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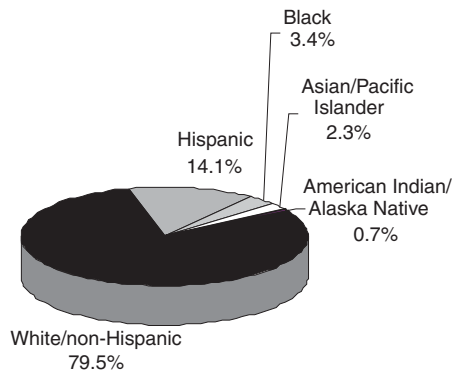
The Health of Women in Colorado

Jodi Drisko, M.S.P.H.

Introduction

Women comprise 50 percent of the adult population in Colorado. According to the 2000 U.S. Census, 1 in 5 (nearly 21%) are members of minority racial and ethnic groups. While many Colorado women maintain good health, disparities do exist for some racial/ethnic groups; that is to say that some groups experience worse health outcomes when compared to the majority population. This brief report will look at the health status, behaviors and outcomes among different racial/ethnic groups of adult women (ages 18 and over).

Figure 1. Population by race/ethnicity: Colorado women 2000



Source: U.S. Census.

Methodology

Five data sources were used to derive estimates for the indicators reported: Colorado 2003 birth certificate data, 2003 death certificate data, Behavioral Risk Factor Surveillance System (BRFSS)¹ 2001-2003 data, Pregnancy Risk Assessment Monitoring System (PRAMS)² 2001-2003 data, and 2002 Colorado Sexually Transmitted Disease data. All of these data were analyzed using five standard racial/ethnic groups³: White/non-Hispanic, Black/non-Hispanic, Hispanic, Asian/Pacific Islander and American Indian/Alaska Native. These groups will be referred to throughout this document as White, Black, Hispanic, Asian, and American Indian/Alaska Native. *Healthy People 2010* (HP2010) objectives are referenced where appropriate. The *Healthy People 2010* objectives are a series of national health-related measures designed to achieve two overarching goals: to increase quality and years of healthy life and to eliminate health disparities.

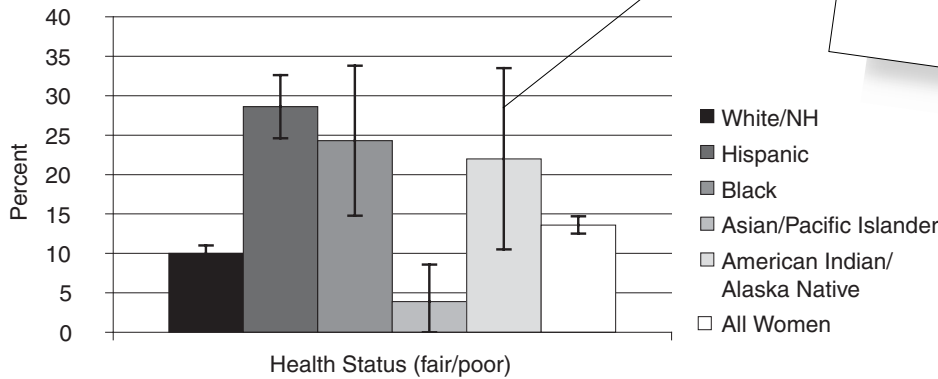
³ The Health Statistics Section joins the Centers for Disease Control and Prevention in recognizing that race and ethnicity do not represent valid biological or genetic categories but are social constructs with cultural and historical meaning.

Results

Health Status

Data from the BRFSS indicate that although the majority of Colorado women report their general health as excellent, very good or good, nearly 14 percent report they have fair or poor health. These data vary greatly among the different racial/ethnic groups of women. Hispanic and Black women are significantly more likely to report fair or poor health than White and Asian women.

Figure 2. Reported health status by race/ethnicity: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

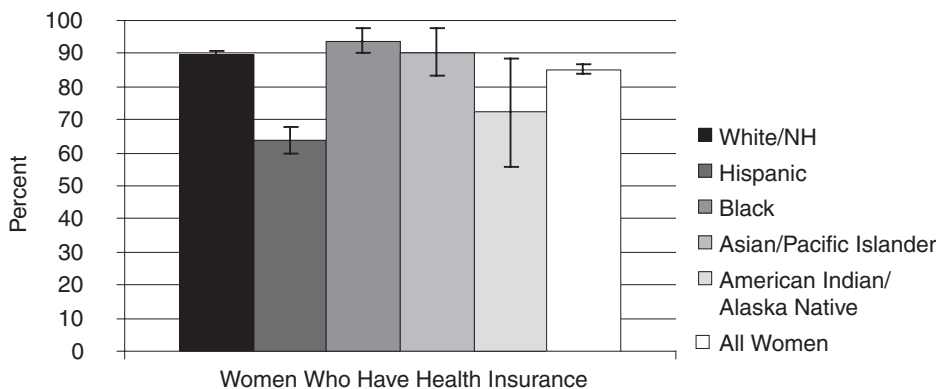
Statistics Primer
What are the lines on the graphs?

Error bars on graphs represent the 95 percent confidence interval for each point estimate. The upper and lower limit of the confidence interval represent the margin of error, or the range of values where the true rate lies 95% of the time. Confidence intervals are used for data that are a sample of the population.

Health Insurance

Access to health care is important to eliminate health disparities and increase the quality and years of healthy life for all women. Health insurance coverage greatly improves one's ability to access health services when needed. Hispanic women are less likely to have health insurance than other groups, with more than one-third of Hispanic women without health care coverage. Approximately 90 percent of Asian, Black and White women have some type of health insurance.

Figure 3. Health insurance status: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

Healthy People 2010 objective:

100% of people have health care coverage.

Weight

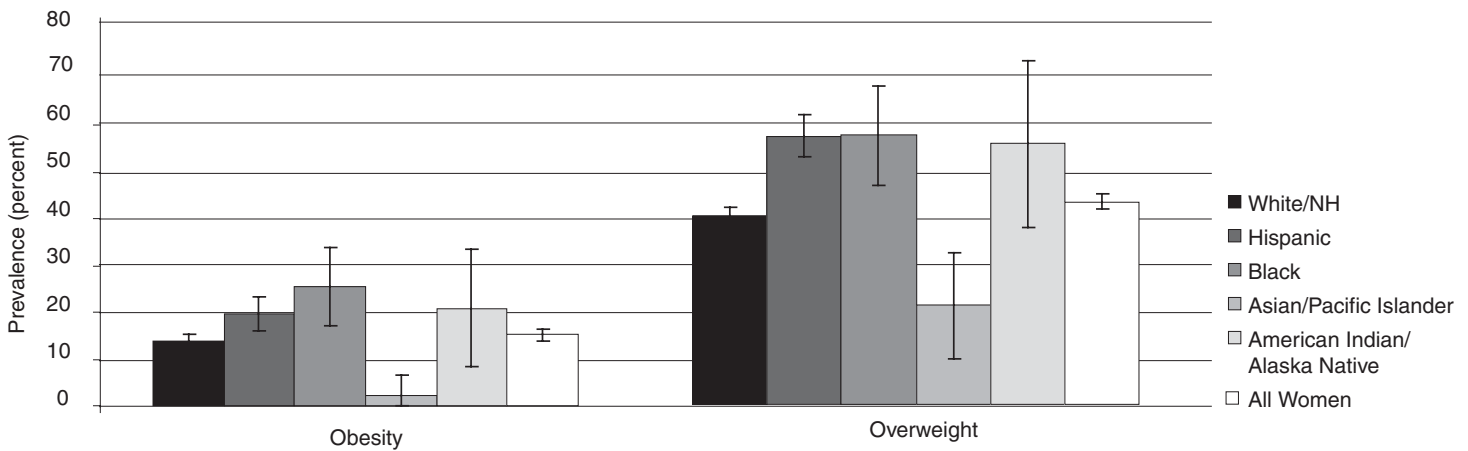
Overweight and obesity are major contributors to many preventable causes of death and disease. The proportion of overweight/obese individuals has been rapidly increasing over the last decade. Overweight is defined as having a body mass index (BMI) of 25 or greater and obesity is defined as having a BMI of 30 or greater. A healthy diet and regular physical activity are both important for maintaining a healthy weight.

Asian women have the lowest prevalence of obesity and overweight, while Hispanic and Black women have the highest prevalence. Over 50 percent of Hispanic, Black and American Indian/Alaska Native women are overweight, while only 20 percent of Asians are overweight. Asian and White/non-Hispanic women are the only groups that meet the HP2010 objective for obesity.

Healthy People 2010 objective:

15% of adults (20 years of age and older) are obese.

Figure 4. Obesity and overweight: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

Nutrition

The *Dietary Guidelines for Americans* recommend three to five servings of various vegetables and vegetable juices and two to four servings of various fruits and fruit juices per day depending on caloric need. In general, only 30 percent of Colorado

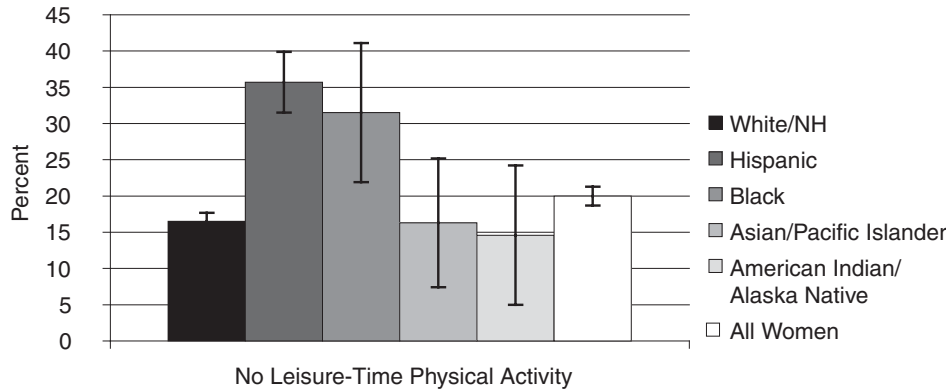
women eat 5 or more servings of fruits and vegetables per day. Although there is variation in the point prevalence among the different racial/ethnic groups, none of the groups are significantly different from one another.

Physical Activity

For most persons, the greatest opportunity for physical activity is associated with leisure time, because few occupations today provide sufficient vigorous or moderate physical activity to produce health benefits. Colorado women tend to be more active

than women in other states, with 80 percent of all women engaging in leisure-time physical activity. The proportion of Colorado women reporting no leisure-time physical activity is higher among Blacks and Hispanics than White women.

Figure 5. Prevalence of no leisure-time physical activity: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

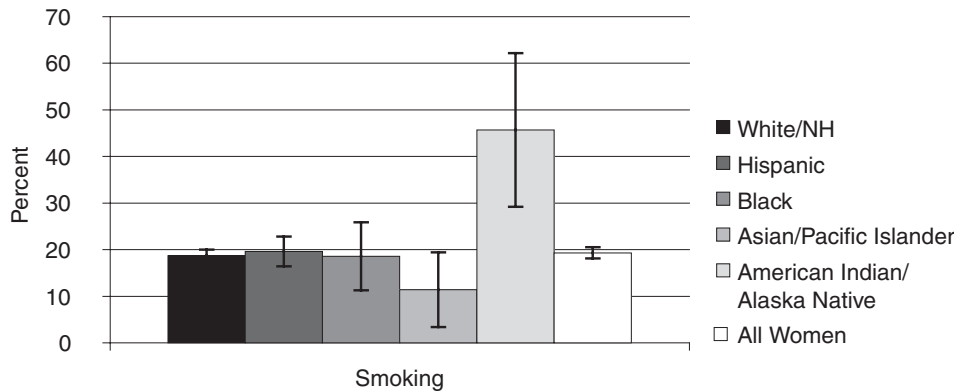
Healthy People 2010 objective:
20% or fewer adults engage in no leisure-time activity.

Smoking

Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth, and bladder), and chronic lung disease. While the prevalence of smoking has decreased over the last decade, many women continue to

smoke. Almost 20 percent of Colorado women smoke cigarettes. Asian women have the lowest prevalence of smoking (11%), while American Indian/Alaska Native women have the highest prevalence at 45 percent.

Figure 6. Prevalence of cigarette smoking: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

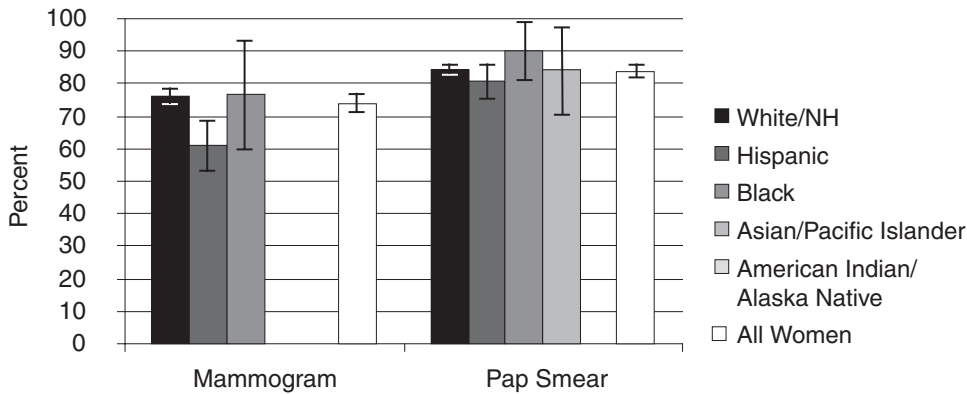
Healthy People 2010 objective:
Reduce cigarette smoking to 12%.

Preventive Health Screening

Breast cancer is the most common cancer among women in the United States. Deaths from breast cancer can be reduced substantially if tumors are discovered at an early stage. Mammography is the most effective method for detecting these early malignancies. Breast cancer deaths can be reduced through increased adherence to recommendations for regular mammography screening. Colorado women exceed the *Healthy People 2010* objective, with 74 percent reporting having a mammogram within the preceding two years. Fewer Hispanic women report having had a mammogram, putting them at risk for undetected breast cancer. Data are not reported for Asian and American Indian/Alaska Native women due to small numbers.

Cervical cancer is the tenth most common cancer among females in the United States. Considerable evidence suggests that screening can reduce the number of deaths from cervical cancer through early detection. A Pap test can identify changes in cervical tissue that may lead to cancer. If cervical cancer is detected early, with appropriate treatment and follow-up the likelihood of survival is almost 100 percent; that is, almost all cervical cancer deaths could be avoided if all females complied with screening and follow-up recommendations. Almost 84 percent of Colorado women report having a Pap test in the last three years. Black and Asian women are the only groups who are meeting the *Healthy People 2010* goal of 90 percent. White and Asian women are at 84 percent, while Hispanic women are at 81 percent. Data are not reported for American Indian/Alaska Native women due to small numbers.

Figure 7. Prevalence of meeting preventive screening guidelines: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

Healthy People 2010 objectives:

- 90% of women ages 18 years and older will receive a Pap test within the preceding 3 years.
- 70% of women ages 40 years and older will receive a mammogram within the preceding 2 years.

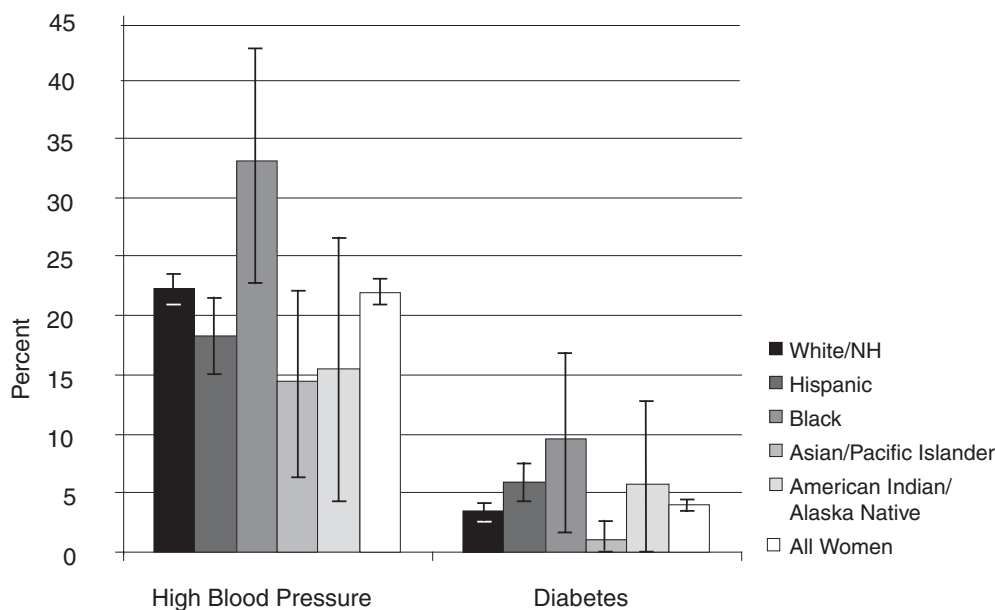
Chronic Health Conditions

High blood pressure is a risk factor for heart disease and stroke, two of the leading killers of women. Over 20 percent of Colorado women report having high blood pressure. One-third of Black women have high blood pressure, while roughly 15 percent of Asian and American Indian/Alaska Native women do.

The occurrence of diabetes in the United States has been steadily

increasing over the past decade, especially among certain racial/ethnic groups. Obesity, poor nutrition and lack of physical activity all contribute to diabetes. Among Coloradans, Asian women have the lowest prevalence of diabetes (1%) and Black women have the highest prevalence (9.5%). Among all Colorado women, the prevalence is 4 percent, almost twice as high as the *Healthy People 2010* objective.

Figure 8. Prevalence of high blood pressure and diabetes: Colorado women, 2001-2003



Source: Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE.

Healthy People 2010 objectives:

- Reduce the proportion of adults with high blood pressure to 16%.
- Reduce the overall rate of clinically diagnosed diabetes to 2.5%.

Reproductive Health

Sexually Transmitted Diseases

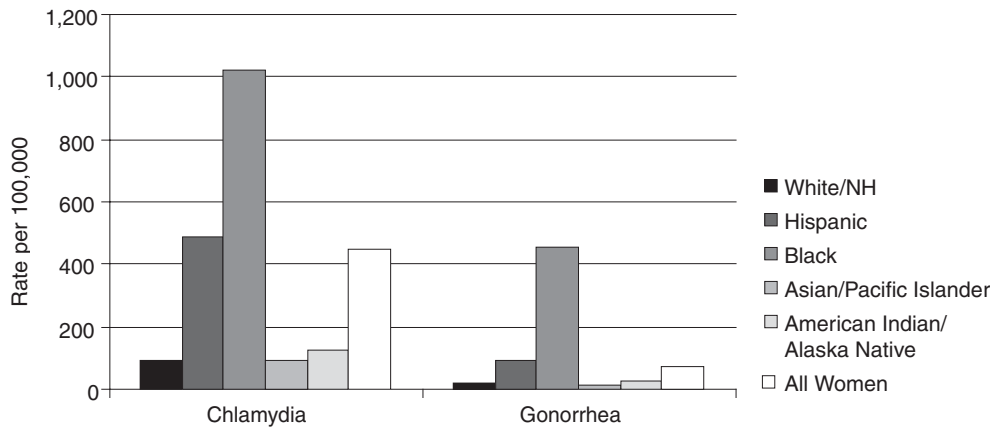
Sexually transmitted diseases (STDs) are infectious agents that are transmitted mainly through unprotected sex. Among the most serious STD complications are pelvic inflammatory disease (PID), ectopic pregnancy, infertility, and chronic pelvic pain. Both chlamydia and gonorrhea are bacterial infections that are reported to the Colorado Department of Public Health and Environment. The chlamydia rate for Black women (1,024.8 per 100,000) is 11 times higher than that of White women (92.9 per 100,000). The Hispanic rate (489.3 per 100,000) for chlamydia

is 5 times higher than for White women. Gonorrhea rates show a similar pattern, with White women having a rate of 17.5, 95.1 for Hispanic women and 457.4 for Black women (all rates per 100,000). These data represent rates that are 5 times higher for Hispanic women and 26 times higher for Black women when compared to White women.

Healthy People 2010 objective:

Gonorrhea rates will decrease to 19 per 100,000 population.

Figure 9. Sexually transmitted disease rates: Colorado women, 2002



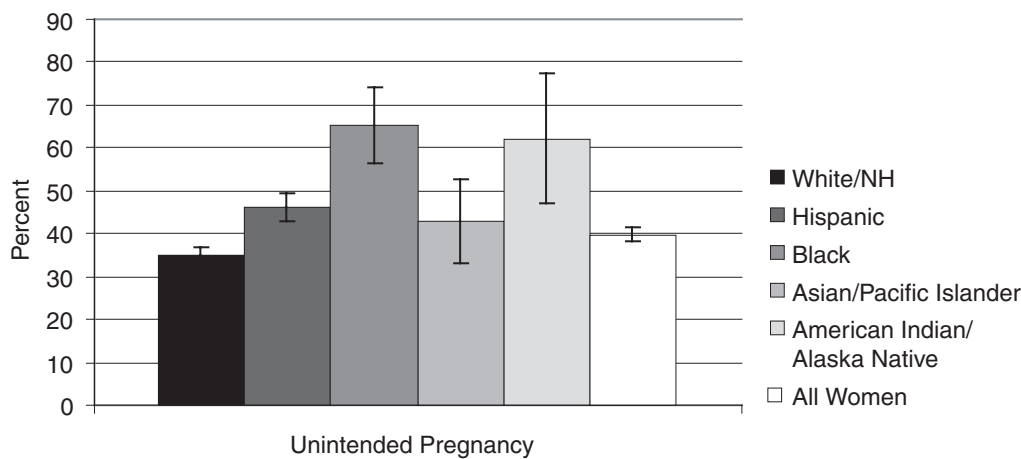
Source: Colorado Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division.

Unintended Pregnancy

Unintended pregnancy has been shown to result in adverse health outcomes that affect the mother, infant, and family. Unintended pregnancy is often thought of as a predominantly adolescent problem; however, unintended pregnancy is a problem among all reproductive age groups. *Unintended* is a broad term that includes pregnancies a woman characterizes as either unwanted (pregnancy not wanted at any time) or mistimed (pregnancy not wanted until some time in the future) at the time of conception. The data depicted here represent unin-

tended pregnancies that resulted in a live birth. Among all Colorado women, nearly 40 percent of births are the result of an unintended pregnancy. The proportion of live births resulting from an unintended pregnancy among Black women is 65.2 percent and among American Indian/Alaska Native women is 62.2 percent. The proportion for Hispanic women is 46.1 percent; Asian women, 42.9 percent; and White women, 35.9 percent.

Figure 10. Proportion of live births resulting from an unintended pregnancy: Colorado women, 2001-2003



Source: Pregnancy Risk Assessment Monitoring System, Health Statistics Section, CDPHE

Prenatal Care

The use of early and continuous prenatal care can identify women at high risk and provide for necessary follow-up treatment and/or education. Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. Each component can contribute to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use, which contribute to poor outcomes.

The *Healthy People 2010* objective is for 90 percent of women to have early, adequate care³ (or 10% inadequate care). White women are the only group of Colorado women who have

achieved this objective. Hispanic, Black and American Indian/Alaska Native women in Colorado all have more than 20 percent inadequate care. This is often due to late entry into care (after the first trimester) and not receiving the recommended number of visits.

Healthy People 2010 objective:

Increase early and adequate prenatal care to 90% (10% inadequate care).

Leading Causes of Death

The five leading causes of death for women vary by racial/ethnic group. Heart disease and cancer are among the top three leading causes of death for all groups of women. The diseases that cause the most deaths among the Asian and American Indian/Alaska Native populations differ somewhat from year to year due to small numbers. Diabetes is one of the top five causes of death

among Hispanic, Black, and American Indian/Alaska Native women in Colorado. Unintentional injury is a leading cause of death among Hispanic, Asian, and American Indian/Alaska Native women. Alzheimer's disease is one of the top five causes of death among White women, but not for the other racial/ethnic groups.

Table 1. Leading causes of death by race/ethnicity: Colorado females (all ages), 2003

Rank	White/NH	White/Hispanic	Black	Asian	American Indian/ Alaska Native	All Women
1	Heart Disease	Malignant Neoplasms	Heart Disease	Malignant Neoplasms	Heart Disease	Heart Disease
2	Malignant Neoplasms	Heart Disease	Malignant Neoplasms	Cerebrovascular Disease	Malignant Neoplasms	Malignant Neoplasms
3	Chronic Lower Respiratory Diseases	Cerebrovascular Disease	Cerebrovascular Disease	Heart Disease	Unintentional Injuries	Cerebrovascular Disease
4	Cerebrovascular Disease	Diabetes Mellitus	Diabetes Mellitus	Unintentional Injuries	Diabetes Mellitus	Chronic Lower Respiratory Diseases
5	Alzheimer's Disease	Unintentional Injuries	Atherosclerosis	Septicemia	Cerebrovascular Disease	Alzheimer's Disease

Source: Death certificate data, Health Statistics Section, CDPHE.

Conclusion

Health and health behaviors vary significantly among various racial/ethnic groups of women. These data show the differences that exist for a handful of health indicators. A fuller picture of health disparities in women can be seen by looking at health data by racial/ethnic group. Since women of color only represent 20 percent of all women in Colo-

rado, looking at summary data for the total population masks many differences among subpopulations. Attention should be paid to these differences to effectively address health disparities in Colorado. Data can be used to gain a fuller understanding of the overall picture of health among various racial/ethnic groups of women.

Additional Information

For more information about Colorado health data, visit the Colorado Department of Public Health and Environment Web site at:

www.cdphe.state.co.us

and click on *Health/Disease Statistics*. Data can also be queried using the Colorado Health Information Dataset (CoHID) at www.cdphe.state.co.us/cohid, or contact the Health Statistics Section at the Colorado Department of Public Health and Environment, 303-692-2160.

¹ The Colorado BRFSS is an ongoing statewide random digital telephone survey of Coloradans ages 18 and older regarding their health, health behaviors and preventive health practices.

² PRAMS is a population-based risk factor surveillance system designed to identify and monitor behaviors and experiences of women before, during, and after pregnancy. Information is collected by surveying a sample of women who have recently given birth.

³ Calculation based on entry into care, number of visits and gestational age