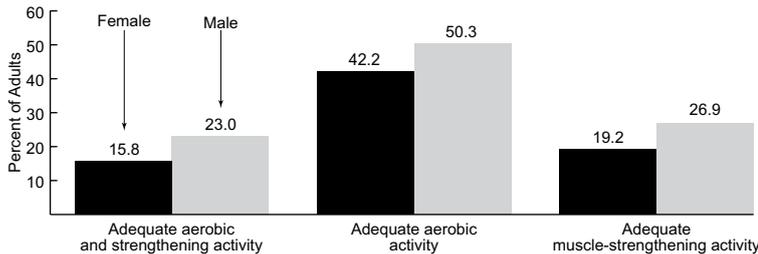


PHYSICAL ACTIVITY

Regular physical activity is critical for people of all ages to achieve and maintain a healthy body weight, prevent chronic disease, and promote psychological well-being. In older adults, physical activity also helps to prevent falls and improve cognitive functioning.¹ The 2008 Physical Activity Guidelines for Americans state that for substantial health benefits, adults should engage in at least 2½ hours per week of moderate intensity (e.g., brisk walking or gardening) or 1¼ hours per week of vigorous-intensity aerobic physical activity (e.g., jogging or kick-boxing), or an equivalent combination of both, plus muscle-strengthening activities on at least 2 days per week. Additional health benefits are gained by engaging in physical activity beyond this amount.¹

Adequate Physical Activity* Among Adults Aged 18 and Older, by Activity Type and Sex, 2008–2010

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Adequate aerobic activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous-intensity activity, or an equivalent combination of both; adequate muscle-strengthening activity is defined as performing muscle-strengthening activities, such as lifting weights or calisthenics, on 2 or more days per week; all estimates are age-adjusted.

In 2008–2010, 15.8 percent of women met the recommendations for adequate aerobic and muscle-strengthening physical activity, compared to 23.0 percent of men. Women were much more likely to have engaged in adequate amounts of aerobic activity, however, compared to muscle-strengthening activity (42.2 versus 19.2 percent, respectively).

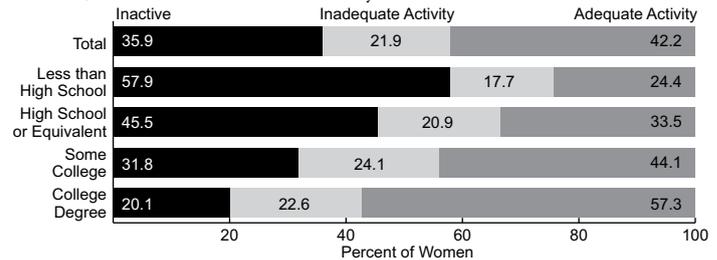
With regard to aerobic activity, about one in five women engaged in an inadequate amount of activity (21.9 percent) and more than one-third reported being inactive (35.9 percent). Inactivity tended to decrease as level of education increased, while the reverse was true for adequate activity. For instance, 57.9 percent of women with less than a high school diploma were inactive, compared to 20.1 percent of women with a college

degree. Similarly, about one-quarter of women who did not graduate high school engaged in adequate aerobic activity, compared to 57.3 percent of women with a college degree.

The proportion of women engaging in aerobic activity also varied with race and ethnicity. Nearly 50 percent of non-Hispanic Black and Hispanic women reported being inactive in 2008–2010 (48.6 and 48.4 percent, respectively), compared to less than one-third of non-Hispanic White women (31.0 percent). More than 40 percent of non-Hispanic American Indian/Alaska Native women also reported being inactive (data not shown). This is particularly important because of strong evidence linking sedentary behavior with the onset of multiple chronic diseases.¹

Aerobic Physical Activity Levels* Among Women Aged 18 and Older, by Level of Education, 2008–2010

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Adequate aerobic activity is defined as 2.5 hours per week of moderate-intensity activity or 1.25 hours per week of vigorous intensity activity, or an equivalent combination of both; inadequate activity is defined as moderate or vigorous activity for 10 minutes or more per week but less than then recommended level for adequate activity; inactive is defined as no leisure-time aerobic activity that lasted at least 10 minutes.

NUTRITION

The *2010 Dietary Guidelines for Americans* recommends eating a variety of nutrient-dense foods while not exceeding caloric needs. Nutrient dense foods include fruits, vegetables, whole grains, lean meats and poultry, eggs, beans and peas. In particular, the U.S. Department of Agriculture's *MyPlate* recommends that fruits and vegetables should account for half of foods consumed daily.²

In 2009, less than one-third of adults in the United States reported consuming fruit two or more times per day (32.5 percent) and vegetables three or more times per day (26.5 percent; data not shown). Women were more likely than men to have consumed fruit at least twice

daily (36.1 versus 28.8 percent, respectively) and vegetables at least three times daily (30.9 and 21.3 percent, respectively; data not shown). Among women, fruit and vegetable consumption varied by education, race and ethnicity, and Body Mass Index (BMI).

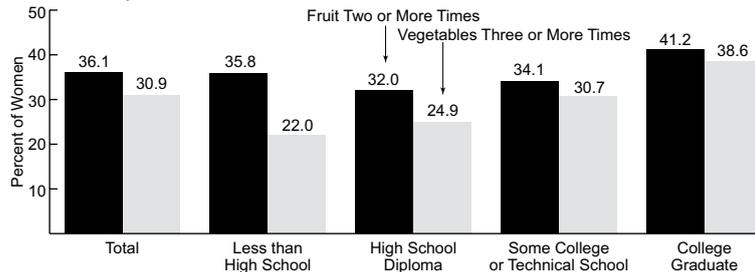
Women without a high school diploma were least likely to have reported consuming vegetables three or more times per day (22.0 percent), while those with a college degree were most likely to have done so (38.6 percent). Similarly, more than 40 percent of college-educated women consumed fruit twice or more daily, compared to about one-third of women with lower levels of education. With regard to race and ethnicity, only about one-quarter of non-

Hispanic Black and Hispanic women consumed vegetables three or more times daily (24.5 and 23.8 percent, respectively) compared to more than 32 percent for all other races and ethnicities (data not shown).

Obese women (BMI ≥ 30) also had lower fruit and vegetable consumption than those who were neither overweight nor obese (BMI < 25). For instance, only 31.6 percent of obese women consumed fruit two or more times per day, compared to 39.3 percent of women who were neither overweight nor obese. Diets high in fruits and vegetables may reduce the risk of many chronic diseases, and fruits and vegetables generally have fewer calories than other foods, which can contribute to better weight management.²

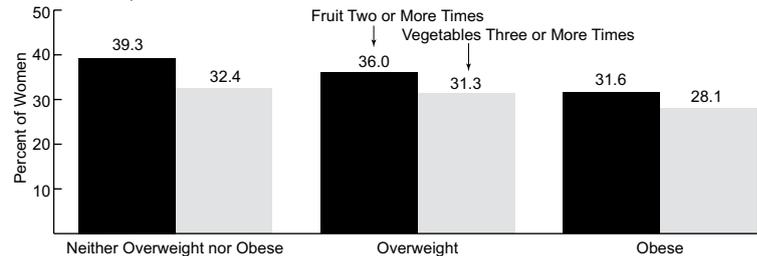
Daily Fruit and Vegetable Consumption Among Women Aged 18 and Older, by Level of Education, 2009

Source II.2: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



Daily Fruit and Vegetable Consumption Among Women Aged 18 and Older, by Weight Status,* 2009

Source II.2: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Neither overweight nor obese is defined as having a BMI of less than 25.0; overweight is defined as having a BMI between 25.0 and 29.9; and obese is defined as having a BMI of 30.0 or more.

ALCOHOL USE

Ethyl alcohol is an intoxicating ingredient found in beer, wine, and liquor which is produced by the fermentation of yeast, sugars, and starches.³ According to the *2010 Dietary Guidelines for Americans*, when alcohol is consumed it should be in moderation and limited to no more than one drink per day for women and two drinks per day for men.² While moderate alcohol consumption may have health benefits² – depending, in part, on the characteristics of the person consuming the alcohol – excessive drinking can lead to many adverse health and social consequences including injury, violence, risky sexual behavior, alcoholism, unemployment, liver diseases, and various cancers.⁴

Excessive drinking includes binge and heavy drinking. The Centers for Disease Control and Prevention defines heavy drinking as consuming more than one drink per day on average for women and two drinks per day on average for men. Binge drinking is defined as drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men (usually over the course of about 2 hours).³

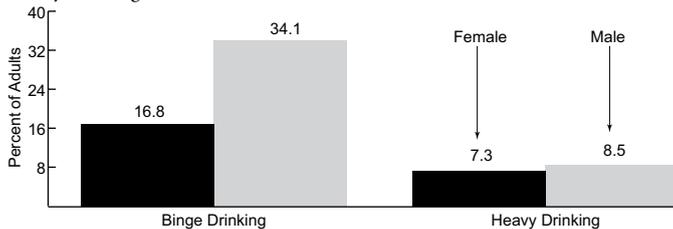
In 2009–2010, men were more likely than women to report both heavy drinking (8.5 versus 7.3 percent, respectively) and binge drinking (34.1 versus 16.8 percent, respectively) in the past 30 days. Despite being less likely to binge drink or drink heavily, women tend to face alcohol-related problems at a lower drink-

ing level than men due to differences in body size and other biological factors.⁵

Binge and heavy drinking among women varies significantly by age, as well as race and ethnicity. Younger women aged 18–25 years were more likely than women of other age groups to report binge and heavy drinking in the past month (33.3 versus 11.5 percent, respectively; data not shown). With respect to race and ethnicity, about 16 percent or more of women in every race and ethnic group reported binge drinking with the exception of non-Hispanic Asian women (7.9 percent). Heavy drinking was most commonly reported among non-Hispanic White women, non-Hispanic women of multiple races, and non-Hispanic American Indian/Alaska Native women (8.7, 7.6, and 6.8 percent, respectively).

Alcohol Use in the Past Month Among Adults Aged 18 and Older, by Level of Drinking* and Sex, 2009–2010

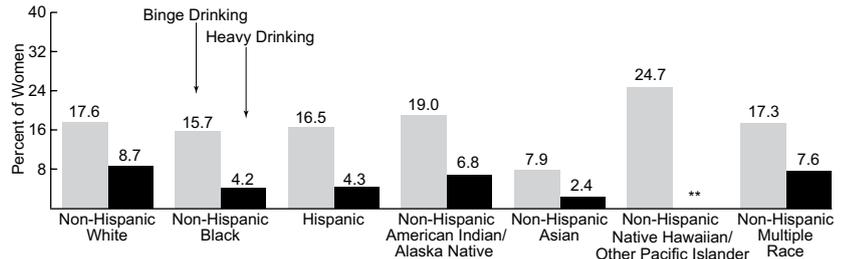
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Binge drinking indicates drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men usually over the course of about 2 hours. Heavy drinking indicates consumption of more than one drink per day on average for women and two drinks per day on average for men.

Binge and Heavy Alcohol Use* in the Past Month Among Women Aged 18 and Older, by Race/Ethnicity, 2009–2010

Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Binge drinking indicates drinking four or more drinks on a single occasion for women and five or more drinks on a single occasion for men usually over the course of about 2 hours. Heavy drinking indicates consumption of more than one drink per day on average for women and two drinks per day on average for men. **Estimate does not meet the standards of reliability or precision.

CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking damages every organ in the human body.⁶ Cigarette smoke contains toxic ingredients that prevent red blood cells from carrying a full load of oxygen, impair genes that control the growth of cells, and bind to the airways of smokers. This contributes to numerous chronic illnesses, including several types of cancers, chronic obstructive pulmonary disease, cardiovascular disease, reduced bone density and fertility, and premature death.⁶ Due to its high prevalence and wide-ranging health consequences, smoking is the single largest cause of preventable death and disease for both men and women in the United States, accounting for an estimated 443,000 premature deaths annually.⁷

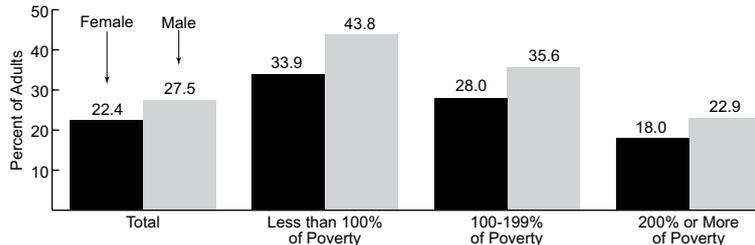
In 2009–2010, women aged 18 and older were less likely than men to report cigarette smoking in the past month (22.4 versus 27.5 percent, respectively). For both men and women, smoking was more common among those with lower incomes. For example, 33.9 percent of women and 43.8 percent of men with household incomes below 100 percent of poverty smoked in the past month, compared to 18.0 percent of women and 22.9 percent of men with incomes of 200 percent or more of poverty. Smoking also varied by race and ethnicity. Among women, smoking prevalence ranged from 6.8 percent among non-Hispanic Asians to 33.1 percent among non-Hispanic American Indian/Alaska Natives (data not shown).

Quitting smoking has major and immedi-

ate health benefits, including reducing the risk of diseases caused by smoking and improving overall health.⁶ In 2009–2010, about 8 percent of women and men who had ever smoked daily and smoked in the previous 3 years had not smoked in the past year. The proportion of adults who quit smoking varied by poverty level for both women and men. For example, women with household incomes of 200 percent or more of poverty were almost twice as likely to have quit smoking as women with household incomes below 100 percent of poverty (9.7 versus 5.6 percent, respectively). In 2011, six States covered comprehensive tobacco cessation benefits in their Medicaid programs and nine states required private insurance plans to cover tobacco cessation treatment.⁸

Cigarette Smoking in the Past Month Among Adults Aged 18 and Older, by Poverty Status* and Sex, 2009–2010

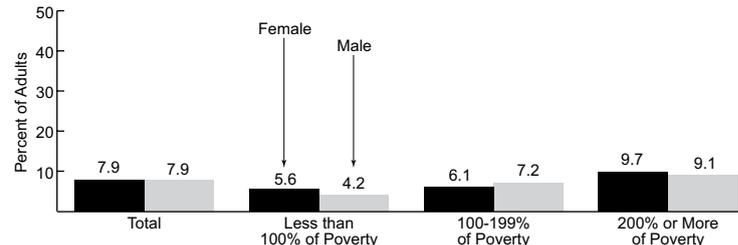
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

Smoking Cessation* in the Past Year Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2009–2010

Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Defined as the proportion of adults who did not smoke in the past year among those who ever smoked daily at some point in their lives and smoked in the past 3 years; excludes adults who started smoking in the past year. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

ILLICIT DRUG USE

Illicit drug use is associated with serious health and social consequences, including addiction and drug-induced death, impaired cognitive functioning, kidney and liver damage, infections—including HIV and Hepatitis—decreased productivity, and family disintegration.^{9,10} Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type psychotherapeutic drugs, such as pain relievers, stimulants, and sedatives. Methamphetamine is a type of psychotherapeutic drug that, in low doses, has limited medical use for narcolepsy and attention

deficit disorder, and is now manufactured and distributed illegally.⁹

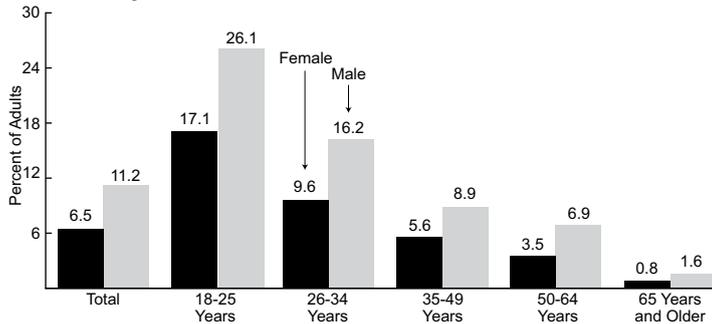
In 2009–2010, 6.5 percent of adult women aged 18 years and older reported using an illicit drug within the past month, compared to 11.2 percent of adult men. Illicit drug use was highest among younger adults; 17.1 of women aged 18–25 reported past-month illicit drug use compared to 9.6 percent of women aged 26–34 and 5.6 percent of women aged 35–49. Rates of past-month illicit drug use also varied by race and ethnicity. Non-Hispanic Asian women were less likely than other women to report past-month use (2.1 percent, data not shown). Mari-

juana was the most commonly used illicit drug among adult women (4.6 percent), followed by the non-medical use of psychotherapeutics (2.4 percent; data not shown).

Past-month illicit drug use varied by poverty level. Among both men and women, illicit drug use was more common among those with lower incomes. For example, 10.4 percent of women and 19.5 percent of men with household incomes below 100 percent of poverty used illicit drugs in the past month, compared to 5.4 percent of women and 9.3 percent of men with incomes of 200 percent or more of poverty.

Any Illicit Drug Use* in the Past Month Among Adults Aged 18 and Older, by Age and Sex, 2009–2010

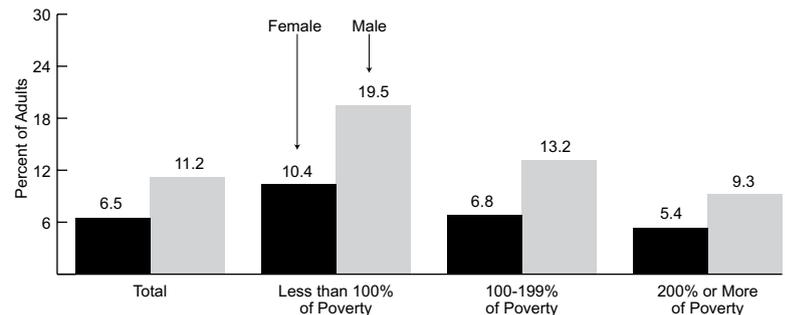
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes.

Any Illicit Drug Use* in the Past Month Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2009–2010

Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and any prescription-type psychotherapeutic drugs used for non-medical purposes. **Poverty level, defined by the U.S. Census Bureau, was \$22,314 for a family of four in 2010; adults aged 18-22 years living in college dormitories were excluded from poverty determinations.

SEXUAL RISK BEHAVIORS

Sexually Transmitted Infections (STIs) can cause a variety of health problems among women if left untreated. Health outcomes that have been associated with untreated STIs include cervical cancer, pelvic inflammatory disease, infertility, and even death in the case of HIV/AIDS (see pages on *Sexually Transmitted Infections* and *HIV/AIDS*).^{11,12} Women can lower their risk of contracting HIV and other STIs by avoiding sexual risk-taking behaviors.

In 2006–2010, 3.9 percent of women aged 15–44 reported engaging in at least one sexual risk behavior during the past 12 months (data not shown). Among women aged 15–44, the most commonly reported sexual risk behaviors

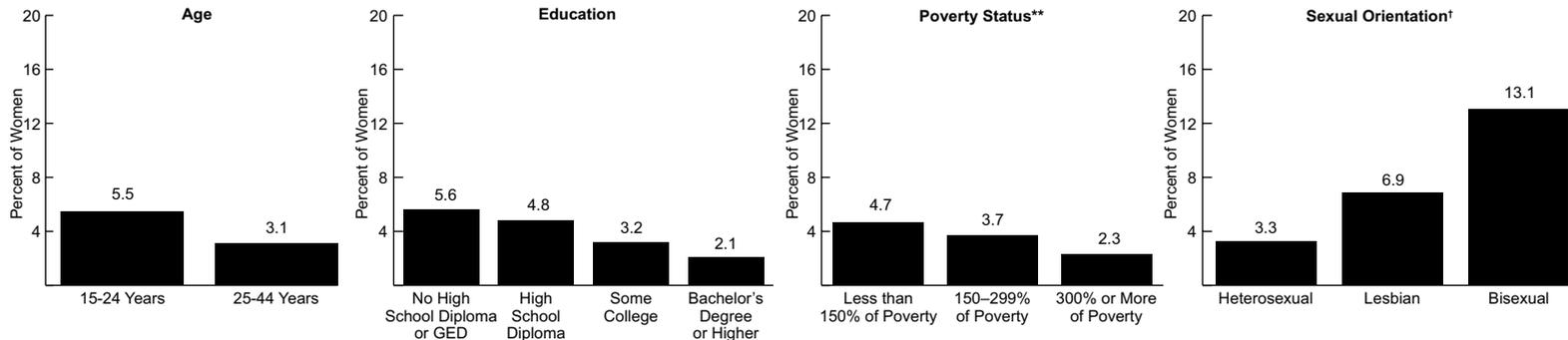
were having five or more male sex partners in the past 12 months (1.8 percent) and having had at least one male sex partner who had had sex with other males (1.4 percent). Less than 1 percent of women reported having had sex in exchange for money or drugs (0.7 percent), having had a sex partner that injects illicit drugs (0.8 percent), or having had an HIV-positive sex partner (0.1 percent; data not shown).

The prevalence of engaging in sexual risk behaviors among women varied by sociodemographic characteristics. Younger women, aged 15–24 years, were more likely to report engaging in at least one sexual risk behavior during the past 12 months (5.5 percent), compared to

women aged 25–44 years (3.1 percent). Women with a high school education or less were also more likely to report any sexual risk behavior compared to those with at least some college, as were women living with household incomes below 150 percent of poverty (4.7 percent) compared to women living with incomes of 150–299 and 300 percent or more of poverty (3.7 and 2.3 percent, respectively). Bisexual women were more likely than heterosexual women to report having engaged in at least one sexual risk behavior during the past 12 months (13.1 versus 3.3 percent, respectively), while no statistically significant difference was observed for lesbian women, compared to heterosexual women.

Any Sexual Risk Taking Behavior* Among Women Aged 15–44 Years, by Selected Characteristics, 2006–2010

Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



*Includes having had more than five opposite-sex sex partners, having sex in exchange for money or drugs, having a male sex partner who has had sex with other males, having a sex partner who injects illicit drugs, or having an HIV-positive sex partner. **Estimates by poverty status are limited to women aged 20–44 years of age at the time of the interview. †Estimates by sexual orientation are limited to women aged 18–44 years of age at the time of the interview.