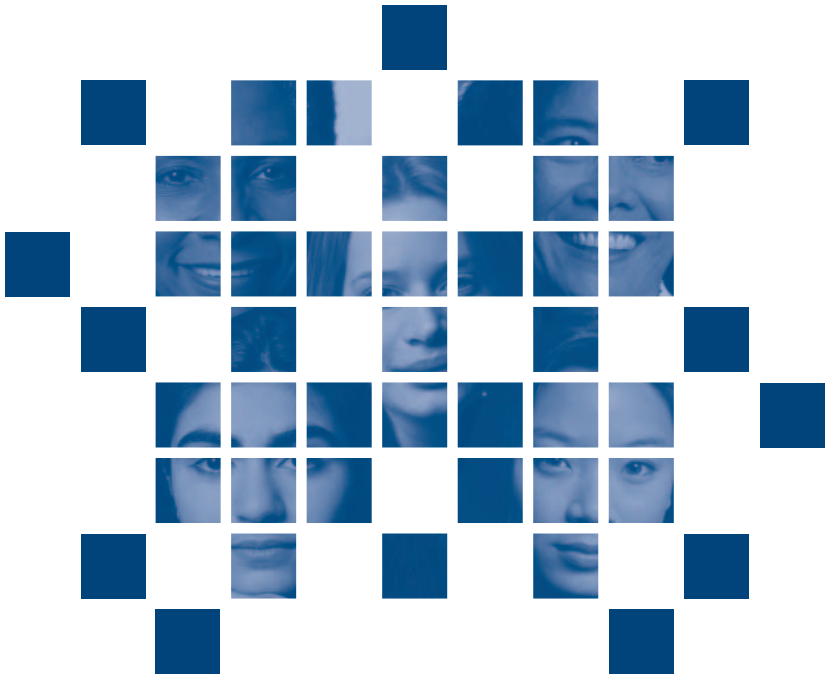

CHAPTER IV

KEY HEALTH DISPARITIES AMONG SPECIAL POPULATIONS OF WOMEN

This chapter contains a discussion of key health disparities among special populations of women and supplements the racial and ethnic information in Chapters I-III. It also includes charts showing leading causes of death for women of different races and ethnicities.[1] The chapter focuses on the following groups of women: Blacks, Hispanics/Latinas, Asians/Pacific Islanders, American Indians/Alaskan Natives (Native Americans), immigrants, and lesbians. It also briefly addresses other groups of women with special health care challenges: women with disabilities, women with HIV/AIDS, women living in rural areas, and women prisoners. Unless otherwise noted, the data are from the national report card in Chapter I or the charts in this chapter. By highlighting some additional health information about certain groups of women with special health concerns, the *Report Card* can provide a better look—although not a complete look—at the significant health disparities confronting women in the United States.

The nation is becoming increasingly diverse, with ethnic and racial minorities projected to make up almost half the population by the year 2050.[2] This growth has prompted greater attention to racial and ethnic health disparities in the United States.[3] These efforts have focused both on obtaining better data about the health of these and other special populations[4] and on determining the causes of different treatment and outcomes, including efforts to determine the role of bias, discrimination and stereotyping in the health system.[5] Since the 2001 *Report Card* was published, there has also been increased attention to health disparities among racial, ethnic, and other groups of women.[6]

Black Women[7]

Black women make up 12.9 percent of all women in the United States, and are tied with Hispanic women as the largest group of women of color. Although sources differ on their definitions of the terms "African American" and "Black,"[8] unless otherwise indicated, in this chapter, the terms "African American" and "Black" are used interchangeably to describe all Black women living in the United States, regardless of country of origin or immigrant status. Sometimes data separate Black Hispanics from Black non-Hispanics, while others do not distinguish between the two groups.[9]

Blacks fare better than other groups on getting Pap tests and second (after Whites) for mammograms, and have the lowest prevalence of osteoporosis. However, they fare worst of all the groups for which data were available in an

Leading Causes of Death for White Women by Age

Per 100,000 Women

All Ages	Coronary heart disease (CHD)	151.0
	Stroke	56.7
	Lung cancer	41.9
	Chronic lower respiratory diseases	39.7
	Breast cancer	26.0
	Unintentional injuries	22.5
	Diabetes (underlying cause)	20.4
	Influenza and pneumonia	20.2
	Alzheimer's disease	19.9
	Colorectal cancer	17.1
25-44	Unintentional injuries	16.2
	Breast cancer	6.9
	Suicides	6.1
	Coronary heart disease (CHD)	4.7
	Lung cancer	3.1
	Homicides	3.0
	Stroke	2.9
	Cirrhosis	2.8
	HIV	2.1
	Cervical cancer	2.1
	Diabetes (underlying cause)	2.1
45-54	Breast cancer	31.1
	Coronary heart disease (CHD)	28.2
	Lung cancer	24.6
	Unintentional injuries	16.7
	Stroke	10.7
	Colorectal cancer	9.1
	Diabetes (underlying cause)	8.9
	Ovarian cancer	8.7
	Cirrhosis	8.5
	Chronic lower respiratory diseases	8.0
55-64	Coronary heart disease (CHD)	105.3
	Lung cancer	95.1
	Breast cancer	57.5
	Chronic lower respiratory diseases	44.6
	Stroke	29.3
	Diabetes (underlying cause)	28.1
	Colorectal cancer	25.0
	Ovarian cancer	20.6
	Unintentional injuries	18.5
	Cirrhosis	13.5
65-74	Coronary heart disease (CHD)	336.5
	Lung cancer	210.9
	Chronic lower respiratory diseases	159.9
	Stroke	105.2
	Breast cancer	87.8
	Diabetes (underlying cause)	72.1
	Colorectal cancer	59.3
	Ovarian cancer	37.2
	Unintentional injuries	30.7
	Influenza and pneumonia	29.3
75-84	Coronary heart disease (CHD)	1088.1
	Stroke	433.1
	Chronic lower respiratory diseases	339.9
	Lung cancer	268.9
	Diabetes (underlying cause)	151.6
	Alzheimer's disease	151.1
	Influenza and pneumonia	130.6
	Breast cancer	129.0
	Colorectal cancer	120.4
	Unintentional injuries	80.2
85+	Coronary heart disease (CHD)	4227.1
	Stroke	1635.2
	Alzheimer's disease	750.9
	Influenza and pneumonia	686.3
	Chronic lower respiratory diseases	546.9
	Diabetes (underlying cause)	290.6
	Unintentional injuries	251.6
	Colorectal cancer	247.2
	Nephritis, nephrotic syndrome, & nephrosis	224.6
	Lung cancer	214.2

National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthy-women.htm, accessed January 20, 2004.

Rates are three-year averages from 1999-2001 and are per 100,000 estimated population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

alarming number of areas. They are the least likely to get prenatal care. Blacks fare worst in exercise and weight. They also have the highest mortality rates for all causes included in the report card pages. Of the conditions examined here, Black women have the highest AIDS rates, coronary heart disease death rate, lung and colorectal cancer incidence rate, diabetes death rate, and unintended pregnancy rate. Blacks also have the shortest life expectancy, the highest infant mortality rate, and the highest poverty rate.

Women's Access to Health Care Services. Black non-Hispanic women are more likely to be uninsured than are women who are White or Asian/Pacific Islander, but less likely than Hispanics or American Indians/Alaskan Natives. When they are insured, Black women are more likely than other groups of women to have publicly funded health insurance through Medicaid.[10] A smaller percentage of Black women receive prenatal care in the first trimester than White women or Hispanic women. In 2000, Black women had higher abortion rates than other categories of women; and, although the abortion rate decreased nationwide between 1994 and 2000, the rate of decline in abortion among Black adolescents was lower than White adolescents.[11]

Wellness and Prevention. Black women age 18 and older had the highest percentage of having a Pap test within the last three years of any other group; Black women age 40 and older fare better than any other over-40 age group except Whites in reporting that they had a mammogram within the last two years.[12] Medicaid and Medicare coverage for screening mammograms and Pap tests,[13] as well outreach programs such as the National Breast and Cervical Cancer Early Detection Program,[14] may account for some of this result.[15] However, older Black populations may not fare as well with mammograms.[16] Black and Hispanic women and women with lower socioeconomic status are less likely to receive screening for colorectal cancer than are other groups of women.[17]

Generally, Black and Hispanic women do not exercise as much as White women do.[18] Furthermore, while physical activity declines sharply among girls during adolescence, Black girls in particular are at risk of becoming sedentary.[19] Non-Hispanic Black women are also significantly more likely to be obese than non-Hispanic White women and Hispanic women.[20] On the other hand, Black women and girls do not smoke as much as some other groups,[21] and their rate of alcohol consumption is also lower.[22]

Leading Causes of Death for Black Women by Age

Per 100,000 Women		
All Ages	Coronary heart disease (CHD)	203.9
	Stroke	75.6
	Diabetes (underlying cause)	49.2
	Lung cancer	39.6
	Breast cancer	34.8
	Nephritis, nephrotic syndrome, & nephrosis	26.3
	Colorectal cancer	24.3
	Chronic lower respiratory diseases	22.9
	Unintentional injuries	22.2
	Septicemia	22.0
25-44	HIV	26.4
	Unintentional injuries	18.0
	Coronary heart disease (CHD)	13.8
	Breast cancer	13.1
	Homicides	11.3
	Stroke	8.5
	Diabetes (underlying cause)	5.2
	Lung cancer	4.0
	Chronic lower respiratory diseases	3.4
	Nephritis, nephrotic syndrome, & nephrosis	3.3
45-54	Coronary heart disease (CHD)	83.4
	Breast cancer	51.9
	Stroke	37.2
	Lung cancer	31.6
	Diabetes (underlying cause)	26.6
	HIV	25.0
	Unintentional injuries	22.2
	Colorectal cancer	16.9
	Chronic lower respiratory diseases	12.6
	Cirrhosis	12.5
55-64	Coronary heart disease (CHD)	243.3
	Lung cancer	94.4
	Diabetes (underlying cause)	81.8
	Breast cancer	81.4
	Stroke	76.9
	Colorectal cancer	42.0
	Nephritis, nephrotic syndrome, & nephrosis	37.0
	Chronic lower respiratory diseases	34.7
	Septicemia	27.3
	Unintentional injuries	21.1
65-74	Coronary heart disease (CHD)	606.9
	Stroke	194.0
	Diabetes (underlying cause)	191.2
	Lung cancer	191.0
	Breast cancer	103.8
	Nephritis, nephrotic syndrome, & nephrosis	93.7
	Colorectal cancer	88.2
	Chronic lower respiratory diseases	85.3
	Septicemia	63.5
	Essential (primary) hypertension and hypertensive renal disease	44.4
75-84	Coronary heart disease (CHD)	1461.3
	Stroke	549.2
	Diabetes (underlying cause)	346.9
	Lung cancer	231.9
	Nephritis, nephrotic syndrome, & nephrosis	176.0
	Colorectal cancer	164.7
	Chronic lower respiratory diseases	159.9
	Septicemia	149.2
	Breast cancer	143.4
	Influenza and pneumonia	130.7
85+	Coronary heart disease (CHD)	3963.9
	Stroke	1518.6
	Diabetes (underlying cause)	549.6
	Influenza and pneumonia	548.6
	Alzheimer's disease	469.7
	Nephritis, nephrotic syndrome, & nephrosis	390.9
	Septicemia	372.6
	Essential (primary) hypertension and hypertensive renal disease	284.0
	Colorectal cancer	279.3
	Chronic lower respiratory diseases	258.6

National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthy-women.htm, accessed January 20, 2004.

Rates are three-year averages from 1999-2001 and are per 100,000 estimated population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

Key Health Conditions, Diseases and Causes of Death. The top three age-adjusted causes of death for Black women are coronary heart disease, stroke and diabetes. White women share the top two causes of death (coronary heart disease and stroke), however, there are dramatic disparities in the mortality rates between these two groups of women. Furthermore, Black women have the highest rate of deaths from breast cancer of any group; White women have the next highest. HIV/AIDS death rates among Black women are 13 times higher than among White women.[23]

Black women have the highest death rates among the racial and ethnic groups listed of death for all cancers combined from 1996 to 2000.[24] More specifically, they have the highest death rates for breast cancer, colorectal cancer, and cervical cancer. Black women rank second highest after White women in lung cancer death rates.

More than any other group, Black women are affected by HIV/AIDS, coronary heart disease, colorectal cancer, unintended pregnancy, and maternal mortality. The HIV/AIDS epidemic is a major health crisis especially affecting Black women.[25] HIV is the leading cause of death for African American women between the ages of 25 and 44, in contrast to unintentional injuries for White women. The rate of females age 13 and older with AIDS cases reported in 2001 is greatest among non-Hispanic Blacks. The AIDS rate for Black women is almost four times that for Hispanic women and almost 20 times that for White non-Hispanic women; Black men, however, had less than nine times greater AIDS diagnoses than White men.[26] Sixty-two percent of children born to HIV-infected mothers were Black.[27]

For the period between 1996 and 2000, incidence rates for all cancers combined were highest for Whites, but followed by Blacks; Black women have the highest incidence rates of the ethnic and racial groups examined for lung and colorectal cancer, and the second highest for breast cancer (after Whites) and cervical cancer (after Hispanics).[28] Several studies have found that Black women are more likely than White women to have late-stage breast cancer at diagnosis and shortened survival.[29] And, although White women are more likely to develop ovarian cancer, Black women diagnosed with the disease may face a higher death risk.[30]

Black women are less likely than White women but more likely than Hispanic women to have arthritis. Black women also have the highest unintended pregnancy and maternal mortality rate.[31] The prevalence of diabetes and high blood pressure is especially high among Black women of African descent, more prevalent than among White and Black women of Caribbean descent, and higher than any of these

groups of men.[32] A greater percentage of Black women have unacceptable cholesterol levels than do White women.[33] Black women are more likely to have coronary heart disease, but less likely to receive standard treatment, than White women.[34]

African American women have the lowest prevalence of osteoporosis. Although there is limited information about special mental health issues for Black women, there is evidence that there are mental health disparities between them and other groups of women.[35] Black women are less likely to have mental health treatment or counseling than White women.[36] There are also mental health differences among groups of Black women, with those of African ancestry reporting more mental health problems than those of Caribbean descent.[37]

Living in a Healthy Community. African American women have shorter life expectancies than do White women or women of other races, and an infant mortality rate more than double that of White women. Furthermore, Black women have the highest poverty rate of all groups analyzed. Black women are also less likely than non-Hispanic Whites and Asian/Pacific Islanders to have graduated from high school.

Black women have serious health problems not only on an absolute level, but also when compared with other racial and ethnic groups of women. Inadequate health care, delayed diagnosis, and high poverty rates undoubtedly contribute to these disparities. Race discrimination contributes to stress-related health problems, such as hypertension and diabetes, as well as overeating, leading to obesity.[38] African American women often lack access to care because of financial barriers, lack of information about disease symptoms and when to seek care, lack of neighborhood health care facilities and racial discrimination and stereotyping encountered when seeking care.[39]

Hispanic/Latina Women[40]

Hispanic (used interchangeably with Latina) women are tied with Blacks as the largest minority group of women (12.9 percent of all women in the United States). The number of Hispanics of any race is expected to surpass Black non-Hispanics by 2005, becoming the largest minority group.[41] Measures of the health of Hispanics as a group can mask important differences within the highly diverse Hispanic population in the United States. Most Hispanics in the United States are from Mexico, but others also come from other regions, including Central and South America, Puerto Rico and Cuba; nearly two-fifths are born outside of the United States.[42] Cultural differences can exist between Hispanic women born in the United States and Hispanic women born abroad.[43]

Leading Causes of Death for Hispanic Women by Age

Per 100,000 Women

All Ages	Coronary heart disease (CHD)	134.4
	Stroke	42.6
	Diabetes (underlying cause)	35.9
	Influenza and pneumonia	17.3
	Chronic lower respiratory diseases	17.0
	Breast cancer	16.7
	Unintentional injuries	16.4
	Lung cancer	14.7
	Colorectal cancer	11.8
	Alzheimer's disease	11.0
25-44	Unintentional injuries	11.1
	Breast cancer	4.9
	HIV	4.7
	Homicides	3.7
	Stroke	2.8
	Cervical cancer	2.4
	Cirrhosis	2.1
	Suicides	2.1
	Coronary heart disease (CHD)	1.9
	Diabetes (underlying cause)	1.5
	Leukemia	1.4
45-54	Breast cancer	24.1
	Coronary heart disease (CHD)	20.2
	Unintentional injuries	13.7
	Stroke	12.6
	Diabetes (underlying cause)	11.7
	Cirrhosis	9.6
	Colorectal cancer	7.5
	Lung cancer	7.1
	HIV	6.6
	Cervical cancer	6.1
55-64	Coronary heart disease (CHD)	89.1
	Diabetes (underlying cause)	49.6
	Breast cancer	39.7
	Stroke	30.4
	Lung cancer	23.6
	Cirrhosis	18.4
	Colorectal cancer	18.3
	Unintentional injuries	16.5
	Ovarian cancer	12.6
	Chronic lower respiratory diseases	11.8
65-74	Coronary heart disease (CHD)	301.5
	Diabetes (underlying cause)	139.3
	Stroke	94.7
	Lung cancer	65.3
	Breast cancer	51.4
	Chronic lower respiratory diseases	42.1
	Colorectal cancer	40.8
	Cirrhosis	38.0
	Nephritis, nephrotic syndrome, & nephrosis	36.2
	Influenza and pneumonia	29.1
75-84	Coronary heart disease (CHD)	981.5
	Stroke	317.5
	Diabetes (underlying cause)	277.1
	Chronic lower respiratory diseases	139.0
	Lung cancer	108.8
	Influenza and pneumonia	108.0
	Alzheimer's disease	82.3
	Colorectal cancer	80.6
	Nephritis, nephrotic syndrome, & nephrosis	78.1
	Breast cancer	71.3
85+	Coronary heart disease (CHD)	3826.4
	Stroke	1078.3
	Influenza and pneumonia	589.3
	Diabetes (underlying cause)	503.2
	Alzheimer's disease	422.7
	Chronic lower respiratory diseases	389.4
	Nephritis, nephrotic syndrome, & nephrosis	192.2
	Septicemia	165.9
	Colorectal cancer	159.9
	Essential (primary) hypertension and hypertensive renal disease	153.3

National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthy-women.htm, accessed January 20, 2004.

Rates are three-year averages from 1999-2001 and are per 100,000 estimated population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

Hispanics fare worse than other groups of women in rates of uninsurance, cervical cancer incidence, depression, and high school graduation, and have the lowest median earnings of any of the groups studied. On the other hand, for many other health measures, their health status is better than that of the other racial and ethnic groups examined in this chapter.

Women's Access to Health Care Services. A greater percentage of Hispanic women are uninsured, almost three times the percentage of White, non-Hispanic women.[44] This lack of insurance has led to poorer medical outcomes, especially among uninsured Hispanic women with breast cancer, although Hispanic women tend to be diagnosed at a later stage for breast cancer than Whites, regardless of insurance status.[45] A smaller percentage of Hispanic women receive prenatal care in the first trimester than do White women and slightly greater than Black, non-Hispanic women. In 2000, Hispanic women (along with Blacks) had higher abortion rates than other categories of women; and although the abortion rate has decreased nationwide, the rate of decline in abortion among Black and Hispanic adolescents was lower than among White adolescents.[46]

Hispanics in the United States often face obstacles to obtaining appropriate health care because of linguistic and cultural differences between them and U.S. health care providers.[47] Such isolation and segregation contribute to the well-documented undercounting of minority groups on the U.S. Census, and affect the distribution of federal resources.[48]

Wellness and Prevention. Cultural traditions requiring that Hispanics seek family members' advice before getting health care, as well as reluctance to disclose to new health care providers their use of indigenous healers and folk medicine, can also discourage some Hispanic women from receiving screening services.[49] Hispanics are the second least likely group to have been screened for cervical cancer in the last three years (Asian Americans are the least likely).[50] Hispanics fare worse than Whites and Blacks in getting mammograms, but better than American Indians/Alaskan Natives and Asian Americans.[51] Hispanic women, like Black women and women with lower socioeconomic status, are less likely to receive screening for colorectal cancer.[52]

In 2001, about the same percentage of Hispanics and non-Hispanic Blacks did not engage in leisure-time physical activity, which was worse than non-Hispanic Whites.[53] There is great disparity in the rates of exercise, weight and obesity within the different groups of Hispanic women, particularly between immigrant Hispanic women and U.S.-born Hispanic women (with more recent immigrants less likely to be obese).[54] Hispanic women are more likely than White women to be obese, but less likely than Black women.[55] Hispanic women are less likely to smoke than any other group except Asian/Pacific Islander women.[56] Generally, Hispanic women have a lower rate of alcohol consumption than White women.[57]

Key Health Conditions, Diseases and Causes of Death. The leading causes of death for Hispanic women are coronary heart disease, stroke and diabetes. The age-adjusted rankings of causes of death are similar to those of White women, with some exceptions. For example, diabetes and influenza/pneumonia rank higher for Hispanic than White women, and lung cancer ranks lower. Of the top ten causes of death, the only cause of death that occurs more frequently among Hispanic women than White women is diabetes.

Hispanic women overall are the only group for which the breast cancer death rate is higher than the lung cancer death rate. One study found that Hispanic women are more likely than White women to have a higher percentage of large breast cancer tumors, which indicates advanced stage disease,[58] even though White women have a higher breast cancer incidence.[59] Hispanics have the second highest cervical cancer death rate after Black women.[60]

Hispanic women have the second highest AIDS rate, after Black women. HIV is the third leading cause of death for Hispanic women ages 25 to 44. Hispanic women have a higher rate of unintended pregnancies than do White women, but a lower rate than do Black women. In addition, a smaller percentage of Mexican American women (the only group of Hispanic women for which data are available) have osteoporosis than Whites, but a greater percentage than Blacks. Hispanic women have the second highest percentage of women who reported being victims of violence, after American Indians/Alaskan Natives.

There is also some evidence that Hispanic women have some more serious mental health issues than other groups of women.[61] For example, almost one in four Hispanic women reported experiencing depression during her lifetime, the highest lifetime prevalence of depression of any other group of women.[62] Hispanic women are also less likely than either Whites or Blacks to have had mental health treatment or counseling.[63]

Hispanics have the highest incidence of cervical cancer of all the racial and ethnic groups examined.[64] The incidence of cervical cancer in Hispanic women age 30 and older is almost twice the incidence in other racial and ethnic groups of the same age.[65]

Living in a Healthy Community. Hispanic women have similar infant mortality rates as White women. However, Hispanic women are more likely than White non-Hispanic women to be poor. Furthermore, while women overall have lower median earnings than men overall, women of color have lower median earnings than White women, with Hispanic women having the lowest median earnings.[66] Hispanic women are concentrated in administrative support and service jobs.[67] Large proportions of Hispanic women also work in the semiconductor and agriculture industries, both of which have substantial occupational hazards. Agricultural workers, for example, are exposed to pesticides and are often required to use faulty equipment.[68] Hispanic women have the lowest rate of high school graduation, with only 58.8 percent of Hispanic women age 22 and older graduating. Hispanic women can also face discrimination based on language, skin color and national origin.[69]

Asian/Pacific Islander Women[70]

Asian and Pacific Islander women make up 4.4 percent of women in the United States. They have ties to more than 20 countries and speak more than 100 different languages. The largest groups of Asian Americans (in descending order) are of Chinese, Filipino, Asian, Korean, Vietnamese, and Japanese ancestry.[71] Asian American women are a heterogeneous group and there are few data on Chinese American, Japanese American, or Southeast Asian American populations specifically. Pacific Islander Americans come from more than 22 islands (Polynesian, Micronesian or Melanesian) and speak as many as 1,000 different languages; the largest group of Pacific Islanders is Native Hawaiians.[72] Cultural differences also exist between women of Asian and Pacific Island descent born in the United States and those born abroad. Efforts are underway to collect and analyze data separately for women of Asian descent and women of Pacific Island descent (as well as groups within these two categories).

Generally, Asian/Pacific Islanders fare best of all groups in the preventive health behaviors of weight (Asian only) and smoking (Asian only), have the lowest death rates for coronary heart disease, the lowest AIDS rate, and the lowest death rate for breast and colorectal cancer. They are, however, disproportionately affected by cervical and ovarian cancer. Furthermore, different subgroups have special problems, as described in more detail below.

Women's Access to Health Care Services. Many Asian/Pacific Islander women confront language barriers, cultural differences and race and sex-based stereotypes that limit their ability to meet their health needs. Communication barriers further limit their ability to obtain

Leading Causes of Death for Asian/Pacific Islander Women by Age

Per 100,000 Women		
All Ages	Coronary heart disease (CHD)	91.8
	Stroke	49.3
	Lung cancer	19.4
	Diabetes (underlying cause)	16.3
	Influenza and pneumonia	15.0
	Breast cancer	12.7
	Unintentional injuries	12.7
	Chronic lower respiratory diseases	11.7
	Colorectal cancer	10.7
	Nephritis, nephrotic syndrome, & nephrosis	7.9
	Essential (primary) hypertension and hypertensive renal disease	5.9
25-44	Unintentional injuries	6.1
	Breast cancer	4.3
	Suicides	3.3
	Homicides	2.3
	Stroke	2.2
	Lung cancer	1.5
	Colorectal cancer	1.4
	Leukemia	1.2
	Ovarian cancer	1.1
	Coronary heart disease (CHD)	1.1
	Cervical cancer	1.0
45-54	Breast cancer	21.7
	Stroke	13.2
	Lung cancer	11.0
	Coronary heart disease (CHD)	10.3
	Unintentional injuries	9.4
	Colorectal cancer	7.8
	Ovarian cancer	6.9
	Cervical cancer	4.7
	Diabetes (underlying cause)	3.7
	Suicides	3.7
	Uterine cancer	2.7
55-64	Coronary heart disease (CHD)	49.8
	Stroke	36.3
	Breast cancer	34.0
	Lung cancer	30.3
	Diabetes (underlying cause)	16.3
	Colorectal cancer	14.9
	Unintentional injuries	12.8
	Ovarian cancer	10.8
	Nephritis, nephrotic syndrome, & nephrosis	7.1
	Viral Hepatitis	7.0
	Chronic lower respiratory diseases	7.0
65-74	Coronary heart disease (CHD)	193.6
	Stroke	107.1
	Lung cancer	81.4
	Diabetes (underlying cause)	54.2
	Colorectal cancer	38.7
	Breast cancer	36.4
	Chronic lower respiratory diseases	33.1
	Unintentional injuries	22.2
	Nephritis, nephrotic syndrome, & nephrosis	21.8
	Influenza and pneumonia	20.5
75-84	Coronary heart disease (CHD)	705.7
	Stroke	372.6
	Diabetes (underlying cause)	143.2
	Lung cancer	139.6
	Influenza and pneumonia	102.8
	Chronic lower respiratory diseases	88.0
	Colorectal cancer	70.7
	Nephritis, nephrotic syndrome, & nephrosis	58.2
	Unintentional injuries	53.6
	Essential (primary) hypertension and hypertensive renal disease	48.5
85+	Coronary heart disease (CHD)	2662.0
	Stroke	1275.0
	Influenza and pneumonia	525.1
	Chronic lower respiratory diseases	291.4
	Diabetes (underlying cause)	269.4
	Alzheimer's disease	233.7
	Lung cancer	205.3
	Nephritis, nephrotic syndrome, & nephrosis	185.0
	Essential (primary) hypertension and hypertensive renal disease	159.1
	Unintentional injuries	158.3

National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthy-women.htm, accessed January 20, 2004.

Rates are three-year averages from 1999-2001 and are per 100,000 estimated population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

appropriate health care services; even women who speak English well may have difficulty translating medical terms without help.[73] While Asian/Pacific Islanders have the second highest percentage of being insured (after White women), still about one in five are not insured. Some groups, particularly those from Southeast Asia, have high poverty rates and are significantly less likely to have insurance coverage through their employers.[74] Simply having insurance, however, may not meet Asian/Pacific Islander women's health care needs since some traditional Asian models of medicine, such as acupuncture and herbal medicines, are often not covered by health insurance plans.[75]

The percent of Asian women receiving prenatal care during the first trimester is similar to the percent of White women, but there is also great variation among different Asian and Pacific Islander groups.[76] In 2000, Asian American and Pacific Islander women had lower abortion rates than others (aside from Native American and White), but their rate rose from 1994 to 2000, whereas it did not rise for Native Americans and Whites.[77] There is also evidence that Asian American women do not have adequate access to reproductive health care providers.[78]

Wellness and Prevention. Asian American women age 18 and older are the least likely to have had a Pap smear within the last three years, compared to other groups.[79] For women age 40 and older, Asian American women are the second least likely (Native Americans are the least likely) to have had a mammogram within the last two years.[80] Asian women have lower rates than White women for colorectal cancer screening.[81]

Although Asian American/Pacific Islander women in general have the lowest rates of overweight, Native Hawaiian and American Samoan women have the highest occurrence of obesity of any other major racial or ethnic group or specific population within those major groups.[82] Asian American/Pacific Islander women are also the least likely population to smoke, but there is great variation among groups, with Japanese American women smoking most and Vietnamese women smoking least.[83] Generally, Native Hawaiian and other Pacific Islander and non-Hispanic White women have higher rates of alcohol consumption than Black women and Hispanic women, and Asian women have a lower rate.[84]

Key Health Conditions, Diseases and Causes of Death. As with White women, the top three causes of death are coronary heart disease, stroke and lung cancer, although the rates are lower for Asian American/Pacific Islander women than White women for each of these causes. Asian American/Pacific Islanders have the lowest rate of all groups listed on the *Report Card* for coronary heart disease and second lowest for strokes (Hispanics are the lowest). Age-adjusted death rates are dramatically lower for Asian/Pacific Islander women compared with White women for chronic lower respiratory disease, coronary heart disease, and lung cancer.

Asian American women have the lowest AIDS rate of the groups listed in the *Report Card* and the lowest rate of experiencing violence in their lifetimes of any other racial or ethnic group.

From 1996 to 2000, Asian/Pacific Islander women had the lowest incidence of deaths from all cancers combined for all groups analyzed.[85] They also have the lowest rate for breast and colorectal cancer deaths, and second to lowest for lung cancer deaths. Although Blacks and Hispanics have the highest death rate for cervical cancer, the disease is also a significant problem for Asian/Pacific Islander women. Cervical cancer, which is largely preventable by screening, is the most commonly occurring cancer in Vietnamese females in the United States; the incidence is four times as high among Vietnamese women as among all Asian American and Pacific Islander populations combined, five times higher than among White women; this high cervical cancer rate could be related to a cultural perception that the pelvic exam and Pap test are invasive and unnecessary.[86]

Ovarian cancer is also significant in the Asian/Pacific Islander community. It is one of the top ten causes of death for this group in ages 25 to 54 (Whites are the only other group in which ovarian cancer is listed as a top ten cause of death for any age group). Incidences of ovarian cancer vary among the Asian American population, with Vietnamese ranking among the highest, while rates were lowest among Korean and Chinese women.[87]

Living in a Healthy Community. Asian American/Pacific Islander women experience high rates of poverty compared to non-Hispanic Whites, but lower poverty rates than Hispanics, non-Hispanic Blacks, and American Indian/Alaskan Native women. Many Asian American/Pacific Islander women are employed in small businesses or factories with unsafe and unhealthy working conditions and no employment benefits such as health insurance.[88] Although there is a great difference in the level of educational attainment among the different groups of Asian American/Pacific Islander women, overall Asian American/Pacific Islander women have lower high school graduation rates than White women, but higher than the other groups listed on the *Report Card*.

American Indian/Alaskan Native (Native American) Women[89]

Native American women (used to mean "American Indian" and "Alaskan Native" women) constitute 1.0 percent of all women in the United States. There are more than 550 recognized tribes and 300 spoken languages.[90] Although this population is very diverse, their shared experiences have had a direct impact on their socioeconomic and health status. These experiences include the rapid and forced change from a cooperative and clan-based society to a capitalistic and nuclear family based system, and the outlawing of language and spiritual practices.[91]

Native American women fare the worst of all ethnic and racial groups studied for mammograms, smoking, alcohol and drug use, cirrhosis death rate, and violence against them. Although other groups performed more poorly than Native Americans on other health measures, Native American women still had significant problems compared to other groups in being uninsured, getting Pap smears, being overweight, having AIDS, and not graduating from high school. Furthermore, many cancers are less common in Native American than other women, but the death rate for Native American women are not proportionately low. Within Native American populations, there are certain groups that have special problems (e.g., prenatal care). There is no health measure examined in the *Report Card* for which Native Americans fare best among the racial and ethnic groups studied.

Women's Access to Health Care Services. The federal government's Indian Health Service (IHS) is charged with providing health care services to members of federally recognized Indian tribes and their descendants.[92] Nonetheless, Native American women face logistical and cultural barriers to obtaining health care services. Because many of these women live in rural communities, and have limited access to transportation, they face great difficulties in obtaining needed care.[93] Native Americans have significantly lower rates of prenatal care during the first trimester than all other groups analyzed.[94]

Wellness and Prevention. Communication barriers also limit access. Many of the commonly spoken languages do not include words for cancer, and it is a common belief that talking about a disease will bring it on, making women less likely to seek preventive services.[95] Native Americans are the third least likely group of women studied age 18 and older to have had a Pap test within the last three years; Native American women age 40 and older are the least likely group to have had mammograms within the last two years.[96]

Leading Causes of Death for American Indian/Alaskan Native Women by Age

Per 100,000 Women		
All Ages	Coronary heart disease (CHD)	102.6
	Diabetes (underlying cause)	45.6
	Stroke	44.4
	Unintentional injuries	35.0
	Chronic lower respiratory diseases	27.8
	Lung cancer	26.8
	Influenza and pneumonia	20.7
	Cirrhosis	19.8
	Nephritis, nephrotic syndrome, & nephrosis	15.1
	Breast cancer	13.5
25-44	Unintentional injuries	33.2
	Cirrhosis	14.5
	Suicides	6.7
	Homicides	6.6
	Coronary heart disease (CHD)	4.7
	Stroke	4.3
	Breast cancer	3.5
	Diabetes (underlying cause)	2.4
	Influenza and pneumonia	2.3
	HIV	2.2
45-54	Cirrhosis	38.9
	Unintentional injuries	29.1
	Coronary heart disease (CHD)	27.8
	Diabetes (underlying cause)	20.5
	Breast cancer	16.5
	Stroke	13.8
	Lung cancer	12.3
	Nephritis, nephrotic syndrome, & nephrosis	6.3
	Septicemia	6.1
	Colorectal cancer	5.4
55-64	Coronary heart disease (CHD)	107.3
	Diabetes (underlying cause)	80.6
	Lung cancer	60.0
	Cirrhosis	48.0
	Stroke	36.5
	Chronic lower respiratory diseases	36.1
	Breast cancer	34.4
	Unintentional injuries	34.4
	Nephritis, nephrotic syndrome, & nephrosis	25.2
	Colorectal cancer	16.5
	Septicemia	14.4
65-74	Coronary heart disease (CHD)	312.3
	Diabetes (underlying cause)	219.3
	Lung cancer	146.0
	Chronic lower respiratory diseases	120.1
	Stroke	102.3
	Nephritis, nephrotic syndrome, & nephrosis	64.1
	Cirrhosis	59.8
	Unintentional injuries	53.0
	Breast cancer	50.5
	Colorectal cancer	40.7
75-84	Coronary heart disease (CHD)	787.0
	Stroke	369.6
	Diabetes (underlying cause)	311.0
	Chronic lower respiratory diseases	228.4
	Lung cancer	175.8
	Influenza and pneumonia	136.3
	Nephritis, nephrotic syndrome, & nephrosis	105.3
	Unintentional injuries	93.3
	Colorectal cancer	82.5
	Alzheimer's disease	80.1
85+	Coronary heart disease (CHD)	2070.2
	Stroke	941.9
	Influenza and pneumonia	607.3
	Diabetes (underlying cause)	420.9
	Alzheimer's disease	341.6
	Chronic lower respiratory diseases	341.6
	Unintentional injuries	193.2
	Nephritis, nephrotic syndrome, & nephrosis	179.4
	Septicemia	138.0
	Lung cancer	134.6
	Essential (primary) hypertension and hypertensive renal disease	127.7

National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthy-women.htm, accessed January 20, 2004.

Rates are three-year averages from 1999-2001 and are per 100,000 estimated population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

Native American women have the second highest rate of being obese, which places them at high risk for diabetes; they have the highest diagnosed diabetes rate.[97] They have by far the highest rate of smoking, a similar trend also appearing in Native American girls.[98] Native American women have the highest rate of alcohol use and the highest mortality rate from illicit drug use of any other population of women; the limited data available suggest that existing addiction treatment programs are culturally inaccessible and ineffective for many Native American women at least in part because they fail to incorporate healing elements from Native American cultures.[99]

Key Health Conditions, Diseases and Causes of Death. The top three leading causes of death for Native American women are coronary heart disease, diabetes, and stroke. In addition, Native American women have the highest death rates for cirrhosis compared to other groups, ranking as the eighth leading cause of death for Native Americans, while it is not listed as among the top ten causes for any other group examined. Native American women ages 45 to 54 are unique among the racial and ethnic groups examined as having cirrhosis as their leading cause of death. This may be attributed to their high rate of alcohol use.

Native American women have the third highest AIDS rate, about three times that of White women. Native American women have the highest rate of experiencing violence in their lifetimes (64.8 percent) as compared to any other racial or ethnic group.[100] American Indian women also may have mental health issues that differ from other groups of women.[101]

Living in a Healthy Community. Native American women experience the second highest rate of poverty of any other group examined and the second lowest rate of high school graduation. Forced relocation of Native Americans has resulted in race discrimination and hostility from non-Native neighbors, which in turn has led to high unemployment and poverty rates.[102] Native American women's health is also affected by environmental degradation. Many live in poor quality housing (often with poisonous lead-based paint), and are exposed to local toxins since they live in areas with uncontrolled toxic waste sites; a large number of their homes lack indoor plumbing, access to a safe water supply or sewage disposal treatment, placing them at greater risk of illness and disease.[103]

Immigrant Women[104]

Immigrant women represent 11.2 percent of the total population of women in the United States.[105] About half of the immigrants in the United States were born in Latin America, about one quarter in Asian countries, with the remaining born in other parts of the world.[106] Experts estimate that approximately three-quarters of immigrants are here legally.[107] Immigrants generally do better than the comparable U.S.-born population in health status and health outcomes such as self-assessed health, number of restricted activity days, bed disability days, work-loss days, physician visits, and hospitalization rates as well as reduced risk of overall mortality.[108] Current research dealing specifically with immigrant women's health is limited. Although vast cultural differences exist between and within the many immigrant populations, many foreign-born women share similar barriers to obtaining adequate health care that may not be experienced by U.S.-born women in the same racial or ethnic group.

Women's Access to Health Care Services. Immigrant women's ability to secure access to health care services is complicated by the lack of health insurance. In 2001, women who were not U.S.-born citizens were more likely than U.S.-born citizen women not to have health insurance and to lack a usual source of care.[109] In 2001, almost 60 percent of low-income non-citizen adult women were uninsured; they were also less likely to receive Medicaid than were native-born low-income women.[110] Medicaid coverage for low-income non-citizens declined from 1995 to 2001 while uninsured rates for this group during that period increased.[111]

Changes in the law during that period no doubt account for some of the reduced access. In 1996, welfare reform significantly limited the extent to which legal immigrants could participate in federal means-tested programs, including Medicaid.[112] In addition to diminishing the already low numbers of immigrant women who are eligible for the program, the law has decreased eligible immigrants' use of Medicaid and health care services. One study cited "heightened fears" of losing residency and the inability to understand the changes as reasons for not participating in Medicaid even when eligible.[113] Other immigrants highlighted the complex Medicaid applications and the inability to afford health care services if not publicly insured as reasons for not seeking care.[114] The lack of health insurance, compounded with language and cultural differences, often prevents many foreign-born women from meeting their health care needs.[115]

Wellness and Prevention. While immigrants encounter a host of health care difficulties (including poorer oral health than native-born),[116] some studies show that many immigrant women who come to the United States voluntarily are healthier than women born in the United States.[117] Some researchers attribute this to a self-selection

process in which only the most resilient women choose to emigrate, as well as the practice of healthy behaviors such as abstention from smoking and alcohol consumption.[118]

Key Health Conditions, Diseases and Causes of Death. One study concluded that immigrant women had a lower overall mortality rate than native-born women. In addition, immigrant women also have a lower risk of death from cardiovascular diseases and lung cancer than native-born women. Immigrant women from various ethnic backgrounds are generally shown to have more favorable birth outcomes than their U.S.-born counterparts of the same race and ethnicity.[119]

Living in a Healthy Community. Immigrants, as a whole, are less likely to graduate from high school than non-immigrants; however, graduation rates vary among ethnicities. A greater percentage of foreign-born than U.S.-born residents lived below the poverty line in 2001. In addition, in 2002, non-native residents earned substantially less than native citizens because they tended to hold lower-level service industry jobs rather than managerial positions or professional specialty occupations. During the same year, immigrant women were also more likely to be unemployed than native women.[120]

Lesbians[121]

Estimates of the lesbian population in the United States range from less than one percent of women nationwide to over eight percent.[122] A 1999 report by the Institute of Medicine identified the serious limitations in knowledge about lesbian health and an urgent need for more research.[123] Much of the current research also fails to address the health concerns experienced by lesbians of different age groups, races, and ethnicities.[124] Since the Institute of Medicine report, researchers and advocacy groups have sought to address these issues, including providing checklists for issues that lesbians should consider when speaking with their health care professionals.[125]

With some exceptions, however, the federal government has not focused on lesbian health concerns, and even reduced their emphasis since 2000.[126] The lack of attention to health issues facing lesbians presents a significant barrier to their health and well-being—adversely affecting access to health care, health research and data collection.[127] A number of the health problems faced by lesbian women are faced by bisexual and transgendered women as well.

Women's Access to Health Care Services. Lesbians face unique barriers to appropriate health care. Studies indicate that lesbians generally seek health care less often than other women do,[128] although the reasons for this disparity are not entirely clear. Some of this difference may be due to indications that lesbians are less likely to have health insurance than are other women.[129] The failure of the federal and state governments to recognize the status of lesbian partners has had a substantial impact on lesbians' financial well-being, and their ability to afford health care. This disparity may be primarily due to discrimination and to the inability to obtain spousal benefits under employer sponsored health insurance. Nevertheless, employers and insurers are increasingly choosing to extend spousal health insurance coverage to partners of lesbian workers.[130]

Some states have enacted laws that offer some health-related benefits to lesbian couples (for example, financial support and other benefits during illness, family leave, workers' compensation, and rights concerning medical treatment decisions, organ donation and hospital visitation, inheritance rights and rarely, health insurance).[131] Even when lesbians are insured, they may face special barriers to care. Lesbians in health maintenance organizations may not have a choice of providers sensitive to their special health care needs.[132] Lesbians uncomfortable with their sexual orientation becoming known (especially to employers) may avoid submitting their insurance claims for fear that the explicit medical information needed for expenses to be approved will reveal that orientation; similar concerns may hinder candid communication between provider and patient.[133]

Wellness and Prevention. One particular problem for lesbians in receiving adequate preventive health care is that they often do not seek care for contraceptive needs, meaning that they also may lose the benefit of other important preventive services, such as breast and cervical cancer screenings, cholesterol tests and blood pressure monitoring, all services that often take place during visits for contraception.[134] Surveys on important risk factors, including smoking and overweight, often fail to inquire about sexual orientation, but those that do reveal a higher prevalence of both conditions among lesbians.[135] Furthermore, lesbians and bisexual women are more likely to report a greater rate of alcohol consumption than heterosexual women, leading to a greater risk of related negative health effects.[136]

Key Health Conditions, Diseases and Causes of Death. Although there is little information about the incidences of specific health conditions among lesbians, existing information suggests areas needing further research. For example, lesbians are sometimes thought to be at higher risk for breast and cervical cancer due to a concentration of risk factors, such as the lack of or delayed childbearing and not

getting annual Pap smears, but there is not sufficient research about the U.S. lesbian population to evaluate this conclusion.[137] Studies indicate a lower prevalence of sexually transmitted diseases among lesbians.[138]

Research is needed on mental health issues, including those related to chronic stress resulting from discrimination and public acknowledgment of sexual orientation.[139] Domestic violence among lesbians is a neglected topic. Although lesbians appear to have a lower reported incidence of domestic violence than do heterosexual women (11 percent and 20 percent respectively), there are still domestic violence issues for lesbians that merit special attention.[140] There is little training and education surrounding lesbian victims and perpetrators of domestic violence; even those trained to help victims of domestic violence generally often are not well versed in the dynamics of violence between same-sex partners, and lesbian perpetrators find little support in treatment groups made up primarily of men.[141] HIV among lesbians, especially the risks of transmission between women, is another area where research is needed.[142]

Living in a Healthy Community. As noted previously, employment discrimination has health implications since it can relegate some lesbians to self-employment, freelance work or lower-paying jobs that do not offer insurance. The *Report Card* reviews state enactment of laws to prevent employment discrimination based on sexual orientation (see Chapter III, page 218). Hate crimes against lesbians present another serious health threat. While statistics vary, one study reported that more than three-fourths of lesbians surveyed had been verbally harassed, and one in ten had been physically assaulted because of her sexual orientation.[143] Some states have adopted policies to prohibit hate crimes based on sexual orientation.[144]

Often, health care providers inadequately provide services for lesbian patients—either due to outright discrimination or to damaging misconceptions—making it difficult for them to get comprehensive care and inhibiting their willingness to seek care. The presumption that a patient is heterosexual, as evidenced by forms that inquire about marital status, and standard questions on birth control use, serve to alienate lesbian women from the health care system, and discourage preventive care.[145] Stereotypes and misconceptions, such as the idea that lesbians do not need Pap smears and other gynecological care, still prevail among both community members and providers.[146] Finally, the growth of the Catholic health care system, with its religious prohibitions against homosexuality, can mean that the partners of lesbian patients may not be allowed the same hospital visitation privileges that spouses have.[147]

Women with Disabilities[148]

It is difficult to determine how many women have disabilities, especially because the definition of "disability" varies in different contexts. Two common approaches are to identify functional activity limitations or to identify those meeting the criteria for eligibility for a program (for example Social Security disability insurance) that addresses a disability.[149] Estimates range from over 29 million women and girls in the United States having some level of disability[150] to about 6 million disabled women (as noted in the national report card.)

Women with disabilities face unique barriers to health care, including physical inaccessibility of medical offices and equipment, limited availability of health information because it is in print format only, and a lack of transportation and related services.[151] In addition, many women with disabilities experience inadequate treatment or outright refusals to be treated by health care providers. Although health care providers must take steps to eliminate these barriers through compliance with accessibility requirements under the Americans with Disabilities Act,[152] compliance is not yet uniform.[153]

The nationwide shift to managed care, particularly in the context of Medicaid, has created new problems for disabled women.[154] Health maintenance organizations have traditionally placed strict limits on therapeutic, supportive and home care services, thus restricting opportunities for people with disabilities to obtain independent living support.[155] Restricted access to specialists also has implications for women with disabilities since disabled women use specialists more often than nondisabled women and only specialists may have the necessary training to treat certain disabilities.[156]

In the area of mammography, standards do not take into account the fact that women with disabilities face special barriers to obtaining these services (e.g., lack of adaptive equipment, providers' lack of familiarity or sensitivity to special needs of women with disabilities).[157]

Women with disabilities have a significantly higher rate of hysterectomy as a method of birth control than nondisabled women, and disabled women are also more likely to not use birth control at all.[158]

Further, women and girls with disabilities are more likely than nondisabled women and girls to experience emotional, physical and sexual abuse by partners, family members and caregivers. Caregiver abuse is a particular problem that can include denial of medications or oversedation, disconnecting a wheelchair's power supply and other forms of abuse. Girls

with disabilities are also almost twice as likely to be sexually abused as nondisabled children, and women and girls with developmental disabilities are far more likely to be sexually assaulted (and revictimized by the same person). Disabled women are less likely to be believed when they report incidents of abuse or assault, and many of these crimes go unreported.[159]

Disabled women and girls also face particular issues regarding mental health. They have a high risk for depression, facing struggles with employment discrimination and a lack of accessible and affordable health care, housing and transportation. One study also found that eating disorders are more prevalent among female adolescents with disabilities than non-disabled adolescents.[160]

Women with HIV/AIDS[161]

Since the beginning of the epidemic through 2002, there have been over 880,000 cases of AIDS diagnosed in the United States.[162] Eighteen percent of these cases are adult or adolescent women.[163] Although the majority of people living with HIV/AIDS are men, women face unique challenges in the wake of this disease. In 1985, of adult and adolescent AIDS cases, seven percent were women. In 2001, the proportion rose to 26 percent.[164] Women represented almost one-third of new HIV infections in 2001, and even though the rate of AIDS cases is leveling off overall, the rate of decline for men is two times the rate for women.[165]

Given that HIV/AIDS is an important health issue for women, particularly women of color, the *Report Card* examines several AIDS-related indicators: a status indicator (the AIDS incidence rate in 2001) and two policy indicators (AIDS Drug Assistance Programs and HIV/STD education). Alarming trends have emerged for some of the populations highlighted in this chapter. The incidence of AIDS has increased most dramatically among women of color. While Black and Hispanic women represent only about one-fourth of all U.S. women, they represent an estimated three-fourths of AIDS cases in women reported from the start of the epidemic to the end of 2002.[166] Black women had a 23 times greater diagnosis rate than White women in 2002.[167] And in a study of heterosexual transmission of HIV in 29 states analyzing CDC data from 1999 to 2002, females accounted for 89 percent of heterosexually acquired HIV infection among 13 to 19 year olds.[168] Women with HIV/AIDS are more likely to be poor (earning less than $10,000 per year in 1996), unemployed, underinsured and less educated than men living with HIV/AIDS.[169]

The major issues faces women living with HIV include access to health care (including dental care), nutrition, housing, child care for those with children (including guardianship issues, and issues related to being pregnant and having a child who is potentially HIV positive), general support (e.g., family or close friends), access to mental health and addiction support services, and discrimination.[170]

Another important difference between men and women is that, in general, disparities related to HIV/AIDS are larger among women than among men.[171] As noted in other sections of this chapter, Black, Hispanic, and low-income women have been especially hard hit by the HIV/AIDS epidemic. For some of the other populations addressed in the chapter (e.g., lesbians), there is not sufficient information about special HIV/AIDS issues.

Women Living in Rural Areas

As of 2000, about 20 percent of U.S. women live in rural areas.[172] Women who live in rural areas tend to obtain fewer recommended preventive health services than women in urban areas.[173] Rural residents often have lower household income, are more likely to be under or uninsured, and have difficulty getting to health appointments (due to difficulties in obtaining time off from work, as well as obtaining transportation and/or long distances to travel). Not surprisingly, rural women are much less likely to obtain colorectal cancer screening, mammograms, and Pap screening than women living in urban areas.[174]

Differences in health behaviors and conditions are also evident for rural women compared to women in more urban areas. Rural women are more likely to report being obese.[175] Rural adolescent and adult women are more likely to smoke than their urban counterparts,[176] and are more likely to smoke during pregnancy.[177] Women in rural areas report higher rates of coronary heart disease, hypertension and cancer.[178] Higher rates of limited activity due to chronic health conditions are seen for rural women.[179] And age-adjusted death rates for girls and young women (ages one to 24) are highest in the most rural counties,[180] while age-adjusted death rates due to unintentional injury are about 80 percent higher in rural counties.[181]

The ten percent of rural women who are members of racial and ethnic minority groups confront additional challenges. They are more likely to have jobs that pay less, and to have poorer insurance coverage (if any at all). While many of the health problems faced are similar to those of urban minority women, these health issues are often heightened:

cardiovascular disease, diabetes, violence (especially intimate partner violence), HIV/AIDS and breast, ovarian and cervical cancer rates are particular examples.[182]

Women Prisoners[183]

The number of incarcerated women (in federal or state prisons or local jails) has been growing. From 1990 to 2000, the total number of these women nearly doubled.[184] This increase is due in part to mandatory minimum sentences for drug offenders.[185] Women prisoners have certain risk factors (i.e., risk factors contributing to women's criminal behavior include substance abuse, mental illness and physical abuse).[186] Women with substance abuse issues often serve jail time and lose their parental rights.[187] Women prisoners face some problems in health care access issues while in prison, and also confront problems upon reentering society that can affect their health.[188]

Clearly, more research and better data collection are needed to address health care disparities faced by certain populations of women. Pervasive problems disproportionately affect Black women in particular, but all the groups discussed in this chapter confront health issues that present unique challenges. Disparities in health care have been ignored for far too long. Only with a commitment to targeted research will the scope of these problems be understood and addressed through appropriate interventions and policies.