Women's Health

Report of the Public Health Service Task Force on Women's Health Issues

Volume I

Foreword

Why a report on women's health? That is a reasonable question, considering past reports on the subject of woman's health and well-being. However, society has changed, and women are moving in step to address the demands of changing circumstances. As a nation, we have learned from the challenges of past decades, and we are now preparing ourselves to address the challenges of the future. Women in the United States are involved in a spectrum of activities today that were barely discernible on yesterday's horizon. They are making significant contributions to America and looking forward to the future. But with this panoply of opportunity has come the need for all of us to assess how the health risks for women are also changing in response to this new set of demands.

This report does not focus strictly on the diseases and problems unique to women in the traditional sense—that is, reproductive problems—but rather is devoted to assessing the problems of women's health, in the context of the lives women in America lead today.

My purpose in appointing this Task Force was to identify those women's health issues that are important in our society today and to lay out a blueprint for meshing those issues with the priorities of the Public Health Service. That has been accomplished. The Task Force has included dedicated, informed, and committed people who have spent many hours identifying the aspects of women's health that are most striking in today's environment. In addition to women's health issues that particularly concern the Public Health Service, meetings were held throughout the country to identify regional issues in women's health, and many citizens have contributed, for which we are grateful.

You may not agree with the specifics, but the recommendations are important and should be implemented with appropriate speed. I am committed to seeing that this report results in action that is beneficial to the women of America.

Edward N. Brandt Jr., MD, PhD
Assistant Secretary for Health

Introduction

Each chapter of this report presents a discussion of women's health issues across the life stages and in the context of sociological changes in the United States. In our initial meetings, discussion of how to approach the task and present the most comprehensive report possible within the structure of the Task Force Charter led us to several decisions regarding the structure and content of the final report. Because these decisions are relevant to the text that follows, they are briefly highlighted here.

This Task Force of the Public Health Service was uniquely aware of the PHS national goals and also recognized the individual missions and goals of the component PHS agencies, as well as those programs that support broad PHS objectives. Thus, the Task Force membership decided to give special attention to the 1990 Objectives for the Nation, as defined in "Promoting Health/Preventing Disease: Objectives for the Nation" (*1*), and to the related research and service programs of the individual agencies. Target objectives that have particular relevance for women's health were identified in an early progress report to the Assistant Secretary for Health.

It is clear that environmental, economic, social, and demographic characteristics influence a woman's health in the United States. If a woman is a member of an ethnic or a cultural minority, if she is physically or mentally disabled, or if, for any reason, she is outside the normal range of what society expects, her health is at greater risk.

The Task Force has attempted to address these issues in this report. A special presentation on the disease risks that are unique to women who are members of minority populations is included in Volume II of this report (to be published later).

Within the text of the Task Force Charter, the Assistant Secretary for Health asked that special attention be given to assessing women's health across the life stages. As fetuses and infants, female babies tend to be hardier than their male counterparts. This biological advantage at birth seems to be maintained through the entire lifespan. The biological changes that take place as a young girl approaches adolescence may occur subtly or abruptly. But it is menarche, the onset of the first menstrual period, that society generally agrees marks the transition to womanhood. It is not until this point that the biological, physical, and emotional differences between girls and women begin to be separable.

The Task Force selected this approach—beginning its assessment of women's health at the onset of menarche—with some caution. Although the health differences between girls and boys and between women and girls can be reasonably segregated, it is necessary to note that not all women are alike. Individual women, like individual men, move through the life stages at different rates, aspire to different goals, and lead different lives. Each of our bodies responds differently to environmental and social stimuli—by nature we are diverse beings. However, within this diversity the Task Force has attempted to identify the common threads that influence the measure of a woman's health.

In recognition of this complexity, the Task Force created four subcommittees to address the factors that significantly influence the health of women. Executive summaries of these four subcommittees' reports begin on page 85. (The full subcommittee reports, with supporting documentation, will appear in Volume II of the Task Force report.)

In addition to the specifically health oriented subcommittees, the Task Force created two assessment subcommittees that provided an inventory of Public Health Service programs related to women's health and an assessment of women's health issues as presented at regional meetings held throughout the country. Summaries of those subcommittees' reports begin on page 98.

Although the organizational method adopted by the Task Force members was agreed upon to allow us to address the health of women in the broadest possible context, we also recognized that we faced a time-limited task. In the interest of efficiency, each summary, as well as the overall Task Force recommendations, targets areas where the circumstances for women are unique, the noted condition is more prevalent, the interventions are different for women than for men, or the health risks are greater for women than for men. This approach mandated a healthy specificity and compelled the Task Force to be focused throughout the course of its study.

The preceding paragraphs provide the context in which the Task Force recommendations were developed. These recommendations are organized into the following categories:

- Promoting a safe and healthful physical and social environment;
- Providing services for the prevention and treatment of disease;
- Conducting research and evaluation;
- Recruiting and training of health care personnel;
- Educating and informing the public and disseminating research information;
- Designing guidance for legislative and regulatory measures.

Within these major categories of recommendations, we have identified, in a general way, our conceptions of those entities whose participation in implementation would ensure the greatest level of success. These are presented in the Summary of the Recommendations.

During the course of our study, it became apparent that a wide variety of expertise regarding the health of women exists at the Federal, State, and local government levels; within the public and private sectors; in the community; in the family; and within women themselves. That expertise is available and waiting to be tapped. A collaborative approach, designed to address the opportunities presented by these recommendations, could be implemented as a vehicle for improving the health status of U.S. women. In this report we have suggested possible activities that we feel are particularly amenable to collaborative approaches.

The recommendations presented by the Public Health Service Task Force on Women's Health Issues have evolved from a careful and in-depth study of the many facets of health in women. In the process of refining our study to the areas that most significantly influence the lives of women today, we have learned that the scope of attention required to address women's health in an active and responsive manner is by no means strictly confined to the arena of public health or the Public Health Service. However, this Task Force was convened on the initiative of the Assistant Secretary for Health, and we have posed our recommendations in a manner that we hope will allow the Service to exercise a leadership role (in cooperation with other public and private sector organizations) to ensure progress toward continued improvement of the health of women.

Ruth L. Kirschstein, MD
Task Force Chair

Dorris H. Merritt, MD
Task Force Co-Chair

References

1. Department of Health and Human Services: Promoting health/preventing disease: objectives for the nation. U.S. Government Printing Office, Washington, DC, fall 1980.

Summary of the Recommendations

General Recommendation

The Public Health Service should continue to review and monitor its activities in regard to women's health and, further, to implement and periodically update the recommendations of this Task Force.

Implementation focus: Office of the Assistant Secretary for Health, HHS.

Promoting a Safe and Healthful Physical and Social Environment

1. *Current laws must be implemented and enforced, and regulations developed and enforced, to ensure that all*

people, regardless of socioeconomic status, have a safe and healthful physical and social environment.

Implementation focus: Federal, State, and local governmental agencies.

2. *Women should increase their efforts to become aware of environmental and behavioral risk factors, as well as factors that promote health and prevent illness, and, further, women should take action to influence the personal and political processes that bear a relationship to their health.*

Implementation focus: Women, women's organizations, and public and private entities serving as advocates for women's health and well-being.

Providing Services for the Prevention and Treatment of Illness

3. *Consideration should be given to establishing a priority area within the Public Health Service regarding the management of chronic illnesses that cannot now be prevented.*

Implementation focus: Public Health Service agencies.

4. *Efforts to increase access to health care should be initiated for women who are underinsured and/or elderly, and for those who are geographically or socially isolated or isolated by virtue of ethnic minority status.*

Implementation focus: Federal, State, and local governments and public and private health care providers.

Conducting Research and Evaluation

5. *Biomedical and behavioral research should be expanded to ensure emphasis on conditions and diseases unique to, or more prevalent in, women in all age groups.*

- *Research efforts should be expanded to develop more effective and acceptable, as well as safe, contraceptive methods for both men and women, with special emphasis on meeting the needs of persons of different ages, and particularly the special needs of handicapped and retarded women.*

- *Studies must be expanded on the causes, prevention, improved diagnosis, and treatment of devastating and debilitating diseases such as cancer of the breast and reproductive system; sexually transmitted diseases; arthritic conditions, including lupus; osteoporosis; and certain mental disorders.*

Implementation focus: Federal, State, and local agencies that support research, as well as private research foundations and organizations.

6. *Longitudinal research should be undertaken to assess how behavioral and social factors interact with biological factors to affect the health of women over the life course.*

Implementation focus: Federal, State, and local agencies that support research, as well as private research foundations and organizations.

7. *Data should be collected and analyzed from State and federally supported surveys on the demographic characteristics of the population by age, sex, and race across income groups, in order to permit better utilization of such data by health policy makers.*

Implementation focus: Federal and State agencies that collect population statistics.

8. *The workplace should be studied to identify and correct health hazards for women as well as for men.*

Implementation focus: Federal, State, and local agencies and private organizations concerned with occupational health.

9. *Research should be undertaken to better understand those cultural conditions and socialization practices that affect women's health differently from that of men.*

Implementation focus: Federal, State, and local agencies that support research, as well as private research foundations and organizations.

Recruiting and Training of Health Care Personnel

10. *A national goal should be established to increase, as rapidly as possible, the number of women in key positions in health practice, administration, research, and education.*

Implementation focus: Health professions schools; universities; professional societies; Federal, State, and local agencies interested in education for health professionals; and women and women's organizations.

11. *Each continuing education program for health professionals should be designed to ensure that the health needs of women in all segments of society are addressed.*

Implementation focus: Health professions schools; universities; professional societies; and Federal, State, and local agencies interested in education for health professionals.

Educating and Informing the Public and Disseminating Research Information

12. *Educational and outreach programs should be initiated and/or expanded by relevant public and private organizations and the media to communicate the importance of a healthful lifestyle.*

Implementation focus: The Public Health Service, public and voluntary organizations, and the media.

13. *A working group of key individuals in the fields of television, films, publishing, and advertising should be organized to examine the effects of media images on health.*

Implementation focus: The media.

14. *The Public Health Service should make special efforts to disseminate up-to-date research information.*

Implementation focus: Initially, agencies of the Public Health Service, with subsequent efforts to focus on professional societies, research institutions, universities, voluntary health organizations, and State and local governments to do the same.

Designing Guidance for Legislative and Regulatory Measures

15. *All organizations interested in women's health and well-being should:*

- *continue to make deliberate efforts to be informed regarding legislative, policy, and service issues that affect women's health;*
- *promote information exchange and public education on health matters; and*
- *be advocates for organizational and public policy changes needed to improve and promote healthful conditions for women.*

Implementation focus: Women's organizations and professional societies interested in women's health.

Conclusions and Recommendations

GOOD HEALTH REQUIRES a safe and healthful physical and social environment, an adequate income, safe housing, good nutrition, access to preventive and treatment services appropriate to the persons to be served, and a population that is educated and motivated to maintain healthful behaviors. Thus, the maintenance of good health is a societal as well as an individual responsibility and is the combined responsibility of Federal, State, and local governments; private sources; professional and community organizations; and citizens themselves. Above and beyond this, there is much that is as yet unknown and requires continuing research and acquisition of knowledge.

Within the entire Department of Health and Human Services, many dedicated professionals work to improve the health and well-being of all Americans. Contributing to meeting the objectives of this department, the Public Health Service has identified a unique set of goals directed toward improving the health status of the population. The PHS is the principal health agency of the Federal Government and the largest public health program in the world; its mission, broadly stated, is to protect and advance the health of the American people by:

- working with other nations and international agencies on global health problems and their solutions;
- conducting and supporting biomedical research and communicating research results to health professionals and the public;
- preventing and controlling disease, identifying health hazards, and promoting healthy lifestyles for the nation's citizens;
- monitoring the adequacy of health manpower and facilities available to serve the nation's needs;
- assisting in the delivery of health care services to medically underserved populations and other groups with special health needs;
- ensuring that drugs and medical devices are safe and effective and protecting the public from unsafe foods and unnecessary exposure to manmade radiation; and
- administering block grants to the states for preventive health and health services; alcohol, drug abuse, and mental health services; maternal and child health services; and primary health care.

These activities are descriptive of the Public Health Service as it exists today. However, what it does today is far different from the mission of the PHS of 1798, then the Marine Hospital Service. Over the years the PHS has changed in response to changes in the recognized health needs of the country. This evolution reflects the experience of our entire society in regard to improvements in health and medical care, increasing geographic mobility, and fluctuating economic times. The PHS objectives of today have developed as a result of the changing needs and demands of our society—in response to different expectations and new opportunities—much the same process that women have struggled with over the past decades in response to the same changes.

An example of the Service's responsiveness to changing needs and conditions in our society is the development of the disease prevention and health promotion initiative. In the truest sense, this is a reflection of national interest in health and primary prevention, and it continues to be an area where the involvement of individuals and health professionals in both the public and private sectors has been sustained. With regard to the Task Force examination of the 1990 Objectives for the Nation, we suggest that the upcoming 1985 review cycle provides an opportune time for attention to be given to ways in which the full spectrum of objectives in the 15 priority areas are relevant to women's health. In the context of our report, we have placed special emphasis on the continuing need to keep the public, particularly women, involved and informed about matters of health and well-being. We feel that heightened emphasis on disease prevention and health promotion in areas beyond the pregnancy and infant health priority category can provide a significant source of information for women, as well as facilitate longer term benefits.

The recommendations developed by the Task Force are presented along with suggestions as to what groups within our society can best implement them. However, the Task Force presents one general recommendation:

The Public Health Service should continue to review and monitor its activities in regard to women's health and, further, to implement and periodically update the recommendations of this Task Force. This should be done under the auspices of the Office of the Assistant Secretary for Health.

This recommendation is made so that such processes may be institutionalized through the recurrent procedures associated with policy development; planning; evaluation; and legislative, regulatory, and budget cycles, thus facilitating consistent attention to these issues by the agencies of the Public Health Service and the Office of the Assistant Secretary for Health.

The Task Force believes that there are a number of opportunities available to implement this recommendation, including the following:

- assignment of responsibility for women's health issues to a lead agency or office within the Public Health Service or the Office of the Assistant Secretary for Health.
- creation of a standing agenda item on "Women's Health" at recurrent policy, planning, legislative, and/or budget meetings.
- creation of a standing committee, composed of agency representatives, who report regularly to the PHS leadership.

The Task Force agrees that other possibilities exist in this regard but would like to emphasize the importance that it attaches to this recommendation over and above the means of its implementation.

Promoting a Safe and Healthful Physical and Social Environment

By the year 1990, many now-evident demographic and social trends will have had a predictable effect on the social status of women in society and consequently on their health status and need for health services.

It is expected that the decreasing number of adolescents and young adults will result in a decrease in the crime rate—particularly the rate of violent street crime—and a decrease in teenage unemployment. Occupational mobility may be blocked because of the disproportionately large number of people at the peak of their careers. The post-World War II "baby boom" generation will be entering middle age as the 20th century draws to a close, and the numbers of older Americans will continue to move upward along the population-age distribution curve. While income levels will be generally high, particularly among two-income families, the disparity in income between such families and families headed by women alone will grow. As more women enter into and remain in the labor force, discrepancies in earnings between the sexes may diminish. It is expected that expansion in the labor market will be greatest in traditionally female occupations: secretaries, sales clerks, food service workers, health aides. In addition, the home will increasingly become a place of paid employment.

Changes in the health care delivery system will undoubtedly result in shifts in the funding of medical care, and these changes will occur in concert with a change in the demography of health professionals as an increasing number of women become physicians, psychologists, and pharmacists, for example.

As general demographic trends continue to improve, a tandem improvement in the quality of life for older women will become a universal goal. Because of the nature of the available data, the Task Force has been compelled to define the older woman as a person over 65 years of age. We feel that the Public Health Service should recognize the heterogeneous nature of this population, because the health needs of older women differ according to their age. For example, the needs of very elderly women, whose risks are immediate and are linked to long-term care, differ from those of women in the 65- to 74-year age group, who can function at a high level until they experience health or economic difficulties.

Other variables also can affect the older woman's health: her educational status, ethnic or cultural background, socioeconomic status, and geographic location. At the close of the 20th century, the percentage of the population over age 65 will have risen from 11.3 to 12.7; of this group, approximately 60 percent will be women.

These anticipated demographic and social changes will alter patterns of health care needs. There will be increased need for attention to health problems of older women and those at midlife. These problems include the effects of the menopause, osteoporosis, and the various cancers that particularly affect women. The smaller birth cohorts of children and young adults will change the demand for health care services and practitioners for the young. Public Health Service programs must take these trends into account in planning and allocating resources for future national programs.

Fundamental to the achievement of improved health for all women is the recognition that their lives have changed dramatically in recent years and that future changes are likely to be even greater. The three most important social changes affecting women's health at the present time are:

- the increasing numbers of women living in poverty;
- the unprecedented entry of women into the labor force, including women with infants and young children; and
- the continuing increase in the longevity of women.

Society as a whole must begin to take these changes into account if programs and policies are to be of maximum benefit.

The relationship between poverty and ill health cannot be overemphasized. Similarly, the disproportionate number of women living in poverty calls for major societal attention. Many women now living in poverty are unable to break a cycle in which financial demands are complicated by unanticipated events and the available resources in the family budget are stretched beyond their capacity. If a woman is a single head of the household and the sole support of her family, her situation is further complicated.

Recommendations:

1. *Current laws must be implemented and enforced, and regulations developed and enforced, to ensure that all people, regardless of socioeconomic status, have a safe and healthful physical and social environment.*

Specific legislative and regulatory actions of particular interest to women are discussed under the heading "Designing Guidance for Legislative and Regulatory Measures," beginning on page 84.

2. *Women should increase their efforts to become aware of environmental and behavioral risk factors, as well as factors that promote health and prevent illness, and, further, women should take action to influence the personal and political processes that bear a relationship to their health.*

To facilitate the success of such efforts, a network of professional and lay persons, including governmental and nongovernmental representatives, should be developed to review and disseminate information on the social factors that affect women's health.

Providing Services for the Prevention and Treatment of Illness

A comprehensive system of health services should be ensured. This should include preventive services for all women, with particular attention to the underinsured and the geographically isolated. Many chronic illnesses cannot be prevented, but they often can be managed so as to minimize their effects. The greater longevity of women contributes to their greater risk for chronic diseases. While access to services is important for all women, it is a particular problem for women confronted by poverty or geographic or social isolation.

Recommendations:

3. *Consideration should be given to establishing a priority area within the Public Health Service regarding the management of chronic illnesses that cannot now be prevented.*

4. *Efforts to increase access to health care should be initiated for women who are underinsured and/or elderly, and for those who are geographically or socially isolated or isolated by virtue of ethnic minority status.*

The Task Force feels that availability of health services is a particular problem for the elderly. The need for services such as home health care or community-based physical and mental health care for older people, especially women, should be addressed by cooperative efforts of the Federal, State, local, and private sectors. In addition, adult day care centers and other programs are needed to provide respite and to relieve chronic social isolation of, and exhaustion and depression in, two groups of women caregivers: (*a*) younger and middle-aged women caring for an older, chronically ill dependent in the home, and (*b*) older women caring for a chronically ill dependent of any age in the home.

The Public Health Service should:

- review existing capabilities and develop a comprehensive plan to ensure that needed health services are available, adequate, and accessible to the elderly, particularly elderly women. Such a plan would include a review of those services available to older women that are funded through categorical and block grant mechanisms.
- coordinate its activities with those of other agencies to increase research on service delivery to the elderly, especially women. Special attention should be given to provision of long-term care and the integration of formal services (provided through organizations and agencies) and informal services (provided through family and friends).

In addition to the continued provision of services to older women, both private and public national and community volunteer programs serving the aged should expand their efforts to involve older women in volunteer activities. This will enhance the quality of life of such persons as well as encourage contributions to the health and well-being of others. The Task Force suggests that:

- the Public Health Service agencies work with other government agencies and the private sector to strengthen and improve health care for employed older women.
- the Public Health Service implement a model preretirement counseling program for its women employees to improve planning efforts for and by women who, as they age, are faced with different problems—for example, the loss of a spouse or inadequate financial preparation as retirement approaches.

Conducting Research and Evaluation

Regardless of what the leading causes of morbidity and mortality in women may be, women themselves appear to be primarily concerned with those diseases about which they perceive little is known or for which appropriate therapies have not been determined. Furthermore, women are deeply concerned with the need to regulate the timing and number of their pregnancies.

Recommendation:

5. *Biomedical and behavioral research should be expanded to ensure emphasis on conditions and diseases unique to, or more prevalent in, women in all age groups:*
- *Research efforts should be expanded to develop more effective and acceptable, as well as safe, contraceptive methods for both men and women, with special emphasis on meeting the needs of persons of different ages, and particularly the special needs of handicapped and retarded women.*
- *Studies must be expanded on the causes, prevention, improved diagnosis, and treatment of devastating and debilitating diseases such as cancer of the breast and reproductive system; sexually transmitted diseases; arthritic conditions, including lupus; osteoporosis; and certain mental disorders.*

In addition, studies are needed:

- to provide baseline data on the cause, treatment, course, and prevention of disorders prevalent in older women and on gender differences in longevity, especially those factors that contribute to such differences among racial and ethnic groups.
- to develop and refine diagnostic and assessment methodologies for comprehensive physical and mental health evaluation of the older woman, including her nutritional status, functional status, psychosocial status, and drug and alcohol use.
- to determine nutritional requirements for older women, including the establishment of nutritional standards, minimum daily requirements for vitamins and minerals, and the relation of food-drug interactions to good health.
- to evaluate the cost-effectiveness of different types of care settings for older women (including the home), measured in terms of (*a*) client-service requirements, (*b*) quality of life—social and health, and (*c*) source of funding—public or private.
- to study the metabolism and disposition (pharmacokinetics) of drugs and alcohol by age and gender.
- to explore the various psychosocial factors that affect the health of older women (such as changing family structure and kinship patterns; the consequences of retirement, either early or late in life; the effects of widowhood and bereavement; and other cultural and ethnic factors).

Research is also needed regarding those most disabling disorders that represent the largest financial drain on

the older woman and that can affect the quality of life and family relationships to the greatest extent. It is important to:

- more clearly understand and define the cause, treatment, course, and prevention of other chronic conditions common among older women, such as incontinence, diabetes, dementia, depression, and late-onset schizophrenia, and
- further assess the safety and efficacy of estrogen therapy and other treatment modalities for the management of menopausal and postmenopausal symptoms and of osteoporosis.

Special efforts should be made to gain knowledge about those diseases related to alcohol and drug abuse, and about mental illnesses of importance to women, by the initiation of:

- research to study depression in women when it occurs alone or in conjunction with alcohol or drug abuse problems.
- studies of the significant factors related to the onset, continuation, and cessation of smoking, drinking, and drug taking by women.
- studies of the role of the family and of cultural attitudes in the maintenance of mental health or the development of mental illness, as well as in the use or misuse of alcohol, drugs, and tobacco.

Many methodological problems, as well as a lack of data, limit our understanding of the status of women's health, women's particular needs, and the services women require. The need for data that are relevant to health and are sex- and age-specific by race and ethnicity is crucial.

Existing data sources should be reviewed as to their ability to provide such information. New studies should, whenever feasible, appropriately sample black, Hispanic, Asian, and Native American women to provide sufficient numbers for analysis. Since current data may have limited usefulness when all persons over age 65 are grouped together, additional separate age categories should be studied.

Recommendations:

6. *Longitudinal research should be undertaken to assess how behavioral and social factors interact with biological factors to affect the health of women over the life course.*

7. *Data should be collected and analyzed from State and federally supported surveys on the demographic characteristics of the population by age, sex, and race across income groups in order to permit better utilization of such data by health policy makers.*

To accomplish this, the Public Health Service should exercise leadership by establishing a policy regarding, and a format for, the collection of statistical data on minority population groups. This format should be consistent with the data collection classifications used by the Bureau of the Census during the most recent Census Survey and thus should include American Indian/Alaska Native, Asian/Pacific Islander, black, and Hispanic population groups.

Because of recent rapid social and demographic changes, many of the data gathered in past decades may not reflect significant changes that have occurred in the health status of women. It is important to support cohort studies to assess the influence of unique historical periods such as war, economic depression, and recession on women's health and ability to function. It is suggested that research be undertaken to determine how the links among poverty, poor housing and nutrition, and inadequate access to preventive care and treatment may differ by gender.

The rapid increase in participation of large numbers of women in the labor force points to the need for research in many areas and on many occupations that have high concentrations of women.

Recommendation:

8. *The workplace should be studied to identify and correct health hazards for women as well as for men.*

- Such studies should aim to reduce hazards rather than prohibit the employment of women in those occupations found to engender problems.
- Studies are necessary to determine the health effects on women of being in occupations where large numbers of women are not traditionally employed (for example, blue collar work and upper echelon management positions).
- Research should be expanded on the health conditions of women in occupations that are predominantly female, such as clerical work and nursing, and on working in the home.

Cultural expectations and practices affect the development and maintenance of beliefs, values, and practices that have consequences for health throughout the life course.

Recommendation:

9. *Research should be undertaken to better understand those cultural conditions and socialization practices that affect women's health differently from that of men.*

Studies are particularly needed in regard to the development of self-concept, of sex-typed behaviors relating to diet and exercise, and of other health- and mental health-related behaviors. It is important to determine the nature of, and to understand and prevent, violence against women, including family violence, sexual assault, and child abuse.

Studies of gender-related differences in the health status of women and their utilization of services should be undertaken to:

- examine how women perceive and respond to various symptoms and to chronic illness on a daily basis, as compared with men.
- determine how to develop, maintain, and modify attitudes and behaviors of women with respect to their health.
- ascertain, through survey and observational research, the attitudes of women regarding the types of health care practitioners and institutions they prefer.

A systematic effort must be made to address issues relating to gender bias, in research and clinical practice, that lead to inadequate attention to the needs of women. Ways to effect such change include:

- the issuance of a Public Health Service-wide policy directing all operating units to review their research guidelines to ensure that sex differences are routinely studied, wherever feasible. Such instructions should be included in grant application kits.
- the requirement that postmarketing surveillance of all prescription drugs should include reporting of the adverse effects in women of drug interactions with alcohol, commonly used psychotherapeutic drugs, and drugs commonly used in relation to hormonal changes in women.
- the requirement that adequate numbers of women be included in clinical trials of drugs that will be used by women, and of all new drugs that are to be recommended for use by women.
- the commissioning of an interdisciplinary panel of senior scientists, including women, to review existing research and research protocols or methodologies and to develop a comprehensive plan for addressing any gender bias identified in research in general, but in particular in alcohol, drug abuse, and mental health research.
- the establishment of a task force to review mental health issues related to women and to make recommendations for changes in the Fourth Revision of the Diagnostic and Statistical Manual (DSM IV) of the American Psychiatric Association (APA), in order to promote adequate diagnosis and treatment of women with alcohol, drug abuse, and mental health problems. Such a task force should work closely with the APA Task Force on Nomenclature and Statistics. In addition, a similar review mechanism should be established for the International Classification of Diseases (ICD–10).

Recruiting and Training of Health Care Personnel

In spite of recent advances, women still are underrepresented in key decisionmaking positions in the health professions.

Recommendation:

10. *A national goal should be established to increase, as rapidly as possible, the number of women in key positions in health practice, administration, research, and education.*

The PHS should take a leadership role in addressing the disproportionate representation of minorities and women in the health care system and should continue to encourage participation and increase representation of minority and women health care providers in the public and private health care delivery system. In order to accomplish this, a number of steps are necessary:

- Barriers preventing women from becoming managers, consultants, planners, and providers of health administration, education, service delivery, and research should be eliminated.
- Training curriculums for service providers, particularly physicians, administrators, and policy makers, should be reviewed to ensure that they are sensitive to the health needs of women and are modified on the basis of problems identified. Particular attention should be paid to training designed to provide services for the population of aging women.
- Training programs for health professionals and allied health workers should give special attention to minority women and ensure their due representation.
- The Public Health Service should review its health professions training and scholarship assistance programs to ensure that minority population groups are appropriately represented. This policy should be implemented consistent with data in the 1980 Bureau of the Census classifications, which identify Hispanic, American Indian, Alaska Native, Asian/Pacific Islander, and black groups.

Recommendation:

11. *Each continuing education program for health professionals should be designed to ensure that the health needs of women in all segments of society are addressed.*

An educational strategy needs to be formulated and implemented promptly for teachers, researchers, and clinicians who are required to provide health care and services for the increasing number of older women in the population. This is particularly needed since examination of the curriculums in many health professions schools reveals that little attention is given specifically to the older years of adult life. It is suggested that:

- gerontological issues, particularly those of older women, need to be integrated into curriculums of health professions schools. The development and provision of intensive short-term continuing education courses are needed to update the knowledge and skills of current faculty, particularly in the area of geriatric assessment.
- sites should be developed so that medical students and others in training can obtain clinical experience with elderly women, particularly those living in the community, but also those in hospitals and nursing homes.
- technical assistance must be developed to devise and provide continuing in-service education programs for the licensed and unlicensed paraprofessional providers of direct health care to the elderly. This is particularly relevant for those in the following settings: adult day care centers, long-term-care facilities, the home, mental health clinics, alcohol rehabilitation clinics, and community health centers.
- the curriculums of institutions that train health care professionals (generalists as well as specialists) should include training for the development of expertise needed to deal effectively with problems related to alcohol and drug abuse as well as mental illness in women.

The Task Force feels that the Public Health Service should take the lead in identifying and eliminating cultural barriers to health service utilization through the promotion of awareness and sensitivity to this issue. This effort should include education, training, and service programs. Persons presently providing health services need to increase their sensitivity to the issue of cultural barriers and provide multicultural and multilingual services where these are needed. All health resources, services, and research programs and projects seeking Federal funding should demonstrate awareness of and give due consideration to the problem as a prerequisite for receiving an award.

Educating and Informing the Public and Disseminating Research Information

The influence of the media on our lives is powerful, pervasive, oftentimes subtle, and for the most part incalculable.

For a number of years, Federal, State, and local governments and private sector groups, including voluntary health agencies, have conducted successful information campaigns on various physical and mental disorders, diseases, and conditions. The health hazards of cigarettes, for example, are well known as a result of health warnings and sustained publicity from the Surgeon General's campaign to reduce cigarette smoking and from the efforts of the American Cancer Society, the American Lung Association, and others. The Public Health Service's National High Blood Pressure Control Program has been successful in encouraging people to seek screening and early diagnosis of hypertension and to comply with medical advice. Health promotion has been an important focus of the PHS drive to reach the targets set by the 1990 Objectives for the Nation. Numerous other national health promotions have been carried out by the PHS with assistance and cooperation from the private sector and State and local health departments.

In the area of women's health, however, efforts aimed at education and dissemination of information have been somewhat sporadic and often have suffered from fragmentation. There is an urgent need for a comprehensive, unified, and consistent approach to educating and informing women about all aspects of their health.

Women must learn to recognize and fully comprehend the serious health risks associated with behaviors such as smoking and drug and alcohol abuse. At the same time, understanding of the dangers of such behavior should be reinforced by health practitioners, the media, and relevant agencies, both public and private. Further, women of all ages should be actively encouraged to adopt practices that will maintain health and enhance well-being. Such practices include good nutrition and appropriate exercise. Women must accept the responsibility for certain aspects of their own health, and women must especially be able to recognize the physical and mental changes that accompany the normal aging process. Women should be advised to seek the counsel of an appropriate health professional to dispel myths about aging and learn how best to cope with particular health concerns, including adoption of appropriate preventive measures.

Recommendation:

12. *Educational and outreach programs should be initiated and/or expanded by relevant public and private organizations and the media to communicate the importance of a healthful lifestyle.*

The Public Health Service should provide leadership for such programs and facilitate the activities of these groups.

• These programs need to stress the risk factors for development of disease, methods for developing appropriate behavioral interventions, and the availability of comprehensive preventive health services appropriate for women of all ethnic, racial, and age groups.
• Educational programs should be intensified, especially for low-income and minority populations, to stress the benefits of early prenatal care in identifying high-risk pregnancies, in order to reduce the incidence of premature and low birth weight infants and their attendant problems.
• Educational efforts regarding the gravity of cultural barriers to health care access should be directed to health policy makers and health care providers as well as consumers of health services.
• Educational programs should be designed that stress the importance of primary prevention and the early identification of potential diseases through regular screenings, including breast self-examination and "Pap" smear testing.

Recommendation:

13. *A working group of key individuals in the fields of television, films, publishing, and advertising should be organized to examine the effects of media images on health.*

• The media should give attention (*a*) to programs in which portions of the content are health related, and (*b*) to the development of programming specifically designed to disseminate health information that is relevant to women.

In addition, there is a need to:

• improve communication between health professionals and women in general, and older women in particular, as measured by accurate interpretation of health information and responsiveness to questions raised in the consultation process by either the provider or the patient.
• identify successful Federal and other educational initiatives and coordinate with private and public entities (including State and local governments) to replicate or encourage replication of such exemplary programs where possible.

Recommendation:

14. *The Public Health Service should make special efforts to disseminate up-to-date research information.*

It is essential that:

• such information be available for use in designing programs, particularly those that relate to alcohol, drug abuse, and mental health problems in women.
• women become aware of the consequences—in addition to those associated with pregnancy—that may result from unhealthy use of drugs and alcohol.
• demonstration projects be established particularly to teach women about proper nutrition and dietary practices, appropriate exercise, weight control, accident and injury prevention, the misuse of alcohol and drugs, and management of stress.

Designing Guidance for Legislative and Regulatory Measures

To ensure that issues regarding the health of women receive appropriate and continuous attention in the future, the leadership of the nation must be involved in developing guidance and, in some cases, new legislative proposals and regulatory changes. Such activities can best occur if there is substantial interest in the community.

Recommendation:

15. *All organizations interested in women's health and well-being should:*
• *continue to make deliberate efforts to be informed regarding legislative, policy, and service issues that affect women's health;*
• *promote information exchange and public education on health matters; and*
• *be advocates for organizational and public policy changes needed to improve and promote healthful conditions for women.*

The Task Force feels that it is important to repeat and expand upon recommendation 1 in this section because it is of such importance:

Current laws must be implemented and enforced, and regulations developed and enforced, to ensure that all people, regardless of socioeconomic status, have a safe and healthful physical and social environment.

• Implementation of Federal legislation aimed at enforcing payment of court-awarded child support must be immediate and vigorous.
• Efforts should be increased, on the part of Federal, State, and local governments as well as community organizations and private citizens, to develop, monitor, and enforce regulations aimed at maintaining a healthful environment in the community, the workplace, and the home.
• Guidance and regulations should be developed, as necessary, by the Public Health Service and other governmental agencies to ensure that gender-related dif-

ferences are minimized in all health programs and plans. Such issuances should include:

—a Public Health Service wide policy directing all operating units to review their research guidelines to ensure that sex differences are routinely studied wherever feasible. Such instructions should be included in grant application kits.

—the requirement that postmarketing surveillance of all prescription drugs include reporting of the adverse effects in women of drug interactions with alcohol, with commonly used psychotherapeutic drugs, and with drugs commonly used in relation to hormonal changes in women.

—guidelines to ensure that adequate numbers of women are included in clinical trials of drugs that will be used by, or recommended for use by, women.

Summary

The Task Force members recognize that this report and its recommendations must, even at best, be incomplete. During the course of our deliberations, several initiatives have developed within the Public Health Service and the Department of Health and Human Services that will facilitate continued and consistent attention to health issues of specific concern to women. The members of the Task Force hope that these conclusions and recommendations will provide a basis for improving the health of women in the United States during the last decade of the 20th century and as the nation enters the 21st century.

Social Factors Affecting Women's Health: Executive Summary

In recent decades, women in the United States have undergone a revolution in their self-perception and their traditional relationships to work, money, marriage, and family. These societal changes have implications for every aspect of women's lives, including health and illness.

Diversity is the hallmark of the lifestyles of contemporary American women. Differences among women may stem from such enduring characteristics as age, race, or ethnicity as well as from such variables as marital and household status, urban or rural living, education, occupation, and income. Research and service programs planned to meet women's health needs must be cognizant of these differences.

It is well recognized that improvements in health status are less likely to come from technological "breakthroughs" than from improvements in environmental and social conditions, changes in lifestyle and behavior, and participation of people in maintenance of their own health. As leading causes of morbidity and mortality have shifted from infectious diseases and other acute problems to chronic illness and accidents, the need to focus on environmental conditions and health-promoting behaviors has increased.

Identifying ways of modifying unhealthful conditions and behaviors is particularly germane to the improvement of women's health. Although women in the United States live an average of about 8 years longer than men, they have higher rates of illness, experience more days of disability, and utilize more health services than men—even when pregnancy-related services are controlled for. It has been suggested that women's health-seeking behavior and their lifestyle characteristics contribute to their greater longevity.

Various social and ethnic factors contribute to the finding that certain groups of women have higher morbidity or mortality rates, or both, than others. For example, maternal deaths are four times as high for black women, and three times as high for Hispanic women, as they are for white women. Rates of depression are higher among married women with children in the home than they are among women who have never married or those whose children have left home. Numerous biological and social factors are thought to contribute both to women's greater morbidity and to their longevity, but only a few of these social factors are considered in this brief overview, which is organized around five sets of issues: cultural and social values and attitudes affecting women's health; economic status; participation in the labor force; family, household structure, and age; and interactions with the health care system.

Cultural and Social Values

Human behavior is shaped by current cultural and social values and societal attitudes. Perhaps nowhere, and at no time, have social values been more diverse, more in flux, and more open for discussion than in the United States in recent times. Much has been written about the effects of sex role stereotypes on the development of boys and girls and the consequences of this stereotyping for adult behavior. Recent research indicates that, in some areas at least, there has been more discussion of change than actual change in child-rearing practices.

Existing sex-role behavior has demonstrable effects on morbidity and mortality. For example, the well-documented greater willingness of women to admit symptoms and seek help may have a protective effect on their health. Women's behavior, which is often less risk-taking than that of men, may protect them from violent acci-

dents and death, but it may also keep them from competitive activities that lead to physical fitness and greater mastery of the environment. Society's expectation of more passive and dependent behavior by women has been associated with the fact that depression is three times as prevalent among women as among men. Social change in sex-role expectations is thought to be a factor contributing to the increase in smoking among girls and women and the subsequently observed increase in lung diseases.

Changing sexual attitudes have given women of all ages the potential for greater freedom and greater choice in sexual matters. Changing sexual behaviors have had various health outcomes, including a reported decrease in the numbers of women seeking help for frigidity and sexual phobias and an increase in the prevalence of sexually transmitted diseases. Among women of childbearing age, concern about the efficacy and safety of contraceptives has increased as knowledge of health hazards has become more available.

Concerns about physical appearance and youthfulness have long been more important to women than to men. More recently, extreme thinness has become a goal of women of all ages, particularly young women. Dieting has become the norm. Eating disorders, such as anorexia and bulimia, and menstrual disorders associated with reduced body fat are increasingly prevalent. These conditions are noted more in high school groups and on college campuses but may well be as frequent among populations not so readily observed.

There is a greatly altered public perception of the role of exercise and physical fitness in women's lives that is reflected in school athletic programs, competitive games for girls and women, and the greatly expanded participation by women in the Olympics. The behavioral changes reflected by this emphasis on physical fitness among women may have long-term positive effects on many aspects of women's health. This recent increase in awareness of health and fitness had included concern for nutritional status, and many more women are now aware of the relationship of diet to healthy functioning at all stages of life.

The communications media have become major agents of socialization in this century. Television, movies, radio, records, and tapes, as well as the print media, reflect and shape public attitudes, norms, and behaviors.

Research on the influence of the media on health has been limited, but it is thought that the images of youth and beauty that are projected may contribute to excessive female concern about weight. Though cigarette advertising is no longer permitted on radio and television, cigarette ads directed toward women dominate other advertising media. Television portrays women as victims of violence more often than is the case in life. The prevalence of violence seen on television, together with other negative social attitudes toward women, has been cited as a factor contributing to domestic violence and the victimization of women and girls. However, it should be noted that the media have the potential to be used more effectively for educational campaigns addressing such health-related issues as smoking, nutrition, exercise, and alcohol and drug abuse.

Economic Status

Poverty and ill health are interrelated. Disadvantaged people become ill because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health care. As a result of these conditions, illness may occur with greater frequency, causing those persons to miss work or lose jobs and become even poorer.

As a group, women are economically disadvantaged in comparison with men, regardless of age, race, ethnicity, education, or employment status. Data from the Bureau of the Census, the Bureau of Labor Statistics, and the Congressional Budget Office confirm that women in the United States are becoming increasingly disadvantaged.

Poverty rates have long been particularly high among black, Hispanic, and Native American women, especially those who are single heads of households. They are now being joined by the "nouveau poor"—white middle-class women raising children alone and older women subsisting on small, fixed incomes. Overall, almost 78 percent of the poor in the United States are women and children. Among the elderly poor, 74 percent are women. Thirty-five percent of all households headed by women, but only 10 percent of those headed by men, were below the poverty level in 1981.

Neither employment nor educational level protects women from economic disadvantage relative to men. Employed women earn about 59 percent of what men earn, and the average college-educated woman earns less than a male high school dropout. Better educated women do, however, have lower poverty rates than other women. Women who have attended college are less than half as likely to be poor as women who have not attended high school.

Among women of all races, a greater proportion of low-income women than of high-income women perceive that their health status is "fair" or "poor." Similarly, low-income women utilize hospital services more than high-income women. Low-income women of all races use more ambulatory services than their male counterparts.

Mortality rates long have been used as reliable indicators of health conditions because, unlike perceptions of health or the decision to use services, they do not reflect judgment but rather facts. While national rates of mater-

nal and infant mortality have declined significantly, they continue to be higher for minority women, unmarried women, and rural women—all groups that have high rates of poverty.

The relationships among gender, race, economic status, availability of health insurance, use of medical care, and health status are complex and warrant continued investigation and programmatic attention by the Public Health Service. Increasing poverty among women is a national issue of major proportions that will have serious implications for women's health and attendant health care costs in the near and long-term future.

Participation in the Labor Force

The rapid rise in the participation of women in the labor force has been the most far-reaching change in recent years. Currently, 52 percent of all women are in the labor force. The most rapid shift in participation has occurred among women with children still in the home. Sixty-six percent of mothers of school-age children and 50 percent of mothers of preschool children are now employed.

The rapid rise in divorce rates—particularly for those who have been married more than 20 years—and the greater longevity of women have led to rising numbers of older women seeking employment. Many of these long-time homemakers who did not anticipate reentry into the labor force are ill-prepared to find employment.

Numerous studies have shown that employed women still assume nearly all the responsibility for household management and child care, whether or not they are currently married. The hours required to run a home and the time required at the worksite add up to a weekly average of 80 hours of work for women and 50 hours for men.

Child-care arrangements continue to be a source of stress for most employed mothers. Arrangements for child care cannot be made just once but require continuous attention; thus, they remain a source of stress until the children have left home.

The long-term effect of multiple roles on the health status of women has received some attention from researchers, but results are equivocal. Studies have shown that gainfully employed women are healthier and generally more satisfied than housewives. It is not known whether this is the case because healthier women take and keep jobs outside the home or whether the jobs, by providing self-esteem, income, and status, result in better physical and mental health.

Contrary to popular belief, symptoms of stress among professional and managerial women are not as frequent as among clerical workers. Symptoms of stress have been found to be more frequent in women with jobs that offer limited opportunities or women who have "dead end" jobs. Lack of occupational mobility is greater for women than for men and greater still for minority women than for white women. Because of demographic changes in the age structure of our society and a reduction in middle-management positions in government and industry, job mobility may be even more limited for the "baby boom" generation than it has been for their employed mothers. The consequences to physical and mental health from this lack of opportunity await further investigation.

The current information and technology revolution will continue to alter the workplace. The availability of computerized information will further reduce the need for middle-management positions. It will also permit some jobs now done in the office to be done in the home.

Since women have lower rates of employment, more intermittent employment, and lower earning power than men, they are still at a disadvantage with regard to both private pension plans and social security benefits. Through the year 2055, Social Security benefits for women are expected to be only two-thirds those for men.

Women are concentrated in occupations in which most of their coworkers are women—occupations in which tasks appear less risky than those handled by men and as a consequence are less often studied in regard to health hazards. Women employed in occupations in which males predominate may have special safety and health problems. Equipment designed for men is often too large for women and thus may be ineffective or even hazardous. In addition, sexual harassment on the job can hinder work performance, increase stress, and lower women's morale.

Family, Household Structure, and Age

Health status is related to various demographic factors in addition to income and occupation. Marital status, age, household structure, and the timing and number of children all have implications for women's health. The family or household is important not only because it is the place where health behaviors are learned, practiced, and reinforced but also because it is where most short-term acute and long-term chronic care occurs.

For most people, the family or household is important as the major source of social support. Considerable research has shown that social supports are beneficial to health and can serve as a buffer against stress. The family also plays a major role in maintaining the economic well-being of individuals and thus influences environmental conditions, access to care, and other factors that affect health.

Currently, there are many family forms, household structures, and lifestyles. Alternate living arrangements

are related to later marriage, increased divorce rates, increases in the number of single-parent heads of households and of single-person households, greater geographic mobility, and an increase in longevity. Women are marrying almost 2 years later than their mothers did, and a growing number of women are remaining childless into their thirties. Almost a fourth of all households were single-person households in 1982; included in this group are the never-married, the divorced, and the widowed.

While marriage is occurring later, the vast majority of men and women do marry. But 50 percent of those people married in 1983 can expect ultimately to be divorced. Divorce has both economic and health consequences. It results in a 50 percent reduction in income for women 35 years of age and older and a 38 percent reduction for those under 35. Rates of illness are higher among the divorced than among the married.

Recent childbearing patterns also have shown many changes. Fewer women are remaining childless than in the past, but they are giving birth later and to fewer children. Birth rates for unmarried women have risen steadily and are higher for women in their twenties than for adolescents and for black women than for white women. Unmarried motherhood is associated with fewer economic resources and less adequate prenatal care. Early childbearing, in or out of marriage, often has a detrimental effect on a woman's education and subsequent earnings.

In recent years some unmarried mature women and some homosexual women have made deliberate decisions to bear or adopt a child. Increasing numbers of women are postponing childbearing into their thirties and even early forties. The social consequences, if any, of delayed childbearing and of rearing children at a later age are not yet clear. The physical consequences of late childbearing are discussed in the report entitled "Women's Physical Health and Well-Being," beginning on page 88.

Interactions with the Health Care System

Studies have repeatedly shown that women are more likely than men to report symptoms of illness and to utilize health services. What is not clear is whether these statistics reflect real differences in morbidity or some combination of gender-related differences in income and age structure, illness behavior, access to care, and response of the health care system.

While health maintenance and treatment services may not guarantee good health, they can avoid, halt, or ameliorate the progression of many diseases. Differences in access to care by men and women, whites and minorities, and rural and urban dwellers all have been examined, as have differences in the way the health care system responds to women. Some research indicates that women are treated with less respect and dignity, that male physicians may be less sensitive to women's needs, and that psychotherapeutic medications are disproportionately prescribed for women. This may change as the increasing proportion of women graduates of medical schools begin to practice medicine.

A woman's health movement has emerged in recent decades to work toward improving the health care system for women. The movement includes lobbying organizations and caucuses and the development of alternative treatment services for women. Some services are devoted to general health needs of women; others, such as rape crisis centers, shelters for abused women, and "birthing centers," focus on special needs. These alternative services have influenced general health care practices, particularly in the area of obstetrical services.

Summary

This overview addresses but a few of the social conditions and factors that affect women's health and their need for health services. Because women use health services more than men, it is important to address those conditions that tend to increase women's need for services and to promote those conditions and behaviors that maintain health.

Women's Physical Health and Well-Being: Executive Summary

WHILE MOST HEALTH DISORDERS are not sex-specific, some problems are more frequent in women than in men, thus contributing to a significantly higher morbidity rate among women. This report includes a brief presentation of the disorders that are unique to women, are more prevalent or serious in women than in men, or require special prevention and intervention strategies for women. It should be emphasized that while much has been and is being done in all the areas discussed, a great deal of research is still required.

Cancer

Cancer is the leading cause of death among women aged 35 to 54. Most cancer deaths among women are attributed to breast cancer, followed by cancer of the lung, colon and rectum, ovary, and uterus.

The number of deaths from lung cancer in women has risen 600 percent in the past 30 years, and by the

mid-1980s lung cancer is expected to supplant breast cancer as the leading cause of cancer deaths among U.S. women. In fact, among women now entering the age group 65 to 74, lung cancer has already replaced breast cancer as the leading cause of cancer mortality. The National Center for Health Statistics reported that, from 1979 to 1980, the death rate for lung cancer increased 13 percent, compared with a 2 percent rise in the death rate for breast cancer.

Endometrial cancer is the third most common cancer among women in the United States. The 5-year survival rate for this malignancy is 34 percent for white and 35 percent for black women.

The incidence and mortality rates for cervical cancer have been declining for the past three decades in both black and white women. However, cervical cancer still occurs more than twice as often in black women as in white women, and the mortality rate for this type of cancer is almost three times as high among blacks as among whites.

Reproductive Functions and Diseases of the Reproductive System

Women today have far more control over the timing of childbearing than ever before. In the United States, 29 million women use some form of contraception. Such birth control methods include oral contraceptives, intrauterine devices, spermicides, barrier devices, sterilization, and interrupted pregnancies. All of these have varying degrees of acceptability and efficacy. Research on the use of brain hormones that control reproduction, on biodegradable implants containing contraceptive hormones, and on new barrier methods is aimed at expanding the range of contraceptive options presently available to both men and women.

U.S. women make more than 30 million visits to physicians each year for disorders of the reproductive system, excluding diseases of the breast. Many of these diseases are serious—including pelvic inflammatory disease, which may lead to infertility and even death.

Progress has been made in microsurgery and in *in vitro* fertilization techniques to correct or bypass blocked fallopian tubes, and it is now possible to induce ovulation safely, using one of several medical techniques. Polycystic ovarian disease, premature ovarian failure, endometriosis, and ectopic pregnancy warrant further study.

Women who contract sexually transmitted diseases (STDs), including herpes and gonorrhea, have more serious physical problems than men because these women incur greater risk of subsequent infertility and cancer. Pregnant women with STDs are confronted by the additional risk of passing the disease on to their offspring. In the United States, 4 to 5 percent of sexually active women carry *Chlamydia trachomatis* organisms in the uterine cervix. Infants born to women with *Chlamydia* infections run a 60 to 70 percent risk of contracting the infection during birth.

On the other hand, the incidence of toxic shock syndrome, which once affected 3 to 14 of every 100,000 menstruating women each year, seems to be decreasing. In 1982, as part of an effort to make women aware of the risk factors associated with tampon use, the Food and Drug Administration required tampon manufacturers to print a warning on the boxes used to package tampons.

The Menstrual Cycle

Numerous disorders can be associated with menstruation. These range from amenorrhea, dysmenorrhea, certain premenstrual problems, and iron-deficiency anemia to problems associated with premature cessation of the menses and the consequences of menopause.

Drugs that inhibit the production of prostaglandin early in the menstrual period have been found to be effective in relieving the symptoms of dysmenorrhea in 75 percent of affected women.

The causes of "premenstrual syndrome," its nature, and indeed its very existence remain unclear. Hormonal imbalance, nutritional or chemical deficiencies, and neurobiological dysfunction have been suggested as associated factors.

About 20 percent of menopausal women have some physical symptoms severe enough to seek medical attention. Although estrogen replacement therapy is often prescribed for menopausal symptoms, it is difficult to prescribe estrogens in the physiologic amounts appropriate for each individual, and slight excesses have been reported to cause unpleasant side effects.

Childbearing—Early and Late

In recent years, much research has focused on two extremes in reproductive patterns: adolescent childbearing and delayed childbearing. While the rate of births to adolescents has declined, the proportion of first births to women over age 30 has risen sharply.

Despite the decline in births to adolescents, more than 500,000 infants are born each year to women under age 20. Pregnancy in very young teenagers can be risky to the physical health of both mother and infant. Furthermore, early pregnancy affects the education of the adolescent mother, her ability to prepare for an occupation, and income opportunities for life. The health and intellectual development of her children may suffer as well.

At the other end of the spectrum, the proportion of women who give birth to a first child after age 30 has increased from 3.9 percent of all first births in 1970 to

9.5 percent in 1981. From a socioeconomic perspective, these women benefit by delaying childbirth. From a medical standpoint, however, older women have a somewhat increased chance of experiencing complications during pregnancy and of subsequent infertility.

Pregnancy

Dramatic improvements have been made in the health of mothers and children in the past two decades, due in large measure to better service delivery programs supported by agencies of the Public Health Service and to advances in prenatal and perinatal care based on findings resulting from biomedical and behavioral research. The maternal death rate from pregnancy and childbirth in the United States dropped from 36.9 per 100,000 live births in 1961 to 7.7 in 1981. During that same period, infant mortality dropped from 25.3 to 11.7 per 1,000 live births.

Adverse conditions contributing to high-risk pregnancies may be medical or nutritional or may be related to use of drugs and other lifestyle factors. Diabetes, hypertension, toxemia, kidney and respiratory problems, certain genetic disorders, poor nutritional status, and lack of prenatal care may all contribute to an adverse outcome of pregnancy. In 1980, in order to address some of these health issues and meet the need for information to facilitate healthy pregnancy and better infant care, the Public Health Service launched a public information program called "Healthy Mothers, Healthy Babies." This program is designed to help women improve their lifestyle during pregnancy, particularly in relation to nutrition, exercise, and rest, and to increase their awareness of the hazards of smoking, alcohol consumption, and use of "street drugs."

Urinary Tract Infections

Urinary tract infections (UTIs) affect one in five women at some time during their lives. Such infections tend to recur and account for more than 6 million visits by women to physicians each year. Women are about five times more likely than men to develop UTIs. If these infections are not detected and treated in the early stages, renal damage may occur. It has also been suggested that pregnant women with untreated UTIs may be at risk for premature delivery.

Osteoporosis

This debilitating chronic disease affects some 20 million Americans, especially older women. It is estimated that about 1.3 million fractures attributable to osteoporosis occur annually in people 45 years of age and older. Current data point to estrogen and calcium deficiencies as the major causes of primary osteoporosis. A recent NIH Consensus Development Panel recommended estrogen replacement therapy where appropriate, calcium and vitamin D supplements, and modest weight-bearing exercise to prevent and control this disease.

Weight Disorders

More than 25 percent of American women between ages 20 and 74 are considered overweight. Obesity is known to be less prevalent in women of higher socioeconomic status and is most common in both black and white women in the lower income group.

It has been estimated that 1 out of 200 American girls between the ages of 12 and 18 will develop some degree of anorexia nervosa and that 10 to 15 percent of those with this disorder will die. It may cause psychological and hormonal problems, including amenorrhea. In bulimia, patients indulge in food binges and then purge themselves either by inducing vomiting immediately after eating or by taking laxatives and diuretics.

Hypertension

About 32 percent of American women and 38 percent of men between 25 and 74 years of age have high blood pressure. The incidence is even higher among blacks, of whom one in four has high blood pressure. Obesity is a major contributor to the development of hypertension, which affects one in six Americans.

Diabetes

Diabetes is the fifth leading cause of death in the United States. It occurs in twice as many women as men and is found more frequently in black and low-income populations. The impact of diabetes in terms of morbidity, mortality, and economic deprivation is very great.

Gestational diabetes frequently leads to complications for both mother and child. Specific problems associated with pregnancy in diabetics include birth defects, fetal death late in pregnancy, delivery of larger than normal babies, and respiratory distress of the newborn.

Cholecystitis and the Development of Cholesterol Gallstones

In the under-50 age group, women are four times more likely than men to develop gallstones, and women over 50 are twice as likely as men to do so. Multiparity and sex hormone levels play a role in gallstone development. A link between oral contraceptives and gallbladder dis-

ease has been suggested. Among certain ethnic groups, such as the Pima Indians of Arizona, gallbladder disease is particularly prevalent.

Arthritis

More than 35 million people in the United States suffer from arthritis, a term that covers more than 100 rheumatic and related disorders of the joints. In general, more women are affected than men. While this may be a function of the greater longevity of women, polyarticular juvenile rheumatoid arthritis (JRA) also affects more girls than boys.

Girls with polyarticular JRA may develop iridocyclitis and failing vision. Treatment for this disease includes medication, rest, exercise, eye care, a balanced diet, and sometimes even surgery. Medication includes aspirin, nonsteroidal anti-inflammatory drugs, gold injections, antimalarial drugs, corticosteroids, and penicillamine.

The symptoms of osteoarthritis, caused by breakdown of cartilage followed by bone overgrowth, tend to worsen in women past menopause. Rheumatoid arthritis affects twice as many women as men. In some, the heart, blood vessels, and lungs also are affected.

Systemic Lupus Erythematosus

This potentially fatal connective tissue disorder strikes some 50,000 people each year. Almost 90 percent of its victims are young women. The disorder may affect the kidneys, heart, lungs, or central nervous system and is three times more common in black women than in white women. Although since 1955 the proportion of lupus patients who survive an average of 4 years after diagnosis has increased from 50 percent to more than 95 percent, many still succumb to the disease. Research is focusing on how lupus affects the body's immune response and on identification of the genetic characteristics of the disease.

Thyroid Disorders

Hyperthyroidism occurs five times more frequently in women than in men. Symptoms include nervousness, increased activity, increased appetite with weight loss, increased sweating, insomnia, tachycardia, and hypersensitivity to heat.

Hypothyroidism is about four times more likely to occur in women than in men. Symptoms include swollen neck and face; dry, scaly skin; intellectual impairment; constipation; excessive menstruation; hair loss; and cold intolerance.

Not all of the multiple causes of these conditions are well defined, and research on them is continuing.

Parathyroid Disorders

Hyperparathyroidism occurs twice as often in women as in men. In this condition, increased production of parathyroid hormone results in calcium imbalance and may lead to fractures, kidney stones, muscular weakness, and abdominal pains. Excessive parathyroid hormone secretion is most often caused by parathyroid adenomas. Hyperplasia and carcinoma are rare.

The Importance of Exercise

A 10-year study of longevity in America has shown conclusively that regular exercise, along with other good living habits, can help increase life expectancy by as much as 7 years for women and 11 years for men. Physical exercise contributes to good health by enhancing musculoskeletal strength and flexibility, improving the efficiency of the heart and lungs, and assisting in weight reduction. Among the benefits of weight reduction are prevention of adult onset diabetes, reduction of emotional stress, and strengthening of stamina and self-image.

The President's Council on Physical Fitness and Sports promotes exercise to increase physical fitness in persons of all ages, including the elderly. The council's programs include provision of advice and technical assistance to schools, clubs, recreation agencies, and employers; regional clinics and workshops in physical fitness and sports; a public information campaign; and a special Presidential Awards Program. In the 1980 publication "Promoting Health/Preventing Disease: Objectives for the Nation" (*1*), the Public Health Service proposed a series of specific objectives aimed at improving the health of Americans by the year 1990. Physical fitness and exercise was listed as 1 of 15 top priority areas requiring attention.

Use of Cosmetics, Cosmetic Surgery, and Megavitamins

In order to meet contemporary societal standards of an attractive image, many women use facial cosmetics, diet aids, perfumes, douches, creams and lotions, bath products, special hair shampoos, and hair dyes and conditioners. In addition to using cosmetics, women may choose to alter their appearance through reconstructive or plastic surgery (for example, face lifts, breast reduction, and breast enlargement).

For many women who need reconstructive surgery following cancer or accidents or in order to correct birth defects, such alterations can affect both mental and physical health in a positive way. For healthy women who choose surgical means to improve or alter their ap-

pearance, the effects may also be positive but should be balanced with the risks associated with such procedures. For example, silicone implants pose a potential risk since the silicone gels have been known to leak and, in rare instances, to break.

"Fad" diets (for example, liquid protein) may have severe and even fatal consequences. Use of megadoses of vitamins (particularly vitamins A and D) may have adverse health effects as well.

Health Status in Relation to Participation in the Labor Force

If there are any biological factors causing differences in mortality rates between males and females in the same occupational environment, they are as yet unknown, since so few occupational studies have included female workers. Because health status in women is so directly linked to socioeconomic status—which, in turn, is largely dependent on income—the most important work-related issue appears to be the consignment of women to low-paying jobs with little or no opportunity for upward mobility.

Nonetheless, several adverse health consequences of specific occupations particularly affect women, not because of any known difference in their susceptibility, but because they are heavily concentrated in low-paying jobs in which working conditions or procedures are hazardous to human health. For example, the "carpal tunnel syndrome" is common in women who work in the garment and electronic industries, in food service workers, and in cashiers and clerical workers. Female textile workers have a relatively higher risk of developing cancer of the reproductive organs than most other women because of their daily exposure to several toxic substances found in natural and synthetic fabrics.

Special Health Concerns of Minority Women

Minority women in the United States carry a disproportionate burden of disease. Life expectancy is shorter and rates of infant and maternal mortality are higher for minority women than for white women. Minority groups also have a higher prevalence of chronic diseases such as diabetes, hypertension, and cardiovascular disease. The death rate from certain cancers is significantly higher in black than in white women. Since many minority women are socioeconomically disadvantaged, their health problems are compounded by poverty, poor nutrition, low motivation and self-esteem, and adverse environmental factors.

Summary

This overview touches on the major health problems of primary concern to women. A more detailed report to be published later as a special supplement of *Public Health Reports* discusses the advances achieved in the past, as well as current educational, service, and research activities designed to alleviate the specific conditions that affect women differently from men. The report also emphasizes areas in which much remains to be done.

References

1. Department of Health and Human Services: Promoting health/preventing disease: objectives for the nation. U.S. Government Printing Office, Washington, DC, fall 1980.

Health Concerns of Older Women: Executive Summary

As the population ages, the maintenance of health in women over 65 will play a greater role in the concerns of public policy makers and health planners, because it is more often women than men who survive to old age, who thus are subject to greater risk for multiple diseases, and who are more likely to need public resources. By the year 2000, it is projected that the population aged 65 and older will reach 35 million, of whom 20 million will be women. Thus, the problems of old age will be problems faced by older women.

It is tempting to lump together a myriad of physical and mental problems as concerns faced by the "older woman"; however, the population of women over 65 is as diverse in its constitution as any other cohort. Health concerns vary across this population within different ethnic and socioeconomic groups as well as within specific subgroups. A confounding factor is that chronological age in a woman is not necessarily an indicator of biological age (for example, two 70-year-old women may age differently). Also, women in the 65–74 year age group may face different health problems than their counterparts in the 75–84 year age range.

Assessing the health status of older women not only requires scrutiny of the prevalence of specific mental and physical disorders but also requires placing that information in the context of prevailing social factors, to which mental and physical health are inextricably tied.

Physical Health Concerns

According to the 1978 National Health Interview Survey, the major health characteristic of women over 65 is the greater prevalence among them of multiple, long-

term chronic illnesses that cause limitations in lifestyle. According to this study's findings, noninstitutionalized women 65 years of age and older had a higher prevalence, compared with women aged 17 to 64, of the following conditions: visual and hearing impairments, arthritis, hypertensive disease, coronary heart disease, cerebrovascular disease, diabetes, impairments of the lower extremities and hip, chronic bronchitis, all diseases of the urinary system, functional and organic symptomatic upper gastrointestinal disorders, constipation, and all types of anemia. It is not uncommon for an older person to be afflicted with several chronic conditions at one time.

Among elderly women, the prevalence of chronic conditions varies by race. For example, hypertensive heart disease, heart conditions, and arthritis are more frequent among elderly black women than among elderly white women. Data from health examinations of the U.S population reveal that prevalence rates for diabetes, and particularly for hypertension and moderate to severe arthritis, are higher among older women than among their male counterparts. In addition, more older women have higher serum cholesterol levels and lower blood hematocrits. The former is a known risk factor for cardiovascular diseases, and the latter is a sign of anemia.

Interestingly, despite the greater life expectancy and generally lower mortality rates of women than of men, women die from the same major causes as men: heart disease, cancer, cardiovascular diseases, and accidents.

Of the chronic conditions afflicting older women, incontinence is a particular problem. It is the second most common reason that women are institutionalized in long-term-care facilities. The cost of managing and caring for incontinent patients (mostly elderly) amounts to about $8 billion a year, or about $3 to $15 per person per day.

Impairments in vision and hearing are also prevalent chronic conditions that limit the mobility and independence of older women. These impairments frequently are not given serious attention, because they are so often regarded as normal accompaniments of old age. However, limited sight or hearing can be a serious threat to the older woman's ability to remain in her own house, enjoy recreational activities, and maintain an independent lifestyle. Similarly, physical conditions prevalent among older women, such as degenerative rheumatoid arthritis, peripheral vascular disorders, and diabetes mellitus, can create serious problems with ambulation, thus restricting access to services and increasing social isolation.

Simple foot care is also difficult to maintain in many older women. Podiatry is an area of health care service often neglected by health professionals. Moreover, the older woman may have difficulty in performing routine nail and foot care because of poor vision and lack of flexibility in her hands.

Incidence rates of acute illness and injuries are higher among older women than among older men. According to a recent Public Health Service study, accidents are the fifth leading cause of death among persons 65–74 years old, and the sixth leading cause of death for those over 75 (most of whom are women). In 1977, accidental injuries resulted in nearly 43 million days of bed disability for persons over 65.

Among women, most injuries occur in and around the home. These injuries include fractures, lacerations, contusions, and burns. In fact, women suffer 200,000 hip fractures annually.

Osteoporosis, a condition in which bones become porous and more susceptible to fractures and other injuries, is more frequent after menopause and may be the underlying cause of the higher rate of injuries among older women. A Consensus Development Conference on osteoporosis sponsored by the National Institutes of Health in April 1984 concluded that this disease is a major public health problem and is the principal underlying cause of bone fractures in postmenopausal women and older persons in general. The threat of hip fractures engenders numerous fears in the older person: loss of independence, additional falls, pain, further fractures, and hospitalization. Thus, the conference report suggests that prevention of initial fractures in osteoporotic individuals is of primary importance.

Cancer still ranks second to heart disease as the leading killer of American women. The greatest risk factor for breast cancer appears to be age. The longer a woman lives, the greater are her chances of developing the disease; thus, the postmenopausal older woman is at high risk. Survival rates are strongly influenced by early detection and treatment.

The risk of death from cervical cancer also increases with age. Research is being conducted on both breast and cervical cancer to determine why this is so.

A rising lung cancer rate among women who smoke is also a serious problem. In 1982, statistics from California showed that lung cancer had surpassed breast cancer as the number one cause of death in women in that State.

Smoking has other serious health consequences as well, such as increased risk for cardiovascular and pulmonary disease. Smoking leads, of course, to health risks that are preventable.

Although menopause is a natural process in the life cycle of women, it has been treated as a disease. While the woman 65 years of age and older is likely to be a number of years past the onset of her menopause, the physiological changes associated with menopause continue to affect various aspects of her life. The most commonly prescribed and used treatment for menopausal symptoms has been exogenous estrogen. A consensus

exists regarding the need for (*a*) systematic collection of data about the way the climacteric is experienced by women who are not treated with estrogen and (*b*) research on alternatives to estrogen therapy for treating menopausal symptoms.

Poor dietary habits, resulting in inadequate nutrition, are related to certain physical and mental disorders. Investigators agree that proper nutrition throughout life, including late in life, is an effective means of maintaining good health and minimizing degenerative changes in later years. Data on the nutritional status of the elderly in the United States—especially elderly women—are scant. Physiological changes that occur with aging may alter the older woman's nutritional requirements. A variety of other factors can also affect her nutritional status—for example, poverty, dental problems, decreased mobility, isolation, loneliness, cultural traditions, and certain medications.

Mental Health Concerns

Although knowledge about the biological, psychological, and social processes associated with aging has increased greatly in recent years, understanding of the mental health problems of aging remains diffuse, particulate, and uncoordinated. While there are no alcohol, drug abuse, or mental health problems unique to women, there are several that are more prevalent among women than men or that affect women differently.

The most common of the mental disorders in older women is depression—estimates of the prevalence of serious depression in the population over age 65 range from 1 percent to 3 percent. Depression, a treatable illness, is frequently confused with dementia; adequate assessment and accurate diagnosis are critical factors in early intervention. In depression, the close interaction between mental and physical health is particularly evident in older women. Depression leads to further social isolation and withdrawal and to inattention to basic nutrition and sanitation, causing physical decline and confusion. Depression can also lead to greater reliance on sedatives and increased alcohol consumption.

Schizophrenia and senile dementia are also important mental disorders of older women. While schizophrenia occurs more frequently in men up to the age of 35, the incidence of the disease begins to increase in women over 35. Senile dementia, of which Alzheimer's disease is the best known type, is not a normal part of the aging process. While only 5 or 6 percent of older persons develop senile dementia, many other conditions, both physical and mental, can mimic the disorder at its various stages. It is essential that older women be carefully evaluated so that incorrect diagnosis and inappropriate treatment are avoided.

Drug Misuse and Abuse

Over-the-counter and prescription drug use by older women can pose a different type of problem. The elderly are generally recognized as heavy users of legal drugs. It is more appropriate, when speaking of the elderly, to speak of drug misuse—that is, inappropriate prescription and use of drugs intended for therapeutic purposes—than of drug abuse.

Persons 65 years of age and older constitute about 11 percent of the total population, but they take about 25 percent of all drugs dispensed over the counter and by prescription in the United States. The elderly are more likely than people in other age groups to have one or more chronic illnesses, such as heart disease, high blood pressure, diabetes, and arthritis. Few such diseases can be treated with just one drug or by just one physician. Elderly women use sedatives, hypnotics, antianxiety drugs, antihypertensive medication, vitamins, analgesics, cardiac drugs, diuretics, laxatives, and tranquilizers at a rate 2½ times that of elderly men.

Poor communication between older patients and their health care professionals, coupled with the fact that older patients may consult several different physicians and pharmacists, increases the likelihood of polypharmacy and potential drug misuse. The adverse effects of taking many different drugs may also be aggravated in older persons, since changes in drug tolerance and metabolism often accompany aging.

Alcohol Abuse

Alcohol abuse is a problem for many elderly women. Although it is estimated that only 2 percent of elderly women are heavy or problem drinkers, the overrepresentation of women in the older population makes the size of the problem, in absolute numbers, substantial. Moreover, the problem is likely to increase in the future. Unlike today's older women, who were in their formative years during the Prohibition period, future cohorts of older women are being socialized at a time when alcohol is readily available and social drinking is an acceptable and often encouraged part of life.

In our society, alcoholics, older people, physically and mentally impaired women, the poor, and minority group members all continue to be subject, in varying degrees, to stigmatization and discrimination. The negative effects on individuals or groups with more than one of these characteristics are compounded. The older female alcoholic is in triple jeopardy. If she is also poor and impaired, a situation not uncommon for older women, and a member of a minority group, the effects can be devastating.

Alcohol abuse within the older population shows an increased association with physical health problems. It is likely that the combined effects of aging and alcohol use significantly decrease the resilience of all body systems, resulting in a decline in physical resources and emotional stamina. Problems with the central nervous system, the circulatory system, the liver, the gastrointestinal tract, and the kidneys also are more common in older alcohol abusers than in younger ones. In addition, sleep disturbances resulting from alcohol use are more common in the elderly.

Prolonged abuse of alcohol may result in certain symptoms, such as confusion and disorientation, that are also seen in Alzheimer's disease, an irreversible and fatal condition. It is important that each of these conditions be promptly and accurately diagnosed. Without early detection and proper treatment, the initially reversible effects of alcohol abuse can, in fact, result in untreatable organic brain syndrome.

Summary

This report discusses many of the physical and mental health concerns, as well as many of the social problems, faced by women over the age of 65. While the report stresses problems that (*a*) are more prevalent among, (*b*) are more serious in, (*c*) are particular to, or (*d*) have more severe consequences for older women, it is important to realize that the majority of older women are healthy and lead active lives well into very old age. The key to good health for older persons, especially women, continues to be a combination of successful health promotion efforts throughout life and adequate access to health care. Better understanding of the ways in which numerous factors—mental, physical, and psychosocial—contribute to the maintenance of good health will enable more women to live productive, satisfying lives well into old age.

Issues Related to Alcohol and Drug Abuse and the Mental Health of Women: Executive Summary

GENDER PLAYS AN IMPORTANT ROLE in the etiology, effects, and treatment of alcohol abuse and alcoholism, abuse of other drugs, and mental illness. But the nature and extent of that role is poorly understood. Perhaps in part because alcohol and drug abuse have been viewed as predominantly male behaviors, research samples frequently have not included women. And though women are no less affected than men by mental illness, in this area, too, gender differences have been neglected.

Health and allied services have been provided—and data collected—as though each of these three major problem areas were separate. While this report discusses each area separately, it stresses their commonalities.

Alcohol Use and Abuse by Women

From childhood to old age, many more men than women use and abuse alcohol. But though women, on the average, drink less than and less often than men, 2 to 8 percent (depending on age) of the nation's women consume an average of two drinks daily.

Though women drink less than men, the acute and chronic effects of alcohol on women are greater. The higher percentage of body fat in women means that even when a woman consumes the same amount of alcohol as a man of equal weight, her tissue concentrations of alcohol will be higher than his.

Although fewer women become alcohol dependent, those who do experience greater morbidity and mortality than male alcoholics. For example, women develop more extensive liver damage earlier in their drinking history and at lower levels of alcohol intake. One theory is that this may be the result of estrogen production, which may make women's livers more vulnerable to alcohol's destructive effects. The decrease in life expectancy of women alcoholics is estimated to be 15 years.

Effects of Alcohol on Reproduction

Fetal alcohol syndrome occurs in about 2 per 1,000 live births. Alcohol use during pregnancy has been described as the third leading known cause of mental retardation in the Western world. Consumption of as few as two drinks daily has been associated with lowered birth weight. Although the amount of alcohol likely to produce congenital anomalies is uncertain, research in animals leaves no doubt that birth defects do result from heavy alcohol ingestion, whether from infrequent binge drinking or from frequent or daily use of alcohol.

Other Alcohol-Related Problems

Women need not be alcohol abusers to be adversely affected. It is estimated that one-half of the reported cases of wife battering are linked with alcohol abuse. Alcohol also is a factor in rape. For example, researchers who studied a group of rapists reported that one-third of the group had histories of alcoholism. Further, as many

as half the women in alcoholism treatment programs report having been raped.

Abuse of Drugs Other Than Alcohol

Like alcohol abuse, abuse of other drugs is much more common among men than among women. Approximately twice as many men as women use marijuana and other illicit drugs regularly. However, there are two notable exceptions to women's generally lower drug use: more young women than young men smoke, and at every age more women than men take prescribed psychoactive medication.

Opiate-Dependent Women

Opiate-dependent women are the smallest group of drug abusers, but they have been the most studied. Compared with male addicts, they have poorer self-esteem and poorer health and are more alienated from society. Pregnancy poses a high risk for these women and their offspring. Serious obstetrical complications are common, and the infants of these women have a death rate four times higher than that of other newborns. While babies born of women in methadone maintenance programs have higher risks than most infants, they are at much lower risk than those whose mothers still use heroin.

Marijuana Users

Of women who are 18 to 25 years of age, three out of five have tried marijuana at some time; one in five reports current use. Female users are predominantly young—only 3 percent of women over 25 reported current use in 1982.

The number of women who use marijuana during pregnancy is not known, but from recent studies it appears to be higher than previously expected. There is evidence from studies in animals that, at high doses, marijuana can interfere with fertility and may be associated with death of the developing fetus or newborn. Evidence in humans is limited, and the effects are more subtle. In one study, researchers found that marijuana use during pregnancy was related to lower birth weight and higher frequency of symptoms of the type seen in fetal alcohol syndrome. However, the effects of marijuana were difficult to separate from those of smoking, alcohol use, and other aspects of lifestyle.

Abusers of Nonprescribed Psychotherapeutic Drugs

Ten times as many women abuse nonprescribed psychotherapeutic drugs as abuse opiates. One in five patients admitted to treatment programs monitored by the National Institute on Drug Abuse (NIDA) listed abuse of psychotherapeutic drugs as their primary problem. The drugs are usually obtained from illicit or semilegitimate sources (for example, from family or friends for whom physicians ordered the drugs) and are often taken for reasons similar to those for which the drugs would ordinarily be prescribed.

These women's lives are often seriously disrupted, and their use of nonprescribed drugs is sometimes combined with heavy drinking. Indiscriminate use of psychotherapeutic drugs carries risks not associated with medically supervised use of the same substances.

Misusers of Prescribed Psychotherapeutic Drugs

Women who misuse prescribed psychotherapeutic drugs often do so be exceeding recommended doses and using the drugs for nonprescribed purposes. Women are more likely than men to escalate their prescribed dosage and to pressure physicians to increase or extend their psychoactive drug prescriptions.

Cigarette Smokers

Cigarette smoking is probably the most common addictive behavior among women. Its grave consequences for the health of women and their infants have been widely publicized.

Investigation of smoking as a drug dependency has not focused on gender differences. The reasons for the present higher rates of smoking among young women than among young men are not known. Pending further research, any explanation of the increasing gender differences in tobacco use is speculative.

The Elderly

Elderly women may unwittingly misuse drugs. Since women outnumber men in old age, and since psychoactive drugs are more often prescribed for women, age-associated drug reactions affect them more often than men. The three major problems related to drug use in the elderly are (*a*) heightened drug effects because of aging, (*b*) more frequent drug interactions and alcohol-drug interactions, and (*c*) toxic drug effects misdiagnosed as senility or mental illness.

The numbers of elderly women affected by these problems are uncertain. In one study of older patients admitted to a state mental hospital, it was found that 15 percent were actually suffering from drug toxicities rather than from senility, senile dementia, or mental illness.

Women and Mental Health

In any given month, 24 million Americans over the age of 18 have a psychiatric disorder; depression and schizophrenia are the most serious of these illnesses.

Rates of unipolar depression are about twice as high among women as among men. There is evidence that the greater frequency in women has both a biological and a psychosocial basis. Biological research has focused on neurochemical, endocrinological, and genetic factors that are sex linked. Psychosocial explanations of depression have explored such factors as "learned helplessness," the lower status of women, their greater dependency, and their more limited options. Epidemiologic studies have reported that depression is more frequent among women with children in the home than among women whose children have left home and that it is more common among widowed and divorced women than among the never married. Various pharmacological interventions, as well as many different psychosocial treatments alone or in combination with drug treatment, have been found to be highly efficacious in alleviating depression.

Schizophrenia, the most disabling of the mental illnesses, is a complex, puzzling disorder impairing 2–3 million Americans. Most research on schizophrenia has been done on male subjects. This may have caused important gender-related differences in the etiology and course of the disease among women to be overlooked. Various pharmacological treatments can allay the most florid symptoms of schizophrenia, and psychosocial treatments may improve social functioning.

Other Mental Disorders

The anxiety disorder agoraphobia affects an estimated 1 million American women. It has been treated successfully with drug therapy and with various psychotherapies, including behavior modification. Somatoform disorders, characterized by pain or physical symptoms without an identifiable organic basis, are more common in women than in men. Young women constitute 95 percent of patients with anorexia nervosa, which has been treated with various types of psychotherapy, with mutual support groups, and more recently with antidepressants.

Violence and Victimization

Violence and victimization are special problems for women. Rape is a very much underreported crime that can have profound and prolonged impact. Older women are particularly vulnerable to assault, especially if they live in high crime areas.

The etiological role of early sexual abuse in later mental health problems is little understood but it is the subject of much speculation and some research. In the area of sexual abuse, most research has focused on establishing rates of victimization and on treatment of victims. Too little research has been aimed at understanding the roots of violence against women and at deterring and treating offenders.

Deinstitutionalization

In recent years, the trend in treatment of the mentally ill has been to hospitalize patients for as short a period as possible or not at all. Unfortunately, few communities provide shelter for released mental patients. Women released from institutions are especially prone to violence. Women in our society also tend to have greater responsibility than men for providing care for family members released from institutions, and few have any respite from the constant burden of providing home care for a seriously disabled relative.

The Common Threads

Although our understanding of the role of gender in alcohol, drug abuse, and mental health problems is limited, it is clear that there are important common elements. There is evidence that women who abuse alcohol and other drugs face a greater social stigma than male abusers of these substances. While there may be greater tolerance within our society for women than for men with minor emotional problems, this is not necessarily true when the problems are more serious. The self-esteem of women is generally lower than that of men. When a women is an alcoholic, a drug abuser, or mentally ill, the associated stigma further detracts from her self-image.

The higher incidence of depression among women adds to the likelihood of self-medication with alcohol and other drugs. Over half of drug-related emergency room admissions of women are identified as suicide attempts. By contrast, in men the motives for using drugs leading to emergency room admission are more likely to be drug dependency or the drugs' mood-altering effects.

Reproductive and sexual dysfunctions are frequent in women who have alcohol, drug abuse, and mental health problems, and these women are more vulnerable to rape and other sexual exploitation. Sexual abuse and assault may also have played an etiological role in their problems.

The economic reality is that women are more often financially dependent, are less likely to have a work-related identity, and are paid significantly less than men. In addition, if divorced, women are more likely than men

to have the added emotional and financial burdens of single parenthood. If married, women abusers of alcohol and other drugs are more likely than male abusers to have spouses with similar problems; thus, women's attempts to recover from alcohol or drug abuse are more likely to encounter resistance or active opposition at home.

Health professionals treating women are not immune to the stereotypic opinions regarding women that society fosters. "Adjustment" may be stressed more for women than for men, and women's anger may be labeled "pathological" more often than is justified. What is "mentally healthy" is often defined differently for women than for men.

Questions regarding the prescribing of psychoactive drugs in greater numbers for women do not have simple answers. Survey evidence suggests that these drugs are usually taken judiciously for the purposes prescribed. But whether they are prescribed with equal judiciousness has not been adequately explored.

Alcohol and drug programs in which the clients are predominantly male may favor men by the way their programs are organized and may be insensitive to women's needs. While there have been some attempts to study the effects of gender—both that of the therapist and that of the client—on therapeutic outcome, this is a complex issue. Sensitivity of the therapist to gender differences may be more important than the sex of the therapist.

Female clients are more likely than male clients to have associated medical problems, and programs designed for men are unlikely to meet those needs. Services such as vocational training, job placement, and child care may be more necessary in rehabilitating women. Rape counseling and female group therapy sessions dealing with issues of sexuality are important. Black, hispanic, and other minority women may be confronted with ethnic or racial prejudices and need programs that take these unique problems into account.

As this report indicates, there are large areas in which our knowledge is partial or nonexistent. But in spite of the special difficulties that face women with alcohol, drug abuse, or mental health problems, more women are being successfully treated for these illnesses today than ever before. More research to prevent these conditions, to provide a better understanding of their etiology, and to improve diagnosis and treatment is needed, not only to alleviate the pain they engender but also to reduce the economic losses they cause. Increased understanding of the ways these problems uniquely affect women will profit everyone.

Assessment of Women's Health Issues as Presented at Regional Meetings: Executive Summary

THE SUBCOMMITTEE ON ASSESSMENT of Women's Health Issues as Presented at Regional Meetings, one of the six subcommittees of the Task Force, was established in June 1983 to develop a mechanism for enlisting the help of knowledgeable members of non-Federal health organizations in assessing the special health needs of women. In implementing this effort, the subcommittee contacted the Public Health Service Regional Health Administrators, who arranged a series of 1-day regional discussion sessions among PHS, State, local, community, and health provider representatives. The information received at these meetings provided a means of balancing the perspective brought by the Task Force to its review of health issues of special concern to women.

Throughout the month of January 1984, the Regional Health Administrators hosted sessions on women's health in Boston, New York, Philadelphia, Atlanta, Chicago, Kansas City, Dallas, Denver, Seattle, and San Francisco. In response to requests from several organizations in the Washington, DC, area to address the Task Force, a meeting was also held in March 1984 at the National Institutes of Health in Bethesda, MD.

In addition to those who were invited or had expressed interest in making formal presentations at these sessions, many members of other non-Federal health organizations and women's groups attended and presented their views on the health problems of women. Others who could not be present were encouraged to forward their comments, ideas, and concerns about women's health to the Task Force.

Summary of the Regional Meetings

The discussions at the regional sessions contributed insightful and often unique information about the many issues that directly or indirectly affect women's health. The theme that seemed to dominate all of the sessions was that women's health is directly related to their access to sound information and quality medical care.

The participants agreed that, although there is a trend toward greater equity in the distribution of medical care in the United States, economically disadvantaged women are medically underserved. The participants identified specific populations of poor women who do not receive attention in the medical care system. These include minorities, the handicapped, the marginally poor, the elderly poor, migrants, female heads of households, rural

women, homosexual women, the homeless, and the incarcerated.

Lack of health insurance and inability to qualify for Medicare, Medicaid, or Aid to Families with Dependent Children prevent many of these women from receiving medical care. Even among those who qualify for assistance under government programs, the attitudes and insensitivity of health care providers often discourage the needy from taking advantage of available help. Insensitivity of and stereotyping by physicians were seen as problems for women of all economic groups, not just the poor.

With regard to research, participants expressed interest in the initiation of studies that include women as well as men and asked that increased attention be focused on issues that relate specifically to women's health.

A number of significant issues were addressed at almost all the regional sessions. These included:

- the impact of social conditions on women's mental and physical health.
- the role of nutrition in women's health.
- female-intensive diseases, especially osteoporosis.
- stress, alcoholism, substance abuse, and suicide as growing problems, especially among younger women. (The mental health consequences of physical disease are often overlooked by physicians.)
- creative approaches to health care, particularly long-term care.
- the need of nurses, nurse practitioners, and midwives for sound information on specific diseases and health problems, so that they can serve as well-informed educators for their patients.
- the fragmentation of government efforts, despite an interest in women's health.

Participants made a number of recommendations for women themselves to implement. For example, several presenters suggested that women should intensify their networking and support group activities to foster self-awareness and encourage healthier female role modeling. Without these activities, participants pointed out, women will choose to continue their lifelong, traditional role of nurturing others while neglecting to obtain help for themselves.

Women were encouraged to participate fully in the sex education of their children, rather than leave this training entirely to the schools. They were also urged to educate themselves about the problems of physical abuse, incest, and sexual abuse and to seek professional help should they see these practices occurring in their homes.

A number of recommendations were also made pertaining to the need for expanding existing data and surveillance systems and information and educational programs.

Review of Reports and Recommendations

The full reports and the hundreds of recommendations that resulted from the regional sessions were discussed and reviewed at length both by this subcommittee and by the full Task Force. In its final assessment, the subcommittee singled out for presentation to the Task Force seven topical areas that seemed to encompass the most important concerns of participants in the regional sessions and formulated recommendations to address these concerns.

Health problems and issues of adolescent females. In reviewing the advances that have led to improvement in health care for women, participants in the regional sessions singled out adolescent females as a group that is frequently overlooked when medical needs are being assessed. They identified a number of general health problems, as well as issues specifically concerning reproduction, as meriting special consideration.

Though barely acknowledged as problems by some care givers, acne, excess weight or obesity, menstrual cramps, and mood swings confound the female teenager, lower her self-esteem, and interfere with her emotional and physical growth and maturation. These conditions can result from complex factors that are both physiological and psychological.

Another range of issues involves fostering early development by adolescents of habits conducive to health, including preventive dental care and good nutrition practices.

The emotional health of the female adolescent is important as well. Unfortunately, statistics indicate an increase in depression, suicide, and certain other mental or emotional illnesses among adolescent females. Eating disorders, such as anorexia nervosa and bulimia, are common in this group. Some forms of substance abuse by adolescents can also be categorized as symptomatic of emotional illness or distress.

In the past decade, an increasing number of teenagers has become sexually active, at an earlier age, with sometimes tragic consequences. Teenagers under 16 years have a higher incidence of pregnancy-induced hypertension and premature births. Many teenage mothers never finish school and are unable to find jobs. If they marry, all too often the marriages end in divorce. The infants born to these young women are at increased risk of adverse neonatal outcome, largely as a reflection of low birth weight, and the babies continue to be at increased risk of death or morbidity in the postneonatal period. The children who survive often become victims of abuse and neglect as a result of maternal inexperience and the socioeconomic disadvantages characteristic of many of these young mothers. Problems are most acute among

economically disadvantaged groups whose access to prenatal care is limited or nonexistent until the time of delivery.

Research issues affecting women's health. Participants in the regional sessions identified gender bias in research as a detriment to obtaining accurate data on women's health, noting that data collected in studies that use only male subjects are often invalid for the female population. They urged that data both on gender and on women's changing role in society be collected and that these data be considered when health programs are developed and assessed.

Societal determinants of women's health. Participants in the regional sessions agreed that women's health is more than a medical issue. Cultural, social, and economic factors determine to a great extent the ease with which women can enter the health care system and receive proper treatment. Some of the factors influencing women's access to, and participation in, the health care system have been experienced by grandmother, mother, and daughter within a single family. Where women live and the attitudes of care givers also influence the accessibility and quality of the services and treatment women receive.

Access to health care and services was identified as being particularly limited for poor or marginally poor, elderly, and unemployed women. These groups include members of ethnic minorities, women who are geographically isolated, homosexual women, and incarcerated women, all of whom require special sensitivity of care as well as improved access to it. The participants noted that even when medical services are available, cultural and language differences often discourage women from using these services.

Training-sensitivity-care options. Participants in the regional sessions addressed the increased need for health services, the rising cost of institutional care, and the disproportionate impact these factors have on poor women, especially in the elderly and minority populations. Possible solutions offered to alleviate these problems emphasized (*a*) the need to train health care givers to educate women about how to stay well and (*b*) the responsibility of the health care establishment to eliminate conditions and attitudes that block women's access—at all stages of their lives—to adequate medical care and services.

Participants agreed that, as important as it is for women to stop smoking, drink only in moderation, eat well-balanced diets, exercise regularly, and get adequate rest, there are many times when the success of these easures depends on help and encouragement from sensitive health care workers.

Women's responsibility for their own health. The need for women to become more deeply involved in their own health care and that of their families, especially in the area of prevention, was emphasized at the regional sessions. Participants identified a variety of preventive measures that women might adopt to safeguard their health. Participants recommended that women, in assuming greater responsibility for their own health, make full use of available information and support networks and become advocates for improvements in the health care system.

Women's role in the health care system. The consensus of participants in the 11 regional sessions was that if women played a greater role in making decisions related to health policy, they would be better able to address constructively the issues that were raised at the sessions. Concern was expressed that the recommendations resulting from the sessions would remain unimplemented until women like those present exerted more influence in the political, economic, informational, societal, and clinical decision arenas pertaining to women's health.

Specific health problems of women. The participants in the sessions reviewed a wide range of health problems that are prevalent among women and a number of issues that adversely affect women's mental and physical health. Osteoporosis, alcohol and drug abuse, stress, sexually transmitted diseases, genetic disorders, and family violence and sexual abuse were singled out for special attention.

Summary

As indicated by the enthusiastic response of invited participants to the regional meetings and the vehemence of the opinions expressed by the participants, there is little doubt that issues related to women's health are of special concern to American health care consumers and health care providers.

Although participants at a number of the regional meetings cited problems unique to particular areas (for instance, the problems of Appalachian women who feel geographically isolated from the mainstream of the American health care system; of poor black women in Mississippi who feel that childbirth is a time of special risk because of their lack of access to prenatal care; of homosexual women in New York City who feel insensitivity on the part of health care providers; and of American Indian women who feel that alcoholism is a special risk for them), the regional meetings were more similar than dissimilar. Common concerns were repeated at each meeting—concerns related to access to care, contraception for teenage girls, health problems of aging women,

health problems of the reproductive system, cancer, family violence, and incest. In most cases, the concerns expressed seemed to indicate that American medical care is excellent, but that access to that care, sensitivity during its provision, and health information and education are overwhelming needs for American women.

The continuing need for biomedical research in certain areas of interest and concern to American women was stressed by many of the participants. However, the threads common to all the regional meetings seemed to be the more diffuse issues of access, sensitivity, information, and education.

Inventory of PHS Programs Related to Women's Health: Executive Summary

THE PURPOSE OF THIS INVENTORY is to provide the Assistant Secretary for Health with a comprehensive description of recently completed, ongoing, and imminent Public Health Service programs concerned with women's health issues. This information is intended to:

- facilitate coordination of program efforts by different components of the Public Health Service regarding women's health matters,
- serve as an information source for non-PHS organizations and individuals actively concerned with women's health issues, and
- serve as baseline information for evaluation of PHS programs addressing women's health issues.

Although a number of statistical and management information systems exist within the Public Health Service, they are not structured for the ready retrieval of information specific to women's health activities. The inventory was the first PHS effort to identify major activities that relate to women's health within the Service's five agencies and other major components.

Methods

Since PHS agencies support or conduct multifaceted biomedical and health services research, information dissemination, technical assistance, resource development, and service delivery efforts, it was apparent that all of these initiatives would include efforts that relate to aspects of women's health. To identify such efforts, the inventory was compiled, using the following five criteria to distinguish specific health problems, conditions, or diseases as women's issues:

- diseases or conditions *unique* to women or some subgroup of women,
- diseases or conditions *more prevalent* in women or some subgroup of women,
- diseases or conditions *more serious* among women or some subgroup of women,
- diseases or conditions for which the *risk factors* are different for women or some subgroup of women, and
- diseases or conditions for which the *interventions* are different for women or some subgroup of women.

An additional distinction was made between diseases or conditions whose effect on women (or some women) is medically, physiologically, or sociologically different and those diseases or conditions that affect women differently because of access, resource, or delivery mode considerations. Examples of the first type include diseases such as osteoporosis, X-linked hereditary traits, mental illness, and functions of the female endocrine and reproductive systems. Examples of the second type include diseases or conditions affected by the availability of health insurance, existence of adequate health care services, and other barriers to health care.

Questionnaire development. An eight-page questionnaire was designed that had 21 items, including identification of the sponsoring component and questions about authority, timing, level of effort, target and user population groups, focus, goals, and objectives. In addition, the respondent was asked for a narrative description of the scope of the activity, its relationship to other programs, and its relevance to health issues.

This inventory of activities also assessed, in a very basic manner, the relationship of women's health activities to overall Public Health Service objectives and goals. It was postulated that the level of concurrence with a series of administrative and programmatic directives that were common to all agency components could provide information on the relationship of these activities to the overall efforts of the Service. Accordingly, three sets of directives, suggested by interviews with key PHS officials, were adopted in the questionnaire as points of inquiry. These included:

- "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention" (*1*),
- "Promoting Health/Preventing Disease: Public Health Service Implementation Plans for Attaining the Objectives for the Nation" (*2*), and
- PHS priorities for program management and administration.

Data collection. The questionnaire was distributed to the heads of PHS principal operating components. More than 200 questionnaires were completed. Each response was assessed for clarity and completeness, and problems or issues needing clarification were resolved through followup telephone calls and, in some instances, personal interviews.

Data analysis and reporting. The approach for data analysis, which was refined over time, focused on the following:

- descriptive information on the scope and nature of activities, budgeted or authorized by the Public Health Service, that are related to women's health status;
- a narrative description of each identified activity; and
- an analysis of information revealed by the process of identifying and describing health activities.

Methods of analysis that were selected included use of content analysis for narrative data provided in the completed questionnaires, limited descriptive statistical analysis (for example, cross-tabulation) for quantitative data, and documentation and retrospective analysis of anecdotal information provided by respondents and key members of the Task Force.

Results

- *What is the scope of women's health issues addressed by the Public Health Service during the period Fiscal Year 1980 through Fiscal Year 1984?*

Respondents indicated more than 25 women's health issue areas addressed by their activities. The scope of issues identified by responses ($N = 202$) includes, but is not limited to, these general areas: general health; social, behavioral, and mental health; reproductive health; specific illnesses and dysfunctions; women's interactions with the health care system; women's participation in the health care system; and health technology.

A number of responses indicated a primary issue area related to women's reproductive capacity and physiological processes. Thirty-three respondents indicated that pregnancy and childbearing constituted their principal activity focus. The only larger primary issue area was specific disease and health conditions. Forty-seven responses cited this area, which includes a wide variety of health and disease conditions, including those affecting the endocrine and reproductive systems.

An examination of reported data suggests that there is concern for women in their roles as (*a*) consumers of health care services, (*b*) service providers in the health care system, and (*c*) extra-market (unpaid) providers of health care and promotion services to families and the community. The scope of health issues addressed also suggests that PHS components are concerned with problems that differentially affect females, including specific diseases, occupational and environmental health hazards, access to appropriate health services, and safety of health technology applications.

- *What is the scope and nature of Public Health Service activities reported as being concerned with women's health issues?*

A total of 116 respondents classified their activities as, at least in part, research. Thirty-seven indicated that the descriptor "data system/evaluation/analysis" typified their activities, and another 32 identified their activities as "education/training." The other respondents indicated the following activity: public information, 27 responses; surveillance, 22; conferences and seminars, 21; technical assistance, 17; planning/regulatory, 15; direct service, 13; other specified, 11; and Task Force, 5.

The Public Health Service activities are comprehensive. That is, a programmatic activity may encompass surveillance, public information, technical assistance, and education/training. Both "programmatic" and "research" categories were selected as descriptors of the scope of several reported activities. Thirty-nine returns indicated that both research and programmatic efforts were within the scope of a single activity. While it is not possible, given these data alone, to say that the Public Health Service provides a full scope of operations related to women's health issues, PHS does support a wide range of operations that include surveillance, regulatory efforts, direct services, health services research, and basic and clinical research and does maintain data systems supporting the overall operations.

- *What is the level of effort for Public Health Service activities concerned with women's health?*

There are not, at this time, sufficient accessible and reliable data to permit estimates of cost for each reported activity. This lack reflects a generic problem of great difficulty: allocating costs for activities that are not specified in a budget line-item. It is even more difficult to analyze these activities for their net allocation of funds for various activities. For some activities with specific legislative authority (or line-item in the budget), the overall costs of their day-to-day operations can be identified. Respondents reporting activities supported by a grant or contract were able to provide information on the discernible costs budgeted for each entity.

Despite these uncertainties, the fact remains that the Public Health Service spends a considerable amount of its budget on women's health.

• *What are the foci of reported Public Health Service activities concerned with women's health issues?*

The following descriptors indicating focal points to describe the general objectives of public health services and organizational strategies were selected:

- health promotion and/or disease prevention,
- detection and/or diagnosis of a disease,
- treatment and/or rehabilitation,
- improving access to health services,
- quality control/assurance, and
- cost containment.

Although an activity may have one or more focal points, health promotion/disease prevention was the descriptor most frequently selected ($N = 155$) by respondents, a finding in keeping with the number of reported activities directed toward research, evaluation/analysis, and education/training operations. Detection/diagnosis of diseases and treatment/rehabilitation were the next most frequently reported emphases.

• *What specific groups (for example, demographic, occupational) of females are identifiable as a primary target population (or subpopulation) for Public Health Service activities?*

This point of inquiry sought information on the diversity of groups of women targeted as particular populations within reported activities, and it included women as consumers of health services sponsored by the Public Health Service. Data obtained from the questionnaire and supporting documents identify types of population groups but do not enumerate specific groups targeted by the respondents. Types of groups include, but are not limited to:

- ethnic and racial groups, including women of Hispanic heritage, blacks, Indo-Chinese, and Native Americans;
- recent immigrants;
- occupational groups, including federally employed women; video display terminal operators; clerical and secretarial workers; and female workers exposed to potentially toxic chemical agents, infectious diseases, and diagnostic X-ray technologies;
- female residents of long- and short-term health care facilities;
- women handicapped or disabled by specific diseases or conditions;
- women affected by changes in lifestyle or life events;
- women living in rural or urban settings, and
- women living with families whose adjusted income is near or less than established poverty levels.

Some respondents identified victims of sexual abuse and domestic violence as a target population group. These social and health problems are the topics of activities reported by the Centers for Disease Control and the Alcohol, Drug Abuse, and Mental Health Administration.

In addition, there are data systems within the Public Health Service—particularly those of the National Center for Health Statistics and the National Center for Health Services Research—that can provide data on women, their characteristics, their health status, and their use of health services.

Respondents also reported programs on prevention and treatment of fetal alcohol syndrome (FAS) and services that address the problems of pregnant drinkers and the effects of FAS on their offspring.

Several projects deal, at least in part, with women who belong to ethnic or racial minorities; who are exposed to actual or potential occupational hazards; or who are affected by conditions such as diabetes, cancer, or sexually transmitted diseases.

Age-specific groups of women are also reported as target populations or subpopulations for activities related to age-specific prevalence of disease (for example, anorexia) and age-specific risk factors (for example, pregnancy) as well as for health-status monitoring, basic and clinical research, and special initiatives benefiting the young and the elderly. Physiological life events (for example, puberty, pregnancy, and menopause) and social life events (for example, widowhood and divorce) appeared to be secondary descriptors of target populations.

Respondents to the inventory questionnaire noted that it was not always possible to provide information on the proportions of women involved in or affected by an activity. It is usually possible to estimate the number of women studied under a single research grant—sampling frames for such an activity may provide this information, as well as demographic data. However, information on number and characteristics of women studied under multifaceted or clustered projects may not be routinely available.

• *What are the relationships between reported women's health activities and existing Public Health Service program directives?*

As noted earlier, three sets of program directives were selected: (*a*) PHS program management priorities; (*b*) PHS health goals identified by the Surgeon General's report "Healthy People" (*1*); and PHS implementation plans for attaining the 1990 Objectives for the Nation (*2*). These directives provide general priorities, goals, and objectives that cut across the PHS organizational structure.

Analysis of PHS programs revealed the following priorities:

- maintaining a strong Federal role in health research,
- achieving disease prevention goals with particular attention to the 1990 objectives,
- expanding private sector participation in Public Health Service activities,
- providing services to American Indians and Alaska Natives,
- strengthening partnerships with State and local governments in the management of public health programs,
- reducing the burden of unneeded regulation of health activities,
- strengthening collaborative efforts to achieve health objectives, and
- continuing to improve the management and performance of Public Health Service programs.

Respondents (N = 202) to the questionnaire indicated that these priorities applied to 192 of their reported activities. Ten responses indicated no direct relationship between any of the priorities and the activity reported. A qualifier such as "indirectly related" was applied to the majority of National Center for Health Statistics data-system activities and to some others.

The priorities selected most frequently were health research, prevention objectives, and collaborative efforts. The Food and Drug Administration's responses reflected efforts to reduce unnecessary regulation. Thirty-seven responses reported and documented collaborative efforts with the private sector, State and local governments, or other entities.

The Surgeon General's "Healthy People" goals also provided a reference for analysis. The overwhelming majority of responses related to the "healthy infants" goals and subgoals. Sixty-nine respondents noted this area as the primary, secondary, or tertiary goal of their reported activity. Programs concerned with maternal and child health services, nutrition activities, and fetal alcohol syndrome often identified these goals. Similarly, programs concerned with cancer, cardiovascular health, and circulatory system diseases noted the "healthy adults" goals.

The third set of directives analyzed was "Promoting Health/Preventing Disease: Public Health Service Implementation Plans for Attaining the Objectives for the Nation" (*2*). The specific objectives and implementation plans outlined in this publication are related to the "Healthy People" goals and fall within 15 specific subject areas:

- high blood pressure control,
- family planning,
- pregnancy and infant health,
- immunization,
- sexually transmitted disease control,
- toxic agent and radiation control,
- occupational safety and health,
- accident prevention and injury control,
- fluoridation and dental health,
- surveillance and control of infectious diseases,
- smoking control,
- alcohol and drug misuse prevention,
- improved nutrition,
- physical fitness and exercise, and
- control of stress and violent behavior.

Pregnancy and infant health was the area identified most frequently (N = 89) as the focus of reported activities, followed by misuse of alcohol and drugs (N = 46). Also reported were activities related to the areas of toxic agent and radiation control (N = 18), occupational safety and health (N = 18), and accident prevention and injury control. An interesting finding was that 40 responses did not indicate relationship of their reported activities to any of these areas.

These data suggest that reported activities related to women's health status are linked to overall PHS performance and achievements.

Conclusion

There are obvious limitations in any collection and analysis of data that preclude the assertion that the inventory is either totally accurate or complete. But the limitations inherent in the data collection and the responses that have been used as the basis for this report should not necessarily be considered flaws in the end product or the conclusions presented. The inventory provides the most comprehensive effort yet made to describe activities in the Public Health Service related to women's health issues.

The subcommittee's recognition of the value of the inventory and its obvious practical utility led them to recommend that the information be made readily accessible and be freely disseminated, and that it be updated at regular intervals in a manner that will enhance and refine the data collection and analytical techniques.

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Public Health Service Task Force on Women's Health Issues

Participating Agencies and Offices:

Alcohol, Drug Abuse, and Mental Health Administration
Centers for Disease Control
Food and Drug Administration
Health Resources and Services Administration
National Institutes of Health
Office of the Assistant Secretary for Health (OASH)
Office of Intergovernmental Affairs

Task Force Members:

Ruth L. Kirschstein, MD (*Chair*), National Institutes of Health.

Doris H. Merritt, MD (*Co-Chair*), National Institutes of Health.

Valerie N. Williams (*Executive Secretary*), Office of Health Planning and Evaluation, OASH.

Lois Chatham, PhD, Alcohol, Drug Abuse, and Mental Health Administration.

Joyce Lazar, Alcohol, Drug Abuse, and Mental Health Administration.

Glenda Cowart, Centers for Disease Control.

Barbara Cohen, Centers for Disease Control.

Mary Ann Danello, PhD, Food and Drug Administration.

Patricia Kuntze, Food and Drug Administration.

Audrey Manley, MD, Health Resources and Services Administration.

Paul Schwab, Health Resources and Services Administration.

Barbara Gaffney, Health Resources and Services Administration.

Mortimer Lipsett, MD, National Institutes of Health.

Duane Alexander, MD, National Institutes of Health.

Penelope Pollard, Office of Disease Prevention and Health Promotion, OASH.

Cheryl Damberg, Office of Disease Prevention and Health Promotion, OASH.

Ruth Behrens, Office of Disease Prevention and Health Promotion, OASH.

Shellie Lengel, Office of Public Affairs, OASH.

Margaret Suter, Office of Public Affairs, OASH.

Task Force Staff:

Valerie N. Williams (*Executive Secretary*), Office of Health Planning and Evaluation, OASH.

Jeanellen Knight, Office of Management, OASH.

Contributing Participants:

Patti Birge-Tyson, Office of the Secretary, Department of Health and Human Services.

Molly Collins, Office of the Secretary, Department of Health and Human Services.

Glenna M. Crooks, PhD, Office of Health Planning and Evaluation, OASH.

Hildegard Topper, National Institutes of Health.

Task Force Subcommittees:

Social Factors Affecting Women's Health

Joyce Lazar (*Chair*), Alcohol, Drug Abuse, and Mental Health Administration.

Cheryl Damberg, Office of Disease Prevention and Health Promotion, OASH.

Wendy Baldwin, PhD, National Institutes of Health.

Barbara Cohen, Centers for Disease Control.

Jerry Weston, PhD, National Center for Health Services Research.

Joanne Luoto, MD, Office of Smoking and Health, OASH.

Tanya Parker, Health Resources and Services Administration.

Magdalena Miranda, Health Resources and Services Administration.

Matilda White Riley, DSc, National Institutes of Health.

Marcia Ory, PhD, National Institutes of Health.

Women's Physical Health and Well-Being

Mortimer Lipsett, MD (*Chair*), National Institutes of Health.

Duane Alexander, MD, National Institutes of Health.

Hildegard Topper, National Institutes of Health.

Juanita Evans, Health Resources and Services Administration.

Elaine Bratic, Office of Public Affairs, OASH.

Health Concerns of Older Women

Mary Ann Danello, PhD (*Chair*), Food and Drug Administration.

Shirley Bagley, National Institutes of Health.

Doris Bloch, PhD, Health Resources and Services Administration.

Monique Braude, Alcohol, Drug Abuse, and Mental Health Administration.

Mary Hill, PhD, Health Resources and Services Administration.

Eleanor Friedenberg, Alcohol, Drug Abuse, and Mental Health Administration.

Rizalina Galicinao, Alcohol, Drug Abuse, and Mental Health Administration.

Mary Ganikos, PhD, Alcohol, Drug Abuse, and Mental Health Administration.

Penelope Pollard, Office of Disease Prevention and Health Promotion, OASH.

Carol Scatarige, MD, Office of Disease Prevention and Health Promotion, OASH.

Issues Related to Alcohol and Drug Abuse and the Mental Health of Women

Lois Chatham, PhD (*Chair*), Alcohol, Drug Abuse, and Mental Health Administration.

Sheila Gardner, Alcohol Drug Abuse, and Mental Health Administration.

Jackie Hall, PhD, Alcohol, Drug Abuse, and Mental Health Administration.

Brenda Hewitt, Alcohol, Drug Abuse, and Mental Health Administration.

Phyllis Berman, National Institutes of Health.

Kathleen Bond, National Institutes of Health.

David Heppel, Health Resources and Services Administration.

Nancy Thompson, Centers for Disease Control.

Assessment of Women's Health Issues as Presented at Regional Meetings

Shellie Lengel (*Chair*), Office of Public Affairs, OASH.

Margaret Suter, Office of Public Affairs, OASH.

Ann Dieffenbach, National Institutes of Health.

R. Anne Thomas, National Institutes of Health.

Pat Lippert, Office of Equal Employment Opportunity, OASH.

Mary Ann Danello, PhD, Food and Drug Administration.

Patricia Kuntze, Food and Drug Administration.

Jackie Hall, PhD, Alcohol, Drug Abuse, and Mental Health Administration.

Ellen Casselberry, Office of Public Affairs, OASH.

Audrey Manley, MD, Health Resources and Services Administration.

Valerie N. Williams, Office of Health Planning and Evaluation, OASH.

Inventory of Public Health Service Programs Related to Women's Health:

Paul Schwab (*Chair*), Health Resources and Services Administration.

Pearl Perry, PhD, Health Resources and Services Administration.

Ann Haendel, National Center for Health Services Research.

Karen Wions, National Center for Health Services Research.

Sheldon Kotzin, National Library of Medicine.

Sandra Smith, National Center for Health Statistics.

Shellie Lengel, Office of Public Affairs, OASH.

Doris H. Merritt, MD, National Institutes of Health.

Gooloo Wunderlich, PhD, Office of Health Planning and Evaluation, OASH.

Valerie N. Williams, Office of Health Planning and Evaluation, OASH.