Women's Health USA 2006

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

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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PREFACE AND READER'S GUIDE

Healthy women in healthy communities is important to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). HRSA is charged with ensuring 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 is pleased to present *Women's Health USA 2006,* the fifth edition of the *Women's Health USA* data book. To reflect the ever-changing, increasingly diverse population and its characteristics, *Women's Health USA* selectively highlights emerging issues and trends in women's health. Data and information on life expectancy, postpartum depression, food security and smoking during pregnancy are a few of the new topics included in this edition. Where possible, every effort has been made to highlight racial and ethnic as well as sex disparities.

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 2006* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal government, including the U.S. Department of Health and Human Services, U.S. Department of Agriculture, U.S. Department of Labor, and U.S. Department of Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years. It is important to note that the incidence data included is generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races and ethnicities. Without age adjustment, it is difficult to know how much of the difference in incidence rates between groups can be attributed to different age distributions. Also, presentation of racial and ethnic data may appear differently on some pages as a result of the design and limitations of the original data source.

Women's Health USA 2006 is available online at either the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth or the Office of Data and Program Development's Web site at http://mchb.hrsa.gov/data/. In an effort to produce a timely document, some of the topics covered in *Women's Health USA 2005* 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 2005*, also available online. The National Women's Health Information Center at www.womenshealth.gov also has updated and detailed women's and minority health data and maps available at the State and county level and by age, race/ethnicity, and sex.

Please provide any feedback on this publication to the HRSA Information Center at: 1-888-ASK-HRSA or www.ask.hrsa.gov. Single copies are available at no charge from: HRSA Information Center, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22812-2536, 703-442-9051 or 1-888-ASK-HRSA.

INTRODUCTION

In 2004, women represented 51 percent of the 285 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 U.S. 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 accounted for 82 percent of women aged 65 years and older, but only 59.3 percent of those under 15 years of age.

In addition to race and ethnicity, income and education are important factors that contribute to women's health and access to health care. In every family structure, women are more likely than men to live in poverty. Poverty rates are highest among women who are heads of their households: nearly one-quarter of female heads of households are poor. Poverty rates are also higher among women with no high school diploma (28.3 percent) than women with a high school diploma (12.3 percent) or at least some college education (8.4 percent). However, the number of women going to college is increasing;

more than 1.5 million women earned post-secondary degrees in 2003, and women now represent more than half of recipients of associate's, bachelor's, and master's degrees.

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 2004, 62 percent of non-Hispanic White females reported themselves to be in excellent or very good health, compared to only 54.5 percent of Hispanic women and 52 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 2004, non-Hispanic Black and Hispanic women accounted for more than three-fourths of women with AIDS. Just over one-third of non-Hispanic White women have ever been tested for the Human Immunodeficiency Virus (HIV), compared to 52.4 percent of non-Hispanic Black women and 45.4 percent of Hispanic women.

Mental health is another important aspect of women's overall health. A range of mental health problems, including depression, anxiety, phobias, and post-traumatic stress disorder, disproportionately affect women. Moreover, pregnancy and the postpartum period are times when women may be especially vulnerable to depression. Nearly one-quarter of new mothers suffer mild depression, 9.7 percent show moderate depression, and 6.5 percent show symptoms of severe depression. Postpartum depression is most common among non-Hispanic Black and American Indian/Alaska Native women.

Physical disabilities are prevalent among women as well. Disability can be defined as impairment of the ability to perform common activities like walking up stairs, sitting or standing for 2 hours or more, grasping small objects, or carrying items like groceries. Therefore, the terms "activity limitations" and "disabilities" are used interchangeably throughout this book. Overall, 15.4 percent of women and 12.8 percent of men report having activity limitations.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and it is especially prevalent among non-Hispanic Black women. Among women in this population, diabetes occurs at a rate of 103.6 per 1,000 women, compared to 61.1 per 1,000 non-Hispanic White women. Hypertension, or high blood pressure, is also more prevalent among non-Hispanic Black women than women of other races. This disease occurs at a rate of 341.1 per 1,000 non-Hispanic Black women compared to 260 per 1,000 non-Hispanic White women and 197.5 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 or greater is considered overweight, and a BMI of 30 or greater is considered obese. In 2004, 51.7 percent of women were overweight or obese. In 12 States, at least one-quarter of women met the standard for obesity.

Some conditions, such as arthritis, disproportionately affect non-Hispanic White women. In 2004, the rate of arthritis among non-Hispanic White women was 279.4 per 1,000 women, compared to 225.2 per 1,000 non-Hispanic Black women and 145.5 per 1,000 Hispanic women.

Other conditions are more closely linked to family income than to race and ethnicity. Rates of asthma, for example, decline as income increases; among women with incomes under the Federal poverty level, more than one-third have been hospitalized for asthma in the past year, compared to 18.8 percent of women with family incomes of 300 percent of the poverty level or more.

Many diseases and health conditions, such as those mentioned above, can be avoided or minimized through good nutrition, regular exercise, and preventive health care. In 2003, 18.6 per-

cent of women's visits to physicians were for preventive care, including prenatal care, screenings, and immunizations. Overall, 65.9 percent of older women reported receiving a flu shot in 2004; however, this percentage ranges from 45.3 percent among non-Hispanic Black women to 68.4 percent of non-Hispanic White women. In addition to preventive health care, preventive dental care is also important to prevent dental caries and gum disease. In 1999-2002, 72.1 percent of women with dental insurance saw a dentist in the past year, compared to 60.3 percent of women with health insurance but no dental coverage, and 38.4 percent of women with no insurance at all.

There are many ways women (and men) can promote health and help prevent disease and disability. Thirty minutes of physical activity on most days of the week can reduce the risk of chronic disease; women who report any exercise at all got an average of 187 minutes of moderate exercise each week in 2004.

A healthy diet can also be a major contributor to long-term health and prevention of chronic disease. However, more than half of adult women's diets include more than the recommended amount of saturated fat and sodium and less than the recommended amount of iron. Overall, 53 percent of women exceed the maximum daily intake of saturated fat, 61.4 percent exceed the maximum amount of sodium, and 82 percent do not meet the recommended amount of iron. In addition, 41.3 percent do not have enough vitamin B12 in their diets.

Contraceptive use is another important health behavior; depending on the method, it can prevent unintended pregnancy and the spread of sexually transmitted infections (STIs). In 2002, 35.8 percent of women with private insurance chose the contraceptive pill, making it the most popular form of contraception in that group. Female sterilization was the most common method of contraception among women on Medicaid (used by 40.5 percent). Condoms, which can prevent both pregnancy and the spread of STIs, were used by the male partners of only 18 percent of women with public or private insurance and 20.3 percent of uninsured women.

While some behaviors have a positive effect on health, a number of others, such as smoking and alcohol and drug use, can have a negative effect. In 2004, 22.3 percent of women smoked. However, 43.9 percent of female smokers tried to quit. In the same year, 44 percent of women reported any alcohol use in the past month; however, relatively few women (14.9 percent) reported binge drinking (5 or more drinks on the same occasion) and even fewer (3.5 percent) reported heavy alcohol use (binge drinking on 5 or more days in the past month).

Use of cigarettes, alcohol, and illicit drugs is particularly harmful during pregnancy. While use of illicit drugs among pregnant women in general is reported by only 4.6 percent of pregnant women, it is more common among pregnant adolescents, of whom 16 percent reported drug use in the past month. The use of tobacco during pregnancy is relatively rare as well, and has declined steadily since 1989. In 2004, 10.2 percent of mothers reported smoking during pregnancy. This rate was highest among American Indian/Alaska Native women (18.2 percent) and non-Hispanic White women (13.8 percent).

Women's Health USA 2006 can be an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women throughout the United States.

POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were over 145 million women and girls in the United States in 2004, representing slightly more than half of the population.

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

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

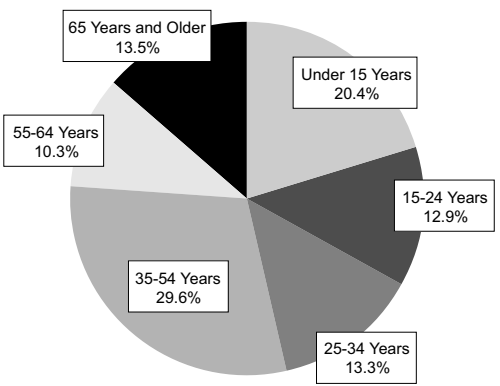
U.S. POPULATION

In 2004, the U.S. population was over 285 million, with females representing 51.1 percent. Females younger than age 35 accounted for 46.6 percent of the female population, those aged 35-64 represented 39.9 percent, and females over age 65 accounted for 13.5 percent.

The distribution by sex was fairly even across all age groups, except among older adults, where women accounted for a greater percentage of the population. Of those aged 65 and older, 57.5 percent were women.

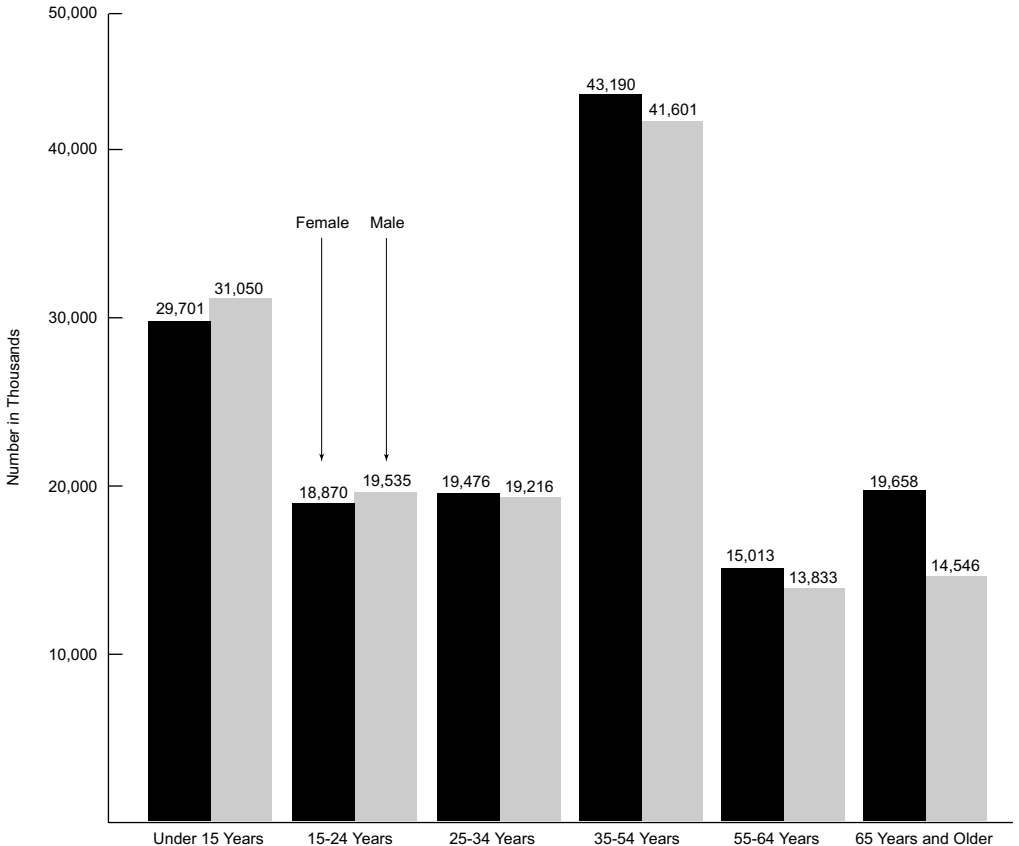
U.S. Female Population,* by Age, 2004

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



U.S. Population, by Age and Sex,* 2004

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



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

U.S. FEMALE POPULATION BY RACE/ETHNICITY

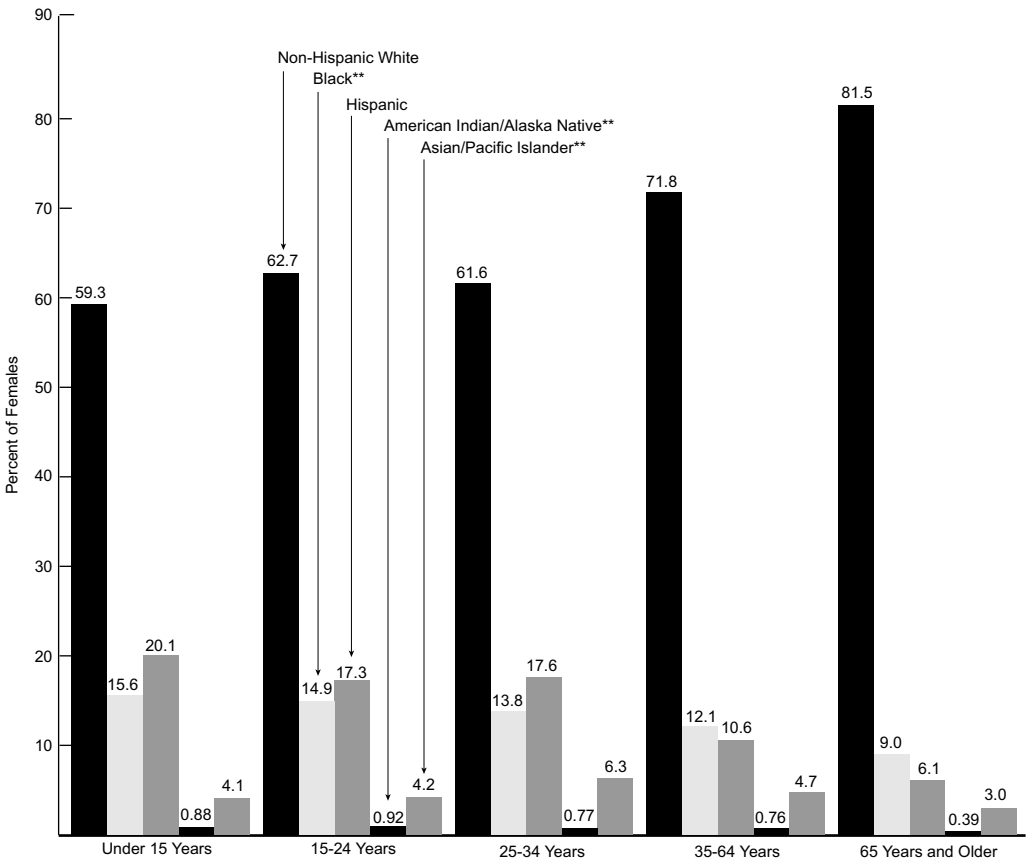
The growing diversity of the U.S. female population is reflected in the racial and ethnic distribution of women across age groups. The younger female population, under 25 years of age, is significantly more diverse than the older female population. In 2004, females who identified as Hispanic or non-White in race and ethnicity represented 39.4 percent of the females under 25 years of age, while among women 65 years and older, only 18.5 percent were Hispanics or non-Whites.

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

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

U.S. Female Population,* by Age and Race/Ethnicity, 2004

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



*Includes only non-institutionalized population not living in group quarters. **May include Hispanics.

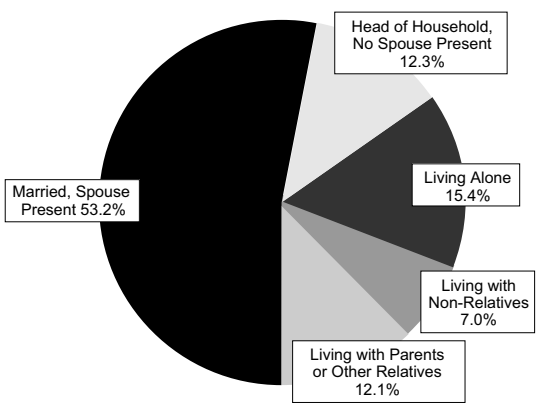
HOUSEHOLD COMPOSITION

In 2004, 53.2 percent of women 18 and older were married and living with their spouses; this includes married couples living with other people, such as parents. Over 12 percent of women over age 18 are the heads of their households, meaning that they have children or other family members, but no spouse, living with them in a house that they own or rent. Women who are heads of households include single mothers, single women with a parent or other close relative in their house, and women with other household configurations. The remaining women lived alone (15.4 percent), with non-relatives (7.0 percent), and with parents or other relatives (12.1 percent).

Women in female-headed households are more likely than women in married-couple families to have incomes below the Federal poverty level (see "Women and Poverty," page 15). Black women are the most likely to be a single head of household (29.1 percent), while Asian women are the least likely (7.2 percent). Hispanic women and women of other races also have high rates of female-headed households (16.4 and 15.9 percent, respectively).

Adult Women,* by Household Composition, 2004

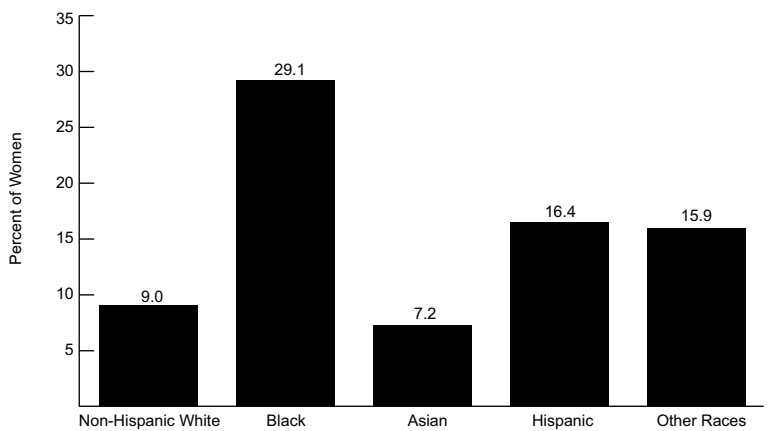
Source I.2: U.S. Census Bureau, Current Population Survey



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

Women Who Are Heads of Households,* by Race/Ethnicity, 2004

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



*Civilian, non-institutionalized population aged 18 years and older; includes women who have children or other family members, but no spouse, living in a house that they own or rent.

WOMEN AND POVERTY

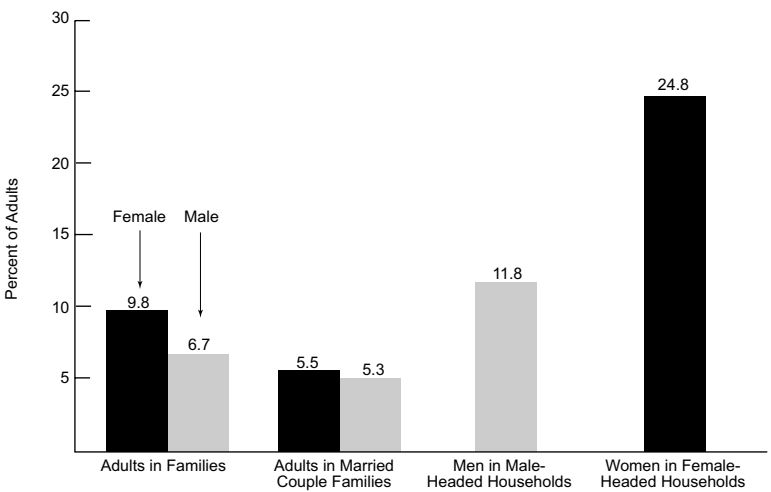
In 2004, nearly 37 million people in the United States lived with incomes below the Federal poverty level.[1] The poverty rate for all women 18 years and older in 2004 was 12.7 percent (representing 14.3 million women), compared to a rate of 9.3 percent for men. Women in families, those who live with people to whom they are directly related, experience higher rates of poverty than men in families (9.8 versus 6.7 percent). Men in households with no spouse present are considerably less likely to have incomes below the poverty level than women in households with no spouse present (11.8 versus 24.8 percent).

Education is related to poverty as well. The poverty rate among women with no high school diploma is 28.3 percent; this is far higher than the rate among women with a high school diploma (12.3 percent). Women with at least a 4-year college degree experience the lowest poverty rate (4.5 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 2004 poverty levels were $9,645 for an individual, $12,334 for a family of two, $15,067 for a family of three, and $19,307 for a family of four.*

Adults in Families,* Living Below the Poverty Level, by Household Type and Sex, 2004

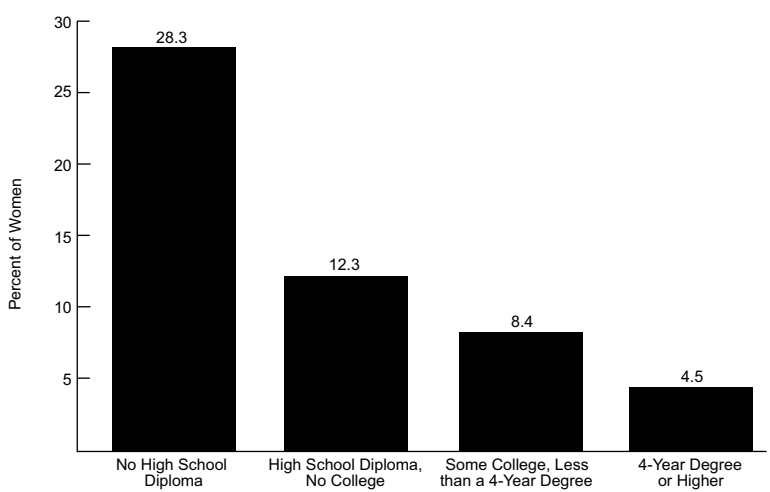
Source I.3: U.S. Census Bureau, Current Population Survey



*Families are defined as a group of two people related by birth, marriage, or adoption and residing together.

Women Aged 25 and Older Living Below the Poverty Level, by Educational Status, 2004

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



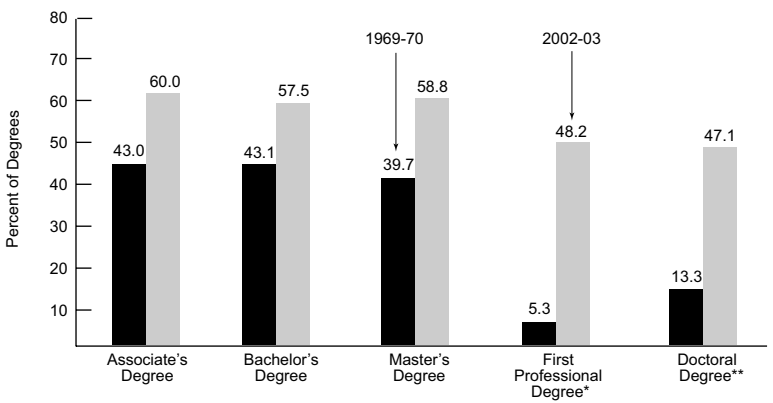
EDUCATIONAL DEGREES AND INSTRUCTIONAL STAFF

The number of post-secondary educational degrees awarded to women rose from just over half a million in the 1969-1970 school year to more than 1.5 million in 2002-03. 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 2002-03, women earned more than 50 percent of all associate's, bachelor's, and master's degrees, and earned almost half of all first professional and doctoral degrees. The most significant increase has been in the proportion of women earning a first professional degree, which jumped from 5.3 percent in 1969-1970 to 48.2 percent in 2002-03. That year, the total number of women earning their first professional degree (38,976) was 21 times greater than in 1969-1970 (1,841).

Males are more likely than females to be employed as full-time instructional staff in degree-granting institutions; overall, 60.6 percent of full-time faculty were male in 2003, while the remaining 39.4 percent were female. With regard to rank, the proportion of males to females declined steadily with rank. The only ranks in which women were a majority were those of instructor and lecturer; males were the majority among full, associate, and assistant professors.

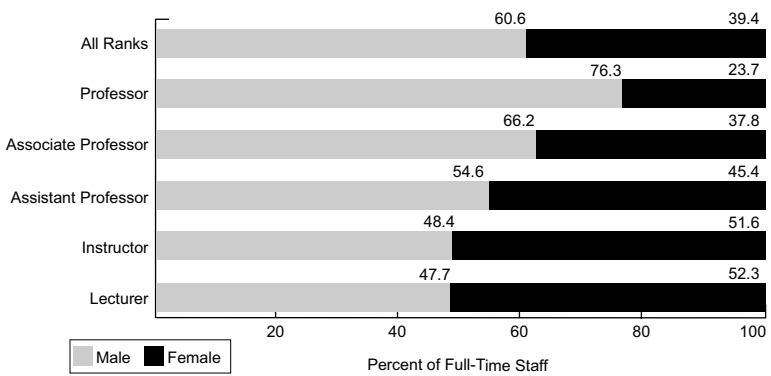
Degrees Awarded to Women, by Type, 1969-70 and 2002-03

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



Full-Time Instructional Staff in Degree-Granting Institutions, by Academic Rank and Sex, 2002-03

Source I.4: 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.

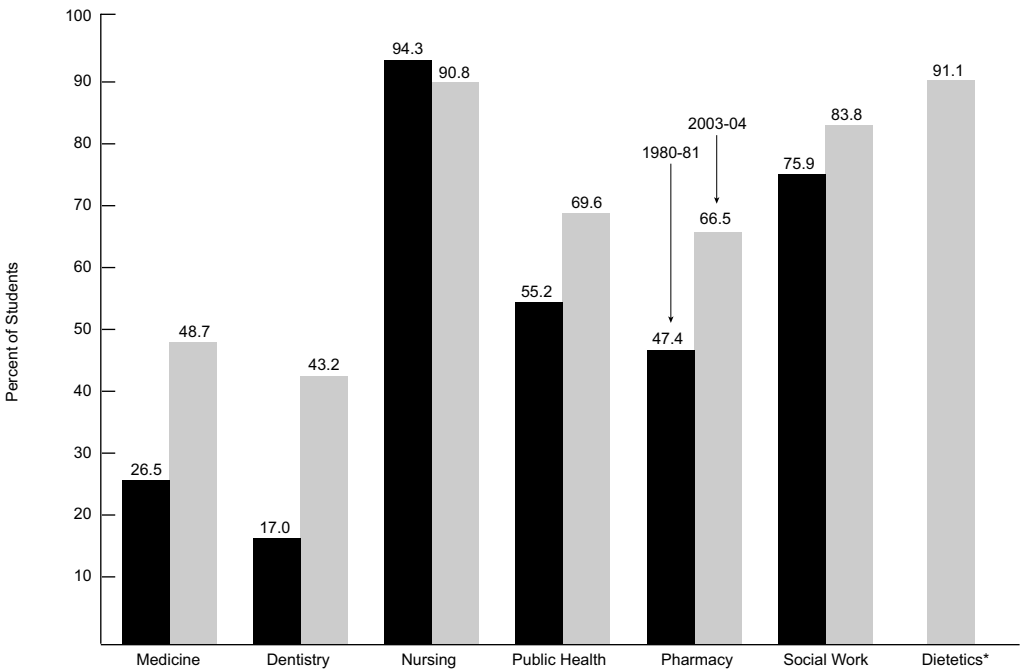
WOMEN IN HEALTH PROFESSIONS SCHOOLS

The health professions have long been characterized by sex disparities. Some professions, such as medicine and dentistry, have historically been dominated by males, while others, such as nursing, have been predominantly female. Over the past several decades, these gaps have narrowed, and in some cases have disappeared. In 1980-81, 47.4 percent of pharmacy students were women, while in the fall of 2004 women represented nearly two-thirds (66.5 percent) of the students. Even in fields where men are still the majority, the representation of female students has grown. In 1980-81, only 26.5 percent of medical students were women compared to nearly one-half (48.7 percent) in the fall of 2004. In schools of osteopathic medicine, women now comprise 46.9 percent of total enrollees. Similar gains have been made in the field of dentistry, where 43.2 percent of students were women in 2003-04 compared to only 17.0 percent in 1980-81.

By the 2004 school year, female students represented a growing majority in a number of health professions schools, including graduate schools of social work (83.8 percent), physical therapy (77.9 percent), public health (69.6 percent), and optometry (62.2 percent). Women also represent the vast majority of enrollees in dietetics programs—in 2004, 91.1 percent of dietetics students and interns were women. Nursing, at both the undergraduate and graduate levels, also continues to be dominated by women, although the proportion of students who are female is slowly declining. In the 1980-81 academic year, 94.3 percent of nursing students were female, while in the fall of 2004, females represented 90.8 percent of nursing students.

Women in Schools for Selected Health Professions, 1980-81 and 2003-04

Source I.5: Professional Associations



*Data from 1980-81 are unavailable.

WOMEN IN THE LABOR FORCE

In 2004, 59.2 percent of women aged 16 and older were in the labor force (either employed or unemployed and actively seeking employment). This represents a 37 percent increase from the 43.3 percent of women who were in the labor force in 1970. Females aged 16 and older made up 46.4 percent of the workforce in 2004.[1] Among working females, 74 percent worked full-time, compared to 89 percent of males.[2]

The representation of females in the labor force varies greatly by occupational sector. In 2004, women composed over 60 percent of sales and office workers, but only 1.3 percent of construction, extraction, and maintenance workers. Other positions which are more commonly held by women than men include services jobs (56.2 percent) and management, professional, and related jobs (50.4 percent). Women are the minority in production, transportation, and moving (23.1 percent), farming, fishing, and forestry (19.6 percent), and military (17.4 percent).

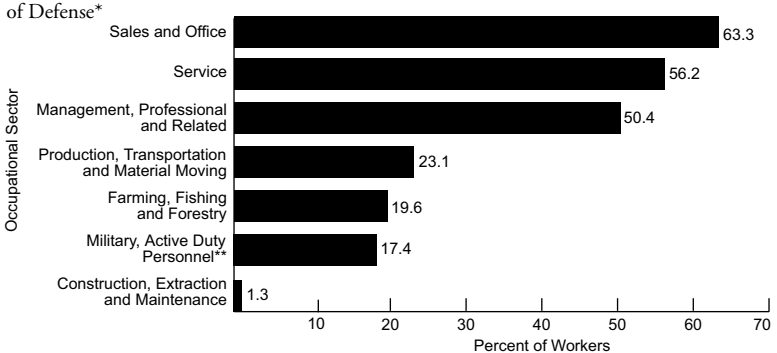
Earnings by women and men also vary greatly. Women represent a majority of earners making less than $25,000 per year. Of earners making less than $2,500 per year, 58.4 percent were women in 2004; however, women represented only 19.1 percent of earners making $100,000 or more per year. The difference between women's and men's earnings is larger among older than younger workers. For instance, women aged 45-54 earned 73 cents for every dollar earned by males aged 45-54, while women aged 16-24 earned 94 cents for every dollar earned by males of the same age.

1 *U.S. Department of Labor, Bureau of Labor Statistics, Women in the Labor Force: A Databook, Report 985, Table 2. Employment status of the civilian noninstitutionalized population 16 years and over by sex, 1970-2004 annual averages. May 2005 at http://www.bls.gov/cps/wlf-table2-2005.pdf*

2 *U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey, Employment and Earnings, Table 8: Employed and unemployed full- and part-time workers by age, sex, race, and Hispanic or Latino ethnicity. January 2005 at http://www.bls.gov/cps/home.htm#annual*

Representation of Females Aged 16 and Older in Occupational Sectors, 2004

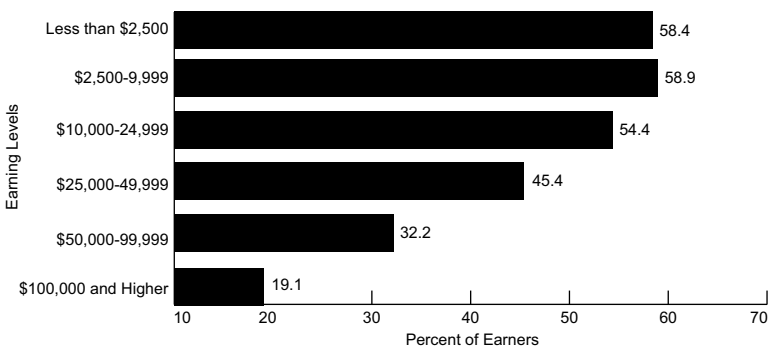
Sources I.1, I.6: U.S. Census Bureau, American Community Survey; U.S. Department of Defense*



*Data on military enlistment are from the Department of Defense, FY 2004; all other are from the Census Bureau. **Excluding cadets in military academies.

Representation of Females Aged 16 and Older in Annual Earning Levels, 2004

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



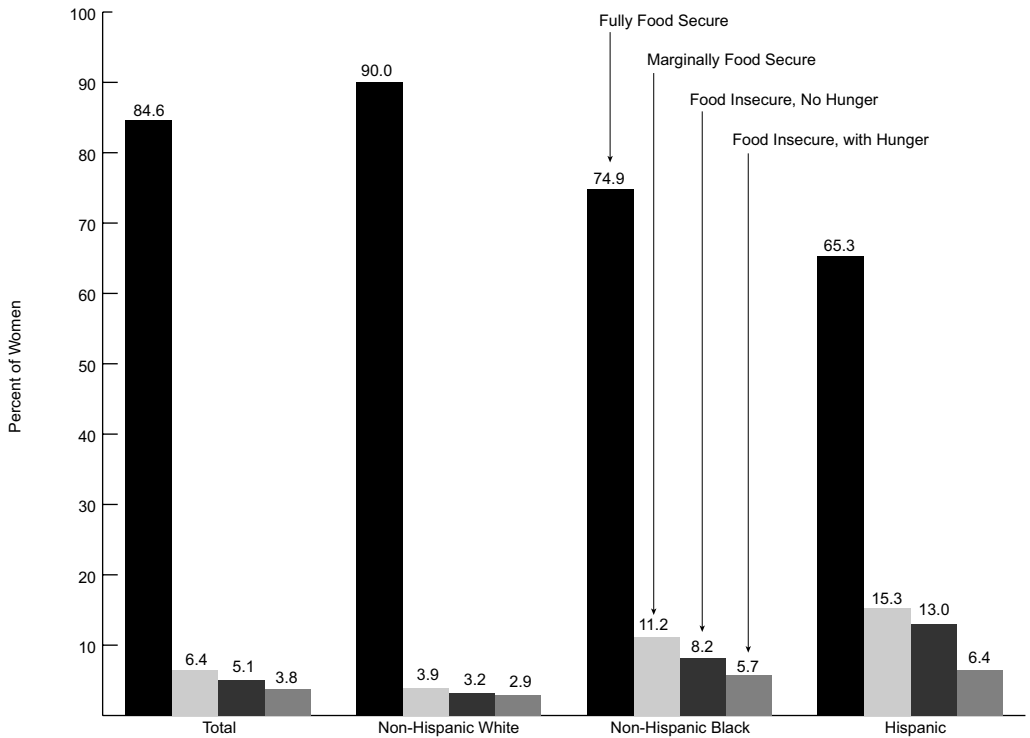
FOOD SECURITY

In 1999-2002, over 15 percent of women were not fully food secure, meaning that they did not always have access to enough food for a healthy, active lifestyle. In the National Health and Nutrition Examination Survey (NHANES), food security and hunger are measured through a series of questions including: whether the respondent worried that food would run out before there would be money to buy more; whether the respondent or his/her family could not afford to eat balanced meals; whether the respondent or his/her family cut the size of meals or skipped meals because there was not enough money for food; and, whether the respondent or his/her family ever went for a whole day without eating because there was not enough food. For many of these questions, respondents were asked how often these situations arose. It should be noted that in many cases the situation is occasional or episodic, not chronic.

Although there is little difference in food security and hunger among men and women, rates varied noticeably by race and ethnicity. Among women, non-Hispanic Whites were most likely to be fully food secure (90.0 percent), while Hispanics were least likely (65.3 percent). Hispanic women also had the highest rates of marginal food security (15.3 percent), food insecurity without hunger (13.0 percent), and food insecurity with hunger (6.4 percent), while non-Hispanic Whites had the lowest rates in each category.

Food Security Among Women 18 Years and Older, by Race/Ethnicity,* 1999-2002

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



*The sample of those of other races was too small to produce reliable estimates.

WOMEN AND FEDERAL PROGRAM PARTICIPATION

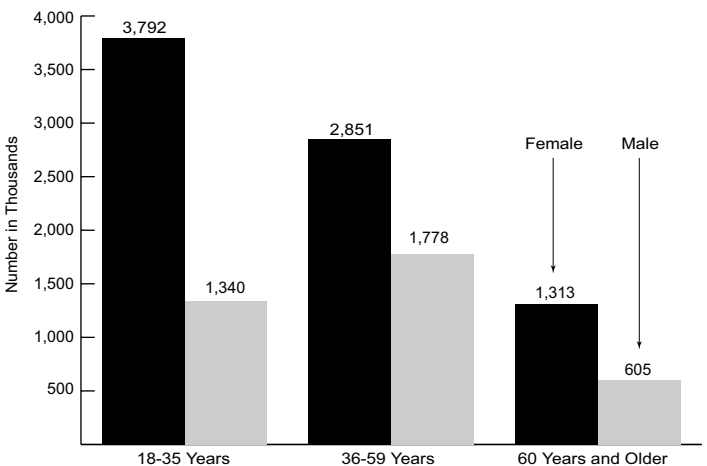
Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Federal Food Stamp Program helps low-income individuals purchase food: in 2004, 68 percent of all adult Food Stamp participants were women. Nearly half of women participants 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 1.9 million women, representing 24.5 percent of WIC participants. From 1992 to 2004, the number of adult women participating in WIC increased by 57 percent, and it continues to rise.

Temporary Assistance for Needy Families (TANF) is a Federal- and State-funded program that provides cash 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 overarching goals of TANF are to move recipients into work and turn welfare into a program of temporary assistance with a lifetime maximum enrollment of 5 years. In Fiscal Year 2002, the last year for which data are available, adult TANF recipients numbered 1.3 million, of whom 1.2 million (over 90 percent) were women.

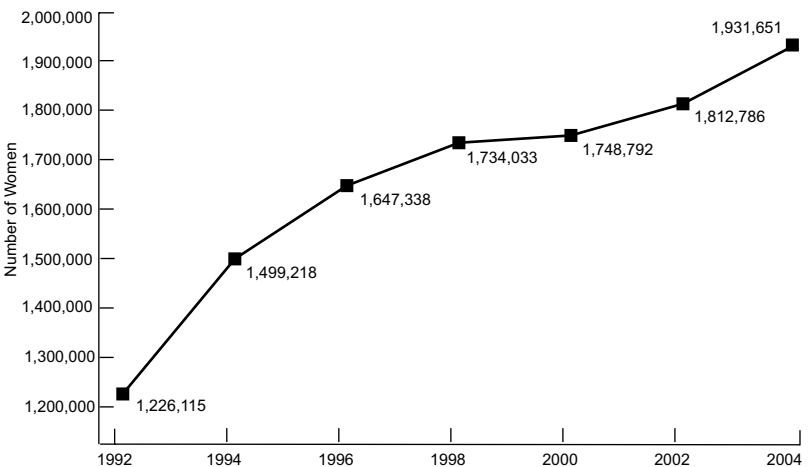
Adult Recipients of Food Stamps, by Age and Sex, 2004

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



Women WIC Participants, Selected Years 1992-2004

Source I.9: U.S. Department of Agriculture, WIC Program Participation Data



HEALTH STATUS

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

In the following section, health status indicators are presented related to morbidity, mortality, health behaviors, and reproductive health. Issues pertinent to selected populations of women, including older, rural, American Indian/Alaska Native women and women in the correctional system 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 such conditions is still being studied, it is vital for women to be aware of their family history so that their risk for developing such conditions can be properly assessed.

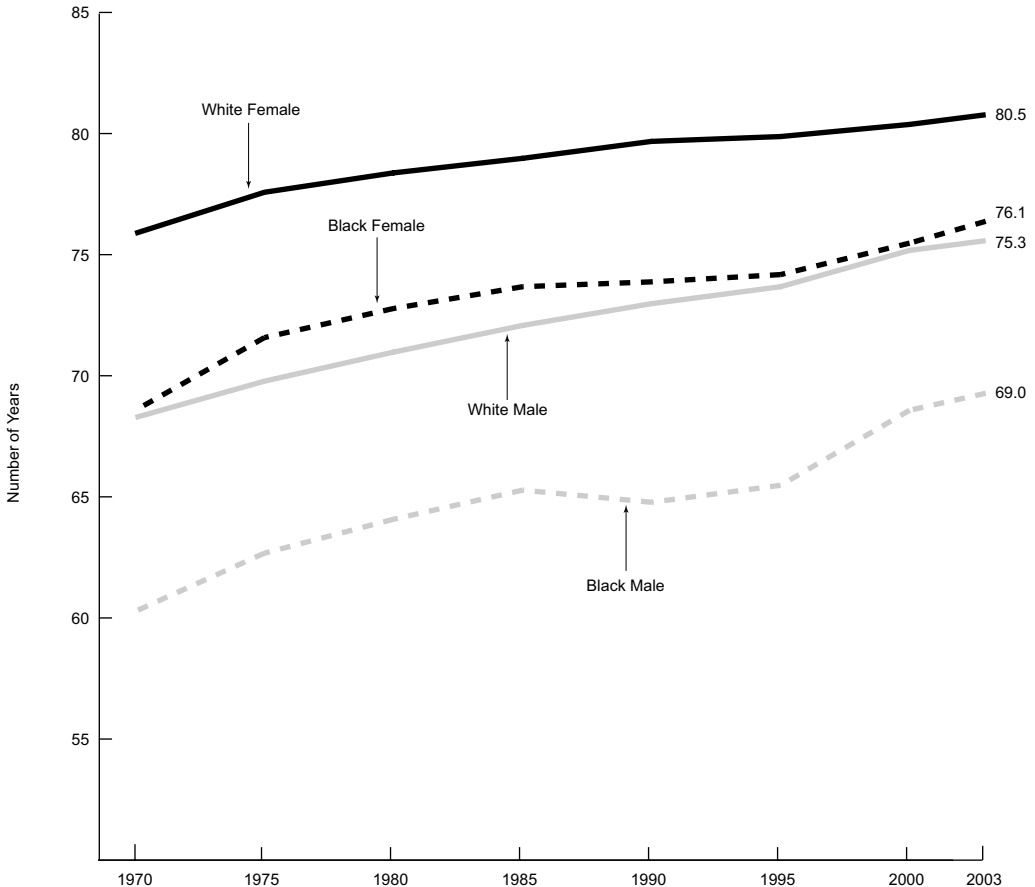
LIFE EXPECTANCY

A baby girl born in the United States in 2003 could expect to live 80.1 years, 5.3 years longer than her male counterpart, whose life expectancy was 74.8 years. The life expectancy at birth for White females was 80.5 years; for Black females, the life expectancy at birth was 76.1 years. The differential between male and female life expectancy was greater among Blacks than Whites; Black males could expect to live 69.0 years, 7.1 years less than Black females, while the difference between White males and females was 5.2 years. The higher infant mortality rate among Blacks may partly account for their relatively lower life expectancy.

Life expectancy has steadily increased since 1970 for males and females in both racial groups. Between 1970 and 2003, White males' life expectancy increased from 68.0 to 75.3 years (10.7 percent), while White females' life expectancy increased from 75.6 to 80.5 years (6.5 percent). Black males' life expectancy increased from 60.0 to 69.0 years (15.0 percent) during the same period, while Black females' life expectancy has increased from 68.3 to 76.1 years (11.4 percent).

Life Expectancy at Birth, by Race and Sex, 1970-2003

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



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-intensity physical activity on most days of the week for adults. To prevent weight gain over time, the Guidelines recommend about 60 minutes of moderate to vigorous physical activity on most days while not exceeding calorie intake requirements.[1]

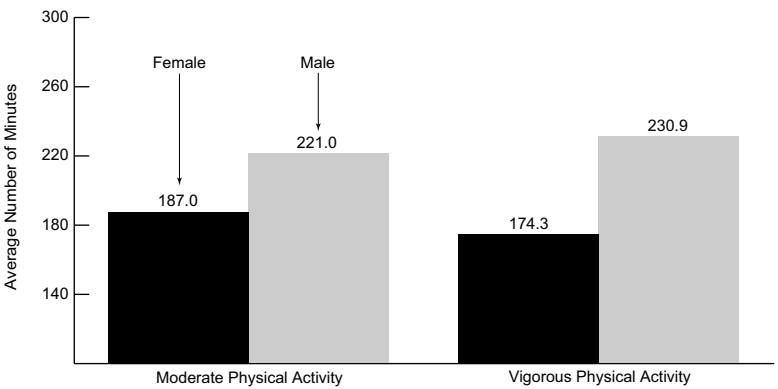
In 2004, 51.7 percent of women reported engaging in at least 10 minutes of moderate leisure-time physical activity per week, and 31.8 percent reported a similar amount of vigorous activity. Men participated in physical activity for a greater average number of minutes than women: among those who reported physical activity in the last week, women averaged 187 minutes of moderate activity compared to 221 minutes among men. Women averaged 174 minutes of vigorous activity compared to 231 minutes among men.

Among adults who participated in physical activity, some of the most popular activities included walking, dancing, and bicycling. Women were more likely than men to report walking (37.6 versus 22.3 percent) and dancing (12.7 versus 7.7 percent), while men were more likely to report bicycling (10.6 versus 8.7 percent) and golf (11.2 versus 3.1 percent).

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

Average Physical Activity Minutes per Week Among Adults Aged 18 Years and Older,* by Sex and Level,** 2004

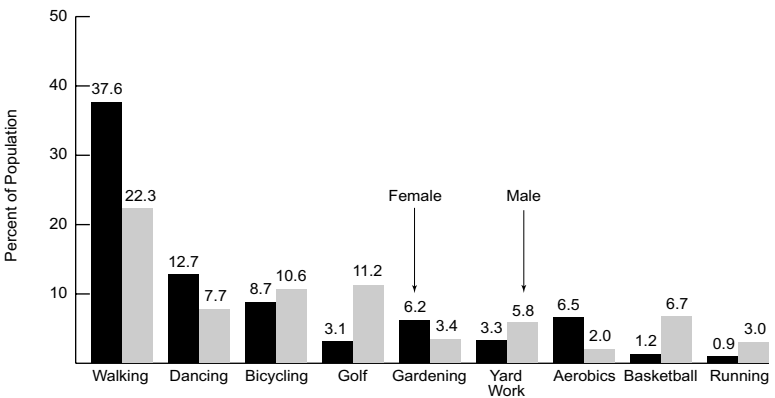
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Selected Types of Physical Activity Reported Among Adults Aged 18 Years and Older,* by Sex, 1999-2002

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



*Among adults who were physically active at least 10 minutes in the week prior to the survey.

NUTRITION

The Dietary Guidelines for Americans published by the U.S. Departments of Health and Human Services (DHHS) and Agriculture (USDA) recommend eating a variety of nutritious foods while staying within caloric needs. For most people, this means eating an assortment of fruits and vegetables, whole grains, lean meats and beans, and low-fat or fat-free milk products while limiting added sugar, sodium, saturated and *trans* fats, cholesterol, and alcohol.[1]

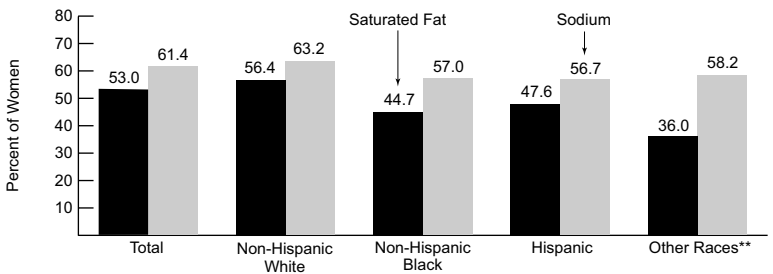
While some fats, in the form of oils, are an important part of a healthy diet, the type of fat and the total amount consumed should be considered. High intake of saturated fats, *trans* fats, and cholesterol may increase the risk of coronary heart disease. Most Americans should consume fewer than 10 percent of calories from saturated fats, less than 300 mg/day of cholesterol, and keep *trans* fatty acid consumption to a minimum. In 1999-2002, 53 percent of women exceeded the recommended maximum daily intake of saturated fat. This was most common among non-Hispanic White women, followed by Hispanic women. Salt, or sodium chloride, also plays an important role in heart health, as high salt intake can contribute to high blood pressure. Overall, almost 62 percent of women exceed the recommended maximum of 2,300 mg of sodium (about 1 teaspoon of salt) per day.

A varied diet comprising the recommended food groups can help to reduce saturated fat and sodium intake and to increase intake of important vitamins and minerals, such as vitamin B12 and iron. B12 helps maintain healthy cells, and is needed to help make DNA, while iron is crucial to oxygen transport and the regulation of cell growth. Overall, 41.3 percent of women did not meet the daily recommendation for B12 and nearly twice as many, 81.3 percent, did not meet the recommendation for intake of iron.

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

Women Exceeding the Recommended Maximum Daily Intake of Saturated Fat and Sodium,* by Race/Ethnicity, 1999-2002

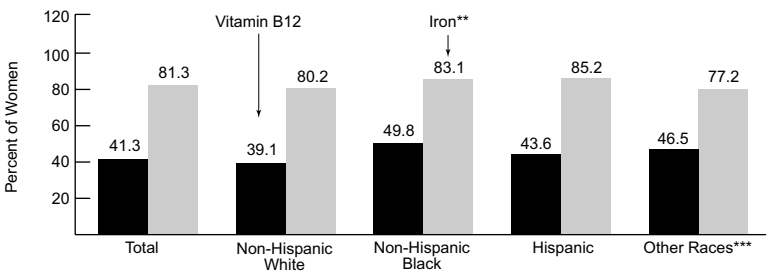
Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Recommended daily intake of saturated fat is 10 percent of daily caloric intake or less; recommended intake of sodium is less than 2,300 milligrams. **Includes Asian/Pacific Islander, American Indian/Alaska Native, and persons of more than one race.

Women Not Meeting the Recommended Daily Intake of Vitamin B12 and Iron,* by Race/Ethnicity, 1999-2002

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



*Recommended daily intake of Vitamin B12 for all women is 2.4 micrograms or greater; recommended intake of iron for women aged 18-50 is 18 milligrams or greater. **Data are for women aged 18-50. ***Includes Asian/Pacific Islander, American Indian/Alaska Native, and persons of more than one race.

CIGARETTE SMOKING

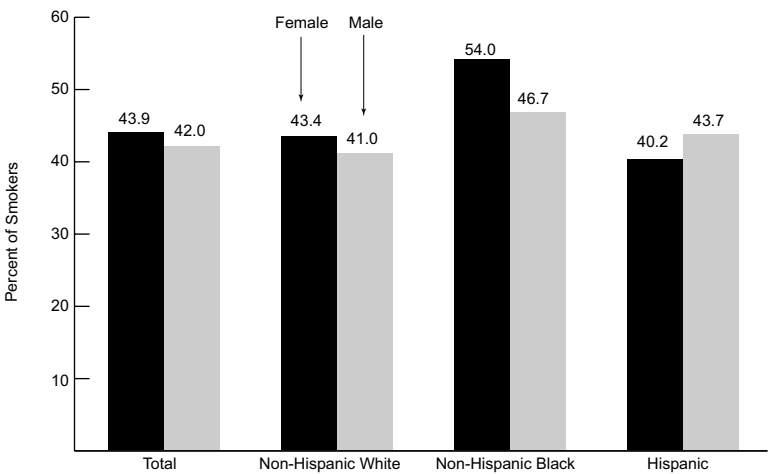
According to the U.S. Surgeon General, smoking damages every organ in the human body. Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impair genes that control the growth of cells, and bind to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[1] In 2004, almost 60 million people in the United States aged 12 and older smoked cigarettes within the past month. Among women, the rate of smoking in the past month was 22.3 percent, compared to 27.7 percent among men. This rate has declined over the past several decades among both sexes. In 1985, the rate among males was 43.4 percent, and among females it was 34.5 percent.

Quitting smoking has major and immediate health benefits. In 2004, over 40 percent of smokers reported trying to quit at least once in the past year. Females were slightly more likely than males to attempt to quit (43.9 versus 42.0 percent). Among both males and females, non-Hispanic Blacks were the most likely to try to quit smoking (46.7 and 54.0 percent, respectively).

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

Adults Aged 18 and Older Who Tried to Quit Smoking in the Past Year, By Sex and Race/Ethnicity,* 2004

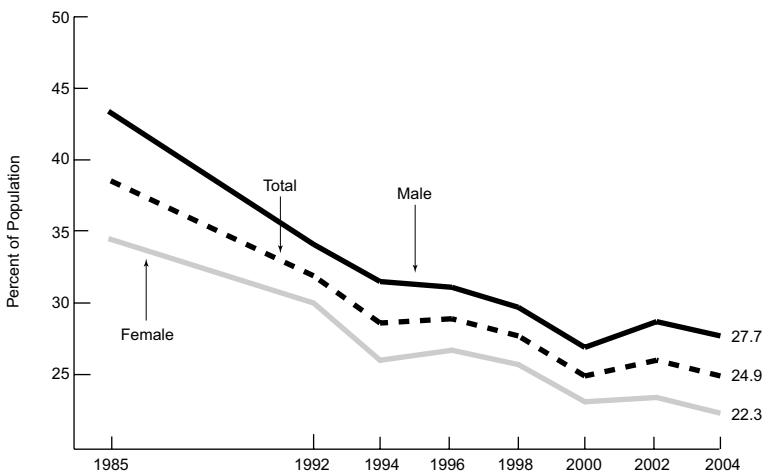
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The sample of Asians and those of other races was too small to produce reliable estimates.

Persons Aged 12 and Older Reporting Past Month Cigarette Use, by Sex, 1985-2004

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



ALCOHOL USE

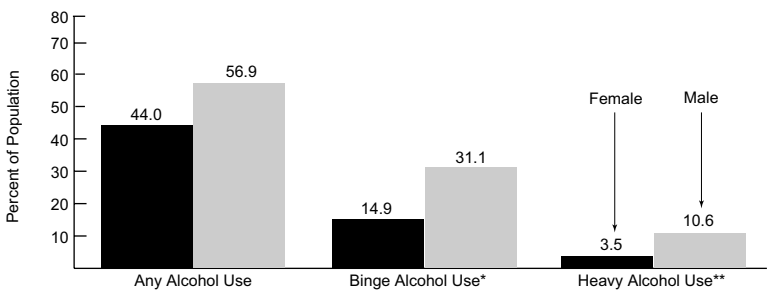
In 2004, 50.3 percent of the U.S. population aged 12 and older reported using alcohol in the past month; among those aged 18 and older, 54.1 percent reported using alcohol. According to the Centers for Disease Control and Prevention, alcohol is a central nervous system depressant that, in small amounts, can have a relaxing effect. Although there is some debate over the health benefits of small amounts of alcohol consumed regularly, the negative short- and long-term health effects of excessive alcohol use and abuse are well-established. Short-term effects include motor vehicle injuries, falls, domestic violence, and child abuse. Long-term effects can include liver cirrhosis, pancreatitis, various cancers, high blood pressure, and psychological disorders, including dependence. Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), infant low birth weight, and developmental delays in children. Current Dietary Guidelines for Americans recommend that the following people not drink any alcoholic beverages: children and adolescents; individuals who cannot restrict their drinking to moderate levels; women who are or may become pregnant; individuals who plan to drive, operate machinery, or take part in other such activities; and individuals taking any medicines that may interact with alcohol.[1]

Overall, males are more likely to drink than females. Past-month alcohol use was reported among 56.9 percent of males compared to 44.0 percent of females. This is true across all age groups with the exception of 12- to 17-year-olds; among that age group, 17.2 percent of males reported past month use compared to 18.0 percent of females. Males are also much more likely than females to engage in binge drinking, which is defined as drinking five or more drinks on the same occasion at least once in the past month, and heavy drinking, which is defined as five or more drinks on the same occasion at least five times in the past month.

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

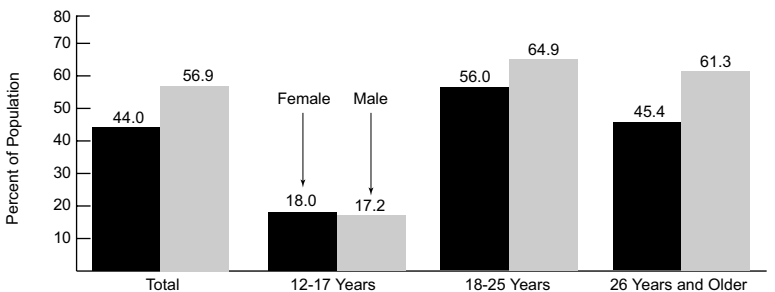
Past Month Alcohol Use, by Type and Sex, 2004

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



Past Month Alcohol Use, by Sex and Age, 2004

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



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

ILLICIT DRUG USE

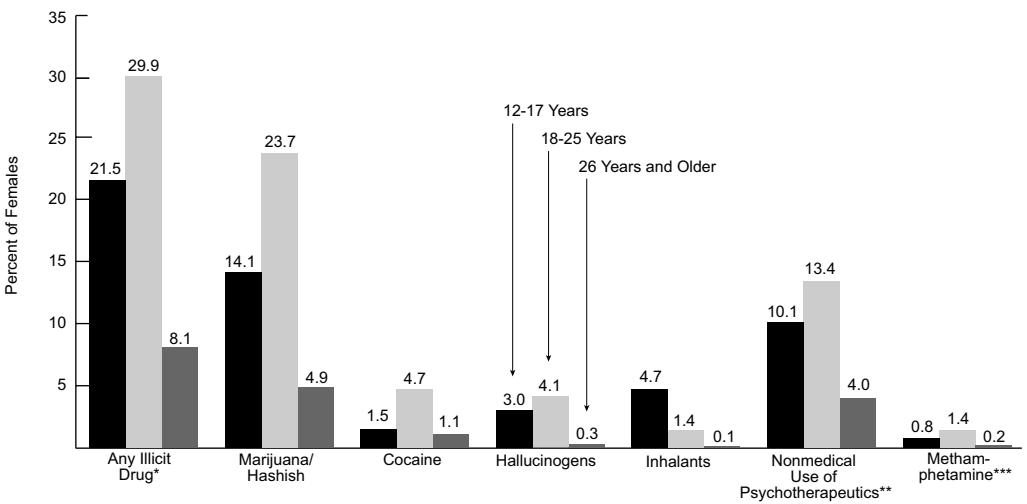
Illicit drugs are associated with serious health consequences including addiction. Drugs classified as illicit are marijuana/hashish, cocaine, inhalants, hallucinogens, crack, and prescription-type psychotherapeutic drugs used for non-medical purposes. In 2004, a total of 12.5 million women (11.2 percent) aged 18 or older reported using an illicit drug within the past year. The past-year illicit drug use rate was significantly higher among women aged 18-25 than among women over age 25 (29.9 percent compared to 8.1 percent). Among adolescent females aged 12-17, 21.5 percent reported using illicit drugs in the past year. When stratified by race, illicit drug use among adolescent females was more common among non-Hispanic Whites (22.9 percent) than Hispanics (22.1 percent) or non-Hispanic Blacks (17.6 percent).

In 2004, 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 (23.7 percent). 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 13.4 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 (4.7 percent) compared to their older counterparts.

In 2003 and 2004, 4.6 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 in six, or 16.0 percent, reported illicit drug use in the past month. This represents a 25 percent increase from a rate of 12.8 percent among this age group in the 2002-03 period. The rate was the same among non-pregnant women in this 15- to 17-year-old age group, while among women aged 18 years and older, the rate of illegal drug use in the last month was much lower among pregnant women than their non-pregnant counterparts.

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2004

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



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes. **Includes prescription-type pain relievers, tranquilizers, stimulants, and sedatives. ***Methamphetamine is a type of stimulant and is therefore included in the overall psychotherapeutics rate.

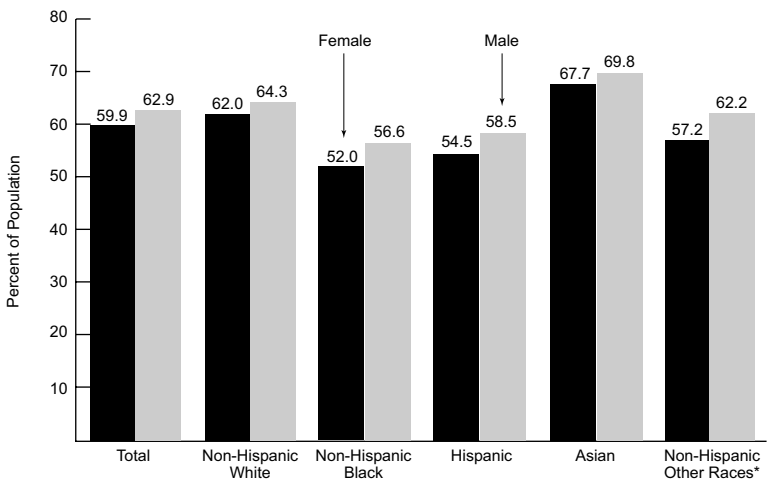
SELF-REPORTED HEALTH STATUS

In 2004, men were more likely than women to report being in excellent or very good health (62.9 versus 59.9 percent); this was true in every racial and ethnic group. Among both sexes, Asians most often reported that they were in excellent or very good health, followed by non-Hispanic Whites and Hispanics; non-Hispanic Blacks were the least likely to report themselves to be in excellent or very good health.

Self-reported health status declines with age: 70.8 percent of women aged 18 to 44 years reported excellent or very good health status, compared to 55.7 percent of those aged 45 to 64 years, 42.7 percent of those aged 65 to 74 years, and 31.5 percent of those aged 75 years or more. Among those in the oldest age group, 31.1 percent reported poor health, compared to only 6.4 percent of those in the youngest age group.

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Sex and Race/Ethnicity, 2004

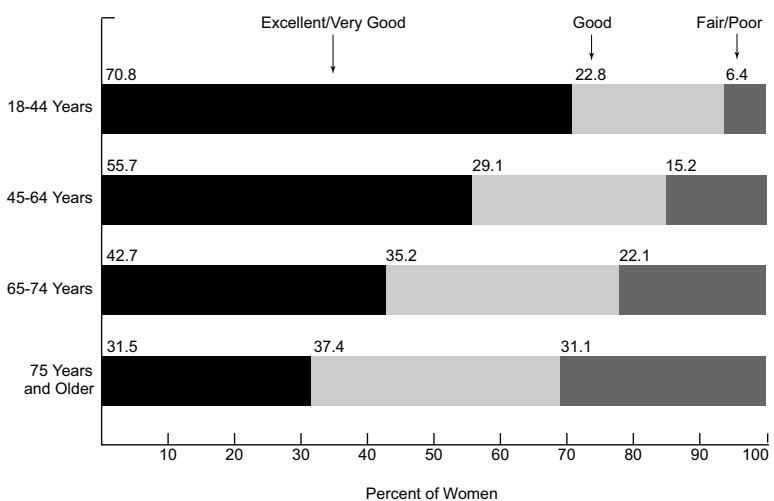
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Self-Reported Health Status of Women Aged 18 and Older, by Age, 2004

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



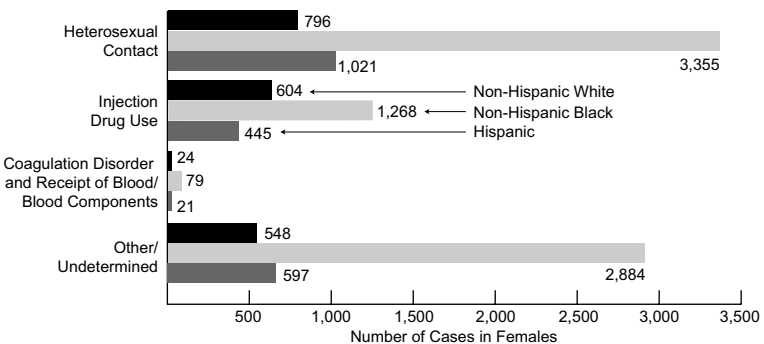
AIDS

Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which damages or kills the cells that are responsible for fighting infection. An AIDS diagnosis is received when an HIV infection becomes advanced and meets certain criteria determined by the Centers for Disease Control and Prevention (CDC). AIDS was first reported in 1981 and during the following decade was primarily diagnosed in men who had sex with men, but the disease has since become more prevalent among women. In 1988, 7,504 AIDS cases were reported among men compared to 524 cases among women. In 2004, the number of cases among women had grown to 11,442, an increase of over 2,000 percent. In 1993, the CDC expanded the criteria for AIDS cases to include persons with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. This change is partially responsible for the greatly increased number of reported AIDS cases among women.

Non-Hispanic Black women are disproportionately affected by AIDS. In 2004, 7,586 non-Hispanic Black women were diagnosed with AIDS, compared to 1,972 non-Hispanic White women and 2,084 Hispanic women. Overall, 44 percent of cases among women were attributable to heterosexual contact, while 20 percent were due to injection drug use, and 1 percent were due to a coagulation disorder or receipt of blood/blood components; the remaining 35 percent were of other or unknown cause. Over the past decade, the numbers of women being diagnosed with AIDS and the number of deaths among women with AIDS has increased only slightly, while the number of women living with AIDS has increased dramatically, due in large part to recent advances in antiretroviral therapy.

Female AIDS Cases, Aged 13 and Older, by Exposure Category* and Race/Ethnicity,** 2004

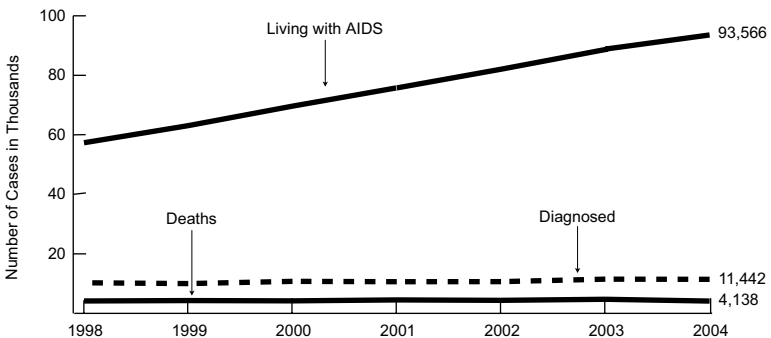
Source II.4: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*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 Women Diagnosed with AIDS, Living with AIDS, and Dying with AIDS,* 1998-2004

Source II.4: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report



*Among women aged 13 and older.

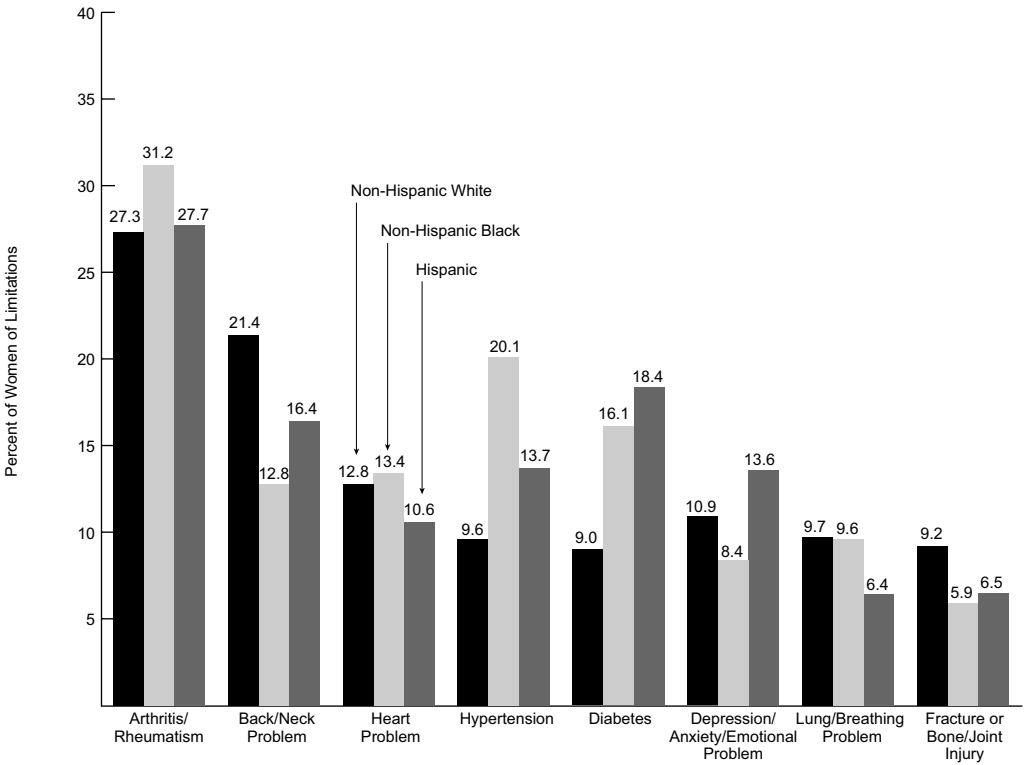
ACTIVITY LIMITATIONS AND DISABILITIES

Although there are many different ways to define a disability, one common guideline is whether a person is able to perform common activities—such as walking up stairs, standing or sitting for several hours at a time, grasping small objects, or carrying items such as groceries—without assistance. In 2004, just over 14 percent of the U.S. population reported having at least one condition that limited their ability to perform one or more of these common activities. Women were more likely to report being limited in their activities than men (15.4 versus 12.8 percent).

Conditions that cause activity limitations among women vary by race and ethnicity. Activity limitations caused by arthritis, for instance, are most common among non-Hispanic Black women (31.2 percent) and least common among non-Hispanic White women (27.3 percent); conversely, limitations caused by back or neck problems are most common among non-Hispanic White women (21.4 percent) and least common among non-Hispanic Black women (12.8 percent). Activity limitations due to hypertension are also most common among non-Hispanic Black women (20.1 percent), and limitations due to diabetes are most common among Hispanic women (18.4 percent).

Selected Conditions Causing Activity Limitations* in Women Aged 18 and Older with at Least One Limitation, by Race/Ethnicity,** 2004

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



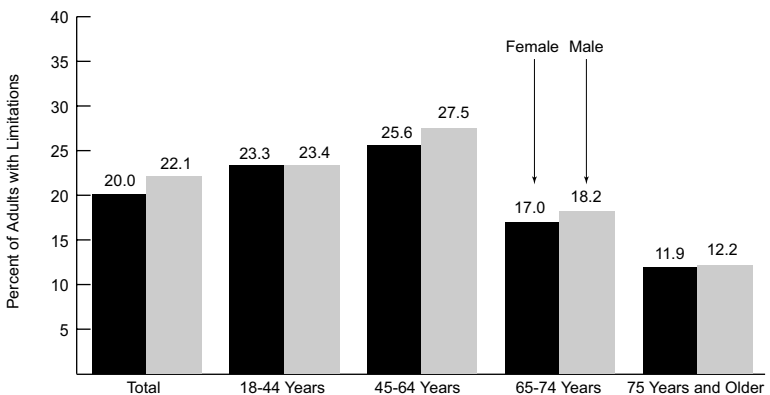
*Activity limitations are defined as conditions that cause difficulty performing certain physical, leisure, and social activities. **The sample of Asians and those of other races was too small to produce reliable estimates.

Back and neck problems are a common cause of activity limitation: in 2004, almost 21 percent of the population reported being limited in one or more activities by a back or neck problem. Among both males and females, activity limitations caused by back or neck problems are most common among people aged 45 to 64 years (reported by 27.5 percent of men and 25.6 percent of women). Thereafter, limitations due to back or neck problems declined with age.

Visual and hearing impairment are not among the most common causes of activity limitations. Visual impairment affects a small proportion of the population, while hearing impairment, although more prevalent, does not generally affect a person's ability to do common physical tasks, such as walk or climb stairs. However, such sensory impairments are widely recognized in broader definitions of disability. There are noticeable gender differences in the occurrence of visual and hearing impairment: women are more likely than men to have a visual impairment (7.4 versus 4.5 percent), while men are more likely than women to have a hearing impairment (16.5 versus 10.1 percent). Just over 3 percent of both men and women experience both visual and hearing impairments. In this case, a visual impairment is defined as having trouble seeing even when wearing corrective lenses and/or being blind or unable to see at all, while a hearing impairment is defined as having any trouble hearing without a hearing aid.

Back or Neck Problem Causing an Activity Limitation* Among Adults Aged 18 and Older, by Sex and Age, 2004

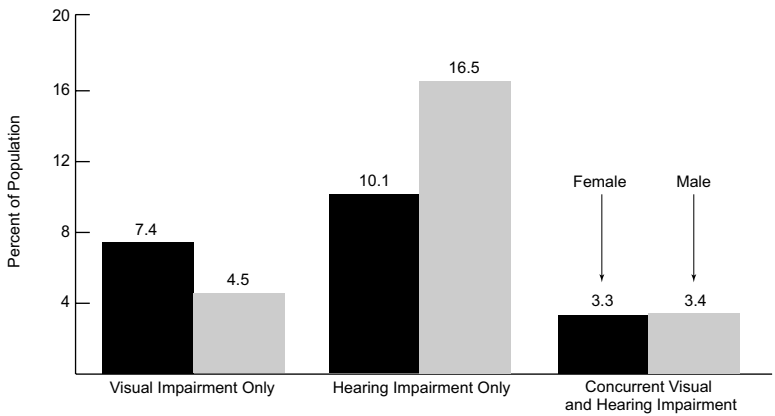
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Visual and Hearing Impairment* Among Adults Aged 18 and Older, by Sex and Type of Impairment, 1997-2004

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



*Visual impairment is defined as having trouble seeing even when wearing corrective lenses and/or being blind or unable to see at all; hearing impairment is defined having any trouble hearing without a hearing aid.

ARTHRITIS

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

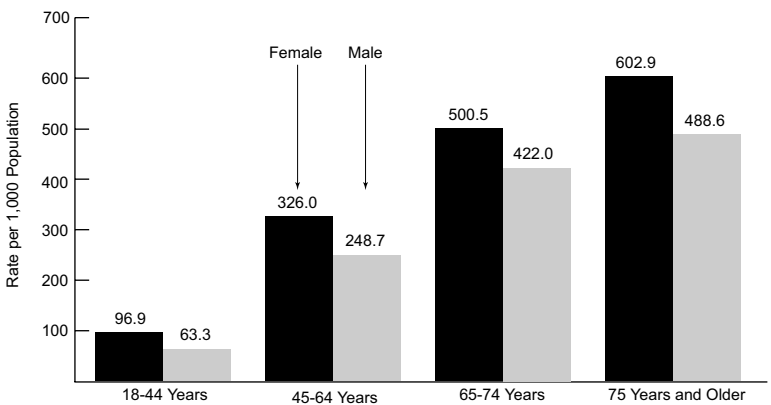
In 2004, over 20 percent of U.S. adults reported that they had ever been diagnosed with arthritis. Arthritis was more common in women than men, and rates of arthritis increased dramatically with age for both sexes. Less than 10 percent of women 18 to 44 years of age had been diagnosed with arthritis, compared to 60 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 (279.4 per 1,000 women), followed by non-Hispanic Black women (225.2 per 1,000); Asian women had the lowest rates of arthritis (128.2 per 1,000). 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, 2004

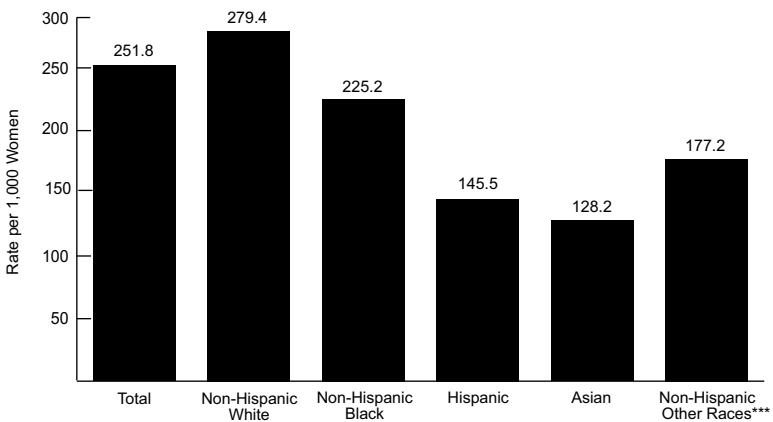
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity,** 2004

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 persons of more than one race.

ASTHMA

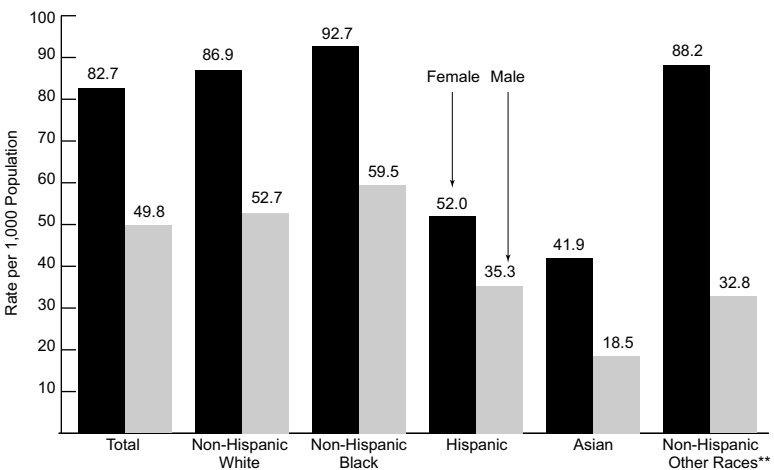
Asthma is a chronic inflammatory disorder of the airway characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. However, by taking certain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

In 2004, women had higher rates of asthma than men (82.7 versus 49.8 per 1,000 population, respectively); this was true in every racial and ethnic group. Among women, non-Hispanic Blacks had the highest asthma rate (92.7 per 1,000), followed by women of other races (88.2 per 1,000); Asian women had the lowest asthma rate (41.9 per 1,000).

Being hospitalized with asthma can be an indication that the asthma is not effectively controlled. In 2004, asthmatic women with lower family incomes were more likely than women with higher family incomes to be hospitalized with asthma. Among women with family incomes below 100 percent of the Federal poverty level (FPL), 36.4 percent of those with asthma were hospitalized, compared to 18.8 percent of asthmatic women with family incomes of 300 percent of FPL and above.

Adults Aged 18 and Older with Asthma,* by Sex and Race/Ethnicity, 2004

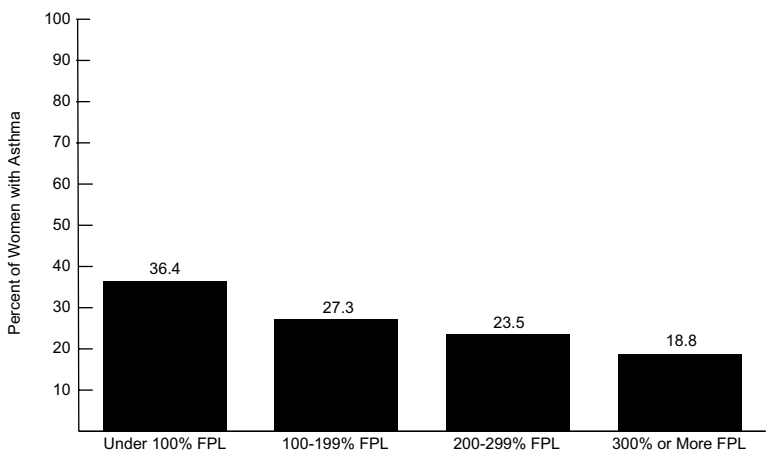
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Asthma, Hospitalized with Asthma in the Past Year, by Poverty Status,* 2004

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



*Federal poverty level (FPL) was equal to $18,850 for a family of four in 2004.

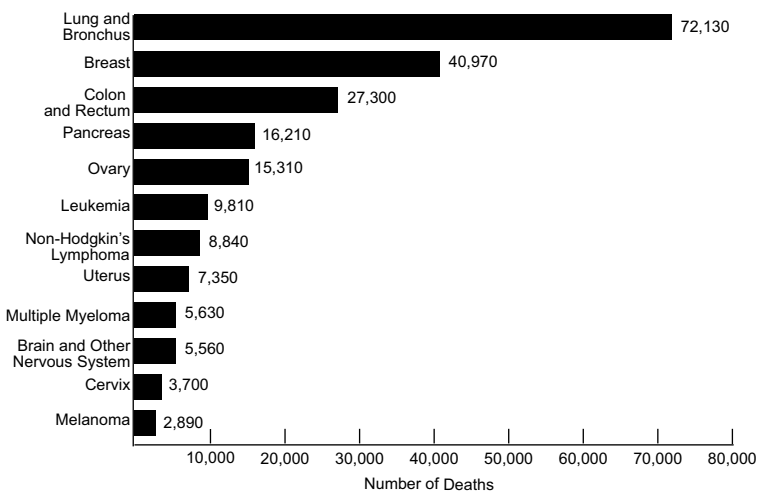
CANCER

It is estimated that almost 274,000 women will die of cancer in 2006. Lung and bronchus cancer causes 26 percent of cancer deaths among women, while the next most common cause of cancer death is breast cancer, which causes 15 percent of deaths. Colon and rectal cancer, pancreatic cancer, and cancer of the ovaries are also leading causes of cancer death among women. Although lung and bronchus cancer causes the greatest number of deaths, breast cancer is the most common type of cancer among women. This is due to relatively high survival rates for breast cancer and low survival rates for lung and bronchus cancer. For instance, in 1995-2001, the 5-year lung and bronchus cancer survival rates among White and Black women were 17.7 and 15.6 percent, respectively, compared to 89.5 and 75.9 percent for breast cancer.

Cancer is diagnosed in stages, which are based upon how far the cancer has traveled from the original site. Localized cancer is confined to the organ of origin, while regional cancer has extended to the surrounding organs, tissues, or lymph nodes. The most serious stage is distant, which indicates that the cancer has spread to parts of the body remote from the primary tumor. Some cancers are also categorized as unstaged because the information necessary for

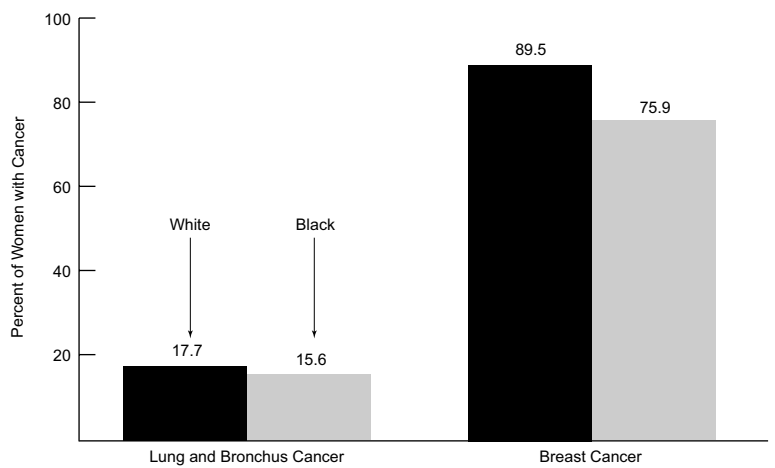
Selected Causes of Cancer Deaths for Females, by Site, 2006 Estimates

Source II.6: American Cancer Society



5-Year Malignant Lung and Bronchus Cancer and Breast Cancer Relative Survival Rates for Females, 1995-2001

Source II.7: National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program

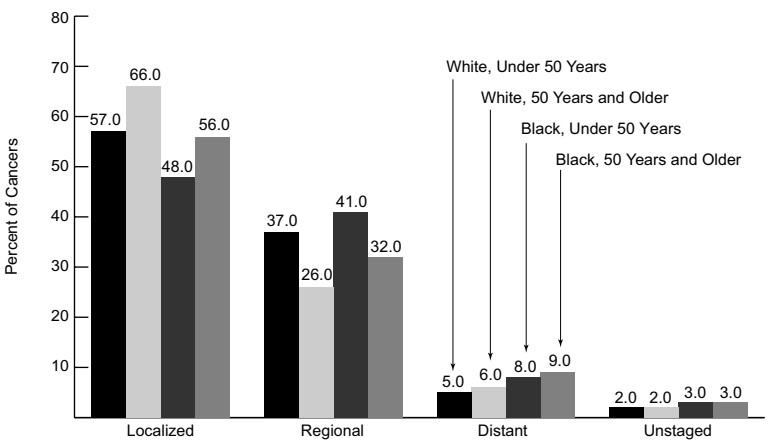


them to be categorized is not available. The majority of breast cancers that occur among both White and Black women of all ages are localized. However, regional breast cancer occurs more frequently in Black women and younger women of both races than among White women and older women. Distant cancer occurs more frequently in Black women than White women; however, these rates vary little by age for either race. The higher incidence of advanced breast cancer among Black women may be due in part to delayed diagnosis and treatment among this group.

Cancers of the lung and bronchus and of the colon and rectum are the second and third most common types of cancer among women, following breast cancer. The incidence of lung and bronchus cancer among women has increased over the past several decades. In 1975, the rate was 24.9 per 100,000 White women and 24.7 per 100,000 Black women; in 2002 those rates were 52.4 and 59.9, respectively. Diagnoses of colon and rectal cancer have dropped slightly among White women during the same period (from 54.0 to 44.8 per 100,000) while they have remained relatively stable among Black women.

Stage* Distribution of Breast Cancer, by Age and Race, 1995-2001

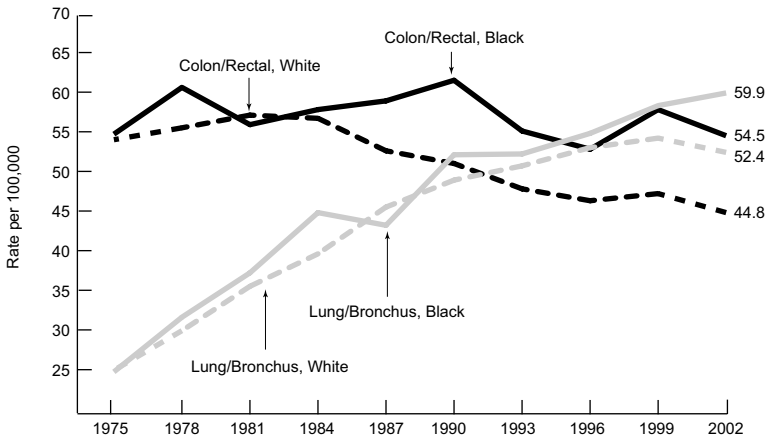
Source II.8: National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program



*Stages: Localized is confined to the organ of origin. Regional has extended to the surrounding organs, tissues, or lymph nodes. Distant has spread to parts of the body remote from the primary tumor. Unstaged lacks necessary information to be assigned to one of the previous categories.

Age-Adjusted Malignant Lung/Bronchus Cancer and Colon/Rectal Cancer Rates Among Females, by Race, 1975-2002

Source II.7: National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program



DIABETES

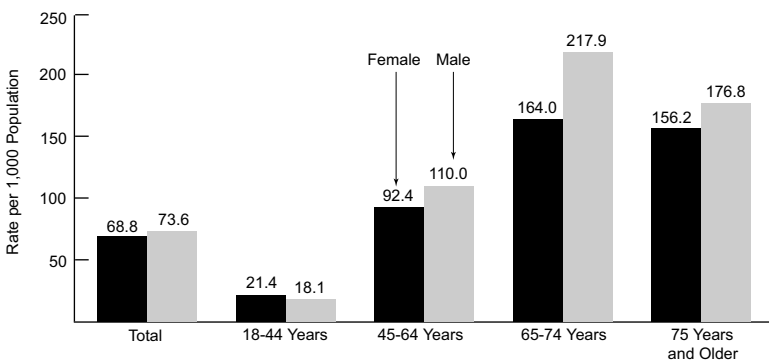
Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, nervous system disease, amputation, and complications during pregnancy. The two main types of diabetes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

In 2004, women under the age of 45 were more likely to report having diabetes than men of the same age. The rate of diabetes increased with age for both sexes; however, older men were more likely to have diabetes than their female counterparts. The rate of diabetes among women under the age of 45 was 21.4 per 1,000 women, compared to 18.1 per 1,000 men of the same age. The rates among women and men 75 years and older were 156.2 and 176.8 per 1,000, respectively.

Non-Hispanic Black women are more likely than women of other racial and ethnic groups to have diabetes: the rate of diabetes among this group was 103.6 per 1,000 in 2004, compared to a rate of 77.8 per 1,000 Hispanic women and 61.1 per 1,000 non-Hispanic White women. Most women with diabetes do not take insulin, which indicates that they likely have Type 2 diabetes. Although diabetes is most common among non-Hispanic Black women, a greater proportion of non-Hispanic White women with diabetes did not take insulin in 2004.

Adults Aged 18 and Older with Diabetes,* by Age and Sex, 2004

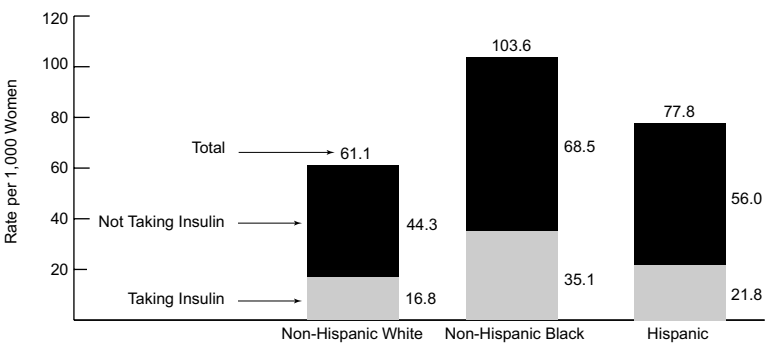
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Current Insulin Use Among Women Aged 18 and Older with Diabetes,* by Race/Ethnicity,** 2004

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



*Reported a health professional has ever told them they have diabetes. **Rates reported are not age adjusted. The sample of Asians and those of other races was too small to produce reliable estimates.

HEART DISEASE

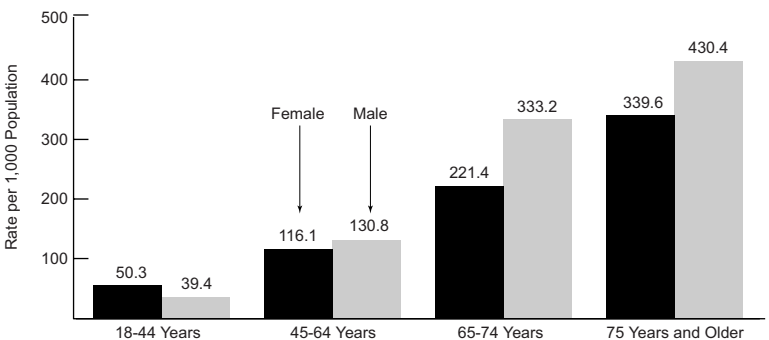
In 2003, heart disease was the leading cause of death for women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common cause of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age. Although some risk factors cannot be modified, a diet low in saturated fat and full of fruits and vegetables can help lessen or eliminate several of these risk factors.

In 2004, women under 45 years of age had a higher rate than their male counterparts (50.3 versus 39.4 per 1,000 population, respectively). However, men had a slightly higher overall rate of heart disease than women. Rates of heart disease among both men and women increased substantially with age and were highest among those 75 years and older, which demonstrates the chronic nature of the disease.

Rates of heart disease among women differ by race and ethnicity. In 2004, the highest rate occurred among non-Hispanic White women (125.2 per 1,000), followed by non-Hispanic Black women (98.3 per 1,000); Asian women had the lowest rate (35.8 per 1,000). Although non-Hispanic White women experience the highest rates of heart disease, deaths from heart disease are highest among non-Hispanic Black women. In order to increase awareness about the risks of heart disease, the National Heart, Lung, and Blood Institute of the U.S. Department of Health and Human Services launched a campaign in 2003 called "The Heart Truth." The red dress that represents the campaign is now commonly recognized as the national symbol for women and heart disease awareness.

Adults Aged 18 and Older with Heart Disease,* by Age and Sex, 2004

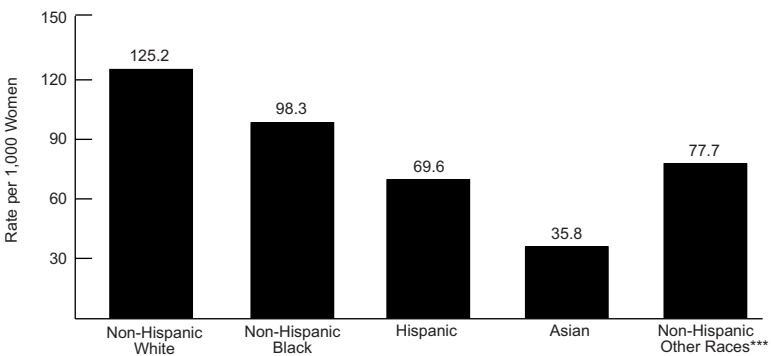
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Heart Disease,* by Race/Ethnicity,** 2004

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



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

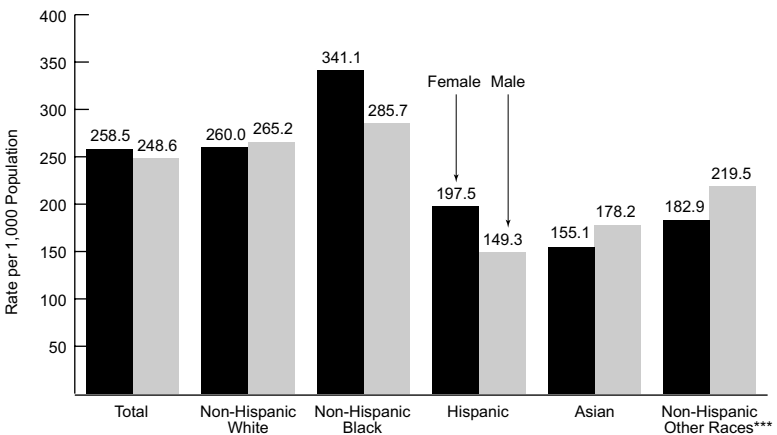
HYPERTENSION

Hypertension, also known as high blood pressure, is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, a diastolic pressure (between heartbeats) of 90 or higher, or both. In 2004, women had higher overall rates of hypertension than men (258.5 versus 248.6 per 1,000 population); however, this varied by race and ethnicity. For instance, non-Hispanic Black and Hispanic women had higher rates of hypertension than their male counterparts, while non-Hispanic White and Asian women had lower rates. Among women, non-Hispanic Blacks had the highest rate of hypertension (341.1 per 1,000), followed by non-Hispanic Whites (260.0 per 1,000); Asian women had the lowest rate (155.1 per 1,000).

Rates of hypertension increase substantially with age and are highest among those 75 years and older, which demonstrates the chronic nature of the disease. The rate among women aged 18 to 44 years was 93.7 per 1,000 in 2004, compared to a rate of 333.9 per 1,000 among those aged 45 to 64 years, 546.8 per 1,000 among those aged 65 to 74 years, and 620.0 per 1,000 among those aged 75 years and older. This means that almost two-thirds of those in the oldest age group have ever been diagnosed with hypertension.

Adults Aged 18 and Older with Hypertension,* by Sex and Race/Ethnicity,** 2004

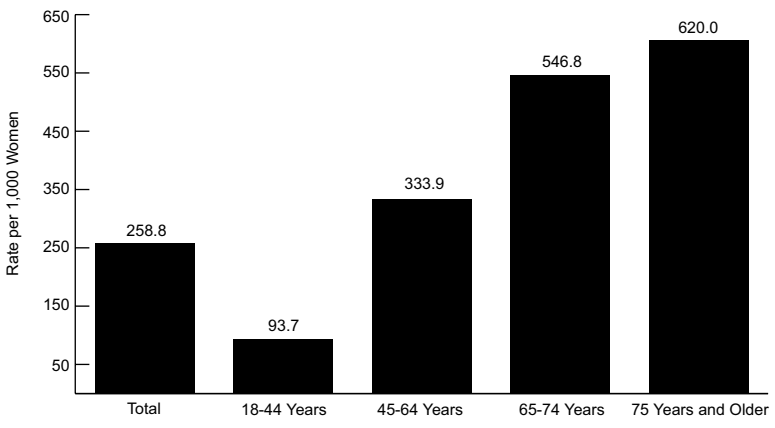
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Hypertension,* by Age, 2004

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



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

INJURY

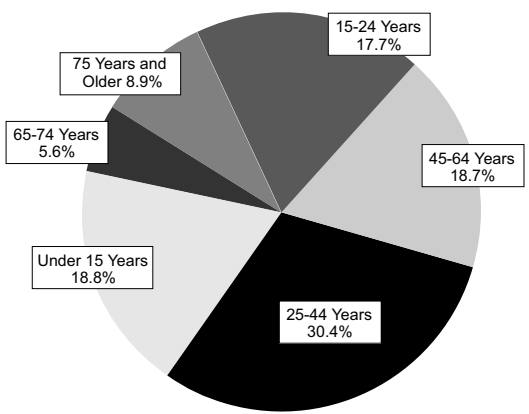
Injuries are largely predictable and preventable, and can be controlled by either preventing an event that causes injury, or by lessening the impact of an injury event. Ways in which this can happen include education, engineering and design of safety products, enactment and enforcement of policies and laws, economic incentives, and improvements in emergency care. Some examples include the design and oversight of car seats and seatbelts, workplace regulations regarding safety practices, vouchers for items such as smoke alarms, and tax incentives for fitting home pools with fences.

There were over 40 million injury-related emergency department (ED) visits in 2003. Among females, 30 percent of all ED visits were injury-related, compared to 41 percent of all male ED visits. This represents 12.7 injury-related visits per 100 females each year compared to 15.5 visits per 100 males. Among females, the highest rate of injury-related ED visits (16.5 per 100 people) occurred among those aged 15 to 24 years and 75 years and older; however, due to the age distribution of the population, they represented only 17.7 and 8.9 percent of all female ED visits, respectively.

Unintentional and intentional injuries represented a higher proportion of ED visits for males than females in 2003. Among males and females aged 18 years and older, unintentional injuries accounted for 27.8 and 20.0 percent of ED visits, respectively, while intentional injuries represented 1.7 and 2.4 percent. Among both males and females, the two most common causes of injury were falls and motor vehicle crashes.

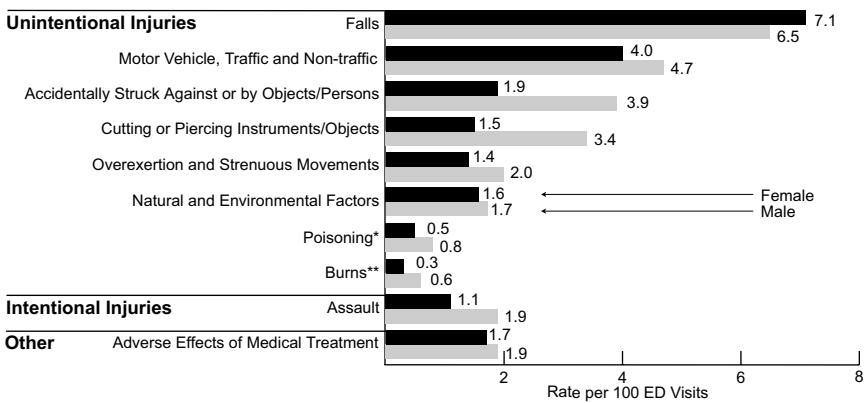
Injury-Related Emergency Department Visits for Females, by Age, 2003

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



Injury-Related Emergency Department Visits Among Adults Aged 18 and Older, by Sex and Mechanism, 2003

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



*Includes poisoning by solids, liquids, gases, or vapors. **Includes burns by flames, hot substances/objects, or caustic/corrosive materials.

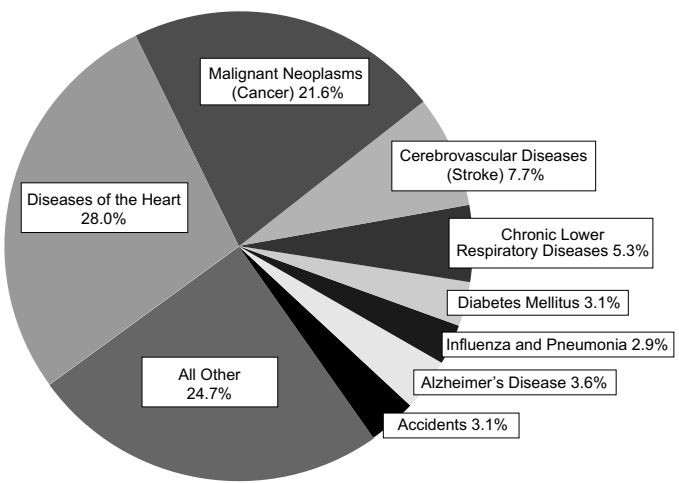
LEADING CAUSES OF DEATH

In 2003, there were over 1.2 million deaths among females. Of these deaths, nearly half were attributed to diseases of the heart and malignant neoplasms (cancer), with 348,994 and 268,912 deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 7.7 percent of all female deaths, followed by chronic lower respiratory diseases which accounted for 5.3 percent.

While age-adjusted death rates varied for women by race and ethnic group, the leading causes were the same for each population: heart disease and cancer. Age-adjusted death rates for four of the top five causes were highest among non-Hispanic Black women, followed by non-Hispanic White women and Hispanic women. The exception was chronic lower respiratory diseases, which caused the highest rate of deaths among non-Hispanic White women, followed by American Indian/Alaska Native women and non-Hispanic Black women.

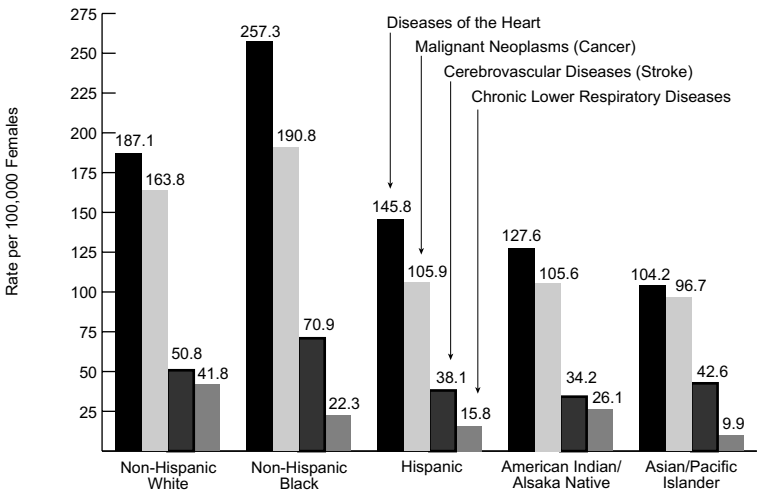
Leading Causes of Death in Females (All Ages), 2003

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



Age-Adjusted Death Rates from Selected Conditions for Females (All Ages), by Race/Ethnicity, 2003

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



MENTAL ILLNESS AND SUICIDE

Mental illnesses affect men and women differently: some disorders are more common in women, while some illnesses display different symptoms. Among women interviewed in 2001-03, 23 percent had experienced an anxiety disorder in the past year compared to fewer than 14 percent of men. Some of the anxiety disorders most common among women include specific phobias, social phobia, post-traumatic stress disorder, and generalized anxiety disorder. Mood disorders, such as depressive disorders and bipolar disorder, are also more common among women than men (11.6 versus 7.7 percent, respectively).

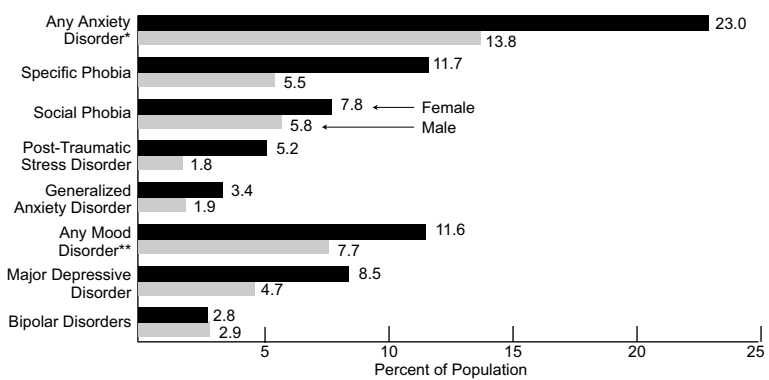
Although a majority of people who suffer from mental illness do not commit suicide, mental illness is a primary risk factor. Over 90 percent of suicide deaths in the United States are associated with mental illness and/or alcohol and substance abuse.[1] The rate of suicide is substantially higher for males than females; however, it is estimated that there are three suicide attempts among females for every one attempt among males.

In 2003, female suicide death rates were highest among non-Hispanic Whites (6.4 deaths per 100,000 women), followed by American Indian/Alaska Natives (4.8 per 100,000). Lower rates were found among Asian/Pacific Islander females (3.8 per 100,000), non-Hispanic Black females (2.4 per 100,000), and Hispanic females (2.1 per 100,000).

1 *Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, eds. Reducing suicide: a national imperative. Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine; 2002.*

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

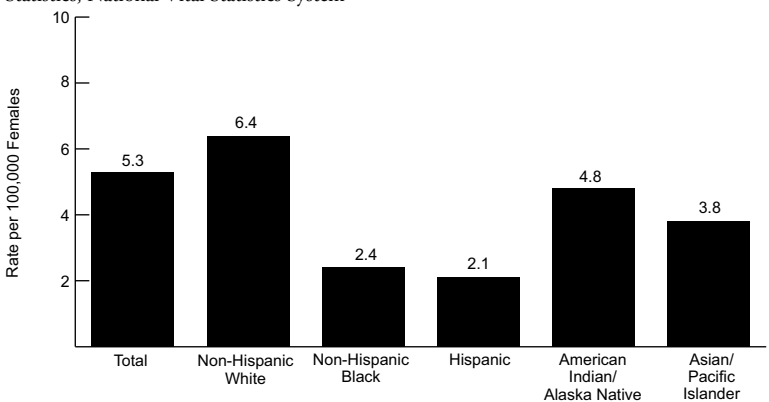
Source II.12: National Comorbidity Survey Replication (NCS-R)



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

Suicide Death Rates for Females Aged 15 Years and Older, by Race/Ethnicity, 2003

Source II.11: Centers for Disease Control and Prevention, National Center 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 impair the ability to eat normally. To prevent caries (cavities) and periodontal (gum) disease, the American Dental Association recommends maintaining a healthy diet with plenty of water, and limiting eating and drinking between meals.[1] Other important preventive measures include regular brushing and flossing and regular dental checkups to remove plaque and examine for caries or other potential problems.[2] These guidelines can be important for parents, since dental caries is an infectious disease. The bacteria causing decay are transmissible from parent or caregiver to child through oral contact and sharing food and utensils.[3]

In 1999-2002, women were less likely than men to have untreated dental caries (8.9 versus 12.6 percent). Among women, non-Hispanic Blacks were most likely to have caries, followed by Hispanic women. Sealants—a hard, clear substance applied to the surfaces of teeth—may help to prevent caries, but women are less likely than men to have sealants. Non-Hispanic Black women are most likely to have caries, but are second only to Hispanic women in having sealants.

Having health insurance, and particularly dental insurance, may affect how often women visit the dentist. In 1999-2002, 72.1 percent of women who had health and dental insurance reported seeing a dentist in the past year, compared to 60.3 percent of women with health insurance but no dental coverage and 38.4 percent of women with no health insurance. Women with no health insurance were the most likely to have gone at least 5 years since a dental visit.

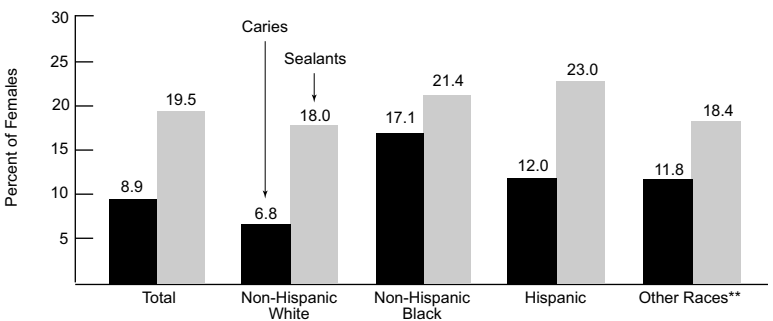
1 *American Dental Association. Diet and oral health: overview. Available from http://www.ada.org/public/topics/diet.asp*

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

3 *American Dental Association. ADA statement on early childhood caries. Available from http://www.ada.org/prof/resources/positions/statements/caries.asp*

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

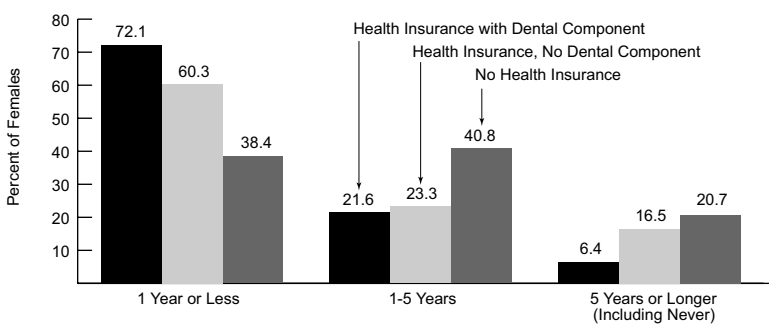
Source I.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Caries are among women aged 18 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 Health Insurance, 1999-2002

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



OSTEOPOROSIS

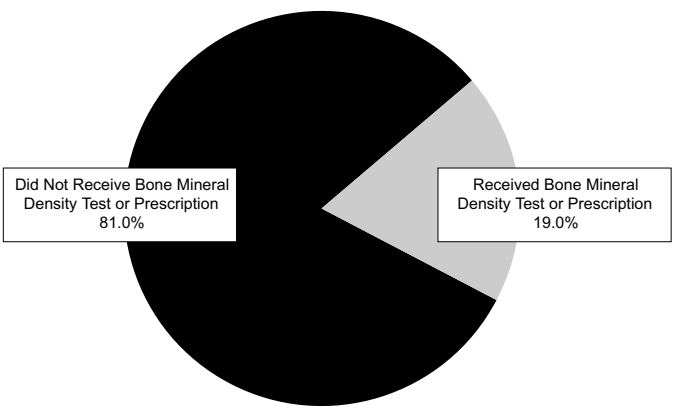
Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even in individuals who have already suffered a fracture. An estimated 10 million Americans have osteoporosis, while another 34 million have low bone mass and are at risk for developing osteoporosis; 80 percent of those affected are women. By 2020, an estimated 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. Fractures can have devastating consequences. For example, hip fractures are associated with an increased risk of mortality, and nearly one in five hip fracture patients ends 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. Calcium is found in diary foods, dark green vegetables, and fortified foods such as oatmeal and cold cereal. Vitamin D is made by the skin when it is exposed to the sun; however, getting sufficient vitamin D in this manner is not practical for many people. Vitamin D is also available in milk and other products that are fortified, and through supplements. Frequent physical activity that puts stress on the bones is also important. This should include regular physical activity, strength training, and activities that help maintain balance. Bone density tests are recommended for all women over 65 and for any man or woman who suffers a fracture after the age of 50. Treatment of osteoporosis has been shown to reduce the risk of subsequent fractures by 30-65 percent.[1] Despite this recommendation, national data in 2004 indicate that only 19 percent of female Medicare beneficiaries aged 67 years and older who had a fracture received either a bone mineral density test or a prescription. Individual plans' rates were consistently low, with almost all plans having osteoporosis management rates below 28.5 percent.

HEDIS®* Measure of Osteoporosis Management in Women Aged 67 and Older Who Had a Fracture, Medicare Plans, 2004**

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 6 months after the date of fracture. This measure was reported for the first time in 2004, and only applies to Medicare plans.

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

OVERWEIGHT AND OBESITY

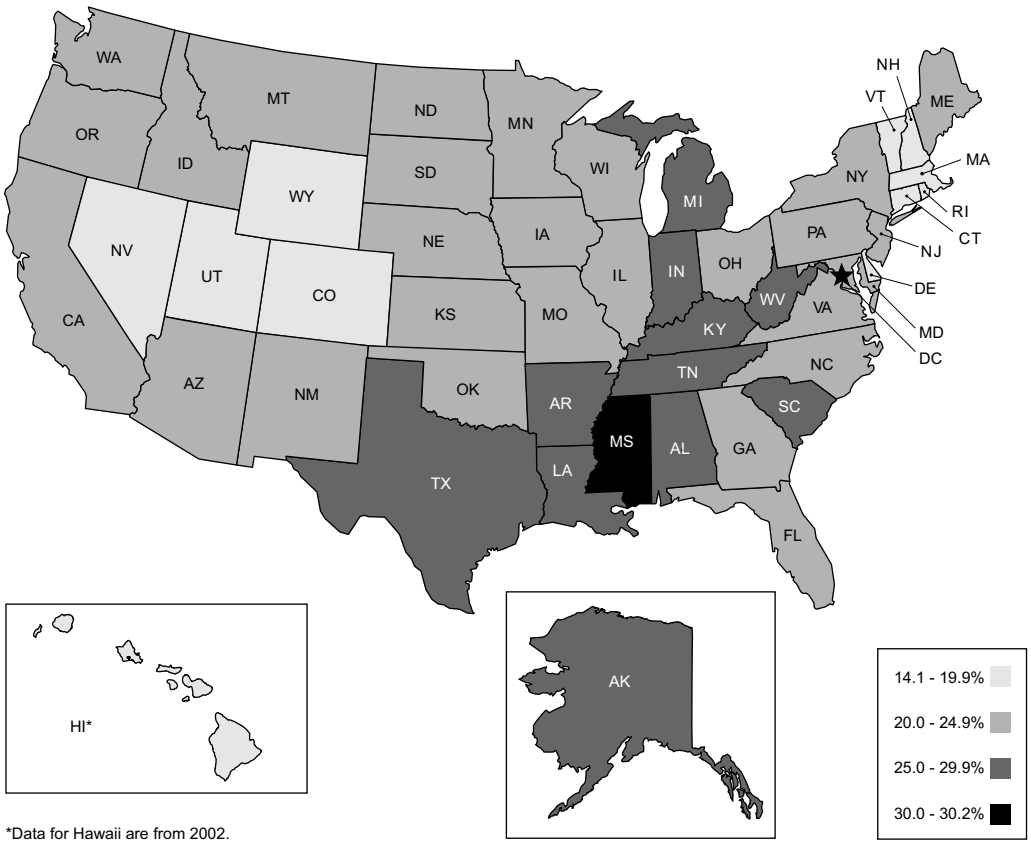
Being overweight or obese increases the risk for numerous ailments, including high blood pressure, diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health.[1] According to the Centers for Disease Control and Prevention, 51.7 percent of women and 67.9 percent of men were overweight or obese in 2004. Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a function of height and weight. Overweight is defined as a BMI of 25.0-29.9, and obese is defined as a BMI of 30 or more; a BMI of 18.5-24.9 is considered normal while a BMI below 18.5 is considered underweight.

In 2004, every State in the nation had an obesity rate of at least 14 percent. Overall, 11 States (located primarily in New England and the Midwest) had obesity rates above 14 but below 20 percent. A majority of States had obesity rates of at least 20 percent but below 25 percent, while 11 States had rates of greater than 25 but less than 30 percent. Only one State in the nation (Mississippi) had an obesity rate of 30 percent or greater.

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*

Women Aged 18 and Older Who are Obese, by State, 2004

Source II.14: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention & Health Promotion, Behavioral Risk Factor Surveillance System



*Data for Hawaii are from 2002.

SEXUALLY TRANSMITTED INFECTIONS

Reported rates of sexually transmitted infections (STIs) among females are highest among adolescents and young adults. In 2004, the rate of chlamydia among females aged 15 to 19 years was 2,761 cases per 100,000, and the rate of gonorrhea diagnoses among this age group was 611 per 100,000. The rates for both of these STIs then begin to decrease with age. While rates of STIs among 10- to 14-year-olds are relatively low, these cases raise concerns about potential sexual abuse of minors.

In 2004, there were 1,722 cases of chlamydia and 592 cases of gonorrhea per 100,000 non-Hispanic Black females, compared to 226 and 40 cases, respectively, per 100,000 non-Hispanic White females. American Indian/Alaska Native females also have high rate of STIs, with 1,127 and 155 cases of chlamydia and gonorrhea, per 100,000 females respectively.

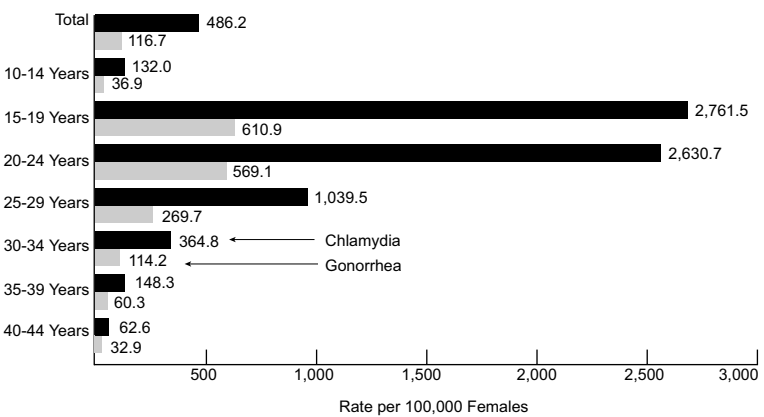
Although these conditions are treatable with antibiotics, STIs can have serious health consequences. Active infections can increase the odds of contracting HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes.

Another STI, genital human papillomavirus (HPV), is estimated to affect at least 50 percent of the sexually active population. There are many different types of HPV, and some, which are referred to as "high-risk," can cause cancer. Although cervical cancer in women is the most serious health problem caused by HPV, it is highly preventable with regular Pap tests and follow-up care.[1]

1 *Centers for Disease Control and Prevention, Division of STD Prevention. HPV: common infection, common reality. May 2004. Available from: http://www.cdc.gov/std/HPV*

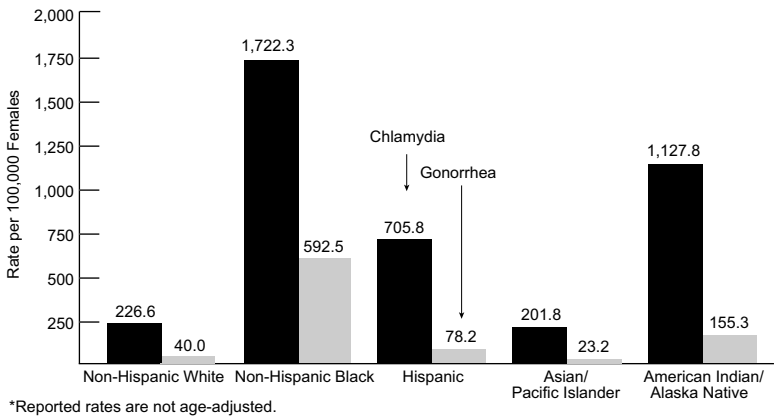
Reported Rates of STIs Among Females Aged 10 and Older, by Age, 2004

Source II.15: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Reported Rates of STIs Among Females Aged 10 and Older, by Race/Ethnicity,* 2004

Source II.15: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



*Reported rates are not age-adjusted.

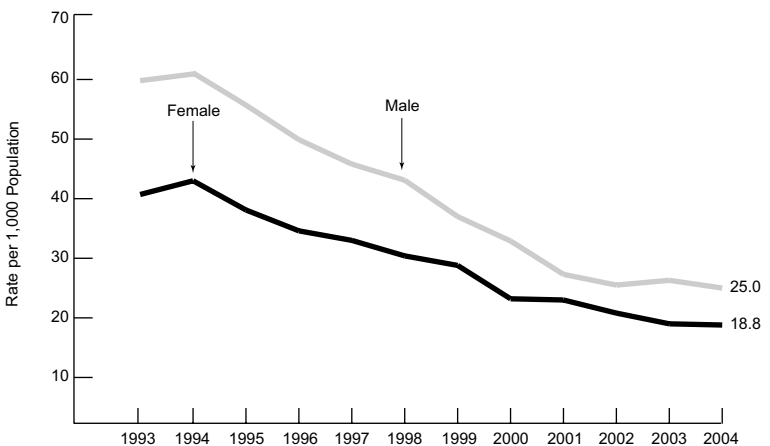
VIOLENCE AND ABUSE

According to the National Crime Victimization Survey, there were over 2.2 million violent crimes committed against females aged 12 and older in the United States in 2004; this includes rape, sexual assault, robbery, aggravated assault and simple assault. In 1993, the rate of violent victimization among men was 59.8 per 1,000 population and the rate among women was 40.7 per 1,000. Those rates had dropped to 25.0 and 18.8 per 1,000, respectively, in 2004. 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 sexual assault and rape, while men are more likely to be victims of robbery and both types of assault. For all types of violent crime, women are more likely than men to know the offender. Among all rape and sexual assault cases in 2004, 67 percent of female victims were attacked by someone that they knew, either an intimate partner (17 percent), other relative (3 percent), or friend/acquaintance (31 percent). Another 31 percent were attacked by a stranger, while the victim/offender relationship in the remaining 2 percent of cases was not determined. Similarly, victims of 54 percent of robberies, 61 percent of aggravated assaults, and 66 percent of simple assaults knew their assailant.

Violent Crime Victimization* Rates Among People Aged 12 and Older, by Sex, 1993-2004

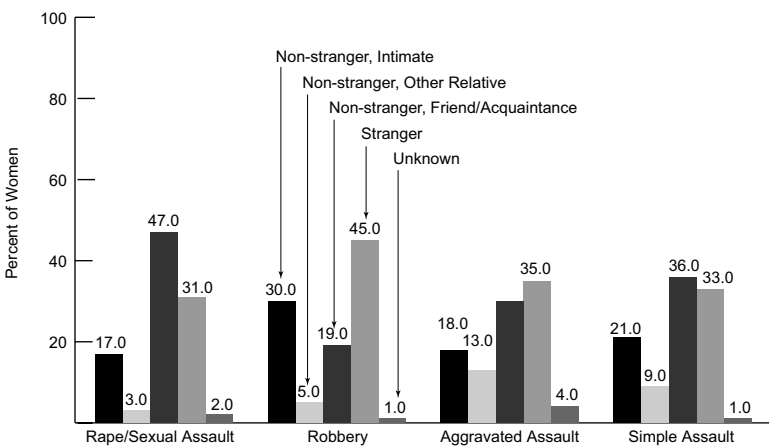
Source II.16: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



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

Victim and Offender Relationship,* Females Aged 12 and Older Who Were Victims of Violent Crime, 2004

Source II.16: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



*Some rates are based on fewer than 10 cases.

WOMEN AND CRIME

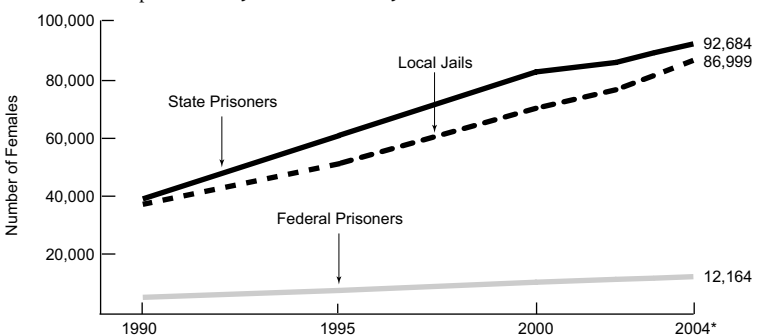
In 2004, the number of incarcerated women continued to increase. The number of women in Federal prisons reached 12,164, while the number of women in State prisons reached 92,684. A 1-day count of jail inmates on June 30, 2004 found 86,999 women in custody. Prisons hold people serving sentences for Federal or State crimes. Local jails are used to hold individuals for shorter periods of time, including people who are awaiting arraignment, trial, conviction, or sentencing; are being transferred to prison; violated probation or parole; received a short sentence, generally under 1 year; or who are unable to stay in prisons due to overcrowding.

Incarceration rates are higher among men than women (1,348 jail and prison inmates per 100,000 men versus 123 female inmates per 100,000 women); however, the number of incarcerated women has grown at a much faster rate than that of men. Racial and ethnic differences continue to exist among incarcerated women. Among those women under State and Federal correctional jurisdiction in 2004, the rate was highest among non-Hispanic Blacks (170 per 100,000 women); the incarceration rate among Hispanic women was 75 per 100,000, and the rate among non-Hispanic White women was 42 per 100,000. These rates do not include women under the jurisdiction of local jail authorities.

Arrests can be another indicator of female perpetration of crime. In 2004, some of the more common reasons for women to be arrested included larceny-theft (13.9 percent of arrests), drug abuse violations (9.9 percent of arrests), and driving under the influence (7.9 percent of arrests). Males are more likely than females to be arrested for violent crimes, while females are more likely to be arrested for property crimes and crimes such as disorderly conduct.

Female Federal and State Prisoners and Local Jail Inmates, 1990-2004

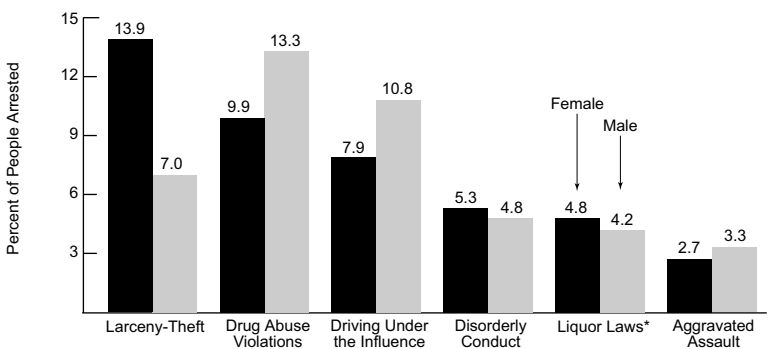
Source II.17: Department of Justice, Bureau of Justice Statistics



*Prison numbers were taken on December 21, 2004; jail numbers were taken on June 30, 2004.

Selected Offenses Among People Who Were Arrested, by Sex, 2004

Source II.17: Department of Justice, Bureau of Justice Statistics



*Violation of laws prohibiting the manufacture, sale, purchase, transportation, possession or use of alcoholic beverages.

LIVE BIRTHS

According to preliminary data, there were 4.1 million births in the United States in 2004, nearly 1 percent more than the number in 2003. The number of births rose among Hispanic, Asian/Pacific Islander, and American Indian women, while it remained the same for non-Hispanic Black women and declined slightly among non-Hispanic White women. Because the total population rose as well, the 2004 birth rate of 14.0 births per 1,000 people represents a slight decrease from the rate reported in 2003.

In 2004, according to preliminary data, 29.1 percent of births took place by cesarean section, the highest rate ever reported. *Healthy People 2010* includes as a goal for the nation the reduction of the cesarean section rate among low-risk women, defined as those whose babies are born at full term, are not twins or other multiples, and are positioned facing downward in the birth canal. An analysis of birth data from 1990 through 2003 showed, however, that even among low-risk women, cesarean section rates are rising, both for women giving birth for the first time and those who have had cesareans in the past. For example, in 1990, 23.9 percent of all first births and 21.0 percent of first births among low-risk women took place by cesareans. In 2003, these percentages were 27.1 percent and 23.6 percent, respectively. Likewise, the percent of women who have vaginal births after a previous cesarean, a procedure known as VBAC, is declining among low-risk women as well as the population as a whole. In 1990, 19.9 percent of women, and 20.8 percent of low-risk women, with a previous cesarean had a VBAC; in 2003, the VBAC rate was 10.6 percent among all women and 11.3 percent among low-risk women with a previous cesarean.

Overall, 99 percent of births took place in hospitals, a rate that has not changed substantially in many years. Of the remainder, the majority took place at home and a small percentage took place in free-standing birthing centers.

Live Births per 1,000 Women, by Age and Race/Ethnicity, 2004*

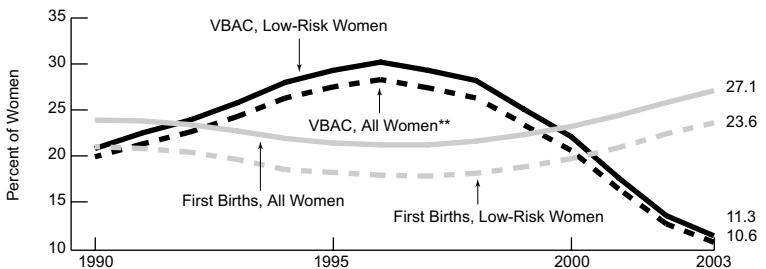
Source II.18: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaska Native	Asian/ Pacific Islander
15-19 Years	41.2	26.8	62.7	82.6	52.5	17.4
20-24 Years	101.8	82.1	126.2	165.2	109.7	60.1
25-29 Years	115.5	110.3	102.5	145.4	92.8	108.7
30-34 Years	95.5	97.4	67.2	103.8	58.2	116.9
35-39 Years	45.4	44.9	33.6	52.7	26.7	62.1
40-44 Years	9.0	8.3	7.8	12.4	6.0	13.7

*Preliminary data.

Cesarean Section Rates and VBAC Rates, for All Women and Low-Risk Women,* 1990-2003

Source II.19: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*A low-risk woman is defined as one with a full-term (at least 37 weeks' gestation), singleton (not a multiple pregnancy), and vertex fetus (head facing downward in the birth canal). **Among women with a previous cesarean delivery.

SMOKING DURING PREGNANCY

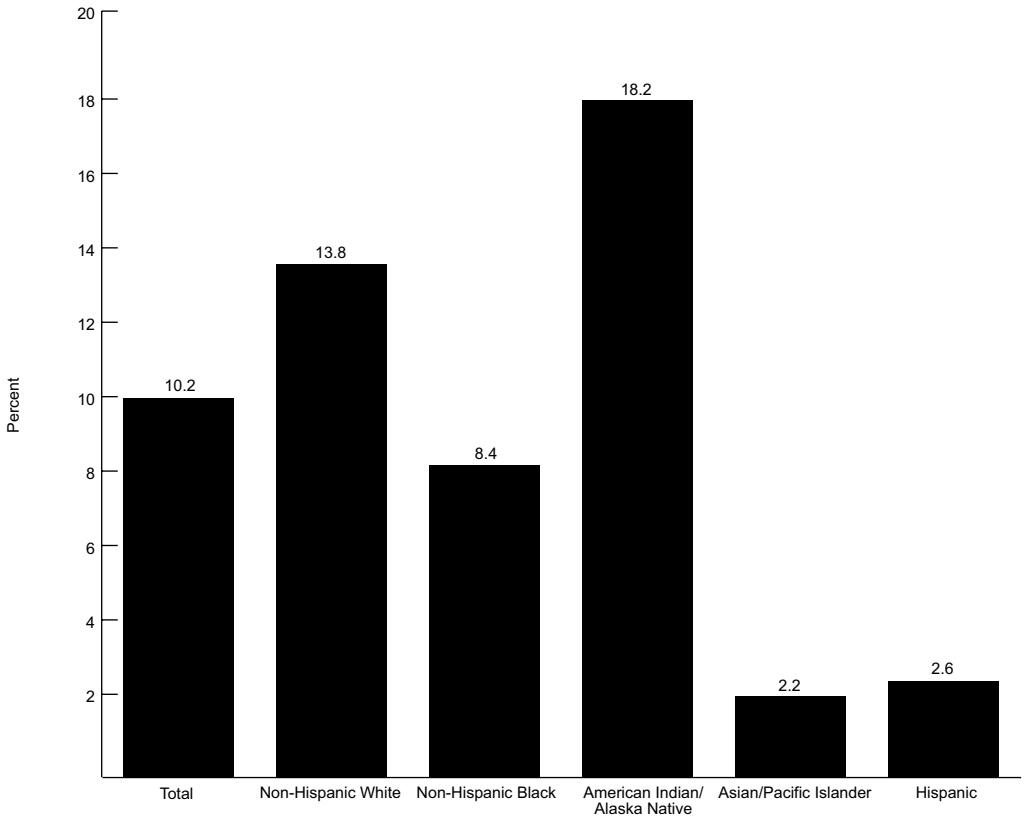
Cigarette smoking during pregnancy is the number one preventable risk factor for low birth weight. Maternal smoking is associated with preterm labor and delivery, neonatal and fetal death, birth defects and other pregnancy complications.[1]

The use of tobacco during pregnancy has been declining since 1989. Based on preliminary data, 10.2 percent of mothers smoked during pregnancy in 2004; this represents a slight decline from the previous year (10.4 percent). Smoking during pregnancy is most common among American Indian/Alaska Native women (18.2 percent) and least common among Asian/Pacific Islander women (2.2 percent). Hispanic women were the only group to show a decrease since 2003, from 2.7 percent to 2.6 percent.

1 *Yu SM, Park CH, Schwalberg RH. Factors associated with smoking cessation among US pregnant women. Maternal and Child Health Journal 2002;6(2):89-97.*

Smoking During Pregnancy,* by Race/Ethnicity, 2004

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



*Preliminary data, based on reporting by 41 States.

CONTRACEPTION

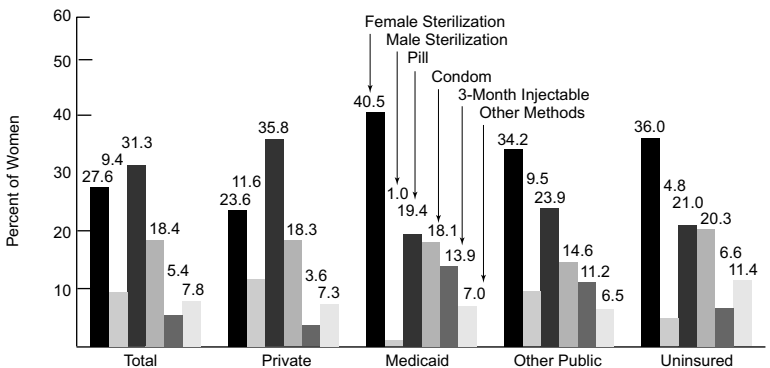
The majority of women of reproductive age (15-44 years) in the United States use contraception. The percent of women in this age group who use contraception increased substantially between 1982 and 1995, from 55.7 percent to 64.2 percent; this rate dropped slightly to 61.9 percent in 2002. It is important to note that these percentages represent all women of reproductive age, not just sexually active women.

Among all women between the ages of 18 and 44 who were using contraception in 2002, the three most common methods were birth control pills (31.3 percent), female sterilization (27.6 percent), and condoms (18.4 percent). The popularity of each of these methods varied substantially by insurance status: female sterilization and the pill were most common among women with Medicaid, female sterilization and the pill were most common among those with private insurance, and female sterilization was most common among women with no insurance. Female sterilization was the most common type of contraception among married women and women who were formerly married; and the pill, condoms, and female sterilization were most common among women who have never been married. Among all marital status categories, male sterilization was the most frequently mentioned by currently married women and least mentioned by never married women.

Among women who do not use contraception, never having had sex or not having sex in the 3 months prior to the interview was the most commonly reported reason for non-use of contraceptives (47.6 percent). The next most common reason was that the woman was pregnant, seeking pregnancy, or postpartum (25.0 percent). Currently married or cohabitating women were the most likely to report pregnancy as a reason for contraceptive non-use, while women who have never been married or who are formerly married were the most likely to report abstinence as the reason for not using contraceptives.

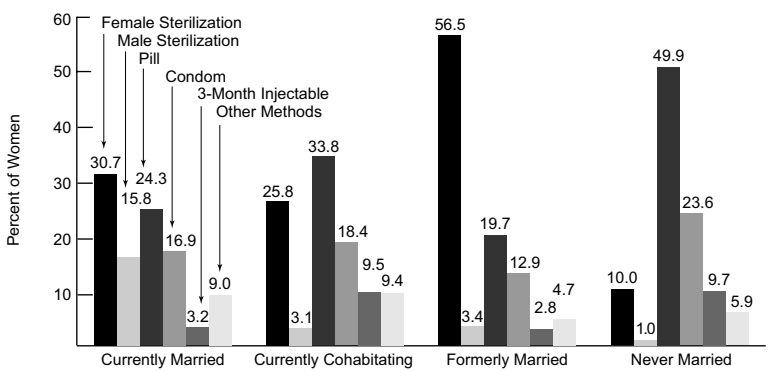
Method of Contraception Use Among Women Aged 18 to 44, Currently Using Contraception, by Insurance Status, 2002

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



Method of Contraception Use Among Women Aged 18 to 44, Currently Using Contraception, by Marital Status, 2002

Source II.20: 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 a decreased risk of breast and ovarian cancers, and possibly a decreased risk of hip fractures and osteoporosis after menopause.[1]

In 2004, 64.7 percent of U.S. infants were breastfed in the hospital after birth. Non-Hispanic Blacks had the lowest hospital breastfeeding rate (48.3 percent) in 2004. This compares to a rate of 72.8 percent among Asian mothers, 69.1 percent among non-Hispanic White mothers, and 62.5 percent among Hispanic mothers. Younger mothers, mothers with lower educational attainment, and mothers receiving WIC program benefits also had lower breastfeeding initiation rates.

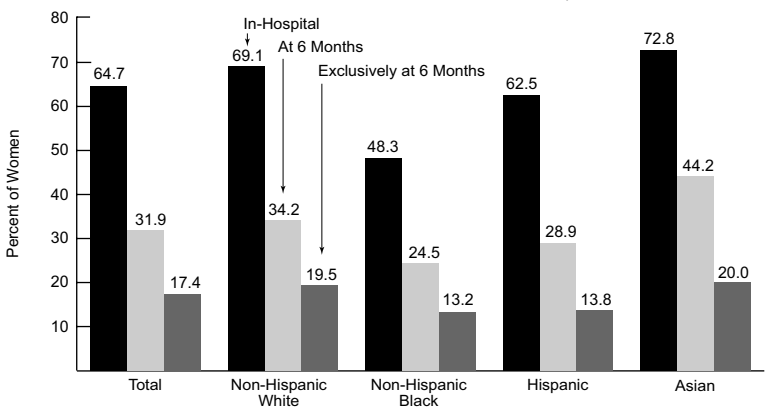
Although a majority of infants are breastfed in the hospital, the rate declines as infants grow older. In 2004, 31.9 percent of infants were fed any breast milk at 6 months. The American Academy of Pediatrics recommends that infants be exclusively breastfed—without supplemental food or liquids—for the first 6 months of life, based on research evidence of reduced risk of upper respiratory and other common infections. Yet in 2004, only 17.4 percent of infants were exclusively breastfed at 6 months.

Mothers who return to work after their infant is born may have an especially difficult time breastfeeding. Breastfeeding mothers need both the time and the facilities to pump their milk; not surprisingly, women who are employed full-time when their infant is 6 months of age are less likely than other women to breastfeed. The breastfeeding rate at 6 months among women employed full-time is 27.5 percent, compared to 35.9 percent among women employed part-time and 33.4 percent among women who are not employed.

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

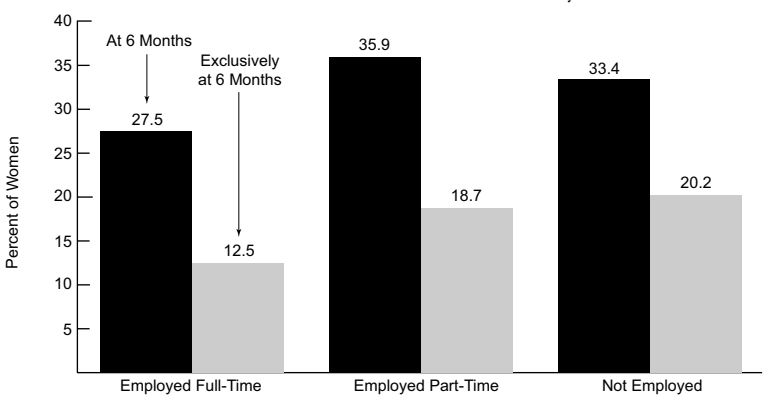
Breastfeeding Rates, by Race/Ethnicity and Duration, 2004

Source II.21: Ross Products Division of Abbott Labs, Mothers Survey



Breastfeeding Rates, by Employment Status, 2004

Source II.21: Ross Products Division of Abbott Labs, Mothers Survey



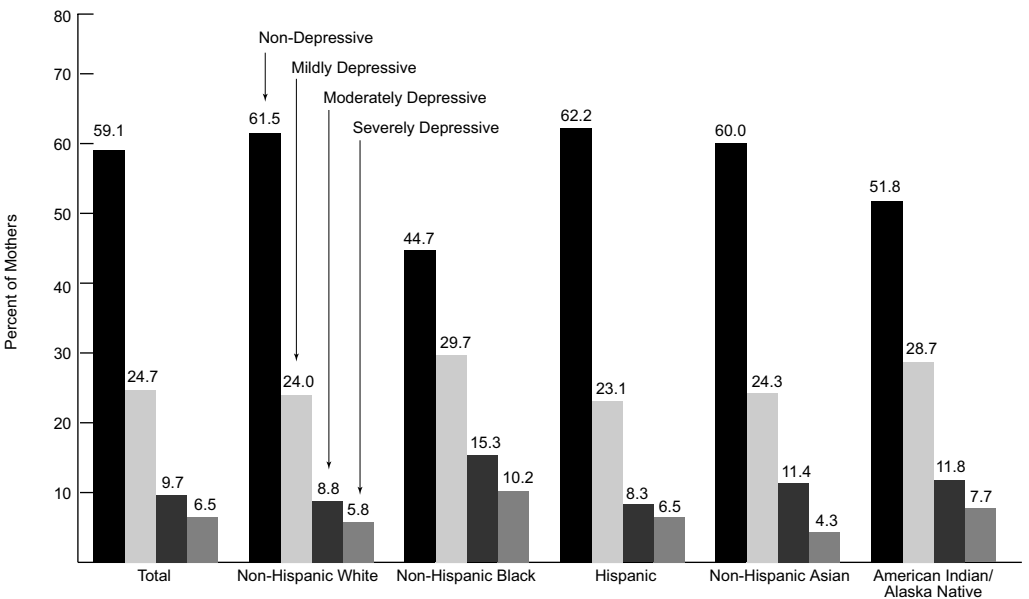
POSTPARTUM DEPRESSION

Depression is a major cause of disability among women, especially women of childbearing age. Pregnancy and the postpartum months are a period when women may be particularly vulnerable to both major and minor depression. Through a large study by the U.S. Department of Education, mothers with a child under one year of age were screened for depression based on the Center for Epidemiologic Studies-Depression Scale (CES-D). They were categorized as having symptom levels that were either non-depressive, mildly depressive, moderately depressive, or severely depressive. Overall, approximately 59 percent of new mothers did not display any depressive symptoms, while almost one-quarter displayed mild depressive symptoms; 9.7 percent of mothers displayed moderate depressive symptoms, and 6.5 percent showed severe symptoms. Hispanic, non-Hispanic White, and non-Hispanic Asian mothers were the most likely to show no depressive symptoms, while non-Hispanic Black and American Indian/Alaska Native mothers were most likely to show some depressive symptoms. The highest rate of moderate depressive symptoms occurred among non-Hispanic Black women (15.3 percent), while the lowest rate occurred among Hispanic women (8.3 percent). The highest rate of severe depressive symptoms was also among non-Hispanic Black women (10.2 percent), while the lowest rate was among non-Hispanic Asian women (4.3 percent).

With training, health care workers can screen women for major depression, although screening for mild depression is more difficult. Providing psychosocial support and counseling to pregnant women at risk of depression may be effective in decreasing symptoms.

Depressive Symptom Levels Among Mothers with a Child Under 1 Year of Age, by Race/Ethnicity, 2001

Source II.22: U.S. Department of Education, National Center for Education Statistics, Early Childhood Longitudinal Survey-Birth Cohort



INFERTILITY SERVICES

In 2002, almost 9 percent of women aged 18 to 44 years in the United States reported receiving infertility services at some time in their lives, and 2 percent had an infertility-related appointment in the past year. The most commonly reported service received was advice from a medical professional (66.1 percent), followed by infertility testing (21.2 percent). The remaining services were: drugs to improve ovulation (7.0 percent), artificial insemination (2.0 percent), surgery to correct blocked tubes (0.9 percent), and other types of medical assistance (2.8 percent).

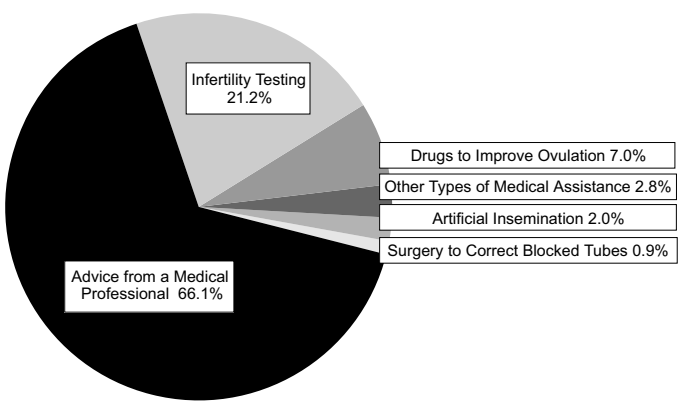
Non-Hispanic White women were most likely to report ever using infertility services (10.7 percent), while non-Hispanic Black women were least likely (4.7 percent). Non-hispanic White women were much more likely than women of other races to receive advice regarding infertility, and only slightly more likely to receive infertility testing or other services.

Of the approximately 5.1 million women who reported ever seeking medical help to get pregnant, 11.1 percent were currently pursuing medical help, and 75.8 percent had private insurance that covered some portion of their infertility services. The average age at first birth among women in the United States reached an all-time national high of 25.1 years in 2002; this rate has risen steadily over the past 3 decades from an average of 21.4 years in 1970.[1] The delay in trying to conceive, coupled with the natural decline in women's fertility beginning in the late 20s or early 30s, may help explain the significant number of women who seek help getting pregnant.

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

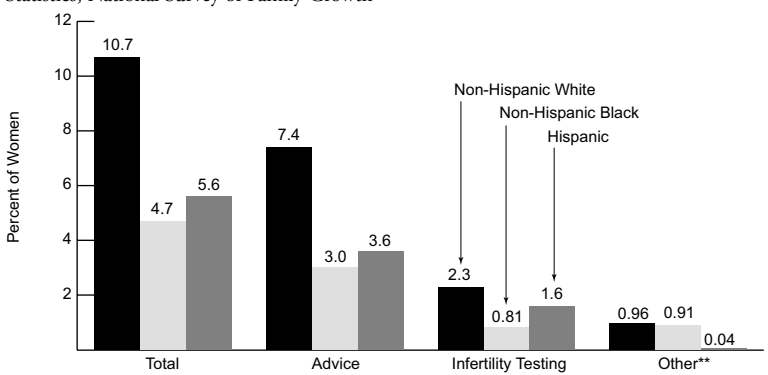
Women Aged 18 to 44 Years Ever Receiving an Infertility Service, by Type of Service, 2002

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



Women Aged 18 to 44 Years Ever Receiving an Infertility Service, by Type of Service and Race/Ethnicity,* 2002

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*The sample of those of other races was too small to produce reliable estimates. **This includes drugs to improve ovulation, surgery, artificial insemination, and other types of medical assistance.

AMERICAN INDIAN/ ALASKA NATIVE WOMEN

Just over one percent of the U.S. adult population, or 2.7 million adults, identify themselves as American Indian or Alaska Native, either alone or combined with one or more other races. American Indian and Alaska Native populations are distributed throughout the country, but are largely located in the West (43 percent), South (31 percent), and Midwest (17 percent); some populations also live in the Northeast (9 percent). The population is diverse and includes many different tribes and cultures. However, these communities generally face many challenges, including higher rates of poverty, lower rates of educational attainment and health insurance coverage, and higher prevalence and mortality rates for a number of diseases than other races.[1] American Indians and Alaska Natives are also more likely than adults of other races to smoke, use alcohol, and be overweight or obese.

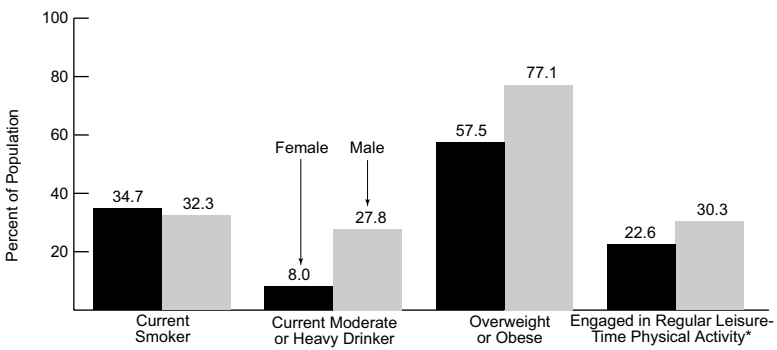
American Indian and Alaska Native women are less likely than their male counterparts to engage in selected health risk behaviors. The only exception is smoking: in 1999-2003, 34.7 percent of women in this population smoked, compared to 32.3 percent of men. However, women were less likely than men to engage in regular leisure-time physical activity (22.6 versus 30.3 percent).

Compared to women of other races, American Indian and Alaska Native women had the highest rates of heart disease, diabetes, ulcers, and migraines or severe headaches, and the second highest rates of hypertension and cancer.

1 *Barnes PM, Adams PF, Powell-Griner E. Health characteristics of the American Indian and Alaska Native adult population: United States, 1999-2003. Advanced Data from Vital and Health Statistics, No. 356; 2005 Apr.*

Selected Health Behaviors Among American Indian/Alaska Native Adults Aged 18 and Older, 1999-2003

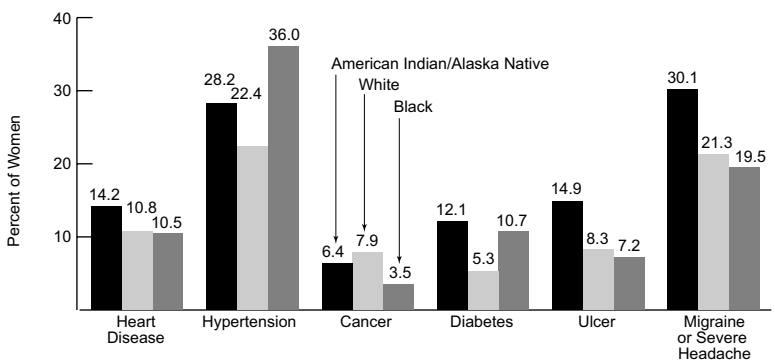
Source II.23: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Light or moderate activities that occur five or more times per week for at least 30 minutes each time and/or vigorous activities that occur three or more times per week for at least 20 minutes each time.

Selected Health Conditions Among Women Aged 18 and Older, by Race,* 1999-2003

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



*May include Hispanics.

OLDER WOMEN

In 2000, there were 34.9 million adults aged 65 and older in the United States; by 2003, that number had grown to 35.9 million, representing 12 percent of the total population. According to the U.S. Census Bureau, the older population is projected to grow to 72 million in 2030, or 20 percent of the total population, due to the aging of the Baby Boom generation. At the time of the 2000 Census, older women composed 7.3 percent of the population while men composed 5.1 percent.

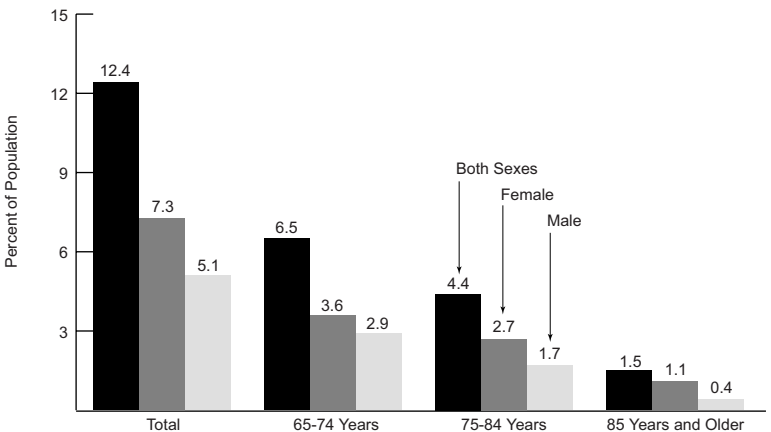
Older people who live alone are more likely to reside in poverty than those who live with their spouses, and living alone can also increase social isolation and reliance upon formal social supports.[1] In 2003, almost three-quarters of older men lived with a spouse, while fewer than half of women had the same living arrangement. Women were more likely to live alone than men (39.7 versus 18.8 percent). Many women also lived with relatives (17.4 percent).

Marital status influences many aspects of people's lives, including living arrangements, income, health, and mortality. Research shows that older married people, especially men, live longer, healthier lives than their unmarried counterparts (including the divorced and widowed).[1] In 2003, 41.1 percent of older women were married, compared to 71.2 percent of men; this corresponds with the percent of each population that lived with a spouse. Women were more likely than men to be widowed (44.3 versus 14.3 percent) and divorced (8.6 versus 7.0 percent).

Older Americans play a large part in the American economy and social structure, participating

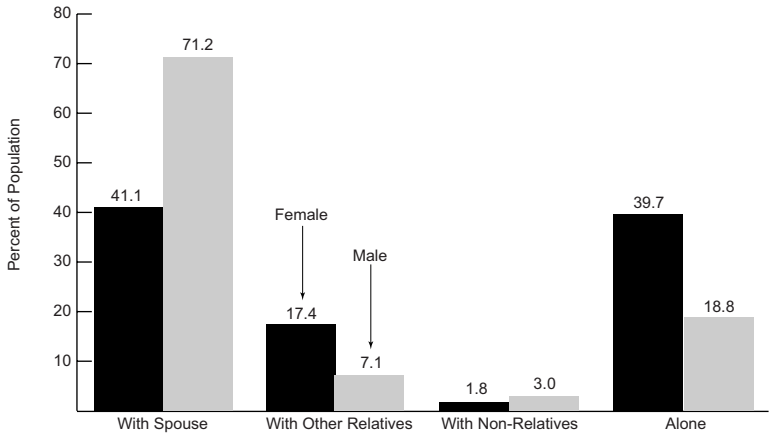
Representation of Adults Aged 65 and Older in the U.S. Population, by Age and Sex, 2000

Source II.24: U.S. Census Bureau



Living Arrangements of Adults Aged 65 and Older,* by Sex, 2003

Source II.24: U.S. Census Bureau



*Civilian, non-institutionalized population.

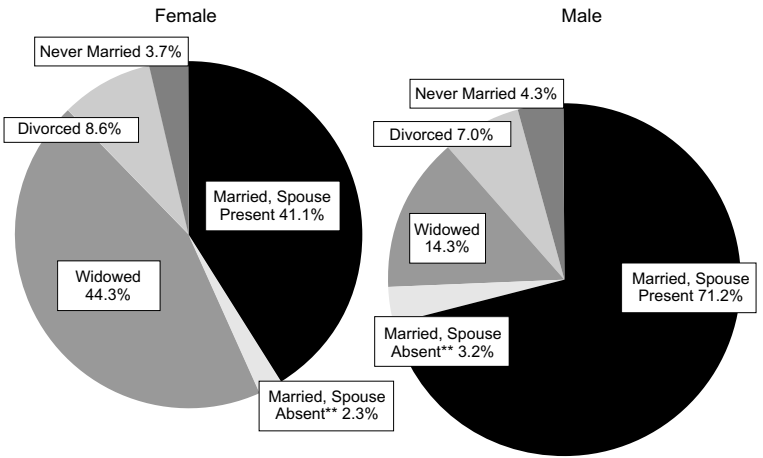
in formal volunteer activities (with an organization), informal volunteer activities (helping others outside of their own household), and caring for family members (including parents, spouses, and grandchildren). The value of these activities, determined through the 2002 Health and Retirement Study, is estimated at $97.6 to $201 billion, or $2,698 per person. In 2002, about 74 percent of older adults volunteered their time or provided unpaid care to family members. Time spent caring for family members represented approximately 61 percent of the total value of unpaid activities. The older population provided grandchild care worth approximately $27.3 billion, spousal care worth $22.1 billion, and parent care worth $13.5 billion. Formal volunteering was worth $25.4 billion while informal volunteering was worth $10.1 billion.

Older women devote more time to volunteering than older men. In 2002, women contributed an estimated $2,968 per capita compared to $2,363 per capita contributed by men. This difference is true in each of the five activity types, but is most pronounced in the care of grandchildren: in 2002, women supplied nearly 70 percent of all grandchild care.

1 *He W, Sengupta M, Velkoff V, Debarros K; U.S. Census Bureau. 65+ in the United States: 2005. Current Population Reports, P23-209. U.S. Government Printing Office, Washington D.C.; 2005.*

Marital Status of Adults Aged 65 and Older,* by Sex, 2003

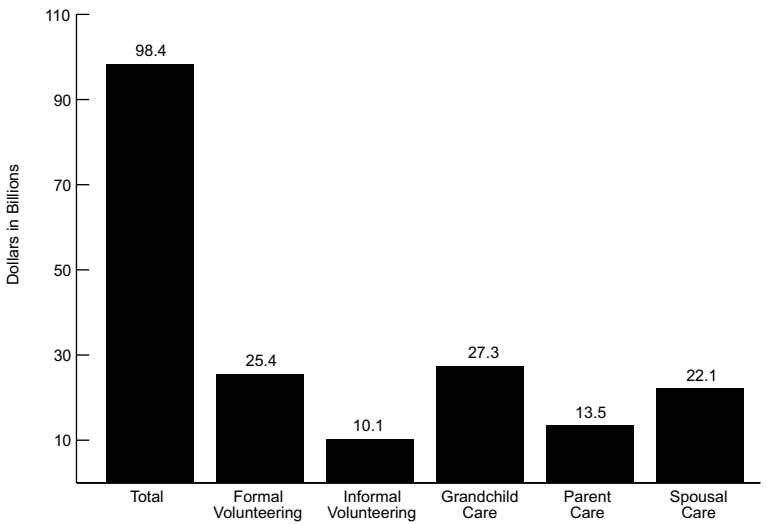
Source II.24: U.S. Census Bureau



*Civilian, non-institutionalized population. **Includes couples who are separated.

Total Value of Unpaid Activities Among Women Aged 65 and Older, by Activity Type, 2002

Source II.25: National Institute on Aging, Health and Retirement Study



RURAL AND URBAN WOMEN

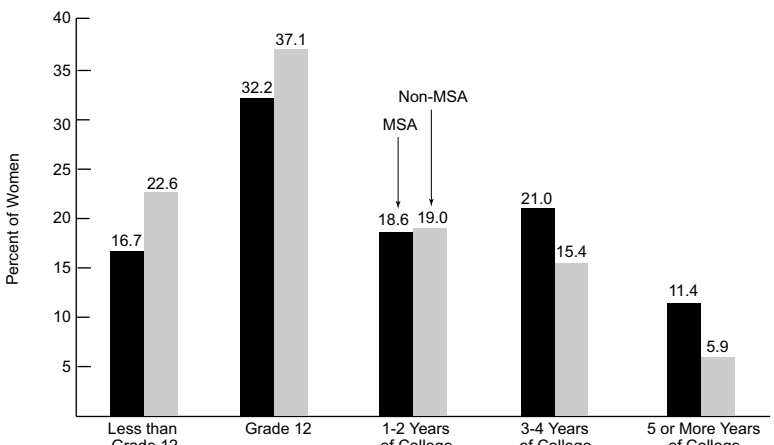
In 2003, almost 54 million people, or 19 percent of the population, lived in an area considered to be non-metropolitan. The number of areas defined as metropolitan changes every year as the population moves and grows. Residents of rural areas tend to be older, poorer, and live farther from health care resources than their metropolitan counterparts.

Women from non-metropolitan areas also tend to complete fewer years of education than women from metropolitan areas. In 2003, 22.6 percent of women aged 25 or older in rural areas had less than a 12th grade education, compared to 16.7 percent of women from metropolitan areas. Women from metropolitan areas were more likely to have 3 to 4 years of college education (21.0 versus 15.4 percent), and 5 or more years of college (11.4 versus 5.9 percent).

In addition to having access to fewer healthcare resources, women in rural areas are also less likely to have private health insurance coverage than their metropolitan counterparts. In 2003, 70.1 percent of women (aged 18 to 64) in non-metropolitan areas had any private insurance coverage for a full year compared to 76.1 percent of women in metropolitan areas. Women in non-metropolitan areas were more likely to have public insurance or be uninsured.

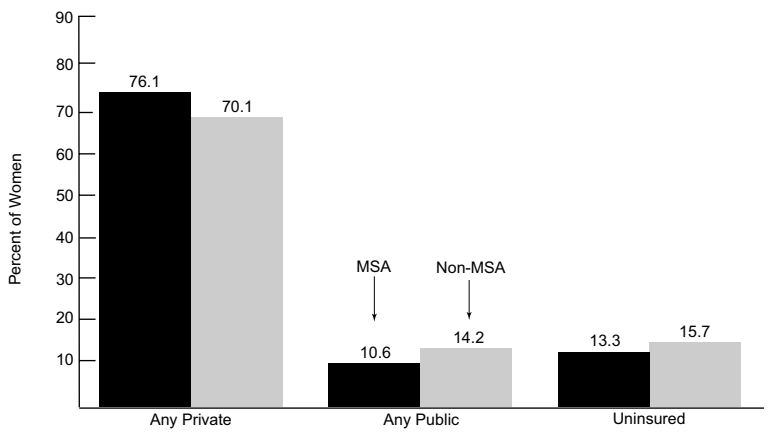
Completed Years of Education Among Women Aged 25 and Older, by Area of Residence,* 2003

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



Full Year Insurance Coverage Among Women Aged 18 to 64 Years, by Area of Residence,* 2003

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



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

HEALTH SERVICES UTILIZATION

Availability of and access to quality health services directly affects all aspects of women's health. 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 quality of life.

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

USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency 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 2004, almost 90 percent of women reported having a usual source of care. Women of all racial and ethnic groups were more likely than men to have a usual source of care, with Asians being the sole exception. Among women, non-Hispanic Whites were most likely to report a usual source of care (91.5 percent), followed by non-Hispanic Blacks (90.3 percent); Hispanic women were least likely to report a usual source of care (77.8 percent).

In 2004, 86.5 percent of women reported an office-based source of care (such as a physician's office), while fewer than 1 percent reported an emergency department as their usual source. This varied by citizenship status: women born in the United States were more likely to report an office-based usual source of care and non-citizen residents of the United States were less likely. Non-citizens were also the most likely to report no usual source of care.

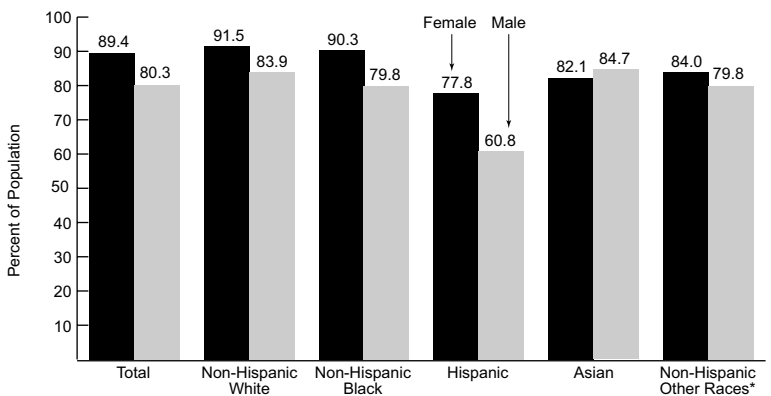
1 *Ettner SL. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference? Medical Care 1999;37(6): 647-55.*

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

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

Adults Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity, 2004

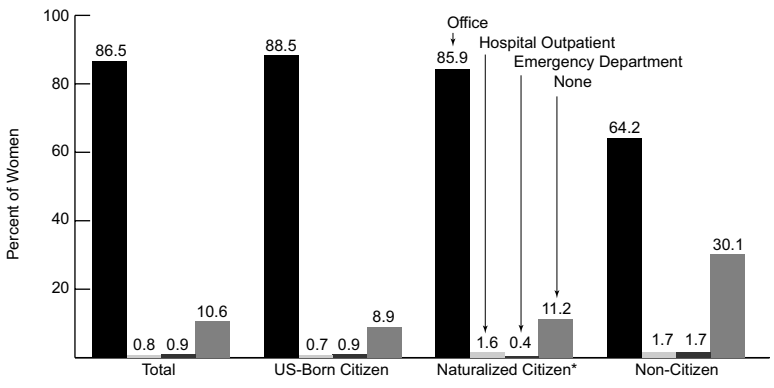
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Usual Source of Care Among Women Aged 18 and Older, by Immigration Status, 2004

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



*Person not born in the United States, but holding U.S. citizenship.

HEALTH INSURANCE

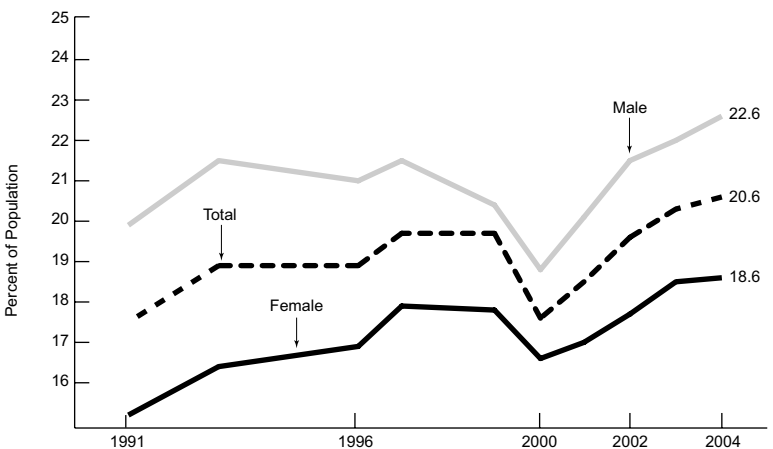
People who are uninsured are less likely than those with insurance to seek preventive care, which can result in poor health outcomes and higher health care costs. In 2004, over 45 million people in the United States, representing 15.7 percent of the population, were uninsured all year. The percentage of people who are uninsured varies considerably across a number of categories, including sex, age, race/ethnicity, income, and education. Males were more likely than females to be without insurance (17.2 versus 14.3 percent), and adults were more likely than children (20.3 versus 11.2 percent).

The percentage of adults without health insurance coverage has risen since the early 1990s. The total rate fluctuated between 17 and 20 percent from 1991 until 2002; then, in 2003, the rate surpassed the 20 percent mark for the first time in recent years (20.3 percent). During each year since 1991, men were more likely than women to be uninsured: in 2004, the rates were 22.6 and 18.6 percent, respectively.

Among females of all ages in 2004, 68.4 percent had private insurance, 28.9 percent had public insurance, and 14.3 percent were uninsured. This varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (76.0 percent); followed by Asian women (70.6 percent). Black females had the highest rate of public insurance coverage (36.6 percent), and Hispanic females had the highest rate of being uninsured (29.5 percent).

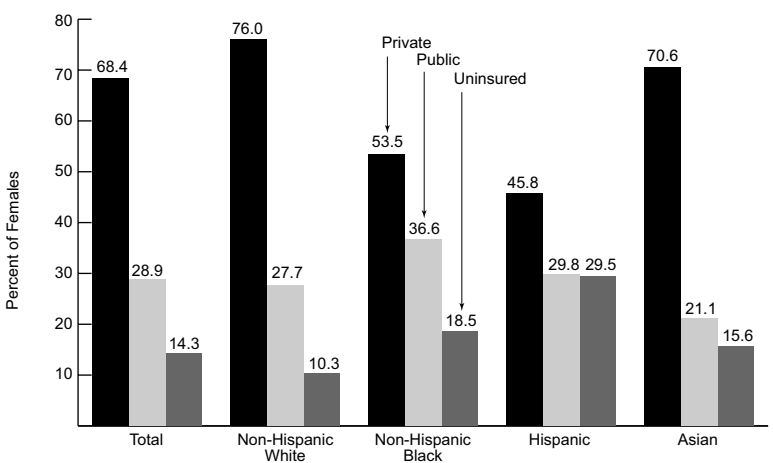
Adults Aged 18 and Older Without Health Insurance, by Sex, 1992-2004

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



Health Insurance Coverage of Females (All Ages), by Type of Coverage and Race/Ethnicity, 2004

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



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 several components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient hospital services, and durable medical equipment. Medicare covers preventive services such as an annual mammogram, Pap smear, bone density scan, and influenza vaccination. Part D, a prescription drug benefit, was added in 2006.

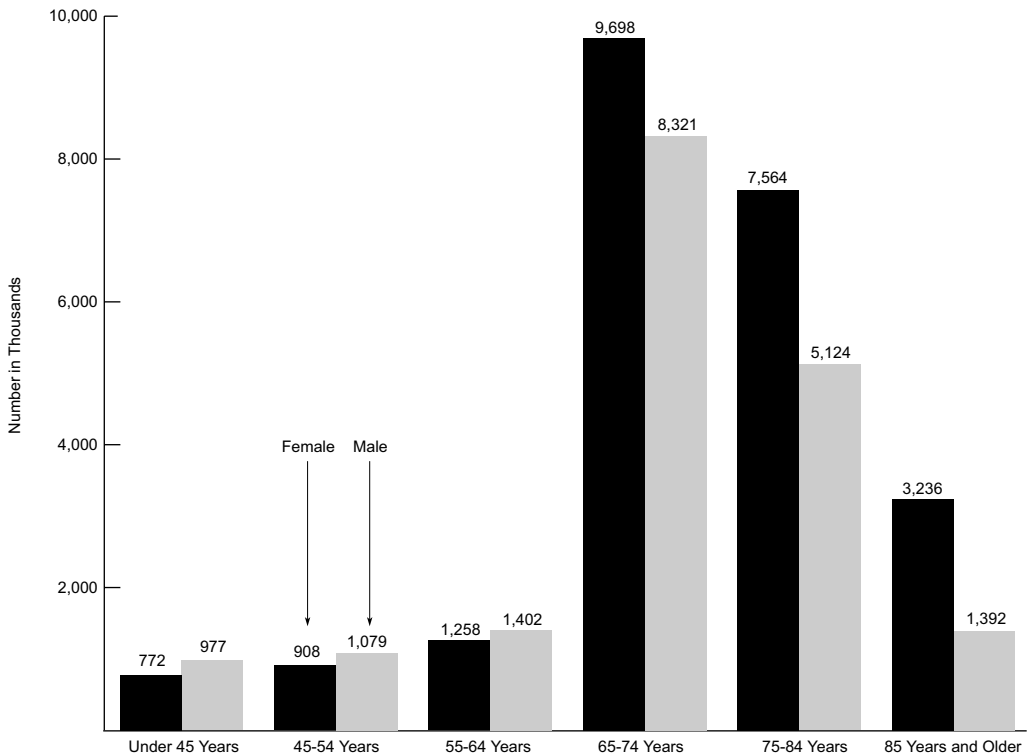
In 2004, Medicare had 41.7 million enrollees, 56 percent of them were females. The large majority of all Medicare enrollees were aged 65 or older, with the elderly representing 87 percent of female enrollees and 81 percent of male enrollees. Of Medicare enrollees aged 65-74, 9.6 million were female and 8.3 million were male. Among enrollees aged 75-84, 7.5 million were female and 5.1 million were male.

Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income individuals and people with disabilities. In 2003, Medicaid covered 55 million individuals, including children; the aged, blind, and disabled; and people who are eligible for cash assistance programs. Fifty-nine percent of all Medicaid enrollees were female; of the adults enrolled in Medicare, 69.5 percent were female.[1]

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

Medicare Enrollees (All Ages), by Age and Sex, 2004

Source III.3: Centers for Medicare and Medicaid Services



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 perinatal services and chlamydia screening is increasing, while the rate of cervical cancer screens among women in commercial plans and mammograms among women in both commercial and Medicaid plans declined between 2003 and 2004.

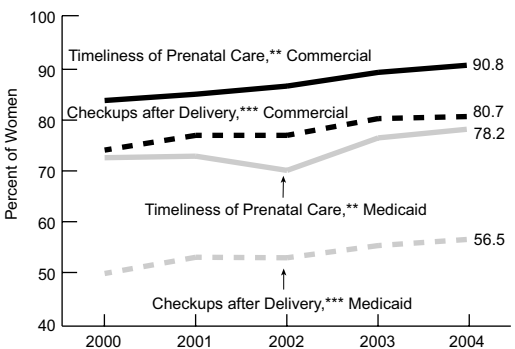
Perinatal services—prenatal care and postpartum checkups—appear to be more accessible in commercial (private) plans than in public-sector plans financed by Medicaid. The same is true of cervical cancer screening, which is received at least once every 3 years by nearly 81 percent of commercially-insured women and 64.7 percent of women covered by Medicaid.

Chlamydia screening is the one screening service that is more common among Medicaid-enrolled women than those with private coverage: 49 percent of Medicaid-enrolled women aged 21-25 had a chlamydia screen in the previous year, compared to 31.7 percent of commercially-insured women.

In 2004, the rate of mammograms for women aged 52-69 was approximately equal for women with private coverage and those covered through Medicare. However, Medicaid-enrolled women are considerably less likely to receive a mammogram at least once every 2 years.

HEDIS®* Measures of Perinatal Care, by Payer, 2000-04

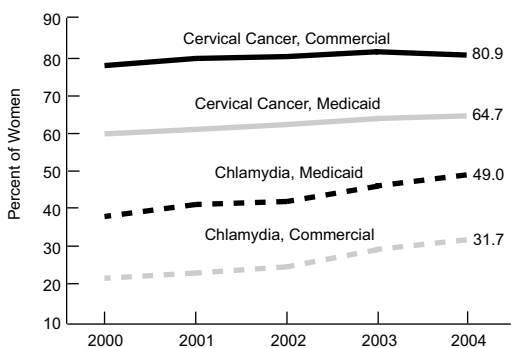
Source II.13: National Committee for Quality Assurance



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

HEDIS®* Rates of Cervical Cancer** and Chlamydia*** Screening by Payer, 2000-04

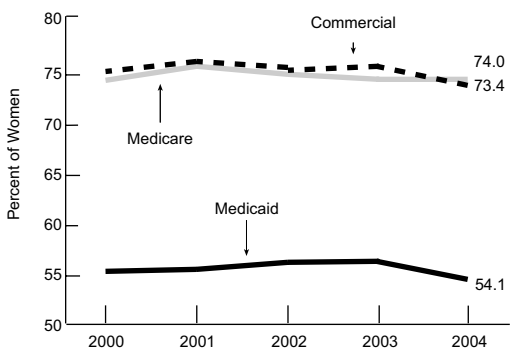
Source II.13: National Committee for Quality Assurance



*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 3 years. ***The percentage of sexually active plan members aged 21-25 who had at least one test for chlamydia in the past year.

HEDIS®* Rates of Mammograms,** by Payer, 2000-04

Source II.13: National Committee for Quality Assurance



*Health plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 52-69 years who had at least one mammogram in the past 2 years.

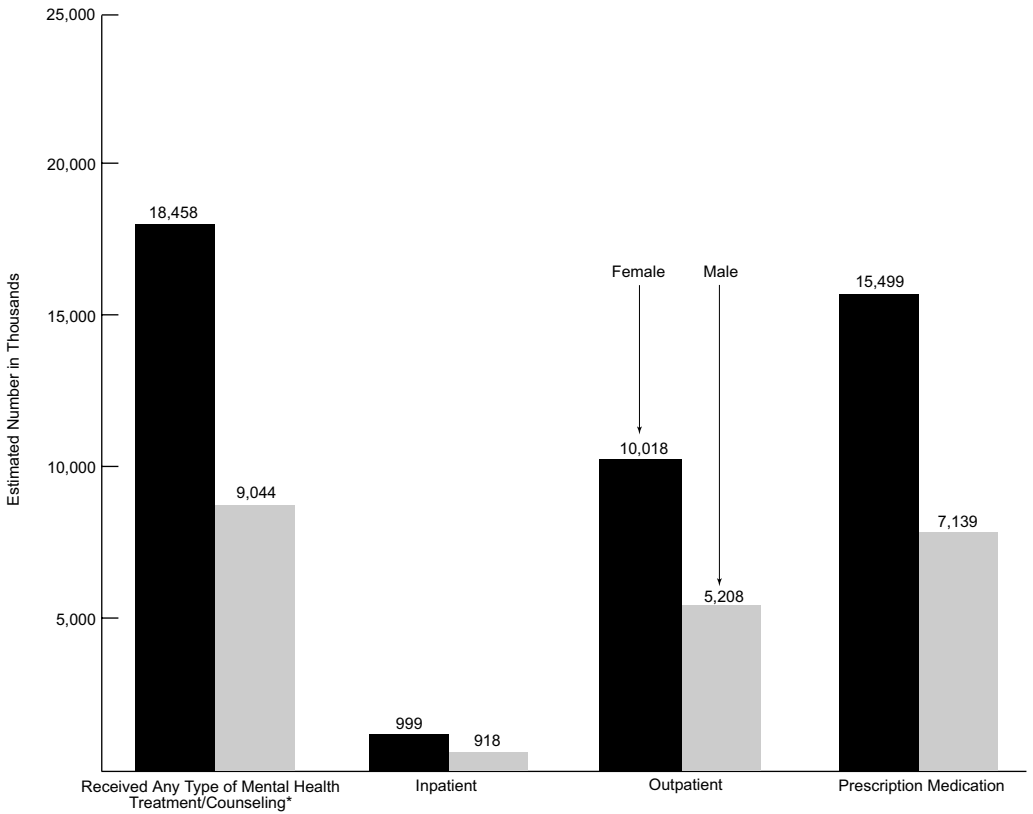
MENTAL HEALTH CARE UTILIZATION

In 2004, an estimated 27.5 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 15.5 million women used prescription medication for treatment of a mental or emotional condition. While this is still twice the number of men (7.1 million) who received similar treatment, it represents a 1 million decline from 2003, when 16.5 million adult women 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 psychological distress are in particular need of services. In 2004, of the 13.4 million women aged 18 or older who reported having serious psychological distress in the past year, nearly one-half (6.4 million women) said they did not receive any type of mental health treatment or counseling. When asked to define their own perceived unmet need, cost was the reason most often cited for not receiving needed mental health treatment.

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Sex and Treatment/Counseling Type, 2004

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



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

HEALTH CARE EXPENDITURES

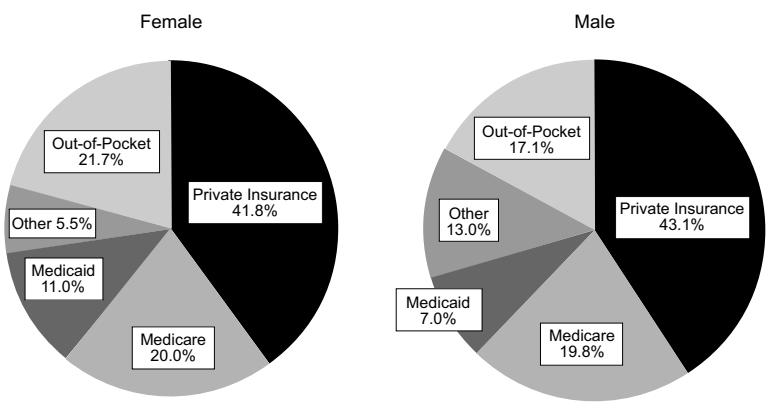
In 2003, the majority of both females' and males' health care expenses were covered by public or private health insurance. For females, approximately one-third of expenses were covered by either Medicare or Medicaid, while nearly 42 percent were covered by private insurance. Although the percentage of expenditures paid through private insurance was approximately equal for both sexes, females' health care costs were more likely than males' to be paid by Medicaid or out of pocket.

Ninety percent of females had at least one health care expenditure in 2003, compared to 80 percent of males. Among those who had at least one health care expense in 2003, the average per-person expenditure was slightly higher for females ($3,644) than for males ($3,550). However, males' expenditures exceeded females' for hospital inpatient services ($19,242 compared to $11,003) and hospital outpatient services, while females' expenditures exceeded males' in the categories of home health services, office-based medical services and prescription drugs.

While the gender gap in health care expenditures has narrowed somewhat since 1998, overall per-capita health care expenditures have increased substantially among both men and women. Males' expenses have increased 67 percent over this period while females' have gone up 34 percent.

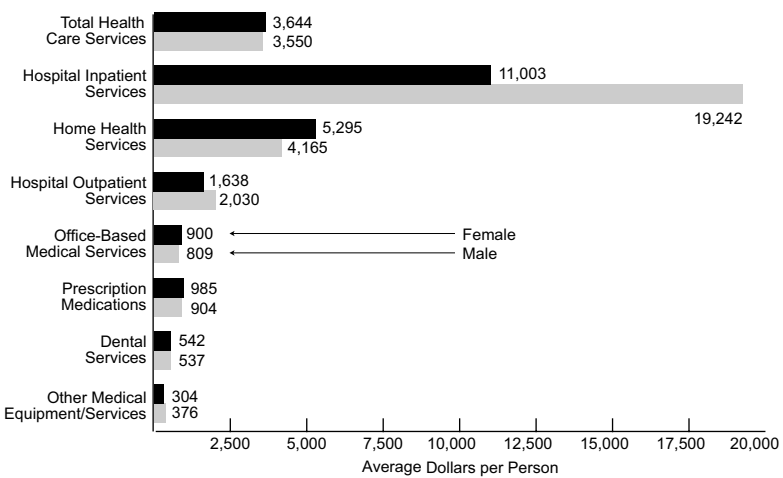
Health Care Expenses, by Source of Payment and Sex (All Ages), 2003

Source III.4: 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, 2003

Source III.4: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



PREVENTIVE CARE

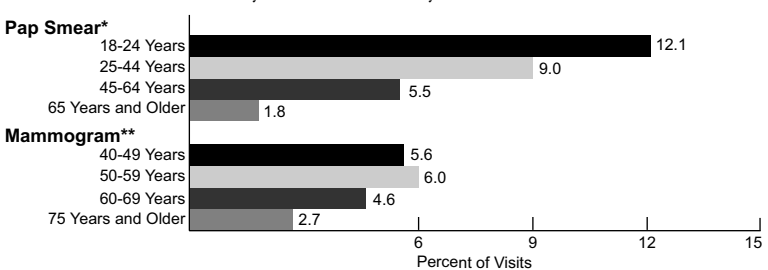
Counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2003, females of all ages made just over 537 million physician office visits, compared to only 368 million made by males. Of visits made by females, 18.7 percent were for preventive care, including prenatal care, screenings, and insurance examination.

Mammograms and Pap smears are two preventive services that are especially important to women's health. Routine Pap smears, which detect the early signs of cervical cancer, are recommended within 3 years of initiation of sexual activity, or by age 21. Mammography is recommended every 1 to 2 years for women aged 40 and older to screen for breast cancer. In 2003, 6 percent of all office visits made by women aged 18 or older included a Pap smear, and 4.6 percent of all office visits made by women 40 and older included a mammogram. An office visit including a Pap smear was most common among women aged 18 to 24 years, while an office visit with a mammogram was most common among women aged 50 to 59 years.

Vaccination is another important preventive measure that women can take to protect their health. Vaccination for influenza is generally recommended for young children, older adults, and adults with certain health conditions. In 2004, 65.9 percent of women aged 65 and older reported receiving a flu vaccine in the past year. Pneumonia vaccine is also recommended for older adults and people with certain health conditions. In 2004, almost 60 percent of women aged 65 and older reported ever receiving the vaccine. Recently, Hepatitis B vaccination was recommended for everyone under age 18 and people with certain health risks. In 2004, almost 60 percent of women aged 18 to 24 years of age reported ever having received at least one dose in the three dose series; rates were highest among non-Hispanic Whites and women of other races, and lowest among Hispanics.

Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits, by Age, 2003

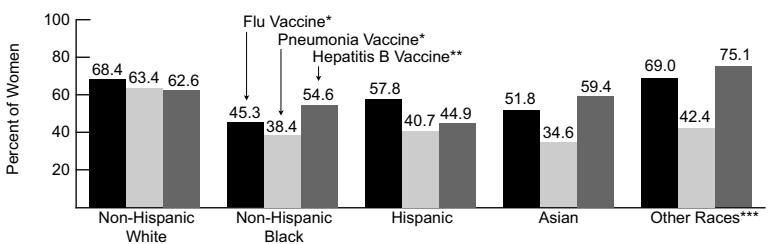
Source III.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



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

Selected Vaccinations Received by Women, by Race/Ethnicity, 2004

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



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

HIV TESTING

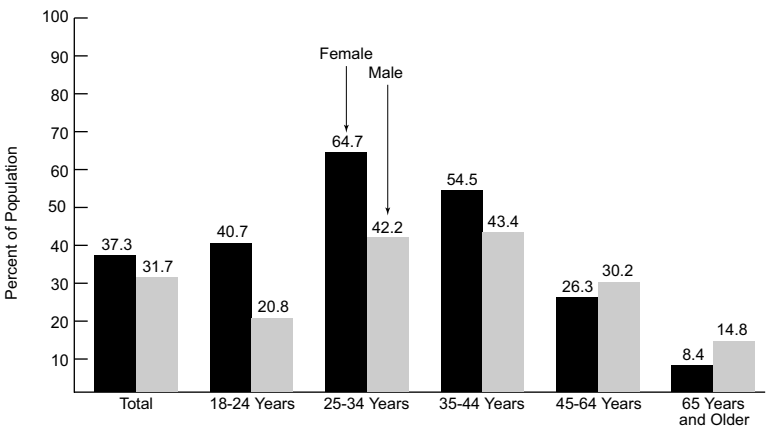
Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek appropriate care. HIV testing requires only a simple blood or saliva test, and it is often offered through confidential or anonymous sources. It is recommended that people who meet any of the following criteria be tested for HIV: have injected drugs or steroids, or shared equipment (such as needles) with others; have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of the previous criteria.[1]

In 2004, almost 35 percent of adults in the United States had ever been tested for HIV. Overall, women were more likely than men to have been tested (37.3 versus 31.7 percent). Women were more likely to have been tested at younger ages, while men were more likely to have been tested at older ages. Among women, non-Hispanic Blacks had the highest testing rate (52.4 percent), followed by Hispanic women (45.4 percent). Asian women had the lowest testing rates (33.3 percent).

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

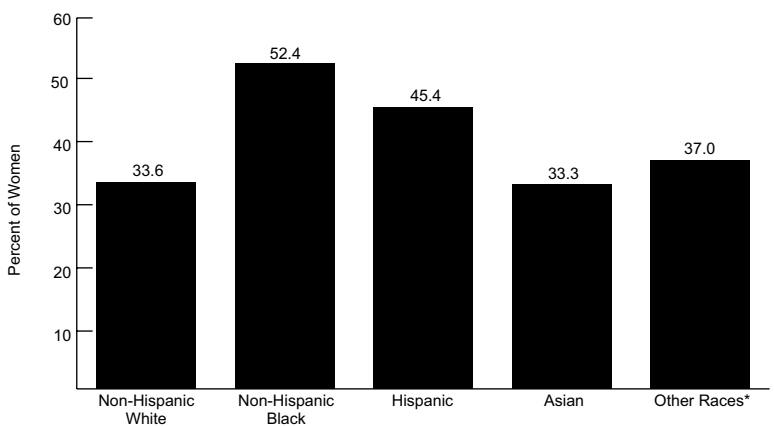
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2004

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, 2004

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

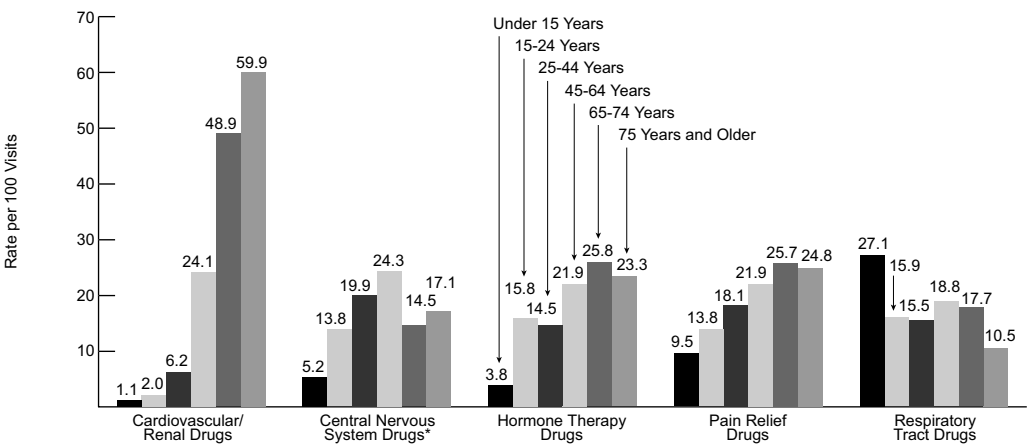
In 2003, medication was prescribed or provided at 595.3 million physician office visits; multiple drugs were recorded at 39.5 percent of all visits. The percent of visits with one or more drugs prescribed or provided was similar for males and females (66.4 versus 65.2 percent). Among females, 34.8 percent of visits did not involve prescribing or providing any drugs, 26.1 percent of visits involved the prescription or provision of one drug, and 15.0 percent of visits involved two drugs. The frequency with which different types of drugs are discussed can be driven by numerous factors, including a change in the prevalence of the disease or condition that the drug treats, evidence regarding the efficacy of the drug, and the level of marketing that the drug receives. For instance, since 2001, overall rates of hormone replacement therapy for women 45 years and older declined from 55.6 to 30.7 drug mentions per 100 office visits. This decline reflects the effects of two large clinical trials that found increases in coronary heart events associated with hormone replacement therapy.[1]

The prescription or provision of medications among females varies by age and drug type. In 2003, the use of cardiovascular/renal and pain relief drugs generally increased with age, while respiratory tract drugs decreased with age. Discussions about central nervous system drugs, including mental health medications such as antidepressants, during physician visits were most common among women in the middle age groups, with the highest rate occurring among women aged 45 to 64 years of age (mentioned 24.3 times per 100 visits). The highest rate of drug mentions was 59.9 mentions per 100 visits; this was for cardiovascular/renal drugs among women 75 years and older. The lowest rate of drug mentions (1.1 per 100 visits) was for cardiovascular/renal drugs among females under 15 years of age; for this age group, the most common type was respiratory tract drugs (mentioned 27.1 times per 100 visits).

1 *Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2003 summary. Advance Data from Vital and Health Statistics, No. 365; 2005 Oct.*

Medication Use Reported for Females During Physician Office Visits, by Age, 2003

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



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

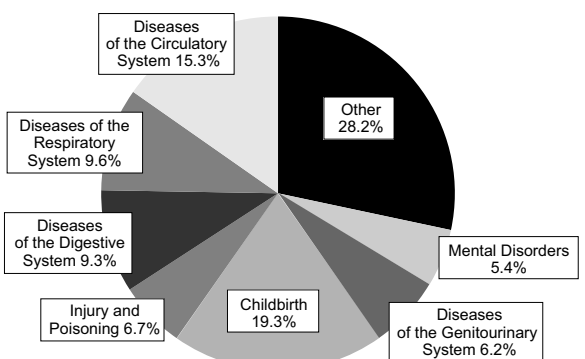
HOSPITALIZATIONS

Females represented 60.1 percent of the over 34 million short-stay hospital discharges in 2003. Nearly 20 percent of discharges for all females were due to childbirth, while 15 percent were due to diseases of the circulatory system. Other common reasons for hospitalization included diseases of the respiratory, digestive, and genitourinary systems, injury and poisoning, and mental disorders.

Overall, females had a higher hospital discharge rate than males (1,792.2 versus 1,228.3 per 10,000 population). Males and females have different rates of discharge for every type of procedure performed. Several of the procedures for which females had a higher discharge rate than males included operations on the digestive system (224.7 versus 170.4 per 10,000) and operations on the genital organs (139.0 versus 17.5 per 10,000). Males had a higher discharge rate than females for operations on the cardiovascular system (276.7 versus 196.0 per 10,000) and a slightly higher rate of operations on the musculoskeletal system (129.5 versus 128.7 per 10,000). Among females, the highest rate of discharges was due to obstetrical procedures (453.2 per 10,000).

Discharges from Non-Federal, Short-Stay Hospitals Among Females (All Ages),* by Diagnosis, 2003

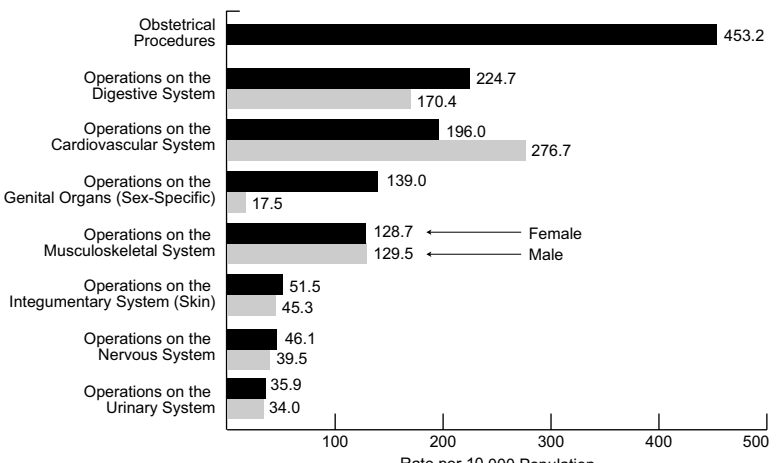
Source III.6: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Procedure Category (All Ages),* 2003

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



*Excludes newborn infants.

ORGAN TRANSPLANTATION

In 2005, there were 28,106 organ transplants in the Unites States. Since 1988, there have been 364,533 transplants, with the number increasing each year. In 2005, the gender distribution among organ donors was almost even (7,246 females and 7,244 males donated organs). Females were more likely than males to donate organs while alive (59.1 percent of living donors were female).

However, the need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of March 3, 2006, there were 90,997 people awaiting the opportunity for a life-saving organ transplant. Females composed 41.9 percent of those patients waiting and only 37.9 percent of those who received a transplant in 2005. Among women waiting on the list, 47.4 percent were White, 28.9 percent were Black, and 15.9 percent were Hispanic. The kidney is the organ in highest demand, with 27,382 females awaiting a kidney as of March 3, 2006.

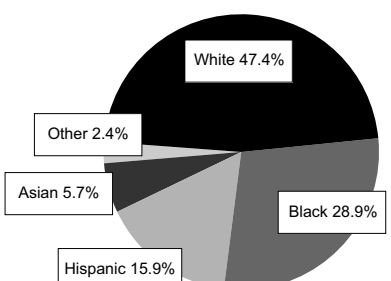
The number of organs donated remained roughly static from 1990-2003. Beginning in 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. In 2004, donations increased by an unprecedented 12 percent over the previous year, and in 2005 they increased yet again by another 9 percent, resulting in an additional 2,000 lives saved or enhanced through transplantation. One of the challenges of organ donation is obtaining consent from the donor family or legal surrogate. Some of the reasons consent rates vary include religious perception, poor communication between health care providers and grieving families, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased.[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.*

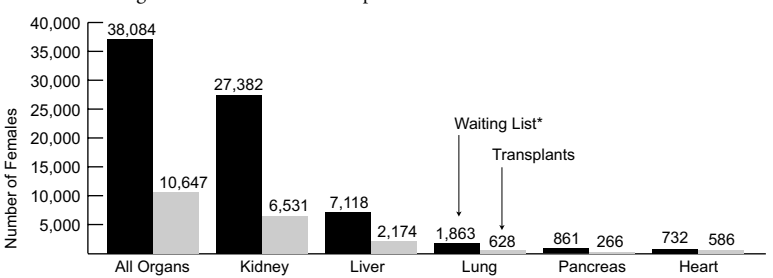
Distribution of Females on Organ Waiting List, by Race/Ethnicity, as of March 3, 2006

Source III.7: Organ Procurement and Transplantation Network



Female Transplant Recipients, 2005, and Females on Transplant Waiting Lists, 2006, by Organ

Source III.7: Organ Procurement and Transplantation Network



*As of March 3, 2006

HRSA PROGRAMS

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports a wide range of programs that increase and promote access to health care for vulnerable groups. Within four of HRSA's key program areas – Health Professions, HIV/AIDS, Maternal and Child Health, and Rural Health – 21 programs support and address the specific needs of women.

The Bureau of Health Professions is committed to the development and retention of a culturally competent work force that provides the highest quality care for diverse populations in need. The grant programs supporting the mission in FY 2004 were: (1) Academic Administrative Units in Primary Care; (2) Advanced Education Nursing; (3) Faculty Development in Primary Care; (4) Graduate Psychology Education Programs; (5) National Research Service Award; (6) Residency Training in General and Pediatric Dentistry; (7) Residency Training in Primary Care; (8) Predoctoral Training in Primary Care; (9) Physician Assistant Training in Primary Care; (10) Residency Training in Dental Public Health.

The mission of the Maternal and Child Health Bureau is to assure the health of 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 and the number of children in low-income households receiving assessments and follow-up services, and provide access and ensure perinatal care for women. The grant programs supporting this mission in FY 2004 were: (1) Disparities in Perinatal Health-Border Initiatives; (2) Family Violence; (3) Healthy Behaviors in Women; (4) Healthy Start Initiative; (5) Improving Screening for Alcohol Use during Pregnancy by Providers; (6) Integrated Comprehensive Women's State MCH Program; (7) Interconception Care for High Risk Women and Their Families; (8) Screening and Intervention for Depression During/Around Pregnancy; (9) Screening for Multiple Behavioral Risk Factors During the Preconception Through Postpartum Period; (10) State Grants for Perinatal Depression; and (11) Women's Behavioral Health Systems Building: Innovative Ideas for Local and State Collaboration.

In the HIV/AIDS Bureau, the Ryan White Title IV program is the cornerstone of the 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.

The Office of Rural Health Policy promotes better health care service in rural America. The Office informs and advises the Department of Health and Human Services on matters affecting rural hospitals and health care, coordinates activities relating to rural health care, and maintains a national information clearinghouse. The Office works within government at Federal, State and local levels, and with the private sector to seek solutions to rural health care problems. In FY 2004, two grant programs supported women's health initiatives: the Rural Health Outreach Special Initiative and the Rural Health Research Grant Program Cooperative Agreement.

The **HRSA Geospatial Data Warehouse** (http://datawarehouse.hrsa.gov) provides access to a broad range of information about HRSA programs, related health resources, and demographic data useful for planning and policy purposes. The Warehouse captures grants, designation of underserved areas, and service demonstration programs and integrates these with data acquired from external sources. As the central source of information used for reporting on HRSA activities, a report tool is available for generating and exporting tabular results. A map tool is available for users who would like to place the data in a geographic context. Features on the map can be identified and are linked to the report tool enabling further analysis.

HRSA Grants Related to Women's Health, FY 2004

In FY 2004, there were 315 grants related to women's health in 21 programs within 4 key areas (Health Professions, HIV/AIDS, Maternal and Child Health and Rural Health).
Prepared by the HRSA Office of Information Technology using the HRSA Geospatial Data Warehouse (http://datawarehouse.hrsa.gov).

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 http://www.hrsa.gov/womenshealth or at http://mchb.hrsa.gov/data/.

Women's Health USA 2002
Lupus
Non-Medical Use of Prescription Drugs
Nursing Home Care Utilization
Unintended Pregnancies
U.S. Population Growth

Women's Health USA 2003
Autoimmune Diseases
Bleeding Disorders
Home Health and Hospice Care
Title V Abstinence Education Programs
Title X Family Planning Services
Vitamin and Mineral Supplement Uses

Women's Health USA 2004
Complementary and Alternative Medicine Use
Eating Disorders
Maternal Morbidity and Mortality
Services for Homeless Women
Women in NIH-Funded Clinical Research

Women's Health USA 2005
Adolescent Pregnancy
Border Health
Immigrant Health
Maternity Leave
Prenatal Care

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CONTRIBUTORS

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

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