

SELF-REPORTED HEALTH STATUS

In 2007, men were slightly more likely than women to report being in excellent or very good health (61.9 versus 59.5 percent, respectively). Among both sexes, self-reported health status improves with income. Women and men with incomes less than 100 percent of poverty were least likely to report excellent or very good health (42.2 and 47.6 percent, respectively), compared to about 60 percent of men and women with

incomes of 200–299 percent of poverty and 73 percent of those with incomes of 300 percent or more of poverty.

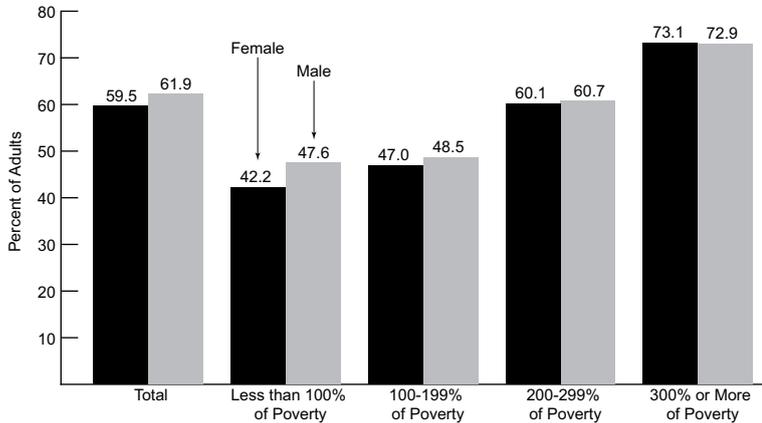
Self-reported health status declines with increasing age: 70.3 percent of women aged 18–44 years reported excellent or very good health, compared to 55.6 percent of those aged 45–64 years, 42.8 percent of those aged 65–74 years, and 32.8 percent of those aged 75 years and older. Among women in the oldest age group, 30.9 percent reported fair or poor health, compared

to only 6.5 percent of those in the youngest age group.

The rate of women reporting excellent or very good health also varies with race and ethnicity. Non-Hispanic Asian women were most likely to report excellent or very good health (64.0 percent), compared to 53.1 percent of Hispanic and 51.0 percent of non-Hispanic Black women. More than 62 percent of non-Hispanic White women reported being in excellent or very good health (data not shown).

Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Sex and Poverty Status,* 2007

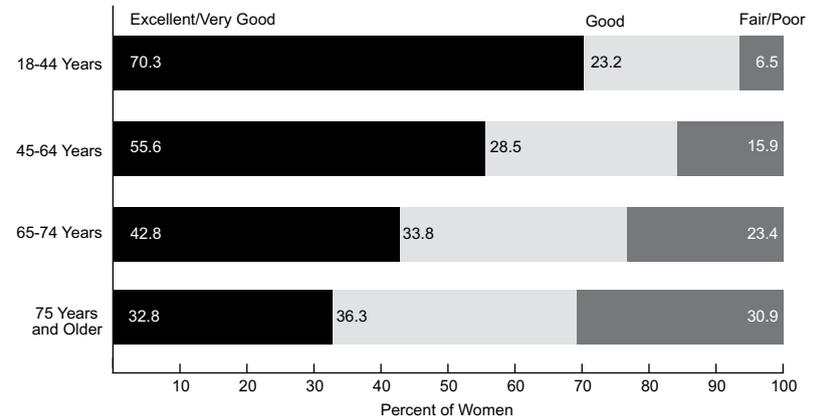
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Poverty, defined by the U.S. Census Bureau, was \$21,027 for a family of four in 2007.

Self-Reported Health Status of Women Aged 18 and Older, by Age, 2007

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



LIFE EXPECTANCY

The overall life expectancy of a baby born in 2006 was 77.7 years (data not shown); this varied, however, by age, sex, and race/ethnicity. A baby girl born in the United States in 2006 could expect to live 80.2 years, 5.1 years longer than a male baby, whose life expectancy would be 75.1 years (data not shown). The differential between male and female life expectancy was greater among Blacks than Whites. Black males could expect to live 69.7 years, 6.8 years fewer than Black females (76.5 years). The difference between White males and females was 4.9 years, with a life expectancy at birth for White females of 80.6 years and 75.7 years for White males. White females could expect to live 4.1 years longer than Black females. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates.

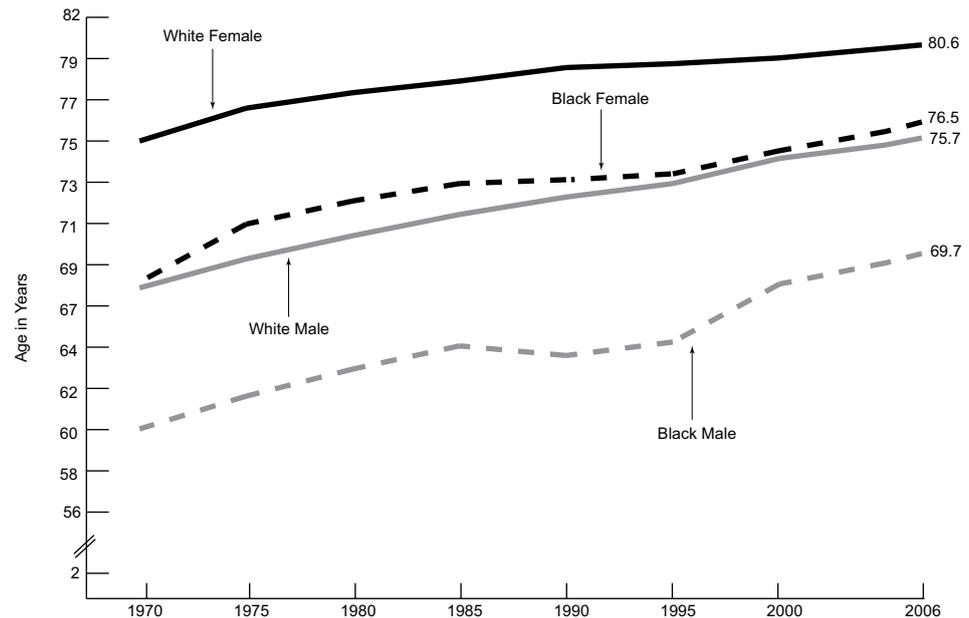
Life expectancy has steadily increased since 1970 for males and females in both racial groups. Between 1970 and 2006, White males' life expectancy increased from 68.0 to 75.7 years (11.3 percent), while White females' life expectancy increased from 75.6 to 80.6 years (6.6 percent). During the same period, the life expectancy for Black males increased from 60.0 to 69.7 years (16.2 percent), while life expectancy increased from 68.3 to 76.5 years (11.7 percent) for Black females.

Life expectancy data have not been uniformly calculated and reported for the Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native populations. According to the most recent estimates available, an American Indian/Alaska Native born in 1999–2001 could expect to live 74.5 years; this represents a 17.1 percent increase over the life expectancy in 1972–1974

(63.6 years).⁶ The U.S. Census Bureau estimated that Hispanics born in 1999 would have a life expectancy of 83.7 years for females and 77.2 years for males. Asian males born in 1999 had a life expectancy of 80.9 years, while life expectancy for Asian females born in that year was 86.5 years (data not shown).⁷

Life Expectancy at Birth, by Race* and Sex, 1970–2006

Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics



*Both racial categories include Hispanics.

LEADING CAUSES OF DEATH

In 2006, there were 1,224,322 deaths of females in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), responsible for 25.8 and 22.0 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 6.7 percent of deaths, and chronic lower respiratory disease, which accounted for 5.3 percent. Among females aged 1–34 years of age, unintentional injury was the leading cause of death (data not shown).

Heart disease was the leading cause of death for women in most racial and ethnic groups; the exceptions were non-Hispanic Asian/Pacific Islander and non-Hispanic American Indian/Alaska Native females, for whom the leading cause of death was cancer. One of the most noticeable differences in leading causes of death by race and ethnicity is that diabetes mellitus was the eighth leading cause of death among non-Hispanic White females, while it was the fourth among all other racial and ethnic groups. Similarly, chronic lower respiratory disease was the fourth leading cause of death among non-Hispanic White females while it ranked sixth or seventh among other racial and ethnic groups. Death in the perinatal period was the ninth leading cause of death among Hispanic females, accounting for 2.1 percent of deaths, and hy-

per-tension was the tenth leading cause among non-Hispanic Asian/Pacific Islander females, accounting for 1.6 percent of deaths (data not shown). Also noteworthy is that non-Hispanic American Indian/Alaska Native females experi-

enced a higher proportion of deaths due to unintentional injury (8.2 percent) and liver disease (4.1 percent; seventh leading cause of death) than females of other racial and ethnic groups.

Ten Leading Causes of Death Among Females (All Ages), by Race/Ethnicity, 2006

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

| | Total | Non-Hispanic White | Non-Hispanic Black | Hispanic | Non-Hispanic Asian/Pacific Islander | Non-Hispanic American Indian/Alaska Native |
|-----------------------------------|----------|--------------------|--------------------|----------|-------------------------------------|--|
| Cause of Death | % (Rank) | % (Rank) | % (Rank) | % (Rank) | % (Rank) | % (Rank) |
| Heart Disease | 25.8 (1) | 26.1 (1) | 25.5 (1) | 22.8 (1) | 22.7 (2) | 18.8 (2) |
| Malignant Neoplasms (cancer) | 22.0 (2) | 22.0 (2) | 21.6 (2) | 21.7 (2) | 27.3 (1) | 19.3 (1) |
| Cerebrovascular Diseases (stroke) | 6.7 (3) | 6.7 (3) | 6.8 (3) | 6.4 (3) | 9.4 (3) | 4.8 (5) |
| Chronic Lower Respiratory Disease | 5.3 (4) | 5.9 (4) | 2.5 (7) | 2.7 (6) | 2.4 (7) | 4.3 (6) |
| Alzheimer's Disease | 4.2 (5) | 4.6 (5) | 2.3 (9) | 2.7 (7) | 2.2 (8) | N/A |
| Unintentional Injury | 3.5 (6) | 3.4 (6) | 3.0 (6) | 5.0 (5) | 3.8 (5) | 8.2 (3) |
| Diabetes Mellitus | 3.0 (7) | 2.5 (8) | 5.0 (4) | 5.4 (4) | 3.8 (4) | 7.1 (4) |
| Influenza and Pneumonia | 2.5 (8) | 2.6 (7) | 2.0 (10) | 2.6 (8) | 2.9 (6) | 2.1 (9) |
| Nephritis (kidney inflammation) | 1.9 (9) | 1.7 (9) | 3.3 (5) | 2.2 (9) | 2.0 (9) | 2.3 (8) |
| Septicemia (blood poisoning) | 1.5 (10) | 1.4 (10) | 2.4 (8) | N/A | N/A | 1.7 (10) |

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

ACTIVITY LIMITATIONS AND DISABILITIES

Although disability may be defined in many different ways, 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 2007, nearly 14.4 percent of adults reported having at least one condition that limited their ability to perform one or more of these common activities (data not shown). Women were more likely than men to report being limited in their activities (15.6 versus 13.0 percent, respectively).

The percentage of adults reporting at least one activity limitation varied with age among both men and women. Only 6.5 percent of women aged 18–44 years reported any activity limitation, compared to 28.9 percent of women aged 65–74 years and 47.9 percent of women aged 75 years or older.

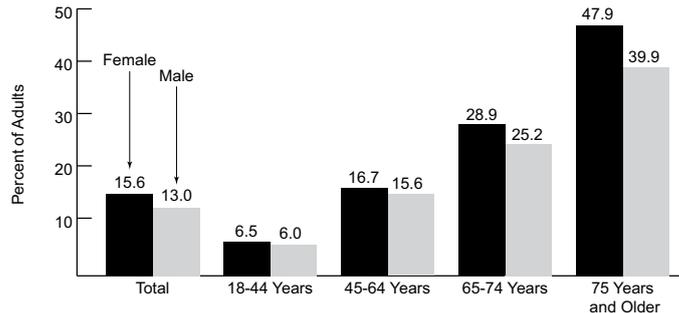
In 2007, the percentage of women reporting at least one activity limitation varied by race and ethnicity. Non-Hispanic Black women were most likely to report at least one limitation (18.4 percent), followed by non-Hispanic White women (16.5 percent). Asian women were least likely to report any activity limitation (7.1 percent).

More than 10 percent of Hispanic women also reported an activity limitation (data not shown).

Among women with any activity limitations, the causes of these limitations also varied by race and ethnicity. For instance, 30.1 percent of non-Hispanic Black women who were limited in some way cited arthritis or rheumatism as the condition limiting their activity, compared to 26.5 percent of non-Hispanic White and 25.5 percent of Hispanic women. Depression, anxiety, and emotional problems were the cause of activity limitation among 16.8 percent of Hispanic women, 12.4 percent of non-Hispanic White and 9.7 percent of non-Hispanic Black women.

Adults Aged 18 and Older with at Least One Activity Limitation,* by Age and Sex, 2007

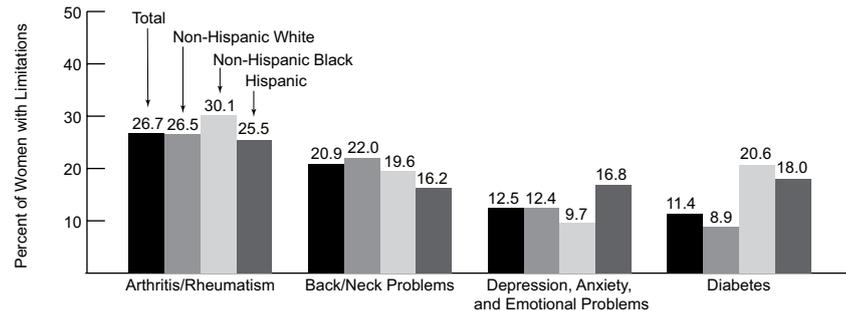
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Activity Limitations,* by Selected Condition and Race/Ethnicity,** 2007

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



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

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

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. Arthritis is the second most common cause of work disability and restricts daily activities such as walking, dressing, and bathing for more than seven million Americans.⁸ The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement due to deterioration in the cartilage covering the ends of bones in the joints. Types of arthritis that primarily affect women

include lupus arthritis, fibromyalgia, and rheumatoid arthritis, which is the most serious and disabling type of arthritis.⁸

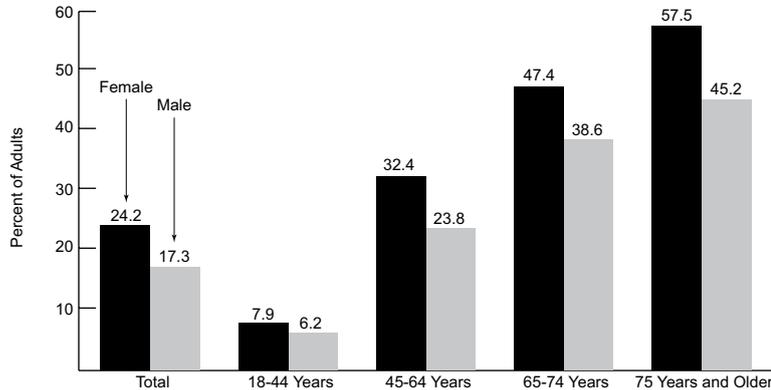
In 2007, nearly 21 percent of adults in the United States reported that they had ever been diagnosed with arthritis; this represents more than 46 million adults (data not shown). Arthritis was more common among women than men (24.2 versus 17.3 percent, respectively), and rates of arthritis increased dramatically with age for both sexes. Fewer than 8 percent of women aged 18–44 years had been diagnosed with arthritis, compared to 47.4 percent of women

aged 65–74 years, and 57.5 percent of women aged 75 years and older.

In 2007, the rate of arthritis among women varied by race and ethnicity. Arthritis was most common among non-Hispanic White women (27.2 percent), followed by non-Hispanic women of other races (23.2 percent) and non-Hispanic Black women (22.2 percent). Non-Hispanic Asian and Hispanic women were least likely to report having ever been told that they have arthritis (8.9 and 15.4 percent, respectively).

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2007

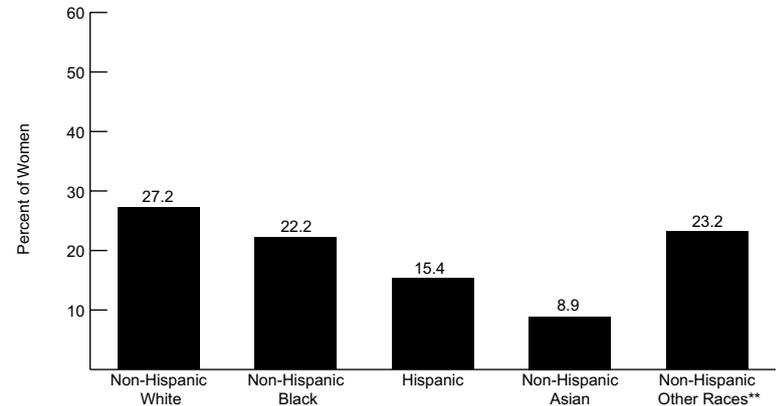
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity, 2007

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



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

ASTHMA

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

In 2007, women were more likely to have asthma than men (9.0 versus 5.4 percent, re-

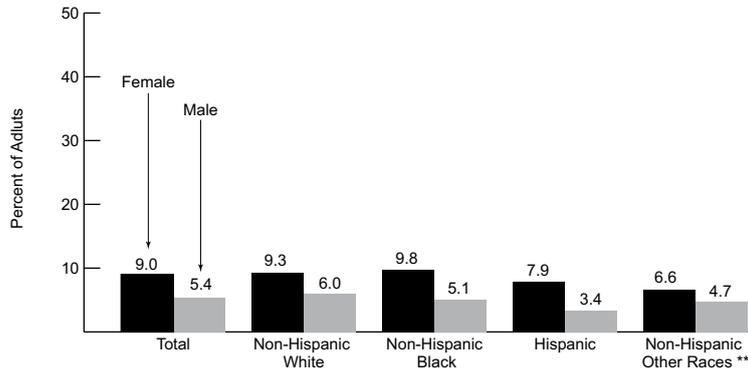
spectively); this was true in every racial and ethnic group. Among women, non-Hispanic Black women were most likely to have asthma (9.8 percent), followed by non-Hispanic White women (9.3 percent). Non-Hispanic women of other races and Hispanic women were least likely to have asthma (6.6 and 7.9 percent, respectively).

A visit to the emergency room due to asthma may be an indication that the asthma is not effectively controlled or treated. In 2007, asthmatic women with family incomes below pov-

erty were more likely than women with higher family incomes to have an emergency room visit due to asthma. Among women with family incomes less than 100 percent of poverty, 32.4 percent of those with asthma had visited the emergency room in the past year, compared to 14.5 percent of asthmatic women with family incomes of 300 percent or more of poverty. Consistent access to and use of medication can reduce the use of hospital and emergency room care for people with asthma.⁹

Adults Aged 18 and Older with Asthma,* by Race/Ethnicity and Sex, 2007

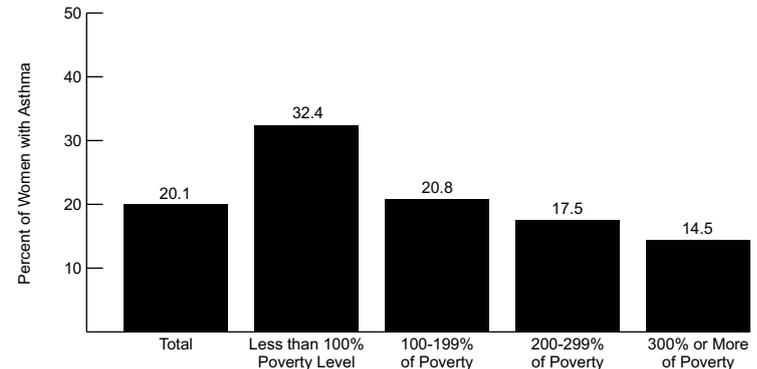
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with an Emergency Room Visit Due to Asthma in the Past Year, by Poverty Status,* 2007

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



*Poverty level, defined by the U.S. Census Bureau, was \$21,027 for a family of four in 2007.

BLEEDING DISORDERS

Bleeding disorders occur when components in the blood, called “factors,” are missing or do not work correctly. This hinders blood clotting and makes it harder for the body to stop bleeding. One widely recognized bleeding disorder, hemophilia, sometimes occurs in females; more often, however, females carry the gene that causes the disorder. The most common bleeding disorder among females is von Willebrand Disease (VWD). Up to 3 million Americans, half of whom are female, have VWD. Typical symptoms of VWD and other bleeding disorders for females include heavy menstrual periods, easy bruising, frequent nosebleeds, and prolonged bleeding after minor injuries, surgery, childbirth, or dental work. Of the approximately 12 percent of menstruating girls and women who have heavy menstrual bleeding (menorrhagia),¹⁰ 13 percent may have an inherited bleeding disorder.¹¹ Unfortunately, most of these disorders go undiagnosed.

The U.S. Department of Health and Human Service’s National Institutes of Health recently published guidelines about diagnosing, evaluating, and treating VWD. Diagnosing a bleeding disorder requires taking a personal medical history, a family medical history, and conducting special laboratory tests. Fortunately, many of these disorders can be treated, allowing affected women to live a normal life. The guidelines

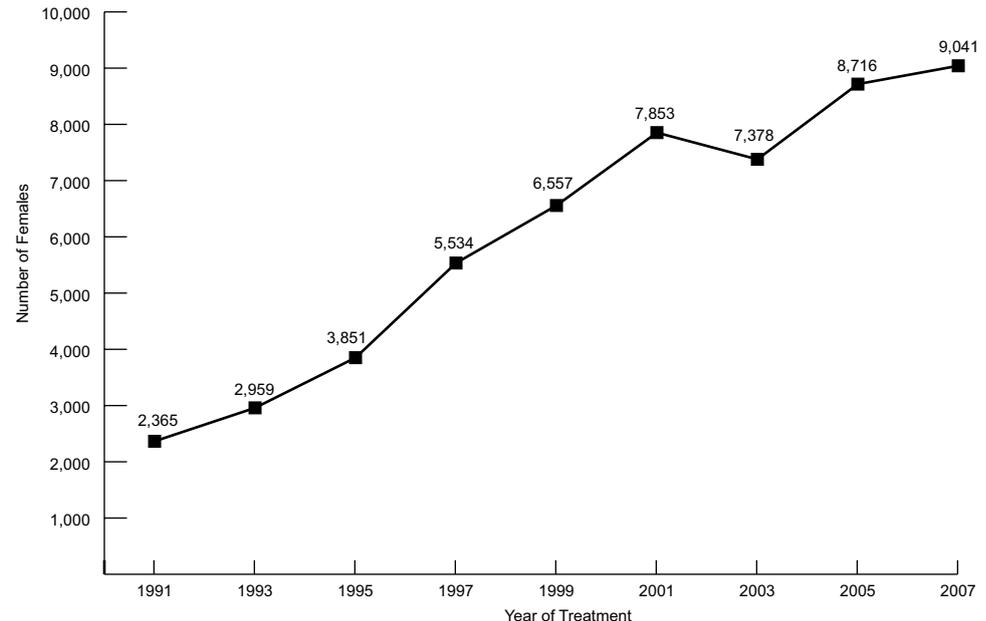
can be found at www.nhlbi.nih.gov/guidelines/vwd/.

Experts in diagnosing and treating bleeding disorders can be found throughout the United States and its jurisdictions at more than 130 federally-funded hemophilia treatment centers (HTC). HTC treat a wide range of bleeding disorders, primarily inherited bleeding and clotting

disorders. From 1991 to 2007, the number of female HTC patients grew nearly 300 percent, from 2,365 to 9,041. To locate an HTC, visit http://www.cdc.gov/ncbddd/hbd/htc_list.htm. For more information about bleeding disorders, call the National Hemophilia Foundation at 1-800-42-HANDI or visit www.hemophilia.org.

Females Treated for Bleeding Disorders at Hemophilia Treatment Centers, 1991–2007

Source II.6: Centers for Disease Control and Prevention and Health Resources and Services Administration

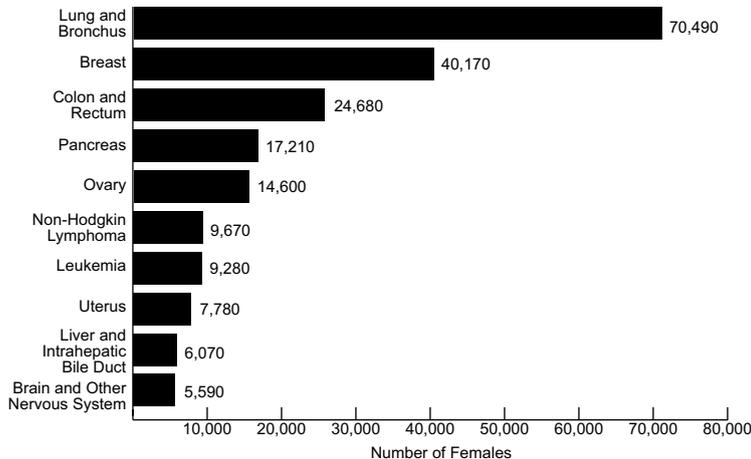


CANCER

It is estimated that 713,220 new cancer cases will be diagnosed among females, and more than 269,000 females will die of cancer in 2009. Lung and bronchus cancer is expected to be the leading cause of cancer death among females, accounting for 70,490 deaths, or 26 percent of all cancer deaths, followed by breast cancer, which will be responsible for 40,170, or 15 percent of deaths. Colon and rectal cancer, pancreatic cancer, and ovarian cancer will also be significant causes of cancer deaths among females, accounting for an additional 56,490 deaths combined.

Leading Causes of Cancer Deaths Among Females, by Site, 2009 Estimates

Source II.7: American Cancer Society



Due to the varying survival rates for different types of cancer, the most common causes of cancer death are not always the most common types of cancer. For instance, although lung and bronchus cancers cause the greatest number of deaths, breast cancer is more commonly diagnosed among women. In 2005, invasive breast cancer occurred among 117.7 per 100,000 women whereas lung and bronchus cancers occurred in only 55.2 per 100,000 women. Other types of cancer that are commonly diagnosed among females but are not among the top 10 causes of cancer deaths include melanoma, thyroid, and

cervical cancer, occurring in 15.1, 14.9, and 8.1 per 100,000 women, respectively.

Cervical cancer incidence varies by race and ethnicity; in 2005, Hispanic and Black females were most likely to have been diagnosed with invasive cervical cancer (12.4 and 10.3 per 100,000, respectively), compared to 7.7 per 100,000 White females. Cervical cancer screenings are recommended at least every 3 years beginning within 3 years of sexual activity or by age 21. In addition, a vaccine for genital human papillomavirus (the leading cause of cervical cancer) was approved for use by the Food and Drug Administration in

Invasive Cancer Rates per 100,000 Females, by Site and Race/Ethnicity, 2005*

Source II.8: Centers for Disease Control and Prevention and National Cancer Institute

| | Total | White** | Black** | Hispanic | Asian/Pacific Islander [†] | American Indian/Alaska Native [†] |
|----------------------|-------|---------|---------|----------|-------------------------------------|--|
| Breast | 117.7 | 119.1 | 110.2 | 89.8 | 78.8 | 59.4 |
| Lung and Bronchus | 55.2 | 56.6 | 50.9 | 25.2 | 26.9 | 24.5 |
| Colon and Rectum | 41.9 | 40.8 | 49.4 | 33.9 | 32.2 | 37.6 |
| Non-Hodgkin Lymphoma | 15.9 | 16.3 | 10.9 | 15.1 | 9.9 | 8.5 |
| Melanoma | 15.1 | 17.0 | 0.9 | 4.2 | 1.3 | 3.6 |
| Thyroid | 14.9 | 15.5 | 9.7 | 14.7 | 14.9 | 6.6 |
| Cervix | 8.1 | 7.7 | 10.3 | 12.4 | 7.4 | 6.2 |

*All rates are age-adjusted. **Includes Hispanics. [†]Results should be interpreted with caution; includes Hispanics.

2006 and is recommended for adolescents and young women aged 9–26 years.¹² In 2006–2007, 10 percent of women aged 18–26 years had been vaccinated for HPV (data not shown).¹³

In 2000–2005, non-Hispanic White females were more likely than women of other races and ethnicities to be diagnosed with endometrial or uterine cancer (25.4 per 100,000). Overall, non-Hispanic White and Black women aged 65 years and older were most likely to have this type of cancer (92.1 and 84.3 per 100,000 women, respectively), followed by Hispanic women of

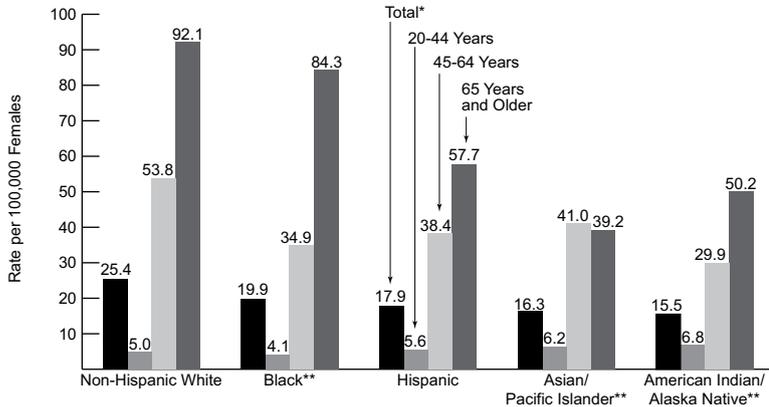
the same age group (57.7 per 100,000). Among 45- to 64-year-olds, American Indian/Alaska Native women were least likely to have endometrial or uterine cancer (29.9 per 100,000), while Black women were least likely among those aged 20–44 years (4.1 per 100,000).

Survival rates for ovarian cancer vary depending on how early it is discovered. For females diagnosed with ovarian cancer in 1996–2004, 45.6 percent could expect to live 5 years or more; however, this varied by race and the stage of the cancer. Black women were slightly more

likely than White women to live at least 5 years when the cancer was diagnosed in the localized stage (94.3 versus 92.1 percent, respectively). Comparatively, 71.3 percent of White females and 50.7 percent of Black females could expect the same when the cancer is in the regional stage (spread beyond the primary site). Among those whose cancer is diagnosed at the distant stage (spread to distant organs or lymph nodes), only 30.7 percent of White females and 22.6 percent of Black females could expect to live 5 more years.

Endometrial and Uterine Cancer Incidence, by Race/Ethnicity and Age, 2000–2005

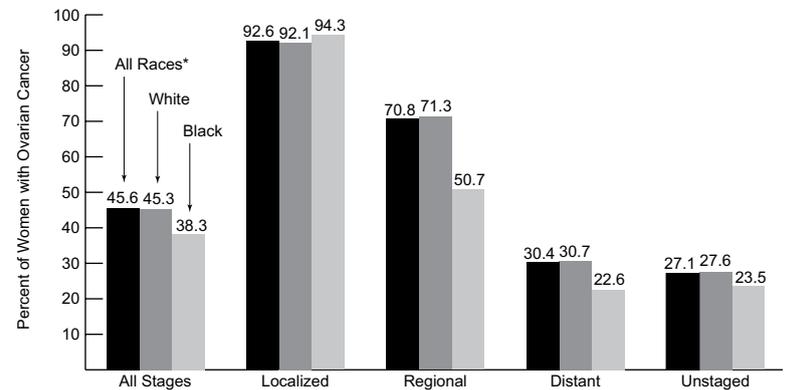
Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*Totals include females of all ages. **May include Hispanics.

Five-year Period Survival Rates for Ovarian Cancer, by Race and Stage,** 1996–2004

Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program



*Includes races and ethnicities other than White and Black. **Localized cancer is limited to the organ in which it began (no evidence of spread); regional cancer has spread beyond the primary site; distant cancer has spread to distant organs or lymph nodes; and unstaged indicates that there was not enough information to determine a stage.

DIABETES

Diabetes mellitus is a chronic condition and a leading cause of death and disability in the United States. Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, and nervous system disease. Diabetes is becoming increasingly common among children and young adults. The main types of diabetes are Type 1, Type 2, and gestational (occurring only during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults, but may occur at any age. Type 2 diabetes is the most common; it is of-

ten diagnosed among adults but has increased among children. Risk factors for Type 2 diabetes include obesity, physical inactivity, and a family history of the disease.

In 2005–2006, 76.0 per 1,000 adults reported that they had been told by a health professional that they have diabetes (data not shown). Women were slightly more likely than men to have diabetes overall (81.2 versus 70.4 per 1,000 adults, respectively) and in most age groups.

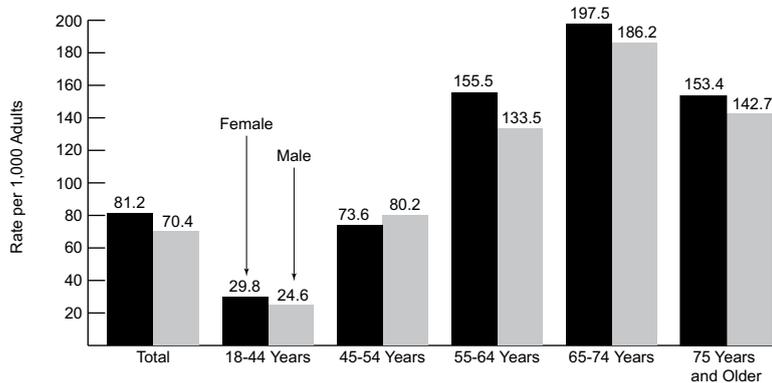
Diabetes prevalence generally increases with age. Fewer than 30 per 1,000 women aged 18–44 years had diabetes, compared to 197.5 per

1,000 women aged 65–74 years. Women aged 55–64 and 75 years and older also had relatively high rates of diabetes (155.5 and 153.4 per 1,000 women, respectively).

Among adults aged 18 years and older who were found to have diabetes (based on the results of a Fasting Plasma Glucose test), 33.2 percent had never been told by a health professional that they have diabetes. Women who tested positive were less likely than men to have reported never being diagnosed by a health professional (24.1 versus 45.2 percent, respectively).

Adults Aged 18 and Older Who Have Been Diagnosed With Diabetes,* by Age and Sex, 2005–2006

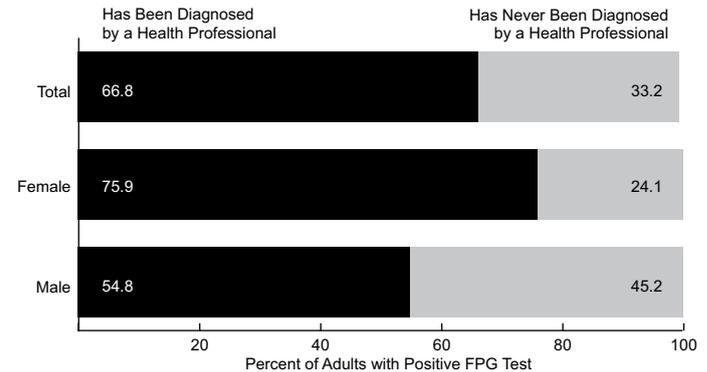
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional has ever told them they have diabetes; does not include gestational diabetes. Rates are not age-adjusted.

Adults Aged 18 and Older Who Tested Positive for Diabetes,* by Sex and Diagnosis Status, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Tested positive on a Fasting Plasma Glucose (FPG) test; does not include people with diabetes whose blood glucose is controlled. Rates are not age-adjusted.

OVERWEIGHT AND OBESITY

Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke, arthritis, certain types of cancer, and reproductive health risks.¹⁴ Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2005–2006, 32.4 percent of adults were overweight (BMI of 25.0–29.9), while an additional 33.8 percent were

obese (BMI of 30.0 or more; data not shown).

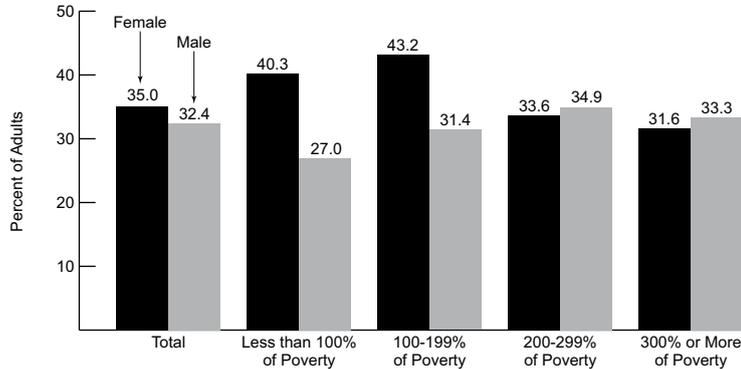
While women and men had similar rates of obesity in 2005–2006 (35.0 and 32.4 percent, respectively), rates among women varied by poverty status. Among women, obesity was lowest among those with higher incomes. More than 40 percent of women with household incomes below 200 percent of the poverty level were obese, compared to 31.6 percent of women with incomes of 300 percent or more of poverty and 33.6 percent of those with incomes of 200–299

percent of poverty. Among men, however, obesity rates did not vary significantly with poverty status.

Women were more likely than men to be severely obese, defined as having a BMI of 40.0 or more (7.3 versus 4.1 percent, respectively). Non-Hispanic Black women were more likely than non-Hispanic White and Hispanic women to be severely obese (13.7 versus 6.6 and 5.4 percent, respectively).

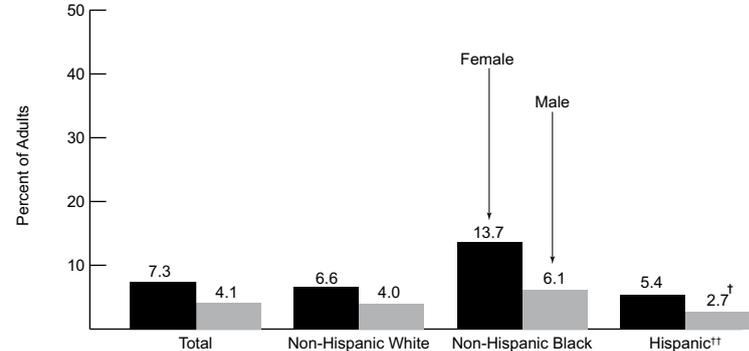
Obesity* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Severe Obesity* Among Adults Aged 18 and Older, by Race/Ethnicity** and Sex, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Defined as having a Body Mass Index (BMI) of 40.0 or more. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of multiple races, and persons of other races was too small to produce reliable results. †This result should be interpreted with caution; the relative standard error was greater than 30 percent. ††Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population.

*Defined as having a Body Mass Index (BMI) of 30.0 or more. Rates are not age-adjusted.
 **Poverty, defined by the U.S. Census Bureau, was \$20,444 for a family of four in 2006.

DIGESTIVE DISORDERS

Digestive disorders, or gastrointestinal diseases, include a number of conditions that affect the digestive system, including heartburn; constipation; hemorrhoids; irritable bowel syndrome; ulcers; gallstones; celiac disease (a genetic disorder in which consumption of gluten damages the intestines); and inflammatory bowel diseases, including Crohn's disease (which causes ulcers to form in the gastrointestinal tract). Digestive disorders are estimated to affect 60–70 million people in the United States.¹⁵

While recent data are not readily available on the prevalence of many of these diseases by race and ethnicity or sex, it is estimated that 8.5 million people in the United States are affected by hemorrhoids each year; 2.1 million people are affected by irritable bowel syndrome; and gallstones affect 20.5 million people.¹⁵

Peptic ulcers are most commonly caused by a bacterium called *Helicobacter pylori* (*H. pylori*). *H. pylori* weakens the mucous coating of the stomach and duodenum, allowing acids to irritate the sensitive lining beneath. In 2007, 7.1 percent of adults reported that they had ever been told by a health professional that they have an ulcer (data not shown). Among women, the likelihood of having ever had an ulcer increased with age. Women aged 65 years and older were most likely to have reported ever having had an ulcer (11.1 percent), followed by women aged

45–64 years (8.6 percent). In comparison, fewer than 4 percent of women aged 18–24 years had ever had an ulcer.

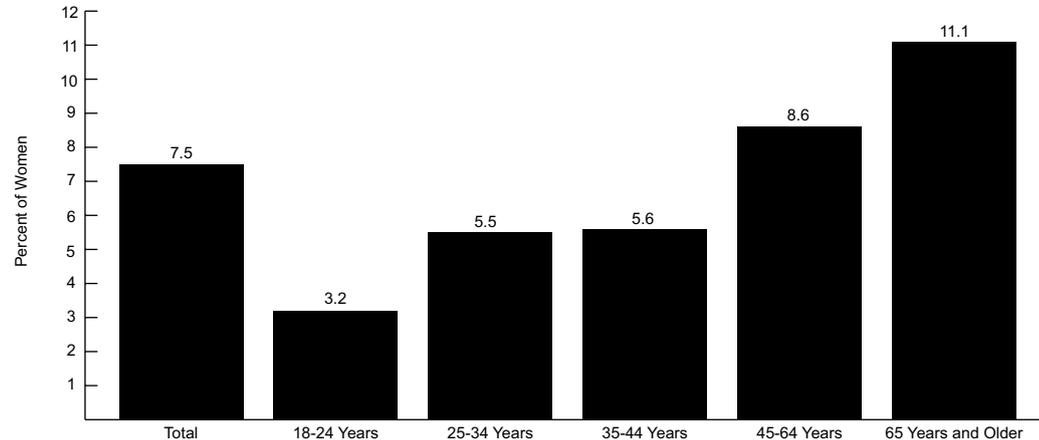
There was also some variation among women reporting having ever had an ulcer by race and ethnicity. Non-Hispanic White women were most likely to report having had an ulcer (8.3 percent), followed by non-Hispanic Black (5.6 percent) and Hispanic women (5.3 percent). Asian women were least likely to report ever having had an ulcer (3.5 percent; data not shown).

Women with family incomes below 200 percent of the poverty line were also more likely than women with incomes above that threshold to have ever had an ulcer (9.8 versus 6.8 percent, respectively; data not shown).

In 2006, digestive system symptoms accounted for 35.9 million visits to doctor's offices and 3.2 million visits to hospital outpatient departments, while an additional 7.2 million visits to emergency departments were attributed to a digestive system diagnosis.¹⁶

Women Aged 18 and Older Who Have Ever Had an Ulcer,* by Age, 2007

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



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

ENDOCRINE AND METABOLIC DISORDERS

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

Polycystic ovary syndrome (PCOS) is one of

the most common endocrine disorders among women of reproductive age, and is the most common cause of endocrine-related female infertility in the United States. An estimated 1 in 10 women of childbearing age has PCOS, and it can occur in females as young as 11 years of age. In addition, PCOS may put women at risk for other health conditions, including high blood pressure, heart disease, and diabetes.¹⁷

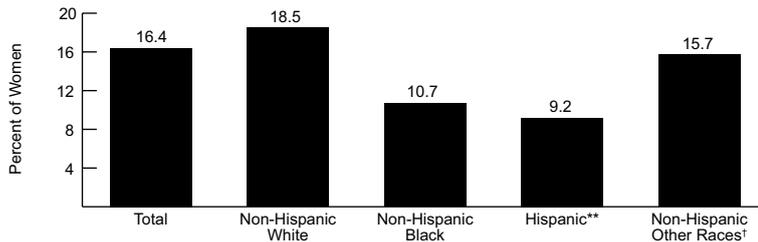
Hyperthyroidism and hypothyroidism are also common endocrine disorders. In 2005–2006, women were nearly five times more likely than men to report having ever been told by a health professional that they have a thyroid problem (16.4 versus 3.4 percent, respectively; data not shown). Among women, rates varied

by race and ethnicity. Non-Hispanic White women were most likely to report a thyroid problem (18.5 percent), while Hispanic women were least likely (9.2 percent).

In 2006, the rate of physician visits due to endocrine and metabolic disorders varied by sex: 4.0 percent of physician visits made by men were for disorders of endocrine glands other than the thyroid, compared to 3.1 percent of visits made by women. The rate of visits due to metabolic and immunity disorders was also higher among men than women (2.7 versus 1.9 percent of visits, respectively). However, the rate of visits for thyroid disorders was higher among women than men (0.8 versus 0.3 percent of visits, respectively).

Thyroid Problems* Among Women Aged 20 and Older, by Race/Ethnicity, 2005–2006

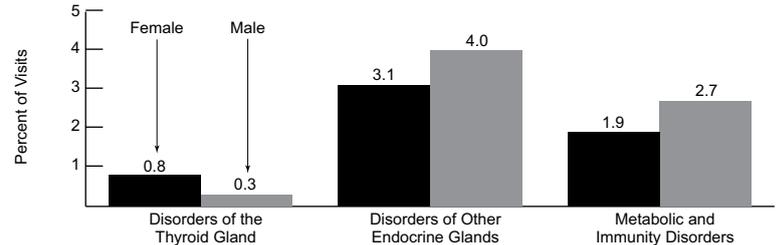
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional has ever told them they have a thyroid problem; includes hyperthyroidism and hypothyroidism **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. †Includes American Indian/Alaska Natives, Asian/Pacific Islanders, persons of more than one race, and persons of all other races.

Physician Visits by Adults Aged 18 and Older Due to Endocrine and Metabolic Disorders,* by Sex, 2006

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



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

GYNECOLOGICAL AND REPRODUCTIVE DISORDERS

Gynecological disorders affect the internal and external organs in the female pelvic and abdominal areas. These disorders include dysmenorrhea (pain associated with menstruation), vulvodynia (unexplained chronic discomfort or pain of the vulva), and chronic pelvic pain (a persistent and severe pain occurring primarily in the lower abdomen for at least 6 months).

Some problems can affect the proper functioning of the reproductive system and may affect a woman's ability to get pregnant. One example, polycystic ovary syndrome, occurs when immature follicles in the ovaries form together to create a large cyst, preventing mature eggs from being released. Another reproductive disorder,

endometriosis, occurs when the type of tissue that lines the uterus grows elsewhere, such as on the ovaries or other abdominal organs. Uterine fibroids are non-cancerous tumors that grow in the uterine cavity, within the wall of the uterus, or on the outside of the uterus.

In 2005–2006, 9.3 percent of women aged 20–54 years had ever been told by a health professional that they have endometriosis and 12.6 percent had been told that they have uterine fibroids. Overall, endometriosis was most common among those aged 35–44 years (13.4 percent), while uterine fibroids were most common among those aged 45–54 years (25.6 percent).

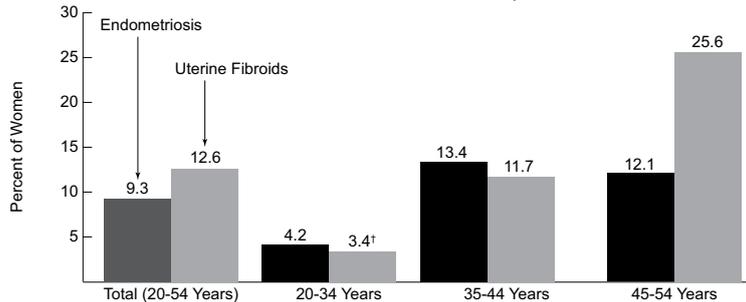
In 2006, 34.1 per 1,000 physician visits among women aged 18 years and older were for gynecological or reproductive problems. Women

aged 18–24 years were most likely to visit a physician for gynecological or reproductive disorders (57.8 per 1,000 visits), while women aged 65 years and older were least likely (16.7 per 1,000).

Some women take supplemental hormones for gynecological or other health problems, sometimes to reduce the symptoms of menopause. In 2005–2006, 27.0 percent of females reported ever having taken female hormones (not including birth control or fertility medications). Non-Hispanic White women (31.8 percent) were more likely than non-Hispanic Black and Hispanic women to report having ever taken hormones (17.2 and 11.6 percent, respectively; data not shown).¹⁸

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

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey

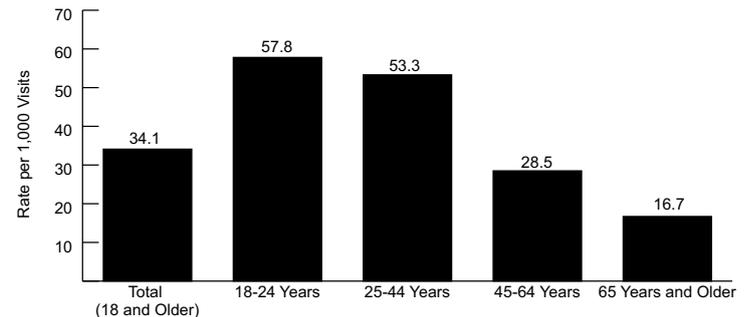


*Reported a health professional had ever told them they have endometriosis or uterine fibroids.

†This result should be interpreted with caution; the relative standard error was greater than 30 percent.

Physician Visits by Women Aged 18 and Older Due to Gynecological and Reproductive Problems,* by Age, 2006

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



*Based on ICD-9-CM codes: 179-184, 221, 256, 614-616, 617-629, and 752.

HEARING PROBLEMS

Hearing problems can significantly and adversely affect a person's quality of life, making it difficult to understand a doctor's advice, hear alarms, and communicate with friends and family members. In 2007, 85.1 percent of adults reported excellent or good hearing without the use of an aid, while 14.7 percent reported at least some trouble hearing and 0.2 percent were deaf (data not shown). Women were less likely than men to have reported trouble hearing overall (11.9 versus 17.7 percent, respectively), and in every age group. For instance, among adults aged 75 years

and older, 37.6 percent of women had trouble hearing compared to 53.1 percent of men.

The percentage of adults who reported trouble hearing increased with age for both men and women. Among women, 5.0 percent of 18- to 44-year-olds reported trouble hearing without the use of an aid, compared to 12.4 percent of those aged 45–64 years and 24.7 percent of those aged 65–74.

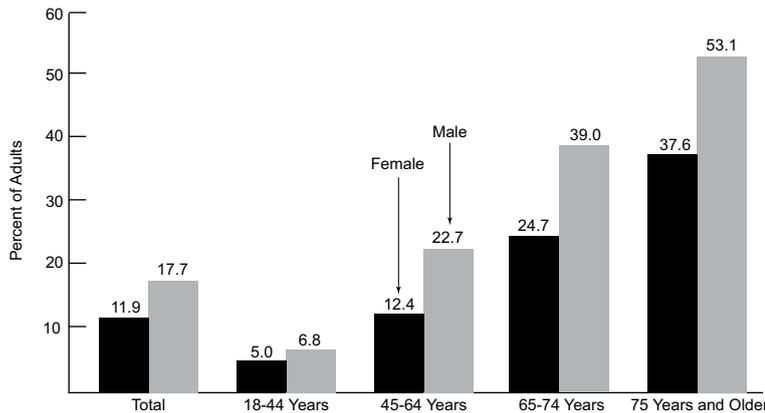
The use of hearing aids also increases with age. Among women, 13.8 percent of those aged 75 and older reported using a hearing aid, while only 3.8 percent of 65- to 74-year-olds and fewer

than 1 percent of those aged 45–64 years did so.

Tinnitus is the term used for a persistent ringing, buzzing, or roaring sound in the ears or head. In 2007, 8.8 percent of women reported symptoms congruent with tinnitus. This varied, however, by race and ethnicity. Non-Hispanic White women were more likely than non-Hispanic Black and Hispanic women to have tinnitus (9.6 versus 7.6 and 6.6 percent, respectively). Non-Hispanic Asian women were least likely to have reported experiencing tinnitus (4.1 percent; data not shown).

Adults Aged 18 and Older Reporting Trouble Hearing,* by Age and Sex, 2007

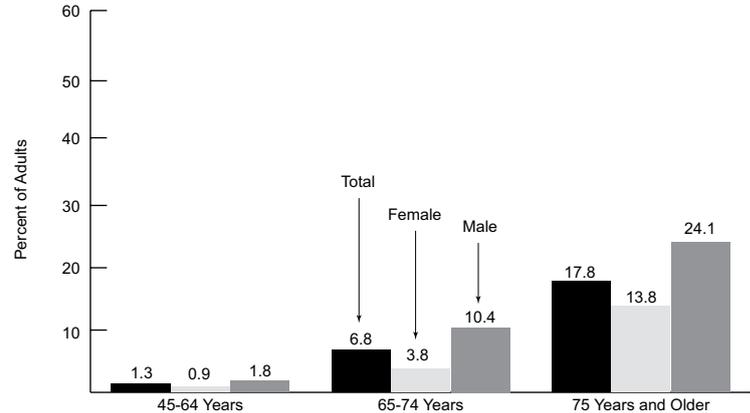
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported "a little," "moderate," or "a lot of" trouble hearing; does not include those reporting "deaf."

Use of Hearing Aids Among Adults Aged 45 and Older, by Age and Sex, 2007

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



HEART DISEASE AND STROKE

In 2006, heart disease was the leading cause of death among both men and women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common type of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow to the heart muscle. Risk factors include obesity, lack of physical activity, smoking, high cholesterol, hypertension, and old age. While the most common symptom of a heart attack is chest pain or discomfort, women are more likely than men to have symptoms such as shortness of breath, nausea and vomiting, and back or jaw pain.¹⁹

Stroke is a type of cardiovascular disease that affects blood flow to the brain. Warning signs

are sudden and can include facial, arm, or leg numbness, especially on one side of the body; severe headache; trouble walking; dizziness; a loss of balance or coordination; or trouble seeing in one or both eyes.¹⁹

In 2007, women were slightly less likely than men to have ever been told by a health professional that they have heart disease (10.7 versus 11.9 percent, respectively). Among women, non-Hispanic Asians and Hispanics were least likely to be diagnosed with heart disease (5.1 and 6.9 percent, respectively).

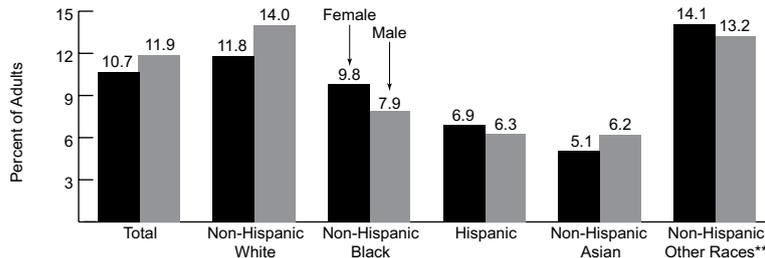
In 2006, there were nearly 2 million hospital discharges due to heart disease among women aged 18 years and older, resulting in a rate of 171.2 discharges per 10,000 women. Rates of hospital discharges due to heart disease increased

with age: the rate among women aged 45–64 years was 125.4 per 10,000, compared to 874.4 per 10,000 women aged 75 years and older.

There is evidence that women diagnosed with acute myocardial infarction (AMI), or heart attack, are less likely than men with AMI to receive certain treatments that have been reported to improve outcomes.²⁰ Research also suggests that physicians are less likely to counsel women about modifiable risk factors, such as diet and exercise, and that after a first heart attack, women are less likely than men to receive cardiac rehabilitation, though the reasons for these sex disparities are unclear.²¹

Adults Aged 18 and Older with Heart Disease,* by Race/Ethnicity and Sex, 2007

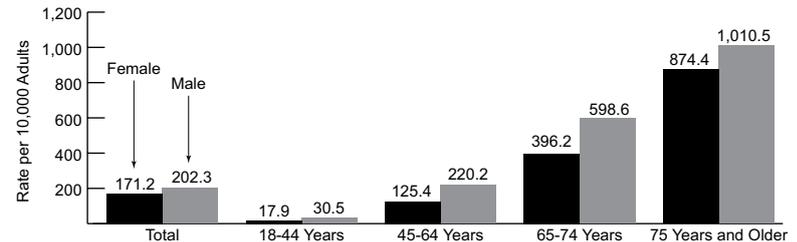
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them they have a heart condition or heart disease. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.

Discharges Due to Heart Disease* from Non-Federal, Short-Stay Hospitals, by Age and Sex, 2006

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



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

HIGH BLOOD PRESSURE

High blood pressure is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. An examination of adults' blood pressure in 2005–2006 showed that men had higher overall rates of high blood pressure than women (17.3 versus 16.0 percent, respectively).

Rates of high blood pressure among women varied by race and ethnicity. Non-Hispanic Black and non-Hispanic White women were most likely to have high blood pressure (19.9

and 16.3 percent, respectively), while Hispanic women were least likely (11.7 percent).

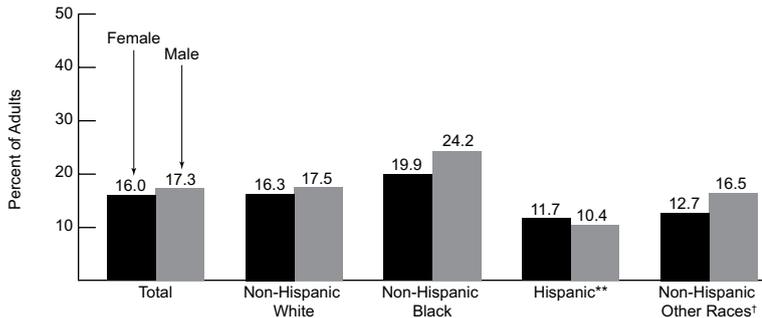
The prevalence of high blood pressure among both men and women increases with age. Among women in 2003–2006, those aged 65 years and older were most likely to have high blood pressure (47.4 percent), compared to 23.4 percent of women aged 45–64 years. Women aged 20–44 years were least likely to have high blood pressure (3.1 percent).

Antihypertensive drugs work to lower the body's blood pressure. The proportion of adults with high blood pressure who were not taking medication for the condition varied by sex, as

well as race and ethnicity. In 2005–2006, 62.6 percent of men and 42.4 percent of women found to have high blood pressure were not taking antihypertensive medication. Among women with high blood pressure, Hispanics were least likely to be taking medication: 64.4 percent reported not taking antihypertensive medication. Nearly one-third of non-Hispanic Black and 41.1 percent of non-Hispanic White women had high blood pressure but were not taking medication for the condition (data not shown).

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

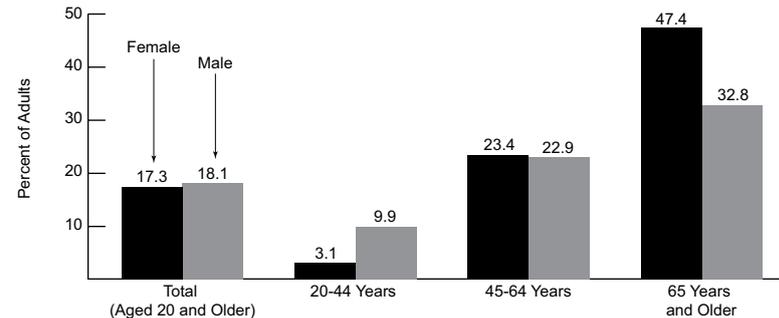
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher. Rates are not age-adjusted. **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population. ¹Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races.

Adults Aged 20 and Older with High Blood Pressure,* by Age and Sex, 2003–2006

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



*At the time of examination had a systolic pressure (during heartbeats) of 140 or higher, and/or a diastolic pressure (between heartbeats) of 90 or higher.

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the final stage of infection with the human immunodeficiency virus (HIV), which destroys or disables the cells that are responsible for fighting infection. AIDS is diagnosed when HIV has weakened the immune system enough that the body has a difficult time fighting infections.²² While HIV and AIDS disproportionately affect men, a growing number of women are also affected; in 2006, there were an estimated 11.9 new cases of HIV per 100,000 females aged 13 and older in the United States.

Rates of HIV incidence vary by sex, age, and race/ethnicity. Among both males and females, rates of new HIV infections increase with age until age 40, then decrease. Among females,

those aged 30–39 years had the highest HIV incidence rate (22.8 per 100,000), followed by females aged 40–49 and 13–29 years (16.6 and 14.0 per 100,000, respectively). Women aged 50 years and older had the lowest HIV incidence rate in 2006 (3.5 per 100,000).

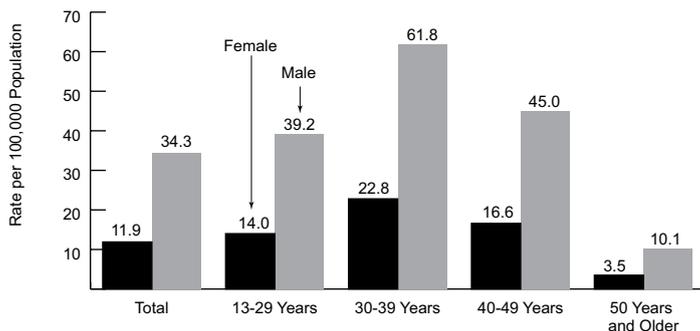
Among females aged 13 and older, Black women had the highest incidence rates (55.7 per 100,000), followed by Hispanic and American Indian/Alaska Native women (14.4 and 12.8 per 100,000, respectively). While being of a particular race or ethnicity does not increase the likelihood of contracting HIV, certain challenges exist for non-Hispanic Black and Hispanic females putting them at greater risk for infection: socioeconomic factors such as limited access to quality health care; language and cultural barriers,

particularly for Hispanics, which can affect the quality of health care; high rates of sexually transmitted infections, which increase the risk of HIV infection; and substance abuse.²³

In 2007, high-risk heterosexual contact (including sex with an injection drug user, sex with men who have sex with men, and sex with an HIV-infected person) accounted for 45.9 percent of new cases of HIV infection among adolescent and adult females, while injection drug use accounted for an additional 14.3 percent. In 39.2 percent of new cases, the transmission category was not reported or identified, and 0.5 percent of new cases were due to blood transfusions or receipt of blood components or tissue (data not shown).

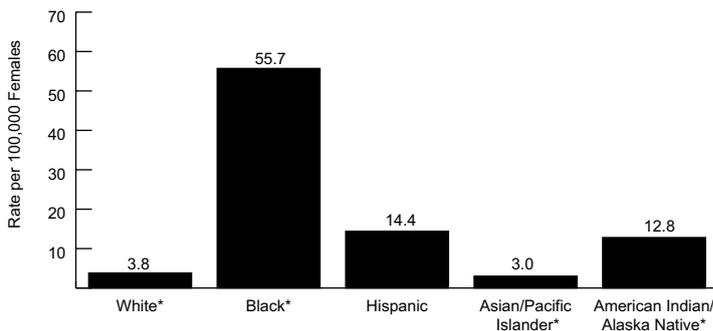
Estimated HIV Incidence Among Persons Aged 13 and Older, by Age and Sex, 2006

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



Estimated HIV Incidence Among Females Aged 13 and Older, by Race/Ethnicity, 2006

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



*Includes Hispanics.

SEXUALLY TRANSMITTED INFECTIONS

Reported rates of sexually transmitted infections (STIs) among females vary by age. Rates of chlamydia, gonorrhea, and syphilis are highest among adolescents and young adults. In 2007, there were 3,004.7 reported cases of chlamydia and 647.9 reported cases of gonorrhea per 100,000 females aged 15–19 years, compared to 28.5 and 12.1 reported cases per 100,000 women aged 45–54 years, respectively. Syphilis was also more common among young women in 2007, occurring among 2.4, 3.5, and 2.6

per 100,000 females aged 15–19, 20–24, and 25–29 years, respectively (data not shown).

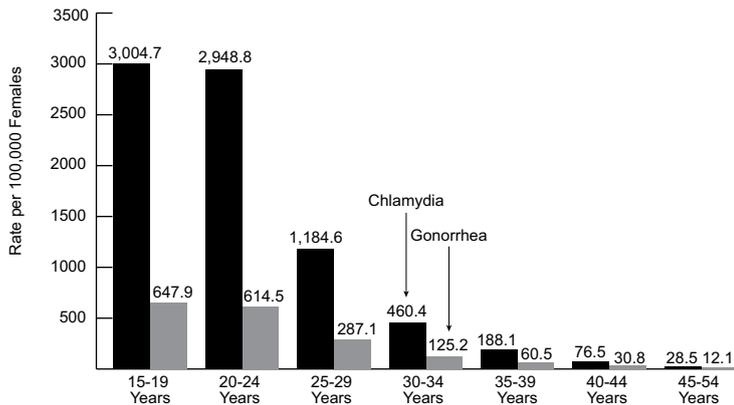
Although chlamydia, gonorrhea, and syphilis can be cured with appropriate antibiotics, left untreated they can have serious health consequences. Active infections can increase the likelihood of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes.

Some STIs cannot be cured with antibiotics but can only be treated to improve symptoms. Herpes Simplex Virus Type 2 (HSV-2) is an un-

treatable viral infection that can cause neonatal infections and increase risk for contracting HIV. HSV-2 is one of two viral infections that cause genital herpes. The prevalence of HSV-2 varies by age and sex. In 1999–2004, females were more likely than males to have HSV-2 (22.8 versus 11.2 percent, respectively). This was true for every age category. Women aged 40–49 years were most likely to have HSV-2 (33.9 percent), compared to 15.6 percent of females aged 20–29 and 2.3 percent of those aged 14–19 years.

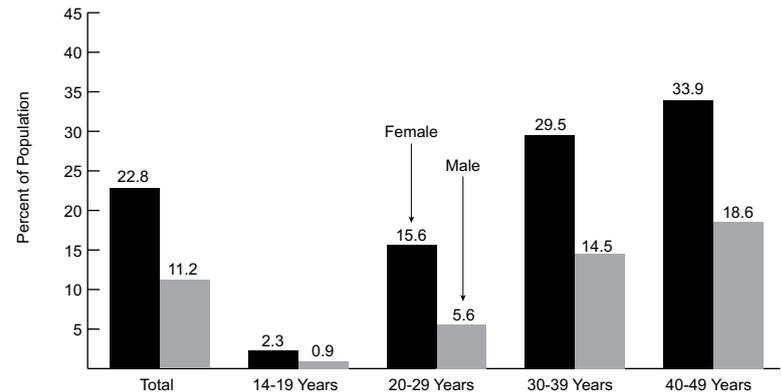
Rates of Chlamydia and Gonorrhea Among Females Aged 15–54, by Age, 2007

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



Evidence of Herpes Simplex Virus Type 2 (HSV-2) Infection Among Persons Aged 14–49, by Age and Sex, 1999–2004

Source II.15: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, as published in Xu, F, et al, 2006



INJURY

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

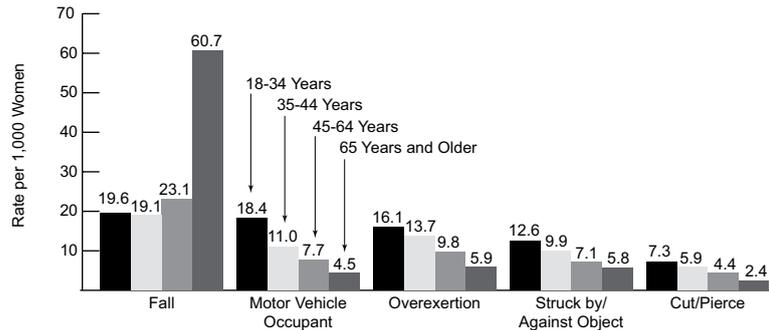
In 2007, unintentional falls were the leading cause of nonfatal injury among women of every age group, and rates generally increased with

age. Women aged 65 years and older had the highest rate of injury due to unintentional falls (60.7 per 1,000 women), while fewer than 20 per 1,000 women aged 18–34 and 35–44 years experienced fall-related injuries. Unintentional injuries sustained as motor vehicle occupants were the second leading cause of injury among 18- to 34-year-olds (18.4 per 1,000 women), while unintentional overexertion was the second leading cause of injury among women of all other age groups; 13.7 per 1,000 women aged 35–44 years experienced injury due to overexertion, as did 9.8 per 1,000 women aged 45–64, and 5.9 per 1,000 women aged 65 years and older.

Unintentional and intentional injuries each represented a higher proportion of emergency department (ED) visits for men than women in 2006. Among women and men aged 18 years and older, unintentional injuries accounted for 18.7 and 25.1 percent of ED visits, respectively, while intentional injuries, or assault, represented 1.7 and 3.0 percent of visits, respectively. Among both women and men, unintentional injury accounted for a higher percentage of ED visits among those living in non-metropolitan areas, while adults living in metropolitan areas had a slightly higher percentage of ED visits due to intentional injury.

Leading Causes of Nonfatal Injury* Among Women Aged 18 and Older, by Age, 2007

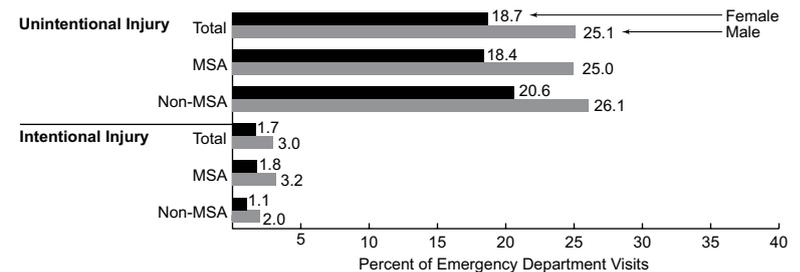
Source II.16: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control



*All of the leading causes of injury in 2007 were unintentional.

Injury-Related Emergency Department Visits Among Adults Aged 18 and Older, by Area of Residence* and Sex, 2006

Source II.17: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



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

OCCUPATIONAL INJURY

In 2007, there were nearly 1.2 million non-fatal occupational injuries in the United States that resulted in at least 1 day of absence from work. Of those injuries, more than 35 percent occurred among females aged 14 and older. While males account for the majority of total injuries, the distribution of injuries by age differs between males and females. More than 35 percent of males with occupational injuries were aged 20–34 years, compared to 29.7 percent of females in the same age group. In comparison,

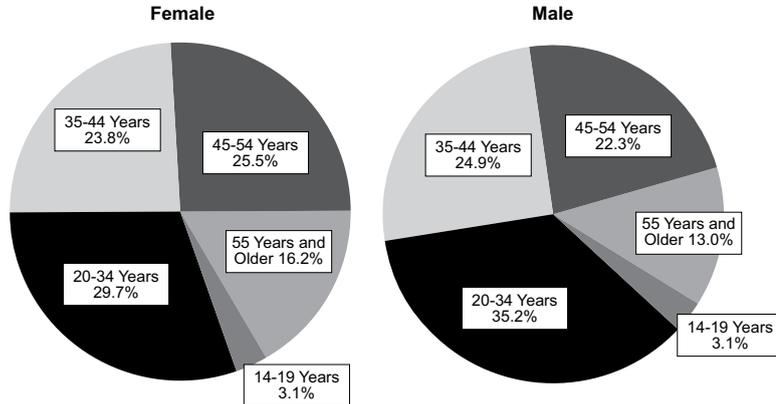
16.2 percent of injuries among females occurred among women aged 55 years and older, while males of this age group accounted for 13.0 percent of injuries.

The distribution of nonfatal occupational injuries by sex varies by occupational sector. In 2007, females accounted for 68.4 percent of injuries occurring in management, professional, and related occupations, despite making up only 51.2 percent of the workforce in that sector. Similarly, females represented 56.4 percent of the service workforce, but accounted for 61.1

percent of injuries in that sector. Conversely, males were somewhat overrepresented in injuries to sales and office workers: males made up 37.1 percent of that workforce, but accounted for 39.3 percent of the injuries. Injuries occurring among males and females in the farming, fishing, and forestry sector, as well as the construction, extraction, and maintenance sector were approximately proportionate to their workforce representation. (See page 17, “Women in the Labor Force,” for data on workforce representation by occupational sector and sex.)

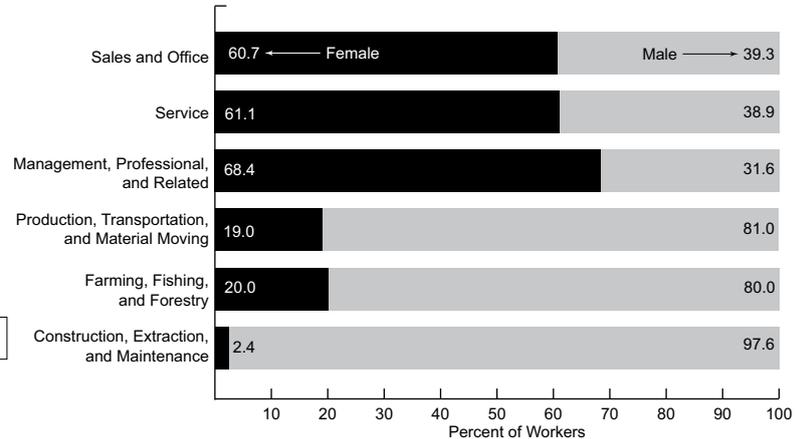
Nonfatal Occupational Injuries and Illnesses of Workers Aged 14 and Older, by Sex and Age,* 2007

Source II.18: U.S. Department of Labor, Bureau of Labor Statistics



Nonfatal Occupational Injuries and Illnesses, by Occupational Sector and Sex, 2007

Source II.18: U.S. Department of Labor, Bureau of Labor Statistics



*Percentages do not equal 100 due to rounding and age not being reported in 2.0 percent of cases.

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) refers to any physical, sexual, or psychological harm by a current or former partner or spouse. IPV can take on many forms and vary in frequency and severity, ranging from threats of abuse to chronic, severe battering. IPV often is underreported, especially with regard to sexual and psychological violence.

According to the National Crime Victimization Survey, which collects data on victimization based on household and individual surveys, 5.7 per 1,000 women aged 18 and older were victims of nonfatal IPV in 2006. Additionally, between 1976 and 2005, 30.0 percent of homicides against females were committed by inti-

mate partners.²⁴ Rates of IPV vary with a number of factors including age, race and ethnicity, income, and marital status.

Rates of women who report experiencing IPV decline with age. In 2006, women aged 18–34 years were most likely to have reported experiencing IPV (12.6 per 1,000 women), compared to 6.4 per 1,000 women aged 35–44 years, and 2.0 per 1,000 women aged 45–64 years.

Similarly, reports of IPV decline as annual household income increases. Women in households with incomes below \$15,000 per year were most likely to have reported IPV (15.9 per 1,000 women), followed by women with incomes of \$15,000–29,999 annually (8.6 per 1,000). Women with annual incomes of

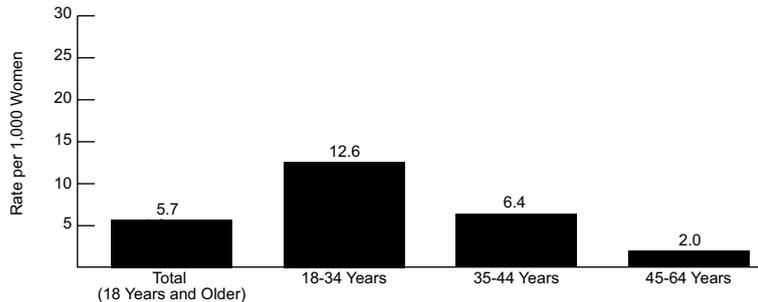
\$50,000 or more were least likely to have reported IPV (2.8 per 1,000).

Non-Hispanic White and Hispanic women were less likely to have reported IPV (5.0 and 5.6 per 1,000, respectively) than non-Hispanic Black women (7.4 per 1,000; data not shown).

Human trafficking is another crime that disproportionately affects women and girls. In 2007–2008, 1,229 alleged human trafficking incidents were reported by task forces in the United States, involving 1,442 victims. In cases where victims' characteristics were reported, women and girls accounted for 92.1 percent of victims. The proportion of sex trafficking victims who were female was even greater: 98.9 percent (data not shown).²⁵

Nonfatal Intimate Partner Violence Among Women Aged 18 and Older,* by Age, 2006

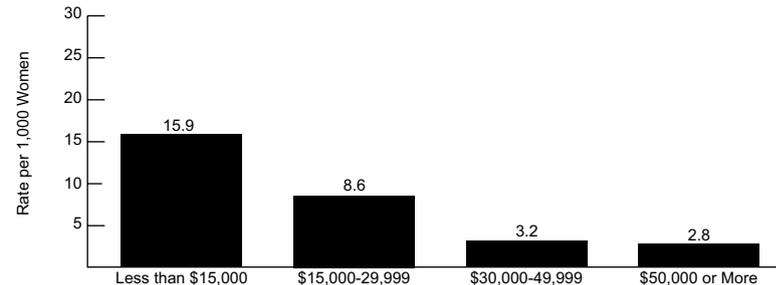
Source II.19: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



*Due to the small sample size, the estimate for the 65 and older age group was not reliable.

Nonfatal Intimate Partner Violence Among Women Aged 18 and Older, by Annual Income, 2006

Source II.19: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



MENTAL ILLNESS

Mental illness affects both sexes, although many types of mental disorders are more prevalent among women.²⁶ For instance, in 2007, 13.3 percent of women and 8.1 percent of men reported experiencing frequent depression in the past year. Similarly, 13.0 percent of women reported experiencing frequent anxiety, compared to 8.6 percent of men (data not shown).

Among women, rates of frequent depression and anxiety increase with age up to age 64, but then decrease. More than 15 percent of women aged 45–64 years experienced frequent depression, compared to 12.8 percent of those aged 25–44 years and 9.6 percent of those aged 18–

24. Similarly, women aged 45–64 years were more likely than women of other ages to experience frequent anxiety (14.7 percent).

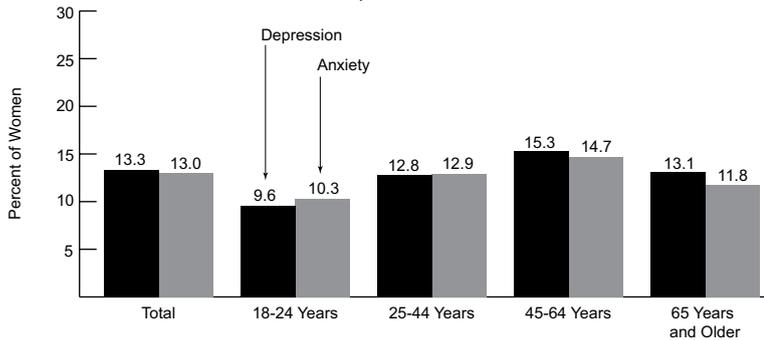
Frequent depression and anxiety among women decrease as household income increases. In 2007, women with incomes of less than 100 percent of the poverty level were most likely to have experienced frequent depression or anxiety (25.1 and 22.4 percent, respectively), followed by women with incomes of 100–199 percent of poverty (18.3 and 17.9 percent, respectively). Women with incomes of 400 percent or more of poverty were least likely to have reported experiencing frequent depression or anxiety in the past year (7.8 and 9.2 percent, respectively).

Although most people who suffer from mental illness do not intentionally injure themselves, mental illness is a major risk factor for self-inflicted injury. In 2003–2005, 13.7 per 10,000 emergency department (ED) visits were for self-inflicted injuries. The rate of emergency department visits due to self-inflicted injury was higher for females than males (16.2 versus 11.3 per 10,000 ED visits, respectively; data not shown).²⁷

Research suggests that women suffering from chronic diseases such as heart disease may be more likely than men to suffer major depression, increasing the risk of mortality and morbidity.²⁸

Frequent Depression and Anxiety* Within the Past Year Among Women Aged 18 and Older, by Age, 2007

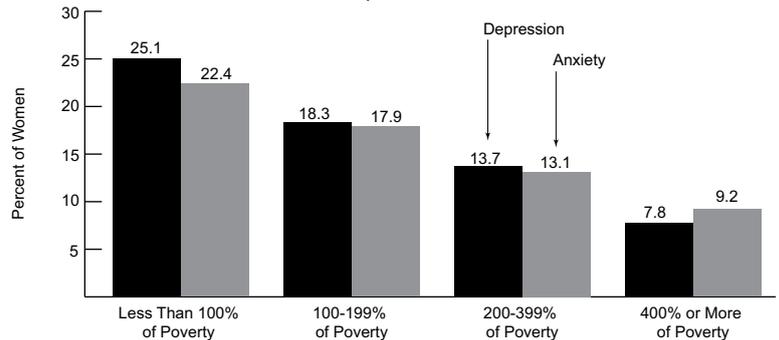
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported they had been frequently depressed or anxious during the past 12 months.

Frequent Depression and Anxiety* Within the Past Year Among Women Aged 18 and Older, by Poverty Status,** 2007

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



*Reported they had been frequently depressed or anxious during the past 12 months.**Poverty level, defined by the U.S. Census Bureau, was \$21,027 for a family of four in 2007.

ORAL HEALTH

Oral health conditions can cause chronic pain of the mouth and face and can impair the ability to eat normally. Regular dental care is particularly important for women because there is some evidence of an association between periodontal disease and certain birth outcomes, such as increased risk of preterm birth and low birth weight.²⁹ To prevent caries (tooth decay) and periodontal (gum) disease, the American Dental Association recommends maintaining a healthy diet with plenty of water, and limiting eating and drinking between meals.³⁰

In 2005–2006, 39.7 percent of women reported that their teeth were in excellent or very good condition. This varied, however, by pover-

ty status; nearly half of women with household incomes below 100 percent of the poverty level reported their teeth to be in fair or poor condition, while fewer than one-quarter reported excellent or very good oral health. In comparison, nearly half of women with incomes of 300 percent or more of poverty reported that their teeth were in excellent or very good condition.

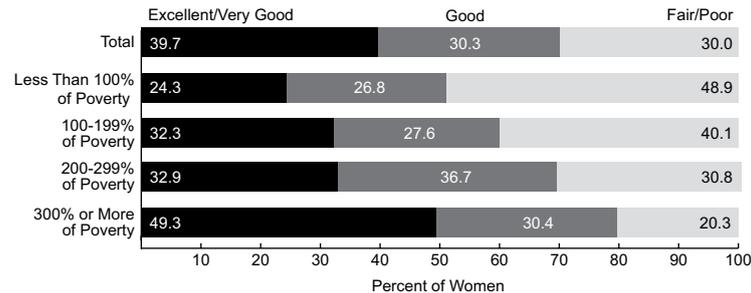
Dental restoration is used to treat cavities caused by caries. In 2005–2006, 82.7 percent of women had had at least one tooth restored, while 19.1 percent of women had untreated tooth decay. Prevalence of dental restoration and untreated tooth decay among women varied with age. Women aged 45–64 years were most likely to have had at least one tooth restored (89.5 per-

cent), compared to 87.3 percent of women aged 25–44 years and 72.0 percent of women aged 18–24 years. Women aged 25–44 years were more likely than women of other ages to have untreated tooth decay (22.8 percent), followed by women aged 18–24 years (21.0 percent).

Since many physical injuries resulting from intimate partner violence (IPV) involve the head, neck, and mouth, dental professionals have a unique opportunity to assess, educate, and refer women experiencing or at risk of IPV to appropriate services. Physical symptoms of IPV that may be observed during a dental visit include trauma in the head and neck region, multiple or old injuries, and untreated rampant caries.³¹

Self-Reported Oral Health Status of Women Aged 18 and Older, by Poverty Status,* 2005–2006

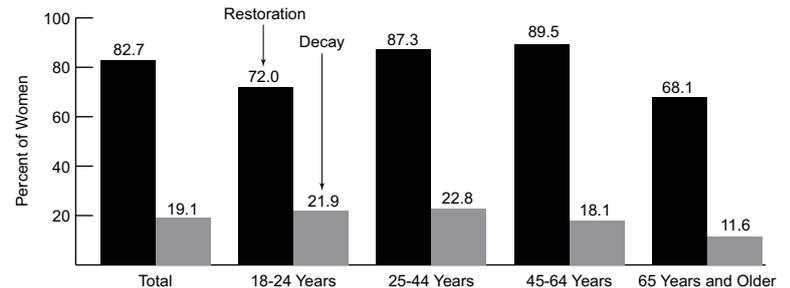
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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

Presence of Tooth Decay and Restoration Among Women Aged 18 and Older, by Age, 2005–2006*

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Beginning in 2005–2006, data collection methods changed, making estimates not comparable to those reported in previous years.

OSTEOPOROSIS

Osteoporosis is the most common underlying cause of fractures in the elderly, but it is not frequently diagnosed or treated, even among individuals who have already suffered a fracture. In 2005–2006, an estimated 10.5 million Americans over the age of 20 had osteoporosis, 84 percent of whom were women. Among adults aged 20 years and older, 8.1 percent of women and 1.7 percent of men reported having ever been told by a health professional that they have osteoporosis. The rate of osteoporosis among women varied significantly with race and ethnicity. Non-Hispanic White women were most likely to have osteoporosis (9.9 percent), compared to non-Hispanic Black

and Hispanic women (3.2 and 3.5 percent, respectively).

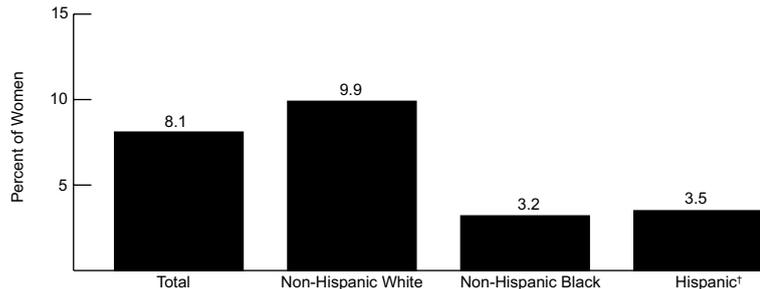
Each year more than 1.5 million people suffer a bone fracture related to osteoporosis, with the most common breaks in the wrist, spine, and hip. Fractures can have devastating consequences. For example, hip fractures are associated with an increased risk of mortality, and nearly 1 in 5 hip fracture patients is admitted to a nursing home within a year.³² In 2006, there were 237,000 hospital discharges due to hip fractures among women aged 18 and older, a rate of 20.5 per 10,000 women. Rates of hospital discharges due to hip fractures were highest among women aged 75 years and older (169.9 discharges per

10,000 women), followed by women aged 65–74 years (28.3 per 10,000 women).

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (i.e. walking), and by taking prescription medication when appropriate. Bone density tests are recommended for women over 65 years and for any man or woman who suffers a fracture after age 50. Treatment for osteoporosis has been shown to reduce the risk of subsequent fractures by 30–65 percent.³² Among women who had been told by a health professional that they have osteoporosis, 76.1 percent reported having been treated for the condition (data not shown).

Women Aged 20 and Older with Diagnosed Osteoporosis,* by Race/Ethnicity,** 2005–2006

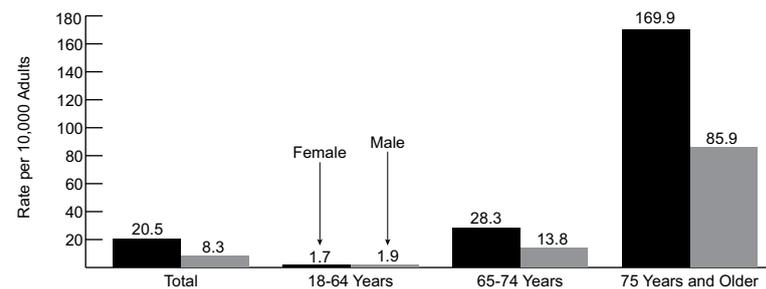
Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they have osteoporosis. **The sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races was too small to produce reliable results. ¹Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population.

Hospital Discharges Due to Hip Fractures* Among Adults Aged 18 and Older, by Age and Sex, 2006

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



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

SEVERE HEADACHES AND MIGRAINES

Severe headaches of any kind can be debilitating. Symptoms of severe headache include intense pain, usually on both sides of the head. Migraine, in addition to severe pain on only one side of the head, may be accompanied by neurological symptoms such as distorted vision, nausea, vomiting, and sensitivity to light or sound. In 2007, 12.3 percent of adults reported experiencing a severe headache or migraine in the past 3 months (data not shown). Severe headaches and migraines are more than twice as common among women as men (16.8 versus 7.4 percent, respectively). For both sexes, the

rate of severe headaches and migraines is highest among those aged 25–44 years and decreases with age. Among women aged 65 years and older, only 5.9 percent reported severe headaches or migraines in the past 3 months, compared to 22.4 percent of women aged 25–44 years.

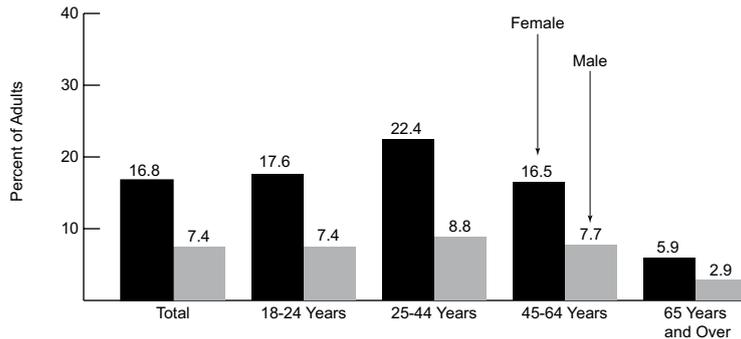
The percentage of women experiencing severe headaches and migraines decreases as household income increases. In 2007, 24.1 percent of women with household incomes below 100 percent of poverty reported experiencing a severe headache or migraine in the past 3 months, compared to 17.9 percent of women with household incomes of 200–399 percent of poverty and 14.8 percent of women with

incomes of 400 percent or more of poverty.

The percentage of women reporting severe headaches or migraines varied by race and ethnicity: 17.9 percent of Hispanic women reported experiencing a severe headache or migraine in the past 3 months, compared to 16.8 percent of non-Hispanic White and 15.7 percent of non-Hispanic Black women. Non-Hispanic Asian women were least likely to report a severe headache or migraine (13.3 percent). Nearly 30 percent of non-Hispanic women of other races reported experiencing a severe headache or migraine (data not shown).

Adults Aged 18 and Older With Severe Headaches or Migraines,* by Age and Sex, 2007

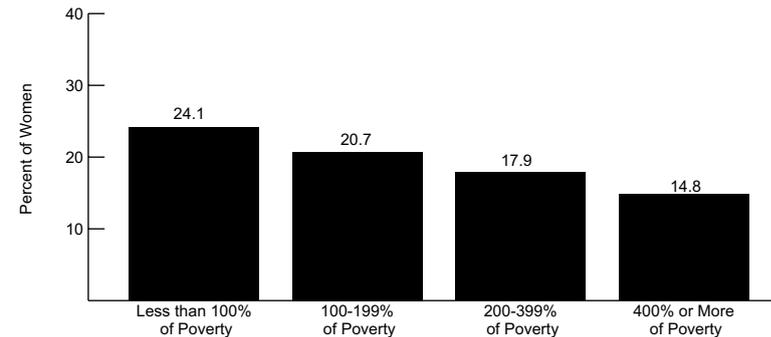
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Occurring within the past 3 months.

Women Aged 18 and Older with Severe Headaches or Migraines,* by Poverty Status,** 2007

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



*Occurring within the past 3 months. **Poverty level, defined by the U.S. Census Bureau, was \$21,027 for a family of four in 2007.

UROLOGIC DISORDERS

Urologic disorders encompass illnesses and diseases of the genitourinary tract. Some examples include urinary incontinence, urinary tract infection, sexually transmitted diseases, urolithiasis (kidney stones), and kidney and bladder cancer. Many of these disorders affect a large number of adult women; annual Medicaid expenditures for urinary incontinence and urinary tract infections among adult women total more than \$234 million and \$956 million, respectively. These same illnesses accounted for \$39 million and \$480 million in expenditures, respectively, for adult men.³³

Urinary incontinence is one of the most prevalent chronic diseases in the United States and

is generally more common among women than men.³³ In 2005–2006, 38.4 percent of women and 11.7 percent of men aged 20 years and older reported that they had urinary leakage less than once a month or more frequently. Among women, urinary leakage was most common among those aged 45–64 and 65 years and older (49.1 and 46.4 percent, respectively), compared to 27.8 percent of women aged 20–44 years. In addition, 21.6 percent of women with urinary leakage reported that it affects their daily activities at least a little, compared to 14.5 percent of men (data not shown).

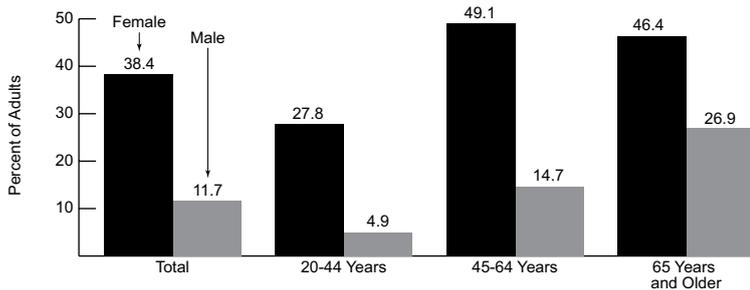
Among women with urinary leakage, 38.7 percent reported that it occurred less than once a month, while 28.3 percent reported occurrence

a few times a month. Nearly 16 percent of those with urinary leakage reported that it occurred a few times a week and 17.2 percent experienced leakage every day and/or night.

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

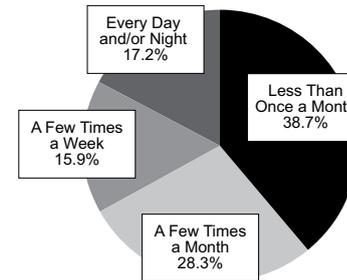
Adults Aged 20 and Older Reporting Urinary Leakage, by Age and Sex, 2005–2006

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Percentages do not equal 100 because of rounding.