



Women's Health USA 2004



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PREFACE AND READER'S GUIDE

"Healthy Women Build Healthy Communities" is the principle that guides the work of the Health Resources and Services Administration's Office of Women's Health. As an agency in the United States Department of Health and Human Services, HRSA is charged with assuring access to quality health care through a network of community-based health centers, maternal and child health programs, and State, Territorial, and community HIV/AIDS programs. In addition, HRSA's mission includes supporting individuals pursuing health careers in medicine, nursing, and many other health disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely and topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA's Office of Women's Health is pleased to present *Women's Health USA 2004*, the third edition of the *Women's Health USA* data book. To reflect the ever changing, increasingly diverse population and its characteristics, *Women's Health USA 2004* will selectively include emerging issues and trends in women's health. Data and information on health care quality, women in clinical trials, organ donation, and hormone therapy are a few of the new

topics included in this edition. Where possible, every effort has been made to highlight racial and ethnic disparities as well as sex disparities.

The data book was developed by HRSA to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. *Women's Health USA 2004* 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. departments of Health and Human Services, Agriculture, Education, Labor, Commerce, and Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years.

It is important to note that the incidence and mortality data included is generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races/ethnicities. Without age

adjustment, it is difficult to know how much of the difference in morbidity and mortality rates can be attributed to different age distributions. Also, presentation of racial and ethnic data may appear different on some pages as a result of the design and limitations of the original data source.

Women's Health USA 2004 is available online on the HRSA Office of Women's Health Web site at www.hrsa.gov/womenshealth. In the effort to produce a timely document, some of the topics covered in *Women's Health USA 2003* were not included in this year's edition because new data were not available. For coverage of these issues, please refer to *Women's Health USA 2003*, also available online at:

www.hrsa.gov/womenshealth

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INTRODUCTION

In 2002, women represented 51 percent of the 282 million people residing in the United States. In most age groups, women account for approximately half of the population, with the exception of people 65 years and older; among older Americans, women represent 57 percent of the population. The growing diversity of the United States population is reflected in the differing racial and ethnic distribution of women across age groups. Black and Hispanic women accounted for 9 and 6 percent of the female population aged 65 and older, respectively, but they represented 16 and 17 percent of those under 25 years of age. Non-Hispanic Whites accounted for 83 percent of women aged 65 years and older, but only 61 percent of those under 25 years of age.

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in health status and the use of health care services. In 2002, 63 percent of non-Hispanic White females reported themselves to be in excellent or very good health, compared to 58 percent of Hispanic women and 56 percent of non-Hispanic Black women. In contrast, 15 percent of non-Hispanic Black women and 14 percent of Hispanic women rated their health as fair or poor, compared to 11 percent of non-Hispanic White women.

A number of diseases and conditions disproportionately affect minority women. One of these diseases is Acquired Immunodeficiency Syndrome, or AIDS. In 2002, non-Hispanic Black and Hispanic women represented less than one-quarter of the female population, but they accounted for more than three-quarters of all women living with AIDS in this country. In 1999, AIDS was the fifth leading cause of death among women aged 25 to 44 years, but the third leading cause of death among African American women of the same age. Nearly one-third of non-Hispanic White women have ever been tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS, compared to 55 percent of non-Hispanic Black women and 43 percent of Hispanic women.

Diabetes is a condition that affects women of all races and ethnicities, but is especially prevalent among non-Hispanic Black women. Among women in this population it occurs at a rate of 99 per 1,000 women, compared to 56 per 1,000 non-Hispanic White women. Hispanic women are affected at a rate of 67 per 1,000 women, and the lowest rate (42.7 per 1,000 women) occurs among non-Hispanic women of other races (includes Asian/Pacific Islanders, American Indian/Alaska Natives, and individuals of more than one race). Non-Hispanic Black women are also disproportionately affected by

hypertension, or high blood pressure, which occurs among this population at a rate of 328 per 1,000 women. This rate is much higher than the rate among non-Hispanic White women (249 per 1,000 women) and Hispanic women (183.8 per 1,000 women). Again, the lowest rate (174.8 per 1,000 women) occurs among non-Hispanic women of other races.

Overweight and obesity are occurring at an ever-increasing rate among Americans of all ages and both sexes. Body Mass Index (BMI) is a measure of the ratio of height to weight, and is often used to determine whether a person's weight is within a healthy range. A BMI of 25 or greater is considered overweight, and a BMI of 30 or greater is considered obese. In 2002, 65 percent of non-Hispanic Black women over the age of 18 were overweight, as were 52 percent of Hispanic women, and 44 percent of non-Hispanic White women. Overweight was least prevalent among non-Hispanic women of other races, at 29 percent. Obesity followed the same trend, and was most prevalent among non-Hispanic Black women, occurring in 38 percent of that population. Among Hispanic and non-Hispanic White women, 22 and 19 percent, respectively, were obese. Only 9 percent of non-Hispanic women of other races were considered obese.

Some conditions, such as arthritis and

osteoporosis, disproportionately affect White women. In 2002, the rate of arthritis among non-Hispanic White women over 18 years of age was 264 per 1,000 women, compared to 151 per 1,000 Hispanic women and 241 per 1,000 non-Hispanic Black women. Osteoporosis is a disease which is characterized by low bone mass and can lead to bone fractures. Eighty percent of those affected by osteoporosis are women. In addition to being female, small body frame and Caucasian or Asian race are risk factors for osteoporosis. National data from 1999-2000 indicate that non-Hispanic White women are four times as likely as non-Hispanic Black women to be diagnosed with osteoporosis.

Non-Hispanic White women are also more prone to mental illness than women of most other racial/ethnic groups. The 2001 suicide rate among non-Hispanic White women was 6.1 per 1,000 women compared to 2.3 among non-Hispanic Black women and 2.1 among Hispanic women. American Indian/Alaska Native women have a suicide rate (6.2 per 1,000 women) that exceeds that of non-Hispanic White women.

Many behaviors — such as substance abuse, tobacco use, physical activity, and use of health care — can influence health. Racial and ethnic differences are evident in these behaviors. The rate of binge alcohol use (having five or more drinks on one occasion) is higher among

non-Hispanic White women than women of most other racial groups. In 2001-2002, 26 percent of non-Hispanic White women aged 15 to 44 reported binge drinking, while only 20 percent of non-Hispanic Black women and 19 percent of Hispanic women did so. American Indian/Alaska Native women had the highest rate of binge drinking, at 35 percent. Non-Hispanic White women also have a higher rate of cigarette use (36 percent) than non-Hispanic Black women (25 percent) and Hispanic women (19 percent). American Indian/Alaska Native women have the highest rate of cigarette use (47 percent).

Physical activity is an important lifestyle factor that directly affects health, yet only 21 percent of non-Hispanic Black women and 21 percent of Hispanic women were found to engage in regular leisure-time physical activity. A greater proportion of non-Hispanic White women (31 percent) reported that they are physically active on a regular basis.

Health insurance can be an important factor in women's ability to stay healthy by improving access to regular medical care and use of preventive services. In 2002, 43.5 million Americans were without health insurance. Among women, Hispanics are most likely to be uninsured, at 29.5 percent. Asian/Pacific Islander and Black women also have a high rate

of uninsurance (18 percent), followed by White women (12.9). In 2002, non-Hispanic White women were most likely to use an office-based source of care (90 percent), while Hispanic women were least likely to do so (74 percent). Among non-Hispanic Black women, 3 percent used an emergency department as their usual source of care, compared to less than one percent of non-Hispanic White women. Among Hispanic women, 21 percent did not have a usual source of care, compared to only 7 percent of non-Hispanic White women.

Regular use of dental care is essential to maintaining good oral health. In 2002, 68 percent of non-Hispanic White women had seen a dentist in the past year, while the same was true for only 53 percent of non-Hispanic Black women. Hispanic women were most likely to go 5 or more years without visiting a dentist, while non-Hispanic White women were least likely to do so.

Health behaviors also varied by race and ethnicity among women during and around the time of pregnancy. Non-Hispanic White women are more likely to smoke cigarettes during pregnancy than women of other racial and ethnic groups, a primary risk factor for low birth weight and other health problems among newborns. In 2002, 24 percent of pregnant non-Hispanic White women reported having

smoked cigarettes in the prior month, compared to only 7.3 percent of pregnant non-Hispanic Black women and 6.0 percent of pregnant Hispanic women. Other factors that can influence maternal and infant health are the use of prenatal care and breastfeeding. Non-Hispanic White women are most likely to enter prenatal care in the first trimester (88.6 percent), followed by Asian/Pacific Islanders (84.8), Hispanic women (76.7), non-Hispanic Black women (75.2), and American Indian/Alaska Native women (69.8). Breastfeeding immediately after delivery is most common among Asian mothers (80 percent did so), followed by White mothers (73 percent), Hispanic mothers (71 percent) and Black mothers (53 percent).

Women's Health USA 2004 can be an important tool for illustrating important disparities in the health status of women from all ages, races, and ethnic backgrounds. Health problems can only be remedied if they are recognized, and this data book provides information on a range of indicators that can help us to track the health behaviors, risk factors, and health care utilization practices of women throughout the United States. Healthy women build healthy communities.



POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of women in the U.S. Representing slightly more than half of the Nation's population, women and girls number approximately 144 million.

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

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



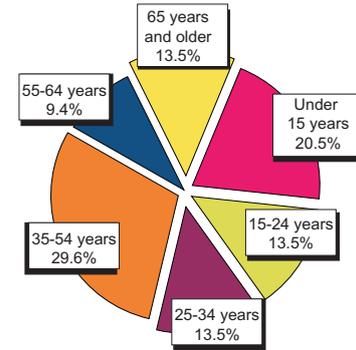
U.S. POPULATION

The U.S. population surpassed 282 million in 2002, with females representing 51.1 percent of the total population. Females younger than age 35 accounted for 47.5 percent of the female population, those aged 35-64 years represented 39.0 percent, and females aged 65 years and older accounted for 13.5 percent.

The distribution by sex was fairly even across all age groups except among older persons, where women accounted for a significantly greater percentage of the population. Of those aged 65 years and older, women represent 57.8 percent of the total population.

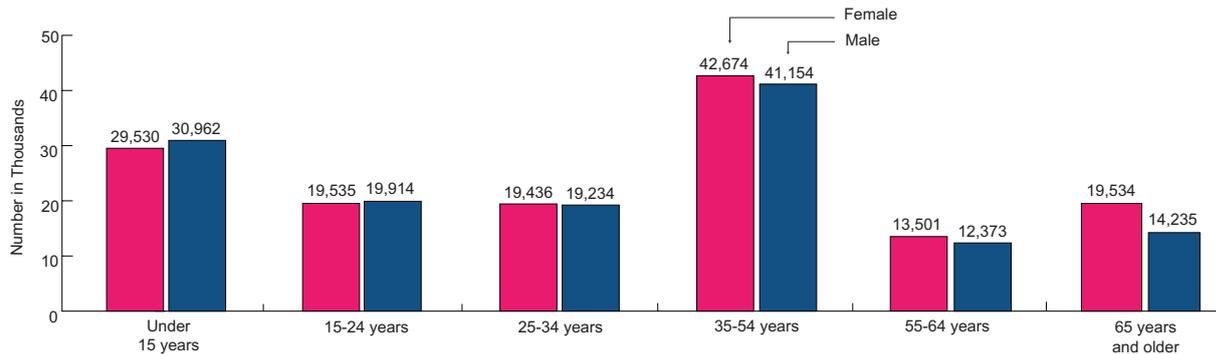
U.S. Female Population, by Age, 2002

Source (I.1): U.S. Census Bureau, Current Population Survey



U.S. Population, by Age and Sex, 2002

Source (I.1): U.S. Census Bureau, Current Population Survey

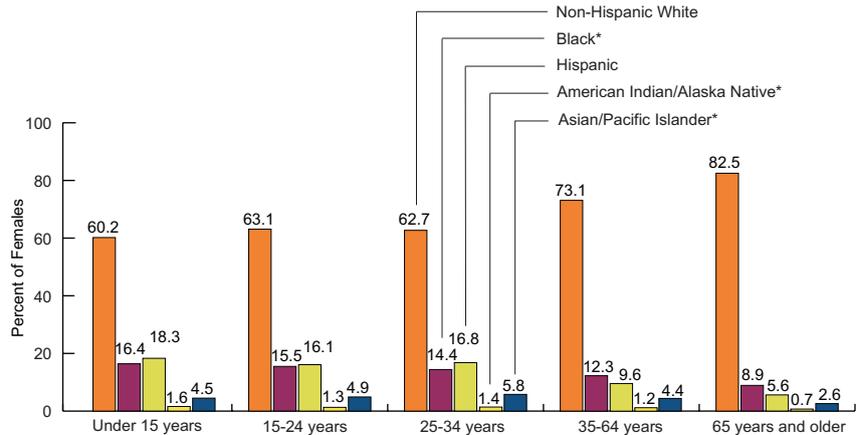


U.S. FEMALE POPULATION BY RACE/ETHNICITY

The growing diversity of the U.S. female population is reflected in the racial and ethnic distribution of women across age groups. The younger female population, under 25 years of age, is significantly more diverse than the older female population. The non-White population represents 39.6 percent of females under 25 years of age, compared with 17.8 percent of females 65 and older. Of females under 25 years of age, 61.3 percent are non-Hispanic White, whereas among females 65 years and older, 82.5 percent are non-Hispanic White.

U.S. Female Population, by Age and Race/Ethnicity, 2002

Source (I.1): U.S. Census Bureau, Current Population Survey



*Does not include Hispanics



EDUCATIONAL DEGREES AWARDED TO WOMEN

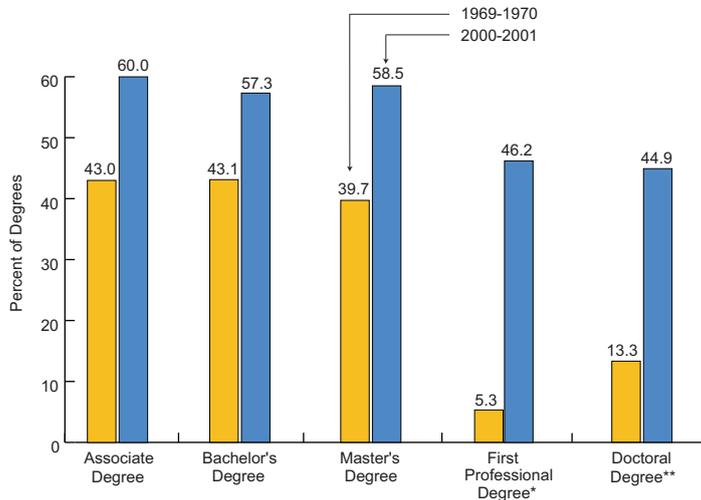
The number of post-secondary educational degrees awarded to women has risen from 518,294 in 1969-1970 to almost 1.4 million in 2000-2001. Although the number of degrees earned by men has also increased, the growth among women has been much faster. Therefore,

the proportion of degrees earned by women has also risen dramatically. In 1969-1970, men earned the majority of every type of degree, while in 2000-2001, women earned more than 50 percent of all associate, bachelor's, and master's degrees, and earned almost half of all first professional and doctoral degrees. The most significant increase has been in the proportion

of women earning a first professional degree, which has increased from 5.3 percent in 1969-1970 to 46.2 percent in 2000-2001. The total number of women earning their first professional degree in 2000-2001 (36,845) was 20 times greater than in 1969-1970 (1,841).

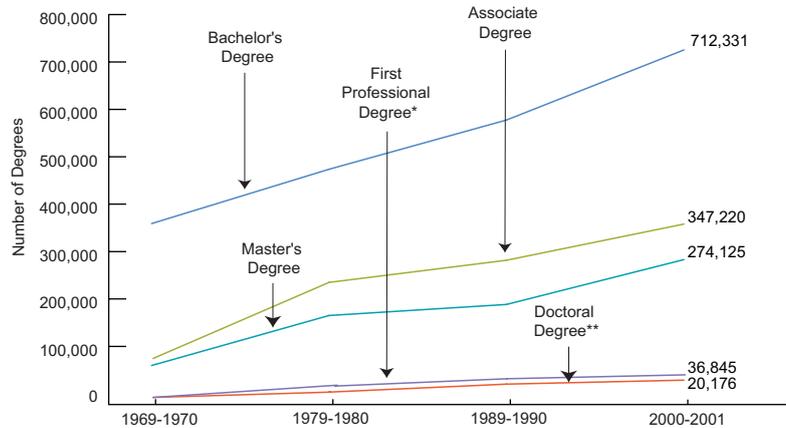
Degrees Awarded to Women, by Type, 1969-1970 and 2000-2001

Source (I.2): U.S. Department of Education, Completions Survey



Degrees Awarded to Women, by Type, 1969-2001

Source (I.2): U.S. Department of Education, Completions Survey



*Includes fields of dentistry (D.D.S. or D.M.D.), medicine (M.D.), optometry (O.D.), osteopathic medicine (D.O.), pharmacy (D.Pharm.), podiatry (D.P.M.), veterinary medicine (D.V.M.), chiropractic (D.C. or D.C.M.), law (LL.B. or J.D.), and theological professions (M.Div. or M.H.L.).

**Includes Doctor of Philosophy degree (Ph.D.) as well as degrees awarded for fulfilling specialized requirements in professional fields such as education (Ed.D.), musical arts (D.M.A.), business administration (D.B.A.), and engineering (D.Eng. or D.E.S.). First-professional degrees, such as M.D., and D.D.S., are not included under this heading.

WOMEN IN HEALTH PROFESSIONS SCHOOLS

The health professions have long been characterized by sex disparities. Some professions, such as medicine and dentistry, have historically been dominated by men, while others, such as nursing, have been predominantly female. Over the past several decades, these gaps have begun to narrow, and in some cases women have begun to outnumber their male counterparts. In 1980-1981, 47.4 percent of pharmacy students were women, while in 2001-2002 women represented the majority of students at 64.5 percent. Even in fields where men are still the majority, the representation of female students has grown. In 1980-1981, only 26.5 percent of medical students were women compared to 45.7 percent in 2001-2002, and in the same year women represented 43.1 percent of the student body at schools of osteopathic medicine. Similar gains have also been made in the field of dentistry, where 40.2 percent of students were women in 2001-2002 compared to only 17 percent 20 years earlier.

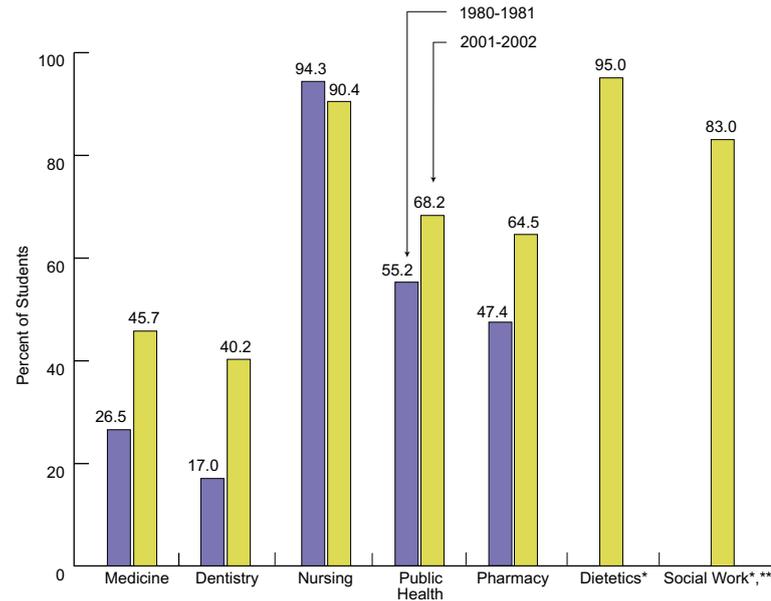
Female students represent the majority of students in a number of health professions schools, including social work (83 percent), public health (68.2 percent), podiatry (61.7 percent, not shown), and optometry (57.4 percent, not shown). Women also represent the vast

majority of enrollees in dietetics programs — in the 2002-2003 academic year, 95 percent of dietetics students were women. Nursing continues to be a field dominated by women, although the proportion of students who are

female is slowly declining. In the 1980-1981 academic year, 94.3 percent of nursing students were female, while in 2001-2002, females constituted 90.4 percent of all master's-level nursing students.

Women in Schools for Selected Health Professions, 1980-1981 and 2001-2002

Source (I.3): Professional Associations



*Data from 1980-1981 are unavailable

**Data are from 2000-2001

WOMEN IN THE LABOR FORCE

In 2002, females ages 16 and older made up 46.6 percent of the workforce. Among working females, 72.4 percent worked full-time, compared to 87.3 percent of males. Females who were full-time wage and salary workers earned a weekly median of \$530 while men earned a median of \$680 per week, a ratio of 76 cents to one dollar. This ratio has risen from 63 cents in 1979, the first year comparable earnings data became available.

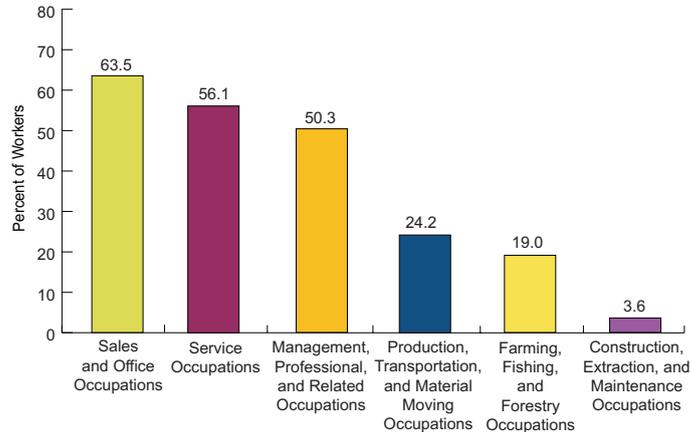
The ratio of females' earnings to those of males differed considerably by age, race, and ethnicity in 2002. Women aged 45 to 54 earned only 74.6 cents for every dollar earned by their male counterparts, while females aged 16 to 24 earned 93.6 cents for every dollar earned by males of the same age. Among Blacks and Hispanics, females earned 91 and 88 cents to every dollar earned by Black and Hispanic males, respectively, while White females earned 78 cents for every dollar earned by their male counterparts. White workers of both sexes

earned more than their Black and Hispanic counterparts; however, the differences among females were smaller than those among males. The earnings of White females were greater than those of both Black and Hispanic females by 15.8 and 38.6 percent, respectively, while White males' earnings were 34.2 and 56.3 percent higher than those of Black and Hispanic males.

The earnings gap between the sexes continues to close, and females have fared better than males in recent years with respect to earnings growth. Both males and females with less than

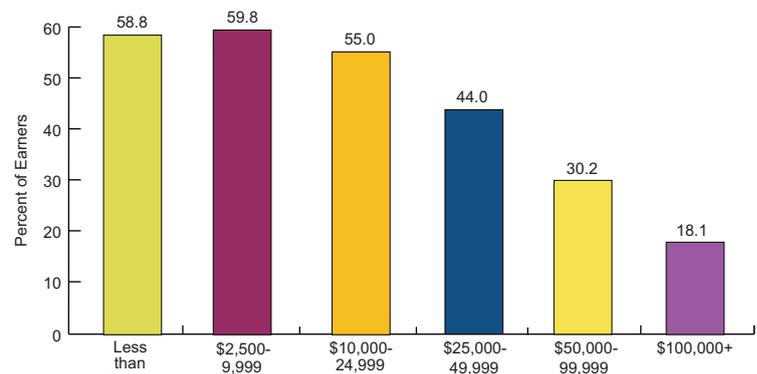
Representation of Females Aged 16 and Older in Occupational Sectors, 2002

Source (I.4): U.S. Census Bureau, American Community Survey



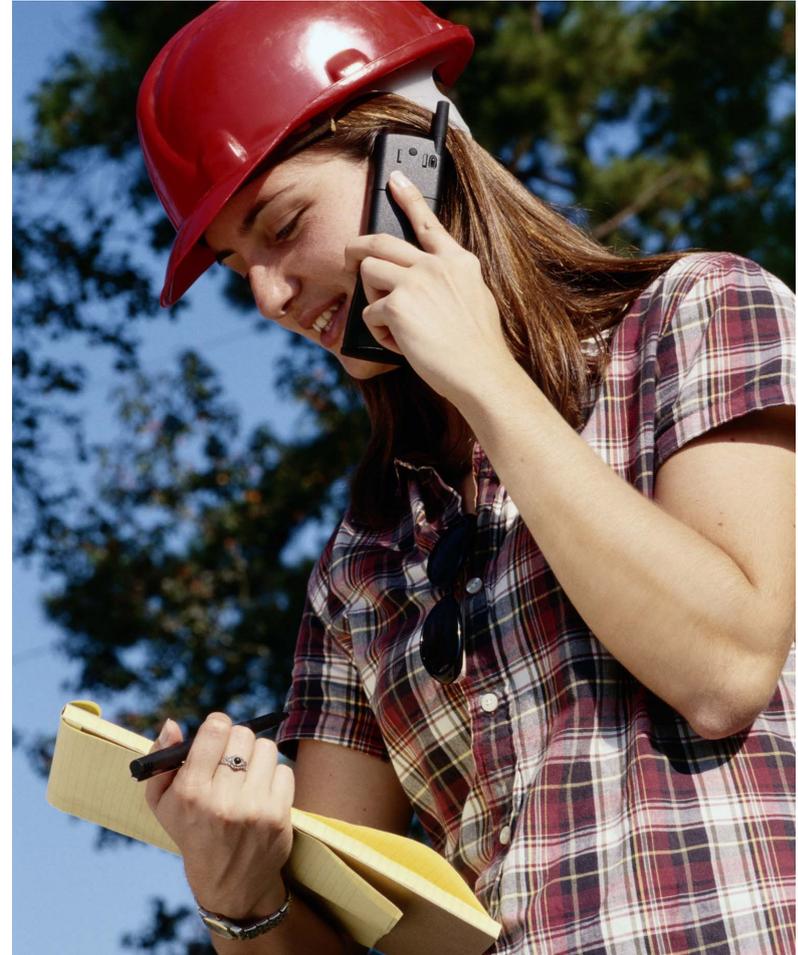
Representation of Females Aged 16 and Older in Earning Levels, 2002

Source (I.4): U.S. Census Bureau, American Community Survey



a high school diploma have experienced a decline in inflation-adjusted earnings since 1979; however, females' earnings have fallen by only 7.2 percent compared to 27.2 percent for males. Among those with college degrees, earnings for women and men have risen 33.7 and 19.9 percent respectively since 1979.

Employment and earnings have significant implications for women's health, as they are associated with access to health insurance and raise issues such as occupational safety and family-friendly work schedules.



WOMEN AND FEDERAL PROGRAM PARTICIPATION

Federal programs can provide low-income women and their families with essential help in obtaining food and income support. The Federal Food Stamp Program helps low-income individuals to purchase food; in 2002, 69 percent of all adult Food Stamp participants were women. Nearly half (46 percent) of women

participants were in the 18-35 age group.

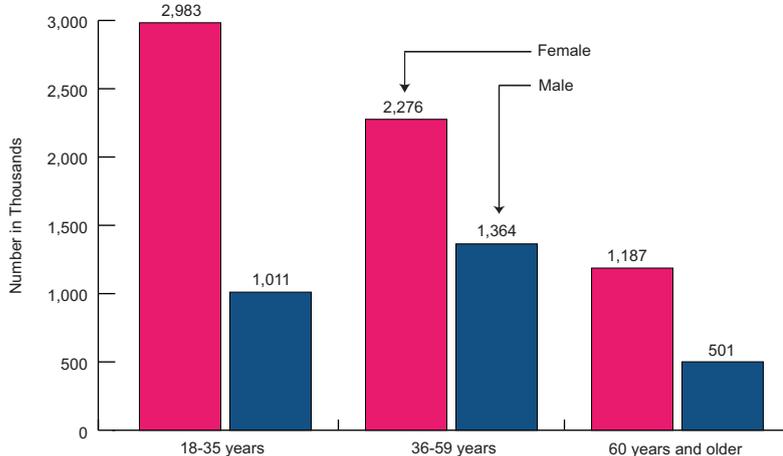
The Supplemental Food Program for Women, Infants and Children (WIC) also plays an important role in serving women and families by providing supplementary nutrition during pregnancy, during the postpartum period, and while breastfeeding. Most WIC recipients (76 percent) are infants and children; however, the program also serves 1.8 million women,

representing 24 percent of WIC participants. From 1992 to 2002, the number of adult women participating in WIC increased by 48 percent.

Temporary Assistance to Needy Families (TANF) is the Federal- and State-funded program that provides cash assistance and work opportunities to needy families. In 1996, TANF replaced the national welfare program known as Aid to Families with Dependent Children (AFDC)

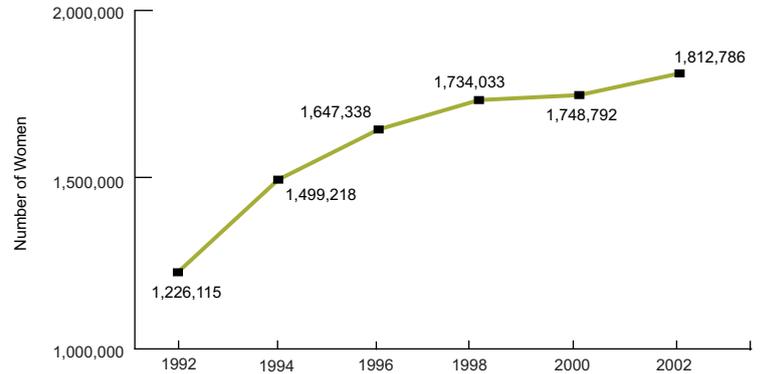
Adult Recipients of Food Stamps, by Age, 2002

Source (I.5): U.S. Department of Agriculture, Food Stamp Quality Control Sample



Women WIC Participants, Selected Years 1992-2002

Source (I.6): U.S. Department of Agriculture, WIC Program Participation Data



WOMEN AND FEDERAL PROGRAM PARTICIPATION (Cont'd)

and related initiatives. The overarching goals of TANF are to move recipients into work and turn welfare into a program of temporary assistance with a lifetime maximum enrollment of 5 years.

In Fiscal Year 2001, adult TANF recipients numbered 1.4 million, of whom 1.27 million

(90 percent) were women. Three-quarters of female TANF recipients were between 20 and 39 years of age. Among adult female TANF recipients, nearly 25 percent were employed, 47 percent were unemployed and looking for work, and 28 percent were not in the labor force (unemployed but not looking for work).

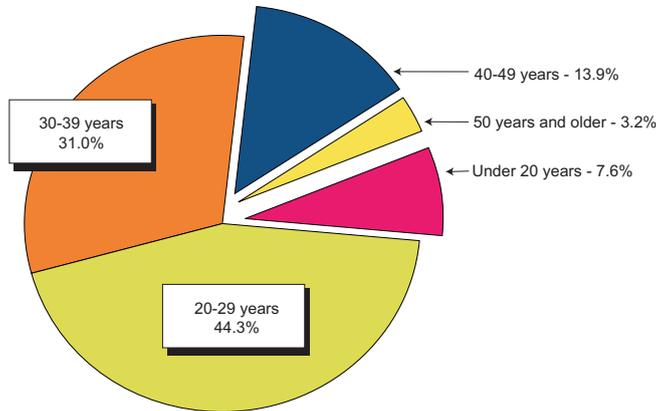
In 2001, the average amount of monthly assistance provided through TANF was \$351

per family. Of TANF families who had earned income, the monthly earnings averaged \$686.

Supplemental Security Income (SSI) is another public assistance program that provides support to low-income people and people with disabilities. In 2002, 61.4 percent of adults receiving SSI payments were women. The majority of adult women receiving SSI payments were under age 65.

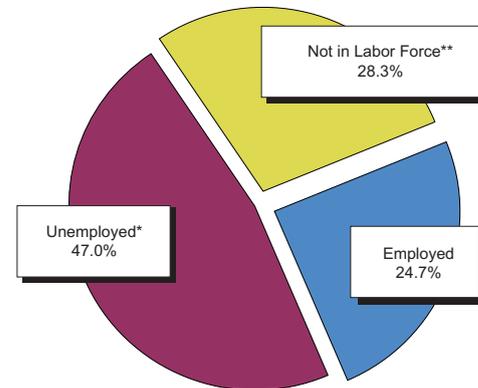
Female Recipients of TANF, by Age, Fiscal Year 2001

Source (I.7): Administration for Children and Families, National TANF Data File



Adult Female Recipients of TANF, by Employment Status, Fiscal Year 2001

Source (I.8): Administration for Children and Families, National TANF Data File



* Looking for work

** Unemployed, not looking for work (includes those who have stopped looking)

WOMEN AND POVERTY

In 2002, there were 34.6 million people living with incomes below the Federal poverty threshold.¹ The poverty rate for all women 18 years and older in 2002 was 12.3 percent (13.5 million women). Poverty rates vary by age group among women, with the youngest women aged 18-24 years reporting a poverty rate of 19.5 percent. The lowest poverty rate,

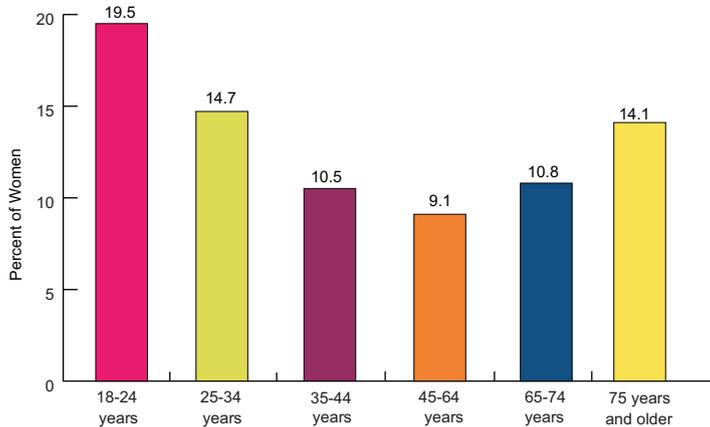
9.1 percent, was found among women aged 45-64. The poverty rate increases for women aged 65-74 to 10.8 percent and 14.1 percent for women aged 75 years and older.

Women in female-headed households with no spouse experienced higher rates of poverty (23.6 percent), whereas women in married couple families experienced lower rates of poverty (5.1 percent).

¹ The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor. Examples of 2002 poverty levels were \$9,183 for an individual, \$11,756 for a family of two, \$14,348 for a family of three, and \$18,392 for a family of four.

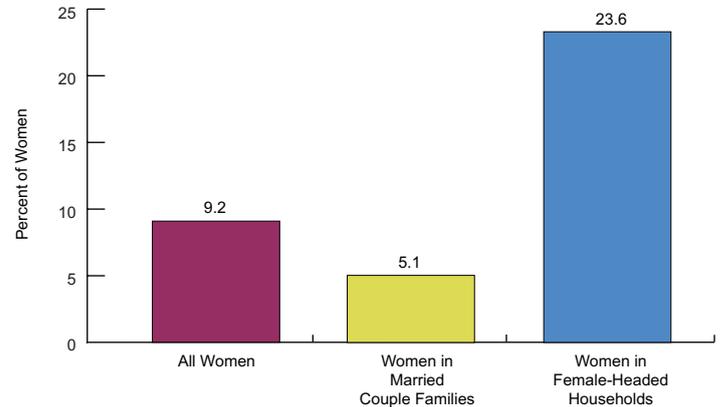
Women Living Below the Poverty Level, by Age, 2002

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



Women, in Families,* Living Below the Poverty Level, for Selected Household Types, 2002

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



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



HEALTH STATUS

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

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

PHYSICAL ACTIVITY

Regular, moderate to vigorous physical activity can help to improve health and well-being. Lack of physical activity has been associated with many serious risk factors and health conditions, such as obesity, hypertension, heart disease, osteoporosis, diabetes, and cancer.

In 2002, women of all ages were less likely to report engaging in regular physical activity

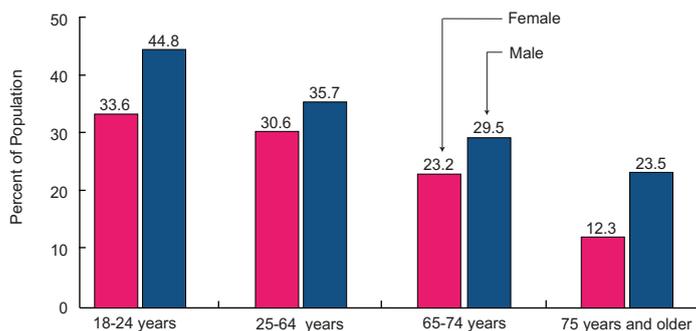
than men. The largest differences were observed among the youngest and oldest segments of the population. At 18 to 24 years, 44.8 percent of men reported regular physical activity compared to 33.6 percent of women; among those aged 75 and older, 23.5 percent of men compared to 12.3 percent of women reported regular activity. With increased age, rates of self-reported physical activity continually decreased among

both men and women.

Rates of regular physical activity among women varied by race and ethnicity as well. Compared to all other racial and ethnic groups, non-Hispanic White women were the most likely to report regular physical activity (31.3 percent), more than 1.5 times that of Hispanic and non-Hispanic Black women.

Adults Aged 18 and Older Who Engaged in Regular Leisure-Time Physical Activity,* by Age and Sex, 2002

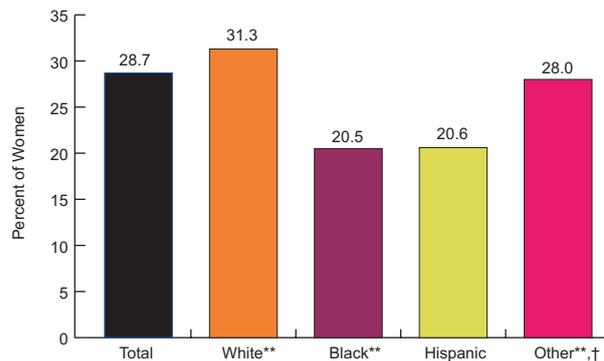
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Regular leisure-time physical activity was defined as engaging in light-moderate leisure-time physical activity for greater than or equal to 30 minutes 5 or more times per week or engaging in vigorous leisure-time physical activity for greater than or equal to 20 minutes 3 or more times per week.

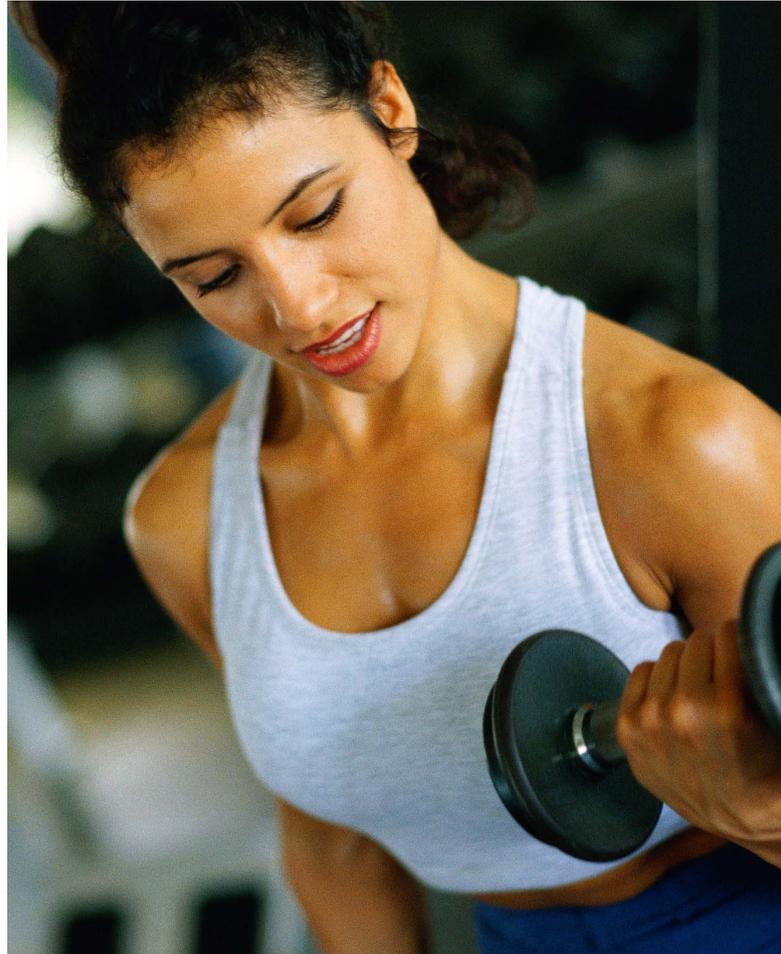
Women Aged 18 and Older Who Engaged in Regular Leisure-Time Physical Activity,* by Age and Race/Ethnicity, 2002

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



**Non-Hispanic

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



CIGARETTE SMOKING

Cigarette smoking is associated with numerous chronic illnesses and premature death. The percentage of females who smoke has remained steady over the last several years at slightly more than 20 percent of females aged 12 and older.¹ In 2002, 23.4 percent of females aged 12 and older reported smoking cigarettes within the past month. Among adolescents aged 12-17, slightly more females than males reported smoking in the past month (13.6 percent versus 12.3 percent). However, women

aged 18 years and older were less likely than men of the same age to have smoked in the previous month.

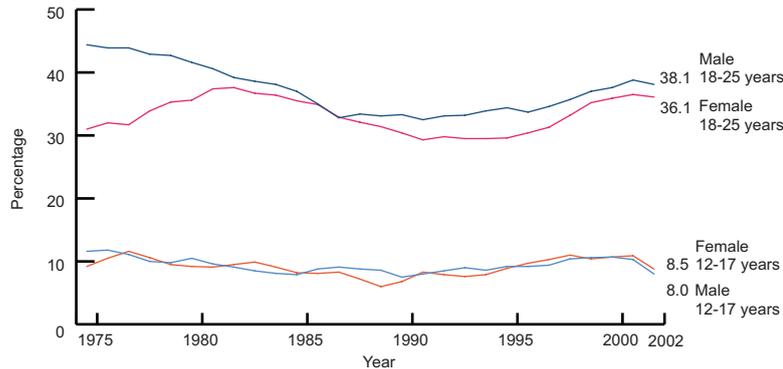
In 2002, 17.3 percent of pregnant women aged 15 to 44 smoked cigarettes in the past month compared with 31.1 percent of non-pregnant women of the same age group. Among females who were not pregnant, American Indian/Alaska Native women were most likely to smoke cigarettes, followed by non-Hispanic White women. Although the prevalence of smoking was lower among pregnant women in

all racial and ethnic groups, non-Hispanic White women were four times as likely to smoke during pregnancy than Hispanic women. Maternal smoking during pregnancy is associated with ectopic pregnancies, miscarriages, newborn low birth weight, and infant mortality.

1 SAMHSA. (2003). *Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774)*. Rockville, MD.

Daily Cigarette Use in Lifetime by Age and Sex: 1975-2002*

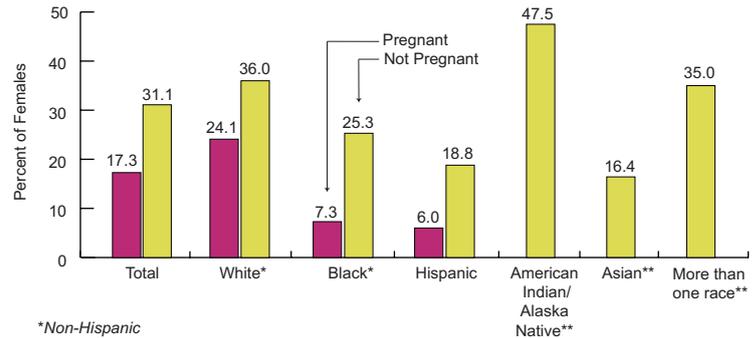
Source (II.2): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Note: Data for years before 2002 are calculated based on respondents' current age and the age at which they first smoked cigarettes.

Females Aged 15-44 Years Reporting Past Month Use of Cigarettes, by Race/Ethnicity and Pregnancy Status, 2002

Source (II.2): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Non-Hispanic

**Low precision, no estimate for pregnant women reported

ALCOHOL MISUSE

In 2002, 22.9 percent of the U.S. population aged 12 years and older reported binge alcohol use, which is defined as having five or more drinks on the same occasion at least once in the month prior to the survey. The rate of binge alcohol use among males was twice that of females (31.2 percent vs. 15.1 percent). Additionally, 3.0 percent of females and 10.8 percent of males 12 years and older reported heavy alcohol use in the past month, defined as having five or more drinks on the same occasion on five or more days within the month prior to the survey. After age 25, binge and

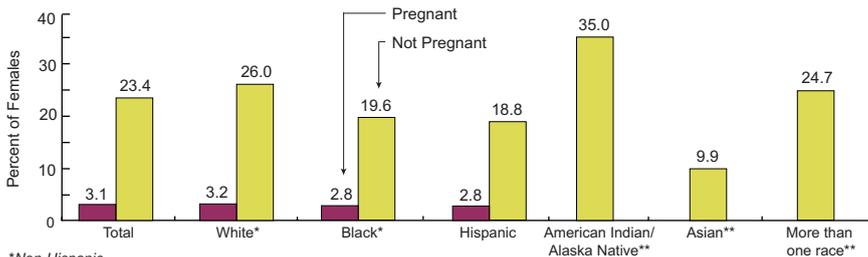
heavy alcohol consumption declined significantly for both males and females.

Alcohol misuse among women is highest for young adult women aged 18-25 years compared to their younger and older counterparts. Among women aged 18-25 years, 31.7 percent reported binge drinking and 8.7 reported heavy drinking in the past month.

Among women aged 15-44 years, alcohol misuse was significantly lower during pregnancy. Overall, 23.4 percent of non-pregnant women and 3.1 percent of pregnant women reported binge drinking in the past month. Among non-pregnant women, American Indian/Alaska

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

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



*Non-Hispanic

**Low precision; no estimate reported.

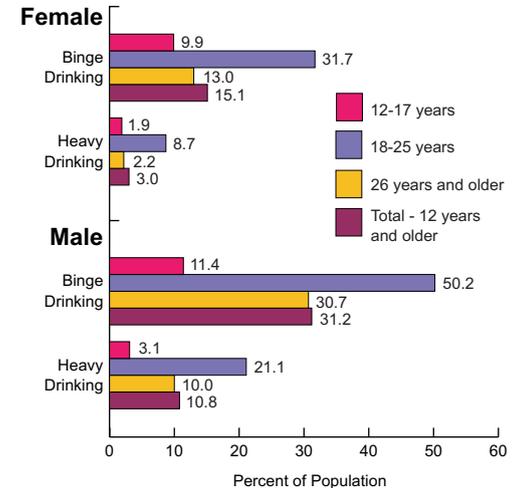
***"Binge" Alcohol Use was defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days.

****"Occasion" means at the same time or within a few hours of each other. "Heavy" Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all "Heavy" Alcohol Users are also "Binge" Alcohol Users.

Native women were most likely to binge drink (35.0 percent) compared to other racial and ethnic groups; Asian women were the least likely to engage in binge drinking (9.9 percent). Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), infant low birth weight, and developmental delays in children.

Persons Reporting Past Month Binge Alcohol Use and Heavy Alcohol Use,** by Age and Sex, 2002

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

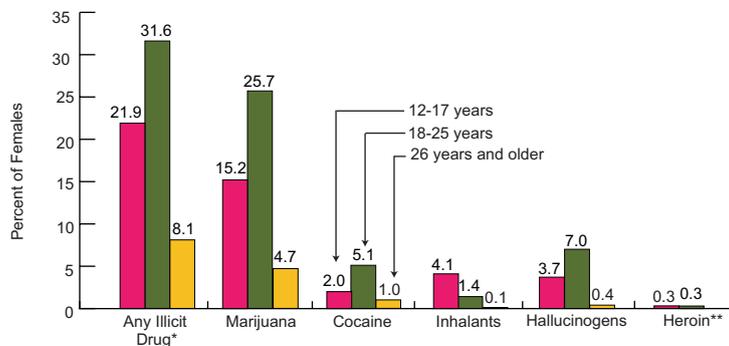


ILLICIT DRUG USE

Because of their association with serious health consequences and addiction, marijuana/hashish, cocaine, inhalants, hallucinogens, heroin, and prescription-type psychotherapeutic drugs used for non-medical purposes are classified as illicit drugs in the U.S. In 2002, 21.9 percent of females aged 12-17 years and 31.6 percent of women aged 18-25 years had used some type of illicit drug within the past year. Marijuana/hashish was the illicit drug most commonly used by all females: over 15.2 percent of females aged 12-17 years, 25.7 percent of women aged 18-25 years, and 4.7 percent of women aged 26 years and older reported using marijuana in the past year. Inhalants were most likely to be used by females aged 12-17 years, whereas the use of cocaine and hallucinogens was highest among the 18- to 25-year-old age group. The use of all illicit substances decreases significantly among women aged 26 and older.

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2002

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



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

**Data for use of heroin not available for females aged 26 years and older.

SELF-REPORTED HEALTH STATUS

In 2002, women and men aged 18 to 64 years old were more likely to report being in excellent or very good health than were adults aged 65 years and older. Among women, 64.6 percent of 18- to 64-year-olds reported excellent or very good health, compared to only 48.2 percent of

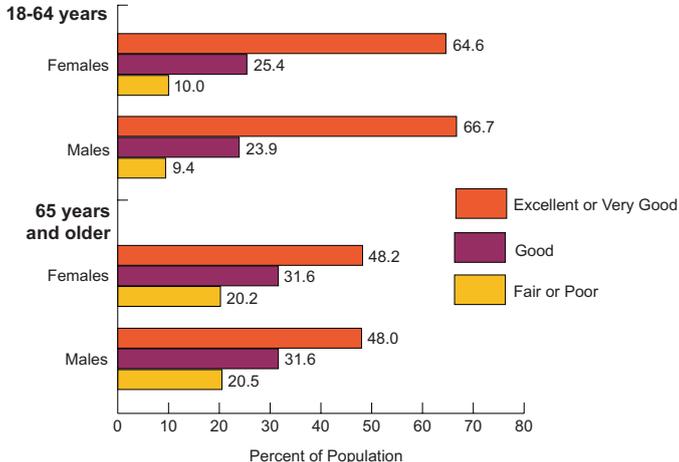
women aged 65 years and older. Women aged 18 to 64 years were as likely to report fair or poor health (10.0 percent) as men of the same age (9.4 percent).

Non-Hispanic Black and Hispanic women were most likely to report their health status as fair or poor (14.9 and 13.6 percent, respectively). In contrast, non-Hispanic women of other races

(including Asian/Pacific Islanders, American Indian/Alaska Natives, and persons of more than one race) were most likely to report their health status as excellent or very good (65.3 percent) followed by non-Hispanic White women (62.9 percent).

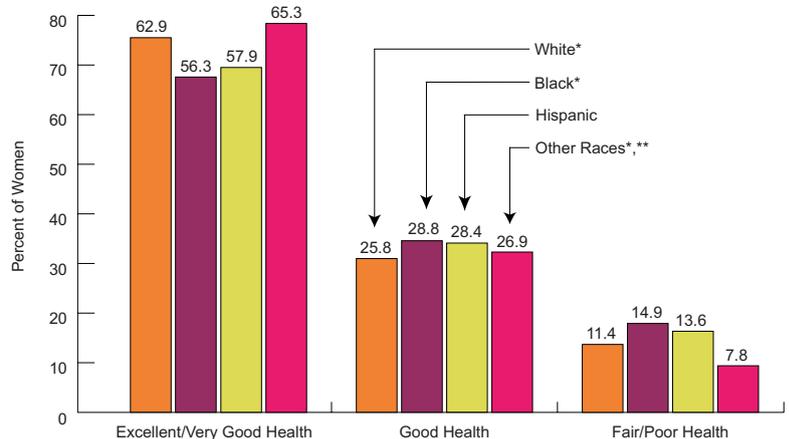
Self-Reported Health Status of Adults Aged 18 and Older, by Age and Sex, 2002

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



Self-Reported Health Status of Women Aged 18 and Older, by Race/Ethnicity, 2002

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



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

ACTIVITY LIMITATIONS

With age, women are more likely to report being limited in their activities due to a physical or mental/emotional problem. In 2002, the percentage of women aged 75 and older reporting activity limitations (33.2 percent) was more

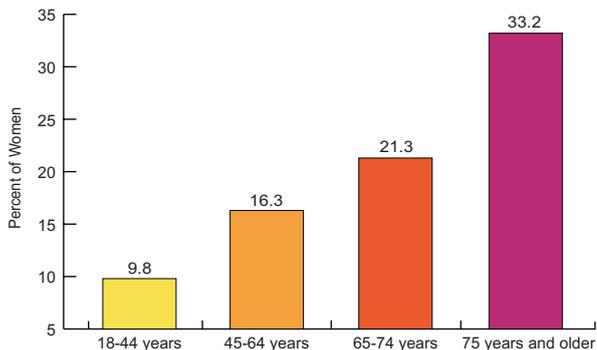
than three times that of younger women aged 18-44 years (9.8 percent).

The four most frequently reported causes of activity limitations among women were arthritis or rheumatism (24.8 percent), back/neck problems (21.0 percent), heart problems

(15.1 percent), and hypertension (12.1 percent). Poor mental health was also implicated as a cause of activity limitation, with 11.6 percent of women reporting that their activities were limited by depression, anxiety, or an emotional problem.

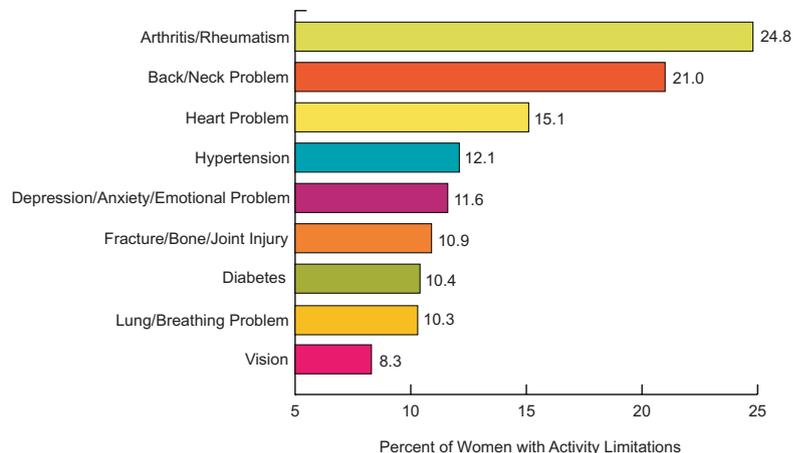
Self-Reported Activity Limitations of Women Aged 18 and Older, by Age, 2002

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



Conditions Causing Activity Limitations in Women Aged 18 and Older, 2002

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





AIDS

Acquired Immunodeficiency Syndrome (AIDS) was primarily diagnosed in men in the early 1980s, but the disease has since become more prevalent among women. In 1988, 7,504 AIDS cases were reported among men compared to 524 among women. By 2002 the number of cases reported among women had grown to 11,279, an increase of 2,052 percent. Over the same period, the number of cases among men increased by 423 percent, to 32,513. The case definition for AIDS evolved between 1985 and 1993.^{1,2,3} In 1993, the definition of AIDS cases was expanded to include persons with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. Such changes are partially responsible for the increased number of reported AIDS cases.

Although the number of AIDS cases has increased among women in general, the epidemic has disproportionately affected some racial and ethnic groups. In 2002, non-Hispanic Black and Hispanic women represented less than one-fourth of all U.S. women, yet they accounted for more than three-fourths of women living with AIDS. In 1999, HIV/AIDS was the fifth leading cause of death among women aged 25-44 years in the U.S., but it was the third leading cause of death among non-Hispanic Black women of the same age.⁴

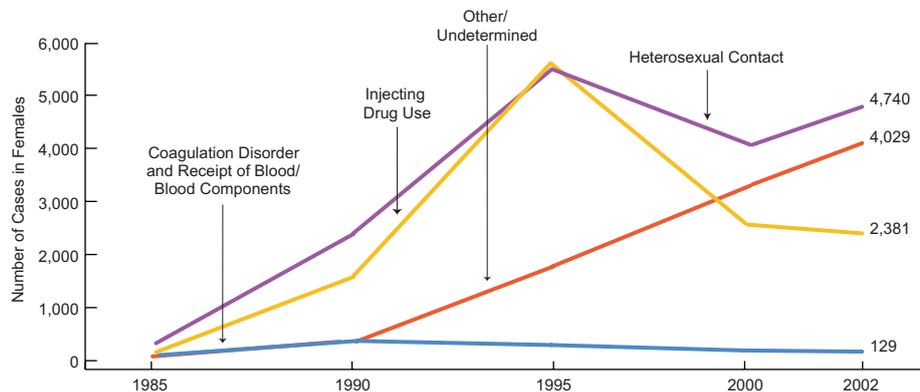
Of the 11,279 reported AIDS cases among women in 2002, 42 percent were infected through heterosexual contact. Of these women, more than three-fourths were exposed through sex with an HIV-infected person without a specified risk, while just under one-fourth were exposed through sex with an injection drug user. Of all reported cases in 2002, another 21 percent were infected through their own

injection drug use. One percent of women were infected by receipt of blood components or tissue, and less than one percent were exposed due to hemophilia or another coagulation disorder. Another 36 percent of women were exposed through a risk that was not reported or identified.

Within each racial and ethnic group, heterosexual contact represented the source of approximately 40 percent of AIDS cases in women

Newly Reported AIDS Cases, by Selected Exposure Categories* for Females Aged 13 Years and Older at Diagnosis, Selected Years 1985-2002

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



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

AIDS (Cont'd)

reported in 2002. However, injecting drug use was the source of 30 percent of cases among non-Hispanic White women, compared to 19 percent in non-Hispanic Blacks and 20 percent in Hispanics.

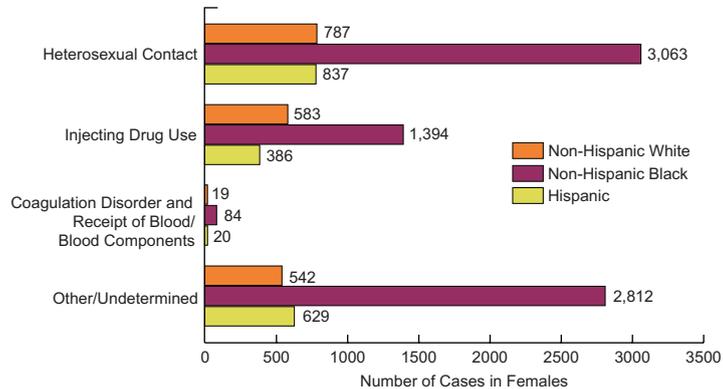
Overall, between 1998 and 2002 the number of women dying of AIDS has remained steady and the number of newly reported cases has risen

only slightly. The number of reported cases is potentially misleading since it does not indicate when a person was infected. In contrast, the number of women living with AIDS rose dramatically (from 57,338 to 82,764) between 1998 and 2002, due in large part to recent advances in combination drug therapies that help people with AIDS live longer.

- 1 Centers for Disease Control and Prevention. Current trends revision of the case definition of Acquired Immunodeficiency Syndrome for national reporting — United States. *MMWR* 1985;34(25):373-5.
- 2 Centers for Disease Control and Prevention. Revision of the CDC surveillance case definition for Acquired Immunodeficiency Syndrome. *MMWR* 1987;36(suppl no. 1S):3S-7S.
- 3 Centers for Disease Control and Prevention. Impact of the Expanded AIDS Surveillance Case Definition on AIDS Case Reporting—United States, First Quarter, 1993. *MMWR* 42(16):308-310.
- 4 Centers for Disease Control and Prevention. HIV/AIDS among U.S. Women: Minority and Young Women at Continuing Risk. May 2002. <http://www.cdc.gov/hiv/pubs/facts/women.htm>

Female Adult/Adolescent AIDS Cases, by Exposure Category* and Race/Ethnicity,** 2002

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

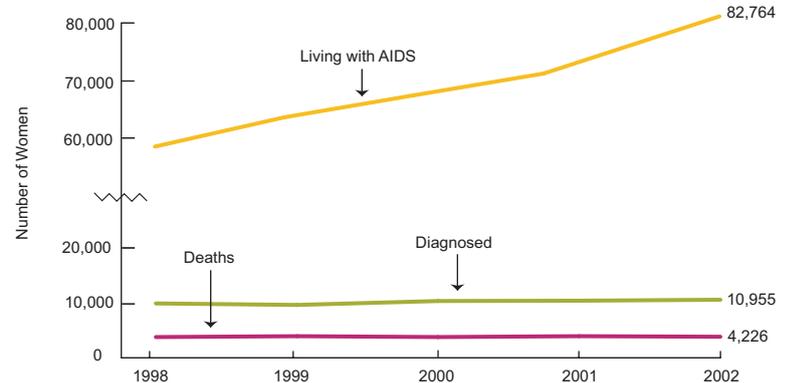


*Each reported case of AIDS is assigned to one exposure category, even if more than one risk factor is present, according to the probability of acquiring the infection from each risk behavior.

**Numbers for Asian/Pacific Islanders and American Indian/Alaska Natives are too small to illustrate on graph.

Estimated Numbers of Women Diagnosed with AIDS, Living with AIDS, and Number of Deaths, by Year, 1998-2002

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



ARTHRITIS

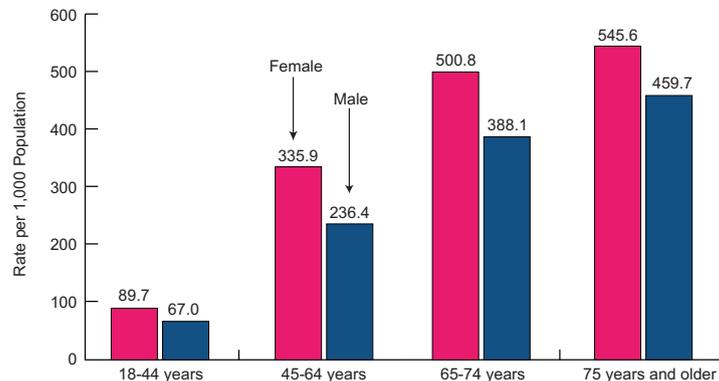
Arthritis is an inflammatory disease that may cause pain, stiffness and/or swelling of the joints, ligaments, muscles, bones, tendons, and some internal organs. This disease is the leading cause of disability in the U.S. for both men and women.

Rates of arthritis increase with age among both men and women. However, women had

higher rates of arthritis than men overall and at all ages. Rates of arthritis also varied by race and ethnicity, with non-Hispanic White women reporting more than twice the rate of non-Hispanic women of other races. The high rate in non-Hispanic White women may be due to the older age distribution of this population.

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2002

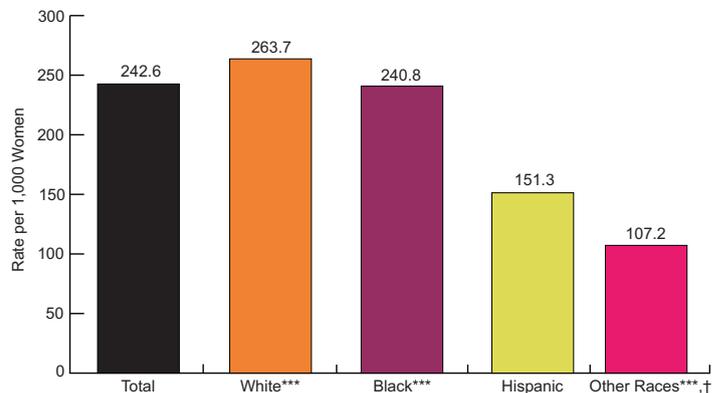
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Arthritis,* by Race/Ethnicity,** 2002

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



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

**Rates reported are not age-adjusted.

***Non-Hispanic

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

ASTHMA

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

and participate in activities of daily living.

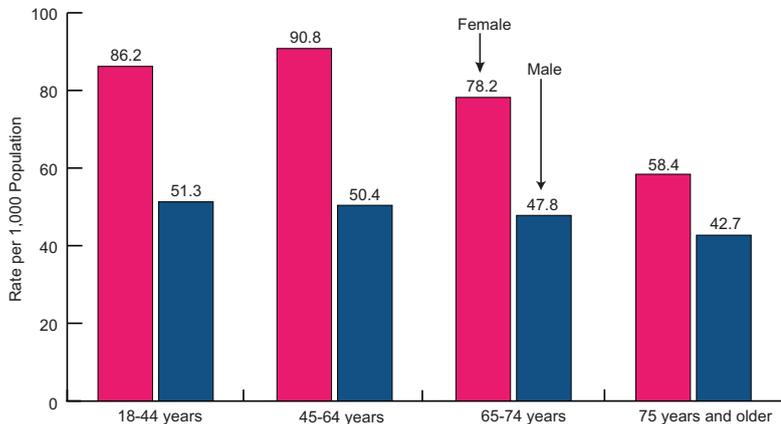
In 2002, women had higher rates of asthma than men. This disparity was most pronounced among women younger than 65, who experienced asthma at nearly twice the rate of men the same age. Between ages 65 and 74, the asthma rate among women was 64 percent higher than that of men, and after age 74, the disparity in asthma rates between men and

women was narrower.

Among women in 2002, rates of asthma also differed among racial and ethnic groups. Non-Hispanic Black and non-Hispanic White women had the highest rates of asthma per 1,000 women (105.6 and 86.6, respectively), followed by women of other races (70.4) and Hispanic women (51.6).

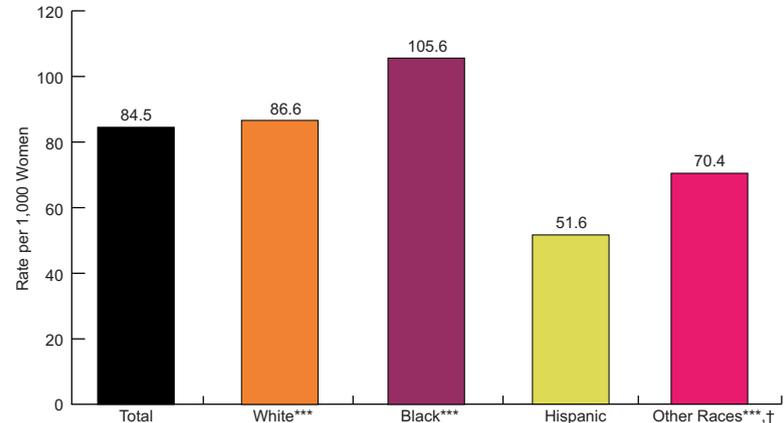
Adults Aged 18 and Older with Asthma,* by Age and Sex, 2002

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



Women Aged 18 and Older with Asthma,* by Race/Ethnicity,** 2002

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



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

**Rates reported are not age-adjusted.

***Non-Hispanic

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

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

CANCER

In 2004, it is estimated that 272,800 females will die of cancer. Of these deaths, it is estimated that 25 percent will be due to lung/bronchus cancer, 15 percent due to breast cancer, and 10 percent due to colon and rectal cancer.

Rates of newly diagnosed cancers are tracked by the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) Program. According to SEER data from 1992 to 2000, age-adjusted rates of new cases of malignant lung and bronchus cancer among all females have remained statistically unchanged (48.8 per 100,000 females in 1992 and 47.2 per 100,000

females in 2000). For American Indian/Alaska Native females, rates of lung and bronchus cancer declined from 1992 to 2000. In 2000, Black and White females had the highest rates of lung/bronchus cancer (53.6 and 49.2 per 100,000, respectively) followed by Asian/Pacific Islander, Hispanic, and American Indian/Alaska Native females. Despite the low incidence rates of lung/bronchus cancer among American Indian/Alaska Native females, cancer is the second leading cause of death for this group.¹

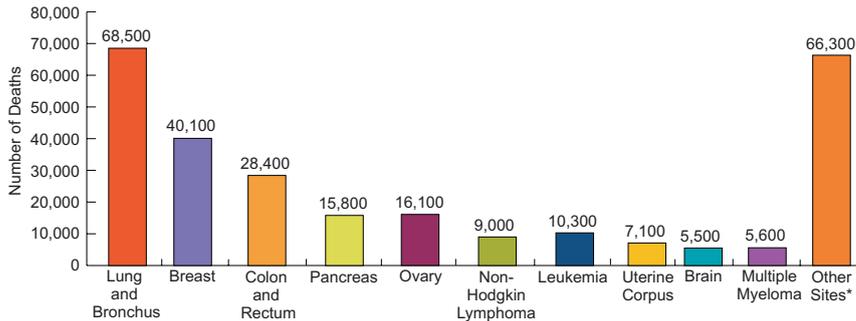
From 1992 to 2000, age-adjusted rates of malignant breast cancer increased among all females. During this same time period, rates

among American Indian/Alaska Native women declined from a high of 63.8 in 1992 to a low of 35.3 per 100,000 females in 2000; rates among Black females remained stable. In 2000, Black and White females had the highest rates of malignant breast cancer (139.1 and 119.8 per 100,000 females, respectively).

From 1992-2000, rates of newly diagnosed malignant colon and rectal cancer remained stable for all females and all racial and ethnic groups of females. In 2000, the highest rates of colon and rectal cancer were among Black (56.5 per 100,000 females) and White (44.8 per 100,000 females) females; the lowest rates were

Leading Causes of Cancer Deaths for Females (All Ages), by Site, 2004 Estimates

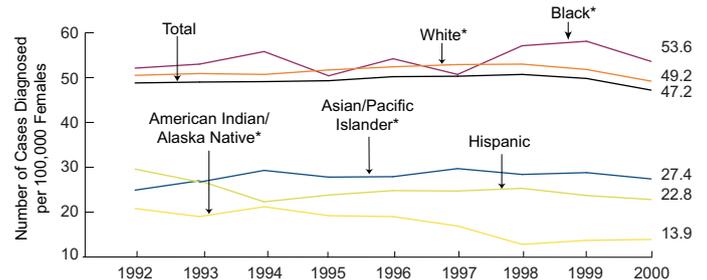
Source (II.5): American Cancer Society



*Includes skin cancer, oral cancers, and cancers of the endocrine and urinary systems, as well as cancers of other or unspecified sites.

Females with Lung and Bronchus Cancer, by Race/Ethnicity, 1992-2000

Source (II.6): National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program



*Does not exclude Hispanics.

CANCER (Cont'd)

among American Indian/Alaska Native females (10.4 per 100,000 females).

Although mortality rates are the highest among females with lung/bronchus cancer, in 2000, rates of new cases of malignant breast cancer among females (132.9 per 100,000) were nearly three times greater than rates of new cases of both lung/bronchus cancer (47.2 per 100,000) and colon/rectal cancer (45.3 per 100,000).

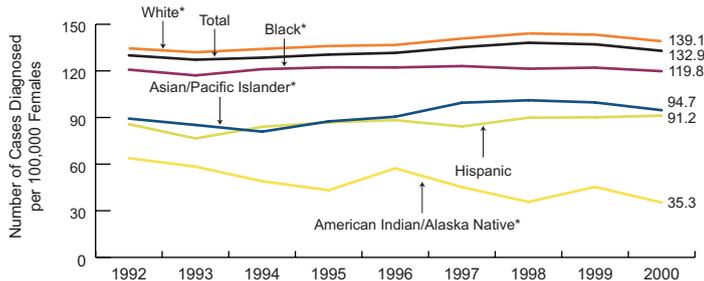
While the specific causes of cancer have not yet been identified, it appears to involve a combination of environmental, behavioral, and

genetic factors. Adopting a healthy lifestyle by achieving optimal weight, exercising regularly, avoiding tobacco, eating nutritiously, and reducing sun exposure may significantly reduce the risk of cancer.² In addition, regular cancer screenings specific to women are recommended. Pap smears are recommended after sexual activity begins, or at the age of 21, whichever comes first, to screen for cervical cancer. Mammograms are recommended for women aged 40 and older to screen for breast cancer; for persons aged 50 and older, fecal occult blood testing and sigmoidoscopy are recommended to screen for colorectal cancer.³

- 1 *National Vital Statistics Report, Vol. 49, No. 11, October 12, 2001.*
- 2 *United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Preventing and Controlling Cancer: The Nation's Second Leading Cause of Death 2004. February 2004. http://www.cdc.gov/nccdphp/laag/laag_dcpc.htm*
- 3 *U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. March 2004. <http://www.abnq.gov/clinic/uspstfix.htm>*

Age-Adjusted Malignant Breast Cancer Rates Among Females, by Race/Ethnicity, 1992-2000

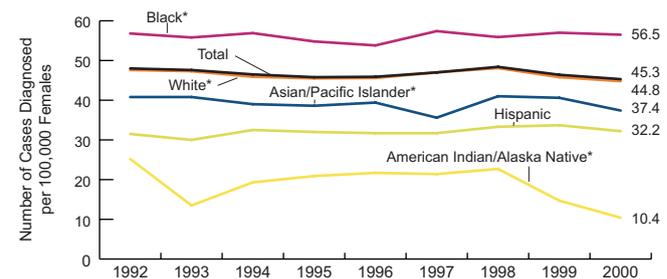
Source (II.6): National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program



*Does not exclude Hispanics.

Age-Adjusted Malignant Colon and Rectal Cancer Rates Among Females, by Race/Ethnicity, 1992-2000

Source (II.6): National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program



*Does not exclude Hispanics.

DIABETES

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

Diabetes can develop at any age. One of the two main types of diabetes, Type 1 diabetes, is usually first diagnosed in children, teenagers, or young adults, and accounts for 5 to 10 percent of all diagnosed cases of diabetes. Type 2 diabetes can develop at any age and accounts for about 90 to

95 percent of all diagnosed cases of diabetes; it is increasingly being diagnosed in children and adolescents. The risk for Type 2 diabetes is associated with obesity, physical inactivity, and family history of diabetes, and is more common among certain racial and ethnic groups.¹

In 2002, among women under the age of 44, the rate of diabetes was higher than that of men of the same age. This trend reverses after the age of 45, however, with the rate of diabetes for males exceeding females among all age groups. The rate of diabetes increases with age among both men and women. In fact, rates among

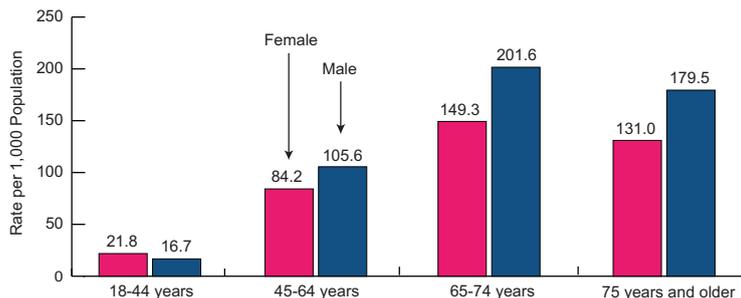
women aged 45 to 64 years and 65 to 74 years were approximately four and seven times higher than those of women under the age of 45 years.

Racial and ethnic differences in diabetes rates were observed in 2002. For every 1,000 women, non-Hispanic Black women had the highest rate of diabetes (99.7) followed by Hispanic women (67.0), non-Hispanic White women (56.0), and non-Hispanic women of other races (42.7).

1 Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2003. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2003.

Adults Aged 18 and Older with Diabetes,* by Age and Sex, 2002

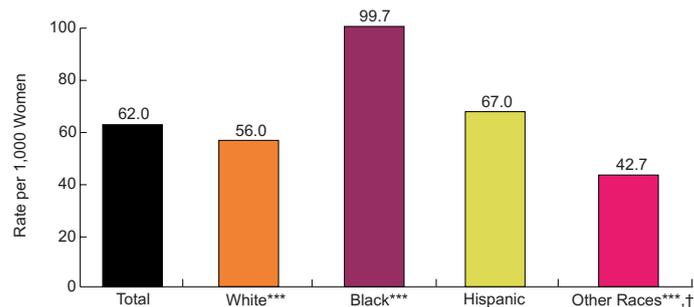
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Diabetes,** by Race/Ethnicity,** 2002

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



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

**Rates reported are not age-adjusted.

***Non-Hispanic

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

EATING DISORDERS

Eating disorders are a source of significant public health concern for adolescent girls and young adult women. These disorders are distinguished by a disturbance in eating or weight-control behavior that often result in major impairment of physical health and psychosocial functioning.¹ Among all the psychiatric disorders, the eating disorder anorexia nervosa is among the most life-threatening.

The classification of the eating disorders and their principal diagnostic criteria can be found in the *Diagnostic and Statistical Manual* (DSM-IV), 4th edition.² Three categories of eating disorders are listed in DSM-IV: 1) anorexia nervosa, 2) bulimia nervosa, and 3) atypical eating disorders (or eating disorders not otherwise specified—EDNOS). Binge eating disorder is currently classified under the EDNOS category.

Anorexia nervosa and bulimia nervosa share some defining clinical characteristics, including an exaggeration of self-perceived shape and body weight, a fear of being fat, and body image dissatisfaction.¹ In response to such perceptions, some individuals suffering from anorexia nervosa engage in self-starvation behavior while others engage in a cycle of both self-starvation and binge/purge behavior; as such, the diagnosis of anorexia is divided into two sub-types. Individuals with bulimia nervosa engage in a

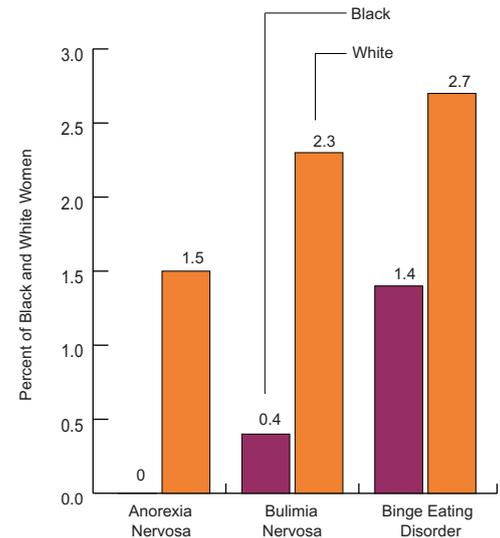
repetitive cycle of binge eating and purging behaviors, including self-induced vomiting, compulsive exercise, rigorous dieting or fasting periods, or laxative and diuretic abuse. Binge eating disorder is characterized by recurrent binge eating without the regular use of purging measures to counter the binge behaviors.

Evidence to date suggests that eating disorders are more common among females than among males, particularly adolescent females and young adult women in their teens and early twenties.² A recent follow-up study to the National Heart, Lung, and Blood Institute's Growth and Health Study examined rates of eating disorders in Black and White women ages 19 to 24. This study reported prevalence rates among White women similar to those of other studies, and found significant differences by race. No Black women were found to have had anorexia nervosa, and the odds of detecting bulimia nervosa in White women were six times that of Black women. The racial disparity in cases of binge eating disorder was narrower, with White women twice as likely as Black women to meet the criteria for this condition. Black women were also significantly less likely than White women to have received treatment for their eating disorders.

- 1 Fairburn, C. G. & Harrison, P.J. (2003). *Eating Disorders. The Lancet*, 361: 407-416.
- 2 American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., pp. 539-545). Washington D.C.: Author.

Eating Disorders Among Black and White Women, 2003

Source (II.7): National Institutes of Health; National Heart, Lung, and Blood Institute; data as published in Striegel-Moore RH et al., 2003



HEART DISEASE

Heart disease remains the leading cause of death for women. Heart disease describes any disorder that prevents the heart from functioning normally. The most common cause of heart disease is coronary heart disease, in which the arteries of the heart slowly narrow, reducing blood flow. Risk factors include obesity, lack of physical

activity, smoking, high cholesterol (low levels of high-density lipoprotein and high levels of low-density lipoprotein), hypertension, and older age.

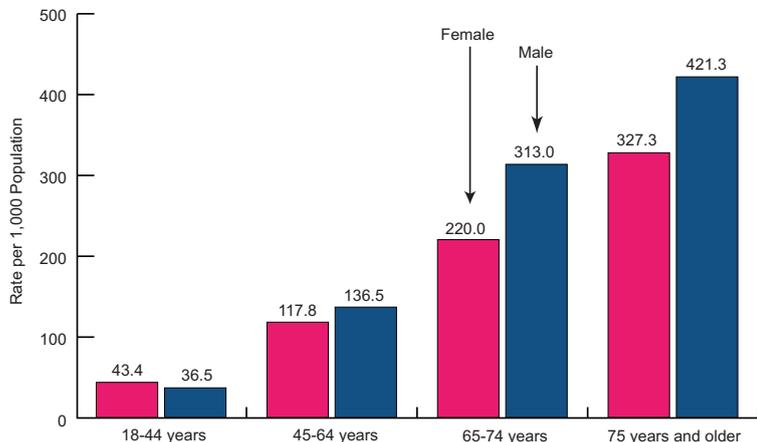
In 2002, men had a higher rate of heart disease than women. Comparing age groups, however, women under the age of 45 years had a higher rate than men (43.4 per 1,000 women compared to 36.5 per 1,000 men). Rates of

heart disease increase substantially with age and are highest among persons aged 75 and older, underscoring the chronic nature of this disease.

Rates of heart disease among women differ substantially by race and ethnicity. The highest rates were reported among non-Hispanic White women, with a rate nearly twice that of Hispanic women.

Adults Aged 18 and Older with Heart Disease,* by Age and Sex, 2002

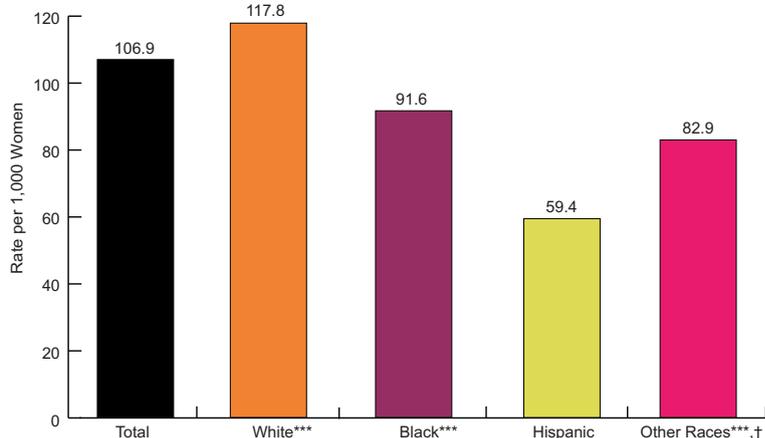
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Heart Disease,* by Race/Ethnicity,** 2002

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



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

**Rates reported are not age-adjusted.

***Non-Hispanic

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

HYPERTENSION

Hypertension, also known as high blood pressure, is a risk factor for heart disease and stroke.

Hypertension is defined as a systolic pressure (during heartbeats) of 140 or higher, diastolic pressure (between heartbeats) of 90 or higher, or both. Overall, in 2002, women had higher rates of hypertension than men. Among those under the age of 75, however, the rates of hypertension among men and women were similar. In contrast, among older persons aged

75 and older, the rate of hypertension was higher among men than women.

Similar to trends found in heart disease and diabetes, the rates of hypertension for both women and men increase with age. The rate of hypertension per 1,000 women consistently increases with age: the rates among women aged 65 and older are more than five times that of women aged 18-44.

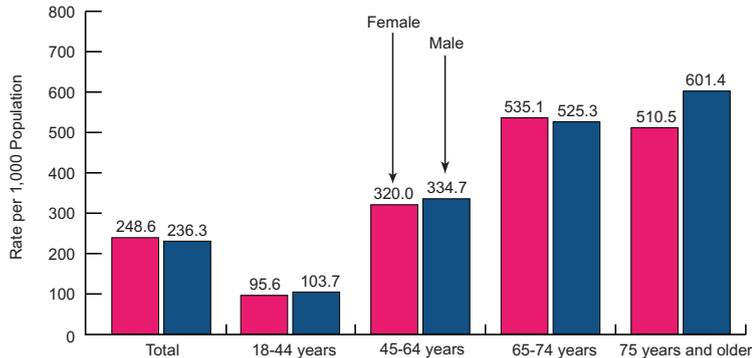
The rate of hypertension was also found to vary widely among women of different racial

and ethnic groups. Non-Hispanic Black women had the highest rates of hypertension (328.1 per 1,000 women), far higher than those of non-Hispanic White women (249.0), Hispanic women (183.8) or non-Hispanic women of other races (174.8).

Blood pressure can be monitored through regular screening and controlled through weight loss; a diet low in saturated fat, cholesterol, and salt; and regular exercise.

Adults Aged 18 and Older with Hypertension,* by Age and Sex, 2002

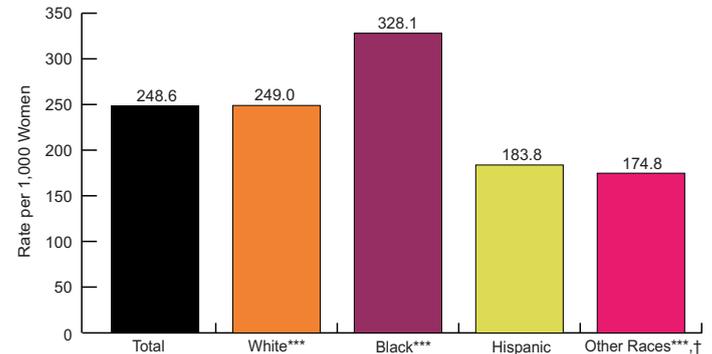
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Women Aged 18 and Older with Hypertension,* by Race/Ethnicity,** 2002

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



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

**Rates reported are not age-adjusted.

***Non-Hispanic

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

INJURY

Although many injuries are preventable, in 2001, there were an estimated 39.4 million injury-related emergency department (ED) visits. Among females, nearly one third of injury-related ED visits were made by 25-44 year olds (31.5 percent), while fewer than 5 percent were made by older women (aged 65-74 years).

Overall, the rates of injury-related ED visits per year were 12.4 percent and 15.8 percent for

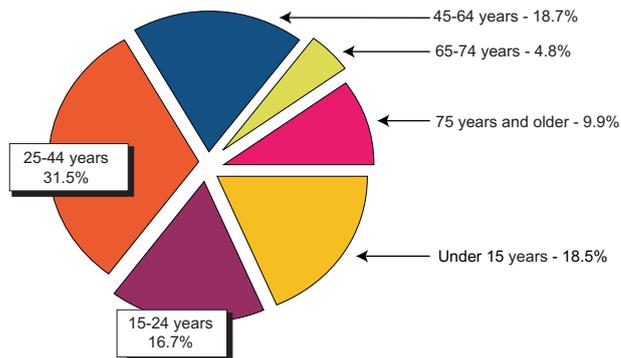
females and males, respectively. Among females, the highest rates were among women 75 and older, whereas for males, the highest rates were among 15-24 year olds. The lowest rates of injury-related ED visits were among 65-74 year olds for both males and females. Between the ages of 45 and 74 years, rates were similar between the sexes, while among persons aged 75 and older, females had higher rates than males.

Falls are a leading cause of injury among women, especially among women aged 65 and older. Other injury causes commonly resulting in an ED visit include being struck by or against a person or object, motor vehicle accidents, overexertion, and cuts.¹

¹ Warner M, Barnes PM, and Fingerhut LA. Injury and poisoning episodes and conditions, National Health Interview Survey, 1997. National Center for Health Statistics, Vital Health Stat 10(202), 2000.

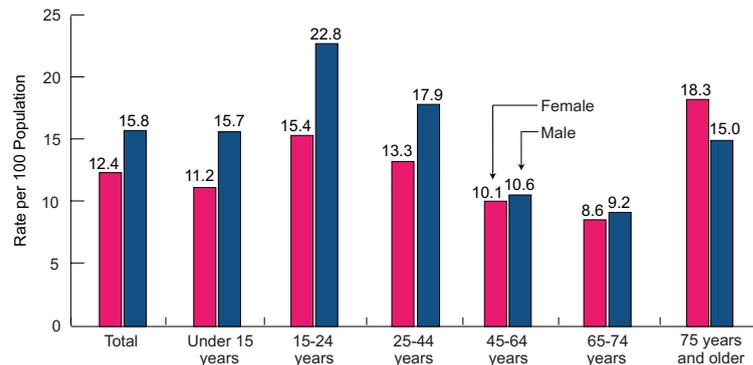
Injury-Related Emergency Department Visits for Females, by Age, 2001

Source (II.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



Injury-Related Emergency Department Visits, by Age and Sex, 2001

Source (II.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey



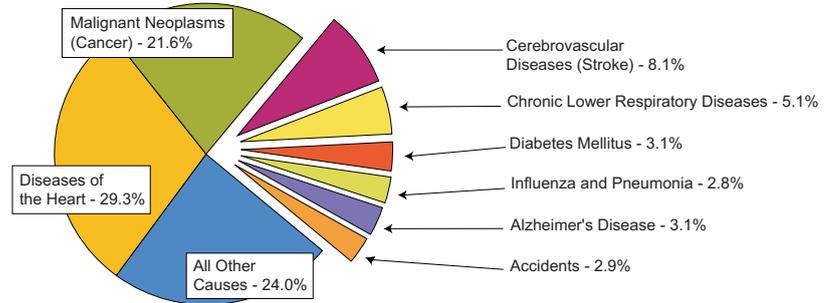
LEADING CAUSES OF DEATH

In 2001, there were over 1.2 million deaths among females. Of these deaths, more than half were attributed to diseases of the heart and malignant neoplasms (cancer), (361,047 and 266,694 deaths, respectively). Cerebrovascular diseases (stroke) accounted for 8.1 percent of all female deaths, followed by chronic lower respiratory diseases (5.1 percent).

Crude death rates varied by race and ethnic group. Among non-Hispanic White, non-Hispanic Black, and Hispanic women, the leading cause of death was heart disease, with 298.4, 215.4, and 71.8 deaths per 100,000 females, respectively. In contrast, among Asian/Pacific Islander and American Indian women, the leading cause of death was malignant neoplasms (74.0 and 68.8 deaths per 100,000 females, respectively).

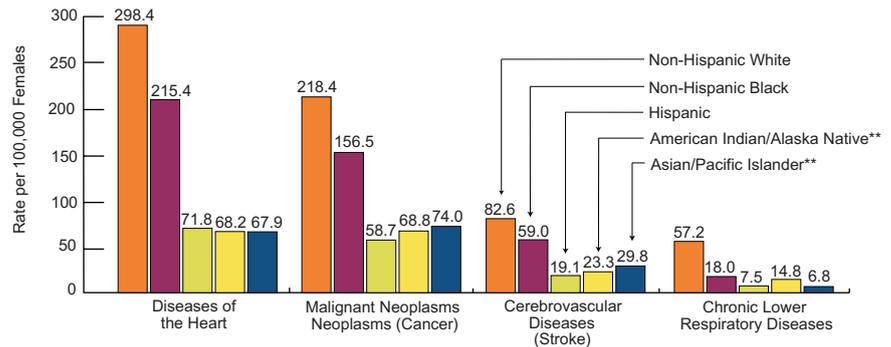
Leading Causes of Death in Females (All Ages), 2001

Source (II.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Crude Death Rates from Selected Conditions for Females (All Ages), by Race/Ethnicity,* 2001

Source (II.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Rates are not age-adjusted.

**Does not exclude Hispanic.

MENTAL ILLNESS AND SUICIDE

In 2002, there were an estimated 17.5 million adults aged 18 years or older with serious mental illness (SMI).¹ Females were disproportionately affected and were more likely than males to report a serious mental illness within the past 12 months. Among those aged 26–49 years and aged 50 years or older, women were nearly twice as likely as men to have experienced a serious mental illness.

Although the majority of people who suffer from a mental illness do not die by suicide,

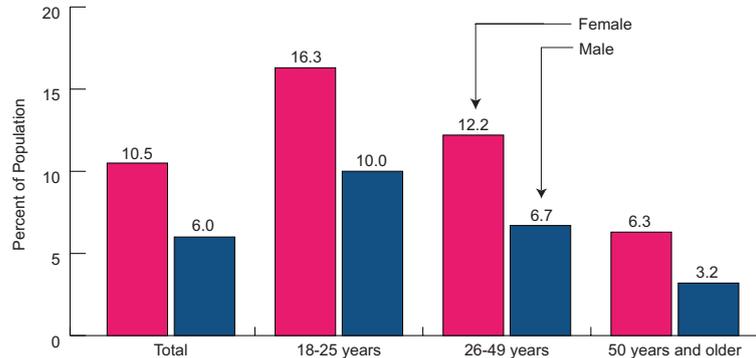
mental illness is a primary risk factor. Over 90 percent of suicides in the U.S. are associated with mental illness and/or alcohol and substance abuse.² In 2001, the rate of suicide continued to be substantially higher for males (17.6 per 100,000 males) than for females (4.1 per 100,000 females). It was estimated, however, that there were three female suicide *attempts* for every one male suicide attempt. Among females whose suicide attempts resulted in death, the rates per 100,000 females were highest among American Indian/Alaska Native females (6.2),

closely followed by non-Hispanic White females (6.1). Lower rates were found among Asian/Pacific Islander females (3.5), non-Hispanic Black females (2.3), and Hispanic females (2.1).

- 1 *The National Survey on Drug Use and Health defines Serious Mental Illness (SMI) as “having a diagnosable mental, behavioral, or emotional disorder that met the DSM-IV criteria and resulted in functional impairment that substantially interfered with or limited one or more major life activities.”*
- 2 *Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (editors). (2002). Reducing Suicide: A National Imperative. Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine.*

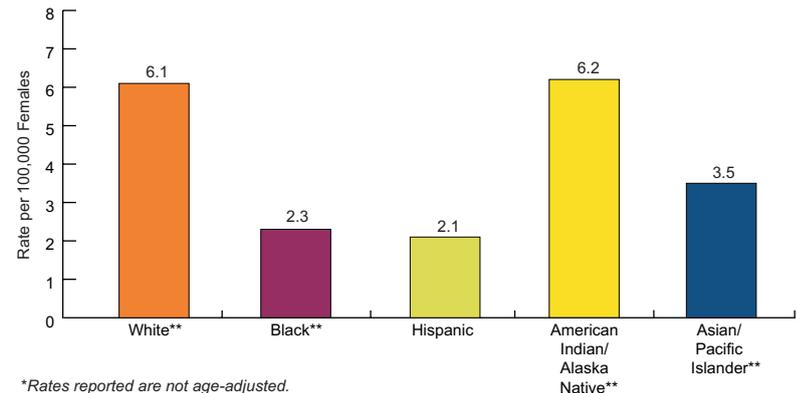
Serious Mental Illness in Past Year, by Age and Sex, 2002

Source (II.10): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



Suicide Death Rates* for Females Aged 15 Years and Older, by Race/Ethnicity, 2001

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



*Rates reported are not age-adjusted.

**Non-Hispanic

ORAL HEALTH

Oral health conditions can cause chronic pain of the mouth and face and can disrupt normal eating behaviors. Certain oral health diseases are indicative of other health problems, and influence the development and management of chronic conditions such as cardiovascular disease and diabetes.¹ Among women, hormonal changes during puberty and pregnancy may contribute to the development of gingivitis, and bone density loss later in life can lead to tooth loss.² With good oral health practices, such as brushing teeth, flossing, and visiting the dentist regularly,

dental disorders may be prevented.

One type of dental disorder, coronal caries (also referred to as cavities or tooth decay) may cause significant pain if untreated. In 1999-2000, rates of men and women with at least one untreated cavity were similar, with 12 percent of females and 13.1 percent of males affected. Sealants, a hard clear substance applied to the surfaces of teeth, may help to prevent caries. In 1999-2000, among persons aged 2 to 34 years, females were more likely to have sealants than males (19.7 and 14.2 percent, respectively).

Non-Hispanic White females were less likely

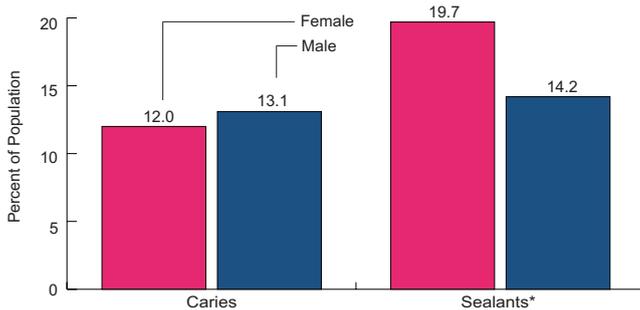
to have untreated dental caries (9.5 percent) than non-Hispanic Black females (19.6 percent). Likewise, non-Hispanic Black females between the ages of 2 and 34 years were less likely to have sealants than non-Hispanic White females (13.1 and 22.6 percent, respectively). Among Hispanic females, 14.3 percent were found to have dental caries and 15.7 percent had sealants.

1 Zeeman GG, Veth EO, Dennison D. *Periodontal Disease: Implications for Women's Health. Obstetrical and Gynecological Survey*; 56(1): 43-49.

2 Allston A. *Improving Women's Health and Perinatal Outcomes: The Impact of Oral Diseases. Baltimore: The Women's and Children's Health Policy Center, 2002.*

Untreated Dental Caries and Use of Sealants* by Sex, 1999-2000

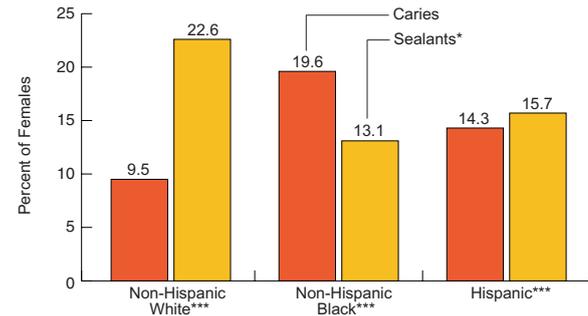
Source (II.12): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Examinations of sealants were conducted on persons aged 2-34 years.

Untreated Dental Caries and Use of Sealants* in Females by Race/Ethnicity,** 1999-2000

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



*Examinations of sealants were conducted on persons aged 2-34.

**Percents displayed are not age-adjusted.

***Does not include multi-racial individuals.

OSTEOPOROSIS

Osteoporosis is characterized by low bone density and deterioration of bone tissue, leading to bone fragility and increasing the risk of fracture, especially of the hip, spine, and wrist. Ten million Americans have osteoporosis and another 34 million are at risk due to low bone mass. Eighty percent of those affected are women. Osteoporosis is responsible for more than 1.5 million fractures annually. One in two women over age 50 will have an osteoporosis-related fracture in her lifetime.¹ Almost one in four (24 percent) individuals with a hip fracture die within a year.²

National data from 1999-2000 indicate that 3.1 percent of women under 65 have ever been told they have osteoporosis, compared to

9.6 percent of women aged 65-74 years and 23.7 percent of women aged 75 and older. Non-Hispanic White women over 20 years of age were four times as likely (6.9 percent) to have ever been told they have osteoporosis as non-Hispanic Black women (1.7 percent) and Mexican American women (1.7 percent).³ The number of women with osteoporosis and low bone mass is projected to increase by almost 40 percent over the next 20 years. Many women with osteoporosis and low bone mass are undiagnosed and untreated, leaving them at risk for fractures.

Risk factors for osteoporosis include female sex, older age, small or thin body size, Caucasian and Asian race, and history of fractures.

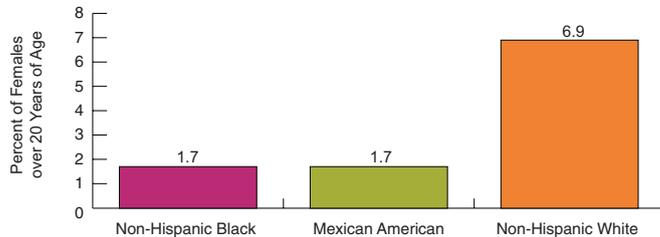
Osteoporosis may be prevented and treated through a diet rich in calcium and vitamin D,

weight-bearing exercise, no smoking or excessive alcohol intake, and medication when appropriate.

- 1 National Institutes of Health Osteoporosis and Related Bone Diseases—National Resource Center. *Osteoporosis Overview*. January 2003. www.osteoporosis.org/newfile.asp?doc=osteoporosis&doctype=HTML+Fact+Sheet
- 2 Office of Technology Assessment, U.S. Congress. *Hip Fracture Outcomes in People Age 50 and Over — Background paper, OTA-BP-H-120*. Washington, DC: U.S. Government Printing Office, July 1994.
- 3 National Center for Health Statistics, Centers for Disease Control and Prevention. *National Health and Nutrition Examination Study (NHANES) 1999-2000*. <http://www.cdc.gov/nchs/data/nhanes/genodoc.pdf>
- 4 *America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation*. National Osteoporosis Foundation, February 2002. (Note: Prevalence projections were generated by applying the prevalence estimates from NHANES III to census counts and projections. Assumptions were made on how to define low BMD in men and on using total population counts vs. the non-institutionalized and civilian population counts used in NHANES III. Changes in the population since NHANES III ended may add uncertainty to projections, as well, e.g., increase in obesity, approval/use of new medications, etc.)

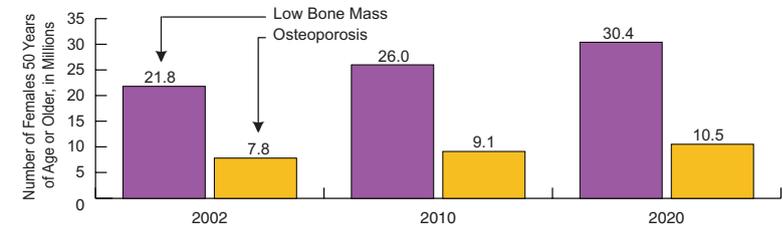
Females Diagnosed with Osteoporosis or Brittle Bones, by Race/Ethnicity, 1999-2000

Source (II.13): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Projected Prevalence of Osteoporosis and/or Low Bone Mass of the Hip in Women 50 Years of Age or Older

Source (II.14): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



OVERWEIGHT AND OBESITY

Being overweight or obese has been found to increase the risk of several conditions, such as high blood pressure, heart disease, diabetes, and stroke. Using self-reported measures of height and weight from the National Center for Health Statistics' National Health Interview Survey (NHIS), a Body Mass Index (BMI) was calculated and used to assess overweight or

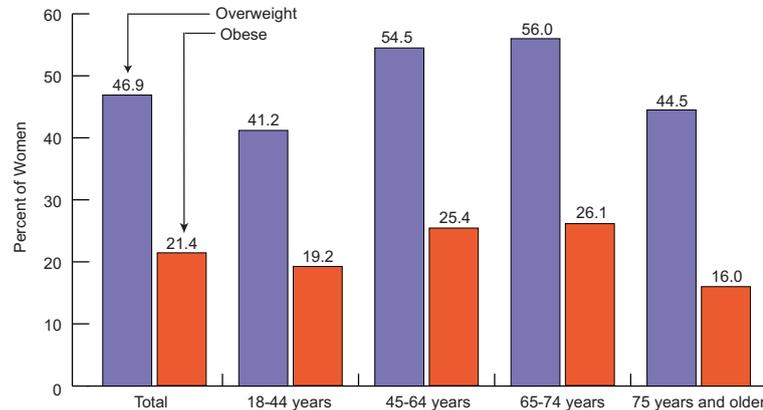
obesity status. As these indicators are based on self-report, it is possible that these estimates may be low, as respondents may have under-stated their weight.

In 2002, a smaller proportion of women than men were overweight or obese. However, this discrepancy was more pronounced in the "overweight" category, in which rates were 25 to 47 percent higher among men than women, than in the "obese" group, where rates among

the two sexes were similar for most age groups. Among women, rates of overweight and obesity were highest among those aged 65-74 years. Differences were also observed among racial and ethnic groups. Non-Hispanic Black women had the highest rate of overweight and obesity (65.0 and 37.6 percent, respectively). The lowest rate of overweight (28.6 percent) and obesity (9.3 percent) was observed among Non-Hispanic women of other races.

Overweight and Obesity* in Women Aged 18 and Older, by Age, 2002

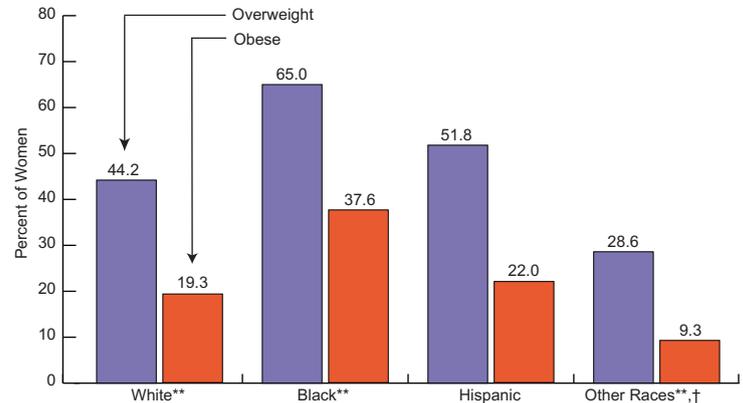
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*In the National Health Interview Survey, obesity was defined as a body mass index of 30.0 or higher. Overweight was defined as a body mass index of 25.0 or higher, including all those defined as obese.

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

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



*In the National Health Interview Survey, obesity was defined as a body mass index of 30.0 or higher. Overweight was defined as a body mass index of 25.0 or higher, including all those defined as obese.

**Non-Hispanic

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

SEXUALLY TRANSMITTED DISEASES

Rates of reported sexually transmitted diseases (STDs) are highest among adolescent and young adult women. In 2002, chlamydia was the most common such infection, followed by gonorrhea, with rates among adolescents (aged 15-19) of 2,626 cases of chlamydia per 100,000 females and 676 cases of gonorrhea per 100,000 females. The rates for both of these STDs decrease with age.

Rates of chlamydia and gonorrhea were much higher among non-Hispanic Black women than among women in other racial and ethnic groups, with 1,638 and 688 cases per 100,000 women, respectively, as compared to 203 and 37 cases per 100,000 non-Hispanic White females.

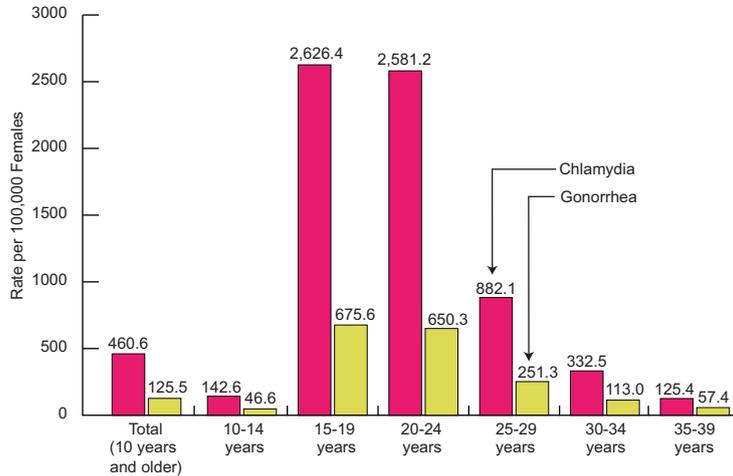
A third STD, syphilis, remains relatively rare (1.1 cases per 100,000 women). In 2002, this condition disproportionately affected non-Hispanic Black females (6.5 per 100,000

females) and American Indian/Alaska Native females (2.2 per 100,000 females).

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

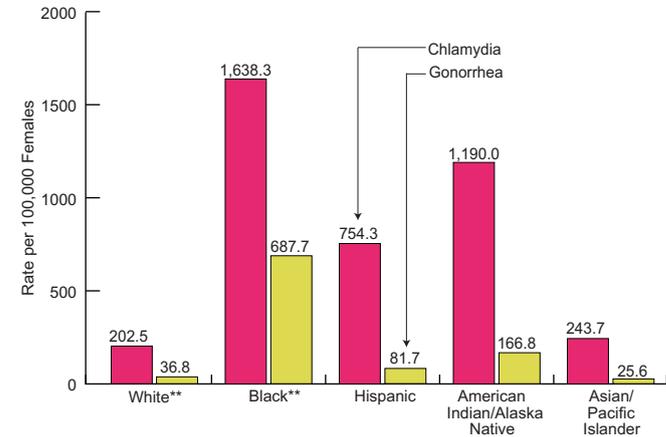
STDs Among Females Aged 10 and Older, by Age, 2002

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



STDs* Among Females Aged 10 and Older, by Race/Ethnicity, 2002

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



*Reported rates are not age-adjusted.

**Non-Hispanic

VIOLENCE AND ABUSE

In 2002, there were 2.5 million violent crimes committed against females aged 12 and older. Violent crimes include rape, sexual assault, robbery, and aggravated and simple assault. Women are more likely than men to be victims of violent acts committed by people they know, such as friends or intimate partners. In 2002, intimate partner violence

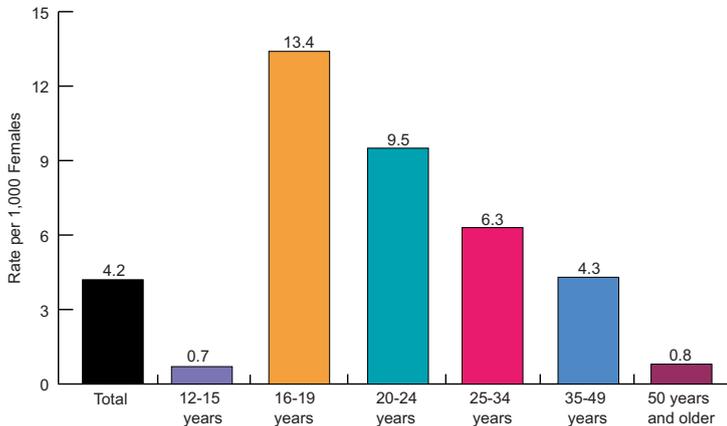
constituted 20 percent of violent crime against women and 2.5 percent of violent crime against men. The overall rate of intimate partner violence against women was 4.2 per 1,000 women, but rates were highest among women aged 16-19 years and 20-24 years (13.4 and 9.5 per thousand women, respectively).

Women are also the primary victims of reported sexual assault and rape. In 2002, of the

247,730 rapes and sexual assaults reported, women made up 87.2 percent of the victims. In addition, completed rape (86,290) was more likely to be reported than attempted rape (58,950) among females. The opposite was true for males where reports of attempted rape (18,520) were higher than completed rape (4,100).

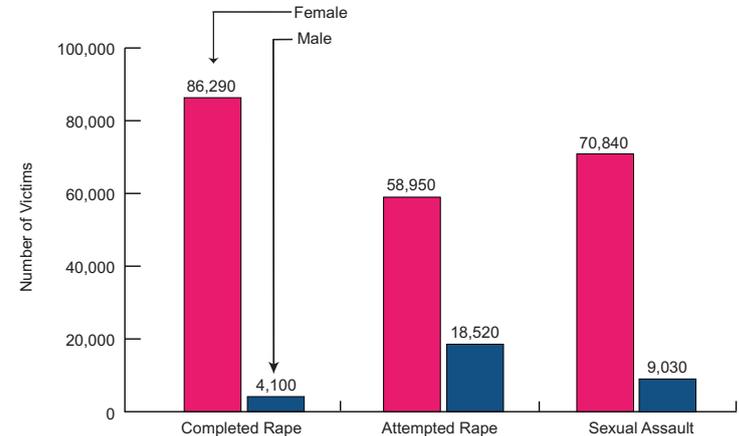
Violent Crimes Committed Against Females Aged 12 and Older by Intimate Partners, by Age 2002

Source (II.16): Bureau of Justice Statistics, National Crime Victimization Survey



Victims Aged 12 and Older of Rape and Sexual Assault, by Sex, 2002

Source (II.17): Bureau of Justice Statistics, National Crime Victimization Survey



PRENATAL CARE

Prenatal care is an important factor in achieving a healthy pregnancy outcome. Beginning prenatal care in the first trimester can help to reduce the incidence of perinatal illness, disability, and death by providing health advice, and identifying and managing medical and psychosocial conditions and risk factors that can affect the health of the pregnant woman and her child. The percentage of mothers receiving prenatal care in their first trimester of pregnancy remained relatively steady between 2001 and 2002, rising only slightly

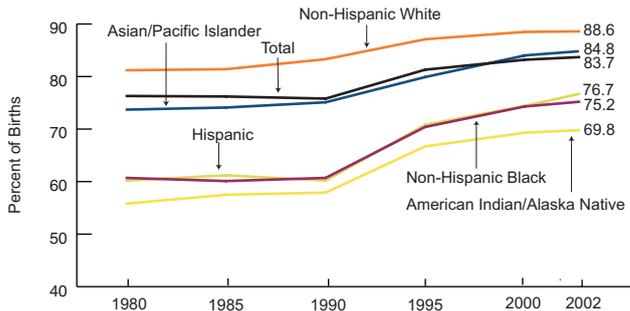
from 83.4 percent to 83.7 percent. Overall this figure has risen 10 percent since 1990, when only 75.8 percent of women received first-trimester care. During this 12-year period, non-Hispanic White women had the smallest increase in early prenatal care utilization (5.4 percent) and Hispanic women had the largest increase (16.5 percent).

Although a positive trend was observed among most racial and ethnic groups, there is still great disparity among women with respect to entering care early in pregnancy. In 2002, 88.6 percent of non-Hispanic White women

entered care in the first trimester, followed by 84.8 percent of Asian/Pacific Islander women, non-Hispanic Black women at 75.2 percent, Hispanic women at 76.7 percent, and American Indian/Alaska Native women at 69.8 percent. Approximately 40,000 women, or one percent of all women who gave birth in 2002, received no prenatal care, and an additional 2.6 percent did not begin care until their last trimester of pregnancy. Since 1990 the number of women receiving late or no care has dropped from 6.1 to 3.6 percent.

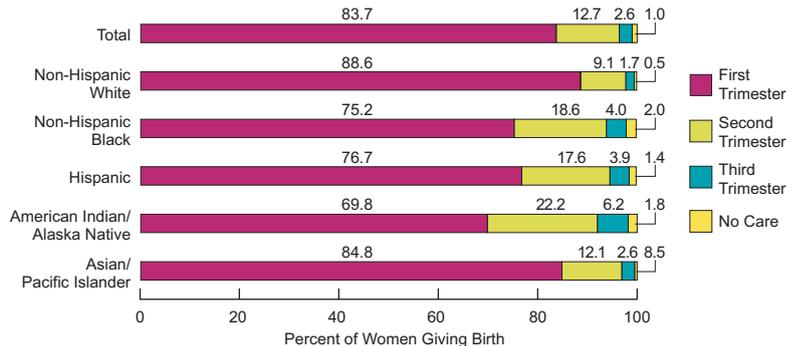
Percent of Births to Women who Began Prenatal Care in the First Trimester, by Race/Ethnicity, 1980-2002

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



Percent of Mothers Beginning Prenatal Care,* by Trimester and Race/Ethnicity, 2002

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



*Excluding births for which timing of entry into care was unknown or not stated on the birth certificate.

LIVE BIRTHS

There were just over 4 million births in the U.S. in 2002, which is approximately the same number as in 2001. While the total number of births remained steady, there were changes within several racial/ethnic categories. While births to non-Hispanic White and non-Hispanic Black women fell by 1 to 2 percent, Hispanic births rose by 3 percent and births to Asian/Pacific Islanders rose 5 percent. The 2002 birth rate of 13.9 births per 1,000 total population is the lowest on record since the data first became available in 1909.

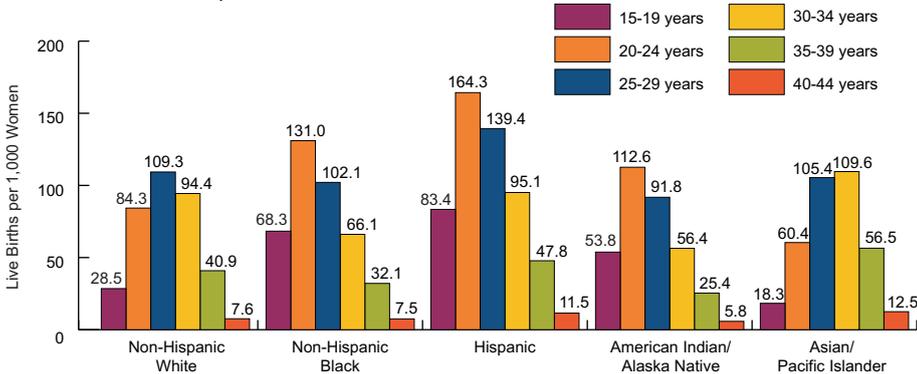
The birth rate among teenagers also reached a record low in 2002. The birth rate for teens aged 10 to 14 years dropped to 0.7 births per 1,000 females, and the rate for those aged 15 to 19 years dropped from 45.3 per 1,000 in 2001 to 43.0 in 2002. As with the total number of births, there were considerable differences in teenage birth rates by race and ethnicity. In 2002, birth rates for teenagers (under 20 years of age) ranged from 18.3 per 1,000 for Asian/Pacific Islander females to 68.3 per 1,000 for non-Hispanic Black females.

Of the 4 million babies born in 2002,

73.5 percent were born via vaginal delivery and 26.1 percent by cesarean (for the remainder, the method of delivery was unknown or not stated). Of the 26 percent of births performed by cesarean, nearly two-thirds were “primary” cesareans (i.e., the mother’s first) while the remainder were repeat cesareans. Almost all of the vaginal births were to mothers who had never had a cesarean; only a small percentage were to mothers who had experienced a cesarean previously. Methods of delivery do not vary greatly by race and ethnicity.

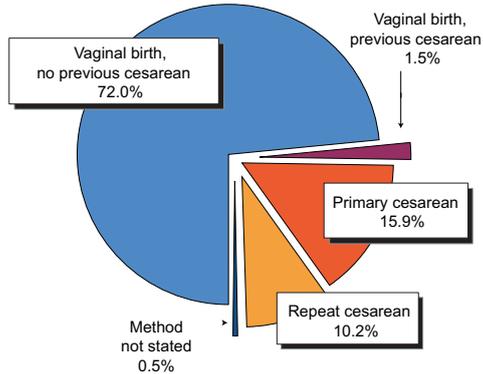
Birth Rates, by Age and Race/Ethnicity of Mother, 2002

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



Live Births, by Method of Delivery, 2002

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



BREASTFEEDING

Breastfeeding is believed to benefit the health, growth, immunity, and development of infants, and has been shown to improve maternal health as well. In the last 30 years, the prevalence of breastfeeding in the U.S. has fluctuated, increasing during the 1970s, decreasing in the 1980s, and again increasing in the 1990s. By 2002 breastfeeding in the hospital and at 6 months of age had reached record highs of 70.1 percent and 33.2 percent respectively. Black and Hispanic mothers, mothers under 24 years of age, WIC recipients, residents of the

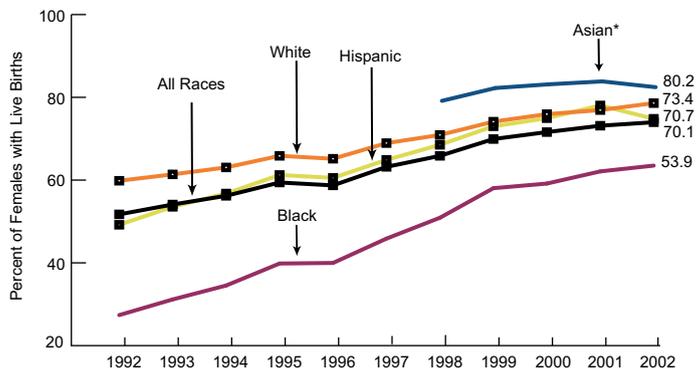
South Atlantic region, those with only grade school education, and mothers of low birth weight infants have all shown large increases in hospital breastfeeding rates.

However, racial and ethnic and economic differences persist. Fifty-five percent of mothers with only a grade-school education breastfed in the hospital, compared to 81.2 percent of those with a college education. The rate of in-hospital breastfeeding among Asian women was 80.2 percent, while the rate for Black mothers was only 53.9 percent, and the rate for WIC participants was 58.8 percent compared to a rate of

79.2 percent among non-WIC participants. While breastfeeding rates for mothers employed full-time and for those who are not employed are identical in the hospital (69 percent), at six months full-time workers are less likely to breastfeed (27.1 percent) than those who are not employed (35.2 percent). Rates of breastfeeding at 6 months are much lower among women in all racial and ethnic groups: the greatest decrease is seen among Black women, whose breastfeeding rates dropped 64 percent between birth and 6 months.

In-Hospital Breastfeeding, by Race/Ethnicity, 1992-2002

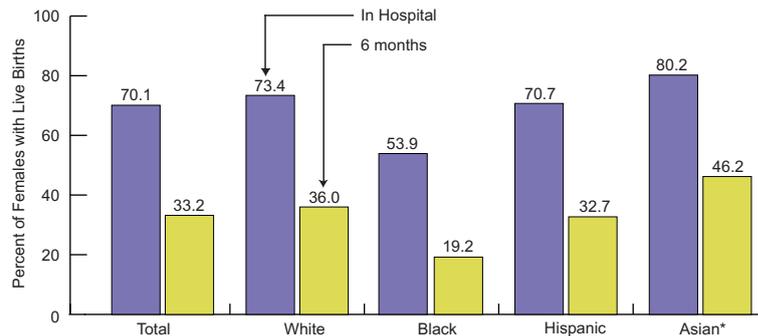
Source (II.20): Abbott Laboratories, Ross Mothers' Survey



*Data not available until 1998.

Women Breastfeeding in Hospital and at 6 Months Postpartum, by Race/Ethnicity, 2002

Source (II.20): Abbott Laboratories, Ross Mothers' Survey



*Data not available until 1998.



MATERNAL MORBIDITY AND MORTALITY

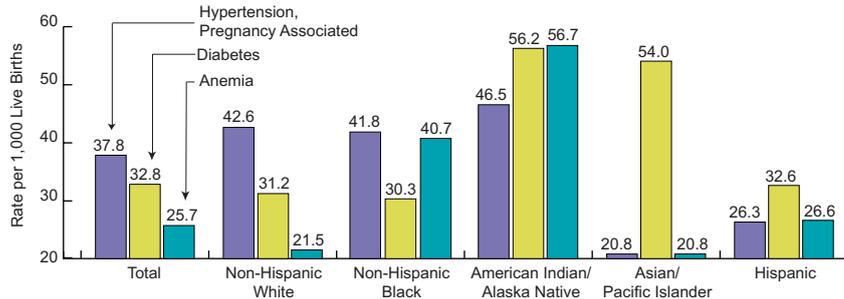
During pregnancy some women experience medical problems that can lead to serious complications and even maternal and infant mortality. In 2002, the most frequently reported medical risk factors in pregnancy were pregnancy-associated hypertension (reported in 37.8 women per 1,000 live births), gestational diabetes (32.8 per 1,000 live births), and anemia (25.7 per 1,000 live births). These have been the most common medical risks since such data became available from birth certificates in 1989. The risk of having a medical condition during pregnancy can vary by both maternal age, and race and ethnicity. For instance, the incidence of anemia among

teenage mothers is greater than among mothers in their thirties (36 women per 1,000 live births versus 20 per 1,000 live births), while the incidence of diabetes among teenage mothers is far lower than among women 40 to 54 years of age (9 per 1,000 live births versus 76 per 1,000 live births). The racial and ethnic differences in medical risk factors include a greater incidence of anemia among American Indian/Alaska Native women than among non-Hispanic White women (56 per 1,000 live births versus 22 per 1,000 live births), and a greater incidence of pregnancy-related hypertension among American Indian/Alaska Native women than among Asian/Pacific Islander women (46.5 per 1,000 live births versus 20.8 per 1,000 live births).

A total of 399 women died of maternal causes in 2001, for an overall rate of 9.9 per 100,000 live births. Maternal deaths are defined as those reported on the death certificate to be related to or aggravated by pregnancy or pregnancy management that occur within 42 days after the end of the pregnancy. Analysis of maternal mortality rates by race and ethnicity shows that non-Hispanic Black women are nearly four times as likely to die of pregnancy-related causes as non-Hispanic White women (24.7 maternal deaths per 100,000 live births compared to 6.5 per 100,000 live births). The rate of maternal mortality has risen in recent years among both Black and White women.

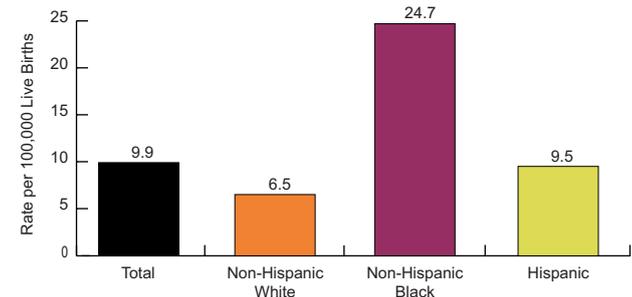
Medical Risk Factors During Pregnancy by Race/Ethnicity, 2002

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



Maternal Mortality, by Race/Ethnicity, 2001

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



IMMIGRANT HEALTH

The immigrant population, especially non-citizens and newly arrived persons, face both language and cultural barriers to accessing health care services. In March of 2002, of the estimated 14.7 million foreign-born women aged 18 years and older residing in the U.S., 58.0 percent were non-citizens.¹

In 2002, women without citizenship were

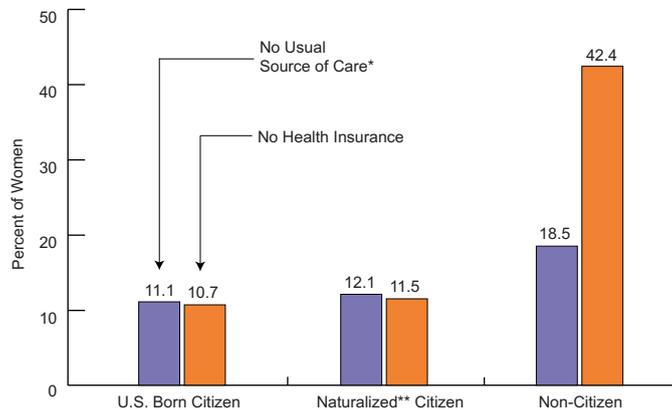
more likely to lack both a usual source of care (18.5 percent) and health insurance (42.4 percent) when compared to naturalized citizens or U.S.-born women. Among foreign-born women, the percentage of women without health insurance decreased with increasing length of time in the U.S., although not consistently for all racial and ethnic groups. The highest rates of uninsurance were reported among

Hispanic (64.5 percent) and non-Hispanic Black women (63.0 percent) in the U.S. for less than five years. After 15 years or more in the U.S., Asian and non-Hispanic White women were the least likely to be uninsured (9.7 percent and 10.8 percent, respectively).

¹ US Census Bureau. Current Population Survey - March 2000 Detailed Tables (PPL-162) <http://www.census.gov/population/www/socdemo/foreign/ppl-162.html>

Women Lacking a Usual Source of Care and Health Insurance, by Citizenship Status,*** 2002

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



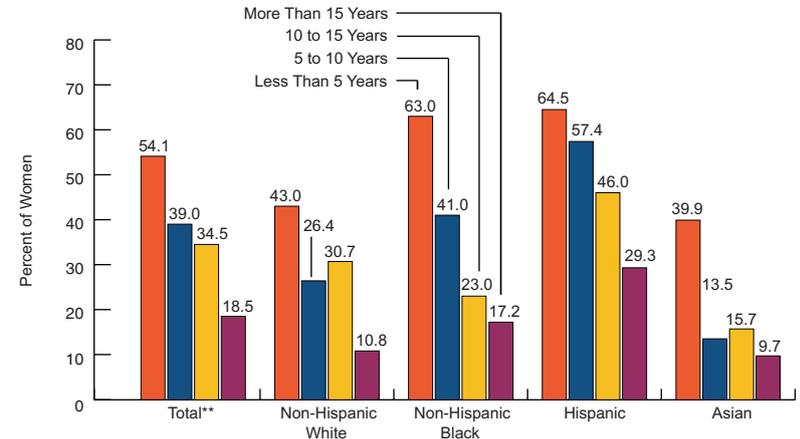
*Defined as not having a place they usually go to when they are sick.

**Person not born in the U.S., but holds U.S. citizenship.

***Percents are not age-adjusted.

Foreign-born Women without Health Insurance, by Length of Time in the U.S. and Race/Ethnicity,* 2002

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



*Percents are not age-adjusted.

**Percents of uninsured Non-Hispanic women of other races by duration of stay in the U.S. are not shown due to small sample size.

BORDER HEALTH

Women along the U.S. side of the U.S.-Mexico border — within 100 kilometers, or 62 miles, of the border — face many health disparities in comparison to their counterparts in the rest of the Nation. Along the approximately 2,000-mile border, the composition of the female population differs from the general U.S. female population. In 2000, in the border region, Hispanic females were the largest racial/ethnic group (49.5 percent) followed by non-Hispanic White females (40.1 percent), and females of other races (10.4 percent). In contrast, non-Hispanic Whites represent the majority of

females in the U.S. (68.3 percent), with Hispanic females representing 13.1 percent. The diverse population along the border creates unique challenges when addressing health disparities; in addition to increasing access to health services, services must be made available in a culturally and linguistically appropriate manner.

In 2000, women in the U.S. border region averaged 2.5 children during reproductive years, greater than the U.S. national average of 2.1. Despite the higher birth rate in this region, only 73 percent of women who gave birth received prenatal care during the first trimester, and only 64 percent received adequate care with

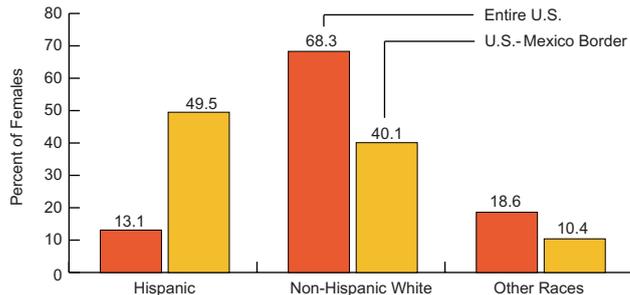
regard to timing and number of prenatal visits.¹

In 2000, women living in the border region had breast cancer death rates similar to the entire U.S. female population (27.2 and 27.1 per 100,000 females). Cervical cancer death rates were 3.7 per 100,000 females and 2.8 per 100,000 females along the border region and entire U.S., respectively. With early detection through regular mammography and Pap smear tests, breast self-examination, and adoption of healthy behaviors, many of these deaths could be prevented.

¹ United States-Mexico Border Health Commission. *Healthy Border 2010: An Agenda for Improving Health on the United States-Mexico Border*. October 2003. <http://www.borderhealth.org>.

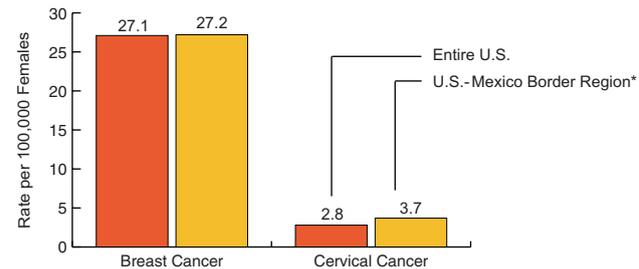
Distribution of Females by Race/Ethnicity in the U.S.-Mexico Border Area, 2000

Source (II.22): Health Resources and Services Administration, Area Resource File



Age-Adjusted Female Breast and Cervical Cancer Death Rates in the U.S.-Mexico Border Area, 2000

Source (II.23): United States-Mexico Border Health Commission, National Center for Health Statistics, National Vital Statistics System



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

INCARCERATED WOMEN

In 2002, the number of incarcerated women continued to increase, reaching 165,800 at midyear. This number has nearly doubled since 1990, when 83,253 women were housed in Federal and State prisons and local jails. The rate of incarceration among women is far lower than among men, with 113 inmates per 100,000 females compared to 1,309 inmates per 100,000 males. However, since 1995 the annual rate of growth in the inmate population has averaged 5.4 percent for women and 3.6 percent for men.¹

Racial and ethnic differences exist in incarceration rates among women. The highest rate of incarceration is among non-Hispanic Black women aged 30-34 years, with a rate of 1,024 inmates per 100,000 non-Hispanic Black women. Among non-Hispanic White and Hispanic women the highest rates are also in the 30-34 year age bracket, with a rate of 366 per 100,000 Hispanic women and 213 per 100,000 non-Hispanic White women. The total rate for women aged 18 years and older is also highest among non-Hispanic Black women at 349 per 100,000 women, compared to 137 per 100,000 Hispanic women and 68 per 100,000 non-Hispanic White women.²

Mental illness is a significant health problem among female inmates. According to a 1998 report, 23.6 percent of female State inmates were

mentally ill, followed by 22.7 percent of jail inmates, 21.7 percent of probationers, and 12.5 percent of Federal inmates. The highest rate of mental illness existed among non-Hispanic White women in State prisons, with 29 percent reported as having a mental health problem. Of these women, 37 percent aged 24 years or younger were mentally ill.³ HIV infection is also a notable health problem among the incarcerated population, with 2.9 percent of female State and Federal prison inmates reported to be infected with the virus in 2001. A greater percentage of women inmates are infected with HIV than men. Nine States reported that more than 5 percent of female inmates were infected, while only one State reported an infection rate of more than 5 percent in males.⁴

1 Harrison PM and Karberg JC. *Prison and Jail Inmates at Midyear 2002*. U.S. Department of Justice, Bureau of Justice Statistics Bulletin, April 2003.

<http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim02.pdf>

2 *Ibid*

3 Ditton PM. *Mental Health and Treatment of Inmates and Probationers*. U.S. Department of Justice, Bureau of Justice Special Report, July 1999.

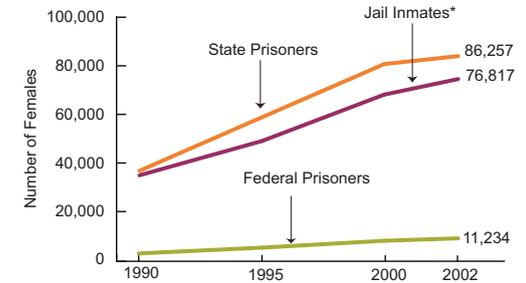
<http://www.ojp.usdoj.gov/bjs/pub/pdf/mbrtip.pdf>

4 Maruschak LM. *HIV in Prisons, 2001*. U.S. Department of Justice, Bureau of Justice Bulletin, January 2004.

<http://www.ojp.usdoj.gov/bjs/pub/pdf/hiv01.pdf>

Female Federal and State Prisoners and Local Jail Inmates, 1990 - 2002

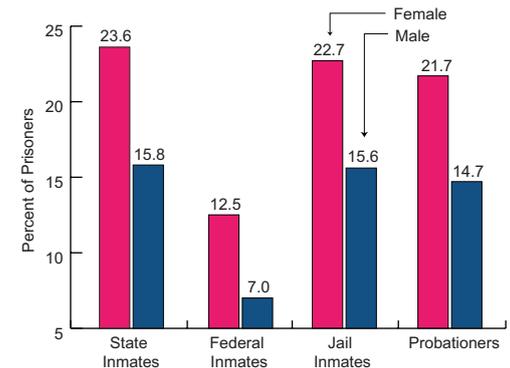
Source (II.24): U.S. Department of Justice



* Based on 1-day counts.

Inmates and Probationers Identified as Mentally Ill, by Sex, 1998

Source (II.25): U.S. Department of Justice



SERVICES FOR HOMELESS WOMEN

While the majority of single homeless adults are men, most homeless adults with children are women.¹ Women may be at risk of homelessness for a number of reasons, including mental health problems and substance abuse in addition to extreme poverty. Numerous studies have found that domestic violence is a major contributor to homelessness among women and their children, and that homeless women are disproportionately likely to have experienced violence or abuse at some time in their lives.²

It is difficult to get an accurate count of the homeless population at any given time, and no national surveys have been attempted since the mid-1990s. However, one way to describe the demographics of this population, if not its size,

is to look at those who use specific services, such as emergency shelters and health care services targeted to homeless people.

The U.S. Census Bureau counted the number of people using emergency and transitional shelters on one night in 2000 as part of the 2000 Census. Of the 170,706 people counted, 38.6 percent were female, and two-thirds of the females were adults. About 40 percent of the women in these shelters were White, 40 percent were Black or African American, 2.5 percent were American Indian or Alaska Native, 8.9 percent were “other,” and 4.4 percent named more than one race. In addition to their racial classification, 18.5 percent listed their ethnicity as Hispanic.

HRSA’s Health Care for the Homeless program offers primary care and substance

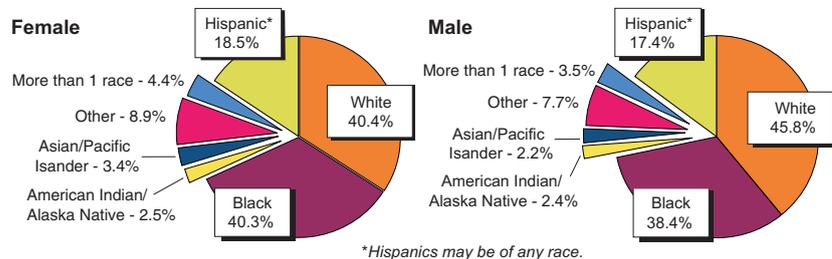
abuse treatment services to homeless people, provides referrals to inpatient care and mental health services, and conducts outreach to identify hard-to-reach homeless persons. In 2002, these clinics served more than 545,000 people, 34 percent of them adult women. Female users of Health Care for the Homeless programs were more likely than males to be young adults or elderly. The health problems most commonly seen in these clinics include hypertension, gastrointestinal problems, neurological disorders, arthritis, and substance abuse.

1 Burt MR, Aron LY, et al. *Homelessness: Programs and the People They Serve*. Washington, DC: The Urban Institute, 1999.

2 DeSimone P et al., *Homelessness in Missouri: Eye of the Storm?* Missouri Association for Social Welfare, 1998; Douglass R *The State of Homelessness in Michigan: A Research Study*. Michigan Interagency Committee on Homelessness, 1995; Owen G et al., *Minnesota Statewide Survey of Persons without Permanent Shelter* Wilder Research Center, 1998.

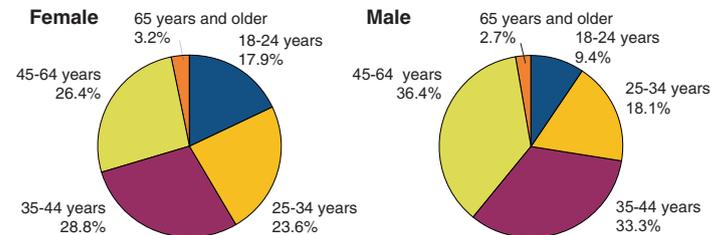
Adult Population Aged 18 and Older in Emergency and Transitional Shelters, by Sex and Race/Ethnicity, 2000

Source (II.26): U.S. Census Bureau



Adults Aged 18 and Older, Served by Healthcare for the Homeless Clinics, by Sex and Age, 2002

Source (II.27): Health Resources and Services Administration, Bureau of Primary Health Care



RURAL AND URBAN HEALTH

In 2000, 59 million people, or approximately 21 percent of the population, lived in a rural area.¹ Residents of rural areas tend to be older, poorer, less educated, have fewer health providers and live farther from health care resources than their metropolitan counterparts. These issues create special health concerns and barriers that can lead to poorer health. In 2002, women in non-metropolitan areas were more likely than urban women to report having been diagnosed with hypertension (high blood pressure) and cancer, two diseases that seriously affect women's health. In addition to the demographic and health access issues listed above, rural women are typically diagnosed with cancer in later stages of the disease than urban residents, decreasing their likelihood of survival.² Rates of heart disease, however, were similar among women in metropolitan and non-metropolitan areas.

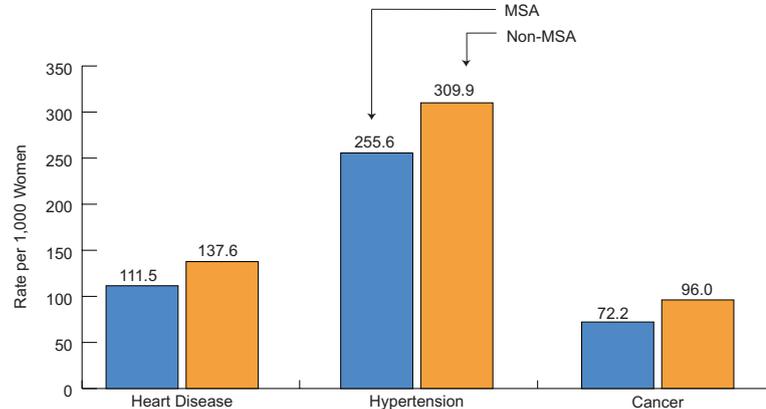
Health behaviors, such as low levels of physical activity, smoking, and heavy drinking may contribute to poor health status; however, the percentage of women reporting regular physical activity or current heavy drinking did not significantly differ between metropolitan and non-metropolitan areas. Although women in non-metropolitan areas were slightly more likely to smoke than metropolitan women, the

higher rates of hypertension and cancer may be attributed to the older age distribution of rural women, as well as the access, transportation, and provider supply barriers that rural women face.

- 1 U.S. Census Bureau 2000. *Census 2000 Summary File 1. Table P2.* <http://factfinder.census.gov/servlet/BasicFactsServlet>
- 2 "Breast and Cervical Cancer Screening: Is it Reaching Rural and Rural Minority Women?" Southwest Rural Health Research Center, April 2003.

Diagnosed Health Conditions in Women Aged 18 and Older, Among Metropolitan Statistical Area (MSA)* and Non-MSA Residence, 2002

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



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

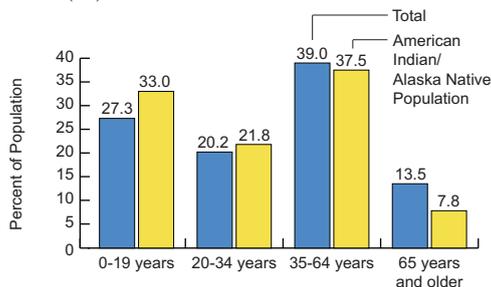
AMERICAN INDIAN/ ALASKA NATIVE WOMEN

According to the U.S. Census Bureau, in 2002 there were almost 3.5 million American Indian/Alaska Natives (AI/AN) in the U.S., and approximately 52 percent were female. In general, younger age groups are more heavily represented in the AI/AN population than among the general population.

According to the Indian Health Service, age-adjusted death rates among the AI/AN population are much higher than among the general U.S. population, both overall and for a number of individual health conditions. In 1994-1996, the total death rate for the AI/AN population was 699.3 per 100,000, compared to 503.9 per 100,000 among the general population. For

American Indian/Alaska Native Females, All Ages, by Age Group, 2002

Source (I.1): U.S. Census Bureau



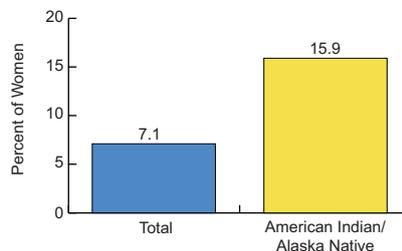
individual causes, the rate of alcohol-related deaths was 627 percent greater, the rate of deaths from tuberculosis was 533 percent greater, and the rate of diabetes-related deaths was 249 percent greater than among the general U.S. population.¹

Among AI/AN women, the leading cause of death in 2001 was diseases of the heart, followed by malignant neoplasms, unintentional injuries, cerebrovascular diseases, and diabetes mellitus. In 2000, the rate of diagnosed cases of malignant breast cancer among AI/AN women was 35.3 per 100,000 — far below the rate of 139.1 among non-Hispanic White women and 119.8 among non-Hispanic Black women.¹

The prevalence of cigarette smoking among AI/AN women exceeds all other racial and ethnic groups. In 2002, the rate of cigarette use in

Women 20 Years and Older with Diabetes, 2002

Source (II.28): Centers for Disease Control and Prevention



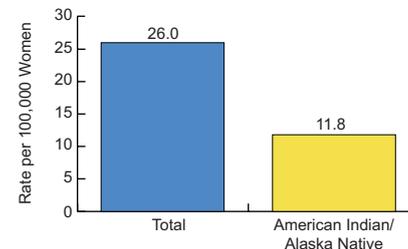
the past month among AI/AN women who were not pregnant was 47.5 percent, compared to 36 percent among non-Hispanic Whites, 25.3 percent among non-Hispanic Blacks, and 18.8 percent among Hispanics. Overweight and obesity are also significant problems among the AI/AN population, with over 60 percent of adult women under 60 years of age likely to be overweight or obese.² This trend may contribute to the high rate of diabetes among the AI/AN population. In 2002, 15.9 percent of AI/AN women over the age of 20 were living with diagnosed diabetes, compared to 7.1 percent of the general population.

1 U.S. Department of Health and Human Services, Indian Health Service. *Trends in Indian health, 1998-1999*. Available at: <http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp>

2 Indian Health Service. *IHS report to Congress: obesity prevention and control for American Indians and Alaska Natives*. April 2001.

Age-Adjusted Death Rate for Breast Cancer Among Women Aged 18 and Older, 2001

Source (II.11): National Center for Health Statistics



OLDER WOMEN

In 2002, an estimated 19.4 million women aged 65 years and older were living in non-institutionalized settings, representing 13.5 percent of all women. The ratio of women to men increases with age, with women comprising 51.1 percent of the entire population and 57.0 percent of people aged 65 and older.¹

In 2001, although the majority (56.6 percent) of non-institutionalized women over the age of 65 years did not report any disabilities, the remaining 43.4 percent were living with either one disability (18.9 percent) or two or more disabilities (24.4 percent). Among women with

one disability, the most commonly reported disabilities were those that limit physical activities such as walking, reaching, or lifting (11.2 percent). Compared to women with only one type of disability, women with two or more types of disabilities were more likely to report a self-care disability (0.1 percent compared to 10.3 percent). These women are likely to need the assistance of paid or family caregivers.

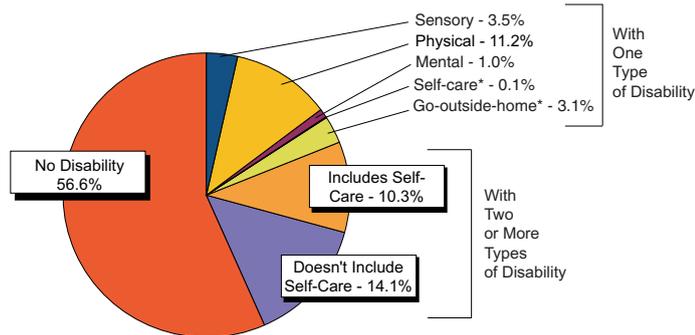
The Centers for Disease Control and Prevention recommends that adults aged 65 and older have an annual influenza (flu) vaccination as well as a pneumococcal vaccination at least once during their lifetime. In 2002, the majority

of women 65 and older received a flu shot (64.5 percent) and/or pneumonia shot (55.8 percent); however, vaccination rates varied by race and ethnicity. Non-Hispanic White women were the most likely (67.9 percent) to have received a flu shot during the past year, whereas Hispanic women were the least likely (46.8 percent). The racial and ethnic disparities in the receipt of a pneumonia vaccination were even greater: the percent of non-Hispanic White women receiving a pneumonia shot (60.2 percent) was more than twice that of Hispanic women (29.8 percent).

¹ US Census Bureau. *American Community Survey Profile 2002. 2003.* <http://www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/Tabular/010/01000US1.htm>

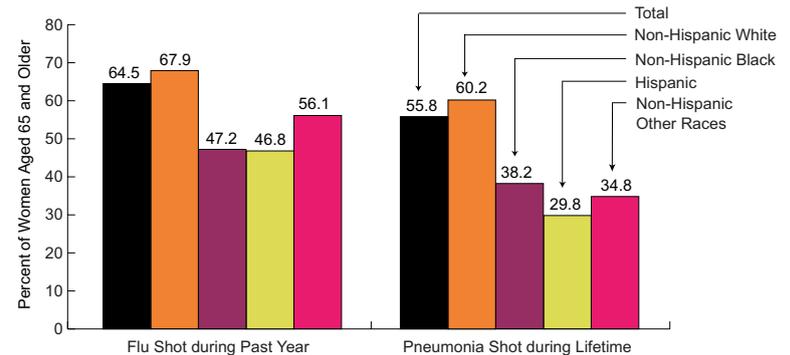
Types of Disability Among Non-Institutionalized Women Aged 65 and Older, 2001

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



Self-Report of Receipt of Vaccinations by Women Aged 65 and Older, by Race/Ethnicity, 2002

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



HEALTH SERVICES UTILIZATION

Availability and access to quality health services directly affects the health of women. For women with disabilities, poor health status, poverty, or lack of insurance, access to a range of health services, preventive treatments, and rehabilitation can be critical to preventing disease and promoting quality of life. The following section presents data on women's health services utilization, including indicators on insurance, usual source of care, health care financing and expenditures, medication use, and use of preventive, dental, hospital, and mental health services.



USUAL SOURCE OF CARE

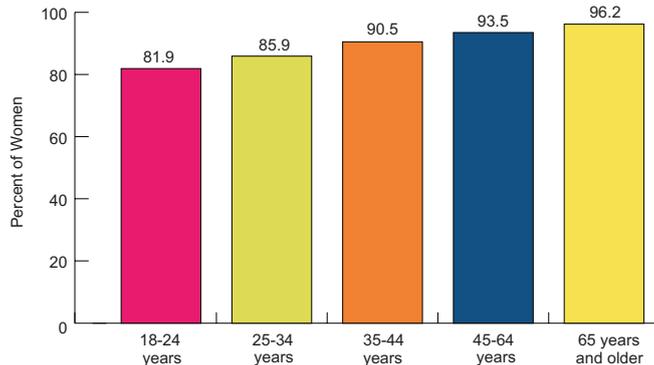
Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,^{1,2} to have access to care (as indicated by use of a physician or emergency room, or not delaying seeking care when needed),³ to receive continuous care, and to have lower rates of hospitalization and lower health care costs.⁴ In 2002, the percentage of women reporting a usual source of care rose with age, to a high of 96.2 percent among

women aged 65 and older. Usual sources of care varied among racial and ethnic groups, with Hispanic women the most likely to report having no usual source of care (20.9 percent), more than twice that reported by non-Hispanic White women. Non-Hispanic Black women were the most likely to report their usual source of care as hospital outpatient clinics (3.0 percent) and emergency departments (2.1 percent) compared to other racial and ethnic groups.

- 1 Eitner SL: *The relationship between continuity of care and the health behaviors of patients: Does a usual physician make a difference?* *Medical Care* 37(6): 547-55, 1999
- 2 Eitner SL: *The timing an preventive services for women and children: The effect of having a usual source of care.* *American Journal of Public Health* 86(12):1748-54, 1996
- 3 Sox CM, Swartz K, Burstin HR, Brennan TA: *Insurance or a regular physician: Which is the most powerful predictor of health care?* *American Journal of Public Health* 88(3):364-70, 1998
- 4 Weiss LJ, Blustein J: *Faithful patients: The effect of long-term physician-patient relationships on the cost and use of health care by older Americans.* *American Journal of Public Health* 86(12):1747-7, 1996

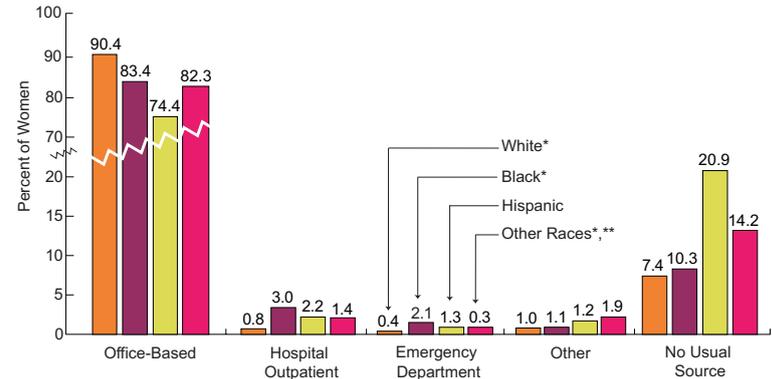
Women Aged 18 and Older with a Usual Source of Care, by Age, 2002

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



Usual Source of Care for Women Aged 18 and Older, by Race/Ethnicity, 2002

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



*Non-Hispanic

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

HEALTH INSURANCE

People who are uninsured are less likely than those with health insurance to seek preventive care, which can result in poor health outcomes and increased health care costs. In 2002, 43.5 million people in the U.S., just over 15 percent of the population, were uninsured. The percentage of people who are uninsured varies considerably across a number of categories including sex, age, race/ethnicity, income, and education. The percentage of females without insurance (13.9 percent) is slightly lower than

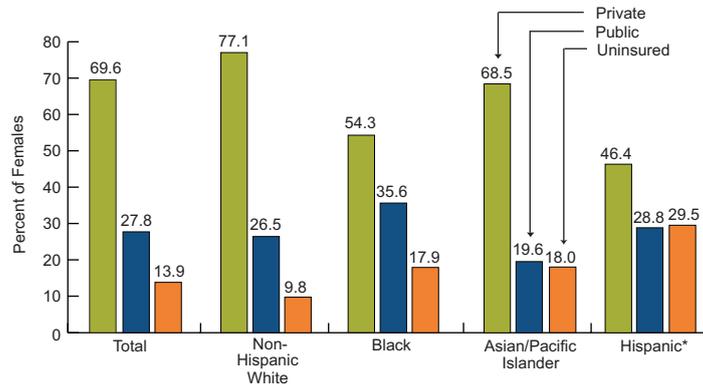
the percentage of males (16.7 percent). However, non-White women are considerably more likely than White women to lack health coverage: 9.8 percent of non-Hispanic White females are uninsured, compared to 17.9 percent of Black females, 18.0 percent of Asian/Pacific Islander females, and 29.5 percent of Hispanic females.

The percentage of people without insurance also varies greatly by age. Young adults of both sexes are the most likely to be uninsured: 29.6 percent of 18- to 24-year-olds lack health insurance, as do 24.9 percent of 25- to 34-year-olds.

In contrast, because of the Medicare program, fewer than 1 percent of women aged 65 years and older are uninsured. Rates of uninsurance decrease steadily as household income increases, ranging from a high of 23.5 percent for those with incomes below \$25,000 to a low of 8.2 percent for those with incomes of \$75,000 or more. Insurance rates rise with increasing levels of education as well, as 28 percent of those without a high school diploma are uninsured, compared to 8.4 percent of those with a bachelor's degree or higher.

Health Insurance Coverage of Females, by Type of Coverage and Race/Ethnicity, 2002**

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

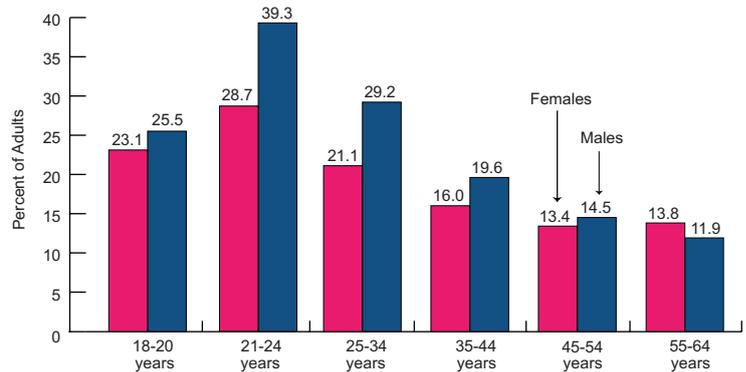


* May be of any race

**Individuals may receive coverage from more than one source.

Adults Aged 18 and Older without Health Insurance, by Age and Sex, 2002

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



QUALITY OF WOMEN'S HEALTH CARE

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

Indicators used to monitor women's health care in managed care plans include: the timeliness of prenatal care, receipt of postpartum checkups after delivery, screening for chlamydia,

screening for cervical cancer, and receipt of mammograms. The accessibility of most of these services is increasing.

Men and women fare approximately equally in the safety of their medical care, with a few exceptions. For example, men suffered from accidental lacerations or punctures during surgical procedures at a rate of 3.3 incidents per 1,000 discharges, while women had a rate of 4.2.¹

About 21 percent of both men and women

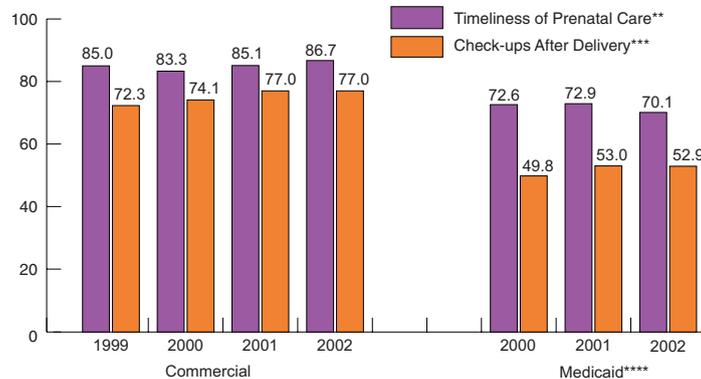
report that they are not satisfied with the quality of care they receive from their provider, but almost 32 percent of women, compared to 28 percent of men, report that their providers do not spend as much time with them as they would like.²

1 Source: Agency for Healthcare Research and Quality, *Healthcare Cost and Utilization Project State Inpatient Databases, 16-State database.*

2 Source: Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey.*

HEDIS* Measures of Perinatal Care, by Payer, 1999-2002

Source (III.2): National Committee for Quality Assurance



*Health plan Employer Data and Information Set

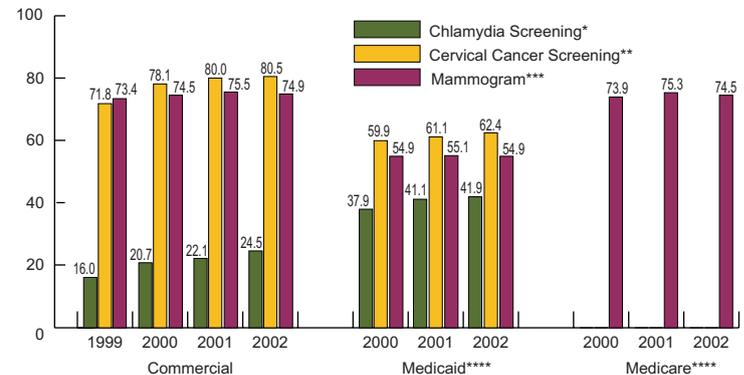
**The proportion of women beginning their prenatal care during their first trimester or within 43 days of enrollment if pregnant at enrollment.

***The proportion of women that had a visit to health care provider between 21 and 56 days after delivery.

****Data for Medicaid enrollees are not available for 1999.

HEDIS Screening Measures for Women, by Payer, 1999-2002

Source (III.2): National Committee for Quality Assurance



*The percentage of sexually active female plan members aged 21-26 who had at least one test for chlamydia during the year.

**The percentage of women aged 21-64 who had a Pap test during the year or the two prior years.

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

****Data on Medicaid and Medicare enrollees are not available for 1999.

MEDICARE AND MEDICAID

Medicare is the Nation's health insurance program for people aged 65 and older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The Medicare program comprises two parts: Part A, which covers hospital, skilled nursing, home health and hospice care, and Part B, which covers physician services, outpatient hospital services, and durable medical equipment. Among the preventive services covered by Medicare are an annual mammogram, Pap smear, bone density scan, and influenza vaccination.

In 2002, Medicare had over 40 million enrollees, of whom 57 percent were female. The large majority of all Medicare enrollees were aged 65 or older, with the elderly representing 89 percent of female enrollees and 82 percent of males.

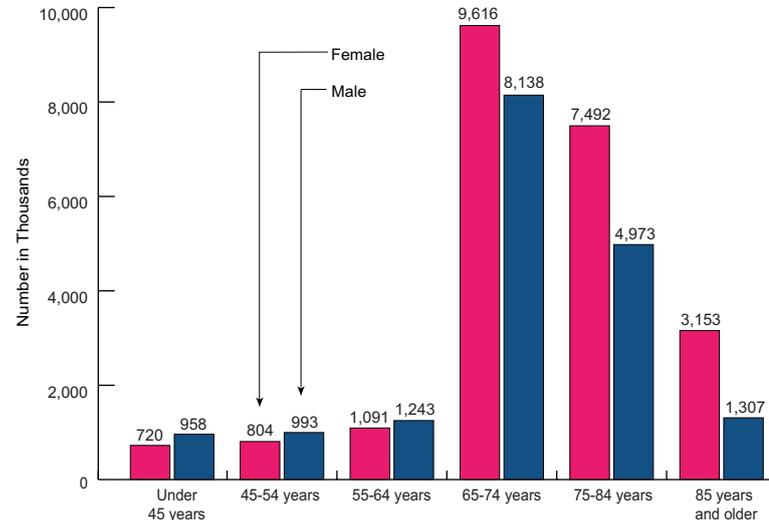
Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income individuals and people with disabilities. In 2000, Medicaid covered nearly 45 million individuals, including children; the aged, blind, and disabled; and people who are eligible for cash assistance programs. Sixty percent of Medicaid recipients were female. Fifty-five percent were under age 21, 34 percent

were between the ages of 21 and 64 years, and 11 percent were aged 65 years and older.¹

¹ U.S. Department of Health and Human Services. 2003 CMS Statistics. Center for Medicare and Medicaid Services, 2003.

Medicare Enrollees (All Ages), by Age and Sex, 2002

Source (III.3): Centers for Medicare and Medicaid Services



PREVENTIVE CARE

Through counseling, education, and screening, healthy behaviors may be promoted in order to prevent the occurrence or reduce the burden of many serious health conditions. In 2001, females made over 520 million physician office visits compared to 360 million made by males. Of visits made by females, 18.5 percent were for preventive care, including prenatal care, general medical examinations, well-baby examinations, and screenings. Various forms of

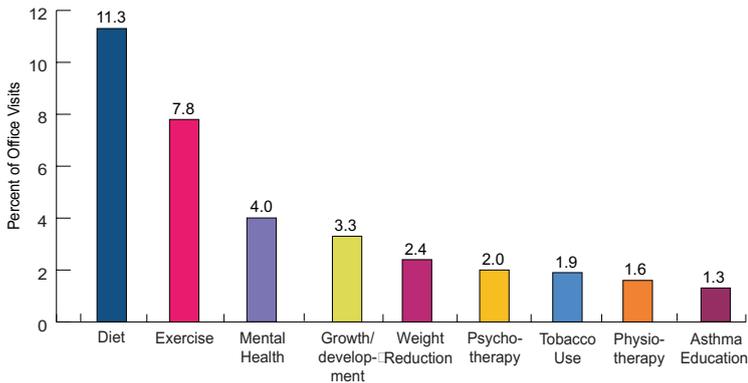
counseling and education occurred during office visits among females and were most commonly related to diet (11.3 percent), exercise (7.8 percent), mental health/stress management (4.0 percent) and/or growth and development (3.3 percent).

In 2003, the U.S. Preventive Task Force revised their recommendations for screening for cervical cancer; Pap smears should begin three years after the initiation of sexual activity, or at the age of 21, whichever comes first. The Task

Force also recommends that women aged 40 and older have a mammogram every 1 to 2 years to detect breast cancer. In 2001, of all office visits among females aged 18 and older, 7.1 percent included a Pap smear. Among office visits by women aged 40 or older, 5.0 percent included mammograms. Rates of Pap smears and mammograms during office visits were similar across racial and ethnic groups.

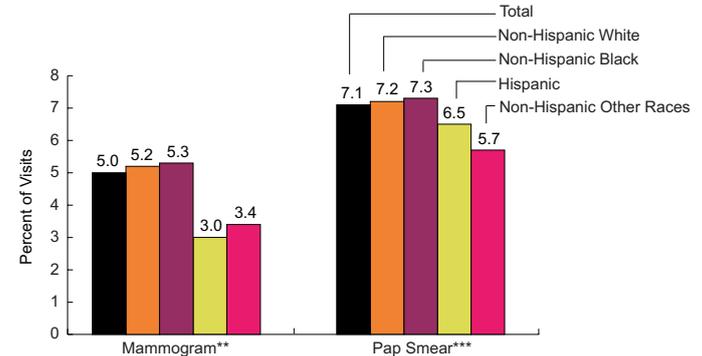
Counseling/Education Provided to Females (All Ages) During Office Visits, 2001

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



Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits by Race/Ethnicity, * 2001

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



*Rates are not age-adjusted.

**Among women aged 40 and older

***Among women aged 18 and older

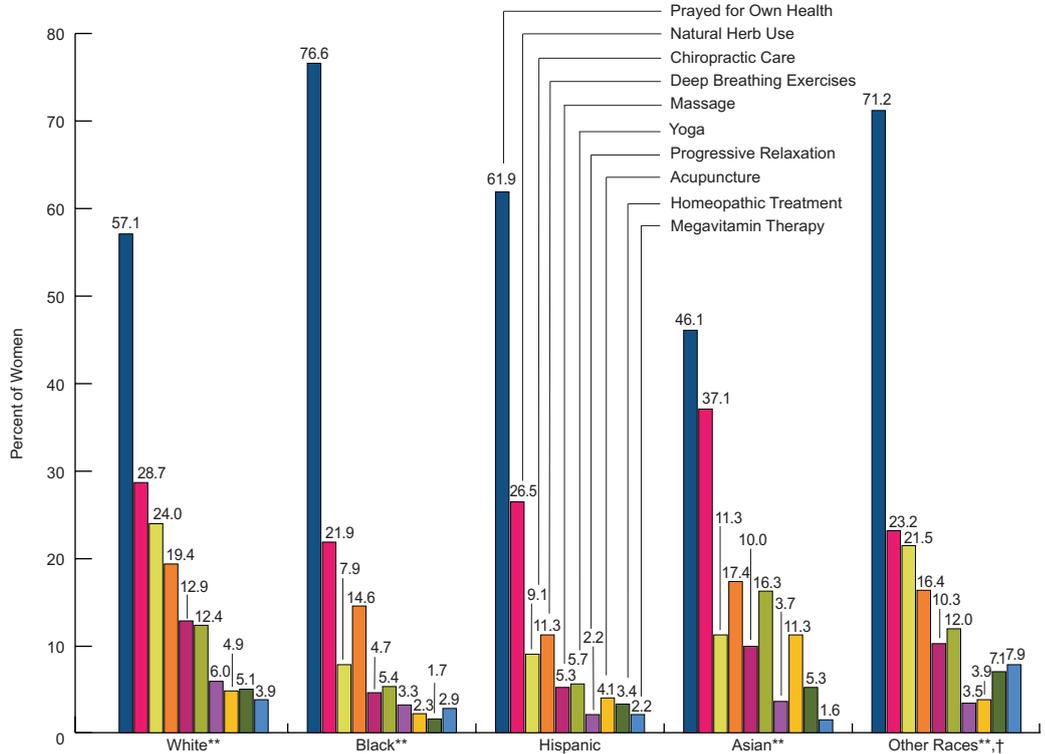
COMPLEMENTARY AND ALTERNATIVE MEDICINE USE

Complementary and alternative medicine (CAM) describes a range of health care practices, therapies, and products that are not considered to be part of conventional medicine. Consumers report using CAM for a variety of reasons, including health promotion, disease prevention, and treatment of specific conditions and illnesses.¹ In 2002, the CAM therapy most commonly reported by women was prayer for one's own health (59.7 percent). Women aged 45-64 years old were most likely to report natural herb use, chiropractic care, deep breathing exercises, massage, progressive relaxation, and acupuncture. Women aged 18-44 years were most likely to report having practiced yoga (12.4 percent).

The rates of CAM therapies used varied by race and ethnicity. Non-Hispanic Black women were most likely to report having ever prayed for their own health (76.6 percent). Asian women reported the highest rates of natural herb use (37.1 percent), yoga (16.3 percent), acupuncture (11.3 percent) and homeopathic treatments (5.3 percent). Non-Hispanic White women reported the highest rates of chiropractic care (24.0 percent), deep breathing exercises (19.4 percent), and massage (12.9 percent).

Complementary and Alternative Medicine Ever Used by Women Aged 18 and Older, by Race/Ethnicity,* 2002

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



* Percents are not age-adjusted.

**Non-Hispanic

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

1 Yu SM, Ghandour RM, Huang ZJ. Herbal Supplement Use Among US Women, 2000. *J Am Med Womens Assoc.* 2004;59(1):17-24.

HIV TESTING

Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives, because of newly available and effective treatments. Testing for HIV, the virus that causes AIDS, is an essential step before infected individuals can seek needed care, and is often offered through confidential and/or anonymous sources.

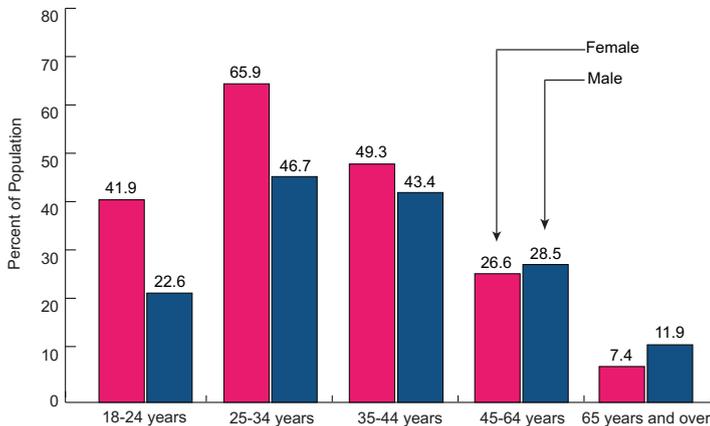
As of 2002, 68.2 million adults reported ever having been tested for HIV, including 30.1 million men and 38.1 million women. The highest percentage of persons that reported ever being tested was among women aged 25 to 34. A higher percentage of women under the age of 45 years reported having been tested than men. For 45- to 64-year-olds, similar rates of testing were reported among both men and women.

After age 65 years, the trend reversed, with more men reporting HIV testing than women.

Among women, non-Hispanic Black women had the highest rate of HIV testing (54.8 percent) followed by Hispanic women (43.2 percent), non-Hispanic women of other races (40.7 percent), and non-Hispanic White women (32.9 percent).

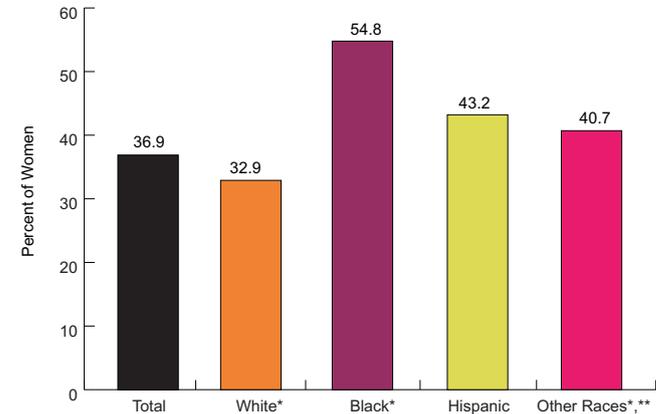
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2002

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



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity,* 2002

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



*Non-Hispanic

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

MEDICATION USE AND HORMONE THERAPY

In 2001, women were more likely than men to discuss medications at physician visits (150.9 and 146.7 mentions per 100 visits, respectively). Specifically, mentions of medication for female patients exceeded males for hormone therapy (19.6 compared to 11.2 mentions per 100 visits, respectively) and central nervous system drugs (14.8 and 10.3 mentions per 100 visits, respectively), which include sedatives, anti-anxiety drugs, and anti-depressants.

The use of medications also increases with age. Medications were mentioned in physician's offices 97.7 times per 100 visits among females aged 15-24 years, compared to 206.3 times per

100 visits among women aged 75 years and older. This pattern was seen for all medication types with the exception of respiratory tract drugs (26.1 mentions per 100 visits) and central nervous system drugs (17.0 mentions per 100 visits), which were most commonly mentioned during visits by younger women.

Hormone therapy is one category of drug for which the number of prescriptions has changed significantly in recent years. In July 2002, findings from two studies, the Heart and Estrogen/Progestin Replacement Study follow-up (HERS II) and the estrogen plus progestin trial of the Women's Health Initiative (WHI), were released which indicated that oral estrogen/progestin hormone therapy may adversely affect the health

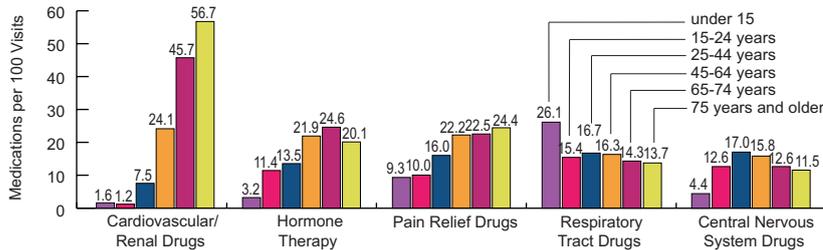
of postmenopausal women. The studies demonstrated that oral estrogen/progestin does not offer a cardiovascular disease benefit, as was previously believed. Instead, this hormone combination therapy slightly increased the risk of breast cancer and cardiovascular disease in postmenopausal women.¹

Researchers tracked hormone therapy prescriptions before and after the study results were released. Between 2002 and 2003, prescriptions fell 66 percent for oral estrogen and 33 percent for oral estrogen/progestin. The total number of hormone therapy prescriptions fell from a high of 91 million in 2001 to 56.9 million in 2003.

¹ Hersh AL, Stefanick ML, Stafford RS. National use of postmenopausal hormone therapy. *JAMA* 2004;291(1):47-53.

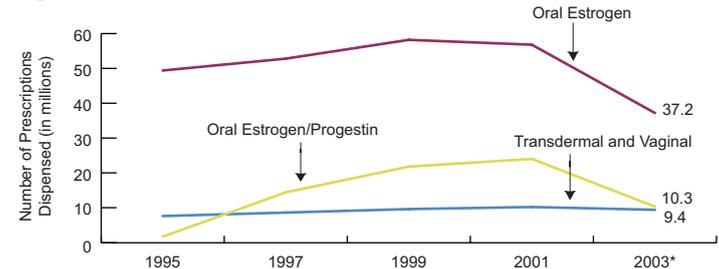
Medication Use Reported for Females During Physician Office Visits, by Age, 2001

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



Prescriptions for Hormone Therapy, by Year, 1995-2003

Source (III.6): IMS HEALTH, National Prescription Audit Plus, as published in Hersh et al., 2004



* 2003 includes annualized figures based on January through July 2003.

DENTAL CARE

Visiting a dentist regularly is important to achieving and maintaining good oral health. In 2002, although most women (64.8 percent) reported visiting the dentist within the past year, 12 percent had either never seen a dentist or had not seen one within the past 5 years. Frequency of dental visits also varied by race and ethnicity. Non-Hispanic Black women were

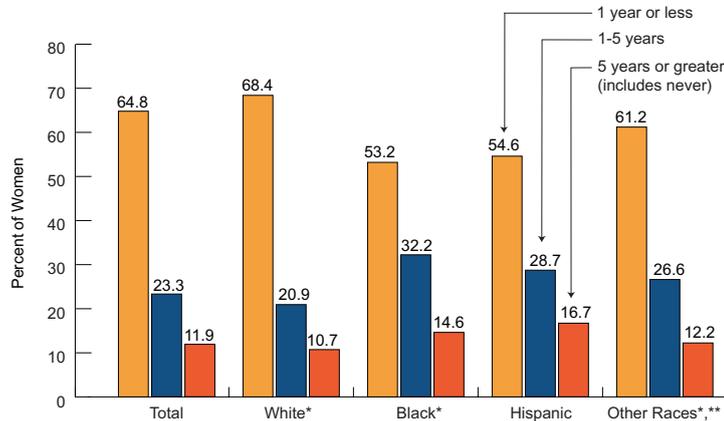
least likely to report having visited a dentist within the last year (53.2 percent), as compared to non-Hispanic white women (68.4 percent), Hispanic women (54.6 percent), and non-Hispanic women of other races (61.2 percent).

Income was associated with the length of time since last dental visit. The percentage of women below the Federal poverty level who reported not having visited a dentist within the past 5 years

(24.0 percent) was almost five times higher than women with incomes of 300 percent or more of the poverty level (5.1 percent). With increasing income, the percentage of women receiving dental care within the past year steadily increased from 44.0 percent among women with incomes below 100 percent of the Federal poverty level to 77.4 percent among women with incomes of 300 percent of the Federal poverty level or more.

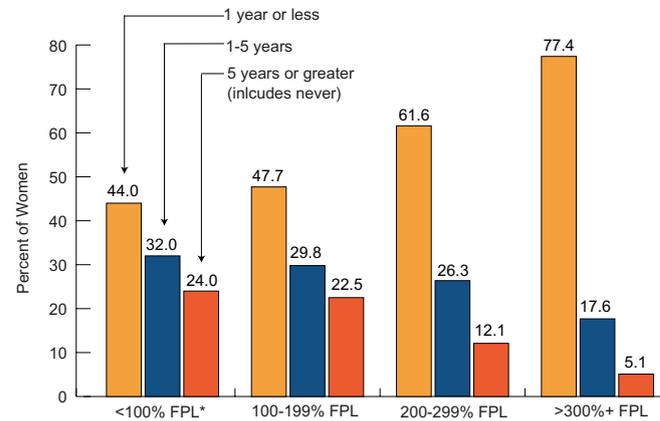
Report by Women Aged 18 and Older of Time Since Last Seen or Talked to a Dentist, by Race/Ethnicity,*** 2002

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



Report by Women Aged 18 and Older of Time Since Last Seen or Talked to a Dentist, by Poverty Status,** 2002

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



*Non-Hispanic

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

***Percents reported are not age-adjusted.

*FPL is the Federal Poverty Level.

**Percents reported are not age-adjusted.

HOSPITALIZATIONS

Females represented 60.6 percent of the nearly 32.7 million short-stay hospital discharges in 2001. Of all female discharges, 38.2 percent occurred among women aged 15-44 years, due in part to hospitalizations for childbirth. Nearly one-fifth of female discharges were for childbirth, and one-quarter of all procedures performed on females were obstetrical in nature. Other diagnoses common among females were diseases of

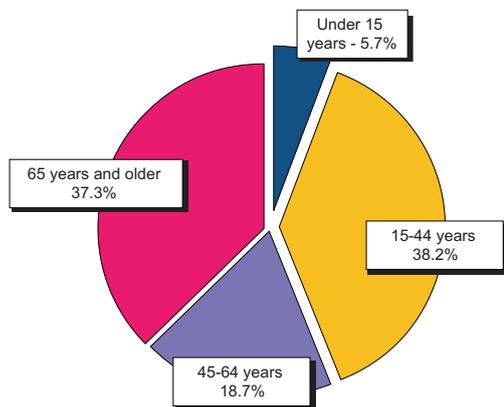
the circulatory system (16 percent of female discharges), and diseases of the respiratory system (9 percent of female discharges).

Overall, females had a much higher hospital discharge rate than males (1,367.3 versus 925.9 per 10,000 population). Differences existed between males and females in the discharge rate for every category of primary diagnosis. Women had a much higher rate of discharges with the primary diagnosis of genitourinary

system diseases, such as kidney diseases (85.8 versus 39.4 per 10,000 population), and neoplasms (71.1 versus 44.2 per 10,000 population). The only primary diagnoses for which men had a higher discharge rate were diseases of the circulatory system (220.3 versus 218.8 per 10,000 population) and mental disorders (86.8 versus 79.7 per 10,000 population).

Discharges from Non-Federal Short-Stay Hospitals for Females (All Ages), by Age, 2001*

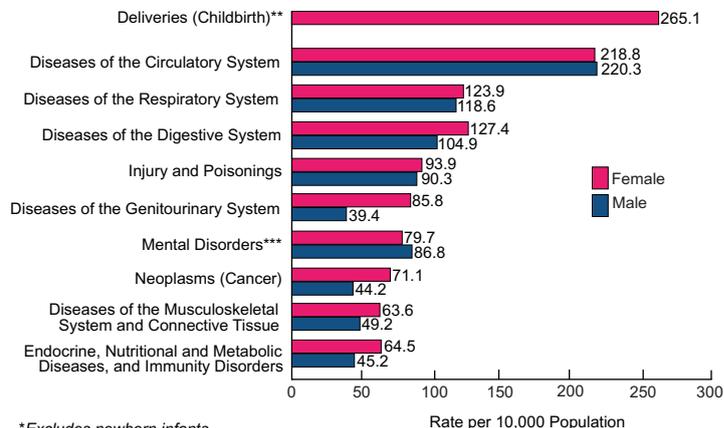
Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Primary Diagnosis (All Ages),* 2001

Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants

**Not applicable to males

***Includes alcohol and drug dependence syndrome

ORGAN DONATION

During 2003, there were more than 24,000 organ transplants in the U.S., but more than 80,000 people were waiting for organs. Females make up 38.5 percent of those receiving transplants and 42.5 percent of those on the waiting list. Racial and ethnic minorities are disproportionately represented among women waiting for an organ: 28.3 percent of women on waiting lists are non-Hispanic Blacks and 15.0 percent are Hispanics. A large disparity exists between the number of organ donors and the number on the waiting list for an organ. The gender distribution among organ donors was fairly even,

with males representing 50.7 percent and females representing 49.3 percent of donors, although women are more likely to be living donors (58.4 percent) compared to men (41.6 percent).

The kidney was the organ in highest demand, with a total of 55,079 individuals awaiting a kidney. Of these, 23,384 were female and 31,695 were male. The number of females on the waiting list for a kidney was nearly four times higher than the numbers of female kidney donors (6,047). Typically, female transplant candidates are able to receive organ donations from either males or females. Only in the case of heart, lung, and liver transplants is the size of

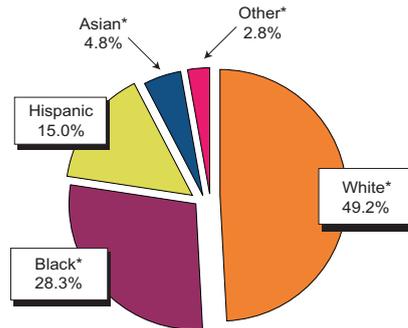
the organ a consideration. In the case of these organs, a female transplant patient is better suited to receive an organ from another female.

Obtaining consent for organ donation has been challenging. Some of the reasons consent rates vary include religious beliefs, poor communication between grieving families and health care providers, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased. Ethnicity may also affect willingness to consent to donation.¹

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

Distribution of Females on Organ Waiting List, by Race/Ethnicity, 2002

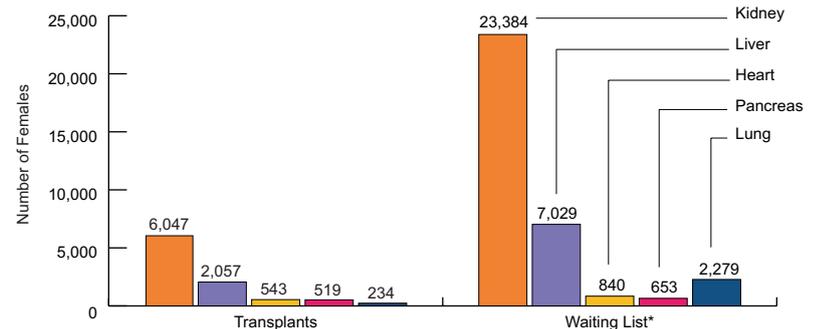
Source: (III.8) Organ Procurement and Transplantation Network



* Non-Hispanic

Female Organ Donors and Females on Waiting List by Organ (All Ages), 2002

Source: (III.8): Organ Procurement and Transplantation Network



* As of February 27, 2004

MENTAL HEALTH CARE UTILIZATION

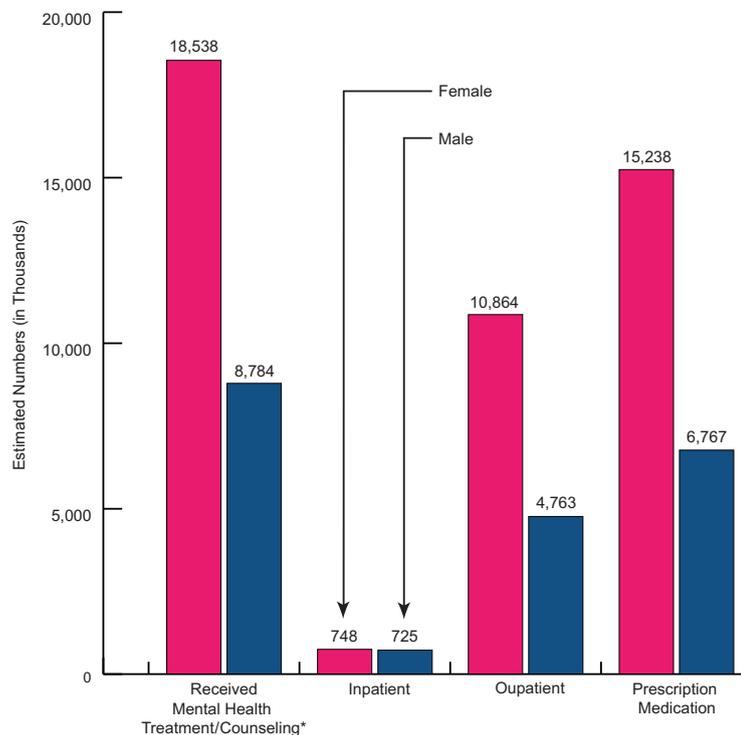
In 2002, an estimated 27.3 million U.S. adults reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services. The most common type of treatment among adults aged 18 years and older was prescription medication, followed by outpatient treatment. Over 15 million women and 6.7 million men used prescription medication for treatment of a mental or emotional condition. Inpatient treatment was the least utilized treatment by adults aged 18 years and older, and was used by both men and women in approximately equal numbers. However, it should be noted that if inpatient treatment for alcohol and drug abuse were included here, men would far outnumber women.

Mental health services are needed, but not received, by millions of adults in the U.S. Among adults with serious mental illness in 2002, 30.5 percent reported an unmet need for treatment or counseling for problems with emotions, nerves, or mental health. Cost was the reason most often cited for not receiving needed mental health treatment.¹

¹ SAMHSA. (2003). *Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774)*. Rockville, MD.

Adults Aged 18 and Older Receiving Mental Health Care Treatment, by Sex and Treatment/Counseling Type, * 2002

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



*Excluding treatment for alcohol or drug use.

WOMEN IN NIH-FUNDED CLINICAL RESEARCH

Of the approximately nine million human subjects in clinical research funded by the National Institutes of Health (NIH) in Fiscal Year 2001, about two-thirds were women. Women also constituted about two-thirds of Phase III clinical research participants. Phase III clinical investigations usually involve several hundred or more human subjects for the purpose of evaluating an experimental intervention

in comparison with a standard or control intervention or comparing two or more existing treatments. When sex-specific studies are excluded, the proportions of women and men participating in NIH funded clinical studies were more closely representative of the general population: 44.4 percent women and 55.2 percent men.¹ When assessing inclusion data, enrollment figures should not be directly compared to the national census figures.

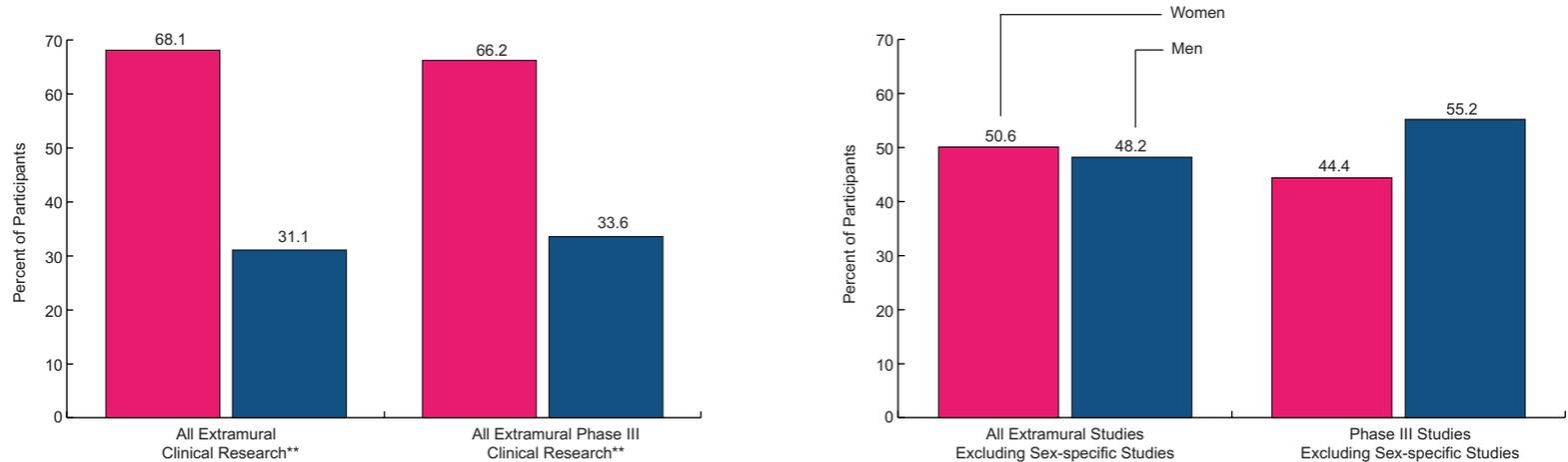
The numbers of women and/or minorities

included in a particular study depends upon the scientific question addressed in that specific study and the prevalence among women, men and minority populations of the disease, disorder, or condition under investigation. Therefore, these data should not be compared to the census figures for the general population.

¹ Department of Health and Human Services, National Institutes of Health. 2003. *Comprehensive Report: Tracking of Human Subjects Research Funded in Fiscal Year 2000 (Reported in FY 2000) and Fiscal Year 2001 (Reported in FY 2002).*

Participants in NIH-Funded Extramural Research Protocols, by Sex,* 2001

Source (III.9): National Institutes of Health



*Excludes <1% of subjects who did not identify sex.

** Including male-only, female-only, and mixed-sex studies.

HEALTH CARE EXPENDITURES

In 2000, the majority of both women's and men's health care expenses were covered by public or private insurance. For women, approximately one-third of expenses were covered by either Medicare or Medicaid, while just over 40 percent of expenses were covered by private insurance. Although the percent of expenditures paid by private insurance were

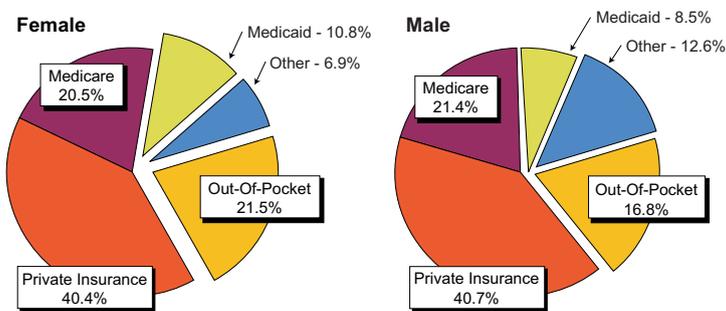
approximately equal for women and men, women's health care costs were more likely than men's to be paid by Medicaid or out of pocket.

Among those who had a health care expenditure in 2000, the average per-person expenditure for females was higher than for males (\$2,757 compared to \$2,633). This gap has narrowed since 1998, as the average expenditure for males increased more steeply than the average for females. This increase was particularly evident in

hospital inpatient services, for which men's average expenses increased by \$3,750 while women's decreased by \$1,715. However, women's average health care expenses continue to exceed those for men in several categories, including home health services, office-based medical provider services, prescription medications, and dental services.

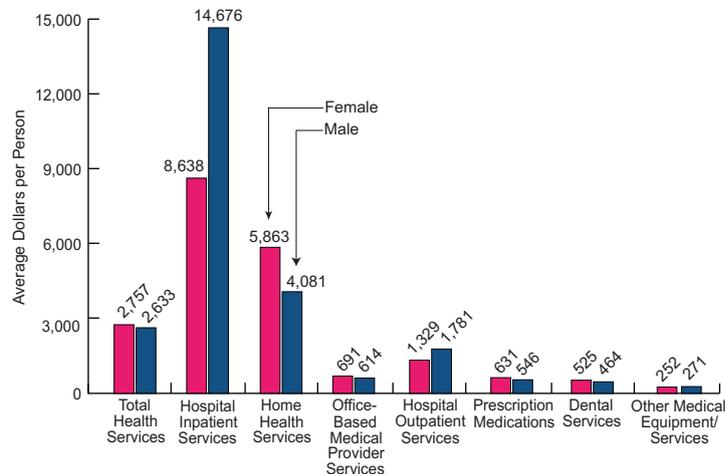
Health Care Expenses, by Source of Payment and Sex (All Ages), 2000

Source (III.10): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 2000

Source (III.10): Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



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 information on the following indicators, please refer to previous editions of *Women's Health USA*, which are available online at <http://www.hrsa.gov/womenshealth>.

Women's Health USA 2002

Household Composition
Life Expectancy
Lupus
Non-Medical Use of Prescription Drugs
Nursing Home Care Utilization
Unintended Pregnancies
US Population Growth
Women as Caregivers

Women's Health USA 2003

Autoimmune Diseases
Bleeding Disorders
Home Health and Hospice Care
HRSA's Populations and Programs
Nutrition
Title V Abstinence Education Programs
Title X Family Planning Services
Vitamin and Mineral Supplement Use

REFERENCES

I. Population Characteristics

- (I.1) U.S. Census Bureau. Current Population Survey, March 2002, Special Populations Branch, Population Division.
- (I.2) U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System, “Completions Survey” (IPEDS-C), various years, and Earned Degrees Conferred Model. <http://nces.ed.gov/programs/projections/>.
- (I.3) Association of American Medical Colleges. AAMC Data Warehouse: Applicant Matriculant File. <http://www.aamc.org/members/wim/statistics/stats03/start.htm>; American Association of Colleges of Osteopathic Medicine. 2002 Annual Report on Osteopathic Medical Education, June 2003; American Association of Colleges of Podiatric Medicine. Unpublished data; American Dental Association. Survey Center, 2001/02 Survey of Predoctoral Dental Education; Association of Schools and Colleges of Optometry. Annual Student Survey, 2001-2002; American Association of Colleges of Pharmacy. Profile of Pharmacy Students Fall 2001; Association of Schools of Public Health. 2001 Annual Data Report; American Association of Colleges of Nursing. 2001-2002 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing; Commission on Accreditation of Dietetics Education. Unpublished data; Council on Social Work Education. Unpublished data.
- (I.4) U.S. Census Bureau. American FactFinder. Tables P067, P111.
- (I.5) U.S. Department of Agriculture. Characteristics of Food Stamp Households: Fiscal Year 2002. Advance Report, July 2003.
- (I.6) U.S. Department of Agriculture. Women, Infants, and Children. Program Data, Monthly Data — National Level, FY 2001 through September 2003. <http://www.fns.usda.gov/pd/wichome.htm>.
- (I.7) Administration for Children and Families, Office of Family Assistance. Characteristics and financial circumstances of TANF recipients. Table 21. <http://www.acf.hhs.gov/programs/ofa/character/FY2001/1021.htm>.
- (I.8) Administration for Children and Families, Office of Family Assistance. Temporary Assistance to Needy Families: Fifth Annual Report to Congress. February 2003. <http://www.acf.hhs.gov/programs/ofa/annualreport5/index.htm>.
- (I.9) U.S. Census Bureau. Current Population Survey, 2003 Annual Social and Economic Supplement. <http://ferret.bls.census.gov>.

II. Health Status

- (II.1) National Center for Health Statistics. National Health Interview Survey, 2002. Analysis Conducted by the Maternal and Child Health Information Resource Center.
- (II.2) SAMHSA. Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD.
- (II.3) SAMHSA. National Survey on Drug Use and Health, 2002.
- (II.4) Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2002, Volume 14. <http://www.cdc.gov/hiv/stats/haslink.htm>.
- (II.5) American Cancer Society. Cancer Facts and Figures 2004. Leading Sites of New Cancer Cases and Deaths. 2004 Estimates. http://www.cancer.org/downloads/STT/CAFF_finalPWSecured.pdf.
- (II.6) Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 11 Regs Public-Use, National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2003, based on the November 2002 submission.
- (II.7) Striegel-Moore RH, Dohm FA, Kraemer HC, Taylor CB, Daniels S, Crawford PB, Schreiber GB. Eating disorders in White and Black women. *American Journal of Psychiatry* 2003 Jul;160(7):1326-31.
- (II.8) McCaig LF and Burt CW. National Hospital Ambulatory Medical Care Survey: 2001 Emergency Department Summary. National Center for Health Statistics, Advance Data from Vital and Health Statistics, No. 335, June 2003. <http://www.cdc.gov/nchs/data/ad/ad335.pdf>.
- (II.9) Anderson RN and Smith BL. Deaths: Leading Causes for 2001. National Vital Statistics Report, Vol. 52, No. 9. Hyattsville, Maryland: National Center for Health Statistics. November 2003.
- (II.10) SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse. Table 6.2B.
- (II.11) National Center for Health Statistics. Health, United States, 2003. Hyattsville, Maryland: 2003.
- (II.12) National Center for Health Statistics. National Health and Nutrition Examination Survey (NHANES), 1999-2000. Analysis conducted by the Maternal and Child Health Information Resource Center.
- (II.13) National Center for Health Statistics, Centers for Disease Control and Prevention. National Health and Nutrition Examination Survey (NHANES) 1999-2000. <http://www.cdc.gov/nchs/data/nhanes/gendoc.pdf>.
- (II.14) National Osteoporosis Foundation. America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation. February 2002.
- (II.15) Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2002. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, September 2003.

- (II.16) U.S. Department of Justice, Bureau of Justice Statistics. Criminal Victimization in the United States, 2002. Analysis conducted by the Maternal and Child Health Information Resource Center.
- (II.17) U.S. Department of Justice, Bureau of Justice Statistics. Criminal Victimization in the United States, 2002. Statistical Tables.
- (II.18) Martín JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. National Vital Statistics Reports, Vol. 52, No. 10. Hyattsville, Maryland: National Center for Health Statistics. December 2003; National Center for Health Statistics. Final natality statistics for each data year 1970-1996. Monthly Vital Statistics Report. Hyattsville, Maryland.
- (II.19) Martín JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. National Vital Statistics Reports, Vol. 52, No. 10. Hyattsville, Maryland: National Center for Health Statistics. December 2003.
- (II.20) Abbott Laboratories, Ross Products Division. Mother's Survey, 1999 and 2003.
- (II.21) Arias E, Anderson RN, Kung HC, Murphy SL, Kochanek KD. National Vital Statistics Reports, Vol. 52, No. 3. Hyattsville, Maryland: National Center for Health Statistics. September 2003.
- (II.22) Health Resources and Services Administration (2004). Area Resource File, 2003. Analysis conducted by the Maternal and Child Health Information Resource Center.
- (II.23) Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: Final Data for 2000. National Vital Statistics Report, Vol. 50, No. 15. Hyattsville, Maryland: National Center for Health Statistics. 2002; United States-Mexico Border Health Commission. Healthy Border 2010: An Agenda for Improving Health on the United States-Mexico Border. October 2003. <http://www.borderhealth.org>; National Center for Health Statistics, unpublished data.
- (II.24) U.S. Department of Justice, Bureau of Justice Statistics. Sourcebook of Criminal Justice Statistics, 2002. <http://www.albany.edu/sourcebook/>.
- (II.25) Ditton PM. Mental Health and Treatment of Inmates and Probationers. U.S. Department of Justice, Bureau of Justice Special Report, July 1999. <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>.
- (II.26) Smith AC and Smith DL. Emergency and Transitional Shelter Population: 2000. US Census Bureau, Census Special Reports, Series CENSR/01-2, US Government Printing Office, Washington, DC, 2001.
- (II.27) Bureau of Primary Health Care, Universal Data System. Table 3A: Users by Age and Gender.
- (II.28) Centers for Disease Control and Prevention. Diabetes prevalence among American Indians and Alaska Natives and the Overall Population-United States, 1994-2002. MMWR 2003 Aug; 52(30):702-704.
- (II.29) U.S. Census Bureau. American Community Survey, 2001 Supplementary Survey, table PCT037.

III. Health Services Utilization

- (III.1) Fronstin P. Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey. Employee Benefit Research Institute, Brief No. 264, December 2003.
- (III.2) National Committee for Quality Assurance. The State of Health Care Quality 2003. Washington, DC: NCQA, 2003.
- (III.3) Centers for Medicare and Medicaid Services. Unpublished data.
- (III.4) Cherry DK, Burt CW, Woodwell DA. National Ambulatory Medical Care Survey: 2001 Summary. Advance Data from Vital and Health Statistics, No. 337, August 2003. <http://www.cdc.gov/nchs/data/ad/ad337.pdf>.
- (III.5) National Center for Health Statistics. National Ambulatory Medical Care Survey, 2001. Analysis conducted by the Maternal and Child Health Resource Center.
- (III.6) Hersh AL, Stefanick ML, Stafford RS. National use of postmenopausal hormone therapy; Annual trends and response to recent evidence. JAMA 2004 Jan; 291(1).
- (III.7) Hall MJ, DeFrances CJ. 2001 National Hospital Discharge Survey. Advance Data from Vital Health and Statistics, No. 332, April 2003.
- (III.8) 2003 Annual Report of the U.S. Scientific Registry of Transplant Recipients and the Organ Procurement and Transplantation Network: Transplant Data 2002. Rockville, MD and Richmond, VA.
- (III.9) Department of Health and Human Services, National Institutes of Health. Comprehensive Report: Tracking of Human Subjects Research Funded in Fiscal Year 2000 (Reported in FY 2000) and Fiscal Year 2001 (Reported in FY 2002). 2003.
- (III.10) Agency for Healthcare Research and Quality. 2000 Medical Expenditure Panel Survey - Table Compendium. AHRQ, Rockville, MD, August 2003. http://www.meps.ahrq.gov/CompendiumTables/TC_TOC.HTM.

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

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