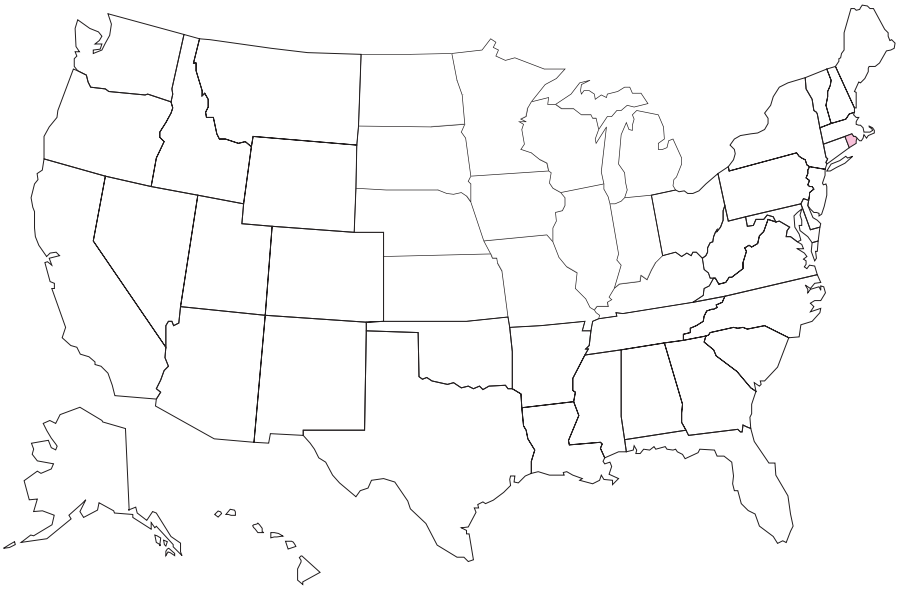
The Status of Women in Rhode Island

POLITICS ◆ ECONOMICS ◆ HEALTH ◆ RIGHTS ◆ DEMOGRAPHICS

Edited by Amy B. Caiazza, Ph.D.



Institute for Women's Policy Research

with the assistance of the Rhode Island Advisory Committee

Co-Publisher
Women's Fund of Rhode Island

Preface from the Rhode Island Advisory Committee

"Creating social change is exciting. It's proof that we are alive and thinking. What could be better than to work for a future where fairness is the bottom line?"
-Alfre Woodard, *Robin Hood Was Right*

For women and girls in Rhode Island, the playing field is not yet level. Indeed, if you're a woman in Rhode Island, prepare to lower your expectations. According to this national benchmarking study, Rhode Island is pretty much a C level performer when it comes to equity for women.

This report, *The Status of Women in Rhode Island*, measures women's status in five key areas: political participation, employment and earnings, social and economic autonomy, reproductive rights, and health and well being. Indicators in each area compare women in Rhode Island to women in the United States and in New England.

Recent years have provided both hope and dismay for the women of the world—across international borders, in the United States, and here in Rhode Island. Women made significant economic, political, and social progress–yet we are still far from achieving gender equity.

Only by focusing attention on inequities in the status of women and girls can we advocate for systemic change. The Women's Fund of Rhode Island (WFRI) is proud to present this important report for the policymakers, service providers, activists, funders, and voters in Rhode Island. We must work together to level the playing field for women and girls.

Consider what the United Nations says: "We the United Nations are committed to promoting and encouraging respect for human rights, for fundamental freedoms for all without distinction as to race, sex, language, or religion." That's what nations agree to when they join the United Nations.

The Beijing Declaration and Platform for Action from the U.N.'s Fourth World Conference on Women (1995) also states that women's rights are human rights. The Declaration notes that "women's empowerment and full participation in all spheres of society, including participation in the decision-making process and access to power, are fundamental for the achievement of equality, development, and peace."

The Beijing Declaration ends with a call to action for governments, non-governmental organizations (nonprofits), and all sectors of civil society to "dedicate ourselves unreservedly to addressing [the] constraints and obstacles, thus enhancing further the advancement and empowerment of women all over the world. And we agree that this requires urgent action in the spirit of determination, hope, cooperation, and solidarity, now and to carry us forward into the next century."

Urgent action with determination, hope, and cooperation. Is that not our challenge? Can we do so here in Rhode Island? And perhaps then in the United States and worldwide?

Please use this report. Please join with the Women's Fund as we champion fairness, impartiality, opportunity, shared power, and responsibility in all spheres of personal and community life, including economic, cultural, educational, social, and political.

This study was sponsored by WFRI and conducted by IWPR with the assistance of WFRI and the Rhode Island Advisory Committee. Recognition and gratitude is extended to all members of the statewide Advisory Committee, who provided extensive volunteer guidance and oversight to the project.

WFRI was founded in fall 2000 to advance equity and social justice for women. WFRI is a field of interest fund at the Rhode Island Foundation.

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Acknowledgments

The Status of Women in the States project has grown tremendously from its beginning in 1996 to become a leading source of analysis of women's status across the country. It is an increasingly participatory project that involves close and ongoing relationships with IWPR's state partners. Not coincidentally, it has also become more visible as a crucial resource for improving state policies that affect women's status.

IWPR would like to express its sincere thanks to the many groups and individuals involved in *The Status of Women in the States* reports. We are especially indebted to the members of the state advisory committees, whose volunteer time and energy on this project are crucial to its success. We are also grateful to the many other state and national organizations that have partnered with IWPR on this 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 Phillips, program officers, both of whom have been extremely supportive of IWPR's work on this project. The Rockefeller Family Fund and the Open Society Institute provided financial support for the outreach work on the project. The Marjorie Cook Family Foundation's generous support of IWPR also contributed to *The Status of Women in the States*. IWPR also received financial support from funders and organizations in the states: the University of Alabama at Birmingham and the University of Alabama for *The Status of Women in Alabama*; the Iowa Women's Foundation and Chrysalis Foundation for *The Status of Women in Iowa*; the Skillbuilders Fund for *The Status of Women in Kansa*s and *The Status of Women in Missouri*; the New Directions Foundation for *The Status of Women in Massachusetts*; the Women's Fund of Rhode Island for *The Status of Women in Rhode Island*; and the Women's Fund of the Greater Milwaukee Foundation, the Brico Fund, A Fund for Women of the Madison Community Foundation, the Women's Fund of the Oshkosh Area Community Foundation, and the French Family Foundation for *The Status of Women in Wisconsin*.

The Status of Women in the States project is blessed with a passionate and impressive staff. April Shaw, Policy Analyst, was a keystone for the project: she coordinated data collection; the production of all charts, tables, and figures; and the revision process. In her second round of States reports, Ms. Shaw's knowledge of and commitment to the project–not to mention her organizational skills–were indispensable. Her kind and positive nature was also much appreciated. New to the project, Jean Sinzdak (IWPR's States Outreach Associate) coordinated the work of the state advisory committees. She showed an outstanding ability to juggle the needs of many individuals and groups and to keep everyone on task, always with a smile on her face. Nancy Mortell, Research/Development Associate, assisted Ms. Shaw in producing the reports and coordinated IWPR's efforts to fundraise for production and dissemination of the reports in the states. Her ability to balance these two tasks efficiently and effectively, and her (dry) sense of humor, were irreplaceable to the research and development staff at IWPR.

IWPR also relied on the work of several interns and work-study students on *The Status of Women in the States* project. Meghan Purvis, Amanda Innes, Lindsay Clark, Julie Hart, Margaret Langsenkamp, Laura Phillips, Katrina Holiday, and Kate Speirs all assisted with data collection and production of the reports. Amy LeMar, IWPR's Mariam K. Chamberlain Fellow in 2001-02, and Melissa Sills, IWPR's George Washington University Fellow in 2001-02, also assisted with the reports.

Many other IWPR researchers also contributed to drafting and editing the reports, including Dr. Stacie Golin, Study Director; Dr. Vicky Lovell, Study Director; Vanessa Melamede, Research Program Assistant; and 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.

IWPR's communications and production staff played a pivotal role in the reports. Linda Silberg, Director of Communications, and Katie O'Neill, Communications Coordinator, worked with the state advisory committees for more than a year to maximize publicity and visibility for each state's report. Both brought fantastic energy and enthusiasm to the project. With Ms. Silberg, Mick Schommer, Publications Manager and Editor, led the process of laying out and producing the final reports.

Thanks, too, to IWPR's development staff—and especially Noris Weiss Malvey and Matt Chayt, along with Nancy Mortell—whose fundraising for the project allowed it to exist. Their easygoing and engaging attitudes were appreciated by everyone involved.

Finally, Dr. Barbara Gault, Director of Research, and Dr. Heidi Hartmann, President and CEO, provided invaluable ongoing support and input for the project. Their creativity and overall brilliance are, as always, the driving force behind the success of IWPR and all its projects.

Amy Caiazza, Ph.D.
Study Director and Editor, *The Status of Women in the States*

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1. Introduction

During the twentieth century, women made significant economic, political, and social advances, but they are far from enjoying gender equality. Throughout the United States, women earn less than men, are seriously underrepresented in political office, and make up a disproportionate share of people in poverty. Even in areas where there have been significant advances in women's status, rates of progress are slow. For example, at the rate of progress achieved over the past ten years, women will not achieve wage parity for more than 60 years. If women's representation in Congress changes at the rate it did during the 1990s, it will take more than a century to achieve equality in political representation.

To make significant progress toward gender equity, policymakers, researchers, and advocates need reliable data about women and the issues affecting their lives. 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 biennial series is now in its fourth round. Over the course of a decade, reports on each of the 50 states and the District of Columbia are being completed. This year, IWPR produced reports on nine states, together with an updated 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 Status of Women in the States reports are produced 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 reports have three main goals: 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. The reports also highlight issues of particular importance to women in different states through the contributions of IWPR's advisory committees in each state.

The 2002 reports contain indicators describing women's status in five main areas: political participation, employment and earnings, social and 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).

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 for this report. All women continue to face important obstacles to achieving economic, political, and social parity.

To address the continuing barriers to women across the United States, the reports also include letter grades for each state for each of the five major issue areas. IWPR designed the grading system to highlight the gaps between men's and women's access to various rights and resources. States were graded based on the difference between their performance and goals set by IWPR (e.g., no remaining wage gap or the proportional representation of women in political office; 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. 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 can quickly identify remaining barriers to equality for women in their state.

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 is a participatory process of preparing, reviewing, producing, and publicizing the reports. This participation has been crucial to improving the reports and increasing their effectiveness and impact in each round. Many of the advisory committees have used the reports to advance policies to improve women's status.

About the Indicators and the Data

IWPR referred to several sources for guidelines on what to include in these reports. The Beijing Declaration and Platform for Action from the U.N. Fourth World Conference on Women guided some of its choices of indicators. This document, the result of an official convocation of delegates from around the world, outlines issues of concern to women, rights fundamental to achieving equality and autonomy, and remaining obstacles to 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 consulted experts in each subject area for input about the most critical issues affecting women's lives. An important source of this expertise was IWPR's Working Group on Social Indicators of Women's Status, described below.

Ultimately the IWPR research team selected indicators by using several principles: relevance, representativeness, reliability, and comparability of data across all the states and the District of Columbia. While women's status is constantly changing, 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 uses only data collected in the same way for each state. Much of the data is from federal government agencies, including the Census Bureau, the Bureau of Labor Statistics, the Centers for Disease Control, and the National Center for Health Statistics. Nonprofit and research organizations also provide 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. The decennial censuses provide the most comprehensive data for states and local areas, but because they are conducted only every ten years, their data are often out of date. CPS data are used to provide more timely information. For this set of reports, IWPR used new economic data from the years 1998-2000. Most 2000 decennial Census data were not yet available at the time these reports were prepared, but IWPR used these data where possible. 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 the CPS has much 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, sexual orientation, and family structure—affect their status or how important it is to implement policies that speak to these differences. IWPR made it a top priority to report these differences wherever possible using existing data. Identifying and reporting on subregions within states (cities, counties, or urban and rural areas) were 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 community-level differences in women's status are not described. While these differences are important, addressing them was not possible due to data and resource constraints.

A lack of reliable and comparable state-by-state data limits IWPR's treatment of several important topics: violence against women; issues concerning nontraditional families of all types; issues of special importance to lesbians; 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. In some cases, IWPR's state advisory committees have contributed their own data and analyses of these issues to the report to supplement IWPR's analysis. Nonetheless, many of these issues do not receive sufficient treatment in national surveys or other data collection efforts.

These 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 the 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 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 also encourages state advisory committees to contribute text presenting state-specific data on topics not covered by the reports. These contributions enhance the reports' usefulness to the residents of each state, while maintaining comparability across all the states, since the contributed data do not affect the rankings or grades.

Readers of this report 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 it is that the difference will be statistically significant.

Finally, when comparing indicators based on data from different years, the reader should note that in the 1990-2002 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 of the 1990s. By 2000, however, the economy had slowed significantly, and a recession began in March 2001.

How *The Status of Women in the States* Reports Are Used

The Status of Women in the States reports have been used throughout the country to highlight remaining obstacles facing women in the United States and to encourage policy changes designed to improve women's status. The reports have helped IWPR's state partners and others to educate the public about issues concerning women's status; inform policies and programs to increase women's voter turnout; and make the case for establishing commissions for women, expanding child care subsidies for low-income women, strengthening supports for women-owned businesses, developing training programs for women to enter non-traditional occupations, and improving women's access to health care. Data on the status of women give citizens the information they need to address the key issues facing women and their families.

2. Overview of the Status of Women in Rhode Island

Rhode Island illustrates both the advances and limited progress achieved by women in the United States. While women in Rhode Island are seeing important changes in their lives and access to political, economic, and social rights, they do not enjoy equality with men and lack many of the legal guarantees that would allow them to achieve it. Women in Rhode Island, and the nation, would benefit from stronger enforcement of equal opportunity laws, better political representation, adequate and affordable child care, stronger poverty reduction programs, and other policies to improve their status.

Despite Rhode Island's relatively strong performance, women in the state have not achieved equality with men. Women in Rhode Island still face significant problems that demand attention from policymakers, women's advocates, and researchers concerned with women's status. As a result, in an evaluation of Rhode Island women's status compared with goals set for women's status, Rhode Island gets a grade of B in reproductive rights, C+ in employment and earnings and in social and economic autonomy, C in health and well-being, and D in political participation (see Chart 2.1).

Chart 2.1
How Rhode Island Ranks on Key Indicators

Indicators	National Rank*	Regional Rank*	Grade
Composite Political Participation Index	**32**	**6**	**D**
Women's Voter Registration, 1998 and 2000	18	3	
Women's Voter Turnout, 1998 and 2000	15	3	
Women in Elected Office Composite Index, 2002	40	6	
Women's Institutional Resources, 2002	1	1	
Composite Employment and Earnings Index	**16**	**5**	**C+**
Women's Median Annual Earnings, 1999	11	3	
Ratio of Women's to Men's Earnings, 1999	30	4	
Women's Labor Force Participation, 2000	33	6	
Women in Managerial and Professional Occupations, 1999	22	6	
Composite Social and Economic Autonomy Index	**14**	**5**	**C+**
Percent with Health Insurance Among Nonelderly Women, 2000	1	1	
Educational Attainment: Percent of Women with Four or More Years of College, 1990	20	5	
Women's Business Ownership, 1997	31	4	
Percent of Women Above the Poverty Level, 1999	23	5	
Composite Reproductive Rights Index	**10**	**4**	**B**
Composite Health and Well-Being Index	**26**	**6**	**C**

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 six (except for the Political Participation indicators, which do not include the District of Columbia) and refer to the states in the New England region (CT, MA, ME, NH, RI, and VT).
Calculated by the Institute for Women's Policy Research.

Of the 50 states and the District of Columbia, Rhode Island scores in the top third of all states in three areas: it is tenth for women's reproductive rights, 14th for social and economic autonomy, and 16th for employment and earnings. It falls in the middle third of all states in two areas: 26th for women's health and well-being and 32nd for political participation.

Rhode Island, Connecticut, Maine, Massachusetts, New Hampshire, and Vermont are part of the New England region. Among these six states, Rhode Island ranks low: fourth for reproductive rights, fifth for social and economic autonomy and employment and earnings, and last for political participation and health and well-being.

There are several important areas where the state needs to improve:

- Rhode Island women have among the lowest levels of elected representation in state and national office in the country.
- Rhode Island women have among the worst mortality rates from heart disease, lung cancer, and breast cancer. They rank last in New England for women's overall health.
- There is great racial disparity in the incidence of AIDS in the state. While just 2.6 per 100,000 white women have AIDS, 32.2 Hispanic women and an even more alarming 78.8 African American women have the disease.
- Within the New England region, Rhode Island women have the lowest labor force participation rate and the lowest proportion of women working in professional and managerial positions.
- Regionally, Rhode Island women have the second lowest rates of educational attainment and the second highest rates of poverty.
- Rhode Island does not provide public funding for low-income women to pay for abortions.

Still, women in Rhode Island do especially well in some areas:

- Women in Rhode Island have the highest levels of health insurance coverage in the country.
- Rhode Island women have the lowest levels of mortality from suicide in the country.
- Women in Rhode Island have among the highest levels of political representation through institutional resources, including a commission for women and a women's legislative caucus.
- Women's earnings in the state are among the highest in the nation.
- Rhode Island is one of the few states that require insurance policies to cover both contraceptives and infertility treatments.
- Rhode Island has several important welfare policies that benefit women. It allows the maximum time under federal law for welfare eligibility, has adopted work exemptions for women experiencing domestic violence, and extends full benefits to children born or conceived while a mother receives welfare. The maximum monthly benefit for families receiving welfare in Rhode Island is also much higher than the national average.
- An Earned Income Tax Credit (EITC) following the federal model has been adopted in Rhode Island.

Rhode Island has the ninth smallest population in the United States. Women of color make up about 28 percent of women in the state, compared with 31 percent in the nation as a whole. Still, Rhode Island's diversity is growing. In particular, the proportion of Hispanic women in Rhode Island more than doubled during the 1990s. Rhode Island also has higher proportions of women over age 65 and foreign-born women than the rest of the country. A much higher proportion of Rhode Island women than U.S. women live in urban areas (see Appendix I). These factors all affect the status of Rhode Island's women.

Women in Rhode Island exemplify both the achievements and shortfalls of women's progress over the past century. Many Rhode Island women are witnessing real improvements in their economic, political, and social status. These advances are evident in some relatively high rankings for women's status compared with other states. But many important problems and obstacles remain.

Political Participation

Women in Rhode Island register and vote at higher rates than women in the United States overall, and they have very high levels of political representation through established institutional resources such as a commission for women. At the same time, Rhode Island women have very low levels of representation in elected office, at 40th in the country. Consequently, the state ranks 32nd and receives a grade of D on the political participation composite index. Regionally, Rhode Island is last for both women's representation and the overall political participation index. Better representation in elected office could benefit women 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 Rhode Island earn more than women in other states. They are also about as likely to participate in the labor force and to work in managerial and professional positions as women in the country as a whole. The wage ratio between women and men in the state is slightly lower than the rest of the country. Within New England, Rhode Island is about average for women's earnings and the wage ratio, but it is last for women's labor force participation and work in managerial and professional positions. These trends earn Rhode Island a ranking of 16th nationally and fifth of sixth regionally. It receives a C+ on the employment and earnings composite index.

Social and Economic Autonomy

Women in Rhode Island have the highest levels of health insurance coverage in the country. In contrast, they have average levels of educational attainment, business ownership, and poverty compared with the nation as a whole. It is fourth out of six in New England for women's business ownership and fifth for women's educational attainment and for women living above poverty. Overall, Rhode Island ranks 14th nationally and fifth out of six regionally for women's social and economic autonomy. Rhode Island's room for improvement is reflected in its grade of C+ for this composite index.

Reproductive Rights

Rhode Island's women have many of the reproductive rights identified as important. The state allows access to abortion without a waiting period, and it requires health insurers to cover contraceptives and infertility treatments. It also requires students to take sex education classes. However, the state requires parental consent for abortions for minors and lacks public funding for abortion. Overall, Rhode Island is tenth nationally and fourth out of six regionally for women's reproductive rights. Because it still has room for improvement, Rhode Island receives a grade of B on the reproductive rights index.

Health and Well-Being

Overall, women in Rhode Island experience about average health status compared with women in other states. They have the lowest levels of mortality from suicide in the country, and they experience better than average levels of diabetes and activities limitations due to health problems. At the same time, they have among the worst levels of mortality from heart disease, lung cancer, and breast cancer. Rhode Island's national rank of 26th on indicators of health and well-being suggests that while the state ranks higher than many others, it still has room for improvement. Within New England, Rhode Island ranks last in women's health. The state receives a C on this composite index.

3. 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.

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 (President's Interagency Council on Women, 2000). In some ways, women in the United States enjoy access to relatively high levels of gender equality compared with women around the world. In other areas, the United States and many individual states have an opportunity to better support women's rights.

The Women's Resources and Rights Checklist, Chart 3.1, provides an overview of the policies supporting women's rights and the resources available to women in Rhode Island. This list was derived 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 (e.g., through welfare and child support collection), women-friendly employment protections, family leave benefits, legislation protecting sexual minorities, reproductive rights, and institutional representation of women's concerns.

Many of the indicators in Chart 3.1 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 Rhode Island's commitment to policies designed to help women achieve economic, political, and social well-being. In Rhode Island, women enjoy many of the rights identified with women's well-being, although they lack others. The state has adopted 20 out of 31 possible policies presented in the Women's Resources and Rights Checklist.

Violence Against Women

Violence against women can significantly affect women's physical health, psychological well-being, and economic and social stability. Women who experience domestic violence, stalking, sexual assault, and other violence often need appropriate social services and health care to help them escape violent situations. They also need protection from perpetrators of violence and increased awareness among police, prosecutors, and health care professionals about the issues facing victims of violence. Rhode Island has a few policies and provisions that can help curtail violence and protect survivors, but it lacks several others.

Rhode Island has adopted a domestic battery statute complementing its assault and battery laws. In many states, such provisions are designed to provide enhanced penalties for repeat offenders. A total of 34 states have adopted this type of law.

Rhode Island also requires domestic violence training for police, although it does not require it for health care professionals. Ten states require domestic violence training for both groups by statute. Importantly, all Rhode Island police officers receive domestic violence training, not just new officers, and as of Spring 2002, 100 percent of officers had undergone this training (Rhode Island Justice Commission, 2002).

Without a law protecting victims of domestic violence, some insurance companies use domestic vio-

Chart 3.1
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				
Has Rhode Island adopted a domestic battery statute complementing assault laws?	✓			34
Does Rhode Island law require domestic violence training of new police recruits and health care professionals?		✓	Police only	10
Does Rhode Island law prohibit domestic violence discrimination in insurance?		✓	Life and health insurance only	22
Is a first stalking offense a felony in Rhode Island?	✓			12
Does Rhode Island law require sexual assault training for police, prosecutors, and health care professionals?[1]		✓		4
Child Support				
Percent of single-mother households receiving child support or alimony:			28%	34%
Percent of child support cases with orders for collection in which support was collected:			28%	39%
Welfare and Poverty Policies				
Does Rhode Island extend TANF benefits to children born or conceived while a mother is receiving welfare?	✓			28
Does Rhode Island allow receipt of TANF benefits up to or beyond the 60-month federal time limit?	✓		60-month limit	44
Does Rhode Island allow welfare recipients at least 24 months before requiring participation in work activities?		✓	2 months	13
Does Rhode Island provide transitional child care under TANF for more than 12 months?[2]		✓		14
Has Rhode Island's TANF plan been certified or submitted for certification under the Family Violence Option or made other provisions for victims of domestic violence?	✓			37
In determining welfare eligibility, does Rhode Island disregard the equivalent of at least 50 percent of earnings from a full-time, minimum wage job?	✓			11
Does Rhode Island have a state Earned Income Tax Credit?[3]	✓			16
Maximum TANF benefit for a family of three (two children) in Rhode Island, 2001:			$554.00	$379.00
Employment/Unemployment Benefits				
Is Rhode Island's minimum wage higher than the federal level as of January 2002?[1]	✓		$6.15	12
Does Rhode Island have mandatory temporary disability insurance?	✓			5
Does Rhode Island provide Unemployment Insurance benefits to:				
Low-wage earners?		✓		14
Workers seeking part-time jobs?		✓		9

Chart 3.1 continued	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Workers who leave their jobs for certain circumstances ("good cause quits")?[4]	✓			30
Has Rhode Island implemented adjustments to achieve pay equity in its state civil service?	✓			20
Family Leave Benefits				
Has Rhode Island proposed legislation extending Unemployment Insurance benefits to workers on temporary leave to care for infants and newly adopted children?		✓		0 Enacted; 20 Proposed
Has Rhode Island proposed legislation allowing use of temporary disability insurance to cover periods of work absence due to family care needs?		✓		1 Enacted; 3 Proposed
Sexual Orientation and Gender Identity				
Does Rhode Island have civil rights legislation prohibiting discrimination on the basis of sexual orientation and/or gender identity?[5]	✓			14
Has Rhode Island adopted legislation creating enhanced penalties or a separate offense for crimes based on sexual orientation?	✓			28
Has Rhode Island avoided adopting a ban on same-sex marriage?	✓			16
Reproductive Rights				
Does Rhode Island allow access to abortion services:				
Without mandatory parental consent or notification?		✓		8
Without a waiting period?	✓			29
Does Rhode Island provide public funding for abortions under any or most circumstances if a woman is eligible?		✓		16
Does Rhode Island require health insurers to provide comprehensive coverage for contraceptives?	✓			19
Does Rhode Island require health insurers to provide coverage of infertility treatments?	✓			11
Does Rhode Island allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?[6]	✓		Lower Court	25
Does Rhode Island require schools to provide sex education?[7]	✓			23
Institutional Resources				
Does Rhode Island have a commission for women?	✓			40
Total Policies	**20**	**11**		**31 possible**

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

[1] Although there is no legislative requirement, all police receive sexual assault training as part of their curriculum. In addition, health care professionals at eight of the state's twelve hospitals received sexual assault training as of April 2002.

[2] All families earning less than 225 percent of the Federal Poverty Level are guaranteed child care assistance regardless of prior TANF status. Former TANF recipients are not guaranteed child care assistance.

[3] Rhode Island's non-refundable EITC is 25.5 percent of the federal EITC.

[4] Rhode Island provides Unemployment Income to workers who leave their jobs due to domestic violence or sexual harassment.

[5] Rhode Island's law bans discrimination on the basis of both sexual orientation and gender identity.

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

[7] Rhode Island requires that both abstinence and contraception be taught in its sex education curriculum.

Compiled by the Institute for Women's Policy Research.

Safety for Women and Children in Rhode Island

Domestic violence is a concern throughout the country. In Rhode Island, efforts to reduce the rates of violence focus on prevention, intervention with children who are exposed to domestic violence or are victims of abuse, and changing societal attitudes. While statistics reveal that there is much work to be done to make Rhode Island safe for women, there are some promising practices from Rhode Island's domestic violence and sexual assault agencies that are a successful part of the state's approach to the problem. Still, Rhode Island could extend even more resources to address violence issues and adopt a few important policies that have worked elsewhere.

The Problem

Domestic Violence

On any given day in Rhode Island, 49 people call a domestic violence hotline, 62 women and children spend the night in a domestic violence shelter, and 25 people seek community-based domestic violence services. A total of 9,311 victims of domestic violence received services in 2001. A total of 3,523 restraining orders were issued in 2000, and 4,846 criminal cases were handled in District Court (Rhode Island Coalition Against Domestic Violence, 2001a).

Sexual Assault

In 2000, Rhode Island had 39.5 incidents of rape per 100,000 residents – 21 percent higher than the national average of 32.7 per 100,000 residents. Since 1990, incidents of rape have risen 37 percent in Rhode Island. A total of 2,273 victims and their families received services for sexual assault and abuse in Rhode Island during 2000 (Sexual Assault and Trauma Resource Center, 2000).

The Impact on Children

Domestic Violence and Children

There were 2,401 children present at the 5,887 domestic violence arrests made in Rhode Island in 2000 (Supreme Court of Rhode Island, Domestic Violence Training and Monitoring Unit, 2000). In 2001, ten percent of the 9,311 clients served by the Rhode Island Coalition Against Domestic Violence's member agencies were children. National statistics reflect that more than one third of teenagers in dating relationships have experienced some physical violence (Molidor and Tolman, 1998).

The child custody and visitation system needs improvement for combating domestic violence in Rhode Island. Although Rhode Island courts are required to consider evidence of past or present domestic violence when making decisions about custody and visitation, there is no legal presumption that custody will be placed with the non-offending parent. Another major gap in the Rhode Island system is the lack of supervised visitation centers for safe visitation with the offending parent and children (Rhode Island Kids Count, 2000).

Sexual Assault and Children

Approximately two-thirds of all victims of sexual assault are children. It is estimated that one in four girls and one in six boys are sexually assaulted before the age of 18 (Snyder, 2000). In Rhode Island in 2000, there were 357 allegations of sexual abuse, involving 254 children (Rhode Island Kids Count, 2001a). In a majority of the cases, the perpetrator was well known to the child. Eighteen percent of the perpetrators were parents, 18 percent were babysitters/caretakers, 15 percent were caretakers who were relatives, and 15 percent were other household member caretakers. Ninety-one arrests were made for child molestation by law enforcement throughout the state (Supreme Court of Rhode Island, Domestic Violence Training and Monitoring Unit, 2000).

(continued on next page)

Perhaps more disturbing are children's attitudes regarding sexual assault. According to a dating attitude survey administered to sixth and ninth graders in 1988 and 1998 by the Sexual Assault and Trauma Resource Center of Rhode Island:

- Approximately 70 percent of boys and 54 percent of girls felt that a date partner had a right to sexual intercourse against their consent if they had sexual intercourse before.
- Approximately 80 percent of boys and 78 percent of girls felt that a man had a right to sexual intercourse against a woman's consent if they were married.
- Approximately 51 percent of boys and 45 percent of girls felt that it was okay for a dating partner to kiss the other against their consent if the partner spent a lot of money on them (Sexual Assault and Trauma Resource Center of Rhode Island, 1998).

Promising Practices

Rhode Island has a well-developed response for children who have been victims of sexual assault, in part thanks to the work of the Child Advocacy Center at the Sexual Assault and Trauma Resource Center of Rhode Island. During 2000, 331 children under the age of 14 were interviewed, evaluated, and treated for sexual assault from this program (Sexual Assault and Trauma Resource Center of Rhode Island, 2000). The Center provides a safe space for children to be interviewed by trained advocates with law enforcement, social services, and attorneys present. The design of the program limits the trauma and re-victimization that is common when multiple interviews by different agencies occur in one case.

In order to change public attitudes, the Rhode Island Coalition Against Domestic Violence, its member agencies, and the Sexual Assault and Trauma Resource Center of Rhode Island provide education in the local schools and outreach to youth agencies. Teen dating violence was also the subject of a large-scale media and educational campaign put on by the Rhode Island Coalition Against Domestic Violence in 2001. Part of this campaign involved the development of a resource guide on domestic violence for teachers and educators in the schools (Rhode Island Coalition Against Domestic Violence, 2001b).

Poverty as a Risk Factor

For women in Rhode Island, poverty is a significant risk factor for domestic violence (Pearlman, et al., 2001). The risk of domestic violence increases by 250 percent for women living in neighborhoods where 20 percent or more of the population is below the poverty line. Women in poor neighborhoods also report domestic violence more frequently (Pearlman, et al., 2001).

Promising Practices

Recognizing that more than half of the women receiving welfare have experienced physical abuse by an intimate partner (Lyon, 2000), the Rhode Island Department of Human Services, in collaboration with the Rhode Island Coalition Against Domestic Violence and the Women's Center of Rhode Island, implemented a successful Family Violence Option program in 1998. This program is part of the Family Independence Program and provides the opportunity for women receiving welfare to be exempted from work and child support enforcement requirements. Between July 1998 and December 2001, 734 Rhode Island women have received support services from an advocate through this innovative collaborative program (Rhode Island Coalition Against Domestic Violence, 2002). Future programming and policy development should continue to address the link between poverty and safety for women, using the Family Violence Option as an example.

lence to justify discrimination against them, by denying, canceling, or limiting coverage and/or charging a higher premium for coverage. A total of 22 states prohibit life, health, and disability insurance companies from using domestic violence as a basis for discrimination. Rhode Island is not one of the states that prohibit all forms of insurance from denying coverage. It does, however, have a law prohibiting discrimination against victims of domestic violence in health and life insurance coverage; it fails to cover disability insurance.

In addition to domestic violence policies, many states have provisions related to crimes such as stalking, harassment, and sexual assault. In twelve states, a first stalking offense is considered a felony. In 26 states, stalking can be classified as either a felony or a misdemeanor, depending on circumstances such as use of a weapon or prior convictions. Felony status is considered preferable because it usually leads to quicker arrest, eliminating the need for police to investigate the seriousness of the stalking to determine probable cause (U.S. Department of Justice, Office of Justice Programs, Violence Against Women Grants Office, 1998). In Rhode Island, a first stalking offense is a felony.

Finally, four states have adopted laws requiring sexual assault training for police, prosecutors, and health care professionals. While Rhode Island is not one of the states that require sexual assault training for police, all officers do participate in a four-hour curriculum on sexual assault and domestic violence as part of their ongoing and new recruit training (Rhode Island Justice Commission, 2002). In addition, although sexual assault training for health care professionals is not mandated by Rhode Island, health care professionals at eight of the state's twelve hospitals had participated in a sexual assault and domestic violence training program during the year preceding April 2002 (Sexual Assault and Trauma Resource Center of Rhode Island, 2002; for more information on violence against women, see Safety for Women and Children in Rhode Island).

Child Support

Many single-mother households experience low wages and poverty, and child support or alimony is one way to supplement their incomes. Child support can make a substantial difference in low-income families' lives by lifting many out of poverty. Among nonwelfare, low-income families with child support arrangements, poverty rates would increase by more than 30 percent without their child support income (IWPR, 1999).

In the United States, approximately 34 percent of single-mother households receive some level of child support or alimony. In Rhode Island, only 28 percent receive such support, somewhat below the national average. According to the U.S. Department of Health and Human Services, Office of Child Support Enforcement, 61 percent of child support cases have support orders established (U.S. Department of Health and Human Services, Administration for Children and Families, 2001). Child support, however, is collected in only 39 percent of cases with orders (or about 24 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 Rhode Island in 1998, child support was collected in only 28 percent. This is substantially below the average for the United States.

Welfare and Poverty 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.

While AFDC provided minimum 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 federal restrictions.

States have adopted widely divergent TANF plans. The provisions of their welfare programs can have important ramifications for 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, leave family situations involving domestic violence and other negative circumstances, and support their families during times of economic hardship. Rhode Island has adopted several TANF policies that are relatively supportive of women, although a few others are punitive.

As of June 2001, 23 states had Child Exclusion policies, or "Family Caps," which deny or limit benefits to children born to a family that is receiving welfare. Such policies are intended to reduce childbearing among unwed parents and to prevent women from having more children for the sole purpose of increasing their cash benefits. Research suggests, though, that cash assistance does not influence women's childbearing decisions, making the Family Cap an unnecessary source of economic hardship (IWPR, 1998). Rhode Island extends full TANF benefits to children born or conceived while a mother receives welfare. Twenty-seven states and the District of Columbia do not have any kind of Family Cap.

Rhode Island's time limits on receiving TANF are the maximum allowed under federal regulations. In Rhode Island, recipients are limited to 60 months. The average for all states is 55.4 months. Thirty-seven states and the District of Columbia have a time limit of 60 months (the maximum allowed under federal law). Seven states report lifetime time limits of less than 60 months. Six states have no lifetime limits for individuals complying with TANF requirements. These states use state money to supplement federal funding.

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 29 states, nonexempt recipients are required to engage in work activities immediately under TANF. Nine other states have work requirements within less than 24 months. Twelve states require recipients to work within 24 months or when determined able to work, whichever comes first. One state, Vermont, allows recipients 30 months before requiring work to receive benefits. Welfare recipients in Rhode Island have just two months before they are required to begin work activities.

PRWORA also replaced former child care entitlements with the Child Care Development Fund, which consolidated funding streams for child care, increased overall child care funds to states, and allowed states significant discretion in determining eligibility for child care. 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 designated as being at risk of becoming dependent on TANF (U.S. Department of Health and Human Services, Administration for Children and Families, 1999). In addition to these funds, many states use TANF 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, for families transitioning away from welfare, 14 states guarantee child care beyond twelve months. Eighteen states provide a total of twelve months of transitional child care. Nineteen states provide less than twelve months of transitional child care. In Rhode Island, families who are transitioning off welfare have no guarantee of child care, although all families earning less than 225 percent of the federal poverty line are guaranteed child care assistance, regardless of former TANF status. Expanding child care services is a crucial form of support for working families, especially single mothers, and can be critical to ensuring families' self-sufficiency.

As of June 2001, 36 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. This option allows victims of violence to be exempted from work requirements, lifetime time limits, or both, as part of state TANF plans. Rhode Island has adopted 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. Rhode Island has a relatively generous policy on how it treats earnings in determining TANF eligibility. The state disregards at least 50 percent of the earnings of a worker in a full-time, minimum-wage job. Generous earnings disregards can help ease the transition away from welfare for women and their families as they strive for self-sufficiency. Eleven states disregard at least 50 percent of earnings when determining income eligibility for TANF.

The federal Earned Income Tax Credit (EITC) program began in 1975 and has been expanded several times over the years to support work and decrease poverty. The EITC program allows low-income families to receive tax rebates on all or some of the taxes taken out of their paychecks during the year. The success of the program has prompted some states to enact state EITCs in recent years. State EITCs reduce poverty and play a critical role in supporting families with low earnings, especially those families making the transition from welfare to work.

Currently, 16 states, including Rhode Island, offer an EITC modeled on the federal EITC (Zahradnik, Johnson, and Mazerov, 2001). Eleven of these states have refundable EITCs, which means that families can receive the full amount of their tax credits even if they exceed the total amount of families' income tax liabilities. Refundable EITCs benefit many more low-income working families than non-refundable EITCs. Rhode Island has a state EITC, although it is not refundable.

Among all 50 states and the District of Columbia, the median maximum cash assistance benefit check in 2001 for families receiving TANF was $379 per month for a family of three (two children and one parent). In Rhode Island, the maximum monthly benefit was $554, substantially above the national average.

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 available resources and 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.

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. Rhode Island employment policies are relatively supportive of women workers, although the state could adopt a few additional policies that would benefit them.

The minimum wage is particularly important to women because they constitute the majority of low-wage workers. Research by IWPR and the Economic Policy Institute has 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 January 2002, eleven states and the District of Columbia had minimum wage rates higher than the federal level of $5.15. Three 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 29 states had state minimum wages equal to the federal level. In Rhode Island, the minimum wage level is higher than the federal level, at $6.15 an hour.

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. 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 leaves through TDI (Hartmann, et al., 1995).

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 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 Rhode Island, UI policies are relatively unsupportive of women. Earnings requirements generally disqualify low-wage earners. Policies also prohibit workers seeking part-time jobs from qualifying for unemployment benefits. Because women are more likely than men to seek part-time work, a failure to cover part-time workers disproportionately harms women. On the other hand, Rhode Island's UI policies allow women to qualify for insurance in cases of "good cause quits," in which a worker leaves a job for personal circumstances. In Rhode Island, this can include harassment on the job or domestic violence.

To decrease wage inequality between women and men, 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. Since 1997, 20 states have implemented programs to raise the wages of workers in female-dominated jobs in their state employment systems (National Committee on Pay Equity, 1997). A study by IWPR found that in states implementing pay equity remedies, the remedies improved female/male wage ratios (Hartmann and Aaronson, 1994). Rhode Island has implemented policies within its state civil service to achieve pay equity for state government employees in selected occupations. However, serious pay inequities remain among state employees. In 1996, a study found a 19 percent difference between men's and women's wages in state government, in large part due to the state's job classification program, but its recommendations for remedying this problem have not yet been adopted (Research Center in Business and Economics, 1996; Rhode Island Department of Administration, 1997).

Family Leave Benefits

As women's labor force participation has increased, so has the need for paid family leave. The Family and Medical Leave Act of 1993 provides for unpaid time off from work to care for sick relatives or a newborn or adopted child, guaranteeing leave-takers' jobs when they return to work. This legislation does not replace the income workers lose while taking leave to care for their families, however. Among workers, 77 percent who need leave but fail to take it cannot afford the time without pay, and 25 percent of low-income workers who do take some leave have to turn to welfare for support (U.S. Department of Labor, 2001).

Some states have responded to this gap in recent years by adopting policies that give families more options for paid family leave. One initiative proposed by 20 states would extend UI benefits to workers on temporary leave to care for infants and newly adopted children (Society for Human Resource Management, 2001; National Partnership for Women and Families, 2001a). If adopted, "Baby UI" is expected to improve parent-child bonding, encourage more stable child-care arrangements, and increase workforce attachment (Lovell and Rahmanou, 2000). Rhode Island has not introduced Baby UI legislation.

Another strategy used by some states to provide paid family leave involves extending mandatory TDI programs to provide insurance coverage for periods of work absence due to family care needs, in addition to the worker's own illness or disability. In September 2002, California amended its TDI program to include family leave with partial pay for up to six weeks. New

York and New Jersey have proposed similar expansions of their plans, and Massachusetts has proposed adopting a new mandatory TDI program that would include coverage for family leave (National Partnership for Women and Families, 2001b). Rhode Island has not. If Rhode Island were to provide family leave benefits by expanding its TDI program and/or adopting Baby UI, all workers would be better able to care for their families.

Sexual Orientation and Gender Identity

Rhode Island has several policies that provide lesbians and other sexual minorities access to the same rights as other citizens. Thirteen states, including Rhode Island, and the District of Columbia have adopted statutes prohibiting discrimination on the basis of sexual orientation. Another 27 states and the District of Columbia have passed laws creating enhanced penalties for perpetrators or separate offenses for hate crimes committed against victims because of their sexual orientation. Rhode Island has passed this kind of hate crime law. Rhode Island has also avoided specifically prohibiting same-sex marriage. Thirty-five 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, which was signed in April 2000, 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 if they have been registered as a civil union.

Reproductive Rights

While indicators concerning reproductive rights are covered in detail later in the report, they also represent crucial components of any list of desirable policies for women. In Rhode Island, women have relatively high levels of access to abortion, contraception, and other family planning resources. Such access can allow women to make careful, informed, and independent decisions about childbearing, which can in turn have a significant impact on their well-being and the well-being of their children.

Institutional Resources

Since Rhode Island women have a state-level 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 details). Forty states currently have state-level commissions for women.

Conclusion

In order for women in Rhode Island 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. These rights and resources are important for improving women's lives and the well-being of their families.

4. Political Participation

Political participation allows women to influence 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 makes ensuring women equal access to avenues for participation and decision-making a major objective. This section presents data on several aspects of women's involvement in the political process in Rhode Island: 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 some of women's political preferences differ from men's. 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. In public opinion surveys, women express concern about issues like education, health care, and reproductive rights at higher rates than men do (Conway, Steuernagel, and Ahern, 1997). Because women are often primary care providers in families, these issues have an especially profound effect on women's lives.

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 officeholders to support women's agendas (Center for American Women and Politics [CAWP], 1991; Swers, 2002). In addition, legislatures with larger proportions of female elected officials tend to address women's issues more often and more seriously than those with fewer female representatives (Dodson, 1991; Thomas, 1994). Finally, representation through institutions

Chart 4.1
Political Participation: National and Regional Ranks

Indicators	National Rank* (of 50)	Regional Rank* (of 6)	Grade
Composite Political Participation Index	**32**	**6**	**D**
Women's Voter Registration (percent of women 18 and older who reported being registered to vote in 1998 and 2000)[a]	18	3	
Women's Voter Turnout (percent of women 18 and older who reported voting in 1998 and 2000)[a]	15	3	
Women in Elected Office Composite Index (percent of state and national elected officeholders who are women, 2002)[b, c, d]	40	6	
Women's Institutional Resources (number of institutional resources for women in Rhode Island, 2002)[e, f]	1	1	

See Appendix II for methodology.
* The national rankings are of a possible 50, because the District of Columbia is not included in these rankings. The regional rankings are of a maximum of six and refer to the states in the New England region (CT, MA, ME, NH, RI, and VT).
Source: [a] U.S. Department of Commerce, Bureau of the Census, 2000c, 2002c; [b] CAWP, 2002a, 2002b, 2002c, 2002d; [c] Council of State Governments, 2000; [d] Compiled by IWPR based on Center for Policy Alternatives, 1995; [e] CAWP, 1998; [f] National Association of Commissions for Women, 2000.
Calculated by the Institute for Women's Policy Research.

such as women's commissions or women's legislative caucuses provides ongoing channels for expressing women's concerns and makes policymakers more accessible to women, especially when those institutions work closely with women's organizations (Stetson and Mazur, 1995).

Overall, women in Rhode Island fare about average for women in the United States as a whole on indicators of women's political participation. The state ranks in the middle third of all states on the political participation composite index, at 32nd, although its rankings for individual indicators vary greatly. It is first in the country for women's institutional resources but just 40th for women in elected office (see Chart 4.1). Rhode Island also falls just above the midpoint for all states on women's voter turnout (15th) and voter registration (18th). Within New England, Rhode Island ranks first of six for institutional resources but is third for women's voter registration, third for voter turnout, and last for the proportion of women in elected office. Rhode Island ranks last regionally for women's political participation overall.

Rhode Island's performance suggests that, for indicators of political participation, the state still has room for improvement. Many eligible women do not vote or register to vote, and relatively few statewide elected officials are women. Since, like most states, Rhode Island could improve significantly on indicators of political participation, it receives a grade of D for political participation. Women in Rhode Island and throughout the country need better representation in 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 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 were denied the right to vote in many states until the Voting Rights Act of 1965 was passed. 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).

Women now register and vote at a slightly higher rate than men. In 2000, about 69 million women, or 65.6 percent of those eligible, reported being registered to vote, compared with more than 60 million, or 62.2 percent, of eligible men (see Table 4.1). Rhode Island's 1998 and 2000 voter registration rates were higher for both men and women than the national rates. In Rhode Island, 65.0 percent of women reported being registered to vote in the November 1998 elections, while 66.8 percent of men did. In 2000, men and women's voter registration rates in Rhode Island were also higher than national rates. In addition, in 2000 women in the state were more likely than men to be registered to vote. Rhode Island ranks 18th among all the states and third in the New England region for women's voter registration in the 1998 and 2000 elections combined.

Women have constituted a majority of U.S. voters since 1964. In both 1998 and 2000, 53 percent of all voters were women. In most states, women have higher voter turnout rates than men. In 1998, 46.9 percent of Rhode Island women reported voting, while in 2000, 62.9 percent did (see Table 4.2; this is general election data). In both years, women's voter turnout in Rhode Island was above national levels. In addition, while in 1998 men's voter turnout rate was higher than women's rate, by 2000 women's turnout had outstripped men's. Rhode Island ranks 15th among all the states and third in the New England region for women's voter turnout in the 1998 and 2000 elections combined.

Voter turnout jumped substantially for both sexes in the nation as a whole between 1998 and 2000, primarily because 2000 was a presidential election year. Presidential elections traditionally have much higher turnout than non-presidential elections. In Rhode Island, women not only voted at a higher rate than men in 2000 (62.9 percent and 56.8 percent respectively), but both women's and men's voter turnout increased considerably from 1998. That

Table 4.1
Voter Registration for Women and Men in Rhode Island and the United States

	Rhode Island		United States	
	Percent	Number	Percent	Number
2000 Voter Registration[a]*				
Women	71.5%	279,000	65.6%	69,193,000
Men	67.7%	230,000	62.2%	60,356,000
1998 Voter Registration[b]*				
Women	65.0%	255,000	63.5%	65,445,000
Men	66.8%	223,000	60.6%	57,659,000
Number and Percent of All Voter Registration Applications, 1999-2000, Received at:[c]				
Public Assistance Offices	1.5%	1,646	2.9%	1,314,500
Disability Services Offices	0.9%	995	0.4%	190,009

* Percent of all women and men aged 18 and older who reported registering, based on data from the 1998 and 2000 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, 2002c; [b] U.S. Department of Commerce, Bureau of the Census, 2000c; [c] Federal Election Commission, 2000.

Compiled by the Institute for Women's Policy Research.

year, 46.9 percent of women and 50.2 percent of men in the state voted. Overall, compared with other Western democracies, voter turnout is relatively low for both sexes in the United States.

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. In 1998, 46.5 percent of white women and 46.4 percent of white men voted, compared with 41.9 percent of African American women and 37.6 percent of African American men. Even lower proportions of Hispanic and Asian American citizens voted in 1998: just 21.3 percent of Hispanic women, 18.8 percent of Hispanic men, 19.7 percent of Asian American women, and 18.6 percent of Asian American men. Data for minorities are not available by sex at the state level for any state, and data on minorities' voting rates are not available at all in Rhode Island. Still, while the overall voting rate in Rhode Island was 50.2 percent, 52.2 percent of whites voted. This suggests that minorities voted at lower rates (data not shown; U.S. Department of Commerce, Bureau of the Census, 2000c).

Table 4.2
Women's and Men's Voter Turnout in Rhode Island and the United States

	Rhode Island		United States	
	Percent	Number	Percent	Number
2000 Voter Turnout[a]*				
Women	62.9%	245,000	56.2%	59,284,000
Men	56.8%	193,000	53.1%	51,542,000
1998 Voter Turnout[b]*				
Women	46.9%	184,000	42.4%	43,706,000
Men	50.2%	168,000	41.4%	39,391,000

* Percent of all women and men aged 18 and older who reported voting, based on data from the 1998 and 2000 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, 2002c; [b] U.S. Department of Commerce, Bureau of the Census, 2000c.

Compiled by the Institute for Women's Policy Research.

Over the years, most U.S. states have developed relatively complicated systems of voter registration. Voting has typically required advance registration at a few specified locations. This system is historically a major cause of low U.S. voting rates (Wolfinger and Rosenstone, 1980). Those in poverty and persons with disabilities are particularly disadvantaged by the inaccessible and cumbersome voter registration system. Voting itself is also more difficult for people with disabilities because of problems such as inadequate transportation to the polls. In response to these issues, several states have eliminated registration requirements or allowed registration on the same day as voting. In these states, both voting and registration rates are among the highest in the country.

Effective 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.

In 1999-2000, states processed voter registration applications for over 20 million people through public agencies, including 1.3 million through public assistance agencies, 1,646 of whom live in Rhode Island (see Table 4.1). Another 190,000 applications in the United States and 995 in Rhode Island were received at disability services offices. A lower proportion of all applications, 1.5 percent, was received through public assistance offices in Rhode Island compared with the nation as a whole (2.9 percent). In contrast, a higher proportion, 0.9 percent, was received through disability service offices in Rhode Island than in the United States (0.4 percent). Rhode Island could increase the visibility of its NVRA voter registration services and improve its application processes, especially for low-income voters.

Women in Public Office

Elected Officials in the Legislative and Executive Branches

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). Thirteen women served in the 2001-02 U.S. Senate (107th Congress). Women also filled 60 of the 435 seats in the 107th 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 21 House seats and no Senate seats. Women from Rhode Island filled no seats in the U.S. House or Senate, meaning that they had no national representation (see Table 4.3).

Table 4.3
Women in Elected Office in Rhode Island and the United States, 2002

	Rhode Island	United States
Number of Women in Statewide Executive Elected Office[a, b]	0	88
Women of Color[c]	0	4
Number of Women in the U.S. Congress:		
U.S. Senate[d]	0 of 2	13 of 100
Women of Color[c]	0	0
U.S. House[e]	0 of 2	60 of 435
Women of Color[c]	0	21
Number of Women Running for the U.S. Congress, 2000[f, g*]		
U.S. Senate**	0 of 2	9 of 89
U.S. House	0 of 3	122 of 799
Percent of State Legislators Who Are Women[h]	22.7%	22.6%

* These figures refer to candidates running for congressional seats in the general election and exclude those running in primaries.
** Rhode Island had no Senate election in 2000.
Source: [a] CAWP, 2002a; [b] Council of State Governments, 2000; [c] CAWP, 2002e; [d] CAWP, 2002c; [e] CAWP, 2002d; [f] CAWP, 2001a; [g] Federal Election Commission, 2001a, 2001b; [h] CAWP, 2002b.
Compiled by the Institute for Women's Policy Research.

At the state level, women also held no elected executive offices in Rhode Island. In contrast, the proportion of women in the state legislature in Rhode Island was about average, at 22.7 percent, compared with a 22.6 percent average for the nation as a whole. Nationally, four women of color served in statewide executive elected offices; no women of color served in this capacity in Rhode Island (see Table 4.3).

Based on the proportion of women in elected office, Rhode Island ranks just 40th in the nation and last in the New England region. As in most states, women in Rhode Island have not attained proportional political representation in elected office.

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 2000, 122 women out of 799 total candidates (15.2 percent) ran for office in the U.S. House of Representatives, while nine women of 89 total candidates (10.1 percent) ran for office in the U.S. Senate. Thus, women's rates of representation (13.8 percent of the House and 13.0 percent of the Senate) were very close to their proportion of candidacies for office. This suggests that for women to win their proportionate share of political offices in the near term, the number and percentage of seats they run for must be much higher than they were during the 1990s. In Rhode Island, no women ran for a seat in either the U.S. House or Senate in the 2000 general election.

Policies and practices that 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 other organizations, and fair and equal media treatment for male and female candidates.

Women Executive Appointees

Women appointed to political positions in the executive branch can also influence policy to better account for women's needs and interests. Women's representation in appointed office in the executive branch has grown considerably over the past several years. In the period between 1997 and 2001, the percentage of women appointees serving in leadership positions in state executive branches across the United States rose by 6.6 percentage points, from 28.3 to 34.9 percent (Center for Women in Government and Civil Society, 2001). Women in Rhode Island served in a slightly lower proportion of appointed executive offices in 2001, at 33.3 percent (Table 4.4). A total of nine women served out of 27 possible positions.

Women of color filled just two appointed executive positions in Rhode Island. Two African American women and no Hispanic, Asian American, or Native American women served in appointed executive office in 2001. In the United States as a whole, out of 1,905 possible positions, 70 African American

Table 4.4
Women in Appointed Office in Rhode Island and the United States, 2002

	Rhode Island	United States
Number and Percent of Women in Appointed Executive Office	9 of 27 33.3%	665 of 1,905 34.9%
White	7	547
African American	2	70
Hispanic	0	29
Asian American	0	18
Native American	0	1

Source: Center for Women in Government and Civil Society, 2001.
Compiled by the Institute for Women's Policy Research.

women, 29 Hispanic women, 18 Asian American women, and just one Native American woman served in appointed executive office (for a proportion of 6.2 percent women of color).

Women in the Judicial Branch

Women can also play an important role in implementing and deciding policy in the judicial branch, especially as judges on state courts. Judicial interpretation of the law is crucial to many policy areas of concern to women, including reproductive rights, discrimination, violence, and family law (Kenney, 2001). Women's presence in judicial policymaking in these areas can shape the way these issues are decided. As of 2001, among state supreme courts, the median rate of representation for women was 26 percent. In Rhode Island, it was much higher, at 40 percent (see Table 4.5).

Recognizing the importance of the court system in guaranteeing women's rights, during the 1980s many states created gender bias task forces designed to analyze whether women received equal treatment under the law within their judicial systems. The first of these was created in 1982 in New Jersey. The first gender bias task force for federal court circuits was created in 1992 within the Ninth Circuit (encompassing nine Western states; Resnik, 1996). These task forces have repeatedly found evidence of discrimination against women and made recommendations for improving judicial equality. As of 1999, 45 states had established gender bias task forces at some point in their history. Rhode Island has a gender bias task force: the Rhode Island Committee on Women in the Courts. This task force produced a report on sex equity in the Rhode Island judiciary in 1987 (NOW Legal Defense and Education Fund, National Judicial Education Program, 2001).

Institutional Resources

Women's institutional resources in state government, including commissions for women and women's caucuses, can increase the visibility of women's political concerns and interests. When adequately staffed and funded, politically stable, and structured to be accessible to women's groups, they can advance women's political voices by providing information about women's issues and attracting the attention of policymakers and the public to women's political concerns (Stetson and Mazur, 1995). They can also serve as an access point for women and women's groups to express their interests to public officials. Such institutions can ensure that women's issues remain on the political agenda.

Rhode Island has a state-level, government-appointed women's commission, the Rhode Island Commission for Women, and a bicameral women's caucus involving both the House of Representatives and the Senate (see Table 4.6). Nationwide, 40 states have state-level commissions for women and 33 have women's caucuses. Fifteen states have both a

Table 4.5
Women in the Judiciary in Rhode Island and the United States

	Rhode Island	Total, United States
Percent of State Supreme Court Seats Held by Women, 2001	40%	26%*
Has Rhode Island Ever Had a Gender Bias Task Force, as of 1999?	Yes	45

* Median for all 50 states.
Source: Kenney, 2001.
Compiled by the Institute for Women's Policy Research.

commission for women and formal caucuses in each house of the state legislature. Based on the number of institutional resources available to women in Rhode Island, the state ranks first in the nation and in the New England region.

Table 4.6
Institutional Resources for Women in Rhode Island and the United States, 2002

	Yes	No	Total, United States
Does Rhode Island have a:			
Commission for Women?[a]	✓		40
Legislative Caucus in the State Legislature?[b]	Bicameral		33
House of Representatives?	✓		
Senate?	✓		

Source: [a] National Association of Commissions for Women, 2000, updated by IWPR; [b] CAWP, 1998, updated by IWPR.
Compiled by the Institute for Women's Policy Research.

5. 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 labor force participation, 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. More married-couple families now rely on both husbands' and wives' earnings. In addition, more women head households on their own, and more women are in the labor force.

Women in Rhode Island rank in the top third of all states, at 16th in the nation, on IWPR's employment and earnings composite index (see Chart 5.1). The state is eleventh for women's earnings and is slightly above average for women in managerial and professional positions, at 22nd. Rhode Island drops slightly lower, to 30th, for the ratio of women's to men's earnings. It is 33rd for women's labor force participation.

Chart 5.1
Employment and Earnings: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Employment and Earnings Index	**16**	**5**	**C+**
Women's Median Annual Earnings (for full-time, year-round workers, aged 16 and older, 1999)[a]	11	3	
Ratio of Women's to Men's Earnings (median annual earnings of full-time, year-round women and men workers aged 16 and older, 1999)[a]	30	4	
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, 2000)[b]	33	6	
Women in Managerial and Professional Occupations (percent of all employed women, aged 16 and older, in managerial or professional specialty occupations, 1999)[c]	22	6	

See Appendix II for methodology.

* The national rankings are of a possible 51, including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England region (CT, MA, ME, NH, RI, and VT).

Source: [a] IWPR, 2001b; [b] U.S. Department of Labor, Bureau of Labor Statistics, 2002; [c] U.S. Department of Labor, Bureau of Labor Statistics, 2001a.

Calculated by the Institute for Women's Policy Research.

Regionally, Rhode Island ranks fifth of the six New England states for women's employment and earnings. While it ranks third for the level of women's earnings, it drops to fourth for the earnings ratio and last for women's labor force participation and the proportion of women in managerial and professional positions. The state's low regional rankings, despite its relatively high rankings nationwide, reflect women's generally better status in the New England area than in many other parts of the country.

Women in Rhode Island do not enjoy economic parity with men. Like women in most states, they continue to lag considerably behind men in their wages and labor force participation. As a result, Rhode Island receives a grade of C+ on the employment and earnings index.

Women's Earnings

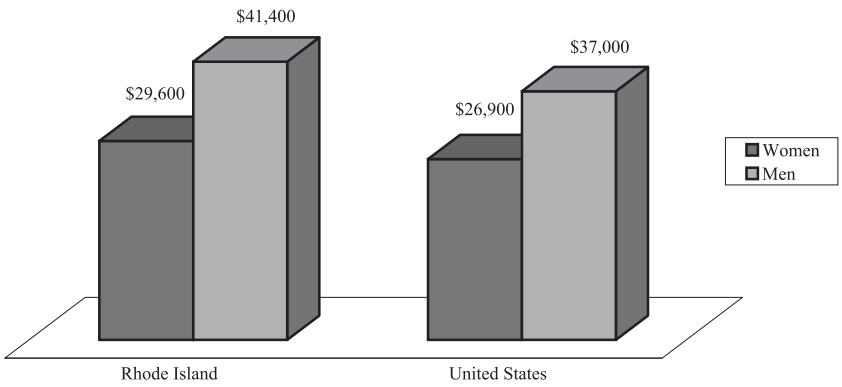
Rhode Island women working full-time, year-round have much higher median annual earnings than women in the United States as a whole ($29,600 and $26,900, respectively; see Figure 5.1; see Appendix II for details on the methodology used for 1998-2000 Current Population Survey data presented in this report). Similarly, median annual earnings for men in Rhode Island are much higher than in the United States as a whole ($41,400 and $37,000, respectively). Median annual earnings for women in Rhode Island rank eleventh in the nation and third in the New England region, a region with relatively high earnings in all six states. Women in the District of Columbia rank the highest with earnings of $35,800.

Between 1989 and 1999, women in Rhode Island saw their median annual earnings increase by 13.1 percent in real terms, the fastest rate of growth in the New England region. Within this region, the second fastest growth rate was Maine's, where women's earnings grew 12.6 percent. In two states, Connecticut and Massachusetts, women's earnings declined: women's earnings decreased by 0.8 percent and 0.9 percent, respectively, in these states (data not shown; all growth rates are calculated for earnings that have been adjusted to remove the effects of inflation; IWPR, 2001b and 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 1999 the median annual earnings of African American women were $24,800, those of Native American women were $23,300, and those of Hispanic women were $20,000, substantially below that of non-Hispanic white women, who earned $28,500. The earnings of Asian American women were the highest of all groups at $30,000 (median earnings of full-time, year-round women workers aged 15 years and over; all data converted to 2000 dollars; IWPR, 2001b).

A national survey by the Census Bureau also shows that, in 1997, the median monthly earnings of women with disabilities were only 78 percent of the earnings of women without disabilities (for female workers 21-64 years of age; McNeil, 2000).

Figure 5.1
Median Annual Earnings of Women and Men Employed Full-Time/Year-Round in Rhode Island and the United States, 1999 (2000 Dollars)



For women and men aged 16 and older. See Appendix II for methodology.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

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

The Wage and Pension Gap

The Wage Gap and Women's Relative Earnings

In the United States, women's wages have historically lagged behind men's. In 1999, the median wages of women who worked full-time, year-round were only 72.7 percent of men's (based on calculations from three years of pooled data). In other words, women were earning about 73 cents for every dollar earned by men.

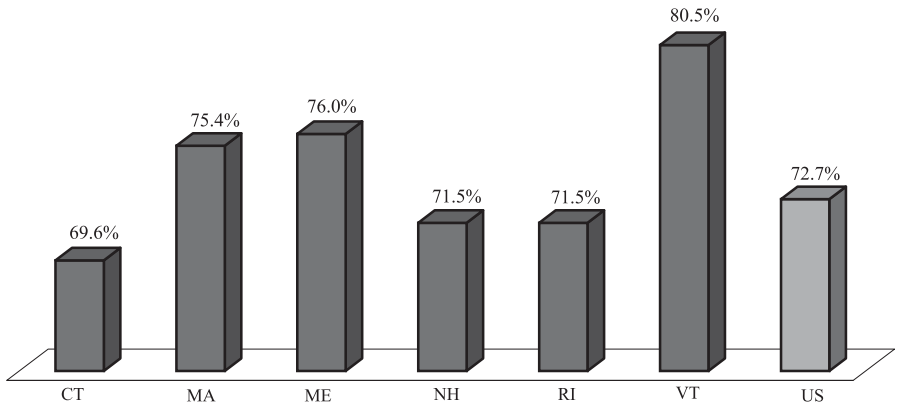
In Rhode Island, women earned about 71.5 percent of what men earned in 1999. Compared with the earnings ratio for the nation as whole, Rhode Island women experience less earnings equality with men (see Figure 5.2). Rhode Island ranks 30th in the nation for the ratio of women's to men's earnings for full-time, year-round work. The District of Columbia has the highest earnings ratio at 89.2 percent. Compared with the other states in the New England region, Rhode Island ranks fourth, tied with New Hampshire. Vermont ranks first with an 80.5 percent wage ratio, and Connecticut ranks sixth at 69.6 percent. The wage gap remains large in Rhode Island, as it does throughout the United States.

There are many factors that help explain differences in women's and men's wages. Earnings are determined partly by human capital, or the development of job-related skills through education, job training, and workforce experience. Women and men continue to differ in the amount of human capital they attain.

Women and men also tend to hold different occupations, work in different industries, and join unions at different rates. Research shows that the combined effect of differences in human capital, jobs, and unionization is likely to account for roughly three-fifths of the gender wage gap (Council of Economic Advisers, 1998), leaving a substantial portion that cannot be explained. Evidence from case studies and litigation suggests that discrimination continues to play a role in reducing women's earnings. Differences in human capital and job characteristics may also reflect discrimination, to the extent that women face greater barriers to obtaining human capital or are discouraged or prevented from entering certain occupations or industries.

This report uses the overall wage gap between women and men who work full-time year-round as an indicator of women's

Figure 5.2
Ratio of Women's to Men's Full-Time/Year-Round Median Annual Earnings in States in the New England Region, 1999



For women and men aged 16 and older. See Appendix II for methodology.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

status because it accurately reflects the difference in women's and men's access to earnings. While some of the earnings gap is due to measurable differences in human capital and job characteristics, women and men do not have equal opportunities to increase their human capital, nor do they face equal employment opportunities in all occupations and industries.

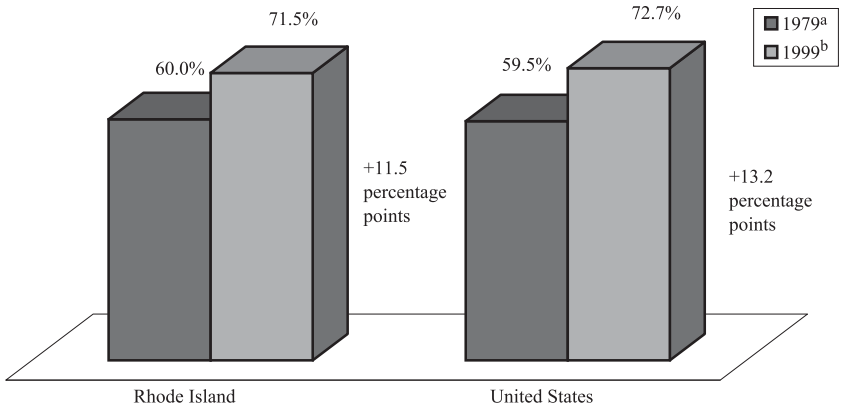
Narrowing the Wage Gap

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, though, 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 considerable narrowing that occurred (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. 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 Rhode Island, the wages of all unionized women were 32.6 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, unionized minority women earned 38.6 percent more than nonunionized ones. Similar data are not available for Rhode Island (Hartmann, Allen, and Owens, 1999).

Although women's real wage growth has been strong over most of the past few decades, part of the narrowing in the wage gap that occurred in the past two decades was due to a fall in men's real earnings. Between 1979 and 1999, about two-thirds (63 percent) of the narrowing of the national female/male earnings gap was due to women's rising real earnings, while about one third (37 percent) was due to men's falling real earnings. During the latter half of this period, the growth in women's real earnings slowed, and even more of the narrowing of the gap was due to falling real wages for men. From 1989 to 1999, almost half (47.5 percent) was due to the fall in men's real earnings (IWPR, 1995a and 2001b). As men's real earnings have increased during the last few years, the wage gap between men and women

Figure 5.3
Change in the Wage Ratio Between 1979 and 1999 in Rhode Island and the United States



For women and men aged 16 and older. See Appendix II for methodology.
Source: [a] IWPR, 1995a; [b] IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

increased again, since women's wage growth did not keep pace with men's. At the national level, the highest wage ratio for annual earnings for full-time, year-round workers, 74.2 percent, was observed in 1997, but by 2000 the ratio had fallen to 73.3 percent, a gap of 26.7 percent (U.S. Department of Commerce, Bureau of the Census, 2002b).

Rhode Island fell behind the United States in increasing women's annual earnings relative to men's between 1979 and 1999 (see Figure 5.3). In Rhode Island, the annual earnings ratio increased by only 11.5 percentage points, compared with an increase of 13.2 percentage points in the United States.

Earnings and Earnings Ratios by Educational Levels

Between 1979 and 1999, women with higher levels of education in Rhode Island and the United States saw their median annual earnings increase more than women with lower levels of educational attainment. As Table 5.1 shows, Rhode Island experienced increases that ranged from 13.2 percent (in constant dollars) for women with a high school education to 45.3 percent for those with more than a four-year college education, while women who had not completed high school experienced an earnings decrease of 8.1 percent.

In contrast, women's relative earnings (as measured by the female/male earnings ratio) increased for women at all levels of education. Those with some college experienced the most narrowing in the wage ratio at 26.1 percent. Women with less than a high school education experienced a 10.3 percent increase in their relative earnings, despite the fact that their real earnings declined, indicating that men with this level of education fared even worse than women in the labor market. Women at other levels of education experienced from a 6.4 percent (for women with a four-year college education) to a 16.0 percent narrowing of the wage gap (for women with high school only).

The low and falling earnings of women with the least 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, but in many cases they are 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 and acquire some education beyond high school (Negrey, et al., 2002). As Table 5.1 shows, women with some college, a college degree, or postgraduate training have much higher earnings than those without, and their real earnings have generally been growing.

Table 5.1
Women's Earnings and the Earnings Ratio in Rhode Island by Educational Attainment, 1979 and 1999 (2000 Dollars)

Educational Attainment	Women's Median Annual Earnings, 1999[a]	Percent Change in Real Earnings, 1979[b] and 1999[a]	Female/Male Earnings Ratio, 1999[a]	Percent Change in Earnings Ratio, 1979[b] and 1999[a]
Less than 12th Grade	$16,900	-8.1	68.4%	+10.3
High School Only	$24,200	+13.2	71.6%	+16.0
Some College	$31,700	+33.5	83.4%	+26.1
College	$32,600	+22.8	62.8%	+6.4
College Plus	$51,700	+45.3	79.4%	+12.6

Source: [a] IWPR, 2001b; [b] IWPR, 1995a.
Calculated by the Institute for Women's Policy Research.

Pension Receipt and Benefit Levels

On average, women earn less and live longer than men. Older women typically enter retirement with fewer economic resources than men. For today's women, the likelihood of having long-term financial support from a man is less than in previous generations. It is particularly unlikely that a woman can depend principally on a husband's financial support in her old age. For older African American and Hispanic women, the economic challenges can be particularly severe. Overall, there is a substantial gender and race gap in all sources of retirement income, including Social Security, pensions, savings, and post-retirement employment (Shaw and Hill, 2001).

In 1999, 18.4 percent of women and 27.8 percent of men aged 50 and older received income from pensions and other retirement sources (excluding Social Security income, but including income from company or union pension plans, government pensions, regular payments from IRA or Keogh accounts, and regular payments from annuities or paid insurance policies) in the United States (see Table 5.2; for data on Social Security receipt see Figure 6.11). Similarly, 17.5 percent of women, compared with 30.3 percent of men, aged 50 and older in Rhode Island received pensions and other retirement income.

In both Rhode Island and the United States, there was also a large gap in the level of benefits received in 1999. Nationally, women aged 50 and older received median annual benefits of $6,200, while men aged 50 and older received benefits twice as large, $12,400. The gap in Rhode Island is even bigger. Median annual benefits for women in Rhode Island were substantially lower than those for women in the United States as a whole ($3,800 and $6,200, respectively). In contrast, median annual benefits for men in Rhode Island were only slightly lower than for the United States as a whole ($12,000 and $12,400, respectively).

Minority men and women are much less likely to receive pensions than white men and women. Unfortunately, the data set used to examine pensions and other retirement income at the state level does not provide enough cases to reliably estimate pensions and other retirement income by state separately for women and men of different races and ethnicities. In the United States, 20.1 percent of white women aged 50 and older received pensions and other retirement income, compared with 11.9 percent of minority women. Similarly, 30.2 percent of white men aged 50 and older received benefits, compared with 17.4 percent of minority men (IWPR, 2001a). This gap is larger than the wage gap between white and minority women.

Table 5.2
Pension-Related Income Among Women and Men Aged 50 and Older in Rhode Island and the United States, 1999

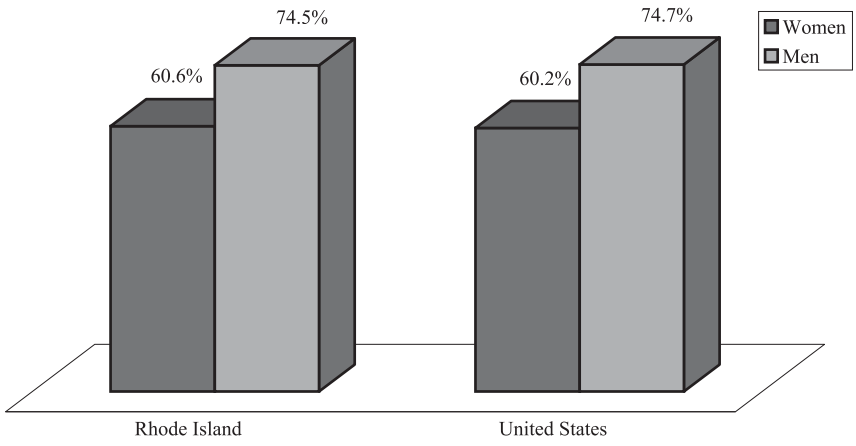
	Rhode Island		United States	
	Women	Men	Women	Men
Percent Receiving Pensions and Other Retirement Income*	17.5%	30.3%	18.4%	27.8%
Median Annual Benefits**	$3,800	$12,000	$6,200	$12,400

* Includes veterans' pensions, survivor pensions, and any other pension and retirement income (excluding Social Security income), including income from company or union pension plans, government pensions, regular payments from IRA or Keogh accounts, and regular payments from annuities or paid insurance policies.
** For those receiving benefits.
Source: IWPR, 2001a.
Calculated by the Institute for Women's Policy Research.

Labor Force Participation

One of the most notable changes in the U.S. economy over the past decades has been the rapid rise in women's participation in the labor force. Between 1965 and 2000, women's labor force participation increased from 39 to 60 percent (these data reflect the proportion of the civilian noninstitutional population aged 16 and older who are employed or looking for work; U.S. Department of Labor, Bureau of Labor Statistics [BLS], 2002). Women now make up nearly

Figure 5.4
Percent of Women and Men in the Labor Force in Rhode Island and the United States, 2000



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 2002.
Compiled by the Institute for Women's Policy Research.

half of the U.S. labor force at 46.5 percent of all workers (full-time and part-time combined). According to projections by the BLS, women's share of the labor force will continue to increase, growing to 48 percent by 2010 (Fullerton and Toossi, 2001).

In 2000, 60.6 percent of women in Rhode Island were in the labor force, compared with 60.2 percent of women in the United States, earning Rhode Island the rank of 33rd in the nation (because the national figure is for the United States as a whole and not the average among all of the states, Rhode Island ranks below the median despite its slightly higher participation rates). Men's labor force participation rate in Rhode Island was about the same as the rate for men in the United States (see Figure 5.4).

Unemployment and Personal Income Per Capita

In Rhode Island, a slightly larger proportion of men and women workers are unemployed than in the nation as a whole. In 2000, the unemployment rate in Rhode Island was 4.2 percent for women and 4.0 percent for men, compared with the nation's 4.1 percent for women and 3.9 percent for men (see Figure 5.5).

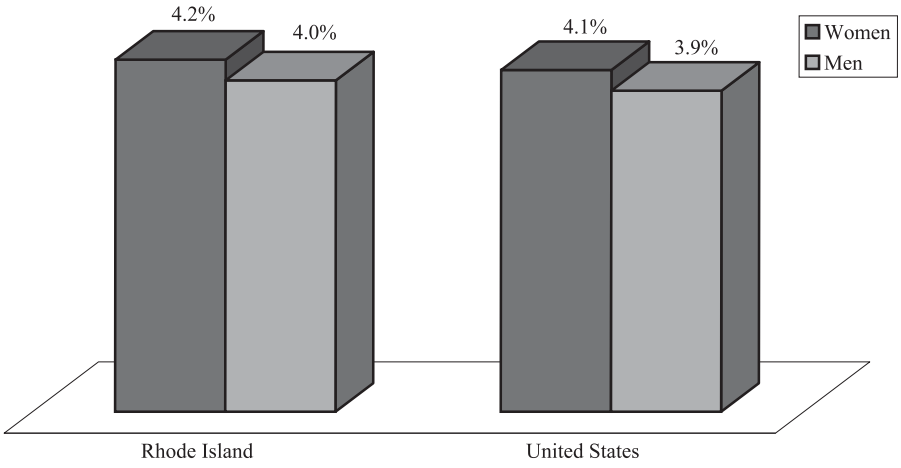
While Rhode Island experienced about average unemployment rates in 2000, the state experienced much lower than average rates during the 1980s, but higher than average rates during the early 1990s. As a result, personal income per capita in Rhode Island grew more quickly than it did for the nation between 1980 and 1990 (28.1 percent versus 19.9 percent; see Table 5.3). From 1990 to 2000, as the unemployment rate increased above the national average and then fell closer to it, income per capita in Rhode Island grew 3.2 percentage points more slowly than in the nation.

Table 5.3
Personal Income Per Capita for Both Women and Men in Rhode Island and the United States, 2000

	Rhode Island	United States
Personal Income Per Capita, 2000	**$29,700**	**$29,700**
Personal Income Per Capita, Percent Change*:		
Between 1990 and 2000	14.1%	17.3%
Between 1980 and 1990	28.1%	19.9%
Between 1980 and 2000	46.1%	40.6%

* In constant dollars.
Source: U.S. Bureau of Economic Analysis, 2001.
Calculated by the Institute for Women's Policy Research.

Figure 5.5
Unemployment Rates for Women and Men in Rhode Island and the United States, 2000



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 2002.
Compiled by the Institute for Women's Policy Research.

Part-Time and Full-Time Work

The percent of the female workforce in Rhode Island employed full-time is smaller than the national average (67.9 percent versus 71.5 percent; see Table 5.4), but the percent working part-time is larger than the national average (28.3 percent versus 24.2 percent). In the part-time category, 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 larger in Rhode

Table 5.4
Full-Time, Part-Time, and Unemployment Rates for Women and Men in Rhode Island and the United States, 1999

	Rhode Island		United States	
	Female Labor Force	Male Labor Force	Female Labor Force	Male Labor Force
Total Number in the Labor Force	**240,000**	**263,000**	**64,855,000**	**74,512,000**
Percent Employed Full-Time	67.9	85.2	71.5	85.8
Percent Employed Part-Time*	28.3	10.6	24.2	10.1
Percent Voluntary Part-Time	23.8	8.4	20.6	8.3
Percent Involuntary Part-Time	2.5	1.1	2.0	1.3
Percent Unemployed	4.0	4.3	4.3	4.1

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, 2001a, Tables 1, 12, and 13.
Compiled by the Institute for Women's Policy Research.

Island than in the United States (2.5 percent and 2.0 percent, respectively). A larger proportion of Rhode Island's female labor force is also working part-time voluntarily compared with that of the United States (23.6 percent and 20.6 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 and Ethnicity

According to IWPR analysis of data from the Current Population Survey from 1998-2000, 61.0 percent of women of all races aged 16 and older in Rhode Island were in the labor force in 1999, a rate slightly higher than in the United States as a whole, 60.5 percent (see Table 5.5). White women's labor force participation rate was also slightly higher in Rhode Island than in the United States as a whole (61.0 percent compared with 60.6 percent). African American women historically have had a higher labor force participation rate than white and Hispanic women and continued to do so in 1999. In Rhode Island, African American women had an average labor force participation rate that was 4.1 percentage points higher than that for white women. Hispanic women traditionally have the lowest average participation rates among women. In the United States, 56.7 percent of Hispanic women were in the workforce in 1999; in Rhode Island, 59.0 percent were, 2.0 percentage points lower than that for white women in the state, but 2.3 percentage points higher than the rate for Hispanic women nationwide. Nationally, labor force participation rates were 59.4 percent for Asian American women and 59.0 percent for Native American women in 1999. Comparable data were not available for Asian American or Native American women in Rhode Island due to small sample sizes.

Table 5.5
Labor Force Participation of Women in Rhode Island and the United States by Race and Ethnicity, 1999

Race and Ethnicity	Rhode Island		United States	
	Number of Women in Labor Force	Percent in Labor Force	Number of Women in Labor Force	Percent in Labor Force
All Races	**243,000**	**61.0**	**65,769,000**	**60.5**
White*	215,000	61.0	47,805,000	60.6
African American*	10,000	65.1	8,602,000	63.9
Hispanic**	11,000	59.0	6,364,000	56.7
Asian American*	N/A	N/A	2,515,000	59.4
Native American*	N/A	N/A	494,000	59.0

For women aged 16 and older.
The numbers and percentages in this table are based on three years of pooled data for the years 1998-2000; they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics, for 1999. See Appendix II for details on the methodology.
N/A = Not available.
* Non-Hispanic.
** Hispanics may be of any race.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

Table 5.6
Labor Force Participation of Women in Rhode Island and the United States by Age, 1999

Age Groups	Rhode Island		United States	
	Number of Women in Labor Force	Percent in Labor Force	Number of Women in Labor Force	Percent in Labor Force
All Ages	**243,000**	**61.0**	**65,769,000**	**60.5**
Ages 16-19	13,000	57.7	3,809,000	48.5
Ages 20-24	29,000	86.0	6,774,000	73.2
Ages 25-34	52,000	84.7	14,750,000	76.7
Ages 35-44	63,000	78.0	17,625,000	78.0
Ages 45-54	56,000	79.8	14,493,000	77.3
Ages 55-64	23,000	59.0	6,477,000	52.9
Ages 65 and Older	7,000	7.9	1,842,000	9.8

For women aged 16 and older.
The numbers and percentages in this table are based on three years of pooled data for the years 1998-2000; they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics, for 1999. See Appendix II for details on the methodology.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

Labor Force Participation of Women by Age

Workforce participation varies across the life cycle. Women's highest levels of participation generally occur between ages 25 and 54, which are also considered the prime earning years. Table 5.6 shows the relationship between labor force participation and age for women in Rhode Island and in the United States. Women in Rhode Island generally have higher labor force participation than their U.S. counterparts. Nationally, the highest labor force participation of women occurs between ages 35 and 44, with 78.0 percent of these women working. In Rhode Island, the highest rate of labor force participation occurs between ages 20 and 24, with 86.0 percent in the workforce (compared with 73.2 percent in the United States as a whole). Young women in their teens (ages 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 Rhode Island, 57.7 percent of teenage women reported being in the labor force, considerably higher than the 48.5 percent for female teens in United States as a whole.

As women near retirement age, they are much less likely to work than younger women. In the United States, women aged 55-64 have a labor participation rate of only 52.9 percent. In Rhode Island, 59.0 percent of these women are in the workforce. In contrast, 7.9 percent of women aged 65 and older in Rhode Island are in the workforce, compared with 9.8 percent of women in that age group in the United States.

Labor Force Participation of Women with Children

Mothers represent the fastest growing group in the U.S. labor market (Brown, 1994). In 1999, 55 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, 2001a). In general, the workforce participation rate for women with children in the United States tends to be higher than the rate for all women (67.5 percent versus 60.5 percent in 1999). 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

Table 5.7
Labor Force Participation of Women with Children in Rhode Island and the United States, 1999

	Rhode Island Percent in the Labor Force	United States Percent in the Labor Force
Women with Children		
Under Age 18*	73.0	67.5
Under Age 6	70.8	63.4

For women aged 16 and older.
* Children under age 6 are also included in children under 18.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

they have much lower labor force participation rates. Mothers, in contrast, tend to be in age groups with higher labor force participation rates. This is also true in Rhode Island, with 73.0 percent of women with children under age 18 in the workforce, compared with 61.0 percent of all women in Rhode Island in 1999. Women with children are much more likely to engage in labor market activity in Rhode Island than in the United States (73.0 percent versus 67.5 percent, respectively; see Table 5.7). Women with children under six are also more likely to be in the labor force in Rhode Island than in the United States, at 70.8 percent versus 63.4 percent, respectively.

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 in a family child care setting; 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 considerable 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 they are often inadequate; many poor women and families do not receive them. The Child Care and Development Fund (CCDF) is the primary federal funding source of child care subsidies for low-income families, although states also receive child care funding from the Social Services Block Grant (SSBG) and TANF. Each state qualifies to receive an amount of CCDF funds each year and can receive additional CCDF funds by spending state dollars for child care subsidies and quality initiatives.

Recent data show that, nationally, only 12 percent of those children potentially eligible for child care subsidies under federal rules actually received subsidies under the federal government's Child Care and Development Fund (CCDF) in 1999. In Rhode Island, a higher proportion, 15 percent, of these children did (see Table 5.8; the proportion of eligible children receiving CCDF subsidies does not include

Table 5.8
Percent of Eligible Children Receiving CCDF* Subsidies in Rhode Island and the United States, 1999

	Rhode Island	United States
Eligibility**		
Number of Children Eligible under Federal Provisions	42,500	14,749,500
Receipt		
Number and Percent of Children Eligible under Federal Law Receiving Subsidies in the State	6,390 15%	1,760,260 12%

* 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 often smaller under state provisions.
Source: U.S. Department of Health and Human Services, Administration for Children and Families, 2000a.
Compiled by the Institute for Women's Policy Research.

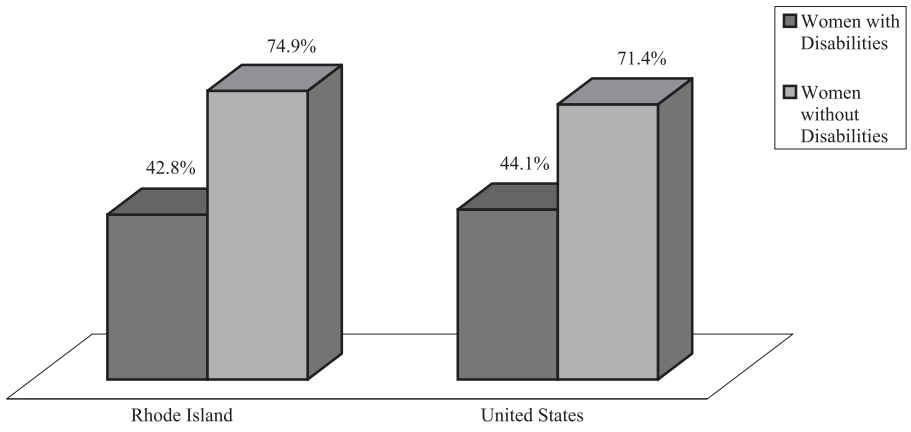
the child care monies that come from SSBG or TANF). Still, many Rhode Island families in need of economic support for child care are clearly not receiving it. The shortage of federal funding for CCDF, coupled with the lack of awareness many families have of their eligibility for child care subsidies, at least partly explains why so few children receive CCDF subsidies across the country (U.S. Department of Health and Human Services, 2000).

In addition to caring for children, many women are responsible for providing care for friends and relatives who experience long-term illness or disability. Although few data on caregiving exist, 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. More than 70 percent of those giving care are female. Caregivers on average provide slightly less than 18 hours per week of care. Many report giving up time with other family members; foregoing vacations, hobbies, or other activities; and making adjustments to work hours or schedules for caregiving (National Alliance for Caregiving and AARP, 1997). Like mothers of young children, other types of caregivers experience shortages of time, money, and other resources. 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.

Labor Force Participation of Women with Disabilities

While the past few decades have seen a dramatic increase in women's labor force participation, especially among working mothers, the increase in labor force participation of women with disabilities has not been as large. The Americans with Disabilities Act (ADA) of 1990 guarantees individuals with disabilities equal opportunity in public accommodations, employment, transportation, state and local government services, and telecommunications. The ADA also provides civil rights protection to individuals with disabilities similar to the protections provided to individuals on the basis of race, sex, national origin, age, and religion. Despite the ADA, women with disabilities continue to encounter numerous forms of discrimination, such as architectural, transportation, and communication barriers; assumptions regarding incapacity and ability; exclusionary qualification standards and criteria; segregation; and relegation to lesser services, benefits, jobs, or other opportunities; and gender discrimination (Kaye, 1998; Robertson, 2001). In addition, disability benefit policies provide some financial disincentives for disabled persons to work. With earnings, they face not only the possible loss of cash benefits but also the potential loss of medical coverage from public insurance programs (Bryen and Moulton, 1998).

Figure 5.6
Labor Force Participation Rates of Women with and without Disabilities in Rhode Island and the United States, 2000



For women in the civilian non-institutional population, aged 21 to 64.
Source: U.S. Department of Commerce, Bureau of the Census, 2001c.
Compiled by the Institute for Women's Policy Research.

The labor force participation of women with disabilities continues to lag too far behind the labor force participation of women without disabilities. In 2000, 71.4 percent of women aged 21 through 64 without a disability in the United States were employed, compared with only 44.1 percent of women in the same age group with a disability (see Figure 5.6). Similarly, in Rhode Island, 74.9 percent of women without a disability were employed, compared with 42.8 percent of women aged 21 through 64 with a disability. Clearly, Rhode Island, like the nation as a whole, could devote more attention to the disadvantaged employment status of women with disabilities.

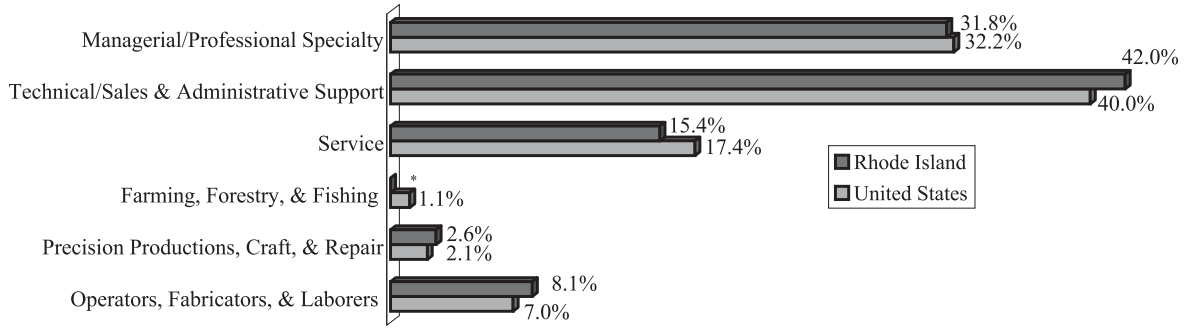
Occupation and Industry

The distribution of women in Rhode Island across occupations is similar to the distribution in the United States. Nationally, technical, sales, and administrative support occupations provide 40.0 percent of all jobs held by women (see Figure 5.7a). At 42.0 percent, women in Rhode Island are slightly more likely to be in these occupations. In contrast, women in Rhode Island are less likely to work in service occupations (15.4 percent versus 17.4 percent). They are more likely to work as operators, fabricators, and laborers (8.1 percent versus 7.0 percent, respectively) and in precision production, craft, and repair (2.6 versus 2.1 percent, respectively).

Women in Rhode Island are slightly less likely to work in managerial and professional specialty occupations than are women in the United States (31.8 percent versus 32.2 percent). Rhode Island ranks 22nd in the nation and last in the New England region for the proportion of its female labor force employed in professional and managerial occupations (because national numbers are for the United States as a whole and not the average among all of the states, Rhode Island can rank above the median despite its slightly lower proportion of women managers and professionals).

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

Figure 5.7a
Distribution of Women Across Occupations in Rhode Island and the United States, 1999

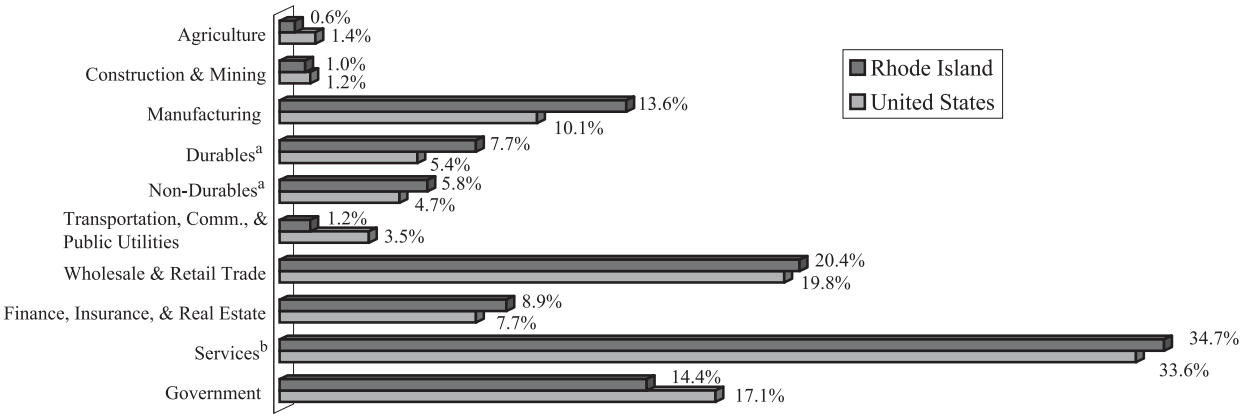


For employed women aged 16 and older.
*Less than 500 persons or less than 0.05% of total employed in Rhode Island are working in this occupational category.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001a, Table 15.
Compiled by the Institute for Women's Policy Research.

in the top fifth. Similarly, a Catalyst (2000) study showed that only 4.1 percent (just 93) of the highest earning high-level executives in Fortune 500 companies were women as of 2000.

The distribution of women in Rhode Island across industries differs somewhat from that of the United States as a whole (see Figure 5.7b). Rhode Island women are much more likely to work in the manufacturing (durables or nondurables) industries (13.6 versus 10.1 percent). This is consistent with their higher representation in blue-collar occupations in Figure 5.7a. Rhode Island women are also more likely to work in the finance, insurance, and real

Figure 5.7b
Distribution of Women Across Industries in Rhode Island and the United States, 1999



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, 2001a, Table 17.
Compiled by the Institute for Women's Policy Research.

estate (F.I.R.E.) industries than are women in the United States as a whole (8.9 percent versus 7.7 percent nationally). Another 34.7 percent of Rhode Island women are employed in the service industries (including business, professional, and personnel services), while 33.6 percent are so employed in the United States. About 19.8 percent of employed women in the United States work in the wholesale and retail trade industries, and a similar proportion—20.4 percent—of women in Rhode Island work in these industries. About 17.1 percent of the nation's women work in government, while many fewer, 14.4 percent, of women in Rhode Island do.

6. Social and Economic Autonomy

While labor force participation and earnings are critical to women's 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 social and economic autonomy: health insurance coverage, educational attainment, business ownership, and poverty.

Each of these issues affects women's lives in distinct yet 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 social and economic autonomy in many ways: through labor force participation, hours of work and earnings, occupational prestige, civic participation, childbearing decisions, and career advancement. Women who own businesses control many aspects of their working lives and participate in their communities in many ways. Finally, women in poverty have limited choices. If they receive public income support, they must comply with legislative and administrative 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 education and training necessary to improve their economic situations.

With its composite index of 14th among the states, Rhode Island ranks in the top half of all states on most measures of social and economic autonomy. The state leads the entire nation for women's health insurance coverage. It is just above the midpoint of all states for women's educational attainment and women above poverty (see Chart 6.1). It is just below the midpoint of all states for women's business ownership, at 31st.

Chart 6.1
Social and Economic Autonomy: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Social and Economic Autonomy Index	**14**	**5**	**C+**
Percent with Health Insurance (among nonelderly women, 2000)[a]	1	1	
Educational Attainment (percent of women aged 25 and older with four or more years of college, 1990)[b]	20	5	
Women's Business Ownership (percent of all firms owned by women, 1997)[c]	31	4	
Percent of Women Above Poverty (percent of women living above the poverty threshold, 1999)[d]	23	5	

See Appendix II for methodology.
* The national rankings are of a possible 51, including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England region (CT, MA, ME, NH, RI, and VT).
Source: [a] Employee Benefit Research Institute, 2001; [b] Population Reference Bureau, 1993; [c] U.S. Department of Commerce, Bureau of the Census, 2001f; [d] IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

Rhode Island ranks fifth among the six states of the New England region for women's social and economic autonomy. The state ranks first for women's health insurance, but it falls to fourth for women's business ownership and fifth for women's educational attainment and for women living above poverty. Thus, on most indicators in this index, Rhode Island is near the bottom in its region.

Throughout the country, women have less access than men to most of the resources measured by the social and economic autonomy composite index. Nationally, men are more likely to have a college education, own a business, and live above the poverty line than women are. Women generally have health insurance at higher rates than men, largely because of public insurance programs for the poor such as Medicaid, but rates of both men and women without health insurance are high in the United States. Except for its high rates of health insurance coverage, trends in Rhode Island do not diverge from these basic patterns. As a result, the state receives a grade of C+ on the social and economic autonomy composite index.

Access to Health Insurance

Women in Rhode Island are much more likely than women in the nation as a whole to have health insurance. In Rhode Island, 6.0 percent of women, compared with 16.6 percent of women in the United States, are not insured (see Table 6.1). Rhode Island ranks first in the nation and in the New England region for the proportion of women insured.

On average, women and men in Rhode Island have much higher levels of access to employer-based health insurance than women and men in the United States as a whole (76.9 percent and 68.7 percent, respectively for women; 76.8 percent and 69.6 percent, respectively, for men). In the United States, men are generally more likely than women to receive health insurance from their own employment, and women are more likely than men to receive employment-based health insurance through their spouses' insurance. Rhode Island is no exception to this general pattern. Still, Rhode Island's women do have considerably more access to health insurance from their own employers than women do nationally (49.1 percent versus just 41.9 percent for the nation as a whole). Slightly more women in Rhode Island also receive health insurance as dependents than do women in the United States as a whole (27.8 percent and 26.8 percent respectively).

In the United States, because women of all ages are more likely than men to have very low incomes, they tend to have a higher rate of health insurance coverage from public sources, such as Medicaid.

Table 6.1
Percent of Women and Men without Health Insurance and with Different Sources of Health Insurance in Rhode Island and the United States, 2000

	Rhode Island		United States	
	Women	Men	Women	Men
Number	**302,000**	**282,000**	**86,993,000**	**83,215,000**
Percent Uninsured	6.0	10.9	16.6	18.8
Percent with Employer-Based Health Insurance	76.9	76.8	68.7	69.6
Own Name	49.1	58.1	41.9	56.4
Dependent	27.8	18.7	26.8	13.2
Percent with Public Insurance	13.7	10.0	11.9	8.5
Percent with Individually-Purchased Insurance	7.6	6.8	6.5	6.1

Women and men aged 18 to 64; total percentages exceed 100 because some people have more than one source of health insurance.
Source: Employee Benefit Research Institute, 2001.
Compiled by the Institute for Women's Policy Research.

This is also the case in Rhode Island. In Rhode Island, the rate of publicly insured women is somewhat higher than the U.S. rate, at 13.7 percent in Rhode Island and 11.9 percent in the United States. This is much higher than the rate of public health insurance among men in the state and nationally (10.0 percent in Rhode Island and 8.5 percent in the United States).

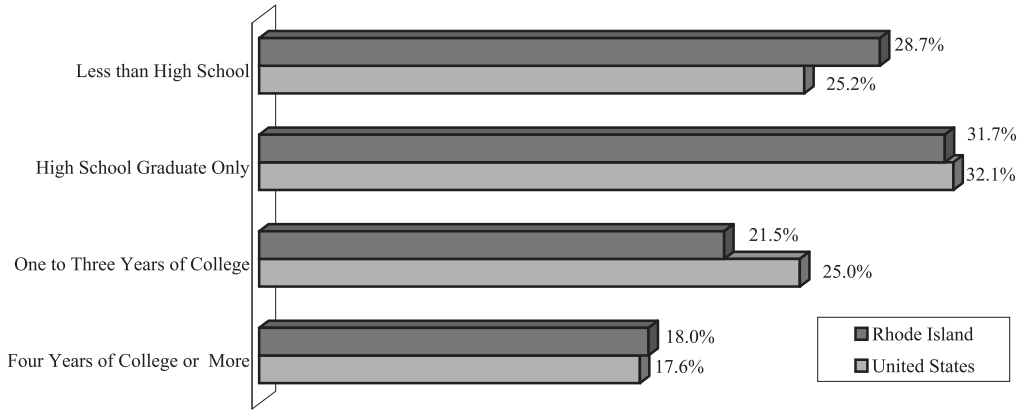
Education

In the United States, women have made steady progress in increasing their levels of education. Between 1980 and 2000, the percent of women aged 25 and older in the United States with a high school education or more increased by about one-fifth. As of 2000, comparable percentages of women and men had completed a high school education (83.4 percent of women and 82.8 percent of men).

During the same period, the percent of women aged 25 and older with four or more years of college increased by about three-fifths, from 13.6 percent in 1980 to 21.8 percent in 2000 (compared with 24.8 percent of men in 2000), bringing women closer to closing the education gap (U.S. Department of Commerce, Bureau of the Census, 2000a). Since 1982, a higher proportion of college graduates have been women than men, but among all those aged 25 and older, male college graduates still outnumber female college graduates.

Women in Rhode Island have slightly more college experience than women in the nation. In 1990, the percent of women with four or more years of college, at 18.0 percent, was about 0.4 percentage points higher than the national average (see Figure 6.1). At the same time, women in Rhode Island were much less likely to have some college than women in the United States, at 21.5 percent and 25.0 percent, respectively. At 31.7 percent, the proportion of women with a high school education was just 0.4 percentage points lower than the national average. Despite the relatively high numbers of college-educated women, the proportion of women older than 25 in Rhode Island without high school diplomas was much larger than that of women in the United States (28.7 percent and 25.2 percent, respectively). Rhode Island ranks fifth in the region and 20th in the nation for women with four or more years of college (for more information, see Barriers to Educational Attainment for Hispanic Women and Girls).

Figure 6.1
Educational Attainment of Women Aged 25 and Older in Rhode Island and the United States, 1990



Source: Population Reference Bureau, 1993.
Compiled by the Institute for Women's Policy Research.

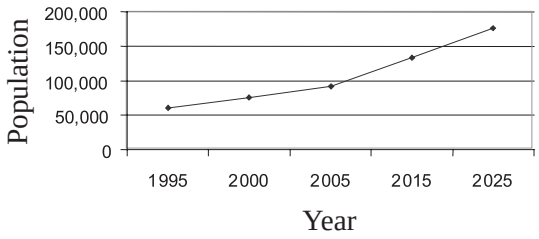
Barriers to Educational Attainment for Hispanic Women and Girls

The Hispanic Population in Rhode Island

- The Rhode Island Hispanic population grew 200 percent, from 45,752 to 90,820, between 1990 and 2000 (U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1990). The Hispanic population is expected to continue to increase to 176,000 by 2025 (see Figure 6.2).

- In 2000, Rhode Island had 35,002 Hispanic children and youth. This represents about 14 percent of the total child and youth population in the state (U.S. Department of Commerce, Bureau of the Census, 2000).

Figure 6.2
Hispanic Population Trends and Projections, Rhode Island, 1995-2025



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

- Eighty-five percent of Hispanic children and youth live in five core cities: Providence, Pawtucket, Central Falls, Newport, and Woonsocket (U.S. Department of Commerce, Bureau of the Census, 2000). These five communities also have the highest child poverty rates in the state (Rhode Island Kids Count, 2001a).

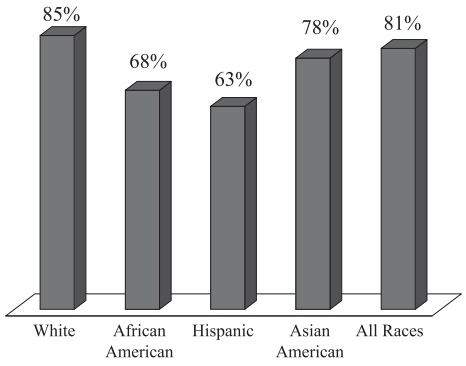
Educational Attainment by Race and Ethnicity in Rhode Island

- The high school graduation rate for Hispanics is the lowest of any racial or ethnic group in Rhode Island, at just 63 percent in 1999-2000 (see Figure 6.3).

- Hispanics in Rhode Island had the lowest achievement ratings of any group in math, reading, and writing from 1998 to 2000 (Rhode Island Department of Elementary and Secondary Education and the National Center on Public Education and Social Policy, 2001).

- In 2000, nearly one out of three Hispanic girls dropped out of Rhode Island high schools (Rhode Island Department of Elementary and Secondary Education, 2001).

Figure 6.3
High School Graduation Rates by Race and Ethnicity, Rhode Island, 1999-2000



Source: Rhode Island Department of Elementary and Secondary Education, 2001.

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- Nationally, the proportion of Hispanic girls who drop out of school is on the rise, while the proportion of Hispanic boys who drop out is falling. Between 1992 and 1995, the dropout rate for Hispanic girls rose 3.4 percent while the dropout rate for Hispanic boys fell 2.1 percent (U.S. Department of Education, 1999).

What Factors Lead to Hispanic Girls Dropping Out of School?

- **Family/School Conflicts.** Sociological analysis suggests that Hispanic family members are expected to place family obligations above all else (Espinosa, 1995). In many Hispanic families, girls are asked to take on family responsibilities that supercede all other obligations, including school (Ginorio and Huston, 2000). As a result, higher education may be a lower priority for Hispanic girls than for other young women.

- **Limited English Skills.** There are currently 10,193 school-aged Rhode Island children who are English language learners. Adults who report that they have some difficulty with English are twelve times more likely to have completed less than five years of schooling and half as likely to have graduated from high school than adults who report no difficulty with English (Rhode Island Kids Count, 2001a). Understanding of both basic English and academic language used in coursework is essential to successful high school completion.

- **Poverty.** Hispanics make up 30 percent of Rhode Island's poor children. Nearly one in two of Rhode Island's Hispanic children are poor (Connor, 2002). Poverty is an important indicator of many social and educational outcomes, including dropping out of school (U.S. Department of Education, 1999).

- **Teen Pregnancy.** In addition to poverty, pregnancy is likely to result in a Hispanic girl's decision to leave school. Two-thirds of girls who give birth before age 18 will not complete high school. Further, the younger an adolescent girl is when she becomes pregnant, the more likely that she will not complete high school (American Association of University Women Educational Foundation, 1998). Notably, the birth rate for Hispanic girls aged 15 to 17 in Rhode Island is more than four times the overall rate for all racial and ethnic groups in the state (Rhode Island Department of Health, Office of Health Statistics, 2000).

Barriers to Higher Education for Hispanic Girls

- Even if they do not drop out of high school, Hispanic girls might not be as well prepared to pursue a higher education as other students. While Hispanic girls were more likely than Hispanic boys to take the Scholastic Aptitude Test (SAT) in 2000-01 (59 percent of all Hispanics who took the test were girls), their scores tended to be lower than boys' scores on the SAT 1 Verbal and Math sections (The College Board, 2001).

- Educational attainment is a factor in the earnings gap between whites and Hispanics, since so many fewer Hispanics than whites graduate from high school and college. But a wage gap persists even among Hispanics and whites with similar education levels. The gap between whites and Hispanics with a high school diploma was $3,823 in 1998 for full-time, year-round workers, while the gap between whites and Hispanics with a bachelor's degree was $10,328. Hispanic college graduates earned $35,014 per year, however, compared with Hispanic high school graduates' earnings of only $20,978 (U.S. Department of Commerce, Bureau of the Census, 1999). Going to college certainly increases earnings for Hispanics as well as other groups, but this large disparity in earnings between

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Hispanics and non-Hispanic whites may be a serious disincentive for Hispanic girls and boys to pursue higher education.

Policy Recommendations To Improve the Educational Status of Hispanic Women and Girls

- Parents and schools should work together to involve families in their daughters' education.
- Schools should practice aggressive recruitment of Hispanic girls to remove them from remedial and language-based tracks.
- Hispanic girls should complete an educational goal-setting process with support from guidance counselors, teachers, and family members. Future guidance counseling should focus on these goals.
- Schools should make Algebra I and geometry mandatory for all students.
- Science departments need to increase the number of girls taking physics, biology, and chemistry, especially at the advanced placement or honors level.
- Administrators should institute school programs that deal with teen pregnancy.
- Guidance counselors should familiarize Hispanic girls with college environments, terminology, prerequisites, and financial aid options.
- Schools should invite women from the community into classrooms and mentoring programs.
- Communities should use school-to-work programs to advance non-traditional careers for girls.
- Communities should create successful adult education programs for ESL and/or bilingual students of all ages.
- More Hispanics and other minorities should be encouraged to enter teaching as a career.
- Teacher education programs need to improve training in issues of science, technology, and equity.

Many of these policies and practices would benefit all girls, not just Hispanics.

Hispanic women and girls in Rhode Island face difficult struggles and obstacles. Rhode Island needs to create and support programs and policies that address the educational needs of our growing Hispanic population.

Table 6.2
Women-Owned Firms in Rhode Island and the United States, 1997

	Rhode Island	United States
Number of Women-Owned Firms	**19,886**	**5,417,034**
Percent of All Firms that Are Women-Owned	24.6%	26.0%
Total Sales and Receipts (in billions, 2000 dollars)	**$2.9**	**$878.3**
Number Employed by Women-Owned Firms	**26,678**	**7,076,081**

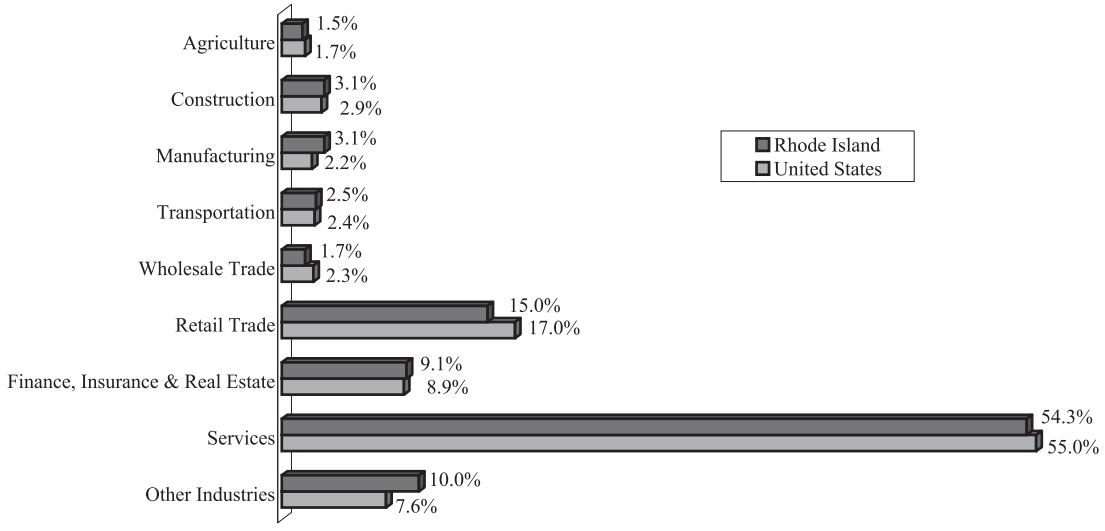
Source: U.S. Department of Commerce, Bureau of the Census, 2001f.
Compiled by the Institute for Women's Policy Research.

Women Business Owners and Self-Employment

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

According to the U.S. Bureau of the Census, women owned more than 5.4 million firms nationwide in 1997, employing just under 7.1 million persons and generating $878.3 billion in business revenues (U.S. Department of Commerce, Bureau of the Census, 2001f). By 1997, women owned 19,886 or 24.6 percent of firms in Rhode Island (slightly below the

Figure 6.4
Distribution of Women-Owned Firms Across Industries in Rhode Island and the United States, 1997



Source: U.S. Department of Commerce, Bureau of the Census, 2001f.
Compiled by the Institute for Women's Policy Research.

Challenges for Women-Owned Businesses

Entrepreneurship is particularly important to economic growth in Rhode Island: within the state, 89.3 percent of all businesses employ 20 people or fewer, and 96 percent of all businesses employ 50 or fewer (Rhode Island Department of Labor and Training, Labor Market Information Division, 2001). With such a high concentration of small businesses in the state, women entrepreneurs should be encouraged to pursue career paths and businesses that have the most potential to succeed and that are born out of opportunity versus necessity.

A recent study by the Kauffman Center for Entrepreneurial Leadership and Babson College found that countries with the highest economic growth rates were also those with the highest levels of entrepreneurial starts. The study also suggested that by increasing the participation of women, countries could achieve the most rapid gain of business start-ups. However, the study also argues that "necessity" entrepreneurs, or entrepreneurs who believe that there are "no better choices for work," have lower business growth aspirations compared to "opportunity" entrepreneurs, who have pursued business opportunity out of personal interest (Reynolds, et al., 2000).

As of 1997, there were 19,886 majority-owned, privately-held, women-owned firms in Rhode Island, accounting for almost 25 percent of all privately-held firms in the state (see Table 6.2). Women-owned firms in Rhode Island employ nearly 27,000 people and generate almost $2.9 billion in sales.

Projecting past growth rates forward, the Center for Women's Business Research estimates that between 1997 and 2002, the number of women-owned firms in Rhode Island increased by 11 percent, while employment and sales remained constant with zero percent growth. The Center estimates that in 2002 there are 4,518 women-owned firms in Rhode Island with one employee or more and that the number of these firms grew by 20 percent from 1997 to 2002—over one and one half times the estimated growth rate of all employer firms in the state (12 percent). However, according to these estimates, Rhode Island will rank only 44th in the number of women-owned firms in 2002, 44th in employment levels, and 46th in sales. According to these estimates, Rhode Island will also rank 40th for the growth in the number of women-owned firms between 1997 and 2002, 41st in employment growth, and 43rd in sales growth among the states and Washington, D.C. In contrast, these estimates suggest that Rhode Island has one of the highest concentrations of Hispanic women-owned businesses, at six percent, to rank it among the top twelve states (Center for Women's Business Research, 2002).

Rhode Island's challenge is to develop an environment where women entrepreneurs can grow and thrive. Rhode Island women entrepreneurs face many unique challenges to success:

- Difficulty in accessing both debt and equity capital.
- Work-family issues such as the need to provide child care, elder care, and adequate health care.
- Need for ongoing peer support networks to develop solutions to business challenges.
- Lack of business management expertise and education.
- Insufficient access to key information and computer technologies.
- Scarcity of accurate information and data on existing women-owned businesses in the state.

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By addressing the barriers that women entrepreneurs presently face, Rhode Island can increase the number of women-owned business start-ups and grow a stronger economic base. The Center for Women and Enterprise, a Small Business Administration-sponsored Women's Business Center, was created in January 2000 to provide business development training, mentoring, and networking opportunities, as well as technical and loan packaging assistance to help Rhode Island women business owners grow and expand their businesses (for contact information, see Appendix V).

With Rhode Island's future oriented toward a global, knowledge-based economy, career paths in technology and science are important vehicles for enhancing the earning power of women and for fueling women-owned business growth. Capital investment is generally made in high growth sectors of the economy, where large returns can be realized quickly. While women-owned firms in Rhode Island are estimated to be growing at one and one half times the growth rate of all firms in the state, educational preparation and venture development in the state's most promising "opportunity" industries are the key factors that will truly lead to women's economic advancement.

U.S. average) and employed 26,678 people (see Table 6.2). As a result, Rhode Island ranks 31st in the nation and fourth in the New England region for this indicator of women's social and economic autonomy. Women-owned businesses in Rhode Island generated $2.9 billion in total sales and receipts in 1997 (in 2000 dollars).

In Rhode Island, 54.3 percent of women-owned firms were in the service industries. The next highest proportion (15.0 percent) was in retail trade (see Figure 6.4). This distribution is similar to national patterns (for more information, see Challenges for Women-Owned Businesses).

Like women's business ownership, self-employment for women (one kind of business ownership) has also been increasing over recent decades. In 1975, women represented one in every four self-employed workers in the United States, and in 1998 they were approximately two of every five (U.S. Small Business Administration, 1999). 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 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, child care and catering). In 1986-87 in the United States, 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 ($5.63); those with two or more types of self-employment with full-time schedules earned somewhat more ($6.68 per hour). In contrast, those who held only one full-time, year-round wage or salaried job earned the most ($12.24 per hour at the median; all figures in 2000 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, including self-employment, in an effort to raise their family incomes (Spalter-Roth, Hartmann, and Shaw, 1993).

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 typical 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 of health insurance coverage (those who lack health insurance entirely are also included in the averages; Spalter-Roth, Hartmann, and Shaw, 1993).

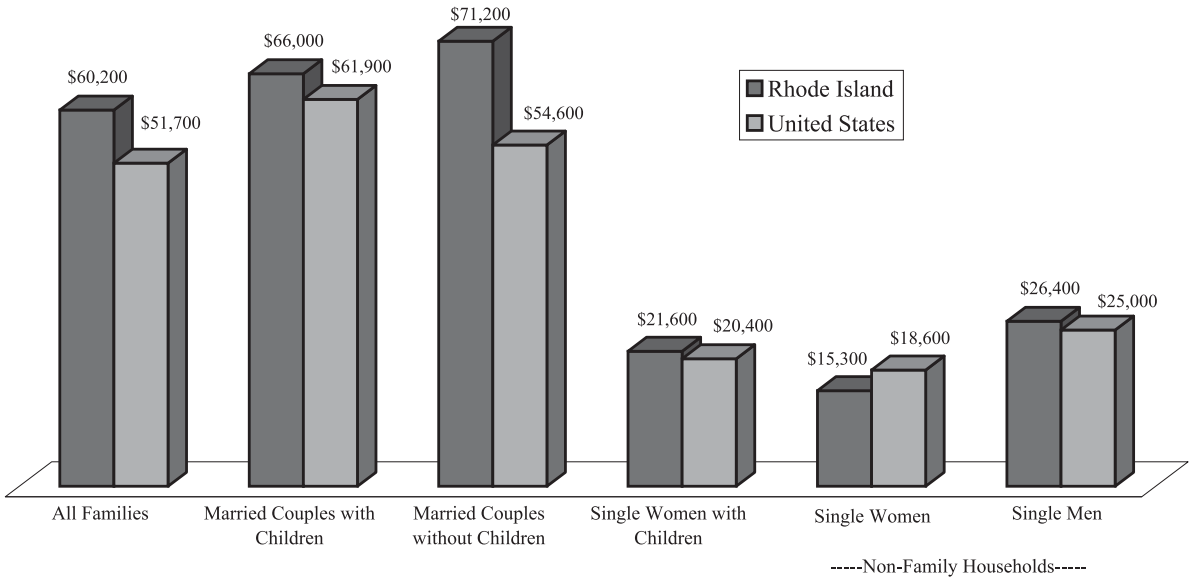
Overall, however, recent research finds that the rising earnings potential of women in self-employment compared with wage and salary work explains most of the upward trend in the self-employment of married women between 1970 and 1990. This suggests that the growing movement of women into self-employment represents an expansion of their opportunities (Lombard, 1996). Women in Rhode Island are less likely to be self-employed than women in the United States. In 1999, 4.8 percent of employed women in Rhode Island were self-employed, compared with 6.1 percent of women nationwide (data not shown; U.S. Department of Labor, Bureau of Labor Statistics, 2001b).

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, median family income for single-mother households was $20,400 in 1999, while that for married couples with children was $61,900 (see Figure 6.5). Figure 6.5 also shows that household income was higher on average for most family types, including single-mother families, in Rhode Island than in the United States as a whole.

In 1999, 10.6 percent of women aged 16 and older lived in poverty in Rhode Island—a smaller proportion than that of women in the United States (12.0 percent; see Figure 6.6). Rhode Island ranks 23rd in

Figure 6.5
Median Annual Income for Selected Family Types and Single Women and Men in Rhode Island and the United States, 1999 (2000 dollars)



Data for single men with children were not available due to small sample size.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

the nation and fifth of the six states in its region for women living above poverty. New Hampshire has the least poverty in the region, with only 7.5 percent of women living in poverty. Among men, poverty rates in 1999 were 6.4 percent in Rhode Island and 8.3 percent in the United States as a whole.

Table 6.3
Number and Percent of Persons in Families with Incomes Less Than a Minimum Family Budget Level* in Rhode Island and the United States, 1998

	Rhode Island	United States
Number of Persons	46,000	14,154,000
Percent of Persons	27.1%	27.6%

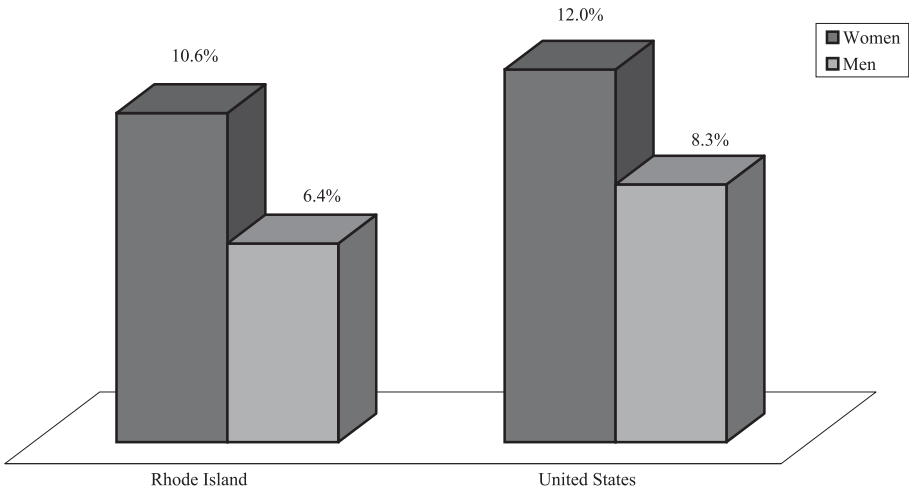
* The Minimum Family Budget Level calculates the amount a family would need to earn to afford housing, food, child care, health insurance, transportation, and utilities. Families consist of one or two parents and one to three children under the age of twelve.
Source: Boushey, et al., 2001.
Compiled by the Institute for Women's Policy Research.

Women's poverty rates vary considerably by race and ethnicity. Nationally, 23.5 percent of African American women, 22.8 percent of Native American women, and 22.4 percent of Hispanic women aged 16 and older were living below the poverty level, compared with only 8.5 percent of white women and 10.9 percent of Asian American women in 1999 (data not shown; IWPR, 2001b). Data on poverty levels by race and ethnicity were not available for Rhode Island due to small sample sizes.

As Figure 6.7 shows, poverty rates among all families and for most family types were lower in Rhode Island than in the nation as a whole. Among single women with children, though, Rhode Island had a higher poverty rate. Coupled with the above-average family income of single women with children (Figure 6.5), this suggests that Rhode Island may have a skewed distribution of income for single mothers, with some doing well and others doing quite poorly.

Although the poverty line is the federal standard of hardship in the United States, some researchers have begun to use basic family budgets as a more realistic measure of hardship. When the federal poverty line was created, it sought to measure the minimum amount of income needed for survival, by calculating

Figure 6.6
Percent of Women and Men Living in Poverty in Rhode Island and the United States, 1999



Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

Making Ends Meet in Rhode Island

Many families in Rhode Island find it difficult to "make ends meet." By far the most costly budget items for low- and moderate-income families are child care, housing, and health care. These costs disproportionately affect women, who have significantly less access to economic resources than do men in the state. The median annual earnings for Rhode Island women employed full-time/year-round were $29,600, compared to $41,400 for men (see Figure 5.1). This earnings disparity is also reflected in poverty levels. In 1999, 10.6 percent of Rhode Island women, compared with only 6.4 percent of men, aged 18 or older lived in poverty (see Figure 6.6). In addition, because of factors including divorce, separation, death, and custody of children born to single parents, an estimated 25 percent of Rhode Island families with children are headed by women (Ayers, 2001; these numbers differ from those in Appendix 1 because they are based on 2000 data). Among female-headed households in Rhode Island, 37.9 percent live in poverty (see Figure 6.7). The "working poor" in Rhode Island includes many of these households (Ayers, 2001).

Over the past six years, Rhode Island has made important and nationally recognized inroads in addressing two areas of need faced by these families: it has significantly expanded access to child care and to health care. The Rhode Island Family Independence Act, enacted in 1996, guarantees subsidized child care to children under age 16 in families with incomes below 225 percent of federal poverty level. Rhode Island has received national acclaim for its investments in improving the quality of child care as well as in providing parents access to quality services (Education Week, 2002). In state fiscal year 2002, an estimated average of 8,000 families will receive subsidized child care for 11,900 children. Ninety percent of these families have a parent who is working (Rhode Island Department of Human Services, 2001).

Rhode Island has also received national recognition for its expansion of health insurance to lower-income children and parents. For both 1999 and 2000, Rhode Island ranked first in the country for its percentage of residents with health insurance (Freyer, 2001). Only 2.4 percent of the state's children did not have health insurance in 2000. In addition, only 6.0 percent of women and 10.9 percent of men were uninsured in 2000 (see Table 6.1). The high level of coverage can be attributed, in part, to the state's RIte Care program, which provides coverage for parents up to 185 percent of the federal poverty level and for children and pregnant women in families up to 250 percent of the federal poverty level. In state fiscal year 2001, 108,000 children and parents in 43,200 families were covered through this program (Rhode Island Department of Human Services, 2002).

At the same time, there is still great need in the area of affordable housing in Rhode Island. Housing is generally viewed as affordable when it costs no more than 30 percent of a family's income. By this measure, 46 percent of renters in the state cannot afford a two-bedroom unit at the average monthly cost of $715. In contrast, for a family of three living at the federal poverty level, an affordable rent would be $354 per month (Rhode Island Kids Count, 2001b). Subsidized public housing is also increasingly unavailable. Nearly two-thirds of the state's assisted living and public housing units are reserved for elderly and disabled citizens, and 17,000 people are on waiting lists for subsidized and affordable housing (Rhode Island Housing and Mortgage Finance Corporation, 2000). Even Rhode Island's home ownership rate of about 61 percent is below the national average of 68 percent (Grow Smart Rhode Island, 2001). Clearly, families face significant financial difficulties related to housing.

Subsidies that assist families with such basic needs are crucial to the well-being of thousands of Rhode Islanders. As an example, the cost of meeting basic needs for a single parent with two children, ages three and eight, is presented in Table 6.4. The total monthly cost of living for this family is $3,381, based

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on a study of the actual costs of child care, rent, health care, food, transportation, and other essential items (clothing, cleaning, utilities, and sales tax) in Rhode Island (Poverty Institute, 2001; these numbers differ slightly from the data presented in Figure 6.8 as they are based on different sources and methodologies).

In Table 6.4, estimated living costs for two families are compared. In each, a single parent earns $10.55 per hour, or 150 percent of the federal poverty level, for her family of three. Each family's monthly income is $1,871, taking into account the value of the Women, Infants, and Children program (WIC) at $46.50, and averaging yearly federal and state tax liabilities and credits, including the Earned Income Tax Credit ($162 per month). Family 1 receives no subsidies, while Family 2 receives child care subsidies and RIte Care.

Table 6.4
Estimated Living Costs for Families With and Without Subsidies

	Family 1 Cost Without Subsidies	Family 2 Cost With Subsidies
Monthly income*	$1,871	$1,871
Costs:		
Child care	$1,095	$114
Rent	$650	$650
Medical	$575	$0
Food	$477	$477
Transportation	$258	$258
Miscellaneous	$326	$326
Total costs	$3,381	$1,825
Gap between costs and income	-$1,510	$46

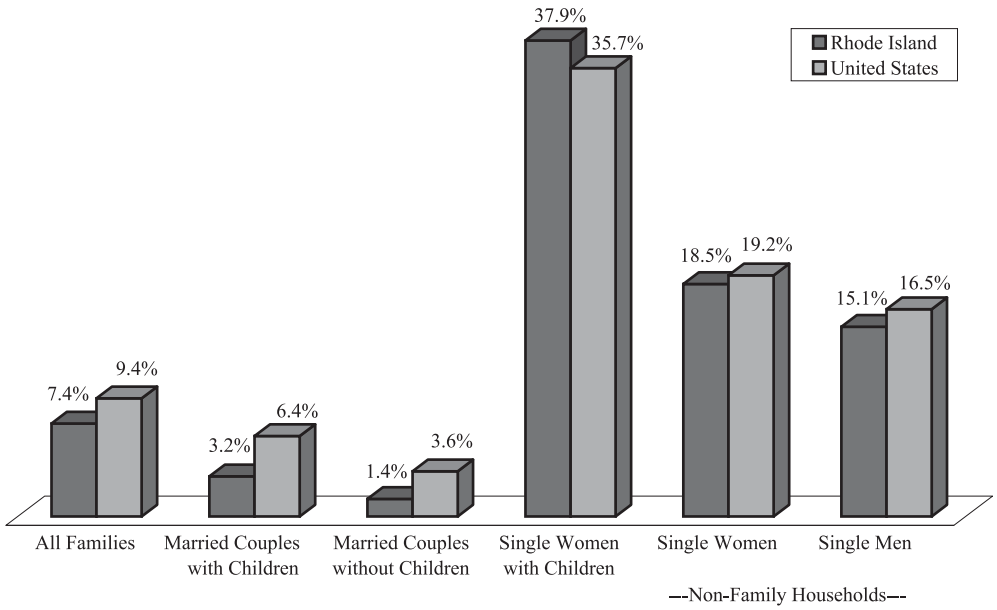
All estimates are for a family of three with one parent and two children.
*Includes values of WIC and all taxes including EITC.
Source: Poverty Institute, 2001.

To meet the basic needs for "no-frills" living in Rhode Island ($3,381 per month), a single parent must earn over $20 per hour, or $40,584 annually. If health care and child care subsidies are not available, families earning less than this amount would most likely not be able to afford health insurance or child care. As the example illustrates, even with subsidies, some families can just barely make it financially each month.

Rent is the second largest item in the budget, and a family's housing can easily be jeopardized as emergencies and unanticipated expenses arise. The need for affordable housing is further underscored by the significant recent rise in homelessness in the state and increased demand for emergency shelter. The most rapidly increasing part of the shelter population is children, who live primarily in female-headed households. From 1998 to 2001, the number of children using shelter increased by approximately 42 percent, and by 2001, over a quarter of shelter clients were under the age of 13 (Rhode Island Emergency Food and Shelter Board, 2001).

Rhode Island has made nationally recognized strides in assisting its families of modest means. Help with child care and health insurance gives these families an opportunity to find and keep gainful employment. The challenge to the state is to not only maintain and improve existing programs, but to build upon them by addressing the high costs of housing in Rhode Island.

Figure 6.7
Poverty Rates for Selected Family Types and Single Women and Men in Rhode Island and the United States, 1999



Data for single men with children were not available due to small sample size.
Source: IWPR, 2001b.
Calculated by the Institute for Women's Policy Research.

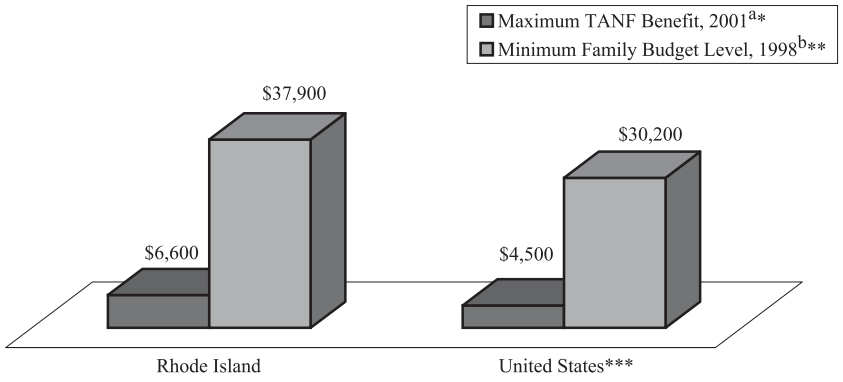
minimum food expenses and multiplying them by three (Fisher, 1992). In contrast, the basic family budget method sets a higher standard by measuring how much income is required for a safe and decent standard of living. It also calculates the cost of every major budget item a family needs—including housing, child care, health care, transportation, food, and taxes—based on family composition and where the family resides (Boushey, et al., 2001). It can be tailored specifically to a particular family type and to a specific region, state, or city. Thus, the family budget measure is more sensitive to variations in cost or standard of living than the federal poverty line, which is the same for all states. Over two and a half times as many people live below the basic family budget level as below the official poverty level in the United States.

Table 6.3 shows the proportion of people in families living below a minimum family budget level in Rhode Island and the United States. Nationally, the proportion of people in these families (consisting of one or two parents and one to three children under the age of twelve) was 27.6 percent in 1999, much higher than the proportion living below the federal poverty line (10.1 percent). In Rhode Island, 27.1 percent of people had incomes below the basic family budget level, slightly lower than in the United States as a whole.

Since Rhode Island is a relatively high-income state, and many high-income states also have higher costs of living, Rhode Island's relatively low rates of poverty may understate hardship in the state. While poverty rates and family budget levels are not completely comparable, it is interesting to note that while the proportion of people in families living in poverty in Rhode Island is much lower than the proportion nationally (see Figure 6.7), only a slightly lower proportion of people are living below the minimum family budget level in Rhode Island than in the United States. This suggests that, despite the state's low poverty rates, families in Rhode Island are not really doing that much better than families in the nation as a whole (for more on self-sufficiency in Rhode Island, see Making Ends Meet in Rhode Island).

As noted above, in contrast with Rhode Island's relatively low overall rate of family poverty, the poverty rate for single women with children is somewhat higher than the nationwide rate (37.9 percent and

Figure 6.8
Maximum Annual TANF Benefits and Minimum Family Budget Levels in Rhode Island and the United States



* TANF benefits are for a family of three with two children.
** The Minimum Family Budget Level calculates the amount a family (consisting of one parent and two children under the age of twelve) would need to earn to afford housing, food, child care, health insurance, transportation, and utilities (in 2000 dollars).
*** United States figures are medians among all 50 states and the District of Columbia.
Source: [a] Welfare Information Network, et al., 2001; [b] Boushey, et al., 2001.
Compiled by the Institute for Women's Policy Research.

35.7 percent, respectively; see Figure 6.7). In Rhode Island and in the nation as a whole, single women with children experience much higher levels of poverty than any other family type.

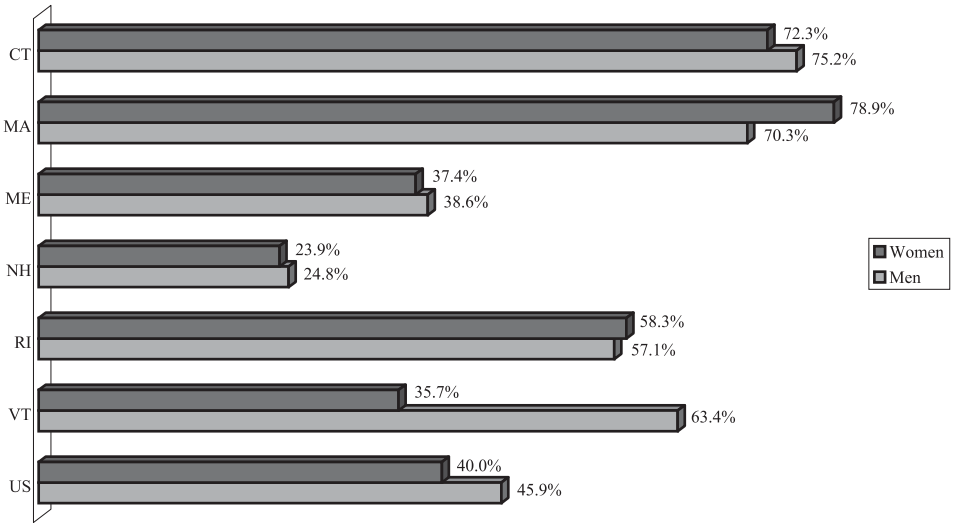
Even these high rates of poverty probably understate the degree of hardship among these families, especially among working mothers. While counting noncash benefits would reduce their poverty rates, adding the cost of child care for working mothers would increase the calculated poverty rates in Rhode Island and the nation (Renwick and Bergmann, 1993). Child care costs were not included at all in family expenditures when federal poverty thresholds were developed. 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 ranging 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 large underestimation. 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. IWPR research has 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 working married women and single mothers approximately in half. In Rhode Island, poverty among working single-mother households would have dropped by almost half, from 19.4 percent to 10.7 percent, in 1997 (Hartmann, Allen, and Owens, 1999). While eliminating the wage gap would not completely eliminate poverty or hardship—there would still be many low-wage jobs—pay equity provisions would help many women support their families.

State Safety Nets for Economic Security

State and national safety nets, such as TANF and unemployment insurance, can be crucial in assisting women and families who lack economic security. The amount of cash welfare benefits varies widely from state to state. Figure 6.8 compares the size of Rhode Island's maximum annual welfare benefit with the basic family budget level in the state, as a measure of how well the state's welfare safety net helps poor women achieve an acceptable standard of living. The poverty of many families is not alleviated by welfare alone; many families also receive food stamps or other forms of noncash benefits. Still, research shows that even when adding the value of noncash benefits, many women and their families remain poor (U.S. Department of Commerce, Bureau of the Census, 1997).

Figure 6.9
Percent of Unemployed Women and Men with Unemployment Insurance in the New England States and the United States, 2001



Source: Emsellem, et al., 2002.
Compiled by the Institute for Women's Policy Research.

In Rhode Island, as in all of the United States, TANF benefits are substantially below basic family budget levels. The state's maximum TANF benefit is higher than the U.S. average, at $6,600 and $4,500 respectively. Its basic family budget level is also higher than nationally, at $37,900 and $30,000 respectively. In Rhode Island, the maximum TANF benefit is 17.4 percent of the minimum basic family budget level in the state, compared with 14.9 percent nationally.

Rhode Island also does a better than average job of providing a safety net for unemployed women. The unemployment rate for women in Rhode Island (4.2 percent) was slightly higher than the national average of 4.1 percent in 2000 (see Figure 5.5). The percent of unemployed women in Rhode Island receiving unemployment insurance benefits was much higher than in the United States as a whole (see Figure 6.9). Similarly, the percent of unemployed men and the rate of unemployment insurance benefit receipt for men were both higher in Rhode Island than in the United States. Rhode Island is one of two states in the New England region (the other is Massachusetts) where unemployment insurance benefit receipt reaches a larger proportion of unemployed women than men. This pattern is unusual: in most states, unemployment insurance benefits reach a higher proportion of unemployed men than unemployed women.

Poverty and Age

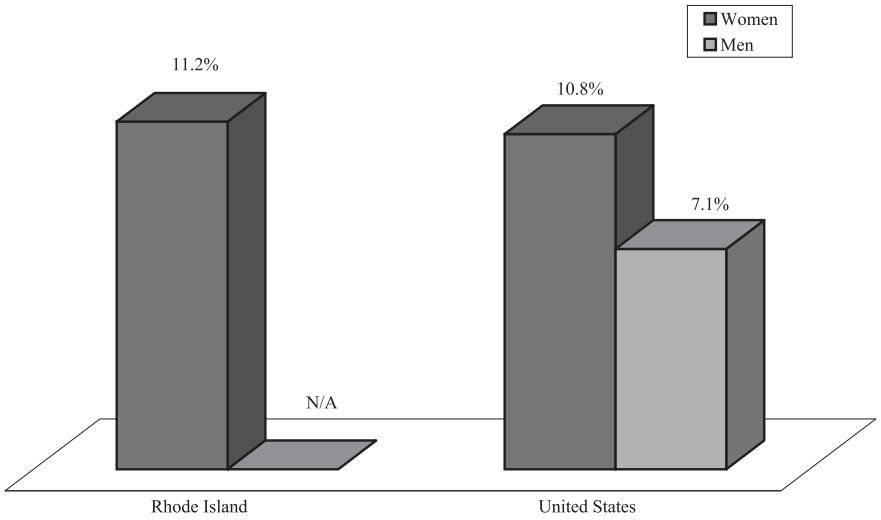
Despite the increase in women's participation in the paid labor force over the past three decades, a variety of factors, such as the persistence of the wage gap, differences in women's and men's family responsibilities, and the rise in divorce and single motherhood, has left many women economically disadvantaged in their old age and is expected to continue to do so (National Council of Women's Organizations, Task Force on Women and Social Security, 1999). In 1999, 10.8 percent of women aged 50 and older were living in poverty, compared with 7.1 percent of men aged 50 and older in the United States (see Figure 6.10). In Rhode Island, 11.2 percent of women aged 50 and older were living in poverty, slightly above the average for the nation. Comparable data for men in Rhode Island were not available due to small sample size.

Among those who receive Social Security benefits, median annual benefits for women aged 50 and older are slightly higher in Rhode Island than they are

nationally ($8,100 and $7,500, respectively). Median annual benefits for men aged 50 and older are slightly lower than nationally ($10,600 and $10,900, respectively; see Figure 6.11). Thus, the gender gap in Social Security benefits is smaller in Rhode Island than in the United States.

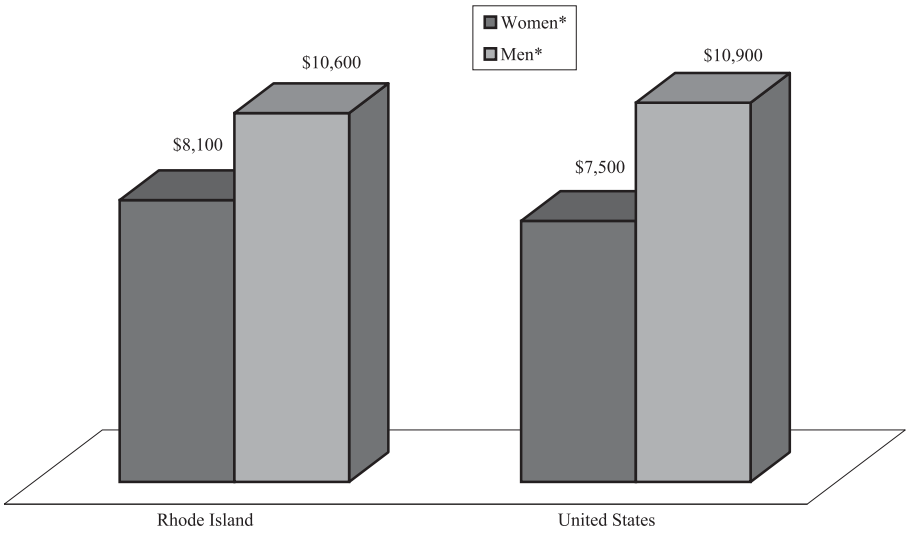
Social Security is the core of our nation's social insurance program for the elderly. For most people, it is the only income source that is adjusted fully for inflation and is not outlived. Typically, women are more dependent on Social Security because they earn less, have fewer pension plan resources, and live longer than men. Indeed, without Social Security, more than half of all women aged 65 or older would be poor. Social Security has helped reduce poverty rates among the elderly from 35 percent in 1959 to less than 11 percent in 1999. For 25 percent of unmarried elderly women (widowed, divorced, separated, or never married), Social Security is their only source of income (National Council of Women's Organizations, Task Force on Women and Social Security, 1999).

Figure 6.10
Percent of Women and Men Aged 50 and Older Living in Poverty in Rhode Island and the United States, 1999



N/A = Not available.
Source: IWPR, 2001a.
Calculated by the Institute for Women's Policy Research.

Figure 6.11
Median Annual Social Security Benefits Among Women and Men Aged 50 and Older in Rhode Island and the United States, 1999



*Among those receiving benefits.
Source: IWPR, 2001a.
Calculated by the Institute for Women's Policy Research.

7. Reproductive Rights

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 (1995). 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. The document also stresses that adolescent girls in particular need information and access to relevant services. Because reproductive issues are so important to women's lives, 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.

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. State legislative and executive bodies are nonetheless continually battling 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 at the state and national levels 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. 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 Rhode Island, which ranks tenth in the nation but just fourth in its region, has many protections for women's reproductive rights and resources when compared with other states. However, women in the state still lack access to some important reproductive resources (see Chart 7.1, Panels A and B). Rhode Island's grade of B on the reproductive rights index reflects the gap between the ideal status of women's reproductive rights and resources 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

Chart 7.1 Panel A
Reproductive Rights: National and Regional Ranks

	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Reproductive Rights Index	**10**	**4**	**B**

See Appendix II for methodology.
* The national ranking is of a possible 51, including the 50 states and the District of Columbia. The regional ranking is of a maximum of six and refers to the states in the New England region (CT, MA, ME, NH, RI, and VT).
Calculated by the Institute for Women's Policy Research.

Chart 7.1 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 Rhode Island allow access to abortion services:				
Without mandatory parental consent or notification?[a]		✓		8
Without a waiting period?[a]	✓			29
Does Rhode Island provide public funding for abortions under any or most circumstances if a woman is eligible?[a]		✓		16
What percent of Rhode Island women live in counties with an abortion provider?[b]			63%	68%
Is Rhode Island's state government pro-choice?[c]				
Governor			Mixed	17
Senate			Mixed	11
House of Representatives			Mixed	8
Does Rhode Island require health insurers to provide comprehensive coverage for contraceptives?[d]	✓			19
Does Rhode Island require health insurers to provide coverage for infertility treatments?[e]	✓			11
Does Rhode Island allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?[f]*	✓		Lower Court	25
Does Rhode Island require schools to provide sex education?[g]**	✓			23

* Most states that allow such adoptions do so as a result of court decisions. In Rhode Island, no case has yet been tried.
**Rhode Island requires that both abstinence and contraception be taught.
Source: [a] NARAL and NARAL Foundation, 2002; [b] Henshaw, 1998; [c] NARAL and NARAL Foundation, 2001; [d] Alan Guttmacher Institute, 2002a; [e] Plaza, 2001a; [f] National Center for Lesbian Rights, 2001; [g] Alan Guttmacher Institute, 2002b.
Compiled by the Institute for Women's Policy Research.

can perform an abortion procedure, while notification laws require that they notify one or both parents of the decision to have an abortion. Of the 43 states with consent or notification laws on the books as of December 2001, 33 enforce their laws. Of these 33 states, 15 enforce notification laws and 18 enforce consent laws. In states with notification or consent laws, 38 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. Two states provide for physician bypass, and two allow for both judicial and physician bypass. Utah is the only state to have no bypass procedure. As of December 2001, Rhode Island still enforces its mandatory consent law (requiring consent of one parent) but allows for a judicial bypass (see Chart 7.1, Panel B).

Waiting period legislation mandates that a physician cannot perform an abortion until a certain number of hours after the patient is notified of her options in dealing with a pregnancy. Waiting periods range from one to 72 hours. Rhode Island is one of 29 states without a waiting period.

Public funding 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. Rhode Island is one of 28 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 threatens the life of the woman.

The percent of women in Rhode Island living 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 lived in counties with at least one provider, while in the top six states, more than 90 percent of women lived in counties with at least one (Henshaw, 1998). At 63 percent of women in counties with a provider, Rhode Island's proportion falls near the middle of the nation. In 41 states, more than half of all counties have no abortion provider, and in 21 states more than 90 percent of counties had none (Henshaw, 1998).

Debates over reproductive rights and family planning policies frequently involve potential restrictions on women's access to abortion and contraception. 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, 2001). 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 Rhode Island, the governor, the state Senate, and the state House of Representatives all received mixed evaluations.

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 39 percent of HMOs cover all five prescription methods (The Alan Guttmacher Institute, 1996). Because of the importance of contraception to women's control over their reproductive lives, women's advocates and policymakers have focused on insurance coverage of contraception as an important issue to women. Responding to a set of lawsuits filed against individual companies, in 2000 the Equal Employment Opportunity Commission ruled that employers that offer coverage for comparable prescription drugs must also cover prescription contraceptives under federal antidiscrimination laws.

Controversy about contraceptive coverage is leading lawmakers in many states to introduce bills that would require health insurers to cover contraception. Nineteen states, including Rhode Island, require all private insurers to provide comprehensive contraceptive coverage. Seven states have provisions requiring partial coverage for contraception. In four of these states, insurance companies must offer at least one insurance package that covers some or all birth control prescription methods. One state, Minnesota, requires coverage of all prescription drugs, including contraceptives. Another, Texas, requires insurers with coverage for prescription drugs to cover oral contraceptives. In Oklahoma, a state regulation mandates that HMOs cover "voluntary family planning services," which is interpreted to include some kind of contraception (NARAL and NARAL Foundation, 2001).

Publicly funded contraceptive services prevent many unintended pregnancies each year among the young, the unmarried, and the poor (Forrest and Amara, 1996). In addition to giving women more control over family planning, contraceptive services are financially beneficial. Every dollar spent for contraceptive services saves three dollars in public funds that would otherwise be needed for prenatal

and newborn medical care alone (Frederick, 1998). In the United States, 39 percent of all women who are in need of publicly supported contraceptive services are served at publicly supported family planning clinics, compared to 33 percent in Rhode Island (Table 7.1). In contrast, just 21 percent of teenage women in need of publicly supported contraceptive services in Rhode Island are served at publicly supported clinics, while nationally 37 percent of teenage women are. These proportions for both women and teens in Rhode Island rank last in the New England region (data not shown). In order to support all women in choosing their family size, states should make a commitment to expand publicly supported contraceptive services.

Infertility treatments can also increase the reproductive choices open to women and men, but they are often prohibitively expensive, especially when they are not covered by insurance. In eleven states, including Rhode Island, legislatures have passed measures requiring insurance companies to pay for infertility treatments. In another three states, insurance companies must offer at least one package with infertility coverage to their policyholders (Plaza, 2001a).

Because there is no comprehensive federal law concerning the reproductive rights of gays and lesbians, state courts currently hold considerable power over their choices in building their families. Courts have exercised this power in many ways, for example, by deciding whether lesbians and gays can legally adopt their partners' children, sometimes called second-parent adoption. Second-parent adoption provides the legal rights to otherwise non-legal parents in same-sex relationships that many legal parents take for granted, such as custodial rights in the case of divorce or death and the right to make health care decisions for the child. Research also suggests that children raised by homosexual parents have the same advantages and levels of health and development as those whose parents are heterosexual (American Academy of Pediatrics, 2002).

Court rulings in 25 states specifically extend second-parent adoption to lesbians and gays. In 18 of those states, lower courts have approved a petition to adopt; in five states, high or appellate courts have prohibited discrimination; and in two states, the state supreme court has prohibited discrimination against gays or lesbians in second-parent adoption cases. In six 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 20 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 (National Center for Lesbian Rights, 2001). In Rhode Island, a lower court ruling stipulates that the non-legal parent in a gay/lesbian couple can adopt his or her partner's child.

Sexuality education is crucial to giving young women and men the knowledge they need to make informed decisions about their sexual activity and to avoid unwanted pregnancy and disease. In 23 states, including Rhode Island, schools are required to pro-

Table 7.1
Contraceptive Coverage Among Low-Income and Teenage Women in Rhode Island and the United States, 1995

	Rhode Island	United States
Percent of All Women in Need of Publicly Supported Contraceptive Services Who are Served by Publicly Supported Family Planning Clinics	33%	39%
Percent of Teenage Women in Need of Publicly Supported Contraceptive Services Who are Served by Publicly Supported Family Planning Clinics	21%	37%

Source: Fredrick, 1998.
Compiled by the Institute for Women's Policy Research.

vide sex education. Of those 23, nine states, including Rhode Island, require that sexuality education teach abstinence and also provide students information about contraception. Three states require sex education programs to teach abstinence but do not require that schools provide students information about contraception (NARAL and NARAL Foundation, 2001).

Fertility and Natality

Women's reproductive rights are crucial to their ability to control the timing and circumstances of giving birth. This, in turn, gives them more control over their economic, health, and social status. Women's reproductive rights can also improve the economic and health status of their children, since women's ability to achieve their own well-being affects the well-being of their families.

By 2000, the median age for women at the time of their first marriage was 25.1 years. As of 1999, the median age at first birth was 24.5 years (Fields and Casper, 2001; National Center for Health Statistics, 2001b). Fertility rates are lower in Rhode Island than in the nation as a whole. Table 7.2 shows 58.1 live births per 1,000 women aged 15-44 in Rhode

Table 7.2
Fertility, Natality, and Infant Health

	Rhode Island	United States
Fertility Rate in 2000 (live births per 1,000 women aged 15-44)[a]	**58.1**	**67.5**
Infant Mortality Rate in 1999 (deaths of infants under age one per 1,000 live births)[b]	**5.7**	**7.1**
Among Whites	5.0	5.8
Among African Americans	N/A	14.6
Percent of Low Birth Weight Babies (less than 5 lbs, 8 oz.),1999[a]	**7.3%**	**7.6%**
Among Whites	6.7%	6.6%
Among African Americans	11.3%	13.1%
Among Hispanics	7.1%	6.4%
Percent of Mothers Beginning Prenatal Care in the First Trimester of Pregnancy, 1999[c]	**91%**	**83%**
By Race and Ethnicity:		
Among Whites	94%	88%
Among African Americans	84%	74%
Among Hispanics	86%	74%
Among Asian Americans	82%	84%
Among Native Americans	83%	70%
By Age:		
Under Age 15	N/A	48%
Ages 15-19	79%	69%
Ages 20-24	87%	78%
Ages 25-29	93%	87%
Ages 30-34	95%	90%
Ages 35 and Older	94%	88%
Births to Teenage Women (aged 15-19 years) as a Percent of all Births, 1999[d]	**12.5%**	**14.5%**
Births to Unmarried Women as a Percent of All Births, 1999[d]	**34.3%**	**33.0%**

N/A = Not Available

Sources: [a] Martin, et al., 2002; [b] National Center for Health Statistics, 2001c; [c] National Center for Health Statistics, Division of Health Promotion, 2001; [d] U.S. Department of Commerce, Bureau of the Census, 2001d.

Compiled by the Institute for Women's Policy Research.

Island, compared with 67.5 births per 1,000 women aged 15-44 in the United States as a whole, in 2000.

Table 7.2 also shows that there were 5.7 infant deaths per 1,000 births in Rhode Island, a rate substantially lower than that for the United States as a whole, at 7.1 infant deaths per 1,000. Infant mortality affects white and African American communities in the United States at very different rates. In Rhode Island, the infant mortality rate is 5.0 per 1,000 for white infants; comparable data are not available for African American infants (however, since overall rates are higher than those for whites, non-white infants in the state must have higher mortality rates). In the United States, mortality rates are 5.8 for white infants and 14.6 for African American infants. Thus, racial and ethnic disparities remain wide in the country as a whole (National Center for Health Statistics, 2001c).

Low birth weight (less than 5 lbs., 8 oz.) among babies also affects different racial and ethnic groups at different rates. In Rhode Island, while the overall low birth weight rate is 7.3 percent (compared to 7.6 percent nationally), the percent of births of low weight is 6.7 among white infants, 7.1 among Hispanic infants, and 11.3 among African American infants. In the United States, the percent of births of low weight among white infants is 6.6; for Hispanic infants, it is 6.4; and for African American infants, it is 13.1. Nationally, 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 reducing the risk of infant mortality and low birth weight (U.S. Department of Health and Human Services, Public Health Service, 2000). Nationally, about 83 percent of women begin prenatal care in their first trimester of pregnancy, while a much greater proportion, 91 percent, of Rhode Island women do. Use of prenatal care varies sharply by race and education. In the United States as a whole, 88 percent of white women use prenatal care in the first trimester, while 84 percent of Asian American women, 74 percent of African American and Hispanic women, and 70 percent of Native American women do. In Rhode Island, 94 percent of white women, 86 percent of Hispanic women, 84 percent of African American women, 83 percent of Native American women, and 82 percent of Asian American women do. Thus, racial and ethnic disparities are somewhat smaller in Rhode Island than nationally. Still, white women are much more likely to use prenatal care than women of color.

Use of prenatal care varies greatly by age, as well. In the United States in 1999, just 48 percent of girls under age 15 received prenatal care in the first trimester of pregnancy, compared with 69 percent of those aged 15-19. Rates were much higher, from 78 to 90 percent, for women over age 20. In Rhode Island, data for girls under 15 were not available, but rates of prenatal care rise from 79 percent among those aged 15-19, to 87 percent among women aged 20-24, and over 90 percent for women over age 25.

Teenage mothers can have difficulties achieving an adequate standard of living because of their limited choices about education and employment (The Alan Guttmacher Institute, 1994; U.S. Department of Health and Human Services, Public Health Service, 2000). In addition, as Table 7.2 shows, teenage women access prenatal care less in the first trimester compared to older women. In 1999, births to teenage mothers accounted for a smaller proportion of all births in Rhode Island (12.5 percent) than they did nationally (14.5 percent). In contrast, births to unmarried mothers accounted for a larger proportion of all births in Rhode Island than they did nationally (34.3 percent in Rhode Island compared with 33 percent for the nation as a whole; U.S. Department of Commerce, Bureau of the Census, 2001d).

8. Health and Well-Being

Health is a crucial factor in women's overall status. Health problems can seriously impair women's quality of life as well as their ability to care for themselves and their families. 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, as well as adequate and affordable quality health care.

This section focuses on women's health in Rhode Island. The composite index of women's health and well-being includes 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 women's everyday activities. Because research links women's health and well-being to their ability to access the health care system (Mead, et al., 2001), this section also presents information on women's use of preventive services, health-related behaviors, and state-level

Chart 8.1
Health and Well-Being: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Health and Well-Being Index	**26**	**6**	**C**
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000, 1996-98)[a]	45	6	
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000, 1996-98)[a]	45	4	
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000, 1996-98)[a]	46	6	
Percent of Women Who Have Ever Been Told They Have Diabetes (2000)[b]	12	4	
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000, 2000)[c]	28	6	
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults, 2000)[d]	31	4	
Average Number of Days per Month on which Women's Mental Health Is Not Good (2000)[b]	24	5	
Average Annual Mortality Rate Among Women from Suicide (per 100,000, 1996-98)[e]	1	1	
Average Number of Days per Month on which Women's Activities Are Limited by Their Health (2000)[b]	14	2	

See Appendix II for methodology.

* The national rankings are of a possible 51, including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England region (CT, MA, ME, NH, RI, and VT).

Source: [a] National Center for Health Statistics, 2001a; [b] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001; [c] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of STD Prevention, 2001; [d] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, 2001; [e] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2001.

Calculated by the Institute for Women's Policy Research.

policies and resources 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 compared with 73 years for men in the United States in 1998—women suffer from more non-fatal 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, et al., 2001).

Women's overall health status is closely connected to many of the other indicators in this report, including women's poverty status, access to health insurance, reproductive rights, and family planning. As a result, it is important to consider women's health as embedded 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 the Oregon Health and Science University, 2001). For example, 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 considerable problems accessing the health care system, which indirectly influences their health status (Mead, et al., 2001). Research shows that, in contrast, women's employment has a positive effect on 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, et al., 1999).

Rhode Island, which ranks 26th of all states, is about average for most states and the nation on indicators of women's health and well-being (see Chart 8.1). The state fares particularly poorly for women's mortality from heart disease and lung and breast cancer, and it is only about average for incidence rates of chlamydia, AIDS, and overall levels of mental health. In contrast, it is in the top third of the country for incidence of diabetes and women's activities limitations due to their health, and it has the lowest rates of mortality from suicide in the nation. Regionally, Rhode Island ranks much worse, last among the New England states, indicating that women's health status is higher overall in this region.

Rhode Island'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 health goals, including those 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. It remains the leading cause of death for women aged 75 and older even when all cancers are combined (National Center for Health Statistics, 2001d). 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 its risk factors and how to modify them. In addition, states can implement policies that facilitate access to health care professionals and preventive screening services.

Women in Rhode Island experience mortality from heart disease at a rate well above the U.S. rate (179.6 and 161.7 per 100,000 women, respectively; see Table 8.1). Rhode Island ranks 45th among all states and last regionally on this indicator. Men's mortality from heart disease is much worse in both Rhode Island and in the country as a whole (295.1 and 266.2 per 100,000 men, respectively; data not shown; National Center for Health Statistics, 2001a).

Women's mortality from heart disease varies greatly by race and ethnicity in Rhode Island and in the United States. As Figure 8.1 shows, mortality rates

Table 8.1
Mortality and Incidence of Disease Among Women in Rhode Island and the United States

Indicator	Rhode Island	United States
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000), 1996-98[a]	179.6	161.7
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000), 1996-98[a]	46.5	41.3
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000), 1996-98[a]	31.5	28.8
Percent of Women Who Have Ever Been Told They Have Diabetes, 2000[b]	5.2	5.9*
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000), 2000[c]	382.7	404.0
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults), 2000[d]	5.3	8.7

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

Source: [a] National Center for Health Statistics, 2001a; [b] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001; [c] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of STD Prevention, 2001; [d] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, 2001.

Compiled by the Institute for Women's Policy Research.

from heart disease are generally much worse among African American women than among white women, while Asian American women have the best rates. In the United States, the mortality rate from heart disease for 1996-98 among all women was 161.7 deaths per 100,000 women. For African American women, it was much worse, at 195.3 deaths per 100,000, while for white women it was 159.8. For Hispanic women, the rate was only 113.4 deaths per 100,000; for Asian American women, it was 89.5; for Native American women, it was 94.2. In Rhode Island, 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 277.6 per 100,000; white women's mortality was 178.1 per 100,000; and Hispanic women's rate was only 63.0 per 100,000. Data were not available for Asian or Native American women in Rhode Island. While African American women had mortality rates much worse in Rhode Island than nationally, Hispanic women in the state had much better rates than those in the United States.

Cancer is the leading cause of death for women aged 45-74. Women's lung cancer in particular, the leading cause of death among cancers, 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). As with 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 Rhode Island, the average mortality rate from lung cancer is 46.5 per 100,000 women, well above the national rate of 41.3. As a result, Rhode Island ranks 45th in the nation and fourth in the New England region on this indicator.

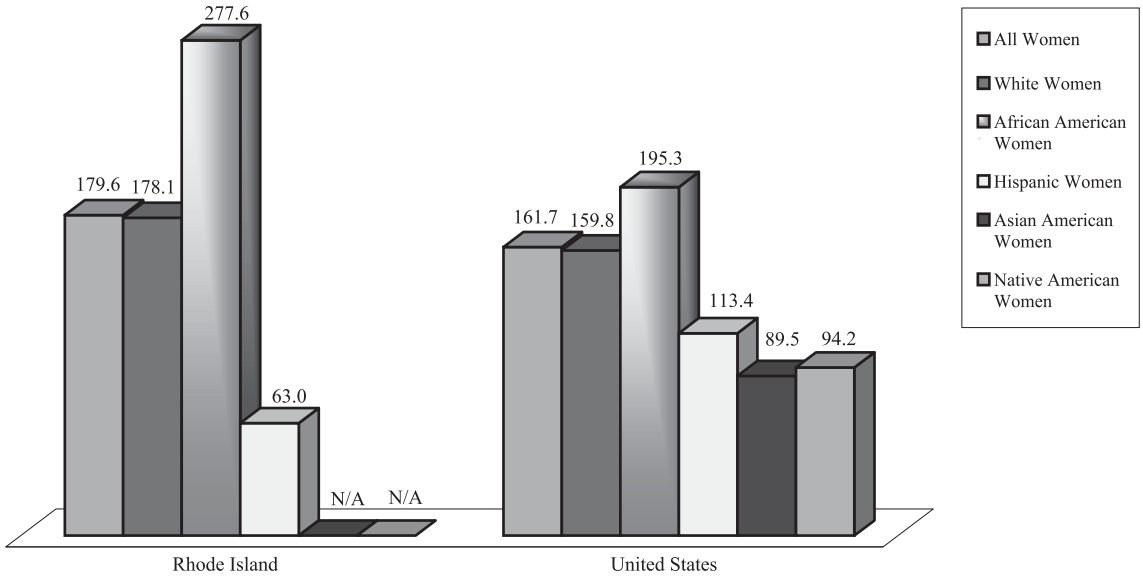
Mortality from lung cancer varies considerably by race and ethnicity. In Rhode Island, 47.0 white women per 100,000 die from lung cancer each year, while 61.9 African American women do (Table 8.2; data not available for Hispanic, Asian American women, or Native American women in Rhode Island). This pattern is very different from national trends. Nationally, white women are slightly more likely to die from lung cancer than African American women and considerably more likely than Hispanic, Asian American, and Native American women to do so: 43.7 white women, 41.3 African American women, 13.8 Hispanic women, 19.4 Asian American women, and 25.0 Native American women per 100,000 died of lung cancer annually in 1996-98.

Among cancers, breast cancer is the second most common cause of death for U.S. women. Approximately 203,500 new invasive cases of breast cancer are expected in 2002 (American Cancer Society, 2002). 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. Rhode Island's rate of mortality from breast cancer, 31.5 per 100,000, is worse than that of the nation, at 28.8 per 100,000 women. Rhode Island ranks 46th in the nation and last in its region on this measure.

Mortality rates from breast cancer are much worse among African American women than they are among women of other races and ethnicities in the nation as a whole: 28.7 white women, 37.8 African American women, 17.6 Hispanic women, 12.8 Asian women, and 15.1 Native American women per 100,000 died of breast cancer annually in 1996-98 (Table 8.2). Unfortunately, comparable data were not available for minority women in Rhode Island due to small sample sizes.

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. 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, 1999). Rates of diabetes vary tremendously by race and ethnicity, with African Americans, Hispanics, and Native Americans 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

Figure 8.1
Average Annual Mortality Rates Among Women from Heart Disease in Rhode Island and the United States by Race and Ethnicity, 1996-98*



* Deaths per 100,000.
N/A=Not Available
Source: National Center for Health Statistics, 2001a.
Compiled by the Institute for Women's Policy Research.

Table 8.2
Average Annual Mortality Rates Among Women from Lung and Breast Cancer in Rhode Island and the United States by Race and Ethnicity, 1996-98

Indicator	Rhode Island	United States
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000)	**46.5**	**41.3**
Among Whites*	47.0	43.7
Among African Americans*	61.9	41.3
Among Hispanics**	N/A	13.8
Among Asian Americans	N/A	19.4
Among Native Americans	N/A	25.0
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000)	**31.5**	**28.8**
Among Whites*	31.9	28.7
Among African Americans*	N/A	37.8
Among Hispanics**	N/A	17.6
Among Asian Americans	N/A	12.8
Among Native Americans	N/A	15.1

* Non-Hispanic.
** Hispanics may be of any race.
N/A = Not available.
Source: National Center for Health Statistics, 2001a.
Compiled by the Institute for Women's Policy Research.

habits in a state. In Rhode Island, 5.2 percent of women have been diagnosed with diabetes at some point in their lifetime, a rate better than the median rate for all states, 5.9 percent. At twelfth in the nation, Rhode Island ranks somewhat higher on this indicator than on other measures of women's health.

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 563,000 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 Rhode Island, chlamydia affects 382.7 women per 100,000, a rate somewhat better than that for the United States as a whole, or 404.0 women per 100,000. Rhode Island ranks 28th in the nation and last in the New England region on this indicator of women's health status (since the national rate is an average for the whole population and not a median rate among the states, Rhode Island can rank below the halfway point among the states despite a rate better than the national average).

The incidence of HIV and AIDS in women is one of the fastest growing threats to their health, especially among younger women. The 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 greater than for women, by 1998-99 men had less 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 those with HIV are women: in 2000, 17 percent of people with AIDS were women, while 28 percent of those with HIV were. The race and ethnic disparities in the incidence of AIDS among women are alarming: in 1999, the AIDS rate per 100,000 women nationwide in the United States was 2.3 among white women, 49.0 among African American women, 14.9 among Hispanic women, 1.4 among Asian American women, and 5.0 among Native American women (Table 8.3). In Rhode Island, the AIDS rate per 100,000 women was 2.6 among white

Table 8.3
Average Annual Incidence Rate of AIDS Among Women in Rhode Island and the United States by Race and Ethnicity, 1999*

Indicator	Rhode Island	United States
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults)	**7.2**	**9.3**
Among Whites	2.6	2.3
Among African Americans	78.8	49.0
Among Hispanics	32.2	14.9
Among Asian Americans	N/A	1.4
Among Native Americans	N/A	5.0

* Data differ from those provided in Table 8.1, which are for 2000. These numbers are based on unpublished numbers from the Centers for Disease Control for 1999.
N/A = Not available.
Source: The Henry J. Kaiser Family Foundation, 2001.
Compiled by the Institute for Women's Policy Research.

women but 32.2 among Hispanic and 78.8 among African American women.

Overall, Rhode Island had a smaller incidence of AIDS than the nation as a whole in 2000, at 5.3 compared with 8.7 per 100,000 women (Table 8.1). The state ranks 31st on this indicator nationally and fourth out of six states in the New England region (since the national rate is an average for the whole population and not a median rate among the states, Rhode Island can rank below the halfway point among the states despite a rate better than the national average). For men, the incidence of AIDS is also smaller in Rhode Island than in the nation as a whole, at 19.1 cases per 100,000 in Rhode Island compared with 28.0 cases in the United States as a whole for men (data not shown; Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, 2001).

Mental Health

Women experience some psychological conditions, such as depression, anxiety, panic, and eating disorders, at higher rates than men. However, they are less likely to suffer from substance abuse and conduct disorders than men are. Overall, about half of all women aged 15-54 experience symptoms of mental illness at some point in their lives (National Center for Health Statistics, 1996). 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 other psychological disorders. These treatments, however, are integral to helping patients achieve good mental health.

Table 8.4
Mental Health Among Women and Men in Rhode Island and the United States

Indicator	Rhode Island		United States	
	Women	Men	Women	Men
Average Number of Days per Month of Poor Mental Health, 2000[a]	3.8	3.0	3.8*	2.5*
Average Annual Mortality Rate from Suicide (per 100,000), 1996-98[b]	2.8	14.0	4.4	19.6

* Median rate for the 50 states and the District of Columbia.
Source: [a] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001; [b] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2001.
Compiled by the Institute for Women's Policy Research.

In Rhode Island, women's self-reported evaluations indicate that women experience an average of 3.8 days per month on which their mental health is not good. The state ranks 24th on this measure (see Table 8.4 and Chart 8.1). Nationally, the median rate for all states is the same. In contrast, men's rate of poor mental health is worse in Rhode Island than the national median, at 3.0 compared with 2.5 days, respectively. In Rhode Island, as in the nation, the median rate of poor mental health days per month for women is worse than it is for men (3.8 versus 3.0 in Rhode Island and 3.8 versus 2.5 in the United States).

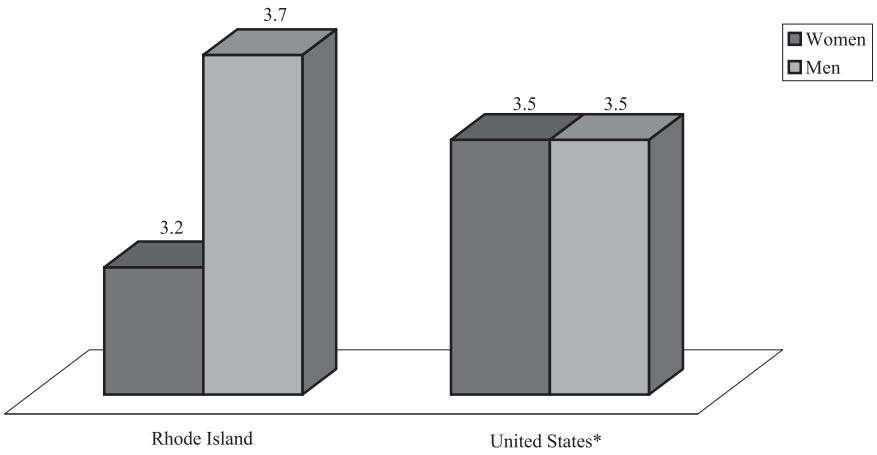
One of the most severe public health problems related to psychological disorders is suicide. In the United States, 1.3 percent of all deaths occur from suicide, about the same number of deaths as from AIDS (National Institute of Mental Health, 1999). Women are much less likely than men to commit suicide, with over four times as many men as women dying by suicide. However, women are two to three times 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 1999, suicide was the fourth leading cause of death among women aged 14-34, the fifth leading cause of death among women aged 35-44, and the eighth leading cause of death among women 45-54 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2002). Among women in the United States, the annual rate of mortality from suicide is 4.4 per 100,000. In Rhode Island, the rate of death by suicide among women is much better, at 2.8 per 100,000. Rhode Island ranks first in the nation and in the New England 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 all these things. Women's self-evaluation of the number of days in a month on which their activities are limited

Figure 8.2
Average Number of Days per Month of Limited Activities Among Women and Men in Rhode Island and the United States, 2000



* Median rates for the 50 states and the District of Columbia.
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001.
Compiled by the Institute for Women's Policy Research.

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 3.5; in Rhode Island, the average number of days of limited activities for women is better, at 3.2 (see Figure 8.2), and the state ranks 14th nationally and second in its region on this measure. In contrast, for men, the rate in Rhode Island (3.7 days per month) is worse than the median rate for all states (3.5 days per month).

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 the elimination of smoking and heavy drinking, can help women avoid many of the diseases and conditions described above. Table 8.5 presents data on women's use of preventive care, early detection resources, and good health habits in Rhode Island.

Generally, women in Rhode Island use preventive care resources at above-average levels. Of women aged 50 and above, 79.7 percent have had a mammogram within the past two years, somewhat higher than the median percent for all states (71.1). Rhode Island women also have slightly higher usage rates of pap tests (88.5 percent compared with 86.8 percent in the United States, among women aged 18 and older), and their rates of cholesterol screenings are much higher than the median for all states (77.5 percent compared with 71.2 percent, respectively for women aged 18 and older).

Table 8.5
Preventive Care and Health Behaviors Among Women in Rhode Island and the United States

	Rhode Island	United States*
Preventive Care		
Percent of Women Aged 50 and Older Who Have Had a Mammogram in the Past Two Years, 2000[a]	79.7	71.1
Percent of Women Aged 18 and Older Who Have Had a Pap Smear in the Past Three Years, 2000[a]	88.5	86.8
Percent of Women Aged 18 and Older Who Have Been Screened for Cholesterol in the Past Five Years, 1997[b]	77.5	71.2
Health Behaviors		
Percent of Women Who Smoke (100 or more cigarettes in their lifetime and who now smoke every day or some days),2000[a]	23.0	21.2
Percent of Women Who Report Binge Drinking (Consumption of five or more drinks on at least one occasion during the preceding month), 1997[b]	9.1	6.7
Percent of Women Who Report No Leisure-Time Physical Activity During the Past Month, 2000[a]	30.6	28.6
Percent of Women Who Do Not Eat Five or More Servings of Fruits or Vegetables per Day, 2000[a]	65.1	73.1

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

Source: [a] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001; [b] Centers for Disease Control and Prevention, 2000.

Compiled by the Institute for Women's Policy Research.

Obesity Among Rhode Island Women

Between 1990 and 2000, the percentage of obese women in Rhode Island grew by 50 percent, from 10.4 percent of the population to 15.8 percent. A total of 43.7 percent of Rhode Island women are at risk for poor health because of their weight. While Rhode Island has a low rate of obesity compared with other states, it ranks 43rd in the country for the proportion of women who are overweight (Rhode Island Department of Health, Office of Health Statistics, 2001). The rapid increase in the number of overweight women is likely to result in a significant increase in related chronic diseases.

Table 8.6
Proportion of Rhode Island Women Who Are Overweight, by Race and Ethnicity, 1998-2000*

Race/Ethnicity	Percent
All Rhode Island Women	**43.7%**
White**	42.4%
African American**	59.3%
Hispanic	53.0%

*Data are not statistically reliable for the Asian American and Native American populations in Rhode Island and therefore are not included.
**Non-Hispanic.
Source: Rhode Island Department of Health, Office of Health Statistics, 2001.

For minority women, the problem of overweight and obesity is even greater than it is for white women (see Table 8.6). Among white women, the rate is 42.4 percent, while among African Americans it is 59.3 percent, and among Hispanics it is 53.0 percent.

National data also show that for all ethnic groups, women of lower socioeconomic status (those below 130 percent of the federal poverty limit) are approximately 50 percent more likely to be obese than those of higher economic status (U.S. Department of Health and Human Services, Office of the Surgeon General, 2001).

The health consequences of the trends toward being overweight and toward obesity are significant. Obesity is closely linked to heart disease, type-II diabetes, certain cancers, and osteoarthritis. All of these diseases lead to disability and, often, premature death. Research has shown that poor diet and less active lifestyles are responsible for the epidemic of obesity in the United States (U.S. Department of Health and Human Services, Office of the Surgeon General, 2001). Both obesity and being overweight are usually due to an imbalance between the level of calories taken in and the amount expended through physical activity.

Rhode Island women who are at risk for poor health because of their weight need access to primary care to treat disease and access to preventive care to lower the risk of disease through diet and exercise. Lower-income women, especially those without young children, and minority women often do not have sufficient levels of health insurance or access to primary care. Diet and exercise patterns, shown to be poor for much of the population, are even worse in low-income and minority populations, who often do not have access to

Table 8.7
Proportion of Rhode Island Women Who Eat Five Daily Servings of Fruits and Vegetables, 1998-2000

Race/Ethnicity	Percent
All Rhode Island Women	**31.5%**
White*	32.7%
African American*	22.8%
Hispanic	24.3%

*Non-Hispanic.
Source: Rhode Island Department of Health, Office of Health Statistics, 2001.

(continued on next page)

Table 8.8
Proportion of Rhode Island Women Who Reported No Physical Activity or Activites for Less Than 30 Minutes or Fewer Than Five Times Per Week, 1998-2000

Race/Ethnicity	Percent
All Rhode Island Women	**77.8%**
White*	77.1%
African American*	82.7%
Hispanic	80.6%

*Non-Hispanic.
Source: Rhode Island Department of Health, Office of Health Statistics, 2001.

physicians or culturally appropriate education on good nutrition and exercise. These women also live predominantly in neighborhoods where fresh fruits and vegetables are less available and the streets are unsafe for outdoor exercise (U.S. Department of Health and Human Services, Office of the Surgeon General, 2001). As Tables 8.7 and 8.8 show, African American and Hispanic women are much less likely than white women to eat the recommended daily servings of fruits and vegetables or to exercise regularly (note: these data differ from those in Table 8.5 because they are based on different data years).

Solving this growing health problem demands an approach that does not merely focus on managing the clinical consequences of obesity but also addresses prevention through diet and exercise. Policies must encourage broadened access to health care through effective programs such as the RIte Care program, which provides comprehensive health care to eligible uninsured pregnant women, parents, and children up to age 19. Programs should address the particular needs of older women and low-income women, especially those without children, and racial and ethnic minority groups. Nutrition counseling should be a covered service in health plans. In addition, broader, population-based approaches are also necessary:

- Communities should set a goal of walkable, safe neighborhoods, especially in urban areas.
- Communities can encourage lifelong patterns of physical exercise by strengthening physical education in the schools.
- Communities should encourage young women to play sports, especially those that can be continued in adulthood.
- Communities should ensure the availability of affordable indoor exercise areas located in all neighborhoods, particularly those that currently lack such facilities. Public school buildings can be effectively used in the evening for community exercise programs.
- Communities should encourage the development of culturally and age-appropriate programs through existing neighborhood organizations.
- Communities should encourage neighborhood grocers to supply fresh produce at affordable prices.
- Rhode Island's government should provide incentives to employers to offer worksite exercise options.

In contrast, women in Rhode Island engage in relatively poor health habits. The percentages of Rhode Island women who smoke, binge drink (five or more alcoholic beverages at one time during the past month), and engage in no leisure-time physical activity are all worse than the medians for all states. The percent of women who do not eat five or more servings of fruits or vegetables, on the other hand, is somewhat better than the median (65.1 versus 73.1, respectively; for more information on health habits in Rhode Island, see Obesity among Rhode Island Women).

State Health Policies and Resources

State policies can contribute to women's health status in important 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. Consequently, over 50 percent more women receive Medicaid benefits than men (U.S. Department of Health and Human Services, Health Care Financing Administration, 1999). In Rhode Island, more women than men receive health insurance from public sources (7.6 percent versus 6.8 percent; see Table 6.1).

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 8.9 shows the level of Medicaid spending per adult enrollee in Rhode Island ("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). At $1,998, Rhode Island's spending was above the average among all states of $1,892 per adult enrollee in 1998. State and federal policy should ensure that, as men and women move off welfare, they do not lose access to health insurance.

Studies show that the quality of insurance coverage largely affects women's access to certain health resources and, consequently, their health status (Mead, et al., 2001). In order to advance women's and men's access to adequate health-related

Table 8.9
Health Policies and Resources in Rhode Island and the United States

	Yes	No	Other Information	Total or Average, United States (of 51)
Medicaid Spending per Adult Enrollee, 1998[c]			**$1,998**	**$1,892**
Does Rhode Island require insurance companies to:				
Cover screenings for cervical cancer?[a]	✓			25
Cover screenings for osteoporosis?[a]		✓		12
Cover inpatient care for a defined period after a mastectomy?[a]	✓			18
Allow women to identify a specialist in obstetrics and gynecology as their primary care physician or allow direct access to one?[a]	✓			39
Cover or offer at least one policy covering mental health services at the same level as other health services?[b]	✓			21

Source: [a] Plaza, 2001b; [b] National Conference of State Legislatures Health Policy Tracking Service, 2001; [c] Kaiser Commission on Medicaid and the Uninsured, 2001.
Compiled by the Institute for Women's Policy Research.

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 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, Rhode Island has many state insurance mandates important to women, including mandated coverage for cervical cancer screenings, inpatient care after mastectomies, direct access to gynecologists, and mental health services. Women in the state would benefit from mandated coverage for osteoporosis screenings.

9. Conclusions and Policy Recommendations

Women in Rhode Island have not achieved equality with Rhode Island men. Women here exemplify both the achievements and shortfalls of women's progress over the past centuries. Many important problems and obstacles remain that require attention to the special needs of women of all ages and backgrounds in the state.

In the various areas measured in this report—political participation, employment and earnings, social and economic autonomy, reproductive rights, and health and well-being—Rhode Island ranks among the top states in the nation in some areas, but it is among the bottom states in others. The same can be said when Rhode Island is compared with its neighboring states in New England.

On the other hand, effective state policies have made Rhode Island a leader in the nation in several areas. For example, women in Rhode Island have the highest levels of health insurance coverage in the country. In addition, Rhode Island is one of the few states that require insurance policies to cover both contraceptives and infertility treatments. Rhode Island is also one of the few states in the nation that has both a state commission for women and a women's legislative caucus.

These are clear examples of how strong government policies can help level the field for women in Rhode Island and can place Rhode Island in a leadership position in the nation. Rhode Island has proven – in some areas – that this can be done!

Despite Rhode Island's strong performance in certain areas, however, women in the state have not achieved equality or equity with men. Women in Rhode Island still face significant problems that demand attention from policymakers, women's advocates, and researchers concerned with women's status.

In comparison to other states in the nation (based on what other states have achieved so far and women's ideal status), Rhode Island's women's status gets grades of:

- **B** in reproductive rights,
- **C+** in social and economic autonomy,
- **C+** in employment and earnings,
- **C** in health and well-being, and
- **D** in political participation.

These grades are not acceptable. In addition, among the six states of New England, Rhode Island ranks extremely low:

- **Fourth** for reproductive rights,
- **Fifth** for social and economic autonomy,
- **Fifth** for employment and earnings,
- **Last** for political participation, and
- **Last** for health and well-being.

So what can be done?

In the area of **political participation**, Rhode Island receives a **D**, ranking 32nd out of 50 states and lowest in the New England region. Rhode Island women are far from achieving political representation in proportion to their share of the population. They have among the lowest levels of elected representation in state and national offices in the country.

Currently, Rhode Island has no women in any executive elected office in the state or in the U.S. Congress. Yet, women represent 52 percent of the state's population. Moreover, greater female political participation can result in more women-friendly policies (Caiazza, 2002). One barrier for women is today's costly campaign process. Women often have

less access to the economic resources required to make them competitive candidates.

Rhode Island ranks high for institutional political representation by having both a commission for women and a women's legislative caucus. These two institutions, however, would nonetheless benefit from budgetary increases that would guarantee their existence and enhance their effectiveness.

Policy recommendations:

- State-level campaign finance reforms, such as public funding, should be adopted to encourage a wider array of candidates, including women and minorities, to run for office.

- Political parties should encourage women in leadership positions to run for office and should invest resources and offer endorsements on their behalf.

In the area of **employment and earnings**, Rhode Island ranks 16th in the nation and fifth in the New England region, receiving an overall **C+** rating.

Rhode Island women made 71.5 percent of what men earned in 1999 for full time, year-round work. Although Rhode Island ranks relatively high for women's median annual earnings, the state ranks lower (fourth among the New England states and 30th in the nation) in the ratio of women's to men's earnings. In addition, only *18 percent of older women, as opposed to 30 percent of men, are receiving pensions and other retirement income.* And for those receiving pension benefits, median benefits for women are $3,800, compared to $12,000 for men.

An important finding in women's employment – with clear policy implications – is that a *larger percentage of women with children under 18 (73 percent) are in the labor force in Rhode Island than are in the rest of the nation (68 percent).* Among women with children under age six, 71 percent are in the labor force. These facts underscore the need for high quality child care.

Policy recommendations:

- Women's wages should be raised by policies such as stronger enforcement of equal employment opportunity laws, improved educational activities, higher minimum wages, living wage ordinances, or the implementation of pay equity adjustments in the state civil service and in the private sector.

- Because women are more dependent on Social Security (since they earn less and have fewer and smaller pension plans), and they live longer than men, the state needs to develop effective policies to increase women's economic self-sufficiency later in life.

- Since women tend to be the primary caregivers, women workers would benefit from the greater provision of high quality, affordable child care and from mandatory paid parental and dependent-care leave policies.

In the area of **social and economic autonomy**, Rhode Island gets a grade of **C+** and ranks of 14th in the nation and fifth in the New England region. Women in Rhode Island have the highest levels of health insurance coverage in the country. *Regionally, however, Rhode Island women have the second lowest rates of educational attainment and the second highest rates of poverty.* The proportion of Rhode Island women older than 25 without a high school diploma is larger than that of women in the United States (29 percent to 25 percent). And 11 percent of women, compared to only six percent of men, aged 18 and older live in poverty.

Policy recommendations:

- Educational opportunities for women of all ages should be created and widely publicized, since higher educational attainment by women results in fewer unwanted pregnancies and lower poverty rates.

- The state can reduce poverty by implementing welfare reform packages that provide meaningful educational and employment opportunities while maintaining a basic safety net (including health care and child care benefits) for those who are earning low wages or who cannot work.

- Women's economic security can be improved by greater state emphasis on child support collection and improved access to unemployment insurance, Medicaid, and food stamps.

In the area of **reproductive rights**, Rhode Island guarantees many of the rights identified as essential, and the state ranks tenth in the country and fourth in the region. The state gets an overall grade of **B**. The state allows access to abortion without a waiting period, and it requires health insurers to cover contraceptives and infertility treatments. Rhode Island also requires students to take sex education classes.

Rhode Island fails in some areas, however: it requires parental consent for abortions and lacks public funding for abortion. In addition, *only 33 percent (compared to 39 percent nationally) of all women who are in need of publicly supported contraceptive services are being served. For teenagers, the gap is even bigger: only 21 percent of teenage women in need of publicly supported contraceptive services are being served compared to 37 percent in the rest of the nation.*

Policy recommendation:

- Rhode Island should make a commitment to expand publicly supported contraceptive services for women of all ages.

In the area of **health and well-being**, Rhode Island receives an overall **C** rating, ranking 26th in the nation and last in the New England region. Rhode Island women have among the worst mortality rates from heart disease and breast cancer, ranking in the bottom ten nationally and last regionally. These poor rankings might be related to the fact that women in Rhode Island engage in relatively poor health habits: the percentages of women who smoke, binge drink, and do not engage in leisure-time physical activity are all higher than in most states.

In addition, a disproportionate burden of disease is borne by African American women, as seen in their annual mortality rates from heart disease (195 deaths per 100,000 compared to 160 for whites) and lung cancer (62 deaths per 100,000 compared to 47 for whites). Hispanic (32 per 100,000) and African American (79 per 100,000) women also have a much higher incidence of AIDS than white women (3 per 100,000) in the state. These rates are also higher than those of Hispanic and African American women nationally.

Policy recommendations:

- Women must have access to health insurance that includes comprehensive coverage for screenings and other preventive measures, especially since more women than men receive health insurance from public sources (7.6 percent versus 6.8 percent).

- Public health efforts need to target early screenings and lifestyle changes to reduce mortality from heart disease, lung cancer, and breast cancer.

- Special preventive programs need to be targeted to minority populations to address health disparities, especially in heart disease, cancer, and AIDS.

This report is based on available data that map the progress made over time in the different areas indicating the overall quality of life for women. It is essential that the state continuously maps the quality of life for its women and monitors their equality and equity with men. *With this in mind, the final policy recommendation from this report is: the state of Rhode Island should require that all state- and federally-funded programs standardize their reports to ensure that quality data is available by race, ethnicity, gender, and income.* These data are essential to monitor the status of all Rhode Islanders and identify successful interventions on behalf of all women in the state.

The findings from this study demonstrate that Rhode Island shows both the advances and limited progress achieved by women in the United States. Many Rhode Island women are witnessing real

improvements in their educational, economic, political, social, and health status. These advances are evident in some relatively high rankings for Rhode Island women's status compared with other states. **But the limited progress is simply not acceptable. Far too many important problems and critical obstacles still face Rhode Island women.** This situation demands the attention of Rhode Island policymakers and activists, women's advocates, and researchers. Now is the time to take action to ensure that social justice and equality are achieved for all women in the state.

The Rhode Island Advisory Committee

Appendices

Table of Appendices

Appendix I: Basic Demographics

This Appendix includes data on different populations within Rhode Island. 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, as well as information on women in prisons. These data present an image of the state's female 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, Rhode Island has an older population, smaller proportions of African American, Hispanic, Asian, and Native American women, a larger proportion of foreign-born women, and a considerably higher 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.

Rhode Island has the ninth smallest population among all the states in the United States. There were more than half a million women of all ages in Rhode Island in 2000 (see Appendix Table 1.1). Between 1990 and 2000, the population of Rhode Island increased by 4.5 percent. The population of the nation as a whole grew by 13.2 percent. Compared with its region, Rhode Island's population growth rate ranks fourth.

White women are a much larger share of the female population in Rhode Island than they are in the United States as a whole, at 82.3 percent of women in the state (compared with 69.3 percent of women in the nation as a whole). Of all the racial/ethnic groups in Rhode Island, Hispanic women make up the next largest group of women in Rhode Island, at 8.5 percent, a proportion that is lower than the national average (12.0 percent). At the same time, between 1990 and 2000 the proportion of Hispanic women more than doubled (from 4.2 to 8.5 percent; data not shown). The other groups combined make up 9.2 percent of the female population in Rhode Island, compared with 18.7 percent nationally (for more information, see Rhode Island Women: Changing Demographics of Age and Race/Ethnicity).

The proportion of married women in Rhode Island is lower than in the country as a whole, while the proportion of single women is higher. The proportions of divorced and widowed women are about the

same as in the nation as a whole. Rhode Island's distribution of family types is similar to that in the nation overall. The proportion of single-person households is larger than in the nation as a whole (28.6 percent versus 25.8 percent), while the proportion of married-couple families is smaller (48.2 versus 51.7 percent). The proportions of female- and male-headed households and other household types

Appendix Table 1.1
Basic Demographic Statistics for Rhode Island and the United States

	Rhode Island	United States
Total Population, 2000[a]	**1,048,319**	**281,421,906**
Number of Women, All Ages, 2000[a]	544,684	143,368,343
Sex Ratio (women to men, aged 18 and older), 2000[a]	1.1	1.1
Median Age of All Women, 1999[b]	38.0	36.6
Proportion of Women Over Age 65, 2000[a]	17.0%	14.4%
Distribution of Women by Race and Ethnicity, All Ages, 2000[c]		
White*	82.3%	69.3%
African American*	3.8%	12.4%
Hispanic**	8.5%	12.0%
Asian American*	2.2%	3.8%
Native American*	0.4%	0.7%
Other Race*	0.8%	0.2%
Two or More Races*	2.0%	1.6%
Distribution of Households by Type, 2000[a]		
Total Number of Family and Nonfamily Households	408,424	105,480,101
Married-Couple Families (with and without their own children)	48.2%	51.7%
Female-Headed Families (with and without their own children)	12.9%	12.2%
Male-Headed Families (with and without their own children)	3.9%	4.2%
Nonfamily Households: Single-Person Households	28.6%	25.8%
Nonfamily Households: Other	6.5%	6.1%
Distribution of Women Aged 15 and Older by Marital Status, 2000[d]		
Married	51.6%	54.3%
Single	27.0%	24.4%
Widowed	10.8%	10.2%
Divorced	10.5%	11.1%
Number of Lesbian Unmarried Partner Households, 2000[e]	**1,299**	**293,365**
Proportion of Women Aged 21-64 with a Disability, 2001[f]	**13.6%**	**13.9%**
Percent of Families with Children Under Age 18 Headed by Women, 2000[c]	**24.7%**	**20.6%**
Proportion of Women Living in Metropolitan Areas, All Ages, 1990[g]	**100.0%**	**83.1%**
Proportion of Women Who Are Foreign-Born, All Ages, 1990[g]	**9.6%**	**7.9%**
Percent of Federal and State Prison Population Who Are Women, 2000[h]	**7.2%**	**6.6%**

* Non-Hispanic.
** Hispanics may be of any race.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 2001b; [b] U.S. Department of Commerce, Bureau of the Census, 2000b; [c] U.S. Department of Commerce, Bureau of the Census, 2002a; [d] U.S. Department of Commerce, Bureau of the Census, 2001e; [e] Smith and Gates, 2001; [f] U.S. Department of Commerce, Bureau of the Census, 2001c; [g] Population Reference Bureau, 1993; [h] U.S. Department of Justice, Bureau of Justice Statistics, 2001.
Compiled by the Institute for Women's Policy Research.

in Rhode Island are about the same as in the nation as a whole. Families with children under age 18 that are headed by women constitute 24.7 percent of all families with children in Rhode Island, a larger proportion than the 20.6 percent nationwide. In 2000, 1,299 lesbian unmarried partner households were reported in Rhode Island, with a total of 293,365 nationwide.

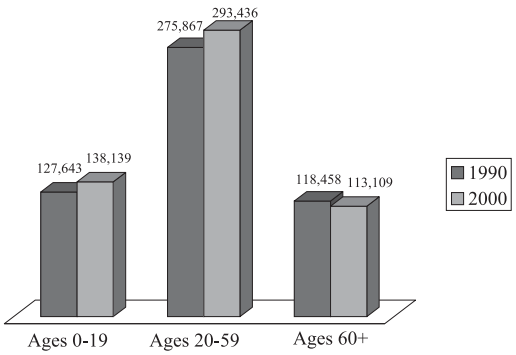
Rhode Island's proportion of women living in metropolitan areas is substantially higher than in the nation overall (100.0 percent compared with 83.1 percent of women in the United States). The percent of Rhode Island's prison population that is female is also higher than the national average. Rhode Island had a much larger foreign-born female population than the United States as a whole in 1990 (9.6 percent compared with 7.9 percent; while 2000 numbers for foreign-born women were not yet available at this writing, 11.4 percent of all Rhode Island residents and 11.1 percent of United States residents were foreign-born in 2000). Rhode Island's proportion of women aged 21-64 with a disability is about the same as the nation overall, at 13.6 percent compared with 13.9 percent.

Rhode Island Women: Changing Demographics of Age and Race/Ethnicity

Age

- In 2000, the Rhode Island female population was 544,684 (see Appendix Table 1.1).
- Rhode Island had more female children and adolescents aged 0 to 19 in 2000 than in 1990. This young population increased eight percent during these ten years (see Appendix Figure 1.1).
- The number of elderly women in Rhode Island has grown substantially since 1990. In 1990, the state had 25,176 women aged 80 and over. By 2000, the number had grown 22 percent to 30,828 (U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1990).

Appendix Figure 1.1
Population of Rhode Island Women by Age, 1990 and 2000



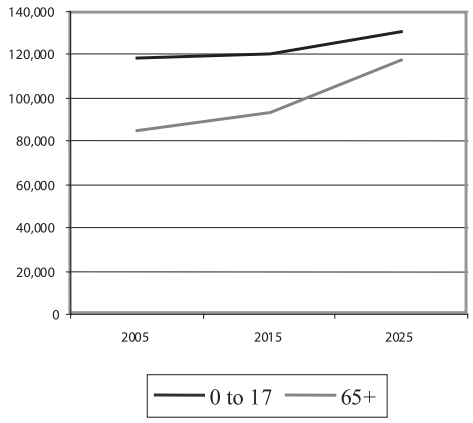
Source: U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1990.

- At the same time, the number of women aged 60 and over decreased from 118,458 to 113,109.

Age Projections, 2005 to 2025

- During the next 25 years, the number of women age 65 and over in Rhode Island is expected to rise dramatically. In 2000, there were 92,400 women age 65 or over in Rhode Island; in 2025, the number is expected to rise to 118,000. This is an increase of 28 percent (U.S. Department of Commerce, Bureau of the Census, 2000; see Appendix Figure 1.2).
- The number of female children and adolescents ages 0 to 17 is also expected to increase, especially between 2015 and 2025.
- These statistics reflect demographic changes with profound social policy implications. Although most women will be in their childbearing and work stages of life, the increasing number of school-age girls emphasizes the importance of strong education policies. The dramatic growth in the elderly population also points to the need for services for the unique needs of these women.

Appendix Figure 1.2
Projected Population Growth Among Rhode Island Women by Age, 2005-2025



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

(continued on next page)

Race and Ethnicity

- The majority of women in Rhode Island are white. However, the number of women identified as white decreased from 478,851 in 1990 to 464,818 in 2000 (this is partially due to a different categorization system used in the 2000 Census, however; see Appendix Table 1.2).

- Non-white racial groups saw major population increases between 1990 and 2000. The African American population increased by 20 percent to 23,285; the Native American population increased by 25 percent to 2,633; and the Asian American population increased by 36 percent to 12,438.

- The Hispanic population in Rhode Island saw the largest increase of any single racial or ethnic group. The female Hispanic population more than doubled between 1990 and 2000, from 22,903 to 46,055.

Appendix Table 1.2
Distribution of Rhode Island Women by Race and Ethnicity, 2000

Race/Ethnicity	Population Percent	Change from 1990*
White	464,818	-3%
African American	23,285	+20%
Asian/Pacific Islander	12,438	+36%
Native American	2,633	+25%
Other†	26,858	+116%
Two or more races	14,652	NA
Hispanic (of any race)	46,055	+101%

*Data on race from Census 2000 are not directly comparable with those from the 1990 Census, largely because respondents have a new option to report more than one race. Comparisons presented here show general trends but do not reflect exact measures of growth.

†Respondents who classify themselves as "other race" on the Census do not wish to identify as white, African American, Asian American, or any other specific racial category.

Source: U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1990.

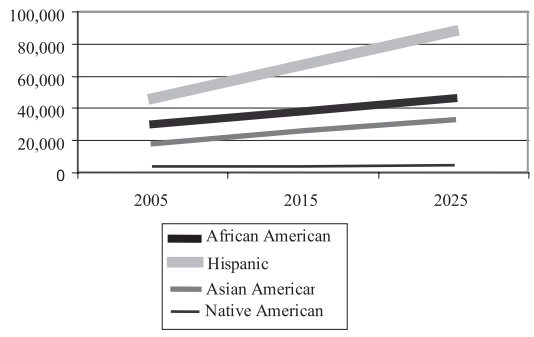
Race and Ethnicity Projections, 2005 to 2025

- During the next 25 years, non-white racial and ethnic groups are expected to make the greatest population increases. While the white female population will grow an estimated seven percent between 2000 and 2025, most other racial and ethnic groups will increase between 90 and 165 percent (U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1996).

- The Hispanic female population is expected to grow 91 percent during the next 25 years; the African American female population is expected to grow 98 percent; and the Asian American population is expected to grow 165 percent (U.S. Department of Commerce, Bureau of the Census, 2000; U.S. Department of Commerce, Bureau of the Census, 1996).

- Women of color are overrepresented among the poor and recent immigrants in this country, putting them at greater social and economic risk than other women. Improved access to education and training in Rhode Island is particularly important to serve the state's changing population of women.

Appendix Figure 1.3
Projected Population Growth Among Rhode Island Women by Race and Ethnicity (non-White), 2005-2025



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

Appendix II: Methodology, Terms, and Sources for Chart 2.1 (the Composite Indices and Grades)

Composite Political Participation Index

This composite index reflects four areas of political participation: voter registration; voter turnout; women in elected office, including state legislatures, statewide elected 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 for a state and dividing the difference by the standard deviation for the United States as a whole. The standardized scores were then given different weights. Voter registration and voter turnout were each given a weight of 1.0. The indicator for women in elected office is itself a composite reflecting different levels of office-holding and was given a weight of 4.0 (in the first two series of reports, published in 1996 and 1998, this indicator was given a weight of 3.0, but since 2000 it has been weighted at 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" (see Appendix Chart 2.1). 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. Each state's score was then compared with the ideal score to determine its grade.

Women's Voter Registration: This component indicator is the average percent (for the presidential and congressional elections of 2000 and 1998) 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, 2000c and 2002c, based on the Current Population Survey.

Women's Voter Turnout: This component indicator is the average percent (for the presidential and congressional elections of 2000 and 1998) 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, 2000c and 2002c, 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 April 2002. 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 4.28. 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, 2002a, 2002b, 2002c, and 2002d; Council of State Governments, 2000.

Appendix Chart 2.1
Criteria for Grading

Index	Criteria for a Grade of "A"	Highest Grade, U.S.
Composite Political Participation Index		**B**
Women's Voter Registration	Women's Voter Registration, Best State (91.1%)	
Women's Voter Turnout	Women's Voter Turnout, Best State (67.9%)	
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		**A-**
Women's Median Annual Earnings	Men's Median Annual Earnings, United States ($36,960)	
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 (74.7%)	
Women in Managerial and Professional Occupations	Women in Managerial and Professional Occupations, Best State (48.0%)	
Composite Social and Economic Autonomy Index		**B+**
Percent of Women with Health Insurance	Percent of Women with Health Insurance, Best State (94.0%)	
Women's 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 (94.9%)	
Composite Reproductive Rights Index	Presence of All Relevant Policies and Resources (see Chart 7.1 Panel B)	**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)	**A-**

Calculated by the Institute for Women's Policy Research.

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 for Women, 2000, and Center for American Women and Politics, 1998, updated by IWPR.

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 first standardized. 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 ratio was set at 100 percent, as if women earned 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 determine the state's grade.

Women's Median Annual Earnings: Median yearly earnings (in 2000 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 1998, 1999, and 2000. 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 data are referred to as 1999 data, the midpoint of the three years analyzed. The sample size for women ranges from 560 in Rhode Island to 5,174 in California; for men, the sample size ranges from 685 in the District of Columbia to 7,906 in California. In Rhode Island, the sample size was 560 for women and 762 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: IWPR calculations of the 1999-2001 Annual Demographic Files (March) from the Current Population Survey, for the 1998-2000 calendar years; IWPR, 2001b.

Ratio of Women's to Men's Earnings: Median yearly earnings (in 2000 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 1998-2000 divided by the median yearly earnings (in 2000 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 1998-2000. See the description of women's median annual earnings above for a more detailed description of the methodology and for sample sizes. Source: IWPR calculations of the 1999-2001 Annual Demographic Files (March) from the Current Population Survey, for the 1998-2000 calendar years; IWPR, 2001b.

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 2000). This includes those employed full-time, part-time voluntarily or part-time involuntari-

ly, and those who are unemployed. Source: U.S. Department of Labor, Bureau of Labor Statistics, 2002 (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 1999). Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001a (based on the Current Population Survey).

Composite Social and Economic Autonomy Index

This composite index reflects four aspects of women's social and 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 first standardized. 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. To create the composite score, women's health insurance coverage, educational attainment, and business ownership were given a weight of 1.0, while poverty was given a weight of 4.0 (in the first three series of reports, published in 1996, 1998, and 2000, this indicator was given a weight of 1.0, but in 2002 IWPR began weighting it at 4.0). 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." The percentage of women with health insurance was set at the highest value for all states; the percentage of women with higher education was set at the national value for men; the percentage of businesses owned by women was set as if 50 percent of businesses were owned by women; and the percentage of women in poverty was set at the national value for men. Each state's score was then compared with the ideal score to determine its grade.

Percent with Health Insurance: Percent of civilian noninstitutionalized women from ages 18 through 64 who are insured. The state-by-state percents are based on the 2001 Annual Demographic Files (March) from the Current Population Survey, for calendar year 2000. Respondents are asked whether they had insurance from a variety of different sources during the previous year. They are counted as uninsured if they did not have health insurance for the entire year 2000. Because respondents are asked to report about all sources of insurance over the past year, some report insurance from more than one source. It is impossible to determine whether they had had more than one type simultaneously or changed sources of insurance over the course of the year. In 2001, the CPS included an expanded sample to improve state estimates of uninsured children. The expanded sample was not used in these estimates, however, because it was not yet available. Source: Employee Benefit Research Institute, 2001.

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 1997, the percent of all firms (legal entities engaged in economic activity during any part of 1997 that filed an IRS Form 1040, Schedule C; 1065; any 1120; or 941) owned by women. This indicator includes five legal forms of organization: C corporations (any legally incorporated business, except subchapter S, under state laws), Subchapter S corporations (those with fewer than 75 shareholders who elect to be taxed as individuals), individual proprietorships (including self-employed individuals), partnerships, and others (a category encompassing cooperatives, estates, receiverships, and businesses classified as unknown legal forms of organization). The Bureau of the Census determines the sex of business owners by matching the social security numbers of individuals who file business tax returns with Social Security Administration records providing the sex codes indicated by individuals or their parents 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. Source: U.S. Department of Commerce, Bureau of the Census, 2001f, based on the 1997 Economic Census.

Percent of Women Above Poverty: In 1998-2000, 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 1999, the poverty level for a family of four (with two children) was $17,463 (in 2000 dollars). Source: IWPR calculations of the 1999-2001 Annual Demographic Files (March) from the Current Population Survey for the calendar years 1998-2000; IWPR, 2001b.

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 or notification laws for minors; access to abortion services without a waiting period; public funding for abortions under any circumstances if a woman is income eligible; percent of women living in counties with at least one abortion provider; whether the governor and state legislature are pro-choice; existence of state laws requiring health insurers to provide coverage of contraceptives; policies that mandate insurance coverage of infertility treatments; whether second-parent adoption is legal for gay/lesbian couples; and mandatory sex education for children in the public school system.

To construct this composite index, each component indicator was rated on a scale of 0 to 1 and assigned a weight. The notification/consent 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/consent 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 determine its 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, 2002.

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, 2002.

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, 2002.

Percent of Women Living in Counties with at Least One Abortion Provider: 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, 2001.

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: The Alan Guttmacher Institute, 2002a.

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: Plaza, 2001a.

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: National Center for Lesbian Rights, 2001.

Mandatory Sex Education: States received a score of 1.0 if they require public middle, junior, or high schools to provide sex education classes. Source: The Alan Guttmacher Institute, 2002b.

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 lung cancer, mortality from breast 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. Lung and breast 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 rates from heart disease, lung cancer, and breast 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, the 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 limita-

tions were also set at the lowest level among all states. Each state's score was then compared with the ideal score to determine the state's grade.

Mortality from Heart Disease: Average annual mortality from heart disease among all women per 100,000 population (in 1996-98). Data are age-adjusted to the 2000 total U.S. population. Source: National Center for Health Statistics, 2001a.

Mortality from Lung Cancer: Average mortality among women from lung cancer per 100,000 population (in 1996-98). Data are age-adjusted to the 2000 U.S. standard population. Source: National Center for Health Statistics, 2001a.

Mortality from Breast Cancer: Average mortality among women from breast cancer per 100,000 population (in 1996-98). Data are age-adjusted to the 2000 U.S. standard population. Source: National Center for Health Statistics, 2001a.

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 2000. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001.

Incidence of Chlamydia: Average rate of chlamydia among women per 100,000 population (2000). Source: Centers for Disease Control, National Center for HIV, STD, and TB Prevention, Division of STD Prevention, 2001.

Incidence of AIDS: Average incidence of AIDS-indicating diseases among females aged 13 years and older per 100,000 population (in 2000). Source: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, 2001.

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 2000. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001.

Mortality from Suicide: Average annual mortality from suicide among all women per 100,000 population (in 1996-98). Data are age-adjusted to the 2000 total U.S. population. Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2001.

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 2000. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2001.

Appendix III: Sources for Chart 3.1 (Women's Resources and Rights Checklist)

Violence Against Women

Separate Offense: States are given a "yes" if they classify domestic violence as an offense separate from general assault and battery or otherwise complement assault and battery laws with domestic violence statutes. These laws or provisions provide enhanced penalties for repeat offenders and help ensure equal treatment for victims of domestic violence. Sources: Institute for Law and Justice, 1999, 2000, and 2001.

Domestic Violence Training: Whether the state has adopted a statute requiring police recruits and health care professionals to undergo training about domestic violence. Sources: Family Violence Prevention Fund, 2001; Institute for Law and Justice, 1999, 2000, and 2001.

Insurance Mandates for Domestic Violence Victims: Whether a state has banned insurance companies from denying coverage to victims of domestic violence. Source: Family Violence Prevention Fund, 2001.

Stalking Offense Status: Whether a state classifies a first offense for stalking as a felony. Sources: Institute for Law and Justice, 1999, 2000, and 2001.

Sexual Assault Training: Whether a state has adopted a legislative requirement mandating sexual assault training for police, prosecutors, and health care professionals. Source: Family Violence Prevention Fund, 2001; Institute for Law and Justice, 1999, 2000, and 2001.

Child Support

Single-Mother Households Receiving Child Support or Alimony: A single-mother household is defined as a family headed by an unmarried 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, 2001). Figures are based on an average of data from the Current Population Survey for 1997-99. Source: Annie E. Casey Foundation, 2001.

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, 2000b.

Welfare and Poverty Policies

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." Sources: Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

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." Sources: Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

Work Requirements: What constitutes work activities is a contentious issue at both the state and federal levels. State policies concerning 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 2002, 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. Sources: Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

Transitional Child Care: Whether a state extends child care to families moving off welfare beyond a minimum of twelve months. Sources: Center for Law and Social Policy and Center for Budget and Policy Priorities, 2000; Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

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 certification or adopted other language providing for victims of domestic violence. Source: NOW Legal Defense and Education Fund, 2001.

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. States that disregard at least 50 percent of low-income workers' earnings are indicated by a "yes." Sources: Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

Size of TANF Benefit: Maximum monthly benefit received by TANF recipient families in a state (for a family of three with two children) in 2001. Sources: Welfare Information Network, 2001; Welfare Information Network, et al., 2001.

Earned Income Tax Credit: Whether a state has implemented a state EITC for low-income families. Source: Johnson, 2001.

Employment/Unemployment Benefits

Minimum Wage: States receive a "yes" if their state minimum wage rate as of January 2002 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, 2002.

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, including by pregnancy and childbirth. Source: Hartmann, et al., 1995.

Access to Unemployment Insurance (UI) for Low-Wage Workers: In order to receive unemployment insurance, potential recipients must meet several eligibility requirements. Two of these are high quarter earnings and base period earnings requirements. The "base period" is a twelve-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. They are more than twice as likely as men to be disqualified from receipt of unemployment insurance benefits because of these requirements (Yoon, Spalter-Roth, and Baldwin, 1995). States typically set eligibility standards for unemployment insurance and can enact policies that are more or less inclusive and more or less generous to claimants. For example, some states have implemented an "alternative base period," allowing the most recent earnings to count to the advantage of the claimant.

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 that fell between the "yes" and "no" ranges. Source: U.S. Department of

Labor, Employment and Training Administration, Unemployment Insurance Service, 2001.

Access to Unemployment Insurance for Part-Time Workers: Only nine states and the District of Columbia allow unemployed workers seeking a part-time position to qualify for unemployment insurance. Source: National Employment Law Project, 2001.

Access to Unemployment Insurance for "Good Cause Quits": Twenty-two states offer unemployment insurance 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: National Association of Child Advocates, 1998; National Employment Law Project, 2001.

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.

Family Leave Benefits

Proposed Use of Unemployment Insurance for Paid Family Leave: Recent initiatives in several states have advanced the idea of using unemployment insurance to provide benefits during periods of family leave (sometimes known as "Baby UI"). At the federal level, as of August 2000, the Department of Labor allowed 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. State legislatures must approve plans to use unemployment insurance in this fashion. Source: National Partnership for Women and Families, 2001a; Society for Human Resource Management, 2001.

Temporary Disability Insurance for Family Leave: In three states–Massachusetts, New Jersey, and New York–legislation has been introduced to cover periods of family leave under new or existing mandatory Temporary Disability Insurance programs. In September 2002, California amended its TDI program to include family leave with partial pay for up to six weeks. Source: National Partnership for Women and Families, 2001b.

Sexual Orientation and Gender

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: National Gay and Lesbian Task Force Policy Institute, 2001a.

Same-Sex Marriage: Whether a state has avoided adopting a policy–statute, executive order, or other regulation–prohibiting same-sex marriage. Source: National Gay and Lesbian Task Force Policy Institute, 2001c.

Hate Crimes Legislation: Whether a state has established enhanced penalties for crimes perpetrated against victims due to their sexual orientation or gender identity. Source: National Gay and Lesbian Task Force Policy Institute, 2001b.

Reproductive Rights

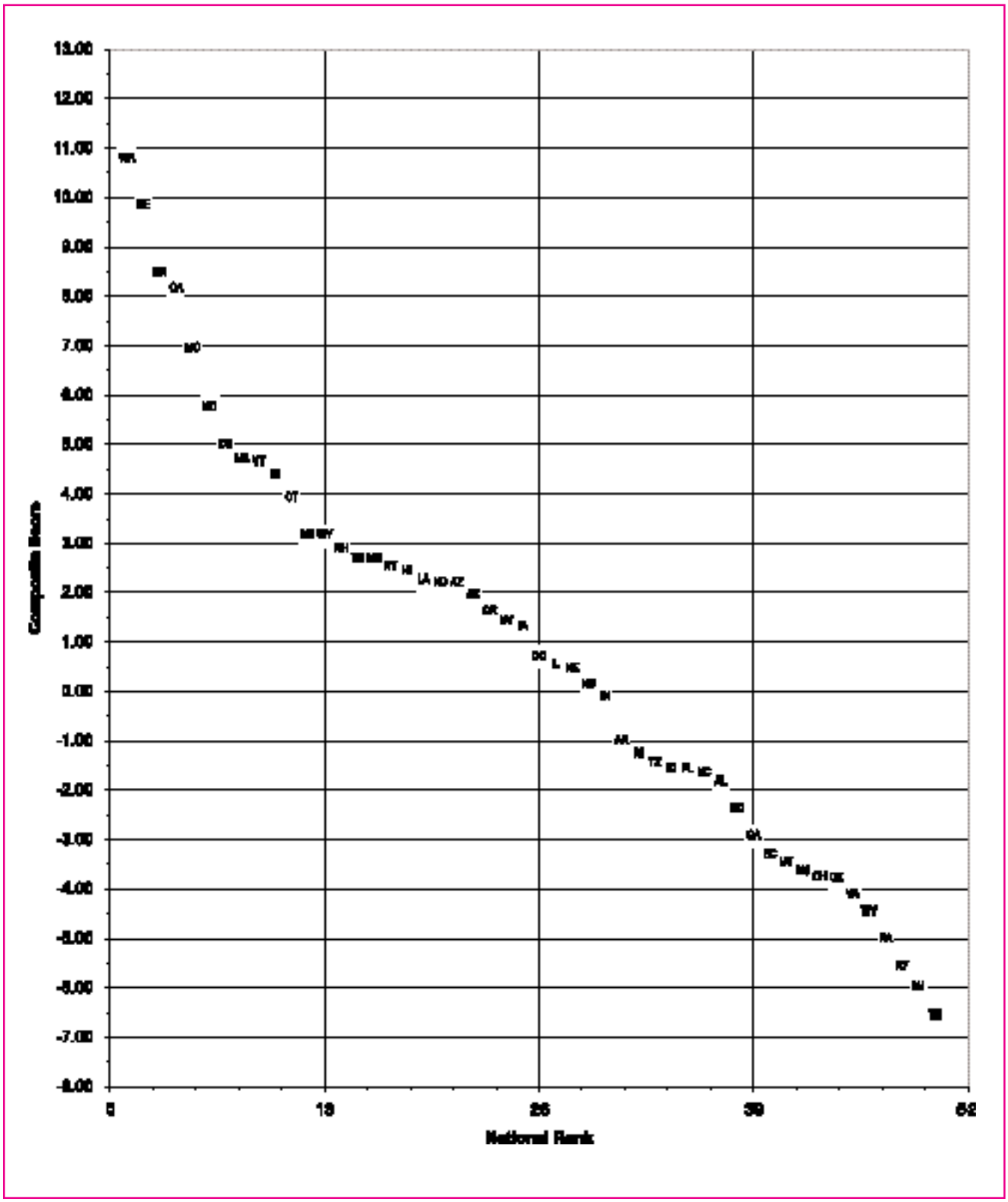
For information on sources concerning these indicators, please see the section describing the Composite Reproductive Rights Index in Appendix II.

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: 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, 1998 and 2000		Percent of Women Who Voted, 1998 and 2000		Number of Institutional Resources Available to Women in the State	
State	**Score**	**Rank**	**Grade**	**Score**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Score**	**Rank**
Alabama	-2.18	37	D	0.94	44	75.0%	5	55.8%	12	1.25	20
Alaska	1.95	22	C	2.08	22	72.8%	12	60.5%	3	0.00	44
Arizona	2.21	21	C	3.33	4	54.2%	47	41.4%	50	0.00	44
Arkansas	-0.98	31	D+	2.03	23	63.9%	37	47.5%	36	0.50	41
California	8.18	4	B	3.87	2	53.6%	48	44.3%	44	2.00	1
Colorado	0.72	26	C-	2.12	21	67.8%	21	53.8%	18	0.25	42
Connecticut	3.93	11	C+	2.62	9	66.8%	27	50.6%	32	1.25	20
Delaware	5.01	7	C+	2.88	6	67.2%	25	51.5%	30	1.00	31
District of Columbia	n/a	n/a	n/a	n/a	n/a	72.0%	n/a	59.4%	n/a	n/a	n/a
Florida	-1.56	35	D	1.52	33	61.8%	44	46.9%	40	2.00	1
Georgia	-2.91	39	D	1.33	38	62.6%	40	43.7%	47	2.00	1
Hawaii	2.44	18	C	2.77	7	51.0%	50	43.9%	46	2.00	1
Idaho	-1.55	34	D	1.55	31	62.9%	39	52.0%	25	1.25	20
Illinois	0.56	27	C-	1.63	28	67.1%	26	52.0%	25	2.00	1
Indiana	-0.08	30	C-	1.55	31	66.8%	27	50.9%	31	2.00	1
Iowa	1.33	25	C	1.60	29	75.3%	4	59.6%	8	1.00	31
Kansas	0.15	29	C-	2.16	19	67.8%	21	51.7%	27	0.00	44
Kentucky	-5.55	48	D-	0.74	49	67.8%	21	49.6%	34	1.00	31
Louisiana	2.28	19	C	1.78	27	74.9%	6	51.7%	27	2.00	1
Maine	9.86	2	B	3.56	3	78.8%	3	60.1%	6	0.00	44
Maryland	5.77	6	B-	2.69	8	65.3%	33	54.2%	16	2.00	1
Massachusetts	4.72	8	C+	2.43	12	68.1%	20	53.2%	22	2.00	1
Michigan	4.40	10	C+	2.38	14	71.9%	13	56.3%	11	1.25	20
Minnesota	8.48	3	B	2.56	11	81.0%	2	67.9%	1	1.25	20
Mississippi	-3.63	42	D-	0.76	48	74.8%	7	52.5%	23	1.25	20
Missouri	6.97	5	B-	2.59	10	74.5%	9	56.5%	10	2.00	1
Montana	3.19	12	C	2.37	16	73.1%	11	59.4%	9	0.00	44
Nebraska	0.48	28	C-	1.57	30	71.9%	13	53.9%	17	1.50	16
Nevada	1.42	24	C	2.92	5	51.6%	49	41.8%	48	1.00	31
New Hampshire	2.89	14	C	2.37	16	67.5%	24	53.3%	21	1.00	31
New Jersey	-5.95	49	F	0.94	44	63.1%	38	45.3%	41	1.00	31
New Mexico	2.71	16	C	2.38	14	62.4%	41	51.7%	27	1.50	16
New York	2.55	17	C	2.41	13	59.8%	46	47.5%	36	2.00	1
North Carolina	-1.63	36	D	1.38	35	65.9%	32	47.0%	39	2.00	1
North Dakota	2.22	20	C	1.13	40	91.1%	1	63.3%	2	1.25	20
Ohio	-3.75	43	D-	1.36	36	66.3%	30	52.5%	23	0.00	44
Oklahoma	-3.76	44	D-	1.12	42	66.6%	29	48.1%	35	1.25	20
Oregon	1.63	23	C	1.88	25	69.9%	16	55.6%	13	1.25	20
Pennsylvania	-5.01	47	D-	0.93	46	62.3%	42	47.3%	38	1.50	16
Rhode Island	-1.25	32	D	1.13	40	68.3%	18	54.9%	15	2.00	1
South Carolina	-3.29	40	D-	0.60	50	71.2%	15	55.6%	13	2.00	1
South Dakota	-2.37	38	D	1.52	33	69.7%	17	53.4%	19	0.00	44
Tennessee	-6.55	50	F	0.80	47	64.2%	36	44.7%	42	1.00	31
Texas	-1.44	33	D	2.03	23	62.1%	43	41.7%	49	1.00	31
Utah	-3.45	41	D-	1.35	37	61.6%	45	49.7%	33	1.00	31
Vermont	4.66	9	C+	2.17	18	73.8%	10	60.1%	6	1.50	16
Virginia	-4.09	45	D-	1.01	43	64.5%	34	44.3%	44	2.00	1
Washington	10.80	1	B	4.28	1	66.0%	31	53.4%	19	0.25	42
West Virginia	-4.44	46	D-	1.17	39	64.4%	35	44.4%	43	1.25	20
Wisconsin	2.71	15	C	1.81	26	74.6%	8	60.2%	5	1.25	20
Wyoming	3.16	13	C	2.16	19	68.2%	19	60.3%	4	1.00	31
United States				**1.89**		**64.6%**		**49.3%**		**1.25**	**(median)**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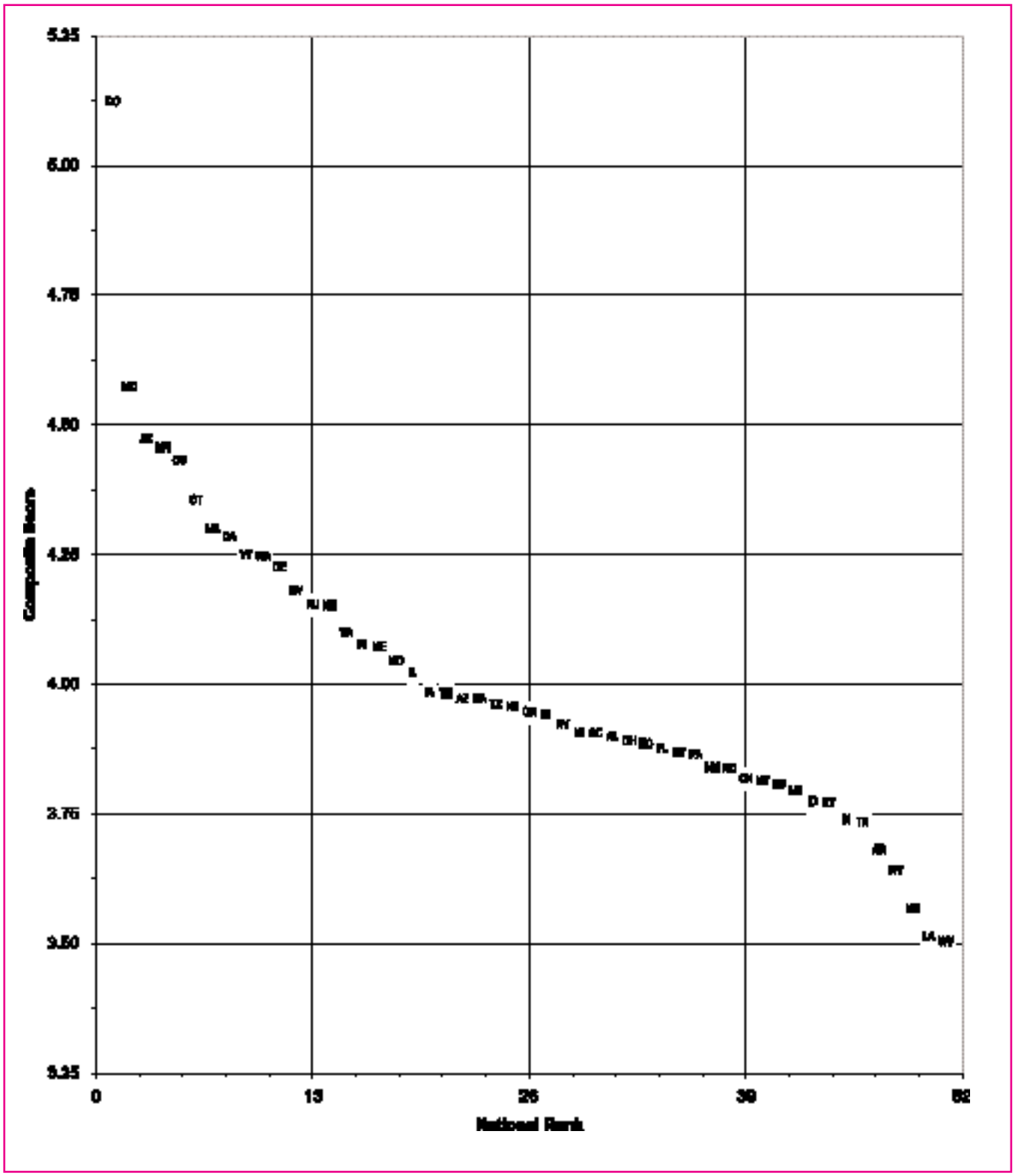
39
52
National Rank

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

	Composite Index			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	3.90	30	C	$25,850	25	76.5%	11	56.9%	45	30.3%	30
Alaska	4.47	3	B	$31,680	2	76.9%	7	67.8%	4	35.7%	6
Arizona	3.97	22	C+	$26,400	20	78.8%	5	56.6%	46	31.1%	26
Arkansas	3.68	47	D-	$22,176	45	74.0%	20	56.1%	47	29.2%	40
California	4.28	8	B	$29,986	10	81.1%	2	59.1%	37	34.5%	12
Colorado	4.43	5	B	$29,568	11	75.3%	16	65.5%	10	38.9%	3
Connecticut	4.35	6	B	$31,680	2	69.6%	41	62.9%	22	37.8%	4
Delaware	4.23	11	B-	$29,568	11	80.0%	4	63.8%	18	31.1%	26
District of Columbia	5.12	1	A-	$35,776	1	89.2%	1	64.7%	13	48.0%	1
Florida	3.88	33	C-	$25,850	25	78.3%	6	55.7%	49	29.4%	38
Georgia	3.97	22	C+	$25,344	30	72.4%	25	63.3%	19	31.6%	23
Hawaii	3.94	27	C	$26,400	20	72.1%	27	62.6%	24	29.8%	33
Idaho	3.77	43	D	$24,000	40	75.8%	14	61.9%	27	26.1%	51
Illinois	4.02	19	C+	$28,000	14	69.4%	42	63.1%	20	31.5%	24
Indiana	3.74	45	D	$25,000	34	67.6%	47	59.8%	34	28.5%	44
Iowa	3.98	20	C+	$25,340	33	74.1%	19	65.7%	8	30.0%	32
Kansas	3.96	24	C+	$25,344	30	72.4%	25	65.7%	8	29.8%	33
Kentucky	3.77	43	D	$24,288	39	71.4%	32	57.9%	40	29.7%	36
Louisiana	3.51	50	F	$22,176	45	65.2%	50	54.2%	50	28.7%	42
Maine	4.07	17	C+	$25,850	25	76.0%	13	63.9%	17	32.3%	19
Maryland	4.57	2	B+	$31,680	2	76.6%	9	64.3%	14	41.0%	2
Massachusetts	4.30	7	B	$30,264	7	75.4%	15	61.4%	30	35.9%	5
Michigan	3.91	29	C	$28,000	14	67.7%	45	61.5%	29	29.4%	38
Minnesota	4.46	4	B	$30,659	6	76.6%	9	70.3%	1	35.2%	9
Mississippi	3.57	49	F	$21,714	49	68.5%	44	57.0%	44	28.0%	46
Missouri	4.04	18	C+	$26,400	20	72.9%	23	64.3%	14	31.9%	20
Montana	3.81	40	D+	$21,500	51	70.5%	35	64.3%	14	31.4%	25
Nebraska	3.79	42	D+	$23,232	41	70.2%	36	69.0%	2	26.3%	50
Nevada	3.92	28	C	$26,400	20	76.1%	12	63.0%	21	27.3%	48
New Hampshire	4.15	13	B-	$27,918	17	71.5%	30	66.7%	7	32.9%	15
New Jersey	4.15	13	B-	$31,020	5	69.8%	39	58.4%	39	34.4%	13
New Mexico	3.84	37	D+	$23,086	43	72.1%	27	57.2%	42	33.4%	14
New York	4.18	12	B-	$30,000	9	76.8%	8	56.1%	47	34.6%	11
North Carolina	3.88	33	C-	$24,816	37	73.0%	22	61.6%	28	30.1%	31
North Dakota	3.84	37	D+	$21,714	49	72.0%	29	67.0%	6	29.8%	33
Ohio	3.89	32	C-	$26,717	19	66.8%	48	60.9%	32	31.1%	26
Oklahoma	3.82	39	D+	$25,000	34	74.9%	17	57.3%	41	29.2%	40
Oregon	3.95	26	C	$25,850	25	68.8%	43	62.2%	26	32.4%	17
Pennsylvania	3.86	36	C-	$26,884	18	70.1%	37	57.1%	43	30.6%	29
Rhode Island	4.08	16	C+	$29,568	11	71.5%	30	60.6%	33	31.8%	22
South Carolina	3.90	30	C	$24,816	37	70.9%	33	59.5%	35	32.8%	16
South Dakota	3.81	40	D+	$22,000	48	70.9%	33	67.7%	5	28.6%	43
Tennessee	3.73	46	D	$23,232	41	73.3%	21	59.1%	37	28.3%	45
Texas	3.96	24	C+	$25,344	30	74.5%	18	59.4%	36	32.4%	17
Utah	3.87	35	C-	$25,000	34	65.8%	49	62.7%	23	31.9%	20
Vermont	4.25	9	B	$25,747	29	80.5%	3	65.3%	11	35.4%	8
Virginia	4.10	15	C+	$28,000	14	67.7%	45	61.3%	31	35.7%	6
Washington	4.25	9	B	$30,096	8	72.8%	24	62.6%	24	35.0%	10
West Virginia	3.50	51	F	$22,176	45	70.0%	38	51.3%	51	27.8%	47
Wisconsin	3.98	20	C+	$26,000	24	69.8%	39	68.3%	3	29.6%	37
Wyoming	3.64	48	F	$22,541	44	64.4%	51	65.1%	12	26.9%	49
United States	**4.00**			**$26,884**		**72.7%**		**60.2%**		**32.2%**	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Composite Score
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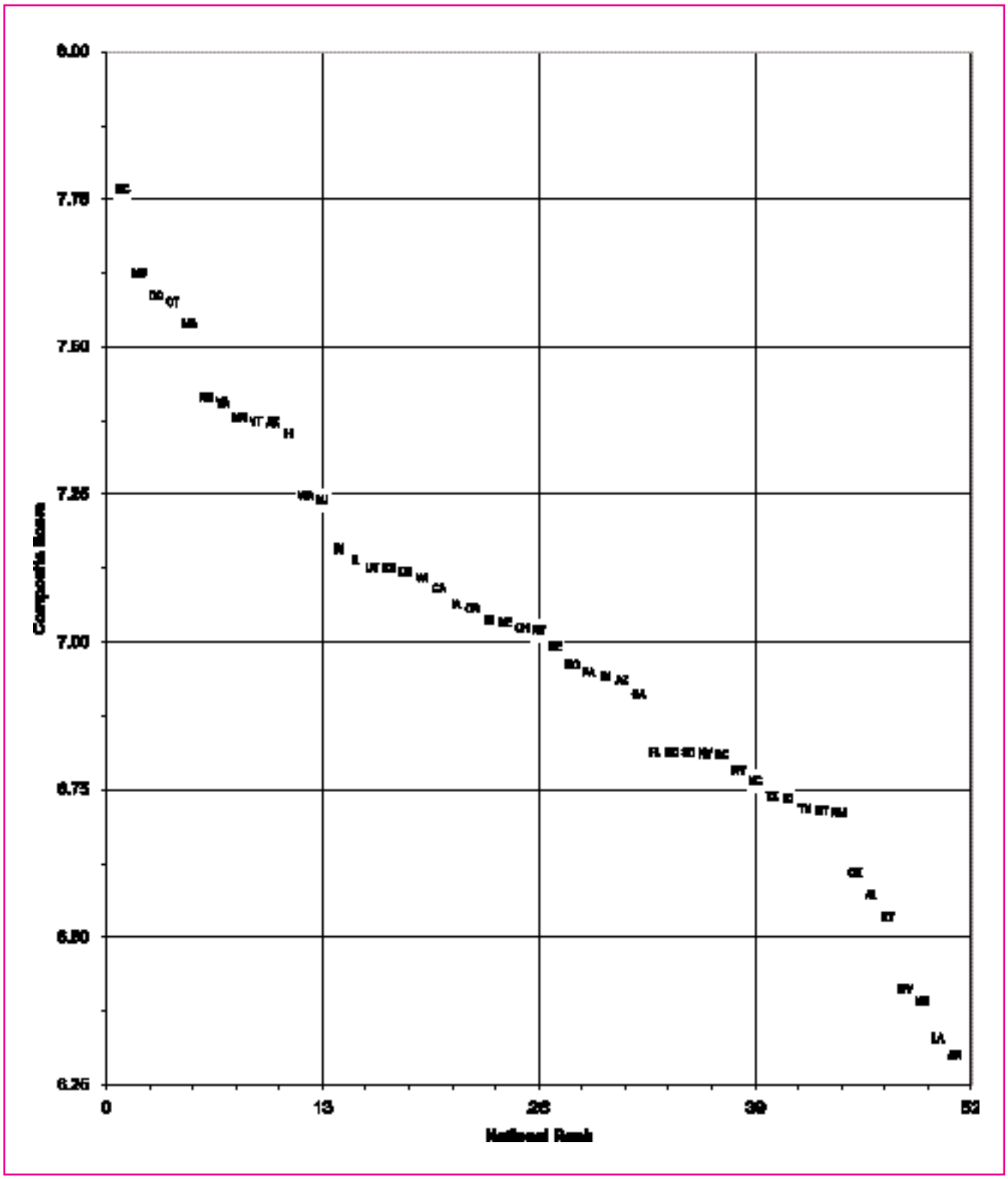
National Rank

Appendix IV: State-by-State Rankings on the Composite Indices and Their Components—Social and 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	6.57	46	D-	83.8%	30	13.5%	45	24.4%	33	85.1%	43
Alaska	7.37	9	B-	81.5%	39	22.2%	7	25.9%	18	91.1%	11
Arizona	6.93	31	C-	80.8%	44	17.2%	25	27.0%	13	87.1%	35
Arkansas	6.30	51	F	81.3%	42	11.9%	50	22.0%	50	83.6%	46
California	7.09	20	C+	79.1%	47	20.1%	13	27.3%	9	87.0%	37
Colorado	7.59	3	B	84.4%	28	23.5%	4	28.0%	4	91.7%	6
Connecticut	7.57	4	B	89.7%	7	23.8%	3	25.5%	24	91.8%	4
Delaware	7.12	16	C+	85.9%	24	18.7%	16	24.1%	36	90.2%	15
District of Columbia	7.77	1	B+	88.9%	10	30.6%	1	30.9%	1	83.2%	47
Florida	6.81	33	D+	79.6%	45	15.1%	36	25.9%	18	88.1%	31
Georgia	6.91	32	C-	83.4%	31	16.8%	27	25.6%	22	87.4%	32
Hawaii	7.35	11	B-	88.6%	11	20.9%	11	27.5%	6	89.1%	26
Idaho	6.73	41	D	83.0%	33	14.6%	41	23.5%	45	88.2%	30
Illinois	7.14	15	C+	83.3%	32	18.4%	17	27.2%	10	89.2%	24
Indiana	6.94	30	C-	87.2%	18	13.4%	46	25.9%	18	91.2%	10
Iowa	7.06	21	C	88.4%	12	15.0%	38	25.3%	25	92.0%	2
Kansas	7.12	16	C+	86.7%	22	18.4%	17	25.6%	22	89.2%	24
Kentucky	6.53	47	D-	81.4%	41	12.2%	49	23.4%	46	87.2%	34
Louisiana	6.33	50	F	76.8%	48	14.5%	42	23.9%	41	80.7%	51
Maine	7.03	24	C	87.0%	20	17.2%	25	24.0%	38	90.1%	16
Maryland	7.63	2	B	87.8%	15	23.1%	6	28.9%	3	91.3%	8
Massachusetts	7.54	5	B	90.1%	5	24.1%	2	26.6%	14	89.6%	20
Michigan	7.04	23	C	88.0%	14	15.1%	36	27.2%	10	89.8%	18
Minnesota	7.38	8	B-	91.4%	3	19.2%	15	26.4%	15	92.0%	2
Mississippi	6.39	49	F	81.5%	39	13.3%	47	22.8%	47	83.2%	47
Missouri	6.96	28	C-	87.2%	18	15.2%	35	25.2%	26	89.9%	17
Montana	6.71	43	D	79.3%	46	18.0%	20	23.9%	41	84.1%	45
Nebraska	6.99	27	C-	89.7%	7	16.7%	28	24.1%	36	89.0%	27
Nevada	6.81	33	D+	82.4%	36	12.8%	48	25.7%	21	90.4%	14
New Hampshire	7.41	6	B-	92.2%	2	21.1%	9	23.6%	44	92.5%	1
New Jersey	7.24	13	B-	83.0%	33	21.0%	10	23.7%	43	91.1%	11
New Mexico	6.71	43	D	70.7%	51	17.8%	22	29.4%	2	82.0%	50
New York	7.02	25	C	81.7%	38	20.7%	12	26.1%	17	85.1%	43
North Carolina	6.76	39	D+	84.7%	27	15.7%	32	24.5%	32	86.1%	41
North Dakota	6.81	33	D+	86.0%	23	16.7%	28	22.5%	49	87.4%	32
Ohio	7.02	25	C	87.5%	17	14.4%	43	26.2%	16	91.3%	8
Oklahoma	6.61	45	D-	76.5%	49	15.0%	38	24.0%	38	86.2%	40
Oregon	7.06	21	C	84.8%	26	18.1%	19	27.6%	5	86.9%	38
Pennsylvania	6.95	29	C-	89.9%	6	15.3%	34	24.2%	35	89.5%	21
Rhode Island	7.16	14	C+	94.0%	1	18.0%	20	24.6%	31	89.4%	23
South Carolina	6.81	33	D+	89.1%	9	14.7%	40	24.7%	30	87.1%	35
South Dakota	6.81	33	D+	86.8%	21	15.5%	33	21.5%	51	89.5%	21
Tennessee	6.72	42	D	87.8%	15	14.0%	44	24.0%	38	86.9%	38
Texas	6.74	40	D	75.8%	50	17.4%	24	25.0%	28	85.4%	42
Utah	7.12	16	C+	85.5%	25	17.5%	23	24.8%	29	91.4%	7
Vermont	7.37	9	B-	88.2%	13	23.2%	5	25.2%	26	88.7%	28
Virginia	7.40	7	B-	84.3%	29	21.3%	8	27.5%	6	90.8%	13
Washington	7.25	12	B-	82.8%	35	19.7%	14	27.5%	6	89.7%	19
West Virginia	6.41	48	F	81.3%	42	10.9%	51	27.1%	12	83.2%	47
Wisconsin	7.11	19	C+	91.4%	3	16.0%	31	24.4%	33	91.8%	4
Wyoming	6.78	38	D+	81.9%	37	16.1%	30	22.6%	48	88.4%	29
United States	**7.00**			**83.4%**		**17.6%**		**26.0%**		**88.0%**	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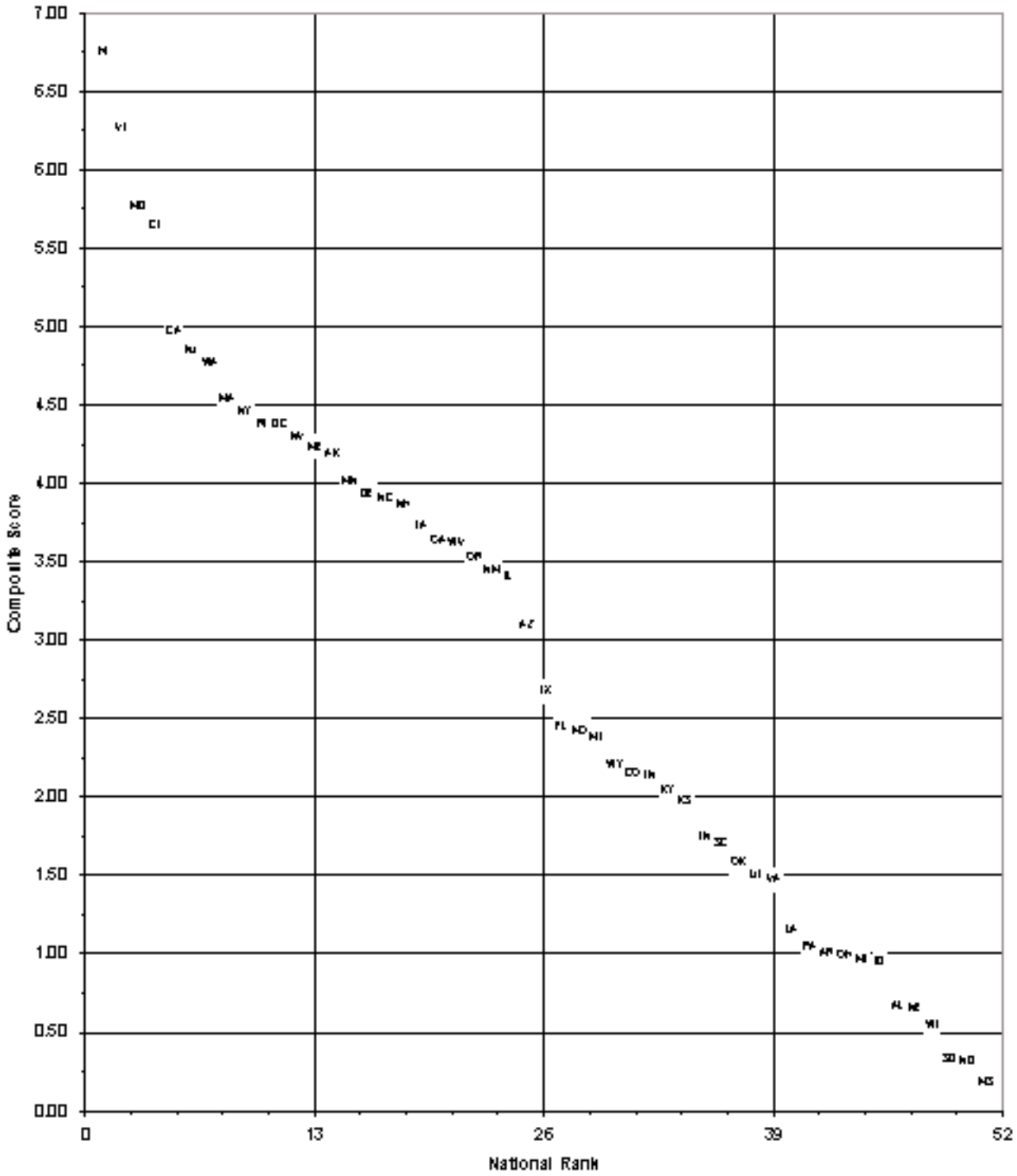
Composite Score
National Rank

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

	Composite Index			Parental Consent/ Notification	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**	**Percent**	**Score**	**Score**	**Score**	**Score**	**Score**
Alabama	0.67	46	F	0	0	0	42%	0.0	0.00	0.0	0.50	0
Alaska	4.19	14	B	0*	1	1	77%	0.0	0.67	0.0	0.50	1
Arizona	3.10	25	C+	0*	1	0	81%	1.0	0.67	0.0	0.25	0
Arkansas	1.01	42	F	0	0	0	22%	0.0	0.17	1.0	0.25	0
California	4.97	5	B+	0*	1	1	97%	1.0	1.00	0.5	0.50	0
Colorado	2.16	31	C-	0*	1	0	66%	0.5	0.50	0.0	0.00	0
Connecticut	5.65	4	A-	1	1	1	90%	1.0	1.00	0.5	1.00	0
Delaware	3.93	16	B-	0	0*	0	85%	1.0	0.83	0.0	0.50	1
Dist.Columbia	4.38	10	B	1	1	0	100%	0.0	1.00	0.0	0.75	1
Florida	2.45	27	C	0*	1	0	78%	0.0	0.17	0.0	0.00	1
Georgia	3.64	20	B-	0	1	0	51%	1.0	0.50	0.0	0.25	1
Hawaii	6.75	1	A	1	1	1	100%	1.0	1.00	1.0	0.50	1
Idaho	0.96	45	F	0	0	0	33%	0.5	0.00	0.0	0.25	0
Illinois	3.41	24	C+	0*	1	0	70%	0.0	0.33	1.0	0.75	1
Indiana	2.14	32	C-	0	0	1	39%	0.0	0.50	0.0	0.50	0
Iowa	3.73	19	B-	0	1	0	31%	1.0	0.67	0.0	0.50	1
Kansas	1.98	34	D+	0	0	0	52%	0.0	0.33	0.0	0.25	1
Kentucky	2.04	33	D+	0	0	0	25%	0.5	0.17	0.0	0.25	1
Louisiana	1.15	40	D-	0	0	0	40%	0.0	0.00	1.0	0.50	0
Maine	4.24	13	B	0	1	0	61%	1.0	1.00	0.0	0.25	1
Maryland	5.77	3	A-	0	1	1	85%	1.0	0.67	1.0	0.50	1
Massachusetts	4.54	8	B	0	0*	1	100%	1.0	0.67	1.0	0.75	0
Michigan	0.97	44	F	0	0	0	72%	0.0	0.00	0.0	0.50	0
Minnesota	4.01	15	B-	0	1	1	43%	0.5	0.33	0.0	0.50	1
Mississippi	0.18	51	F	0	0	0	18%	0.0	0.00	0.0	0.00	0
Missouri	2.43	28	C	0	1	0	47%	1.0	0.33	0.0	0.25	0
Montana	2.38	29	C	0*	0*	1	59%	0.0	0.17	1.0	0.25	0
Nebraska	0.66	47	F	0	0	0	53%	0.0	0.00	0.0	0.25	0
Nevada	4.30	12	B	0*	1	0	88%	1.0	0.67	0.0	0.50	1
New Hampshire	3.87	18	B-	1	1	0	74%	1.0	1.00	0.0	0.25	0
New Jersey	4.85	6	B+	0*	1	1	97%	0.5	0.50	0.0	0.75	1
New Mexico	3.45	23	C+	0*	1	1	53%	1.0	0.17	0.0	0.50	0
New York	4.46	9	B	1	1	1	92%	0.0	0.67	1.0	0.75	0
North Carolina	3.90	17	B-	0	1	0	61%	1.0	0.67	0.0	0.25	1
North Dakota	0.33	50	F	0	0	0	20%	0.0	0.00	0.0	0.25	0
Ohio	1.00	43	F	0	0	0	50%	0.0	0.00	1.0	0.00	0
Oklahoma	1.59	37	D	0	1	0	46%	0.5	0.00	0.0	0.25	0
Oregon	3.54	22	B-	1	1	1	62%	0.0	0.67	0.0	0.50	0
Pennsylvania	1.08	41	F	0	0	0	63%	0.0	0.17	0.0	0.50	0
Rhode Island	4.38	10	B	0	1	0	63%	1.0	0.50	1.0	0.50	1
South Carolina	1.71	36	D	0	0	0	42%	0.0	0.17	0.0	0.25	1
South Dakota	0.34	49	F	0	0	0	21%	0.0	0.00	0.0	0.25	0
Tennessee	1.75	35	D	0	0*	0	46%	0.0	0.17	0.0	0.25	1
Texas	2.68	26	C	0	1	0	68%	1.0	0.00	0.5	0.50	0
Utah	1.51	38	D	0	0	0	51%	0.0	0.00	0.0	0.00	1
Vermont	6.27	2	A-	1	1	1	77%	1.0	1.00	0.0	1.00	1
Virginia	1.48	39	D	0	0	0	52%	0.5	0.33	0.0	0.25	0
Washington	4.77	7	B+	1	1	1	85%	1.0	0.67	0.0	0.50	0
West Virginia	3.62	21	B-	0	1	1	16%	0.0	0.33	1.0	0.25	1
Wisconsin	0.55	48	F	0	0	0	38%	0.0	0.17	0.0	0.00	0
Wyoming	2.21	30	C-	0	1	0	25%	0.0	0.33	0.0	0.25	1

** Indicates the legislation is not enforced but remains part of the statutory code.*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Composite Score
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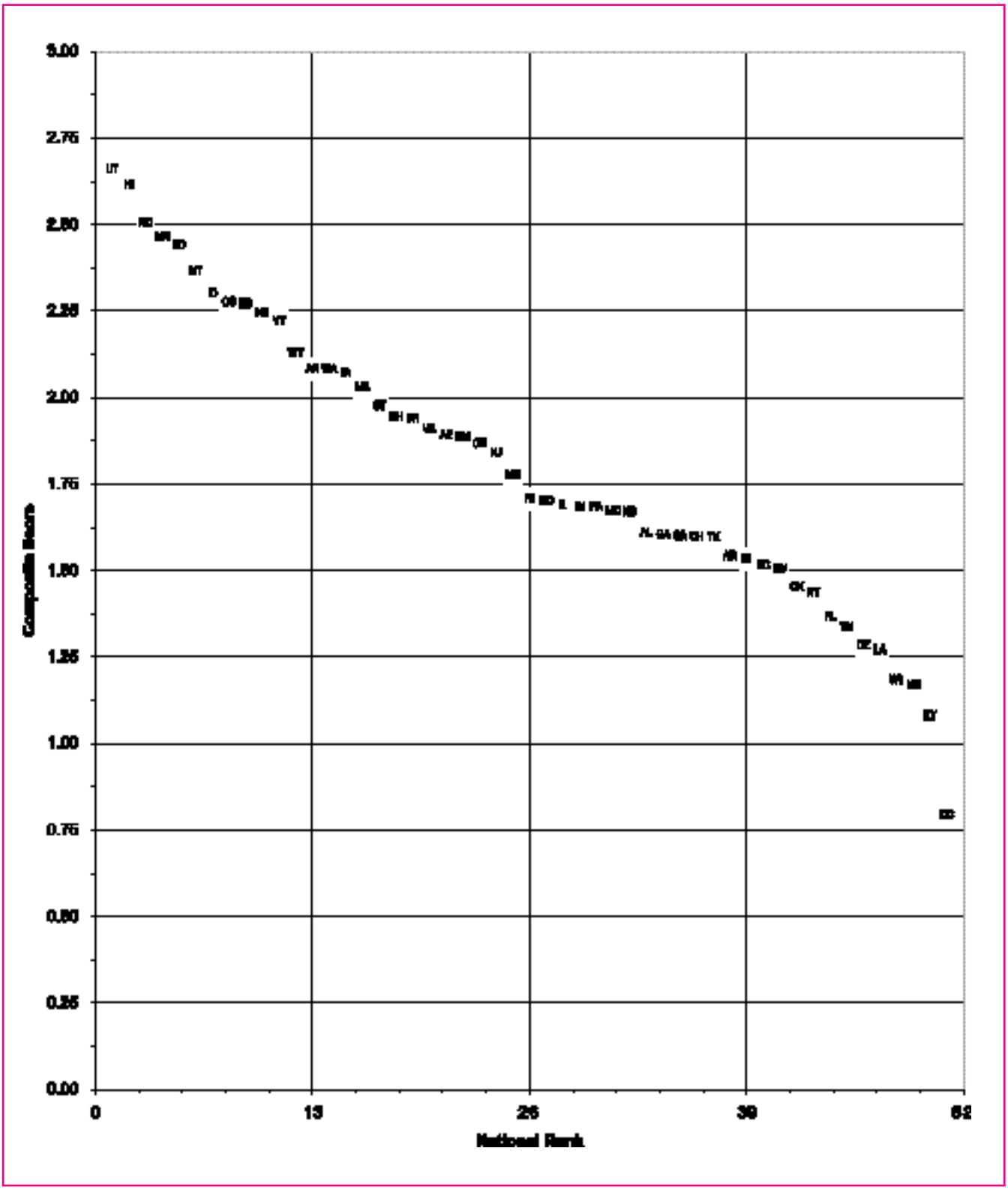
National Rank

Appendix IV: 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	1.61	33	C-	130.5	17	38.7	16	26.9	13	7.4%	44	604.9	47	5.8	33	4.1	38	4.7	29	4.4	45
Alaska	2.08	13	B-	91.5	1	45.9	42	25.5	6	4.0%	1	632.8	49	2.6	20	3.7	21	8.4	50	2.9	5
Arizona	1.89	21	C+	138.6	21	38.8	17	25.7	7	5.8%	23	414.6	33	3.1	24	3.2	9	6.5	49	3.7	32
Arkansas	1.54	38	D+	160.9	32	43.6	33	26.6	10	6.3%	33	380.4	27	4.0	28	4.2	41	4.8	31	4.4	45
California	1.60	34	C-	164.6	36	39.1	19	27.2	17	6.1%	29	435.7	37	4.6	29	3.9	30	4.9	35	4.2	41
Colorado	2.27	8	B	112.6	6	31.3	3	23.6	2	4.1%	3	427.7	34	1.6	12	3.8	24	6.2	45	3.5	26
Connecticut	1.97	17	B-	144.9	24	41.5	26	30.1	39	5.1%	9	369.3	26	16.0	45	3.4	12	3.2	5	3.2	14
Delaware	1.28	46	D	166.0	39	50.2	48	33.5	50	5.6%	20	586.4	45	19.4	47	3.8	24	3.6	11	4.3	43
Dist. Columbia	0.79	51	F	137.2	19	41.4	25	40.4	51	8.2%	50	1009.5	51	87.8	51	4.2	41	3.1	4	3.6	29
Florida	1.37	44	D	162.0	35	43.8	34	27.1	14	6.9%	41	354.2	21	21.3	49	3.7	21	6.0	43	4.5	48
Georgia	1.60	34	C-	143.5	23	39.3	20	28.5	31	7.5%	46	602.1	46	9.6	40	4.0	32	4.2	20	3.8	35
Hawaii	2.62	2	A-	94.2	2	29.0	2	19.9	1	4.7%	7	464.6	41	2.8	22	2.7	1	5.1	38	3.3	18
Idaho	2.30	7	B	115.6	7	33.5	8	26.3	9	5.1%	9	228.8	8	0.2	2	4.2	41	5.1	38	3.2	14
Illinois	1.69	28	C	166.5	40	41.6	27	31.0	45	6.8%	40	407.6	29	8.0	37	3.5	14	3.2	5	3.5	26
Indiana	1.68	29	C	160.1	30	45.3	39	29.7	38	6.5%	35	358.4	23	2.6	20	4.1	38	4.2	20	3.4	23
Iowa	2.07	15	B-	161.6	34	36.5	11	28.0	26	6.1%	29	304.3	14	1.2	6	2.9	3	4.1	17	2.9	5
Kansas	2.27	8	B	126.1	13	38.3	13	26.2	8	5.5%	18	368.7	24	2.0	16	3.4	12	4.1	17	2.8	3
Kentucky	1.08	50	F	165.4	38	52.9	50	28.0	26	6.1%	29	317.4	16	2.4	18	5.3	51	4.2	20	6.1	51
Louisiana	1.27	47	D	160.8	31	45.0	37	30.5	42	7.5%	46	621.6	48	10.1	41	3.6	19	4.8	31	4.5	48
Maine	1.78	25	C+	148.7	25	50.2	48	27.8	23	5.5%	18	178.1	4	1.3	8	3.7	21	4.5	25	4.2	41
Maryland	1.67	31	C	157.9	29	46.3	44	31.5	46	5.8%	23	455.1	39	20.2	48	3.5	14	3.6	11	3.2	14
Massachusetts	2.03	16	B-	128.5	16	44.5	35	30.2	41	5.6%	20	264.4	11	11.9	43	3.8	24	3.2	5	3.3	18
Michigan	1.53	39	D+	182.8	47	42.7	30	28.9	36	6.7%	37	412.8	32	4.8	30	4.5	50	3.6	11	3.4	23
Minnesota	2.46	4	B+	97.8	3	35.6	9	27.6	20	5.1%	9	241.7	9	1.8	14	3.2	9	3.5	9	3.6	29
Mississippi	1.17	49	D-	182.6	46	40.0	21	28.6	33	8.2%	50	763.2	50	11.3	42	4.2	41	4.5	25	3.9	37
Missouri	1.70	27	C	177.2	44	45.7	41	27.9	24	5.9%	26	408.9	30	3.5	26	3.8	24	4.9	35	2.8	3
Montana	2.36	6	B	101.0	5	40.5	24	25.2	5	5.3%	15	247.1	10	0.0	1	3.0	5	6.4	48	3.1	10
Nebraska	2.25	10	B	120.3	9	33.2	7	27.7	22	4.5%	5	354.5	22	2.9	23	3.0	5	4.1	17	4.0	38
Nevada	1.50	41	D+	141.3	22	56.3	51	27.1	14	4.8%	8	351.7	20	6.2	34	4.2	41	9.2	51	3.5	26
New Hampshire	1.94	18	B-	161.0	33	47.7	46	30.1	39	4.0%	1	145.7	2	1.2	6	3.1	8	5.6	40	3.3	18
New Jersey	1.84	24	C+	173.6	43	42.9	31	32.6	49	5.4%	16	226.0	7	17.1	46	3.5	14	2.9	3	2.9	5
New Mexico	1.88	22	C+	124.4	12	31.9	5	26.7	12	6.7%	37	471.9	42	1.3	8	4.4	48	6.3	46	3.6	29
New York	1.44	43	D+	216.9	51	38.3	13	31.7	48	6.0%	27	285.7	13	23.4	50	3.8	24	2.8	1	3.4	23
North Carolina	1.67	31	C	153.9	27	39.0	18	28.6	33	6.7%	37	472.6	43	5.6	32	3.5	14	4.6	28	4.0	38
North Dakota	2.50	3	B+	120.9	10	31.7	4	28.0	26	5.2%	12	208.2	6	0.4	4	2.9	3	3.5	9	3.0	9
Ohio	1.60	34	C-	169.7	42	45.0	37	30.5	42	6.3%	33	431.7	35	2.2	17	4.0	32	3.4	8	3.7	32
Oklahoma	1.45	42	D+	184.5	48	44.5	35	27.5	19	6.0%	27	448.9	38	3.8	27	2.7	1	5.9	41	4.3	43
Oregon	1.87	23	C+	117.4	8	46.2	43	27.6	20	5.8%	23	309.3	15	1.4	10	4.3	46	6.3	46	3.7	32
Pennsylvania	1.68	29	C	168.6	41	40.3	22	30.8	44	7.4%	44	343.4	18	8.4	39	3.9	30	3.8	15	3.1	10
Rhode Island	1.71	26	C	179.6	45	46.5	45	31.5	46	5.2%	12	382.7	28	5.3	31	3.8	24	2.8	1	3.2	14
South Carolina	1.51	40	D+	155.0	28	38.3	13	27.9	24	7.0%	43	433.7	36	13.8	44	4.0	32	4.8	31	4.4	45
South Dakota	2.44	5	B+	127.7	14	32.1	6	25.0	4	5.4%	16	351.0	19	0.3	3	3.0	5	4.3	23	2.6	1
Tennessee	1.33	45	D	190.2	49	43.3	32	28.5	31	7.6%	48	410.6	31	8.1	38	3.5	14	5.0	37	4.0	38
Texas	1.59	37	C-	165.0	37	40.4	23	26.6	10	6.1%	29	559.4	44	6.4	35	4.1	38	4.4	24	3.8	35
Utah	2.66	1	A-	98.9	4	17.9	1	24.9	3	5.2%	12	150.3	3	1.9	15	4.0	32	6.0	43	2.9	5
Vermont	2.22	11	B	151.5	26	42.1	28	28.4	30	4.1%	3	143.2	1	1.5	11	3.2	9	3.7	14	3.1	10
Virginia	1.91	20	C+	137.8	20	42.2	29	29.4	37	6.9%	41	369.2	25	7.3	36	4.0	32	4.7	29	2.7	2
Washington	2.08	13	B-	123.0	11	45.5	40	27.1	14	5.7%	22	331.1	17	3.2	25	3.6	19	4.8	31	3.1	10
West Virginia	1.18	48	D-	190.2	49	50.1	47	28.6	33	7.6%	48	191.1	5	1.7	13	4.3	46	4.5	25	5.0	50
Wisconsin	1.94	18	C+	132.6	18	37.5	12	27.4	18	6.5%	35	462.6	40	2.4	18	4.4	48	4.0	16	3.3	18
Wyoming	2.13	12	B-	127.8	15	35.9	10	28.1	29	4.6%	6	279.5	12	0.5	5	4.0	32	5.9	41	3.3	18
United States	**1.72**			**161.7**		**41.3**		**28.8**		**5.9%***		**404.0**		**8.7**		**3.8***		**4.4**		**3.5***	

** Median for all 50 states and the District of Columbia.*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52
National Rank

Selected Rhode Island Resources

100 Black Women
P.O. Box 27739
Providence, RI 02907

Big Sisters of Rhode Island
845 Oaklawn Avenue
Suite 200
Cranston, RI 02920-2825
Tel: (401) 943-7500
Fax: (401) 943-0811
www.bigsistersri.org

Blackstone Shelter
P. O. Box 5643
Pawtucket, RI 02862
Tel: (401) 723-3057
Fax: (401) 724-8820

Bryant College Women's Center
1150 Douglas Pike
Smithfield, RI 02917
Tel: (401) 232-6926

Business and Professional Women of Rhode Island
81 Cranston Circle
North Kingstown, RI 02852
Tel: (401) 295-2324

Center for Hispanic Policy and Advocacy
421 Elmwood Avenue
Providence, RI 02907
Tel: (401) 467-0111
Fax: (401) 467-2507
www.chispa.org

Center for Women and Enterprise
55 Claverick Street
Suite 102
Providence, RI 02903
Tel: (401) 277-0800
Fax: (401) 277-1122
www.cweonline.org

Child and Family Services of Newport County
24 School Street
Newport, RI 02840
Tel: (401) 849-2300
www.cfsnewport.org

Children's Friend and Service
153 Summer Street
Providence, RI 02903-4011
Tel: (401) 331-2900
Fax: (401) 331-3285
www.childrensfriendservice.org

Connecting for Children and Families, Inc.
28 First Avenue
Woonsocket, RI 02895-4032
Tel: (401) 766-3384
Fax: (401) 762-2324

Dorcas Place Parent Literacy Center, Inc.
270 Elmwood Avenue
Providence, RI 02907
Tel: (401) 273-8866
Fax: (401) 273-8893
www.dorcasplace.org

Elizabeth Buffum Chace House
P.O. Box 9476
Warwick, RI 02888
Tel: (401) 738-9700

Family Service Inc.
55 Hope Street
Providence, RI 02906-2001
Tel: (401) 331-1350
Fax: (401) 274-7602
www.familyserviceri.org

Girl Scouts of Rhode Island
125 Charles Street
Providence, RI 02904
Tel: (401) 331-4500
Fax: (401) 421-2937
www.gsri.org

Grey Panthers
32 East Avenue
Pawtucket, RI 02860
Tel: (401) 725-1122

HERA Educational Foundation
560 Main Street, Box 336
Wakefield, RI 02891
Tel: (401) 789-1488

Hispanic American Chamber of Commerce
550 Broad Street
Providence, RI 02907
Tel: (401) 331-2615
www.haccri.org

Jewish Family Service
229 Waterman Street
Providence, RI 02906
Tel: (401) 331-1244
www.jfsri.com

Johnson and Wales University Women's Center
10 Abbott Park Place
Providence, RI 02903
Tel: (401) 598-8338

League of Women Voters of Rhode Island
172 Taunton Avenue
Suite 8
East Providence, RI 02914
Tel: (401) 434-6440
www.lwvri.org

Lincoln School
301 Butler Avenue
Providence, RI 02906
Tel: (401) 331-9696
Fax: (401) 751-6670
www.lincolnschool.org

National Association of Women in Construction
19 Southbury Road
Cumberland, RI 02864
Tel: (401) 658-1645

National Conference for Community and Justice (NCCJ)
134 Thurbers Avenue
P.O. Box 6, Suite 118
Providence, RI 02905
Tel: (401) 467-1717
Fax: (401) 467-2707
www.nccj.org

National Council of Jewish Women
282 Meshanticut Valley Parkway
Cranston, RI 02920

National Organization for Women – Rhode Island
P.O. Box 8413
Warwick, RI 02888
www.rinow.org
ri_now@hotmail.com

Ocean State Action/Health Care Organizing Project
99 Bald Hill Road
Cranston, RI 02920
Tel: (401) 463-5368

Options for Working Parents
30 Exchange Terrace
Providence, RI 02903
Tel: (401) 272-7510

Planned Parenthood of Rhode Island
P. O. Box 41059
Providence, RI 02940
Tel: (401) 421-7820
Fax: (401) 621-6250
www.ppri.org

Portuguese American Women's Association
Contact: Susan Pacico, President
33 Milburn Road
East Providence, RI 02914
Tel: (401) 435-9111
Fax: (401) 435-4549

The Poverty Institute
Rhode Island College School of Social Work
600 Mt. Pleasant Avenue
Providence, RI 02908
Tel: (401) 456-4634
Fax: (401) 456-4550
www.povertyinstitute.org

Progreso Latino, Inc.
626 Broad Street
Central Falls, RI 02863-2835
Tel: (401) 728-5920
Fax: (401) 724-5550
www.progresolatino.org

Providence College, Women's Studies
549 River Avenue
Providence, RI 02908
Tel: (401) 865-2923

Providence Human Relations Commission
151 Weybosset Street
Providence, RI 02903
Tel: (401) 421-3708
Fax: (401) 274-1070

Rhode Island Alliance For Lesbian, Gay, and Bisexual Civil Rights
P. O. Box 5758
Providence, RI 02903-0758

Rhode Island Breast Cancer Coalition
300 Quaker Lane
Suite 7
Warwick, RI 02886
Tel: (401) 822-7984

Rhode Island Campaign to Eliminate Childhood Poverty
32 East Avenue
Pawtucket, RI
Tel: (401) 728-5555
Fax: (401) 725-1020

Rhode Island Coalition Against Domestic Violence
422 Post Road
Suite 202
Warwick, RI 02888
Tel: (401) 467-9940
Fax: (401) 467-9943
www.ricadv.org

Rhode Island College, Women's Studies
600 Mount Pleasant Avenue
Providence, RI 02908
Tel: (401) 456-8377

Rhode Island College, Women's Center
600 Mount Pleasant Avenue
Providence, RI 02908
Tel: (401) 456-8474

Rhode Island Commission on Women
260 West Exchange Street
Suite 4
Providence, RI 02903
Tel: (401) 222-6105
Fax: (401) 222-5638
www.ricw.state.ri.us

Rhode Island Department of Education
255 Westminster Street
Providence, RI 02903
Tel: (401) 222-4600
www.doa.state.ri.us

Rhode Island Department of Health
Office of Women's Health
Three Capitol Hill
Providence, RI 02908
Tel: (401) 222-1171
www.healthri.org/disease/owh/Home.htm

Rhode Island Department of Human Services
Aime Forand Building
600 New London Avenue
Cranston, RI 02920
Tel: (401) 462-6252
Fax: (401) 462-6165
www.doa.state.ri.us

Rhode Island Department of Labor and Training
Labor, Market, and Information Unit
1511 Pontiac Ave.
Cranston, RI 02920
Tel: (401) 462-8762
www.doa.state.ri.us

Rhode Island Department of Mental Health, Retardation, and Hospitals
600 New London Avenue
Cranston, RI 02920
Tel: (401) 464-3201
Fax: (401) 464-3204
www.doa.state.ri.us

Rhode Island Feminist Chorus
Box 327
Harmony, RI 02829
www.geocities.com/rifeministchorus/
information@rifeministchorus.org

Rhode Island Girls Coalition
c/o YWCA
790 North Main Street
Providence, RI 02906
Tel: (401) 831-9922

Rhode Island Kids Count
One Union Station
Providence, RI 02903
Tel: (401) 728-2512
www.rikidscount.org

Rhode Island Medical Women's Association
106 Francis Avenue
Providence, RI 02903

Rhode Island Parents for Progress
807 Broad Street
Providence, RI 02907
Tel: (401) 780-6840
Fax (401) 467-0628

Rhode Island Women's Health Collective
7 Granada Terrace
Middletown, RI 02842-4919
Tel: (401) 454-1330

Rhode Island Women's Political Caucus
P.O. Box 405
Saunderstown, RI 02874
Tel: (401) 295-7338

Roger Williams University, Women's Center
Old Ferry Road
Bristol, RI 02809
Tel: (401) 253-1040

Salve Regina University, Women's Center
100 Ochre Point Avenue
Newport, RI 02840
Tel: (401) 341-3103

Sarah Doyle Women's Center
Brown University
P.O. Box 1829
Providence, RI 02912
Tel: (401) 863-2189
www.brown.edu/Departments/Sarah_Doyle_Center/

Sexual Assault and Trauma Resource Center
300 Richmond Street
Suite 205
Providence, RI 02903-4222
Tel: (401) 421-4100
Fax: (401) 454-5565
www.satrc.org

Socio-Economic Development Center
620 Potters Avenue
Providence, RI 02907
Tel: (401) 941-8422
Fax: (401) 467-3210
www.ultranet.com/~interlab

Sojourner House
Two Richmond Square
Suite 210
Providence, RI 02906
Tel: (401) 861-6191
Fax: (401) 861-6157

Sophia Academy
807 Broad Street, Box 41
Providence, RI 02907
Tel: (401) 461-0070

United Sisters
P.O. Box 40520
Providence, RI 02940
Tel: (401) 487-4153

United Way of Southeastern New England
229 Waterman Street
Providence, RI 02906-5297
Tel: (401) 444-0600
Fax: (401) 444-0635
www.unitedwaysene.org

University of Rhode Island
College of Continuing Education
25 West Independence Way
Independence Square
Kingston, RI 02881
Tel: (401) 874-4860
Fax: (401) 874-4361
www.uri.edu

University of Rhode Island, Women's Center
316 Eleanor Roosevelt Hall
Kingston, RI 02881
Tel: (401) 874-2097

Urban League
191 Rutherglen Avenue
Providence, RI 02907
Tel: (401) 455-1984

Victims of Crime Helpline
Tel: (800) 494-8100

Women and Infants Hospital
101 Dudley Street
Providence, RI 02905
Tel: (401) 274-1122
www.womenandinfants.com

Women In Transition, Inc.
P.O. Box 20135
Cranston, RI 02920-0942
Tel: (401) 462-1767
Fax: (401) 462-0281

Women's Center of Rhode Island
P.O. Box 603300
Providence, RI 02906
Tel: (401) 861-2760
Fax: (401) 861-2762
www.womenscenterri.org

Women's Fund of Rhode Island
One Union Station
Providence, RI 02903
Tel: (401) 274-4564
www.rifoundation.org

Women's Health and Education Fund
PO Box 5863
Providence, RI 02903
Tel: (401) 738-7141
www.caseyfamilyservices.org

Women's Resource Center-Bristol County
501 Main Street
Warren, RI 02885
Tel: (401) 247-2070
Fax: (401) 247-9257
www.wrcnbc.org

Women's Resource Center of Newport
114 Touro Street
Newport, RI 02840
Tel: (401) 846-5263
Fax: (401) 848-0910
www.wrcnbc.org

Women's Resource Center of South County
61 Main Street
Wakefield, RI 02879
Tel: (401) 782-3995
Fax: (401) 782-3999
www.wrcsc.org

Youth Pride, Inc.
134 George M. Cohan Blvd.
Providence, RI 02903-4410
Tel: (401) 421-5626
Fax: (401) 274-1990
www.wrcsc.org

YWCA of Greater Rhode Island
790 North Main Street
Providence, RI 02904-5706
Tel: (401) 831-9922
Fax: (401) 831-9928
www.wrcsc.org

YWCA of Northern Rhode Island
514 Blackstone Street
Woonsocket, RI 02895
Tel: (401) 769-7450
Fax: (401) 769-7454
www.wrcsc.org

National Resources

AARP
601 E Street, NW
Washington, DC 20049
Tel: (202) 434-2277
Tel: (800) 424-3410
Fax: (202) 434-7599
www.aarp.org

ACORN
739 8th Street, SE
Washington, DC 20003
Tel: (202) 547-2500
Fax: (202) 546-2483
www.acorn.org

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.gov

AFL-CIO Civil, Women's,
and Human Rights Department
815 16th Street, NW
Washington, DC 20006
Tel: (202) 637-3000
Fax: (202) 637-5058
www.aflcio.org

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

African American Women's Institute
Howard University
P.O. Box 590492
Washington, DC 20059
Tel: (202) 806-4556
Fax: (202) 806-9263
blackwomen@howard.edu
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) 594-1364
Fax: (301) 594-2283
info@ahrq.gov
www.ahcpr.gov

Alan Guttmacher Institute
1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Tel: (202) 296-4012
Fax: (202) 223-5756
policyinfo@guttmacher.org
www.guttmacher.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
info@alz.org
www.alz.org

American Association of Black Women Entrepreneurs
P.O. Box 13933
Silver Spring, MD 20911-3933
Tel: (301) 565-0527

American Association of Homes and Services for the Aging
2519 Connecticut Ave, NW
Washington, DC 20008-1520
Tel: (202) 783-2242
Fax: (202) 783-2255
www.aahsa.org

American Association of University Women
1111 16th Street, NW
Washington, DC 20036
Tel: (800) 326-AAUW
TTY: (202) 785-7777
Fax: (202) 872-1425
info@aauw.org
www.aauw.org

AFSCME
American Federation of State, County, and Municipal Employees
1625 L Street, NW
Washington, DC 20036-5687
Tel: (202) 429-1000
TTY: (202) 659-0446
Fax: (202) 429-1923
www.afscme.org

American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005
Tel: (202) 789-7400
Fax: (202) 789-7485
www.ama-assn.org

American Women's Medical Association
801 Fairfax Street, Suite 400
Alexandria, VA 22314
Tel: (703) 838-0500
Fax: (703) 549-3864
info@amwa-doc.org
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: (202) 336-5510
Tel: (800) 374-2721
TTY: (202) 336-6123
Fax: (202) 336-5500
www.apa.org

American Sociological Association
1307 New York Avenue, NW
Suite 700
Washington, DC 20005
Tel: (202) 383-9005
TTY: (202) 872-0486
Fax: (202) 638-0882
executive.office@asanet.org
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
orgs.womenconnect.com/awed

Asian Women in Business
One West 34th Street
Suite 200
New York, NY 10001
Tel: (212) 868-1368
Fax: (212) 863-1373
info@awib.org
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 for Health Services Research
1801 K Street, NW
Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
Fax: (202) 292-6800
info@ahsrhp.org
www.ahsr.org

Association of Women in Agriculture (AWA)
1909 University Avenue
Madison, WI 53705
Tel: (608) 231-3702
www.sit.wisc.edu/~awa/

Black Women United for Action
6551 Loisdale Court
Suite 222
Springfield, VA 22150
Tel: (703) 922-5757
Fax: (703) 922-7681
www.bwufa.org

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

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

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

Center for Law and Social Policy
1015 15th Street, NW
Suite 400
Washington, DC 20005
Tel: (202) 906-8000
Fax: (202) 842-2885
www.clasp.org

Center for Policy Alternatives
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20009
Tel: (202) 387-6030
Fax: (202) 387-8529
www.cfpa.org

Center for the Prevention of Sexual and Domestic Violence
2400 North 45th Street, #10
Seattle, WA 98103
Tel: (206) 634-1903
Fax: (206) 634-0115
cpsdv@cpsdv.org
www.cpsdv.org

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

Center for Research on Women
University of Memphis
Clement Hall 339
Memphis, TN 38152-3550
Tel: (901) 678-2770
Fax: (901) 678-3652
crow@memphis.edu
ca.memphis.edu/isc/crow

Center for Women's Business Research
1411 K Street, NW, Suite 1350
Washington, DC 20005-3407
Tel: (202) 638-3060
Fax: (202) 638-3064
www.womensbusinessresearch.org

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

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
1600 Clifton Road
Atlanta, GA 30333
Tel: (404) 639-3311
www.cdc.gov/nchs

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 Avenue, 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
cdfinfo@childrensdefense.org
www.childrensdefense.org

Church Women United
475 Riverside Drive, Suite 1626
New York, NY 10115
Tel: (212) 870-2347
Fax: (212) 870-2338
www.churchwomen.org

Coalition of Labor Union Women
1925 K Street, NW, Suite 402
Washington, DC 20006
Tel: (202) 223-8360
Fax: (202) 776-0537
info@cluw.org
www.cluw.org

Coalition on Human Needs
1120 Connecticut Avenue, NW
Suite 910
Washington, DC 20036
Tel: (202) 223-2532
Fax: (202) 223-2538
chn@chn.org
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

Equal Rights Advocates
1663 Mission Street
Suite 250
San Francisco, CA 94103
Tel: (415) 621-0672
Fax: (415) 621-6744
Advice/Counseling Line:
(800) 839-4ERA
www.equalrights.org

Family Violence Prevention Fund
383 Rhode Island Street
Suite 304
San Francisco, CA 94103
Tel: (415) 252-8900
TTY: (800) 595-4TTY
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 Boulevard
Suite 801
Arlington, VA 22209
Tel: (703) 522-2214
Fax: (703) 522-2219
femmaj@feminist.org
www.feminist.org

First Chance
Colorado Nonprofit Development
Center
4130 Tejon Street Suite A
Denver CO 80211
Tel: 720 855 0501
www.ruralwomyn.net/firstchance.html

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: (215) 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.girlscouts.org

Hadassah
50 West 58th Street
New York, NY 10019
Tel: (212) 355-7900
Fax: (212) 303-8282
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

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
washington@ilo.org
www.ilo.org

International Women's Democracy Center
1730 Rhode Island Avenue, NW
Suite 715
Washington, DC 20036
Tel: (202) 530-0563
Fax: (202) 530-0564
info@iwdc.org
www.iwdc.org

Jacobs Institute of Women's Health
409 12th Street, SW
Washington, DC 20024-2188
Tel: (202) 863-4990
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.jointcenter.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.lww.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

McAuley Institute
8300 Colesville Road, Suite 310
Silver Spring, Maryland 20910
Tel: (301)588-8110
Fax: (301)588-8154
www.mcauley.org

Mexican American Legal Defense and Educational Fund
634 S. Spring Street
Los Angeles, CA 90014
Tel: (213) 629-2512
Fax: (213) 629-0266
www.maldef.org

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

9 to 5, National Association of Working Women
231 W. Wisconsin Avenue Suite 900
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) 667-5890
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
Suite 900
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 Child Advocates
1522 K Street NW, Suite 600
Washington, DC 20005-1202
Tel: (202) 289-0777
Fax: (202) 289-0776
naca@childadvocacy.org
www.childadvocacy.org

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

National Association of the Deaf
814 Thayer Street
Silver Spring, MD 20910-4500
Tel: (301) 587-1788
TTY: (301) 587-1789
Fax: (301) 587-1791
NADinfo@nad.org
www.nad.org

National Association of Female Executives
P.O. Box 469031
Escondido, CA 92046
Tel: (800) 634-NAFE
Fax: (760) 745-7200
www.nafe.com

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

National Association of Women Business Owners
1595 Spring Hill Road
Suite 330
Vienna, VA 22182
Tel: (703) 506-3268
Fax: (703) 506-3266
national@nawbo.org
www.nawbo.org

National Black Women's Health Project
600 Pennsylvania Avenue, SE
Suite 310
Washington, DC 20003
Tel: (202) 543-9311
Fax: (202) 543-9743

National Breast Cancer Coalition
1707 L Street, NW
Suite 1060
Washington, DC 20036
Tel: (202) 296-7477
Tel: (800) 622-2838
Fax: (202) 265-6854
www.natlbcc.org

National Center for American Indian Enterprise Development
815 NE Northgate Way
2nd Floor
Seattle, WA 98125
Tel: (206) 365-7735
Fax: (206) 365-7764
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 80218-0749
Tel: (303) 839-1852
Fax: (303) 831-9251
www.ncadv.org

National Committee on Pay Equity
P.O. Box 34446
Washington, DC 20043-4446
Tel: (301) 277-1033
Fax: (301) 277-4451
fairpay@patriot.net
www.feminist.com/fairpay

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

National Council of Women's Organizations
733 15th Street, NW
Suite 1011
Washington, DC 20005
Tel: (202) 393-7122
Fax: (202) 387-7915
info@womensorganizations.org
www.womensorganizations.org

National Education Association
1201 16th Street, NW
Washington, DC 20036
Tel: (202) 833-4000
Fax: (202) 822-7974
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 Family Planning & Reproductive Health Association
1627 K Street NW
12th Floor
Washington, DC 20006
Tel: (202) 293-3114
info@nfprha.org
www.nfprha.org

National Federation of Democratic Women
19432 Burlington Drive
Detroit, MI 48203-1454
Tel: (313) 892-6199
Fax: (313) 892-8424
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 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 Law Center on Homelessness and Poverty
1411 K Street, NW
Suite 1400
Washington, DC 20005
Tel: (202) 638-2535
Fax: (202) 628-2737
nlchp@nlchp.org
www.nlchp.org

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

National Organization for Women Legal Defense and Education Fund
359 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 650
Washington, DC 20009
Tel: (202) 986-2600
Fax: (202) 986-2539
info@nationalpartnership.org
www.nationalpartnership.org

National Political Congress of Black Women
8401 Colesville Road
Suite 400
Silver Spring, MD 20910
Tel: (301) 562-8000
Tel: (800) 274-1198
Fax: (301) 562-8303
info@npcbw.org
www.npcbw.org

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

National Urban League
120 Wall Street
New York, NY 10005
Tel: (212) 558-5300
Fax: (212) 344-5332
info@nul.org
www.nul.org

National Women's Business Council
409 Third Street, SW
Suite 210
Washington, DC 20024
Tel: (202) 205-3850
Fax: (202) 205-6825
nwbc@sba.gov
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
nwsa@umail.umd.edu
www.nwsa.org

New Ways to Work
425 Market Street, Suite 2200
San Francisco, CA 94105
Tel: (415) 995-9860
Fax: (707) 824-4410
www.nww.org

OWL
The Voice of Midlife and Older Women
666 11th Street, NW, Suite 700
Washington, DC 20001
Tel: (202) 783-6686
Tel: (800) 825-3695
Fax: (202) 638-2356
www.owl-national.org

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

Pennsylvania Coalition Against Domestic Violence and National Resource Center
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112
Tel: (717) 545-6400
Tel: (800) 537-2238
TTY: (800) 553-2508
Legal Line: (800) 903-0111
ext. 72
Fax: (717) 545-9456
www.pcadv.org

Pension Rights Center
1140 19th Street, NW
Suite 602
Washington, DC 20036
Tel: (202) 296-3776
Fax: (202) 833-2472
pnsnrights@aol.com
www.pensionrights.org

Planned Parenthood Federation of America
801 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 20009-5728
Tel: (202) 483-1100
Fax: (202) 328-3937
popref@prb.org
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
info@prrac.org
www.prrac.org

Project Vote
88 Third Avenue, 3rd Floor
Brooklyn, NY 11217
Tel: (718) 246-7929
Fax: (718) 246-7939
pvnatfield@acorn.org

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

Service Employers International Union
1313 L Street, NW
Washington, DC 20005
Tel: (202) 898-3200
Fax: (202) 898-3481
www.seiu.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fisher's Lane
Rockville, MD 20857
Tel: (301) 443-4795
Fax: (301) 443-0284
www.samhsa.gov

Third Wave Foundation
511 West 25th Street
Suite 301
New York, NY 10001
info@thirdwavefoundation.org
www.thirdwavefoundation.org

United Food and Commercial Workers International Union
Working Women's Department
1775 K Street, NW
Washington, DC 20006
Tel: (202) 223-3111
Fax: (202) 728-1836
www.ufcw.org

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
Washington, DC 20523-3801
Tel: (202) 712-0570
Fax: (202) 216-3173
genderreach@dai.com
www.genderreach.org

U.S. Small Business Administration
Office of Women's Business Ownership
409 Third Street, NW
Fourth Floor
Washington, DC 20416
Tel: (202) 205-6673
owbo@sba.gov

The White House Project
110 Wall Street, 2nd Floor
New York, NY
Tel: (212) 785-6001
admin@thewhitehouseproject.org
www.thewhitehouseproject.org

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

Women & Philanthropy
1015 18th Street, NW, Suite 202
Washington, DC 20036
Tel: (202) 887-9660
Fax: (202) 861-5483
www.womenphil.org

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

Women, Ink.
777 United Nations Plaza
New York, NY 10017
Tel: (212) 687-8633
Fax: (212) 661-2704
wink@womenink.org
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
815 Pollard Road
Los Gatos, CA 95032
Tel: (650) 326-6500
Fax: (408) 866-3858

Women's Environmental and Development Organization
355 Lexington Avenue
3rd Floor
New York, NY 10017-6603
Tel: (212) 973-0325
Fax: (212) 973-0335
wedo@wedo.org
www.wedo.org

Women's Foreign Policy Group
1875 Connecticut Avenue, NW
Suite 720
Washington, DC 20009
Tel: (202) 884-8597
Fax: (202) 882-8487
wfpg@wfpg.org
www.wfpg.org

Women's Funding Network
1375 Sutter Street, Suite 406
San Francisco, CA 94109
Tel: (415) 441-0706
Fax: (415) 441-0827
info@wfnet.org
www.wfnet.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.wilpf.org

Women's Law Project
125 S. 9th Street, Suite 300
Philadelphia, PA 19107
Tel: (215) 928-9801
info@womenslawproject.org
www.womenslawproject.org

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

Women's Rural Entrepreneurial Network (WREN)
2015 Main Street
Bethlehem, NH 03574
Tel: (603) 869-WREN (9736)
Fax: (603) 869-9738
www.wrencommunity.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) 273-7939
www.ywca.org

The Young Women's Project
1328 Florida Avenue, NW
Suite 2000
Washington, DC 20009
Tel: (202) 332-3399
Fax: (202) 332-0066
ywp@youngwomensproject.org
www.youngwomensproject.org

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

References

The Alan Guttmacher Institute. 2002a. *State Policies in Brief: Insurance Coverage of Contraceptives, As of May 1, 2002*. New York: The Alan Guttmacher Institute.

The Alan Guttmacher Institute. 2002b. *State Policies in Brief: State Sexuality Education Policy, As of May 1, 2002*. New York: The Alan Guttmacher Institute.

The Alan Guttmacher Institute. 1996. *Reproductive Health Services and Managed Care Plans: Improving the Fit*. New York: The Alan Guttmacher Institute.

The Alan Guttmacher Institute. 1994. *Sex and America's Teenagers*. New York: The Alan Guttmacher Institute.

American Academy of Pediatrics. 2002. "AAP Says Children of Same-Sex Couples Deserve Two Legally Recognized Parents." Press Release. Washington, DC: American Academy of Pediatrics.

American Association of University Women Educational Foundation. 1998. *Gender Gaps: Where Schools Still Fail Our Children*. Washington, DC: American Association of University Women Educational Foundation.

American Cancer Society. 2002. *Cancer Facts and Figures 2002*. Atlanta, GA: American Cancer Society.

The Annie E. Casey Foundation. 2001. *Kids Count Data Book: State Profiles of Child Well-Being*. Baltimore, MD: The Annie E. Casey Foundation.

Ayers, Toby. 2001. Unpublished calculations based on the 2000 U.S. Census Supplementary Survey.

Bernstein, Jared, Heidi Hartmann, and John Schmitt. 1999. *The Minimum Wage Increase: A Working Woman's Issue*. Washington, DC: Economic Policy Institute and the Institute for Women's Policy Research.

Blau, Francine, and Lawrence Kahn. 1997. "Swimming Upstream: Trends in the Gender Wage Differential in the 1980s." *Journal of Labor Economics* 15 (1, Part 1): 1-42.

Blau, Francine, and Lawrence Kahn. 1994. "Rising Wage Inequality and the U.S. Gender Gap." *American Economic Review*, 84(2).

Boushey, Heather, Chauna Brocht, Bethany Gundersen, and Jared Bernstein. 2001. *Hardships in America: The Real Story of Working Families*. Washington, DC: Economic Policy Institute.

Brown, Robin. 1994. *Children in Crisis*. New York: The H.W. Wilson Company.

Bryen, Diane Nelson, and Bonnie M. Moulton. 1998. "Why 'Employment, Independence, Marriage, and Sexuality?' Because…We Want it All!" Paper presented at the Sixth Annual Pittsburgh Employment Conference for Augmented Communicators, "Employment, Independence, Marriage, and Sexuality." Pittsburgh, PA.

Burrell, Barbara. 1994. *A Woman's Place Is in the House: Campaigning for Congress in the Feminist Era*. Ann Arbor: University of Michigan Press.

Caiazza, Amy. 2002. *Research-in-Brief: Does Women's Representation in Elected Office Lead to Women-Friendly Policy?* Washington, DC: Institute for Women's Policy Research. Paper available at website: www.iwpr.org/pdf/i910.pdf. Accessed June 2002.

Cancian, Maria, Sheldon Danzinger, and Peter Gottschalk. 1993. "Working Wives and Family Income Inequality Among Married Couples." In *Uneven Tides: Rising Inequality in America*, Sheldon Danziger and Peter Gottschalk (eds). New York: Russell Sage Foundation.

Carroll, Susan J., and Linda M.G. Zerrilli. 1993. "Feminist Challenges to Political Science." In *Political Science: The State of the Discipline II*, Ada W. Finifter (ed.). Washington, DC: American Political Science Association.

Catalyst. 2000. *The 2000 Catalyst Census of Women Corporate Officers and Top Earners*. New York: Catalyst.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2002a. *Fact Sheet: Statewide Elective Executive Women 2002*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2002b. *Fact Sheet: Women in State Legislatures 2002*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2002c. *Fact Sheet: Women in the U.S. Congress 2002*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2002d. *Fact Sheet: Women in the U.S. House of Representatives 2002*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2002e. *Fact Sheet: Women of Color in Elective Office 2002*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 2001. *Fact Sheet: Women Candidates in 2000: Winners and Losers for U.S. Congress and Statewide Office*. New Brunswick, NJ: Center for American Women and Politics.

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 1998. *Women's Caucuses in State Legislatures*, CAWP News and Notes 11(3).

Center for American Women and Politics (CAWP), Eagleton Institute of Politics, Rutgers University. 1991. *The Impact of Women in Public Office: Findings at a Glance*. New Brunswick, NJ: Center for American Women and Politics.

Center for Law and Social Policy and Center for Budget and Policy Priorities. 2000. *State Policy Documentation Project: Child Care Provision after Leaving Cash Assistance*. Data available at website: www.spdp.org. Accessed July 2001.

Center for Policy Alternatives. 1995. *A Matter of Simple Justice: Beijing Blue Book*. Washington, DC: Center for Policy Alternatives.

Center for Women in Government and Civil Society. 2001. *Appointed Policy Makers in State Government: A Demographic Analysis: Gender, Race, and Ethnicity Data*. Albany, NY: Center for Women in Government and Civil Society.

Center for Women's Business Research. 2002. *Hispanic Women-Owned Businesses in 2002: Trends in the U.S. and 50 States*. Information available on website: www.nfwbo.org/MinorityReports.html. Accessed May 2002.

Centers for Disease Control and Prevention. 2000. *State- and Sex-Specific Prevalence of Selected Characteristics–Behavioral Risk Factor Surveillance System, 1996 and 1997*. Morbidity and Mortality Weekly Report 49 (SS-6).

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2001. *2000 BRFSS Summary Prevalence Report*. Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 1999. *Diabetes: A Serious Public Health Problem, At-A-Glance 1999*. Report from website: www.cdc.gov/diabetes/pubs/glance.htm. Accessed December 1999.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 1998. *Chronic Diseases and Their Risk Factors*. Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention. 2001. *Female Adult/Adolescent Annual AIDS Rates Per 100,000 Population, for Cases Reported in 2000, United States*. Table from website: www.cdc.gov/hiv/stats/hasr1202/fig1.htm. Accessed June 2001.

Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of STD Prevention. 2001. *Sexually Transmitted Disease Surveillance 2000*. Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2002. *10 Leading Causes of Death, United States, 1999, All Races, Females*. Table from website: http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html. Accessed June 2002.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2001. *1996-1998, United States, Suicide Deaths and Rates Per 100,000*. Table from website: webapp.cdc.gov/sasweb/ncipc/mortrate.html. Accessed October 2001.

The College Board. 2001. *2001 College-Bound Seniors: A Profile of SAT Program Test Takers*. New York: NY: College Entrance Examination Board.

Connor, Royce. Unpublished calculations based on the 1999-2001 Current Population Survey March Demographic Supplements, for calendar years 1998-2000.

Conway, M. Margaret, Gertrude A. Steuernagel, and David W. Ahern. 1997. *Women and Political Participation: Cultural Change in the Political Arena*. Washington, DC: CQ Press.

Council of Economic Advisers. 1998. *Explaining Trends in the Gender Wage Gap*. Washington, DC: Council of Economic Advisers.

Council of State Governments. 2000. *The Book of the States*. Lexington, KY: Council of State Governments.

Devine, Theresa J. 1994. "Characteristics of Self-Employed Women in the United States." *Monthly Labor Review*, 117(3).

Dodson, Debra. 1991. *Gender and Policy Making: Studies of Women in Office*. New Brunswick, NJ: Center for the American Woman and Politics.

Education Week. 2002. *Quality Counts 2002: Building Blocks for Success*. Washington, DC: *Education Week*.

Employee Benefit Research Institute. 2001. Unpublished calculations based on the 2001 Current Population Survey March Demographic Supplements, for calendar year 2000.

Emsellem, Maurice, Jessica Goldberg, Rick McHugh, Wendell Primus, Rebecca Smith, and Jeffrey Wenger. 2002. *Failing the Unemployed: A State by State Examination of Unemployment Insurance Systems*. Washington, DC, and New York: Economic Policy Institute, Center on Budget and Policy Priorities, and National Employment Law Project.

Espinosa, Linda M. 1995. *Hispanic Parent Involvement in Early Childhood Programs*. Syracuse, NY: ERIC Clearinghouse on Elementary and Early Childhood Education, EDO-PS-95-3.

Family Violence Prevention Fund. 2001. *2001 State-By-State Legislative Report Card on Health Care Laws and Domestic Violence*. San Francisco, CA: Family Violence Prevention Fund.

Federal Election Commission. 2001a. *2000 House Campaign Summaries—Candidates Listed by State and District*. Data available at website: www.fec.gov/2000/state99.htm. Accessed February 2001.

Federal Election Commission. 2001b. *2000 Senate Campaigns—Candidates Listed by State*. Data available at website: www.fec.gov/2000/state20.htm. Accessed February 2001.

Federal Election Commission. 2000. *The Impact of the National Voter Registration Act on Federal Elections 1999-2000*. Washington, DC: Federal Election Commission.

Fields, Jason, and Lynne M. Casper. 2001. "America's Families and Living Arrangements 2000." *Current Population Reports*, P20-537.

Fisher, Gordon M. 1992. "The Development and History of the Poverty Thresholds." *Social Security Bulletin*, 55(4).

Forrest, J.D., and R. Amara. 1996. "Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditure." *Family Planning Perspectives*, 28(5).

Fredrick, Beth. The Alan Guttmacher Institute. 1998. *Contraception Counts: State by State Information*. New York, NY: The Alan Guttmacher Institute.

Freyer, Felice. 2001. "The New Rhode Island Census 2000 – State's Uninsured on Downward Trend." *Providence Journal-Bulletin*. October 2.

Fullerton, Howard N., Jr., and Mitra Toossi. 2001. "Labor Force Projections to 2010: Steady Growth and Changing Composition." *Monthly Labor Review Online* 124 (11). Article available at website: www.bls.gov/opub/mlr/2001/11/art2exc.htm. Accessed June 2002.

Gershenzon, Leora. 1993. *U.S. Child Support Performance*. San Francisco, CA: The Child Support Reform Initiative.

Ginorio, Angela, and Michelle Huston. 2000. *Si, Se Puede! Yes, We Can: Latinas in School*. Washington, DC: American Association of University Women Educational Foundation.

Grow Smart Rhode Island. 2001. "The Housing Network: A Key Smart Growth Partner." *Grow Smart Newsletter*. December.

Hartmann, Heidi, and Stephanie Aaronson. 1994. "Pay Equity and Women's Wage Increases: Success in the States, A Model for the Nation." *Duke Journal of Gender Law & Policy*, volume 1.

Hartmann, Heidi, Katherine Allen, and Christine Owens. 1999. *Equal Pay for Working Families: National and State Data on the Pay Gap and its Costs*. Washington, DC: AFL-CIO and Institute for Women's Policy Research.

Hartmann, Heidi, Joan A. Kuriansky, and Christine L. Owens. 1996. "Employment and Women's Health," in *Women's Health: The Commonwealth Survey*, Marilyn M. Falik and Karen Scott Collins (eds). Baltimore, MD: Johns Hopkins University Press.

Hartmann, Heidi, Young-Hee Yoon, Roberta Spalter-Roth, and Lois Shaw. 1995. *Temporary Disability Insurance: A Model to Provide Income Security Over the Life Cycle*. Paper presented at the 1995 Annual Meetings of the American Economics Association of the Allied Social Science Associations. Washington, DC: Institute for Women's Policy Research.

The Henry J. Kaiser Family Foundation. 2001. *Women and HIV/AIDS*. Washington, DC: The Henry J. Kaiser Family Foundation.

Henshaw, Stanley K. 1998. "Abortion Incidence and Services in the United States, 1995-1996." *Family Planning Perspectives*, 30(6).

Institute for Law and Justice. 2001. *2001 Session Laws*. Alexandria, VA: Institute for Law and Justice.

Institute for Law and Justice. 2000. *2000 Legislative Session: Violence Against Women Legislation*. Alexandria, VA: Institute for Law and Justice.

Institute for Law and Justice. 1999. *Domestic, Stalking, and Sexual Assault Legislation: State-by-State Analysis of 1999 Legislation*. Alexandria, VA: Institute for Law and Justice.

Institute for Women's Policy Research (IWPR). 2001a. Calculations based on the 1999-2001 Current Population Survey March Demographic Supplements, for calendar years 1998-2000. Originally prepared for the AARP Public Policy Institute. Available at website: http://research.aarp.org/econ/beyond50_states.html.

Institute for Women's Policy Research (IWPR). 2001b. Unpublished calculations based on the 1999-2001 Current Population Survey March Demographic Supplements, for calendar years 1998-2000.

Institute for Women's Policy Research (IWPR). 1999. *Research-in-Brief: How Much Can Child Support Provide? Welfare, Family Income, and Child Support*. Washington, DC: Institute for Women's Policy Research.

Institute for Women's Policy Research (IWPR). 1998. "Reproductive Issues and Welfare Reform." *Welfare Reform Network News* 11/12.

Institute for Women's Policy Research (IWPR). 1996. *Research-in-Brief: Childcare Usage Among Low-Income and AFDC Families*. Washington, DC: Institute for Women's Policy Research. October.

Institute for Women's Policy Research (IWPR). 1995a. *A Cross-State Comparison of the Economic Status of Women. Calculations based on the U.S. Bureau of the Census Public Use Microdata Sample, 1990 and 1980*. Prepared by Susan M. Dynarski under the Public Policy Masters Program at the John F. Kennedy School of Government, Harvard University.

Institute for Women's Policy Research (IWPR). 1995b. *Research-in-Brief: Restructuring Work: How Have Women and Minority Managers Fared?* Washington, DC: Institute for Women's Policy Research. January.

Johnson, Nicole. 2001. *A Hand Up: How State Earned Income Tax Credits Help Working Families Escape Poverty in 2001*. Washington, DC: Center on Budget and Policy Priorities.

Kaiser Commission on Medicaid and the Uninsured. 2001. *Table 13: Medicaid Expenditures per Enrollee, by Group, 1998*. Table produced by the Urban Institute based on data from HCFA-2082 and NCFA-64 reports. Available at website: http://www.kff.org/docs/state/medicaiddata. Accessed December 2001.

Kawachi, Ichiro, Bruce P. Kennedy, Vanita Gupta, and Deborah Prothrow-Stith. 1999. "Women's Status and the Health of Women and Men: A View from the States." *Social Science and Medicine*, (48) 21-32.

Kaye, H. Stephen. 1998. *Disability Watch: The Status of People with Disabilities in the United States*. Oakland, CA: Disability Rights Advocates.

Kenney, Sally J. 2001. "Counting Women Judges: The Intersection of Law and Politics." Paper presented at conference on Critical Junctures in Women's Economic Lives, sponsored by the Center for True Economic Progress. St. Paul, MN.

Ku, Leighton, and Bowen Garrett. 2000. *How Welfare Reform and Economic Factors Affected Medicaid Participation: 1984-96*. Washington, DC: Urban Institute.

Lombard, Karen. 1996. *Female Self-Employment and the Demand for Flexible, Non-Standard Work Schedules*. Working Paper. Miami, FL: University of Miami.

Lovell, Vicky, and Hedieh Rahmanou. 2000. *Fact Sheet: Paid Family and Medical Leave: Essential Support for Working Women and Men*. Washington, DC: Institute for Women's Policy Research.

Lyon, Eleanor. 2000. *Welfare, Poverty, and Abused Women: New Research and Its Implications*. Harrisburg, PA: National Resource Center on Domestic Violence, Pennsylvania Coalition on Domestic Violence.

Martin, Joyce A., Brady E. Hamilton, Stephanie J. Ventura, Fay Menacker, and Melissa M. Park. 2002. "Births: Final Data for 2000." *National Vital Statistics Report*, 50(5).

McNeil, John M. 2000. "Employment, Earnings, and Disability." Paper presented at the 2000 Annual Conference of the Western Economic Association International. Vancouver, British Columbia. Available at website: www.census.gov/hhes/www/disability.html. Accessed February 2002.

Mead, Holly, Kristine Witkowski, Barbara Gault, and Heidi Hartmann. 2001. "The Influence of Income, Education and Work Status on Women's Well-Being." *Women's Health Issues*, 11(3).

Molidor, Christian, and Richard Tolman. 1998. "Gender and Contextual Factors in Adolescent Dating Violence." *Violence Against Women*, vol. 4: 180-94.

NARAL and NARAL Foundation. 2002. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*. Washington, DC: NARAL.

NARAL and NARAL Foundation. 2001. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*. Washington, DC: NARAL.

National Alliance for Caregiving and AARP. 1997. *Family Caregiving in the U.S.: Findings from a National Survey*. Bethesda, MD, and Washington, DC: NAC and AARP.

National Association of Child Advocates. 1998. *Issue Brief: Unemployment Insurance for Low-Income Families: New Challenges for Child Advocates*. Washington, DC: National Association of Child Advocates.

National Association of Commissions for Women. 2000. *Commissions for Women Roster 2000*. Data from website: www.nacw.org/mc_roster.html. Accessed August 2001.

National Center for Health Statistics. 2001a. *Death Rates and Number of Deaths by State, Race/Ethnicity, Sex, Age, and Cause, 1994-1998*. Table available from website: www.cdc.gov/nchs/statestatsbysexrace.htm. Accessed October 2001.

National Center for Health Statistics. 2001b. *National Vital Statistics Report*, 49(1).

National Center for Health Statistics. 2001c. *National Vital Statistics Report*, 49(8).

National Center for Health Statistics. 2001d. *National Vital Statistics Report*, 49(11).

National Center for Health Statistics. 1996. *Health, United States, 1995 Chartbook*. Hyattsville, MD: Public Health Service.

National Center for Health Statistics, Division of Health Promotion Statistics. 2001. *The Healthy People 2010 Database*. Data from website: http://wonder/cdc/gov/data2010/objsearc.htm. Accessed October 2001.

National Center for Lesbian Rights (NCLR). 2001. *Second Parent Adoptions: An Information Sheet*. San Francisco, CA: National Center for Lesbian Rights.

National Committee on Pay Equity. 1997. *State Government Pay Equity Activity*. Washington, DC: National Committee on Pay Equity.

National Conference of State Legislatures Health Policy Tracking Service. 2001. *Fact Sheet: Parity*. Washington, DC: National Conference of State Legislatures Health Policy Tracking Service.

National Council of Women's Organizations, Task Force on Women and Social Security. 1999. *Strengthening Social Security for Women: A Report from the Working Conference on Women and Social Security*. Washington, DC: Institute for Women's Policy Research.

National Employment Law Project. 2001. *Expanding Unemployment Insurance For Low-Wage Workers: State Legislative Highlights (1996-2001)*. New York: National Employment Law Project.

National Gay and Lesbian Task Force Policy Institute. 2001a. *GLBT Civil Rights Laws in the U.S.—August 2001*. Table from website: www.ngltf.org/downloads/civilmap0801.pdf. Accessed September 2001.

National Gay and Lesbian Task Force Policy Institute. 2001b. *Hate Crimes Laws in the U.S.—June 2001*. Table from website: www.ngltf.org/downloads/hatemap0601.pdf. Accessed September 2001.

National Gay and Lesbian Task Force Policy Institute. 2001c. *Specific Anti-Same-Sex Marriage Laws in the U.S.—June 2001*. Table from website: www.ngltf.org/downloads/marriagemap0601.pdf. Accessed September 2001.

National Institute of Mental Health. 1999. *In Harm's Way: Suicide in America*. Bethesda, MD: National Institute of Mental Health.

National Partnership for Women and Families. 2001a. *A Menu of Policy Models for State and Local Policy Leaders*. Washington, DC: National Partnership for Women and Families.

National Partnership for Women and Families. 2001b. *State Round-Up: State Family Leave Benefit Initiatives in 2001: Making Family Leave More Affordable*. Washington, DC: National Partnership for Women and Families.

National Women's Law Center, FOCUS on the Health of Women at the University of Pennsylvania Medical Center, and the Oregon Health and Science University. 2001. *Making the Grade on Women's Health: A National and State-by-State Report Card*. Washington, DC: National Women's Law Center, FOCUS on the Health of Women at the University of Pennsylvania Medical Center, and the Oregon Health and Science University.

National Women's Political Caucus. 1995. *Factsheet on Women's Political Progress*. Washington, DC: National Women's Political Caucus.

National Women's Political Caucus. 1994. *Perception and Reality: A Study Comparing the Success of Men and Women Candidates*. Washington, DC: National Women's Political Caucus.

Negrey, Cynthia, Stacie Golin, Sunhwa Lee, Holly Mead, and Barbara Gault. 2002. *Working First But Working Poor: The Need for Education and Training Following Welfare Reform*. Washington, DC: Institute for Women's Policy Research.

NOW Legal Defense and Education Fund. 2001. *Family Violence Option: 2001 State Law Update*. Washington, DC: NOW Legal Defense and Education Fund.

NOW Legal Defense and Education Fund, National Judicial Education Program. 2001. *Task Forces on Gender Bias in the Courts*. Available at website: www.nowldef.org/html/njep/tfstat.htm. Accessed September 2001.

Pearlman, D., S. Zierler, A. Gjelsvik, and W. Oftedahl. 2001. "Are Economic and Social Deprivation Related to Intimate Partner Violence? A New Approach to Measuring and Monitoring Violence Against Women." Paper presented at the 129th Annual Meeting of the American Public Health Association, Atlanta, GA, Oct. 21-25.

Plaza, Carla I. 2001a. *Women's Health: Coverage for Infertility Treatments*. Washington, DC: National Conference of State Legislatures Health Policy Tracking Service.

Plaza, Carla I. 2001b. *Women's Health: An Overview of Mandated Benefits*. Washington, DC: National Conference of State Legislatures Health Policy Tracking Service.

Population Reference Bureau. 1993. *What the 1990 Census Tells Us About Women: A State Factbook*. Washington, DC: Population Reference Bureau.

Poverty Institute. 2001. *The 2001 Rhode Island Standard of Need*. Providence, RI: Rhode Island College School of Social Work.

President's Interagency Council on Women. 2000. *America's Commitment: Women 2000*. Washington, DC: White House Office of Women's Initiatives and Outreach.

Renwick, Trudi J. 1993. "Budget-Based Poverty Measurement: 1992 Basic Needs Budgets." Proceedings of the Social Statistics Section. Alexandria, VA: American Statistical Association.

Renwick, Trudi J., and Barbara R. Bergmann. 1993. "A Budget-Based Definition of Poverty with an Application to Single-Parent Families." *Journal of Human Resources*, 28(1).

Research Center in Business and Economics. 1996. *Pay Equity in Public Service: What Is the Reality for Rhode Island's Classified Workforce?* Kingston, RI: College of Business Administration, University of Rhode Island.

Resnik, Judith. 1996. "Asking about Gender in Courts." *Signs* 21(4): 952-990.

Reynolds, Paul, Michael Hay, William D. Bygrave, S. Michael Camp, and Erkko Autio. 2000. *Global Entrepreneurship Monitor 2000 Executive Report*. Kansas City, MO: Ewing Marion Kauffman Foundation.

Rhode Island Coalition Against Domestic Violence. 2002. *Family Violence Option Advocacy Program Report*. Warwick, RI: Rhode Island Coalition Against Domestic Violence.

Rhode Island Coalition Against Domestic Violence. 2001a. *Annual Report*. Warwick, RI: Rhode Island Coalition Against Domestic Violence.

Rhode Island Coalition Against Domestic Violence, 2001b. *Resource Guide for Educators*. Warwick, RI: Rhode Island Coalition Against Domestic Violence.

Rhode Island Department of Administration. 1997. *Personnel Reform in Rhode Island: The Dynamics of Work and Equity*. Providence: Rhode Island General Assembly Commission on Pay Equity and Comparable Worth.

Rhode Island Department of Elementary and Secondary Education. 2001. *Public High School Graduates by District, Race, and Gender.* Providence, RI: Rhode Island Department of Elementary and Secondary Education.

Rhode Island Department of Elementary and Secondary Education and the National Center on Public Education and Social Policy. 2001. *Information Works! Measuring Rhode Island Schools for Change*. Providence, RI: Rhode Island Department of Elementary and Secondary Education.

Rhode Island Department of Health, Office of Health Statistics. 2001. *1998 – 2000 Behavioral Risk Factor Surveillance System*. Providence, RI: Rhode Island Department of Health.

Rhode Island Department of Health, Office of Health Statistics. 2000. *Maternal and Child Health Database, Birth Files, 1995-1999*. Providence, RI: Rhode Island Department of Health.

Rhode Island Department of Human Services. 2002. Personal correspondence with staff, 2002.

Rhode Island Department of Human Services. 2001. *Subsidized Child Care Charts Prepared for the Rhode Island General Assembly for 2001 Budget Hearings*. Providence, RI: Rhode Island Department of Human Services.

Rhode Island Department of Labor and Training, Labor Market Information Division. 2001. *Industry Size by Class*. Report available on website: www.dlt.state.ri.us/webdev/lmi/S&FDigest00/privateemp16.htm. Accessed April 2002.

Rhode Island Emergency Food and Shelter Board. 2001. *Rhode Island Emergency Shelter Information Project Annual Report, July 1, 2000 to June 30, 2001*. Providence, RI: Rhode Island Emergency Food and Shelter Board.

Rhode Island Housing and Mortgage Finance Corporation. 2000. *Comprehensive Plan, January 2000*. Providence, RI: Rhode Island Housing and Mortgage Finance Corporation.

Rhode Island Justice Commission. 2002. *Annual Police Training Data.* Providence, RI: Rhode Island Justice Commission.

Rhode Island Kids Count. 2001a. *2001 Rhode Island Kids Count Fact Book*. Providence, RI: Rhode Island Kids Count.

Rhode Island Kids Count. 2001b. *Issue Brief: Safe and Affordable Housing for Rhode Island Children*. Providence, RI: Rhode Island Kids Count.

Rhode Island Kids Count. 2000. *Issue Brief: Children Exposed to Domestic Violence*. Providence, RI: Rhode Island Kids Count.

Robertson, Barbara. 2001. *Women and Disability Resources*. Information from the Society for Disability Studies, University of Illinois at Chicago. Information from website: http://members.tripod.com/~Barbara_Robertson/Women.html. Accessed February 2002.

Schumacher, Rachel, and Mark Greenberg. 1999. *Child Care After Leaving Welfare: Early Evidence from State Studies*. Washington, DC: Center for Law and Social Policy.

Sexual Assault and Trauma Resource Center of Rhode Island. 2002. *Annual Training Data*. Providence, RI: Sexual Assault and Trauma Resource Center of Rhode Island.

Sexual Assault and Trauma Resource Center of Rhode Island. 2000. *Annual Report*. Providence, RI: Sexual Assault and Trauma Resource Center of Rhode Island.

Sexual Assault and Trauma Resource Center of Rhode Island. 1998. *Annual Report*. Providence, RI: Sexual Assault and Trauma Resource Center of Rhode Island.

Shaw, Lois, and Catherine Hill. 2001. *The Gender Gap in Pension Coverage: Evidence From the Survey of Income and Program Participation*. Final Report to the U.S. Department of Labor. Washington, DC: Institute for Women's Policy Research.

Smith, David, and Gary J. Gates. 2001. *Gay and Lesbian Families in the United States: Same-Sex Unmarried Partner Households: A Preliminary Analysis of 2000 United States Census Data*. Washington, DC: Human Rights Campaign.

Snyder, Howard. 2000. *Sexual Assault of Young Children As Reported to Law Enforcement: Victim, Incident, and Offender Characteristics*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Society for Human Resource Management. 2001. *Birth and Adoption Leave Compensation: Legislation in the States*. Alexandria, VA: Society for Human Resource Management.

Spalter-Roth, Roberta, Heidi Hartmann, and Linda M. Andrews. 1990. *Mothers, Children, and Low-Wage Work: The Ability to Earn a Family Wage*. Washington, DC: Institute for Women's Policy Research.

Spalter-Roth, Roberta, Heidi Hartmann, and Nancy Collins. 1993. *What Do Unions Do for Women?* Washington, DC: Institute for Women's Policy Research.

Spalter-Roth, Roberta, Heidi Hartmann, and Lois Shaw. 1993. *Exploring the Characteristics of Self-Employment and Part-Time Work Among Women*. Washington, DC: Institute for Women's Policy Research.

Stetson, Dorothy McBride, and Amy Mazur (eds.). 1995. *Comparative State Feminism*. Thousand Oaks, CA: Sage.

Supreme Court of Rhode Island, Domestic Violence Training and Monitoring Unit. 2000. *Violence Against Women Act (VAWA) Report*. South Kingston, RI: Supreme Court of Rhode Island, Domestic Violence Training and Monitoring Unit.

Swers, Michele. 2002. *The Difference Women Make: The Policy Impact of Women in Congress*. Chicago: University of Chicago Press.

Thomas, Sue. 1994. *How Women Legislate*. New York: Oxford University Press.

U.N. Fourth World Conference on Women. 1995. *Beijing Declaration and Platform for Action*. New York: United Nations.

U.S. Bureau of Economic Analysis. 2001. *Regional Accounts Data: Annual State Personal Income: Per Capita Personal Income*. Table from website: www.bea.doc.gov/bea/regional/spi/drill.cfm. Accessed July 2001.

U.S. Department of Commerce, Bureau of the Census. 2002a. *American FactFinder: Detailed Tables*. Data available at website: http://factfinder.census.gov.

U.S. Department of Commerce, Bureau of the Census. 2002b. *Historical Income Tables—People: Table P-38, Full-Time, Year-Round Workers (All Races) by Median Earnings and Sex: 1960-2000*. Table from website: www.census.gov/hhes/income/histinc/p38.html. Accessed February 2002.

U.S. Department of Commerce, Bureau of the Census. 2002c. *Reported Voting and Registration of the Total Voting-Age Population, by Sex, Race, and Hispanic Origin, for States: November 2000*. Table available at website: www.census.gov/population/www/socdemo/voting/p20-542.html. Accessed April 2002.

U.S. Department of Commerce, Bureau of the Census. 2001a. *Fertility of American Women: June 2000*. Census Bureau Reports, P20-543RV.

U.S. Department of Commerce, Bureau of the Census. 2001b. *Profile of General Demographic Characteristics*. Table from website: www.census.gov/prod/cen2000/index.html. Accessed November 2001.

U.S. Department of Commerce, Bureau of the Census. 2001c. *Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population Five Years and Over*. Table from website: http://factfinder.census.gov/servlet/DatasetMainPageServlet. Accessed November 2001.

U.S. Department of Commerce, Bureau of the Census. 2001d. *Statistical Abstract of the United States: 2001*. Washington, DC: Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 2001e. *Sex by Marital Status for the Population 15 Years and Over*. Table from website: http://factfinder.census.gov/servlet/DatasetMainPageServlet. Accessed November 2001.

U.S. Department of Commerce, Bureau of the Census. 2001f. *Women-Owned Businesses: 1997 Economic Census, Survey of Women-Owned Business Enterprises*. Company Statistics Series. EC97CS-2. Washington, DC: Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 2000a. *Educational Attainment in the United States*. Current Population Reports P20-536.

U.S. Department of Commerce, Bureau of the Census. 2000b. *Population Estimates for the U.S. and States by Selected Age Groups, Annual Time Series, July 1, 1990 to July 1, 1999*. Table from website: www.census.gov/population/estimates/state/st-99-09.txt. Accessed September 2001.

U.S. Department of Commerce, Bureau of the Census. 2000c. *Reported Voting and Registration, by Sex, Race, and Hispanic Origin, for States: November 1998*. Table from website: www.census.gov/population/socdemo/voting/cps1998/tab04.txt. Accessed November 2001.

U.S. Department of Commerce, Bureau of the Census. 2000d. *Statistical Abstract of the United States: 2000*. Washington, DC: Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 2000e. *Summary File 2, Census 2000 – 100 Percent Data*. Washington, DC: U.S. Department of Commerce, Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 2000f. *Voting and Registration in the Election of November 1998*. P20-523RV. Washington, DC: Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 1999. *Educational Attainment in the United States*. Washington, DC: Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 1997. *Poverty in the U.S.: 1996.* Current Population Reports. P60-198.

U.S. Department of Commerce, Bureau of the Census. 1996a. *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*. Population Paper Listing 47. Washington, DC: U.S. Department of Commerce, Bureau of the Census.

U.S. Department of Commerce, Bureau of the Census. 1996b. *Who's Minding Our Preschoolers?* Current Population Reports, P-70-53.

U.S. Department of Commerce, Bureau of the Census. 1990. *Summary File 1, Census 1990 – 100 Percent Data*. Washington, DC: U.S. Department of Commerce, Bureau of the Census.

U.S. Department of Education. 1999. *Dropout Rates in the United States: 1998*. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

U.S. Department of Health and Human Services, Administration for Children and Families. 2001. *FY 2000 Preliminary Data Preview Report, July 2001*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Administration for Children and Families. 2000a. *Child Care and Development Block Grant/Child Care and Development Fund: Children served in Fiscal Year 1999 (average monthly)*. Table available at website: www.acf.dhhs.gov/news/press/2000/cctable.htm. Accessed December 2001.

U.S. Department of Health and Human Services, Administration for Children and Families. 2000b. *Twenty-Third Annual Report to Congress*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Administration for Children and Families. 1999. *Temporary Assistance for Needy Families (TANF) Program: Second Annual Report to Congress, August 1999*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Health Care Financing Administration. 1999. *Medicaid Eligibles by Basis of Eligibility and State, Fiscal Year 1997*. Table from website: www.hcfa.gov/medicaid/MCD97T17.htm. Accessed January 2000.

U.S. Department of Health and Human Services, Office of the Surgeon General. 2001. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001*. Rockville, MD: Office of the Surgeon General. Available at website: www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf. Accessed May 2002.

U.S. Department of Health and Human Services, Public Health Service. 2000. *Healthy People 2010: National Health Promotion and Disease Prevention Objectives.* Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Justice, Bureau of Justice Statistics. 2001. *Prisoners in 2000*. Bureau of Justice Statistics Bulletin No. NCJ-188207. Washington, DC: U.S. Department of Justice.

U.S. Department of Justice, Office of Justice Programs, Violence Against Women Grants Office. 1998. *Stalking and Domestic Violence: The Third Annual Report to Congress under the Violence Against Women Act*. Washington, DC: Office of Justice Programs.

U.S. Department of Labor. 2002. *Minimum Wage Laws in the States*. Data available at website: www.dol.gov/esa/minwage/america.htm. Accessed April 2002.

U.S. Department of Labor. 2001. *Balancing the Needs of Families and Employers: Family and Medical Leave Surveys*. Washington, DC: U.S. Department of Labor.

U.S. Department of Labor, Bureau of Labor Statistics. 2002. *Employment Status of the Civilian Noninstitutional Population by Sex, Age, Race, and Hispanic Origin, 2000 Annual Average*. Data available at website: www.bls.gov/gps/home.htm. Accessed January 2002.

U.S. Department of Labor, Bureau of Labor Statistics. 2001a. *Geographic Profile of Employment and Unemployment, 1999*. Washington, DC: Government Printing Office.

U.S. Department of Labor, Bureau of Labor Statistics. 2001b. *Table 19. States: Experienced Labor Force by Class of Worker, Sex, Selected Age, Race, and Hispanic Origin, Annual Average 1999*. Unpublished table based on the Current Population Survey.

U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service. 2001. *Comparison of State Employment Insurance Laws*. Washington, DC: U.S. Department of Labor.

U.S. Small Business Administration. 1999. *1999 Small Business Profile: United States*. Washington, DC: U.S. Small Business Administration.

Welfare Information Network. 2001. Personal correspondence with staff, December.

Welfare Information Network, National Governors' Association, Association of Public Human Service Agencies, and Administration for Children and Families. 2001. *State Plan Database*. Data available at website: www.welfareinfo.org/SPD-reports.htm. Accessed July 2001.

Wolfinger, Raymond, and Steven Rosenstone. 1980. *Who Votes?* New Haven: Yale University Press.

Yoon, Young-Hee, Roberta Spalter-Roth, and Marc Baldwin. 1995. *Unemployment Insurance: Barriers to Access for Women and Part-Time Workers*. Washington, DC: Institute for Women's Policy Research.

Zahradnik, Bob, Nicholas Johnson, and Michael Mazerov. 2001. *State Income Tax Burdens on Low-Income Families in 2000: Assessing the Burden and Opportunities for Relief*. Washington, DC: Center on Budget and Policy Priorities.