Florida Commission on the Status of Women
and the
Florida Department of Health

Good Health for a Lifetime: A Woman's Guide

Women's Health Data Report

2008/2009

Joint Report

> Introduction

By the end of the 20th century, the average woman could look forward to a far longer and healthier life than her early-century counterpart. Her life expectancy at birth was about 80 years—a gain of more than 30 years compared to 1900, which was largely due to improved public health measures.

The major causes of death for women at the beginning of the century were infectious diseases. By the end of the century, the major causes of death were chronic illnesses. While much changed in women's health during the 20th century, one important factor did not: the major causes of death and disease remained largely preventable.

Fully 50 percent of the actual causes of death in the United States in the 1990's were attributed to behaviors such as smoking, poor diet, lack of exercise, alcohol abuse, illicit drug use, unsafe sex, motor vehicle accidents, pollution, and infectious agents. It is these behavioral factors that distinguish women of the late 1990s from those of the early century. It is also these factors that will continue to pose challenges for women's health in the 21st century.

This is why the Florida Commission on the Status of Women and the Florida Department of Health have made the focus of the report women's health. We hope it will be a useful resource in making for a healthier 21st century for Florida Women.

Mortality Trends in Women: 1900 and 1990

Leading Causes of Death	
1900	**1990**
Tuberculosis	Cardiovascular Disease
Syphilis	Cancer
Pneumonia	Stroke
Influenza	Diabetes

Source: http://www.womenshealth.gov/archive/owh/pub/century/chapter2.cfm

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Good Health for a Lifetime: A Woman's Guide

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Dear Fellow Floridian,

As our leaders in Washington train their focus on the issue of national health reform, the members of the Florida Commission on the Status of Women decided it important to study the state of women's health here at home in the Sunshine State. To that end, our 2009 annual report, Good Health For A Lifetime: A Woman's Guide, not only studies the current situation, but provides insights on more holistic, multi-dimensional wellness and prevention approaches moving forward, offering alternatives to the more customary linear path of disease management.

The Florida Legislature enabled and charged the Commission to not only study and report on the ever-changing roles of women in American society, but to explore and present new challenges to encourage and foster individual development. This annual report is designed to fulfill this mission at a time when it is evident that our basic methodologies must change if we are to be successful in meeting the diverse health care challenges at hand.

We believe it is clearly time to start "thinking outside of the box." Little is more important to a vibrant and flourishing society than a dedication to its health and well-being. To that end, we are pleased to present our Annual Report to the citizens of Florida for their thoughtful consideration.

Respectfully,

Claudia Kirk Barto
Chair,
Florida Commission on the Status of Women

Susanne Hebert
Annual Report Committee Chair

Mona Jain, M.D., Ph.D.
Florida Interagency Committee on Women's Health Member

> Acknowledgments

The Florida Commission on the Status of Women is dedicated to empowering women from all walks of life in achieving their fullest potential and to recognizing women's accomplishments.

The Florida Commission on the Status of Women (FCSW) is grateful to the many individuals whose knowledge and dedication made this report possible. This document would not be possible without the expertise of numerous women's health professionals and organizations, many of whom donated their expertise to this publication, including Commissioner Mona Jain, M.D., Ph.D. and Elsie B. Crowell, Ph.D. Past Commissioner and Chairwoman; US Department of Health and Human Services, Office on Women's Health; the U.S. Departments of Agriculture (USDA) and Health and Human Services (HHS); the American Heart Association / the American Lung Association; the National Cancer Institute; Congresswoman Debbie Wasserman Schultz; Robert W. Hoffman, D.O., FACP; and the Centers for Disease Control and Prevention.

We especially thank the Florida Department of Health Women's Health Program, Kimberly Berfield, Deputy Secretary of Health Officer of Women's Health Strategy, and Corine Mealing Stancil, M.P.H., M.Ed, Women's Health Coordinator, Women's Health Program, Florida Department of Health.

Noteworthy thanks to Florida Attorney General Bill McCollum for his leadership in making Florida a safer place for kids and Alexis Lambert, Assistant Attorney General for her guidance.

A special note of appreciation goes to the FCSW Annual Report Committee for their dedication to this project: Susanne Hebert, Chair, Laura McLeod, Janet Mabry, Laurie Pizzo, Carrie Estevez Lee, and Claudia Kirk Barto. Former Commissioner Dr. Jeanne O'Kon is thanked for her editorial assistance.

For their contributions throughout the creation of this report, FCSW employees Kimberly Mehr, Ebony Haynes, Michele S. Manning, CPM, and Kelly S. Sciba, APR, are thanked. FCSW would also like to extend our gratitude to Governor Charlie Crist, The Florida Legislature, Chief Financial Officer Alex Sink and Commissioner of Agriculture Charles Bronson for their continued support of the Commission and making this publication possible.

Part I

Good Health For A Lifetime: A Woman's Guide

> Florida Women's Health: A Status Report

by Commissioner Mona Jain, M.D., Ph.D. and Elsie B. Crowell, Ph.D. Past Commissioner and Chairwoman

Past: (1993-1996)

During the past years, the Florida Commission on the Status of Women (FCSW) has strengthened its efforts and continued to intensify community awareness and involvement regarding health issues affecting women across the life-span and the quality of life of Florida's communities. It is the desire of the Commission to have a positive impact on the health status of women and families especially in Florida and the nation in general.

This report will show that promotion, prevention, early intervention, diagnosis and treatment are important factors in women's health care. Women's health is not only a gender issue but also a human concern.

While Florida has made progress in reducing morbidity and mortality for some groups of women, wide variations still exist among racial and ethnic groups. During the time these reports were published, limited information and public awareness existed about the significant death rates among women caused by heart disease. We are pleased that since that time, aggressive publicity is now underway to inform the public and women in particular about the causes of heart disease and to share appropriate prevention strategies for heart health. The month of February is now designated as "Go Red" in an effort to spotlight and focus on heart disease in women and to inform health care professionals in general. Recently, we are learning that more women than men are suffering from strokes. Reducing the prevalence of high blood pressure and high cholesterol levels is essential in preventing and/or minimizing the chance of a stroke.

From an historical perspective, it is important to review the earlier recommendations of the FCSW Annual Reports dating back to 1993 and 1996. The following recommendations and assessments remain critical and relevant.

1. Conduct research in Florida to determine the extent of gender differences in medical interventions. Shortly after the Commission completed its 1992 report, the National Institutes of health announced the establishment of the Women's Health Initiative which was designed to address many important health issues facing women. The subset for this major clinical trial was based in two Florida cities and universities: Dr. Marian Limacher, Principal Investigator, University of Florida in Gainesville and Dr Marianna Baum, Principal Investigator, University of Miami.

2. Develop a systematic method for collecting and reporting women's health data. Progress was made in this area as a direct result of the Commission's recommendations in addition to follow-up letters to each agency responsible for providing such data.

3. Develop and conduct public educational campaigns to inform women about prevention measures to protect themselves against diseases.

4. Develop promotional materials for distribution to employers emphasizing the importance and cost-efficiency of providing health coverage for women.

The Commission supported the Small

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Employers Health Care Access Act passed by the 1992 Florida Legislature. This Act provided for health insurance plan to small business employers regardless of health claims experience of an employee in that group. The benefits include guarantee issue, portability, standard and basic health plans and modified community rating.

5. Establish required courses in Florida's medical schools that address a holistic approach to women's health care. The National Institute of Health Initiative completed an evaluation of curricula in each medical school in the U.S. The evaluation was designed to look at how much was required of student's in addressing women's health.

6. Train all participants working with and in the Judicial System in domestic violence. Since the initial health report was published, the Governor's Task Force on Domestic Violence recommended extensive changes to include increased awareness and providing training to the law enforcement community. Many of the recommendations were included in a series of statutory changes by the Florida legislative. Florida remains one of the leading states in enacting domestic violence laws to train and protect victims of domestic violence.

7. Provide access to long-term care for Florida's elderly population. Since the FCSW Report, The Commission on Long-Term Care in Florida was created under proviso language under the 1994-1995 General Appropriation Act. Its mission was to re-address comprehensively the existing programming and financing of services that provide a continuum of care for the people of Florida. The majority of Florida's population requiring long-term care services are women. The Department of Elderly Affairs was created in to provide more focused and extensive attention to elderly. The Long-Term Care Ombudsman Program was created to investigate and resolve complaints by residents of long-term care facilities. These concerns may range from issues with medication, appropriate health care and protection of legal rights.

8. Create and staff a permanent Women's Health Bureau in the State of Florida.

9. Establish a central health resource center for Florida Women.

10. Research the topic of women's mental health: lack of adequate insurance coverage for diagnosis and treatment.

The Present (2007-2009)

Since these earlier recommendations were published, we are pleased to report significant progress in all areas. According to the Department of Health's Annual Report (2007), an officer of Women's Health Strategy was created by the 2004 legislature, (section 381.04015, Florida Statutes) within the Department of Health for the purpose of improving the overall health status of women in Florida through research, awareness, and education. Specific policy issues and directions are provided to the Department of health to address a wide range of issues relating to women's health. Those specifically relating and applicable to the FCSW's past recommendations are as follows.

- Assess the health status of women through the collection of health data and trend.
- Review the state's insurance code as

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it relates to women's health issues.

- Work with medical school curriculum committees to develop course requirements on women's health.
- Promote employer incentives for wellness programs.
- Serve as the primary state resource for women's health information.
- Develop a statewide, web-based clearinghouse on women's health issues and resources.
- Promote public awareness campaigns and education on the health needs of women.

Unfortunately, according to Florida's Vital Statistics Report (2006), heart disease remains the leading cause of death among women of all races/ethnicity groups. Strokes and cancer also remain significant causes of death after heart disease. The top ten causes vary by race/ethnicity. For example, HIV is the fifth leading cause of death in Black women. Yet, HIV is not among the top ten causes of death for any other group (race/ethnicity) of women.

In many cases, health is related to the accessibility of care which can depend on economics-the affordability of health coverage and insurance. Lack of insurance coverage is one of the main barriers to affordable and quality health care for families. The largest racial/ethnicity component of the uninsured people in the U.S, and Florida is Hispanics. Health disparity rates are more pervasive among Blacks, Hispanics, low-income and uninsured patients than white, high-income and insured patients (Crowell, 2008; Commonwealth Fund, 2006). Florida ranks number three after Texas and New Mexico with the highest uninsured rate at 20.3 percent. One in five or 3.6 million Floridians were uninsured in 2006 (De-Navas-Walt, Proctor & Smith, 2007). Anthony Esbcobio, director of patient financial services at Tampa General Hospital told the St Petersburg Times that his institution had experienced a 39 percent increase in uninsured patients between 2004 and 2006 (Crowell, 2008; Huntley & Nohlgren, 2007). These uninsured rates complicate the ability of women and families to be proactive in responding to recommended health prevention screenings and subsequent treatment.

February 4, 2009, President Obama signed the State Children's Health Insurance Bill (SCHIP). The reauthorization of this program will expand coverage to four million more children and eliminates a five-year waiting period for legal documented immigrant. The approval of this program is expected to expand health insurance coverage to additional families, thereby providing increased access to basic health care. (www.whitehouse.gov).

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> Recommended Screenings and Immunizations

by US Department of Health and Human Services, Office on Women's Health www.womenshealth.gov

Getting regular check ups, preventive screening tests, and immunizations are among the most important things you can do for yourself. Take time to review the following guidelines for screening tests and immunizations. Use the charts to remind yourself of when you need to see your doctor or nurse based on your personal health profile. Make an appointment today!

Then, become a partner with your doctor or nurse to decide when you need your screenings and immunizations. Share your family history, speak up, voice your concerns, and always ask questions. For instance, if your doctor or nurse asks you to increase the amount you exercise, ask for examples of exercises that are best for you. If you are confused about how to do a monthly breast self-exam, ask and practice until you understand and feel comfortable doing it. If you are wondering if you need certain screenings, ask your doctor or nurse. You owe it to yourself.

Prevention is the key to living long and living well. Getting preventative screenings and immunizations are among the most important things you can do for your health. Take time to review these guidelines for screening tests and immunizations. Your healthcare provider will personalize the timing of each test and immunizations to meet your individual health needs.

Visit http://www.womenshealth.gov

Women Ages 18—39

Screening Tests	When/How Often
General health: Full checkup, including weight and height	Discuss with your healthcare provider.
Thyroid test (TSH)	Starting at age 35, then every 5 years
Heart health: Blood pressure	At least every 2 years
Heart health: Cholesterol test	Start at age 20, discuss with your healthcare provider
Diabetes: Blood glucose test	Discuss with your healthcare provider.
Reproductive health: Pap test and pelvic exam	Every 1—3 years if you have been sexually active or are older than 21
Sexually transmitted infections (STI) tests	Both partners should get tested for STIs, including HIV, before initiating sexual intercourse.
Mental health screening	Discuss with your healthcare provider.
Colorectal health: rectal exam	Discuss with your healthcare provider.
Eye and ear health: Complete eye exam	At least once between the ages 20 and 29 ant at least twice between the ages of 30 and 39, or any time you have a problem with your eye(s)
Eye and ear health: hearing test	Starting at age 18, then every 10 years
Skin health: mole exam	Monthly self-exam; by a doctor every 3 years, starting at age 20
Oral health: dental exam	One to two times every year

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 18—39

Immunizations	When/How Often
Influenza vaccine	Discuss with your healthcare provider.
Tetanus-diphtheria booster vaccine	Every ten years
Human Papilloma virus (HPV) vaccine	Up to age 26, discuss with your healthcare provider.
Meningococcal vaccine	Discuss with your healthcare provider. If attending college.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 40-49

Screening Tests	When/How Often
General health: Full checkup, including weight and height	Discuss with your healthcare provider.
Thyroid test (TSH)	Every 5 years
Heart health: Blood pressure	At least every 2 years
Heart health: Cholesterol test	Discuss with your healthcare provider.
Diabetes: Blood glucose test	Starting at age 45, then every 3 years
Reproductive health: Pap test and pelvic exam	Every 1—3 years
Sexually transmitted infections (STI) tests	Both partners should get tested for STIs, including HIV, before initiating sexual intercourse.
Mental health screening	Discuss with your healthcare provider.
Colorectal health: Rectal exam	Discuss with your healthcare provider.
Eye and ear health: Complete eye exam	Every 2-4 years
Eye and ear health: Hearing test	Starting at age 18, then every 10 years
Skin health: Mole exam	Monthly self-exam; by a doctor every year
Oral health: Dental exam	One to two times every year
Bone health: Bone mineral density test	Discuss with your healthcare provider.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 40—49

Immunizations	When/How Often
Influenza vaccine	Discuss with your healthcare provider.
Tetanus-diphtheria booster vaccine	Every ten years

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 50-64

Screening tests	When/How Often
General health: Full checkup, including weight and height	Discuss with your healthcare provider.
Thyroid test (TSH)	Every 5 years
Heart health: Blood pressure	At least every 2 years
Heart health: Cholesterol test	Discuss with your healthcare provider.
Diabetes: Blood glucose test	Every 3 years
Reproductive health: Pap test and pelvic exam	Every 1—3 years
Sexually transmitted infections (STI) tests	Both partners should get tested for STIs, including HIV, before initiating sexual intercourse.
Mental health screening	Discuss with your healthcare provider.
Colorectal health: Fecal occult blood test	Yearly
Flexible sigmoidoscopy	Every 5 years (if not having a colonoscopy)
Double contrast barium enema (DCBE)	Every 5—10 years (if not having colonoscopy)
Colonoscopy	Every 10 years
Rectal exam	Every 5-10 years with each rectal screening
Eye and ear health: Complete eye exam	Every 2-4 years
Eye and ear health: Hearing test	Every 3 years
Skin health: Mole exam	Monthly self-exam; by a doctor every year
Oral health: Dental exam	One to two times every year
Bone health: Bone mineral density test	Discuss with your healthcare provider.
Breast health: Mammogram	Every 1—2 years. Discuss with your healthcare provider.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 50-64

Immunizations	When/How Often
Influenza vaccine	Yearly
Tetanus-diphtheria booster vaccine	Every ten years
Herpes zoster vaccine (to prevent shingles)	Starting at age 60, one time only. Ask your doctor if it is okay to get it.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 65 and older

Screening tests	When/How Often
General health: Full checkup, including weight and height	Discuss with your healthcare provider.
Thyroid test (TSH)	Every 5 years
Heart health: Blood pressure	At least every 2 years
Heart health: Cholesterol test	Discuss with your healthcare provider.
Diabetes: Blood glucose test	Every 3 years
Reproductive health: Pap test and pelvic exam	Discuss with your healthcare provider.
Sexually transmitted infections (STI) tests	Both partners should get tested for STIs, including HIV, before initiating sexual intercourse.
Mental health screening	Discuss with your healthcare provider.
Colorectal health: Fecal occult blood test	Yearly
Flexible sigmoidoscopy	Every 5 years (if not having a colonoscopy)
Double contrast barium enema (DCBE)	Every 5—10 years (if not having colonoscopy)
Colonoscopy	Every 10 years
Rectal exam	Every 5-10 years with each rectal screening
Eye and ear health: Complete eye exam	Every 1-2 years
Eye and ear health: Hearing test	Every 3 years
Skin health: Mole exam	Monthly self-exam; by a doctor every year
Oral health: Dental exam	One to two times every year
Bone health: Bone mineral density test	At least once. Discuss with your healthcare provider about repeat testing.
Breast health: Mammogram	Every 1—2 years. Discuss with your healthcare provider.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

Women Ages 65 and older

Immunizations	When/How Often
Influenza vaccine	Yearly
Tetanus-diphtheria booster vaccine	Every ten years
Pneumococcal vaccine	One time only
Herpes zoster vaccine (to prevent shingles)	Starting at age 60, one time only. Ask your doctor if it is okay to get it.

Source: U.S. Department of Health and Human Services, Office on Women's Health; www.womenshealth.gov

> Nutritional Guidelines

by The U.S. Departments of Agriculture (USDA) and Health and Human Services (HHS)
http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2005/2005DGConsumerBrochure.pdf

You may be eating plenty of food, but not eating the right foods that give your body the nutrients you need to be healthy. You may not be getting enough physical activity to stay fit and burn those extra calories. This booklet is a starting point for finding your way to a healthier you.

Eating right and being physically active aren't just a "diet" or a "program"—they are keys to a healthy lifestyle. With healthful habits, you may reduce your risk of many chronic diseases such as heart disease, diabetes, osteoporosis, and certain cancers, and increase your chances for a longer life.

The sooner you start, the better for you, your family, and your future. Find more specific information at www.healthierus.gov/dietaryguidelines.

Make smart choices from every food group.
The best way to give your body the balanced nutrition it needs is by eating a variety of nutrient-packed foods every day. Just be sure to stay within your daily calorie needs. A healthy eating plan is one that:

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products.
- Includes lean meats, poultry, fish, beans, eggs, and nuts.

Is low in saturated fats, transfats, cholesterol, salt (sodium), and added sugars.

Mix up your choices within each food group.
Focus on fruits. Eat a variety of fruits—whether fresh, frozen, canned, or dried—rather than fruit juice for most of your fruit choices. For a 2,000-calorie diet, you will need 2 cups of fruit each day (for example, 1 small banana, 1 large orange, and 1/4 cup of dried apricots or peaches).

Vary your veggies. Eat more dark green veggies, such as broccoli, kale, and other dark leafy greens; orange veggies, such as carrots, sweetpotatoes, pumpkin, and winter squash; and beans and peas, such as pinto beans, kidney beans, black beans, garbanzo beans, split peas, and lentils.

Make half your grains whole. Eat at least 3 ounces of whole-grain cereals, breads, crackers, rice, or pasta every day. One ounce is about 1 slice of bread, 1 cup of breakfast cereal, or 1/2 cup of cooked rice or pasta. Look to see that grains such as wheat, rice, oats, or corn are referred to as "whole" in the list of ingredients.

Get your calcium-rich foods. Get 3 cups of low-fat or fat-free milk—or an equivalent amount of low-fat yogurt and/or low-fat cheese (11/2 ounces of cheese equals 1 cup of milk)—every day. For kids aged 2 to 8, it's 2 cups of milk. If you don't or can't consume milk, choose lactose-free milk products and/or calcium-fortified foods and beverages.

Go lean with protein. Choose lean meats and poultry. Bake it, broil it, or grill it. And vary your protein choices—with more fish, beans, peas, nuts, and seeds.

Get the most nutrition out of your calories. There is a right number of calories for you to eat each day. This number depends on your age, activity

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level, and whether you're trying to gain, maintain, or lose weight.* You could use up the entire amount on a few high-calorie items, but chances are you won't get the full range of vitamins and nutrients your body needs to be healthy.

Choose the most nutritionally rich foods you can from each food group each day—those packed with vitamins, minerals, fiber, and other nutrients but lower in calories. Pick foods like fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products more often.

- *2,000 calories is the value used as a general reference on the food label. But you can calculate your number at www.healthierus.gov/dietaryguidelines.*

Most packaged foods have a Nutrition Facts label. For a healthier you, use this tool to make smart food choices quickly and easily. Try these tips:

Keep these low: saturated fats, transfats, cholesterol, and sodium.

Get enough of these: potassium, fiber, vitamins A and C, calcium, and iron.

Use the % Daily Value (DV) column when possible: 5% DV or less is low, 20% DV or more is high.

Check servings and calories. Look at the serving size and how many servings you are actually consuming. If you double the servings you eat, you double the calories and nutrients, including the % DVs.

Make your calories count. Look at the calories on the label and compare them with what nutrients you are also getting to decide whether the food is worth eating. When one serving of a single food item has over 400 calories per serving, it is high in calories.

The food and physical activity choices you make every day affect your health—how you feel today, tomorrow, and in the future.

Don't sugarcoat it. Since sugars contribute calories with few, if any, nutrients, look for foods and beverages low in added sugars. Read the ingredient list and make sure that added sugars are not one of the first few ingredients. Some names for added sugars (caloric sweeteners) include sucrose, glucose, high fructose corn syrup, corn syrup, maple syrup, and fructose.

Know your fats. Look for foods low in saturated fats, transfats, and cholesterol to help reduce the risk of heart disease (5% DV or less is low, 20% DV or more is high). Most of the fats you eat should be polyunsaturated and monounsaturated fats. Keep total fat intake between 20% to 35% of calories.

Reduce sodium (salt), increase potassium. Research shows that eating less than 2,300 milligrams of sodium (about 1 tsp of salt) per day may reduce the risk of high blood pressure. Most of the sodium people eat comes from processed foods, not from the saltshaker. Also look for foods high in potassium, which counteracts some of sodium's effects on blood pressure.

> How Do I Read Food Labels

by the American Heart Association / the American Lung Association http://www.americanheart.org/

When you go grocery shopping, be certain to take take time to read the nutrition labels on your purchases. Compare nutrients and calories in one food to those in another. The information may surprise you. You want to make sure that you aren't bringing home foods high in saturated fat and cholesterol! One easy way to do "healthier" grocery shopping is to spend more time in the outer aisles of the store where fresh foods are kept. Spend less time in the middle aisles where packaged foods, snacks and soft drinks are stocked.

How do I read the label?

• Most foods in the grocery store must now have a nutrition label and list of ingredients.

• Claims like "low cholesterol" and "fat free" can be used only if a food meets legal standards set by the government.

- The "Nutrition Facts" label contains this information:

– Serving Size — If you eat double the serving size listed, you need to double the calories, fat and nutrients. If you eat half the size shown, cut the calories and nutrients in half.

– Calories — This is very helpful to know if you're cutting calories to lose weight.

– Total Fat — Most people need to cut back on calories and fat! Too much fat may contribute to heart disease and cancer. The label gives you the number of grams of fat per serving (so you can track your daily intake) and the number of calories from fat. If you are overweight or trying to lose weight, your goal is an overall intake of no more than 25 to 35 percent of your total calories from fat, with less than 7 percent as saturated fat and less than 1 percent as trans fat. You should keep track of the amount of calories you consume and the amount of calories you burn.

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– Saturated Fat — This is one part of the total fat in food. It's a key nutrient for raising your blood cholesterol and your risk of heart disease and stroke. Eat less saturated fat!

– Cholesterol — Too much of it in your diet may lead to too much of it in your blood. And too much cholesterol in your blood can lead to heart disease and stroke. It's best to eat less than 300 mg each day. People with heart disease, high LDL cholesterol levels or who are taking cholesterol medication should consume less than 200 mg of cholesterol per day.

– Sodium — Watch for both natural and added sodium. Ordinary table salt is sodium chloride — 40 percent sodium by weight. Healthy adults should take in less than 2,300 mg of sodium each day. That's equal to about 1 tsp. of salt. Some people — African Americans, middle-aged and older adults, and people with high blood pressure — need less than 1,500 mg per day.

– Total Carbohydrate —Emphasize fruits and vegetables, and whole-grain breads and cereals.

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– Dietary Fiber — Fruits, vegetables, whole grains, peas and beans are good sources and can help reduce the risk of heart disease.

– Protein — Where there's animal protein, there's also fat and cholesterol. Eat small portions.

– Vitamins and Minerals — Eating a variety of foods will help you reach your daily goal of 100 percent of vitamin A, vitamin C, calcium and iron.

– Daily Value — The daily values are guides for people who eat 2,000 calories each day. If you eat more or less than that, your daily value may be higher or lower. Choose foods with a low % daily value of fat, saturated fat, cholesterol and sodium. Try to reach 100 percent of the daily value of total carbohydrates, dietary fiber, vitamins and minerals.

How can I learn more?

1. Talk to your doctor, nurse or other health-care professionals. If you have heart disease or have had a stroke, members of your family also may be at higher risk. It's very important for them to make changes now to lower their risk.

2. Call 1-800-AHA-USA1 (1-800-242-8721) or visit americanheart.org to learn more about heart disease.

3. For information on stroke, call 1-888-4-STROKE (1-888-478-7653) or visit StrokeAssociation.org.

We have many other fact sheets and educational booklets to help you make healthier choices to reduce your risk, manage disease or care for a loved one. Knowledge is power, so Learn and Live!

Nutrition Facts

Serving Size 3 oz (85g)
Servings Per Container 1

Amount Per Serving	
Calories 180	Calories from Fat 90
	% Daily Value*
Total Fat 10g	**15%**
Saturated Fat 40g	**20%**
Trans Fat 0.5g	
Cholesterol 70mg	**23%**
Sodium 60mg	**3%**
Total Carbohydrate 0g	**0%**
Dietary Fiber 0g	**0%**
Sugars 0g	
Protein 22g	

Vitamin A 0%	•	Vitamin C 0%
Calcium 2%	•	Iron 15%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your caloric needs:

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Saturated Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodiuum	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

Calories per gram:
Fat 9 • Carbohydrate 4 • Protein 4

> Get Up and Get Moving: Physical Activity

by the US Department of Health and Human Services, 2008 Physical Activity Guidelines for Americans

All Americans should be regularly physically active to improve overall health and fitness and to prevent many adverse health outcomes. The benefits of physical activity occur in generally healthy people, in people at risk of developing chronic diseases, and in people with current chronic conditions or disabilities.

Regular activity can help prevent unhealthy weight gain and also help with weight loss, when combined with lower calorie intake. If you are overweight or obese, losing weight can lower your risk for many diseases. Being overweight or obese increases your risk of heart disease, high blood pressure, stroke, type 2 diabetes, breathing problems, osteoarthritis, gallbladder disease, sleep apnea (breathing problems while sleeping), and some cancers.

Regular physical activity can also improve your cardiorespiratory (heart, lungs, and blood vessels) and muscular fitness. For older adults, activity can improve mental function. Additional of the benefits of regular physical activity include:

- Reduces the risk of dying from coronary heart disease and of developing high blood pressure, colon cancer, and diabetes.
- Helps maintain healthy bones, muscles, and joints.
- Helps control weight, build lean muscle, and reduce body fat.
- Helps control joint swelling and pain associated with arthritis.
- May enhance the effect of estrogen replacement therapy in decreasing bone loss after menopause.
- Reduces symptoms of anxiety and depression and fosters improvements in mood and feelings of well-being.
- Can help reduce blood pressure in some women with hypertension.

Physical activity need not be strenuous to achieve health benefits.

Women of all ages benefit from a moderate amount of physical activity, preferably daily. The same moderate amount of activity can be obtained in longer sessions of moderately intense activities (such as 30 minutes of brisk walking) as in shorter sessions of more strenuous activities (such as 15-20 minutes of jogging).

Additional health benefits can be gained through greater amounts of physical activity. Women who can maintain a regular routine of physical activity that is of longer duration or of greater intensity are likely to derive greater benefit. However, excessive amounts of activity should be avoided, because risk of injury increases with greater amounts of activity, as does the risk of menstrual abnormalities and bone weakening.

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Previously sedentary women who begin physical activity programs should start with short intervals (5-10 minutes) of physical activity and gradually build up to the desired level of activity.

Women with chronic health problems, such as heart disease, diabetes, or obesity, or who are at high risk for these conditions should first consult a physician before beginning a new program of physical activity. Women over age 50 who plan to begin a new program of vigorous physical activity should first consult a physician to be sure they do not have heart disease or other health problems.

Health benefits are gained by doing the following each week:

- 2 hours and 30 minutes of moderate-intensity aerobic physical activity; *or*
- 1 hour and 15 minutes of vigorous-intensity aerobic physical activity; *or*
- A combination of moderate and vigorous-intensity aerobic physical activity *and* Muscle-strengthening activities on 2 or more days.

This physical activity should be in addition to your routine activities of daily living, such as cleaning or spending a few minutes walking from the parking lot to your office.

Moderate Activity
During moderate-intensity activities you should notice an increase in your heart rate, but you should still be able to talk comfortably. An example of a moderate-intensity activity is walking on a level surface at a brisk pace (about 3 to 4 miles per hour). Other examples include ballroom dancing, leisurely bicycling, moderate housework, and waiting tables.

FACTS
- More than 60 percent of U.S. women do not engage in the recommended amount of physical activity.
- More than 25 percent of U.S. women are not active at all.
- Physical inactivity is more common among women than men.
- Social support from family and friends has been consistently and positively related to regular physical activity.

Vigorous Activity
If your heart rate increases a lot and you are breathing so hard that it is difficult to carry on a conversation, you are probably doing vigorous-intensity activity. Examples of vigorous-intensity activities include jogging, bicycling fast or uphill, singles tennis, and pushing a hand mower.

Does the type of physical activity I choose matter?

Yes! Engaging in different types of physical activity is important to overall physical fitness. Your fitness routine should include aerobic and strength-training activities, and may also include stretching activities.

Aerobic activities
These activities move large muscles in your arms, legs, and hips over and over again. Examples include walking, jogging, bicycling, swimming, and tennis.

Strength-training activities
These activities increase the strength and endurance of your muscles. Examples of

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strength-training activities include working out with weight machines, free weights, and resistance bands. (A resistance band looks like a giant rubber band. You can buy one at a sporting goods store.) Push-ups and sit-ups are examples of strength-training activities you can do without any equipment. You also can use soup cans to work out your arms.

Aim to do strength-training activities at least twice a week. In each strength-training session, you should do 8 to 10 different activities using the different muscle groups throughout your body, such as the muscles in your abdomen, chest, arms, and legs. Repeat each activity 8 to 12 times, using a weight or resistance that will make you feel tired. When you do strength-training activities, slowly increase the amount of weight or resistance that you use. Also, allow one day in between sessions to avoid excess strain on your muscles and joints.

Stretching

Stretching improves flexibility, allowing you to move more easily. This will make it easier for you to reach down to tie your shoes or look over your shoulder when you back the car out of your driveway. You should do stretching activities after your muscles are warmed up — for example, after strength training. Stretching your muscles before they are warmed up may cause injury.

I am a larger woman. Can I be physically active?

Yes! You may face special challenges, but you can work hard to overcome them. You may not be able to bend or move in the same way that other people can. It may be hard to find clothes and equipment. You also may feel self-conscious being active around other people. But you can get past these hurdles. Keep trying different ways to make physical activity a part of your life. It is important to your health!

Activities such as swimming or exercising while seated put less stress on your joints because your legs are not supporting the weight of your body. If your feet or joints hurt when you stand, nonweight-bearing activities may be best for you. Ask your doctor for help in coming up with a physical activity plan that's right for you.

Remember that physical activity does not have to be hard or boring to be good for you. Anything that gets you moving around — even for only a few minutes a day — is a healthy start to getting more fit. Over time, you will be able to work out longer and vary the types of activity you can do.

If you commit to being physically active on a regular basis, your body will thank you because it can make a big difference to your health. Even if you do not lose weight, you will still lower your risk of getting many diseases by being physically active. And if you do lose weight, you'll get even more health benefits!

How much physical activity do I need to do to lose weight?

If you want to lose a substantial (more than 5 percent of body weight) amount of weight, you need a high amount of physical activity unless you also lower calorie intake. This is also the case if you are trying to keep the weight off. Many people need to do more than 300 minutes of moderate-intensity activity a week to meet weight-control goals.

For more information

For more information on physical activity, please call womenshealth.gov at 1-800-994-9662 or contact the following organizations:

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Nutrition and Physical Activity
MS K-46
4770 Buford Highway, NE
Atlanta, Georgia 30341-3724
1-888-CDC-4NRG or
1-888-232-4674 (Toll Free)
http://www.cdc.gov

The President's Council on Physical Fitness and Sports
Box SG
Suite 250
701 Pennsylvania Avenue, NW
Washington, DC 20004

Physical Activity Guidelines for Americans (2008), HHS, ODPHP
Phone: 800-336-4797
Internet Address: http://www.health.gov/paguidelines

Division of Nutrition and Physical Activity, NCCDPHP, CDC
Phone: (770) 488-6042
Internet Address: http://www.cdc.gov/nccdphp/dnpa/

Food and Nutrition Information Center, NAL, USDA
Phone: (301) 504-5414
Internet Address: http://www.nal.usda.gov/fnic/

HealthierUS.gov
Phone: (301) 565-4167
Internet Address: http://www.healthierus.gov/exercise.html

Weight Control Information Network, NIDDK, NIH, HHS
Phone: (877) 946-4627
Internet Address: http://www.niddk.nih.gov/health/nutrit/win.htm

American Council on Exercise
Phone: (888) 825-3636
Internet Address: http://www.acefitness.org/

America On the Move
Phone: (800) 807-0077
Internet Address: http://aom.americaonthemove.org/

> Heart Disease and Women

by US Department of Health and Human Services, Office on Women's Health www.womenshealth.gov

What is heart disease?
Heart disease includes a number of problems affecting the heart and the blood vessels in the heart. Types of heart disease include:

Coronary artery disease (CAD) is the most common type and is the leading cause of heart attacks. When you have CAD, your arteries become hard and narrow. Blood has a hard time getting to the heart, so the heart does not get all the blood it needs. CAD can lead to:

Angina (an-JEYE-nuh). Angina is chest pain or discomfort that happens when the heart does not get enough blood. It may feel like a pressing or squeezing pain, often in the chest, but sometimes the pain is in the shoulders, arms, neck, jaw, or back. It can also feel like indigestion (upset stomach). Angina is not a heart attack, but having angina means you are more likely to have a heart attack.

Heart attack. A heart attack occurs when an artery is severely or completely blocked, and the heart does not get the blood it needs for more than 20 minutes.

Heart failure occurs when the heart is not able to pump blood through the body as well as it should. This means that other organs, which normally get blood from the heart, do not get enough blood. It does not mean that the heart stops. Signs of heart failure include:

- Shortness of breath (feeling like you can't get enough air)
- Swelling in feet, ankles, and legs
- Extreme tiredness

Heart arrhythmias (uh-RITH-mee-uhz) are changes in the beat of the heart. Most people have felt dizzy, faint, out of breath or had chest pains at one time. These changes in heartbeat are harmless for most people. As you get older, you are more likely to have arrhythmias. Don't panic if you have a few flutters or if your heart races once in a while. **If you have flutters and other symptoms such as dizziness or shortness of breath, call 911 right away.**

Do women need to worry about heart disease?
Yes. Among all U.S. women who die each year, one in four dies of heart disease. In 2004, nearly 60 percent more women died of cardiovascular disease (both heart disease and stroke) than from all cancers combined. The older a woman gets, the more likely she is to get heart disease. But women of all ages should be concerned about heart disease. All women should take steps to prevent heart disease.

Both men and women have heart attacks, but more women who have heart attacks die from them. Treatments can limit heart damage but they must be given as soon as possible after a heart attack starts. Ideally, treatment should start within one hour of the first symptoms.

Do women of color need to worry about heart disease?
Yes. African American and Hispanic American/Latina women should be concerned about getting heart disease because they tend to have more risk factors than white women. These risk factors include obesity, lack of physical activity, high blood pressure, and diabetes.

What can I do to prevent heart disease?

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Know your blood pressure. Years of high blood pressure can lead to heart disease. People with high blood pressure often have no symptoms, so have your blood pressure checked every 1 to 2 years and get treatment if you need it.

Don't smoke. If you smoke, try to quit. If you're having trouble quitting, there are products and programs that can help:

- Nicotine patches and gums
- Support groups
- Programs to help you stop smoking
- Ask your doctor or nurse for help. For more information on quitting, visit Quitting Smoking.

Get tested for diabetes. People with diabetes have high blood glucose (often called blood sugar). People with high blood glucose often have no symptoms, so have your blood glucose checked regularly. Having diabetes raises your chances of getting heart disease. If you have diabetes, your doctor will decide if you need diabetes pills or insulin shots. Your doctor can also help you make a healthy eating and exercise plan.

Get your cholesterol and triglyceride levels tested. High blood cholesterol (koh -LESS-tur-ol) can clog your arteries and keep your heart from getting the blood it needs. This can cause a heart attack. Triglycerides (treye-GLIH-suh-ryds) are a form of fat in your blood stream. High levels of triglycerides are linked to heart disease in some people. People with high blood cholesterol or high blood triglycerides often have no symptoms, so have both levels checked regularly. If your levels are high, talk to your doctor about what you can do to lower them. You may be able to lower your both levels by eating better and exercising more. Your doctor may prescribe medication to help lower your cholesterol.

Maintain a healthy weight. Being overweight raises your risk for heart disease. Calculate your Body Mass Index (BMI) to see if you are at a healthy weight. Healthy food choices and physical activity are important to staying at a healthy weight:

- Start by adding more fruits, vegetables, and whole grains to your diet.
- Each week, aim to get at least 2 hours and 30 minutes of moderate physical activity, 1 hour and 15 minutes of vigorous physical activity, or a combination of moderate and vigorous activity.

If you drink alcohol, limit it to no more than one drink (one 12 ounce beer, one 5 ounce glass of wine, or one 1.5 ounce shot of hard liquor) a day.

Find healthy ways to cope with stress. Lower your stress level by talking to your friends, exercising, or writing in a journal.

What does high blood pressure have to do with heart disease?

Blood pressure is the force your blood makes against the walls of your arteries. The pressure is highest when your heart pumps blood into your arteries – when it beats. It is lowest between heart beats, when your heart relaxes. A doctor or nurse will write down your blood pressure as the higher number over the lower number. For instance, you could have a blood pressure of 110/70 (read as "110 over 70"). A blood pressure reading below 120/80 is usually considered normal. Very low blood pressure (lower than 90/60) can sometimes be a cause of concern and should be checked out by a doctor.

High blood pressure, or hypertension, is a blood pressure reading of 140/90 or higher. Years of high blood pressure can damage artery walls, causing them to

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become stiff and narrow. This includes the arteries carrying blood to the heart. As a result, your heart cannot get the blood it needs to work well. This can cause a heart attack.

A blood pressure reading of 120/80 to 139/89 is considered prehypertension. This means that you don't have high blood pressure now but are likely to develop it in the future.

How can I lower my blood pressure?
If you have hypertension or prehypertension, you may be able to lower your blood pressure by:

- losing weight if you are overweight or obese
- getting at least 2 hours and 30 minutes of moderate physical activity or 1 hour and 15 minutes of vigorous activity each week.
- limiting alcohol to one drink per day
- quitting smoking if you smoke
- reducing stress
- following the DASH (Dietary Approaches to Stop Hypertension) Eating Plan, which includes cutting down on salt and sodium and eating healthy foods, such as fruits, vegetables, and low-fat dairy products

If lifestyle changes do not lower your blood pressure, your doctor may prescribe medicine.

What does high cholesterol have to do with heart disease?
Cholesterol is a waxy substance found in cells in all parts of the body. When there is too much cholesterol in your blood, cholesterol can build up on the walls of your arteries and cause blood clots. Cholesterol can clog your arteries and keep your heart from getting the blood it needs. This can cause a heart attack.

There are two types of cholesterol:

Low-density lipoprotein (LDL) is often called the "bad" type of cholesterol because it can clog the arteries that carry blood to your heart. For LDL, lower numbers are better.

High-density lipoprotein (HDL) is known as "good" cholesterol because it takes the bad cholesterol out of your blood and keeps it from building up in your arteries. For HDL, higher numbers are better.

All women age 20 and older should have their blood cholesterol and triglyceride levels checked at least once every 5 years.

How can I lower my cholesterol?

You can lower your cholesterol by taking these steps:

Maintain a healthy weight. If you are overweight, losing weight can help lower your total cholesterol and LDL ("bad cholesterol") levels. Calculate your Body Mass Index (BMI) to see if you are at a healthy weight. If not, try making small changes like eating an apple instead of potato chips, taking the stairs instead of the elevator, or parking farther away from the entrance to your office, the grocery store, or the mall. (But be sure to park in a safe, well-lit spot.)

Eat better. Eat foods low in saturated fats, trans fats, and cholesterol.

Eat more:

- Fish, poultry (chicken, turkey--breast meat or drumstick is best), and lean meats (round, sirloin, tenderloin). Broil, bake, roast, or poach foods. Remove the fat and skin before eating.

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- Skim (fat-free) or low-fat (1%) milk and cheeses, and low-fat or nonfat yogurt
- Fruits and vegetables (try for 5 a day)
- Cereals, breads, rice, and pasta made from whole grains (such as "whole-wheat" or "whole-grain" bread and pasta, rye bread, brown rice, and oatmeal)

Eat less:

- Organ meats (liver, kidney, brains)
- Egg yolks
- Fats (butter, lard) and oils
- Packaged and processed foods

Get moving. Exercise can help lower LDL ("bad cholesterol") and raise HDL ("good cholesterol"). Exercise at a moderate intensity for at least 2 hours and 30 minutes each week, or get 1 hour and 15 minutes of vigorous intensity physical activity each week.

Take your medicine. If your doctor has prescribed medicine to lower your cholesterol, take it exactly as you have been told to.

What are the signs of a heart attack?

For both women and men, the most common sign of a heart attack is:

Pain or discomfort in the center of the chest. The pain or discomfort can be mild or strong. It can last more than a few minutes, or it can go away and come back.

- Other common signs of a heart attack include:
- Pain or discomfort in one or both arms, back, neck, jaw, or stomach
- Shortness of breath (feeling like you can't get enough air). The shortness of breath often occurs before or along with the chest pain or discomfort.
- Nausea (feeling sick to your stomach) or vomiting
- Feeling faint or woozy
- Breaking out in a cold sweat

Women are more likely than men to have these other common signs of a heart attack, particularly shortness of breath, nausea or vomiting, and pain in the back, neck, or jaw. Women are also more likely to have less common signs of a heart attack, including:

- Heartburn
- Loss of appetite
- Feeling tired or weak
- Coughing
- Heart flutters

Sometimes the signs of a heart attack happen suddenly, but they can also develop slowly, over hours, days, and even weeks before a heart attack occurs.

The more heart attack signs that you have, the more likely it is that you are having a heart attack. Also, if you've already had a heart attack, your symptoms may not be the same for another one. Even if you're not sure you're having a heart attack, you should still have it checked out.

If you think you, or someone else, may be having a heart attack, wait no more than a few minutes — five at most — before calling 911.

For more information

For more information on heart disease, please call womenshealth.gov at 1-800-994-9662 or contact the following organizations:

American Heart Association
Phone Number(s): (800) 242-8721
Internet Address:
http://www.americanheart.org

WomenHeart
Phone Number(s): (202) 728-7199
Internet Address:
http://www.womenheart.org

> Understanding Breast Cancer

by The National Cancer Institute www.cancer.gov

Cancer begins in cells, the building blocks that make up tissues. Tissues make up the organs of the body.

Normally, cells grow and divide to form new cells as the body needs them. When cells grow old, they die, and new cells take their place.

Sometimes, this orderly process goes wrong. New cells form when the body does not need them, and old cells do not die when they should. These extra cells can form a mass of tissue called a growth or tumor.

Tumors can be benign or malignant.

Benign tumors are not cancer:

- Benign tumors are rarely life-threatening. Generally, benign tumors can be removed.
- They usually do not grow back. Cells from benign tumors do not invade the tissues around them.
- Cells from benign tumors do not spread to other parts of the body.

Malignant tumors are cancer:

- Malignant tumors are generally more serious than benign tumors. They may be life-threatening.
- Malignant tumors often can be removed. But sometimes they grow back.
- Cells from malignant tumors can invade and damage nearby tissues and organs.
- Cells from malignant tumors can spread (metastasize) to other parts of the body. Cancer cells spread by breaking away from the original (primary) tumor and entering the bloodstream or lymphatic system. The cells invade other organs and form new tumors that damage these organs. The spread of cancer is called metastasis.
- When breast cancer cells spread, the cancer cells are often found in lymph nodes near the breast. Also, breast cancer can spread to almost any other part of the body. The most common are the bones, liver, lungs, and brain. The new tumor has the same kind of abnormal cells and the same name as the primary tumor. For example, if breast cancer spreads to the bones, the cancer cells in the bones are actually breast cancer cells. The disease is metastatic breast cancer, not bone cancer. For that reason, it is treated as breast cancer, not bone cancer. Doctors call the new tumor "distant" or metastatic disease.

Risk Factors

No one knows the exact causes of breast cancer. Doctors often cannot explain why one woman develops breast cancer and another does not. They do know that bumping, bruising, or touching the breast does not cause cancer. And breast cancer is not contagious. You cannot "catch" it from another person.

Research has shown that women with certain risk factors are more likely than others to develop breast cancer. A risk factor is something that may increase the chance of developing a disease.

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Studies have found the following risk factors for breast cancer:

Age: The chance of getting breast cancer goes up as a woman gets older. Most cases of breast cancer occur in women over 60. This disease is not common before menopause.

Personal history of breast cancer: A woman who had breast cancer in one breast has an increased risk of getting cancer in her other breast.

Family history: A woman's risk of breast cancer is higher if her mother, sister, or daughter had breast cancer. The risk is higher if her family member got breast cancer before age 40. Having other relatives with breast cancer (in either her mother's or father's family) may also increase a woman's risk.

Certain breast changes: Some women have cells in the breast that look abnormal under a microscope. Having certain types of abnormal cells (atypical hyperplasia and lobular carcinoma in situ [LCIS]) increases the risk of breast cancer.

Gene changes: Changes in certain genes increase the risk of breast cancer. These genes include BRCA1, BRCA2, and others. Tests can sometimes show the presence of specific gene changes in families with many women who have had breast cancer. Health care providers may suggest ways to try to reduce the risk of breast cancer, or to improve the detection of this disease in women who have these changes in their genes. NCI offers publications on gene testing.

Reproductive and menstrual history:

- The older a woman is when she has her first child, the greater her chance of breast cancer.
- Women who had their first menstrual period before age 12 are at an increased risk of breast cancer.
- Women who went through menopause after age 55 are at an increased risk of breast cancer.
- Women who never had children are at an increased risk of breast cancer.
- Women who take menopausal hormone therapy with estrogen plus progestin after menopause also appear to have an increased risk of breast cancer.
- Large, well-designed studies have shown no link between abortion or miscarriage and breast cancer.

Race: Breast cancer is diagnosed more often in white women than Latina, Asian, or African American women.

Radiation therapy to the chest: Women who had radiation therapy to the chest (including breasts) before age 30 are at an increased risk of breast cancer. This includes women treated with radiation for Hodgkin's lymphoma. Studies show that the younger a woman was when she received radiation treatment, the higher her risk of breast cancer later in life.

Breast density: Breast tissue may be dense or fatty. Older women whose mammograms (breast x-rays) show more dense tissue are at increased risk of breast cancer.

Taking DES (diethylstilbestrol): DES was given to some pregnant women in the United States between about 1940 and 1971. (It is no longer given to pregnant women.) Women who took DES during

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pregnancy may have a slightly increased risk of breast cancer. The possible effects on their daughters are under study.

Being overweight or obese after menopause: The chance of getting breast cancer after menopause is higher in women who are overweight or obese.

Lack of physical activity: Women who are physically inactive throughout life may have an increased risk of breast cancer. Being active may help reduce risk by preventing weight gain and obesity.

Drinking alcohol: Studies suggest that the more alcohol a woman drinks, the greater her risk of breast cancer.

Other possible risk factors are under study. Researchers are studying the effect of diet, physical activity, and genetics on breast cancer risk. They are also studying whether certain substances in the environment can increase the risk of breast cancer.

Many risk factors can be avoided. Others, such as family history, cannot be avoided. Women can help protect themselves by staying away from known risk factors whenever possible.

But it is also important to keep in mind that most women who have known risk factors do not get breast cancer. Also, most women with breast cancer do not have a family history of the disease. In fact, except for growing older, most women with breast cancer have no clear risk factors.

If you think you may be at risk, you should discuss this concern with your doctor. Your doctor may be able to suggest ways to reduce your risk and can plan a schedule for checkups.

Screening for breast cancer before there are symptoms can be important. Screening can help doctors find and treat cancer early. Treatment is more likely to work well when cancer is found early.

Your doctor may suggest the following screening tests for breast cancer:

- *Screening mammogram*
- *Clinical breast exam*
- *Breast self-exam*

You should ask your doctor about when to start and how often to check for breast cancer.

Screening Mammogram
To find breast cancer early, NCI recommends that:

- Women in their 40s and older should have mammograms every 1 to 2 years. A mammogram is a picture of the breast made with x-rays.
- Women who are younger than 40 and have risk factors for breast cancer should ask their health care provider whether to have mammograms and how often to have them.

Mammograms can often show a breast lump before it can be felt. They also can show a cluster of tiny specks of *calcium*. These specks are called *microcalcifications*. Lumps or specks can be from cancer, *precancerous* cells, or other conditions. Further tests are needed to find out if abnormal cells are present.

If an abnormal area shows up on your mammogram, you may need to have more x-rays. You also may need a *biopsy*. A biopsy is the only way to tell for sure if cancer is present.

Mammograms are the best tool doctors have to find breast cancer early. However,

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mammograms are not perfect:

- A mammogram may miss some cancers. (The result is called a "false negative.")
- A mammogram may show things that turn out not to be cancer. (The result is called a "false positive.")
- Some fast-growing tumors may grow large or spread to other parts of the body before a mammogram detects them.

Mammograms (as well as dental x-rays, and other routine x-rays) use very small doses of radiation. The risk of any harm is very slight, but repeated x-rays could cause problems. The benefits nearly always outweigh the risk. You should talk with your health care provider about the need for each x-ray. You should also ask for shields to protect parts of your body that are not in the picture.

Clinical Breast Exam

During a clinical breast exam, your health care provider checks your breasts. You may be asked to raise your arms over your head, let them hang by your sides, or press your hands against your hips.

Your health care provider looks for differences in size or shape between your breasts. The skin of your breasts is checked for a rash, dimpling, or other abnormal signs. Your nipples may be squeezed to check for fluid.

Using the pads of the fingers to feel for lumps, your health care provider checks your entire breast, underarm, and collarbone area. A lump is generally the size of a pea before anyone can feel it. The exam is done on one side, then the other. Your health care provider checks the lymph nodes near the breast to see if they are enlarged.

A thorough clinical breast exam may take about 10 minutes.

Breast Self-Exam

You may perform monthly breast self-exams to check for any changes in your breasts. It is important to remember that changes can occur because of aging, your *menstrual cycle*, pregnancy, menopause, or taking birth control pills or other *hormones*. It is normal for breasts to feel a little lumpy and uneven. Also, it is common for your breasts to be swollen and tender right before or during your menstrual period.

You should contact your health care provider if you notice any unusual changes in your breasts.

Breast self-exams cannot replace regular screening mammograms and clinical breast exams. Studies have not shown that breast self-exams alone reduce the

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You may want to ask the doctor the following questions about screening:

- **Which tests do you recommend for me? Why?**
- **Do the tests hurt? Are there any risks?**
- **How much do mammograms cost? Will my health insurance pay for them?**
- **How soon after the mammogram will I learn the results?**
- **If the results show a problem, how will you learn if I have cancer?**

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number of deaths from breast cancer.

Symptoms
Common symptoms of breast cancer include:

- A change in how the breast or nipple feels
- A lump or thickening in or near the breast or in the underarm area
- Nipple tenderness
- A change in how the breast or nipple looks
- A change in the size or shape of the breast
- A nipple turned inward into the breast
- The skin of the breast, areola, or nipple may be scaly, red, or swollen. It may have ridges or pitting so that it looks like the skin of an orange.
- Nipple discharge (fluid)

Early breast cancer usually does not cause pain. Still, a woman should see her health care provider about breast pain or any other symptom that does not go away. Most often, these symptoms are not due to cancer. Other health problems may also cause them. Any woman with these symptoms should tell her doctor so that problems can be diagnosed and treated as early as possible.

National Cancer Institute Information Resources
You may want more information for yourself, your family, and your doctor. The following National Cancer Institute (NCI) services are available to help you.

Telephone
The NCI's Cancer Information Service (CIS) provides accurate, up-to-date information on cancer to patients and their families, health professionals, and the general public. Information Specialists translate the latest scientific information into understandable language and respond in English, Spanish, or on TTY equipment. Calls to the CIS are free.

Telephone: 1-800-4-CANCER
(1-800-422-6237)
TTY: 1-800-332-8615

Internet
The NCI's Web site (http://www.cancer.gov) provides information from numerous NCI sources. It offers current information on cancer prevention, screening, diagnosis, treatment, genetics, supportive care, and ongoing clinical trials. It has information about NCI's research programs and funding opportunities, cancer statistics, and the Institute itself. Information Specialists provide live, online assistance through LiveHelp at http://www.cancer.gov/cis.

> Smokefree Women

by National Cancer Institute, http://women.smokefree.

Smoking causes harm to nearly every part of your body. Quit for your health.

You breathe in more than 40,000 chemicals each time you smoke a cigarette. All forms of tobacco are harmful and even deadly. Both women and men are hurt by these poisons.

Cancers
More women in the United States die from lung cancer than any other type of cancer. Your chance of getting lung cancer goes up the longer you smoke and the more you smoke two or more packs of cigarettes a day than among women who do not smoke. This means that if you smoke two or more packs of cigarettes a day, you are much more likely to die of lung cancer than your friends who do not smoke.

Good News... Once you are smoke-free for 5 years, you are less likely to die from lung cancer and other lung diseases than if you were still a smoker. The longer you stay smoke-free, the lower your chances of getting these diseases.1 Women of all ages who quit smoking can largely lower their chance of getting diseases such as cancer. For smokers who have do get cancer, quitting smoking helps their bodies to heal and to respond to cancer treatment. Quitting also lowers their chance of getting a second cancer.

Heart Disease and Stroke
More women die of heart disease than anything else. Smoking causes heart disease in women. A woman's chance of getting heart disease goes up with the number of cigarettes she has smoked and how long she has been smoking.

Good News... Your chance of getting heart disease greatly goes down within 1 or 2 years of quitting smoking. Once you are smoke-free for 10 years, your risk of heart disease is the same as if you had never been a smoker.

Women who smoke are more likely to have a stroke than non-smokers.

Good news... You can lower your chance of having a stroke by quitting smoking. Five to 15 years after quitting, your chance of stroke is the same as that of a woman who has never smoked.

Lungs
Cigarette smoking is the #1 cause of COPD (chronic obstructive pulmonary disease) among women. Emphysema and chronic bronchitis are two kinds of COPD. Your chance of getting COPD goes up the more you smoke and the longer you smoke. In women in the United States, cigarette smoking causes about 9 out of every 10 deaths from COPD.

Teen girls who smoke have lungs that don't grow as much as non-smokers' lungs, and adult women who smoke have lungs that don't work as well as non-smokers' lungs.

> Educating Young Women about Breast Cancer

by Congresswoman Debbie Wasserman Schultz

Congresswoman Debbie Wasserman Schultz

Breast cancer is a disease that knows no boundaries. It strikes women from all backgrounds, races, and ethnicities, the rich and the poor, the old and the young.

Yes, you did read that last part correctly. Despite the perception, young women can and do get breast cancer and the result can be devastating.

In 2008, the American Cancer Society estimated that there would be 182,460 new cases of breast cancer in women. Of these cases, more than 10,000 – 11,000 of these women would be under 40 years of age.

Although the incidence of breast cancer in young women is much lower than that of older women, young women's breast cancers are generally more aggressive, are diagnosed at a later stage, and result in lower survival rates. In fact, breast cancer is the leading cause of cancer deaths in young women under the age of 40.

Additionally, certain ethnic groups, including Ashkenazi Jews, and African American young women, have an increased risk of breast cancer.

Despite these facts, many young women mistakenly believe that breast cancer is only a problem for women over 40 years old. As a result, diagnoses are delayed and young women's lives are cut short.

We cannot afford to be silent about these specific risks and how they impact certain communities; not when our children's lives are on the line.

To that end, I've introduced the Education and Awareness Requires Learning Young Act, or EARLY Act. This legislation directs the Centers for Disease Control to develop and implement a national education campaign about the threat breast cancer poses to young women of all ethnic and cultural backgrounds, and the particular heightened risks of certain groups.

The campaign will help educate young women and better enable health care professionals to identify the specific threats and warning signs of breast cancer, which will lead to early diagnoses and saved lives. The bill calls for $9 million a year from 2010 to 2014.

The EARLY Act will also provide grants to organizations that support young women diagnosed with breast cancer in order to receive the assistance they need—including social and psychological support, fertility preservation counseling, and recurrence prevention training.

The purpose of my legislation is not to alarm people, but to educate and empower young women so we can reduce the number fatalities from this horrific disease.

Because at the end of the day, the old saying rings true: knowledge is power.

By making sure young women know their

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risk factors, the EARLY Act is a first step in transforming how we approach the fight against breast cancer.

As you may know, for seventeen years as an elected official, I have been a staunch advocate for transforming our approach towards breast cancer, and worked towards its eradication.

However, this issue took on a greater significance in my life, when, a little more than a year ago, after I found a lump in my breast while doing a routine self-exam, my doctor diagnosed me with breast cancer.

My doctor's initial recommendation, because I found the lump so early and it was less than a half centimeter, was to simply have the cancer removed, followed by radiation. However, after sitting down with a nurse educator who asked me many, many questions about my personal and family health history, I also decided to have a blood test that would show whether I had a genetic alteration in the BRCA1 or BRCA2 gene.

The test proved to be positive for the BRCA2 gene and I decided, based on this information, to have my breast tissue removed as well as my ovaries, to significantly reduce the chance of a recurrence of the cancer.

Seven surgeries later I am now cancer free and have a smaller chance of developing cancer than the average women. Some people might say I was lucky. While I certainly was fortunate enough to have access to good health care, I didn't find my tumor early because of luck. I found my tumor early because of knowledge and awareness. I knew that I should perform breast self-exams, and I was aware of what my body was supposed to feel like.

We need to ensure that every young woman in America can rely on more than luck. Their survival depends on it.

I'm working for you in Washington and right here in South Florida. If you need help, want information, or want to share your opinion with me, you can reach my office in Pembroke Pines at (954) 437-3936, in Aventura at (305) 936-5724, or in Washington, DC at (202) 225-7931.

> Lupus and Women's Health

by Robert W. Hoffman, D.O., FACP, Professor of Medicine and Microbiology & Immunology
Chief, Division of Rheumatology and Immunology Miller School of Medicine University of Miami

Systemic lupus erythematosus (SLE or lupus) is what is called an autoimmune disease. Autoimmune disease occurs when the bodies own immune system attacks other organs, in lupus this results in inflammation in many different areas of the body including the skin the joints, the kidneys and other organs. Lupus most often strikes young women and remains with them for the rest of their life. In the more severe cases of those who suffer from lupus it can result in their death or in other cases shorten their life.

Robert W. Hoffman, D.O., FACP

It has been estimated that there are almost a half million people who have SLE in the United States and as many as 5 million people worldwide with SLE. Like other autoimmune diseases, lupus affects women disproportionately. There are approximately 9 times as many women as men who have lupus. It is thought that the reason more women than men have lupus may be due to the effects estrogens and other female sex hormones have in making the disease worse.

Lupus can cause many problems. The areas of the body that can be injured by inflammation in lupus include the skin, joints, lungs, brain, kidneys and heart. The initial symptoms of lupus in most patients are vague and non-specific. Most patients have a skin rash, joint pain and/or joint swelling, and feel tired or lack energy. Because of the very vague nature and wide range of initial symptoms in lupus, there is often a substantial delay between the onset of symptoms and a proper medical diagnosis. In a few patients, lupus can quickly lead to life-threatening problems such as kidney failure, bleeding disorders, epilepsy or seizure, and strokes. In these cases rapid recognition of the disease is urgent.

Until the 1950s lupus was typically a fatal disease. The discovery of cortisone (and related compounds, such as prednisone, prednisolone, methlyprednisone and others) led to better treatments for inflammation in lupus. The subsequent widespread use of these anti-inflammatory drugs to treat lupus has led to an improvement in the disease and the prevention of death in many patients. Patients have also benefited by the development of newer drugs to fight inflammation.

The development of specific laboratory test for diagnosing lupus has also assisted in early medical recognition of the disease leading to appropriate treatment. Despite these advances, lupus remains a serious illness, which can substantially shorten or otherwise adversely impact the lives of those individuals who suffer from it.

Lupus has long been recognized as a disease with a strong inherited or so called genetic risk. Lupus appears to be more common and more severe in Hispanics and African Americans. The high rate of the disease in women, compared to men, as well as the increased risk for certain ethnic

groups are both suggestive of a genetic effects. Strong genetic evidence comes from twin studies, where the identical twins are both more likely to have the disease (15 and 59% of the time) compared to only 2 to 5% in non-identical twins. Recent genetic analysis has also successfully identified several specific genetic variants that are associated with lupus. This is an active area of ongoing research.

The development of newer and more effective drugs to treat the symptoms and complications of lupus, including blood pressure lowering drugs, lipid lowering drugs and antibiotics for example, have help patients live longer and more productive lives despite suffering with lupus. There have been some advances in the development of drugs, which help restore normal immune function (with immune dysfunction thought to be the fundamental underlying cause of the disease), such as hydroxychloroquine, cyclophosphamide, and mycophenolate. The development of newer agents that help restore normal immune function is also an area of active research in what is called Lupus appears to be more common and more severe in Hispanics and African Americans. clinical trials, studying patients with lupus.

While there have been advances in awareness of lupus by the general public, we could do much better. The failure to recognize the symptoms of lupus early (such as skin rash, joint pain, fever and fatigue in a young woman) can lead to delays in obtaining proper treatments and in some cases life-threatening problems. This may be especially true among minority populations who more often develop the disease. An upcoming nation-wide campaign for lupus awareness by the Ad Council in scheduled to launch in early 2009 in effort to bring broader attention to the serious problem of lupus.

For more information on lupus visit the Lupus Foundation of America: www.lupusfl.org

LUPUS™ Foundation of America Southeast Florida Chapter, Inc.

Lupus Foundation of America,
Southeast Florida Chapter, Inc.
75 NE 6th Avenue, Suite 110
Delray Beach, FL 33483
800-339-0586
www.lupusfl.org
9-5
Information available in English Spanish Kreyol

> Inflammatory Bowel Disease

by US Department of Health and Human Services, Office on Women's Health www.womenshealth.gov

Inflammatory bowel disease (IBD) is an ongoing or chronic health problem that causes inflammation and swelling in the digestive tract. The irritation causes bleeding sores called ulcers to form along the digestive tract. This in turn can cause crampy, abdominal pain and severe bloody diarrhea.

There are two main types of inflammatory bowel disease: ulcerative colitis (UC) and Crohn's disease (CD). The diseases are very similar. In fact, doctors often have a hard time figuring out which type of IBD a person has. The main difference between UC and CD is the area of the digestive tract they affect. CD can occur along the entire digestive tract and spread deep into the bowel wall. In contrast, UC usually only affects the top layer of the large intestine (colon) and rectum. Medicine can control the symptoms of IBD in most women. But for people who have severe IBD, surgery is sometimes needed. Over the course of a person's life, the symptoms of IBD often come and go. With close monitoring and medicines, most people with IBD lead full and active lives.

Who gets inflammatory bowel disease (IBD)?

People of every race, sex and class all over the world have IBD. But researchers have found that IBD is more common among certain groups of people. These include:

- people who have a family member with IBD
- white people of Jewish decent
- people of higher socioeconomic classes
- people who live in cities
- people who live in developed countries

Smoking also seems to affect a person's risk of getting IBD. People who smoke are more likely to develop CD.

More than 1 million people in the United States alone have IBD. About 30,000 people discover they have IBD each year in this country. Most people find out they have IBD between the ages of 15 and 35. Approximately the same number of women and men get IBD.

What causes inflammatory bowel disease (IBD)?

No one knows for sure what causes IBD. But, researchers think the following things may all play a role:

- a faulty immune system
- heredity
- environment

Many researchers think that abnormal action of a person's immune system may trigger IBD. Normally, the immune system protects the body from infections caused by viruses or bacteria. Once the infection has cleared up, the immune system "shuts off."

But in people with IBD, the immune system seems to overreact to something in the digestive tract. And once it starts working, the immune system in IBD fails to "shut off." This causes the ongoing inflammation, ulcers and other problems of IBD. Some researchers think a virus or bacterium may trigger the immune system to act this way.

IBD clearly tends to run in families. Roughly 10 to 30 percent of people with IBD have a relative with the disease. Women who have family members with IBD have at least 10 times the chance of developing IBD compared with other

people.

Some things in a person's environment also seem to boost a person's chances of getting IBD. These include:

- a lifestyle that includes little physical activity
- higher socioeconomic status
- living in a developed country

Contrary to popular belief, neither stress nor diet alone can cause IBD. But both can affect the symptoms. Stress can worsen the symptoms of IBD. Similarly, certain foods seem to aggravate IBD. By changing her diet and relieving stress, a woman can help control her symptoms of IBD.

When should I call my doctor?
It is important to call your doctor if you see blood in the stool, have a change in bowel habits that last more than 10 days, or if you have any of the following symptoms that do not improve with over-the-counter medicines.

- Severe abdominal cramps or pain
- Severe diarrhea or bloody diarrhea
- Weight loss
- Unexplained fever lasting more than 3 or 4 days
- Exhaustion
- Loss of appetite
- Nausea

Is pregnancy safe for women with inflammatory bowel disease (IBD)?

Women with IBD should talk with their doctors **before** getting pregnant. If you think you might be pregnant, it is important to call your doctor immediately. Some of the medicines used to treat IBD may harm the growing fetus.

Research shows that it is best for women with IBD to get pregnant while their disease is inactive (in remission). If the baby is conceived at this time, most women with IBD seem to have fairly normal pregnancies. But when a woman gets pregnant while her disease is active, IBD usually stays active or can get worse. Flare-ups usually happen in the first trimester and right after the baby is born.

Limited research shows that some medicines used to treat IBD are safe or likely safe in pregnancy. A few studies have shown that taking prednisone, sulfasalazine, and 5 ASAs during pregnancy does not hurt the developing fetus. But the effects of other medicines on pregnancy have not been well-studied. Surgery, if necessary, is safest in the second trimester.

For more information

Contact the National Women's Health Information Center at 1-800-994-9662 or the following organizations:

National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK)
Internet Address: www.niddk.nih.gov

National Digestive Diseases Information Clearinghouse
2 Information Way Bethesda, MD 20892-3570
E-mail: nddic@info.niddk.nih.gov

Crohn's & Colitis Foundation of America, Inc.
Phone Number(s): (800) 932-2433 or (212) 685-3440
Internet Address: www.ccfa.org

The American College of Gastroenterology
Phone Number(s): (703) 820-7400
Internet Address: www.acg.gi.org/

American Gastroenterological Association
Phone Number(s): (301) 654-2055
Internet Address: www.gastro.org

> Diabetes

by US Department of Health and Human Services, Office on Women's Health www.womenshealth.gov

Diabetes means that your blood glucose (sugar) is too high. Your blood always has some glucose in it because the body uses glucose for energy; it's the fuel that keeps you going. But too much glucose in the blood is not good for your health.

Your body changes most of the food you eat into glucose. Your blood takes the glucose to the cells throughout your body. The glucose needs insulin to get into the body's cells. Insulin is a hormone made in the pancreas, an organ near the stomach. The pancreas releases insulin into the blood. Insulin helps the glucose from food get into body cells. If your body does not make enough insulin or the insulin does not work right, the glucose can't get into the cells, so it stays in the blood. This makes your blood glucose level high, causing you to have diabetes.

If not controlled, diabetes can lead to blindness, heart disease, stroke, kidney failure, amputations (having a toe or foot removed, for example), and nerve damage. In women, diabetes can cause problems during pregnancy and make it more likely that your baby will be born with birth defects.

What is pre-diabetes?

Pre-diabetes means your blood glucose is higher than normal but lower than the diabetes range. It also means you are at risk of getting type 2 diabetes and heart disease. There is good news though: You can reduce the risk of getting diabetes and even return to normal blood glucose levels with modest weight loss and moderate physical activity. If you are told you have pre-diabetes, have your blood glucose checked again in 1 to 2 years.

What are the different types of diabetes?

The three main types of diabetes are:

Type 1 diabetes is commonly diagnosed in children and young adults, but it's a lifelong condition. If you have this type of diabetes, your body does not make insulin, so you must take insulin every day. Treatment for type 1 diabetes includes taking insulin shots or using an insulin pump, making healthy food choices, getting regular physical activity, taking aspirin daily (for many people), and controlling blood pressure and cholesterol levels.

Type 2 diabetes is the most common type of diabetes — about 9 out of 10 people with diabetes have type 2 diabetes. You can get type 2 diabetes at any age, even during childhood. In type 2 diabetes, your body makes insulin, but the insulin can't do its job, so glucose is not getting into the cells. Treatment includes taking medicine, making healthy food choices, getting regular physical activity, taking aspirin daily (for many people), and controlling blood pressure and cholesterol levels. If you have type 2 diabetes, your body generally produces less and less insulin over time. This means that you may need to increase your medications or start using insulin in order to keep your diabetes in good control.

Gestational (jess-TAY-shun-ul) diabetes occurs during pregnancy. This type of diabetes occurs in about 1 in 20 pregnancies. During pregnancy your body makes hormones that keep insulin from doing its job. To make up for this, your body makes extra insulin. But in some women this extra insulin is not enough, so they get gestational diabetes. Gestational diabetes usually goes away when the pregnancy is over. Women who have had

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gestational diabetes are very likely to develop type 2 diabetes later in life.

Who gets diabetes?
About 24 million Americans have diabetes, about half of whom are women. As many as one quarter do not know they have diabetes.

Type 1 diabetes occurs at about the same rate in men and women, but it is more common in Caucasians than in other ethnic groups.

Type 2 diabetes is more common in older people, mainly in people who are overweight. It is more common in African Americans, Hispanic Americans/Latinos, and American Indians.

What causes diabetes?
Type 1 and type 2 diabetes —The exact causes of both types of diabetes are still not known. For both types, genetic factors make it possible for diabetes to develop. But something in the person's environment is also needed to trigger the onset of diabetes. With type 1 diabetes, those environmental triggers are unknown. With type 2 diabetes, the exact cause is also unknown, but it is clear that excess weight helps trigger the disease. Most people who get type 2 diabetes are overweight.

Gestational diabetes — Changing hormones and weight gain are part of a healthy pregnancy, but these changes make it hard for your body to keep up with its need for insulin. When that happens, your body doesn't get the energy it needs from the foods you eat.

Am I at risk for diabetes?
The risk factors for type 1 diabetes are unknown. Things that can put you at risk for type 2 diabetes include:

Age — being older than 45
Overweight or obesity
Family history — having a mother, father, brother, or sister with diabetes
Race/ethnicity — your family background is African American, American Indian/Alaska Native, Hispanic American/ Latino, Asian American/Pacific Islander and Native Hawaiian
Having a baby with a birth weight more than 9 pounds
Having diabetes during pregnancy (gestational diabetes)
High blood pressure — 140/90 mmHg or higher. Both numbers are important. If one or both numbers are usually high, you have high blood pressure.
High cholesterol — total cholesterol over 240 mg/dL
Inactivity — exercising less than 3 times a week
Abnormal results in a prior diabetes test
Having other health conditions that are linked to problems using insulin, like Polycystic Ovarian Syndrome (PCOS)
Having a history of heart disease or stroke

What are the signs of diabetes?
- being very thirsty
- urinating a lot
- feeling very hungry
- feeling very tired
- losing weight without trying
- having sores that are slow to heal
- having dry, itchy skin
- losing feeling in or having tingling in the hands or feet
- having blurry vision
- having more infections than usual

If you have one or more of these signs, see your doctor.

Is there a cure for diabetes?

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There is no cure for diabetes at this time, but there is a great deal of research going on in hopes of finding cures for both type 1 and type 2 diabetes. Many different approaches to curing diabetes are being studied, and researchers are making progress.

Is there anything I can do to prevent type 2 diabetes?
Yes. The best way to prevent diabetes is to make some lifestyle changes:

Maintain a healthy weight
Being overweight raises your risk for diabetes. Calculate your Body Mass Index (BMI) to see if you're at a healthy weight. If you're overweight, start making small changes to your eating habits by adding more whole grain foods, fruits, and vegetables. Start exercising more, even if taking a short walk is all you can do for now. If you're not sure where to start, talk to your doctor. Even a relatively small amount of weight loss – 10 to 15 pounds – has been proven to delay or even prevent the onset of type 2 diabetes.

Eat healthy
Eat lots of whole grains (such as whole wheat or rye bread, whole grain cereal, or brown rice), fruits, and vegetables.

Choose foods low in fat and cholesterol. Read food labels. If you eat 2,000 calories per day, you should eat no more than 56 grams of fat each day.

If you drink alcohol, limit it to no more than one or two drinks (one 12-ounce beer, one 5-ounce glass of wine, or one 1.5-ounce shot of hard liquor) a day.

Get moving
Health benefits are gained by doing the following each week:

2 hours and 30 minutes of moderate intensity aerobic physical activity ***or***
1 hour and 15 minutes of vigorous-intensity aerobic physical activity ***or***
A combination of moderate and vigorous-intensity aerobic physical activity ***and***
Muscle-strengthening activities on 3 days

Some suggestions for fitting physical activity in:

- Take the stairs instead of the elevator
- Take a brisk walk on your lunch break.
- Park at the far end of the parking lot and walk.

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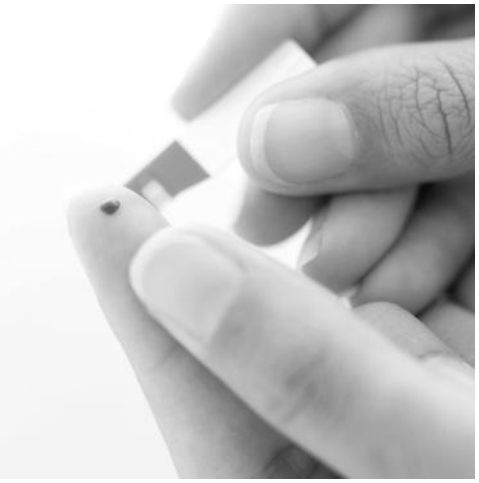

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- Get off the bus or subway a few stops early and walk the rest of the way.
- Walk or bicycle whenever you can.

For more information

For more information on diabetes, call the womenshealth.gov Call Center at 1-800-994-9662 or contact the following organizations:

National Diabetes Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases
Phone number: (800) 860-8747
Internet Address: http://www.niddk.nih.gov/health/diabetes/diabetes.htm

National Diabetes Education Program
Phone number: (800) 693-6337 (publications ordering)
Internet Address: http://ndep.nih.gov/

Centers for Disease Control and Prevention
Phone number: (800) 232-4636
Internet Address: http://www.cdc.gov/diabetes/

American Diabetes Association
Phone number: (800) 342-2383
Internet Address: http://www.diabetes.org

Juvenile Diabetes Foundation International
Phone number: (800) 533-2873
Internet Address: http://www.jdf.org

- ***Of the 15.7 million people with diabetes in the United States, more than half (8.1 million) are women. Minority racial and ethnic groups are the hardest hit by type 2 diabetes; the prevalence is at least 2-4 times higher among black, Hispanic, American Indian, and Asian Pacific Islander women than among white women.***
- ***About 90 to 95 percent of women with diabetes have type 2 diabetes (formerly called adult-onset).***
- ***The risk of heart disease, the most common complication of diabetes, is more serious among women than men. Among people with diabetes who have had a heart attack, women have lower survival rates and a poorer quality of life than men.***
- ***Women with diabetes have a shorter life expectancy than women without diabetes, and women are at greater risk of blindness from diabetes than men.***

National Center for Chronic Disease Prevention and Health Promotion
http://www.cdc.gov/diabetes/pubs/women/index.htm

> Swine and Avian Flu Pandemics

by U.S. Department of Health and Human Services

A pandemic is a global disease outbreak. A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease spreads easily person-to-person, causes serious illness, and can sweep across the country and around the world in very short time. An influenza pandemic may be caused by either swine (pig) or avian (bird) flu viruses.

There are currently cases of human infection with H1N1 throughout the world, including the United States. Health professionals are concerned about the possibility that this virus could become a pandemic for the following reasons:

- It is a never-before seen combination of human, swine, and avian influenza viruses.
- It is being spread from human to human.
- The age group most affected is healthy, young adults (unlike seasonal flu)
- Like other influenza viruses, it continues to evolve.

How You can Prepare

There are a number of things that you can do to prepare yourself and those around you for a flu pandemic. It is important to think about the challenges that you might face, particularly if a pandemic is severe.

You can prepare for an influenza pandemic now. You should know both the magnitude of what can happen during a pandemic outbreak and what actions you can take to help lessen the impact of an influenza pandemic on you and your family.

To plan for a pandemic:

- Store a two week supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.
- Periodically check your regular prescription drugs to ensure a continuous supply in your home.
- Have any nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.
- Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them in your home.
- Volunteer with local groups to prepare and assist with emergency response.
- Get involved in your community as it works to prepare for an influenza pandemic.

To limit the spread of germs and prevent infection:

- Teach your children to wash hands frequently with soap and water, and model the correct behavior.
- Teach your children to cover coughs and sneezes with tissues, and be sure to model that behavior.

Teach your children to stay away from others as much as possible if they are sick.

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Stay home from work and school if sick.

For More Information
Visit: www.pandemicflu.gov

The Centers for Disease Control and Prevention (CDC) hotline 1-800-CDC-INFO (1-800-232-4636), is available in English and Spanish, 24 hours a day, 7 days a week. TTY: 1-888-232-6348. Questions can be e-mailed to cdcinfo@cdc.gov.

Stay home from work and school if sick.

Items to Have on Hand for an Extended Stay at Home:

Examples of food and non-perishables	Examples of medical, health, and emergency supplies
Ready-to-eat canned meats, fish, fruits, vegetables, beans, and soups	Prescribed medical supplies such as glucose and blood-pressure monitoring equipment
Protein or fruit bars	Soap and water, or alcohol-based (60-95%) hand wash
Dry cereal or granola	Medicines for fever, such as acetaminophen or ibuprofen
Peanut butter or nuts	Thermometer
Dried fruit	Anti-diarrheal medication
Crackers	Vitamins
Canned juices	Fluids with electrolytes
Bottled water	Cleansing agent/soap
Canned or jarred baby food and formula	Flashlight
Pet food	Batteries
Other non-perishable items	Portable radio
	Manual can opener
	Garbage bags
	Tissues, toilet paper, disposable diapers

> Health Resources

Federal Health Sites

U.S. Department of Agriculture, Food and Nutrition Service, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
http://www.fns.usda.gov/wic/
WIC serves to safeguard the health of low -income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

U.S. Department of Health and Human Services (HHS)
http://www.hhs.gov/
http://www.womenshealth.gov/
HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. http://www.womenshealth.gov/.

Agency for Healthcare Research and Quality (AHRQ)
http://www.ahrq.gov/
AHRQ is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. Also visit the AHRQ Women's Health web page. http://www.ahrq.gov/research/womenix.htm

Food and Drug Administration (FDA)
http://www.fda.gov/
http://www.fda.gov/ScienceResearch/SpecialTopics/WomensHealthResearch/default.htm
FDA ensures that the food we eat is safe and wholesome, that the cosmetics we use won't harm us, and that medicines, medical devices, and radiation-emitting consumer products such as microwave ovens are safe and effective. FDA also oversees feed and drugs for pets and farm animals.

Health Resources and Services Administration (HRSA)
http://www.hrsa.gov/
http://mchb.hrsa.gov/whusa08/
HRSA assures quality health care to underserved, vulnerable, and special-need populations and promotes appropriate health profession workforce capacity and practice, particularly in primary care and public health.

Indian Health Service (IHS)
http://www.ihs.gov/
http://www.ihs.gov/MedicalPrograms/MCH/W/
IHS assures that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

National Institutes of Health (NIH)
http://www.nih.gov/
http://orwh.od.nih.
NIH is one of the world's foremost biomedical research centers and the federal focal point for biomedical research in the United States. NIH conducts research in its own laboratories; supports the research of non-federal scientists in universities, medical schools, hospitals, and research institutions throughout the country and abroad; helps in the training of research investigators; and fosters communication of biomedical information.

Office of Population Affairs (OPA)
http://www.hhs.gov/opa/
OPA provides resources and policy advice on population, family planning, reproductive health, and adolescent pregnancy issues.

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Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/
SAMHSA improves the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

U.S. Department of Veterans Affairs (VA), Center for Women Veterans
http://www1.va.gov/WOMENVET/
The Center for Women Veterans ensures that women veterans have access to VA benefits and services and that VA health care and benefit programs are responsive to the gender-specific needs of women veterans.

Florida Women's Health

Florida Department of Health Women's Health Program
http://www.doh.state.fl.us/Family/wh/index.html
In 2004, Florida passed legislation establishing the Department of Health Officer of Women's Health Strategy with the charge to direct public policy to address the distinct health needs of women across the life span. The Women's Health Program has adopted a new overarching theme of health literacy, which is defined as "the ability to understand and act appropriately on health information." The theme of health literacy will be used to strengthen collaborative relationships within the Department of Health, external partners, including other state agencies. One such state entity is the Florida State Library System within the Department of State (DOS).

EveryWomanFlorida.com
http://everywomanfl.com/

EveryWomanFlorida.com is funded by a Community Grant from the March of Dimes. The site explore reasons for a healthier lifestyle while providing information on how to improve the health and well-being of women.

Infant, Maternal & Reproductive Health
http://www.doh.state.fl.us/family/mch/index.html
The Clearinghouse for Applied Research and Public Service in conjunction with the Florida Board of Governors.

Speaking of Women's Health
http://www.speakingofwomenshealth.com/
What started as a one-day conference in 1996 has turned into a foundation that hosts conferences nationwide! Speaking of Women's Health combines education and pampering into a forum where women can learn from each other and become inspired to take charge of their health!

EveryWomanFlorida.com
http://www.floridahealthfinder.gov/

Other informational Websites

American Cancer Society (ACS)
http://www.cancer.org/docroot/home/index.asp
ACS is dedicated to preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and service.

American College of Obstetricians and Gynecologists (ACOG)
http://www.acog.org/
ACOG is the nation's leading group of physicians providing health care for women.

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(Continued from page 47)

American Medical Women's Association (AMWA)
http://www.amwa-doc.org
AMWA is an organization of women physicians and medical students dedicated to serving as the unique voice for women's health and the advancement of women in medicine.

American Psychological Association (APA)
http://www.apa.org/
APA is a scientific and professional organization that represents psychology in the United States.

American Public Health Association (APHA)
http://www.apha.org/
APHA is the oldest and largest organization of public health professionals in the world.

Black Women's Health Imperative
http://www.blackwomenshealth.org/
The Black Women's Health Imperative seeks to improve the health of black women by providing wellness education and services, health information, and advocacy.

Chronic Disease Directors Women's Health Council (WHC)
http://www.chronicdisease.org
WHC helps state agencies advance and protect the health of women across the life span through chronic disease prevention and control.

March of Dimes
http://www.marchofdimes.com/
The March of Dimes improves the health of babies by preventing birth defects and infant mortality.

United Nations, Division for the Advancement of Women
http://www.un.org/womenwatch/daw/
The Division for the Advancement of Women advocates improvement of the status of the women of the world and the achievement of their equality with men.

World Health Organization (WHO), Department of Gender, Women, and Health (GWH)
http://www.who.int/gender/en/
GWH brings attention to the ways in which biological and social differences between women and men affect health and the steps needed to achieve health equity. Also visit the WHO Reproductive Health and Research web page.

Women's Health: Information from your family doctor
http://www.familydr.org
Information on frequently asked questions from the American Academy of Family Physicians.

Health Insight: Women's Health
http://www.ama-assn.org/insight/h_focus/wom_hlth/wom_hlth.htm
General health information for women from the American Medical Association's Health Insight.

JAMA Women's Health Information Center
http://www.ama-assn.org/special/womh/womh.htm
The Women's Health Information Center maintained by the Journal of the American Medical Association. Designed as a resource for physicians and other health professionals the site is open to the general public, with recent women's health news and libraries of information on STD's and contraception.

Part II

Florida Commission on the Status of Women 2008 Annual Report

The Florida Commission on the Status of Women

The Florida Commission on the Status of Women is dedicated to empowering women achieving their fullest potential, to eliminating barriers to that achievement, and to recognizing women's accomplishments.

The Commission is administratively housed in the Office of Attorney General Bill McCollum.

About the Commission

The Florida Commission on the Status of Women (FCSW) is established in the Office of the Florida Attorney General, and consists of 22 members. The Governor, the Speaker of the House of Representatives, the President of the Senate, and the Attorney General appoint four members, and the Chief Financial Officer and Commissioner of Agriculture each appoint three members. Each member serves for a term of four years. No member may serve more than eight consecutive years.

Commission Mandate

As required by Section 14.24, Florida Statutes, the Commission is mandated to study and make recommendations to the Governor, Cabinet and Legislature on issues affecting women. These recommendations are presented in the form of an annual report, which is distributed during the first quarter of each year. Topics may include, but are not limited to:

- socioeconomic factors influencing the status of women;
- the development of individual potential;
- the encouragement of women to utilize their capabilities and assume leadership roles;
- the coordination of efforts of numerous organizations interested in the welfare of women;
- the identification and recognition of contributions made by women to the community, state and nation; and,
- the implementation of recommendations to improve working conditions, financial security, and legal status of both sexes.

For more information about the Commission, visit our website at www.fcsw.net.

Commission Publications

Each year, the Commission produces an Annual Report on issues affecting women. In addition, the Commission has produced a number of educational brochures, calendars and special reports. Please contact the Commission office for copies of the following FCSW Publications:

- 1992 Annual Report "Women in the Workplace"
- 1993 Annual Report "Women's Health Care"
- 1994 Annual Report "Justice and Human Rights; How They Apply to Women"
- 1995 Annual Report "Welfare Reform in Florida"
- 1996 Annual Report Benchmark Study
- 1996 Publication "Women and Health, A Status Report"
- 1997 Annual Report "Women and Economic Development"
- 1998 Annual Report "A Definitive Study on Young Women Ages 12-18 in Florida"
- 1999 Annual Report "Reflections and Projections: Women in Florida"
- 2000 Annual Report "A Study of Women's History Education in Florida's Public Schools"
- 2001 Annual Report "Prevention by Intervention: Girls in Florida's Juvenile Justice System"
- 2002 Publication "Creating Change Challenging Tradition: Florida Women Public Officials"
- 2002 Annual Report "A Passion to Play! 30 Years of Women's Athletics in Florida"
- 2003 Annual Report "Women and Money: Practical Money Skills for Women"
- 2004 Annual Report "Legally Yours: A Guide for Florida Women"
- 2005 Annual Report "Florida Women Mean Business"
- 2006 Annual Report "Life Issues of Florida Women: Mid-life and Beyond"
- 2007 Annual Report "Smart Surfing: Protecting You and Your Family from Cyber-crime"
- 2005—2008 "Summary of Florida Laws Affecting Women"
- 1999, 2000, and 2004 FCSW Calendar
- 2001, 2002 and 2003 Women's History Calendar
- Women's Hall of Fame Brochure

> Commission History Highlights

1961 President John F. Kennedy created the Presidential Commission on the Status of Women (PCSW).

1964 Florida Governor Farris Bryant created the Governor's Commission on the Status of Women (COSW) to study laws and regulations pertaining to women in Florida and make recommendations to the legislature based on their findings.

1966 The Commission presented its first report to Governor Farris Bryant.

1967 Florida Governor Claude Kirk announced the appointment of 14 new members to the COSW, bringing the total number of commissioners to 24.

1971 Governor Reubin Askew reestablished the Governor's Commission on the Status of Women by executive order.

Governor Reubin Askew appointed an executive director to help coordinate the Commission's activities.

1974

The Commission's budget is cut and its fate between 1977 and 1978 are not known.

1977

Governor Bob Graham reactivated the Governor's Commission on the Status of Women (still referred to as the COSW) by means of Executive Order 79-60.

1979

The first Florida Women's Hall of Fame ceremony and reception was held by the Commission at the Governor's Mansion in Tallahassee in May of 1982.

1982

Governor Lawton Chiles lobbied the Florida Legislature to statutorily create the Florida Commission on the Status of Women after he took office in 1991. The leading sponsor in the House of Representatives for CS/CS/HB 109 was Representative Elaine Gordon, while Senator Carrie Meek sponsored the companion bill, SB 1324. The Commission's legislative authority now exists in Section 14.24, Florida Statutes. Since 1991, the Florida Commission on the Status of Women has been fully supported by the Governor, the Cabinet and the Florida Legislature.

1991

> Florida Women's Hall of Fame

The Florida Women's Hall of Fame began in 1982 under the aegis of the Governor's Commission on the Status of Women. A total of 27 women were selected as members of the Hall in 1982, 1984 and 1986. In 1992, legislation was passed that created a permanent Florida Women's Hall of Fame. Since 1993, up to three women have been inducted into the Hall annually pursuant to Section 265.001, Florida Statutes. Nominations to the Hall may be made between April 1 and July 15 of each year.

To obtain a nomination form or review member biographies, visit the commissions' web site at *www.fcsw.net* or contact the office at 850-414-3300. The Commission appreciates the public input that assists in honoring meritorious women and in educating citizens on the significant and varied accomplishments of women in Florida's history.

2007/2008 Florida Women's Hall of Fame Inductees

Justice Barbara J. Pariente
1948-

Dr. Pallavi Patel
1950-

Ileana Ros-Lehtinen
1952—

> **The Hall of Fame recognizes and honors women who, through their works and lives, have made significant contributions to the improvement of life for women and for all citizens of the state of Florida.**

Florida Women's Hall of Fame Members 1982—2007

2006/2007 Inductees
Maryly VanLeer Peck
Peggy A. Quince

2005/2006 Inductees
Caridad Asensio
Tillie Kidd Fowler
Lucy W. Morgan

2004/2005 Inductees
Shirley D. Coletti
Marion P. Hammer
Judith Kersey

2003 Inductees
Sarah Ann Blocker
Gloria Estefan
Mary R. Grizzle

2002 Inductees
Victoria Joyce Ely, R.N.
Senator Toni Jennings
Frances Langford Stuart

2001 Inductees
Jessie Ball DuPont
Lenore Carrero Nesbitt
Lynda Keever

2000 Inductees
Chris Evert
Paula Fickes Hawkins
MG Marianne Mathewson-Chapman, Ph.D.

1999 Inductees
Althea Gibson
Sister Jeanne O'Laughlin, OP, Ph.D.
Dessie Smith Prescott

1998 Inductees
Helen Gordon Davis
Mattie Belle Davis
Christine Fulwylie-Bankston

1997 Inductees
Alicia Baro
Carita Doggett Corse
M. Athalie Range

1996 Inductees
Marjorie Harris Carr
Betty Castor
Ivy Julia Cromartie Stranahan

1995 Inductees
Evelyn Stocking Crosslin, M.D.
JoAnn Hardin Morgan
Sarah 'Aunt Frances' Brooks Pryor

1994 Inductees
Nikki Beare
Betty Mae Jumper
Gladys Nichols Milton

1993 Inductees
Betty Skelton Frankman
Paulina Pedroso
Janet Reno

1992 Inductees
Jacqueline Cochran
Carrie P. Meek
Ruth Bryan Owen

1986 Inductees
Annie Ackerman
Rosemary Barkett
Gwendolyn Sawyer Cherry

1986 Inductees
Dorothy Dodd
Marjory Stoneman Douglas
Elsie Jones Hare
Elizabeth McCullough Johnson
Frances Bartlett Kinne
Arva Moore Parks
Marjorie Kinnan Rawlings
Florence Barbara Seibert
Marilyn K. Smith
Eartha Mary Magdalene White

1984 Inductees
Roxcy O'Neal Bolton
Barbara Landstreet Frye
Lena B. Smithers Hughes
Zora Neale Hurston
Sybil Collins Mobley
Helen Muir
Gladys Pumariega Soler
Julia DeForest Sturtevant Tuttle

1982 Inductees
Mary McLeod Bethune
Helene S. Coleman
Elaine Gordon
Wilhelmina Celeste Goehring Harvey
Paula Mae Milton
Barbara Jo Palmer

> 2008 Commissioners

NANCY C. ACEVEDO

Commissioner Nancy Acevedo of Winter Springs was last appointed to the Commission in 2004 by Speaker of the House Tom Feeney. Commissioner Acevedo is currently an Intelligence Analyst with the Seminole County Sheriff's Office/ Intelligence Center/Homeland Security. She is a graduate of the University of Puerto Rico and the Inter-American University, and holds a Ph.D. in Education. She is a graduate of the SCSO Community Law Enforcement Academy, member of the Advisory Board for the Use of Excessive Force since 2000, Vice President/Member of the Florida Crime Intelligence Analyst Association (FCIAA), the International Association of Crime Analysts (IACA) and the International Association of Law Enforcement Intelligence Analysts (IALEIA). Commissioner Acevedo currently serves as Diplomat to the Florida International Business Council, and as a gubernatorial appointee to the East Central Florida Regional Planning Council. Recently she received a Presidential appointment to the US Small Business Administration National Advisory Board.

CLAUDIA KIRK BARTO

Commissioner Claudia Kirk Barto of West Palm Beach was last appointed to the Commission in 2007 by Commissioner of Agriculture Charles Bronson. Commissioner Barto is currently the Executive Director of the Lupus Foundation of America, Southeast Florida Chapter. She received her degree in communications from Florida State University. Commissioner Barto has numerous years of non-profit leadership experience, most recently as Executive Director of the Palm Beach Office of the Cystic Fibrosis Foundation. Prior to that she served as Deputy Executive Director for the Leukemia & Lymphoma Society. She spent six years with the United Way of Palm Beach County learning the intricacies of area nonprofits and the many needs that go unmet in her community. Claudia grew up in Palm Beach where philanthropy is a way of life.

Dorothy Bendross-Mindingall

Commissioner Dorothy Bendross-Mindingall of Miami was appointed to the Commission in 2008 by Speaker of the House Marco Rubio. She is a former classroom teacher, principal and current adult education administrator. After graduating from Miami Northwestern Senior High School, she matriculated at Tuskegee (Alabama) Institute, Nova University, Barry University and Florida International University, completing Bachelor's and Master's degrees, and several Master-level certifications. Commissioner Bendross-Mindingall is a former State Representative for District 109. She has previously served as the first chairperson of the Governor's Commission on African American Affairs. Commissioner Bendross-Mindingall recently opened a learning center within a Miami-Dade housing project, designed to get even more parents off welfare, and armed with the skills needed to stay focused and productive.

BLANCA BICHARA

Commissioner Blanca Bichara of Miami was appointed to the Commission in January 2000 by Governor Jeb Bush and subsequently re-appointed in February 2004 by Governor Jeb Bush. Commissioner Bichara currently co-owns and manages Flamingo Graphics, a minority printing company specializing in the printing of lottery products for the online games for the United States and the International Legalized Lottery Industry.

Commissioner Bichara also has served and continues to serve in many non-profit boards. She serves as the Business liaison on the School Advisory Board of Kinloch Park Middle School in Dade County is past member of the Dade County School Advisory Board at the district level. She served as past Vice President of kids voting in Miami and was the treasurer of the League of Women Voters in Dade County. She is currently the President of the board of Chrysalis Center which provides mental health services in the South Florida area.

THELMA V. CRUMP

Commissioner Thelma V. Crump was appointed in October 2005 to the Florida Commission on the Status of Women (FCSW) by Governor Jeb Bush. She received a Bachelor of Science degree in journalism with a concentration in public relations and political science from the School of Journalism, Media and Graphic Arts, as well as a Master's degree in Business Administration in Marketing and Management from the School of Business and Industry at Florida Agricultural and Mechanical University. She has completed coursework toward a Ph.D. in communication from the College of Communication at Florida State University.

Commissioner Crump is a Regulatory Supervisor Consultant for the Florida Public Service Commission (PSC). She is a nationally-known authority on utility consumer education and has worked with the state and national media on consumer education for the PSC, the Federal Communications Commission, the Federal Trade Commission and the National Association of Regulatory Utility Commission. She has promoted current telecommunication issues, such as Lifeline Assistance and Link-Up Florida, and has written a monthly newspaper column for the chairman and former chairmen of the PSC. She is a managing partner with Crump Management, Inc., a company specializing in the development of real estate properties.

BERTICA CABRERA-MORRIS

Commissioner Bertica Cabrera-Morris of Orlando was appointed to the Commission in 2007 by Speaker of the House Marco Rubio. In 1993 she started Bertica Cabrera Consulting Firm - a public relations, marketing and governmental affairs consulting firm of which she is the principal and sole proprietor. Commissioner Cabrera-Morris attended the UCLA Banking Academy of Los Angeles and made the transition to the financial world through employment with the First Interstate Bank of Los Angeles, followed by employment with the Independence Bank of Encino. Currently, she is an active member of the Hispanic Chamber of Commerce and also serves on the Arts Council for Central Florida. Commissioner Cabrera-Morris was appointed to the Board of Trustees for Valencia Community College in 2005 and was re-appointed in 2007 for a 4 year term.

LOURDES CASTILLO DE LA PEÑA

Commissioner Lourdes Castillo de la Peña of Miami was appointed to the Commission in 2008 by Attorney General Bill McCollum. Commissioner Castillo de la Peña earned her wings working with an established public-relation company in Miami – Dade before opening her own boutique PR firm, LMC Communications in 1993. She attended St. Thomas University, where she graduated with a degree in Marketing and Public Relations in 1989. She has been active in civic affairs in Miami -Dade County for the past several decades, holding leadership positions on a myriad of prestigious not –for –profit Boards, committees and organizations. Commissioner Castillo de la Peña has also served on several national boards such as The American Red Cross, Voices for Children, National Alzheimer's Association, Republican National Senatorial Committee, as well as local boards; Miami Children Hospital, Fisher Island Philanthropic Fund, Miami City Ballet, Angels of Mercy. She is presently serving a four year board term on the Florida Friends of the Orphans.

SHARON DAY

Commissioner Sharon Day of Fort Lauderdale was appointed to the Commission in 2008 by Governor Charlie Crist. Sharon is a retired executive with marketing, group health insurance and re-insurance experience. She is an entrepreneur who has built and sold numerous businesses and is a strong supporter of small business. Commissioner Day serves on the Broward County Housing Authority as Chairman of the Commission and is Broward County's State Committeewoman and Florida's Republican National Committeewoman. In 2000, she was appointed to serve on the Committee for Election Reform for the State of Florida by Governor Bush. In 2006, she was appointed to act as Florida's representative on the 2008 Republican Convention Committee on Arrangements and was selected to be Chairman of the 2008 Republican Convention's Special Events.

ANASTASIA GARCIA, Esq.

Commissioner Anastasia Garcia, Esq. of Coral Gables was appointed to the Commission in 2004 by Commissioner of Agriculture Charles Bronson. Commissioner Garcia is an attorney practicing in the area of Matrimonial Law. She is also a Florida Supreme Court Certified Family Mediator. Commissioner Garcia earned her J.D. in 1992 from the George Washington University National Law Center. Commissioner Garcia has served on various boards including the Cuba Museum, where she currently serves as secretary. Commissioner Garcia is the owner of the Law Offices of Anastasia M. Garcia, she is a partner in Lakes Title Services LLC and she is a shareholder and corporate counsel for Dade Steel Sales Corporation.

SUSANNE HEBERT

Commissioner Susanne Hebert of Clearwater was last appointed to the Commission in 2007 by Senate President Ken Pruitt. She serves as a corporate executive with Macys in Tampa, Florida. A graduate of the University of Florida in Ornamental Horticulture, Susanne previously served as both an interior horticultural designer and exterior landscape planner for Burdines. She was formerly president of the Tampa Bay Chapter of the Florida Nurserymen and Grower's Association. Commissioner Hebert serves as a board member of the Feather Sound Municipal Taxing District, a member of the Advisory Committee for the Patel Conservatory's Youth Orchestra and rehearsal manager for the orchestra's Senior Orchestra, where she enjoys helping talented young musicians realize their dreams.

CHERYL HOLLEY

Commissioner Holley of Tampa was appointed to the FCSW in 2004 by Speaker of the House Johnnie Byrd . She has been a successful entrepreneur since the young age of 19. She has worked for the Republican Party of Florida as well as running several National and State political races from the Presidency, Governor and local House Seats. She also started her own company, Personally Yours, which continues today. Commissioner Holley serves on the boards of the Sylvia Thomas Center for Adoptive and Foster Parents 2004, Hillsborough County Republican Executive Committee, as well as the Outback Bowl Hostess Committee. Commissioner Holley is also active in her community through many volunteer involvements. She has received many awards for her outstanding work in the community, including the "Women of Achievement" award.

MONA JAIN , M.D., Ph.D.

Commissioner Mona Jain, M.D., Ph.D. of Bradenton was last appointed to the Commission in 2006 by Senate President Tom Lee. Dr. Jain is the former Director of Children and Family Services for Manatee County Head Start, and has worked for educational opportunities for all students, especially continuing education for non-traditional mature students. Since 1961, she has been an educator and administrator in American, British and Indian education systems. Dr. Jain, now retired as Director of Children and Family Services for Manatee County Head Start, has worked for educational opportunities for all students, especially continuing education for non-traditional mature students.

Throughout her career she has been recognized for outstanding professional and community involvements including: Community Service Award from the American Medical Women's Association; the 2001 Distinguished Alumnus Award from the University of South Florida; recognition from the United Negro College Fund for her distinguished career in education and Leadership and Professional Awards from the American Association of University Women and Delta Kappa Gamma International. Recognition of her commitment and dedication is not limited to the United States; during her visit to India, her country of birth, she was granted a private audience with the International Humanitarian Mother Teresa.

DEBORAH JALLAD

Commissioner Deborah Jallad of Winter Park was appointed to the Commission in 2007 by Attorney General Bill McCollum. She is the President/Chairman of Accredited Holding Corporation and Accredited Surety and Casualty Company., Inc. – a Florida-based insurance company holding system specializing in the underwriting of non-contract surety bonds that was founded in 1959. With more than 40 years experience in non-contract surety bonds, Commissioner Jallad has been actively involved in developing industry standards and lobbying for reform. She works closely with Accredited's political consultants, state and national bail associations, and legislatures to increase safety for bail agents and the public. Accredited is the nation's only insurance company owned by women that specializes in bail bond underwriting. Commissioner Jallad has earned numerous awards for both her community service and professional expertise.

GLORIOUS JOHNSON

Commissioner Glorious Johnson of Jacksonville was appointed to the Commission in 2008 by Governor Charlie Crist. She has been an elected official since 2003. Prior to becoming an elected official, Commissioner Johnson was an educator, in which she taught music in the public school system. Later, she became an instructor at the college level, teaching business courses. She received her Bachelor Degree from Jacksonville University in Music as a concert pianist, her first Master Degree was from Nova Southeastern University (Ft. Lauderdale, FL.), in School Administration and Supervision; and her second Master Degree came from Teachers College/Columbia University (New York City), majoring in Educational Administration/Organizational Leadership.

AMY KRYAK

Commissioner Amy Kryak of Port St. Lucie was appointed to the Commission in 2008 by Senate President Ken Pruitt. She is president and creative director of Lost Art Advertising in Port St. Lucie, Florida. An entrepreneur and business owner since 1986, Kryak has won more than 200 awards for creative excellence in advertising, along with the prestigious ANGEL award for public service. She was Soroptimist Business Woman of the Year in 2002 for St. Lucie County; she has served as president of the Port St. Lucie Business Women and is a former board member of the Treasure Coast Advertising Federation. Commissioner Kryak is a former Assistant Dean at Indian River State College and former Director of the college's Small Business Development Center; she currently serves as an adjunct instructor at Florida Atlantic University. In addition to her successful business career, Commissioner Kryak and her husband are co-founders of Never Leave a Child Unattended®, a public education campaign founded in 1993 to help prevent injury and drowning of children which results from children not being supervised.

CARRIE ESTEVEZ LEE

Commissioner Caridad Lee of Gainesville was last appointed to the Commission in 2005 by Governor Jeb Bush and served as the 2005 - 2006 Commission Chair. Commissioner Lee has worked along with her husband in the Real Estate field for over 25 years and is also a Real Estate Broker. She graduated from the University of Florida with a Bachelor of Arts in Secondary English and a Masters in Education in Reading and Middle School Education. She has taught in both public and parochial schools. Commissioner Lee has been involved in many community organizations and is a 2005 Honorary member of Florida Blue Key. She currently is a Board Member of the University of Florida Museum of Science and Natural History, and serves as Board Chair of Gainesville Catholic Charities as well as being a member of the St. Augustine Diocesan Catholic Charities Board.

SHELLIE SACHS LEVIN

Commissioner Shellie Sachs Levin of Miami was appointed to the Commission in 2008 by Chief Financial Officer Alex Sink. She is a licensed Florida attorney who practiced law in Miami-Dade County for 25 years. In 1997, she left the practice of law to co-organize community initiatives and to help elect Democratic candidates to local, state and federal office. For the past 10 years Commissioner Levin has worked for EMILY's List, the largest independent political action committee in the country. She currently directs the EMILY's List Majority Council programs in the Southeastern United States and portions of the Midwest. In addition to her work with EMILY's List, Commissioner Levin has served on the National Women's Reproductive Healthcare Advisory Board and is a former Board member of the Women's Chamber of Commerce for Miami-Dade County. She served on the Miami-Dade County Commission on the Status of Women, as a Board member of the Women's Emergency Network, as Public Policy Chair for AAUW Miami and on the State Public Policy Committee for AAUW Florida.

MARIE FLORE LINDOR-LATORTUE

Commissioner Marie Flore Lindor-Latortue of Miami was appointed to the Commission in November 2004 by Governor Jeb Bush. She was born and raised in Port-au-Prince, Haiti. In 1992, she graduated from the Interamerican University of Puerto Rico with a double major: BA in Education and BA in Psychology. In 1995, she obtained her master degree in Health Services Administration at Barry University, Miami, Florida. She is currently a Ph. D. candidate in Leadership and Higher Education Administration. She has served voluntarily in several non-profit organizations particularly "The Make a Wish Foundation of Florida" and WDMA Jazz Station and community radio. Commissioner Lindor-Latortue is the Executive Director of the Association of Exchange and Development of Activities and Partnerships, Inc (AEDAP), an organization that supports small projects in Haiti and encourages leadership among youth, partnership projects among existing organizations.

JANET MABRY

Commissioner Janet Mabry of Gulf Breeze was last appointed to the FCSW by in March of 2006 by Chief Financial Officer Tom Gallagher. She is currently the President and owner of Mabry and Associates, a lobbying and government consulting firm since 1982. She received her B.A. in Political Science from Florida State University and went on to receive a dual Master's degree in Sociology and Political Science from Northern Arizona University. She has worked as a Legislative Assistant to House minority leader Ron Richmond and served as the Director at the St. Petersburg Adult Day Care Center and the Clearwater/St. Petersburg Girls Club Inc. Commissioner Mabry is very active as a volunteer in her community schools and charitable organizations. She is also the mother of two children.

ALCI MALDINADO

Commissioner Alci Maldonado of Lakeland was first appointed to the Commission in 2008 by Governor Charlie Crist. She is an Interior Designer but dedicates much of her time to charity. She is a long time volunteer of the United Methodist Church, especially with its Music Ministries to Children. Commissioner Maldonado has also volunteered with the Boy Scouts of America, has served as the Lakeland Senior High School Band Parents Head Chaperone and was a Board member of the Florida State University Parents Association. A veteran Republican activist, she has served on political campaigns at all level of politics. She has volunteered, worked with, advised or has been the manager of political campaigns for over thirty years in Florida and has also worked with the Massachusetts Republican Party as a volunteer.

NANCY PEEK MCGOWN

Commissioner Nancy Peek McGowan of Jacksonville, was appointed to the Commission in 2008 by Attorney General Bill McCollum. A conservative activist since 1990, she has a passion for public policy. Married to P. Ted McGowan, and mother of 5 children, Nancy began her career in the United States Senate as a legislative intern while attending the University of Florida, where she obtained a B.A. in Political Science in 1982. She's served on P.T.A. boards, a twice commissioned Respect Life Coordinator for the Diocese of St, Augustine, a 25 year lector at her church, President of San Jose Country Club Swim Team 2006, she serves on the Executive Board of the Justice Coalition, a victims' rights organization in Jacksonville. For the past 5 years, Nancy served as the Legislative Chairman for the Republican Women's Club of Duval Federated, is a member of the Republican Executive Committee of Duval County and 2008 Co-Chair Women for Mitt Romney of Duval County.

Nancy was recognized with an award from the Justice Coalition, along with bill sponsors Sen. Steve Wise and State Rep. Dick Kravitz for her roll in moving the Final Closing Arguments legislation out of the Senate Judiciary Committee. She delivered the pro-side of the argument against former Judiciary Senate Chairman, John Grant. This bill which came out of committee 8-0, and gave the State of Florida Final Closing Arguments in a jury trial for the first time in 150 years. H.B. 147 was signed into law by Gov. Jeb Bush on June 7th, 2006.

LAURA MCLEOD

Commissioner McLeod of Tallahassee was last appointed to the Commission in 2006 by Commissioner of Agriculture Charles Bronson. Commissioner McLeod, a native of Orlando, Florida, began her professional career in the field of health prevention, education and treatment. This encompassed her career for over a decade, as well as opening her first business in management consulting and personnel placement in health care. Commissioner McLeod then entered association management for a statewide, not -for-profit association where she implemented a statewide drug prevention/education program for which she won a national education award. Commissioner McLeod most recently was a governmental consultant for fifteen years and is now Executive Director for the Florida Association of DUI Programs.

ANITA MITCHELL

Commissioner Anita Mitchell of West Palm Beach was last appointed to the Commission in January 2004 by Chief Financial Officer Tom Gallagher. Commissioner Mitchell is president of The Mitchell Group, a governmental relations consulting firm. She has worked as a corporate communications specialist, political activist, lobbyist, media consultant, radio talk show host, program facilitator, fund-raiser, public relations practitioner, sales and marketing. She presently serves on the Board of Directors of the World Trade Center, Palm Beaches, the Constitutional Accountability Commission and as Chairman of the Mission Sandbox Foundation. Commissioner Mitchell has been listed in Who's Who in Communications and Who's Who in Politics South/ Southwest, and is a graduate of Leadership Palm Beach County.

LAURIE PIZZO

Commissioner Laurie Pizzo of Spring Hill was appointed the Commission by Attorney General Bill McCollum in 2007. Commissioner Pizzo has been a Multi-Million $$ Producer with Century 21 Alliance Realty since 2004. Commissioner Pizzo is a member of the Brooksville Rotary, the Greater Hernando County Chamber of Commerce, the Florida and National Association of Realtors, and the Realtors Political Action Committee. She was a 2007 recipient of the Tillie Fowler Excellence in Public Service Series Scholarship, a statewide leadership training program for women. She was one of six highly qualified women selected for the scholarship-based program supported by the Republican National Committee. Commissioner Pizzo is also a 2007 graduate of Leadership Hernando for the Greater Hernando County Chamber of Commerce and a 2007 graduate of Hernando County Association of Realtors Leadership Development Program.

MONICA RUSSO

Commissioner Monica Russo of Miami was appointed to the Commission in 2008 by Chief Financial Officer Alex Sink. Commissioner Russo is president of SEIU Healthcare Florida, the largest union of health care workers in the state of Florida and the South, representing more than 16,000 nurses, hospital and nursing home workers at 100 facilities across the state. Commissioner Russo serves on numerous Boards including, South Florida Workforce Investment Board, the Florida Commission on the Status of Women, Coalition for Comprehensive Immigration Reform, Florida International University's Research Institute for Social and Economic Policy, Congressman Kendrick Meek's Haitian Advisory Task Force, Congresswoman Debbie Wasserman-Schultz's Healthcare Working Group, Miami-Dade Branch NAACP Executive Committee and Labor Committee Co-Chair, and the United Way

ANNE VOSS

Commissioner Voss of Tampa was appointed in January 2006 to the FCSW by former Senate President Tom Lee. She was born in Houston, Texas and graduated from Occidental College in Los Angeles with a BA in Political Science and was chosen to attend American University for an honor's study program. She is the Vice President of Strategic Solutions of Tampa, a political consulting firm and Senior Vice President of the Women's Political Network. Prior to her husband's retirement from the U.S. Army, Commissioner Voss was Coordinator for the US Army Child Development Services at Picatinny Arsenal, N. J. and an Assistant Station Manager for the American Red Cross in Pirmasens, Germany. Commissioner Voss is currently President of the Florida Republican Women's Network and serves on the Vestry of St. John's Episcopal Church. Commissioner Voss's awards include: Department of Army, Commander's Award for Civilian Service; Department of Army, Achievement Medal for Civilian Service; Department of Army, Commendation and Red Cross Certificate of Recognition for 16 years of volunteer service.

NORMA WHITE, L.H.D.

2007 - 2008 Commission Chair Norma White of Jacksonville was appointed in January 2000 to the Commission by Commissioner of Insurance Bill Nelson and re-appointed in January 2004 by Senator James "Jim" King. Commissioner White attended Julliard School of Music, earned a master's degree from Columbia University, and is the recipient of an honorary doctorate from Florida A and M University. She worked in the Duval County School District for 37 years, serving as band director, assistant principal, magnet coordinator and music supervisor. She also served as the program facilitator for Florida Community College. Commissioner White was the first female member of the famed FAMU "Marching 100"--as well as the first female to direct that band, the first African-American to win the EVE Award in Fine Arts, the first Florida resident to become International President of Alpha Kappa Alpha Sorority, Incorporated and was the first Vice Chairman of the Florida A and M University Board of Trustees.

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Part III

2008/2009 Women's Health Data Report

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

Greetings,

It is with great pleasure that I share the 2009 Women's Health Data Report. The Women's Health Data Report is generated in an effort to continue the comprehensive assessment of the health of women in the State of Florida. This tool will be critical as we review the broad range of determinants impacting women's health and generate a Statewide Women's Health Plan.

The report documents and reviews issues such as how gender affects an individuals' social status, access to resources, and experience with health and illness throughout women's lives. At the same time it notes how heart disease, diabetes, stroke, unintentional injuries, and cancer are important health concerns that not only influence the life one leads, but can lead to premature deaths. In addition, the report highlights areas of concern for special population such as homeless women and female veterans and realizes the unique challenges that face these individuals in our population.

The most crucial message this report reinforces is that of prevention. The data reflects that prevention is one of the answers to premature death among women due to the number of preventable behavioral factors such as poor diet, obesity, and physical inactivity that contribute to premature death among women. Prevention can only be accomplished by educating women about health literacy and personal responsibility. Recognizing this makes our goal of mobilizing women to embrace healthier lifestyles and to reduce the number of premature deaths experienced today.

We look forward to incorporating the results of this data report with the efforts being made with our nongovernmental and governmental stakeholders to develop a strong and influential Statewide Women's Health Plan which will be available by 2010.

Loyally,

Kimberly A. Berfield
Deputy Secretary of Health
Officer of Women's Health Strategy
Florida Department of Health

> Executive Summary

The 2004 Florida Legislature recognized that women have gender-specific healthcare needs and that public policy needs to address their distinct health issues to improve their overall health status. To ensure that the state's polices and programs are responsive to sex and gender differences, and to women's health needs across the lifespan, the Florida Legislature created an Officer of Women's Health Strategy within the Florida Department of Health, (DOH), effective

July 1, 2004 (Appendix I). This landmark legislation, section 381.04015, *F.S.*, authorizes the assessment of health status of women in Florida.

More than 9 million women live in Florida. The estimated female population in Florida represents 51% of the estimated total state population (Florida Charts, 2008). There are higher proportions of White women in the older age categories and higher proportions of Black women in younger age categories. The racial gap in women's life expectancies has dramatically improved over the last 75 years. In 2007, White women had a life expectancy of 83.4 years; Non-White women had a life expectancy of 80.5 years. The disparity has narrowed to less than 3 years, compared to a 4 year difference in 2002; consistent with (Florida Vital Statistics Annual Report, 2007). Women are more likely than men to live in poverty (US Census, 2007), which ultimately impacts quality of life issues such as health care coverage, lifestyle behaviors, and stress.

According to the Department of Health and Human Services Office on Women's Health (www.4women.gov), when compared to other states, Florida ranks among the best states for its low rates of death for cancer, stroke, diabetes, and influenza and pneumonia. However, nationally the state ranks 44th in suicides among women, and 39th in chronic lower respiratory disease mortality. Non-Hispanic White women have much higher rates of death from these two causes than every other population group. Florida ranks among the top 15 best states in two indicators: no smoking during pregnancy and obesity. Florida ranks 44th in health insurance coverage with 78% of females covered. (Appendix II).

The top leading causes of death among females in Florida, 2005-2007 were due to: heart disease, stroke, lung cancer, chronic lower respiratory disease, Alzheimer's disease, unintentional injury, breast cancer, diabetes, colorectal cancer, influenza and pneumonia.

Poor lifestyle behaviors such as inadequate diet, obesity and physical inactivity are associated with the chronic diseases of heart disease, stroke, diabetes, and cancer. A few point raised in the data report are:

- The state has high rates of death for suicide and chronic lower respiratory disease.
- Chronic diseases continue to dominate the leading causes of death for women.
- Black women continue to bear a disproportionate share of HIV/AIDS mortality rates.

(Continued on page 73)

(Continued from page 72)

- Infant mortality among Blacks is still considerably higher than their counterparts.
- Access to care continues to be an issue for women with only 75.9 % of women receiving first trimester prenatal care.

This report underscores the fact that women of color are more likely to experience more adverse health outcomes than White women throughout the course of life and die at younger ages. All women can improve their health by adopting healthy lifestyle behaviors, such as a diet rich in fruits and vegetables, engaging in moderate physical activity at least five times a week for 30 minutes a day, adhering to screening recommendations, utilizing safety practices, and avoiding substance abuse. It is also important for women to attend to their mental, emotional, spiritual and physical needs to ensure they are healthy in all aspects of their lives.

What is Prenatal Care and Why is it Important?

Prenatal care is the care woman gets during a pregnancy. Getting early and regular prenatal care is important for the health of both mother and the developing baby.

In addition, health care providers are now recommending a woman see a health care provider for preconception care, before she is even trying to get pregnant.

Health care providers recommend women take the following steps to ensure the best health outcome for mother and baby:

- Getting at least 400 micrograms of folic acid every day to help prevent many types of neural tube defects. Health care providers recommend taking folic acid both before and during pregnancy.
- Being properly vaccinated for certain diseases (such as chicken pox and rubella) that could harm a developing fetus—it is important to have the vaccinations before becoming pregnant
- Maintaining a healthy weight and diet and getting regular physical activity before, during, and after pregnancy
- Avoiding smoking, alcohol, or drug use before, during, and after pregnancy

Source: US Department of Health and Human Services. http://www.nichd.nih.gov/health/topics/pregnancy.cfm

> Introduction

Background

The 2004 Florida Legislature recognized that women have gender-specific healthcare needs and that public policy needs to address their distinct health issues to improve their overall health status. To ensure that the state's polices and programs are responsive to sex and gender differences, and to women's health needs across the lifespan, the Florida Legislature created an Officer of Women's Health Strategy within the Florida Department of Health, (DOH), effective

July 1, 2004 (Appendix I). This landmark legislation, section 381.04015, F.S., authorizes the assessment of health status of women in Florida.

Definition of Women's Health

The definition of women's health guiding this report is:

"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social, spiritual, and physical well-being and is determined by the social, political, and economic context of their lives, as well as biology."

Data Sources

The following sources of data on Florida statistics are included in this report:

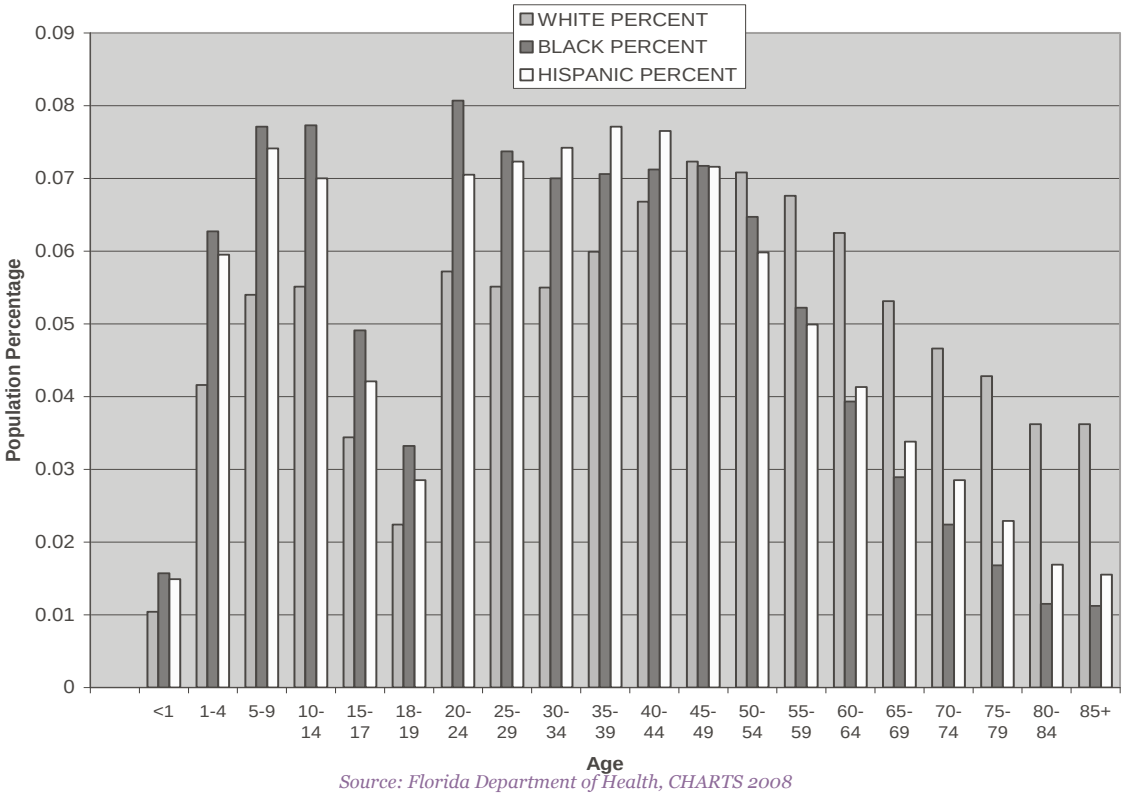
- Behavior Risk Factor Surveillance System
- Bureau of Research and Data Analysis, Florida Department of Corrections
- Community Health Assessment Resource Tool Set (CHARTS)
- Florida Cancer Data System
- Florida Department of Children and Families
- Florida Legislature, Office of Economic and Demographic Research
- Florida Office of Vital Statistics
- Florida Department of Health, Bureau of Epidemiology
- Florida Department of Health, Division of Family Health Services
- Florida Department of Health, Refugee Health
- North Florida/South Georgia Veterans Health System
- U.S. Census Bureau
- U.S. Department of Health and Human Services, Office of Women's Health,
- U.S. Department of Homeland Security
- U.S. Department of Veteran Affairs

Limitations of existing morbidity and mortality data often preclude detailed analyses of age, race, and ethnicity.

> Demographics

In 2008, the estimated female population in Florida was 9,640,583, which represent 51% of the estimated total state population (CHARTS). Chart 1 shows higher proportions of White women in the older age categories and higher proportions of Black women in the younger age categories. Therefore a higher proportion of White women are likely to be affected by health problems associated with older age groups and a higher proportion of the population of Black women are likely to be more affected by health problems associated with younger ages. Overtime, this may change as younger Black women age.

Chart 1: Florida Female Population By Race and Age



Source: Florida Department of Health, CHARTS 2008

Florida's racial/ethnic composition is primarily persons of White race, Black race, and Hispanic ethnicity. According to the 2000 Census, only 2% of its female population is Asian/Pacific Islander, and 0.4% is American Indian/Alaskan Native. Given the substantial proportion of Florida's Hispanic population, over 16%, it is important to understand how the Hispanic population is distributed by age. Table 2 reflects the estimated Hispanic female population in Florida for 2007. It is important to note that for these population estimates, the Hispanic ethnicity population includes Hispanic persons of all racial groups.

Table 1. Estimated Florida Hispanic Female Population By Age, 2007

Age	Estimated 2007 Female Hispanic Population
1-4	112,325
5-9	143,951
10-14	137,339
15-19	137,707
20-24	138,231
25-34	289,001
35-44	303,118
45-54	252,006
55-64	174,610
65-74	121,408
75-84	77,417
85 +	29,614

Note: Hispanic Ethnicity Population includes all racial groups
Source: The Florida Legislature, Office of Economic and Demographic Research

Hispanics make up over 16% of Florida's overall population.

> Physical Health

On average, minority women suffer poorer health than White women throughout their life and die at younger ages. While the health status of women in Florida has generally improved in the last century, Black women's health status has improved at a slower rate than that of their White counterparts. This section reports data on Florida women's life expectancy, morbidity and mortality. Women, in general, have higher morbidity but lower mortality rates than men. A number of diseases disproportionately affect minority women, particularly Black women. It is important to note that the limitations of the source data may have prevented the provision of detailed racial/ethnic differences, which is why some discussions focus solely on Black and White racial subgroup differences.

Life Expectancy

In the last 75 years, the racial gap in women's life expectancies for women has dramatically improved. Over the last 75 years non-White women lived on average, to just 49 years, and White women lived to 64 years, which was a life expectancy difference of 15 years. Table 2 highlights the fact that today the life expectancy disparity in life expectancy has narrowed to less than three years.

Table 2. YEARS OF LIFE EXPECTANCY AT BIRTH BY RACE FOR FLORIDA WOMEN, SELECTED YEARS 1919-1991 AND 2002-2007

YEAR	WHITE	NON-WHITE	DIFFERENCE
1919-1921	60.6	NA	NA
1929-1931	64.2	48.9	15.3
1939-1941	68.8	54.4	14.4
1949-1951	74.0	62.2	11.8
1959-1961	76.2	65.9	10.3
1969-1971	76.8	67.9	8.9
1979-1981	78.9	72.4	6.5
1989-1991	80.9	75.3	5.6
2002	81.7	77.7	4.0
2003	81.9	77.8	4.1
2004	82.4	78.5	3.9
2005	82.5	78.9	3.6
2006	83.0	79.4	3.6
2007	83.4	80.5	2.9

Source: Florida Vital Statistics Annual Report 2007

> Mortality Data

The review of leading causes of death in women is broken down by race and ethnicity. The leading causes of death rates for Florida women are shown as deaths per 100,000. Table 3 summarizes the leading causes of mortality for women of all ages for the years 2005 – 2007. This table suggests that heart disease, stroke, and lung cancer are serious problems for Florida women. It also draws attention to racial disparities with Black women having mortality rates that are often two or more times that of their White counterparts (such as stroke and diabetes). Hispanic women have higher Alzheimer's related deaths than White and Black Women. White women have much higher related to lung cancer, chronic lower respiratory disease, and unintentional injuries.

Table 3. Age-Adjusted Rates by Race for leading Causes of Death among Florida Women, 2005-2007

Age-Adjusted Rates (2005-2007)	WHITE	BLACK	HISPANIC	TOTAL
Deaths from Heart Diseases (2005-07)	131.9	177.8	137.6	136.8
Deaths from Stroke (2005-07)	31.5	60.1	27.5	34.2
Deaths from Lung Cancer (2005-07)	39.5	25.0	14.9	38.0
Deaths from C.L.R.D. (including Asthma) (2005-07)	34.7	16.1	18.5	33.0
Deaths from Alzheimer's Disease (2005-07)	18.9	17.6	20.8	18.8
Deaths from Unintentional Injury (Accidents) (2005-07)	28.6	19.7	15.6	27.0
Deaths from Breast Cancer (2005-07)	19.9	27.6	15.8	20.8
Deaths from Diabetes (2005-07)	14.5	43.1	18.8	17.2
Deaths from Colorectal Cancer (2005-07)	12.6	17.2	12.5	13.0
Deaths from Influenza & Pneumonia (2005-07)	8.0	11.0	7.7	8.3

Source: Florida Department of Health, Office of Vital Statistics

Death due to heart disease remains the leading cause of death for women in Florida, although mortality has decline over recent years. Table 4 illustrates the number of deaths due to heart disease across the lifespan. Death due to heart disease prior to age 15 are included in the total count. There has been a steady decrease in the number of heart disease related deaths in most age categories.

Table 4. Florida Deaths from Heart Disease, All Races, Female, Non-Hispanic, All Age Groups, 2005-2007

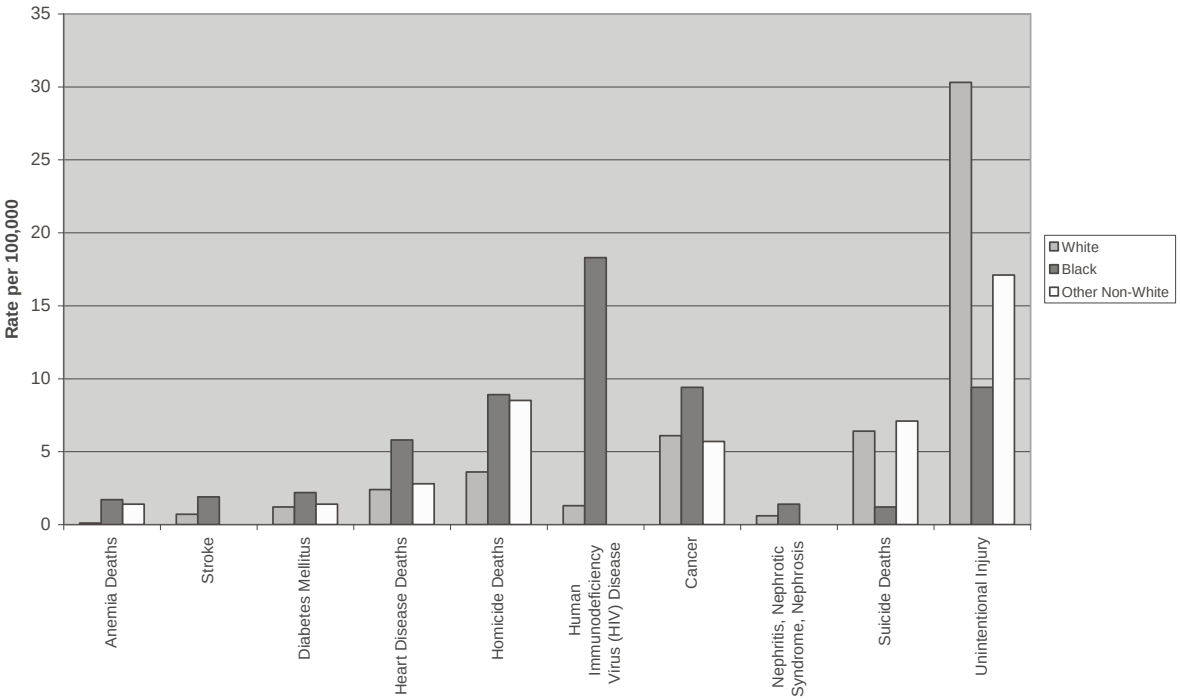
Year	Total	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
2007	17,518	4	10	42	177	585	1,073	1,849	4,777	8,984
2006	18,645	6	10	35	191	521	1,016	1,901	5,389	9,557
2005	19,683	2	7	50	201	550	1,042	2,084	5,648	10,089

Source: Florida Department of Health, CHARTS 2008

Chart 2 summarizes the leading causes of mortality by race for women 18-34 and shows that priorities for women's health can differ when examining race and age-specific data. The chart clearly shows that death from unintentional injuries is a top killer for Non-Hispanic White women, followed by death from suicide and cancer.

For Non-Hispanic Black women, death from HIV is the top concern, followed by death from cancer, unintentional injuries, and homicide. For other non-White females, the leading causes of death are unintentional injuries, homicide, and suicide

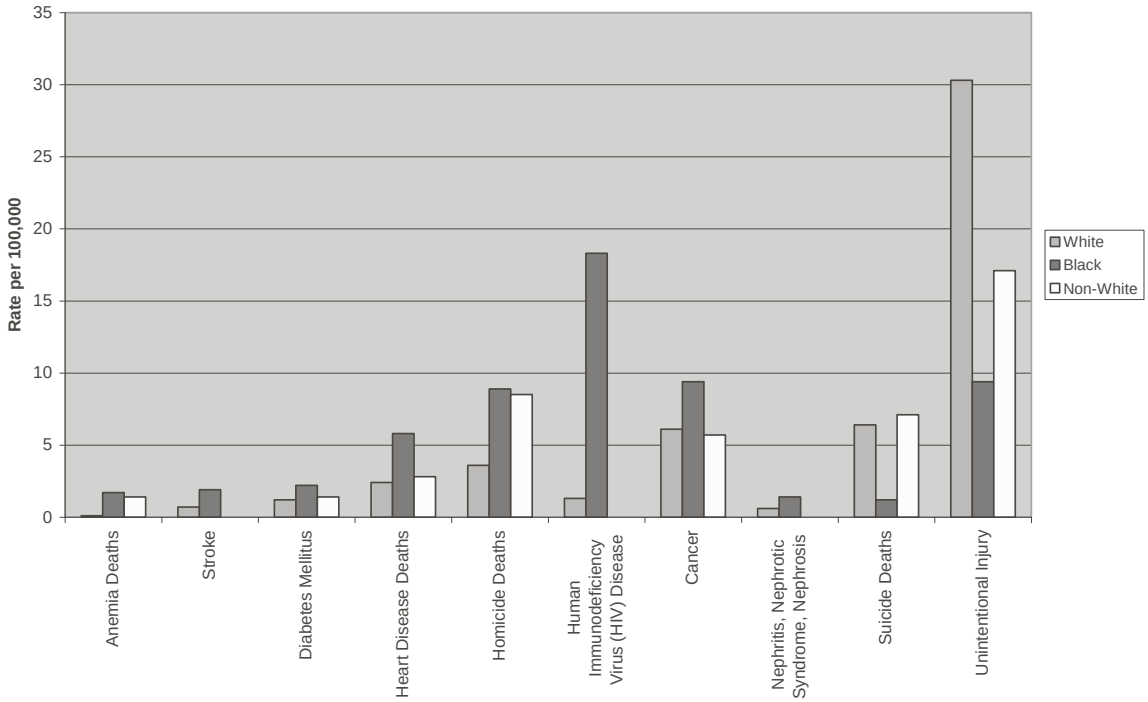
Chart 2. Mortality Rates by Race for Leading Causes of Death Among Florida Women Ages 18-34, 2007



Source: Florida Department of Health, CHARTS 2008

Chart 3 shows that unintentional injuries, suicide, and cancer continue to be the leading causes of death for women at the higher age groups of 45-54 years of age. For Black women, HIV, homicides, and heart disease become the leading causes of death. HIV continues to disproportionately affect Black women. For other non-White women, unintentional injuries, suicide, cancer and homicide are the leading causes of death

Chart 3. Mortality Rates By Race for Leading Causes of Death Among Florida Women Ages 45-54, 2007



Source: Florida Department of Health, CHARTS 2008

Chart 4 shows that continue to be the leading causes of death for women 55-84 years of age.

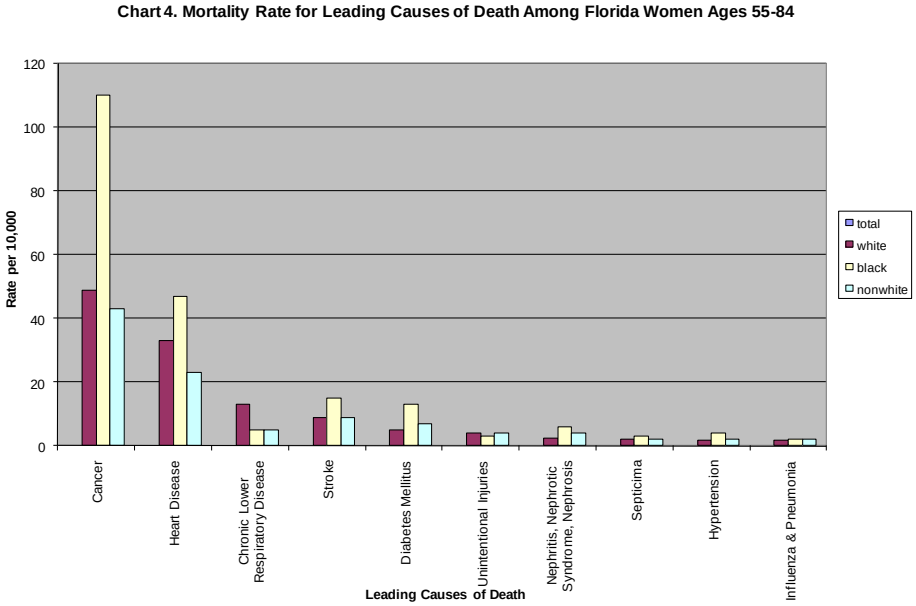
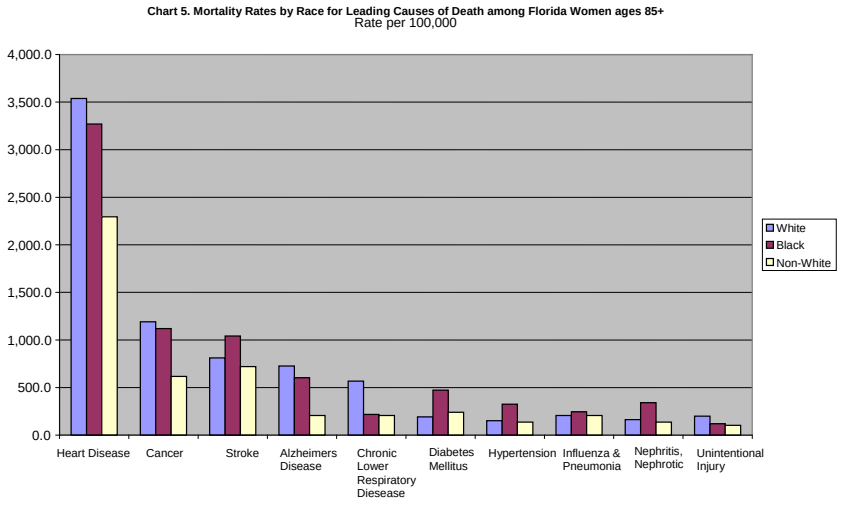


Chart 5 summarizes mortality rates by race for women age 85 and older. Heart disease, stroke, cancer and Alzheimer's disease are the leading causes of death for this age group. Black women in this age group still die from diabetes at twice the rate of White and other non-White women. In addition, Black women suffer from stroke and hypertension at higher rates than their counterparts. Again, proper diet, physical fitness, and stress management are ways to reduce one's risk for heart disease, stroke and hypertension. White women have higher rate of death due to Chronic Respiratory disease than their counterparts.



Source: Florida Department of Health, CHARTS 2008

> Morbidity

Cancer

Table 5 shows the age-adjusted incidence rate (per 100,000) for cancer by site in women.

Breast cancer is the most common site of cancer, followed by colorectal, lung and bronchus.

Table 5. Cancer by Site among Black Women in Florida, Age-adjusted Rate per 100,000, 2005

Breast	Colorectal	Lung and bronchus	Non-Hodgkin's lymphoma	Cervical	Ovarian
86.3	42.8	38.5	13.0	11.1	8.6

Source: Florida Cancer Data System

Table 6. Cancer by Site among White Women in Florida, Age-adjusted rate per 100,000, 2005

Breast	Colorectal	Lung and bronchus	Melanoma	Non-Hodgkin's lymphoma	Cervical	Ovarian
110.5	37.9	59.7	15.6	14.7	9.3	13.1

Source: Florida Cancer Data System

In Florida, White women have higher incidences of breast, lung and bronchus, melanoma, Non-Hodgkin's lymphoma cancer, and ovarian cancer; while Black women have higher incidences of colorectal, and cervical cancer. Data was not available for Hispanic women. Table 7 illustrates the Florida and national statistics, for the comparison of the incidence of cancer for all women regardless of race and ethnicity.

Table 7. Comparison of Cancer Incidence by Type, Florida and the U.S., Age –Adjusted Rate per 100,000, 2004

Cancer Type	Lung	Colorectal	Breast	Cervical	Melanoma
Florida	73.9	48.5	59.1	4.5	16.4
US	67.4	49.5	64	4.1	17.1

Source: Florida Cancer Data System

Florida's age-adjusted incidence rates are lower, with the exception of lung and cervical cancer.

In 2006, Floridians had a higher percentage of adults 50 and over who had a colonoscopy or sigmoioscopy than the national percentage, 58.9% and 57.1% respectively. In 2006, women in Florida aged 40+ had a mammogram within the past two years at 78%, higher than the 76.5% national percentage. However, when looking at cervical cancer, fewer women in Florida, 82.8%, received a pap test in the past three years compared to the national percentage of 84.0% in 2006.

Diabetes

According to Florida CHARTS, in 2007, Hispanic women had the lowest percentage statewide among women with diagnosed diabetes, 6.4%. Non-Hispanic white women and Non-Hispanic Black women had a percentage of diagnosed diabetes of 7.9% and 13.3% respectively.

Black women continue to have a higher percentage of diabetes than their female counterparts. The risks for diabetes can be significantly reduced with proper diet and physical activity (Florida Department of Health, Bureau of Epidemiology).

HIV/AIDS

Table 8 depicts cases of HIV and AIDS among Florida women reported in 2007 by race and Hispanic ethnicity. In Florida, the rate of HIV and AIDS among Black women is substantially higher than that of White or Hispanic women. In 2007, the Black-White ratio of reported HIV cases per 100,000 women is 3 :1 (or for every 3 reported HIV cases of Black women there is 1 reported HIV case for White women. The Hispanic-White ratio of reported HIV case in 2007 is 1:1. Reported HIV cases include cases that have converted to AIDS. The Black-White ratio of reported AIDS cases per 100,000 women is 4.7:1, and the Hispanic-White AIDS cases 1.0:1 (Hispanic: White).

Table 8. HIV and AIDS Cases in Adult Women By Race/Ethnicity (age 13+) Rate per 100,000 Population*, Florida, 2007

Race/Ethnicity	AIDS Cases	AIDS Rate*	HIV Cases	HIV Rate*
White, non-Hispanic	200	3.9	373	7.2
Black, non-Hispanic	945	78.0	1,115	92.0
Hispanic	143	9.2	266	17.1
Other	29	14.7	22	11.1

Source: 2007 Florida Population Estimates, DOH, Office of Planning, Evaluation and Data Analysis

Without accounting for gender, Florida represents 13% of AIDS cases; and 10% of HIV cases in the United States, second only to New York. Among U.S. metropolitan statistical areas (MSA), the Miami (MSA) ranked second behind the New York City MSA. During this same period, the Miami (MSA) had the highest AIDS case rate in the nation with 41.9 per 100,000 population, followed by the New York City MSA (29.2). Florida reported a slightly higher percentage of AIDS cases among Blacks (54%) compared with the United States (40%). Florida also reported a higher percentage of cases among women (34%) compared with the United States (19%). The state reported a slightly lower percentage of HIV cases among blacks (45%) compared with the United States (46%). Florida also reported a slightly lower percentage of cases among women (29%) compared with the United States (30%) (Florida Department of Health, Bureau of HIV/AIDS).

In 1998, 38% of the HIV cases reported in Florida were female. The proportion of HIV cases among women has decreased steadily over the past nine years. The result is an increase of the male-to-female ratio, from 1.6:1 in 1998 to 2.4:1 in 2007. This increase in the male-to-female ratio differs from the pattern seen for the ratio for AIDS cases during the same time period. In 2007, a total of 2,571 adult males and 1,317 adult females were reported with AIDS, representing 66% and 34% of cases, respectively. Also in 2007, a total of 3,608 adult males and 1,579 adult females were reported with HIV infection, representing 70% and 30% of cases, respectively. (Florida Department of Health, Bureau of HIV/AIDS)

Learn about the

Governor's Council on Physical Fitness

http://www.healthyfloridians.com/council.html

> Health Behaviors

This section reviews the evidence for pre-disposing behaviors that directly impact women's health. These behaviors include smoking, alcohol abuse, physical activity, and obesity. Data were obtained from the Florida County-level Behavioral Risk Factors Surveillance Telephone Survey conducted by the Florida Department of Health, Bureau of Epidemiology.

Smoking

In 2007, non-Hispanic White women had the highest smoking percentage among women who reported to be current smokers, with 19.7%. The second highest group of female smokers was non-Hispanic Black females with 15%, followed by Hispanic females with 12%. These rates are higher than the Healthy People 2010 objective of 12%. The rates among all groups have decreased in the last 5 years. According to 2002-2004 data, smoking rates among was highest among non-Hispanic White women were (26%), followed by non-Hispanic Black women (14%), and Hispanic women (13%). The research shows that there has been a greater decrease among non-Hispanic White women smokers. The reduction may be due to the increase awareness around smoking cessation; however the precise reason is unknown.

Alcohol Abuse

In 2007, non-Hispanic White women had the highest drinking percentage among women who reported to engage in heavy or binge drinking with 14.5%. The second highest group of heavy or binge drinkers was non-Hispanic Black women with 9.2%, followed by Hispanic women with 8.6%. Alcohol binge drinking is an important risk factor for diseases such as cancer and motor vehicle injuries. The data shows that public health campaigns focused on heavy or binge drinking may need to target non-Hispanic White women to reduce this unhealthy lifestyle behavior.

Overweight/Obese

Obesity is an important risk factor because it is associated with heart disease, diabetes, and stroke. All leading causes of death among women in Florida. According to 2007 data, non-Hispanic Black and Hispanic women are substantially more likely to report being overweight or obese than non-Hispanic White women. All three groups all exceed the Healthy People 2010 obesity objective of 15%. Table 9 details the percentage of overweight and obese women:

Table 9. Percentage of Adult Women Who are Overweight or Obese, 2007

Race/Ethnicity - Women	Overweight	Obese
Non-Hispanic White	30.2%	19.9%
Non-Hispanic Black	33.1%	39%
Hispanic	28.2%	26.1%

Source: Florida Department of Health, Bureau of Epidemiology

It is important to note that the percentage of non-Hispanic Black women who report being obese exceeds the percentage of non-Hispanic Black women who stated that they were overweight. This data relies on self-reports form the Florida County-level Behavioral Risk Factors Surveillance Telephone Survey (BRFFS). Actual rates of obesity and overweight among Florida women may vary. Obesity is an important risk factor because it is associated with heart disease, diabetes, and stroke, all top killers of women.

Physical Activity

In 2007, Hispanic women reported most often to having a sedentary lifestyle (40.8%), followed by non-Hispanic Black women (33.9%), and non-Hispanic White Women at (24.1%). A lack of physical activity is strongly linked to overweight, obesity, and chronic diseases such as diabetes and hypertension. There is considerably more work to be done to increase physical fitness in the lifestyles of Hispanic and non-Hispanic Black women.

Health Tip: Log Your Exercise

You may have tried tracking what you eat, but how about logging your daily exercise?

Keeping tabs on your activity routine may even inspire you to do more.

The American Academy of Family Physicians offers these suggestions on what to track in your exercise journal:

- **Write down every physical activity that you do each day, including what you do and how long you spend doing it.**
- **Don't just log going for a run or lifting weights. Everyday chores that burn calories count, too. Track activities such as cleaning and vacuuming, or even walking the dog.**
- **Keep the journal with you, so you can write things down before you forget.**
- **Commit to entering information in the journal every day.**

Source: U.S. Department of Health and Human Services; http://www.womenshealth.gov/news/english/622529.htm

> Access to Care

Access to quality health care is a concept that includes the fact that services need to be available, affordable, and perceived as "usable" by the population. Access to care is necessary to allow individuals an opportunity to maintain good health and to engage in prevention and management of infectious and chronic diseases.

The U.S. Department of Health and Human Services produced a report entitled, Literature Review on Effective Sex- and Gender- Based Systems/Models of Care in 2007. The following points were cited in the report.

Access to Care

- Women tend to have fewer resources in their own names, and therefore face unique access barriers to the healthcare system compared with men. Women are more likely to seek preventive care than men, partially due to socialization and exposure to seeking routine medical care due to reproductive health needs.
- Women appear to receive worse quality of care than men do, especially with acute conditions. However, women may receive better preventive care then men due to being frequent users of services.
- Despite significant gains, women remain relatively understudied in medical research studies. Medical treatments may not be as appropriate for women as they are for men, and women may be subject to greater adverse drug reactions than men.

Reaching the Underserved

A variety of approaches have been taken to engage and retain the underserved including the use of community health workers, emphasizing cultural competency, reaching people where they are and providing information in the appropriate language or literacy level.

- Efforts have been made to reduce barriers to access such as providing transportation to facilities.
- Healthcare providers are encouraged to maintain awareness and be responsive to cultural needs including different traditional beliefs, values and languages to retain populations. Implementation needs include strong organizational leadership, adequate funding, and the efforts to overcome institutional barriers and resistance to change.

Systems Approach and Insurance/ Costs Trends

- U.S. patients have been estimated to receive a little over half of the care they should receive. Nearly a fifth of the U.S population lacks health insurance coverage. Slightly more women than men have health insurance coverage which may be due to women being more likely to get public assistance through Medicaid because of pregnancy.
- Men are more likely to hold health insurance policies in their names, while women are more likely to be covered as dependents, which makes them vulnerable to disruptions in coverage due to death or divorce.
- Women are more likely to be financially disadvantaged compared with men, and have greater family

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responsibilities. As a result, healthcare costs become a greater burden for women than for men. Women pay a larger percentage of their income out of pocket and are more likely to skip needed doses of medications because of cost limitation. Because of their lower incomes, women also may be more sensitive to co-payment amounts, thus contributing to poorer quality of care and reduced care outcomes.

Sex- and Gender-Based Healthcare Practices

- Research is limited in showing the overall effectiveness of gender-based healthcare practices. It is believed that once gender-based medical practices are fully implemented they will be highly effective.
- Universally, the women who attend such clinics rate their overall satisfaction as quite high. In addition, studies are showing that these women are receiving better quality care, especially better preventive care on traditional women's issues.
- The primary barriers to implementing this kind of women's care model are inertia, insufficient funding, and space. Data to demonstrate the effectiveness of sex- and gender-based approaches to care are extremely sparse. Women are still not included in medical research trials to the extent of men. In addition, existing reporting systems both fail to report on gender and do not collect adequate sample size to allow for gender-based analysis.

Approaches for Improving Care

- There is anecdotal evidence that increasing the number of women leaders in healthcare improves care for women, and substantial evidence that male and female doctors communicate and interact with patients in different ways. Evidence indicates women have different care preferences than men, but no data exists to suggest whether attention to these areas will substantially improve care for women.
- Much of the burden of achieving the goal of gender-specific medicine will fall to physicians. To accomplish this mission will undoubtedly require changes in clinical care; increasing parity in terms of women and minority medical leadership; better training for the entire medical community on sex- and gender- based differences; and attention to other aspects of care, such as communication and expectations that may differ in important ways between male and female patients. Patient education will be critical to the success of this effort.

(Report Source: Office of Women's Health, U.S. Department of Health and Human Services by Uncommon Insights, LLC.)

Insurance Coverage

In 2007, non-Hispanic White women in Florida reported not having any type of healthcare insurance (88.1%), which is higher than non-Hispanic Black women (78.8%) and Hispanic women (64.9%). Hispanic women reported more often to not seeing a doctor at least once in the past year due to cost (24.1%), closely followed by non-Hispanic Black women (23.8%), and least often by non-Hispanic white women (13.2%). (Florida Department of Health, Bureau of Epidemiology)

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Healthcare Service Utilization

Women's access to care can be analyzed by examining use of service, particularly preventive care, and screening tests. The use of specific, recommended screening tests include pap smears, mammograms, cholesterol screening and colorectal test indicate access to care. The Florida Profile, Health Disparities chart (Appendix IV) identifies the percentage in which women engage in preventive care.

Cholesterol Screening in past 5 years (2003-2005)
As a state, Florida falls short of the Healthy People 2010 National Target of 80.0% with only 77.4% of women receiving cholesterol screening. American Indian/Alaskan Native engage in the highest cholesterol screening with 83.2%, and Hispanic women the lowest with 69.8%.

Mammogram in past 2 years, age 40 and older (2002-2004)
As a state, Florida surpasses the Healthy People 2010 National Target of 70% with a statewide percentage of 76.3%. Asian/ Pacific Islander had the highest percentage with 88.9%, compared to Hispanic women with 69.9%, which is very close to the national target.

Pap smear in past 3 years (2002-2004)
As a state, Florida falls short of the Healthy People 2010 National Target of 90.0% with only 83.6% of women receiving a pap smear in the past three years. Non-Hispanic Black women have the highest percentage at 86.1%, with Asian/Pacific Islander only receiving pap smears at 61.3%.

Blood stool test in past 2 years, age 50 and older (2002-2004)
As a state, Florida falls short of the Healthy People 2010 National Target of 33.0% with only 31.9% of women 50 and older receiving a blood stool test in the past two years . Non-Hispanic White women have the highest percentage at 34.5, over the national level, compared with the lowest, American Indian/Alaskan Native at 10.1%.

Routine check-up in past 2 years (2005)
Nearly 87% of Florida women received a checkup in the past two years. The highest rate of participation in routine care is among Non-Hispanic Black Women at 92.2% and the lowest is among Asian/ Pacific Islander at 74.2%.

*(*U.S. Department of Health and Human Services, Office on Women's Health).

Nearly 87% of Florida women received a checkup in the past two years.

> Reproductive Health

Receiving early and adequate prenatal care has been shown to reduce infant mortality and the number of babies born with low birth weight. Overall, women in Florida fall short of the Healthy People 2010 National Target of 90% with only 75.9% of women receiving first trimester prenatal care. In 2007, 78.4% of White and 67.3% of Black mothers received prenatal care in the first trimester. (Florida Department of Health, Office of Vital Statistics.)

Infant death is a death of a live born infant prior to its first birthday. According to Florida CHARTS, the 2007 infant mortality rate per 1,000 in Florida among all races is 7.1. The infant mortality rate per 1,000 live births for White and Black Infants is 5.2 and 13.4 respectively. Nationally and statewide, there is a large disparity between Black and White infant mortality. Research is unclear why this disparity exists.

Neonatal death is the death of a live born within the first 28 days of life. The statewide rate for 2007 is 4.4 per 1,000 live births. For White infants the neonatal mortality rate is 3.4 per 1,000 live births, and for Black infants the rate is 8.5 per 1,000 live births. The neonatal death rate for Black infants is 2.5 times higher than the rate for White infants.

Risk factors significantly associated with a pregnancy-related death with the following characteristics: Black race, older than 35, have not received a high school degree or GED, do not receive prenatal care, are overweight or obese, and who have a cesarean delivery.

During 1995-2005, the Pregnancy Associated Mortality Review (PAMR) committee reviewed 381 pregnancy associated deaths and identifies 264 (69%) deaths as pregnancy-related deaths. Of the pregnancy-related deaths, 134 (51%) were Black women, 123 (47%) were White women, and 7 (3%) were of other races. The average ratio overall was 18 pregnancy related deaths per 100,000 live births. The Black pregnancy related mortality ratio remains three to four times higher than the white ratio (Florida Department of Health, Division of Family Health Services).

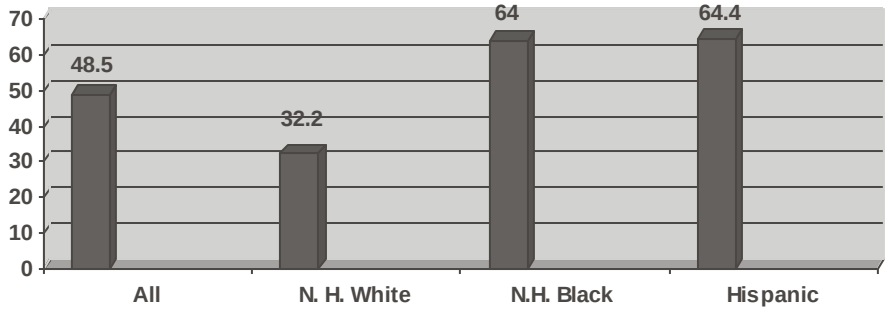
The data presented in the following section is from the 2005 Florida Pregnancy Risk Assessment Monitoring System (PRAMS), an on-going survey of Florida resident women who have given birth. (Florida Department of Health, Bureau of Epidemiology.)

Maternal Health and Behaviors

Insurance Status

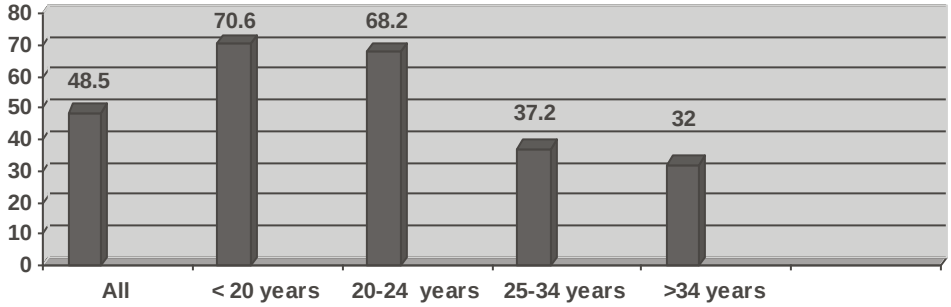
Non-Hispanic Black and Hispanic women are more likely to be uninsured before pregnancy. Having insurance coverage is critical for gaining access to prenatal care throughout and after pregnancy. It is a well established fact, that the health of the mother influences her health during and after pregnancy, as well as birth outcomes. In addition, women up until age 24, have the highest percentage of not having health insurance during pregnancy.

Chart 6. Prevalence (Percent) of Being Uninsured Before Pregnancy Among Women in Florida (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

Chart 7. Prevalence (Percent) of Being Uninsured Before Pregnancy Among Women in Florida (By Age)

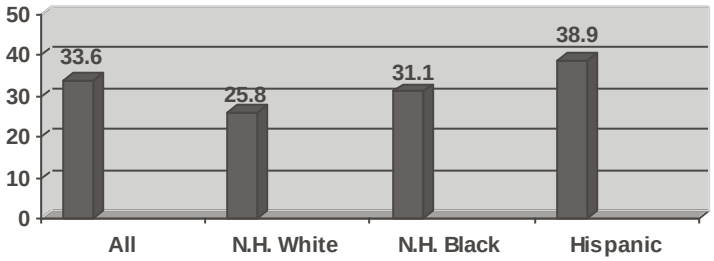


Source: Florida Department of Health, Bureau of Epidemiology

The chart below shows that Non-Hispanic Black and Hispanic women have higher chances of experiencing difficulty in obtaining Medicaid during pregnancy.

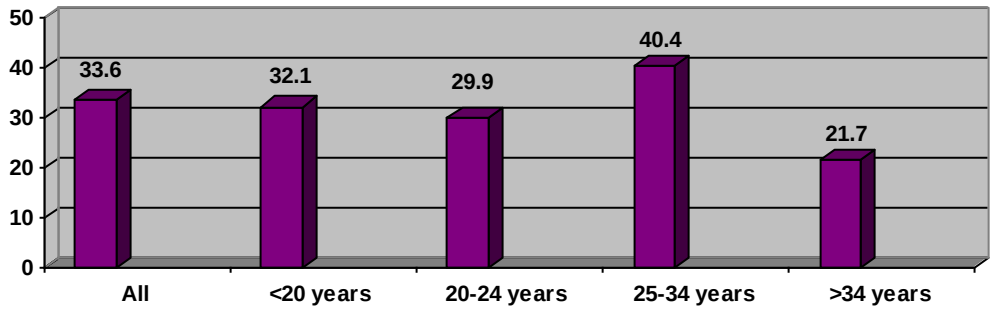
Prenatal care is essential to having better health outcomes for the mother and child. Women ages 25-34, experience the most difficulty in obtaining Medicaid.

Chart 8. Prevalence (Percent) of Having Difficulty in Getting Medicaid During Pregnancy Among Women Who Tried to Get Medicaid in Florida Department of Health (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

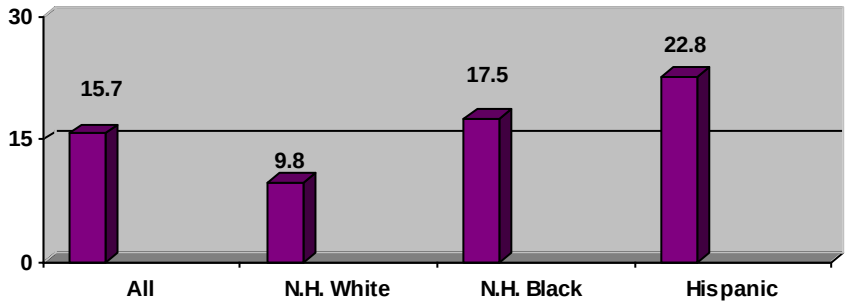
Chart 9. Prevalence (Percent) of Having Difficulty in Getting Medicaid During Pregnancy Among Women Who Tried to Get Medicaid in Florida Department of Health (By Age)



Source: Florida Department of Health, Bureau of Epidemiology

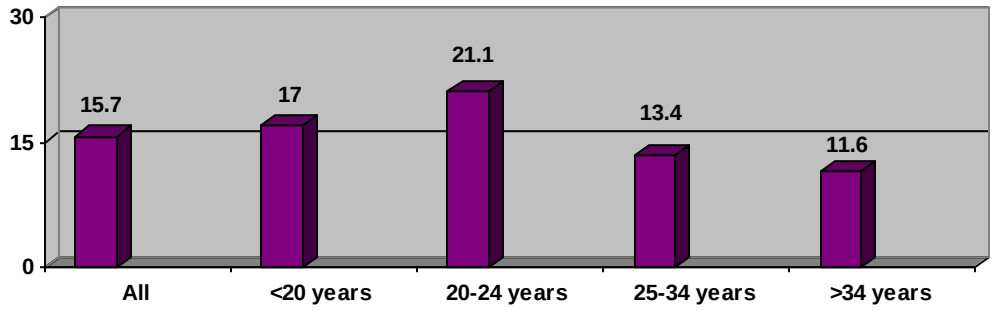
Florida's high infant mortality rates highlighted the need to focus on areas that can be addressed to improve outcomes. Prenatal care is one area that public health professionals are addressing. Non-Hispanic Black (17.35%) and Hispanic women (22.8%) faced difficulties in obtaining prenatal care due to insufficient money or insurance. Women ages 20-24 faced hardship obtaining prenatal care due to insufficient money or insurance at 21.1%. Improving the health of a woman prior to pregnancy (preconception health) is another area that is being addressed.

Chart 10. Prevalence (Percent) of Barrier to Early Prenatal Care Among Women in Florida: Insufficient Money or Insurance (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

Chart 11: Prevalence (Percent) of Barrier to Early Prenatal Care Among Women in Florida: Insufficient Money or Insurance (By Age)



Source: Florida Department of Health, Bureau of Epidemiology

Maternal Health

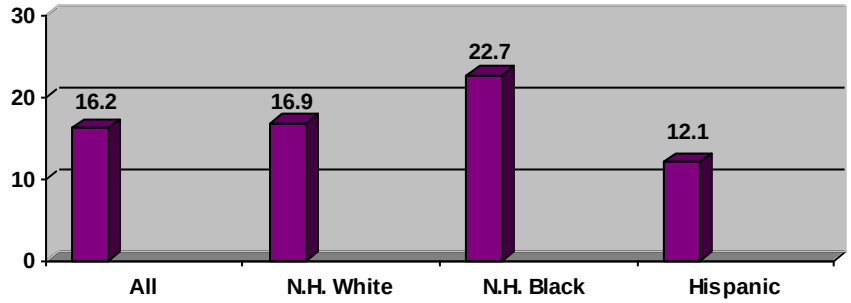
A women's health prior to conception is an important health indicator for the maternal and child health during pregnancy. Mothers are advised to maintain a healthy pre-pregnancy and post-pregnancy weight; take a daily multi-vitamin with folic acid; eat healthy meals; and have annual screenings.

Healthy Weight

Maintaining a healthy weight before, during, and after pregnancy is an important factor in overall maternal and infant health. A mother's weight is an indicator to maternal dietary habits, physical fitness levels, and her risk of hypertension and/or diabetes.

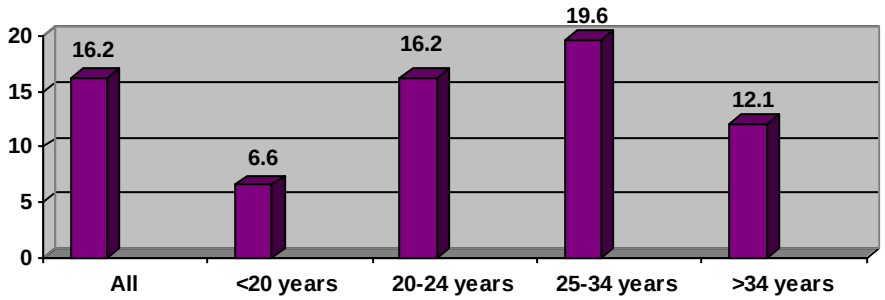
Non-Hispanic Black and Non-Hispanic White women had higher percentages of pre-pregnancy obesity, at 22.7% and 16.9% respectively. Women between the ages of 25-34 had the highest pre-pregnancy obesity at 19.6%.

Chart 12. Prevalence (Percent) of Pre-Pregnancy Obesity Among Women in Florida (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

Chart 13. Prevalence (Percent) of Pre-Pregnancy Obesity Among Women in Florida (By Age)



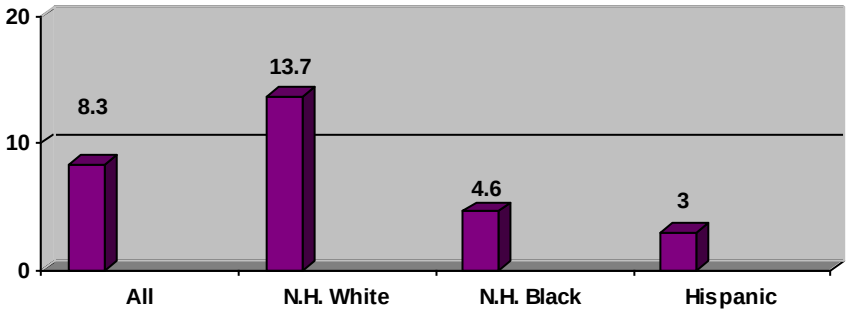
Source: Florida Department of Health, Bureau of Epidemiology

Alcohol and Tobacco Use During Pregnancy

Drinking alcohol and smoking are known to be detrimental to the health of the fetus during pregnancy. Alcohol and tobacco use during pregnancy are known to contribute to birth defects and low infant birth weight.

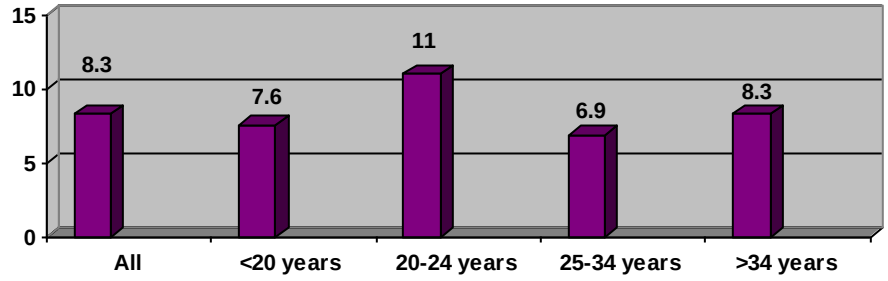
Non-Hispanic White women had higher prevalence of smoking during pregnancy at 13.7%, almost three times as much as Non-Hispanic Black and Hispanic women. The highest age group for smoking during pregnancy was with women 20-24 years of age.

Chart 14. Prevalence (Percent) of Cigarette Smoking During Pregnancy Among Women in Florida (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

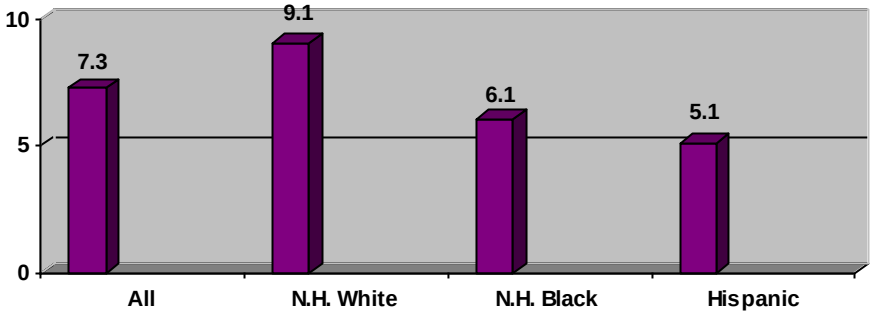
Chart 15. Prevalence (Percent) of Cigarette Smoking During Pregnancy Among Women in Florida (By Age)



Source: Florida Department of Health, Bureau of Epidemiology

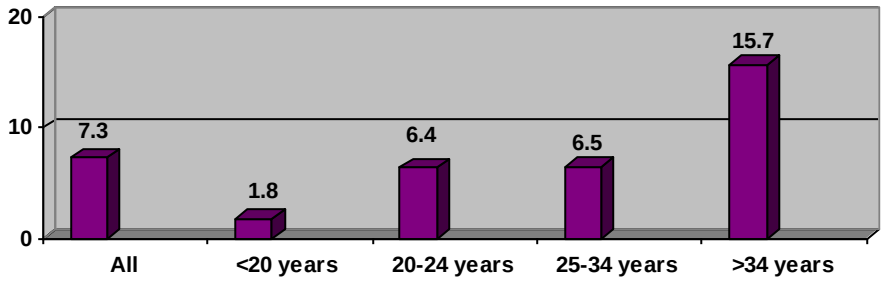
Non-Hispanic White women have a higher prevalence of drinking alcohol during pregnancy at 9.1%. The highest age group among women for this behavior, by far, is 34 years of age and older.

Chart 16. Prevalence (Percent) of Alcohol Use During Pregnancy Among Women in Florida (By Race)



Source: Florida Department of Health, Bureau of Epidemiology

Chart 17. Prevalence (Percent) of Alcohol Use During Pregnancy Among Women in Florida (By Age)



Source: Florida Department of Health, Bureau of Epidemiology

The 2005 Florida Pregnancy Risk Assessment Monitoring System (PRAMS) report provides a very detailed examination of multiple factors and aspects of maternal and infant health.

Refer to the full report for additional data information for much of the information could not be presented here.

> Special Populations

Homeless

In the state of Florida, a homeless person is defined as a person who lacks a fixed, regular, and adequate nighttime residence, or one whose primary nighttime residence is one of the following places:

- A public or private shelter or transitional housing;
- A place not meant for human habitation, including parks, the street, or automobiles;
- A temporary residence for persons intended to be in an institution;

Based on the data submitted to the Department of Children and Families by the local homeless coalitions, the 2008 count of persons who are homeless totals 59,036. In 2007, the count was 610,168. While the statewide total count number has decreased, the results vary by county. In 16 counties, the count was higher than the 2007 results. Twenty-two of Florida's 67 counties reported no change in number of homeless persons. The remaining 29 counties reported decreases in homeless populations.

Homelessness is a result of a person's inability to afford and or maintain his or her own place to live. Income and the ability to find affordable housing are critical issues. Economic concern places more people at risk of becoming homeless. The foreclosure crisis in Florida is displacing many families and adds to the demand of available affordable housing. In 2007, there were 279,325 filings for foreclosures in Florida. As a result, 195,000 homes were lost to foreclosure. In February 2008, there were 32,447 filing for foreclosure in the state. This is an increase of 69% over February 2007 filings. Overall, Florida ranks second in the country in the number of foreclosures. The top five counties in February 2008 were: Broward (4,739), Miami-Dade (4,558), Lee (3,739), Orange (1,936), and Hillsborough (1,735).

Other state economic indicators include the rise in the number of families applying for cash assistance under the federal Temporary Assistance for Needy Families program (TANF). From 2007 to 2008, there was a 20.5% increase in the number of applications received to determine TANF eligibility. (Table 10)

Table 10. Temporary Assistance for Needy Families Program, 2007-2008

February 2008	436,315
February 2007	362,182
Increase	74,129
% Change	**20.5%**

Source: Florida Department of Children and Families

From February 2007 to February 2008, there was a 17.4% increase in the number of persons receiving Food Stamps. When analyzing data from March 2007 to March 2008, the percentage increases to 18.9%. (Table 11)

Table 11. Food Stamps, 2007-2008

February 2008	1,424,675	March 2008	1,441,726
February 2007	1,213,699	March 2007	4,211,941
Increase	210,976	Increase	229,785
Percent Change	**17.4%**	**Percent Change**	**18.9%**

Source: Florida Department of Children and Families

Unfortunately, reduced state and local budgets makes it increasingly difficult to fund critical human services. Local networks of homeless service providers reported declining contributions from their donors, and less money from local governments.

Gender

In 2008, women (15,870) made up 33.5% of the homeless population, and represented 51.0% of the total state population.

Age

The following table (12) details the homeless population by age. Data was not collected to identify what percentage are women. In 2008, the largest homeless population is adults, ages 18 to 60 years old. This population also represents the age ranges that are most likely to be in the workforce.

Table 12. Florida Homeless Population by Age, 2007-2008

Source	Children under 18	Adults 18 to 60	Elderly Over 60	Total
2008 Homeless	**8,667**	**34,391**	**2,727**	**45,785**
	18.9%	75.1%	6.0%	
2007 Homeless	21.0%	74.0%	5.0%	
2000 Census	25.3%	52.5%	22.2%	

Source: Florida Department of Children and Families

Women are negatively impacted by being homeless, because women are often caregivers to children. Lack of economic means greatly impacts every other area of health: access to healthcare, adequate shelter, proper nutrition, dental care and hygiene, substance use, and safety. Homeless women are highly vulnerable to a wide array of potential life threatening situations. (Florida Department of Children and Families, Office of Homelessness).

Veterans

The total veteran population in the United States and Puerto Rico, as of September 2008, was approximately 23.4 million. The population of women veterans numbered 1,802,491. States with the largest number of women veterans were California (166,984), Texas (148,960), Florida (138,342), Virginia (88,082), and Georgia (73,390) (US Department of Veteran Affairs, 2008).

Female veterans face unique physical, mental, emotional, and social issues due to time served in the military.

Appendix V highlights the gender and age demographics of female veterans in Florida. The age group with the largest number of veterans is 45-49 years of age. Non-Hispanic white women represent the largest racial demographic of female veterans across the lifespan.

Table 13 shows that in Florida, almost 9% of veterans are female; and almost 28% identify with having a disability. An overwhelming majority, 70.2% identify with being overweight or obese and almost half do not engage in sufficient or any physical activity. Only a quarter of the veterans eat at least 5 servings of fruit or vegetables a day. This data underscores the value of health promotion among veterans to ensure that they are adopting healthy lifestyle behaviors (North Florida/ South Georgia Veterans Health System).

Table 13. Selected health behaviors and characteristics of veterans and non-veterans in Florida, 2007

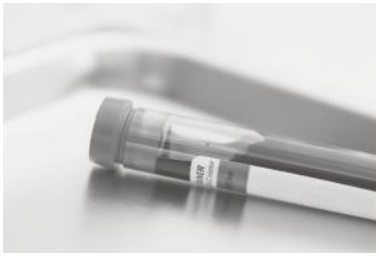
Variable	Veteran	Non-veteran
Female	8.9% (7.6-10.4)	59.2% (57.8-60.5)
With a disability	27.7% (25.5-30.0)	18.2% (17.3-19.1)
Frequent mental distress (≥14 days poor mental health in the past 30 days)	7.8% (6.6-9.2)	10.1% (9.3-10.9)
Fair or poor general health	19.0% (17.1-21.1)	16.2% (15.3-17.2)
Overweight or obese (BMI ≥25.0)	70.2% (67.4-72.8)	60.6% (59.2-61.9)
Insufficient or no physical activity	48.1% (43.9-52.6)	53.4% (51.1-55.9)
Eats ≥5 servings of fruits/ vegetables per day	24.1% (21.9-26.3)	26.6% (25.5-27.8)
Heavy drinker	7.9% (6.0-10.3)	5.9% (5.3-6.6)
Current smoker	18.7% (16.5-21.0)	19.4% (18.4-20.5)

Source: North Florida/South Georgia Veterans Health System

> Special Disease

Sickle Cell

Sickle cell disease is a group of inherited red blood cell disorders. Sickle cell disease is a genetic condition that is present at birth. It is inherited when a child receives two sickle cell genes – one from each parent. Healthy red blood cells are round, and move through small blood vessels to carry oxygen to all parts of the body. In sickle cell disease, the red blood cells become hard and sticky and look like a C-shaped farm tool called a "sickle". Sickle cells die early, which causes a constant shortage of red blood cells. Also, when they travel through small blood vessels, the sickle cells become lodged and clog the blood flow. This can cause pain and other serious problems. Sickle cell disease is diagnosed with a simple blood test; the condition is most often found at birth during routine newborn screening test at the hospital. In addition, sickle cell disease can be diagnosed before birth.



People with sickle cell disease start to have symptoms during the first year of life, usually around 5 months of age. Children with sickle cell disease are at an increased risk of infection and other health problems, early diagnosis and treatment are important. Symptoms and complications of sickle cell disease are different for each person and can range from mild to severe.

Women with sickle cell disease are more likely to have problems during pregnancy that can affect their health and the health of their unborn baby. During pregnancy, the disease can become more severe and pain episodes can occur more frequently. A pregnant woman with sickle cell disease is at a higher risk of preterm labor and of having a low birth weight baby. However, with early prenatal care and careful monitoring throughout pregnancy, women with sickle cell disease can have a healthy pregnancy. During pregnancy, there is a test to find out if the baby will have sickle cell disease, sickle cell trait, or neither one. The test is usually done after the second month of pregnancy. Women with sickle cell disease are encouraged to see a genetic counselor to find information about the disease and the possibility of the baby inheriting the sickle cell disease.

Sickle cell is a major public health concern. In the United States more than 70,000 people have sickle cell disease and approximately 2 million people have the sickle cell trait. Having sickle cell is very different than having the sickle cell trait. Sickle cell disease occurs in 1 in every 500 African American births and 1 in 12 African American infants will be born with the sickle cell trait. From 1989 through 1993, there was an average of 75,000 hospitalizations due to sickle cell disease in the United States, costing approximately $475 million. (Centers for Disease Control and Prevention, Sickle Cell Fact Sheet)

> Conclusions

This report documents the status of women's health in Florida. However, it was the aim to provide an overarching view of the health status of the Florida women.

Throughout this report, the fact has been highlighted, that women of color tend to experience poorer health than White women throughout the life course and are more likely to die at younger ages. Infant mortality has been universally accepted as an indicator of the health status of populations. This report documents that the Black Infant health is much worse, often 3 times as worse, as their White counterparts. In addition, Black women die at a much higher rate from HIV/AIDS then any other group of women. White women have higher mortality rates with unintentional injuries.

Mortality analyses established that health concerns change over the lifespan, and suggested the following disease are important concerns for women's health:

- heart disease
- diabetes
- stroke
- unintentional injuries
- cancer

In addition, the adoption of healthy lifestyle behaviors among women, specifically women of color, is critical to potentially reduce the risk of developing chronic (and often times preventable) diseases such as hypertension or diabetes. Healthy lifestyle behaviors include a balanced diet, physical exercise, and screenings. The field of public health would benefit from research to understand the barriers that exist to women adopting healthy lifestyles. The data suggests that women of all races and ethnicities need to improve their health behaviors.

- Black women in particular have a greater tendency towards obesity
- Hispanic women are the least likely to engage in routine physical activity
- American Indian/Alaskan Native and White women are more likely to be smokers and engaged in binge drinking

Although there are things that women can do, existing systematic barriers for women trying to obtain good healthcare must be addressed. Black and Hispanic women are disproportionately affected by a lack of insurance. More needs to be done to ensure that Florida women are meeting and surpassing the Healthy People 2010 National targets for preventative care in all areas.

The social status of women needs to be addressed to ensure that women of all racial, ethnic and social backgrounds are provided the same opportunities as men. In so doing, women would be afforded the possibility of benefiting in a higher quality of life through better health. In addition to racial and ethnic disparities, there are special populations (homeless women, female veterans, incarcerated women, undocumented women, and lesbians) that also have special health needs that need to be addressed. Policies must take the whole woman into consideration to ensure that physical, social, emotional, and spiritual needs are addressed.

> Notes

Age-Adjusted Death Rates

The frequency with which health events occur is almost always related to age. In fact, the relationship of age to risk often dwarfs other important risk factors. For example, acute respiratory infections are more common in children of school age because of their immunologic susceptibility and exposure to other children in schools. Chronic conditions, such as arthritis and atherosclerosis, occur more frequently in older adults because of a variety of physiologic consequences of aging. Mortality rates tend to increase after the age of 40. Because the occurrence of many health conditions is related to age, the most common adjustment for public health data is age adjustment. The age-adjustment process removes differences in the age composition of two or more populations to allow comparisons between these populations independent of their age structure.

The age-adjusted death rate is a summary measure that eliminates the effect of the underlying age distribution of the population. The result is a figure that represents the theoretical risk of mortality for a population, if the population had an age distribution identical to that of a standard population. For example, a county's age-adjusted death rate is the weighted average of the age-specific death rates observed in that county, with the weights derived from the age distribution in an external population standard, such as the U.S. population.

In the past, the National Center for Health Statistics (NCHS) age-adjusted rates used the US 1940 standard population. Other agencies used the US 1970 Standard. However, beginning with 1999 data, federal agencies began age-adjusting to the US 2000 Standard Million Population.

Age-adjusted rates are utilized throughout the Florida CHARTS and the following should be kept in mind:

- Age-adjusted rates answer the question: "How does the rate in my county compare to the rate in another even though the distribution of persons by age may vary?"
- Age-adjusted rates are specialized measurements and therefore should not be compared with other types of rates or be used to calculate the actual number of events.
- Age-adjusted rates can illuminate important trends by removing age-related differences.
- Age-adjusted rates using the same standard US populations (1940, 1970, or 2000) may be compared. Because of shifts in the distribution of persons by age in each year, rates calculated using the 1940 standard population, for example, should not be compared to rates calculated using the 2000 standard population.

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> Appendix I – 381.04015 Florida Statutes

381.04015 Women's Health Strategy; legislative intent; duties of Officer of Women's Health Strategy; other state agency duties.--

(1) LEGISLATIVE INTENT.--The Legislature recognizes that the health care needs of women are gender-specific and that public policy must take into account the distinct characteristics of women's health issues. Priority shall be given to improve the overall health status of women through research and education on women's health issues. The Legislature recognizes the importance of understanding why there are such large differences between how women and men experience certain diseases and also recognizes that biomedical research is the key to finding these answers. Such research has important implications for both women and men in terms of clinical practice and disease prevention and manifestation. The Legislature recognizes that as the state's population continues to age and life expectancy for women continues to rise, it is of the utmost importance for the Legislature to encourage effective medical research on long-term health issues for women and to educate elder women about the importance of participating in medical studies. The Legislature finds and declares that the design and delivery of health care services and the medical education of health care practitioners shall be directed by the principle that health care needs are gender-specific.

(2) DUTIES.--The Officer of Women's Health Strategy in the Department of Health shall:

(a) Ensure that the state's policies and programs are responsive to sex and gender differences and to women's health needs across the life span.

(b) Organize an interagency Committee for Women's Health for the purpose of integrating women's health programs in current operating and service delivery structures and setting priorities for women's health. This committee shall be comprised of the heads or directors of state agencies with programs affecting women's health, including, but not limited to, the Department of Health, the Agency for Health Care Administration, the Department of Education, the Department of Elderly Affairs, the Department of Corrections, the Office of Insurance Regulation of the Department of Financial Services, and the Department of Juvenile Justice.

(c) Assess the health status of women in the state through the collection and review of health data and trends.

(d) Review the state's insurance code as it relates to women's health issues.

(e) Work with medical school curriculum committees to develop course requirements on women's health and promote clinical practice guidelines specific to women.

(f) Organize statewide Women's Health Month activities.

(g) Coordinate a Governor's statewide conference on women's health, cosponsored by the agencies participating in the Committee for Women's Health and other private organizations and entities impacting women's health in the state.

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(h) Promote research, treatment, and collaboration on women's health issues at universities and medical centers in the state.

(i) Promote employer incentives for wellness programs targeting women's health programs.

(j) Serve as the primary state resource for women's health information.

(k) Develop a statewide women's health plan emphasizing collaborative approaches to meeting the health needs of women. The plan shall:

1. Identify activities designed to reduce the number of premature deaths in women, including:

a. Providing specific strategies for reducing the mortality rate of women.

b. Listing conditions that may cause or contribute to disease in women and the best methods by which to identify, control, and prevent these conditions from developing.

c. Identifying the best methods for ensuring an increase in the percentage of women in the state who receive diagnostic and screening testing.

2. Provide for increasing research and appropriate funding at institutions in the state studying disease in women.

3. Provide recommendations for the development of practice guidelines for addressing disease in women.

4. Provide recommendations for reducing health disparities among women in all races and ethnic groups.

5. Coordinate with existing program plans that address women's health issues.

(l) Promote clinical practice guidelines specific to women.

(m) Serve as the state's liaison with other states and federal agencies and programs to develop best practices in women's health.

(n) Develop a statewide, web-based clearinghouse on women's health issues and resources.

(o) Promote public awareness campaigns and education on the health needs of women.

(p) By January 15 of each year, provide the Governor, the President of the Senate, and the Speaker of the House of Representatives a report with policy recommendations for implementing the provisions of this section.

(3) DUTIES OF OTHER STATE AGENCIES.--

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(a) Women's health issues shall be taken into consideration in the annual budget planning of the Department of Health, the Agency for Health Care Administration, and the Department of Elderly Affairs.

(b) The inclusion of gender considerations and differential impact shall be one of the criteria when assessing research and demonstration proposals for which state funding is being sought from the Department of Health, the Agency for Health Care Administration, and the Department of Elderly Affairs.

(c) Boards or advisory bodies that fall under the purview of the Department of Health, the Agency for Health Care Administration, and the Department of Elderly Affairs shall be encouraged to seek equal representation of women and men and the inclusion of persons who are knowledgeable and sensitive to gender and diversity issues.

(4) RESPONSIBILITY AND COORDINATION.--The officer and the department shall direct and carry out the Women's Health Strategy established under this section in accordance with the requirements of this section and may work with the Executive Office of the Governor and other state agencies to carry out their duties and responsibilities under this section.

History.--s. 3, ch. 2004-350.

> Appendix II – State Rankings, Florida's Profile

	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaskan Native	Asian/Pacific Islander	State Total	Healthy People 2010 National Target	State Rank
Population (2005) (all ages)	62.7	15.2	19.6	0.5	2.4	**17,768,191**		
Major causes of death (rate per 100,000)¶								
All cause	789.1	1,051.2	621.7	330.8	334.9	**788.4**	+	13
Heart disease	219.3	297.6	202.2	79.1	95.0	**222.7**	+	25
Coronary heart diseese	178.5	237.0	168.8	59.6	74.5	**180.9**	162.0	33
Total cancer	191.4	215.2	130.6	74.7	73.3	**184.1**	158.6	13
Colorectal cancer	17.6	24.3	16.2	*	7.5	**17.8**	13.7	11
Lung cancer	60.9	49.5	26.8	23.9	17.4	**55.3**	43.3	29
Stroke	43.5	83.2	34.5	21.5	32.7	**45.7**	50.0	5
Chronic lower respiratory diseases (age 45 & over)	128.4	77.8	59.8	66.2	20.0	**116.4**	62.3	15
Diabetes-related	45.8	113.9	50.0	29.0	31.1	**51.0**	46.0	2
Influenza and pneumonia	14.0	19.6	13.7	*	8.7	**14.4**	+	1
Unintentional injuries	47.1	36.1	32.2	27.9	15.4	**42.2**	17.1	32
Suicide	16.9	4.6	7.6	*	4.8	**13.3**	4.8	39
Health risk factors (%) §								
Diagnosed high blood pressure (2003–2005)	26.9	37.0	21.9	29.9	15.1	**26.7**	+	29
Obesity (2003–2005) (age 20 & over)	20.2	32.2	24.8	17.7	13.9	**22.0**	15.0	14
No leisure-time physical activity (2003–2005)	21.0	32.7	36.7	25.8	25.7	**25.7**	20.0	38
Smoking currently (2003–2005)	26.8	15.9	18.5	36.0	12.2	**23.0**	12.0	35
Eats 5+ fruits and vegetables a day (2003–2005)	24.0	23.6	22.3	23.5	36.4	**24.2**	+	18
Preventive care (%) §								
Cholesterol screening in past 5 yrs. (2003–2005)	78.2	75.2	67.5	80.2	70.0	**75.9**	80.0	11
Routine check-up in past 2 yrs. (2005)	81.8	90.1	82.2	86.0	78.4	**82.9**	+	19
Health insurance coverage (%)								
Health insurance coverage (2003–2005) (ages 18–64)	81.0	74.5	58.8	66.6	73.9	**75.0**	100.0	48

¶ Estimate age-adjusted and for all ages unless noted.
§ Estimate age-adjusted and for 18 years of age and over unless noted.
* Figure does not meet standard of reliability or precision.
+ No Healthy People 2010 target associated with this health indicator.

NOTE: All data are from 2001-2003 unless noted.
NOTE: Low numerical rankings indicate better relative health status.
NOTE: State rank includes the 50 states, District of Columbia, and Puerto Rico, where data are available and reliable.
NOTE: Healthy People targets correspond with the Healthy People 2010 Midcourse Review.

Source: www.4women.gov Department of Health and Human Service Office on Women's Health Accessed on December 22, 2008

> Appendix III – Estimated Florida Female Population

Table 1. ESTIMATED 2008 FLORIDA FEMALE POPULATION % BY RACE AND AGE

AGE	FLORIDA ESTIMATED 2008 FEMALE POPULATION ALL RACES	ALL RACES %	FLORIDA ESTIMATED 2008 FEMALE POPULATION WHITE	WHITE percentage	FLORIDA ESTIMATED 2008 FEMALE POPULATION BLACK	BLACK percentage
<1	110,262	1.14%	80,388	1.04%	25,508	1.57%
1-4	441,046	4.57%	321,550	4.16%	102,033	6.27%
5-9	564,899	5.86%	417,710	5.40%	125,559	7.71%
10-14	573,564	5.95%	425,924	5.51%	125,917	7.73%
15-17	360,063	3.73%	266,377	3.44%	80,001	4.91%
18-19	236,611	2.45%	173,529	2.24%	54,031	3.32%
20-24	595,772	6.18%	442,374	5.72%	131,374	8.07%
25-29	566,782	5.88%	426,147	5.51%	119,973	7.37%
30-34	559,155	5.80%	425,310	5.50%	113,972	7.00%
35-39	598,461	6.21%	463,447	5.99%	115,014	7.06%
40-44	652,203	6.77%	516,249	6.68%	115,875	7.12%
45-49	695,968	7.22%	559,027	7.23%	116,792	7.17%
50-54	670,511	6.96%	547,216	7.08%	105,259	6.47%
55-59	622,130	6.45%	522,682	6.76%	84,906	5.22%
60-64	558,515	5.79%	483,455	6.25%	64,024	3.93%
65-69	465,958	4.83%	410,789	5.31%	47,075	2.89%
70-74	402,648	4.18%	360,000	4.66%	36,409	2.24%
75-79	362,760	3.76%	330,709	4.28%	27,370	1.68%
80-84	301,992	3.13%	279,971	3.62%	18,809	1.15%
85+	301,283	3.13%	280,019	3.62%	18,209	1.12%
All Age	9,640,583	100.00%	7,732,873	100.00 %	1,628,110	100.00%
Data Source: CHARTS, The Florida Legislature, Office of Economic and Demographic Research						

> Appendix III – Estimated Florida Female Population

	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/ Alaskan Native	Asian/Pacific Islander	State Total	Healthy People 2010 National Target	State Rank
Female population (2005) (all ages)	62.9	15.4	19.0	0.4	2.5	**9,052,532**		
Major causes of death among females (rate per 100,000)¶								
All cause	653.9	898.4	511.8	311.0	296.4	**656.9**	+	9
Heart disease	173.6	262.8	171.5	79.5	76.9	**180.2**	+	25
Coronary heart disease	137.7	206.2	142.5	58.8	58.8	**143.1**	162.0	33
Total cancer	160.4	173.2	104.5	61.2	65.9	**153.3**	158.6	9
Breast cancer	23.7	29.9	16.9	*	7.5	**23.3**	21.3	10
Colorectal cancer	14.5	20.8	13.9	*	5.4	**14.9**	13.7	8
Lung cancer	48.8	30.4	15.1	*	12.5	**42.6**	43.3	30
Stroke	42.9	81.4	32.3	*	35.4	**44.9**	50.0	5
Chronic lower respiratory diseases (age 45 & over)	154.5	47.6	14.9	55.5	9.0	**128.1**	62.3	40
Diabetes-related	35.1	112.4	43.3	32.5	27.4	**41.9**	46.0	3
Influenza and pneumonia	11.8	14.5	12.3	*	*	**12.1**	+	2
Unintentional injuries	29.5	20.9	16.0	20.2	11.2	**25.5**	17.1	25
Suicide	7.8	1.5	2.3	*	*	**5.8**	4.8	44
Health risk factors (%) §								
Diagnosed high blood pressure (2003–2005)	22.6	36.2	21.1	27.4	11.4	**23.7**	+	26
Obesity (2003–2005) (age 20 & over)	17.8	34.8	25.2	15.8	13.9	**20.9**	15.0	14
No leisure-time physical activity (2003–2005)	23.1	35.1	39.9	26.5	26.6	**28.3**	20.0	38
Binge drinking (2003–2005)	10.1	5.0	4.9	5.0	2.8	**8.0**	+	23
Smoking currently (2003–2005)	26.1	11.7	13.5	19.6	6.6	**20.6**	12.0	31
No smoking during pregnancy (all ages)	85.6	95.9	98.2	91.7	98.4	**91.4**	99.0	13
Eats 5+ fruits and vegetables a day (2003–2005)	28.4	29.9	24.1	41.8	43.7	**28.5**	+	19
Preventive care (%) §								
Cholesterol screening in past 5 yrs. (2003–2005)	79.0	80.2	69.8	83.2	70.1	**77.4**	80.0	14
Mammogram in past 2 yrs. (2002–2004) (age 40 & over)	76.9	79.5	69.9	74.9	88.9	**76.3**	70.0	17
Pap smear in past 3 yrs. (2002–2004)	85.4	86.1	80.3	78.8	61.3	**83.6**	90.0	31
Blood stool test in past 2 yrs. (2002–2004) (age 50 & over)	34.5	28.1	19.0	10.1	*	**31.9**	33.0	18
Routine check-up in past 2 yrs. (2005)	85.2	92.2	87.5	78.7	74.2	**86.6**	+	25
First trimester prenatal care	89.7	76.6	83.2	68.1	88.7	**85.1**	90.0	19
Health insurance coverage (%)								
Health insurance coverage (2003–2005) (ages 18–64)	83.1	77.2	62.1	70.7	79.8	**77.6**	100.0	44

¶ Estimate age-adjusted and for all ages unless noted.

§ Estimate age-adjusted and for 18 years of age and over unless noted.

* Figure does not meet standard of reliability or precision.

+ No Healthy People 2010 target associated with this health indicator.

NOTE: All data are from 2001-2003 unless noted.

NOTE: Low numerical rankings indicate better relative health status.

NOTE: State rank includes the 50 states, District of Columbia, and Puerto Rico, where data are available and reliable.

NOTE: Healthy People targets correspond with the Healthy People 2010 Midcourse Review.

Source: www.4women.gov Department of Health and Human Services Office on Women's Health
Accessed on December 22, 2008

> Appendix V – Veterans by State, Race/Ethnicity, Age Group, Gender, 2000—2003

Date	8/5/2008

VETERANS BY STATE, RACE/ETHNICITY, AGE GROUP, GENDER, 2000-2003

	Hispanic	White Non-Hispanic	Black Non-Hispanic	American Indian	Asian	Pacific Islander	Other Or Multiple Race	Grand Total
Age Groups	ALL							
Florida	10,759	95,282	23,432	991	1,424	193	2,902	134,983
Age Groups	< 20							
Florida	13	66	35	1	0	0	8	123
Age Groups	20 - 24							
Florida	507	1,743	808	40	68	11	121	3,299
Age Groups	25 - 29							
Florida	1,211	4,945	2,279	110	165	38	316	9,064
Age Groups	30 - 34							
Florida	1,153	5,929	2,705	67	204	18	372	10,449
Age Groups	35 - 39							
Florida	1,229	7,131	3,059	105	173	9	329	12,035
Age Groups	40 - 44							
Florida	1,507	9,136	3,411	77	185	24	368	14,709
Age Groups	45 - 49							
Florida	1,691	13,031	3,934	223	164	51	489	19,582
Age Groups	50 - 54							
Florida	1,289	12,169	3,320	184	151	27	282	17,421
Age Groups	55 - 59							
Florida	722	8,775	1,793	71	136	3	218	11,719
Age Groups	60 - 64							
Florida	460	5,805	820	40	46	1	110	7,282
Age Groups	65 - 69							
Florida	235	4,482	386	26	61	7	84	5,281
Age Groups	70 - 74							
Florida	223	4,026	256	29	31	1	86	4,654
Age Groups	75 - 79							
Florida	199	4,096	311	9	24	1	33	4,672
Age Groups	80 - 84							
Florida	137	3,956	169	6	5	0	53	4,326
Age Groups	85 - 89							
Florida	154	7,678	100	1	7	0	31	7,972
Age Groups	90+							
Florida	29	2,315	46	0	1	0	1	2,393

Source: North Florida/South Georgia Veterans Health System


FLORIDA COMMISSION
WOMEN
ON THE STATUS OF


FLORIDA DEPARTMENT OF
HEALTH

2008/2009

Women's Health Data Report

Florida Department of Health

Office of Women's Health

4052 Bald Cypress Way, Bin A00

Tallahassee, FL 32399-1701

2008

Florida Commission on the Status of Women

Office of the Attorney General

The Capitol, PL-01

Tallahassee, FL 32399-1050