Introduction

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Maps have historically played a crucial role in the identification and resolution of public health problems, beginning with John Snow's maps of the nineteenth century cholera epidemic in London. During the past 40 years, public health researchers have documented persistent geographic disparities in heart disease mortality in the United States. However, most of these studies have reported findings only for men. While there is growing awareness that heart disease is the leading cause of death for women, claiming over 372,000 lives in 1995 alone, few studies of heart disease in women have examined geographic disparities.

Why is it critical to understand local geographic disparities in the burden of heart disease among women? We contend that health disparities among places reflect underlying inequalities in local social environments that make some communities more health-promoting than others. The social environment provides the context within which individuals are exposed to structural risk factors (e.g. lack of economic opportunity, poverty, and social isolation) that contribute to the adoption of disadvantageous behaviors (e.g. cigarette smoking, physical inactivity, poor diet). Ameliorating the social environment in local communities will require structural and institutional changes, improvements in community social relations, and reductions in inequalities within those communities. Identifying the places that bear the greatest burden of heart disease mortality is a necessary first step to targeting appropriate resources to improving the local social environment and health outcomes in those communities.

In *Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality*, we have produced an extensive series of national and state maps that present local variation in heart disease death rates for all women, American Indian and Alaska Native women, Asian and Pacific Islander women, black women, Hispanic women, and white women for the period

1991-1995. These maps highlight both substantial racial and ethnic disparities in heart disease and the marked geographic disparities in the burden of heart disease that exist within each race and ethnicity group. In addition, we have included national maps of local indicators of the social environment. These indicators include the geographic distribution of population by race and ethnicity, availability of local economic resources, social isolation of elderly women, and the availability of medical care resources.

An important strength of *Women and Heart Disease* is our examination of geographic disparities in heart disease mortality for American Indian and Alaska Native women, Asian and Pacific Islander women, and Hispanic women. Previous reports have focused predominantly on reporting data for blacks and whites. While there are important data quality limitations for race and ethnic groups other than whites and blacks, we chose to present results for women of all race and ethnicity groups. We hope that these results will both highlight the need for improved death certificate and population data quality, and provide useful information to public health agencies and advocacy groups who are working to improve health outcomes in diverse populations.

Two perspectives on geographic disparities in heart disease among women are presented in *Women and Heart Disease:* a national perspective and a state perspective. The national perspective allows the comparison of heart disease death rates for all localities in the United States, visible on national maps that present county death rates separately for each race and ethnicity group. In contrast, the state perspective allows the comparison of heart disease death rates for all localities within a single state. *Women and Heart Disease* includes over 200 state maps, with at least two maps (for all women and white women) and up to six maps presented for each state. The national and state perspectives provide complementary information useful for targeting resources to high risk communities.