Ohio Women's Health Data Book 2000

Ohio Department of Health

Office of Women's Health Initiatives

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Introduction

The principle purpose of the *Ohio Women's Health Data Book 2000* is to provide information to state policy makers, legislators, state agency program staff, and others to guide state policy decisions related to women's health. The book was also created so that a wide range of Ohioans, including the general public and the medical community, can interpret and use the data for community-based programming. The data for the book were compiled from a range of public sources, primarily state agencies. Each chart is accompanied by bulleted text explaining the data and providing further information.

The interpretations contained within are solely the interpretations of the Office of Women's Health Initiatives and should not be construed as representing the points of view of the data sources. Nonetheless, care has been taken to selectively disseminate this data book prior to publication to assure the accuracy of the data and their interpretations.

The development of integrated and consistent data collection methods is imperative if we are to understand the health status of women in Ohio. The Office of Women's Health Initiatives considers it a priority to work with public agencies collecting women's health data to assure availability, appropriateness and applicability to public policy making.

The Office of Women's Health Initiatives is eager to receive your comments about this data book. Your suggestions for additions or corrections, as well as your impressions about the value of this manual to policy makers, the medical community, and the general public, are welcome.

The Office of Women's Health Initiatives

The Office of Women's Health Initiatives, located in the Office of Policy, Planning and Health Care Data Center at the Ohio Department of Health, was created by an act of the Ohio Legislature (Am.Sub.S.B.131, sponsored by Senator Karen Gillmor), and signed into law in July 1993. The mission of the Office of Women's Health Initiatives is to improve the health status of women in Ohio through advocacy, policy development, education and research.

Recent focuses of the Office include: Osteoporosis education and awareness, eating disorders and body image issues, preventing violence against women, heart disease, mental health/depression, cancer, adolescent health, nutrition, environmental influences on women's health, and mid-life health issues, among others.

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Limitations of the Data

Much of the data presented in this book only describe white and black Ohio women. It is not the intention of the Office of Women's Health Initiatives to repeat the often-committed error of neglecting women from other racial and ethnic groups. The data for this book, however, were dependent on the reporting mechanisms of the various data collection systems, many of which are outmoded. Thus, data for other racial and ethnic groups were either unavailable, collected as aggregate "other" data, or in such small numbers as to not provide useful comparisons.

In all cases, the most recent data available are included. Because different sources were used, the most recent annual data available may differ. Most sources take at least a year to report annual data. Thus, in most instances, the most recent data available were from 1997 or 1998.

I. Demographics

Female Population Projections

- Ohio women are shifting into older age groups. Currently, more women are between 30 to 39 than any other age group. In 2015, it is projected that there will be a more even distribution among age groups with slightly more females falling between ages 50 to 59.

- In 2015, the number of women between ages 55 and 64 will increase by 4.8 percent. The number of women between ages 65 and 74 will increase by 0.9 percent.[1]

- Nationally, the life expectancy for women in 1993 was 78.8 years, almost 7 years longer than that of men. The life expectancy for women has been higher than for men since 1900.

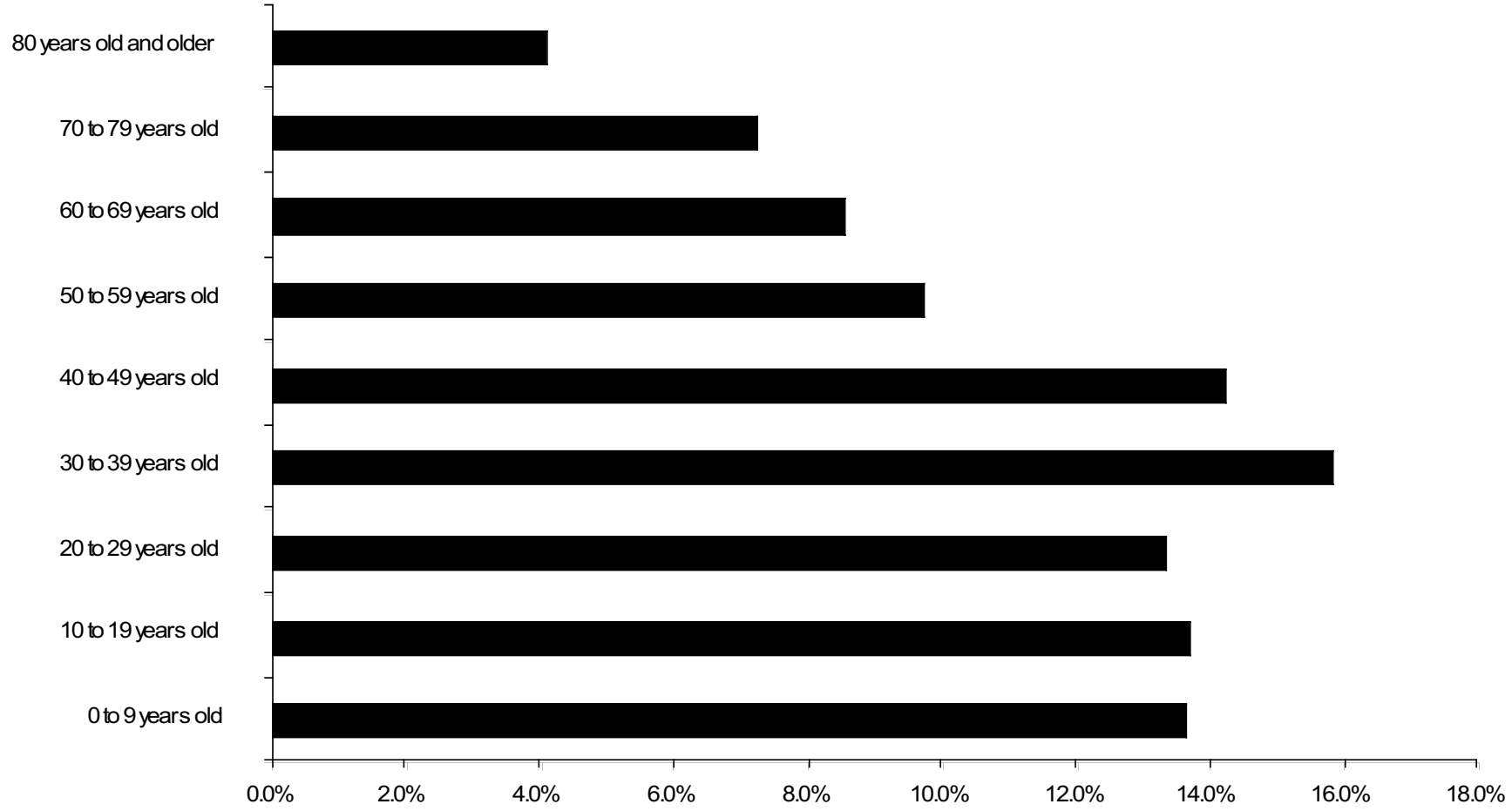
- The life expectancy for both American men and women has risen since 1940, although the increase has been more dramatic for women.[2]

- The number of Ohio women in their childbearing years (ages 15 to 44) exceeds 2.5 million.[3]

References:

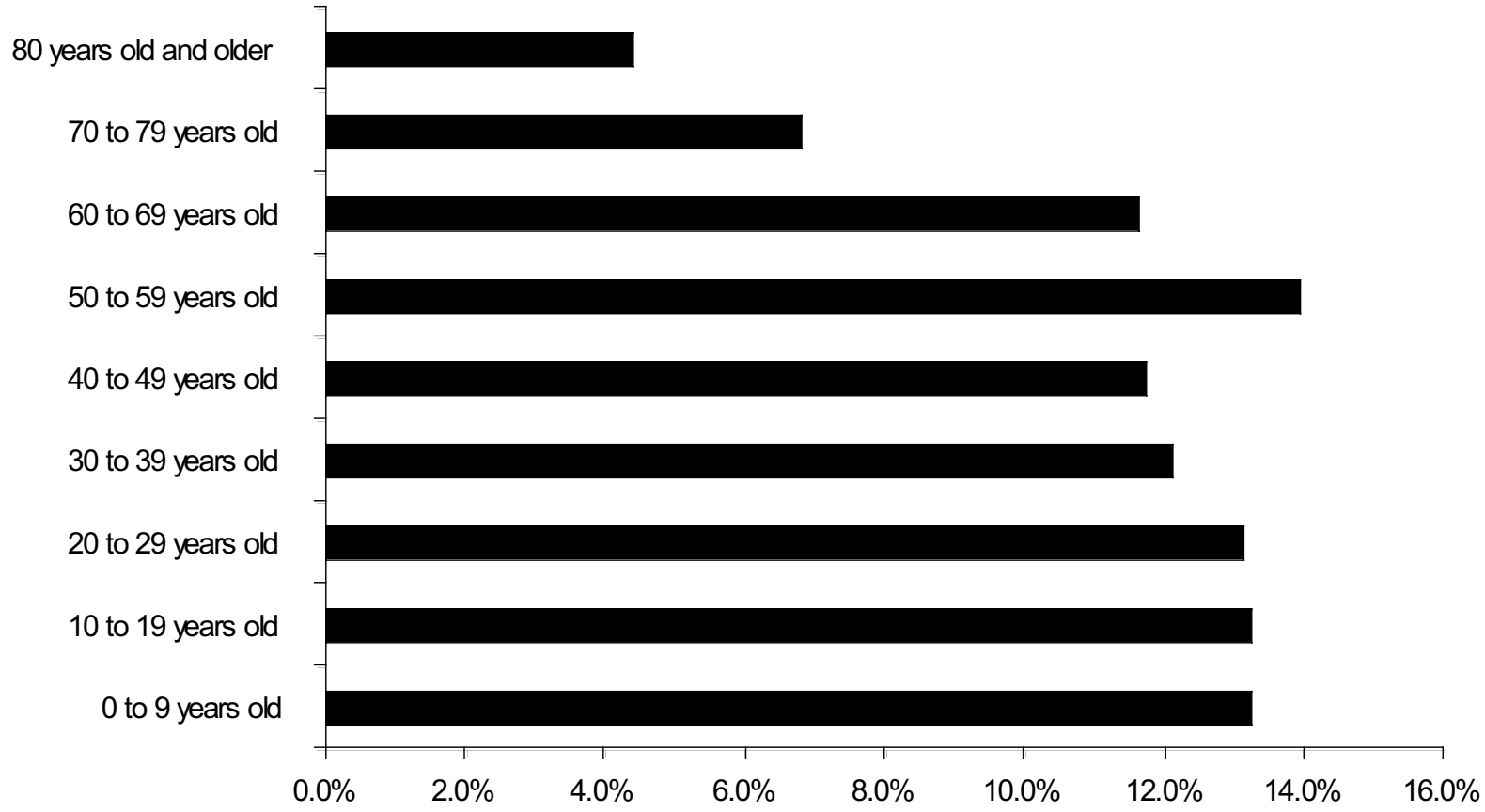
1. Office of Strategic Research, Ohio Department of Development
2. *Health, United States, 1995*. National Center for Health Statistics. Hyattsville, MD, 1996.
3. Office of Strategic Research, Ohio Department of Development

Ohio Female Population Estimates by Age, 1998



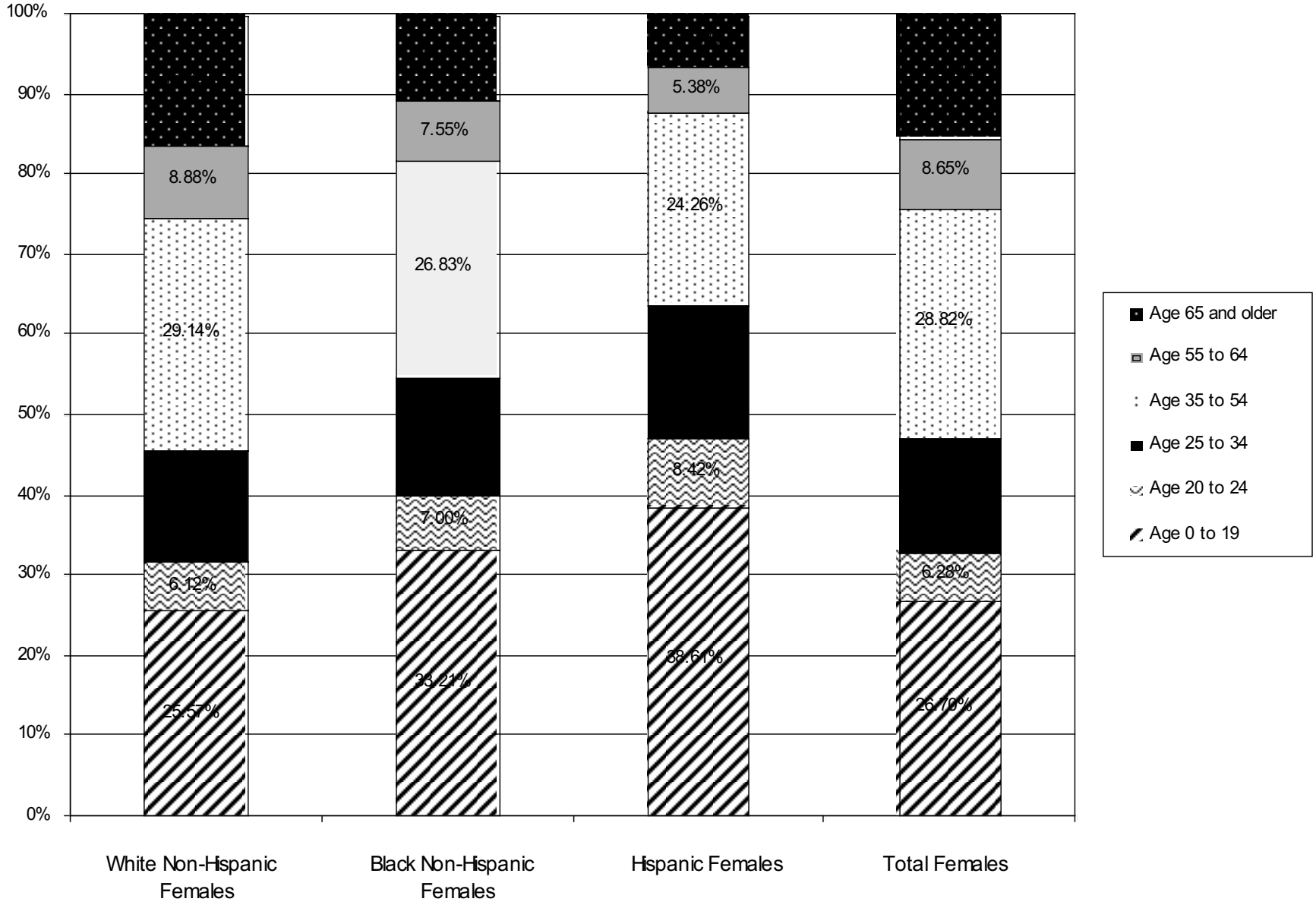
Source: Office of Strategic Research, Ohio Department of Development (Census Data Estimates)

Ohio Female Population Projections by Age, 2015



Source: Office of Strategic Research, Ohio Department of Development (Census Data Estimates)

Ohio Women by Age, Race and Ethnicity, 1997



Source: Population Estimates Branch, U.S. Bureau of Census. Prepared by: Office of Strategic Research, Ohio Department of Development, May 1999.

Women in Poverty; Women in the Labor Force

- The poverty rate for girls under 5 years of age is roughly three times that of women between 18 and 64 years of age.[1]

- Poverty rates are several times higher for households headed by women with children under 18 years old than for those headed by similarly situated men.[2]

- The 1998 federal poverty threshold (100 percent of poverty) was $13,133 for one adult and two children.

- Approximately one in four girls between 0 and 5 years old live below the poverty threshold.[3]

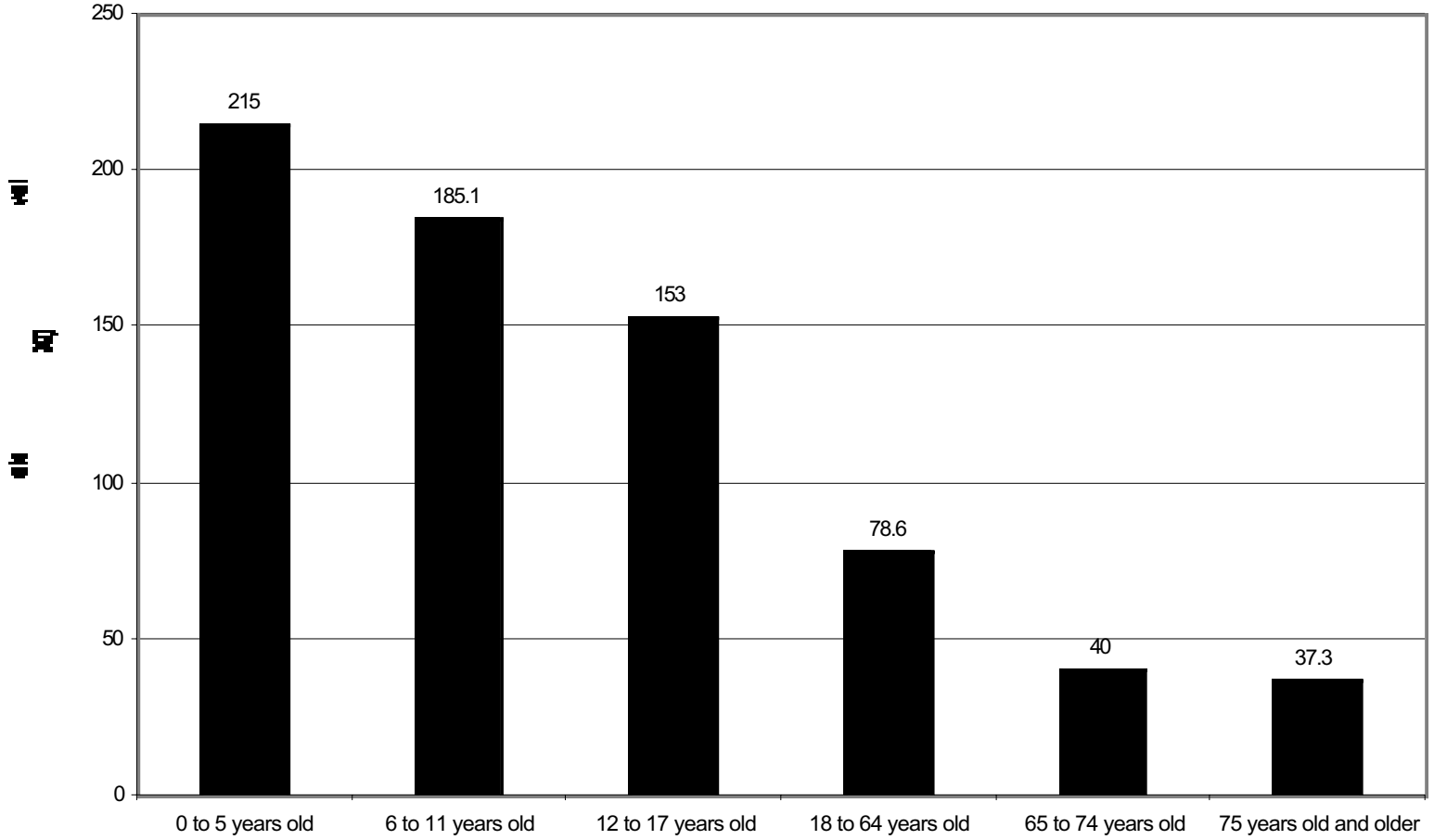
- Men are employed at much higher rates than women in Ohio. In 1990, 688.42 per 1,000 men over age 16 were employed compared to 510.8 per 1,000 women over age 16.[4]

- Women's higher rates of not participating in the labor force represent their greater reliance on other wage earners.

References:

1. 1990 Census Population Estimates
2. *1995 State Health Resources Plan*, Ohio Department of Health
3. 1990 Census Population Estimates
4. Ibid.

Federal Poverty Status of Ohio Females by Age, 1989



Source: 1990 Census Population Estimates

Women with Disabilities

- Overall, a higher proportion of U.S. women experience activity limitation than men, 15.4 versus 14.6 percent.[1]

- During the period of 1976 to 1996, the percentage of younger U.S. women (ages 30 to 44) receiving Social Security Disability Insurance more than doubled while the percentage of older U.S. women (ages 55 to 64) has declined.[2]

- Mental disorders (other than mental retardation) are the most prevalent diagnoses of U.S. women receiving Social Security Disability Insurance.[3]

- Despite the passage of the Americans with Disabilities Act in 1990, the number of people with disabilities in the U.S. workforce has continued to decline since 1984.[4]

References:

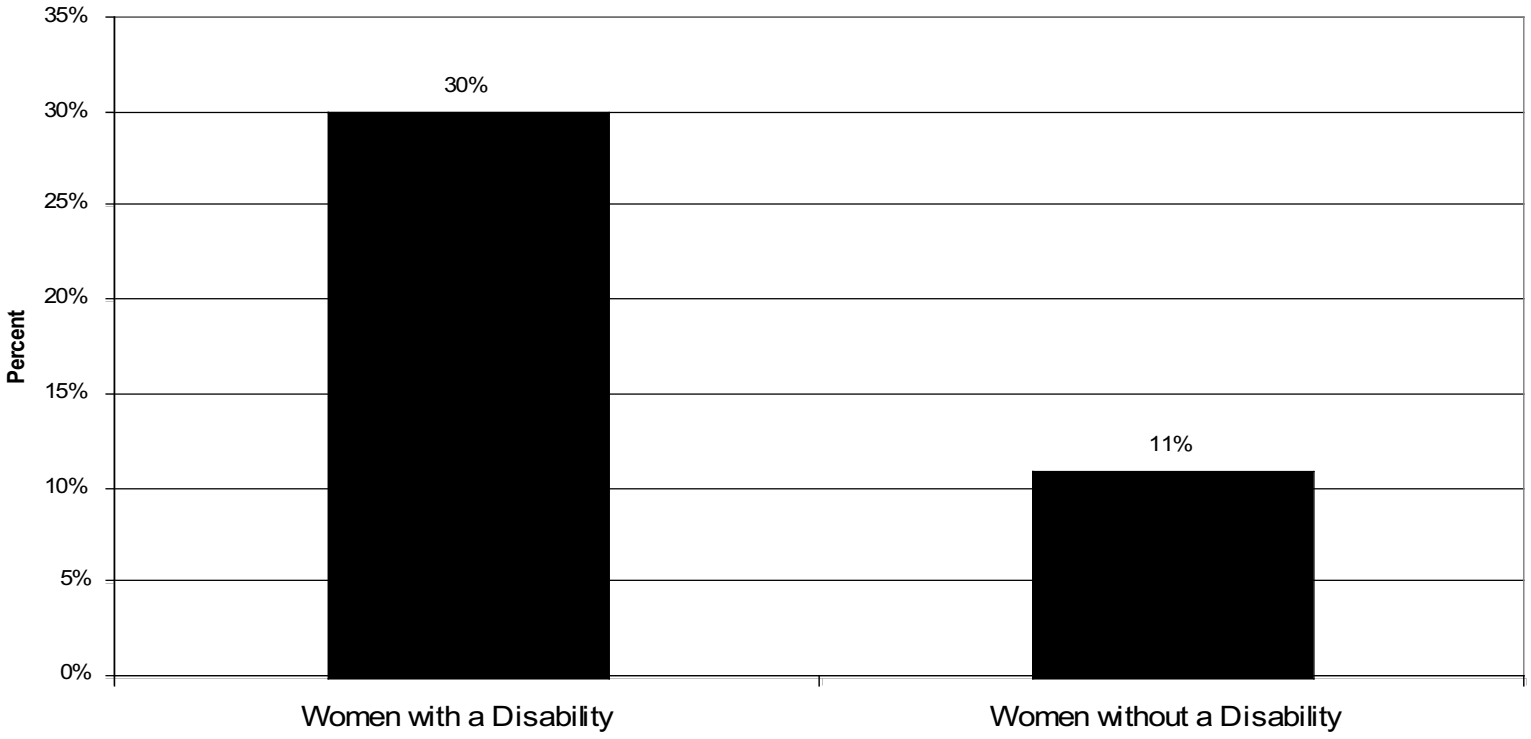
1, *Disability Watch*, 1997

2. *Social Security Bulletin Annual Statistical Supplement*, 1997

3. Ibid.

4. *Disability Watch*, 1997

Women Under Age 65 Who Experienced a Delay in Getting Medical Care, Women with Disabilities versus Women without a Disability, United States, 1995



Source: Overcoming the Odds: The Health of Women with Physical Disabilities in the United States, Center for Research on Women with Disabilities, Baylor College of Medicine, Houston, TX.

Causes of Death among Ohio Women

- Heart disease is the number one cause of death for Ohio women. In 1997, 17,571 Ohio women died from coronary heart disease.

- Cancer is the second most frequent cause of death among Ohio women. Lung cancer causes the most deaths in women, followed by breast, colon and rectum, ovarian and uterine cancers, respectively.[1]

- Diabetes is a larger health risk among black and other women than white women. It is the fourth leading cause of death among black and other women and the sixth leading cause of death among white women.[2]

References:

1. Ohio Cancer Surveillance System, Chronic and Environmental Disease Surveillance Section, Bureau of Health Surveillance Information and Operational Support, 1996.
2. Ibid.

Most Common Causes of Death Among Ohio Women, 1997

Cause	n	Percent
Heart Disease	17,571	32.70%
Cancer	12,083	22.50%
Stroke	4,771	8.90%
Pulmonary (COPD*)	2,652	4.90%
Diabetes	2,006	3.70%

*COPD – Chronic Obstructive Pulmonary Disease

Source: Vital Statistics, ODH, 1996

Child Care

- 1,667,613 children in Ohio, 62 percent of all children, live in homes where a single or both parents work.[1]

- In 1980, 42 percent of Ohio mothers with children under age 6 worked. By 1990, 58 percent of Ohio mothers with children under age 6 worked and 69 percent of mothers with children ages 6 to 17 worked.[2]

- Typical childcare fees are $78/week for one preschool child. Therefore, a parent making about $10/hour would be spending about 20 percent of his or her wages on child care for one preschool child.[3]

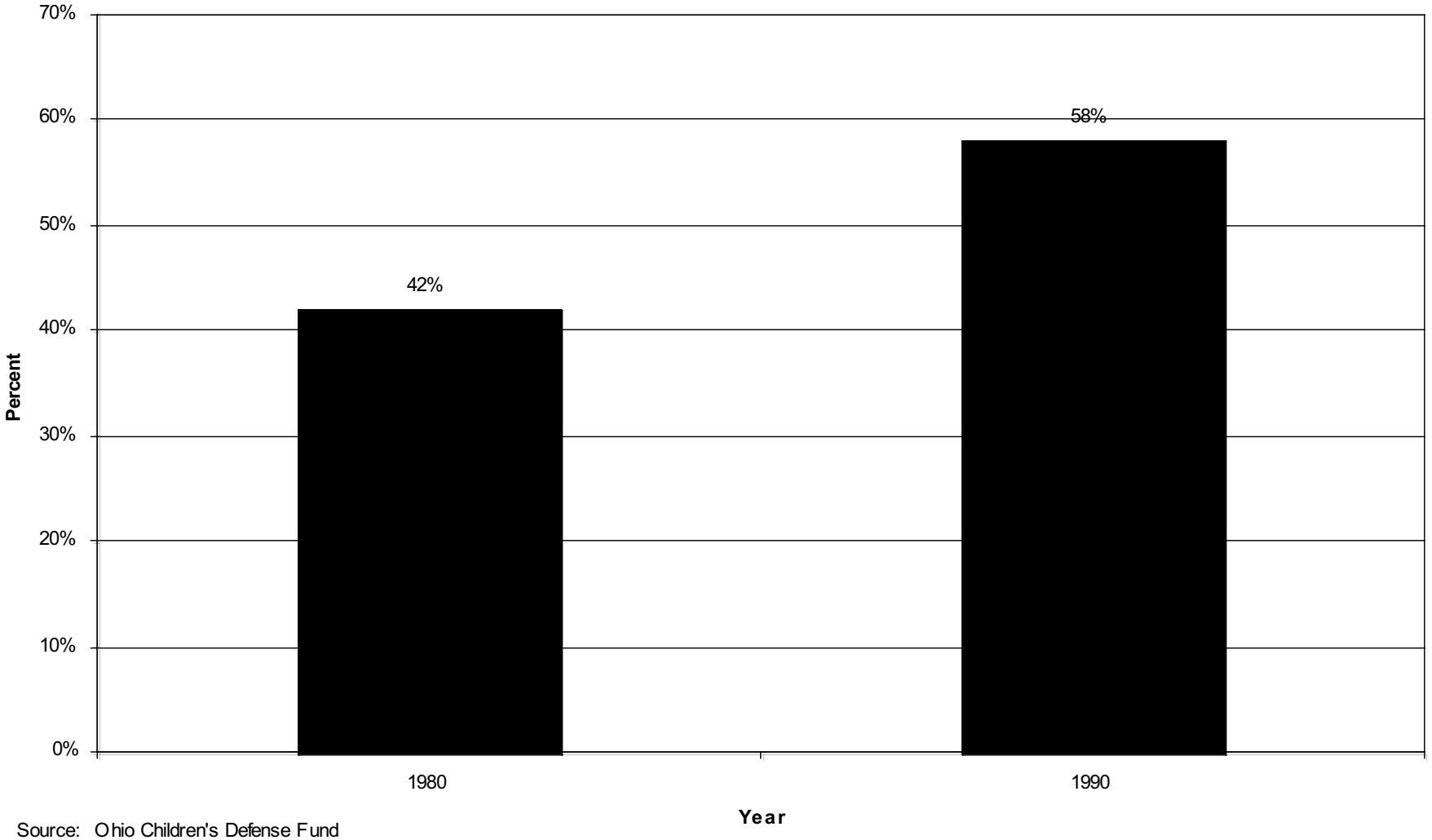
- In 1998, there were 5,048 licensed childcare programs in Ohio, up from 2,167 child care programs in 1984.[4]

- Working parents earning up to 150 percent of poverty ($7.98/hour for a parent with one child) are eligible for help with childcare costs. Ohio guarantees childcare assistance to families working their way off welfare.

References:

1. 1990 Census Data
2. *Child Care: A County by County Factbook*, Children's Defense Fund - Ohio
3. Ibid.
4. Ibid.

Ohio Working Mothers with Children Under 6 Years Old



Source: Ohio Children's Defense Fund

II. Reproductive Health

Fertility Rates

- The fertility rate is the number of live births per 1,000 women between 15 to 44 years of age.

- Fertility rates in Ohio have remained constant since 1983. The total fertility rate has declined slightly, from 63.4 per 1,000 women in their childbearing years in 1983 to 59.9 per 1,000 women in their childbearing years in 1996.

- The fertility rate for white women declined from 61.1 per 1,000 women in their childbearing years in 1983 to 56.2 per 1,000 in 1996. Black women's fertility rate rose marginally, from 83.2 per 1,000 in 1983 to 84.8 per 1,000 in 1996.[1]

References:

1. Vital Statistics, The Ohio Department of Health

Fertility Rate Trends for Ohio Women by Race of Mother, 1984 to 1996

Source: Vital Statistics, Ohio Department of Health

Fertility Rates among Teenage Women

- Fertility rates among teenage women are the lowest of any age group.

- Fertility rates among girls younger than 15 in Ohio have stayed relatively constant since 1985. The rate among girls ages 15 to 19, however, has increased by 21 percent from 41.8 per 1,000 in 1985 to 50.7 per 1,000 in 1996.

- The fertility rate for black teens ages 15 to 19 has risen at a higher rate than white teens.

- Among white teens ages 15 to 19, the rate increased 15 percent from 35.4 per 1,000 in 1985 to 40.6 per 1,000 in 1996. The rate for black teens ages 15 to 19 increased 29 percent from 91.7 per 1,000 in 1985 to 118.3 per 1,000 in 1996.[1]

References:

1. Vital Statistics, The Ohio Department of Health

Fertility Rates among Women Ages 20 to 34

- Ohio women ages 20 to 34 have the highest fertility rates.

- The fertility rate for women ages 25 to 29 has been declining. In 1985, the rate for this age group was 114.6 per 1,000 women of childbearing age; in 1996 the rate was 97.7 per 1,000, a decrease of 16 percent.

- The fertility rate among women ages 20 to 24 is higher among black women. The rate of black women ages 20 to 24 increased 28 percent from 1985 to 1996. The fertility rates of black women ages 25 to 29 and ages 30 to 34 were lower overall in 1996 than in 1985, having decreased slightly since 1990.[1]

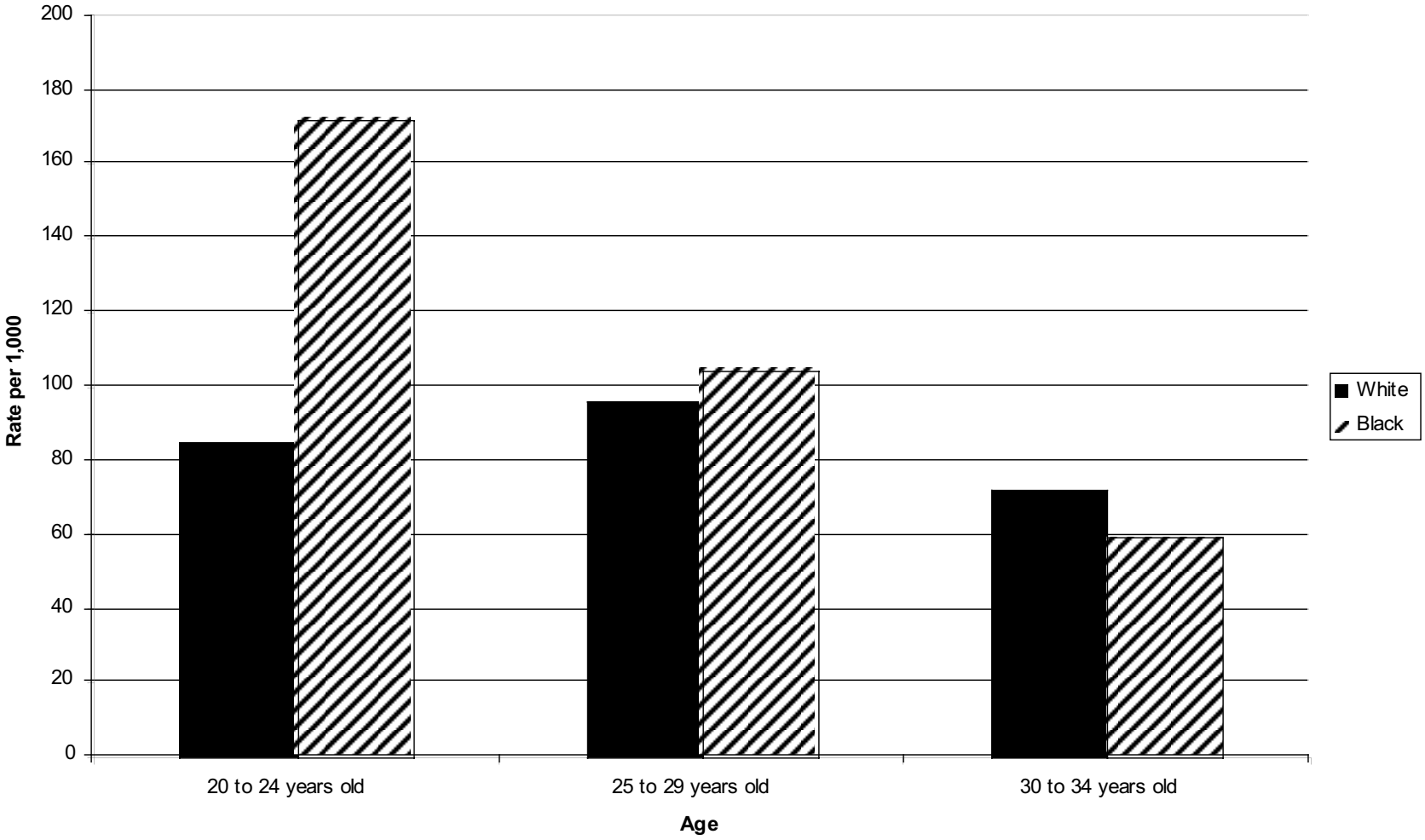
- It is a goal of the national health promotion project *Healthy People 2000* to "increase to at least 60 percent, the proportion of primary care providers who provide age-appropriate preconception care and counseling." Preconception counseling can provide potential parents information about medical treatments, environmental factors and behavioral risks that could endanger a pregnancy, as well as provide information about prenatal care.[2]

- National data suggest that 57 percent of all pregnancies are unintended at the time of conception.

References:

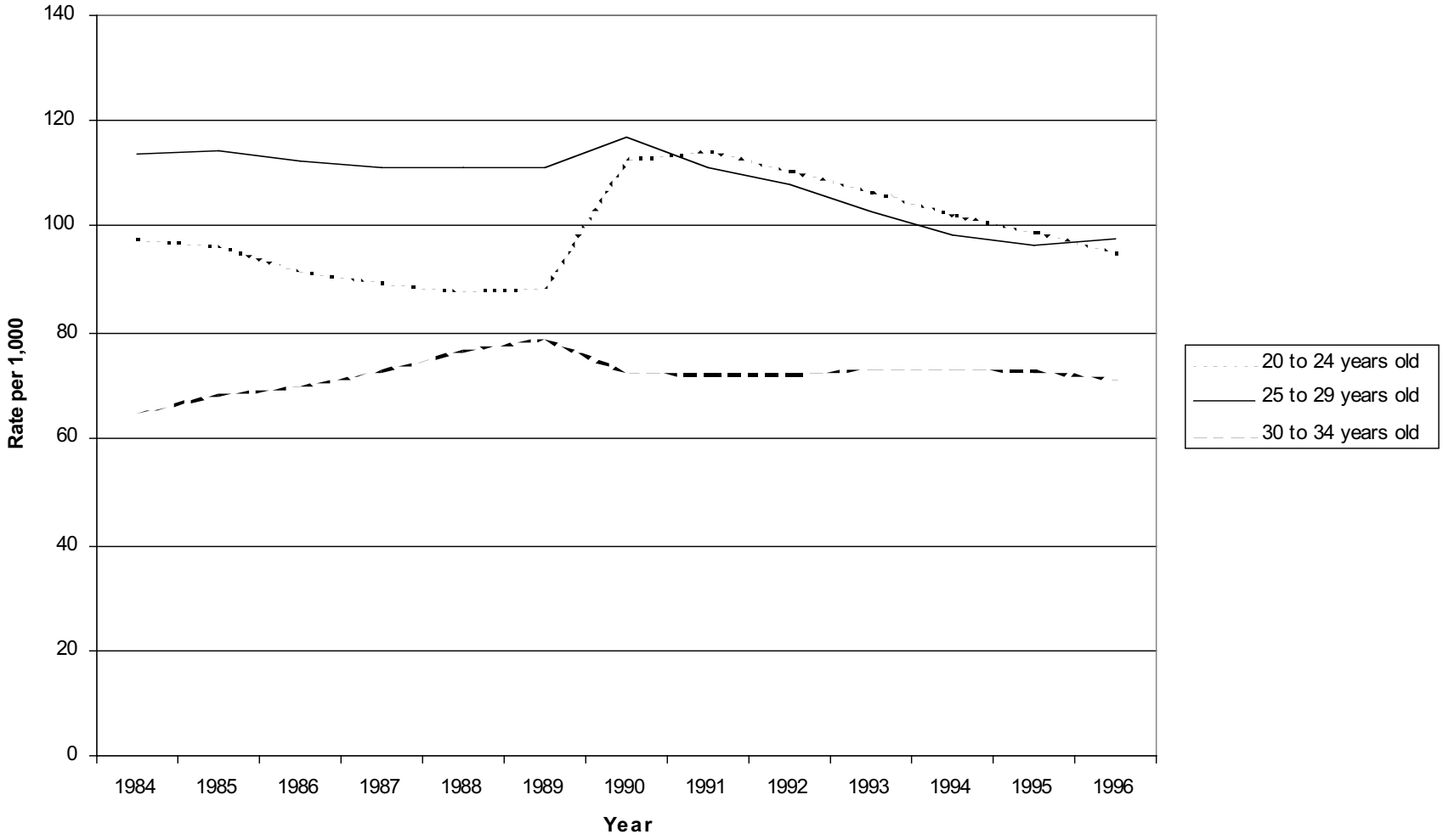
1. Vital Statistics, The Ohio Department of Health
2. *Healthy People 2000*, U.S. Department of Health and Human Services
3. *Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, D.C., National Academy Press.

Fertility Rates among Ohio Women Ages 20 to 34 by Age and Race of Mother, 1996



Source: Vital Statistics, The Ohio Department of Health

Fertility Rates among Ohio Women Ages 20 to 34 by Age of Mother, 1984 to 1996



Source, Vital Statistics: The Ohio Department of Health

Fertility Rates among Women Ages 35 to 44

- The fertility rates among mid-life women have stayed consistently low.
- 1996 fertility rates among all Ohio women were: 31.6 per 1,000 among women ages 35 to 39; 5.9 per 1,000 among women ages 40 to 44; and 0.3 per 1,000 among women over 45.[1]
- Nationally, four in ten women ages 30 to 44 are at risk for unintended pregnancy. Women are considered at risk for unintended pregnancy if they have had sexual intercourse, are fertile, and are neither intentionally pregnant nor have been trying to become pregnant.[2]
- Non-white women are three times as likely as white women to die of pregnancy-related causes. Black women are most at risk for maternal mortality.[3] However, pregnancy-related deaths are rare.

References:

1. Vital Statistics, The Ohio Department of Health
2. *Best Intentions: Unintended Pregnancy and the Well-Being of Families,* Washington, D.C., The National Academy Press
3. The Women's Health Data Book, 1995, The Jacobs Institute of Women's Health.

Prenatal Care and Method of Delivery

- In 1997, 85 percent of women began receiving prenatal care during the first trimester of pregnancy.

- 80 percent of recorded live births in 1997 were by vaginal delivery. Nineteen percent of births that year occurred via C-Section.

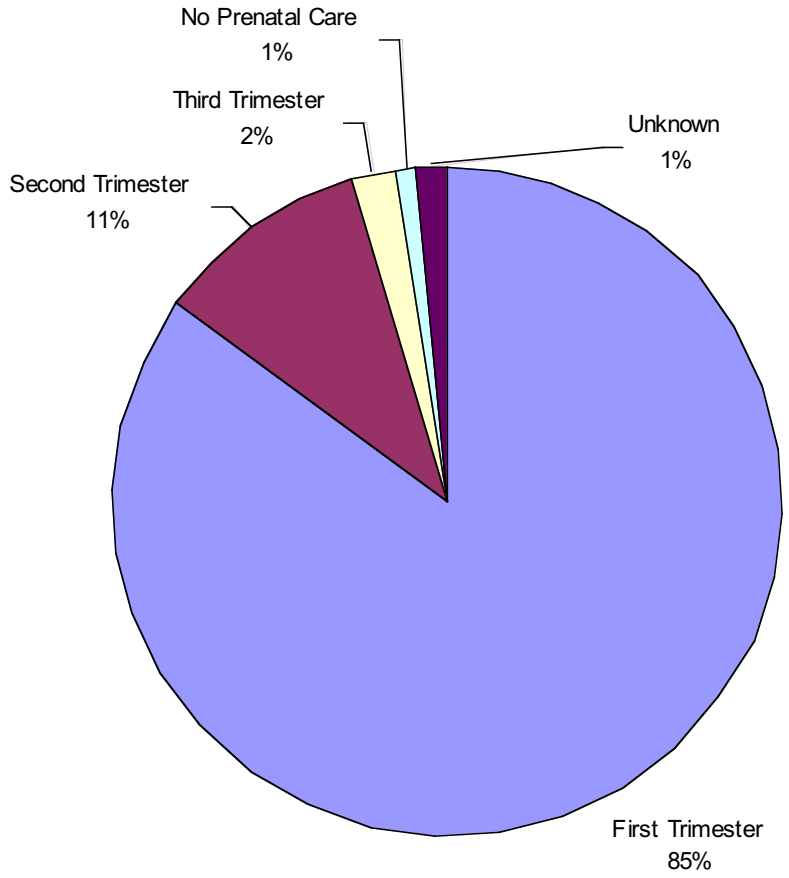
- The proportions of all live births delivered vaginally increased from 1990 to 1995. The proportion of live births delivered vaginally increased from 717.9 per 1,000 births to 748.5 per 1,000. The most noted increase was in the proportion of live births delivered vaginally after a C-Section, increasing from 20.0 per 1,000 to 38.3 per 1,000.

- The proportions of live births delivered by C-Section diminished from 1990 to 1995. The proportion of live births delivered by primary C-Section decreased from 145.7 per 1,000 births to 122.1 per 1,000. The proportion of live births delivered by repeat C-Section decreased from 93.9 per 1,000 births to 76.0 per 1,000.

References:

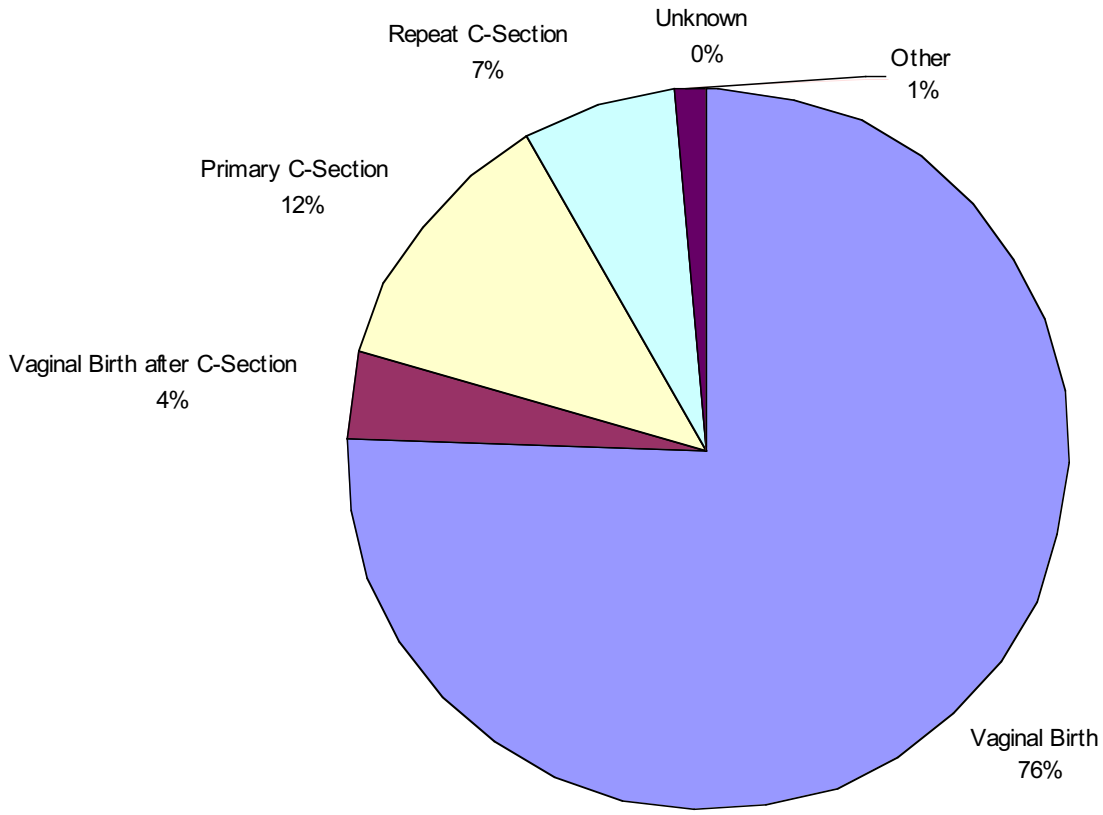
1. Vital Statistics, The Ohio Department of Health

Pregnancies among Ohio Mothers by Trimester Prenatal Care Began, 1997



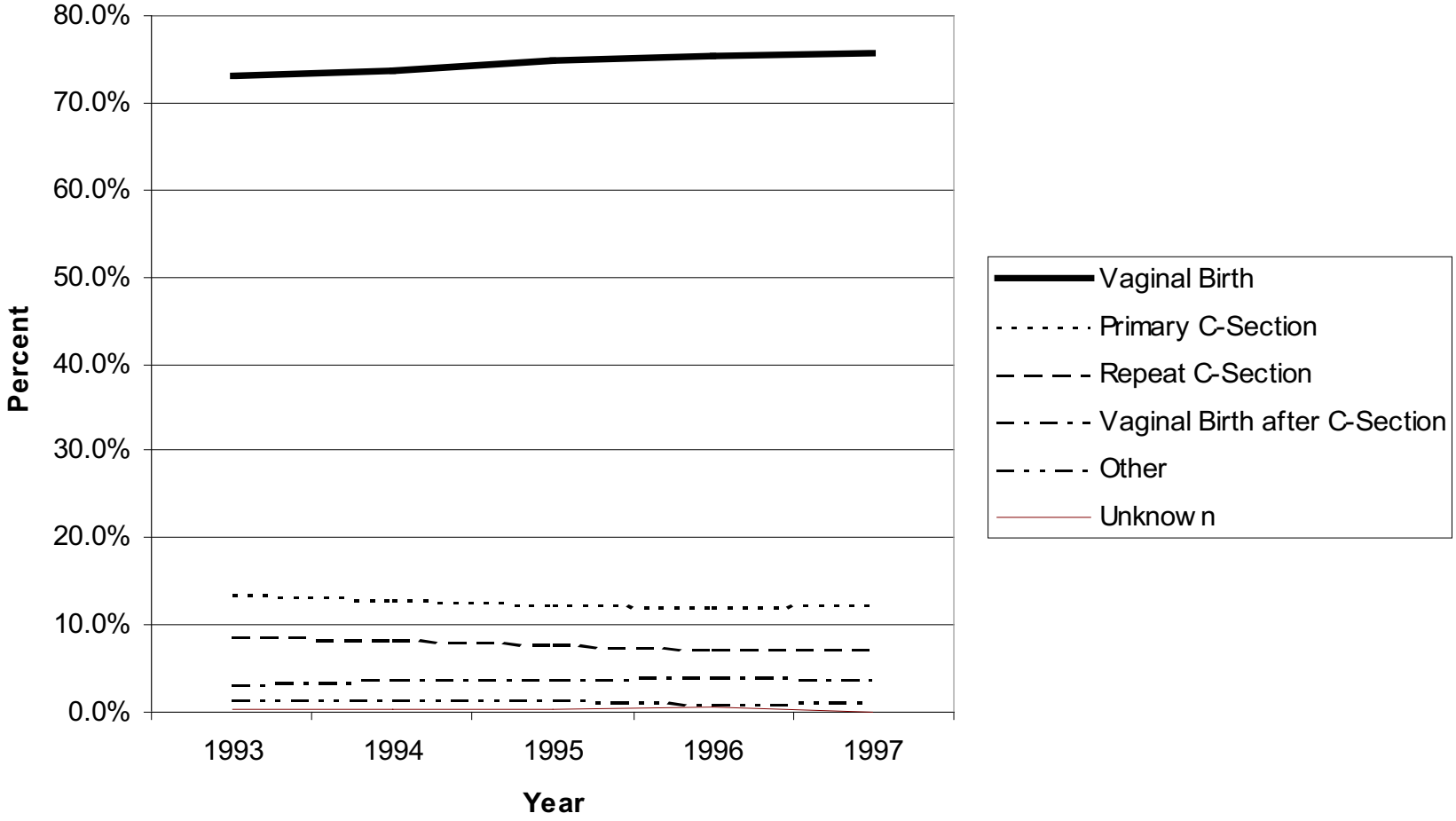
Source: Vital Statistics, The Ohio Department of Health

Births among Ohio Mothers by Method of Delivery, 1997



Source: Vital Statistics, The Ohio Department of Health

Method of Delivery Trends among Ohio Mothers, 1993 to 1997



Source: Vital Statistics, The Ohio Department of Health

Alcohol and Tobacco Use During Pregnancy

- Approximately one in four mothers smoked cigarettes during their pregnancy.[1] Smoking during pregnancy increases the risk of low birthweight, Sudden Infant Death Syndrome (SIDS), spontaneous abortion, bleeding during pregnancy, and other pregnancy complications.

- Young pregnant women (18 and 19 year olds) show the highest levels of smoking during pregnancy, 33 percent.[2]

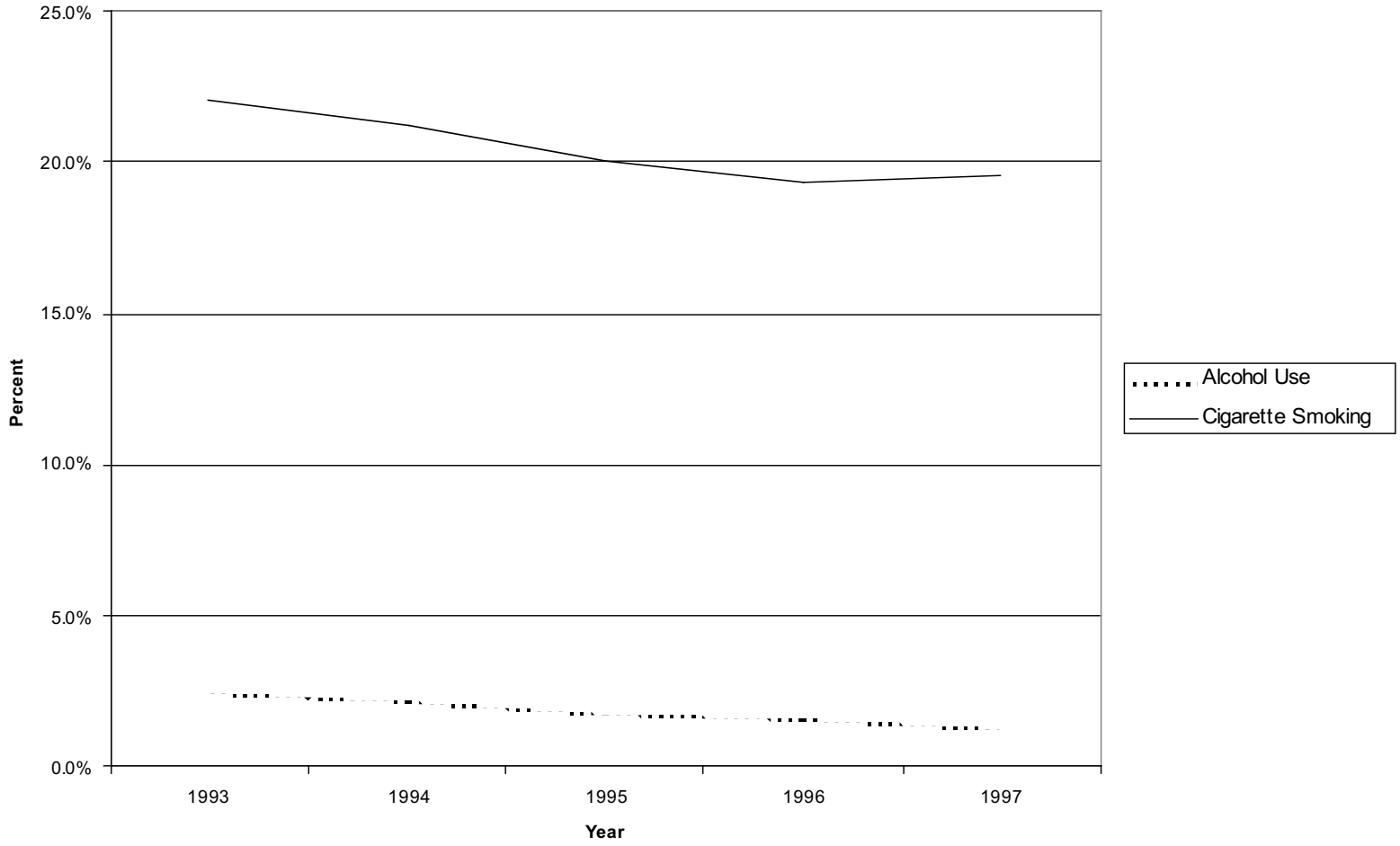
- Among mothers who gave birth while receiving assistance from the Medicaid program: 54 percent of those with less than a high school education smoked; 35 percent of those with a high school diploma smoked; and 23 percent of those with more than a high school education smoked.

- Alcohol use during pregnancy is a leading preventable cause of birth defects. Heavy alcohol use during pregnancy causes Fetal Alcohol Syndrome, a condition which is characterized by abnormal features of the face and head, growth retardation, and abnormalities of the central nervous system that are often reflected in mental retardation.[3]

References:

1. Vital Statistics, The Ohio Department of Health
2. Bureau of Chronic Diseases, The Ohio Department of Health
3. *Healthy People 2000*, U.S. Department of Health and Human Services

Self-Reported Alcohol Use and Smoking during Pregnancy, Trends among Ohio Mothers, 1993 to 1997



Source: Vital Statistics, The Ohio Department of Health

Average Length of Stay for Childbirth

- From the period of 1991 to 1996, the average length of stay in hospitals among privately insured women for all methods of childbirth decreased significantly.

- In October 1996, Ohio passed a law which requires all insurance companies to cover a mother's stay in the hospital for 48 hours after a vaginal birth and 96 hours after a C-Section birth.

- Since the passage of this law, the average length of stay for childbirth, private pay only*, has started to increase. No Medicaid data are available on this topic.

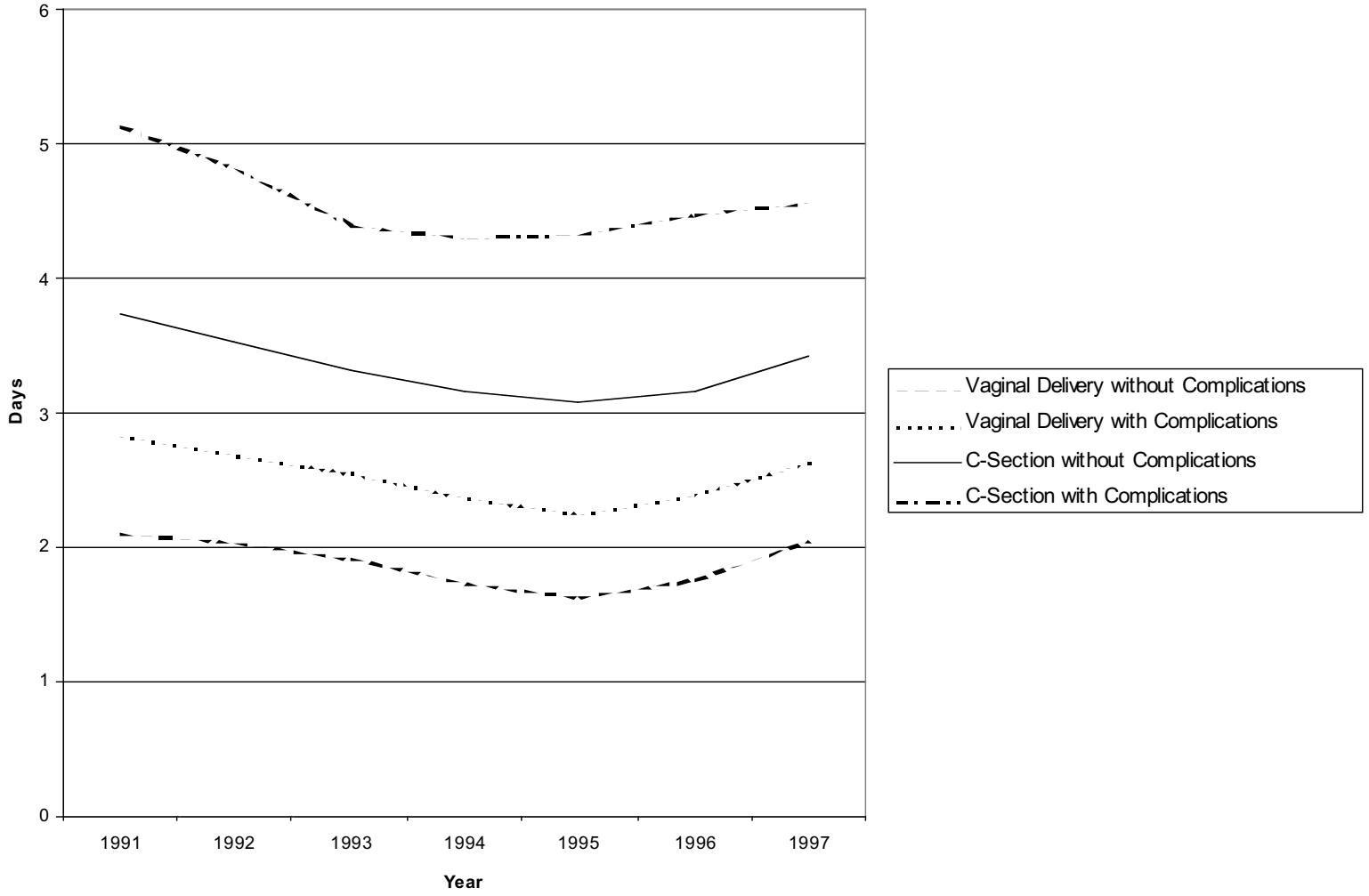
- In 1997, the average length of stay for a vaginal birth without complications was 2.06 days.[1]

* Private Pay = Non-Medicaid, non-Medicare, non-military or other non-government payor

References:

1. Annual Hospital Disclosure DRG Reports, Office of Policy, Planning, and Data Center, The Ohio Department of Health

Average Length of Stay Trends for Childbirth among Ohio Women by Type of Delivery, Private Pay Only*, 1991 to 1997



Source: Annual Hospital Disclosure (DRG) Reports, Office of Policy, Planning and Data Center, The Ohio Department of Health

Low Birthweight Infants

- Low birth weight is defined as an infant born weighing less than 2,500 grams, or 5 pounds, 8 ounces.

- The Ohio and United States low birthweight (LBW) rates have been steadily rising over the last 15 years.[1] Ohio has been above the national average for the past five years.[2]

- Low birthweight is associated with many health problems, including mental retardation and cerebral palsy, as well as being a major predictor of infant mortality.[3] Unfortunately, there is limited clinical understanding of what causes LBW and prevention efforts have not led to a significant reduction in rates.

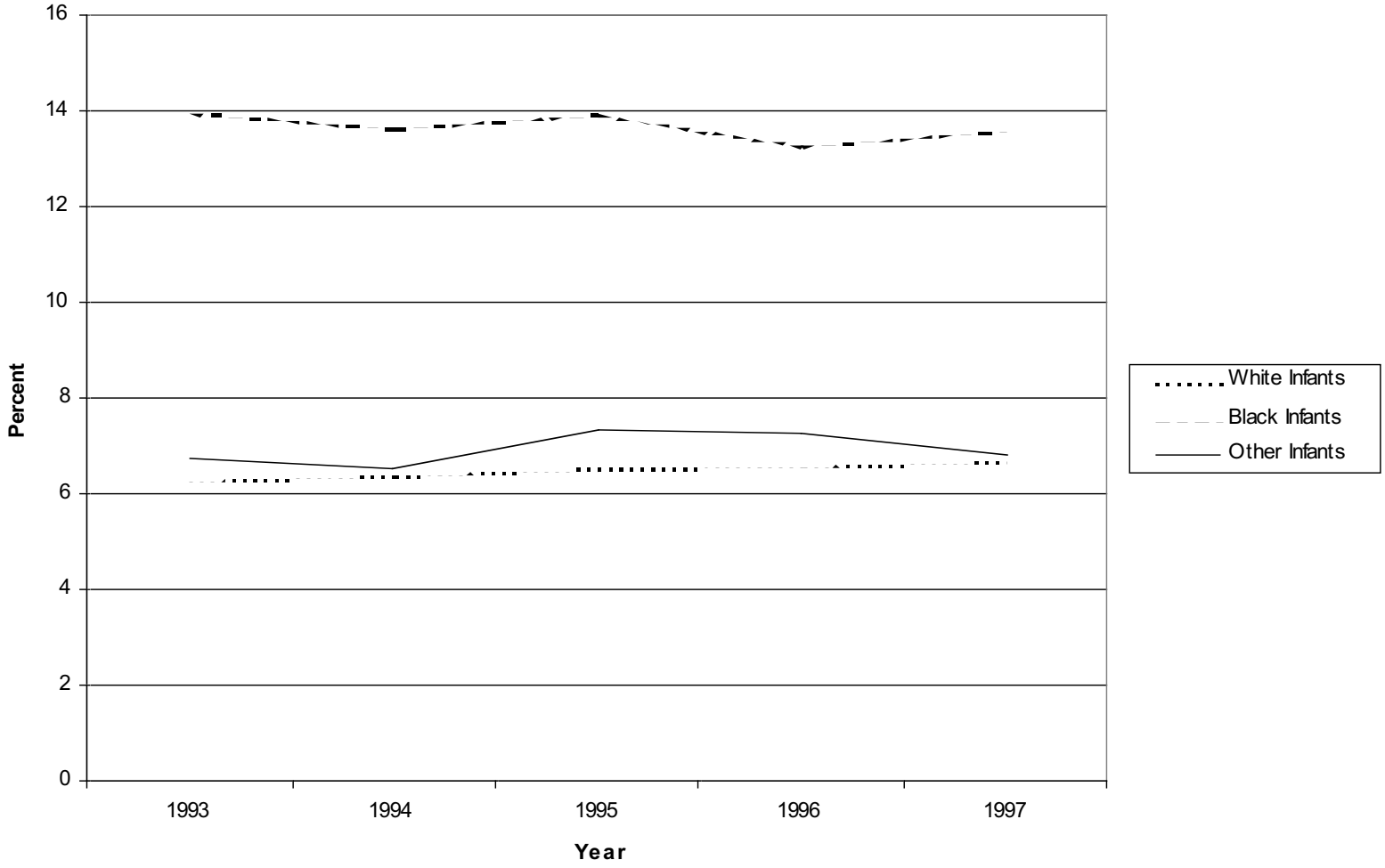
- Blacks are nearly twice as likely as whites to have LBW infants. Although only 17 percent of all 1993 Ohio births were to black women, 31 percent of LBW births occurred in this population. Teenagers, women over 35, and women who have a history of LBW deliveries also have higher rates of LBW infants.

- Smoking has a profound impact on the rates of LBW in Ohio and nationally. Smoking one pack of cigarettes daily increases the risk of LBW to more than double that of non-smokers.

References:

1. *Infants Born with Low Birth Weight in Ohio: The Ohio Health Monograph Series.* Division of Family and Community Health Services, The Ohio Department of Health, October 1996.
2. Ibid.
3. Ibid.

Low Birthweight (Less than 2,500 Grams) Trends among Ohio Births by Race, 1993 to 1997



Source: Vital Statistics, The Ohio Department of Health

Infant Mortality

- Ohio's infant mortality rate has been slowly but steadily declining. The leading causes of infant death from 1990 to 1994 were: Sudden Infant Death Syndrome (SIDS), prematurity and related conditions, congenital anomalies, and external injuries.

- In 1990, there were 9.8 Ohio infants who died per 1,000 live births compared with 8.7 per 1,000 live births in 1995. In 1995 the U.S. infant mortality rate was the lowest ever recorded, at 7.6 per 1,000 live births.

- The leading causes of infant mortality were similar for black and white infants; however, Ohio's 1994 rate for black infants (15.95 per 1,000 live births) was significantly higher than the rate for white infants (7.32 per 1,000 live births.)

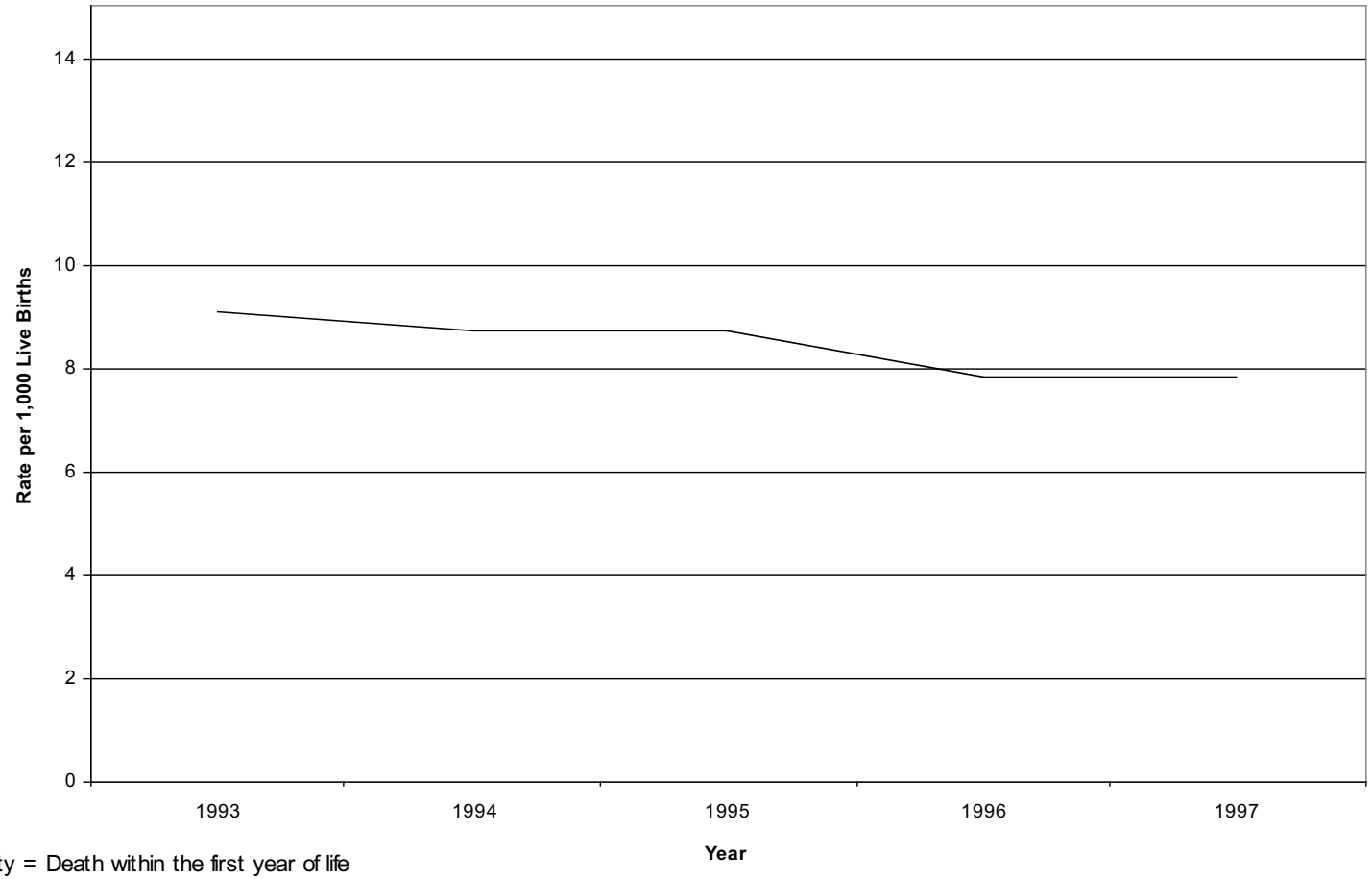
- Prematurity and related conditions accounted for the largest percentage of deaths among blacks (53.2 percent); the largest percentage of deaths among whites (23.8 percent) were attributable to congenital anomalies.[1]

- Low birthweight is a major predictor of infant mortality.[2]

References:

1. 1996 State Health Resources Plan, The Ohio Department of Health
2. Ibid.

Infant Mortality Rate* Trends among Ohio Live Births, 1993 to 1997



* Infant Mortality = Death within the first year of life

Source: Vital Statistics, The Ohio Department of Health

Sexually Transmitted Diseases: Diagnosed Cases in Ohio Women

- Currently, as many as one in four Americans has an STD. Two-thirds of those are under age 25.

- Adolescents, young adults, women, minorities, and people with low incomes are most affected by STDs.[1, 2]

- Because of anatomical factors, women are more susceptible to STD infections than men but are less likely to notice the symptoms. Undetected and untreated, STDs can lead to Pelvic Inflammatory Disease with severe, chronic pain, impaired fertility, and ectopic or tubal pregnancy, which is fatal to the fetus and life-threatening to the mother.[3]

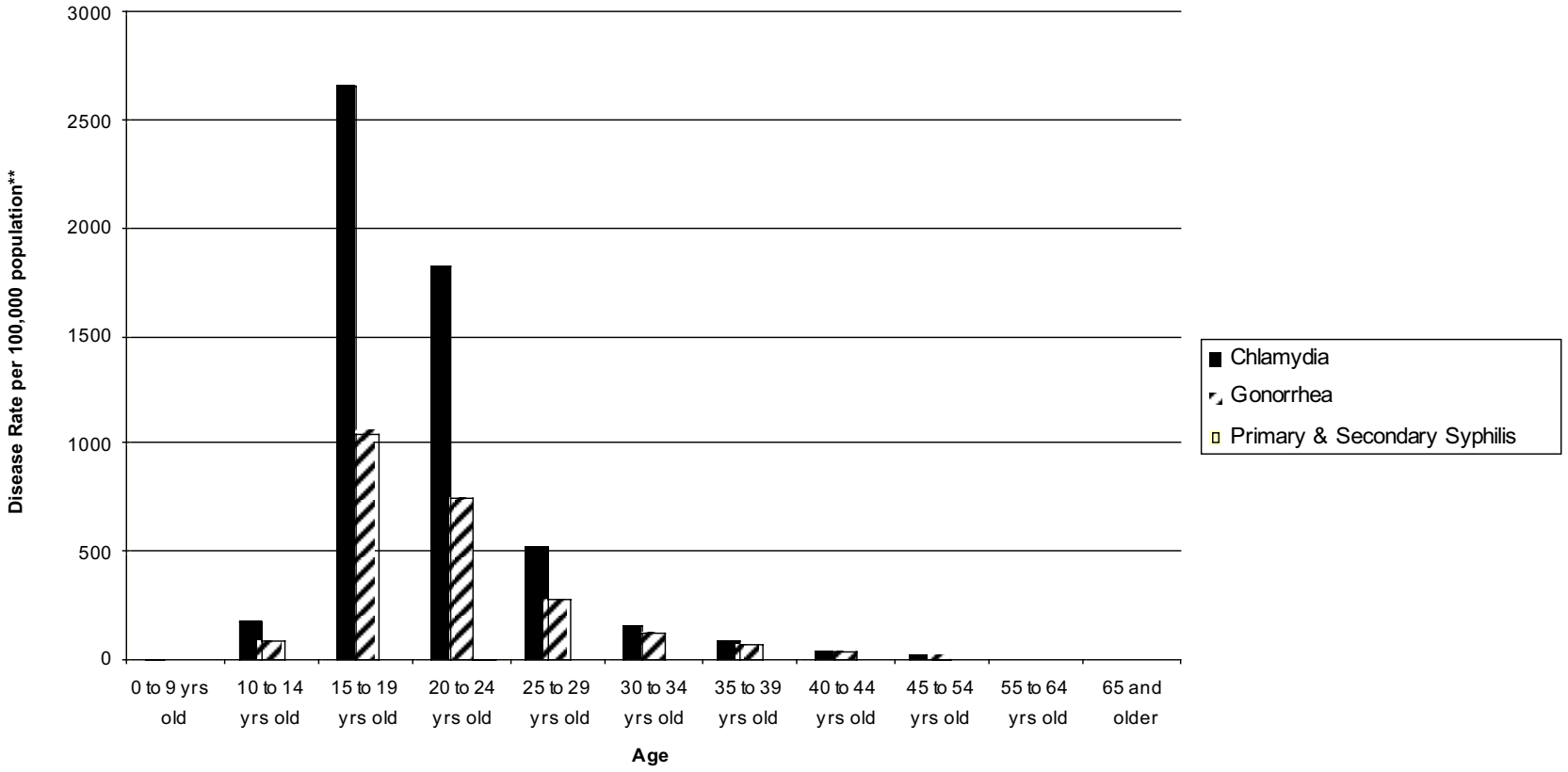
- Since women do not always experience symptoms, routine screening is needed to identify and treat women with sexually transmitted diseases.

- Although case reporting is required for the three major STDs (Chlamydia, Syphilis, and Gonorrhea), there are a host of other sexually transmitted diseases and related conditions that significantly affect women's health. Nationally there were an estimated 5.5 million cases of Human Papilloma Virus, 1 million cases of Genital Herpes, 77,000 cases of Hepatitis B, and 5 million cases of Trichomoniasis in 1996.[4]

- A person with an STD is three to five times as likely to acquire HIV infection through sexual contact than an individual who does not have an STD. Further, an individual co-infected with the HIV virus and another STD is three to five times more likely than other HIV-infected persons to transmit the virus through sexual contact.[5]

References:
1. American Social Health Association, Annual Report 1994, 1995.
2. STD/HIV Prevention Program
3. American Social Health Association, Annual Report 1994, 1995.
4. Henry J. Kaiser Foundation, Melo Park, CA 1998.
5. Wasserheit, JH, 1992. A Epidemiology Synergy: interrelationship between human immunodeficiency virus infection and other sexually transmitted diseases. *Sexually Transmitted Diseases* 9:61-77.

Rates of Chlamydia, Gonorrhea, and Primary and Secondary Syphilis Cases among Ohio Women by Age, 1998*



* Presented by date of diagnosis, which is defined as the date the specimen was collected by the provider

** Per 100,000 based on the 1990 U.S. Census

Source: STD/HIV Prevention Program, The Ohio Department of Health

Sexually Transmitted Diseases: Syphilis among Ohio Women

- Among those STDs for which state data are collected, syphilis is the least prevalent but potentially the most deadly. In 1998, there were only 72 reported female cases of primary and secondary syphilis.

- A pregnant woman infected with syphilis has about a 40 percent chance of delivering a stillborn baby or a baby who dies shortly after birth.[1] Most syphilitic babies do not exhibit symptoms until two weeks to three months after birth. In 1998, there were 6 cases of congenital syphilis in Ohio.[2]

- Men and women in Ohio have similar rates of primary and secondary syphilis infection (1998), 0.2 cases per 100,000 people. Black individuals have the highest rate of 9.7 cases per 100,000 people.

- The age group with the highest case rate of primary and secondary syphilis is somewhat older than that of chlamydia or gonorrhea. Women ages 20 to 24 are most likely to be infected with primary and secondary syphilis; in 1998 there were 4.7 cases per 100,000 women ages 20 to 24 years.[3]

- Although treatment is available, the early symptoms of syphilis can be mild, and are often ignored. An infected person who does not get treatment may infect others during the first two stages and during the early latent stage, which usually lasts one to two years. In its latent stages, untreated syphilis can cause serious heart abnormalities, mental disorders, blindness, other neurological problems, and death.

References:

1. Division of STD Prevention. Sexually Transmitted Diseases Surveillance, 1995. U.S. Department of Health and Human Services, Public Health Service. Atlanta: Centers for Disease Control and Prevention, September 1996.

2. Office of Communications< National Institute of Allergy and Infectious Disease, National Institutes of Health. August 1992.

3. STD/HIV Prevention Program, The Ohio Department of Health

Sexually Transmitted Diseases: Gonorrhea among Ohio Women

- Infections due to gonorrhea, like those due to chlamydia, are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain. 1996 estimates indicate that 650,000 cases occur each year in the U.S.[1]

- Men and women have similar reported rates of gonorrhea in Ohio. There were 151.9 cases per 100,000 men and 176.5 cases per 100,000 women during 1998.

- In Ohio, black females had substantially higher rates of gonorrhea: 676.6 cases per 100,000 in 1998. The reported case rate for white females was 25.6 per 100,000 in 1998.

- In 1998, teenage girls ages 15 to 19 have the highest reported case rate of gonorrhea in Ohio: 1052.9 cases per 100,000 adolescents ages 15 to 19 years.[2]

- The national cost of gonorrhea and its complications is estimated at close to $1 billion annually.[3]

- If gonorrhea is not treated, the bacteria can spread to the bloodstream and infect the joints, heart valves or brain.[4]

- Fifty percent of gonococcal infections in women are asymptomatic, causing many women to delay seeking medical treatment as well as risk infertility and ectopic pregnancy.

- Ectopic pregnancy, often due to gonorrhea infection, is the leading cause of first trimester, pregnancy related deaths in black women.[5]

- Because gonorrhea is highly contagious and yet may have no symptoms, women who have had sexual contact with more than one partner or whose partner(s) has had sexual contact with other partners should be tested regularly.

References:

1. Henry J. Kaiser Foundation, Menlo Park, CA 1998.
2. STD/HIV Prevention Program, The Ohio Department of Health
3. U.S. Department of Health and Human Services
4. Office of Communications, National Institute of Allergy and Infectious Diseases, National Institutes of Health. August 1992.
5. U.S. Department of Health and Human Services. September 1995.

Sexually Transmitted Diseases: Chlamydia among Ohio Women

- Chlamydia is the most prevalent sexually transmitted disease in the United States with a 1996 estimate of three million new cases that year.[1] Among women, infections due to chlamydia often result in serious reproductive tract complications, such as pelvic inflammatory disease, infertility, and ectopic pregnancy. Women with chlamydia can infect their babies during birth.

- In Ohio, rates of reported chlamydia are significantly higher in women than men; 403.0 per 100,000 Ohio women versus 78.9 per 100,000 men in 1998.[1] This is mainly due to increased detection of asymptomatic infection in women through active screening programs. The low rates of men suggest that many of the sex partners of women with chlamydia are not diagnosed or reported.[2] Fifty percent of infected women and twenty-five percent of infected men experience no symptoms.[3]

- In 1998, there were 403.0 reported cases of chlamydia per 100,000 female Ohioans. Adolescent and young adult females between the ages of 15 and 24 years have the highest prevalence of chlamydia: 2656.8 reported cases per 100,000 adolescents ages 15 to 19 years, and 1822.4 reported cases per 100,000 young adults ages 20 to 24 years.

- In Ohio, black females have the highest rate of chlamydia infection: 1,008.3 per 100,000 black women compared to 86.9 cases per 100,000 white females in 1998.[3]

- The annual cost of chlamydial infections and related conditions, like pelvic inflammatory disease, is estimated to exceed $2 billion.

- Nearly half of the estimated one million new cases of PID in women each year may be due to chlamydial infections. The results from a randomized controlled trial of chlamydial screening in a managed care setting indicated that such screening can reduce the incidence of PID by as much as 60 percent.[4]

- A baby who is exposed to chlamydial bacteria in the birth canal during delivery may develop conjunctivitis or pneumonia.[5]

References:

1. Henry J. Kaiser Foundation, Melo Park, CA 1998.

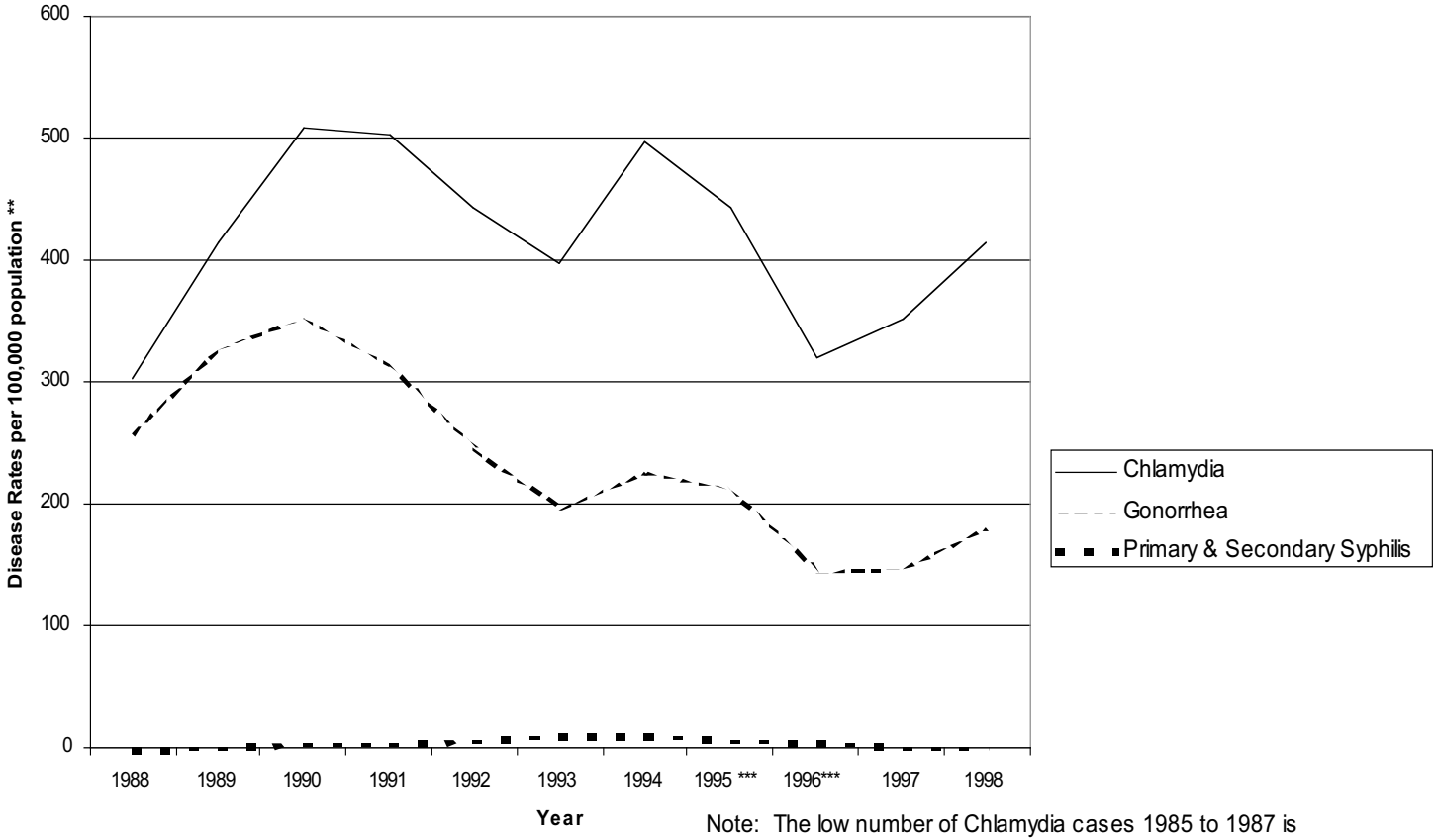
2. STD/HIV Prevention Program, The Ohio Department of Health

3. Division of STD Prevention, Department of Health and Human Services.

4. Scoles D, Stergachis A, Heidrich FE, Andrilla H, Holmes KK, Stamm WE. Prevention of pelvic inflammatory disease by screening of cervical chlamydial infection. *Engl J Med* 1996; 34(21):1326-66.

5. Office of Communications, National Institute of Allergy and Infectious Diseases, National Institutes of Health, August 1992.

Rates of Chlamydia, Gonorrhea, and Primary and Secondary Syphilis among Ohio Women, Reported Cases 1988 to 1998*



Note: The low number of Chlamydia cases 1985 to 1987 is probably due to poor reporting compliance as Chlamydia did not become mandatory until 1984.

* Presented by date of report to the Ohio Department of Health

** Per 100,000 based on the 1990 U.S. Census

*** The drop in the number of cases from 1995 to 1996 is partially due to an Ohio Department of Health initiative to control duplicate counts of case reports.

Source: STD/HIV Prevention Program, The Ohio Department of Health

HIV/AIDS: Female Populations at Risk

- While just over 10.3 percent of Ohio's female population is black, 53.9 percent of the women living with HIV/AIDS in Ohio are black.[1]

- Hispanic women are over-represented among HIV/AIDS cases as well, making up one percent of the Ohio female population and over six percent of Ohio females living with HIV/AIDS.[2]

- As with males, the majority of female HIV/AIDS cases are between the ages of 25 and 40. This is of special importance to women because of the risk of transmitting the infection to the child while pregnant.

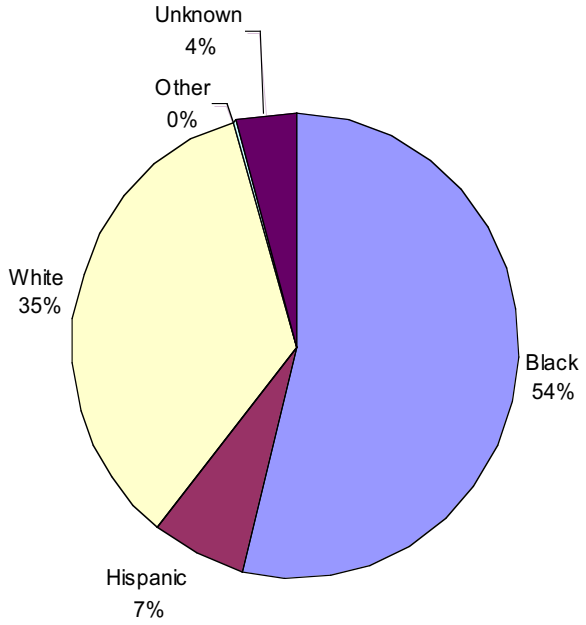
- The majority of the reported risk exposures among Ohio women are undetermined, most likely because women do not want to reveal their high risk activities. The second most commonly cited risk exposure is high risk heterosexual contact.[3]

References:

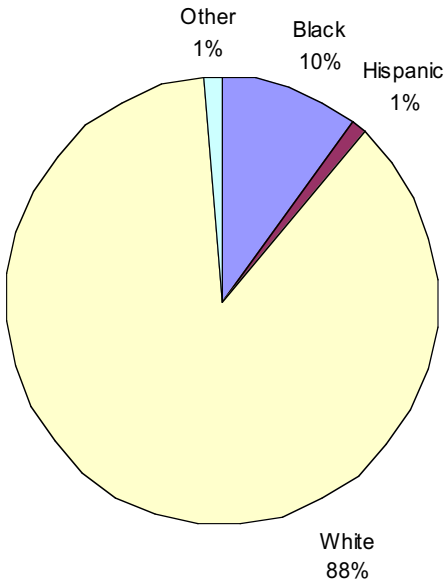
1. HIV/AIDS Surveillance, The Ohio Department of Health
2. Ibid.
3. Ibid.

Reported Cases of Women Diagnosed in Ohio Living with HIV/AIDS by Race compared to Ohio's Female Racial Distribution

Women Living with HIV/AIDS



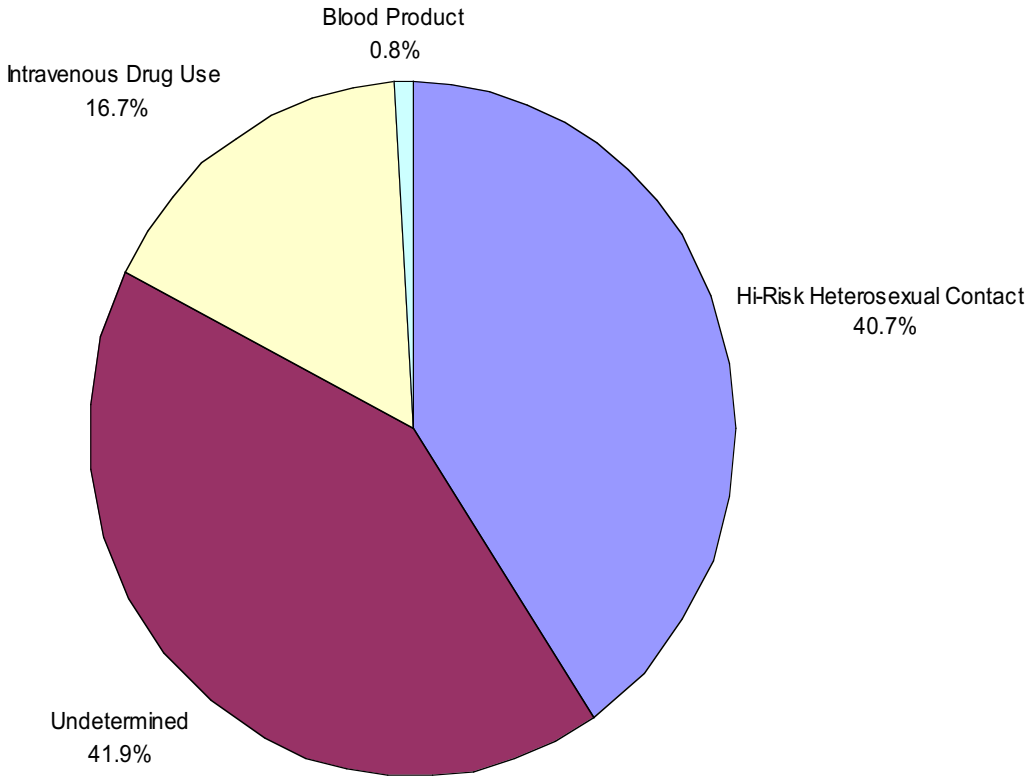
Ohio Female Population



Note: Includes females Ages 13 and Older

Source: STD/HIV Prevention Program, The Ohio Department of Health

Reported Cases of Women Diagnosed in Ohio Living with HIV/AIDS by Risk Exposure, 1998



Note: Includes females agers 13 and older

Source: STD/HIV Prevention Program, The Ohio Department of Health

III. Selected Health Conditions

Cardiovascular Disease

- Cardiovascular disease (CVD) is the leading cause of death in Ohio. It includes a variety of individual conditions including heart disease and cerebrovascular disease. Heart disease is the leading cause of death among Ohio women; cerebrovascular disease is third.

- High blood pressure, elevated blood cholesterol, smoking, sedentary lifestyle, obesity, and diabetes are significant risk factors for CVD that can largely be prevented or controlled by such activities as preventive nutrition counseling and physical activity.

- Nationally black women are at higher risk for stroke mortality and heart disease mortality than white women and are more likely to experience premature mortality.[1]

- One in three U.S. women over the age of 65 has some form of CVD. After menopause a woman's risk for CVD steadily increases. Women's CVD typically develops later in life than men and also tends to be more severe.[2]

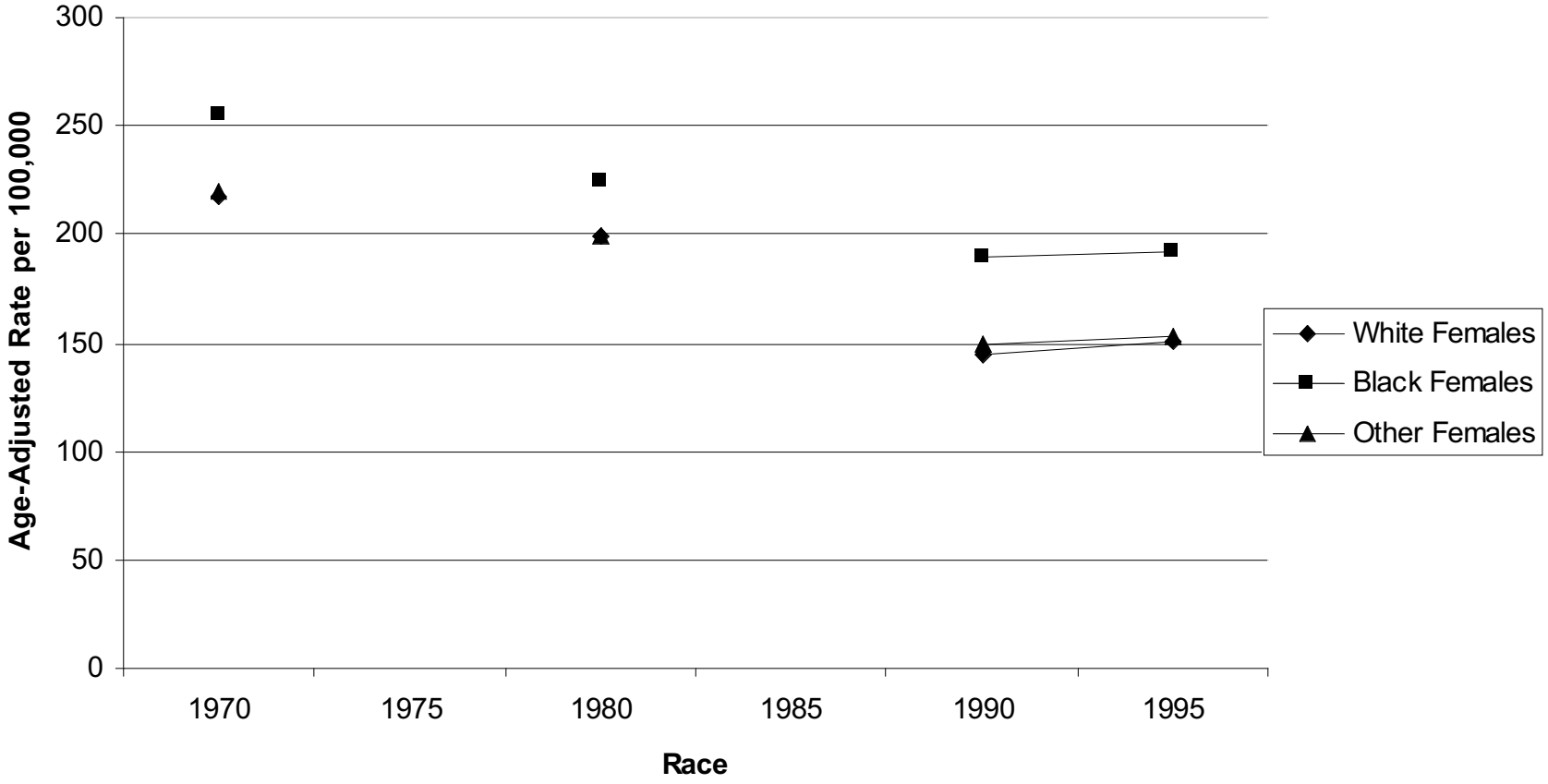
- Women are more likely than men to have fatal cardiac events, poorer prognoses after myocardial infarction and more complications after coronary procedures.[3] A woman's heart disease death is frequently sudden and unexpected; 63 percent of women who die of coronary heart disease never experienced any prior symptoms.[4]

- Women often delay seeking medical attention for heart symptoms, perhaps because women's symptoms for CVD are atypical. Some women report inadequate response of health care providers to complaints of chest pain.

References:

1. 1996 State Health Resources Plan, The Ohio Department of Health
2. National Women's Health Resource Center, 1991. National Women's Health Report: Heart Health
3. Wenger NK, Speroff L, Packard B. Special Article: Cardiovascular health and disease in women. *N Engl Journal of Medicine* 1993; 329:756-62.
4. Cardiovascular Health Fact Sheet, Hoffman=LaRoche Inc.

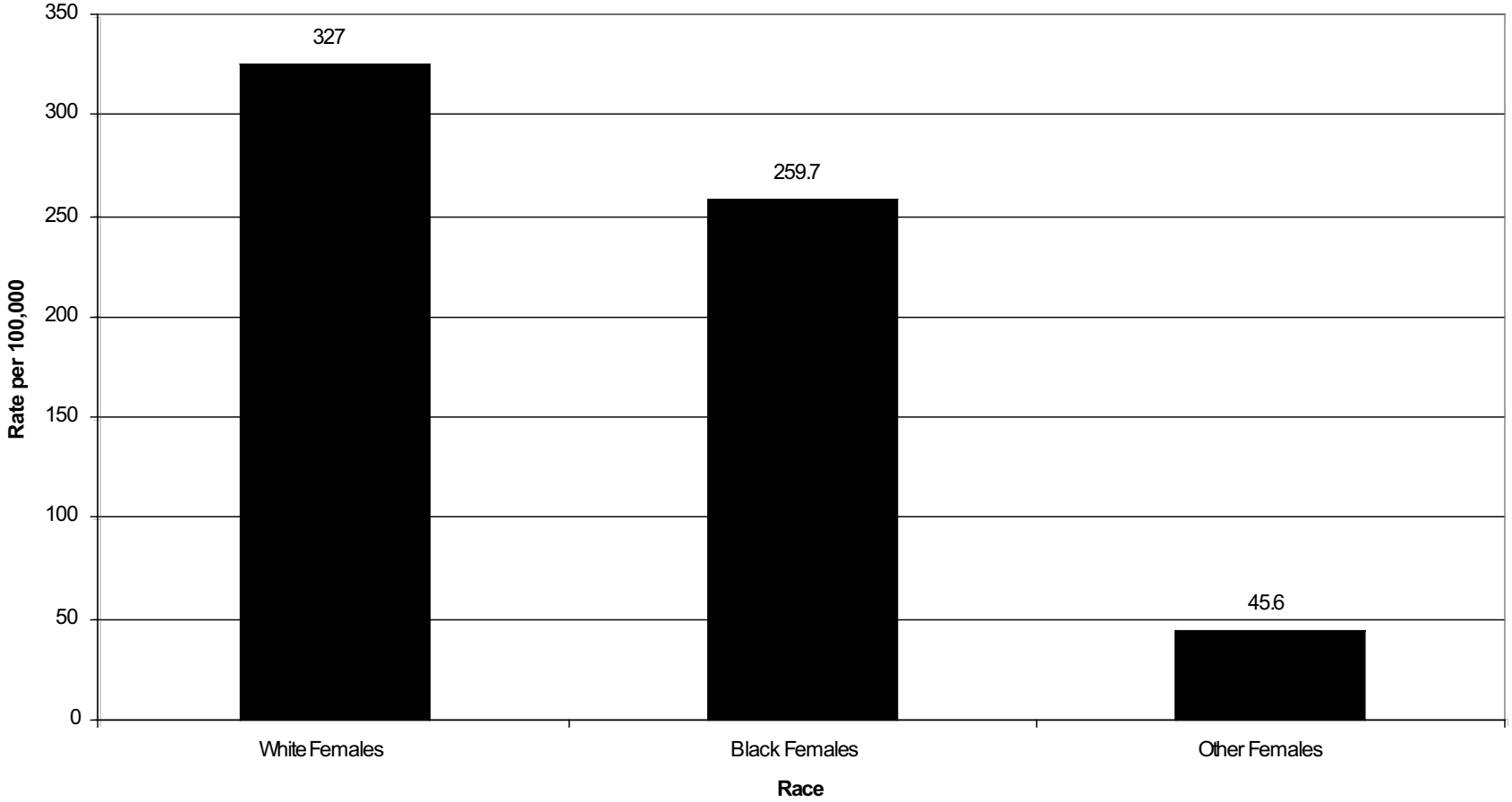
Mortality Trends from Diseases of the Heart among Ohio Women by Race, 1970 to 1995



Note: Diseases of the heart includes ICD-9 codes 390-398, 402, and 404-429

Source: Vital Statistics, The Ohio Department of Health

Mortality from Diseases of the Heart among Ohio Women by Race, 1996



Note: Diseases of the heart includes ICD-9 codes 390-398, 402, and 404-429

Source: Vital Statistics, The Ohio Department of Health

Diabetes

- The mortality rates for diabetes are higher in Ohio women than the mortality rates nationally. Diabetes is the fifth leading cause of death among Ohio women. It is the fourth leading cause of death among minority women in Ohio.[1]

- Cardiovascular disease is the leading cause of death among people with diabetes in the United States, accounting for half of all deaths.[2] Diabetes is frequently cited as a secondary cause of death.

- Risk factors for type I and II diabetes include family history, obesity and race.[3] Diabetes is most prevalent among native Americans, hispanics and blacks.

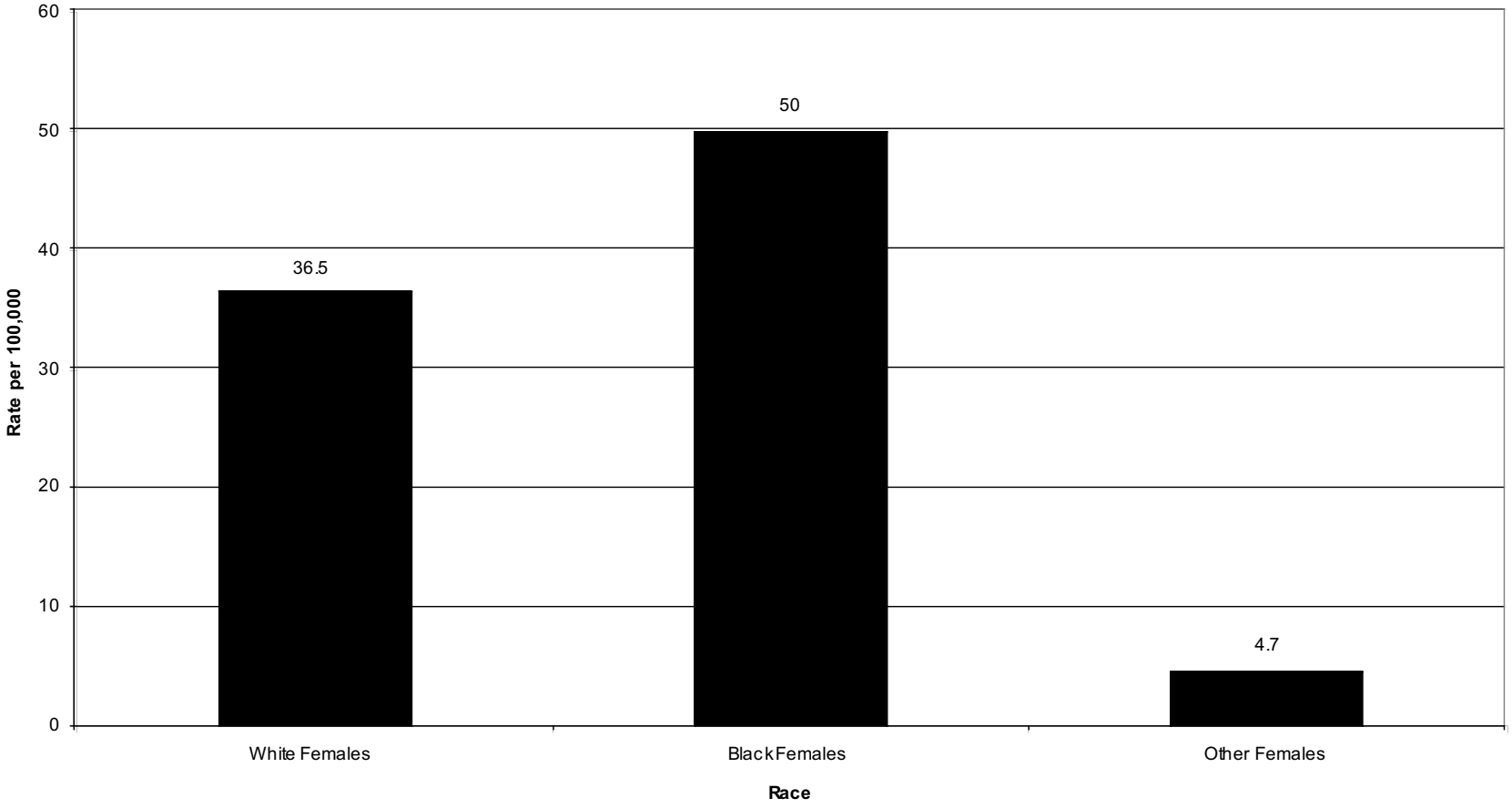
- Pre-gestational and gestational diabetes can lead to excessive fetal growth and may contribute to intrauterine fetal death, slowed fetal lung development and neonatal hypoglycemia.

- The Centers for Disease Control and Prevention recommend that all pregnant women be screened for gestational diabetes between the 24th and 28th week of pregnancy. Gestational diabetes can be effectively managed with good prenatal care.

References:

1. Chronic and Environmental Disease Surveillance Section, Bureau of Health Surveillance, The Ohio Department of Health
2. *Health People 2000*, U.S. Department of Health and Human Services
3. *Diabetes Care*. Position Statement, January 1996.

Mortality from Diabetes Mellitus among Ohio Women by Race, 1996



Source: Vital Statistics, The Ohio Department of Health

Osteoporosis

- Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures of the hip, spine and wrist.

- Of the 20 million Americans who suffer from osteoporosis, 80 percent are women. It is estimated that one in two women over age 65 will experience a bone fracture due to osteoporosis in her lifetime. A woman's risk of hip fracture over the course of her lifetime is equal to her combined risk of breast, uterine, and ovarian cancer.[1]

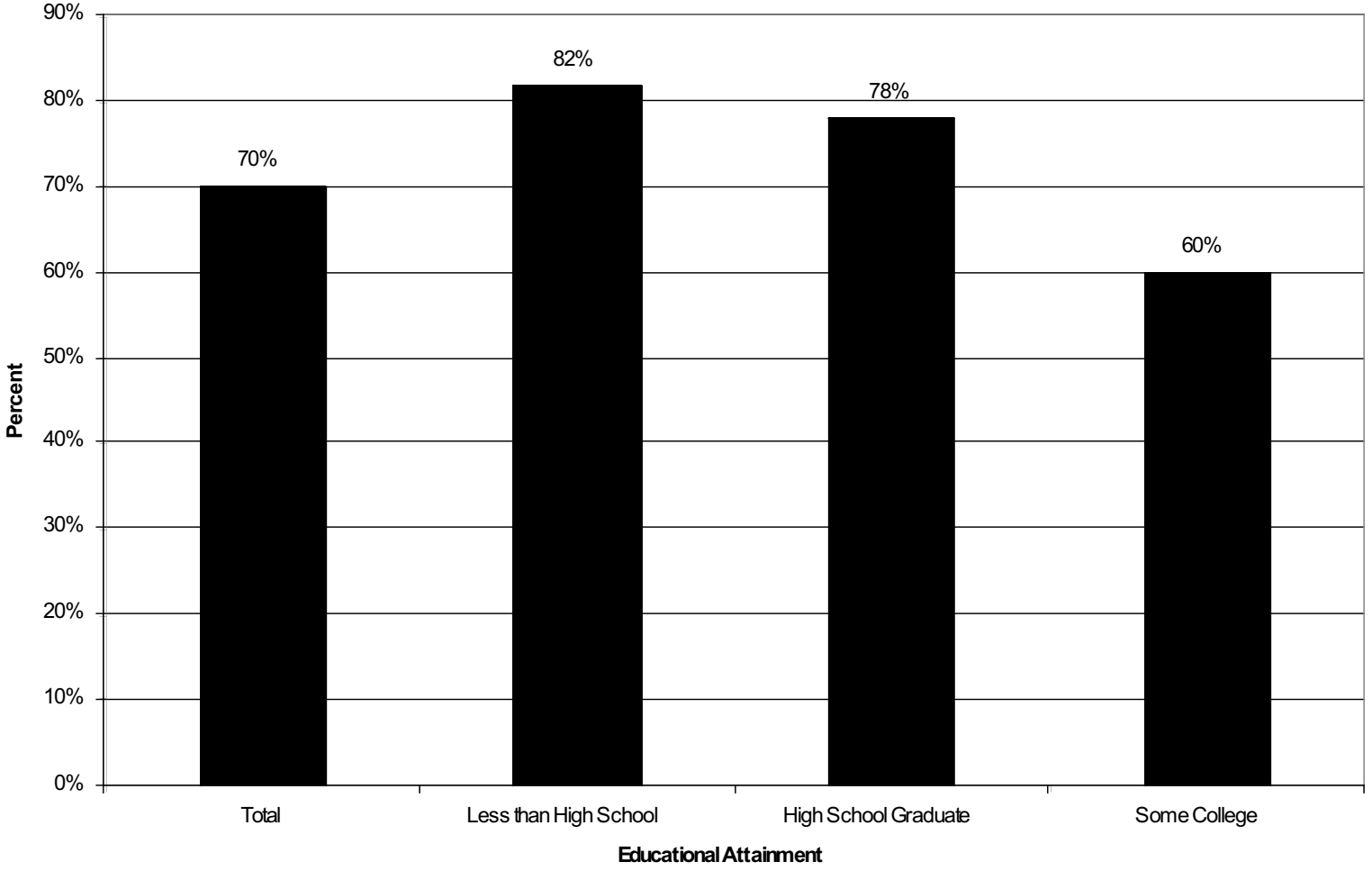
- As the population ages, the incidence of bone fracture due to osteoporosis is likely to increase. One and half million fractures occur annually in the United States due to osteoporosis. Of these, more than 300,000 are hip fractures. Many others are fractures of the spine and wrist. One out of every five persons who has a hip fracture will not survive more than one year.[2]

- Osteoporosis can be prevented with education and early awareness. Eating foods rich in calcium and Vitamin D, *especially before the age of 35*, can prevent osteoporosis and the harmful and costly fractures that are associated with it.[3]

References:

1. Fast Facts on Osteoporosis. ORBD-NRC. 1996.
2. *A Status Report on Osteoporosis: The Challenge to Midwife & Older Women.* Older Women;s League. April 1995.
3. ORBD-NRC.

Women Not Familiar with Osteoporosis, United States, 1993



Source: The Commonwealth Fund Women's Health Survey, Louis Harris and Associates, Inc., 1993

Cancer Mortality

- Cancer is the second leading cause of death in Ohio and the nation.[1]

- 12,493 Ohio women died of cancer in 1996, an age-adjusted mortality rate of 152 per 100,000.[2]

- Cancer of the lung and bronchus is the leading cause of cancer related deaths for women in Ohio and nationally.[3] In 1996, 3,104 Ohio women died of lung cancer, representing 24 percent of Ohio cancer deaths among Ohio females. Survival is low: only 16 percent of women are still alive five years after diagnosis with lung cancer. Cigarette smoking is responsible for at least 80 percent of lung cancer deaths among women.[4]

- Breast cancer, while the most common cancer type among women, has the second highest mortality rate. 2,157 Ohio women died of breast cancer in 1996 - 17 percent of all female cancer deaths in Ohio that year.[5] The five year survival rate is 98 percent.[6]

- Colon and rectum cancer has the third highest cancer mortality rate among women in Ohio and the U.S. It caused 1,432 deaths to Ohio women in 1996, about 12 percent of the cancer deaths that year. The five year survival rate is 62 percent.[6]

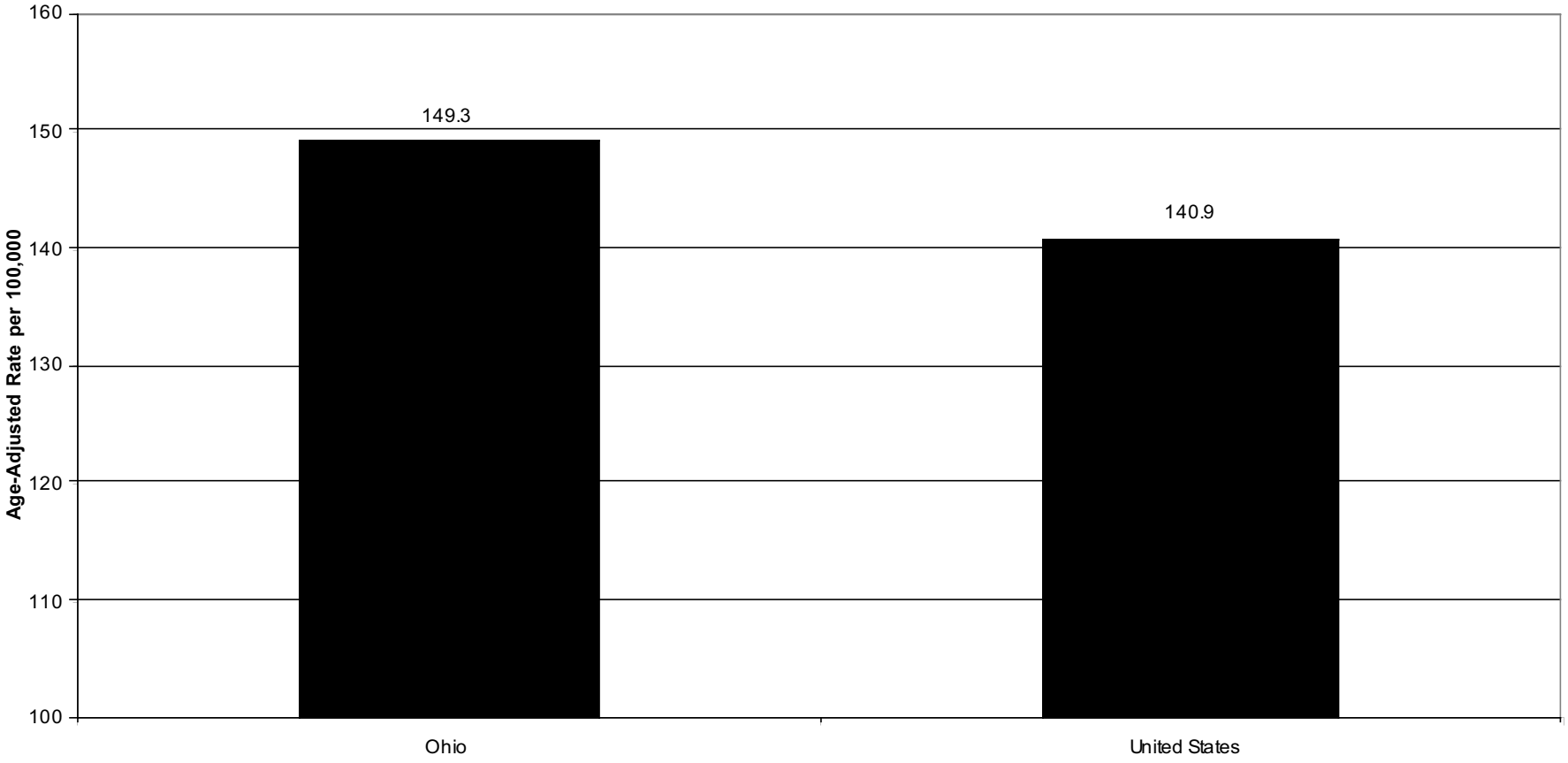
- In 1996, the mortality rate was higher for black and other women in Ohio than it was for white Ohio women for several individual cancer types: lung and bronchus, breast, colorectal, endometrial and cervical cancers.[7]

- White women in Ohio had higher mortality rates than black and other women for ovarian cancer and melanoma.

References:

1. 1996 State Health Resources Plan, The Ohio Department of Health
2. Chronic and Environmental Disease Surveillance, The Ohio Department of Health
3. Ries LAG, Kosary CL, Hankey BF, Miller BA, Edwards BK (eds.), *SEER Cancer Statistics Review, 1973-1995*, National Cancer Institute, Bethesda, MD, 66-7.
4. Ernster VL, The epidemiology of lung cancer in women, *Ann Epidemiol* 4 (1994): 102-110.
5. American Cancer Society
6. Ibid.
7. Chronic and Environmental Disease Surveillance, The Ohio Department of Health

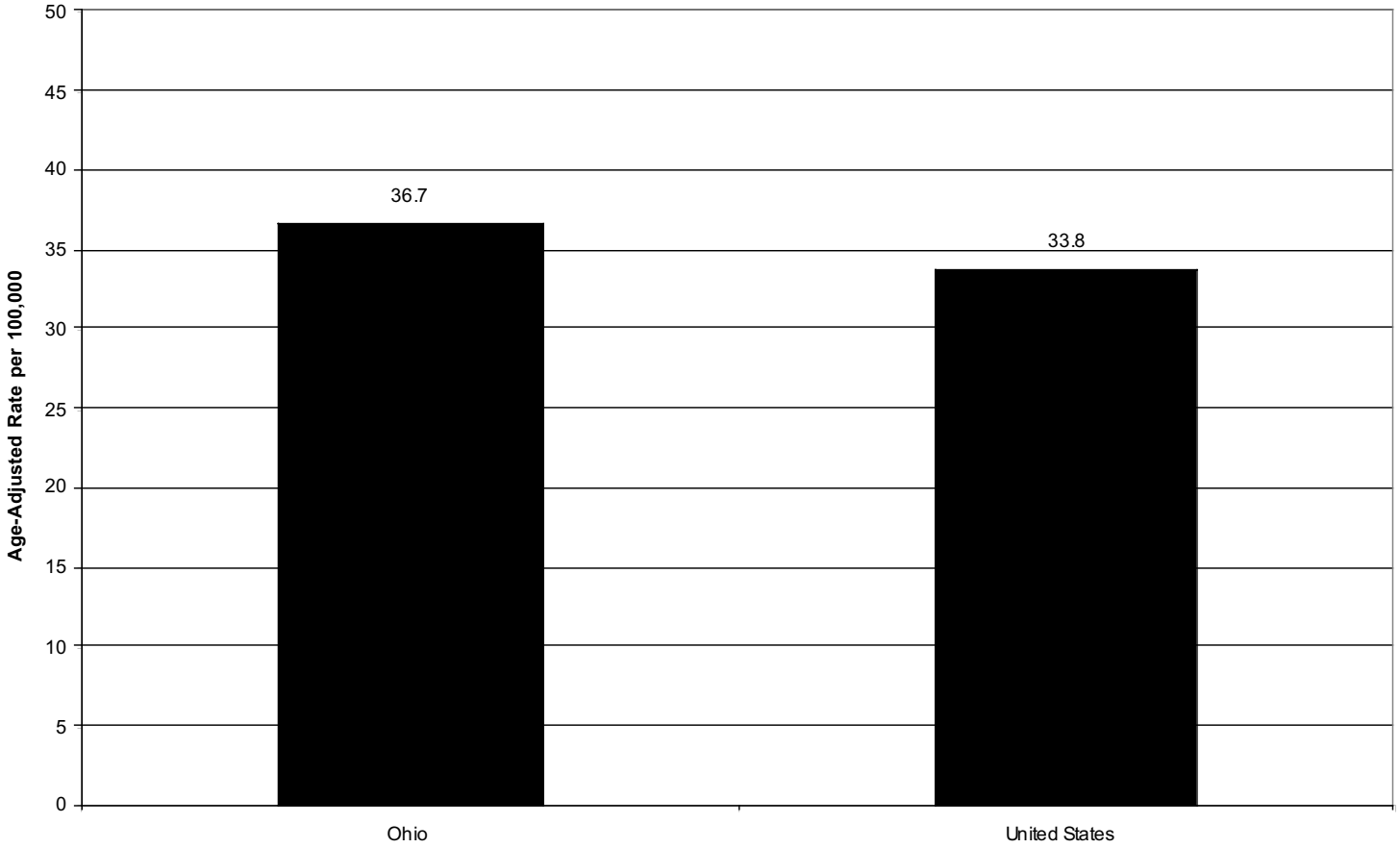
Average Annual Age-Adjusted Mortality Rate for Cancer at All Sites among Women, Ohio versus the United States, 1992 to 1996



Note: Rates are Age-Adjusted to the 1970 U.S. standard population

Source: SEER Cancer Statistics Review 1973-1996, National Cancer Institute, The National Institutes of Health

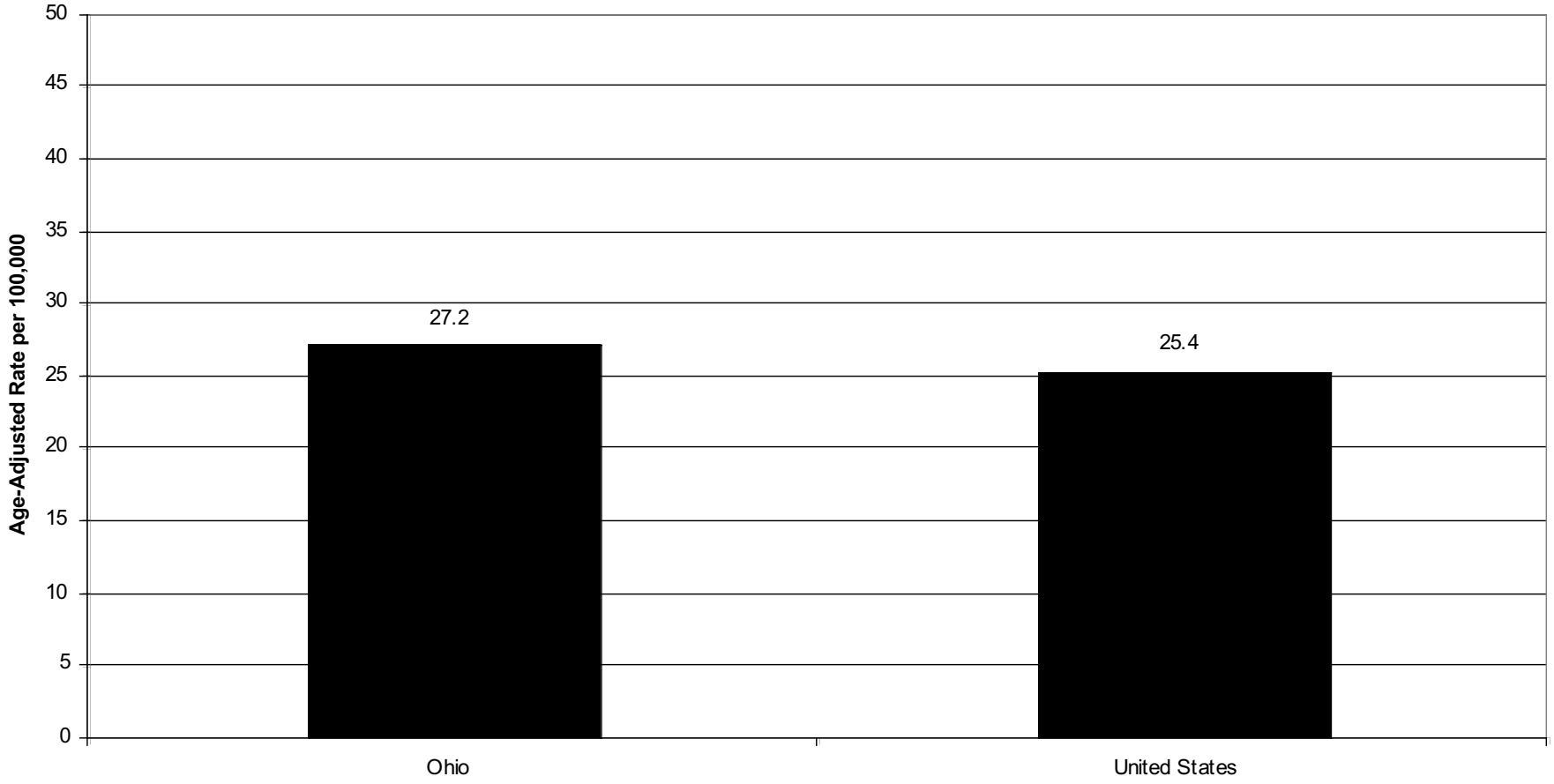
Average Annual Age-Adjusted Mortality Rate for Lung and Bronchus Cancer among Women, Ohio versus the United States, 1992 to 1996



Note: Rates are Age-Adjusted to the 1970 U.S. standard population

Source: SEER Cancer Statistics Review 1973-1996, National Cancer Institute, The National Institutes of Health

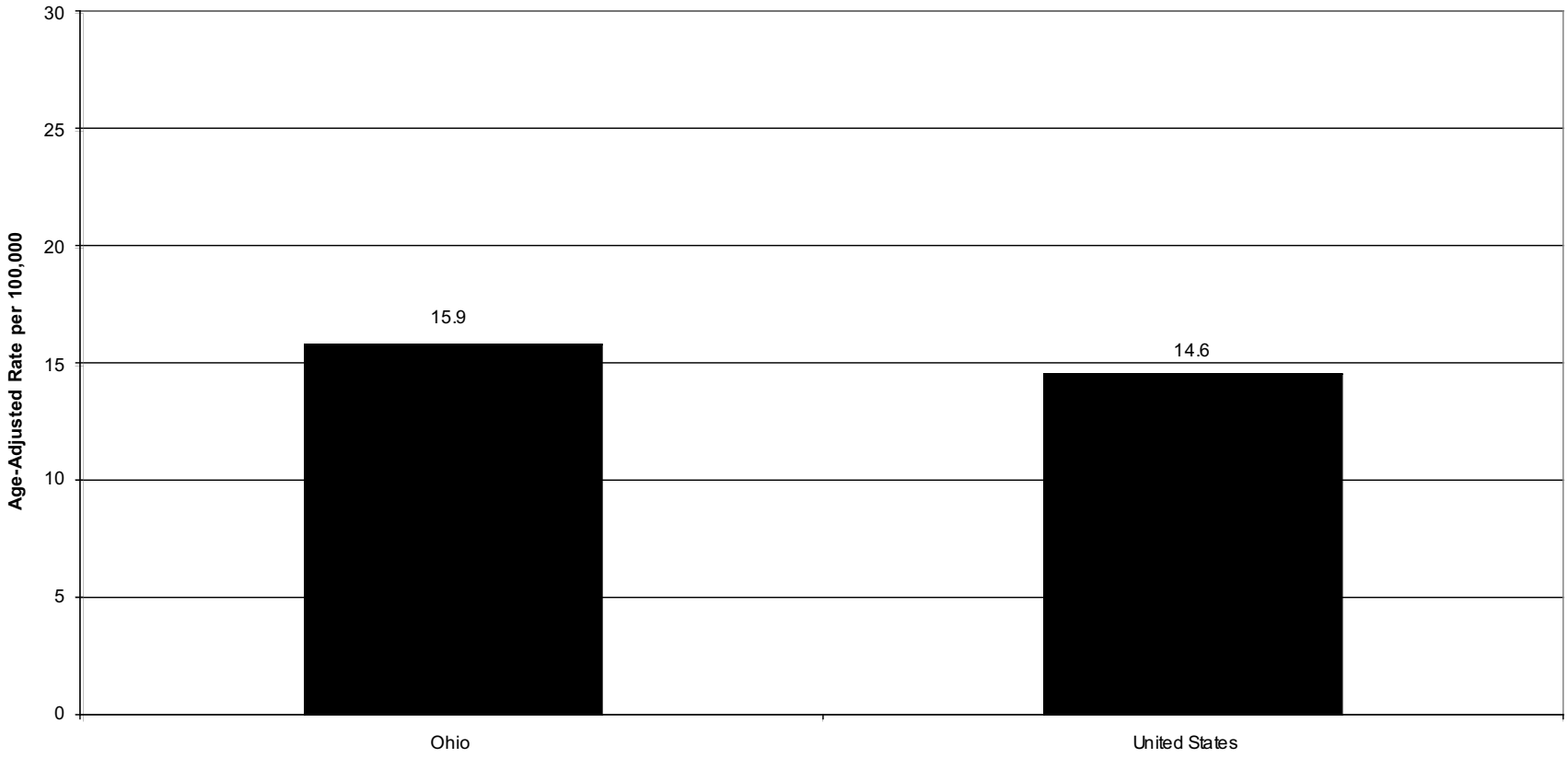
Average Annual Age-Adjusted Mortality Rate for Breast Cancer among Women, Ohio versus the United States, 1992 to 1996



Note: Rates are Age-Adjusted to the 1970 U.S. standard population

Source: SEER Cancer Statistics Review 1973-1996, National Cancer Institute, The National Institutes of Health

Average Annual Age-Adjusted Mortality Rate for Colon and Rectum Cancer among Women, Ohio versus the United States, 1992 to 1996



Note: Rates are Age-Adjusted to the 1970 U.S. standard population

Source: SEER Cancer Statistics Review 1973-1996, National Cancer Institute, The National Institutes of Health

- Selected Health Behaviors and Behavioral Risks

Tobacco Smoking

- Tobacco is a significant public health concern for Ohio women, contributing substantially to deaths due to cancer, especially lung cancer; cardiovascular disease, including coronary artery disease and stroke; lung disease, including chronic obstructive pulmonary disease; and pneumonia. Smoking also increases the risk of cervical cancer, osteoporosis, premature menopause, pregnancy complications, poor birth outcomes and impaired fertility.[1]

- 24.8 percent of Ohio women report smoking cigarettes.[2]

- Smoking prevalence is inversely related to educational and income level. The lower the level of educational attainment and income, the more likely a woman will smoke.[3]

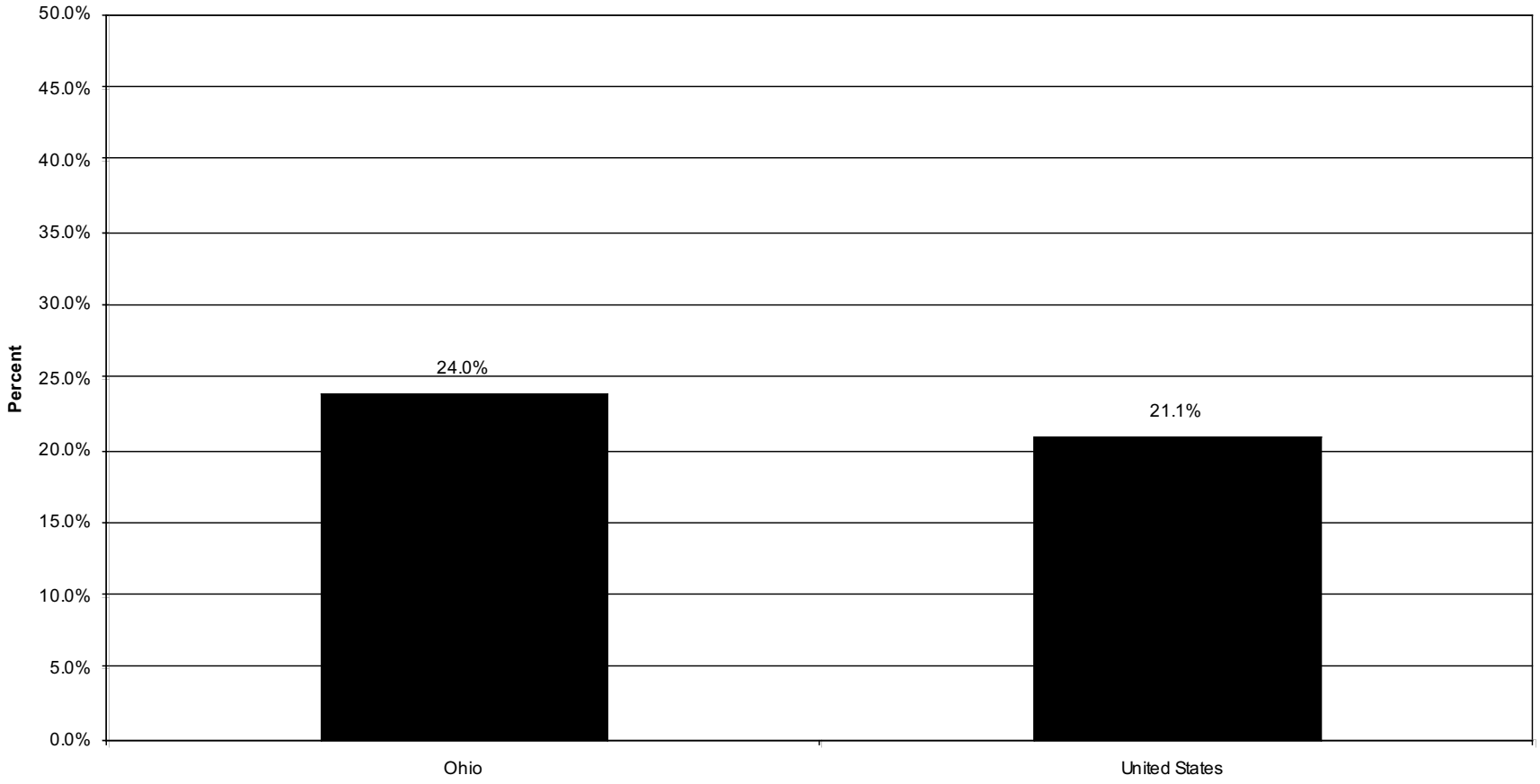
- Cigarette smoking typically begins in adolescence.[4] Twenty percent of female high school students in Ohio report smoking two or more cigarettes per day.[5]

- In recent years, Ohioans have spent approximately $1.6 billion annually in direct medical costs related to smoking.[6]

References:

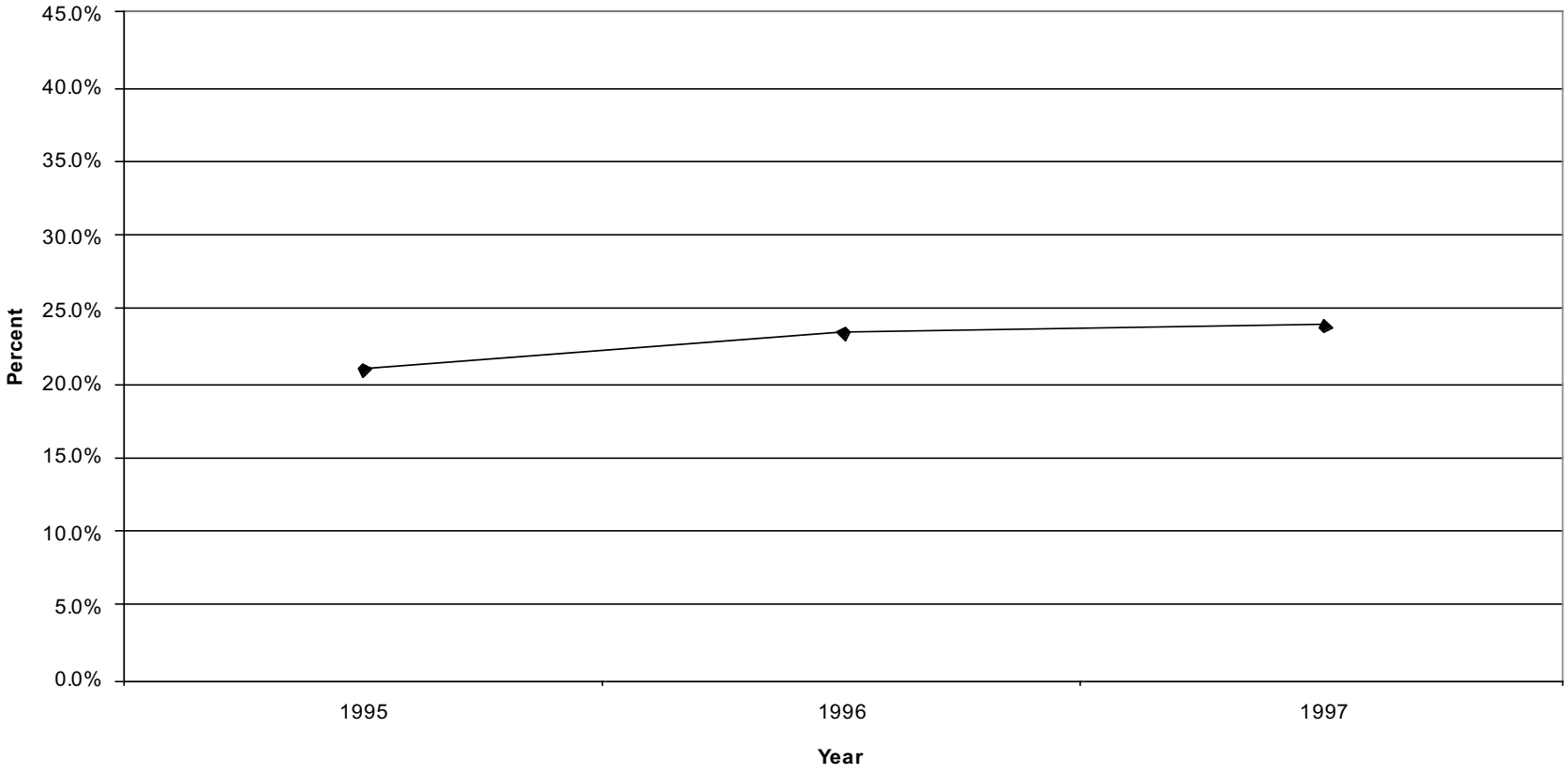
1. Office of Policy, Planning and the Data Center, The Ohio Department of Health.
2. 1997 Behavioral Risk Factor Surveillance, The Ohio Department of Health
3. Ibid.
4. *Preventing Tobacco Use among Young People: A Report of the Surgeon General.* 1994. U.S. Department of Health and Human Services.
5. 1993 Ohio Youth Risk Behavior Survey, The Ohio Department of Education
6. *Tobacco Use: An Ohio Profile*, The Ohio Department of Health, 1994.

Self-Reported Prevalence of Tobacco Smoking by Women, Ohio versus the United States, 1997



Source: 1997 Behavioral Risk Factor Surveillance System, Nactional Center for Health Statistics

Self-Reported Prevalence of Tobacco Smoking by Women, Ohio Trends, 1995 to 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

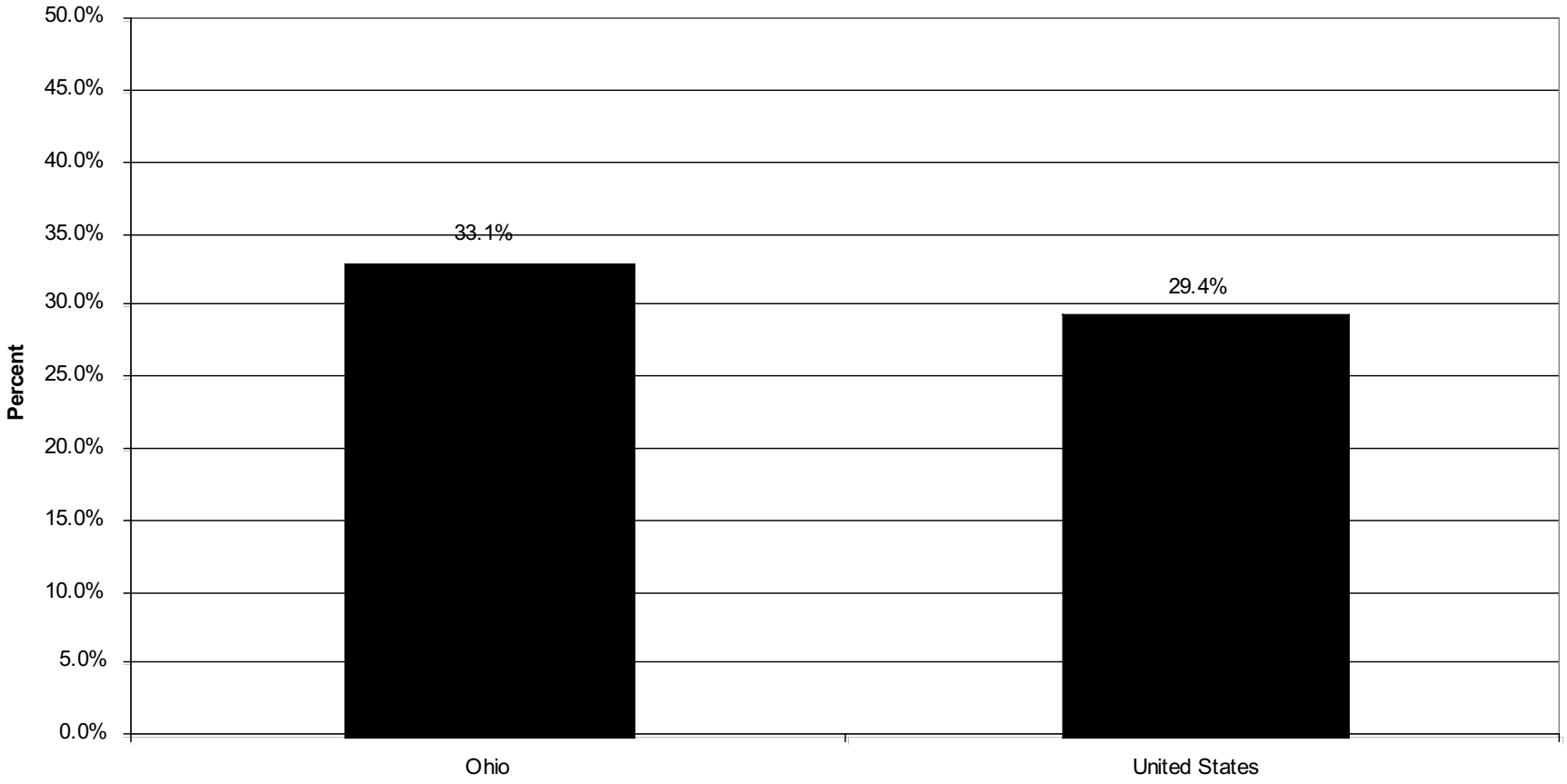
Overweight Status among Ohio Women

- 33 percent of Ohio women are overweight according to their body mass index (BMI).[1]
- Obesity is a risk factor for non-insulin dependent diabetes mellitus, coronary heart diseases, hypertension, gout, gall bladder disease, osteoarthritis of weight bearing joints, and gastroesophageal reflux disease.
- Obesity increases the relative risk of cancer of the breast, uterus and colon.[2]
- Generally, obesity is correlated with low income and low educational attainment.[3]
- National data suggest there has been dramatic increase in the percentage of overweight over the last decade. Between 1976-80 and 1988-91, the age-adjusted prevalence of overweight among women 20 to 74 years of age rose from 27 to 34 percent.[4]

References:

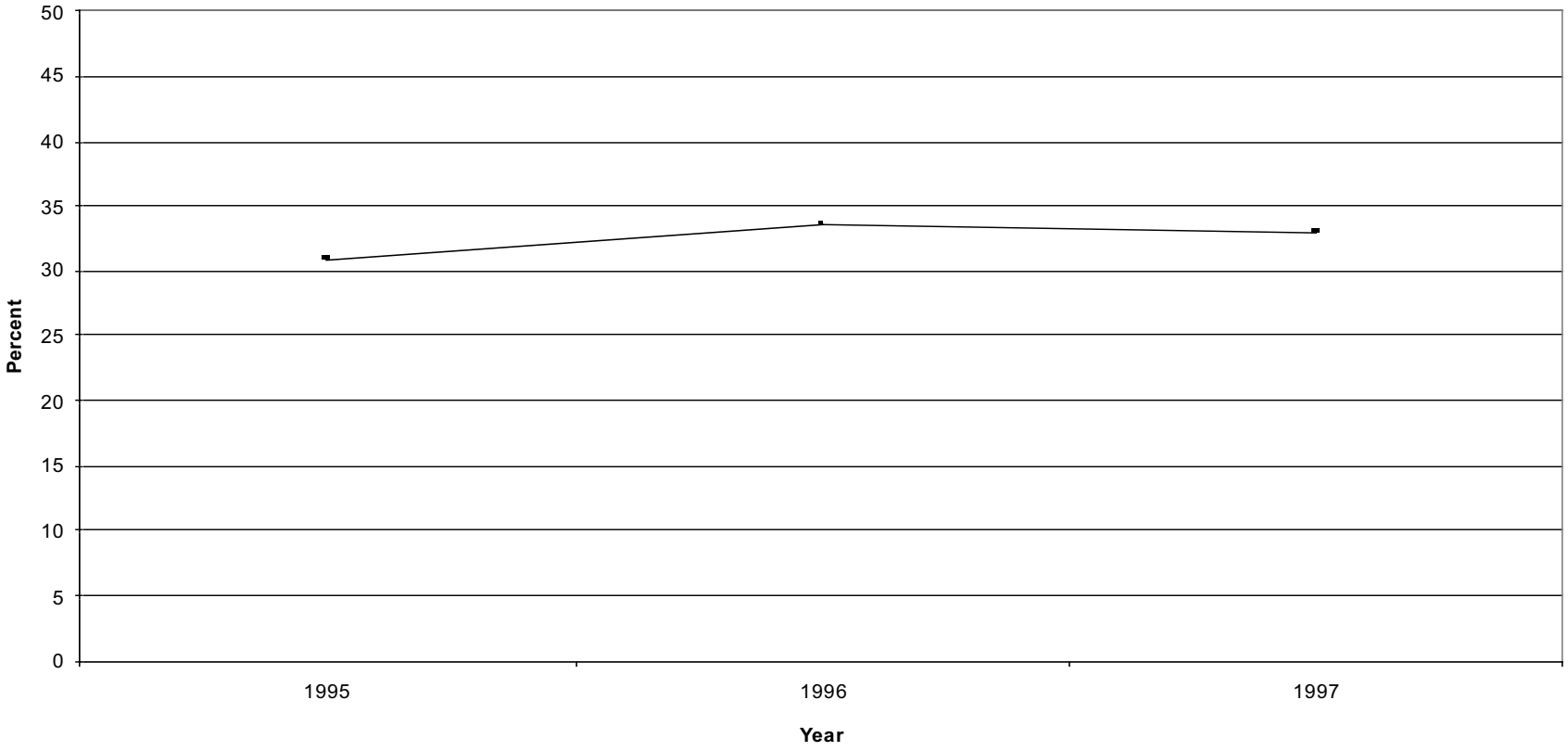
1. Ohio Behavioral Risk Factor Surveillance, Division of Prevention, ODH, 1997.
2. 1996 State Health Resources Plan, The Ohio Department of Health
3. Ohio BRFSS
4. National Center for Health Statistics. *Health, United States, 1995.*

Prevalence of Women Classified as being Overweight, Ohio versus the United States, 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Prevalence of Women Classified as being Overweight, Ohio Trends, 1995 to 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Hypertension

- About 22 percent of Ohio women have high blood pressure, putting them at risk for coronary heart disease and cerebrovascular disease, renal failure and cardiomyopathy.[1,2]

- A higher proportion of Ohio women are hypertensive than U.S. women: 22 percent compared to 23 percent respectively.

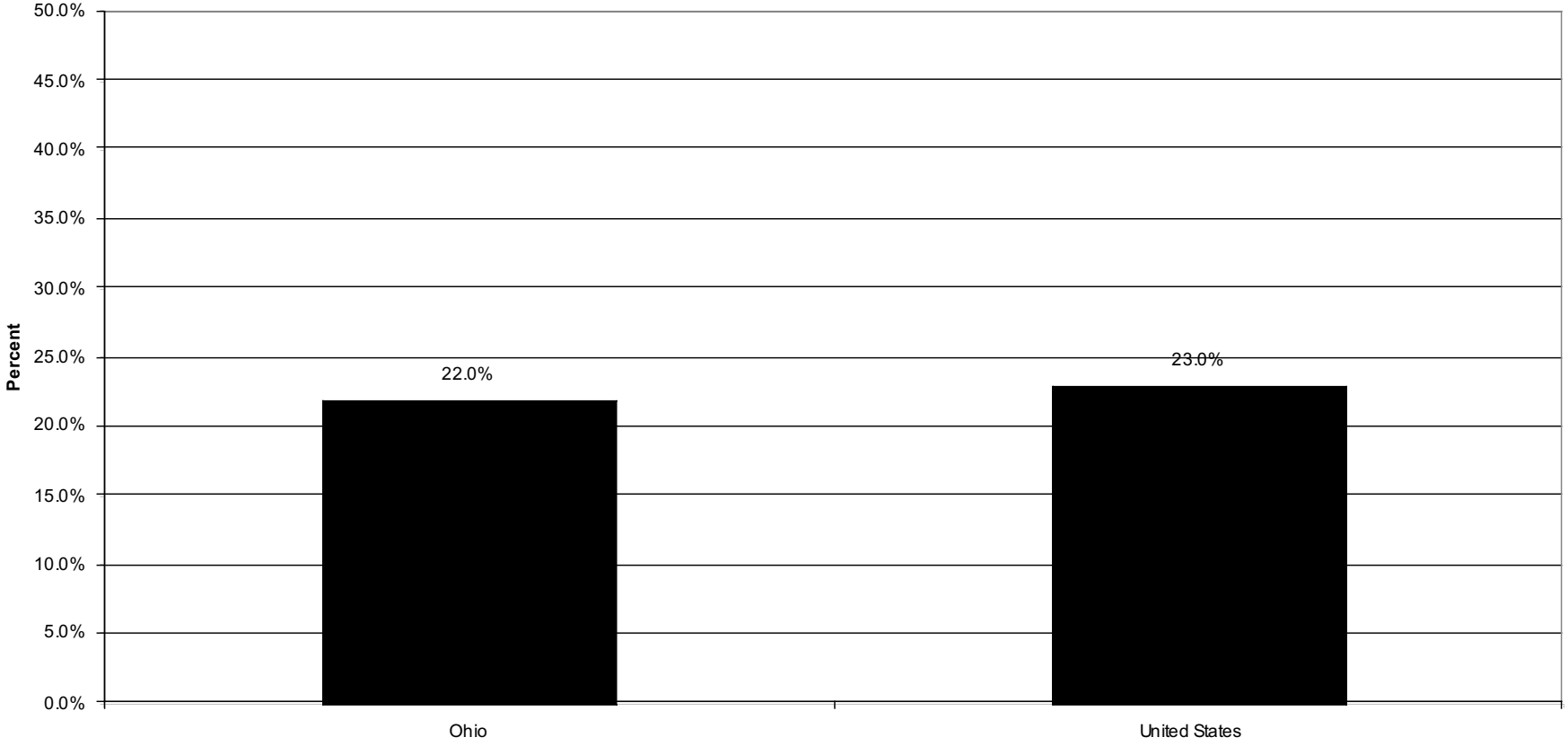
- The risk factors for hypertension include age, excessive alcohol intake, family history, obesity, and high sodium intake.[3]

- After menopause, hypertension is more prevalent among women than men. Black and hispanic Americans are more likely to suffer from hypertension than whites.[4] This translates into higher cardiovascular disease mortality rates for black women than for white women.

References:

1. Ohio BRFSS, 1997.
2. 1996 State Health Resources Plan, The Ohio Department of Health
3. Office of Policy, Planning and Data Center, The Ohio Department of Health
4. Heart and Stroke Facts: 1994 Statistical Supplement, American Heart Association.

Self-Reported Prevalence of Hypertension among Women, Ohio versus the United States, 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Sedentary Lifestyle

- One *Healthy People 2000* goal is to reduce to 15 percent the proportion of people over age six who engage in no leisure time physical activity.[1]

- High levels of physical activity appear to be associated with increased health and longevity. Lack of physical activity increases mortality and morbidity for a number of chronic diseases, including cancer, cardiovascular disease, arthritis, osteoporosis, and diabetes.

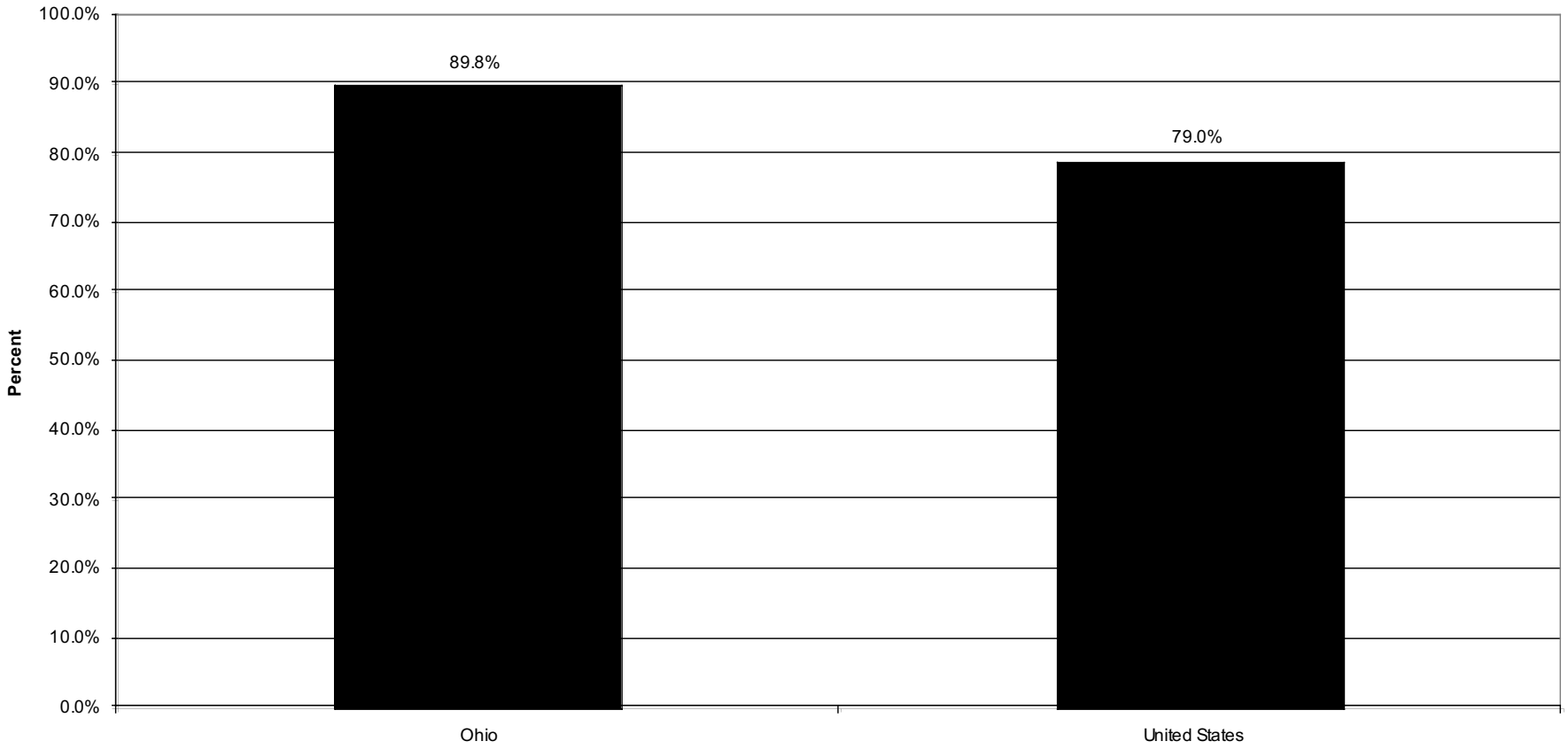
- In 1997, 89.8 percent of Ohio Women were determined to be at increased health risk due to a sedentary lifestyle, compared to 79 percent of U.S. women.[2]

- Sedentary lifestyle is defined as having less than 20 minutes per session and/or less than three times a week in leisure time physical activity during the past month.

References:

1. 1996 State Health Resources Plan, The Ohio Department of Health
2. Ohio BRFSS, 1997.

Women at Increased Health Risk due to a Lack of Regular and Sustained Physical Activity, Ohio versus the United States, 1996



Source: 1996 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Violence Against Women

- Domestic violence is the single largest cause of injury to women in the United States, more common than automobile accidents, muggings and rapes combined. Woman battering is the most under-reported crime in America.[1]

- The FBI estimates that one woman is beaten by her partner or husband every 15 seconds in the United States.[2] Rarely is battering an isolated event and battering tends to increase and become more violent over time.

- In more than half of wife-abusing families, children are also abused.[3] In state fiscal year 1996, 1,000 more children than women were housed in emergency women's shelters.[4]

- In 1994, Ohio had a higher rate of forcible rape than the nation: 47.1 per 100,000 people in Ohio versus 39.2 per 100,000 people in the United States.

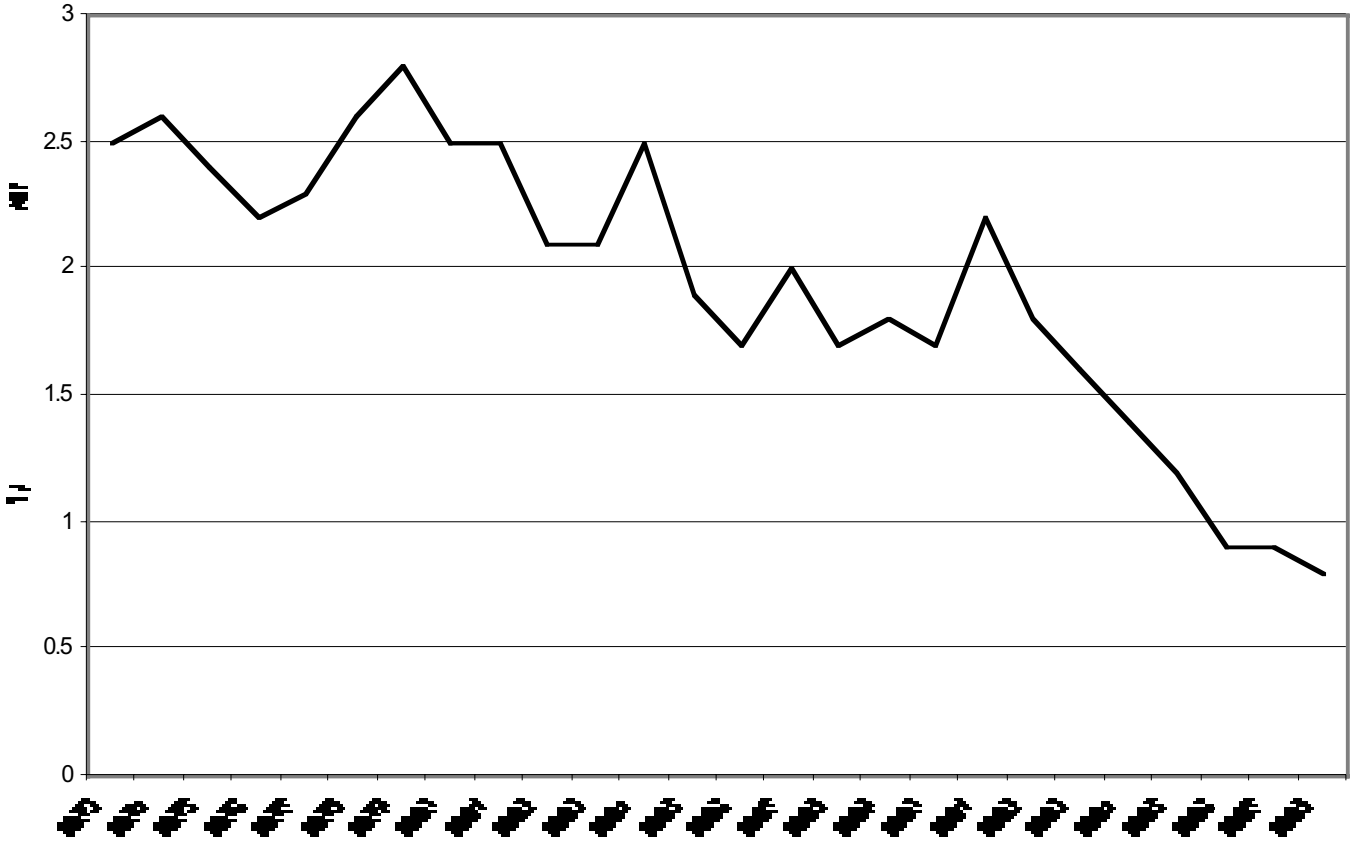
- According to the Ohio Office of Criminal Justice, 4,091 rapes were reported to law enforcement officials in Ohio in 1995.

- The economic cost of rape in Ohio, based on a 1993 estimate from the U.S. Surgeon General's Office, was $6,261,000.[5]

References:

1. Facts on Battering. Texas Women's University Prevention of Battering During Pregnancy Program.
2. Federal Bureau of Investigation, U.S. Department of Justice, 1988.
3. Domestic Violence Fact Sheet, The Ohio Department of Health, 1994.
4. Ohio Department of Human Services
5. Rape Prevention and Crisis Intervention, The Ohio Department of Health

Rape Trends in the United States, 1973 to 1998



Note: Includes victims ages 12 and older

Source: Bureau of Justice Statistics, U.S. Department of Justice

Substance Abuse

- National rates of drug abuse suggest that more than one million Ohio women will abuse one or more drugs during their lifetimes.[1] Approximately one-third of American women abuse alcohol or are dependent on it.[2]

- Chronic alcohol abuse inflicts greater physical harm on women than on men. Female alcoholics have death rates 50 to 100 percent higher than those of male alcoholics. Moreover, female alcoholics are more likely than male alcoholics to die from suicide, alcohol-related accidents, circulatory disorders, and cirrhosis of the liver.[3]

- Generally, drugs are abused differently by men than women. While men are more likely to abuse illegal drugs, women are more likely to become addicted to prescription medications.

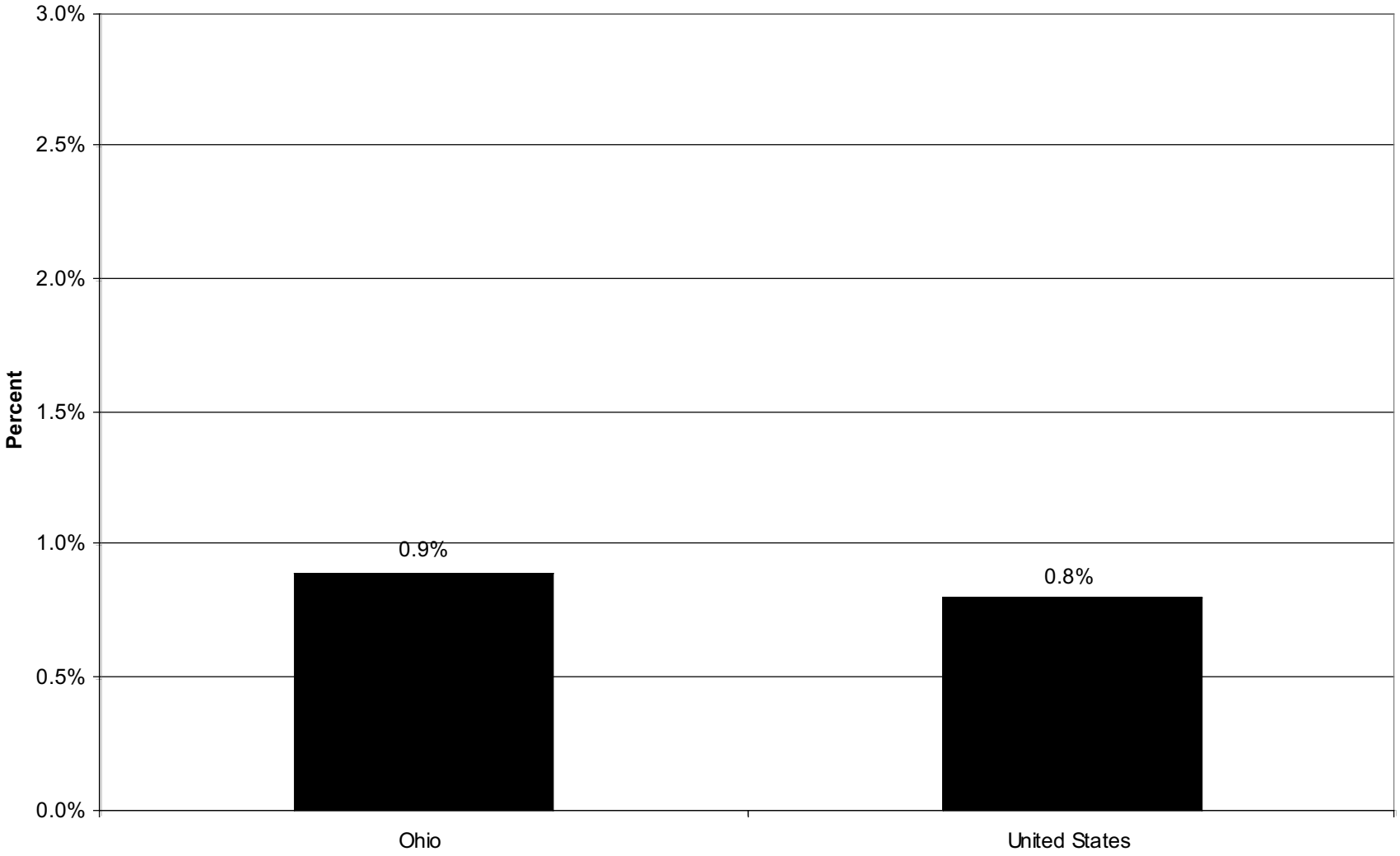
- Maternal drug use may put children at risk for low birth weight, small head circumference, prematurity, as well as other medical and developmental complications.

- According to national self-reported data, women are significantly less likely than men to receive drug abuse treatment, 0.6 percent compared to 1.5 percent respectively.[4]

References:

1. *Selected Facts on U.S. Women's Health: A Chart Book*, 1997 The Commonwealth Fund.
2. Alcohol Alert, 1990. National Institute on Alcohol Abuse and Alcoholism.
3. Ibid.
4. National Household Survey on Drug Abuse: Main Findings 1994, Substance Abuse and Mental Health Services Administration.

Women at Risk for Alcohol-Related Illness, Ohio versus the United States, 1997



Source: 1997 Ohio BRFSS

Cancer Screening

- The American Cancer Society recommends that women ages 20 to 39 perform monthly breast self exams and receive a clinical breast exam at least once every three years. Women ages 40 to 49 should receive clinical breast exams and mammograms every one to two years as well as continue monthly self exams. Women ages 50 and older should receive annual mammograms.[1]

- To screen for cancer of the uterus or cervix, the American Cancer Society recommends that women ages 18 and older have annual pelvic exams and receive regular PAP tests.[2]

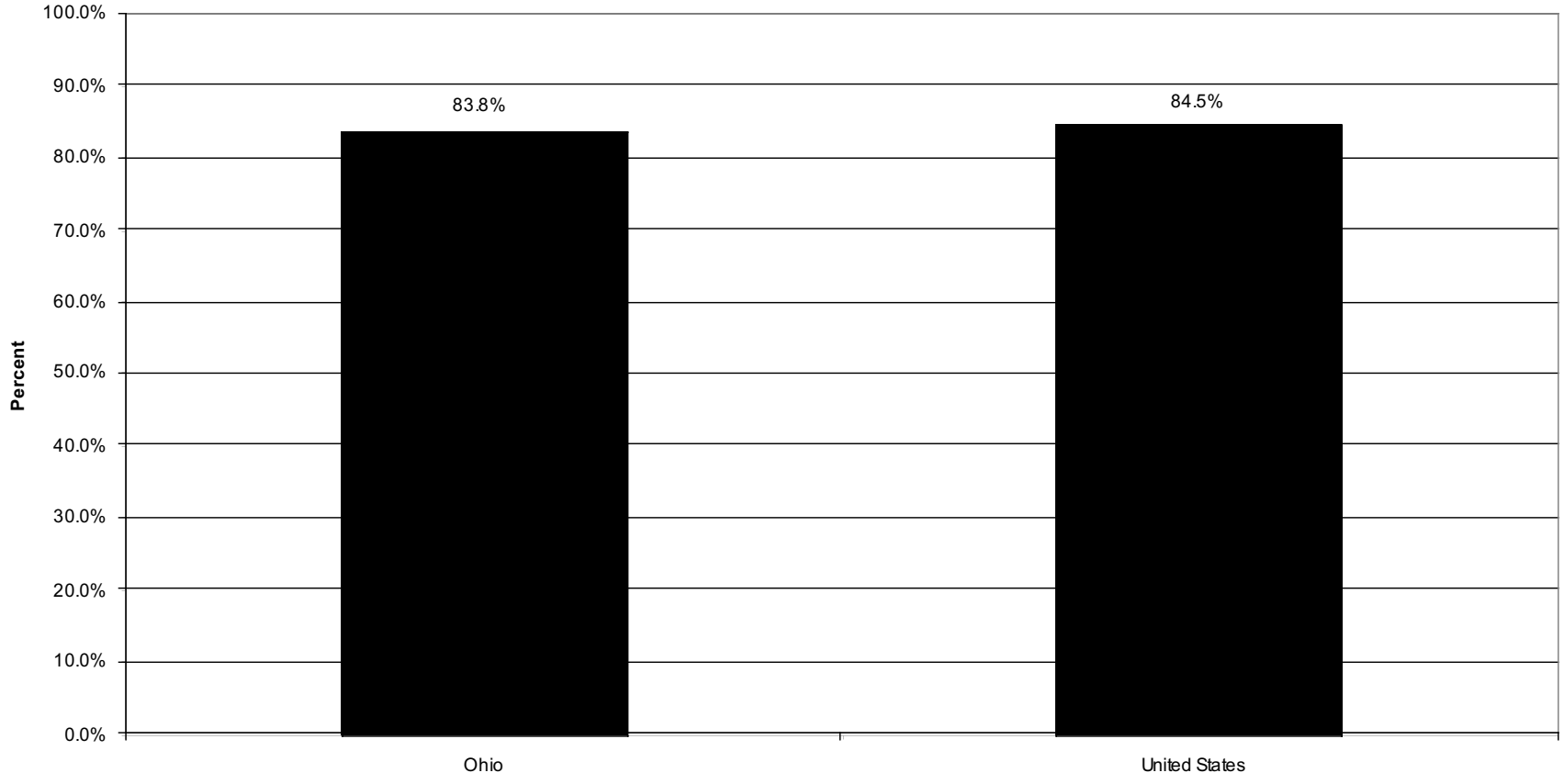
- According to American Cancer Society guidelines, beginning at age 50, individuals should receive a yearly fecal occult blood test plus flexible sigmoidoscopy every five years; or a colonoscopy every 10 years; or a double contrast barium enema every 5 to 10 years.[3]

- Early detection, especially of breast, cervical and colon and rectum cancers, can reduce mortality.

References:

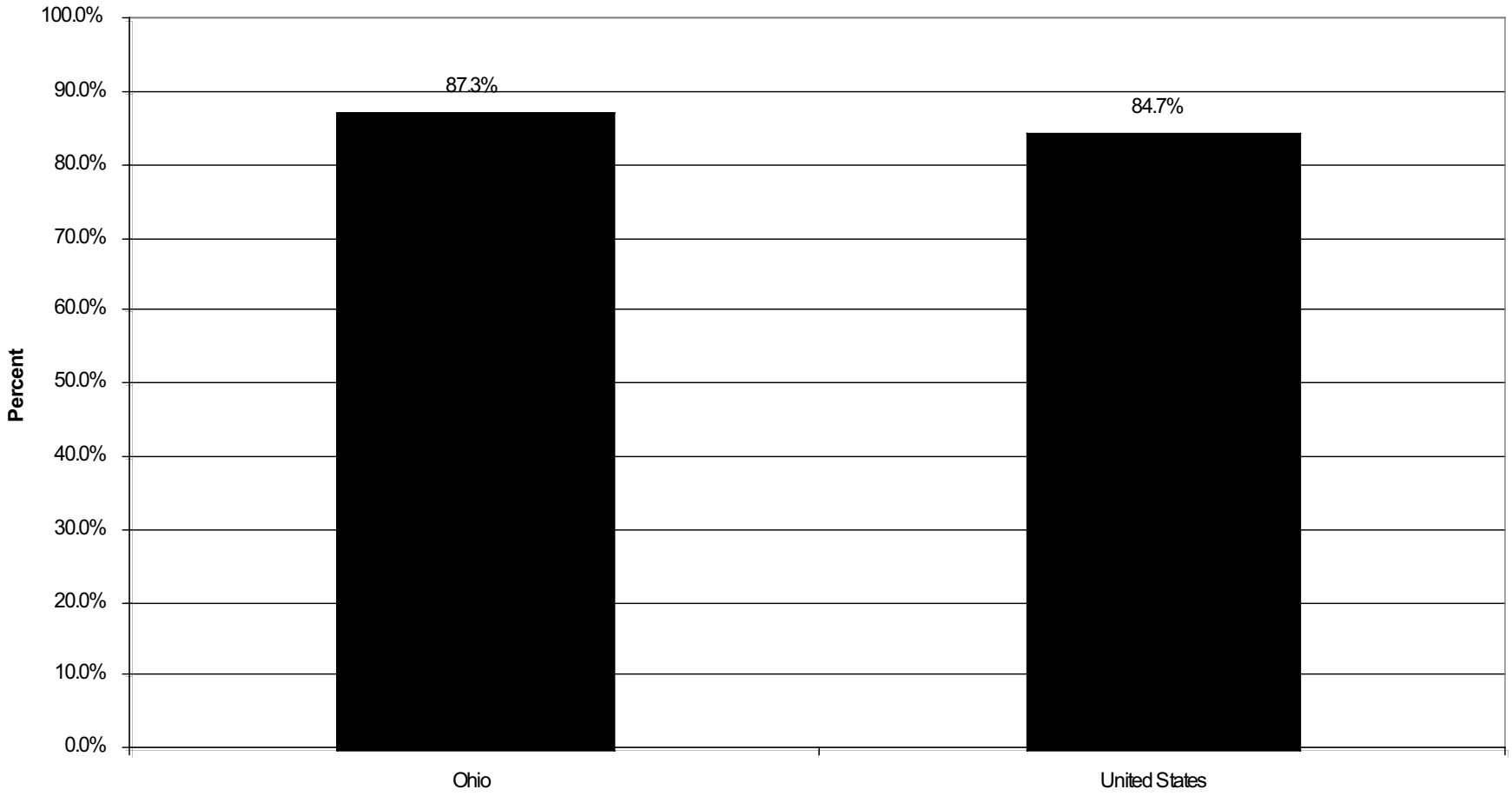
1. American Cancer Society
2. Ibid.
3. Ibid.

Women Over 40 Who Report Having at Least One Mammogram, Ohio versus United States, 1997



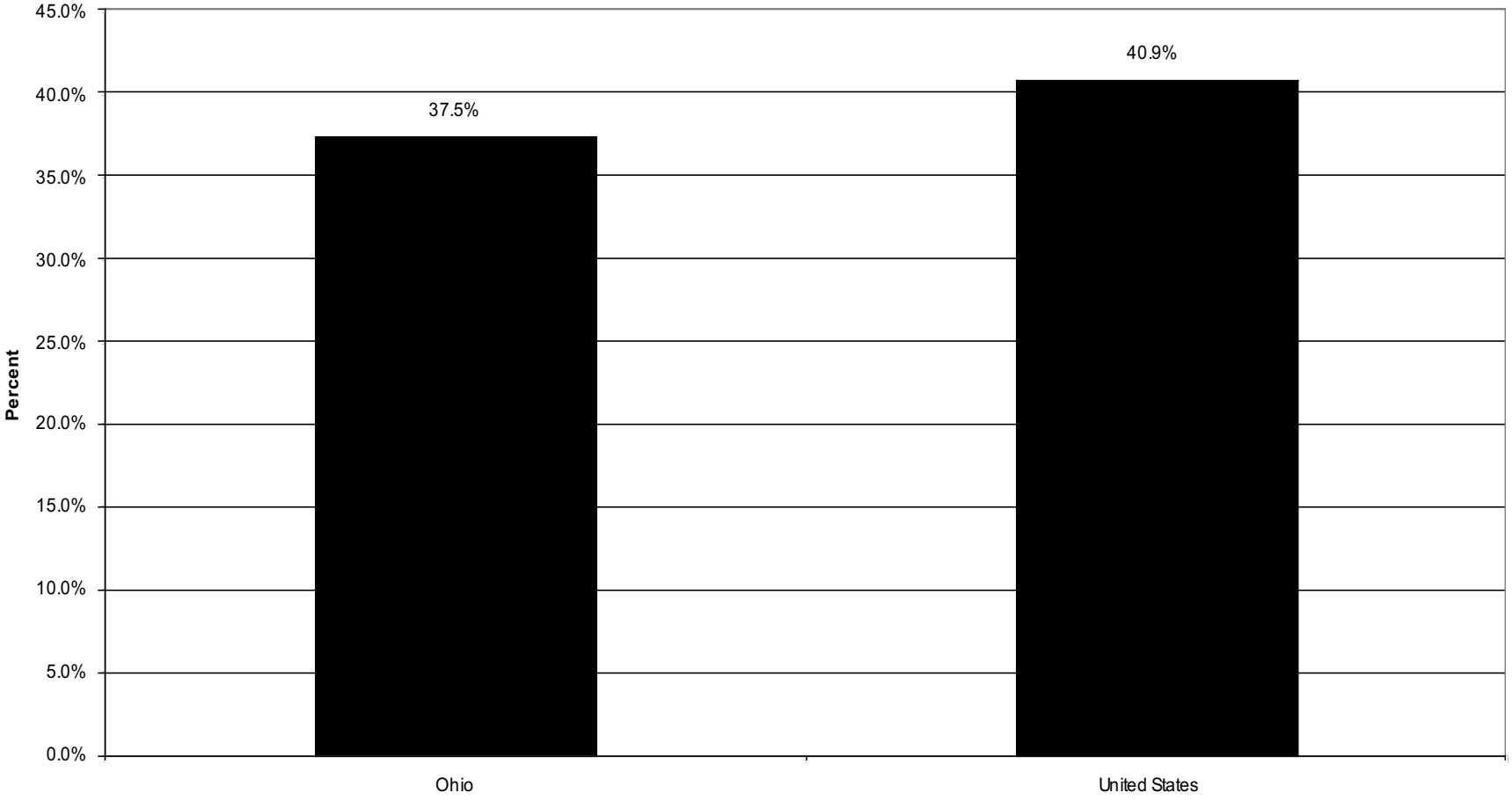
Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Women Who Report Having a PAP Smear in the Past 3 Years, Ohio versus the United States, 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Women Over 50 Who Report Having at Least One Proctoscopic Exam, Ohio versus the United States, 1997



Source: 1997 Behavioral Risk Factor Surveillance System, National Center for Health Statistics

Eating Disorders

- Eating disorders have reached epidemic proportions in the U.S. and affect all minorities and cross all social classes. It is estimated that over 7 million women and 1 million men are affected by an eating disorder. The two main eating disorders are anorexia nervosa and bulimia nervosa.

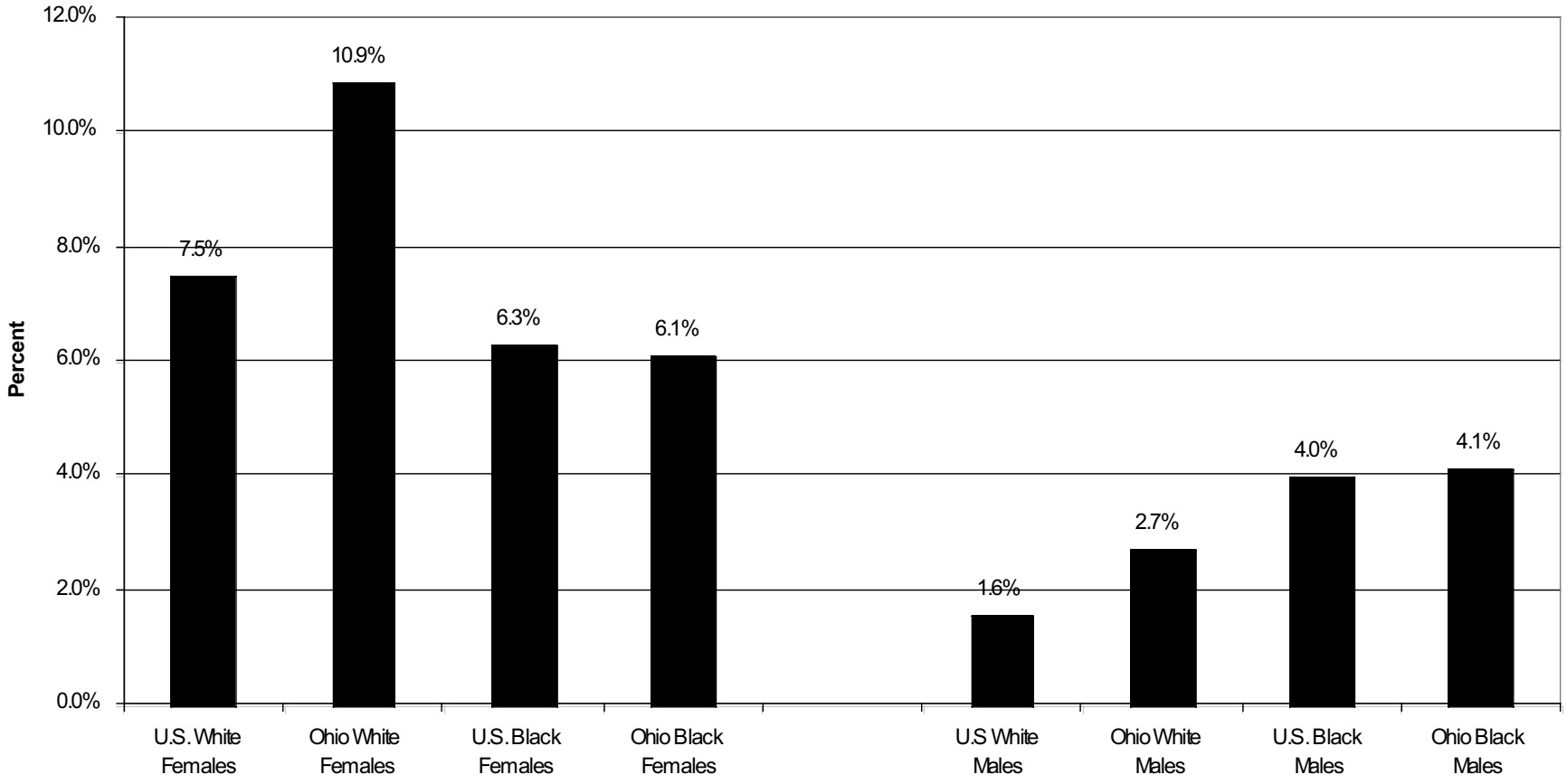
- The National Association of Anorexia Nervosa and Associated Disorders (ANAD) reports that 77 percent of individuals with an eating disorder report a duration of illness from 1 to 15 years with only 50 percent reporting being cured. It is estimated that six percent of serious cases die.[1]

- The cost of inpatient treatment can be $30,000 or more a month. The cost of outpatient treatment can exceed $100,000.[2]

References:

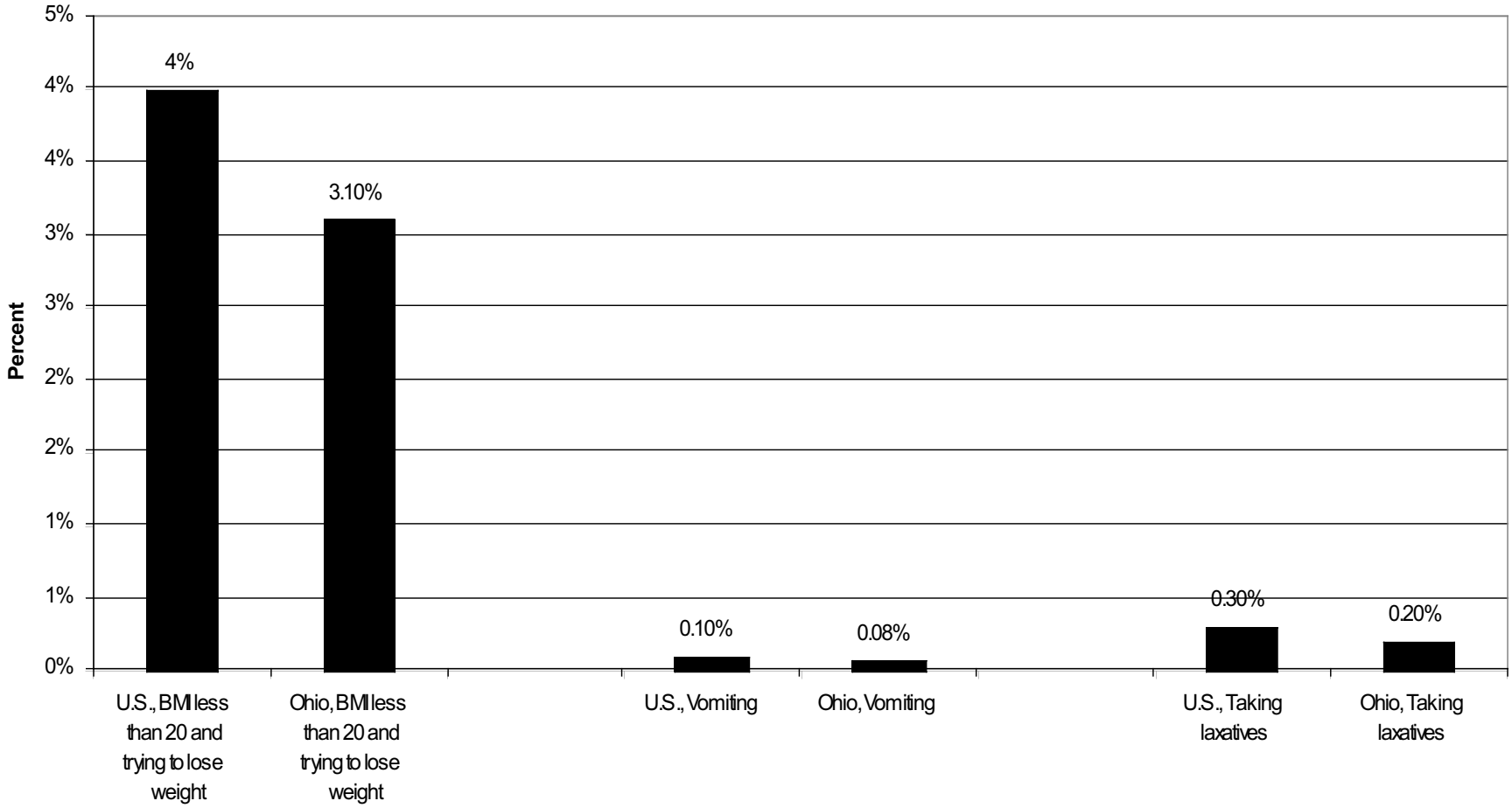
1. "Facts about Eating Disorders", ANAD, 1993.
2. 1993 Youth Risk Behavior Survey

Adolescents Who Reported Vomiting or Using Laxatives to Try and Lose Weight by Gender and Race, Ohio versus the United States, 1997



Source: Eating Disorders among Ohio Women, Office of Women's Health Initiatives, The Ohio Department of Health

Disordered Eating Patterns among Adults, Ohio versus the United States, 1993



BMI = Body Mass Index (body fat indicator)

Source: Eating Disorders among Ohio Women, Office of Women's Health Initiatives, The Ohio Department of Health

V. Use of the Health Care System

Health Insurance

- In Ohio, men and women report being uninsured at fairly equal rates: 13.5 percent of Ohio women versus 14.2 percent of Ohio men reported being uninsured.

- Low income women are most likely to be uninsured; 37.2 percent of women reporting a 1997 family income of less than $15,000 were uninsured in 1998 versus 3.7 percent of women reporting income of $35,000 or more. Among women with income between $25,000 and $35,000, 12.9 percent were uninsured.

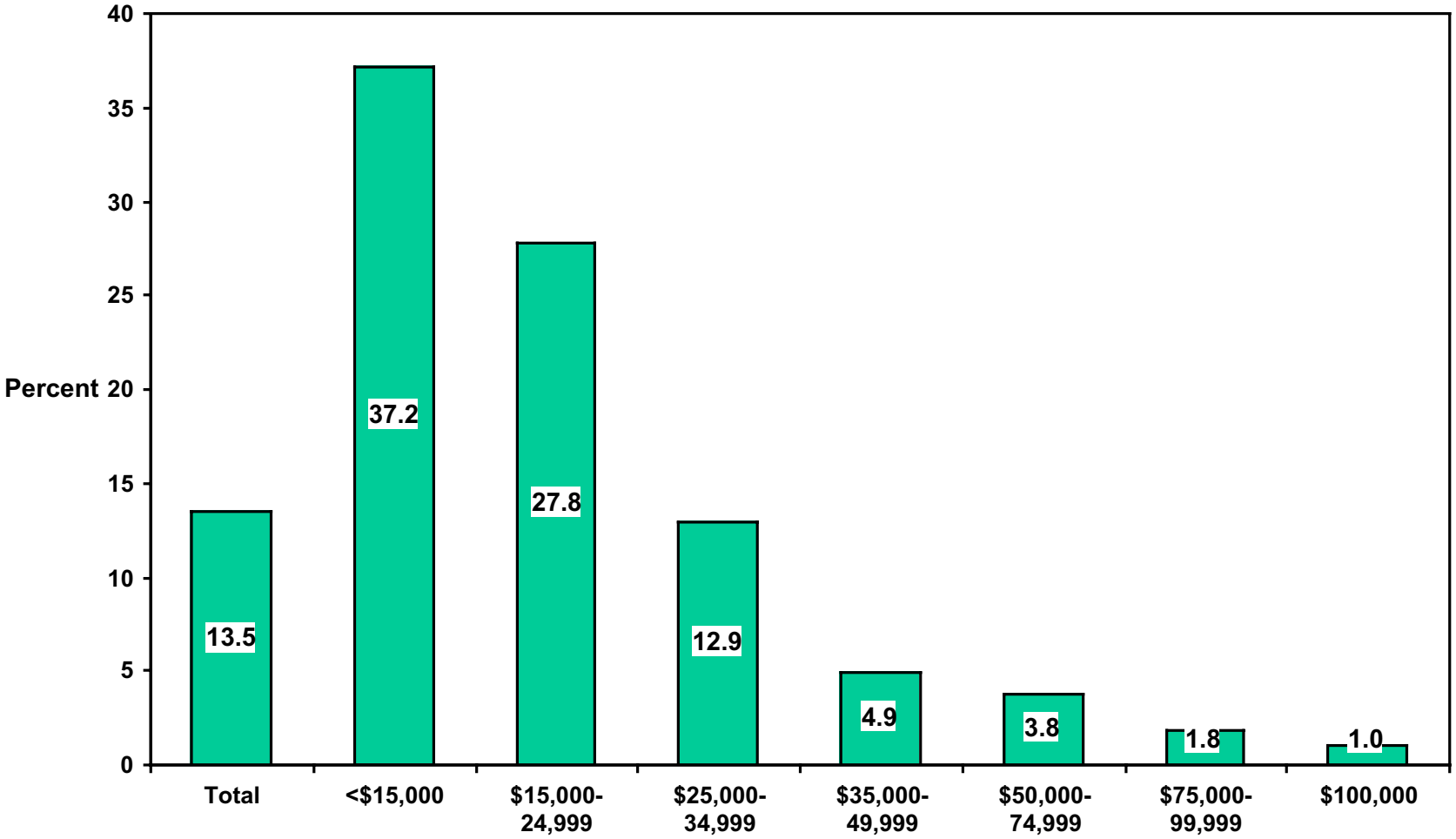
- Young adults are most likely to be without health insurance: 27.9 percent of Ohio women ages 18 to 24 years reported being uninsured.

- Black women are more than 1.5 times more likely than White women to be uninsured.

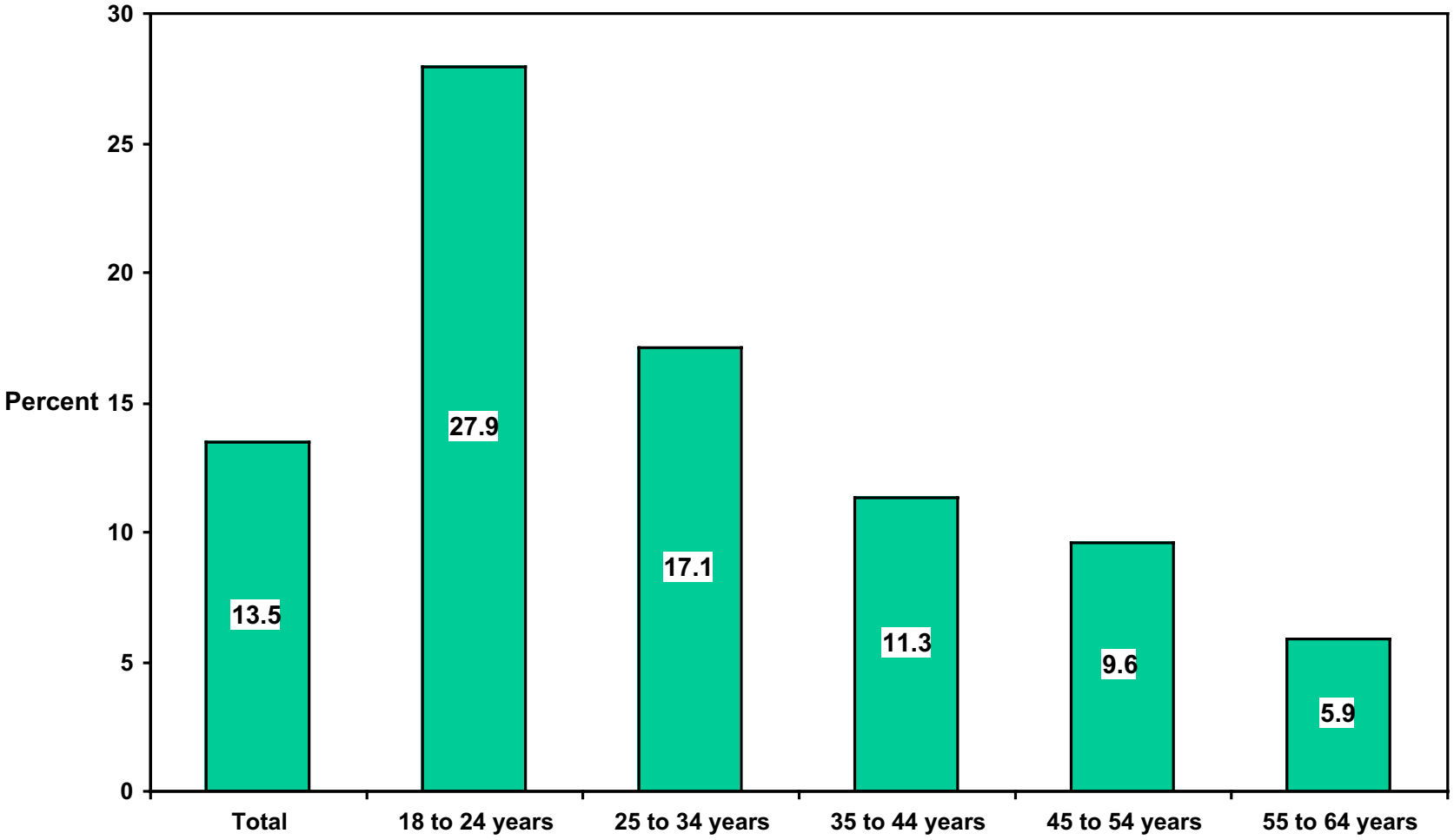
- Women who are not married are more likely to be uninsured: 26.2 percent of never married women or members of an unmarried couple reported being uninsured, compared to 8.1 percent of married women.

- Women were more likely to be covered as a dependent through another's employer-sponsored insurance than men: 50.2 percent of women versus 18.5 percent of men reported insurance coverage as a dependent.

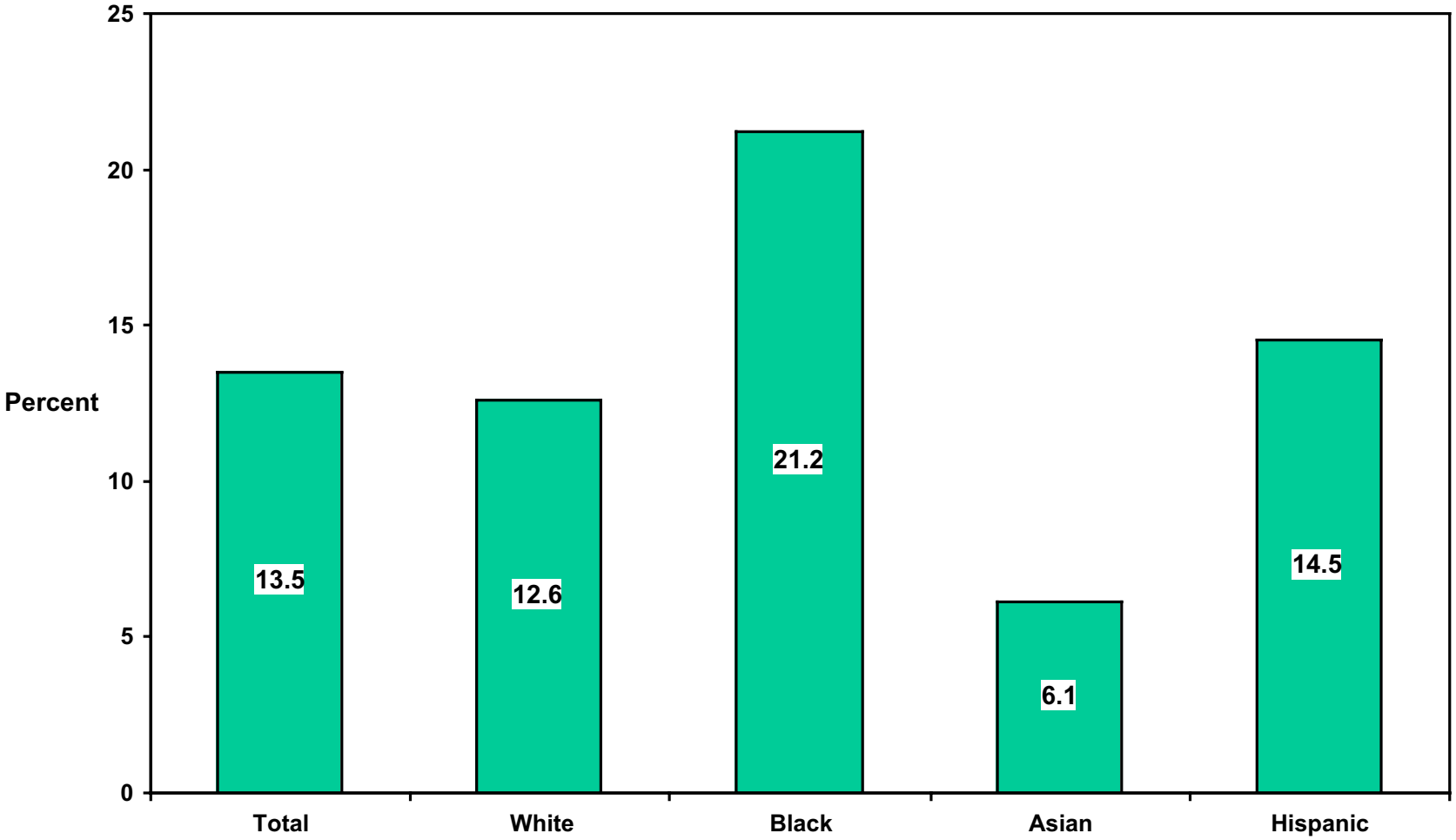
Percent of Ohio Women Uninsured by Income, 1998



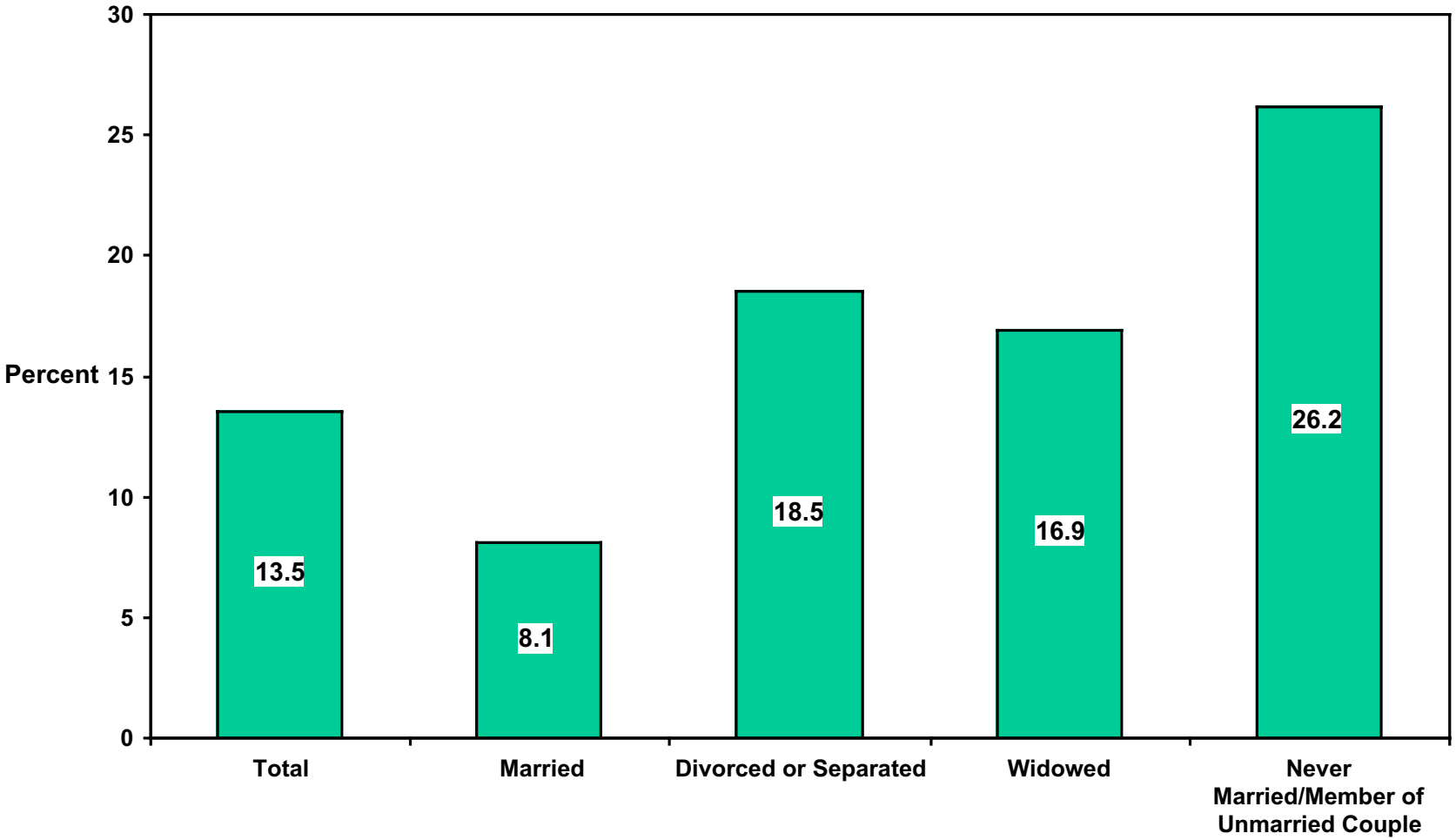
Percent of Ohio Women Uninsured by Age, 1998



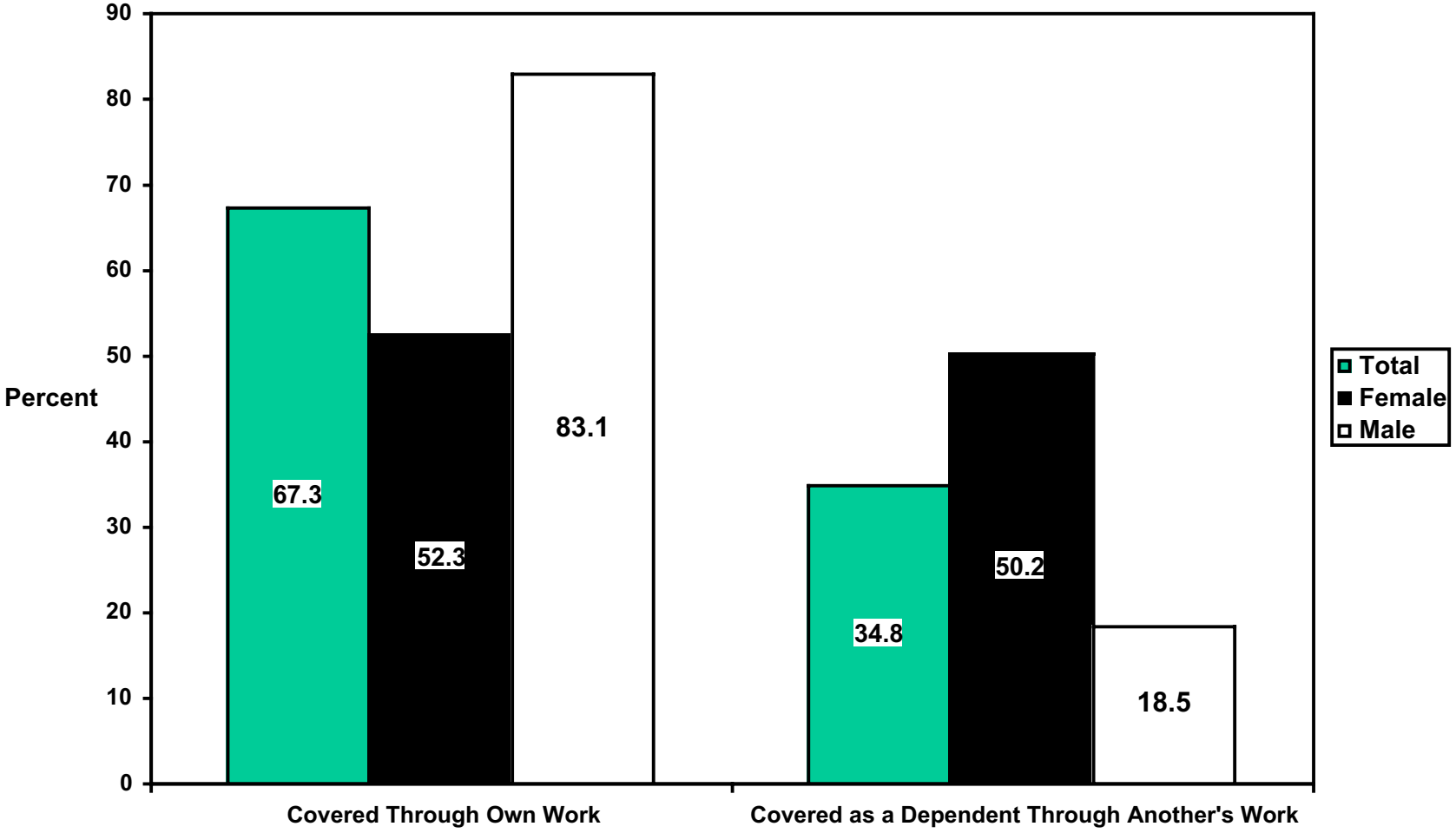
Percent of Ohio Women Uninsured by Race/Ethnicity, 1998



Percent of Ohio Women Uninsured by Marital Status, 1998



Policyholder Status of Ohioans with Employer-Based Insurance by Gender, 1998



Note: The percentages add up to more than 100 percent because some persons are insured in both categories.

Access to and Utilization of Health Care Services

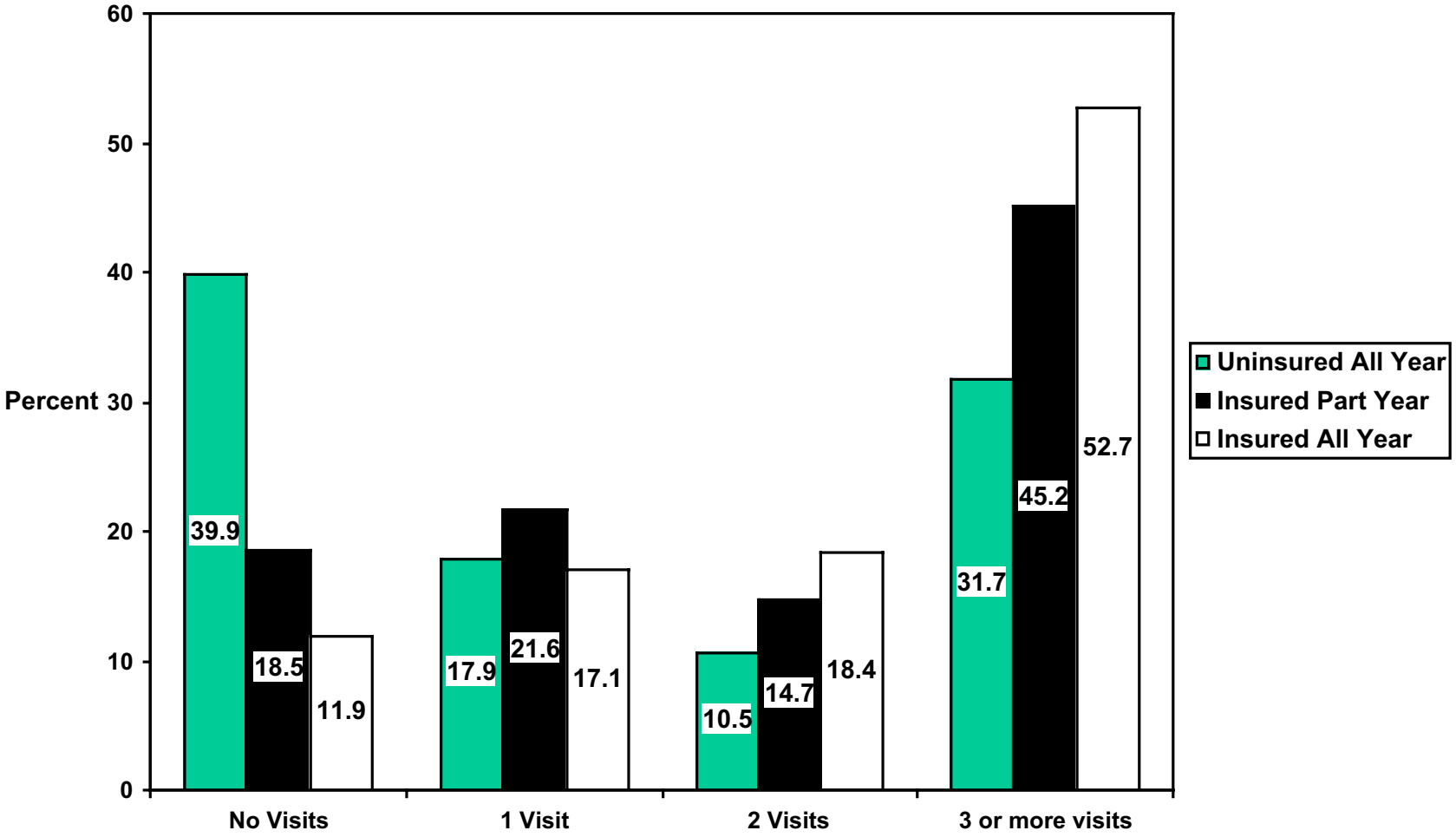
•*Uninsured* Ohio women were significantly more likely than *insured* Ohio women to report having no doctor or dental visits in the 12 month period prior to the survey. For doctor visits, close to 40 percent of women *uninsured* all year reported no doctor visit versus 11.9 percent of women *insured* all year. For dental visits, 63.9 percent of *uninsured* women reported no dental visit versus 30 percent of women *insured* all year.

•*Uninsured* Ohio women were significantly more likely than *insured* women to report no usual source of care: 23.9 percent of *uninsured* women reported no usual source of care versus 8.2 percent of *insured* women. Additionally, 10.6 percent of *uninsured* women versus 1.5 percent of *insured* women reported the emergency room as their usual source of care.

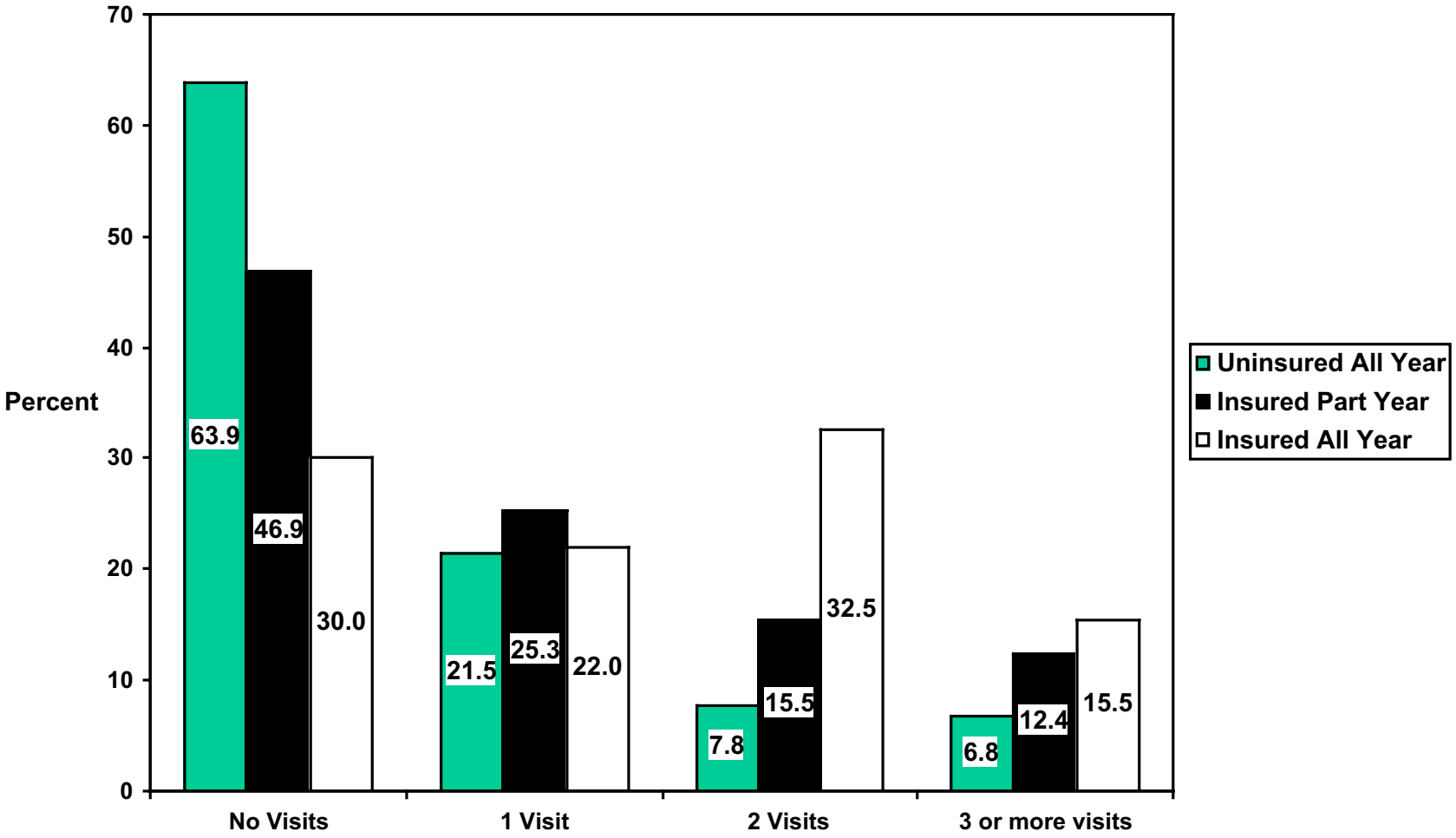
•*Uninsured* Ohio women were significantly less likely to report having a Pap test in the 12 month period prior to the survey than insured Ohio women: 30.4 percent of women *uninsured* all year reported having a Pap test versus 57.3 of women *insured* all year.

•*Uninsured* Ohio women were significantly less likely to report having a mammogram in the 12 month period prior to the survey than insured Ohio women: 19.8 percent of women *uninsured* all year reported having a mammogram versus 51.4 of women *insured* all year.

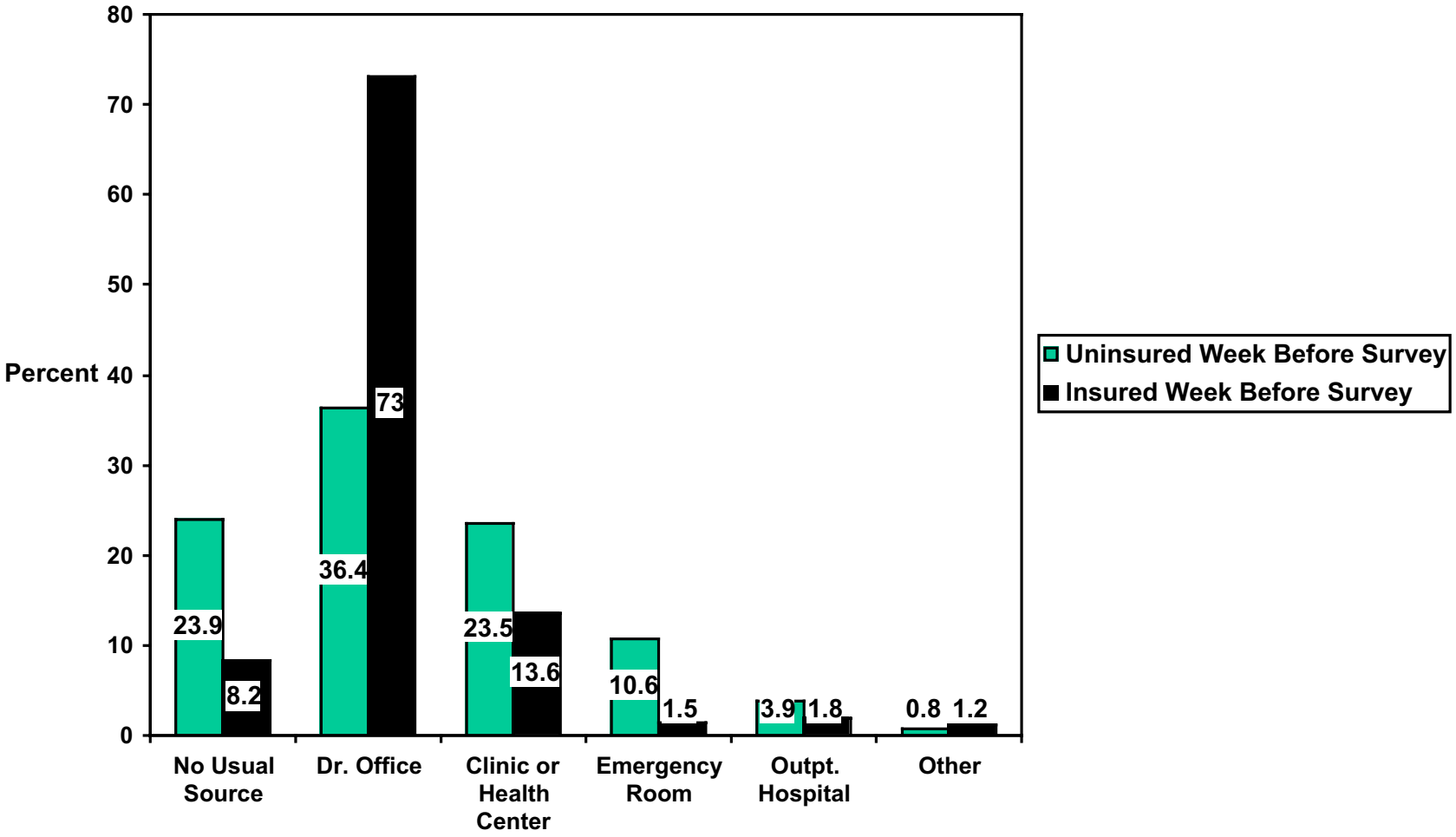
Doctor Visits in the Prior 12 Months Among Ohio Women by Health Insurance Status, 1997-98



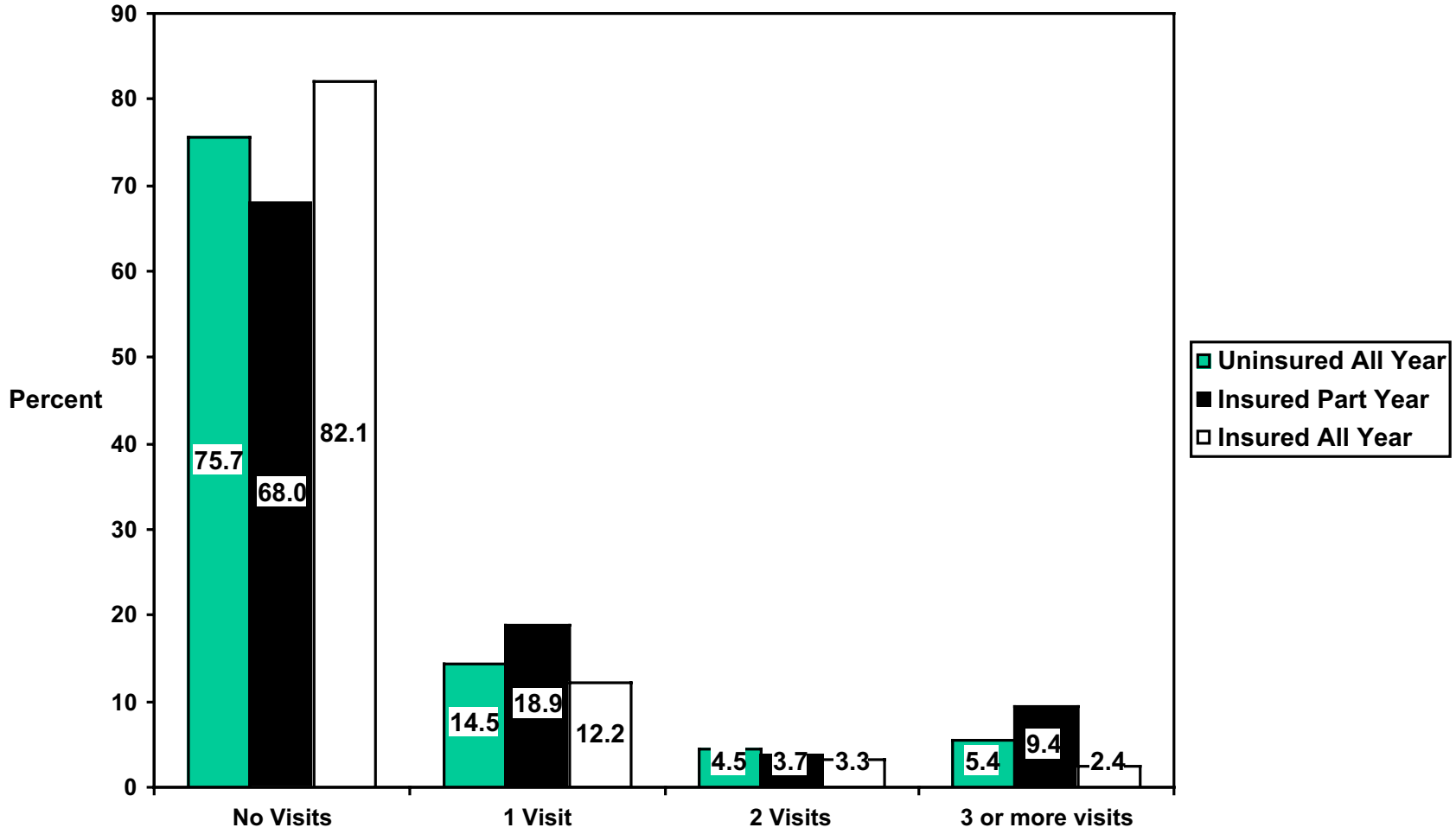
Dental Visits in the Prior 12 Months Among Ohio Women by Health Insurance Status, 1997-98



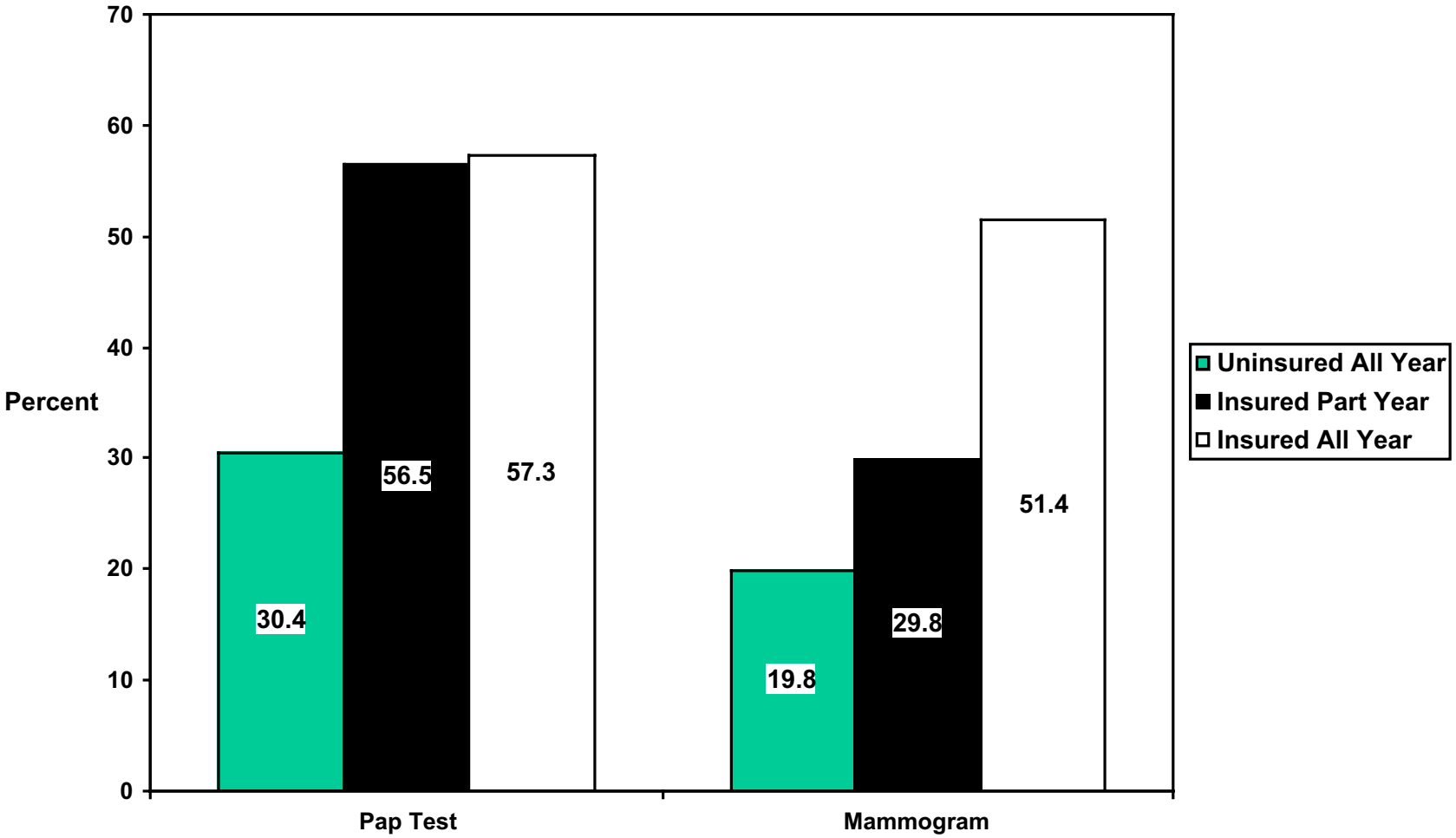
Usual Source of Care Among Ohio Women by Insurance Status, 1998



Emergency Room Visits in the Prior 12 Months Among Ohio Women by Health Insurance Status, 1997-98



Pap Tests and Mammograms in the Prior 12 Months, 1997-98



Long Term Care

- In Ohio, 75 percent of those enrolled in long-term care nursing facilities are women.[1]

- Nationally, about two-thirds of those under the care of a home health agency on an average day are women. Fifty-four percent of hospice patients are women.

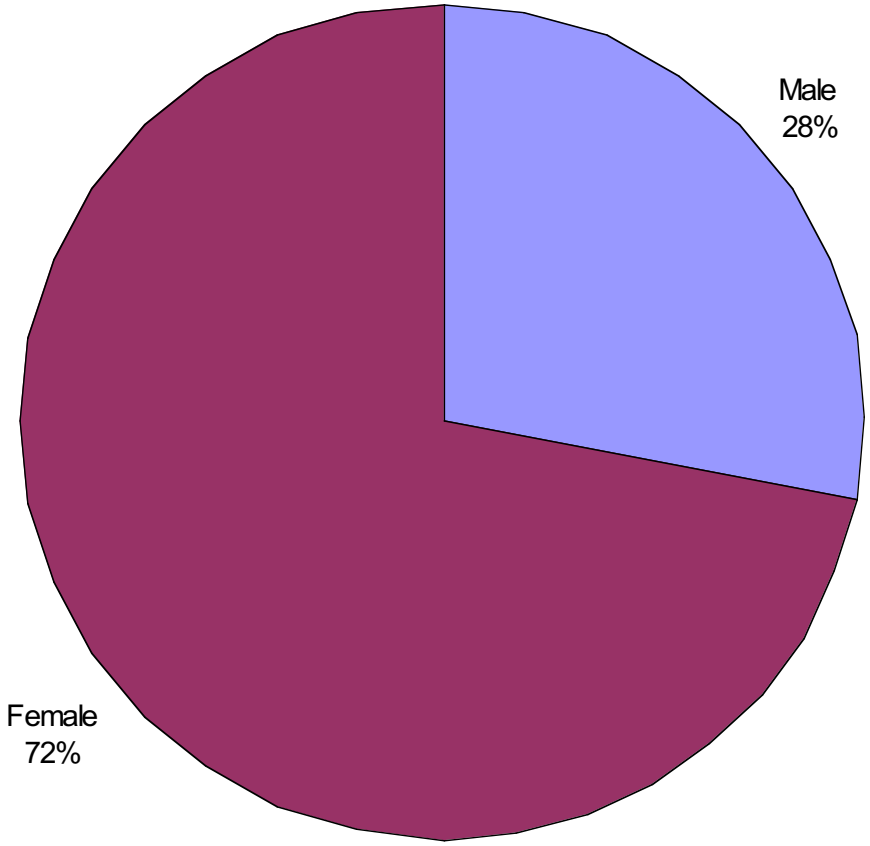
- Women rely more heavily on nursing facilities than men. Forty-five percent of women who reach age 65 use nursing home care at least once before death, compared to only 28 percent of men.

- Approximately 72 percent of caregivers are women.[2] According to the Select Committee on Aging, 19 percent of caregivers are daughters, 23 percent are wives, 20 percent are other women. Many of these women have other jobs outside the home.

References:

1. Ohio Department of Aging.
2. Fact Sheet: Selected Caregiver Statistics, Family Caregiver Alliance.

Ohio Nursing Home Facilities: Population by Gender, 1996



Source: Annual Survey of Long Term Care Facilities, Office of Policy, Planning and Data Center, ODH

Glossary

Age— Age is reported as age at last birthday, that is, age in completed years, often calculated by subtracting date of birth from the reference date, with the reference date being the date of the examination, interview, or other contact with an individual.

Age adjustment— Age adjustment, using the direct method, is the application of the age-specific rates in a population of interest to a standardized age distribution in order to eliminate the differences in observed rates that result from age differences in population composition. This adjustment is usually done when comparing two or more populations at one point in time or two or more points in time.

Anorexia nervosa— Extreme levels of dieting characterized by weight loss of more than 85 percent of the normal body weight, irregular or no menstruation, hair loss, poor body image, low self esteem, and an extreme fear of getting fat. Vomiting, abuse of laxatives, diuretics, and exercise may also be used in an attempt to control weight.

Atypical eating disorder— Signs and symptoms of eating disorders which are not severe enough to meet criteria for anorexia of bulimia nervosa. It is estimated that between 2-13 percent of middle and high school girls and 3-6 percent of postpubertal females are affected.

Average annual rate of change (percent change)— In this data book average annual rates of change or growth rates are calculated as follows:

$((P_n / P_o)^{1/N} - 1) \times 100$

where P_n = later time period
P_o = earlier time period
N = number of years in interval.

This geometric rate of change assumes that a variable increases or decreases at the same rate during each year between the two time periods.

Average length of stay— In the National Health Interview Survey, the average length of stay per discharged patient is computed by dividing the total number of hospital days for a specified group by the total number of discharges for that group. Similarly, in the National Hospital Discharge Survey, the average length of stay is computed by dividing the total number of days of care, counting the date of admission but not the date of discharge, by the number of patients discharged. The American Hospital Association computes the average length of stay by dividing the number of inpatient days by the number of admissions. As measured in the National Nursing Home Survey, length of stay for residents is the time from their admission until the reporting time, and the length of stay for Discharges is the time between the date of admission and the date of discharge.

Behavioral Risk Factor Surveillance System— (BRFSS) A unique, state-based surveillance system active in all 50 states. This is the primary source of state-based information on risk behaviors among adult populations. Since the early 1980s the CDC has worked with the states to develop questions designed to gather information from adults on their knowledge, attitudes, and practices related to issues such as health status and access to care, tobacco and alcohol use, dietary patterns, leisure-time physical activities, injury control including the use of seatbelts, women's health issues, use of preventive services, HIV and AIDS.

Birthweight— The first weight of the newborn obtained after birth. Low birthweight is defined as less than 2,500 grams or 5 pounds 8 ounces. Very low birthweight is defined as less than 1,500 grams or 3 pounds 4 ounces.

Bulimia nervosa— Characterized by consuming large amounts of high-calorie food in a relatively short time period, then using vomiting or laxatives to purge the food before it can be absorbed by the body. Weight usually stays within normal ranges, although there can be extreme fluctuations. The problem can usually remain hidden, although dentists may be the first to suspect it due to damage to the tooth enamel and gums.

Cause of death— For the purpose of national mortality statistics, every death is attributed to one underlying condition, based on information reported on the death certificate and utilizing the international rules for selecting the underlying cause of death from the reported conditions. Beginning with 1979 the *International Classification of Diseases, Ninth Revision* (ICD-9) has been used for coding cause of death.

Cause of death ranking— For infants, based on the List of 61 Selected Causes of Infant Death and HIV infection (ICD-9 Nos. 042-044). For other ages based on the List of 72 Selected Causes of Death and HIV infection. The List of 72 Causes of Death was adapted from one of the special lists for mortality tabulations recommended by the World Health Organization for use with the *Ninth Revision of the International Classification of Diseases*. Two group titles--Certain conditions originating in the perinatal period and Symptoms, signs and ill-defined conditions--are not ranked from the List of 61 Selected Causes of Infant Death; and two group titles--Major cardiovascular diseases and Symptoms, signs, and ill-defined conditions--are not ranked from the List of 72 Selected Causes. In addition, category titles that begin with the words "Other" and "All other" are not ranked. The remaining category titles are ranked according to number of deaths to determine the leading causes of death.

Current smoker— In 1992 the definition was modified to specifically include persons who smoked on "some days." Before 1992, a current smoker was defined by the following questions from the Health Interview Survey "Have you ever smoked 100 cigarettes in your lifetime?" and "Do you smoke now?" (traditional definition). Starting with 1993 data estimates of cigarette smoking prevalence are based on the revised question "Do you smoke everyday, some days, or not at all?" and this is considered a more complete estimate of smoking prevalence.

Family income— For purposes of survey, all people within a household related to each other by blood, marriage, or adoption constitute a family. Family income is the total income received by the members of a family in the 12 months before the interview.

Healthy People 2000— A national agenda which has grown out of a health strategy initiated in 1979 with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and expanded with publication in 1980 of *Promoting Health/Preventing Disease: Objectives for the Nation*, which set out an agenda for the ten years leading up to 1990. The purpose of Healthy People 2000 was to commit the Nation to the attainment of three broad goals:

1. Increase the span of healthy life for Americans
2. Reduce health disparities among Americans
3. Achieve access to preventive services for all Americans

Hispanic origin— Includes persons of Mexican, Puerto Rican, Cuban, Central and South American, and other or unknown Spanish origins. Persons of Hispanic origin may be of any race. See related *Race*.

ICD; ICD codes— See *Cause of death; International Classification of Diseases, Ninth Revision*.

Incidence— The number of cases of disease having their onset during a prescribed period of time. It is often expressed as a rate (for example, the incidence of measles per 1,000 children 5-15 years of age during a specified year). Incidence is a measure of morbidity or other events that occur within a specified period of time. See related *Prevalence*.

International Classification of Diseases, Ninth Revision (ICD-9)— Classifies mortality information for statistical purposes. The ICD was first used in 1900 and has been revised about every 10 years since then. The ICD-9, published in 1977, is used to code U.S. mortality date beginning with data year 1979.

Leading causes of death— See *Cause of death ranking*.

Length of stay— See *Average length of stay*.

Live birth— The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life such as heartbeat, umbilical cord pulsation, or definite movement of voluntary muscles, whether the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Mean length of stay— See *Average length of stay*.

Medicaid— A state operated and administered program having federal financial participation. Within certain broad federally determined guidelines, states decide who is eligible; the amount, duration, and scope of services covered; rates of payment for providers; and methods of administering the program. Medicaid provides health care services for certain low-income persons. Medicaid does not provide health services to all poor people in every state. It categorically covers participants in the Aid to Families with Dependent Children ("Ohio Works First") program and in the Supplemental Security Income program. In most states it also covers certain other people deemed to be medically needy. The program was authorized in 1965 by Title XIX of the Social Security Act.

Medicare— This is a nationwide health insurance program providing health insurance protection to people 65 years of age and over, people entitled to social security disability payments for two years or more, and people with end-stage renal disease, regardless of income. The program was enacted July 30, 1965, as Title XVIII, *Health Insurance for the Aged* of the Social Security Act, and became effective on July 1, 1966. It consists of two separate but coordinated programs, hospital insurance (Part A) and supplementary medical insurance (Part B).

Poverty level— Poverty statistics are based on definitions originally developed by the Social Security Administration. These include a set of money income thresholds that vary by family size and composition. Families or individuals with income below their appropriate thresholds are classified as below the poverty level. These thresholds are updated annually by the U.S. Bureau of the Census to reflect changes in the Consumer Price Index for all urban consumers.

Prevalence— The number of cases of a disease, infected persons, or persons with some other attribute present during a particular interval of time. It is often expressed as a rate (for example, the prevalence of diabetes per 1,000 persons during a year). See related *Incidence*.

Private insurance— Insurance offered by an employer or privately purchased by an individual.

Race— Beginning in 1976 the federal government's data systems classified individuals into the following racial groups: American Indian or Alaskan Native, Asian or Pacific Islander, Black and White. Depending on the data source, the classification by race may be based on self-classification or an observation by an interviewer or other persons filling out the questionnaire.

Rate— A measure of some event, disease, or condition related to a unit of population, along with some specification of time.

•*Birth and related rates*

Birth rate is calculated by dividing the number of live births in a population in a year by the midyear resident population. Birth rates are expressed as the number of live births per 1,000 population. The rate may be restricted to births to women of specific age, race, marital status, or geographic location (specific rate), or it may be related to the entire population (crude rate).

Fertility rate is the number of live births per 1,000 women of reproductive age, 15-44 years.

•*Death and related rates*

Death rate is calculated by dividing the number of deaths in a population in a year by the midyear resident population. Rates for the Hispanic and non-Hispanic white population in each year are based on unrounded State population estimates for as the number of deaths per 100,000 population. The rate may be restricted to deaths

in specific age, race, sex, or geographic groups or from specific causes of death (specific rate) or it may be related to the entire population (crude rate).

Fetal death rate is the number of fetal deaths with stated or presumed gestation of 20 weeks or more divided by the sum of live births plus fetal deaths. Late fetal death rate is the number of fetal deaths with stated or presumed gestation of 28 weeks or more divided by the sum of live births plus fetal deaths, stated per 1,000 live births plus late fetal deaths.

Infant mortality rate is calculated by dividing the number of infant deaths during a year by the number of live births reported in the same year. It is expressed as the number of infant deaths per 1,000 live births.

Smoker— See *Current smoker*.

State fiscal year— (SFY) Beginning on July 1 and ending on June 30 of the following year, in the state of Ohio.

Work disability— A specific physical or mental condition that occurred due to work.