their doctors or other health care providers communicate with them and individuals' experiences with their health plans.

In 2006, 40.7 percent of women were not satisfied with their experiences related to their health plans, which could include health plan customer service, understanding or finding

information related to their plan, and completing or submitting paperwork for the plan. This varied by race and ethnicity. Asian women were most likely to be dissatisfied (46.5 percent), followed by non-Hispanic White women (42.9 percent). Fewer than 35 percent of non-Hispanic Black women and 36.3 percent of Hispanic women were unsatisfied with their experiences related to their health plans.

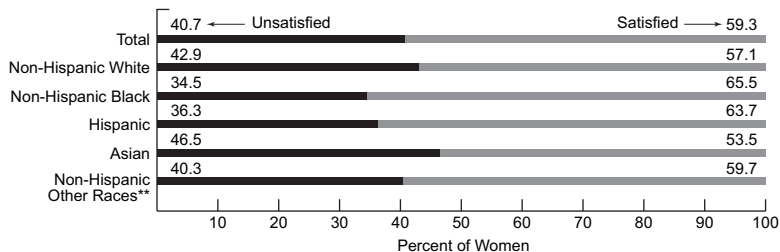
Satisfaction with how well doctors communicate also varies by women's race and ethnicity. In 2006, Hispanic women (25.9 percent) and Asian women (24.0 percent) were more likely to be dissatisfied with how well their doctors communicate than women of other races. Fewer than 20 percent of non-Hispanic Black women

and 15.7 percent of non-Hispanic White women were not satisfied with aspects of communication with their doctors.

More than 36 percent of women were not satisfied with their experiences in getting the care they need when they needed it, including seeing specialists; getting necessary care, tests or treatment; and delays in receiving care caused by waiting for health plan approval. The percentage of women reporting dissatisfaction was greatest among Asian women (47.1 percent). Nearly 40 percent of Hispanic women and 34 percent each of non-Hispanic Black and non-Hispanic White women were also not satisfied with getting the care they needed (data not shown).

Women's Satisfaction with Experiences Related to Health Plans,* by Race/Ethnicity, 2006

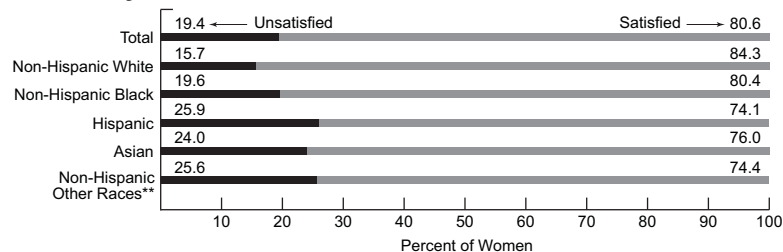
Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS* Benchmarking Database



*Based on questions related to respondents' experiences with their health plans in the past 6 (Medicaid respondents) or 12 months (commercial health plan respondents). **Includes American Indian/Alaska Natives, all other races not specified, and multiple races.

Women's Satisfaction with How Well Doctors Communicate,* by Race/Ethnicity, 2006

Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS* Benchmarking Database



*Based on questions related to care received from doctors or other health providers in the past 6 (Medicaid respondents) or 12 months (commercial health plan respondents). **Includes American Indian/Alaska Natives, all other races not specified, and multiple races.

HRSA PROGRAMS RELATED TO WOMEN'S HEALTH

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports several programs that promote access to health care for vulnerable populations. HRSA's Office of Women's Health (OWH) coordinates efforts that address women's health across their lifespan. The Bright Futures for Women's Health and Wellness Initiative provides materials on topics such as physical activity and healthy eating, emotional wellness, and maternal wellness. These tools, data books, and research reports can be found on the OWH Web site at www.hrsa.gov/womenshealth.

The HRSA Web site, at www.hrsa.gov, provides information about HRSA's bureaus and offices. HRSA's Maternal and Child Health Bureau (MCHB), online at www.mchb.hrsa.gov, administers the MCH Block Grant, a Federal-State partnership to improve the health of mothers and children. *Depression During and After Pregnancy: A Resource for Women, Their Partners, Family and Friends (2007)* and *The Business Case for Breastfeeding: Steps for Creating a Breastfeeding-Friendly Worksite* are two new HRSA publications available for consumers.

The Bureau of Health Professions (BHP) provides national leadership in the development, distribution, and retention of a culturally

competent health workforce. In 2006, women represented 62 percent of those who received assistance from the Centers of Excellence and 71 percent of those involved with the Health Careers Opportunity Programs.

The HIV/AIDS Bureau (HAB) addresses the needs of women living with HIV/AIDS through the Ryan White Program including Part D, which targets services to women, infants, children, youth, and their families. HAB aims to improve access and retention in care through training and technical assistance programs, culturally competent border health initiatives, oral health care programs, and Special Projects of National Significance.

The new Bureau of Clinician Recruitment and Services' (BCRS) mission is to improve the health of the Nation's underserved communities by coordinating recruitment and retention of health professionals to build integrated and sustainable systems of care. Clinicians participating in the National Health Service Corps program provide staffing support to Federally Qualified Health Centers.

The Bureau of Primary Health Care (BPHC) manages the Health Center Program, which funds a national network of 1,002 grantees at over 3,800 comprehensive, primary health care service delivery sites. Through community health centers, school-based centers, and other centers

focused on migrant health, health care for the homeless, and public housing, the Program delivers preventive and primary care services to patients regardless of their ability to pay. Almost 40 percent of patients have no insurance coverage. Overall, the number of patients served has risen from 10.3 million in 2001 to an estimated 15 million in 2006. In 2006, 59 percent of patients served were women.

Health Centers Supported by the Bureau of Primary Health Care, 2005

Source III.7: Uniform Data System, Bureau of Primary Health Care, HRSA, HHS

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

INDICATORS IN PREVIOUS EDITIONS

Each edition of *Women's Health USA* contains the most current available data on health issues important to women. If no updated data are available, indicators may be replaced to make room for information on new indicators.

For more information on the indicators listed here, please reference previous editions of *Women's Health USA* which can be accessed online at either of these Web sites:

www.hrsa.gov/womenshealth

www.mchb.hrsa.gov/data

Women's Health USA 2007

Autoimmune Diseases
 HIV in Pregnancy
 Obstetrical Procedures and Complications of Labor and Delivery
 Sleep Disorders
 Violence and Abuse
 Weight Gain During Pregnancy

Women's Health USA 2006

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

Women's Health USA 2005

Adolescent Pregnancy
 Border Health
 Immigrant Health
 Maternity Leave
 Prenatal Care

Women's Health USA 2004

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

Women's Health USA 2003

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

Women's Health USA 2002

Lupus
 Non-Medical Use of Prescription Drugs
 Nursing Home Care Utilization
 Unintended Pregnancies



ENDNOTES

Population Characteristics

- Centers for Disease Control and Prevention, Office of Minority Health. Disease burden and risk factors. June 5, 2007. <http://www.cdc.gov/omhd/AMH/dbrf.htm>, accessed 11/28/07.
- The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor. Examples of 2006 poverty levels were \$10,488 for an individual, and \$20,444 for a family of four. These levels differ from the Federal Poverty Level used to determine eligibility for Federal programs.
- U.S. Department of Agriculture, Economic Research Service. Food Security in the United States: Measuring Household Food Security. [online] Nov 2007. <http://www.ers.usda.gov/Briefing/FoodSecurity/measuremt.htm>, accessed 07/31/08.
- U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

Health Status

- U.S. Department of Health and Human Services; U.S. Department of Agriculture. Dietary Guidelines for Americans 2005. Washington, DC: U.S. Government Printing Office, January 2005.
- U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.
- Mayo clinic. Food and Nutrition, Alcohol and your health: Weighing the pros and cons [online]. May 2006. www.mayoclinic.com/health/Alcohol/SC00024, accessed 03/31/08.
- U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. 2004.
- Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2006. Analysis conducted by the Maternal and Child Health Information Resource Center.
- Ranney L, Melvin C, Lux L, McClain E, Morgan L, Lohr K. Tobacco Use: Prevention, Cessation, and Control. Evidence Report/Technology Assessment No. 140. (Prepared by the RTI International) University of North Carolina Evidence-Based Practice Center under Contract No. 290-02-0016). AHRQ Publication No. 06-E015. Rockville, MD: Agency for Healthcare Research and Quality. June 2006.
- National Institutes of Health, National Institute on Drug Abuse. Drugs of Abuse Information: Drugs of Abuse/Related Topics

- [online] Jan 2008. <http://www.drugabuse.gov/drugpages.html>, accessed 03/31/08.
- Johnston, LD, O'Malley, PM, Bachman, JG, & Schulenberg, JE. Monitoring the Future national survey results on drug use: 1975-2006: Volume II, College students and adults ages 19-45 (NIH Publication No. 07-6206) Bethesda, MD: National Institute on Drug Abuse. 2007.
 - U.S. Department of Health and Human Services, Indian Health Service. IHS Fact Sheets: Indian Population. January 2007 [online]. <http://info.ihs.gov/>, accessed 01/24/08.
 - U.S. Census Bureau, Population Division, National Projections Program. Projected Life Expectancy at Birth by Race and Hispanic Origin, 1999 to 2100. January 13, 2000 [online]. <http://www.census.gov/>, accessed 01/24/08
 - Arthritis Foundation. Learn about arthritis. 2007. <http://www.arthritis.org>, accessed 12/18/07.
 - Stern L, Berman J, Lumry W, Katz L, Wang L, Rosenblatt L, Doyle JJ. Medication compliance and disease exacerbation in patients with asthma: a retrospective study of managed care data. *Annals of Allergy, Asthma and Immunology*. 2006; 97(3):402-408.
 - U.S. Centers for Disease Control and Prevention. Chronic Fatigue Syndrome: Basic Facts. May 9, 2006. <http://www.cdc.gov/cfs/cfsbasicfacts.htm>, accessed 2/5/08.
 - Reeves WC, Jones JF, Maloney E, Heim C, Hoaglin DC, Boneva RS, Morrissey M, Devlin R. Prevalence of chronic fatigue syndrome in metropolitan, urban, and rural Georgia. *Population Health Metrics*. 2007; 5:5.
 - Reyes M, Nisenbaum R, Hoaglin DC, Unger ER, Emmons C, Randall B, Stewart JA, Abbey S, Jones JF, Gantz N, Minden S, Reeves WC. Prevalence and incidence of chronic fatigue syndrome in Wichita, Kansas. *Archives of Internal Medicine*. 2003; 163:1530-1536.
 - Centers for Disease Control and Prevention. Sexually Transmitted Diseases: HPV and HPV Vaccine - Information for Healthcare Providers. Aug 2006. <http://www.cdc.gov/std/hpv/default.htm>, accessed 01/16/08.
 - Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Overweight and obesity. November 2007 [online]. www.cdc.gov/nccdphp/dnpa/obesity, accessed 01/24/08.
 - American Heart Association. Heart Attack, Stroke, and Cardiac Arrest Warning Signs. 2007. www.americanheart.org/presenter.jhtml?identifier=3053, accessed 02/15/08.
 - Brown A. (2007) Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes: Summary of a Meeting of Maternal, Child, and Oral Health Experts. Washington, DC: National Maternal and Child Oral Health Resource Center.
 - American Dental Association. Diet and oral health: overview [online] <http://www.ada.org/public/topics/diet.asp>, accessed 04/14/08.
 - American Dental Association. Preventing periodontal disease. *Journal of the American Dental Association* 2001; 132: 1339.
 - National Institute of Health. NIH Senior Health [online]. April 2008. <http://nihseniorhealth.gov/listoftopics.html>, accessed 05/06/08.
 - U.S. Department of Health and Human Services. Bone Health and Osteoporosis: A Report of the Surgeon General. Rockville, MD: Office of the Surgeon General; 2004.
 - National Digestive Diseases Information Clearinghouse (NND-DIC). Digestive Diseases Statistics [online]. December 2005. <http://digestive.niddk.nih.gov/statistics/statistics.htm>, accessed 02/06/08.
 - Centers for Disease Control and Prevention, National Center for Health Statistics. NCHS – FastStats: Digestive Disorders [online] November 20, 2007. <http://www.cdc.gov/nchs/fastats/digestiv.htm>, accessed 02/06/08.
 - U.S. Department of Health and Human Services, Office on Women's Health, National Women's Health Information Center. Polycystic Ovary Syndrome (PCOS). [online] April 2007. <http://www.4women.gov/faq/pcos.htm#b>, accessed 02/22/08.
 - Centers for Disease Control and Prevention. HIV/AIDS Basic Information [online] April 2007. <http://www.cdc.gov/hiv/topics/basic/index.htm>, accessed 04/22/08.
 - 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; www.cdc.gov/hiv/topics/surveillance/incidence.htm.
 - Centers for Disease Control and Prevention. HIV/AIDS in the United States: A Picture of Today's Epidemic. [online] March 2008. <http://www.cdc.gov/hiv/resources/factsheets/us.htm>, accessed 04/22/08.
 - Fox, Maggie. "Too few US adults get their shots, survey shows." Reuters. January 23, 2008 [online]. <http://www.reuters.com/article/idUSN23640678>, accessed 03/26/08.
 - U.S. Centers for Disease Control and Prevention. Attention-Deficit/Hyperactivity Disorder [online]. September 20, 2005. <http://www.cdc.gov/ncbdd/adhd/what.htm>, accessed 02/25/08.
 - U.S. Department of Health and Human Services, Office on Women's Health. Attention Deficit Hyperactivity Disorder [online]. May 2007. <http://www.4woman.gov/mh/conditions/adhd.cfm?style=large>, accessed 02/25/08.

33. Kessler RC, Adler L, Ames M, Barkley RA, Birnbaum H, Greenberg P, Johnston JA, Spencer T, Ustun TB. The Prevalence and Effects of Adult Attention Deficit/Hyperactivity Disorder on Work Performance in a Nationally Representative Sample of Workers. *Journal of Occupational & Environmental Medicine*. 2005; 47(6): 565-572.
 34. Mental Health America. Factsheet: AD/HD and Adults [online]. Jan 9, 2007. <http://mentalhealthamerica.net/go/information/get-info/ad/hd/ad/hd-and-adults>, accessed 02/25/08.
 35. Kessler RC, Berglund PA, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2003 Jun;62(6):593-602.
 36. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-Based Injury Statistics Query and Reporting System (WISQARS™). Injury Mortality Report [online]. (2005). Available from URL: www.cdc.gov/nceip/wisqars, accessed 02/05/08.
 37. Bair-Merritt MH, Feudtner C, Localio AR, Feinstein JA, Rubin D, Holmes WC. Health Care Use of Children Whose Female Caregivers Have Intimate Partner Violence Histories. *Archives of Pediatrics & Adolescent Medicine*. [online] 2008; 162(2): 134-139. <http://archpedi.highwire.org/cgi/content/full/162/2/134>, accessed 02/26/08.
 38. Rivara FP, Anderson ML, Fushman P, Bonomi AE, Reid RJ, Carrell D, Thompson RS. Intimate Partner Violence and Health Care Costs and Utilization for Children Living in the Home. *Pediatrics*. 2007; 120(6): 1270-1277.
 39. Litwin MS, Saigal CS, editors. *Urologic Diseases in America*. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Washington, DC: U.S. Government Printing Office, 2007; NIH Publication No. 07-5512.
 40. Harlow et al. A Population-Based Assessment of Chronic Unexplained Vulvar Pain: Have we underestimated the prevalence of vulvodynia? *JAMWA*. 2003; 58: 82-88.
 41. U.S. Department of Health and Human Services, Office on Women's Health, National Women's Health Information Resource Center. *Health Topics: Pregnancy and Reproductive Health*. www.womenshealth.gov/faq, accessed 04/01/08.
 42. 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).
 43. In the 37 reporting areas (including New York City and Washington, DC) using the 1989 Standard Certificate of Live Birth (unrevised).
 44. Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Evidence Report/Technology Assessment No. 153 (Prepared by Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E0007. Rockville, MD: Agency for Healthcare Research and Quality. April 2007.
 45. Ryan AS, Zhou W, Arensberg MB. The Effect of Employment Status on Breastfeeding in the United States. *Women's Health Issues*. 2006; 16: 243-251.
 46. U.S. Department of Labor, Bureau of Labor Statistics. Employment characteristics of families in 2006 (USDL 07-0673). Washington, DC: The Department; May 2007. [Table 6] <http://www.bls.gov/news.release/pdf/famee.pdf>, accessed 12/11/07.
 47. U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. 2004.
 48. Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007; Data for three states were not comparable to either the unrevised or revised birth certificate data.
 49. Centers for Disease Control and Prevention. Preconception and Interconception Health Status of Women Who Recently Gave Birth to a Live-Born Infant – Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 26 Reporting Areas, 2004. Surveillance Summaries, Dec 14, 2007. *MMWR* 2007; 56 (No SS-10).
 50. American Diabetes Association. Gestational Diabetes. <http://www.diabetes.org/gestational-diabetes.jsp>, accessed 04/01/08.
 51. U.S. Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment Number 14: Management of chronic hypertension during pregnancy. Publication #00E011; Aug 2000.
 52. National Center for Health Statistics. *Health, United States, 2007 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD: 2007. <http://www.cdc.gov/nchs/hus.htm>, accessed 04/01/08.
- ### Health Services Utilization
1. DeVoe JE, Fryer GE, Phillips R, Green LA. Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care. *AJPH*. 2003;93(5):786-791.
 2. Fryer GE, Dovey SM, Green LA. The importance of having a usual source of health care. *Am Fam Physician*. 2000;62:477.
 3. Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. *AJPH* 1996;86(12):1742-7.
 4. This statistic does not include adults aged 65 and older because that is the age when people become eligible for Medicare coverage based on age.
 5. Cherry DK, Woodwell DA, Rechtsteiner EA. National Ambulatory Medical Care Survey: 2005 Summary. Advance data from vital and health statistics; no 387. Hyattsville, MD: National Center for Health Statistics. 2007. www.cdc.gov, accessed 01/16/08.
 6. Centers for Disease Control and Prevention. Cervical Cancer: Screening Recommendations. [online] http://www.cdc.gov/cancer/cervical/basic_info/screening/recommendations.htm, accessed 01/16/08.
 7. Centers for Disease Control and Prevention. Trends in Cholesterol Screening and Awareness of High Blood Cholesterol — United States, 1991—2003. *MMWR*, Sept 9, 2005; 54(35): 865-870. <http://www.cdc.gov/MMWR/>, accessed 01/16/08.
 8. Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*, July 28, 2006; 55(RR10); 1-42. <http://www.cdc.gov/MMWR/>, accessed 01/16/08.
 9. Centers for Disease Control and Prevention. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. *MMWR*, Dec 8, 2006; 55(RR16); 1-25. <http://www.cdc.gov/MMWR/>, accessed 01/16/08.
 10. Centers for Disease Control and Prevention. Sexually Transmitted Diseases: HPV and HPV Vaccine – Information for Healthcare Providers. Aug 2006. <http://www.cdc.gov/std/hpv/default.htm>, accessed 01/16/08.
 11. Fox, Maggie. “Too few US adults get their shots, survey shows.” Reuters. January 23, 2008 [online] <http://www.reuters.com/article/idUSN23640678>, accessed 01/24/08.
 12. Cherry DK, Woodwell DA, Rechtsteiner EA. National Ambulatory Medical Care Survey: 2005 Summary. Advance data from vital and health statistics; no 387. Hyattsville, MD: National Center for Health Statistics. 2007. <http://www.cdc.gov/nchs/about/major/ahcd/adata.htm>, accessed 01/14/08.
 13. Centers for Disease Control and Prevention, National HIV Testing Resources. Frequently asked questions about HIV and HIV testing. <http://www.hivtest.org>, accessed 01/02/08.
 14. 2007 data are from January 1–November 30, 2007.
 15. 2003 OPTN/SRTR Annual Report: Transplant Data 1992-2002. HHS/HRSA/SPB/DOJ; UNOS; URREA.
 16. Fan VS, Burman M, McDonnell MB, Fihn SD. Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care. *Journal of General Internal Medicine*. 2005; 20:226-233.

DATA SOURCES

Population Characteristics

- I.1 U.S. Census Bureau, American FactFinder. 2006 American Community Survey. <http://factfinder.census.gov>, accessed 11/28/07.
- I.2 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. America's Families and Living Arrangements, 2006. March 2007. <http://www.census.gov>, accessed 12/4/07.
- I.3 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007. Current Population Survey Table Creator. Available online at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html, accessed 12/3/07.
- I.4 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2005-2006. Analysis conducted by the Maternal and Child Health Information Resource Center.
- I.5 Nord M, Andrews M, Carlson S. Household Food Security in the United States, 2006. ERR-49, U.S. Department of Agriculture, Econ. Res. Serv. November 2007. www.ers.usda.gov/publications/err49/, accessed 03/17/08.
- I.6 U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition and Evaluation, Characteristics of Food Stamp Households: Fiscal Year 2006, FSP-07-CHAR, by Kari Wolkowitz. Project Officer, Jerry Genser. Alexandria, VA: 2007.
- I.7 U.S. Department of Agriculture, Women, Infants, and Children Program Data. Monthly Data – National Level, FY 2004- September 2007. <http://www.fns.usda.gov/pd/wicmain.htm>, accessed 12/17/07.
- I.8 American Association of Colleges of Osteopathic Medicine, Annual Osteopathic Medical School Questionnaires, 2004-2005 through 2006-07 academic years. (Table 9A). 2007; American Association of Colleges of Pharmacy, Fall 2006 Profile of Pharmacy Students, (Table 40). 2007. <http://www.aacp.org>; American Dental Association, Survey Center, 2005-2006 Survey of Dental Education; Association of American Medical Colleges, Data Warehouse. Facts—Applicants, Matriculants, and Graduates (Table 27), 2007. www.aamc.org; Association of Schools & Colleges of Optometry, Annual Student Data Report, Academic Year 2006-2007 (Table 2.2). 2007; Association of Schools of Public Health, 2006 Annual Data Report, (Table 3-1). <http://www.asph.org>; Commission on Accreditation for Dietetics Education, 2007 Annual Report; Council on Social Work Education. Research Brief: 2006 Annual Survey of Social Work Programs. Alexandria, VA: Council on Social Work Education, 2007; Fang, D, Wilsey-Wisniewski, SJ, Bednash, GD. 2006-2007 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington DC: American Association of Colleges of Nursing, (Table 8), 2007. Web sites accessed 02/27/08.

- I.9 U.S. Department of Education, National Center for Education Statistics. Digest of Education Statistics Tables and Figures, 2006. [Tables 232,251]. <http://nces.ed.gov>, accessed 12/4/07.
- I.10 U.S. Department of Defense, Defense Manpower Data Center, Statistical Information Analysis Center. Military Personnel Statistics, Active Duty Military Personnel by Rank/Grade. September 2006 and September 2006 (Women Only) reports. <http://siadapp.dmdc.osd.mil/personnel/MILITARY/Miltop.htm>, accessed 12/4/07.

Health Status

- II.1 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2006. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.2 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2003-2004. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.3 U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. NATIONAL SURVEY ON DRUG USE AND HEALTH, 2006 [Computer file]. ICPSR21240-v2. Research Triangle Park, NC: Research Triangle Institute [producer], 2007. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2007-12-03.
- II.4 Substance Abuse and Mental Health Services Administration. (2007). Results from the 2006 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD. <http://www.oas.samhsa.gov/nsduhlatest.htm>, accessed 01/08/08.
- II.5 Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: Final data for 2005. National vital statistics reports; vol 56 no 10. Hyattsville, MD: National Center for Health Statistics. 2008.
- II.6 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Analysis of National Vial Statistics System 2005 data. [online]. www.cdc.gov/ncipc/wisqars, accessed 01/28/08.
- II.7 American Cancer Society. Cancer Facts & Figures 2008. Atlanta: American Cancer Society; 2008.
- II.8 Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 17 Regs Limited-Use, Nov 2006 Sub (1973-2004 varying), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2007, based on the November 2006 submission.
- II.9 Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services,

- Centers for Disease Control and Prevention, 1996 & 2006. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.10 Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey, 2005. Unpublished data.
- II.11 Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey: 2005. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.12 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2005. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.13 Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2006. Vol 18. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007. <http://www.cdc.gov>, accessed 04/18/08.
- II.14 Centers for Disease Control and Prevention. Sexually Transmitted Disease surveillance, 2006. Atlanta, GA: U.S. Department of Health and Human Services; 2007.
- II.15 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Nonfatal [online]. (2005). Available from URL: www.cdc.gov/ncipc/wisqars, accessed 01/15/08.
- II.16 Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey 2005. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.17 U.S. Department of Labor, Bureau of Labor Statistics. Case and Demographic Characteristics for Work-related Injuries and Illnesses Involving Days Away From Work, Supplemental Tables, 2006. [Table 1b] <http://www.bls.gov/iif/oshcdnew.htm>, accessed 01/28/08.
- II.18 Children and Adults with Attention Deficit/Hyperactivity Disorder, National Resource Center on AD/HD. Living with AD/HD: A lifespan disorder [online]. <http://www.help4adhd.org/en/living/workplace>, accessed 02/25/08.
- II.19 Catalano, S. Bureau of Justice Statistics. Intimate Partner Violence in the United States. December 2007. <http://www.ojp.usdoj.gov/bjs/intimate/ipv.htm>, accessed 01/14/08.
- II.20 Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2006. National vital statistics reports; vol 56 no 7. Hyattsville, MD: National Center for Health Statistics. 2007. <http://www.cdc.gov/nchs/births.htm>, accessed 12/12/07.
- II.21 Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007. <http://www.cdc.gov/nchs/births.htm>, accessed 12/12/07.
- II.22 Menacker F. Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990–2003. National vital statistics reports; vol 54 no 4. Hyattsville, MD: National Center for Health Statistics. 2005. <http://www.cdc.gov/nchs/births.htm>, accessed 12/12/07.
- II.23 Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. <http://www.cdc.gov/nchs/vitalstats.htm>, accessed 12/12/07.
- II.24 Centers for Disease Control and Prevention. Breastfeeding practices—results from the National Immunization Survey. 2006. http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm, accessed 12/11/07.
- II.25 Centers for Disease Control and Prevention. National Center for Health Statistics. National Vital Statistics System, 2005. Unpublished data.
- II.26 U.S. Agency for Health Care Research and Quality. Medical Expenditure Panel Survey (MEPS) 2005. Analysis conducted by the Maternal and Child Health Information Resource Center.
- II.27 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey. Unpublished data.
- Health Services Utilization**
- III.1 U.S. Centers for Medicare and Medicaid Services. Unpublished data.
- III.2 DeFrances CJ, Hall MJ. 2005 National Hospital Discharge Survey. Advance data from vital and health statistics; no 385. Hyattsville, MD: National Center for Health Statistics. 2007.
- III.3 U.S. Agency for Healthcare Research and Quality. Total Health Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2005. Medical Expenditure Panel Survey Component Data. Generated interactively. (January 14, 2008).
- III.4 Organ Procurement and Transplantation Network. National Data, and Advanced Reports. <http://www.optn.org>, accessed 02/04/08.
- III.5 National Committee for Quality Assurance. The State of Health Care Quality 2007. Washington, DC: NCQA, 2007.
- III.6 U.S. Agency for Healthcare Research and Quality, Consumer Assessment of Healthcare Providers and Systems (CAHPS®), 2006. The CAHPS® data used in this analysis were provided by the National CAHPS® Benchmarking Database (NCBD). The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and administered by Westat under Contract No. 290-01-0003. Analysis conducted by the Maternal and Child Health Information Resource Center.
- III.7 U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. 2005. Unpublished data.

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Association of Schools and Colleges of
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