Women's Health USA 2013

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PREFACE AND READER'S GUIDE

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

HRSA is pleased to present *Women's Health USA 2013*, the twelfth edition of the Women's Health USA data book. The data book serves as a concise, easy-to-use reference for policymakers and program managers at the Federal, State, and local levels to identify and better address critical health challenges facing women, their families, and their communities. Data are included on a variety of population health determinants, health behaviors, health status, and health care utilization practices of women throughout the United States, bringing together the latest available information from various agencies within the Federal government, including the U.S. Departments of Health and Human Services, Agriculture, Commerce, Education, Labor, and Veterans Affairs. 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 chronic obstructive pulmonary disease (COPD), fast

food and sugar-sweetened beverage consumption, patient-centered care, and prediabetes are among the new indicators included in this edition. New special population pages also feature data on the characteristics and health of women served by community health centers, immigrant women, and lesbian and bisexual women.

Women's Health USA 2013 is a valuable 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. Disparities by sex, race and ethnicity, and socioeconomic factors, including education and income, are highlighted throughout the databook. Where race and ethnicity data are reported, groups are mutually exclusive (i.e., non-Hispanic race groups and the Hispanic ethnic group) except in a few cases where the original data do not present the groups separately. Throughout the data book, those categorized as being of Hispanic ethnicity may be of any race or combination of races. In some instances, it was not possible to provide data for all races due to the design of the original data source or the size of the sample population; therefore, estimates with a numerator of less than 20 or a relative standard error of 30 percent or greater were considered unreliable and were not reported. Where possible, comparisons across groups are age-adjusted to the 2000 standard of the United States, which helps illuminate differences between groups in the prevalence or incidence of a condition that are not simply a function of differences in the groups' age distributions. In general, only statistically significant differences are commented on; however, not all significant differences are discussed.

Women's Health USA 2013 and previous editions are available online. In each new edition, some indicators are replaced by new health topics or population features. For information on topics or populations covered in previous editions, please refer to the *Women's Health USA* website (mchb.hrsa.gov/publications/womenshealthusa). In 2013, many maternal health indicators are included in a special perinatal edition of *Child Health USA 2013*, also available online (mchb.hrsa.gov/chusa13). In addition, the U.S. Department of Health and Human Services' Office on Women's Health offers detailed State and county level health data by sex, race and ethnicity, and age available through Quick Health Data Online (www.healthstatus2020.com/).

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POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of the Nation's population. There were more than 158 million females in the United States in 2011, representing slightly more than half of the population.

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

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

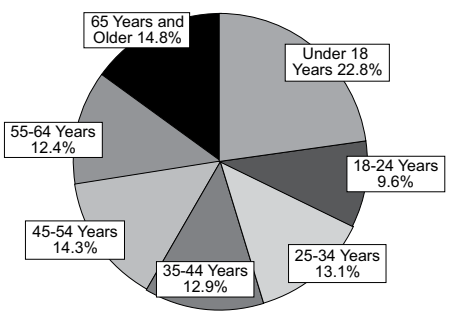
U.S. POPULATION

In 2011, the U.S. population was more than 311 million, with females comprising 50.8 percent of the total population. Females younger than 18 years accounted for nearly one-quarter of the 158 million U.S. females, while women aged 18–44 years accounted for 35.6 percent, those aged 45–64 years accounted for 26.8 percent, and women aged 65 years and older accounted for 14.8 percent.

The distribution of the population by sex was fairly even across younger age groups; however because women have longer life expectancies, they represented a greater proportion of those aged 65 years and older in 2011. Women accounted for 56.7 percent of all individuals aged 65 years and older, 60.5 percent of individuals aged 75 years and older, and over two-thirds of individuals aged 85 years and older (67.0 percent; data not shown).

U.S. Female Population,* by Age, 2011

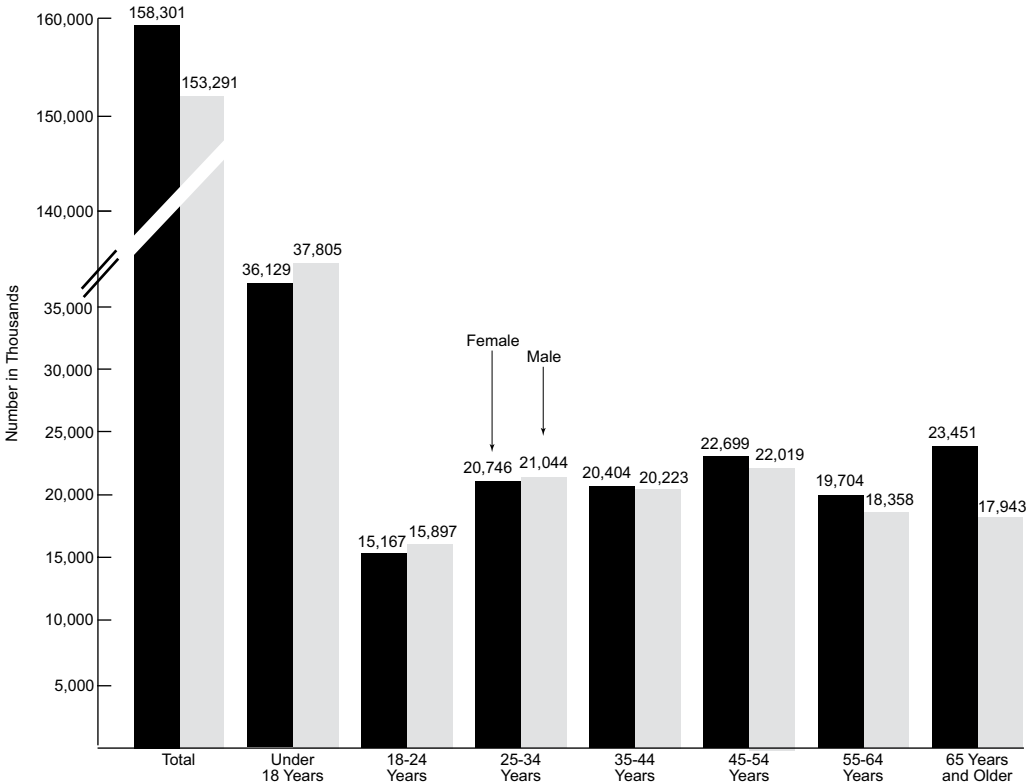
Source I.1: U.S. Census Bureau, Annual Estimates of the Resident Population



*Estimates may not total to 100 due to rounding.

U.S. Population, by Age and Sex, 2011

Source I.1: U.S. Census Bureau, Annual Estimates of the Resident Population



U.S. FEMALE POPULATION

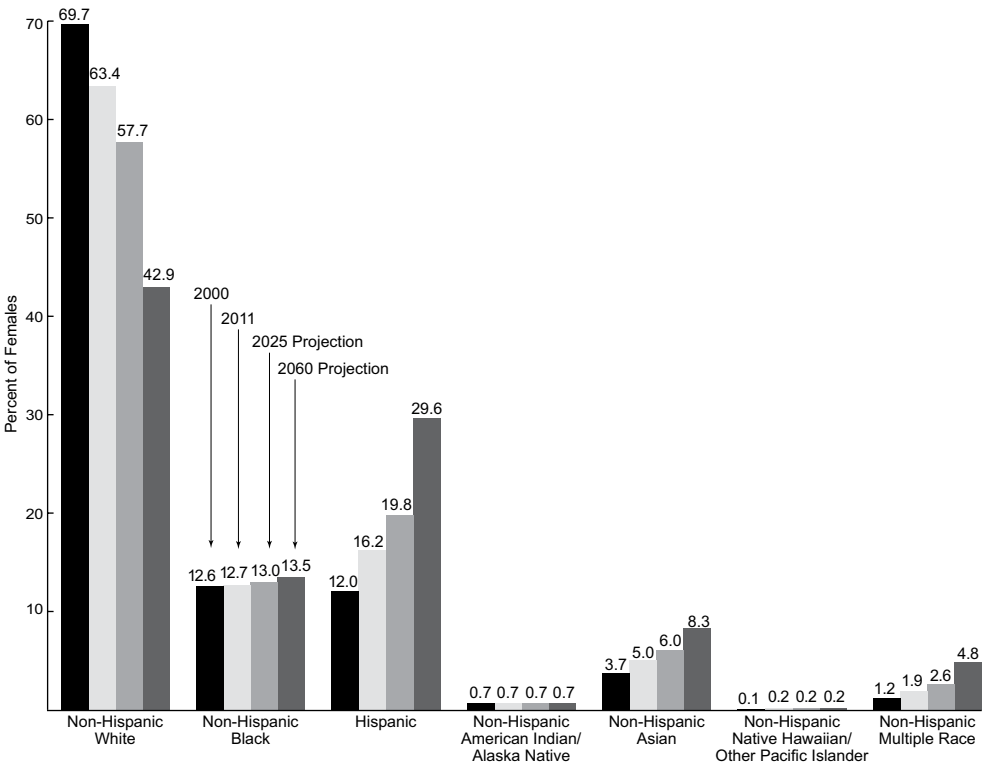
In 2011, the majority of the total female population was non-Hispanic White (63.4 percent), while 16.2 percent were Hispanic, 12.7 percent were Black, and 5.0 percent were non-Hispanic Asian. Less than 1 percent of the female population was non-Hispanic American Indian/Alaska Native or non-Hispanic Native Hawaiian/Other Pacific Islander, while 1.9 percent were non-Hispanic multiple race. Non-Hispanic White females are expected to no longer be the majority by 2045. By 2060, the proportion of females who are non-Hispanic White is expected to fall to 42.9 percent while the proportion who are Hispanic, non-Hispanic Asian, and non-Hispanic multiple race are expected to double or triple compared to the start of the millennium.

The increasing diversity of the U.S. population is a function of different fertility, mortality, and migration patterns according to race and ethnicity. The younger female population (under 18 years) is significantly more diverse than the older female population. In 2011, 53.0 percent of females under 18 years of age were non-Hispanic White, while 23.6 percent of that group were Hispanic. In contrast, among women aged 65 years and older, 78.9 percent were non-Hispanic White and only 7.3 percent were Hispanic (data not shown).[1]

The increasing diversity of the U.S. population underscores the importance of promoting racial and ethnic equity in health and health care. Significant racial and ethnic disparities persist in health status and access to health care which can be attributed to a variety of social, behavioral, environmental, and biological determinants.[2] The future health of America will greatly depend on using a multifaceted approach to improving the health of racial and ethnic minorities and other disadvantaged groups.

U.S. Female Population (All Ages), by Race/Ethnicity, 2000–2060

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



HOUSEHOLD COMPOSITION

In 2012, 50.3 percent of women aged 18 years and older were married and living with a spouse; this includes married couples living with other people, such as parents. About 13 percent of women over age 18 were the heads of their households, meaning that they have children or other family members, but no spouse, living with them. Women who are heads of households include single mothers, single women with a parent or other close relative living in their home, and women with other household compositions. About 15 percent of women lived alone, 13.8 percent lived with relatives, and 7.9 percent lived with non-relatives.

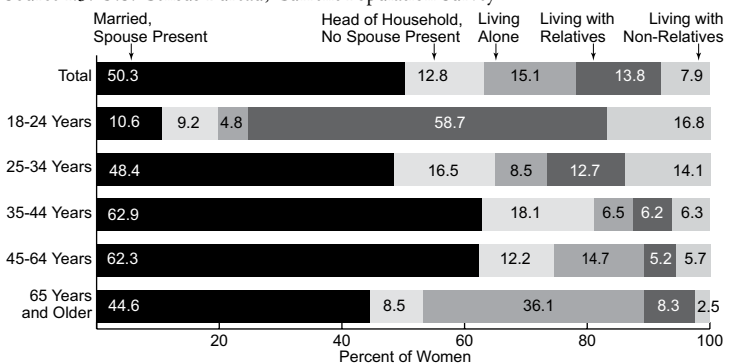
Household composition varies significantly by age. Young women aged 18–24 years were most likely to be living with relatives (58.7 percent) and with non-relatives (16.8 percent), while over 60 percent of women aged 35–44 and 45–64 were living with a spouse. Being a head of household with no spouse present was most common among women aged 25–44. Older women, aged 65 and above, were most likely to be living alone or with a spouse.

In 2012, non-Hispanic Black women were most likely to be single heads of households with family members present (27.5 percent), while non-Hispanic Asian and non-Hispanic White women were least likely (7.6 and 9.4 percent, respectively). Over 30 percent of single female heads of households with family members had incomes below the poverty level (see *Women's Health USA, 2012*).

In 2011, same-sex couples comprised about 1 percent of all households, with female couples accounting for 53.0 percent of those households.[3] Almost one-quarter of female same-sex couple households had children (23.2 percent) compared to 11.0 percent of male same-sex couple households and 40.7 percent of opposite-sex couple households.[3] Householders within same-sex couples tend to have higher levels of educational attainment than those of opposite-sex couples. Over half of male same-sex couple householders had a college degree (52.3 percent), followed by 45.7 percent of female same-sex couple householders, and 35.8 percent of opposite-sex couple householders (data not shown).[3]

Women Aged 18 and Older,* by Age and Household Composition, 2012

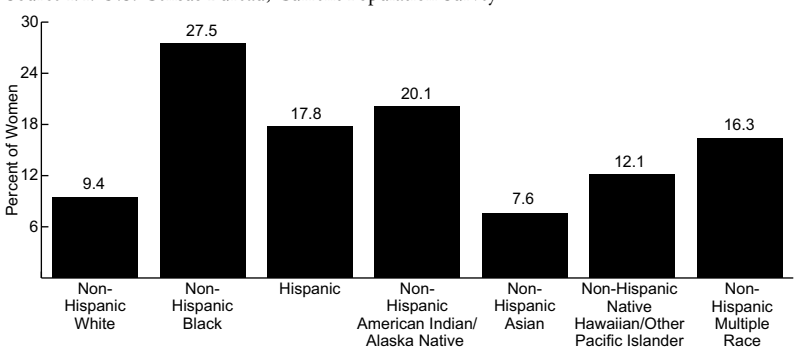
Source I.3: U.S. Census Bureau, Current Population Survey



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

Women Aged 18 and Older Who Are Heads of Households with Family Members,* by Race/Ethnicity, 2012

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



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

WOMEN AND POVERTY

In 2011, more than 46 million people in the United States lived with incomes below the poverty level, representing 15.0 percent of the U.S. population.[4,5] Approximately 17.7 million of those were women aged 18 and older, accounting for 14.6 percent of the adult female population. In comparison, 10.9 percent of adult men (or 12.4 million) lived in poverty (data not shown). With regard to race and ethnicity, non-Hispanic White women were least likely to experience poverty (10.6 percent), followed by non-Hispanic Asian women (11.9 percent). In contrast, about one-quarter of Hispanic, non-Hispanic Black, and non-Hispanic American Indian/Alaska Native women lived in poverty.

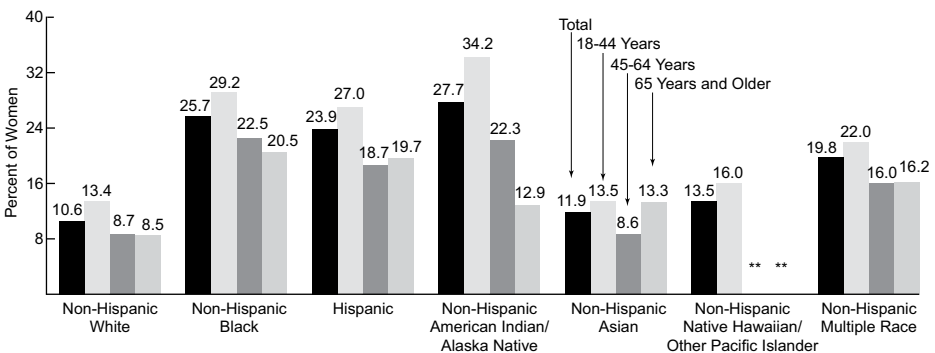
Poverty status varies with age. Among women of each race and ethnicity, those aged 45–64 years and 65 years and older were less likely to experience poverty than those aged 18–44. For instance, 29.2 percent of non-Hispanic Black women aged 18–44 were living in poverty in 2011, compared to 22.5 percent of those aged 45–64 years, and 20.5 percent of those aged 65 years and older.

Poverty status also varies with educational attainment. Among women aged 25 years and older in 2011, nearly one-third (32.8 percent) of those without a high school diploma were living in poverty, compared to 16.0 percent of those with a high school diploma or equivalent, 11.5 percent of those with some college education, and 4.9 percent of those with a Bachelor's degree or higher (data not shown).

In 2011, 11.8 percent of families—a group of at least two people related by birth, marriage, or adoption and residing together—were living in poverty. Married-couple families were least likely to be poor (6.2 percent). Among single-headed households with no spouse present, those headed by an adult female were twice as likely to be poor as those headed by an adult male (31.2 versus 16.1 percent, respectively). Overall, women in families were more likely than men to be poor (11.4 versus 8.0 percent, respectively; data not shown).

Women Aged 18 and Older Living Below the Poverty Level,* by Race/Ethnicity and Age, 2011

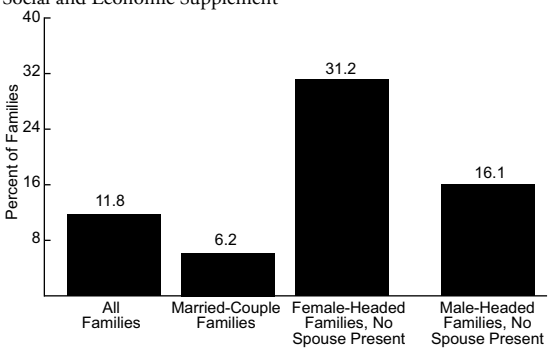
Source I.4: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



**Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011. **Estimate does not meet the standard of reliability; numerator <20.*

Families* Living Below the Poverty Level, by Household Type, 2011**

Source I.4: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



**Families are groups of at least two people related by birth, marriage, or adoption and residing together. **Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011.*

FOOD SECURITY

Food security is defined as having access at all times to enough food for an active, healthy life. Food security status is determined based on individuals' responses to questions about experiences and behaviors related to food insecurity, such as being unable to afford balanced meals, cutting the size of meals because of too little money for food, or being hungry because of too little money for food.[6]

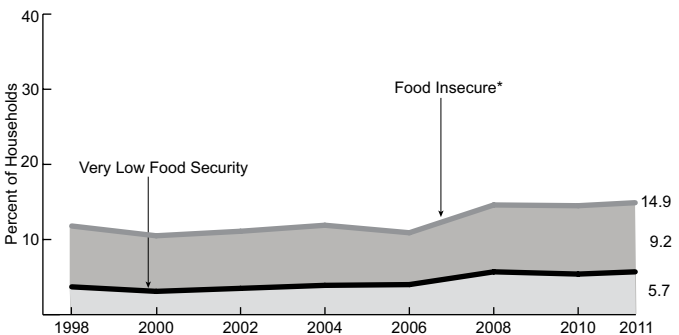
Households or persons experiencing food insecurity may be categorized as experiencing "low food security" or "very low food security." Low food security generally indicates multiple food access issues but little if any reduced food intake, while very low food security indicates reduced food intake and disrupted eating patterns due to inadequate resources for food. Periods of low or very low food security are usually recurrent and episodic rather than chronic. Nonetheless, nutritional risk due to poor dietary quality can persist across periods of food insecurity, and may increase the risk of nutritional deficiencies and diet sensitive conditions like hypertension and diabetes.[7]

In 2011, an estimated 17.9 million or 14.9 percent of all households experienced food insecurity for one or more household members at some point in the past year; this rate did not change significantly from 2010. However, the prevalence of very low food security increased from 5.4 percent in 2010 to 5.7 percent in 2011, marking a return to levels seen in 2008 and 2009.

Food security status varies by household composition. While adult men and women living alone had similar rates of food insecurity in 2011 (15.5 and 15.6 percent, respectively), female-headed households with children and no spouse present were more likely than male-headed households with no spouse present to experience food insecurity (36.8 versus 24.9 percent, respectively). Female-headed households with children were also more likely than male-headed households with children to experience very low food security (11.5 versus 7.5 percent, respectively).

Household Food Insecurity, 1998–2011

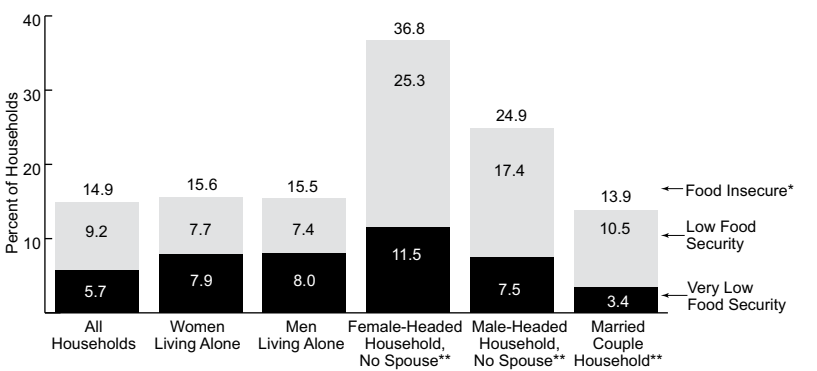
Source I.5: U.S. Census Bureau, Current Population Survey, Food Security Supplement



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

Food Security Status, by Household Composition, 2011

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



**Food insecure includes very low and low food security. Percentages may not add to totals due to rounding. **With children less than 18 years old.*

WOMEN AND FEDERAL NUTRITION PROGRAMS

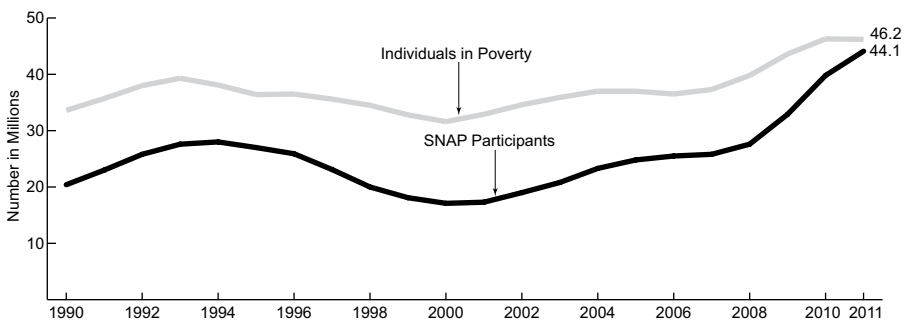
Federal programs administered by the U.S. Department of Agriculture provide essential help to low-income women and their families in obtaining food. The Supplemental Nutrition Assistance Program (SNAP), formerly the Federal Food Stamp Program, provides benefits for purchasing foods to individuals and families with incomes generally below 130 percent of the federal poverty level.[8] In 2011, following an economic recession, the number of people served by SNAP hit a record high of 44.1 million per month, on average, or about 1 in 7 Americans. Of the 24.2 million adults served, over 15 million (62.5 percent) were women (data not shown).[9] Between 1990 and 2011, the number of people served by SNAP tracked strongly over time with the number of people in poverty, demonstrating the critical role of SNAP in responding to need. In 2011, 1.7 million children and 2.2 million adults, 62 percent of whom were women, were lifted above the poverty line after adding the value of SNAP benefits to household income.[10]

Among the households that relied on SNAP in 2011, 5.1 million (24.5 percent) were female-headed households with children, accounting for 52.1 percent of all SNAP households with children (data not shown).[9]

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) also plays an important role in serving low-income women and families by providing supplementary nutritious foods, nutrition education, breastfeeding support, and referrals to health and other social services. WIC serves pregnant, postpartum, and breastfeeding women, as well as infants and children up to age 5 who are at nutritional risk and have household incomes generally at or below 185 percent of the federal poverty level.[11] In 2012, more than three-quarters of the 8.9 million individuals receiving WIC benefits were infants and children (76.5 percent); however, the program also served nearly 2.1 million pregnant women and mothers, representing 23.5 percent of WIC participants. About 63 percent of those eligible for WIC participate in the program, though rates vary from about 85 percent among eligible infants to 70.8 percent for pregnant women and only 52.4 percent for eligible children.[12] SNAP participation rates are about 72 percent overall, ranging from 92 percent among eligible children to only 34 percent among the elderly.[8]

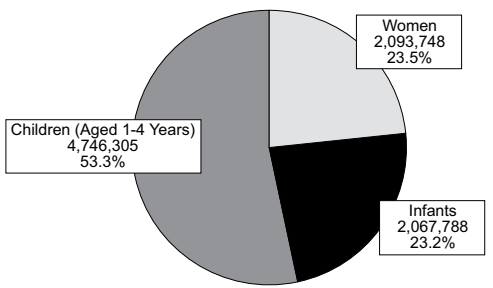
SNAP Participants and Individuals in Poverty, 1990–2011

Sources I.6: U.S. Department of Agriculture, Food Stamp Quality Control Sample; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



Participants in WIC, 2012*

Source I.7: U.S. Department of Agriculture, WIC Program Participation Data



Based on Federal Fiscal Year (October to September)

EDUCATIONAL ATTAINMENT

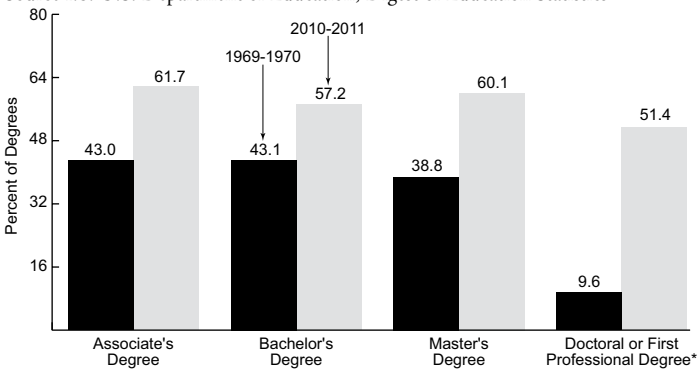
In 2012, slightly more women than men aged 25–29 years had earned a high school or general equivalency degree (91.1 versus 88.4 percent, respectively; data not shown).[13] Although there has not historically been a sex disparity in secondary education, a large disparity in postsecondary educational attainment has been eliminated or reversed over the last four decades. In 1969–1970, men earned a majority of every type of post-secondary degree, while in 2010–2011, women earned more than half of all associate's, bachelor's, master's, and doctoral or first professional degrees, including degrees in medicine, dentistry, and law. The most significant increase has been in the proportion of doctoral or first professional degrees earned by women, which rose from 9.6 percent in 1969–1970 to 51.4 percent in 2010–2011.

Despite the overall female advantage in postsecondary education, there are significant disparities by discipline. For example, in 2010–2011, women earned less than one in five bachelor's degrees in computer sciences (17.6 percent) and engineering (17.2 percent). Conversely, women earned the overwhelming majority of bachelor's degrees in education (79.6 percent) and health professions (85.0 percent). Within the health professions, women earned a smaller proportion but still a majority of doctoral degrees (57.8 percent); representation was higher in pharmacy (61.8 percent), physical therapy (68.5 percent), health care administration (72.6 percent), and public health (71.9 percent), but lower for dentistry (45.5 percent) and medicine (48.4 percent; data not shown). Approximately 90 percent of all registered nursing degrees were awarded to women in 2010–2011.[13]

There are also racial and ethnic disparities in educational attainment. Although 34.7 percent of all women aged 25–29 years had a college degree in 2009–2011, fewer than one in six non-Hispanic Native Hawaiian or Pacific Islander (10.4 percent), non-Hispanic American Indian/Alaska Native (14.2 percent), and Hispanic women (15.5 percent) had a college degree, followed by 21.9 percent of non-Hispanic Black women. Non-Hispanic Asian and non-Hispanic White women were most likely to have a bachelor's degree (62.7 and 41.4 percent, respectively; data not shown).[14]

Degrees Awarded to Women, by Type, 1969–1970 and 2010–2011

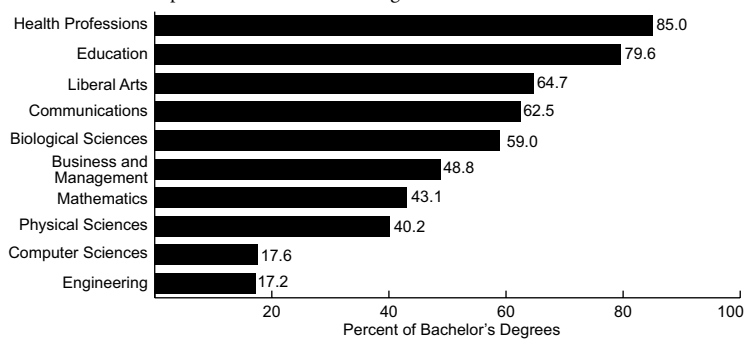
Source I.8: U.S. Department of Education, Digest of Education Statistics



**Includes Ph.D., Ed.D., and comparable degrees at the doctoral level as well as degrees formerly classified as first-professional, such as M.D., D.D.S., and law degrees.*

Bachelor's Degrees Awarded to Women, by Selected Discipline, 2010–2011

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



WOMEN IN THE LABOR FORCE

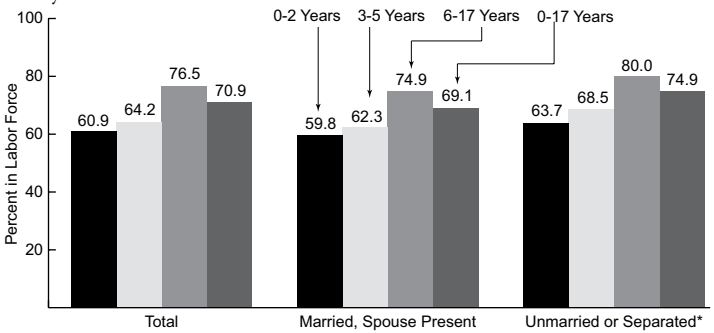
In 2011, 58.1 percent of women aged 16 and older were in the labor force (either employed or not employed and actively seeking employment) compared to 70.5 percent of men.[15] Between 1970 and 2000, women's participation in the labor force increased from 43.3 to 59.9 percent and has remained relatively stable through 2011. Among women with children under 18 years of age, 70.9 percent were in the labor force in 2011, up from 47.4 percent in 1975 (data not shown). Labor force participation is higher among women with older children and those who have never been married or are divorced or separated. In 2011, labor force participation ranged from 59.8 percent among married mothers with children under 3 years of age to 80.0 percent among unmarried or separated mothers with children aged 6–17 years.

Although the average annual rate of unemployment (not employed and actively seeking employment) for persons aged 16 and older was lower among women than men in 2011 (8.5 versus 9.4 percent, respectively; data not shown), the median weekly earnings of full-time workers aged 25 and older was $168 more for men than women ($886 versus $718). Earnings rise dramatically with increasing education but the gender gap in earnings persists with female full-time workers earning 19 to 25 percent less than male full-time workers at every level of education. For example, while women with a high school diploma or equivalent earned a weekly average of $554 in 2011, their male counterparts earned an average of $720. Only about half of the gender pay gap can be explained by differences in industry and occupation.[16]

Women were more likely than men to be among the working-poor, defined as those who were in the labor force for at least 27 weeks but lived below the official poverty level. In 2011, 7.6 percent of women aged 16 and older were working poor compared to 6.7 percent of men. Among women, the working-poor rate was highest among women aged 16–19 and 20–24 years (15.7 and 18.3 percent, respectively) and among Black and Hispanic women (14.5 and 13.8 percent, respectively; data not shown).

Labor Force Participation Among Mothers, by Marital Status and Age of Youngest Child, 2011

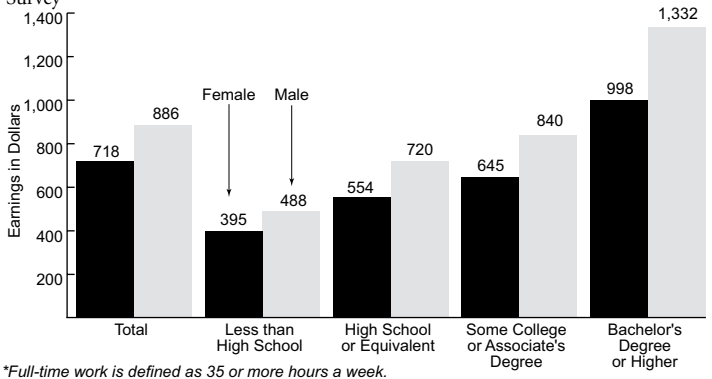
Source I.10: U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey



*Includes never-married, divorced, separated, and widowed persons.

Median Weekly Earnings of Full-Time Workers* Aged 25 and Older, by Educational Attainment Level and Sex, 2011

Source I.10: U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey



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

RURAL AND URBAN WOMEN

Residents of rural areas tend to face greater socioeconomic disadvantage and live farther from health care resources than their urban counterparts. For example, rural areas have fewer physicians and dentists per capita than urban areas, and may lack certain specialists altogether.[17] A variety of social, economic, and geographic factors are likely to contribute to higher rates of chronic disease, injury, and mortality observed in rural areas (see *Women's Health USA, 2012*).

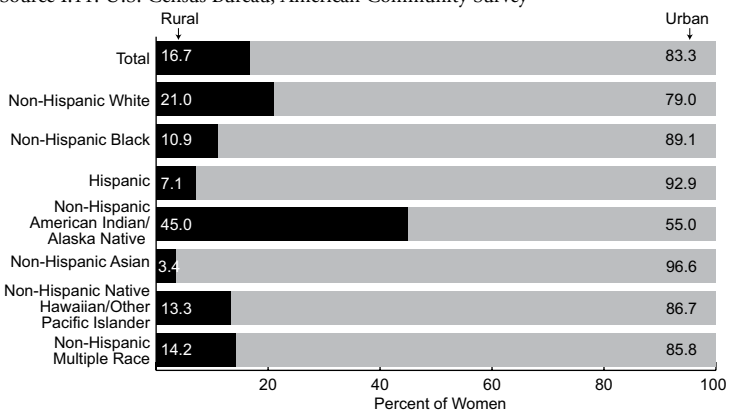
A common definition of rural and urban relies on residence outside or inside metropolitan statistical areas—counties with an urbanized area of at least 50,000 people or adjacent commuting counties. In 2011, over 19 million women aged 18 and older lived in non-metropolitan or rural areas, representing 16.7 percent of all women.

Rural women were more likely to be older and less racially and ethnically diverse than their urban counterparts. In 2011, the median age of rural women was 4 years older than for urban women (50 versus 46 years, respectively) and 23.0 percent of rural women were aged 65 years or older, compared to 18.3 percent of urban women (data not shown). Non-Hispanic White and non-Hispanic American Indian/Alaska Native women were the only racial and ethnic groups that were more likely to reside in rural areas than the total population of women. Nearly half of non-Hispanic American Indian/Alaska Native women (45.0 percent) resided in rural areas and 21.0 percent of non-Hispanic White women lived in rural areas compared with 16.7 percent of women overall and less than 15 percent of women of other racial and ethnic groups.

Women living in rural areas also had lower levels of educational attainment and higher levels of poverty than urban women. Among women aged 25 and older, 19.1 percent of rural women had a college degree or higher, compared to 30.8 percent of urban women. About 18 percent of rural women had household incomes below the poverty level, compared with 15 percent of urban women (data not shown).

Rural and Urban* Women Aged 18 and Older, by Race/Ethnicity, 2011

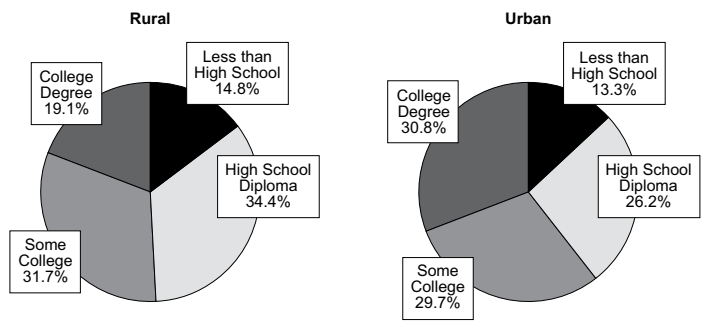
Source I.11: U.S. Census Bureau, American Community Survey



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

Educational Attainment Among Women Aged 25 and Older, by Rural and Urban Residence,* 2011

Source I.11: U.S. Census Bureau, American Community Survey



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

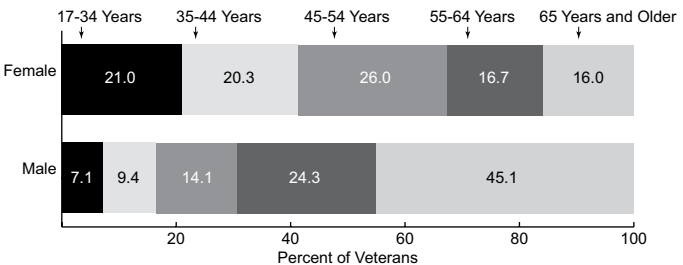
WOMEN VETERANS

As of September 2013, women were estimated to comprise 2.5 million, or 10.3 percent, of all living veterans.[18] By 2030, women are projected to make up 15 percent of all veterans—similar to the current proportion of active duty military personnel that are female.[18,19] About half of living women veterans today are from the Gulf War Era and the most recent conflicts, Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND).[20] The continually changing military roles of women, multiple deployments, and the blurring of combat and non-combat operations in Iraq and Afghanistan suggest that the needs of these women veterans may differ greatly from the needs of women veterans from previous eras.

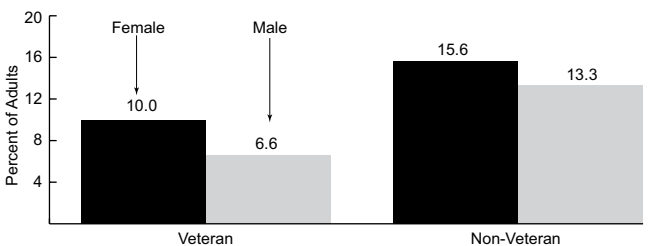
Due to the more recent increase in military enrollment and opportunities for women, female veterans are much younger than their male counterparts. In 2011, 21.0 percent of female veterans were aged 17–34 compared to only 7.1 percent of male veterans. Conversely, 45.1 percent of male veterans were aged 65 and older compared to only 16.0 percent of female veterans. Veteran women were slightly older than non-veteran women on average (49 versus 47 years, respectively; data not shown). While women veterans were less likely to be living in poverty than their non-veteran counterparts (10.0 versus 15.6 percent, respectively), their poverty rate was still higher than male veterans (6.6 percent).

Among OEF/OIF veterans using the Department of Veterans Affairs (VA) health care in FY 2002–2007, 15.1 percent of women and 0.7 percent of men reported experiencing military sexual trauma—defined as sexual assault and/or severe and threatening sexual harassment that occurred during military service.[21] Deployment to war zones, combat exposure, and military sexual trauma all raise the risk of post-traumatic stress disorder, depression, and substance abuse. The VA is improving services to make sure women who are eligible for VA health care can access services tailored to their needs and has expanded research on the impacts of trauma and combat exposure for women, mental health outcomes of civilian reintegration, and overall health care needs of women veterans.

Veteran Population, by Sex and Age, 2011
Source I.12: U.S. Census Bureau, American Community Survey



Adults Aged 17 and Older Living Below the Poverty Level,* by Veteran Status and Sex, 2011
Source I.12: U.S. Census Bureau, American Community Survey



**Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011.*

HEALTH STATUS

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

In this section, health status indicators related to health behaviors, morbidity, and mortality are presented. New topics include chronic obstructive pulmonary disease (COPD) and reproductive and gynecologic disorders. For the first time in the databook, analyses of fast food and sugar-sweetened beverage consumption, prediabetes, leading causes of death by age, and intimate partner violence by sexual orientation are presented. In addition, special pages are devoted to summarizing the characteristics and health of immigrant women, women served by community health centers, and lesbian and bisexual women. The data throughout this section are displayed by various characteristics including sex, age, race and ethnicity, education, and income.

PHYSICAL ACTIVITY

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

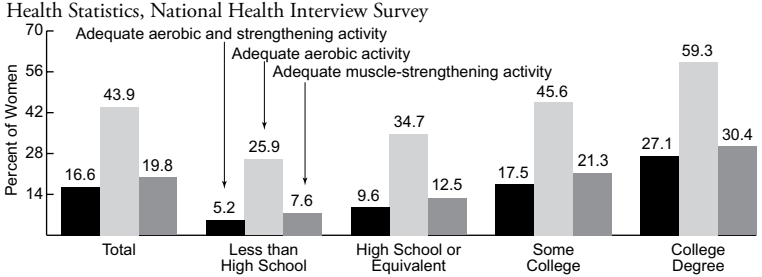
In 2009–2011, 16.6 percent of women met the recommendations for both adequate aerobic and muscle-strengthening activity, compared to 24.0 percent of men (data not shown). Muscle-strengthening activities provide additional benefits to those of aerobic exercise, such as increased bone strength[1]; however, women were much less likely to meet recommended levels of muscle-strengthening activity as compared to aerobic activity (19.8 versus 43.9 percent, respectively).

Physical activity varied by education and race and ethnicity. Compared to women with less than a high school diploma, women with a college degree were more than twice as likely to meet aerobic activity guidelines (59.3 versus 25.9 percent, respectively) and four times as likely to meet muscle-strengthening guidelines (30.4 versus 7.6 percent, respectively). Non-Hispanic White women and non-Hispanic women of multiple races were generally more likely to report adequate levels of aerobic activity and muscle-strengthening activity than women of other race and ethnic groups. For example, about 23 percent of non-Hispanic White and non-Hispanic women of multiple races reported adequate levels of muscle-strengthening activity compared to 15 percent or less among women of other races and ethnicities.

While not everyone may have access to fitness facilities, communities can promote physical activity through designs that include sidewalks, crosswalks, bike lanes, walking trails, and parks.[1]

Adequate Physical Activity* Among Women Aged 18 and Older, by Educational Attainment and Activity Type, 2009–2011

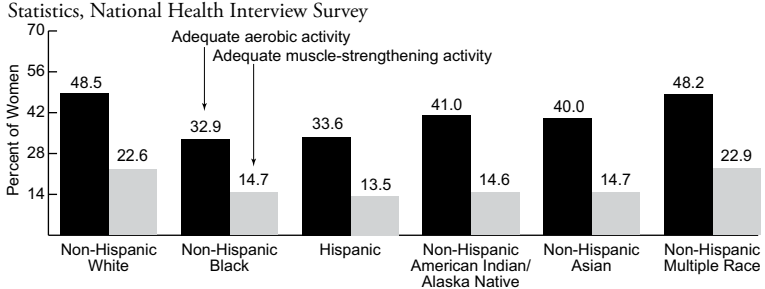
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



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

Adequate Physical Activity* Among Women Aged 18 and Older, by Race/Ethnicity and Activity Type, 2009–2011**

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



**Adequate aerobic activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous-intensity activity, or an equivalent combination of both; adequate muscle-strengthening activity is defined as performing muscle-strengthening activities, such as lifting weights or calisthenics, on 2 or more days per week; all estimates are age-adjusted. **The sample of Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.*

NUTRITION

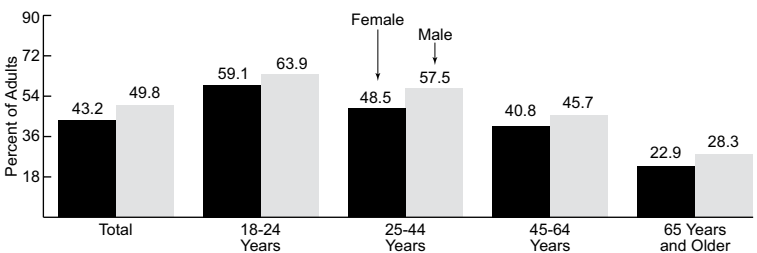
The 2010 Dietary Guidelines for Americans recommends eating a variety of nutrient-dense foods while not exceeding caloric needs.[2] Nutrient-dense foods include fruits, vegetables, whole grains, lean meats and poultry, eggs, beans, and peas. Studies have shown that people who frequently eat fast foods are less likely to consume these nutrient-dense foods and more likely to be obese.[3]

In 2007–2010, based on two non-consecutive 24-hour dietary recalls, 43.2 percent of women reported that they had consumed fast food compared to 49.8 percent of men. On average, however, both women and men who ate fast food consumed roughly one fourth of their total daily calories from such items (data not shown). Fast food consumption decreased with age. For example, 59.1 percent of women aged 18–24 years reported fast food consumption which declined to 22.9 percent among women aged 65 and older. Over half of non-Hispanic Black women consumed fast food (55.5 percent), followed by 47.8 percent of Mexican American women, and 41.4 percent of non-Hispanic White women (data not shown).

In addition to fast food, it is recommended that adults limit their intake of sugar-sweetened beverages, such as non-diet soda, flavored water, energy drinks, and sports drinks, because these items provide excess calories with little nutritional value[2] and have been associated with an increased risk of obesity and diabetes.[4] In 2007–2010, men were more likely than women to have consumed sugar-sweetened beverages (57.2 and 48.5 percent, respectively). Sugar-drink consumption varied by household income. For example, about 60 percent of women with household incomes of less than 200 percent of poverty consumed sugar drinks compared to 36.3 percent of women with incomes of 400 percent or more of poverty. With respect to race and ethnicity, sugar-drink consumption ranged from 43.2 percent among non-Hispanic White women to 66.1 percent among non-Hispanic Black women (data not shown). For data on fruit and vegetable consumption, see *Women's Health USA 2012*.

Fast Food Consumption* Among Adults Aged 18 and Older, by Age and Sex, 2007–2010

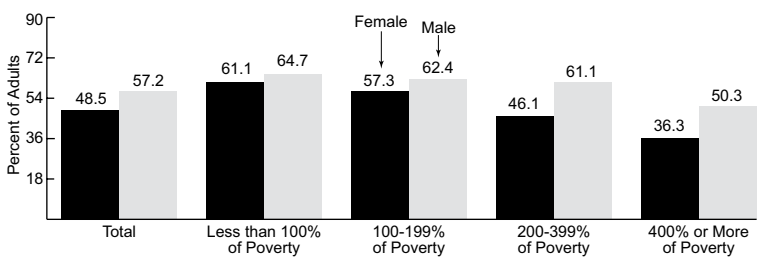
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Estimates are based on two non-consecutive 24-hour dietary recalls; fast food includes foods with the source of food coded as "restaurant fast food/pizza;" total estimates are age-adjusted.*

Sugar-Sweetened Beverage Consumption* Among Adults Aged 18 and Older, by Poverty Level and Sex, 2007–2010**

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



**Estimates are based on two non-consecutive 24-hour dietary recalls; sugar drinks include fruit drinks, sodas, energy drinks, sports drinks, and sweetened bottled waters and do not include diet drinks, 100% fruit juice, sweetened teas, and flavored milks; all estimates are age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010.*

ALCOHOL USE

Ethyl alcohol is an intoxicating ingredient found in beer, wine, and liquor which is produced by the fermentation of yeast, sugars, and starches. While moderate alcohol consumption may have some health benefits[2] – depending, in part, on the characteristics of the person consuming the alcohol – excessive drinking can lead to many adverse health and social consequences including injury, violence, risky sexual behavior, alcoholism, unemployment, liver diseases, and various cancers.[5] Women tend to face alcohol-related problems at a lower drinking level than men due to differences in body size and other biological factors.[6] Women who binge drink are also at greater risk of unintended pregnancy, which tends to delay pregnancy recognition and increase fetal alcohol exposure and risk of fetal alcohol spectrum disorders.[7]

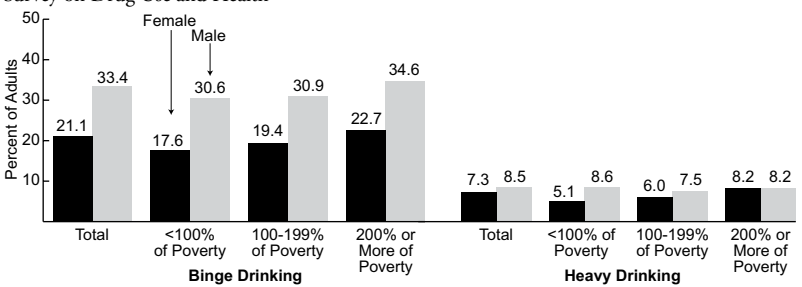
The Centers for Disease Control and Prevention defines binge drinking as consuming four or more drinks on a single occasion for women and five or more drinks on a single occasion for men (usually over the course of about 2 hours).[2] Heavy drinking is defined as consuming on average more than one drink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

In 2009–2011, men were more likely than women to report both binge drinking (33.4 versus 21.1 percent, respectively) and heavy drinking (8.5 versus 7.3 percent, respectively) in the past 30 days. However, among women, heavy drinking increased with household income, and at incomes of 200 percent or more of the poverty level women and men were equally likely to drink heavily (8.2 percent). Binge drinking tended to increase with income for both women and men.

Binge and heavy drinking also varied significantly by age and race/ethnicity. Nearly 38 percent of women aged 18–25 years reported binge drinking in the past month compared to 6.2 percent of women aged 65 and older. Heavy drinking was also more common among women aged 18–25 years (11.4 percent) and decreased to less than 7 percent among women aged 35 and older. With respect to race and ethnicity, past-month binge drinking ranged from 9.0 percent among non-Hispanic Asian women to about 25 percent among non-Hispanic White and non-Hispanic Native Hawaiian/Other Pacific Islander women (data not shown).

Past-Month Binge and Heavy Drinking* Among Adults Aged 18 and Older, by Poverty Level and Sex, 2009–2011**

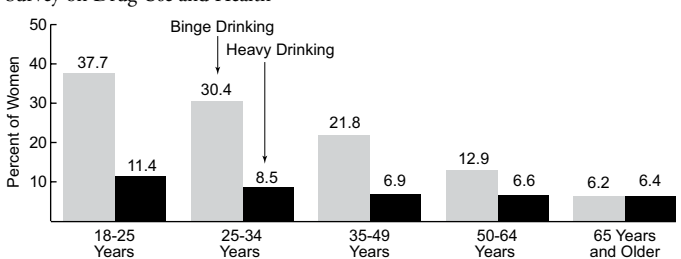
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Binge drinking indicates drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men usually over the course of about 2 hours. Heavy drinking indicates consumption of more than one drink per day on average for women and two drinks per day on average for men. All estimates are age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011.

Past-Month Binge and Heavy Drinking* Among Women Aged 18 and Older, by Age, 2009–2011

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



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

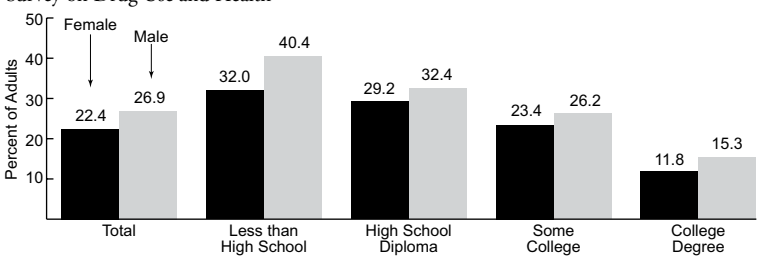
CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body.[8] Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impair genes that control the growth of cells, and bind to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease (COPD), cardiovascular disease, reduced bone density and fertility, and premature death.[8] Due to its high prevalence and wide-ranging health consequences, smoking is the single largest cause of preventable death and disease for both men and women in the United States, accounting for an estimated 443,000 premature deaths annually.[9] In 2009–2011, women aged 18 and older were less likely than men to report cigarette smoking in the past month (22.4 versus 26.9 percent, respectively). For both men and women, smoking was more common among those with lower levels of educational attainment. For example, 32.0 percent of women and 40.4 percent of men without a high school diploma smoked in the past month, compared to 11.8 percent of women and 15.3 percent of men with a college degree. Smoking also varied by race and ethnicity. Among women, smoking prevalence ranged from 6.9 percent among non-Hispanic Asians to 33.9 percent among non-Hispanic American Indian/Alaska Natives (data not shown).

Quitting smoking has major and immediate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.[8] In 2009–2011, 8 to 9 percent of women and men who had ever smoked daily and smoked in the previous 3 years had not smoked in the past year. For both women and men, the proportion of adults who quit smoking varied by educational attainment. For example, women with college degrees were almost twice as likely to have quit smoking as women who did not finish high school (12.2 versus 6.2 percent, respectively). The Affordable Care Act required new, private insurance plans to cover tobacco cessation treatment and counseling without cost-sharing in 2010 and will require the same for plans in the health insurance marketplaces in 2014.[10]

Past-Month Cigarette Smoking* Among Adults Aged 18 and Older, by Educational Attainment and Sex, 2009–2011

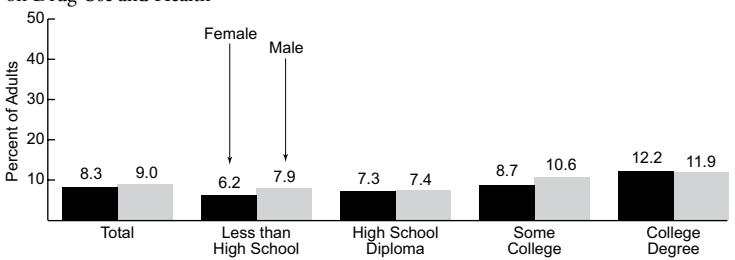
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*All estimates are age-adjusted.

Past-Year Smoking Cessation* Among Adults Aged 18 and Older, by Educational Attainment Level and Sex, 2009–2011

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



*Defined as the proportion of adults who did not smoke in the past year among those who ever smoked daily at some point in their lives and smoked in the past 3 years; excludes adults who started smoking in the past year. All estimates are age-adjusted.

ILLICIT DRUG USE

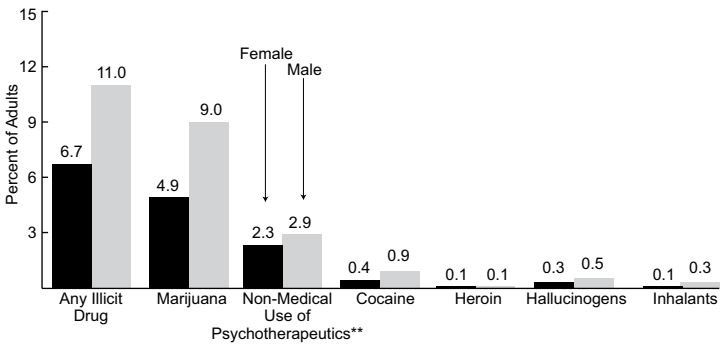
Illicit drug use is associated with serious health and social consequences, including addiction and drug-induced death, impaired cognitive functioning, kidney and liver damage, infections—including HIV and hepatitis—decreased productivity, and family disintegration.[11,12] Federally illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type psychotherapeutic drugs, such as pain relievers, stimulants, and sedatives.[11] Poisoning deaths, most of which are drug-related, are rising with abuse of prescription pain relievers and have surpassed motor vehicle accidents as the leading cause of fatal injury in the United States.[13]

In 2009–2011, 6.7 percent of women aged 18 years and older reported using an illicit drug within the past month, compared to 11.0 percent of adult men. The most commonly used drugs among both women and men were marijuana (4.9 and 9.0 percent, respectively) and non-medical use of psychotherapeutic drugs (2.3 and 2.9 percent, respectively). Fewer than 1 percent of women and men reported using cocaine, heroin, hallucinogens, or inhalants.

Illicit drug use varied greatly by age and race and ethnicity. Among women, for example, 17.2 percent of those aged 18–25 years reported using an illicit drug in the past month compared to less than 5 percent of women aged 50 years and older (data not shown). Non-Hispanic Asian women and Hispanic women were less likely than women of all other racial and ethnic groups to report using illicit drugs in the past month (2.2 and 4.7 percent, respectively). Illicit drug use was more common among non-Hispanic women of multiple race (9.1 percent) and non-Hispanic White women (7.5 percent) than among non-Hispanic Black women (6.7 percent); no other racial and ethnic differences were significant.

Past-Month Use of Illicit Drugs* Among Adults Aged 18 and Older, by Drug Type and Sex, 2009–2011

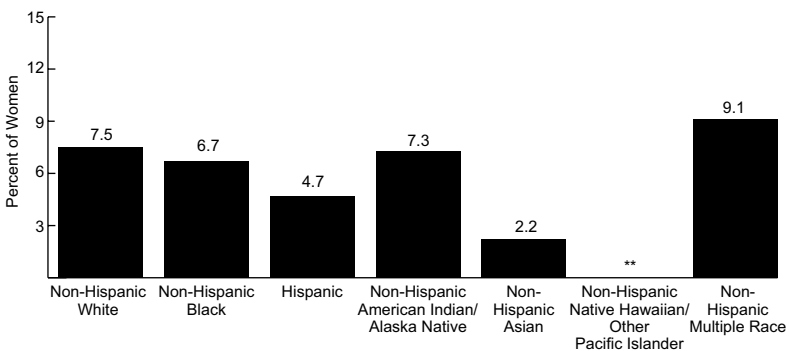
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes; all estimates are age-adjusted. **Includes prescription-type pain relievers, tranquilizers, stimulants, and sedatives, but not over-the-counter drugs.

Past-Month Use of Any Illicit Drug* Among Women Aged 18 and Older, by Race/Ethnicity, 2009–2011

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



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes; all estimates are age-adjusted. **Estimate does not meet the standards of reliability or precision.

LIFE EXPECTANCY

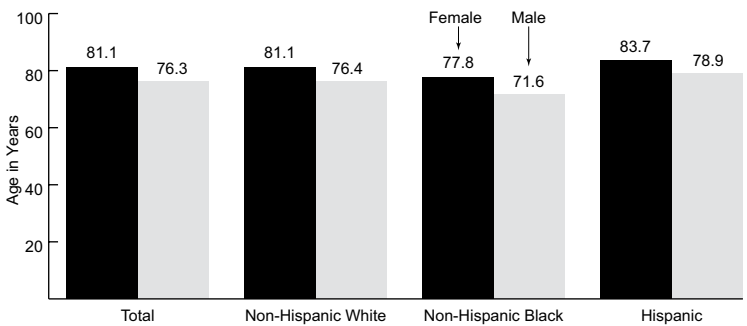
Based on preliminary data, the overall life expectancy of a baby born in 2011 was 78.7 years (data not shown); this varied, however, by sex and race and ethnicity. A baby girl born in the United States in 2011 could expect to live 81.1 years, 4.8 years longer than a male baby, whose life expectancy would be 76.3 years. Females had longer life expectancies than males within every race and ethnic group, ranging from an advantage of 4.7 years among non-Hispanic Whites to 6.2 years among non-Hispanic Blacks. A variety of social and biological factors may explain the female longevity advantage, including better health and health-care seeking behaviors and cardiovascular benefits of estrogen.[14]

Non-Hispanic Blacks had the lowest life expectancy for both females and males (77.8 and 71.6 years, respectively), while Hispanics had the longest life expectancy for both females and males (83.7 and 78.9 years, respectively). The lower mortality rates of the Hispanic population, despite greater levels of socioeconomic disadvantage, known as the Hispanic paradox, may be due to more favorable health among those who are able to immigrate from their home countries, as well as the possibility that they may return to those countries to die and are not counted in mortality statistics.[15] Life expectancy data are not reported for Asian, Native Hawaiian and other Pacific Islander, and American Indian/Alaska Native populations due to known issues of under-reporting on death certificates.

Life expectancy has increased since 1970 for both females and males. Between 1970 and 2011, female life expectancy increased by 6.4 years from 74.7 to 81.1 years (8.6 percent), while male life expectancy increased by 9.2 years from 67.1 to 76.3 years (13.7 percent). Between 1970 and 2011, the greater gains in life expectancy for males than females have led to reduced disparities by sex, shrinking from a differential of 7.6 to 4.8 years. Of concern, however, is that female mortality rates have recently increased in over 40 percent of U.S. counties whereas the same was true for male mortality rates in only 3.4 percent of counties.[16]

Life Expectancy at Birth, by Race/Ethnicity* and Sex, 2011**

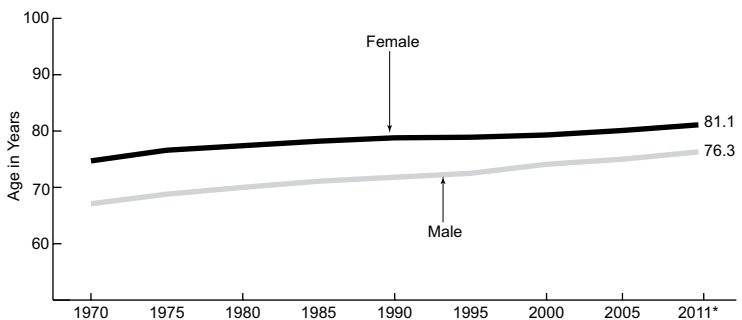
Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for American Indian/Alaska Natives, Asians, and Native Hawaiian/Other Pacific Islanders were not available. **Data are preliminary.

Life Expectancy at Birth, by Sex, 1970–2011*

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



*Data are preliminary.

LEADING CAUSES OF DEATH

In 2010, there were 1,219,545 deaths of women aged 18 and older in the United States. Of these deaths, nearly half were attributable to heart disease and cancer, which were responsible for 23.8 and 22.4 percent of deaths, respectively. Men had a similar relative burden of death due to heart disease (25.4 percent) and cancer (24.8 percent) but unintentional injury was the third leading cause of death (6.0 percent of deaths) for men compared to the sixth leading cause for women (3.5 percent of deaths). Women, however, had a greater relative burden of mortality from stroke, which was the third leading cause of death compared to the fifth leading cause for men. Following chronic lower respiratory diseases, Alzheimer's disease was the fifth leading cause of death for women but was ranked eighth for men (data for men not shown).

Leading causes of death vary greatly by age. While cancer and heart disease were prominent causes of death among women of all ages, unintentional injury was the leading cause of death among women aged 18–44 years and the third leading cause for those aged 45–64 years, compared to the ninth leading cause for women aged 65 and older. Intentional injuries, suicide and homicide, were the fourth and fifth leading causes of death, respectively, for women aged 18–44 years. HIV and pregnancy complications were the ninth and tenth leading causes of death for younger women aged 18–44 but were not within the top ten causes for other age groups. Liver disease was also represented within the top ten causes of death only among women younger than 65. Conversely, Alzheimer's disease and flu and pneumonia were leading causes of death unique to women aged 65 and older. (For differences in leading causes of death by race and ethnicity, see *Women's Health USA 2012*.)

Between 2000 and 2010, four causes of death increased in relative burden: chronic lower respiratory diseases (5.1 to 6.0 percent of deaths), Alzheimer's disease (2.9 to 4.8 percent of deaths), unintentional injury (2.6 to 3.5 percent of deaths), and kidney disease (1.6 to 2.1 percent of deaths; data from 2000 not shown).

Ten Leading Causes of Death Among Women Aged 18 and Older, by Age, 2010

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

Rank	Total	18-44 Years	45-64 Years	65 Years and Older
1	Heart Disease (23.8%)	Unintentional Injury (24.0%)	Cancer (38.3%)	Heart Disease (25.9%)
2	Cancer (22.4%)	Cancer (19.5%)	Heart Disease (16.2%)	Cancer (19.4%)
3	Stroke (6.3%)	Heart Disease (9.8%)	Unintentional Injury (5.7%)	Stroke (7.0%)
4	Chronic Lower Respiratory Disease (6.0%)	Suicide (7.1%)	Chronic Lower Respiratory Disease (4.8%)	Chronic Lower Respiratory Disease (6.4%)
5	Alzheimer's Disease (4.8%)	Homicide (3.9%)	Stroke (3.7%)	Alzheimer's Disease (5.9%)
6	Unintentional Injury (3.5%)	Stroke (2.6%)	Diabetes (3.4%)	Diabetes (2.6%)
7	Diabetes (2.8%)	Diabetes (2.3%)	Liver Disease (2.9%)	Flu & Pneumonia (2.4%)
8	Flu & Pneumonia (2.2%)	Liver Disease (2.2%)	Suicide (1.9%)	Kidney Disease (2.2%)
9	Kidney Disease (2.1%)	HIV (2.0%)	Septicemia (1.7%)	Unintentional Injury (2.1%)
10	Septicemia (1.5%)	Pregnancy Complications (1.6%)	Kidney Disease (1.6%)	Septicemia (1.5%)

HEALTH-RELATED QUALITY OF LIFE

Health-related quality of life encompasses multiple aspects of health and can be measured in different ways, including self-reported health status and the number of days in the past month that a person felt that either their physical or mental health was not good.[17]

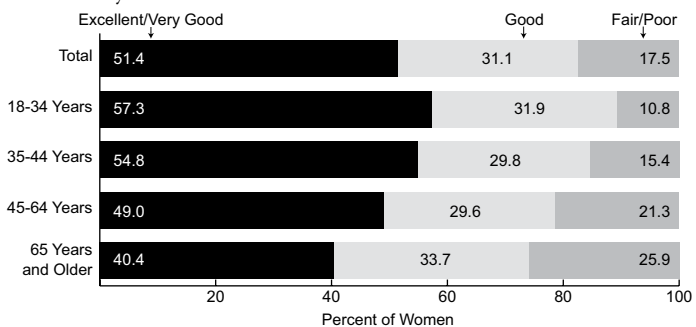
In 2012, 51.4 percent of women reported being in excellent or very good health, while 31.1 percent reported being in good health and 17.5 percent reported being in fair or poor health. Self-reported health status was similar among men and women but varied greatly with age and educational attainment. Over half of young women aged 18–34 years reported being in excellent or very good health (57.3 percent), compared to 40.4 percent of women aged 65 and older. Conversely, only 10.8 percent of women aged 18–34 years reported fair or poor health, compared to 25.9 percent of women aged 65 years or older. Self-reported health status improved with increasing levels of education. Less than one-quarter of women without a high school diploma reported excellent or very good health (23.4 percent), compared to 69.6 percent of women with a college degree (data not shown).

In 2012, women reported more physically and mentally unhealthy days than men. Women reported an average of 4.2 days of poor physical health, compared to 3.6 days per month for men. Similarly, women reported an average of 4.5 mentally unhealthy days, while men reported an average of 3.3 days per month (data not shown).

For both physically and mentally unhealthy days, non-Hispanic American Indian/Alaska Native women and non-Hispanic women of multiple races reported the highest average numbers of unhealthy days in the past month, with 6.1 and 5.9 physically unhealthy days, respectively; and 6.7 and 6.2 mentally unhealthy days, respectively. Non-Hispanic Asian women and non-Hispanic Native Hawaiian/Pacific Islander women reported the lowest number of physically and mentally unhealthy days on average (2.5 and 2.6 physically unhealthy days, respectively; and 2.7 and 3.7 mentally unhealthy days, respectively).

Self-Reported Health* Among Women Aged 18 and Older, by Age, 2012

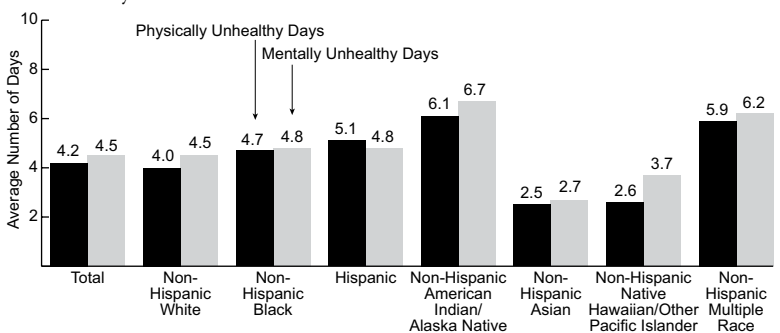
Source II.7: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Total estimates are age-adjusted.

Average Number of Physically and Mentally Unhealthy Days* in Past Month Among Women Aged 18 and Older, by Race/Ethnicity, 2012

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



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

ACTIVITY LIMITATIONS

Activity limitations can be defined by whether a person is able to perform physical tasks (e.g., walking up 10 steps, standing for 2 hours, carrying a ten pound object) or engage in social activities and recreation (e.g., going shopping, visiting friends, sewing, reading) without the assistance of another person or using special equipment.[18] In 2009–2011, 34.6 percent of adults reported being limited in their ability to perform one or more of these common activities (data not shown). Women were more likely than men to report being limited in their activities (38.3 versus 30.6 percent, respectively).

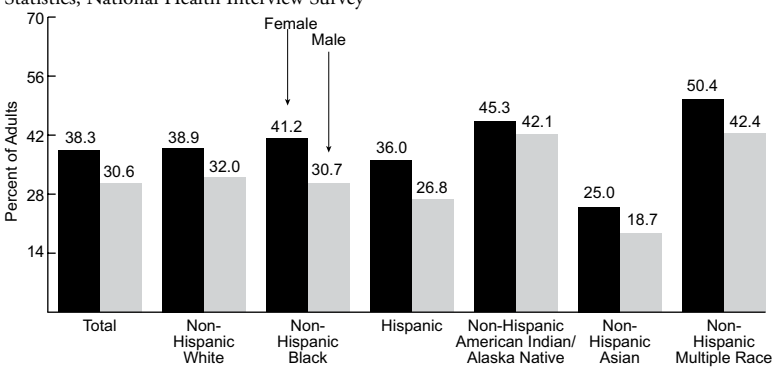
The percentage of adults reporting activity limitations increases with age. For example, 19.3 percent of those aged 18–34 years reported activity limitations compared to 28.1 percent of women aged 35–44 years, 47.6 percent of 45- to 64-year-olds, and 70.0 percent of women aged 65 years and older (data not shown).

The prevalence of activity limitations also varied by poverty level and race and ethnicity. Over half (50.5 percent) of women living in households with incomes less than 100 percent of poverty reported activity limitations compared to 30.5 percent of women living in households with incomes of 400 percent or more of poverty (data not shown). With respect to race and ethnicity, activity limitations affected about 40 percent or more of non-Hispanic White (38.9 percent), non-Hispanic Black (41.2 percent), and non-Hispanic American Indian/Alaska Native women (45.3 percent) compared to one-quarter of non-Hispanic Asian women and slightly more than one-third of Hispanic women (36.0 percent).

In 2009–2011, the most commonly reported causes of activity limitations were back or neck problems and arthritis (29.1 and 27.5 percent, respectively), followed by depression, anxiety, or emotional problems (11.0 percent), bone or joint injuries (10.2 percent), and weight problems (7.7 percent). Vision and hearing problems were reported to cause limitations in 2.5 and 1.0 percent of women with activity limitations, respectively.

Adults Aged 18 and Older with Activity Limitations,* by Race/Ethnicity and Sex, 2009–2011**

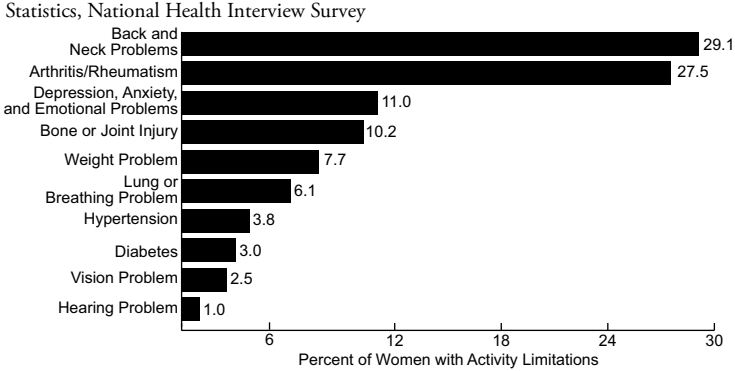
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as having difficulty performing certain physical, social, or recreational activities without the assistance of another person or using special equipment; all estimates are age-adjusted. **The sample of Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Selected Activity Limiting Conditions Among Women Aged 18 and Older with Activity Limitations,* 2009–2011

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



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

ARTHRITIS

Arthritis is the most common cause of disability and activity limitations among U.S. adults.[19] Arthritis comprises more than 100 different diseases that affect areas in or around the joints. The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement in areas such as the knees, hips, hands and spine.[20] Treatment for osteoarthritis focuses on relieving symptoms and there is no known cure for this condition. Types of arthritis that primarily affect women include lupus, fibromyalgia, and rheumatoid arthritis, which is the most serious and disabling type of arthritis.[21]

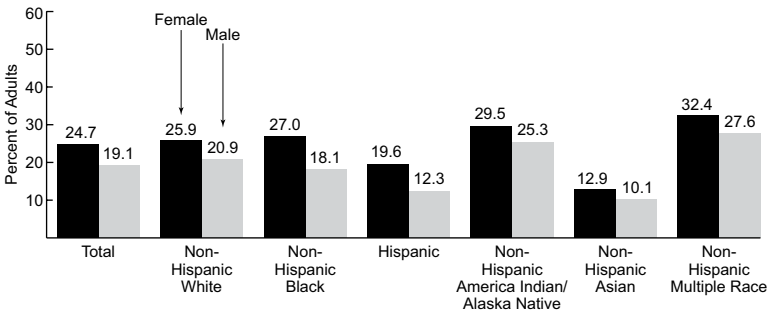
In 2009– 2011, 22.1 percent of adults in the United States reported that they had ever been diagnosed with arthritis (data not shown). Arthritis was more common among women than men (24.7 versus 19.1 percent, respectively) and increased greatly with age. For example, among women, 5.4 percent of those aged 18–34 years had ever been diagnosed with arthritis, compared to 15.3 percent of 35- to 44-year-olds, 34.1 percent of those aged 45–64 years, and 55.7 percent of women aged 65 years and older (data not shown).

Arthritis prevalence also varied by race and ethnicity. In 2009–2011, more than one-quarter of non-Hispanic White, non-Hispanic Black, non-Hispanic American Indian/Alaska Native, and non-Hispanic women of multiple races reported having been diagnosed with arthritis (25.9, 27.0, 29.5 and 32.4 percent, respectively), compared to 19.6 percent of Hispanic women and 12.9 percent of non-Hispanic Asian women. Hispanic and non-Hispanic Asians also had the lowest arthritis prevalence among men.

Obesity has been associated with the onset and progression of osteoarthritis.[20] In 2009–2011, nearly one-third of obese adults and one-fifth of overweight adults had been diagnosed with arthritis, compared to 17.3 percent of adults who were neither overweight nor obese. An arthritis diagnosis was reported by 33.4 percent of obese women, compared to 19.0 percent of women who were neither overweight nor obese.

Adults Aged 18 and Older with Arthritis,* by Race/Ethnicity and Sex, 2009–2011**

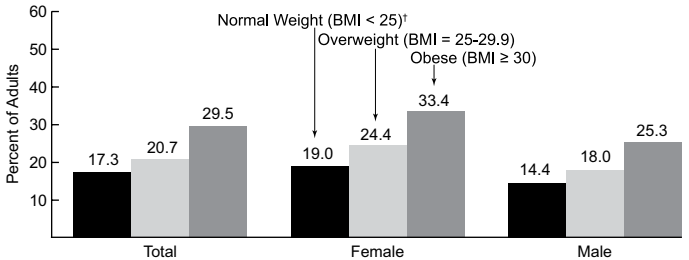
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have arthritis; all estimates are age-adjusted.
**The sample of Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Adults Aged 18 and Older with Arthritis,* by Sex and Weight Status, 2009–2011**

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; all estimates are age-adjusted. **Body Mass Index (BMI) is a ratio of weight to height. †Includes underweight.

OVERWEIGHT AND OBESITY

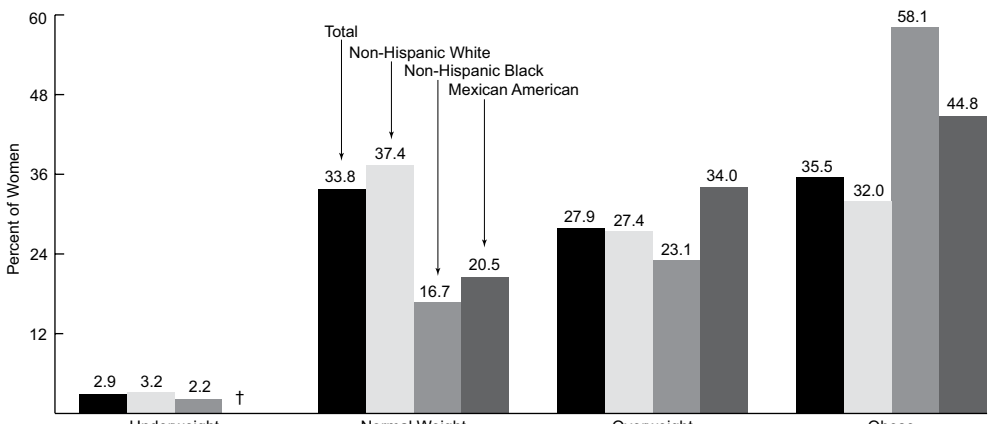
Overweight and obesity are associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, cardiovascular and liver diseases, arthritis, certain types of cancer, and reproductive health risks.[22] As a result, annual medical costs for people who are obese have been estimated to be $1,429, or 42 percent, higher than people of normal weight, aggregating to a total of $147 billion.[22] Overweight and obesity are measured by Body Mass Index (BMI), which is a ratio of weight to height. In 2009–2010, the majority of women were overweight or obese (63.4 percent); this includes 27.9 percent who were classified as overweight (BMI of 25.0–29.9) and 35.5 percent who were classified as obese (BMI of 30.0 or more). Compared with women, men were equally likely to be obese but more likely to be overweight (34.6 and 38.1 percent, respectively; data not shown).

Less than 3 percent of women were underweight in 2009–2010 (BMI <18.5). With the exception of the underweight category, weight status varied greatly by race and ethnicity. About 37 percent of non-Hispanic White women were of normal weight (BMI 18.5–24.9) compared with only 16.7 percent of non-Hispanic Black women and 20.5 percent of Mexican American women. Most of this racial and ethnic variation in normal weight is explained by differences in obesity rates. Non-Hispanic Black and Mexican American women had the highest rates of obesity (58.1 and 44.8 percent, respectively), compared with 32.0 percent of non-Hispanic White women. Obesity has increased significantly over the past decade for non-Hispanic Black and Mexican American women, contributing to widening health disparities.[23] Higher obesity rates have also been reported among American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander women, while lower rates have been reported among Asian women.[24]

Obesity also varied by age and income. Obesity rates increased with age from 25.8 percent of women aged 18–24 years to about 40 percent of women aged 45 and older in 2009–2010. With respect to income, 45.3 percent of women living in households with incomes below the poverty level were obese, compared to 29.1 percent of women with a household income of 300 percent or more of poverty (data not shown). Community strategies that can help to prevent obesity include efforts to improve access to healthy foods and safe places for physical activity.[25]

Women Aged 18 and Older, by Weight Status* and Race/Ethnicity,** 2009–2010

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



*Underweight is defined as having a Body Mass Index (BMI) of less than 18.5; normal weight is defined as having a BMI between 18.5 and 24.9; overweight is defined as having a BMI between 25.0 and 29.9; obesity is defined as having a BMI of 30.0 or more. Percentages may not add to totals due to rounding; all estimates are age-adjusted. **The sample of American Indian/Alaska Natives, Asians, Native Hawaiian/Other Pacific Islanders, and persons of multiple race was too small to produce reliable results. †Estimate did not meet the standards of reliability or precision.*

DIABETES

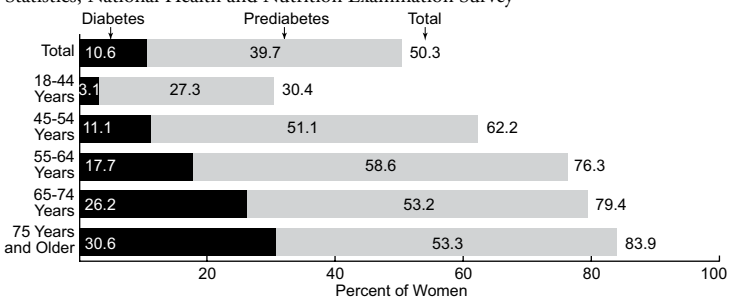
Diabetes mellitus is a chronic condition characterized by high blood sugar and is among the leading causes of death in the United States.[26] Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, nervous system disease, and amputation. The main types of diabetes are Type 1, Type 2, and gestational (diabetes occurring or first recognized during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults. Type 2 diabetes accounts for 90 to 95 percent of all diabetes cases, with risk factors that include obesity, physical inactivity, a family history of the disease, and gestational diabetes.

In 2007–2010, 13 million women (10.6 percent) tested positive for diabetes and another 48 million women (39.7 percent) had prediabetes, where blood glucose levels were higher than normal but not high enough to be called diabetes. Those with prediabetes are more likely to develop Type 2 diabetes, heart disease, and stroke.[27] Overall, diabetes was slightly more common in men (13.6 percent; not shown) and increased greatly with age: from 3.1 percent among women aged 18–44 years to 30.6 percent among women aged 75 years and older. Diabetes prevalence also varied by race and ethnicity. Non-Hispanic White women were least likely to have diabetes (8.9 percent) compared to non-Hispanic Black (16.5 percent), and Mexican American women (16.9 percent; data not shown). Other minority groups have also been shown to have higher rates of diabetes.[26]

Diabetes can be successfully managed through diet modification, physical activity, glucose monitoring, and medication.[26] Diagnosis is critical to develop a treatment plan and prevent serious complications. Among women who tested positive for diabetes, only 41.8 percent reported having been told by a health professional that they had diabetes. Non-Hispanic Black women with diabetes were more likely than non-Hispanic White women with diabetes to have been diagnosed and therefore to be aware of their condition (63.4 versus 34.9 percent).

Diabetes and Prediabetes Among Women Aged 18 and Older,* by Age, 2007–2010

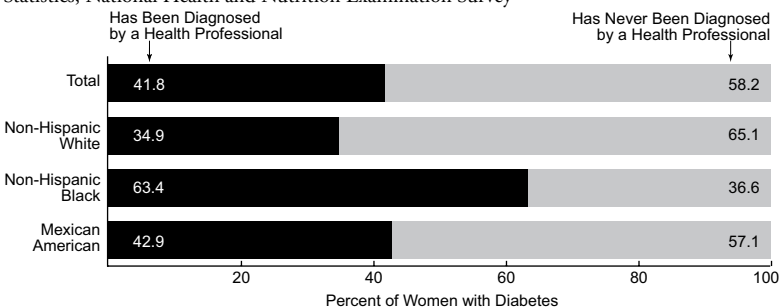
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Diabetes determined by Fasting Plasma Glucose (FPG) test ≥126 mg/dL, glycohemoglobin A1C test ≥6.5%, or 2-hour oral glucose tolerance test ≥200 mg/dL; Prediabetes determined by Fasting Plasma Glucose (FPG) test 100-125mg/dL, glycohemoglobin A1C test 5.7-6.4%, or 2-hour oral glucose test 140-199 mg/dL; total estimate is age-adjusted.*

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

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



**Report of whether or not a health professional has ever told them they have diabetes among those who tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test; all estimates are age-adjusted.*

HIGH BLOOD PRESSURE

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

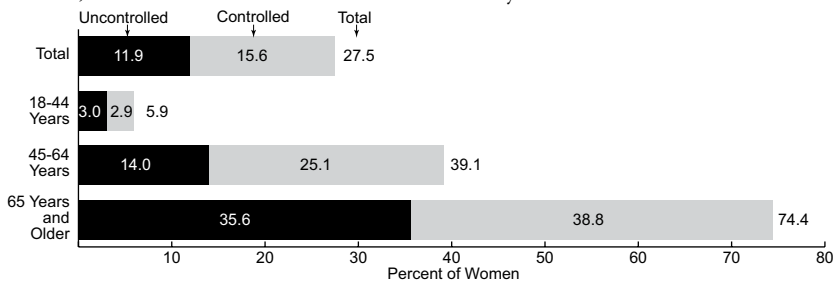
In 2009–2010, 27.5 percent of women were identified as having high blood pressure. This includes 15.6 percent of women with controlled hypertension, who had a normal blood pressure measurement and reported using blood pressure-lowering medication, and 11.9 percent with uncontrolled hypertension, who had a high blood pressure measurement with or without the use of medication. Although men were similarly affected by hypertension overall (29.3 percent), they were more likely to have uncontrolled hypertension (14.9 percent; data not shown). In addition to medication, high blood pressure can also be controlled by losing excess body weight, participating in regular physical activity, adopting a healthy diet with lower sodium and higher potassium intake, avoiding tobacco smoke, and managing stress.[28]

High blood pressure increases greatly with age, affecting only 5.9 percent of women aged 18–44 but rising to 39.1 percent among those aged 45–64 years and occurring among nearly three in four women aged 65 and older (74.4 percent). Hypertension also varies by race and ethnicity. Over 40 percent of non-Hispanic Black women had hypertension in 2009–2010, compared to about 25 percent of non-Hispanic White and Hispanic women (data not shown).

It has been estimated that every 10 percent increase in hypertension treatment could prevent 14,000 deaths per year.[29] However, 44.8 percent of women identified as having uncontrolled hypertension in 2009–2010 reported that they had never received a diagnosis from a health care professional. More than half of younger women aged 18–44 years with uncontrolled hypertension were undiagnosed (56.6 percent) compared to 36.2 percent of those aged 45–64 years and 31.7 percent of those aged 65 years and older.

High Blood Pressure Among Women Aged 18 and Older,* by Age, 2009–2010

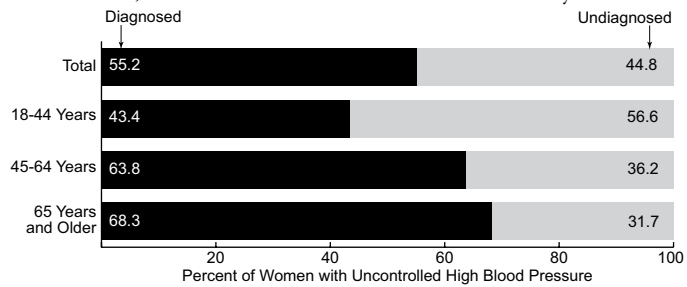
Source II.8: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Includes a measured systolic pressure (during heartbeats) of ≥140mmHg or a diastolic blood pressure (between heartbeats) ≥90mmHg (uncontrolled hypertension, with or without blood pressure-lowering medication) and normal blood pressure (≤140/90mmHg) with reported current medication use (controlled hypertension); percentages may not add to totals due to rounding; total estimates are age-adjusted.

Diagnosis Status* Among Women Aged 18 and Older with Uncontrolled High Blood Pressure, by Age, 2009–2010**

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



*Reported whether they had ever been told by a health professional that they have high blood pressure; total estimates are age-adjusted. **Includes a measured systolic pressure (during heartbeats) of ≥140mmHg or a diastolic blood pressure (between heartbeats) ≥90mmHg.

HEART DISEASE AND STROKE

Heart disease and stroke are the most common forms of cardiovascular disease[30] and are the first and third leading causes of death for women in the United States (see *Leading Causes of Death*). It is estimated that nearly one-fourth of all cardiovascular deaths are preventable through lifestyle modifications and medications, such as aspirin, when appropriate.[31]

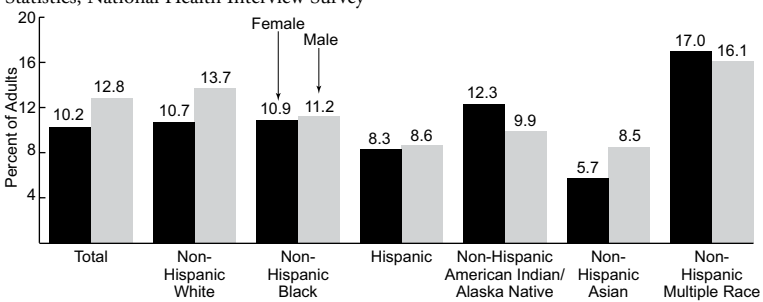
Risk factors for both heart disease and stroke include high blood pressure and cholesterol, diabetes, excess weight, physical inactivity, age, smoking, and family history. Stroke involves blocked blood flow to the brain whereas heart disease involves reduced blood flow to the heart, which can result in a heart attack. Chest pain is a common heart attack symptom; however, women are more likely than men to have other symptoms, such as shortness of breath, nausea and vomiting, and back or jaw pain.[32] Stroke symptoms can include numbness, headache, dizziness, confusion, trouble speaking, and blurred vision.[32]

In 2009–2011, men were slightly more likely than women to report having been diagnosed with heart disease (12.8 versus 10.2 percent, respectively). Non-Hispanic Asian and Hispanic women were less likely to have been diagnosed with heart disease (5.7 and 8.3 percent, respectively) than women of other race and ethnic groups. Heart disease increases with age and was reported by one in five women aged 65–74 years and one in three women aged 75 years and older (data not shown).

In 2009–2011, 2.6 percent of both women and men reported that they had ever been diagnosed with a stroke. Among women and men, the likelihood of having had a stroke was higher among those with lower household income. For example, 4.5 percent of women with household incomes below the poverty level reported having a stroke, compared to 1.8 percent of those with household incomes of 400 percent or more of poverty. Similar to heart disease, stroke also increases with age and was reported by 6.1 percent of women aged 65–74 years old and 10.9 percent of women aged 75 years and older (data not shown).

Heart Disease* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2009–2011**

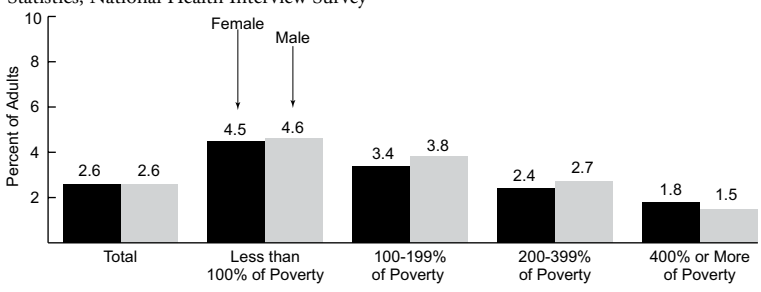
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them that they had coronary heart disease, angina pectoris, heart attack, or any other heart condition or disease; all estimates are age-adjusted. **The sample of Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Stroke* Among Adults Aged 18 and Older, by Poverty Level and Sex, 2009–2011**

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



*Reported a health professional had ever told them that they had a stroke; estimates are age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011.

CANCER

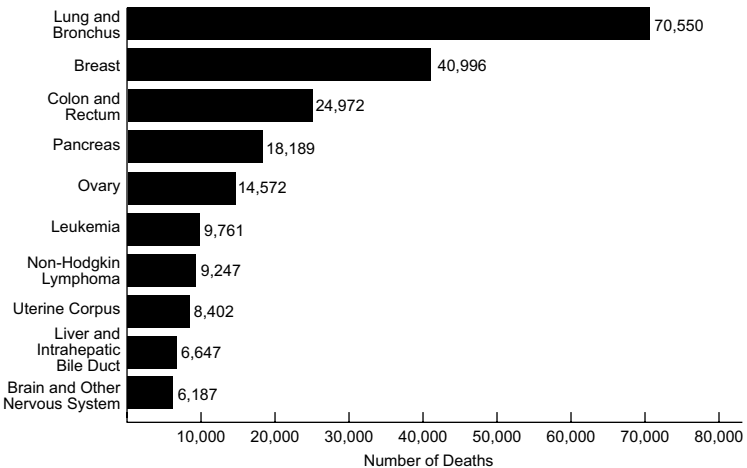
Cancer is the second leading cause of death among adults overall, and is the leading cause of death among women between the ages of 35 and 84.[33] In 2010, 711,113 new cancer cases were diagnosed among females and 273,706 females died of cancer. Lung and bronchial cancer was the leading cause of cancer death among females, accounting for 70,550 deaths (26 percent of all cancer deaths), followed by breast cancer, which was responsible for 40,996 deaths (15 percent of deaths). Colorectal cancer, pancreatic cancer, and ovarian cancer were also major causes of cancer deaths among females, accounting for an additional 57,733 deaths combined.

Due to the varying survival rates for different types of cancer, the most common causes of death from cancer are not always the most common types of cancer. For instance, although lung and bronchial cancer causes the greatest number of deaths, breast cancer is more commonly diagnosed among females. In 2010, invasive breast cancer occurred among 118.7 per 100,000 females, whereas lung and bronchus cancer occurred in only 52.4 per 100,000. Other types of cancer that are commonly diagnosed but are not among the top 10 causes of cancer death include thyroid, melanoma, and cervical cancer.

An estimated 70 percent of cancer cases are attributable to behavioral and environmental risk factors, such as smoking, obesity, and physical inactivity.[34] Vaccines are also available to help prevent hepatitis B and human papillomavirus (HPV) which can cause liver and cervical cancer, respectively. Recommended screening can help detect several forms of cancer in early, more treatable stages, including breast, colorectal, and cervical cancer, and is shown to reduce mortality.[35]

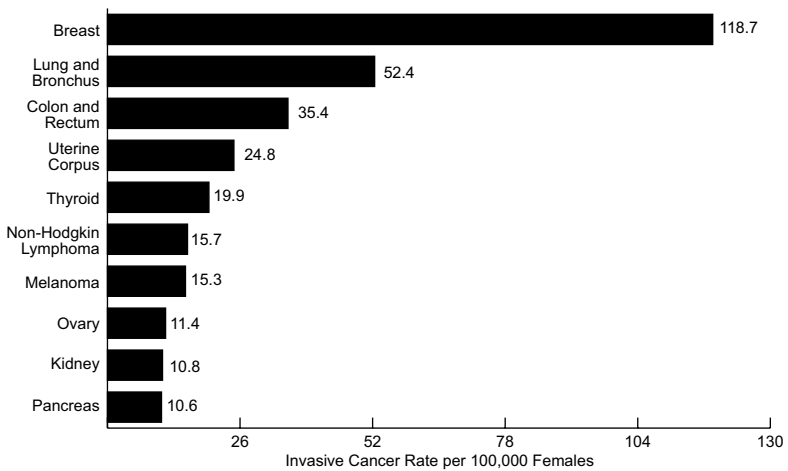
Leading Causes of Cancer Deaths Among Females (All Ages), by Site, 2010

Source II.9: Centers for Disease Control and Prevention



Age-Adjusted Invasive Cancer Incidence Rates per 100,000 Females (All Ages), by Site, 2010

Source II.9: National Cancer Institute



CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis, is an irreversible, progressive disease that impairs breathing.[36] Symptoms include coughing, phlegm production, wheezing, shortness of breath, and tightness in the chest. The leading risk factor for COPD is cigarette smoking, however other contributors include exposure to lung irritants, such as chemicals, pollution, and dust, and genetic factors.[37] Chronic lower respiratory disease, which includes both COPD and asthma, was the fourth leading cause of death in 2010 among U.S. women aged 18 years and older (see *Leading Causes of Death*).

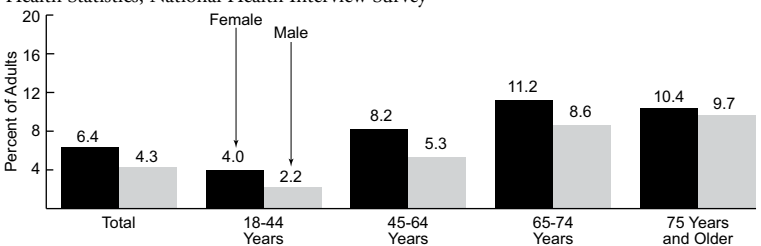
In 2009–2011, 5.4 percent of U.S. adults reported a diagnosis of COPD (data not shown). Women were more likely than men to report COPD (6.4 versus 4.3 percent, respectively). Among both men and women, COPD is more common among older age groups. For example, among women, the prevalence of COPD was highest among those aged 65–74 years (11.2 percent) and 75 years or older (10.4 percent) compared to 4.0 percent among women aged 18–44 years.

COPD prevalence also varied by race and ethnicity and poverty level. Among women, COPD was most common among non-Hispanic American Indian/Alaska Natives and non-Hispanic women of multiple races (8.6 and 9.9 percent, respectively), followed by non-Hispanic White women (7.0 percent), non-Hispanic Black women (6.1 percent), and Hispanic women (4.9 percent). COPD was least common among non-Hispanic Asian women (2.6 percent). With regard to income, women with household incomes less than 100 percent of poverty were more than twice as likely to report a COPD diagnosis as compared to those with incomes of 400 percent or more of poverty (10.1 versus 4.6 percent, respectively; data not shown).

While there is no cure, treatment for COPD begins with smoking cessation for those who smoke.[38] Additional therapies to control symptoms and slow disease progression may include medication, oxygen therapy, pulmonary rehabilitation, and surgery.

Chronic Obstructive Pulmonary Disease* Among Adults Aged 18 and Older, by Age and Sex, 2009–2011

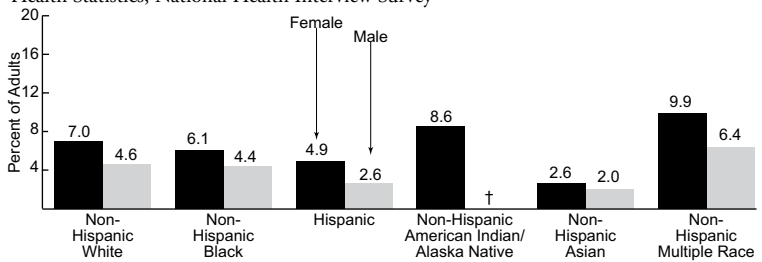
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Reported ever being diagnosed by a doctor or other health professional with emphysema or being diagnosed with chronic bronchitis in the past twelve months; total estimates are age-adjusted.*

Chronic Obstructive Pulmonary Disease* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2009–2011**

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



**Reported ever being diagnosed by a doctor or other health professional with emphysema or being diagnosed with chronic bronchitis in the past twelve months; all estimates are age-adjusted. **The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results. †Estimate does not meet the standards of reliability or precision.*

MENTAL ILLNESS

Overall, mental illness affects both women and men equally, and about half of all Americans will meet the criteria for a diagnosable mental disorder over the course of their lives.[39]However, specific types of mental disorders vary by sex. For instance, women are more likely than men to experience an anxiety or mood disorder, such as depression, while men are more likely to experience an impulse-control or substance use disorder.

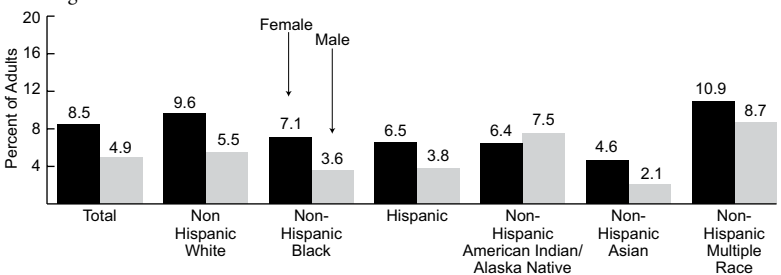
A major depressive episode (MDE) is defined as a period of 2 weeks or longer during which an individual experiences either depressed mood or loss of interest or pleasure in daily activities and at least four other symptoms that reflect a change in functioning, such as problems with sleep or eating.[2] In 2009–2011, an estimated 9.9 million women aged 18 years and older, comprising 8.5 percent of that population, reported experiencing an MDE in the past year, compared to 5.5 million, or 4.9 percent of, men.

The prevalence of past-year MDE varied by race and ethnicity. Among women, for example, non-Hispanic White and non-Hispanic multiracial women were most likely to report experiencing past year MDE (9.6 and 10.9 percent, respectively), while non-Hispanic Asian women were least likely to do so (4.6 percent). Past-year MDE was also more common among women below retirement age, affecting 9 to 11 percent of women under age 65, compared to 2.7 percent of women aged 65 and older (data not shown).

Although women were more likely than men to experience a past-year MDE, men were nearly twice as likely as women to experience a past-year substance use disorder (11.9 versus 6.0 percent, respectively). Substance use disorder encompasses both abuse and dependence on alcohol or illicit drugs.[40] Women who experienced past year MDE were three times as likely to report a substance use disorder than those who did not (15.8 versus 5.0 percent, respectively), while men who experienced a past-year MDE were nearly 2.5 times as likely as their non-affected counterparts to report a substance use disorder (26.3 versus 11.1 percent, respectively).

Past-Year Major Depressive Episode* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2009–2011**

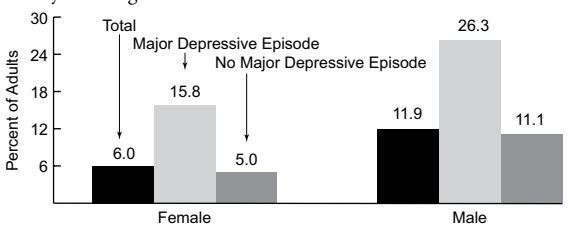
Source II.3: Substance Use and Mental Health Services Administration, National Survey on Drug Use and Health



**A past-year major depressive episode is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep and eating; all estimates are age-adjusted. **The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.*

Past-Year Substance Use Disorder,* by Sex and Past-Year Major Depressive Episode, 2009–2011**

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



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

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) has been defined as physical violence, sexual violence, threats of physical or sexual violence, and psychological aggression by a current or former spouse or dating partner. IPV can occur among heterosexual and same-sex couples and does not require sexual intimacy.[41] In 2010, 35.6 percent of adult women aged 18 years and older, or 42.4 million women, reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime while nearly one-half (48.4 percent) reported having experienced psychological aggression.[42]

The prevalence of IPV varies by sexual orientation. In 2010, bisexual women (56.9 percent) were more likely than either lesbians (40.4 percent) or heterosexual women (32.3 percent) to report any lifetime experience of physical IPV, including slapping, pushing, or shoving and severe acts such as being beaten, burned, or choked.

Among women who reported experiencing physical violence, more than half of bisexual women (55.1 percent) reported having ever been slapped, pushed, or shoved by an intimate partner, compared to 36.3 percent of lesbian women and 29.8 percent of heterosexual women. Bisexual women were also more likely to report having experienced severe physical violence, such as having been choked or beaten (49.3 percent) than lesbian (29.4 percent) or heterosexual women (23.6 percent; data not shown).

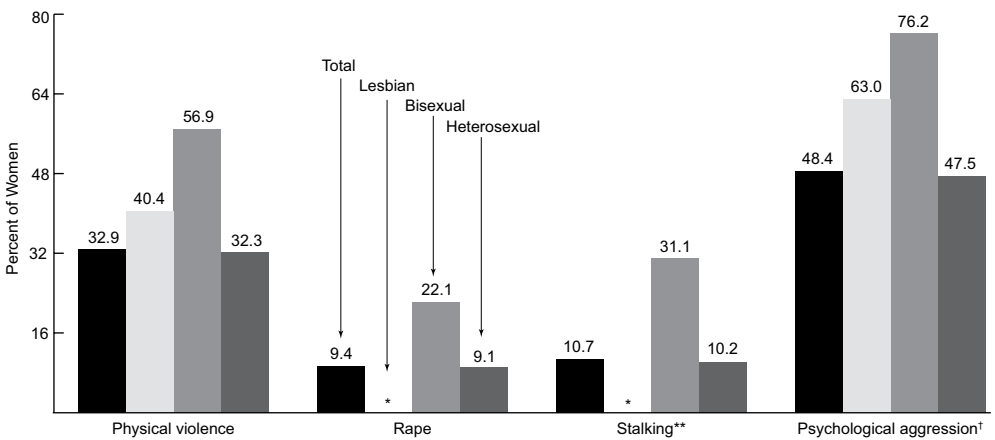
Lifetime experience of rape by an intimate partner was reported by approximately 1 in 5 bisexual women and 1 in 10 heterosexual women. Stalking, defined as a pattern of harassing or threatening tactics that is both unwanted and causes fear or safety concerns for the victim, was also more common among bisexual women than heterosexual women (31.1 versus 10.7 percent, respectively). Estimates of rape and stalking for lesbians were not reliable.

Finally, both bisexual and lesbian women reported higher rates of lifetime psychological aggression (such as name calling, humiliation, or coercion) by an intimate partner than heterosexual women (76.2, 63.0, and 47.5 percent, respectively).

Among bisexual women who experienced rape, physical violence, and/or stalking by an intimate partner, approximately 90 percent reported only male perpetrators. Among lesbian survivors of IPV, 67.4 percent reported only female perpetrators (data not shown).

Lifetime Prevalence of Intimate Partner Violence Among Women Aged 18 and Older, by Type of Violence and Sexual Orientation, 2010

Source II.10: Centers for Disease Control and Prevention, National Intimate Partner and Sexual Violence Survey



**Estimate does not meet the standards of reliability or precision. **Includes harassing or threatening tactics that are unwanted and cause fear or safety concerns. †Includes expressive aggression (such as name calling, insulting, or humiliating an intimate partner), and coercive control, which includes behaviors that are intended to monitor and control or threaten an intimate partner.*

SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS

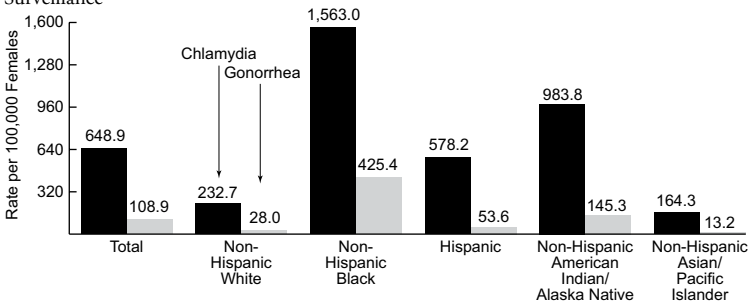
Sexually transmitted infections (STIs) are considered a hidden epidemic because symptoms are often absent and the causes are not openly discussed. Yet there are nearly 20 million new STIs in the United States each year at an annual health care cost of nearly 16 billion dollars.[43] Untreated STIs can increase the likelihood of contracting another STI, such as HIV, and can lead to various reproductive problems and certain types of cancers, such as those caused by human papillomavirus (HPV) and hepatitis.[44] Safer sex practices, HPV and hepatitis vaccination, and screening and treatment can help reduce the burden of STIs.

States require reporting of new chlamydia, gonorrhea, syphilis, and HIV cases and data are shared with the Centers for Disease Control and Prevention. Reported STI rates among females vary by age, as well as race and ethnicity. Rates are highest among adolescents and young adults: in 2011, over 70 percent of all chlamydia and gonorrhea cases in females occurred among those under 25 years of age (data not shown). With the exception of non-Hispanic Asian/Pacific Islanders, minority females had higher STI rates than non-Hispanic White females. For example, compared with non-Hispanic White females, the chlamydia rate was 6.7 times as high for non-Hispanic Black females, 4.2 times as high for non-Hispanic American Indian/Alaska Native females, and 2.5 times as high for Hispanic females.

HIV and AIDS disproportionately affect men who have sex with men; however, a substantial proportion of HIV/AIDS diagnoses occur among women, and particularly Black women. In 2011, females accounted for 20.8 percent of estimated new HIV cases, of which nearly two-thirds were non-Hispanic Black females (data not shown). New HIV diagnosis rates for non-Hispanic Black females were 20 times the rate for non-Hispanic White females (40.0 versus 2.0 cases per 100,000 females), and were also higher for Hispanic, non-Hispanic American Indian/Alaska Native, and non-Hispanic females of multiple races (7.9, 5.5, and 7.5 cases per 100,000 females, respectively). Early detection of HIV infection is critical in preventing transmission of the virus to others and receiving treatment that can prevent progression to AIDS.

Rates of Chlamydia and Gonorrhea Among Females (All Ages), by Race/Ethnicity,* 2011

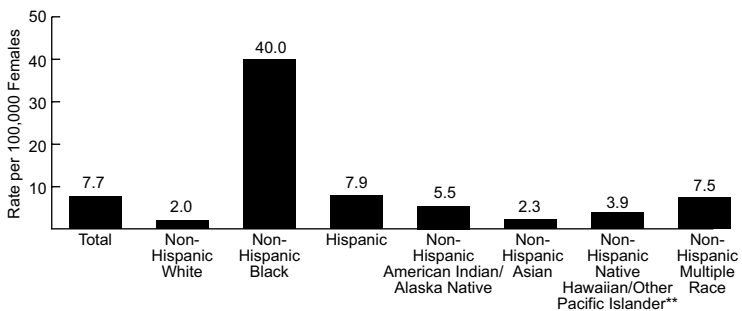
Source II.11: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Separate data for Asians, Native Hawaiians, and Other Pacific Islanders were not available.

Estimated Rates of New HIV Cases* Among Females Aged 13 and Older, by Race/Ethnicity, 2011

Source II.12: Centers for Disease Control and Prevention, HIV Surveillance Report



*Estimated rates are adjusted for reporting delays but not incomplete reporting.
**Interpret with caution; estimated rate is based on fewer than 10 cases.

REPRODUCTIVE AND GYNECOLOGIC DISORDERS

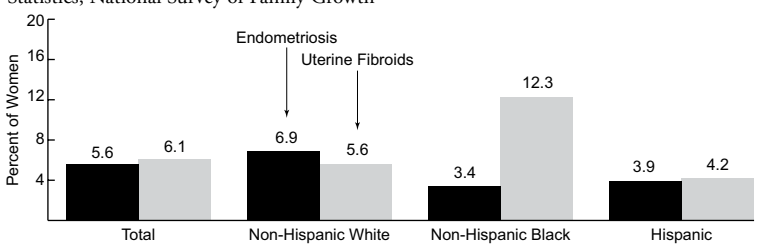
Reproductive and gynecologic disorders include conditions that affect female external and internal organs along the reproductive tract. Some disorders like dysmenorrhea (menstrual pain) and vulvodynia (vulvar pain) cause discomfort that may interfere with normal activity, while others may also affect reproductive functioning and fertility, such as endometriosis, uterine fibroids, and ovarian cysts.

Endometriosis is a condition in which the tissue of the uterine lining grows outside of the uterus, often onto the ovaries, fallopian tubes, or other abdominal organs.[45] Uterine fibroids are muscular tumors that grow in the uterine wall.[46] Both conditions can cause pelvic pain and heavy menstrual bleeding. Endometriosis in particular can cause fertility problems, while fibroids may complicate pregnancies and increase the likelihood of cesarean delivery. In 2006–2010, 5.6 and 6.1 percent of women aged 15–44 years reported that they had ever been diagnosed with endometriosis and uterine fibroids, respectively. The prevalence of both conditions increase with age and is highest among women aged 35–44 years: 10.1 and 13.0 percent of women in that age group had reported ever being diagnosed with endometriosis and uterine fibroids, respectively (data not shown). There are also racial and ethnic differences, with endometriosis being more common among non-Hispanic White women (6.9 percent) and uterine fibroids being more common for non-Hispanic Black women (12.3 percent). Although most cases of fibroids and endometriosis can be treated with pain or hormonal medication and certain surgeries, these two conditions are the most common reasons for hysterectomy—the removal of the uterus.[47]

Infertility, defined as not getting pregnant within 12 months of having unprotected sex with the same partner, affected 5.8 percent of married or cohabiting women aged 15–44 years in 2006–2010 (data not shown). This figure is higher among women who have not already had a birth (14.0 percent), and increases with age from 7.3 percent of nulliparous women aged 15–24 years to 29.6 percent of those aged 40–44 years. In addition to age-related reductions in the quality and quantity of eggs, other conditions that affect fertility also increase with age, including endometriosis, obesity, and polycystic ovary syndrome which impairs ovulation.[48]

Diagnosed Endometriosis and Uterine Fibroids Among Women Aged 15–44,* by Race/Ethnicity, 2006–2010**

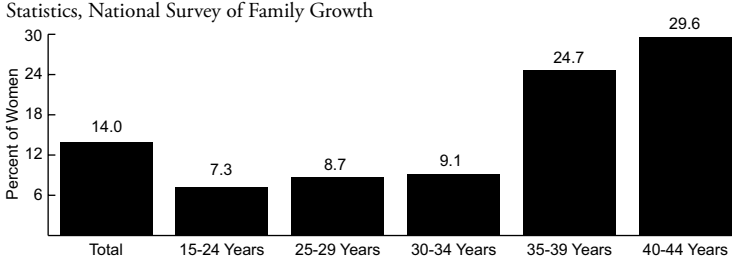
Source II.13: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Reported ever being diagnosed with endometriosis or uterine fibroids; all estimates are age-adjusted.
**The sample of Asians, American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Infertility* Among Married or Cohabiting Women Aged 15–44 Without a Previous Birth, by Age, 2006–2010

Source II.14: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Infertility is defined as not getting pregnant within 12 months of having unprotected sex with the same partner.

OSTEOPOROSIS

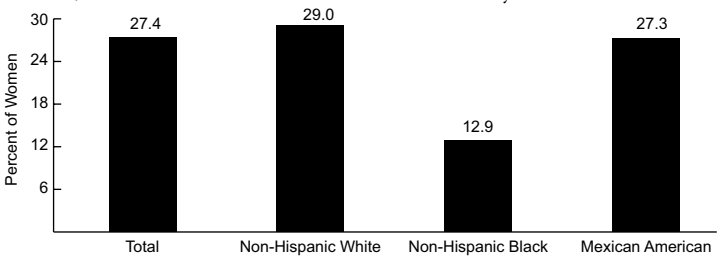
Osteoporosis is a bone weakness characterized by low bone density with symptoms that generally occur only after the disease is advanced.[49] Bone fractures are the most common consequence; others include loss of height, stooped posture, and back and neck pain from spinal fractures. Risk of osteoporosis is much higher among women than men and increases with age. In 2007–2010, an estimated 10 million women (9.0 percent) and 1.3 million men (1.3 percent) reported having been diagnosed with osteoporosis (data not shown). More than one in four women aged 65 and older reported having been diagnosed with osteoporosis (27.4 percent). Non-Hispanic White and Mexican American women aged 65 and older were more likely to have been diagnosed with osteoporosis than non-Hispanic Black women of the same age (29.0 and 27.3 percent versus 12.9 percent, respectively). Asian women have also been shown to be at higher risk of osteoporosis.[49]

Getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (such as walking), are critical in building peak bone mass in adolescence, maintaining bone health in adulthood, and slowing bone loss at older ages.[49,50] To promote early diagnosis of osteoporosis and the prevention of complications, bone density tests are recommended for all women aged 65 and older and younger women who have a risk factor, including low weight, parental history of hip fracture, smoking, and daily alcohol use.[51]

Bone fractures among the elderly most commonly occur among those with osteoporosis and can have devastating consequences. For example, 1 in every 5 hip fracture patients dies within a year of their injury.[50] Falls are a common direct cause of osteoporosis-related fracture and are the leading cause of injury—both fatal and nonfatal—among adults aged 65 and older. In 2011, there were 2.4 million unintentional nonfatal fall injuries treated in emergency departments among adults aged 65 and older (data not shown). The rate of nonfatal fall injury was higher among women than men and increased with age. Among both women and men, the rate of nonfatal fall injury was about five times higher among those aged 85 and older than those aged 65–69. Fall prevention efforts can include muscle strengthening, home hazard assessments and modifications, and avoiding sedative medications that may impair balance and coordination.[50]

Diagnosed Osteoporosis* Among Women Aged 65 and Older, by Race/Ethnicity,** 2007–2010

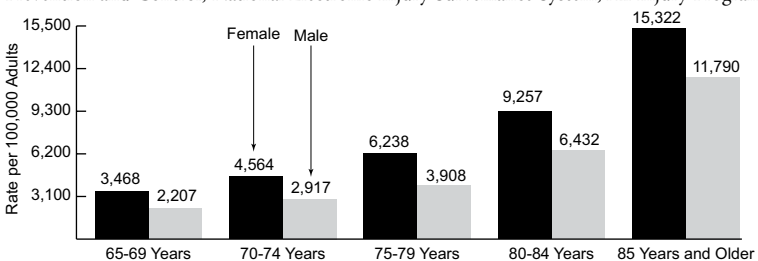
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they had osteoporosis. **The sample of American Indian/Alaska Natives, Asians, Native Hawaiian/Other Pacific Islanders, and persons of multiple race was too small to produce reliable results.

Nonfatal Unintentional Injury Due to Falls* per 100,000 Adults Aged 65 and Older, by Age and Sex, 2011

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



*Treated in hospital emergency departments.

ALZHEIMER'S DISEASE

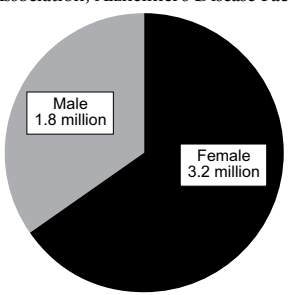
Alzheimer's disease is the most common form of dementia accounting for an estimated 60 to 90 percent of all dementia cases.[52] Early signs include difficulty remembering names and completing familiar tasks, with later disease progression leading to disorientation, personality changes, and difficulty speaking, swallowing, and walking. Although the risk for Alzheimer's disease increases with age, it is not a normal part of aging. Risk factors include a family history, head trauma or traumatic brain injury, and cardiovascular disease risk factors such as high cholesterol, hypertension, diabetes, smoking, and physical inactivity.

In 2013, 5 million or 11 percent of U.S. adults aged 65 and older are estimated to have Alzheimer's disease and another 200,000 below age 65 are thought to have early-onset Alzheimer's. Due to the aging of the population, the number of adults aged 65 and older with Alzheimer's disease is expected to triple by 2050.[52] Women constitute 3.2 million, or nearly two-thirds, of adults aged 65 and older with Alzheimer's.

Alzheimer's disease is the fifth leading cause of death among men and women aged 65 and older.[52] Severe dementia causes complications, such as immobility and swallowing disorders, that can lead to death due to malnutrition and infections like pneumonia. Between 2000 and 2010, the age-adjusted rate of death due to Alzheimer's for those aged 65 and older has increased by about 40 percent, from 141.2 to 196.9 deaths per 100,000 people. The increase was similar for both women and men and may reflect an increase in recognition of this disease as an underlying cause of death.[52] In 2010, the age-adjusted death rate for women aged 65 and older was 30 percent higher that of their male counterparts (214.3 versus 164.8 deaths per 100,000). The greater rates of Alzheimer's prevalence and mortality among women are related to their longer life expectancy rather than an increased sex-specific risk of disease.[52]

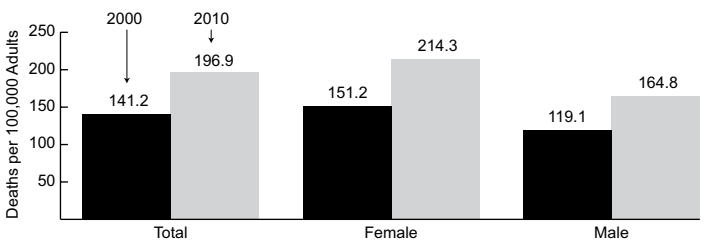
Not only are women more likely than men to have Alzheimer's, they are also more likely to be caregivers for someone with Alzheimer's—exacting a substantial toll of emotional and physical stress. Of the 15.4 million Americans who provide unpaid care for a person with Alzheimer's or another dementia, an estimated 70 percent are women.[52] Given the large and increasing burden of Alzheimer's disease, advances in prevention, early diagnosis, and treatment are greatly needed. In 2011, a new diagnostic category of "preclinical Alzheimer's disease" was developed to aid research for early detection and treatment prior to the onset of symptoms.[52]

Adults Aged 65 and Older with Alzheimer's Disease,* by Sex, 2013
Source II.15: Alzheimer's Association, Alzheimer's Disease Facts and Figures



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

Age-Adjusted Alzheimer's Disease Death Rates* Among Adults Aged 65 and Older, by Sex, 2000 and 2010
Source II.16: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



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

INJURY

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

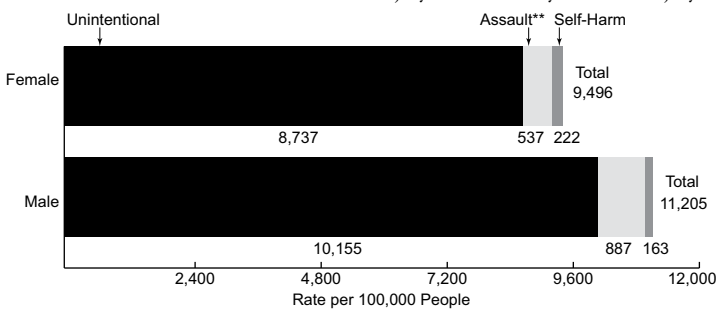
In 2011, there were 25.6 million nonfatal injuries among persons aged 15 and over, resulting in emergency department visits, of which 12.1 million, or 47 percent, were to females.[53] There were 9,496 nonfatal injuries per 100,000 females compared to 11,205 per 100,000 males. Although men had higher rates of nonfatal unintentional and assault injury than women, women had higher rates of injury due to self-harm (222 versus 163 per 100,000).

More than 90 percent of nonfatal injuries treated in an emergency department were unintentional for both males and females. Unintentional falls were the leading cause of nonfatal injury for women in every age group with the exception of 15–19 year olds for whom being struck by or against an object was the leading cause (data not shown). Unintentional injury rates due to falls increase with age (see *Osteoporosis*).

Injuries are the most common cause of death among both women and men aged 15–44.[33] In 2010, over 56,000, or 41.3 per 100,000, females aged 15 and over died due to injury. Unintentional injury deaths were most common (31.2 per 100,000), followed by suicide and homicide (6.3 and 2.5 per 100,000 females; data not shown). Although men have higher rates of fatal injury (101.1 per 100,000), females have experienced substantially greater increases in fatal injury rates over the past decade (18.0 versus 5.5 percent; data for men not shown). Between 2000 and 2010, motor vehicle traffic death rates declined while poisoning death rates more than doubled to become the leading mechanism of fatal injury, with the majority caused by drugs and specifically prescription painkillers.[54] Women are more likely to have chronic pain and may be more vulnerable to prescription painkiller dependency.[55] Fatal injury rates due to falls also increased over the past decade.

Nonfatal Injury* Rates Among Persons Aged 15 and Older, by Intent and Sex, 2011

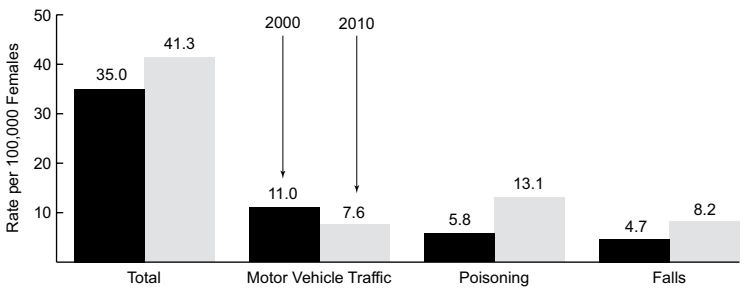
Source II.6: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Electronic Injury Surveillance System – All Injury Program



*Injuries resulting in emergency department visits; all rates are age-adjusted. **Includes injuries sustained during legal intervention (e.g., police pursuit and restraint).*

Fatal Injury Rates Among Females Aged 15 and Older, by Selected Mechanism, 2000 and 2010*

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



All rates are age-adjusted.

WOMEN SERVED BY COMMUNITY HEALTH CENTERS

Administered by the Health Resources and Services Administration's Bureau of Primary Health Care, Community Health Centers (CHCs) are a nationwide network of clinics that provide comprehensive primary care services, regardless of the ability to pay.[56] Some health centers also target services to specific populations, such as homeless persons and migrant workers.

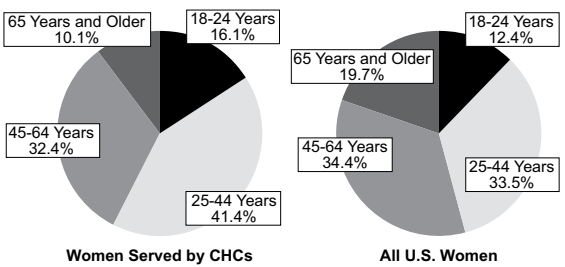
In 2012, Federally-supported CHCs served 21.1 million people, of whom 9.0 million were adult women aged 18 and older. Women served by CHCs tend to be younger than the general population. More than half of women (57.5 percent) served by CHCs were of reproductive age (18–44 years) compared to 45.9 percent of all women nationally.

In 2012, 92.6 percent of CHC patients had incomes at or below 200 percent of poverty, 61.6 percent were racial or ethnic minorities, 36.0 percent were uninsured, and 40.8 percent were Medicaid insured.[57] As a critical access point for the uninsured, CHCs will be pivotal to the success of the Affordable Care Act in helping to enroll and care for newly insured patients and continuing to serve those who may remain uninsured, including immigrants and low-income individuals in States that do not expand Medicaid.[58]

CHCs have a 45-year record of providing high-quality care that has helped to reduce health disparities.[59] Despite serving a low-income, mostly uninsured or publicly insured population, rates of recommended breast and cervical cancer screening among women seen at CHCs are similar to national averages for all women. In 2009, 74.5 and 85.2 percent of female CHC patients reported having received recommended breast and cervical cancer screenings, respectively, similar to 73.1 and 81.2 percent of all U.S. women. Moreover, women who were either publicly insured or uninsured and seen at CHCs were more likely to have received screenings than comparable women nationally. For example, fewer than half of uninsured women received recommended mammography screening (41.7 percent) compared to 3 out of 5 uninsured women seen at CHCs (62.0 percent).

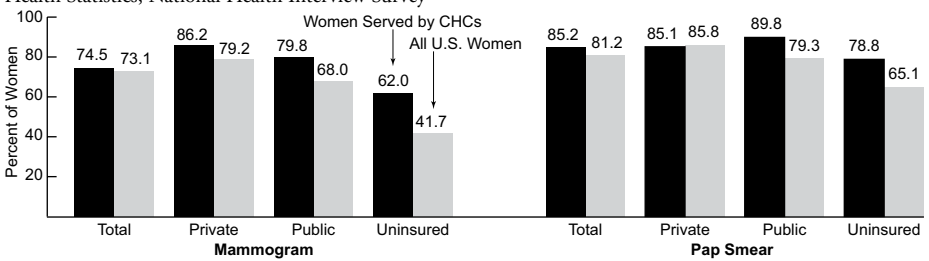
Women Aged 18 and Older Served by Community Health Centers Compared to All U.S. Women, by Age, 2012

Source II.17: Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System and U.S. Census Bureau, Annual Estimates of the Resident Population



Receipt of Recommended Breast and Cervical Cancer Screening* Among Women Served by Community Health Centers Compared to All U.S. Women, by Health Insurance Coverage,** 2009

Sources II.18: Health Resources and Services Administration, Bureau of Primary Health Care, Community Health Center Patient Survey and Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Based on U.S. Preventive Services Task Force recommendations of biennial mammography for women aged 50–74 years and a Pap smear every three years for women aged 21–65 years; CHC data are from the 2009 CHC Patient Survey; U.S. data are from the 2008/2010 National Health Interview Survey. **Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

IMMIGRANT WOMEN

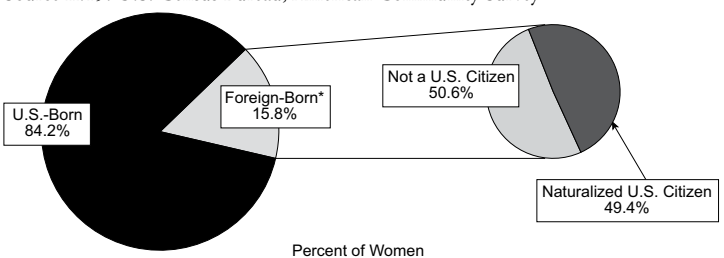
In 2011, 19.3 million women, representing 15.8 percent of all women residing in the United States, were immigrants, defined as foreign-born and not a U.S. citizen at birth. About half of immigrant women had become naturalized U.S. citizens, with the remaining half of non-citizens comprising legal permanent residents, temporary residents (e.g., foreign students), humanitarian migrants (e.g., refugees), and undocumented migrants. Over half of all U.S. immigrants are from Latin America (53.1 percent), followed by Asia (28.2 percent) and Europe (12.1 percent; data not shown).[60] Immigrants tend to be younger and have lower levels of education and income than the general U.S. population, despite having higher levels of labor force participation.[60]

Although immigrants tend to be healthier than U.S.-born populations, perhaps due to culturally-protective behaviors, this advantage erodes with length of U.S. residence[61] and may be hastened by barriers to health care, including limited health insurance access, lower income, and language barriers.[62] In 2011, nearly one in three foreign-born women were uninsured (29.4 percent) compared to 13.9 percent of U.S.-born women. Immigrant women were also nearly twice as likely as U.S.-born women to lack a usual source of care (19.9 versus 11.3 percent, respectively). Among immigrant women, non-citizens were most likely to be uninsured (41.1 percent) and have no usual source of care (25.6 percent). These barriers to care may translate into lower utilization of preventive services. In 2011, immigrant women were less likely than their U.S.-born counterparts to have received recommended vaccinations for HPV (15.2 versus 32.6 percent, respectively) and pneumococcal disease (45.4 versus 67.4 percent, respectively), which protect against cervical cancer and an infection that may cause pneumonia and other life-threatening complications. Non-citizen immigrant women were less likely than those with citizenship to have received pneumococcal vaccination.

Citizens and legal immigrants without health insurance may gain coverage options through Medicaid expansions and health insurance marketplaces as part of the Affordable Care Act, while community health centers will continue to be critical providers of high-quality, culturally-competent care for those who lack coverage (see *Women Served by Community Health Centers*).[63]

Women Aged 18 and Older, by Nativity and Citizenship Status, 2011

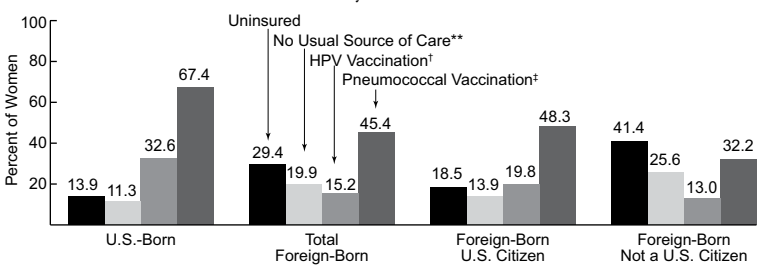
Source II.19: U.S. Census Bureau, American Community Survey



**Includes those born in another country and not a U.S. citizen at birth; naturalized citizens are those that have applied and been granted citizenship through a test and interviews; non-citizens include legal permanent residents, temporary residents (e.g. foreign students), humanitarian migrants (e.g. refugees), and undocumented migrants.*

Selected Health Care Indicators for Women Aged 18 and Older,* by Nativity and Citizenship Status, 2011

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



**Estimates of uninsured and no usual source of care are age-adjusted. **Defined as having a place where one usually receives care when sick, excluding emergency departments. †Aged 18-26 years; received at least one dose. ‡Aged 65 years and older.*

LESBIAN AND BISEXUAL WOMEN

Lesbian and bisexual women have been shown to be at increased risk for adverse health outcomes, including overweight and obesity, poor mental health, substance abuse, violence, and barriers to optimal health care resulting from social and economic inequities.[64,65] Although frequently referred to as part of a larger group of sexual minorities, including gay men and transgender individuals, the health status and needs of lesbian and bisexual women are shaped by a range of factors including sexual identity and behavior, as well as traditional sociodemographic factors, like age, education, and race and ethnicity. The terms "lesbian" and "bisexual" are used to define women according to their sexual orientation which can reflect sexual identity, behavior, or attraction;[66] on this page the terms lesbian and bisexual refer to women's self-reported sexual identity.[67]

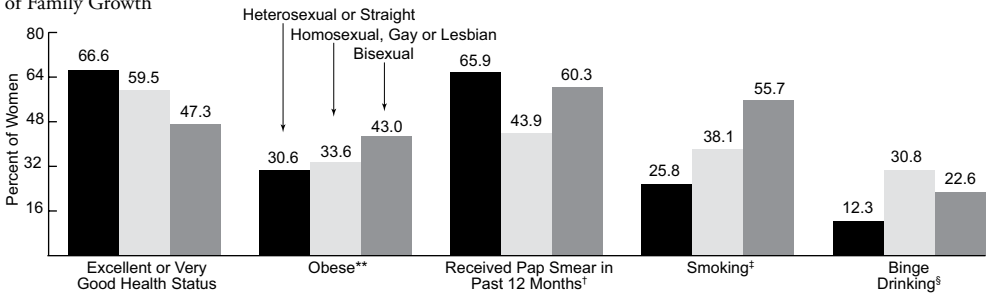
In 2006–2010, 1.2 percent of women aged 18–44 years self-identified as homosexual, gay, or lesbian and 3.9 percent self-identified as bisexual. The proportion of women who reported any same-sex sexual behavior, however, was substantially higher at 14.2 percent, while 16.5 percent of women in this age group reported some degree of same-sex attraction (data not shown).

Among reproductive-aged women in 2006–2010, differences were observed for several health indicators by sexual identity. Bisexual women were less likely than heterosexual women to report being in excellent or very good health (47.3 versus 66.6 percent, respectively) and more likely to be obese (43.0 versus 30.6 percent, respectively); no significant differences were observed between lesbian and heterosexual women for either indicator. Conversely, while 65.9 percent of heterosexual and 60.3 percent of bisexual women received a Pap smear in the past 12 months, only 43.9 percent of lesbians reported receiving this service. Both lesbian and bisexual woman, however, were more likely than heterosexual women to report smoking, with over half of bisexual women reporting this health risk behavior (55.7 percent), compared to 38.1 percent of lesbian women and 25.8 percent of heterosexual women. Similarly, 30.8 percent of lesbians and 22.6 percent of bisexual women reported binge drinking (defined as consuming 5 or more drinks within a couple of hours at least once a month on average during the past year), compared to 12.3 percent of heterosexual women.

A recent report from the Institute of Medicine concluded that to better understand and meet the unique needs of lesbian, gay, bisexual and transgender people, more data are needed in several priority areas: demographics, social influences, health care inequalities, and transgender-specific health needs.[66] The U.S. Department of Health and Human Services is working to increase the number of federally-funded health and demographic surveys that collect and report data on sexual orientation and gender identity.[68]

Selected Health Indicators Among Women Aged 18–44 Years, by Sexual Identity, 2006–2010*

Source II.13: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Estimates are age-adjusted. **Based on Body Mass Index (BMI), a number calculated from a person's weight and height. Obese is defined as a BMI of 30.0 or higher. †Calculated for females aged 20-44 years. ‡Smoked at least one cigarette per day on average in the past year. §Defined as consuming 5 or more drinks within a couple of hours at least once a month on average in the past year.

HEALTH SERVICES UTILIZATION

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

This section presents data on women's use of health services, including data on women's health insurance coverage, usual source of care, health care expenditures, and use of various services, such as preventive care, oral health care, and mental health services. New features within this section include data on contraceptive use and patient-centered care.

HEALTH INSURANCE

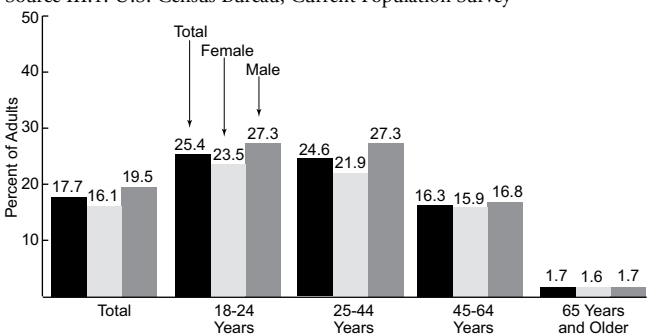
People who are uninsured face substantial financial barriers to health care, which can result in delayed diagnoses and poor health outcomes, including premature death.[1] Overall, 15.7 percent or 48.6 million people in the United States lacked health insurance in 2011, a decline from 16.3 percent in 2010.[2] Adults aged 18 and older accounted for 86 percent of all uninsured individuals in 2011 and have higher rates of uninsurance than children due to more limited eligibility for public insurance (17.7 versus 9.4 percent, respectively; data for children not shown). In 2011, women were less likely than men to be uninsured (16.1 versus 19.5 percent, respectively). Women are more likely to be in poverty (see *Women and Poverty*) and to qualify for Medicaid insurance available to low-income individuals who are pregnant, children, parents, elderly, or disabled.[1,3] Younger adults were most likely to be uninsured—about one in four adults under age 45 lacked health insurance compared to 16.3 percent of those aged 45–64 years and only 1.7 percent of those aged 65 and older, most of whom are eligible for Medicare coverage.

Among women aged 18–64 years in 2011, 67.3 percent had some form of private insurance, 13.2 percent had only public insurance, and 19.5 percent were uninsured. This distribution varied by race and ethnicity with non-Hispanic White women having the highest rates of any private insurance coverage (75.4 percent), compared to 55.2 percent of non-Hispanic Black women and less than half of non-Hispanic American Indian/Alaska Native and Hispanic women (46.6 and 45.3 percent, respectively). Public coverage alone was most common among non-Hispanic Black and non-Hispanic American Indian/Alaska Native women (21.9 and 23.5 percent, respectively). The highest rates of uninsurance were among Hispanic women and non-Hispanic American Indian/Alaska Native women (37.4 and 30.0 percent, respectively).

Of the nearly 13 million women aged 18–64 who rely on publicly-funded insurance, over two-thirds are covered by Medicaid alone, while 13.1 percent are covered by Medicare alone, and 10.3 percent have dual coverage. Another 9.4 percent rely on some other form of public coverage, including insurance from the military (data not shown).

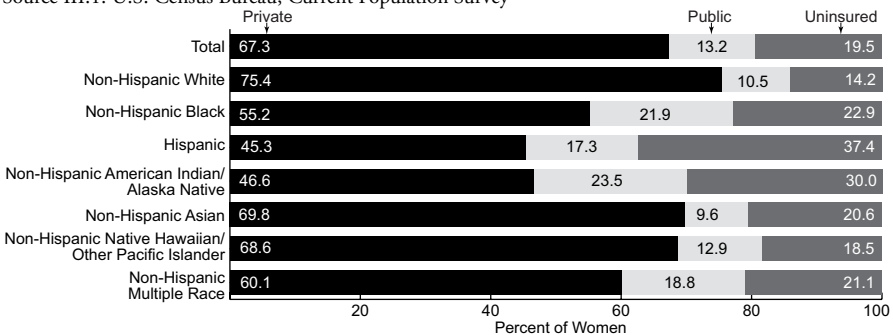
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2011

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



Health Insurance Coverage of Women Aged 18–64, by Race/Ethnicity and Health Insurance Coverage,* 2011

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



**Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans. Estimates may not add to 100 due to rounding.*

BARRIERS TO CARE AND UNMET NEED FOR CARE

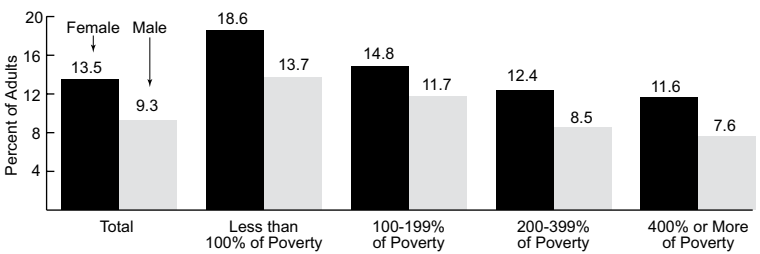
Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation.[4] Barriers to care contribute to socioeconomic, racial/ethnic, and geographic differences in health care utilization and health status.

In 2011, 11.4 percent or 26.4 million adults reported that they delayed getting medical care in the past year due to various logistical or structural factors, such as not being able to get an appointment soon enough and inconvenient office hours (data not shown). Women were more likely than men to report having delayed care due to logistical barriers in the past year (13.5 versus 9.3 percent, respectively). For both men and women, those with lower household incomes were more likely to report having delayed care as a result of logistical factors. For example, nearly 1 in 5 women (18.6 percent) living in households with income below 100 percent of poverty reported having delayed care, compared to about 12 percent of women in households with incomes of 200 percent or more of poverty. Hispanic and non-Hispanic American Indian/Alaskan Native women were more likely than non-Hispanic White, non-Hispanic Black, and non-Hispanic Asian women to report having delayed care due to logistical barriers (17.9 and 23.7 percent versus 12.4, 14.0, and 12.4 percent, respectively; data not shown).

Women were also slightly more likely than men to have forgone needed health care due to cost (8.7 versus 7.4 percent, respectively). For both women and men, the proportion who did not get needed care due to cost varied by insurance status. Among women, more than 1 in 4 (28.2 percent) of those without health insurance experienced an unmet need for health care due to cost compared to 3.9 percent of women with private insurance and 8.8 percent with public insurance. The Affordable Care Act helps to remove financial barriers to care by expanding Medicaid eligibility for more low-income people, establishing health insurance marketplaces where many individuals and small businesses will qualify for financial assistance with health insurance, and requiring private plans to cover preventive services without copays.[5]

Adults Aged 18 and Older Who Delayed Care Due to Logistical Barriers* in Past Year, by Poverty Level and Sex, 2011**

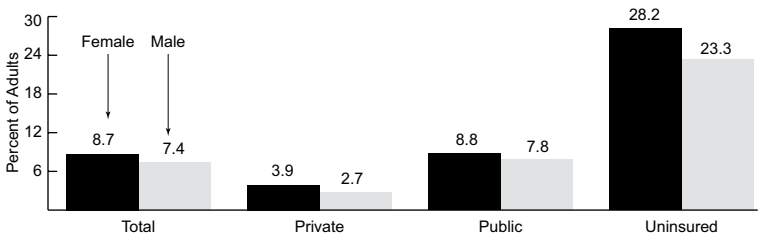
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they delayed getting medical care in the past year due to any of five reasons: couldn't get through on phone, couldn't get appointment soon enough, office room wait too long, inconvenient office hours, no transportation; all estimates are age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011.

Adults Aged 18 and Older with Unmet Need for Health Care* Due to Cost, by Health Insurance Coverage and Sex, 2011**

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



*Reported that they needed but did not get medical care because they could not afford it; excludes dental care; all estimates are age-adjusted. **Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

USUAL SOURCE OF CARE

In 2009–2011, 86.8 percent of women and 77.7 percent of men reported having a usual source of care, defined as a place where one usually goes when sick, such as a physician's office or health center but not an emergency department. Having a usual source of care has been shown to improve care quality and the receipt of preventive services.[6]

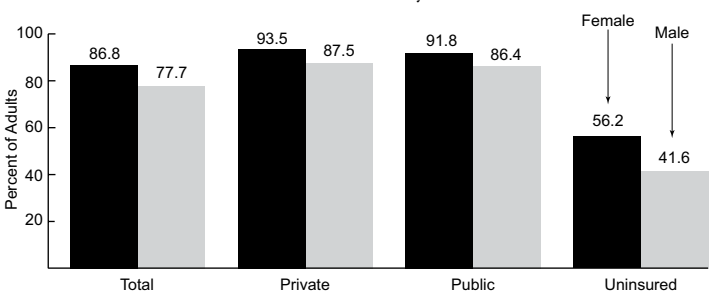
Health insurance coverage greatly increases the likelihood of having a usual source of care. Over 90 percent of women with private or public insurance coverage had a usual source of care, compared to only 56.2 percent of uninsured women. Having both a usual source of care and health insurance coverage has been found to significantly reduce problems obtaining needed medical care and delaying or forgoing needed care.[7]

Access to a usual source of care varies by race and ethnicity. For example, non-Hispanic White women were most likely to report a usual source of care (89.3 percent), while Hispanic women were least likely to do so (78.6 percent). Hispanic women are also least likely to have health insurance (see *Health Insurance*). Among women with private or public insurance, the proportion reporting a usual source of care was about 90 percent or higher for all racial and ethnic groups (data not shown).

Having a usual source of care also varies by age and is more common among older adults, who are most likely to have health insurance (see *Health Insurance*). For example, nearly all women aged 65 years and older (96.9 percent) had a usual source of care, compared to 78.6 percent of women aged 18–34 years. However, the likelihood of having a usual source of care increased with age even among those with private insurance: from 88.4 percent of women aged 18–34 years to 97.8 percent of those aged 65 years and older (data not shown).

Usual Source of Care* Among Adults Aged 18 and Older, by Health Insurance Coverage and Sex, 2009–2011**

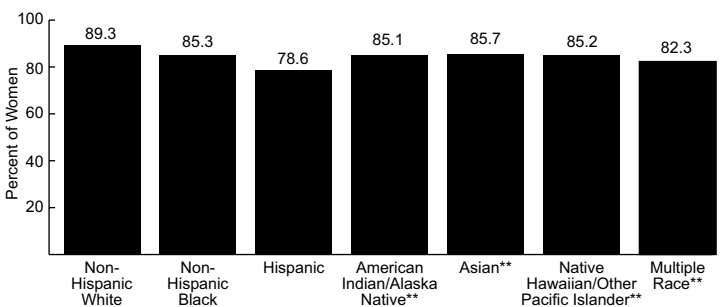
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Defined as having a place where one usually receives care when sick, excluding emergency departments; all estimates are age-adjusted. **Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.*

Usual Source of Care* Among Women Aged 18 and Older, by Race/Ethnicity, 2009–2011

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



**Defined as having a place where one usually receives care when sick, excluding emergency departments; all estimates are age-adjusted. **May include Hispanics.*

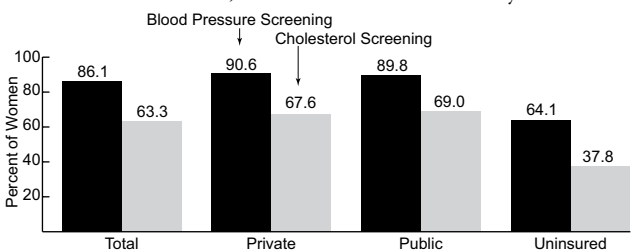
PREVENTIVE CARE

Preventive health care can help prevent or minimize the effects of many serious health conditions. The U.S. Preventive Services Task Force (USPSTF) recommends specific screening tests, counseling, immunizations, and preventive medications for a variety of diseases and conditions.[8] For example, annual blood pressure screening is recommended for adults aged 18 and older and annual cholesterol screenings are recommended for adults aged 20 and older with other cardiovascular risk factors. High blood pressure and cholesterol are risk factors for heart disease and stroke that can be lowered with identification and treatment. In 2011, 86.1 percent of women aged 18 and older had a blood pressure screening and 63.3 percent of women aged 20 and older received a cholesterol screening in the past year. Receipt of screening was much lower among women without health insurance. For example, only 64.1 percent of uninsured women had their blood pressure checked in the past year compared to about 90 percent of insured women.

To protect against certain strains of the Human Papillomavirus (HPV) that cause cervical cancer, anal cancer, and genital warts, vaccination is now universally recommended for girls and boys aged 11–12 years with catch-up vaccination for females aged 13–26 years and males aged 13-21 years who have not been previously vaccinated.[9] Pneumococcal vaccination protects against a bacterial infection that may cause pneumonia or other life-threatening illnesses and is recommended for young children, adults aged 65 years and older, and persons with certain health conditions.[9] In 2011, only 30.4 percent of women aged 18–26 years had received at least one dose of HPV vaccine and 64.5 percent of women aged 65 and older had received pneumococcal vaccination. Hispanic and non-Hispanic Asian women had lower HPV vaccination rates compared to women of other racial/ethnic groups. Along with non-Hispanic Black women, Hispanic and non-Hispanic Asian women also had lower rates of pneumococcal vaccination. The Affordable Care Act improves access to preventive care by expanding health insurance and requiring new private plans to cover USPSTF-recommended preventive services and additional services for women, such as well-woman visits, without copays.[5]

Receipt of Selected Screenings in Past Year Among Women,* by Health Insurance Coverage,** 2011

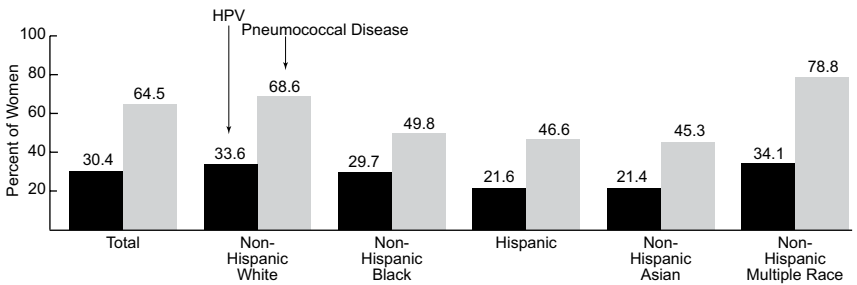
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Aged 18 or over for blood pressure screen and aged 20 or older for cholesterol screen; reported to have been checked by a health professional; all estimates are age-adjusted. **Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

Receipt of Selected Vaccinations Among Women,* by Race/Ethnicity,** 2011

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



*Reported having ever received the HPV vaccine among women aged 18–26 years and having ever received the pneumonia vaccine among women aged 65 years and older. **The sample of American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

CONTRACEPTIVE USE

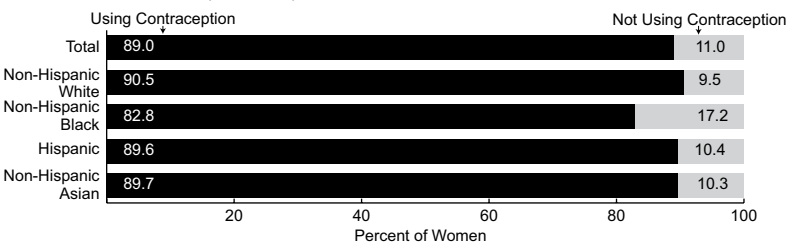
Family planning is considered to be among the top 10 public health achievements of the past century, enabling women to achieve desired birth spacing and family size, and resulting in improved health of infants, children, and women.[10] Yet, half of all pregnancies and one-third of all births in the United States are estimated to be unintended at the time of conception with wide disparities by race and ethnicity and other demographic characteristics.[11] Unintended pregnancies that lead to births are associated with both short- and long-term negative outcomes for both mother and child, including delayed prenatal care, maternal depression, increased risk for intimate partner violence, and poor developmental and educational outcomes for children.[12]

In 2006–2010, there were 43 million women at risk of unintended pregnancy—who were either currently using contraception or having intercourse and not sterile (for noncontraceptive reasons), pregnant, postpartum, or trying to get pregnant—of whom 89.0 percent reported using contraception while the remaining 11.0 percent did not. Non-Hispanic Black women were more likely than women of other races and ethnicities to not use contraception while at risk of unintended pregnancy (17.2 percent). Younger and never-married women were also more likely than their older or married counterparts to not use contraception while at risk of unintended pregnancy (data not shown).

Among women aged 15–44 years who were using contraception, the most commonly used methods were female or male sterilization (36.6 percent), the pill (27.5 percent), and condoms (16.4 percent), followed by other hormonal methods such as implants, patches, and rings (7.2 percent) and intrauterine devices (IUDs; 5.6 percent). Effectiveness rates based on typical use, including incorrect or inconsistent use, are highest for sterilization, IUDs, the pill, and other hormonal methods, and fall below 90 percent for condoms, sponges, withdrawal, and periodic abstinence.[13] Variation in contraceptive use and method may help to explain demographic patterns of unintended pregnancy. The Affordable Care Act ensures women have access to a full range of recommended preventive services by expanding insurance coverage and requiring most private health plans to provide FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling without copays.[14]

Contraceptive Use Among Women Aged 15–44 Years at Risk of Unintended Pregnancy,* by Race/Ethnicity, 2006–2010**

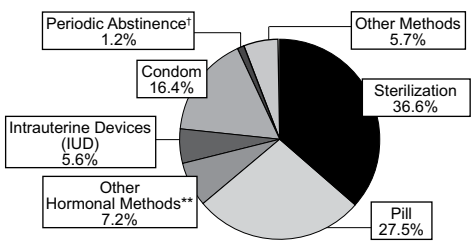
Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*At risk of unintended pregnancy is defined as either currently using contraception or having had intercourse in the last 3 months among those who were not currently pregnant, postpartum, trying to get pregnant, or sterile for noncontraceptive reasons. **The sample of American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Contraceptive Method Used Among Women Aged 15–44 Years Using Contraception, 2006–2010*

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



*Women who used more than one form of contraception are classified according to the most effective form listed; estimates may not total to 100 due to rounding. **Includes hormonal implants, patches, injectables, and rings. †Includes calendar rhythm, natural family planning (NFP), cervical mucus test, and temperature rhythm.

MENTAL HEALTH CARE UTILIZATION

In 2009–2011, 31 million, or 13.6 percent of adults in the United States reported receiving mental health treatment in the past year for a mental, behavioral, or emotional disorder other than a substance use disorder (data not shown). Women were more likely than men to receive treatment or counseling (17.5 versus 9.4 percent), which is consistent with the higher prevalence of mental illness (excluding substance use disorder) among women (see *Mental Illness*).

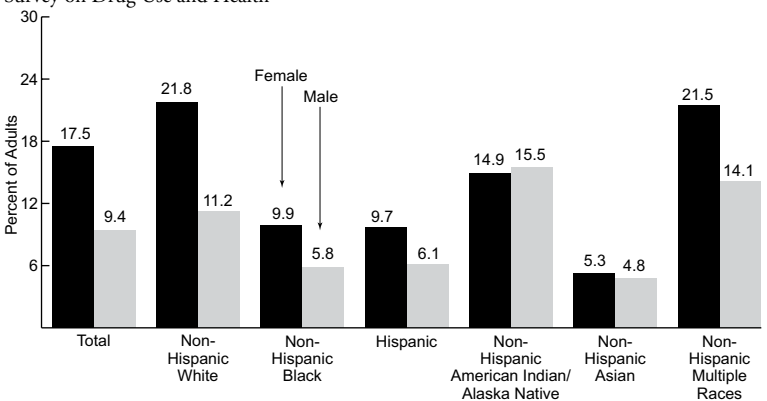
Utilization of mental health services was highest among non-Hispanic White and multiracial women with more than one in five reporting past-year treatment or counseling (21.8 and 21.5 percent, respectively). Non-Hispanic Asian women were least likely to have reported receiving past year mental health treatment or counseling (5.3 percent).

In 2009–2011, 17.7 million women aged 18 years and older reported using prescription medication for treatment of a mental or emotional condition, representing 14.9 percent of women, which is almost twice the proportion of men (7.8 percent). Women were also nearly twice as likely as men to report receiving outpatient mental health treatment (8.6 versus 4.7 percent, respectively). Less than 1 percent of men and women received inpatient treatment during this period (data not shown).

In 2009–2011, mental health services were needed, but not received in the previous year, by 5.0 percent of adults. Women were twice as likely as men to report an unmet need for mental health treatment or counseling in the past year (6.7 versus 3.3 percent, respectively; data not shown). Among women, cost was the most commonly reported reason for not receiving needed services (45.4 percent), followed by the belief that the problem could be handled without treatment (25.0 percent).

Past-Year Mental Health Treatment/Counseling* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex, 2009–2011**

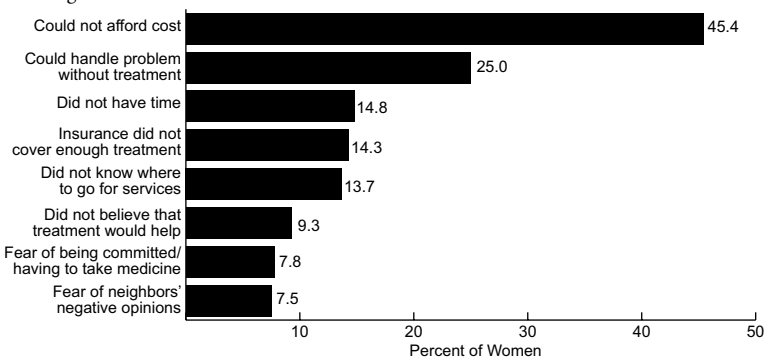
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use; all estimates are age-adjusted. **The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

Reasons for Not Receiving Mental Health Treatment/Counseling* Among Women Aged 18 and Older with an Unmet Need for Mental Health Services, 2009–2011

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



*Defined as a perceived need for mental health treatment/counseling that was not received; all estimates are age-adjusted.

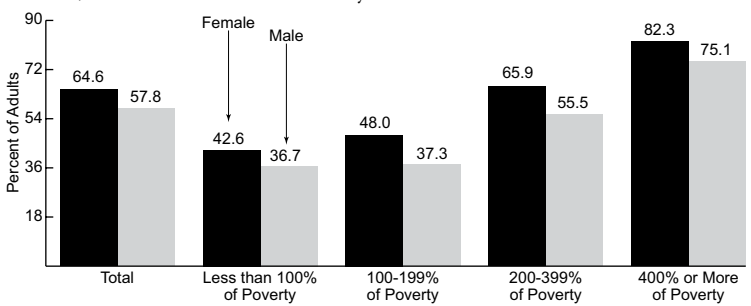
ORAL HEALTH CARE UTILIZATION

Regular dental care is essential to promote oral health and to prevent and treat tooth decay and infection. Untreated dental disease can produce significant pain and disability, and can result in tooth loss. In addition to daily brushing and flossing, the American Dental Association recommends regular dental exams and cleanings.[15] In 2011, women were somewhat more likely to have a past-year dental visit than men (64.6 and 57.8 percent, respectively). Among both men and women, those with greater household incomes were more likely to have had a dental visit. For example, 82.3 percent of women with household incomes of 400 percent or more of poverty had a past year dental visit, compared to 42.6 percent of women with incomes less than 100 percent of poverty.

Cost is a significant barrier to appropriate utilization of dental care. In 2011, only 20.4 percent of adults had private insurance coverage that included dental care (data not shown). Medicaid and Medicare generally do not cover dental care and even private plans with dental coverage contain limited benefits with high cost-sharing.[16] In 2011, 16.4 percent of women reported that they did not obtain needed dental care in the past year because they could not afford it; this was slightly higher than the percentage of men who reported an unmet need for dental care due to cost (13.0 percent). The likelihood of not getting dental care due to cost varies significantly by health insurance coverage. For example, only 7.0 percent of women with private insurance that included dental benefits reported that they did not obtain needed dental care in the past year due to costs, which nearly doubles to 13.7 percent of women with private insurance that did not include dental benefits. However, the likelihood of not getting needed dental care because of cost was considerably higher for women with public insurance (22.7 percent) and highest for women without any insurance (36.3 percent).

Past-Year Dental Visit Among Adults Aged 18 and Older, by Poverty Level,* 2011

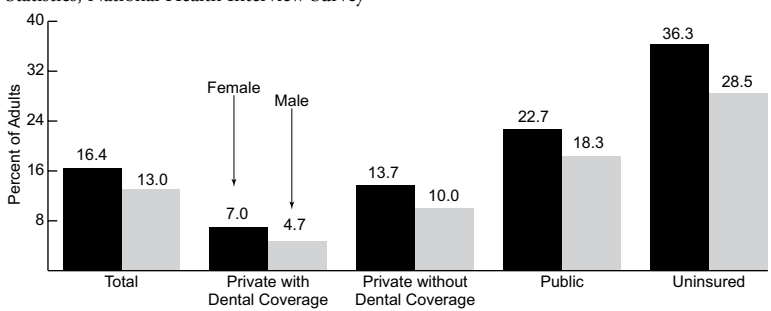
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Poverty level, defined by the U.S. Census Bureau, was $23,021 for a family of four in 2011; all estimates are age-adjusted.*

Unmet Need for Dental Care Due to Cost Among Adults Aged 18 and Older,* by Health Insurance Coverage, 2011**

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



**Reported needing dental care in the past year, but not getting it because of costs; all estimates are age-adjusted. **Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.*

HEALTH CARE EXPENDITURES

In 2010, 89.4 percent of women had at least one health care expense, compared to 78.7 percent of men (data not shown). For both women and men, about 40 percent of expenses were paid by private insurance while about 35 percent were paid by Medicare or Medicaid, and slightly less than 15 percent were paid out of pocket.

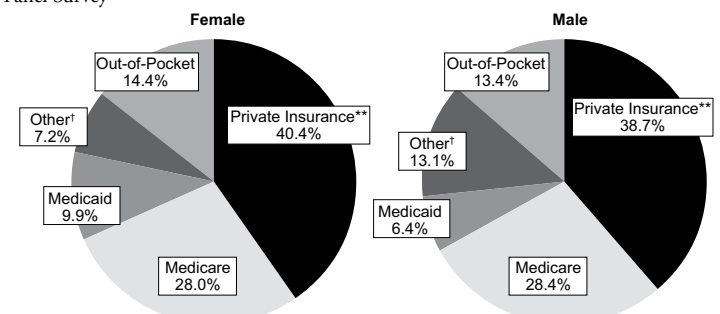
In 2010, women paid an average of $928 out-of-pocket for health care services compared to $798 paid by men (data not shown). The proportion of health care expenses paid out-of-pocket by women varied by insurance coverage. Almost one-fifth (17.1 percent) of the expenses reported by privately insured women younger than 65 were paid out-of-pocket, compared to 5.7 percent of expenses reported by publicly-insured women and nearly one-third (32.0 percent) of the expenses reported by uninsured women (data not shown).

Among adults who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was slightly higher for women ($6,066) than for men ($5,547). However, men's average expenditures significantly exceeded women's for hospital inpatient services ($22,118 versus $15,792, respectively). Women's average expenditures significantly exceeded men's only in the category of office-based medical services ($1,645 versus $1,455, respectively). The overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 10.6 percent of women had hospital inpatient services, which includes childbirth delivery, compared to 6.5 percent of men.

The Affordable Care Act contains a number of provisions to reduce health care costs, for example by eliminating copayments for recommended preventive services in private plans and testing new payment systems for Medicare to improve quality and efficiency.[17]

Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment*, 2010

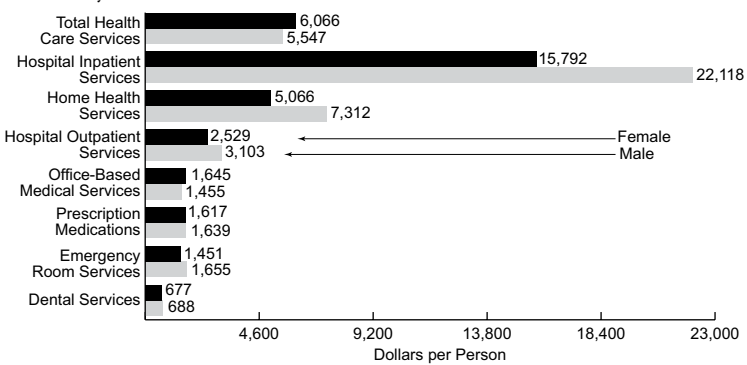
Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



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

Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2010

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



HEALTH CARE QUALITY

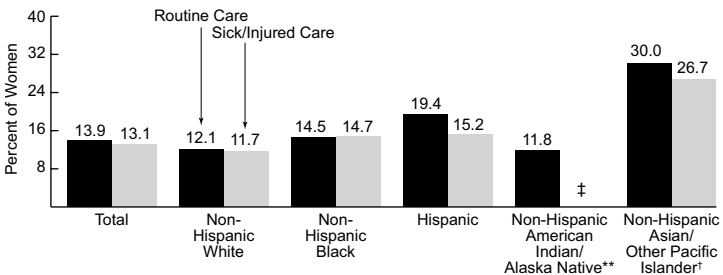
High quality health care can support effective disease prevention, detection, and treatment as well as opportunities to promote health and wellness. The quality of health care can be measured in many ways, including patient safety, receipt of evidence-based clinical services, care coordination, the timeliness of care and the extent to which patients feel that they are able to communicate with their doctors and engage in health care decision-making.[18,19]

In 2010, nearly one-sixth of women reported that they were only sometimes or never able to make an appointment for routine care and sick care as soon as they wanted (13.9 and 13.1 percent, respectively). This varied by race and ethnicity. For example, non-Hispanic Asian/Pacific Islander and Hispanic women (30.0 and 19.4 percent, respectively) were more likely to report difficulty in making timely appointments for routine care than non-Hispanic Black (14.5 percent), non-Hispanic White (12.1 percent), or non-Hispanic American Indian/Alaska Native women (11.8 percent).

Patient centeredness refers to health care that is delivered in partnership with patients (and their families) and prioritizes informed patient engagement in health care decision-making.[20] In 2010, approximately three in five women who reported going to a doctor's office or clinic in the previous 12 months reported that their health care provider always listened carefully to them (61.1 percent); a similar proportion reported that their provider always explained things clearly (60.9 percent). Nearly two-thirds (65.0 percent) reported that their provider showed respect for what they had to say, while only about half reported that their provider always spent enough time with them (50.4 percent). Among women younger than 65 years of age, privately insured women were more likely than publicly insured and uninsured women to report that their health care providers always engaged in each type of patient-provider communication. For example, 62.8 percent of privately insured women reported that their provider always explained things clearly compared to about 54 percent of publicly insured and uninsured women.

Trouble Making Appointments* for Routine and Sick/Injured Health Care Among Women Aged 18 and Older, by Race/Ethnicity, 2010

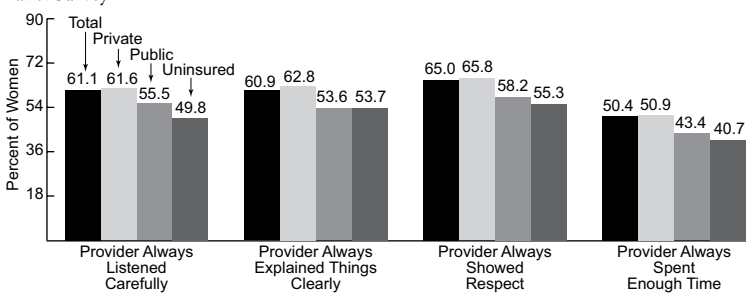
Source III.5: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



**Sometimes or never able to get an appointment as soon as desired among women who reported making an appointment for routine health care in the past 12 months. **Includes individuals of multiple races. †Separate estimates for Asians, Native Hawaiians, and Other Pacific Islanders were not available. ‡Estimate does not meet standards of reliability or precision.*

Patient Centeredness Experienced by Women Aged 18 and Older,* by Health Insurance Coverage, 2010**

Source III.5: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



**Among women who reported going to a doctor's office or clinic in the past 12 months. **Insurance type is presented for women under 65 years of age, consistent with the data source; totals include all women aged 18 and older. Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.*

HRSA PROGRAMS RELATED TO WOMEN'S HEALTH

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) is the Federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA's mission, "To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs," supports the Affordable Care Act which will provide Americans with better health security, expand health insurance coverage, and enhance the quality of care.

HRSA's Office of Women's Health (OWH) is the agency lead for women's health policy and programming. OWH engages with Bureaus and Offices to enhance HRSA programs through collaborations focusing on reducing sex and gender-based disparities and supporting the HRSA mission. Priorities include violence prevention coordination; mobile health; and the HRSA-supported Women's Preventive Health Service Guidelines under the Affordable Care Act. In 2013, the office launched the "Care Counts: Educating Women and Families Challenge" to support enrollment in the health insurance marketplace.

The Maternal and Child Health Bureau (MCHB) supports access to comprehensive women's health care to improve their health across the life course through the Title V MCH Block Grant, Home Visiting, and Healthy Start Programs. MCHB is focused on reducing maternal morbidity and mortality through the integration of the life course model by addressing women's health before, during, and after pregnancy. The Bureau is also supporting the provisions under the Affordable Care Act to promote primary preventive health services for women, primarily through its community-based Home Visiting and Healthy Start programs.

The **HIV/AIDS Bureau** (HAB) provides resources and services for individuals living with HIV/AIDS through the Ryan White Program; Part D specifically addresses the needs of women, infants, children and youth, and their families. HAB funds two Special Projects of National Significance (SPNS) which include Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color and Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color. Given the intersection between interpersonal violence and HIV/AIDS, HAB grantees with significant numbers of female clients are more likely to provide screening, counseling, and referrals to domestic violence and shelter services.

The **Bureau of Primary Health Care** (BPHC) aims to improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, and quality primary health care services. In 2012, BPHC-supported health centers served 9 million women aged 18 and older, representing 63 percent of all health center patients aged 18 and older. See page on *Women Served by Community Health Centers*.

The **Bureau of Clinician Recruitment and Service** (BCRS) administers the National Health Service Corps (NHSC) and NURSE Corps programs, which provide loan repayment and scholarships to clinicians working in underserved communities. The NHSC consists of nearly 10,000 clinicians in practice or in training. Nearly 62 percent of NHSC in practice and nearly 71 percent of NHSC students are female. The NURSE Corps has about 3,250 registered and advanced practice nurses in practice or in training. More than 62 percent of NURSE Corps in practice and nearly 85 percent of NURSE Corps students are female.

The **Bureau of Health Professions** (BHPr) provides policy leadership and health professions training grants in support of workforce quality and culturally appropriate care in medically underserved areas. Initiatives include promoting interprofessional teams and integrating population health into training programs. BHPr supports women's health continuing education programs and discipline-specific degree and residency programs to address early detection and prevention across the life span on topics such as prenatal health, breastfeeding, breast and cervical cancer.

ENDNOTES

Population Characteristics

1. U.S. Census Bureau, Population Division. Estimates of the Resident Population by Sex, Single Year of Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2011. May 2012. Retrieved from http://factfinder2.census.gov/. Accessed 04/30/13.
2. National Partnership for Action to End Health Disparities. National Stakeholder Strategy for Achieving Health Equity. Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health; April 2011. Retrieved from http://www.minorityhealth.hhs.gov/. Accessed 04/30/13.
3. U.S. Census Bureau. 2011 American Community Survey. Characteristics of Same-Sex Couple Households, 2011. Retrieved from http://www.census.gov/. Accessed 06/14/13.
4. The U.S. 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 2011 poverty levels were $11,484 for an individual and $23,021 for a family of four. These levels differ from the poverty guidelines used to determine eligibility for Federal programs.
5. DeNavas-Walt C, Proctor BD, and Smith JC. U.S. Census Bureau. Current Population Reports, P60-243, Income, Poverty, and Health Insurance Coverage in the United States: 2011. Washington, DC: U.S. Government Printing Office; 2012.
6. Coleman-Jensen A, Nord M, Singh A. Household Food Security in the United States in 2012. ERR-155. Washington, DC: U.S. Department of Agriculture, Economic Research Service; September 2013. Retrieved from http://www.ers.usda.gov/publications/err-economic-research-report/err155.aspx. Accessed 11/05/13.
7. Seligman HK, Laraia BA, Kushel MB. Food insecurity is associated with chronic disease among low-income NHANES participants. Journal of Nutrition. February 2010;140(2):304-10.
8. U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. Building a Healthy America: A Profile of the Supplemental Nutrition Assistance Program. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis; April 2012.
9. Strayer M, Eslami E, and Leftin J. Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2011. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis; 2012.
10. U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2012. CPS Table Creator. Retrieved from http://www.census.gov/. Accessed 06/21/13.
11. U.S. Department of Agriculture, Food and Nutrition Service. WIC: Frequently Asked Questions. Retrieved from http://www.fns.usda.gov/wic/FAQs/FAQ.HTM. Accessed 06/21/13.
12. Martinez-Schiferl M, Zedlewski S, Giannarelli L. National and State-Level Estimates of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Eligibles and Program Reach, 2010. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis; January 2013.
13. U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics. Digest of Educational Statistics: 2012, Table 9 and 317. Retrieved from http://nces.ed.gov/. Accessed 08/22/13.
14. U.S. Census Bureau. 2009-2011 American Community Survey – Public Use Microdata Sample. Analysis conducted by the Maternal and Child Health Bureau.
15. U.S. Department of Labor, Bureau of Labor Statistics. Women in the Labor Force: A Databook. Retrieved from http://www.bls.gov/. Accessed 05/02/13.
16. Blau F, Kahn L. The Gender Pay Gap: Have Women Gone as Far as They Can? Academy of Management Perspectives. February 2007;21(1):7-23.
17. National Rural Health Association. What's different about rural health care? Retrieved from http://www.ruralhealthweb.org/. Accessed 06/21/13.
18. U.S. Department of Veterans Affairs, Office of Policy and Planning. Veteran Population Projection Model 2011 National Table by Age and Gender. Retrieved from http://www.va.gov/vetdata/Veteran_Population.asp. Accessed 08/26/13.
19. National Center for Veterans Analysis and Statistics. America's Women Veterans: Military Service History and VA Benefit Utilization Statistics. Washington, DC: National Center for Veterans Analysis and Statistics, Department of Veterans Affairs; November 2011.
20. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. Profile of Veterans: 2011, Data from the American Community Survey. Retrieved from http://www.va.gov/vetdata/Report.asp. Accessed 08/28/13.
21. Kimerling R, Street AE, Pavao J, Smith MW, Cronkite RC, Holmes TH, Frayne SM. Military-related sexual trauma among Veterans Health Administration patients returning from Afghanistan and Iraq. Am J Public Health. August 2010;100(8):1409-12.

Health Status

1. U.S. Department of Health and Human Services. 2008 Physical Activity Guidelines for Americans. October 2008. Retrieved from http://www.health.gov/. Accessed 09/02/13.
2. U.S. Department of Agriculture, U.S. Department of Health and Human Services. Dietary Guidelines for Americans, 2010. 7th ed. Washington, DC: U.S. Government Printing Office; 2010. Retrieved from http://www.health.gov/dietaryguidelines/. Accessed 09/20/13.
3. Bowman SA, Vinyard BT. Fast food consumption of U.S. adults: Impact on energy and nutrient intakes and overweight status. J Am Col Nutr. 2004;23(2):163–8.
4. Harvard School of Public Health. Sugary Drinks and Obesity Fact Sheet. Retrieved from http://www.hsph.harvard.edu/nutritionsource/sugary-drinks-fact-sheet/. Accessed 09/20/13.
5. Centers for Disease Control and Prevention. Fact Sheets: Alcohol Use and Health. Retrieved from http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm. Accessed 06/15/13.
6. National Institute on Alcohol Abuse and Alcoholism. Women and Alcohol. Retrieved from http://pubs.niaaa.nih.gov/publications/womensfact/womensfact.htm. Accessed 06/15/13.
7. Centers for Disease Control and Prevention. Vital Signs: Binge Drinking – A serious and under-recognized problem among women and girls. Retrieved from http://www.cdc.gov/vitalsigns/BingeDrinkingfemale/. Accessed 06/15/13.
8. U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 2010. Retrieved from http://www.surgeongeneral.gov/. Accessed 06/15/13.
9. Centers for Disease Control and Prevention (CDC). Smoking-attributable mortality, years of potential life lost, and productivity losses--United States, 2000-2004. MMWR Morb Mortal Wkly Rep. November 14, 2008;57(45):1226-8.
10. Koh HK, Sebelius KG. Promoting prevention through the Affordable Care Act. N Engl J Med. September 30, 2010;363(14):1296-9.
11. National Institutes of Health, National Institute on Drug Abuse. Commonly Abused Drugs Chart. Retrieved from http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/commonly-abused-drugs-chart. Accessed 06/16/13.

12. Centers for Disease Control and Prevention. Persons Who Use Drugs: Infections among Persons Who Use Drugs. Retrieved from http://www.cdc.gov/. Accessed 06/16/13.
13. Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980–2008. NCHS data brief, no. 81. Hyattsville, MD: National Center for Health Statistics; 2011.
14. Desjardins, B. Why is life expectancy longer for women than it is for men? Scientific American [serial online]. August 30, 2004. Retrieved from http://www.scientificamerican.com/.
15. Riosmena F, Wong R, Palloni A. Migration selection, protection, and acculturation in health: a binational perspective on older adults. Demography. June 2013;50(3):1039-64.
16. Kindig DA, Cheng ER. Even as mortality fell in most U.S. counties, female mortality nonetheless rose in 42.8 percent of counties from 1992 to 2006. Health Aff (Millwood). March 2013;32(3):451-8.
17. Centers for Disease Control and Prevention. Health Related Quality of Life. Retrieved from http://www.cdc.gov/hrqol/. Accessed 09/09/13.
18. Centers for Disease Control and Prevention, National Center for Health Statistics. 2009 National Health Interview Survey (NHIS) Questionnaire: Adult Health Status and Limitations. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics; 2009.
19. Centers for Disease Control and Prevention. Arthritis: Meeting the Challenge of Living Well. Retrieved from http://www.cdc.gov/. Accessed 09/12/13.
20. Centers for Disease Control and Prevention. Arthritis. Osteoarthritis. Retrieved from http://www.cdc.gov/arthritis/basics/osteoarthritis.htm. Accessed 09/20/13.
21. Arthritis Foundation. Arthritis in Women. Retrieved from http://www.arthritis.org/. Accessed 09/20/13.
22. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Overweight and Obesity: Adult Obesity Facts. Retrieved from http://www.cdc.gov/. Accessed 09/05/12.
23. Flegal KM, Carroll MD, Kit BK, Ogden CL. Prevalence of obesity and trends in the distribution of body mass index among U.S. adults, 1999-2010. JAMA. February 1, 2012;307(5):491-7.
24. Schoenborn CA, Adams PF, Peregoy JA. Health behaviors of adults: United States, 2008–2010. National Center for Health Statistics. Vital Health Stat. 2013;10(257).
25. Centers for Disease Control and Prevention. Recommended community strategies and measurements to prevent obesity in the United States. Morbidity and Mortality Weekly Report. 2009;24;58(RR-7):1-26.
26. Centers for Disease Control and Prevention. 2011 National Diabetes Fact Sheet. Retrieved from http://www.cdc.gov/. Accessed 08/20/13.
27. National Institute of Diabetes and Digestive and Kidney Diseases. Prediabetes: What You Need to Know. Retrieved from http://diabetes.niddk.nih.gov/. Accessed 08/20/13.
28. American Heart Association. High Blood Pressure. Retrieved from http://www.heart.org/hbp. Accessed 06/30/13.
29. Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths preventable in the U.S. by improvements in use of clinical preventive services. Am J Prev Med. June 2010;38(6):600-9.
30. Cardiovascular Disease Foundation. What is Cardiovascular Disease? Retrieved from http://www.cvdf.org/. Accessed 09/16/13.
31. Centers for Disease Control and Prevention. Vital Signs: Avoidable Deaths from Heart Disease, Stroke, and Hypertensive Disease, United States 2001-2010. MMWR. 2013;62:721-727.
32. American Heart Association. Heart attack, stroke, and cardiac arrest warning signs. Retrieved from http://www.heart.org/. Accessed 09/13/13.
33. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): Leading Causes of Death. Retrieved from http://www.cdc.gov/injury/wisqars /leading_causes_death.html. Accessed 07/06/13.
34. Colditz GA, Wei EK. Preventability of cancer: the relative contributions of biologic and social and physical environmental determinants of cancer mortality. Annu Rev Public Health. 2012;33:137-56.
35. American Cancer Society. Cancer Facts and Figures 2013. Atlanta: American Cancer Society; 2013. Retrieved from http://www.cancer.org/. Accessed 06/23/13.
36. National Institutes of Health. What is COPD? Retrieved from http://www.nhlbi.nih.gov/. Accessed 09/20/13.
37. The Mayo Clinic. COPD: Risk Factors. Retrieved from http://www.mayoclinic.com/. Accessed 09/20/13.
38. American Lung Association. COPD: Symptoms Diagnosis and Treatment. Retrieved from http://www.lung.org/. Accessed 09/22/13.
39. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry. 2005;62(6):593-602.
40. Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.
41. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Intimate Partner Violence: Definitions. Retrieved from http://www.cdc.gov/. Accessed 07/25/13.
42. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
43. Centers for Disease Control and Prevention. Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States. February 2013. Retrieved from http://www.cdc.gov/std/stats/. Accessed 08/05/13.
44. Centers for Disease Control and Prevention. Sexually Transmitted Diseases. Retrieved from http://www.cdc.gov/std/default.htm. Accessed 08/05/13.
45. Office on Women's Health, U.S. Department of Health and Human Services. Endometriosis Fact Sheet. Retrieved from http://www.womenshealth.gov/. Accessed 08/23/13.
46. Office on Women's Health, U.S. Department of Health and Human Services. Uterine Fibroids Fact Sheet. Retrieved from http://www.womenshealth.gov/. Accessed 08/23/13.
47. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health. Women's Reproductive Health: Hysterectomy. Retrieved from http://www.cdc.gov/. Accessed 08/23/13.
48. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health. Infertility. Retrieved from http://www.cdc.gov/. Accessed 08/23/13.
49. Mayo Clinic. Osteoporosis. June 2013. Retrieved from http://www.mayoclinic.com/. Accessed 06/23/13.
50. U.S. Department of Health and Human Services. Bone Health and Osteoporosis: A Report of the Surgeon General. Rockville, MD: Office of the Surgeon General; 2004.
51. U.S. Preventive Services Task Force. Screening for Osteoporo-

sis. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf/uspsoste.htm. Accessed 06/23/13.
52. Alzheimer's Association. 2013 Alzheimer's Disease Facts and Figures. Retrieved from http://www.alz.org/alzheimers_disease_facts_and_figures.asp. Accessed 06/30/13.
53. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS):Nonfatal Injury. Retrieved from http://www.cdc.gov/injury/wisqars/nonfatal.html. Accessed 07/06/13.
54. Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM. Drug poisoning deaths in the United States, 1980–2008. NCHS data brief, no. 81. Hyattsville, MD: National Center for Health Statistics; 2011.
55. Centers for Disease Control and Prevention. VitalSigns: Prescription Painkiller Overdoses. July 2013. Retrieved from http://www.cdc.gov/. Accessed 06/15/13.
56. Health Resources and Services Administration, Bureau of Primary Health Care. What is a Health Center? Retrieved from http://bphc.hrsa.gov/about/index.html. Accessed 09/06/13.
57. Health Resources and Services Administration, Bureau of Primary Health Care. Health Center Data. Retrieved from http://bphc.hrsa.gov/uds/datacenter.aspx. Accessed 09/06/13.
58. Kaiser Family Foundation. The Uninsured: A Primer. October 2012. Retrieved from http://kff.org/. Accessed 09/06/13.
59. Politzer RM, Yoon J, Shi L, Hughes RG, Regan J, Gaston MH. Inequality in America: the contribution of health centers in reducing and eliminating disparities in access to care. Med Care Res Rev. June 2001;58(2):234-48.
60. Grieco EM, Acosta YD, de la Cruz GP, et al. The Foreign-Born Population in the United States: 2010. Washington, DC: U.S. Census Bureau; May 2012.
61. Argeseanu Cunningham S, Ruben JD, Narayan KM. Health of foreign-born people in the United States: a review. Health Place. December 2008;14(4):623-35.
62. Derose KP, Bahney BW, Lurie N, Escarce JJ. Review: immigrants and health care access, quality, and cost. Med Care Res Rev. August 2009;66(4):355-408.
63. Kaiser Family Foundation. Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act. March 2013. Retrieved from http://kff.org/. Accessed 09/19/13.
64. U.S. Department of Health and Human Services. Healthy People 2020: Lesbian, Gay, Bisexual and Transgender Health. Retrieved from http://www.healthypeople.gov/. Accessed 08/23/13.
65. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: what we know and what needs to be done. Am J Public Health. 2008;98(6):989-995.
66. National Academies of Science, Institute of Medicine. The health of lesbian, gay, bisexual and transgender people: building a foundation for better understanding. Retrieved from http://www.iom.edu/. Accessed 08/23/13.
67. Chandra A, Mosher WD, Copen C, Sionean C. Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2008 National Survey of Family Growth. National health statistics reports; no 36. Hyattsville, MD: National Center for Health Statistics; 2011.
68. U.S. Department of Health and Human Services. Recommended Actions to Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities. Retrieved from http://www.hhs.gov/lgbt/health.html. Accessed 08/23/13.

Health Services Utilization

1. Kaiser Family Foundation. The Uninsured: A Primer. Washington, DC: Kaiser Family Foundation; October 1, 2012. Retrieved from http://kff.org/. Accessed 04/23/13.
2. DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-243, Income, Poverty, and Health Insurance Coverage in the United States: 2011. Washington, DC: U.S. Government Printing Office; 2012.
3. Kaiser Family Foundation. Visualizing Health Policy: The Role of Medicaid and Medicare in Women's Health Care. Washington, DC: Kaiser Family Foundation; May 15, 2013. Retrieved from http://kff.org/. Accessed 05/25/13.
4. Carrillo JE, Carrillo VA, Perez HR, Salas-Lopez D, Natale-Pereira A, Byron AT. Defining and targeting health care access barriers. Journal of Health Care for the Poor and Underserved. 2011;22(2):562-75.
5. Kaiser Family Foundation. Health Reform: Implications for Women's Access to Coverage and Care. August 29, 2013. Retrieved from http://kff.org/. Accessed 09/04/13.
6. Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. J Gen Intern Med. September 2008 [Epub Ahead of Print May 28, 2008];23(9):1354-60.
7. DeVoe JE, Tillotson CJ, Lesko SE, Wallace LS, Angier H. The case for synergy between a usual source of care and health insurance coverage. J Gen Intern Med. September 2011 [Epub Ahead of Print March 16, 2011];26(9):1059-66.
8. U.S. Preventive Services Task Force. Recommendations. Retrieved from http://www.uspreventiveservicestaskforce.org/recommendations.htm. Accessed 09/11/13.
9. Centers for Disease Control and Prevention. ACIP Vaccine Recommendations. Retrieved from http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Accessed 09/11/13.
10. Centers for Disease Control and Prevention. Achievements in public health, 1900–1999: Family planning. MMWR. December 3, 1999;48(47): 1073–81.
11. Mosher WD, Jones J, Abma JC. Intended and unintended births in the United States: 1982–2010. National health statistics reports; no 55. Hyattsville, MD: National Center for Health Statistics; 2012.
12. U.S. Department of Health and Human Services. Healthy People 2020 Topics and Objectives: Family Planning. Retrieved from http://www.healthypeople.gov/. Accessed 08/19/13.
13. Trussell J. Contraceptive failure in the United States. Contraception. May 2011;83(5):397-404.
14. U.S. Department of Health and Human Services. Preventive Health Services for Women. Retrieved from https://www.healthcare.gov/. Accessed 08/19/13.
15. American Dental Association. Questions About Going to the Dentist. Retrieved from http://www.mouthhealthy.org/. Accessed 09/11/13.
16. Kaiser Family Foundation, Commission on Medicaid and the Underserved. Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access. June 2012. Retrieved from http://kff.org/. Accessed 09/11/13.
17. Kaiser Family Foundation. Health Care Costs: A Primer. Washington, DC: Kaiser Family Foundation; May 9, 2012. Retrieved from http://kff.org/. Accessed 07/31/13.
18. Agency for Healthcare Research and Quality. 2012 National Healthcare Quality Report. Rockville, MD: Agency for Healthcare Research and Quality, June 2013. Retrieved from http://www.ahrq.gov/. Accessed 08/26/13.
19. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Guide to Health Care Quality. Retrieved from http://www.ahrq.gov/. Accessed 08/26/13.
20. Hurtado MP, Swift EK, Corrigan JM, eds .Envisioning the National Health Care Quality Report. National Academies of Science, Institute of Medicine. Retrieved from http://www.nap.edu/. Accessed 08/26/13.

DATA SOURCES

Population Characteristics

I.1 U.S. Census Bureau, Annual Estimates of the Resident Population. Retrieved from http://www.census.gov/popest/data/national/asrh/2011/index.html. Accessed 04/30/13.

I.2 U.S. Census Bureau, Population Division. Intercensal Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2000 to July 1, 2010 (US-EST00INT-02). September 2011. Retrieved from http://www.census.gov/popest/data/intercensal/national/nat2010.html. Accessed 04/30/13; U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2011 (NC-EST2011-03). May 2012. Retrieved from http://www.census.gov/popest/data/national/asrh/2011/index.html. Accessed 04/30/13; U.S. Census Bureau, Population Division. Projections of the Population by Sex, Race, and Hispanic Origin for the United States: 2015 to 2060 (NP2012-T4). December 2012. Retrieved from http://www.census.gov/population/projections/data/national/2012/summarytables.html. Accessed 04/30/13.

I.3 U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement. Table A2. Family Status and Household Relationship of People 15 Years and Over, by Marital Status, Age, and Sex: 2012. Retrieved from http://www.census.gov/hhes/families/data/cps2012.html. Accessed 06/07/13.

I.4 U.S. Census Bureau, Current Population Survey (CPS) Table Creator II for the Annual Social and Economic Supplement. Retrieved from http://www.census.gov/cps/data/cpstablecreator.html.

I.5 Coleman-Jensen A, Nord M, Andrews M, Carlson S. Household Food Security in the United States in 2011. ERR-141, U.S. Department of Agriculture, Economic Research Service, September 2012. Retrieved from http://www.ers.usda.gov/. Accessed 05/02/13.

I.6 U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis, Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2011, by Mark Strayer, Esa Eslami, and Joshua Leftin. Project Officer, Jenny Genser. Alexandria, VA: 2012; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, Historical Poverty Tables. Retrieved from http://www.census.gov/. Accessed 06/21/13.

I.7 U.S. Department of Agriculture, Women, Infants, and Children Program Data. Monthly Data: National Level, FY 2010–March 2013. Retrieved from http://www.fns.usda.gov/pd/wicmain.htm. Accessed 06/21/13.

I.8 U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics. Digest of Educational Statistics: 2012, Table 310. Retrieved from http://nces.ed.gov/. Accessed 08/22/13.

I.9 U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics. Digest of Educational Statistics: 2012, Table 317. Retrieved from http://nces.ed.gov/. Accessed 08/22/13.

I.10 U.S. Department of Labor, Bureau of Labor Statistics. Women in the Labor Force: A Databook. Retrieved from http://www.bls.gov/. Accessed 05/02/13.

I.11 U.S. Census Bureau, 2011 American Community Survey. Accessed via Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

I.12 U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. Profile of Veterans: 2011, Data from the American Community Survey. Retrieved from http://www.va.gov/vetdata/Report.asp. Accessed 08/28/2013.

Health Status

II.1 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2009-2011. Analysis conducted by the Maternal and Child Health Bureau.

II.2 Centers for Disease Control and Prevention, National Center for Health Statistics. National Health and Nutrition Examination Survey, 2007-2010. Analysis conducted by the Maternal and Child Health Epidemiology and Statistics Program.

II.3 United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Survey on Drug Use and Health, 2009-2011. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2013-06-20. doi:10.3886/ICPSR34481.v2. Analysis conducted by the Maternal and Child Health Epidemiology and Statistics Program.

II.4 Hoyert DL, Xu JQ. Deaths: Preliminary data for 2011. National vital statistics reports; vol 61 no 6. Hyattsville, MD: National Center for Health Statistics. 2012.

II.5 Murphy SL, Xu JQ, Kochanek KD: Final Data for 2010. National Vital Statistics Reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Hoyert DL, Xu JQ. Deaths: Preliminary data for 2011. National vital statistics reports; vol 61 no 6. Hyattsville, MD: National Center for Health Statistics. 2012.

II.6 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved from http://www.cdc.gov/injury/wisqars. Accessed 07/07/13.

II.7 Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey, 2012. Analysis conducted by the Maternal and Child Health Bureau.

II.8 Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey, 2009-2010. Analysis conducted by the Maternal and Child Health Epidemiology and Statistics Program.

II.9 U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2010 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2013. Retrieved from www.cdc.gov/uscs.

II.10 Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/. Accessed 07/25/13; Walters, M.L., Chen J., & Breiding, M.J. (2013). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/. Accessed 07/25/13.

II.11 Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2011. Atlanta: U.S. Department of Health and Human Services; 2012.

II.12 Centers for Disease Control and Prevention. HIV Surveillance Report 2011; vol 23. Feb 2013. Retrieved from http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. Accessed 07/23/13.

II.13 Centers for Disease Control and Prevention, National Center for Health Statistics. National Survey of Family Growth, 2006–2010. Analysis conducted by the Maternal and Child Health Epidemiology and Statistics Program.

II.14 Chandra A, Copen CE, Stephen EH. Infertility and impaired fecundity in the United States, 1982–2010: Data from the National Survey of Family Growth. National health statistics reports; no 67. Hyattsville, MD: National Center for Health Statistics. 2013.

II.15 Alzheimer's Association. 2013 Alzheimer's Disease Facts and Figures. Retrieved from http://www.alz.org/alzheimers_disease_facts_and_figures.asp. Accessed 06/30/13.

II.16 Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from http://wonder.cdc.gov/ucd-icd10.html. Accessed 06/30/13.

II.17 Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System. Table 3A - Patients by Age and Gender – 2012. Available upon request OQDrequest@hrsa.gov; U.S. Census Bureau, Annual Estimates of the Resident Population. Retrieved from http://www.census.gov/popest/data/national/asrh/2012/index.html. Accessed 09/05/13.

II.18 Health Resources and Services Administration, Bureau of Primary Health Care, Community Health Center Patient Survey, 2009. Analysis conducted by the Bureau of Primary Health Care. Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2008/2010. Analysis conducted by the Maternal and Child Health Bureau.

II.19 U.S. Census Bureau, American Community Survey, 2011 (1-year estimates). Table B05003: Sex by Age by Nativity. Retrieved from http://factfinder2.census.gov/. Accessed 09/18/13.

II.20 Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2011. Analysis conducted by the Maternal and Child Health Bureau.

Health Services Utilization

III.1 U.S. Census Bureau, Current Population Survey (CPS) Table Creator II for the Annual Social and Economic Supplement. Retrieved from http://www.census.gov/cps/data/cpstablecreator.html.

III.2 Centers for Disease Control and Prevention. National Center for Health Statistics. Health Data Interactive. Retrieved from http://www.cdc.gov/nchs/hdi.htm. Accessed 08/15/13.

III.3 Jones J, Mosher W, Daniels K. Current contraceptive use in the United States, 2006–2010, and changes in patterns of use since 1995. National health statistics reports; no 60. Hyattsville, MD: National Center for Health Statistics. 2012.

III.4 U.S. Agency for Healthcare Research and Quality. Total Health Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2010. Medical Expenditure Panel Survey Household Component Data. Generated interactively. Accessed 07/31/13.

III.5 U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey 2010, Summary Data Tables. Data tabulated interactively by the Maternal and Child Health Bureau.

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U.S. Department of Labor
U.S. Department of Veterans Affairs

Non-Governmental Contributors

Alzheimer's Association
American Cancer Society

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Each edition of *Women's Health USA* contains current data on health issues important to women with several new health topics or population features that may replace those included in previous editions. For information on topics or populations covered in previous editions, please visit the *Women's Health USA* web site which can be accessed at:

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