

Healthy People 2010 Focus Areas

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-Based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. HIV
14. Immunization and Infectious Diseases
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. Oral Health
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Diseases
25. Sexually Transmitted Diseases
26. Substance Abuse
27. Tobacco Use
28. Vision and Hearing

Leading Health Indicators

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization
- Access to health care

p.17 *Should note that many of these areas are women, and older women, specific such as 2, 19, 27, and 28, though not presented here as such.*

22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. p.26

Health Impact of Physical Activity

Regular physical activity is associated with lower death rates for adults of any age, even when only moderate levels of physical activity are performed. Regular physical activity decreases the risk of death from heart disease, lowers the risk of developing diabetes, and is associated with a decreased risk of colon cancer. Regular physical activity helps prevent high blood pressure and helps reduce blood pressure in persons with elevated levels.

Regular physical activity also:

- n Increases muscle and bone strength.
- n Increases lean muscle and helps decrease body fat.
- n Aids in weight control and is a key part of any weight loss effort.
- n Enhances psychological well-being and may even reduce the risk of developing depression.
- n Appears to reduce symptoms of depression and anxiety and to improve mood.

In addition, children and adolescents need weight-bearing exercise for normal skeletal development, and young adults need such exercise to achieve and maintain peak bone mass. Older adults can improve and maintain strength and agility with regular physical activity. This can reduce the risk of falling, helping older adults maintain an independent living status. Regular physical activity also increases the ability of people with certain chronic, disabling conditions to perform activities of daily living.

Populations With Low Rates of Physical Activity

- n Women generally are less active than men at all ages...
- n By age 75, one in three men and one in two women engage in *no* regular physical activity. p.27

Exercise for bone density, weight management, and to prevent depression is an older woman's issue here placed in a more universal context.

Health Impact of Overweight and Obesity

Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem.

Populations With High Rates of Overweight and Obesity

More than half of adults in the United States are estimated to be overweight or obese... Obesity is especially prevalent among women with lower incomes and is more common among African American and Mexican American women than among white women. Among African Americans, the proportion of women who are obese is 80 percent higher than the proportion of men who are obese. This gender difference also is seen among Mexican American women and men, but the percentage of white, non-Hispanic women and men who are obese is about the same.

Reducing Overweight and Obesity

Obesity is a result of a complex variety of social, behavioral, cultural, environmental, physiological, and genetic factors. Efforts to maintain a healthy weight should start early in childhood and continue throughout adulthood, as this is likely to be more successful than efforts to lose substantial amounts of weight and maintain weight loss once obesity is established.

A healthy diet and regular physical activity are both important for maintaining a healthy weight. Over time, even a small decrease in calories eaten and a small increase in physical activity can help prevent weight gain or facilitate weight loss. It is recommended that obese individuals who are trying to lose substantial amounts of weight seek the guidance of a health care provider.

Dietary and Physical Activity Recommendations

The *Dietary Guidelines for Americans* recommend that to build a healthy base, persons aged 2 years and older choose a healthful assortment of foods that includes vegetables; fruits; grains (especially whole grains); fat-free or low-fat milk products; and fish, lean meat, poultry, or beans. The guidelines further emphasize the importance of choosing foods that are low in saturated fat and added sugars most of the time and, whatever the food, eating a sensible portion size. Adults who are trying to maintain healthy weight after weight loss are advised to get even more physical activity.

p.29

Health Impact of Cigarette Smoking

Smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung diseases—all leading causes of death. Smoking during pregnancy can result in miscarriages, premature delivery, and sudden infant death syndrome. Other health effects of smoking result from injuries and environmental damage caused by fires.

Adults.

Men have only somewhat higher rates of smoking than women within the total U.S. population.

p.31

18-9b. Increase the proportion of adults with recognized depression who receive treatment. p.36

Populations With High Rates of Depression

Serious mental illness clearly affects mental health and can affect children, adolescents, adults, and older adults of all ethnic and racial groups, both genders, and people at all educational and income levels. Adults and older adults have the highest rates of depression. Major depression affects approximately twice as many women as men. Women who are poor, on welfare, less educated, unemployed, and from certain racial or ethnic populations are more likely to experience depression. In addition, depression rates are higher among older adults with coexisting medical conditions. For example, 12 percent of older persons hospitalized for problems such as hip fracture or heart disease are diagnosed with depression. Rates of depression for older persons in nursing homes range from 15 to 25 percent. p.36

14-29a, b. Increase the proportion of noninstitutionalized adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease. p.42

Recommended immunizations for adults aged 65 years and older include a yearly immunization against influenza (the “flu shot”) and a one-time immunization against pneumococcal disease. Most of the deaths and serious illnesses caused by influenza and pneumococcal disease occur in older adults and others at increased risk for complications of these diseases because of other risk factors or medical conditions. p.43

Bibliography of references explicitly focused on women

Objectives for Improving Health (Part A: Focus Areas 1-14)

1. Access to Quality Health Services

Although patient awareness and acceptance of some interventions are high (such as screening for breast cancer) other interventions (for example, colorectal cancer screening and sexually transmitted disease [STD] screening) are less uniformly accepted. p.1-4

Long-Term Care and Rehabilitative Services

1-15 Long-term care services. p.1-12

LTC issues not sensitive to women, the group that makes up the bulk of its users.

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

1-3h. Management of menopause (females aged 46 to 56 years) Developmental p.1-15 to 1-16

Access to Quality Health Services Page 1-17

Clinician counseling should be tailored to the individual risk factors, needs, preferences, and abilities of each patient.¹ For some preventive interventions, such as hormone therapy in postmenopausal women, the optimal strategy depends on how individual women value potential benefits and risks. Counseling of perimeno-pausal and postmenopausal women should encourage shared decision making based on individual risk factors and patient preferences.¹ p. 1-17 to 1-18

Report illustrates problem areas and goals but does not outline a plan of action for reaching those goals.

Related Objectives From Other Focus Areas

2. Arthritis, Osteoporosis, and Chronic Back Conditions

2-2. Activity limitations due to arthritis

2-3. Personal care limitations

2-6. Racial differences in total knee replacement

2-7. Seeing a health care provider

2-11. Activity limitations due to chronic back conditions

3. Cancer

3-10. Provider counseling about cancer prevention

3-11. Pap tests

3-12. Colorectal cancer screening

3-13. Mammograms

5. Diabetes

5-1. Diabetes education

5-4. Diagnosis of diabetes

5-11. Annual urinary microalbumin measurement

5-12. Annual glycosylated hemoglobin measurement

5-13. Annual dilated eye examinations

- 5-14. Annual foot examinations
 - 5-16. Aspirin therapy
 - 18. Mental Health and Mental Disorders**
 - 18-6. Primary care screening and assessment
 - 19. Nutrition and Overweight**
 - 19-1. Healthy weight in adults
 - 19-2. Obesity in adults
 - 19-3. Overweight or obesity in children and adolescents
 - 19-4. Growth retardation in children
 - 19-17. Nutrition counseling for medical conditions
 - 19-18. Food security
 - 22. Physical Activity and Fitness**
 - 22-14. Community walking
 - 22-15. Community bicycling
 - 28. Vision and Hearing**
 - 28-1. Dilated eye examinations
 - 28-2. Vision screening for children
 - 28-10. Vision rehabilitation services and devices
 - 28-14. Hearing examination
 - 28-15. Evaluation and treatment referrals
- p.1-36 to 1-39

References used that explicitly refer to women:

Ettner, S.L. The timing of preventive services for women and children: The effect of having a usual source of care. *American Journal of Public Health* 86:1748-1754, 1996.

Cooper-Patrick, L.; Gallo, J.; Gonzales, J.; et al. Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association* 282:583-589, 1999.

2. Arthritis, Osteoporosis, and Chronic Back Conditions

The current and projected growth in the number of people aged 65 years and older in the United States has focused attention on preserving quality of life as well as length of life. Chief among the factors involving preserving quality of life are the prevention and treatment of musculoskeletal conditions—the major causes of disability in the United States. Among musculoskeletal conditions, arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions have the greatest impact on public health and quality of life. p.2-3

Osteoporosis

About 13 to 18 percent of women aged 50 years and older and 3 to 6 percent of men aged 50 years and older have osteoporosis, a reduction in bone mass or density that leads to deteriorated and fragile bones. These rates correspond to 4 million to 6 million women and 1 million to 2 million men in the United States who have osteoporosis.¹⁶ Another 37 to 50 percent of women aged 50 years and older and 28 to 47 percent of men of the same age group have some degree of osteopenia, reduction in bone mass that is not as severe as osteoporosis.

The major health consequence of osteoporosis is an increased risk of fractures. Approximately 1.5 million fractures per year are attributed to osteoporosis.¹⁷ One in three women and one in eight men aged 50 years and older will experience an osteoporotic-related fracture in their lifetime.¹⁷ Health care costs for these fractures are estimated at \$13.8 billion per year in 1996 dollars.¹⁸

The risk of any fracture increases with the presence of osteoporosis, but hip fractures represent the most serious impact in terms of health care costs and consequences for the individual. In 1994, there were 281,000 hospital discharges for hip fracture among people aged 45 years and older. Of these, 74,000, or 26 percent, were among men.¹⁶ In all, 1 out of 6 white women and 1 out of 17 white men will experience a hip fracture by the time they reach age 90 years.¹⁹ Although the hip fracture rate among women seems relatively constant, the rate among men seems to be increasing over time.²⁰

An average of 24 percent of hip fracture patients aged 50 years and older die in the year following fracture, with higher death rates among men than among women.²¹ Also, hip fracture is more likely to lead to functional impairment than are other serious medical conditions, including heart attack, stroke, and cancer.²¹ For example, half of all hip fracture patients will be unable to walk without assistance.¹⁷ p.2-5

A number of personal factors may be risk factors for low back pain. These include nonmodifiable factors, such as age and gender, some anthropometric characteristics (for example, height and body build), history of low back problems, and spinal abnormalities as well as modifiable factors, such as weight, physical fitness, smoking, some aspects of lumbar flexibility, trunk muscle strength, and hamstring elasticity. p.2-6

Disparities

Arthritis is more common in women aged 18 years and older than in men and is the leading chronic condition and cause of activity limitation among women.^{33, 34} p.2-6

Osteoporosis is more common among women than men. The rates of disease increase markedly with increasing age. Rates are higher among non-Hispanic white Americans than among Mexican Americans or non-Hispanic African Americans.¹⁶ White postmenopausal women are at highest risk of the disease. The risk for chronic back pain increases with age. Although back pain appears to be equally common in men and women, impairment from back and spine conditions is more common in women. p.2-7

Women need to be particularly concerned about bone loss occurring at the time of menopause, when bone can be lost at the rate of 2 to 4 percent per year. Women should be counseled on methods to minimize their bone loss. Evidence indicates that older persons, even those who have had a fracture, can benefit from treatment to prevent further bone loss or restore some lost bone to decrease the risk of subsequent fractures.⁵⁵ p.2-8

Women aged 65 years and older who are eligible under Medicare criteria to have an initial bone density measurement are the focus of the fourth topic about bone fracture prevention. p.2-8

Interim Progress Toward Year 2000 Objectives

The national health objectives for the year 2000 included two objectives for osteoporosis, one objective for chronic back conditions, and no objectives for arthritis. The objective of increasing the proportion of women of menopausal age who have been counseled about estrogen replacement therapy for the prevention of osteoporosis had no data subsequent to the 1994 baseline to chart progress. Annual hip fracture rates increased among people aged 65 years and older, and rates of activity limitation due to chronic back conditions increased from the 1986–88 baseline. p.2-9

Healthy People 2010—Summary of Objectives

Arthritis, Osteoporosis, and Chronic Back Conditions

Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Number Objective Short Title

Osteoporosis

2-9 Cases of osteoporosis

2-10 Hospitalization for vertebral fractures

p.2-10

Osteoporosis

2-9. Reduce the proportion of adults with osteoporosis.

Target: 8 percent.

Baseline: 10 percent of adults aged 50 years and older had osteoporosis as measured by low total femur bone mineral density (BMD) in 1988–94 (age adjusted to the year 2000 standard population).

Target setting method: 20 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Osteoporosis as Measured by Low Bone Mineral Density

Adults Aged 50 Years and Older, 1988–94

Percent

TOTAL 10

Race and ethnicity

American Indian or Alaska Native DSU

Asian or Pacific Islander DSU

Asian DNC

Native Hawaiian and other Pacific Islander DNC

Black or African American 7

White 10

Hispanic or Latino DSU

Mexican American 10

Not Hispanic or Latino 10

Black or African American 7

White 10

Gender

Female 16

Male 3

Education level

Less than high school 11

High school graduate 11

At least some college 9

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population.

BMD has been identified as one of the primary predictive factors for osteoporosis-related fractures.^{63, 64, 65} Osteoporosis is defined as a BMD value that is more than 2.5 standard deviations below that of an average young adult.⁶⁶

The proportion of adults aged 50 years and older with osteoporosis in the total femur region is 10 percent (16 percent in women and 3 percent in men). Osteoporosis occurs in nonwhite women and in men, although the rates of disease are not as high as the rates found among white women. These estimates are based on the total femur; estimates based on a different skeletal site (or combination of sites) may differ. For example, the proportion of white women with osteoporosis in Olmsted County, Minnesota, was established to be approximately 16 to 17 percent at the femur, lumbar spine, or wrist when each site was considered separately. However, 30 percent of women had osteoporosis in at least one of the three sites.⁶⁷

Osteoporosis is a major risk factor for hip fracture. Virtually all persons with a hip fracture are hospitalized for treatment.²¹ Two-thirds of persons who fracture a hip do not return to their prefracture level of functioning. Health care expenditures for hip fractures in 1995 have been estimated at \$8.7 billion.¹⁸ Interventions that reduce the rate of osteoporosis should have a marked impact on the rate of hip fractures. Estimates indicate that osteoporosis contributes to 90 percent of hip fractures in women and 80 percent of hip fractures in men.⁶⁵ Increasing BMD by 5 percent may decrease the risk of fractures by 25 percent.⁶⁸

Although osteoporosis increases the risk of fractures, most hip fractures result from falls.⁶⁶ Some risk factors associated with falls may be amenable to interventions. These risk factors include impaired vision, use of long-acting psychotropic drugs, physical inactivity, muscle weakness, and poor health.⁶⁹ (See Focus Area 15. Injury and Violence Prevention.)

2-10. Reduce the proportion of adults who are hospitalized for vertebral fractures associated with osteoporosis.

Target: 14.0 hospitalizations per 10,000 adults aged 65 years and older.

Baseline: 17.5 hospitalizations per 10,000 adults aged 65 years and older were for vertebral fractures associated with osteoporosis in 1998 (age adjusted to the year 2000 standard population).

Target setting method: 20 percent improvement.

Data source: National Hospital Discharge Survey (NHDS), CDC, NCHS.

Arthritis, Osteoporosis, and Chronic Back Conditions Page 2-19

**Hospitalizations for Vertebral Fractures Associated With Osteoporosis
Adults Aged 65 Years and Older, 1998**

Rate per 10,000

TOTAL 17.5

Race and ethnicity

American Indian or Alaska Native DSU
Asian or Pacific Islander DSU
Asian DNC
Native Hawaiian and other Pacific Islander DNC
Black or African American DSU
White 14.0
Hispanic or Latino DSU
Not Hispanic or Latino DSU
Black or African American DSU
White DSU

Gender

Female 19.6
Male 13.9

Select populations

Age groups (not age adjusted)
65 to 74 years 6.7
75 to 84 years 26.0
85 years and older 39.0

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population.

Vertebral fractures are the most common fracture due to osteoporosis.⁷⁰ About 30 to 50 percent of women and 20 to 30 percent of men will experience vertebral fractures in their lifetime.⁷⁰ The overall number of cases of these fractures rises rapidly with increasing age. Among white women, the rate rises from 6 percent among those aged 50 to 59 years to about 75 percent among those aged 90 years and older.⁷¹ Most of these fractures cause little difficulty and go unrecognized. However, 33 percent of the fractures will be diagnosed clinically, 8 percent will require hospitalization,⁷² and about 2 percent will require long-term nursing care.⁷³

The most common symptom of vertebral fractures is back pain, which is reported in about half of the cases. People with these fractures are more likely to have difficulty performing activities of daily living, such as bending, reaching above the head, and walking. Changes in the outward appearance of people experiencing these fractures is a loss of height and the development of a humped back.⁷⁰

Interventions that reduce the number of persons with osteoporosis should reduce the rates of vertebral fractures. Falls associated with fractures at other sites do not play a prominent role in these fractures. Normal daily activities can place sufficient stress on the vertebra to cause fractures.⁷¹

For discussion of calcium and vitamin D, see Focus Area 19. Nutrition and Overweight.
p.2-17 to 2-20

Osteoporosis increases the risk of vertebral compression, which may account for the increase in reported low back pain in older females.^{78, 79}
p.2-21

Related Objectives From Other Focus Areas

19. Nutrition and Overweight

19-1. Healthy weight in adults

19-2. Obesity in adults

19-11. Calcium intake

19-16. Worksite promotion of nutrition education and weight management

19-17. Nutrition counseling for medical conditions

p.2-22

These, again, are related to older women's health, though not explicitly so.

References used that focus specifically on women:

19 Melton, III, L.J.; Chrischilles, E.A.; Cooper, C.; et al. How many women have osteoporosis? *Journal of Bone and Mineral Research* 7:1005-1010, 1992.

20 Bacon, W.E. Secular trends in hip fracture occurrence and survival: Age and sex differences. *Journal of Aging Health* 8(4):538-553, 1996.

33 CDC. Prevalence and impact of arthritis among women. United States, 1989-1991. *Morbidity and Mortality Weekly Report* 44(17):329-334, 517-518, 1995.

34 Callahan, L.F.; Rao, J.; and Boutaugh, M. Arthritis and women's health: Prevalence, impact, and prevention. *American Journal of Preventive Medicine* 12(5):401-409, 1996.

41 Felson, D.T.; Zhang, Y.; Anthony, J.M.; et al. Weight loss reduces the risk for symptomatic knee osteoarthritis in women. The Framingham Study. *Annals of Internal Medicine* 116(7):535-539, 1992.

66 World Health Organization (WHO). *Assessment of Fracture Risk and Its Application to Screening for Postmenopausal Osteoporosis*. Technical Report Series No. 843. Geneva, Switzerland: WHO, 1994.

67 Melton, III, L.J. How many women have osteoporosis now? *Journal of Bone and Mineral Research* 10(2):175-177, 1995.

79 Buchanan, J.R.; Myers, C.; Greer, III, R.B.; et al. Assessment of the risk of vertebral fracture in menopausal women. *Journal of Bone and Joint Surgery* 69(2):212-218, 1987.

3. Cancer

The lung and bronchus, prostate, female breast, and colon and rectum were the most common cancer sites for all racial and ethnic populations in the United States and together accounted for approximately 54 percent of all newly diagnosed cancers.¹

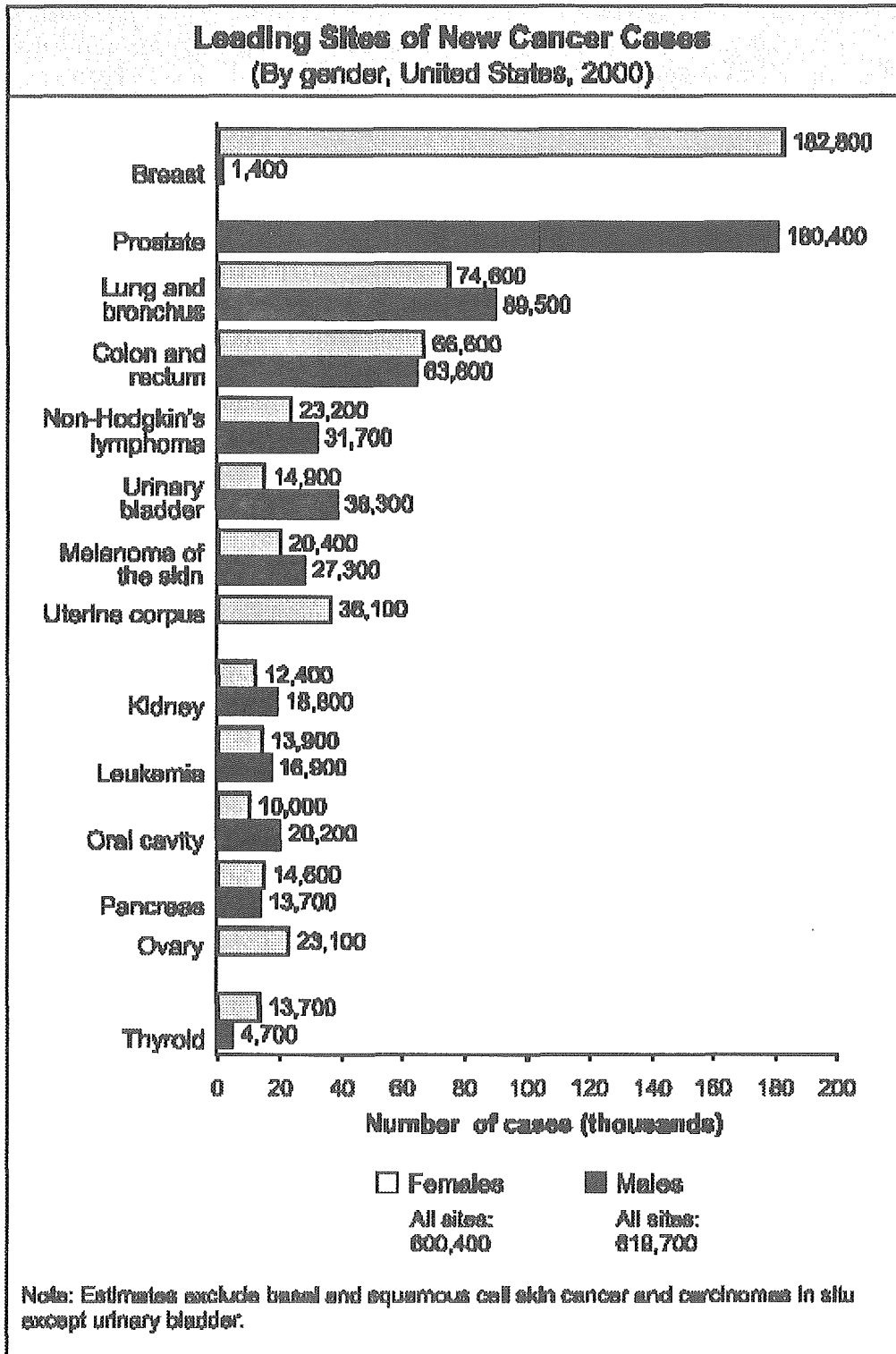
p.3-3

Treatment for lung, breast, and prostate cancers alone accounts for more than half of the direct medical costs.

p.3-3

Disparities

Cancer death rates vary by gender, race, and ethnicity.³ Male cancer death rates peaked in 1990 at 220.8 per 100,000, and female death rates peaked a year later at 142.2 per 100,000. After the peak year, through 1996, male cancer deaths for all sites decreased on average by 1 percent per year, and female deaths decreased on average by 0.4 percent per year. There were significant decreases in death for lung, prostate, brain, and other nervous system cancers in males and a significant decrease in breast cancer death for females.³ Among males, lung cancer death rates have declined since 1990. In contrast, lung cancer death rates have continued to increase among females. Since 1987, more females have died from lung cancer than breast cancer.



Source: American Cancer Society. *Surveillance Research, 2000.*

p.3-4

The recent decrease in deaths from breast cancer in white females is attributed to greater use of breast cancer screening in regular medical care. However, deaths due to breast cancer in African American females continue to increase, in part, because breast cancer is diagnosed at later stages in African American females.¹

p.3-5

Scientific data from randomized trials of cancer screening together with expert opinions indicate that adherence to screening recommendations for cancers of the breast, cervix, and colon/rectum reduces deaths from these cancers. To reduce breast cancer deaths in the United States, a high percentage of females aged 40 years and older need to comply with screening recommendations. A reduction in breast cancer deaths could be expected to occur after a delay of roughly 7 years.¹¹ To reduce cervical cancer deaths, a high percentage of females in the United States who are aged 18 years and older need to comply with screening recommendations. Evidence from randomized preventive trials is unavailable, but expert opinion suggests that a beneficial impact on cervical cancer death rates would be expected to occur after a delay of a few years.

Evidence shows that a reduction in CRC deaths can be achieved through detection and removal of precancerous polyps and treatment of CRC in its earliest stages. The findings from three randomized controlled trials indicate that biennial screening with fecal occult blood tests (FOBT) can reduce deaths from CRC by 15 to 21 percent in people aged 45 to 80 years.^{12, 13, 14} One trial¹⁵ reported a 33 percent reduction in deaths with annual screening in the same age groups, and a simulation model showed a 56 percent reduction.¹⁶ The efficacy of sigmoidoscopy has been supported by three case-control studies^{17, 18, 19} that showed 59 to 79 percent reductions in CRC deaths from cancers within reach of the sigmoidoscope in age groups 45 years and older.

p.3-6 to 3-7

Data also showed some improvement in the proportion of women receiving mammograms and Pap tests. In addition, for both mammograms and Pap tests, the disparity in use rates for most of the population subgroups and those for all women either has been reduced or eliminated.

p.3-7 to 3-8

Healthy People 2010—Summary of Objectives

Cancer

Goal: Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.

Number Objective Short Title

3-3 Breast cancer deaths

3-4 Cervical cancer deaths

3-11 Pap tests

3-13 Mammograms

p.3-9

3-3. Reduce the breast cancer death rate.

Target: 22.3 deaths per 100,000 females.

Baseline: 27.9 breast cancer deaths per 100,000 females occurred in 1998 (age adjusted to the year 2000 standard population).

Target setting method: 20 percent improvement.

Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Breast Cancer Deaths Females, 1998

Rate per 100,000

TOTAL 27.9

Race and ethnicity

American Indian or Alaska Native 14.2

Asian or Pacific Islander 13.1

Asian DNC

Native Hawaiian and other Pacific Islander DNC

Black or African American 35.7

White 27.3

Hispanic or Latino 16.8

Not Hispanic or Latino 28.5

Black or African American 36.7

White 27.9

Education level (aged 25 to 64 years)

Less than high school 20.0

High school graduate 28.4

At least some college 22.0

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population.

Breast cancer is the most common cancer among women in the United States. An estimated 184,200 new cases were expected to be diagnosed in 2000. About 40,800 U.S. women were expected to die from breast cancer in 2000, accounting for about 15.2 percent of cancer deaths among women.¹ Death from breast cancer can be reduced substantially if the tumor is discovered at an early stage. Mammography is the most effective method for detecting these early malignancies. Clinical trials have demonstrated that mammography screening can reduce breast cancer deaths by 20 to 39 percent in women aged 50 to 74 years and about 17 percent in women aged 40 to 49 years.²⁴ Breast cancer deaths can be reduced through increased adherence with recommendations for regular mammography screening.

Many breast cancer risk factors, such as age, family history of breast cancer, reproductive history, mammographic densities, previous breast disease, and race and ethnicity, are not subject to intervention.^{25, 26} However, being overweight is a well-established breast cancer risk for postmenopausal women that can be addressed. ²⁵ Avoiding weight gain is one method by which older women may reduce their risk of developing breast cancer.

3-4. Reduce the death rate from cancer of the uterine cervix.

Target: 2.0 deaths per 100,000 females.

Baseline: 3.0 cervical cancer deaths per 100,000 females occurred in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Vital Statistics System (NVSS), CDC, NCHS.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Cervical Cancer Deaths Females, 1998

Rate per 100,000

TOTAL 3.0

Race and ethnicity

American Indian or Alaska Native 2.5

Asian or Pacific Islander 3.3

Asian DNC

Native Hawaiian and other Pacific Islander DNC

Black or African American 6.0

White 2.7

Cervical Cancer Deaths Females, 1998

Rate per 100,000

Hispanic or Latino 3.3

Not Hispanic or Latino 3.0

Black or African American 6.2

White 2.6

Education level (aged 25 to 64 years)

Less than high school 7.2

High school graduate 4.8

At least some college 2.1

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

Cervical cancer is the 10th most common cancer among females in the United States, with an estimated 12,800 new cases in 2000. The number of new cases of cervical cancer is higher among females from racial and ethnic groups than among white females. An estimated 4,600 U.S. females were expected to die from cervical cancer in 2000.¹ Cervical cancer accounts for about 1.7 percent of cancer deaths among females. Infections of the cervix with certain types of sexually transmitted human papilloma virus increase risk of cervical cancer and may be responsible for most cervical cancer in the United States.²⁷

Considerable evidence suggests that screening can reduce the number of deaths from cervical cancer. Invasive cervical cancer is preceded in a large proportion of cases by precancerous changes in cervical tissue that can be identified with a Pap test. If cervical cancer is detected early, the likelihood of survival is almost 100 percent with appropriate treatment and followup; that is, almost all cervical cancer deaths could be avoided if all females complied with screening and followup recommendations. ²⁸ Risk is substantially decreased among former smokers in comparison to continuing smokers.⁷

p. 3-12 to 3-14

3-10. Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.

Objective	1988 Baseline (unless noted)	2010 Target	Percent
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3-10f. Primary care providers who counsel about mammograms	37	85	
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3-10g. Primary care providers who counsel about Pap tests	55	85	
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3-10h. Primary care providers who counsel about physical activity	22 (1995)	85	
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Target setting method: Better than the best.

Data sources: Survey of Physicians' Attitudes and Practices in Early Cancer Detection, NIH, NCI; National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; Survey of Current Issues in Dentistry, American Dental Association.

Smoking cessation,^{7, 21} adoption of healthy diets,⁸ increased physical activity,^{9, 10} and increased cancer screening^{11, 12, 13, 14, 15, 16, 17, 18, 19} can all contribute to reduced numbers of cancer deaths. Experts recommend that providers screen patients for breast, cervical, and colorectal cancers and counsel patients to prevent or reduce tobacco use, promote physical activity, and promote a healthy diet.³² Provider counseling should be conducted in a linguistically and culturally appropriate manner.

p.3-22

3-11. Increase the proportion of women who receive a Pap test.

Target and baseline: 1998 Baseline*	2010 Target
Objective Increase in Pap Testing	<i>Percent</i>

3-11a. Women aged 18 years and older who have ever received a Pap test 92 97

3-11b. Women aged 18 years and older who received a Pap test within the preceding 3 years 79 90

*Age adjusted to the year 2000 standard population. Includes women without a uterine cervix.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

p.3-23

Women Aged 18 Years and Older, 1998 (unless noted)	Pap Test	
	3-11a. Ever	3-11b. In Preceding 3 Years
TOTAL	92	79
Race and ethnicity		
American Indian or Alaska Native	88	72
Asian or Pacific Islander	78	67
Asian	78	67
Native Hawaiian and other Pacific Islander	80	66
Black or African American	94	83
White	93	79
Hispanic or Latino		
Hispanic or Latino	85	74
Not Hispanic or Latino	93	80
Black or African American		
Black or African American	94	83
White	94	80
Education level (aged 25 years and older)		
Less than high school	89	69
High school graduate	95	78
At least some college	97	83

Women Aged 18 Years and Older, 1998 (unless noted)	Pap Test	
	3-11a. Ever	3-11b. In Preceding 3 Years
Family income level		
Poor	88	69
Near poor	92	73
Middle/high income	94	83
Geographic location		
Urban	92	80
Rural	93	78
Disability status		
With activity limitations	95 (1994)	74 (1994)
Without activity limitations	94 (1994)	78 (1994)

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population. Includes women without a uterine cervix.
 p.2-23 to 2-24

3-13. Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.

Target: 70 percent.

Baseline: 67 percent of women aged 40 years and older received a mammogram within the preceding 2 years in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

Women Aged 40 Years and Older, 1998 (unless noted)	Mammogram
	Percent
TOTAL	67
Race and ethnicity	
American Indian or Alaska Native	45
Asian or Pacific Islander	61
Asian	61
Native Hawaiian and other Pacific Islander	DSU
Black or African American	66
White	67
Hispanic or Latino	
Hispanic or Latino	61
Not Hispanic or Latino	68
Black or African American	66
White	68
Education level	
Less than high school	53
High school graduate	66
At least some college	73
Family income level	
Poor	50
Near poor	54
Middle/high income	73
Geographic location	
Urban	68
Rural	65

Women Aged 40 Years and Older, 1998 (unless noted)	Mammogram
	Percent
Disability status	
Persons with activity limitations	55 (1994)
Persons without activity limitations	61 (1994)

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: Age adjusted to the year 2000 standard population.

p.3-26 to 3-27

References:

24 Kerlikowske, K.; Grady, D.; Rubin, S.M.; et al. Efficacy of screening mammography. A meta-analysis. *Journal of the American Medical Association* 273:149-154, 1995.

25 Henderson, B.E.; Pike, M.C.; Bernstein, L.; et al. Breast cancer. In: Schottenfeld, D., and Fraumeni, Jr., J.F., eds. *Cancer Epidemiology and Prevention*. 2nd ed. New York, NY: Oxford University Press, 1996, 1022-1039.

28 Schiffman, M.H.; Brinton, L.A.; Devesa, S.S.; et al. Cervical cancer. In: Schottenfeld, D., and Fraumeni, Jr., J.F., eds. *Cancer Epidemiology and Prevention*. 2nd ed. New York, NY: Oxford University Press, 1996, 1090-1116.

4. Chronic Kidney Disease

There is a slight preponderance of kidney failure in men. In 1997, the incidence of treated chronic kidney failure was 322 per million population in men, compared with 271 per million in women.⁸

p.4-6

Significant disparities exist in the people who are registered on the waiting list. Women and people from certain racial and ethnic groups—particularly, African Americans—are less likely than other kidney transplant candidates to be registered on the waiting list.^{40, 55, 56}

p.4-17

References:

42 Bloembergen, W.E.; Mauger, E.A.; and Wolfe, R.A. Association of gender and access to cadaveric renal transplantation. *American Journal of Kidney Diseases* 30(6):733-738, 1997.

55 Soucie, J.M.; Neylan, J.F.; and McClellan, W. Race and sex differences in the identification of candidates for renal transplantation. *American Journal of Kidney Diseases* 19:414-419, 1992.

5. Diabetes

While premenopausal nondiabetic women usually are at less risk of cardiovascular disease than men, the presence of diabetes in women is associated with a three- to four-fold increase in coronary heart disease compared to nondiabetic females.⁵

p.5-3

Gender
Female 49
Male 42

References:

84 ADA. Preconception care of women with diabetes. *Diabetes Care* 20(S1):40-43, 1997.

6. Disability and Secondary Conditions

...eliminate disparities between people with and without disabilities in the U.S. population.

- (1) all people with disabilities automatically have poor health, (2) public health should focus only on preventing disabling conditions, (3) a standard definition of “disability” or “people with disabilities” is not needed for public health purposes, and (4) the environment plays no role in the disabling process. These misconceptions have led to an underemphasis of health promotion and disease prevention activities targeting people with disabilities and an increase in the occurrence of secondary conditions (medical, social, emotional, family, or community problems that a person with a primary disabling condition likely experiences). p.6-3

also wording like: “Health promotion interventions for people with disabilities—in the community, clinical settings, or elsewhere—should include culturally and linguistically appropriate elements.”

Many health promotion interventions already in place for the population at large may be easily adapted to the needs of people with disabilities. New strategies can be influenced by results from studies that describe risk factors for secondary conditions or protective factors against additional impairments. For example, the number of cases of secondary osteoporosis among able-bodied women and their range of bone mineral density deficits can be estimated by using existing Federal data sets. The degree to which women exercise and ingest calcium or estrogen supplements also can be estimated, leading to measurements of the influence of both risk and protective factors associated with osteoporosis in the able-bodied population. Because women with mobility impairments experience an elevated risk for secondary osteoporosis at earlier ages, their risk factors, including diminished bone mineral density, and their potential protective factors, including optimal calcium or estrogen supplementation and types of exercise, become critically important epidemiologic parameters.^{15, 16} The results of investigations of secondary osteoporosis already influence health promotion strategies among able-bodied women. Similar investigations can augment the development of health promotion strategies among women with disabilities.

Current guidelines provide opportunity to design health promotion interventions targeting people with disabilities that accommodate ongoing evidence-based evaluation¹⁷ and demonstrate cost-