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30 Achievements in Women's Health in 30 Years (1984 – 2014)

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Introduction

Since the establishment of the HHS Coordinating Committee on Women’s Health (CCWH) in 1984, we have made significant strides in improving the physical and mental health of women in the United States. Along with the U.S. Congress, the White House, and millions of women, health care providers, and researchers, the agencies and offices represented on the Committee played a key role in these achievements. Together we have improved access to health care, implemented new programs, developed or funded new treatments and screening techniques, executed key policy changes, approved lifesaving vaccines, issued landmark reports, and much more.

In May 1983, the HHS Assistant Secretary for Health appointed the first-ever task force to identify women’s health issues and to identify an action plan on women’s health. The [Public Health Service Task Force on Women’s Health](#) was the precursor to the CCWH.

In honor of the Committee’s 30th anniversary in 2014, we highlight here 30 of the most noteworthy achievements in women’s health between 1984 and 2014. These achievements include everything from improvements in breast cancer screening to the inclusion of women in clinical trials to the approval of an HPV vaccine and the enactment of the Affordable Care Act. Join us in celebrating our anniversary by learning more about how together we have changed the course of women’s health and where we can go in the future.

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Affordable Care Act Improves Women's Health

The 2010 passage of the [Affordable Care Act](#), also known as health care reform, is the most important advance in women's health policy since Medicare became law in 1965. The law increases the number of American women who can get health insurance, lowers the costs of health care for many women, and improves the quality of the health care women receive.

The Affordable Care Act also improves preventive care for women – providing for evidence-based [preventive services](#) at no cost – including annual mammograms and well-woman visits, birth control, and breastfeeding support.

Under the Affordable Care Act, women cannot be charged more simply because they are women, nor can they be denied health insurance coverage because of a preexisting health condition, such as cancer, pregnancy, or diabetes. And there are no more annual or lifetime dollar limits on coverage.

[Learn more](#) about the Affordable Care Act and how it addresses the unique needs of women.

Increasing Women's Lifespan

Over the past 30 years women have been living longer. In 1984, a woman's life expectancy was 78.¹ Today, women on average live to 81 — and that number continues to rise.² However, the life expectancy of American women ranks far below Asian and European women, whose life expectancies range from 87 to 90 years.³

Living longer means more women are at risk for chronic conditions such as heart disease, cancer, stroke, and Alzheimer's disease. But, there's good news, too. Women are living longer because of preventive measures and new, better treatments for diseases, according to a recent CDC report.⁴ A large majority of this prevention and improved treatment results from federally funded research from agencies such as NIH, CDC, AHRQ, and SAMHSA.

Other examples of HHS' work are programs that target health behaviors or specific diseases, such as heart disease, which is the leading cause of death for American women. Recent programs and campaigns include the CDC's [Well-integrated Screening and Evaluation for Women Across the Nation](#) (WISEWOMAN) program, NHLBI's [The Heart Truth](#)[®] and OWH's [Make the Call. Don't Miss a Beat](#).

Programs and campaigns across the government help raise awareness and support women in taking care of their health. But we still have improvements to make. In the next 30 years, we all need to work together to support women in their decisions to stop smoking, eat healthier, get active, and see their doctor regularly for screenings. Thanks to the passage of the 2010 Affordable Care Act, many women can now get annual well-woman visits and many [preventive services](#) at no cost. Together we can help women live longer.

¹ CDC, [National Vital Statistics Reports](#)

² CDC, [National Vital Statistics Reports](#)

³ WHO, [Life expectancy: Life expectancy - Data by country](#)

⁴ CDC, [National Vital Statistics Reports](#)

Improvements in Breast Cancer Screening

A mammogram is an X-ray picture of the breast used to check for breast cancer, the second most deadly cancer in women.¹ Mammograms can find cancer early, sometimes up to three years before a woman or her doctor can feel a lump², and more than 90% of these early-stage cancers can be cured.³

In 1987, only 27% of women 50 and older reported having a mammogram in the previous two years.⁴ Today, 72% of women 50 and older report having a mammogram in the last two years.⁵ [Federally Qualified Health Centers](#) (FQHCs), sponsored by HRSA, also experienced improvements in breast cancer screening rates. The number of women getting screened at FQHCs increased from 63% in 1995 to 76% in 2002.⁶

Beginning in 2002, HRSA sponsored targeted efforts to increase screening rates for breast cancer as well as colon and cervical cancers. A 2005 study found that breast cancer deaths in the United States have dropped about 10% because of mammography screening.⁷ Under the 2010 Affordable Care Act, most insurance companies must now cover [breast cancer screening](#) at no cost to women over 40.

In 1990, Congress directed the CDC to create the [National Breast and Cervical Cancer Early Detection Program](#) (NBCCEDP). Since 1991, NBCCEDP-funded programs have:

- Served 4.4 million low-income, uninsured, and underserved women
- Provided 11 million breast and cervical cancer screening examinations
- Diagnosed more than 59,000 breast cancers

In 1992, Congress passed the [Mammography Quality Standards Act](#). By October 1, 1994, all mammography facilities were certified by the FDA, ensuring American women nationwide have access to quality mammography services.⁸

¹ NIH, NCI, [A Snapshot of Breast Cancer](#)

² CDC, [What Is a Mammogram and When Should I Get One?](#)

³ NIH, NCI, [Cancer of the Breast - SEER Stat Fact Sheets: Breast Cancer](#)

⁴ CDC, [Table 82 \(page 1 of 3\)](#)

⁵ CDC, [Cancer Screening — United States, 2010](#)

⁶ HRSA, [Breast Cancer Screening](#)

⁷ HRSA, [Breast Cancer Screening](#)

⁸ ASL, [Testimony on The Mammography Quality Standards Act \(MQSA\) of 1992 by D. Bruce Burlington, M.D.](#)

Decrease in Breast Cancer Deaths

Today, fewer American women are dying from breast cancer. In the past 10 years, the death rates from breast cancer have dropped an average of 1.9% per year, while the rate of breast cancer diagnoses has been stable.¹ Federally funded research, increased screening, and new and improved treatments have saved lives and improved women's quality of life when they are confronted with a breast cancer diagnosis.

30 years ago...	Today...
Breast cancer death rates for all women peaked in 1985 at 32.98 per 100,000 women. ²	Thanks to new cancer treatments and screening that finds cancer earlier, the breast cancer death rate for all women continues to decline, and is currently at 21.92 per 100,000 women. ³
Mastectomy (surgery to remove the breast) was the commonly accepted surgical option for breast cancer treatment. ⁴	Breast-conserving surgery (lumpectomy) and radiation treatment have replaced mastectomy for the treatment of early-stage breast cancer. ⁵
Scientists began studying hormonal treatments (called selective estrogen receptor modulators, or SERMs) after breast cancer surgery. ⁶	Hormonal medications (like tamoxifen) are now standard for estrogen receptor-positive breast cancer, both as an additional treatment before or after surgery, and in treating inoperable breast cancer. ⁷
We did not know which genetic factors increased a woman's risk for breast cancer. ⁸	We now know of several genetic mutations (changes to genes) that can lead to breast cancer, including <i>BRCA1</i> , <i>BRCA2</i> , <i>TP53</i> , and <i>PTEN/MMAC1</i> . ⁹
Prevention of breast cancer seemed unlikely.	Women who are at high risk because of a breast cancer gene (or other family history) now have medical and surgical options to help prevent breast cancer. And all women can take steps, such as eating right and exercising, to help reduce their risk for breast cancer. ¹⁰

¹ NIH, NCI, [Cancer of the Breast - SEER Stat Fact Sheets: Breast Cancer](#)

² NIH, NCI, [Cancer Statistics Review, 1975-2010 - Table 4.10 Cancer of the Female Breast \(Invasive\)](#)

³ NIH, NCI, [Cancer Statistics Review, 1975-2010 - Table 4.10 Cancer of the Female Breast \(Invasive\)](#)

⁴ NIH, NCI, [Cancer Advances in Focus – Breast Cancer](#)

⁵ NIH, NCI, [Cancer Trends Progress Report – 2011/2012 Update – Breast Cancer Treatment](#)

⁶ NIH, NCI, [Cancer Advances in Focus – Breast Cancer](#)

⁷ NIH, NCI, [Cancer Advances in Focus – Breast Cancer](#)

⁸ NIH, NCI, [Cancer Advances in Focus – Breast Cancer](#)

⁹ NIH, NCI, [Cancer Advances in Focus – Breast Cancer](#)

¹⁰ NIH, NCI, [Breast Cancer Risk in American Women](#)

Decrease in Smoking Rates in Women

Today millions more women are smoke-free than 30 years ago. In 1985, 28% of adult women in the United States reported smoking.¹ In 2012, that percentage had dropped to 16% of adult women.²

The landmark Surgeon General's 1964 report, [Smoking and Health](#), was the first federal report to highlight harmful effects of smoking during pregnancy and the first federal report to identify lung cancer as a probable result of smoking in women. The highest smoking rate among American women was in 1963, when 34% were smokers.³

Subsequent [reports](#) from the Surgeon General in 1980 and 2001 focused specifically on the health risks women face because of smoking. Women and men who smoke have a greater risk for many health problems, including heart disease, stroke, and lung cancer.⁴ But smoking also affects women in different ways than men. Smoking can cause painful periods, earlier menopause, infertility, and depression.⁵ Pregnant women who smoke also increase their baby's risk for sudden infant death syndrome (SIDS) and low birth weight.⁶

Since 1987, the CDC's [Pregnancy Risk Assessment Monitoring System](#) has collected data from new mothers on their health, including tobacco use. In 1989, 19.5% of women reported smoking during pregnancy.⁷ In 2010, over half of the women who smoked before pregnancy (54%) quit during pregnancy.⁸ In 2012, the prevalence of women smoking during pregnancy was down to 12%.⁹

In 2012, the CDC began the [Tips From Former Smokers](#) campaign, resulting in 1.6 million additional smokers making a quit attempt and adding a half a million quality-adjusted life-years to the U.S. population.¹⁰

The 2014 Surgeon General's [report](#) on smoking and health highlights the success of federal and state programs and outlines a national strategy for ending the tobacco epidemic. The 2010 Affordable Care Act expands access to smoking cessation services and now requires most insurance companies to [cover cessation treatments and medications](#). The federal government offers free smoking cessation services in many formats – by phone, app, texts, websites, and print publications. [Learn more](#) about these free quit smoking resources for women.

¹ CDC/NCHS, [Table 54](#) (page 1 of 2). Current cigarette smoking among adults aged 18 and over, by sex, race, and age: United States, selected years 1965–2012

² CDC/NCHS, [Table 54](#) (page 1 of 2). Current cigarette smoking among adults aged 18 and over, by sex, race, and age: United States, selected years 1965–2012

³ OSG, [Smoking and Health: A Report of the Surgeon General](#)

⁴ CDC, [Health Effects of Cigarette Smoking](#)

⁵ [women.smokefree.gov](#), [11 Harmful Effects of Smoking on Women's Health](#)

⁶ OSG, [The Health Consequences of Smoking](#)

⁷ CDC, [Tobacco Use by Pregnant Women, United States](#)

⁸ CDC, [Tobacco Use and Pregnancy](#)

⁹ CDC, [Trends in Smoking Before, During, and After Pregnancy — Pregnancy Risk Assessment Monitoring System, United States, 40 Sites, 2000–2010](#)

¹⁰ CDC, [Press Release](#)

Decrease in Lung Cancer Deaths in Women

Lung cancer is the leading cause of cancer death among women¹, and the second-leading cause of death after heart disease.^{2,3} But the good news is that lung cancer deaths in women continue to decline each year,⁴ thanks in part to federal programs to help women quit smoking and federally funded research leading to improved treatments, scientific understanding, and public health policies.^{5,6}

Smoking is the leading risk factor for lung cancer, yet 1 in 5 women diagnosed with lung cancer have never smoked. Women are more likely than men to develop non-small cell lung cancer (NSCLC), a type of lung cancer that is most commonly found in non-smokers.⁷ The hormone estrogen may play a role. A 2009 report from the [Women's Health Initiative](#) found that hormone therapy increased the risk of dying from lung cancer in post-menopausal women.⁸ However, women of all ages are more likely to survive longer with lung cancer than men.⁹ Women who have surgery for certain types of lung cancer, including NSCLC, also have better survival rates than men.¹⁰ They also respond better to some of the chemotherapy medications used for lung cancer.¹¹

Lung cancer death rates in women decreased each year from 2004 to 2010 because of advances in treatments and successful smoking cessation programs.¹² The U.S. Preventive Services Task Force has recently recommended lung cancer screening for high risk individuals.¹³ This may allow for the identification of lung cancer in its early stages when it is most treatable.

¹ CDC, [Lung Cancer](#)

² CDC, [Leading Causes of Death in Females United States, 2010 \(current listing\)](#)

³ NIH, NCI, [A Snapshot of Lung Cancer](#)

⁴ CDC, [Cancer Mortality Trends Among Women by Race/Ethnicity](#)

⁵ CDC, [Lung Cancer Incidence Trends Among Men and Women — United States, 2005–2009](#)

⁶ NIH, NCI, [Lung Cancer Treatment](#)

⁷ NIH, NCI, [Lung Cancer Incidence Rates High Among Women Who Have Never Smoked](#)

⁸ Chlebowski, RT, et al. (2009). [Oestrogen plus progestin and lung cancer in postmenopausal women \(Women's Health Initiative trial\): a post-hoc analysis of a randomised controlled trial. *Lancet*: 374\(9697\): 1243-51.](#)

⁹ NIH, NCI [Fast Stats](#)

¹⁰ Scaglia, NC, et al (2013). [Role of gender in the survival of surgical patients with nonsmall cell lung cancer. *Ann Thorac Med*; 8\(3\): 142-147.](#)

¹¹ Marquez-Garban, DC, et al. (2009). [Targeting Aromatase and Estrogen Signaling in Human Non-Small Cell Lung Cancer. *Ann NY Acad Sci*: 1155: 194-205.](#)

¹² CDC, [Rates of new lung cancer cases drop in U.S. men and women](#)

¹³ USPSTF, [Screening for Lung Cancer](#)

Cervical Cancer Prevention and Screening

Every year, about 12,000 women in the United States are diagnosed with cervical cancer.¹ Most cases of cervical cancer are caused by the human papillomavirus (HPV). HPV is passed from person to person through sexual contact. HPV infection usually goes away on its own, but if it does not, it can lead to cervical cancer if left untreated.²

In 1991, the CDC created the [National Breast and Cervical Cancer Early Detection Program](#) (NBCCEDP). Since the start of the program, more than 28,000 women have had cervical cancers or precancerous lesions detected through this free or low-cost screening. Also in 1991, the FDA approved the first diagnostic test for the detection of high-risk, or cancer-causing, HPV types.³

In 2000, Congress passed the [Breast and Cervical Cancer Prevention and Treatment Act](#), which allows uninsured women who are diagnosed with cancer in the NBCCEDP access to treatment through their state's Medicaid program. In 2001, with passage of the [Native American Breast and Cervical Cancer Treatment Technical Amendment Act](#), American Indian and Alaska Native women are also eligible for this option if they are eligible for health services provided by IHS or by a tribal organization.

Prevention of cervical cancer became possible in 2006 when the FDA approved the first HPV vaccine. A second vaccine was approved in 2009.⁴ NIH National Cancer Institute researchers are the first and second inventors on government-owned patents for HPV vaccines licensed to drug companies. As a direct result of their work, vaccines now can prevent high-risk HPV infections.⁵ In 2013, CDC researchers reported that the rates of high-risk HPV have fallen by 56% among U.S. girls ages 14 to 19.⁶ The 2010 Affordable Care Act requires that most insurers cover, at no cost, [the HPV vaccine](#), [Pap testing](#), and [HPV testing](#).

¹ NIH, NCI, [Cervical Cancer](#)

² NIH, NCI, [Cancer Advances in Focus – Cervical Cancer](#)

³ FDA, [Digene Hybrid Capture 2 High-Risk HPV DNA Test - P890064 S009 A004](#)

⁴ CDC, [FDA Licensure of Bivalent Human Papillomavirus Vaccine \(HPV2, Cervarix\) for Use in Females and Updated HPV Vaccination Recommendations from the Advisory Committee on Immunization Practices \(ACIP\)](#)

⁵ NIH, NCI, [Notes](#)

⁶ CDC, [Press Release](#)

Decrease in HIV/AIDS Deaths in Women

The CDC identified the first case of AIDS in the United States in 1981.¹ By 1994, AIDS was the leading cause of death for all Americans (men and women) ages 25 to 44.² Today 25% of people living with HIV in the United States are women.³ HIV/AIDS remains among the 10 leading causes of death for black women ages 15 to 59⁴ and Hispanic/Latina women ages 30 to 49⁵. Although HIV/AIDS affects more African-American women and Latinas compared with other women, new HIV infections among black women have decreased since 2008.⁶

As the HIV/AIDS epidemic spread in the 1980s, we needed better ways to estimate the number of women with HIV/AIDS. AIDS reporting to the CDC began in 1981.⁷ In 1988, CDC researchers began to analyze routine blood tests from newborn infants to test for HIV in their mothers in what was to become the first nationwide, population-based survey of HIV prevalence.⁸ In 1993, NIH established the [Women's Interagency HIV Study](#) – the largest and longest-running study to investigate the impact of HIV on women in the United States.

Fewer women are dying from AIDS due to the introduction of highly active antiretroviral drugs. Treatment with these types of drugs can suppresses viral replication (stop the virus from multiplying) for decades, allowing patients to enjoy longer and healthier lives and making them less infectious to others.⁹

In 2003, CDC revised its recommendations to make HIV testing a routine part of all medical care. It also recommended universal prenatal testing, with rapid tests during labor and after delivery if the mother was not screened prenatally. By 2006, the CDC recommended screening of all adults ages 13 to 64, with repeat screening at least annually for those at high risk.¹⁰ The 2010 Affordable Care Act requires most insurers to cover [HIV screening](#) at no cost for everyone 15 to 65 and those at other ages who may be at increased risk.

¹ AIDS.gov, [A Timeline of AIDS](#)

² AIDS.gov, [A Timeline of AIDS](#)

³ CDC, [HIV Among Women Fact Sheet](#)

⁴ CDC, [Deaths, Percent of Total Deaths, and Death Rates for the 15 Leading Causes of Death in 5-year Age Groups, by Race and Sex: United States, 1999-2010](#)

⁵ CDC, [Deaths, Percent of Total Deaths, and Death Rates for the 15 Leading Causes of Death in 5-year Age Groups, by Hispanic Origin, Race for Non-Hispanic Population and Sex: United States, 1999-2010](#)

⁶ CDC, [HIV Among African Americans Fact Sheet](#)

⁷ CDC, [HIV Surveillance Supported by the Division of HIV/AIDS Prevention](#)

⁸ Gwinn, M. et al. (1991). [Prevalence of HIV Infection in Childbearing Women in the United States: Surveillance Using Newborn Blood Samples](#). *JAMA*; 265(13): 1704-1708.

⁹ CDC, [HIV Surveillance --- United States, 1981--2008](#)

¹⁰ CDC, [Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings](#)

Mother-to-child Transmission of HIV Decreased

Women with HIV who take antiretroviral medication during pregnancy can reduce the risk of transmitting HIV to their babies to less than 1%.¹ The rates of mother-to-child transmission peaked in 1992², and continue to fall to very low levels, despite an increase in the number of women with HIV giving birth.³

In 1987, the FDA approved the antiretroviral drug azathioprine (AZT) as the first drug for the treatment of HIV.⁴ Treatment with AZT slows the progression of HIV infection and helps prevent the transmission of HIV from infected pregnant women to their babies. In a 1994 NIH study, babies born to HIV-infected women were two-thirds less likely to become infected with HIV if their mother took AZT during pregnancy and if they received AZT after birth.⁵ These results prompted the U.S. Public Health Service to recommend that pregnant women be given AZT to reduce the risk of perinatal transmission of HIV. In 2003, the CDC updated its recommendations to make HIV testing a routine part of all medical care and to endorse universal prenatal testing, with rapid tests during labor and after delivery if the mother was not screened prenatally.⁶ The CDC also recommends repeat screening in the third trimester for those at high risk.⁷

Within 10 years of CDC's initial recommendation in 1994, the mother-to-child transmission of HIV had declined by 94% in the United States, thanks to continued improvements in HIV treatment.⁸ In 2007, the CDC launched the [One Test. Two Lives.](#) campaign for health professionals to promote HIV testing of all pregnant women.

Another leading contributor to the decline in mother-to-child transmission of HIV is HRSA's [Ryan White Services for Women, Infants, Youth, Children, and Families, Title IV](#) (now Part D) program. The program contributed to a drop in mother-to-child transmission of HIV from about 2,000 babies born HIV-positive in 1990 to around 200 in 2005.⁹

¹ CDC, [HIV Among Pregnant Women, Infants, and Children](#)

² CDC, [Achievements in Public Health: Reduction in Perinatal Transmission of HIV Infection --- United States, 1985--2005](#)

³ CDC, [HIV Among Pregnant Women, Infants, and Children](#)

⁴ FDA, [HIV/AIDS Historical Time Line 1981-1990](#)

⁵ NIH, NIAID, [HIV Infection in Women](#)

⁶ CDC, [Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings](#)

⁷ CDC, [STDs & Pregnancy – CDC Fact Sheet](#)

⁸ CDC, [Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings](#)

⁹HRSA, [Part D: Women and Families in a Circle of Care](#)

Decrease in Deaths from the Leading Killer of Women – Heart Disease

Heart disease is the leading cause of death for American women.¹ But today, fewer women die of heart disease.² Between 2003 and 2004, the number of women who died from heart disease shifted from 1 in 3 women to 1 in 4 women.³ The ongoing decline in death from heart disease is due to both a reduction in risk factors (such as high blood pressure) and improved treatments for heart disease.⁴

In the past 30 years, HHS began several efforts to help women recognize the signs and symptoms of heart disease and understand their risk of heart disease. In 1997, the CDC launched the [WISEWOMAN](#) program, which screens low-income women for chronic diseases like heart disease. Women at high risk are then invited to join lifestyle programs like cooking classes or walking clubs to lower their risk.

In 2002, NIH launched a national campaign to educate women about heart disease, [The Heart Truth Campaign](#)[®], and its symbol, the Red Dress. By 2009, *The Heart Truth* campaign reported an increased awareness of heart disease as the leading cause of death for women – up from 34% in 2000 to 69% in 2009.

Research sponsored by AHRQ has found important differences in the approaches to treatment and prevention of heart disease between women and men. For example, women are more likely to experience delays in the ER when they have cardiac symptoms.⁵ OWH introduced [Make the Call. Don't Miss a Beat.](#) in 2010 to educate women about the symptoms of a heart attack and empower them to call 9-1-1 as soon as the symptoms arise.

In 2011, HHS started [Million Hearts](#)[®], a national, public-private initiative to prevent 1 million heart attacks and strokes by 2017. Co-led by the CDC and CMS, the initiative brings together communities of all kinds to improve care and empower Americans to make heart-healthy choices.

The 2010 Affordable Care Act requires most insurers to provide [preventive care and screening](#), including the [“ABCs” of cardiovascular prevention](#): aspirin use (A), blood pressure control (B), cholesterol management (C), and smoking cessation (S) at no cost. Remember these “ABCs₂” and together we can prevent heart attacks and strokes.

¹ CDC, [Deaths: Leading Causes for 2010](#)

² NIH, NHLBI, [2012 NHLBI Morbidity and Mortality Chart Book](#)

³ NIH, NHLBI, [Heart Disease Deaths in American Women Decline](#)

⁴ CDC, [Vital Signs: Avoidable Deaths from Heart Disease, Stroke, and Hypertensive Disease – United States, 2001–2010](#)

⁵ AHRQ, [Cardiovascular Disease and Other Chronic Conditions in Women](#)

Making Birth Control Better, Safer, and More Accessible for Women

In the United States, 62 million women are in their childbearing years (ages 15 to 44). About 70% of them are at risk of unintended pregnancy.¹

Because women typically use contraception for more than a third of their lives², having safe and effective options is important. The FDA monitors the safety and effectiveness of birth control methods and may limit the use of a contraceptive method or remove it from the market entirely. In 1988, for example, the FDA withdrew birth control pills with more than 50 micrograms of the female hormone estrogen after reports of an increased risk for rare but fatal blood clots.³

Since 1984, the FDA has approved many new forms of contraception, giving women more options. In addition to male condoms and oral contraceptive pills, women can now choose from hormonal vaginal rings, shots, a skin patch, female condoms, IUDs, and implants.⁴ Today, some types of contraceptives can control acne and reduce menstrual pain and heavy periods, in addition to preventing pregnancy.⁵

Since 1995, the proportion of women who use a long-acting, reversible contraceptive method—such as implants, shots, the patch, the ring, and the IUD – has increased.⁶ These methods became more available in the 1990s, and they are associated with lower rates of unintended pregnancies compared with most other methods.⁷

Cost should no longer be a barrier. Since 1970, [Title X family planning centers](#), administered by OPA, have provided birth control and other family planning services to low-income women. These clinics help avert an estimated 1 million unintended pregnancies each year.⁸ Since 1972, states have been required to provide family planning services and supplies to people on Medicaid.⁹ Under the 2010 Affordable Care Act, insurance plans in the Health Insurance Marketplace and many other plans must cover [FDA-approved birth control](#) prescribed by a woman's doctor without cost-sharing.

¹ CDC, [Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995](#)

² The White House Council on Women and Girls, [Keeping America's Women Moving Forward](#)

³ FDA, [HIV/AIDS Historical Time Line 1981-1990](#)

⁴ FDA, [Birth Control: Medicines To Help You](#)

⁵ OPA, [Birth Control Pill Fact Sheet](#)

⁶ CDC, [Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995](#)

⁷ CDC, [Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995](#)

⁸ OPA, [Title X Family Planning](#)

⁹ CMS, [RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans](#)

Cancer and Steroid Hormone (CASH) Study

Family planning, and the modern era of birth control that was ushered in by the first approval of birth control pills in 1960¹, has been named one of the [Ten Great Public Health Achievements in the 20th Century](#) by the CDC. But, a number of studies suggested possible links between birth control pills and cancer or heart disease that required further research.²

In the 1980s, the CDC, and the National Cancer Institute and National Institute of Child Health and Human Development at NIH, supported the [Cancer and Steroid Hormone](#) (CASH) Study. Its purpose was to study the relationship between oral contraceptives and breast, endometrial (or uterine), and ovarian cancers in U.S. women. The study enrolled women ages 20 to 54 with newly diagnosed breast, endometrial, or ovarian cancer. The investigators found that use of birth control pills did not increase the risk for breast cancer. They also found that women who had used oral contraceptives had a lower risk of ovarian cancer, and the risk went down the longer a woman used the pill. The effect lasted more than 10 years after a woman stopped taking the pill. Additionally, the risk of endometrial cancer in women who had used combination oral contraceptives with estrogen and progestin was only about half the risk compared with women who had never taken the pill.³

Other research studies since the CASH study continue to find that birth control pills reduce a woman's risk of ovarian and endometrial cancer.⁴

¹ CDC, [Achievements in Public Health, 1900-1999: Family Planning](#)

² NIH, [Oral Contraceptives and Cancer Risk](#)

³ CDC, [Oral Contraceptives and Cancer Risk](#)

⁴ NIH, [Oral Contraceptives and Cancer Risk](#)

Approval of Emergency Contraception

Emergency contraception can help prevent pregnancy in women who had sex without using birth control, whose birth control method failed, and who were sexually assaulted. Emergency contraceptives, which are much like birth control pills, prevent pregnancy by stopping release of the egg from the ovary and by blocking sperm's access to the egg.¹ The copper IUD can also be used as a method of emergency contraception.²

The FDA first approved prescription emergency contraceptive pills in 1998.³ In 2006, the FDA approved the first over-the-counter (OTC) emergency contraception option for women 18 and older.⁴ In June 2013, the FDA approved the OTC product for use by women of all ages without a prescription.⁵

Between 2006 and 2010, 11% (or 5.8 million) of sexually active females ages 15 to 44 reported using emergency contraception at least once.⁶ This is a substantial increase from 2002, when 4% of girls and women used it at least once, and 1995, when less than 1% used it.⁷

¹ OPA, [Emergency Contraception Fact Sheet](#)

² OPA, [Emergency Contraception Fact Sheet](#)

³ FDA, [Plan B: Questions and Answers - August 24, 2006; updated December 14, 2006](#)

⁴ FDA, [Plan B: Questions and Answers - August 24, 2006; updated December 14, 2006](#)

⁵ FDA, [FDA approves Plan B One-Step emergency contraceptive for use without a prescription for all women of child-bearing potential](#)

⁶ CDC, [Use of Emergency Contraception Among Women Aged 15–44: United States, 2006–2010](#)

⁷ CDC, [Use of Emergency Contraception Among Women Aged 15–44: United States, 2006–2010](#)

Decrease in Teen Pregnancy

Teen mothers and their infants are at increased risk for lifelong health problems and social and economic challenges.¹ Today the U.S. teen birth rate is at an all-time low.² Since 1991, the rates of teen pregnancy have dropped by half.³ In 2013, the CDC reported that birth rates for U.S. teens 15-19 years old dropped to a record low not seen since 1946.⁴ This decline in teen pregnancies crossed all races and ethnicities.⁵

Decreases in teen pregnancy rates are partially due to lower rates of sexual activity among young women.⁶ Also, more of those who are sexually active appear to be using birth control than in previous years.⁷

Several federal programs have made reducing teen pregnancy a high priority. One is the [Title X Family Planning Program](#), which provides high-quality affordable family planning and reproductive health care for low-income teens.

As early as 1997, HHS-supported initiatives that included teen pregnancy prevention had reached about 30% of U.S. communities.⁸ In addition, since 2009, HHS has reviewed results of programs to reduce teen pregnancy to learn which ones work. OAH maintains a list of programs that have been shown to be effective in reducing teen pregnancy to help states focus on successful programs.⁹ Since 2010, OAH's [Teen Pregnancy Prevention Program](#) has funded grants supporting the replication of evidence-based programs and the implementation of demonstration programs to prevent teen pregnancy. ACF's [Family and Youth Services Bureau](#) supports state, tribal, and community efforts to promote comprehensive sex education, adulthood preparation programs, and abstinence education.

¹ OAH, [Teen Pregnancy and Childbearing](#)

² CDC, [Teen Pregnancy](#)

³ CDC, [Births: Final Data for 2012](#)

⁴ CDC, [Births: Final Data for 2012](#)

⁵ CDC, Teen Pregnancy, [About Teen Pregnancy – Teen Pregnancy in the United States](#)

⁶ CDC, [Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006–2010 National Survey of Family Growth](#)

⁷ CDC, [Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006–2010 National Survey of Family Growth](#)

⁸ HHS, ASPE, [The National Strategy to Prevent Out-of-Wedlock Teen Pregnancy Prevention](#)

⁹ OAH, [Evidence-Based Programs \(31 programs\)](#)

Efforts to Improve Pregnant Women’s Health and Outcomes

Today, most women in the United States receive excellent health care during pregnancy. As a result, the U.S. infant mortality rate has dropped to an all-time low of 6 deaths per 1,000 births.¹ However, pregnancy-related deaths and serious complications for mothers have increased in the United States during the last 30 years, for reasons that are uncertain. The increase could be due to a combination of circumstances, including improved data collection on pregnancy mortality, an increase in the number of older mothers, and the increase in obesity among women.²

Researchers do know that pregnant women today are more likely to have chronic diseases such as high blood pressure, diabetes, and heart disease, which can put them at risk for poor outcomes.³ Also, large differences in pregnancy-related death and complications between racial and ethnic groups and geographic areas must be addressed.⁴ HHS is working to improve the health of all women, including women who may become pregnant.

Since the CDC began monitoring pregnancy health in 1987 with the [Pregnancy Risk Assessment Monitoring System](#), women have learned about the important ways they can improve their health during pregnancy. CDC launched the [Show Your Love](#) campaign in 2013. The campaign encourages women to get a checkup before they become pregnant, to help ensure a healthy pregnancy and baby.

Learning more about how medications affect women during pregnancy is also important to improve pregnancy outcomes. FDA encourages women to participate in [Pregnancy Exposure Registries](#). These registries collect health information from women who take medications or get vaccines during pregnancy or while breastfeeding.

To promote healthy pregnancy and provide information about infant care, HHS entered into a public-private partnership to help launch [text4baby](#) in 2010.⁵ This mobile information service provides free text messages to pregnant women and new moms to help keep them safe and healthy. In 2012, CMS, HRSA, and ACF began the [Strong Start initiative](#) to help reduce early births and to improve outcomes for moms and babies.

Because of the 2010 Affordable Care Act, health insurance companies cannot deny women coverage, or charge them more, due to pre-existing health conditions, including a pregnancy.⁶ The Affordable Care Act also requires insurance companies to cover, with no cost-sharing, many [preventive services](#) for pregnant women. Under the Affordable Care Act, maternity and newborn care is an [essential health benefit](#) that must be covered by all plans in the Marketplace.

¹ CDC, [Recent Declines in Infant Mortality in the United States, 2005 - 2011](#)

² CDC, [Pregnancy Mortality Surveillance System](#)

³ CDC, [Pregnancy Mortality Surveillance System](#)

⁴ CDC, [Pregnancy Mortality Surveillance System](#)

⁵ text4baby, [Government Partner: U.S. Dept. of Health and Human Services](#)

⁶ HHS, [Women and the Affordable Care Act](#)

Increase in Breastfeeding

The CDC's 2013 [Breastfeeding Report Card](#) marks continued progress over the last ten years in protecting, promoting, and supporting breastfeeding in the United States. In recent decades, mothers, their families, and health professionals have realized the importance of breastfeeding while acknowledging that each mother's decision about how she feeds her baby is a personal one.¹ Every mother deserves information, guidance, and support in making this decision.

In addition to the well-known benefits breastfeeding brings to infants, there are also benefits for breastfeeding mothers. Breastfeeding moms are less likely to develop type 2 diabetes, breast and ovarian cancer, and postpartum depression.² And the longer moms breastfeed, the more the health benefits stack up.

In 1984, Surgeon General C. Everett Koop convened the first [Surgeon General's Workshop on Breastfeeding](#). At that time, about 60% of mothers reported breastfeeding.³ Today, 77% of mothers initiate breastfeeding after birth and almost half (49%) are still breastfeeding six months after birth.⁴

In 1990, the United States signed onto a worldwide declaration to support breastfeeding, and in 1999, the Surgeon General requested a formal policy on breastfeeding. As a result, HHS released the [HHS Blueprint for Action on Breastfeeding](#) in 2000 under the leadership of OWH. This document declared breastfeeding to be a key public health issue in the United States and provided the first comprehensive breastfeeding framework for the nation. This was followed in 2011 by the [Surgeon General's Call to Action to Support Breastfeeding](#), which outlines specific steps everyone can take to participate in a society-wide effort to support breastfeeding. The 2010 Affordable Care Act requires most insurance companies to provide, with no copay or deductible, [breastfeeding support, counseling, and supplies](#).

Today more women are breastfeeding and for longer. Although differences still exist in breastfeeding rates between racial and ethnic groups, the gaps are getting smaller.⁵

¹ OSG, [The Surgeon General's Call to Action to Support Breastfeeding, 2011](#)

² OWH, [Why breastfeeding is important](#)

³ OSG, [The Surgeon General's Call to Action to Support Breastfeeding, 2011](#)

⁴ CDC, [Breastfeeding Report Card, United States/2013](#)

⁵ CDC, [Breastfeeding, Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences – United States, 2000 – 2008 Births](#)

Federal Funding to Address Violence Against Women

Just 35 years ago, domestic violence was hidden behind closed doors.¹ It wasn't until the 1970s that states began addressing violence against women, including sexual assault, rape, and domestic violence.² One decade later, in 1984, the federal Department of Justice Task Force on Family Violence issued the first-ever report to examine the scope and effects of domestic violence in America.³

ACF began the [Family Violence Prevention and Services Program](#) in 1984 with the first federal funding for emergency shelter and services for victims of domestic violence and their children. In 1984, CDC started collecting data on sexual and intimate partner violence through the Behavioral Risk Factor Surveillance System.⁴

In 1994, the [Violence Against Women Act](#) (VAWA) was first passed and administered through the Department of Justice and HHS. The VAWA authorized the opening of the 24-hour, toll-free [National Domestic Violence Hotline](#) and funding for women's shelters, through ACF. The hotline provides nationwide crisis assistance and local shelter referrals to victims of domestic violence. In 1996, the CDC, along with other parts of the federal government, jointly sponsored the National Violence Against Women Survey to further the understanding of violence against women.⁵ Beginning in 2010, CDC and other parts of the federal government began collecting nationwide population-based information on violence against women in the [National Intimate Partner and Sexual Violence Survey](#).

In 2010, in response to high rates of sexual assault among Native American women, IHS began initiatives to develop domestic violence prevention activities and sexual assault response teams for IHS hospitals.

The 2010 [Affordable Care Act](#) requires most insurers to cover screening and brief counseling for domestic or interpersonal violence for all women at no cost. More recently, in 2013, a White House report⁶, with leadership from HHS, explored the link between HIV/AIDS and violence against women and girls.

¹ The White House, [Remarks by the President and Vice President at Signing of the Violence Against Women Act](#)

² Department of Justice, [The History of the Violence Against Women Act](#)

³ Department of Justice, [The History of the Violence Against Women Act](#)

⁴ CDC, [Sexual Violence: Data Sources](#)

⁵ CDC, [Sexual Violence: Data Sources](#)

⁶ The White House, [Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities](#)

Improvements in Mental Health Care for Women

The first Surgeon General's report on mental health was released in 1999.¹ Since then, awareness of the societal burden of mental illness, and the need for equitable treatment of it alongside physical health concerns, has increased. HHS, with leadership from SAMHSA and CMS, implements mental health parity laws to ensure that insurers cannot discriminate against those with mental illness by covering mental health treatments at a lower level than physical health concerns.^{2, 3}

Mental health research, including research funded by the National Institute of Mental Health and other parts of NIH, has highlighted gender differences in mental health and the greater burden women face from several types of mental illness. Major depressive disorder affects women twice as often as men, and 1 in 5 women develop a major depressive disorder in her lifetime.⁴ Women also have higher rates of other mental health issues, such as anxiety, PTSD, and eating disorders.⁵

One mental health treatment advance occurred in 1987 when the FDA first approved a new class of drugs called selective serotonin reuptake inhibitors (SSRIs). SSRIs were a breakthrough in depression treatment because they tend to have fewer side effects and are easier to take.⁶ After SSRIs were introduced, antidepressant prescriptions greatly increased, with the majority of them being for SSRIs and other newer antidepressant medications.⁷

In 2009, OWH coordinated the Women's Mental Health Initiative and published the report [Action Steps for Improving Women's Mental Health](#). Along with the release of the [Federal Mental Health Action Agenda](#) in 2009, led by SAMHSA, the federal government took steps forward in recognizing mental illness in women and removing barriers to treatment and care. Also, every other year, SAMHSA releases its [Mental Health, United States](#) report on the state of mental health services.

Today the 2010 Affordable Care Act provides one of the largest expansions of mental health and substance use disorder coverage in a generation, requiring Health Insurance Marketplace plans to cover these services.⁸ These new protections build on the [Mental Health Parity and Addiction Equity Act](#) to expand mental health benefits and parity protections to 62 million Americans.

¹ OSG, [Mental Health: A Report of the Surgeon General](#)

² SAMHSA, [Mental Health Parity and Addiction Equity](#)

³ CMS, [The Mental Health Parity and Addiction Equity Act](#)

⁴ NIH, NIMH, [Women and Depression: Discovering Hope](#)

⁵ OSG, [Surgeon General's Workshop on Women's Mental Health: November 30-December 1, 2005, Denver, Colorado](#)

⁶ NIH, NIMH, [Depression](#)

⁷ Pirraglia, PA, Stafford, RS, Singer, DE. (2003). [Trends in Prescribing of Selective Serotonin Reuptake Inhibitors and Other Newer Antidepressant Agents in Adult Primary Care. *Prim Care Companion J Clin Psychiatry*; 5\(4\): 153-157](#)

⁸ MentalHealth.gov, [Health Insurance and Mental Health Services](#)

Improvements in Support to Caregivers

Nearly two-thirds of caregivers for older adults are women — usually the wives or daughters of those who need support.¹ These women provide long-term care and support, from grocery shopping and housecleaning to help in dressing and eating. Caregivers might also help with finances or make medical decisions. More than half of informal caregivers are also working at full-time or part-time jobs.

To meet the diverse needs of the growing numbers of older people in the United States, the Older Americans Act of 1965 created the [National Aging Network](#), which is headed by AOA. Reauthorized in 2006, the National Aging Network is the primary way community-based services for older Americans and their caregivers are organized and coordinated.

In 2000, Congress recognized the need to support caregivers and created the [National Family Caregiver Support Program](#) (NFCSP) through AOA and the National Aging Network. The NFCSP offers caregivers information, assistance, counseling and training, and respite care. By 2010, the NFCSP served over 700,000 caregivers.

Through the Lifespan Respite Care Act of 2006, ACL, through the AOA, provides funding for state and local health departments to expand respite services for caregivers and provide relief for planned and emergency care.²

The [Eldercare Locator](#), a public service of AOA, is a nationwide service that connects older Americans and their caregivers with information on senior services. The service began telephone operation in 1991, and its website launched in 2001.

¹ LongTermCare.gov, [Who Will Provide Your Care?](#)

² ACL, AOA, [2013 Lifespan Respite Care Programs: Grants to New States](#)

Improvements in Older Women's Health

Women are not only living longer today, but their quality of life as they age has improved in the past 30 years. We owe part of this progress to improved treatments and better medications to treat stroke, HIV/AIDS, and certain cancers, including colon and breast cancers.¹

In 1994, AOA created the Older Women's Policy and Resource Center to address the needs of older women in particular. Across the country, programs provide education on income security, health resources, and caregiving support.

In 1998, the FDA and OWH created [Use Medicines Wisely](#) public awareness campaign for women over 45 with the goal of helping women live longer, healthier lives.

A significant advance in care for older women came in 2003 with the creation of [Medicare Part D](#), or the Medicare prescription drug benefit. The benefit helps cover the costs of prescription drugs and premiums for people with Medicare (primarily people 65 and older). Just four months after the law went into effect in 2006, 90% of Medicare's 43 million beneficiaries had drug coverage.²

The Affordable Care Act requires a free annual wellness visit for everyone on Medicare since 2011.³ For women under 65 (and not on Medicare), an annual well-woman visit is a required, free [preventive service](#) under most insurance plans. The Affordable Care Act also requires additional preventive services with no copay for older women, including bone density scans and mammograms.

¹ U.S. Burden of Disease Collaborators. (2013) [The State of US Health, 1990-2010 Burden of Diseases, Injuries, and Risk Factors. JAMA: 310\(6\): 591-606](#)

² Safran, DG, Strollo, MK, et al. (2010). [Prescription Coverage, Use and Spending Before and After Part D Implementation: A National Longitudinal Panel Study. J Gen Intern Med; 25\(1\): 10-17](#)

³ HHS, [Ring in the New Year with New Health Care Benefits](#)

Largest Women's Health Prevention Study Ever – Women's Health Initiative

Some of the most common diseases that affect women after menopause are cardiovascular disease (the leading cause of death among U.S. women¹), breast cancer (the second-leading cause of cancer deaths in U.S. women²), colorectal cancer (the third-leading cause of cancer death among U.S. women³), and osteoporosis (the leading cause of bone fracture in U.S. women⁴).

In 1991, the National Heart, Lung, and Blood Institute, part of NIH, launched the [Women's Health Initiative](#) (WHI) to understand better how these diseases affect post-menopausal women and to reduce the number of women who develop and die from these diseases. More than 160,000 post-menopausal women ages 50 to 79 participated in the 15-year study, making it one of the largest prevention studies involving women in the United States.⁵

WHI results in 2002 found that post-menopausal women taking combination (estrogen and progestin) hormone therapy for menopause symptoms had an increased risk for breast cancer, heart disease, stroke, blood clots, and urinary incontinence. Although women using combined hormone therapy had a lower risk of fractures and colorectal cancer, these benefits did not outweigh the risks. As a result, many women stopped taking hormone therapy, reducing their risk for breast cancer. One of the most important outcomes of the WHI was the sharp decline in breast cancer in 2003 after the WHI results were released in 2002.⁶ Today, the FDA urges women who take hormone therapy to take the lowest helpful dose for the shortest amount of time.⁷

¹ CDC, [Leading Causes of Death in Females United States, 2010 \(current listing\)](#)

² NIH, NCI, [A Snapshot of Breast Cancer](#)

³ NIH, NCI, [A Snapshot of Colorectal Cancer](#)

⁴ MedlinePlus, [Osteoporosis - overview](#)

⁵ NIH, NHLBI, [WHI Background and Overview](#)

⁶ NIH, NCI, [Decrease in Breast Cancer Rates Related to Reduction in Use of Hormone Replacement Therapy](#)

⁷ FDA, [Menopause and Hormones: Common Questions](#)

Building Better Osteoporosis Treatments

Osteoporosis is a disease that weakens bones, causing them to become fragile and break more easily. Osteoporosis can occur in both men and women and at any age, but it is most common in older women. Women lose bone mass at a faster rate after menopause, when the body stops making the hormone estrogen.¹ Osteoporosis causes half of all women over age 50 to break a bone in their lifetime.²

In 1984, the FDA released an updated guidance document on the treatment of osteoporosis. Since that time, the FDA has approved several different types of osteoporosis treatment and prevention medications: bisphosphonates (medicines that slow bone loss), peptide hormones (hormones made by the thyroid gland), estrogen (in the form of menopausal hormone therapy) for postmenopausal women, and selective estrogen receptor modulators (raloxifene for postmenopausal women).³

In 1994, NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases began the [Osteoporosis and Related Bone Diseases National Resource Center](#) to increase awareness, knowledge, and understanding of osteoporosis and other bone diseases. The Center focused efforts on targeting minority women and provided publications for various populations. The 2004 first-ever Surgeon General's report on bone health and osteoporosis showed the large burden that bone disease places on older women.⁴

The 2010 Affordable Care Act requires most insurers to cover [osteoporosis screening](#) at no cost for women over 60 who are at increased risk for the disease.

¹ NIH, NIAMS, [What Is Osteoporosis? Fast Facts: An Easy-to-Read Series of Publications for the Public](#)

² MedlinePlus, [Osteoporosis - overview](#)

³ AHRQ, [Treatment To Prevent Fractures in Men and Women With Low Bone Density or Osteoporosis: Update of a 2007 Report](#)

⁴ OSG, [Bone Health and Osteoporosis: A Report of the Surgeon General](#)

Dangerous Drugs and Devices for Women Removed from Market

Women have historically played an important role in supporting safe food and effective medicines¹, with the support of women's groups helping to usher in the modern FDA.² Today, FDA is responsible for approving medications based on data from clinical trials. But the FDA's supervision of drugs doesn't end with approval. The agency continues to collect information about complications from drugs and medical devices after they are on the market.³ Sometimes, for example, a drug or device may have side effects not shown in clinical trials. When this happens, the FDA reviews the facts and may request withdrawal of the drug or device from the market.

Instances when the FDA removed drugs or devices from the market, or limited their use, due to safety concerns include the following:

- In 1992, the FDA restricted silicone gel-filled breast implants to women who needed reconstruction surgery or their existing silicone gel-filled implants replaced. The FDA has since continued to work with manufacturers on improving the safety of these implants.⁴
- In 1997, the FDA removed the appetite suppressants fenfluramin and dexfenfluramine because of increased risk for heart valve disease.⁵
- In 1988, the FDA removed birth control pills containing more than 50 micrograms of estrogen from the market because of a higher risk for rare but fatal thromboembolisms.⁶
- In 2011, the FDA cautioned women about the complications that can occur when surgical mesh is used to treat pelvic organ prolapse and stress urinary incontinence.⁷

[Learn more](#) about the stages of drug development and review by the FDA.

¹ FDA, [100 Years of Protecting and Promoting Women's Health](#)

² FDA, [The Story of the Laws Behind the Labels](#)

³ FDA, [The FDA's Drug Review Process: Ensuring Drugs Are Safe and Effective](#)

⁴ FDA, [Regulatory History of Breast Implants in the U.S.](#)

⁵ FDA, [Fen-Phen Safety Update Information](#)

⁶ FDA, [100 Years of Protecting and Promoting Women's Health](#)

⁷ FDA, [Urogynecologic Surgical Mesh: Update on the Safety and Effectiveness of Transvaginal Placement for Pelvic Organ Prolapse](#)

FDA Helps Women and Families Meet Their Nutritional Needs

The [Nutrition Labeling and Education Act](#) (NLEA) of 1990 gave FDA the authority, for the first time, to require nutrition labeling on foods. The Nutrition Facts label provides consumers with easy-to-understand, per-serving information on calories, fat, protein, sodium, cholesterol, dietary fiber, and vitamins. To help people choose heart-healthy foods, in 2003, the FDA required food labels to include trans fat content. One year later, in 2004, the **Food Allergy Labeling and Consumer Protection Act** also required the labeling of any food that contains peanuts, soybeans, cow's milk, eggs, fish, crustacean shellfish, tree nuts, and wheat.

A U.S. Department of Agriculture (USDA) study found that the percentage of working-age adults using the Nutrition Facts Panel when food shopping increased to 42% in 2010, from 34% in 2007.¹ Among older adults, the percentage that used the Nutrition Facts Panel increased from 51% to 57% over the same time period.²

Today, the FDA is looking at revising the food label again to help consumers make the healthiest choices. The FDA is also considering banning partially hydrogenated oil in all food products.³ Also, because Americans get more than one-third of their calories outside of the home⁴, the 2010 Affordable Care Act requires chain restaurants to post the number of calories in each standard menu item and for vending machine companies to post calorie information with vending machines.⁵ The Affordable Care Act authorizes the FDA to establish standards for this information.

In addition to the Nutrition Facts label, the FDA also regulates all food coloring and additives. In 1998, the FDA required grain products to include folic acid (a B vitamin) to help prevent birth defects of the brain and spine in the developing fetus.⁶ Studies show that the number of neural tube defects, such as spina bifida, has dropped by 25% since then.⁷ Today, the FDA works with the USDA, the CDC, and NIH to produce [FoodSafety.gov](#) to help all consumers make healthy and safe food choices.

¹ USDA, [Changes in Eating Patterns and Diet Quality Among Working-Age Adults, 2005 - 2010](#)

² USDA, [Changes in Eating Patterns and Diet Quality Among Working-Age Adults, 2005 - 2010](#)

³ Federal Register, [Tentative Determination Regarding Partially Hydrogenated Oils; Request for Comments and for Scientific Data and Information](#)

⁴ USDA, [Americans' Food Choices at Home and Away: How Do They Compare With Recommendations?](#)

⁵ FDA, [Questions and Answers on the New Menu and Vending Machines Nutrition Labeling Requirements](#)

⁶ FDA, [100 Years of Protecting and Promoting Women's Health](#)

⁷ CDC, [Spina Bifida and Anencephaly Before and After Folic Acid Mandate --- United States, 1995--1996 and 1999--2000](#)

Policy of Inclusion of Women in Clinical Trials

In 1977, the FDA issued a guideline banning most women of “childbearing potential” from participating in clinical research studies. This was the result of certain drugs (most notably thalidomide) causing serious birth defects.¹ At the time, the focus was on protecting the most vulnerable populations at all other costs.²

With the establishment of the first HHS task force on women’s health in 1983, a shift away from this approach began. There was new recognition³ that many factors, including body size, hormonal environment, and even body fat distribution can affect the way drugs are metabolized.⁴ This could potentially mean that life-saving drugs may not work, may not work as well, or may not work similarly, in women as they do in men.⁵

As a result of the 1985 [Report of the Public Health Service Task Force on Women's Health Issues](#), which encouraged reexamining current polices, NIH and the FDA both issued new guidelines to encourage more inclusion of women in studies. However, subsequent government analyses found that women were still seriously underrepresented in important studies on common diseases such as heart disease.⁶

In 1993, the FDA issued a new guideline and formally rescinded the 1977 policy that banned most women from participating in studies.⁷ To ensure that the policies for inclusion were firmly implemented by NIH, the Congress made what had previously been policy into law, through a section in the NIH Revitalization Act of 1993.⁸

A government report issued in 2000 concluded that NIH had made significant progress in implementing this law, and in the most recent report submitted to Congress, NIH states that substantial numbers of both women and men, and people of all different races and ethnicities, have participated in NIH research.⁹ But many women’s health experts and advocates agree that more progress is needed.

Under the 2010 Affordable Care Act, health insurance companies cannot drop or limit a person’s coverage because they are participating in a clinical trial.¹⁰

¹ Merkatz, RB. (1998). [Inclusion of women in clinical trials: a historical overview of scientific, ethical, and legal issues](#). *J Obstet Gynecol Neonatal Nurs.*; 27(1): 78-84

² McCarthy, CR. (1994). [Historical background of clinical trials involving women and minorities](#). *Acad Med*; 69(9): 695-8

³ NIH, ORWH, [Inclusion of Women and Minorities in Clinical Research](#)

⁴ JSchiebinger, L. (2003). [Women's health and clinical trials](#). *J Clin Invest.*; 112 (7): 973–977. doi:10.1172/JCI19993

⁵ Merkatz, RB. (1998). [Inclusion of women in clinical trials: a historical overview of scientific, ethical, and legal issues](#). *J Obstet Gynecol Neonatal Nurs.*; 27(1): 78-84

⁶ Merkatz, RB. (1998). [Inclusion of women in clinical trials: a historical overview of scientific, ethical, and legal issues](#). *J Obstet Gynecol Neonatal Nurs.*; 27(1): 78-84

⁷ FDA, [Guidance for Industry](#)

⁸ NIH, ORWH, [Inclusion of Women and Minorities in Clinical Research](#)

⁹ NIH, [Comprehensive Report: Tracking of Clinical Research as Reported in Fiscal Year 2011 and Fiscal Year 2012](#)

¹⁰ HHS, [Key Features of the Affordable Care Act By Year - 2014](#)

Addressing Sex Differences in Health

Not only is a woman's body obviously different from a man's, but each cell in a person's body has a sex.¹ So it is no surprise that diseases, and the medications and medical devices used to treat them, may affect women differently. Yet the prevention, management, and treatment of many health conditions still often follow the one-size-fits-all approach.

Heart disease is an example where there are sex differences. Women are less likely than men to experience the classic symptoms of a heart attack.² And traditional diagnostic procedures are not optimal for women — sometimes resulting in a delayed diagnosis or misdiagnosis.³ Also, because women are diagnosed with heart disease 10 years later than men, on average, they are more likely to have other chronic diseases at the same time.⁴ We are still learning more about the differences between men and women that result in different outcomes from heart attack, stroke, and other cardiovascular conditions.

The federal government began addressing sex differences in health almost 30 years ago, in 1986, when the NIH established a policy to include women in clinical research.⁵ This allowed researchers to study how medications, procedures, and diseases affect women differently from men. One year later, the FDA published the "Demographic Rule," which required manufacturers to show prior to approval how their drug is safe and effective by sex, age, and race.⁶

Including women in clinical research has led to new developments benefiting women. One example is the FDA's 2010 approval of a smaller left ventricular assist device.⁷ This device is used in patients with severe heart failure who are not candidates for a heart transplant. The smaller version of this device was created to address to sex differences in body size, giving more women access to this lifesaving treatment.

FDA's Office of Women's Health has been collaborating with private sector partners on a new [Women's Health Curriculum](#) and toolbox for pharmacy educators and students nationwide. Students in the program will study how sex differences affect women's health across the lifespan and how they may influence the safety and efficacy of FDA-regulated drugs and devices.

[More information](#) on sex and gender differences in health and disease is available through the NIH Office of Research on Women's Health.

¹ Straface, E. et al (2012). [Sex differences at cellular level: "cells have a sex". *Handb Exp Pharmacol*; \(214\): 49-65](#)

² OWH, [Signs of a heart attack](#)

³ Maas, A., Appelman, Y. (2010). [Gender differences in coronary heart disease. *Neth Heart J*; 18\(12\): 598-602](#)

⁴ Worrall-Carter, L. et al. (2011). [Systematic review of cardiovascular disease in women: assessing the risk. *Nurs Health Sci*; 13\(4\): 529-35.](#)

⁵ NIH, ORWH [Inclusion of Women and Minorities in Clinical Research](#)

⁶ FDA, [Promoting Safe and Effective Drugs for 100 Years](#)

⁷ FDA, [FDA Approves Left Ventricular Assist System for Severe Heart Failure Patients](#)

Addressing Minority Women's Health

We've worked hard over the past 30 years to improve the health of all Americans. In 1985, HHS released its first-ever national report on the health of minorities – the [Report of the Secretary's Task Force on Black and Minority Health](#). At the time of this landmark report, 60,000 more deaths occurred each year in minority populations than in the white population. The report's results prompted HHS to establish the [Office of Minority Health](#) (OMH) in 1986. Over the years, OMH's campaigns and programs, such as the 2011 [National Partnership for Action plan](#), have helped raise awareness of and worked to overcome health disparities for minorities.

Improvements in health care have led to a reduction in, and in some cases elimination of, disparities in certain areas. For example, more minority women are getting mammogram screenings for breast cancer, getting treatment with antibiotics earlier, and seeking counseling for smoking cessation.¹ Today, some minority women have a longer life expectancy than white women. Latinas in the United States have the longest life expectancy at almost 84 years, compared with 81 years for white women.² Hispanic, American Indian, and Asian women all have lower death rates from heart disease when compared with white women.³ Lung cancer death rates have been declining for African-American females since 2003, while breast cancer deaths have been declining among African-American women since 1991.⁴

The overall health of American women has improved over the past few decades, but not all women have benefitted equally. Minority women have experienced similar declines, compared with white women, in the leading causes of death,^{5,6} but serious health disparities still exist. Many minority women continue to lag behind white women in a number of areas, including quality of care, access to care, timeliness, and outcomes. Although there have been improvements in minority women's health, we still have a lot of progress to make.

A focus on reducing health disparities remains a top priority for HHS. A 2013 CDC report, [Health Disparities and Inequalities](#), found that women and almost all minority groups were more likely to report poor health.⁷ The 2011 [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#) outlines goals and actions that HHS, with leadership from OMH, will take to reduce health disparities among racial and ethnic minorities. The Affordable Care Act is working to address barriers to care by providing [preventive services for all women](#) and helping millions of minority women get insurance.^{8,9, 10, 11}

¹ AHRQ, [Minority Health: Recent Findings. Program Brief](#)

² HRSA, [Women's Health USA 2011](#)

³ NIH, NHLBI, [2012 NHLBI Morbidity and Mortality Chart Book](#)

⁴ NIH, NCI, [SEER Cancer Statistics Review 1975-2010 National Cancer Institute](#)

⁵ NIH, NHLBI, [2012 NHLBI Morbidity and Mortality Chart Book](#)

⁶ NIH, NCI, [SEER Cancer Statistics Review 1975-2010 National Cancer Institute](#)

⁷ CDC, [CDC Health Disparities and Inequalities Report – U.S. 2013](#)

⁸ HHS, [The Affordable Care Act and African Americans](#)

⁹ HHS, [The Affordable Care Act and Latinos](#)

¹⁰ HHS, [The Affordable Care Act and Asian Americans and Pacific Islanders](#)

¹¹ HHS, [Fact Sheet: The Affordable Care Act and American Indian and Alaska Native People](#)

Recognizing the Needs of Lesbian, Bisexual, and Transgender Women

Lesbian, bisexual, and transgender women **face** health disparities linked to social discrimination and denial of their civil and human rights. These disparities¹ include the following:

- Lesbians are less likely to get preventive services for cancer.
- Lesbians and bisexual females are more likely to be overweight or obese.
- Transgender women are more at risk for HIV and sexually transmitted infections (STIs), violence, mental health issues, and suicide and are less likely to have health insurance.
- Bisexual women are at greater risk of rape, physical violence, and stalking than lesbian and heterosexual women.²

As a result of these disparities, HHS set up the first-ever Lesbian, Gay, Bisexual, and Transgender (LGBT) Issues Coordinating Committee in 2010.³ The committee developed a set of [recommendations](#), first released in 2011 and updated annually.

Since 2010, HHS agencies have taken several actions to promote equal treatment of LGBT Americans, provide additional resources for LGBT health issues, and develop better information about LGBT health needs. CMS has increased enforcement of hospital visitation rights, and HHS has updated guidelines about medical decision-making. CMS has also clarified Medicaid and Medicare rules about spousal protections and rights to include same-sex partners.⁴ To help disseminate this information, and other important health information and assistance, AOA has created a national resource center for older LGBT people.⁵ In March 2011, the Institute of Medicine (IOM) released a report commissioned by NIH on the state of the science of LGBT health. The report provides the scientific community with the first comprehensive overview of research on LGBT health issues — an important step in identifying research gaps and opportunities.⁶ In October 2011, HRSA released [Women's Health USA 2011](#), with the first-ever feature focus on the health of lesbian and bisexual women. Since January 2013, the CDC has included a sexual orientation-specific question on the National Health Interview Survey to further improve data on the health of lesbian, gay, bisexual, and transgender populations.⁷ [Learn more](#) about other HHS actions on improving LGBT health.

Today, the 2010 Affordable Care Act is also [improving care and access to health coverage](#) for lesbian, bisexual, and transgender women. This is important because studies have shown that health disparities related to sexual orientation and gender identity are due in part to lower rates of health coverage.⁸

¹ HealthyPeople.gov, [Lesbian, Gay, Bisexual and Transgender Health - Overview](#)

² CDC, [Intimate Partner Violence in the United States — 2010](#)

³ HHS, [HHS LGBT Issues Coordinating Committee 2012 Report](#)

⁴ HHS, [Better Health and Well-Being](#)

⁵ AOA, [Lesbian, Gay, Bisexual and Transgender \(LGBT\)](#)

⁶ NIH, [Statement by NIH Director Francis S. Collins, M.D., Ph.D., on opportunities for advancing LGBT health research](#)

⁷ HHS, [HHS LGBT Issues Coordinating Committee 2013 Report](#)

⁸ HHS, [U.S. Department of Health and Human Services Recommended Actions to Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities](#)

Creation of Offices on Women’s Health at the Federal Level

Within HHS there are several offices and agencies dedicated to women’s health. Congress has played a key role in establishing and authorizing these offices on women’s health in the federal government, in addition to funding the work of the government each year. The 2010 Affordable Care Act codifies the establishment of several Offices of Women’s Health within HHS and gives these offices, all of which were already in existence, new authority, agency, and protection from termination or reorganization without the direct approval of Congress. (For more information see “Title III. Improving the Quality and Efficiency of Health Care, Section 3509, Improving Women’s Health” of the [2010 Affordable Care Act](#).)

At NIH, the [Office of Research on Women’s Health](#) was established in September 1990 as the first Public Health Service office dedicated specifically to promoting women’s health and sex differences research.

In 1991, the [HHS Office on Women’s Health](#) (OWH) was established to advance and coordinate a comprehensive women's health agenda throughout HHS. In 1993, OWH began leading and overseeing the HHS [Coordinating Committee on Women's Health](#) (CCWH), which had been established in 1984 to advise the HHS Assistant Secretary for Health. The committee's members include senior-level representatives from each of the federal agencies and offices within HHS.

In 1992, an Associate Administrator for Women’s Services was established at SAMHSA. In 1994, Offices of Women’s Health were established at the [FDA](#) and the [CDC](#). In 1999, AHRQ established an [Office of Women’s Health and Gender Research](#), and in 2000, HRSA established an [Office of Women’s Health](#).

All of these federal offices coordinate their work to advance women’s health through the HHS CCWH. [Learn more](#) about recent women’s health activities across the federal government.

Creation of Women’s Health Information Resources

OWH launched the National Women’s Health Information Center (NWHIC) in 1998 with support from ACF, AHRQ, AOA, ATSDR, CDC, FDA, CMS, HRSA, IHS, NIH, and SAMHSA. The original function of NWHIC was to provide a gateway to the vast array of federal health information available at a time when the Internet was still a new technology. A key part of the NWHIC was the toll-free call center — an alternative way to reach people who needed women’s health information. While the technology of NWHIC has evolved over the years from printed publications and a call center to flagship websites and social media channels, the outcome has been consistent — OWH, other federal Offices of Women’s Health, and several HHS agencies and offices provide the reliable, unbiased information women and girls need to learn about their health and how they can improve it.

Each HHS agency and office provides access to reliable, unbiased women’s health information as it relates to their mission. In addition, most agencies and offices use social media to ensure that women have access to the latest health information at their fingertips. Many agencies and offices have also created apps or other web tools such as risk calculators so that women can easily participate in their own or their family’s health care decisions.

Over the last 30 years, information technology has changed the way we live. Here at HHS we will continue to evolve to ensure that we are providing women and girls with the information they need to achieve the best possible health.

Appendix A: Agency and Office Descriptions – HHS and Women’s Health

Meeting women’s health needs and improving their health is one of the most urgent priorities of the [U.S. Department of Health and Human Services](#) (HHS). Every day, millions of children, families, and seniors have health care, food, and child care through the efforts of various HHS agencies. Every day, research funded and performed by HHS agencies advances our knowledge of how to treat and prevent disease and how to be a healthier nation.

Here is a brief description of HHS agencies that contribute to women’s health needs.

Administration for Children and Families (ACF)

Website: www.acf.hhs.gov

The Administration for Children and Families (ACF) supports the needs of children and families, individuals, and communities through programs for early childhood development, ending human trafficking, family violence prevention, healthy marriages, and more. More than 80% of ACF’s \$49 billion budget is devoted to programs that directly support children and families.

Administration for Community Living (ACL)

Website: www.acl.gov

The Administration for Community Living (ACL), which includes the [Administration on Aging](#) (AOA), supports the needs of the aging and disabled populations and enhances access to quality health care and long-term services for all individuals. The ACL also supports the [National Family Caregiver Support Program](#).

Agency for Healthcare Research and Quality (AHRQ)

Website: www.ahrq.gov

The Agency for Healthcare Research and Quality (AHRQ) supports and leads research to help make health care safer, higher quality, more accessible, more equitable, and more affordable. AHRQ also works with other HHS agencies and partners to make sure the research is understood and used.

Centers for Disease Control and Prevention (CDC)

Website: www.cdc.gov

The Centers for Disease Control and Prevention (CDC) is the nation’s public health agency. Through its numerous health surveillance programs, the CDC detects and responds to any new and emerging health threats. The CDC also translates the data collected into reliable health information to promote healthy

and safe behaviors. The CDC collaborates closely with state and local health agencies on key public health concerns.

Food and Drug Administration (FDA)

Website: www.fda.gov

The Food and Drug Administration (FDA) is charged with protecting public health by ensuring the safety, effectiveness, quality, and security of drugs, vaccines, and medical devices. The agency is also responsible for protecting the nation's food supply and regulating all cosmetics, dietary supplements, tobacco, and more.

Health Resources and Services Administration (HRSA)

Website: www.hrsa.gov

The Health Resources and Services Administration (HRSA) works to improve access to quality health care for those who are uninsured or living with HIV/AIDS and for pregnant women, mothers, and children. HRSA funds Federally Qualified Health Centers — community-based health centers serving those most in need.

Indian Health Services (IHS)

Website: www.ihs.gov

The Indian Health Services (IHS) provides health information, health care, and services for almost 2 million American Indians and Alaska Natives.

National Institutes of Health (NIH)

Website: www.nih.gov

The National Institutes of Health (NIH) is made up of 27 Institutes and Centers, each with a specific research agenda, from maternal and child health to cancer and mental health. NIH funds biomedical research in every state and around the globe. Out of the \$31 billion that the NIH will invest in 2014 in medical research, almost \$4 billion will fund research specifically on women's health.

Offices of the Assistant Secretary for Health (OASH)

Website: www.hhs.gov/ash

There are many offices under the HHS Office of the Assistant Secretary for Health that are cornerstones for delivery of public health services. These include:

Office of the Surgeon General (OSG)

Website: www.surgeongeneral.gov

Provides Americans the best scientific information available on how to improve their health and reduce their risk of illness and injury.

National Vaccine Program Office (NVPO)

Website: www.hhs.gov/nvpo

Ensures collaboration among the many federal agencies involved in vaccine and immunization activities.

Office of Adolescent Health (OAH)

Website: www.hhs.gov/ash/oah

Coordinates adolescent health promotion and disease prevention initiatives across HHS.

Office of Disease Prevention and Health Promotion (ODPHP)

Website: www.odphp.osophs.dhhs.gov

Provides leadership, coordination, and policy development for public health and prevention activities. Leads the Healthy People initiative for HHS.

Office of HIV/AIDS and Infectious Disease Policy (OHAIDP)

Website: www.hhs.gov/ash/ohaidp

Is responsible for coordinating, integrating, and directing the department's policies, programs, and activities related to HIV/AIDS, viral hepatitis, and other infectious diseases of public health significance, and blood safety and availability.

Office of Minority Health (OMH)

Website: www.minorityhealth.hhs.gov

Addresses health status and quality of life for minority populations in the United States.

Office of Population Affairs (OPA)

Website: www.hhs.gov/opa

Advises on issues related to family planning and population affairs, and supports Title X family planning clinics nationwide.

Office on Women's Health (OWH)

Website: www.womenshealth.gov

Addresses the health of women nationwide by providing leadership and coordination through policy, education, and model programs.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Website: www.samhsa.gov

Through its programs and campaigns, the Substance Abuse and Mental Health Services Administration (SAMHSA) works to make substance abuse and mental health information and services available and accessible.