

PREVENTATIVE HEALTH CARE

OPPORTUNITIES FOR IMPROVING WOMEN'S HEALTH

A combination of biological attributes, sociocultural conditions, personal health behaviors, and health care variables produces healthy women.

I. The Social Contest of Women's Health

- Currently, a multi-issue, life span perspective has replaced earlier perspectives on women's health.
- Women in the United States have a life expectancy that is about six years longer than it is for men. In 1996, the average life expectancy at birth for women was 79.1 years and 73.1 years for men.
- Gender influences an individual's access to health-producing resources such as a safe environment, adequate nutrition, education, paying jobs, social network and community involvement, and health information and services.
- Historically, women obtain less formal education than men, are less likely to be employed for pay, earn less income than men, are more likely to be exposed to violence in their homes, and have greater caregiving responsibilities for children and other family members.

A. Education

- Higher levels of education are associated with more healthful behaviors, greater use on preventive health services, and better health status. Education has an effect on health-related knowledge, jobs, income, health insurance, and safe housing and neighborhoods. Women's educational achievements have increased steadily in the United States.

B. Paid Employment

- An increase in women in the labor force is an important trend in women's status in the twentieth century. Employment has been beneficial to women's health due to its economic and psychosocial benefits. Some job-related stresses—such as exposure to unsafe working conditions, workplace sexual harassment, lack of childcare, or heavy job demands combined with low levels of job control—may be associated with risks to women's health.

C. Poverty

- Despite gains in education, employment, and earnings, women are more likely than men to live in poverty.

D. Marriage and Parenthood

- Patterns of marriage have been changing. Both men and women are delaying marriage.
- In American culture, childbearing is less and less associated with marital status.
- Births among unmarried women have been increasing: the percent of live births to unmarried women increased from about 11% in 1970 to 32% in 1996.
- Unintended pregnancy has been associated with risks to the woman's health, delayed initiation of prenatal care, poor birth outcomes, and an increased number of abortions.

E. Caregiving Roles

- Caring for children and other family members remains largely the responsibility of women.
- The stresses associated with caregiving can have detrimental effects on women's health. The greatest caregiving burdens are thought to accrue to mothers who do not have access to adequate childcare or support from a spouse, and to midlife or older women who are caring for aging parents, sometimes concurrently with caring for their own children.
- In the 1993 Commonwealth Fund Survey of Women's Health, for example, married women ages 65 and younger whose husbands were involved in housework and childcare reported fewer depressive symptoms and higher self-esteem than women whose husbands did not share these responsibilities. Among women caregivers of elderly parents, depressive symptoms and social withdrawal are among the most common problems.

II. Women's Health Across the Life Span

- An awareness of women's health across their life span—from childhood through adulthood is needed to provide appropriate health services to women in all age groups. This awareness helps to develop approaches for preventing or delaying the onset of diseases and disabilities in older age groups. For examples, healthy behaviors (such as regular exercise, adequate nutrition, and smoking cessation) and comprehensive clinical screening services at earlier ages can reduce the burden of chronic diseases and disability.

A. Adolescence and Early Adulthood Age 13 to 22 Years

- Adolescent development can be divided into three intervals, which correspond to chronological age: early adolescence (ages 10 to 13), middle adolescence (ages 14 to 17) and late adolescence (ages 18 to 22)
- Deaths from unintentional injuries, mostly motor vehicle crashes, are the leading cause of mortality for women ages 15 to 24, followed by homicide and suicide.
- The overall mortality pattern for women ages 15 to 24 suggests the importance of risk-taking behaviors (including substance abuse), exposure to violent situations, and mental health problems for the health of young women. Depression is more common in young women than in young men, and is associated with suicide among adolescents. The use of alcohol and illicit drugs typically begins in adolescence or early adulthood.

Physical Development

- The physical transition to adolescence, known as puberty, generally proceeds in an orderly fashion.
- The typical sequence of pubertal growth involves accelerated linear growth (height), breast budding, the appearance of pubic hair, and menarche occurs at an average age of 12.9 for Caucasian girls and 12.2 for African-American girls in the U.S.
- Aberrations from the normal timing and sequence of puberty should be evaluated. These aberrations include, Pubertal growth before age 7, Absence of breast budding by age 12, No menarche by age 15 or 16, or onset of vaginal bleeding prior to breast or pubic hair development.
- The nutritional and exercise habits established in childhood and adolescence can have important consequences for subsequent health status, including the development of osteoporosis later in life.
- Eating disorders (anorexia and bulimia nervosa) are more common in women than in men and typically appear during adolescence or early adulthood.

Cognitive Development

- The ability to think abstractly is a major marker of adult cognitive function.
- The incomplete cognitive development of adolescents leads to a number of characteristic aspects of adolescent thinking: the inability to prioritize solutions to problems; the concept of having an imaginary audience (assuming that what is important to them is important to everyone else, or that everyone is aware of their own personal and intimate thoughts/feelings); apparent hypocrisy (the ability to conceptualize rules but the inability to apply them consistently to themselves); and the “personal fable” (the feeling of “specialness” or invulnerability). These aspects of adolescent development are developmentally normal, but can lead to frustration for clinicians and parents.
- The early and middle adolescent who becomes prematurely sexually active is often an ineffective contraceptive, in part because of these aspects of cognitive development: the inability to conceptualize the consequences of her actions. The inability to successfully choose and use a method of contraception consistently; and the feeling that “it (pregnancy) can’t happen to me.”

Psychosocial Maturation

- The adolescent’s development of self within a social context includes the tasks of effectively separating from parents and family by gaining independence, the achievement of a realistic vocational goal, the achievement of a mature level of sexuality, and the consolidation of a realistic and positive self-image. Early adolescents will typically begin to demonstrate their desire to separate from the family in ways that include temper outbursts and tantrums.
- By middle adolescence, individuals are identifying with a mixed-gender peer group. The influence of this peer group can be either a positive or negative one. This time has been described as an opportunity for an individual to try out different identities with their peers until they find one with which they are comfortable.
- By late adolescence, the peer group becomes less important and individual choices more comfortable.

Sexuality

- Children and adolescents are sexual beings. Sexuality does not begin suddenly at adolescence. Adolescence is a time of heightened sexual awareness.
- An understanding of normal adolescent development is essential for the clinician who sees adolescents and evaluates, manages, and treats their gynecologic and general medical problems. Failing to understand that an adolescent may look physically mature, but has not yet accomplished the developmental tasks necessary for adulthood and maturity is an important concept for clinicians.
- Adolescence and early adulthood are times of intense social pressure on young women to adopt normative sexual roles and to initiate sexual activity. As a result, this is a period of high risk for unintended pregnancy and sexually transmitted infections (STI), both of which may have long-term impacts on women's health and well being.
- The most prevalent STI in women is chlamydia. Sexually transmitted infections may lead to reproductive cancers, pelvic inflammatory disease, infertility, ectopic pregnancy, and perinatal mortality and morbidity
- Younger women have greater exposure to violence, including sexual violence. Major depression, posttraumatic stress disorder, and alcohol and substance abuse are more common among women who have experienced sexual assault.
- Unintended births (that is, births that were mistimed or unwanted at conception) were more prevalent among women under the age of 25.
- Unintended pregnancy also contributes to abortion rates, and the majority of women who have abortions are under the age of 25.

Communication

- Adolescents appreciate clinicians who take a genuine interest in their health and well being, which is manifest with a friendly, open, and respectful manner. Each clinician develops her or his own style of communication; however, the language should be understandable and not patronizing. Avoid giving a lecture.
- **Confidentiality** - The concept of confidentiality is an absolutely essential aspect of adolescent health care. Numerous studies demonstrate that without assurances of confidentiality, some adolescents are not honest or

forthcoming about issues dealing with sexuality, depression, substance use, or sexually transmitted infections (STI's). Confidentiality must occasionally be breached if suicide, homicide, or abuse are at issue.

- The concept of confidentiality should be discussed with parents and reinforced with the adolescent individually. This can be done in a way that helps parents recognize and respect the adolescent's growing independence, but that also encourages parents and teens to communicate with one another.
- Adolescents who have reached the age of majority-usually 18 or 21-may consent to treatment; medical care of younger individuals usually requires parental consent. True medical emergencies constitute an exception.

The Gynecologic Visit

- An adolescent's initial visit to an obstetrician/gynecologist for health guidance, screening, and preventive services should take place around age 13 to 15.
- Health risks of adolescents are related to risk-taking behaviors such as smoking, alcohol and other substance abuse, premature sexual activity, and morbidity/mortality due to accidental and intentional injuries or depression and suicide.
- Most of the time this first visit does not include a pelvic examination.

Visit Structure

- The clinician meets first with both the parent (usually the mother) and the adolescent. The structure and purpose of the visit should be explained-screening, preventive guidance, establishing a health care relationship, and allowing for a discussion of any concerns or questions about health.
- After getting this initial information, the clinician should tell the mother to wait in the waiting area (not just outside the office door), and the teen should be seen alone. The concepts of confidentiality and the caveats outlining the situations in which confidentiality must be breached (homicidal or suicidal ideation or abuse) are restated.
- A social and sexual history are obtained from the teen. The social history should include an assessment of the teen's functioning in school, extracurricular activities including athletics, and her functioning with peers and with family.

- A review of symptoms is important-including questions about gynecologic and endocrine function and symptoms of gastrointestinal/genitourinary (GI/GU) disease.
- Suicide is a significant cause of death among adolescents. Physicians who see adolescents must be alert to the signs of depression and the frequency of suicidal ideation. The primary health provider must make appropriate inquiries about thoughts and plans and of suicide.
- The teen should be asked about weight loss or gain, her feelings about current weight (feeling “too fat” when she is of normal or low weight).
- Health promotion measures-the importance of regular exercise, healthy diet with adequate calcium intake and lower fat-can be offered through teen-appropriate patient education brochures.
- Give the teen patient an opportunity to ask any health or sex-related questions and to discuss any concerns.
- Teens will quickly “tune out” a clinician who is condescending, judgmental, or who does not show a genuine interest in their health. At age 14, adolescents need to know the facts, including information about anatomy, menstruation, conception and pregnancy, abstinence as the only sure method to prevent STI’s/pregnancy, birth control methods and STI’s, including HIV.

Specific Medical Issues

Normal and Abnormal Menses
 Dysmenorrhea
 Pelvic Pain
 Menorrhagia
 Sexual Activity
 STIs

B. Young Adulthood Ages 22 to 39

- The practice of preventive medicine should ideally include primary prevention, such as immunization, which prevents disease from occurring; secondary prevention, such as breast examinations, which detects already existing disease that has not yet become clinically apparent; and tertiary prevention, such as aspirin after a stroke, which prevents progression of an already apparent disease. Prevention also includes counseling to identify and help eliminate risk factors for a disease.
- In young adult women, ages 25 to 44, the leading overall causes of death in 1993 included cancer, unintentional injuries (62% from motor vehicle crashes), heart disease, HIV infection, and homicide.

Sexually Transmitted Infections and Contraception

- The most pressing health care needs of the reproductive age female relates to the reproductive system. Concerns related to childbearing and impaired fertility are prominent in this age group. More women have their first babies after age 25. In 1996, 65% women in the later stage of early adulthood are most likely to experience impaired fertility.
- Prevention of STIs is rooted in education. Physicians must discuss the short-and long-term dangers of STIs, and emphasize their easy transmissibility and prevention. Forty-five percent of all AIDS cases in women in 1996 were diagnosed among those ages 30 to 39 Most women contract HIV through heterosexual contact rather than through injecting drugs.
- Screening should be done on the basis of risk factors.
- The patient diagnosed with an STI should be treated and counseled regarding the need for treatment of her partner and future condom use.

Screening for Medical Problems

- Screening programs for many common cancers have been shown to significantly decrease mortality, and more sophisticated screening, using genetic markers, is now emerging. Prevention of cancer through diet, lifestyle, and therapies is an important objective for patients.
- **Breast:** In addition to the complete patient and family histories that should be performed, screening should include instruction in the breast self-exam, which reproductive-age patients should perform during the first 7 days following the onset of menses on a monthly basis.
- **Cervix:** The Pap smear has developed into an effective cancer screening technique, and has resulted in a significant reduction in mortality from cervical cancer. Recommendations are that patients begin screening with annual Pap smears at age 18, or with the onset of sexual activity if that occurred earlier than age 18. Low-risk women can increase this interval after three negative smears.
- **Skin:** Screening consists of careful physical examination of the skin by the physician, with attention to nevi with irregular borders, color changes, itching, and bleeding. Primary prevention includes limiting exposure to the sun either by avoiding the outdoors at midday, or by using an appropriately rated sunblock formulation.

- ***Osteoporosis:*** Bone content rises through ages 25 to 30. Women achieve peak bone mass of both trabecular and cancellous bone by age 30.
- Reproductive-age women can begin life-style changes that will have long-term effects on fracture rates. Such prevention includes exercising and diets high in calcium and low in protein, phosphorous, fat, sodium, and caffeine, all of which either increase urinary excretion of calcium or decrease its intestinal absorption. Calcium intake of 1.0 to 1.5 g per day, particularly during adolescence and the 20s, increases peak bone mass and decreased the risk of future fractures. Calcium supplementation should be encouraged to ensure adequate daily intake. Alcohol and smoking are both associated with decreased peak bone mass and with increased rates of bone loss and of osteoporosis.
- ***Cardiovascular:*** Cigarette smoking, obesity, hypercholesterolemia, diabetes, and hypertension are all identified risk factors for cardiovascular disease, and are all influenced by habits that often form before or during the reproductive-age years. Counseling about diet and exercise should comprise a prominent part of the health care of reproductive-age females.
- ***Depression*** occurs most frequently in women ages 25 to 44, but studies suggest that the age of onset increasingly occurs in the adolescent and early adult years. Women are at increased risk of depression during pregnancy and following childbirth. 10 percent of pregnant women have major depression. 10 to 15 percent of new mothers have postpartum major depression.

C. Middle Adulthood Age 40 to 64

- The cumulative effects of the life experiences, earlier investments in health (including prevention) and risk behaviors (such as smoking) have important consequences for the pattern of chronic conditions and disabilities in middle adulthood.
- The two leading causes of death in women ages 45 to 64. 1993 were cancer and heart disease in 1993. Breast cancer is predominant before age 55, with lung cancer surpassing breast among 55 – 64-year-olds.
- Other leading causes of death for women ages 45-64 are cerebrovascular disease, chronic obstructive pulmonary disease (COPD), and diabetes mellitus.

- The most frequent health problems reported in midlife women are arthritis, high blood pressure, anxiety or depression, urinary tract infections, and urinary incontinence.
- The percentage of women with osteoporosis increases with each decade of life after age 50.
- The 1994 National Health Interview Survey shows that it is in midlife (ages 45 to 64) when the impact of chronic disease on women's functioning increases substantially.
- The average age of menopause in U.S. women is approximately 51. The length of the perimenopausal transition has been estimated at nearly 4 years. Post menopausal bone loss and heart disease are important health concerns at this time.

Screening for Medical Problems

- ***Ovary Cancer:*** No screening for early detection. 10 percent of ovarian cancer is hereditary. 80 percent is in post menopause.
- ***Colon Cancer:*** The risk of colon cancer is minimal for the average-risk reproductive-age woman. The need for screening begins at age 50, according to the American Cancer Society Screening (ACS).
- ***Diabetes:*** All women should be tested at age 45, with repeat testing every 3 years, if normal. Testing at a younger age and at more frequent intervals should be performed for high-risk patients, which include those with obesity; family history of a first-degree relative with diabetes; hypertension; history of gestational diabetes or of a baby weighing >9 lb; HDL cholesterol <35 mg/dl; triglyceride level >250 mg/dl; membership in a high-risk ethnic population such as African-American, Hispanic, Asian, or Native American; or previous impaired glucose testing. The preferred method of testing is the fasting plasma glucose (FPG) performed after at least 8 h of fasting; FPG > 126mgdl establishes the diagnosis of diabetes, <110 is normal, and 110 and 125 is considered "impaired"
- ***Thyroid:*** hypo and hyperthyroidism more common in females. Hypothyroidism tends to be diagnosed in women over age 60, but has a slow onset and may exist sub clinically in reproductive age women. Current screenings begin for low risk women at age 50 with measurement of TSH, but premenopausal women with a review of systems suggestive of disease should undergo thyroid testing.

D. Later Adulthood Ages 65 and older

- Health concerns of older women include chronic conditions and disabilities.
- For older adult women, ages 65 and over, the leading causes of death are cancer and heart disease.
- Chronic conditions among women ages 65 and over are arthritis, high blood pressure, and heart disease.
- Dementing disorders, including Alzheimer's disease, increase with age.

III. PREVENTION

- Physicians can do an enormous amount for their patients by utilizing preventive strategies and helping patients modify high-risk behaviors.
- The health care team can identify current or potential high-risk behaviors and emphasize the importance of healthy life styles to their patients.
- Preventative strategy should include the evaluation of the following aspects of a women's life, patient behavior and habits (smoking, drug use, alcohol use), diet and exercise, sexual behavior, psychosocial issues
- (depression , domestic violence), screening for disease, immunizations, and safety issues

IV. MEDICAL HISTORY

The Importance of a Detailed Personal, Social, and Family History

- Obtaining a detailed history through medical history is one of the first steps in initiating and establishing the doctor-patient relationship. Time spent with the patient shows genuine interest on the part of the clinician. A trusting relationship increases patient receptivity to education and increased the probability of patient compliance.
- By gathering historical data, the clinician can focus the physical examination, order appropriate laboratory tests, and formulate a differential diagnosis. All of these steps will lead to a plan for long-term treatment and preventive care.

The following outlines the medical history that the physician needs to obtain.

- I. Biographical Data
- II. Source of History
- III. Chief Complaint and Present Illness
- IV. Past Medical History
 - a. Allergies
 - b. Medications
 - c. Illness/Hospitalizations
 - d. Surgery
 - e. Trauma
 - f. Bleeding tendencies
 - g. Transfusion history
 - h. Immunizations
- V. Obstetric and Gynecologic History
 - a. Menstrual history
 - b. Sexual history
 - c. Contraception
 - d. Vaginal and pelvic infections
 - e. Pap smear history
 - f. Gynecologic surgery or procedures
 - g. Urologic history
 - h. Breast disease, prior mammography
 - i. Pregnancies
- VI. Family history
 - a. Breast, gynecologic, colon, or other cancers
 - b. Genetic diseases, congenital anomalies, twinning, preeclampsia
 - c. Hypertension, diabetes, cardiovascular disease, etc.
 - d. Psychiatric and social
- VII. Social History
 - a. Habits: alcohol, tobacco, illicit drugs
 - b. Marital status
 - c. Living arrangements
 - d. Education
 - e. Occupation
 - f. Diet/exercise
 - g. Possible exposure to abuse or neglect
- VIII. Review of Systems
 - a. Head and neck
 - b. Cardiovascular/respiratory
 - c. Gastrointestinal
 - d. Genitourinary
 - e. Neurologic
 - f. Psychiatric

- The family history should include inquiries about premature coronary artery disease in first-degree relatives, diabetes, hypertension, and hyperchlesterolemia.
- One should specifically ask about the age, sex, and health of parents, siblings, and other close relatives. The age and cause of deceased relatives should be recorded.
- The social history should include questions about tobacco use, alcohol intake, drug use, domestic violence, mental health history such as depression, and any history of sexually transmitted diseases. It cannot be stressed enough that specific and direct questions must be asked of the patient. In these sensitive areas, patients will often not volunteer their concerns.
- In obtaining the patient's psychosocial history, it is also important to identify the patient's living arrangements, level of formal education, occupation, marital status, sexual orientation, and ethnic and cultural background.
- Social history may identify stress levels. Occupational histories may reveal environmental hazards or exposures particularly relevant to pregnancy. All of these demographic features of the social history may give clues to the amount and type of education needed to insure patient compliance.
- Patients will frequently modify unhealthy behaviors if physician interest is demonstrated to them, and counseling is provided

VI. PREVENTATIVE SCREENING THROUGHOUT A WOMAN'S LIFE

- A primary role of the physician is to help women stay healthy. If disease does occur, it must be diagnosed as early as possible to afford the greatest likelihood of cure or long-term control of the problem, the risk of. The screening and prevention strategies that are most important for any given woman depend on her individual risk factors (genetic, environmental, and behavioral). The strategies change as the woman ages and evolves through the phases of her life.

Periodic Health Assessment and Preventive Care for Women Ages 13 to 22 Years

- I. Screening
 - A. Review problem list and continuity-of-care records
 - B. Periodic history: reason for visit; interval medical, surgical, and family history; dietary/nutritional assessment; exercise; tobacco, alcohol, other drugs; abuse/neglect; sexual practices
 - C. Periodic physical; height, weight, BP, Tanner staging of secondary sexual characteristics; general physical examination; pelvic examination (yearly when sexually active or by age 18 years)
 - D. Laboratory tests
 - 1) Pap test –yearly when sexually active or by age 18 years
 - 2) Sexually transmissible infection (STI) testing-for women with a history of multiple sexual partners or with a sexual partner with multiple contacts; women who have a partner with an STI; women with a repeated history of STI's; women who attend an STI clinic; routine screening for chlamydia and gonorrhea (GC) infection for all sexually active adolescents and other asymptomatic women at risk for infection
 - 3) HIV testing-for high risk women; for women seeking treatment for STI's; for women with a past or present history of drug use by injection; current or past history of prostitution; women whose past or present sexual partners are HIV-positive or bisexual or who inject drugs; women with recurrent genital tract disease; women born, or with long-term residence, in an area with a high prevalence of HIV infection; women transfused between 1978 and 1985; women younger than age 50 who have invasive cervical cancer; women who are pregnant or planning for pregnancy.
 - 4) Lipid profile-periodic screening for women with an elevated cholesterol level; a history of a parent or a sibling with high blood cholesterol level or with documented coronary artery disease at a very young age; presence of diabetes mellitus, smoker
 - 5) Tuberculosis skin test-regular testing for teens; for women infected with HIV; for close contacts of persons known or suspected to have TB; persons with medical risk factors known to increase the risk of disease if infection has occurred; persons born in countries with high TB prevalence; medically underserved; low-income populations; alcoholics and IV drug users; residents of long-term care facilities correctional institutions, mental institutions, and nursing homes; health professionals working in high-risk health care facilities

- II. Evaluation and Counseling
 - A. Sexuality
 - 1) Development
 - 2) High-risk behaviors
 - 3) Preventing unintended pregnancy (postponing sexual involvement; contraceptive options)
 - 4) Sexually transmissible infections (partner selection; barrier protection)
 - B. Fitness
 - 1) Hygiene (including dental); fluoride supplementation
 - 2) Dietary/nutritional assessment
 - 3) Exercise: discussion of program
 - 4) Folic acid supplementation (0.4 mg/day)
 - C. Psychosocial evaluation: interpersonal/family relationships, sexual identity, personal goal development, behavioral/learning disorders, abuse/neglect, satisfactory school experience
 - D. Cardiovascular risk factors: family history, hypertension, dyslipidemia, obesity, diabetes mellitus
 - E. Health/risk behaviors
 - 1) Injury prevention - safety belts and helmets, recreational hazards, firearms, hearing
 - 2) Skin exposure to ultraviolet rays
 - 3) Suicide: depressive symptoms
 - 4) Tobacco, alcohol, other drugs

- III. Immunizations
 - A. Tetanus-diphtheria booster once between ages 13 and 16 years
 - B. Measles, mumps, rubella (MMR) for all women unable to show proof of immunity
 - C. Hepatitis B vaccine: for those not previously immunized
 - D. Varicella vaccine if no previous evidence of immunity
 - E. Hepatitis A vaccine for high-risk individuals

Periodic Health Assessment and Preventive Care for Women Ages 22 to 39 Years

- I. Screening
 - A. Review problem list and continuity-of-care records
 - B. Periodic history
 - C. Physical examination including pelvic exam
 - D. Laboratory tests
 - 1) Pap test After 3 consecutive normal tests in low risk women, use physician and patient discretion as to whether it is annual
 - 2) Bacteriuria testing: periodic testing particularly for women with diabetes mellitus

- 3) Mammography: women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative (may need to begin earlier depending upon the age at diagnosis)
- 4) Cholesterol every 5 years beginning at age 20
- 5) Sexually transmissible infection (STI) testing: for women with a history of multiple sexual partners or with a sexual partner with multiple contacts; women who have a partner with an STI; women with a repeated history of STIs; women who attend an STI clinic.
- 6) HIV testing: for high risk women; for women seeking treatment for STIs; for women with a past or present history of drug use by injection; current or past history of prostitution; women whose past or present sexual partners are HIV-positive or bisexual or who inject drugs; women with recurrent genital tract disease; women born, or with long-term residence, in an area with a high prevalence of HIV infection; women transfused between 1978 and 1985; women younger than age 50 years who have invasive cervical cancer; women who are pregnant or planning for pregnancy
- 7) Tuberculosis skin test: for women infected with HIV; for close contacts of persons known or suspected to have TB; persons with medical risk factors known to increase the risk of disease if infection has occurred; foreign-born persons from countries with high TB prevalence; medically underserved; low-income populations; alcoholics and IV drug users; residents of long-term care facilities, correctional institutions, mental institutions, and nursing homes; health professionals working in high-risk health care facilities; schools may require testing

II. Evaluation and Counseling

A. Sexuality

- 1) High-risk behaviors
- 2) Contraceptive options: discussions to include genetic counseling, prevention of unwanted pregnancy
- 3) Preconception counseling for desired pregnancy
- 4) Sexually transmissible infections - partner selection, barrier protection
- 5) Sexual function

B. Fitness

- 1) Hygiene (including dental)
- 2) Dietary/nutritional assessment
- 3) Exercise: discuss program
- 4) Folic acid supplementation (0.4 mg/day)
- 5) Calcium supplementation

C. Psychosocial evaluation: interpersonal/family relationships, domestic

- violence, job satisfaction, lifestyle/stress, sleep disorders
- D. Cardiovascular risk factors: family history, hypertension, dyslipidemia, obesity, diabetes mellitus, lifestyle
- E. Health/risk behaviors
- 1) Injury prevention: safety belts and helmets, occupational hazards, recreational hazards, firearms, hearing
 - 2) Breast self-examination
 - 3) Skin exposure to ultraviolet rays
 - 4) Suicide: depressive symptoms
 - 5) Tobacco, alcohol, other drugs

III. Immunizations

- A. Tetanus-diphtheria booster every 10 years
- B. Measles, mumps, rubella - for all women unable to show proof of immunity
- C. Hepatitis B vaccine - for all high risk women; intravenous drug users; current recipient of blood products; health-related job with exposure to blood products; household or sexual contact with hepatitis B virus carriers; history of prostitution; history of sexual activity with multiple partners in last 6 months; schools may require vaccination
- D. Influenza vaccine: residents of chronic care facilities; women with chronic cardiopulmonary disorders; women with metabolic diseases including diabetes mellitus, hemoglobinopathies, immunosuppression, or renal dysfunction; women who will be in the second or third trimester of pregnancy during the epidemic season
- E. Hepatitis A vaccine for high-risk individuals

Periodic Health Assessment and Preventive Care for Women Ages 40 to 64 Years

I. Screening

- A. Review problem list and continuity-of-care records
- B. Periodic history
- C. Physical examination including pelvic exam
- D. Laboratory tests
- 1) Mammography: annual
 - 2) Bacteriuria testing: periodic testing particularly for women with diabetes mellitus
 - 3) Fecal occult blood test: beginning at ages.40-50 years
 - 4) Sigmoidoscopy: starting at age 50 and above average-risk women should have either a sigmoidoscopy every 5 years, or a colonoscopy every 10 years, or a barium enema every 5 to 10 years
 - 5) Colonoscopy - for women with a personal history of inflammatory bowel disease or colonic polyps or colon cancer;

- or a family history of familial polyposis coli, colorectal cancer, or cancer family syndrome
- 6) Hemoglobin: periodic testing
 - 7) Sexually transmissible infection (STI) testing: for women with a history of multiple sexual partners or with a sexual partner with multiple contacts; women who have a partner with an STI; women with a repeated history of STIs; women who attend an STI clinic; in addition perform routine screening for chlamydial and gonorrhea (GC) infection for all asymptomatic women at risk for infection
 - 8) Human immunodeficiency virus testing: for high risk women; for women seeking treatment for STIs; for women with a past or present history of drug use by injection; current or past history of prostitution; women whose past or present sexual partners are HIV-positive or bisexual or who inject drugs; women with recurrent genital tract disease; women born, or with long-term residence, in an area with a high prevalence of HIV infection; women transfused between 1978 and 1985; women younger than age 50 who have invasive cervical cancer; women who are pregnant or planning for pregnancy
 - 9) Tuberculosis skin testing: for women infected with HIV; for close contacts of persons known or suspected to have TB; persons with medical risk factors known to increase the risk of disease if infection has occurred; persons born in countries with high TB prevalence; medically underserved; low-income populations; alcoholics and IV drug users; residents of long-term care facilities, correctional institutions, mental institutions, and nursing homes; health professionals working in high-risk health care facilities
 - 10) Pap test: after three consecutive normal annual tests, in a low-risk woman, physician and patient discretion as to whether this must continue to be annual
 - 11) Cholesterol - every 5 years

II. Evaluation and counseling

A. Sexuality

- 1) High-risk behaviors
- 2) Contraceptive options: discussions to include genetic counseling, prevention of unwanted pregnancy
- 3) Preconceptional counseling for desired pregnancy
- 4) Sexually transmissible infections: partner selection, barrier protection
- 5) Sexual function

B. Fitness

- 1) Hygiene (including dental)

- 2) Dietary/nutritional assessment
 - 3) Exercise (discussion of program)
 - 4) Folic acid supplementation (0.4 mg/day before age 50 years)
 - 5) Calcium supplementation
- C. Psychosocial evaluation: family relationships, domestic violence, job/work satisfaction, retirement planning, lifestyle/stress, sleep disorders
- D. Cardiovascular risk factors: family history, hypertension, dyslipidemia, obesity, diabetes mellitus, lifestyle
- E. Health/risk behaviors
- 1) Hormone replacement therapy
 - 2) Injury prevention: seat belts and helmets, occupational hazards, recreational hazards, sports involvement, firearms, hearing
 - 3) Breast-self-examination
 - 4) Skin exposure to ultraviolet rays
 - 5) Suicide: depressive symptoms
 - 6) Tobacco, alcohol, other drugs

III. Immunizations

- A. Tetanus-diphtheria booster every 10 years
- B. Influenza vaccine for all women annually beginning at age 55 years and for anyone who wishes to reduce the chance of becoming ill with influenza; (prior to age 55 years it should be given to residents of chronic care facilities; women with chronic cardiopulmonary disorders; women with metabolic diseases including diabetes mellitus, hemoglobinopathies, immunosuppression, or renal dysfunction; and women who will be in the second or third trimester of pregnancy during the epidemic season)
- C. Measles, mumps, rubella (MMR): for all women unable to show proof of immunity
- D. Hepatitis B vaccine: intravenous drug users; current recipient of blood products; health-related job with exposure to blood products; household or sexual contact with hepatitis B virus carriers; history of prostitution; history of sexual activity with multiple partners in last 6 months; other high-risk individuals
- E. Pneumococcal vaccine: women with factors for influenza vaccine plus sickle cell disease, Hodgkin's disease, asplenia, alcoholism, cirrhosis, or multiple myeloma, and other chronic illnesses
- F. Varicella vaccine: women with no evidence of immunity
- G. Hepatitis A vaccine for high-risk individuals

III Opportunities for Improving Women's Health

- Women's access to quality health care is a key determinant of their health. The primary care provider assumes a significant role in coordinating of education of patients and the public about health promoting behaviors.

- Primary care providers for women, have a responsibility to ensure that their patients receive comprehensive, high quality clinical care and the patients are linked to the information and non-medical services needed to maintain or improve their health.
- Team approaches to women's health care are important. Nurses, psychologists, social workers, and peer counselors, can play an important role in primary care. Written material can aid the primary care physicians in educating patients. Empowering women as partners in their health care is essential for women's health promotion.