VIRGINIA DEPARTMENT OF HEALTH'S

Report of the Virginia Department of the Statistical Profile of Women's Health Status in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 82

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

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February, 1994

TO: The Honorable George Allen
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

I am pleased to transmit this report which constitutes the response of the Virginia Department of Health to House Joint Resolution No. 621 of the 1993 Session of the General Assembly of Virginia.

This report offers the results of the Department's study and findings presented as the statistical profile of women's health status in Virginia.

Respectfully Submitted,

Robert B. Stroube, MD, MPH
State Health Commissioner

Enclosure

House Joint Resolution No. 621

STATISTICAL PROFILE OF WOMEN'S HEALTH STATUS IN VIRGINIA

December 1993

Prepared by:

Virginia Department of Health
Division of Women's and Infants' Health

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EXECUTIVE SUMMARY

House Joint Resolution No. 621 requested the Department of Health to prepare a statistical profile of women's health status in the Commonwealth, focusing on women of child bearing age up to age 65. This profile is meant to be a tool for identifying current and potential women's health issues and for making recommendations for data collection and targeting of resources.

A Women's Health Task Force of persons with expertise in women's issues reviewed the preliminary findings and assisted the Department of Health in identifying women's health issues of particular concern for Virginia and in developing recommendations.

Findings

Women's Health Status

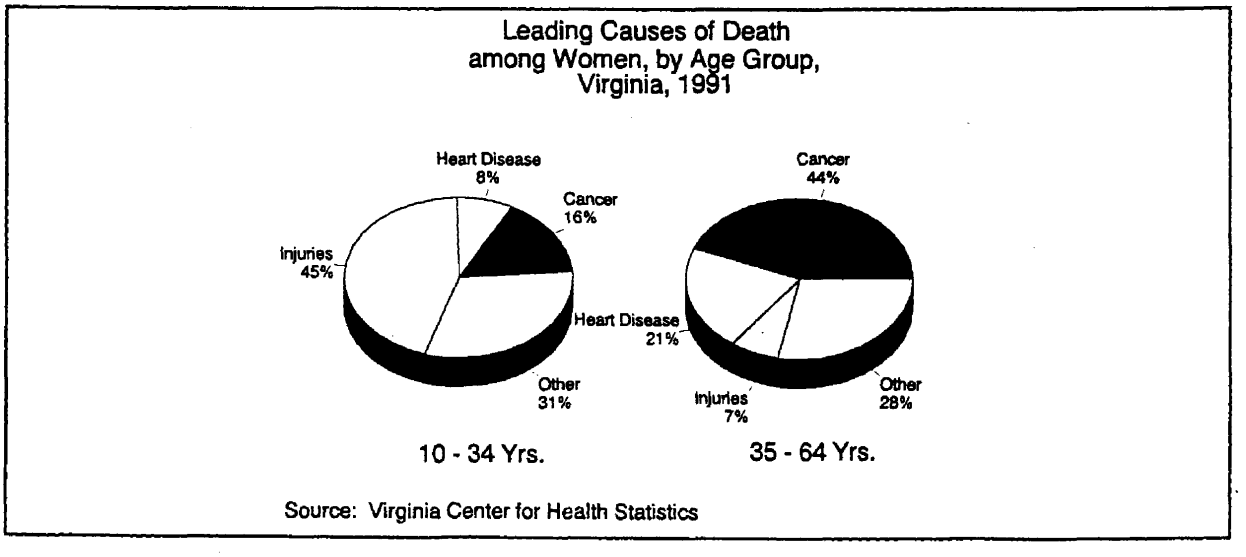
Women in Virginia have a variety of health concerns, many of which are related to age. The major health concerns of young adult women differ significantly from those of middle-aged women. See Figure 1. Some health problems are more common in particular racial and ethnic groups, which often reflect a difference in the group's economic status. Poverty is a major contribution to the status of women's health as poverty limits one's ability to purchase basic health care services and commodities to provide for good health including nutritious foods, housing and transportation.

Leading Causes of Death to Women in Virginia

1. Injuries are the leading cause of death for both men and women under 34 years of age in Virginia. Motor vehicle crashes account for 45% of these deaths in women and 33% of these deaths in men. Rates of death from unintentional injuries are decreasing. While further study is needed to explain the decreasing death rates from unintentional injuries among females in Virginia, contributing factors may include safety education programs, use of automobile safety belts, safer automobiles and highways, and new medical technology and management of trauma.

2. Cancer is the leading cause of death among Virginia women 35 to 64 years of age with breast cancer being the most common form of cancer death. The rate of cancer deaths among all females is increasing, notably from breast cancer and lung cancer.

Figure 1



Selected Conditions With Major Impact on Women's Health

1. In 1993, 25,922 battered women were served by the Virginia Family Violence Prevention Program; of these, 16,575 were first visits. The number of women requesting services from domestic violence programs has increased significantly in recent years.

2. In 1992, there was a 36% increase in new cases of AIDS among Virginia women; 75% of these women were African-American. HIV infection and AIDS among women is increasing at an alarming rate.

3. In 1992, there were 6,744 Virginia women reported with gonorrhea; 75% of these women belonged to racial minorities. The highest age specific incidence rate was among female teenagers.

4. In 1991, it is documented that 6,908 Virginia teens under 18 became pregnant. Non-white teens were twice as likely as other Virginia teens to become pregnant.

5. In 1993, 8% of women 18 and older reported that they at some time had been diagnosed with depression.

Health Risk Behavior That Affect Women

1. 20% of women in Virginia 18 and older are overweight, compared to 18% of men.

2. 76% of women in Virginia 18 and older reported a sedentary lifestyle, compared to 71% of men..

3. 18% of women in Virginia 18 and older reported that they were regular smokers, compared to 25% of men.

4. 22% of women do not consistently use a seatbelt, compared to 32% of men.

5. 2% of women in Virginia 18 and older reported that in a month prior to the survey they had driven when they perhaps had had too much to drink, compared to 5% of men.

6. 8.5% of women in Virginia 18 and older reported binge drinking on at least one occasion during the month prior to the survey, compared to 22% of men.

Gaps in Resources for Women

1. 24% of Virginia women over age 40 have never had a mammogram.

2. In 1993, 62% of the battered women and their children who sought shelter in Virginia were turned away due to lack of space.

3. One in four Virginia women is uninsured or underinsured.

4. Teens lack access to comprehensive health services due to limited financial resources or inadequate medical insurance, limited trained providers and lack of suitable hours.

Availability of Data on Women's Health Status

1. None of the current data systems are set up to focus on women's health. Therefore, to extract the data on women requires significant work. Trend data are not readily available for most conditions and must be generated from annual reports.

2. The most comprehensive data are available for population demographics, pregnancies, births, deaths, infectious diseases, and cancer. These data are available by age, race, and geographic location.

3. Data for the population at large are not routinely available for chronic diseases, such as heart disease, diabetes, arthritis, osteoporosis, and lupus; injuries which do not result in death or hospitalization; mental health problems; and substance abuse. The Patient Level Data System is an anticipated new source of data on serious chronic and acute diseases and injuries.*

4. Data are incomplete or not available on educational level, income level, and minority groups.

Recommendations

Targeting Resources to Impact on the Health of Women

The implementation of the Joint Commission on Health Care recommendations to increase overall access to primary care services and to provide health insurance for Virginians who currently lack coverage will improve the health status of women as well as men. However, specific attention should be given to insure that the issues specific to women are recognized and addressed.

1. To promote the general health of women, there should be better access to primary health care services including services of obstetrician/gynecologists and mid-level practitioners. Priority should be given to making clinical preventive services available to all women.

2. Public and private funding for health education and prevention programs should be directed to:

   - Programs to prevent teenage pregnancies as recommended by the Maternal and Child Health Council.
   - HIV/AIDS education and prevention programs targeted toward women, minorities and teens.
   - Programs that address lifestyle risk factors such as smoking, overweight, lack of exercise and the consequences of sexual activity.

*The Virginia Patient Level Data System is an integrated system for collection and analysis of data on acute care hospital admissions.

- A concise brochure on women's health status in the Commonwealth should be prepared and distributed for use by employers, health care providers, educators and the various branches of state and local government.

Further Data Collection: Measuring the Health Status of Women

1. Existing data systems should be modified to collect and analyze health-related data on women. This should include data by specific minority groups for those problems that disproportionately affect minorities.

2. The incidence and effects of violence against women should be focal points for additional data collection because exiting data are not adequate to determine the full impact of violence on the health of women.

3. The Department of Health should continue to study information needs and methods for collecting data to adequately measure women's health in Virginia, and to make specific recommendations to improve the complete assessment of women's health. The Healthy People 2000: National Health Promotion and Disease Prevention Objectives should be used as a guideline for measuring the health status of Virginia's women.

I. INTRODUCTION

The perspective on women's health is changing in Virginia as well as nationally. In the past, women's health programs have focused almost exclusively on reproductive health. Traditionally, most medical research was designed using males as the standard. We now recognize that the special health concerns of women are broader than reproductive health and differ from the health concerns of men. Important health issues of particular significance to women may be masked when looking at the health of the population as a whole.

Recognizing the special health concerns of women and the need for effective allocation of resources the General Assembly, through House Joint Resolution No. 621, requested the Department of Health to prepare a statistical profile of women's health status in the Commonwealth, focusing on women between the ages of 12 and 64. This age group includes women of child bearing age up to the usual age of retirement, when Medicare coverage begins. This profile is meant to be a tool for identifying current and potential women's health issues and for making recommendations for data collection and targeting of resources. It focuses on health problems that are more prevalent among women than men and on health problems that are unique to women or affect women differently than men.

The Department of Health identified existing statewide data reporting systems, both within and outside of the Department, that collect and compile health data for women. Descriptions of these data sources are found in the Data Systems Reports section of this documents. The most current available data are presented in this report. Therefore, time periods vary with the source of the data.

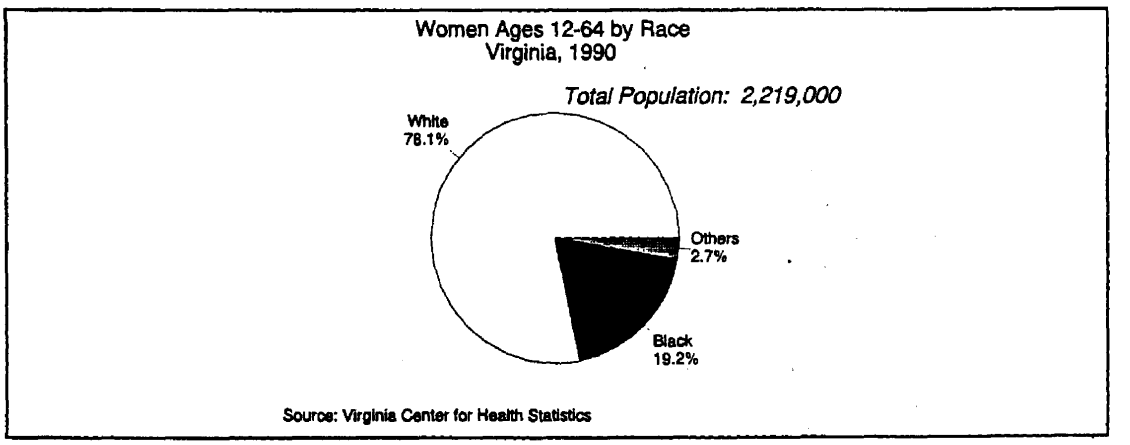
A Women's Health Task Force of persons with expertise in women's issues reviewed the preliminary findings and assisted the Department in identifying women's health issues of particular concern for Virginia and in developing recommendations. Task Force members and the organizations they represent are listed on the cover page of this document.

II. WOMEN IN VIRGINIA

Women in Virginia are a diverse group with a variety of health concerns, many of which are related to age. The major health problems of young adult women differ significantly from those of middle-aged women. Some health problems are more common in particular racial and ethnic groups, often reflecting a difference in economic status.

The 1990 census reports 2,218,970 females age 12 to 64 years living in Virginia (see Figure 2 for breakdown by race). The proportions of African-American, Asian, and Hispanic women are increasing.

Figure 2

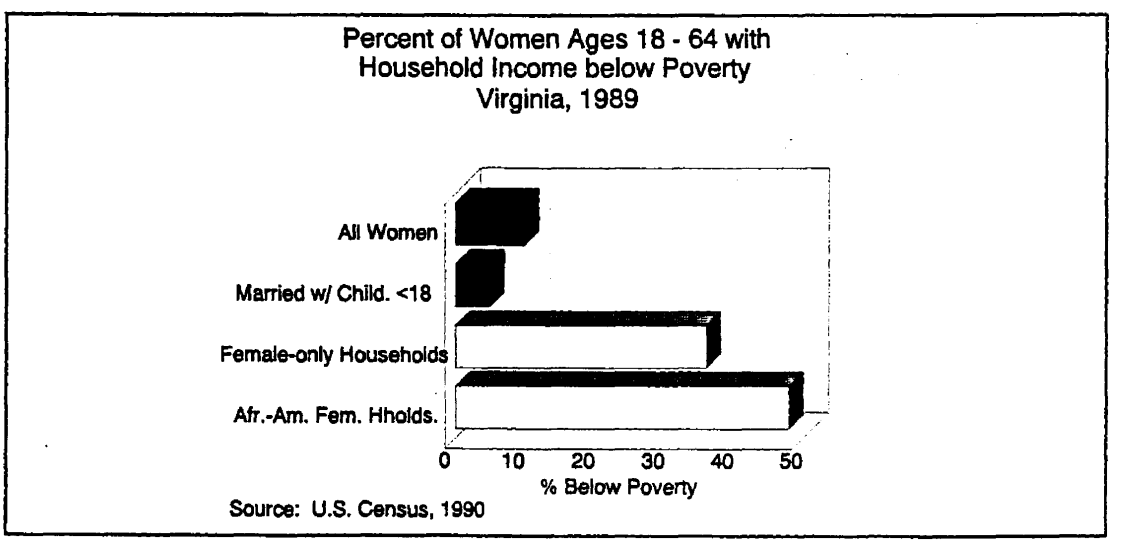


The population of women 12 to 64 years of age by planning district can be found in Appendix A.

Sixty-seven percent of all Virginia women 16 years and older were employed in 1989. Seven percent of women 16 to 64 had a work related disability.[1]

Poverty is a major predictor of poor health status. Poverty is defined as those living at or below 100% of the federal income poverty level. For example,the poverty level for a single woman is $6,970. In 1989, the household income of 10 percent of Virginia women 18 to 64 was below the federal poverty level. Six percent of white women, 17 percent of African-American women, and 10 percent of women of other races in this age group were below poverty. The household income was below poverty in 5 percent of married couples with children under 18 years of age, 36 percent of female-only headed households, and 48 percent of African-American female-only headed households.[1] Because poor health status is associated with poverty, the disparity among racial groups for many measures of health status may reflect differences in economic status among racial groups.

Figure 3



Nationally, the rise in the number of women in poverty can be attributed to an increase in the number of single-mother households, a decline in the purchasing power of minimum wage workers, and the declining value of federal income assistance to low-income families.

In 1991 there were 27,066 births to single women in Virginia. This means an out-of-wedlock birth rate of 279.7 per 1000 live births compared to 196.3 in 1982, a sharp rise. African-American women out-of-wedlock birth rate was almost 4 times higher than the white rate in 1991.[2]

After a divorce many men in Virginia take with them the income used to support their families leaving many women with minimum support, uncollectible child support or no income at all. In 1991, 27,995 divorces and annulments were granted in Virginia resulting in a rate of 4.5 per 1,000 population.[2] This was up from the 1990 rate of 4.4. Since 1961, there has been a 400% increase in divorce, from just over 7,000 to almost 28,000. Women of divorce not only loose income, but frequently loose their health insurance and therefore access to medical services previously available.

In 1991, 48% of the total divorces and annulments in Virginia involved children less that 18 with women having primary custody of these children.

III. WOMEN'S HEALTH ISSUES

Chronic Diseases

Chronic diseases are those diseases that are of long duration or reoccur frequently. Data is readily available on deaths attributed to chronic diseases, but death statistics under-represent the problem. Many chronic diseases, such as arthritis and osteoporosis, are not life-threatening but can result in severe disability. Others, such as heart disease, diabetes, and lupus are sometimes, but not always the cause of death. Death statistics capture only a portion of those women who have serious health consequences from these diseases.

Cancer

Cancer is the leading cause of death among women 35 to 69 years of age in Virginia.[2] For men in this age group, deaths from heart disease exceed cancer. The rate of cancer deaths among all females is increasing. See Figures 4 and 5. Five percent of Virginia women 18 years of age or older report that they have been diagnosed with cancer.[3] While further study is needed to explain the increasing cancer death rates among females in Virginia, most of the overall increase in cancer rates nationally has been attributed to an increase in lung cancer.[21]

Figure 4

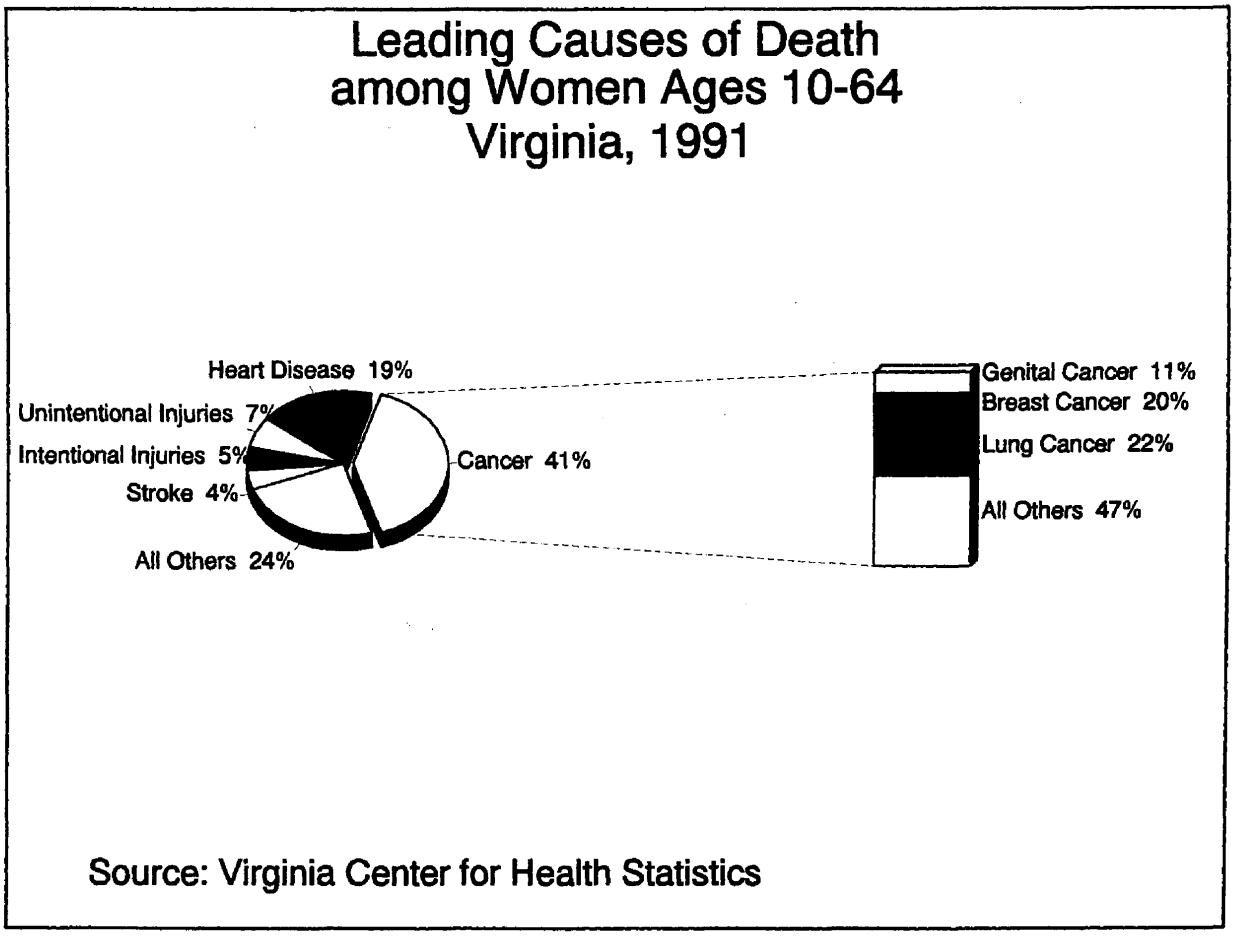
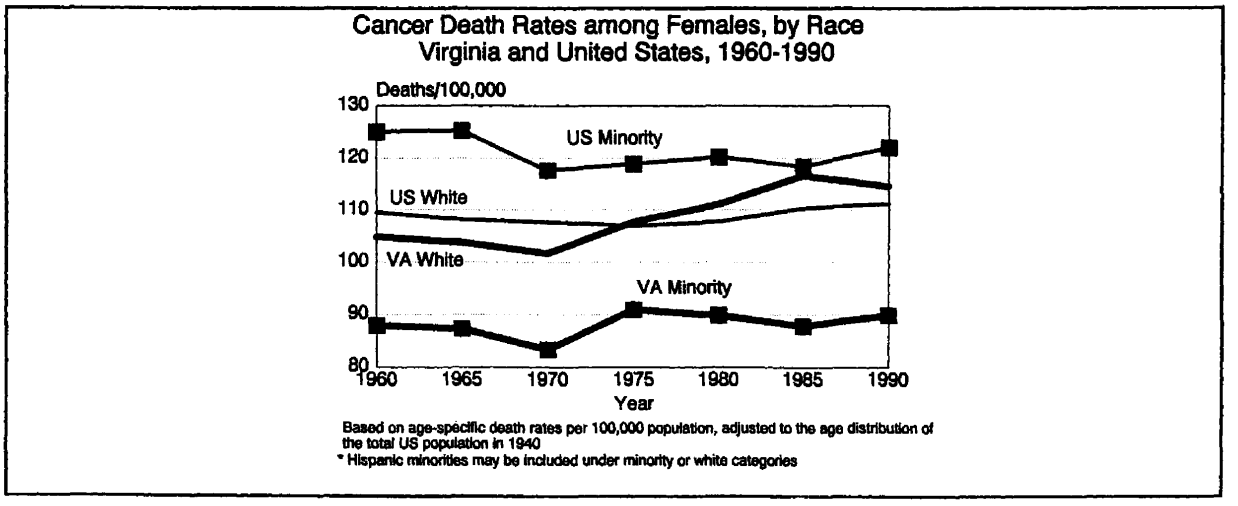


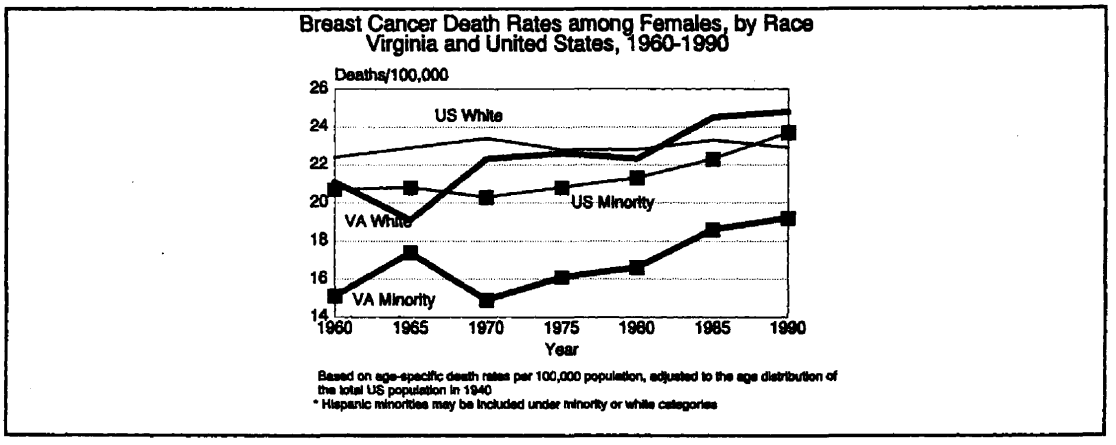
Figure 5



Breast cancer is the leading cause of cancer deaths among women under age 65 in Virginia. In 1991, 480 women under age 65 died from breast cancer.[2] In 1990, 2,310 new cases of breast cancer were diagnosed among women under age 65. Of these women, 85 percent were white, 14 percent African-American, 1 percent Asian, and less than 1 percent other race.[4]

The death rate from breast cancer is increasing. See Figure 6. The 1991 rate of deaths from breast cancer in Virginia was 27.8 per 100,000 women (age adjusted to the 1970 population.)[2]

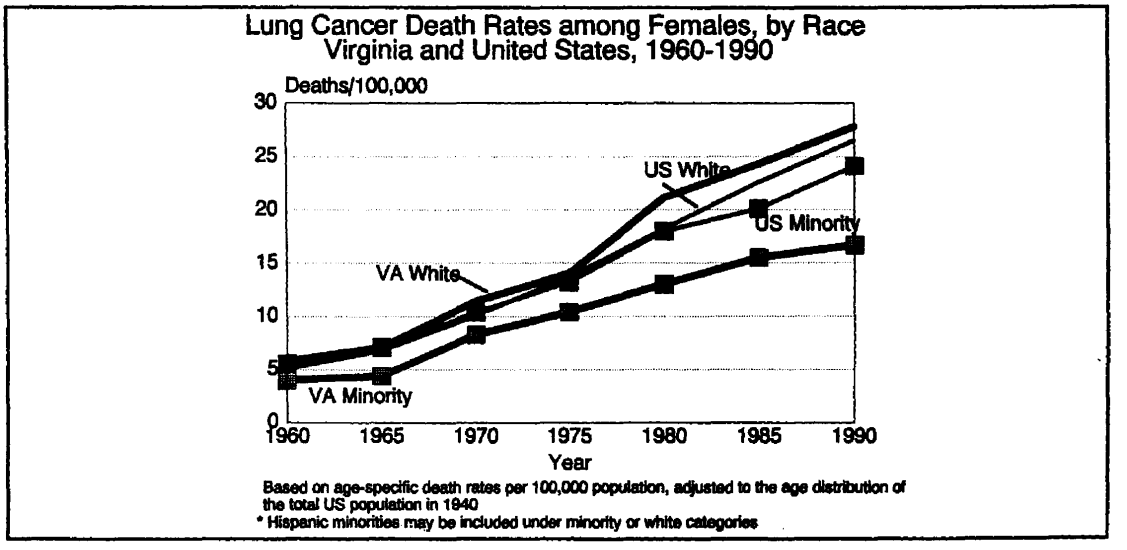
Figure 6



The most significant risk factor for breast cancer death is late detection. Of those cases of breast cancer reported in 1990, only 46 percent of cases among African-American women were diagnosed in the early stages of disease compared with 58 percent of cases among white women and 68 percent among Asian women.[4] In 1991, 83 percent of women in Virginia age 18 or older reported that they examine their own breasts for lumps or other changes, but only 59 percent of those who check their breasts do so at least seven times a year.[3] In 1991, 76 percent of women in Virginia age 40 or older reported ever having a mammogram.[5]

Lung cancer is the second leading cause of cancer deaths among women under age 65 and the leading cause of cancer deaths among women of all ages in Virginia.[2] The rate of lung cancer deaths in women is increasing. (See Figure 7.) **While the incidence of lung cancer is higher in men than in women, it is increasing among women while decreasing among men.**[4] The increase in lung cancer among women is attributed to the increase in tobacco use by women over the past 30 years. In 1991, 440 women under age 65 died from lung cancer.[2] In 1990, 550 new cases of lung cancer were diagnosed among women under age 65. Of these women, 80 percent were white, 19 percent African-American, 1 percent Asian, and less than 1 percent other races.[4]

Figure 7



Cigarette smoking is the major risk factor for lung cancer, accounting for 75 percent of cases in women.[16] In 1991, 18 percent of women in Virginia 18 years of age or older reported that they were regular smokers.[5]

Cervical cancer was the cause of death for 74 Virginia women under age 65 in 1991. The 1991 death rate from cancer of the cervix in Virginia was 3.2 per 100,000 women (age adjusted to the 1970 population).[2] In 1990, 899 new cases of cervical cancer were diagnosed among women under age 65. Of these women, 83 percent were white, 15 percent African-American, and 2 percent Asian.[4]

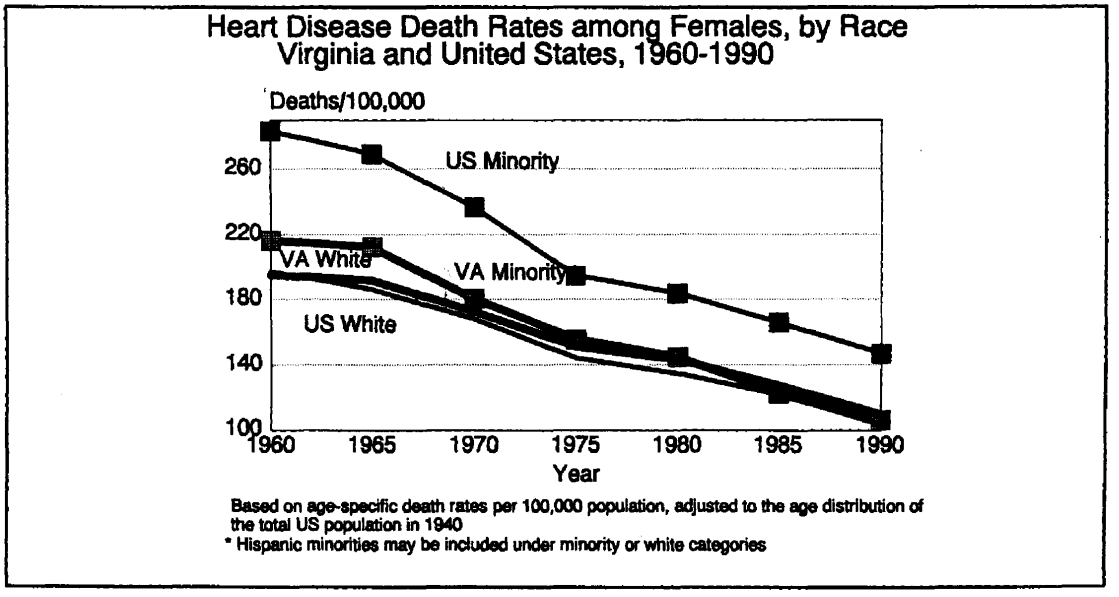
This relatively low rate of cervical cancer death and improved survival rate is, in part, due to early detection.[16] In 1991, 86 percent of women in Virginia 18 years or older with an intact cervix-uteri reported having had a Pap test in the past 2 years.[5]

Of those cases of cervical cancer in women less than 65 years of age reported in 1990, 53 percent were diagnosed in the earliest stage of disease and 32 percent in advanced stages. Only 44 percent of the cases among African-American women and 43 percent of cases among Asian women were diagnosed in the earliest stage compared to 54 percent of cases among white women.[4]

Heart Disease

Heart disease is the second leading cause of death among women 40 to 69 years of age and the leading cause of death for all women in Virginia. It is the leading cause of death for Virginia men over age 40. Yet, in Virginia the rate of deaths due to heart disease in women is decreasing. See Figure 8. Eight percent of women in Virginia 18 years of age or older report that they have been diagnosed with heart disease.[3] While further study is needed to explain the decreasing death rates from heart disease among females in Virginia, contributing factors probably include life styles changes, new medical technology, improved drugs, better surgical techniques, and more effective medical management.

Figure 8



The most significant risk factors for heart disease are smoking, hypertension, and elevated serum cholesterol.[16] In 1991, 97 percent of all women 18 years of age or older in Virginia reported having had their blood pressure checked in the past two years. Seventy percent of women in Virginia reported having had their cholesterol checked in the past five years. While 74 percent of white women had their cholesterol checked, this was true for only 60 percent of minority women.[5]

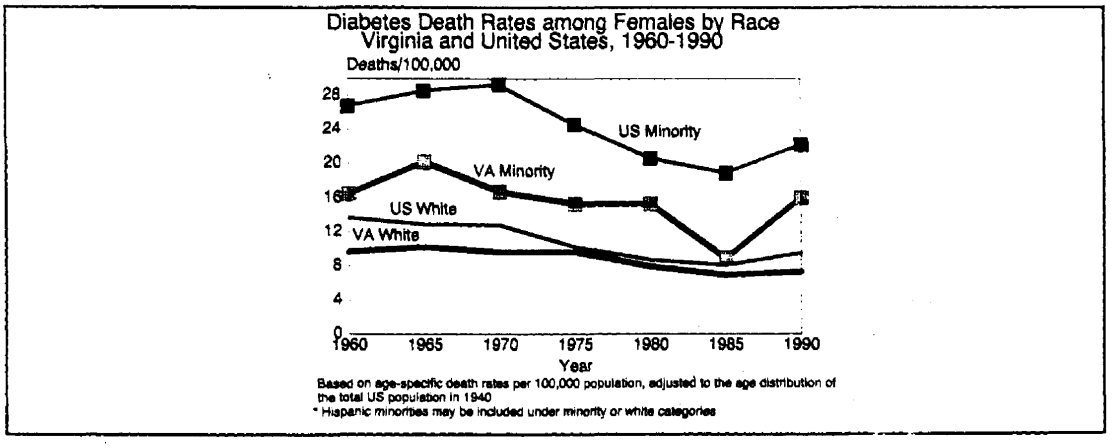
Overweight is associated with elevated serum cholesterol levels and elevated blood pressure and is an independent risk factor for coronary heart disease.[21] Twenty percent of women in Virginia 18 years of age or older are overweight. Overweight is more prevalent among minority women in Virginia. In 1991, 30 percent of minority females in Virginia aged 18 or older were overweight.[5]

Physical activity enhances weight loss or control and is important in preventing and managing obesity, coronary heart disease, and diabetes mellitus.[21] In 1991 in Virginia, 76 percent of all women aged 18 or older and 79 percent of minority women aged 18 or older reported a sedentary lifestyle.[5]

Diabetes

Diabetes is a metabolic disease characterized by high blood glucose levels. Persons with diabetes are more likely to develop heart disease and other chronic conditions, which can lead to amputations, blindness, and the need for kidney dialysis or transplant. In 1991, 105 Virginia women aged 10 to 64 died of diabetes.[2]

Figure 9



Nationally, African-American females have the highest prevalence of diagnosed diabetes, higher than African-American males and twice that of white females.[16] Seven percent of women in Virginia 18 years of age or older report having been diagnosed with diabetes.[3]

Smoking, obesity, lack of exercise, and hypertension are all recognized risk factors for diabetes.[16] Screening to identify diabetes, control of blood sugar, and early detection and treatment of complications are important to the prevention of death and disability from diabetes.

The risk of serious congenital malformations in babies born to mothers with diabetes is two to three times greater than in the general population. The chances of a good pregnancy outcome are enhanced if the diabetes is well controlled prior to the pregnancy.[16]

Arthritis

Arthritis, degeneration or inflammation of the joints, is an important cause of limited mobility in older women. Arthritis is more prevalent among women than men.[16] Twenty-one percent of women in Virginia 18 years of age or older report having been diagnosed with arthritis.[3]

Osteoporosis

Osteoporosis, an age-related disorder characterized by decrease in bone mass, is an important cause of bone fractures in postmenopausal women.[16] Three percent of women in Virginia age 18 or older report having been diagnosed with osteoporosis.[3]

Estrogen replacement therapy is reported to be effective in preventing osteoporosis. The risks, however, must be evaluated along with the benefits.[16] While further research is needed, there is evidence that estrogen replacement therapy in postmenopausal women also reduces the risks of developing and dying from coronary heart disease.[18] Ten percent of women in Virginia 18 years of age or older report that they are presently taking estrogen.[3]

Lupus

Lupus is a disease of the immune system that sometimes leads to skin rashes, joint problems, kidney failure, and shortened life expectancy. Lupus affects women nine times more often than men and is three times more prevalent among African-American women than among white women. There are no national or state data sets to assess the prevalence of lupus.[16]

In Virginia from 1982 to 1991, women accounted for 82 percent of the 268 deaths from lupus; 46 percent of all lupus deaths were among white females and 35 percent among African-American females.[2]

Injuries

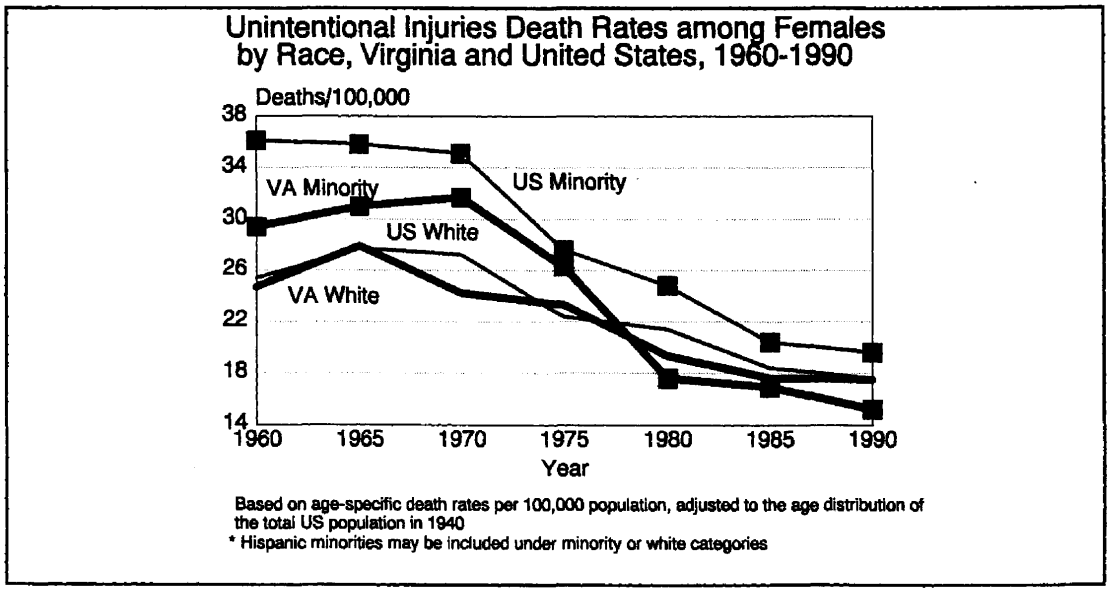
Injuries are the leading cause of death among both men and women under 35 years of age and the second leading cause among women and men 35 to 49 years of age in Virginia.[2] In 1990, 4,600 injuries serious enough to require hospitalization were treated in Virginia hospital emergency departments for women aged 12 to 65. Of these injuries, 74 percent were to white women, 22 percent to African-American women.[6]

Unintentional Injuries

Ten percent of women in Virginia 18 years of age or older report that they injured themselves in an accident in the past year.[3] The death rate for unintentional injuries among all females is decreasing. See Figure 10.

While further study is needed to explain the decreasing death rates from unintentional injuries among females in Virginia, contributing factors may include safety education programs, use of automobile safety belts, safer automobiles and highways, and new medical technology, and more effective medical management of trauma.

Figure 10



In 1991, 225 deaths from motor vehicle accidents accounted for 68 percent of all injury deaths among females 10 to 64 years of age in Virginia.[2] In 1990, 1,975 motor vehicle injuries serious enough to require hospitalization were treated in Virginia hospital emergency departments in women aged 12 to 65.[6] While auto crashes are the most frequent cause of death due to injury to women and the most common reason for hospitalization due to injury, this is not a problem of special significance to women compared to men.

Seatbelt use reduces the risk of serious injury and death from motor vehicle crashes. In 1991, 78 percent of women in Virginia aged 18 years or older reported that they always use a seatbelt when driving or riding in a car; an additional 11 percent report that they nearly always use a seatbelt.[5] Of women aged 12 to 65 treated in Virginia hospital emergency departments for automobile injuries serious enough to require hospitalization, only 40 percent were using a seatbelt.[6]

Nationally, approximately half of all motor vehicle crash fatalities are alcohol related. Alcohol-related traffic crashes are the leading cause of death and spinal cord injury for young Americans.[21] In 1991, 2 percent of women in Virginia aged 18 years or older reported that in the past month they had driven when they perhaps had too much to drink.[5]

Homicide and Battering

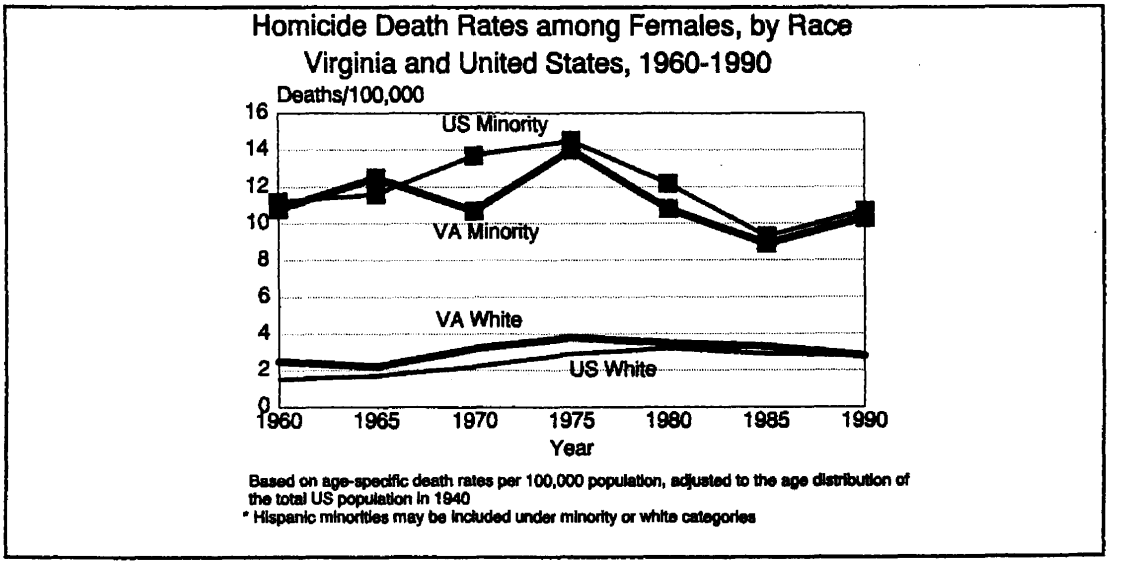
Violent and abusive behaviors are an important cause of injury-related death and long-term disability. In addition, domestic violence is associated with suicide attempts, substance abuse, and mental illness among women. Nationally, the availability and quality of data on morbidity and disability related to violence are poor.[21]

Women are more often assaulted by a male partner than by a stranger. Although male partners are also abused, women appear to be at greater risk for injury from abuse.[21] In fiscal year 1993, 25,922 battered women requested and received services from the domestic violence programs funded through the Virginia Family Violence Prevention Program; of these, 16,575 were initial cases. This probably represents only a fraction of the actual number of battered women.[7]

In fiscal year 1993, shelter was provided for 3,281 women, at least 90 percent of whom were abused by their current or former male partner. The shelters had to turn away 5,390 families for lack of space. Sixty-one percent of the sheltered women were white, 33 percent were African-American, 3 percent Hispanic, 1 percent Asian, less than 1 percent American Indian, and 2 percent unknown. Ninety percent of the sheltered women were 13 to 44 years of age; 6 percent were 45 to 64 years of age. Of the women sheltered, 279 were pregnant.[7] These numbers are based on data from those 36 out of 44 shelters funded by the Department of Social Services and, therefore, underrepresent the problem. There is an increase in the number of women requesting services from domestic violence programs in recent years.

Nationally, approximately one out of six homicides occur within the family, primarily among young adults and African-Americans. The risk of being killed by one's spouse is 1.3 times higher for wives than for husbands.[21] In 1991, 106 Virginia women aged 15 to 64 were victims of homicide. Half of all female homicide victims were aged 15 to 34, and half of all female homicide victims were African-American. The 1991 homicide rate for young African-American women in Virginia was 17.2 per 100,000 African-American women aged 15 to 34.[2]

Figure 11



Sexual Assault

In fiscal year 1992, victims of child abuse (less than 18 years of age) were fairly evenly divided between the sexes until 12 years of age after which the number of female victims exceeds that of males. The higher number of female victims after age 12 is largely due to the higher number of sexual abuse victims who are girls compared with boys. Eighty-one percent of identified victims of child sexual abuse were girls.[8]

In fiscal year 1992, sexual assault crisis programs in Virginia provided services to 4,509 victims of sexual assault. Over 90 percent of these victims were female, and approximately 90 percent were between the ages of 13 and 64 years.[9] Approximately 85 percent of all victims of sexual assault in which the offender was convicted were female.[20]

Forcible rape accounts for approximately 25 percent of convicted sexual assault offenses.[20] In 1992 police received 2,008 reports of forcible rape (including attempted forcible rape) of females of all ages. Rape is acknowledged to be under-reported.[10] Nationally, only about one half of rapes and attempted rapes are reported to law enforcement officials.[21]

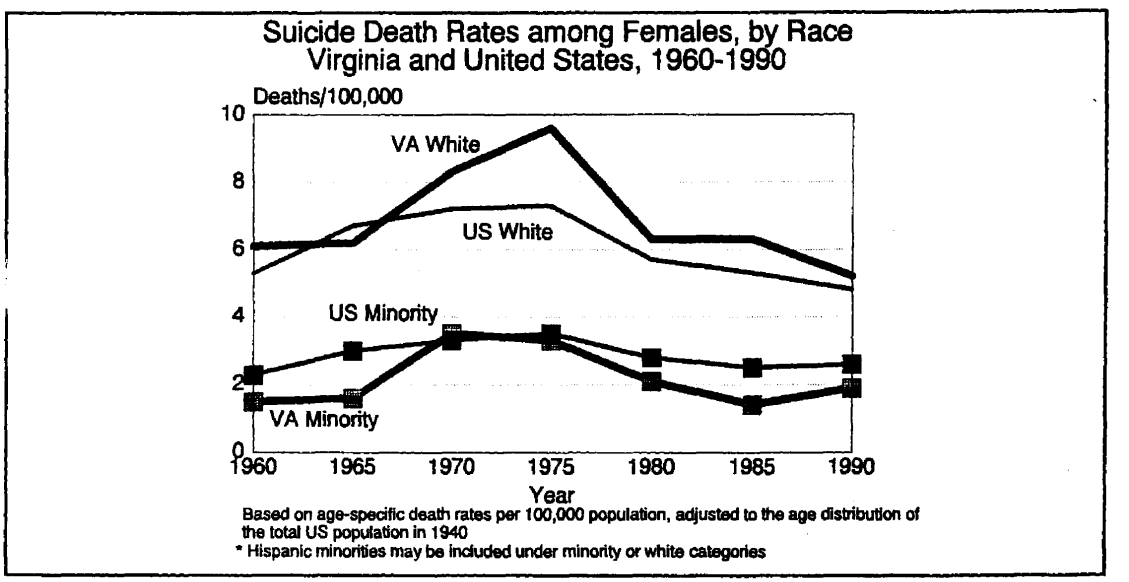
Based on the above information, in 1992 there were an estimated 73 rapes and attempted rapes per 100,000 women aged 12 and older and 134 rapes and attempted rapes per 100,000 women aged 12 to 34 in Virginia. These estimates are believed to underrepresent the actual incidence of rape and attempted rape in Virginia.

Mental Health

Suicide

In 1991, 135 Virginia women age 10 to 64 died from suicide compared to 513 Virginia men in this age group. For women in Virginia, there has been a gradual decline in suicide rates through the 1970s and 1980s.[2] See Figure 12.

Figure 12



Depression

While those who complete suicide tend to be males, those who make nonfatal suicide attempts tend to be young females. Suicide attempts are thought to be a proxy measure of depression.[16]

Major depression is the most common serious mental disorder in women. It occurs most frequently in women 25 to 44 years of age. Women are at higher risk than men for most types of depression.[16]

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services uses national prevalence rates to estimate the numbers of people in Virginia diagnosed with selected mental disorders. In 1990 there were an estimated 120,000 Virginia women between 18 and 64 years of age with major affective disorders, which include manic-depressive psychosis as well as depression. The highest prevalence rate was for white/other women 30 to 44 years old (8.3 percent). Affective disorders were estimated to be less prevalent among African-American women compared to white/other women in the 30 to 64 age group but more prevalent among African-American women compared to white/other women in the 18 to 20 age group.[23] Responding to the 1993 Commonwealth Poll, 8 percent of women 18 years of age and older reported that they had ever been diagnosed with depression.[3]

Eating Disorders

Anorexia nervosa and bulimia nervosa are serious mental health problems whose incidence appears to be increasing nationally. About 90 to 95 percent of cases of anorexia occur in adolescents or young females, most of whom are white and from middle-class families. Bulimia typically starts in late adolescence.[16] The number of women in Virginia with eating disorders is not known.

Substance Abuse

Alcohol and Substance Abuse

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services uses national prevalence rates to estimate the numbers of people in Virginia with serious drug or alcohol problems. An estimated 160,000 Virginia women age 12 and older have drug and alcohol problems requiring treatment.[23] Women are more likely than men to become addicted to prescription drugs.[16] Although cigarette smoking is more prevalent among men than women in Virginia,[5] it remains a major addiction among women.

In 1991, 8.5 percent of females in Virginia aged 18 years and older reported binge drinking on at least one occasion during the previous month, and 1.5 percent of women reported chronic drinking. White women were more likely to report chronic drinking than were minority women.[5]

Women, especially pregnant women and mothers with young children, have limited access to drug and alcohol services[21] because of special needs for medical care, child care, and a safe environment.

Fetal Alcohol Syndrome

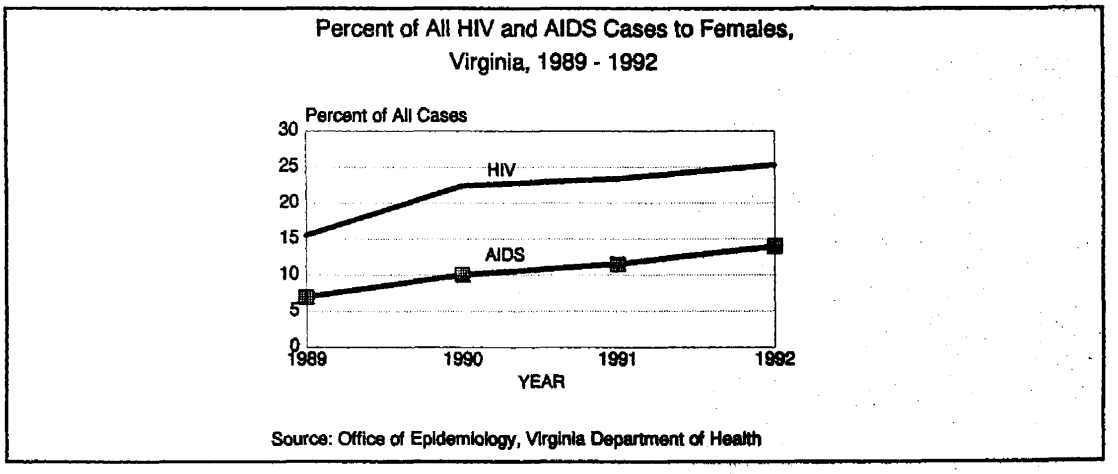
Alcohol use during pregnancy is a leading preventable cause of birth defects.[16] Seventeen cases of fetal alcohol syndrome have been reported among children born in Virginia in 1992. The 1991 rate of reported fetal alcohol syndrome in Virginia was 0.10 per 1,000 live births.[11]

Infectious Diseases

HIV/AIDS

Although more men than women are infected with Immunodeficiency Virus (HIV) and have Acquired Immunodeficiency Syndrome (AIDS), the gap is closing. See Figure 13. In 1992 women accounted for 26 percent of the HIV reports and 14 percent of the AIDS reports in Virginia.

Figure 13



In 1992, 105 women developed AIDS. This was an increase of 36 percent from the 77 new cases reported among women in 1991. AIDS case reports among African-American women increased 50 percent from 50 cases in 1991 to 75 cases in 1992, while case reports among white women increased 13 percent.

In 1992, 350 new cases of HIV infection were reported in females. This number represents only those women tested and therefore, this data is not a good measure of the true prevalence of HIV infection since many women are infected and not yet tested. African-American women accounted for 75 percent of these cases, and white women accounted for 21 percent. Forty-nine percent of the women were reported to have been infected with HIV through heterosexual contact, 22 percent from injecting drugs, 2 percent from blood transfusion The mode of transmission has not been determined for 26 percent.[4] This trend of increasing numbers of women infected with HIV signals a continued increase in women with AIDS in future years.

Maternal Transmission of HIV

An estimated 30 percent of infants born to HIV-infected mothers will have acquired HIV infection prior to birth.[19] In 1992, 25 Virginia children were reported with HIV infection or AIDS acquired prenatally from their mothers.[4] The prevalence of HIV infection was 148 per 100,000 women giving live birth.[12] There is an increasing trend of HIV infection and AIDS among women.

Other Sexually Transmitted Diseases

The medical complications associated with sexually transmitted diseases (STDs) are more serious for women than for men. Prevention and control of STDs are particularly important during a woman's reproductive years. Complications from STDs may result in infertility, ectopic pregnancy, fetal and infant death, and pneumonia, birth defects, blindness, and mental retardation of the newborn.[16]

Gonorrhea

In 1992, 6,744 cases of gonorrhea were reported among females in Virginia. Forty-seven percent of these cases were in women aged 15 to 29. Teenagers aged 15 to 19 had the highest rate of gonorrhea with 1,033 cases per 100,000 females. Of the gonorrhea cases among women in Virginia in 1992, 75 percent were reported in minority females, 9 percent were reported in white females, and 16 percent were reported without a specified race. The gonorrhea incidence rate was 402 cases per 100,000 women aged 15 to 44.[4]

Chlamydia Trachomatis

The Centers for Disease Control and Prevention estimates that Chlamydia trachomatis infection is twice as frequent as gonorrhea. The Virginia data are expected to underestimate the incidence of chlamydia infections because (1) screening has been limited to high risk females attending certain public health clinics, (2) as many as 75 percent of women with uncomplicated chlamydia infections are asymptomatic, and (3) persons with gonorrhea presumptively treated for chlamydia infection are not included in the case counts.

During 1992, 10,725 cases of chlamydia infection were reported in females. Eighty-two percent were aged 15 to 29, and 40 percent aged 15 to 19. Of the chlamydia cases among females, 48 percent were in minority females, 31 percent were in white females, and 21 percent were reported with race unspecified.[4]

Early Syphilis

Early syphilis includes the primary, secondary, and early latent stages of syphilis. 1992 was the first year of decline for early syphilis among women since 1985; however, it is also the first year that the number of reported cases among women surpassed the number of reported cases among men.

During 1992, 687 cases of early syphilis cases were reported among females. The majority (71 percent) of these cases were in women aged 15 to 29. Ninety-two percent of the syphilis cases in females were reported in minority females.[4]

Congenital Syphilis

Pregnant women who are infected with syphilis and do not receive adequate treatment risk transmitting the infection to their unborn child. The 1991 rate of congenital syphilis in Virginia was 53 cases per 100,000 live births. In 1992, 59 cases of congenital syphilis were reported, an increase of 16 percent from 1991. The average age of the mothers was 24 years with a range of 15 to 35 years. Congenital syphilis can be prevented by testing and treating pregnant women.[4]

Rubella (German Measles)

Rubella presents a serious threat to women of childbearing age. Intrauterine rubella infection can cause congenital rubella syndrome, which may result in miscarriage, stillbirth, or birth defects such as blindness, deafness, or mental retardation.[16] No cases of rubella were reported in Virginia in 1991. One case was reported in 1990.[4]

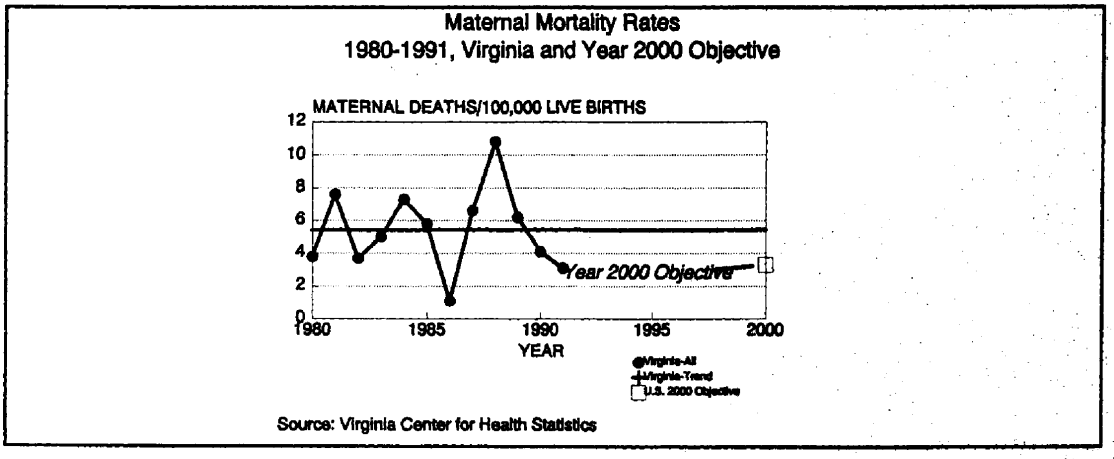
Reproductive Health

Pregnancy

Eighty percent of Virginia women 18 years of age and older report that they have been pregnant. Of these women, 48 percent report that their last pregnancy was unplanned.[3]

There were an estimated 753,600 women in Virginia at risk of unintended pregnancy in 1990. An estimated 340,000 women, (21 percent of all women in Virginia aged 13 through 44 years) were in need of subsidized or organized contraceptive services.[15] Local health departments in Virginia serve 57 percent of the women at risk with income at or below 100 percent of poverty and 36 percent of the women at risk at or below 185 percent of poverty. Service data by other providers are not available. While the maternal mortality rate fluctuated over the pat 10 years, the overall trend is level. See Figure 14.

Figure 14



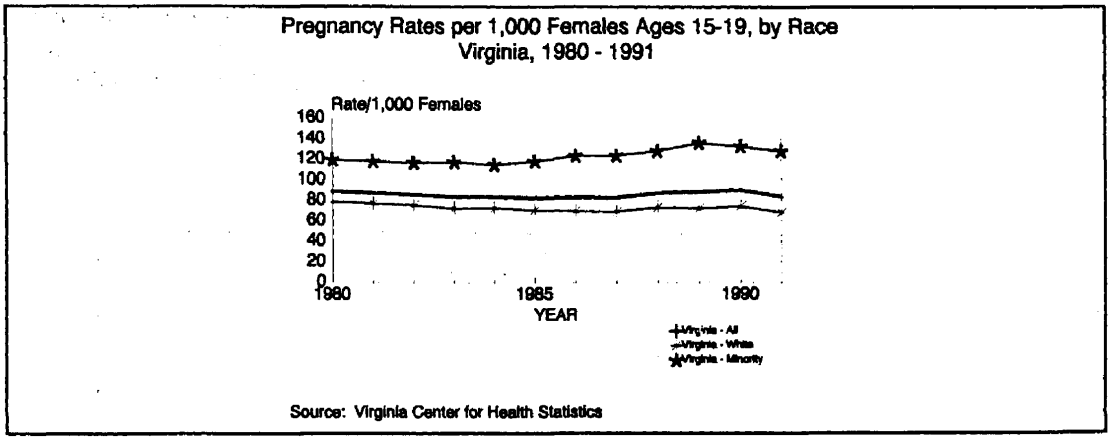
The most prevalent medical risk factors during pregnancy are pregnancy-associated hypertension, diabetes, and anemia. Of the 96,777 Virginia women giving birth in 1991, 2,718 (2.8 percent) had pregnancy-associated hypertension, 2,518 (2.6 percent) had diabetes, and 1,548 (1.6 percent) had anemia.[2]

Nationally in 1988, approximately 1 in 12 women of childbearing age reported difficulty in becoming pregnant.[16] The most preventable cause of infertility is sexually transmitted disease, accounting for approximately 20 percent of cases of infertility.[21] Data on infertility are not available for Virginia.

Teen Pregnancy

Teenage pregnancy and child-rearing have negative social and economic consequences for the teen parent.[21] Teenage pregnancy is more prevalent among minority females. See Figure 15. Poverty is likely a significant factor in this difference.

Figure 15

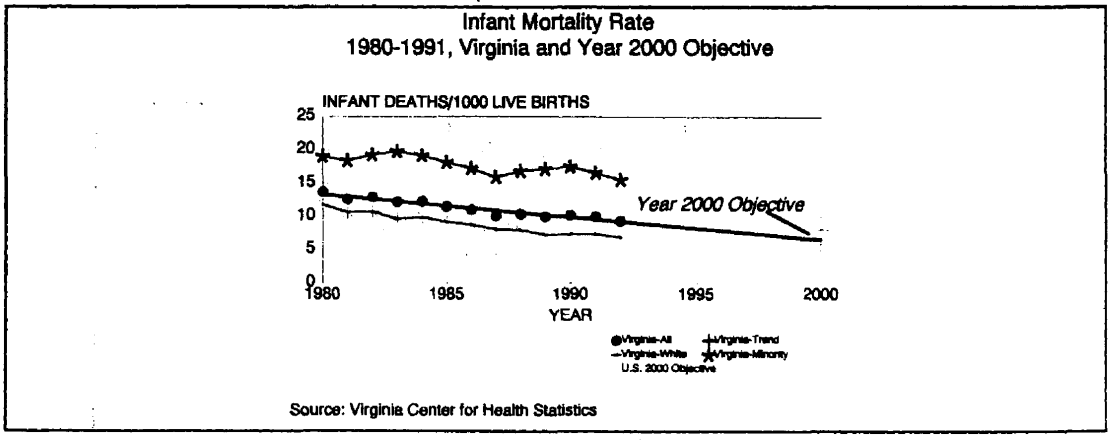


In 1991, 6,908 Virginia teens under 18 years of age became pregnant; the outcomes were 3,899 live births, 2,739 abortions, and 270 fetal deaths. This represents a rate of 55 pregnancies per 1,000 adolescents aged 15 to 17. There were 104 pregnancies per 1,000 African-American adolescents aged 15 to 17.[2]

Infant Mortality

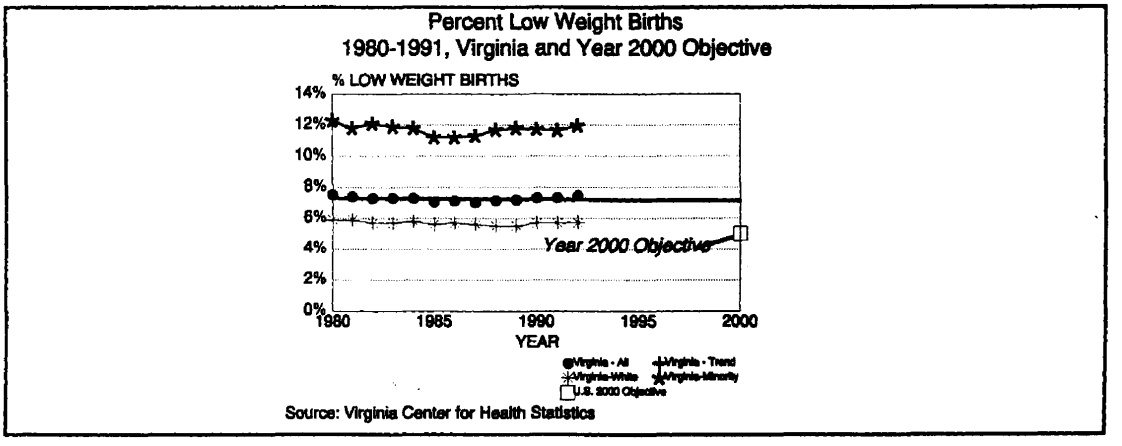
The infant mortality rate is frequently related to the health of women of childbearing age. Women who are in good health, including adequate nutrition, are much more likely to deliver a healthy baby. Mothers of infants free from uncontrolled diabetes and other chronic diseases; infectious diseases, including rubella, HIV infection, and other sexually transmitted diseases; substance abuse; and emotional stress; are more likely to deliver a healthy infant which will survive the first year of life. In Virginia, the infant mortality rate has dropped from 13.7 in 1980 to 9.3 per 1,000 live births in 1992.[2] (See Figure 16).

Figure 16



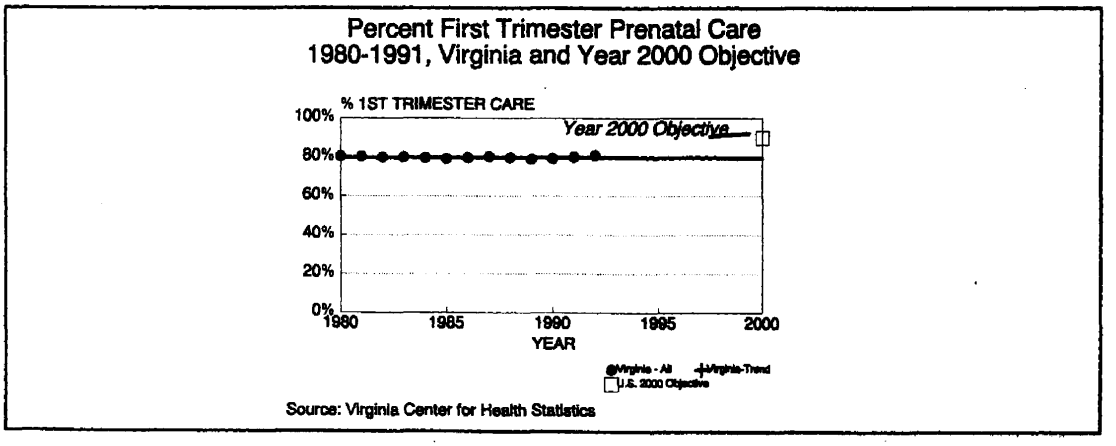
Low birth weight is the most important predictor of infant mortality. Maternal risk factors for having a low birth weight baby include younger and older maternal age, high number of pregnancies, poor reproductive history, low socioeconomic status, low level of education, late entry into prenatal care, low pregnancy weight gain and/or low prepregnancy weight, smoking, and substance abuse.[21] The low birth weight rate has been relatively stable over the past 10 years. See Figure 17. In 1992, 7.5 percent of live births to all women and 12.8 percent of live births to African-American women in Virginia were low weight.[2]

Figure 17



Early, high-quality prenatal care is critical to improving the health of women as well as pregnancy outcomes, especially for women at increased medical and/or social risk.[21] For births in 1991, 80 percent of all pregnant women in Virginia and 66 percent of African-American pregnant women began prenatal care in the first trimester of pregnancy. Only 54 percent of pregnant women less than 18 years of age began prenatal care in the first trimester of pregnancy. Among those women whose baby died within the first year, 32 percent lacked early prenatal care.[2] The percent of women who began prenatal care in the first trimester has been stable over the past 10 years. See Figure 18.

Figure 18



IV. NATIONAL HEALTH OBJECTIVES

Healthy People 2000: National Health Promotion and Disease Prevention Objectives prepared by the U. S. Department of Health and Human Services, Public Health Service, presents a national strategy for improving the health of the nation by the year 2000.[21] The Virginia Department of Health has adopted these objectives as a framework for needs assessment and planning in a variety of documents, including the Six Year Plan and federal grant applications. Only those Healthy People 2000 objectives which specifically target women are included in this report.

Virginia in 1991, has already met the following Year 2000 Objectives::

- ▲ Gonorrhea ages 15 - 44
- ▲ Fetal alcohol syndrome
- ▲ Maternal mortality rate
- ▲ Congenital rubella
- ▲ Rape/attempted rape ages ≥ 12
- ▲ Pap test ≥ 18

Virginia needs to make further progress in meeting the following Year 2000 Objectives::

- ▼ Cervical cancer deaths
- ▼ Prenatal care in the first trimester of pregnancy
- ▼ Tobacco use during reproductive age
- ▼ Overweight black women ≥ 20
- ▼ HIV positive women giving birth
- ▼ Infant mortality rate
- ▼ Breast exam and mammogram to women ≥ 40
- ▼ Pregnancies to teenagers ≤ 17
- ▼ Homicides to women ages 15 - 34
- ▼ Congenital syphilis

A complete statement of these objectives can be found in Appendix B

V. ACCESS TO HEALTH SERVICES

Not all Virginia women are receiving needed preventive health services. In general, minority women are less likely than white women to receive recommended services. Gaps in services for problems discussed in the body of this report are highlighted below.

- One out of four Virginia women age 40 and older have never had a mammogram. Breast cancer is less likely to be detected in the early stages for African-American women compared to Asian and white women.
- Fourteen percent of Virginia women age 18 and older have not had a Pap test in the past 2 years. Testing and early detection is less frequent in African-American and Asian women compared to white women.
- Thirty percent of women in Virginia have not had their cholesterol checked in the past five years. Minority women are less likely than white women to have their cholesterol checked.
- Over half the battered women and their children who seek shelter in State supported Virginia facilities are turned away due to lack of space.
- Twenty percent of all pregnant women and 34 percent of African-American pregnant women in Virginia began prenatal care after the first trimester of pregnancy.

Insurance Coverage

Insurance coverage is one factor influencing whether or not women receive health care services. Nationally, 75.8 percent of women have private health insurance coverage, 7.5 percent have public assistance health coverage, and 12.7 percent have no coverage. Women aged 45 to 64 are more likely than men of the same age to be uninsured. This group has the lowest percentage of women covered by public health insurance. Many health insurance plans lack coverage for preventive health services. Few private health plans appear to pay for routine family planning services.[16]

In Virginia in 1993, 70 percent of women had comprehensive health insurance coverage compared to 67 percent of men. Seventeen percent of both men and women had noncomprehensive coverage. Twelve percent of women and 16 percent of men had no health insurance.[17]

Not all indigent women in Virginia are covered by Medicaid. Except during pregnancy, only those women who qualify for Supplemental Security Income (SSI) or Aid to Families with Dependent Children (ADC) can receive Medicaid benefits. To qualify for ADC, family income generally must be below 60 percent of the federal income poverty level. The federal poverty level for a family of four is $13,190. Pregnant women, including those who are married, may be eligible for Medicaid up to 133 percent of poverty. Virginia has not elected the federal option to extend Medicaid coverage up to 185 percent of poverty during pregnancy.

Virginia Medicaid covers preventive services for recipients under 21 years of age but, in general, does not cover preventive medical care for women 21 years of age and older. Medicaid coverage specifically excludes routine physical examinations and immunizations, rehabilitative treatment of substance abuse, services to persons under age 65 in mental hospitals, and weightloss programs. Coverage is provided for annual or biannual screening

mammograms for women over age 35, some mental health services, family planning services, and prenatal care services.

Other Barriers to Primary Care

In 1991, in response to Senate Joint Resolution No. 179, district health directors, along with representatives of the private medical care community, businesses, schools, hospitals, consumers, non-profit service organizations, and many others, compiled data to identify which people in their localities lacked access to primary health care services and the barriers to access. While the study looked at primary health care for all Virginians, many of the barriers to primary care are relevant for women aged 12 to 64.

- Lack of primary care physicians
- Restricted access for persons not covered by insurance
- Lack of transportation to medical providers
- Insufficient perinatal services
- Limited services for the chronically ill, particularly those of low income and the uninsured
- Lack of health promotion and disease prevention services
- Poor perception by health care providers of Medicaid services
- High teen pregnancy rates
- Use of hospital emergency rooms for regular primary care

The 1990 reports of the Virginia Health Planning Board "Alternative Providers in Medically Underserved Areas" and "Access To Obstetrical Care" recommend the use of mid-level practitioners to increase access to primary health services.

VI. INFORMATION SYSTEMS AVAILABLE TO MEASURE WOMEN'S HEALTH STATUS

Data on the health status of women in Virginia are available from numerous sources. The 1990 United States census provides a demographic profile of the population. Data reporting systems of the Virginia Departments of Health, State Police, Corrections, and Social Services, the Virginians Aligned Against Sexual Assault the Behavioral Risk Factor Surveillance System and Commonwealth Poll statewide surveys provide health status data. Descriptions of these data sources are found in the Data Systems Reports section of this document.

When collected, data is generally available by gender, age, race, and geographic location. Not all data systems collect and report information for specific minority groups. Analysis of data by subpopulations of women is limited.

Trend data are not routinely reported. Information on education is collected only for pregnancies and deaths. It is tabulated and reported for births but not for deaths. Data are not available by income level.

In addition to current data systems, the recently initiated Virginia Patient Level Data System will collect information on women admitted to acute care hospitals. Available information will include health problems, race, age, residence, insurance coverage, and employment status. The first year for which data will be available is 1994.

Chronic Diseases

While not routinely compiled for women, long-term trend data are available for deaths from chronic diseases. Data on the number of new cases of disease are available for cancer only, beginning with 1990. Information is not routinely available on the total number of women with chronic diseases. The Commonwealth Poll was employed to obtain limited data for this study. In the future, additional information on women with chronic diseases will be available from the Virginia Patient Level Data System.

While cancer stands out as a major concern in this report, this is in part a reflection of the lack of data on other chronic diseases which disproportionately effect women, such as diabetes, arthritis, osteoporosis, and lupus.

Injuries

Long-term trend data are available for deaths from injuries, though not routinely compiled for women. Data is also available on serious injuries treated in hospital emergency rooms for recent years. The Department of Motor Vehicles complies data on injuries and deaths due to motor vehicles. However, information on the causes of the injuries is often incomplete. Information on less serious injuries is not routinely available. The Commonwealth Poll supplied limited data on accidents for this report. In the future, additional information on women with serious injuries will be available from the Virginia Patient Level Data System.

The criminal justice system collects information on acts of violence, but information on victims is available only for homicides and rapes. Social services agencies collect information on women who seek services for sexual assault and spouse abuse. These sources do not capture information about women who do not seek police or social services assistance. Insufficient data are available to measure the extent of the problems of violence or how they may have changed over time.

Mental Health and Substance Abuse

Data on Virginia women with mental health problems and with alcohol and drug abuse problems are not routinely available for the population at large. The Commonwealth Poll provided limited data on depression for this report.

Infectious Diseases

Much information is available on cases of infectious diseases for which women seek medical treatment. Because only cases of infectious diseases that are diagnosed and reported are included in this available data, the data underrepresents the problem.

Reproductive Health

Information is not routinely available about women who are planning pregnancies, the proportion of pregnancies which are unplanned, and the number of women having difficulty becoming pregnant. Much information is available about women who become pregnant and the outcomes of the pregnancies. No data are available connecting pregnancy outcomes with income levels.

VII. RECOMMENDATIONS

Targeting Resources to Impact on the Health of Women

The implementation of the Joint Commission on Health Care recommendations to increase overall access to primary care services and to provide health insurance for Virginians who currently lack coverage will improve the health status of women as well as men. However, specific attention should be given to insure that the issues specific to women are recognized and addressed.

1. To promote the general health of women, there should be better access to primary health care services including services of obstetrician/gynecologists and mid-level practitioners. Priority should be given to making clinical preventive services available to all women. Clinical preventive services should be made available to all women in accordance with recommendations of the U.S. Preventive Services Task Force listed below.[22] With the exception of screening and counseling for women contemplating pregnancy, these recommendations are included in the essential health services plan established pursuant to SB 506, 1992.

☐ The Medical Societies are encouraged to educate and foster the use of the Preventive Services task force standards of care.

- All women over age 40 should receive an annual clinical breast examination. Mammography every one to two years is recommended for women beginning at age 50.

- Regular Pap testing is recommended for all women who are or have been sexually active. Pap smears should begin with the onset of sexual activity and should be repeated every one to three years at the physician's discretion.

- Clinicians should emphasize the primary prevention of coronary artery disease (CAD) by periodically screening for high blood pressure and high serum cholesterol and by routinely investigating behavioral risk factors for CAD such as tobacco use, dietary fat and cholesterol intake, and inadequate physical activity.

- All women should receive periodic height and weight measurements.

- Clinicians should counsel all women to engage in a program of regular physical activity, tailored to their health status and personal lifestyle.

- Clinicians should provide periodic counseling regarding dietary intake of calories, fat (especially saturated fat), cholesterol, complex carbohydrates (starches), fiber, sodium, and calcium and iron intake.

- Estrogen replacement therapy should be considered for asymptomatic women who are at increased risk for osteoporosis, who lack contraindications, and who have received adequate counseling about potential benefits and risks.

- All women should be urged to use safety belts, to wear safety helmets when riding motorcycles, and to refrain from driving while under the influence of alcohol or other drugs.

- All women should be asked to describe their use of alcohol and other drugs. Women in whom alcohol or other drug abuse or dependence is confirmed should receive appropriate counseling, treatment, and referrals. All women who use alcohol, especially pregnant women, should be encouraged to limit their consumption, and all persons who use alcohol or other intoxicating drugs should be counseled about the dangers of operating a motor vehicle or performing other potentially dangerous activities while intoxicated.

- Tobacco cessation counseling should be offered on a regular basis to all women who smoke cigarettes, pipes, or cigars, and to those who use smokeless tobacco. Women who do not currently use tobacco products should be advised not to start.

- Routine screening for syphilis in asymptomatic women is recommended for those in high-risk groups and for pregnant women.

- Routine testing for gonorrhea in asymptomatic persons is recommended for persons at high risk and for pregnant women.

- Routine testing for Chlamydia trachomatis is recommended for asymptomatic persons at high risk of infection. Pregnant women in high-risk categories should be tested at the first prenatal visit.

- Screening for infection with HIV should be offered periodically to persons seeking treatment for sexually transmitted diseases, intravenous drug users, and others at increased risk of infection. Testing should also be offered to pregnant women and women contemplating pregnancy who are at increased risk for HIV infection.

- Serologic testing for rubella antibodies should be performed at the first clinical encounter with all pregnant and nonpregnant women of childbearing age lacking evidence of immunity.

- Clinicians should obtain a complete sexual history from all women. Sexually active women who do not want to become pregnant should receive detailed counseling on methods to prevent unintended pregnancy. Sexually active patients should also receive information on measures to prevent sexually transmitted diseases.

- Additional screening and counseling is recommended for pregnant women and women contemplating pregnancy.

- All women should be encouraged to visit a dental care provider on a regular basis.

2. Public and private funding for health education and prevention programs should be directed to:

- Programs to prevent teenage pregnancies as recommended by the Maternal and Child Health Council.
  - Expansion of the Better Beginnings Coalitions.
  - Statewide expansion of the Resource Mothers Program.
  - Implementation of a statewide teen pregnancy prevention public awareness program.
- HIV/AIDS education and prevention programs targeted toward women and minorities. Examples are:
  - Home health parties, a home-based education strategy, for women in low income housing and substance abuse recovery programs.
  - Educational presentations for women in correctional facilities and in group homes for teens in crisis.
  - Educational presentations in health department maternity, family planning, and WIC clinics and waiting rooms.
  - Educational presentations, counseling, and testing services designed for special populations, such as minority women, and teens.
  - Case management services for HIV infected women.

- Programs that address lifestyle risk factors such as smoking, weight control, exercise and the consequences of sexual activity. Examples are:
  - Project Assist - American Stop Smoking Intervention Study
  - CommonHealth - Virginia's Employee Health Improvement Program
  - The Breast and Cervical Cancer Early Detection Program
- A concise brochure on women's health status in the Commonwealth should be prepared and distributed for use by employers, health care providers, educators and the various branches of state and local government.

Further Data Collection: Measuring the Health Status of Women

1. Existing data systems should be augmented to collect and analyze health-related data on women. This should include data by specific minority groups for those problems that disproportionately affect minorities.
2. The incidence and effects of violence against women should be focal points for additional data collection since existing data are not adequate to determine the full impact of violence on the health of women.
3. The Department of Health should continue to study information needs and methods for collecting data to adequately measure women's health in Virginia, and to make specific recommendations to improve the complete assessment of women's health. The Healthy People 2000 objectives should be used as a guideline for measuring the health status of Virginia's women.

SOURCES

Data Systems Reports

1 State Data Center, Virginia Employment Commission

The State Data Center, in cooperation with the United States Bureau of the Census, stores and disseminates demographic, economic, and social data for Virginia.

2 Virginia Vital Statistics, Annual Report. Center for Health Statistics, Virginia Department of Health.

The Virginia Department of Health has a system for collecting data on deaths to Virginia residents. This data is collected by sex, race, age, residence, and cause of death. Data is also available on live births and fetal deaths by age, race, education, marital status, and residence of mother. Data are from birth and death certificates and reports of induced termination of pregnancy. This data is reported annually in the Center for Health Statistics annual report.

3 Commonwealth Poll

The Commonwealth Poll is conducted annually from the facilities of the Survey Research Laboratory at Virginia Commonwealth University. The survey polls a randomly-selected sample of Virginia residents aged 18 and over in households with telephones. Information in this report is from the April 1993 survey. While responses are tabulated by age, education, race, region, family income, and marital status, results for subgroups of women are generally not meaningful due to the small sample size.

4 Reportable Disease Surveillance, Virginia. Office of Epidemiology, Virginia Department of Health.

The Virginia Department of Health has a system for collecting data on reportable disease occurrences to Virginia residents. This data is collected by place of occurrence, age, race, sex, and onset. The data system is limited to (1) diseases reported according to the provisions Regulations for Disease Reporting and Control (primarily communicable diseases) and (2) cancer cases reported to the Virginia Cancer registry. Statistical summaries of numbers, rates and trends are reported annually in the Office of Epidemiology annual report.

5 Behavioral Risk Factor Surveillance System

The Virginia Department of Health, Centers for Disease Control, and the Survey Research Laboratory of Virginia Commonwealth University participate collaboratively in a surveillance system to collect data on behavioral risk factors for specific health problems in Virginia. Data comes from telephone surveys of Virginians 18 years of age and older.

6 Trauma Registry, Office of Emergency Medical Services, Virginia Department of Health.

The Virginia Department of Health has a system for collecting data on injuries to all persons admitted to the hospital, who die in a hospital emergency department due to trauma, or who are transferred from one facility to another due to trauma.

7 Report of Spouse Abuse Services in Virginia, Adult Services Program, Virginia Department of Social Services.

The Virginia Department of Social Services collects data on clients served by domestic violence programs funded through the Virginia Family Violence Prevention Program which includes 36 of the 44 programs in Virginia. This system provide demographic information on those clients served.

8 Child Protective Services Annual Report, Child Protective Services Unit, Division of Service Programs, Virginia Department of Social Services.

The Virginia Department of Social Services has a system for collecting data on suspected abuse or neglect of children less than 18 years of age.

9 Virginians Aligned Against Sexual Assault

The Virginians Aligned Against Sexual Assault has a system for collecting data on clients served by the 22 sexual assault crisis programs, including sex, race, age, and type of assault.

10 Crime in Virginia, Virginia Uniform Crime Reporting Program, Department of State Police.

The Department of State Police has a system for collecting data on reported crimes in Virginia which is offender based. Information about victims of crimes is not collected. Murder/Nonnegligent Manslaughter is the one exception. Information includes the age, sex, and race of the victim. Also, victims of Forcible Rape are female by definition. Virginia is in the process of implementing an Incident Based Reporting system that will include information about the victims, including injury, for the most serious offenses.

11 Virginia Congenital Anomalies Reporting and Education System (VaCARES), Division of Children's Specialty Services, Virginia Department of Health

The Virginia Department of Health has a system for collecting data on children diagnosed with a congenital anomaly up to age two. Data comes from birth certificates, the Newborn Screening Program, and mandatory reports for children discharged from the hospital. Regular reports are not compiled from the VaCARES.

12 Survey of Childbearing Women For HIV Infection, STD/AIDS Program, Virginia Department of Health.

The Virginia Department of Health has a system for collecting data on the HIV status of newborns from blood specimens of infants collected to test for newborn metabolic or genetic disorders. The presence of HIV antibodies in newborn sera indicates whether or not the mother is infected. This data is collected and reported anonymously.

13 Adult Protective Services in Virginia, Statistical Reports for Fiscal Year, Virginia Department of Social Services.

The Virginia Department of Social Service has a system for collecting data on investigations into suspected abuse, neglect, and/or exploitation of older or incapacitated adult Virginians.

14 Pre-Sentence Investigation data base, Virginia Department of Corrections.

The Virginia Department of Corrections has a system for collecting data on all persons convicted of a felony, including information about the current offence.

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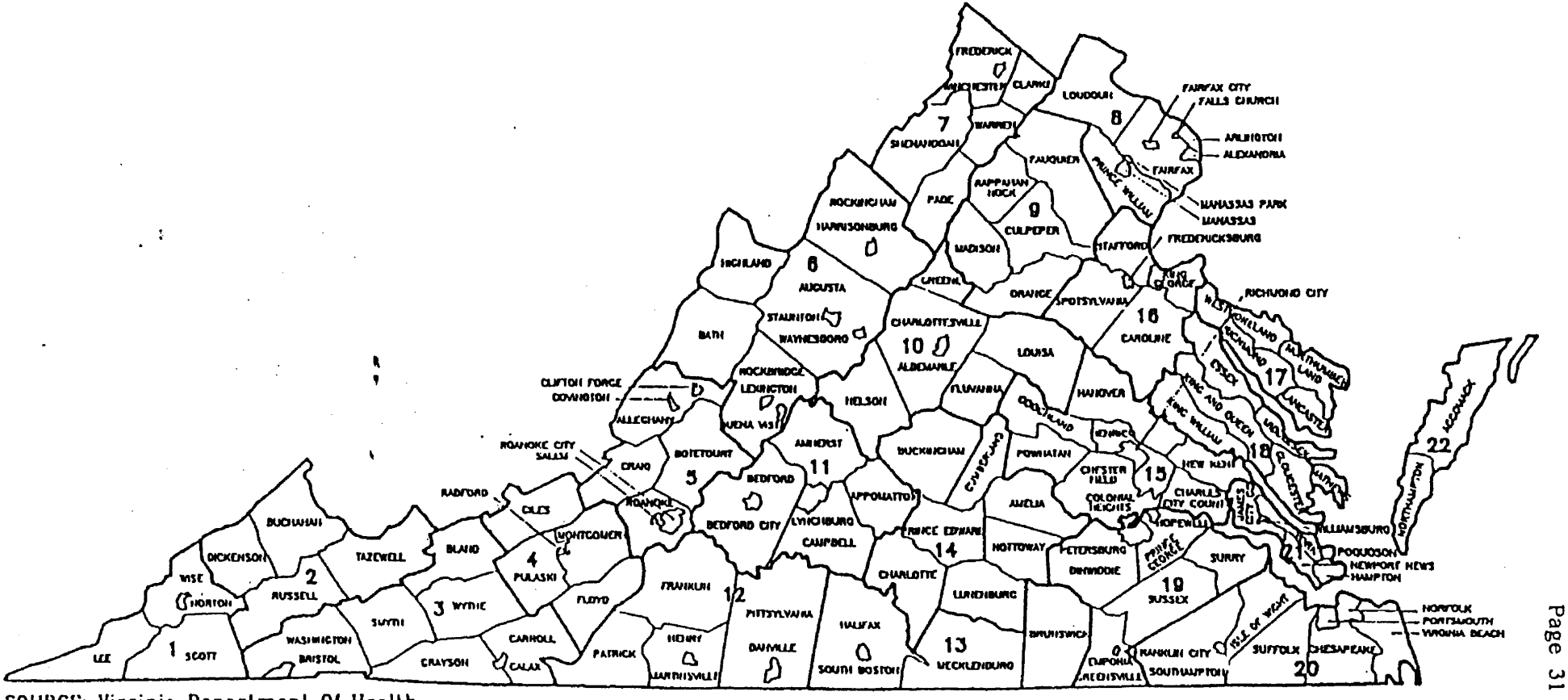
23 Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. Virginia Comprehensive State Plan, 1994 - 2000 (Draft). June 1993

Population of Women by Age, Race, and Planning District, Virginia, 1990

Planning District	Ages 12 to 64 TOTAL	Ages 12 to 64 White	Ages 12 to 64 Minority	Ages 12 to 64 Percent Minority	Ages 12 to 44 TOTAL	Ages 12 to 44 White	Ages 12 to 44 Minority	Ages 12 to 44 Percent Minority	Ages 45 to 64 TOTAL	Ages 45 to 64 White	Ages 45 to 64 Minority	Ages 45 to 64 Percent Minority
State	2,247,660	1,732,173	515,487	22.9	1,648,286	1,248,331	399,955	24.3	599,374	483,842	115,532	19.3
1	32,347	31,856	491	1.5	22,375	22,001	374	1.7	9,972	9,855	117	1.2
2	44,916	44,174	742	1.7	31,686	31,150	536	1.7	13,230	13,024	206	1.6
3	63,236	61,417	1,819	2.9	42,147	40,794	1,353	3.2	21,089	20,623	466	2.2
4	57,144	53,438	3,706	6.5	43,621	40,510	3,111	7.1	13,523	12,928	595	4.4
5	91,190	79,517	11,673	12.8	63,069	54,239	8,830	14.0	28,121	25,278	2,843	10.1
6	80,498	75,920	4,578	5.7	57,146	53,602	3,544	6.2	23,352	22,318	1,034	4.4
7	55,529	53,001	2,528	4.6	38,590	36,741	1,849	4.8	16,939	16,260	679	4.0
8	559,044	451,954	107,090	19.2	421,547	334,184	87,363	20.7	137,497	117,770	19,727	14.3
9	40,569	34,769	5,800	14.3	28,745	24,515	4,230	14.7	11,824	10,254	1,570	13.3
10	60,852	49,576	11,276	18.5	45,457	36,743	8,714	19.2	15,395	12,833	2,562	16.6
11	74,802	60,275	14,527	19.4	52,892	42,031	10,861	20.5	21,910	18,244	3,666	16.7
12	85,133	62,902	22,231	26.1	57,483	40,987	16,496	28.7	27,650	21,915	5,735	20.7
13	27,979	15,688	12,291	43.9	18,717	9,782	8,935	47.7	9,262	5,906	3,356	36.2
14	28,543	17,650	10,893	38.2	19,741	11,969	7,772	39.4	8,802	5,681	3,121	35.5
15	276,494	192,244	84,250	30.5	204,520	139,620	64,900	31.7	71,974	52,624	19,350	26.9
16	61,054	51,025	10,029	16.4	46,562	38,992	7,570	16.3	14,492	12,033	2,459	17.0
17	14,360	9,557	4,803	33.4	8,799	5,474	3,325	37.8	5,561	4,083	1,478	26.6
18	25,117	19,319	5,798	23.1	17,246	13,199	4,047	23.5	7,871	6,120	1,751	22.2
19	55,455	30,289	25,166	45.4	39,006	20,211	18,795	48.2	16,449	10,078	6,371	38.7
20	351,108	233,694	117,414	33.4	268,502	176,550	91,952	34.2	82,606	57,144	25,462	30.8
21	147,128	94,947	52,181	35.5	110,520	69,502	41,018	37.1	36,608	25,445	11,163	30.5
22	15,162	8,961	6,201	40.9	9,915	5,535	4,380	44.2	5,247	3,426	1,821	34.7

Source: U. S. Bureau of the Census

PLANNING DISTRICTS AND THEIR COMPONENT COUNTIES AND INDEPENDENT CITIES COMMONWEALTH OF VIRGINIA



SOURCE: Virginia Department Of Health

HEALTHY PEOPLE 2000
NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES

Health Status Objectives

- A Healthy People 2000 Objective for the Nation is to reduce breast cancer deaths to no more that 25.2 per 100,000 women (age adjusted to the 1970 population). The 1991 rate in Virginia was 27.8 per 100,000 women.[2]

- A Healthy People 2000 Objective for the Nation is to reduce deaths from uterine cervix cancer to no more than 1.5 per 100,000 women (age adjusted to the 1970 population). The 1991 rate in Virginia was 3.2 per 100,000 women.[2]

- A Healthy People 2000 Objective for the Nation is to reduce homicides to no more than 16.0 per 100,000 black women aged 15 to 34. The 1991 rate in Virginia was 17.2 per 100,000 black women aged 15 to 34.[2]

- A Healthy People 2000 Objective for the Nation is to reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. Data are not available for Virginia.

- A Healthy People 2000 objective is to reduce rape and attempted rape to no more than 108 per 100,000 women aged 12 and older and to no more than 225 per 100,000 women aged 12 to 34. Based on the above information, in 1992 there were an estimated 73 rapes and attempted rapes per 100,000 women aged 12 and older and 134 rapes and attempted rapes per 100,000 women aged 12 to 34 in Virginia. These estimates are believed to underrepresent the actual incidence of rape and attempted rape in Virginia.

- A Healthy People 2000 objective is to reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births. The reported 1991 incidence in Virginia was 0.10 per 1,000 live births.[11]

- A Healthy People 2000 Objective for the Nation is to confine the prevalence of HIV infection to no more that 100 per 100,000 women giving live birth. In 1992 in Virginia, the prevalence of HIV infection was 148 per 100,000 women giving live birth.[12]

- A Healthy People 2000 Objective for the Nation is to reduce gonorrhea to an incidence of no more that 501 cases per 100,000 women aged 15 to 44. The rate in Virginia for 1992 was 402 cases per 100,000 women aged 15 to 44.[4]

- A Healthy People 2000 Objective for the Nation is to reduce congenital syphilis to an incidence of no more than 50 cases per 100,000 live births. The 1991 rate in Virginia was 53 cases per 100,000 live births.[4]

- A Healthy People 2000 Objective for the Nation is to reduce cases of Congenital Rubella Syndrome to zero. Virginia is meeting this objective.

- A Healthy People 2000 Objective for the Nation is to reduce to no more than 30 percent the proportion of all pregnancies that are unintended. Of those Virginia women who have been pregnant, 48 percent report that their last pregnancy was unplanned.[3]

- A Healthy People 2000 Objective for the Nation is to reduce pregnancies among girls 17 and younger to no more than 50 per 1,000 adolescents. In 1991 in Virginia there were 55 pregnancies per 1,000 adolescents aged 15 to 17. There were 104 pregnancies per 1,000 black adolescents aged 15 to 17.[2]

- A Healthy People 2000 Objective for the Nation is to reduce the maternal mortality rate to no more than 3.3 per 100,000 live births. The 1991 rate for Virginia is 3.1 maternal deaths per 100,000 live births.[2]

- A Healthy People 2000 Objective for the Nation is to reduce the infant mortality rate to no more than 7 per 1,000 live births. The 1991 rate in Virginia was 10.0 per 1,000 live births.[2]

Risk Reduction Objectives

- A Healthy People 2000 Objective for the Nation is to reduce tobacco use among women of reproductive age to 12 percent by the year 2000. In 1991, 18 percent of women in Virginia 18 years of age or older reported that they were regular smokers.[5]

- A Healthy People 2000 Objective for the Nation is to reduce overweight to a prevalence of no more than 20 percent among black women aged 20 and older. In 1991, 30 percent of minority females in Virginia aged 18 or older were overweight.[5]

- A Healthy People 2000 Objective for the Nation is to reduce low birth weight to an incidence of no more than 5 percent of live births and 9 percent of live births to black women. In 1991, 7.3 percent of live births to all women and 12.5 percent of live births to black women in Virginia were low weight.[2]

Services and Protection Objectives

- A Healthy People 2000 Objective for the Nation is to increase to at least 80 percent the proportion of women aged 40 and older who have ever received a clinical breast examination and a mammogram. In 1991, 76 percent of women in Virginia age 40 or older reported ever having had a mammogram.[5]

- A Healthy People 2000 Objective for the Nation is to increase to at least 85 percent the proportion of women aged 18 or older with uterine cervix who received a Pap test within the preceding 1 to 3 years. In 1991, 86% of women in Virginia 18 years or older with an intact cervix-uteri reported having had a Pap test in the past 2 years.[5]

- A Healthy People 2000 Objective for the Nation is to increase to at least 90 percent the proportion of perimenopausal women who have been counseled about the benefits and risks of estrogen replacement therapy for prevention of osteoporosis. Data are not available for Virginia.

- A Healthy People 2000 Objective for the Nation is to reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space. In fiscal year 1993, over half of battered women and their children in Virginia who sought shelter were turned away due to lack of space.[7]

- A Healthy People 2000 Objective for the Nation is to establish and monitor in all states comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people.

- A Healthy People 2000 Objective for the Nation is to increase to at least 90 percent the proportion of all pregnant women and 90 percent the proportion of black pregnant women who receive prenatal care in the first trimester of pregnancy. For births in 1991, 80 percent of all pregnant women in Virginia and 66 percent of black pregnant women in Virginia began prenatal care in the first trimester of pregnancy.[2]

GENERAL ASSEMBLY OF VIRGINIA--1993 SESSION

HOUSE JOINT RESOLUTION NO. 621

Requesting the Virginia Department of Health to prepare a statistical profile of women's health status in the Commonwealth.

Agreed to by the House of Delegates, February 4, 1993
Agreed to by the Senate, February 16, 1993

WHEREAS, women, as wage earners, care providers, child bearers and the nucleus of the family, play a vital role in supporting the economic and social structure of the Commonwealth; and

WHEREAS, although the majority of health service users are women, until recently, little research was conducted on diseases predominantly affecting women, such as lupus and breast cancer, or on how the sequela of specific diseases differ between women and men, e.g., human immunodeficiency virus infection and substance abuse; and

WHEREAS, gender comparisons of disease prevalence demonstrating lower disease rates for women than for men may mask the actual severity of women's health risk; and

WHEREAS, for example, although the incidence of some sexually transmitted diseases is lower among women, the possible complications for women of sexually transmitted diseases, some of which may remain asymptomatic in women, can be vastly greater, resulting in infertility, severe complications, particularly during pregnancy, and even death; and

WHEREAS, gender neutral reporting of mortality, disease, and lifestyle data may hide important issues related to women's health, as evidenced by statistics reporting an overall decline in smoking notwithstanding an increased incidence of smoking among adolescent and young adult women; and

WHEREAS, no constituency—medicine, business or government—possesses a complete picture of women's health status in the Commonwealth; and

WHEREAS, Virginia is committed to ensuring the highest quality health care to all its people in a fiscally responsible manner, increasing effectiveness of care and accessibility while containing costs; and

WHEREAS, the Commonwealth will spend over $3 billion over the next two years on health care services; and

WHEREAS, a compilation of statistics concerning women's health status in Virginia could provide valuable baseline data for meaningful policy decisions and reducing costs through increased efficiency and accessibility to appropriate care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Virginia Department of Health is hereby requested to prepare a statistical profile of women's health status in the Commonwealth, concentrating on women between the ages of twelve and sixty-four. The Department shall cooperate with other relevant federal, state and local agencies in developing this profile through utilization of available data. All agencies of the Commonwealth shall provide assistance to the Department by providing available data.

General data, necessary to interpreting health statistics, on age, race, education, single women heads of households, employment, salaries and incomes, and geographic locations of the women in Virginia shall be included in this profile.

In the profile, the Department shall also include, in so far as possible, health status information gathered according to women's age, race, income, education, and geographic locations describing:

1. Access to and cost of public and private health care providers and health insurance, with emphasis on continuity of care, early care, prevention, and health promotion;
2. Reproductive health, including family planning, pregnancy, infertility, and the relationship between the mother's health status and the incidences of babies with low birth weights or significant congenital anomalies;
3. Incidence of infectious diseases, including rubella, human immunodeficiency virus/acquired immunodeficiency syndrome, and other sexually transmitted diseases;
4. Incidence of acute and chronic diseases, disorders, and conditions, including, but not limited to, coronary heart disease, cancer, lupus, diabetes, and osteoporosis;
5. Incidence of mental illness and disorders, including clinical depression, suicide, and eating disorders;
6. Substance abuse;
7. Violence against women, including sexual assault, battering, and homicide; and
8. Incidence of mortality and disability from accidents.

Upon amassing the available data, the Department shall evaluate the information; identify current and potential women's health issues, including the targeting of resources; and recommend areas of further data collection or adjustments in data collection to provide needed unavailable information. The Department shall utilize the collected data to

prepare and distribute a concise brochure on women's health status in the Commonwealth for use by employers, health care providers, educators, and the various branches of state and local government.

The Department of Health shall report its interim findings to the Joint Commission on Health Care by November 1, 1993, and shall submit its final report to the Governor, the Joint Commission, and the 1994 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.