The Status of Women in Indiana

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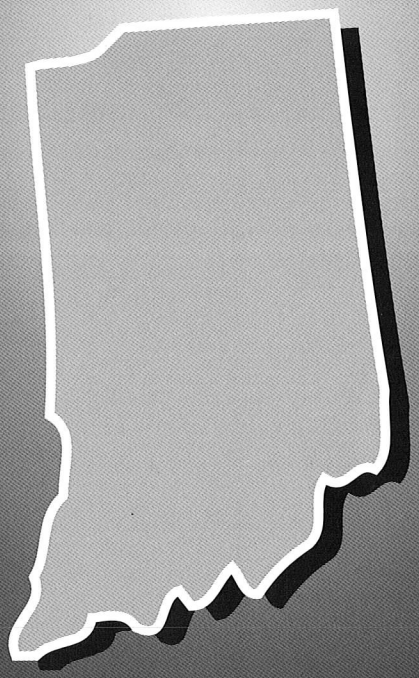

INSTITUTE FOR WOMEN'S POLICY RESEARCH

About This Report

The Status of Women in Indiana is part of an ongoing research project conducted by the Institute for Women's Policy Research (IWPR) to establish baseline measures of the status of women in all 50 states and the District of Columbia. The effort is part of a larger IWPR Economic Policy Education Program, funded by the Ford Foundation, intended to improve the ability of advocates and policymakers at the state level to address women's economic issues. The first two series of reports were released in 1996 and 1998 and included a summary national report and 24 state reports. This report is part of the third series, which includes eight other states as well as an update of the national report. See IWPR's website (www.iwpr.org) for more information.

The data used in each report come from a variety of sources, primarily government agencies, although other organizations also provided data where relevant. The Economic Policy Institute (EPI) analyzed much of the economic data presented in the report. EPI is a nonprofit, nonpartisan research organization that seeks to broaden the public debate about strategies to achieve a prosperous and fair economy. EPI's studies and popular education materials are available at www.epinet.org.

While every effort has been made to check the accuracy and completeness of the information presented, any errors are the responsibility of the authors and IWPR. Please do not hesitate to contact the Institute with any questions or comments.

About the Institute for Women's Policy Research

The Institute for Women's Policy Research (IWPR) is a public policy research organization dedicated to informing and stimulating the debate on public policy issues of critical importance to women and their families. IWPR focuses on poverty and welfare, employment and earnings, work and family issues, the economic and social aspects of health care and domestic violence, and women's civic and political participation.

The Institute works with policymakers, scholars, and public interest groups around the country to design, execute, and disseminate research that illuminates economic and social policy issues affecting women and families, and to build a network of individuals and organizations that conduct and use women-oriented policy research. IWPR, an independent, nonprofit organization, also works in affiliation with the graduate programs in public policy and women's studies at The George Washington University.

IWPR's work is supported by foundation grants, government grants and contracts, donations from individuals, and contributions from organizations. Members and affiliates of IWPR's Information Network receive reports and information on a regular basis. IWPR is a 501(c)(3) tax-exempt organization.

About IWPR's Partners in this Project

In producing these reports, IWPR called upon many individuals and organizations in the states. Charlotte Zietlow, Middle Way House, Inc., served as Chair of the Indiana Advisory Committee, coordinating the various individuals on the Committee, who represented organizations from all over the state. Dr. Zietlow organized the Committee meetings and provided data for the focus boxes. The Committee made many contributions, including reviewing the draft report for accuracy, making suggestions to ensure that the data contained in the report would be useful, and organizing the dissemination of and publicity surrounding the release of the report.

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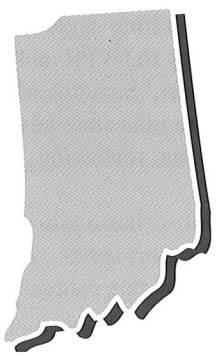
The Status of Women in Indiana

POLITICS ◆ ECONOMICS ◆ HEALTH ◆ RIGHTS ◆ DEMOGRAPHICS

Edited by Amy B. Caiazza, Ph.D.



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Acknowledgments

In its third round, *The Status of Women in the States* has become larger, more complex, and more comprehensive than ever. Its growing size and visibility are the direct result of the contributions of the many impassioned and talented people who have worked on the report series, particularly members of the state advisory committees, and of the cooperation of myriad state and national organizations. IWPR's staff, partners, and colleagues contributed vast amounts of time, energy and expertise to the project.

IWPR would like to express its special appreciation to the Ford Foundation for primary financial support of this project, and to Helen Neuborne and Barbara Philips Sullivan, program officers, who have both been extremely supportive of the Institute. Additional funding was provided by the Motorola Corporation, by Kristie Graham and the Stocker Foundation for The Status of Women in Arizona, and by the Minnesota Women's Foundation for The Status of Women in Minnesota. In Indiana, Eli Lilly and Company, the Department of 4-H Youth/Communities Against Rape Initiative at Purdue University, Indiana University Bloomington, the Office for Women's Affairs at Indiana University Bloomington, and the Indiana State Office of Women's Health all provided funding for the production of this report.

This year's reports could not have been completed without the tireless work of the staff on the Status of Women in the States Project. In particular, IWPR relied heavily on the work of April Shaw, Research Assistant at IWPR, who was in charge of collecting and updating much of the data in the reports as well as creating all of the charts, tables, and figures for them. Ms. Shaw maintained a tireless commitment to her work, attention to detail, and a cheerful attitude throughout the course of the project. She also brought the invaluable asset of a great sense of humor. Lorna Mejia and Stephanie Dorko, interns at IWPR, both helped Ms. Shaw with the data collection, and Beth Tipton, also an intern, helped with the data collection and with editing several of the reports. In addition to their vital contributions to the series itself, all three brought great energy to IWPR and helped inspire the staff on the project. Ms. Tipton and Ms. Shaw also wrote much of the national report. Suzanne McFadden, State Issues Coordinator, was responsible for assembling and coordinating the work of the nine state advisory committees. In doing so, her organizational and diplomatic skills smoothed the process of writing, reviewing, and editing the reports.

Dr. Amy Caiazza, IWPR's resident political scientist, has again lent her expertise, wisdom, judgment, and intelligence to the complex task of producing the 2000 report series. As the Study Director for the project, she oversaw the monumental process of identifying and evaluating data sources, devising analyses, coordinating input from advisory committees, writing the reports, preparing policy recommendations, and developing outreach and dissemination strategies. Her perseverance, analytical skills, and policy savvy are unrivaled.

In addition to the official staff for the project, many other IWPR researchers also contributed to drafting and editing the reports, including Dr. Stacie Golin, Study Director; Dr. Catherine Hill, Study Director; Dr. Vicki Lovell, Study Director; Holly Mead, Research Fellow; Dr. Cynthia Negrey, Study Director; and Dr. Lois Shaw, Senior Consulting Economist. All of these researchers took time from their own projects to assist in producing the reports, and the staff of the Status of Women in the States owes them a debt of gratitude. Associate Director of Research Barbara Gault and Director and President Heidi Hartmann also reviewed and edited the reports. Both Dr. Gault and Dr. Hartmann took time out of an otherwise busy summer (including vacation time) to help complete the reports, and, more importantly, both provided ongoing encouragement, new ideas, fantastic energy, and a host of inspirations to the project—and to all of IWPR's work.

IWPR's appreciation also goes to Jared Bernstein, Labor Economist, and Jeff Strohl, Programmer, at the Economic Policy Institute, who provided analysis of the 1997-99 Current Population Survey data, which was used in several sections of the report.

Finally, IWPR's communications and production staff played a pivotal role in the publication of the reports. Nasserie Carew, Associate Director of Communications, oversaw the layout and final preparation of the reports and was responsible for planning and coordinating the dissemination of and publicity surrounding the release of the reports. Her work was crucial to transforming the reports into their final format and to helping IWPR's state advisory committees call attention to their findings.

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Preface

The Institute for Women's Policy Research (IWPR) has compiled a significant amount of data that give planners, policymakers, activists and other interested parties a solid footing for action. Having facts on which to base our discussions and actions is a gift, indeed, and we hope that the report will contribute to more effective action in the near- and long-term.

The Committee feels it is essential to note that whatever the status of women in Indiana may be generally, the status of individual women is strongly impacted by their geographical location, their education, their income and their race. Data about the status of women need to be viewed in the context of data about the status of all citizens of Indiana, particularly when it comes to educational attainment, earnings, public assistance programs, and other economic criteria. For example, the economic status of women here is relatively poor, in part due to the nature of the economy in general. In addition, the majority of policymakers are male, and Indiana is a fiscally conservative state, resulting in low taxes and low funding of public assistance programs. The demographics of the state must also be taken into consideration to fully understand the status of all women within Indiana.

Indiana is a state that has one first-class city (cities with populations over 500,000), Indianapolis, and 16 second-class cities (cities with populations over 35,000 but under 500,000; Indiana, 2000). Lake County includes three second-class cities and thereby is the second most populous county in the state. The remaining 77 counties are small town or rural in nature (Indiana University, 2000a). In addition, Indiana's African-American population is concentrated in its first- and second-class cities, with the vast majority of African Americans residing in Marion and Lake Counties (Indiana University, 2000a). A growing Hispanic population is spreading across the state, but it remains largely uncounted at this time.

Indiana is a state in which the per capita income is 92.1 percent of the U.S. average, which places it 29th in the nation (Indiana Economic Development Council, 1999c). The unemployment rate in Indiana has been below the national average for the past twelve years (Indiana Economic Development Council, 1999b). People work in Indiana. However, managerial and professional jobs comprise 21.9 percent of Indiana jobs, compared to 29 percent for the nation, and 54 percent of Indiana's jobs are in occupations with a median wage below $10 per hour ($20,800 per year; Indiana Economic Development Council, 1999a). Only 7 percent of jobs have a median wage above $20 per hour (Indiana Economic Development Council, 1999a). At the same time a family's basic needs budget is between $17,000 and $32,000 per year, depending on its size and composition (Indiana Economic Development Council, 1999a).

Education is widely available in Indiana, and Indiana colleges and universities produce the 14th largest number of baccalaureates in the nation (Indiana Economic Development Council, 1999c). Women graduate at a somewhat higher rate than do men (56.5 percent compared with 43.5 percent for men; Indiana Commission for Higher Education, 2000). Men graduate from professional schools and obtain doctorates at a higher rate than women (53.9 percent and 59.2 percent compared with 46.1 percent and 40.8 percent; Indiana Economic Council, 1999b). However, the public high school graduation rate is only 70.1 percent, 31st in the nation, and only 17.7 percent of adults have a four-year degree or higher (47th in the nation; Indiana Economic Development Council, 1999c). At the same time, in Indiana only 16.8 percent of jobs require a four-year college degree or higher, compared to 20.7 percent of all jobs in the United States and only 0.8 percent of jobs in Indiana require a master's degree or higher, compared with 3.1 percent of all jobs nationwide (Indiana Economic Development Council, 1997).

Differences in access to health care, post-secondary education, and jobs that pay family wages—which are often caused by the state's demographics, the relatively low-paying job opportunities, and a workforce with comparatively few highly educated adults—create a challenging situation for women in Indiana. The chal-

lenge becomes even greater when taking into account Indiana's fiscal nature and women's representation in policymaking positions.

Indiana is a fiscally conservative state with a distinctly middle-earnings, blue-collar economy. In this situation it is not surprising that priorities such as health care, transportation, and social services do not receive the public support that they need. Indiana was, in fact, one of the very first states to institute "welfare reform," to include a two-year limit on welfare benefit receipt, and to legislate a Family Cap. The state's Medicaid eligibility cap is $4,564 per year for a woman heading a family of three (Indiana Family and Social Services Administration, 1998).

Indiana is also a cautious state that is wary of government and taxes--Indiana state and local taxes are the lowest as a percentage of Gross State Product in the Midwest and 0.5 percent lower than the national average (17th where 1 is the lowest; Indiana Economic Development Council, 1999c). Indiana is one of the lowest states in terms of personal tax burden (14th where 1 is lowest). It is the lowest state in spending for both state and local governments, seventh for state government expenditures, and 22nd for local government spending (where 1 is lowest; Indiana Economic Development Council, 1999c). And Indiana is one of the lowest states, 47th, in amount of public debt (Indiana Economic Development Council, 1999c). Although taxes in Indiana are relatively low, Indiana's income tax schedule is regressive. Indiana has the sixth lowest tax threshold in the nation. A single-parent family of three is required to pay taxes on an income of $9,000 or above, and a two-parent family of four is required to pay on an income of $9,500 or above. At the same time, in 1999, a family of three with an income at the poverty line ($13,290) paid $248 in taxes, the sixth highest tax rate in the nation (Johnson, Sahradnik and McNichol, 2000)

Therefore it is particularly noteworthy that in the past two years, both the Child Care Voucher program and the Children's Health Insurance Program (CHIPs) have received strong support and funding from the state, and (as of this writing) there is a strong, yet unsuccessful push for full-day kindergarten (Indiana General Assembly, 2000a). Public K through 12 education is funded at a level slightly below average for the country (26th), but higher education, which is a net exporter of baccalaureates to other states, is funded above average (13th; Indiana Economic Development Council, 1999c).

Participation in public office has also been difficult for women in Indiana, but there are occasional bright spots. The General Assembly currently has 13 women in the 50-member Senate and 14 women in the 100-member House of Representatives (CAWP, 1999a). Of the 117 cities in the state, eleven have women mayors, but five of those preside over five of the 16 second-class cities. Of the 276 County Commissioners, 31 are currently women (Association of Indiana Counties, 2000). In 1988 there were five.

We are making slow progress in the area of women in elected office at the local level and seeing more appointed female department heads at the state level. Yet in the year 2000, the largest university in the state emphasizing the Arts and Sciences still has no publicly appointed woman trustee (Indiana University, 2000b). The Supreme Court is entirely male; the Court of Appeals 75 percent male; and the overwhelming majority of state appointed decision-makers are not only male, but white (Access Indiana, 2000a). Given the lack of women's voices in decision-making capacities in Indiana, how can we expect women, persons of color, low-income individuals, persons with disabilities, victims of domestic abuse, even children and young people to remain on the radar screen when plans and decisions are being made? There is room at the table, and there is work to do, but it still requires pressure, connections or an extraordinary performance somewhere along the line to attract attention. We have our work cut out for us.

Finally, while data such as those included in this report are essential to understanding the status of women in Indiana, statewide statistics obscure differences between women living in rural versus urban areas, and they are inadequate in defining differences of experience and reality based on race, age and sexual orientation. We

applaud the inclusion of statistics that describe disparities in health care along geographic, racial, ethnic and age lines and regret the lack of available differentiating statistics in a number of other areas. And we are dismayed that statistics in some critical areas—incidence and severity of domestic violence and rape and sexual assault—are not yet gathered in a systematic and comprehensive fashion.

There are success stories in this state for women, as there are everywhere. The challenge is to make those non-exceptional and to recognize the disparities in the kinds of services, opportunities, and support available to all our citizens. While many of these resources and opportunities are scarce due to the nature of our economy and culture, they should be made available to all women regardless of their race, ethnic heritage, geographic location, age and sexual orientation. We need to raise all boats, and women need to sail their share.

With many thanks to the Institute for Women's Policy Research, the advisory committee encourages the readers of this Report to study, digest, question and use the information here to move forward on an enlightened path.

Charlotte Zietlow
Middle Way House, Inc.
Chair, Indiana Advisory Committee, *The Status of Women in Indiana*

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Introduction

During the twentieth century, women made significant economic, political and social advances, but they are still far from achieving gender equality. Throughout the United States, women still earn less than men, are seriously underrepresented in political office, and make up a disproportionate share of those in poverty. To make significant progress toward gender equity, policymakers need reliable and relevant data about the issues affecting women's lives. Moreover, as many policymaking responsibilities shift to the states, advocates, researchers and policymakers need state-level data about women. Recognizing this need, the Institute for Women's Policy Research (IWPR) initiated a series of reports on *The Status of Women in the States* in 1996. The biannual series is now in its third round and will, over the course of a decade, encompass reports on each of the 50 states and the District of Columbia. This year, IWPR produced reports on nine states as well as a national report summarizing results for all the states and the nation as a whole.

Goals of *The Status of Women in the States* Reports

The staff of IWPR prepared these reports on *The Status of Women in the States* to inform citizens about the progress of women in their state relative to women in other states, to men and to the nation as a whole. The essence and goals of the reports have remained the same since 1996: 1) to analyze and disseminate information about women's progress in achieving rights and opportunities; 2) to identify and measure the remaining barriers to equality; and 3) to provide baseline measures and a continuing monitor of women's progress throughout the country. In addition, members of each state advisory committee prepared information on several topics to highlight issues of particular importance to women in their state.

In each report published in 2000, indicators describe women's status in political participation, employment and earnings, economic autonomy, reproductive rights, and health and well-being. In addition, the reports provide information about the basic demographics of the state (see Appendix I). For the five major issue areas addressed in this report, IWPR compiled composite indices based on the indicators presented to provide an overall assessment of the status of women in each area and to rank the states from 1 to 51 (including the District of Columbia; see Appendix II for details). The composite index on women's health status is an innovation for the 2000 reports; earlier reports presented information on women's health but did not rank the states on this issue.

Although state-by-state rankings provide important insights into women's status throughout the country—indicating where progress is greater or less—in no state do women have adequate policies ensuring their equal rights. Women have not achieved equality with men in any state, including those ranked relatively high on the indices compiled in this report. All women continue to face important obstacles to achieving economic, political and social parity.

To address the continuing barriers to women in this country, the 2000 series of reports includes another innovation: in addition to rankings for each of the issue areas, each state is given a grade for women's political participation, employment and earnings, economic autonomy, reproductive rights, and health and well-being. IWPR designed the grading system to highlight the gaps between men's and women's access to various rights and resources. States were thus graded based on the difference between their performance and goals (such as no remaining wage gap or the proportional representation of women) set by IWPR (see Appendix II). For example, since no state has eliminated the gap between women's and men's earnings, no state received an A on the employment and earnings composite index, despite rankings near the top for some states on the indicators encompassed by this index. Because women in the United States are closer to achieving some goals than others, the curve for each index is somewhat

different. Using the grades, policymakers, researchers and advocates in high-ranking states can quickly identify remaining barriers to equality for women in their state.

In addition to assessing women's status throughout the country, IWPR designed *The Status of Women in the States* to actively involve state researchers, policymakers and advocates concerned with women's status. Beginning in 1996, state advisory committees helped design *The Status of Women in the States* reports, reviewed drafts, and disseminated the findings in their states. IWPR's partnership with the state advisory committees has developed into a participatory process of preparing, reviewing, producing and publicizing the reports. Their participation has been crucial to improving the reports in each round.

About the Indicators and the Data

IWPR referred to several sources for guidelines on what information to include in these reports. Many of the economic indicators chosen, such as median earnings or the wage gap, are standard indicators of women's status. The same is true of indicators of voter participation and women's electoral representation. In addition, IWPR used the Beijing Declaration and Platform for Action from the U.N. Fourth World Conference on Women to guide its choice of indicators. This document was the result of an official convocation of delegates from around the world. It outlines issues of utmost concern to women, rights fundamental to achieving equality and autonomy, and remaining obstacles to their advancement.

IWPR also turned to members of its state advisory committees, who reviewed their state's report and provided input for improving the project as a whole. Finally, IWPR staff turned to experts in each of the subject areas for input about the most critical issues related to the various topics. An important source of this expertise for the 2000 reports was IWPR's Working Group on Social Indicators of Women's Status, described in detail below. Ultimately, the IWPR research team made data selection decisions on the basis of several principles and constraints: relevance, succinctness, representativeness, reliability, and comparability of data across all the states and the District of Columbia. As a result, while women's status is constantly changing throughout the United States, the evidence contained in this report represents a compilation of the best available data for measuring women's status.

To facilitate comparisons among states, IWPR used data collected in the same way for each state. While most of the data are from federal government agencies, other organizations also provided data. Many figures rely on the U.S. Census Bureau's Current Population Survey (CPS), a monthly survey of a nationally representative sample of households. To ensure sufficiently large sample sizes for cross-state comparisons, several years of data were combined and then tabulated. CPS data analyses were conducted for IWPR by the Economic Policy Institute (EPI). While the decennial censuses provide the most comprehensive data for states and local areas, since they are conducted only every ten years, decennial census data are often out of date. CPS data are therefore used to provide more timely information. For this set of reports, IWPR incorporated new economic data from the years 1996-98. Some figures necessarily rely on older data from the 1990 Census and other sources; historical data from 1980 or earlier are also presented on some topics.

Because CPS data have smaller sample sizes than the decennial Census, the population subgroups that can be reliably studied are limited (for information on sample sizes, see Appendix II). The decision to use more recent data with smaller sample sizes is in no way meant to minimize how profoundly differences among women—for example, by race, ethnicity, age, sexuality and family structure—affect their status or how important it is to design policies that speak to these differences. Identifying and reporting on areas within the states (cities, counties, urban and rural areas) were also beyond the scope of this project. The lack of disaggregated data often masks regional differences among women within the states: for example, pockets of poverty are not identified and groups with lower or higher status may be overlooked. While IWPR does not mean to downplay these differences, addressing them was not possible due to data and other constraints.

A lack of reliable and comparable data at the state level limits the treatment of several important topics: domestic violence; older women's issues; pension coverage; issues concerning nontraditional families of all types, including intergenerational families; lesbian issues; and issues concerning women with disabilities. The report also does not analyze women's unpaid labor or women in nontraditional occupations. In addition, income and poverty data across states are limited in their comparability by the lack of good indicators of differences in the cost of living by states: thus, poor states may look worse than they really are, and rich states may look better than they really are. IWPR firmly believes that all of these topics are of utmost concern to women in the United States and continues to search for data and methods to address them. However, many of these issues do not receive sufficient treatment in national polls or other data collection efforts.

Such data concerns highlight the sometimes problematic politics of data collection: researchers do not know enough about many of the serious issues affecting women's lives because women do not yet have sufficient political or economic power to demand the necessary data. As a research institute concerned with women, IWPR presses for changes in data collection and analysis in order to compile a more complete understanding of women's status. Currently, IWPR is leading a Working Group on Social Indicators of Women's Status designed to assess current measurement of women's status in the United States, determine how better indicators could be developed using existing data sets, make recommendations about gathering or improving data, and build short- and long-term research agendas to encourage policy-relevant research on women's well-being and status.

To address gaps in state-by-state data and to highlight issues of special concern within particular states, IWPR added another innovation in 2000. This year, state advisory committees were invited to contribute text presenting state-specific data on topics covered by the reports. These contributions enhance the reports' usefulness to the residents of each state, while maintaining comparability across all the states.

Finally, the reader should keep a few technical notes in mind. In some cases, differences reported between two states or between a state and the nation for a given indicator are statistically significant. That is, they are unlikely to have occurred by chance and probably represent a true difference between the two states or the state and the country as a whole. In other cases, these differences are too small to be statistically significant and are likely to have occurred by chance. IWPR did not calculate or report measures of statistical significance. Generally, the larger a difference between two values (for any given sample size), the more likely the difference is statistically significant. In addition, when comparing indicators based on data from different years, the reader should note that in the 1990-2000 period, the United States experienced a major economic recession at the start of the decade, followed by a slow and gradual recovery, with strong economic growth (in most states) in the last few years.

About IWPR

IWPR is an independent research institute dedicated to conducting and disseminating research that informs public policy debates affecting women. IWPR focuses on issues that affect women's daily lives, including employment, earnings, and economic change; democracy and society; poverty, welfare, and income security; work and family policies; and health and violence. IWPR also works in affiliation with the George Washington University's graduate programs in public policy and women's studies.

The Status of Women in the States reports seek to provide important insights into women's lives and to serve as useful tools for advocates, researchers and policymakers at the state and national levels. The demand for relevant and reliable data at the state level is growing. This report is designed to fill this need.

Overview of the Status of Women in Indiana

Indiana women continue to face serious obstacles in achieving equality with men and in attaining a standing equal to the average for women in the United States. Their problems are evident in rankings below the median on most of the composite indices calculated by IWPR. Of the 50 states and the District of Columbia, Indiana ranks 24th, just above the middle, for health and well-being and for political participation, but the state falls to 36th in economic autonomy, 43rd for reproductive rights, and 44th in employment and earnings (see Chart I, Panel A).

Indiana clearly does not ensure equal rights for women, and the problems facing Indiana women demand significant attention from policymakers, women's advocates or researchers concerned with women's status. As a result, in an evaluation of Indiana's women's status compared with goals set for women's ideal status, Indiana earns the grades of C+ in health and well-being, C in political participation, C- in economic autonomy, D- in employment and earnings, and F in reproductive rights (see Chart I, Panel B).

Chart I. Panel A.
How Indiana Ranks on Key Indicators

Indicators	National Rank*	Regional Rank*
Composite Political Participation Index	**24**	**2**
Women's Voter Registration, 1992-96	31	5
Women's Voter Turnout, 1992-96	32	5
Women in Elected Office Composite Index, 2000	22	1
Women's Institutional Resources, 2000	1	1
Composite Employment and Earnings Index	**44**	**5**
Women's Median Annual Earnings, 1997	39	5
Ratio of Women's to Men's Earnings, 1997	48	5
Women's Labor Force Participation, 1998	25	2
Women in Managerial and Professional Occupations, 1998	44	5
Composite Economic Autonomy Index	**36**	**5**
Percent with Health Insurance Among Nonelderly Women, 1997	21	5
Educational Attainment: Percent of Women with Four or More Years of College, 1990	46	5
Women's Business Ownership, 1992	22	3
Percent of Women Above the Poverty Level, 1997	6	2
Composite Reproductive Rights Index	**43**	**3**
Composite Health and Well-Being Index	**24**	**3**

See Appendix II for a detailed description of the methodology and sources used for the indices presented here.

* The national rankings are of a possible 51, referring to the 50 states and the District of Columbia except for the Political Participation indicators, which do not include the District of Columbia. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI).

Calculated by the Institute for Women's Policy Research.

Chart I. Panel B.
Criteria for Grading and Indiana's Grades

Index	Criteria for a Grade of "A"	Grade, Indiana	Highest Grade, U.S.
U.S.Composite Political Participation Index		**C**	**B**
Women's Voter Registration	Women's Voter Registration, Best State (91.2%)		
Women's Voter Registration	Women's Voter Registration, Best State (91.2%)		
Women's Voter Turnout	Women's Voter Turnout, Best State (72.5%)		
Women in Elected Office Composite Index	50 Percent of Elected Positions Held by Women		
Women's Institutional Resources	Commission for Women and a Women's Legislative Caucus in Each House of State Legislature		
Composite Employment and Earnings Index		**D-**	**B+**
Women's Median Annual Earnings	Men's Median Annual Earnings, United States ($34,532)		
Ratio of Women's to Men's Earnings	Women Earn 100 Percent of Men's Earnings		
Women's Labor Force Participation	Men's Labor Force Participation, United States (74.9%)		
Women in Managerial and Professional Occupations	Women in Managerial and Professional Occupations, Best State (46.3%)		
Composite Economic Autonomy Index		**C-**	**B+**
Percent with Health Insurance	Percent with Health Insurance, Best State (91.9%)		
Educational Attainment	Men's Educational Attainment (percent with four years or more of college, United States; 24.0%)		
Women's Business Ownership	50 Percent of Businesses Owned by Women		
Percent of Women Above Poverty	Percent of Men Above Poverty, Best State (91.5%)		
Composite Reproductive Rights Index	Presence of All Relevant Policies and Resources (see Chart VI, Panel B)	**F**	**A-**
Composite Health and Well-Being Index	Best State or Goals Set by Healthy People 2010 (U.S. Department of Health and Human Services) for All Relevant Indicators (see Appendix II for details)	**C+**	**A-**

See Appendix II for a detailed description of the methodology and sources for the indices and grades presented here.
Compiled by the Institute for Women's Policy Research.

Indiana's rankings and grades for each of the composite indices were calculated by combining data on several indicators of women's status in each of the five areas. These data were used to compare women in Indiana with women in each of the 50 states and the District of Columbia. In addition, they were used to evaluate women's status in the state in comparison with women's ideal status (for more information on the methodology for the composite indices and grades, see Appendix II).

Indiana joins Illinois, Michigan, Ohio, and Wisconsin as part of the East North Central census region. The status of women in Indiana is generally below average for women in the region. Within the five states of the East North Central region, Indiana ranks third in reproductive rights, third in health and well-being, and last in both employment and earnings and economic autonomy. It ranks somewhat better in the region on women's political participation, at second.

Indiana is the 14th largest state in the country, with about 5.9 million people living within its borders, three million of whom are women. Women in Indiana have labor force participation rates that are

slightly higher than the national average, especially among mothers. Indiana's women are less diverse than women nationally, with proportionally fewer immigrants, African Americans, Hispanics, Asian Americans, and Native Americans. Patterns of family structure in Indiana (56 percent of women are married) are very similar to national patterns, although a slightly smaller proportion of women is single and slightly larger proportions are divorced or widowed.

Finally, a slightly smaller proportion of Indiana women live in metropolitan areas when compared to the United States as a whole (80.2 percent compared with 83.1 percent; see Appendix I for further details). Women living in rural and urban areas face significant differences in access to resources that can affect women's status, and these differences are not accounted for in the data contained in this report.

Political Participation

Women in Indiana register and vote at rates that are near average for the country as a whole, and they have political representation through institutional resources such as a commission for women. However, they have nowhere near adequate political representation in elected office. Only one member of the state's twelve-member congressional delegation is a woman, and women constitute only 18 percent of the state legislature. Consequently, the state ranks 24th and receives a grade of C on the political participation composite index. More active voter participation and greater representation in elected office could benefit women overall by encouraging the adoption of more women-friendly policies, which in turn could enhance women's status in other areas.

Employment and Earnings

Women in Indiana participate in the workforce slightly more but earn much lower wages and work as managers or professionals much less often than women in the nation as a whole. At 48th, their earnings in relation to men's are also considerably lower than in most of the country. These factors combine to place Indiana 44th in the nation on the employment and earnings composite index. Because women are so far from achieving equality in this area, the state received a grade of D-. In addition, over 75 percent of Indiana women with children under 18 years of age are employed. Indiana's parents increasingly need adequate and affordable child care, a policy demand not yet adequately addressed in Indiana or in the United States as a whole. In an economic era when all able or available parents work for pay to support their children, public policies lag far behind reality.

Economic Autonomy

Ranking 36th in economic autonomy, Indiana's women face serious obstacles in this area as well. On the one hand, they are much more likely to live above the poverty line than women in most of the country. However, the percentages of women in Indiana who own their own business and have health insurance are only about average for the nation as a whole, and a much smaller proportion of women in the state have a college education. In fact, while low rates of unemployment in Indiana in recent years suggest the state's economy is doing well, the occupational and earnings opportunities of women in the state may be limited by their relatively low levels of education. The uneven situation of women on the indicators composing this index yields a grade of C- for the state.

Reproductive Rights

Indiana women have few of the reproductive rights and resources identified as important, and as a result the state ranked 43rd of 51 and received a grade of F on the reproductive rights composite index. State policies restrict access to abortion by mandating parental consent and waiting periods, and poor women can receive public funding for abortion only under federally mandated, limited circumstances. For many women, especially those in rural areas, abortion is virtually inaccessible: only 39 percent of Indiana women live in counties with abortion providers. Finally, women in Indiana are not legally guaranteed that their health insurers will provide coverage for contraception.

Health and Well-Being

Overall, women in Indiana experience about average health status compared with women in other states. While they report few days per month when their activities are limited by their health, and the incidences of sexually transmitted diseases such as AIDS and chlamydia among women are relatively low, mortality rates from heart disease and lung cancer are quite high. Indiana's national rank of 24th on indicators of health and well-being suggests that while the state ranks higher than many others, it also has room for improvement. As a result the state received a C+ on this composite index. Indiana women would benefit from more preventive health care services, including education programs designed to encourage better health habits associated with nutrition, exercise and smoking.

Conclusion

Indiana illustrates many of the difficult obstacles still facing women in the United States. While women in Indiana and the United States as a whole are seeing important changes in their lives and in their access to political, economic and social rights, they by no means enjoy equality with men, and they still lack many of the legal guarantees that would allow them to achieve that equality. Women in Indiana and the nation as a whole would benefit from stronger enforcement of equal opportunity laws, better political representation, adequate and affordable child care, and other policies that would help improve their status.

Women's Resources and Rights Checklist

The Fourth World Conference on Women, held in Beijing in September 1995, heightened awareness of women's status around the world and pointed to the importance of government action and public policy for the well-being of women. At the conference, representatives of 189 countries, including the United States, unanimously adopted the Beijing Declaration and Platform for Action, which pledged their governments to action on behalf of women. The Platform for Action outlines critical issues of concern to women and remaining obstacles to women's advancement.

In the United States, the President's Interagency Council on Women continues to follow up on U.S. commitments made at the Fourth World Conference on Women. According to the Council (2000), many of the laws, policies and programs that already exist in the United States meet the goals of the Platform for Action and support the rights of women identified in the Platform. Women in the United States enjoy access to relatively high levels of resources and gender equality compared with women around the world. In some areas, however, the United States and many individual states have an opportunity to better support women's rights.

Chart II, the Women's Resources and Rights Checklist, provides an overview of the policies supporting women's rights and the resources available to women in Indiana. This list derives from ideas presented in the Platform for Action, including the need for policies that help prevent violence against women, promote women's economic equality, alleviate poverty among women, improve their physical, mental, and reproductive health and well-being, and enhance their political power. The rights and resources outlined in the Women's Resources and Rights Checklist fall under several categories: protection from violence, access to income support (through welfare and child support collection), women-friendly employment protections, legislation protecting sexual minorities, reproductive rights, and institutional representation of women's concerns.

Many of the indicators in Chart II can be affected by state policy decisions (see Appendix III for detailed explanations of the indicators). As a result, the Women's Resources and Rights Checklist provides a measure of Indiana's commitment to policies designed to help women achieve economic, political, and social well-being. In Indiana, women lack most of the rights on this checklist. The state receives a total score of only six out of 28 possible measures presented in the Women's Resources and Rights Checklist.

Violence Against Women

Indiana lacks several of the policies and provisions identified in this report that can help curtail violence against women and protect victims. The state has not adopted domestic battery laws that supplement assault statutes. Creating a separate offense for domestic battery allows enhanced penalties for repeat offenders and equal treatment for victims of domestic violence, since victims of domestic violence are often treated less seriously than victims of other kinds of assault (Miller, 1999a). A total of 30 states have adopted this type of law. In contrast, Indiana does require domestic violence training among new police recruits to ensure that police are aware of state laws, the prevalence and significance of domestic violence, and the resources available to victims (Miller, 1999a). Thirty-one states and the District of Columbia require domestic violence training by statute.

In addition to domestic violence policies, many states also have provisions related to crimes such as stalking, harassment, and sexual assault. In ten states, a first stalking offense is considered a felony, while in 23 others stalking can be classified as either a felony or a misdemeanor, depending on circumstances such as use of a weapon or prior convictions. Straight felony status is considered preferable because it usually leads to quicker arrest, since otherwise police must investigate the level of seriousness of the stalking in determining probable cause

Chart II.
Women's Resources and Rights Checklist

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Violence Against Women				
Is domestic violence a separate criminal offense in Indiana?		✓		30
Does Indiana law require domestic violence training of new police recruits?	✓			32
Domestic violence and sexual assault spending per person:			$0.69	$1.34
Is a first stalking offense a felony in Indiana?			Felony or misdemeanor	10
Does Indiana law require sexual assault training for police and prosecutors?		✓		10
Child Support				
Percent of single-mother households receiving child support or alimony:			50%	34%
Percent of child support cases with orders for collection in which support was collected:			36.4%	39.2%
Welfare Policies				
Does Indiana extend TANF benefits to children born or conceived while a mother is on welfare?		✓		27
Does Indiana allow receipt of TANF benefits up to or beyond the 60-month federal time limit?		✓	24-month limit	30
Does Indiana allow welfare recipients at least 24 months before requiring participation in work activities?	✓			23
Does Indiana provide transitional child care under TANF for more than 12 months?		✓		33
Has Indiana's TANF plan been certified or submitted for certification under the Family Violence Option or made other provisions for victim of domestic violence?	✓		Certified	40
In determining welfare eligibility, does Indiana disregard the equivalent of at least 50 percent of earnings from a full-time, minimum wage job?		✓		25
Average TANF benefit in Indiana, 1997-98:			$229.34	$358.08
Employment/Unemployment Benefits				
Is Indiana's minimum wage higher than the federal level as of March 2000?		✓		11
Does Indiana have mandatory temporary disability insurance?		✓		5

Chart II continued

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Does Indiana provide Unemployment Insurance benefits to:				
Low-wage workers?		✓		12
Workers seeking part-time jobs?		✓		9
Workers who leave their jobs for certain circumstances ("good cause quits")?		✓		23
As of July 2000, has Indiana proposed policies allowing workers to use Unemployment Insurance for paid family leave?	✓			0 Enacted; 13 Proposed
Has Indiana implemented adjustments to achieve pay equity in its state civil service?		✓		20
Sexual Orientation and Gender Identity				
Does Indiana have civil rights legislation prohibiting discrimination on the basis of sexual orientation and/or gender identity?		✓		19
Does Indiana have a Hate Crimes law covering sexual orientation?		✓		24
Has Indiana avoided adopting a ban on same-sex marriage?		✓		20
Reproductive Rights				
Does Indiana allow access to abortion services:				
Without mandatory parental consent or notification?		✓		9
Without a waiting period?		✓		33
Does Indiana provide public funding for abortions under any or most circumstances if a woman is eligible?		✓		15
Does Indiana require health insurers to provide comprehensive coverage for contraceptives?		✓		11
Does Indiana require health insurers to provide coverage of infertility treatments?		✓		10
Does Indiana allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?[1]	✓		Lower Court	21
Does Indiana require schools to provide sex education?		✓		18
Institutional Resources				
Does Indiana have a Commission for Women?	✓			39
Total Policies[2]	**6**	**21**		**28 possible**

See Appendix III for a detailed description and sources for the items on this checklist.

[1] Most states that allow such adoptions do so as the result of court decisions. In Indiana, a lower-level court has ruled in favor of second-parent adoptions.

[2] Policies in the "yes" and "no" columns do not add up to 28 because some of Indiana's policies have mixed evaluations and thus fall in the "other" column.

Compiled by the Institute for Women's Policy Research.

(U.S. Department of Justice, Office of Justice Programs, Violence Against Women Grants Office, 1998). In Indiana, stalking can be either a felony or misdemeanor. In addition, ten states have provisions requiring training on sexual assault for police and prosecutors; Indiana is not one of those states.

In fiscal year 1994-95, Indiana administered $0.69 of federal and state funds for domestic violence and sexual assault programs per person in the state, substantially below the U.S. average of $1.34. Of these funds, federal money constituted 72 percent and state money, 28 percent. Of the federal funds 91 percent was spent on domestic violence programs, while 8 percent was spent on sexual assault programs. All state funds were spent on domestic violence programs. Investing in programs to decrease the prevalence of domestic battery and sexual assault, as well as to provide services to victims, is important to reducing both types of crimes and to helping victims rebuild their lives.

Child Support

Many mother-headed households experience poverty and low wages, and child support or alimony is one way to supplement their incomes. In the United States, approximately 34 percent of female-headed households receive some level of child support or alimony. In Indiana, 50 percent receive such support, substantially more than the national average.

According to the U.S. Department of Health and Human Services Office of Child Support Enforcement, 55 percent of all child support cases that go to trial are granted a support order by a judge. However, child support is collected in only 39.2 percent of cases with orders (or about 22 percent of all child support cases). The enforcement efforts made by state and local agencies can affect the extent of collections (Gershenzon, 1993). Of all child support cases with orders for collection in Indiana, child support was collected in only 36.4 percent. This proportion is slightly below the average for the United States as a whole. IWPR research shows that child support can make a substantial difference in low-income families' lives by lifting many out of poverty. Among non-welfare, low-income families with child support agreements, poverty rates would increase by more than 30 percent without their child support income (IWPR, 1999).

Welfare Policies

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) enacted the most sweeping changes to the federal welfare system since it was established in the 1930s. PRWORA ended entitlements to federal cash assistance, replacing the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program. Where AFDC provided minimal guaranteed income support for all eligible families (most frequently those headed by low-income single mothers), TANF benefits are restricted to a five-year lifetime limit and are contingent on work participation after 24 months. TANF funds are distributed to states in the form of block grants, and states are free to devise their own eligibility rules, participation requirements and sanction policies within the federal restrictions.

Within federal restrictions, states have adopted widely divergent TANF plans, and the provisions of their welfare programs can have important ramifications on the economic security of low-income residents, the majority of whom are women and children. These policies affect the ability of welfare recipients to receive training and education for better-paying jobs, to leave family situations involving domestic violence and other circumstances, and simply to support their families during times of economic hardship. Although it has a few supportive policies, Indiana has adopted many welfare policies that are relatively harmful to women, even given existing federal restrictions.

Under a "Family Cap," Indiana does not extend TANF benefits to children born or conceived while a mother receives welfare. As of August 1999, 24 states have Child Exclusion policies, or Family Caps. Of these states, two, not including Indiana, have a modified Family Cap and therefore give partial increases in benefits to additional children. Twenty-six states and the District of Columbia do not have any kind of Family Cap (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c).

Indiana's time limits on receiving TANF are also more stringent than required by federal regulations. In Indiana, recipients are limited to 24 months, while the average for all states is just over 46 months. Twenty-seven states and the District of Columbia have a time limit of 60 months (the maximum allowed under federal law). Nineteen other states report lifetime time limits of less than 60 months. Four states have no lifetime limits for individuals complying with TANF requirements. Of these four, two supplement federal funds with state monies, and two have other kinds of restrictions on receipt after 24 months (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). In Indiana, even if adults in a household lose eligibility under the state's time limit, children can continue to receive benefits until their eligibility expires, as long as they meet other eligibility criteria.

Federal law requires nonexempt residents to participate in work activities within two years of receiving cash assistance. States have the option of establishing stricter guidelines, and many have elected to do so. In 20 states, nonexempt recipients are required to engage in work activities immediately under TANF. Six states have work requirements within less than 24 months. Twenty-two states and the District of Columbia require recipients to work within 24 months or when determined able to work, whichever comes first. In one state, Arizona, work requirements are evaluated on an individual basis (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). Welfare recipients in Indiana have 24 months before they are required to work, allowing them the maximum allowable time for upgrading of skills through training or education.

PRWORA also replaced former child care entitlements with the Child Care and Development Fund block grant, which consolidated funding streams for child care and provided new child care funds to states. This new system requires that states use no less than 70 percent of the new funds to provide child care assistance to several types of families: those receiving TANF, those transitioning away from welfare through work activities, and those at risk of becoming dependent on TANF (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). In addition to these funds, many states use TANF funds or additional state funds to provide child care services. States also have substantial discretion over designing their child care programs, including how long they provide child care services to families. Currently, while all of the states provide a minimum of twelve months of child care to families transitioning away from welfare, 33 states extend child care beyond twelve months. Indiana provides transitional child care to families for only twelve months (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). Providing expanded child care services can be a crucial form of support for working families, especially single mothers, and can be critical to ensuring families' self-sufficiency.

As of August 1999, 27 states and the District of Columbia were recognized by the U.S. Department of Health and Human Services, Administration for Children and Families, as having adopted the Family Violence Option, which allows victims of violence to be exempted from work requirements, lifetime time limits, or both as part of state TANF plans (U.S. Department of Health and Human Services, 1999c). Another five states are in the process of developing screening and counseling standards, and seven others have adopted exemptions for domestic violence but have not received certification. The remaining eleven states have not applied for or received the optional certification and have not adopted other language. Indiana has been certified under the Family Violence Option.

PRWORA also gave states increased flexibility in how they treat earnings in determining income eligibility for TANF applicants. One standard for measuring the generosity of state rules is whether they disregard 50 percent or more of the earnings of a full-time, minimum-wage worker. Indiana does not have a generous policy on how it treats earnings in determining TANF eligibility. Generous earnings disregards can help ease the transition away from welfare for women and their families as they strive for self-sufficiency.

In the United States as a whole, in the period from October 1997 to September 1998, over three million families received an average cash assistance benefit

Focus on Welfare Reform in Indiana

One of the first states to engage in welfare reform, Indiana implemented the Partnership for Personal Responsibility (PPR) in May 1995, a year before substantial changes were made in the national welfare system through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Similar to PRWORA, Indiana's reform focused on "workfirst" (requiring participation in work activities shortly after enrollment); time limits for receiving benefits; sanctions for failure to meet parenting responsibilities, such as having children immunized and enforcing school attendance; and a Family Cap provision. The continuing goals of Indiana's welfare reform program are to "increase clients' employment, decrease reliance on welfare and increase self-sufficiency, make work more financially rewarding than public assistance, encourage responsible parenting, and develop working partnerships with local government and business" (Beecroft, 1998).

In part as a result of PPR, between January and December of 1996 Indiana registered the largest AFDC caseload decline in the country, at 38 percent (Beecroft, 1998). In addition, 79 percent of welfare recipients obtained employment during the first two years they were subject to the new regulations (Beecroft, 1998). However, as in all states, declining caseloads and employment rates in Indiana do not adequately measure the success of welfare reform. Employment has generally been limited to those recipients who have prior job experience and higher levels of education and who do not have children under age three. In addition, the majority of adults who have left welfare were not earning enough at the end of a two-year follow-up period to move their families above the federal poverty line (Beecroft, 1998).

These results point to a need for policies aimed at increasing job-readiness for participants, increasing the availability and affordability of child care, and increasing the earnings of former welfare recipients. Such policies might include strengthening training and education programs, increasing and expanding subsidies for child care, increasing earnings disregards, and encouraging the placement of former welfare participants in higher paying jobs with room for growth.

of $358.08 per month. In Indiana, the average monthly benefit was $229.34, below the national average (U.S. Department of Health and Human Services, Administration for Children and Families, 1999b).

Even states with relatively generous welfare policies do not always provide welfare recipients adequate opportunities to take advantage of the resources available to them, often because of poor implementation of state TANF plans. For example, welfare recipients are not always aware of the benefits that are available to them, such as child care, Food Stamps or Medicaid, especially after they lose cash assistance under TANF (Shumacher and Greenberg, 1999; Ku and Garrett, 2000). In addition, they may not be aware of policies such as Family Violence exemptions or other regulations allowing them to extend their eligibility for receiving benefits. Through rigorous training of caseworkers, an emphasis on informing welfare recipients of their rights, and other policies, states can work to ensure that welfare recipients are able to take full advantage of the economic and support services available to them (for more information on welfare in Indiana see Focus on Welfare Reform in Indiana).

Employment/Unemployment Benefits

Employment policies and protections are crucial to helping women achieve economic self-sufficiency and to providing them a safety net during periods of unemployment. Indiana lacks many employment policies that would be supportive of women workers.

The minimum wage is particularly important to women because they constitute the majority of low-wage workers. Recent research by IWPR and the Economic Policy Institute found that women would be a majority of the workers affected by a one-dollar increase in the minimum wage (Bernstein, Hartmann, and Schmitt, 1999). As of March 2000, ten states and the District of Columbia had minimum wage rates higher than the federal level of $5.15. Six states had minimum wage rates lower than the federal level (but the federal level generally applies to most employees in these states). Seven states had no minimum wage law, and 27 states had state minimum wages equal to the federal level. Indiana's minimum wage is the same as the federal minimum (U.S. Department of Labor, 1999).

Temporary Disability Insurance (TDI) is also an important resource for women because it provides partial income replacement to employees who leave work because of an illness or accident unrelated to their jobs. In the five states with mandated programs (California, Hawaii, New Jersey, New York and Rhode Island), employees and/or their employers pay a small percentage of the employee's salary into an insurance fund and, in return, employees are provided with partial wage replacement if they become ill or disabled. Moreover, in states with TDI programs, women workers typically receive eight to twelve weeks of partial wage replacement for maternity leave through TDI (Hartmann, Yoon, Spalter-Roth and Shaw, 1995). Indiana does not require mandatory TDI. Failure to require mandatory TDI coverage leaves many women, especially single mothers, vulnerable in case of injury or illness.

Unemployment Insurance (UI) provides workers and their families a safety net during periods of unemployment. In order to receive UI, potential recipients must meet several eligibility requirements. IWPR research has shown that nearly 14 percent of unemployed women workers are disqualified from receiving UI by two earnings criteria, more than twice the rate for unemployed men (see Appendix III for more details on UI requirements; Yoon, Spalter-Roth and Baldwin, 1995). States typically set eligibility standards for UI and can enact policies that are more or less inclusive and more or less generous to claimants. In Indiana, UI policies are unsupportive of women workers. Earnings re-quirements generally disqualify the majority of low-wage workers. In addition, policies do not allow workers seeking part-time jobs to qualify for unemployment benefits. Because women are more likely than men to seek part-time work, the failure to cover workers seeking part-time work disproportionately harms women. Indiana's policy also does not allow women to qualify for insurance in cases of "good cause quits," in which a worker leaves a job for personal circumstances, which might include moving with a spouse, harassment on the job, or other situations.

Finally, Indiana has considered legislation that would allow women to use UI to provide benefits during work absences covered under the Family and Medical Leave Act. While women currently cannot do so in any state, as of July 2000, such policies have been proposed in 13 states. In addition, the Department of Labor recently issued a ruling allowing states to provide partial wage replacement under the unemployment compensation program on a voluntary, experimental basis to parents who take leave or who otherwise leave employment following the birth or adoption of a child. The new regulations were issued in June of 2000 and took effect in August. To implement them, state legislatures must adopt a plan allowing this use of UI.

Some states have implemented pay equity remedies, which are policies designed to raise the wages of jobs undervalued at least partly because of the sex or race of the workers who hold those jobs. By 1997, 20 states had implemented programs to raise the wages of workers in female-dominated jobs in their states' civil services (National Committee on Pay Equity, 1997). A study by IWPR found that for states that implemented pay equity remedies, the remedies improved female/male wage ratios (Hartmann and Aaronson, 1994). Indiana has not implemented policies within its state civil service to achieve pay equity.

Sexual Orientation and Gender Identity

Indiana lacks polices that would provide lesbians and other sexual minorities access to to the same rights that other citizens have. Eighteen states and the District of Columbia have adopted statutes prohibiting discrimination on the basis of sexual orientation. Indiana has not adopted such a law. In addition, 23 states and the District of Columbia have passed laws creating enhanced penalties for perpetrators of hate crimes committed against victims because of their sexual orientation. Indiana has not passed a hate crime bill that addresses crimes against gay, lesbian and bisexual residents. Indiana also has specifically prohibited same-sex marriage. Thirty-one states have banned same-sex marriage. Only one state, Vermont, has expressly allowed gay and lesbian couples to take advantage of the same rights and benefits extended to married couples under state law, through the passage of a "civil union" act. Vermont's law was signed in April 2000 and allows gay and lesbian couples to claim benefits such as inheritance rights, property rights, tax advantages, and the authority to make medical decisions for a partner, once they register as a civil union.

Reproductive Rights

While indicators concerning reproductive rights are covered in more detail later in the report, they also represent crucial components of any list of desirable policies for women. Overall, in Indiana, women have relatively low levels of access to abortion, contraception, and other family planning resources. As a result, women lack important resources that might help them make careful, informed, and independent decisions about childbearing, which can in turn have a significant impact on their lives and well-being and the lives and well-being of their children.

Institutional Resources

Finally, since Indiana women have a state commission for women, they have one form of representation that might help create more women-friendly policies in their state (see the section on Political Participation for more details). A total of 39 states currently have state-level commissions for women.

Conclusion

In order for women in Indiana to achieve more equality and greater well-being, the state should adopt the policies it still lacks from the Women's Resources and Rights Checklist. Although this list does not encompass all the policies necessary to guarantee equality, it represents a sample of exemplary women-friendly provisions. Each of the policies also reflects the goals of the Beijing Declaration and Platform for Action by addressing issues of concern to women and obstacles to women's equality. Thus these rights and resources are important for improving women's lives and the well-being of their families.

Political Participation

Political participation allows women to influence the policies that affect their lives. By voting, running for office, and taking advantage of other avenues for participation, women can make their concerns, experiences and priorities visible in policy decisions. Recognizing the lack of equity in political participation and leadership throughout the world, the Beijing Declaration and Platform for Action cites ensuring women equal access to avenues for participation and decision-making as a major objective. This section presents data on several aspects of women's involvement in the political process in Indiana: voter registration and turnout, female state and federal elected and appointed representation, and women's state institutional resources.

Over the past few decades, a growing gender gap in attitudes among voters—the tendency for women and men to vote differently—suggests that women's political preferences at times differ from men's (Conway, Steuernagel and Ahern, 1997). Women, for example, tend to support funding for social services and child care, as well as measures combating violence against women, more than men do. Many women also stress the importance of issues like education, health care and reproductive rights. Because women are often primary care providers in families, these issues can affect women's lives profoundly.

Political participation allows women to demand that policymakers address these and other priorities. Voting is one way for them to express their concerns. Women's representation in political office also gives them a more prominent voice. In fact, regardless of party affiliation, female officeholders are more likely than male ones to support women's agendas (Center for American Women and Politics [CAWP], 1991). In addition, legislatures with larger proportions of female elected officials tend to address women's issues more often and more

Chart III.
Political Participation: National and Regional Ranks

Indicators	National Rank* (of 50)	Regional Rank* (of 5)	Grade
Composite Political Participation Index	**24**	**2**	**C**
Women's Voter Registration (percent of women 18 and older who reported being registered to vote in 1992 and 1996)[a]	31	5	
Women's Voter Turnout (percent of women 18 and older who reported voting in 1992 and 1996)[a]	32	5	
Women in Elected Office Composite Index (percent of state and national elected officeholders who are women, 2000)[b, c, d]	22	1	
Women's Institutional Resources (number of institutional resources for women in Indiana, 2000)[e, f]	1	1	

See Appendix II for methodology.

* The national rank is of a possible 50, because the District of Columbia is not included in this ranking. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI).

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1993, 1998b; [b] CAWP, 1999a, 1999c, 1999d, 1999e; [c] Council of State Governments, 1998; [d] Compiled by IWPR based on Center for Policy Alternatives, 1995; [e] CAWP, 1998; [f] Compiled by IWPR based on National Association of Commissions on Women, 1997.

Calculated by the Institute for Women's Policy Research.

seriously than those with fewer female representatives (Dodson, 1991; Thomas, 1994). Finally, representation through institutions such as women's commissions or women's legislative caucuses can both provide ongoing channels for expressing women's concerns and make policymakers more accessible to women, especially when those institutions work closely with women's organizations (Stetson and Mazur, 1995).

Overall, levels of political participation and representation among women in Indiana are similar to those seen among women in the United States as a whole. The state ranks 24th, near the middle, on the political participation composite index. Its rankings on individual indicators range from first on women's institutional resources to 32nd on women's voter turnout (see Chart III). Indiana falls slightly above the midpoint on women in elected office (22nd) and below the midpoint on women's voter registration (31st).

Indiana's grade of C for the political participation indicators represents women's muted voice in the political process of the state. Most notably, despite Indiana's rank of 22nd for women's representation in political office, very few state and national elected officials in the state are women. In no state do women hold a proportionate number of elected offices; however, even relatively speaking, Indiana performs poorly in this area. Women throughout the country and in Indiana need better representation within the political process.

Voter Registration and Turnout

Voting is one of the most fundamental ways Americans express their political needs and interests. Through voting, citizens choose leaders to represent them and their concerns. Recognizing this, early women's movements made suffrage one of their first goals. Ratified in 1920, the Nineteenth Amendment established U.S. women's right to vote, and in November of that year, about eight million out of 51.8 million women voted for the first time (National Women's Political Caucus, 1995). African American and other minority women, however, were denied the right to vote in many states until the Voting Rights Act of 1965 was passed. But even after women of all races were able to exercise their right to vote, many candidates and political observers did not take women voters seriously. Instead, they assumed women would either ignore politics or simply vote like their fathers or husbands (Carroll and Zerrilli, 1993).

Table 1.
Voter Registration for Women and Men in Indiana and the United States

	Indiana		United States	
	Percent	Number	Percent	Number
1996 Voter Registration*[a]				
Women	68.7	1,513,000	67.3	67,989,000
Men	68.3	1,391,000	64.4	59,672,000
1992 Voter Registration*[b]				
Women	69.7	1,581,000	69.3	67,324,000
Men	66.0	1,265,000	66.9	59,254,000
Number of Unregistered Women Eligible to Vote, 1996[c]	N/A	598,000	N/A	23,775,050
Percentage and Number of Public Assistance Recipients Registered under the National Voter Registration Act, 1996[c]	33.3	58,280	14.1	1,312,000

* Percent of all women and men aged 18 and older who reported registering, based on data from the 1993 and 1997 November Supplements of the Current Population Survey. These data are self-reports and tend to overstate actual voter registration.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1998b; [b] U.S. Department of Commerce, Bureau of the Census, 1993; [c] HumanSERVE, 1996.

Compiled by the Institute for Women's Policy Research.

Neither prediction came true. Women now register and vote slightly more often than men. By 1996, almost 68 million women, or 67.3 percent of those eligible, reported being registered to vote, compared with nearly 60 million or 64.4 percent of eligible men (see Table 1). Indiana's voter registration rates are slightly higher for women and somewhat higher for men than national ones. In Indiana, 68.7 percent of women reported being registered to vote in the November 1996 elections, while 68.3 percent of men did.

Women have constituted a majority of U.S. voters since 1964. In 1996, 53 percent of voters were women while in 1992, 56 percent were. Indiana has slightly higher voter turnout than the nation as a whole. In 1992, 65.4 percent of Indiana women reported voting, and 56.1 percent reported voting in 1996 (see Table 2). As a result Indiana ranks 32nd among all the states and fifth in the East North Central region for women's voter turnout in the 1992 and 1996 elections combined. Notably, voter turnout dropped substantially for both sexes in the nation as a whole between 1992 and 1996. Although turnout fell for Indiana women in 1996, it remained slightly higher than the rate for men and higher than for men and women in the United States as a whole (because many of the larger states have low levels of voter turnout, the national rate is lower than the median rate for all states; thus several states with higher voter turnout than in the nation as a whole rank below the midpoint for all states). Overall, compared with other Western democracies, voter turnout is relatively low for both sexes in the United States. Furthermore, in Indiana, polls close at 6 pm on election days, creating an obstacle to voter participation (Indiana Secretary of State, Elections Division, 2000)

Minority men and women in the United States generally vote at lower rates than white men and women. In 1996, 54.8 percent of white men and 57.2 percent of white women voted, compared with 46.6 percent of African American men, 53.9 percent of African American women, 24.2 percent of Hispanic men, and 29.3 percent of Hispanic women. Separate data for minority men and women are not available at the state level. However, in Indiana, 57.2 percent of all whites and 43.1 percent of all African Americans voted in 1996 (data not shown; data not available for Hispanics in Indiana; U.S. Department of Commerce, Bureau of the Census, 1998b). Lower levels of voter turnout among minority men and women can mean that their interests and concerns are less well represented in the political process.

Over the years, most states in the United States have developed relatively complicated systems of voter registration. Voting has typically required advance registration in a few specified locations, and this system is historically a major cause of low U.S. voting rates (Wolfinger and Rosenstone, 1980). Two groups most underserved by this system are the poor and persons with disabilities, and voting itself is more difficult for people with disabilities because of problems such as inadequate transportation to the polls.

Table 2.
Women's and Men's Voter Turnout in Indiana and the United States

	Indiana		United States	
	Percent	Number	Percent	Number
1996 Voter Turnout*[a]				
Women	56.1	1,236,000	55.5	56,108,000
Men	55.5	1,131,000	52.8	48,909,000
1992 Voter Turnout*[b]				
Women	65.4	1,483,000	62.3	60,554,000
Men	60.1	1,152,000	60.2	53,312,000

* Percent of all women and men aged 18 and older who reported voting, based on data from the 1993 and 1997 November Supplements of the Current Population Survey. These data are self-reports and tend to overstate actual voter turnout.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1998b; [b] U.S. Department of Commerce, Bureau of the Census, 1993.

Compiled by the Institute for Women's Policy Research.

Effective as of January 1995, the National Voter Registration Act (NVRA) required states to allow citizens to register to vote when receiving or renewing a driver's license or applying for AFDC, Food Stamps, Medicaid, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and disability services. Under the new welfare system, applicants for TANF and related programs continue to have the opportunity to register to vote when seeking welfare benefits. By 1996, the NVRA successfully enrolled or updated voting addresses for over eleven million people, including 1.3 million through public assistance agencies, approximately 58,000 of whom live in Indiana (see Table 1). As of 1996, 14.1 percent of eligible public assistance recipients were registered to vote through public assistance offices, and in Indiana, 33.3 percent were. Despite these changes, nearly 24 million eligible women remain unregistered in the United States, and nearly 600,000 of them live in Indiana.

Table 3.
Women in Elected and Appointed Office in Indiana and the United States, 2000

	Indiana	United States
Number of Women in Statewide Executive Elected Office[a, b]	4	91
Women of Color[c]	1	6
Number of Women in the U.S. Congress		
U.S. Senate[d]	0 of 2	9 of 100
Women of Color[c]	0	0
U.S. House[e]	1 of 10	56 of 435
Women of Color[c]	1	20
Number of Women Running for the U.S. Congress, 1998*[f, g]		
U.S. Senate	0 of 2	10 of 79
U.S. House	3 of 21	121 of 779
Percent of State Legislators Who Are Women[h]	18.0%	22.4%
Percent of Women in Appointed Office[i]	27.4%	29.8%

* These figures refer to candidates running for congresssional seats in the general election and exclude those running in primaries.

Source: [a] CAWP, 1999a; [b] Council of State Governments, 1998; [c] CAWP, 1999f; [d] CAWP, 1999e; [e] CAWP, 1999d; [f] CAWP, 1999f; [g] Federal Election Commission, 1998a, 1998b; [h] CAWP, 1999c; [i] Center for Women in Government, 1998.

Compiled by the Institute for Women's Policy Research.

Elected Officials

Although women constitute a minority of elected officials at both the national and state levels, their presence has grown steadily over the years. As more women hold office, women's issues are also becoming more prominent in legislative agendas (Thomas, 1994). Nine women served in the 1999-2000 U.S. Senate (106th Congress). Women also filled 56 of the 435 seats in the 106th U.S. House of Representatives (not including Eleanor Holmes Norton, the nonvoting delegate from the District of Columbia, and Donna Christian-Green, the nonvoting delegate from the Virgin Islands). Women of color filled only 20 House seats and no Senate seats, and only one openly lesbian woman served in Congress. Women from Indiana filled one seat in the U.S. House but none in the U.S. Senate, leading to a rate of representation below the national average (see Table 3). A woman of color, Julie Carson, holds the single House seat held by a woman in the Indiana delegation.

At the state level, women in Indiana held four elected executive offices: attorney general, secretary of state, state auditor, and the head of the Department of Education. One woman of color serves in statewide elected office. Women's proportion of the Indiana state legislature is also low, as women make

up 18.0 percent of the legislature, compared with a 22.4 percent average for the nation as a whole. Finally, as of October 1999, women constituted 27.4 percent of top-level public appointees with policy-making responsibility that were appointed by the current governor in Indiana. The national average is 29.8 percent.

Based on the proportion of women in elected office, Indiana ranks 22nd in the nation and first in the East North Central region on this component of the political participation index. Its ranking just above the midpoint for all states despite proportionately low levels of women's representation illustrates the lack of political power women have attained in elected office in the country as a whole.

Research on women as political candidates suggests that they generally win elected office at similar rates to men, but far fewer women run for office (National Women's Political Caucus, 1994). In 1998, 121 women out of 779 total candidates (15.5 percent) ran for office in the U.S. House of Representatives, while ten women of 79 total candidates (12.7 percent) ran for office in the U.S. Senate. In Indiana, only three women of 21 total candidates ran for the ten seats in the House in the 1998 general election, and no woman ran for the Senate. At three female candidates of a total of 23, Indiana's proportion of women running for Congress was relatively low at 13.0 percent (CAWP, 1999b; FEC 1998a, 1998b).

For women to win their proportionate share of political offices in the near term, the number and percentage of seats they hold must increase much more quickly than they did during the 1990s. Policies and practices that might encourage women to run for office—including those that would help them challenge incumbents—can be integral to increasing women's political voice (Burrell, 1994). Such policies include campaign finance reform, recruitment of female candidates by political parties, and fair and equal media treatment for male and female candidates.

Institutional Resources

Women's institutional resources can play an important role in providing information about women's issues and attracting the attention of policymakers and the public to women's political concerns. They can also serve as an access point for women and women's groups to express their interests to public officials. Thus such institutions can ensure that women's issues remain on the political agenda. Indiana has both a government-appointed commission for women at the state level, the Indiana Commission for Women, and women's caucuses in both chambers of the state legislature (see Table 4). In the country as a whole, 39 states have state-level commissions on women and 34 have women's caucuses. Fifteen states have both a commission for women and caucuses in each house of the state legislature. Notably, in Indiana, women have another institutional resource: the Indiana Office of Women's Health is specifically dedicated to improving the health status of women in Indiana through assessment of health needs, increased public awareness and education, and coordinated development of women's health events (Access Indiana, 2000b).

Table 4.
Institutional Resources for Women in Indiana

	Yes	No	Total, United States
Does Indiana have a:			
Commission for Women?[a]	✔		39
Legislative Caucus in the State Legislature?[b]	Bicameral		34
Assembly?	✔		
Senate?	✔		

Source: [a] Compiled by IWPR, based on National Association of Commissions on Women, 1997; [b] CAWP, 1998.
Compiled by the Institute for Women's Policy Research.

Employment and Earnings

Because earnings are the largest component of income for most families, earnings and economic well-being are closely linked. Noting the historic and ongoing inequities between women's and men's economic status, the Beijing Declaration and Platform for Action stresses the need to promote women's economic rights. Its recommendations include improving women's access to employment, eliminating occupational segregation and employment discrimination, and helping men and women balance work and family responsibilities. This section surveys several aspects of women's economic status by examining the following topics: women's earnings, the female/male earnings ratio, women's earnings by educational attainment, labor force participation, unemployment rates, and the industries and occupations in which women work.

Families often rely on women's earnings to remain out of poverty (Cancian, Danziger and Gottschalk, 1993; Spalter-Roth, Hartmann and Andrews, 1990). Moreover, women's employment status and earnings have grown in importance for the overall well-being of women and their families as demographic and economic changes have occurred. Men, for example, experienced stagnant or negative real wage growth during the 1980s and the early portion of the 1990s. At the same time, more married-couple families now rely on both husbands' and wives' earnings to survive. In addition, more women head households alone, and more women are in the labor force.

Women in Indiana rank 44th in the nation and fifth, or last, in the East North Central region on the employment and earnings composite index (see Chart IV). The state ranks near the bottom nationally, 48th, on the ratio of women's to men's earnings, and it ranks almost as poorly on other important measures of employment and earnings. The state ranks 44th in the percent of women working in

Chart IV.
Employment and Earnings: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 5)	Grade
Composite Employment and Earnings Index	**44**	**5**	**D-**
Women's Median Annual Earnings (for full-time, year-round workers, aged 16 and older, 1997)[a]	39	5	
Ratio of Women's to Men's Earnings (median annual earnings of full-time, year-round women and men workers aged 16 and older, 1997)[a]	48	5	
Women's Labor Force Participation (percent of all women, aged 16 and older, in the civilian non-institutional population who are either employed or looking for work, 1998)[b]	25	2	
Women in Managerial and Professional Occupations (percent of all employed women, aged 16 and older, in managerial or professional specialty occupations, 1998)[b]	44	5	

See Appendix II for methodology.

* The national rank is out of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI).

Source: [a] Economic Policy Institute, 2000; [b] U.S. Department of Labor, Bureau of Labor Statistics, 1999c.
Calculated by the Institute for Women's Policy Research.

managerial and professional occupations and 39th in the level of women's median annual earnings. Overall, and on these three component indicators of the employment and earnings index, Indiana ranks in the bottom third of all the states. Its best ranking is in women's labor force participation, in which it ranks near the middle of all states, at 25th. Within its region, Indiana ranks last on all the measures of employment and earnings except women's labor force participation, for which it ranks second regionally.

Women in Indiana clearly do not have sufficient access to the economic resources of the state. Like women in most states, they lag significantly behind men in their wages and labor force participation, and they lag behind women in most other states on the majority of the indicators included here. As a result, Indiana received a D- on the employment and earnings index.

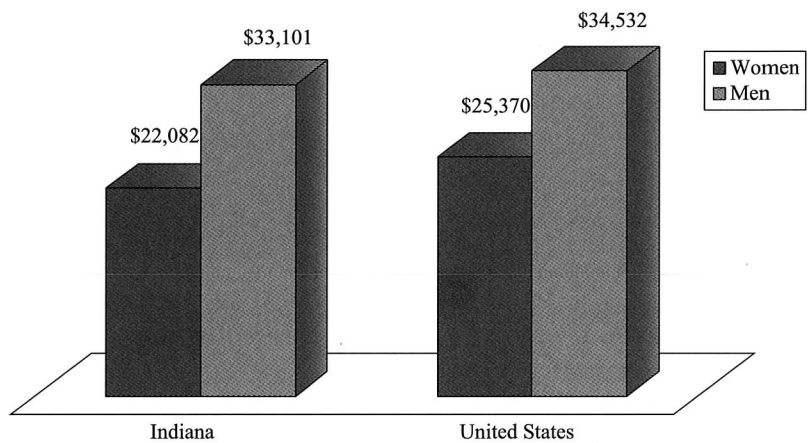
Women's Earnings

Indiana women working full-time, year-round have much lower median annual earnings than women in the United States as a whole ($22,082 and $25,370, respectively; see Figure 1). Similarly, median annual earnings for men in Indiana are lower than for the United States as a whole ($33,101 and $34,532, respectively). Indiana ranks last in the East North Central region and 39th in the nation for median annual earnings for women. Women in the District of Columbia rank the highest with earnings of $30,495.

Between 1989 and 1997, women in Indiana saw their median annual earnings increase by 1.8 percent in real terms, a rate of growth that places them in the middle of East North Central region, behind both Wisconsin and Ohio (at 8.5 percent and 5.7 percent, respectively) but ahead of Illinois and Michigan, where women's earnings fell -0.8 percent and -1.0 percent, respectively (data not shown; all growth rates are calculated for earnings that have been adjusted to remove the effects of inflation; EPI, 2000; IWPR, 1995a).

Unfortunately, the data set used to estimate state-level women's earnings does not provide enough cases to reliably estimate earnings separately for women of different races and ethnicities. National data show, however, that in 1997 the median annual earnings of African American women were $22,378 and those of Hispanic women were $19,269, substantially below that of non-Hispanic white women, who earned $26,319. The earnings of Asian American women were the highest of all groups at $28,214 (median earnings of full-time, year-round women workers aged 15 years and older; U.S. Department of Commerce, Bureau of the Census, 1999c; all data converted to 1998 dollars). Earnings for Native American women are not available between decennial Census years, but in 1989, their earnings for year-round, full-time work were only 84 percent of white women's earnings (U.S.

Figure 1.
Median Annual Earnings of Women and Men Employed Full-Time/Year-Round in Indiana and the United States, 1997 (1998 Dollars)

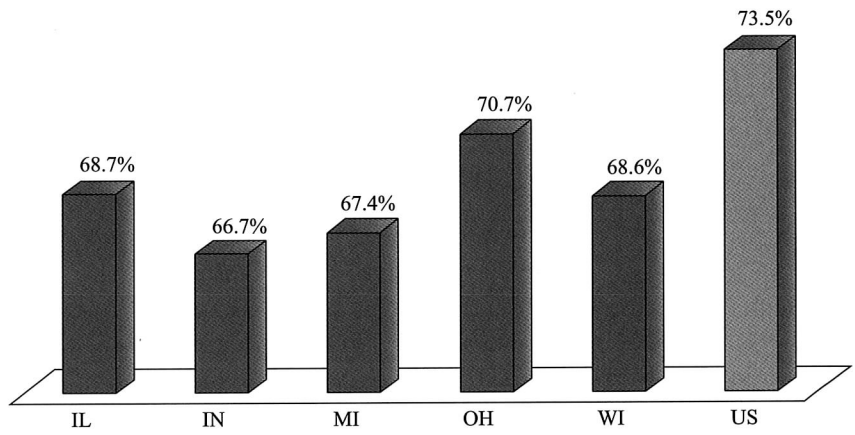


For women and men aged 16 and older. See Appendix II for methodology.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Department of Commerce, Bureau of the Census, 1990).

In addition, a national survey by the Census Bureau showed that in 1994-95 the median monthly income of women with disabilities was only 80 percent of the income of women with no disability (for female full-time workers 21-64 years of age; U.S. Department of Commerce, Bureau of the Census, 1995).

Figure 2.
Ratio of Women's to Men's Full-Time/Year-Round Median Annual Earnings in States in the East North Central Region, 1997



For women and men aged 16 and older. See Appendix II for methodology.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Low earnings levels in Indiana may overstate differences between workers' living standards in Indiana and other states because low earnings may be partially offset by lower costs of living. Similarly in other states, high earnings may be partially offset by a high cost of living. Cost-of-living data are not available by state, however, so no adjustments were made to state earnings data.

The Wage Gap

The Wage Gap and Women's Relative Earnings

In the United States, wages for women historically lag behind men's. In 1997, the median wages of women working full-time, year-round were only 73.5 percent of men's (based on calculations from three years of pooled data). In other words, women earned about 74 cents for every dollar earned by men.

In Indiana, women earned about 66.7 percent of what men did in 1997. Therefore, compared with the earnings ratio for the nation as whole, Indiana women experience less earnings equality with men (see Figure 2). As a result, Indiana ranks 48th in the nation for the ratio of women's to men's earnings for full-time, year-round work. In contrast, the District of Columbia has the highest earnings ratio at 85.7 percent. Compared with the other states in the East North Central region, Indiana ranks last. Ohio ranks first with a 70.7 percent wage ratio. Unfortunately, the wage gap remains large in Indiana, as it does throughout the United States.

Narrowing the Wage Gap

Throughout the 1960s and 1970s, the ratio of women's earnings to men's in the United States remained fairly constant at around 60 percent. During the 1980s, however, women made progress in narrowing the gap between men's earnings and their own. Women increased their educational attainment and their time in the labor market and entered better-paying occupations in large numbers, partly because of equal opportunity laws. At the same time, however, adverse economic trends such as declining wages in the low-wage sector of the labor market began to make it more difficult to close the gap, since women still tend to be concentrated at the low end of the earnings distribution. If women had not increased their relative skill levels and work experience as much as they did during the 1980s, those adverse trends might have led to a widening of the gap rather than the significant narrowing that did occur (Blau and Kahn, 1994).

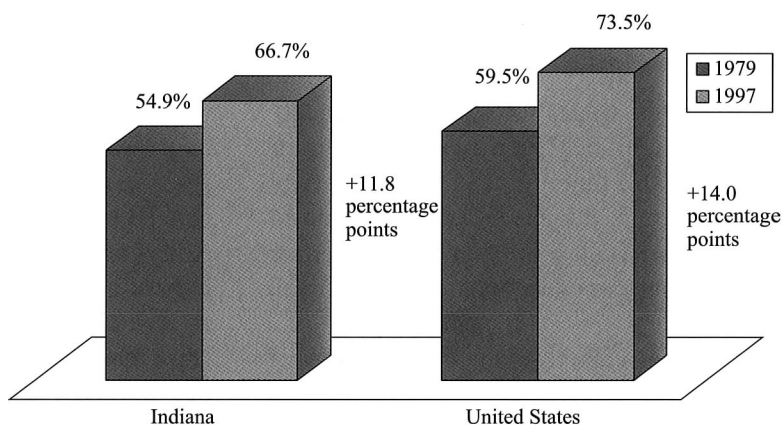
One factor that probably also helped to narrow the earnings gap between women and men is unionization. Women have increased their share of union membership, and being unionized tends to raise women's wages relatively more than men's. Recent research by IWPR found that union membership raises women's weekly wages by 38.2 percent and men's by 26.0 percent (data not shown; Hartmann, Allen and Owens, 1999). In Indiana, the wages of all unionized women were 47.3 percent higher than those of nonunionized women. Unionization also raises the wages of women of color relatively more than the wages of non-Hispanic white women and the wages of low earners relatively more than the wages of high earners (Spalter-Roth, Hartmann and Collins, 1993). In the United States as a whole, unionized minority women earned 38.6 percent more than nonunionized ones (Hartmann, Allen and Owens, 1999); data for minority women in Indiana are not available.

Unfortunately, part of the narrowing in the wage gap that occurred during the 1980s and 1990s was due to a fall in men's real earnings. According to research done by IWPR, less than half (47.8 percent) of the narrowing of the national female/male earnings gap between 1979 and 1997 was due to women's rising real earnings, while more than half (52.2 percent) was due to men's falling real earnings. The slowdown in real earnings growth for women during the later portion of this period is even more disturbing. From 1989 to 1997, more than two-thirds (71.5 percent) of the narrowing of the gap was due to the fall in men's real earnings. In Indiana, a larger percentage of the narrowing of the gap between 1989 and 1997 was due to men's falling real earnings—85.9 percent of the narrowing of the gap was from a decrease in men's earnings, while just 14.1 percent was from an increase in women's earnings.

Indiana fell behind the United States as a whole in increasing women's annual earnings relative to men's between 1979 and 1997 (see Figure 3). In Indiana, the annual earnings ratio increased by only 11.8 percentage points, compared with an increase of 14.0 percentage points in the United States.

Weekly earnings data provide an interesting comparison to annual earnings figures. Unlike annual earnings data, the weekly data released by the Bureau of Labor Statistics (BLS) do not include earnings from self-employed workers, approximately 6 percent of the labor force. Thus, because they are more complete, the annual earnings statistics are used in IWPR's employment and earnings composite indicator. In 1997, women in Indiana earned 65.9 percent of men's weekly earnings for full-time work. This ratio indicates that Indiana ranks second to last, at 50th, in the nation in this ratio of female-male median weekly earnings, slightly worse than its ranking on annual earnings. According to the weekly data series, the District of Columbia ranked

Figure 3.
Change in the Wage Ratio between 1979[a] and 1997[b] in Indiana and the United States



For women and men aged 16 and older. See Appendix II for methodology.
Source: [a] IWPR, 1995a; [b] Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

first in the ratio of women's to men's weekly earnings at 97.1 percent (Council of Economic Advisors, 1998).

Earnings and Earnings Ratios by Educational Levels

Between 1979 and 1997, women with higher levels of education in both Indiana and the United States saw their median annual earnings increase more than women with lower levels of educational attainment. As Table 5 shows, the annual earnings for women in Indiana increased from 0.2 percent (in constant dollars) for women with some college to 37.9 percent for those with more than a college education, while women who had not completed high school experienced an earnings decrease of -10.3 percent.

In contrast, women's relative earnings (as measured by the female/male earnings ratio) increased for women in all educational groups. Those with high school, some college, and college graduation did best in narrowing the wage gap between 1979 and 1997. In Indiana, those with the lowest education attainment (less than high school completion) also did well relative to men, with a narrowing of the wage ratio of 16.5 percent; thus men with less than high school education had declines in real wages even larger than those of women at that educational level. Women with education beyond college narrowed the gap the least, only 2.9 percentage points (because men's wage growth was also strong at this educational level).

The low and falling earnings of women with less education make it especially important that all women have the opportunity to increase their education. For example, many welfare recipients lack a high school diploma or further education, yet in many cases they are being encouraged or required to leave the welfare rolls in favor of immediate employment. These single mothers may be consigned to a lifetime of low earnings if they are not allowed the opportunity to complete high school and acquire a few years of education beyond high school (IWPR, 1997). As Table 5 shows, women with some college, who have completed college, or who have postgraduate training have higher earnings than those without any college, and their earnings have generally been growing. In contrast, women with a high school education or less have seen their earnings decline.

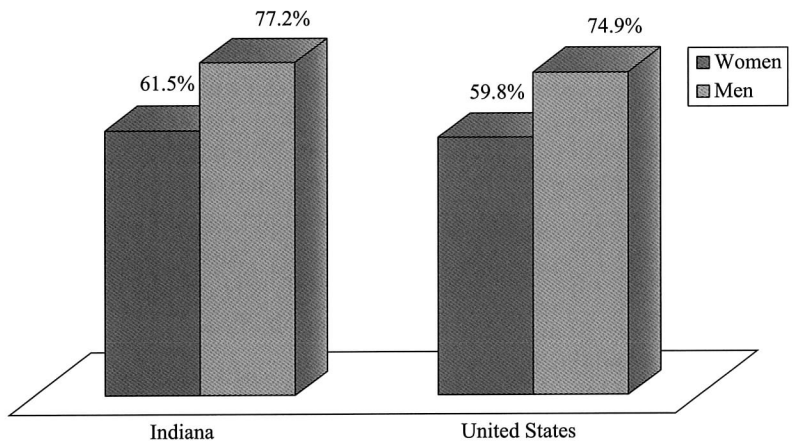
While the availability of educational opportunities is important to women in Indiana, the nature of Indiana's employment base also plays an effect on both men's and women's potential earnings. Relative to the United States, unskilled and semi-skilled occupations are over-represented in Indiana (58.4 percent in Indiana versus 52.1 percent in the United States), while "knowledge" or "high-education" occupations are underrepresented (16.8 percent in Indiana versus 21.9 percent in the nation). The availability of low- or semi-skilled occupations in Indiana and the lack of jobs requiring high levels of education may contribute to both the out-

Table 5.
Women's Earnings and the Earnings Ratio in Indiana by Educational Attainment, 1979 and 1997 (1998 Dollars)

	Women's Median Annual Earnings 1997[a]	Percent Change in Real Earnings 1979[b] and 1997[a]	Female/Male Earnings Ratio, 1997[a]	Percent Change in Earnings Ratio, 1979[b] and 1997[a]
Educational Attainment				
Less than 12th Grade	$17,128	-10.3	66.1%	+16.5
High School Only	$20,286	-1.8	66.4%	+22.7
Some College	$22,509	+0.2	69.1%	+24.2
College	$32,671	+21.2	67.5%	+18.0
College Plus	$44,915	+37.9	70.1%	+2.9

For women and men working full-time year-round.
Source: [a] Economic Policy Institute, 2000; [b] IWPR, 1995a.
Calculated by the Institute for Women's Policy Research.

Figure 4.
Percent of Women and Men in the Labor Force in Indiana and the United States, 1998



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Tables 1 and 12.
Compiled by the Institute for Women's Policy Research.

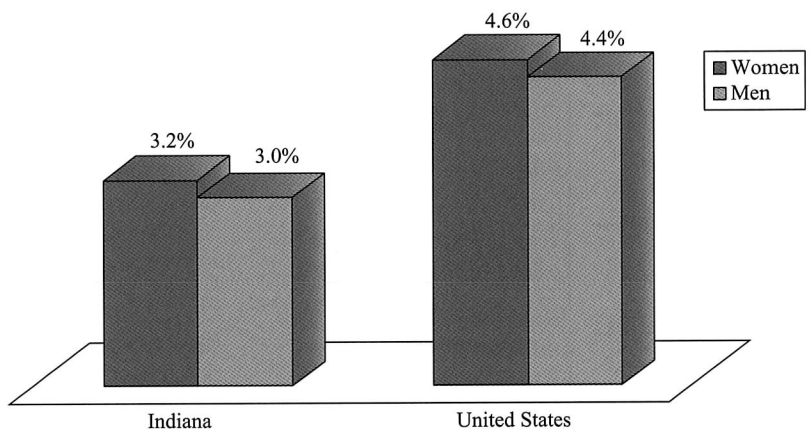
migration of college and graduate educated men and women and to the low earnings of Indiana's men and women (Indiana Economic Development Council, 1999b).

Labor Force Participation

One of the most notable changes in the U.S. economy over the past four decades has been the rapid rise in women's participation in the labor force. Between 1965 and 1997, women's labor force participation increased from 39 to 60 percent (these data reflect the proportion of the civilian non-institutional population aged 16 and older who are employed or looking for work; U.S. Department of Labor, Bureau of Labor Statistics, 1999c). Women now make up nearly half of the U.S. labor force at 46.2 percent of all workers (full-time and part-time combined). According to projections by BLS, women's share of the labor force will continue to increase, growing from 46 to 48 percent between 1998 and 2008 (U.S. Department of Labor, Bureau of Labor Statistics, 1999a).

In 1998, 61.5 percent of women in Indiana were in the labor force, compared with 59.8 percent of women in the United States, earning Indiana the rank of 25th in the nation and second in the East North Central region. Men's labor force participation rate in Indiana was also higher than the rate for men in the United States as a whole (see Figure 4).

Figure 5.
Unemployment Rates for Women and Men in Indiana and the United States, 1998



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c.
Compiled by the Institute for Women's Policy Research.

Unemployment and Personal Income Per Capita

Indiana has a strong and growing economy. A smaller percent of workers is unemployed in Indiana than in the nation as a whole. In 1998, the unemployment rate in Indiana was 3.2 percent for women and 3.0 percent for men, compared with the nation's 4.6 percent for women and 4.4 percent for men (see Figure 5).

While Indiana experienced lower than average unemployment rates in 1998 and in much of the 1990s, the state had experienced higher than average rates during the early and mid 1980s. As a result, personal income per capita in Indiana grew more slowly than it did for the nation between 1980 and 1990 (15.9 percent versus 19.9 percent; see Table 6). From 1990 to 1998, as the unemployment rate in Indiana fell below the national rate, income per capita in Indiana grew 2.6 percentage points faster than the nation.

Table 6.
Personal Income Per Capita for Both Men and Women in Indiana and the United States, 1998

	Indiana	United States
Personal Income Per Capita, 1998	**$24,219**	**$26,412**
Personal Income Per Capita, Percent Change*:		
Between 1990 and 1998	+16.3	+13.7
Between 1980 and 1990	+15.9	+19.9
Between 1980 and 1998	+34.8	+36.3

* In constant dollars.
Source: U.S. Bureau of Economic Analysis, 1999.
Calculated by the Institute for Women's Policy Research.

Part-Time and Full-Time Work

The percent of the female workforce in Indiana employed full-time is virtually identical to the national average (70.6 percent versus 70.7 percent). The percent employed part-time is slightly larger than nationally, while unemployment is lower than the national average. Within the part-time category in Indiana, the percent of women in the labor force who are "involuntary" part-time employees—that is, they would prefer full-time work were it available—is lower than in the United States as a whole (1.6 percent and 2.3 percent, respectively; see Table 7). This pattern reflects national

Table 7.
Full-Time, Part-Time and Unemployment Rates for Women and Men in Indiana and the United States, 1998

	Indiana		United States	
	Female Labor Force	Male Labor Force	Female Labor Force	Male Labor Force
Total Number in the Labor Force	**1,447,000**	**1,642,000**	**63,714,000**	**73,959,000**
Percent Employed Full-Time	70.6	87.2	70.7	85.5
Percent Employed Part-Time*	26.1	9.7	24.8	10.2
Percent Voluntary Part-Time	22.9	8.3	20.8	8.2
Percent Involuntary Part-Time	1.6	0.8	2.3	1.4
Percent Unemployed	3.2	3.0	4.6	4.4

For men and women aged 16 and older.
* Percent part-time includes workers normally employed part-time who were temporarily absent from work the week of the survey. Those who were absent that week are not included in the numbers for voluntary and involuntary part-time. Thus, these two categories do not add to the total percent working part-time.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Tables 1, 12, and 13.
Calculated by the Institute for Women's Policy Research.

trends, in which involuntary part-time work correlates highly with unemployment rates (Blank, 1990); thus the low unemployment rate in Indiana corresponds with a low rate of involuntary part-time employment. A larger proportion of Indiana's female labor force is working part-time voluntarily compared with the United States as a whole (22.9 percent and 20.8 percent, respectively).

Workers are considered involuntary part-time workers if, when interviewed, they state that their reason for working part-time (fewer than 35 hours per week) is slack work—usually reduced hours at one's normally full-time job, unfavorable business conditions, reduced seasonal demand, or inability to find full-time work. Many reasons for part-time work, including lack of child care, are not considered involuntary by the Bureau of Labor Statistics, since workers must indicate they are available for full-time work to be considered involuntarily employed part-time. This definition, therefore, likely understates the extent to which women would prefer to work full-time.

Labor Force Participation of Women by Race/Ethnicity

According to analysis of data from the Current Population Survey from 1996-98, 62.1 percent of women of all races aged 16 and older in Indiana were in the labor force in 1997, a rate slightly higher than in the United States as a whole, 60.1 percent (see Table 8; see Appendix II for details on the methodology used for the 1996-98 Current Population Survey data presented in this report). White women's labor force participation rate was also higher in Indiana than in the United States as a whole (62.1 percent compared with 60.2 percent; see Table 8). African American women historically have had a higher labor force participation rate than white and Hispanic women and did so in 1997. This is also true in Indiana, where African American women had an average labor force participation rate that was 4.6 percentage points higher than that for white women (and 3.3 percentage points higher than the national rate for African American women). Hispanic women traditionally have the lowest average participation rates among women. This is not the case in Indiana, however, where Asian American and other women (including Native American women) have the lowest labor force participation rate of only 48.1 percent, nearly 12 percentage points lower than the national rate for this group. In Indiana, 52.3 percent of Hispanic women were in the labor force, ahead of Asian American and other women, but several percentage points lower than in the United States as a whole, where 55.8 percent of Hispanic women were in the workforce in 1997. Separate data for Asian American women were not available for 1997; however, in 1990, they had the highest participation rate (60.2 percent) of women in the United States. The

Table 8.
Labor Force Participation of Women in Indiana and the United States by Race/Ethnicity, 1997

	Indiana		United States	
Race/Ethnicity	**Number of Women in Labor Force**	**Percent in Labor Force**	**Number of Women in Labor Force**	**Percent in Labor Force**
All Races	**1,466,000**	**62.1**	**64,027,000**	**60.1**
White*	1,314,000	62.1	47,124,000	60.2
African American*	117,000	66.7	8,317,000	63.4
Hispanic	21,000	52.3	5,771,000	55.8
Asian American/ Other*	14,000	48.1	2,815,000	59.8

For women aged 16 and older.
*Non-Hispanic.
Hispanics may be of any race.
Source: Economic Policy Institute, 2000.
Since the numbers and percentages in this table are based on three years of pooled data for data years 1996-98, they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics for 1997. See Appendix II for details on the methodology.
Compiled by the Institute for Women's Policy Research.

national labor force participation rate for Native American women was 55.4 percent in 1990 (Population Reference Bureau, 1993); separate data were not available for Native American women in either Indiana or the nation as a whole for 1997.

Table 9.
Labor Force Participation of Women in Indiana and the United States by Age, 1997

	Indiana		United States	
Age Groups	Number of Women in Labor Force	Percent in Labor Force	Number of Women in Labor Force	Percent in Labor Force
All Ages	**1,466,000**	**62.1**	**64,027,000**	**60.1**
Ages 16-19	101,000	63.3	4,046,000	52.7
Ages 20-24	155,000	76.4	6,420,000	73.0
Ages 25-34	341,000	77.6	15,087,000	76.6
Ages 35-44	385,000	80.3	17,352,000	77.3
Ages 45-54	308,000	73.5	13,440,000	76.3
Ages 55-64	135,000	53.9	6,005,000	51.6
Over 65	42,000	10.1	1,677,000	9.0

For women aged 16 and older.

Source: Economic Policy Institute, 2000.

Since the numbers and percentages in this table are based on three years of pooled data for data years 1996-98, they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics for 1997. See Appendix II for details on the methodology.

Compiled by the Institute for Women's Policy Research.

Labor Force Participation of Women by Age

Workforce participation varies across the life cycle. The highest participation generally occurs between ages 25 and 44, which are also generally considered the prime earning years. Table 9 shows the relationship between labor force participation and age for women in Indiana and in the United States as a whole. Women in Indiana generally have a higher rate of labor force participation than their U.S. counterparts. Nationally, the highest labor force participation rate of women occurs between ages 35 and 44, with just over 77 percent of these women working. In Indiana, the highest rate occurs among women in the same age group, at 80.3 percent. Young women in their teens (16-19), many of whom are attending school, are much less likely to participate in the labor market than any other age group except the pre-retirement and retired cohorts. In Indiana, 63.3 percent of teenage women reported being in the labor force, substantially higher than the reported 52.7 percent for female teens in United States as a whole. Only women aged 45-54 have lower labor force participation rates in Indiana than in the nation as a whole, at 73.5 and 76.3 percent, respectively.

As women near retirement age, they are much less likely to work than younger women. In the United States as a whole, women aged 55-64 have a labor participation rate of only 51.6 percent. In Indiana, 53.9 percent of these women are in the workforce. Women aged 65 and older in Indiana had a labor force participation rate of 10.1 percent; in the United States as a whole, only about 9.0 percent are working or looking for work in that age group.

Labor Force Participation of Women with Children

Mothers represent the fastest growing group in the U.S. labor market (Brown, 1994). In 1998, 59 percent of women with children under age one were in the labor force, compared with 31 percent in 1976 (U.S. Department of Commerce, Bureau of the Census, 2000). In general, the workforce participation rate for women with children in the United States tends to be higher than the rate for all women (70.3 percent versus 60.1 percent in 1997; EPI, 2000). This is partially explained by the fact that the overall labor force participation rate is for all women aged 16 and older; thus both teenagers and retirement-age women are included in the statistics even though they have much lower labor force par-

ticipation rates. Mothers, in contrast, tend to be in age groups with higher labor force participation rates. This is also true in Indiana, with 75.1 percent of women with children under age 18 in the workforce, compared with 62.1 percent of all women in Indiana in 1997. Women with children are also much more likely to engage in labor market activity in Indiana than in the United States as a whole (75.1 percent versus 70.3 percent; see Table 10).

Child Care and Other Caregiving

The high and growing rates of labor force participation of women with children suggest that the demand for child care is also growing. Many women report a variety of problems finding suitable child care (affordable, good quality and conveniently located), and women use a wide variety of types of child care. These arrangements include doing shift work to allow both parents to take turns providing care; bringing a child to a parent's workplace; working at home; using another family member (usually a sibling or grandparent) to provide care; using a babysitter in one's own home or in the babysitter's home; using a group child care center; or leaving the child unattended (U.S. Department of Commerce, Bureau of the Census, 1996b).

As full-time work among women has grown, so has the use of formal child care centers, but child care costs are a significant barrier to employment for many women. Child care expenditures use up a large percentage of earnings, especially for lower-income mothers. For example, among single mothers with family incomes within 200 percent of the poverty level, the costs for those who paid for child care amount to 19 percent of the mother's earnings on average. Among married mothers at the same income level, child care costs amount to 30 percent of the mother's earnings on average (although the costs of child care are similar for both types of women, the individual earnings of married women with children are less on average than those of single women with children; IWPR, 1996).

As more low-income women are encouraged or required (through welfare reform) to enter the labor market, the growing need for affordable child care must be addressed. Child care subsidies for low-income mothers are essential to enable them to purchase good quality child care without sacrificing their families' economic well-being. Currently, subsidies exist in all states but are often inadequate; many poor women and families do not receive them. Recent data show that, nationally, only 10 percent of those children potentially eligible for child care subsidies actually receive subsidies under the federal government's Child Care and Development Fund. In Indiana, a much lower proportion, only 4 percent, of these children do (see Table 11). Indiana also maintains stricter criteria for eligibility for receiving child care subsidies than required by federal law. If state income eligibility limits were equal to the federal maximum, 299,800 children would qualify for subsidies, while in Indiana, only about two-thirds of that number, 197,200, are eligible under existing state eligibility policies. Clearly many Indiana families in need of financial support for child care are not receiving it.

In addition to caring for children, many women provide care for friends and relatives who experience long-term illness

Table 10.
Labor Force Participation of Women with Children in Indiana and the United States, 1997

	Indiana	United States
	Percent in the Labor Force	Percent in the Labor Force
Women with Children		
Under Age 18*	71.5	70.3
Under Age 6*	67.4	64.1

For women aged 16 and older.
* Children under age 6 are also included in children under 18.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Table 11.
Percent of Eligible Children Receiving CCDF* Subsidies in Indiana and the United States, 1998

	Indiana	United States
Eligibility**		
Number of Children Eligible under Federal Provisions	299,800	14,749,300
Number of Children Eligible under State Provisions	197,200	9,851,100
Receipt		
Number and Percent of Children Eligible under Federal Law Receiving Subsidies in the State	12,670 4%	1,530,500 10%

*Child Care and Development Fund (CCDF).

** "Children eligible under federal provisions" refers to those children with parents working or in education or training who would be eligible for CCDF subsidies if state income eligibility limits were equal to the federal maximum. Many states set stricter limits, and therefore the pool of eligible children is smaller under state provisions.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999a.
Compiled by the Institute for Women's Policy Research.

or disability. Although few data on caregiving exist, recent research suggests that about a quarter of all households in the United States are giving or have given care to a relative or friend in the past year, and over 70 percent of those giving care are female. Caregivers on average provide just under 18 hours a week of care, and many report giving up time with other family members; giving up vacations, hobbies, or other activities; and making adjustments to work arrangements for caregiving (National Alliance for Caregiving and American Association of Retired Persons, 1997). Like mothers of young children, other types of caregivers experience shortages of time, money and other resources, and they too require policies designed to lessen the burden of long-term care. Nonetheless, few such policies exist, and this kind of caregiving remains an issue for state and national policymakers to address.

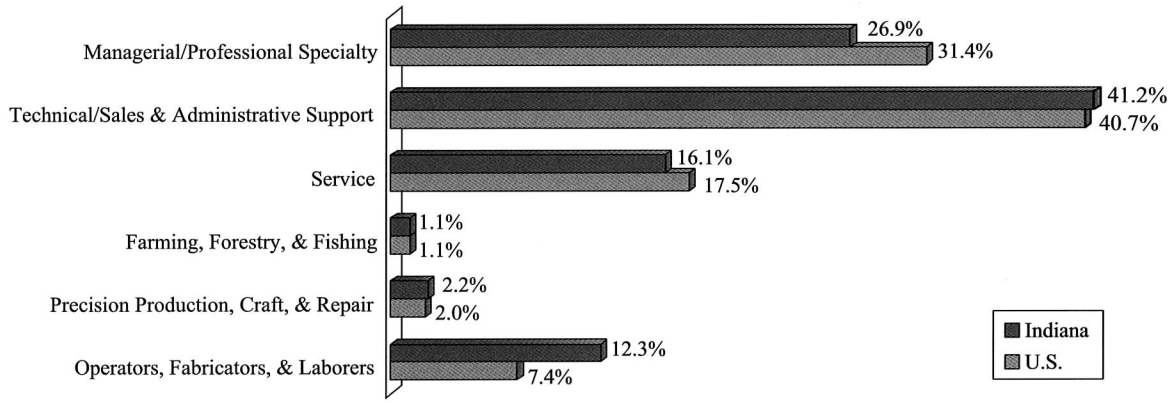
Occupation and Industry

The distribution of women in Indiana across occupations differs somewhat from the distribution found in the United States as a whole. In the United States, technical, sales and administrative support occupations provide 40.7 percent of all jobs held by women (see Figure 6a). At 41.2 percent, women in Indiana are slightly more likely to be in technical, sales and administrative support occupations than women in the United States as a whole. In addition, the percent of men in Indiana employed in technical, sales and administrative support occupations is substantially less than the percent of women employed in these occupations at 16.5 percent (data not shown; U.S. Department of Labor, Bureau of Labor Statistics, 1999c). Women in Indiana are less likely to work in service occupations (16.1 percent versus 17.5 percent) and substantially more likely to work as operators, fabricators and laborers than women in the United States as a whole (12.3 percent versus 7.4 percent). A much smaller percentage of men work in service occupations in Indiana, 8.5 percent, while a larger percentage of men than women work as operators, fabricators and laborers, 27.2 percent (data not shown, U.S. Department of Labor, Bureau of Labor Statistics, 1999c).

Women in Indiana are considerably less likely to work in managerial and professional specialty occupations than are women in the United States (26.9 percent versus 31.4 percent). As a result, Indiana ranks 44th in the nation and last in the East North Central region for the proportion of its female labor force employed in professional and managerial occupations. In Indiana 24.3 percent of men work in managerial and professional specialty occupations, also less than the 28.1 percent of men in similar occupations in the United States (data not shown; U.S. Department of Labor, Bureau of Labor Statistics, 1999c).

Even when women work in the higher-paid occupations, such as managers, they earn substantially less than men. A national IWPR (1995b) study shows that women managers are unlikely to be among top earners in managerial positions. If

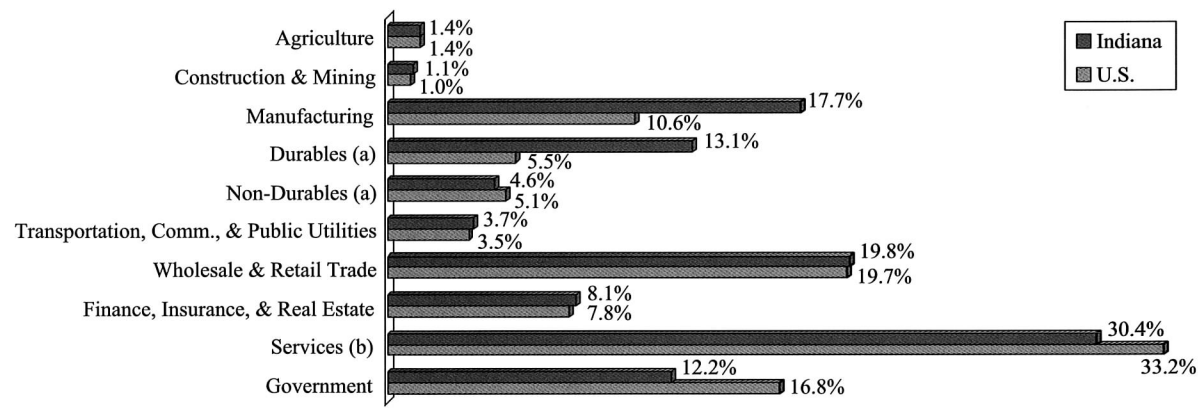
Figure 6a.
Distribution of Women Across Occupations in Indiana and the United States, 1998



For employed women aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Table 15.
Compiled by the Institute for Women's Policy Research.

women had equal access to top-earning jobs, 10 percent of women managers would be among the top 10 percent of earners for all managers; however, only 1 percent of women managers have earnings in the top 10 percent. In fact, only 6 percent of women had earnings in the top fifth. Similarly, a

Figure 6b.
Distribution of Women Across Industries in Indiana and the United States, 1998



For employed women aged 16 and older.
Percents do not add up to 100 percent because "self-employed" and "unpaid family workers" are excluded.
(a) Durables and non-durables are included in manufacturing.
(b) Private household workers are included in services.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Table 17.
Compiled by the Institute for Women's Policy Research.

Catalyst (1999) study showed that only 3.3 percent (just 77) of the highest-earning high-level executives in Fortune 500 companies were women as of 1999.

The distribution of women in Indiana across industries also differs somewhat from that of the United States as a whole (see Figure 6b). In Indiana, 30.4 percent of all women are employed in the service industries (including business, professional and personnel services), considerably less than the 33.2 percent in these industries in the United States. About 19.7 percent of employed women in the United States work in the wholesale and retail trade industries, and a similar proportion, 19.8 percent, of women in Indiana work in these industries. About 16.8 percent of the nation's women work in government, while a much smaller proportion of Indiana's women do (12.2 percent). In contrast, Indiana women are much more likely to work in the manufacturing industries, at 17.7 percent versus 10.6 percent in the nation as a whole. In Indiana, most women in manufacturing work in durables, as 13.1 percent of women in Indiana work in these industries, compared with 5.5 percent in the United States. In contrast, a smaller proportion of women in Indiana work in non-durables, at 4.6 versus 5.1 percent in the nation as a whole. Finally, women in Indiana are slightly less likely to work in the finance, insurance and real estate (F.I.R.E.) industry than are women in the United States as a whole. Indiana's industrial pattern echoes that shown in the occupational distribution above—a disproportionately large blue-collar economic base with correspondingly less white-collar work.

Economic Autonomy

While labor force participation and earnings are significant in helping women achieve financial security, many additional issues affect their ability to act independently, exercise choice and control their lives. The Beijing Declaration and Platform for Action stresses the importance of adopting policies and strategies that ensure women equal access to education and health care, provide women access to business networks and services, and address the needs of women in poverty. This section highlights several topics important to women's economic autonomy: health insurance coverage, educational attainment, women's business ownership and female poverty.

Each of these issues contributes to women's lives in distinct if interrelated ways. Access to health insurance plays a role in determining the overall quality of health care for women in a state and governs the extent of choice women have in selecting health care services. Educational attainment relates to economic autonomy in many ways: through labor force participation, hours of work, earnings, childbearing decisions and career advancement. Women who own their own businesses control many aspects of their working lives. Finally, women in poverty have limited choices. If they receive public income support, they must comply with legislative regulations enforced by their caseworkers. They do not have the economic means to travel freely. In addition, they often do not have access to the skills and tools necessary to improve their economic situation.

With its composite index of 36th among the states, Indiana ranks in the bottom third of all states for women's economic autonomy. The state ranks among the top ten for the percent of women above poverty. However, it falls to 21st and 22nd, respectively, for the percent of women with health insurance and women's business ownership. The state is near the bottom of all states, at 46th, in women's educational attainment (see Chart V). Within the East North Central region, Indiana ranks second for women above poverty, third for women-owned businesses, and last for women with health insurance and women with higher education.

Chart V.
Economic Autonomy: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 5)	Grade
Composite Economic Autonomy Index	**36**	**5**	**C-**
Percent with Health Insurance (among nonelderly women, 1997)[a]	21	5	
Educational Attainment (percent of women aged 25 and older with four or more years of college, 1990)[b]	46	5	
Women's Business Ownership (percent of all firms owned by women, 1992)[c]	22	3	
Percent of Women Above Poverty (percent of women living above the poverty threshold, 1997)[d]	6	2	

See Appendix II for methodology.

* The national rank is of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI).

Source: [a] Employee Benefit Research Institute, 1999; [b] Population Reference Bureau, 1993; [c] U.S. Department of Commerce, Bureau of the Census, 1996a; [d] Economic Policy Institute, 2000.

Calculated by the Institute for Women's Policy Research.

On most of the indicators of economic autonomy, women have far less access than men to the resources identified as important. Throughout the country, men are more likely to have a college education, own a business and live above the poverty line than women are. Although women generally do have health insurance at rates higher than men, largely because of public insurance like Medicaid, the rates of uninsured men and women are both growing. Trends in Indiana do not diverge from these basic patterns; moreover, women in the state have even fewer resources than women in many other states. As a result, the state received a grade of C- on the economic autonomy composite index.

Access to Health Insurance

Women in Indiana are somewhat more likely than women in the nation as a whole to have health insurance. In Indiana, 14.3 percent of women, compared with 18.5 percent in the United States, are not insured (see Table 12). Among all the states, Indiana ranks 21st in the nation and last in the East North Central region for the proportion of women who are insured.

On average, women and men in Indiana have greater access to employer-based health insurance than women and men in the United States as a whole (74.1 percent and 66.4 percent, respectively, for women; 76.5 percent and 67.4 percent, respectively, for men). This type of health insurance accounts for much of Indiana's high rates of insurance coverage for women. Many women receive employer-based health insurance as dependents. In Indiana, 30.6 percent of all women receive employer-based insurance this way, compared with 26.4 percent in the nation as a whole. However, a higher proportion, 43.5 percent in Indiana and 40.1 percent in the nation, also receive employer-based health insurance in their own name.

In the United States as a whole, women tend to have health insurance coverage from public sources, such as Medicaid, at higher rates than men. In Indiana, the rate of publicly insured women is much lower than the U.S. rate (only 6.9 percent in Indiana and 12.5 percent in the United States) and is similar to rates of public health insurance among men (6.9 percent versus 6.2 percent, respectively). A higher percentage of women in Indiana (7.4 percent) purchase their own health insurance than in the United States overall (6.4 percent). Despite Indiana's relatively high rates of health insurance when compared with the rest of the nation, access to health insurance coverage remains a problem for many women across Indiana and the country.

Table 12.
Percent of Women and Men without Health Insurance and with Different Sources of Health Insurance in Indiana and the United States, 1997

	Indiana		United States	
	Women	Men	Women	Men
Number	**1,828,000**	**1,773,000**	**85,132,000**	**81,458,000**
Percent Uninsured	14.3	14.1	18.5	21.0
Percent with Employer-Based Health Insurance	74.1	76.5	66.4	67.4
Own Name	43.5	63.2	40.1	54.9
Dependent	30.6	13.3	26.4	12.5
Percent with Public Insurance	6.9	6.2	12.5	8.7
Percent with Individually-Purchased Insurance	7.4	5.6	6.4	5.8

Women and men ages 18 to 64; numbers do not add to 100 percent because some people have more than one source of health insurance.

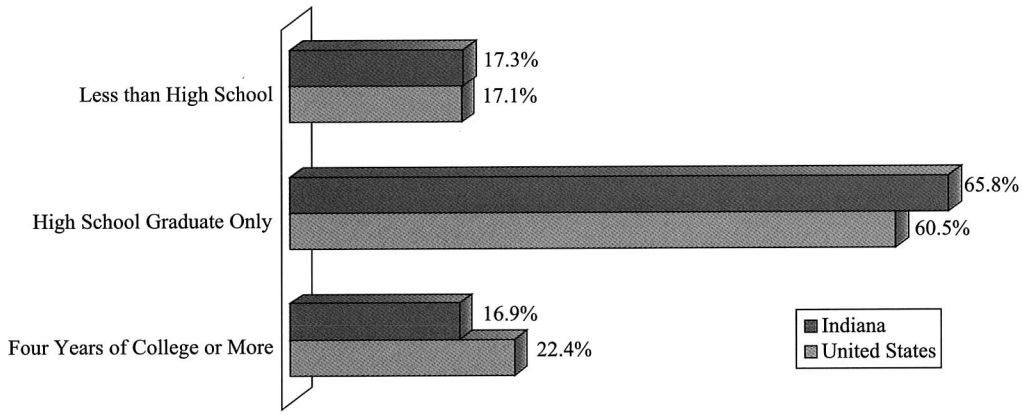
Source: Employee Benefit Research Institute, 1999.

Compiled by the Institute for Women's Policy Research.

Education

In the United States, women have made steady progress in achieving higher levels of education. Between 1980 and 1998, the percent of women in the United States with a high school education or more increased by

Figure 7.
Educational Attainment of Women Aged 25 and Older in Indiana and the United States, 1998



Source: U.S. Department of Commerce, Bureau of the Census, 1999a.
Compiled by the Institute for Women's Policy Research.

about one-fifth, and as of 1998, comparable percentages of women and men had completed a high school education (82.9 percent of women and 82.7 percent of men). During the same period, the percent of women with four or more years of college increased by three-fifths, from 13.6 percent in 1980 to 22.4 percent in 1997 (compared with 26.5 percent of men in 1997), bringing women closer to closing the education gap (U.S. Department of Commerce, Bureau of the Census, 1998a, 1998c).

Regional differences in education are conspicuous. The South and much of the Midwest have achieved lower levels of educational attainment than other areas of the country. Indiana fits this pattern with its rank of 46th in the proportion of the female population aged 25 years and older who have attained four or more years of college. In 1998, only 16.9 percent of women in Indiana had completed four years of college or more, compared with 22.4 percent of women in the United States as a whole (see Figure 7). In 1998, a higher proportion of men, 18.5 percent, in Indiana had completed four years of college or more. Nonetheless, this proportion is less than the 26.5 percent of men with four years of college or more in the United States as a whole (data not shown; U.S. Department of Commerce, Bureau of the Census, 1998). The proportion of women older than 25 in Indiana without high school diplomas is comparable to that of women in the United States as a whole (17.3 percent and 17.1 percent, respectively). The proportion of men older than 25 in Indiana without high school diplomas, 15.6 percent, was less than that of women in Indiana and of men in the United States as a whole (17.2 percent; data not shown; U.S. Department of Commerce, Bureau of the Census, 1998). Finally, a somewhat larger proportion of women aged 25 and older in Indiana are high school graduates, at 65.8 percent compared to 60.5 percent in the United States. This rate is comparable to men in Indiana, 65.9 percent of who are high school graduates as of 1998. Only 56.3 percent of men in the United States as a whole have just a high school education (data not shown; U.S. Department of Commerce, Bureau of the Census, 1998). The higher proportions of men and women whose highest education level is high school completion are consistent with Indiana's relatively low rate of college education for both women and men among its adult population.

Because data for 1998 were only available for the larger states, the rankings on this indicator are based on 1990 data. In 1990, 13.4 percent of women in Indiana had four years of college or more, a much lower proportion than the national average of 17.6 percent. In the period from 1990 to 1998, while the proportion of women in the United States with a

college education increased by 4.8 percentage points, in Indiana it increased by only 3.5 percentage points. As a result, during the 1990s, Indiana fell even further behind the nation as a whole.

Women Business Owners and Self-Employment

Owning a business can bring women increased control over their working lives, create important financial opportunities for them, and enhance their sense of empowerment. It can encompass a wide range of arrangements, from owning a corporation, to consulting, to engaging in less lucrative activities such as child care provision. Overall, both the number and proportion of businesses owned by women have been growing.

Between 1987 and 1992, the number of women-owned businesses grew 39.4 percent in Indiana, somewhat lower than the 43.1 percent growth of women-owned businesses in the United States as a whole (for purposes of comparability over time, these data exclude Type C corporations; for a definition of Type C corporations, see Appendix II). By 1992, women owned 125,411 firms in Indiana, and women-owned businesses employed 188,160 people (see Table 13). In Indiana, 50.0 percent of women-owned firms were in the service industries, and the next highest proportion (23.1 percent) was in retail trade (see Figure 8). Business receipts of women-owned businesses in Indiana rose by 45.9 percent (in constant dollars) between 1987 and 1992. This growth is substantially lower than the increase of 87.0 percent in business receipts for women-owned firms in the United States but higher than the 34.9 percent increase for all firms in the United States during the same time period, also adjusted for inflation (data not shown).

In 1992, the U.S. Bureau of the Census reported that women owned more than 6.4 million firms nationwide, employing over 13 million persons and generating $1.6 trillion in business revenues (unlike the figures in Table 13, these numbers include all women-owned businesses, including Type C corporations; U.S. Department of Commerce, Bureau of the Census, 1996a). Projecting women's business growth rates forward from 1987 to 1992 and including Type C corporations, the National Foundation for Women Business Owners (NFWBO) estimates the 1999 number of women-owned firms for Indiana to be 190,400 of the more than 9.1 million estimated for the United States as a whole (NFWBO, 1999).

Like women's business ownership, self-employment for women (one kind of business ownership) has also been rising over recent decades. In 1975, women represented one in every four self-employed workers in the United States, and in 1998 they were approximately one in two. The decision to become self-employed is influenced by many factors. An IWPR study shows that self-employed women tend to be older and married, have no young children, and have higher levels of education than the

Table 13.
Women-Owned Firms in Indiana and the United States, 1992

	Indiana	United States
Number of Women-Owned Firms*	**125,411**	**5,888,883**
Percent of All Firms that Are Women-Owned	34.4%	34.1%
Percent Increase, 1987-1992	39.4%	43.1%
Total Sales & Receipts (in billions, 1992 dollars)	**$16,055,833**	**$642,484,352**
Percent Increase (in constant dollars), 1987-1992	45.9%	87.0%
Number Employed by Women-Owned Firms	**188,160**	**6,252,029**

* For reasons of comparability between 1987 and 1992, these statistics do not include data on Type C corporations; see Appendix II.

Source: U.S. Department of Commerce, Bureau of the Census, 1996a.

Compiled by the Institute for Women's Policy Research.

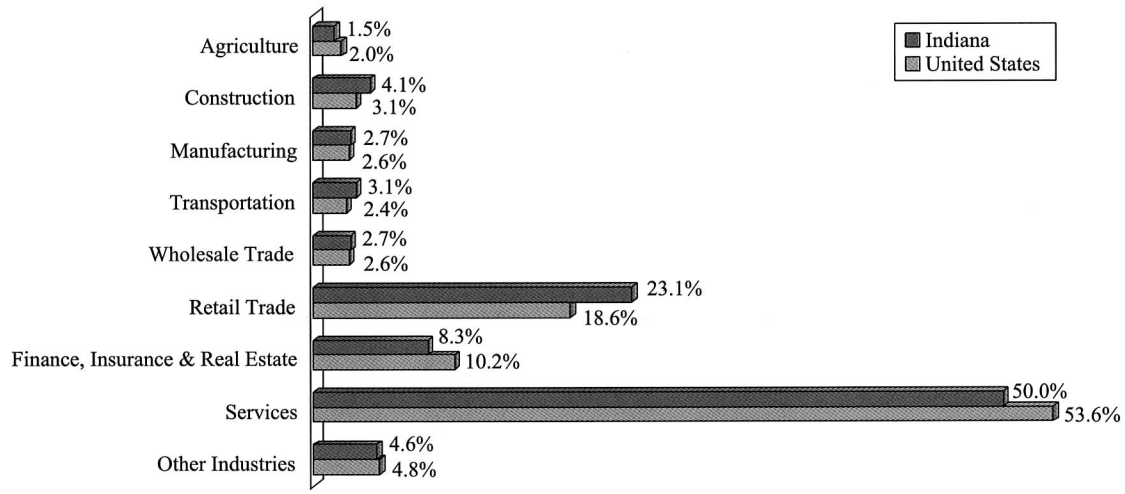
average. They are also more likely to be covered by another person's health insurance (Spalter-Roth, Hartmann and Shaw, 1993). Self-employed women are more likely to work part-time, with 42 percent of married self-employed women and 34 percent of nonmarried self-employed women working part-time (Devine, 1994)

Unfortunately, most self-employment is not especially well-paying for women, and about half of self-employed women combine this work with another job, either a wage or salaried job or a second type of self-employment (for example, babysitting and catering). In 1986-87 in the United States as a whole, women who worked full-time, year-round at only one type of self employment had the lowest median hourly earnings of all full-time, year-round workers ($5.38); those with two or more types of self-employment with full-time schedules earned somewhat more ($6.33 per hour). In contrast, those who held only one full-time, year-round wage or salaried job earned the most ($11.59 per hour at the median; all figures in 1998 dollars). Those who combined wage and salaried work with self-employment had median earnings that ranged between these extremes. Many low-income women package earnings from many sources in an effort to raise their family incomes (Spalter-Roth, Hartmann and Shaw, 1993).

Moreover, some self-employed workers are independent contractors, a form of work that can be largely contingent, involving temporary or on-call work without job security, benefits, or opportunity for advancement. Even when working primarily for one client, independent contractors may be denied the fringe benefits (such as health insurance and employer-paid pension contributions) offered to wage and salaried workers employed by the same client firm. The average self-employed woman who works full-time, year-round at just one type of self-employment has health insurance an average of only 1.7 months out of twelve, while full-time wage and salaried women average 9.6 months (those who lack health insurance entirely are also included in the averages; Spalter-Roth, Hartmann and Shaw, 1993).

Overall, however, recent research finds that the rising earnings potential of women in self-employment compared with wage and salary work explains most of the upward trend in the self-employment of married women between 1970 and 1990. This suggests

Figure 8.
Distribution of Women-Owned Firms Across Industries in Indiana and the United States, 1992



Source: U.S. Department of Commerce, Bureau of the Census, 1996a.
Compiled by the Institute for Women's Policy Research.

that the growing movement of women into self-employment represents an expansion in their opportunities (Lombard, 1996). Women in Indiana are about as likely to be self-employed as women in the United States. In 1997, 6.1 percent of working women in Indiana and the United States were self-employed (U.S. Department of Labor, Bureau of Labor Statistics, 1995).

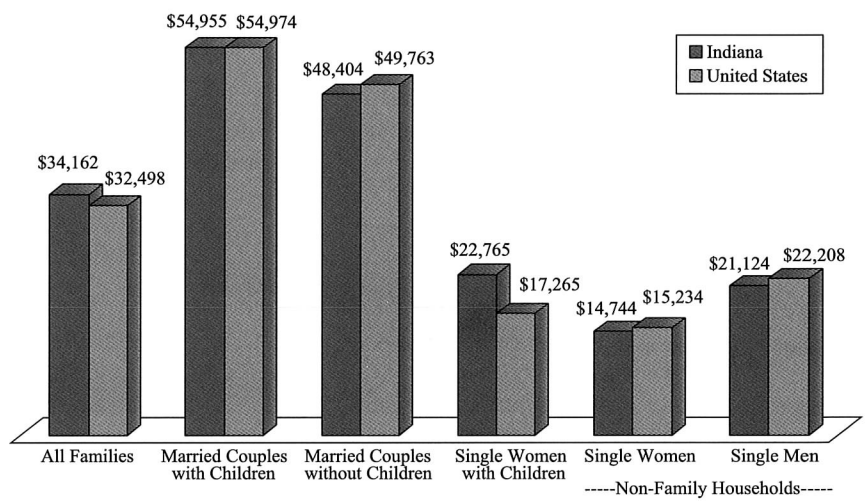
Women's Economic Security and Poverty

As women's responsibility for their families' economic well-being grows, the continuing wage gap and women's prevalence in low-paid, female-dominated occupations impede their ability to ensure their families' financial security, particularly for single mothers. In the United States, the median family income for families comprised of single women with children was $17,265 in 1997, while that for married couples with children was $54,974 (see Figure 9). Figure 9 also shows that family income was somewhat higher on average for all families in Indiana than in the United States as a whole. However, different family types fared differently relative to the nation. Single-female families with children had higher incomes than similar families in the United States, while single individuals and married couples without children had less income on average than their national counterparts. Because Indiana has a higher proportion of high-income family types than nationally (generally, married couples), and because single-female families with children have relatively high incomes, even though median family income is slightly lower for most family types in Indiana than nationally, the average income for all families together is slightly higher.

The proportion of women in poverty in Indiana in 1997 was also less than that of women in the United States: 9.2 percent and 13.1 percent, respectively (see Figure 10). Thus Indiana ranks sixth in the nation and second of the five states in its region for women living above poverty. Wisconsin has the least poverty in the East North Central region, at 8.4 percent of women living below the poverty line, while Ohio has the most, at 11.4 percent.

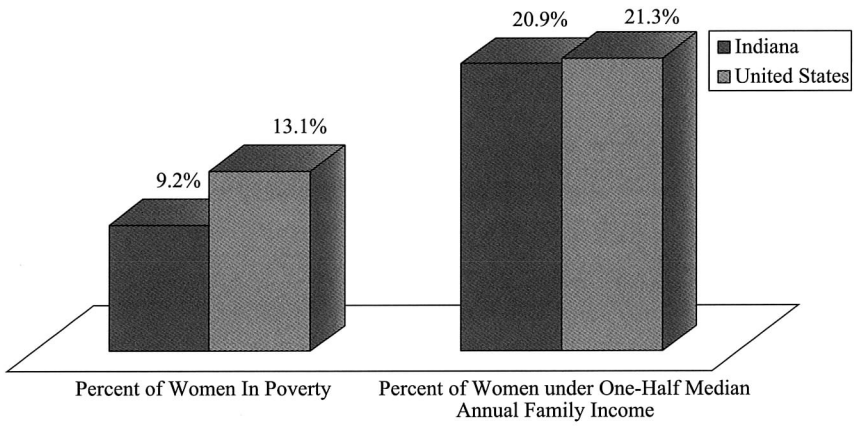
Although the poverty line is the federal standard of hardship in the United States, to measure hardship in wealthier countries, many researchers use one-half median income as an indicator of families' access to adequate social and economic resources (Miringoff and Miringoff, 1999; Smeeding, 1997). Because median income varies by state, this measure is more sensitive to variations in cost or standard of living than the federal poverty line, which is the same for all states. Figure 10 also shows the proportion of women living under one-half of median income in the state and in the United States as a whole.

Figure 9.
Median Annual Income for Selected Family Types and Single Women and Men, in Indiana and the United States, 1997 (1998 dollars)



Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Figure 10.
Percent of Women Living in Poverty and Living under One-Half Median Annual Family Income in Indiana and the United States, 1997



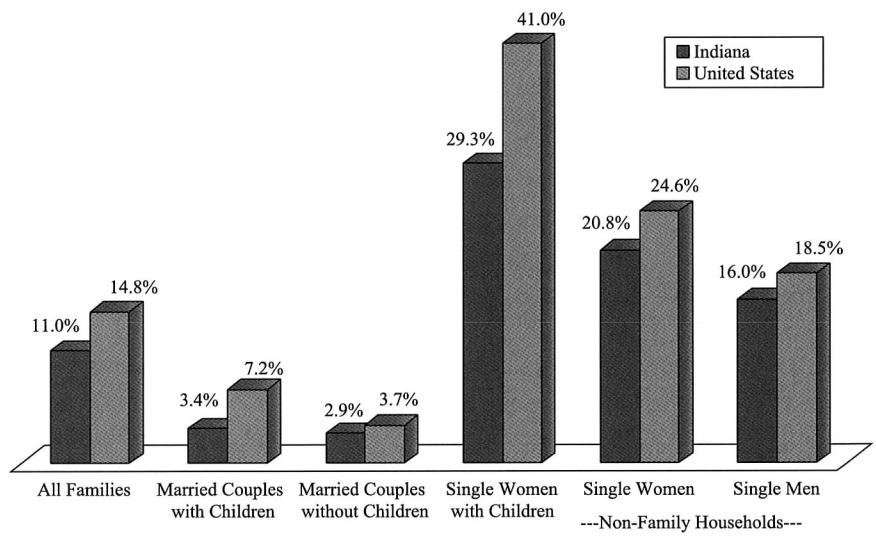
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

about average in terms of family income, and not as much better as the difference between the Indiana and U.S. poverty rates (3.9 percentage points) would indicate.

Along with Indiana's lower overall rate of female poverty, the poverty rate for single women with children is considerably lower than the nationwide rate (29.3 percent and 41.0 percent, respectively). Nonetheless, in Indiana and in the nation as a whole, single women with children experience much higher levels of poverty than any other family type (see Figure 11). Moreover, even the high rates of poverty among these families probably understate the degree of their

Overall, this measure shows much higher rates of hardship than the poverty rate does. In the United States as a whole, the proportion of women living in families with incomes under one-half median income was 21.3 percent, much higher than the percent of women living in families with incomes below the federal poverty line (13.1 percent). In Indiana, 20.9 percent of women were living under one-half median family income in 1997. This number is also much higher than the poverty rate among women in the state. In addition, it is similar to the national rate for women living under one-half median income, indicating that compared with women in other states, women in Indiana fare only

Figure 11.
Poverty Rates for Selected Family Types and Single Men and Women in Indiana and the United States, 1997



Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

hardship, especially among those with working mothers. While counting noncash benefits would reduce their poverty rates, adding the cost of child care for working mothers would increase the calculated poverty rates both in Indiana and the nation (Renwick and Bergmann, 1993). Child care costs were not included at all in family expenditures when federal poverty thresholds were developed. However, for the country as a whole, single parents who do not work have basic cash needs at about 64 percent of the poverty line, while those who work have basic cash needs from 113 to 186 percent of the poverty line, depending on the number and ages of their children. Overall, the net effect of this under- and over-estimation of poverty was a significant underestimation, and Renwick and Bergmann estimate a 1989 national poverty rate of 47 percent, compared with an official estimate of 39 percent, for single-parent families (Renwick and Bergmann, 1993). Poverty rates for low-income, married-couple families would also be much higher if child care costs were included (Renwick, 1993).

Another factor contributing to poverty among all types of households is the wage gap. Recent IWPR research found that in the nation as a whole, eliminating the wage gap, and thus raising women's wages to a level equal to those of men with similar qualifications, would cut the poverty rate among married women and single mothers in half. In Indiana, poverty among single-mother households would drop by about 40 percent (Hartmann, Allen and Owens, 1999). As a result, while eliminating the wage gap would not completely eliminate poverty or hardship—especially for women and men in low-wage jobs—pay equity provisions would help many women support their families.

Finally, despite the overall growth in women's earnings and a strong economy, in most states—including both high and low earnings states—inequality among families is growing. Research by the Economic Policy Institute notes that in the nation as a whole in 1996-98, the income of the average family in the top 20 percent of families was 10.6 times the income of the average family in the bottom 20 percent. This represents a substantial increase from 1978-80, when families in the top 20 percent had about 7.4 times as much income as those in the bottom 20 percent. In Indiana, families in the top 20 percent received 7.3 times as much income as those in the bottom 20 percent in 1996-98, which was also an increase from 1978-80, when top-income families received 5.8 times the income of bottom-income families (Bernstein, McNichol, Mishel and Zahradnik, 2000). However, inequality in Indiana is lower than in the nation as a whole and is growing more slowly, at 1.5 percentage points in the period from 1978-80 to 1996-98, compared with 3.2 percentage points in the nation as a whole.

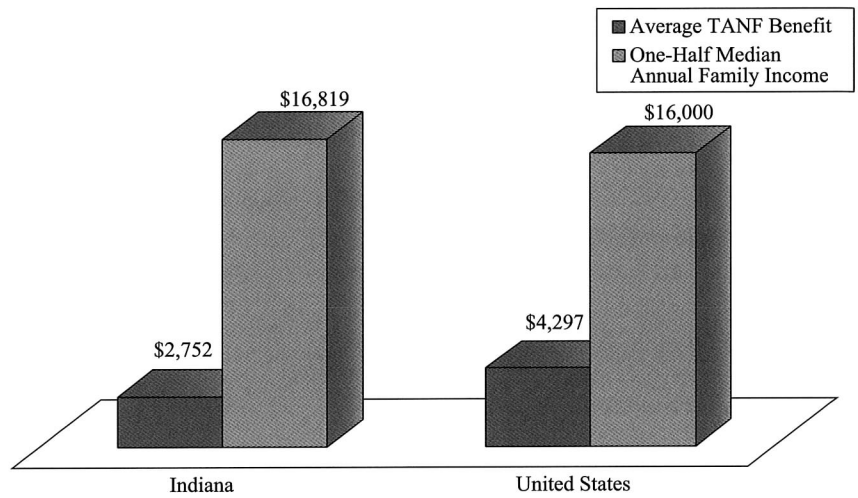
State Safety Nets for Economic Security

The amount of cash welfare benefits varies widely from state to state. Figure 12 compares the size of Indiana's average welfare benefit with one-half median family income in the state, as a measure of how well the state's welfare safety net helps poor women achieve an acceptable standard of living. Obviously, the poverty of many families is not alleviated by welfare alone, and many families also receive Food Stamps or other forms of noncash benefits. Still, research shows that, even adding the value of noncash benefits, many women remain poor (U.S. Department of Commerce, Bureau of the Census, 1997b). In Indiana, as in all of the United States, TANF benefits are substantially below one-half median income. In addition, cash benefits in Indiana are substantially lower than the U.S. average, even though one-half median family income is slightly higher than for the United States as a whole. As a result, Indiana's cash benefits comprise only 16.4 percent of one-half median annual income in the state, compared with 26.9 percent in the nation as a whole.

Indiana also does a worse than average job of providing a safety net for employed women. The unemployment rate for women in Indiana (3.2 percent) is less than the national average of 4.6 percent (see Table 7). However, among women who are unemployed, benefit receipt is also low: the percent of unemployed women in Indiana receiving unemployment insurance benefits is four percentage points lower than in the United States as a whole (see Figure 13). The same is true for unemployed men in Indiana: the percent of unemployed men is lower and the rate of unemployment insurance benefit

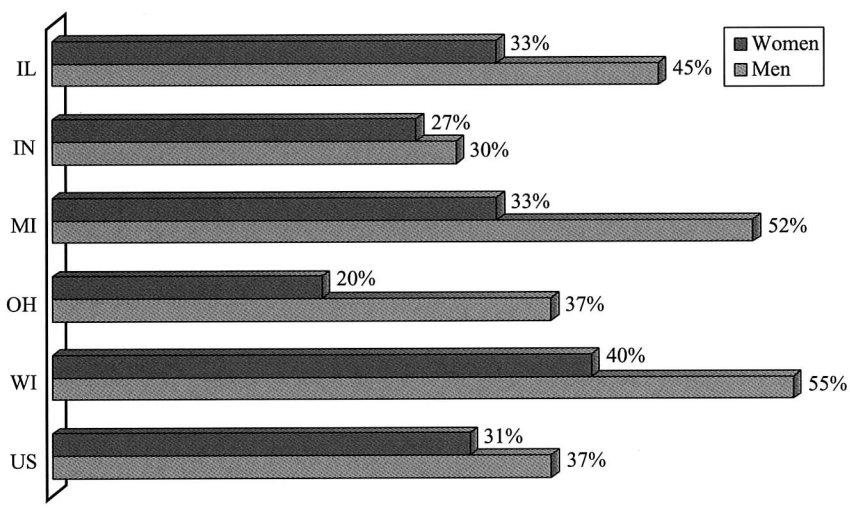
receipt for men is lower in Indiana than nationwide. In Indiana as in most states and the nation as a whole, unemployment insurance benefit receipt for women is lower than it is for men. In fact, despite the three-point gap between men's and women's recipiency rates in the state, in Indiana, women's and men's rates of unemployment insurance benefit receipt are closer than in any other state in the East North Central region.

Figure 12.
Average Annual TANF Benefit[a] and One-Half Median Annual Family Income[b] in Indiana and the United States, 1997



Source: [a] U.S. Department of Health and Human Services, Administration for Children and Families, 1999b; [b] Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Figure 13.
Percent of Unemployed Women and Men with Unemployment Insurance in the East North Central States and the United States, 1997



Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, 1999.
Compiled by the Institute for Women's Policy Research.

Reproductive Rights

This section provides information on state policies concerning abortion, contraception, gay and lesbian adoption, infertility, and sex education. It also presents data on fertility and natality, including births to unmarried and teenage mothers. Issues pertaining to reproductive rights and health can be controversial. Nonetheless, 189 countries, including the United States, adopted by consensus the Platform for Action from the U.N. Fourth Conference on Women. This document stresses that reproductive health includes the ability to have a safe, satisfying sex life, to reproduce, and to decide if, when and how often to do so (U.N. Fourth World Conference on Women, 1995). The document also stresses that adolescent girls in particular need information and access to relevant services.

In the United States, the 1973 Supreme Court case *Roe v. Wade* defined reproductive rights for federal law to include both the legal right to abortion and the ability to exercise that right at different stages of pregnancy. However, state legislative and executive bodies are continually in battle over legislation relating to access to abortion, including parental consent and notification, mandatory waiting periods, and public funding for abortion. The availability of providers also affects women's ability to access abortion. Because of ongoing efforts in many states and at the national level to win judicial or legislative changes that would outlaw or restrict women's access to abortion, the stances of governors and state legislative bodies are critically important.

Reproductive issues encompass other policies as well. Laws requiring health insurers to cover contraception and infertility treatments allow insured women to exercise choice in deciding when and if to have children. Policies allowing gay and lesbian couples to adopt their partners' children give them a fundamental family planning choice. Finally, sex education for high school students can provide them with the information they need to make educated choices about sexual activity.

The reproductive rights composite index shows that Indiana, which ranks third in its region and 43rd in the nation, clearly lacks adequate policies concerning the reproductive rights and resources of women when compared with other states (see Chart VI, Panel A). Moreover, Indiana's grade of F on the reproductive rights index reflects the gap between the ideal status of women's reproductive rights and their actual status within the state.

Access to Abortion

Mandatory consent laws require minors to gain the consent of one or both parents before a physician can perform an abortion procedure, while notification laws require they notify one or both parents of the decision to have an abortion. Of the 42 states with consent or notification laws on the books as of January 2000, 32 enforce their laws. Of these 32 states, 15 enforce notification laws and 17 enforce

Chart VI. Panel A.
Reproductive Rights: National and Regional Ranks

	National Rank* (of 51)	Regional Rank* (of 5)	Grade
Composite Reproductive Rights Index	**43**	**3**	**F**

See Appendix II for methodology.

* The national rank is of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI)

Calculated by the Institute for Women's Policy Research.

consent laws. In states with notification or consent laws, 37 allow for a judicial bypass if the minor appears before a judge and provides a reason that parental notification would place an undue burden on the decision to have an abortion. Three states provide for physician bypass, and two allow minors to petition for either judicial or physician bypass. Of the 32 states that enforce consent and notification laws, only Idaho and Utah have no bypass procedure. As of January 2000, Indiana still enforces its mandatory consent law but allows for a judicial bypass (see Chart VI, Panel B; NARAL and NARAL Foundation, 2000).

Waiting-period legislation mandates that a physician cannot perform an abortion until a certain number of hours after his or her patient is notified of her options in dealing with a pregnancy. Waiting periods range from one to 72 hours. Of the 18 states with mandatory waiting periods, as of January 2000,

Chart VI. Panel B.
Components of the Reproductive Rights Composite Index

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Does Indiana allow access to abortion services:				
Without mandatory parental consent or notification?[a]		✓		9
Without a waiting period?[a]		✓		33
Does Indiana provide public funding for abortions under any or most circumstances if a woman is eligible?[a]		✓		**15**
What percent of Indiana women live in counties with an abortion provider?[b]			**39%**	**68%**
Is Indiana's state government pro-choice?[c]				
Governor			Mixed	15
Senate			Mixed	13
Assembly		✓		7 of 49
Does Indiana require health insurers to provide comprehensive coverage for contraceptives?[a]		✓		**11**
Does Indiana require health insurers to provide comprehensive coverage for infertility treatments?[d]		✓		**10**
Does Indiana allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?*[e]	✓		**Lower Court**	**21**
Does Indiana require schools to provide sex education?[a]		✓		**18**

* Most states that allow such adoption do so as the result of court decisions. In Indiana, a lower-level court has ruled in favor of second-parent adoptions.

Source: [a] NARAL and NARAL Foundation, 2000; [b] Henshaw, 1998; [c] NARAL and NARAL Foundation, 1999; [d] Stauffer and Plaza, 1999; [e] National Center for Lesbian Rights, 1999.

Compiled by the Institute for Women's Policy Research.

Indiana is one of 14 states (with waiting periods ranging from one to 24 hours) that enforce their laws (NARAL and NARAL Foundation, 2000).

Public funding for abortion for women who qualify can be instrumental in reducing the financial obstacles to abortion for low-income women. In some states, public funding for abortions is available only under specific circumstances, such as rape or incest, life endangerment to the woman, or limited health circumstances of the fetus. Indiana is one of 29 states that do not provide public funding for abortions under any circumstances other than those required by the federal Medicaid law, which are when the pregnancy results from reported rape or incest or when the pregnancy threatens the life of the woman. Additionally, Indiana requires that cases of rape and incest be reported to a law enforcement or social service agency in some circumstances in order for the woman to be eligible for a publicly funded abortion (NARAL and NARAL Foundation, 2000).

The percent of women in Indiana who live in counties with abortion providers measures the availability of abortion services to women in the state. This proportion ranges from 16 to 100 percent across the states. As of 1996, in the bottom three states, 20 percent or fewer women live in counties with at least one provider, while in the top six states, more than 90 percent of women live in counties with at least one (Henshaw, 1998). At 39 percent of women in counties with a provider, Indiana's proportion falls near the bottom of the nation. In addition, only 7 percent of counties in Indiana have abortion providers. For those women in counties without a provider, especially in rural areas, access can be problematic. In 41 states, more than half of all counties have no abortion provider, and in 21 states more than 90 percent of counties have none (Henshaw, 1998).

Debates over reproductive rights policies frequently involve potential restrictions on women's access to abortion and contraception, and the stances of elected officials play an important role in the success or failure of these efforts. To measure the level of support for or opposition to potential restrictions, the National Abortion and Reproductive Rights Action League (NARAL) examined the votes and public statements of governors and members of state legislatures. NARAL determined whether these public officials would support restrictions on access to abortion and contraception, including (but not limited to) provisions concerning parental consent, mandatory waiting periods, prohibitions on Medicaid funding for abortion and bans on certain abortion procedures. NARAL also gathered official comments from governors' offices and conducted interviews with knowledgeable sources involved in reproductive issues in each state (NARAL and NARAL Foundation, 1999). For this study, governors and legislators who would support restrictions on abortion rights are considered anti-choice, and those who would oppose them are considered pro-choice. In Indiana, the governor and state Senate were evaluated as closely divided on abortion; the state Assembly is considered anti-choice.

Other Family Planning Policies and Resources

About 49 percent of traditional health plans do not cover any reversible method of contraception such as the pill or IUD. Others will pay for one or two types but not all five types of prescription methods—the pill, implants, injectables, IUDs and diaphragms. About 38 percent of HMOs cover all five prescription methods (Gold and Daley, 1994). Controversy about contraceptive coverage is leading lawmakers in many states to introduce bills that would require health insurers to cover contraception. Eleven states require all private insurers to provide comprehensive contraceptive coverage. Seven states have provisions requiring partial coverage for contraception. In five of these states, insurance companies must offer at least one insurance package that covers some or all prescription birth control methods. One state, Minnesota, requires coverage of all prescription drugs, including contraceptives, and another, Texas, requires insurers with coverage for prescription drugs to cover oral contraceptives. Indiana does not have any of these requirements (NARAL and NARAL Foundation, 2000).

Infertility treatments can also widen the reproductive choices open to women and men, but they are often prohibitively expensive, especially when they are not covered by insurance. In ten states, legislatures have passed measures requiring insurance

companies to pay for infertility treatments, and in three states, insurance companies must offer at least one package with infertility coverage to their policyholders. In Indiana, insurance companies are not required to cover infertility treatments at all (Stauffer and Plaza, 1999).

State courts currently hold considerable power to determine what legally constitutes lesbian and gay families, because there is no comprehensive federal law concerning their reproductive rights. Courts have exercised this power in many ways, including allowing or denying lesbians and gays to legally adopt their partners' children, or second-parent adoption. Second-parent adoption provides legal rights to non-legal parents in same-sex relationships that legal parents take for granted. 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. Court rulings in 21 states specifically allow second-parent adoption to lesbians and gays. In 15 of those states, lower courts have approved a petition to adopt; in five states, high or appellate courts have prohibited discrimination; and in one state, the state supreme court has prohibited discrimination against gays or lesbians in second-parent adoption cases. In five states, courts have ruled against second-parent adoption. Because many of the rulings have been issued from lower-level courts, there is room for these laws, both in favor of and against second-parent adoption, to be overturned by courts at a higher level. In addition, courts in the remaining 24 states have not ruled on a case involving second-parent adoption, creating a sense of ambiguity for lesbian and gay families. Only one state, Florida, has specifically banned second-parent adoption through state statute. In Indiana, at least one lower-court ruling stipulates that the non-legal parent in a gay/lesbian couple may adopt his or her partner's child (National Center for Lesbian Rights, 1999). In 1999, members of the Indiana State Legislature attempted to prohibit homosexuals from adopting or becoming foster parents. Both the House and Senate versions of this bill died in their respective committees (Hawes, 1999).

Sexuality education is crucial to giving young women and men the knowledge they need to make informed decisions about their sexual activity and avoid unwanted pregnancy. In 18 states, schools are required to provide sex education. Of those 18, nine states require that sexuality education teach abstinence and also provide students information about contraception. Three states require that sex education teach abstinence but do not require that schools provide information about contraception. In ten states, schools that teach sex education are required to teach abstinence until marriage. Indiana does not mandate sex education but does require schools that teach sex education to teach abstinence until marriage. Indiana schools that teach sex education are not required to include information about contraception (NARAL and NARAL Foundation, 2000).

Fertility, Natality, and Infant Health

Current trends in the United States reveal a decline in the birth rate for all women, in part due to women's tendency to marry and give birth later in life. In 1998, the median age for women at the time of their first marriage was 25.0 years, while as of 1994, the median age at first birth was 23.8 years (U.S. Department of Commerce, Bureau of the Census, 1999a; National Center for Health Statistics, 1997). Fertility rates in Indiana are lower than in the nation as a whole. Table 14 shows 62.9 live births per 1,000 women aged 15-44 in Indiana and 65.0 births per 1,000 women aged 15-44 in the United States in 1997.

Table 14 also shows 8.2 infant deaths per 1,000 births in Indiana, a rate higher than that for the United States as a whole, at 7.2 infant deaths per 1,000. Infant mortality, however, affects white and African American communities in the United States at very different rates. In Indiana, the infant mortality rate is 7.3 for white infants and 15.8 for African American infants. In the United States, respective rates are 6.0 for white infants and 14.2 for African American infants.

Low birth weight (less than 5 lbs., 8 oz.) among babies also differs by racial and ethnic group. In Indiana, 7.0 percent of white and Hispanic infants and 13.6 percent of African American infants are born at low birth weights. In the United States as a whole, the percent of low-weight births for white infants is 6.5; for Hispanic infants, it is 6.4; and for

African American infants, it is 13.1. In the country as a whole, disparities in both infant mortality and low birth weight rates between African Americans and whites are growing. These differences are probably related to a variety of factors, including disparities in socioeconomic status, nutrition, maternal health, and access to prenatal care, among others (U.S. Department of Health and Human Services, Public Health Service, 2000).

For all women, access to prenatal care can be crucial to health during pregnancy and to lowering the risk of infant mortality and low birth weights (U.S. Department of Health and Human Services, Public Health Service, 2000). In the country as a whole, about 82.5 percent of women begin prenatal care in their first trimester of pregnancy, while 80.1 percent of women in Indiana do. However, use of prenatal care varies by race. In the United States as a whole, 84.7 percent of white women use prenatal care in the first trimester, while 72.3 percent of African American and 73.7 percent of Hispanic women do. In Indiana, 81.8 percent of white women, 66.1 percent of African American women, and 66.6 percent of Hispanic women use first trimester prenatal care. Racial and ethnic disparities in prenatal care are larger in Indiana than nationally.

Births to teenage mothers can make it difficult for them to achieve an adequate standard of living by limiting their choices about education and employment (The Alan Guttmacher Institute, 1994; U.S. Department of Health and Human Services, Public Health Service, 2000). In 1997, births to teenage mothers accounted for a larger proportion of all births in Indiana (14.2 percent) than they did nationally (12.8 percent). Births to unmarried mothers accounted for a slightly smaller proportion of all births in Indiana than they did nationally (32.2 percent in Indiana compared with 32.4 percent for the nation as a whole). In 1998, of births to unmarried mothers in Indiana, 66 percent were to women age 20 and over, while 34 percent of unmarried women who gave birth were age 19 and under (Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1998).

Table 14.
Fertility, Natality, and Infant Health, 1997

	Indiana	United States
Fertility Rate in 1997 (live births per 1,000 women aged 15-44)[a]	**62.9**	**65.0**
Infant Mortality Rate in 1997 (deaths of infants under age one per 1,000 live births)[b]	**8.2**	**7.2**
Among Whites	7.3	6.0
Among African Americans	15.8	14.2
Percent of Low Birth Weight Babies (less than 5 lbs, 8 oz.), 1997[a]	**7.7%**	**7.5%**
Among Whites	7.0%	6.5%
Among African Americans	13.6%	13.1%
Among Hispanics	7.0%	6.4%
Percent of Mothers Beginning Prenatal Care in the First Trimester of Pregnancy, 1997[a]	**80.1%**	**82.5%**
Among Whites	81.8%	84.7%
Among African Americans	66.1%	72.3%
Among Hispanics	66.6%	73.7%
Births to Teenage Women (aged 15-19 years) as a Percent of All Births, 1997[c]	**14.2%**	**12.8%**
Births to Unmarried Women as a Percent of All Births, 1997[c]	**32.2%**	**32.4%**

Source: [a] National Center for Health Statistics, 1999a; [b] National Center for Health Statistics, 1999b; [c] U.S. Department of Commerce, Bureau of the Census, 1999f.
Compiled by the Institute for Women's Policy Research.

Health and Well-Being

Health is a crucial factor in women's overall well-being. Health problems can seriously impair women's quality of life as well as their ability to care for themselves and their families. Illness can be costly and painful and can interrupt daily tasks people take for granted. The healthier the inhabitants of an area are, the better their quality of life, and the more productive those inhabitants are likely to be. As with other resources described in this report, women in the United States vary in their access to health-related resources. To ensure equal access, the Beijing Declaration and Platform for Action stresses the need for strong prevention programs, research and information campaigns targeting all groups of women, and adequate and affordable quality health care.

This section focuses on the quality of health of women in Indiana. The composite index of women's health and well-being ranks the states on several indicators, including mortality from heart disease, breast cancer and lung cancer; the incidence of diabetes, chlamydia, and AIDS; women's mental health status and mortality from suicide; and limitations on

Chart VII.
Health and Well-Being: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 5)	Grade
Composite Health and Well-Being Index	**24**	**3**	**C+**
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000, 1995)[a]	40	2	
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000, 1991-95)[b]	41	5	
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000, 1991-95)[b]	32	1	
Percent of Women Who Have Ever Been Told They Have Diabetes (1998)[c]	34	3	
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000, 1997)[d]	17	1	
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults, July 1998 through June 1999)[e]	16	2	
Average Number of Days per Month on which Women's Mental Health Is Not Good (1998)[c]	23	3	
Average Annual Mortality Rate Among Women from Suicide (per 100,000, 1995-97)[f]	17	5	
Average Number of Days per Month on which Women's Activities Are Limited by Their Health (1998)[c]	7	2	

See Appendix II for methodology.

* The national rank is of a possible 51, including the 50 states and the District of Columbia. The regional rankings are of a maximum of five and refer to the states in the East North Central Region (IL, IN, MI, OH, WI).

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1998; [b] American Cancer Society, 1999; [c] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [d] Centers for Disease Control, Division of STD Prevention, 1998; [e] U.S. Department of Health and Human Services, Public Health Service, 1999; [f] Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Calculated by the Institute for Women's Policy Research.

women's everyday activities. Because research links women's health and well-being to their ability to access the health care system (Mead, Witkowski and Hartmann, forthcoming), this section also presents information on women's use of preventive services, health-related behaviors and state-level policies concerning women's health issues. Information on women's access to health insurance is presented earlier in this report.

Although women on average live longer than men—79 years for women compared with 73 years for men in the United States in 1998—women suffer from more nonfatal acute and chronic conditions and are more likely to live with disabilities and suffer from depression. In addition, women have higher rates of health service use, physician visits, and prescription and nonprescription drug use than men (Mead, Witkowski and Hartmann, forthcoming).

Women's overall health status is closely connected to many of the other indicators in this report, including their poverty status, access to health insurance, and reproductive rights and family planning. As a result, it is important to consider women's health as imbedded in and related to their political, economic, and social status (National Women's Law Center, FOCUS on the Health of Women at the University of Pennsylvania Medical Center, and Lewin Group, forthcoming). For example, women's health is significantly influenced by their socioeconomic status. Many studies find direct and indirect relationships between income, education and work status, and health. Poor, uneducated women with few work opportunities are more likely to be unhealthy. Women with low incomes, little education and no jobs also face significant problems accessing the health care system, which indirectly influences their health status (Mead, Witkowski and Hartmann, forthcoming). On the other hand, research shows that employment has a positive effect on women's health. Studies suggest the link may result both because work provides health benefits to women and because healthier women "self-select" to work (Hartmann, Kuriansky and Owens, 1996). Finally, research suggests that across the states, women's mortality rates, cause-specific death rates and mean days of activity limitations due to health are highly correlated with their economic and political status, and especially with their political participation and with a smaller wage gap (Kawachi, Kennedy, Gupta and Prothrow-Stith, 1999).

Indiana, which ranks 24th of all states, is near the average for most states and the nation as a whole on indicators of women's health and well-being. The state fares particularly well on the average number of days per month on which women's activities are limited by their health, ranking seventh in the nation and second in the East North Central region. Women in the state also have relatively low incidences of AIDS and chlamydia, at 16th and 17th, respectively, in the nation. But Indiana ranks below the median for all states for mortality rates among women from lung cancer and heart disease, at 41st and 40th, respectively. Indiana's grade of C+ on the health and well-being index reflects the difference between women's actual health status in the state and national goals concerning their health status, including goals set by the U.S. Department of Health and Human Services in its Healthy People 2010 program (see Appendix II for a discussion of the composite methodology).

Mortality and Incidence of Disease

Heart disease has been the leading cause of death for both women and men of all ages in the United States since 1970. It is the second leading cause of death among women aged 45-74, following all cancers combined (but is the leading cause when cancers are examined separately). It remains the leading cause of death for women aged 75 and older even when all cancers are combined (National Center for Health Statistics, 1996). Since many of the factors contributing to heart disease, including high blood pressure, smoking, obesity and inactivity, can be addressed by changing women's health habits, states can contribute to decreasing rates of death from heart disease by raising awareness of the risk factors and how to modify them. In addition, states can help by implementing policies that facilitate access to health care professionals and preventive screening services. Women in Indiana experience mortality from heart disease at a rate well above the median for all states (106.6 and 90.9 per 100,000 population, respectively; see Table 15) and ranks 40th

among all states on this indicator. Notably, men's mortality from heart disease is much higher in both Indiana and in the country as a whole (203.3 and 174.4 per 100,000 population, respectively; data not shown). Despite its poor performance, within its region Indiana ranks second on mortality from heart disease, indicating that heart disease is a problem in the area generally.

Mortality from heart disease varies greatly by race in Indiana and the United States as a whole. As Figure 14 shows, mortality rates from heart disease are generally much higher among African American women than among white women, while Asian American women have the lowest rates. In the United States, the mortality rate from heart disease for 1991-95 among all women 35 and older was 401 deaths per 100,000 women (these data differ from those in Table 15, which presents 1995 mortality rates for women of all ages). For African American women, it was much higher, at 553 deaths per 100,000, while for white women it was 388. For Hispanic women, the rate was only 265 deaths per 100,000; for Asian American, it was 221; for Native American women, it was 259. In Indiana, patterns of mortality from heart disease among women of different racial and ethnic groups were similar to those in the nation as a whole. African American women experienced mortality from heart disease at a rate of 571 per 100,000; white women did at a rate of 413 per 100,000; Hispanic women's rate was only 209 per 100,000; and Asian American women's was 183. No data

Table 15.
Components of the Health and Well-Being Composite Index

Indicator	Indiana	United States
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000), 1995[a]	**106.6**	**90.9***
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000), 1991-95[b]	**36.0**	**33.3**
Among White Women[c]	35.3	33.8
Among African American Women[c]	43.9	32.7
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000), 1991-95[b]	**25.7**	**26.0**
Among White Women[c]	25.7	25.6
Among African American Women[c]	29.7	31.5
Percent of Women Who Have Ever Been Told They Have Diabetes (1998)[d]	**5.8%**	**5.3%***
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000), 1997[e]	**261.1**	**335.8**
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults), July 1998 through June 1999[f]	**1.8**	**9.4**
Average Number of Days of Poor Mental Health Among Women, 1998[d]	**3.5**	**3.5***
Average Annual Mortality Rate Among Women from Suicide (per 100,000), 1995-97[g]	**3.6**	**3.9**
Average Number of Days of Limited Activities Among Women, 1998[d]	**2.9**	**3.6***

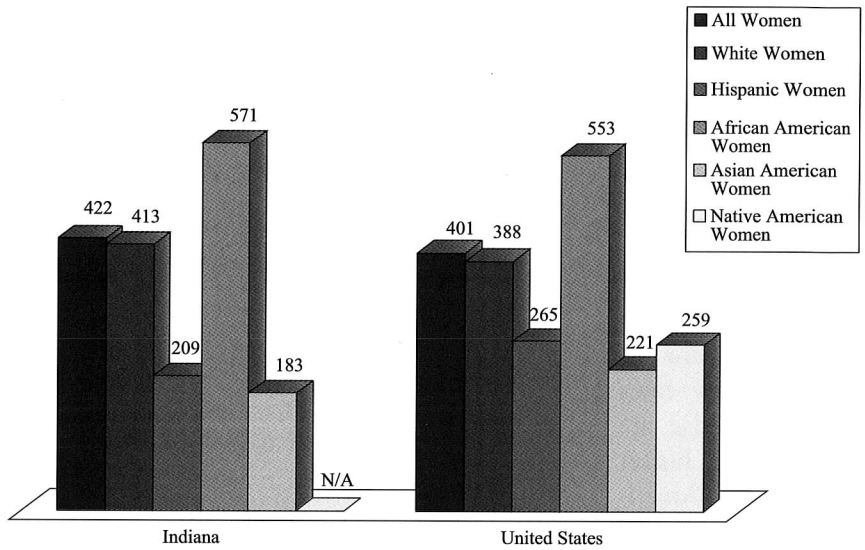
* Median rate for the 50 states and the District of Columbia.

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1998; [b] American Cancer Society, 1999; [c] American Cancer Society, 2000; [d] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [e] Centers for Disease Control, Division of STD Prevention, 1998; [f] U.S. Department of Health and Human Services, Public Health Service, 1999; [g] Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Compiled by the Institute for Women's Policy Research.

were available for Native American women in Indiana. Notably, while African American and white women had mortality rates slightly higher in Indiana than nationally, Hispanic and Asian American women in Indiana had much lower rates than Hispanic and Asian American women nationally.

Figure 14.
Average Annual Mortality Rates among Women from Heart Disease in Indiana and the United States, 1991-95*



* Average annual mortality rates (deaths per 100,000) for women aged 35 years and older. Data for Hispanics are also included within each of the four categories of race. Data for Native American women are not available for Indiana. Data differ from those provided in Table 15, which are for women of all ages for 1995.

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2000.

Compiled by the Institute for Women's Policy Research.

Cancer is the leading cause of death for women aged 45-74, and women's lung cancer, the leading cause of death among cancers, in particular is on the rise. Among women nationally, the incidence of lung cancer doubled and the death rate rose 182 percent between the early 1970s and early 1990s (National Center for Health Statistics, 1996). Like heart disease, lung cancer is closely linked with cigarette smoking. State public awareness efforts on the link between cancer and smoking can be crucial to lowering lung cancer incidence and mortality. In Indiana, the average mortality rate from lung cancer is 36.0, well above the national rate of 33.3 per 100,000 women. As a result, Indiana ranks 41st in the nation and last in the East North Central region on this indicator. In addition, in Indiana mortality from lung cancer is much higher among African American women than among white women. In Indiana, 35.3 white women per 100,000 die from lung cancer each year, while 43.9 African American women do. In contrast, nationally, white women are slightly more likely to die from lung cancer: 33.8 white women compared to 32.7 African American women per 100,000.

Among cancers, breast cancer is the second-most common cause of death for U.S. women. Approximately 175,000 new invasive cases of breast cancer are expected in 1999 (American Cancer Society, 1999). Breast cancer screening is crucial not just for detecting breast cancer but also for reducing breast cancer mortality. Consequently, health insurance coverage, breast cancer screenings, and public awareness of the need for screenings are all important issues to address as states attempt to diminish death rates from the disease. Indiana's rate of mortality from breast cancer, 25.7 per 100,000, is close to that of the nation at 26.0 per 100,000 population. Indiana ranks 32nd in the nation but quite high at first in its region on this measure, suggesting that the region as a whole could take steps to address breast cancer as an important health issue for women. Like mortality rates from lung cancer, mortality rates from breast cancer are higher among African American women than they are among white women in Indiana: 25.7 per 100,000 white women but 29.7 per 100,000 African American women. This is similar to national trends, in which mortality rates from breast cancer are 25.6 per 100,000 white women and 31.5 per 100,000 African

American women (for more details on race and women's health in Indiana, see Focus on Disparities in Women's Health in Indiana).

People with diabetes are two to four times more likely to develop heart disease or stroke, blindness, kidney disease, and other serious health conditions than those without it, and women with diabetes have the same risk of heart disease as men (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999b). Rates of diabetes vary tremendously by race, with African Americans, Hispanics, and American Indians experiencing much higher rates than white men and women (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1998). The overall risk of diabetes can be decreased by lowering the level of obesity and by improving health habits in a state. In Indiana, 5.8 percent of women have been diagnosed with diabetes at some point in their lifetime, a rate somewhat higher than the median rate

Focus on Disparities in Women's Health in Indiana

Racial disparities in women's health status in Indiana are evident in many indicators of women's health and well-being, encompassing issues from maternal and child health (see Table 14), to incidences of mortality from cancer and heart disease (see Table 15 and Figure 14), to the leading causes of death among women (see Illustration 1 below).

Among all cancers, death rates for African American women are higher than those of white women in Indiana (187.6 per 100,000 for African American women compared with 141.9 for white women; see Illustration 1). Death rates among African American women are higher than those of white women for cancer of the lung and bronchus, colon and rectum, pancreas, and stomach. Death rates due to breast and cervical cancer are also substantially higher for African American women than for white women, as is the death rate from multiple myeloma. On the other hand, white women are more likely to die from ovarian cancer, lymphoma, and brain cancer than are African American women . Death rates from leukemia are almost the same for African American and white women.

In addition, as Illustration 2 shows, among the five leading causes of death for women in Indiana, African American women have higher rates from malignant neoplasms (158.3 per 100,000 African American women compared with 108.9 per 100,000 white women), heart disease (153.0 per 100,000 African American women compared with 93.3 per 100,000 white women), and cerebrovascular disease (43.0 per 100,000 African American women compared with 25.9 per 100,000 white women) than white women. The remaining two leading causes of death differ for African American and white women: the fourth and fifth leading causes of death for African American women are diabetes mellitus and nephritis and nephrosis (32.8 per 100,000 women and 12.2 per 100,000 women,

(continued on next page)

respectively), while for white women they are lung disease and pneumonia (15.5 per 100,000 women and 9.7 per 100,000 women, respectively). Overall, African American women have much higher mortality rates than white women, at 605.4 versus 375.5 per 100,000 population.

The leading causes of death for younger African American and white women also differ drastically in Indiana. Homicide is the leading cause of death for African American women between the ages of 15 and 34, while motor vehicle accidents are the leading cause of death for this age group among white women (see Illustrations 3a-d). And while suicide is not among the top three leading causes of death for African American women, it is the third leading cause of death for white women aged 15-34. Overall, death rates from all causes among younger African American women are more than twice those of younger white women in Indiana.

Racial differences in the incidence of and mortality from disease point to the need for targeted educational campaigns and prevention programs, as well as quality health insurance coverage for women of all races and socioeconomic status.

Focus Box Illustration 1.
Cancer Death Rates for Women in Indiana by Race, 1994

Type of Cancer	African American Women	White Women
Lung and Bronchus	43.4	34.3
Colon and Rectum	23.3	16.2
Pancreas	10.6	6.8
Lymphoma	3.8	6.2
Leukemia	5.2	5.1
Brain	2.0	3.6
Stomach	4.9	2.0
Multiple Myeloma	6.3	2.2
Breast	31.2	25.6
Ovary	6.9	8.1
Cervix	5.8	2.9
All Sites	**187.6**	**141.9**

Rates per 100,000 population; all data are age adjusted.

Source: Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999a.

Focus Box Illustration 2.
Top Five Leading Causes of Death for Women in Indiana by Race, 1998

Leading Causes of Death for African American Women	Rate
Malignant Neoplasms (cancer)	158.3
Heart Disease	153.0
Cerebrovascular Disease (stroke)	43.0
Diabetes Mellitus	32.8
Nephritis and Nephrosis	12.2
All Causes	**605.4**

Leading Causes of Death for White Women	Rate
Malignant Neoplasms (cancer)	108.9
Heart Disease	93.3
Cerebrovascular Disease (stroke)	25.9
Other Chronic Pulmonary Disease (lung cancer)	15.5
Pneumonia	9.7
All Causes	**375.5**

All rates per 100,000 population; all data are age adjusted.
Source: Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999b.

Focus Box Illustration 3a.
Top Five Leading Causes of Death in Indiana for African American Women Aged 15-24, 1998

Leading Causes of Death	Rate
Homicide	36.0
Motor Vehicle Accidents	24.0
Malignant Neoplasms (cancer)	4.8
Other Symptoms and Ill Defined Conditions	4.8
Asthma	4.8
All Causes	**93.5**

All rates per 100,000 population; all data are age adjusted.
Source: Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999c and 1999d.

(continued on next page)

Focus Box Illustration 3b.
Top Five Leading Causes of Death in Indiana for African American Women Aged 25-34, 1998

Leading Causes of Death	Rate
Homicide	22.6
Heart Disease	22.6
Cerebrovascular disease (stroke)	10.1
Malignant Neoplasms (cancer)	7.5
Diabetes Mellitus	7.5
All Causes	**135.8**

Focus Box Illustration 3c.
Top Five Leading Causes of Death in Indiana for White Women Aged 15-24, 1998

Leading Causes of Death	Rate
Motor Vehicle Accidents	21.4
Other Accidents	4.4
Suicide	3.3
Homicide	2.7
Malignant Neoplasms (cancer)	2.5
All Causes	**44.7**

Focus Box Illustration 3d.
Top Five Leading Causes of Death in Indiana for White Women Aged 25-34, 1998

Leading Causes of Death	Rate
Motor Vehicle Accidents	10.8
Malignant Neoplasms (cancer)	10.0
Suicide	5.0
Other Accidents	5.0
Heart Disease	3.4
All Causes	**58.4**

For Focus Box Illustrations 3b-d:

All rates per 100,000 population; all data are age adjusted.

Source: Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999c and 1999d.

for all states, 5.3 percent. At 34th in the nation and third in the region, Indiana ranks just barely in the top two-thirds of all states on this indicator.

Sexually transmitted diseases (STDs) are a common threat to younger women's health. As with many other health problems, education, awareness, and proper screening can be key to limiting the spread of STDs and diminishing the health impact associated with them. One of the more common STDs among women is chlamydia, which affects over 436,000 women in the United States. Chlamydia is often asymptomatic, as up to 85 percent of women who have it manifest no symptoms. Nonetheless, chlamydia can lead to Pelvic Inflammatory Disease (PID), which is a serious threat to female reproductive capacity (U.S. Department of Health and Human Services, Public Health Service, 2000). As a result, screening for chlamydia is important to women's reproductive health. In Indiana, chlamydia affects 261.1 women per 100,000 population, a rate substantially lower than that for the United States as a whole, or 335.8 women per 100,000 population. As a result, Indiana ranks 17th in the nation and first in the region on this indicator of women's health status.

Another serious STD is gonorrhea. While rates of gonorrhea have been steadily decreasing in Indiana from 1986 to 1998, rates of the disease remain quite high in metropolitan areas, especially Lake, Marion and Allen counties. Although these three counties contain only 28 percent of the population, they accounted for 68 percent of the reported cases on gonorrhea in 1998. Moreover, Marion county alone accounted for 75 percent of the cases in these three counties in 1998 (Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999g).

Finally, the incidence of HIV and AIDS in women is one of the fastest growing threats to their health, especially among younger women. In fact, the original gap between the incidence of AIDS in women and men is diminishing quickly. While in 1985 the incidence of AIDS-related illnesses among men was 13 times more than for women, by 1998-99 men had fewer than four times as many AIDS-related illnesses as women. The proportion of people with AIDS who are women is likely to continue rising, since a higher proportion of HIV cases are women: in 1998-99, 23 percent of AIDS cases were women, while 32 percent of HIV cases were (U.S. Department of Health and Human Services, Public Health Service, 1999). Moreover, the majority of the AIDS burden falls on minority women: in 1998, 63 percent of women diagnosed with AIDS were African American, and over 18 percent were Hispanic (U.S. Department of Health and Human Services, Public Health Service, 1999). Overall, Indiana has a much lower incidence rate of AIDS among women than the nation as a whole, at 1.8 and 9.4, respectively, per 100,000 population. For men, the incidence rate of AIDS is also much lower in Indiana, at 13.3 cases per 100,000 population compared with 33.2 cases in the United States as a whole (data not shown; U.S. Department of Health and Human Services, Public Health Service, 1999). In addition, according to the Indiana State Department of Health, in 1998, HIV rates were substantially higher for African American women (at 12.6 per 100,000 women) than for white women and Hispanic women, who both had rates of 1.5 per 100,000 (Indiana State Department of Health, Operational Services Commission, Epidemiology Resource Center, Data Analysis Team, 1999e; 1999f).

Mental Health

Women experience certain psychological disorders, such as depression, anxiety, panic disorders, and eating disorders, at higher rates than men. However, they are less likely to suffer from substance abuse and conduct disorder than men are. Overall, about half of all women aged 15-54 experience symptoms of psychological disorders at some point in their lives (National Center for Health Statistics, 1996). However, because of stigmas associated with psychological disorders and their treatment, many go untreated. In addition, while many health insurance policies cover some portion of alcohol and substance abuse programs, many do not adequately cover treatments of psychological disorders. These treatments, however, are integral to helping patients achieve good mental health.

In Indiana, women's self-reported evaluations indicate that women experience an average of 3.5 days per month on which their mental health is not good, and the state ranks 23rd on this measure (see Table

15 and Chart VII). Nationally, the median rate for all states is also 3.5 days per month of poor mental health. In contrast, the rate of poor mental health for men in Indiana is slightly higher than the national median, at 2.9 and 2.4 days, respectively (data not shown). In Indiana, the lower rate of poor mental health for men compared with women is similar to national trends: in the nation as a whole, the median rate for women is over one day more than it is for men (3.5 and 2.4 days per month, respectively); in Indiana the median rate for women is about 0.6 days more than for men.

One of the most severe public health problems related to psychological disorders is suicide. In the United States as a whole, 1.3 percent of all deaths occur from suicide, about the same number of deaths as from AIDS (National Institute of Mental Health, 1999). Women are much less likely than men to commit suicide, with four times as many men as women dying by suicide. However, women are twice as likely to attempt suicide as men are, and a total of 500,000 suicide attempts are estimated to have occurred in 1996. In addition, in 1997, suicide was the fourth leading cause of death among women aged 14-24 and 35-44, the sixth leading cause of death among women aged 25-34, and the eighth leading cause of death among women 45-54 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2000). Among women in the United States, the annual rate of mortality from suicide is 3.9 per 100,000 population; in Indiana, the rate of death by suicide among women is slightly lower, at 3.6. As a result, Indiana ranks 17th in the nation and fifth in the East North Central region on this indicator of women's health status.

While risk factors for suicide often occur in combination, research indicates that 90 percent of men and women who kill themselves are experiencing depression, substance abuse, or another diagnosable psychological disorder (National Institute of Mental Health, 1999). As a result, policies that extend and expand mental health services to those who need them can help potential suicide victims. According to the National Institute of Mental Health, the most effective programs prevent suicide by addressing broader mental health issues, such as stress and substance abuse (National Institute of Mental Health, 1999).

Limitations on Activities

Women's overall health status strongly affects their ability to carry out everyday tasks, provide for their families, fulfill their goals, and live full and satisfying lives. Illness, disability and generally poor health can obstruct their ability to do so. Women's self-evaluation of the number of days in a month on which their activities were limited by their health status measures the extent to which women are unable to perform the tasks they need and want to complete. Among all states, the median is 3.6 days; in Indiana, the average number of days of limited activities for women is considerably lower, at 2.9 (see Table 15), and the state ranks seventh in the nation and second in the region on this measure. Indiana's high score on this measure runs counter to the poor score for women on some of the other indicators of health status. In contrast, for men, the rate in Indiana (3.5 days per month) is the same as the median rate for all states (3.5 days per month; data not shown).

Preventive Care and Health Behaviors

Women's health status is affected tremendously by their use of early detection measures, preventive health care, and good personal health habits. In fact, preventive health care, healthy eating and exercise, as well as elimination of smoking and heavy drinking, can help women avoid many of the diseases and conditions described above. Table 16 presents data on women's use of preventive care, early detection resources, and good health habits in Indiana. Generally, women in Indiana use preventive care resources at below-average levels. Of women over age 50, 63.9 percent have had a mammogram within the past two years, lower than the median number for all states (67.8 percent). Likewise, Indiana women have lower usage rates of pap tests and cholesterol screenings than the median rate for all states (80.9 percent versus 84.9 percent and 64.8 percent versus 68.2 percent, respectively).

Women in Indiana also have relatively poor health habits compared with the nation as a whole. The percent of adult women in Indiana who smoke, 22.7 percent, is above the median for all states, 20.8 percent (see Table 16). The percent of Indiana women

Table 16.
Preventive Care and Health Behaviors

	Indiana	United States*
Preventive Care		
Percent of Women Aged 50 and Older Who Have Had a Mammogram in the Past Two Years, 1998[a]	63.9	67.8
Percent of Women Aged 18 and Older Who Have Had a Pap Smear in the Past Three Years, 1998[a]	80.9	84.9
Percent of Women Aged 18 and Older Who Have Been Screened for Cholesterol in the Past Five Years, 1995[b]	64.8	68.2
Health Behaviors		
Percent of Women Who Smoke (100 or more cigarettes in their lifetime and who now smoke everyday or some days), 1998[a]	22.7	20.8
Percent of Women Who Report Chronic Drinking (60 or more alcoholic beverages during the previous month), 1995[b]	0.9	0.7
Percent of Women Who Report No Leisure-Time Physical Activity During the Past Month, 1998[a]	30.8	29.9
Percent of Women Who Do Not Eat 5 or More Servings of Fruits or Vegetables per Day, 1998[a]	73.7	72.2

* National rates are median rates for the 50 states and the District of Columbia.

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [b] Centers for Disease Control, 1997.

Compiled by the Institute for Women's Policy Research.

who drink chronically (60 or more alcoholic beverages a month) is also higher than the median for all states (0.9 and 0.7, respectively). Finally, women in Indiana are slightly less likely to participate in physical activity and eat the recommended amount of fruits and vegetables than women in other states.

State Health Policies and Resources

State policies can contribute to women's health status in significant ways. Because poverty is closely associated with poor health among women, policies allocating resources to Medicaid programs to help low-income men and women cover health-related expenses are critical for improving health and well-being. Women are particularly affected by resource allocations to Medicaid programs since more women than men live in poverty and, consequently, over 50 percent more women receive Medicaid benefits than men (U.S. Department of Health and Human Services, Health Care Financing Administration, 1999a). In Indiana, only slightly more women than men receive health insurance from public sources (6.9 percent versus 6.2 percent; see Table 12). During the 1990s, states gained increased autonomy in setting eligibility and benefit levels for Medicaid programs, and as a result their spending varied substantially. Table 17 shows the level of Medicaid spending per adult enrollee in Indiana ("adults" are generally defined as nondisabled people aged 18-64, although some states extend "adult" to cover some younger people, such as pregnant teens or mothers classified as head-of-household). In 1997, at $1,522, Indiana's spending was far below the average among all states of $1,874 per adult enrollee. Without adequate financial support for their health care needs, the health status of low-income women and their families is likely to suffer. State and federal policies should also ensure that as men and women move away from welfare and into the workforce, they do not lose access to health insurance.

Domestic violence and stalking can also significantly affect women's physical health and mental well-being. Very little reliable data on rates of violence against women exist, however, because many incidences of violence go unreported. Women who suffer from domestic violence, stalking, and other crimes often need appropriate services to help them

make the transition from a violent and unhealthy situation to an independent and stable life. Still, state spending related to violence against women varies tremendously. Table 17 shows that Indiana's funding for domestic violence and stalking programs, at $0.69 per person in the state, is also far below the national average of $1.34. Of these funds, federal money constituted 72 percent and state money constituted 28 percent. In addition, of federal funds, 91 percent was spent on domestic violence programs while 8 percent was spent on sexual assault programs. All state funds were spent on domestic violence programs.

Studies show that the quality of insurance coverage significantly affects women's access to certain health resources and, consequently, their health (Mead, Witkowski and Hartmann, forthcoming). In order to advance women's and men's access to adequate health-related resources, many states have passed policies governing health care coverage by insurance companies for their policyholders. These policies include required coverage for preventive screenings for cervical cancer and osteoporosis; laws allowing women to choose a specialist in obstetrics and gynecology as their primary care physician or allowing direct access to one without a referral; and mandates for coverage of mental health services. In addition, some states have mastectomy stay laws, requiring insurance companies to cover inpatient care for defined periods following a mastectomy. Overall, while Indiana has a few state insurance mandates important to women, it still lacks several significant policies (see Table 18). In particular, Indiana women would benefit from policies requiring insurance companies to cover screenings for cervical cancer and osteoporosis, as well as inpatient care for a defined period after a mastectomy.

Table 17.
Medicaid Spending and Domestic Violence and Sexual Assault Spending Per Person in Indiana and the United States

	Indiana	United States
Medicaid Spending Per Adult Enrollee, 1997[a]	**$1,522**	**$1,874**
Domestic Violence and Sexual Assault Services and Prevention Spending Per Capita, 1994-95[b]	**$0.69**	**$1.34**

Source: [a] Urban Institute, 1999; [b] Centers for Disease Control, National Center for Injury Prevention and Control, 1997.
Compiled by the Institute for Women's Policy Research.

Table 18.
State Health Insurance Mandates in Indiana, 1999

	Yes	No	Total, United States (of 51)
Does Indiana require insurance companies to...			
Cover screenings for cervical cancer?[a]		✓	23
Cover screenings for osteoporosis?[a]		✓	7
Cover inpatient care for a defined period after a mastectomy?[a]		✓	19
Allow women to identify a specialist in obstetrics and gynecology as their primary care physician or allow direct access to one?[a]	✓		37
Cover or offer at least one policy covering mental health services at the same level as other health services?[b]	✓		20

Source: [a] Stauffer and Plaza, 1999; [b] Delaney, 1999.
Compiled by the Institute for Women's Policy Research.

Conclusions and Policy Recommendations

Women in the United States have made a great deal of progress in recent decades. Women are more educated, they are more active in the workforce, and they have made strides in narrowing the wage gap. In other areas, however, women face substantial and persistent obstacles to attaining equality. Women are far from achieving political representation in proportion to their share of the population, and the need to defend and expand their reproductive rights endures. Moreover, many improvements in women's status are complicated by larger economic and political factors. For example, while women are approaching parity with men in labor force participation, women's added earnings are in many cases simply compensating for earnings losses among married men in the last two decades. And since women's median earnings still lag behind men's, they cannot contribute equally to supporting their families, much less achieve economic autonomy.

Many of the factors affecting women's status are interrelated. Educational attainment often directly relates to earnings; full-time work often correlates with insurance coverage. Greater female political representation can result in more women-friendly policies. But today's costly campaign process presents another barrier to women, who often have less access to the economic resources required to make them more competitive candidates. Thus in many cases the issues covered by this report are interdependent and mutually reinforcing.

Women's status varies significantly across states and regions, and the reasons for these differences are not well understood. Very little research has been done on the causes of the regional disparities revealed in this report or the factors associated with them. Different local and regional economic structures—whether based on manufacturing, commerce, or government—undoubtedly affect women's employment and earnings opportunities, while cultural and historical factors may better explain variations in educational attainment, reproductive rights and women's political behavior and opportunities. Variance in specific public policies undoubtedly accounts for some of the contrasts in outcomes among the states. Indicators such as those presented here can be used to monitor women's progress and evaluate the effects of policy changes on a state-by-state basis.

Indiana is a fiscally conservative state that has traditionally leaned away from public assistance programs. In this environment, many activists had traditionally looked to the federal government to raise the standards of public policies in Indiana. Now, in a time when the federal government is transferring many responsibilities to the state and local level, women in Indiana are in even greater danger of lacking those public policies that adequately address the complex issues around women's status. Therefore, it is more important than ever for those working on women's behalf in Indiana to address these issues on the state level.

First, to understand the needs of the state, we need improved data on a number of issues:

- Data should be collected in a number of categories more thoroughly and systematically. These categories include statistics on domestic violence, sexual assault, and rape.

- Data should be collected that more clearly illuminate disparities based on race, geographic location, sex, and sexual orientation. Furthermore, these data need to be codified in an easily accessible format for purposes of planning, analysis and funding.

- Indiana needs complete information about the incidence of underreported illnesses such as mental health illnesses and chlamydia. In addition, data should be collected about the demand for health care services for these illnesses.

To make strides towards improving the status of women in Indiana, the state should also adopt the following policies:

- Develop a more realistic and humane "welfare to work" program, with reliable and comprehensive tracking systems to determine how women fare after exiting welfare;
- Develop training, education and support systems for women leaving welfare;
- Implement an expanded and more effective Medicaid program for low-income women;
- Create and implement a health care system that increases access and responsiveness to women, both in the preventive and treatment stages;
- Implement realistic and age-appropriate health education, including education about STDs, HIV/AIDS and sexuality;
- Implement gender-based programs for treating mental health problems and disorders;
- Mandate insurance coverage or an alternative for mammograms and contraceptives;
- Create and implement better and more extensive public transportation and alternative forms of transportation in rural areas where extensive public transportation systems are less feasible, so as to better serve rural women and increase their access to the state's resources;
- Develop and implement full-day kindergarten and more after-school programs to benefit working mothers as well as their families;
- Encourage more female leaders and those who are knowledgeable about women's concerns to run for office;
- Create economic development initiatives focused on improving opportunities for everyone in the state, but targeting women as an underutilized resource, through women's economic development initiatives.

National policies also remain important in improving women's status in the states and in the country as a whole:

- The federal minimum wage, federal equal employment opportunity legislation and federal health and safety standards are all critical in ensuring minimum levels of decency and fairness for women workers.
- Because union representation correlates strongly with higher wages for women and improved pay equity, benefits and working conditions, federal laws that protect and encourage unionization efforts would assist women workers.
- Policies such as paid family leave could be legislated nationally as well as at the state level through, for example, mandatory insurance or the establishment of an employee pay-in system.
- Because most income redistribution occurs at the national level, federal legislation on taxes, entitlements and income security programs (such as the Earned Income Tax Credit, Social Security, Medicaid, Medicare, Food Stamps and welfare) will continue to profoundly affect women's lives and should take women's needs and interests into account.

In most cases, both state and national policies lag far behind the changing realities of women's lives.

IWPR's series of reports on *The Status of Women in the States* establishes baseline measures for the status of women in the 50 states and the District of Columbia. In accordance with IWPR's purpose—to meet the need for women-centered, policy-relevant research—these reports describe women's lives and provide the tools to analyze the policies that can and do affect them.

The Indiana Advisory Committee

Appendix I
Basic Demographics

This Appendix includes data on different populations within Indiana. Statistics on age, the sex ratio and the elderly female population are presented, as are the distribution of women by race/ethnicity and family type and information on women in prisons. These data present an image of the state's female

Appendix Table 1.
Basic Demographic Statistics for Indiana and the United States

	Indiana	United States
Total Population, 1998[a]	**5,899,195**	**270,298,524**
Number of Women, All Ages[b]	3,026,689	138,252,197
Sex Ratio (women to men, aged 18 and older)[b]	1.09:1	1.08:1
Median Age of All Women[b]	36.4	36.3
Proportion of Women Over Age 65[b]	14.6%	14.6%
Distribution of Women by Race and Ethnicity, All Ages, 1995[c]		
White*	88.7%	73.0%
African American*	8.3%	12.8%
Hispanic**	2.0%	9.8%
Asian American*	0.8%	3.6%
Native American*	0.2%	0.8%
Distribution of Households by Type, 1990[d]		
Total Number of Family and Nonfamily Households	2,062,779	91,770,958
Married-Couple Families (with and without their own children)	59.3%	56.2%
Female-Headed Families (with and without their own children)	10.2%	11.3%
Male-Headed Families (with and without their own children)	2.8%	3.2%
Nonfamily Households: Single-Person Households	23.8%	24.4%
Nonfamily Households: Other	3.9%	4.9%
Distribution of Women Aged 15 and Older by Marital Status, 1990[e]		
Married	56.7%	55.6%
Single	21.0%	23.1%
Widowed	12.1%	11.9%
Divorced	10.2%	9.4%
Percent of Households with Children Under Age 18 Headed by Women, 1990[f]	**18.0%**	**19.5%**
Proportion of Women Living in Metropolitan Areas, All Ages, 1990[g]	**80.2%**	**83.1%**
Proportion of Women Who Are Foreign-Born, All Ages, 1990[h]	**1.8%**	**7.9%**
Percent of Federal and State Prison Population Who Are Women, 1998[i]	**6.2%**	**6.5%**

* Non-Hispanic.

** Hispanics may be of any race.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1999b; [b] U.S. Department of Commerce, Bureau of the Census, 1999d; [c] U.S. Department of Commerce, Bureau of the Census, 1997a; [d] Population Reference Bureau, 1993, Table 7; [e] Population Reference Bureau, 1993, Table 10; [f] IWPR, 1995a; [g] Population Reference Bureau, 1993, Table 6; [h] Population Reference Bureau, 1993, Table 3; [i] U.S. Department of Justice, Bureau of Justice Statistics, 1999, Tables 3 and 7.

Compiled by the Institute for Women's Policy Research.

Focus on Women in Prison in Indiana

In the period from January 1997 to January 2000, there was a substantial increase in the number of women incarcerated in Indiana, with the number of women in prison increasing by 21.5 percent, compared with only a 14.0 percent increase of all adult prisoners (see Illustration 4). Consequently, the percent of adult prisoners who are women grew from 6.0 to 6.4 percent. An even larger increase occurred in the female juvenile prison population. From January 1997 to January 2000, the number of girls incarcerated increased by 46.0 percent, while the juvenile prison population for both girls and boys combined increased by only 27.0 percent. As a result, the percent of juvenile prisoners who are women increased by 3.2 percentage points, from 19.8 percent to 23.0 percent.

Such drastic increases in both the number and percent of women and girls imprisoned in Indiana point to a growing need for crime prevention programs targeted towards women and girls.

Focus Box Illustration 4.
Women and Girls Incarcerated in Indiana, 1997 and 2000

	January 1999	January 2000	Percent Increase in Prison Population
Number of Women in Prison	**1,017**	**1,236**	**21.5%**
Total Adult Prison Population	16,949	19,309	14.0%
Females as a Percent of the Total Prison Population	6.0%	6.4%	
Number of Girls in Prison	**189**	**276**	**46.0%**
Total Juvenile Prison Population	956	1,217	27.0%
Females as a Percent of the Total Juvenile Prison Population	19.8%	23.0%	

Source: Indiana Department of Corrections, 2000.

population and can be used to provide insight on the topics covered in this report. For example, compared with the United States as a whole, Indiana has a slightly higher ratio of women to men, much smaller proportions of African American, Hispanic, Asian American, Native American, and foreign-born women, and a lower proportion of women living in urban areas. Demographic factors have implications for the location of economic activity, the types of jobs available, market growth, and the types of public services needed.

Indiana has the 14th largest population among all the states in the United States. There were over three million women of all ages in Indiana in 1998 (see Appendix Table 1). Between 1990 and 1998, the population of Indiana grew by 6.4 percent, less than the growth of the nation as a whole (8.7 percent; U.S. Department of Commerce, Bureau of the Census, 1999d). Compared with its region, Indiana's population growth rate was the second highest, slightly behind Wisconsin's 6.8 percent, and more than the regional growth rate of 5.2 percent. White women are a larger share of the female population in Indiana than they are in the United States as a whole, with minorities making up slightly over 11 percent of women in the state (compared with 27 percent for the nation as a whole). Among the minority racial/ethnic groups in Indiana, African American women (8.3 percent) constitute a proportion substantially lower than the national average (12.8 percent). The other groups combined make up only 3.0 percent of the female population in Indiana, over 11 percentage points lower than for the rest of the United States.

The proportion of single women in Indiana is lower than in the country as a whole, and the proportions of divorced and widowed women are slightly higher (see Appendix Table 1). The proportion of women in Indiana who are married is also slightly higher than the proportion nationally (56.7 percent compared with 55.6 percent). Indiana's distribution of family types diverges somewhat from that in the nation as a whole. The proportion of single-person households is slightly smaller than in the nation as a whole, and the proportion of female-headed families (10.2 percent) is smaller than in the United States as a whole (11.3 percent). The proportion of married-couple families in Indiana is somewhat higher than nationally (59.3 and 56.2, respectively). There are proportionally fewer male-headed families and non-family households in Indiana than in the nation. Finally, female-headed families with children under age 18 constitute 18.0 percent of all families with children in Indiana, a smaller proportion than the 19.5 percent nationwide.

Indiana's proportion of women living in metropolitan areas is lower than in the nation as a whole (80.2 percent compared with 83.1 percent of women in the United States). The percent of Indiana's prison population that is female is slightly less than the national average (see Appendix Table 1; for more details, see Focus on Women in Prison in Indiana). There is a large difference between Indiana and the nation as a whole in terms of the proportion of the population that is foreign-born. Indiana has a much smaller foreign-born female population than does the United States as a whole (just 1.8 percent compared with 7.9 percent).

Appendix II
Methodology, Terms and Sources for Chart I (the Composite Indices)

Composite Political Participation Index

This composite index reflects four areas of political participation: voter registration; voter turnout; women in elective office, including state legislatures, statewide elective office and positions in the U.S. Congress; and institutional resources available for women (such as a commission for women or a legislative caucus).

To construct this composite index, each of the component indicators was standardized to remove the effects of different units of measurement for each state's score on the resulting composite index. Each component was standardized by subtracting the mean value (for all 50 states) from the observed value and dividing by the standard deviation. The standardized scores were then given different weights. Voter registration and voter turnout were each given a weight of 1.0. The component indicator for women in elected office is itself a composite reflecting different levels of office-holding and was given a weight of 4.0. The last component indicator, women's institutional resources, is also a composite of scores indicating the presence or absence of each of two resources: a commission for women and a women's legislative caucus. It received a weight of 1.0. The resulting weighted, standardized values for each of the four component indicators were summed for each state to create a composite score. The states were then ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women's voter registration and voter turnout were each set at the value of the highest state for these components; each component of the composite index for women in elected office was set as if 50 percent of elected officials were women; and scores for institutional resources for women assumed the ideal state had both a commission for women and a women's legislative caucus in each house of the state legislature. Because states can have a negative score on this composite index, values for each of the components were set at low levels as well: voter registration and turnout were each set at the value of the lowest state; each component of the composite index of women in elected office was set at 0.0, and women's institutional resources were each set at 0.0. Each state's score was then compared with the difference between the ideal score and the lowest possible score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Women's Voter Registration: This component indicator is the average percent (for the presidential and congressional elections of 1992 and 1996) of all women aged 18 and older (in the civilian noninstitutionalized population) who reported registering. Source: U.S. Department of Commerce, Bureau of the Census (1993, 1998b) based on the Current Population Survey.

Women's Voter Turnout: This component indicator is the average percent (for the presidential elections of 1992 and 1996) of all women aged 18 and older (in the civilian noninstitutionalized population) who reported voting. Source: U.S. Department of Commerce, Bureau of the Census (1993, 1998b) based on the Current Population Survey.

Women in Elected Office: This composite indicator is based on a methodology developed by the Center for Policy Alternatives (1995). It has four components and reflects office-holding at the state and national levels as of January 2000. For each state, the proportion of office-holders who are women was computed for four levels: state representatives; state senators; statewide elected executive officials and U.S. Representatives; and U.S. Senators and governors. The percents were then converted to scores that ranged from 0 to 1 by dividing the observed value for each state by the highest value for all states. The scores were then weighted according to the degree of political influence of the

position: state representatives were given a weight of 1.0, state senators were given a weight of 1.25, statewide executive elected officials (except governors) and U.S. Representatives were each given a weight of 1.5, and U.S. Senators and state governors were each given a weight of 1.75. The resulting weighted scores for the four components were added to yield the total score on this composite for each state. The highest score of any state for this composite office-holding indicator is 7.62. These scores were then used to rank the states on the indicator for women in elected office. Source: Data were compiled by IWPR from several sources including the Center for American Women and Politics (1999a, 1999c, 1999d, and 1999e); Council of State Governments, 1998.

Women's Institutional Resources: This indicator measures the number of institutional resources for women available in the state from a maximum of two, including a commission for women (established by legislation or executive order) and a legislative caucus for women (organized by women legislators in either or both houses of the state legislature). States receive 1.0 point for each institutional resource present in their state, although they can receive partial credit if a bipartisan legislative caucus does not exist in both houses. States receive a score of 0.25 if informal or partisan meetings are held by women legislators in either house, 0.5 if a formal legislative caucus exists in one house but not the other, and 1.0 if a formal legislative caucus is present in both houses or the legislature is unicameral. Source: National Association of Commissions on Women, 1997, updated in 1999 by IWPR, and Center for American Women and Politics, 1998.

Composite Employment and Earnings Index

This composite index consists of four component indicators: median annual earnings for women, the ratio of the earnings of women to the earnings of men, women's labor force participation, and the percent of employed women in managerial and professional specialty occupations.

To construct this composite index, each of the four component indicators was standardized; that is, for each of the four indicators, the observed value for the state was divided by the comparable value for the entire United States. The resulting values were summed for each state to create a composite score. Each of the four component indicators has equal weight in the composite. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women's earnings were set at the median annual earnings for men in the United States as a whole; the wage gap was set at 100 percent, as if women earn as much as men; women's labor force participation was set at the national number for men; and women in managerial and professional positions was set at the highest score for all states. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Women's Median Annual Earnings: Median yearly earnings (in 1998 dollars) of noninstitutionalized women aged 16 and older who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996, 1997 and 1998. Earnings were converted to constant dollars using the Consumer Price Index and the median was selected from the merged data file for all three years. Three years of data were used in order to ensure a sufficiently large sample for each state. The sample size for women ranges from 511 in Vermont to 4,805 in California; for men, the sample size ranges from 641 in the District of Columbia to 7,594 in California. For Indiana, the sample size is 734 for women and 1,075 for men. These earnings data have not been adjusted for cost-of-living differences between the states because the federal government does not produce an index of such differences. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey, for the 1996-98 calendar years; Economic Policy Institute, 2000.

Ratio of Women's to Men's Earnings: Median yearly earnings (in 1998 dollars) of noninstitutionalized women aged 16 and older who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996-98

divided by the median yearly earnings (in 1998 dollars) of noninstitutionalized men aged 16 and older who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996-98. See the description of women's median annual earnings, above, for a more detailed description of the methodology and for sample sizes. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey; Economic Policy Institute, 2000.

Women's Labor Force Participation (proportion of the adult female population in the labor force): Percent of civilian noninstitutionalized women aged 16 and older who were employed or looking for work (in 1998). This includes those employed full-time, part-time voluntarily or part-time involuntarily, and those who are unemployed. Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c (based on the Current Population Survey).

Women in Managerial and Professional Occupations: Percent of civilian noninstitutionalized women aged 16 and older who were employed in executive, administrative, managerial or professional specialty occupations (in 1998). Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999b (based on the Current Population Survey).

Composite Economic Autonomy Index

This composite index reflects four aspects of women's economic well-being: access to health insurance, educational attainment, business ownership, and the percent of women above the poverty level.

To construct this composite index, each of the four component indicators was standardized; that is, for each indicator, the observed value for the state was divided by the comparable value for the United States as a whole. The resulting values were summed for each state to create a composite score. Each of the four components has equal weight in the composite. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women with health insurance was set at the highest value for all states; women with higher education was set at the national value for men; women-owned business was set as if 50 percent of businesses were owned by women; and women in poverty was set at the national value for men. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Percent with Health Insurance: Percent of civilian noninstitutionalized women between ages 18 and 65 who are insured. The state-by-state percents are based on the averages of three years of pooled data from the 1997-99 Current Population Survey from the Bureau of the Census, for data years 1996-98. Source: Employee Benefit Research Institute, 1999.

Educational Attainment: In 1989, the percent of women aged 25 and older with four or more years of college. Source: Population Reference Bureau, 1993, based on the Public Use Microdata Sample of the 1990 Census of Population.

Women's Business Ownership: In 1992, the percent of all firms (legal entities engaged in economic activity during any part of 1992 that filed an IRS Form 1040, Schedule C; 1065; or 1120S) owned by women. This indicator excludes Type C corporations. The Census Bureau estimates that there were approximately 517,000 Type C corporations in 1992. The Bureau of the Census was required to provide data on women's ownership of Type C corporations by the Women's Business Ownership Act of 1988. The Bureau's methodology for doing so differs from the methods used for other forms of business ownership, which include individual proprietorships and self-employment, partnerships and Subchapter S corporations (those with fewer than 35 shareholders who can elect to be taxed as individuals). Type C corporations are non-Subchapter S corporations. The Bureau of the Census determines the sex of business owners by matching the social security numbers of individuals who file business tax returns (Form 1040, Schedule C; 1065; or 1120S) with Social Security Administration records

providing the sex codes indicated by individuals on their original applications for social security numbers. For partnerships and corporations, a business is classified as women-owned based on the sex of the majority of the owners. Data for Type C corporations do not come from tax returns and because of the limitations of the sample are considered less reliable. Source: U.S. Department of Commerce, 1996a, based on the 1992 Economic Census. (Please note that results of the 1997 Economic Census were not available at the time of production of this report.)

Percent of Women Above Poverty: In 1996-98, the percent of women living above the official poverty threshold, which varies by family size and composition. The average percent of women above the poverty level for the three years is used; three years of data ensure a sufficiently large sample for each state. In 1997, the poverty level for a family of four was $16,700. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey for the calendar years 1996-98; Economic Policy Institute, 2000.

Composite Reproductive Rights Index

This composite index reflects a variety of indicators of women's reproductive rights. These include access to abortion services without mandatory parental consent laws for minors; access to abortion services without a waiting period; public funding for abortions under any circumstances if a woman is eligible; percent of women living in counties with at least one abortion provider; whether the governor or state legislature is pro-choice; existence of state laws requiring health insurers to provide coverage of contraceptives; policy that mandates that insurers cover infertility treatments; whether second-parent adoption is legal for gay/lesbian couples; and mandatory sex education.

To construct this composite index, each component indicator was rated on a scale of 0 to 1 and assigned a weight. The notification and waiting-period indicators were each given a weight of 0.5. The indicators of public funding for abortions, pro-choice government, women living in counties with an abortion provider, and contraceptive coverage were each given a weight of 1.0. The infertility coverage law and gay/lesbian adoption law were each given a weight of 0.5. Finally, states were given 1.0 point if they mandate sex education for students. The weighted scores for each component indicator were summed to arrive at the value of the composite index score for each state. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." An "ideal state" was assumed to have no notification or waiting period policies; public funding for abortion; pro-choice government; 100 percent of women living in counties with an abortion provider; insurance mandates for contraceptive coverage and infertility coverage; maximum legal guarantees of second-parent adoption; and mandatory sex education for students. Each state's score was then compared with the resulting ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Mandatory Consent: States received a score of 1.0 if they allow minors access to abortion without parental consent or notification. Mandatory consent laws require that minors gain the consent of one or both parents before a physician can perform the procedure, while notification laws require they notify one or both parents of the decision to have an abortion. Source: NARAL and NARAL Foundation, 2000.

Waiting Period: States received a score of 1.0 if they allow a woman to have an abortion without a waiting period. Such legislation mandates that a physician cannot perform an abortion until a certain number of hours after notifying the woman of her options in dealing with a pregnancy. Source: NARAL and NARAL Foundation, 2000.

Restrictions on Public Funding: If a state provides public funding for abortions under most circumstances for women who meet income eligibility standards, it received a score of 1.0. Source: NARAL and NARAL Foundation, 2000.

Percent of Women Living in Counties with at Least One Abortion Provider: For the indicator of the percent of women in counties with abortion providers, states were given a scaled score ranging from 0 to 1, with states with 100 percent of women living in counties with abortion providers receiving a 1. Source: Henshaw, 1998.

Pro-Choice Governor or Legislature: This indicator is based on NARAL's asssessment of whether governors and legislatures would support a ban or restrictions on abortion. Governors and legislatures who would support restrictions on abortion rights are considered anti-choice, and those who would oppose them are considered pro-choice. Each state received 0.33 points per pro-choice governmental body—governor, upper house and lower house—up to a maximum of 1.0 point. Those governors and legislatures with mixed assessments received half credit. Source: NARAL and NARAL Foundation, 1999.

Contraceptive Coverage Laws: Whether a state has a law or policy requiring that health insurers who provide coverage for prescription drugs extend coverage for FDA-approved contraceptives (e.g., drugs and devices) and related medical services, including exams and insertion/removal treatments. States received a score of 1.0 if they mandate full contraceptive coverage. They received a score of 0.5 if they mandate partial coverage, which may include mandating that insurance companies offer at least one insurance package covering some or all birth control prescription methods or requiring insurers with coverage for prescription drugs to cover oral contraceptives. Source: NARAL and NARAL Foundation, 2000.

Coverage of Infertility Treatments: States mandating that insurance companies provide coverage of infertility treatments received a score of 1.0, while states mandating that insurance companies offer policyholders at least one package with coverage of infertility treatments received a score of 0.5. Source: Stauffer and Plaza, 1999.

Same-Sex Couples and Adoption: Whether a state allows gays and lesbians the option of second-parent adoption, which occurs when a nonbiological parent in a couple adopts the child of his or her partner. At the state level, courts and/or legislatures have upheld or limited the right to second-parent adoption among gay and lesbian couples. States were given 1.0 point if the state supreme court has prohibited discrimination against these couples in adoption, 0.75 if an appellate or high court has, 0.5 if a lower court has approved a petition for second parent adoption, 0.25 if a state has no official position on the subject, and no points if the state has banned second parent adoption. Source: Hawes, 1999.

Mandatory Sex Education: States received a score of 1.0 if they require middle, junior or high schools to provide sex education classes. Source: NARAL and NARAL Foundation, 2000.

Composite Health and Well-Being Index

This composite index includes nine measures of women's physical and mental health: mortality from heart disease, mortality from breast cancer, mortality from lung cancer, incidence of diabetes, incidence of chlamydia, incidence of AIDS, prevalence of poor mental health, mortality from suicide, and mean days of activity limitations. To construct the composite index, each of the component indicators was converted to scores ranging from 0 to 1 by dividing the observed value for each state by the highest value for all states. Each score was then subtracted from 1 so that high scores represent lower levels of mortality, poor health, or disease. Scores were then given different weights. Mortality from heart disease was given a weight of 1.0. Breast and lung cancer were each given a weight of 0.5. Incidence of diabetes, chlamydia, and AIDS were each given a weight of 0.5. Mean days of poor mental health and women's mortality from suicide were given a weight of 0.5. Activity limitations were given a weight of 1.0. The resulting values for each of the component indicators were summed for each state to create a composite score. The states were then ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Mortality from heart disease, breast cancer and lung cancer were set according to national goals for the year 2010, as determined by the U.S. Department of Health and

Human Services under the Healthy People 2010 program (U.S. Department of Health and Human Services, Public Health Service, 2000). For heart disease and breast cancer, this entailed a 20 percent decrease from the national number. For lung cancer, it entailed a 22 percent decrease from the national number. For incidence of diabetes, chlamydia and AIDS and mortality from suicide, Healthy People 2010 goals are to achieve levels that are "better than the best," and thus the ideal score was set at the lowest rate for each indicator among all states. In the absence of national objectives, mean days of poor mental health and mean days of activity limitations were also set at the lowest level among all states. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Mortality from Heart Disease: Average annual mortality from heart disease among all women per 100,000 population (in 1995). Data are age-adjusted to the 1970 total U.S. population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1998.

Mortality from Breast Cancer: Average mortality among women from breast cancer per 100,000 population (in 1991-95). Data are age-adjusted to the 1970 U.S. standard population. Source: American Cancer Society, 1999.

Mortality from Lung Cancer: Average mortality among women from lung cancer per 100,000 population (in 1991-95). Data are age-adjusted to the 1970 U.S. standard population. Source: American Cancer Society, 1999.

Percent of Women Who Have Ever Been Told They Have Diabetes: As self-reported by female respondents in the Behavioral Risk Factor Surveillance System (BRFSS) survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Incidence of Chlamydia: Average rate of chlamydia among women per 100,000 population (1993-97). Source: Centers for Disease Control, Division of STD Prevention, 1998.

Incidence of AIDS: Average incidence of AIDS-indicating diseases among women aged 13 years and older per 100,000 population (July 1998-June 1999). Source: U.S. Department of Health and Human Services, Public Health Service, 1999.

Poor Mental Health: Mean number of days in the past 30 days on which mental health was not good, as self-reported by female respondents in the BRFSS survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Mortality from Suicide: Average annual mortality from suicide among all women per 100,000 population (in 1995-97). Data are age-adjusted to the 1970 total U.S. population. Source: Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Mean Days of Activity Limitations: Mean number of days in the past 30 days on which activities were limited due to health status, as self-reported by female respondents in the BRFSS survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Appendix III
Sources for Chart II
(Women's Resources and Rights Checklist)

Violence Against Women

Separate Offense: States are given a "yes" if they classify domestic violence as a separate offense from normal assault and battery. A separate offense allows enhanced penalties for repeat offenders and helps ensure equal treatment for victims of domestic violence. Source: Miller, 1999a.

Domestic Violence Training: Whether the state has adopted a legislative statute requiring new police recruits to undergo training about domestic violence. Source: Miller, 1999a.

State Funding for Domestic Violence and Stalking Programs: Amount of federal and state money allocated to a state's domestic violence and stalking programs per person in the state. Funding estimates come from a poll by the Centers for Disease Control and Prevention (CDC) of state and federal agencies administering and distributing the funds. The CDC notes that these numbers may not include all funding because of difficulties with the survey process; specifically, because violence against women and stalking funds are distributed to and by many different state agencies, the survey may not cover them all, and as such it may leave out some funding. Moreover, because data on incidence of domestic violence and stalking are unreliable, it is difficult to gauge how much funding states need to address the problem. The information is provided to indicate which states are above or below the national average. Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1997.

Stalking Offense Status: Whether a state classifies a first offense for stalking as a felony. Source: Miller, 1999b.

Sexual Assault Training: Whether a state has adopted a legislative requirement mandating sexual assault training for police and prosecutors. Source: Miller, 1999b.

Child Support

Single-Mother Households Receiving Child Support or Alimony: A single-mother household is defined as a family headed by a nonmarried woman with one or more of her own children (by birth, marriage or adoption). Such a family is counted as receiving child support or alimony if it received full or partial payment of child support or alimony during the past year (Annie E. Casey Foundation, 1999). Figures are based on an average of data from the Current Population Survey for 1994-98. Source: Annie E. Casey Foundation, 1999.

Cases with Collection: A case is counted as having a collection if as little as one cent is collected during the year. These figures include data on child support for all family types. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1998.

Welfare

Child Exclusion/Family Caps: Whether a state extends TANF benefits to children born or conceived while a mother receives welfare. Many states have adopted a prohibition on these benefits, sometimes called a "family cap." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Time Limits: States may not use federal funds to assist families with an adult who has received federally funded assistance for 60 months or more. They can set lower time limits, however. States that allow welfare recipients to receive benefits for the maximum allowable time or more are indicated by "yes." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Work Requirements: What constitutes work activities is a contentious issue at both the state and federal level. State policies around these issues continue to evolve and are subject to caseworker

discretion. This report uses each state's self-reported policy to identify which states require immediate work activities and which allow recipients time before they lose benefits. Those states that allow at least 24 months are indicated as "yes." To receive the full amount of their block grants, states must demonstrate that a specific portion of their TANF caseload is participating in activities that meet the federal definition of work. In fiscal year 2000, states must show that 40 percent of their TANF caseload is working. The required proportion grows each year until 2002, when states must demonstrate that 50 percent of their TANF caseload is engaged in work. PRWORA also restricts the amount of a caseload that may be engaged in basic education or vocational training to be counted in the state's work participation figures and allows job training to count as work only for a limited period of time for any individual. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Transitional Child Care: Whether a state extends child care to families moving off welfare beyond a minimum of twelve months. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Family Violence Provisions in TANF Plans: States can provide exemptions to time limits and other policies to victims of domestic violence under the Family Violence Option. This measure indicates whether a state has opted for the optional certification or adopted other language providing for victims of domestic violence. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Earnings Disregards: States are given leeway in determining how much of a low-income worker's earnings to disregard in determining eligibility for welfare recipiency. Six states have not changed their earnings disregards policy from the test that existed under the former welfare program, AFDC, which disregarded $90 for work expenses and $30 plus one-third of remaining earnings for four months; $120 for the next 8 months; and $90 after a full year. Forty-four states and the District of Columbia have changed their policies. Those that disregard at least 50 percent of earnings are indicated by a "yes." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Size of TANF Benefit: Average monthly amount received by TANF recipient families in the state. This number is not adjusted for family size differences among the states. The average number of individuals in a TANF family in the United States as a whole was 2.8, with two of the family members children. While two in five families had only one child, one in ten had more than three children. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999b.

Employment/Unemployment Benefits

Minimum Wage: States receive a "yes" if their state minimum wage rate as of March 2000 exceeded the federal rate. According to the Fair Labor Standards Act, the state minimum wage is controlling if it is higher than the federal minimum wage. A federal minimum wage increase was signed into law on August 20, 1996 and raised the federal standard to $5.15 per hour on September 1, 1997. Source: U.S Department of Labor, 1999.

Temporary Disability Insurance (TDI): In the five states with mandated Temporary Disability Insurance programs (California, Hawaii, New Jersey, New York and Rhode Island), employees and/or their employers pay a small percentage of the employee's salary into an insurance fund and, in return, employees are provided with partial wage replacement if they become ill or disabled. Source: Hartmann, Yoon, Spalter-Roth and Shaw, 1995.

Access to Unemployment Insurance (UI) for Low-Wage Workers: In order to receive UI, potential recipients must meet several eligibility requirements. Two of these are high quarter earnings and base period earnings requirements. The "base period" is a 12-month period preceding the start of a spell of unemployment. This, however, excludes the current calendar quarter and often the previous full calendar quarter (this has serious consequences for low-wage and contingent workers who need to count more recent earnings to qualify). The base period criterion states that the individual must have earned a minimum amount during the base period. The high quarter earnings criterion requires that

individuals earn a total reaching a specified threshold amount in one of the quarters within the base period. IWPR research has shown that women are less likely to meet the two earnings requirements than men are and thus are more likely to be disqualified from receipt of UI benefits. IWPR found that nearly 14 percent of unemployed women workers were disqualified from receiving UI by the two earnings criteria. This rate is more than twice that for unemployed men (Yoon, Spalter-Roth and Baldwin, 1995). States typically set eligibility standards for UI and can enact policies that are more or less inclusive and more or less generous to claimants. For example, some states have implemented a "movable" base period, allowing flexibility to the advantage of the claimant. Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, 1999.

Since states have the power to decide who receives unemployment insurance benefits, some states set high requirements, thereby excluding many low earners. A state was scored "yes" if it was relatively generous to low earners, such that base period wages required were less than or equal to $1,300 and high quarter wages required were less than or equal to $800. If the base period wages required were more than $2,000 or if high quarter wages required were more than $1,000, the state was scored "no"; "sometimes" was defined as base period and high quarter wages which fell between the "yes" and "no" ranges.

Access to UI for Part-Time Workers: Only eight states and the District of Columbia allow unemployed workers seeking a part-time position to qualify for UI. Source: American Federation of State, County and Municipal Employees, 1999.

Access to UI for "Good Cause Quits": Eleven states offer UI coverage for voluntary quits caused by a variety of circumstances, such as moving with a spouse, harassment on the job, or other situations. The specifics of which circumstances are considered "good cause" differ by state. Source: American Federation of State, County and Municipal Employees, 1999.

Use of UI for Paid Family Leave: Recent initiatives in several states have advanced the idea of using UI to provide benefits during periods of family leave. At the federal level, the Department of Labor now allows states to provide partial wage replacement under the unemployment compensation program on a voluntary, experimental basis to parents who take leave or otherwise leave employment following the birth or adoption of a child. The new regulations were issued in June of 2000 and took effect on August 14, 2000. To implement them, state legislatures must approve of plans to use UI in this fashion. Source: National Partnership for Women and Families, 2000.

Pay Equity: Pay equity, or comparable worth, remedies are designed to raise the wages of jobs that are undervalued at least partly because of the gender or race of the workers who hold those jobs. States that have these policies within their civil service system are marked as "yes." Source: National Committee on Pay Equity, 1997.

Sexual Orientation and Gender Identity

Civil Rights Legislation: Whether a state has passed a statute extending anti-discrimination laws to apply to discrimination on the basis of sexual orientation or gender identity. Source: Hawes, 1999.

Same-Sex Marriage: Whether a state has avoided adopting a policy—statute, executive order, or other regulation—prohibiting same-sex marriage. Source: Hawes, 1999.

Hate Crimes Legislation: Whether a state has established enhanced penalties for crimes perpetrated against victims due to their sexual orientation or gender identity. Source: Hawes, 1999.

Reproductive Rights

For information on sources concerning these indicators, please see the section describing the Composite Reproductive Rights Index in Appendix II.

Institutional Resources

For information on sources concerning institutional resources, please see the section on institutional resources within the description of the Composite Political Participation Index in Appendix II.

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Political Participation

	Composite Index			Women in Elected Office Composite Index		Percent of Women Registered to Vote, 1992 and 1996		Percent of Women Who Voted, 1992 and 1996		Number of Institutional Resources Available to Women in the State	
State	**Score**	**Rank**	**Grade**	**Score**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Score**	**Rank**
Alabama	-2.51	41	D	0.93	44	76.7%	10	61.5%	29	1.5	20
Alaska	1.93	22	C	1.99	15	76.9%	9	65.6%	16	0	44
Arizona	5.15	7	C+	3.11	4	66.5%	38	58.3%	36	0	44
Arkansas	-1.97	39	D	1.79	20	66.1%	39	55.1%	43	0.5	40
California	8.38	3	B	3.60	2	58.5%	50	52.0%	49	2	1
Colorado	2.83	16	C+	2.15	14	74.7%	16	65.6%	16	0.25	41
Connecticut	6.86	5	B-	2.60	6	74.8%	15	66.2%	13	1.25	21
Delaware	2.74	17	C+	2.24	11	68.2%	34	62.0%	28	1	31
District of Columbia	n/a	n/a	n/a	n/a	n/a	77.0%	n/a	66.4%	n/a	1	n/a
Florida	-1.65	37	D	1.52	33	64.2%	47	54.7%	44	2	1
Georgia	-3.79	43	D-	1.16	40	65.1%	43	52.7%	47	2	1
Hawaii	2.51	21	C	2.58	7	58.7%	49	50.1%	50	2	1
Idaho	1.53	23	C	1.69	25	72.9%	22	66.0%	15	1.25	21
Illinois	0.83	29	C	1.55	32	71.4%	27	61.3%	30	2	1
Indiana	1.32	24	C	1.72	22	69.2%	31	60.8%	32	2	1
Iowa	1.09	26	C	1.48	35	76.6%	11	66.5%	10	1.25	21
Kansas	2.94	14	C+	2.20	12	73.8%	21	67.7%	9	0	44
Kentucky	-6.95	50	F	0.71	49	67.3%	35	55.2%	41	1	31
Louisiana	3.22	13	C+	1.72	22	75.5%	13	66.2%	13	2	1
Maine	12.39	1	B	3.52	3	84.4%	2	70.8%	3	0	44
Maryland	6.26	6	B-	2.56	8	69.9%	29	62.4%	24	2	1
Massachusetts	1.05	27	C	1.58	28	70.9%	28	62.2%	26	2	1
Michigan	0.90	28	C	1.60	27	74.6%	17	63.6%	23	1.25	21
Minnesota	6.95	4	B	2.18	13	83.7%	3	72.1%	2	1.25	21
Mississippi	-5.58	47	D-	0.72	48	76.2%	12	61.0%	31	0.25	41
Missouri	3.74	10	C+	1.74	21	78.0%	7	66.3%	12	2	1
Montana	2.58	20	C+	1.85	19	78.1%	6	72.5%	1	0	44
Nebraska	1.18	25	C	1.57	30	74.3%	19	64.4%	21	1.5	16
Nevada	3.59	11	C+	2.92	5	64.7%	44	56.9%	39	0	44
New Hampshire	4.80	8	C+	2.50	9	71.9%	25	62.1%	27	1	31
New Jersey	-0.94	34	D+	1.71	23	66.8%	37	58.6%	35	1	31
New Mexico	0.69	30	C-	1.90	18	65.9%	41	58.8%	34	1.5	16
New York	-2.54	42	D	1.37	38	63.1%	48	55.2%	41	2	1
North Carolina	-2.28	40	D	1.16	40	69.2%	31	57.8%	38	2	1
North Dakota	3.50	12	C+	1.45	36	91.2%	1	68.5%	6	1.25	21
Ohio	-1.54	36	D	1.40	37	69.8%	30	62.4%	24	1	31
Oklahoma	-1.67	38	D	1.10	42	74.5%	18	64.6%	19	1.25	21
Oregon	2.61	18	C+	1.67	26	77.1%	8	68.8%	5	1.25	21
Pennsylvania	-6.14	48	F	0.75	47	64.6%	45	56.8%	40	1.5	16
Rhode Island	-0.27	33	D+	1.22	39	72.6%	23	64.5%	20	2	1
South Carolina	-5.26	45	D-	0.62	50	68.8%	33	57.9%	37	2	1
South Dakota	0.55	31	C-	1.58	28	79.4%	5	68.3%	7	0	44
Tennessee	-5.53	46	D-	0.99	43	65.8%	42	53.8%	46	1.25	21
Texas	-1.15	35	D+	1.95	17	64.5%	46	52.1%	48	1	31
Utah	0.36	32	C-	1.57	30	73.9%	20	64.2%	22	1	31
Vermont	4.00	9	C+	1.99	15	75.2%	14	66.5%	10	1.5	16
Virginia	-3.83	44	D-	0.88	45	67.0%	36	59.6%	33	2	1
Washington	10.77	2	B	3.67	1	72.6%	23	65.5%	18	0.25	41
West Virginia	-6.88	49	F	0.78	46	66.1%	39	54.5%	45	1	31
Wisconsin	2.86	15	C+	1.52	33	82.0%	4	70.7%	4	1.25	21
Wyoming	2.60	19	C+	2.30	10	71.9%	25	68.1%	8	1	31
United States				**0.00**		**68.3%**		**58.9%**		**1.25(median)**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Employment and Earnings

	Composite Score			Median Annual Earnings Full-Time, Year-Round for Employed Women		Earnings Ratio between Full-Time, Year-Round Employed Women and Men		Percent of Women in the Labor Force		Percent of Employed Women, Managerial or Professional Occupations	
State	**Score**	**Rank**	**Grade**	**Dollars**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**
Alabama	3.64	46	D-	$22,084	38	68.8%	41	56.9%	42	27.8%	41
Alaska	4.42	3	B	$30,119	3	74.1%	17	67.8%	5	34.3%	10
Arizona	3.88	26	C	$23,277	30	79.0%	5	56.5%	45	29.7%	26
Arkansas	3.53	50	F	$19,100	51	72.5%	23	56.9%	42	26.4%	48
California	4.22	9	B	$28,001	9	78.7%	6	58.1%	39	33.7%	12
Colorado	4.38	4	B	$26,422	10	74.5%	15	68.1%	3	37.4%	3
Connecticut	4.37	5	B	$30,447	2	75.2%	12	61.5%	25	35.2%	6
Delaware	3.97	19	C+	$25,206	19	71.3%	30	62.3%	23	30.4%	20
District of Columbia	4.87	1	B+	$30,495	1	85.7%	1	61.2%	29	46.3%	1
Florida	3.83	33	C-	$23,355	26	76.7%	8	55.1%	49	29.8%	24
Georgia	3.89	25	C	$23,410	24	72.2%	25	63.1%	19	29.3%	33
Hawaii	4.03	16	C+	$25,246	18	83.8%	2	63.2%	17	26.2%	49
Idaho	3.77	37	D	$22,049	40	74.8%	14	63.3%	15	25.9%	51
Illinois	3.99	17	C+	$25,874	12	68.7%	42	61.5%	25	31.5%	17
Indiana	3.66	44	D-	$22,082	39	66.7%	48	61.5%	25	26.9%	44
Iowa	3.95	21	C+	$23,226	31	76.4%	9	65.7%	10	28.2%	39
Kansas	3.92	22	C	$23,403	25	70.2%	34	65.5%	11	29.7%	26
Kentucky	3.76	38	D	$22,407	33	72.7%	21	56.3%	47	29.6%	28
Louisiana	3.57	49	F	$21,109	44	64.8%	50	56.6%	44	28.6%	38
Maine	3.88	26	C	$22,177	37	72.7%	21	61.5%	25	31.0%	19
Maryland	4.63	2	B+	$30,077	4	79.8%	3	64.0%	12	40.4%	2
Massachusetts	4.35	6	B	$28,367	6	77.6%	7	63.4%	14	35.1%	7
Michigan	3.84	30	C-	$25,372	16	67.4%	47	59.8%	35	28.9%	36
Minnesota	4.32	7	B	$26,241	11	72.4%	24	70.1%	1	35.3%	5
Mississippi	3.61	47	F	$20,356	46	71.5%	27	54.6%	50	29.1%	35
Missouri	4.14	11	B-	$24,421	21	75.4%	11	62.7%	20	34.7%	8
Montana	3.74	42	D	$20,327	48	68.9%	40	63.9%	13	29.4%	32
Nebraska	3.81	35	C-	$21,651	41	71.4%	29	66.6%	7	27.5%	43
Nevada	3.85	29	C-	$24,124	23	74.1%	17	62.4%	22	26.5%	47
New Hampshire	4.08	14	C+	$25,258	17	70.2%	34	66.1%	8	32.1%	15
New Jersey	4.11	12	B-	$28,495	5	70.0%	37	59.1%	38	32.8%	13
New Mexico	3.84	30	C-	$21,376	43	70.2%	34	57.6%	40	33.8%	11
New York	4.16	10	B-	$28,126	7	79.3%	4	55.8%	48	32.7%	14
North Carolina	3.84	30	C-	$22,761	32	75.2%	12	59.9%	34	28.8%	37
North Dakota	3.68	43	D-	$19,540	50	69.6%	39	67.6%	6	26.1%	50
Ohio	3.91	23	C	$25,094	20	70.7%	32	59.8%	35	30.1%	23
Oklahoma	3.79	36	D+	$22,393	34	74.1%	17	57.3%	41	29.5%	30
Oregon	3.82	34	C-	$23,322	28	67.7%	46	61.7%	24	29.8%	24
Pennsylvania	3.88	26	C	$25,424	14	71.5%	27	56.4%	46	30.2%	22
Rhode Island	3.91	23	C	$25,492	13	68.6%	44	60.2%	30	30.4%	20
South Carolina	3.76	38	D	$22,212	36	68.7%	42	60.1%	32	29.6%	28
South Dakota	3.76	38	D	$20,171	49	70.9%	31	68.1%	3	26.9%	44
Tennessee	3.66	44	D-	$20,927	45	70.7%	32	59.2%	37	27.7%	42
Texas	3.96	20	C+	$23,324	27	76.4%	9	60.2%	30	31.2%	18
Utah	3.75	41	D	$22,317	35	64.9%	49	63.3%	15	29.3%	33
Vermont	4.05	15	C+	$23,294	29	73.8%	20	66.1%	8	32.1%	15
Virginia	4.09	13	B-	$25,398	15	69.9%	38	60.1%	32	35.7%	4
Washington	4.26	8	B	$28,087	8	74.4%	16	62.6%	21	34.4%	9
West Virginia	3.48	51	F	$21,626	42	72.1%	26	47.8%	51	26.6%	46
Wisconsin	3.99	17	C+	$24,387	22	68.6%	44	69.0%	2	29.5%	30
Wyoming	3.60	48	F	$20,352	47	62.8%	51	63.2%	17	27.9%	40
United States	**4.00**			**$25,370**		**73.5%**		**59.8%**		**31.4%**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Economic Autonomy

	Composite Index			Percent of Women with Health Insurance		Percent of Women with Four or More Years of College		Percent of Businesses that are Women-Owned		Percent of Women Living above Poverty	
State	**Score**	**Rank**	**Grade**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**
Alabama	3.67	46	D-	81.9%	33	13.5%	45	31.5%	47	85.1%	39
Alaska	4.29	9	B-	83.3%	32	22.2%	7	32.9%	35	91.2%	4
Arizona	3.97	25	C	75.3%	49	17.2%	25	37.6%	3	84.2%	43
Arkansas	3.49	50	F	75.9%	48	11.9%	50	31.6%	45	83.1%	46
California	4.10	20	B-	76.8%	47	20.1%	13	35.5%	12	85.3%	37
Colorado	4.50	2	B	83.8%	30	23.5%	4	37.6%	3	90.4%	10
Connecticut	4.44	5	B	86.7%	12	23.8%	3	33.6%	28	90.8%	6
Delaware	4.19	13	B-	85.7%	21	18.7%	16	35.3%	14	90.7%	8
District of Columbia	4.89	1	B+	84.3%	28	30.6%	1	41.3%	1	79.2%	50
Florida	3.84	39	C-	78.5%	43	15.1%	36	35.2%	16	85.9%	32
Georgia	3.92	31	C	80.8%	38	16.8%	27	33.6%	28	85.9%	32
Hawaii	4.42	7	B	91.9%	1	20.9%	11	37.6%	3	87.3%	29
Idaho	3.81	42	D+	79.9%	40	14.6%	41	33.8%	25	87.7%	27
Illinois	4.13	18	B-	85.9%	17	18.4%	17	34.5%	21	88.7%	19
Indiana	3.86	36	C-	85.7%	21	13.4%	46	34.4%	22	90.8%	6
Iowa	3.96	28	C	87.0%	10	15.0%	38	34.3%	23	90.3%	12
Kansas	4.14	16	B-	86.1%	15	18.4%	17	34.7%	19	88.5%	22
Kentucky	3.62	48	D-	83.9%	29	12.2%	49	31.4%	48	84.7%	41
Louisiana	3.65	47	D-	77.0%	46	14.5%	42	32.5%	37	80.8%	48
Maine	3.98	24	C	85.0%	25	17.2%	25	32.2%	40	88.8%	18
Maryland	4.49	3	B	84.9%	26	23.1%	6	37.1%	6	91.6%	1
Massachusetts	4.44	5	B	87.0%	10	24.1%	2	33.3%	31	89.9%	14
Michigan	3.97	25	C	86.5%	13	15.1%	36	35.2%	16	88.7%	19
Minnesota	4.24	12	B-	90.0%	2	19.2%	15	34.6%	20	90.4%	10
Mississippi	3.52	49	F	77.8%	45	13.3%	47	30.2%	51	80.7%	49
Missouri	3.93	30	C	85.9%	17	15.2%	35	33.8%	25	89.2%	17
Montana	3.94	29	C	79.9%	40	18.0%	20	33.2%	32	83.7%	44
Nebraska	4.07	21	C+	87.6%	8	16.7%	28	35.1%	18	88.5%	22
Nevada	3.84	39	C-	81.6%	36	12.8%	48	36.9%	7	89.8%	15
New Hampshire	4.27	10	B-	88.2%	5	21.1%	9	32.2%	40	91.1%	5
New Jersey	4.17	14	B-	81.8%	34	21.0%	10	31.9%	42	90.7%	8
New Mexico	3.92	31	C	72.5%	51	17.8%	22	37.8%	2	79.1%	51
New York	4.12	19	B-	80.8%	38	20.7%	12	34.1%	24	83.4%	45
North Carolina	3.86	36	C-	83.4%	31	15.7%	32	32.4%	38	86.9%	31
North Dakota	3.91	33	C	85.8%	20	16.7%	28	31.7%	44	85.8%	34
Ohio	3.90	34	C-	87.4%	9	14.4%	43	33.7%	27	88.6%	21
Oklahoma	3.80	43	D+	79.8%	42	15.0%	38	33.6%	28	85.8%	34
Oregon	4.17	14	B-	86.1%	15	18.1%	19	36.8%	8	87.5%	28
Pennsylvania	3.88	35	C-	88.1%	6	15.3%	34	31.2%	49	88.3%	24
Rhode Island	4.05	22	C+	88.6%	4	18.0%	20	31.6%	45	88.2%	26
South Carolina	3.77	44	D	80.9%	37	14.7%	40	32.8%	36	85.1%	39
South Dakota	3.86	36	C-	85.9%	17	15.5%	33	31.9%	42	85.7%	36
Tennessee	3.73	45	D	84.8%	27	14.0%	44	31.1%	50	85.3%	37
Texas	3.84	39	C-	74.3%	50	17.4%	24	33.0%	34	84.7%	41
Utah	4.14	16	B-	86.2%	14	17.5%	23	35.3%	14	91.4%	3
Vermont	4.48	4	B	88.1%	6	23.2%	5	35.7%	11	90.1%	13
Virginia	4.31	8	B-	85.2%	24	21.3%	8	35.4%	13	88.3%	24
Washington	4.27	10	B-	85.7%	21	19.7%	14	36.6%	9	89.4%	16
West Virginia	3.47	51	F	77.9%	44	10.9%	51	32.3%	39	82.3%	47
Wisconsin	4.02	23	C+	89.3%	3	16.0%	31	33.1%	33	91.6%	1
Wyoming	3.97	25	C	81.8%	34	16.1%	30	35.9%	10	87.0%	30
United States	**4.00**			**81.5%**		**17.6%**		**34.1%**		**86.9%**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Reproductive Rights

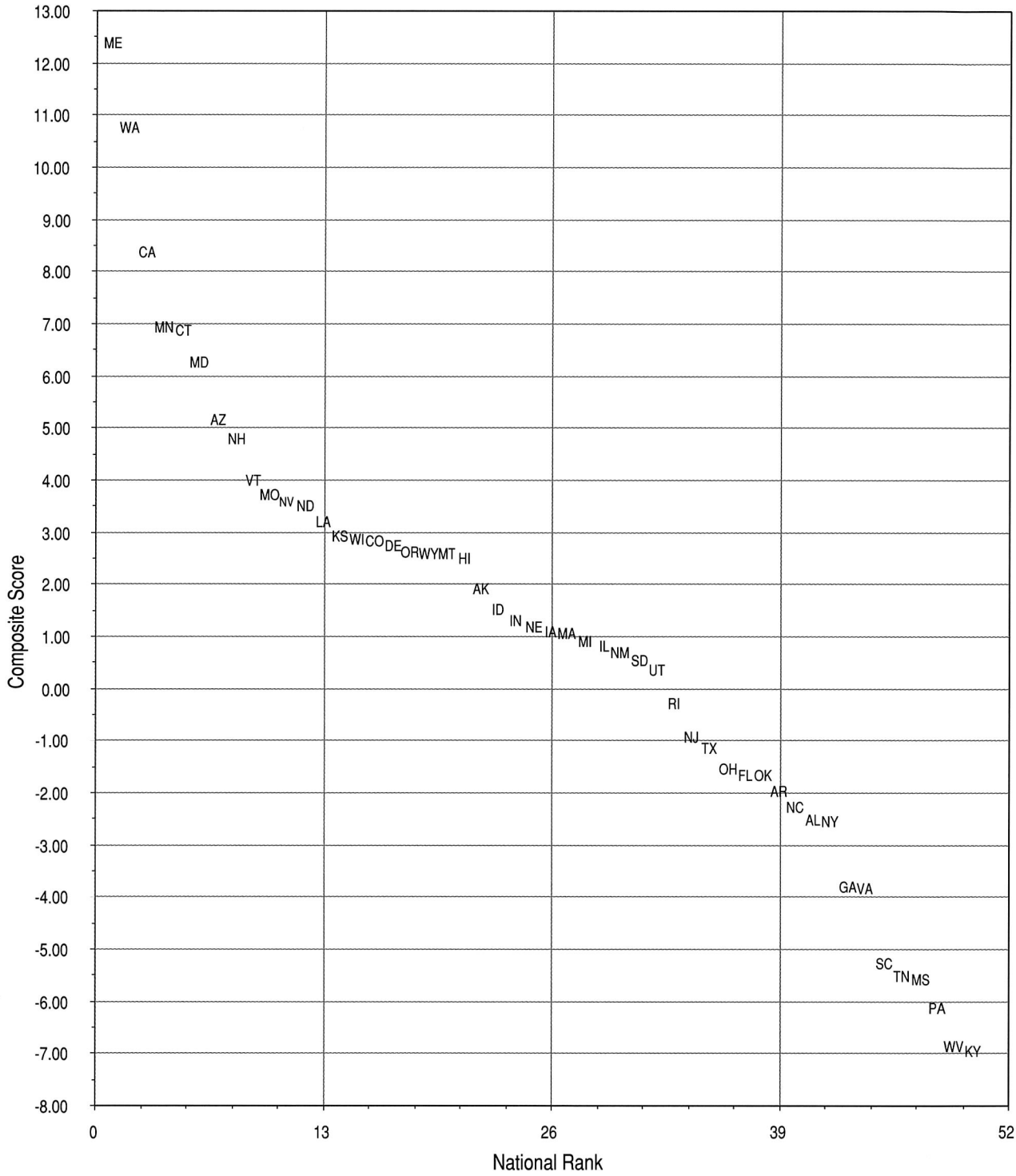
	Composite Index			Parental Consent	Waiting Period	Public Funding	Percent of Women Living in Counties with Providers	Contraceptive Coverage	Pro-Choice Government	Infertility	Second-Parent Adoption	Mandatory Sex Education
State	**Score**	**Rank**	**Grade**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Alabama	1.50	36	D	0	1	0	0.42	0.0	0.33	0.0	0.50	0
Alaska	2.85	23	C	0*	1	1	0.77	0.0	0.33	0.0	0.50	0
Arizona	1.94	31	D+	0*	1	0	0.81	0.0	0.50	0.0	0.25	0
Arkansas	1.68	32	D	0	1	0	0.22	0.0	0.33	1.0	0.25	0
California	4.97	6	B+	0*	1	1	0.97	1.0	1.00	0.5	0.50	0
Colorado	2.33	25	C-	0*	1	0	0.66	0.5	0.67	0.0	0.00	0
Connecticut	4.98	5	B+	1	1	1	0.90	1.0	0.83	0.5	0.00	0
Delaware	4.14	10	B	0	1	0	0.85	1.0	0.67	0.0	0.25	1
District of Columbia	4.38	7	B	1	1	0	1.00	0.0	1.00	0.0	0.75	1
Florida	1.28	38	D-	0*	1	0	0.78	0.0	0.00	0.0	0.00	0
Georgia	3.64	15	B-	0	1	0	0.51	1.0	0.50	0.0	0.25	1
Hawaii	5.46	3	A-	1	1	1	1.00	1.0	0.83	1.0	0.25	0
Idaho	0.96	45	F	0	0	0	0.33	0.5	0.00	0.0	0.25	0
Illinois	3.08	20	C	0*	1	0	0.70	0.0	0.00	1.0	0.75	1
Indiana	0.97	43	F	0	0	0	0.39	0.0	0.33	0.0	0.50	0
Iowa	2.73	24	C	0	1	0	0.31	0.5	0.17	0.0	0.50	1
Kansas	1.98	30	D+	0	0	0	0.52	0.0	0.33	0.0	0.25	1
Kentucky	2.04	29	D+	0	0*	0	0.25	0.5	0.17	0.0	0.25	1
Louisiana	0.53	48	F	0	0	0	0.40	0.0	0.00	0.0	0.25	0
Maine	3.07	21	C	0	1	0	0.61	1.0	0.83	0.0	0.25	0
Maryland	5.77	2	A-	0	1	1	0.85	1.0	0.67	1.0	0.50	1
Massachusetts	3.67	14	B-	0	0*	1	1.00	0.0	0.67	1.0	1.00	0
Michigan	0.97	43	F	0	0	0	0.72	0.0	0.00	0.0	0.50	0
Minnesota	3.01	22	C	0	1	1	0.43	0.5	0.33	0.0	0.50	0
Mississippi	0.31	51	F	0	0	0	0.18	0.0	0.00	0.0	0.25	0
Missouri	1.43	37	D	0	1	0	0.47	0.0	0.33	0.0	0.25	0
Montana	2.22	26	C-	0*	0*	1	0.59	0.0	0.00	1.0	0.25	0
Nebraska	0.66	47	F	0	0	0	0.53	0.0	0.00	0.0	0.25	0
Nevada	4.30	8	B	0*	1	0	0.88	1.0	0.67	0.0	0.50	1
New Hampshire	3.87	13	B-	1	1	0	0.74	1.0	1.00	0.0	0.25	0
New Jersey	5.01	4	B+	0*	1	1	0.97	0.5	0.67	0.0	0.75	1
New Mexico	3.61	16	B-	0*	1	1	0.53	0.0	0.33	0.0	0.50	1
New York	4.30	8	B	1	1	1	0.92	0.0	0.50	1.0	0.75	0
North Carolina	3.90	12	B-	0	1	0	0.61	1.0	0.67	0.0	0.25	1
North Dakota	0.49	49	F	0	0	0	0.20	0.0	0.17	0.0	0.25	0
Ohio	1.00	42	F	0	0	0	0.50	0.0	0.00	1.0	0.00	0
Oklahoma	1.59	34	D	1	1	0	0.46	0.0	0.00	0.0	0.25	0
Oregon	3.20	19	C+	1	1	1	0.62	0.0	0.33	0.0	0.50	0
Pennsylvania	1.05	41	F	0	0	0	0.63	0.0	0.17	0.0	0.50	0
Rhode Island	3.21	18	C+	0	1	0	0.63	0.0	0.33	1.0	0.50	1
South Carolina	2.05	28	D+	0	0	0	0.42	0.0	0.50	0.0	0.25	1
South Dakota	0.34	50	F	0	0	0	0.21	0.0	0.00	0.0	0.25	0
Tennessee	1.59	34	D	0	0*	0	0.46	0.0	0.00	0.0	0.25	1
Texas	2.18	27	C-	0	1	0	0.68	0.5	0.00	0.5	0.50	0
Utah	1.64	33	D	0	0	0	0.51	0.0	0.00	0.0	0.25	1
Vermont	6.15	1	A-	1	1	1	0.77	1.0	1.00	0.0	0.75	1
Virginia	1.15	40	D-	0	1	0	0.52	0.0	0.00	0.0	0.25	0
Washington	4.10	11	B	1	1	1	0.85	0.0	1.00	0.0	0.50	0
West Virginia	3.29	17	C+	0	1	1	0.16	0.0	0.00	1.0	0.25	1
Wisconsin	0.71	46	F	0	0	0	0.38	0.0	0.33	0.0	0.00	0
Wyoming	1.21	39	D-	0	1	0	0.25	0.0	0.33	0.0	0.25	0

* Indicates the legislation is not enforced but remains part of the statutory code.

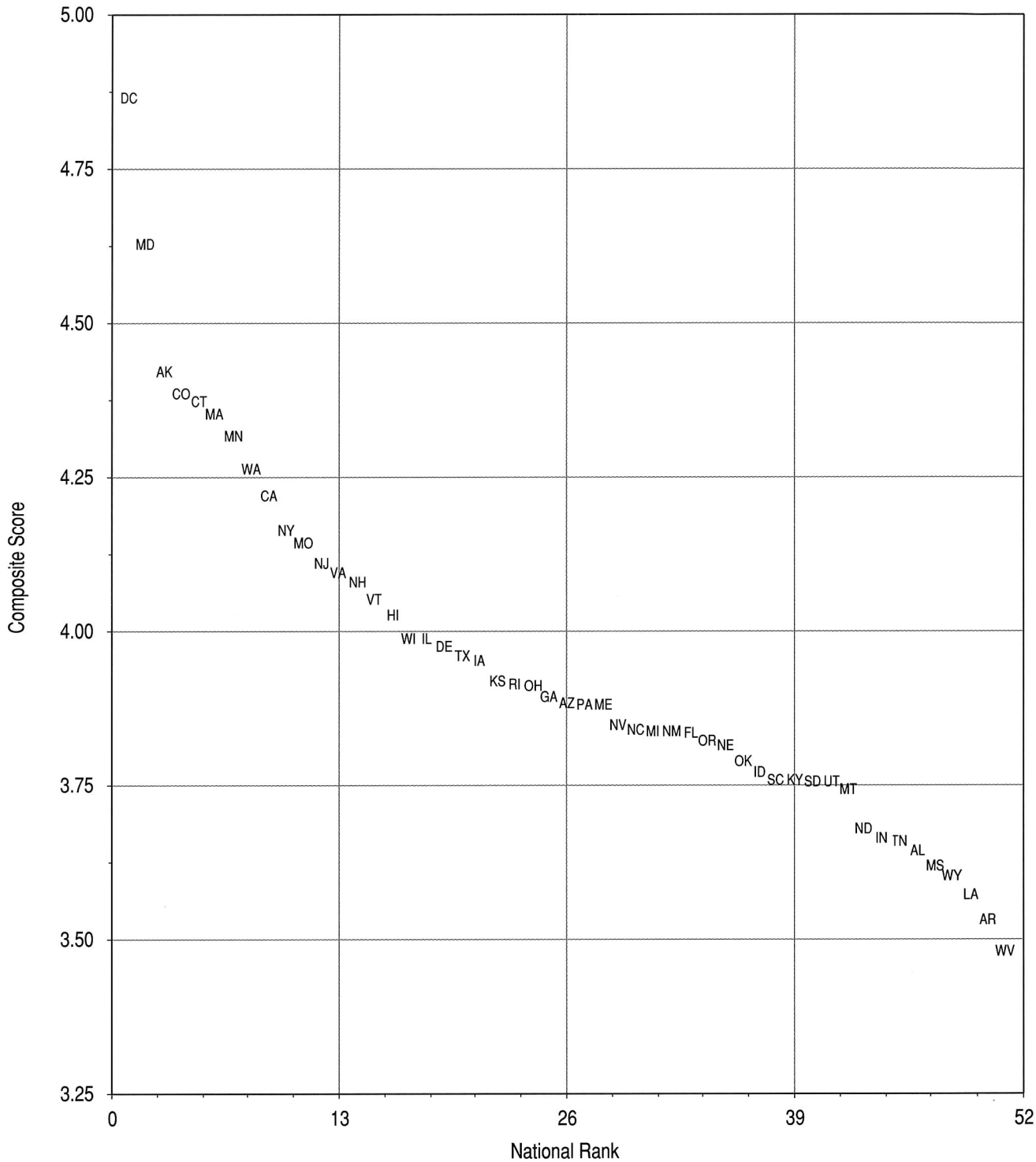
Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Health and Well-Being

	Composite Index			Heart Disease Mortality		Lung Cancer Mortality		Breast Cancer Mortality		Incidence of Diabetes		Incidence of Chlamydia		Incidence of AIDS		Poor Mental Health		Suicide Mortality		Limited Activities	
State	**Score**	**Rank**	**Grade**	**Rate**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Percent**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Days**	**Rank**	**Rate**	**Rank**	**Days**	**Rank**
Alabama	1.81	38	C-	82.6	15	30.0	14	23.7	9	7.9	50	358.4	36	5.7	32	4.3	47	3.9	23	5.1	45
Alaska	2.22	22	C+	69.7	7	40.0	46	22.5	3	2.6	1	448.4	46	1.3	7	3.0	8	6.6	50	2.6	1
Arizona	2.29	18	B-	86.9	22	32.1	20	23.3	6	2.9	2	384.6	40	3.9	29	1.2	1	5.9	47	3.7	27
Arkansas	1.73	43	D+	102.9	37	35.4	34	23.3	6	6.4	41	181.1	5	3.0	26	3.8	36	4.5	37	5.7	47
California	2.01	31	C	96.3	33	33.9	28	24.8	22	5.5	29	327.7	31	5.1	30	3.4	18	4.4	34	4.0	37
Colorado	2.39	16	B	64.1	4	25.5	5	23.0	5	4.6	16	284.4	25	2.3	23	3.7	30	5.7	46	3.1	13
Connecticut	2.47	10	B	84.9	18	32.6	23	26.0	37	3.8	9	298.9	29	13.6	45	3.2	13	3.0	8	3.2	15
Delaware	1.54	48	D-	89.0	25	41.2	48	28.4	45	4.5	15	557.1	49	13.5	44	3.7	30	3.6	17	6.0	49
District of Columbia	1.51	49	D-	75.7	12	34.7	32	33.2	51	7.2	46	335.8	32	86.7	51	2.4	2	2.3	1	5.9	48
Florida	1.63	45	D	98.0	34	35.7	36	24.9	23	5.9	35	296.4	28	24.1	49	3.7	30	5.0	42	4.8	44
Georgia	2.13	27	C+	93.4	31	31.2	18	24.4	16	5.1	24	369.4	37	11.6	42	4.0	42	3.8	22	3.4	19
Hawaii	2.71	1	A-	60.6	1	22.9	2	17.5	1	5.7	31	261.3	18	2.7	24	2.6	4	4.8	40	3.0	12
Idaho	2.55	7	B+	75.0	11	27.5	8	23.3	6	3.9	11	224.7	12	1.4	10	3.4	18	4.9	41	2.8	4
Illinois	2.26	20	B-	108.0	41	33.7	26	28.4	45	5.9	35	285.4	27	5.5	31	3.5	23	2.9	6	2.7	2
Indiana	2.20	24	C+	106.6	40	36.0	41	25.7	32	5.8	34	261.1	17	1.8	16	3.5	23	3.6	17	2.9	7
Iowa	2.45	12	B	92.3	27	29.8	12	25.1	24	5.3	26	266.7	20	1.1	6	3.6	26	3.3	12	2.8	4
Kansas	2.56	5	B+	85.4	19	29.8	12	23.9	12	3.6	5	255.4	15	2.0	20	3.0	8	3.7	19	3.3	17
Kentucky	1.43	50	F	108.4	42	41.8	50	25.1	24	5.7	31	256.8	16	2.7	24	5.5	51	3.3	12	6.7	51
Louisiana	1.82	36	C-	100.1	36	35.9	38	26.5	38	6.8	45	417.8	44	11.5	41	3.3	15	4.6	38	3.4	19
Maine	2.25	21	B-	92.7	28	39.1	45	25.7	32	4.9	21	141.3	4	1.3	7	3.4	18	3.5	15	4.2	40
Maryland	1.91	34	C	86.7	21	37.7	43	27.8	42	5.7	31	460.0	47	21.6	48	4.1	43	3.1	9	3.8	33
Massachusetts	2.47	10	B	85.8	20	35.7	36	29.1	49	3.1	3	206.9	6	13.0	43	3.2	13	2.8	5	3.6	24
Michigan	1.79	41	C-	112.4	47	34.9	33	27.0	40	7.6	48	371.9	39	3.7	28	4.6	50	3.2	10	3.6	24
Minnesota	2.45	12	B	71.2	9	28.2	10	25.3	26	5.1	24	209.9	7	2.1	21	3.7	30	3.3	11	4.2	40
Mississippi	1.80	39	C-	93.1	29	30.0	14	23.7	9	8.2	51	483.3	48	9.5	40	3.8	36	3.9	24	4.0	37
Missouri	1.84	35	C-	113.6	48	35.9	38	25.4	28	5.6	30	391.1	42	3.4	27	3.9	39	4.1	29	3.7	27
Montana	2.36	17	B	63.9	3	32.0	19	24.5	18	4.1	13	213.3	10	0.5	1	3.4	18	6.1	49	3.2	15
Nebraska	2.44	14	B	77.6	13	26.9	6	24.7	21	5.0	23	271.4	21	1.9	18	3.3	15	3.7	21	3.7	27
Nevada	1.82	36	C-	80.5	14	46.0	51	25.3	26	3.6	5	211.6	8	6.5	34	4.1	43	7.9	51	2.9	7
New Hampshire	2.27	19	B-	93.3	30	38.0	44	28.3	43	3.7	8	108.3	1	1.4	10	3.8	36	4.4	35	3.4	19
New Jersey	2.16	26	C+	111.0	44	33.9	28	29.6	50	4.9	21	234.7	13	20.3	47	2.9	6	2.7	3	3.7	27
New Mexico	2.13	27	C+	60.8	2	24.4	4	22.7	4	4.8	19	403.7	43	1.4	10	4.3	47	5.9	48	3.9	36
New York	1.38	51	F	144.0	51	32.2	21	28.6	47	6.7	43	659.1	51	29.7	50	3.6	26	2.5	2	4.1	39
North Carolina	1.76	42	D+	99.5	35	30.2	16	25.4	28	7.5	47	386.6	41	6.2	33	3.7	30	4.3	32	4.4	43
North Dakota	2.55	7	B+	82.8	16	24.3	3	25.5	30	4.2	14	212.3	9	0.8	3	3.0	8	4.0	26	3.5	23
Ohio	1.98	32	C	114.8	49	35.9	38	27.3	41	5.3	26	342.3	34	1.9	18	3.3	15	3.0	7	4.3	42
Oklahoma	1.55	47	D-	110.9	43	34.4	31	24.3	15	7.8	49	371.5	38	1.7	14	2.4	2	5.4	43	5.1	45
Oregon	2.18	25	C+	72.9	10	40.0	46	24.4	16	4.7	18	237.5	14	1.0	5	3.6	26	5.4	44	3.4	19
Pennsylvania	2.08	29	C	104.0	38	32.2	21	28.3	43	6.0	38	276.0	23	8.8	39	3.1	11	3.5	14	3.8	33
Rhode Island	2.03	30	C	111.4	46	34.1	30	28.7	48	5.9	35	338.3	33	7.9	37	3.5	23	2.8	4	3.7	27
South Carolina	1.68	44	D	106.4	39	29.4	11	25.5	30	6.3	40	581.7	50	16.3	46	3.6	26	4.5	36	3.7	27
South Dakota	2.58	4	B+	90.9	26	26.9	6	24.2	14	3.6	5	278.5	24	1.3	7	2.7	5	4.0	25	2.9	7
Tennessee	1.80	39	C-	111.0	44	33.4	25	25.7	32	6.4	41	349.6	35	6.7	35	4.2	46	4.2	31	3.8	33
Texas	1.92	33	C	96.2	32	32.6	23	23.9	12	6.2	39	441.7	45	7.9	37	4.1	43	4.1	28	3.6	24
Utah	2.62	2	B+	64.8	5	14.0	1	22.0	2	3.8	9	135.2	3	1.8	16	4.4	49	5.5	45	3.3	17
Vermont	2.61	3	B+	82.9	17	35.4	34	25.8	35	4.6	16	126.9	2	0.8	3	3.1	11	3.7	20	2.7	2
Virginia	2.21	23	C+	87.7	24	33.8	27	26.5	38	4.8	19	300.3	30	7.2	36	3.9	39	4.1	30	3.1	13
Washington	2.41	15	B	68.5	6	36.7	42	24.6	20	5.3	26	265.3	19	2.2	22	3.7	30	4.3	32	2.8	4
West Virginia	1.57	46	D-	117.4	50	41.3	49	23.8	11	6.7	43	274.2	22	0.6	2	2.9	6	4.0	27	6.1	50
Wisconsin	2.53	9	B+	87.5	23	28.0	9	25.8	35	4.0	12	284.6	26	1.7	14	3.4	18	3.6	16	2.9	7
Wyoming	2.56	5	B+	70.5	8	30.7	17	24.5	18	3.1	3	224.2	11	1.5	13	3.9	39	4.6	39	2.9	7
United States				**90.9**		**33.3**		**26.0**		**5.3**		**335.8**		**9.4**		**3.5**		**3.9**		**3.6**	

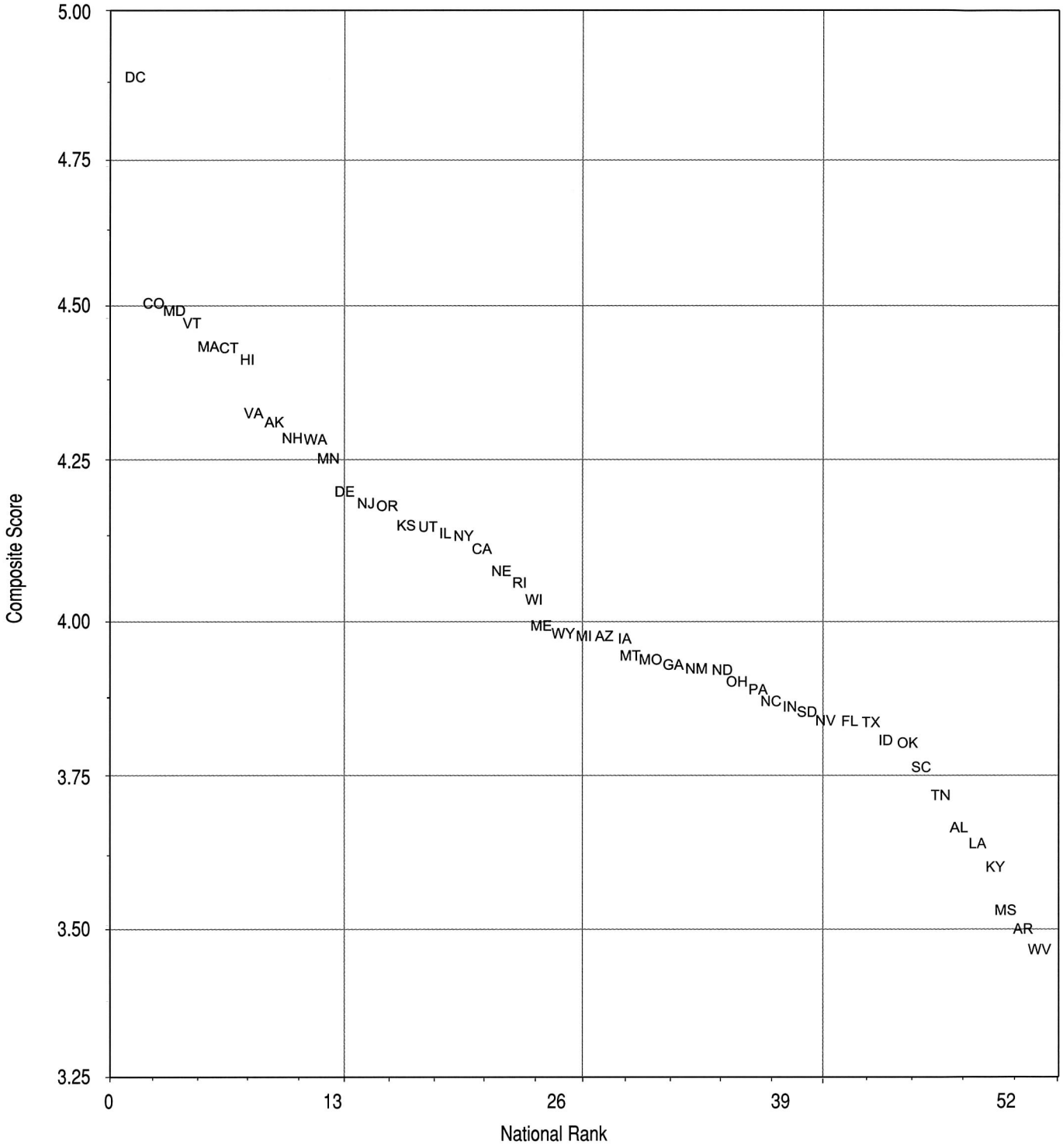
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Political Participation



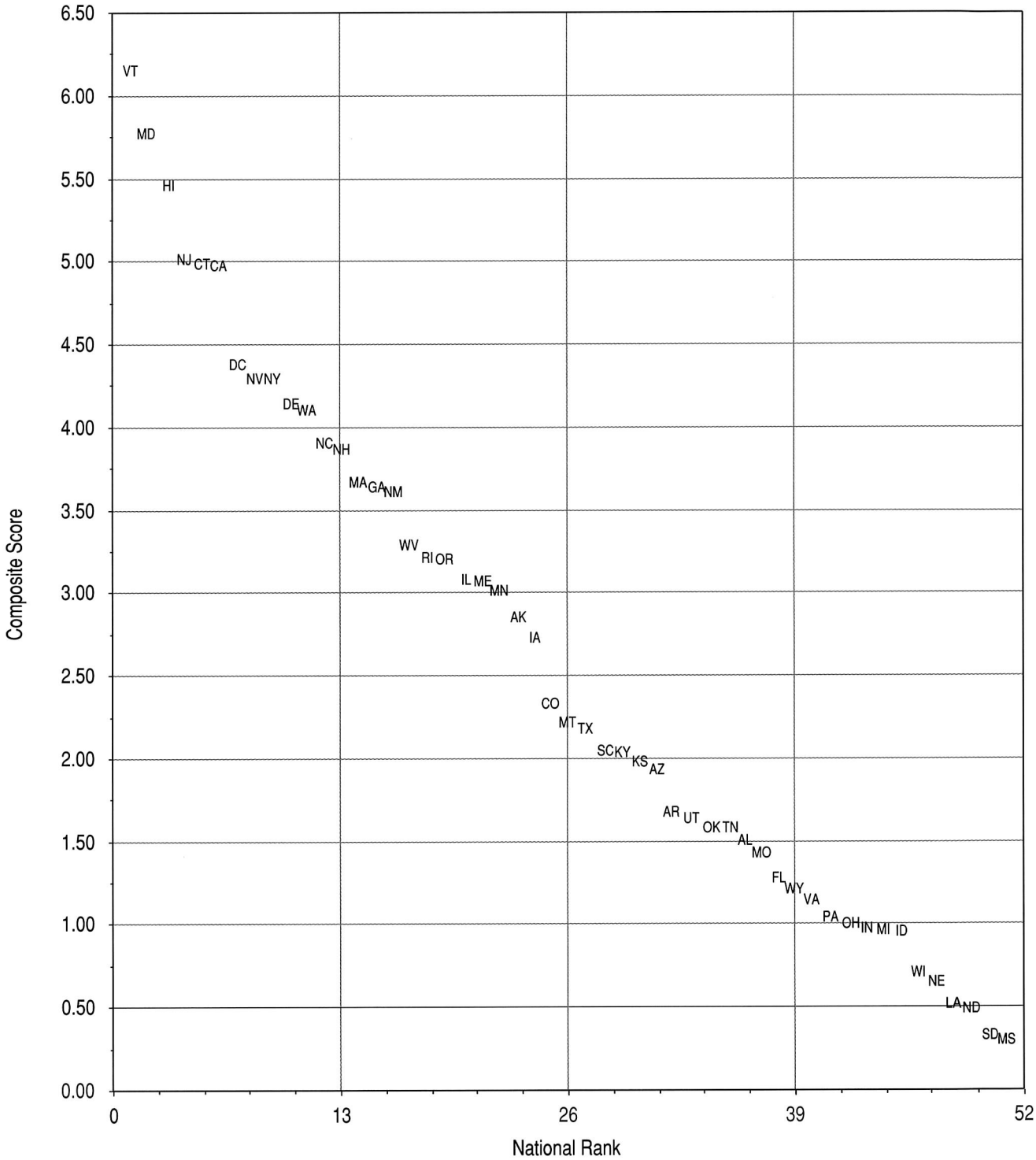
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices Employment and Earnings



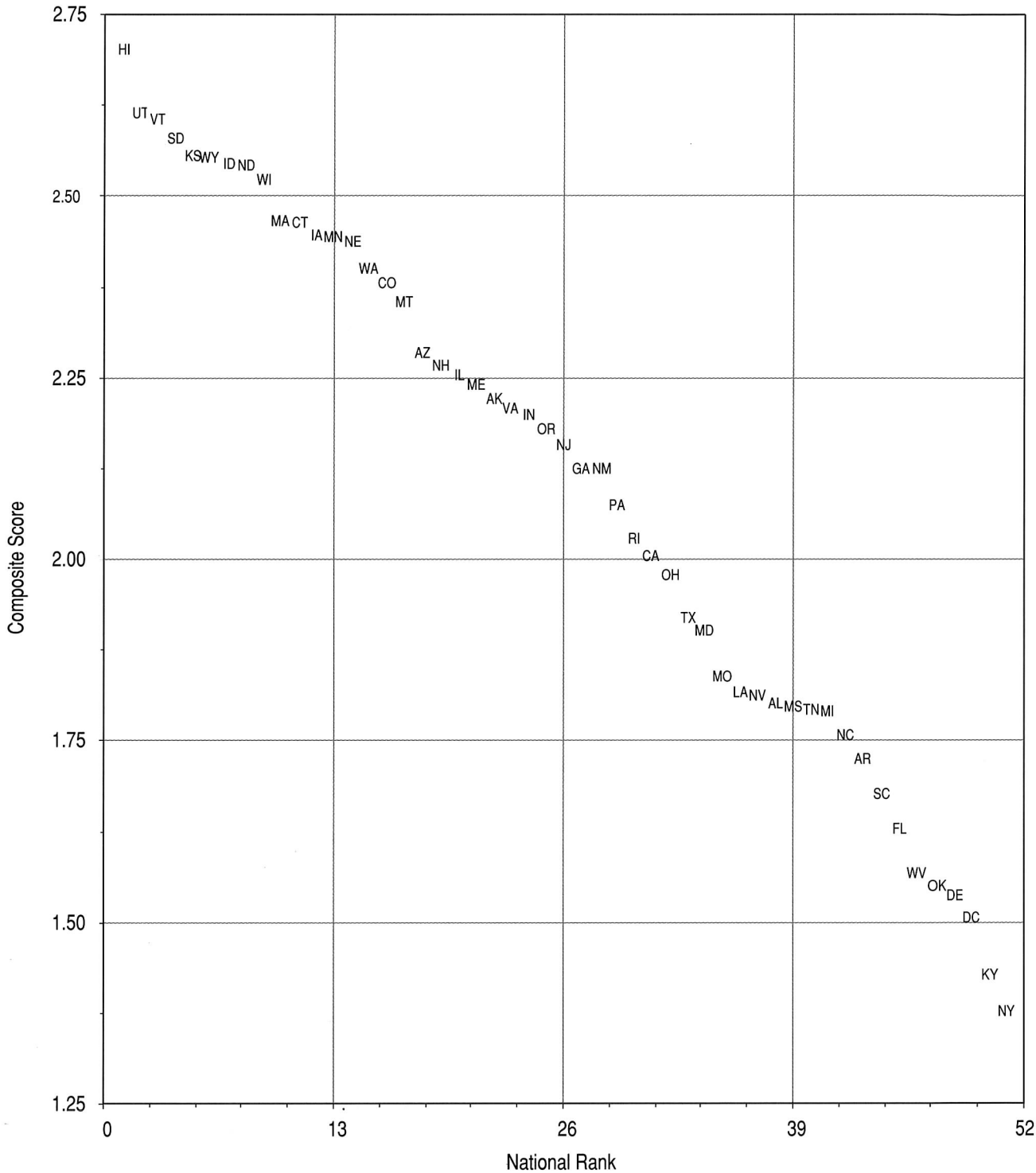
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Economic Autonomy



Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Reproductive Rights



Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices Health and Well-Being



Appendix V
State and National Resources

Selected Indiana Resources

AIDS Resource Group of Evansville
201 NW 4th St.
Old Courthouse Suite B7
Evansville, IN 47702
Tel: (812) 421-0059
Fax: (812) 424-9059
www.geocites.com/HotSprings/Spa/2744/index.htm

CARE Communities
1161 Agricultural Admin. Bldg.
Room 227
Purdue University
West Lafayette, IN 47907
Tel: (765) 494-6871
Fax: (765) 494-6871
www.four-h.purdue.edu

Fort Wayne Metropolitan Human Relations Commission
City-County Building
Room 680
1 E. Main Street
Fort Wayne, IN 46802
Tel: (219) 427-1146
Fax: (219) 427-1126

Fort Wayne Women's Bureau
303 E. Washington Blvd.
Fort Wayne, IN 46802
Tel: (219) 424-7977
Fax: (219) 426-7576
www.ft-wayne.in.us/social/fort_wayne_womens_bureau/

Fresh Start of Indianapolis
P.O. Box 26103
Indianapolis , IN 46226
Tel: 317-541-1655
FSofIndy@aol.com
www.joylight.com/fsofindy.html

Harbor House
P.O. Box 601
Vincennes, IN 47591
Tel: (812) 882-7900
Fax: (812) 882-7932

Indiana Coalition Against Sexual Assault
2511 East 46th St.
Suite N-13
Indianapolis, IN 46205
Tel: (317) 568-4001
Tel: (800) 691-2272
Fax: (317) 568-4045
INCASA@netdirect.net
www.incasa.org

Indiana Commission for Women
100 N. Senate Avenue
Room N 103
Indianapolis, IN 46204-2211
Tel: (317) 233-6303
Fax: (317) 232-6580

Indiana Family Health Council
21 Beachway Drive, Suite B
Indianapolis, IN 46224
Tel: (317) 247-9151
Fax: (317) 247-9159

Indiana Minority Health Coalition, Inc.
3737 N. Meridian St.
Suite 303
Indianapolis, IN 46208
Tel: (317) 926-4011
Fax: (317) 926-4012

Indiana Resource and Training Institute on Violence Against Women
2511 E. 46th St.
Suite N-3
Indianapolis, IN 46205
Tel: (317) 543-1321
Tel: (800) 538-3393
Fax: (317) 377-7050
www.violenceresource.org

Indiana Women's Political Network
P.O. Box 88271
Indianapolis, IN 46208
Tel: (317) 283-2006

Indiana Youth Institute
3901 N. Meridian St.
Suite 200
Indianapolis, IN 46208
Tel: (317) 924-3657
Fax: (317) 924-1314

The Julian Center
2511 E. 46th St. Suite 1
Indianapolis, IN 46205
Tel: (317) 545-1970
Fax: (317) 941-2208
www.juliancenter.org

Labor Institute for Training
Indiana AFL-CIO
1701 West 18th Street
Indianapolis, IN 46202
Tel: (317) 632-9147
Fax: (317) 638-1217
www.aflcio.in.us.gen

League of Women Voters of Bloomington-Monroe County
P.O. Box 5592
Bloomington, IN 47407
Tel: (812) 334-1984
www.bloomington.in.us/iris/league_of_women_voters.html

Middle Way House, Inc.
P.O. Box 95
Bloomington, IN 47402
Tel: (812) 333-7404
Crisis Line: (812) 336-0846
Fax: (812) 333-7404
www.bloomington.in.us/iris/middle_way_house.htm

Notre Dame Women's Resource Center
LaFortune, 2nd Floor
Notre Dame , IN 46556
Tel: (219)631-9028
www.nd.edu/~wrc/

Planned Parenthood of Northeast Indiana
347 West Berry
Suite 300
Fort Wayne, IN 46802
Tel: (219) 423-1322
Fax: (219) 423-2692

Tecumseh Area Planned Parenthood
P.O. Box 1114
Lafayette, IN 47902
Tel: (317) 742-9073

Tri-State Alliance
P.O. Box 2901
Evansville, IN 47728
Tel: (812) 474-4853
www.tsagl.com

Y-ME Breast Cancer Network of Central Indiana
1010 E 86th St.
Building 1030 #34F
Indianapolis, IN 46240
Tel: (317) 240-3331

YWCA Family Intervention Center
406 E Sycamore
Kokomo, IN 46901
Tel: (765) 459-0314
Fax: (765) 457-4416

YWCA of Anderson
304 West 11th St.
Anderson, IN 46016
Tel: (765) 642-0211
Fax: (765) 642-0212

YWCA of Elkhart County
200 E. Jackson Blvd.
Elkhart, IN 46516
Tel: (219) 295-6915
Fax: (219) 294-2731

YWCA of Richmond
1900 South L St.
Richmond, IN 47375
Tel: (317) 966-0538
Fax: (317) 966-0530

YWCA of St. Joseph County
802 North Lafayette Blvd.
South Bend, IN 46601
Tel: (219) 233-9491
Fax: (219) 333-9616

YWCA of Terre Haute
951 Dresser Drive
Terre Haute, IN 47807
Tel: (812) 232-3358
Fax: (812) 235-2959

National Resources

Administration on Aging
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 619-7501
Fax: (202) 260-1012
www.aoa.dhhs.gov

AFL-CIO Department of Working Women
815 16th Street, NW
Washington, DC 20006
Tel: (202) 637-5064
Fax: (202) 637-6902
www.aflcio.org

African American Women Business Owners Association
3363 Alden Place, NE
Washington, DC 20019
Tel: (202) 399-3645
Fax: (202) 399-3645
twarren@idfa.org
www.blackpgs.com/aawboa.html

African American Women's Institute
Howard University
P.O. Box 590492
Washington, DC 20059
Tel: (202) 806-4556
Fax: (202) 806-9263
www.aawi.org

Agency for Health Care Research and Quality
U.S. Department of Health and Human Services
2101 E. Jefferson Street
Suite 501
Rockville, MD 20852
Tel: (301) 594-6662
Fax: (301) 594-2168
www.ahcpr.gov

Alan Guttmacher Institute
1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Tel: (202) 296-4012
Fax: (202) 223-5756
www.agi-usa.org

Alzheimer's Association
919 North Michigan Avenue
Suite 1100
Chicago, IL 60611-1676
Tel: (312) 335-8700
Tel: (800) 272-3900
Fax: (312) 335-1110
www.alz.org

American Association of Homes and Services for the Aging
901 E Street, NW, Suite 500
Washington, DC 20004-2011
Tel: (202) 783-2242
Fax: (202) 783-2255
www.aahsa.org

American Association of Retired Persons
601 E Street, NW
Washington, DC 20049
Tel: (202) 434-2277
Tel: (800) 424-3410
Fax: (202) 434-6477
www.aarp.org

American Association of University Women
1111 16th Street, NW
Washington, DC 20036
Tel: (202) 785-7700
Tel: (800) 326-AAUW
Fax: (202) 872-1425
www.aauw.org

American Federation of State, County, and Municipal Employees (AFSCME)
1625 L Street, NW
Washington, DC 20036-5687
Tel: (202) 429-1000
Fax: (202) 429-1293
www.afscme.org

American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005
Tel: (202) 789-7400
Fax: (202) 789-7458
www.ama-assn.org

American Medical Women's Association
801 N. Fairfax Street, Suite 400
Alexandria, VA 22314
Tel: (703) 838-0500
Fax: (703) 549-3864
www.amwa-doc.org

American Nurses Association
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024
Tel: (202) 651-7000
Tel: (800) 274-4ANA
Fax: (202) 651-7001
www.ana.org

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
Tel: (800) 374-2721
Fax: (202) 336-5500
www.apa.org

American Sociological Association
1307 New York Avenue, NW
Suite 700
Washington, DC 20005
Tel: (202) 383-9005
Fax: (202) 638-0882
www.asanet.org

American Women's Economic Development Corporation
216 East 45th Street, 10th Floor
New York, NY 10017
Tel: (212) 692-9100
Fax: (212) 692-9296
www.orgs.womenconnect.com/awed/

The Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Tel: (410) 547-6600
Fax: (410) 547-6624
webmail@aecf.org
www.aecf.org

Asian Women in Business/ Asian American Professional Women
One West 34th Street, Suite 200
New York, NY 10001
Tel: (212) 868-1368
Fax: (212) 868-1373
www.awib.org

Association of American Colleges and Universities
1818 R Street, NW
Washington, DC 20009
Tel: (202) 387-3760
Fax: (202) 265-9532
www.aacu-edu.org

Association of Black Women Entrepreneurs, Inc.
P.O. Box 49368
Los Angeles, CA 90049
Tel: (213) 624-8639
Fax: (213) 624-8639

Association for Health Services Research
1801 K Street, Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
Fax: (202) 292-6800
www.ahsr.org

Black Women United for Action
6551 Loisdale Court, Suite 222
Springfield, VA 22150
Tel: (703) 922-5757
Fax: (703) 313-8716
www.bwufa.org

Business and Professional Women USA
2012 Massachusetts Avenue, NW
Washington, DC 20036
Tel: (202) 293-1100
Fax: (202) 861-0298
www.bpwusa.org

Catalyst
120 Wall Street
New York, NY 10005
Tel: (212) -514-7600
Fax: (212) 514-8470
www.catalystwomen.org

Catholics for a Free Choice
1436 U Street, NW, Suite 301
Washington, DC 20009-3997
Tel: (202) 986-6093
Fax: (202) 332-7995
www.igc.org/catholicvote

Center for the Advancement of Public Policy and
Washington Feminist Faxnet
1735 S Street, NW
Washington, DC 20009
Tel: (202) 797-0606
Fax: (202) 265-6245
www.essential.org/capp

Center for American Women and Politics
Rutgers, The State University of New Jersey
191 Ryders Lane
New Brunswick, NJ 08901-8557
Tel: (732) 932-9384
Fax: (732) 932-0014
www.rci.rutgers.edu/~cawp/

Center for the Child Care Workforce
733 15th Street, NW, Suite 1037
Washington, DC 20005-2112
Tel: (202) 737-7700
Tel: (800) U-R-WORTHY
Fax: (202) 737-0370
www.ccw.org

Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
Tel: (404) 639-3311
www.cdc.gov/nchs

Center for Law and Social Policy
1616 P Street, NW, Suite 150
Washington, DC 20036
Tel: (202) 328-5140
Fax: (202) 328-5195
www.clasp.org

Center for Policy Alternatives
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20009
Tel: (202) 387-6030
Fax: (202) 986-2539
www.cfpa.org

Center for the Prevention of Sexual and Domestic Violence
936 N 34th Street, Suite 200
Seattle, WA 98103
Tel: (206) 634-1903
Fax: (206) 634-0115
www.cpsdv.org

Center for Reproductive Law and Policy
1146 19th Street, NW
Washington, DC 20036
Tel: (202) 530-2975
Fax: (202) 530-2976
www.crlp.org

Center for Research on Women
University of Memphis
Campus Box 526105
Memphis, TN 38152-6105
Tel: (901) 678-2770
Fax: (901) 678-3652
cas.memphis.edu/isc/crow

Center for Women's Policy Studies
1211 Connecticut Avenue, NW
Suite 312
Washington, DC 20036
Tel: (202) 872-1770
Fax: (202) 296-8962
www.centerwomenpolicy.org

Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
Tel: (202) 408-1080
Fax: (202) 408-1056
www.cbpp.org

Child Care Action Campaign
330 Seventh Avenue, 14th Floor
New York, NY 10001
Tel: (212) 239-0138
Fax: (212) 268-6515
www.childcareaction.org

Child Trends, Inc.
4301 Connecticut Ave, NW
Suite 100
Washington, DC 20008
Tel: (202) 362-5580
Fax: (202) 362-5533
www.childtrends.org

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Tel: (202) 628-8787
Tel: (800) CDF-1200
Fax: (202) 662-3540
www.childrensdefense.org

Church Women United
475 Riverside Drive, Suite 500
New York, NY 10115
Tel: (212) 870-2347
Fax: (212) 870-2338
www.churchwomen.org

Coalition of Labor Union Women
1126 16th Street, NW
Washington, DC 20036
Tel: (202) 466-4610
Fax: (202) 776-0537
www.cluw.org

Coalition on Human Needs
1120 Connecticut Avenue, NW,
Suite 910
Washington, DC 20006
Tel: (202) 223-2532
www.chn.org

Communication Workers of America
501 Third Street, NW
Washington, DC 20001
Tel: (202) 434-1100
Fax: (202) 434-1279
www.cwa-union.org

Economic Policy Institute
1660 L Street, NW, Suite 1200
Washington, DC 20036
Tel: (202) 775-8810
Fax: (202) 775-0819
www.epinet.org

EMILY'S List
805 15th Street, NW
Suite 400
Washington, DC 20005
Tel: (202) 326-1400
Fax: (202) 326-1415
www.emilyslist.org

Equal Rights Advocates
1663 Mission Street, Suite 550
San Francisco, CA 94103
Tel: (415) 621-0672
Fax: (415) 621-6744
www.equalrights.org

Family Violence Prevention Fund
383 Rhode Island Street
Suite 304
San Francisco, CA 94103
Tel: (415) 252-8900
Fax: (415) 252-8991
www.fvpf.org

Federally Employed Women
P.O. Box 27687
Washington, DC 20038-7687
Tel: (202) 898-0994
www.few.org/

The Feminist Majority Foundation
1600 Wilson Blvd, Suite 801
Arlington, VA 22209
Tel: (703) 522-2214
Fax: (703) 522-2219
www.feminist.org

General Federation of Women's Clubs
1734 N Street, NW
Washington, DC 20036-2990
Tel: (202) 347-3168
Fax: (202) 835-0246
www.gfwc.org

Girls Incorporated National Resource Center
120 Wall Street, 3rd Floor
New York, NY 10005
Tel: (212) 509-2000
Fax: (212) 509-8708
www.girlsinc.org

Girl Scouts of the USA
420 5th Avenue
New York, NY 10018-2798
Tel: (800) GSUSA-4U
Fax: (212) 852-6509
www.gsusa.org

Hadassah
50 West 58 Street
New York, NY 10019
Tel: (212) 355-7900
Fax: (212) 303-8018
www.hadassah.com

Human Rights Campaign
919 18th Street, NW, Suite 800
Washington, DC 20006
Tel: (202) 628-4160
Fax: (202) 347-5323
www.hrc.org

HumanSERVE
Campaign for Universal Voter Registration
739 8th Street, SE, Suite 202
Washington, DC
Tel: (202) 546-3492
Fax: (202) 546-2483
www.igc.org/humanserve

Institute for Research on Poverty
University of Wisconsin—Madison
1180 Observatory Drive
3412 Social Science Building
Madison, WI 53706-1393
Tel: (608) 262-6358
Fax: (608) 265-3119
www.ssc.wisc.edu/irp

Institute for Women's Policy Research
1707 L Street, NW, Suite 750
Washington, DC 20036
Tel: (202) 785-5100
Fax: (202) 833-4362
iwpr@iwpr.org
www.iwpr.org

International Center for Research on Women
1717 Massachusetts Avenue, NW,
Suite 302
Washington, DC 20036
Tel: (202) 797-0007
Fax: (202) 797-0020
www.icrw.org

International Labour Organization
1828 L Street, NW, Suite 600
Washington, DC 20036
Tel: (202) 653-7652
Fax: (202) 653-7687
www.ilo.org

Jacobs Institute of Women's Health
409 12th Street, SW
Washington, DC 20024-2188
Tel: (202) 863-4990
Fax: (202) 554-0453
www.jiwh.org

Jewish Women International
1828 L Street, NW, Suite 250
Washington, DC 20036
Tel: (202) 857-1300
Fax: (202) 857-1380
www.jewishwomen.org

Joint Center for Political and Economic Studies
1090 Vermont Avenue, NW
Suite 1100
Washington, DC 20005-4928
Tel: (202) 789-3500
Fax: (202) 789-6390
www.jointctr.org

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005-3904
Tel: (212) 809-8585
Fax: (212) 809-0055
www.lambdalegal.org

League of Conservation Voters
1920 L Street, NW, Suite 800
Washington, DC 20036
Tel: (202) 785-8683
Fax: (202) 835-0491
www.lcv.org

League of Women Voters
1730 M Street, NW, Suite 1000
Washington, DC 20036
Tel: (202) 429-1965
Fax: (202) 429-0854
www.lwv.org

MANA—A National Latina Organization
1725 K Street, NW, Suite 501
Washington, DC 20006
Tel: (202) 833-0060
Fax: (202) 496-0588
www.hermana.org

Ms. Foundation for Women
120 Wall Street, 33rd Floor
New York, NY 10005
Tel: (212) 742-2300
Fax: (212) 742-1653
www.ms.foundation.org

9 to 5, National Association for Working Women
231 W. Wisconsin Avenue
Milwaukee, WI 53203-2308
Tel: (800) 522-0925
Tel: (414) 274-0925
Fax: (414) 272-2870
www.9to5.org

National Abortion Federation
1755 Massachusetts Avenue, NW
Suite 600
Washington, DC 20036
Tel: (202) 667-5881
Fax: (202) 67-5890
www.prochoice.org

National Abortion and Reproductive Rights Action League
1156 15th Street, NW
Suite 700
Washington, DC 20005
Tel: (202) 973-3000
Fax: (202) 973-3096
www.naral.org

National Asian Women's Health Organization
250 Montgomery Street, Suite1500
San Francisco, CA 94104
Tel: (415) 989-9747
Fax: (415) 989-9758
www.nawho.org

National Association of Anorexia Nervosa and Associated Disorders
P.O. Box 7
Highland Park, IL 60035
Tel: (847) 831-3438
Fax: (847) 433-4632
www.anad.org

National Association of Commissions for Women
8630 Fenton Street, Suite 934
Silver Springs, MD 20910-3808
Tel: (301) 585-8101
Tel: (800) 338-9267
Fax: (202) 585-3445
www.nacw.org

National Association of Negro Business and Professional Women's Clubs, Inc
1806 New Hampshire Avenue
Washington, DC 20009-3208
Tel: (202) 483-4206
Fax: (202) 462-7253
www.nanbpwc.org

National Association of Women Business Owners
1411 K Street, NW
Washington, DC 20005
Tel: (202) 347-8686
Tel: (800) 556-2926
Fax: (202) 347-4130
www.nawbo.org

National Association of Women in Education
1325 18th Street, NW
Suite 210
Washington, DC 20036
Tel: (202) 659-9330
Fax: (202) 457-0946
www.nawe.org

National Breast Cancer Coalition
1707 L Street, NW, Suite 1060
Washington, DC 20036
Tel: (202) 296-7477
Tel: (202) 622-2838
Fax: (202) 265-6854
www.natlbcc.org

National Center for American Indian Enterprise Development
934 North 143rd Street
Seattle, WA 98133
Tel: (800) 4-NCAIED
Fax: (480) 545-4208
www.ncaied.org

National Center for Lesbian Rights
870 Market Street, Suite 570
San Francisco, CA 94102
Tel: (415) 392-6257
Fax: (415) 392-8442
www.nclrights.org

National Coalition Against Domestic Violence
P.O. Box 18749
Denver, CO 80218
Tel: (303) 839-1852
Fax: (303) 831-9251
www.ncadv.org

National Committee on Pay Equity
1126 16th Street, NW, Suite 411
Washington, DC 20036
Tel: (202) 331-7343
Fax: (202) 331-7406
www.feminist.com/fairpay.htm

National Conference of Puerto Rican Women
5 Thomas Circle, NW
Washington, DC 20005
Tel: (202) 387-4716
http://buscapique.com/latinusa/bucafile/wash/nacoprw.htm

National Council for Research on Women
11 Hanover Square
New York, NY 10005
Tel: (212) 785-7335
Fax: (212) 785-7350
www.ncrw.org

National Council of Negro Women
633 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 737-0120
Fax: (202) 737-0476
www.ncnw.com

National Council of Women's Organizations
733 15th Street, NW, Suite 1011
Washington, DC 20036
Tel: (202) 393-7122
Fax: (202) 387-7915
www.womensorganizations.org

National Education Association
1201 16th Street, NW
Washington, DC 20036
Tel: (202) 833-4000
Fax: (202) 822-7397
www.nea.org

National Employment Law Project, Inc.
55 John Street, 7th Floor
New York, NY 10038
Tel: (212) 285-3025
Fax: (212) 285-3044
www.nelp.org

National Federation of Democratic Women
719 Woodacre Road
Jackson, MS 39206
Tel: (601) 982-0750
Fax: (601) 713-3068
www.nfdw.org

National Federation of Republican Women
124 North Alfred Street
Alexandria, VA 22314
Tel: (703) 548-9688
Fax: (703) 548-9836
www.nfrw.org

National Foundation for Women Business Owners
1411 K Street, NW, Suite 1350
Washington, DC 20005
Tel: (202) 638-3060
Fax: (202) 638-3064
www.nfwbo.org

National Gay and Lesbian Task Force
1700 Kalorama Road, NW
Washington, DC 20009-2624
Tel: (202) 332-6483
Fax: (202) 332-0207
www.ngltf.org

National Latina Institute for Reproductive Health
1200 New York Avenue, NW
Suite 206
Washington, DC 20005
Tel: (202) 326-8970
Fax: (202) 371-8112
www.nlirh.org

National Law Center on Homelessness and Poverty
1411 K Street, NW, Suite 1400
Washington, DC 20005
Tel: (202) 638-2535
Fax: (202) 628-2737
www.nlchp.org

National Organization for Women
733 15th Street, NW, 2nd Floor
Washington, DC 20005
Tel: (202) 628-8669
Fax: (202) 785-8576
www.now.org

National Organization for Women Legal Defense and Education Fund
395 Hudson Street, 5th Floor
New York, NY 10014
Tel: (212) -925-6635
Fax: (212) -226-1066
www.nowldef.org

National Partnership for Women and Families
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20005
Tel: (202) 986-2600
Fax: (202) 986-2539
www.nationalpartnership.org

National Political Congress of Black Women
8401 Colesville Road, Suite 400
Silver Spring, MD 20910
Tel: (301) 562-8000
Fax: (301) 562-8303
www.npcbw.org

National Prevention Information Network (HIV, STD, TB)
Centers for Disease Control
P.O. Box 6003
Rockville, MD 20849-6003
Tel: (800) 458-5231
Fax: (888) 282-7681
www.cdcnpin.org

National Resource Center on Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112-2778
Tel: (717) 545-6400
Tel: (800) 537-2238
Fax: (717) 545-9456
www.healthfinder.gov/text/orgs/HR2494.htm

National Women's Business Council
409 Third Street, SE, Suite 210
Washington, DC 20024
Tel: (202) 205-3850
Fax: (202) 205-6825
www.nwbc.gov

National Women's Health Network
514 10th Street, NW, Suite 400
Washington, DC 20004
Tel: (202) 347-1140
Fax: (202) 347-1168
www.womenshealthnetwork.org

National Women's Health Resource Center
120 Albany Street, Suite 820
New Brunswick, NJ 08901
Tel: (877) 986-9472
Fax: (732) 249-4671
www.healthywomen.org

National Women's Law Center
11 Dupont Circle, NW
Suite 800
Washington, DC 20036
Tel: (202) 588-5180
Fax: (202) 588-5185
www.nwlc.org

National Women's Political Caucus
1630 Connecticut Avenue, NW
Suite 201
Washington, DC 20009
Tel: (202) 785-1100
Fax: (202) 785-3605
www.nwpc.org

National Women's Studies Association
University of Maryland
7100 Baltimore Boulevard
Suite 500
College Park, MD 20740
Tel: (301) 403-0525
Fax: (301) 403-4137
www.nwsa.org

New Ways to Work
785 Market Street, Suite 950
San Francisco, CA 94103
Tel: (415) 995-9860
Fax: (415) 995-9867
www.nww.org

Older Women's League
666 11th Street, NW, Suite 700
Washington, DC 20001
Tel: (202) 783-6686
Fax: (202) 638-2356
www.aoa.dhhs.gov/aoa/dir/207.html

Organization of Chinese-American Women
4641 Montgomery Avenue
Suite 208
Bethesda, MD 20814
Tel: (301) 907-3898
Fax: (301) 907-3899

Pension Rights Center
918 16th Street NW, Suite 704
Washington, DC 20006
Tel: (202) 296-3776
Fax: (202) 833-2472
www.aoa.dhhs.gov/aoa/dir/210.html

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
Tel: (212) 541-7800
Fax: (212) 245-1845
www.plannedparenthood.org

Population Reference Bureau, Inc.
1875 Connecticut Avenue, NW
Suite 520
Washington, DC 20009
Tel: (202) 483-1100
Fax: (202) 328-3937
www.prb.org

Poverty and Race Research Action Council
3000 Connecticut Avenue, NW
Suite 200
Washington, DC 20008
Tel: (202) 387-9887
Fax: (202) 387-0764
www.prrac.org

Religious Coalition for Reproductive Choice
1025 Vermont Avenue, NW
Suite 1130
Washington, DC 20005
Tel: (202) 628-7700
Fax: (202) 628-7716
www.rcrc.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
3600 Fisher's Lane
Room 12-105
Rockville, MD 20857
Tel: (301) 443-4795
Fax: (301) 443-0284
www.samhsa.gov

U.N. Division for the Advancement of Women
Two United Nations Plaza
New York, NY 10017
Tel: (212) 963-3177
Fax: (212) 963-3463

The Urban Institute
2100 M Street, NW
Washington, DC 20037
Tel: (202) 833-7200
Fax: (202) 331-9747
www.urban.org

U.S. Agency for International Development
Office of Women in Development
RRB 3.8-042U
Washington, DC 20523-3801
Tel: (202) 712-0570
www.genderreach.com

U.S. Department of Commerce
Bureau of the Census
Population Division
Washington, DC 20233
Tel: (301) 457-4100
Fax: (301) 457-4714
www.census.gov

U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-0498
Tel: (202) 401-1576
Tel: (800) USA-LEARN
Fax: (202) 401-0689
www.ed.gov

U.S. Department of Justice, Violence Against Women Office
Office of Justice Programs
810 Seventh Street, NW
Washington, DC 20531
Tel: (202) 616-8894
Fax: (202) 307-3911
www.ojp.usdoj.gov/vawo

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 619-0257
www.os.dhhs.gov

U.S. Department of Labor
Bureau of Labor Statistics
State Labor Force Data
2 Massachusetts Avenue, NE
Washington, DC 20012
Tel: (202) 691-5200
Fax: (202) 691-7890
stat.bls.gov

U.S. Department of Labor
Women's Bureau
200 Constitution Avenue, NW
Room No. S-3002
Washington, DC 20210
Tel: (202) 219-6611 x157
Tel: (800) 827-5335
Fax: (202) 219-5529
www.dol.gov/dol/wb

Victim Services, Inc.
2 Lafayette Street, 3rd Floor
New York, NY 10007
Tel: (212) 577-7700
Fax: (212) 385-0331
www.victimservices.org

White House Office for Women's Initiatives and Outreach
Room 15, O.E.O.B.
Washington, DC 20502
Tel: (202) 456-7300
Fax: (202) 456-7311
www2.whitehouse.gov/women

Wider Opportunities for Women
815 15th Street, NW, Suite 916
Washington, DC 20005
Tel: (202) 638-3143
Fax: (202) 638-4885
www.w-o-w.org

Women Employed
111 N. Wabash
13th Floor
Chicago, IL 60602
Tel: (312) 782-3902
Fax: (312) 782-5249
www.womenemployed.org

Women, Ink.
777 United Nations Plaza
New York, NY 10017
Tel: (212) 687-8633
Fax: (212) 661-2704
www.womenink.org

Women Work!
The National Network for Women's Employment
1625 K Street, NW, Suite 300
Washington, DC 20006
Tel: (202) 467-6346
Fax: (202) 467-5366
www.womenwork.org

Women's Cancer Center
900 Welch Road, Suite 300
Palo Alto, CA 94304
Tel: (650) 326-6500
Fax: (650) 326-6553
www.wccenter.com

Women's Environmental and Development Organization
355 Lexington Avenue
3rd Floor
New York, NY 10017
Tel: (212) 973-0325
Fax: (212) 973-0335
www.wedo.org

Women's Institute for a Secure Retirement
1201 Pennsylvania Avenue, NW,
Suite 619
Washington, DC 20004
Tel: (202) 393-5452
Fax: (202) 638-1336
www.network-democracy.org/socialsecurity/bb/whc/wiser.html

Women's International League for Peace and Freedom
1213 Race Street
Philadelphia, PA 19107
Tel: (215) 563-7110
Fax: (215) 563-5527
www.people-link.com/wilpf

Women's International Network
Charlotte Crafton
c/o Women's International Network
45 E. City Line Avenue
Suite 299
Bala Cywnyd, PA 19004
Tel: (215) 871-7655
Tel: (888) 594-3342
www.w-i-n.com

Women's Research and Education Institute
1750 New York Avenue, NW
Suite 350
Washington, DC 20006
Tel: (202) 628-0444
Fax: (202) 628-0458
www.wrei.org

Young Women's Christian Association of the USA (YWCA)
Empire State Building
350 Fifth Avenue, Suite 301
New York, NY 10118
Tel: (212) 273-7800
Fax: (212) 465-2281
www.ywca.org

The Young Women's Project
923 F Street, NW, 3rd Floor
Washington, DC 20004
Tel: (202) 393-0461
Fax: (202) 393-0065
www.tidalwave.net/~ywp

Appendix VI:
List of Census Bureau Regions

East North Central

Illinois
Indiana
Michigan
Ohio
Wisconsin

East South Central

Alabama
Kentucky
Mississippi
Tennessee

Middle Atlantic

New Jersey
New York
Pennsylvania

Mountain West

Arizona
Colorado
Idaho
Montana
New Mexico
Nevada
Utah
Wyoming

New England

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Pacific West

Alaska
California
Hawaii
Oregon
Washington

South Atlantic

Delaware
District of Columbia
Florida
Georgia
Maryland
North Carolina
South Carolina
Virginia
West Virginia

West North Central

Iowa
Kansas
Minnesota
Missouri
Nebraska
North Dakota
South Dakota

West South Central

Arkansas
Louisiana
Oklahoma
Texas

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