





Women's Health USA 2009

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PREFACE AND READER'S GUIDE

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

HRSA is pleased to present *Women's Health USA 2009*, the eighth edition of the *Women's Health USA* data book. To reflect the ever-changing, increasingly diverse population and its characteristics, *Women's Health USA* selectively highlights emerging issues and trends in women's health. Data and information on women veterans, bleeding disorders, hearing problems, and severe headaches and migraines are a few of the new topics included in this edition. There is also a new section providing State-specific data on leading causes of death, overweight and

obesity, and smoking among women. A special supplement on women's health along the U.S.–Mexico border is also new this year and covers a range of topics including population characteristics, health insurance coverage, and reproductive health.

Racial and ethnic, sex, and socioeconomic disparities are highlighted throughout the document where possible. Where race and ethnicity data are reported, every effort was made to ensure that groups are mutually exclusive. In some instances, it was not possible to provide data for all races due to the design of the original data source or the size of the sample population; therefore, data with a relative standard error of 30 percent or greater were considered unreliable and were not reported. For estimates relying on the 2005–2006 National Health and Nutrition Examination Survey, data presented for the Hispanic population should be interpreted with caution. Due to the sampling design of the survey, the data may not be representative of the entire U.S. Hispanic population.

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 2009* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal government, including the U.S. Department of Health and Human Services, U.S. Department of Agriculture, U.S. Department of Labor, and U.S. Department of Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past 5 years. It is important to note that the data included are generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races and ethnicities. Without age adjustment, it is difficult to know how much of the difference in incidence rates between groups can be attributed to differences in the groups' age distributions.

Women's Health USA 2009 is available online through the HRSA Maternal and Child Health Bureau (MCHB), Office of Women's Health Web site at http://hrsa.gov/womenshealth or the MCHB Office of Data and Program Development's Web site at www.mchb.hrsa.gov/data. Some of the topics covered in *Women's Health USA 2008* were not included in this year's edition because either new data were not available or because preference was given to an emerging issue in women's health. For coverage of these issues, please refer to *Women's Health USA 2008*, also available online. The National Women's Health Information Center, located online at www.womenshealth.gov, has detailed women's and minority health data and maps. These data are available through Quick Health Data Online at www.4woman.gov/quickhealthdata. Data are available at the State and county levels, by age, race and ethnicity, and sex.

 Please provide any feedback on this publication to the HRSA Information Center which offers single copies of the data book at no charge:

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INTRODUCTION

In 2007, women represented 50.7 percent of the 302 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people aged 65 years and older; within this age group, women represented 58 percent of the population. The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. Black and Hispanic women accounted for 8.9 and 6.5 percent of the female population aged 65 years and older, respectively, but they represented 14.6 and 21.5 percent of females under 15 years of age. Non-Hispanic Whites accounted for 80.2 percent of women aged 65 years and older, but only 55.9 percent of those under 15 years of age.

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in health status and the use of health care services. In 2007, 62.1 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 53.1 percent of Hispanic women and 51.0 percent of non-Hispanic Black women. Minority women are disproportionately affected by a number of diseases and health conditions, including HIV/AIDS, sexually transmitted infections, diabetes, and asthma. For instance, in 2006, HIV incidence was highest among Black (55.7 per 100,000 females) and Hispanic females (14.4 per 100,000 females). One-third of non-Hispanic White women had ever been tested for HIV, compared to 55.5 percent of non-Hispanic Black women and 48.8 percent of Hispanic women.

Hypertension, or high blood pressure, was also more prevalent among non-Hispanic Black women than women of other races. In 2005–2006, this condition occurred at a rate of 199.2 per 1,000 non-Hispanic Black women,

compared with 163.0 per 1,000 non-Hispanic White women and 117.0 per 1,000 Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and is especially prevalent among minority populations. Among women with any disability or condition limiting their activity, 11.4 percent cited diabetes as the cause of the activity limitation. In 2007, non-Hispanic Black women and Hispanic women were much more likely to suffer limitations due to diabetes (20.6 and 18.0 percent of women with any activity limitation) than non-Hispanic White women (8.9 percent).

Some conditions, such as arthritis and heart disease, disproportionately affect non-Hispanic White women. For instance, in 2007, more than 27 percent of non-Hispanic White women had arthritis, compared to 22.2 percent of non-Hispanic Black women and 15.4 percent of Hispanic women.

In addition to race and ethnicity, income and education are important factors that contribute to women's health and access to health care. Regardless of family structure, women are more likely than men to live in poverty. Poverty rates were highest among women who were heads of their households (24.9 percent). Poverty rates were also highest among non-Hispanic American Indian/Alaska Native women (23.4 percent), followed by non-Hispanic Black and Hispanic women (23.3 and 20.8 percent, respectively). Non-Hispanic Black and Hispanic women were also more likely to be heads of households than their non-Hispanic White and non-Hispanic Asian counterparts.

Some conditions and health risks are more closely linked to family income than to race and ethnicity, such as asthma. Rates of asthma decline as income increases and women with higher incomes are more likely to effectively manage their asthma. Among women with asthma whose incomes were below 100 percent of poverty, 32.4 percent had an asthma-related emergency room visit in the past year, compared to 14.5 percent of women with family incomes of 300 percent or more of poverty.

Mental health is another important aspect of women's overall health. A range of mental health problems including depression, anxiety, phobias, and post-traumatic stress disorder, disproportionately affect women. Women with lower incomes were significantly more likely than those with higher incomes to report frequent depression and anxiety in 2007.

Severe headaches and migraines were also more common among women than men, and were more common among women with lower family incomes. In 2007, nearly one-quarter of women with family incomes below 100 percent of poverty experienced severe headaches or migraines, compared to 14.8 percent of women with incomes of 400 percent or more of poverty.

Physical disabilities are more prevalent among women as well. Disability can be defined as impairment of the ability to perform common activities like walking up stairs, sitting or standing for 2 hours or more, grasping small objects, or carrying items like groceries. Therefore, the terms "activity limitations" and "disabilities" are used interchangeably throughout this book. Overall, 15.6 percent of women and 13.0 percent of men reported having activity limitations in 2007.

Men, however, bear a disproportionate burden of some health conditions, such as HIV/AIDS, hypertension, and heart disease. In 2006, for instance, the rate of newly reported HIV cases for adolescent and adult males was more than 3 times the rate for females (34.3 versus 11.9 per 100,000, respectively). Despite the greater risk, though, a smaller proportion of men had ever been tested for HIV than women (34.3 versus 38.8 percent, respectively).

Certain health risks, such as cigarette use, illicit drug use, and injury, occur more commonly among men than women. In 2007, 22.3 percent of men smoked cigarettes, compared to

17.4 percent of women. Among men, 28.1 percent of emergency department visits were injury-related, while only 20.4 percent of women's visits were due to injury. In addition, men were more likely than women to lack health insurance.

Many diseases and health conditions, such as those mentioned above, can be avoided or minimized through good nutrition, regular physical activity, and preventive health care. In 2006, 21.5 percent of women's visits to physicians were for preventive care, including prenatal care, preventive screenings, and immunizations. In 2007, 66.3 percent women aged 65 years and older reported receiving a flu shot; however, this percentage ranged from 54.0 percent of Hispanic women to 68.4 percent of non-Hispanic White women.

In addition to preventive health care, preventive dental care is also important to prevent dental caries and gum disease. In 2006, 65.7 percent of women reported receiving annual dental checkups; however, this was more common among women in metropolitan areas than in non-metropolitan areas (67.3 versus 57.7 percent, respectively).

There are many ways women (and men) can promote health and help prevent disease and disability. Regular physical activity is one of these. In 2007, 10.0 percent of women participated in at least 30 minutes of moderate-intensity physical activity on most days of the week or 20 minutes of vigorous-intensity activity on 3 or more days per week. Non-Hispanic White women and women with higher incomes were most likely to meet this level of physical activity.

Healthy eating habits can also be a major contributor to long-term health and prevention of chronic disease. In 2005–2006, however, more than half of all women had diets that included more than the recommended amount of saturated fat and sodium and less than the recommended amount of folate and calcium. Overall, 63.0 percent of women exceeded the maximum recommended daily intake of saturated fat, and 68.0 percent exceeded the maximum recommended amount of sodium.

While some behaviors have a positive effect on health, a number of others, such as smoking, illicit drug use, and excessive alcohol use can have a negative effect. In 2007, 39.6 percent of women reported any alcohol use in the past year, but of those women, relatively few (13.4 percent) reported moderate drinking (more than three, up to seven drinks per week) and even fewer (7.7 percent) reported heavy drinking (more than seven drinks per week). In the same year, 12.6 percent of women used illicit drugs, including marijuana, cocaine, hallucinogens, inhalants, and prescription-type drugs for non-medical purposes.

Cigarette, alcohol, and illicit drug use is particularly harmful during pregnancy. The use of tobacco during pregnancy has declined steadily since 1989. Based on data from 32 States and 2 reporting areas, 9.9 percent of pregnant women reported smoking during pregnancy in 2006. This rate was highest among non-Hispanic American Indian/Alaska Native women (16.9 percent) and lowest among non-Hispanic Asian/Pacific Islander women (2.0 percent).

Women's Health USA 2009 can be an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women throughout the United States.