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The Chester County Fund for Women and Girls is pleased to share *An Update to the Blueprint Report: Leveraging Progress*, an objective and comprehensive assessment of the status of women and girls in Chester County compared to the status of women and girls across Pennsylvania and the United States. The data collection, analysis and release of this report required the collaboration of numerous research and community partners. The Fund sincerely appreciates the contributions of all the county government departments, nonprofit organizations, service providers, researchers and volunteers that participated in this extraordinary effort. We would also like to thank the county, state and national agencies whose reliable and publicly accessible data informed this report.

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METHODOLOGY

Introduction

“The Fund leads and unites the community through philanthropy and advocacy to ensure that women and girls have resources and opportunities to thrive.”

Chester County Fund for Women and Girls Mission Statement

Given the mission and strategic direction of the Chester County Fund for Women and Girls, the objective of this report is to provide community stakeholders with a comprehensive and objective assessment of the current status of women in Chester County and offer insight regarding how the interests of women can be better served. In an effort to accurately portray the diverse experiences of women across the county, numerous sources, both existing and primary (i.e., newly collected), were consulted. To provide additional context for these experiences, data regarding the status of women across the Commonwealth of Pennsylvania and the United States is also presented. A list of existing data sources used is included as an appendix to the report.

Using Multiple Methodologies

Since the 1980s, the use of multiple research methodologies has increasingly become the most utilized mode of analysis in the social and behavioral sciences (Tashakkori and Teddlie, 2003). Mixed methods research is a methodology for conducting research that involves collecting, analyzing and integrating (or mixing) quantitative and qualitative research (and data) in a single study or a longitudinal program of inquiry. The purpose of this form of research is that both qualitative and quantitative research, in combination, provides a better understanding of a research problem or issue than either research approach does alone.

The use of a mixed methods approach is beneficial for several reasons (Clark and Cresswell, 2008):

- Variation in data collection leads to greater validity
- Answers the question from a number of perspectives
- Ensures that there are no “gaps” in the data collected
- Ensures that pre-existing assumptions from the researcher are less likely
- Provides an alternative when one methodology does not provide all the information required.

This strategy provides researchers with the most access to data of all types and presumably allows for the best planning and decision making since no single data source is used. For this report, four methodologies were chosen to gather both quantitative and qualitative data. Data collection and analysis for both data types are detailed in the following sections of this report. A brief summary of these methodologies follows:

1. Analysis of existing local, regional and national data sources (to gather quantitative data)
2. Chester County Nonprofit and Provider Snapshot Survey (to gather quantitative and qualitative data)
3. Focus groups with community organizers, service providers, and business leaders from across Chester County (to gather qualitative data)
4. In-depth interviews conducted with relevant stakeholders (to gather qualitative data).
Analysis of Existing Data

National, regional and local data sources were referenced in the preparation of this report. National sources include, but are not limited to, the U.S. Census, the U.S. Centers for Disease Control, the U.S. Department for Health and Human Services, the U.S. Bureau of Labor Statistics and the Center for American Women and Politics. Regional sources include, but are not limited to, the Pennsylvania Department of Health, the Pennsylvania Department of Education and the Pennsylvania Youth Survey. Local sources include, but are not limited to, the Chester County Department of Community Development, the Chester County Health Department, and the Chester County Association of Township Officials.

In particular, the report relies heavily on data from the Current Population Survey (CPS) and the American Community Survey (ACS). CPS is a monthly survey of a nationally representative sample of households conducted jointly by the U.S. Census Bureau and the Bureau of Labor Statistics that produces statistics for major economic indices and rankings. The ACS is a large annual survey conducted by the U.S. Census Bureau of a representative sample of the entire resident population in the United States. The ACS’s larger sample sizes compared with the CPS make it possible to provide data on women disaggregated by race/ethnicity and age at the state and county level. For this report, researchers accessed ACS data through the Minnesota Population Center’s Integrated Public Use Microdata Series. The most recent data available were used for most indicators and, in some cases, data from multiple years were used to ensure sufficient sample sizes. In some cases, the report references sources citing earlier data to provide a direct comparison to earlier years.

Nonprofit and Provider Snapshot Survey

This survey was used as a “point in time” survey to understand the needs of women in Chester County, the scope and capacity of services provided to meet those needs and what challenges and gaps exist in providing those services. Organizations were asked to give the number clients that were unable to be served in the previous month and year. Additionally, organizations were asked to provide basic demographic information and describe the their programs, staff and volunteers. The survey was administered electronically to all health and human services organizations and agencies registered with the Chester County Community Resource Directory. Four hundred and twenty-four surveys were emailed and the response rate was approximately 42 percent, with 178 completed surveys. The majority (67 percent) also reported that they offer services county-wide.

Of the 178 respondents, 63 percent are nonprofit organizations, 21 percent are government agencies and 16 percent self-identified as “other.” The majority of respondents indicated that they are operating fewer than five programs that primarily serve women and girls in Chester County. Sixteen percent of respondents indicated that they offer five or more programs that serve women and girls. Approximately 24 percent of responding organizations/agencies reported that they offer programs at more than one site across the county.

Respondents were asked to identify the services provided by their organization or agency. The most common responses included: education (40 percent), information and referral (37 percent), mental health (27 percent), housing (19 percent), food and clothing assistance (19 percent), employment (18 percent) and other (20 percent). Organizations/agencies that selected “other” described those services as youth development, healthy living, social responsibility, mentoring and community service, and veteran’s outreach. Respondents were also asked which services in Chester County were difficult for women and girls to access, and were provided the same list of service areas. Over
half of all respondents indicated that the following services are difficult for women and girls to access: housing (55 percent), child care (57 percent) and transportation (51 percent). Respondents also indicated that parental support and education (40 percent), employment (45 percent) and mental health (42 percent) services were difficult to access.

The survey asked responding organizations and agencies to estimate the number of women and girls they were unable to serve in the past month and previous year. While these numbers varied widely, the two most commonly cited reasons for why the organization or agency was unable to provide services were insufficient funding (64 percent) and service not available; the third most common response was lack of capacity (36 percent). When asked where service gaps exist, 66 percent of responding organizations and agencies cited transportation services; 47 percent cited mental health services; and 44 percent cited housing services. Other frequently cited service gaps for women and girls in Chester County include: child care (31 percent), parental support and education (25 percent) and financial assistance (19 percent).

Regarding the availability of services for particular populations of women and girls, the majority of responding organizations (59 percent) indicated that their programs and services were restricted to women and girls in specific age groups. Most respondents (69 percent) offer programs for adult women (69 percent for women aged 22 – 59) and adolescents (62 percent for women and girls aged 14 – 21). Forty-six percent of responding organization/agencies offer programs for girls aged 6 – 13. The smallest number of programs and services are offered for girls aged 0 – 5 (12 percent). Almost all responding agencies and organizations (91 percent) provide services for women and girls regardless of their citizenship, and 73 percent do not require that their service beneficiaries live in a particular area of the county.

**Focus Groups**

Focus groups are an important research tool for interpreting survey data. This methodology allows respondents to elaborate on issues in more detail than possible with a survey alone. Focus groups also provide opportunities to clarify issues that arise during the initial analysis of survey results and to probe issues that require more explanation. Four focus groups were held to collect qualitative data to supplement the Nonprofit and Provider Snapshot Survey. Professional moderators facilitated the focus groups and research staff was present to record data and clarify information.

Participants were recruited in an effort to ensure that this report represents variety of perspectives and experiences. The first focus group consisted of community leaders and included elected officials, executives from nonprofit organizations and municipal agencies and representatives from institutions of higher education. The second and third focus groups consisted of service providers from nonprofit organizations and public agencies across Chester County. The fourth focus group consisted of industry leaders and included representatives from the local finance sector, the local legal community and the Chester County Chamber of Business and Industry. Like the survey, focus group questions focused on the capacity of service providers in Chester County to meet the needs of its female population. Focus groups included women and men and were diverse in terms of the participants’ ages and racial/ethnic compositions. Data from the focus groups were transcribed and coded into themes so that it could be compared to the data generated by the Nonprofit and Provider Snapshot Survey.
In-depth Interviews

In-depth interviews can be valuable as part of a mixed methods research strategy and are often used when researchers are interested in individual experience, perceptions and feelings regarding specific topics of interest. In this study, four in-depth interviews were conducted with individuals who the project partners felt represented perspectives not adequately captured through the survey or focus group methodologies. Interview questions were similar to those asked in the survey and focus groups and were intended to provide researchers with a more complete understanding of women’s needs in Chester County. Each of the four interviews lasted between 30 and 45 minutes. Data from the focus groups were transcribed and coded into themes so that it could be compared to the data generated by the Nonprofit and Provider Snapshot Survey and focus groups.

Identification of Relevant Themes and the Selection of Indicators

Researchers referred to several sources for guidelines on what to include in An Update to the Blueprint Report: Leveraging Progress. First, researchers consulted staff from the Chester County Fund for Women and Girls and considered the Fund’s recent (2015) strategic planning process. As a result of this process, the Fund revised its mission (stated above) and identified seven principles to guide the organization as it pursues its mission. The Fund’s Guiding Principles are outlined below.

<table>
<thead>
<tr>
<th>Equality</th>
<th>We are dedicated to achieving equal status, rights and opportunities for women and girls.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security</td>
<td>We are dedicated to ensuring that women and girls are safe, their lives are stable and they have access to opportunities that will improve their economic independence and their health and wellness.</td>
</tr>
<tr>
<td>Community</td>
<td>We build community as a core strategy by connecting partners, ideas, dialogues and resources; by investing in the leadership of women and girls; by collaborating with a wide range of partners; and by strengthening organizations that are the cornerstones of service and advocacy.</td>
</tr>
<tr>
<td>Knowledge</td>
<td>We raise awareness, educate the community and generate solutions through research, data, community input and outreach.</td>
</tr>
<tr>
<td>Inclusion</td>
<td>We welcome all who seek to learn, to serve and to support others in the pursuit of the Fund’s mission, recognizing that our work will be strongest with a rich variety of perspectives and with diverse leadership.</td>
</tr>
<tr>
<td>Integrity</td>
<td>We are thoughtful, strategic and transparent with the stewardship of our resources. We hold ourselves accountable for achieving high-impact outcomes and for being responsive to the community’s needs.</td>
</tr>
<tr>
<td>Strength</td>
<td>We build on the strength of women and girls. We raise issues. We take stands. We believe that, together, we will achieve positive change for women and girls.</td>
</tr>
</tbody>
</table>

Following these principles, the Fund identified four strategic goals designed to hold the organization accountable to its mission and community stakeholders. These strategic goals are outlined below.

I. Women and Girls Framework

Update and augment the Fund’s grantmaking and non-grantmaking approaches, activities and programming to align all efforts with a consistent framework focused on four community-identified priorities for women and girls:
II. Leadership Role in the Community

Position the Fund as a leading advocate for women and girls in Chester County and beyond.

III. Community Engagement and Inclusion

Build the capacity of the Fund to operate and to lead as a responsive organization that is fully inclusive of the broad spectrum of diversity in its community.

IV. Sustainability and Growth

Strengthen the Fund’s business model, brand, leadership capacity and structure, and evaluation processes to enhance the Fund’s position and impact in the community.

In particular, An Update to the Blueprint Report: Leveraging Progress is informed by Goal I. Women and Girls Framework. These priorities reflect the voices of women and girls in Chester County and were a logical place to start.

Building on the Women and Girls Framework, researchers referred to additional sources examining women’s issues. The Beijing Declaration and Platform for Action (1995) from the U.N. Fourth World Conference on Women provided insight for this process. This document, the result of an official convocation of delegates from around the world, outlines issues of concern to women, rights fundamental to achieving equality and autonomy, and remaining obstacles to women’s advancement. Although this document is more than 20 years old, most of the issues highlighted persist as critical challenges faced by contemporary women.

Research produced by the Institute for Women’s Policy Research was instrumental in further identifying areas of concern for women in the United States and Pennsylvania. These sources, combined with the primary data collected in the course of this study, resulted in the identification of seven critical areas of concern to women’s progress in achieving rights and opportunities in Chester County: employment and earnings, work and family, poverty and opportunity, reproductive rights, health and well-being, violence and safety and political participation.

Researchers selected indicators related to these areas based on several principles: relevance, representativeness, reliability, efficiency and comparability of data. The availability of data from previous years was also an important consideration. The presentation of older data on selected indicators allowed for comparison across time with regard to both the rate of change and the size of change in Chester County compared to Pennsylvania and the United States.
INTRODUCTION

Women in the United States, Pennsylvania and Chester County have made remarkable social, economic and political progress in the 21st century, but further improvements are needed. Over the last several decades, the gender wage gap has narrowed, women have graduated from college and moved into higher-paying jobs in increasing numbers and women’s representation in political office has increased. Women in states across the nation and here in Chester County, however, face challenges such as a still-large gender wage gap, poverty, limited access to affordable child care, restricted reproductive rights, adverse health conditions and threats to their personal safety. Women continue to be significantly underrepresented in political office relative to their share of the population, and face stubborn disparities in opportunities and outcomes in all areas, such as business ownership—disparities that exist among women of different racial and ethnic groups, ages, geographic areas and sexual orientations. Addressing these challenges and disparities is essential to promoting the continued advancement of women and the well-being of families and communities in Chester County and beyond.

An Update to the Blueprint Report: Leveraging Progress provides critical data to identify areas of progress for women and girls in Chester County and Pennsylvania and pinpoints where additional improvements are still needed. It presents data points across seven areas that affect the lives of women and girls. These areas were identified through a data collection and analyses process that began with the recent strategic planning process undertaken by the Chester County Fund for Women and Girls. Through this process, the Fund identified four strategic goals shaped by a framework focused on four community-identified priorities for women and girls: meeting the core needs of women and girls, increasing access to economic access for women and girls, improving the health and wellness of women and girls, and challenging the myriad inequalities faced by women and girls in Chester County. Using this framework, researchers analyzed existing local, regional and national data sources, administered a Nonprofit and Provider Snapshot survey to understand the challenges and gaps in health and human services available to women and girls in Chester County, and conducted focus groups with community organizers, service providers and business leaders across Chester County.

What emerged was the identification of seven themes or topic areas of central concern to women’s progress in achieving rights and opportunities in Chester County: employment and earnings, work and family, poverty and opportunity, reproductive rights, health and well-being, violence and safety, and political participation. It is the goal of this report to 1) to analyze and disseminate information about the status of women and girls in Chester County relative to these areas; and 2) to identify and explore the remaining barriers to equality. The report considers progress over time, covers basic demographic statistics on women and presents additional data on a range of topics related to women’s status. In addition, it gives an overview of how women from various population groups fare, including women of color, young women, older women, immigrant women and women living with a same-sex partner. The data and analysis in this report are largely consistent with findings from the Institute for Women’s Policy Research (2015) long-standing work on women’s status nationally and will hopefully serve as a resource for advocates, policymakers and other stakeholders who seek to develop community investments, programs and public policies that can lead to positive changes for women and families.
Key Findings

Employment & Earnings

- While the gender earnings ratio has improved for women in Chester County over the past 10 years, the discrepancy between median earnings for men and women is higher than the state and nation as a whole. Across racial and ethnic categories, Hispanic women in Chester County face the largest earnings gap, with median annual earnings that are slightly more than half of White men.

- Higher educational attainment for women decreases the gender wage gap. While women of all education levels in Chester County are earning more than women across the state and the country, they are still earning significantly less than male residents with commensurate levels of education.

- Median household incomes for Chester County residents are higher than median household incomes in the United States, Pennsylvania and neighboring counties.

- Women in Pennsylvania who belong to labor unions earn significantly more and experience a smaller gender wage gap than their nonunion counterparts. The difference in earnings between those with and without union representation is largest for Hispanics in Pennsylvania and the United States. Hispanic women represented by unions have median weekly earnings that are significantly higher than those without union representation.

- More women in Chester County are active in the labor force than in Pennsylvania and the United States. Among the largest racial and ethnic groups, Black women aged 16 and older had the highest workforce participation rates.

- Part-time labor force participation by women in Chester County is slightly higher than the national and state rates. These women are less likely to receive employment benefits such as paid vacation days, paid family or medical leave, paid sick days, health care insurance or employer contributions to retirement saving funds.

- Women’s unemployment rates in Chester County are generally lower than those of women in Pennsylvania and the United States. Black women in Chester County, however, are more likely to be unemployed than Black women in Pennsylvania and the United States. Single mothers and young women across all racial and ethnic categories are more likely to be unemployed. Single mothers and young women in Chester County, however, have lower rates of unemployment than single mothers and young women in Pennsylvania and the United States.

- Women in Chester County are most likely to be employed in the health care, education, leisure and other services and least likely to be employed in mining and construction. Women in government have the highest median earnings and a narrower gender earnings ratio than women in other occupations.

- Chester County’s percentage of women working in science, technology, engineering, and mathematics (STEM) occupations is slightly higher than the state and national percentages. In the United States, Pennsylvania and Chester County, Asian/Pacific Islander women are the most likely to work in these occupations.

Work & Family

- Compared to many other states, Pennsylvania residents have greater access to paid leave as a result of state laws and voluntary employer benefits. Women workers in Chester County, however, are far less likely to have access to paid sick time than men. Hispanic women are less likely than any other racial or ethnic population to receive paid sick time.

- Across the United States and Pennsylvania, women are almost twice as likely as men to work part-time. The percentage is slightly higher for women in Chester County. The most commonly
cited reason for women working part-time instead of full-time is family and caregiving responsibilities.

• Compared to other states and localities, Pennsylvania and Chester County provide relatively few long-term care services and supports for individuals caring for elder and dependent family members.

• The percentage of households with children in Chester County is higher than the both the national and state percentages. While the percentage of married couple households is also higher than the national and state percentages, the number of female-headed households is more than twice the number of male-headed households.

• The number of Pennsylvania children eligible for child care subsidies was only 50 percent of those eligible according to federal requirements due to more stringent state income eligibility requirements.

**Poverty & Opportunity**

• Women in Chester County have demonstrated gains in several indicators of poverty and opportunity in the past decade, including the percentage of women with health insurance, the percentage of women with bachelor’s degrees, the percentage of women business owners and the percentage of women living above the poverty line.

• In general, women aged 18-64 in Chester County have slightly higher rates of insurance coverage compared to women in Pennsylvania and the United States. Hispanic, Native American, and Black women in Chester County, however, have lower rates of coverage than White, Asian/Pacific Islander, and women of two or more races.

• More women in Chester County earned a bachelor’s degree or higher than in either the state or country. Asian/Pacific Islander women in Chester County are most likely to hold a bachelor’s degree or higher, while Hispanic women are the least likely. Compared to national statistics, women of all races and ethnicities in Chester County are more likely to hold at least a bachelor’s degree, an associate degree or to have completed some college. Additionally, fewer women in all racial and ethnic categories are dropping out before earning a high school diploma or equivalent.

• While a higher percentage of women in Chester County are living above the poverty line than in the United States and Pennsylvania, they are still less likely than men in Chester County to be living above the poverty line.

• Women in Chester County are less likely to be living in poverty than women in the United States and Pennsylvania; the poverty rate for women is higher than men across all racial and ethnic categories. Similar to national and state trends, the difference is greatest between Hispanic women and men.

• Like state and national trends, married couples in Chester County tend to experience poverty less than non-married individuals. Additionally, women and men with children in Chester County experience poverty at higher levels than those without children.

**Reproductive Rights**

• While women can obtain an abortion in Chester County, there are numerous state restrictions that impact women’s access to abortion. These restrictions include: mandatory counseling and a 24-hour waiting period, restrictions on health insurance coverage related to abortion, parental consent for minors and restrictions on public funding for abortion.

• Pennsylvania has extended Medicaid benefits to include some family planning services to individuals through a State Plan Amendment. The income ceiling is relatively high compared to other states with similar expansion programs. Pennsylvania is, however, one of 20 states that include men and individuals younger than 19 years old as part of the population eligible for
Medicaid coverage of family planning services.

• Pennsylvania does not require insurance companies to cover infertility treatments.

• Sex education is not mandated in Pennsylvania schools.

• The percentage of women beginning prenatal care in the first trimester was lower in Chester County (74.4 percent) than in Pennsylvania or the United States (79.4 percent and 83.6 percent, respectively). This percentage was lower for Black women (50.6 percent) in Chester County compared to all other racial and ethnic groups for which data are available.

• In Pennsylvania and Chester County, the percentage of all women delivering babies with low birth weight increased slightly in the period between 2001 and 2013. Of all racial and ethnic groups for which data are available, Black women in Chester County are most likely to deliver low birth weight babies. White women in Chester County are least likely to deliver babies with low birth weight.

• Improvements in infant mortality rates in Chester County were observed across all racial and ethnic categories. While infant mortality rates decreased 1.2 per 1,000 live births for Black and Hispanic women in Chester County, both groups experience higher infant mortality rates than Black and Hispanic women across the United States. Black women in Chester County are twice as likely to experience infant mortality as White women across the United States.

Health & Well-Being

• Mortality rates for heart disease, lung cancer and breast cancer, and the incidence of AIDS, decreased for women in Chester County between 2002 and 2013.

• The median percentage of women in Chester County who have ever been told that they have diabetes, the rate of reported cases of chlamydia, the median number of days per month women aged 18 and older in the reported experiencing poor mental health, the suicide mortality rate, and the median number of days per month during which women aged 18 and older reported that their activities were limited by their mental or physical health status increased between 2002 and 2013.

• The heart disease mortality rate in Chester County (138.7 per 100,000) is lower than the state rate but higher than the national rate. Black women in the United States, Pennsylvania and Chester County have the highest heart disease mortality rates.

• Black women in Pennsylvania and Chester County have significantly higher rates of lung cancer mortality compared to Black women across the United States and are more likely to die of lung cancer than any other racial or ethnic group in the state and county.

• Breast cancer mortality rates for women in Chester County are lower than national and state rates. Across racial and ethnic groups, Black women in the United States, Pennsylvania and Chester County have the highest mortality rates from breast cancer.

• Of all racial and ethnic groups, Black women in Chester County are the most likely to be diagnosed with diabetes. In Chester County, rates of diabetes across all racial and ethnic groups are higher than rates in the United States.

• The rate of AIDS among adolescent and adult women (aged 13 and older) declined in Pennsylvania and Chester County between 2001 and 2012. The rate of AIDS among Black women in the United States, Pennsylvania and Chester County is higher than any other racial and ethnic group.

• Between 2002 and 2012, the rate of chlamydidal infection increased in the United States, Pennsylvania and Chester County. Among the largest racial and ethnic groups, Black women had the highest rate of reported cases of chlamydia in 2013.

• While the overall number and rate of increase is lower than the state and nation, women in Chester County are reporting increases in the number of days per month that they experience poor mental health. In Chester County, Native American women, women of two or more race, and
Hispanic women reported the highest number of poor mental days per month.  
- Women in Chester County reported fewer days of limited activity per month as a result of poor health than women in Pennsylvania and the United States. In Chester County, Native American and Hispanic women report more days per month in which their activity is limited due to health status.  
- There are fewer overweight and obese women in Chester County compared to the United States and Pennsylvania. Among women from the largest racial and ethnic groups, Black women in the United States, Pennsylvania and Chester County are the most likely to be overweight or obese.  
- Among women aged 18 and older in Chester County, White women are the most likely to exercise at least 150 minutes per week (51.0 percent), but have higher than average rates of smoking and are the second most likely to say they have engaged in binge drinking at least once in the preceding month.  
- Among women aged 50 and older in Chester County, Black women—who have the highest breast cancer mortality rate—and Asian/Pacific Islander women are the most likely to say that they have had a mammogram in the past two years.  
- Black women in Chester County are the most likely to have ever been tested for HIV (60.7 percent) and to have been screened for cholesterol in the past five years.  

**Violence & Safety**  
- Nearly one in three women experiences physical violence by an intimate partner at some point in her lifetime. A smaller, but still substantial percentage experience partner stalking, rape or other sexual violence by an intimate partner.  
- Nationally, it is estimated that more than half of Native American and multiracial women, more than four in 10 Black women, three in 10 White and Hispanic women, and three in 20 Asian/Pacific Islander women have experienced physical violence by an intimate partner.  
- If national estimates for intimate partner violence against women are applied to the female population of Chester County, approximately 122,527 women in 2014 had experienced psychological aggression and 81,845 had experienced physical violence at the hands of their partners at some point in their lifetimes.  
- Chester County does not have a local Domestic Violence Fatality Review Advisory Group team.  
- The total reported domestic violence-related deaths reported in Chester County for 2014 were four, of whom two were victims and two were perpetrators. Of all Pennsylvania counties, Chester County has the ninth highest count of domestic violence fatalities (39) since 2004.  
- In the United States, 19.3 percent of women are raped at some time in their lives, and 43.9 percent experience sexual violence other than rape.  
- Nearly one in four (23.7 percent) girls and one in six (15.6 percent) boys in the United States reported having experienced bullying on school property one or more times in the past year.  
- An estimated 15.2 percent of adult women and 5.7 percent of adult men in the United States have been stalked at some point in their lifetimes.  
- During the 2012–2013 school year, an estimated 74.1 percent of LGBT students aged 13 to 21 were verbally harassed because of their sexual orientation and 55.2 percent because of their gender expression.  

**Political Participation**  
- Pennsylvania ranks in the bottom 10 of all states and the District of Columbia on the Institute for Women’s Policy Research Political Participation Composite Index.
An Update to the Blueprint Report: Leveraging Progress

- In 2016, nine of the 50 (18 percent) Pennsylvania Senate seats and 37 of the 203 (18 percent) Pennsylvania House of Representatives seats are held by women. While the number of women serving in state legislatures has increased in the past several decades, the share of seats held by women in state legislatures across the country is well below women’s share of the overall population.

- Pennsylvania Attorney General Kathleen Kane, is the first and only woman serving in a Pennsylvania statewide elected executive office in 2016.

- Only the 155th legislative district in Pennsylvania is represented by a woman, state Rep. Becky Corbin (R), who was elected in 2013.

- Two of the three members of the Chester County Board of Commissioners are women.

- The Chester County sheriff, clerk of courts, register of wills and treasurer are women.

- Women of color hold none of the county-wide elected offices.

- Chester County has 57 townships with 212 elected supervisors, 16 percent (34) of whom are women. There are 23 women tax collectors and 48 women auditors in townships across the county.

- Chester County has 15 boroughs. Three boroughs have women mayors. Of 101 elected council members, 31.2 percent (32) are women. Across the county’s boroughs, there are seven women tax collectors and three women auditors.

- The Pennsylvania Center for Women and Politics (PCWP) is the only organization to focus on women’s political involvement in Pennsylvania.

- The Represent! PAC and the Pennsylvania NOW PACS are the only women’s political action committees in Pennsylvania.

- Two women’s commissions provide regular input on state and local policies and legislation that impact women. The governor of Pennsylvania is advised by the Pennsylvania Commission for Women, and the Chester County Women’s Commission provides legislative advocacy on the status and needs of women in Chester County.

Connectivity & Cultural Competency

A common theme across all focus groups, and related to all areas of concern identified in this report, is the challenge of reaching diverse populations with regard to race, socio-economic status and political orientation. Cultural differences were identified as a persistent problem encountered by nonprofit and municipal service providers in Chester County. Thirteen percent of the Nonprofit and Provider Snapshot Survey respondents reported that either language or cultural barriers had prevented them from providing services in the past year. Participants in all focus groups consistently identified a lack of connectivity and understanding among different groups of women and girls in Chester County as a significant barrier to their progress.
EMPLOYMENT & EARNINGS

Introduction
Women make up nearly half of the U.S. workforce, and their earnings are essential to the economic security of families across the nation. In 2014, the population of Chester County reached 512,784. Approximately 50 percent of these residents are women (260,204), and 41.3 percent are between the ages of 18 and 62 (U.S. Census Bureau, 2015a); yet, gender equality at work remains elusive. Women who work full-time, year-round still earn only 78 cents on the dollar compared with men. During the last decade, little improvement has been made in closing the gender wage gap (DeNavas-Walt and Proctor, 2014). The glass ceiling persists, and occupational segregation—the concentration of women in some jobs and men in others—remains a stubborn feature of the U.S. labor market (Hegewisch et al., 2010).

National Trends in Employment & Earnings
Across the United States, women’s status in the area of employment and earnings has improved on some indicators and remained unchanged or declined on others. Women’s median annual earnings for full-time, year-round work in 2013 ($39,157) were nearly identical to their earnings for similar work in 2002 ($39,108 when adjusted to 2013 dollars) (IWPR, 2015). The gender earnings ratio improved during this time from 76.6 to 78.3 percent (DeNavas-Walt and Proctor, 2014), narrowing the gender wage gap by 1.7 percentage points, and the share of women working in professional or managerial occupations grew from 33.2 to 39.9 percent. Women’s labor force participation rate, however, declined from 59.6 in 2002 to 57.0 percent in 2014 (IWPR 2004; U.S. Bureau of Labor Statistics 2015a).

During the last thirty years, men’s real earnings in the United States have remained essentially the same, while women’s have grown, albeit from a much smaller base. Between 1980 and 2013, after adjusting for inflation, real median earnings for women’s full-time, year-round work grew nationally from $30,138 to $39,157, while men’s decreased slightly from $50,096 to $50,033 (DeNavas-Walt and Proctor, 2014). Among women, the growth in real median annual earnings took place in the 1980s and 1990s; since the early 2000s, women’s earnings, like men’s, have stagnated. The importance of women’s earnings to family economic security, however, has steadily increased. As of 2012, 29 percent of married women where both spouses work had annual earnings that were higher than their husbands, an increase of 11 percentage points since 1987 (U.S. Bureau of Labor Statistics 2014a).

These national trends are evident in both Pennsylvania and Chester County. This section of the Blueprint Report examines women’s earnings and the gender wage gap, women’s labor force participation and the occupations and industries in which women work. It also considers areas where women have experienced progress toward gender equity in the workforce and places where progress has slowed or stalled.

Employment and Earnings in the United States, Pennsylvania & Chester County
The Institute for Women’s Policy Research (2015) developed the Employment & Earnings Composite Index, which compares states’ performance on four key component indicators of women’s status in the domain of employment and earnings: median annual earnings for women who work full-time, year-round; the gender earnings ratio among full-time, year-round workers; women’s labor force participation; and the percent of employed women who work in managerial or professional
occupations. Composite scores ranged from a high of 5.33 to a low of 3.43, with the higher scores reflecting a stronger performance in the area of employment and earnings. The composite scores were also used to establish a ranking of best and worst states as well as a state-specific grade relative to employment and earnings.

Pennsylvania, with a composite score of 3.97, is ranked 23 out of 51 (all states and the District of Columbia), and received a grade of C+ based on data collected in 2013 (IWPR, 2015). These results are slightly down from 2004, at which time Pennsylvania earned a composite score of 4.0, was ranked 21 out of 51 and also earned a grade of C+ (IWPR, 2004). During this time period, Pennsylvania improved its ranking with regard to the percent of women in the labor force and the percent of women employed in managerial or professional occupations. In both data collection years, the state fell squarely within the middle third of the Employment & Earnings Composite Index.

Table 1. Comparison of Pennsylvania’s Status on Employment and Earnings Composite Index and Its Components, 2004 – 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Score</th>
<th>Rank</th>
<th>Grade</th>
<th>Median Annual Earnings Full-time, Year-Round for Employed Women</th>
<th>Earnings Ratio Between Full-Time, Year-Round Employed Women and Men</th>
<th>Percent of Women in the Labor Force</th>
<th>Percent of Employed Women, Managerial or Professional Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>4.0</td>
<td>21</td>
<td>C+</td>
<td>$30,700</td>
<td>74.7%</td>
<td>58.9%</td>
<td>33.5%</td>
</tr>
<tr>
<td>2013</td>
<td>3.97</td>
<td>23</td>
<td>C+</td>
<td>$38,000</td>
<td>76%</td>
<td>58.6%</td>
<td>40.5%</td>
</tr>
</tbody>
</table>

Source: IWPR, 2004 and 2015.

Table 2 provides a comparison of the total population, employment status and median earnings for men and women in the United States, Pennsylvania and Chester County (U.S. Census). The percentage of male and female residents in Chester County and Pennsylvania reflect approximately the same population demographics of the United States. The percentage of residents 16 years and older in Chester County is slightly above that of Pennsylvania and the United States, as is the percentage of females 16 years and older in the labor force. Unemployment rates in Chester County’s broader population, as well as for females 16 years and older, are also comparatively lower than for Pennsylvania and the United States.

Table 2. Population, Employment and Earnings in the United States, Pennsylvania, and Chester County

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>318,857,056</td>
<td>12,187,209</td>
<td>512,784</td>
</tr>
<tr>
<td>Male</td>
<td>49.2%</td>
<td>48.9%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Female</td>
<td>50.8%</td>
<td>51.1%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population 16 years and older</td>
<td>253,588,947</td>
<td>10,405,544</td>
<td>406,461</td>
</tr>
<tr>
<td>In labor force</td>
<td>63.3%</td>
<td>62.5%</td>
<td>69.1%</td>
</tr>
<tr>
<td>Not in labor force</td>
<td>36.7%</td>
<td>37.5%</td>
<td>30.9%</td>
</tr>
<tr>
<td>Female 16 years and older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In labor force</td>
<td>58.2%</td>
<td>58.3%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Employed</td>
<td>54.0%</td>
<td>54.5%</td>
<td>59.3%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4.1%</td>
<td>3.7%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Median Earnings for full-time, year-round workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>$48,745</td>
<td>$50,412</td>
<td>$70,530</td>
</tr>
<tr>
<td>Female</td>
<td>$39,941</td>
<td>$39,905</td>
<td>$51,872</td>
</tr>
</tbody>
</table>

The Gender Earnings Ratio

The change and stagnation in women’s and men’s real earnings over the last several decades have contributed to the narrowing of the gender wage gap in earlier decades and more recently stalled progress in further closing this gap. Between 1980 and 2000—when women’s real earnings grew while men’s remained unchanged—the gender earnings ratio increased from 60.2 percent (in 1980) to 71.6 percent (in 1990) to 73.7 percent (in 2000). Between 2001 and 2012—when both women’s and men’s earnings stagnated—the gender earnings ratio remained virtually constant. The national gender earnings ratio has improved in recent years (DeNavas-Walt and Proctor 2014), yet in every state in the nation women still earn less than men. In Pennsylvania, the gender earnings ratio improved between 2004 and 2013 from 74.7 to 76 percent (Table 1). Practically speaking, this means that the median earning potential for women in Pennsylvania and Chester County in 2014 is $10,507 and $18,658 less than their male counterparts, respectively.

Focus group participants from all groups—community leaders, business leader, and service providers—observed that while there has been progress in the area of economic opportunity for women and girls in Chester County, there is still much work to be done. One nonprofit executive director noted that gender roles in Chester County have improved over the past 20 years. She has observed an increase in the number of men waiting with children at bus stops and believes that this reflects an increase in the number of women in the local workforce. A business leader commented that there has been an increase in opportunities for women’s professional development in regional corporations. Other participants noted, however, that women continue to face challenges in acquiring leadership positions and that men were able to rise within organizations and industries at a faster pace than women. Focus group participants across the groups discussed the disproportionate number of older, White males in business and political leadership positions compared to the gender distribution of the general workforce in Chester County. Participants in each group subsequently agreed that there is a need for more mentoring opportunities for women and girls. Similarly, when asked to identify services that are difficult for women and girls to access in Chester County, 26 percent of respondents to the Nonprofit and Provide Snapshot Survey selected leadership development.

If progress continues at the current slow rate, the disparity between women’s and men’s earnings in the United States overall will not close until the year 2058. In five states, women’s earnings are not expected to equal men’s until the next century. The gender wage gap in Pennsylvania is expected to close in the year 2072 (IWPR, 2014a). With a higher discrepancy in median earnings for men and women than the state as a whole, closing this gap in Chester County may take more time.

Earnings and the Gender Wage Gap for Women of Color

Women’s earnings differ considerably by race and ethnicity. Across the largest racial and ethnic groups in the United States, Asian/Pacific Islander women have the highest median annual earnings at $46,000, followed by White women ($40,000). Native American and Hispanic women have the lowest earnings at $31,000 and $28,000, respectively (Figure 1). In all the racial and ethnic groups shown in Figure 1, women earn less than men. Among the groups in Figure 1, the differences are smallest for Blacks and Hispanics, due to the comparatively low earnings of Black and Hispanic men, which are considerably less than the earnings of men overall.
Figure 1. Median Annual Earnings for Women and Men Employed Full-Time, Year-Round by Race/Ethnicity, United States, 2013

Notes: For women and men aged 16 and older. Racial groups are non-Hispanic. Hispanics may be of any race or two or more races.

Comparing earnings for different groups of women with the largest group in the labor force, White men, is an alternative way to examine gender earnings differences. Hispanic women face the largest earnings gap, with median annual earnings that are slightly more than half those of White men (53.8 percent). Asian/Pacific Islander women face the smallest gap, but still earn only 88.5 percent of White men’s earnings (IWPR, 2015; Table 3).

Table 3. Women’s and Men’s Median Annual Earnings and the Gender Earnings Ratio, Full-time, Year-Round Workers, United States, Pennsylvania, and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
<th>Ratio of Women’s Earnings to Men’s of the Same Racial/Ethnic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>United States</td>
<td>PA</td>
<td>Chester County</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>$46,000</td>
<td>$47,500</td>
<td>$56,270</td>
</tr>
<tr>
<td>White</td>
<td>$40,000</td>
<td>$42,500</td>
<td>$51,027</td>
</tr>
<tr>
<td>Other Race or Two or More races</td>
<td>$38,000</td>
<td>$39,000</td>
<td>$49,600</td>
</tr>
<tr>
<td>Black</td>
<td>$34,000</td>
<td>$35,100</td>
<td>$44,680</td>
</tr>
<tr>
<td>Native American</td>
<td>$31,000</td>
<td>$31,900</td>
<td>$42,290</td>
</tr>
<tr>
<td>Hispanic</td>
<td>$28,000</td>
<td>$28,900</td>
<td>$37,060</td>
</tr>
</tbody>
</table>

TOTAL

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
<th>Ratio of Women’s Earnings to Men’s of the Same Racial/Ethnic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>United States</td>
<td>PA</td>
<td>Chester County</td>
</tr>
<tr>
<td>American Community Survey</td>
<td>$38,000</td>
<td>$39,905</td>
<td>$51,172</td>
</tr>
</tbody>
</table>

Notes: For women and men aged 16 and older. Racial groups are non-Hispanic. Hispanics may be of any race or two or more races. Source: IWPR, 2015; Analysis of American Community Survey microdata (Integrated Public Use Microdata Series, Version 5.0).

In Chester County, the median annual earnings for all women are only 73.5 percent of men in Chester County (Table 4). Compared to White men in Chester County, the gender earnings gap is smallest for Asian/Pacific Islander women in Chester County (80.6 percent) and White women (73.1 percent). Hispanic women in Chester County have the lowest median annual earnings across racial and ethnic categories. Like their peers across the United States, these women earn just slightly more than half that of White men (53.1 percent). Earnings gaps for Native American (60.1 percent) and Black (64 percent) women in Chester County relative to White men are smaller, but these women are still
earning substantially less than White men.

Respondents to the Nonprofit and Provider Snapshot survey indicated that employment services are the fourth most difficult service for women to access in Chester County behind child care, housing and transportation. The relative difficulty for women in accessing child care and reliable transportation compounds the challenges they face in finding and maintaining work.

Table 4. Ratio of Women’s Earnings by Ethnicity to White Men’s Earnings, Chester County, 2013

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>77.9%</td>
<td>77.2%</td>
<td>73.4%</td>
</tr>
<tr>
<td>White</td>
<td>76.9%</td>
<td>77.0%</td>
<td>73.1%</td>
</tr>
<tr>
<td>Other Race or Two or More</td>
<td>84.4%</td>
<td>83.9%</td>
<td>78.0%</td>
</tr>
<tr>
<td>Black</td>
<td>90.7%</td>
<td>89.3%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Native American</td>
<td>83.8%</td>
<td>83%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>90.6%</td>
<td>90.4%</td>
<td>84.74%</td>
</tr>
</tbody>
</table>

Notes: For women and men aged 16 and older. Racial groups are non-Hispanic. Hispanics may be of any race or two or more races. Source: IWPR, 2015; Analysis of American Community Survey microdata (Integrated Public Use Microdata Series, Version 5.0).

Two Pennsylvania state representatives recently (May, 2015) introduced legislation aimed at prohibiting pay discrimination based on gender as part of a wider Pennsylvania Agenda for Women’s Health campaign (Packel, 2015). Current law allows "any factor other than sex" to be a legitimate justification for disparities in pay. The proposed legislation would update and clarify the legal standards for pay-equity lawsuits by narrowing the determining factors for pay to solely education, training and experience. The bill will also increase transparency around pay by creating protections that permit employees to inquire about salaries without fear of termination. It would prohibit employers from requiring that employees, as a condition of employment, refrain from discussing wages or sign waivers preventing them from discussing wages. Companion legislation was introduced in the Pennsylvania Senate in January 2015; neither version made it out of committee (Packel, 2015).

The Earnings Ratio by Educational Attainment

Education increases women’s earnings but does not eliminate the gender wage gap. In the United States, women with a bachelor’s degree earn, on average, more than twice the amount that women with less than a high school diploma earn (Table 5). Women who work full-time year-round, however, earn less than men at the same educational level, and at all but one level they earn the same as or less than men with lower educational qualifications. The gap in earnings is largest for those with the highest levels of educational attainment: women with a graduate degree earn only 69.1 percent of what comparable men earn, and women with a bachelor’s degree earn 71.4 percent of the amount their male counterparts earn. These data indicate that women need more educational qualifications than men do to secure jobs that pay well.

Table 5. Women’s Earnings Ratio by Educational Attainment, 2013

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school graduate</td>
<td>73.8%</td>
<td>71.1%</td>
<td>72.6%</td>
</tr>
<tr>
<td>High school diploma/equivalent</td>
<td>75.0%</td>
<td>73.7%</td>
<td>74.7%</td>
</tr>
<tr>
<td>Some college</td>
<td>75.7%</td>
<td>74.3%</td>
<td>75.4%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>80.0%</td>
<td>78.4%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>71.4%</td>
<td>70.1%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Graduate or professional degree</td>
<td>69.1%</td>
<td>67.5%</td>
<td>70.4%</td>
</tr>
</tbody>
</table>
An Update to the Blueprint Report: Leveraging Progress


An analysis of median earnings by educational attainment and gender shows that while women of all education levels in Chester County are earning more than women across the state and the country, they are earning significantly less than male residents with commensurate levels of education in their own communities (Table 6). Focus participants generally agreed that while economic opportunity for women in Chester County has increased in the past two decades, there is still a “good old boys” club that impedes upward mobility for many women. Participants in the business leaders focus group agreed that workplace cultures do not promote a family lifestyle and often force women to choose between having a family and advancing their career. This choice often forces women into lower-paid, hourly wage positions.

Service provider focus group participants noted that many women thought that obtaining a college degree would ensure future financial stability. They reported instances of local women making questionable decisions, such as re-mortgaging their homes and taking on considerable loans, based on the assumption that their earnings potential would increase commensurately with their male counterparts. The result is a population of well-educated women with fewer employment opportunities, less upward mobility and an inability to repay loans and other forms of debt.

Table 6. Median Earnings in the Past 12 Months by Educational Attainment and Gender in the United States, Pennsylvania, and Chester County

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Less than high school graduate</td>
<td>$23,104</td>
<td>$15,369</td>
<td>$26,019</td>
</tr>
<tr>
<td>High school diploma/equivalent</td>
<td>$33,336</td>
<td>$22,377</td>
<td>$36,002</td>
</tr>
<tr>
<td>Some college/associate degree</td>
<td>$41,506</td>
<td>$28,393</td>
<td>$42,456</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>$61,619</td>
<td>$41,917</td>
<td>$60,208</td>
</tr>
<tr>
<td>Graduate or professional degree</td>
<td>$64,137</td>
<td>$56,185</td>
<td>$83,106</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Cumulative Losses from the Gender Wage Gap

Losses from the gender wage gap accumulate over the course of a woman’s lifetime. Average lifetime losses for all women who were born between 1955 and 1959 and worked full-time, year-round each year total $531,502 by age 59 (IWPR, 2015). Among college-educated women, the losses were even greater, due in part to the larger gender wage gap that women with this level of education face (see Table 6). Women with a college education who were born between 1955 and 1959 and worked full-time, year-round each year lost, on average, nearly $800,000 by age 59 due to the gender wage gap (IWPR, 2015). State and county data demonstrating cumulative losses from the gender wage gap for the same time period are not available. It is reasonable, however, to assume that women in Pennsylvania and Chester County have experienced similar losses.

Gender Inequality in Low and High Paid Jobs

Median earnings capture the midpoint in the earnings distribution: half of all workers earn above and half earn below the median. Another way of comparing earnings is to examine the gender composition of those among the highest and lowest earnings quartiles in a state. In 2013, women were less likely
than men to be among the highest earners in all states in the nation (IWPR, 2015; Table 7).

Table 7. Gender Inequality at the Top and Bottom of the Labor Market: Quartile Distributions in Pennsylvania and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Percent of Women in the Bottom Earnings Quartile</th>
<th>Percent of Men in the Bottom Earnings Quartile</th>
<th>Percent of Women in the Top Earnings Quartile</th>
<th>Percent of Men in the Top Earnings Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>32.1%</td>
<td>19.5%</td>
<td>17.9%</td>
<td>30.9%</td>
</tr>
<tr>
<td>Chester County</td>
<td>36.4%</td>
<td>18.7%</td>
<td>14.1%</td>
<td>36.8%</td>
</tr>
</tbody>
</table>

Notes: Full-time, year-round workers aged 16 and older. Top and bottom earnings quartiles are calculated for all workers residing in each state.

Available data for Chester County show that the median annual household income is $85,373. Median income is the amount which divides the income distribution into two equal groups, half having incomes above the median, half having incomes below the median. The medians for households, families and unrelated individuals are based on all households, families and unrelated individuals, respectively. The medians for people are based on people 15 years old and over with income (U.S. Census). In Chester County, the household incomes of the wealthiest households tend to inflate the mean (average) household income in a way that is less reliable than focusing on the median household income. While the median household income for Chester County in 2014 is $85,373, for example, the mean (average) household income is $114,895 (U.S. Census). By calculating the median values for income (the middle point if every household income is listed in order by value), it is possible to gain a better understanding of the midpoint. In this way, median values are less influenced by polar distributions of either very high or very low incomes. Table 8 provides the median household income in the United States, Pennsylvania, Chester County and three neighboring counties as reported in the 2014 and 2010 U.S. Census American Community Survey.

Table 8. Comparison of Median Household Income in the United States, Pennsylvania, Chester County and Surrounding Counties

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$53,657</td>
<td>$51,914</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$53,234</td>
<td>$50,398</td>
</tr>
<tr>
<td>Chester County</td>
<td>$85,373</td>
<td>$84,741</td>
</tr>
<tr>
<td>Bucks County</td>
<td>$77,917</td>
<td>$74,828</td>
</tr>
<tr>
<td>Delaware County</td>
<td>$62,993</td>
<td>$61,867</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>$79,495</td>
<td>$76,380</td>
</tr>
</tbody>
</table>


The relatively high median annual household incomes in Chester County can be misleading. There are significant pockets of poverty in the region. Although Chester County is the 24th wealthiest county in the nation (Forbes, 2014), more than 6 percent of its population lives in poverty. Additionally, the cost of living—health care, child care, food, transportation and taxes—in Chester County is also high. According to The Self-Sufficiency Standard for PA, 2012 (Center for Women’s Welfare), a single parent with one preschooler needs an annual salary of $53,410 to make ends meet. A single adult needs a minimum hourly wage of $13.81 and an annual salary of $29,176. For a family of two, the self-sufficiency standard in Chester County is 356 percent above the federal poverty line.

Focus group participants reported that there is a lack of awareness among many affluent residents of Chester County regarding the challenges faced by their economically disadvantaged neighbors. One
focus group participant described how policymakers and community leaders largely misunderstood Chester County’s “culture of poverty.” Another participant observed the overall lack of connection prevalent in Chester County. She explained that there are two groups of women and girls in Chester County, the “haves” and “have nots,” and although both face some common challenges, they operate in separate, parallel worlds.

The Union Advantage

Union representation brings wage setting into the open and helps ensure that employers set wages based on objective criteria, such as skill, effort and responsibility. Research shows that labor unions tend to raise wages and improve benefits for all represented workers, especially those at the middle and bottom of the wage distribution, who are disproportionately women (Jones, Schmitt, and Woo, 2014).

Among full-time workers aged 16 and older, women represented by labor unions earn an average of $212, or 30.9 percent, more per week than women in nonunion jobs. The same population of women in Pennsylvania earn an average of $142 more than their nonunion counterparts. Although the union wage advantage is greater in some other states, union women in Pennsylvania still experience a significantly smaller gender wage gap than nonunion women. County-level union wage advantage data are unavailable. Women who are represented by unions earn 88.7 cents on the dollar compared with their male counterparts, a considerably higher earnings ratio than the earnings ratio between all women and men in the United States (Jones, Schmitt, and Woo, 2014).

Among the racial and ethnic groups shown in Table 9, the difference in earnings between those with and without union representation is largest for Hispanics. Hispanic women represented by unions have median weekly earnings that are 42.1 percent and 38.3 percent higher than those without union representation in the United States and Pennsylvania, respectively. Although county-level data are unavailable, the Pennsylvania union wage advantage is of particular concern for the growing population of Hispanic women in Southern Chester County.

The union wage advantage for women varies across broad occupational groups. In all of the occupational groups shown in Table 10 below, unionized women earn more than their nonunionized counterparts in the United States and Pennsylvania. The difference is largest in natural resources, construction, and maintenance occupations in both the United States and Pennsylvania (95.5 percent and 84.9 percent, respectively), and smallest in management, business and financial occupations (7.1

---

1 The earnings and pension data in this section are calculated for all workers and are not controlled for age, education or industry; when controlled for these factors, the union advantage is smaller but still significant, especially for women and minorities (Jones, Schmitt, and Woo, 2014)
percent and 5.4 percent, respectively).

Table 10. Women’s Union Wage Advantage for Full-Time Workers by Union Status, United States and Pennsylvania, 2014

<table>
<thead>
<tr>
<th>Union Wage Advantage</th>
<th>United States</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management, Business and Financial Occupations</td>
<td>7.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Professional and Related Occupation</td>
<td>13.7%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Service Occupations</td>
<td>26.4%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Sales and Related Occupations</td>
<td>8.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Office and Administrative Support Occupations</td>
<td>22.0%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Natural resources, Construction and Maintenance Occupations</td>
<td>95.5%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Production, Transportation and Material Moving Occupations</td>
<td>26.7%</td>
<td>18.1%</td>
</tr>
<tr>
<td>All Occupations</td>
<td>31.3%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>


Women who are union members (or covered by a union contract) are also more likely to participate in a pension plan than those who are not unionized. Approximately three in four unionized women (74.1 percent) have a pension plan, compared with slightly more than four in 10 (42.3 percent) of their nonunion counterparts (Jones, Schmitt, and Woo, 2014).

Women’s Labor Force Participation

Women’s increased labor force participation represents a significant change in the U.S. economy since 1950. As of 2014, nearly six in 10 women aged 16 and older (57 percent) worked outside the home (U.S. Bureau of Labor Statistics, 2015a), compared with 33.9 percent in 1950 and 43.3 percent in 1970 (Fullerton, 1999). Women now comprise nearly half of the U.S. labor force at 46.8 percent (U.S. Bureau of Labor Statistics, 2015a). In each state, however, women are still less likely to be in the workforce than men.

Figure 2. Percent of Population Aged 16 and Older in the Labor Force by Gender, United States, Pennsylvania, and Chester County, 2013

In Pennsylvania, 58.6 percent of women aged 16 and older are active in the labor force compared to 67.4 percent of men. In Chester County, 62.4 percent of such women are active in the labor force compared to 71.3 percent of men (Figure 2). While more women aged 16 and older in Chester County are working, they continue to face significant challenges in acquiring and maintaining gainful employment. As previously mentioned, 45 percent of regional nonprofit and municipal service providers identified employment services as “difficult to access” in Chester County. Focus group participants further commented on how the accessibility of employment and other services is not
equitable across racial and ethnic categories in Chester County.

Among the largest racial and ethnic groups, Black women aged 16 and older had the highest workforce participation rates in 2014 in the United States, Pennsylvania and Chester County at 62.4 percent, 63.6 percent, and 67.1 percent, respectively (U.S. Bureau of Labor Statistics, 2015c; Figure 3).

Figure 3. Percent of Women in the Labor Force by Ethnicity, United States, Pennsylvania, and Chester County, 2014

![Bar chart showing labor force participation rates for different ethnic groups in 2014.](source)

Labor force participation rates also vary by age (Antecol, 2015; IWPR, 2015). Among women, rates are highest for those in their prime working years (aged 25–54); after increasing between 1960 and 1999, however, the national labor force participation rate of women in this age group decreased nearly three percentage points between 2000 and 2014—while the labor force participation rate of men aged 25–54 was declining by more than three percentage points (Antecol, 2015). The labor force participation rate for young women (16–24) reached its high point in 1987 and declined more than nine percentage points between 2000 and 2014, while the young men’s labor force participation rate declined by more than 12 percentage points, reflecting the longer time this generation now spends in education, a weak labor market during the Great Recession and the slow recovery for many young adults (Antecol, 2015).

Among women aged 55 years and older—who are much less likely to be in the workforce than younger women—labor force participation has increased over the last three decades, especially in the 2000s, after having remained fairly constant from 1960 until the mid-1980s, when the labor force participation rate of young women was growing rapidly (Antecol, 2015). In 2014, 34.9 percent of older women were in the workforce, compared with 26.1 percent in 2000. Older men, in contrast, experienced a steady decline in their workforce participation rates between 1960 and the mid-1990s, before their labor force participation rate increased between the mid-1990s and 2014, reaching its high point in 2012 (Antecol, 2015).

**Part-Time Work**

Although the majority of employed women and men in the United States work full time, women are nearly twice as likely as men to work part-time (29.4 percent compared with 15.8 percent) (IWPR, 2015; Table 11). In Pennsylvania 30.7 percent of women in 2013 were working part time compared to...
14.9 percent of men. Part-time labor force participation in Chester County in the same year was slightly higher than the national and state rates for women and men at 32.5 percent and 16.1 percent, respectively (Table 11). Working part time makes it less likely that a worker will receive employment benefits such as paid vacation days, paid family or medical leave, paid sick days, health care insurance or employer contributions to retirement saving funds (Society for Human Resource Management, 2011; Van Giezen, 2012).


<table>
<thead>
<tr>
<th></th>
<th>Part-Time</th>
<th>Full-Time / Year-Round</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>United States</td>
<td>29.4%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>30.7%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Chester County</td>
<td>32.5%</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

Notes: Aged 16 and older. Part-time includes those who usually work fewer than 35 hours per week. Part-time workers may work either part-year or full-year. Full-time, year-round includes those who work at least 35 hours per week, for at least 50 weeks per year. Percentages of part-time and full-time, year-round workers do not sum to 100 because those who work full-time but less than year-round are not included.


Women work part time for various reasons. The majority who work part time do so by choice (although these choices may be constrained by factors such as their children’s school hours and the high costs of child care). For some women, however, part-time work is involuntary; approximately one in five women who usually worked part time in 2013 said they did so because they could not find full-time work or had their hours at work temporarily reduced (IWPR, 2014b).

Whether part-time work is voluntary or not, an increasing number of workers report not knowing from one week to the next how many hours and at what times they are expected to work. They may be expected to be available for full-time work, but without any guarantee of how many hours they actually will be scheduled to work. A recent national survey of younger workers between the ages of 26 and 32 found that approximately 70 percent of hourly and non-hourly women workers experience fluctuations in their hours worked per week. Such fluctuations are particularly common for workers classified as part time (Lambert, Fugiel, and Henly, 2014). In addition to potentially creating havoc with workers’ family lives, and their own and children’s school schedules, these unpredictable schedules can make it hard to secure a steady income that enables them to meet their financial needs. Unpredictable scheduling also can make it difficult for workers to combine two or more part-time jobs to increase earnings or combine part-time work with their own schooling (Lambert, Fugiel, and Henly, 2014).

Unemployment

Preliminary data from the Bureau of Labor Statistics show that in 2014, 6.1 percent of women aged 16 and older in the nation’s civilian, noninstitutionalized population were unemployed, compared with 6.3 percent of men (U.S. Bureau of Labor Statistics, 2015d). These unemployment rates were the lowest for women and men since 2008, when 5.4 percent of women and 6.1 percent of men were unemployed (U.S. Bureau of Labor Statistics, 2014b). This decrease in unemployment reflects improvement in the nation’s economy following the Great Recession that officially lasted from 2007 to 2009. The lower rates, however, may also reflect the decision of some workers to give up their active search for a job in the face of dim employment prospects (Davis, 2014). As noted above, labor force participation rates have fallen, and some adults may have left the labor market out of discouragement.
Unemployment rates in Chester County in 2015 were lower than unemployment rates in the United States and neighboring counties (Figure 4). In fact, at 2.8 percent, Chester County Chester County has the lowest unemployment rate in the Philadelphia-Camden-Wilmington, Pa.-N.J.-Del.-Md. Metropolitan Statistical Area (U.S. Bureau of Labor Statistics, 2015).

In the United States, women’s unemployment rates vary considerably by race and ethnicity. According to preliminary data, Black women in 2014 had the highest unemployment rate among women at 10.5 percent, followed by Hispanic women (8.2 percent), White women (5.2 percent) and Asian women (4.6 percent; data are not available for Native American women). For each racial and ethnic group except Hispanics, women’s unemployment rates were lower than men’s (U.S. Bureau of Labor Statistics, 2015e).

While the exact unemployment rate for women in Chester County is unknown, women claimed 50 percent of unemployment compensation initial claims in the workforce investment area in 2015 (Table 12). This is lower than the percentage of women in Pennsylvania who claimed unemployment benefits in the same year, but more than the percentage of women claiming unemployment benefits in three neighboring counties (Table 12). Whites in the state and all counties for which data are presented claimed the highest percentage of initial claims. This is expected, as the population in these areas is predominantly White. The percentage of claims made by Black men and women is the second highest percentage across each geographic area.

Table 12. Unemployment Compensation Benefits Percentage of Initial Claims in Pennsylvania, Chester County, Bucks County, Delaware County and Montgomery County Workforce Investment Areas by Gender, Race/Ethnicity, 2015

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Race and Ethnicity</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>White</td>
<td>Black</td>
<td>Hispanic</td>
<td>Native American</td>
<td>Asian</td>
<td>Unknown</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>36.7%</td>
<td>63.3%</td>
<td>75.8%</td>
<td>14.2%</td>
<td>5.7%</td>
<td>&lt;0.5%</td>
<td>1.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Chester County WIA</td>
<td>50.0%</td>
<td>50.0%</td>
<td>76.0%</td>
<td>13.6%</td>
<td>5.0%</td>
<td>&lt;0.5%</td>
<td>2.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Bucks County WIA</td>
<td>58.4%</td>
<td>41.6%</td>
<td>85.2%</td>
<td>6.2%</td>
<td>3.1%</td>
<td>&lt;0.5%</td>
<td>3.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Delaware County WIA</td>
<td>53.7%</td>
<td>46.3%</td>
<td>56.7%</td>
<td>34.6%</td>
<td>2.3%</td>
<td>&lt;0.5%</td>
<td>2.2%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Montgomery County WIA</td>
<td>58.0%</td>
<td>42.0%</td>
<td>74.6%</td>
<td>14.8%</td>
<td>3.1%</td>
<td>&lt;0.5%</td>
<td>4.0%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Note: All data are seasonally adjusted.
Source: PA Unemployment Compensation System

Unemployment rates also vary across different age groups. In Pennsylvania and the Bucks and Montgomery County WIs, men and women aged 45-54 made the highest percentage of initial unemployment benefits claims in 2015 (Table 13). In the Chester County WIA, however, the highest number of claims was made by men and women aged 55-65. Claims made by men and women aged
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65 and older in the Chester County WIA were also higher than those made by men and women of the same age group in Pennsylvania and neighboring counties.

Table 13. Regular Unemployment Compensation Benefits Percentage of Initial Claims by Workforce Investment Area and Age, April 2015

<table>
<thead>
<tr>
<th>Age</th>
<th>24 and Younger</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-65</th>
<th>65 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>7.9%</td>
<td>21.9%</td>
<td>20.2%</td>
<td>24.5%</td>
<td>20.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Chester County WIA</td>
<td>4.7%</td>
<td>17.2%</td>
<td>19.1%</td>
<td>23.5%</td>
<td>24.1%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Bucks County WIA</td>
<td>5.3%</td>
<td>17.9%</td>
<td>18.8%</td>
<td>25.2%</td>
<td>20.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Delaware County WIA</td>
<td>8.1%</td>
<td>25.0%</td>
<td>20.1%</td>
<td>21.8%</td>
<td>19.1%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Montgomery County WIA</td>
<td>4.5%</td>
<td>18.6%</td>
<td>18.7%</td>
<td>26.5</td>
<td>22.3%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Note: All data are seasonally adjusted.
Source: PA Unemployment Compensation System

Single mothers and young women also have high levels of unemployment. In 2013, single mothers with children under 18 were more than twice as likely to be unemployed as married mothers with a spouse present (12 percent compared with 4.8 percent) (U.S. Bureau of Labor Statistics, 2014c). According to preliminary data for 2014, the nation’s youngest female workers (aged 16–19) had an unemployment rate of 17.7 percent; those aged 20–24 fared better but still had a relatively high unemployment rate (10.1 percent) (U.S. Bureau of Labor Statistics, 2015d). Many young women face the dual disadvantage of having limited or no prior work experience and a lack of higher educational credentials.

Additionally, collecting unemployment compensation for reasons related to maternity leave is not an option for women in Pennsylvania. The American Recovery and Reinvestment Act of 2009 provided incentives to the states to “modernize” their unemployment compensation systems. Part of the “modernization” was to expand the eligibility for benefits to include “compelling family reasons.” Twenty-two states took advantage of these incentives to expand the eligibility criteria. However, Pennsylvania has not acted on these incentives. Employees must show a necessary and compelling reason for leaving work voluntarily. Leaving work to care for an infant or to recover from childbirth, does not appear to rise to this standard (Growing Family Benefits, 2014).

Challenges associated with reentering the workforce after maternity leave also contributes to women’s unemployment. The share of mothers not working outside the home rose to 29 percent in 2012, up from a low of 23 percent in 1999 (Cohn, Livingston, and Wang, 2012). This rise represents the reversal of a long-term decline in “stay-at-home” mothers. The “choice” not to work is complicated and represents a mix of demographic, economic and societal factors. Despite a recent increase in the number of mothers choosing to “stay-at-home,” public ambivalence about the impact of working mothers on young children persists (Cohn, Livingston, and Wang, 2012). A growing share of stay-at-home mothers (6% in 2012, compared with 1% in 2000) say they are home with their children because they cannot find a job. With incomes stagnant in recent years for all but the college educated, less educated workers in particular may weigh the cost of child care against wages and decide it makes more economic sense to stay home.

The broad category of “stay-at-home” mothers includes not only mothers who say they are at home in order to care for their families, but also those who are at home because they are unable to find work, disabled or enrolled in school. The largest share consists of “traditional” married, stay-at-home mothers with working husbands. They made up roughly two-thirds of the nation’s 10.4 million stay-at-home mothers in 2012 (Cohn, Livingston, and Wang, 2012). According to Census data, married stay-
at-home mothers are more likely than single or cohabiting stay-at-home mothers to say they are not employed because they are caring for their families (85 percent in 2012). By comparison, only 41 percent of single stay-at-home mothers and 64 percent of cohabiting mothers give family care as their primary reason for being home (Cohn, Livingston, and Wang, 2012).

The share of stay-at-home mothers has risen since 2000 among married mothers with working husbands and single mothers. No matter what their marital status, mothers at home are younger and less educated than their working counterparts. Among all stay-at-home mothers in 2012, 42 percent were younger than 35. This compares with roughly a third (35 percent) of working mothers. Stay-at-home mothers are less likely than working mothers to be White (51 percent are White, compared with 60 percent of working mothers) and more likely to be immigrants (33 percent vs. 20 percent). One of the most striking demographic differences between stay-at-home mothers and working mothers relates to their economic well-being. A third (34 percent) of stay-at-home mothers are living in poverty, compared with 12 percent of working mothers (Cohn, Livingston, and Wang, 2012).

Gender Differences in Employment by Industry
In the United States, gender differences persist across industries. An industry encompasses all employees of a firm or organization, whether they work as a janitor, secretary, accountant or information technology specialist. Employment in services such as health care, nongovernmental education, leisure, and other services account for more than four in 10 women’s jobs (nationally 43.2 percent), but only one in four men’s jobs (24.8 percent). The construction industry (1.3 percent of women and 11.1 percent of men), manufacturing (6.6 percent of women and 14.4 percent of men), and transportation and communications (3.0 percent of women and 7.8 percent of men) together account for the jobs held by about one in 10 employed women, but by about one-third of employed men.

The different industries in which women and men work affect their economic status. During the Great Recession of 2007 to 2009, for example, job losses were particularly high in construction and manufacturing while jobs in health and education grew, resulting in differences in the size and timing of job losses and gains experienced by women and men (Hartmann and English, 2010). In the five years after the official end of the Great Recession in June 2009, jobs in health care and education grew by almost two million, benefitting mainly women, while jobs in construction grew by only 7,000 (with net growth only for men) (Hartmann, Shaw, and O’Connor, 2014).

Median annual earnings and the gender earnings ratio for full-time, year-round work differ substantially across industries (Hartmann, Shaw, and O’Connor, 2014; IWPR, 2015). Women in government (which includes federal government as well as state and local services such as police and education) have the highest median earnings ($45,000) and a narrower gender earnings ratio than the ratio for all women and men (83.3 compared with 79.2 percent). Among major industries, the gender earnings ratio is widest in finance, insurance, and real estate (61.8 percent) and narrowest in mining and construction (95.2 percent), an industry that employs proportionately far fewer women than men. Manufacturing provides middle-income jobs to women, with median annual earnings of $37,000, but median earnings for men in these jobs are substantially higher at $50,000 (resulting in a gender wage ratio of 74.0 percent) (Hartmann, Shaw, and O’Connor, 2014).

Table 14 shows the distribution of women aged 16 and older across industries in the United States, Pennsylvania and Chester County in 2013. At the national, state and county levels, the health care, education, leisure, and other services industry category employs the highest percentage of women. In the United States and Pennsylvania, the industry with the lowest proportion of women is agriculture,
forestry, and fishing. Mining and Construction, however, represents the industry with the smallest proportion of women workers in Chester County.

Table 14. Distribution of Women Across Industries, United States, Pennsylvania, and Chester County, 2013

<table>
<thead>
<tr>
<th>Industry</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture, Forestry and Fishing</td>
<td>1.0%</td>
<td>.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mining and Construction</td>
<td>1.3%</td>
<td>1.2%</td>
<td>.9%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>6.6%</td>
<td>7.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Transportation, Communication, and Utilities</td>
<td>3.0%</td>
<td>2.7%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Wholesale and Retail Trade</td>
<td>20.7%</td>
<td>20.5%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Finance, Insurance and Real Estate</td>
<td>7.3%</td>
<td>7.1%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Health Care, Education, Leisure and Other Services</td>
<td>43.2%</td>
<td>48.5%</td>
<td>51.1%</td>
</tr>
<tr>
<td>Government</td>
<td>16.9%</td>
<td>11.9%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

Notes: For employed women aged 16 and older. All public sector workers are included in government; other sectors are private sector only.


Women in Managerial or Professional Occupations

Nationally, 39.9 percent of employed women and 33.0 percent of employed men work in professional or managerial occupations (IWPR, 2015; Table 15). This category encompasses a range of occupations—from management, lawyers, doctors, nurses, teachers and accountants to engineers and software developers—that mostly require at least a college degree. These jobs offer opportunities for higher earnings for women, although typically even more so for men; women who work in managerial or professional occupations often earn substantially less than men (IWPR, 2015). The three jurisdictions with the highest shares of women working in professional or managerial occupations—the District of Columbia, Maryland and Massachusetts—also have the highest median annual earnings for women (IWPR, 2015). Women are much more likely than men to work in professional and related occupations (26.2 compared with 17.5 percent, respectively) but slightly less likely than men to work in management, business and financial occupations (13.7 compared with 15.4 percent) (IWPR, 2015).

Pennsylvania is in the top third (17) of states with women aged 16 and older working in professional and managerial positions (IWPR, 2015). Chester County’s percentage of women aged 16 and older working in similar positions is slightly lower than the national and state rates at 38.9 percent; the percentage of men working in professional and managerial positions in Chester County is commensurately higher compared to the United States and Pennsylvania. Table 15 shows the percentage of women and men working in professional and managerial occupations in the United States, Pennsylvania and Chester County for 2013.

Table 15. Women and Men in Professional and Managerial Occupations, United States, Pennsylvania, and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Percent Employed in Managerial or Professional Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
</tr>
<tr>
<td>United States</td>
<td>39.9%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>40.5%</td>
</tr>
<tr>
<td>Chester County</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

Notes: Women and men aged 16 and older.

Women in Service Occupations

Women are also much more likely than men to work in service occupations (IWPR, 2015; Table 16), which include personal care aides, home health aides, nursing assistants, cooks and food service staff—occupations that are projected to see high growth in the coming years, but which have median annual earnings for women of less than $25,000 per year. According to IWPR analysis of 2013 American Community Survey microdata, one-third of employed Hispanic women (32.2 percent) and more than one in four employed Black (28.2 percent) and Native American (27.4 percent) women work in service occupations, compared with 20.6 percent of Asian/Pacific Islander women and 18.3 percent of White women (IWPR, 2015).

Table 16. Distribution of Women Across Broad Occupational Groups, United States, Pennsylvania, and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Management, Business and Financial</th>
<th>Professional and Related</th>
<th>Service</th>
<th>Sales and Related</th>
<th>Office and Administrative Support</th>
<th>Natural Resources, Construction and Maintenance</th>
<th>Production, Transportation and Material Moving</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United States</strong></td>
<td>13.7%</td>
<td>26.3%</td>
<td>21.8%</td>
<td>11.4%</td>
<td>20.3%</td>
<td>.9%</td>
<td>5.7%</td>
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<tr>
<td><strong>Pennsylvania</strong></td>
<td>12.8%</td>
<td>27.8%</td>
<td>21.4%</td>
<td>10.9%</td>
<td>21.0%</td>
<td>.7%</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Chester County</strong></td>
<td>13.4%</td>
<td>26.5%</td>
<td>22.0%</td>
<td>11.3%</td>
<td>21.2%</td>
<td>.4%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>


Women in STEM Occupations

Science, technology, engineering and mathematics (STEM) occupations have experienced much faster growth than other occupations in the last decade and play a key role in the sustained growth and stability of the U.S. economy (U.S. Department of Commerce, 2011). These fields are among the higher paid; analysis of 2013 American Community Survey microdata indicates that in 2013, full-time, year-round median annual earnings in STEM occupations were $64,000 for women and $78,000 for men (IWPR, 2015). Women are far less likely to go into STEM fields than men; nationally, only 4.6 percent of women work in STEM occupations, compared with 10.3 percent of men (Figure 5).

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2 This analysis uses the Bureau of Labor Statistics’ definition of STEM occupations, which includes the social sciences and managers of STEM workers, but excludes support occupations, health occupations, and most technical and trade occupations that do not require a four-year degree (U.S. Bureau of Labor Statistics, 2012). Rothwell (2013) and Carnevale, Smith, and Melton (2011) also find a wage advantage for STEM related occupations not requiring a four-year degree.
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Figure 5. Women and Men in Science, Technology, Engineering and Mathematics (STEM) Occupations, United States, Pennsylvania, and Chester County, 2013

Notes: Aged 16 and older. This definition of STEM occupation follows the U.S. Bureau of Labor Statistics definition of STEM occupations, which includes the social sciences and managerial occupations in social science fields, but excludes support occupations, health occupations, and most technical and trade occupations that do not require a four-year degree.


Women are less likely than men to work in STEM occupations in every state, but their shares of STEM occupations vary considerably (IWPR, 2015). Nationally, women represent 28.8 percent of STEM workers. In Pennsylvania and Chester County, women account for 30.4 percent and 29.6 percent, respectively, of the STEM workforce. The higher percentage of employed women working in these occupation in Chester County may be attributed to the concentration of higher education and pharmaceutical-related jobs in the region, even though overall employment for women is slightly below the state percentage.

The percentage of women working in STEM occupations varies across the largest racial and ethnic groups. Analysis of American Community Survey microdata finds that full time, year-round employment in STEM occupations in Chester County reflect broader national and state trends. In the United States, Pennsylvania and Chester County, Asian/Pacific Islander women are the most likely to work in these occupations (11.3 percent of employed Asian/Pacific Islander women in Chester County), followed by White women (4.9 percent in Chester County), Black women (2.8 percent in Chester County), and Native American and Hispanic women (2.3 percent each in Chester County).

Focus group participants did note that they felt that opportunities for women and girls in STEM fields were increasing in Chester County. They identified schools in the county that had dedicated STEM programs that targeted girls. Additionally, two nonprofit organizations that responded to the Nonprofit and Provider Snapshot Survey identified increasing access to STEM education for girls as their primary program-related activity.

Conclusion

The differences in occupations in which women and men work are just one factor indicating that much more progress needs to be made before women can achieve equality in the workforce. Occupational segregation continues to be a persistent feature of the U.S., Pennsylvania and Chester County labor force, with the occupations in which women are concentrated paying less than those in which men are concentrated. Women’s participation in the labor force has declined since 2002, and women in all states across the nation continue to earn less than men. Despite signs of progress, the gender wage gap is not expected to close for several decades if progress continues at the rate since 1960. These
findings point to the need for policies and practices that can accelerate the pace of change for women and improve their status in employment and earnings in all states and the nation overall.

More women in Chester County are active in the labor force than in Pennsylvania and the United States. The discrepancy between median earnings for men and women in Chester County, however, is higher than the state and nation. Hispanic women in Chester County face the largest earnings gap, with median annual earnings that are slightly more than half of White men. Among the largest racial and ethnic groups, Black women aged 16 and older have the highest workforce participation rates. While single mothers and young women in Chester County have lower rates of unemployment than single mothers and young women in Pennsylvania and the United States, members of these groups are most likely to be unemployed. Women working in Chester County are most likely to be employed in health care, education, leisure and other services and least likely to be employed in mining and construction. Chester County’s percentage of women working in science, technology, engineering and mathematics (STEM) occupations is slightly higher than the state and national percentages. Part-time labor force participation by women in Chester County is also slightly higher than national and state rates. These women are less likely to receive employment benefits such as paid vacation days, paid family or medical leave, paid sick days, health care insurance or employer contributions to retirement saving funds.
Emerging Issues and Advocacy Opportunities

The Employment and Earnings of Older Women

The majority of older people (aged 65 and above) in the United States are women, and many are active in the workforce. In 2014, nearly 14 percent of women aged 65 and older were in the labor force; among the youngest of this age group—those aged 65–74—more than one in five women (22 percent) were in the workforce. Slightly more than half of employed women aged 65 and older work part-time (51.4 percent). (All calculations based on 2014 American Community Survey microdata.)

- The median annual earnings of women aged 65 and older who work full time, year-round in the United States are $37,000, slightly less than the earnings for all women aged 16 and older ($38,000). Women aged 75 and older who work full time, year-round have median earnings that are $8,000 less than those aged 65–74 ($30,000 compared to $38,000).
- The gender earnings ratio between women and men aged 65 and older who work full time, year-round is lower than the earnings ratio between all women and men. Older women earn 72.5 cents on the dollar compared to their male counterparts.
- Approximately 35.6 percent of employed women aged 65 and older work in managerial or professional occupations, a smaller percentage than their male counterparts (42.7 percent). Among all employed women and men aged 16 and older, the pattern differs: women are considerably more likely than men to work in professional or managerial occupations (39.9 percent compared with 33.0 percent).
- As with all employed women and men, older women and men tend to be concentrated in different jobs. Older women are substantially more likely than older men to work in service or in office and administrative support occupations; more than four in 10 (45.9 percent) older women work in these occupations, compared with just one in five (19.6 percent) older men. Older women are much less likely than their male counterparts to work in management, business and financial occupations (12.0 percent compared with 21.0 percent) and in construction or production occupations (5.8 percent compared with 24.9 percent). These general patterns also hold true for all ages of women and men, with slight differences.

The Employment and Earnings of Millennials

The millennial generation has come of age in difficult economic times, with student debt reaching all-time highs and employment opportunities in short supply. Research indicates that, in 2013, the average loan debt among bachelor’s degree students graduating with debt from public and private nonprofit colleges was $28,400.

In the face of difficult economic times, millennial women—defined as those aged 16-34 in 2013—are pursuing many different career paths and jobs. Much like their older counterparts, however, they face a range of challenges in the workforce (Reed and Cochrane, 2014).

- Nearly seven in 10 (67.8 percent) millennial women (aged 16–34) are in the workforce, compared with 73.1 percent of their male counterparts.
- Millennial women and men have been highly vulnerable to unemployment: 11.6 percent of millennial women and 12.5 percent of millennial men were unemployed in 2013, which is well above the unemployment rates for women and men overall.
- Millennial women face a gender wage gap, albeit one that is narrower than the wage gap between all women and men. In 2013, the national median annual earnings for millennial women working full time, year-round were $30,000, compared with $35,000 for their male counterparts.
counterparts, resulting in an earnings ratio of 85.7 percent.

- In Pennsylvania, the median annual earnings for millennial women working full time, year-round in 2013 were $32,105, compared with $37,283 for their male counterparts: an earnings ratio of 86.1 percent.
- More than one in three (34.2 percent) millennial women work in managerial or professional occupations, compared with one in four (25.4 percent) millennial men.
- Millennial women are slightly more likely than millennial men to work in management, business and financial operations (10.2 percent of employed millennial women compared with 9.7 percent of employed millennial men). Millennial women are also considerably more likely than their male counterparts to work in professional or related occupations (24 percent compared with 15.7 percent). As with older women, millennial women are much more likely than their male counterparts to work in service occupations (27.2 percent compared with 20.5 percent), and much less likely to work in construction or production occupations (5.4 percent of employed millennial women compared with 32.9 percent of employed millennial men).

State Statutes That Address the Gender Wage Gap

- **Tackling Pay Secrecy:** As of 2014, 10 states had enacted laws that prohibit employer retaliation against employees who inquire about other employees' wages or disclose their own: California, Colorado, Illinois, Louisiana, Maine, Michigan, Minnesota, New Hampshire, New Jersey and Vermont (U.S. Department of Labor, 2014).
- **Tackling the Undervaluation of Women's Work:** As of January 2015, the District of Columbia and at least five states—Iowa, Minnesota, Montana, Washington and West Virginia—have “comparable worth” statutes or regulations for public employees to address the undervaluation of work performed mainly by women. These statutes and regulations require that compensation for work of comparable worth—measured by the skill, effort, responsibility and working conditions—be equitable (IWPR, n.d.).
- **Tackling Low Wages:** As of Jan. 1, 2015, 29 states and the District of Columbia had a minimum wage that was higher than the federal minimum wage of $7.25. The minimum wage was highest in the District of Columbia at $9.50 per hour; seven states had a minimum wage of at least $9 per hour (U.S. Department of Labor, 2015a). Several other states are scheduled to increase above $9.50 in future years. Pennsylvania Governor Tom Wolf raised the minimum wage for state government employees and workers on jobs contracted by the state to $10.15 by executive order on March 7, 2016. All other Pennsylvania wages are set at the federal minimum wage.
- **Tackling the Low Tipped Minimum Wage:** As of 2014, seven states required employers to pay tipped workers the full state minimum wage: Alaska, California, Minnesota, Montana, Nevada, Oregon and Washington (U.S. Department of Labor, 2015b). An additional 26 states and the District of Columbia required employers to pay tipped workers above the federal tipped minimum wage of $2.13 an hour, ranging from a state tipped minimum wage of $2.23 in Delaware to a state tipped minimum wage in Connecticut of $5.78 (for the hotel and restaurant industry) and $7.46 (for bartenders who customarily receive tips). The Pennsylvania tipped minimum wage is $2.83 (U.S. Department of Labor, 2015b).

The Employment and Earnings of Immigrant Women

According to a 2014 study, approximately 21 million female immigrants lived in the United States in 2013, making up just over 13 percent of the nation’s female population. Immigrant women come from all over the world, with the largest shares from Mexico (25.6 percent), the Philippines (5.3 percent),
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China (4.7 percent) and India (4.6 percent). In their multiple roles as students, professionals and other workers, spouses, parents and caregivers, immigrant women make important contributions to local communities, the economy and society (Hess and Henrici, 2014).

- Immigrant women are less likely than U.S.-born women to be in the labor force (56.2 percent compared with 59.0 percent). While many immigrant women are thriving in the workforce, others encounter challenges that hinder their workforce participation or limit their access to higher quality employment. These challenges include the same barriers all women face—such as the undervaluation of work performed predominantly by women and the lack of a work-family infrastructure—and often additional challenges as well, such as limited English proficiency and, for those who are undocumented, lack of access to legal status (Hess, Henrici, and Williams, 2011; Hess and Henrici, 2014).

- Median annual earnings for immigrant women working full time, year-round in 2013 were $32,000, which was much less than the earnings for U.S.-born women ($39,000). Among the 10 largest sending countries for female immigrants—Mexico, the Philippines, China, India, Vietnam, Korea, El Salvador, Cuba, the Dominican Republic and Canada—immigrant women’s earnings varied considerably. Women from India had the highest earnings at $65,000—well above the median earnings for all women of $38,000—and women from Mexico had the lowest earnings at $22,000. These differences likely stem, in part, from differences in levels of education; immigrant women from India typically have more years of higher education (Hess and Henrici, 2014).

- Immigrant women overall are less likely than U.S.-born women to work in managerial or professional occupations (32.7 percent compared with 41.1 percent) (Hess and Henrici, 2014).

- Immigrant women are disproportionately represented in service occupations. One in three (32.5 percent) immigrant women work in these occupations, compared with 19.9 percent of U.S.-born women. Immigrant women are also nearly twice as likely as U.S.-born women to work in production, transportation, and material moving occupations (9.9 percent compared with 5.0 percent). They are less likely than U.S.-born women to work in office and administrative support occupations (13.3 percent of employed immigrant women work in these occupations compared with 21.5 percent of employed U.S.-born women) and in professional and related occupations (21.8 percent compared with 27.0 percent) (Hess and Henrici, 2014).

The Employment and Earnings of Women with Disabilities

According to the National Women’s Law Center (2014), approximately 2.6 million women aged 16 and older in the 2013 labor force had disabilities, including cognitive, ambulatory, sight, hearing and self-care or independent living difficulties. They comprised 3.6 percent of all women in the labor force at the time.

- The labor force participation rate of women aged 16 and older with disabilities in 2013 was 17.1 percent, compared with 62.7 percent of women without disabilities.

- Finding work is harder for women with a disability than for other women. In 2013, the rate of unemployment for women with a disability was 13.5 percent, compared with 6.8 percent for women without a disability.

- Women with disabilities are more likely to work part-time. The percentage of women with
disabilities working part-time in 2014 was 38.4 percent, compared with 28.9 percent of women without disabilities.

- Women with disabilities are about as likely as other women to work in sales and office occupations (31.8 and 30.4 percent, respectively) and slightly more likely to work in service occupations (24.8 and 21.6 percent). They are less likely to work in management, professional and related occupations (34.9 percent of women with disabilities and 41.8 percent of women without disabilities).

- Women aged 16 and older with disabilities that worked full time, year-round reported lower earnings than those without disabilities ($32,500 compared with $38,000) in 2013.
WORK & FAMILY

Introduction
Women make up almost half of the workforce. Few families have someone who can stay at home to take care of health emergencies, pick children up from school and supervise homework, or take an elderly parent to a doctor’s appointment. In half of all families with children, women are the primary or co-breadwinner\(^3\) (IWPR, 2015). Low-income families are particularly likely to have all parents in the labor force (Boushey, 2014). As mothers’ labor force participation has dramatically increased in the past decades (U.S. Bureau of Labor Statistics, 2014) and the number of women and men aged 50 and older who provide care for a parent more than tripled between 1994 and 2008 (MetLife 2011)\(^4\), the development of an infrastructure to support workers with family caregiving responsibilities has been largely neglected. Many workers lack access to even the most basic supports such as earned sick days and job-protected paid parental leave. Quality child care is also out of reach for many families because it is not affordable. Women comprise the large majority of family caregivers,\(^5\) and in the absence of reliable family supports, too many women are forced to make difficult decisions between keeping their jobs and caring for their family members.

Investments in work-family supports not only improve women’s economic security, but also contribute to economic growth (Council of Economic Advisors, 2014). This section of the Blueprint Report examines available supports for work and family in the United States, Pennsylvania and Chester County. It begins with an overview of the Work & Family Composite Index and the overall ranking of states in this area of women’s status. It then discusses paid leave, elder and dependent care, motherhood and female breadwinners, and child care and preschool education. The section ends with a discussion of differences in the time spent on paid and unpaid work between mothers and fathers.

Work & Family in the United States, Pennsylvania and Chester County
The Institute for Women’s Policy Research (2015) developed the Work & Family Composite, which compares states’ performance across three components of work-family policy—paid leave, dependent and elder care, and child care—and a fourth component, the gender gap in the labor force participation of parents of children under six, an indicator that highlights gender inequality in family care of young children (IWPR, 2015). Each of the three policy components has a number of indicators selected to represent the ease or difficulty of obtaining work family supports.

The paid leave component includes state policies on Temporary Disability Insurance (TDI), paid family and medical leave, and paid sick days. For dependent and elder care, the component includes the availability of unemployment insurance benefits for a worker who has to leave employment for family care reasons; the availability and level of dependent care tax credits for the care of a dependent adult relative; and the delegation of long-term support services to domestic care agency staff (such delegation can lower the costs of providing care for a family member). The child care component includes three indicators: enrollment of four-year-olds in publicly funded pre-Kindergarten (Pre-K), preschool special education, and state and federal Head Start programs; state

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\(^1\) A primary or co-breadwinner is defined as a single mother, or as a married mother with children under 18 who earns at least 40 percent of a couple’s total earnings.

\(^2\) The large majority of family caregivers aged 50 to 64 are employed (Metlife, 2011).

\(^3\) In this report, the term “family caregiver” refers someone providing unpaid care to a family member. A person paid to provide such care is referred to as a “domestic care worker.”
systems to ensure quality of Pre-K education; and the cost of center-based infant care. The indicator selection is intended to provide a succinct portrait rather than a comprehensive catalogue of all aspects of work and family; the selection of indicators is also informed by the availability of data for state-by-state comparisons.6

Each of the four components of the Work & Family Composite Index is weighted equally. From a maximum score of 8 across all indices, state composite scores range from a low of 2.03 to a high of 5.55, with higher scores reflecting a stronger performance in this area of women’s status and receiving higher letter grades (IWPR, 2015). Pennsylvania earned a composite score of 3.43, is ranked 33 out of 51 (all states and the District of Columbia) and received a grade of D+ based on data collected in 2013 and 2014 (Table 17).

Table 17. Pennsylvania Women’s Status on the Work & Family Composite Index and Its Components

<table>
<thead>
<tr>
<th></th>
<th>Composite Index</th>
<th>Paid Leave Legislation Index</th>
<th>Elder and Dependent Care Index</th>
<th>Child Care Index</th>
<th>Gender Gap in Parents’ Labor Force Participation Rates</th>
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<td>Score</td>
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<td>Grade</td>
<td>Score</td>
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<td>3.43</td>
<td>33</td>
<td>D+</td>
<td>.33</td>
<td>9</td>
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Source: IWPR, 2015.

Because the Work & Family Composite Index is a new measure developed for the most recent Status of Women in the States report, there is no basis for comparison regarding Pennsylvania’s ranking over the past decade. Compared to other states, data place Pennsylvania squarely within the middle third of state rankings on this index. No state received a grade higher than a B on the Work & Family Composite Index. California, New York and the District of Columbia received a B, and New Jersey, Rhode Island and Oregon a B-. Three states—Indiana, Utah and Montana—each received an F (IWPR, 2015).

Paid Leave and Paid Sick Days

Everyone is likely to need to take leave from work at some time due to personal illness, the demands of parenthood or the need to provide care for someone in their family. Because women are the majority of those providing care for children as well as elderly and disabled adult family members, and because of their greater need for leave related to pregnancy and childbirth, having access to job-protected paid leave is particularly important for them. Research has documented the benefits of paid leave for women and their families and the negative effects of not having access to leave (Gault et al., 2014; Earle, Mokomane, and Heymann, 2011; and Winston, 2014). Paid leave helps women remain in the labor force when faced with caregiving responsibilities—whether the caregiving is for a baby, child, parent or spouse—and the continuous attachment to the labor force can also help them advance in their careers. Paid leave for men can help address the unequal division of caregiving tasks between women and men and can reduce the potential for stereotyping and discrimination against women if they are the only ones making use of paid leave benefits (Patnaik, 2015). The United States is one of only two countries in the world without a national paid maternity leave law, and one of a small minority of high-income countries that does not require employers to provide paid sick days (Earle, Mokomane, and Heymann, 2011; International Labour Organization, 2014; Ray,

6 The data in IWPR’s Status of Women in the States reports come from federal government agencies and other sources; data also rely on analysis from organizations such as AARP, Child Care Aware of America, the National Partnership for Women & Families, the National Institute for Early Education Research, and Tax Credits for Working Families.
The Family and Medical Leave Act (FMLA) of 1993 provides up to 12 weeks of unpaid, job-protected leave in a given year to care for a newborn or a newly adopted or fostered child, to address one’s own serious health condition, or to care for a family member with a serious health condition; 26 weeks of leave are available for care of an injured service member (Gault et al., 2014). Because of restrictions in coverage to employees working for public and private employers with 50 or more employees within 75 miles of their worksite, and who have worked at least 1,250 hours in the past year, only 59 percent of employees are eligible to take FMLA leave (Klerman, Daley, and Pozniak, 2014). Coverage is also restricted because of the law’s narrow definition of family. Spouses (including same-sex spouses), children, grandchildren and parents are included, but care for an adult child (unless mentally or physically disabled), sibling, parent-in-law or grandparent is not.

State laws and voluntary employer benefits are only partially filling the vacuum left by a lack of federal laws. Nearly 40 percent of all women workers, and about half of Hispanic women workers, do not have access to any paid sick time (Figure 6). Part-time workers (the majority of whom are women) are only rarely covered by paid leave benefits of any kind (Figure 6). Less than half of all employed women (41 percent) received paid maternity leave before or after the birth of their child (Laughlin, 2011).

Figure 6. Percent of Workers with Access to Paid Sick Days by Gender and Race/Ethnicity, United States, 2013

Access to paid leave is highly unequal (Figure 7). Nine in 10 high-income workers have access to paid sick time, compared with only one in five low-income workers (O’Connor, Hayes, and Gault, 2014). Fifty-three percent of lower-income workers did not receive pay during their most recent FMLA leave, compared with just 18 percent of higher-paid workers who did not receive paid leave as part of their employers’ benefit package (Klerman, Daley, and Pozniak, 2014). Nearly half of all employees (46 percent) who reported that they needed leave for FMLA reasons in 2012 reported not having been able to take it because the leave would have been unpaid and they could not forego their earnings (Klerman, Daley, and Pozniak, 2014).
A small but growing number of states have statutes providing workers access to paid leave, with seven states providing some kind of leave as of early 2015. The Work & Family Composite Index scores states on three paid leave policies: statewide Temporary Disability Insurance, or TDI (which provides women with paid maternity leave of four to six weeks for a normal pregnancy and birth as part of providing TDI to all workers with temporary disabilities); paid family leave insurance (which covers the care of newborns and care of family members with illness or aging parents, the type of leave covered under the FMLA for up to four to six weeks) and paid sick days.

Pennsylvania ranked 9 out of 51 (all states and the District of Columbia) on the Paid Leave Legislation by State component index (IWPR, 2015). Neither TDI nor paid leave for FMLA-related reasons are offered statewide. Paid sick days, however, is a local legislative matter. In Chester County, public sector workers receive six paid sick days per year, prorated from date of hire. After the first year of employment, the number of paid sick days increases to 12 full days. Year-to-year carry-over is allowed with limited buyback options offered in instances of voluntary termination (Chesco.org).

Workers in only one state, California, are covered by TDI and family leave insurance (up to six weeks of paid family leave) and have a right to earn paid sick days (paid for by employers). In 40 states, workers lack statutory rights to paid family and medical leave and do not have a statutory right to paid sick days on the job (Gault et al., 2014; National Partnership for Women and Families, 2014).

**Elder and Dependent Care**

Many elderly people and many people with disabilities live healthy and independent lives, and provide support—financial or otherwise—for their families. Many others, however, rely on the care of family members to function. A quarter of the adult population under the age of 65 (24 percent), and an even larger share of those older than 65 (39 percent), have one or more disabilities (Centers for Disease Control and Prevention, 2015; West et al., 2014). According to the 2015 *Caregiving in the U.S.* study, 39.8 million people provided informal care to an adult during the prior twelve months, and 34 million provided care for an adult aged 50 years or older (National Alliance for Caregiving and AARP, 2015). A study focused on care for those 65 years and older found that, each month in 2011, nine million older adults received informal assistance and 18 million family members and friends provided such informal care (Spillman et al., 2014). It is estimated that the value of unpaid service by family
caregivers is nearly $470 billion a year, which is nearly equivalent to the total amount spent on the federal Medicaid program (Skidmore, 2015). The large majority of caregivers under the age of 65 combine caregiving with paid work (MetLife, 2011). Additionally, family caregivers spend on average more than $5,000 per year out of pocket on related expenses, and caregivers age 50 and older who are unable to maintain employment suffer income-related losses of more than $300,000 over their lifetime (Skidmore, 2015).

Women are the majority of those who provide care for adult family members needing assistance, whether the person who needs care lives with them or elsewhere. As the American population ages further—the share of the population age 65 and older has grown from 9.9 percent in 1970 to 14.1 percent in 2013 and is projected to reach 20 percent in 2030 (West et al., 2014; U.S. Census Bureau, 2012a)—the demand for informal care will continue to increase, with proportionately fewer family members available to provide such care.

Nationally, in 2011-2013 one in seven adult women under the age of 65 lived with a person aged 15 or older with one or more disabilities. The share of women who live with someone with one or more disabilities varies considerably between states, from fewer than one in 10 women under the age of 65 in Nebraska (9.8 percent) and to one in five women in West Virginia (20.9 percent) (IWPR, 2015). Approximately one in seven women (14.4 percent) in Pennsylvania under the age of 65 lived with a person aged 15 or older with one or more disabilities, which is consistent with the national average (IWPR, 2015).

The National Alliance for Caregivers and AARP study (2015) found that, on average, caregivers spent 20 hours per week providing care, rising to almost 40 hours per week for those who lived with the person who needed care. The weekly time spent is not much lower for those who are employed: the 2014 Older Adult Caregiver Study found that adults who worked full time while providing care for someone aged 50 and older spent a median of 16 hours per week on such care (Matos, 2014). Time spent on support for parents and in-laws is twice as high for families living in poverty than it is for high-income families (Heymann, 2005).

Balancing both employment and caregiving responsibilities, particularly for women, leads to significantly higher levels of stress than those experienced by non-caregiving peers (MetLife, 2011). This effect may be even stronger for people with elder care responsibilities, as elder care needs may arise more suddenly and intensively, because of a fall or a stroke, for example, than care for a child, making it harder to plan and prepare (Reinhard et al., 2011). The unequal division of family caregiving work between women and men is demonstrated by the fact that women are nine times as likely as men to work part time for family care reasons (Figure 8). In Chester County, 32.5 percent of women aged 16 and older and in the labor force work part-time jobs compared to 16.1 percent of men (Figure 8). While women are also approximately twice as likely to work part time across the United States and Pennsylvania at 29.4 percent and 30.7 percent, respectively, the percentage is higher in Chester County (Figure 8).

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1 Estimates vary according to the source of data and the type of caregiving that is considered, but all find women to be the majority of those who provide unpaid family care; see Bianchi, Folbre, and Wolf 2012; Lee and Tang 2013; National Alliance for Caregiving and AARP 2015; Spillman et al. 2014.

2 According to a 2014 study, 55 percent of employed adults aged 18 and older had provided care for at least one person aged 65 or older during the last five years; 8 percent only provided care for someone aged 50 to 64; and 37 percent had not provided care for someone aged 50 or older (Matos, 2014).

3 The ACS defines a person with a disability as someone who has one or more of the following: hearing difficulty; vision difficulty; cognitive difficulty (having difficulty remembering, concentrating, or making decisions because of a physical, mental, or emotional problem); having serious difficulty walking or climbing stairs; having difficulty bathing or dressing; independent living difficulty (having difficulty doing errands alone such as visiting a doctor’s office or shopping because of a physical, mental, or emotional problem; U.S. Census Bureau, 2012b).
Part-time work means lower earnings (and lower Social Security contributions) than full-time work; part-time workers are also much less likely than full-time workers to have access to paid leave of any kind or to benefit from employer contributions to employer-provided health insurance or pension plans (SHRM, 2011; Van Giezen, 2013). Women are also three times as likely as men to report having left their job because of caregiving responsibilities (6 percent compared with 2 percent respectively, according to a 2013 AARP survey of people aged 45 to 74) (Perron, 2014). A study by MetLife (2011) estimated that women with caregiving responsibilities who are over the age of 50 lose $324,044 in income and benefits over their lifetime when they completely exit the workforce for caregiving reasons.

Focus group participants from the two service provider groups noted that many women in their service areas worked part-time jobs and frequently cited reasons such as those presented in Figure 9. Focus group discussions, as well as survey responses related to which services are most difficult for women to access in Chester County, reveal that while Census numbers accurately reflect the reasons women are working part-time, they do not reflect their interrelatedness. County service providers report that many women cite numerous reasons for not working full time. The alleviation of one reason does not necessarily mean that a woman can easily transition into a full-time, higher-paying job with better benefits. Decreasing the share of women’s part-time work hinges on addressing multiple facets of gender disparity.
State policies can support family caregivers in a number of ways. They can support them directly through providing supports for respite care, assessments and training, and through legislating access to paid leave at work, and indirectly by properly funding and enforcing quality standards for nursing care and long-term service support workers. In a 2014 assessment of long-term care services and supports (LTSS) for older adults, people with disabilities and family caregivers in all 50 states and the District of Columbia, Pennsylvania ranked in the bottom quartile. This assessment examined data related to 26 indicators across five dimensions: affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers and effective transitions. Table 18 provides Pennsylvania’s overall ranking as well as its ranking by dimension.

Table 18. Pennsylvania Ranking on LTSS System Performance Overall and by Dimension

<table>
<thead>
<tr>
<th>Rank</th>
<th>Overall</th>
<th>Affordability and Access</th>
<th>Choice of Setting and Provider</th>
<th>Quality of Life and Care</th>
<th>Support for Family Caregivers</th>
<th>Effective Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42</td>
<td>46</td>
<td>25</td>
<td>37</td>
<td>36</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: Reinhard et al., 2014.

Indicators of state-by-state family caregiver needs, and of work-family supports specifically designed to support family caregivers, are still evolving. The elder and dependent care component of the Work & Family Composite Index scores states on three items linked to financial supports for caregivers: unemployment insurance benefits for workers who have to leave their jobs because of family care; tax credits for dependent care that are not limited to child care, are refundable, and are $500 or higher; and nurse delegation of LTSS tasks to domestic care agency workers—which can lower the costs of hiring external help to provide care.

Pennsylvania ranked in the bottom third of all states and the District of Columbia on the Elder and Dependent Care by State component index (IWPR, 2015). Table 19 provides the data from each indicator used to calculate the state’s rank and score. Pennsylvania is one of 24 states that recognize family care reasons as a legitimate cause of job loss for receiving unemployment benefits insurance, but does not allow residents to claim dependent care tax credits for the care of an adult family member. Of a total of 16 LTSS medical tasks, Pennsylvania does not allow registered nurses to delegate any to domestic care workers. In the context of lower earnings for many women in Pennsylvania, the high costs of hiring external help to care for a loved one may force a person to choose between her employment and providing the care herself.
Table 19. Pennsylvania Elder and Dependent Care Component Index by Indicator

<table>
<thead>
<tr>
<th>Unemployment Insurance Covers Family Care Reasons</th>
<th>Dependent Care Credits Not Limited to Child Care</th>
<th>Dependent Care Credit Refundable</th>
<th>Maximum Dependent Care Credit</th>
<th>Dependent Care Credit Total Rank</th>
<th>Number of Long-Term Support Services that Can be Delegated to a Home Care Agency Worker (out of 16)</th>
<th>Rank</th>
<th>Elder and Dependent Care Total Score</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>$0</td>
<td>23</td>
<td>0</td>
<td>47</td>
<td>50</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: IWPR, 2015.

State and Local Laws to Support Caregivers at Work

Currently, many workers juggle both work and caregiving responsibilities. Those responsibilities extend not only to spouses and children, but also to parents and other older family members, or to relatives with disabilities. Women, particularly women of color, remain disproportionately likely to exercise primary caregiving responsibilities for children, parents and relatives with disabilities. Numerous studies have found that flexible workplace policies enhance employee productivity, reduce absenteeism, reduce costs and appear to positively affect profits (Shabo, 2016). Legislation in the following areas could provide much needed relief for caregivers in Pennsylvania.

Caregiver discrimination: A number of states have passed laws to protect family caregivers from discrimination at work (such as being fired for needing leave or denying leave for caregiving reasons or not being hired or promoted because one has caregiving responsibilities) (Redfoot, Feinberg, and Smith Fitzpatrick, 2014; Williams et al. 2012). The U.S. Equal Employment Opportunity Commission (EEOC) has clarified that both under Title VII of the Civil Rights Act and under the Americans with Disabilities Act it constitutes discrimination for an employer to treat a person adversely because he or she is a family caregiver or “associated with a person with a disability” (U.S. EEOC, 2007). A number of states have issued laws to extend protections for family caregivers beyond what is covered in federal laws; most statutory protections in this field, however, have happened at the local level in cities and districts. At least 67 localities in 22 states have passed family caregiver protection ordinances; only 30 of these are not limited to workers with child care responsibilities and include care for parents or ill or disabled spouses (Williams et al., 2012).

Rights to Request Flexible Work: Since 2014, workers in Vermont and San Francisco have a formal “right to request” flexible work arrangements. The Vermont law defined these as “intermediate or long-term changes in the employee’s regular working arrangements, including changes in the number of days or hours worked, changes in the time the employee arrives at or departs from work, work from home, or job sharing” (Vermont Commission on Women, 2014). Under the law, the employer must consider an employee’s request in good faith and may not retaliate against an employee for making a request. The law does not provide a right to changed working conditions, and there are a number of legitimate reasons for an employer to reject a request. While the impact of the Vermont law has not yet been evaluated, similar laws elsewhere in the world have contributed to making alternative work arrangements more widely accessible to workers (Hegewisch, 2009).

Six in 10 employed family caregivers made adjustments to their work arrangements in response to their caregiving responsibilities (National Alliance for Caregivers and AARP, 2015). The proportion of employers in the 2014 National Study of Employers reporting that they provide elder care supports and allow job-protected leave for employees with elder care needs has increased since 2008 (Matos and Galinsky, 2015). The same study also finds that a falling share of employers allow more systematic (rather than one-off) adjustments to work arrangements. The share of employers who allow: at least some employees to job share fell from 29 percent in 2008 to 18 percent in 2014; to take a sabbatical from 38 to 28 percent; and to have a break for personal or family responsibilities...
from 64 to 52 percent. Of those who left their jobs because of elder care responsibilities, more than half (52 percent) said they did so because their employers did not allow them the flexibility needed to combine work and elder care (Matos, 2014). While both men and women find it difficult to combine employment with elder care, women are significantly more likely than men to report work-related difficulties (Matos 2014).

**Predictable work schedules:** In January 2015, the Retail Workers Bill of Rights became law in San Francisco. The law applies to large retailers and provides workers with a right to two weeks’ notice of their schedules; penalty pay if schedules are changed with less than one week’s notice; equal treatment for part-time and full-time workers; and minimum pay for workers who are on-call (whether they are called or not) (Jobs with Justice, 2015). San Francisco, to date, is the only locality to have passed such a statute; eight states and the District of Columbia have statutes that entitle an employee to receive some pay if he or she was scheduled to work but then is not needed (Golden, 2015).

Whether caring for a child or a person with a disability, providing such care requires predictability and punctuality. Schedule irregularity, and corresponding variability in earnings, has increased strongly since 2000 and is reported by a significant number of workers irrespective of whether they formally work full time, part time, or are self-employed (Golden, 2015). Schedule flexibility is a particular problem for low wage workers in retail and restaurants (Lambert, Fugiel, and Henly, 2014; Watson and Swanberg, 2011). According to one recent study, over four in 10 mothers working in restaurants reported that their shifts changed weekly (39 percent) if not daily (5 percent); almost a third of mothers had incurred fines from their child care provider or had to change their child care arrangement altogether because of scheduling changes (Restaurant Opportunity Center, 2013).

**Mothers as Breadwinners**

The large majority of mothers are in the workforce, including 62 percent of mothers who gave birth within the last 12 months (U.S. Department of Labor Women’s Bureau, 2015). One in three workers (32 percent) have children under 18, and of these, a quarter have children younger than 6 years old (U.S. Bureau of Labor Statistics, 2014). Nationally, of 116,211,092 households, 33.9 million households have children under age 18 (Table 20). Of the U.S. households, 56.2 million are headed by married couples, 15.1 million by single mothers and 5.5 million by single fathers (Table 20).

In Pennsylvania and Chester County, approximately 17.8 percent and 32.4 percent, respectively, of total households have children under age 18. The percentage of households with children in Chester County is higher than both the national and state percentages. While the percentage of married couple households is also higher than the national and state percentages, the number of female-headed households is more than twice the number of male-headed households (Table 20).

Table 20. Distribution of Households with Children Under 18 by Type, United States, Pennsylvania and Chester County, 2014

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Households</td>
<td>116,211,092</td>
<td>4,957,736</td>
<td>185,306</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>Households with Own Children Under 18 Years</td>
<td>33,917,911</td>
<td>29.2%</td>
<td>883,173</td>
</tr>
<tr>
<td>Married Couple Family Household</td>
<td>56,270,862</td>
<td>48.4%</td>
<td>2,394,178</td>
</tr>
<tr>
<td>Female Householder, No Husband Present</td>
<td>15,143,154</td>
<td>13.0%</td>
<td>1,943,856</td>
</tr>
<tr>
<td>Male Householder, No Wife Present</td>
<td>5,543,754</td>
<td>4.8%</td>
<td>215,905</td>
</tr>
</tbody>
</table>

Note: Percentages are rounded to the nearest tenth and do not equal 100.
Regardless of whether or not the household is headed by a married couple or a single parent, mothers’ earnings make a major contribution to their family’s income. In half of all families, they are the sole provider or, in married couples, contribute at least 40 percent of family earnings (Table 21). Single mothers are a slight majority of female breadwinners (51 percent of mothers who make at least 40 percent of household income). In married families with children, over a third of wives (37 percent) earn at least 40 percent of the couple’s joint earnings.

Among all families with children, the District of Columbia has the highest share (64 percent) of breadwinner mothers. The state with the lowest share of female breadwinners is Utah (35 percent) (IWPR, 2015). In Pennsylvania and Chester County, 50.4 percent and 46.4 percent, respectively, of households have breadwinner mothers. The share of single mothers in Chester County is 48.3 percent and 49.4 percent in Pennsylvania compared to 50.7 percent across the United States (Table 21). The share of married mothers among breadwinners in Chester County is also slightly below the national and state percentages, at 37.8 percent.

Table 21. Breadwinner Mothers in Households with Children Under 18, United States, Pennsylvania and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Households with Children Under 18</th>
<th>Households with a Breadwinner Mother as a Percent of All Households with Children</th>
<th>Single Mothers as Percent of All Female Breadwinners</th>
<th>Married Couples with a Female Breadwinner as Percent of All Married Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>United States</td>
<td>32,280,267</td>
<td>28.6%</td>
<td>49.8%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>859,031</td>
<td>26.0%</td>
<td>50.4%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Chester County</td>
<td>58,074</td>
<td>29.3%</td>
<td>46.4%</td>
<td>48.3%</td>
</tr>
</tbody>
</table>

Notes: Data are three-year (2011–2013) averages. Data on households with children under 18 are as percent of all households in the state. A breadwinner mother is defined as a single mother who is the main householder (irrespective of earnings) or a married mother who earns at least 40 percent of the couple’s joint earnings; single mothers who live in someone else’s household (such as with their parents) are not included.


Having children can present a formidable range of obstacles at work, including inadequate protections during and after pregnancy, the high cost of child care, particularly for young children, and school days and years unaligned with the working day. Added to such challenges are biases against mothers at work (Correll, Benard, and Paik, 2007; Williams and Segal, 2003). Research suggests that mothers’ earning power is curtailed by discrimination against them as mothers, in addition to general factors that contribute to the gender wage gap (Budig, 2014). Research finds no evidence that lower earnings are a reflection of lower productivity or of other factors that may justify lower earnings (Kmec, 2011). The motherhood penalty is particularly marked for White mothers (Glauber, 2007); the lack of a motherhood penalty for women of color is likely an expression of higher general levels of discrimination faced by all Black and Hispanic women and men.

Participants in the service provider focus groups confirmed that working mothers in Chester County face significant challenges. They noted that steady increases in the cost of living without commensurate wage increases and simultaneous budget cuts in programs benefitting women and families had crippling impacts on single mothers in Chester County. Responses to the Nonprofit and Provider Snapshot survey support these assertions. The most frequently cited reason for inability to provide programs and services was insufficient funding (64 percent).

Participants from all focus groups identified transportation as a major obstacle faced by many women...
in Chester County, especially single mothers and women working part-time and hourly wage jobs with inconsistent schedules. Similarly, transportation was identified by 51 percent of survey respondents as “difficult to access” in Chester County.

**Child Care**

Reliable child care support is essential for parents’ employment. Quality early care and education also promote children’s school readiness and have positive effects that last into adulthood (Yoshikawa et al. 2013) and are important for developing economically vibrant communities (Warner 2009). State policies on child care and early care and education differ regarding many aspects, including: access and affordability of provisions, the number of hours provided by public programs, the training and supports available to/required of providers and teachers, after school and school vacation care, subsidies for low-income parents and guidance provided to parents choosing providers (see for example Barnett et al. 2013; Child Care Aware of America 2013 and 2014a; Minton and Durham 2013; QRIS Compendium 2015; Schmit and Reeves 2015; Schulman and Blank 2013). The child care component of the Work & Family Composite Index focuses on just three indicators: the costs of full-time center care for an infant as a proportion of the median annual earnings for women in the state, a measure chosen to illustrate the potential barriers created by the costs of care for families considering having children generally and particularly for mothers of young children who want to return to work; the share of four-year-olds who are in publicly funded pre-K, Headstart and special education; and policies in place to ensure quality of pre-K care (each is discussed in greater detail below). States and localities vary widely across these indicators. Families in the Northeast and the South tend to have better access to quality, affordable care than families in the Mountain States and the West, but no state provides adequate child care supports to a majority of children under five.

*The Costs of Early Care*

The cost of child care can present a formidable burden to families with young children. Between 1985 and 2011, the weekly out-of-pocket expenditure on child care for families with an employed mother almost doubled in real terms (U.S. Census Bureau, 2013). Only a small minority of young children—16 percent of infants and 25.5 percent of toddlers of employed mothers, and fewer than five percent of toddlers and infants of mothers who are not employed—are in center care (Laughlin, 2013). Families with children who have income below the poverty line spent 30 percent of their income on child care in 2011, more than three times the proportion families with above-poverty income spent (U.S. Census Bureau, 2013; Smith and Adams, 2013). The majority of all parents rely on care by relatives (including older siblings and grandparents), and more than one in four working mothers reports multiple child care arrangements (Laughlin 2013). Reliable and affordable child care is an important factor in enabling mothers in low-wage jobs to maintain employment and advance at work (Lee, 2007).

Focus group participants consistently identified access to child care as a central issue of concern for women in Chester County; 57 percent of respondents to the Nonprofit and Provider Snapshot survey identified child care as difficult to access. One service provider observed that she has seen a dramatic rise in the number of single mothers forced to apply for benefits such as Supplemental Nutrition Assistance Program (SNAP) to offset the costs of child care. Other focus group participants noted that the costs of child care are high even for families with two working parents.

As Child Care Aware of America (2014a) has documented, in the majority of states and the District of Columbia, the annual costs of center care for an infant are higher than the costs of attending a year of college at a public university, and in 22 states, including Pennsylvania, and the District of Columbia,
the costs of center care for an infant exceed 40 percent of the median annual income of single mothers.

Recent legislation in Pennsylvania, however, encourages low-income families in the state to earn their way out of poverty through educational supports and breaks down the current so-called “benefits cliff” for child care assistance programs (Murt and Bloom, 2016). House Bills 1164 and 934 reform two separate programs, which were serving as disincentives to economic growth and self-reliance. In the past, families who earned more money eventually reached a point where even a slight increase in their income made them ineligible for child care subsidies worth substantially more than the potential raise. This discouraged many families from accepting pay increases or working additional hours (Murt and Bloom, 2016). The recently approved legislation addresses this issue by increasing co-payments as parents earn more income. Under the new law, when parents reach the current benefits cliff, they would not be cut off from services. Instead, as they earn more money, their responsibility for the cost of services would increase until their income can support it entirely (Murt and Bloom, 2016).

This relative measure of the costs of child care does not capture the quality of center care; indeed, lower relative costs of center care may simply reflect lower quality, such as high ratios of children to staff, larger group sizes and lack of requirements for teacher certification. Lower cost may also indicate the absence of a market for higher-quality (higher-cost) infant care because of lower median earnings or, where costs are high, may be the sign of a market for high-quality, high-cost child care in response to higher numbers of well-paid women (Child Care Aware of America, 2014a). By its nature, quality child care is labor intensive, with limited scope for labor saving technologies or other cost saving innovations; without significant public funding, quality child care will remain out of reach for the majority of families (Blau, 2001).

**Child Care Subsidies**

Child care subsidies help mothers and fathers access better quality child care, improve performance and advancement at work, and reduce child care-related work interruptions (Forry and Hofferth, 2011; Tekin, 2005; Wagner, 2010). Nationally, in 2011 fewer than 4 percent of all infants and toddlers received any child care subsidies, and even among low-income families, only 11.8 percent of children under five received any financial supports for child care from government sources (Laughlin, 2013). Federal funding for child care is provided to states through the Child Care Development Block Grant (CCDBG). States are permitted to use funds from the CCDBG to provide subsidies to eligible families with incomes below 85 percent of state median income, and states have considerable flexibility in how the subsidy system is designed and how families are treated when earnings rise above the income eligibility levels (Minton and Durham, 2013). Whether parents receive child care assistance depends on a host of factors and policy decisions that differ from state to state, such as income eligibility limits, work requirements, waiting lists for child care assistance, copayments required of parents receiving child care assistance, reimbursement rates for child care providers serving families receiving child care assistance and eligibility for child care assistance for parents searching for a job (Schulman and Blank, 2013).
In 2012—the most recently published national data—only 17 percent of potentially eligible children under the federal CCDBG parameters received any child care subsidy (ASPE, 2015). Figure 10 shows the proportion of eligible children who received subsidies for different age groups; even the lowest-income households (with incomes of less than 100 percent of poverty) were often left to their own devices, with only 25 percent of eligible infants and 56-62 percent of eligible toddlers, having received any subsidies (Figure 10).

Within the federal eligibility parameters of CCDF, states have flexibility in setting income eligibility guidelines, parental co-payment fees, reimbursement rates to child care providers, target populations receiving priority for services, the number of work or education/training hours required and the length of certification periods. State income eligibility parameters are generally higher than those established by the federal government. Expressed in terms of state median income, state limits for initial income eligibility in CCDF plans for fiscal year 2012 ranged from 35 percent to 80 percent of state median income. An estimated 14.3 million children were federally-eligible for child care assistance in an average month in 2012. Under state-defined eligibility rules, however, the estimated number of children eligible for child care assistance in an average month in 2012 was reduced to 8.4 million (ASPE, 2015).

In Pennsylvania, approximately 481,690 children were potentially eligible under federal parameters (i.e., family incomes less than 85 percent of state median income) in 2012. To be eligible under Pennsylvania’s state plan, however, a family of three has to have income below 74 percent of the state median income. Thus, in 2012 the number of Pennsylvania children eligible for child care subsidies was 242,390, or only 50 percent of those eligible according to federal requirements (ASPE, 2014).

CCDBG rules require most families to pay part of the child care costs, but the share of families required to make a co-payment varies widely between states (from fewer than 15 percent of families in Arkansas and Nebraska to 90 percent or more of families in Connecticut, Illinois, New Hampshire, Ohio and Utah). In Pennsylvania, approximately 84 percent of families are required to make a co-payment (U.S. Department of Health and Human Services, 2014a). The level of co-pay also varies widely, from an average of 3 percent of family income in the District of Columbia, Michigan and
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Minnesota to 26 percent in Mississippi. In Pennsylvania, families are required to pay an average of seven percent of their income for child care costs (U.S. Department of Health and Human Services, 2014b).

The Nonprofit and Provider Snapshot survey did not ask specifically about the percentage of child care costs covered by service beneficiaries, but child care services were identified by 57 percent of responding organizations and agencies as difficult to access. When asked to gauge the degree of difficulty in accessing certain services, more organizations and agencies rated child care as “very difficult” than “difficult” or “somewhat difficult.” Participants across focus groups also identified finding and paying for quality child care as a critical issue faced by women in Chester County. Elected officials and service providers, in particular, reported a sharp and increasing demand for subsidized child care across the region and state. These individuals underscored recent reductions in public child care subsidies and called attention to related negative impacts on women and families. Like discussions around other needs areas in Chester County, focus group participants discussed how the lack of reliable public and private transportation greatly amplifies the challenges related to accessing affordable child care.

The Coverage and Quality of Pre-Kindergarten Education

The benefits of preschool education for children’s cognitive and social development are well established (see Yoshikawa et al., 2013 for a review of evidence). Expansions of publicly funded early care and education also improve mothers’ labor force participation and wage progression (Cascio, 2006; Gelbach, 2002) and have economic and job-creation benefits as a local economic development strategy (Warner, 2009).

Nationally, in the 2013/2014 school year, 40.1 percent of four-year-olds were enrolled in publicly funded pre-K, Head Start or special education programs (27.9 percent were in pre-K, and 12.2 percent were in Head Start or special education (Barnett et al., 2015). The national proportion of 4-year-old children who are in publicly funded programs has increased substantially since 2001/2002, when it was only 31.2 percent (Barnett et al., 2003). The level of enrollment varies dramatically across the states. Enrollment rates vary from only 12 percent in New Hampshire to 100 percent in the District of Columbia. In the District of Columbia, pre-K is offered on the same schedule as school for older children (1,068 contact hours per child during the school year) (Barnett et al., 2015).

There were 296,957 children ages 3 and 4 in Pennsylvania during the 2012-2013 academic school year. Of those children, 180,470 (61 percent) lived in families below 300 percent poverty. Sixty-nine percent of children did not have access to high-quality pre-K; 19 percent of Pennsylvania children had access to publicly funded, high-quality pre-K; and, only 12 percent had access to privately funded, high-quality pre-K (Figure 11). There were 13,163 children ages 3 and 4 living in Chester County in 2015. Forty percent (5,221) of those children lived in families below 300 percent poverty ($72,750 for a family of four). Of children living 300 percent below poverty, 4,320 children in Chester County did not have access to publicly funded, high quality pre-K in 2015 (Pre-K for PA, 2015).

Figure 11. Access to High-Quality Pre-K, Children Aged 3-4, Pennsylvania, 2012-2013

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Head Start is a means tested program intended to provide comprehensive early education and support services to low-income 3- and 4-year-old children and their families; in 2013 only 42 percent of eligible children received services (Walker, 2014).
In 2014, a coalition of organizations, including the Chester County Fund for Women and Girls, launched the bi-partisan, statewide pre-K for PA campaign (Pre-K for PA, 2016). This initiative advocates for high quality pre-K for all 3- and 4-year-olds in Pennsylvania regardless of socioeconomic status. Led by the Pittsburgh Association for the Education of Young Children, other partners include the Delaware Valley Association for the Education of Young Children, Economy League of Greater Philadelphia, Public Citizens for Children and Youth, the United Way of Greater Philadelphia and Southern New Jersey, Fight Crime, Invest in Kids, Mission: Readiness, Pennsylvania Association for the Education of Young Children, Pennsylvania Head Start Association and Pennsylvania Partnerships for Children.

Pre-K for PA campaign engaged in research to model the impact of a significant expansion of Pennsylvania’s high-quality pre-K system and its potential impact on the economy of the state and its major economic regions. The report documents that investments in early learning provide a significant, immediate economic boost for local businesses and help build stronger communities over the long term (ReadyNation, 2015). Researchers found that a $340 million investment in pre-K would generate $609 million in new spending in Southeastern Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia). This spending would be spread over several major sectors, including $61 million in services, $46 million in real estate and construction, $49 million in insurance and finance, and $35 million in retail and wholesale trade (ReadyNation, 2015).

The Gap in Mothers’ and Fathers’ Labor Force Participation
During the past four decades, the labor force participation rate for mothers of children under 6 has more than doubled, from just under a third (32.1 percent) in 1970 to just over two-thirds (67.1 percent) in 2013 (IWPR, 2015). During the same period, the labor force participation rate of fathers hardly changed at all, falling from 97.9 percent in 1970 to 94.4 percent in 2013. Trends in the allocation of time between paid work, child care and housework between 1975 and 2011 show that both mothers and fathers of young children now spend more time on these three activities combined than they did 40 years ago (Pew Research Center, 2015). While mothers spend more time in paid work and fathers more time on housework and child care; overall, mothers still do the large majority of family work and fathers still do the majority of paid work (Figure 11).
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Figure 12. Time Spent on Paid Work, Housework, and Child Care, Mothers and Father, 1975 and 2011

![Bar chart showing time spent on various activities by mothers and fathers in 1975 and 2011.]

Note: Resident parents of children under 18.
Source: Compilation of data from Pew Research Center, 2015.

There are substantial differences in the likelihood that mothers of young children are in the workforce among women of the largest racial and ethnic groups. The labor force participation rates of black mothers of young children are substantially higher than among comparable mothers of any other racial/ethnic background. Seventy-nine percent of black mothers of children under the age of six are in the workforce, more than 10 percentage points higher than the rate for all women (67.1 percent; Figure 13). Hispanic and Asian/Pacific Islander women have the lowest rates (59.2 and 60.0 percent, respectively). Fathers are more likely to be in the workforce than mothers among all of the major racial and ethnic groups, and there is less variation among groups. Asian/Pacific Islanders and White men have the highest rates (95.1 and 95.0 percent, respectively), and Native American fathers have the lowest rate (84 percent). The gap in parents’ labor force participation rates is smallest for blacks and largest for Asian/Pacific Islanders and Hispanics (Figure 13).

Figure 13. The Labor Force Participation Rate of Parents of Children Under Six by Gender and Race/Ethnicity, United States, 2013

![Bar chart showing labor force participation rates for parents of children under six by gender and race/ethnicity.]


Mothers of children under six are less likely than fathers to be in the labor force in all states (67.1 percent compared to 94.4 percent), but the rates of mothers’ labor force participation vary considerably across the states (IWPR, 2015). Only 53 percent of mothers in Utah are in the
workforce, compared with 80 percent of mothers in South Dakota. There is a much smaller range for fathers’ participation rates, ranging from 89 percent in Maine to 98 percent in Wyoming (IWPR, 2015). In Pennsylvania 70.5 percent of mothers and 94 percent of fathers are in the workforce. Table 22 shows the gender gap in parents’ labor force participation rates in the United States, Pennsylvania, and Chester County in 2013.

Table 22. Gender Gap in Parents’ Labor Force Participation Rates, United States, Pennsylvania and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Mothers’ Labor Force Participation Rate</th>
<th>Father’s Labor Force Participation Rate</th>
<th>Difference in Labor Force Participation rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>67.1%</td>
<td>94.4%</td>
<td>+28.2</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>70.5%</td>
<td>94.0%</td>
<td>+23.5</td>
</tr>
<tr>
<td>Chester County</td>
<td>72.1%</td>
<td>94.9%</td>
<td>+22.8</td>
</tr>
</tbody>
</table>

Notes: Difference in labor force participation rates equals fathers’ labor force participation rate minus mothers’ labor force participation rate. For women and men with a child under six in the household related by birth, marriage, or adoption. Source: IWPR, 2015; Analysis of 2013 American Community Survey microdata (Integrated Public Use Microdata Series, Version 5.0).

Conclusion

Given the high costs of quality child care, it is perhaps not surprising that many families reduce their time in the workforce when children are young, particularly when they have more than one child. In dual-earner families, women’s lower earnings provide an economic rationale for the (lower-earning) mother rather than the (higher-earning) father to be the one to leave paid work and focus on family care. Having sustained time out of employment, however, reduces women’s earnings progression and over a lifetime, this interruption can cost women dearly through lower earnings, fewer advancement opportunities and reduced pension and retirement assets (Rose and Hartmann, 2004).

Compared to many other states, Pennsylvania residents have greater access to paid leave as a result of state laws and voluntary employer benefits. Women workers in Chester County, however, are far less likely to have access to paid sick time than men. Hispanic women are less likely than any other racial or ethnic population to receive paid sick time. Compared to other states and localities, Pennsylvania and Chester County provide relatively few long-term care services and supports for individuals caring for elder and dependent family members. Additionally, the percentage of households with children in Chester County is higher than the both the national and state percentages. While the percentage of married couple households is also higher than the national and state percentages, the number of female-headed households is more than twice the number of male-headed households. The most commonly cited reason for women working part time instead of full time is family and caregiving responsibilities. It is not surprising then, that women in Chester County are almost twice as likely as men to work part time, and slightly more likely than women statewide and across the United States.
Emerging Issues and Advocacy Opportunities

Pregnancy at Work

The number of women who work during their pregnancies has increased sharply during the past decades (Laughlin, 2011). Pregnancy-related employment discrimination has increased, too. Between 1992 and 2007, charges of pregnancy discrimination filed with the U.S. Equal Employment Opportunity Commission increased by 65 percent (National Partnership for Women and Families, 2008) and have increased further since then (U.S. EEOC, 2015). The National Partnership study found a particularly sharp rise in claims from women of color; the study also found that pregnancy claims had increased in the majority of states.

The Pregnancy Discrimination Act (PDA) of 1978 clarified that employment discrimination on the basis of pregnancy, childbirth or related medical conditions is sex discrimination under Title VII of the Civil Rights Act of 1964. The law: prohibits an employer from firing, or refusing to hire, a woman because of pregnancy as long as she is still able to perform the major functions of her job; prohibits an employer from treating an applicant or worker differently on the basis of pregnancy; mandates that an employer treat an employee temporarily unable to perform her job the same way as any other temporarily disabled employee; and requires that any health insurance provided by an employer cover expenses for pregnancy-related conditions, among other provisions (U.S. Department of Labor, 2015c). While the PDA protects women from pregnancy-related discrimination and from employers withholding benefits or accommodations to pregnant women that are received by other employees, it does not provide a general right to pregnancy accommodations (for example, a temporary shift to lighter duties). Such rights are universal in other high-income countries (ILO, 2014).

Since the Affordable Care Act was signed into law in 2010, new mothers returning to work have the right to reasonable time for pumping milk or breastfeeding, in a private space, and to facilities for storing breast milk (U.S. Department of Labor, 2015b). The new rule increased potential access to breastfeeding especially for low-wage mothers who are less likely to breastfeed than mothers with higher earnings (Drago, Hayes, and Yi, 2010). Breastfeeding has positive effects on infant and child health (Golen and Ramey, 2014; Horta and Victora, 2013; Victora et al., 2015).

State Laws to Expand Pregnancy Protection

- Protections against pregnancy discrimination: Forty-five states and the District of Columbia offer protections against pregnancy discrimination. The five states that do not offer such protections are Alabama, Indiana, Nevada, North Carolina and South Dakota (U.S. Department of Labor 2015c).

- Pregnancy accommodation: In 14 states—Alaska, California, Connecticut, Delaware, Hawaii, Illinois, Louisiana, Maryland, Minnesota, Nebraska, New Jersey, North Dakota, Texas, and West Virginia—and the District of Columbia, as well as in five cities in other states, employers, by law, must provide reasonable accommodations for pregnant workers. Examples include transfers to a less strenuous or hazardous position, tasks that do not involve heavy lifting, breaks to go to the bathroom and the option of sitting rather than standing (City of Pittsburgh, 2014; National Partnership for Women & Families, 2014c).

- Workplace breastfeeding rights: Nineteen states and the District of Columbia have passed laws providing workplace breastfeeding rights (such as break times and a private space for pumping breast milk): Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois,
An Update to the Blueprint Report: Leveraging Progress

Indiana, Louisiana, Maine, Minnesota, Montana, New Mexico, New York, Oregon, Rhode Island, Tennessee, Vermont, and Virginia (U.S. Department of Labor, 2015c).

- Pennsylvania Pregnant Workers Fairness Act (HB 1176) was introduced in the Pennsylvania House of Representatives before the House Labor and Industry Committee, where it is still pending. HB 1176 was intended to promote workplace fairness for pregnant workers by requiring employers to make reasonable accommodations for conditions related to pregnancy or childbirth, just as they do for limitations caused by other conditions (LegiScan, 2016).

- House Bill 1100, An Act Providing for the Workplace Accommodations for Nursing Mothers Act, was introduced in the 2015-2016 Pennsylvania regular legislative session and referred to the House Labor and Industry Committee, where it is still pending. The legislation reintroduced legislation offered last year, the former House Bill 1895, to require all employers in the commonwealth to provide a private, sanitary space for employees who need to express breast milk. This bill is part of the Pennsylvania Agenda for Women’s Health, a comprehensive proposal to address the real health issues affecting Pennsylvania women (Pennsylvania House of Representatives, 2015).

State Laws That Expand Family and Medical Leave Coverage

The Family and Medical Leave Act (FMLA) was implemented over two decades ago (1993) to provide employees the right to job-protected leave. The law met a growing need for legislated leave. With the erosion of employer-provided fringe benefits and weakened job security, employees are increasingly unable to take medical leave while struggling with a serious illness or temporary disability (Jorgenson and Appelbaum, 2014). Moreover, the demand for time off to care for a family member has increased as more women have joined the workforce. About 18 million employees take family and medical leave annually; nonetheless, unmet need for leave continues to be a concern to millions of employees who are not eligible for job protection or cannot afford to take leave (Jorgenson and Appelbaum, 2014).

- Expanding access for workers in smaller businesses: As of 2014, six states—Maine, Maryland, Minnesota, New Jersey, Oregon and Vermont—and the District of Columbia had expanded FMLA eligibility to workers of smaller businesses, ranging from those with at least 15 employees within 75 miles of the worksite in Maine, Maryland, and Vermont to 50 employees worldwide in New Jersey (Gault et al., 2014; National Partnership for Women & Families, 2014a).

- Expanding access for pregnant workers: As of 2014, nine states—California, Connecticut, Hawaii, Iowa, Louisiana, Massachusetts, Montana, New Hampshire, and Washington—had expanded FMLA eligibility to workers of smaller businesses in cases of pregnancy only, ranging from those with any number of employees in Hawaii and Montana to those with at least 25 employees in Louisiana (Gault et al., 2014; National Partnership for Women & Families, 2014a).


- Including same-sex partners and spouses in the definition of family: In 10 states—California, Colorado, Connecticut, Hawaii, Maine, New Jersey, Oregon, Vermont, Washington and Wisconsin—and the District of Columbia, same-sex partners or spouses were explicitly included in the definition of family (National Partnership for Women & Families 2014a).

- Broadening the definition of family: In five states—California, Minnesota, Oregon, Rhode Island and Washington—leave can be taken to care for a grandparent. In six states—California, New Jersey, Oregon, Rhode Island, Vermont and Washington—leave can be taken to care for a parent-in-law. In California and Maine, leave can be taken to care for a sibling (Gault et al. 2014).
POVERTY & OPPORTUNITY

Introduction
Access to quality education and training, health care services and business networks can help women to thrive in the workforce and achieve economic success. Even with access to these resources, however, many women struggle to achieve financial security and independence. Women are as likely as men to complete a college degree and are more likely than men to have health insurance, but they face higher poverty rates than men and are much less likely to own businesses (IWPR, 2015a; IWPR, 2015b).

This section of the Blueprint Report examines four topics that are integral to women’s economic security: access to health insurance coverage, educational attainment, business ownership and poverty. It considers how Pennsylvania and Chester County rate on these indicators, and examines the relationships among these indicators and their implications for women’s well-being. This section also examines trends in the data across time and disparities that exist among racial and ethnic groups in this area of women’s status.

Poverty & Opportunity in the United States, Pennsylvania and Chester County
The Institute for Women’s Policy Research (2015) developed the Poverty & Opportunity Composite Index, which combines four component indicators of women's economic security and access to opportunity: health insurance coverage, college education, business ownership and the poverty rate. At the state level, composite scores ranged from a high of 8.00 to a low of 6.18, with the higher scores reflecting a stronger performance in the area of poverty and opportunity and receiving a higher letter grade. Among all 50 states and the District of Columbia, the District of Columbia has the best score on the Poverty & Opportunity Composite Index (8.00) and received the highest letter grade (A-). This grade reflects both the district’s accomplishments—its well above average scores for the percentage of women with health insurance coverage, the percentage of women with a bachelor’s degree or higher, and the share of businesses that are women-owned—and its need for improvement in the area of women’s poverty (IWPR, 2015). Mississippi has the worst score on this index. It ranks last in the percentage of women above poverty, is among the bottom 10 in the percentage of women with health insurance coverage and with a bachelor’s degree or higher, and ranks 30th for women-owned businesses (IWPR, 2015).

Pennsylvania ranked in the middle third on the Poverty & Opportunity Index. The state’s composite index score is 7.07 and its overall rank is 21, with a letter grade of C (IWPR, 2015). Eighty-eight percent of women aged 18-64 reported having some health insurance in 2013. This component score is the ninth highest in the country. The percent of women in Pennsylvania living above the poverty line is also relatively high at 86.5 percent, which ranked 15th. Rankings related to educational attainment and business ownership, however, were significantly lower at 27th (28.6 percent) and 29th (27.0 percent), respectively. Interestingly, men in Pennsylvania fared slightly better on educational attainment and significantly better on business ownership, but slightly worse on health insurance coverage and individuals living above the poverty line. Table 23 shows the state’s overall rank and score for women on the index, as well as percentage data and rank for each individual component compared to comparable data for men in Pennsylvania.
Table 23. Comparison of Pennsylvania Men and Women on Poverty & Opportunity Index Component Rankings

<table>
<thead>
<tr>
<th></th>
<th>Composite Index</th>
<th>% of Residents 18-64 with Health Insurance 2013</th>
<th>% of Residents with a Bachelor’s Degree or Higher, 25 and Older, 2013</th>
<th>% of Businesses Owned, 2007</th>
<th>% Living Above Poverty, 18 and Older, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Rank</td>
<td>Grade</td>
<td>Percent</td>
<td>Rank</td>
</tr>
<tr>
<td>Women</td>
<td>7.07</td>
<td>21</td>
<td>C</td>
<td>88.0%</td>
<td>9</td>
</tr>
<tr>
<td>Men</td>
<td>83.7%</td>
<td>11</td>
<td>C</td>
<td>28.7%</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: IWPR, 2015 and American Community Survey microdata.

Trends in Poverty & Opportunity

Women’s status in the area of poverty and opportunity in the United States has improved on two indicators since the early 2000s and declined on two others. The share of women with a bachelor’s degree or higher increased 6.9 percentage points since the 2004 Status of Women in the States publication, from 22.8 to 29.7 percent, and the share of women-owned businesses increased from 26.0 to 28.8 percent. The percent of women living above poverty, however, declined from 87.9 in 2002 to 85.5 in 2013 (IWPR 2004; U.S. Department of Commerce 2014a). The percentage of women with health insurance in 2013 (81.5) was also slightly lower than in 2002 (82.3 percent), but the 2013 data do not reflect shifts in coverage following the passage of the Patient Protection and Affordable Care Act (ACA) of 2010.

Women’s status in the area of poverty and opportunity in Pennsylvania, however, has improved on all indicators and its overall composite index score. Table 24 compares the state’s composite index data from 2013 and 2002, demonstrating gains in all areas except the percentage of women aged 18-64 with health insurance, which remained constant. It should be noted that, while the percentage of women living above the poverty line in Pennsylvania decreased, the state’s ranking compared to all other states and the District of Columbia improved.

Table 24. Comparison of Pennsylvania’s Status on the Poverty & Opportunity Index, 2002 – 2013

<table>
<thead>
<tr>
<th></th>
<th>Composite Index</th>
<th>% of Women Residents 18-64 with Health Insurance</th>
<th>% of Women Residents with a Bachelor’s Degree or Higher, 25 and Older</th>
<th>% of Women Businesses Owned</th>
<th>% of Women Living Above Poverty, 18 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Rank</td>
<td>Grade</td>
<td>Percent</td>
<td>Rank</td>
</tr>
<tr>
<td>2013</td>
<td>7.07</td>
<td>21</td>
<td>C</td>
<td>88.0%</td>
<td>9</td>
</tr>
<tr>
<td>2002</td>
<td>6.99</td>
<td>26</td>
<td>C</td>
<td>88.3%</td>
<td>9</td>
</tr>
</tbody>
</table>


Similarly, women in Chester County have demonstrated gains in the same areas over the same time period. A comparison of the same indicators reveals commensurate gains in the percentage of women with a bachelor’s degree or higher and larger gains in the percent of women aged 18-64 with health insurance, the percent of women-owned businesses and the percent of women living above the poverty line (Table 25). The increase in the percentage of women living above the poverty line is Chester County is particularly significant. In 2002, the county was slightly lower than the state on this indicator, but had surpassed the state percentage as of 2013. Additionally, while the state experienced a slight loss on this indicator, Chester County experienced a small gain between 2002-2013.
Table 25. Comparison of Chester County’s Status on the Poverty & Opportunity Index Component Indicators, 2003 – 2013

<table>
<thead>
<tr>
<th></th>
<th>% of Women Residents 18-64 with Health Insurance</th>
<th>% of Women Residents with a Bachelor’s Degree or Higher, 25 and Older</th>
<th>% of Women Businesses Owned</th>
<th>% of Women Living Above Poverty, 18 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>90.2%</td>
<td>30.4%</td>
<td>28.3%</td>
<td>88.1%</td>
</tr>
<tr>
<td>2002</td>
<td>88.3%</td>
<td>22.3%</td>
<td>25.1%</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

Note: The IWPR 2005 and 2015 publications analyzed data from 2003 and 2013, respectively. Data for this table reflects county-level data from the same time period for comparison.


Access to Health Insurance

Health insurance gives women access to critical health services that can also contribute to well-being in other areas of their lives, such as their economic and employment status. In the United States, 81.5 percent of nonelderly women (aged 18–64) had health insurance coverage in 2013, a slightly higher proportion than men of the same age range (77.1 percent). According to 2013 American Community Survey microdata, 59.6 percent of nonelderly women were insured through a union or employer, either their own or their spouse’s. Medicare covered 3.8 percent of nonelderly women, and Medicaid and other means-tested programs covered 15.6 percent. Approximately 9.5 percent of women had health insurance purchased directly from an insurance company.

In 2013, Pennsylvania was ranked among the top 10 states for women aged 18-64 to have health insurance. The Patient Protection and Affordable Care Act (ACA) dramatically reduced rates of uninsurance among women aged 18 to 2, by allowing adult children to stay on their parents’ health insurance plans until the age of 26. Between 2008 and 2014, the percentage of women aged 18 to 24 without health insurance decreased by more than a third, from 24.9 to 15.9 percent. Uninsurance rates for women of all ages dropped nearly one-fifth between 2008 and 2014, from 13.0 percent of women lacking insurance in 2008, to 10.6 percent in the first nine months of 2014 (Martinez and Cohen, 2009; 2015). Complete data reflecting health insurance changes following the ACA, including state-by-state data, are not yet available.

The Patient Protection and Affordable Care Act

The landscape of women’s health insurance coverage is changing as a result of the passage of the Patient Protection and Affordable Care Act (ACA) of 2010. The ACA enacted measures designed to expand access to affordable health insurance coverage for women and men in the United States who lack coverage. It has led to state-based exchanges through which individuals can purchase coverage, with premium and cost-sharing benefits available to those with low incomes. It has also established separate exchanges through which small businesses can purchase health insurance coverage for their employees. Along with these changes, the Affordable Care Act requires U.S. citizens and legal residents to acquire insurance or pay a penalty, with some exemptions related to factors such as financial hardship and religious objections (Kaiser Family Foundation 2013a). As noted above, starting in 2010 the ACA allowed adult children to stay on their parents’ health insurance until the age of 26.
To help those who may have struggled in the past to afford insurance, the ACA seeks to expand Medicaid eligibility to all individuals under age 65 who are not eligible for Medicare and have incomes up to 138 percent of the federal poverty line. In Pennsylvania individuals were previously eligible only if they were pregnant, the parent of a dependent child, 65 years of age or older or disabled, in addition to meeting income requirements (National Conference of State Legislatures, 2011). States can, however, choose to opt out of this Medicaid expansion. As of March 2015, 28 states, including Pennsylvania, and the District of Columbia had chosen to expand Medicaid coverage.

New Comprehensive Coverage for Women’s Preventive Care

The ACA helps make prevention affordable and accessible for all Americans by requiring most health plans to cover and eliminate cost sharing for preventive services recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Bright Futures Guidelines recommended by the American Academy of Pediatrics (Shaw et al., 2014). The law also requires insurers to cover additional preventive health benefits for women (Sonfield and Pollack, 2013; Johnson, 2010).

In 2011, the U.S. Department of Health and Human Services (HHS) adopted new guidelines recommended by the Institute of Medicine (IOM) for women’s preventive services to fill the gaps in current preventive services guidelines for women’s health. The guidelines help ensure a comprehensive set of preventive services for women. IOM conducted a scientific review and provided recommendations on specific preventive measures that meet women’s unique health needs and help keep them healthy. HHS based its Guidelines for Women’s Preventive Services on the IOM report issued July 19, 2011 (Sonfield and Pollack, 2013). The eight additional women’s preventive services that are covered without cost-sharing requirements include: well-woman visits; gestational diabetes screening; HPV DNA testing; sexually transmitted infection counseling; HIV screening and counseling; contraception and contraceptive counseling; breastfeeding support, supplies and counseling; and, interpersonal and domestic violence screening and counseling (Sonfield and Pollack, 2013).

Health Insurance Coverage by Race and Ethnicity

Health insurance coverage rates vary by race and ethnicity. Among the largest racial and ethnic groups, White (86.8 percent) and Asian/Pacific Islander (82.8 percent) women had the highest rates of coverage in 2013. Hispanic and Native American women had the lowest rates at 64.0 and 67.7 percent, respectively. For all racial and ethnic groups, women had higher coverage rates than men. Figure 14 shows national health insurance coverage rates by race/ethnicity for men and women aged 18-64.

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11 Federal law allows for the expansion of Medicaid to individuals with incomes at or below 133 percent of the federal poverty line. The law also includes a five percent “income disregard,” which effectively makes the limit 138 percent of poverty (Center for Mississippi Health Policy 2012).
Figure 14. Health Insurance Coverage Rates by Gender and Race/Ethnicity, Aged 18-64, United States 2013

Note: Racial categories are non-Hispanic. Hispanics may be of any race or two or more races.
Source: IWPR, 2015; Analysis of American Community Survey microdata (IPUMS, Version 5.0).

Analysis of national, state and county American Community Survey microdata reveal that while women aged 18-64 in Chester County tend to have slightly higher rates of coverage, coverage by gender and race and ethnicity reflect state and national trends (Figure 15). Across racial and ethnic categories, women have higher rates of coverage than men. Hispanic and Native American women in Chester County have the lowest rates of health insurance coverage, while White and Asian/Pacific Islander women have the highest rates of coverage.

Figure 15. Health Insurance Coverage Rates by Gender and Race/Ethnicity, Aged 18-64, Chester County 2013

Note: Racial categories are non-Hispanic. Hispanics may be of any race or two or more races.
Source: IWPR, 2015; Analysis of American Community Survey microdata (IPUMS, Version 5.0).

Responses to the Nonprofit and Provider Snapshot Survey and focus group discussions support the Census data regarding the disparities in women’s health care coverage by race and ethnicity in Chester County. Of the organizations and agencies providing health care services, all reported language and cultural barriers as reasons why they were unable to provide services over the past year. Focus group participants shared how Hispanic women in Chester County often did not speak
enough English to complete the complicated health insurance enrollment forms. One service provider also pointed out that cultural competence is more complex than language alone. She explained that individuals helping immigrant women enroll in health insurance and other benefits need to have knowledge of the women’s social and cultural traditions in addition to being bi-lingual.

Education
Women in the United States have closed the gender gap in education over the past several decades, aided in part by the passage of Title IX of the 1972 Education Amendments, which prohibited discrimination in educational institutions (Rose, 2015). While men outnumbered women among those receiving bachelor’s degrees throughout the 1970s, women surpassed men in 1981 and have received more bachelor’s degrees every year since then. During the 2012–2013 academic year, women comprised 57 percent of the nation’s college students (Rose, 2015).

Educational attainment in the United States has improved substantially among men as well as among women in recent years, but women have made progress at a faster rate. In 1990, 23.3 percent of men aged 25 and older held at least a bachelor’s degree, while only 17.6 percent of women had such credentials (U.S. Department of Commerce, 1994). In 2000, 26.1 percent of men and 22.8 percent of women aged 25 and older had completed a bachelor’s degree or higher (Bauman and Graf, 2003). In 2013, women not only outnumbered men among those receiving bachelor’s degrees, but the share of women who held these degrees also slightly surpassed the share of men who had obtained them: 29.7 percent of women and 29.5 percent of men aged 25 and older held a bachelor’s degree or higher.

Pennsylvania ranked 27 out of 51 (all states and the District of Columbia) for the percentage of women aged 25 and older that had completed a bachelor’s degree. The proportion of women who had achieved at least this level of educational attainment is larger than the proportion of men in 29 states, including Pennsylvania.

Although more women are receiving high school diplomas and completing college than ever before (U.S. Department of Education, 2013; U.S. Department of Education, 2014), a significant proportion of women either do not finish high school or end their education with only a high school diploma. In 2013, 12.8 percent of women aged 25 and older in the United States had not completed high school, and 27.3 percent had a high school diploma or the equivalent as their highest level of educational attainment.

In the same year in Pennsylvania, a smaller percentage of women earned less than a high school diploma (10.5 percent), more women earned their high school diploma or equivalent (36.1 percent), and fewer women completed some college or earned at least a bachelor’s degree (24.8 percent and 28.6 percent, respectively). More women in Chester County earned a bachelor’s degree or higher (30.7%) than in either the state or country (Table 26). This may be attributable to the concentration of institutions of higher education in and around Chester County.

Table 26. Women’s Highest Level of Educational Attainment in the United States, Pennsylvania and Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>Less Than a High School Diploma</th>
<th>High School Diploma or Equivalent</th>
<th>Some College or an Associate’s Degree</th>
<th>Bachelor’s Degree or Higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>12.8%</td>
<td>27.3%</td>
<td>30.3%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>10.5%</td>
<td>36.1%</td>
<td>24.8%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Chester County</td>
<td>8.6%</td>
<td>34.4%</td>
<td>26.3%</td>
<td>30.7%</td>
</tr>
</tbody>
</table>
An Update to the Blueprint Report: Leveraging Progress

Focus group participants noted that, in general, educational opportunities for women and girls in Chester County had improved over the past several decades. Some observed that increased emphasis on leadership and independence in schools had led to enhanced economic opportunities for some girls. Most participants agreed, however, that such gender-oriented instruction was not equally emphasized across school districts.

Educational Attainment by Race and Ethnicity

The educational progress women have made has not been distributed equally across racial and ethnic groups (Figure 16). Nationally, Asian/Pacific Islander women are the most likely to hold a bachelor’s degree or higher (48.4 percent), followed by women who identify with another race or two or more races (32.6 percent) and White women (32.5 percent). Native American and Hispanic women are the least likely to hold at least a bachelor’s degree (15.5 percent and 15.3 percent, respectively). One in three Hispanic women (33.9 percent) have less than a high school diploma; the proportion of Hispanic women with this level of education is approximately twice as large as the proportion of Native American women, the group with the second largest share of women holding the lowest level of education. White women are the least likely to have less than a high school diploma.

Figure 16. Educational Attainment Among Women by Race and Ethnicity, Aged 25 and Older, United States, 2013

<table>
<thead>
<tr>
<th>Education Level</th>
<th>All Women</th>
<th>Asian/Pacific Islanders</th>
<th>Other Race or Two or More Races</th>
<th>White</th>
<th>Black</th>
<th>Native American</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than a High School Diploma</td>
<td>29.70%</td>
<td>27.30%</td>
<td>30.30%</td>
<td>29.70%</td>
<td>27.30%</td>
<td>27.30%</td>
<td>26.00%</td>
</tr>
<tr>
<td>High School Diploma or Equivalent</td>
<td>48.40%</td>
<td>16.50%</td>
<td>19.70%</td>
<td>48.40%</td>
<td>16.50%</td>
<td>16.50%</td>
<td>29.50%</td>
</tr>
<tr>
<td>Some College or Associate's Degree</td>
<td>35.80%</td>
<td>35.80%</td>
<td>35.80%</td>
<td>32.60%</td>
<td>35.40%</td>
<td>35.40%</td>
<td>32.50%</td>
</tr>
<tr>
<td>Bachelor's Degree or Higher</td>
<td>32.50%</td>
<td>32.05%</td>
<td>31.20%</td>
<td>32.50%</td>
<td>31.20%</td>
<td>31.20%</td>
<td>24.90%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Note: Racial categories are non-Hispanic. Hispanics may be of any race or two or more races.
Source: IWPR, 2015; Analysis of American Community Survey microdata (IPUMS, Version 5.0).

Figure 17 shows educational attainment for women aged 25 and older by race and ethnicity in Chester County, which are very similar to women across the United States. Asian/Pacific Islander women in Chester County are most likely to hold a bachelor’s degree or higher (44.3 percent), while Hispanic women are the least likely (22.5 percent). Compared to national statistics, women of all races and ethnicities in Chester County are more likely to hold at least a bachelor’s or associate degree, or to have completed some college. Additionally, fewer women in all racial and ethnic categories are dropping out before earning a high school diploma or equivalent.
Focus group participants generally agreed that, while educational opportunity had improved for women and girls overall in Chester County, the distribution of resources to schools across the county was not equitable. These discussions were consistent with broader discussions of the social and cultural gap that exists between those living in prosperity in Chester County and those living in poverty.

**Gender Differences in Fields of Study**

The fields of study that women choose in college have implications for their earnings once they graduate. In general, women tend to be concentrated in fields that lead to jobs with relatively low wages, such as social work and early childhood education, whereas men tend to be concentrated in fields that lead to higher paying jobs, such as the science, technology, engineering and mathematics fields (Carnevale, Strohl, and Melton, 2011). (See Figure 5. Women and Men in Science, Technology, Engineering, and Mathematics (STEM) Occupations, United States, Pennsylvania, and Chester County, 2013 and Table 16. Distribution of Women Across Broad Occupational Groups, United States, Pennsylvania, and Chester County, 2013.)

Analysis of the earnings of women and men with terminal bachelor’s degrees in different fields indicates that women make up less than half of the workers in all 10 fields with the highest median annual earnings for women. In some of these fields, they are a very small percentage of workers. For example, in electrical and mechanical engineering—which tied for fourth place among the top 10 majors with the highest earnings for women—women represent just seven percent of those with a terminal bachelor’s degree. By contrast, men comprise more than 90 percent of terminal bachelor’s degree holders in eight of the 10 majors with the highest earnings for men (Carnevale, Melton, and Strohl, 2011).\(^\text{12}\)

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\(^{12}\) These majors are petroleum engineering, pharmaceutical sciences and administration, chemical engineering, aerospace engineering, electrical engineering, engineering and industrial management, naval architecture and marine engineering, environmental engineering, metallurgical engineering and mechanical engineering.
Women who go into higher-paying fields generally earn less than their male counterparts. Carnevale, Strohl and Melton (2011) found that for nine out of the 10 majors with the highest earnings for women, the earnings of women who had bachelor’s degrees in these fields and worked full time, year-round were less than the earnings of similar men. Only women with bachelor’s degrees in information sciences earned more than their male counterparts.

**Women Business Owners and Self-Employment**

Like education, business ownership can bring women increased control over their working lives and create financial and social opportunities. Nationally, 28.8 percent of businesses are women-owned (IWPR 2015b); the large majority are owner-operated and have no other employees (88.3 percent), which is also true for men-owned businesses, although the share of men owned firms with no other employees is lower (U.S. Department of Commerce, 2010). Business ownership can encompass various arrangements, from owning a corporation, to consulting or providing child care in one’s home.

Between 1997 and 2007, the proportion and number of women-owned businesses in the United States increased from 26.0 percent, with 5.4 million businesses, to 28.8 percent, with 7.8 million businesses (U.S. Small Business Administration 2011). Many of these businesses are in industries that employ more women than men. For example, more than six in 10 (61 percent) health care and education firms are women-owned. In traditionally male-dominated industries, the shares of businesses owned by women are much smaller. Women own only 35 percent of businesses in professional, scientific, and technical services; 32 percent in finance, insurance and real estate; 25 percent in manufacturing; and 14 percent in transportation and warehousing (U.S. Department of Commerce, 2010).

Women-owned businesses are concentrated in industries where firms are usually smaller and have smaller sales/receipts than the industries in which men-owned businesses are concentrated. The average sales/receipts for women-owned businesses in the United States are about one-fourth of the average sales/receipts for men-owned businesses (U.S. Department of Commerce, 2010). Nationally, women-owned businesses account for only 11 percent of sales and 13 percent of employment of all privately-held businesses, which is a considerably smaller proportion than women’s share of the ownership of all privately-held businesses (U.S. Department of Commerce, 2010). As of 2007, women owned 27 percent of Pennsylvania businesses, situating the state in the middle third (29th) nationwide (IWPR, 2015)—a slight increase from 24.2 percent (35th) in 2004 (IWPR, 2004).

While the current number of women-owned business in Chester County is unknown, there are several organizations dedicated to encouraging the development of women-led businesses. Chester County Women (CCW) is an organization that supports women executives, professionals and business owners. CCW provides an informal atmosphere to promote strategies for women looking to make the most of their careers (Chester County Women, 2009). The Women’s Business Connection (WBC) focuses on organically connecting women in business and supporting charitable organizations in Chester County that support women’s interests (Women’s Business Connection, 2015).

The number and share of women-owned firms that are owned by women of color has increased dramatically in recent years. In 1997, women of color—who constitute approximately 35 percent of the female population aged 18 and older (IWPR, 2015)—owned 929,445 businesses in the United States, representing 17 percent of all women-owned firms. By 2014, this number had grown to an estimated 2,934,500, or 32 percent of women-owned firms (American Express Open, 2014). Firms

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13 These majors are pharmaceutical sciences and administration, information sciences, chemical engineering, computer science, electrical engineering, mechanical engineering, industrial and manufacturing engineering, computer engineering, business economics, and civil engineering.
owned by Black or African American women have experienced the most rapid growth; between 1997 and 2014, African American women-owned firms are estimated to have grown by 296 percent and their revenues to have increased by 265 percent, surpassing the growth among all women-owned firms—which are estimated to have increased in number by 68 percent and in revenues by 72 percent. Asian, Hispanic or Latin, and Native Hawaiian/Pacific Islander women-owned firms have also experienced more rapid growth in the number of firms and revenues than all women-owned firms. Among firms owned by non-minority women, growth in both the number of firms (37 percent) and revenues (58 percent) was slower than among all women-owned businesses.

Like women’s business ownership, women’s self-employment (a form of business ownership) has increased over the past several decades. In 1976, women made up just over a quarter of the self-employed workforce (26.8 percent); in 2013 they were 40.7 percent (U.S. Bureau of Labor Statistics, 2014). In 2013, 5.2 percent of employed women in nonagricultural industries were self-employed compared with 6.7 percent of similarly employed men (U.S. Bureau of Labor Statistics, 2014). Among both women and men, self-employed individuals are more likely to have college degrees than those who are not self-employed. They are also more likely to be married and older, which means they are less likely to have young children in their care (U.S. Department of Commerce, 2010).

Self-employed women work slightly more hours per week than women who are not self-employed (40.1 hours per week, on average, compared with 38.9 hours) (U.S. Department of Commerce, 2010). Despite working more hours, self-employed women have slightly lower average annual earnings than women who are not self-employed ($38,172 compared with $38,670). They also face a larger gender wage gap; the average annual earnings of women who are self-employed are 55 percent of the earnings of their male counterparts, compared with 70 percent among women and men who are not self-employed. When controlling for the average number of hours worked per week and the number of weeks worked in the year, the gender wage gap narrows for both women who are self-employed and those who are not self-employed, but self-employed women still face a lower gender earnings ratio (63 percent compared with 77 percent for women who are not self-employed) (U.S. Department of Commerce, 2010).

**Women’s Poverty and Economic Security**

Women's economic security is directly linked to their family income, which includes not only earnings from jobs and any other family members but also income from other sources, such as investments, retirement funds, Social Security and government benefits. Many women in the United States enjoy comfortable family incomes, but others struggle to make ends meet. Analysis of data from the Current Population Survey (U.S. Department of Commerce, 2014a) indicates that 14.5 percent of women aged 18 and older in 2013 had family incomes that placed them below the federal poverty line, compared with 11.0 percent of men.

Figure 18 shows the percentage of women and men, aged 18 and older, living above the poverty line in the United States, Pennsylvania and Chester County. While a higher percentage of women in Chester County are living above the poverty line than in the United States and Pennsylvania, they are still less likely than males in Chester County to be living above the poverty line.
Poverty by Race and Ethnicity

Poverty rates vary considerably among adult women from the largest racial and ethnic groups. Native American women have the highest poverty rate at 28.1 percent, followed by Black (25.7 percent) and Hispanic (24.0 percent) women. The national poverty rate for White women is the lowest among the groups shown in Figure 27 and is less than half the rate for Native American, Black and Hispanic women (11.7 percent). For each of the largest racial and ethnic groups, women’s poverty rate is higher than men’s; the difference is greatest between Hispanic women and men (Figure 27). Differences in educational levels correspond to the disparities in poverty rates among racial and ethnic groups; the groups with the lowest poverty rates also are more likely to have college degrees.

While women in Chester County are less likely to be living in poverty than women in the United States and Pennsylvania, the poverty rate for women is higher than men across all racial and ethnic categories (Table 27). Similar to national and state trends, the difference is greatest between Hispanic women and men.

Table 27. Percent Living Below the Federal Poverty Line, Aged 18 and Older, by Gender and Race/Ethnicity, United States, Pennsylvania and Chester County, 2013

<table>
<thead>
<tr>
<th>Percent Living Below Poverty, Aged 18 and Older</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>All</td>
<td>15.5%</td>
<td>11.9%</td>
<td>13.5%</td>
</tr>
<tr>
<td>White</td>
<td>11.7%</td>
<td>9.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>24.0%</td>
<td>17.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Black</td>
<td>25.7%</td>
<td>20.4%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13.0%</td>
<td>12.2%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Native American</td>
<td>28.1%</td>
<td>24.4%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Other Race or Two or More Races</td>
<td>19.7%</td>
<td>15.3%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>


Poverty by Household Type

In the United States, poverty rates vary considerably by household type. Households headed by single women with children under age 18 are more likely to be poor than those headed by single men.
or married couples with children. More than four in 10 households (43.1 percent) headed by single women with children live in poverty, compared with nearly one in four (23.6 percent) households headed by single men with children and fewer than one in 10 (8.5 percent) married couples with children. Married couples without children have the lowest poverty rate (4.0 percent; Figure 19).

**Figure 19. Percent of Households with Income Below Poverty by Household Type, United States, Pennsylvania, and Chester County, 2013**

![Figure 19](image)

Notes: Households with children are those with children under age 18. Households headed by women and men can consist of unmarried women and men living with relatives, other unrelated individuals, or alone.

In Chester County, more single women, with and without children (44.4 percent and 21.5 percent, respectively), live below the poverty line compared to state and national statistics. Fewer single men, with and without children (20.8 percent and 15.3 percent, respectively), in Chester County, however, are living in poverty. As previously mentioned, respondents to the Nonprofit and Service Provider Snapshot Survey indicate that services such as child care, housing and transportation are generally considered difficult for women to access. These challenges are compounded for single women with children, especially those in Chester County. As an alternative to the Federal Poverty Level, the Self-Sufficiency Standard was created to better assess the true cost of the minimum income required needed to sustain individuals and their families. The standard takes into consideration many more of the major expenditures (housing, child care, food, health care, transportation, etc.) needed to maintain a standard of living, whereas the Federal Poverty Level only accounts for food and estimates those expenditures as one-third of the cost needed to sustain an individual or their family.

In Chester County, the annual self-sufficiency standard for one adult and one preschooler is $51,853, or 356 percent of the Federal Poverty Level (Pearce, 2010). This ranks Chester County as having the highest self-sufficiency standard of all counties in the state. Given that housing comprises the largest single expenditure category within the standard, it is clear that the high cost of housing in Chester County increases the amount of income needed to sustain individual and familial basic needs. In fact, when compared to the U.S. average (including mortgage payments, apartment rents and property tax), Chester County is 72 percent higher (Sperling 2015).

Fewer married couples in Chester County, with and without children (7.2 percent and 3.4 percent, respectively), are living in poverty compared to married couples across the United States and Pennsylvania. Like state and national trends, though, married couples in Chester County tend to experience poverty less than non-married individuals, and women and men with children in Chester...
County experience poverty at higher levels than those without children.

Multiple factors contribute to women’s higher poverty rate compared with men’s, particularly among single parents with children. Perhaps the most important is lower earnings, due in part to occupational segregation and the gender wage gap. Research indicates that closing the wage gap would significantly reduce poverty: if all working women aged 18 and older were paid the same as comparable men—men who are of the same age, have the same level of education, work the same number of hours, and have the same urban/rural status—the poverty rate for all working women would be cut in half, from 8.1 percent to 3.9 percent. The poverty rate for working single mothers would fall from 28.7 percent to 15.0 percent (Hartmann, Hayes, and Clark, 2014). Other factors contributing to women’s poverty include unemployment, lack of work-family supports (Hess and Román forthcoming), the challenges of accessing public benefits (Waters Boots, 2010) and low benefit levels in many states (Huber, Kassabian, and Cohen, 2014).

**Poverty and the Social Safety Net**

Public programs such as Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP, formerly called food stamps), Medicaid and the Earned Income Tax Credit (a federal tax credit aimed at offsetting federal income taxes for low-income working families and individuals) lessen the financial hardship many families face. Such programs, however, often fail to reach women and families who could benefit from their assistance. Nationally, more than one in three nonelderly women in poverty (35.4 percent) lacked health insurance coverage in 2013 (IWPR, 2015), and in 2012/2013 only 26 percent of families in poverty received TANF benefits (Center on Budget and Policy Priorities, 2014). Limited access to these programs stems partly from complicated application and eligibility determination processes, lack of transportation and information about programs and how to enroll in them, and inconvenient appointment times to complete the application process (Waters Boots, 2010). In addition, even those who receive benefits may still experience economic hardship because benefit levels for these programs are often quite low (Huber, Kassabian, and Cohen, 2014).

Participants from all focus groups highlighted the hardships experienced by women in Chester County as a result of reduction in funding for various public benefits. In addition, there was much discussion regarding how many women are coping with challenges across the areas of concern. Struggles with financing child care, finding safe and affordable housing, providing regular and nutritional sustenance for multiple children are complicated and interrelated.

**Conclusion**

Increasing women’s access to resources that foster their economic independence and success is integral to the overall well-being of women, families and communities. Women have made great gains in education in recent years and are a driving force behind the nation’s growth in businesses and the revenues they generate; yet, many women lack economic security and do not have the opportunity to pursue the education and training that might put them on a path to increased financial stability. In addition, women continue to face significant racial and ethnic disparities, and access to public benefits that serve as an important source of support is often limited. Women’s access to the resources that enable economic independence varies across states; pinpointing these differences and increasing supports that help women to thrive in the workforce and beyond is essential to elevating women’s status.
Women in Chester County have demonstrated gains in several indicators of poverty and opportunity in the past decade, including the percentage of women with health insurance, the percentage of women with bachelor's degrees, the percentage of women business owners and the percentage of women living above the poverty line. In general, women aged 18-64 in Chester County have slightly higher rates of insurance coverage compared to women in Pennsylvania and the United States. Hispanic, Native American and Black women in Chester County, however, have lower rates of coverage than White, Asian/Pacific Islander and women of two or more races. More women in Chester County earned a bachelor’s degree or higher than in either the state or country. Asian/Pacific Islander women in Chester County are most likely to hold a bachelor’s degree or higher, while Hispanic women are the least likely. Compared to national statistics, women of all races and ethnicities in Chester County are more likely to hold at least a bachelor’s or associate degree, or to have completed some college. Additionally, fewer women in all racial and ethnic categories are dropping out before earning a high school diploma or equivalent.

Women in Chester County are less likely to be living in poverty than women in the United States and Pennsylvania; the poverty rate for women is higher than men across all racial and ethnic categories. Similar to national and state trends, the difference is greatest between Hispanic women and men. While a higher percentage of women in Chester County are living above the poverty line than in the United States and Pennsylvania, they are still less likely than males in Chester County to be living above the poverty line. Like state and national trends, married couples in Chester County tend to experience poverty less than non-married individuals. Additionally, women and men with children in Chester County experience poverty at higher levels than those without children.
Emerging Issues and Advocacy Opportunities

Poverty and Opportunity Among Millennial Women

Millennial women—defined here as those aged 16–34 in 2013—are a well-educated cohort who nonetheless face the challenges of managing student debt and relatively high rates of poverty.

- More than one in five millennial women (22.4 percent) lives below the poverty line, compared with one in six (16.8 percent) millennial men. Millennial women’s poverty rate is higher than the rate for adult women overall. Millennial women are of childbearing age and supporting children on their own contributes to their high poverty rate.

- Millennial women aged 25–34 are considerably more likely than millennial men of the same age range to have a bachelor’s degree or higher (36.3 percent compared with 28.3 percent). This difference between millennial women’s and men’s education is much larger than the difference between women and men overall (29.7 percent of women and 29.5 percent of men overall have a bachelor’s degree or higher).

- Many millennial women and men have substantial student debt. One study analyzing college affordability found that average undergraduate debt one year after graduation for students who have debt is higher for women than for men, among both those who have children and those who do not. For women with children, average debt is $29,452 compared with $26,181 for men with children; for women and men without children, average debt is $25,638 and $24,508, respectively (Gault, Reichlin, and Román, 2014).

- Millennial women had higher rates of health insurance coverage than millennial men in 2013 (79.2 percent compared with 72.8 percent), but lower rates of coverage than all nonelderly women and men. Coverage rates also varied among younger and older millennials: in the United States overall, women aged 16–25, who under the ACA are allowed to stay on their parents’ health insurance plan (U.S. Department of Labor, undated) were more likely to have coverage than those aged 26–34 (80.6 compared with 77.5 percent).

- Rates of uninsurance among millennial women under age 25 decreased dramatically following implementation of the ACA. The percentage of women aged 18 to 24 without health insurance decreased by more than a third, from 24.9 percent to 15.9 percent (Martinez and Cohen 2009; 2015).

The Official and Supplemental Poverty Measures

While poverty remains a serious problem for many women in the United States, the poverty rate alone does not fully capture the extent of the hardship that women face. Established by the federal government in the 1960s, the federal poverty threshold has been adjusted for inflation but not for increases in widely accepted living standards; therefore, it does not accurately measure the resources needed to avoid economic hardship (Fremstad 2010). A family is considered poor if its pre-tax cash income falls below the poverty threshold; as an example, the 2014 poverty threshold for a family of four with two children was $24,008 (U.S. Department of Commerce, 2015)—an amount that is not sufficient to make ends meet, let alone to build assets to ensure long-term economic security. Given the inadequacy of the official poverty measure, the proportion of women and men who face economic hardship is likely much higher than the proportion living below the federal poverty threshold.
The Census Bureau recently developed a Supplemental Poverty Measure (SPM), which is based in large part on recommendations made by a National Academy of Sciences panel in the mid-1990s. This measure takes into account the value of the Earned Income Tax Credit (EITC), Supplemental Nutrition Assistance Program (SNAP) and certain other forms of nutrition assistance, and means-tested rental housing assistance, which are not counted as income under the current official measure. The SPM also makes some modest changes to the poverty thresholds, including establishing different thresholds by housing status: for households with two adults and two children in 2013, the SPM poverty threshold for renters ($25,144) and for homeowners with mortgage payments ($25,639) was higher than the official poverty threshold that year ($23,624), but the SPM poverty threshold for homeowners without a mortgage ($21,397) was lower (Short, 2014). The SPM subtracts payroll and other taxes from income, as well as out-of-pocket expenditures on child care and health care, but it does not take into account unmet health care and child care needs (Fremstad, 2010).

Under the SPM, poverty rates for women and men are slightly higher overall than under the official measure (about one-third of a percentage point for women and 1.6 percentage points for men) (IWPR, 2012; Short, 2014). The rate for female householder units remains high (nearly 29 percent) but does not change significantly; and the poverty rate for children declines; and elderly poverty rates increase (Short, 2014). Poverty researchers have generally shown strong support for the SPM, although concerns have been raised about the extent to which it adequately accounts for health care and child care needs (Fremstad, 2010).

Poverty, Opportunity, and Economic Security Among Women Living with Same-Sex Partners

Lesbian, gay, bisexual, and transgender (LGBT) Americans have gained strong momentum in securing greater rights and societal acceptance in recent decades. As of February 2015, 37 states and the District of Columbia had authorized same-sex marriage (Human Rights Campaign, 2015); President Barack Obama had issued an executive order prohibiting discrimination based on sexual orientation and gender identity among federal contractors (The White House, 2014); the Justice Department had expanded the interpretation of the Civil Rights Act of 1964 to protect against discrimination of transgender government employees (U.S. Department of Justice, 2014); and the U.S. Equal Employment Opportunity Commission had chosen to interpret “sex discrimination” in Title VII to include discrimination based on sex or gender identity and begun accepting charges on those bases (U.S. Equal Opportunity Employment Commission, undated). Same-sex marriage has been legally recognized in Pennsylvania since May 20, 2014, when a U.S. federal district court judge ruled that the Commonwealth’s 1996 statutory ban on recognizing same-sex marriage was unconstitutional (Botelho, 2014). In 2013, the Supreme Court struck down parts of the Defense of Marriage Act (DOMA), clearing the way for same-sex spouses in states that recognize same-sex marriage to file joint tax returns, receive service member spousal benefits, sponsor a partner for U.S. residency and qualify for the Family and Medical Leave Act (FMLA), among other benefits (Human Rights Campaign, 2014).

- One study that analyzed four surveys—the National Survey of Family Growth (NSFG), General Social Survey (GSS), National Health Interview Survey (NHIS) and Gallup Daily Tracking Survey—found that across the surveys the proportion of adults in the United States who identify as LGBT ranged from 2.2 percent (in the NHIS) to 4.0 percent (in the Gallup data; Gates 2014a). Analysis of the Gallup data indicates that among those aged 18 and older, 4.1 percent of women and 3.9 percent of men identify as LGBT, with adults in the West (4.6 percent) and East (4.3 percent) more likely to identify as LGBT than those in the South (4.0 percent) and Midwest (3.8 percent) (Gates, 2014a).
The same study shows that across the four surveys, younger adults are more likely to identify as LGBT than older adults (in the Gallup data, 7.2 percent of adults aged 18–29 compared with 2.1 percent of those aged 60 and older) (Gates 2014a).

Among adults aged 18 and older, a higher percentage of Hispanics (5.7 percent) and Blacks (5.6 percent) identify as LGBT than Asians (4.4 percent) and Whites (3.6 percent) (Gates, 2014a). Those who identify with another race or as multiracial are the most likely to identify as LGBT (6.5 percent).

The median annual earnings for women who live with a same-sex partner ($48,000) are considerably lower than those of men who live with a same-sex partner ($58,000) and lower than married men in different-sex households ($56,000), but higher than earnings for married women in different-sex households ($42,000) and women who live in a cohabiting relationship with a different sex partner ($33,000). Women living with a same-sex partner also have higher earnings than men cohabiting with a different-sex partner ($38,000).

Women aged 16 and older who live with a same-sex partner are much more likely to participate in the labor force than women of the same age range who are married to men (74.8 percent compared with 60.0 percent). Women who live with a same-sex partner, however, are less likely to be in the workforce than unmarried women who live with a male partner (76.4 percent).

Women who live with a same-sex partner are considerably more likely to hold a bachelor’s or advanced degree (43.7 percent) than married women in different-sex households (34.9 percent) and women who live with a different-sex partner (25.0 percent). Men who live with a same-sex partner are the most likely to hold at least a bachelor’s degree (48.5 percent).

Women who live with a same-sex partner are more likely to live in poverty than women married to men (7.4 percent compared with 6.2 percent) and men living with a same-sex partner (3.5 percent). Single women and women who live with (but are not married to) a different-sex partner have much higher poverty rates at 24.5 and 14.3 percent, respectively.

Same-sex couples are 1.7 times more likely than different-sex couples to receive food stamps; women, bisexuals and people of color within the LGBT community among the most likely to be recipients (Gates ,2014b). About one-third (34 percent) of LGBT women did not have enough money for food in a one-year period between 2011 and 2012, compared with 20 percent of non-LGBT women and 24 percent of LGBT men. During this time, 37 percent of Black LGBT adults and 55 percent of Native Americans LGBT adults experienced food insecurity, compared with 23 percent of White LGBT adults (Gates, 2014b).

Rates of economic insecurity and discrimination within the transgender community are especially high. One study analyzing the National Transgender Discrimination Survey found that transgender adults were nearly four times more likely than adults in the general population to have a household income below $10,000 and twice as likely to be unemployed. In addition, almost one in five (19 percent) had experienced homelessness. Ninety percent of survey respondents reported having experienced harassment or mistreatment in the workplace, and 47 percent said they have experienced an adverse job outcome, such as being fired, not hired or denied a promotion (Grant, Mottet, and Tanis, 2011).
An Update to the Blueprint Report: Leveraging Progress

- The percentage of LGBT Americans lacking health insurance coverage has decreased substantially since the Affordable Care Act’s provisions mandating health insurance went into effect in 2014. Still, LGBT Americans are less likely to be insured than their non-LGBT counterparts. Approximately 18 percent of LGBT adults aged 18 and older report not having health insurance, compared with 13 percent of non-LGBT adults (Gates 2014c).

- LGBT women are significantly more likely than non-LGBT women to report not having enough money to pay for health care or medicine (29 percent compared with 19 percent), and not having a personal doctor (29 percent compared with 16 percent) (Gates, 2014c).

These findings underline the need to increase legal protections for LGBT individuals, eliminate discrimination, and foster acceptance of diverse gender identities and expressions.

Poverty and Opportunity Among Immigrant Women

Immigrant women in the United States are a diverse group with varied levels of education and access to resources and supports. In Chester County, the total female population is approximately 260,204; of that number, nine percent (23,277 women) are foreign born (U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates). While Chester County serves as home to immigrant women from all over the world, southern Chester County is a recognized enclave for Mexican and other South and Central American immigrants. The total Hispanic or Latina population in Chester County is approximately 6,914 (U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates).

- More than one in four immigrant women in the United States (27.9 percent) holds a bachelor’s or advanced degree, compared with 30.0 percent of U.S.-born women. Immigrant women from India (71.8 percent), the Philippines (51.4 percent) and Korea (46.1 percent) are the most likely to have a bachelor’s degree or higher. Some immigrant women who have college degrees, however, find that their qualifications are not recognized in this country and can find only low-skilled, low-paying jobs (Redstone Akresh, 2006).

- While a substantial share of immigrant women hold bachelor’s degrees, three in 10 (29.6 percent) have less than a high school diploma. Among the 10 largest sending countries, women from Mexico and El Salvador are the most likely to have less than a high school diploma (57.3 and 52.7 percent, respectively). Immigrant women from the Philippines and Canada are the least likely to lack a high school diploma (8.6 and 9.4 percent, respectively).

- Immigrant women are more likely than U.S.-born women to live in poverty (19.7 percent compared with 14.7 percent). Among the 10 largest sending countries, immigrant women from the Dominican Republic (30.3 percent), Mexico (30.0 percent), Cuba (22.6 percent) and El Salvador (20.8 percent) have the highest poverty rates. Immigrant women from India (5.7 percent), the Philippines (6.9 percent) and Canada (11.1 percent) have the lowest poverty rates.

- Immigrant women are significantly less likely to have health insurance coverage than U.S.-born women (66.3 percent of immigrant women aged 18–64 compared with 84.6 percent of U.S.-born women of the same age range). Immigrants face multiple barriers in accessing basic health coverage, including a federal law that bans many immigrants from means-tested benefit programs such as Medicaid in their first five years of legal status (Broder and Blazer, 2011; National Immigration Law Center, 2014).
REPRODUCTIVE RIGHTS

Introduction
Reproductive rights—having the ability to decide whether and when to have children—are important to women’s socioeconomic well-being and overall health. Research suggests that being able to make decisions about one’s own reproductive life and the timing of one’s entry into parenthood is associated with greater relationship stability and satisfaction (National Campaign to Prevent Teen and Unplanned Pregnancy, 2008), more work experience among women (Buckles, 2008) and increased wages and average career earnings (Miller, 2011). In addition, the ability to control the timing and size of one’s family can have a significant effect on whether a young woman attends and completes college (Buckles, 2008; Hock, 2007). Given that a postsecondary degree considerably increases earnings (Gault, Reichlin, and Román, 2014), the ability to make family planning choices could mean the difference between a woman trapped at poverty-level wages or achieving long-term financial security.

In recent years, policies affecting women’s reproductive rights in the United States have substantially changed at both the federal and state levels. The 2010 Patient Protection and Affordable Care Act (ACA) increased access to preventive women’s health services and contraceptive methods and counseling for millions of women (Burke and Simmons, 2014), and facilitated states’ ability to expand Medicaid family planning services. At the same time, legal limitations to women’s reproductive rights have increased in states across the country, making it harder for women to access the reproductive health services and information they need (Guttmacher Institute, 2015a; NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, 2015). In the first quarter of 2015 alone, state legislators introduced a total of 332 provisions to restrict access to abortion services; by April 2015, 53 of these provisions had been approved by a legislative chamber and nine had been enacted (Guttmacher Institute 2015a).

This section of the Blueprint Report provides information on a range of national, state and local policies related to women’s reproductive health and rights. It examines abortion, contraception, the access of individuals in same-sex couples to full parental rights, infertility, and sex education. It also presents data on fertility and natality—including infant mortality—and highlights disparities in women’s reproductive rights by race and ethnicity. In addition, this section examines recent shifts in federal and state policies related to reproductive rights. It explores the impact of Pennsylvania’s decision to expand Medicaid coverage under the ACA, as well as state policies to extend eligibility for Medicaid family planning services. It also reviews the recognition of same-sex marriage in a growing majority of states across the nation (National Center for Lesbian Rights 2015)—a change that has profound implications for the ability of same-sex couples to create the families they desire.

Reproductive Rights in the United States, Pennsylvania and Chester County
The Institute for Women’s Policy Research (2015) developed the Reproductive Rights Composite Index, which includes nine component indicators of women’s reproductive rights: mandatory parental consent or notification laws for minors receiving abortions; waiting periods for abortions; restrictions on public funding for abortions; the percentage of women living in counties with at least one abortion provider; pro-choice governors or legislature; Medicaid expansion or state Medicaid family planning eligibility expansions; coverage of infertility treatments; same-sex marriage or second-parent adoption
for individuals in a same-sex relationship; and mandatory sex education. States receive composite scores and corresponding grades based on their combined performance on these indicators, with higher scores and letter grades reflecting stronger performance.

Oregon has the highest score on the Composite Reproductive Rights Index (IWPR, 2015). It does not require parental consent or notification or waiting periods for abortion; provides public funding to poor women for abortion; has 78 percent of women living in counties with abortion providers; has a pro-choice governor, senate and house of representatives; has adopted the expansion of Medicaid coverage under the ACA of up to 138 percent of the federal poverty line and enacted a state Medicaid family planning eligibility expansion; recognizes same-sex-marriage; and requires schools to provide sex education. Oregon does not, however, require insurance companies to cover infertility treatments. The worst-ranking state for reproductive rights is South Dakota (IWPR, 2015). It requires parental consent or notification and waiting periods for abortion; does not provide public funding to poor women for abortion; has just 23 percent of women living in counties with abortion providers; does not have a pro-choice state government; has not adopted the overall Medicaid expansion or expanded eligibility for Medicaid family planning services; does not require insurance companies to cover infertility treatments; does not recognize same-sex marriage or allow second-parent adoption for same-sex couples; and does not require schools to provide mandatory sex education.

Pennsylvania ranked 31 out of 51 (all states and the District of Columbia) with a composite index score of 2.53 and a letter grade of C (IWPR, 2015). The state’s score and ranking reflect a number of restrictions on abortion laws that relate to component indicators considered by the index. According to Pennsylvania’s abortion laws, a woman must receive state-directed counseling that includes information designed to discourage her from having an abortion and then wait 24 hours before the procedure. Parental consent of minors seeking an abortion is also required. Public funding for abortion is only provided in cases of life endangerment, rape or incest. Additionally, state health plans under the ACA can only cover abortions when the woman’s life is endangered or the pregnancy is a result of rape or incest, unless an optional rider is purchased at an additional cost (FindLaw, undated). As of 2011, 53 percent of women in Pennsylvania lived in a county with an abortion provider (IWPR, 2015). Pennsylvania has a pro-choice governor, a mixed-choice senate and an anti-choice house of representatives (NARAL Pro-Choice America, 2015).

Pennsylvania’s performance on other reproductive rights component indicators is as follows. The state has adopted the expansion of Medicaid coverage under the ACA of up to 138 percent of the federal poverty line and enacted a state Medicaid family planning eligibility expansion. Pennsylvania does not require insurers to either cover or offer coverage for infertility diagnosis and treatment (National Conference of State Legislatures, 2014; Kaiser Family Foundation, 2015). Schools in Pennsylvania are not required to teach sexuality education. Primary, intermediate, middle and high schools are, however, required to teach sexually transmitted disease (STD)/HIV education. Schools must use materials that have been determined by the local school district, are age-appropriate, discuss prevention and stress abstinence as “the only completely reliable means of preventing sexual transmission” (National Coalition to Support Sexuality Education, 2011). The state also has created the Academic Standards for Health, Safety, and Physical Education, which include STD- and HIV-prevention education (Pennsylvania Code, 1999). School districts do not have to follow a specific curriculum, but they must use these standards as a framework for the development of their curricula. School districts must publicize the fact that parents and guardians can review all curriculum materials. Parents and guardians whose principles or religious beliefs conflict with instruction may excuse their children from the programs as part of an “opt-out” policy. Pennsylvania recognizes same-sex marriage or allows same-sex couples the option of second-parent adoption (which occurs when a
non-biological parent in a couple adopts the child of his or her partner) (Human Rights Campaign, 2016).

Access to Abortion
In the United States, the 1973 Supreme Court case Roe v. Wade established the legal right to abortion. State legislative and executive bodies nonetheless continue to battle over legislation related to access to abortion, including parental consent and notification and mandatory waiting periods (Guttmacher Institute, 2015b). Public funding for abortion remains a contested issue in many states: federal law has banned the use of federal funds for most abortions since 1977 and currently does not allow the use of federal funds for abortions unless the pregnancy resulted from rape or incest or the woman’s life is in danger (Boonstra, 2013). The Affordable Care Act of 2010 reinforces these restrictions, but state Medicaid programs have the option to cover abortion in other circumstances using only state and no federal funds (Salganicoff, et al., 2014).

State legislative efforts to limit access to abortion have become commonplace. In 2013 and 2014, a broad range of legislation was introduced and passed, including bills requiring women to have an ultrasound before obtaining an abortion, stringent regulatory measures targeting abortion providers, bans or restrictions preventing women from obtaining health insurance coverage for abortion, and bans on abortion at later stages of pregnancy (National Women’s Law Center, 2014a; 2014b).

- Twenty-six of the 30 states that, as of March 2015, had statutes requiring mandatory waiting periods for obtaining an abortion enforced these statutes, with waiting periods that ranged from 18 to 72 hours (Guttmacher Institute, 2015b).
- As of March 2015, 43 states had parental consent or notification laws—which require parents of a minor seeking an abortion to consent to the procedure or be notified—and 38 of the 43 enforced these laws. Among these 38 states, 12 enforced the notification of parents and 21 enforced parental consent (Guttmacher Institute, 2015b).
- Seventeen states, as of March 2015, fund abortions for low-income women who were eligible for Medicaid in all or most medically necessary circumstances. In 27 states and the District of Columbia, state funding for abortions is available only in situations where the woman’s life is in danger or the pregnancy resulted from rape or incest (Guttmacher Institute, 2015b).
- As of 2011—the most recent year for which data are available—the percentage of women aged 15–44 who lived in counties with an abortion provider ranged across states from a low of four percent in Wyoming to a high of 100 percent in the District of Columbia and Hawaii (Guttmacher Institute, 2014).
- As of December 2014, the governor and majority of state legislators in 21 states were anti-choice (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, 2015).

Pregnancies and Their Outcomes
In 2011, the 63 million women of reproductive age (15-44) in the United States had 6 million pregnancies. Sixty-seven percent of these pregnancies resulted in live births and 18 percent in abortions; the remaining 15 percent ended in miscarriage (Guttmacher Institute, 2011). In Pennsylvania, 212,400 of the 2,434,698 women of reproductive age became pregnant in 2011; 67 percent of these pregnancies resulted in live births and 17 percent in induced abortions (Guttmacher Institute, 2011).

In 2011, 1.1 million American women obtained abortions, a rate of 16.9 abortions per 1,000 women of reproductive age. The rate is a decrease from 2008, when the abortion rate was 19.4 abortions per
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1,000 women aged 15-44 (Guttmacher Institute, 2011). In 2011, 36,870 women obtained abortions in Pennsylvania, a rate of 15.1 abortions per 1,000 women of reproductive age (Guttmacher Institute, 2011). Some of these women were from other states, and some Pennsylvania residents had abortions in other states, so this rate may not reflect the abortion rate of state residents. The rate decreased 9 percent since 2008 when it was 16.7 abortions per 1,000 women aged 15-44. Abortions in Pennsylvania represent 3.5 percent of all abortions in the United States (Guttmacher Institute, 2011).

Where Do Women Obtain Abortions?

There were 1,720 abortion providers in the United States in 2011. This is a slight (4 percent) decrease from 2008, when there were 1,787 abortion providers. Thirty-five percent of these providers were hospitals; 19 percent were abortion clinics (clinics where more than half of all patient visits were for abortion); 30 percent were clinics where fewer than half of all visits were for abortion; and 17 percent were private physicians' offices. Sixty-three percent of all abortions were provided at abortion clinics, 31 percent at other clinics, 4 percent at hospitals and 1 percent at private physicians’ offices (Guttmacher Institute, 2011). In 2011, there were 47 abortion providers in Pennsylvania; 20 of those were clinics. This represents a 6 percent decline in overall providers and a 9 percent decline in clinics from 2008, when there were 50 abortion providers overall, of which 22 were abortion clinics (Guttmacher Institute, 2011).

In 2011, 89 percent of U.S. counties had no abortion clinic; 38 percent of American women lived in these counties, which meant they would have to travel outside their county to obtain an abortion. Of women obtaining abortions in 2008, one-third traveled more than 25 miles (Guttmacher Institute, 2011). In 2011, 87 percent of Pennsylvania counties had no abortion clinic; 49 percent of Pennsylvania women lived in these counties. Planned Parenthood is the only abortion provider in Chester County (personal communication, 2016).

Restrictions on Abortion

In Pennsylvania, the following restrictions on abortion were in effect as of Dec. 1, 2015:

- A woman must receive state-directed counseling that includes information designed to discourage her from having an abortion and then wait 24 hours before the procedure is provided.
- Health plans offered in the state’s health exchange under the Affordable Care Act can only cover abortion in cases when the woman's life is endangered, rape or incest, unless an optional rider is purchased at an additional cost.
- Abortion is covered in insurance policies for public employees only in cases of life endangerment, rape or incest.
- The parent of a minor must consent before an abortion is provided.
- Public funding is available for abortion only in cases of life endangerment, rape or incest.

The Affordable Care Act and Contraceptive Coverage

The 2010 Patient Protection and Affordable Care Act (ACA) has expanded women’s access to contraception in several ways, including by requiring health care insurers to cover contraceptive counseling and services and all FDA-approved contraceptive methods without any out-of-pocket costs to patients (U.S. Department of Health and Human Services, 2014). This change is particularly significant for lower-income women who often struggle with the financial burden associated with
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purchasing contraception on a regular basis (Center for Reproductive Rights, 2012). According to the Guttmacher Institute, the average cost of a year’s supply of birth control pills is the equivalent of 51 hours of work for a woman making the federal minimum wage of $7.25 an hour (Sonfield, 2014). One national study estimates that for uninsured women, the average cost of these pills over a year ($370) is 68 percent of their annual out-of-pocket expenditures for health care services (Liang, Grossman, and Phillips, 2011).

Prior to the ACA, state contraceptive equity laws were the only legal protections ensuring that women could access affordable contraceptives as easily as they could other prescription drugs (Guttmacher Institute, 2015c). These laws required state-regulated plans providing coverage for prescription medications to do the same for contraceptive drugs and devices (National Women’s Law Center, 2012). Only 28 states, however, required full or partial contraceptive coverage; the remaining states and the District of Columbia had no such legal protection safeguarding access to affordable contraception (Guttmacher Institute, 2015c). The ACA has significantly increased the proportion of women who have access to contraception at no cost: one study focusing on about 900 women who had private health insurance and used a prescription contraceptive method found that between the fall of 2012 (before the ACA’s contraceptive coverage requirement took effect for most women) and the spring of 2014, the percentage of women paying zero dollars out of pocket for oral contraception increased from 15 to 67 percent (Sonfield, et al., 2015).

The ACA’s contraceptive requirement, however, has some notable exceptions. Some religious organizations, such as churches and other houses of worship, are exempt from the requirement to include birth control in their health insurance plans (National Women’s Law Center, 2015). An “accommodation” is also available to religiously-affiliated nonprofit organizations that certify their religious objections to the health insurance carrier or third party administrator, or notify the Department of Health and Human Services of their objection; those who qualify for the accommodation do not have to cover contraceptives for their female employees, but these employees can still get birth control coverage directly from the insurance company (National Women’s Law Center 2015; Sobel, Salganicoff, and Kurani, 2015). In addition “grandfathered” health plans that existed prior to the ACA are temporarily exempt from the requirement to provide contraceptive coverage through employer-sponsored health plans, except in states with a contraceptive equity law that already requires coverage (although contraceptive equity laws do not require insurers to provide contraceptive coverage without cost sharing; National Women’s Law Center, 2012). A Supreme Court decision, Burwell v. Hobby Lobby Stores, Inc., has also expanded allowable exemptions to certain family-owned, “closely held” corporations with religious objections to contraception (Dreweke, 2014; National Women’s Law Center, 2015). The ruling does not supersede state contraceptive equity laws, but it does mean that employees of firms such as Hobby Lobby, which self-insures its employees and therefore is subject only to federal law, may lose their coverage of contraceptive drugs and services (Rovner, 2014).

While the ACA expands access to contraception for many women, some have expressed concern that insurance-related delays in access or denials of a preferred method of contraception may undermine the law’s intent to eliminate barriers to all FDA-approved methods of contraception (Armstrong, 2013). Insurers often use “medical management techniques”—such as limiting quantity and/or supply or requiring provider authorization before providing a drug or service—that can deter patients from using certain services and shape the course of treatment. While such practices, in some circumstances, can improve efficiency and save costs, they can also prevent or delay access to services. When insurers adopt practices that limit women’s options for contraception, some women may be left without access to the method that works best for them (Armstrong, 2013). One recent
report that reviewed the insurance plan coverage policies of 20 insurance carriers in five states found that while most carriers are complying with the ACA’s contraceptive provision, there exists some variation in how the guidelines for contraceptive coverage issued by the U.S. Department of Health and Human Services are interpreted; as a result, not all carriers cover all contraceptive methods without cost sharing (Sobel, Salganicoff, and Kurani, 2015). To help ensure that women have access to the full range of contraceptive methods without cost sharing, the state of California passed a post-ACA contraceptive coverage law (SB 1053) that limits medical management as applied to contraception and goes beyond federal law in prohibiting non-grandfathered and Medi-Cal plans from instituting cost-sharing requirements or imposing restrictions or delays in providing contraceptive benefits (Sobel, Salganicoff, and Kurani, 2015).

Emergency Contraception
Emergency contraception—birth control that can be taken up to several days after unprotected sex, contraceptive failure or sexual assault—can prevent unwanted pregnancies and allow women to maintain control over the timing and size of their families. Plan B—approved for use in the United States in 1999—was the first oral form of emergency contraception to be available, but others were subsequently introduced (Kaiser Family Foundation, 2014c). The Affordable Care Act’s contraceptive provision that requires all new private health plans to cover all contraceptive drugs and devices prescribed to patients without cost sharing includes emergency contraception (Kaiser Family Foundation, 2014c).

State legislatures have taken different approaches to addressing the issue of emergency contraception. Some have sought to restrict access by excluding it from state Medicaid family planning eligibility expansions or contraceptive coverage mandates, or by allowing some pharmacists or pharmacies to refuse to provide contraceptive services (Guttmacher Institute, 2015d). Others have expanded access by: requiring emergency rooms to provide information about emergency contraception to sexual assault victims; requiring emergency rooms to dispense emergency contraception to sexual assault victims who request it; allowing women to obtain emergency contraception without a doctor’s prescription; or directing pharmacies or pharmacists to fill all valid prescriptions (Guttmacher Institute, 2015d). Public health and educational initiatives have led to an increase in awareness and use of emergency contraception (Kaiser Family Foundation, 2014c); one study that analyzed data from the National Survey of Family Growth found that in 2006–2010, 11 percent of sexually experienced women aged 15 to 44 reported having ever used emergency contraception pills, compared with 4 percent in 2002 (Daniels, Jones, and Abma, 2013).

Women still continue to encounter barriers to accessing emergency contraception. Although most women have heard of emergency contraception, for example, some are not aware of its existence (Kaiser Family Foundation 2014c). Federal law also requires women of all ages to have a prescription to obtain ella, the most effective form of emergency contraception for women who are overweight or obese; Plan B and generic forms of emergency contraception can be purchased over-the-counter (Kaiser Family Foundation, 2014c). Another barrier is that health care providers also do not always discuss emergency contraception with women in clinical settings, leaving some women without the information they need (Kaiser Family Foundation, 2014c). One study of 180 pharmacies in 29 states also found that progestin-based EC pills are often not stocked on store shelves or held behind the counter due to their high cost (American Society for Emergency Contraception, 2014).
Medicaid Expansion and State Medicaid Family Planning Eligibility Expansion

In addition to requiring most health insurers to cover contraceptive counseling and services and all FDA-approved contraceptive methods, the Affordable Care Act has increased women’s access to contraception by expanding the number of people who have health insurance coverage. The ACA has dramatically reduced rates of uninsurance among women aged 18 to 24 by allowing adult children to stay on their parents’ health insurance plans until the age of 26. Between 2008 and 2014, the percentage of women aged 18 to 24 without health insurance decreased from 24.9 to 15.9 percent. During this time period, uninsurance rates for women of all ages dropped almost one-fifth, from 13.0 percent in 2008 to 10.6 percent in the first nine months of 2014 (Martinez and Cohen, 2009 and 2015). Complete data reflecting changes in health insurance for women following the ACA are not yet available.

The ACA has also increased the number of people with health insurance through changes to Medicaid, a public health coverage program for low-income individuals. To help those who may have struggled in the past to afford insurance, the ACA seeks to expand Medicaid eligibility to all individuals under age 65 who are not eligible for Medicare and have incomes up to 138 percent of the federal poverty line. Individuals were previously eligible only if they were pregnant, the parent of a dependent child, 65 years of age or older, or disabled, in addition to meeting income requirements (National Conference of State Legislatures, 2011). This change increases the number of women who are eligible to receive family planning services, along with other health care services; however, states can opt out of this Medicaid expansion. As of March 2015, 28 states including Pennsylvania and the District of Columbia had chosen to adopt the Medicaid expansion, and six were in the process of deciding whether to do so (Kaiser Family Foundation 2015).

In addition to the overall Medicaid expansion, the ACA provides states with a new pathway to expand eligibility for family planning coverage through changes to their state Medicaid program. Before the ACA, states could expand their programs by obtaining a waiver of federal policy from the Centers for Medicare and Medicaid Services (Guttmacher Institute, 2015e). States interested in expanding family planning through Medicaid can now either complete the process through a waiver from the federal government (which is a temporary solution), or through an expedited option called a State Plan Amendment, which is a permanent change to the state’s Medicaid program (Guttmacher Institute 2015e).

As of April 2015, 28 states had extended family planning services to individuals who are otherwise ineligible, either through a waiver or through a State Plan Amendment. The income ceiling among states that have expanded their programs ranged from a low of 105 percent of the federal poverty line in Virginia (where the expansion includes those losing postpartum coverage) to a high of 306 percent of the federal poverty line in Wisconsin. Pennsylvania does have a State Plan Amendment; however, its income ceiling is relatively high at 220 percent of the federal poverty line. Pennsylvania is also one of 20 states that include men and individuals younger than 19 years old as part of the population eligible for Medicaid coverage of family planning services (Guttmacher Institute 2015e).

Other Family Planning Policies and Resources

Access to Infertility Treatments

Infertility treatments can increase the reproductive choices of women and men, but they are often prohibitively expensive, especially when they are not covered by insurance. As of June 2014, the legislatures of 12 states—Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts,
Montana, New Jersey, New York, Ohio, Rhode Island and West Virginia—had passed measures requiring insurance companies to cover infertility treatments. In another two states—California and Texas—insurance companies had to offer infertility coverage to their policy holders (National Conference of State Legislatures, 2014). Pennsylvania currently does not require insurance companies to cover infertility treatments.

**Mandatory Sex-Education in Schools**

Research has shown that sex education is critical to giving young women and men the knowledge they need to make informed decisions about their sexual activity and to avoid unwanted pregnancy and disease (Kirby, 2007). In 22 states and the District of Columbia, schools are required to provide sex education. One of these states, Tennessee, requires schools to provide sex education if the pregnancy rate among 15-to-17-year-olds is 19.5 per 1,000 or higher. Of the 23 jurisdictions with a statute on the books requiring sex education, all but two—Mississippi and North Dakota—also require HIV education. Eighteen states and the District of Columbia require that information about contraception be included in the curricula, and 37 states require that information regarding abstinence be included (Guttmacher Institute, 2015f).

Sex education is not mandated in Pennsylvania schools. While HIV education is mandated, there are no regulations that require schools to ensure that the information provided is medically accurate or culturally appropriate and unbiased. The only content requirement is that HIV-education curricula must “stress” abstinence. Parents are notified that their children will receive HIV education and have an opt-out option (Guttmacher Institute, 2015f).

**Same-Sex-Marriage and Second-Parent Adoption**

The laws that shape the ability of individuals in same-sex couples to form the families they want have changed substantially in recent years. Because there is no federal law that guarantees same-sex couples the same parenthood rights afforded to different-sex married couples, state courts have held considerable power to determine what legally constitutes lesbian and gay families. In the past, they have exercised this power in many ways, including by denying lesbian and gay individuals the right to legally adopt their partners’ children, or granting them this right through second-parent adoption, which provides legal rights to second parents in same-sex relationships that are automatically available to biological parents. These rights include (but are not limited to) custodial rights in the case of divorce or death and the right to make health care decisions for the child (Movement Advancement Project, Family Equality Council, and Center for American Progress, 2011 and 2012).

At the end of the 20th century, second-parent adoption represented the only option for many lesbian and gay individuals seeking to be legal co-parents of their children. Since then, the recognition of marriage for same-sex couples in 37 states (including Pennsylvania) and the District of Columbia, whether by legislation or pursuant to a state or federal court ruling (National Center for Lesbian Rights, 2015), has opened up new options for same-sex couples. It has given married same-sex couples who have a child together the same parental rights as married different-sex couples.14 The recognition of same-sex marriage has also made stepparent adoption—a legal process available to married couples where the non-biological parent adopts the child or children of their spouse—a

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14 Even in states where same-sex marriage is recognized, in some circumstances there may still be obstacles to consistent legal recognition of non-biological parents even if they are married to the birth parent (National Center for Lesbian Rights, personal communication, 2015).
possibility for many individuals in same-sex couples who marry after one or both partners has a child or children.

Fertility, Natality and Infant Mortality

Women’s Fertility

The fertility rate for women in the United States has declined in recent years, due in part to women’s tendency to marry and give birth later in life. In 2013 the median age for women at the time of their first marriage was 26.6 years, up from 20.3 years in 1960 (U.S. Census Bureau, 2013; Cohn et al., 2011). In 2013 the mean age for women at the time of their first birth was 26.0 years, compared with 21.4 years in 1970 (Martin et al., 2015a; Mathews and Brady, 2009). In 2013 the fertility rate was 62.5 live births per 1,000 women aged 15–44 in the United States. This represents a significant decline since 1960, when the fertility rate was 118 births per 1,000 (Martin et al., 2015a). In the 10-year period between 2003 and 2013, the fertility rate among women aged 15–44 declined from 66.1 to 62.5 births per 1,000 women (Martin et al., 2015a).

Pennsylvania is among one of the states with the 10 lowest fertility rates. In 2014, the fertility rate for women aged 15–44 in Pennsylvania was 51.9 live births per 1,000. In the same year, New Hampshire had the lowest fertility rate at 50.8 live births per 1,000, followed by Vermont at 51.4 and Rhode Island at 51.6. Four other states in the Northeast—Connecticut, Maine, Massachusetts and New York—the District of Columbia and Oregon also ranked among the 10 jurisdictions with the lowest fertility rates (Martin et al., 2015a).

The annual general fertility rate in Chester County in 2014 was 58.0 live births per 1,000. There were 6,504 reported pregnancies in Chester County in 2012. Women aged 30 and over reported the most pregnancies, live births and fetal deaths. Women aged 20-29 reported the highest number of induced abortions (Table 28).

Table 28. Natality and Reported Pregnancies, Chester County, 2012

<table>
<thead>
<tr>
<th>Age of Woman</th>
<th>Reported Pregnancies</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Live Births</td>
<td>Fetal Deaths</td>
</tr>
<tr>
<td>All Ages</td>
<td>6,504</td>
<td>5,441</td>
</tr>
<tr>
<td>Under 15</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>15-17</td>
<td>90</td>
<td>50</td>
</tr>
<tr>
<td>18-19</td>
<td>215</td>
<td>131</td>
</tr>
<tr>
<td>20-29</td>
<td>2,688</td>
<td>2,054</td>
</tr>
<tr>
<td>30 and Over</td>
<td>3,491</td>
<td>3,193</td>
</tr>
</tbody>
</table>

Source: Pennsylvania Department of Health Division of Health Informatics, 2014.

Prenatal Care

Women who receive prenatal care throughout their pregnancy are, in general, more likely to deliver healthy babies (U.S. Department of Health and Human Services, 2009). In the United States in 2012, 84 percent of women began receiving prenatal care in the first trimester of pregnancy, which was a similar proportion to 2001, when 83 percent of all mothers did so. Between 2001 and 2012, the percentage of women beginning prenatal care in the first trimester of pregnancy increased among Native American women (a 12 percentage point gain, from 69 to 81 percent). Black and Hispanic women each experienced a 7 percentage point gain (from 74 to 81 percent for Black women, 76 to 83 percent for Hispanic women). The percentage of Asian/Pacific Islander women beginning prenatal care in the first trimester stayed the same (84 percent), and the percentage of White women receiving early prenatal care declined from 89 to 86 percent (IWPR 2004; Table 29).
Table 29. Prenatal Care, Infant Mortality, and Low Birth Weight by Race and Ethnicity, United States, Pennsylvania

<table>
<thead>
<tr>
<th></th>
<th>Percent of Mothers Beginning Prenatal Care in the First Trimester of Pregnancy</th>
<th>Infant Mortality Rate (deaths of infants under age one per 1,000 live births)</th>
<th>Percent of Low Birth-Weight Babies (less than 5 lbs., 8 oz.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Women</td>
<td>83.6%</td>
<td>79.4%</td>
<td>6.0</td>
</tr>
<tr>
<td>White</td>
<td>85.7%</td>
<td>81.8%</td>
<td>5.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>82.6%</td>
<td>78.4%</td>
<td>5.1</td>
</tr>
<tr>
<td>Black</td>
<td>80.9%</td>
<td>76.8%</td>
<td>11.2</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>83.9%</td>
<td>80.3%</td>
<td>4.1</td>
</tr>
<tr>
<td>Native American</td>
<td>81.0%</td>
<td>76.8%</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Notes: Data on prenatal care are for 2012. Data on infant mortality are for 2013. Infant mortality rates reflect deaths of infants under age one per 1,000 live births. Data on the percent of low birth-weight babies are for 2014. Low birth weight considered less than 5 lbs., 8 oz. For data on prenatal care and low birth weight, Whites and Blacks are non-Hispanic; other racial groups include Hispanics. For data on infant mortality, all racial categories are non-Hispanic. Hispanics may be of any race or two or more races. Source: Centers for Disease Control and Prevention, 2013; Centers for Disease Control and Prevention, 2014; Hamilton et al., 2014.

Pregnant women of color are more likely than White women to begin prenatal care toward the end of their pregnancies, or to not receive it at all. One study that analyzed natality data from the Centers for Disease Control and Prevention found that between 2007 and 2013, only 4.4 percent of White women nationwide received late (not beginning until the third trimester) or no prenatal care, compared with 5.4 percent of Asian/Pacific Islander women, 7.6 percent of Hispanic women, 10.0 percent of Black women, and 11.3 percent of Native American women (Child Trends, 2014).

The percent of women beginning prenatal care in the first trimester was lower in Chester County (74.4 percent) than in Pennsylvania or the United States (79.4 percent and 83.6 percent, respectively; Table 29). This percentage was lower for Black women (50.6 percent) in Chester County compared to all other racial and ethnic groups for which data are available (Table 30).

Table 30. Prenatal Care and Births to Women under 18, Chester County, 2012

<table>
<thead>
<tr>
<th></th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Mothers Beginning Prenatal Care in the First Trimester of Pregnancy</td>
<td>74.4%</td>
<td>77.5%</td>
<td>50.6%</td>
<td>57.8%</td>
</tr>
<tr>
<td>Percent of Births to Mothers Under 18</td>
<td>1.0%</td>
<td>.7%</td>
<td>3.9%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Notes: Data for Native Americans and Asian/Pacific Islanders not available. Data for Hispanics are for Hispanics of any race. Source: Pennsylvania Department of Health Division of Health Informatics, 2014.

Low Birth Weight

Low birth weight is a health concern in states across the nation. Nationally, 8 percent of singleton births in the United States in 2013 had low birth weight, i.e., less than 5 pounds, 8 ounces (Martin et al., 2015b). The Healthy People 2020 target goal for low birth weight births is 7.8 percent. Among the largest racial and ethnic groups, non-Hispanic Black women were the most likely to have low-birth weight babies (13.1 percent), followed by Asian/Pacific Islander women (8.3 percent), Native American women (7.5 percent), Hispanic women (7.1 percent), and White women (7.0 percent) (Martin et al., 2015a).

Nationwide, the percent of babies with low birth weight has increased slightly, from 7.7 percent in 2001 to 8 percent in 2013. Among Blacks, the percent of babies born with low birth weight stayed the same (13.1 percent in both years), while among Whites it increased a bit (from 6.8 to 7 percent for
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Whites and 7.3 to 7.5 percent for Native Americans). Among Hispanics and Asian/Pacific Islanders, the percent of babies with low birth weight increased more substantially from 6.5 to 7.1 percent for Hispanics and from 7.5 to 8.3 percent for Asian/Pacific Islanders (IWPR 2004; Table 31).

Table 31. Percent of Low Birth-Weight Babies (less than 5 lbs., 8 oz.) by Race/Ethnicity, United States, Pennsylvania and Chester County, 2001 and 2013

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>White</th>
<th>Hispanic</th>
<th>Black</th>
<th>Native American</th>
<th>Asian/Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>7.7%</td>
<td>8.0%</td>
<td>6.8%</td>
<td>7.0%</td>
<td>6.5%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7.8%</td>
<td>8.0%</td>
<td>6.5%</td>
<td>6.8%</td>
<td>7.8%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Chester County</td>
<td>7.8%</td>
<td>7.9%</td>
<td>6.3%</td>
<td>6.5%</td>
<td>8.2%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

Notes: N/A=not available. Racial categories are non-Hispanic. Hispanics may be of any race or two or more races. State and county data are not available for Asian/Pacific Islanders, Native Americans, or those who identify with another race/ethnicity or with two or more races.

Sources: Data for all women are from the Centers for Disease Control and Prevention, 2014; data by race and ethnicity are from the Centers for Disease Control and Prevention 2013; IWPR, 2004.

In Pennsylvania and Chester County, the percentage of all women delivering babies with low birth weight also increased slightly between 2001 and 2013 (Table 31). Among Blacks, the percent of babies born with low birth weight has decreased slightly (from 13 percent to 12.7 percent). Of all racial and ethnic groups (for which data are available), Black women in Chester County are most likely to deliver low birth weight babies. White women in the county are least likely to deliver babies with low birth weight. Like White women across the United States, however, this percentage has increased slightly since 2001, from 6.3 percent to 6.5 percent. The percentage of low birth weight babies delivered to Hispanic women in the county has also increased, from 8.2 percent to 8.6 percent. While this is higher than the national percentage, the rate of increase in the percentage of low birth weight babies born to Hispanic women in Chester County is less than in the United States and Pennsylvania.

**Infant Mortality**

In the United States, infant deaths occur at a rate of 6.0 per 1,000 live births. Among women of the largest racial and ethnic groups, Asian/Pacific Islander women (4.1 per 1,000 live births), White women (5.0 per 1,000 live births) and Hispanic women (5.1 per 1,000 live births) have the lowest rates of infant mortality, while Black women and Native American women have the highest rates (11.2 and 8.4 per 1,000 live births, respectively; Table 32).

Between 2001 and 2013, the infant mortality rate in the United States decreased from 6.8 to 6.0 per 1,000 live births. These gains were experienced across all racial and ethnic groups. Rates of infant mortality among White women decreased from 5.7 to 5.0 per 1,000 births, from 13.5 to 11.2 among Black women, from 9.7 to 8.4 among Native American women, from 5.4 to 5.1 among Hispanic women, and from 4.7 to 4.1 among Asian/Pacific Islander women (IWPR 2004; Table 32).

Table 32. Infant Mortality Rates (deaths of infants under age one per 1,000 live births) by Race/Ethnicity, United States, Pennsylvania and Chester County, 2001 and 2013

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>White</th>
<th>Hispanic</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>Native American</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>6.8</td>
<td>6.0</td>
<td>5.7</td>
<td>5.0</td>
<td>5.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7.2</td>
<td>7.0</td>
<td>5.8</td>
<td>5.4</td>
<td>9.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Chester County</td>
<td>7.0</td>
<td>6.6</td>
<td>5.6</td>
<td>5.1</td>
<td>9.4</td>
<td>8.2</td>
</tr>
</tbody>
</table>
An Update to the Blueprint Report: Leveraging Progress

Notes: N/A = not available. Whites and Blacks are non-Hispanic; other racial categories include Hispanics. Hispanics may be of any race or two or more races.
Sources: Data for all women are from the Centers for Disease Control and Prevention 2014; data by race and ethnicity are from the Centers for Disease Control and Prevention 2013; IWPR, 2004.

Similar gains have been made in Chester County (Table 32). Although county-level data are not available for Asian/Pacific Islander and Native American women, infant mortality rates for White, Hispanic, and Black women in Chester County decreased between 2001 and 2013. The most significant improvements in infant mortality rates in Chester County were observed in the Hispanic and Black populations. Rates for both groups decreased 1.2 per 1,000 live births. Black and Hispanic women in Chester County, however, still experience infant mortality at higher rates than Black and Hispanic women across the United States. Black women in Chester County are twice as likely to experience infant mortality as White women nationwide.

Conclusion

Women’s status in the area of reproductive rights has seen minor gains, as well as substantial setbacks, over the past two decades. The rate of infant mortality has declined, states across the nation have recognized same-sex marriage and many states have expanded their Medicaid programs under the ACA, increasing women’s access to reproductive health services. The number of states requiring mandatory waiting periods for abortion has, however, increased, and the percentage of low birth weight babies has risen. While the implementation of the Affordable Care Act has changed the landscape of reproductive health care for women by granting more women access to much needed reproductive and family planning services. However, some women still face barriers to obtaining the services they need, and women’s reproductive rights continue to be contested in state legislatures across the nation. Increasing access to reproductive rights and resources will help advance women’s health, economic security and overall well-being.

While women can obtain an abortion in Chester County, there are numerous state restrictions that impact abortion access. These restrictions include: mandatory counseling and a 24-hour waiting period; restrictions on health insurance coverage related to abortion; parental consent for minors and restrictions on public funding for abortion. Additionally, Pennsylvania does not require insurance companies to cover infertility treatments. Pennsylvania has extended Medicaid benefits to include some family planning services to individuals through a State Plan Amendment. The income ceiling is relatively high compared to other states with similar expansion programs. Pennsylvania is, however, one of 20 states that include men and individuals younger than 19 years old as part of the population eligible for Medicaid coverage of family planning services.

The percentage of Pennsylvania women who receive prenatal care in the first trimester of pregnancy is lower than the national percentage. Consistent with national trends, White women in Pennsylvania are most likely and Black women least likely to receive prenatal care. Also consistent with national trends, the percent of women in Chester County delivering babies with low birth weight increased slightly in the period between 2001 and 2013. Of all racial and ethnic groups for which data are available, Black women in the county are most likely to deliver low birth weight babies. White women in the county are least likely to deliver babies with low birth weight. Improvements in infant mortality rates in Chester County were observed across all racial and ethnic categories. While infant mortality rates decreased 1.2 per 1,000 live births for Black and Hispanic women in Chester County, both groups experience infant mortality at higher rates than Black and Hispanic women across the United States. Black women in Chester County are twice as likely to experience infant mortality.
Emerging Issues and Advocacy Opportunities

**LGBT Reproductive Rights**

The United States has a long and complicated history of debating who deserves to become a parent and LGBT individuals have often been at the center of this debate. While the traditional conception of the family is shifting, and LGBT reproductive rights are gaining greater recognition, many LGBT individuals still face challenges in their paths to parenthood. These challenges range from finding a culturally competent health care provider to outright discrimination or legal prohibitions in pursuing adoption, foster parenting, surrogacy, or donor insemination (Cooper and Cates, 2006; Lambda Legal, 2015).

- An estimated 122,000 same-sex couples are raising children under the age of 18 in the United States. Married same-sex couples are considerably more likely to be raising children than unmarried same-sex couples (27 percent compared with 15 percent) (Gates, 2015).

- While same-sex couples are less likely to be raising children than different-sex couples, same-sex couples are nearly three times as likely to be raising an adopted or foster child (4.0 percent compared with 1.4 percent) (Gates 2015). The majority of children of same-sex couples are biologically related to one of their parents (61 percent, compared with 90 percent of children of different-sex couples).

- More than one-third (35 percent) of women of color in same-sex couples are raising a child under the age of 18, compared with 24 percent of White women in same-sex couples (Gates, 2015). Seventy-one percent of same-sex married couples and 81 percent of same-sex unmarried couples raising children under the age of 18 are female.

- Six states—California, Massachusetts, New Jersey, Oregon, Rhode Island and Wisconsin—prohibit discrimination against LGBT parents who want to foster a child. One state, Nebraska, restricts fostering by LGBT parents. Forty-three states and the District of Columbia are silent on the issue (Movement Advancement Project, 2015).

- In 35 states and the District of Columbia, LGBT parents can petition for joint adoption. In three states—Louisiana, Michigan and Mississippi—same-sex couples face legal restrictions when petitioning for joint adoption. In 12 states, the status of joint adoption for same-sex couples is uncertain (Movement Advancement Project, 2015).
HEALTH & WELL-BEING

Introduction
Health is a critical component of women’s economic security and overall well-being. Poor health can pose obstacles to women’s financial stability, educational attainment and employment, just as good health can enable women to thrive in each of these areas of life. Multiple factors shape women’s health status, including genetics and behaviors. The environments where women live and work also play a role: structural factors such as economic insecurity, access to affordable health care, poor housing quality, lack of safety, inadequate access to healthy food (World Health Organization, 2008) and racism (Williams, 1999) all influence women’s health and their likelihood of experiencing health problems.

This section of the Blueprint Report provides data on women’s health status in the United States, Pennsylvania and Chester County, beginning with a composite index of women’s health that includes nine indicators covering chronic disease and sexual, mental and physical health. It analyzes data on additional aspects of women’s health, including behavioral measures such as smoking, exercise and diet, and preventive health care measures, such as mammograms, pap tests and screenings for HIV. This section also examines how women’s health status has improved or declined in these areas in recent years. It also notes places where women’s health status varies by race/ethnicity and age and examines the health status of those who identify as a sexual minority.

Women’s Health & Well-Being in the United States, Pennsylvania and Chester County
The Health & Well-Being Composite Index, developed by the Institute for Women’s Policy Research (2015), compares the states’ performance on nine component indicators: mortality rates from heart disease, breast cancer and lung cancer; incidence of diabetes, chlamydia and AIDS; average number of days per month that mental health is not good; average number of days per month that activities were limited due to health status; and suicide mortality rates. Composite scores ranged from a high of 2.81 to a low of 1.20, with the higher scores and letter grades reflecting stronger performance in women’s health.

Minnesota ranks first in the nation on the Composite Index of Women’s Health & Well-Being. The state has the lowest female mortality rate from heart disease and ranks in the top 10 on all other component indicators except for lung cancer and suicide mortality rates and incidence of AIDS, for which the state ranks 11th, 12th, and 30th, respectively (IWPR, 2015). Mississippi ranks last among all states and the District of Columbia for women’s health. It has the worst ranking on mortality from heart disease, and the second worst ranking on the percentage of women with diabetes. The state also ranks in the bottom 10 for mortality from breast cancer, the average number of days per month on which health status limited women’s activities, incidence of AIDS and chlamydia, and poor mental health (IWPR, 2015).

Pennsylvania ranks in the middle third (31) of the nation on the Composite Index of Women’s Health & Well-Being and earned a grade of C- (IWPR, 2015). Table 33 how Pennsylvania ranks on the index and its components compared to all 50 states and the District of Columbia. The table also provides national statistics for each index component as well as statistics for Chester County. Composite Index scores and rankings were not calculated at the county level.
Table 33. Women’s Status on the Health & Well-Being Composite Index and Its Components, Unite States, Pennsylvania and Chester County

<table>
<thead>
<tr>
<th>Composite Index</th>
<th>Heart Disease Mortality</th>
<th>Lung Cancer Mortality</th>
<th>Breast Cancer Mortality</th>
<th>Incidence of Diabetes</th>
<th>Rate of Reported Cases of Chlamydia</th>
<th>Incidence of AIDS</th>
<th>Poor Mental Health</th>
<th>Suicide Mortality</th>
<th>Limited Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A 136.1</td>
<td>N/A</td>
<td>N/A 10</td>
<td>N/A 623.1</td>
<td>N/A 4.8</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>2.02</td>
<td>31</td>
<td>C-</td>
<td>143.6</td>
<td>35 37.4</td>
<td>30 545.8</td>
<td>18 5.6</td>
<td>37 4.6</td>
<td>36 5.2</td>
</tr>
<tr>
<td>Chester County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A 140.1</td>
<td>N/A</td>
<td>N/A 30</td>
<td>N/A 3.9</td>
<td>N/A 4.7</td>
</tr>
</tbody>
</table>

Notes: Data on heart disease, lung cancer, breast cancer, chlamydia, and suicide mortality are for women of all ages; data on diabetes, poor mental health, and limited activities are for women aged 18 and older; and data on AIDS are for women aged 13 and older.

Source: IWPR, 2015; Compilation of data from the Centers for Disease Control and Prevention, 2015a.

Trends in Health & Well-Being

In the United States, women’s health status has improved in some areas and declined in others. Women’s mortality rates from heart disease, lung cancer and breast cancer have decreased since the publication of IWPR’s 2004 *Status of Women in the States* report, as has the incidence of AIDS among female adolescents and adults. Women’s incidence of chlamydia and diabetes, however, has increased (IWPR 2004; Table 33). The average number of poor mental health days per month, suicide mortality rate and average number of days per month of limited activities has also gone up for women across the United States.

On the composite score for women’s health, only the District of Columbia and 10 states—California, Colorado, Connecticut, Delaware, Florida, Kentucky, Maine, Nebraska, New Jersey and Texas—have improved in their scores. Delaware and California experienced the largest gains, with scores that increased by 8.5 and 7.0 percent, respectively. Among states whose composite scores have declined, Alabama and Tennessee experienced the biggest losses, with scores that decreased by 27.6 and 25.4 percent.

What Has Improved

Nationally, the rate of heart disease among women of all ages declined 36 percent between 2001 and 2013, from 211.5 to 136.1 per 100,000. All states in the nation have experienced a decrease. The lung cancer mortality rate among women of all ages in the United States declined between 2001 and 2013 from 41 per 100,000 to 36.3 per 100,000, or about 11 percent. The overall female breast cancer mortality rate in the United States decreased 20 percent between 2001 and 2013, from 26.5 per 100,000 to 21.3 per 100,000. Every state in the nation experienced a decline. Between 2001 and 2012, the incidence of AIDS among adolescent and adult women aged 13 years and older decreased 47 percent nationally, from 9.1 per 100,000 to 4.8 per 100,000. Nine states—Arizona, Connecticut, Delaware, Florida, Hawaii, New Jersey, New York, South Dakota and Vermont—experienced a decline of 50 percent or more in their female AIDS incidence rate. All but nine states—Alaska, Georgia, Iowa, Kansas, Louisiana, Minnesota, North Dakota, Utah and Wyoming—experienced a decrease in their AIDS incidence rate among women.

What Has Worsened

Across the 50 states and the District of Columbia, the median percentage of women aged 18 and older who have ever been told they have diabetes increased between 2001 and 2013 from 6.5

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percent to 9.7 percent, an increase of about 49 percent. The rate of reported cases of chlamydia among women of all ages in the United States increased 37 percent between 2002 and 2013, from 455.4 to 623.1 cases per 100,000. According to the Centers for Disease Control and Prevention (2014), increases in rates of reported cases of chlamydia may stem from an increase in screenings, the use of more sensitive tests and more complete reporting, as well as from infection rate increases. The median number of days per month that American women aged 18 and older overall report experiencing poor mental health increased from 3.8 to 4.2, or about 11 percent, between 2000 and 2013. Only four jurisdictions—the District of Columbia, New Mexico, Virginia and Wisconsin—improved on this indicator. The suicide mortality rate among all women increased 35 percent between 2001 and 2013, from 4 per 100,000 to 5.4 per 100,000. Every state experienced an increase. Nationwide the median number of days per month during which women aged 18 and older reported that their activities were limited by their mental or physical health status increased between 2000 and 2013 from 3.5 to 4.6, or about 31 percent.

Table 34 shows how each of these indicators has changed in Pennsylvania and Chester County between 2002 and 2013. Data demonstrate that trends related to women’s health and well-being in the county are largely consistent with national trends relative to what has improved and what has worsened. Mortality rates for heart disease, lung cancer, breast cancer, and the incidence of AIDS have decreased. The median percentage of women in Chester County who have ever been told they have diabetes, the rate of reported cases of chlamydia, the median number of days per month that women aged 18 and older reported experiencing poor mental health, the suicide mortality rate, and the median number of days per month during which women aged 18 and older reported that their activities were limited by their mental or physical health status increased between 2002 and 2013.

Table 34. Women’s Status on the Health & Well-Being Composite Index and Its Components, Pennsylvania and Chester County, 2002 and 2013

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease Mortality (Per 100,000)</td>
<td>222.1</td>
<td>143.6</td>
<td>40.2</td>
<td>37.4</td>
<td>26.5</td>
<td>22.5</td>
<td>6.7</td>
<td>10.1</td>
<td>370.7</td>
<td>545.8</td>
<td>9.3</td>
<td>5.6</td>
<td>3.9</td>
<td>4.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Lung Cancer Mortality Per 100,000)</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Breast Cancer Mortality Per 100,000)</td>
<td>3.3</td>
<td>3.9</td>
<td>3.6</td>
<td>3.1</td>
<td>4.6</td>
<td>4.6</td>
<td>3.6</td>
<td>5.2</td>
<td>3.1</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence of Diabetes (Percent)</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Rate of Reported Cases of Chlamydia Per 100,000)</td>
<td>6.4</td>
<td>10.1</td>
<td>370.7</td>
<td>545.8</td>
<td>9.3</td>
<td>5.6</td>
<td>3.9</td>
<td>4.6</td>
<td>3.6</td>
<td>5.2</td>
<td>3.1</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence of AIDS Per 100,000</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Poor Mental Health (Days per Month)</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Suicide Mortality Per 100,000</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Limited Activities (Days per Month)</td>
<td>36.7</td>
<td>34.2</td>
<td>25.3</td>
<td>19.7</td>
<td>6.4</td>
<td>9.6</td>
<td>385.9</td>
<td>566.2</td>
<td>7.5</td>
<td>3.8</td>
<td>3.3</td>
<td>3.9</td>
<td>3.2</td>
<td>4.7</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Notes: Data on heart disease, lung cancer, breast cancer, chlamydia, and suicide mortality are for women of all ages; data on diabetes, poor mental health, and limited activities are for women aged 18 and older; and data on AIDS are for women aged 13 and older.

Source: Source: IWPR, 2015; 2004; Compilation of data from the Centers for Disease Control and Prevention, 2015a.

Focus group discussions concerning the health and well-being of women and girls in Chester County, like other areas of concern identified in this report, focused on the disparity in outcomes experienced by different populations of women in Chester County. Language barriers, cultural incompatibilities, lack of awareness and lack of trust between patients and health care providers were identified as significant barriers in improving the health and well-being of women and girls in the county.

Chronic Disease

Heart Disease

One in four women in the United States dies from heart disease (U.S. Department of Health and Human Services, 2014). Coronary heart disease—which is the most common form—is the leading cause of death among both women and men. Women are at higher risk than men for other forms of heart disease, such as coronary microvascular disease (in which the walls of the heart’s tiny arteries are damaged or diseased) and stress-induced cardiomyopathy (in which emotional stress leads to
Nationwide, the mortality rate from heart disease among women of all ages is 136.1 per 100,000 (Table 33), meaning that more than 136 in 100,000 women die of heart disease each year. Heart disease mortality rates, however, vary considerably across states. Among the 50 states and the District of Columbia, Minnesota has the lowest heart disease mortality rate for women (89.3 per 100,000), followed by Hawaii (98.2 per 100,000) and Alaska (100.9 per 100,000). The rate of heart disease mortality in the worst state, Mississippi (191.7 per 100,000), is more than twice the rate of Minnesota. Pennsylvania has a heart disease mortality rate of 143.6 per 100,000. The heart disease mortality rate in Chester County (138.7 per 100,000) is lower than the state rate, but higher than the national rate (Figure 20).

As Figure 20 shows, mortality rates from heart disease vary substantially by race and ethnicity. Black women in the United States, Pennsylvania and Chester County have the highest rates, followed by White and Native American women. Asian/Pacific Islander and Hispanic women have the lowest rates of heart disease mortality. Although Asian/Pacific Islander women have the lowest rate, heart disease remains the second biggest killer for this group (Centers for Disease Control and Prevention 2014a), and rates of heart disease mortality differ across Asian/Pacific Islander populations. One study that examined heart disease mortality rates among Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese women and men found that Asian Indian women and men had the highest rates of mortality among these groups and were more likely to die from heart disease than non-Hispanic White women and men (Jose et al. 2014).

Figure 20. Heart Disease Mortality Rates (per 100,000) Among Women by Race/Ethnicity, United States, Pennsylvania, and Chester County, 2013

Note: Data include women of all ages and are age-adjusted to the U.S. standard population
Source: Centers for Disease Control and Prevention, 2015a

Cancer

The nation has made considerable progress in the prevention, detection and treatment of certain forms of cancer in recent decades; nevertheless, cancer is the second leading cause of death for all women in the United States (Centers for Disease Control and Prevention, 2013a). Lung and breast cancer are the forms of cancer from which women are most likely to die (Centers for Disease Control and Prevention, 2013b).
The national mortality rate from lung cancer among women of all ages is 36.3 per 100,000 (Table 33). Since lung cancer, like heart disease, is often linked to cigarette smoking, efforts to raise public awareness about the health risks of smoking are essential to reducing lung cancer incidence and mortality. The female mortality rate from lung cancer of 36.3 per 100,000 represents a decline in the mortality rate among women from this disease since 1999–2001, when the rate was 41.0 per 100,000 (IWPR 2004; Table 33). This decline is due, in part, to tobacco prevention and control efforts (Henley et al., 2014).

Lung cancer mortality rates vary sharply among the largest racial and ethnic groups (Figure 21). In the United States, White women have the highest rate (39.9 per 100,000), followed by Black women (35.7 per 100,000). Hispanic women have the lowest rates of lung cancer mortality (13.3 per 100,000), followed by Asian/Pacific Islander women (18.3 per 100,000 women) (Table 33). Black women in Pennsylvania and Chester County (48.5 and 44.3 per 100,000, respectively), however, have significantly higher rates of lung cancer mortality compared to Black women across the United States and are more likely die of lung cancer than any other racial or ethnic group in the state and county. As in the United States, Hispanic women in Chester County have the lowest lung cancer mortality rate (15.4 per 100,000). The mortality rate for all women in Chester County, however, is lower than both the national and state rates. (Data for lung cancer mortality rates among Native American women are not available for Pennsylvania and Chester County.)

Figure 21. Lung Cancer Mortality Rates (per 100,000) Among Women by Race/Ethnicity, United States, Pennsylvania, and Chester County, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>United States</th>
<th>Pennsylvania</th>
<th>Chester County</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Women</td>
<td>36.3</td>
<td>37.4</td>
<td>34.2</td>
</tr>
<tr>
<td>White</td>
<td>39.9</td>
<td>37.2</td>
<td>37.2</td>
</tr>
<tr>
<td>Black</td>
<td>35.7</td>
<td>48.5</td>
<td>44.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13.3</td>
<td>15.8</td>
<td>15.4</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>18.3</td>
<td>17.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Native American</td>
<td>31.1</td>
<td>31.1</td>
<td>31.1</td>
</tr>
</tbody>
</table>

Note: Data include women of all ages and are age-adjusted to the U.S. standard population
Source: Centers for Disease Control and Prevention, 2015a.

While lung cancer is the deadliest cancer for women in the United States, breast cancer is the most common form of the disease. Approximately 231,840 new cases of breast cancer and 40,290 deaths were expected among the nation’s women in 2015 (American Cancer Society, 2015). The mortality rate for women of all ages from breast cancer is 21.3 per 100,000 nationally, 22.5 in Pennsylvania and 19.7 in Chester County.

As with the other types of cancer, mortality rates due to breast cancer vary widely by race and ethnicity (Figure 22). Black women in the United States, Pennsylvania and Chester County have the highest mortality rates from breast cancer (30.2, 31.6 and 29.6 per 100,000 women, respectively). That is more than double the rate for Asian/Pacific Islander, Native America and Hispanic women and considerably higher than the rate for White women. Asian/Pacific Islander women have the lowest mortality rate from breast cancer in the United States (11.3 per 100,000) and Pennsylvania (11.8 per 100,000). (Data for breast cancer mortality among Native Americans in Pennsylvania and Chester
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Fortunately, Black women are also more likely than women overall to have had a mammogram; 85.6 percent of Black women aged 50 and older in Chester County report having had a mammogram in the past two years, compared with 80.9 percent of all women.

Figure 22. Breast Cancer Mortality Rates (per 100,000) Among Women by Race/Ethnicity, United States, Pennsylvania and Chester County, 2013

The racial and ethnic disparities in mortality from disease are alarming. Black women are considerably more likely than women of all other racial and ethnic groups to die from heart disease and breast cancer; Black women have a rate of heart disease mortality that is more than double the rate for Asian/Pacific Islander women, the group with the best rate, and a breast cancer mortality rate that is nearly triple the rate for Asian/Pacific Islander women. White women have the second worst mortality rate from both of these diseases. In addition, White and Black women have the highest rates of lung cancer mortality; the rate for White women is three times that of Hispanic women, the group with the best rate, and the rate for Black women is more than 2.5 times the rate for Hispanic women (Figure 21). These striking disparities indicate that much more needs to be done to reduce the very high rates of mortality from disease, especially among Black and White women who generally have the highest mortality rates.

Diabetes

Women and men with diabetes are considerably more likely than those without it to develop heart disease or stroke, blindness, kidney disease and other serious health conditions (Centers for Disease Control and Prevention, 2011a). In the United States, 10 percent of women and 10.4 percent of men aged 18 and older report having been told they have diabetes (IWPR 2015b). Among the 50 states and the District of Columbia, Colorado (5.9 percent), Alaska (6.6 percent), and Utah (6.8 percent) have the smallest percentages of women living with diabetes. Alabama (14.1 percent), Mississippi (13.7 percent) and South Carolina (13.4 percent) have the largest percentages of women living with diabetes. In Pennsylvania, 10.1 percent of women report having been told they have diabetes—close to Chester County’s 9.8 percent rate.

Rates of diabetes vary by age and among the largest racial and ethnic groups (Figure 23). Black and Native American women in the United States have the highest rates of diabetes (15.1 and 14.9
percent, respectively) and are twice as likely as Asian/Pacific Islander women, who have the lowest rate (7.5 percent), to have ever been told they have diabetes (Figure 23). Native American women in Pennsylvania, however, are nominally more likely to have diabetes than Black women. In Chester County, rates of diabetes across all racial and ethnic groups are higher than rates in the United States.

One study that analyzed 2010–2012 data from the National Health Interview Survey found that among Hispanic adults, the rate of diagnosed diabetes was highest among Puerto Ricans (14.8 percent) and Mexican Americans (13.9 percent; data not available by gender), and lowest among Central and South Americans (8.5 percent) and Cubans (9.3 percent) (Centers for Disease Control and Prevention 2014b). Differentiation among Hispanic populations is important in Chester County due to the large Mexican population in southern Chester County.

**Figure 23. Percent of Women Who Have Ever Been Told They Have Diabetes by Race and Ethnicity, United States, Pennsylvania and Chester County, 2013**

![Bar chart showing diabetes rates by race and ethnicity]

*Note: Data include women of all ages and are age-adjusted to the U.S. standard population*

*Source: Compilation of data from the Centers for Disease Control and Prevention, 2015.*

**HIV/AIDS**

Although the majority of individuals in the United States with HIV infections and newly diagnosed AIDS cases are men, women—particularly women of color—are also profoundly affected by HIV/AIDS. In 2010, there were 9,500 new diagnoses of HIV among female adolescents and adults in the United States and 8,102 such diagnoses the following year (Kaiser Family Foundation, 2014). Young women (aged 25–34) comprise the largest share of new HIV infections among women (29 percent), followed by women aged 35–44 (25 percent) and aged 13–24 (22 percent) (Kaiser Family Foundation, 2014).

The national incidence rate for AIDS among adolescent and adult women was 4.8 per 100,000 in 2012 (Table 33) compared with 15.3 per 100,000 among adolescent and adult men (Centers for Disease Control and Prevention, 2015b). The incidence of AIDS has declined from 9.1 per 100,000 women in 2001 to 4.8 per 100,000 in 2012 (IWPR, 2004; Table 33). The rate for men also declined

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16 AIDS diagnoses data include six U.S. dependent areas.
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during this time period (Centers for Disease Control and Prevention, 2015b).

The rate of AIDS among adolescent and adult women declined in 40 states and the District of Columbia between 2001 and 2012. The rate of AIDS among adolescent and adult women (aged 13 and older) in Pennsylvania declined from 9.3 per 100,000 to 5.6 per 100,000, and from 7.5 per 100,000 to 3.8 per 100,000 in Chester County (Centers for Disease Control and Prevention, 2015b).

The rate of AIDS among Black women in the United States (27.5 per 100,000) is higher than for any other racial and ethnic group and is nearly six times the rate for all women (4.8 per 100,000). Asian/Pacific Islander and White women have the lowest incidence rates (0.9 and 1.2 per 100,000, respectively) (Centers for Disease Control and Prevention, 2015b).

While there continues to be no cure for HIV/AIDS, the medical community has made significant advances in the treatment of HIV and AIDS with the introduction of antiretroviral drugs that can suppress the HIV virus and slow the progression of the disease (Anderson et al., 2015). These medications have helped reduce the number of deaths from AIDS, yet early detection remains critical. The CDC recommends that persons at high risk for HIV be screened at least annually, and that HIV screening is included in routine prenatal screening tests for pregnant women (U.S. Preventive Services Task Force, 2013).

In 2011, Pennsylvania lawmakers passed an amendment to Pennsylvania’s HIV-testing law, commonly known as Act 148. The revised law no longer requires written informed consent for an HIV test, utilizes an opt-out format for offering the test, and no longer requires negative test results to be given in person. The idea behind the change is the more HIV-positive people who know their status, the better they can prevent further transmission of the virus. The AIDS Law Project, while acknowledging that the legislation was well-intentioned, has criticized the action, claiming that it diminishes the ability of Pennsylvanians to be in control of their health care decisions (AIDS Law Project of Pennsylvania, 2011).

The percentage of women who have ever been screened for HIV also varies considerably across racial and ethnic groups. According to IWPR analysis of 2013 Behavioral Risk Factor Surveillance System microdata, approximately 60.7 percent of Black women in the United States report having been screened, compared with 50.8 percent of Hispanic women, 45.0 percent of Native American women, 33.3 percent of Asian/Pacific Islander women, 32.5 percent of White women, and 51.3 percent of women who identify as multiracial or with another racial group (Table 35. Health Behaviors and Preventive Care Among Women by Race and Ethnicity, United States).

Sexual Health

National data show that women are more likely than men to be diagnosed with a sexually transmitted infection, or STI (U.S. Department of Health and Human Services, 2012a). Women are biologically more susceptible to certain STIs than men (Centers for Disease Control and Prevention, 2011b). Women also visit doctors more often—and, therefore, may be more likely to be screened for STIs (Centers for Disease Control and Prevention, 2011b). As with many other health problems, education, awareness and proper screening can limit the spread of STIs and diminish their health impact.

One of the more common STIs among women is chlamydia. In 2013 the rate of reported cases of chlamydia was 633.1 per 100,000 women in the United States, 545.8 per 100,000 women in Pennsylvania, and 568.5 per 100,000 women in Chester County (Centers for Disease Control and Prevention, 2015c). While approximately 75 percent of women and 50 percent of men with chlamydia do not experience symptoms (Centers for Disease Control and Prevention, undated), the infection
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can lead to pelvic inflammatory disease (PID), a common cause of infertility, miscarriage and ectopic pregnancy (Centers for Disease Control and Prevention, 2014c). Screening for chlamydia is, therefore, important to women’s overall reproductive health.

Among women, young women aged 20–24 have the highest rates of chlamydia with a rate of 3,621.1 cases per 100,000, followed by young women aged 15–19 (3,043.3 cases per 100,000). The rate for women aged 25–29 (1,428.3 cases per 100,000) is less than half the rate of women aged 20–24. The rates of infection are lower in older age groups (Centers for Disease Control and Prevention, 2014d).

Between 2002 and 2012, the rate of chlamydial infection increased in every state and the District of Columbia (IWPR 2004; Table 33). The national rate for women nearly doubled between 1996 and 2013, increasing from 315.5 to 623.1 cases per 100,000. Among the largest racial and ethnic groups, Black women had the highest rate of reported cases of chlamydia in 2013 (1491.7 per 100,000 women), followed by Native American women (1079.2 per 100,000). Asian/Pacific Islander women had the lowest rate at 154.6 cases per 100,000, which is nearly 10 times lower than the rate among Black women.

**Mental Health**

Since the early 2000s, an increasing body of evidence from research and scholarship, public policy analysis, consumer advocacy and health care practice has underscored the critical importance of mental health to the overall health of women—and to the United States as a whole. Many advances have been made in understanding mental illnesses, effective treatments and promising approaches for promoting mental health, resilience and fulfilling lives for those living with mental illnesses. A key component of this progress has been the increased understanding of the critical role of gender in the risks, course, and treatment of mental illnesses (U.S. Department of Health and Human Services, 2009).

The evidence from recent research has carried implications for the well-being of all Americans but has particular significance for the health and well-being of women. Women suffer disproportionately from a number of mental illnesses (Figure 24). Women have higher incidences than men of certain mental health conditions, including anxiety, depression and eating disorders (Eaton et al., 2012). Further, mental illnesses affect women and men differently. Some disorders are more common in women, and some express themselves with different symptoms. Women also serve as primary caretakers for those suffering from mental illnesses, make many of the health decisions in the family, and play a critical role in perpetuating or breaking the intergenerational effects of mental illnesses (U.S. Department of Health and Human Services, 2009).
A parallel body of research has demonstrated the profound influence of mental health on physical health and survival (U.S. Department of Health and Human Services, 2009). Studies from the world of business and economic analysis have highlighted the enormous costs of mental illnesses on American society, and research has shed new light on the long-term consequences of intergenerational risks and effects associated with mental illnesses (e.g., depression) or family dysfunction (e.g., abuse or neglect). Additional findings have elucidated the impact of trauma, violence and abuse on the development of mental illnesses, particularly as they affect girls, women and female veterans (U.S. Department of Health and Human Services, 2009).

**Rates of Mental Illness: Gender Difference**

Although overall, men and women experience mental illness at similar rates, some mental disorders occur more frequently in women than men (Kessler et al., 2005; Figure 24). For example, women are nearly twice as likely as men to suffer from major depression, which is associated with problems such as lost productivity, higher morbidity from medical illness, greater risk of poor self-care or poor adherence to medical regimens, and increased risk of suicide. Perinatal depression affects an estimated 8-11 percent of women during pregnancy and 6-13 percent of mothers in the first postpartum year (Gaynes et al., 2005). Women are three times more likely than men to engage in non-fatal suicidal behavior (e.g., taking an excessive dose of sleeping pills), though less likely to use a lethal method (e.g., firearm) and die by suicide (Weissman, Bland, Canino, 1999; Minino, 2002).

Rates of anxiety disorders are two to three times higher in women than men; this includes post-traumatic stress disorder (PTSD), which affects women more than twice as often as men (Gaynes et al., 2005). Women represent 90 percent of all cases of eating disorders, which carry the highest mortality rate of all mental illnesses. Eating disorders frequently are associated with other psychiatric disorders, such as depression, substance abuse, obsessive-compulsive disorder and social phobia. In contrast, men are more likely than women to suffer from impulse control disorders and from substance use disorders (Birmingham, 2005).

The disproportionate prevalence of particular mental illnesses in women is all the more important in

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**Figure 24. Rates of Mental Disorder for Women and Men**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>36%</td>
<td>25%</td>
</tr>
<tr>
<td>Panic Disorders</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Phobias</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>PTSD</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorders</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>20%</td>
<td>3%</td>
</tr>
<tr>
<td>Impulse Control Disorders</td>
<td>29%</td>
<td>22%</td>
</tr>
<tr>
<td>Substance Abuse Disorders</td>
<td>26%</td>
<td>14%</td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>1.40%</td>
<td>1.30%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1.00%</td>
<td>1.30%</td>
</tr>
</tbody>
</table>

light of the fundamental links between mental health, overall health, and social well-being. For instance, in the case of major depression, the disorder can precipitate chronic disease or be exacerbated by the presence of chronic disease. Individuals with depression are at greater risk of developing diseases such as cancer or cardiovascular disease (Rumsfeld, 2005). Some of the sex-based variation in rates of selected mental illnesses and in the risk, course or treatment of these disorders may be associated with biological differences between men and women. For example, research has demonstrated that the female hormones, estrogen and progesterone, influence brain function and stress response. Studies of reproductive events such as menstruation, pregnancy, postpartum, perimenopause, and other changes in female hormone levels find that these changes lead to an increase in the occurrence and intensity of symptoms of depression and other mood disorders, such as bipolar disorder and dysthymia (Burt, 2004).

Cultural Effects and Disparities

Individual attitudes and responses to mental illness are highly affected both positively and negatively by one’s family and cultural environment. These environments influence the meaning individuals assign to illness, how they make sense of it, what the causes may be and how much stigma surrounds mental illness. In addition, they affect whether individuals will seek help (and from whom), how supportive their families may be, the pathways they take to obtain mental health services, and how well they may respond to different types of treatments (U.S. Department of Health and Human Services, 2001).

Cultural disparities can place women at greater risk for mental illnesses. Factors such as racism, discrimination, violence and poverty have measurable effects on rates of mental illness. These effects are coupled with the finding that racial and ethnic minorities are less likely to receive needed services, including mental health services, and more likely to receive low-quality care (U.S. Department of Health and Human Services, 2001). In addition, women who are recent immigrants or refugees may face extra stresses and traumas associated with their immigration experiences. Migration itself is a stressful life event, requiring the need to adapt to a new culture (U.S. Department of Health and Human Services, 2001). At highest risk are the estimated 50,000 women and children who are victims of human trafficking each year into the United States. Research suggests that nearly 90 percent of internationally trafficked women rely on drugs or alcohol to cope with their situation, 50 percent report feeling hopeless, 85 percent experience depression, and 31 percent say they have had suicidal thoughts (Raymond and Hughes, 2001).

Trauma, Violence, and Abuse

Research has increasingly focused on the relatively high prevalence of trauma, violence and abuse in women’s lives and their effect on women’s mental health and overall well-being. Findings from the National Violence Against Women Survey indicate that 17.6 percent of women compared to 3 percent of men report having experienced a completed or attempted rape in their lifetime, and 24.8 percent of women compared to 7.6 percent of men report being raped or physically assaulted by an intimate partner (Tjaden and Thoennes, 2000). Thus, women are six times more likely than men to report being a victim of rape or attempted rape, and they are three times more likely than men to suffer from sexual or physical intimate partner violence. Data also show that violence and abuse in women’s lives begin early in the lifespan. For example, women are five times more likely than men to report being a victim of sexual abuse in childhood (Tjaden and Thoennes, 2000).

One of the newly emerging areas of research regarding women’s experience of trauma, violence, and abuse concerns the effects of military service and combat on female veterans (Zinzow et al., 2007). A
number of factors are combining to generate greater interest in this area including the growing numbers of women in active duty; increasing rates of male and female soldiers returning from the conflicts in Iraq and Afghanistan who are being diagnosed with mental disorders such as PTSD, generalized anxiety, or depression; and findings suggesting that female veterans are at higher risk of PTSD and sexual abuse than either their non-combatant counterparts or male veterans (Hoge, Castro, and Messer, 2004; Zinzow et al., 2007).

Research investigating differences in PTSD rates between men and women in the military suggests that female veterans may face a higher risk of PTSD than their male counterparts, with rape being the most common cause of onset. National surveys suggest that from 13 to 30 percent of women veterans experience rape during their military service, increasing their risk of PTSD and associated problems such as poorer overall health functioning, depression and substance abuse (Zinzow et al., 2007). Researchers conclude that these findings point to a need for regular screening of women veterans for sexual trauma and PTSD to promote early detection and intervention. They also recommend increased efforts to ensure that female veterans obtain needed treatment services in a timely fashion along with greater research to better understand the specific nature of violence against women in the military and identify effective prevention and treatment measures (Zinzow et al., 2007).

Life Span and Intergenerational Issues

Mental illnesses, including those that disproportionately affect women such as depression and anxiety disorders, are often chronic or recurrent. They may influence women’s lives across the life span and those of their families across generations. Findings from the National Comorbidity Survey indicate that mental illnesses in both men and women often begin at a young age, with half occurring before age 14 and three-fourths by the age of 24 (Kessler et al., 2005). If left unrecognized or untreated, mental illnesses that occur in childhood frequently persist into adulthood. In addition, they may lead to conditions such as more risk taking behaviors, low self-esteem and school failure that can set forth a downward spiral of poor outcomes that reduce an individual’s quality of life and ability to meet his or her full potential. Indeed, research on child and adolescent mental health indicates that no other illness has such damaging effects on children as does mental illness (U.S. Department of Health and Human Services, 2001). These findings are important for young and adolescent girls, who appear to be at increased risk compared to their male peers, of being a victim of abuse, developing an eating disorder, experiencing depression or anxiety or engaging in suicidal behavior (Burt, 2004). They also underscore the importance of prevention and early intervention in stemming the risks of mental illness and the associated health and social problems later in life. Thus, one strategy is to try to prevent abuse and trauma before they occur by creating safe, stable and nurturing environments for children, youth and families (Burt, 2004).

Frequency and Impacts of Poor Mental Health

Analysis of data from the 2013 Behavioral Risk Factor Surveillance System indicates that adult women in the United States—when asked to think about their mental health, including stress, depression and problems with emotions—report having an average of 4.3 days per month on which their mental health is not good (Table 33). The number of poor mental health days that women report experiencing is higher than the average number of poor mental health days per month reported by men (3.3) (IWPR, 2015b).

Between 2000 and 2013, the average number of days on which women experienced poor mental
health increased in all but five states—New Mexico, Texas, Virginia, Wisconsin and Wyoming—and the District of Columbia (IWPR 2004). While the overall number and rate of increase in is lower than the state and nation, women in Chester County are reporting increases in the number of days per month that they experience poor mental health. In Pennsylvania, the number of poor mental health days reported by women increased from 3.6 to 5.2 days, and from 3.3 to 3.9 days in Chester County (Table 34).

Among women from the largest racial and ethnic groups, Native American women report having, on average, the most number of days per month of poor mental health (6.3), followed by women who identify with another racial group or two or more races (5.9 days), Black women (4.8 days), Hispanic women (4.6 days), and White women (4.2 days). Asian/Pacific Islander women report having the fewest days per month of poor mental health (2.7 days on average) (IWPR, 2015b; Figure 25).

Figure 25. Average Number of Days per Month of Poor Mental Health Among Women by Race and Ethnicity, United States, Pennsylvania and Chester County, 2013

Focus group participants commonly identified mental health problems, low self-esteem and low confidence as problems faced by women of all ages, races and socio-economic status in Chester County. Forty-two percent of respondents to the Nonprofit and Provider Snapshot Survey, however, identified mental health services as difficult to access. Similarly, of the organizations and agencies that cited “service not available at this organization/agency” as a reason for not being able to serve clients, many indicated that many of the clients turned away were seeking help for anxiety, depression and other mental health-related reasons.

Suicide

Suicide is another public health problem related to mental health that poses a serious concern for many communities. In the United States, women are much less likely than men to commit suicide but more likely to have suicidal thoughts (Crosby et al., 2011) and to attempt suicide (McIntosh and Drapeau, 2014). In 2011, there were an estimated 987,950 suicide attempts in the United States; women were three times more likely to attempt suicide than men (McIntosh and Drapeau, 2014). During this same year, there were 8,515 deaths from suicide among women and 31,003 among men (McIntosh and Drapeau, 2014).

The national suicide rate is 5.4 per 100,000 for women (Table 33) and 20.2 per 100,000 for men. The District of Columbia had the lowest suicide mortality rate among women between 2011 and 2013 at
3.1 per 100,000; Montana had the highest rate, at 10.8 per 100,000. In Pennsylvania the suicide rate is slightly lower than the national rate at 5.2 per 100,000 (Centers for Disease Control and Prevention, 2015e).

Suicide rates also vary across racial and ethnic groups (Figure 26). The overall suicide rate for women in Chester County is lower than the suicide rates in Pennsylvania and the United States. Like national and state trends, more Native American women in Chester County (6.8 per 100,000) die of suicide than any other racial or ethnic group and Asian/Pacific Islander women are least likely (2.5 per 100,000).

Figure 26. Suicide Mortality Rate Among Women (per 100,000) by Race and Ethnicity, United States, Pennsylvania and Chester County, 2013

Limits on Women’s Activities
Illness, disability, and overall poor health make it difficult for women to thrive at home and in the workplace. Women aged 18 and older who participated in the Centers for Disease Control and Prevention’s 2013 Behavioral Risk Factor Surveillance System survey reported that their activities were limited by their health status for an average of 4.8 days in the month preceding the survey (Table 33).

Women in North Dakota report having the fewest days per month during which their activities were limited, at 3.5 days; Tennessee women reported 6.5 such days, the most nationwide. Women in Pennsylvania reported that their activities were limited by their health status for an average of 5.2 days per month, which ranks the state 23rd among all 50 states and the District of Columbia (IWPR. 2015).

Among women from the largest racial and ethnic groups, Native American women have the highest self-reported average number of days per month of activities limitations at 7, more than double the average number of days for Asian/Pacific Islander women, who have the least. The self-reported number of days of limited activities among women of different racial and ethnic groups in Pennsylvania and Chester generally follow national trends (Figure 27). Women in general, White, Black and Asian/Pacific Islander women in Chester County report fewer poor mental health days per
month than women in the United States and Pennsylvania. Hispanic and Native American women in Chester County, however, report more poor mental health days per month than women in the United States.

Figure 27. Average Number of Days per Month of Limited Activity due to Health Status Women by Race and Ethnicity, United States, Pennsylvania, and Chester County, 2013

Notes: Data are for women aged 18 and older. Data for all women are for 2013; all other data are three-year (2011–2013) averages. Racial groups are non-Hispanic. Hispanics may be of any race or two or more races.
Source: Analysis of Behavioral Risk Factor Surveillance System microdata.

Obesity and Healthy Weight

Being overweight or obese is a growing health concern for women in the United States (Figure 28). Nationally nearly six in ten women (57.6 percent) aged 18 and older are overweight or obese (classified as having a body mass index of 25 or greater). Overweight and obesity rates vary across the states. Hawaii (45.7 percent), Massachusetts (48.7 percent) and Colorado (48.9 percent) had the lowest proportion of women who are overweight or obese in 2013. Two-thirds of women (66.0 percent) in the state with the worst ranking, Mississippi, are overweight or obese. In both Pennsylvania (57.6 percent) and Chester County (56.8 percent), a majority of the women are overweight or obese.

Among women from the largest racial and ethnic groups, Black women in the United States are the most likely to be overweight or obese at 73.3 percent, followed by Native American women (64.1 percent), Hispanic women (63.7 percent), and White women (54.3 percent). Asian/Pacific Islander women are the least likely to be overweight or obese (30.5 percent). For each racial and ethnic group, the percentage of women who are overweight or obese varies considerably across states and localities. The distribution of overweight and obese women according to race and ethnicity in Pennsylvania and Chester County reflect national trends. Notably, the proportion of overweight and obese women in Chester County is lower than national and state percentages across all categories (Figure 28).
Preventive Care and Health Behaviors

Practicing preventive health care and maintaining good health behaviors are important components of women’s health and overall well-being. In Chester County, fewer than half of women aged 18 and older (48.2 percent) report exercising at least 150 minutes per week (Table 35). Oregon (64.6 percent), Colorado (59.1 percent) and Vermont (59.0 percent) have the largest proportions of women who say they get this much exercise. The states with the smallest proportions of women who report exercising at least 150 minutes per week are Mississippi (33.1 percent), Tennessee (34.7 percent), and Arkansas (38.1 percent). In Pennsylvania, 44.3 percent of women report exercising at least 150 minutes per week (IWPR 2015b).

Only 20.6 percent of women aged 18 and older in Chester County say they eat five or more servings of fruits and vegetables every day (Table 35). Across Pennsylvania, fewer women of the same age report eating five or more servings of fruits and vegetables a day (17.3 percent). Women in West Virginia, Tennessee and Mississippi are the least likely to eat this amount of fruits and vegetables daily, and women in California, Oregon, and Vermont are the most likely. Even in the best ranked state, California, nearly seven in 10 women do not eat at least five servings of fruits and vegetables per day (IWPR, 2015b).

In Chester County, 15.8 percent of adult women report that they have smoked 100 or more cigarettes in their lifetime and now smoke every day or some days (Table 35). Utah has the smallest proportion of women who smoke at 9.2 percent, and West Virginia has the largest (26.5 percent (IWPR, 2015b). In Pennsylvania, 17.3 percent of adult women report that they have smoked 100 or more cigarettes in their lifetime and now smoke every day or some days (IWPR, 2015b). Overall, the percentage of women in the United States who report smoking has declined considerably since 2000, when 21.2 percent of women said they had smoked 100 or more cigarettes in their lifetime and smoke every day or some days (IWPR, 2002).

In Chester County, 11.2 percent of women aged 18 and older report binge drinking (having consumed...
four or more drinks on at least one occasion during the preceding month) (Table 35). The percentage of women who report binge drinking in the District of Columbia (18.7 percent), which fares the worst on this indicator, is more than three times that of West Virginia (5.7 percent), which fares the best. In Pennsylvania, 13.8 percent of women aged 18 and older report binge drinking (IWPR, 2015b).

Nearly 80 percent (79.5) women aged 18 and older in Chester County report having had a pap test in the past three years (Table 35). In Pennsylvania, 74.2 percent of women in the same age group report having had a pap test in the past three years (IWPR, 2015b). Women in the District of Columbia, Massachusetts and Maryland are the most likely to say they have had a pap test; those in Idaho, Montana and Oklahoma are the least likely to report having done so (IWPR, 2015b).

Of women aged 50 and older in Chester County, 80.9 percent report having had a mammogram in the past two years (Table 35). This is higher than the statewide rate of 76.9 percent. (IWPR, 2015b). Massachusetts (89.5 percent), the District of Columbia (86.3 percent) and Rhode Island (86.2 percent) have the largest shares of women who have had a breast cancer screening; Wyoming (70.6 percent), Idaho (72.4 percent) and Oklahoma (73.4 percent) have the smallest shares (IWPR 2015b).

Table 35. Health Behaviors and Preventive Care Among Women by Race and Ethnicity, Chester County, 2013

<table>
<thead>
<tr>
<th></th>
<th>All Women</th>
<th>White</th>
<th>Hispanic</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>Native American</th>
<th>Other Race or Two or More Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Who Exercise 150 Minutes per Week</td>
<td>48.2%</td>
<td>51.0%</td>
<td>42.5%</td>
<td>39.6%</td>
<td>45.4%</td>
<td>48.9%</td>
<td>50.8%</td>
</tr>
<tr>
<td>Percent Who Eat Five or More Servings of Fruits and Vegetables per Day</td>
<td>20.6%</td>
<td>20.0%</td>
<td>23.7%</td>
<td>19.0%</td>
<td>23.5%</td>
<td>20.4%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Percent Who Smoke (Some Days or Every Day and Have Smoked at Least 100 Cigarettes in Lifetime)</td>
<td>15.8%</td>
<td>17.5%</td>
<td>9.2%</td>
<td>16.3%</td>
<td>4.8%</td>
<td>30.5%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Percent Who Report Binge Drinking (Four or More Drinks on One Occasion at Least Once in the Past Month)</td>
<td>11.2%</td>
<td>12.1%</td>
<td>10.1%</td>
<td>8.4%</td>
<td>8.3%</td>
<td>11.3%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Percent Aged 50 and Older Who Have Had a Mammogram in Past Two Years</td>
<td>80.9%</td>
<td>60.3%</td>
<td>80.0%</td>
<td>85.6%</td>
<td>85.7%</td>
<td>75.4%</td>
<td>75.4%</td>
</tr>
<tr>
<td>Percent Who Have Had a Pap Test in the Past Three Years</td>
<td>79.5%</td>
<td>76.3%</td>
<td>86.9%</td>
<td>87.0%</td>
<td>87.1%</td>
<td>76.8%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Percent Who Have Been Screened for Cholesterol in the Past Five Years</td>
<td>61.6%</td>
<td>63.6%</td>
<td>51.4%</td>
<td>65.8%</td>
<td>57.4%</td>
<td>57.4%</td>
<td>56.3%</td>
</tr>
<tr>
<td>Percent Who Have Ever Been Tested for HIV</td>
<td>39.0%</td>
<td>32.5%</td>
<td>50.8%</td>
<td>60.7%</td>
<td>33.3%</td>
<td>45.0%</td>
<td>51.3%</td>
</tr>
</tbody>
</table>

Notes: Data are for women aged 18 and older, except for the percent of women who have had a mammogram in the past two years. Racial groups are non-Hispanic. Hispanics may be of any race or two or more races. Source: Analysis of Behavioral Risk Factor Surveillance System microdata.

Health behaviors and preventive care also vary by race and ethnicity. Among women aged 18 and older in Chester County, White women are the most likely to exercise at least 150 minutes per week (51 percent), but have higher than average rates of smoking and are the second most likely to say they have engaged in binge drinking at least once in the preceding month (Table 35). Among women aged 50 and older in Chester County, Black women—who have the highest breast cancer mortality rate—and Asian/Pacific Islander women are the most likely to say that they have had a mammogram in the past two years. Among women aged 18 and older, Asian/Pacific Islander, Black, and Hispanic women are the most likely to say they have had a pap test in the past three years. Black women are the most likely to have ever been tested for HIV (60.7 percent) and to have been screened for cholesterol in the past five years (65.8 percent).
Conclusion
Some measures of women’s health status have shown signs of progress since the early 2000s, but in other ways women’s health status has worsened. Women are less likely to die from heart disease, breast cancer and lung cancer, but more likely to experience poor mental health, have their activities limited by their health status, and to be diagnosed with diabetes or chlamydia. In addition, the suicide mortality rate among women has increased. The implementation of the Affordable Care Act has changed the landscape of health care for women, providing more women access to preventive care and other services, yet some women continue to face barriers to obtaining the services they need. Ensuring that women have adequate access to preventive care, health care services and information about specific health conditions is integral to promoting the good health women need to work, pursue educational and career opportunities, achieve economic security and maintain their overall well-being.

Mortality rates for heart disease, lung cancer, breast cancer and the incidence of AIDS for women in Chester County decreased between 2002 and 2013. The median percentage of women in Chester County who have ever been told they have diabetes; the rate of reported cases of chlamydia; the median number of days per month women aged 18 and older in the reported experiencing poor mental health; the suicide mortality rate; and the median number of days per month on which women aged 18 and older reported that their activities were limited by their mental or physical health status increased between 2002 and 2013.

The heart disease mortality rate in Chester County is lower than the state rate but higher than the national rate. Black women in the United States, Pennsylvania, and Chester County have the highest heart disease mortality rates. Black women in Pennsylvania and Chester County also have significantly higher rates of lung cancer mortality compared to Black women across the United States, and are more likely die of lung cancer than any other racial or ethnic group in the state and county. Similarly, breast cancer mortality rates for women in Chester County are lower than national and state rates. Across racial and ethnic groups, Black women in the United States, Pennsylvania and Chester County have the highest mortality rates from breast cancer. In Chester County, rates of diabetes across all racial and ethnic groups are higher than rates in the United States, and higher among Black women than either the state or nation. The rate of AIDS among adolescent and adult women (aged 13 and older) declined in Pennsylvania and Chester County between 2001 and 2012. The rate of AIDS among Black women in the United States, Pennsylvania and Chester County is higher than for any other racial and ethnic group. The rate of chlamydial infection increased in the United States, Pennsylvania and Chester County in the same time period. Among the largest racial and ethnic groups, Black women had the highest rate of reported cases of chlamydia in 2013. There are fewer overweight and obese women in Chester County compared to the United States and Pennsylvania. Black women in the United States, Pennsylvania and Chester County are the most likely to be overweight or obese.

Women in Chester County reported fewer days of limited activity per month as a result of poor health than women in Pennsylvania and the United States. In Chester County, Native American and Hispanic women report more days per month in which their activity is limited due to health status. Among women aged 18 and older in Chester County, White women are the most likely to exercise at least 150 minutes per week (51 percent). But have higher than average rates of smoking and are the second most likely to say they have engaged in binge drinking at least once in the preceding month. Among women aged 50 and older in Chester County, Black women—who have the highest breast cancer mortality rate—and Asian/Pacific Islander women are the most likely to say that they have had a mammogram in the past two years and are the racial group most likely to have ever been tested for HIV and to have been screened for cholesterol in the past five years.
While the overall number and rate of increase in is lower than the state and nation, women in Chester County are also reporting increases in the number of days per month that they experience poor mental health. In Chester County, Native American women, women of two or more races and Hispanic women reported the highest number of poor mental days per month.
Emerging Issues and Advocacy Opportunities

**Older Women’s Health**

As women age, they are more likely to experience chronic health conditions (Crescioni et al. 2010; Robinson 2007) and limitations in activities of daily living (Kaiser Family Foundation, 2013b). Many older women do not have a spouse or relative who can provide the care they need, in part because women have a longer life expectancy than men (U.S. Census Bureau, 2012), often marry men who are older than they are, and are less likely than men to remarry following divorce or spousal death (Livingston, 2014). Older women’s lower likelihood of having a spouse, combined with their greater health care needs and larger share of the elderly population, means that they have higher average expenditures for home health care services and long-term care than men (Robinson, 2007).

Given older women’s lower socioeconomic status, tendency to experience more chronic health conditions than men and greater longevity, the financing of their health care is an especially important issue. Medicare, the federal health program that provides health coverage to Americans aged 65 and older and younger adults with permanent disabilities, is a key source of health insurance for older women. More than half (56 percent) of all older Medicare recipients are women, and women constitute two-thirds of Medicare beneficiaries aged 85 and older (Kaiser Family Foundation, 2013b). Medicare helps cover the costs of a range of basic medical care services, but the program has important gaps in coverage and charges relatively high cost sharing that can result in higher out-of-pocket expenses for recipients (National Partnership for Women and Families, 2012). Among Medicare beneficiaries, older women have higher expenses than older men, with the difference in out-of-pocket expenses the largest among women and men aged 85 and older ($7,555 for women and $5,835 for men) (Kaiser Family Foundation, 2013b). The average out-of-pocket expenditures for older women who receive Medicare increase with age (Kaiser Family Foundation, 2013b), which means that the highest expenditures come as some women’s financial resources are becoming more limited or depleted.

The Affordable Care Act includes some provisions that address the gaps in Medicare coverage. In addition to the ACA’s coverage of annual wellness visits and some preventive benefits that previously required co-pays—a financial barrier for many older women with low incomes and limited financial resources in retirement—the legislation begins to close a gap in coverage for prescription drugs that some individuals who use Medicare’s Part D drug benefit encounter and will fully close the gap by 2020 (National Partnership for Women and Families, 2012). The ACA created the Center for Medicare and Medicaid Innovation to support the development and testing of new payment and service delivery models that improve the quality of care and lower costs. It also funds hospitals and community-based groups to provide transitional care services (from a hospital to home or another care facility) to high-risk beneficiaries to help make these transitions smoother and safer (National Partnership for Women and Families, 2012). Since older women are more likely than older men to be Medicare recipients and to require transitional care services, these changes will especially benefit older women.

**Women’s Access to Health Care Services and Resources**

Health insurance gives women access to critical health services. In the United States in 2013, 81.5 percent of nonelderly women (aged 18–64) had health insurance coverage, a higher proportion than men of the same age range (77.1 percent) (IWPR, 2015a). These data do not reflect the full implementation of the Patient Protection and Affordable Care Act (ACA) of 2010, which enacted measures to expand access to affordable health insurance coverage for those who lack coverage,
including creating state-based exchanges through which individuals can purchase coverage (with premium and cost-sharing benefits available to those with low incomes); establishing separate exchanges through which small businesses can purchase health insurance coverage for their employees; and seeking to expand Medicaid eligibility to all individuals under age 65 who are not eligible for Medicare and have incomes up to 138 percent of the federal poverty line (Kaiser Family Foundation, 2013a). Recent data show that women’s health insurance coverage has increased substantially since the implementation of the ACA. Between 2008 and 2014, uninsurance rates for women of all ages dropped by almost one-fifth, from 13 percent of women lacking coverage in 2008 to 10.6 percent in the first nine months of 2014 (Martinez and Cohen, 2009; 2015).

The ACA has also changed the landscape of health care coverage for women in the United States by requiring health plans to cover annual well-woman visits and preventive services such as mammograms and pap tests with no cost sharing. State policies do continue to contribute to women’s health status in important ways. States can choose to opt out of the Medicaid expansion; as of March 2016, 31 states, including Pennsylvania, and the District of Columbia had adopted the expansion, and six were deciding whether to do so (Kaiser Family Foundation, 2016). Research indicates that women in states that had not chosen to expand Medicaid coverage may especially struggle to access needed services. One report found that in the 22 states that had not expanded Medicaid coverage as of October 2014, more than three million women with low incomes fall into a “coverage gap” and have no affordable coverage options (National Women’s Law Center, 2014).

Other factors also limit many women’s access to health care resources, such as a lack of transportation, substantial travel time needed to get to the doctor and limited availability of health care services in one’s community (Kullgren et al., 2012). Immigrant women and men face multiple barriers in accessing basic health coverage, including a federal law that bans many immigrants from means-tested benefit programs such as Medicaid in their first five years of legal status (Broder and Blazer, 2011; National Immigration Law Center, 2014).

The Health Status of LGBT Women

LGBT women face health disparities that may stem from a variety of factors, including the stresses of being part of a sexual minority, societal stigma toward the LGBT community, barriers to accessing health insurance and outright denial of care due to sexual orientation or gender nonconforming behavior (Grant et al., 2011; Institute for Medicine, 2011; Lick et al., 2013; Rangy et al., 2014).

- Research indicates that lesbian and bisexual women aged 18 and older are less likely than heterosexual women to describe their health as excellent or very good (53.4 percent and 55.5 percent, respectively, compared with 59.8 percent) (Ward et al., 2014). Among men, the pattern differs: those who identify as gay are the most likely to say their health is excellent or very good (66.2 percent, compared with 63.6 percent of bisexual men and 61.6 percent of heterosexual men).

- Analysis of data from one survey of nearly 5,000 LGBT individuals in the United States found that nearly 56 percent of respondents reported having faced discrimination in a health care setting, including being refused needed care, having a health care professional use excessive precautions or refuse to touch them, being blamed for their health status or having a health care professional use harsh or abusive language toward them (Lambda Legal, 2010). Such discrimination may mean that LGBT women do not receive the care they need.

- One study analyzing Gallup-Healthways Well-Being Index data found that LGBT women are
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... considerably more likely than non-LGBT women (29 percent compared with 16 percent) to report that they do not have a personal doctor. Among LGBT and non-LGBT men, the difference is not significant (29 percent and 27 percent, respectively) (Gates, 2014).

- Among women aged 20 and older, lesbian (36.7 percent) and bisexual women (40.9 percent) are considerably more likely to be obese than heterosexual women (28.3 percent) (Ward et al., 2014).

- Lesbian (25.7 percent) and bisexual women (28.5 percent) aged 18 and over are more likely than heterosexual women (15.0 percent) to be current cigarette smokers (Ward et al., 2014).

- Bisexual women aged 18 and older are more than twice as likely as heterosexual women of the same age range to report consuming five or more alcoholic drinks in one day at least once in the past year (33.8 percent compared with 14.3 percent). Lesbian women (25.8 percent) also are more likely than heterosexual women to report having had at least five alcoholic drinks in one day in the past year (Ward et al., 2014).

- LGBT women (29 percent) are more likely than LGBT men (21 percent) and non-LGBT women and men (19 and 15 percent, respectively) to say that they did not have enough money for health care needs at least once in the past year (Gates, 2014).

- Lesbian and bisexual women aged 18 and older are more likely than heterosexual women to report having experienced serious psychological distress in the past 30 days. Approximately 10.9 percent of bisexual women and 5.3 percent of lesbian women say they have recently experienced serious distress, compared with 4.2 percent of heterosexual women (Ward et al., 2014).

- LGBT youth are more likely to experience mood and anxiety disorders, depression and suicidal ideation and attempts than their non-LGBT counterparts (Institute for Medicine, 2011). Analysis of Youth Risk Behavior Surveys conducted between 2001 and 2009 found that the prevalence of attempted suicide among high school students during the 12 months before the survey ranged from: 3.8 to 9.6 percent (median: 6.4 percent) among heterosexual students; 15.1 to 34.3 percent (median: 25.8 percent) among gay or lesbian students; 20.6 to 32.0 percent (median: 28.0 percent) among bisexual students; and 13.0 to 26.7 percent (median: 18.5 percent) among students who describe themselves as unsure of their sexual orientation (Kann et al., 2011).

- Transgender adults often face specific challenges to maintaining good health, including harassment and discrimination in medical settings, economic insecurity and lack of access to health insurance, refusal of care and lack of knowledge among providers about the health care needs of transgender persons (Grant, Mottet and, Tanis, 2011). Analysis of the National Transgender Discrimination Survey found that 19 percent of respondents reported having been refused care due to their transgender or gender nonconforming status, 28 percent said they had experienced verbal harassment in medical settings and 50 percent reported having to teach their medical provider about transgender care. One in four respondents (26 percent) reported having used drugs or alcohol to cope with the impacts of discrimination (Grant, Mottet, and Tanis, 2011).
Millennial Women’s Health

Establishing good health behaviors and practicing preventive medical care is critical to millennial women’s ability to maintain good health as they age (Behavioral Risk Factor Surveillance System).

- Only about half (49.4 percent) of millennial women in the United States get at least 150 minutes per week of moderate or vigorous physical activity (such as running, calisthenics, gardening or walking for exercise) outside of their jobs.

- Approximately one in five millennial women (19.9 percent) report that they eat five or more servings of fruits and vegetables per day.

- One in five millennial women (20 percent) say they have engaged in binge drinking (defined for women as drinking four or more drinks on one occasion) in the past month. Nationally, more than one in three millennial men (35 percent) report having engaged in binge drinking (defined for men as drinking five or more drinks on one occasion).

- Millennial women report having, on average, 4.9 days per month of poor mental health, compared with 3.6 days for millennial men and 4.3 days for women overall.

- Nearly half of young women (46.5 percent) in the United States are overweight or obese, defined as having a body mass index of 25 or greater.

- More than nine in 10 young women in the United States (94 percent) say they have had a pap test in the past three years.
VIOLENCE & SAFETY

Introduction
Over the last few decades, the nation has made considerable progress in addressing the violence and abuse many women experience at the hands of partners, acquaintances and strangers. Since the 1970s, the movement to end partner abuse has led to many reforms in the United States (and worldwide) on the part of federal agencies, the criminal justice system, child welfare programs and others that have increased protections for women and children (Aron and Olson 1997; Stark, 2012a).

Despite this progress, threats to women’s safety continue to profoundly affect their economic security, health, civic engagement, and overall well-being. For many women, experiences with violence and abuse make it difficult to pursue educational opportunities (Riger et al., 2000) and to perform their jobs without interruption (Logan et al., 2007; Riger et al., 2000). Although contextual factors such as poverty status and racial/ethnic background correlate with the prevalence of victimization, no one remains immune (Benson and Fox, 2004; Breiding et al., 2014). Violence and abuse affect women and girls from all walks of life.

This section of the Blueprint Report examines many of the major topics that advocates in this area have prioritized, including intimate partner violence and abuse, rape and sexual assault, stalking, workplace violence and sexual harassment, teen dating violence and bullying, gun violence and human trafficking. Because quantitative data on these issues are limited, especially at the state and county level, the report provides an overview of available data on selected indicators. The report also considers state laws intended to protect survivors, where information on these laws has been compiled and analyzed by experts in the field. Such laws may increase women’s safety but may also fall short of providing the full range of protections that women need.

Intimate Partner Violence and Abuse
The Prevalence of Intimate Partner Violence and Abuse

Domestic (or intimate partner) violence is a pattern of behavior in which one person seeks to isolate, dominate and control the other through psychological, sexual and/or physical abuse (Breiding et al., 2014). According to analysis of the 2011 Centers for Disease Control and Prevention’s National Intimate Partner and Sexual Violence Survey (NISVS), nearly one in three women (31.5 percent) experiences physical violence by an intimate partner at some point in her lifetime. A smaller, but still substantial, percentage experience partner stalking (9.2 percent), rape (8.8 percent, or other sexual violence by an intimate partner (15.8 percent; Figure 29).17 Nearly half of all women experience, at some point in their lifetimes, psychological aggression from an intimate partner. This aggression—which is arguably the most harmful component of intimate partner violence (Stark 2012b)—includes both expressive aggression, such as name calling, and attempts to monitor, threaten or control their partner’s behavior (Figure 29).

17 Other sexual violence includes “being made to penetrate, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences” (Breiding et al., 2014).
Many victims experience more than one of these forms of harm. Perpetrators often combine attempts to subjugate and control victims with physical and sexual violence, creating a condition of “entrapment” that undermines victims’ physical and psychological integrity (Stark, 2012b). Nearly four in 10 female victims interviewed for the 2010 NISVS reported having experienced more than one form of partner violence (Black et al., 2011). Approximately 14 percent said they experienced physical violence and stalking; nine percent reported experiencing rape and other forms of physical violence by an intimate partner; nearly 13 percent said they experienced rape, other physical violence, and stalking; and a very small percentage said they experienced both rape and stalking by an intimate partner (Black et al., 2011).

**Intimate Partner Violence by Race and Ethnicity**

The prevalence of intimate partner violence and abuse varies across the largest racial and ethnic groups. In the United States, it is estimated that more than half of Native American and multiracial women, more than four in 10 Black women, three in 10 White and Hispanic women, and three in 20 Asian/Pacific Islander women have experienced physical violence by an intimate partner (Figure 30). An even higher proportion have experienced psychological aggression: more than six in 10 Native American and multiracial women report having experienced psychological aggression by an intimate partner, as have more than half of Black women, more than four in 10 White and Hispanic women, and three in 10 Asian/Pacific Islander women (Figure 30). Sexual violence within intimate partner relationships also affects a disturbingly large share of the population. Breiding et al. (2014) estimate that about 11 percent of women who identify with two or more races, 10 percent of White women, 9 percent of Black women, and 6 percent of Hispanic women have experienced rape by an intimate partner. A larger proportion—27 percent of multiracial women, 17 percent of Black and White women, and 10 percent of Hispanic women—have experienced sexual violence other than rape by an intimate partner (Breiding et al., 2014). Data on sexual violence other than rape are not available for Asian/ Pacific Islander or Native American women.

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18 As a result of smaller sample sizes, the 95 percent confidence intervals published by the CDC suggest that the estimates for women of color on rape, sexual violence other than rape, physical violence, and psychological aggression contain more sampling variability than the estimates for non-Hispanic White women.
While state and county-level data for intimate partner violence are not available, the incidence of physical violence and psychological aggression against women in Chester County can be estimated according to national trends. Figure 31 shows the distribution of women by race and ethnicity in Chester County in 2014. If national estimates for intimate partner violence against women are applied to the female population of Chester County, approximately 122,527 women in 2014 had experienced psychological aggression and 81,845 had experienced physical violence at the hands of their partners at some point in their lifetimes.

The issue of domestic violence against women and girls in Chester County was addressed in focus group discussions. Participants overwhelmingly agreed that instances of domestic violence are underreported in Chester County and that resources for victims of domestic violence are scarce. Focus group participants also discussed the lack of education around this issue and called for increased efforts to raise awareness.

**Intimate Partner Violence and Older Women**

Violence and abuse can affect women of all ages, including in the later stages of life. One study
analyzing data from the National Crime Victimization Survey—which focuses on violent crime, not including economic domination or psychological abuse—found that the rate for IPV victimization among older women (aged 50 and older) in the United States is 1.3 per 1,000; while this rate is much lower than the victimization rate for younger women (9.7 per 1,000 women aged 18–24, 12.1 per 1,000 women aged 25–34 and 9.6 per 1,000 women aged 35–49) (Catalano, 2012a), the prevalence of elder IPV may be higher than the social science literature reports (Rennison and Rand, 2003).\textsuperscript{19} Older women are also at risk for other forms of family violence, including abuse from adult children and from other institutional and non-institutional caregivers. One statewide study found that unlike younger women, older women were more likely to be abused by non-intimate family members than intimate partners (Klein et al., 2008).

Older women who experience intimate partner or family violence and abuse may face challenges in accessing services and extricating themselves from abusive situations. Adult protective services in all states serve older women who are abused, yet these services focus primarily on frail, elderly victims, and most abuse cases do not come to their attention. Shelters and services for abused women are also generally set up to address the needs of younger women with children (Brandl and Cook-Daniels, 2011). Older women—who may have been out of the workforce for some time or lack the skills to obtain a living-wage job—may also find that leaving their abusive spouse could leave them without financial security and health insurance, at a time when they most need it (Rennison and Rand, 2003). Older women who experience violence and abuse may have even fewer options than their younger counterparts.

**Domestic Violence Fatality Review Teams**

Domestic violence is sometimes fatal: in 2012, 924 women in the United States were killed by their spouse or by an intimate partner (Violence Policy Center, 2014). To reduce domestic violence-related deaths, many states have established domestic violence fatality review teams (DVFRTs) that bring together professionals from different fields—including health, education, social services, criminal justice and policy—to review fatal and near fatal domestic violence cases to identify trends and patterns, offer recommendations and track the implementation of those recommendations (Sullivan and Websdale, 2006). Domestic violence fatality review teams—which vary in their size, composition, and review processes—focus on developing best practices and implementing coordinated, cross-disciplinary approaches to meet the needs of domestic violence survivors and reduce fatalities in their local communities (Sullivan and Websdale, 2006). A 2013 report found that 32 states had enacted legislation establishing Domestic Violence Fatality Review teams; some domestic and sexual violence coalitions, state governments and local municipalities have also developed such teams without legislative direction (Durborow et al., 2013).

The Pennsylvania Domestic Violence Fatality Review Project was established in 2004 and is administered by the Pennsylvania Coalition Against Domestic Violence (PCADV, 2010). PCADV, however, has contracted with a newspaper clipping service to chronicle domestic violence fatalities in Pennsylvania since 1998, and has produced its annual Domestic Violence Homicide/Fatality Report since that time. The mission of the project is to examine domestic violence-related homicides and suicides in an effort to reduce domestic violence in Pennsylvania. The project focuses its efforts on improving public and systems’ understanding of domestic violence; increasing safety for victims and accountability for perpetrators of domestic violence; and making recommendations for systems

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\textsuperscript{19} Some older women—who were socialized during a time when society provided domestic violence victims with little support—may be reluctant to report abuse (Rennison and Rand 2003).
enhancements to improve domestic violence investigation, intervention and prevention.

The project has established a partnership between a state-level Domestic Violence Fatality Review Advisory Group and local, community-based domestic violence fatality review teams. This two-level (state/local) structure allows for flexibility at the local level to accommodate varying procedures, and continuity and comparability of information at the state level. Pennsylvania is home to seven local domestic violence and/or women’s death review teams. As of 2010, existing teams are located in Berks, Bucks, Cambria, Centre, Montgomery, York and Philadelphia counties. These teams review homicides, suicides and suspicious deaths. The examination of these incidents leads to recommendations for improvement in systems, enhanced prevention and intervention strategies, and greater coordination among systems responding to domestic violence. Recommendations from these teams range from changing an intake form for a local health care provider to creating a new statewide law to address a particular issue.

Local efforts are complemented by the state-level Domestic Violence Fatality Review Advisory Group. This group is charged with supporting and assisting the local teams; coordinating, collating, and analyzing local data; and producing statewide recommendations for system improvement. In addition to representatives from local fatality review teams, the statewide advisory group includes representatives from the Pennsylvania State Police, the District Attorneys’ Association, the Coroners’ Association, the Sheriffs’ Association, the Pennsylvania Coalition Against Rape, the Pennsylvania Commission on Crime and Delinquency, the Office of the Victim Advocate, the Attorney General’s Office, the disabilities community, batterers’ intervention services, members of the bench, legislative staff, domestic violence advocates and others.

In consultation with the Domestic Violence Fatality Review Advisory Group, PCADV proposed legislation (the Pennsylvania Domestic Violence Fatality Review Act) that would statutorily establish a statewide fatality review process. The legislation was first introduced in the 2005-06 legislative session, then reintroduced in the 2007-08 legislative session as Senate Bill 595 and House Bill 1215. The legislation was defeated; the PCADV is currently examining options for reintroduction and/or pursuing the project without legislative enactment.

Figure 32. Pennsylvania Domestic Violence Fatalities by Gender, 2014

Source: PCADV, 2014.

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20 Women’s Death Review Teams are different from domestic violence fatality review teams in that they examine deaths caused by factors other than (although including) domestic violence. Women’s Death Review Teams are in Philadelphia and Cambria counties; the remaining teams are domestic violence fatality review teams.
The proposed Domestic Violence Fatality Review Act would, in essence, formalize the current work of PCADV and enhance its ability to conduct comprehensive reviews, aggregate data and produce reports and recommendations. The proposed act would codify the existing structure of a state advisory body working in conjunction with local community-based teams. At the state level, the proposed act would establish a partnership between the PCADV and the attorney general’s office as co-administrators of the project. The legislation does not mandate the establishment of local review teams, but rather respects that the effort to establish and administer review teams must be driven at the local level.

According to PCADV’s 2014 Fatality Report, there were 141 domestic violence-related deaths in Pennsylvania: 97 victim deaths and 44 perpetrator deaths. Of the victim deaths, 61 percent (59) were women and 39 percent (38) were men (Figure 32); 38 percent (37) were White, 23 percent (22) were Black, 5 percent (5) were Hispanic and 34 percent (33) were of unknown origin (Figure 33).

![Figure 33. Pennsylvania Domestic Violence Fatalities by Race and Ethnicity, 2014](image)

Source: PCADV, 2014.

Domestic violence-related deaths in Pennsylvania, including victims and perpetrators, decreased by 11 percent from 158 in 2013 to 141 in 2014. The total number of victims who were killed decreased by approximately 9 percent from 107 in 2013 to 97 in 2014 (PCADV, 2014). The total reported domestic violence-related deaths reported in Chester County for 2014 were four, of whom two were victims and two were perpetrators (PCADV, 2014). Of all Pennsylvania counties, Chester County has the ninth highest count of domestic violence fatalities (39) since 2004 (PCADV, 2014). In response to one of those fatalities, Chester County District Attorney Tom Hogan stated, “This crime is another tragedy of domestic violence. Two children have been left without a mother. There is no excuse and no good explanation for this sort of violence” (6abc 2014). In 2015, Hogan announced that Chester County was leading the state “in its use of the Lethality Assessment Program, considered a best practice to protect the safety of victims of domestic violence” (ChaddsFordLive, 2015). “LAP is about saving lives. Many victims do not realize the danger they are in at the hands of their abusers until they go through the LAP screening or are already badly injured, and the latter is too late, Deputy District Attorney Michelle Frei, the county’s lead domestic violence prosecutor, said in a release. Once the LAP screening takes place, domestic violence victims hopefully will recognize the danger and reach out for the services that we have available here in Chester County. The goal is to identify the danger before the case turns into a homicide” (ChaddsFordLive, 2015).

In addition to monitoring domestic violence fatalities, PCADV works with 60 community domestic violence centers and local law enforcement to assess the potential lethality risk of domestic violence.
calls made to police (PCADV, 2014). Lethality Assessment Program (LAP) officers who respond to domestic violence calls ask brief screening questions to identify certain risk factors in intimate partner relationships. If officers identify a high-risk victim, they connect the victim with a domestic violence program and an advocate, who helps put a safety plan in motion. Seventy percent of Pennsylvania domestic violence victims who were screened by police in 2013 were found to be at high risk of dying at the hands of their abuser (intimate partner). Of this group, 69 percent chose to speak to a hotline advocate immediately. The following 27 municipalities and organizations in Chester County participated in the Pennsylvania LAP in 2014:

- Caln Township
- City of Coatesville
- Downingtown Borough
- East Brandywine Township
- East Coventry Township
- East Fallowfield Township
- East Pikeland Township
- Easttown Township
- Kennett Square Borough
- Lincoln University
- Malvern Borough
- New Garden Township
- North Coventry Township
- Oxford Borough
- Parkesburg Borough
- Phoenixville Borough
- Spring City Borough
- Tredyffrin Township
- Uwchlan Township
- Valley Township
- West Caln Township
- West Brandywine Township
- Borough of West Chester
- West Chester University
- West Goshen Township
- West Whiteland Township
- Westtown-East Goshen Regional

Unmet Needs for Services and Supports

While many domestic violence victims seek assistance from anti-violence programs and services in their local areas, services are not always available to them. In September 2015, the National Network to End Domestic Violence conducted its annual one-day count of domestic violence shelters and services across the country (National Network to End Domestic Violence, 2015b). Nationally, 87 percent of all identified local domestic violence service programs were surveyed (1,649 out of 1,905). The programs surveyed served 66,581 adults and children in a single day, offering services such as individual and/or children’s support or advocacy, emergency shelter, court or legal services and transportation services. On that one day, 9,641 requests for services went unmet, 60 percent (5,778) of which were for housing. Multiple factors contribute to these unmet needs, including reduced funding for domestic violence services and lack of staff resources to administer them (National Network to End Domestic Violence, 2015b). The number of unmet needs varies greatly by state, with states that have larger population sizes generally having more instances of unmet needs.

On Sept. 16, 2015, all 60 domestic violence programs in Pennsylvania, including the Domestic Violence Center of Chester County, participated in the 2015 National Census of Domestic Violence Services (Table 36). On that day, participating programs nationwide served 2,600 victims of domestic violence:

- 1,332 domestic violence victims (697 children and 635 adults) found refuge in emergency shelters or transitional housing provided by local domestic violence programs;
- 1,268 adults and children received non-residential assistance and services, including counseling, legal advocacy and children’s support groups;
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- 748 hotline calls were answered; 2,475 individuals in communities across Pennsylvania attended 74 training sessions; and,
- 444 requests for services were unmet, of which 84 percent were for housing (National Network to End Domestic Violence, 2015b).

Many programs reported a critical shortage of funds and staff to assist victims in need of services. In addition to housing and emergency shelter, programs reported that of the service requests they could not meet, rental assistance/utilities and attorney/legal representation services were most in demand.

Across Pennsylvania, during the past year 23 individual services at local programs were reduced or eliminated: 15 percent of programs reported government funding cuts; 15 percent of programs reported staffing cuts or reductions; 5 percent of programs reported reductions in private funding; and, 3 percent of programs reported fewer individual donations (National Network to End Domestic Violence, 2015b).

Focus group participants discussed the reticence of women to seek help in instances of domestic violence as well as a number of reasons why women remain in abusive relationships. Several participants noted that the perception of social stigma is a strong disincentive for women to seek help. Participants also observed that a lack of financial independence often contributes to a woman’s decision to remain in an abusive relationship.

Table 36. Percentage of Programs Providing Services in Pennsylvania as Reported by the 2015 National Census of Domestic Violence Services

<table>
<thead>
<tr>
<th>Services Provided by Local Programs</th>
<th>September 16, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Support or Advocacy</td>
<td>98%</td>
</tr>
<tr>
<td>Children’s Support or Advocacy</td>
<td>82%</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>80%</td>
</tr>
<tr>
<td>Court or Legal Accompaniment/Advocacy</td>
<td>72%</td>
</tr>
<tr>
<td>Transportation</td>
<td>40%</td>
</tr>
<tr>
<td>Legal Representation by an Attorney</td>
<td>28%</td>
</tr>
<tr>
<td>Bilingual Advocacy</td>
<td>25%</td>
</tr>
<tr>
<td>Homicide Reduction Initiative/Lethality Assessment</td>
<td>22%</td>
</tr>
</tbody>
</table>


Rape and Sexual Violence
Sexual violence and rape are alarmingly common and pose a serious threat to women’s health and well-being. One study analyzing data from the 2011 NISVS found that in the United States, 19.3 percent of women are raped at some time in their lives and 43.9 percent experience sexual violence other than rape (Breiding et al., 2014). The perpetrator is often someone the victim knows: almost half of the female rape victims surveyed (46.7 percent) said they had at least one perpetrator who was an acquaintance and a similar proportion (45.4 percent) said they had at least one perpetrator who was an intimate partner (Breiding et al., 2014).

Nearly eight in 10 female rape victims were first raped before age 25 and approximately 40 percent were raped before age 18 (Breiding et al., 2014). Victimization at a young age is associated with revictimization later in life. One report analyzing the 2010 NISVS found that more than one-third of women who were raped as minors were also raped as adults, compared with 14 percent of women who had no history of victimization prior to adulthood (Black et al., 2011).
Campus Sexual Assault

One in five women are sexually assaulted while in college (Krebs, Lindquist, Warner, Fisher, & Martin, 2007). Ninety percent of these offenses on college campuses are never reported. Consistent with the trends of rape and sexual violence overall, the vast majority of campus sexual assaults are committed by an acquaintance of the victim (Fisher, Cullen, & Turner, 2000). Alcohol is also a significant contributor to campus sexual assault. Of the self-reported perpetrators, 75 percent reported that they had used alcohol prior to their most recent incident (Kingree & Thompson, 2014).

Chester County’s five colleges and universities (Table 37) reported offenses related to dating violence and sexual assault in the time period of 2012 through 2014. Four of the five schools reported forcible sexual offenses, stalking and rape. Studies suggest that the number of offenses is significantly higher as sexual assault is often under-reported. More than 90% of victims on college campuses do not report the assault (Fisher, Cullen, & Turner, 2000).

The statistics provided represent offenses reported to campus security and/or local law enforcement agencies. All postsecondary institutions are required to submit this information annually. In 2013, Congress reauthorized the Violence Against Women Reauthorization Act and included provisions to improve campus safety. This included the addition of reporting the number of domestic violence, dating violence and stalking incidents that occur on campus in addition to the longstanding requirement to disclose other crimes, including sexual assault incidents (AAUW).

Table 37. Number of Campus Sexual Assault Offenses from 2012-2014 reported by the postsecondary institutions in Chester County to the U.S. Department of Education

<table>
<thead>
<tr>
<th>Offenses</th>
<th>Cheyney U.</th>
<th>Immaculata U.</th>
<th>Lincoln U.</th>
<th>U. of Valley Forge</th>
<th>West Chester U.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dating Violence</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fondling</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Rape</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sex offenses-Forcible</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Stalking</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: The Campus Safety and Security Data Analysis Cutting Tool
Note: PSU- Great Valley was excluded as it does not include on-campus housing.

Violence and Safety Among Teen Girls

Youth violence—especially bullying and teen dating violence—is a serious public health concern for girls and boys. The Centers for Disease Control and Prevention’s 2014 Youth Risk Behavior Survey finds that nearly one in four (23.7 percent) girls and one in six (15.6 percent) boys reported having experienced bullying on school property one or more times in the 12 months prior to the survey. Twenty-one percent of girls, and 8.5 percent of boys, said they had been bullied in the past 12 months through electronic means such as e-mail, chat rooms, websites, instant messaging, and texting. Also, 8.7 percent of high school girls and 5.4 percent of high school boys did not attend school at least once in the previous 30 days because they felt unsafe either at school or traveling to and/or from school (Figure 34). State and local data for Pennsylvania are not available.
Figure 34. Percent of High School Students Feeling Unsafe or Experiencing Bullying by Gender, United States, 2014

Notes: For students in grades 9–12. The percent of those who experienced bullying are for the 12 months prior to the survey; the percent of those who did not go to school is for the 30 days prior to the survey. Source: Centers for Disease Control and Prevention’s 2014 Youth Risk Behavior Survey.

Thirteen percent of girls and 7.4 percent of boys who dated or went out with someone during the 12 months before the survey said they experienced physical dating violence, including being hit, slammed into something or injured on purpose. About 14.4 percent of girls and 6.2 percent of boys who dated or went out with someone during the 12 months before the survey said they had experienced sexual dating violence, including kissing, touching or being physically forced to have sexual intercourse by someone they were dating (Figure 35).

Figure 35. Percent of High School Students Experiencing Dating Violence in the Past 12 Months by Type of Violence and Gender, 2014

Notes: For students in grades 9–12. The percent of those who experienced bullying are for the 12 months prior to the survey; the percent of those who did not go to school is for the 30 days prior to the survey. Source: Centers for Disease Control and Prevention’s 2014 Youth Risk Behavior Survey.

Several other national studies indicate that as technology has advanced, “electronic” abuse has become a significant issue in teen relationships. A survey of 615 teens aged 13–18 and 414 parents of teens of this age range, for example, found that in 2006, 25 percent of teens reported having been called names, harassed or put down by their partner via cell phone or texting. Twenty-two percent reported having been asked by cell phone or the internet to engage in unwanted sexual activity, and 19 percent said their partner has used a cell phone or the internet to spread rumors about them.
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(Picard, 2007). In another study that examined the prevalence of electronic dating abuse among 5,647 seventh- to 12th-grade youth from 10 schools in three Northeastern states, 29 percent of girls and 23 percent of boys in a current or recent dating relationship said they had been a victim of electronic abuse in the past year (Zweig et al., 2013).

Despite the sizable number of teens who experience violence or bullying, few states recognize teens as domestic violence victims, and state laws vary considerably with respect to the protections and services they provide for youth (Break the Cycle, 2010). The nonprofit organization Break the Cycle’s State Law Report Cards assess aspects of each state’s civil protection order laws that are relevant to teens facing domestic and dating violence and provide additional information about services available to teens experiencing these forms of harm. States were assigned grades on the basis of teens’ access to civil protection orders, access to critical services and school response to dating violence. Only the District of Columbia and six states—California, Illinois, New Hampshire, Oklahoma, Rhode Island and Washington—received an A. Pennsylvania received a D (Break the Cycle, 2010).

Pennsylvania’s State Law Report Card notes that while all minors can consent to sensitive services such as contraception services, HIV/STI testing and treatment, prenatal care and other medical care, parental notice is required. Minors in Pennsylvania can obtain protection from abuse orders (PFAs), but the law does not specify whether PFAs can be granted against minor abusers. Pennsylvania does allow people in sexual relationships to seek PFAs against their abusers. Pennsylvania law does not provide for a school response to dating violence. In light of these facts, Break the Cycle recommended the following policy and legislative changes: allow minors to petition for PFAs on their own behalf and explicitly describe the procedure for doing so; allow courts to issue PFAs against minors; explicitly allow individuals in dating relationships to access PFAs; and allow all minors to access all sensitive services without parental involvement (Break the Cycle, 2010). To date, these recommendations have not been implemented.

Focus group participants also discussed the need for education about violence against women as a protective measure. Participants across groups agreed that both adolescent girls and boys should be exposed to the prevalence of domestic violence and intimate partner abuse. Education in this area should address how to recognize early signs of abuse, how to avoid abusive relationships, and how to end abusive relationships. This type of education is not widespread in Chester County. Of the 178 organizations and agencies that responded to the Nonprofit and Provider Snapshot Survey, only 13 (7 percent) offer programs or activates related to violence and safety.

Stalking

Prevalence of Stalking and Common Stalking Behaviors

Stalking is an unfortunately common crime in the United States. A 2009 study by the Bureau of Justice Statistics found that during a 12-month period between 2005 and 2006, an estimated 3.3 million people aged 18 and older were stalked; the majority of victims were female, with those who are divorced or separated especially at risk (Catalano, 2012b). Another study found that an estimated 15.2 percent of adult women and 5.7 percent of adult men in the United States have been stalked at some point in their lifetimes (Breiding et al., 2014). Nearly seven in 10 victims are stalked by someone they know (Catalano, 2012b). Studies have found that intimate partner stalkers are more violent and threatening than non-intimate partner stalkers (Mohandie et al., 2006; Palarea et al., 1999), and that partner stalkers tend to stalk their victims more frequently and more intensely than non-partner stalkers (Mohandie et al., 2006).
Stalking is defined as “a course of conduct directed at a specific person that would cause a reasonable person to feel fear” (Catalano, 2012b). Common stalking behaviors include leaving unwanted messages, sending unsolicited e-mails or letters, spreading rumors about the victim, following or spying on her or him and leaving unwanted gifts (Catalano, 2012b). Many victims suffer serious effects from such behaviors; even when stalking does not lead to physical violence, most victims experience psychological harm (Blauw et al., 2002; Brewster, 1999). Some also experience financial disruption, especially those who are forced to move or leave their jobs (Mullen, Pathe, and Purcell, 2009). Research suggests that stalking creates enormous problems for women’s participation in the labor force; many victims experience disruption in their work life, job performance problems and harassment at work (Logan et al., 2007; Swanberg and Logan, 2005). Perpetrators may show up at the victim’s workplace, make threatening phone calls to their co-workers, and use other harassing behaviors that make it difficult for victims to sustain employment (Swanberg and Logan, 2005).

Stalking poses a serious threat to personal safety in part because it is difficult to prosecute. Many stalking victims often do not report their experiences to the police because they do not think the incidents are serious or consider them a private matter (National Center for Victims of Crime, 2002). Even when it is reported, the crime can be difficult for the criminal justice system to address. Stalking can be hard for law enforcement officers to identify, since the perpetrator’s behaviors may be recognized as harmful only when understood within the broader framework of the perpetrator’s course of conduct, which may involve behaviors that in another context would be considered harmless, such as sending letters or making phone calls to the victim. The unpredictable nature of stalking behaviors makes it difficult to predict if, and when, these behaviors may lead to physical harm (National Center for Victims of Crime, 2002).

While stalking is an extremely difficult crime to address and prosecute, states have taken steps to offer victims greater protection. Although all 50 states, the District of Columbia, and the federal government have passed laws that criminalize stalking (Catalano, 2012b; National Center for Victims of Crime, 2007), the intent of these laws is often not carried out in practice. The laws were created to protect victims from a series of actions that add up to criminal abuse, yet research indicates that prosecutors often do not use stalking statutes to address this crime. They are more likely to charge stalking behaviors as harassment or domestic violence-related crimes, such as assault or violation of a protective order (Klein et al., 2009; Tjaden and Thoennes, 2000)—a decision that can be particularly significant in jurisdictions where stalking constitutes a felony and most domestic violence charges are misdemeanors (Klein et al., 2009).

**Stalking Statutes in Pennsylvania**

Pennsylvania’s stalking law defines the crime as repeated harassment that creates substantial emotional distress. According to current criminal statutes in Pennsylvania, the stalker must complete at least two acts of unwanted stalking behavior, no matter how close or far apart in time they are, and the victim must experience reasonable fear of serious bodily injury or substantial emotional distress. A conviction of stalking is a misdemeanor of the 1st degree. If the defendant has a prior conviction for stalking the same victim, it is considered to be a felony of the 3rd degree (PCADV, 2012).

Protection from abuse (PFA) orders are an additional form of protection available to stalking victims. A PFA order allows the police to arrest the stalker even if they did not witness the stalking behavior. Pennsylvania courts are required to accept and process a PFA petition without charging a filing fee (PCADV, 2012). In order to obtain a PFA, victims must prove that they are either related to the stalker, is/was married to the stalker, has children with the stalker, or has/had an intimate relationship.
with the stalker (either sexual or dating), and that they were followed or contacted by the stalker for no lawful reason and are afraid that the stalker will cause them serious bodily injury (PCADV, 2012).

If a criminal complaint is filed against the stalker, a victim may be eligible for a victim/witness protective order. This is a type of order that prosecutors may request for victims and witnesses in any criminal case, including stalking cases. A victim/witness protective order will allow police to arrest the stalker more quickly. The court may order the stalker to stay away from the victim’s home, work, school or neighborhood. In order for a criminal victim/witness protective order to be issued, a criminal complaint must be filed; the prosecutor must request the protection from the court; and, the court must find there is substantial evidence that the victim/witness has been or is likely to be intimidated (PCADV, 2012).

**Civil Protection Orders**

To address stalking and domestic violence victims’ need for safety, states have enacted statutes authorizing civil protection orders (CPOs). First initiated by Pennsylvania in 1976 (Goldfarb 2008), CPOs have been enacted by statute in all 50 states and the District of Columbia (American Bar Association Commission on Domestic & Sexual Violence, 2014; Goldfarb, 2008). Civil protection orders are an important legal resource for women experiencing intimate partner or other family violence. Research suggests that protection orders reduce violence and the fear many victims experience, although they may be less effective for those who have experienced severe violence (Logan et al., 2009).

Not all victims who want a civil protection order are able to obtain one. Many individuals who pursue this legal recourse face significant barriers, including difficulty in navigating the legal system, discouragement from clerks handling the paperwork, limited hours of access to file the petition, difficulty taking off work or arranging for child care to follow through with the process (Logan et al., 2009) and difficulty meeting a state’s criteria for obtaining a protective order (Eigenberg et al., 2003).

**Violence and Safety Among LGBT Women and Youth**

LGBT Americans face heightened exposure to hate crimes and physical violence. Although one study that analyzed four national surveys found that the proportion of adults in the United States who identified as LGBT ranged from 2.2 to 4.0 percent (Gates, 2014), sexual orientation-based hate crimes made up about 21 percent of hate crimes reported by law enforcement in 2014 to the Bureau of Justice Statistic’s Uniform Crime Reporting program (U.S. Department of Justice, 2015). This percentage is probably an underestimate, given that state and local agencies are not required to release statistics to the FBI and a number of LGBT survivors of hate violence may not report their abuse to the police (National Coalition of Anti-Violence Programs, 2014).

An analysis of the 2010 National Intimate Partner Violence Survey finds that bisexual women are significantly more likely than heterosexual or lesbian women to have experienced violence: 46.1 percent of bisexual women aged 18 and older report having experienced rape, 74.9 percent report having experienced sexual violence other than rape, 36.6 percent say they have been stalked, and 61.1 percent report having experienced intimate partner violence (Table 38). Among lesbian and heterosexual women, the prevalence of these forms of violence is considerably lower.
Table 38. Lifetime Prevalence of Violence by Type of Violence and Sexual Orientation, United States, 2010

<table>
<thead>
<tr>
<th></th>
<th>Rape</th>
<th>Sexual Violence Other than Rape</th>
<th>Stalking Victimization</th>
<th>Intimate Partner Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual Women</td>
<td>46.1%</td>
<td>74.9%</td>
<td>36.6%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Lesbian Women</td>
<td>13.1%</td>
<td>46.4%</td>
<td>N/A</td>
<td>43.8%</td>
</tr>
<tr>
<td>Heterosexual Women</td>
<td>17.4%</td>
<td>43.3%</td>
<td>15.5%</td>
<td>35.0%</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual Men</td>
<td>N/A</td>
<td>47.4%</td>
<td>N/A</td>
<td>37.3%</td>
</tr>
<tr>
<td>Gay Men</td>
<td>N/A</td>
<td>40.2%</td>
<td>N/A</td>
<td>26.0%</td>
</tr>
<tr>
<td>Heterosexual Men</td>
<td>.7%</td>
<td>20.8%</td>
<td>N/A</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

Note: N/A = insufficient sample size. Intimate partner violence includes rape, physical violence, and/or stalking by an intimate partner. Source: Walters, Chen, and Breiding, 2013.

LGBT youth are also vulnerable to violence and discrimination. One study, which analyzed data from the 2013 National School Climate Survey, found that during the 2012–2013 school year an 74.1 percent of LGBT students aged 13 to 21 were verbally harassed because of their sexual orientation and 55.2 percent were verbally harassed because of their gender expression (Figure 36). Almost one in three (32.6 percent) were physically harassed (e.g., being shoved or pushed) because of their sexual orientation and more than one in five (22.7 percent) were physically harassed because of their gender expression. A smaller, but still substantial, percentage of LGBT students were physically assaulted because of their sexual orientation or gender expression (Figure 36). Forty-nine percent of LGBT students experienced cyberbullying, and more than half (55.5 percent) reported personally experiencing LGBT-related discriminatory policies or practices at school (Kosciw et al., 2015). LGBT students who experienced higher levels of victimization had lower GPAs than those who experienced lower levels of victimization. They were also more than three times as likely to miss school in the month before the survey, twice as likely to have no plans to pursue postsecondary education, and had lower self-esteem and greater levels of depression (Kosciw et al., 2015).

Figure 36. Percent of LGBT Students Experiencing Verbal Harassment, Physical Harassment or Physical Assault in the Past School Year Based on Sexual Orientation or Gender Expression, United States, 2014

Note: Students aged 13 to 21.
Source: Compilation of data based on the 2014 National School Climate Survey (Kosciw et al., 2015).
The Consequences of Violence and Abuse
Domestic violence, abuse, harassment and stalking have a multitude of individual and societal consequences. At the societal level, female victims of intimate partner violence over the age of 18 in the United States lose about 5.6 million days of household productivity and nearly eight million days of paid work each year, which amounts to approximately 32,000 full-time jobs. 1995 is the most recent year for which an estimate is available, and the costs of domestic violence in the United States were estimated to be $5.8 billion, with $4.1 billion paying for direct medical and mental health services (the study did not include civil and criminal justice costs) (Max et al. 2004). In 2015 dollars, these costs would be about $8.9 billion, with approximately $6.3 billion for direct medical and mental health services.

Violence and abuse also have profound psychological, health, and social consequences for victims. In the short term, these forms of harm can result in serious physical injuries. These injuries, however, are only a part of the consequences many women face: the ongoing and controlling nature of abuse can lead victims to experience a range of chronic physical conditions, such as frequent headaches, chronic pain, difficulty sleeping and activities limitations (Black et al., 2011). Survivors may also experience mental health problems such as depression, suicidality and posttraumatic stress disorder (Black et al., 2011). Violence and abuse are also associated with negative health behaviors, including smoking, physical inactivity, poor nutrition and substance abuse (McNutt et al., 2002). Over time the negative physical and mental health outcomes that survivors may experience can interfere with their daily functioning, disrupting their employment and other dimensions of their lives (Loya, 2014). In some instances, the unaddressed psychological and social effects of violence and abuse can lead to an ongoing cycle of harm. Research indicates, for instance, that girls who experience physical violence are more likely to be victimized as adults (Whitfield et al., 2003). According to the Centers for Disease Control, the impact of intimate partner violence can manifest itself in increased health care costs for victims for more than 15 years (Centers for Disease Control, 2016).

Conclusion
These sobering realities point to the need to continue working to enhance our understanding of violence and abuse and to develop effective responses to the multiple forms of harm that women face. At a basic level, this requires improving data collection in the area of violence and abuse by ensuring that survey data are available with sufficiently large samples to allow for analysis at the state level and by race and ethnicity, age, sexual orientation and other contextual factors. Having improved data will allow researchers to pinpoint the needs of various populations and will help advocates, policymakers, and others to strengthen effective institutional, political and community responses.

Increasing women’s safety is integral to elevating their overall status. Violence and abuse have devastating consequences that go beyond physical injury to undermine women’s autonomy, liberty and dignity, preventing them from fully participating in the economy and in civic and political life (Stark 2012b). Often the non-physical abuse women experience is not or cannot be categorized as a crime and, therefore, falls outside the scope of the legal protections available. Improving effective responses to these forms of harm entails developing laws and policies that reflect a broader perspective on what victims are facing (Stark 2012b), as well as continuing to invest in programs and services that address the threats to safety that prevent women’s full participation in social, political and economic life. If national estimates for intimate partner violence against women 18 and older are applied to the female population of Chester County, approximately 100,176 women will experience psychological aggression and 66,817 will experience physical violence at the hands of their partners at some point in their lifetimes.
POLITICAL PARTICIPATION

Introduction
The equal participation of women in politics and government is integral to building strong communities and a vibrant democracy in which women and men can thrive. By voting, running for office and engaging in civil society as leaders and activists, women shape laws, policies and decision-making in ways that reflect their interests and needs, as well as those of their families and communities.

Public opinion polling shows that women express different political preferences than men, even in the context of the recent recession and recovery, when the economy and jobs topped the list of priorities for both women and men. A poll conducted by the Pew Research Center (2012) found that women express concern about issues such as education, health care, birth control, abortion, the environment and Medicare at higher rates than men. Women's engagement in the political process—both voting and running for office—is essential to ensuring that these issues are addressed in ways that reflect their needs. Research indicates that women in elected office make the concerns of women, children and families integral to their policy agendas (Center for American Women and Politics, undated; Swers, 2013).

Women today constitute a powerful force in the electorate and inform policymaking at all levels of government. Yet, women continue to be underrepresented in governments across the nation and face barriers that often make it difficult for them to exercise political power and assume leadership positions in the public sphere. This chapter presents data on several aspects of women's involvement in the political process in the United States: voter registration and turnout, female state and federal elected and appointed representation, and state-based institutional resources for women. It examines how women fare on these indicators of women's status, the progress women have made and where it has stalled, and how racial and ethnic disparities compound gender disparities in specific forms of political participation.

Women’s Political Status: Significant Indicators
The Institute for Women's Policy Research (2004; 2015) identifies four significant component indicators of women’s political status. These include: voter registration, voter turnout, representation in elected office and women’s institutional resources. Voter registration measures the percent of all women aged 18 and older who reported registering for presidential and congressional elections. Voter turnout measures the percent of all women aged 18 and older who voted in presidential and congressional elections. Representation in elected office measures the proportion of office-holders who are women for four levels: state representatives; state senators; statewide elected executive officials and U.S. representatives; and U.S. senators and governors. Women’s institutional resources measures the number of institutional resources for women available in a given state, including a commission for women (established by legislation or executive order), a campaign training program for women, a women’s political action committee (PAC), and a state chapter of the National Women’s Political Caucus (NWPC) (IWPR, 2015).

Based on these four component indicators, IPWR assigned each state and the District of Columbia a Political Participation Composite Score. Across the 50 states, composite scores range from a high of 14.40 to a low of -8.12, with the higher scores reflecting a stronger performance in this area of women’s status and receiving higher letter grades (IWPR, 2015). New Hampshire has the highest
score for women’s overall levels of political participation. It ranks in the top one-third for women’s voter registration and voter turnout and is first in the nation for women in elected office. Utah has the lowest levels of women’s political participation. The state ranks in the bottom 10 for women’s voter registration, women’s voter turnout and women in elected office, and is 36th for its number of institutional resources.

Pennsylvania ranks in the bottom 10 of all states and the District of Columbia (Table 39). It received an overall score of -5.29; is ranked 45th of 51; and, received a grade of D-. Its lowest ranking on the four component indicators is representation in elected office (48) and its highest ranking is in women’s institutional resources (11).

Table 39. Pennsylvania Women’s Status on the Political Participation Composite Index, 2012

<table>
<thead>
<tr>
<th>Composite Index</th>
<th>Women in Elected Office Index</th>
<th>Percent of Women Registered to Vote, 2010/2012 Average</th>
<th>Percent of Women Who Voted, 2010/2012 Average</th>
<th>Women’s Institutional Resources Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>-5.29</td>
<td>1.02</td>
<td>66.9</td>
<td>51.4%</td>
</tr>
</tbody>
</table>

Source: IWPR, 2015.

Trends in Women’s Political Participation: United States and Pennsylvania

Between 2004 and 2015, the number and share of women in state legislatures and in the U.S. Senate and House of Representatives increased, while the number and share of women in statewide elective executive office declined (CAWP, 2015a; IWPR, 2004). The percentage of women who registered to vote also was lower in the 2010/2012 elections than in the 1998/2000 elections, but the percentage of women who went to the polls increased during this period (CAWP, 2015a).

Twenty of 100 members of the U.S. Senate (20 percent) and 84 of 435 members of the U.S. House of Representatives (19.3 percent) are women in 2016. These numbers represent an increase since 2004, when women held 14 of 100 seats in the U.S. Senate and 60 of 435 seats in the U.S. House of Representatives (CAWP, 2016a; IWPR 2004). Even though seats held by women in the U.S. Congress are at an all-time high, their share of seats is well below women’s share of the overall population. Pennsylvania has two senators in the U.S. Senate and 18 representatives in the U.S. House of Representatives; none are women.

In 2016 women hold 1,363 of 5,411 seats in state house assemblies (25.2 percent) and 445 of 1,972 state senate seats (22.6 percent) across the country, compared with 1,659 of 7,382 seats (22.5 percent) in state legislatures in 2004 (CAWP 2016a; IWPR 2004). While the number of women serving in state legislatures has more than quintupled since 1971, the share of seats held by women in state legislatures across the country is well below women’s share of the overall population. Nine of the 50 (18 percent) Pennsylvania Senate seats and 37 of the 203 (18 percent) Pennsylvania House of Representatives seats are held by women in 2016 (CAWP, 2016b).

The number of women in statewide elective executive office21 declined from 81 (of 315) in 2004 to 77 (of 312) in 2016 (CAWP 2004a; CAWP 2016). The Attorney General, Kathleen Kane, is the first woman elected to serve in this position and is currently the only woman serving in a Pennsylvania

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21 Statewide elected executive offices include Governor, Lieutenant Governor, Attorney General, Secretary of State, State Treasurer/Chief Financial Officer, State Auditor, State Comptroller, Chief State Education Officer, Commissioner of Insurance, Commissioner of Labor, Corporation Commissioner, Agriculture and Commerce Commissioner, Public Service Commissioner, Public Utilities Commissioner, and Railroad Commissioner.
statewide elected executive office in 2016 (CAWP, 2016). She is not seeking reelection this year.

In the 1998 and 2000 elections combined, 64.6 percent of women aged 18 and older in the United States registered to vote and 49.3 percent voted. In the 2010 and 2012 elections combined, 64.3 percent of U.S. women registered to vote, and 50.6 percent went to the polls (CAWP, 2015a). In Pennsylvania, 66.9 percent of women aged 18 and older registered to vote in the 2010 and 2012 elections and 51.4 percent voted (Table 38). Participation in Pennsylvania regarding these indicators is up compared to voter registration and turnout from the 1998 and 2000 elections, which was 62.3 percent and 47.3 percent, respectively (IWPR, 2004).

Voter Registration and Turnout

Voting is a critical way for women to express their concerns and ensure that their priorities are fully taken into account in public policy debates and decisions. By voting, women help to choose leaders who represent their interests and concerns. Although women in the United States were denied the right to vote until 1920, and in the following decades were often not considered serious political actors (Carroll and Zerrili, 1993), women today have a significant voice in deciding the outcomes of U.S. political elections. In the nation as a whole, women make up a majority of registered voters and have voted since 1980 at higher rates in presidential elections than men (Center for American Women and Politics, 2015c).

Women's stronger voter turnout relative to men's in the United States reflects an ongoing worldwide struggle to increase women's political participation. Efforts at the national level to expand opportunities for women to engage in the political process, and the international movement for women's rights, have helped to make the inclusion of women in the electorate acceptable in countries around the world. Although women's political participation varies among nations, women today vote in all countries with legislatures except Saudi Arabia, sometimes at higher rates than men (Paxton, Kunovich, and Hughes 2007).

In the United States, women are considerably more likely to be registered to vote and to go to the polls than men: 61.5 percent of women were registered to vote in the 2010 midterm election and 42.7 percent voted, compared with 57.9 percent of men who registered to vote and 40.9 percent who cast a ballot (U.S. Department of Commerce, 2011). In the 2012 general election, 67 percent of women were registered to vote and 58.5 percent voted, compared with 63.1 percent and 54.4 percent of men (U.S. Department of Commerce, 2013). Registration and turnout are higher for both women and men in presidential election years than in midterm election years, when, in terms of national office, only members of Congress are elected.

Women's voting rates vary across the largest racial and ethnic groups. In 2012 Black and non-Hispanic White women had the highest voting rates among the total female population aged 18 and older, at 66.1 percent and 64.5 percent, respectively (U.S. Department of Commerce, 2013). Their voting rates were approximately twice as high as the rates for Hispanic women (33.9 percent) and Asian women (32.0 percent; published rates from the U.S. Census Bureau are not available for Native American women). The higher voting rate among Black women compared with non-Hispanic white women reflects a shift that first occurred in the 2008 elections, differing from the voting patterns of the elections up to 2004, when a larger share of white women had voted compared with any other group of women (U.S. Department of Commerce, undated). This change likely stems from the presence of Barack Obama, the first African American to be a major party nominee for president, on the general election ballot (Philpot, Shaw, and McGowen, 2009).
National voting rates also vary considerably among women of different ages. Young women have a much lower voting rate than older women. In the 2012 election, 41.3 percent of women aged 18–24 voted, compared with 58.5 percent of adult women. Women aged 65–74 had the highest voting rate in 2012 at 70.1 percent, followed by women aged 75 years and older (65.6 percent), women aged 45–64 years (65.0 percent), and women aged 25–44 years (52.6 percent) (U.S. Department of Commerce, 2013). Overall, 81.7 million women reported having registered to vote in 2012 and 71.4 million voted, compared with approximately 71.5 million men who said they had registered to vote and 61.6 million who cast a ballot (Figure 37).

![Figure 37. Voter Registration and Turnout aged 18 and older by Gender, United States, 2012](image)

**Note:** Numbers represent millions.

**Source:** U.S. Department of Commerce, 2013.

Women’s voter registration rates vary across states. In 2012, women were more likely to be registered to vote than men in all but three states: Alaska, Montana and New Hampshire. Mississippi and Louisiana had the highest voter registration rates for women in 2010/2012 at 80.8 percent and 76.9 percent, respectively. Women’s voter registration is lowest overall in the western part of the United States. Hawaii had the lowest reported women’s voter registration rate in 2012 at 52.3 percent, followed by California (53.8 percent) and Nevada (56.2 percent) (IWPR, 2015). In Pennsylvania, 66.9 percent of women registered to vote in the 2010/2012 elections (Table 38).

Women’s voter turnout also varies among the states. Wisconsin had the highest women’s voter turnout in the country in 2010/2012 at 64.8 percent, followed by Maine (64.3 percent) and Mississippi (63.3 percent). Women’s voter turnout was lowest in Texas in 2010/2012, where only 40.9 percent of women reported voting (IWPR, 2015). In Pennsylvania, 51.4 percent of women turned out to vote in the 2010/2012 elections (Table 38).

### Women in Elected Office

**Trends in Women’s Share of Elected Officials**

Although women have become increasingly active in U.S. politics, the majority of political office holders at the state and federal levels are still male. In 2016, women hold just 104 of 535 (19.4 percent) seats in the U.S. Congress, 1,808 of 7,383 (24.5 percent) seats in the nation’s state legislatures, and 77 of 312 (24.7 percent) statewide elective executive offices (Table 40). Among women of color, the level of representation is especially low: women of color—who constitute approximately 18 percent of the population aged 18 and older (IWPR 2015b)—hold about 6.2 percent of seats in the U.S. Congress, 5.4 percent of seats in state legislatures, and 2.9 percent of statewide
elective executive positions (CAWP, 2016). Pennsylvania has two senators in the U.S. Senate and 18 representatives in the U.S. House of Representatives; none are women.

Table 40, Women of Color in Elected Offices in the United States and Pennsylvania, 2016

<table>
<thead>
<tr>
<th>Women in the U.S. Congress</th>
<th>From Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>U.S. Senate</td>
<td>20 of 100</td>
</tr>
<tr>
<td>Women of Color</td>
<td>1</td>
</tr>
<tr>
<td>U.S. House</td>
<td>84 of 435</td>
</tr>
<tr>
<td>Women of Color</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women in State Legislature</th>
<th>From Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>State Senate</td>
<td>445 of 1972</td>
</tr>
<tr>
<td>Women of Color</td>
<td>102</td>
</tr>
<tr>
<td>State House</td>
<td>1,363 of 5411</td>
</tr>
<tr>
<td>Women of Color</td>
<td>296</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women in Statewide Executive Elected Office</th>
<th>From Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Statewide Executives</td>
<td>77 of 312</td>
</tr>
<tr>
<td>Women of Color</td>
<td>9</td>
</tr>
</tbody>
</table>


While these figures reflect substantial advances for women over the last several decades, little progress has been made in recent years. In 1980 women held 3 percent of seats in the U.S. Congress, 10 percent of state legislature seats and 11 percent of statewide elective executive offices. The percentage of seats in the U.S. Congress held by women is now six times larger, and the percentage of state legislature and statewide elective executive offices held by women has more than doubled. However, between 2010 and 2016, women’s representation in Congress grew only minimally, from 16.8 percent to 19.4 percent. During this same time period, their representation in statewide elective executive offices also barely changed (increasing slightly from 22.6 percent to 24.5 percent), and their representation in state legislatures decreased from 24.3 percent to 24.2 percent (Figure 38).
Research suggests that women generally win elected office at similar rates as men (Dolan, 2004), but fewer women run for office (Lawless and Fox, 2010). Other studies emphasize the barriers women face nearly every step of the way (Baer and Hartmann, 2014). Women are less likely than men to decide to run on their own and need to be recruited to run for office (Carroll and Sanbonmatsu, 2013), yet women are much less likely than men to be encouraged to run (Lawless and Fox, 2010) and to have access to networks of political leaders who could help them get elected (Goetz, 2007). For some women, the lack of supportive policies for working families in the United States—such as subsidized child care and paid maternity and caregiving leaves—may be a deterrent to running for elected office. One study that investigated how women make the decision to run for elected office also found that in some cases women are discouraged by political party leaders, their peers or other elected officeholders from running for or serving in higher offices (Baer and Hartmann, 2014).

**Women in Elected Office: Chester County**

According to the 2016 Legislative Directory for Chester County (League of Women Voters, 2016), only the 155th legislative district is represented by a woman, State Representative Becky Corbin (R), who was elected in 2013. The 155th district includes 10 municipalities: Caln Township, Downingtown, East Brandywine Township, East Caln Township, South Coventry Township, Uwchlan Township, West Brandywine Township, West Pikeland Township and West Vincent Township. There are no women from Chester County serving in the Pennsylvania State Senate or the U.S. Congress.

Three commissioners, two of whom are women, make up the Chester County Board of Commissioners: Kathi Cozzone (D), vice chair, and Michelle Kichline (R). Both were elected in 2015 and are currently serving four-year terms. Sheriff Carolyn "Bunny" Welsh is the first woman to be elected sheriff of Chester County. She is one of two female sheriffs in the Commonwealth of Pennsylvania, and one of only 38 female sheriffs in the nation. Several other county-wide elected offices are held by women, including the clerk of courts, the register of wills and the treasurer. None, however, are women of color. Chester County has 57 townships with 212 elected supervisors, 16 percent (34) of whom are women. There are 23 women tax collectors and 48 women auditors in townships across the county. Chester County has 15 boroughs. Three boroughs have women mayors. Of 101 elected council members, 31.2 percent (32) are women. Across the county’s boroughs, there are seven women tax collectors and three women auditors (personal communication...
with Trish Fagan, Chester County Association of Township Officials). Of elective judicial positions in Chester County, four of 18 Chester County Court of Common Pleas judges are women (chesco.org) and four of 15 magisterial district court judges are women. No female judges in Chester County are women of color. Statewide, two of six Supreme Court justices are women nine of 17 Pennsylvania Superior Court judges are women; and six of 13 Commonwealth Court Judges are women (PA Courts, 2016).

Christine Kimmel was elected as the first female supervisor of East Marlborough Township (Unionville-Chadds Ford area) in 2015. Nearby Pocopson Township made local history as the first township in Chester County to elect an all-female board of supervisors. Supervisors Alice Balsama and Elaine DiMonte joined incumbent Ricki Stumpo in 2016. The only other all-female board of supervisors in the region (Philadelphia and its four surrounding counties) sits in Yeadon Township, Delaware County. An analysis of regional election results conducted by the Philadelphia Inquirer in 2015 revealed that although women make up 52 percent of the population, only 25 percent of the seats on councils and boards are held by women (McDaniel and McCabe, 2015). Officeholders and political analysts interviewed for the same study acknowledged progress in this area, but generally described the climate at the state and local levels as slow to welcome women’s voices.

Local officials echo a national conversation about the lack of gender parity in government. Observers cite many reasons for the imbalance, including higher expectations for female candidates, a dearth of female political role models, and the fact that women simply run less often. In fact, research shows that men and women win elections at nearly identical rates (CAWP, 2016). Out of nearly 900 candidates who ran for council member, supervisor or commissioner in Southeastern Pennsylvania in 2015, just one in four was a woman. Such disproportionate gender representation at local levels has implications for national politics as well. Gender can influence the kinds of policies that are passed and an absence of women serving in lower offices can mean an absence of women running for higher ones.

**Women’s Institutional Resources**

In addition to women’s voting and election to local, state and federal offices, institutional resources dedicated to helping women succeed in the political arena and to promoting and prioritizing women’s policy issues play a key role in connecting women constituents to policymakers. Institutional resources include campaign training for women, women’s Political Action Committees (PACs), women’s commissions and state chapters of the National Women’s Political Caucus (NWPC). These institutional resources serve to amplify the voices of women in government and increase the access of women, their families and their communities to decision-makers on the policy issues that matter most to them. Institutional resources and statewide associations also provide peer support systems for elected female officials and establish informal networks that can help them navigate a political system that remains predominantly male (Strimling, 1986).

Campaign training for women provides valuable insight into running successful campaigns and strengthens the pipeline to higher office. One study found that nine in 10 women who participated in a training before running found it extremely helpful; many also believed that campaign training should be expanded to be more women-centric so as to address the issue of “campaigning-while-female” (Baer and Hartmann, 2014). Experienced women candidates also expressed a need for a range of candidate training, from running for one’s first office to running for a seat in one’s congressional delegation, which as a national office requires the candidate to learn a new range of skills. Most training, however, seems to be aimed at encouraging women to run for their first office.
The Pennsylvania Center for Women and Politics (PCWP) is the only organization to focus on women's political involvement in Pennsylvania. The center, located at Chatham University in Pittsburgh, integrates disciplinary knowledge, civic education and coalition building, and examines the intersection of women and public policy. The center conducts candidate and advocacy training, offers educational programs in applied politics and provides analysis on women’s issues. Its training offerings include the National Education for Women (NEW) Leadership Pennsylvania, an intensive, weeklong residential leadership and public policy institute designed to educate young women about future political participation and leadership; and Ready to Run Pennsylvania, which provides bipartisan political training to encourage women to run for government leadership positions. Targeting women considering or recently deciding to run for political office, Ready to Run provides training and mentoring by campaign professionals, political women and officeholders. It is part of the Ready to Run National Training Network of the Center for American Women and Politics (CAWP) at Rutgers University (Pennsylvania Center for Women and Politics, 2016).

Political action committees (PACs) raise and spend money for the purpose of electing and defeating candidates. A PAC may give directly to a candidate’s committee, a national party committee or another PAC, within the contribution limits (Open Secrets, 2015). A women’s PAC may be critical to supplying a female candidate with the campaign contributions she needs to launch a successful campaign. A women’s PAC may also bolster candidates who support women-friendly policy and legislation. In 2014 there were 23 national and 47 state or local PACs or donor networks that either gave money primarily to women candidates or had a primarily female donor base (CAWP, 2014).

Represent! PA, a state PAC established in southeastern Pennsylvania, focuses on raising money to increase the number of Democratic women in elected office in Pennsylvania by providing early campaign donations to strong candidates who need the investment to hire campaign staff. In 2015 Represent! PA created a separate federal PAC dedicated to electing more Democratic women to U.S. Senate seats and governors’ offices (Represent! PA, 2016). Pennsylvania NOW, the state chapter of the National Organization for Women, also sponsors a state PAC. NOW, the largest feminist political organization in the United States, is a statewide grassroots nonprofit volunteer organization with over 13,000 contributing members and 20 local chapters in Pennsylvania. The PA NOW PAC endorses political candidates whose platforms are consistent with the broader PA NOW mission (Pennsylvania State National Organization for Women, 2016).

A women’s commission is typically established through legislation or executive order and works to prioritize issues that disproportionately affect women’s lives (National Conference of State Legislatures, 2014c). In many states across the nation, women’s commissions—which can operate at the city, county or state level—strive to identify inequities in laws, policies and practices and recommend changes to address them. Women’s commissions may engage in a variety of activities to benefit women in their geographic areas, such as conducting research on issues affecting the lives of women and families, holding briefings to educate the public and legislators on these issues, developing a legislative agenda and advocating for gender balance in leadership throughout both the public and private sectors (National Association of Commissions for Women, 2014c).

The Pennsylvania Commission for Women, which consists of volunteer members, is responsible for advising the governor on policies and legislation that impact women; supporting economic and civic opportunities for women; encouraging mentoring programs for girls and young women; identifying programs and opportunities for the benefit and advancement of women; and, serving as a resource center for Pennsylvania women (Pennsylvania Commission for Women, 2016).

The Chester County Women's Commission (CCWC) of Pennsylvania was established in 1993 by the
Chester County Commissioners. The CCWC’s purpose is to provide regular input on the status and needs of women in Chester County through legislative advocacy and other activities in the areas of health care, economics and education. The commission is comprised of volunteer members who are appointed by the Chester County Commissioners. Appointments are designed to ensure that the diverse interests of Chester County women are represented (Chester County Women’s Commission, 2016).

From focusing their extended network of women on poverty in an affluent county to linking local businesses with nonprofit organizations for mutual benefit or having one-on-one meetings with local legislators, the diverse women of the CCWC volunteer their time and talent to further the commission’s mission of empowering the women of Chester County to reach their highest potential. Residing throughout the county, the group is a cross section of county women who represent different races, ethnic backgrounds, education levels and employment status.

Conclusion
Although there are many institutions that promote women’s civic engagement and political participation, obstacles to women’s political participation and leadership persist. Women’s lesser economic resources compared with men’s, their greater caregiving responsibilities, their more limited access to important supports that would help them to run for office and succeed as office holders, and the greater scrutiny that women candidates seem to face from the public and the media, all restrict women’s political participation and leadership in states across the nation. Progress in advancing women’s political status continues to move at a sluggish pace. In 2016, women’s representation at all levels of government remains well below their share of the overall population. Efforts to recruit more women to run for office and to increase their success as candidates and office holders will be crucial to increasing their representation in the future.

Women in Pennsylvania and Chester County continue to struggle for political representation. Nine of the 50 (18 percent) Pennsylvania Senate seats and 37 of the 203 (18 percent) Pennsylvania House of Representatives seats are held by women. While the number of women serving in state legislatures has increased in the past several decades, the share of seats held by women in state legislatures across the country is well below women’s share of the overall population. Chester County also lags in terms of representation of women of color in elected offices. Such disproportionate gender and racial representation at local levels has implications for national politics as well. Gender can influence the kinds of policies that are passed and an absence of women serving in lower offices can mean an absence of women running for higher ones.
Emerging Issues and Advocacy Opportunities

Campaigning-While-Female

“Campaigning-while-female” refers to experiences that many women running for elective office believe are different from men’s. Campaigning-while-female highlights experiences that differ from incidents of discrimination. Discrimination is seen in instances where women candidates and elected officials may receive fewer resources such as campaign donations and party financial support, or fewer opportunities to sponsor legislation or participate in influential committees (Baer and Hartmann, 2014). Campaigning-while-female refers to a range of inappropriate and sexist comments and behaviors, such as a focus on outward appearance, questioning of qualifications for office and increased curiosity about a woman’s personal life, such as her role as a wife and mother. While male candidates may also experience unwelcome curiosity about their private lives, women believe these concerns are expressed much more strongly to women candidates, including frequent comments to single women regarding their dating lives (Baer and Hartmann, 2014). Women candidates and elected officials have expressed the need to be always “on,” to always observe societal norms for how a woman in leadership should act and look. Many have experienced this “double bind” and seek to overcome it; they act like strong leaders, but hope to escape the stigma of being labeled an aggressive woman (Political Parity, 2014).

Campaigning-while-female is relatively common; one study of women candidates and elective officials found that approximately nine in 10 (88 percent) participants said women’s campaign experiences are different from men’s (Baer and Hartmann, 2014). The most notorious example of campaigning-while-female came about during the 2008 presidential election, when Democratic candidate Hillary Clinton and Republican vice presidential nominee Sarah Palin were often portrayed as the “bitch” and the “ditz” (New York Magazine, 2008). This sexist treatment is most commonly associated with media coverage, but women also receive it from constituents, donors, peers and colleagues, and political party operatives and leaders.

The sexist treatment of women candidates and elected officials may dissuade women from running for political office, or may influence a voter’s likelihood of supporting a female candidate (Lake Research Partners, 2010). In one survey of 800 likely voters nationwide, both female and male participants who heard sexist attacks by the media on a hypothetical female candidate were less likely to vote for her than the control group that heard a non-sexist attack on the candidate. There was also backlash against the male candidate for issuing sexist attacks. However, the female candidate endured the greatest toll on her favorability and the likelihood that a voter might vote for her. However, when the female candidate or a surrogate called out the sexist treatment by the media, support for the female candidate strengthened (Lake Research Partners, 2010). This finding emphasizes the importance of candidates and supportive networks calling out double standards and unfair treatment not only by the media but also by other candidates (Political Parity, 2014).

Barriers to Political Office for Women

Women’s active participation in elective office is critical to ensuring the democratic character of the United States; still, women are largely underrepresented at every level of office, and progress toward achieving parity has nearly stalled.

In a recent report, Shifting Gears: How Women Navigate the Road to Higher Office (Hunt Alternatives Fund, 2014), Political Parity, a program of the Hunt Alternatives Fund, has identified the barriers women face in seeking political office, especially in attempting to move to higher political office (such
An Update to the Blueprint Report: Leveraging Progress

as governorships and positions in the U.S. Congress). The report uses the analogy of the “driver” and “the road” to describe the debate in the political science field about whether women are holding themselves back because they have less ambition (Lawless and Fox, 2012) or whether women are held back by various potholes and barriers along the road (Baer and Hartmann, 2014; Carroll and Sanbonmatsu, 2013). It suggests that both the driver and the road are essential. Women are often seen to perform as well as men when they campaign for office—with similar fundraising totals and electoral success—yet fewer women decide to pursue candidacy.

One study attributes the underrepresentation of women in higher office to a gender gap in political ambition (Lawless and Fox, 2012). The study analyzed data from a survey of 4,000 male and female potential candidates—those who are well-situated to pursue candidacy—and found that 62 percent of the men, compared with 46 percent of the women, had ever considered running for office; 22 percent of the men, compared to 14 percent of the women, were interested in running for office in the future. A separate, qualitative, study of 60 women candidates who have run for the U.S. Congress or for state and local offices (or have seriously considered running for office) identified barriers women face to running for higher office and action items for increasing the number of women in elected office. Among the most cited barriers were: fundraising, which must be ramped up to a much higher level when running for Congress or a statewide office—making the ask, developing relationships with donors so that when asked they respond, and having access to good call lists as well as campaigning while female, balancing family obligations and office holding with campaigning; and the dominance of informal, male political networks that often exclude women (Baer and Hartmann, 2014).

Proposed action items for increasing the number of female officeholders include recruiting and asking women to run; expanding and enhancing woman-centered campaign training, especially ongoing training that emphasizes pursuing politics as a career and making long-term plans for strategically choosing which offices to seek; launching an organized effort to build the pipeline to political office and improve strategic race placement; providing for mentoring and sponsorship of women candidates and elected officials; increasing understanding of fundraising, which includes building relationships with sponsors, who may be established office holders or those who do not hold political office but often support candidates they think can be successful; strengthening networks of women’s organizations; raising awareness among the public of female role models and increasing respect for women; and making campaigning and office holding more family-friendly (Political Parity, 2014). Many of these strategies require that outside groups, such as a strengthened network of women’s organizations, become more active in supporting women who run for office (Baer and Hartmann, 2014; Carroll and Sanbonmatsu, 2013).

Following through with these recommendations may make the difference in encouraging more women to run for office and in helping them excel once they get there. Only then will our institutions of government be able to fully elevate women’s perspectives and policy priorities and will the nation be able to benefit from women’s leadership.
LEVERAGING OPPORTUNITY: THE PATH FORWARD

Introduction
Women in the United States, Pennsylvania and Chester County face challenges that demand attention from policymakers, advocates, employers and funders. While there has been progress on many indicators of women’s status in general, and while some women in Chester County fare better than their peers in Pennsylvania and across the United States, gender disparities in the social, economic and political influence wielded by women and men persist. Women in Chester County still earn less than men, own a smaller proportion of businesses, are more likely than their male counterparts to live in poverty, are vastly underrepresented in public office and experience gender-based violence at alarming rates. Further, substantial racial and ethnic disparities have been documented for almost every indicator of women’s status. Black and Hispanic women in Chester County, in particular, experience higher gender wage gaps, have lower educational attainment, are more likely to be victims of intimate partner abuse and are less likely to be represented in local and state government by women with similar ethnic or racial backgrounds than their White and Asian neighbors.

Policies and programs to address these inequities can improve women’s status and make a powerful difference in the lives of women, men and children in Chester County. It is critical that community stakeholders explore ways to:

• Support employment and increased earnings for women
• Support work-life balance
• Reduce poverty and expand opportunities for women
• Increase women’s access to reproductive rights
• Improve women’s health and access to health care services
• Reduce violence and increase women’s safety
• Strengthen women’s political participation.

Such changes are essential to improving the economic security, health, overall well-being and civic and political participation of women in Chester County and Pennsylvania. Women and girls are an integral part of each township, borough and city’s future, and their progress can positively affect the lives of all residents. Information—and data that track progress over time—can strengthen efforts to make each community a place where women from all walks of life can thrive.

Recommendations
The following recommendations can be utilized to leverage the success of previous and current efforts to improve the lives of women in Chester County.

Supporting Employment and Increasing Earnings for Women

• Employers should be held accountable for their obligation to monitor their hiring, compensation and promotion practices and remedy gender and race disparities. They should be required by federal, state and local policies to increase transparency about pay and promotion decisions and
allow workers to share pay information without retaliation.

- States and localities should make the receipt of public contracts conditional on contractors’ reviewing their pay and grading systems to make sure they are gender neutral and equitably reward skills, effort and responsibility.
- Support federal legislation to increase women’s earnings and reduce poverty by raising the minimum wage, which would improve economic security among women, particularly women of color, who are disproportionately represented among low-wage workers.
- Uniformly raising the state minimum wage and tie the minimum wage to cost-of-living increases to set a reasonable wage floor.
- Fully enforce labor standards and equal pay and equal employment opportunity laws, such as the Equal Pay Act and Title VII of the Civil Rights Act of 1964.
- Employers should protect women’s rights on the job, including the right to organize, since women with union jobs have higher earnings and better benefits than nonunionized workers. State government can also ensure that women have adequate access to information by enforcing Title IX rules about equal access to educational programs at elementary and secondary schools, colleges and universities.

Supporting Work-Life Balance

- Help women stay in their jobs and advance by enacting policies such as paid family leave and paid medical leave, paid sick days, and schedule predictability, which are currently not available to many workers, especially those with low wages.
- Ensure that laws and regulations fully reflect the needs of workers with caregiving responsibilities, including pregnant workers, parents and caregivers of elderly parents or other adult family members.
- Develop policies to require fair work scheduling practices.
- Provide technical assistance and information to employers on innovative working time and scheduling arrangements to improve work-life balance.
- Improve access to quality and affordable child care by increasing state and local resources for early care and education and ensure that eligible parents receive child care subsidies whether they are in work, looking for work or pursuing training and education.
- Ensure that school hours (including pre-K and kindergarten) are aligned with the traditional working day and that affordable facilities are available to parents during school vacations.

Reducing Poverty and Expanding Opportunities for Women

- Increase women’s access to health care services by expanding public health programs to a wider range of women, including women with lower incomes and immigrant women who may be ineligible for public health insurance.
- Expand state Medicaid programs by expanding eligibility for all Medicaid services to those with incomes up to 138 percent of the poverty line, or by expanding Medicaid family planning services to women who need assistance but are otherwise ineligible.
- Policymakers, funders and education and workforce development leaders should adopt strategies to promote gender and racial/ethnic equity in access to higher paid, traditionally male career training opportunities.
- Educators and career counselors should ensure that career advice for women and girls explicitly addresses the earnings potential of different fields of study and occupations; in addition, they should work to encourage and support women pursuing nontraditional fields, including science, technology, engineering and mathematics (STEM) fields.
- Vocational and education training programs should actively encourage and recruit women to
pursue nontraditional majors and careers.

- Rates of women’s business ownership and the growth of women’s businesses can be increased by ensuring that federal, state and local government contracts are accessible to women-owned businesses, and through public and private sector investments in loan and entrepreneurship programs that expand business opportunities for all.
- Support initiatives that provide increased technical assistance to women entrepreneurs by helping them identify good business and financing opportunities to start and grow businesses.
- Support states and federal legislation designed to strengthen the basic safety net for those who earn very low wages or cannot work, including expanded benefits provided by programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance (SNAP), Supplemental Security Income (SSI) and the Earned Income Tax Credit (EITC).
- Support federal legislation to protect Social Security benefits, a vital economic base for dependent survivors, the disabled and older women that keeps many above the poverty line.

**Increasing Women’s Access to Reproductive Rights**

- Support policies to expand women’s access to reproductive health services and their rights to determine the timing and size of their families.
- Eliminate barriers that make it difficult for women to access contraception and abortion and to obtain the full range of reproductive health services and information they need.
- Ensure that all women who are pregnant or have recently given birth have adequate access to prenatal and infant care. This includes supporting health insurance coverage and early enrollment, efforts to educate women about the importance of prenatal care, and training for health care providers to give culturally sensitive care.

**Improving Women’s Health and Access to Health Care Services**

- Increase resources for health prevention and treatment for groups that disproportionately suffer from chronic diseases, such as heart disease, cancer, and HIV/AIDS, with the goal of reducing disparities in health outcomes among women from different racial/ethnic and socioeconomic groups.
- Increase the utilization of available services by investing in programs designed to train health providers to understand the health care needs of all women—including minority and LGBT women—and address them appropriately and with sensitivity.

**Reducing Violence and Increasing Women’s Safety**

- Increase enforcement of existing policies to promote women’s safety and develop new statutes to ensure that women can live free from violence, harassment, stalking, and abuse.
- Support funding streams that provide essential services and supports for domestic violence victims.
- Raise awareness about sexual and dating violence on college campuses and strategies for addressing it.
- Protect the employment rights of domestic violence victims.
- Expand statutes that recognize stalking as a serious crime that includes a wide range of behaviors, among other actions.
- Increase data collection on women’s experiences with violence and abuse to help researchers and policymakers develop a more complete understanding of the challenges women face and solutions to address them. Investing in data collection and studies to produce consistent and reliable quantitative estimates on key indicators related to women’s safety, and information...
disaggregated by race and ethnicity, is essential to pinpointing the greatest threats to safety for women, reducing violence and abuse, and holding perpetrators accountable.

- Encourage schools to implement a health curriculum on physical and mental health that includes dating violence, online harassment, and bullying prevention.

**Strengthening Women’s Political Participation**

- Invest in initiatives that strengthen the pipeline of women to political office in an effort to amplify women’s political voice and ensure that policymaking at all levels—local, state and federal—addresses issues of concern to women.
- Expand campaign trainings for women.
- Ask and encourage more women to run for office.
- Educate the public about the reality of “campaigning-while-female.”
- Encourage women’s organizations to get involved in electing more women to office.
- Hold political parties accountable for supporting and promoting women candidates.
- Support federal legislation to increase pathways to citizenship for undocumented immigrants, rendering them eligible to vote and increasing their political voice.
Appendix A: Bibliography


An Update to the Blueprint Report: Leveraging Progress


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Survey based on Ruggles et al., Integrated Public Use Microdata Series (Integrated Public Use Microdata Series, Version 5.0).


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http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01_tables.pdf.


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Appendix B: Provider Snapshot Survey

The Center for Social and Economic Research at West Chester University has been contracted by the Chester County Fund for Women and Girls to update the Blueprint Report. One of the methodologies being used to inform the updated report is a Provider Snapshot. The purpose of the Provider Snapshot is to help us understand the availability of health and human services available to women and girls in Chester County, and any gaps in services that may exist. In order to better understand the needs of women and girls in the county, we need your assistance in answering the following questions.

Please note that all responses are confidential and that each agency or nonprofit organization should only submit one survey.

1. Which choice best describes your provider?
   a. Nonprofit Organization
   b. Government Entity
   c. Other

2. Indicate the type of nonprofit organization you work for.

3. Indicate the type of provider you work for.

4. Please provide the following information regarding your agency:
   a. Agency Name
   b. Street Number
   c. Street Name
   d. City
   e. State
   f. Zip code
   g. Municipality
   h. Email Address
   i. Executive Director's name
   j. Number of sites your agency operates in Chester County
   k. Number of programs your agency operates in Chester County

5. Does your agency provide services countywide?
   a. Yes
   b. No

6. Please check below the services provided by your agency (check all that apply):
   a. After school youth activities
   b. Aging Arts and cultural
   c. Child care
   d. Educational Employment
   e. Food/Clothing assistance
   f. Health care
   g. Housing
   h. Information and referral
i. Legal assistance  
j. Literacy/ESL  
k. Mental health  
l. Intellectual disability  
m. Parent support/parent education  
n. Prenatal care  
o. Recreation  
p. Substance abuse  
q. Transportation  
r. Youth activities  
s. Leadership Development  
t. Financial Assistance  
u. Wholeness / Wellness  
v. Domestic Violence  
w. Safety  
x. Other

7. Please describe the “Other” services provided by your agency.

8. Please check below the services you feel women and girls have difficulty accessing in Chester County.

- a. After school youth activities  
- b. Aging Arts and cultural  
- c. Child care  
- d. Educational Employment  
- e. Food/Clothing assistance  
- f. Health care  
- g. Housing  
- h. Information and referral  
- i. Legal assistance  
- j. Literacy/ESL  
- k. Mental health  
- l. Intellectual disability  
- m. Parent support/parent education  
- n. Prenatal care  
- o. Recreation  
- p. Substance abuse  
- q. Transportation  
- r. Youth activities  
- s. Leadership Development  
- t. Financial Assistance  
- u. Wholeness / Wellness  
- v. Domestic Violence  
- w. Safety  
- x. Other

9. Please indicate the “Other” services that you feel women and girls have a difficult time accessing in Chester County.

10. Please indicate the degree of difficulty women and girls have in accessing these services in Chester County.

<table>
<thead>
<tr>
<th>Service</th>
<th>Somewhat Difficult</th>
<th>Difficult</th>
<th>Very Difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>After school youth activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aging Arts and cultural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care</td>
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<td></td>
<td></td>
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<tr>
<td>Educational employment</td>
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<tr>
<td>Food/clothing assistance</td>
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<td></td>
<td></td>
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<tr>
<td>Health care</td>
<td></td>
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<td></td>
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<tr>
<td>Housing</td>
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<tr>
<td>Information and referral</td>
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<tr>
<td>Legal assistance</td>
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<tr>
<td>Literacy/ESL</td>
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<tr>
<td>Mental health</td>
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<tr>
<td>Intellectual disability</td>
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</tbody>
</table>
11. Please indicate the number of women and girls your agency was unable to provide services to in the past month (for each applicable service).
   a. After school youth activities
   b. Aging Arts and cultural
   c. Child care
   d. Educational Employment
   e. Food/Clothing assistance
   f. Health care
   g. Housing
   h. Information and referral
   i. Legal assistance
   j. Literacy/ESL
   k. Mental health
   l. Intellectual disability
   m. Parent support/parent education
   n. Prenatal care
   o. Recreation
   p. Substance abuse
   q. Transportation
   r. Youth activities
   s. Leadership Development
   t. Financial Assistance
   u. Wholeness / Wellness
   v. Domestic Violence
   w. Safety
   x. Other

12. Please describe "Other" service that was unable to be provided within the past month.

13. Why was your agency unable to provide services in these identified instances? (Please select all that apply).
   a. Client refused services
   b. Client unable to pay
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c. Insufficient funding for program
d. Insurance did not cover requested services
e. Lack of capacity (staffing)
f. Lack of physical space
g. Language barrier
h. Service not available at this organization/agency
i. Other

14. Please describe the "Other" reason your agency was unable to provide services in these instances within the past month.

15. Please indicate the number of women and girls your agency was unable to provide services to in the past year (for each applicable service).
   a. After school youth activities
   b. Aging Arts and cultural
   c. Child care
   d. Educational Employment
   e. Food/Clothing assistance
   f. Health care
   g. Housing
   h. Information and referral
   i. Legal assistance
   j. Literacy/ESL
   k. Mental health
   l. Intellectual disability
   m. Parent support/parent education
   n. Prenatal care
   o. Recreation
   p. Substance abuse
   q. Transportation
   r. Youth activities
   s. Leadership Development
   t. Financial Assistance
   u. Wholeness / Wellness
   v. Domestic Violence
   w. Safety
   x. Other

16. Please describe "Other" service that was unable to be provided within the past year.

17. Why was your agency unable to provide services in these identified instances? (Please select all that apply).
   a. Client refused services
   b. Client unable to pay
   c. Insufficient funding for program
   d. Insurance did not cover requested services
   e. Lack of capacity (staffing)
   f. Lack of physical space
   g. Language barrier
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h. Service not available at this organization/agency
i. Other

18. Please describe the "Other" reason your agency was unable to provide services in these instances within the past month.

19. Please indicate the areas where you feel service gaps for women and girls exist in Chester County by checking the boxes (Select all that apply).
   a. After school youth activities
   b. Aging Arts and cultural
   c. Child care
   d. Educational Employment
   e. Food/Clothing assistance
   f. Health care
   g. Housing
   h. Information and referral
   i. Legal assistance
   j. Literacy/ESL
   k. Mental health
   l. Intellectual disability
   m. Parent support/parent education
   n. Prenatal care
   o. Recreation
   p. Substance abuse
   q. Transportation
   r. Youth activities
   s. Leadership Development
   t. Financial Assistance
   u. Wholeness / Wellness
   v. Domestic Violence
   w. Safety
   x. Other

20. Please describe the "Other" service gap indicated.

21. Of the issues indicated, which one do you think needs the most attention right now?

22. Thinking about the future of women and girls Chester County, what do you think community leaders and officials should focus on?

23. Is the growth Chester County is experiencing improving your service area, making it worse, or does it have no effect?
   a. Improving
   b. Getting worse
   c. Stayed the same
   d. Not sure

24. Thinking about the past year, when it comes to how people from different races get along, would you say things are getting better, getting worse, or have stayed the same in your service area?
   a. Improving
   b. Getting worse
   c. Stayed the same
   d. Not sure

25. Thinking about the past year, when it comes to crime in Chester County, would you say things are getting better, getting worse, or have stayed the same?
   a. Improving (Less crime)
   b. Getting worse
   c. Stayed the same
   d. Not sure
26. In terms of making a living over the past year, do you think things in Chester County are getting better for families, getting worse, or have they stayed the same?
   a. Improving
   b. Getting worse
   c. Stayed the same
   d. Not sure

27. Please provide the following information regarding your agency:
   a. Number of full-time staff
   b. Number of part-time staff
   c. Number of volunteers hours annually

28. Please provide the following information for each program provided by your agency:
   a. Program Name
   b. Program capacity each year
   c. Percentage of time the program operates at capacity each year

29. Please indicate the following percentages for the identified program.

<table>
<thead>
<tr>
<th>Percentage of time the program operates at capacity each year</th>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
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<tbody>
<tr>
<td>Percentage of the total persons served annually in this program that are uninsured</td>
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<tr>
<td>Percentage of the total persons served annually in this program that require bilingual services</td>
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</tbody>
</table>

30. People served in this program must be a certain age/age group.
   a. Yes
   b. No

31. Indicate age group(s) below:
   a. 0 – 5
   b. 6 – 13
   c. 14 – 21
   d. 22 – 59
   e. 60 and above

32. People served in this program must be United States citizens.
   a. Yes
   b. No

33. People served in this program must live in a specific area of the county.
   a. Yes
   b. No
34. Indicate area(s) below:
   a. Avon Grove
   b. Downingtown
   c. Kennett area
   d. Phoenixville Area
   e. Pottstown area
   f. Tredyffrin/Easttown
   g. Unionville/Chadds Ford
   h. Coatesville area
   i. Great Valley
   j. Octorara area
   k. Oxford Area
   l. Springford area
   m. Twin Valley
   n. West Chester area

35. How many additional programs do you need to report?

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | 20 |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 |

**Survey Loop:** The survey will automatically repopulate Questions 28 – 34 for the number of programs to report indicated in Question 35.