Improving Women's Health from Communities to Care Settings

A Report on the 2010 Grantmakers In Health Fall Forum

November 9 - 10
Washington, DC

Updated January 2011

If you care about health, then women are key because their health and health-related decisions ripple outward to set the tone for families and communities. Women's health problems mirror the nation's health problems, and the factors that affect their health and shape their health choices reflect the challenges women face as members of families and communities, as caregivers, and as health decisionmakers. Understanding these factors helps us identify opportunities for prevention and intervention that serve not only women, but families and communities as a whole.

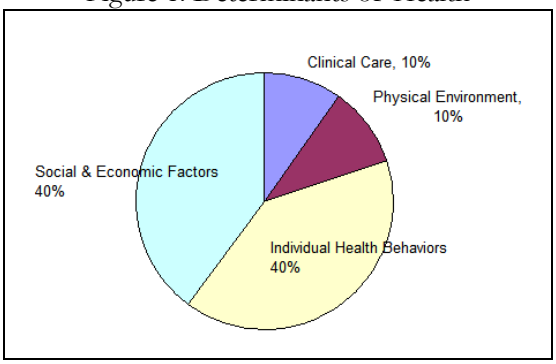
GIH's 2010 Fall Forum, *Improving Women's Health from Communities to Care Settings*, looked in-depth at the challenges facing women, to show how they shape their health and that of their families and to stimulate thinking about the part funders can play in changing conditions for the better.

> Women's health is essential to the prosperity and opportunity of all, to the stability and development of nations.
>
> Secretary of State Hillary Clinton, 2010

Around the world, there is now enormous interest and investment in improving women's health and quality of life. The Fall Forum was part of that continuum. It provided the latest information about women's health and use of health care, examined the broader factors that affect women's health, and highlighted the work of foundations and organizations that are developing and implementing solutions.

Often, we look at women's health in terms of specific health problems. But in doing this, we lose sight of the big picture. In order to understand the patterns of health and disease among women, we have to look holistically at the factors that affect their health (Figure 1). Specific health problems are of course important, but by understanding why they occur and why certain women are more affected than others, we are in a better position to develop effective solutions.

Figure 1: Determinants of Health



Source: Henry and Russo 2009

This report begins with a brief review of current health statistics and the broader context of women's health and illness, then summarizes the highlights of *Improving Women's Health from Communities to Care Settings*. A previous version was circulated as background for the meeting.

Women's Health and Illness—A Statistical Sketch

Self-Reported Health

In general, women are slightly less likely than men to report being in excellent or very good health (60 versus 62 percent, respectively) (HRSA 2009). About 13 percent of women consider themselves to be in fair or poor health (Table 1). Overall, women's self-reported health reflects the struggle all Americans are experiencing to modify the risk factors—smoking, poor eating habits, lack of exercise—that are major contributors to chronic diseases and death. About a quarter of women consider themselves to be obese (although actual numbers are much higher, see the "Diseases and Disability" section below), and 22 percent report being a smoker.

Self-reported health indicators are generally better for white, Asian, and Native Hawaiian/Pacific Island women and worse for black, Hispanic, and American Indian/Alaska Native women. However, both white women and American Indian/Alaska Native women not only smoke more than other groups, but also report higher levels of serious psychological distress.

Table 1: Self-Reported Health Status among Women

Health Status	All Women	White	All Minority	Black	Hispanic	Asian and NHPI	American Indian/Alaska Native
Fair or Poor Health	12.8%	9.5%	19.7%	16.9%	26.9%	7.9%	22.1%
Unhealthy Days (mean days/month)	7.3	7.2	7.3	7.6	7.4	5.5	10.5
Limited Days	3.5	3.2	3.9	4.3	3.8	2.7	6.2
Diabetes	4.2%	3.3%	6.2%	7.5%	6.1%	3.2%	8.6%
Heart Disease	3.2%	2.7%	3.9%	4.8%	4.0%	1.2%	8.7%
Obesity	22.7%	20.1%	28.4%	37.8%	27.3%	8.4%	30.4%
Smoking	21.9%	24.7%	14.6%	18.7%	11.5%	8.4%	35.7%
Cancer Mortality/100,000 women	162.2	161.4	---	189.3	106.7	96.7	112.0
New AIDS Cases/100,000 women	9.4	2.3	26.4	50.1	12.4	1.8	7.0
Low-Birth Weight Infants	8.1%	7.2%	9.9%	13.8%	6.8%	7.9%	7.4%
Serious Psychological Distress	15.7%	16.7%	13.8%	13.5%	14.1%	9.6%	26.1%

Source: The Henry J. Kaiser Family Foundation 2009

Reproductive Health

The United States continues to lead other developed countries in the number of annual births per woman. In 2006 the total fertility rate (TFR)—or average number of children per woman given current birth rates—was 2.1 children per woman. Among racial and ethnic groups, the TFR was highest for Hispanics at 3.0 children per woman, compared with 2.1 for non-Hispanic whites, 2.1 for non-Hispanic blacks, 1.9 for Asian and Pacific Islanders, and 1.8 for American Indians and Alaska Natives (NCHS 2009).

In 2006 the country's teen birth rate rose for the first time since the early 1990s, although it is still too early to tell whether this is a trend or a statistical blip. The teen birth rate varies widely by state. In certain regions, especially the South and Southwest, as many as 30 percent of teenage girls are likely to become mothers (Perper and Manlove 2009).

In 2002, 63 percent of U.S. women ages 15-44 were using contraception (Guttmacher Institute 2010a). This was about 6 percent more than 20 years earlier. Eighty-three percent of sexually active teen females and 91 percent of teen males report using contraceptives. This is a marked improvement since the mid-1990s, when only 71 percent of teen females and 82 percent of teen males had used a contraceptive method at last sex (Guttmacher Institute 2010b).

The country's abortion rates have declined steadily since peaking at 36 per 100 live births in 1980. In 2005 the rate was about 23 per 100 live births. Rates were highest for black women, unmarried women, and women under the age of 24 or older than 40 (CDC 2009a). Nearly a third of all teen pregnancies end in abortion (Guttmacher Institute 2010b).

Leading Causes of Death

Women and men in the United States share most of the leading causes of death, although they are not affected equally by them. For both sexes, heart disease and cancer are at the top of the list (Table 2), lung cancer being the leading cause of cancer death among women, followed by breast cancer (HRSA 2009). In addition to being causes of death, heart disease and stroke are also major sources of long-term disability for women (National Women's Health Information Center 2010).

In the general population, HIV/AIDS is not a leading cause of death, but in communities of color HIV/AIDS is a common killer, especially among younger women. For African American women ages 25-34, HIV/AIDS is *the* leading cause of death (CDC 1999).

Maternal mortality is also more common among African American women, whose rate is three to four times that of white women (HHS 2010). A recent report has reawakened concerns about maternal mortality in the United States, with its finding that pregnancy-related mortality is rising significantly and that rates are much higher than in many other developed countries (Amnesty International 2010).

Table 2: Leading Causes of Death for Females and Males, 2003-2006

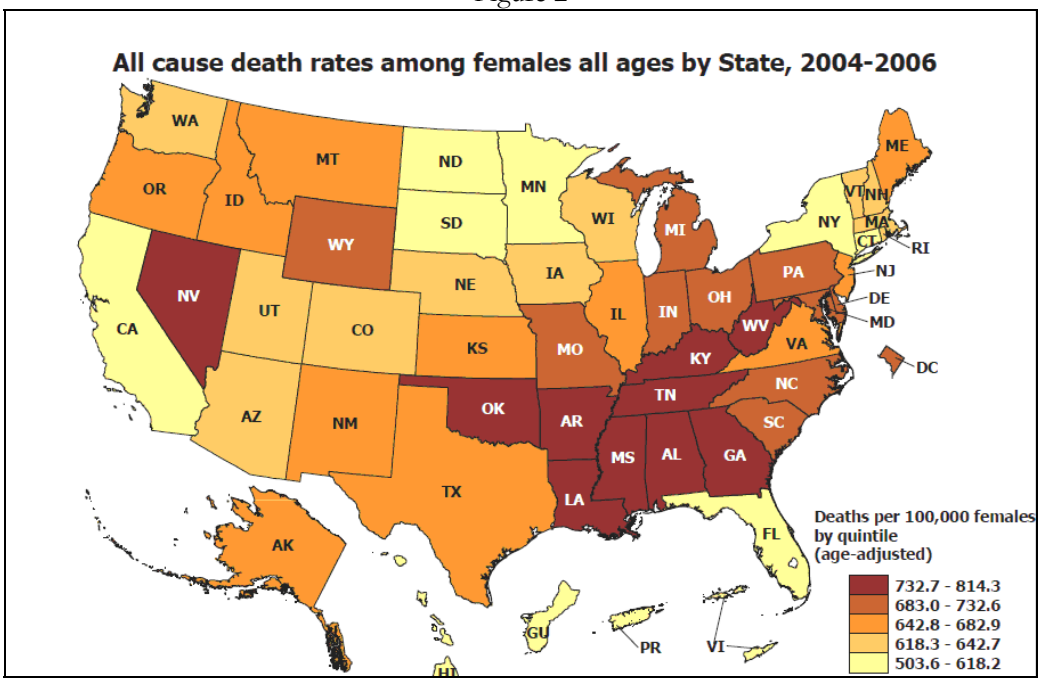
All Females, All Ages	Percent	All Males, All Ages	Percent
Heart disease	25.8	Heart disease	26.3
Cancer	22	Cancer	24.1
Stroke	6.7	Unintentional injuries	6.6
Chronic lower respiratory diseases	5.3	Chronic lower respiratory diseases	4.9
Alzheimer's disease	4.2	Stroke	4.5
Unintentional injuries	3.5	Diabetes	3
Diabetes	3	Suicide	2.2
Influenza and pneumonia	2.5	Influenza and pneumonia	2.1

Kidney disease	1.9	Kidney disease	1.8
Septicemia	1.5	Alzheimer's disease	1.8

Source: CDC 2009

Death rates among women vary considerably by region (Figure 2). In the South, high death rates from heart disease, cancer, stroke, and diabetes reflect higher rates of obesity and hypertension in those states, as well as the effects of poverty and limited access to health care.

Figure 2



Source: HHS 2009

Diseases and Disability

Diseases and causes of disability that are more common in women than in men include osteoarthritis, obesity, depression, and intimate partner violence.

- Arthritis affects more women than men in every age group. By age 55, about 43 percent of women have experienced arthritis, compared to 32 percent of men. This difference continues into later life (CDC 2010).

- About 35 percent of women over the age of 20 are obese, compared to 32 percent of men. Women's obesity rates are rising and range from 32 percent of women over 20 for non-Hispanic white women, to 42 percent of Hispanic women, to 53 percent of non-Hispanic black women (CDC 2009b; NIDDK 2010).

- About 12 million women each year are affected by a depressive disorder, compared to about 6 million men—a twofold difference (NIMH 2010).

- Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States. On average, between 2001 and 2005, nonfatal intimate partner victimizations represented 22 percent of nonfatal violent victimizations against females age 12 or older, compared to 4 percent of nonfatal violent victimizations against males age 12 or older. In contrast to many health trends, the rate of intimate partner violence has been declining since the early 1990s (DOJ 2010).

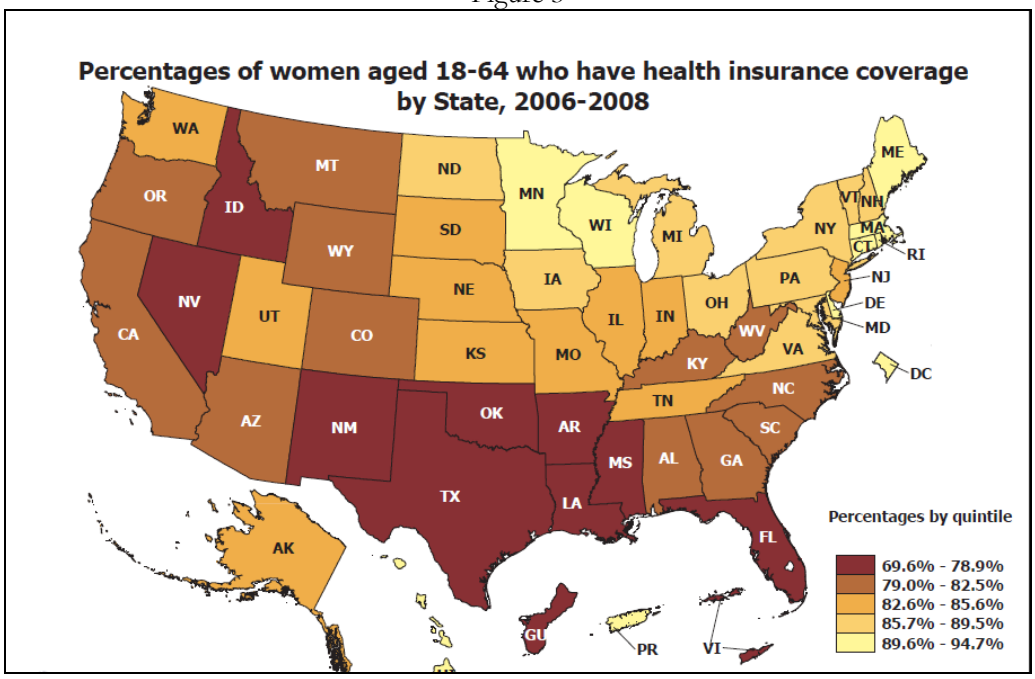
Access, Coverage, and Quality of Care

Even with health reform, many women face barriers to basic health care services, mainly because of costs and lack of insurance coverage. For example, in 2007 more than half (52 percent) of women reported problems accessing needed care because of cost, and nearly half (45 percent) accrued medical debt or reported problems with medical bills (The Commonwealth Fund 2009).

In 2006, 17 million women were uninsured. The uninsured report more problems getting care and get less therapeutic care. They are diagnosed at later disease stages, sicker when hospitalized, and are more likely to die early (AHRQ 2005). Uninsured women are less likely to have a regular doctor than insured women; are more likely not to fill prescriptions because of the costs; and are more likely not to get needed care, including needed tests (National Institute for Reproductive Health 2010).

Historically, women's health insurance coverage has varied widely across the country, from states where close to a third of women lacked coverage, to states where almost all women were covered (Figure 3). Generally speaking, women in southern and southwestern states were most likely not to have coverage.

Figure 3



Source: HHS 2009

The Broader Context of Women's Health and Illness

The Social Determinants of Health

The past two decades have witnessed phenomenal advances in our understanding of how health and disease develop (Halfon 2009). In particular, a growing body of research makes clear that factors related to the social, economic, and physical environment—called collectively the social determinants of health (SDOH)—have a major effect on people's health. Applying the SDOH perspective to women's health, we see that several factors profoundly shape women's health status and health-related choices (see Box 1).

Box 1: Key Social Determinants of Health

One of the largest social determinants of health and health care use is socioeconomic status, or social class, which is often measured by income, education, and occupation.

- Women are more likely to live in poverty than men, and women of color are more likely than either white men or white women to live below the poverty line. These differences are related in part to the fact that women continue to shoulder the major responsibility for raising children.

- Socioeconomic disadvantage, whether defined by income, education, or occupation, is associated with high-risk health behaviors, worse access to health care, and poorer health outcomes.

Neighborhood and housing characteristics also have an important impact on health.

- Factors such as crime, the availability of healthy foods, the availability of parks and other athletic facilities, home ownership, and segregation have all been shown to affect health.

- Segregated neighborhoods also affect the economic and educational opportunities of their residents.

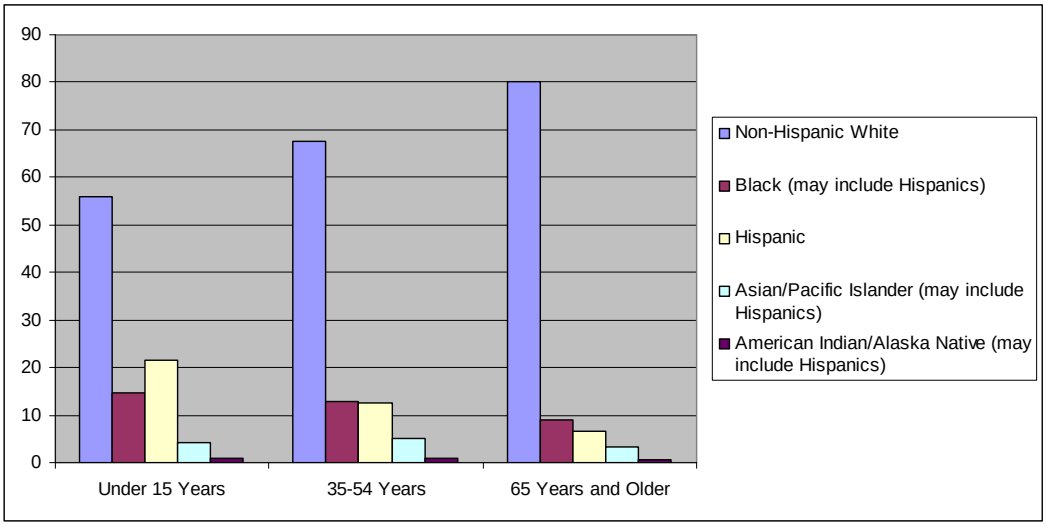
Source: The Henry J. Kaiser Family Foundation 2009

Using the SDOH perspective gives us new tools for understanding the factors that shape women's health by focusing attention on the root causes of the problems women experience—whether HIV/AIDS, breast cancer, or domestic violence.

The health of women of color is especially challenged because of the multiple negative effects of racial and ethnic discrimination, poverty, and social marginalization. Because of the increasing diversity of the female population, more and more women are also women of color. As illustrated in Table 3, today nearly half of children and teenage girls under the age of 15 are non-white (HRSA 2009). This racial/ethnic distribution contrasts sharply with the breakdown for women over the age of 65, where 80 percent are non-Hispanic white.

For immigrant women—many of whom are also women of color—disparities can be exacerbated by language and cultural barriers encountered in the community and in health care settings. Immigrant women's working conditions may expose them to toxic chemicals, pesticides, poor ventilation, or dangerous conditions. Many immigrant women work long hours for little pay, without health benefits, and with no job security. Lack of documented immigration status and/or confusion of legal status can be a huge obstacle to health care because access to publicly funded programs is now usually contingent upon immigration status (Glasford and Huang 2008).

Table 3: Diversity among Women, 2007



Source: HRSA 2009

The Henry J. Kaiser Family Foundation report *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* (2009) identified racial and ethnic disparities in every state on most measures—with some states having quite stark differences. The social determinants framework explains how these social differences result in disparities in health status and health care.

Specific findings of the report included:

- major health and socioeconomic challenges faced by American Indian and Alaska Native women;
- consistent problems of access and utilization for Hispanic women, although they fared better on some health status indicators;
- consistently higher rates of health problems among black women;
- low rates of some preventive health screenings for Asian American, Native Hawaiian, and other Pacific Islander women;
- better scores for white women than minority women on many indicators, with the exception of higher rates of smoking, cancer mortality, serious psychological distress, and not getting routine checkups; and
- larger disparities in the south central, mountain, and midwestern states, compared to the national average.

The Environment

Women are exposed to toxins in the air, water, cosmetics, food, household building materials, household cleaners, and pesticides. These exposures have both an immediate and a multigenerational effect; over a lifetime they accumulate in women's bodies and are passed on to the next generation *in utero* and then again

through breast milk. A 2005 study found 287 different chemicals in the cord blood of 10 newborn babies, including chemicals from pesticides, fast food packaging, coal and gasoline emissions, and trash incineration (Jackson 2010). New lines of research are now showing that prenatal exposures may also contribute to health problems that typically arise later in life—such as obesity, diabetes, cardiovascular disease, cancer, and Parkinson's disease (Environmental Health Perspectives 2010).

In the words of Teresa Heinz (2005):

> The evidence shows…that we do indeed live in a world so infused with industrial chemicals that they have made their way into our own tissues and into the bodies of those we love, into our fat, our blood, our bones, our brains, and even our breast milk… [A]s women, we are more susceptible to certain chemicals, and our chemical exposures have consequences for our children…

Again, minority women are at increased risk. Throughout the country, communities of color are more likely than others to be exposed to high levels of toxins and environmental hazards. One study found that even higher-income black neighborhoods were disproportionately exposed to pollutants (Downey and Hawkins 2008a). Similarly, a recent California study found that, regardless of income, census tracts with 15 percent more Latinos than average were exposed to 84 percent more toxic waste from cleaning solvents, paints, petroleum products, lead, polychlorinated biphenyls (PCBs), wood dust, and air pollution, while those with 15 percent more Asians than average were exposed to 34 percent more toxic waste (Health Justice Network 2010).

Female-headed households are especially at risk from environmental exposures. One study concluded that the average female-headed family lives in a neighborhood 1.13 times more toxic than that of the average male-headed family, and 1.36 times more toxic than that of the average married-couple family (Downey and Hawkins 2008b).

Women's Health across the Life Course

The life course model of health provides a framework for understanding how disorders, disability, and death among adults are rooted in the health and environmental exposures of childhood (Forrest and Riley 2004). The approach also draws attention to the interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, that influence health throughout a lifetime (MCHB 2010). Many studies show that early experiences and exposures have lasting effects on health that may not manifest until a much later age.

The life course perspective, like the SDOH approach, is a source of new thinking about disease prevention and treatment. Both are especially relevant to women's health, not only because of worsening chronic disease trends for women that often have their roots in childhood, but also because of mothers' responsibility for their children's health. For example, the health of the mother before she conceives affects the *in utero* environment she provides for her pregnancy. That, in turn, influences the health of her offspring into adulthood, setting the stage for a variety of conditions such as chronic hypertension and type 2 diabetes mellitus. After conceiving, a woman's health during pregnancy can affect her health status for years afterward. Women who gain excessive weight during pregnancy are at greater risk for the development of type 2 diabetes later in life, and women who suffer from preeclampsia during pregnancy are at increased risk for developing cardiovascular disease later (Bernstein and Merkatz 2010).

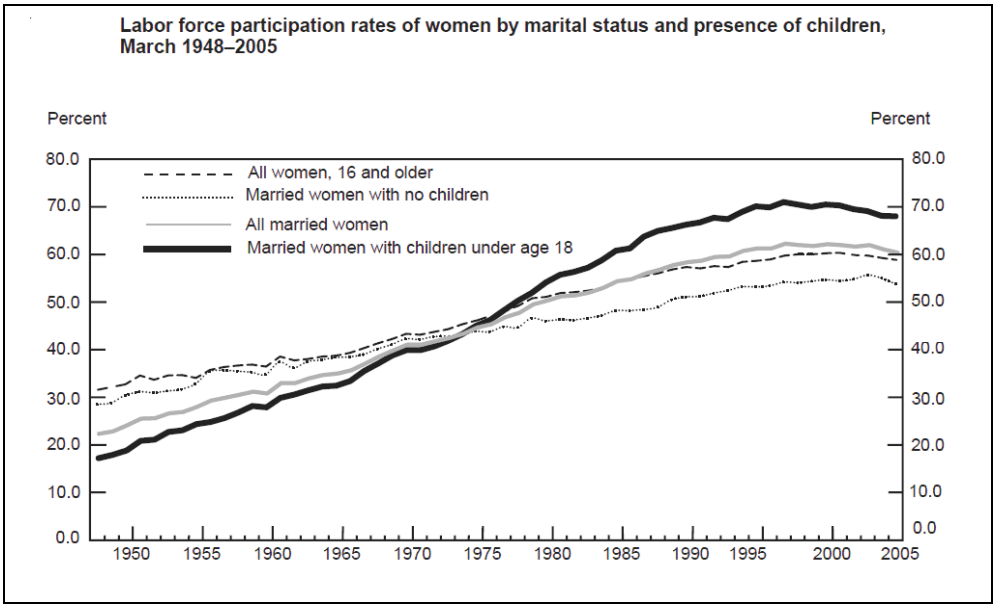
Taking a life course approach to women's health opens up new possibilities for prevention and intervention in the community, clinical, and work settings, including before, during, and after pregnancy; at the time of childbirth; and on through the years (Pies et al. 2009).

Women in the Workforce

In a dramatic shift from just a generation ago, women now make up half of the U.S. workforce. Moreover, mothers are the primary breadwinners or co-breadwinners in nearly two-thirds of American families—even though women continue to be paid 23 cents less than men for every dollar earned in our economy (Boushey and O'Leary 2009; Boushey 2009).

Women's rising numbers as workers have not been matched by the development of policies that recognize their continuing role as family caregivers. Today, most female workers do not have any workplace flexibility, nearly half do not have the right to a paid sick day to care for an ill child or family member, and most do not have access to paid family leave. Research indicates that family leave policies help improve child and family health and well-being and contribute to greater family economic security (Fass 2009). These issues are not just elements of women's health, they are also central to achieving equality for women in the American workplace of the 21st century.

Chart 1: Labor Force Trends for Women



Source: Cohany and Sok 2007

Health Policy

The Patient Protection and Affordable Care Act, as the greatest single legislative advancement for Americans' health since Medicare and Medicaid were signed into law nearly 45 years ago, has significant potential for improving women's health, especially through its impact on access and coverage.

> Since women use more health care services than men, they are more exposed to the fragmentation and failings of the...health care system.
>
> The Commonwealth Fund, 2009

Health reform's benefits for women include:

- coverage of contraceptives, which means millions more women will gain access to family planning;
- preventive care, such as PAP tests and mammograms, as basic benefits—without any co-pays

or deductibles—as well as maternity coverage, which is not in most individual policies currently;

- elimination of "gender rating," the practice of charging women more for the same coverage (48 percent in some cases), for individuals and workplaces with under 100 employees;

- banning of discrimination in favor of higher-paid employees so that employers will not be able to give lesser plans to lower-paid workers who are more likely to be women and people of color (Stites 2010; National Women's Law Center 2010);

- a requirement for employers to offer breaks and space for nursing mothers to pump breast milk;

- tax credits for small-business owners—the majority of whom are women—who provide insurance to their employees (Business and Professional Women's Foundation 2010); and

- establishment of a new Office of Women's Health within the U.S. Department of Health and Human Services that will set priorities related to disease prevention, health promotion, service delivery, research, and public and health care professional education for issues of particular concern to women throughout their lifespan (GPO 2010).

But for all of its benefits, health reform also places limits on women's access to reproductive health care, particularly with regard to coverage for abortion services. The law mandates abortions cannot be covered by any federal subsidy or funding (in accordance with the longstanding Hyde Amendment), but that individuals may buy insurance plans that offer abortion coverage as long as they pay for it with their own money. In addition, individual states may pass a law to "opt out" of allowing abortion coverage.

By denying women the full scope of reproductive health care services, these restrictions may potentially affect other aspects of their health. Using the yardsticks employed to assess health care quality more generally, research shows that current abortion restrictions reduce quality by limiting evidence-based clinical practice, training of new providers, and clinical innovation (Weitz and Yanow 2008). Likewise, the growing refusal among care providers to provide reproductive health care treatment for ideological or religious reasons undermines the standard of care by interfering with patients' ability to receive medically accurate and unbiased information about their treatment options, and by inhibiting their ability to access medically appropriate care (National Health Law Program 2010; Weitz and Fogel 2010).

Funding for Women's Health

Historically, relatively few philanthropic dollars have reached organizations and programs serving women and girls (Capek 2001). But, there are signs of improvement. In recent years, funding for women and girls by the broader foundation community has grown at a faster rate than foundation giving on the whole—although it is still below 7.5 percent of annual grant dollars (Foundation Center 2009).

The growth of women's funds has helped raise awareness of the benefits of investing in programs and organizations that support women and promote women-led solutions in communities (Foundation Center 2009). However, the giving of most women's funds is targeted to small, grassroots organizations that address the issues of women and girls in their local areas. A challenge for health philanthropy is to find ways to leverage these local efforts in order to bring about wider change for women.

The dual role of women as both consumers and providers of health services offers extraordinary potential for women as agents of change (Samb 2010). It also represents a tremendous opportunity for philanthropy to improve the health of families and communities.

Meeting Summary

Improving Women's Health from Communities to Care Settings examined current and emerging issues in women's health, women's health across the life course, environmental factors and women's health, the implications of health reform for women, and current issues in reproductive health. Panels of advocates and practitioners described their work locally and nationally to promote women's health, especially in communities of color. The presentations are available on-line.

Main points of the discussion included the following.

Why is a focus on women's health important?

- Women and men differ in what their health needs are, how diseases manifest, how they respond to treatment, and how they use the health system.
- Women have less money to work with than men. As a result, cost is more likely to affect their access to health care.
- Women and men have different kinds of health coverage. Women are more likely to have dependent coverage, which they lose if their partner loses his job or the marriage breaks up.
- The bottom line: We are not going to make the changes that are needed for the whole population until we deal with women's health.

Why are sick leave and maternal leave important for women's health?

- Paid sick leave is important because it reduces the duration of illness and cost of health care, and decreases the spread of illness in the workplace. Among economically competitive countries, all have sick leave with the exception of the United States.
- Maternal leave improves women's health in several ways, including through the impact of breastfeeding on increasing postpartum weight loss, and lowering the risk of osteoporosis and breast and ovarian cancer. It also improves children's health outcomes.
- Maternal leave helps women economically by increasing long-term employment and earning prospects. It benefits employers by reducing staff turnover.
- Virtually every country in the world has paid maternal leave, except the United States and few other patches on the map.
- Leave to care for sick family members matters because parental involvement helps children recover more rapidly. For example, parental visits have been shown to shorten hospital stays.

What opportunities does health care reform present for improving women's health?

- There will be new models of care delivery that address women across the lifespan.
- Health care will be more affordable for many women.
- Patient navigation and administrative procedures will be simplified.

- Reform will benefit women's reproductive health, with the exception of access to abortion.

Where are grantmakers needed? What can grantmakers do?

- In the area of sick leave and maternal leave, grantmakers can take action at the city and state levels to ensure the availability of sick leave. At those levels and nationally, grantmakers can make sure that the public is aware of the benefits of leave for working women.

- To support health reform, funders can set the record straight by putting a human face on reform's changes by educating the public about the benefits of health exchanges, Medicaid expansion, and the young adult expansion. Funders can create learning collaboratives to educate the public and other community organizations about reform. Funders can help people understand what reform is and is not, and the work remaining to be done in areas like reproductive health and immigrant health.

> Women's health and gender work should be part of everything we do…what are the projects you're working on? How might they affect men and women differently?
>
> —Alina Salganicoff, 2010

- Funders can refocus on the importance of maternity care. Rising Cesarean section and preterm birth rates, disparities in maternal mortality, and a significant post-partum depression rate all point to a serious national problem that is getting little national attention.

- Funders can make sure that women's organizations are involved from the outset in any community programs that relate to, or affect, women's health.

- Funders can support comparative effectiveness research, such as on the efficacy of medical homes, to compare health effects and outcomes.

- Funders can use their ability to move quickly to address issues affecting women's health that the government might require years to study.

- Funders can use their knowledge of communities and community processes to engage women in developing solutions. We know from experience that women in the community can be trained as both teachers and researchers.

References

Agency for Healthcare Research and Quality (AHRQ), "Women's Health Care in the United States Selected Findings from the 2004 National Healthcare Quality and Disparities Reports," <http://www.ahrq.gov/qual/nhqrwomen/nhqrwomen.htm>, May 2005.

Amnesty International, "Deadly Delivery: The Maternal Health Care Crisis in the USA," <http://www.amnesty.org/en/library/info/AMR51/019/2010/en>, March 2010.

Bernstein, Peter S., and Irwin R. Merkatz, "A Life Course Perspective on Women's Reproductive Health and the Outcome of Pregnancy," *Journal of Women's Health* 19(3):555-560, 2010.

Boushey, Heather, "The New Breadwinners," *The Shriver Report: A Study by Maria Shriver and the Center for American Progress*, <http://www.americanprogress.org/issues/2009/10/pdf/awn/chapters/economy.pdf>, 2009.

Boushey, Heather, and Ann O'Leary, "Executive Summary," *The Shriver Report: A Study by Maria Shriver and the Center for American Progress*, <http://www.americanprogress.org/issues/2009/10/womans_nation.html/#executive_summary>, 2009.

Business and Professional Women's Foundation, "Women's Health," <http://www.bpwfoundation.org/i4a/pages/index.cfm?pageid=5048>, accessed July 9, 2010.

Capek, Mary Ellen S., *Women and Philanthropy: Old Stereotypes, New Challenges (Volume 2 of the Monograph Series)*, <http://web.archive.org/web/20070205113146/http://www.wfnet.org/news/story.php?story_id=49>, 2001.

Centers for Disease Control and Prevention (CDC), "Leading Causes of Death by Age Group, Black, Females, United States–1999," <http://www.cdc.gov/women/lcod/99black.pdf>, 1999.

Centers for Disease Control and Prevention (CDC), "Health United States 2009," <http://www.cdc.gov/nchs/data/hus/hus09.pdf#014>, 2009a.

Centers for Disease Control and Prevention (CDC), "QuickStats: Prevalence of Obesity Among Adults Aged ≥20 Years, by Race/Ethnicity and Sex– National Health and Nutrition Examination Survey, United States, 2003-2006",<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5838a6.htm>, 2009b.

Centers for Disease Control and Prevention (CDC), "Arthritis. NHIS Arthritis Surveillance, Arthritis Prevalence in Women and Men," <http://www.cdc.gov/arthritis/data_statistics/national_nhis_text.htm#1a>, 2010.

Clinton, Hillary, remarks on the 15th Anniversary of the International Conference on Population and Development, January 8, 2010.

Cohany, Sharon R., and Emy Sok, "Trends in Labor Force Participation of Married Mothers of Infants," *Monthly Labor Review*, <http://www.bls.gov/opub/mlr/2007/02/art2full.pdf>, February 2007.

The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (New York, NY: May 2009).

Environmental Health Perspectives, "Delayed Reaction: The Fetal Basis of Adult Disease, with Deborah Cory-Slechta," podcast,

<http://ehp03.niehs.nih.gov/article/fetchArticle.action?articleURI=info%3Adoi%2F10.1289%2Fehp.trp070110>, 2010.

Downey, Liam, and Brian Hawkins, "Race, Income, and Environmental Inequality in the United States," *Sociological Perspectives* 51(4):759-781, December 2008a.

Downey, Liam, and Brian Hawkins, "Single-Mother Families and Air Pollution: A National Study," *Social Science Quarterly* 89(2):523-536, May 2008b.

Fass, Sarah, National Center for Children in Poverty, "Paid Leave in the States; A Critical Support for Low-wage Workers and Their Families," <http://www.nccp.org/publications/pub_864.html>, 2009.

Foundation Center, *Accelerating Change for Women and Girls: The Role of Women's Funds* (New York, NY: April 2009).

Guttmacher Institute, "Facts on Contraceptive Use in the United States, June 2010," <http://www.guttmacher.org/pubs/fb_contr_use.html>, 2010a.

Guttmacher Institute, "Facts on American Teens' Sexual and Reproductive Health," <http://www.guttmacher.org/pubs/FB-ATSRH.html>, 2010b.

Health Resources and Services Administration (HRSA), *Women's Health USA 2009* (Rockville, MD: U.S. Department of Health and Human Services, September 2009).

Henry, Brenda, and Pamela Russo, Robert Wood Johnson Foundation, "Health Reform: Time for a Paradigm Shift," Views from the Field, *GIH Bulletin*, <http://www.gih.org/usr_doc/Health_reform_paradigm_shift_RWJ_December_2009.pdf>, December 2009.

Glasford, Aishia, and Priscilla Huang, "Immigrant Women's Health a Casualty in the Immigration Policy War," *Women's Health Activist Newsletter*, http://nwhn.org/immigrant-womens-health-casualty-immigration-policy-war>, 2008.

Halfon, Neal, "Life Course Health Development: A New Approach for Addressing Upstream Determinants of Health and Spending," *Expert Voices*, <http://www.nihcm.org/pdf/ExpertVoices_Halfon_FINAL.pdf>, February 2009.

Health Justice Network, "More Toxic Exposure for Latinos, Asians," <http://healthjusticenetwork.wordpress.com/2010/07/22/more-toxic-exposure-for-latinos-asians/>, 2010.

Heinz, Teresa, *Are We Living in a Chemical Stew?*, remarks at the 9th Annual Conference on Women's Health and the Environment, <http://www.heinzfamily.org/programs/wc_2005/teresa_heinz_opening_remarks_2005.html,> accessed July 9, 2010.

Jackson, Lisa P., remarks at the Women's Health and the Environment Conference, <http://yosemite.epa.gov/opa/admpress.nsf/8d49f7ad4bbcf4ef852573590040b7f6/79a3f13c301688828525770c0063b277!OpenDocument>, 2010.

The Henry J. Kaiser Family Foundation, *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*, <http://www.kff.org/minorityhealth/upload/7886.pdf>, June 2009.

Maternal and Child Health Bureau (MCHB), Heath Resources and Services Administration, U.S. Department of Health and Human Services, "The Life Course Approach," <http://mchb.hrsa.gov/lifecourseresources.htm>, 2010.

National Health Law Program, "Women at Risk: New Study Finds Health Care Refusals Undermine Medical Standards of Care on Wide Range of Services," <http://www.healthlaw.org/index.php?option=com_content&view=article&id=476:standards-of-care-press-release&catid=37:news-a-alerts&Itemid=123>, July 9, 2010.

National Institute for Reproductive Health, "Quick Sheet: Uninsured Women's Access to Care," <http://www.nirhealth.org/sections/publications/documents/UninsuredWomen1.pdf>, 2010.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), "Statistics Related to Overweight and Obesity," <http://www.win.niddk.nih.gov/statistics/index.htm>, 2010.

National Institute of Mental Health (NIMH), "Men and Depression," <http://www.nimh.nih.gov/health/publications/men-and-depression/complete-index.shtml>, 2010.

National Women's Health Information Center, Office on Women's Health, U.S. Department of Health and Human Services, "Heart Health & Stroke," <http://womenshealth.gov/heart-stroke/>, 2010.

National Women's Law Center, *What Women Need to Know about Health Reform: Improving Access to Affordable Preventive Care* (Washington, DC: June 2010).

Perper, Kate, and Jennifer Manlove, "Estimated Percentage of Females Who Will Become Teen Mothers: Differences Across States," <http://www.childtrends.org/Files//Child_Trends-2009_03_19_RB_PercentTeenMothers.pdf>, 2009.

Pies, Cheri, Padmini Parthasarathy, Milton Kotelchuck, and Michael Lu, *Making a Paradigm Shift in Maternal and Child Health: A Report on the National MCH Life Course Meeting*, <http://www.cchealth.org/groups/lifecourse/pdf/2009_10_meeting_report_final.pdf>, 2009.

Salganicoff, Alina, The Henry J. Kaiser Family Foundation, remarks at the Grantmakers In Health Fall Forum, *Improving Women's Health from Communities to Care Settings*, November 9-10, 2010.

Samb, Badara, "Reforming Country Health Systems for Women's Health," *The Lancet* 375(9712):354-355, January 30, 2010.

Stites, Jessica, "What the Health Care Bill Means for Women," <http://msmagazine.com/blog/blog/2010/03/24/what-the-health-care-bill-means-for-women/>, accessed July 13, 2010.

U.S. Department of Health and Human Services (HHS), Office on Women's Health, *Women's Health and Mortality Chartbook, 2009 Edition*, <http://www.healthstatus2010.com/owh/chartbook/images/Maps_Chartbook_2010Edition.pdf>, 2009.

U.S. Department of Health and Human Services (HHS), "Maternal, Infant, and Child Health," *Healthy People 2010*, <http://www.healthypeople.gov/document/html/volume2/16mich.htm>, 2010a.

U.S. Department of Justice (DOJ), "Bureau of Justice Statistics, Intimate Partner Violence in the U.S.," <http://bjs.ojp.usdoj.gov/content/intimate/victims.cfm>, 2010.

U.S. Government Printing Office (GPO), "H.R. 3590 (ENR)-Patient Protection and Affordable Care Act,"

<http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=BILLS-111hr3590ENR>, 2010.

Weitz, Tracy A., and Susan Berke Fogel, "The Denial of Abortion Care Information, Referrals, and Services Undermines Quality Care for U.S. Women," *Women's Health Issues* 20:7-11, 2010.

Weitz, Tracy, and Susan Yanow, "Implications of the Federal Abortion Ban for Women's Health in the United States," *Reproductive Health Matters* (supplement) 16(31):99-107, May 2008.