Women's Health USA 2005

U. S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Women's Health USA 2005

U. S. Department of Health and Human Services

HRSA

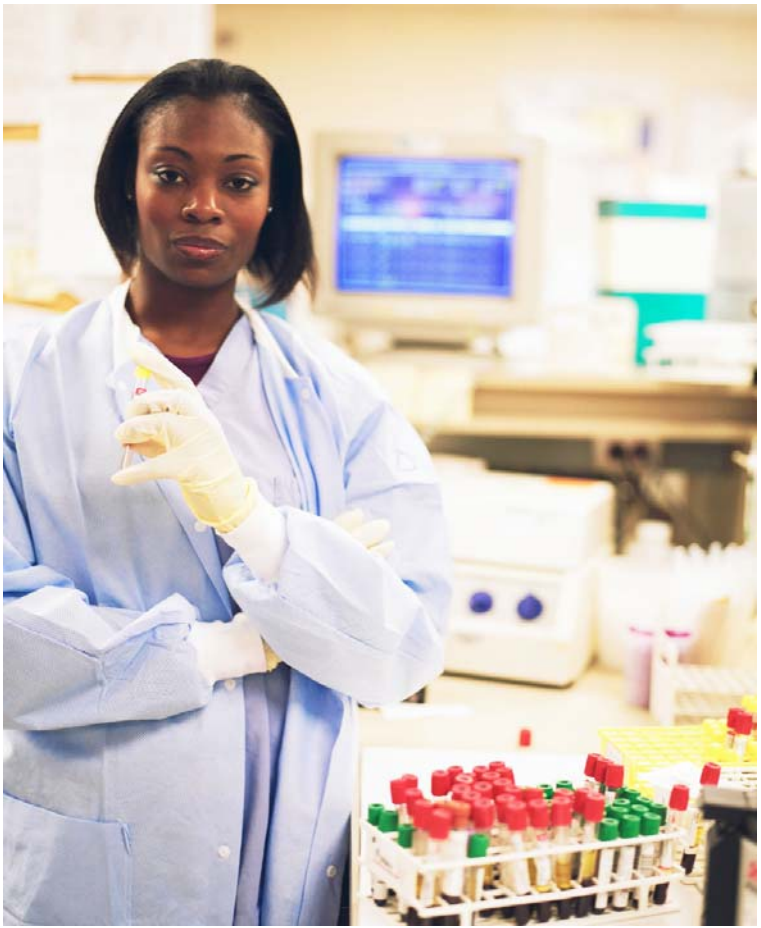
Health Resources and Services Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Please note that *Women's Health USA 2005* is not copyrighted. Readers are free to duplicate and use all or part of the information contained in this publication.

Suggested Citation:
U.S. Department of Health and Human Services,
Health Resources and Services Administration. *Women's Health USA 2005.*
Rockville, Maryland: U.S. Department of Health and Human Services, 2005.

This publication is available online at www.hrsa.gov/womenshealth
Single copies of this publication are also available at no charge from the
HRSA Information Center
P.O Box 2910
Merrifield, VA 22116
1-888-ASK-HRSA or ask@hrsa.gov



PREFACE AND READER'S GUIDE

"Healthy Women Build Healthy Communities" is the principle that guides the work of the Health Resources and Services Administration's (HRSA) Office of Women's Health. As an agency in the United States Department of Health and Human Services, HRSA is charged with assuring access to quality health care through a network of community-based health centers, maternal and child health programs, and State, Territorial, and community HIV/AIDS programs. 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 and topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA's Office of Women's Health is pleased to present *Women's Health USA 2005,* the fourth edition of the data book. To reflect the ever changing, increasingly diverse population and its characteristics, *Women's Health USA 2005* will selectively include emerging issues and trends in women's health. Information and data on household composition, maternity leave, contraception, and adolescent pregnancy are a few of the new topics included in this edition. Where possible, every effort has been made to highlight racial and ethnic disparities as well as sex/gender differences.

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 2005* 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 at the national level from a variety of data sources. The data book uses the latest available information from various agencies within the Federal Government, including the U.S. Departments of Health and Human Services, Agriculture, Labor, Commerce, and 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 and mortality 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 morbidity and mortality rates between groups can be attributed to different age distributions. Presentation of racial and ethnic data may appear different on some pages as a result of the design and limitations of the original data source.

Women's Health USA 2005 is available online on the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth. In an effort to produce a timely document, some of the topics covered in *Women's Health USA 2004* 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 2004,* also available online.

Women's Health USA 2005 is not copyrighted. Readers are free to duplicate and use the information contained in this publication.

Please provide any feedback on this publication to the HRSA Information Center at:

1-888-ASK-HRSA or
ask@hrsa.gov

Single copies are available at no charge from:

HRSA Information Center
P.O. Box 2910
Merrifield, VA 22116
1-888-ASK-HRSA

INTRODUCTION

In 2003, women represented 51 percent of the nearly 283 million people residing in the United States. In most age groups, women account for approximately half of the population, with the exception of people 65 years and older; among older Americans, women represent almost 58 percent of the population. The growing diversity of the United States population is reflected in the racial and ethnic distribution of women across age groups. Black and Hispanic women account for 9 and 6 percent of the female population aged 65 and older, respectively, but they represent 16 and 20 percent of females under 15 years of age. Non-Hispanic Whites account for 82 percent of women aged 65 years and older, but only 60 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 2003, 63 percent of non-Hispanic White females reported themselves to be in excellent or very good health, compared to only 53 percent of Hispanic women and 51 percent of non-Hispanic Black women. Minority women are disproportionately affected by a number of diseases and health conditions, including AIDS, diabetes, hypertension, and overweight and obesity. For instance, in

2003 non-Hispanic Black and Hispanic women accounted for more than three-fourths of women with AIDS. In 1999, AIDS was the fifth leading cause of death among women aged 25 to 44 years, but was the third leading cause of death among African American women of the same age. Just over one-third of non-Hispanic White women have ever been tested for the Human Immunodeficiency Virus (HIV), compared to 54 percent of non-Hispanic Black women and 47 percent of Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States. It is especially prevalent among non-Hispanic Black women, among whom it occurs at a rate of 91 per 1,000 women, compared to 61 per 1,000 non-Hispanic White women. Hispanic women are also affected at a rate of 61 per 1,000 women, and the lowest rate (47 per 1,000 women) occurs among Asian women. Hypertension, or high blood pressure, is also more prevalent among non-Hispanic Black women than women of other races. This disease occurs among non-Hispanic Black women at a rate of 360 per 1,000 women, compared to 261 per 1,000 non-Hispanic White women and 195 per 1,000 Hispanic women.

Overweight and obesity are occurring at an increasing rate among Americans of all ages and both sexes. Body Mass Index (BMI) is a measure of the ratio of height to weight, and is often used to determine whether a person's weight is within a healthy range. A BMI of 25.0 or greater is considered overweight, and a BMI of 30.0 or greater is considered obese. In a survey conducted between 1999 and 2002, 27 percent of non-Hispanic Black women were overweight, as were 33 percent of Hispanic women. Obesity follows the same trend, and was most prevalent among non-Hispanic Black women, occurring in 45 percent of that population. Overall, 73 percent of non-Hispanic Black women, 67 percent of Hispanic women, and 56 percent of non-Hispanic White women are considered overweight or obese.

Some conditions, such as arthritis, disproportionately affect White women. In 2003, the rate of arthritis among non-Hispanic White women was 281 per 1,000 women, compared to 239 per 1,000 non-Hispanic Black women and 144 per 1,000 Hispanic women. Mental illness is also more prevalent in non-Hispanic White women than women of other races and ethnicities. The 2002 suicide rate among non-Hispanic White females aged 15 and older was 5.1 per 1,000 women; this was the highest rate of women of any race or ethnicity. American Indian/ Alaska Native women had the second-highest suicide rate (4.1 per 1,000), followed by Asian/ Pacific Islander women (3.0 per 1,000), Hispanic women (1.8 per 1,000) and Black women (1.6 per 1,000).

Many diseases and health conditions can be avoided or minimized through preventive health care. In 2002, 10.1 percent of physician office visits made by non-Hispanic Black women included a Pap smear to screen for cervical cancer, compared to 7.6 percent of visits made by non-Hispanic White women. Conversely, 5.3 percent of visits by non-Hispanic White women included a mammogram, compared to 4.0 percent of visits made by non-Hispanic Black and Hispanic women.

Health insurance can be an important factor in women's ability to stay healthy by improving access to regular medical care and use of preventive services. In 2003, 45 million Americans were without health insurance (15.6 percent of the population and 14.4 percent of females). Among women, Hispanics are most likely to be uninsured, at 29.6 percent. Asian and Black women also had high rates of uninsurance (18.5 and 17.8 percent, respectively); non-Hispanic White women are least likely to be uninsured (10.4 percent). Non-Hispanic White women were most likely to use an office-based source of care (91 percent), while Hispanic women were least likely to do so (76 percent). Among non-Hispanic Black women, almost 2 percent used an emergency department as their usual source

of care, compared to 0.4 percent of non-Hispanic White women. Among Hispanic women, 20 percent did not have a usual source of care, compared to 8 percent of non-Hispanic White women.

Many behaviors can promote health and help prevent disease and disability. Physical activity is an important lifestyle factor that directly impacts health, yet only 23 percent of non- Hispanic Black women and 22 percent of Hispanic women engaged in the recommended amount of physical activity in 2003. Non-Hispanic White women were the most likely to engage in recommended activity (33 percent). Some forms of contraception, when used properly, can prevent unintended pregnancy and the spread of sexually transmitted diseases (STDs). In 2002, 34 percent of non-Hispanic White women who were using contraception chose the contraceptive pill, making it the most popular form of contraception among that group. Female sterilization was the most common method of contraception among non-Hispanic Black and Hispanic women (used by 39 and 34 percent, respectively). However, these forms of contraception do not prevent the spread of STDs or HIV. Condoms, which can both prevent pregnancy and the spread of STDs, are the primary form of contraception for only 17 percent of non-Hispanic White women, 19 percent of Hispanic women, and 20 percent of non-Hispanic Black women.

While some behaviors positively impact health status, a number of other behaviors, such as cigarette smoking and drug use, can have the opposite effect. In 2002-2003, 36 percent of non-Hispanic White women reported cigarette use in the past year. Asian women were least likely to report cigarette use (13 percent), followed by Hispanic women (19 percent) and non-Hispanic Black women (25 percent); American Indian/Alaska Native women were most likely to report cigarette use in the past year (52 percent). Binge drinking—five or more drinks on the same occasion—is another behavior that can negatively impact health. Similar to cigarette use, American Indian/Alaska Native women reported the highest rate of past-month binge alcohol use in 2002-2003 (35 percent), followed by non-Hispanic White women (26 percent), non-Hispanic Black women and Hispanic women (19 percent each). Asian women were least likely to report binge alcohol use in the past month (9 percent).

Preventive care during pregnancy is important to the health of both mother and baby. In 2003, 89 percent of non-Hispanic White women began prenatal care in the first trimester, compared to 85 percent of Asian/Pacific Islanders, 77 percent of non-Hispanic Blacksand 76 percent of Hispanics; American Indian/Alaska Native women were least likely to receive first trimester care (71 percent). Breastfeeding positively affects the health of children, and it has been shown to improve maternal health as well. In 2003, Asian women were most likely to breastfeed in the hospital (74 percent), followed by White women (71 percent), and Hispanic women (64 percent); Black women were least likely to do so (48 percent). Behaviors such as smoking and drinking during pregnancy can negatively affect the health of women and their unborn children. In 2002-2003, 18 percent of pregnant women reported cigarette use in the past year with pregnant non-Hispanic White women reporting the highest rate of past-year cigarette use (25 percent). Binge drinking was far less common among pregnant women with only 4 percent reporting it in the past month.

Women's Health USA 2005 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, and this data book provides information on indicators that can help us to 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 women in the U.S. Representing slightly more than half of the Nation's population, women and girls accounted for over 144 million in 2003.

Analysis and comparison of data by sex, age, and race and ethnicity can be used to tailor the development and evaluation of programs and policies serving women's health.

The following section presents data on population characteristics that affect women's health. These factors include age, race and ethnicity, household composition, education, income, occupation, and participation in Federal programs.

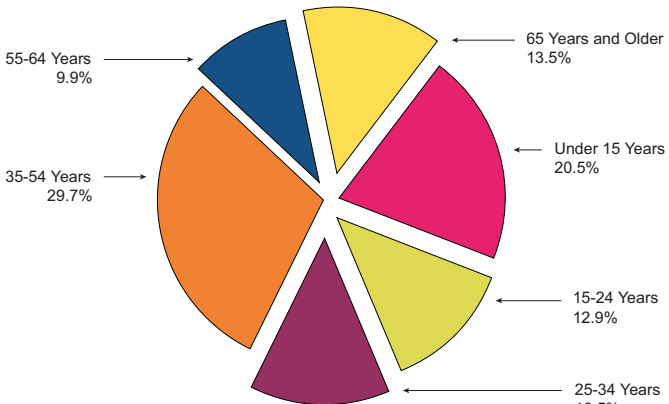
U.S. POPULATION

In 2003, the U.S. population reached almost 283 million, with females representing 51.1 percent of the population. Females younger than age 35 accounted for 46.9 percent of the female population, those aged 35 to 64 years represented 39.6 percent, and females over age 65 years accounted for 13.5 percent.

The distribution by sex was fairly even across all age groups except among older persons, where women accounted for a greater percentage of the population. Of those aged 65 years and older, 57.6 percent were women.

U.S. Female Population,* by Age, 2003

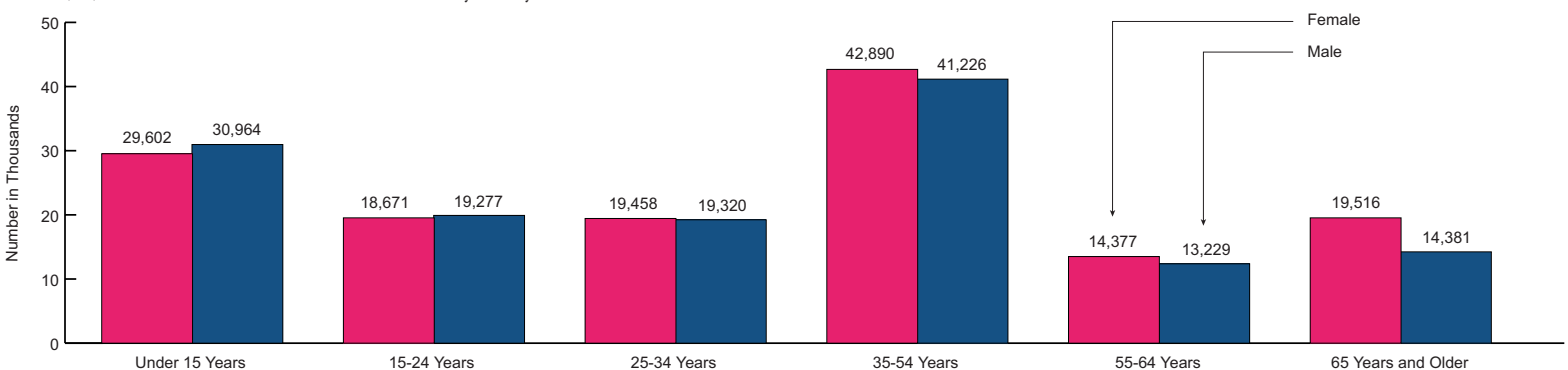
Source (I.1): U.S. Census Bureau, American Community Survey



*Includes only noninstitutionalized population not living in group quarters.

U.S. Population, by Age and Sex,* 2003

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

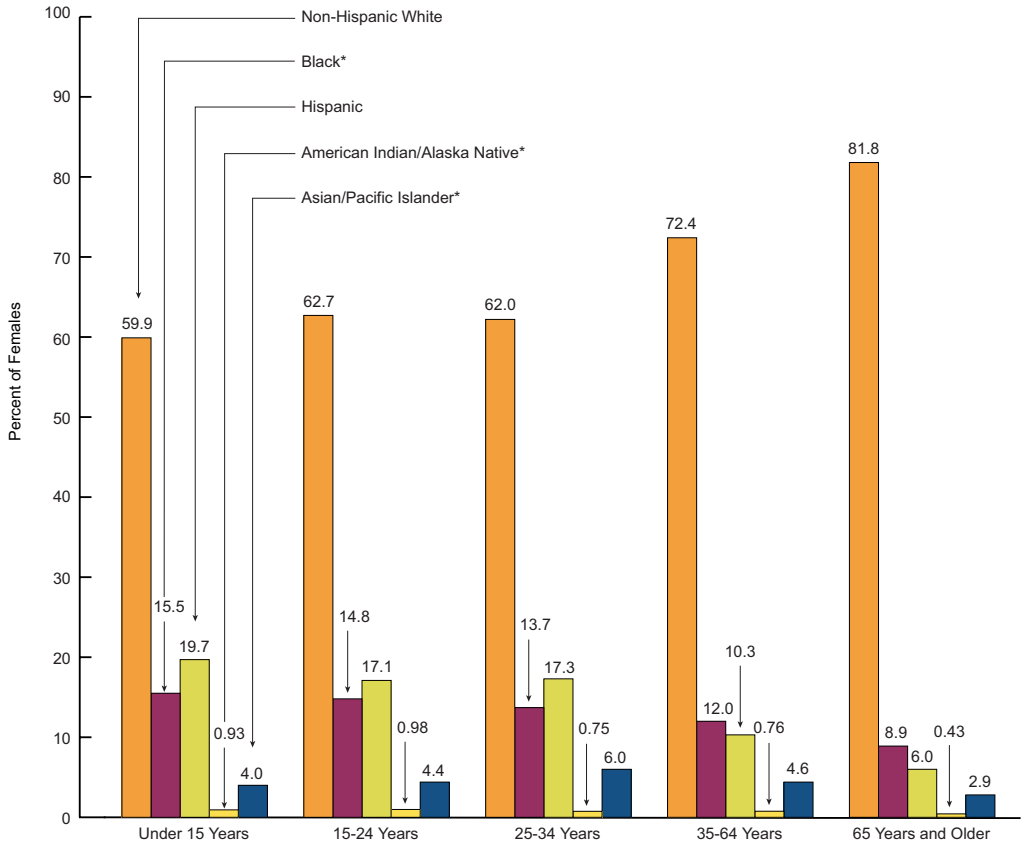


U.S. FEMALE POPULATION BY RACE/ETHNICITY

The growing diversity of the U.S. female population is reflected in the racial and ethnic distribution of women across age groups. The younger female population, under 25 years of age, is significantly more diverse than the older female population. The non-White population represents 39 percent of females under 25 years of age compared to only 18 percent of females 65 and older. Non-Hispanic Whites represent 61 percent of females under 25 years of age and 82 percent of females 65 and older.

U.S. Female Population, by Age and Race/Ethnicity, 2003

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



*Does not exclude Hispanics.

HOUSEHOLD COMPOSITION/ WOMEN AS CAREGIVERS

In 2003, 50.3 percent of adult women were married and living with a spouse. Over 10 percent of women were the head of a household, meaning that they had children or other relatives living in their household, but no spouse. Another 16.6 percent of adult women lived in the home of a parent or other relative. Almost 15 percent of adult women lived alone, and nearly 7 percent were living with non-relatives.

The households in which women live have a variety of structures. For instance, among women living with a spouse, just over 2 percent lived with their spouse in someone else's home (such as with parents or roommates). In 2003, almost 5 million women lived in unmarried-partner households. Of these women, 93.5 percent lived with a male partner and the other 6.5 percent lived with a female partner.[1] Many women also live with their adult children or their grandchildren. In 2000 there were 3.7 million women living with their grandchildren, compared to just over 2 million men.[2]

Women often function as caregivers for the people with whom they live, or for other relatives or friends. One out of every four people is a caregiver for a family member or friend, and, in the absence of an able spouse, a daughter or daughter-in-law is most likely to assume the role of caregiver.[3] Approximately 75 percent of caregivers for older family members and friends are female.[4] Of the 2.4 million grandparents who live with and are responsible for grandchildren, 63 percent are women.

1 *U.S. Census Bureau. 2003 American Community Survey Summary Tables. American FactFinder, Table PCT008.*

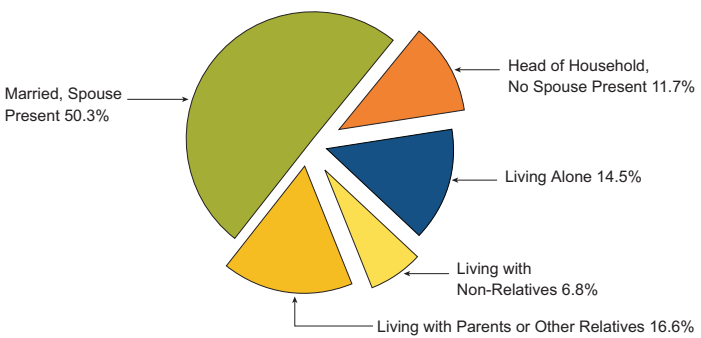
2 *U.S. Census Bureau. Grandparents living with grandchildren: 2000. Census 2000 Brief, October 2003.*

3 *U.S. Department of Health and Human Service, Administration on Aging. Snapshot: National Family Caregiver Support Program. August 2003.*

4 *Family Caregiver Alliance. Selected caregiver statistics. http://www.caregiver.org*

Adult Women,* by Household Composition, 2003

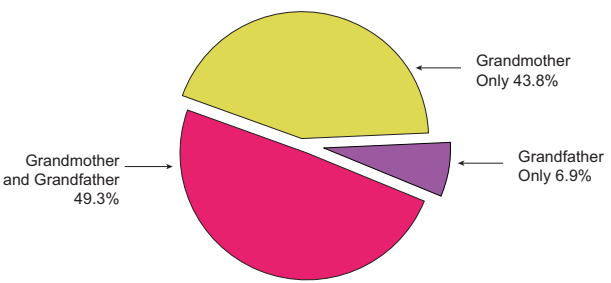
Source (I.2): U.S. Census Bureau, Current Population Survey



**Civilian, non-institutionalized population ages 15 years and older.*

Grandchildren Living with their Grandparents, 2002

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



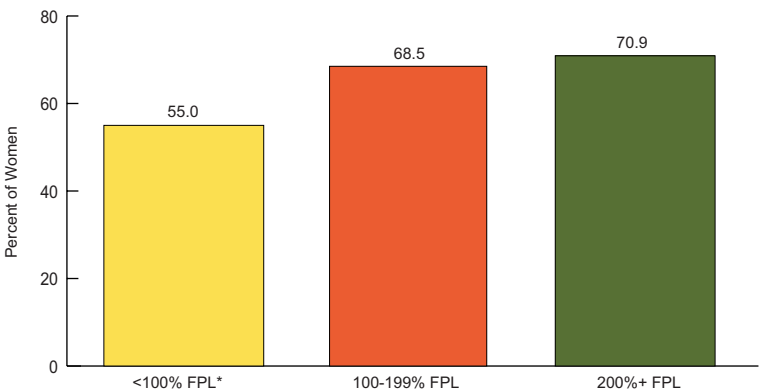
MATERNITY LEAVE

The time a mother takes off from work, paid or unpaid, due to pregnancy and childbirth is known as maternity leave. Since 1997, of mothers who were employed at the time of their last pregnancy, 70.2 percent took maternity leave after birth. Women between the ages of 30 and 34 were most likely to have taken maternity leave for their last pregnancy (78.9 percent), while women between the ages of 18 and 25 were least likely (55.8 percent). This rate also varied across race and ethnicity groups, with Hispanic women being the least likely to have taken maternity leave (60.1 percent). A majority of women who reported taking maternity leave for their last pregnancy had household incomes at 200 percent of the Federal Poverty Level (FPL) or greater.

The Family and Medical Leave Act (FMLA) guarantees women who are on maternity leave that their job will be protected for up to 12 weeks in any 12-month period. Among women who took maternity leave during their last pregnancy, 80.7 percent reported taking 12 weeks or less. Because paid maternity leave is not readily available from most employers, women usually use a combination of short-term disability, sick leave, vacation, and personal days in order to have some portion of their maternity leave paid. However, among women who reported taking maternity leave for their last pregnancy, 29.7 percent did not have any portion of their maternity leave paid.

Women Aged 18 to 44 Who Took Maternity Leave for Their Last Pregnancy, by Poverty Level, 2002

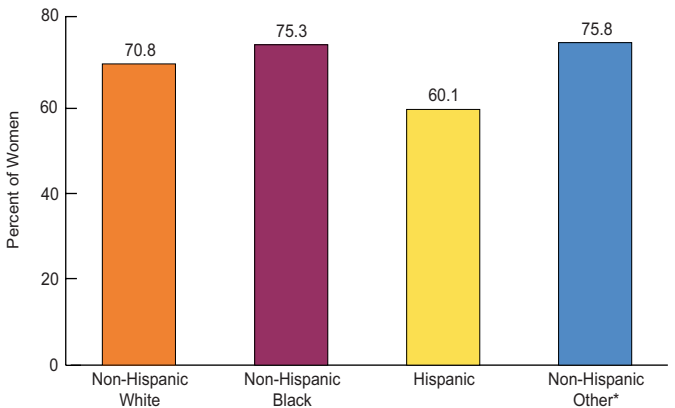
Source (I.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Federal Poverty Level

Women Aged 18 to 44 Who Took Maternity Leave for Their Last Pregnancy, by Race/Ethnicity, 2002

Source (I.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Includes Asian/Pacific Islander, American Indian/Alaska Native, and persons of more than one race.

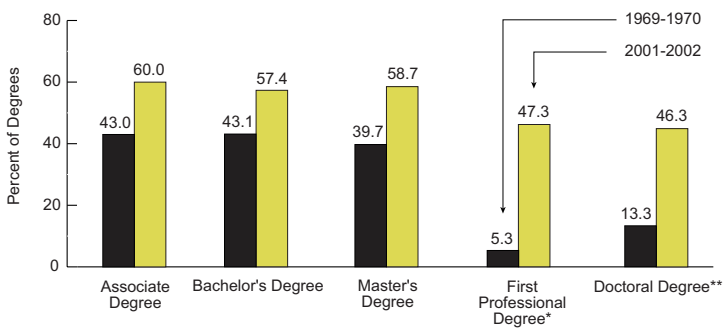
EDUCATIONAL DEGREES AND TENURE AWARDED TO WOMEN

The number of post-secondary educational degrees awarded to women has risen from just over half a million in 1969-1970 to more than 1.4 million in 2001-2002. Although the number of degrees earned by men has also increased, the growth among women has been much faster and therefore the proportion of degrees earned by women has also risen dramatically. In 1969-1970, men earned a majority of every type of degree, while in 2001-2002, women earned more than 50 percent of all associate, bachelor's, and master's degrees, and earned almost half of all first professional and doctoral degrees. The most significant increase has been in the proportion of women earning a first professional degree, which jumped from 5.3 percent in 1969-1970 to 47.3 percent in 2001- 2002. The total number of women earning their first professional degree (38,191) was 20 times greater than in 1969-1970 (1,841).

Among women working as full-time instructional staff for degree-granting institutions, 41.5 percent had tenure during the 2001-2002 academic year, compared to 56.5 percent of men. This varied greatly by rank, with the highest rate of tenure among women with the rank of Professor (90.7 percent). This is the only rank where the rate of tenure was higher among men (92.3 percent) than women.

Degrees Awarded to Women, by Type, 1969-1970 and 2001-2002

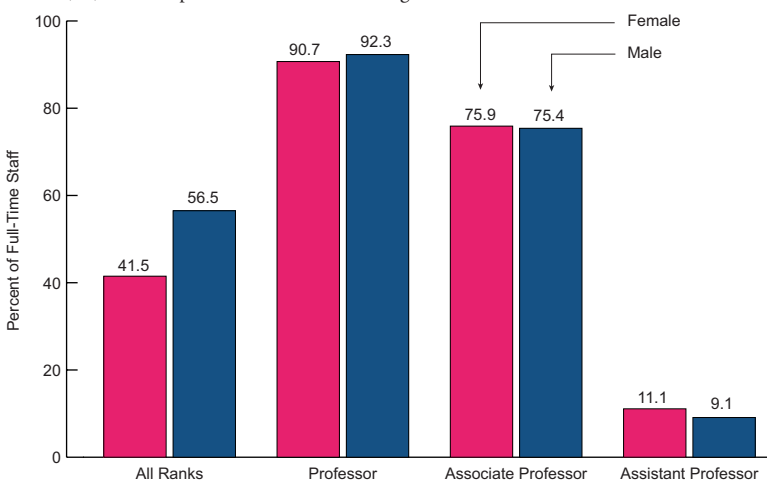
Source (I.5): U.S. Department of Education, Digest of Education Statistics



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

Full-Time Instructional Staff with Tenure in Degree-Granting Institutions, by Academic Rank and Sex, 2001-2002

Source (I.5): U.S. Department of Education, Digest of Education Statistics



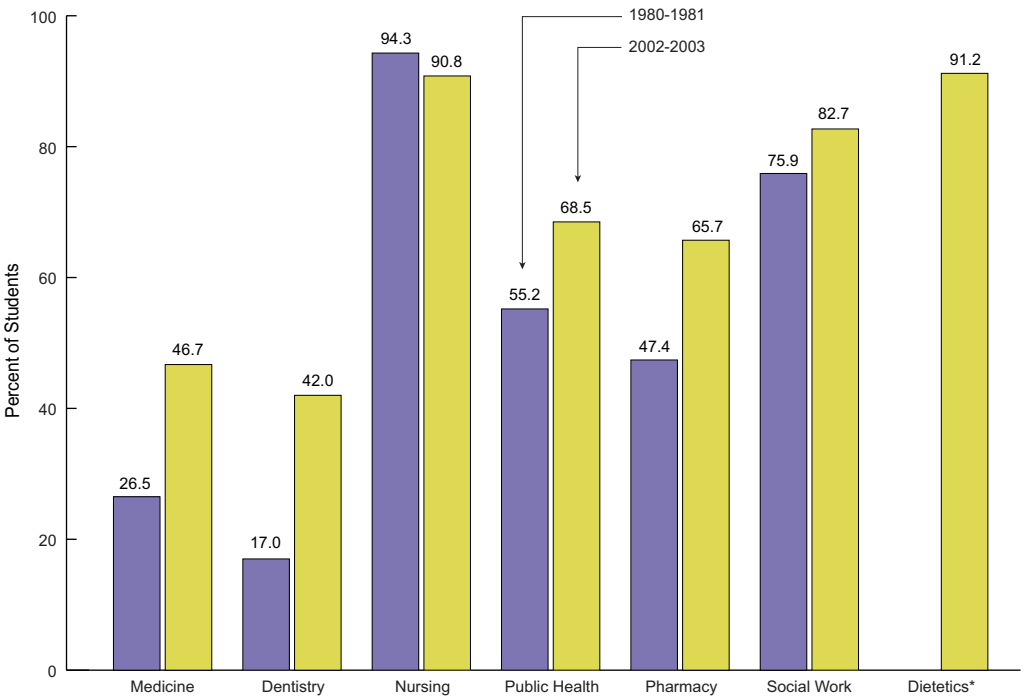
WOMEN IN HEALTH PROFESSIONS SCHOOLS

The health professions have long been characterized by sex disparities. Some professions, such as medicine and dentistry, have historically been dominated by men, while others, such as nursing, have been predominantly female. Over the past several decades, these gaps have narrowed, and in some cases women outnumber their male counterparts. In 1980-1981, 47.4 percent of pharmacy students were women, while in 2002-2003, women represented the majority at 65.7 percent. Even in fields where men are still the majority, the representation of female students has grown. In 1980-1981, only 26.5 percent of medical students were women compared to 46.7 percent in 2002-2003; in 2002, women represented 44.6 percent of the student body at schools of osteopathic medicine (data not shown). Similar gains have been made in the field of dentistry, where 42.0 percent of students were women in 2002-2003 compared to only 17.0 percent in 1980-1981.

Female students represent the majority in a number of health professions schools, including social work (82.7 percent), public health (68.5 percent), and optometry (58.6 percent, not shown). Women also represent the vast majority of enrollees in dietetics programs—in 2002, 91.2 percent of dietetics students and interns were women. Nursing also continues to be a field dominated by women, although the proportion of students who are female is slowly declining. In the 1980-1981 academic year, 94.3 percent of nursing students were female, while in 2003, females composed 90.8 percent of all master's-level nursing students.

Women in Schools for Selected Health Professions, 1980-1981 and 2002-2003

Source (I.6): Professional Associations



*Data from 1980-1981 are unavailable

WOMEN IN THE LABOR FORCE

In 2003, females aged 16 and older made up 46.4 percent of the workforce. Among working females, 75 percent worked full-time, compared to 89 percent of males. Females who were full-time wage and salary workers earned a weekly median of $552 while men earned a median of $695 per week, a ratio of 79.5 cents to one dollar. This ratio has risen from 63 cents to a dollar in 1979. In 2003, 5.7 percent of employed women held multiple jobs, compared to 4.8 percent of men. Among women holding multiple jobs, 46 percent held a primary job full time and a secondary job part time, 32 percent held two part time jobs, and 2 percent held two full time jobs.[1]

The ratio of females' earnings to those of males differed considerably by age, race, and ethnicity in 2003. Women aged 45 to 54 earned only 73 cents for every dollar earned by their male counterparts, while women aged 16 to 24 earned 93.3 cents for every dollar earned by males of the same age. Among Blacks and Hispanics, females earned 88 cents for every dollar earned by their male counterparts, while White females earned 79 cents for every dollar earned by their male counterparts. The earnings of Asian females were 5 percent greater than those of White females, 22 percent greater than those of Black females, and 46 percent greater than those of Hispanic females. Comparatively, the earnings of Asian men were 8 percent greater than those of White men, 39 percent greater than those of Black men, and 66 percent greater than those of Hispanic men.[2]

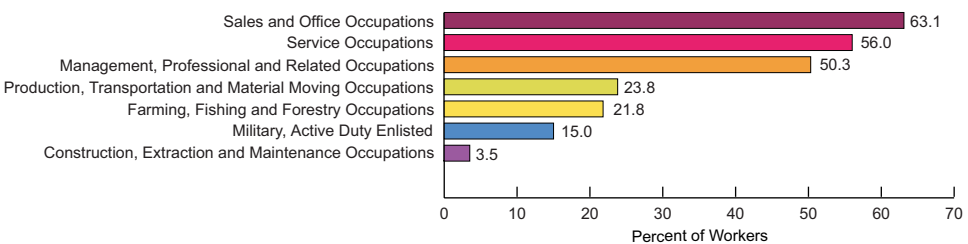
Both males and females with less than a high school diploma have experienced a decline in inflation-adjusted earnings since 1979; however, females' earnings have fallen by only 8 percent compared to 28 percent for males. Among those with college degrees, earnings for women and men have risen 34 and 22 percent respectively since 1979.[2]

1 *U.S. Department of Labor, Bureau of Labor Statistics. The employment situation: December 2004. January 2005.*

2 *U.S. Department of Labor, Bureau of Labor Statistics. Highlights of women's earnings in 2003. Report #978. September 2004.*

Representation of Females Aged 16 and Older in Occupational Sectors, 2003

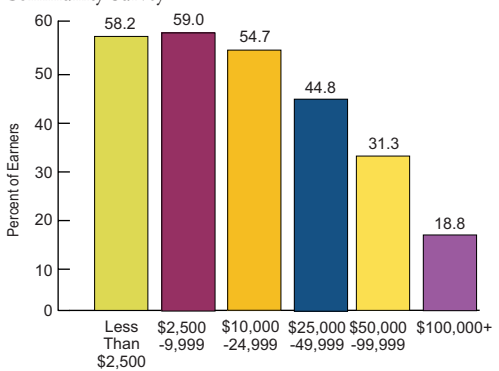
Source (I.7): U.S. Census Bureau, American Community Survey; Department of Defense*



*Data on military enlistment are from the Department of Defense, FY 2002; all other are from the Census Bureau.

Representation of Females Aged 16 and Older in Annual Earning Levels, 2003

Source (I.8): U.S. Census Bureau, American Community Survey



WOMEN AND POVERTY

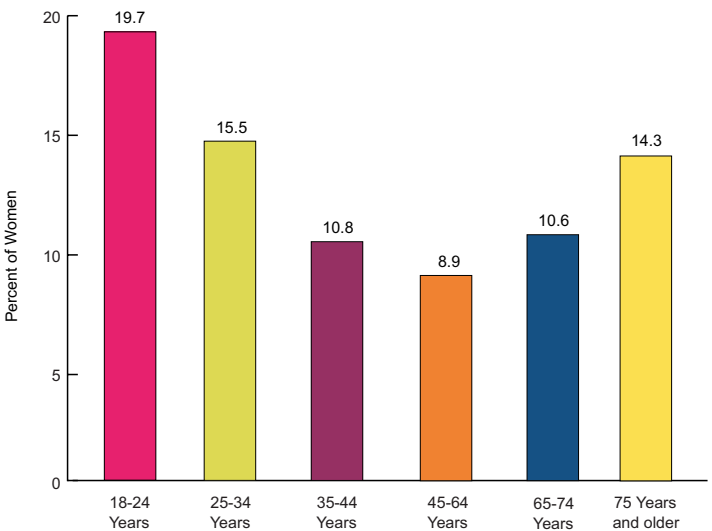
In 2003, there were 35.9 million people living with incomes below the Federal poverty threshold.[1] The poverty rate for all women 18 years and older in 2003 was 12.4 percent (13.8 million women). Poverty rates vary by age group among women, with the youngest women aged 18-24 years reporting a poverty rate of 19.7 percent. The lowest poverty rate (8.9 percent) was found among women aged 45-64. The poverty rate increases to 10.6 percent for women aged 65-74 and to 14.3 percent for women aged 75 years and older.

Women in female-headed households with no spouse experienced higher rates of poverty (24.4 percent) than women in married-couple families (5.2 percent) and men in male-headed households (8.8 percent).

1 The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor. Examples of 2003 poverty levels were $9,393 for an individual, $12,015 for a family of two, $14,680 for a family of three, and $18,810 for a family of four.

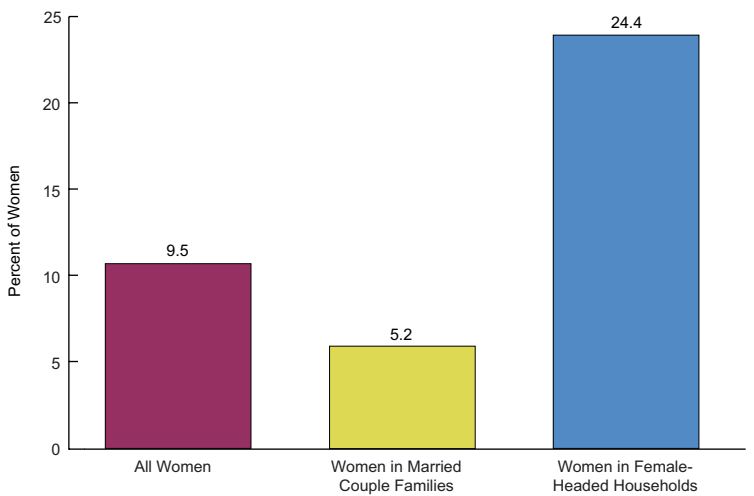
Women Living Below the Poverty Level, by Age, 2003

Source (I.9): U.S. Census Bureau, Current Population Survey



Women in Families,* Living Below the Poverty Level, by Household Type, 2003

Source (I.9): U.S. Census Bureau, Current Population Survey



**A group of 2 people or more related by birth, marriage, or adoption and residing together.*

WOMEN AND FEDERAL PROGRAM PARTICIPATION

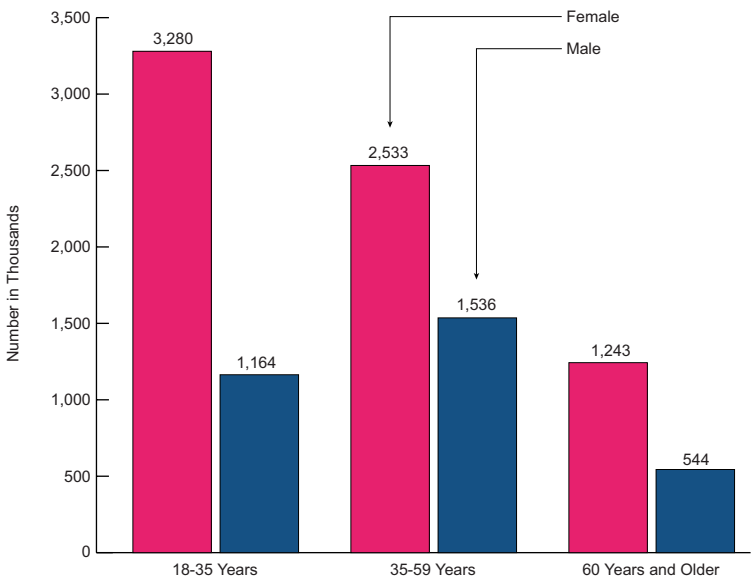
Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Federal Food Stamp Program helps low-income individuals purchase food; in 2003, 68 percent of all adult Food Stamp participants were women. Nearly half (46 percent) of women participants were in the 18-35 age group.

The Supplemental Food Program for Women, Infants, and Children (WIC) also plays an important role in serving women and families by providing supplementary nutrition during pregnancy, the postpartum period, and while breastfeeding. Most WIC participants (76 percent) are infants and children; however, the program also serves over 1.8 million women, representing 24 percent of WIC participants. From 1992 to 2003, the number of adult women participating in WIC increased by 51 percent, and it continues to rise.

Temporary Assistance for Needy Families (TANF), Federally- and State-funded, provides

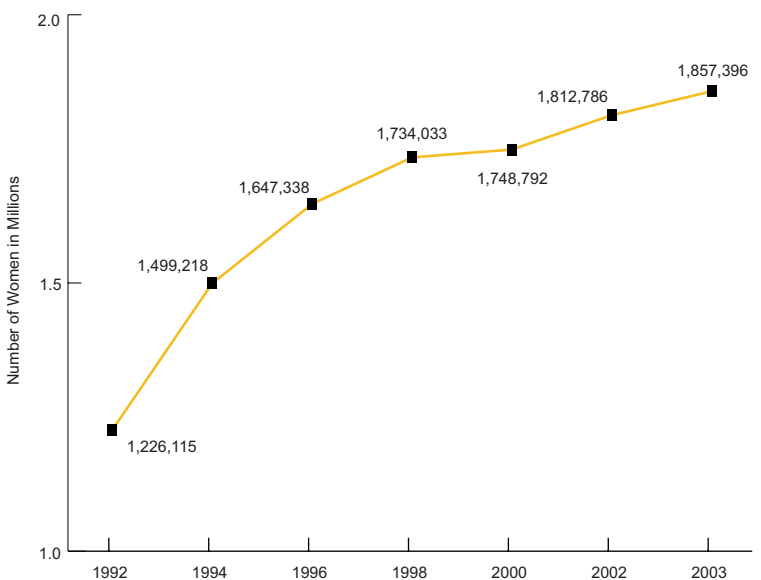
Adult Recipients of Food Stamps, by Age and Sex, 2003

Source (I.10): U.S. Department of Agriculture, Food Stamp Quality Control Sample



Women WIC Participants, Selected Years 1992-2003

Source (I.11): U.S. Department of Agriculture, WIC Program Participation Data



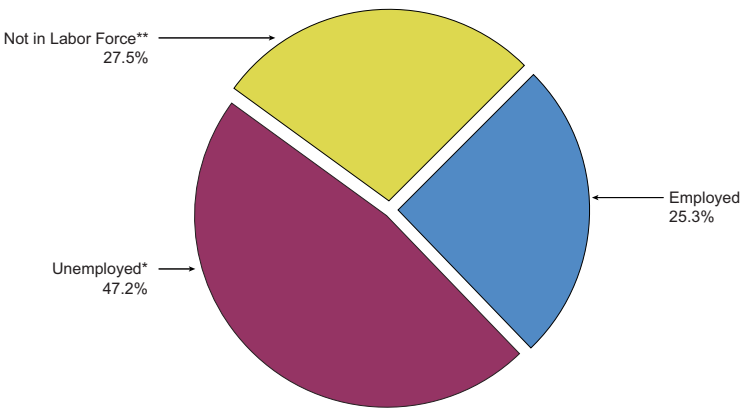
monetary assistance and work opportunities to needy families. In 1996, TANF replaced the national welfare program known as Aid to Families with Dependent Children (AFDC) and related initiatives. The main goals of TANF are to move recipients into work and to turn welfare into a program of temporary assistance with a lifetime maximum enrollment of 5 years.

In Fiscal Year 2002, adult TANF recipients numbered 1.3 million, of whom 1.2 million (over 90 percent) were women. Over three-quarters of female TANF recipients were in the 20-39 year age group. Among adult female TANF recipients, 25 percent were employed, 47 percent were unemployed and work, and 27.5 percent were not in the labor force (unemployed and not looking for work.)

In 2002, the average amount of monthly assistance provided through TANF was $418 per family. Of TANF families who had earned income, the monthly earnings averaged $683.

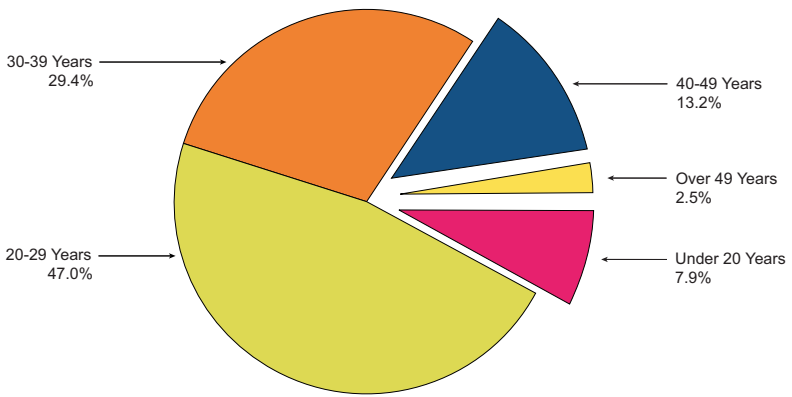
Adult Female Recipients of TANF, by Employment Status, Fiscal Year 2002

Source (I.12): Administration for Children and Families, National TANF Data File



Female Recipients of TANF, by Age, Fiscal Year 2002

Source (I.12): Administration for Children and Families, National TANF Data File



*Looking for work
**Unemployed, not looking for work (including those who have stopped looking).

HEALTH STATUS

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

In the following section, health status indicators are presented related to mortality, morbidity, health behaviors, and reproductive health. Issues pertinent to selected populations of women, including older, immigrant, rural, and incarcerated women are also addressed. The data are displayed by sex, age, and race and ethnicity, where available. Many of the conditions discussed, such as cancer, heart disease, hypertension, and stroke, have an important genetic component. Although the full impact of genetic risk factors on many of these conditions is still being studied, it is vital for women to be aware of their family history so that their risk for developing such conditions can be properly assessed.

NUTRITION

The U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (DHHS) recommend that Americans eat a variety of nutrient-dense foods and beverages while staying within their calorie needs. For most people, this means eating an assortment of fruits and vegetables, whole grains, and low-fat milk products while limiting sugar, sodium, saturated and trans fats, cholesterol, and alcohol.[1] Two dietary nutrients that are especially important to women are folate (or folic acid) and calcium. Folate is a B vitamin that supports growth and development, prevents certain birth defects and anemia during pregnancy, and may lower the risk of heart disease and certain cancers. Calcium is the most abundant mineral in the human body and is vitally important to bone health; inadequate calcium intake can lead to osteoporosis, which may result in painful fractures and disability.

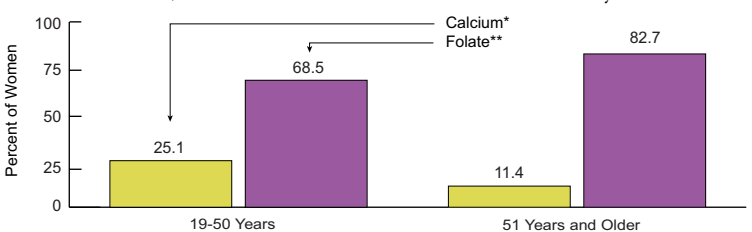
Despite their importance, many women are not consuming enough folate or calcium. In 1999-2002, only 19.9 percent of women consumed the recommended amount of calcium through their diets (not including supplements). One quarter of women ages 19 to 50 consumed 1000 mg/day, the recommended amount for that age group; only 11.4 percent of women ages 51 and older consumed the recommended 1200 mg/day. Non-Hispanic White women were most likely to consume enough calcium (22.8 percent), while non-Hispanic Black women were least likely (9.9 percent).

Women were much more likely to have an RBC (red blood cell) folate level of at least 220 ng/ml, the amount set as a goal for the Nation in Healthy People 2010. Overall, 73.9 percent of women had this folate level, although this varied widely by age. Two-thirds of women ages 18 to 44 had RBC folate levels of at least 220 ng/ml, while 83 percent of women ages 75 and older had the same. Non-Hispanic White women were most likely to have a RBC folate level of at least 220 ng/ml (79.4 percent), while non-Hispanic Black women were least likely (47.2 percent).

1 *U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th edition, Washington, D.C.: U.S. Government Printing Office, January 2005.*

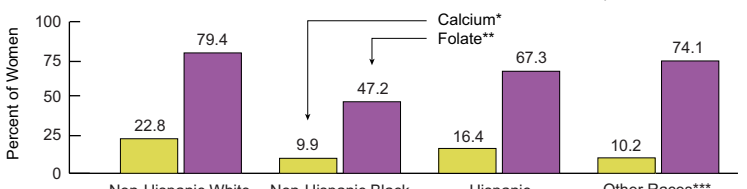
Women's Intake of Folate and Calcium, by Age, 1999-2002

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



Women's Intake of Folate and Calcium, by Race/Ethnicity, 1999-2002

Source: (II.1) Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**At least 1000mg/day for women aged 19-50 years and at least 1200 mg/day for women aged 51 and older, excluding supplements.*
***Red blood cell folate level of at least 220 ng/ml.*
****Includes Asian/Pacific Islander, American Indian/Alaska Native, and persons of more than one race.*

PHYSICAL ACTIVITY

Regular physical activity promotes health, psychological well-being, and a healthy body weight. To reduce the risk of chronic disease, the current Dietary Guidelines for Americans recommend at least 30 minutes of moderate to intense physical activity on most days of the week for adults. To prevent weight gain over time, the Guidelines recommend about 60 minutes of physical activity per day.[1]

In 2003, women of all ages were less likely to report engaging in regular physical activity than men. The largest differences were observed among the youngest and oldest segments of the population. At 18 to 24 years, 36.8 percent of women reported regular physical activity, compared to 48.4 percent of men. Among those aged 75 and older, 14.3 percent of women reported regular physical activity, compared to 23.0 percent of men. With increased age, rates of self-reported physical activity decreased among both men and women.

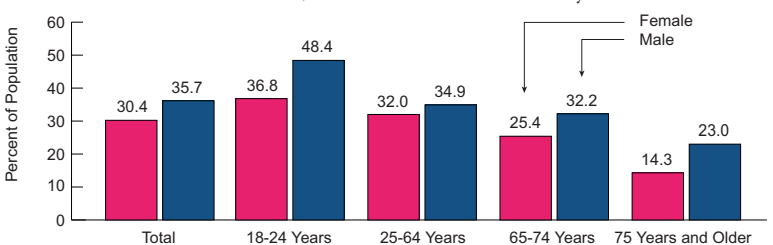
Physical activity in adolescence is important to health in adulthood. Childhood obesity or other health issues related to lack of physical activity may be a precursor for adverse health effects in adulthood,[2] and physical activity during youth may be a habit that is carried into adulthood. In 2003, 51.0 percent of female high school students played on one or more sports teams; the rate was lower among 12th graders than 11th graders and younger students. Among all high school females, 52.8 percent were enrolled in physical education; however, only 26.4 percent attended these classes daily.

1 *U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th edition, Washington, D.C.: U.S. Government Printing Office, January 2005.*

2 *Boreham C, Riddoch C. The physical activity, fitness, and health of children. Journal of Sports Sciences 2001 Dec;19(12):915-29.*

Adults Aged 18 and Older Who Engaged in Recommended Amounts of Physical Activity,* by Age and Sex, 2003

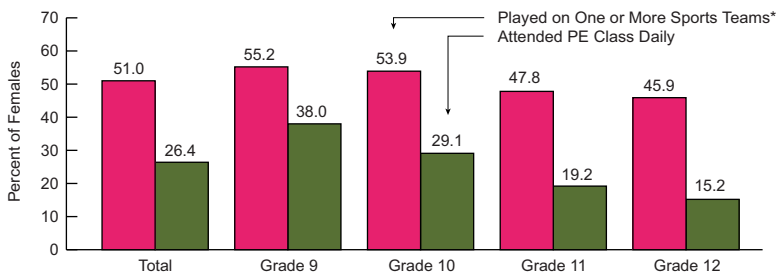
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Recommended physical activity is defined as moderate activity 5 times a week for 30 minutes, or vigorous activity 3 times a week for 20 minutes.*

High School Females Participating in Sports and Physical Education Classes,* by Grade, 2003

Source (II.3): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



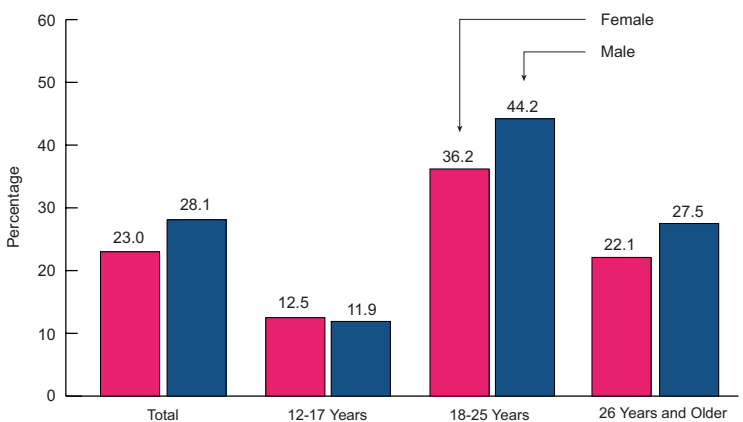
**Run by their school or community groups during the 12 months preceding the survey.*

CIGARETTE SMOKING

Cigarette smoking is associated with numerous chronic illnesses and premature death. In 2003, 60.4 million people aged 12 and older smoked cigarettes within the past month. Nearly one out of every four adult women smoked cigarettes in the past month, representing 26.6 million women aged 18 or older. For both women and men, smoking cigarettes often begins in adolescence and increases in prevalence among the young adult population. Among females, in 2003 the rate of cigarette smoking was 12.5 percent among 12-17 year-olds, 36.2 percent among 18-25 year-olds, and 22.1 percent among those aged 26 and older. While adult women (aged 18 and older) were less likely than men to have smoked in the previous month (24.1 percent compared to 30.1 percent), smoking was slightly more common among adolescent girls than among their male peers (12.5 percent of females compared to 11.9 percent of males in the 12-17 age group). While women in all racial and ethnic groups are less likely to smoke while they are pregnant, 25.0 percent of non-Hispanic White women smoked during pregnancy, more than 3 times the rate among Hispanic women.

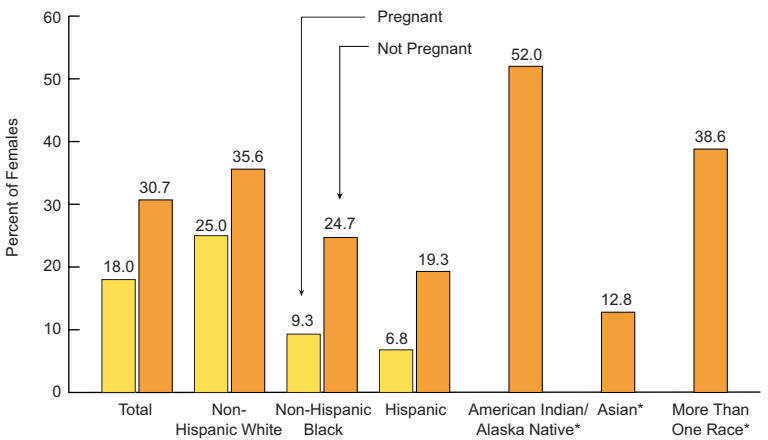
Percent of Persons Aged 12 and Older Reporting Past Month Cigarette Use, by Age and Sex, 2003

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



Females Aged 15-44 Years Reporting Past Month Cigarette Use, by Race/Ethnicity and Pregnancy Status, 2002 and 2003 Combined

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



**Low precision, no estimate for pregnant women reported.*

ALCOHOL MISUSE

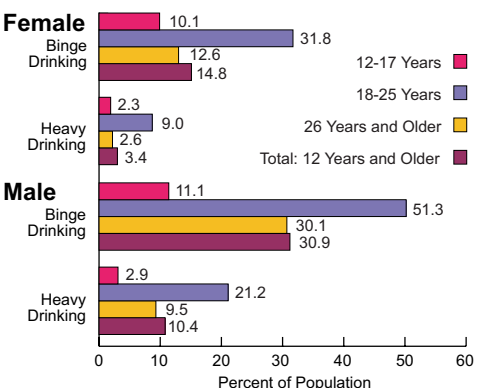
In 2003, 24 percent of the U.S. adult population (aged 18 years and older) reported binge alcohol use, which is defined as having five or more drinks on the same occasion at least once in the month prior to the survey. The rate of binge alcohol use among males was more than twice that of females (30.9 percent compared to 14.8 percent). Additionally, 3.4 percent of adult women and 10.4 percent of adult men reported heavy alcohol use in the past month.

For many women, alcohol misuse begins in adolescence, though its prevalence rises significantly and peaks in the 18-25 age group. Among these young adult women, 31.8 percent reported binge drinking and 9.0 percent reported heavy drinking in the past month. Among their younger counterparts aged 12-17, 10.1 percent reported binge drinking and 2.3 percent reported heavy alcohol use in the past month. The rates for the 26 and older group are closer to the adolescent group, with 12.6 percent reporting binge drinking and 2.6 percent reporting heavy drinking. The significant gender disparity in alcohol use noted above does not exist for adolescent males and females aged 12-17 years.

Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), infant low birth weight, and developmental delays in children. Findings from the 2002 and 2003 National Surveys on Drug Use and Health reveal that 4.1 percent of pregnant women aged 15-44 reported binge drinking in the past month. This compares to a rate of binge drinking during the past month of 23.2 percent among non-pregnant women. Among non-pregnant women in this age group, American Indian/Alaska Native women were most likely to binge drink (35.1 percent) compared to other racial and ethnic groups, non-Hispanic White women (26.1 percent) followed. Asian, non-pregnant women were the least likely to report binge drinking (9.1 percent).

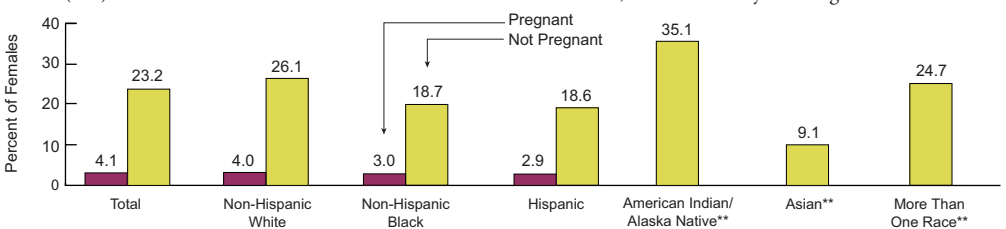
Persons Reporting Past Month Binge Alcohol Use and Heavy Alcohol Use,* by Age and Sex, 2003

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



Females Aged 15-44 Years Reporting Past Month Binge* Alcohol Use, by Race/Ethnicity and Pregnancy Status, 2002 and 2003 Combined

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



*"Binge" Alcohol Use was defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. "Occasion" means at the same time or within a few hours of each other. "Heavy" Alcohol Use is defined as drinking five 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.
**Low precision; no estimate reported for pregnant women.

ILLICIT DRUG USE

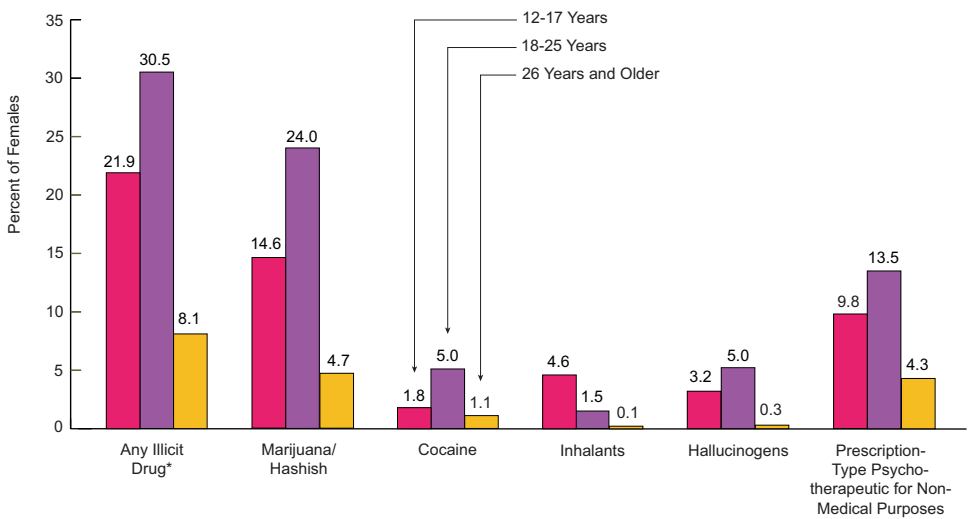
Because of their association with serious health consequences and addiction, marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes are classified as illicit drugs. In 2003, a total of 12.5 million women (11.3 percent) aged 18 or older reported using an illicit drug within the past year. The past-year illicit drug use rate is significantly higher among women aged 18-25 than among women over age 25 (30.5 percent compared to 8.1 percent). Among adolescent females (aged 12-17), 21.9 percent reported using illicit drugs in the past year. When stratified by race, the rate of illicit drug use among adolescent females was more common among non-Hispanic Whites (23.4 percent) than Hispanics (21.8 percent) or non-Hispanic Blacks (18.2 percent).

In 2003, marijuana was the illicit drug most commonly used by females in all age groups. Among females, those aged 18-25 had the highest rate of past year marijuana use (24.0 percent), though the rate of marijuana use in this age group declined from 2002 to 2003. The second most common type of illicit drugs used in the past year by women aged 18-25 was prescription-type psychotherapeutic drugs used for non-medical purposes—these were used by 13.5 percent of women aged 18-25 years. Adolescent females' drug use patterns differed from those of adult women. Those aged 12-17 reported the highest rate of inhalant use compared to their older counterparts.

In 2002 and 2003, 4.3 percent of pregnant women aged 15 to 44 years reported using illicit drugs in the month prior to their survey interview. Among the subgroup of 15- to 17-year-old pregnant youth, approximately one of eight, or 12.8 percent, reported illicit drug use in the past month. At the same time, it is important to note that the past-month illicit drug use rate was much lower among pregnant women than among non-pregnant women in all age groups.

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2003

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



*This category includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic drugs used for non-medical purposes.

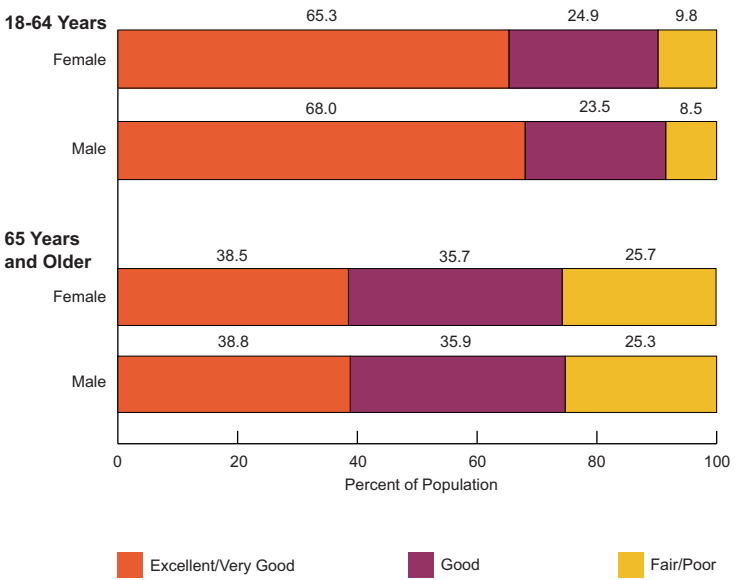
SELF-REPORTED HEALTH STATUS

In 2003, women and men aged 18 to 64 years were more likely to report being in excellent or very good health than were adults aged 65 years and older. Among women, 65.3 percent of those aged 18 to 64 years reported excellent or very good health, compared to only 38.5 percent of women aged 65 years and older. Women aged 18 to 64 years were about as likely to report fair or poor health (9.8 percent) as men of the same age (8.5 percent).

Non-Hispanic Black and Hispanic women were most likely to report their health status as fair or poor (18.6 and 15.5 percent, respectively). Asian women were most likely to report their health status as excellent or very good (66.5 percent), followed by non-Hispanic White women (63.2 percent).

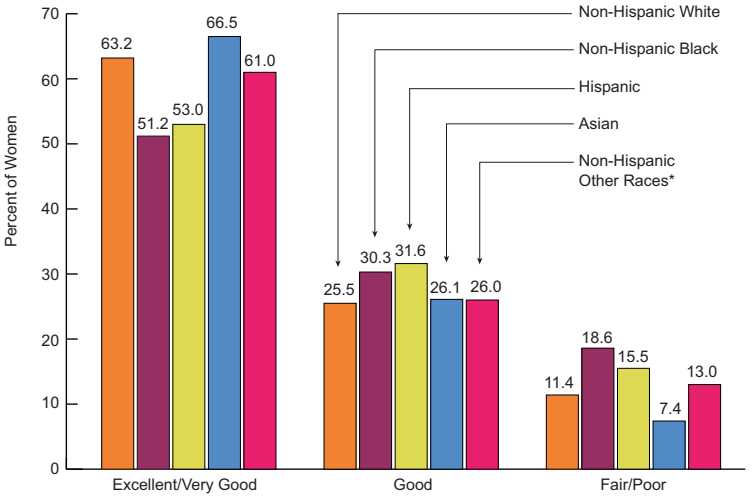
Self-Reported Health Status of Adults Aged 18 and Older, by Age and Sex, 2003

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



Self-Reported Health Status of Women Aged 18 and Older, by Race/Ethnicity, 2003

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



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

ACTIVITY LIMITATIONS

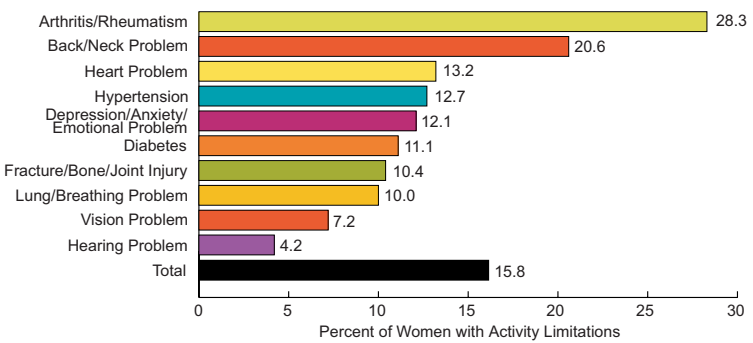
Women are more likely than men to report being limited in their activities due to a physical or mental/emotional problem, and among both sexes activity limitations are more common with older age. In 2003, 15.8 percent of women reported at least one activity limitation, compared to 13.0 percent of men. Among women 75 and older, 47.8 percent reported at least one activity limitation; this is more than seven times the rate reported among women aged 18 to 44 years. Among men 75 and older, 41.4 percent reported an activity limitation.

The four most frequently reported causes of activity limitation among women were arthritis or rheumatism (28.3 percent), back/neck problems (20.6 percent), heart problems (13.2 percent), and hypertension (12.7 percent). Poor mental health was also a cause of activity limitation, with 12.1 percent of women reporting that their activities were limited by depression, anxiety, or an emotional problem.

Vision problems caused activity limitations among 7.2 percent of women; however, 23.0 percent of women used adaptive devices for their vision in 2002, including telescopic or other prescriptive lenses, magnifiers, large print or talking materials, white cane, or guide dog. The use of adaptive devices was most common among women aged 75 years and older (28.5 percent), followed by those aged 45 to 64 years (24.6 percent). Overall, the use of adaptive devices among men and women was approximately equal; however, men were more likely to use these devices at younger ages while women were more likely to use them at older ages. The use of vision rehabilitation services was low among both females and males (1.4 and 1.5 percent, respectively).

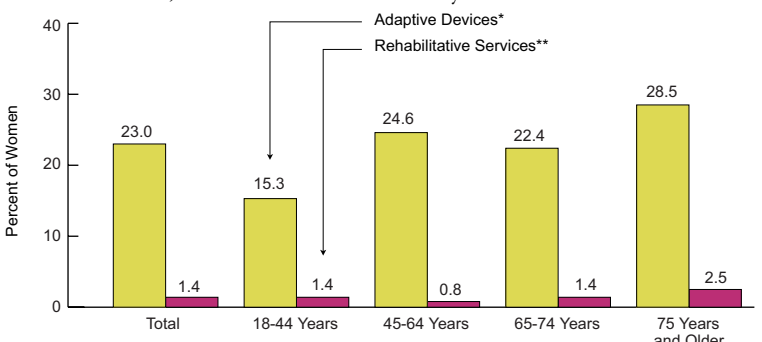
Conditions Causing Activity Limitations in Women Aged 18 and Older, 2003

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



Use of Adaptive Visual Devices and Vision Rehabilitative Services Among Women, by Age, 2002

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



*Includes telescopic or other prescriptive lenses, magnifiers, large print or talking materials, white cane, or guide dog.
**Includes job training, counseling, or training in daily living skills and mobility.

AIDS

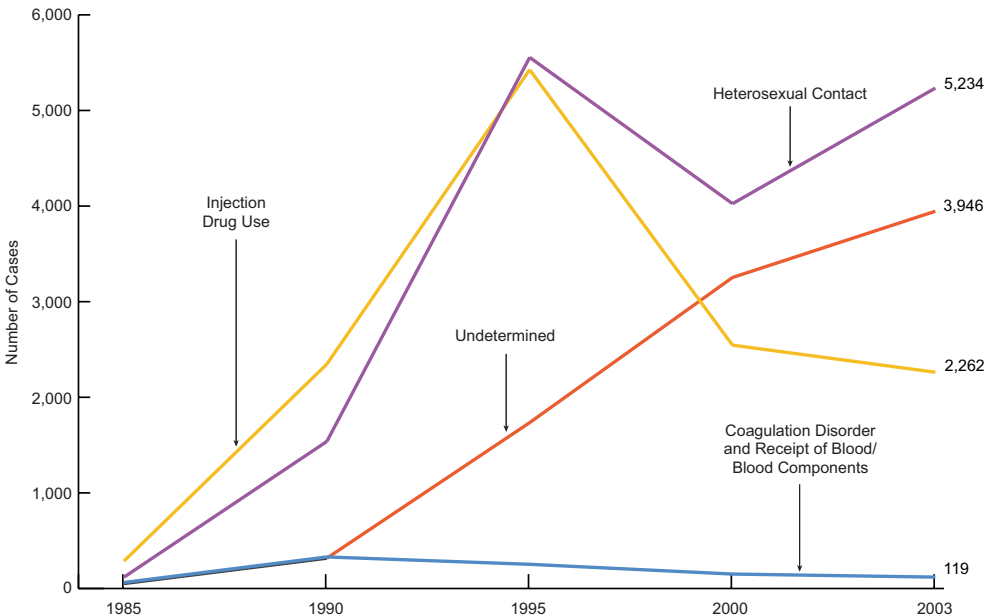
Acquired Immunodeficiency Syndrome (AIDS) was primarily diagnosed in men in the early 1980s, but the disease has since become more prevalent among women. In 1988, AIDS cases reported among men were 7,504 compared to 524 among women. By 2003, the number of cases reported among women had grown to 11,561, an increase of over 2,000 percent. In 1993, the Centers for Disease Control and Prevention expanded the criteria for AIDS cases to include persons with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.[1] This change is partially responsible for the greatly increased number of reported AIDS cases.

Although the number of AIDS cases has increased among women in general, the epidemic has disproportionately affected particular racial and ethnic groups. In 2003, non-Hispanic Black and Hispanic women represented less than one-fourth of all U.S. women, yet they accounted for more than three-fourths of women with AIDS. In 2002, HIV/AIDS represented the 5th leading cause of death among women aged 35-44, but it was the 3rd leading cause among non-Hispanic Black women in this age group and the leading cause among non-Hispanic Black women aged 25-34.[2]

Of the 11,561 reported AIDS cases among women in 2003, 45 percent were infected through heterosexual contact. Among these women, 76 percent were exposed through sex with an HIV-infected person without a specified risk, 18.8 percent were exposed through sex with an injection drug user, and 4.3 percent were exposed through sex with a bisexual male. Of all reported cases among women in 2003, another 19.5 percent were infected through their own injection drug use. One percent of

AIDS Cases, by Selected Exposure Categories* for Females Aged 13 Years and Older at Diagnosis, Selected Years 1985-2003

Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Changes in reporting procedures in 1993 led to an increase in the number of cases reported without information about the exposure category.

women were infected by receipt of blood components or tissue, and less than one percent were exposed due to hemophilia or another coagulation disorder. An additional 34 percent of women were exposed through a risk that was not reported or identified.

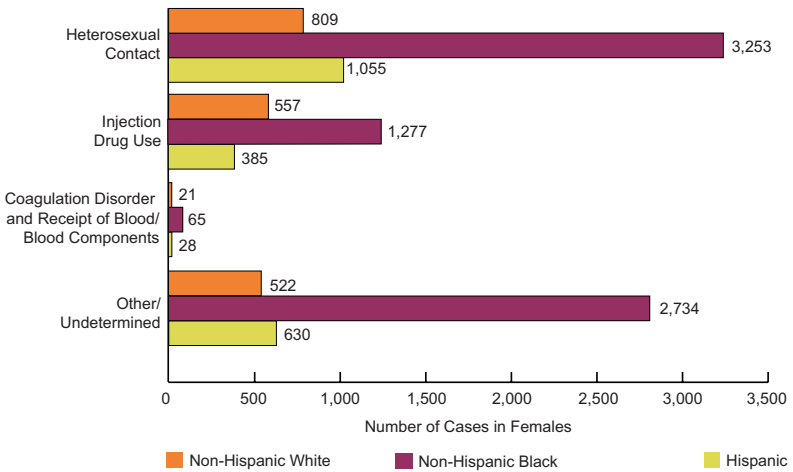
Overall, between 1998 and 2003 the number of women dying with AIDS and the number of new diagnoses increased only slightly. The number of reported cases is potentially misleading since it does not indicate when a person was infected. In contrast, the number of women living with AIDS rose dramatically (from 57,338 to 88,815) between 1998 and 2003, due in large part to recent advances in combination drug therapies.

1 *Centers for Disease Control and Prevention. Impact of the Expanded AIDS Surveillance Case Definition on AIDS Case Reporting-United States, First Quarter, 1993. MMWR 42(16):308-310.*

2 *Anderson RN, Smith BL. Deaths: Leading Causes for 2002. National Vital Statistics Report 2005; 53(17).*

Female AIDS Cases, Aged 13 and Older, by Exposure Category* and Race/Ethnicity,** 2003

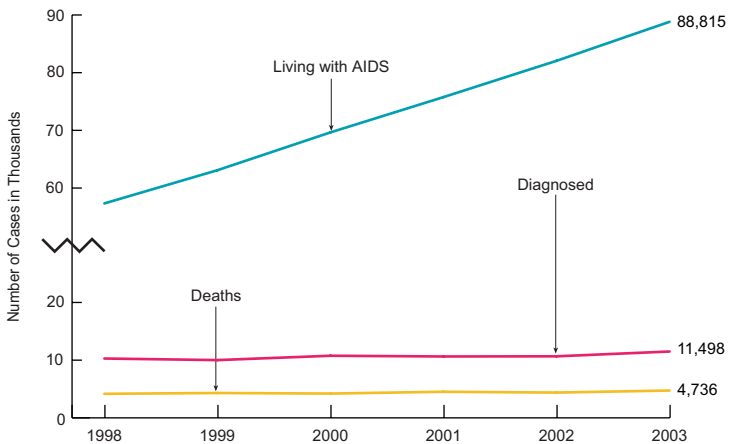
Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



**Each reported case of AIDS is assigned to one exposure category, even if more than one risk factor is present, according to the probability of acquiring the infection from each risk behavior.*
***Numbers for Asian/Pacific Islanders and American Indian/Alaska Natives are too small to illustrate on graph.*

Estimated Number of Diagnoses of AIDS, Women Living with AIDS, and Deaths Among Women with AIDS,* 1998-2003

Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



**Among women ages 13 and older*

ARTHRITIS

Arthritis, the leading cause of disability among Americans over 15 years of age, encompasses more than 100 different diseases that affect areas in or around the joints.[1] The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement as the cartilage covering the ends of joint bones deteriorates. Other arthritis types are rheumatoid arthritis, lupus arthritis, gout, and fibromyalgia.

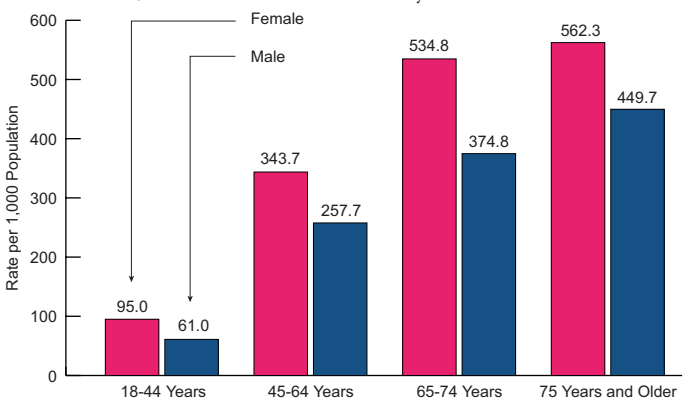
In 2003, over 20 percent of U.S. adults reported that they had ever been diagnosed with arthritis. Arthritis was more common in women than men, and rates of arthritis increased with age for both sexes. Less than 10 percent of women 18 to 44 years of age had been diagnosed with arthritis, compared to over 55 percent of women 75 years and older.

Rates of arthritis among women varied by race and ethnicity. It was most common among non-Hispanic White women, followed by non-Hispanic Black women; Asian women had the lowest rates of arthritis. The high rate among non-Hispanic White women may be due to the older age distribution of this population.

1 *Arthritis Foundation. The facts about arthritis. 2004. http://www.arthritis.org*

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2003

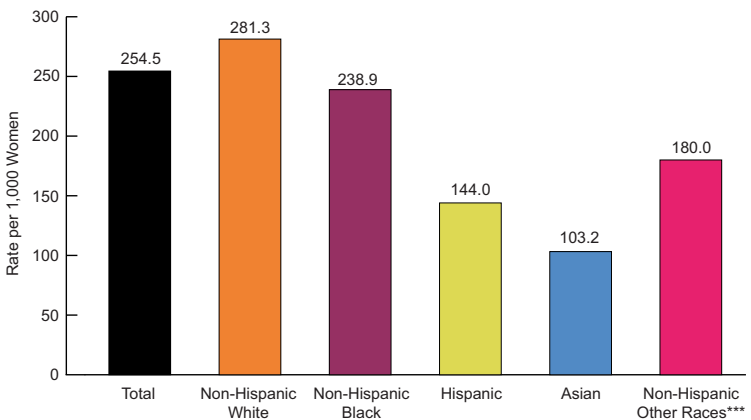
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity,** 2003

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



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

ASTHMA

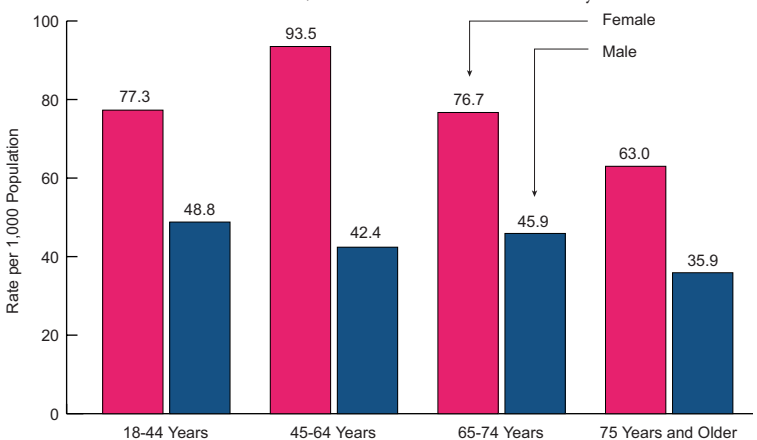
Asthma is a chronic inflammatory disorder of the airways characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. However, by taking certain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

In 2003, women had higher rates of asthma than men (81.1 compared to 45.7 per 1,000 population). This disparity was most pronounced among those between the ages of 45 and 64 years, where women experienced asthma at more than twice the rate of men. The difference in asthma rates among men and women was the smallest among those 18-44 years of age, although women in this group still experienced asthma at more than 1.5 times the rate of men.

Among women, rates of asthma differed among racial and ethnic groups. Non-Hispanic Black and non-Hispanic White women had the highest rates of asthma (86 per 1,000 females), followed by Hispanic women (60.8 per 1,000 women); Asian women had the lowest rates (22.8 per 1,000 women).

Adults Aged 18 and Older with Asthma,* by Age and Sex, 2003

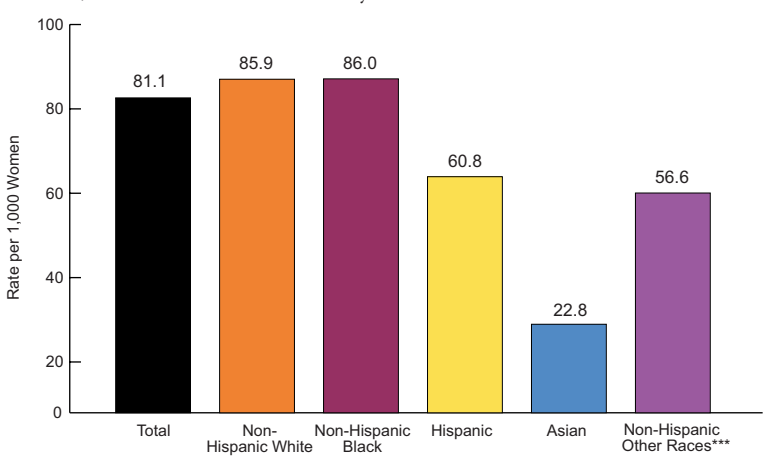
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have asthma and report they still have asthma.

Women Aged 18 and Older with Asthma,* by Race/Ethnicity,** 2003

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



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

CANCER

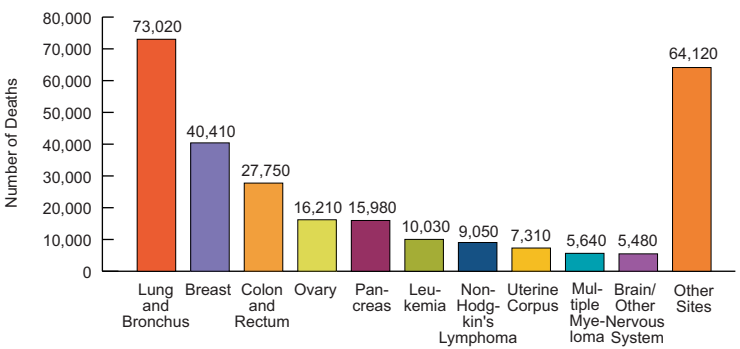
In 2005, it is estimated that 275,000 females will die of cancer. Of these, it is estimated that 27 percent will be due to lung/ bronchus cancer, 15 percent due to breast cancer, and 10 percent due to colon and rectal cancer.[1] Lung and bronchus cancer, the leading cause of cancer death among women, is most prevalent among Black and White women. The rate of lung and bronchus cancer among Black women (averaged over the 5 years from 1997-2001) was 54.5 cases per 100,000 females, and the rate among White women was 51.3 per 100,000 females. Rates among other racial and ethnic groups were approximately half of those for Black and White women: 28.5 cases per 100,000 Asian/Pacific Islander women, 23.9 per 100,000 Hispanic women, and 23.4 per 100,000 American Indian/Alaska Native women.

While lung cancer is the leading cause of cancer death, breast cancer is the most prevalent form of cancer among women. Over the period 1997-2001, rates of breast cancer were highest among White women, with a rate of 141.7 cases diagnosed per 100,000 females, followed by Black women, with a rate of 119.9 cases per 100,000 females. The rate of breast cancer among Asian/Pacific Islander women was 96.8 cases per 100,000, and Hispanic women had a rate of 89.6 cases per 100,000. The rate of breast cancer among American Indian/Alaska Native women, who had a rate of 54.2 cases per 100,000 females, was the lowest.

Rates of colon and rectal cancer appear to vary less dramatically across racial and ethnic groups. The highest rates were reported among Black women (56.5 cases per 100,000 females), followed by White women (45.9 cases per 100,000). Among the other three racial/ethnic groups, rates were approximately even: 38.6 cases per 100,000 Asian/Pacific Islander females, 32.7 per 100,000 American Indian/

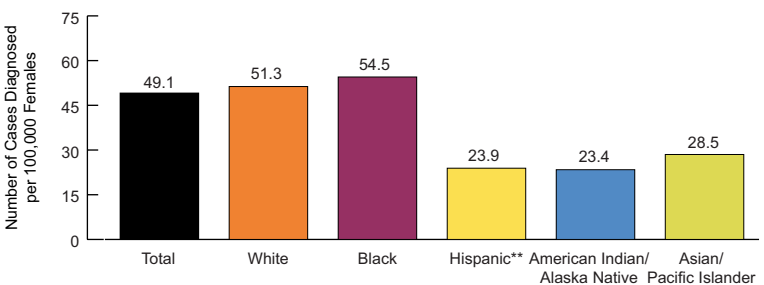
Leading Causes of Cancer Deaths for Females, by Site, 2005 Estimates

Source (II.7): American Cancer Society



Age-Adjusted Malignant Lung and Bronchus Cancer Rates Among Females, by Race/Ethnicity, 1997-2001*

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



*5 Year average.
**May be of any race.

Alaska Native women, and 32.5 per 100,000 Hispanic females.

Survival rates among women vary for each type of cancer. Of the most common types of cancer, lung and bronchus cancer has the lowest survival rate (17.2 percent), followed by colon and rectal cancer (63.1 percent) and breast cancer (87.7 percent).

While the specific causes of cancer have not yet been identified, it appears to involve a combination of environmental, behavioral, and genetic factors. Adopting a healthy lifestyle by achieving optimal weight, exercising regularly, avoiding tobacco, eating nutritiously and reducing sun exposure may significantly reduce the risk of cancer.[2] In addition, regular cancer screenings specific to women are recommended. Pap smears are recommended after sexual activity begins, or at the age of 21, whichever comes first, to screen for cervical cancer. Mammograms are recommended for women aged 40 years and older to screen for breast cancer and, for persons aged 50 and older, fecal occult blood testing and sigmoidoscopy are recommended to screen for colorectal cancer.[3] A recent study has found that breastfeeding may also reduce the risk for premenopausal breast cancer and ovarian cancer.[4]

1 *American Cancer Society. Cancer facts & figures 2005. Atlanta: The Society; 2005.*

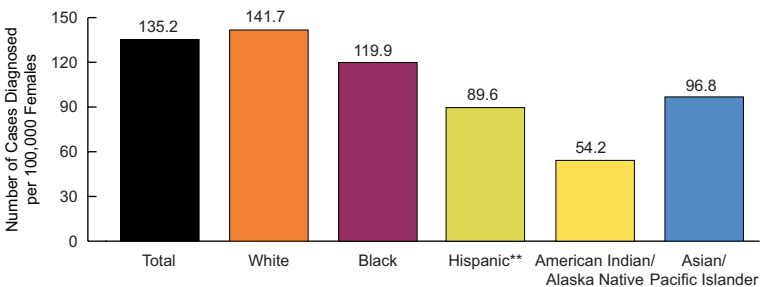
2 *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Preventing and controlling cancer: the nation's second leading cause of death 2004. February 2004. http://www.cdc.gov/nccdphp/aag/aag_dcpc.htm*

3 *U.S. Preventive Services Task Force. Guide to clinical preventive services. March 2004. http://www.ahrq.gov/clinic/uspstfix.htm*

4 *Labbok MH. Effects of breastfeeding on the mother. Pediatric Clinics of North America 2001; 48(1):143-157.*

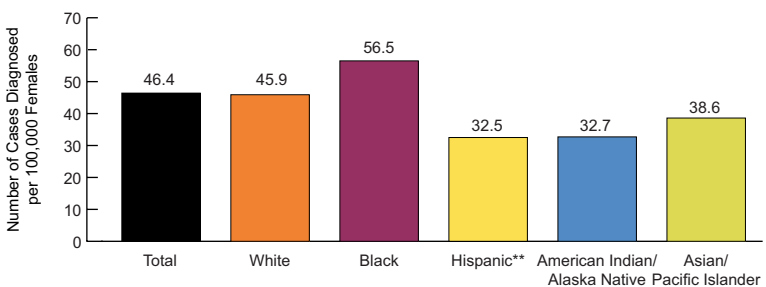
Age-Adjusted Malignant Breast Cancer Rates Among Females, by Race/Ethnicity, 1997-2001*

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



Age-Adjusted Malignant Colon and Rectal Cancer Rates Among Females, by Race/Ethnicity, 1997-2001*

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



*5 Year average.
**May be of any race.

DIABETES

Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, nervous system disease, amputation, and complications in pregnancy.

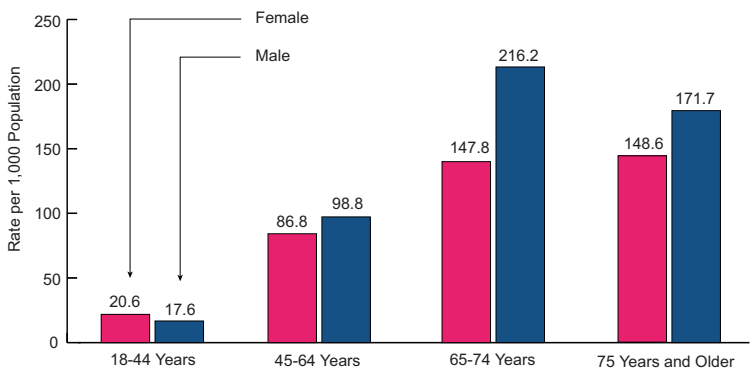
The two main types of diabetes are Type 1 and Type 2. Type 1 diabetes is usually diagnosed in children and young adults, and is commonly referred to as "juvenile diabetes." Type 2 diabetes is the most common type; it is often diagnosed among adults but is becoming more common among children. Risk factors for Type 2 diabetes include obesity, physical inactivity, and a family history of the disease.

In 2003, women under the age of 45 were more likely to report having diabetes than men of the same age. The rate of diabetes increases with age for both sexes; however, older men were more likely to have diabetes than their female counterparts. The rate of diabetes among women under the age of 45 was 20.6 per 1,000 women, compared to 17.6 per 1,000 men of the same age. The rates among women and men 75 years and older were 148.6 and 171.7 per 1,000, respectively.

There were racial and ethnic differences in diabetes rates among women in 2003. Non-Hispanic Black women had the highest rate of diabetes (91.2 per 1,000), followed by Hispanic women (61.0 per 1,000) and non-Hispanic White women (60.8 per 1,000); Asian women had the lowest rate of diabetes (47.1 per 1,000).

Adults Aged 18 and Older with Diabetes,* by Age and Sex, 2003

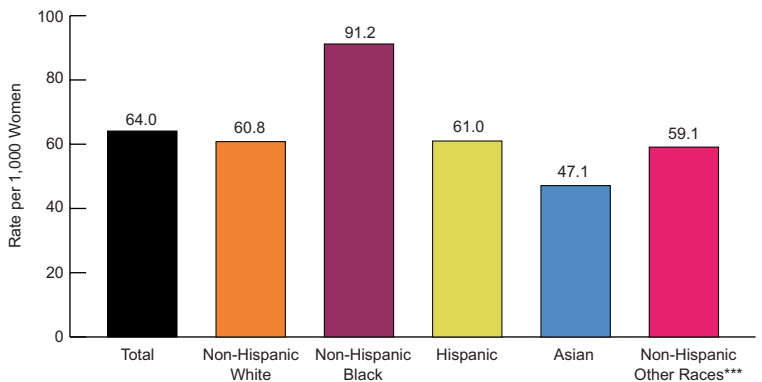
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Diabetes,* by Race/Ethnicity,** 2003

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



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

HEART DISEASE

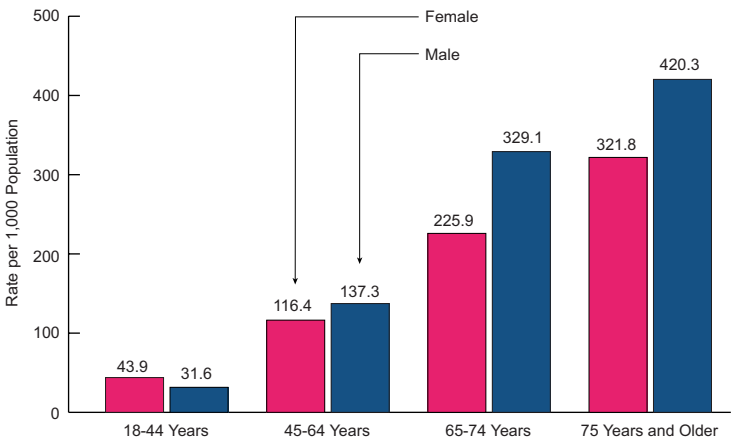
In 2002, heart disease was the leading cause of death for women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common cause of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age.

Overall, in 2003, men had a higher rate of heart disease than women. However, women under 45 years of age had a higher rate than men (43.9 per 1,000 women compared to 31.6 per 1,000 men). Rates of heart disease increase substantially with age and are highest among those 75 years and older. This demonstrates the chronic nature of this disease.

Rates of heart disease among women differ by race and ethnicity. The highest rates were reported among non-Hispanic White women (120.3 per 1,000), followed by non-Hispanic Black women (88.6 per 1,000). Asian women had the lowest rate (42.1 per 1,000). Death rates from heart disease among Black women exceed those of White women.

Adults Aged 18 and Older with Heart Disease,* by Age and Sex, 2003

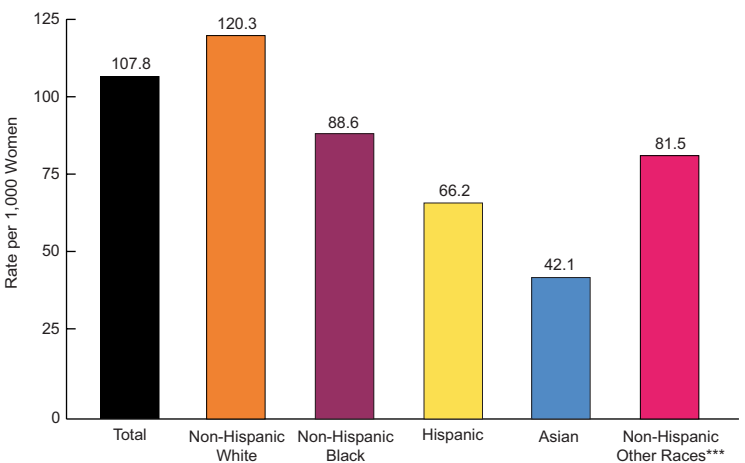
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Respondents who reported that a health professional has ever told them that they have a heart condition or disease.

Women Aged 18 and Older with Heart Disease,* by Race/Ethnicity,** 2003

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



*Respondents who reported that a health professional has ever told them that they have a heart condition or disease.
**Rates reported are not age-adjusted.
***Includes American Indian/Alaska Native and those of more than one race.

HYPERTENSION AND STROKE

Hypertension, also known as high blood pressure, is a risk factor for heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, a diastolic pressure (between heartbeats) of 90 or higher, or both. In 2003, women had higher overall rates of hypertension than men (260.9 per 1,000 women compared to 243.0 per 1,000 men). Rates of hypertension were similar among both sexes under the age of 65; however, among older persons the rate of hypertension was higher among women than men.

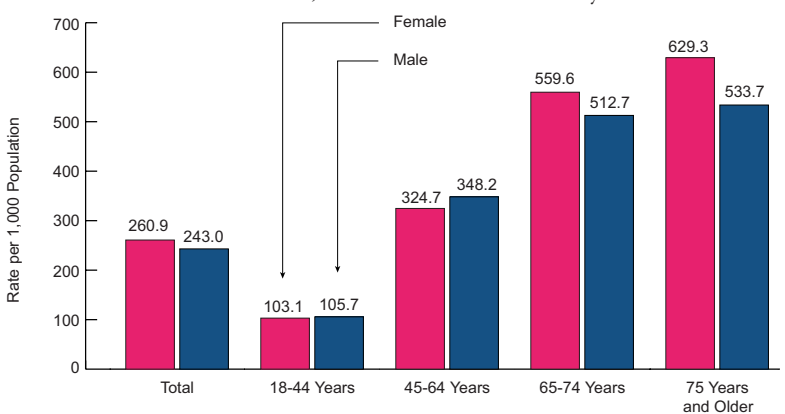
The rates of hypertension among women differ by race and ethnicity. In 2003, non-Hispanic Black women had the highest rate of hypertension (360.0 per 1,000), followed by non-Hispanic White women (261.1 per 1,000); Asian women had the lowest (150.4 per 1,000).

In 2002, the latest year for which mortality data are available, stroke—one of the major risks of hypertension—was the third leading cause of death among women resulting in 100,050 deaths among women and 62,622 among men.[1] In 2003, 2.4 percent of both men and women reported ever having a stroke. Stroke was most commonly reported by non-Hispanic Black women, followed by non-Hispanic White women; Hispanic women were least likely to report ever having a stroke.

1 *National Center for Health Statistics. Health, United States, 2004. Hyattsville, MD: 2004.*

Adults Aged 18 and Older with Hypertension,* by Age and Sex, 2003

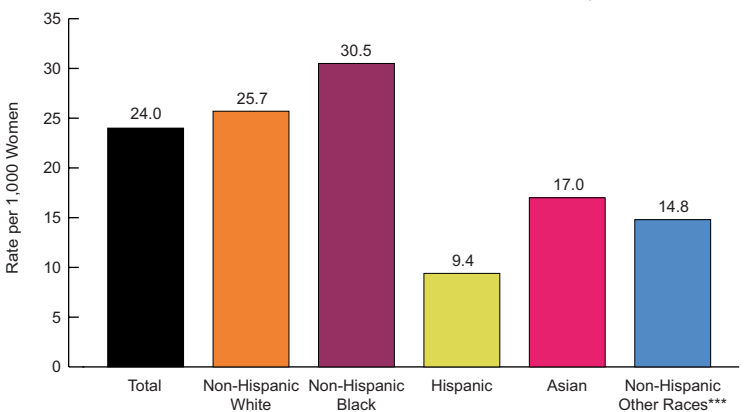
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Respondents who reported that a health professional has ever told them that they have ever had hypertension.

Women Aged 18 and Older Who Have Ever Had a Stroke,* by Race/Ethnicity,** 2003

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



*Respondents who reported that a health professional has ever told them that they have ever had a stroke.
**Rates reported are not age-adjusted.
***Includes American Indian/Alaska Native and those of more than one race.

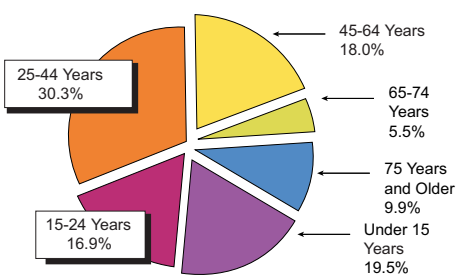
INJURY

Although many injuries are preventable, there were an estimated 39 million injury-related emergency department (ED) visits in 2002. Overall, the rate of injury-related ED visits was higher among males than females (15.4 compared to 12.3 percent of visits per year). Among females, nearly one-third of injury-related ED visits were made by those aged 25 to 44 years, while fewer than 6 percent were made by women aged 65 to 74 years. However, the highest rate (18 per visits per 100 people) occurred among women 75 years and older (data not shown); among males, the highest rate (21 visits per 100 people) occurred among men aged 15 to 24 years.

Unintentional and intentional injuries represented a higher proportion of ED visits for males than females in 2002. Among males and females aged 18 years and older, unintentional injuries accounted for 27.6 and 19.3 percent of ED visits, respectively, while intentional injuries represented 2.9 and 1.6 percent of ED visits, respectively. Among both sexes, the two most common causes of injury were falls (6.1 percent of ED visits among females and males) and motor vehicle crashes (4.2 percent of ED visits among females and 5.1 percent of ED visits among males). Injuries accounted for a greater percentage of ED visits for males than females for every cause, with the exception of adverse medical effects; for that cause, the rate was 1.6 compared to 1.3 percent of ED visits for women and men respectively. Other common causes of injury among females included being accidentally struck by an object or person, cutting or piercing instruments or objects, and natural or environmental factors.

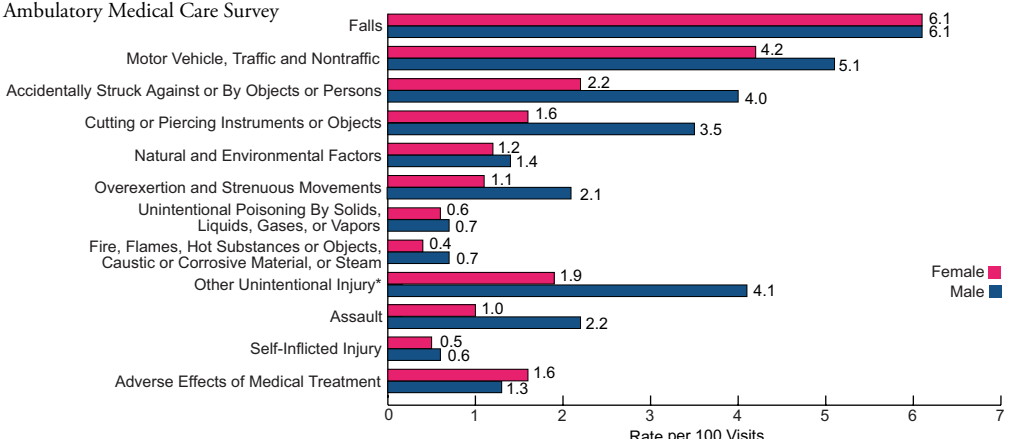
Injury-Related Emergency Department Visits for Females, by Age, 2002

Source (II.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



Injury-Related Emergency Department Visits, by Sex and Mechanism, 2002

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



*Includes drowning and suffocation, cycles, machinery, and firearm accidents.

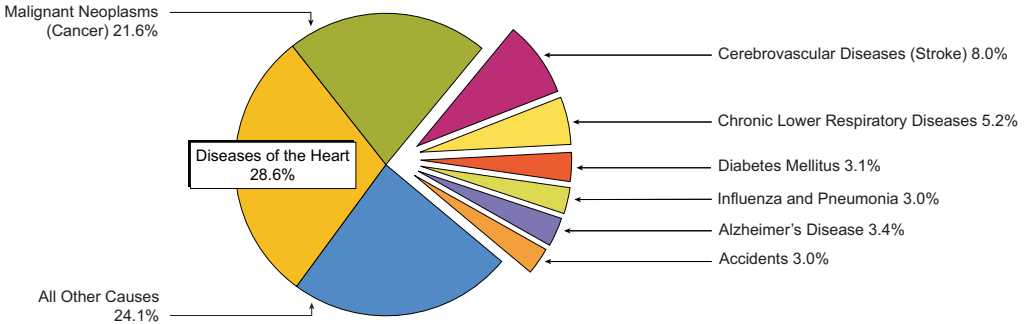
LEADING CAUSES OF DEATH

In 2002, there were over 1.2 million deaths among females. Of these deaths, more than half were attributed to diseases of the heart and malignant neoplasms (cancer). Heart disease represented 356,014 deaths (28.6 percent), while 268,503 (21.6 percent) were from cancer. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 8.0 percent of all female deaths. This was followed by chronic lower respiratory diseases which accounted for 5.2 percent.

Crude death rates varied for women by race and ethnic group. For non-Hispanic White, non-Hispanic Black, and Hispanic women, the leading cause of death was heart disease, with 292.3, 211.6, and 69.7 deaths per 100,000 females, respectively. In contrast, among American Indian/Alaska Native and Asian/Pacific Islander women, the leading cause of death was malignant neoplasms, accounting for 71.0 and 72.6 deaths per 100,000 females, respectively.

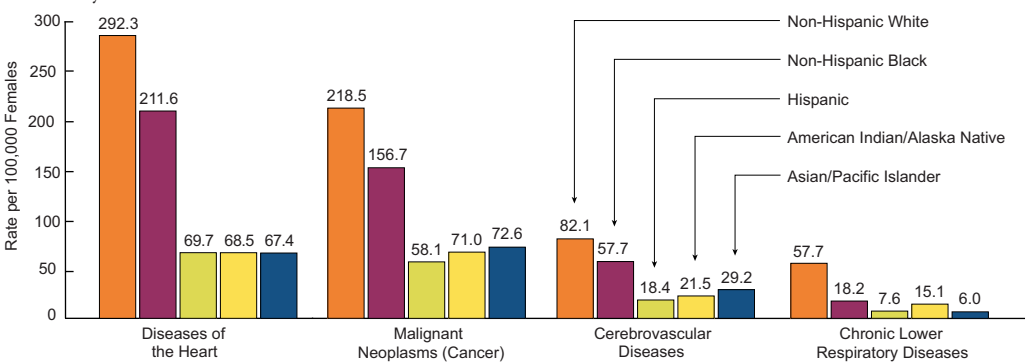
Leading Causes of Death in Females (All Ages), 2002

Source (II.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Crude Death Rates* from Selected Conditions for Females (All Ages), by Race and Ethnicity, 2002

Source (II.12): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Rates are not age-adjusted.

MENTAL ILLNESS AND SUICIDE

In 2003, there were an estimated 19.6 million men and women aged 18 years or older with serious mental illness (SMI).[1] Females were disproportionately affected and were more likely than males to report a SMI within the past year. The highest rate of serious mental illness occurred among women in the 18-25 age group, with 17.3 percent of these women reporting an SMI within the past year. The greatest disparity between men and women occurred in the 26-49 age group, with women nearly twice as likely as men to have experienced an SMI in the past year (13.8 compared to 7.0 percent).

Although the majority of people who suffer from mental illness do not commit suicide, mental illness is a primary risk factor. Over 90 percent of suicides in the U.S. are associated with mental illness and/or alcohol and substance abuse.[2] In 2002, the rate of suicide continued to be substantially higher for males (18.4 per 100,000) than for females (4.2 per 100,000). However, it is estimated that there were three suicide attempts among females for every one among males.

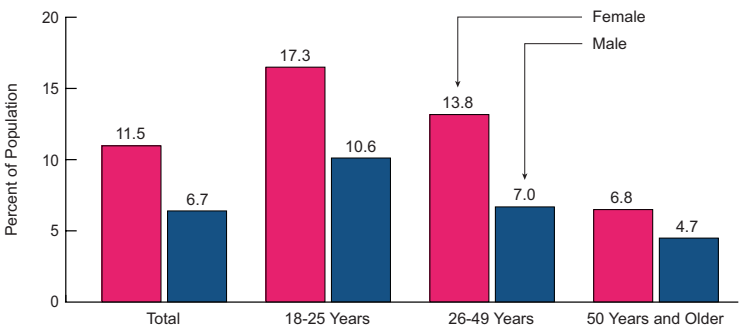
Among women who did commit suicide, rates were highest among non-Hispanic White women (5.1 deaths per 100,000), followed by American Indian/Alaska Native women (4.1 deaths per 100,000). Lower rates were found among Asian/Pacific Islander women (3.0 per 100,000), Hispanic women (1.8 per 100,000), and Non-Hispanic Black women (1.6 per 100,000).

1 *The National Survey of Drug Use and Health defines serious mental illness as "having a diagnosable mental, behavioral, or emotional disorder that met the DSM-IV criteria and resulted in functional impairment that substantially interfered with or limited one or more major life activities."*

2 *Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors. (2002) Reducing Suicide: A National Imperative. Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine.*

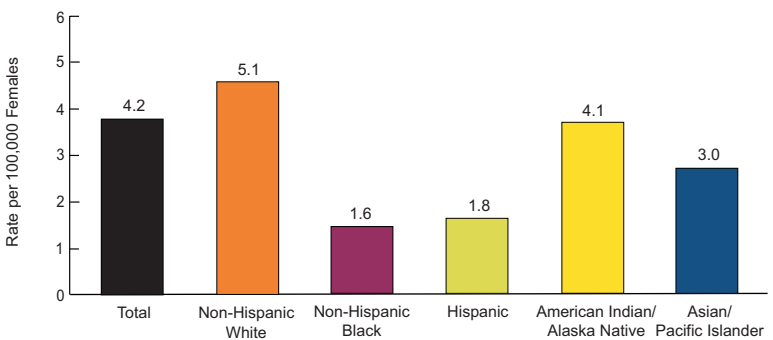
Serious Mental Illness in Past Year, by Age and Sex, 2003

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



Suicide Death Rates for Females Aged 15 Years and Older, by Race/Ethnicity, 2002

Source (II.4): National Centers for Health Statistics, National Vital Statistics System



ORAL HEALTH AND DENTAL CARE

Oral health conditions can cause chronic pain of the mouth and face, and can disrupt normal eating behaviors. Dental caries (also referred to as cavities or tooth decay) is one type of dental disorder that may cause problems if left untreated. In 1999-2003, women were less likely than men to have untreated dental caries (8.9 percent of women compared to 12.6 percent of men). Non-Hispanic Black women were most likely to have caries (17.1 percent), followed by Hispanic women (12.0 percent); non-Hispanic White women were least likely to have caries (6.8 percent).

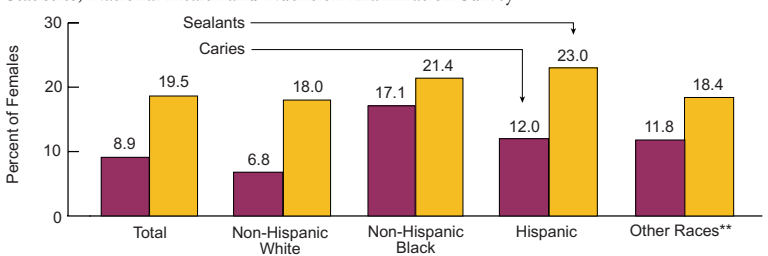
Sealants—a hard, clear substance applied to the surfaces of teeth—may help to prevent caries. Although women are less likely to have caries than men, they are also less likely to have sealants. In 1999-2002, 19.5 percent of women had sealants compared to 23.1 percent of men. Hispanic women were most likely to have sealants (23.0 percent), followed by non-Hispanic Black women (21.4 percent); non-Hispanic White women were least likely to have sealants (18.0 percent).

Proper dental care is important for preventing dental caries and maintaining overall oral health. In 1999-2002, 62.7 percent of women had seen a dentist in the past year. Hispanic women were least likely to have seen a dentist in the past year (51.5 percent), followed by non-Hispanic Black women (52.2 percent). Hispanic women and non-Hispanic Black women were also most likely to have gone at least five years since their last dental visit (16.0 and 15.6 percent, respectively).

Length of time since last dental visit also varies by income. In 1999-2002, women with incomes between 100 and 199 percent of the poverty level were least likely to have seen a dentist in the past year (47.0 percent) and most likely to have gone at least five years since a dental visit (21.1 percent). Women with incomes over 300 percent of the poverty level were most likely to have regular dental visits.

Untreated Dental Caries and Presence of Sealants in Females,* by Race/Ethnicity, 1999-2002

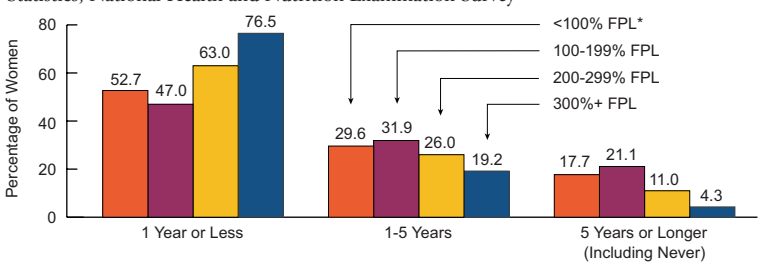
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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

Time Since Last Seen a Dentist Among Women Aged 18 and Older, by Poverty Status, 1999-2002

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



*Federal Poverty Level

OSTEOPOROSIS

Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even in individuals who have already suffered a fracture. Ten million Americans have osteoporosis, while another 34 million have low bone mass and are at risk for developing osteoporosis. Eighty percent of those affected are women. By 2020, one in two Americans over age 50 will be at risk for osteoporosis and low bone mass.

Each year about 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks in the wrist, spine, and hip. One in five individuals who fracture a hip die within a year of the fracture and about one in five individuals with a hip fracture end up in a nursing home within a year. The direct care costs for osteoporotic fractures alone are up to $18 billion each year.[1]

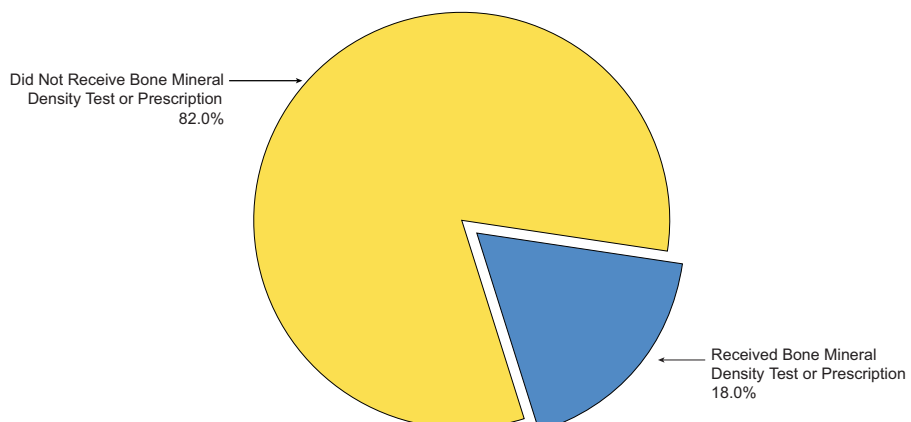
Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and physical activity, and by taking prescription medication when appropriate. Bone density tests are recommended for all women over 65 and for any man or woman who suffers even a minor fracture after age 50. Treatment of osteoporosis has been shown to reduce the risk of subsequent fractures by 30-65 percent.[1]

National data in 2003 indicate that only 18 percent of female Medicare beneficiaries 67 years of age or older who had a fracture received either a bone mineral density test or a prescription. Most plans were in the range of 10 to 26 percent. Based on voluntary reporting of a subset of plans, it is estimated that about 10 percent of women received only a prescription and about 8 percent of women received only the test. Only about 3 percent of women aged 67 or older received both the bone mineral density test and a prescription. This is considered the highest standard of care.

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

HEDIS®* Measure of Osteoporosis Management in Women Aged 67 and Older Who Had a Fracture, Medicare Plans, 2003**

Source (II.13): National Committee for Quality Assurance



*HEDIS (Health Plan Employer Data and Information Set) is a registered trademark of NCQA.
**The HEDIS Osteoporosis Management in Women Who Had a Fracture measure estimates the percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density test or a prescription for a drug to treat or prevent osteoporosis in the six months after the date of fracture. This measure was reported for the first time in 2004, and only applies to Medicare plans.

OVERWEIGHT AND OBESITY

Being overweight or obese increases the risk for numerous ailments, including high blood pressure, diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health.[1] The National Health and Nutrition Examination Survey (NHANES) from the National Center for Health Statistics (NCHS) was used to measure the Body Mass Index (BMI) of a representative sample of the U.S. population. For NHANES, BMI is based on height and weight, as measured by health professionals, and may be more accurate than surveys that rely on self-reporting of these measurements by participants.

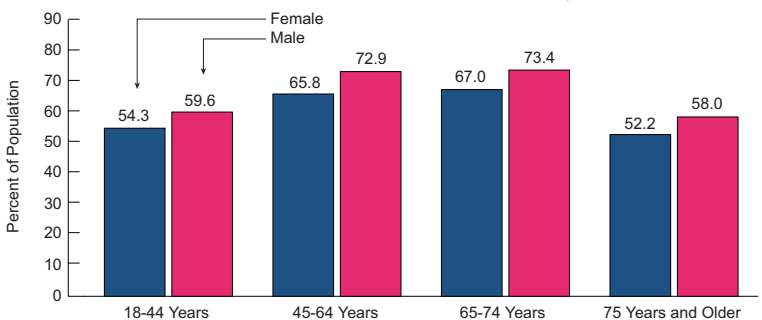
In 2003, men of all ages were more likely to be obese than their female counterparts. The highest rate of overweight and obesity among men (73.4 percent) occurred in the 65 to 74 age group; the highest rate among women (67.0 percent) also occurred among those 65 to 74 years of age.

Overall, 27.3 percent of adult women are overweight and 31.6 percent are obese, but these rates vary by race and ethnicity. Hispanic women had the highest rate of overweight (32.7 percent), while Non-Hispanic White women had the lowest rate (26.0 percent). Non-Hispanic Black women had the highest rate of obesity (45.3 percent), followed by Hispanic women (34.5 percent). Overall, Non-Hispanic Black women were the most likely to be overweight or obese (72.6 percent).

1 *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Overweight and obesity. June 2004. http://www.cdc.gov/nccdphp/dnpa/obesity/.*

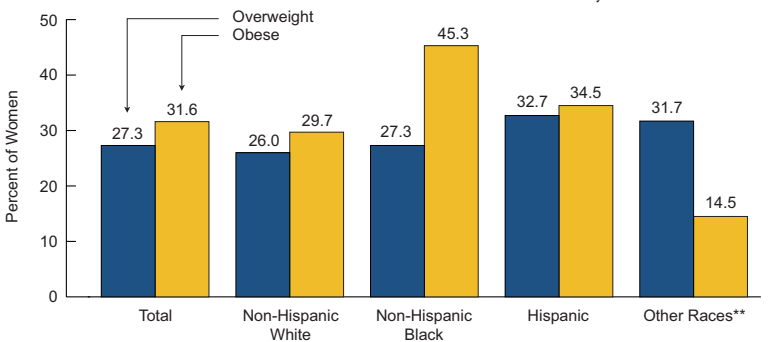
Overweight and Obesity* in Adults Aged 18 and Older, by Age, 1999-2002

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Overweight and Obesity* in Women Aged 18 and Older, by Race/Ethnicity, 1999-2002

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Obesity was defined as a body mass index of 30.0 or higher. Overweight was defined as a body mass index of 25.0 to 29.9.*
***Includes Asian/Pacific Islander, American Indian/Alaska Native and those of more than one race.*

SEXUALLY TRANSMITTED DISEASES

Rates of reported sexually transmitted diseases (STDs) are highest among adolescent and young adult women. In 2003, chlamydia and gonorrhea were the most commonly diagnosed STDs. The rate of chlamydia among adolescents (aged 15-19) was 2,687 cases per 100,000 females, and the rate of gonorrhea was 635 per 100,000 females. The rates for both of these STDs decrease with age.

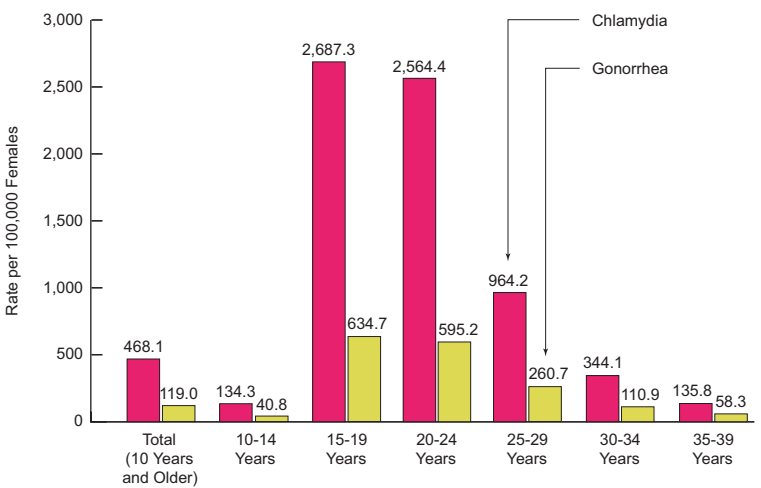
Significant racial and ethnic differences exist in the reported rates of chlamydia and gonorrhea. Among non-Hispanic Black females there were 1,633 cases of chlamydia and 616 cases of gonorrhea per 100,000 females in 2003, compared to 218 and 39 cases, respectively, per 100,000 non-Hispanic White females.

A third STD, syphilis, remains relatively rare (0.8 cases per 100,000 women). In 2003, this condition disproportionately affected non-Hispanic Black females (4.2 per 100,000 females) and American Indian/Alaska Native females (1.5 per 100,000 females).

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

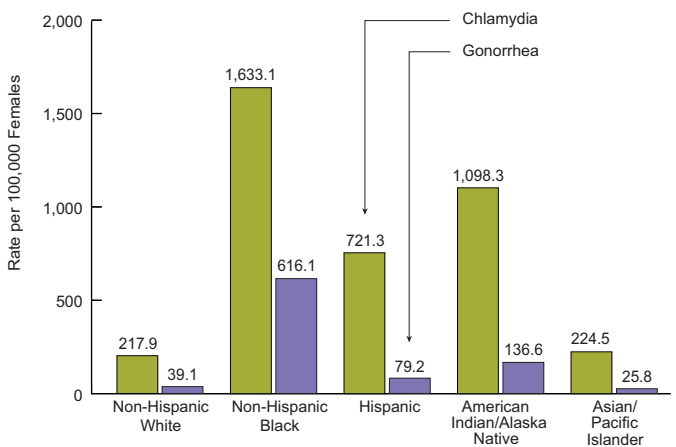
STDs Among Females Aged 10 and Older, by Age, 2003

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



STDs Among Females Aged 10 and Older,* by Race/Ethnicity, 2003

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



*Reported rates are not age-adjusted.

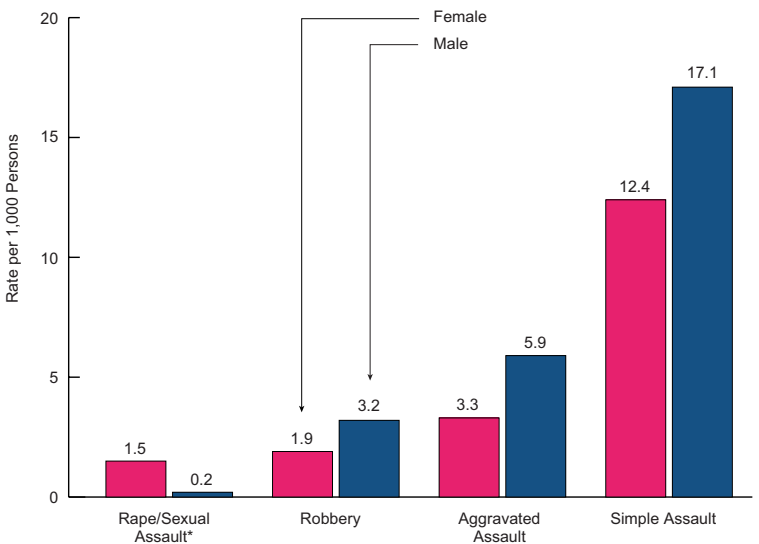
VIOLENCE AND ABUSE

In 2003, there were 2.3 million violent crimes committed against females aged 12 and older, including rape, sexual assault, robbery, and aggravated and simple assault. This follows the downward trend in violent crime victimization rates for women over the past decade. Women are more likely than men to be victims of reported sexual assault and rape; however, men are more likely to be victims of robbery, aggravated assault, and simple assault. In 2003, 1.5 of every 1,000 females aged 12 and older were victims of rape or sexual assault.

Women are more likely than men to be victims of violent acts committed by people they know intimately, such as friends or intimate partners. In 2003, violence by intimate partners constituted 19 percent of violent crimes against women, compared to 3 percent of violent crimes against men. The overall rate of intimate partner violence against females was 4.6 per 1,000 females, with the highest rates occurring among females aged 15 to 24 and 25 to 34 years (6.1 and 7.9 per 1,000 females, respectively).

Violent Crime Victims Aged 12 and Older, by Sex, 2003

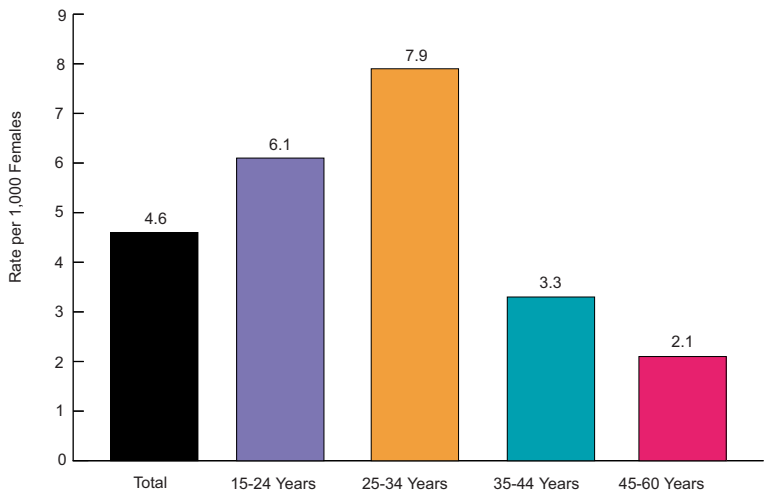
Source (II.15): U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



*The estimated rate among males may not be reliable because it is based on 10 or fewer cases.

Women Experiencing Intimate Partner Violence, by Age, 2003

Source (II.15): U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



INCARCERATED WOMEN

In 2003, the number of women incarcerated in the Nation's prisons and local jails continued to increase, reaching 181,752 at midyear. While the number of women incarcerated in prisons and jails is significantly lower than men (181,752 women compared to 1,963,599 men), the number of incarcerated women has grown at a much faster rate than that of men. Since 1995, the average annual increase in women in prisons and jails was 5.2 percent, compared to a 3.4 percent annual increase in the number of incarcerated men. Since 1990, the number of incarcerated women has more than doubled, increasing by 118 percent.[1]

Racial and ethnic differences continue to exist among incarcerated women. In 2003, the highest rate of incarceration was among non-Hispanic Black women (aged 18 and older) who had an incarceration rate of 352 per 100,000 women. Non-Hispanic Black women were nearly 2.5 times more likely than Hispanic women (with a rate of 148 per 100,000 women) and over 4.5 times more likely than non-Hispanic White women (with a rate of 75 per 100,000) to be incarcerated in 2003. These differences remain in all age groups of adult women, with the highest rates found among non-Hispanic Black women aged 35-39 years (926 per 100,000 women).[2]

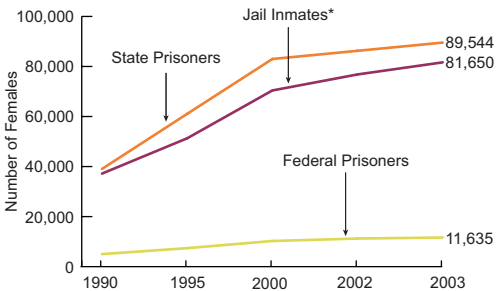
In 2002, the most common reason for arrest among women was "other offenses" (25.2 percent of arrests); these included all offenses except traffic violations that did not fall under one of the 28 main categories of offenses charged. The most common specific offenses among women included larceny/theft (13.8 percent of arrests), assault other than aggravated assault (9.7 percent), drug abuse violations (8.8 percent), driving under the influence (7.9 percent), disorderly conduct (5.2 percent), and violation of liquor laws (5.1 percent). Among female jail inmates, the most serious current offenses included drug possession (14.5 percent), fraud (14.0 percent), drug trafficking (10.9 percent), larceny/ theft (10.3 percent), and assault (8.0 percent). Female jail inmates were less likely than men to be perpetrators of violent crimes. The offense of murder/nonnegligent manslaughter accounted for 1.4 percent of the most serious offenses among female jail inmates and 2.1 percent among male inmates. Rape was the most serious crime of 0.7 percent of male inmates, but it was listed as "not applicable" for female inmates. Other sexual assault was the most serious offense for 3.1 percent of males and only 0.9 percent of females.

1 *Harrison PM and Karberg, JC. Prison and Jail Inmates at Midyear 2003. U.S. Department of Justice, Bureau of Justice Statistics Bulletin, May 2004.*

2 *Ibid.*

Female Federal and State Prisoners and Local Jail Inmates,* 1990-2003

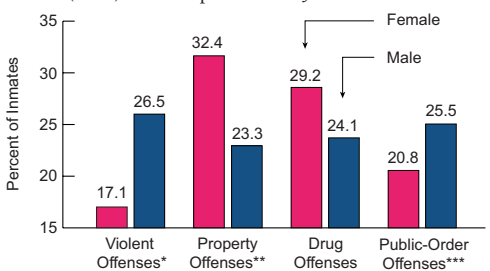
Source (II.16): U.S. Department of Justice



** Based on 1-day counts.*

Most Serious Current Offense of Jail Inmates, by Sex, 2002

Source (II.16): U.S. Department of Justice



**Includes murder, manslaughter, rape, robbery, assault.*
***Includes burglary, theft, fraud.*
****Includes weapons violations, obstruction of justice, driving while intoxicated, parole violations.*

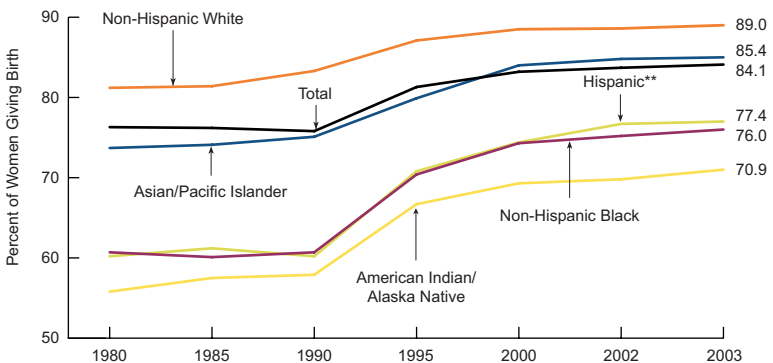
PRENATAL CARE

Prenatal care is an important factor in achieving a healthy pregnancy outcome. Receiving early prenatal care can help to reduce the incidence of perinatal illness, disability, and death by providing health care advice to mothers and identifying and managing any chronic or pregnancy-related risks. The percentage of mothers receiving prenatal care in their first trimester of pregnancy increased slightly from 2002 to 2003, from 83.7 percent to 84.1 percent. Overall this figure has risen 11 percent since 1990, when only 75.8 percent of women received first trimester care.

Although a positive trend was observed among most racial/ethnic groups, there are still great disparities among these groups in the likelihood of entering care early in pregnancy. In 2003, 89.0 percent of non-Hispanic White women entered care in the first trimester, followed by Asian/Pacific Islander women at 85.4 percent, Hispanic women at 77.4 percent, non-Hispanic Black women at 76.0 percent, and American Indian women at 70.9 percent. Since 1990 the total number of women receiving late or no care has dropped from 6.1 to 3.5 percent although the rate of late or no care remains high among American Indian/Alaska Native women (7.6 percent), non-Hispanic Black women (6.0 percent), and Hispanic women (5.3 percent).

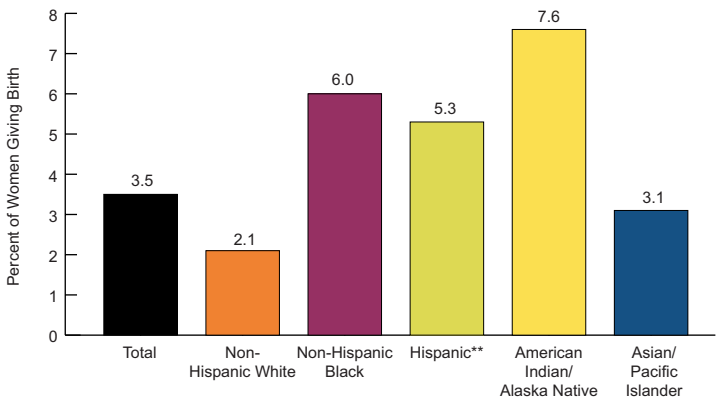
Mothers Beginning Prenatal Care in the First Trimester, by Race/Ethnicity, 1980-2003*

Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Mothers Receiving Late or No Prenatal Care, by Race/Ethnicity, 2003*

Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*2003 data are preliminary.
**May be of any race.

LIVE BIRTHS

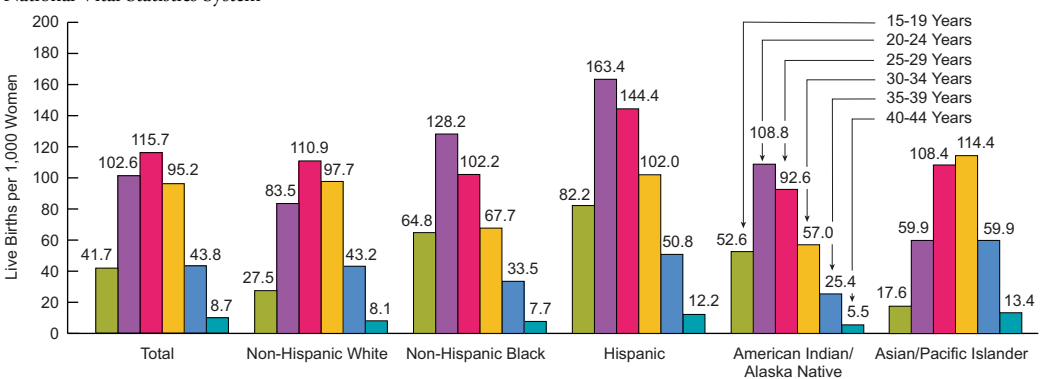
There were just over 4 million births in the United States in 2003, which is slightly higher than the number of births in 2002. This is reflected in the birth rate, which increased from 13.9 births per 1,000 population in 2002 to 14.1 births per 1,000 in 2003. The number of births rose in nearly all racial and ethnic groups, from 1 percent among non-Hispanic White and American Indian women to 4 percent among Hispanic women and 5 percent among Asian and Pacific Islander women. The only exception to this trend was among non-Hispanic Black women, whose births decreased by less than 1 percent between 2002 and 2003.

The birth rate among teenagers also reached a record low in 2003. The birth rate for teens aged 10 to 14 years dropped to 0.6 births per 1,000 females from 0.7 in 2002, and the rate for those 15 to 19 years dropped from 43.0 per 1,000 in 2002 to 41.7 in 2003. As with the total number of births, there are considerable differences in teenage birth rates by race/ethnicity. In 2003, birth rates for teenagers ages 15-19 ranged from a low of 17.6 per 1,000 Asian or Pacific Islander females to a high of 82.2 per 1,000 Hispanic females.

Of the 4 million babies born in 2003, approximately 71.4 percent were born via vaginal delivery and 27.6 percent by cesarean (for the remainder, the method of delivery was not stated). This represents an increase in the cesarean delivery rate from 2002, when 26.1 percent of births were via cesarean. However, among women who had a previous cesarean, 90.4 percent had a repeat cesarean, and only 10.6 percent had a vaginal birth. Only 19.1 percent of women without a previous cesarean gave birth via cesarean in 2003.

Birth Rates, by Age and Race/Ethnicity of Mother, 2003*

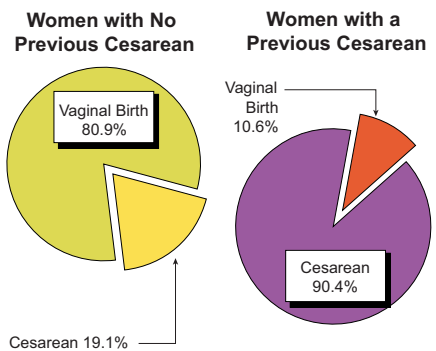
Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Preliminary data

Live Births, by Method of Delivery, 2003*

Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



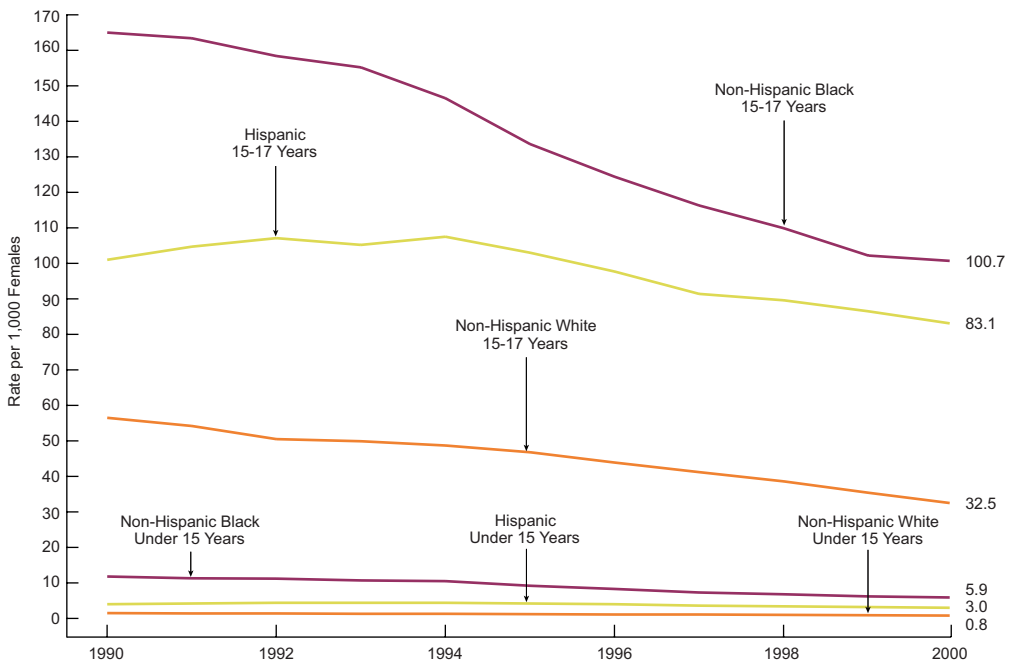
ADOLESCENT PREGNANCY

Pregnancy rates are the total rates of live births, abortions, and fetal losses (miscarriages). Pregnancy rates among adolescents of all racial and ethnic groups have declined steadily over the past decade. Overall, pregnancy rates among those under age 15 dropped 40 percent and rates for those 15-17 declined 33 percent between 1990 and 2000 (the last year for which complete data are available). Among adolescents under age 15, the steepest decline was seen among non-Hispanic Blacks, whose pregnancy rate fell 50 percent, from 11.8 to 5.9 pregnancies per 1,000 females aged 10-14. Among adolescents aged 15-17, the total pregnancy rate declined from 80 pregnancies per 1,000 females in 1990 to 54 per 1,000 in 2000. Rates within this age group vary by race and ethnicity, with the highest rates seen among non-Hispanic Blacks, (100.7 pregnancies per 1,000) and Hispanics (83.1 per 1,000), compared to non-Hispanic White females (32.5 per 1,000). Within the 15-17 age group, the greatest decline was among non-Hispanic Blacks whose pregnancy rate fell 63 percent, from 165.0 to 100.7 pregnancies per 1,000 females.

For adolescents under age 15, the rate of each potential pregnancy outcome declined about 40 percent. For those aged 15-17, the abortion rate dropped 46 percent while the rates of live birth and fetal loss each declined by approximately 25 percent. In 2000, among those aged 15-17, a higher percentage of pregnancies resulted in births compared to those in 1990. This pattern was particularly evident among non-Hispanic White adolescents, among whom the abortion rate declined 60 percent while the rate of live births and fetal losses dropped 32 percent.

Pregnancy Rates for Adolescents, 1990-2000, by Age and Race/Ethnicity

Source (II.18): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



CONTRACEPTION

The majority of women of reproductive age (15-44 years) in the U.S. use contraception. The percent of women in this age group who use contraception increased substantially between 1982 and 1995, from 55.7 percent and 64.2 percent, and dropped slightly to 61.9 percent in 2002. These percentages represent all women of reproductive age, not just sexually active women. Therefore, a woman's reason for non-contraceptive use is an important factor to consider when comparing these rates.

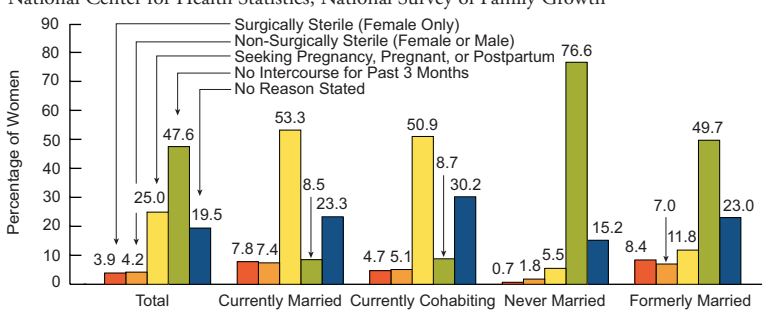
Among the 38.1 million women between the ages of 15 and 44 who were using contraception in 2002, the three most common methods were birth control pills (30.6 percent), female sterilization (27.0 percent), and condoms (18.0 percent). The popularity of each of these methods varied substantially across age groups. More than 50 percent of women between the ages of 15 and 24 reported using the pill and roughly 25 percent used condoms. Pill and condom use decreased and female sterilization increased steadily with age. Among women between the ages of 40 and 44, only 11.0 percent reported using the pill and 11.6 percent reported using condoms. The most popular choices among this group were female sterilization (50.2 percent) and male sterilization (18.4 percent).

The popularity of contraceptive methods also varied across racial and ethnic groups. Non-Hispanic White women reported using the pill most often, 34.4 percent, while non-Hispanic Black and Hispanic women reported using female sterilization most often (38.9 and 33.8 percent, respectively).

Among women who do not use contraception, never having had sex or not having sex within 3 months prior to the interview was the most commonly reported reason among women who were never married or who were formerly married (76.6 percent and 49.7 percent). Pregnancy or being postpartum was the most commonly reported reason among women who were currently married or cohabiting (53.3 percent and 50.9 percent).

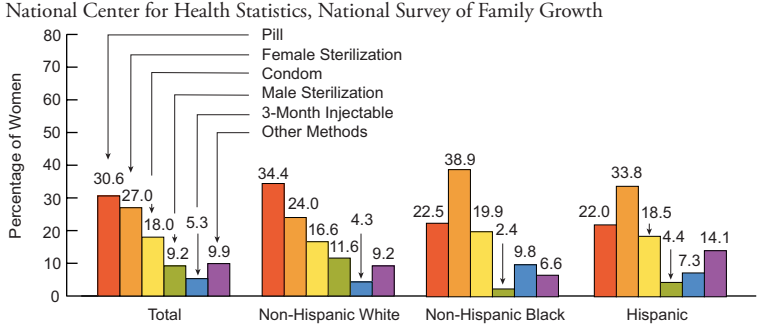
Reasons for Contraceptive Non-Use Among Women Aged 15 to 44, by Marital Status, 2002

Source (II.19): Centers for Disease Control and Prevention,
National Center for Health Statistics, National Survey of Family Growth



Method of Contraception Among Women Aged 15 to 44, Currently Using Contraception, by Race/Ethnicity, 2002

Source (II.19): Centers for Disease Control and Prevention,
National Center for Health Statistics, National Survey of Family Growth



BREASTFEEDING

Breast milk benefits the health, growth, immunity, and development of infants. Mothers who breastfeed have increased bone strength to protect against bone fractures in older age, reduced risk of ovarian cancer, and may have a reduced risk of breast cancer in the pre-menopausal years.[1]

In 2003, 70.9 percent of mothers in the U.S. ever breastfed their babies. There have historically been significant variations in breastfeeding rates among socio-demographic groups within the U.S. Non-Hispanic Blacks had the lowest rates of breastfeeding initiation (51.1 percent) in 2003. This compares to a rate of 77.8 percent among Hispanic mothers and 72.2 percent among non-Hispanic White mothers. Younger mothers (under age 20) also had much lower breastfeeding rates (54.5 percent) than older mothers; 74.9 percent of mothers age 30 and over ever breastfed. Family income is also clearly a factor, as breastfeeding rates decline from 79.7 percent for those in families with income at or above 350 percent of poverty, to 62.7 percent for those living below the poverty level. Among mothers receiving WIC program benefits, only 64.2 percent reported ever breastfeeding their babies in 2003.

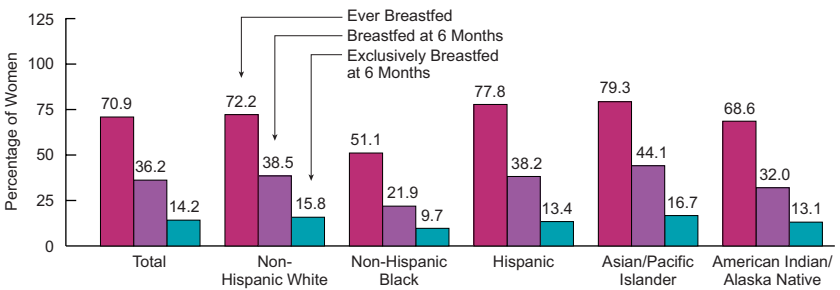
Although a majority of mothers begin breastfeeding, fewer continue for 6 months or more. The largest decline was among mothers under age 20 (whose initial breastfeeding rate was 54.5 percent and 6-month continuation rate was 14.9 percent) and non-Hispanic Black mothers (whose initial breastfeeding rate was 51.1 percent and 6-month continuation rate was 21.9 percent).

The American Academy of Pediatrics recommends that an infant be exclusively breastfed—without supplemental foods and liquids—for the first 6 months of age, based on research evidence of significant declines in upper respiratory and other common infections among infants who are exclusively breastfed. Yet, in 2003 only 14.2 percent of all babies were exclusively breastfed when they were 6 months old. The highest exclusive breastfeeding rates were among Asian or Pacific Islander women and mothers age 30 or older (16.7 and 16.4 percent respectively).

1 *American Academy of Pediatrics, Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics 2005;115(2):496-506.*

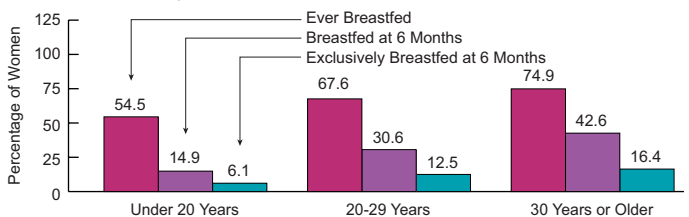
Breastfeeding Rates by Race/Ethnicity and Duration, 2003

Source (II.20): Centers for Disease Control and Prevention, National Immunization Survey



Breastfeeding Rates by Maternal Age and Duration, 2003

Source (II.20): Centers for Disease Control and Prevention, National Immunization Survey



PERINATAL DEPRESSION

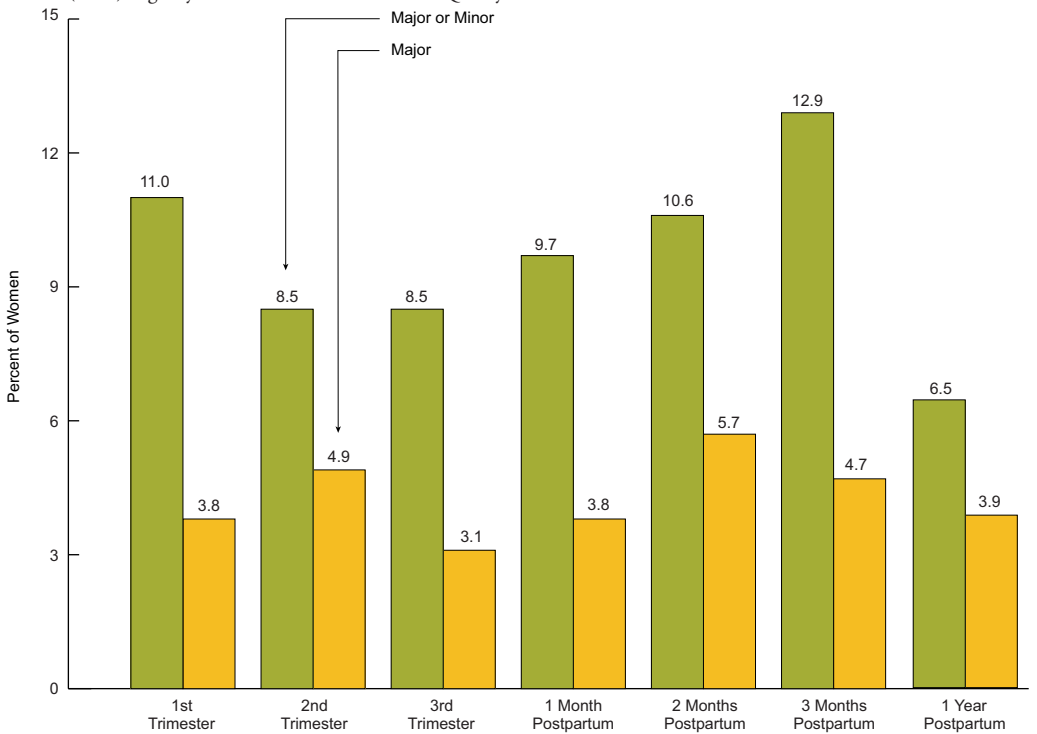
Depression is a major cause of disability among women, particularly women of childbearing age. While there is little evidence that depression rates during pregnancy are higher than at other points in a woman's life, pregnancy and the postpartum months are a period when some women may be particularly vulnerable to both major and minor depression. Perinatal depression includes major depressive episodes as well as minor depressive episodes (which are less severe but still impairing). These episodes begin during pregnancy or within the first 12 months after delivery.

The exact prevalence of perinatal depression is unknown, and estimates range from 6.5 percent to 12.9 percent of new mothers. A systematic review of the studies that produced these estimates found that new episodes of major depression alone may occur in 3.1 to 4.9 percent of women at various times during pregnancy, and in 1.0 percent to 5.9 percent of women at different times during the first year after birth. Either major or minor depression may affect 8.5 to 11 percent of women during pregnancy, and 6.5 to 12.9 percent during the first year after birth. Many women continue to suffer from depressive episodes that began prior to pregnancy.

With training, physicians can screen women accurately for major depression alone, but screening for minor depression is more difficult. Little is known about the specific risk factors for perinatal depression or the warning signs that providers should watch for. Providing psychosocial support and counseling to pregnant women at risk of depression may be effective in decreasing symptoms of depression.

Estimated Prevalence of Perinatal Depression

Source (II.21): Agency for Healthcare Research and Quality



INFERTILITY SERVICES

In 2002, approximately 8.9 percent of women 18-44 years of age in the U.S. reported receiving infertility services at some time in their life and 2.0 percent had an infertility-related medical appointment within the past year. Infertility services include receiving advice from a medical professional, infertility testing, drugs to improve ovulation, surgery to correct tubes, and artificial insemination. Non-Hispanic White women were most likely to report ever seeking medical help to get pregnant (10.7 percent) compared to other racial and ethnic groups; non-Hispanic Black women were least likely (4.7 percent) to seek medical help.

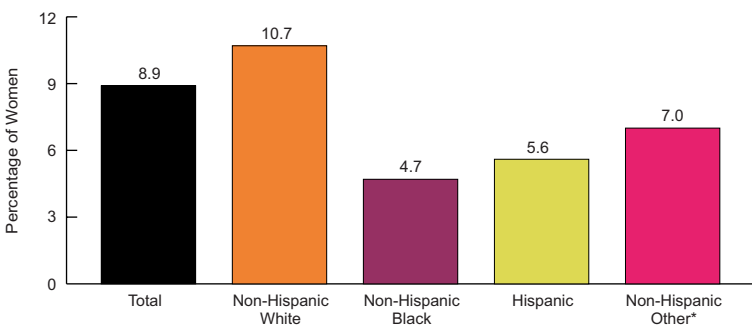
The average age at first birth among women in the U.S reached an all-time national high of 25.1 years in 2002. The age at first birth has risen steadily over the past three decades from an average of 21.4 years in 1970.[1] This reflects a drop in the birth rate among teens and an increase among women in their 30s-50s. The delay in trying to conceive, coupled with the natural decline in women's fertility beginning in the late 20s or early 30s, may be one reason why women between the ages of 40 and 44 were likely to report ever seeking medical help to get pregnant; this age group represented 11.7 percent of women using infertility services. Women aged 30-34 years represented 34.8 percent of women using these services in the past year.

Of the approximately 5.1 million women who reported ever seeking medical help to get pregnant, 11.1 percent were currently pursuing medical help to get pregnant, and 75.8 percent had private insurance that covered some portion of their infertility services. The three most commonly reported services were advice (66.1 percent), infertility testing (21.2 percent), and drugs to improve ovulation (7 percent).

1 *National Vital Statistics Reports, Vol. 52, No. 10, December 17, 2003.*

Women Aged 18 to 44 Who Have Ever Received Infertility Services, by Race/Ethnicity, 2002

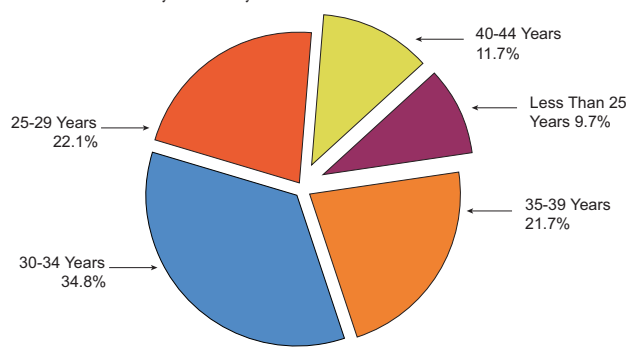
Source (I.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Includes Asian/Pacific Islander, American Indian/Alaska Native and those of more than one race.

Women Aged 18 to 44 Who Have Had an Infertility Related Medical Appointment in the Past Year, by Age, 2002

Source (I.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



IMMIGRANT HEALTH

The immigrant population, especially newly arrived persons and non-citizens, faces both language and cultural barriers to accessing health care services. Of the estimated 16.6 million foreign-born women in the U.S. in 2003, more than half (59.2 percent) were non-citizens (including documented and undocumented immigrants).[1]

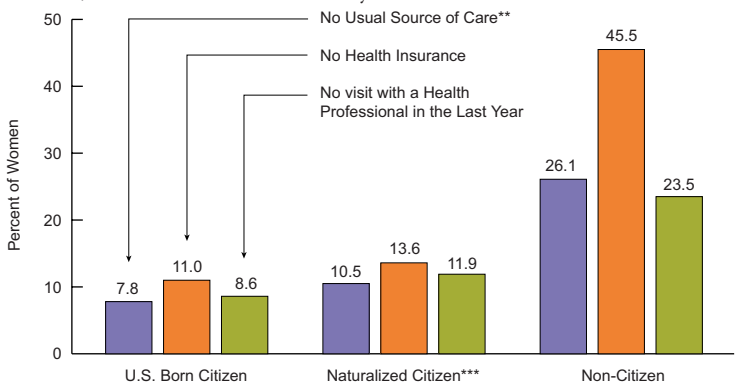
In 2003, women without U.S. citizenship were more likely than naturalized citizens or women born in the U.S. to lack a usual source of care (26.1 percent) and to lack health insurance (45.5 percent). The percentage without insurance decreased as length of time in the U.S. increased, although this trend was more evident among certain racial and ethnic groups. Non-Hispanic Black and Hispanic women who had been in the U.S. for less than 5 years had the highest uninsurance rates in 2003 (61.7 and 64.5 percent, respectively).

Foreign-born women were also less likely to have seen a health care professional within the last year. A greater proportion of non-citizen women (23.5 percent) had not seen a health professional in the past year compared to those born in the U.S. (8.6 percent).

1 *U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2003. August 2004. http://www.census.gov/population/socdemo/foreign/ppl-174/tab01-01.pdf*

Women Lacking a Usual Source of Care, Health Insurance and a Recent Visit with a Health Professional, by Citizenship Status,* 2003

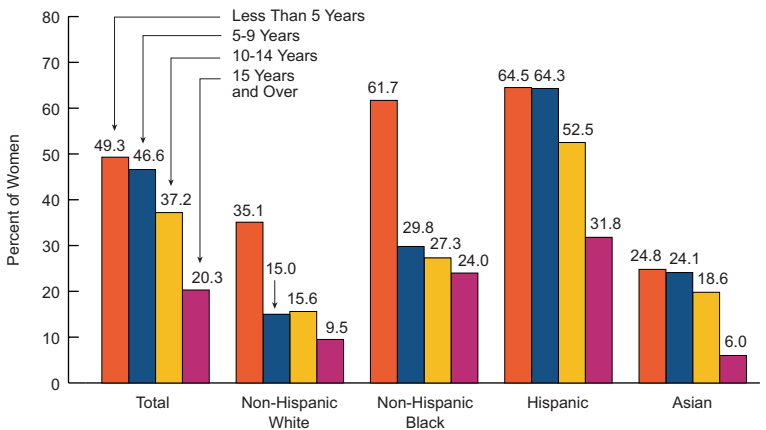
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Percents are not age-adjusted.
**Defined as not having a place they usually go when sick.
***Person not born in the U.S., but holding U.S. citizenship.

Foreign-Born Women Without Health Insurance, by Length of Time in the U.S. and Race/Ethnicity,* 2003

Source (II.22): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Percents are not age-adjusted; Non-Hispanic women of other races are not shown due to small sample size.

BORDER HEALTH

Women along the U.S. side of the U.S.-Mexico border—within 100 kilometers, or 62 miles of the border—face many health disparities. More than one-third of families in the border region of the U.S. have incomes at or below the Federal poverty level. Because this population is likely to lack health insurance, access to health care is an important issue in this region. Approximately one-third of U.S. border residents reside in areas designated as Health Professional Shortage Areas for primary care.

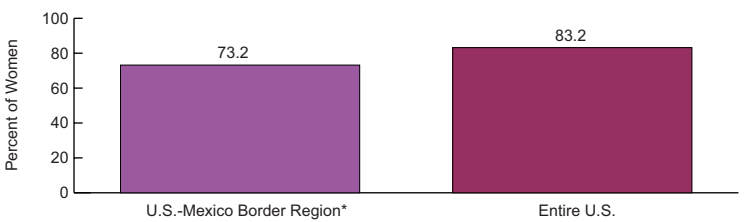
The quality of the air, water, and soil in the border region is another area of concern that can particularly affect the health of women (especially women of childbearing age) and children. Many households in the region are not connected to sources of clean water. The high level of industry and agriculture creates exposure to potentially harmful pesticides and other chemicals. Although there are few sources of data on these problems, the U.S.-Mexico Border Health Commission has among its objectives to reduce the proportion of households without complete bathroom facilities—in 2000, 1.1 percent of households on the U.S. side of the border had no complete bathroom facilities—and to reduce the number of hospitalizations as a result of pesticide poisoning.

In 2000, women in the U.S. border region averaged 2.5 children during their reproductive years, which is greater than the U.S. national average of 2.1. Despite the greater number of children born on the border, only 73.2 percent of women who gave birth received prenatal care during the first trimester, and only 64 percent received adequate care with regard to timing and number of prenatal visits compared to 83.2 percent in the U.S. as a whole during the same year.

Infectious diseases, including tuberculosis, hepatitis A, and hepatitis B, are also more prevalent in the border region than in the general U.S. population. In 2000, the incidence of tuberculosis in the border region was 10.0 cases per 100,000 people, compared to 6.0 per 100,000 people nationally. The rate of hepatitis A was 11.0 cases per 100,000 people in the border region, compared to 4.9 nationally, and the rate of hepatitis B was 6.3 cases per 100,000 persons, in the border region compared to 2.9 nationally.

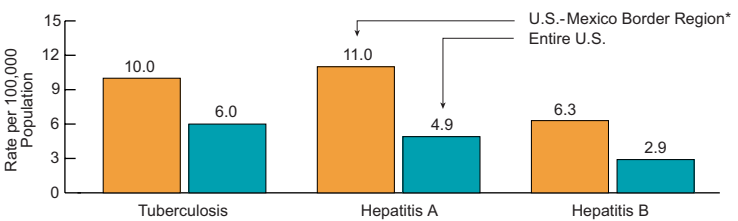
Pregnant Women Beginning Prenatal Care in the First Trimester, 2000

Source: (II.22) United States-Mexico Border Health Commission; Centers for Disease Control and Prevention, National Center for Health Statistics



Rates of Selected Infectious Diseases in the U.S.-Mexico Border Area, 2000

Source: (II.22) United States-Mexico Border Health Commission; Centers for Disease Control and Prevention, National Center for Health Statistics



*Includes 44 U.S. counties located within 100 kilometers north of the U.S-Mexico border excluding Maricopa, Pinal and La Paz counties in Arizona and Riverside County in California.

RURAL AND URBAN HEALTH

In 2000, 59 million people, or approximately 21 percent of the population, lived in a rural area.[1] Residents of rural areas tend to be older, poorer, less educated, have fewer health care providers and live farther from health care resources than their metropolitan counterparts. These issues increase special health concerns and barriers that can lead to poorer health, especially for women.

In 2002, women in non-metropolitan areas were more likely to be older than men in the same regions and than women in metropolitan areas. Among women living in non-metro areas, 17.3 percent were aged 65-90, compared to 13.8 percent of men in non-metro areas and 13.4 percent of metropolitan women.

Rural women were also more likely to report poorer health status than urban women. Of women in non-metro regions, 14.5 percent reported their health status to be fair or poor, a percentage that was not significantly different from men in the same areas, but was significantly higher than that of women in metropolitan areas (11.1 percent). Conversely, only 25.4 percent of non-metropolitan women described their health status as excellent, compared to 29.6 percent of non-metropolitan men and 29.9 percent of metropolitan women.

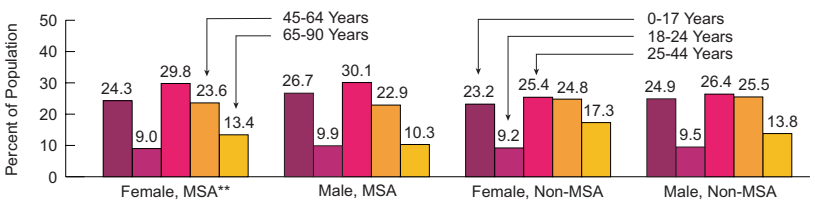
Women in non-metropolitan areas spend more on health care than their urban counterparts. The average annual health care expenditure for females in non-metropolitan areas was $3,358, compared to $2,949 for non-metropolitan males and $3,063 for metropolitan women.

HRSA's Office of Rural Health Policy (ORHP) maintains a wide range of programs to address the health of rural women. It supports the Rural Assistance Center, www.raconline.org, which has information on rural women's health and domestic abuse in rural areas. ORHP currently supports six community rural health outreach grantees throughout the U.S. that are addressing women's health and domestic violence issues. ORHP is also funding a study of poverty, parental stress, and violent disagreements in the home among rural families. Other research addresses the quality of women's care in rural health clinics.

1 *U.S. Census Bureau 2000. 2000 Summary File 1. Table P2. http://factfinder.census.gov/servlet/BasicFactsServlet.*

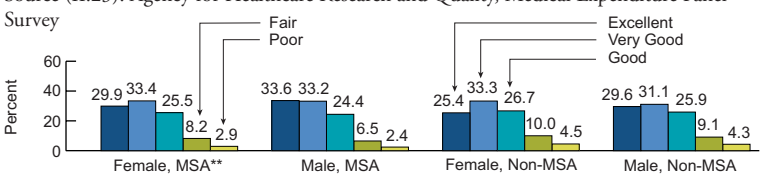
U.S. Population* by Age, Sex, and Area of Residence, 2002

Source (II.23): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



U.S. Population* by Health Status, Sex, and Area of Residence, 2002

Source (II.23): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*Includes only the civilian, noninstitutionalized population.

**Metropolitan Statistical Areas (MSA) include at least: one city with 50,000 or more inhabitants, or a Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000 (75,000 in New England). Additional "outlying counties" are included in the MSA if they meet specified requirements of commuting to the central counties and other selected requirements of metropolitan character. In New England, the MSAs are defined in terms of cities and towns rather than counties.

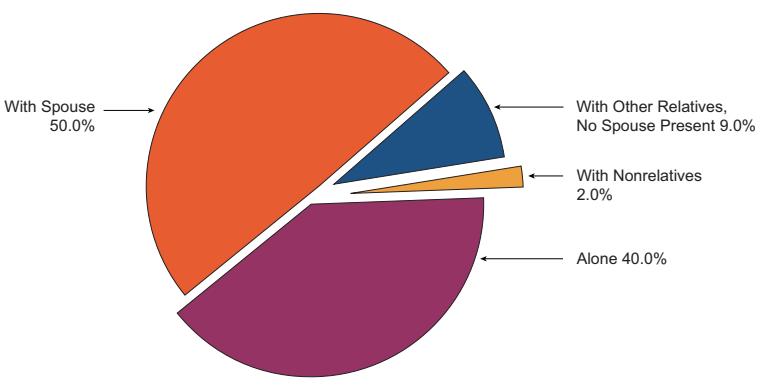
OLDER WOMEN

There are 20.8 million women age 65 and older living in the U.S. These older women are more likely to be living alone (40 percent) than older men (19 percent). The pattern of living arrangement varies by race and ethnicity with 2 percent of older non-Hispanic White women living alone, compared to 39 percent of Black women, 22 percent of Hispanic women, and 19 percent of Asian women. Variation also occurs in the likelihood of an older woman to be living with a non-spousal relative with non-Hispanic White women being the least likely to live with relatives other than a spouse (7 percent), compared to 13 percent of Black women, 25 percent of Hispanic women, and over 35 percent of Asian women. The proportion of elderly women living with a spouse or with nonrelatives did not vary substantially across racial/ethnic groups.

Racial and ethnic differences are evident in the leading causes of death for women aged 65 and older. While heart disease, cancer, and cerebrovascular diseases are the three leading causes of death for all racial/ethnic groups, diabetes is the 4th leading cause for women in all groups except non-Hispanic Whites. Among non-Hispanic Whites, Alzheimer's Disease is the 5th leading cause, but this ranks 9th for Black and American Indian women, 10th for Asian women, and 7th for Hispanic women. Hypertension and hypertensive renal disease are among the top 10 leading causes of death for Black and Asian/Pacific Islander women, 10th for Blacks and 9th for Asian/Pacific Islanders, but is not among the top 10 for the population as a whole. Chronic liver disease and cirrhosis is the 10th leading cause of death for American Indian women, but is not among the 10 leading causes in the general elderly female population.

Living Arrangements of Women Aged 65 and Over,* 2003

Source (II.24): U.S. Census Bureau, Current Population Survey



*These data refer to the civilian noninstitutionalized population.

Rank of Leading Causes of Death Among Women Aged 65 and Older, 2001

Source (II.24): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	White	Black	Hispanic	American Indian	Asian/Pacific Islander
Diseases of the Heart	1	1	1	1	1
Malignant Neoplasms	2	2	2	2	2
Cerebrovascular Diseases	3	3	3	3	3
Chronic Lower Respiratory Diseases	4	6	6	5	6
Alzheimer's Disease	5	9	7	9	10
Influenza and Pneumonia	6	7	5	6	5
Diabetes Mellitus	7	4	4	4	4
Nephritis, Necrotic Syndrome and Necrosis	9	5	8	8	7
Unintentional Injuries	8	*	9	7	8
Septicemia	10	8	10	*	*

*Not among the ten leading causes for this group.

HEALTH SERVICES UTILIZATION

Availability of and access to quality health services directly affect the health and well-being of women. For women with 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 women's quality of life.

The following section presents data on women's health services utilization, including indicators on insurance, usual source of care, medication use, and use of preventive, dental, hospital, and mental health services.

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 room, 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 2003, the percentage of women reporting a usual source of care rose with age, from a low of 81.8 percent among women 18 to 24 years of age, to a high of 97.3 percent among those aged 65 years and older.

Usual sources of care varied among racial and ethnic groups. Hispanic women were the most likely to report no usual source of care (19.8 percent). Non-Hispanic White women were the most likely to report an office setting as a usual source of care (90.7 percent), while non-Hispanic Black women were the most likely to use a hospital outpatient clinic or an emergency room as a usual source of care (3.2 and 1.6 percent, respectively).

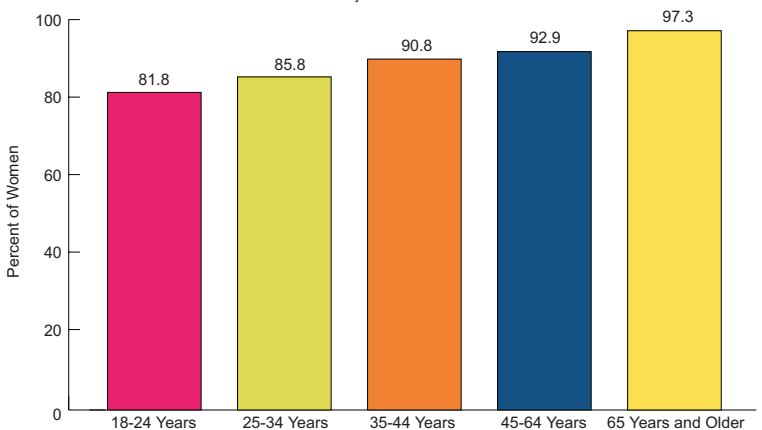
1 *Ettner SL. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference? Medical Care 1999;37(6):647-55.*

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

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

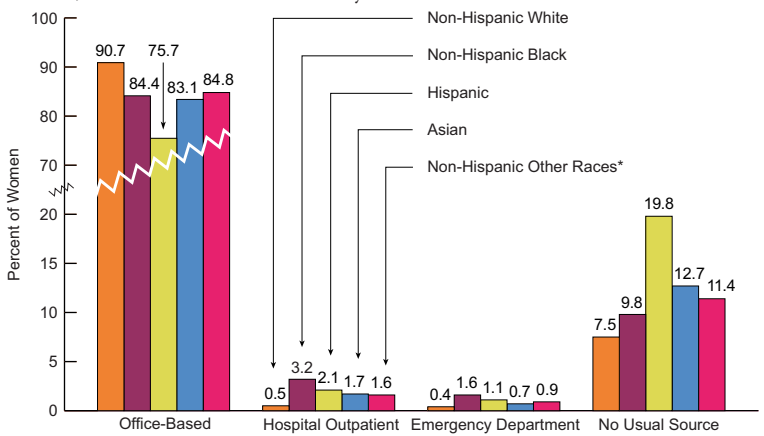
Women Aged 18 and Older with a Usual Source of Care, by Age, 2003

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



Usual Source of Care for Women Aged 18 and Older, by Race/Ethnicity, 2003

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



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

HEALTH INSURANCE

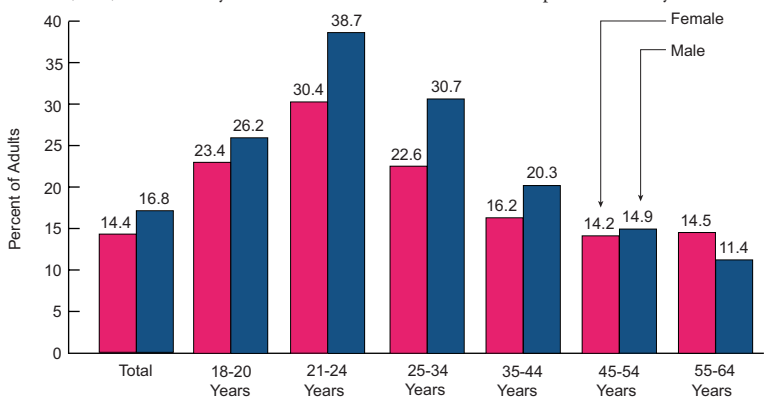
People who are uninsured are less likely than those with insurance to seek preventive care, which can result in poor health outcomes and higher health care costs. In 2003, 45 million people in the U.S., representing 15.6 percent of the population, were uninsured all year. The percentage of people who are uninsured varies considerably across a number of categories, including sex, age, race/ethnicity, income, and education. The percentage of females without insurance (14.4 percent) is slightly lower than the percentage of males (16.8 percent). However, non-White women are more likely than White women to lack coverage: 10.4 percent of non-Hispanic White females (of all ages) were uninsured, compared to 17.8 percent of Black females, 18.5 percent of Asian females, and 29.6 percent of Hispanic females.

The percentage of people without health insurance also varies greatly by age. Young adults of both sexes are the most likely to be uninsured: 34.5 percent of 21 to 24 year-olds lack health insurance, as do 26.6 percent of 25 to 34 year-olds. In contrast, because of the Medicare program, fewer than 1 percent of women aged 65 years and older are uninsured.

Rates of uninsurance decrease steadily as household income increases, ranging from a high of 24.2 percent for those with incomes below $25,000 to a low of 8.2 percent for those with incomes of $75,000 or more.

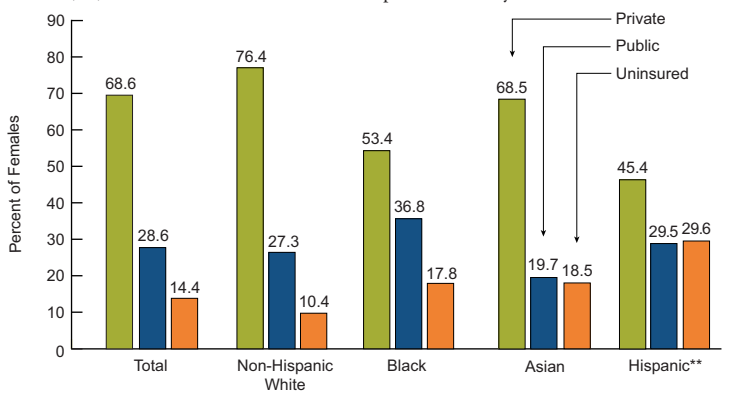
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2003

Source (III.1): EBRI Analysis of U.S. Census Bureau, Current Population Survey



Health Insurance Coverage* of Females, by Type of Coverage and Race/Ethnicity, 2003

Source (I.9): U.S. Census Bureau, Current Population Survey



*Individuals may receive coverage from more than one source.
** May be of any race.

QUALITY OF WOMEN'S HEALTH CARE

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

Indicators used to monitor women's health care in managed care plans include the timeliness of prenatal care, receipt of postpartum checkups after delivery, screening for chlamydia, screening for cervical cancer, and receipt of mammograms. The accessibility of most of these services is increasing in commercial, Medicare, Medicaid managed care plans.

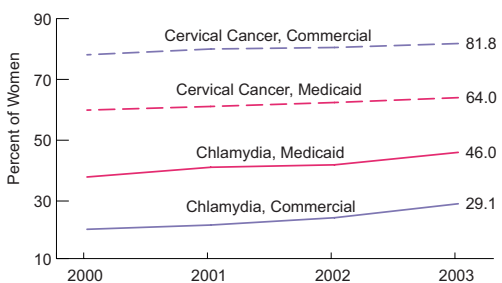
Perinatal services—prenatal care and postpartum checkups—appear to be more accessible in commercial (private) plans than in public-sector plans financed by Medicaid. The same is true of cervical cancer screening, which is received at least once every 3 years by nearly 82 percent of commercially-insured women and 64 percent of women covered by Medicaid.

In 2003, the rate of breast cancer screening (mammograms) for women aged 52-69 was approximately equal for women in private plans and those covered through Medicare. However, Medicaid-enrolled women in this age group are considerably less likely to receive a mammogram at least once every 2 years.

Chlamydia screening is the one screening service that is more common among Medicaid-enrolled women than those with private coverage: 46 percent of Medicaid-enrolled women aged 21-25 had a chlamydia screen in the previous year, compared to 29 percent of commercially-insured women.

HEDIS®* Rates of Cervical Cancer** and Chlamydia*** Screening, by Payer, 2000-2003

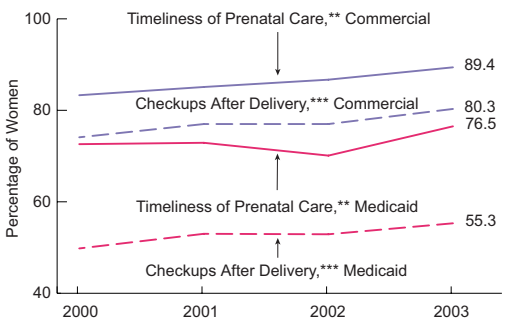
Source (II.13): National Committee for Quality Assurance



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

HEDIS®* Measures of Perinatal Care, by Payer, 2000-2003

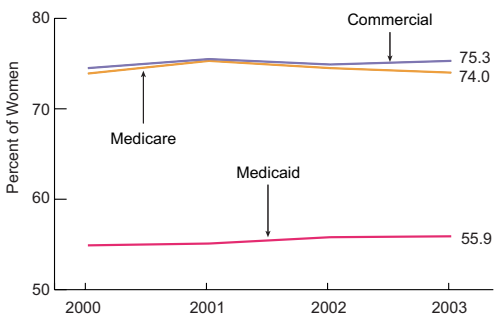
Source (II.13): National Committee for Quality Assurance



**The percentage of women beginning their prenatal care in first trimester or within 43 days of enrollment if pregnant at enrollment.
***The percentage of women who had a visit to their health care provider between 21 and 56 days after delivery.

HEDIS®* Rates of Mammograms,** by Payer, 2000-2003

Source (II.13): National Committee for Quality Assurance



**The percentage of women aged 52-69 years who had at least one mammogram in the past two years.

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 people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The Medicare program has two components: Part A, which covers hospital, skilled nursing, home health, and hospice care, and Part B, which covers physician services, outpatient hospital services, and durable medical equipment. Among the preventive services covered by Medicare are an annual mammogram, Pap smear, bone density scan, and influenza vaccination.

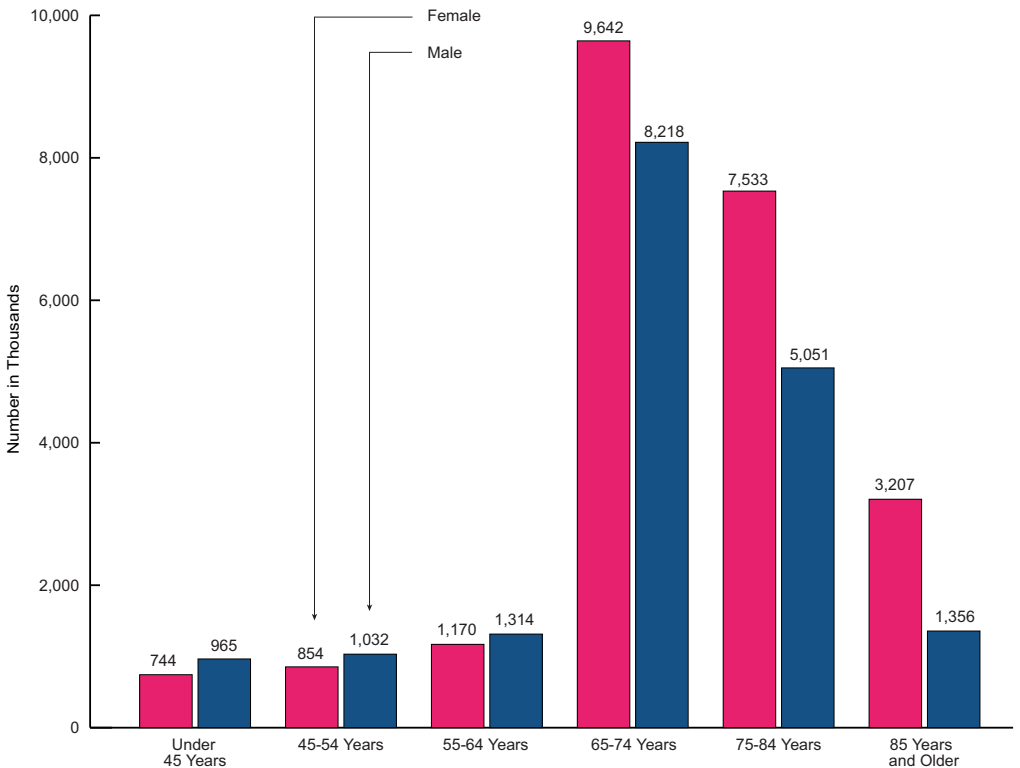
In 2003, Medicare had over 41 million enrollees, of whom 56 percent were female. The large majority of all Medicare enrollees were aged 65 or older, with the elderly representing 88 percent of female enrollees and 82 percent of males.

Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income individuals and people with disabilities. In 2002, Medicaid covered 51.5 million individuals, including children; the aged, blind, and disabled; and people who are eligible for cash assistance programs. Sixty percent of Medicaid enrollees were female. Of all Medicaid enrollees, 54 percent were under age 21, 35 percent were between the ages of 21 and 64, and 11 percent were aged 65 and older.[1]

1 *Center for Medicare and Medicaid Services, Medicaid Statistical Information System.*

Medicare Enrollees (All Ages), by Age and Sex, 2003

Source (III.2): Center for Medicare and Medicaid Services



PREVENTIVE CARE

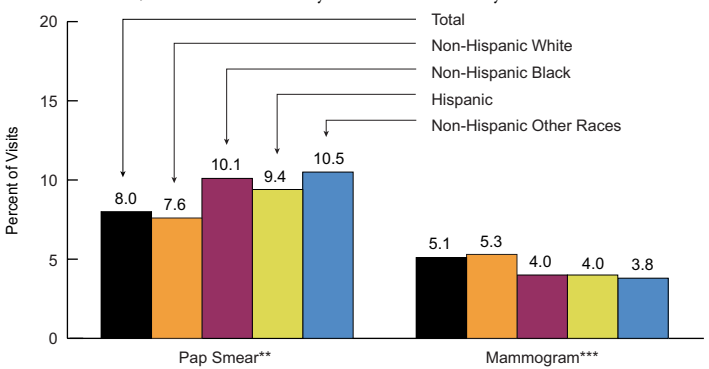
Counseling, education, and screening can promote healthy behaviors that prevent or minimize the occurrence of many serious health conditions. In 2002, females of all ages made almost 530 million physician office visits, compared to only 361 million visits made by males. Of visits made by females, 18.3 percent were for preventive care, including prenatal care, screenings, and insurance examinations. Women aged 25 to 44 years made the most preventive visits (23.5 percent), followed by those under 15 years of age (14.6 percent).

Mammograms and Pap smears are two preventive services that are especially important to women's health. The U.S. Preventive Services Task Force recommends that Pap smears to screen for cervical cancer begin within three years from the initiation of sexual activity, or at age 21, whichever comes first. The Task Force recommends mammography every one to two years for women aged 40 and older. In 2002, 8.0 percent of all office visits made by women 18 and older included a Pap smear, and 5.1 percent of all office visits made by women 40 and older included a mammogram.

Counseling and education are sometimes offered during physician visits. In 2002, counseling or education related to nutrition was offered during 15.0 percent of visits made by females. Other types of counseling or education that were offered include exercise (10.5 percent of visits), mental health (4.9 percent), and weight reduction (3.9 percent).

Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits, by Race/Ethnicity,* 2002

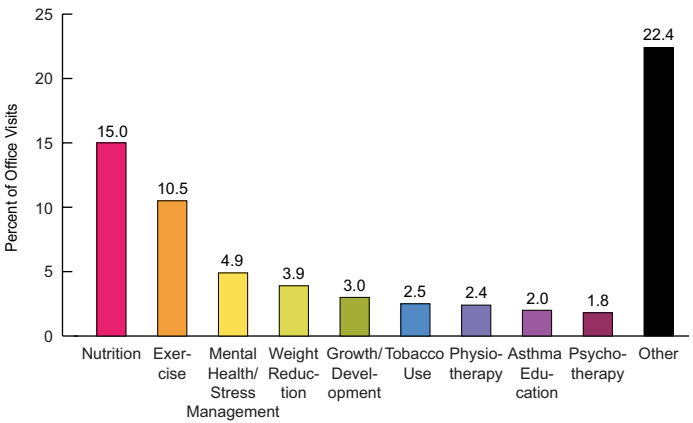
Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Rates are not age-adjusted.
**Among women aged 18 and older.
***Among women aged 40 and older.

Counseling/Education Provided to Females (All Ages) During Office Visits, 2002

Source (III.4): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



HIV TESTING

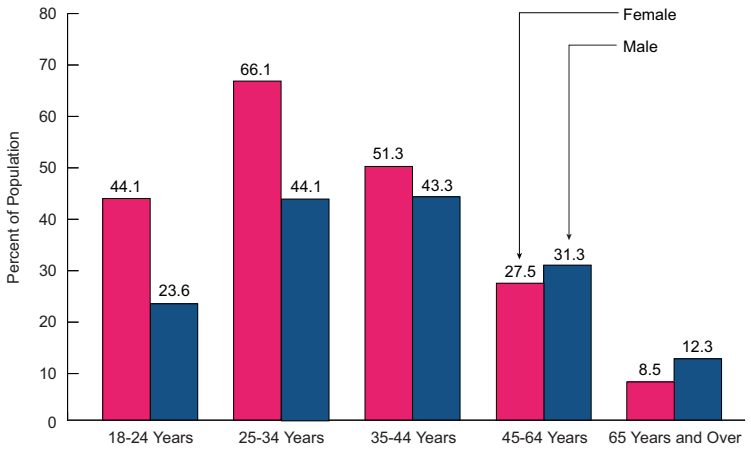
Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek appropriate care. HIV testing requires only a simple blood or saliva test, and it is often offered through confidential and/or anonymous sources.

As of 2003, almost 36 percent of U.S. adults had ever been tested for HIV. Of all adults, women between the ages of 25 and 34 were most likely to report ever being tested. Among the younger population, women were more likely to have been tested than men; however, among the older population the opposite was true. Older men were more likely to have been tested than their female counterparts.

In 2003, there were racial and ethnic differences in testing rates among women. Non-Hispanic Black women had the highest rate of HIV testing (54.4 percent), followed by Hispanic women (46.7 percent); Asian women and non-Hispanic White women had the lowest rates of testing (34.0 and 33.9 percent, respectively).

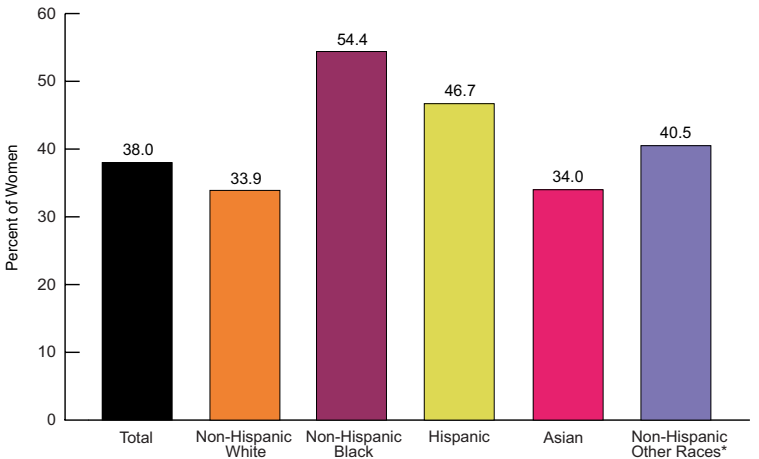
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2003

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



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2003

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



*Includes American Indian/Alaska Native and those of more than one race.

MEDICATION USE

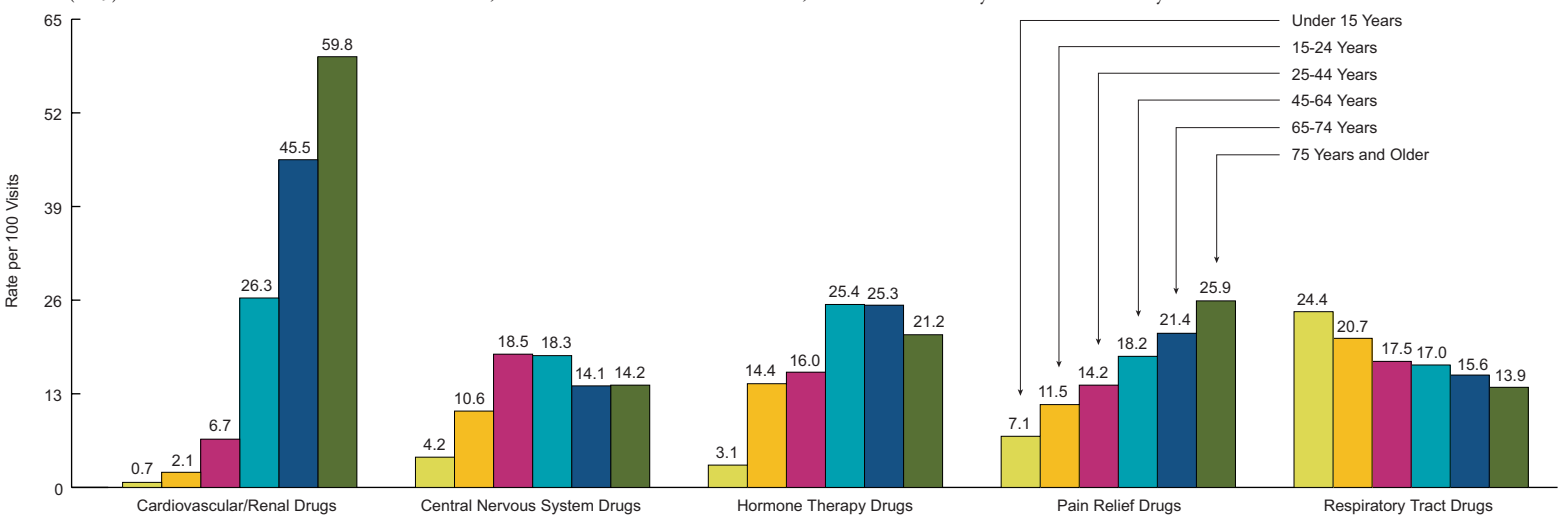
In 2002, medication was prescribed or provided at 577.1 million physician office visits, which represents 1.3 billion prescriptions. The percent of visits at which one or more drugs was prescribed or provided was slightly higher for females than males (65.5 compared to 63.9 percent). The overall drug mention rate was similar between 2001 and 2002; however, the rate at obstetrics/gynecology visits increased 48 percent, due in part to an increase in the discussion of contraceptives and vitamins.[1]

The use of medications among females varies by age and drug type. In 2002, the use of cardiovascular/renal and pain relief drugs among women increased with age, while respiratory tract drug use decreased with age. Discussions about central nervous system drugs, including antidepressives, during physician visits were most common among women in the middle age groups, with the highest rate occurring among women aged 25-44 (18.5 percent of office visits). The most commonly mentioned drug types were cardiovascular/renal drugs among women 75 and older (59.8 percent of visits). The lowest rate was for cardiovascular/renal drugs among females under the age of 15 (0.7 percent of visits). Among females under age 15, respiratory tract drugs were most likely to be discussed (24.4 percent of visits).

1 *Woodwell DA, Cherry DK. National Ambulatory Medical Care Survey: 2002 summary. Advance Data from Vital and Health Statistics, No. 346, August 2004.*

Medication Use Reported for Females During Physician Office Visits, by Age, 2002

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



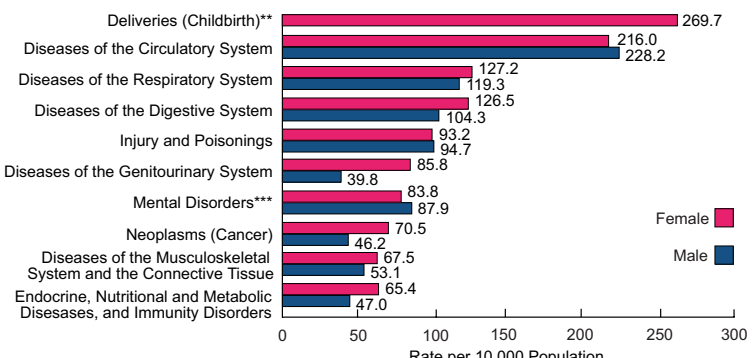
HOSPITALIZATIONS

Females represented 60.3 percent of the nearly 34 million short-stay hospital discharges in 2002. Among all hospital discharges among females, women aged 15-44 years accounted for 38.5 percent, due in part to hospitalizations for childbirth, while women 65 years and older accounted for another 36.4 percent. Nearly one-fifth of discharges for all females were for childbirth, and one-quarter of all procedures performed on females were obstetrical in nature. Other common diagnoses were diseases of the circulatory system (16 percent of female discharges), diseases of the respiratory system, and diseases of the digestive system (9 percent each).

Overall, females had a higher hospital discharge rate than males (1,388 compared to 952.3 per 10,000 population). Differences existed between the discharge rate of males and females for every category of primary diagnosis and for every type of procedure performed. Several of the diagnoses for which women had a higher discharge rate than men included diseases of the digestive system (126.5 compared to 104.3 per 10,000 population), genitourinary system diseases, such as kidney diseases (85.8 compared to 39.8 per 10,000), and neoplasms (70.5 compared to 46.2 per 10,000). Most commonly, women were discharged for obstetrical procedures (453.6 per 10,000). The discharge rate of females was higher for almost all of the most common procedures, including operations on the digestive system, operations on the musculoskeletal system, and operations on the integumentary system, such as treatments for wounds or burns.

Discharges from Non-Federal, Short Stay Hospitals, by Sex and Primary Diagnosis (All Ages),* 2002

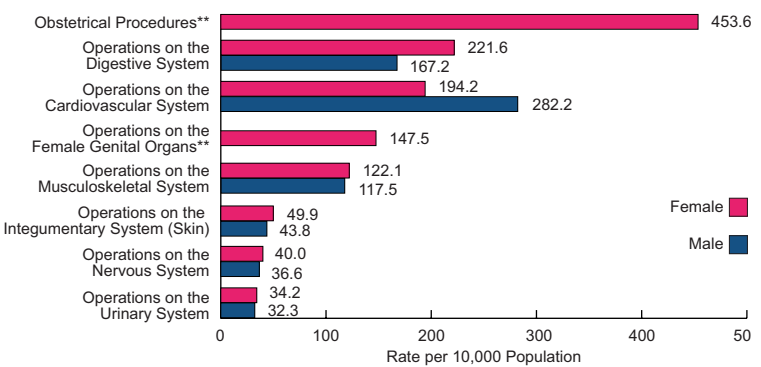
Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants
**Not applicable to males.
***Includes alcohol and drug dependence syndrome

Discharges from Non-Federal, Short Stay Hospitals, by Sex and Procedure Category (All Ages),* 2002

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



ORGAN TRANSPLANTATION

During 2003, there were 25,462 organ transplants in the United States. Since 1988, the number of organ transplants has increased each year. The gender distribution among organ donors was fairly even in 2003 (6,644 females and 6,634 males donated organs.) In 2003, women were more likely than men to donate organs while alive (58.4 percent of living donors were women).

Waiting lists for organs continue to increase because the need for donated organs greatly outweighs the availability. As of February 11, 2005, there were 87,178 people certified for a transplant and waiting for organs. Females made up 37.9 percent of those receiving transplants in 2003 and 42.2 percent of those on the waiting list. Racial and ethnic minorities are disproportionately represented among women waiting for an organ. Among women on the waiting list, 28.5 percent were Blacks and 15.3 percent were Hispanics. The kidney was the organ in highest demand, with a total of 60,859 individuals awaiting a kidney, 42 percent of whom were female.

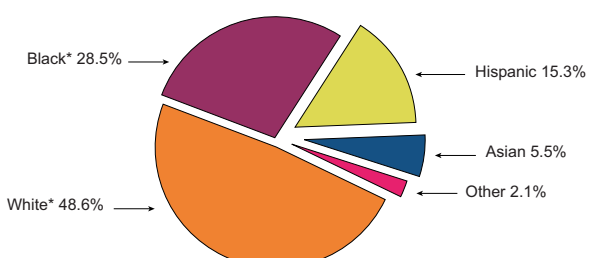
Although there has been an increase in organ donations each year since 1988, obtaining consent for organ donation has been challenging. Consent primarily must be obtained from the donor family or a legal surrogate. Some of the reasons consent rates vary include religious perceptions, poor communication between grieving families and health care providers, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased. Race and ethnicity also appear to be a strong predictor of willingness to consent to donation.[1]

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

1 2003 OPTN/SRTR Annual Report: Transplant Data 1992-2002. HHS/HRSA/SPB/DOT; UNOS; URREA.

Distribution of Females on Organ Waiting List, by Race/Ethnicity on February 11, 2005

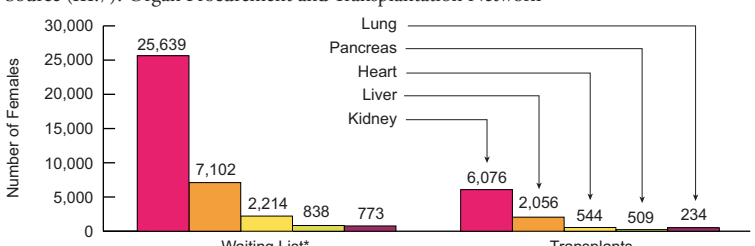
Source: (III.7) Organ Procurement and Transplantation Network



** Includes Hispanic*

Female Transplant Recipients, 2003, and Females on Transplant Waiting Lists, 2005, by Organ

Source (III.7): Organ Procurement and Transplantation Network



**On February 11, 2005*

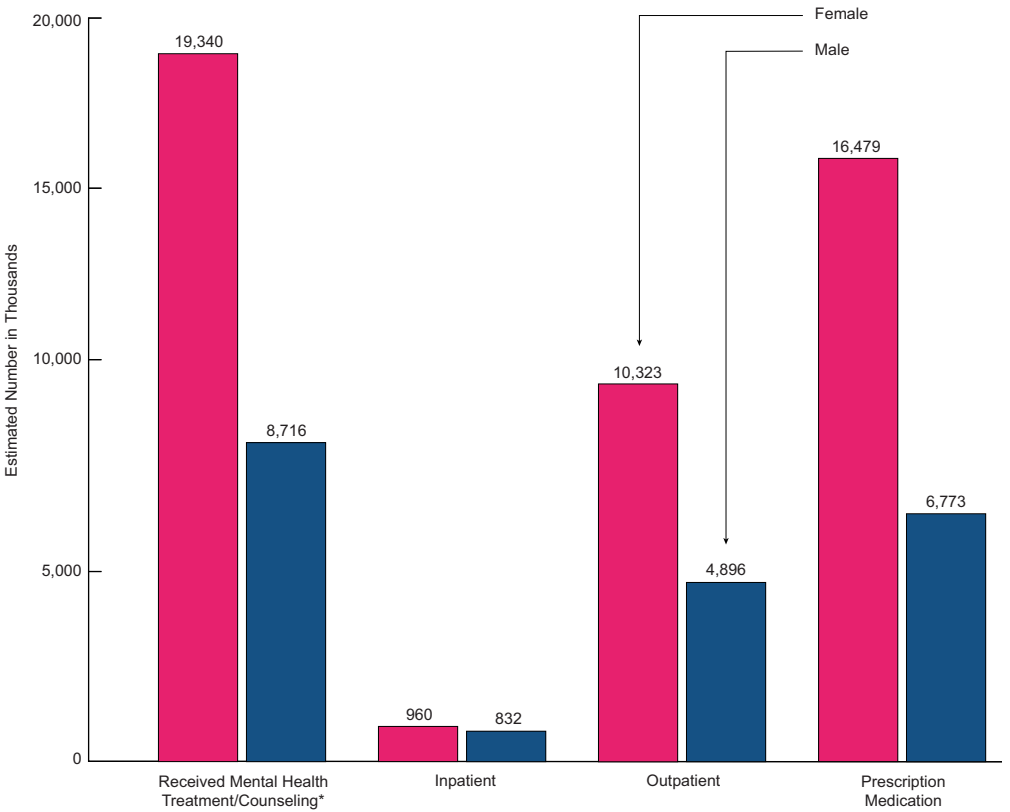
MENTAL HEALTH CARE UTILIZATION

In 2003, an estimated 27.3 million U.S. adults reported receiving mental health treatment in the past year. Women represented more than two-thirds of users of mental health services. The most common type of treatment obtained by adults was prescription medication, followed by outpatient treatment. Nearly 16.5 million women and 6.8 million men used prescription medication for treatment of a mental or emotional condition.

Mental health services are needed, but not received, by millions of adults in this country. Those with serious mental illness are in particular need of services. In 2003, of the 12.7 million women aged 18 or older who reported having a serious mental illness in the past year, nearly one-half (6.1 million women) did not report receiving any type of mental health treatment or counseling. When asked to define their own perceived unmet need, 30.1 percent of adults with serious mental illness reported an unmet need for treatment or counseling for problems with emotions, nerves or mental health. Cost was the reason most often cited for not receiving needed mental health treatment.

Adults Aged 18 and Older Receiving Mental Health Treatment,* by Sex and Treatment/Counseling Type, 2003

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



*Excluding treatment for alcohol or drug use.

HEALTH CARE EXPENDITURES

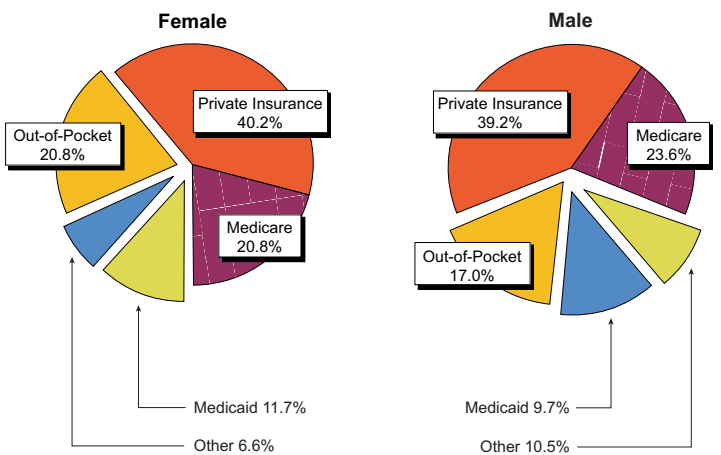
In 2002, the majority of both women's and men's health care expenses were covered by public or private health insurance. For women, approximately one-third of expenses were covered by either Medicare or Medicaid, while just over 40 percent were covered by private insurance. Although the percentage of expenditures paid through private insurance was approximately equal for women and men, women's health care costs were more likely than men's to be paid by Medicaid or out of pocket.

Ninety percent of females had at least one health care expenditure in 2002, compared to 80 percent of males. Among those who had at least one health care expense in 2002, the average per-person expenditure was higher for females ($3,461) than for males ($3,116). However, men's expenditures exceeded women's for hospital inpatient services ($14,221 compared to $10,371), home health services, and hospital outpatient services, while women's expenditures exceeded men's in the categories of office-based medical services and prescription drugs.

While the gender gap in health care expenditures has narrowed somewhat since 1998, overall per-capita health care expenditures have increased substantially among both men and women. Men's expenses have increased 46 percent over this period while women's have gone up 28 percent.

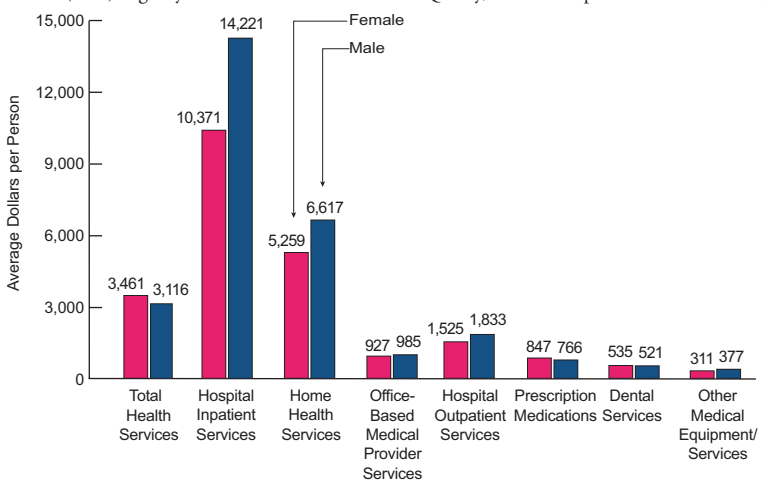
Health Care Expenses, by Source of Payment and Sex (All Ages), 2002

Source (III.8): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 2002

Source (III.8): Agency for Healthcare Research and Quality, Medical Expenditure Panel Surve



HRSA PROGRAMS

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services supports a wide range of programs that increase and promote access to health care for vulnerable groups. HRSA's five Bureaus—the Maternal and Child Health Bureau, Bureau of Health Professions, HIV/AIDS Bureau, Bureau of Primary Health Care, and Healthcare Systems Bureau—as well as the Office of Rural Health Policy, all support programs that address the specific needs of women. Highlighted below are some core programs representing a few ways that HRSA serves women across the lifespan.

The Nation's network of **Federally Qualified Health Centers (FQHCs)** provide low-cost primary health care services to women, men, and children who are uninsured or underinsured, or who lack access to private-sector providers. Of the 12.4 million people served by FQHCs in 2003, 7.3 million, or 59 percent, were female.

All **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act** programs serve women. In 2003, 352,334 (31.4 percent) of the 1,121,032 clients served by CARE Act providers were females. This includes both HIV-infected and -affected clients. The CARE Act's Title IV is the cornerstone of the Act's response to HIV/AIDS among underserved women, infants, children and youth. Comprehensive care for pregnant women has been shown to be equally critical in reducing perinatal transmission rates, which at some Title IV sites is zero percent.

AIDS Drug Assistance Programs funded under Title II of the CARE Act, provide HIV-related prescription drugs to people with HIV/AIDS who have limited or no prescription drug coverage. The programs serve approximately 136,000 clients each year. In June 2003, the programs served a total of 85,825 clients, 21 percent of whom were women.[1]

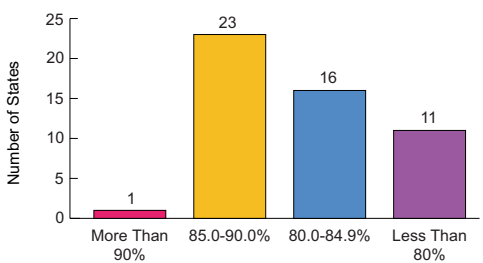
The **Bureau of Health Professions'** Division of Health Careers Diversity and Development is committed to developing culturally competent health professionals by ensuring grantees have implemented policies, practices, and initiatives which demonstrate their commitment to diverse populations in need. The Division of Medicine and Dentistry supports cultural competency training through grants and contracts, such as Cultural Competency in Medical Education: A Guidebook for Schools, developed under a contract with the American Medical Student Association Foundation.

The mission of the **Maternal and Child Health Block Grant Program** is to assure the health of all mothers and children, including children with special health care needs. All programs work to reduce infant mortality and incidence of handicapping conditions among children; increase the number of appropriately immunized children; increase the number of children in low-income households who receive assessments and follow-up services; and provide and ensure access to comprehensive perinatal care for women. The development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children with special health care needs is also part of the Block Grant Program.

1 *Davis MD, Aldridge C, Penner M, Kates J, Chou L, Kubert D. National ADAP Monitoring Project Annual Report, May 2004.*

Percent of Infants Born to Women Receiving Prenatal Care Beginning in the First Trimester, by States, 2003

Source: (III.3) Health Resources and Services Administration, Maternal and Child Health Bureau, Title V Information System



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 these indicators, please reference previous editions of *Women's Health USA*, which can be accessed online at www.hrsa.gov/womenshealth.

Women's Health USA 2002

Life Expectancy

Lupus

Non-Medical Use of Prescription Drugs

Nursing Home Care Utilization

Unintended Pregnancies

U.S. Population Growth

Women's Health USA 2003

Autoimmune Diseases

Bleeding Disorders

Home Health and Hospice Care

Title V Abstinence Education Programs

Title X Family Planning Services

Vitamin and Mineral Supplement Use

Women's Health USA 2004

American Indian/Alaska Native Women

Complementary and Alternative Medicine Use

Eating Disorders

Maternal Morbidity and Mortality

Services for Homeless Women

Women in NIH-Funded Clinical Research

REFERENCES

I. Population Characteristics

I.1 U.S. Census Bureau. 2003 American Community Survey summary tables. American FactFinder, Tables P004, P005.

I.2 U.S. Census Bureau. Current Population Survey, 2003 Annual Social and Economic Supplement. September 2004.

I.3 U.S. Census Bureau. Children's living arrangements and characteristics: March 2002. Current Population Report, June 2003.

I.4 Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth, 2002. Analysis conducted by the Maternal and Child Health Information Resource Center.

I.5 U.S. Department of Education, National Center for Education Statistics. Digest of education statistics, 2003; Chapter 3. Available from: http://nces.ed.gov/programs/digest/d03/list_tables.asp.

I.6 American Association of Medical Colleges. AMC Data Warehouse: Applicant Matriculant File, Medical School Student as of 7/14/2003; American Association of Colleges of Osteopathic Medicine. 2003 Annual Report on Osteopathic Medical Education; American Dental Association, Survey Center, 2002-03 Survey of Predoctoral Dental Education; Association of Schools and Colleges of Optometry. Annual Students Survey, 2002-2003; American Association of Colleges of Pharmacy. Profile of Pharmacy Students, Fall 2002; Association of Schools of Public Health. 2002 Annual data Report; American Association of Colleges of Nursing. 2002-2003 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing; Commission on Accreditation of Dietetics Education. Unpublished data; Council on Social Work Education. Unpublished data.

I.7 U.S. Census Bureau. American Community Survey summary tables. American FactFinder, Table P67; U.S. Department of Defense. Population representation in the military services: 2002. Available from: http://www.humrro.org/poprep2002/.

I.8 U.S. Census Bureau. American Community Survey summary tables. American FactFinder, Table P111.

I.9 U.S. Census Bureau. Current Population Survey, 2004 Annual Social and Economic Supplement. Available from: http://www.bls.census.gov/cps/asec/adsmain.htm.

I.10 U.S. Department of Agriculture. Characteristics of Food Stamp Households: Fiscal Year 2003. November 2004.

I.11 U.S. Department of Agriculture. Women, Infants, and Children. Program Data, Monthly Data—National Level, FY 2002 through October 2004. Available at http://www.fns.usda.gov/pd/WIC_Monthly.htm.

I.12 Administration for Children and Families, Office of Family Assistance. Temporary Assistance for Needy Families: Sixth Annual Report to Congress. November 2004. Available from: http://www.acf.hhs.gov/programs/ofa/annualreport6/ar6index.htm.

II. Health Status

II.1 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 1999-2002. 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 Interview Survey, 2003. Analysis conducted by the Maternal and Child Health Information Resource Center.

II.3 Centers for Disease Control and Prevention. Surveillance summaries. MMWR 2004 May;(53SS-2).

II.4 Substance Abuse and Mental Health Services Administration. Results for the 2003 National Survey on Drug Use and Health: detailed tables. Office of Applied Studies, Rockville, MD, September 2004.

II.5 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2002. Analysis conducted by the Maternal and Child Health Information Resource Center.

II.6 Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2003, Vol. 15. Available from: http://www.cdc.gov/hiv/stats/hasrlink.htm.

II.7 American Cancer Society. Cancer facts and figures 2005. Available from: http://www.cancer.org/downloads/STT/CAFF2005PWSecured4.pdf.

II.8 Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 11 Regs Public-Use. National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch. Released April 2004.

II.9 McCaig LF, Burt CW. National Hospital Ambulatory Medical Care Survey: 2002 Emergency Department summary. Advance Data from Vital and Health Statistics, No. 340, March 2004.

II.10 Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey. Analysis conducted by the Maternal and Child Health Information Resource Center.

II.11 Kochanek, M.A., et al. Deaths: final data for 2002. National Vital Statistics Reports, Volume 53, No. 5. Hyattsville, MD: National Center for Health Statistics. October 2003.

II.12 Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2004. Hyattsville, MD: 2004.

II.13 National Committee for Quality Assurance. The State of Health Care Quality 2004. Washington, DC: NCQA, 2004.

II.14 Centers for Disease Control and Prevention. Sexually transmitted disease surveillance, 2003. Atlanta, GA: September 2004.

II.15 Catalano SM. Criminal victimization, 2003. Bureau of Justice Statistics, National Crime Victimization Survey. September 2004, NCJ 205455.

II.16 U.S. Department of Justice, Bureau of Justice Statistics. Sourcebook of criminal justice statistics online. Available from: http://www.albany.edu/sourcebook.

II.17 Hamilton BE, Martin JA, Sutton PD. Births: preliminary data for 2003. National Vital Statistics Reports 2004;5(39).

II.18 Ventura SJ, Abma JC, Mosher WD, Henshaw S. Estimated pregnancy rates for the United States, 1990-2000: an update. National Vital Statistics Reports 2004;52(23).

II.19 Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States: 1982-2002. Advance Data from Vital and Health Statistics, No. 350, December 2004.

II.20 Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the 2003 National Immunization Survey.

II.21 Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, Brody S, Miller WC. Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evidence Report/Technology Assessment No. 119. Rockville, MD: Agency for Healthcare Research and Quality. January 2005.

II.22 Healthy Border 2010: An agenda for improving health on the United States-Mexico border. October 2003. Available from: http://www.borderhealth.org; Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2003. Hyattsville, MD: 2003.

II.23 Agency for Healthcare Research and Quality. 2002 Full Year Consolidated Data File (HC-070). Released December 2004. Medical Expenditure Panel Survey Household Component Data. Generated using MEPSnet/HC. Available from: http://www.meps.ahrq.gov/mepsnet/HC/MEPSnetHC.asp.

II.24 Federal Interagency Forum on Aging-Related Statistics. Older Americans 2004: key indicators of well-being. Federal Interagency Forum on Aging-Related Statistics, November 2004.

III. Health Services Utilization

III.1 Employee Benefit Research Institute. Sources of health insurance and characteristics of the uninsured: analysis of the March 2004 Current Population Survey. Issue Brief No. 276, December 2004.

III.2 Centers for Medicare and Medicaid Services. Unpublished data.

III.3 Health Resources and Services Administration, Maternal and Child Health Bureau, Title V Information System. Available from: https://performance.hrsa.gov/mchb/mchreports/Search/search.asp.

III.4 Woodwell DA, Cherry DK. National Ambulatory Medical Care Survey: 2002 summary. Advance Data from Vital and Health Statistics, No. 346, August 2004.

III.5 National Center for Health Statistics. National Ambulatory Medical Care Survey, 2002. Analysis conducted by the Maternal and Child Health Information Resource Center.

III.6 DeFrances CJ, Hall MJ. 2002 National Hospital Discharge Survey. Advance Data from Vital and Health Statistics, No. 342, May 2004.

III.7 Organ Procurement and Transplantation Network. Data tables. http://www.optn.org/data/.

III.8 Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey: 2002 compendium of tables—household medical expenditures. AHRQ, Rockville, MD, December 2004. Available from: http://www.meps.ahrq.gov/CompendiumTables/TC_TOC.htm.

CONTRIBUTORS

This publication was prepared for the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) and Office of Women's Health, by the MCHB's Maternal and Child Health Information Resource Center.

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

Agency for Healthcare Research and Quality
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Health Resources and Services Administration
National Institutes of Health
Substance Abuse and Mental Health Services Administration

Other Federal Contributors

Federal Interagency Forum on Aging-Related Statistics
U.S. Departments of Agriculture, Education, Justice, Labor, and Commerce

Non-Governmental Contributors

American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Cancer Society
American Dental Association
Association of American Medical Colleges
Association of Schools and Colleges of Optometry
Association of Schools of Public Health
Commission on Accreditation of Dietetics Education
Council on Social Work Education
Employee Benefit Research Institute
National Committee for Quality Assurance
Organ Procurement and Transplantation Network

Photography on cover and pages 1, 4, 6, 9, 10, 13, 22, 24, 31, 55, 62, and 80 copyright Jupiter Images. Photo on page 75 contributed by Michael King.


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


DEPARTMENT OF HEALTH & HUMAN SERVICES · USA