



Women's Health USA 2012

January 2013

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



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PREFACE AND READER'S GUIDE

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

HRSA is pleased to present *Women's Health USA 2012*, the eleventh 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 adverse childhood experiences, Internet use for health information, sexual risk behaviors, and sexual violence are among the new topics included in this edition. Other topics that have not been covered in the past 5 years include in-

carcerated women and impaired fecundity and infertility treatment. In addition, this year's special population pages feature new data on the health of Asian women, rural and urban women, and women veterans.

Disparities by sex, race and ethnicity, and socioeconomic factors, including education and income, are highlighted throughout the document where possible. Where race and ethnicity data are reported, groups are mutually exclusive



(i.e., non-Hispanic race groups and the Hispanic ethnic group) except in a few cases where the original data do not present the groups separately. Throughout the data book, those categorized as being of Hispanic ethnicity may be of any race or combination of races. In some instances, it was not possible to provide data for all races due to the design of the original data source or the size of the sample population; therefore, estimates with a numerator of less than 20 or a relative standard error of 30 percent or greater were considered unreliable and were not reported.

The data book was developed by HRSA to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. *Women's Health USA 2012* 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 Commerce, U.S. Department of Education,

U.S. Department of Labor, U.S. Department of Justice, and U.S. Department of Veterans Affairs. 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. The data included are generally age-adjusted to the 2000 population standard of the United States when there are clear age-related patterns that affect comparisons across various groups, especially those of different races and ethnicities. Age-adjustment helps to see differences between groups in the prevalence or incidence of a condition that are not simply a function of differences in the groups' age distributions.

Women's Health USA 2012 is available online through the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth or the HRSA Maternal and Child Health Bureau's Office of Epidemiology and Research Web site at www.mchb.hrsa.gov/researchdata. Some of the topics covered in *Women's Health USA 2011* were not included in this year's edition either because new data were not available or because preference was given to an emerging issue in women's health. For coverage of these issues, please refer to *Women's Health USA 2011*, also available online. The U.S. Department of Health and Human Services' Office on Women's Health

(www.womenshealth.gov) has detailed women's and minority health data and maps. These data are available through Quick Health Data Online at www.healthstatus2010.com/owh. Data are available at the State and county levels, by sex, race and ethnicity, and age.

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INTRODUCTION

In 2010, females represented 50.8 percent of the 308 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people aged 65 years and older; within this age group, women represented 56.9 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 and time. Non-Hispanic Whites accounted for 79.3 percent of women aged 65 years and older, but only 53.4 percent of those under 18 years of age. Between 2000 and 2010, the Hispanic and non-Hispanic Asian female population grew the most—increasing their proportion of the female population by about 30 percent. Hispanics grew from 12.1 to 15.9 percent of the female population and non-Hispanic Asians increased from 3.8 to 4.9 percent. By 2050, non-Hispanic White females are projected to no longer be the majority (46.1 percent) and about one-third of females will be Hispanic (29.9 percent).

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in the social determinants of health, health status, and the use of health care services. In 2010, at least one in five non-Hispanic Black (25.5 percent), Hispanic (25.0 percent), non-Hispanic American Indian/Alaska Native women (25.0 percent), and non-His-

panic Native Hawaiian/Other Pacific Islander women (20.3 percent) were living in households with income below the poverty level compared to just 12.2 percent of non-Hispanic Asians and 10.4 percent of non-Hispanic Whites. Similarly, fair or poor health was reported by more than one in five Hispanic (29.5 percent), non-Hispanic American Indian/Alaska Native (26.0 percent), non-Hispanic Black (23.2 percent), and non-Hispanic Native Hawaiian/Other Pacific Islander women (20.8 percent), compared to about 13 percent of non-Hispanic White and non-Hispanic Asian women. Many minority women are disproportionately affected by several diseases and health conditions, including diabetes, high blood pressure, overweight and obesity, asthma, HIV/AIDS, and sexually transmitted infections. For instance, in 2010, rates of new HIV cases were highest among non-Hispanic Black, Hispanic, and non-Hispanic American Indian/Alaska Native females (41.7, 9.2, and 6.4 per 100,000 females, respectively), compared to just 2.1 cases per 100,000 non-Hispanic White females. Diabetes was nearly twice as common among non-Hispanic Black and Mexican American women (16.5 and 16.9 percent, respectively) than among non-Hispanic White women (8.9 percent). Similarly, obesity was considerably higher among non-Hispanic Black and Mexican American women (58.0 and 44.0 percent, respectively) than non-Hispanic

White women (33.1 percent).

Although Asian women tend to be healthier, some subgroups may face higher rates of diabetes, hepatitis infection, and certain types of cancer. For example, in 2006–2010, 12.4 percent of Asian Indian women reported having been diagnosed with diabetes compared to 4.7 percent of Chinese women. The receipt of recommended cervical cancer screening was substantially lower among Asian Indian, Chinese, and Other Asian (71.5, 71.6, and 70.2 percent, respectively) compared to Filipina (86.9 percent) and non-Hispanic White women (84.6 percent). Cultural differences in health-related beliefs may contribute to this disparity.

However, many conditions and health risks are more closely linked to education and family income than to race and ethnicity and tend to explain a large portion of racial and ethnic health differences. For example, healthy choices for diet and exercise may not be as accessible to those with lower levels of education and income and may contribute to higher obesity levels among minority women. In 2008–2010, over half of college-educated women (57.3 percent) achieved recommended levels of physical activity compared to less than one-quarter of women without a high school diploma (24.4 percent). Fruit and vegetable consumption also increased with educational attainment. For instance, in 2009, about 40 percent of women with a col-

lege degree ate vegetables three times per day compared to 22.0 percent of those who hadn't finished high school.

Health care access also varies greatly by income and education. In 2008–2010, about 20 percent of women with incomes below 200 percent of the poverty level had forgone needed health care due to cost compared to 6.5 percent of women with incomes of 400 percent or more of poverty. Only 41.6 percent of women with less than a high school education had a dental visit in the past year compared to 80.9 percent of women with a college degree.

In addition to income and education, there are also geographic barriers to health care. For example, rural areas have fewer physicians and dentists per capita than urban areas, and may lack certain specialists altogether. In 2010, rural women were less likely than urban women to have had a past year dental visit (64.4 versus 77.9 percent, respectively). Compared to their urban counterparts, rural women were also more likely to smoke (20.5 versus 14.4 percent, respectively), to be physically inactive (29.2 versus 25.1 percent, respectively) and to be obese (30.4 versus 25.9 percent, respectively).

Women veterans are another population group that may face unique health problems due to possible exposure to combat-related stress and trauma. Although women veterans were more likely than civilian women to have had a past-

year preventive health visit in 2010 (76.2 versus 72.0 percent, respectively), they were more likely to report limitations in activity due to physical, mental, or emotional problems (29.3 versus 20.7 percent, respectively) and to report poor mental health on 14 or more days in the past month (18.1 versus 12.5 percent, respectively).

A variety of conditions increase with age and are more likely to affect older women, including activity limitations, arthritis, obesity, diabetes, high blood pressure, infecundity, maternal morbidity, osteoporosis, and Alzheimer's disease. For example, nearly three-quarters of women aged 65 and older had high blood pressure in 2009–2010 and 71.1 percent were overweight or obese. However, some health behaviors and indicators improve with age, such as mental health-related quality of life, the receipt of preventive check-ups, and positive health behaviors prior to pregnancy. For instance, among recent mothers aged 40 and older, only 12.4 percent reported smoking and 15.3 percent reported binge drinking in the 3 months prior to pregnancy, compared to 34.2 and 25.5 percent, respectively, among mothers aged 20–24 years. Older mothers were more likely to have taken daily preconception multivitamins, which dramatically reduce the risk of neural tube defects, and to have intended or planned their pregnancy.

Since women live an average of about 5 years longer than men, they are more likely to have

certain age-related conditions like Alzheimer's disease. Regardless of age, however, women are also more likely to have activity limitations, asthma, arthritis, osteoporosis, and depression. For example, 9.0 percent of women had osteoporosis in 2007–2010, compared to 1.3 percent of men. Women also experience more physically and mentally unhealthy days than men. In 2010, women reported an average of 3.9 days of poor physical health, compared to 3.3 days per month for men. Similarly, women reported an average of 4.1 mentally unhealthy days, while men reported an average of 3.0 days per month. Men, nonetheless, bear a greater burden of certain health conditions, such as HIV/AIDS, heart disease, and substance use disorders, and were less likely than women to have received a preventive check-up or dental visit in the past year.

Women's Health USA 2012 is 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 population health determinants, health behaviors, health status, 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 more than 157 million females in the United States in 2010, representing slightly more than half of the population.

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

This section presents data on population characteristics that may affect women's physical, social, and mental health, as well as access to health care. Some of these characteristics include age, race and ethnicity, education, poverty, employment, household composition, and participation in Federal nutrition programs. The characteristics of incarcerated women are also reviewed and analyzed. The population characteristics and health status of rural and urban women and women veterans are examined as special population features.

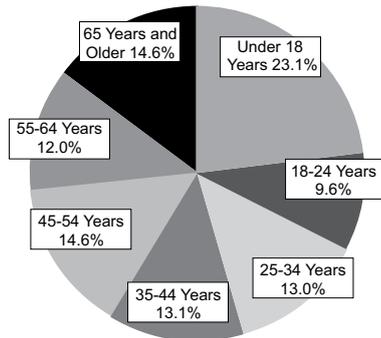
U.S. POPULATION

In 2010, the U.S. population was more than 308 million, with females comprising 50.8 percent of the total population. Females younger than 18 years accounted for nearly one-quarter of the 157 million U.S. females, while women aged 18–34 years accounted for 22.6 percent, those aged 35–64 years accounted for 39.7 percent, and women aged 65 years and older accounted for 14.6 percent.

The distribution of the population by sex was fairly even across younger age groups; however because women have longer life expectancies, they represented a greater proportion of those aged 65 years and older. Women accounted for 56.9 percent of all individuals aged 65 years and older, 60.8 percent of individuals aged 75 years and older, and over two-thirds of individuals aged 85 years and older (data not shown).

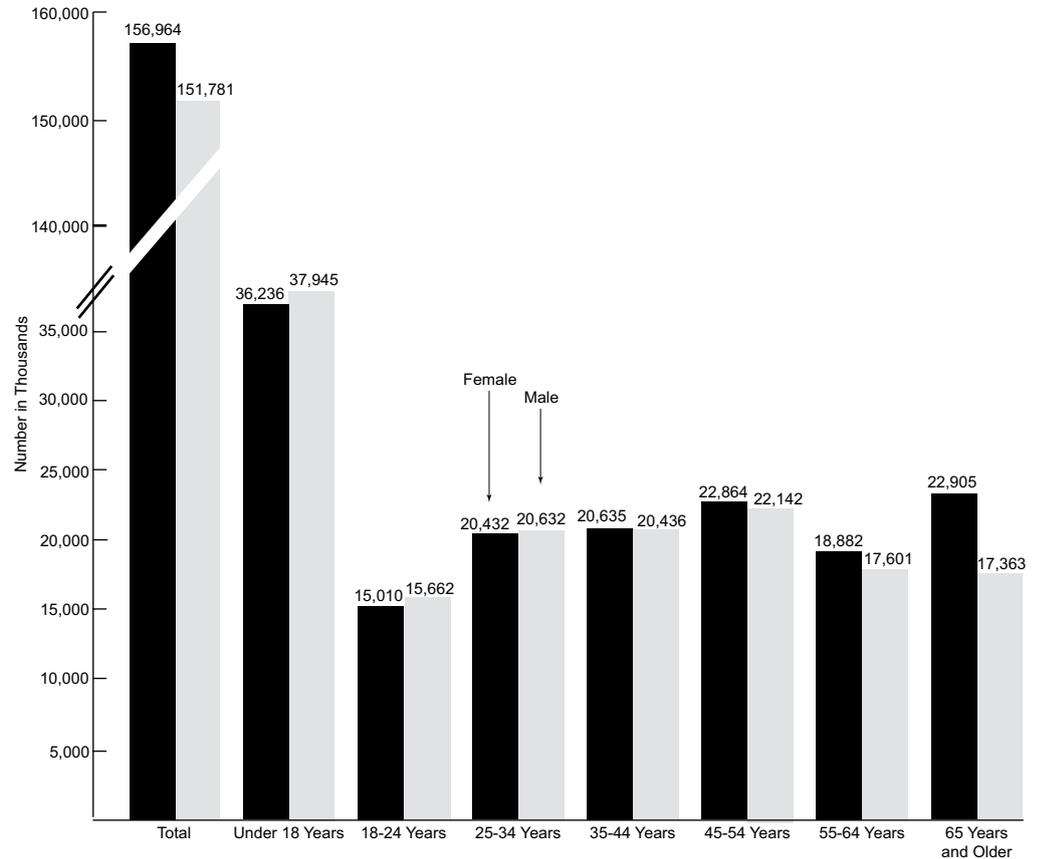
U.S. Female Population, by Age, 2010

Source I.1: U.S. Census Bureau, 2010 Census



U.S. Population, by Age and Sex, 2010

Source I.1: U.S. Census Bureau, 2010 Census



U.S. FEMALE POPULATION

In 2000, more than two-thirds of the total female population was non-Hispanic White (69.5 percent), followed by non-Hispanic Black and Hispanic females (12.6 and 12.1 percent, respectively). By 2010, the proportion of the female population that was non-Hispanic White dropped to 63.8 percent and the proportion Hispanic increased to 15.9 percent. By 2025, non-Hispanic White females are projected to account for 57.7 percent of the female population and by 2050 they are projected to no longer be the majority (46.1 percent). By 2050, the proportions of females who are Hispanic, non-Hispanic Asian, and non-Hispanic multiple race are expected to double or triple compared to the start of the millennium.

The increasing diversity of the U.S. population is a function of different fertility, mortality, and migration patterns according to race and ethnicity. The younger female population (under 18 years) is significantly more diverse than the older female population (data not shown). In 2010, 53.4 percent of females under 18 years of age were non-Hispanic White, while 23.2 percent of that group were Hispanic. In contrast, among women aged 65 years and older, 79.3 percent were non-Hispanic White and only 7.0 percent were Hispanic.¹

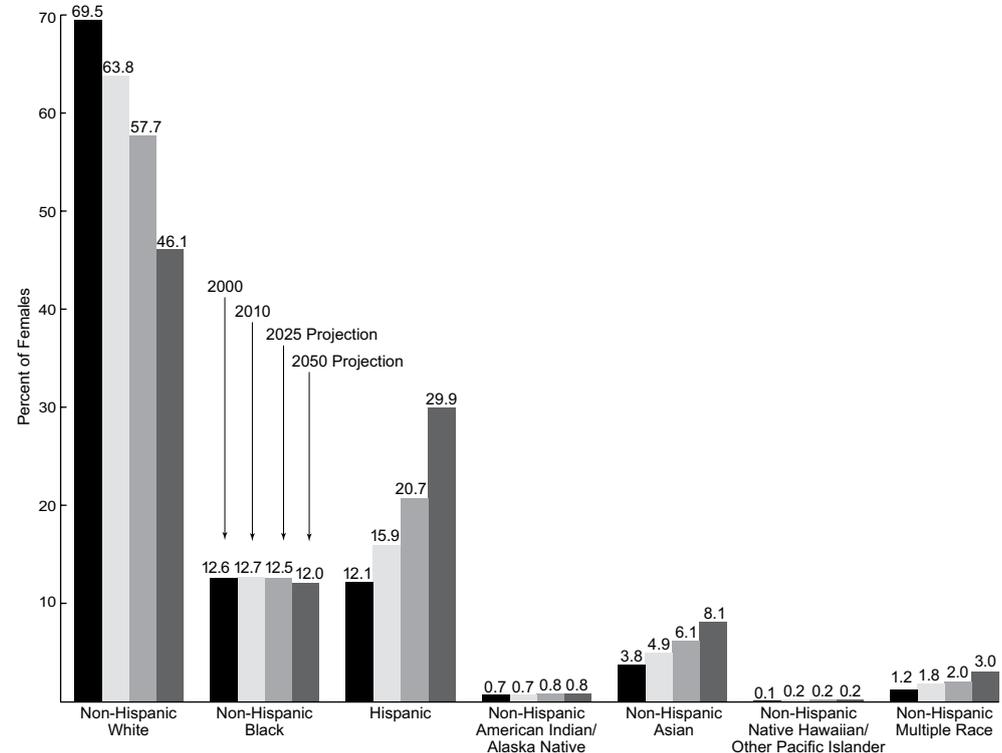
The increasing diversity of the U.S. population underscores the importance of promoting

racial and ethnic equity in health and health care. Significant racial and ethnic disparities persist in health status and access to health care which can be attributed to a variety of social, behavioral, environmental, and biological de-

terminants.² The future health of America will greatly depend on using a multifaceted approach to improving the health of racial and ethnic minorities and other disadvantaged groups.

U.S. Female Population (All Ages), by Race/Ethnicity, 2000–2050*

Source I.2, I.3: U.S. Census Bureau, Population Division



*Totals may not sum to 100 percent due to rounding, and the exclusion of non-Hispanic females of other races.

HOUSEHOLD COMPOSITION

In 2011, 48.5 percent of women aged 18 and older were married and living with a spouse; this includes married couples living with other people, such as parents. About 13 percent of women over age 18 were the heads of their households, meaning that they have children or other family members, but no spouse, living with them. Women who are heads of households include single mothers, single women with a parent or other close relative living in their home, and women with other household compositions. More than 17 percent of women lived alone, 15.5 percent lived with relatives, and 5.5 percent lived with non-relatives.

Household composition varies significantly by age. Young women aged 18–24 years were most likely to be living with relatives (59.7 percent) and with non-relatives (12.1 percent). About 60 percent of women aged 35–44 and 45–64 were living with a spouse. Being a head of household with no spouse present was most common among women between the ages of 25 and 44. Older women, aged 65 and above, were most likely to be living alone (37.3 percent) with another 43.5 percent living with a spouse.

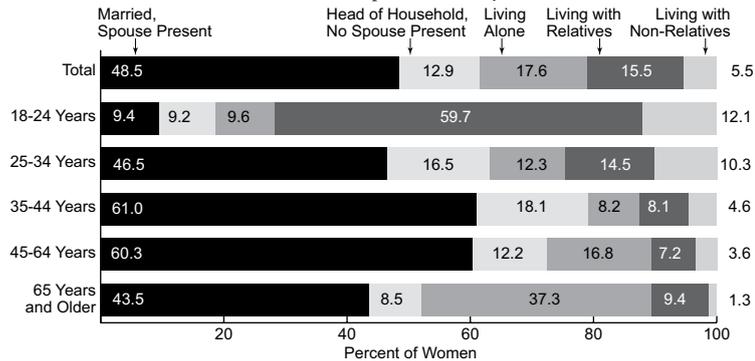
In 2011, non-Hispanic Black women were most likely to be single heads of households with family members present (27.5 percent), while non-Hispanic Asian and non-Hispanic White women were least likely (7.5 and 9.4 percent,

respectively). Over 30 percent of female single heads of households with family members had household incomes below the poverty level (see Women in Poverty).

Same-sex couples accounted for 646,464 households in 2010, representing an 80.4 percent increase since the 2000 Census.³ However, same-sex couples still account for fewer than 1 percent of all households (0.6 percent). Female couples comprised 51.5 percent of same-sex households.⁴ Almost one-quarter of female same-sex couple households contained children (23.9 percent) compared to 10.0 percent of male same-sex couple households and about 40 percent of opposite-sex couple households (data not shown).^{3,4}

Women Aged 18 and Older,* by Age and Household Composition, 2011

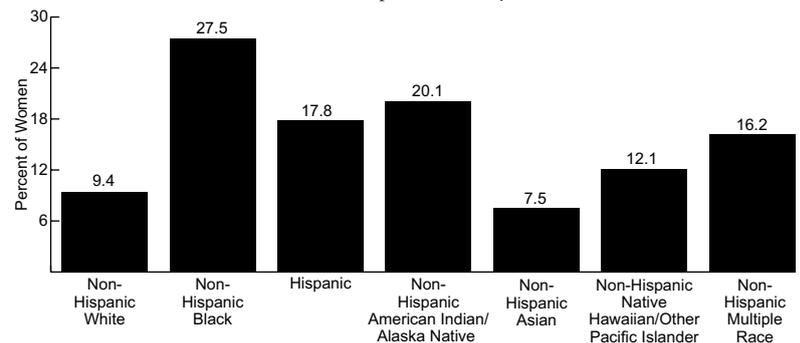
Source I.4: U.S. Census Bureau, Current Population Survey



*Includes the civilian, non-institutionalized population. Percentages may not equal 100 due to rounding.

Women Aged 18 and Older Who Are Heads of Households with Family Members,* by Race/Ethnicity, 2011

Source I.4: U.S. Census Bureau, Current Population Survey



*Includes the civilian, non-institutionalized population; includes those who are heads of households and have children or other family members, but no spouse, living in a house that they own or rent.

WOMEN AND POVERTY

In 2010, more than 46 million people in the United States lived with incomes below the poverty level, representing 15.1 percent of the U.S. population.⁵ More than 17 million of those were women aged 18 and older, accounting for 14.5 percent of the adult female population. In comparison, 11.2 percent of adult men lived in poverty (data not shown). With regard to race and ethnicity, non-Hispanic White women were least likely to experience poverty (10.4 percent), followed by non-Hispanic Asian women (12.2 percent). In contrast, about one-quarter of Hispanic, non-Hispanic Black, and

non-Hispanic American Indian/Alaska Native women lived in poverty.

Poverty status varies with age. Among women of each race and ethnicity, those aged 45–64 years and 65 years and older were less likely to experience poverty than those aged 18–44. For instance, 30.0 percent of non-Hispanic Black women aged 18–44 were living in poverty in 2010, compared to approximately 20 percent of those aged 45 years and older.

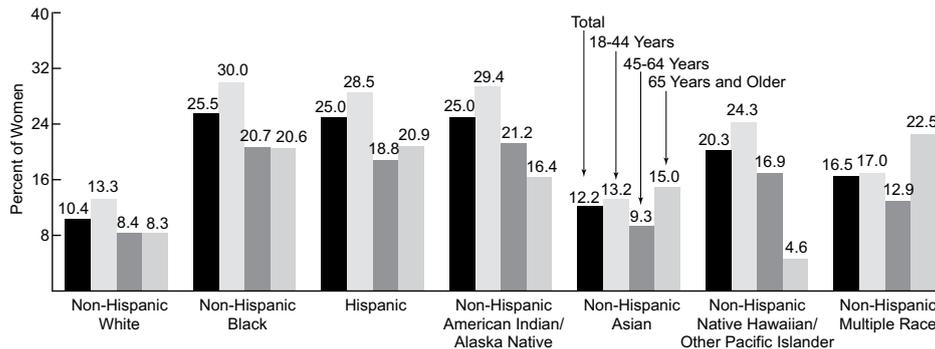
Poverty status also varies with educational attainment. Among women aged 25 years and older in 2010, one-third (33.2 percent) of those without a high school diploma were living in poverty, compared to 15.6 percent of those with

a high school diploma or equivalent, 10.5 percent of those with some college and 4.6 percent of those with a Bachelor's degree or higher (data not shown).

In 2010, 11.7 percent of families—a group of at least two people related by birth, marriage, or adoption and residing together—were living in poverty. Married-couple families were least likely to be poor (6.2 percent). Among single-headed households with no spouse present, those headed by an adult female were twice as likely to be poor as those headed by an adult male (31.5 versus 15.6 percent). Overall, women in families were more likely than men to be poor (11.5 versus 7.9 percent; data not shown).

Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity and Age, 2010

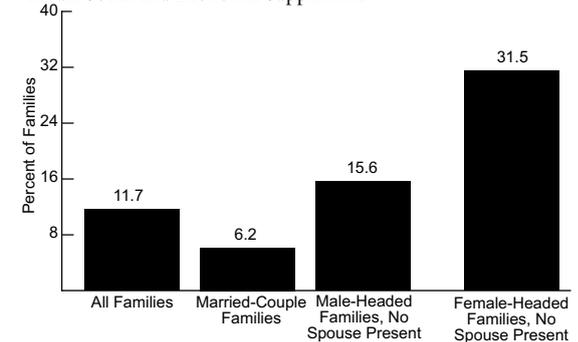
Source I.5: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



*Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010.

Families* Living Below the Poverty Level,** by Household Type, 2010

Source I.5: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



*Families are groups of at least two people related by birth, marriage, or adoption and residing together. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010.

FOOD SECURITY

Food security is defined as having access at all times to enough nutritionally adequate and safe foods to lead a healthy, active lifestyle.⁶ Food security status is assessed based on individuals' responses to questions such as whether an individual worried that food would run out before there would be money to buy more; whether an individual or his/her family cut the size of meals or skipped meals because there was not enough money for food; and whether an individual or his/her family had ever gone a whole day without eating because there was not enough food.

Households or persons experiencing food insecurity may be categorized as experiencing

“low food security” or “very low food security.” Low food security generally indicates multiple food access issues, while very low food security indicates reduced food intake and disrupted eating patterns due to inadequate resources for food. Periods of low or very low food security are usually recurrent and episodic rather than chronic. Nonetheless, nutritional risk due to poor dietary quality can persist across periods of food insecurity, and may increase the risk of nutritional deficiencies and diet sensitive conditions like hypertension and diabetes.⁷

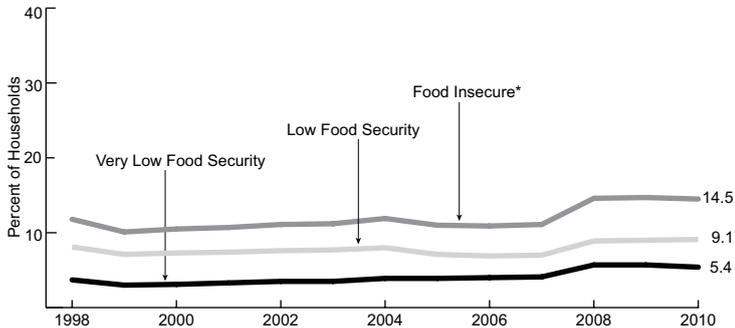
In 2010, an estimated 17.2 million or 14.5 percent of all households experienced food insecurity among one or more household members at some point in the past year; this rate has not

changed significantly since 2008 and remains at the highest level documented since measurement began in 1998.⁸ However, the prevalence of very low food security declined slightly from 5.7 percent in 2009 to 5.4 percent in 2010.

Food security status varies by household composition. While adult men and women living alone had similar rates of food insecurity in 2010, female-headed families with no spouse present were more likely than male-headed families with no spouse present to experience food insecurity (35.1 versus 25.4 percent, respectively). Female-headed families were also more likely than male-headed families to experience very low food security (10.8 versus 6.7 percent, respectively).

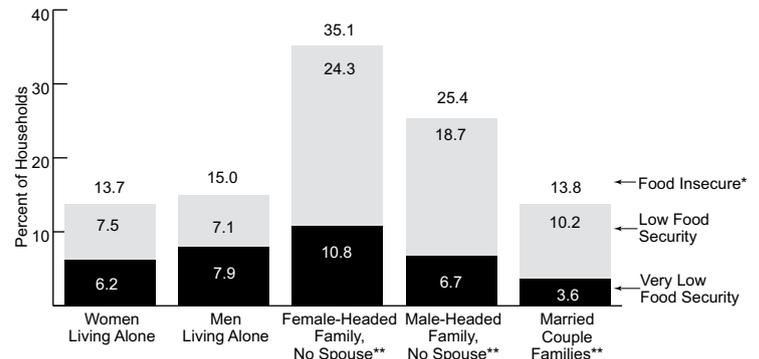
Household Food Insecurity, 1998–2010

Source I.6: U.S. Census Bureau, Current Population Survey, Food Security Supplement



Food Security Status, by Household Composition, 2010

Source I.6: U.S. Census Bureau, Current Population Survey, Food Security Supplement



*Food insecure includes very low and low food security. Percentages may not add to totals due to rounding.

*Food insecure includes very low and low food security. Percentages may not add to totals due to rounding. **Family defined as a household with children less than 18 years old.

WOMEN AND FEDERAL NUTRITION PROGRAMS

Federal programs can provide essential help to low-income women and their families in obtaining food and income support. The Supplemental Nutrition Assistance Program (SNAP), formerly the Federal Food Stamp Program, helps low-income individuals and families purchase food. In 2010, following an economic recession, the number of people served by SNAP hit a record high of 39.8 million per month, on average. Of the 21.2 million adults served, over 13 million (62.8 percent) were women (data not shown).⁹ Between 1990 and 2010, the number of people served by SNAP tracked strongly over time with the number of people

in poverty, demonstrating the critical role of SNAP in responding to need. In 2010, 1.7 million children and 2.2 million adults, 61 percent of whom were women, were lifted above the poverty line after adding the value of SNAP benefits to household income.¹⁰

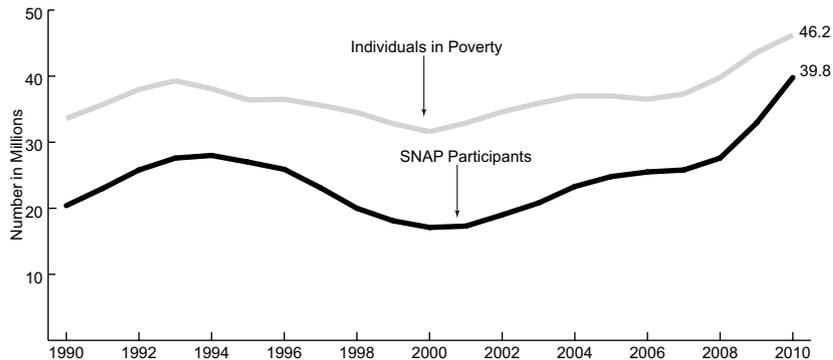
Among the households that relied on SNAP in 2010, 4.6 million (25.2 percent) were female-headed households with children, accounting for 51.8 percent of all SNAP households with children (data not shown).⁹

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) also plays an important role in serving low income women and families by providing supplementary nutritious foods, nutrition education, and re-

ferred to health and other social services. WIC serves pregnant, postpartum, and breastfeeding women, as well as infants and children up to age 5. In 2011, more than three-quarters of all individuals receiving WIC benefits were infants and children (76.6 percent); however, the program also served nearly 2.1 million pregnant women and mothers, representing 23.4 percent of WIC participants. In contrast to SNAP, WIC is not an entitlement program that guarantees benefits to all eligible applicants. However, funding for WIC has increased over the years, and the number of women, infants, and children served by WIC has increased by over 100-fold between 1974 and 2011, from 88,000 to 8.9 million (data not shown).¹¹

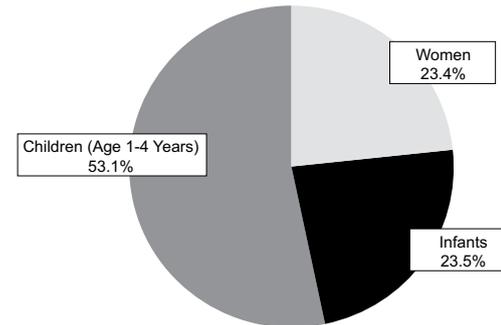
SNAP Participants and Individuals in Poverty, 1990–2010

Sources I.7: U.S. Department of Agriculture, Food Stamp Quality Control Sample; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



Participants in WIC, 2011*

Source I.8: U.S. Department of Agriculture, WIC Program Participation Data



*Based on Federal Fiscal Year (October to September)

EDUCATIONAL ATTAINMENT

In 2009, 89.8 percent of female and male young adults aged 18–24 had earned a high school or general equivalency degree; this is an increase from the 1972 level of 82.3 percent (data not shown).¹² While there has not been a sex disparity in high school educational attainment, a large disparity in post-secondary educational attainment has been eliminated or reversed over the last four decades. In 1969–1970, men earned a majority of every type of post-secondary degree, while in 2008–2009, women earned more than half of all associate’s, bachelor’s, master’s, and doctoral degrees, and

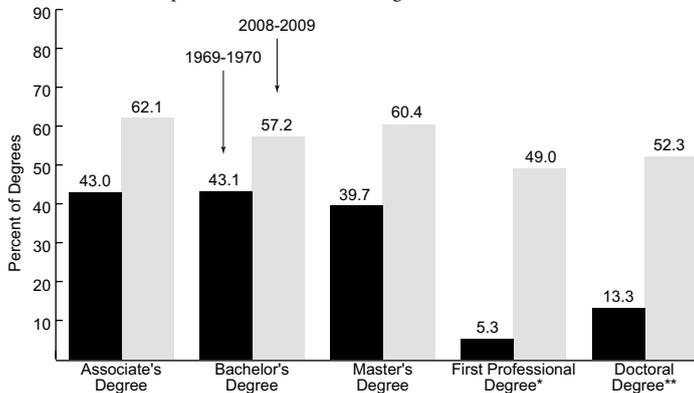
nearly half of all first professional degrees. The most significant increase has been in the proportion of first professional degree earners who are women, which jumped from 5.3 percent in 1969–1970 to 49.0 percent in 2008–2009. Although the sex disparity in degrees awarded has disappeared or reversed, there are still disparities by discipline. For example, women are under-represented in science and technology and over-represented in education and nursing.¹³

There are also racial and ethnic disparities in educational attainment. Although slightly more than one-third of all young adult women had a college degree in 2008–2010, this ranged from

15 percent or less of Hispanic, non-Hispanic American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander women to more than 60 percent of non-Hispanic Asian women. Hispanic and non-Hispanic American Indian/Alaska Native young adult women were most likely to lack a high school diploma (27.6 and 14.9 percent, respectively). Education confers great benefit to health status both through greater knowledge of risk and protective factors, as well as the economic resources to facilitate healthy behaviors.¹⁴ Increasing educational attainment will depend, in part, on improving school quality and the affordability of college.

Degrees Awarded to Women, by Type, 1969–1970 and 2008–2009

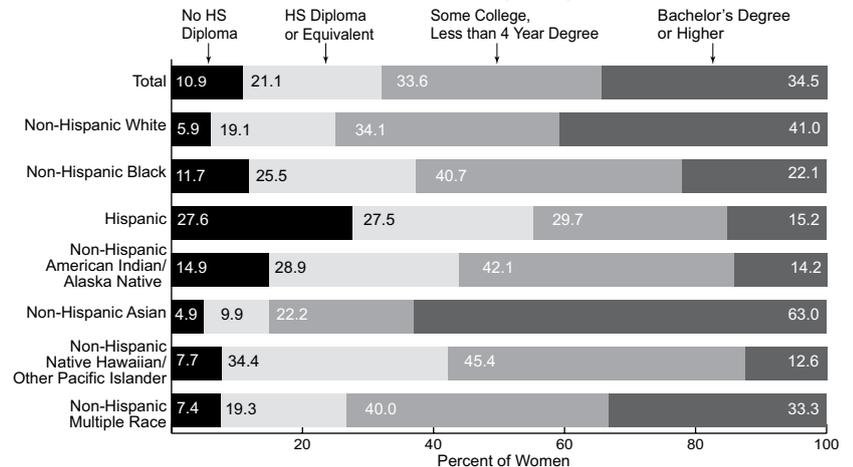
Source I.9: U.S. Department of Education, Digest of Education Statistics



*Includes fields of dentistry, medicine, optometry, osteopathic medicine, pharmacy, podiatry, veterinary medicine, chiropractic, public health, law, and theological professions. **Includes Doctor of Philosophy degree and degrees awarded for fulfilling specialized requirements in professional fields such as education, musical arts, and engineering. Does not include first professional degrees.

Educational Attainment Among Women Aged 25–29, by Race/Ethnicity, 2008–2010

Source I.10: U.S. Census Bureau, American Community Survey



WOMEN IN THE LABOR FORCE

In 2010, 58.6 percent of women aged 16 and older were in the labor force (either employed or not employed and actively seeking employment) compared to 72.3 percent of men.¹⁵ Between 1970 and 2000, women's participation in the labor force increased from 43.3 to approximately 60 percent, and has remained relatively stable over the last decade. Among mothers with children under 18 years of age, 71.3 percent were in the labor force in 2010, up from 47.4 percent in 1975 (data not shown). Labor force participation is higher among mothers with older children and those who are unmarried or separated.¹⁵

Following the recession of 2007–2009, the average annual rate of unemployment (not em-

ployed and actively seeking employment) for persons aged 16 and older in 2010 was 9.6 percent, reaching the highest level since 1983. The unemployment rate was lower among women than men in 2010 (8.6 versus 10.5 percent, respectively) and during the previous three recessions. Women's employment has been less sensitive to recent recessions because of their greater representation in growing occupations, such as health care.¹³

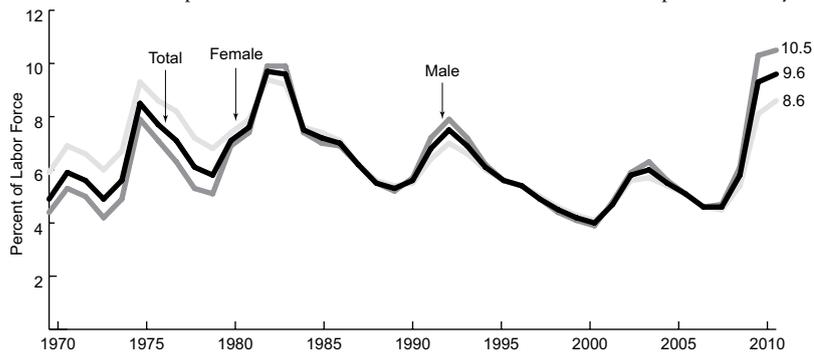
Although women had lower levels of unemployment in 2010, the median weekly earnings of full-time workers aged 25 and older was \$170 more for men than women (\$874 versus \$704). Earnings rise dramatically with increasing education but the gender gap in earnings persists with female full-

time workers earning about 75 cents for every dollar earned by male full-time workers at every level of education. For example, while women with a high school diploma or equivalent earned a weekly average of \$543 in 2010, their male counterparts earned an average of \$710. Only about half of the gender pay gap can be explained by differences in industry and occupation.¹⁶

Despite the gender gap in earnings, families are increasingly dependent on the employment and income of women. From 1967 to 2008, the number of families with mothers serving as breadwinners increased from 11.7 to 39.3 percent.¹⁷ Breadwinner mothers include single mothers who work and married mothers who earn as much as, or more than, their husbands.

Annual Average Unemployment* Rate Among Workers Aged 16 and Older, by Sex, 1970–2010

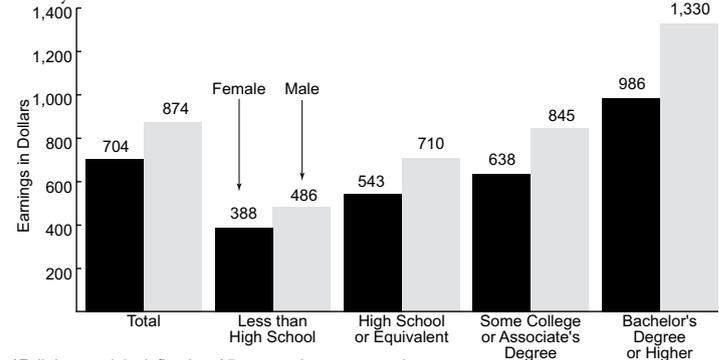
Source I.11: U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey



*Not employed and actively seeking employment.

Median Weekly Earnings of Full-Time Workers* Aged 25 and Older, by Education and Sex, 2010

Source I.11: U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey



*Full-time work is defined as 35 or more hours per week.

INCARCERATED WOMEN

In 2010, there were a total of 1,612,395 prisoners serving sentences of more than a year under the jurisdiction of State or Federal correctional authorities in the United States. This includes 1,499,573 men and 112,822 women, resulting in incarceration rates of 943 and 67 per 100,000, respectively. While men are more likely to be incarcerated than women, women have seen a greater incarceration rate increase than men from 2000 to 2010 (13.6 versus 4.3 percent, respectively; data not shown).¹⁸

Among both women and men, there continue to be substantial racial and ethnic disparities in incarceration. For example, non-Hispanic Black women are more than twice as likely to be incarcerated as non-Hispanic White women

(133 versus 47 per 100,000 women, respectively). Rates also vary with age, peaking among women aged 30–34 years at 175 per 100,000 (data not shown).

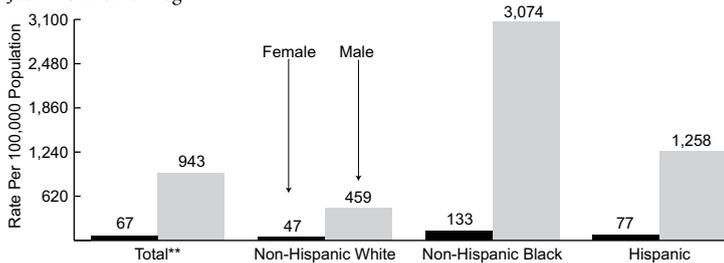
Compared to their male counterparts, female prisoners serving State sentences of more than a year were more likely to be incarcerated for property and drug-related offenses and less likely to be incarcerated for violent crimes. In 2009, nearly 30 percent of women prisoners were incarcerated for property crimes, including burglary and fraud, and 25.7 percent were incarcerated for drug offenses, while less than 20 percent of men were incarcerated for either type of offense. By contrast, over half of male prisoners (54.4 percent) were serving sentences for violent crimes including murder, manslaughter,

or assault, compared to 35.9 percent of female prisoners.

Incarcerated women often enter the criminal justice system either already suffering from, or at risk for, a wide range of chronic physical, mental, and behavioral health challenges including sexually transmitted infections and HIV, substance abuse disorders, and depression. Further, a majority of female prisoners are of reproductive age and may be pregnant or parenting when incarcerated. The American College of Obstetricians and Gynecologists recommends that incarcerated females be treated according to the same standards of care for non-incarcerated individuals with an emphasis on identifying and treating infectious diseases and mental health needs.¹⁹

Incarceration Rate* Under State and Federal Jurisdiction, by Race/Ethnicity and Sex, 2010

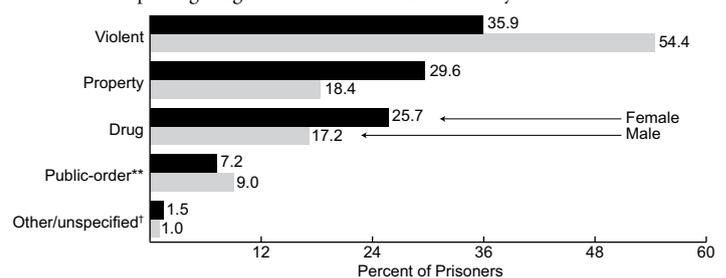
Source I.12: Bureau of Justice Statistics, National Prisoner Statistics Program and Federal Justice Statistics Program



*Based on prisoners with a sentence of more than 1 year; includes persons under the age of 18 years.
 **Includes American Indians/Alaska Natives, Asians, Native Hawaiian/Other Pacific Islanders, and persons identifying two or more races.

Offenses of Sentenced Prisoners* Under State Jurisdiction, by Sex, 2009

Source I.12: Bureau of Justice Statistics, National Prisoner Statistics Program, National Corrections Reporting Program and National Inmate Survey



*Counts based on prisoners with a sentence of more than 1 year; percentages may not total to 100 due to rounding. **Includes weapons, drunk driving, court offenses, commercialized vice, morals and decency offenses, liquor law violations, and other public-order offenses. †Includes juvenile offenses and other unspecified offense categories.

HEALTH STATUS

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

In this section, health status indicators related to health behaviors, morbidity, mortality, and maternal health are presented. New topics include adverse childhood experiences, impaired fecundity and infertility treatment, sexual risk behaviors, sexual violence, and sleep health. In addition, special pages are devoted to summarizing the health of Asian women, rural and urban women, and women veterans. The data throughout this section are displayed by various characteristics including sex, age, race and ethnicity, education, and income.

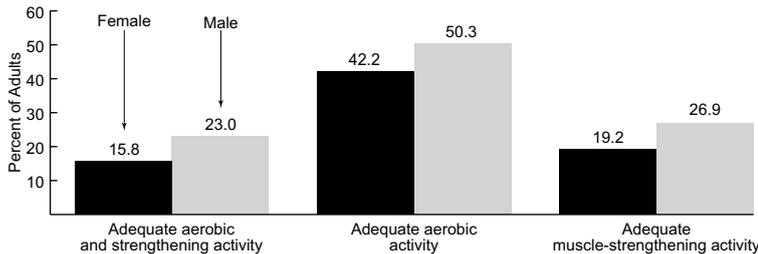


PHYSICAL ACTIVITY

Regular physical activity is critical for people of all ages to achieve and maintain a healthy body weight, prevent chronic disease, and promote psychological well-being. In older adults, physical activity also helps to prevent falls and improve cognitive functioning.¹ The 2008 Physical Activity Guidelines for Americans state that for substantial health benefits, adults should engage in at least 2½ hours per week of moderate intensity (e.g., brisk walking or gardening) or 1¼ hours per week of vigorous-intensity aerobic physical activity (e.g., jogging or kick-boxing), or an equivalent combination of both, plus muscle-strengthening activities on at least 2 days per week. Additional health benefits are gained by engaging in physical activity beyond this amount.¹

Adequate Physical Activity* Among Adults Aged 18 and Older, by Activity Type and Sex, 2008–2010

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



*Adequate aerobic activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous-intensity activity, or an equivalent combination of both; adequate muscle-strengthening activity is defined as performing muscle-strengthening activities, such as lifting weights or calisthenics, on 2 or more days per week; all estimates are age-adjusted.

In 2008–2010, 15.8 percent of women met the recommendations for adequate aerobic and muscle-strengthening physical activity, compared to 23.0 percent of men. Women were much more likely to have engaged in adequate amounts of aerobic activity, however, compared to muscle-strengthening activity (42.2 versus 19.2 percent, respectively).

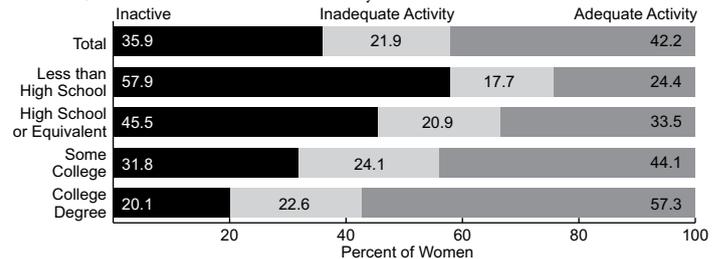
With regard to aerobic activity, about one in five women engaged in an inadequate amount of activity (21.9 percent) and more than one-third reported being inactive (35.9 percent). Inactivity tended to decrease as level of education increased, while the reverse was true for adequate activity. For instance, 57.9 percent of women with less than a high school diploma were inactive, compared to 20.1 percent of women with a college

degree. Similarly, about one-quarter of women who did not graduate high school engaged in adequate aerobic activity, compared to 57.3 percent of women with a college degree.

The proportion of women engaging in aerobic activity also varied with race and ethnicity. Nearly 50 percent of non-Hispanic Black and Hispanic women reported being inactive in 2008–2010 (48.6 and 48.4 percent, respectively), compared to less than one-third of non-Hispanic White women (31.0 percent). More than 40 percent of non-Hispanic American Indian/Alaska Native women also reported being inactive (data not shown). This is particularly important because of strong evidence linking sedentary behavior with the onset of multiple chronic diseases.¹

Aerobic Physical Activity Levels* Among Women Aged 18 and Older, by Level of Education, 2008–2010

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



*Adequate aerobic activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous intensity activity, or an equivalent combination of both; inadequate activity is defined as moderate or vigorous activity for 10 minutes or more per week but less than then recommended level for adequate activity; inactive is defined as no leisure-time aerobic activity that lasted at least 10 minutes.

NUTRITION

The *2010 Dietary Guidelines for Americans* recommends eating a variety of nutrient-dense foods while not exceeding caloric needs. Nutrient dense foods include fruits, vegetables, whole grains, lean meats and poultry, eggs, beans and peas. In particular, the U.S. Department of Agriculture's *MyPlate* recommends that fruits and vegetables should account for half of foods consumed daily.²

In 2009, less than one-third of adults in the United States reported consuming fruit two or more times per day (32.5 percent) and vegetables three or more times per day (26.5 percent; data not shown). Women were more likely than men to have consumed fruit at least twice

daily (36.1 versus 28.8 percent, respectively) and vegetables at least three times daily (30.9 and 21.3 percent, respectively; data not shown). Among women, fruit and vegetable consumption varied by education, race and ethnicity, and Body Mass Index (BMI).

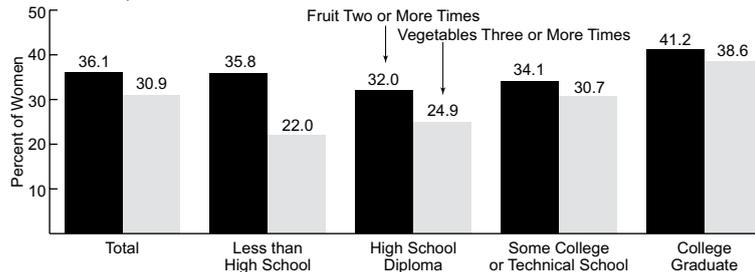
Women without a high school diploma were least likely to have reported consuming vegetables three or more times per day (22.0 percent), while those with a college degree were most likely to have done so (38.6 percent). Similarly, more than 40 percent of college-educated women consumed fruit twice or more daily, compared to about one-third of women with lower levels of education. With regard to race and ethnicity, only about one-quarter of non-

Hispanic Black and Hispanic women consumed vegetables three or more times daily (24.5 and 23.8 percent, respectively) compared to more than 32 percent for all other races and ethnicities (data not shown).

Obese women (BMI ≥ 30) also had lower fruit and vegetable consumption than those who were neither overweight nor obese (BMI < 25). For instance, only 31.6 percent of obese women consumed fruit two or more times per day, compared to 39.3 percent of women who were neither overweight nor obese. Diets high in fruits and vegetables may reduce the risk of many chronic diseases, and fruits and vegetables generally have fewer calories than other foods, which can contribute to better weight management.²

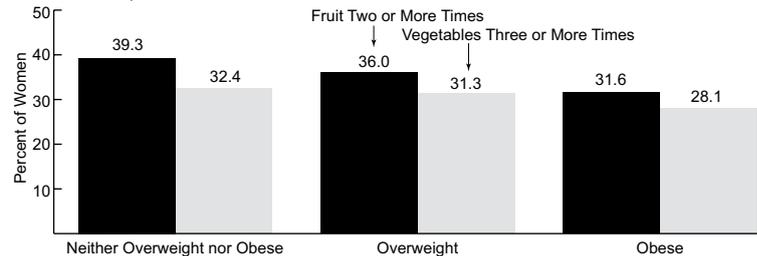
Daily Fruit and Vegetable Consumption Among Women Aged 18 and Older, by Level of Education, 2009

Source II.2: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



Daily Fruit and Vegetable Consumption Among Women Aged 18 and Older, by Weight Status,* 2009

Source II.2: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Neither overweight nor obese is defined as having a BMI of less than 25.0; overweight is defined as having a BMI between 25.0 and 29.9; and obese is defined as having a BMI of 30.0 or more.

ALCOHOL USE

Ethyl alcohol is an intoxicating ingredient found in beer, wine, and liquor which is produced by the fermentation of yeast, sugars, and starches.³ According to the *2010 Dietary Guidelines for Americans*, when alcohol is consumed it should be in moderation and limited to no more than one drink per day for women and two drinks per day for men.² While moderate alcohol consumption may have health benefits² – depending, in part, on the characteristics of the person consuming the alcohol – excessive drinking can lead to many adverse health and social consequences including injury, violence, risky sexual behavior, alcoholism, unemployment, liver diseases, and various cancers.⁴

Excessive drinking includes binge and heavy drinking. The Centers for Disease Control and Prevention defines heavy drinking as consuming more than one drink per day on average for women and two drinks per day on average for men. Binge drinking is defined as drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men (usually over the course of about 2 hours).³

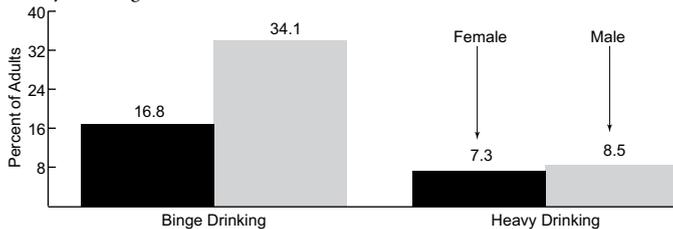
In 2009–2010, men were more likely than women to report both heavy drinking (8.5 versus 7.3 percent, respectively) and binge drinking (34.1 versus 16.8 percent, respectively) in the past 30 days. Despite being less likely to binge drink or drink heavily, women tend to face alcohol-related problems at a lower drink-

ing level than men due to differences in body size and other biological factors.⁵

Binge and heavy drinking among women varies significantly by age, as well as race and ethnicity. Younger women aged 18–25 years were more likely than women of other age groups to report binge and heavy drinking in the past month (33.3 versus 11.5 percent, respectively; data not shown). With respect to race and ethnicity, about 16 percent or more of women in every race and ethnic group reported binge drinking with the exception of non-Hispanic Asian women (7.9 percent). Heavy drinking was most commonly reported among non-Hispanic White women, non-Hispanic women of multiple races, and non-Hispanic American Indian/Alaska Native women (8.7, 7.6, and 6.8 percent, respectively).

Alcohol Use in the Past Month Among Adults Aged 18 and Older, by Level of Drinking* and Sex, 2009–2010

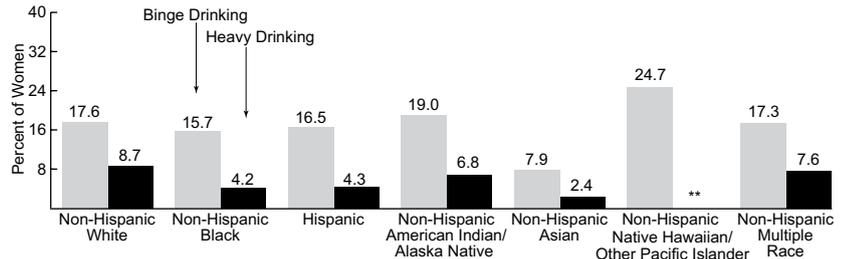
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Binge drinking indicates drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men usually over the course of about 2 hours. Heavy drinking indicates consumption of more than one drink per day on average for women and two drinks per day on average for men.

Binge and Heavy Alcohol Use* in the Past Month Among Women Aged 18 and Older, by Race/Ethnicity, 2009–2010

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



*Binge drinking indicates drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men usually over the course of about 2 hours. Heavy drinking indicates consumption of more than one drink per day on average for women and two drinks per day on average for men. **Estimate does not meet the standards of reliability or precision.

CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body.⁶ 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, cardiovascular disease, reduced bone density and fertility, and premature death.⁶ Due to its high prevalence and wide-ranging health consequences, smoking is the single largest cause of preventable death and disease for both men and women in the United States, accounting for an estimated 443,000 premature deaths annually.⁷

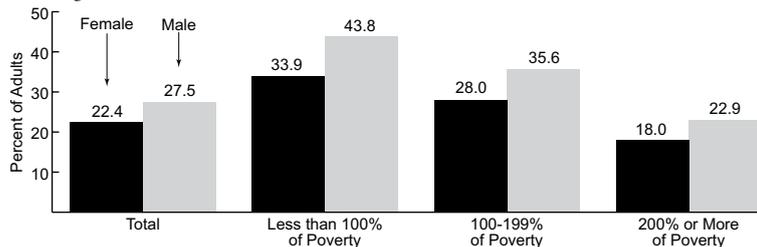
In 2009–2010, women aged 18 and older were less likely than men to report cigarette smoking in the past month (22.4 versus 27.5 percent, respectively). For both men and women, smoking was more common among those with lower incomes. For example, 33.9 percent of women and 43.8 percent of men with household incomes below 100 percent of poverty smoked in the past month, compared to 18.0 percent of women and 22.9 percent of men with incomes of 200 percent or more of poverty. Smoking also varied by race and ethnicity. Among women, smoking prevalence ranged from 6.8 percent among non-Hispanic Asians to 33.1 percent among non-Hispanic American Indian/Alaska Natives (data not shown).

Quitting smoking has major and immedi-

ate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.⁶ In 2009–2010, about 8 percent of women and men who had ever smoked daily and smoked in the previous 3 years had not smoked in the past year. The proportion of adults who quit smoking varied by poverty level for both women and men. For example, women with household incomes of 200 percent or more of poverty were almost twice as likely to have quit smoking as women with household incomes below 100 percent of poverty (9.7 versus 5.6 percent, respectively). In 2011, six States covered comprehensive tobacco cessation benefits in their Medicaid programs and nine states required private insurance plans to cover tobacco cessation treatment.⁸

Cigarette Smoking in the Past Month Among Adults Aged 18 and Older, by Poverty Status* and Sex, 2009–2010

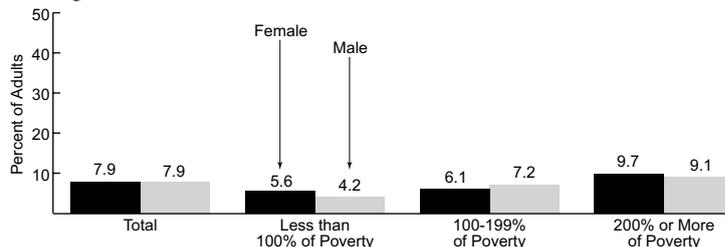
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

Smoking Cessation* in the Past Year Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2009–2010

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



*Defined as the proportion of adults who did not smoke in the past year among those who ever smoked daily at some point in their lives and smoked in the past 3 years; excludes adults who started smoking in the past year. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

ILLICIT DRUG USE

Illicit drug use is associated with serious health and social consequences, including addiction and drug-induced death, impaired cognitive functioning, kidney and liver damage, infections—including HIV and Hepatitis—decreased productivity, and family disintegration.^{9,10} Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type psychotherapeutic drugs, such as pain relievers, stimulants, and sedatives. Methamphetamine is a type of psychotherapeutic drug that, in low doses, has limited medical use for narcolepsy and attention

deficit disorder, and is now manufactured and distributed illegally.⁹

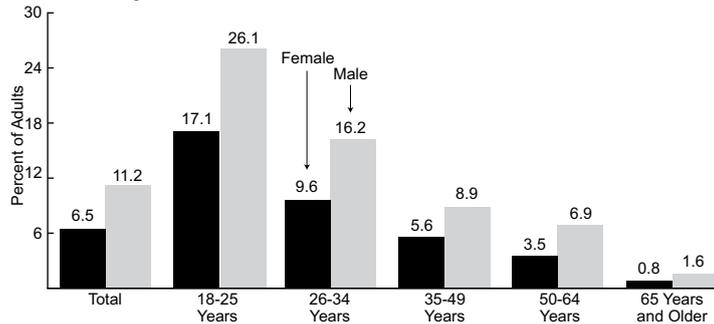
In 2009–2010, 6.5 percent of adult women aged 18 years and older reported using an illicit drug within the past month, compared to 11.2 percent of adult men. Illicit drug use was highest among younger adults; 17.1 of women aged 18–25 reported past-month illicit drug use compared to 9.6 percent of women aged 26–34 and 5.6 percent of women aged 35–49. Rates of past-month illicit drug use also varied by race and ethnicity. Non-Hispanic Asian women were less likely than other women to report past-month use (2.1 percent, data not shown). Mari-

juana was the most commonly used illicit drug among adult women (4.6 percent), followed by the non-medical use of psychotherapeutics (2.4 percent; data not shown).

Past-month illicit drug use varied by poverty level. Among both men and women, illicit drug use was more common among those with lower incomes. For example, 10.4 percent of women and 19.5 percent of men with household incomes below 100 percent of poverty used illicit drugs in the past month, compared to 5.4 percent of women and 9.3 percent of men with incomes of 200 percent or more of poverty.

Any Illicit Drug Use* in the Past Month Among Adults Aged 18 and Older, by Age and Sex, 2009–2010

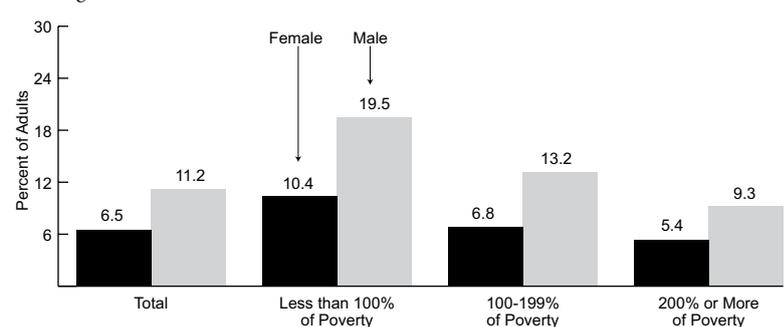
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



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

Any Illicit Drug Use* in the Past Month Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2009–2010

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. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

SEXUAL RISK BEHAVIORS

Sexually Transmitted Infections (STIs) can cause a variety of health problems among women if left untreated. Health outcomes that have been associated with untreated STIs include cervical cancer, pelvic inflammatory disease, infertility, and even death in the case of HIV/AIDS (see pages on *Sexually Transmitted Infections* and *HIV/AIDS*).^{11,12} Women can lower their risk of contracting HIV and other STIs by avoiding sexual risk-taking behaviors.

In 2006–2010, 3.9 percent of women aged 15–44 reported engaging in at least one sexual risk behavior during the past 12 months (data not shown). Among women aged 15–44, the most commonly reported sexual risk behaviors

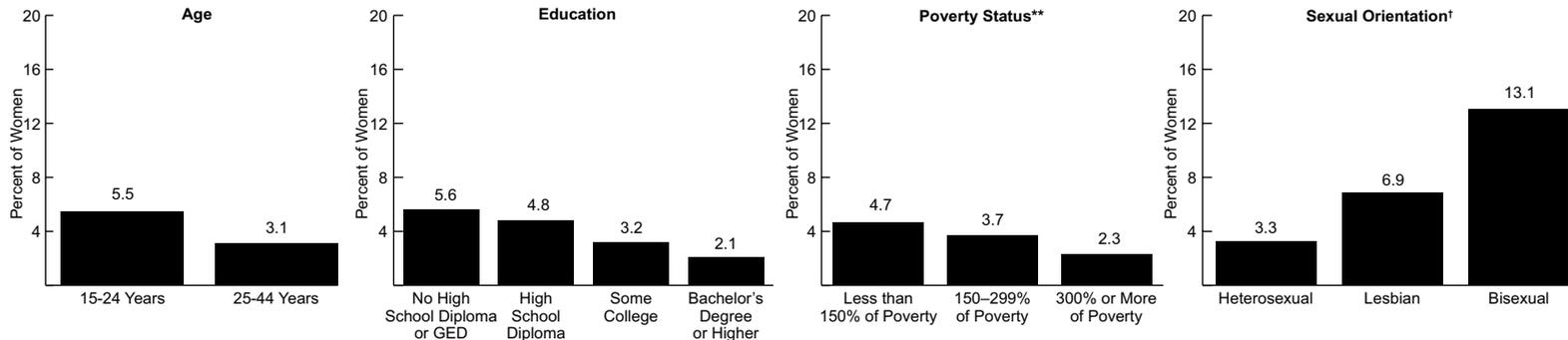
were having five or more male sex partners in the past 12 months (1.8 percent) and having had at least one male sex partner who had had sex with other males (1.4 percent). Less than 1 percent of women reported having had sex in exchange for money or drugs (0.7 percent), having had a sex partner that injects illicit drugs (0.8 percent), or having had an HIV-positive sex partner (0.1 percent; data not shown).

The prevalence of engaging in sexual risk behaviors among women varied by sociodemographic characteristics. Younger women, aged 15–24 years, were more likely to report engaging in at least one sexual risk behavior during the past 12 months (5.5 percent), compared to

women aged 25–44 years (3.1 percent). Women with a high school education or less were also more likely to report any sexual risk behavior compared to those with at least some college, as were women living with household incomes below 150 percent of poverty (4.7 percent) compared to women living with incomes of 150–299 and 300 percent or more of poverty (3.7 and 2.3 percent, respectively). Bisexual women were more likely than heterosexual women to report having engaged in at least one sexual risk behavior during the past 12 months (13.1 versus 3.3 percent, respectively), while no statistically significant difference was observed for lesbian women, compared to heterosexual women.

Any Sexual Risk Taking Behavior* Among Women Aged 15–44 Years, by Selected Characteristics, 2006–2010

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



*Includes having had more than five opposite-sex sex partners, having sex in exchange for money or drugs, having a male sex partner who has had sex with other males, having a sex partner who injects illicit drugs, or having an HIV-positive sex partner. **Estimates by poverty status are limited to women aged 20–44 years of age at the time of the interview. †Estimates by sexual orientation are limited to women aged 18–44 years of age at the time of the interview.

LIFE EXPECTANCY

In 2010, the overall life expectancy of a baby born was 78.7 years (data not shown); this varied, however, by sex and race. A baby girl born in the United States in 2010 could expect to live 81.0 years, 4.8 years longer than a male baby, whose life expectancy would be 76.2 years (data not shown). The differential between male and female life expectancy was greater among Blacks than Whites. Black males born in 2010 could expect to live 71.8 years, 6.2 years fewer than Black females (78.0 years). The difference between White males and females was 4.8 years, with life expectancies at birth of 76.5 and 81.3 years, respectively. White females could expect to live 3.3 years longer than Black females.

Life expectancy has increased since 1970 for males and females in both racial groups. Between 1970 and 2010, White males' life expectancy increased from 68.0 to 76.5 years (12.5 percent), while White females' life expectancy increased from 75.6 to 81.3 years (7.5 percent). During the same period, the life expectancy for Black males increased from 60.0 to 71.8 years (19.7 percent), while life expectancy increased from 68.3 to 78.0 years (14.2 percent) for Black females. Between 1970 and 2010, the greater gains in life expectancy for males than females and for Blacks than Whites have led to reduced disparities by sex and race.

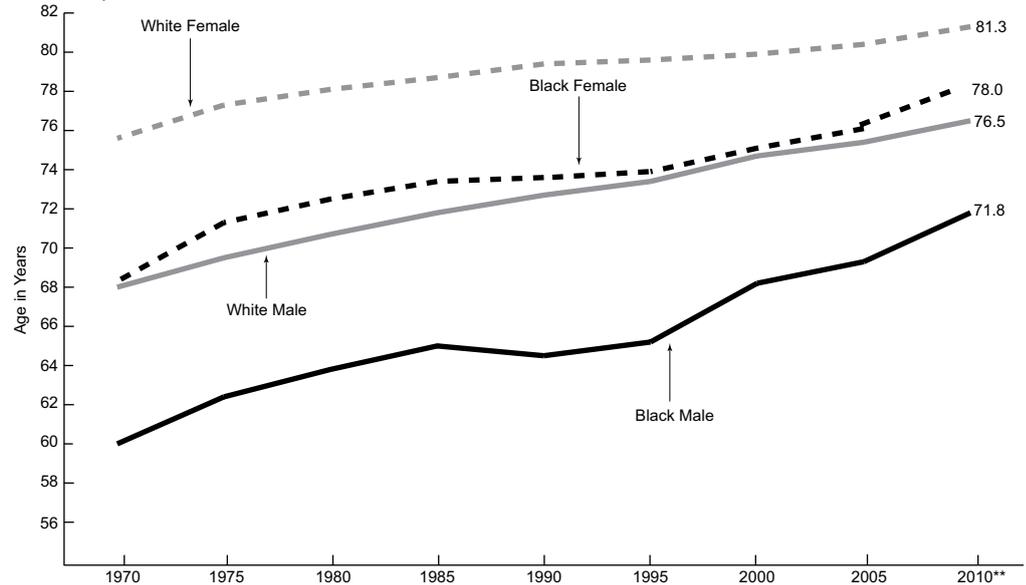
Life expectancy among the Hispanic popula-

tion has been reported only recently. In 2010, reported life expectancy by sex and race/ethnicity was highest for Hispanic females (83.8 years), followed by non-Hispanic White females (81.1 years), Hispanic males (78.5 years), non-Hispanic Black females (77.7 years), non-Hispanic White males (76.4 years), and non-Hispanic

Black males (71.4 years, data not shown).¹³ Life expectancy data are not reported for Asian, Native Hawaiian and other Pacific Islander, and American Indian/Alaska Native populations due to known issues of under-reporting on death certificates.

Life Expectancy at Birth, by Race* and Sex, 1970–2010

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



*Both racial categories include Hispanics.

LEADING CAUSES OF DEATH

In 2010, there were 1,219,545 deaths of women aged 18 and older in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), which were responsible for 23.8 and 22.4 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 6.3 percent of deaths, and chronic lower respiratory diseases, which accounted for 6.0 percent.

Heart disease was the leading cause of death for non-Hispanic White and non-Hispanic Black women, while cancer was the leading cause among all other racial and ethnic groups. One of the most noticeable differences in leading causes of death by race and ethnicity is that diabetes mellitus was a more prominent cause of death among minority women than non-Hispanic White women. Diabetes was the fourth leading cause of death among women of all racial and ethnic groups except non-Hispanic White women, for whom it ranked as the eighth leading cause. Conversely, chronic lower respiratory disease was a more prominent cause of death among non-Hispanic White women, ranking third for non-Hispanic White women versus sixth or higher for other racial and ethnic groups. Nephritis, or kidney inflammation, was the fifth leading cause of death among non-His-

panic Black women, but ranked eighth or ninth among women of other races and ethnicities.

Hypertension was the tenth leading cause among non-Hispanic Black and non-Hispanic Asian/Pacific Islander women, accounting for 2.1 and 2.0 percent of deaths, respectively. Also noteworthy is that non-Hispanic American Indian/Alaska Native women experienced

a higher proportion of deaths due to unintentional injury (7.5 percent; third leading cause of death) and liver disease (5.3 percent; fifth leading cause of death) than women of other racial and ethnic groups. Liver disease was also the tenth leading cause of death among Hispanic women, accounting for 2.1 percent of deaths (data not shown).

Ten Leading Causes of Death Among Women Aged 18 and Older, by Race/Ethnicity, 2010

Source II.6: 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 American Indian/Alaska Native	Non-Hispanic Asian/Pacific Islander
Cause of Death	% (Rank)	% (Rank)	% (Rank)	% (Rank)	% (Rank)	% (Rank)
Heart Disease	23.8 (1)	23.8 (1)	24.8 (1)	22.0 (2)	17.2 (2)	21.7 (2)
Malignant Neoplasms (cancer)	22.4 (2)	22.0 (2)	23.3 (2)	23.6 (1)	20.0 (1)	28.8 (1)
Cerebrovascular Diseases (stroke)	6.3 (3)	6.2 (4)	6.6 (3)	6.3 (3)	4.4 (7)	8.7 (3)
Chronic Lower Respiratory Diseases	6.0 (4)	6.6 (3)	3.0 (6)	3.2 (7)	5.3 (6)	2.4 (8)
Alzheimer's Disease	4.8 (5)	5.2 (5)	2.7 (7)	3.7 (6)	2.5 (9)	3.1 (6)
Unintentional Injury	3.5 (6)	3.6 (6)	2.6 (8)	4.1 (5)	7.5 (3)	3.2 (5)
Diabetes Mellitus	2.8 (7)	2.3 (8)	4.7 (4)	5.2 (4)	6.3 (4)	3.7 (4)
Influenza and Pneumonia	2.2 (8)	2.2 (7)	(N/A)	2.3 (9)	2.2 (10)	3.0 (7)
Nephritis (kidney inflammation)	2.1 (9)	1.9 (9)	3.5 (5)	2.5 (8)	2.7 (8)	2.4 (9)
Septicemia (blood poisoning)	1.5 (10)	1.4 (10)	2.4 (9)	(N/A)	(N/A)	(N/A)

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

HEALTH-RELATED QUALITY OF LIFE

Health-related quality of life encompasses multiple aspects of health and is often measured in different ways, including self-reported health status and the number of days in the past month that a person felt that either their physical or mental health was not good.¹⁴

In 2010, 54.2 percent of women reported being in excellent or very good health, while 29.5 percent reported being in good health and 16.3 percent reported being in fair or poor health. Self-reported health status was similar among men and women but varied greatly by age, education, and race and ethnicity. About 60 percent of women aged 18–34 years reported excellent or very good health compared to 39.4 percent

of women aged 65 and older (data not shown). Nearly 70 percent of women with a college degree reported excellent or very good health compared to less than one-quarter of women without a high school diploma. Conversely, fair or poor health was only reported by 7.5 percent of women with a college degree compared to 40.6 percent of women of who had not finished high school.

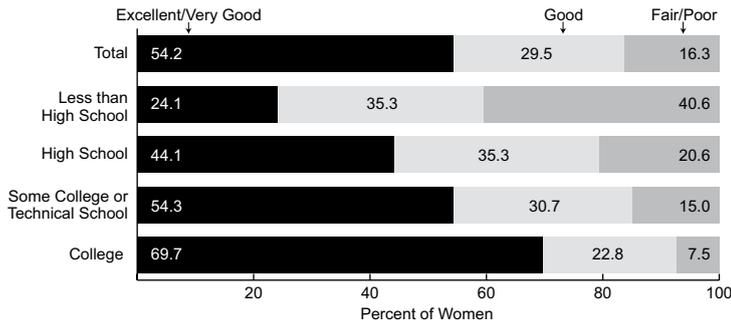
With regard to race and ethnicity, fair or poor health was more likely to be reported among Hispanic (29.5 percent), non-Hispanic American Indian/Alaska Native (26.0 percent), non-Hispanic Black (23.2 percent), and non-Hispanic Native Hawaiian/Other Pacific Islander women (20.8 percent) compared to non-Hispanic White and non-Hispanic Asian women (12.9 and 12.7

percent, respectively; data not shown).

In 2010, women reported more physically and mentally unhealthy days than men. Women reported an average of 3.9 days of poor physical health, compared to 3.3 days per month for men. Similarly, women reported an average of 4.1 mentally unhealthy days, while men reported an average of 3.0 days per month (data for men not shown). While physically unhealthy days per month consistently increased with age, mentally unhealthy days decreased at age 65 and older. For example, on average, women aged 18–34 years reported only 2.5 physically unhealthy days per month but 4.4 mentally unhealthy days, whereas women aged 65 and older reported 5.7 physically unhealthy days per month but only 2.6 mentally unhealthy days.

Self-Reported Health* Among Women Aged 18 and Older, by Level of Education, 2010

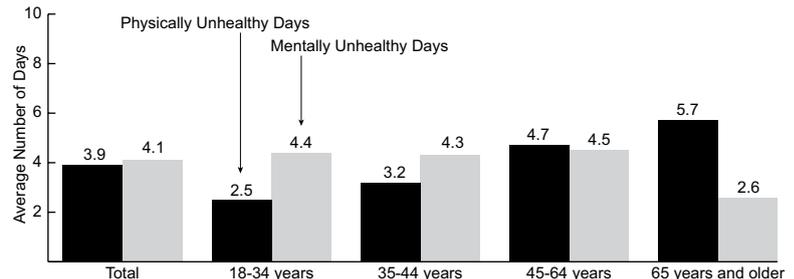
Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Estimates are age-adjusted.

Average Number of Physically and Mentally Unhealthy Days* in Past Month Among Women Aged 18 and Older, by Age, 2010

Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Self-reported number of days in past 30 days that physical or mental health were not good; total estimates are age-adjusted.

ACTIVITY LIMITATIONS

Activity limitations are defined in different ways. One common definition is whether a person is able to perform physical tasks (e.g., walking up 10 steps, standing for 2 hours, carrying a ten pound object), or engage in social activities and recreation (e.g., going shopping, visiting friends, sewing, reading) without the assistance of another person or using special equipment.¹⁵ In 2008–2010, 33.6 percent of adults reported being limited in 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 (37.5 versus 29.3 percent, respectively).

The percentage of adults reporting activity limitations increased with age for both women and men. Among women, for example, only 19.1 percent of women aged 18–34 years reported activity limitations, compared to 27.7 percent of women aged 35–44 years, 45.8 percent of women aged 45–64 years, and 69.1 percent of women aged 65 years and older.

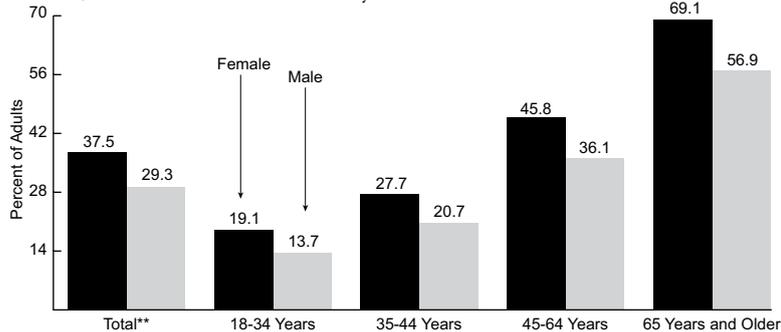
The prevalence of activity limitations also varied with poverty level and educational attainment. For example, over half (50.2 percent) of women living in households with incomes less than 100 percent of poverty reported activity limitations compared to 29.8 percent of women living in households with incomes of 400 per-

cent or more of poverty. Similarly, 47.1 percent of women with less than a high school education reported activity limitations compared to 28.5 percent of women with a college degree or higher (data not shown).

In 2008–2010, the most commonly reported conditions among women with activity limitations were back or neck problems and arthritis (28.0 and 27.7 percent, respectively), followed by depression, anxiety, or emotional problems (11.1 percent), bone or joint injuries (9.7 percent), and weight problems (8.0 percent). Vision and hearing problems were reported to cause limitations in 2.6 and 0.9 percent of women with activity limitations, respectively.

Adults Aged 18 and Older with Activity Limitations,* by Age and Sex, 2008–2010

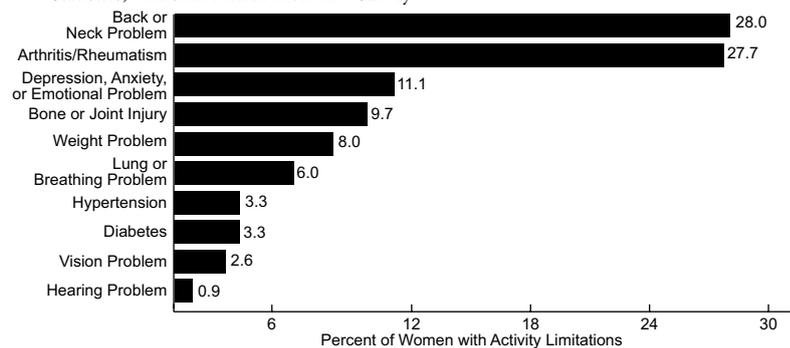
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as having difficulty performing certain physical, social, or recreational activities without the assistance of another person or using special equipment. **Total estimates are age-adjusted.

Women Aged 18 and Older with Activity Limitations,* by Selected Conditions, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as having difficulty performing certain physical, social, or recreational activities without the assistance of another person or using special equipment; estimates are age-adjusted.

ARTHRITIS

Arthritis is the leading cause of disability and activity limitations among U.S. adults. Arthritis comprises more than 100 different diseases that affect areas in or around the joints.¹⁶ 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.¹⁷

In 2008–2010, 22.0 percent of adults in the United States reported that they had ever been diagnosed with arthritis; representing nearly 52 million adults (data not shown). Arthritis was

more common among women than men (24.9 versus 18.8 percent, respectively). The proportion of adults with arthritis increases dramatically with age for both sexes. Only 5.3 percent of women aged 18–34 years had ever been diagnosed with arthritis, compared to 15.6 percent of 35- to 44-year-olds, 34.2 percent of those aged 45–64 years, and 56.4 percent of women aged 65 years and older. Similarly, only 3.5 percent of men aged 18–34 years had ever been diagnosed with arthritis, compared to 44.1 percent of those aged 65 years and older.

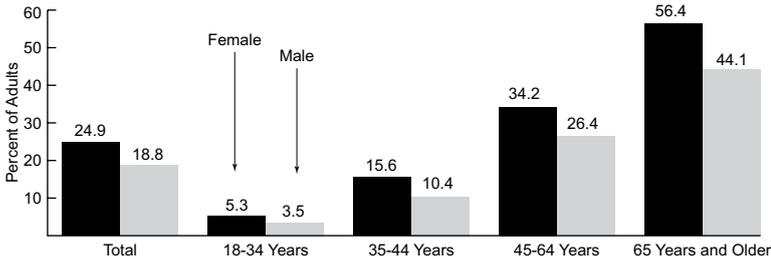
Among women, arthritis prevalence varied significantly by race and ethnicity. More than one-quarter of non-Hispanic American Indian/Alaska Native, non-Hispanic Black, non-

Hispanic White, and women of multiple races reported having been diagnosed with arthritis (26.9, 26.7, 26.2, and 31.4 percent, respectively), compared to 13.3 percent of non-Hispanic Asian women and 19.6 percent of Hispanic women (data not shown).

Obesity has been associated with the onset and progression of osteoarthritis.¹⁶ In 2008–2010, nearly one-third of obese adults and one-fifth of overweight adults had been diagnosed with arthritis, compared to 17.4 percent of adults who were neither overweight nor obese. Among women, having been diagnosed with arthritis was reported by 33.6 percent of obese women, compared to 19.3 percent of women who were neither overweight nor obese.

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2008–2010

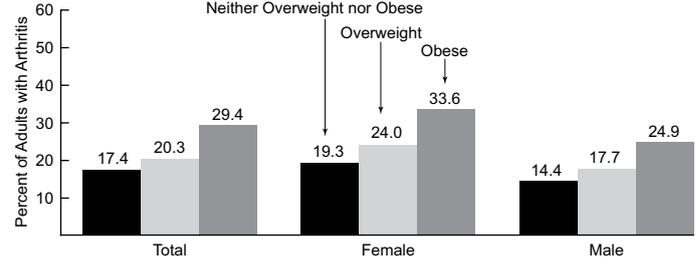
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have arthritis; total estimates are age-adjusted.

Adults Aged 18 and Older with Arthritis,* by Sex and Weight Status,** 2008–2010

Source II.8: 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; estimates are age-adjusted. **Body Mass Index (BMI) is a ratio of weight to height. Neither overweight nor obese is defined as having a BMI of less than 25.0; overweight is defined as having a BMI between 25.0 and 29.9; and obese is defined as having a BMI of 30.0 or more.

OVERWEIGHT AND OBESITY

Overweight and obesity are 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.¹⁸ As a result, annual medical costs for people who are obese have been estimated to be \$1,429, or 42 percent, higher than people of normal weight, aggregating to a total of \$147 billion.¹⁸ Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2009–2010, more than two-thirds of adults were overweight or obese (68.3 percent); this includes 33.0 percent who were classified as overweight (BMI of 25.0–29.9) and 35.3 percent of adults who were classified as obese (BMI of 30.0 or more; data not shown).

In 2009–2010, women were less likely than men to be overweight (28.1 versus 38.3 percent, respectively), but equally as likely to be obese (approximately 35 percent; data for men not shown). Weight status varied by age among both women and men, although the prevalence of obesity increased markedly for both sexes after age 25. Among women, obesity was most prevalent among those aged 45–64 and 65 years and older (40.5 and 38.6 percent, respectively) compared to one-third of those aged 25–44 years and one-quarter of women aged 18–24 years. While overall, less than 2 percent of adults were under-

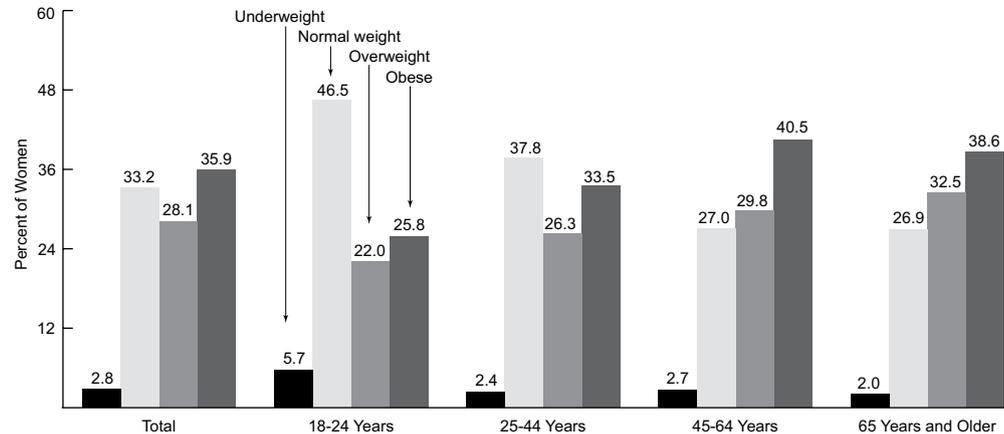
weight (BMI of 18.5 or less; data not shown), 5.7 percent of women aged 18–24 years met this criteria in 2009–2010.

Obesity also varies by poverty, as well as race and ethnicity. In 2009–2010, 43.6 percent of women living in households with incomes below the poverty level were obese, compared to 30.5 percent of women with a household income of 300 percent or more of poverty. Non-Hispanic Black and Mexican American women were also significantly more likely to be obese than non-Hispanic White women (58.0 and

44.0 versus 33.1 percent, respectively; data not shown). In contrast to non-Hispanic White women, non-Hispanic Black and Mexican American women have experienced significant increases in obesity over the last decade.¹⁹ Higher obesity rates have also been reported among non-Hispanic American Indian/Alaska Native women while lower rates have been reported for non-Hispanic Asian women.²⁰ Community strategies that can help to prevent obesity include efforts to improve access to healthy foods, parks, and recreational facilities.²¹

Weight Status* Among Women Aged 18 and Older, by Age, 2009–2010

Source II.9: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Underweight is defined as having a Body Mass Index (BMI) of less than 18.5; normal weight is defined as having a BMI between 18.5 and 24.9; overweight is defined as having a BMI between 25.0 and 29.9; obesity is defined as having a BMI of 30.0 or more.

DIABETES

Diabetes mellitus is a chronic condition characterized by high blood sugar and is among the leading causes of death in the United States.²² Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, nervous system disease, and amputation. The main types of diabetes are Type 1, Type 2, and gestational (diabetes occurring or first recognized during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults and has risk factors that include autoimmune, genetic, and environmental factors. Type 2 diabetes accounts for 90 to 95 percent of all diabetes cases, with risk factors that include obesity, physical inactivity, a family history of the disease, and gestational diabetes.

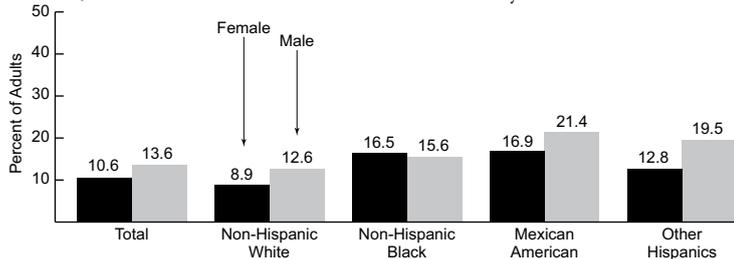
In 2007–2010, 28 million or 12.0 percent of adults were found to have diabetes (tested positive for the condition on a fasting plasma glucose test, glycohemoglobin A1C test, or 2-hour oral glucose test; data not shown). Overall, diabetes was slightly more common in men than women (13.6 versus 10.6 percent, respectively) and was also higher for racial and ethnic minority groups than among non-Hispanic Whites. Among women, for example, non-Hispanic White women were least likely to have diabetes (8.9 percent) compared to non-Hispanic Black (16.5 percent), Mexican American (16.9 percent), and Other Hispanic women (12.8 percent). Diabetes prevalence increases greatly with age from 3.1 percent of women aged 18–44 years to 30.6 percent among women aged 75 years and older,

and was also more common for women with less than a high school education compared to those who had graduated from college (15.6 versus 5.8 percent, respectively; data not shown).

Diabetes can be successfully managed through diet modification, physical activity, glucose monitoring, and medication.²² Diagnosis is critical to develop a treatment plan and prevent serious complications. Among women who were found to have diabetes, only about half (49.4 percent) reported having been told by a health professional that they had diabetes. Non-Hispanic Black women were more likely than non-Hispanic White and Mexican American women to have ever been told by a health professional that they have diabetes (70.6 versus 40.5 and 54.0 percent, respectively).

Diabetes* Among Adults Aged 18 and Older, by Race/Ethnicity** and Sex, 2007–2010

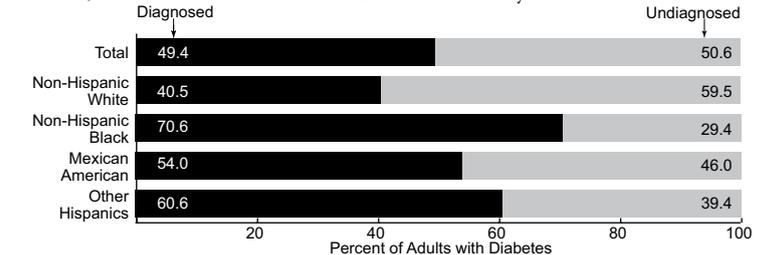
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test; estimates are age-adjusted. **The samples of American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.

Diagnosis Status* Among Women Aged 18 and Older Who Have Diabetes**, by Race/Ethnicity†, 2007–2010

Source II.10: 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. **Tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test. †The samples of American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple races were too small to produce reliable results.

HIGH BLOOD PRESSURE

High blood pressure, or hypertension, is a risk factor for heart disease and stroke, which are among the leading causes of death in the United States (see *Heart Disease and Stroke*). It is defined as a systolic blood pressure (during heartbeats) of 140 mmHg or higher, a diastolic blood pressure (between heartbeats) of 90 mmHg or higher, or current use of blood pressure-lowering medication.

In 2007–2010, 27.5 percent of women were identified as having high blood pressure. This includes 15.6 percent of women with controlled hypertension, who had a normal blood pressure measurement and reported using blood pressure-lowering medication, and 11.9

percent with uncontrolled hypertension, who had a high blood pressure measurement with or without the use of medication. In addition to medication, high blood pressure can also be controlled by losing excess body weight, participating in regular physical activity, avoiding tobacco smoke, and adopting a healthy diet with lower sodium and higher potassium intake.²³

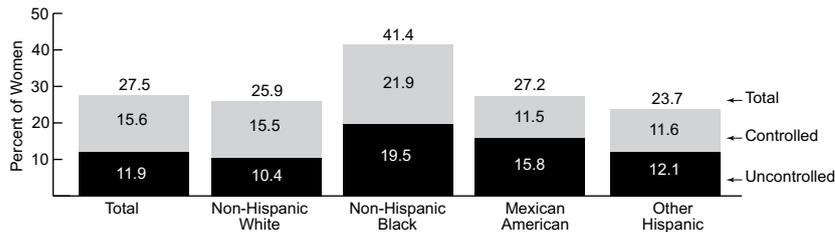
The prevalence of hypertension does not vary by sex, but increases with age, affecting approximately 3 out of 4 women aged 65 and older in 2007–2010 (74.4 percent; data not shown). Hypertension also varies by race and ethnicity. Over 40 percent of non-Hispanic Black women had hypertension compared to about 25 percent of non-Hispanic White, Mexican American, and

Other Hispanic women. However, both non-Hispanic Black and Mexican American women were more likely to have uncontrolled hypertension than non-Hispanic White women (19.5 and 15.8 versus 10.4 percent; respectively).

Hypertension presents a unique public health challenge because many of those affected are unaware of their condition.²⁴ Among women with uncontrolled hypertension, 44.8 percent had not been previously diagnosed by a health care professional. About half of non-Hispanic White and Mexican American women with uncontrolled hypertension had not been diagnosed (52.5 and 47.9 percent, respectively), compared to only about one-third of non-Hispanic Black women (32.2 percent).

High Blood Pressure Among Women Aged 18 and Older,* by Race/Ethnicity,** 2007–2010

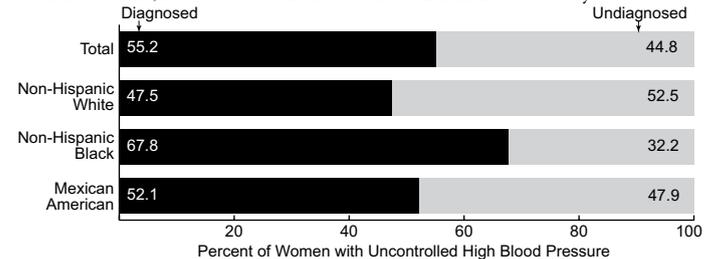
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Includes a measured systolic pressure (during heartbeats) of ≥ 140 mmHg or a diastolic blood pressure (between heartbeats) ≥ 90 mmHg (uncontrolled hypertension, with or without blood pressure-lowering medication) and normal blood pressure ($\leq 140/90$ mmHg) with reported current medication use (controlled hypertension); percentages may not add to totals due to rounding; estimates are age-adjusted. **The samples of American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.

Diagnosis Status* Among Women Aged 18 and Older with Uncontrolled High Blood Pressure,** by Race/Ethnicity,† 2007–2010

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



*Reported whether they had ever been told by a health professional that they have high blood pressure; estimates are age-adjusted. **Includes a measured systolic pressure (during heartbeats) of ≥ 140 mmHg or a diastolic blood pressure (between heartbeats) ≥ 90 mmHg. †The samples of Other Hispanics, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.

HEART DISEASE AND STROKE

Cardiovascular disease is the abnormal functioning of the heart and blood vessels. Heart disease and stroke are the most common forms of cardiovascular disease and are the first and third leading causes of death for both men and women in the United States.²⁵ Risk factors for both include high blood pressure and cholesterol, excess weight, physical inactivity, age, and family history. Stroke involves interrupted blood flow to the brain, whereas heart disease involves reduced blood flow to the heart, which can result in a heart attack. Chest pain is a common heart attack symptom; however, women are more likely than men to have other symptoms, such as shortness of breath, nausea and vomiting, and back or jaw pain.²⁶ Stroke symptoms can include numbness,

headache, dizziness, confusion, trouble speaking, and blurred vision.²⁶

In 2008–2010, 11.8 percent of adults reported a diagnosis of heart disease (data not shown). Overall, men were slightly more likely to have been diagnosed with heart disease (12.8 versus 10.6 percent, respectively). Heart disease increases with age; among women, heart disease ranged from 4.7 percent of those aged 18–44 years to 32.2 percent of those aged 75 and older. As age increases, men are substantially more likely than women to have heart disease. Almost half (46.1 percent) of all men aged 75 and older have been diagnosed with heart disease.

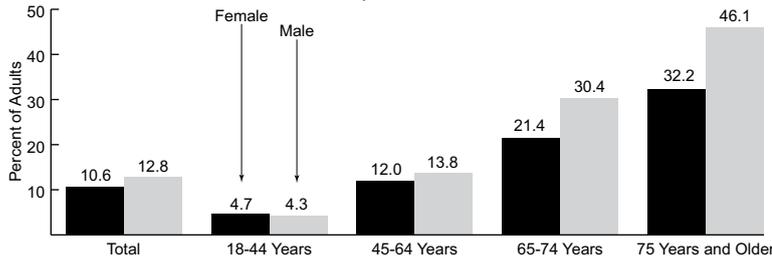
In 2008–2010, similar percentages of women and men reported that they had ever been diagnosed with a stroke (2.6 and 2.7 percent, respec-

tively). Among both women and men, the proportion of persons ever having had a stroke was generally higher among non-Hispanic Blacks. For example, 4.1 percent of non-Hispanic Black women had reported having a stroke compared to 2.5 percent of non-Hispanic White women and 2.6 percent of Hispanic women. Non-Hispanic Asian women were least likely to report having had a stroke (1.1 percent).

For reasons that are poorly understood, 42 percent of women will die within a year of having a heart attack compared to 24 percent of men.²⁷ There is evidence that women diagnosed with cardiovascular disease are less likely than men to receive certain treatments that have been reported to improve outcomes, and women may also be more likely to have other chronic conditions.²⁷

Heart Disease* Among Adults Aged 18 and Older, by Age and Sex, 2008–2010

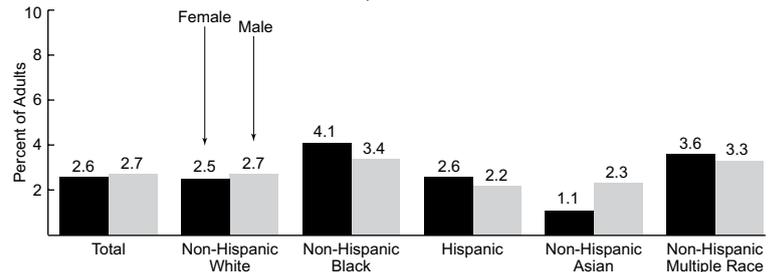
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them that they had coronary heart disease, angina pectoris, heart attack, or any other heart condition or disease; total estimates are age-adjusted.

Stroke* Among Adults Aged 18 and Older, by Race/Ethnicity** and Sex, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them that they had a stroke; estimates are age-adjusted.

**The sample of American Indian/Alaska Natives and Native Hawaiian/Pacific Islanders was too small to produce reliable results.

CANCER

Cancer is the second leading cause of death for both men and women. It is estimated that 790,740 new cancer cases will be diagnosed among females and more than 275,000 females will die of cancer in 2012.²⁸ Based on prior years, lung and bronchus cancer is expected to be the leading cause of cancer death among females, accounting for 72,590 deaths (26 percent of all cancer deaths), followed by breast cancer, which will be responsible for 39,510 (14 percent of deaths). Colorectal cancer, pancreatic cancer, and ovarian cancer will also be major causes of cancer

deaths among females, accounting for an additional 59,260 deaths combined.

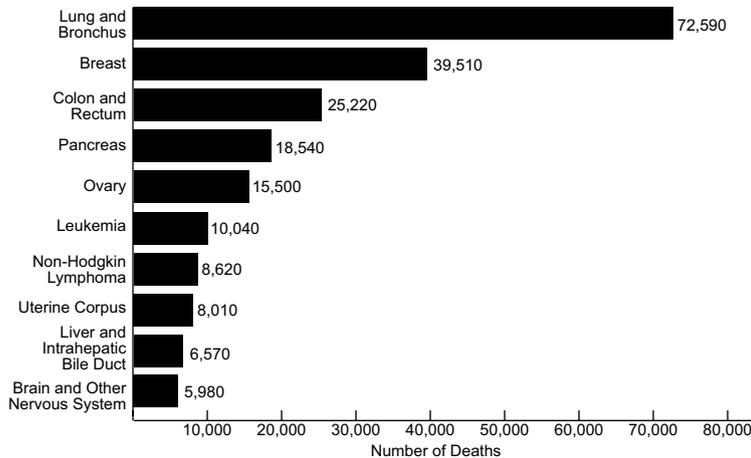
Due to the varying survival rates for different types of cancer, the most common causes of death from cancer are not always the most common types of cancer. For instance, although lung and bronchus cancer causes the greatest number of deaths, breast cancer is more commonly diagnosed among females. In 2008, invasive breast cancer occurred among 121.9 per 100,000 females, whereas lung and bronchus cancer occurred in only 54.5 per 100,000. Other types of cancer that are commonly diagnosed but are not

among the top 10 causes of cancer death include thyroid, melanoma, and cervical cancer.

Racial and ethnic disparities in cancer incidence may be explained by differences in behavioral risk factors, such as smoking, heavy alcohol consumption, obesity, poor nutrition, and physical inactivity that are largely a product of socioeconomic differences.²⁸ Racial and ethnic disparities in cancer death rates tend to be even greater than disparities in incidence rates because they are a function of differences in incidence, as well as stage at diagnosis, treatment, and patient survival, which are greatly influenced by health care access and quality.

Leading Causes of Cancer Deaths Among Females (All Ages), by Site, 2012 Estimates

Source II.11: American Cancer Society



Age-Adjusted Invasive Cancer Incidence Rates per 100,000 Females (All Ages), by Site and Race/Ethnicity, 2008

Source II.12: Centers for Disease Control and Prevention and National Cancer Institute

Type of Cancer	Total (Rank)	White*	Black*	Hispanic [†]	American Indian/Alaska Native* [†]	Asian/Pacific Islander* [†]
Breast	121.9 (1)	122.6	118.0	92.8	65.6	87.9
Lung and Bronchus	54.5 (2)	56.2	49.4	26.4	38.9	26.8
Colon and Rectum	38.7 (3)	37.6	46.0	31.5	27.3	31.1
Uterine Corpus	24.4 (4)	24.8	22.6	20.4	14.2	16.6
Thyroid	18.6 (5)	19.4	11.2	18.1	9.4	19.4
Non-Hodgkin Lymphoma	15.9 (6)	16.3	10.9	14.9	10.2	11.0
Melanoma	15.1 (7)	17.2	0.9	4.1	3.5	1.0
Ovary	12.2 (8)	12.6	9.3	11.2	9.0	9.2
Kidney	11.1 (9)	11.1	12.5	11.1	11.3	5.1
Pancreas	10.5 (10)	10.1	13.9	10.0	6.8	7.9

*May include Hispanics. [†]Estimates should be interpreted with caution.

Recommended screening can help detect several forms of cancer in early, more treatable stages, including breast, colorectal, and cervical cancer, and is shown to reduce mortality.²⁸ Vaccines are also available to help prevent hepatitis B and human papillomavirus (HPV) which can cause liver and cervical cancer, respectively. The Affordable Care Act of 2010 requires health insurance plans to cover recommended preventive services, including cancer screenings and vaccinations, free-of-charge to beneficiaries.²⁹

In 2005–2009, cervical cancer incidence rates ranged from 5.8 per 100,000 American Indian/Alaska Native females to 11.8 per 100,000 Hispanic females. For Black, Hispanic, and Asian/

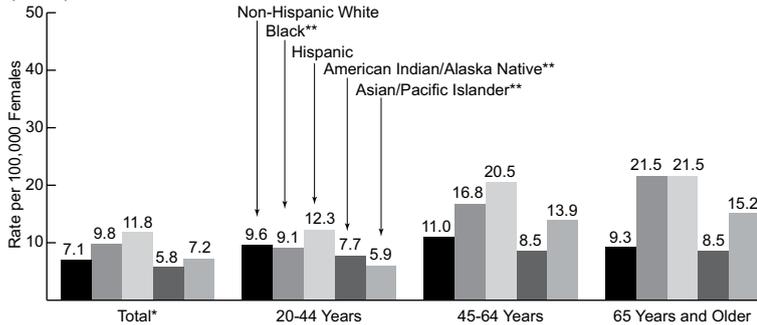
Pacific Islander females, cervical cancer incidence increased with age, which may indicate a lack of early screening and treatment that can prevent invasive cancer from developing. The Pap test, a cervical cell examination, is recommended every 3 years for women aged 21–65 years to screen for precancerous lesions and cervical cancer.³⁰ Precancerous lesions and early, localized invasive cervical cancer are highly treatable; however, about half of invasive cervical cancer cases are not detected in the early, localized stage.²⁸

Breast cancer is the most common cancer in women but is also highly treatable when diagnosed early; 99 percent of women will survive 5 years after a breast cancer diagnosis in the

early, localized stage. Mammography screening is universally recommended every other year for women aged 50–74 years.³⁰ In 2005–2009, the proportion of breast cancer cases detected in the early, localized stage ranged from 54.5 percent among Black women to 65.2 percent among non-Hispanic White women. Disparities in early detection, as well as stage-specific survival, contribute to overall survival differences by race and ethnicity. In 2004–2008, more than 90 percent of non-Hispanic White and Asian/Pacific Islander women survived 5 years after breast cancer diagnosis, compared to about 80 percent of Black and American Indian/Alaska Native women (data not shown).

Invasive Cervical Cancer Incidence Among Females, by Race/Ethnicity and Age, 2005–2009*

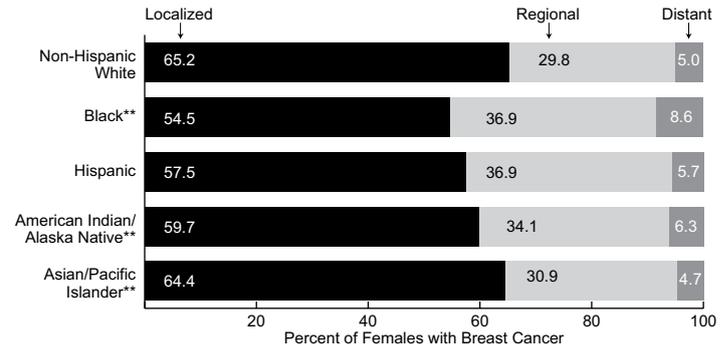
Source II.13: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER)



*All rates are age-adjusted; total includes females of all ages. **May include Hispanics.

Stage* at Breast Cancer Diagnosis Among Females, by Race/Ethnicity, 2005–2009

Source II.13: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER)



*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; percentages may not total to 100 due to rounding. **May include Hispanics.

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, environmental tobacco smoke and air pollution, poor housing conditions (mold, cockroaches, and dust mites), infections of the respiratory tract, and exercise.³¹ However, by taking certain precautions, persons with asthma may be able to effectively manage this disorder and participate in daily activities.

In 2008–2010, women were more likely to have asthma than men (9.7 versus 5.7 percent, respectively); this was true at all income levels and for all racial and ethnic groups. Among women, asthma prevalence decreased as income

increased: 13.2 percent of women with household incomes below 100 percent of poverty reported having asthma, while 8.4 percent of women with incomes of 400 percent or more of poverty did so. Non-Hispanic American Indian/Alaska Native and non-Hispanic women of multiple races were most likely to have asthma (19.2 and 17.9 percent, respectively), while non-Hispanic Asian and Hispanic women were least likely to have asthma (5.6 and 7.6 percent, respectively; data not shown).

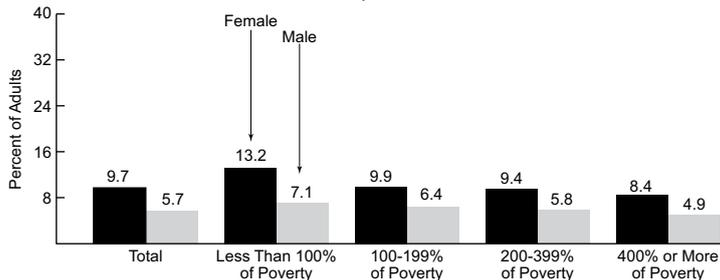
A visit to the emergency room due to an asthma attack may indicate that asthma is not being effectively controlled or treated. In 2008–2010, 22.7 percent of women with an asthma attack in the past year sought emergency care for their condition. The proportion of

women suffering an asthma attack who visited the emergency room varies with race and ethnicity, as well as household income. With regard to race and ethnicity, non-Hispanic Black and women of multiple races were most likely to have visited an emergency room (39.0 and 36.3 percent, respectively), while non-Hispanic White women were the least likely to have done so (17.4 percent).

The likelihood of women with asthma visiting an emergency room decreases as household income increases: nearly one-third of women with household incomes below 100 percent of poverty visited an emergency room in the past year (32.8 percent), compared to 17.5 percent of those with incomes of 400 percent or more of poverty (data not shown).

Asthma* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2008–2010

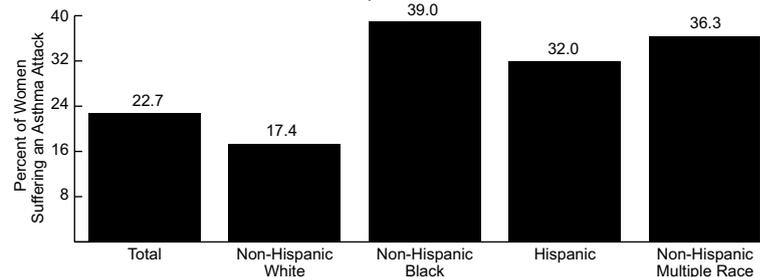
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that (1) a health professional has ever told them that they have asthma, and (2) they still have asthma. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010.

Emergency Room Visits Among Women Suffering an Asthma Attack* in the Past Year, by Race/Ethnicity,** 2008–2010

Source II.8: 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 had an asthma attack in the past year. **The sample of Native Hawaiian/Pacific Islanders, non-Hispanic American Indian/Alaska Native, and non-Hispanic Asians was too small to produce reliable results.

INJURY

Injury is a major cause of morbidity and mortality, particularly among the young and the elderly. Injury includes unintentional accidents as well as intentional violence inflicted by the self or others. Injury prevention can include education, home hazard assessment and modification, as well as laws and regulations, such as seat belt and gun laws, sobriety checkpoints, and prescription drug tracking systems.

In 2010, there were 23.2 million non-fatal injuries among adults aged 18 and over, resulting in emergency department visits, of which 11.2 million or 48 percent were to women (data not shown). At younger ages, men were more likely than women to visit the emergency department for a non-fatal injury. This pattern was reversed,

however, for those aged 65 and older, among whom the rate of emergency department use for non-fatal injuries was 10,191.4 per 100,000 women and 7,717.2 per 100,000 men. More than 90 percent of non-fatal injuries treated in an emergency department were unintentional (data not shown). Although falls are the leading cause of non-fatal injury in every adult age group, they are more prominent at older ages.³² Being struck by or against an object, motor vehicle crashes, and overexertion are more prominent mechanisms of non-fatal injury at younger ages.

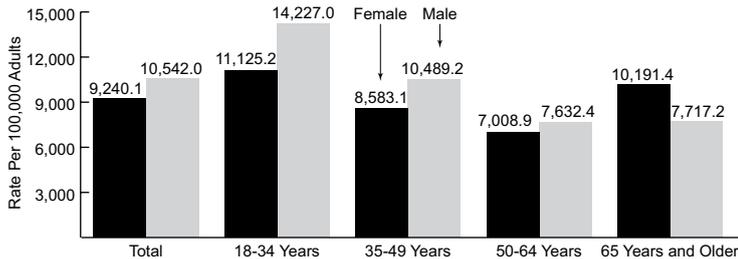
Injuries are the leading cause of death among both men and women aged 18–34. In 2010, men were twice as likely to die of injury as women (102.2 versus 45.9 per 100,000 population; data not shown). Fatal injury rates also

vary greatly by race and ethnicity. Among women, injury death rates from all causes were highest for non-Hispanic American Indian/Alaska Native women and lowest for Hispanic and non-Hispanic Asian/Pacific Islander women (71.7, 20.7, and 17.5 deaths per 100,000, respectively). Poisoning recently surpassed motor vehicle traffic as the leading mechanism of fatal injury, with the majority caused by drugs.³³

With regard to violent deaths, suicide was more common than homicide among women of most racial and ethnic groups, with the exception of non-Hispanic Black women. Non-Hispanic Black women had the highest rate of homicide and lowest rate of suicide among all racial and ethnic groups (6.0 and 2.3 deaths per 100,000, respectively).

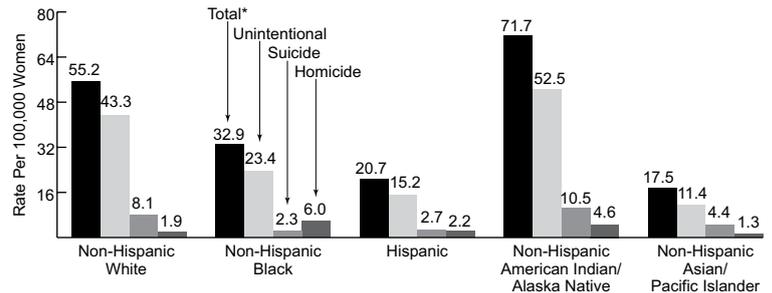
Non-Fatal Injury* Among Adults Aged 18 and Older, By Age and Sex, 2010

Source II.6: Centers for Disease Control and Prevention, National Center for Injury Prevention & Control, National Electronic Injury Surveillance System – All Injury Program



Fatal Injury Among Women Aged 18 and Older, by Intent of Injury and Race/Ethnicity, 2010

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



*Includes listed categories in addition to undetermined intent and injury from legal intervention (e.g., police pursuit).

*Non-fatal injuries resulting in an emergency department visit.

MENTAL ILLNESS

Overall, mental illness affects both women and men equally and about half of all Americans will meet the criteria for a diagnosable mental disorder over the course of their lives.³⁴ However, types of mental disorders vary with sex. Women are more likely than men to experience an anxiety or mood disorder, such as depression, while men are more likely to experience an impulse-control or substance use disorder.

A major depressive episode (MDE) is defined according to the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning,

such as problems with sleep, eating, energy, concentration, and self-image. In 2009–2010, an estimated 9.8 million women aged 18 years and older, comprising 8.4 percent of that population, reported experiencing an MDE in the past year, compared to 5.5 million or 5.0 percent of men.

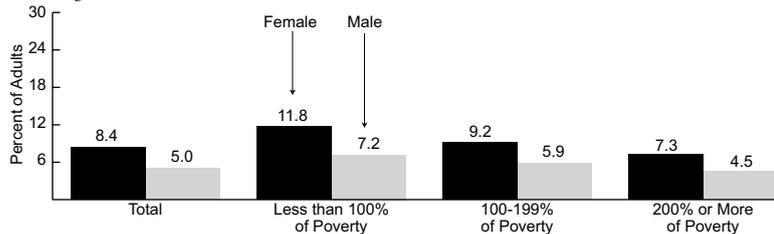
Among both men and women, MDE was reported more frequently among those with lower incomes. For example, 11.8 percent of women and 7.2 percent of men with household incomes below 100 percent of poverty experienced past-year MDE, compared to 7.3 percent of women and 4.5 percent of men with incomes of 200 percent or more of poverty.

Although women were more likely than men to experience a past-year MDE, men were twice as likely as women to experience a past-year

substance use disorder (12.6 versus 5.8 percent, respectively). Substance use disorder, as defined by the DSM-IV, encompasses both abuse and dependence on alcohol or illicit drugs; abuse relates to social problems with work, family, or the law due to substance use and dependence relates to health and emotional problems, such as tolerance or withdrawal. Women who experienced a past-year MDE were nearly four times as likely to report a substance use disorder than those who did not (17.5 versus 4.8 percent, respectively), while men who experienced a past-year MDE were 2.5 times as likely as their non-affected counterparts to report a substance use disorder (29.4 percent versus 11.7 percent, respectively).

Past Year Major Depressive Episode* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2009–2010

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

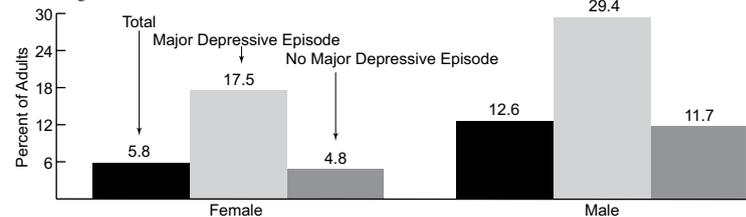


*A past year major depressive episode is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.

**Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

Past Year Substance Use Disorder,* by Sex and Past Year Major Depressive Episode,** 2009–2010

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



*Substance use disorder is abuse or dependence on alcohol or illicit drugs; abuse relates to social problems due to substance use, such as problems with work, family, or the law; dependence relates to health and emotional problems, such as tolerance or withdrawal. **A past year major depressive episode is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.

ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences include verbal, physical, and sexual abuse, as well as forms of family dysfunction such as having a substance-abusing household member or witnessing domestic violence.³⁵ Exposure to these types of traumatic experiences early in life has been associated with many mental and physical health problems throughout the lifespan, including substance abuse, depression, cardiovascular disease, and premature death.^{36,37}

In 2009–2010 among a 7-State reporting area, more than one-in-four women (26.0 percent) reported that they had been verbally

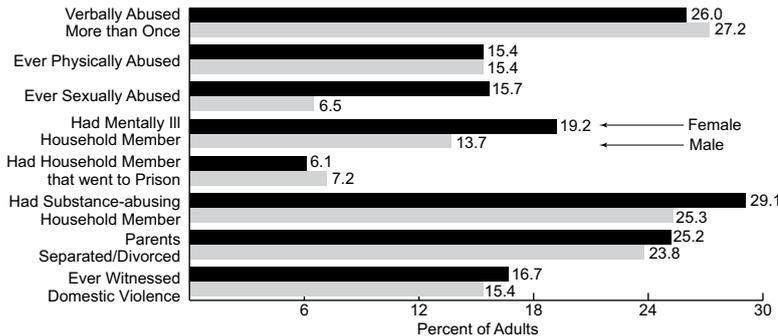
abused as a child on more than one occasion—defined as being sworn at, insulted or put down by a parent or adult in the home—and about 15 percent reported that they had ever been physically or sexually abused as a child (15.4 and 15.7 percent, respectively). Types of childhood family dysfunction among women ranged from 6.1 percent who reported that a household member had gone to prison to more than a quarter who had a substance-abusing household member (29.1 percent) or whose parents separated or divorced (25.2 percent). Compared to men, women were more than twice as likely to have experienced sexual abuse (15.7 versus 6.5

percent, respectively) and were also more likely to report having had a mentally ill or substance-abusing household member.

The likelihood of negative health outcomes later in life increases with the number of adverse childhood experiences.³⁷ Among the 7-State reporting area in 2009–2010, 9.6 percent of women reported having five or more adverse experiences in childhood. Women with less than a high school education were most likely to have reported five or more adverse childhood experiences (17.0 percent) while college-educated women were least likely to have endured five or more adverse childhood experiences (6.5 percent).

Adverse Childhood Experiences* Among Adults Aged 18 and Older in 7 States,** By Type and Sex, 2009–2010

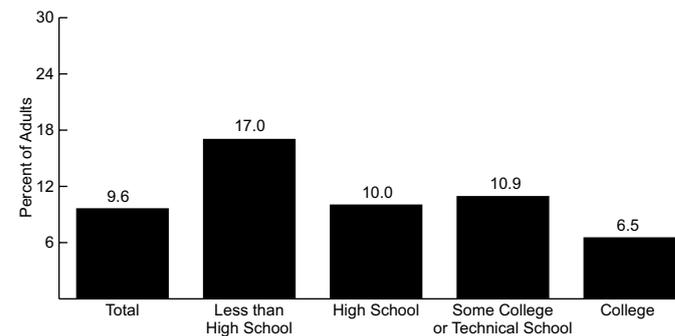
Source II.14: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Report of adverse experiences that occurred prior to 18 years of age; physical abuse did not include spanking. **Arkansas and Louisiana contributed data in 2009 and DC, Hawaii, Nevada, Vermont, and Wisconsin contributed data in 2010.

Five or More Adverse Childhood Experiences* Among Women Aged 18 and Older in 7 States,** By Education Level, 2009–2010

Source II.14: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Report of five or more types of adverse experiences that occurred prior to 18 years of age (types listed in previous figure). **Arkansas and Louisiana contributed data in 2009 and DC, Hawaii, Nevada, Vermont, and Wisconsin contributed data in 2010.

VIOLENCE AGAINST WOMEN: INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) has been defined as physical violence, sexual violence, threats of physical or sexual violence, stalking and psychological aggression by a current or former intimate partner. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy.^{38,39} In 2010, 35.6 percent of adult women aged 18 years and older, or 42.4 million women, reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime while nearly 6 percent reported at least one of these experiences in the past 12 months.

Of these forms of IPV, lifetime experience of physical violence was most commonly reported by women (32.9 percent), followed by stalking (10.7 percent), and rape (9.4 percent). While rape and stalking were less commonly reported among men, 28.5 percent of adult men reported having experienced any IPV in their lifetime.

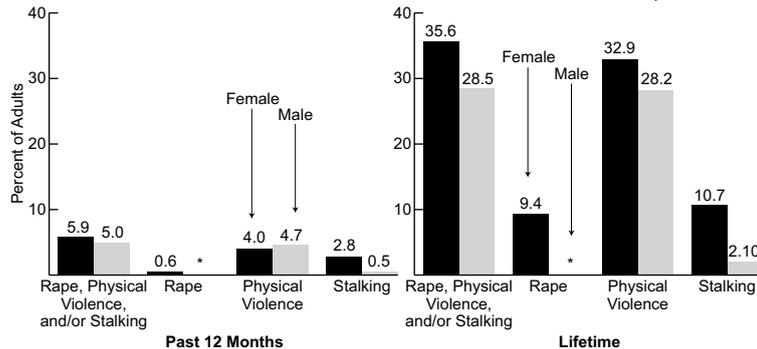
Psychological aggression is a common form of IPV experienced by nearly half of all women and men during their lifetime. Women who experienced psychological aggression reported being called names (64.3 percent), insulted or humiliated (58.0 percent), witnessing anger by their intimate partner that seemed dangerous (57.9 percent), and facing demands to know where she

was and what she was doing (61.7 percent). In addition, 8.6 percent of women reported that an intimate partner tried to get them pregnant when they did not want to or refused to use a condom (data not shown).

IPV has been associated with a range of both short- and long-term health and social consequences.⁴⁰ Among women who have experienced IPV, 80.8 percent reported at least one IPV-related impact, such as injury, symptoms of post-traumatic stress disorder (PTSD), or missing work or school. The most commonly reported impacts were fearfulness (72.2 percent), PTSD symptoms (62.6 percent), and concern for safety (62.3 percent).

Past Year and Lifetime Prevalence of Rape, Physical Violence, and Stalking by an Intimate Partner Among Adults Aged 18 and Older, by Sex, 2010

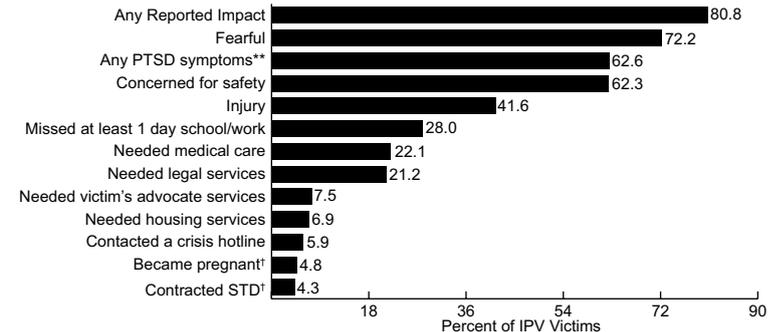
Source II.15: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Intimate Partner and Sexual Violence Survey



*Estimate does not meet the standards of reliability or precision.

Impacts of Intimate Partner Violence Among Female Victims Aged 18 and Older,* 2010

Source II.15: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Intimate Partner and Sexual Violence Survey



*Includes rape, physical violence and/or stalking by an intimate partner. **Includes nightmares; tried not to think about or avoided being reminded of; felt constantly on guard, watchful, or easily startled; felt numb or detached. †Asked only of those who reported rape by an intimate partner.

VIOLENCE AGAINST WOMEN: SEXUAL VIOLENCE

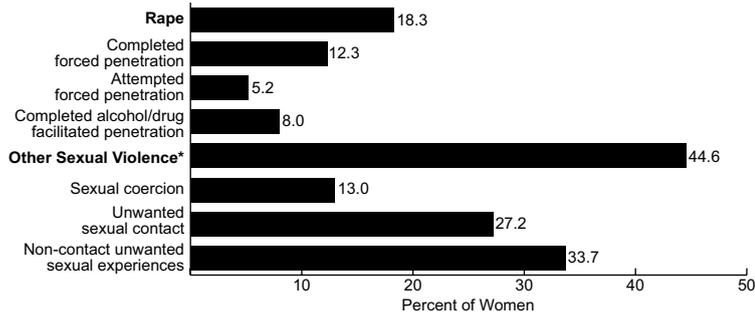
Sexual violence includes rape, sexual coercion, and unwanted sexual experiences, regardless of whether the perpetrator was an intimate partner, acquaintance, or stranger.³⁸ In 2010, nearly one-fifth (18.3 percent), or 21 million U.S. women reported having been raped in their lifetime while 1.1 percent, or 1.3 million experienced rape in the past year. More than three-quarters of female victims of rape were first raped before the age of 25 years (data not shown). Less than 1.5 percent of men reported having been raped in their lifetime (data not shown).

Lifetime experience of sexual victimization other than rape was reported by 53 million or 44.6 percent of women in 2010. This includes non-contact unwanted sexual experiences, such as someone harassing or exposing themselves without physical contact, which was reported by 33.7 percent of women, and unwanted sexual contact, such as unwanted fondling, reported by 27.2 percent of women. Sexual coercion, defined as unwanted sexual penetration that occurs after non-physical pressure such as repeated demands for sex, was also reported by 13.0 percent of women. Nearly one-quarter of men reported having experienced sexual victimization other than rape in their lifetime (data not shown).

The prevalence of rape and other forms of sexual violence reported by women vary by race and ethnicity. Non-Hispanic women of multiple races and non-Hispanic American Indian/Alaska Native women were most likely to report having experienced rape at some point in their lifetime (33.5 and 26.9 percent, respectively), while Hispanic and non-Hispanic White women were least likely (14.6 and 18.8 percent, respectively). Nearly 60 percent of non-Hispanic women of multiple races reported having experienced some form of sexual violence other than rape in their lifetime as did 40–50 percent of non-Hispanic White, non-Hispanic Black and non-Hispanic American Indian/Alaska Native women.

Lifetime Prevalence of Rape and Other Forms of Sexual Violence Among Women Aged 18 and Older, 2010

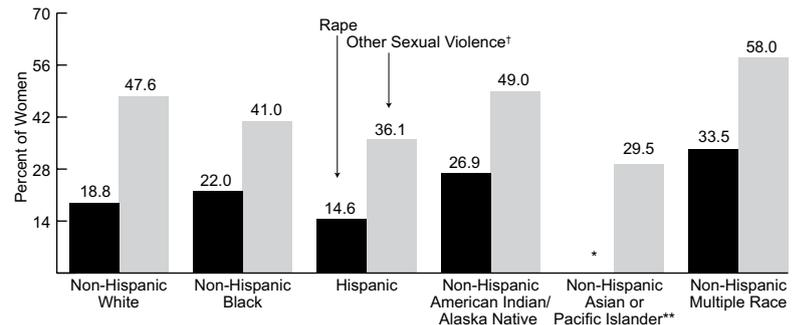
Source II.15: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Intimate Partner and Sexual Violence Survey



*Includes sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences.

Lifetime Prevalence of Rape and Other Forms of Sexual Violence Among Women Aged 18 and Older, by Race/Ethnicity, 2010

Source II.15: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Intimate Partner and Sexual Violence Survey



*Estimate does not meet the standard of reliability; relative standard error >30% or cell size ≤ 20. **Separate estimates were not available for Asian and Native Hawaiian and Other Pacific Islanders. †Includes sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are considered a hidden epidemic because symptoms are often absent and the causes are not openly discussed. Yet there are approximately 19 million new STI cases in the United States each year at an annual health care cost of nearly 17 billion dollars.⁴¹ 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. Safer sex practices, screening, and treatment can help reduce the burden of STIs.

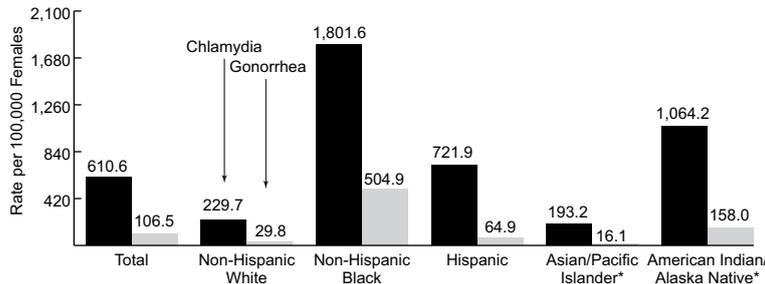
The Centers for Disease Control and Prevention requires State and local reporting of new chlamydia, gonorrhea, syphilis, and

HIV cases (see page on HIV/AIDS). Reported STI rates among females vary by age and race and ethnicity. Rates are highest among adolescents and young adults; over 70 percent of all chlamydia and gonorrhea cases in females occurred among those under 25 years of age in 2010 (data not shown). With the exception of Asian/Pacific Islanders, minority females had higher STI rates than non-Hispanic White females. For example, compared with non-Hispanic White females, the chlamydia rate was 7.8 times higher for non-Hispanic Black females, 4.6 times higher for American Indian/Alaska Native females, and 3.1 times higher for Hispanic females. The syphilis rate was also highest among non-Hispanic Black females (7.5 versus 0.3 per 100,000 non-Hispanic White females; data not shown).

Although chlamydia, gonorrhea, and syphilis can be cured with appropriate antibiotics, viral STIs, such as HIV, human papillomavirus (HPV), and herpes cannot be cured but can be monitored and managed to prevent symptoms and disease progression.¹² Herpes Simplex Virus Type 2 (HSV-2) is an infection that causes genital herpes and can lead to blindness, neonatal infections, and increased risk for HIV. Herpes Simplex Virus Type 1 (HSV-1) can also cause genital herpes, but it is more commonly associated with sores around the mouth, and recurring symptoms are less common than with HSV-2.⁴² Overall, 59.2 percent of women aged 18–49 years tested positive for HSV-1 and 22.0 percent tested positive for HSV-2 in 2009–2010. The prevalence of both HSV-1 and HSV-2 increased with age.

Rates of Chlamydia and Gonorrhea Among Females (All Ages), by Race/Ethnicity, 2010

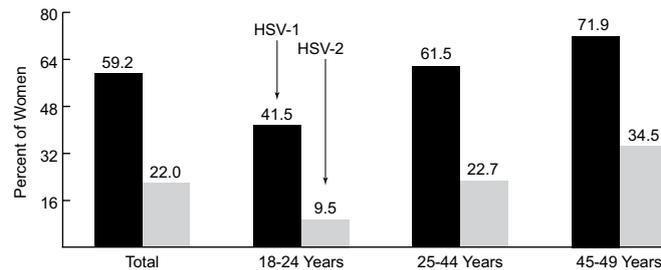
Source II.16: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



*May include Hispanics.

HSV-1 and HSV-2 Infection Among Women, by Age, 2009–2010

Source II.9: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



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 difficulty fighting infections.⁴³ HIV is predominantly transmitted through sexual contact and injection drug use. While HIV and AIDS disproportionately affect men who have sex with men, a notable proportion of HIV/AIDS diagnoses occur among women and particularly minority women. In 2010, adolescent and adult females accounted for 21.3 percent of new HIV diagnoses at ages 13 and older,

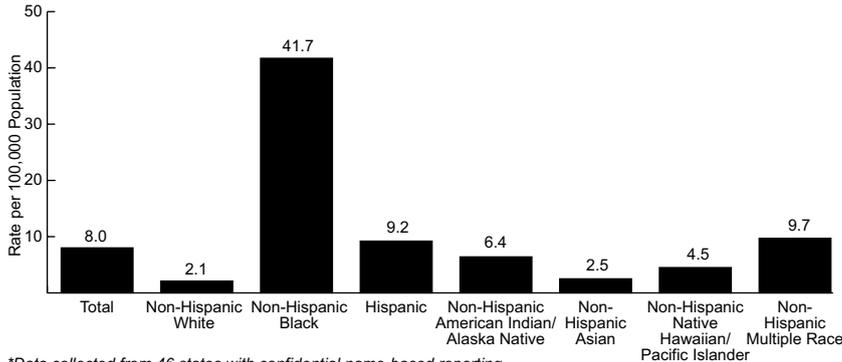
with a rate of 8.0 cases per 100,000 females. The rate of new diagnoses among males was 31.4 per 100,000 (data not shown).⁴⁴

Rates of new HIV cases among adolescent and adult females vary dramatically by race and ethnicity. HIV disproportionately affects non-Hispanic Black females at a rate that is nearly twenty times higher than among non-Hispanic White females (41.7 versus 2.1 cases per 100,000 females, respectively). Non-Hispanic Black females accounted for two-thirds of all new HIV diagnoses among females.⁴⁴ New HIV diagnoses are also elevated among Hispanic, non-Hispanic American Indian/Alaska Native, and non-Hispanic females of multiple races (9.2, 6.4, and 9.7 cases per 100,000 females, respectively).

Early detection of HIV infection is critical in preventing transmission of the virus to others, and persons aware of their HIV infection can benefit from advances in medicine that may significantly prolong their lives. Early entry to care can also produce significant cost savings for medical treatment.⁴⁵ Despite these individual and societal benefits, a sizeable proportion of people identified as HIV-positive receive an AIDS diagnosis simultaneously or within a year of HIV diagnosis. In 2009, 30.3 percent of HIV-positive females received an AIDS diagnosis within 12 months of their HIV diagnosis, which was slightly less than for males (33.1 percent, all ages included).

Estimated Rates of New HIV Cases Reported Among Females Aged 13 and Older, by Race/Ethnicity, 2010*

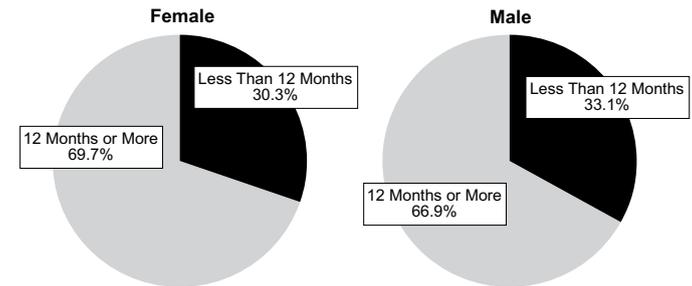
Source II.17: Centers for Disease Control and Prevention, HIV Surveillance Report



*Data collected from 46 states with confidential name-based reporting.

Time to an AIDS Diagnosis After a Diagnosis of HIV Infection (All Ages), by Sex, 2009*

Source II.17: Centers for Disease Control and Prevention, HIV Surveillance Report



*Data collected from 46 states with confidential name-based reporting.

OSTEOPOROSIS

Osteoporosis is a bone weakness characterized by low bone density with symptoms that generally occur only after the disease is advanced.⁴⁶ Bone fractures are the most common consequence; others include loss of height, stooped posture, and back and neck pain from spinal fractures. Risk of osteoporosis increases with age and is much more common among women than men. In 2007–2010, an estimated 10 million women (9.0 percent) and 1.3 million men (1.3 percent) had osteoporosis. More than one in four women aged 65 and older had been diagnosed with osteoporosis, compared with 4.3 percent of men. Osteoporosis also varied significantly by race and ethnicity. About 30 percent of non-Hispanic White and Hispanic women aged 65 and older reported that they had been diagnosed

with osteoporosis, compared to 12.9 percent of non-Hispanic Black women of the same age (data not shown).

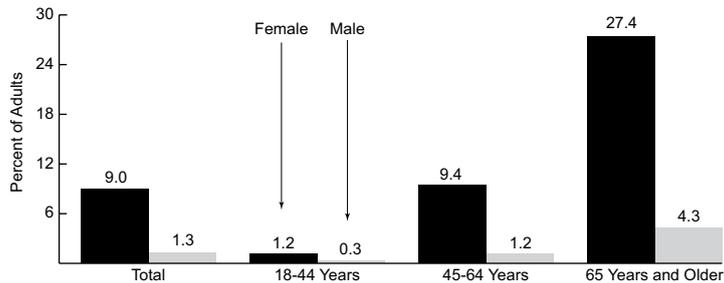
Osteoporosis may be prevented and treated by getting the recommended amounts of calcium and vitamin D, by engaging in regular weight-bearing physical activity (such as walking), and by taking prescription medication when appropriate.^{46,47} To promote early diagnosis and the prevention of complications, bone density tests are recommended for all women aged 65 and older and younger women who have a risk factor, including low weight, parental history of hip fracture, smoking, and daily alcohol use.⁴⁸

Bone fractures among the elderly most commonly occur among those with osteoporosis and can have devastating consequences. For example, 1 in every 5 hip fracture patients

die within a year of their injury.⁴⁷ Falls are a common direct cause of osteoporosis-related fracture and are the leading cause of injury—both fatal and nonfatal—among adults aged 65 and older. In 2010, there were 2.4 million unintentional nonfatal fall injuries treated in emergency departments among adults aged 65 and older (data not shown). The rate of nonfatal fall injury was higher among women than men and increased with age. Among both women and men, the rate of nonfatal fall injury was about five times higher among those aged 85 and older than those aged 65–69. Fall prevention efforts can include muscle strengthening, home hazard assessments and modifications, and avoiding sedative medications that may impair balance and coordination.⁴⁷

Diagnosed Osteoporosis* Among Adults Aged 18 and Older, By Age and Sex, 2007–2010

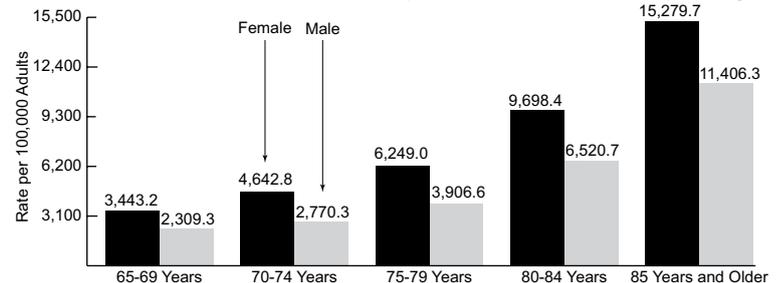
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they had osteoporosis.

Nonfatal Unintentional Injury Due to Falls* per 100,000 Adults Aged 65 and Older, by Age and Sex, 2010

Source II.6: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Electronic Injury Surveillance System, All Injury Program



*Treated in hospital emergency departments.

ALZHEIMER'S DISEASE

Alzheimer's disease is the most common form of dementia.⁴⁹ Early signs include difficulty remembering names and completing familiar tasks, with later disease progression leading to disorientation, personality changes, and difficulty speaking, swallowing, and walking. Although the risk for Alzheimer's disease increases with age, it is not a normal part of aging. Risk factors include a family history, head trauma or traumatic brain injury, and cardiovascular disease risk factors such as high cholesterol, hypertension, diabetes, smoking, and physical inactivity.

In 2012, 5.2 million or 13 percent of U.S. adults aged 65 and older are estimated to have Alzheimer's disease and another 200,000 below age 65 are thought to have early-onset Alzheimer's. Due to the aging of the population, the number

of adults aged 65 and older with Alzheimer's disease is expected to triple by 2050.⁴⁹ Women constitute 3.4 million or nearly two-thirds of adults aged 65 and older with Alzheimer's.

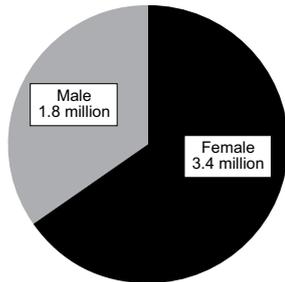
Alzheimer's disease is the fifth leading cause of death among men and women aged 65 and older.¹ Severe dementia causes complications, such as immobility and swallowing disorders, that can lead to death. In 2010, 205.2 per 100,000 or nearly 83,000 adults aged 65 and older, about 70 percent of whom were women, died of Alzheimer's. The risk of death due to Alzheimer's increases greatly with age, ranging from 19.8 deaths per 100,000 for those aged 65–74 years to 987.1 deaths per 100,000 for those aged 85 and older. Overall, women are about 75 percent more likely than men to die of Alzheimer's disease (257.6 versus 144.0 deaths per 100,000 adults aged 65

and older). The greater rates of Alzheimer's prevalence and mortality among women are related to their longer life expectancy rather than an increased sex-specific risk of disease.⁴⁹

Not only are women more likely than men to have Alzheimer's, they are also more likely to be caregivers for someone with Alzheimer's—exacting a substantial toll of emotional and physical stress. Of the nearly 15 million Americans who provide unpaid care for a person with Alzheimer's or another dementia, about 70 percent are women.⁴⁹ Given the large and increasing burden of Alzheimer's disease, advances in prevention, early diagnosis, and treatment are greatly needed. In 2011, a new diagnostic category of “preclinical Alzheimer's disease” was developed to aid research for early detection and treatment prior to the onset of symptoms.⁴⁹

Adults Aged 65 and Older with Alzheimer's Disease,* By Sex, 2012

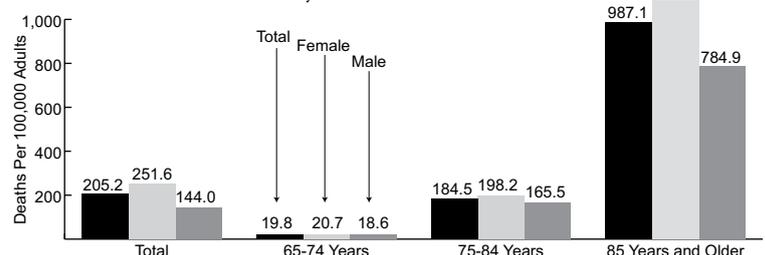
Source II.18: Alzheimer's Association, Alzheimer's Disease Facts and Figures



*Estimates are based on the Chicago Health and Aging Project incidence rates converted to prevalence estimates and applied to population projections; assumes the same proportion female as in 2010.

Deaths Due to Alzheimer's Disease* per 100,000 Adults Aged 65 and Older, By Age and Sex, 2010

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



*Deaths with Alzheimer's disease listed as underlying cause.

SLEEP HEALTH

Just like good nutrition and physical activity, adequate sleep is vital to healthy functioning and well-being. Inadequate sleep increases the likelihood of occupational errors and motor vehicle accidents and is also linked to various chronic conditions including diabetes, obesity, cardiovascular disease, and depression.⁵⁰ In addition to competing demands and insufficient time for sleep, conditions such as insomnia and sleep apnea (sleep-disordered breathing) can also contribute to poor sleep quality.⁵¹

The National Sleep Foundation recommends that adults get 7–9 hours of sleep per day.⁵² In 2008–2010, about 70 percent of women and men reported getting an adequate amount of

sleep, defined as 8 or more hours for persons aged 18–21 years of age and 7 or more hours for those aged 22 years or older. Among both women and men, the probability of getting adequate sleep generally increased with age for both women and men and was highest among those aged 65 years and older (75.6 and 80.1 percent, respectively). By contrast, only about 63 percent of young adults aged 18–24 years reported getting an adequate amount of sleep.

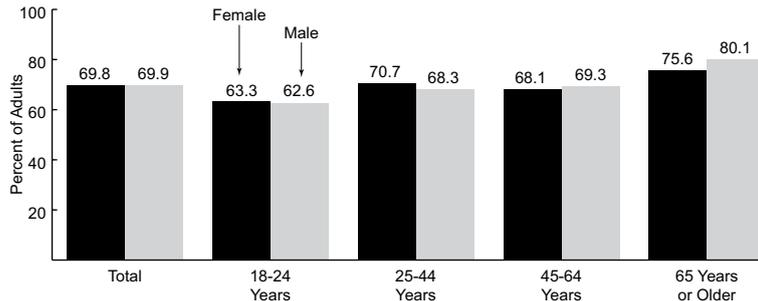
Among women, single mothers were least likely to report getting adequate hours of sleep (60.1 percent), followed by single women without children (67.1 percent). Women who were married or cohabitating without children and those in two-parent families were more likely to

get a sufficient amount of sleep (76.1 and 72.1 percent, respectively).

Adequate sleep also varied by poverty status and race and ethnicity. Fewer than two-thirds (64.4 percent) of women living in households with incomes below the poverty level had sufficient hours of sleep, compared to nearly three-quarters of women living in households with incomes of 400 percent or more of poverty (73.4 percent; data not shown). With respect to race and ethnicity, non-Hispanic Black women were less likely than women of other racial and ethnic groups to get adequate hours of sleep (62.8 percent compared to about 70 percent of other women; data not shown).

Adequate Sleep* Among Adults Aged 18 and Older, by Age and Sex, 2008–2010

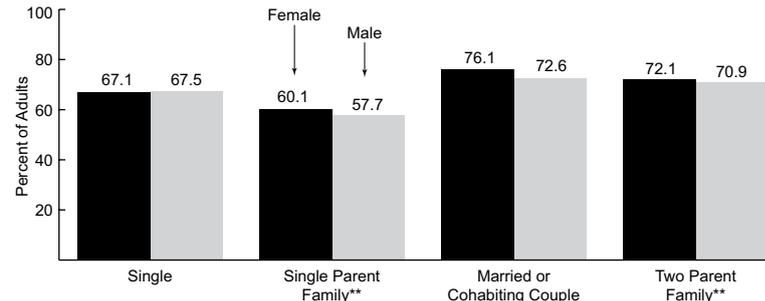
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Defined as reporting an average of 8 or more hours of sleep per day for persons aged 18-21 years and 7 or more hours for persons aged 22 years and older; total estimates are age-adjusted.

Adequate Sleep* Among Adults Aged 18 and Older, by Family Structure and Sex, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Defined as reporting an average of 8 or more hours of sleep per day for persons aged 18-21 years and 7 or more hours for persons aged 22 years and older; estimates are age-adjusted. **Includes at least one child under 18 years of age.

PRECONCEPTION HEALTH

Efforts to improve pregnancy outcomes and the health of mothers and infants should begin prior to conception, whether before a first or a subsequent pregnancy.⁵³ It is important to establish health and healthy behaviors well before pregnancy as most women do not become aware of their pregnancy, until several weeks or more after conception. Key indicators of preconception health include not smoking or drinking prior to pregnancy, taking a daily multivitamin, and achieving a healthy weight prior to pregnancy.⁵⁴

Frequent drinking, especially early in pregnancy, can cause fetal alcohol syndrome and alcohol-related birth defects.^{54,55} Smoking also increases the risk of pregnancy complications, preterm birth, and low birth weight.⁵³ In 2007–2009, about 1 in 5 recent mothers in a 32-State area reported binge drinking (consumed 5 or more drinks in a sitting) at least once within 3 months prior to pregnancy (21.1 percent) and 23.6 percent reported smoking. Binge drinking and smoking in the 3 months prior to pregnancy tend to be higher among younger mothers. For example, among 20- to 24-year-old women, 25.5 percent reported preconception binge drinking and 34.2 percent reported preconception smoking compared to 15.3 and 12.4 percent, respectively, among women aged 40 years and older.

Daily use of multivitamins containing folic acid can reduce the risk of neural tube defects

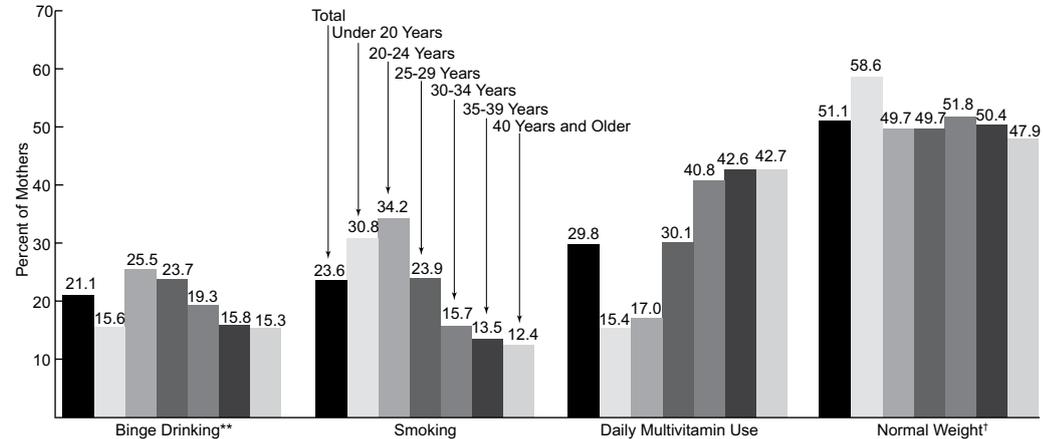
in infants by two-thirds.⁵³ In 2007–2009, only 29.8 percent of recent mothers reported daily multivitamin use in the month prior to pregnancy. Daily preconception multivitamin use increased with maternal age. Over 40 percent of women aged 30 years and older reported taking a daily multivitamin in the month prior to pregnancy compared with less than 20 percent of women younger than 25 years of age.

Women should also attain a healthy weight prior to pregnancy to prevent complications, such as diabetes and hypertension, which may necessitate preterm delivery.⁵³ Only about

half of new mothers (51.1 percent) reported a healthy or normal pre-pregnancy weight for their height. This proportion did not vary by maternal age with the exception of teenage mothers who were more likely to have had a normal pre-pregnancy weight (58.6 percent). With regard to race and ethnicity, non-Hispanic Asian mothers were most likely to have attained a healthy pre-pregnancy weight (66.4 percent), while non-Hispanic Black mothers were least likely (40.4 percent; data not shown). See *Women's Health USA 2011* for additional estimates by race and ethnicity.

Selected Preconception Health Indicators Among Recent Mothers, by Age, 2007–2009*

Source II.20: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System



*Includes data from a total of 32 States and New York City; 25 states contributed all 3 years; mothers completed surveys between 2 and 9 months postpartum. **Defined as drinking five or more alcohol drinks in one sitting at least once in the 3 months prior to pregnancy. †Defined as a pre-pregnancy body mass index (ratio of weight to height) between 18.5 and 24.9.

UNINTENDED PREGNANCY AND CONTRACEPTION

Unintended pregnancy is a pregnancy that is mistimed (occurred too soon) or unwanted (occurred when the woman wanted no future pregnancies) at the time of conception. Unintended pregnancies that lead to births are associated with both short and long-term negative outcomes for both mother and child, including delayed prenatal care, maternal depression, increased risk for intimate partner violence, and poor developmental and educational outcomes for children.⁵⁶ Historically, it has been difficult to estimate the rate of unintended pregnancy due to reporting issues specifically related to the underreporting of pregnancies ending in abortion. However, in 2006–2010 women reported that 37.1 percent of live births occurring in the

past 5 years were unintended at the time of conception. This includes 13.8 percent of pregnancies that were unwanted and 23.3 that were mistimed. Of births that were mistimed at the time of conception, 14.0 percent were reported by the mother to have occurred 2 or more years too soon (data not shown). Overall, the proportion of births that were unintended has not changed significantly since 1982.⁵⁷

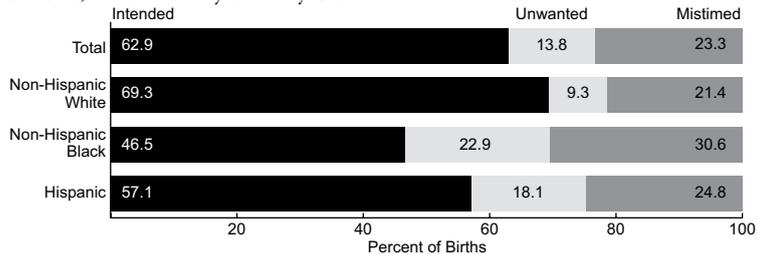
Unintended pregnancy varies by a variety of factors including age, as well as race and ethnicity. In 2006–2010, over three-quarters (77.2 percent) of births in the past 5 years to mothers aged 15–19 years were unintended at the time of conception. The same was true for half (50.1 percent) of births to women aged 20–24 years and one-quarter (25.4 percent) among those aged 25–44 (data not shown). Births to non-

Hispanic Black and Hispanic women were more likely than those to non-Hispanic White women to have been unintended (53.5 and 42.9 versus 30.7 percent, respectively). Of births to non-Hispanic Black women that were mistimed, 21.8 percent were 2 or more years too soon, which is two times higher than for births to non-Hispanic White women (10.8 percent; data not shown).

Unintended pregnancies can be averted with proper use of effective contraceptives. In 2006–2010, 4.7 million or 11.0 percent of women at risk of unintended pregnancy—who were having intercourse and not sterile, pregnant, or trying to get pregnant—reported that they were not using contraception. Younger women were more likely to not be using contraception while at risk for unintended pregnancy.

Intendedness of Births at Conception* Among Women Aged 15–44, by Race/Ethnicity,** 2006–2010

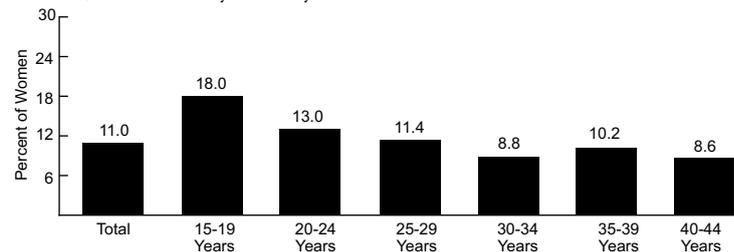
Source II.21: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Reported for all births occurring in the 5-year period prior to the interview. Percentages may not add to 100 due to rounding. **Samples of non-Hispanic persons of other races and those reporting two or more race or origin groups were too small to produce reliable results.

No Current Contraceptive Use Among Women Aged 15–44 at Risk of Unintended Pregnancy,* by Age, 2006–2010

Source II.22: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*At risk of unintended pregnancy is defined as having had intercourse in the last 3 months among those who were not currently pregnant, trying to get pregnant, or sterile for health reasons.

SMOKING DURING PREGNANCY

Smoking during pregnancy can have a negative impact on the health of women, infants, and children by increasing the risk of fertility problems and pregnancy complications, as well as preterm birth, low birth weight, and sudden infant death syndrome—some of the leading causes of infant mortality.⁶ Smoking cessation prior to and any time during pregnancy carries benefits, especially considering the many additional risks of postnatal tobacco smoke exposure for infants and children including respiratory infections, ear infections, and asthma.⁶

In 2007–2009, 12.5 percent of recent mothers in a 32-State area reported that they had smoked in the last 3 months of pregnancy.

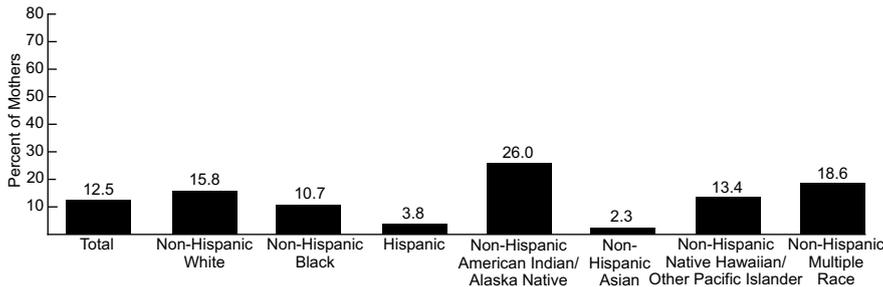
Smoking in the last 3 months of pregnancy varied significantly by race and ethnicity. About one-quarter of non-Hispanic American Indian/Alaska Native mothers (26.0 percent) reported having smoked in the last 3 months of pregnancy, while less than 5 percent of non-Hispanic Asian and Hispanic mothers reported doing so (2.3 and 3.8 percent, respectively). Smoking in the last 3 months of pregnancy also varied by maternal education, ranging from 2.3 percent among mothers with at least 16 years of education to about 20 percent among mothers with 12 or fewer years of education (data not shown).

Due to awareness of the neonatal health consequences of smoking, pregnancy may be a time of heightened motivation to quit. In 2007–2009,

47.3 percent of mothers in a 32-State area who reported smoking in the 3 months prior to pregnancy had not smoked in the last 3 months of pregnancy. Prenatal smoking cessation rates increased with maternal education, ranging from 32.2 percent among mothers with less than 12 years of education to 74.5 percent among mothers with 16 or more years of education. Hispanic and non-Hispanic Asian mothers had the highest rates of smoking cessation at about 67 percent, while fewer than half of mothers of other racial and ethnic groups had quit smoking during pregnancy (data not shown). In addition to clinical screening and counseling,⁵⁸ increases in State tobacco taxes and smoke-free laws have been shown to improve prenatal smoking cessation.⁵⁹

Cigarette Smoking in the Last 3 Months of Pregnancy, by Race/Ethnicity, 2007–2009*

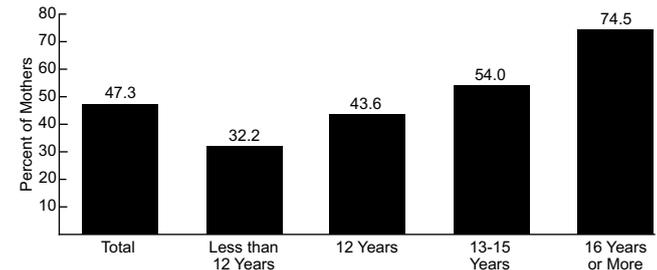
Source II.20: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System



*Includes data from a total of 32 States and New York City; 25 States contributed all 3 years; mothers completed surveys between 2 and 9 months postpartum.

Smoking Cessation During Pregnancy,* by Maternal Education, 2007–2009**

Source II.20: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System



*Defined as the proportion of mothers who reported not smoking in the last 3 months of pregnancy among those who reported smoking in the three months prior to pregnancy.

**Includes data from a total of 32 States and New York City; 25 States contributed all 3 years; mothers completed surveys between 2 and 9 months postpartum.

LIVE BIRTHS AND DELIVERY TYPE

In 2010, there were 4 million live births in the United States and the birth rate among women aged 15–44 years was 64.1 births per 1,000, a decrease of 3 percent from 2009 and the lowest rate reported in over a decade.⁶⁰ Overall birth rates were highest among mothers aged 25–29 years (108.3 live births per 1,000 women), followed by those aged 30–34 years (96.5 births per 1,000 women). Between 2009 and 2010, the birth rate declined or remained unchanged in every age group except for 40–44 years, which increased 2 percent to the highest level since 1967.^{60,61} The birth rates among

teens aged 15–19 years and young women aged 20–24 years declined to the lowest levels ever reported (34.2 and 90.0 per 1,000, respectively). Only birth rates among women aged 30 years and older are higher now than in 1990.

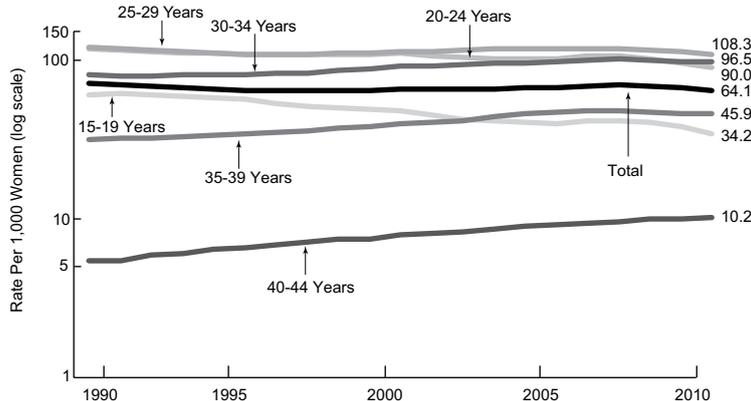
The average age at first birth increased to 25.4 in 2010, an increase of 4 years since 1970.^{61,62} Asian/Pacific Islander women had the highest average age at first birth while American Indian/Alaska Native women had the lowest (29.1 and 22.3 years, respectively; data not shown).⁶⁰

The proportion of births delivered by cesarean section declined slightly from 32.9 percent in 2009 to 32.8 percent in 2010. This represents

the first decline in cesarean delivery since 1996, when 20.7 percent of births were delivered by cesarean section. The U.S. cesarean delivery rate far exceeds the upper limit of 15 percent recommended by the World Health Organization.⁶³ *Healthy People 2020* has set national objectives to reduce the cesarean delivery rate by 10 percent among low-risk women giving birth for the first time and among low-risk women with a prior cesarean section.⁵⁴ In 2010, 27.3 percent of low-risk women giving birth for the first time and 89.9 percent of low-risk women with a prior cesarean section delivered by cesarean (data not shown).⁶⁴

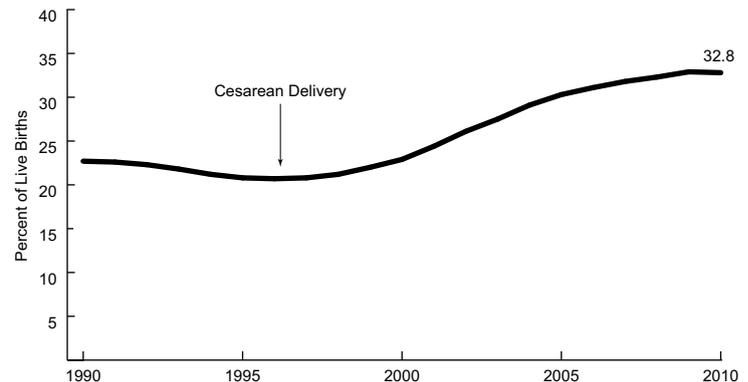
Live Births per 1,000 Women, by Age, 1990–2010

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



Births by Cesarean Delivery, 1990–2010

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



MATERNAL MORBIDITY AND MORTALITY

Diabetes and hypertension are the most commonly reported health conditions among pregnant women. Diabetes, both chronic and gestational (developing only during pregnancy), may pose health risks to a woman and her baby. Women with gestational diabetes are at increased risk for developing diabetes later in life.⁶⁵ In 2010, among the 33 States that collected this information on the revised birth certificate, chronic or pre-existing diabetes occurred at a rate of 7.0 per 1,000 live births while gestational diabetes was a complication in 44.2 per 1,000 live births. Both chronic and gestational diabetes increase significantly with maternal age to a peak among mothers aged 40 years and older of 16.7 and 97.0

per 1,000 live births, respectively.

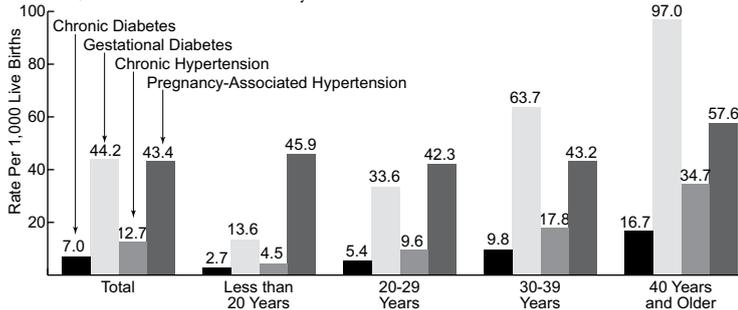
Hypertension during pregnancy can also be either chronic in nature or gestational. Severe hypertension during pregnancy can result in preeclampsia, fetal growth restriction, and early delivery.⁶⁶ In 2010, in the 33 States that used the revised birth certificate, chronic and pregnancy-associated hypertension were present in 12.7 and 43.4 per 1,000 live births, respectively. Chronic and pregnancy-associated hypertension were highest among mothers aged 40 or older (34.7 and 57.6 per 1,000, respectively). These conditions also varied by race and ethnicity (data not shown, see *Women's Health USA 2011*).

In 2006–2007, there were 1,294 deaths found to be pregnancy-related (15.1 per 100,000 live

births), which are defined as deaths related to or aggravated by pregnancy and occurring during or within one year after the end of the pregnancy.⁶⁷ This definition includes more deaths than the traditional definition of maternal mortality, which counts pregnancy-related deaths only up to 42 days after the end of pregnancy. Cardiovascular disease was the leading cause of pregnancy-related mortality (13.5 percent) and other chronic conditions including heart muscle diseases (12.6 percent) and non-cardiovascular diseases (11.8 percent) also contributed substantially. The maternal mortality ratio among Black women was roughly 3 times the rate among White women (34.8 versus 11.0 per 100,000 live births – see *Child Health USA 2012*).

Selected Maternal Morbidities and Risk Factors in Pregnancy, by Maternal Age, 2010*

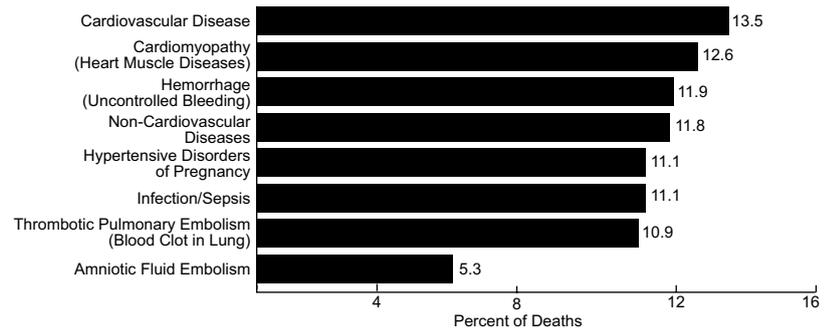
Source II.24: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data are from 33 States that implemented the 2003 revision of the death certificate as of January 1, 2010, representing 76 percent of all U.S. births.

Leading Causes of Pregnancy-Related Death,* 2006–2007

Source II.25: Centers for Disease Control and Prevention, Division of Reproductive Health, Pregnancy Mortality Surveillance System



*The cause of death was unknown for 5.6 percent of all pregnancy-related deaths in 2006–2007.

POSTPARTUM DEPRESSIVE SYMPTOMS

The birth of a child is a major life event that can be joyous, but also stressful in its new demands and responsibilities. Hormonal changes and lack of sleep can contribute to “baby blues” or mild depressive symptoms, such as occasional sadness, crying, irritability, and trouble concentrating, which are common and transient.⁶⁸ Depression occurs when these symptoms, including depressed mood and loss of interest in activities, are severe and last for more than two weeks.⁶⁹ Other symptoms can include changes in appetite, feelings of worthlessness or guilt, and suicidal thoughts.

In 2009, 11.9 percent of recent mothers in a 29-State area reported postpartum depres-

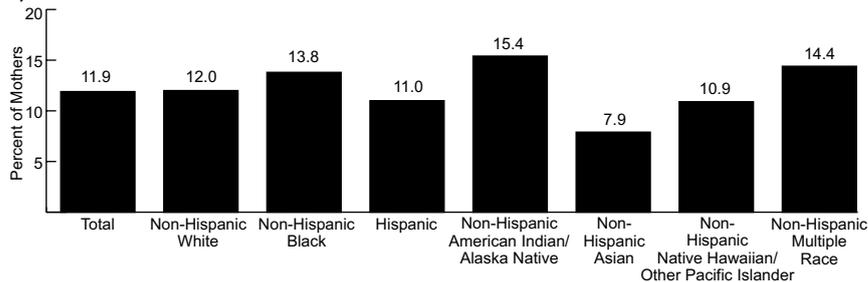
sive symptoms since the birth of their child in the previous 2–9 months. Postpartum depressive symptoms varied significantly by race and ethnicity. The proportion of mothers reporting postpartum depressive symptoms was highest among non-Hispanic American Indian/Alaska Natives, non-Hispanic mothers of multiple races, and non-Hispanic Black mothers (15.4, 14.4, and 13.8 percent, respectively), and was lowest among non-Hispanic Asian mothers (7.9 percent). Postpartum depressive symptoms also varied greatly by level of maternal education, from 6.9 percent among mothers with at least 16 years of education to 22.2 percent among mothers with less than 12 years of education (data not shown). Factors that may increase the risk of postpartum depression include previous

depressive episodes, stressful life events, and limited social support.^{68,69}

Early diagnosis and treatment are important as postpartum depression can interfere with maternal-infant bonding and child development.⁶⁹ Screening for depression is encouraged by the American College of Obstetricians and Gynecologists both during and after pregnancy. In 2007–2009, 76.6 percent of recent mothers in a 10-State area reported that a health care provider talked with them about “baby blues” or postpartum depression during or after their most recent pregnancy; this ranged from 73.0 percent of mothers with less than 12 years of education to 79.2 percent of mothers with 16 or more years of education (see *Women's Health USA 2011* for estimates by race and ethnicity).

Postpartum Depressive Symptoms* Among Mothers with a Recent Live Birth, by Race/Ethnicity, 2009**

Source II.26: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System

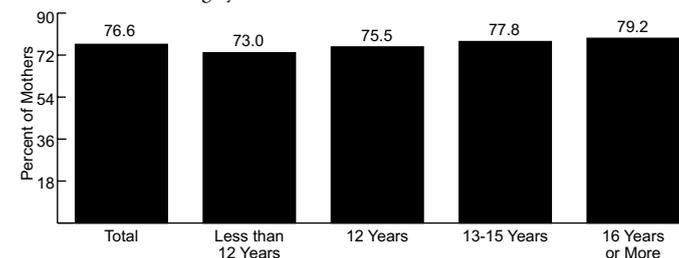


*Defined as a sum of 10 or higher in response to 3 questions of how often the mom reported feeling down, depressed, or sad; hopeless; or slowed down since the birth of the baby, where 1=never, 2=rarely, 3=sometimes, 4=often, 5=always.

**Includes data from a total of 29 States; mothers completed surveys between 2 and 9 months postpartum.

Women with a Recent Live Birth Who Reported That a Health Care Provider Discussed Postpartum Depression, by Maternal Education,* 2007–2009**

Source II.20: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System



**Includes data from a total of 10 States and New York City; 4 States contributed all 3 years; mothers completed surveys between 2 and 9 months postpartum.

BREASTFEEDING

Breast milk benefits the health, growth, immunity, and development of infants, and mothers who breastfeed may have a reduced risk of Type 2 diabetes and breast and ovarian cancer.⁷⁰ Among infants born in 2008, 74.6 percent were reported to have ever been breastfed, representing a significant increase over the 70.9 percent of infants ever breastfed in 2000.⁷¹ The American Academy of Pediatrics recommends that infants be exclusively breastfed—without supplemental solids or liquids—for the first 6 months of life; however, only 44.3 percent of infants born in 2008 were breastfed at 6 months of age and only 14.8 percent were exclusively breastfed through the first 6 months.

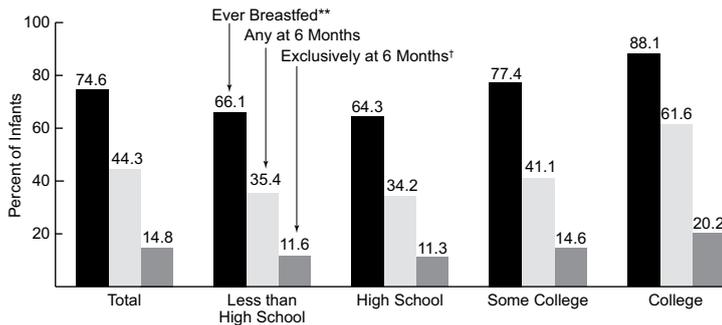
Breastfeeding practices vary considerably by a number of factors, including maternal race and ethnicity, education, age, and income. With respect to education, infants born to mothers with a college education were most likely to have ever been breastfed (88.1 percent), while infants born to mothers with a high school degree or less were least likely (64.3 and 66.1 percent, respectively). With respect to race and ethnicity, Asian infants were most likely to ever be breastfed (86.7 percent) while non-Hispanic Black infants were the least likely to ever be breastfed (59.0 percent). Infants born to older mothers and those with higher household incomes were also more likely to be breastfed (data not shown). These sociodemographic pat-

terns generally persist with regard to the duration and exclusivity of breastfeeding.

Maternal employment can also affect whether and for how long an infant is breastfed; mothers working full-time are less likely to breastfeed at 6 months than those working part-time or not at all.⁷² In 2011, more than half of all mothers with children under 1 year of age were employed, and two-thirds of those mothers were employed full-time (data not shown).⁷³ The Affordable Care Act of 2010 helps to support breastfeeding among working women by requiring break time and a private, sanitary place for nursing mothers to express breast milk during the workday.⁷⁴

Infants* Who Are Breastfed, by Maternal Education and Duration, 2008

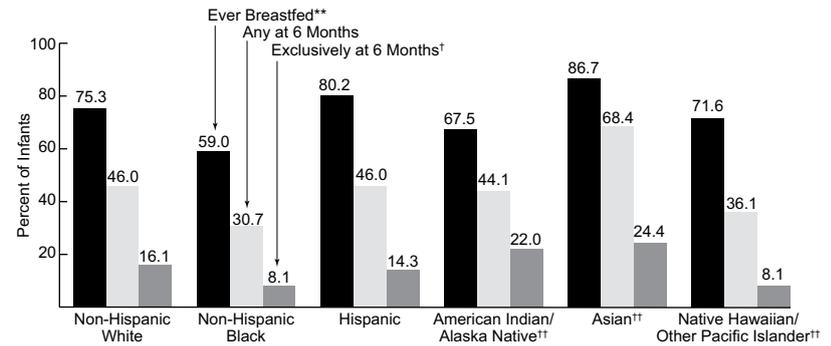
Source II.27: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2008; data are provisional. **Reported that child was ever breastfed or fed human breast milk. *Exclusive breastfeeding is defined as only human breast milk—no solids, water, or other liquids.

Infants* Who Are Breastfed, by Race/Ethnicity and Duration, 2008

Source II.27: Centers for Disease Control and Prevention, National Immunization Survey



*Includes only infants born in 2008; data are provisional. **Reported that child was ever breastfed or fed human breast milk. *Exclusive breastfeeding is defined as only human breast milk—no solids, water, or other liquids. **Includes Hispanics.

IMPAIRED FECUNDITY AND FERTILITY SERVICES

Infertility generally refers to difficulties in becoming pregnant after trying for 1 year, whereas impaired fecundity includes problems either in becoming pregnant or carrying a pregnancy to term.⁷⁵ Factors that can increase a women's risk for infertility or impaired fecundity include older age, smoking, excessive alcohol use, stress, poor diet, being severely over- or underweight, a history of sexually transmitted infections, and certain health conditions such as polycystic ovarian syndrome (PCOS) which can interfere with ovulation.⁷⁵

In 2006–2010, 10.9 percent of women aged 15–44 had impaired fecundity (data not shown). Impaired fecundity varied by maternal age and

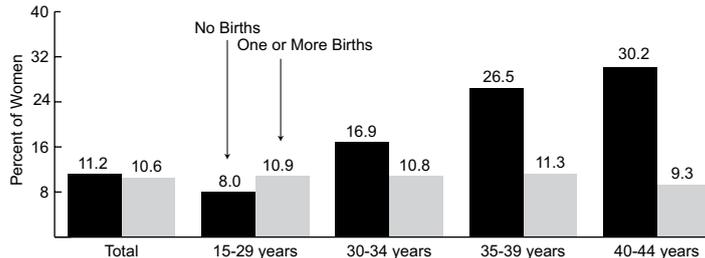
parity (the number of children a woman has had). Among nulliparous women—or those without a previous birth—prevalence of impaired fecundity increased with age from only 8.0 percent of women aged 15–29 to more than one in four women aged 35–44. In contrast, impaired fecundity did not vary greatly with age among women with a previous birth, ranging from 9 to 11 percent across age groups. Among women with a previous birth, the proportion who are surgically sterile (i.e., tubal ligation or hysterectomy) increases to over 50 percent of women by age 40–44, and thus a smaller proportion are at risk of impaired fecundity (data not shown).

Difficulties having a baby can be addressed with medications, surgery, artificial insemination and assisted reproductive technol-

ogy (ART).⁷⁵ In 2006–2010, 11.9 percent of women aged 15–44 years reported that they or their spouses or partners had ever received some form of infertility service and 4.9 percent had received medical help to prevent a miscarriage (data not shown). The most common type of infertility service received was advice (6.5 percent), followed by infertility testing (5.0 percent) and medications to improve ovulation (4.0 percent). Between one-fifth and one-quarter of nulliparous women aged 35–39 and 40–44, respectively, had ever received infertility services. Levels of infertility service use were also higher among non-Hispanic White women (13.4 percent) than non-Hispanic Black and Hispanic women (8.6 and 9.6 percent, respectively; data not shown).

Impaired Fecundity* Among Women Aged 15–44, by Age and Parity, 2006–2010

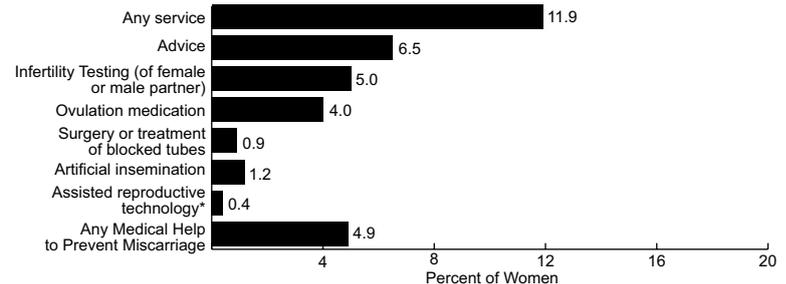
Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Impaired fecundity is defined as being not surgically sterile and having problems getting pregnant or carrying a baby to term.

Types of Infertility Services Received by Women Aged 15–44, 2006–2010

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



*Assisted reproductive technology (ART) works by removing eggs from a woman's body. The eggs are then mixed with sperm to make embryos. The embryos are then put back in the woman's body.

ASIAN WOMEN

In 2010, over 6 million U.S. women (5.0 percent) identified themselves as Asian.⁷⁶ Between 2000 and 2010, the Asian population increased by 43.3 percent—more than any other race group.⁷⁷ Incredibly diverse, the Asian population comprises people native to the Far East, Southeast Asia, or the Indian subcontinent. Among the Asian population in the United States, the largest nationalities are Chinese (22.8 percent), Asian Indian (19.4 percent), Filipino (17.4 percent), Vietnamese (10.6 percent), Korean (9.7 percent), and Japanese (5.2 percent).⁷⁸ Although Asian American women are generally healthier and have the longest life expectancy of any race group, there is great variation with some groups shown to have higher rates of certain conditions including diabetes, cancer, and

Hepatitis B infection—a virus that causes liver disease and cancer.⁷⁹

In 2006–2010, compared to non-Hispanic White women, Asian women overall were slightly more likely to report ever having been diagnosed with diabetes (7.2 versus 6.4 percent, respectively) or ever having hepatitis (3.4 versus 2.6 percent, respectively). However, among subgroups with available data, only Asian Indian women had significantly higher risk of diabetes (12.4 percent), and only Chinese women had a higher risk of hepatitis (4.3 percent) than non-Hispanic White women.

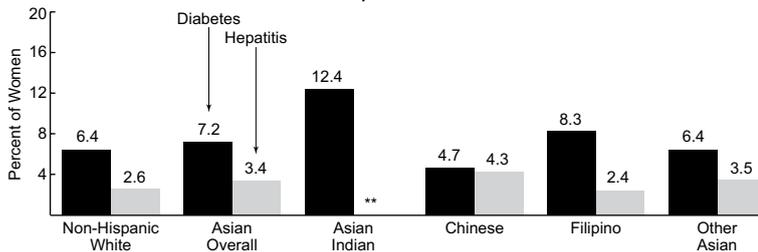
Due in part to health-related cultural beliefs, cervical cancer screening rates are lower among Asian women.⁸⁰ In 2010, 75.7 percent of Asian women aged 21–65 had received a pap smear within the past 3 years compared with 84.6

percent of non-Hispanic White women. Of the Asian subgroups with available data, only Filipinas had screening rates comparable to non-Hispanic White women (86.9 percent). Higher cervical cancer rates have been shown for Cambodian, Laotian, and Vietnamese women.⁸¹ Liver and stomach cancer rates are also higher among many Asian groups due to infection with hepatitis and a stomach bacterium known as *H. pylori*, respectively; which are common in countries where many Asian Americans were born and migrated from.⁸¹

Increasing the prevention and treatment of hepatitis and improving data collection on the health and well-being of the Asian and Pacific Islander population, including detail on ethnic subgroups, are among the health goals of a White House Initiative on Asian Americans and Pacific Islanders.⁸²

Diabetes and Hepatitis Among Women,* by Selected Race Group, 2006–2010

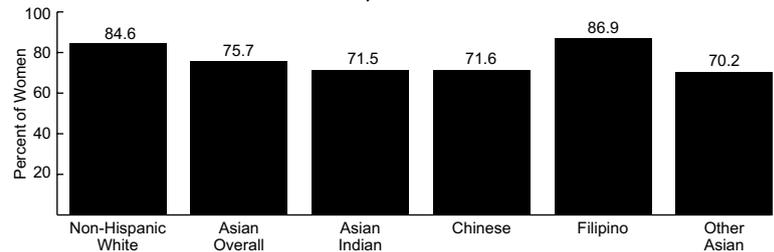
Source II.28: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that a health professional had ever told them that they had diabetes; reported ever having had hepatitis; all estimates are age-adjusted. **Estimate does not meet the standards of reliability or precision.

Receipt of Recommended Cervical Cancer Screening Among Women Aged 21–65,* by Selected Race Group, 2010

Source II.28: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Based on U.S. Preventive Services Task Force recommendations of a Pap smear every 3 years for women aged 21–65 years; all estimates are age-adjusted.

RURAL AND URBAN WOMEN

Residents of rural areas tend to face greater socioeconomic disadvantage and live farther from health care resources than their urban counterparts. For example, rural areas have fewer physicians and dentists per capita than urban areas, and may lack certain specialists altogether. A variety of social, economic, and geographic factors are likely to contribute to higher rates of chronic disease, injury, and mortality observed in rural areas.⁸³

A common definition of rural and urban relies on residence outside or inside metropolitan statistical areas—counties with an urbanized area of at least 50,000 people or adjacent commuting counties. In 2010, over 19 million

women aged 18 and older lived in non-metropolitan or rural areas, representing 16.9 percent of all women.

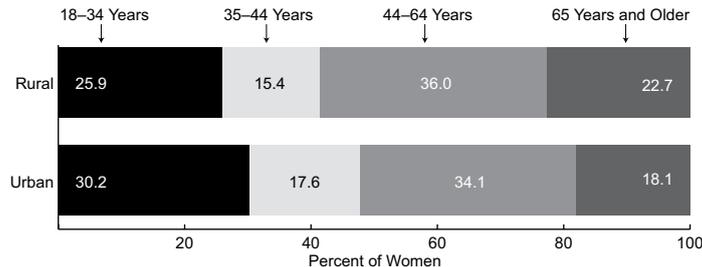
Rural women were more likely to be older and non-Hispanic White than their urban counterparts. In 2010, the median age of rural women was 3 years older than for urban women (49 versus 46 years, respectively; data not shown) and 22.7 percent of rural women were aged 65 years or older, compared to 18.1 percent of urban women. More than four out of five rural women were non-Hispanic White (81.7 percent) compared to 62.2 percent of urban women (data not shown). Non-Hispanic American Indian/Alaska Native women were

the only other racial and ethnic group to have greater representation in rural than urban areas (1.6 versus 0.4 percent, respectively).

Women living in rural areas also had lower levels of income and educational attainment than urban women. In 2010, 40.3 percent of rural women lived in households with incomes below 200 percent of poverty compared to 32.3 percent of urban women. Conversely, 38.4 percent of urban women had household incomes of 400 percent or more of poverty, compared to 27.1 percent of rural women. Among women aged 25 and older, 18.7 percent of rural women had a college degree or higher compared to 30.4 percent of urban women (data not shown).

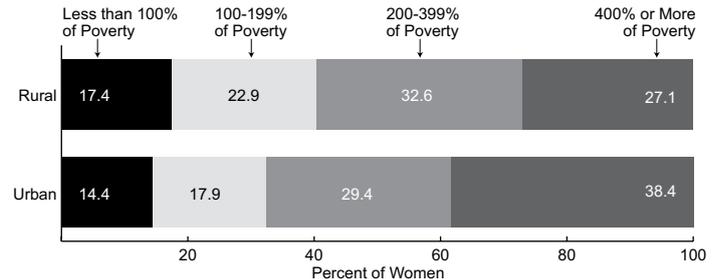
Rural and Urban* Women Aged 18 and Older, By Age, 2010

Source II.29: U.S. Census Bureau, American Community Survey



Rural and Urban* Women Aged 18 and Older, By Poverty Level, 2010

Source II.29: U.S. Census Bureau, American Community Survey



*Defined as residence in non-metropolitan (rural) and metropolitan (urban) statistical areas.

*Defined as residence in non-metropolitan (rural) and metropolitan (urban) statistical areas; percentages may not total to 100 due to rounding.

In 2010, one in five rural women reported smoking cigarettes (20.5 percent) compared to 14.4 percent of urban women. Women residing in rural areas were also more likely than those living in urban areas to be physically inactive (29.2 versus 25.1 percent, respectively) and obese (30.4 versus 25.9 percent, respectively). Opportunities for regular exercise may be less accessible in some rural areas that lack sidewalks or nearby trails. Reflecting greater barriers to care, rural women were also more likely than their urban counterparts to be uninsured (18.0 versus 14.3 percent, respectively) and to not have had a dental visit in the past year (35.6 versus 28.1 percent, respectively).

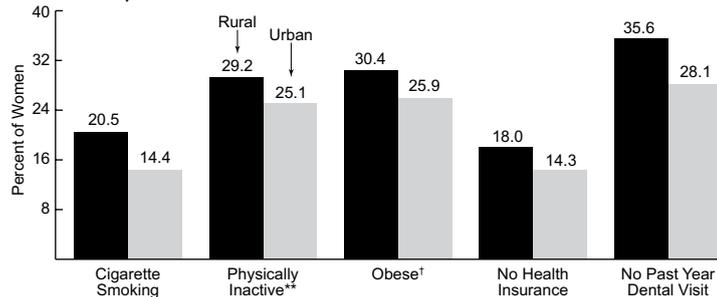
Consistent with poorer indicators of health status and access to health care, rural women tend to have higher mortality rates. In 2009, the age-adjusted mortality rate for rural women was 868.2 per 100,000 compared to 764.0 per 100,000 for urban women. Heart disease, chronic lower respiratory diseases, and unintentional injury ranked higher among the leading causes of death for rural than for urban women. However, mortality rates for every leading cause of death were higher for rural women. The largest absolute disparity between rural and urban women was for heart disease—an excess of 23.9 deaths per 100,000 (201.2 versus 177.3 per 100,000, respectively). Unintentional injury

mortality had the largest relative disparity; the mortality rate was 53.1 percent higher for rural versus urban women (42.1 versus 27.5 deaths per 100,000, respectively). In particular, motor vehicle accident deaths were more than twice as high for rural compared to urban women (14.4 versus 6.5 per 100,000; data not shown).

The Health Resources and Services Administration's Office of Rural Health Policy provides funding to rural hospitals and state offices of rural health to improve access and quality of care in rural areas.⁸⁴ Other HRSA programs, such as Community Health Centers and the National Health Service Corps, aim to improve health care capacity in underserved rural and urban areas.

Selected Health Indicators Among Women Aged 18 and Older, by Rural/Urban Residence,* 2010

Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Defined as residence in non-metropolitan (rural) and metropolitan (urban) statistical areas; all estimates are age-adjusted. **No leisure time physical activity in the past month. †Body mass index ≥30.

Age-Adjusted Mortality Rates Per 100,000 Females Aged 15 and Older, by Leading Cause of Death and Rural/Urban Residence,* 2009

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

	Rural Rate (Rank)	Urban Rate (Rank)
Total	868.2 (-)	764.0 (-)
Heart Disease	201.2 (1)	177.3 (2)
Malignant Neoplasms	194.0 (2)	184.7 (1)
Chronic Lower Respiratory Diseases	56.7 (3)	46.0 (4)
Cerebrovascular Disease (Stroke)	56.3 (4)	46.1 (3)
Unintentional Injury	42.1 (5)	27.5 (6)
Alzheimer's Disease	36.2 (6)	31.2 (5)
Diabetes Mellitus	27.1 (7)	21.5 (7)

*Defined as residence in non-metropolitan (rural) and metropolitan (urban) statistical areas; all estimates are age-adjusted.

WOMEN VETERANS

As of September 2012, women were estimated to comprise more than 1.8 million, or 8.6 percent, of all living veterans. This represents a 33 percent increase since 2002, when women represented 6.4 percent of all living veterans, and this percentage is expected to increase in future years. By 2035, women are projected to make up 15 percent of all veterans—similar to the current proportion of active duty military personnel that are female.⁸⁵

The largest group of living women veterans today are from the Gulf War Era and the most recent conflicts: Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). The continually changing military roles of women, multiple deployments, and the blurring of combat and non-combat operations in Iraq and Afghanistan

suggest that the needs of these women veterans may differ greatly from the needs of women veterans from previous eras.

Due to the more recent increase in military enrollment and opportunities for women, female veterans are much younger than their male counterparts. In 2010, 21.6 percent of female veterans were aged 18–34 compared to only 6.9 percent of male veterans. Conversely, 44.0 percent of male veterans were aged 65 and older compared to only 15.8 percent of female veterans. Expressed differently, women comprised 19.6 percent of all veterans aged 18–34 years but only 2.7 percent of veterans aged 65 and older (data not shown).

In addition to being younger, women veterans are also more racially diverse and more highly educated than their male counterparts. In 2010, 31.8 percent of women veterans were of minor-

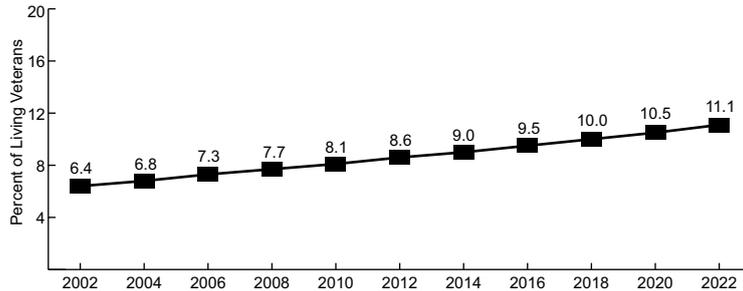
ity race or ethnicity compared to 18.5 percent of male veterans. Female veterans were particularly more likely to be non-Hispanic Black than male veterans (19.3 versus 10.2 percent, respectively). Nearly 80 percent of women veterans had obtained post-secondary education beyond high school (78.1 percent) compared to 60.9 percent of male veterans (data not shown).

Relative to civilian non-veteran women, female veterans tend to be slightly older, more likely to be non-Hispanic Black, more educated, and less likely to be in poverty.⁸⁶

Overall, in 2010, a higher proportion of female than male veterans reported having a service-connected disability (18.0 versus 15.4 percent, respectively)—determined by the Veterans Benefits Administration as injuries or illnesses incurred or aggravated during military service. Regardless of sex, the prevalence of service-con-

Living Women Veteran Population, 2002–2022*

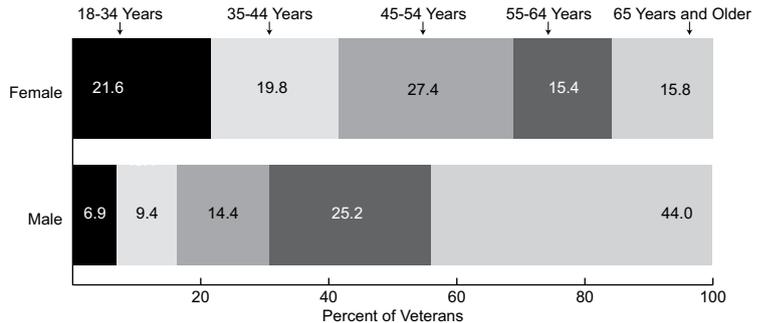
Source II.30: Department of Veterans Affairs, Office of Policy & Planning



*Historical data from 2000–2005; projected data from 2008 onward.

Veteran Population, by Sex and Age, 2010

Source II.31: U.S. Census Bureau, American Community Survey



nected disability declined with age. At older ages, male veterans are more likely to have a service-connected disability than women veterans. For example, for those aged 65 and older, 12.0 percent of male veterans had a service-connected disability compared to 9.0 percent of women veterans. The most prevalent service-connected disabilities for women veterans in 2009 were post-traumatic stress disorder (PTSD), lower back pain, and migraines, accounting for 15 percent of service-connected disabilities (data not shown).⁸⁶ Among users of the U.S. Department of Veterans Affairs (VA) health care, a link between PTSD and military sexual trauma—defined as sexual assault and/or severe and threatening sexual harassment that occurred during military service—may be stronger for women than men.⁸⁷

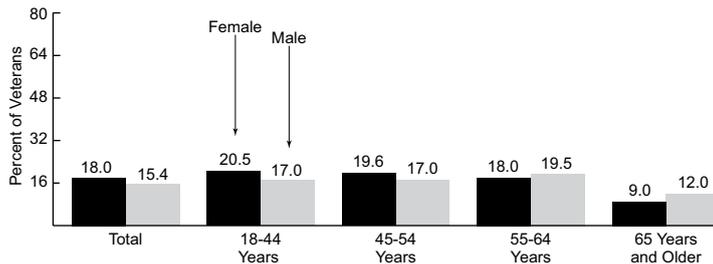
For the above reasons and despite higher educational attainment and income,⁸⁶ women veterans may face greater health challenges compared to civilian women.⁸⁸ In 2010, women veterans were more likely than their civilian counterparts to report smoking (18.5 versus 15.5 percent, respectively), being overweight or obese (61.2 versus 55.9 percent, respectively), and having limitations in activity due to physical, mental, or emotional problems (29.3 versus 20.7 percent, respectively). Women veterans were also more likely than civilian women to report having poor mental health on 14 or more days in the past month (18.1 versus 12.5 percent, respectively). Levels of activity limitations and frequent mental distress were also higher than

those reported by male veterans (23.3 and 11.1 percent of male veterans, respectively; data not shown). However, women veterans were more likely than civilian women to have received a past-year preventive visit (76.2 versus 72.0 percent, respectively).

Today, more than 337,000 women veterans or 19 percent of all women veterans use VA health care, double the number from a decade ago.⁸⁹ The VA is improving services to make sure women who are eligible for VA care can access services tailored to their needs and has expanded research on the impacts of trauma and combat exposure for women, mental health outcomes of civilian reintegration, and overall health care needs of women veterans.

Service-Connected Disability* Among Veterans, by Age and Sex, 2010

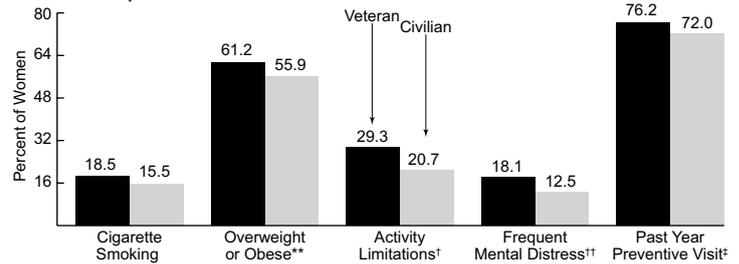
Source II.31: U.S. Census Bureau, American Community Survey



*Report of injuries or illnesses incurred or aggravated during military service as determined by the Veterans Benefits Administration.

Selected Health Indicators* Among Women Aged 18 and Older, by Veteran Status, 2010

Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*All estimates are age-adjusted. **Body mass index ≥ 25 . †Report of limitations to activity due to physical, mental, or emotional problems. ††Report of having poor mental health ≥ 14 days in past month. ‡Report of a routine checkup in the past year, defined as a general physical exam that was not for a specific injury, illness, or condition.

HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affect all aspects of women's health. Access to health care is critical to prevent the onset of disease, as well as to identify health issues early and prevent disease progression. Although health care is important for all women, it may be particularly important among women who have poor health status, chronic conditions, or disabilities. Appropriate utilization can be hampered by limited financial resources and lack of health insurance or comprehensive insurance, as well as language, transportation, and other barriers.

This section presents data on women's use of health services, including data on women's health insurance coverage, usual source of care, health care expenditures, and use of various services, such as preventive care, HIV testing, oral health care, and mental health services. A new topic within this section explores women's use of the internet for health information.



HEALTH INSURANCE

People who are uninsured face substantial financial barriers to health care, which can result in delayed diagnoses and poor health outcomes, including premature death.¹ In 2010, 42.6 million adults (18.4 percent) were uninsured, up from 37.5 million adults (16.7 percent) in 2007 (2007 data not shown). The recent rise in the uninsured population has been attributed to job loss and the economic recession.¹ The percentage of people who are uninsured varies considerably across a number of factors, including age, sex, marital status, race and ethnicity, income, and education.

Among adults in 2010, those aged 18–24

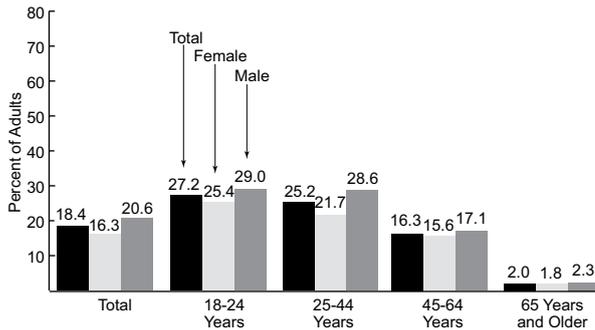
years were most likely to lack health insurance (27.2 percent). However, those aged 18–24 years were the only group to experience a significant decline in uninsurance between 2009 and 2010,² which is likely attributable to the Affordable Care Act provision allowing children to stay on their parents' insurance plan until age 26.¹ Men aged 18–64 years were more likely than women of the same age to be uninsured. The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage.

In 2010, 67.8 percent of women aged 18–64 years had private health insurance, 17.1 percent had public insurance, and 19.6 percent

were uninsured. This distribution varied by marital status: women who were married and whose spouse was present were most likely to have private insurance coverage (77.8 percent) and least likely to be uninsured (14.2 percent). Conversely, women who were married, but whose spouse was absent or reported being separated were least likely to have private health insurance (48.7 and 47.2 percent, respectively) and most likely to be uninsured (32.2 and 30.3 percent, respectively). Women who were separated from their spouses or widowed were most likely to have public health insurance coverage (26.9 and 25.9 percent, respectively). [Respondents could report more than one type of coverage.]

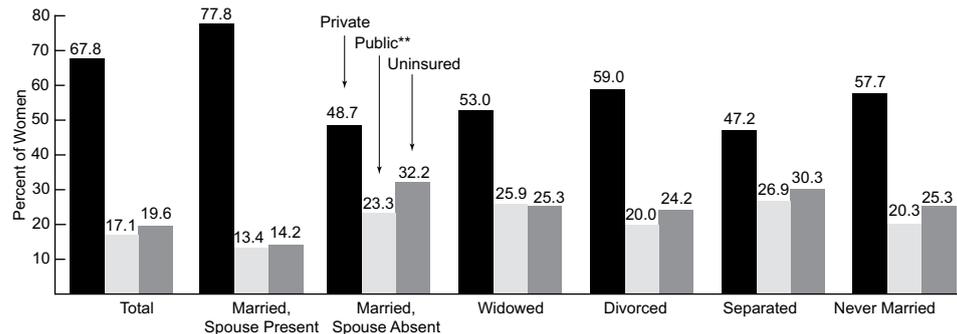
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2010

Source I.5: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Marital Status and Type of Coverage,* 2010

Source I.5: U.S. Census Bureau, Current Population Survey



*Percentages may add to more than 100 because it was possible to report more than one type of coverage. **Includes Medicaid, Medicare, military health care, and state health plans.

MEDICAID AND MEDICARE

Medicaid, jointly funded by Federal and State governments, provides medical coverage to certain categories of low-income people.³ In 2009, Medicaid covered 62.2 million people including low-income pregnant women, children, parents, elderly individuals, and those with disabilities. Adults aged 19 and older accounted for about half of Medicaid enrollees (31.9 million), and women accounted for 68.2 percent of all adult enrollees. Medicaid serves as a critical safety net for those who might otherwise be uninsured; increasing enrollment has helped to offset declines in employer-sponsored coverage, but more notably for children than adults due to greater eligibility and expansions for children.¹

Women accounted for a larger proportion of adult Medicaid enrollees in every age group,

most noticeably among those aged 19–44 and 85 years and older (72.5 and 79.3 percent, respectively). Nearly 13.5 million women, representing 62.0 percent of adult female Medicaid enrollees, were of childbearing age (data not shown). Because the Medicaid eligibility threshold is lowered in the postpartum period, 31 States have expanded family planning through a Federal waiver or State plan amendments to cover women who would not otherwise be eligible for Medicaid.⁴

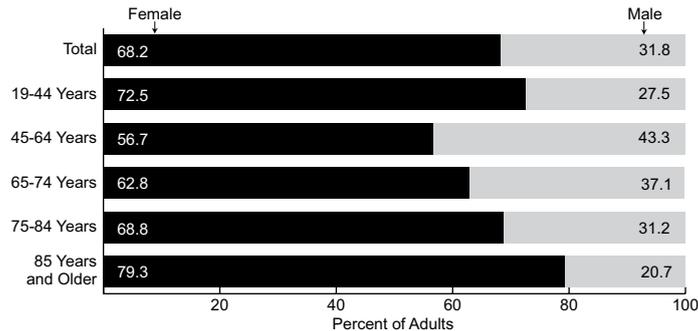
Medicare is the Nation's health insurance program for people aged 65 years and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician

services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase coverage through private insurers; and Part D allows for coverage of prescription drugs through private insurers.³

In 2010, 55.2 percent of Medicare's 47.7 million enrollees were female (data not shown). Due to age-related eligibility, those in older age groups accounted for a greater proportion of overall enrollment among both women and men. However, a greater proportion of male enrollees were under 65 compared to female enrollees (19.6 versus 14.6 percent, respectively). In contrast, adults aged 85 years and older comprised a greater proportion of female than male enrollees. (14.4 versus 8.5 percent, respectively), due to the longer life expectancy of women.

Adult Medicaid Enrollees Aged 19 and Older, by Age and Sex, 2009*

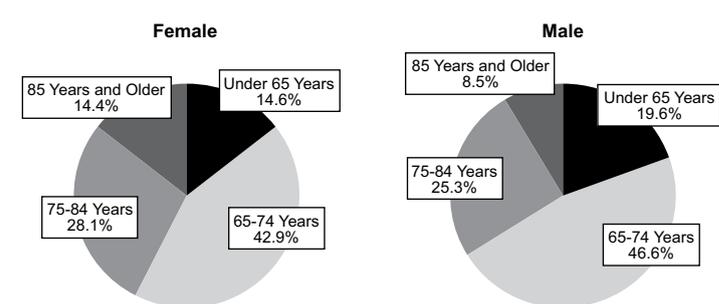
Source III.1: Centers for Medicare and Medicaid Services



*Based on Federal Fiscal Year (October to September); percentages may not add to 100 due to rounding.

Medicare Enrollees, by Sex and Age, 2010*

Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2010.

BARRIERS TO CARE AND UNMET NEED FOR CARE

Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation.⁵ Barriers to care contribute to socioeconomic, racial and ethnic, and geographic differences in health care utilization and health status.

In 2008–2010, 11.8 percent or 26.4 million adults reported that they delayed getting medical care in the past year due to various logistical or structural factors, such as not being able to get an appointment soon enough and inconvenient office hours (data not shown). Women were more likely than men to report having delayed care due to logistical barriers in the past year

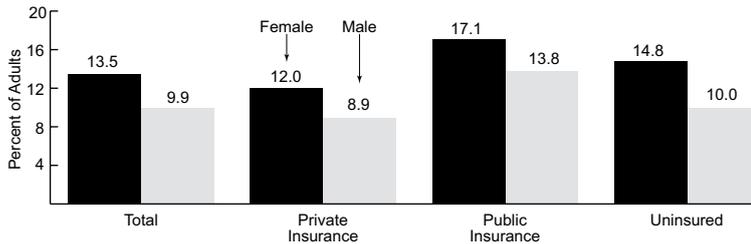
(13.5 versus 9.9 percent, respectively). For both men and women, those with public insurance or no insurance were more likely to report having delayed care as a result of logistical factors than those with private coverage. For example, 12.0 percent of women with private health insurance reported having delayed care compared to 17.1 percent of women with public coverage and 14.8 percent of uninsured women. Non-Hispanic Black and Hispanic women also were more likely than non-Hispanic White women to report delayed care due to logistical barriers (16.3 and 16.7 versus 12.2 percent, respectively; data not shown).

Women were also slightly more likely than men to have forgone needed health care due to cost (13.0 versus 11.1 percent, respectively). For

both women and men, the proportion who delayed needed care due to cost varied by poverty level. Among women, about one-fifth of those living in households with incomes less than 200 percent of poverty experienced an unmet need for health care due to cost, compared to 13.5 percent of those with household incomes of 200–399 percent of poverty and 6.5 percent of those with household incomes of 400 percent or more of poverty. The Affordable Care Act of 2010 helps to remove financial barriers to care by expanding Medicaid eligibility for more low-income people, mandating employer-sponsored coverage for large employers, establishing state-based insurance exchanges, and requiring insurance coverage under new health plans to cover preventive services without copays or cost-sharing.⁶

Adults Aged 18 and Older who Delayed Care Due to Logistical Barriers* in Past Year, by Type of Insurance, 2008–2010

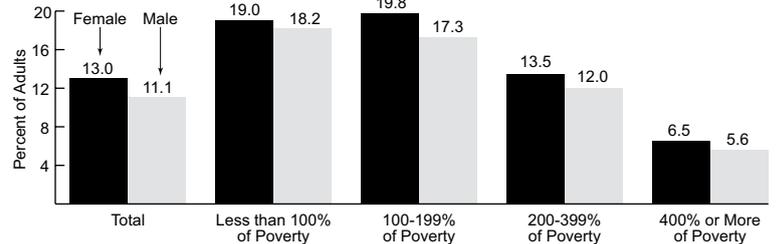
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they delayed getting medical care in the past year due to any of five reasons: couldn't get through on phone, couldn't get appointment soon enough, office room wait too long, inconvenient office hours, no transportation.

Adults Aged 18 and Older with Unmet Need for Health Care* Due to Cost, by Poverty Status** and Sex, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they needed but did not get medical care because they could not afford it; excludes dental care. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010.

USUAL SOURCE OF CARE

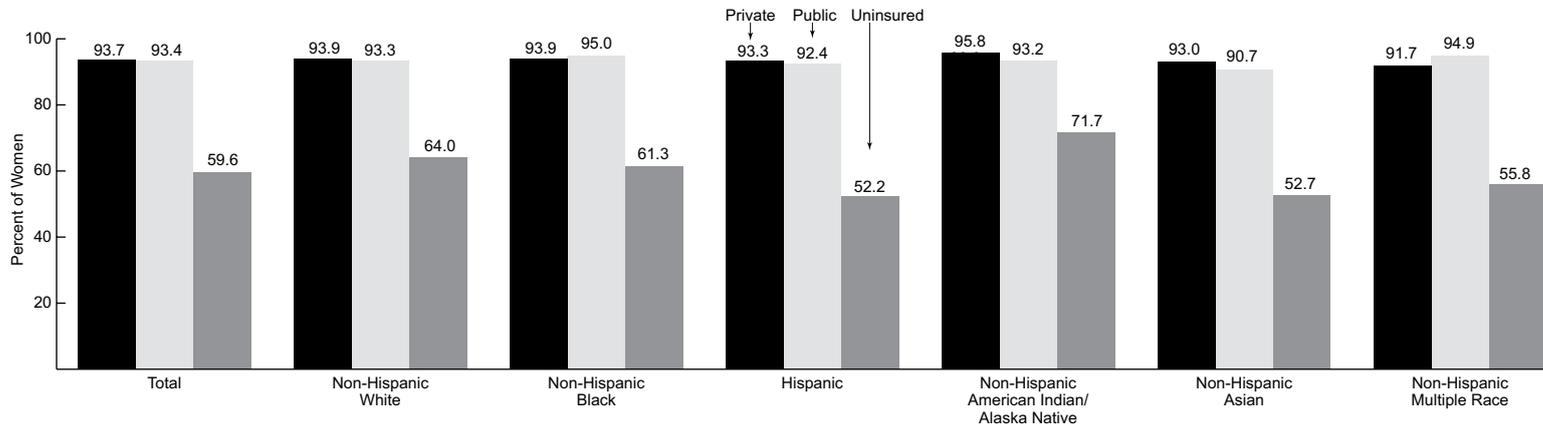
In 2008–2010, 88.3 percent of women reported having a usual source of care (a place where one usually goes when sick, such as a physician's office or health center), compared to 79.0 percent of men (data not shown). Having a usual source of care is more common among older adults. For example, nearly all women aged 65 years and older (97.2 percent) had a usual source of care compared to 80.9 percent of women aged 18–34 years (data not shown). Having a usual source of care has been shown to improve care quality and the receipt of preventive services.⁷

Overall, non-Hispanic White women were most likely to report a usual source of care (90.1 percent), while Hispanic women were least likely to do so (80.8 percent; data not shown). The proportion of women of different races and ethnicities who have a usual source of care varied by health insurance coverage. Overall, approximately 94 percent of women with private or public insurance had a usual source of care compared to 59.6 percent of uninsured women. Among women with private or public insurance, those reporting a usual source of care exceeded 90 percent for all racial and ethnic groups. Women lacking health insurance were least likely to have a usual source of care,

with significant variation by race and ethnicity. Among women without health insurance, non-Hispanic American Indian/Alaska Native, non-Hispanic White, and non-Hispanic Black women were most likely to report a usual source of care (71.7, 64.0, and 61.3 percent, respectively), while only about half of uninsured Hispanic, non-Hispanic women of multiple races, and non-Hispanic Asian women had a usual place to go when they were sick. Having both a usual source of care and health insurance coverage has been found to significantly reduce problems obtaining needed medical care and delaying or forgoing needed care.⁸

Women Aged 18 and Older with a Usual Source of Care,* by Health Insurance Status and Race/Ethnicity,** 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*All estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.

PREVENTIVE CARE

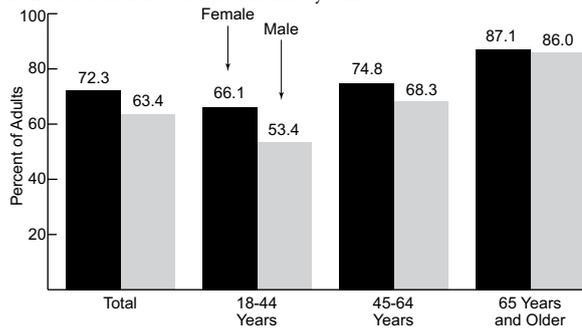
Preventive health care, including counseling, education, and screening, can help prevent or minimize the effects of many serious health conditions. In 2010, 72.3 percent of women reported that they had received a routine checkup or general physical exam that was not for a specific injury, illness, or condition, compared to 63.4 percent of men. For both men and women, the receipt of preventive health care increased with age and exceeded 85 percent among those aged 65 years and older. Among those aged 18–44 years, however, women were much more likely than men to have had a preventive checkup (66.1 versus 53.4 percent, respectively).

The U.S. Preventive Services Task Force recommends specific screening tests, counseling, immunizations, and preventive medications for a variety of diseases and conditions including several types of cancer, cardiovascular disease, injury, infectious diseases, mental health, and substance abuse.⁹ For example, biennial breast cancer screenings (mammograms) are recommended for every woman aged 50–74 years and cervical cancer screenings (Pap smears) are recommended every 3 years for women aged 21–65 years. In 2010, 79.8 percent of women aged 50–74 years reported receiving a mammogram within the past 2 years and 84.5 percent of women aged 21–65 reported receiving a Pap

smear within the past 3 years. Non-Hispanic American Indian/Alaska Native and non-Hispanic women of multiple races were less likely than women of other races and ethnicities to have met the mammogram guidelines (65.5 and 72.7 percent, respectively). Non-Hispanic Asian, non-Hispanic American Indian/Alaska Native, and women of multiple races were least likely to have met the Pap smear guidelines (74.6, 77.8, and 78.1 percent, respectively). Under the Affordable Care Act, women's preventive health care, such as breast and cervical cancer screening, prenatal care, and other services, is covered with no cost-sharing for new health plans.¹⁰

Past Year Preventive Check-up Among Adults Aged 18 and Older,* By Age and Sex, 2010

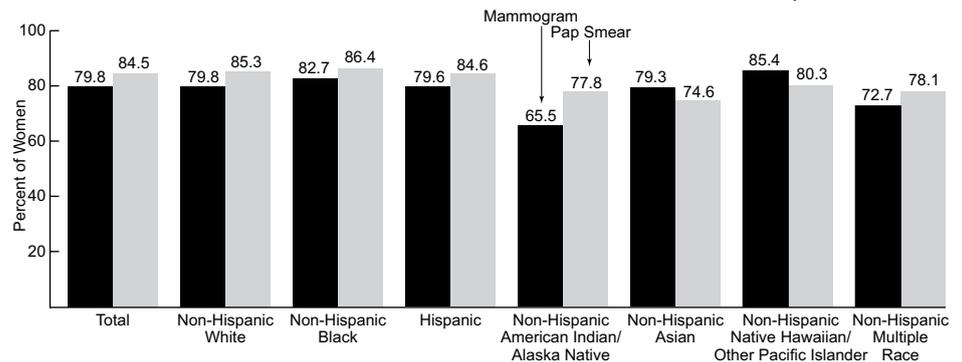
Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Report of a routine checkup in the past year, defined as a general physical exam that was not for a specific injury, illness, or condition; total estimates are age-adjusted.

Receipt of Recommended Breast and Cervical Cancer Screening Among Women,* by Race/Ethnicity, 2010

Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Based on U.S. Preventive Services Task Force recommendations of biennial mammography for women aged 50–74 years and a Pap smear every three years for women aged 21–65 years; all estimates are age-adjusted.

VACCINATION

Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in mortality and morbidity for many infectious diseases.¹¹ An annual influenza (flu) vaccination is now recommended for all persons aged 6 months and older; however, it is especially important for certain groups, including pregnant women and older adults, who are at higher risk for flu complications.¹² In November of 2011, only 43.2 percent of pregnant women reported receiving flu vaccine for the 2011–2012 season. Those with household incomes less than 100 percent of poverty were less likely to have received vaccination than those living at or above poverty (38.8 versus 45.2 percent, respectively). To prevent potentially fatal infection in the newborn, a tetanus, diphtheria, and acellular pertussis (whooping cough) vaccine (Tdap) is also

recommended for pregnant women (>20 weeks' gestation) if they have not received Tdap vaccination in the last 10 years.¹³ In 2011, only 24.2 percent of pregnant women reported having received a current Tdap vaccination. Tdap vaccination was lower among pregnant women with household incomes below poverty compared to those with higher incomes (20.5 versus 25.3 percent, respectively).

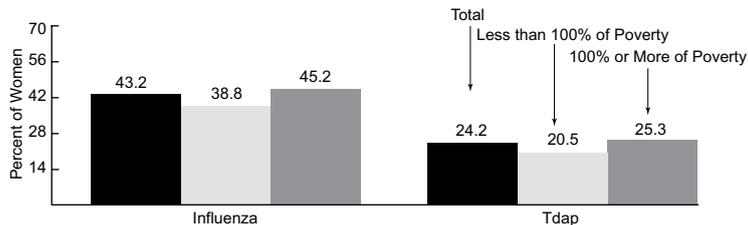
Pneumococcal vaccination protects against a bacterial infection that may cause pneumonia or other illnesses that can lead to severe complications including death. Pneumococcal vaccination is recommended for young children, adults aged 65 years and older, those with certain health conditions including asthma, and for adults who smoke cigarettes.¹² In 2010, 61.3 percent of women aged 65 and older reported ever receiving a pneumococcal vaccination. Pneumococcal vac-

cination was lower among women with household incomes of less than 100 percent of poverty, compared to those with higher incomes (42.2 versus 64.1 percent, respectively).

Shingles vaccination, first recommended in 2006, protects against herpes zoster—a reactivation of the virus that causes chickenpox, which is called shingles. Shingles occurs mostly in older adults and produces a skin rash that can create debilitating pain lasting months or even years. The shingles vaccine is recommended for all persons aged 60 years and older, except for those with conditions that severely weaken the immune system.¹² In 2010, only 16.0 percent of women aged 60 and older reported receiving the shingles vaccination. Shingles vaccination was lower among women with household incomes below 100 percent of poverty than those with higher incomes (9.1 versus 17.4 percent, respectively).

Receipt of Selected Vaccinations* Among Pregnant Women, by Poverty Status,** 2011†

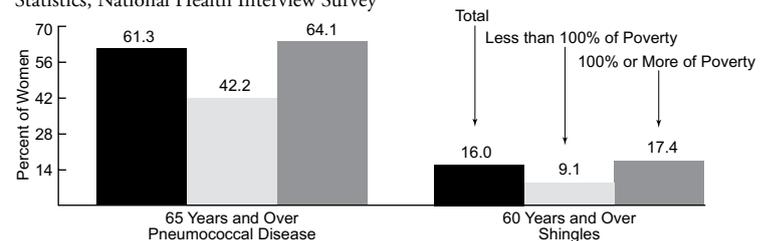
Source III.2: Centers for Disease Control and Prevention, Internet Panel Survey



*Having received the influenza vaccination since August 1, 2011; having received the tetanus shot including acellular pertussis (whooping cough) vaccine since 2005, when Tdap first became licensed and recommended. **Poverty level, defined by the U.S. Census Bureau, was \$22,811 for a family of four in 2011. †Women pregnant at anytime from August to November were surveyed in November, 2011.

Receipt of Selected Vaccinations* Among Women, by Recommended Age Group and Poverty Status,** 2010

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Having ever received the pneumonia shot; zoster or Shingles vaccine. **Poverty level, defined by the U.S. Census Bureau, was \$22,113 for a family of four in 2010.

HIV TESTING

People aware of and receiving appropriate care for positive HIV serostatus may be able to live longer and healthier lives because of newly available, effective treatments. It is recommended that people who meet any of the following criteria be tested at least annually for HIV: those who have injected drugs or steroids, or shared drug use equipment (such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have

had unprotected sex with anyone who meets any of these criteria.¹⁴ In addition, the CDC recommends that all health care providers include HIV testing as part of their patients' routine health care and that all pregnant women be tested during their pregnancy.

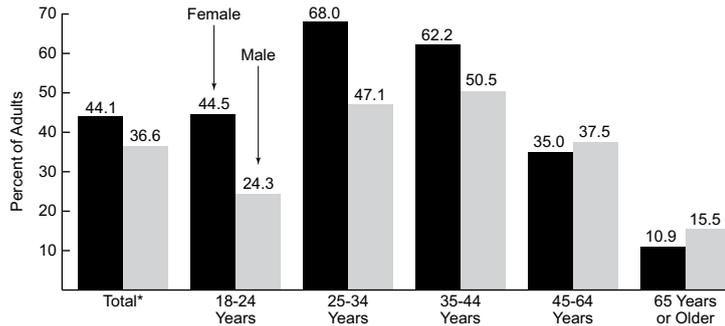
In 2008–2010, 40.3 percent of adults in the United States had ever been tested for HIV (data not shown). Overall, women were more likely than men to have been tested (44.1 versus 36.6 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, however, men were more likely to have been tested at older ages (45 years and older).

With respect to race and ethnicity, non-Hispanic Black women and men were most likely to have ever been tested (59.6 and 55.9 percent, respectively), while non-Hispanic Asian women and men were least likely to have ever been tested (34.7 and 30.7 percent, respectively). Women were generally more likely than men to have ever been tested for HIV within every race and ethnic group.

Among women who had not been tested, 78.6 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 19.1 percent reported that there was no particular reason they had not done so (data not shown).

Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2008–2010

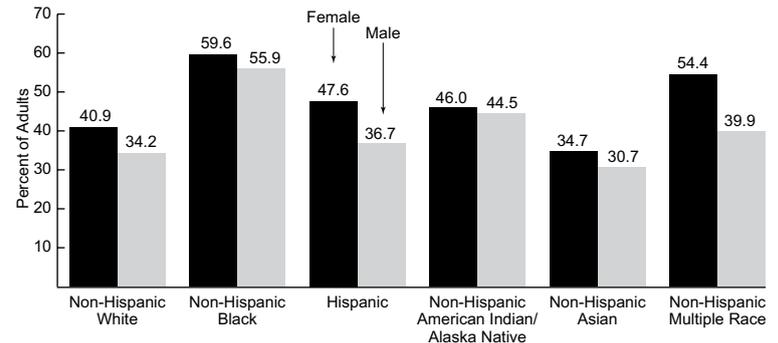
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Total estimates are age-adjusted.

Adults Aged 18 and Older Who Have Ever Been Tested for HIV,* by Race/Ethnicity,** 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.

MENTAL HEALTH CARE UTILIZATION

In 2009–2010, nearly 31 million, or 13.6 percent of adults in the United States reported receiving mental health treatment in the past year for a mental, behavioral, or emotional disorder other than a substance use disorder. Women were more likely than men to receive treatment or counseling (17.5 versus 9.4 percent), which is roughly commensurate with the higher prevalence of mental illness (excluding substance use disorder) among women (see page on Mental Illness).¹⁵ Utilization of mental health services was more common among women with higher educational attainment. Approximately

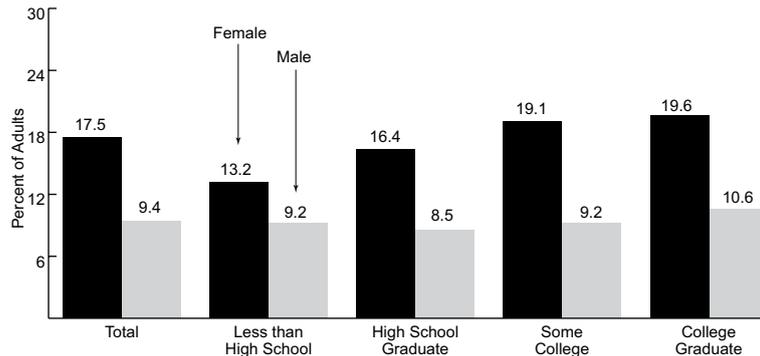
20 percent of college-educated women reported past year mental health treatment compared to 13.2 percent of women without a high school diploma.

Over 17 million women aged 18 years and older reported using prescription medication for treatment of a mental or emotional condition, representing 15.1 percent of women, which is almost twice the proportion of men (7.7 percent). Women were also nearly twice as likely as men to report receiving outpatient mental health treatment (8.4 versus 4.6 percent, respectively). Less than 1 percent of men and women received inpatient treatment in 2009–2010 (data not shown).

In 2009–2010, mental health services were needed, but not received in the previous year, by about 11.5 million adults, corresponding to 5.1 percent of adults in the United States. Women were almost twice as likely as men to have an unmet need for mental health treatment or counseling in the past year (6.6 versus 3.4 percent, respectively; data not shown). Among women, cost was the most commonly reported reason for not receiving needed services (46.9 percent) followed by the belief that the problem could be handled without treatment (26.5 percent), not having enough time (17.6 percent), and not knowing where to go for treatment (15.1 percent).

Past Year Mental Health Treatment/Counseling* Among Adults Aged 18 and Older, by Educational Attainment and Sex, 2009–2010

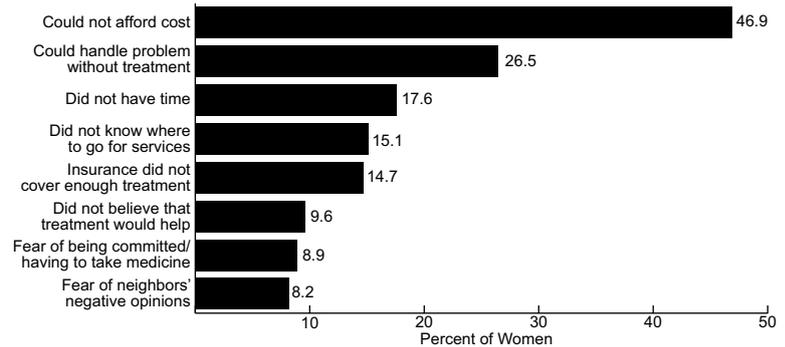
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use.

Reasons for Not Receiving Mental Health Treatment/Counseling* Among Women Aged 18 and Older with an Unmet Need for Mental Health Services, 2009–2010

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



*Defined as a perceived need for mental health treatment/counseling that was not received.

ORAL HEALTH CARE UTILIZATION

Regular dental care is essential to promote oral health and to prevent and treat tooth decay and infection. Untreated dental disease can produce significant pain and disability, and can result in tooth loss. In addition to daily brushing and flossing, the American Dental Association recommends regular dental exams and cleanings.¹⁶ Overall, 60.7 percent of adults reported having a dental visit in 2008–2010 (data not shown). Women were somewhat more likely to have had a past-year dental visit than men (64.1 and 57.0 percent, respectively).

Among both men and women, those with higher levels of education were more likely to

have had a dental visit. For example, 80.9 percent of women with a college degree or higher had a past year dental visit, compared to only 41.6 percent of women with less than a high school education. Similarly, three-quarters of men with at least a college degree reported a past-year visit compared to 35.0 percent of those who did not graduate high school.

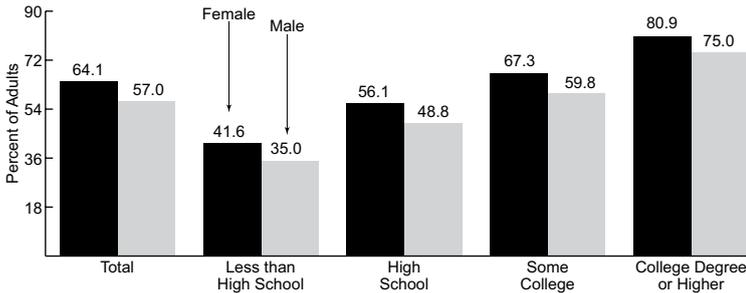
The proportion of women experiencing an unmet need for oral health care varies by race and ethnicity. In 2008–2010, 16.5 percent of women reported that they did not obtain needed dental care in the past year because they could not afford it; however, unmet need for care ranged from 9.1 percent among non-Hispanic Asian women to

30.3 percent among non-Hispanic women of multiple races.

Cost remains a significant barrier to receiving dental health services, even among adults with health insurance. Approximately 10 percent of women with private health insurance reported that they did not obtain needed dental care in the past year due to costs, while the same was true for 18.8 percent of women with public coverage. Those without insurance fared worse, however, with 43.4 percent of uninsured women reporting that they did not obtain needed care due to costs (data not shown). Even those with public or private insurance may face cost barriers due to limited or no coverage for dental services.¹⁷

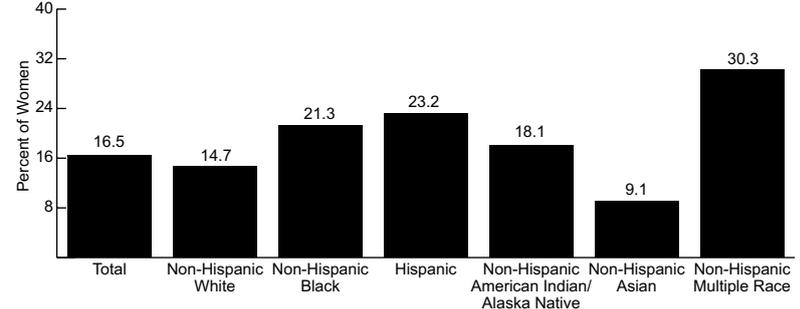
Past Year Dental Visit Among Adults Aged 18 and Older, by Level of Education, 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Unmet Need for Dental Care Due to Cost Among Women Aged 18 and Older,* by Race/Ethnicity,** 2008–2010

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Past year report of needing dental care but not getting it because of cost. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.

HEALTH CARE EXPENDITURES

In 2009, the majority of total health care expenses for both women and men were covered by public or private health insurance. For both men and women, about 40 percent of expenses were paid by private insurance and about 35 percent were paid by Medicare or Medicaid. However, compared to men, health care costs for women were more likely to be paid out of pocket (15.3 versus 14.1 percent) and less likely to be paid by other sources (8.1 versus 11.3 percent).

In 2009, 90.0 percent of women had at least one health care expense, compared to 77.6 percent of men (data not shown). Among adults

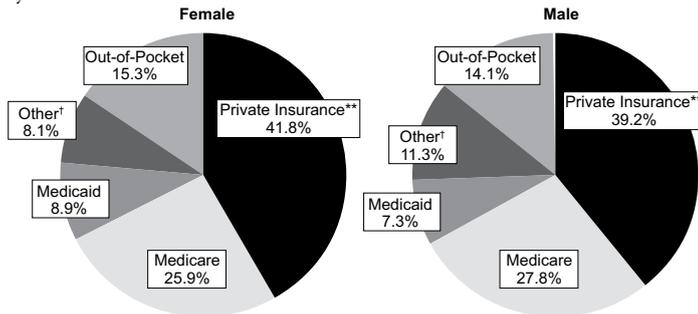
who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was slightly higher for women (\$6,011) than for men (\$5,389). However, men's average expenditures significantly exceeded women's for hospital inpatient services (\$20,268 versus \$14,558, respectively). Women's expenditures significantly exceeded men's only in the category of office-based medical services (\$1,772 versus \$1,447, respectively). The overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 10.3 percent of women had hospital inpatient services,

which includes childbirth delivery, compared to 6.4 percent of men.

Overall per capita health care expenditures have increased substantially in the past decade. In 2009, average health care expenses for women and men were 83.0 and 87.9 percent higher than in 1999 (data not shown). The increasing development and utilization of new technologies may account for a large part of rising health care expenses.¹⁸ The Affordable Care Act of 2010 contains a number of provisions to reduce costs to consumers and more generally, for example by limiting co-payments for covered benefits and testing new payment systems for Medicare to improve quality and efficiency.¹⁸

Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment*, 2009

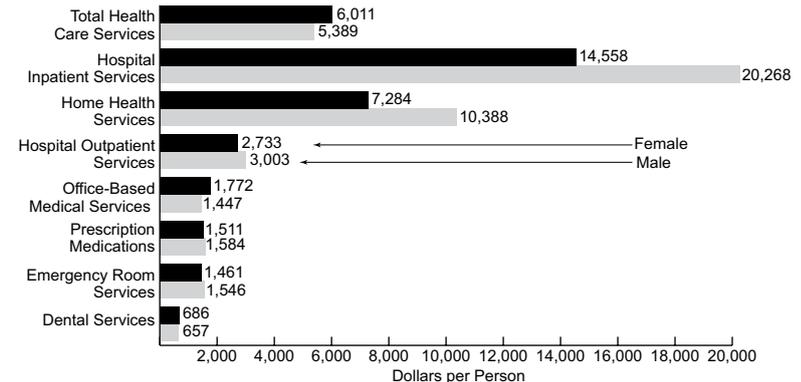
Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*Percentages may not sum to 100 due to rounding. **Includes Tricare (Armed-Forces-related coverage). †Includes other public programs, such as Department of Veterans Affairs, Indian Health Service, and community clinics, worker's compensation, as well as other unclassified sources.

Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2009

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



QUALITY OF WOMEN'S HEALTH CARE

Health care quality indicators can provide important information about the effectiveness, safety, timeliness, patient-centeredness, and efficiency of health services.¹⁹ Some common indicators used to monitor women's health care in managed care plans include screening for chlamydia and cervical cancer, and the receipt of timely prenatal and postpartum care.²⁰

Often referred to as a "silent" disease because most infected individuals do not experience symptoms, chlamydia is the most commonly reported bacterial STD in the United States.²¹ In 2010, women aged 21–24 years enrolled in Medicaid were more likely than those enrolled in

commercial plans to have been screened for chlamydia (62.3 versus 45.7 percent, respectively).

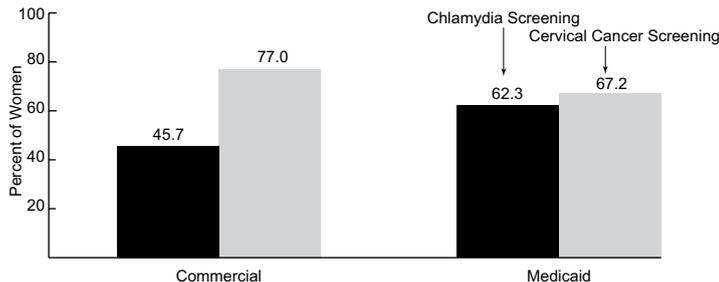
In comparison, cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 21–64 years, cervical cancer screenings were received at least once during the previous 3 years by 77.0 percent of commercially-insured women and 67.2 percent of those covered by Medicaid. Cervical cancer is almost entirely preventable with appropriate screening, evaluation, and treatment.²² [See pages on *Cancer* and *Preventive Care*.]

In 2010, women with commercial insurance coverage were also more likely than those with Medicaid to have received timely prenatal

and postpartum care. More than 90 percent of commercially-insured women received prenatal care in either their first trimester or within 42 days of enrollment, compared to 83.7 percent of those covered by Medicaid. Similarly, 80.7 percent of women with commercial coverage had a postpartum visit between 21 and 56 days after delivery, compared to 64.4 percent of women participating in Medicaid. Although Medicaid-insured women are less likely to have received timely prenatal and postpartum care than commercially-insured women, they have made greater improvements since 2001. For example, the proportion of women receiving timely postpartum care increased 21.5 percent among Medicaid participants compared to 4.8 percent among commercially-insured postpartum women.

HEDIS®* Screening for Chlamydia** and Cervical Cancer,† by Payer, 2010

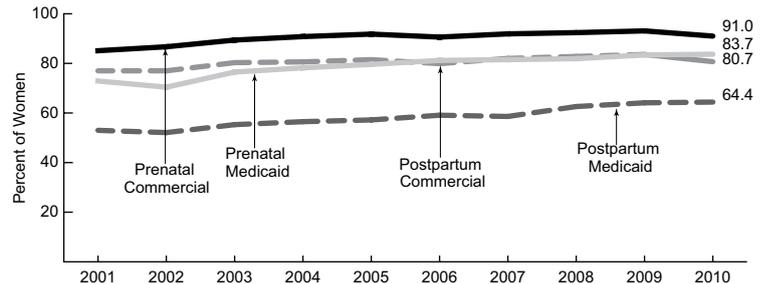
Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active women aged 21–24 years who had at least one test for Chlamydia in the past year. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years.

HEDIS®* Timeliness of Prenatal** and Postpartum Care,† by Payer, 2001–2010

Source III.5: National Committee for Quality Assurance



*Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of pregnant women who received a prenatal care visit in either the first trimester or within 42 days of enrollment. †The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.

INTERNET USE FOR HEALTH INFORMATION

Due in part to the growth in high-speed broadband, wireless networks, and mobile devices, the percentage of adults in the United States who use the Internet has increased substantially, from 47 percent in 2000 to 78 percent in 2011.²³ With regard to health, the Internet can provide valuable information on specific conditions, rankings and reviews of medical professionals, health assessment questionnaires, and other tools to better inform consumers of treatment options and preventative measures.²⁴ However, disparities in Internet access persist by age, race and ethnicity, education, and income.²³

In 2009, 45.5 percent of all adults reported

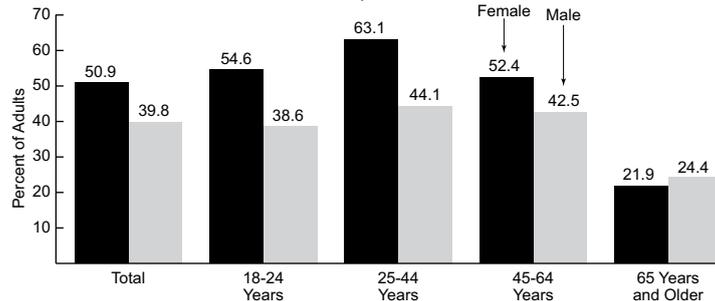
having used the Internet to obtain health information in the past year (data not shown). Overall, women were more likely than men to have utilized this resource (50.9 versus 39.8 percent, respectively). Internet use for health information also varied by age. Among women, those aged 25–44 years were most likely to use the Internet for health information (63.1 percent) while similar percentages of men, about 40 percent, had used the Internet for health information between 18 and 64 years of age. For both women and men, those aged 65 and older were least likely to use the Internet for health information and there was no significant sex difference among this age group (21.9 and 24.4 percent, respectively).

Internet use for health information increased

greatly with income and education. Among women, two-thirds of those with household incomes of 400 percent or more of poverty had used the Internet for health information in the past year, compared to less than one-third of those with incomes below the poverty level (66.3 versus 29.2 percent, respectively). Similarly, women with a college degree were more than 5 times as likely as women who had not finished high school to have used the Internet for health information (74.6 versus 14.5 percent, respectively; data not shown). With respect to race and ethnicity, Internet use for health information was highest among non-Hispanic White women (57.0 percent) and lowest among Hispanic women (31.9 percent; data not shown).

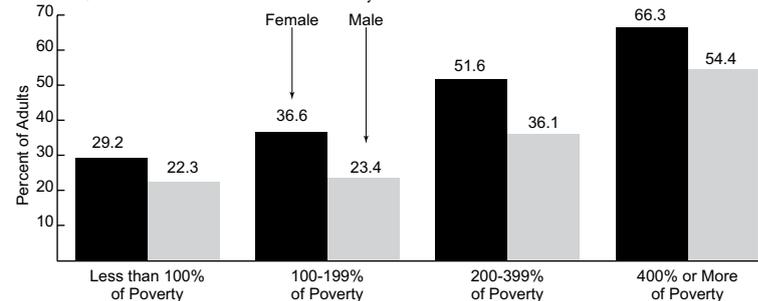
Adults Aged 18 and Older Who Used the Internet for Health Information in Past Year, by Age and Sex, 2009

Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Adults Aged 18 and Older Who Used the Internet for Health Information in Past Year, by Poverty Status* and Sex, 2009

Source II.8: 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 \$23,021 for a family of four in 2009.

HRSA PROGRAMS RELATED TO WOMEN'S HEALTH

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) is the Federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA's goal to "Build Healthy Communities," includes a focus on health promotion and disease prevention through community-led strategies, including community health workers, peer-to-peer engagement, and public-private collaborations.

The Office of Women's Health (OWH) is the agency lead for women's health policy and programming. OWH leads collaborations to strengthen HRSA programs focusing on reducing sex and gender-based disparities and supporting comprehensive, culturally competent, and quality health care. Priorities include violence prevention activities coordination; mobile health utilized as a health education strategy for underserved women; and the HRSA-supported Women's Preventive Health Service Guidelines under the Affordable Care Act (ACA).

The Maternal and Child Health Bureau (MCHB) supports access to comprehensive women's health care to improve their health across the life course through the Title V MCH Block Grant, Home Visitation, and Healthy Start

Programs. MCHB is focused on the integration of strategies to reduce maternal morbidity and mortality, and supporting the provisions under the ACA to promote primary preventive health services for women.

The HIV/AIDS Bureau (HAB) provides resources and services for individuals living with HIV/AIDS through the Ryan White Program; Part D, in particular, addresses the needs of women, infants, children and youth, and their families. HAB funds two Special Projects of National Significance (SPNS) which include Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color and Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color.

The Bureau of Primary Health Care (BPHC) funds the Health Center Program, which provides comprehensive primary health care to low income, uninsured, and other vulnerable populations. In 2011, Community Health Centers served more than 9 million women aged 15 and older, representing 62.1 percent of all patients aged 15 and older. In 2012, BPHC provided supplemental funding to 810 community health centers to improve care quality and ensure more women are screened for cervical cancer.

The Bureau of Clinician Recruitment and Service (BCRS) administers the National Health Service Corps (NHSC) program, which con-

sists of a cadre of nearly 10,000 clinicians who are frontline health care workers. Seventy-four percent of current NHSC members are female. NHSC supports female providers by offering various resources and webinars related to women's health and up to 35 days of maternity leave without incurring any extension of their service.

The Bureau of Health Professions (BHP) provides policy leadership and health professions training grants to produce a workforce that can provide high-quality, culturally appropriate care, particularly in medically underserved areas. Initiatives include boosting the primary care workforce, promoting interprofessional teams, and integrating population health into training programs. BHP supports women's health continuing education programs to address early detection and prevention across the life span, on topics such as prenatal health, breastfeeding, and breast and cervical cancer.

The Office of Rural Health Policy (ORHP) addresses the needs of rural populations. One community-level resource is the Rural Health Care Services Outreach program. In addition, ORHP is funding several Rural Research Centers that have projects focusing on prevention, home visitation utilizing community health workers, and women's health, and a research project "Quality of Women's Care in Rural Health Clinics: A National Analysis."

ENDNOTES

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CONTRIBUTORS

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INDICATORS IN PREVIOUS EDITIONS

Each edition of *Women's Health USA* contains the most current available data on health issues important to women. If no updated data are available, indicators may be replaced to make room for information on new indicators. For more information on the indicators listed here, please reference previous editions of *Women's Health USA* which can be accessed online at either of these Web sites:

<http://www.hrsa.gov/womenshealth/>
<http://www.mchb.hrsa.gov/publications/>

Women's Health USA 2011

American Indian and Alaska Native Women
Hospitalization and Home Health Care
Lesbian and Bisexual Women
Maternity Leave
Native Hawaiian and Other Pacific Islander Women
Oral Health
Organ Transplantation
Secondhand Tobacco Smoke Exposure

Women's Health USA 2010

Digestive Disorders
Gynecological and Reproductive Disorders
Satisfaction with Health Care
Severe Headaches and Migraines
Urologic Disorders
Women and Aging

Women's Health USA 2009

Bleeding Disorders
Complementary and Alternative Medicine
Endocrine and Metabolic Disorders
Healthy People 2010 Update
State Data on Cigarette Smoking,
Leading Causes of Death, and Overweight
and Obesity
Supplement on U.S.–Mexico Border Health

Women's Health USA 2008

Attention Deficit Hyperactivity Disorder
Chronic Fatigue Syndrome
Eye Health
Genetics and Women's Health
Medication Use

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