



The
Montgomery County Foundation Inc.

Inspiration...Collaboration...Impact

The Status of Women in Montgomery County, Pennsylvania: 2018 Report

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CENTER FOR SOCIAL AND ECONOMIC
POLICY RESEARCH

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INTRODUCTION & METHODOLOGY

The purpose of this report is to provide a comprehensive baseline assessment of the status of women in Montgomery County, Pennsylvania that can be used by community leaders, stakeholders, and policymakers who want to improve the well-being of women in the county. Data for this report was obtained from both primary and secondary sources. Primary data was gathered by the researcher through a nonprofit provider survey, focus groups, and in-depth interviews. Secondary data already exists and was gathered by someone else other than the researcher, and in this report, it came from a variety of government agencies and nonprofit organizations. National, state, and county level data were provided when possible to provide a basis of comparison for interpretation. Every effort has been made to include the most recent data available at the time this report was originally drafted.

Methodology

Both quantitative and qualitative data were gathered for this study to provide a greater understanding of the topic. Quantitative data was gathered through the secondary data analysis and a nonprofit provider “snapshot” survey. The descriptive statistics presented here provide an easy basis of comparison between outcomes for women and men and for women of color. Qualitative data was gathered in the focus groups, interviews, and open-ended survey questions to provide a deeper understanding of women’s experiences and challenges in Montgomery County that cannot be easily quantified.

Secondary Data Analysis

A variety of national, state, and county or regional sources and databases were used in this report. Even though the secondary data presented here are available through a variety of existing sources, this report compiled all of the data into one comprehensive examination that focuses specifically on women and topics of interest to The Montgomery County Foundation, Inc. National and/or state level data was provided as a basis of comparison and to illustrate overall trends when county-level data was unavailable or when county-level data on women of color was unavailable due to small sample sizes. Data sources include, but are not limited to, the list below:

- Center for American Women and Politics
- Institute for Women’s Policy Research
- National Conference of State Legislatures
- Montgomery County Administration
- Montgomery County Health Department
- Montgomery County Planning Commission
- Montgomery County Veteran Affairs
- Montgomery County Voter Services
- Pennsylvania Coalition against Domestic Violence

- Pennsylvania Department of Education
- Pennsylvania Department of Health
 - *EDDIE (Enterprise Data Dissemination Informatics)*
 - *Opioid Data Dashboard*
 - *Pennsylvania and County Health Profiles*
- Pennsylvania Department of Labor and Industry
- Pennsylvania Department of State
- National Institute of Mental Health
- Social Security Administration
- U.S. Census Bureau
 - *American Community Survey*
 - *Current Population Survey*
 - *Voting and Registration Supplement*
- U.S. Department of Health and Human Services
- U.S. Centers for Disease Control and Prevention
 - *Behavioral Risk Factor Surveillance System*
 - *Cancer Statistics Data Visualizations*
 - *Interactive Atlas of Heart Disease and Stroke*
 - *The National Intimate Partner and Sexual Violence Survey*
 - *NCHHSTP AtlasPlus*
 - *WISQARS (Web-Based Injury Statistics Query and Reporting System)*
- U.S. Department of Labor
 - *Women’s Bureau*
 - *Bureau of Labor Statistics*
- U.S. Department of Veteran Affairs
- U.S. Office of Women’s Health

Nonprofit Provider “Snapshot” Survey

In order to determine the needs, resources, and barriers that women face in terms of services, a Nonprofit Provider “Snapshot” Survey was distributed to nonprofit organizations and government agencies that provide social services within Montgomery County. Organizations were asked to describe the programs and services provided, to identify services women had difficulty accessing, as well as any barriers they might face in serving clients.

Focus Groups

Focus groups allow a researcher to find out how people feel about a particular topic or issue. By conducting multiple focus groups, a researcher can assess recurring themes (Krueger and Casey 2009). The Montgomery County Foundation, Inc. recruited participants from a variety of backgrounds and experiences to participate in focus groups in order to gather a diversity of perspectives on the resources and needs of women in Montgomery County. Special attention was given to demographic and geographic diversity in the composition of each focus group. In

total, the Center for Social and Economic Policy research conducted five focus groups with the following populations: nonprofit executives, community leaders, nonprofit staff, and nonprofit clients. It was important to The Montgomery County Foundation, Inc. to reach out specifically to women who utilize nonprofits in the county in order to learn about their perspectives. The Center for Social and Economic Policy conducted two focus groups with nonprofit clients at local nonprofit organizations – one at a women’s resource center and one at a Latino family center. Translation was provided at the Latino community center to garner the greatest levels of participation possible.

In-Depth Interviews

Two in-depth interviews were conducted to gather more detailed information about vulnerable female populations that could not be fully captured in focus groups or surveys. After the focus groups were conducted, The Montgomery County Foundation, Inc. and the Center for Social and Economic Policy Research collaborated with one another to determine what populations of women were least represented and targeted interviews for those groups. One interview was conducted in person, and one interview was conducted over the phone.

Montgomery County: An Overview

Montgomery County is one of the wealthiest counties in Pennsylvania (Montgomery County Planning Commission 2014), and it has the third largest population out of 67 counties in the state. According to the U.S. Census Bureau, the population of Montgomery County was 826,075 in 2017 (U.S. Census Bureau QuickFacts), and the median age was 41.4 in 2016 (U.S. Census Bureau 2016a). The racial and ethnic demographics of the county are 82% White, 77% non-Hispanic White, 9% Black or African American, 7% Asian, 5% Hispanic, less than .5% American Indian or Alaska Native, less than .5% Native Hawaiian and Other Pacific Islander, 1% some other race, and 2% two or more races. Individuals who are Hispanic may be of any race. Veterans make up 6.7% of Montgomery County’s population (U.S. Census Bureau 2016b).

In Montgomery County, the median household income was \$81,902 in 2016 (U.S. Census Bureau 2016a). Approximately 7% of households had incomes below \$15,000 a year, and about 21% had incomes over \$150,000. The poverty rate was 4.6% in 2016, but was 6.6% from 2012-2016. In 2016, the veteran unemployment rate was 7.2% (Pennsylvania Department of Labor and Industry 2018).

Educational levels are high in Montgomery County. From 2012-2016, 94% of the population over 25 years had graduated from high school, and 47% had obtained a bachelor’s degree or higher (U.S. Census Bureau 2016b). Only 6% had not completed high school.

Approximately 90% of Montgomery County residents were native residents of the United States (U.S.) from 2012-2016, and about 10% were foreign born (U.S. Census Bureau 2016b). Of those who were foreign born, 56% were naturalized U.S. citizens. The majority of foreign born residents came from Asia (52.1%), Latin America (21%), and Europe (20%).

A plurality of residents (25.4%) in Montgomery County worked in the industry of “education services, health care, and social assistance” services. Approximately 49.2% of the civilian work force aged 16 and over worked in management, business, science, and arts occupations (U.S. Census Bureau 2016b).

The median gross rent was \$1,218, substantially higher than Pennsylvania’s median rent of \$881. Among renters in Montgomery County, 48% of them spent 30% or more of their household income on housing. About 1% of households had no telephone services, and 6% had no automobiles (U.S. Census Bureau 2016b).

The income inequality index as measured by the Gini index was .4653 for Montgomery County from 2011-2015 (U.S. Census Bureau 2015). This is slightly lower than the national average of .4787 for the United States and .4667 for Pennsylvania, meaning that income inequality was somewhat less in Montgomery County compared to the nation and state.

Outline of Report

Although American women received the right to vote in 1920, progress towards equality has been slow because of legal barriers and social norms surrounding gender. In the 1960s, women started to make substantial progress towards political, economic, and social equality. Most legal barriers have been removed, and gendered expectations have started to change. However, women still face a number of inequalities in various aspects of their work and home life. This report explores each of those areas systematically and is organized around the following topics related to the quality of women’s lives: employment and earnings, work and family, poverty and opportunity, health and well-being, reproductive rights and infant health, violence and safety, political participation, and women veterans. Following the examination of these topics is a summary of the challenges women face in Montgomery County, gathered from themes that emerged in the nonprofit provider survey, focus groups, and interviews. Last, a list of recommendations is provided.

Although the basic topical framework for this report is modeled after research conducted by the Institute for Women’s Policy Research, it includes additional topics and comparative data from Montgomery County and Pennsylvania, as well as more recent data when available. The specific subtopics explored also vary considerably. Further, this report includes primary data from surveys, focus groups, and interviews in order to gather data specific to Montgomery County.

EMPLOYMENT & EARNINGS

Introduction

Despite the fact that women make up almost half of the workforce, their wages lag behind those of men. Although there was a great deal of improvement in women's wages during the 1980s, that progress slowed in the 1990s. The gender wage gap is still a concern for women nationwide. Women make 80.5 cents for every dollar that men make (IWPR #C463, 2018; National Women's Law Center 2018). At the current rate, it would take until the year 2059 for women to receive equal pay nationally. Historically, women's lower educational levels contributed to the gender gap, but women are earning college degrees at slightly higher rates than men. One of the biggest contributors to the gender wage gap is occupational segregation, the distribution of women and men in certain occupations where men's occupations receive higher pay regardless of the necessary education or skills (Levanon et al. 2009). Women of color are even more likely to be segregated into lower paying jobs than their white female counterparts (Alonso-Villar and Otero 2013).

In 2017, women in Pennsylvania earned approximately 78.4 cents for every dollar that a man made (IWPR #R532, 2018). At the current rate, it would take until the year 2068 for women in Pennsylvania to receive equal pay (IWPR, #C464, 2018). Approximately 32.1% of women in Pennsylvania work in low wage jobs, and men are 2.2 times more likely to work in STEM (Science, Technology, Engineering, and Math) fields than women (Hess et al. 2015).

Employment & Earnings in the United States, Pennsylvania, & Montgomery County

According to the Institute for Women's Policy Research (IWPR), the state of Pennsylvania ranked 23rd out of all 50 states and the District of Columbia in regard to employment and earnings for women in 2016. This ranking is based on research performed by the Institute for Women's Policy Research, which created the Employment and Earnings Composite Index in 1996. This measure was created by standardizing the score for four different areas related to women's wages: women's median annual earnings, the gender wage gap (ratio of women's to men's earnings), women's labor force participation, and women's representation in professional or managerial occupations. These scores were then combined to create a composite score that was used for ranking the states. Higher composite scores indicate better performance. Over the past 20 years, Pennsylvania's ranking among the states has improved. Table 1.1 shows Pennsylvania's ranking has increased from a rank of 36 in 1996 to a rank of 34 in 2006 to a rank of 23 in 2016. The overall grade has improved as well from a C- in 2006 to a C+ in 2016. Overall, Pennsylvania's most current ranking places it in the middle third of the states.

Table 1.1. Comparison of Pennsylvania’s Status on Employment and Earnings Composite Index and Its Components, 1996, 2006, 2016

Composite Score				Median Annual Earnings Full-time, Year-Round for Employed Women	Earnings Ratio Between Full-Time, Year-Round Employed Women & Men		Percent of Women in the Labor Force		Percent of Employed Women, Managerial, or Professional Occupations		
Year	Score	Rank	Grade	Dollars	Rank	Percent	Rank	Percent	Rank	Percent	Rank
1996	3.79	36	n/a	\$18,000	20	65.5%	38	54.60%	48	27.2%	32
2006	3.84	34	C-	\$31,800	19	74.8%	30	58.1%	38	31.5%	35
2016	3.98	23	C+	\$40,000	17	78.4%	32	58.0%	32	41.7%	21

Source: Status of Women in the States, Fact Sheet, IWPR #R532, 2018 and IWPR Status of Women in the States Data

Table 1.2 compares the population, employment status, and earnings for men and women in the United States, Pennsylvania, and Montgomery County. The population of women in Montgomery County (16 years and older) is similar to that of the U.S. and Pennsylvania. The percentage of women in the labor force is slightly higher in Montgomery County at 66.1% than it is in Pennsylvania (62.6%) or the U.S. (63.5%). Median earnings are also higher for women at \$52,279 in Montgomery County. Median earnings for women are \$40,223 in Pennsylvania and are \$39,923 for women nationwide.

Table 1.2. Population, Employment, and Earnings in the United States, Pennsylvania, and Montgomery County, 2016

	United States	Pennsylvania	Montgomery County
Total population	323,127,515	12,802,503	821,725
Men	49.2%	49.0%	48.6%
Women	50.8%	51.0%	51.4%
Employment status			
Population 16 years & older	253,323,709	10,402,780	657,401
In labor force	63.5%	62.6%	66.1%
Not in labor force	36.5%	37.4%	33.9%
Female 16 years & older	129,683,350	5,366,558	341,942
In labor force	58.4%	58.2%	62.9%
Employed	54.1%	54.3%	59.5%
Unemployed	7.4%	7.2%	5.9%
Median earnings for full-time, year-round workers			
Men	\$50,586	\$51,780	\$68,634
Women	\$40,626	\$41,047	\$52,254

Source: U.S. Census Bureau, 2016 American Community Survey, 1-Year Estimates

The Gender Wage Gap

The gender wage gap refers to the ratio of women’s earnings to men’s. It can be measured in a variety of ways, including the average or median yearly earnings compared to men’s. It can also be measured using weekly full-time earnings, but this report refers to median yearly earnings in most instances. There was little improvement in the wage gap during the 1960s and 1970s (IWPR #C464, 2018). There was not significant progress until the 1980s. From 1980 to 1990, the ratio of female-to-male earnings increased by over ten percentage points from 60.2% to 71.6% (of men’s wages). During the 1990s, the wage gap went up and down, netting an improvement of about two percentage points. Since 2000, the wage gap has again increased and decreased, but overall, the ratio of female-to-male earnings has improved by about five percentage points. In 2016, women’s earnings were 80.5% of men’s earnings in the United States. The gender wage gap also varies considerably by state. In 2016, California had the smallest wage gap, with women’s earnings at 90% of men’s earnings. Louisiana had the largest gender gap, with women’s earnings at 69% of men’s. Pennsylvania falls in the middle third of states with a rank of 32. In 2016, women’s earnings in Pennsylvania were 78.4% of men’s earnings (IWPR #R532, 2018).

Earnings and the Gender Wage Gap for Women of Color

Women’s earnings vary considerably by race and ethnicity (Table 1.3). Among women, those of Asian descent have the highest median annual earnings at \$50,831 followed by White women at \$41,607. Hispanic women and those who identify as “some other race” have the lowest median annual earnings at \$30,482 and \$28,063 respectively.

Table 1.3. Median Annual Earning for Women and Men Employed Full-Time, Year-Round by Race/Ethnicity, United States, 2016

Median Annual Earnings		
Race/Ethnicity	Women	Men
White	\$41,607	\$52,102
Black or African American	\$35,382	\$39,431
American Indian or Alaska Native	\$32,379	\$37,128
Asian	\$50,831	\$63,239
Native Hawaiian or Other Pacific Islander	\$33,453	\$41,837
Some Other Race	\$28,063	\$32,010
Two or More Races	\$39,556	\$45,860
Hispanic or Latino origin (of any race)	\$30,482	\$35,069
White, Not Hispanic or Latino	\$43,346	\$56,386
All full-time, year-round workers 16 years & over with earnings	\$40,626	\$50,586

Source: U.S. Census, American Community Survey, 1-Year Estimates, 2016

Table 1.4 shows the median annual earnings of women and men in the United States, Pennsylvania, and Montgomery County along with the ratio of women's earnings to men's within the same racial/ethnic group. In Montgomery County, median annual earnings of women and men in all racial/ethnic groups outpace those of the United States and Pennsylvania although there is no county level data on female American Indians/Alaska Natives. In terms of the gender wage gap, women in Montgomery County fare worse when it comes to their racial/ethnic counterparts. In Montgomery County, the median annual earnings for all women are only 75.7% of men's earnings (Table 4), compared to the national average of 80.5% (IWPR #C464, 2018).

Asian men and women have the highest median annual salaries in their respective genders, but the gender wage gap is largest for Asian women in Montgomery County - where they only make 67.4% of Asian men's annual earnings. The ratio is similar at the state level for Asian women at 67.9%, but the ratio at the national level is substantially higher at 80.4%. The gender wage gap is the lowest among Black women and men in Montgomery County at 97.5%. In Pennsylvania, this ratio is similar at 98.4%, and in the United States, the ratio is 94.7%. To clarify, the gender wage gap is best for Black women (when compared to Black men) and worst for Asian women (when compared to Asian men). Annual earnings for Hispanic women and men are the lowest in the United States, Pennsylvania, and Montgomery County. In terms of the gender wage gap, Hispanic women's salaries in Montgomery County are 76.6% of Hispanic men's salaries. When the salaries of women in all racial/ethnic groups are compared to the salaries of White men, the wage gap widens considerably (Table 1.4).

Table 1.4. Women’s and Men’s Median Annual Earnings & the Gender Earnings Ratio by Ethnicity, United States, Pennsylvania, & Montgomery County, 2016

Race/ Ethnicity	Women			Men			Ratio of Women's Earning to Men's by Racial/Ethnic Group		
	US	PA	Montgomery County	US	PA	Montgomery County	US	PA	Montgomery County
Asian	\$50,831	\$41,947	\$55,059	\$63,239	\$61,814	\$81,740	80.4%	67.9%	67.4%
White	\$41,607	\$41,732	\$53,599	\$52,102	\$52,971	\$71,470	79.9%	78.8%	75.0%
Two or More Races	\$39,566	\$35,897	\$50,810	\$45,860	\$40,143	\$54,077	86.2%	89.4%	94.0%
Black	\$35,382	\$36,780	\$46,940	\$39,431	\$37,371	\$48,148	94.7%	98.4%	97.5%
Hispanic	\$30,482	\$30,420	\$37,478	\$35,069	\$37,141	\$48,913	86.9%	81.9%	76.6%
American Indian/ Alaskan Native	\$32,379	\$27,013	--	\$37,128	\$45,687	\$100,132	87.2%	59.1%	--
Native Hawaiian or Other Pacific Islander	\$33,453	\$30,180	--	\$41,837	\$65,753	--	80.0%	45.90%	--
TOTAL	All Women to All Men								
American Community Survey	\$40,626	\$41,047	\$52,254	\$50,586	\$51,780	\$68,634	80.3%	79.3%	75.7%

Source: Compiled from American Community Survey, 1-Year Estimates (AmericanFactFinder.census.gov)

Notes: 2016 Inflation-Adjusted Dollars, Population 16 Years and Over, Full-time Year-Round Workers

Table 1.5 shows the ratio of women’s earnings by race/ethnic group compared to men of the same racial/ethnic group and White men at the national, state, and county level. The second column of Table 5 is the same as the last column of Table 4, but more easily provides a direct comparison to earnings of White men. In every racial/ethnic group, women earn less than men in the same group and less than White men.

At the national level, Asian women fare the best in terms of the wage gap, with annual earnings that are 97.5% of White men’s earnings. In fact, the wage gap for Asian women is better when compared to White men than to other Asian men at 80.4%. In Montgomery County and

Pennsylvania, Asian women’s earnings are the highest of all women when compared to the earnings of White men at 77% and 79.1% respectively. Hispanic women fare the worst earnings ratio compared to White men at all levels. Hispanic women’s earnings are 58.5% of White men’s earnings in the United States, 57.4% in Pennsylvania, and 52.4% in Montgomery County. While Black women’s median earnings may be close to Black men’s, they are not close to those of White men’s. Black women’s earnings are 68.5% of White men’s earnings in Montgomery County, 69.4% of White men’s earnings in Pennsylvania, and 62.1% of White men’s earnings nationwide.

Table 1.5. Ratio of Women’s Earnings by Race/Ethnicity to White Men’s Earnings, United States, Pennsylvania, & Montgomery County, 2016

Race/ Ethnicity	Ratio of Women’s Earnings to Men’s Earnings of the Same Racial/Ethnic Group			Ratio of Women’s Earnings to White Men’s		
	U.S.	PA	Montgomery County	U.S.	PA	Montgomery County
Asian	80.4%	67.9%	67.4%	97.5%	79.1%	77.0%
White	79.9%	78.8%	75.0%	79.8%	78.8%	75.0%
Two or More Races	86.2%	89.4%	94.0%	75.9%	67.8%	71.0%
Black	94.7%	98.4%	97.5%	67.9%	69.4%	68.5%
Hispanic	86.9%	81.9%	76.6%	58.5%	57.4%	52.4%
American Indian/ Alaskan Native	87.2%	59.1%	--	62.1%	51.2%	--
Native Hawaiian or Other Pacific Islander	80.0%	45.90%	--	62.1%	51.0%	--

Source: Compiled from American Community Survey, 1-Year Estimates (AmericanFactFinder.census.gov)

Notes: 2016 Inflation-Adjusted Dollars, Population 16 Years and Over, Employed Full-Time, Year-Round

The Earnings Ratio and Educational Attainment

Educational attainment is strongly associated with higher levels of annual earnings for both men and women (Table 1.6). The more education a person has, the more money he/she is likely to earn at the national, state, and county level. Regardless of the level of education that women achieve, however, men’s earnings outpace women’s (Tables 1.6 and 1.7). Table 1.6

breaks down the median annual earnings of men and women by educational attainment. In 2016, men made more than women in all categories of education in the United States, Pennsylvania, and Montgomery County. Women who have less than a high school education earn approximately the same in the United States, Pennsylvania, and Montgomery County. When women have a graduate or professional degree, however, they make substantially more in raw dollars in Montgomery County compared to Pennsylvania and the United States. As a ratio of men’s earnings, though, women in Montgomery County make less than their male counterparts at the state and national level (Table 1.7).

Table 1.6. Median Earnings in the Past 12 Months by Gender and Educational Attainment in the United States, Pennsylvania, and Montgomery County, 2016

Level of Education	United States		Pennsylvania		Montgomery County	
	Men	Women	Men	Women	Men	Women
Less than high school graduate	\$25,943	\$16,618	\$27,422	\$16,859	\$32,672	\$16,922
High school graduate (includes equivalency)	\$35,427	\$23,010	\$37,115	\$23,682	\$44,682	\$28,399
Some college or associate's degree	\$42,071	\$29,854	\$42,748	\$30,649	\$47,300	\$34,558
Bachelor's degree	\$63,113	\$43,047	\$61,491	\$42,127	\$71,711	\$47,271
Graduate or professional degree	\$86,879	\$58,724	\$86,290	\$59,533	\$102,069	\$67,335

Source: Compiled from U.S. Census Bureau, American Community Survey, 2016, 1-Year Estimates

Notes: Median Earnings in the Past 12 Months (in 2016 Inflation-Adjusted Dollars) by Sex by Educational Attainment for the Population 25 Years and Over

While Table 1.6 shows median earnings of men and women and educational level, Table 1.7 shows these earnings as a ratio of women’s earnings to men’s earnings. The earnings gap at the national level ranges from a low of 64.0% for “less than a high school education” to a high of 70.9% for “some college or associate’s degree.”

Nationwide, women who have less than a high school education have the largest gap in earnings compared to men - making only 64.0% of what men who have less than a high school education do. At the state level in Pennsylvania, women who have less than a high school education also have the largest gap at 61.4% - meaning women with less than a high school education only make 61.4% compared to similarly educated men. Similarly, in Montgomery County, women with less than a high school education have the largest gap – earning only 48.2% of their male counterparts. Thus, women with less than a high school education in Montgomery County are making substantially less than their male counterparts compared to the national and state ratios.

Women with some college or an associate’s degree fare the best in terms of the gender earnings ratio. With this level of educational attainment, women earn 70.9% of what their male counterparts do in the United States, 71.7% in Pennsylvania, and 73.1% in Montgomery County. Women in Montgomery County have a lower gender earnings ratio at all levels of education compared to the United States and Pennsylvania, except for those who have some college or an associate’s degree. For example, women with a graduate degree in Montgomery County only earn 66.0% of what their male counterparts earn, while women in Pennsylvania earn 69.0%, and women in the United States earn 67.6%.

Table 1.7. Women's Earnings Ratio by Educational Attainment for the United States, Pennsylvania, and Montgomery County, 2016

Level of Education	Gender Earnings Ratio		
	United States	Pennsylvania	Montgomery County
Less than high school graduate	64.0%	61.4%	48.2%
High school graduate (includes equivalency)	65.2%	63.8%	63.6%
Some college or associate's degree	70.9%	71.7%	73.1%
Bachelor's degree	68.2%	68.5%	65.9%
Graduate or professional degree	67.6%	69.0%	66.0%

Source: Compiled from U.S. Census Bureau, American Community Survey, 1-Year Estimates

Even though millennial women (born between 1980 and 1996) are the most educated in the history of the United States, they still face a wage gap. However, this gap is less for millennial women than women of other age groups. In 2013, millennial women’s median annual earnings (full-time, year-round) were \$30,000, while millennial men’s earnings were \$35,000. Thus, the earnings ratio for millennial women was 85.7% - which is slightly better than the national earnings ratio for women at 80.5% in 2016. In 2013, millennial women aged 16-34, participated in the workforce at a rate of 67.8%, compared to 73.1% for millennial men. Further, millennial women are more likely to be in managerial or professional occupations (37.2%) than their male counterparts (25.4%) (Hartman et al, 2016, p. 46). In Pennsylvania, the earnings ratio for millennial women working full-time, year-round was an average of 86.1% from 2011-2013. Pennsylvania ranks 33 among states in regard to the gender earnings ratio for millennial women (Hess et al. 2015).

Cumulative Losses from the Gender Wage Gap

Over the course of a lifetime, women lose a tremendous amount of money due to the wage gap. In 2016, lifetime losses in earnings for women added up to \$414,440 nationwide calculated at the current wage gap for a 40-year career (National Women’s Law Center 2018).

For women born between 1955 and 1959 who worked full-time, year-round, the losses were even greater at \$531,502 by the time they were 59 years old (Hess et al. 2015). For women with a college education in that same cohort, the losses were almost \$800,000. The State of Pennsylvania ranked 30 out of 50 states and the District of Columbia with lifetime losses in earnings at \$429,320 – also calculated at the current wage for a 40-year career (National Women’s Law Center 2018). Women in Pennsylvania would need to work until age 70 in order to make what a man would make by age 60.

Women of color fare even worse in terms of cumulative losses due to the gender wage gap. In 2016, lifetime losses for Black women added up to \$867,920 nationwide, calculated at the current wage gap for a 40-year career (National Women’s Law Center 2018). Compared to other states, Pennsylvania ranked 9th in Black women’s lifetime losses of earnings at \$679,920. Lifetime losses for Asian women are the best among all groups of women at \$292,400 nationwide and \$418,280 in Pennsylvania. However, it must be noted there is considerable variation among subgroups of Asian women’s earnings and losses. In 2015, Burmese and Fijian women earned 44% and 45% respectively of what a White man earns (National Women’s Law Center 2017). Hmong and Cambodian women earned 55% of a White man’s salary. As a result of these disparities, the numbers regarding Asian women must be interpreted with caution. Latina women fared the worst lifetime losses among women of color, with lifetime losses of \$1,056,120 in the United States and \$908,880 in Pennsylvania (National Women’s Law Center 2018).

Gender Inequality in Low and High Paid Jobs

Occupational segregation is the distribution of women and men into certain occupations. The highest paid occupations tend to be dominated by men, and the lowest paid occupations tend to be dominated by women. Figure 1.1 shows the distribution of women and men in top and bottom quartiles in Pennsylvania. In 2013, women made up 32.1% of the bottom quartile of jobs in terms of compensation, while men made up only 19.5% of this quartile. Women only comprised 17.9% of the top quartile of jobs, while men made up 30.9% of this quartile.

Figure 1.1. Gender Inequality at the Top and Bottom of the Labor Market: Quartile Distributions in Pennsylvania, 2013



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates

Median household income in Montgomery County is the second highest in the region at \$84,113 (Table 1.8). This is considerably higher than the median household income for Pennsylvania, which is \$56,907 and the United States, which is \$57,617. Table 1.8 provides the median household income for the United States, Pennsylvania, Montgomery County, and three adjacent counties in southeastern Pennsylvania.

Table 1.8. Comparison of Median Household Income in the United States, Pennsylvania, Montgomery County & Surrounding Counties, 2016

Geographic Region	Median Household Income in the Past 12 Months (2010)	Median Household Income in the Past 12 Months (2016)	Percent Change
United States	\$51,914	\$57,617	11.0%
Pennsylvania	\$50,398	\$56,907	12.9%
Montgomery County	\$76,380	\$84,113	9.5%
Bucks County	\$74,828	\$79,936	6.8%
Chester County	\$84,741	\$92,407	9.1%
Delaware County	\$61,867	\$67,950	9.8%

Source: Compiled from U.S. Census Bureau, American Community Survey, 1-Year Estimates

Even though the median household income for Montgomery County is higher than the national and state average, this can be misleading since the cost of living is also high. According to the Self-Sufficiency Standard, an adult with one preschooler needs to make \$52,278 annually in

Montgomery County to meet basic expenses. The Self-Sufficiency Standard was created in the mid-1990s for the Women and Poverty Project and is a measure of the income needed to meet basic needs without public subsidy or private assistance. Unlike the Official Poverty Measure, the Self-Sufficiency Standard goes beyond examining food costs only by calculating costs for a variety of areas including housing, child care, food, health care, transportation, and taxes. This helps account for regional variation. In 2012, about 25.6% of households in Pennsylvania lacked the necessary income to meet basic expenses. In 2010, 33% of households headed by women in Pennsylvania were below the Standard compared to 19.5% of households headed by men (Pearce 2012, 86). In Pennsylvania, the four most expensive counties to live in according to the Self-Sufficiency Standard are Montgomery, Bucks, Chester, and Delaware Counties (Pearce 2012, 7). While poverty is not as widespread in Montgomery County (20 to 25% of households below the Standard) as other parts of the state, the high cost of living does present significant challenges for families who have insufficient income (Pearce 2012, 13).

Union Membership Advantages

Belonging to a union has numerous advantages, particularly for women. As indicated in Table 1.9, median weekly earnings were higher at the state and national level in 2016. For all women, median weekly wages were 30% higher at the national level in 2016 and 20.6% higher at the state level in 2014 (Table 1.9). In the United States, women who belong to unions were also more likely to have health insurance provided by the employer or the union (IWPR #C463, 2018). Hispanic women received the largest gain from union membership, both in earnings and in terms of health insurance. Hispanic women's wages were 46.7% higher at the national level and 38.3% higher in Pennsylvania (Table 1.9). In addition, health coverage rates are about 70% for Hispanic women who belong to unions, while coverage rates for Hispanic women who do not belong to unions are about 41% (IWPR #C463, 2018).

Table 1.9. Median Weekly Earnings for Full-Time Wage and Salary Workers by Union Affiliation and Race/Ethnicity for the United States (2016) and Pennsylvania (2014)

Median Weekly Earnings for Full-Time Wage and Salary Workers						
	Union		Nonunion		Union Wage Advantage	
	U.S. (2016)	PA (2014)	U.S. (2016)	PA (2014)	U.S. (2016)	PA (2014)
All Women (16+)	\$942	\$832	\$723	\$690	\$219 (30%)	\$142 (20.6%)
Hispanic	\$829	\$675	\$565	\$488	\$264 (46.7%)	\$187 (38.3%)
Black	\$790	\$719	\$616	\$552	\$174 (28.2%)	\$167 (30.6%)
White	\$975	\$842	\$738	\$668	\$237 (32.1%)	\$174 (26.0%)
Asian	\$975	\$867	\$892	\$776	\$83 (9.3%)	\$91 (11.7%)

Source: Compilation of data from the U.S. Bureau of Labor Statistics 2015b and Hess et al. 2015

Note: Hispanics may be of any race or two or more races and are classified by both ethnicity and race. Asians include Pacific Islanders. Data are not available for Native Americans or those who identify with two or more races. Self-employed workers are excluded.

The gender wage gap is also lower for women who belong to a union. In 2017, the wage gap for weekly earnings was about 18.4% for non-union workers compared to 12% for union workers (Patrick and Heydemann 2018). This means that women who did not belong to unions earned 81.6% of what a man did, while women who did belong to unions earned 88% of what their male counterparts did. Women of color who belonged to unions had a lower gender and race wage gap as well. Union membership provides a larger advantage for women than men. In 2017, male union members received a 21% bump in salary while female union members received a 30% bump (Patrick and Heydemann 2018). Latina women make 36% more per week; Black women make 23% more, and Asian women make 14% more than non-union members.

In Table 1.10, the union wage advantage for women is further broken down by occupation group. Across the United States, women earn more when they belong to a union. This ranges from a 7.1% advantage (compared to non-union salaries) for women in management, business, and financial occupations to a 95.5% advantage for women in natural resources, construction, and maintenance occupations. In the State of Pennsylvania, women also receive an earnings advantage for belonging to a union although this advantage is not as large at the state level. Similar to the national level, women in natural resources, construction, and maintenance occupations receive the largest boost at 84.9% and the lowest boost in the field of management, business, and financial occupations at 5.4%.

Table 1.10. Women’s Union Wage Advantage for Full-Time Workers by Occupational Group in the United States and Pennsylvania, 2011-2014

Occupational Group	Union Wage Advantage	
	United States	Pennsylvania
Management, Business, and Financial Occupations	7.1%	5.4%
Professional and Related Occupation	13.7%	11.2%
Service Occupations	26.4%	19.6%
Sales and Related Occupations	8.0%	5.9%
Office and Administrative Support Occupations	22.0%	17.4%
Natural Resources, Construction, and Maintenance Occupations	95.5%	84.9%
Production, Transportation, and Material Moving Occupations	26.7%	18.1%
All Occupations	31.3%	21.6%

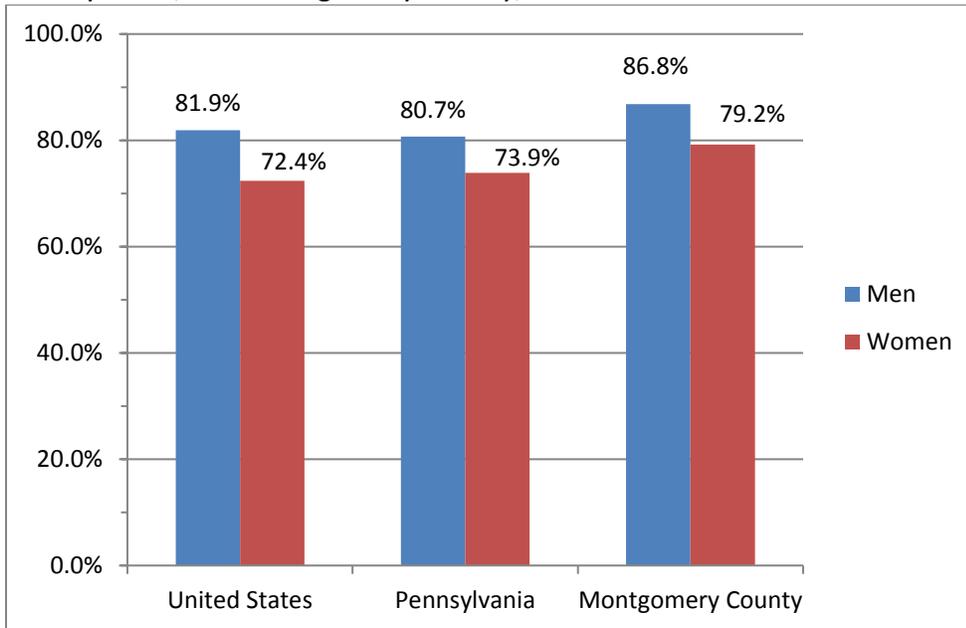
Source: Hess et al. 2015, IWPR

Note: For workers aged 16 and older, full-time. Data are four-year (2011–2014) averages. Earnings are in 2014 dollars.

Women’s Labor Force Participation

Women’s participation in the paid work force has increased considerably since 1950, but is still less than men’s (Hess et al. 2015). According to the U.S. Bureau of Labor Statistics, women aged 16 and older made up 46.8% of the paid labor force in 2015 (Hess et al. 2015). Among women aged 20-64, 72.4% participated in the labor force in the United States, compared to 81.9% of men (Figure 1.2). In Pennsylvania, 73.9% of women participated in the labor force in Pennsylvania, compared to 80.7% of men. Labor force participation rates for women were higher in Montgomery County at 79.2% for women and 86.8% for men. For both women and men, labor force participation rates are higher in Montgomery County compared to Pennsylvania and the United States.

Figure 1.2. Percent of Population in Labor Force (Ages 20-64) by Gender in the United States, Pennsylvania, and Montgomery County, 2016



Source: U.S. Census Bureau, 2016 American Community Survey, 1-Year Estimates

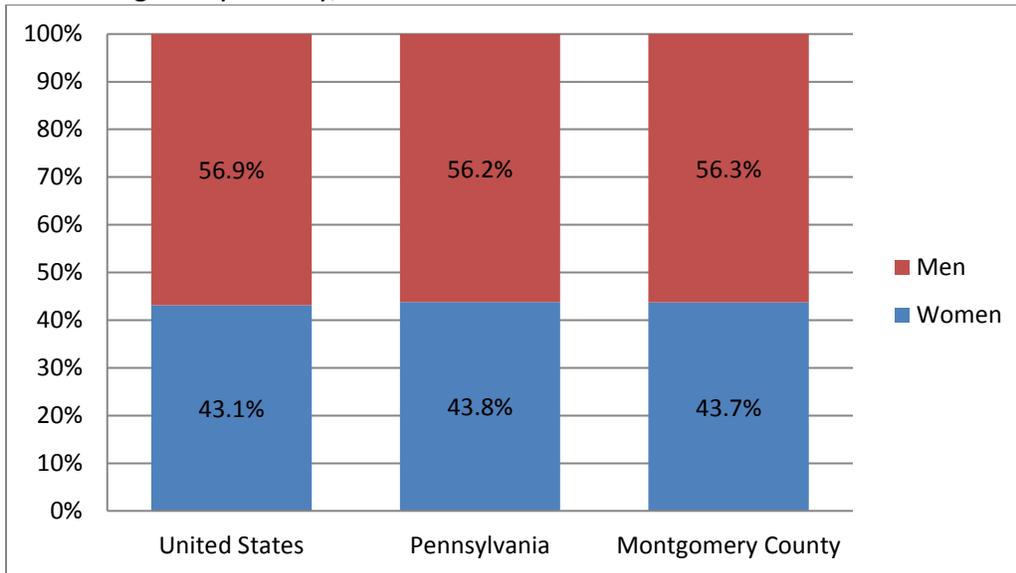
Notes: For workers ages 20-64

Full-Time and Part-Time Work

Men are more likely to work full-time than women, and women are almost twice as likely as men to work part-time. In 2013, 30.7% of women in Pennsylvania worked part-time compared to 14.9% of men (Hess et al. 2015). Part-time work has several disadvantages aside from earnings alone. Even though women often choose to work part-time for flexibility to take care of their families, they tend to lose out on a variety of benefits including health insurance, paid vacation, paid sick days or family leave, and employer contributions to retirement funds (Hess et al. 2015). Working part-time is not always a choice, though. In 2013, approximately 20% of women who worked part-time said they did so because they would not find full-time work or their hours had been reduced (Hess et al. 2015).

Among those individuals who worked full-time in the United States in 2016, 56.9% were men, and 43.1% were women (Figure 1.3). In Pennsylvania, 56.2% of those who worked full-time were men, and 43.8% were women. In Montgomery County, 56.3% of those who worked full-time were men, and 43.7% were women. Thus, women make up about the same percentage of full-time workers in the United States, Pennsylvania, and Montgomery County.

Figure 1.3. Percent of Full-Time Employed Women and Men in the United States, Pennsylvania, and Montgomery County, 2016



Source: U.S. Census Bureau, 2016 American Community Survey, 1-Year Estimates

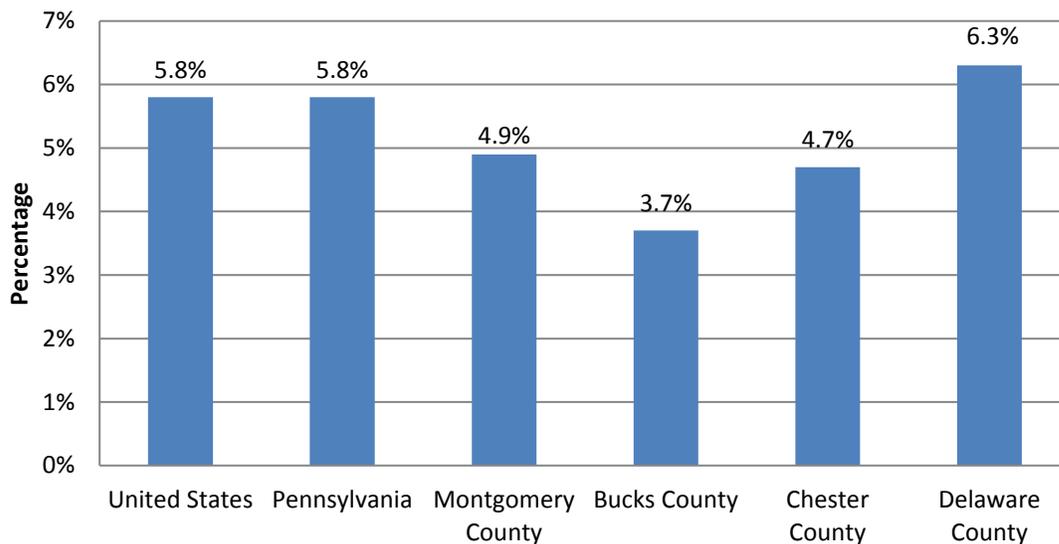
Note: Class of Work by Sex for Full-Time, Year-Round, Civilian Employed Population, 16 Years and Over

Unemployment

In 2018, the national unemployment rate dipped to 3.9% in August, and the state unemployment rate dipped to 4.1%. In June of 2018, the unemployment rate in Montgomery County was 3.6%, compared to 3.3% in Chester County and 3.7% in Bucks County.

In 2016, the overall unemployment rate was higher at 5.8% in the United States and Pennsylvania (Figure 1.4). In Montgomery County, the unemployment rate was 4.9%. While this rate was lower than the national and state unemployment rate, it was in the third highest among neighboring counties in southeastern Pennsylvania. Both Bucks and Chester County had lower unemployment rates.

Figure 1.4. Unemployment Rates for the United States, Pennsylvania, Montgomery County, Bucks County, Chester County, & Delaware County, 2016



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates

In the United States, the unemployment rate was roughly the same for men and women in 2017, at 5.0% and 4.8% respectively (Table 1.11). However, women in Pennsylvania have slightly lower unemployment rates than their male counterparts. The unemployment rate in Pennsylvania was 5.1% for men and 4.6% for women. In Montgomery County, the unemployment rate was the same for men and women at 3.5%. Although women may have lower unemployment rates at times, they still make considerably less than men and are less likely to work full-time.

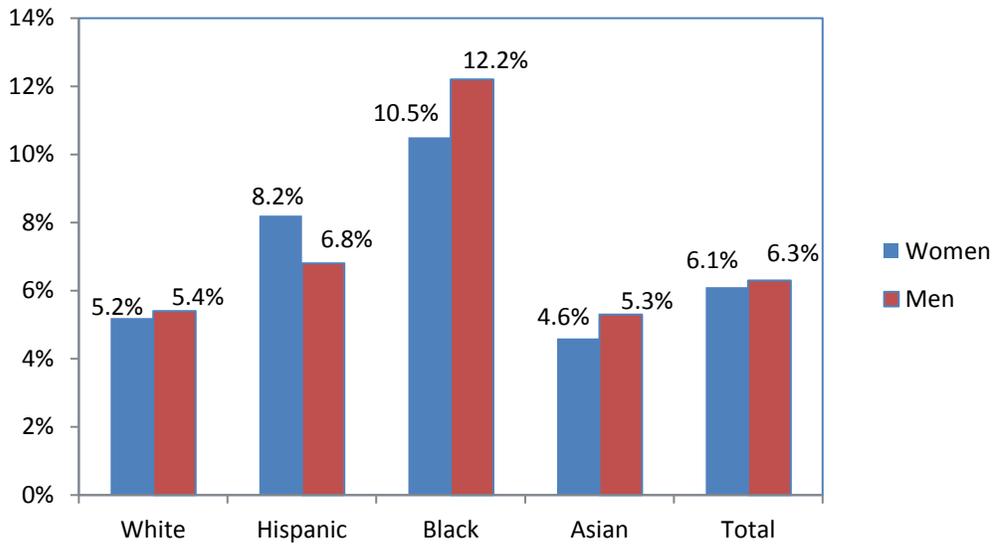
Table 1.11. Unemployment Rate by Gender (Ages 20-64) for the United States, Pennsylvania, and Montgomery County, 2017

	United States		Pennsylvania		Montgomery County	
	Men	Women	Men	Women	Men	Women
Unemployment Rate	5.0%	4.8%	5.1%	4.6%	3.5%	3.5%

Source: U.S. Census Bureau, American Community Survey, 2017

Unemployment rates also vary by race and ethnicity. Every racial or ethnic group has higher unemployment rates than Whites except for Asians. In 2013, unemployment rates were highest for Black men (12.2%) and women (10.5%) in the United States (Figure 1.5). The lowest rates of unemployment were among Asian women (4.6%) and men (5.3%) and were better than unemployment rates for White women (5.2%) and men (5.4%).

Figure 1.5. Unemployment Rates by Gender and Race & Ethnicity in the United States, 2014



Source: Hess et al. 2015 (IWPR compilation of data from the U.S. Department of Labor)

Notes: Includes the civilian, non-institutionalized population aged 16 and older. Hispanics or Latinos may be of any race and are classified by both ethnicity and race. Asians do not include Pacific Islanders. Data are not available for Native Americans or for those who identify with another race or two or more races.

Gender Differences in Employment by Industry

Occupational segregation is a key cause of the gender wage gap. Female-dominated occupations pay less than male-dominated occupations do. While women are well-represented in some industries like government and retail trade (Table 1.12), they are underrepresented in industries like construction, agriculture-related industries, and mining-related industries. Interestingly, women are better represented in agriculture-related industries in Montgomery County (31.3%) than in Pennsylvania (16.7%) or the United States (16.2%).

Table 1.12. Distribution of Women across Industries (as a percent) in the United States, Pennsylvania, & Montgomery County, 2016

Industry	United States	Pennsylvania	Montgomery County
Agriculture, Forestry, Fishing, & Hunting	16.2%	16.7%	31.3%
Mining, Quarrying, Oil, & Gas Extraction	15.2%	11.9%	0.0%
Manufacturing	37.5%	25.7%	31.4%
Construction	8.6%	8.6%	16.5%
Transportation, Warehousing, & Utilities	22.0%	20.4%	25.3%
Wholesale Trade	28.1%	26.6%	31.1%
Retail Trade	42.6%	43.7%	43.1%
Government	43.0%	43.2%	40.4%

Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Even in female-dominated occupations, however, women make less than their male counterparts. For example, nursing is a field dominated by women at 88%, but there is still a wage gap. In 2017, female nurses earned 90.7% of men’s median weekly earnings in the U.S. Women are also much more likely to earn poverty-level wages. Two of the most common occupations for women are cashiers and maids or household cleaners. The median earnings for these occupations are below the poverty threshold for a family of four (IWPR #C467, 2018).

Women and Occupational Segregation

Some occupations tend to be relatively low paid and are dominated by women. In 2016, women comprised 70.7% of “office and administrative support positions” in the United States, 71.7% in Pennsylvania, and 70.4% in Montgomery County (Table 1.13). Women also made up the majority of community and social service workers – 64.1% in the U.S., 66.5% in Pennsylvania, and 70.4% in Montgomery County.

Table 1.13. Distribution of Women across Selected Occupational Groups in the United States, Pennsylvania, & Montgomery County, 2016

Occupation	United States		Pennsylvania		Montgomery County	
	Women	Men	Women	Men	Women	Men
Management, Business, & Financial	43.5%	56.5%	42.5%	57.5%	56.7%	43.3%
Community & Social Services	64.1%	35.9%	66.5%	33.5%	70.4%	29.6%
Healthcare Practitioner & Technical Occupations	72.5%	27.5%	75.0%	25.0%	70.5%	29.5%
Service	49.8%	50.2%	52.2%	47.8%	47.6%	52.4%
Office & Administrative Support	70.7%	29.3%	71.7%	28.3%	70.4%	29.6%

Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Women in Computer, Engineering, & Science Occupations

The fields of computers, engineering, and science have experienced rapid growth in recent years, and these industries also have higher compensation than many other ones (Hess et al. 2015). The Institute for Women’s Policy research analyzed census data for 2013 and found that median salaries in STEM (science, technology, engineering, mathematics) disciplines were \$68,000 for women and \$78,000 for men (Hess et al. 2015). Only 4.6% of women work in STEM occupations while 10.3% of men do.

There is also a great deal of variation across racial and ethnic groups. Asian/Pacific Islander women are more likely to go into STEM-related occupations than any other group. Approximately 11.3% of Asian/Pacific Islander women work in STEM occupations, compared to White women at 4.6%, Black women at 2.8%, and Native American and Hispanic women at

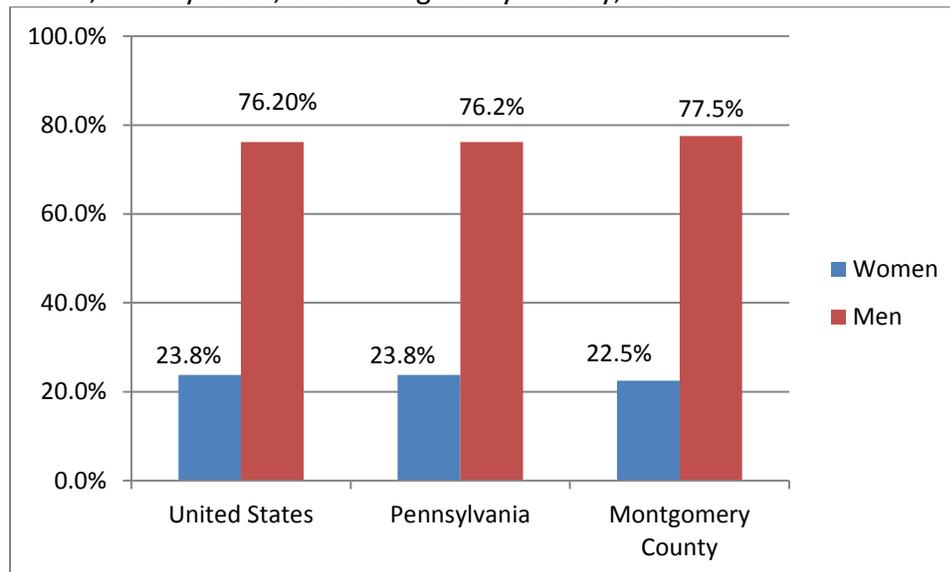
2.3%. Participation in STEM fields is also low for Black and Hispanic women and men. In 1990, Blacks made up 7% of the STEM workforce, and 9% today. Hispanic representation in STEM fields has increased from 4% in 1990 to 7% today, but this is still extremely low.

It is worth noting that women’s work in STEM fields varies considerably by occupation. Women only make up about 7% of sales engineers and 8% of mechanical engineers, but women comprise 95% of speech-language pathologists and 95% of dental hygienists. The largest growing STEM field is computer related, but women’s representation in computer occupations has decreased from 32% to 25% between 1990 and 2017 (Funk 2018).

Nationwide, women in STEM occupations are more likely to say that they have experienced discrimination in the workplace than women in non-STEM occupations (50% for STEM and 41% for non-STEM) (Funk 2018). In a 2017 survey conducted by the Pew Research Center, women were less likely than men to think that they were “usually treated fairly” in regard to promotions at work.

Figure 1.6 shows the percent of men and women who have entered the fields of computer, engineering, and science occupations in the United States, Pennsylvania, and Montgomery County in 2016. Women are clearly underrepresented in computer, engineering, and science occupations. In the United States, women made up 23.8% of computer, engineering, and science occupations compared to men’s 76.2 % (Figure 1.6). The percentage of women in these fields is similar in Pennsylvania (23.8%) and Montgomery County (22.5%).

Figure 1.6. Women & Men in Computer, Engineering, & Science Occupations in the United States, Pennsylvania, and Montgomery County, 2016



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Notes: Occupation by Sex for the Civilian Employed Population 16 Years and Over, Full-Time, Year-Round

Women in Management

Women are less likely to occupy managerial roles, which also contributes to the wage gap. Table 1.14 shows the percentage of women in management positions in 2016. In Montgomery County, 38.5% of women held management positions compared to 61.5% of men. This trend is similar in Pennsylvania and the United States with 37.2% and 38.8% of women holding management positions compared to 62.8% and 61.2% of men respectively.

Table 1.14. Percent of Women and Men in Management in the United States, Pennsylvania, & Montgomery County, 2016

Occupation	United States		Pennsylvania		Montgomery County	
	Women	Men	Women	Men	Women	Men
Management	38.8%	61.2%	37.2%	62.8%	38.5%	61.5%

Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Conclusion

Discrimination is still a driving factor when it comes to the gender wage gap (Blau and Kahn 2016). Women earn less than their male counterparts in all occupations whether occupations are dominated by women, dominated by men, or are mixed. One of the primary factors contributing to the wage gap is occupational segregation, but this does not happen in a vacuum. Gender socialization contributes to women’s selection of career choice. Although the gender gap is typically less in the most common occupations for women, it increases in the most common occupations for men. Women are eight times more likely than men to work in occupations with poverty level wages (IWPR #C467, 2018). This gap varies even more by race and ethnicity. Black and Hispanic women are twice as likely to work in service occupations compared to White women. The median weekly earnings of Hispanic women are below the federal poverty threshold for a family of four (IWPR #C467, 2018).

WORK & FAMILY

Introduction

Over the past several decades, women's participation in the labor force has increased significantly, but employer policies often hurt women in the workplace disproportionately because women are still the primary caregivers in families and perform the bulk of unpaid household labor (Women's Bureau 2016). Mothers, in particular, often face challenges due to their additional responsibilities at home. Working mothers spend more time caring for children and performing unpaid household labor than working fathers (Women's Bureau 2016). Even women who do not have children are more likely to be a caregiver for another family member, so it is an issue that concerns all women to a certain extent.

Not only do women generally make less than men in the United States, but the gender gap for mothers is even greater. Nationwide, mothers earn about 71 cents on the dollar compared to what fathers earn (Jee et al. 2018). Mothers' participation in the labor force has increased considerably over time. Of those mothers who have children under 18 years old, about 70% are employed, and over 75% are employed full time (DeWolf 2017).

Work & Family Composite Index

In 2015, the Institute for Women's Policy Research (IWPR) created the Work and Family Composite Index, which is a composite or summary statistic made up of several different indicators. The Work and Family Composite Index was created from the following indicators related to work and family policy: paid leave, dependent and elder care, child care, and the gender gap in labor force participation of parents of children under six years old (Hess et al. 2015). Each one of these indicators is also a composite score that consists of several data points. The paid leave indicator is comprised of state policies on paid family and medical leave, temporary disability insurance, and paid sick days. The dependent and elder care index combines the following: availability of unemployment insurance benefits for a worker who has to leave work for family care purposes, the availability and level of dependent care tax credits for care of an adult relative, and the delegation of long-term support services to domestic care agency staff. The childcare index aggregates the following: enrollment of four year olds in publicly funded pre-Kindergarten (pre-K), state and federal Head Start programs, preschool special education, cost of center-based infant care, and state systems to ensure the quality of Pre-K education (Hess et al. 2015). Each one of these indicators is weighted equally.

The Work and Family Composite Index can then be used to compare one state's performance to another. The maximum score for all of these indices is an 8. To provide context for interpreting Pennsylvania's score, the highest state composite score was a 5.55 while the lowest score was 2.03. Table 2.1 shows Pennsylvania's Work and Family Composite Index as well as all its components.

Table 2.1. Work & Family Composite Index and Its Components for Pennsylvania and Surrounding States, 2015

State	Composite Index			Paid Leave Legislation Index		Elder & Dependent Care Index		Child Care Index		Gender Gap in Parents' Labor Force Participation Rates	
	Score	Rank	Grade	Score	Rank	Score	Rank	Score	Rank	Percentage Points	Rank
Pennsylvania	3.43	33	D+	0.33	9	0.5	40	1.07	34	23.5	13
Delaware	3.85	25	C-	0.00	12	1.06	21	1.21	26	21.3	8
New Jersey	4.99	4	B-	1.67	2	0.44	42	1.42	11	26.3	31
New York	5.55	1	B	1.00	4	1.69	5	1.38	14	25.7	25
Maryland	4.06	22	C	0.00	12	1.13	19	1.40	13	23.1	11

Source: Hess et al. 2015

Pennsylvania received a composite index score of 3.43 and was ranked 33rd out of all 50 states and the District of Columbia (Table 2.1). It also received an overall grade of a D+. This ranking puts Pennsylvania within the second third of states, but just barely. Since the Work and Family Composite Index is a new measure developed by the Institute for Women and Policy Research, no long-term data is available to evaluate improvement (or decline) over time. The highest grade earned by any state was a B. New York, California, and the District of Columbia received a B on the composite index, with a score of 5.55, 5.30, and 5.20, respectively. Compared to surrounding states, Pennsylvania has the lowest grade. Delaware, New Jersey, New York, and Maryland all have a higher composite index, a higher ranking, and a higher grade.

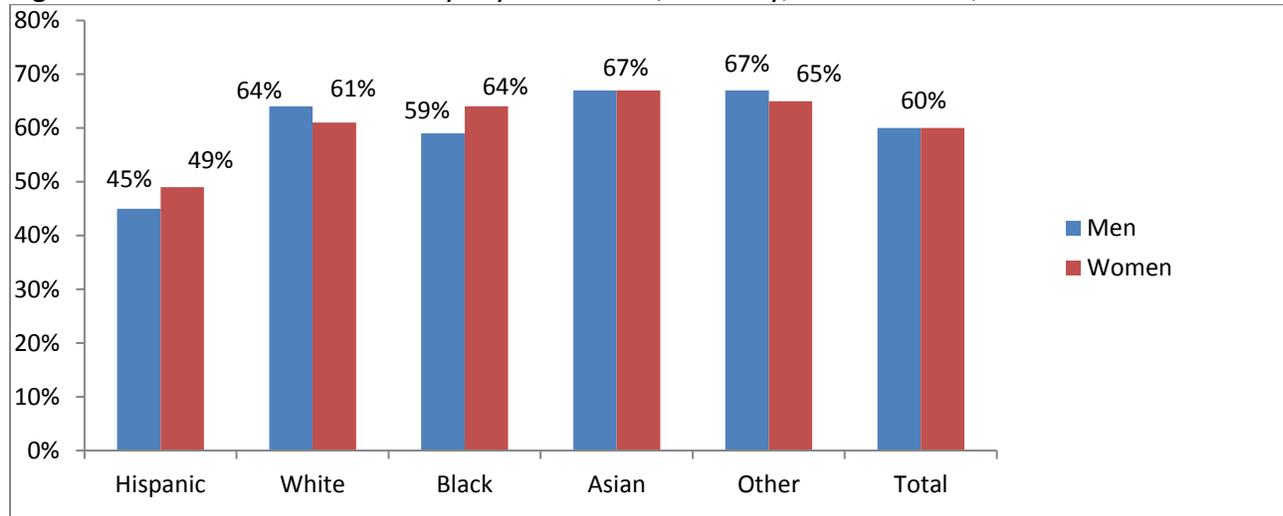
Paid Leave and Paid Sick Days

Research has shown that having access to paid sick days provides a variety of benefits not only to workers and their families, but also to employers and communities (IWPR #B356, 2016). Benefits of paid sick days include reduced health care costs, lower turnover costs, reduced spread of illness, and safer work environments (IWPR #B356, 2016).

In an analysis of data from the 2014 National Health Interview Survey, the Institute for Women's Policy Research found that 60% of workers have access to paid sick leave, but this varies according to race and ethnicity (IWPR #B356, 2016). In the United States, Asian Americans are the most likely to have access to paid sick days at 67%, but only 46% of Hispanics have access to paid sick days (IWPR #B356, 2016). Although the rates of access to paid sick days are the same overall for women and men at 60% (Figure 2.1), a few differences in certain racial and ethnic groups are apparent. Hispanic and Black women are somewhat more likely to have access to paid sick days than men in their respective racial or ethnic group (Figure 2.1). White women's access to paid sick days is 61%, which is considerably higher than rates for

Hispanic and Black women, but their rates of access are slightly lower than White men’s access at 64%.

Figure 2.1. Access to Paid Sick Days by Sex & Race/Ethnicity, United States, 2014

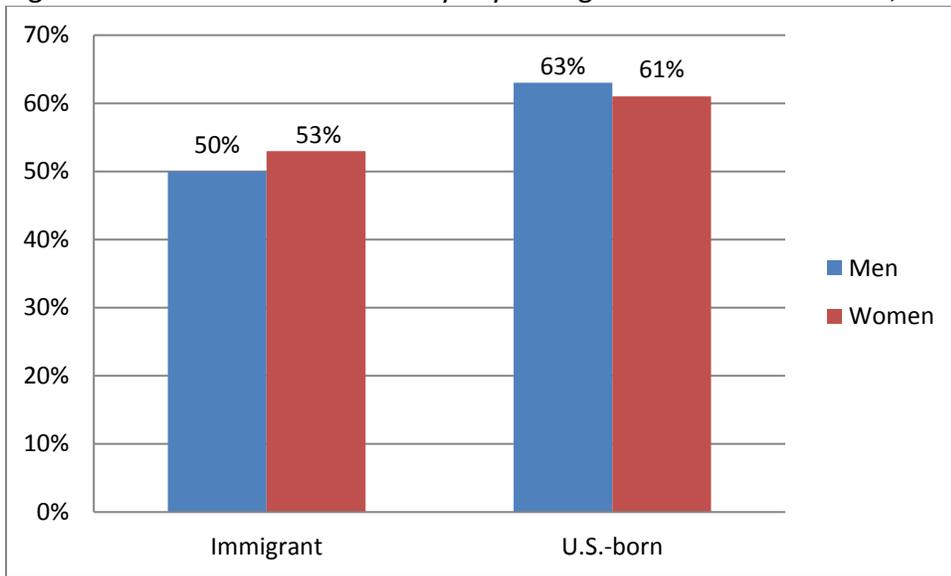


Source: Institute for Women’s Policy Research, Analysis of the 2014 National Health Interview Survey, IWPR #B356, 2016

Notes: Rates of access to paid sick days are calculated for employed individuals ages 18 and older who responded yes or no to the following question: “Do you have paid sick leave on your main job or business?” No data was available by gender for American Indians or Alaska Natives, but overall 53% of American Indians or Alaskan Natives had access to paid sick leave (IWPR #B356, 2016).

Immigrants are less likely to have access to paid sick days than those who are born in the United States. While 63% of men born in the U.S. have access to paid sick days, only 50% of male immigrants have access (Figure 2.2). Similarly, 61% of U.S.-born women have access to paid sick days, while 53% of female immigrants have access. While immigrant women are slightly more likely than immigrant men to have access to paid leave, women born in the U.S. are somewhat less likely to have access than their male counterparts (Figure 2.2).

Figure 2.2. Access to Paid Sick Days by Immigration Status & Gender, 2014

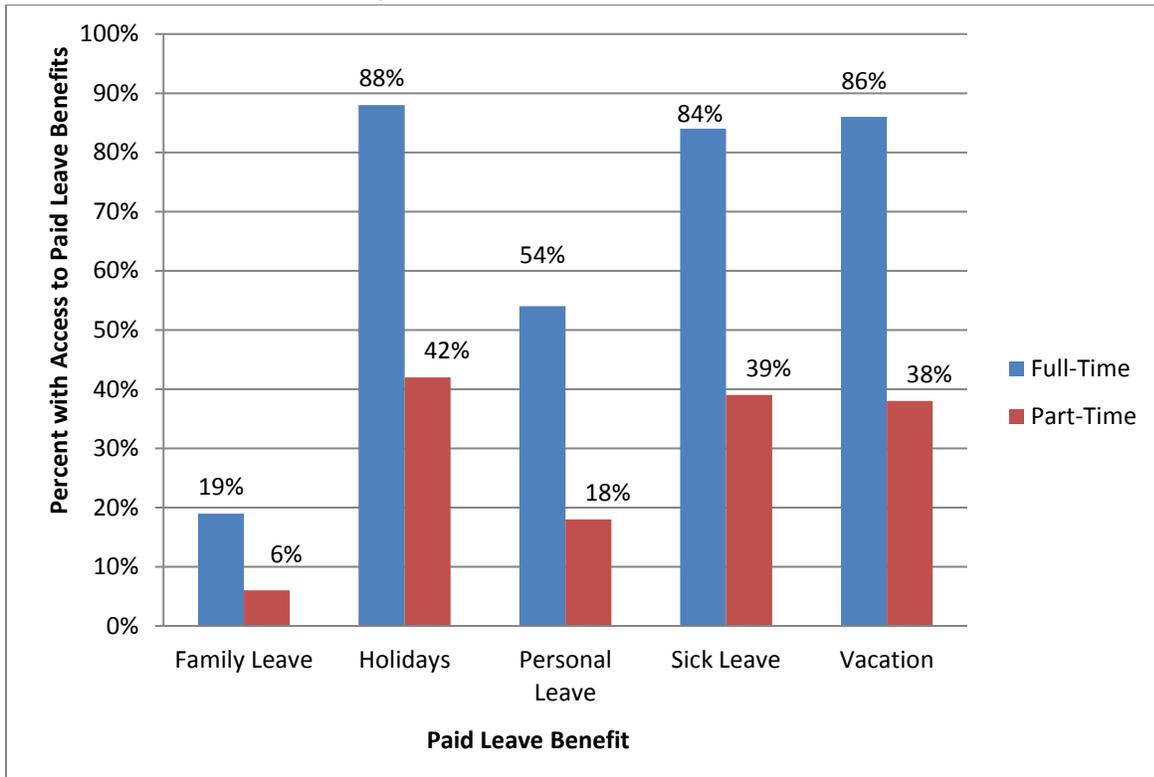


Source: Institute for Women’s Policy Research, Analysis of the 2014 National Health Interview Survey, IWPR #B356, 2016

Note: Based on employed individuals 18 years and older. Access rates were calculated for employed individuals who responded yes or no to the following question: Do you have paid sick leave on your main job or business?

There are several discrepancies in access to paid leave benefits depending on full-time or part-time worker status. Full-time workers are much more likely to have access to an array of paid leave benefits. While 88% percent of full-time workers have access to paid holidays, only 42% of part-time workers do (Figure 2.3). The least common paid leave benefit for both full-time and part-time workers is family leave. Only 19% of full-time workers have paid family leave, compared to 6% of part-time workers.

Figure 2.3. Percent of Workers with Access to Paid Leave Benefits for Full-Time and Part-Time Workers in the United States, 2017



Source: U.S. Bureau of Labor Statistics, National Compensation Survey, December 2017

Note: This includes all civilian workers (private industry and all state and local government workers).

The Institute for Women’s Policy Research gave Pennsylvania a score of .33 and a tied rank of 9 on the Paid Leave Legislation by State Component Index. With a ranking of 1, California had a score of 2.00. California offers workers temporary disability insurance, family leave insurance (up to six weeks), and an opportunity to earn paid sick days (paid for by the employer) (Hess et al. 2015). Six states (California, New York, New Jersey, Washington, Rhode Island, and Massachusetts) and the District of Columbia offer paid family and medical leave insurance funds (National Partnership for Women & Families 2018a).

Pennsylvania has no statewide laws that provide for paid leave benefits, but paid family and medical leave are of particular importance since Pennsylvania has the fourth oldest population in the U.S., and workers spend approximately 1.4 billion unpaid hours caring for the elderly. In 2017, 70.4% of employees in Pennsylvania received some form of wage replacement for paid sick days, vacation, short-term disability insurance, or paid family leave (PA Department of Labor and Industry 2017). The employees most likely to receive one of these forms of wage replacement are high earning White men between the ages of 45 and 64 working at a large firm/organization. Young workers (ages 16-24) and workers below the federal poverty guidelines are much less likely to receive these paid leave benefits (PA Department of Labor and Industry 2017).

Within Pennsylvania, one city does offer a paid sick leave policy. In 2015, the City of Philadelphia passed the Promoting Healthy Families and Workplace ordinance. This ordinance requires all employers within the City limits to offer employees an opportunity to earn paid or unpaid sick days. The law applies only to employers with ten or more employees and to full-time employees who work 40 hours a week. It does not cover the following employee groups: independent contractors, season workers, adjunct professors, employees hired for a term of less than six months, interns, pool employees, employees covered by collective bargaining agreements, and state and federal employees (City of Philadelphia 2015). Although Pittsburgh passed a similar ordinance in 2015, the Commonwealth Court of Pennsylvania ruled that the city did not have the authority to do so. Philadelphia has a First Class City designation, and its authority comes from a different law than does Pittsburgh's (Santucci et al. 2017).

In 2018, ten states currently have paid sick day laws: Connecticut, California, Massachusetts, Oregon, Vermont, Arizona, Washington, Rhode Island, Maryland, and New Jersey. Two counties and 32 cities have also passed paid sick days laws. Nearly half of these cities are located in New Jersey (National Partnership for Women & Families 2018b).

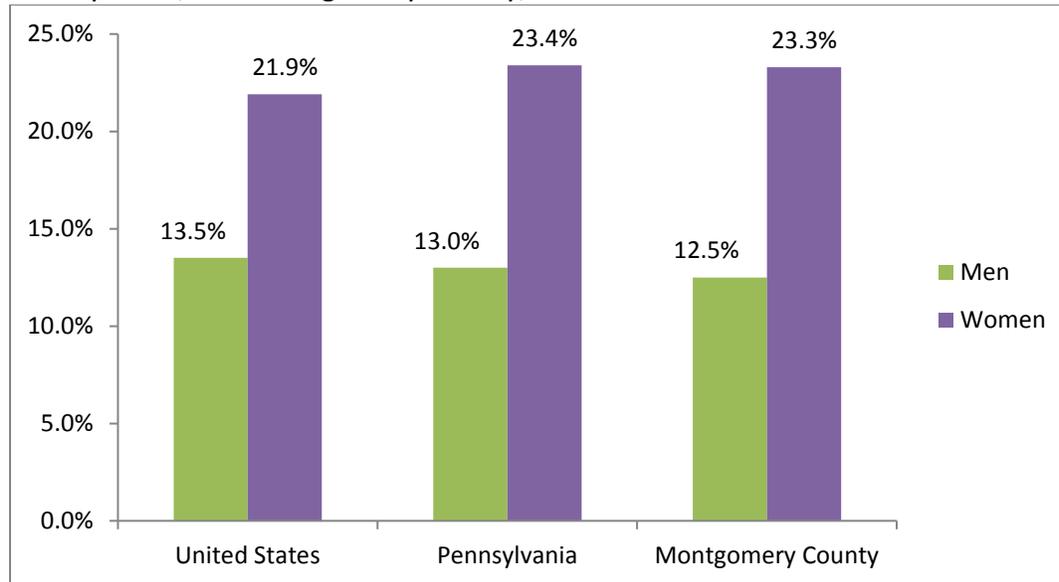
Elder and Dependent Care

Although many elderly people live independent lives, there are also many who rely on their families for care. Because of increased life expectancy rates and the aging baby boomer generation, the elderly population is growing. According to the Social Security Administration, a man who turns 65 today lives to an average age of 84.3 (SSA 2018). For a woman who turns 65, the average age is 86.7 (SSA 2018). According to the 2015 *Caregiving in the U.S. Report* (sponsored by the AARP and National Alliance for Caregiving), about 34.2 million people in the U.S. have provided care for someone aged 50 years or older, and about 43.5 million people have provided unpaid care to an adult or a child in 2015.

Women are typically more likely to perform caregiving responsibilities for elderly family members. About 60% of women are caregivers, compared to 40% of men. About 65% of those receiving care are women, and the average age is 69.4 (Caregiving 2015). Women over 85 years old are the fastest growing demographic in the U.S. (White House 2015). Caregiving is time-consuming as caregivers spend an average of 24.4 hours a week on caregiving responsibilities. About 42% of these caregivers have had no training or preparation. When asked if they had a choice in whether or not to provide care, 50% of respondents said no (Caregiving 2015).

Because women are more likely to be caregivers than men, they are also more likely to be employed part-time in order to manage these caregiving responsibilities (Figure 2.4). The percent of men working part-time is similar at the national, state, and county levels. About 13.5% of men work part-time in the United States, 13% in Pennsylvania, and 12.5% in Montgomery County. The percent of women who work part-time is considerably higher ranging from 21.9% in the United States, to 23.4% in Pennsylvania, to 23.3% in Montgomery County.

Figure 2.4. Percent of Employed Women and Men Working Part-Time in the United States, Pennsylvania, and Montgomery County, 2012-2016



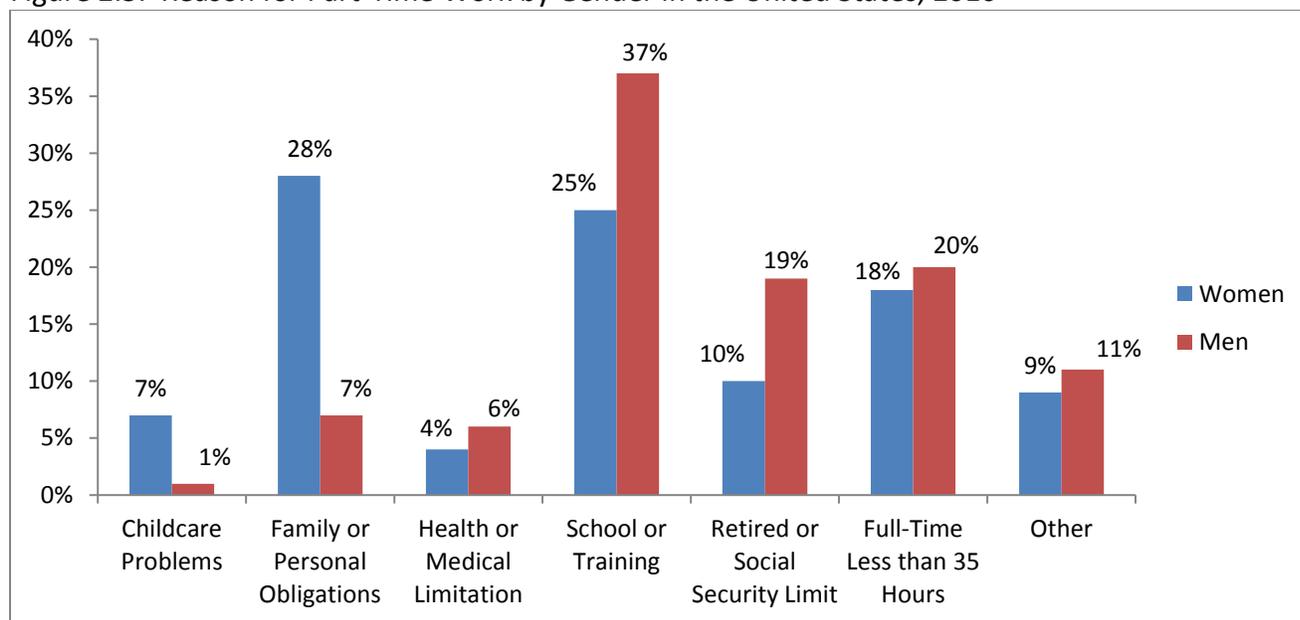
Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Notes: Sex by Work Status in the Past Months by Usual Hours Worked per Week in the Past 12 Months by Weeks Worked in the Past 12 Months for the Population 16 to 64 Years

Working part-time means that women not only make less money, but they also have fewer benefits. Part-time workers are less likely to have benefits such as health insurance, pension plans, paid sick days, and paid vacation. About one-third of caregivers have to leave the work force or reduce their hours (MetLife 2011). In 2011, MetLife performed a study that indicated men and women pay a tremendous cost for caregiving in terms of Social Security, pension, and wage losses - ranging from \$283,716 for men to \$324,044 for women (MetLife 2011).

Overall, the most common reason that people worked part-time in 2016 was school attendance. Although this was the most common reason for men and workers ages 16 to 24, it was not the most common reason women worked part-time (Figure 2.5). For women, the most common reason was “other personal or family obligations.” While 28% of women reported that these obligations were why they worked part-time, only 7% of men cited this as a reason. According to the American Time Use Survey, 18% of women provided care for the elderly, compared to 15% of men. Similarly, women spend more time caring for children than men (Dunn 2018).

Figure 2.5. Reason for Part-Time Work by Gender in the United States, 2016



Source: Dunn 2018 (U.S. Bureau of Labor Statistics)

Caregiving also has a disproportionate effect on women’s earnings and retirement funds. Women lose approximately \$142,693 in wages during their lifetime, compared to \$89,107 for men (MetLife 2011). Estimated losses in Social Security benefits are \$131,351 for women and \$144,609 for men (MetLife 2011). Elderly women are less likely to have a pension than men. About 31.6% of unmarried women over age 65 had a private pension (as a retired worker or survivor), compared to 34.3% of unmarried men (SSA 2016). Women were also more likely to receive a lower pension benefit than men because they were more likely to work part-time and have lower wages (SSA 2016).

On the Elder and Dependent Care Index created by the Institute for Women’s Policy Research, Pennsylvania ranked 40th out of all 50 states and the District of Columbia in 2014 (Table 2.2). This index is comprised of three indicators: unemployment insurance benefits for someone who had to leave their job due to caretaking, the availability of dependent care tax credits, and long-term support services (Hess et al. 2015).

Table 2.2. Pennsylvania Elder and Dependent Care Component Index with Indicators, 2014

Unemployment Insurance Covers Family Reasons	Yes
Dependent Care Credits Not Limited to Child Care	No
Dependent Care Credit Refundable	N/A
Maximum Dependent Care Credit	\$0
Dependent Care Credit Total Rank	\$23
Number of Long-Term Support Services That Can Be Delegated to a Home Care Agency Worker (out of 16)	0
Rank	47
Elder & Dependent Care Total Score	0.5
Rank	40

Source: Hess et al. 2015

In 2014, Pennsylvania was one of 25 states that provided unemployment insurance if a worker had to leave a job for family caregiving reasons. Pennsylvania only allowed dependent care credits for child care, not other family care. Pennsylvania also does not allow any long-term support services to be delegated to a home care agency worker (Hess et al. 2015).

The AARP (American Association of Retired Persons) also produces a scorecard evaluating long-term services and supports in each state with a different set of dimensions than the IWPR: affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers, and effective transitions (Table 2.3). Overall, Pennsylvania ranked 36th out of 50 states in 2017. This was in the third quartile, but was an improvement from 2014 when Pennsylvania was in the bottom quartile and ranked 42nd. In the dimension of support for family caregivers, Pennsylvania ranked even lower at 43rd in 2017 (Reinhard 2017). In all other dimensions, Pennsylvania improved from 2014. Choice of setting and provider has dropped from a rank of 12 in 2011 to a rank of 25 in 2014 and a rank of 23 in 2017.

Table 2.3. Pennsylvania Long-Term Services and Supports Scorecard Results, 2017, 2014, & 2011

Dimension	Rank		
	2017	2014	2011
Overall	36	42	39
Affordability & Access	37	46	47
Choice of Setting & Provider	23	25	12
Quality of Life & Care	25	37	22
Support for Family Caregivers	43	36	46
Effective Transitions	28	28	n/a

Source: Compiled from AARP, State Scorecard on Long-Term Services and Supports, 2017, 2014, & 2011

The State of Pennsylvania does offer a Caregiver Support Program with a variety of services that may include education and counseling, caregiving assistance, and reimbursement for supplies

used for providing care (PA Department of Aging 2018). Montgomery County also offers a Family Caregiver Support Program that provides financial support for caregiving or grants to make necessary home modifications (Montgomery County 2018).

Laws to Support Caregivers at Work

The Family and Medical Leave Act (FMLA) of 1993 is the only federal policy that offers employees leave for family caregiving responsibilities, but it is unpaid. Under FMLA, employees can take up to twelve weeks of job-protected unpaid leave a year for the birth or adoption of a child, caregiving for a child, parent, or spouse, or personal health reasons. The United States is the only developed country that does not have a federal family and medical leave policy that is paid.

In 2018, only four states have paid family and medical leave: California, New Jersey, Rhode Island, and New York (National Conference of State Legislatures 2018a). The District of Columbia and the State of Washington passed family and medical leave laws in 2017 that will take effect in 2020 (National Conference of State Legislatures 2018a). Because there are so few states that offer paid leave options, most Americans are at the mercy of their employer when it comes to paid leave.

According to a 2016 report from the Center for WorkLife Law, there has been a 269% increase in federal caregiver discrimination claims over the last decade and a 650% increase in elder care cases specifically (Williams et al. 2016). Although the U.S. Congress has not passed a law that specifically prohibits caregiver discrimination, this type of discrimination can fall under Title VII of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990. As a result, the Equal Employment Opportunity Commission (EEOC) has issued guidelines regarding caregiver discrimination. There are a variety of ways in which disparate treatment of caregivers might occur: sex-based disparate treatment, pregnancy discrimination, discrimination against male caregivers, discrimination against women of color, caregiver stereotyping under the ADA, hostile work environment, and retaliation. Employers are also required to honor caregiving-related requests protected under the Family and Medical Leave Act (FMLA) and state or local laws (EEOC 2007).

The following states have some sort of caregiving protection law: Alaska, Connecticut, the District of Columbia, Minnesota, New Jersey, New York, and Oregon (Hess et al. 2015, Family 2017). However, some of these laws only apply to childcare. There are also 67 municipalities across 22 different states that have passed caregiving protection ordinances (Hess et al. 2015). Overall, 52% of plaintiffs succeed in family responsibility cases, but only 37% of plaintiffs succeed in elder care cases because there are fewer legal protections (Williams et al. 2016).

According to the 2016 National Study of Employers, 55% of large employers were able to provide a high level of child or elder care assistance, compared to 25% of small employers (Matos et al. 2017). Nonprofit organizations were more likely than for-profit organizations to provide a high level of child or elder care assistance. Organizations that were comprised of

more than 50% women and organizations that had women or racial and ethnic minorities reporting to executive leadership were also more likely to provide a high level of child or elder care assistance.

Rights to Request Flexible Work

No national laws address the right to request flexible work arrangements. Nonetheless, some states and municipalities have adopted laws or ordinances that give employees the right to request a flexible schedule (Hess et al. 2015). Vermont, New Hampshire, Seattle, and San Francisco offer a right to request a flexible work arrangement (National Partnership for Women and Families 2017). This means that the employer must consider the request and cannot retaliate against the employee for asking, but employers do not have to grant the request. Nonprofit organizations are more likely to provide flexible work arrangements (Matos et al. 2016).

Predictable Work Schedules

It can also be difficult for caregivers to plan out their responsibilities if they cannot predict their work schedules. Low-wage workers are more susceptible to unfair scheduling practices, and women – particularly women of color – are more likely to have low-wage jobs. Unfair scheduling practices also disproportionately affect single mothers. As of 2018, no federal laws address predictable work schedules, but a few states and municipalities have addressed fair scheduling. The City of San Francisco passed a law in 2015 that requires large retailers to provide schedules to their employees at least two weeks in advance (Hess et al. 2015). Seattle, Washington and Emeryville, California have passed laws that require both retail and fast food employers to give workers 14 days advanced notice of their schedules. New York City also requires this, but only for fast food employers (National Partnership for Women and Families 2017). In 2017, Oregon passed the most comprehensive legislation at the state level – requiring large retail, food service, and hospitality employers to give employees: (1) a “good faith estimate” of hours to be worked weekly, (2) notice of employee schedules two weeks in advance, (3) an employee right to have input in his/her schedule, and (4) a right to a rest between consecutive shifts (National Partnership for Women and Families 2017).

Female-Headed Households

In 2015, 69.9% of mothers with children less than 18 years of age participated in the labor force. From 1975 to 2015, the labor force participation rate for mothers with children under three years old increased from 34.3% to 61.4% (Women’s Bureau 2016). Labor force participation rate for mothers varies considerably by race and ethnicity. In 2015, the labor force participation rates were 76.3% for Black mothers, 69.6% for White mothers, 62% for Asian mothers, and 61.6% for Hispanic mothers (Women’s Bureau 2016).

The average percentage of households with children under 18 years old from 2012-2016 was 28.5% in the United States, 25.6% in Pennsylvania, and 29.7% in Montgomery County (Table

2.4). There were slightly more households with children under 18 and more married couple households in Montgomery County, compared to the U.S. and Pennsylvania. In all locations, the majority of households were married-couple families, with or without children. Married-couple families comprised 48.5% of households in the U.S., 48% in Pennsylvania, and 55.5% in Montgomery County. Married couples who had children less than 18 years old made up 19.2% of households in the U.S., 17.3% in Pennsylvania, and 23.2% in Montgomery County. There were more female-headed families than male-headed families, with or without children. In 2012-2016, 7% of families in the U.S. were headed by single mothers with children under 18 years of age, and 6.3% of families were headed by single mothers in Pennsylvania. The percent of single-mother households in Montgomery County was slightly lower at 4.7%. In the United States, Pennsylvania, and Montgomery County, the percentage of households headed by single fathers was less than half of those headed by single mothers at 2.3%, 2.1%, and 1.7% respectively.

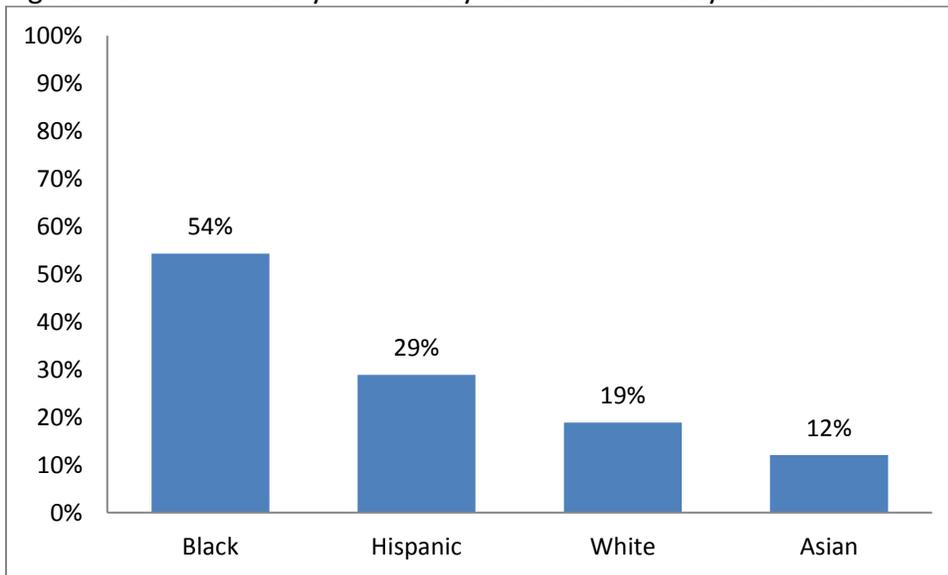
Table 2.4. Distribution of Household Type and Presence of Children in the United States, Pennsylvania, & Montgomery County, 2012-2016

	United States		Pennsylvania		Montgomery County	
	Number	Percent	Number	Percent	Number	Percent
Total Households	117,716,237		4,961,929		309,884	
Households with Own Children Under 18 Years	33,567,475	28.5%	1,272,561	25.6%	91,889	29.7%
Married Couple Family Household	56,781,405	48.2%	2,383,420	48.0%	171,919	55.5%
Married Couple Family Household with Own Children Under 18	22,632,647	19.2%	860,131	17.3%	71,973	23.2%
Female Householder, No Husband Present	15,146,110	12.9%	592,632	11.9%	29,062	9.4%
Female Householder, No Husband Present, with Own Children Under 18	8,232,608	7.0%	310,185	6.3%	14,567	4.7%
Male Householder, No Wife Present	5,681,312	4.8%	219,525	4.4%	11,336	3.7%
Male Householder, No Wife Present, with Own Children Under 18	2,702,220	2.3%	102,245	2.1%	5,349	1.7%

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

In the United States, mothers were the sole provider for almost one-quarter of households with children under 18 (Women’s Bureau 2016). The number of single-parent households has increased from 16.3% in 1975 to 31.3% in 2015. Of those single-parent households, 78.2% were mother-only families. Mother-only families were also more likely to have two or more children under the age of 18 - 51% compared to 40% of father-only families (Women’s Bureau 2016). Mother-only families also vary considerably by race and gender (Figure 2.6). Black women, in particular, are much more likely to face challenges associated with single parenthood.

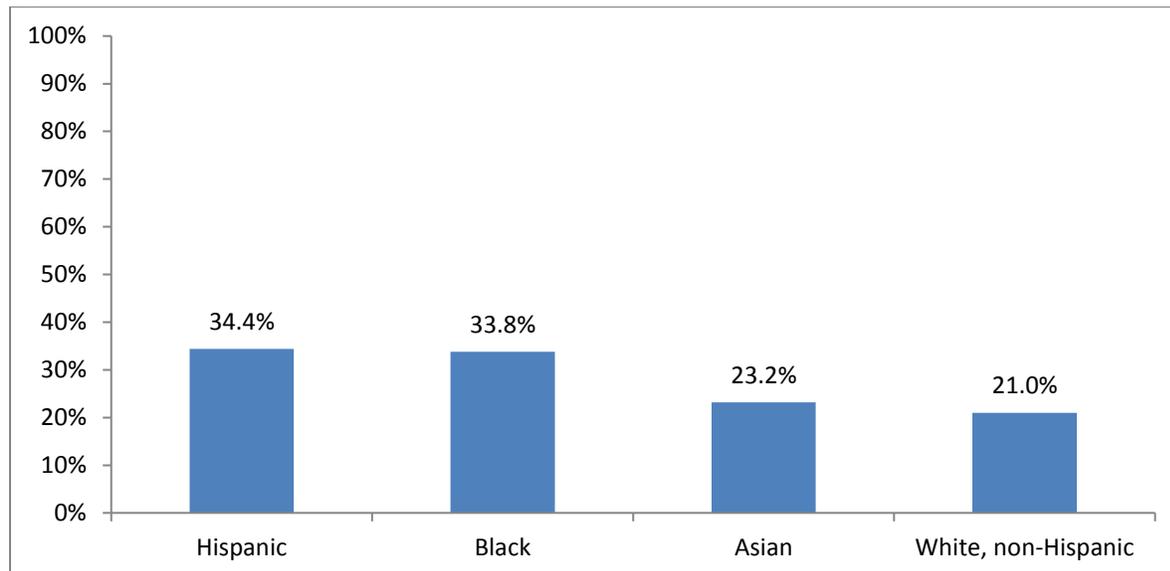
Figure 2.6. Mother-Only Families by Race and Ethnicity in the United States, 2015



Source: Compiled from Women’s Bureau, U.S. Department of Labor, *Working Mothers Issue Brief, 2016b*

In the United States, poverty rates for mother-only families are higher than married couples (Women’s Bureau 2016). In 2014, 28.5% of mother-only families lived in poverty, compared to 3.4% of married couple families. Poverty rates for mother-only families with children under 18 also vary by race and ethnicity (Figure 2.7). Women of color who headed families were far more likely to be living in poverty as defined by the U.S. Census. Hispanic and Black women in mother-only families with children under 18 lived in poverty at rates of 34.4% and 33.8% respectively in 2014 (Figure 2.7). Asian and White mother-headed households were less likely to live in poverty at rates of 23.2% and 21% respectively.

Figure 2.7. Percent in Poverty for Mother-Only Families by Race and Ethnicity, United States, 2014



Source: Compiled from Women's Bureau, U.S. Department of Labor, *Working Mothers Issue Brief, 2016b*

Note: Poverty rates were based on the U.S. Census Bureau income thresholds. People of two or more races are not included. Hispanics may be of any race. This is based on families with children under age 18.

The poverty rate in female-headed households (with no spouse present) is also higher than male-headed households (with no spouse present) in the U.S. In 2014, the poverty rate for mother-only families with children under 18 years was 28.4%, compared to 15.5% for father-only families (Women's Bureau 2016). The poverty rate is even higher if a child under six years old is present in the household. While 39.5% of mother-only households live in poverty (with a child under six years), 21.4% of father-only households do (Women's Bureau 2016). The poverty rate for married couples was 5.2% for families with children under 18 years and 7% for families with children under six years old (Women's Bureau 2016).

As the number of mothers in the labor force has increased nationwide, so have the number of households in which mothers are the primary or sole earners in a family. Overall, mothers were the primary or sole earner for 39.6% of households with children under 18 years in 2014. Of those families where mothers were the sole earners, 14.6% were from married couple households, while 39.6% were from mother-only families (Women's Bureau 2016).

Child Care

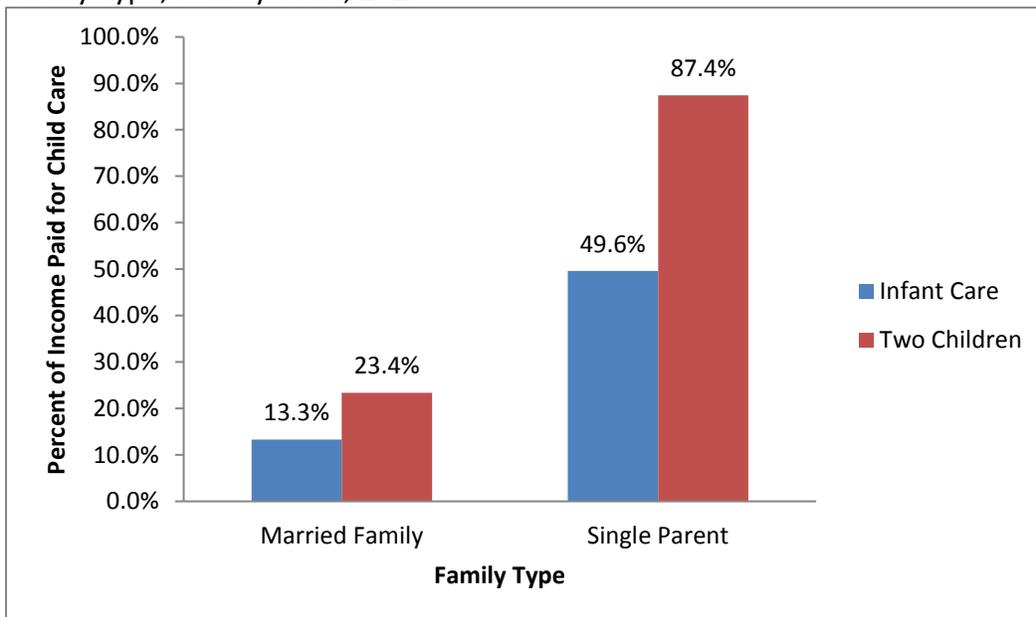
The Costs of Early Care

Child care is one of the most significant expenses for families across the United States. The average cost of infant center-based child care is about 27% of a family's income, which is up 3 percentage points from 2016 (Child Care Aware 2017a). If parents have access to affordable quality child care, they are less likely to miss work. Mothers and single parents are more likely

to be adversely affected by lack of reliable and affordable child care. In 28 states and the District of Columbia, the average annual cost of public college tuition was less than the annual cost for an infant in center-based child care.

In Pennsylvania, the average annual cost for an infant in center-based child care was \$12,129, compared to the average annual cost of public college tuition, which was \$14,436 (Child Care Aware 2017b). Single parents in Pennsylvania paid about 49.6% of their income for center-based child care for an infant (Figure 2.8). As a percent of family income, single parents paid considerably higher for child care. While a married couple pays 23.4% of its income towards child care for two children, a single parent pays 87.4% of her/his income in comparison. This is a significant difference that often serves to disadvantage women. Pennsylvania ranked 32nd on the IWPR's Child Care Index in 2013 (Hess et al. 2015).

Figure 2.8. Percent of Income for Child Based Center Care (of Infants and Two Children) by Family Type, Pennsylvania, 2017



Source: *Child Care Aware, 2017 Annual Report*

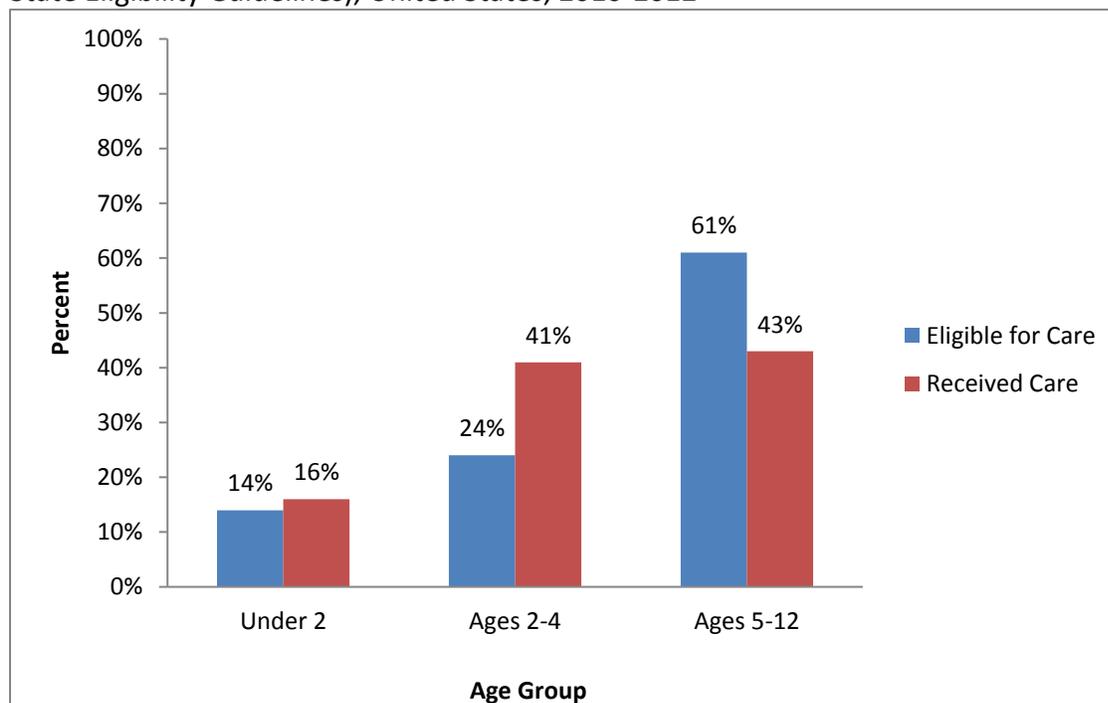
Child Care Subsidies

The U.S Department of Health and Human Services (HHS) provides subsidies for child care to low-income working parents through two programs. About two-thirds of funding comes from the Child Care and Development Fund (CCDF) while one-third comes from the Temporary Assistant for Needy Families (TANF) program (Chien 2017). In 2013, the federal government and states spent \$10 billion on child care subsidies. In an average month about 13.4 million children were eligible for child care subsidies under federal rules in 2013 (Chien 2017). Federal guidelines dictate that (1) children must be younger than 13 (or 19 if the child has special needs), (2) income must be 85% less than the state median income for a family of the same size in a given state, and (3) parents must have a job or be in school and/or training (Chien 2017).

While the federal government sets broad guidelines for eligibility, states may set stricter guidelines if they wish.

From 2010-2012, about 8.6 million children less than 13 years old were eligible for child care subsidies under their state guidelines in an average month, and about 1.5 million received subsidies (GAO-17-60, 2016). Figure 2.9 shows the average percent of children who were eligible for child care subsidies and the percent of children who received child care subsidies from 2010 to 2012 in an average month. Of children eligible for subsidies, 14% were children under two years old, 24% were between two and four years old, and 61% were between five and twelve years old. Of those children who received subsidies, 43% were between five and twelve years old, 41% were between two and four years old, and 16% were under two years old.

Figure 2.9. Percent of Children Eligible for and Receiving Child Care Subsidies by Age (Based on State Eligibility Guidelines), United States, 2010-2012



Source: GAO017-60. Government Accountability Office, Report to Congressional Committees, Child Care Access to Subsidies and Strategies to Manage Demand Vary across States, GAO Analysis of Department of Health & Human Service Data, 2016

Notes: Percentages may not total 100 percent due to rounding. Figures represent eligibility and receipt in an average month.

In 2015, 847,400 families and 1.4 million children received child subsidies in an average month. Almost half of the families that received subsidies had income below the federal poverty level, which was \$20,090 for a family of three in 2015. In Pennsylvania, 55,100 families and 93,500 children received subsidies (CCDF 2016).

The Coverage and Quality of Pre-Kindergarten Education

Pre-Kindergarten education has a variety of lifelong benefits including the development of social, academic, cognitive, and emotional skills (Diffey et al. 2017). In 2013-15, Pennsylvania ranked 28th among the fifty states and D.C. in the percentage of four year olds enrolled in State Pre-K, Preschool Special Education, and State and Federal Head Start. Pre-school standards were ranked 34th with a 5.6 out of 10 on the quality of preschool (Hess et al. 2015).

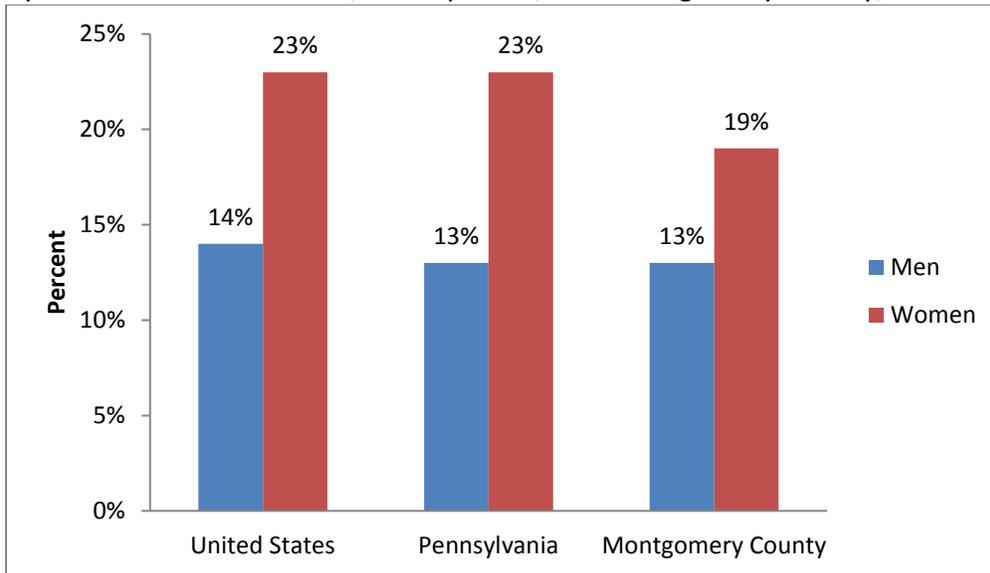
In Pennsylvania, about 64% of three and four-year-old children (living in families that earned up to 300% of the federal poverty level) did not have access to early education programs that were publicly funded and high quality such as Pennsylvania Pre-K Counts or Head Start Supplemental Assistance Program (PA Department of Education 2017). Pennsylvania Pre-K Counts provides high-quality pre-kindergarten education to three and four year olds who are at-risk. In 2016-17, the state increased the funding it provided to Pennsylvania Pre-K Counts by 23% and to Head Start Supplemental Assistance Program by 13% (Diffey et al. 2017). Six states did not provide any funding for pre-K education: Idaho, Montana, New Hampshire, North Dakota, South Dakota, and Wyoming (Diffey et al. 2017).

Montgomery County is among one of the underserved counties in Pennsylvania, with an unmet need of 75.4%, compared to the state average of 64% (PA Department of Education 2017).

Grandparents as Caregivers

Female grandparents are more likely to be responsible for their own grandchildren under the age of 18 than are male grandparents. About 14% of male grandparents were taking care of their own grandchildren in the United States, 13% in Pennsylvania, and 13% in Montgomery County. In the United States, and Pennsylvania, 23% of female grandparents were taking care of their grandchildren, but that was lower in Montgomery County at 19% (Figure 2.10).

Figure 2.10. Percent of Grandparents Responsible for Own Grandchildren Under 18 Years Old by Sex in the United States, Pennsylvania, and Montgomery County, 2012-2016

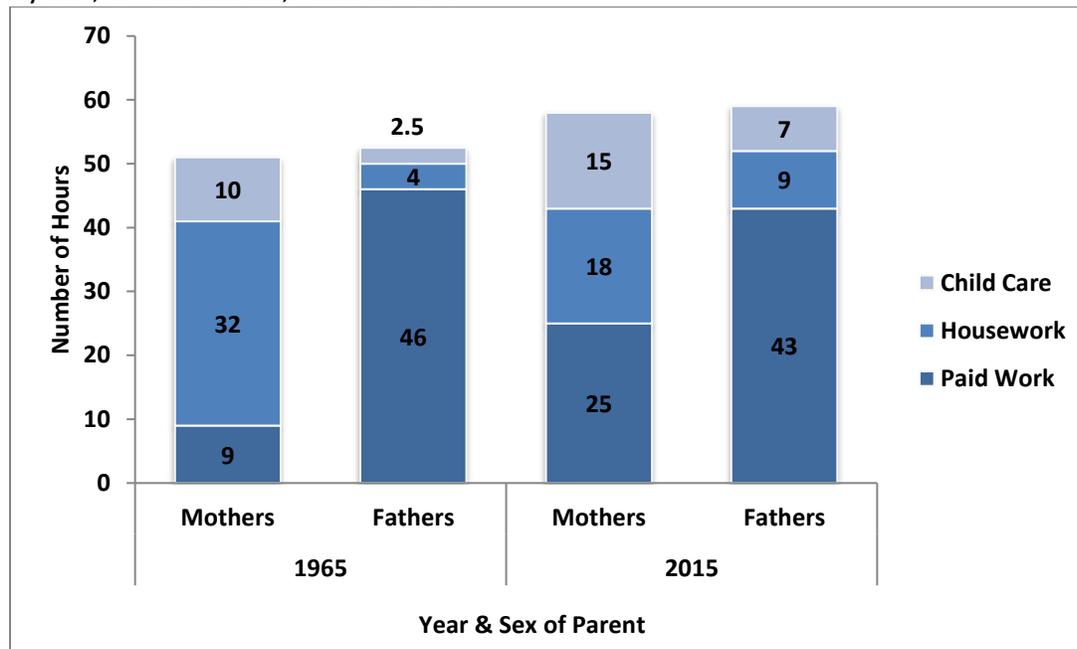


Source: U.S. Census Bureau, American Community Service Survey, 5-Year Estimates, 2012-2016

The Gap in Mothers' and Fathers' Labor Force Participation

Historically, women have been less likely to work outside the home and more likely to care for children and to perform unpaid labor inside the home. Men have been far more likely to work outside the home and have been less likely to care for children or to perform unpaid labor inside the home. According to the American Time Use Survey, fathers in the United States reported they spent more time on child care and housework in 2015 compared to 1965. In 2015, fathers reported they spent seven hours a week on child care, nine hours a week on housework, and 43 hours a week on paid work (Figure 2.11). In 1965, fathers reported they only spent two and half hours on child care, four hours on housework, and 46 hours on paid work. Mothers have increased the time they spend in paid work and child care. In 1965, mothers reported that they spent ten hours a week on child care, compared to 15 hours a week in 2015. In 1965, mothers reported they spent nine hours a week on paid work, compared to 25 hours a week in 2015. The number of hours spent on housework has decreased, from 32 hours a week in 1965 to 18 hours in 2015 (Figure 2.11).

Figure 2.11. Average Number of Hours per Week Spent on Child Care, Housework, & Paid Work by Sex, United States, 1965 & 2015

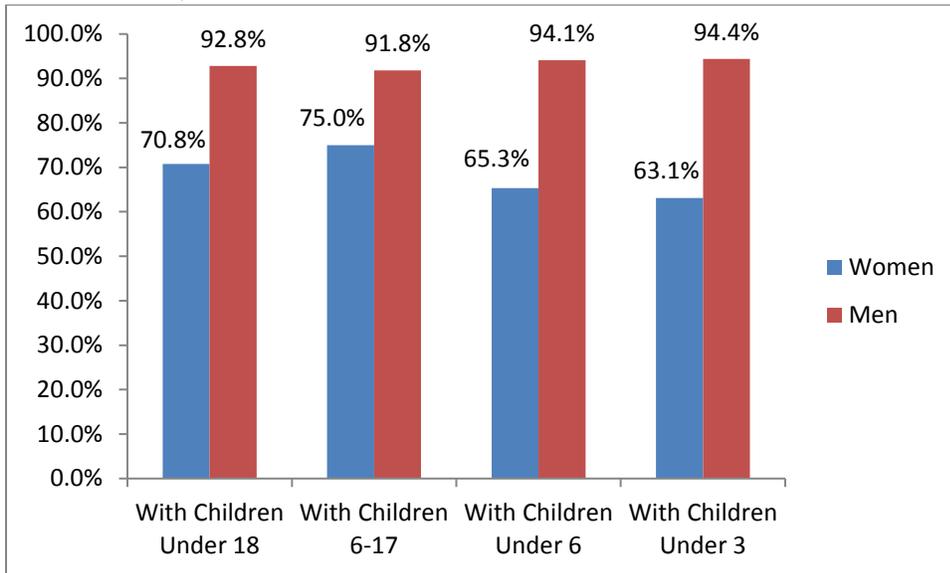


Source: Compiled from Parker and Livingston 2018, Pew Research Center

Despite the fact that the percentage of mothers entering the labor force has increased over the years, there is still a gender gap in labor force participation rates. In 1975, only 47.4% of mothers with children under 18 years old participated in the labor force (Women’s Bureau 2016), compared to 70.8% in 2016 (U.S. Bureau of Labor Statistics 2017). The percent of mothers with children under three years has increased the most from 34.3% in 1975 (Women’s Bureau 2016) to 63.1% in 2016 (U.S. Bureau of Labor Statistics 2017).

In 2016, men with children of any age were more likely to participate in the labor force than women with children. Men’s labor force participation rate varied little in 2016 depending on the age of the children, ranging from a low of 91.8% with children 6 to 17 years old and a high of 94.4% with children under three years old (Figure 2.12). Women’s labor force participation rates varied considerably depending on the age of the child or children. In 2016, 63% of women with children under three years old participated in the labor force compared to 75% of women who participated in the work force if they had children between the ages of 6 to 17 (Figure 2.12). For mothers with children under 18 years old in 2016, unmarried mothers were more likely to participate in the work force than married mothers at 75.9% and 68.6% respectively (U.S. Bureau of Labor Statistics 2017).

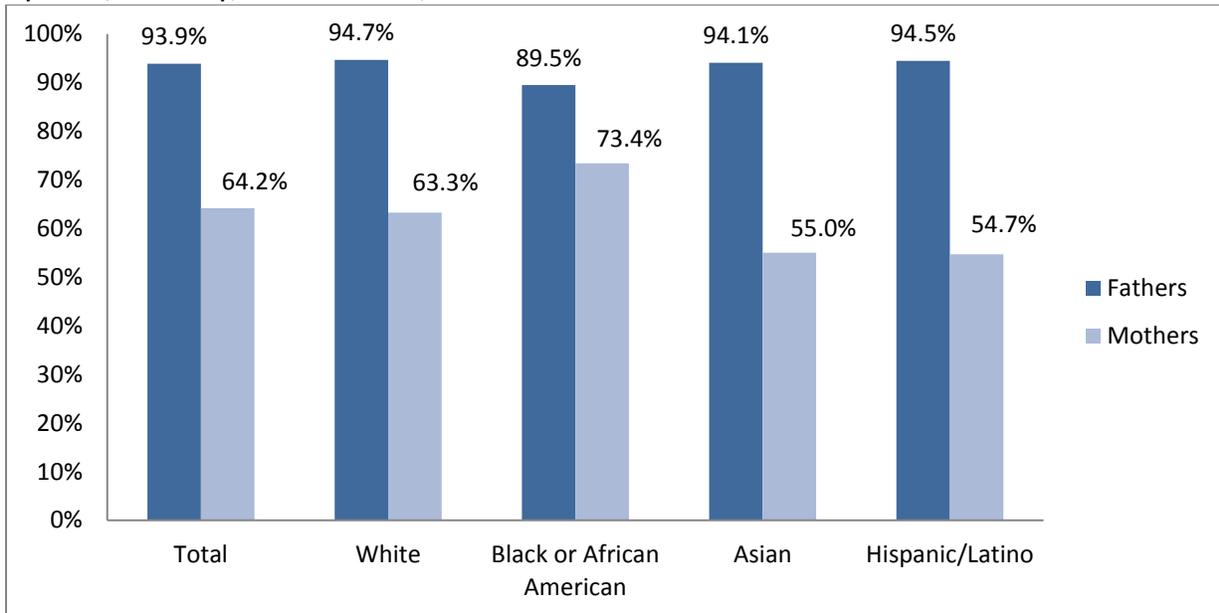
Figure 2.12. Labor Force Participation Rates for Women & Men with Children by Age Group, United States, 2016



Source: U.S. Bureau of Labor Statistics, Report 1071, *Women in the Labor Force: A Databook*, 2017

Labor force participation rates for parents also differ according to race and ethnicity. There is considerably less variation among fathers regardless of race and ethnicity. In 2015, 89.5% of Black fathers with children under six years old participated in the work force, compared to 94.7% of White fathers. Among women, Black mothers were the most likely to work at 73.4%, which is considerably higher than the overall rate of mothers' labor force participation rate of 64.2% (Figure 2.13). In 2015, Hispanic and Latino mothers were the least likely to work at 54.7%, compared to 55% of Asian mothers and 63.3% of White mothers (Figure 2.13).

Figure 2.13. Labor Force Participation Rates of Male & Female Parents with Children Under 6, by Race/Ethnicity, United States, 2015



Source: U.S. Bureau of Labor and Statistics, Report 1062: Labor Force Characteristics by Race and Ethnicity, 2016

Conclusion

Women are more likely to work part-time than men or not at all because they have more caregiving and domestic household responsibilities and because many people assume that it is best for women to stay at home while children are young. A study by the Pew Research Center in 2012 showed that 33% of Americans felt the “ideal situation” was for young children to have a mother “who is not working at all,” and 42% of respondents said the mother should be “working part-time” (Parker 2015). Only 16% of respondents said the “ideal situation” was a mother with young children “working full-time” (Parker 2015). An international study published in 2018 examined the relationship between a mother’s employment and the employment of adult sons and daughters as well as the amount of domestic duties they perform (McGinn et al. 2018). The authors found that adult daughters were more likely to be employed and to make higher incomes if their mothers were employed, while sons were more likely to care for other family members. Even though women are still disadvantaged by the wage gap, having more equitable responsibilities at home that allow women to work full-time means women’s earnings will improve.

POVERTY & OPPORTUNITY

Introduction

In 2016, the poverty rate of the United States was 12.7% or 40.6 million people (Semega et al. 2016). This figure is slightly down from 2015 when the poverty rate was 13.5% (Proctor et al. 2015). Although the number of people living in poverty decreased for most groups, it actually increased for adults aged 65 and older. Poverty rates decreased in the Northeast and South and stayed about the same in the Midwest and West. Despite the fact that women’s educational levels have increased over the past several decades, women are still more likely to live in poverty than men.

Poverty & Opportunity Index

The Institute for Women’s Policy Research (IWPR) developed a Poverty and Opportunity Composite Index to measure women’s economic security and access to opportunity (Hess et al. 2015). This index combines four different indicators: (1) the percent of women with health insurance coverage, (2) the percent of women with a college education, (3) the percent of businesses owned by women, and (4) the percent of women above the poverty level (Hess et al. 2015). In 2013, scores ranged from a high of 8 to a low of 6.18.

Pennsylvania’s ranking and score on the Poverty and Opportunity Composite Index has increased and decreased slightly, but the ranking has remained in the middle third of states, and the grade has remained in the C and C- range. Although Pennsylvania had initially improved its overall ranking and grade in 2013, Pennsylvania fared about the same in 2002 and 2016. In 2016, Pennsylvania ranked 26th out of 50 states and the District of Columbia with a score of 6.98 and a grade of a C-.

Table 3.1. Poverty & Opportunity Composite Index and Components in Pennsylvania, 2016, 2013, 2002

Composite Index		Percent of Women Aged 18-64 with Health Insurance		Percent of Women Aged 25+ with a Bachelor's Degree or Higher		Percent of Businesses Owned by Women		Percent of Women Aged 18+ Above Poverty			
Year	Score	Rank	Grade	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
2016	6.98	26	C-	93.6%	15	31.0%	28	31.2%	42	85.7%	18
2013	7.07	21	C	88.0%	9	28.6%	27	27.0%	29	86.5%	15
2002	6.99	26	C-	88.3%	9	20.6%	34	24.2%	35	89.8%	17

Source: IWPR #R532, Fact Sheet, Status of Women in the States, 2018; Hess et al., 2015; and Werschkul & Williams, 2004

The components of the composite index have also had erratic progress. Most notable, is the increase in the percent of women with health insurance. While approximately 88% of women had health insurance in 2002 and 2013, 93.6% had insurance in 2016. Interestingly, however, the rank of Pennsylvania dropped from 9 in 2013 to 15 in 2016. Even though more women were able to get health insurance, their progress was slower than that of women in other states. Overall, there has been progress in the number of women who earned bachelor's degrees and higher. In 2001, 20.6% of women had earned a bachelor's degree or higher, but this jumped to 28.6% in 2013 and 31% in 2016. Again, even though the percentage of women earning a degree increased, Pennsylvania's ranking compared to other states dropped down from 27 to 28. The percent of women business owners in Pennsylvania has steadily increased from 24.2% in 2002, to 27% in 2013, to 31.2% in 2016. The percent of women living above the poverty level has also decreased over time in Pennsylvania. In 2002, 89.8% of women lived above the poverty level – compared to 86.5% in 2013 and 85.7% in 2016. Compared to other states, Pennsylvania is on the borderline of the top third of states.

Health Insurance

Medical expenses can be a cause of bankruptcy, so health insurance can be particularly important to women who already make less because of the gender wage gap. According to a recent poll by the Kaiser Family Foundation, 26% of people (under the age of 65) reported that they (or someone in their household) had difficulty paying their medical bills in the past 12 months (Kaiser Foundation 2018). Of those who had difficulty, 74% reported that they cut household spending, and 58% reported they spent all or most of their savings.

Most people in the United States have private health insurance coverage through their employer, but a significant portion of people have insurance through government programs such as Medicare and Medicaid (Barnett and Berchick 2017). About 67.5% of health insurance is provided through private insurers, and 37.3% is provided through the government (Barnett and Berchick 2017).

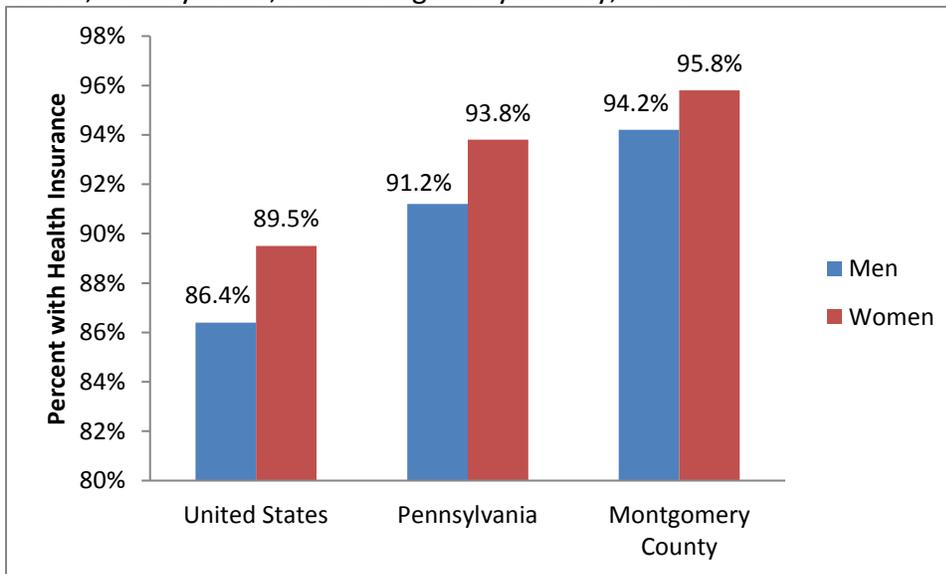
In 2010, the passage of the Patient Protection and Affordable Care Act (ACA or Affordable Care Act) changed the parameters of health insurance in the United States by providing greater access to affordable health insurance. It created state-based exchanges where people and small businesses could purchase health insurance and included an individual mandate that required people to purchase health insurance. Since the passage of the ACA, the percent of women with health insurance has increased. For example, 1 out of 5 elderly women were uninsured in 2013, compared to 1 out of 10 elderly women in 2017 (Ranji 2018). In 2013, 18% of women ages 18 to 64 were uninsured. This fell to 12% in 2017 (Ranji 2018).

Since the 2016 Presidential election, the future of the ACA is uncertain. One of the more controversial components of the ACA was the individual mandate. Although the ACA has not been repealed by Congress, the individual mandate was effectively repealed by the tax reforms passed in December 2017 that eliminated the tax penalty associated with the ACA (Fiedler 2018). Analysis by the Congressional Budget Office and the Brookings Institute demonstrated

that the individual mandate increased the number of people with health insurance coverage, so it is possible the number of women with health insurance may go down again after the tax penalty is removed.

In 2016, health insurance was one area where women consistently fared better than men. In the United States, 86.4% of men had health coverage, compared to 89.5% of women (Figure 3.1). In Pennsylvania, 91.2% of men had health coverage compared to 93.8% of women. In Montgomery County, 94.2% of men had health coverage compared to 95.8% of women. Overall, individuals in Montgomery County were more likely to have health insurance than in Pennsylvania and the United States. Women were more likely to have health insurance than men overall.

Figure 3.1. Percent of Men and Women Covered by Health Insurance, Age 18-64, in the United States, Pennsylvania, and Montgomery County, 2016



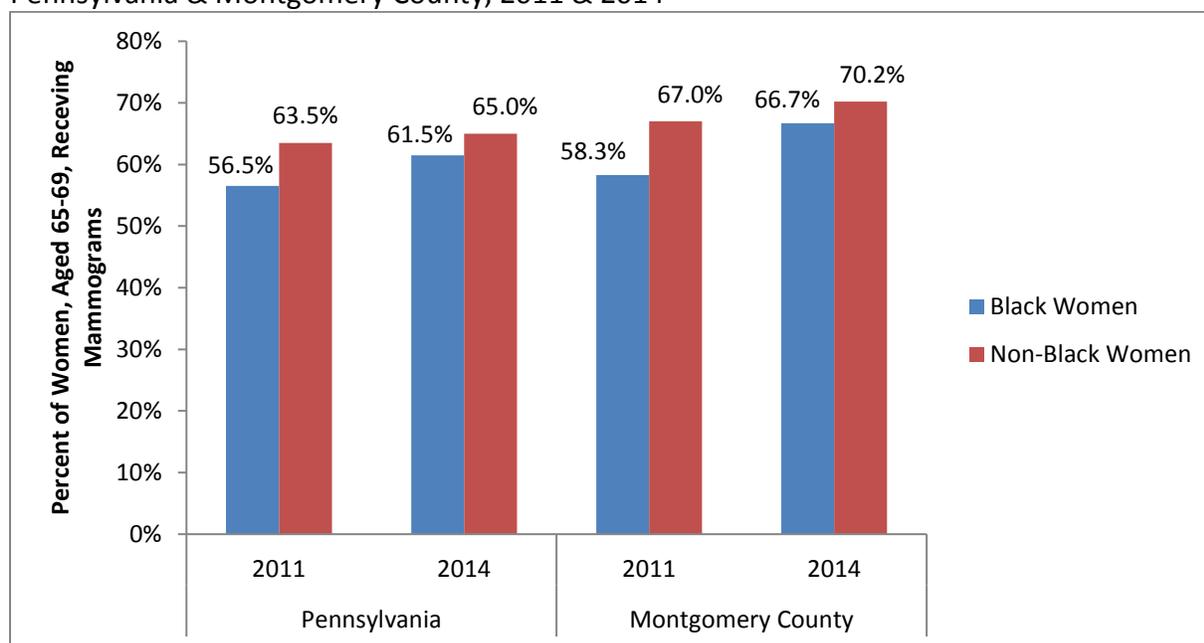
Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Comprehensive Coverage for Women’s Preventative Care

In 2011, the Department of Health and Human Services established guidelines for Women’s Preventative Services that were part of the Affordable Care Act (ACA). There was a provision within ACA that required insurance providers to provide certain women’s preventative health services with no out-of-pocket costs for the patient. This included well-woman visits, contraception, counseling for sexually transmitted infections, screening for cervical cancer, screening for breast cancer, interpersonal domestic violence screening, gestational diabetes screening, and breastfeeding services and supplies (National Partnership for Women & Families 2018c). In 2018, about 62 million women had access to preventative services through the ACA (National Partnership for Women & Families 2018c).

Since 2011, the number of mammograms performed on women between the ages of 65 and 69 increased. Black women were less likely to have mammograms than non-Black women, but there was improvement from 2011 to 2014 (Figure 3.2). In Pennsylvania, the percentage of Black women (aged 65-69) who had mammograms increased from 56.5% in 2011 to 61.5% in 2014. In Montgomery County, the percentage of Black women who had mammograms (aged 65-69) increased from 58.3% to 66.7%. While 67% of non-Black Montgomery County women had mammograms in 2011, 70.2% did in 2014. In Pennsylvania, 65% of non-Black women had mammograms compared to 63.5% in 2011. Overall, non-Black women were more likely to have had a mammogram, but all women’s rates in this age group were higher in Montgomery County than in Pennsylvania.

Figure 3.2. Percent of Female Medicare Enrollees (Aged 67-69) Receiving Mammograms in the Pennsylvania & Montgomery County, 2011 & 2014

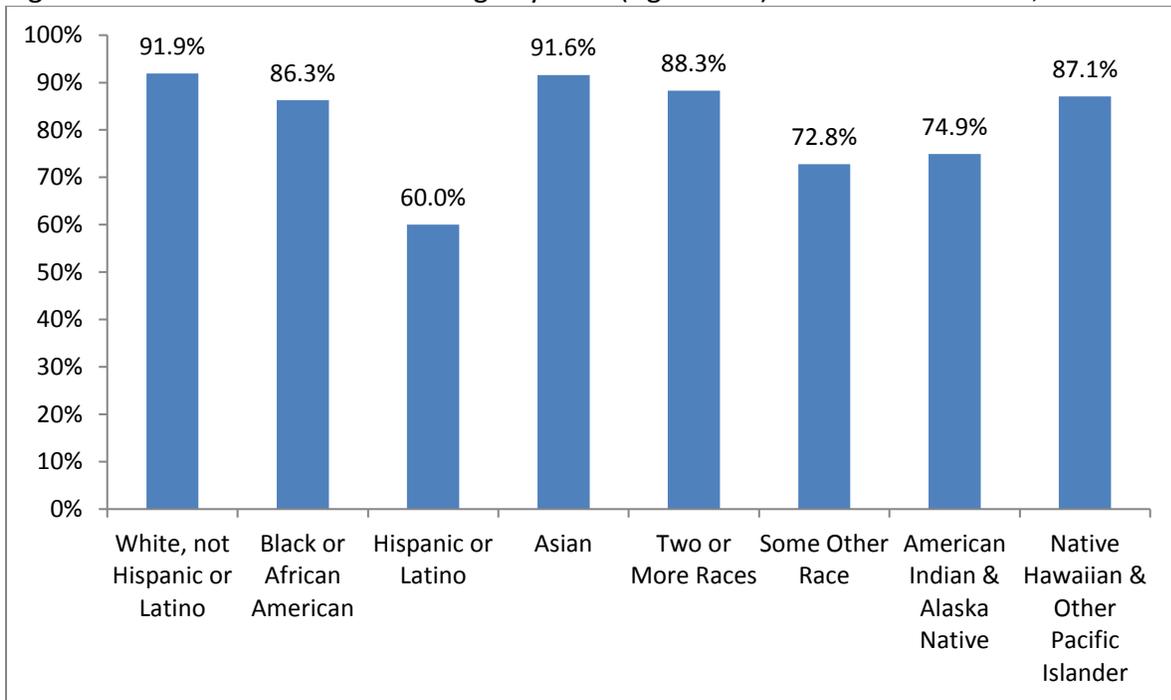


Source: DataUSA Pennsylvania and DataUSA Montgomery County

Health Insurance by Race and Ethnicity

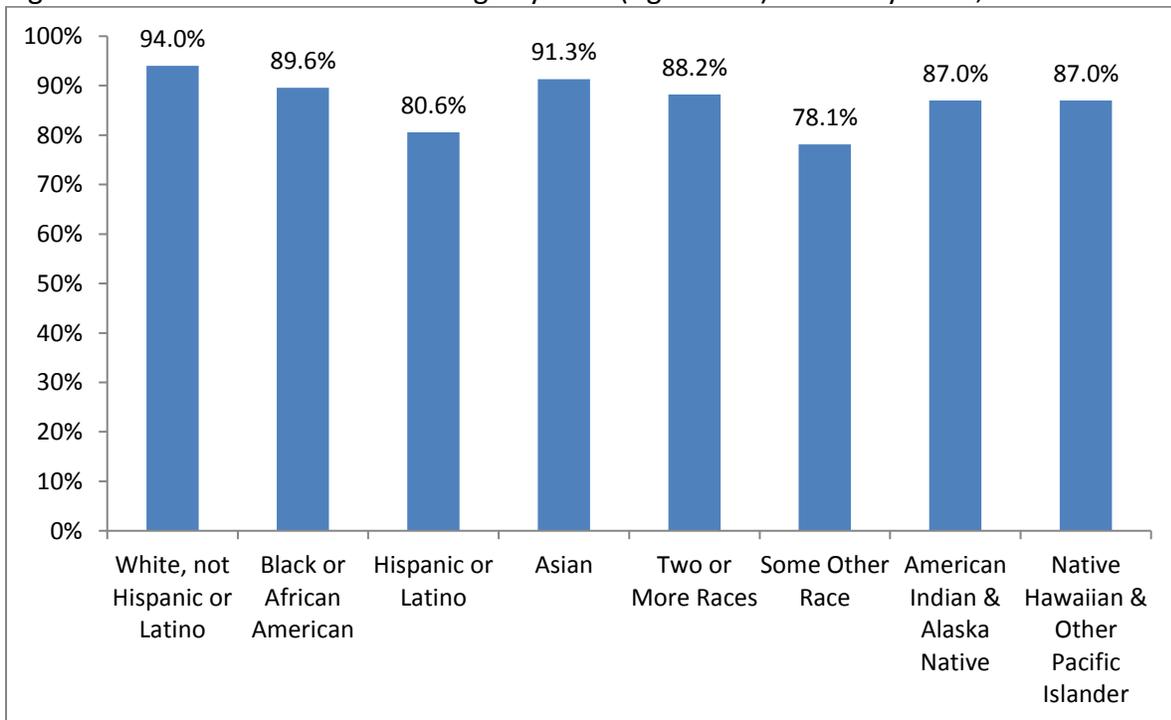
Health insurance coverage also varies by race and ethnicity. In 2016, 91.9% of Whites and 91.6% of Asians in the United States had health insurance coverage, but only 60% of Hispanics or Latinos did (Figure 3.3). Overall, health insurance coverage was better in Pennsylvania (Figure 3.4) and Montgomery County (Figure 3.5) than in the United States as a whole. Although the percentage of people with health insurance was considerably better for Hispanics or Latinos in Pennsylvania (80.6%), only 72.5% of Hispanics or Latinos had health insurance coverage in Montgomery County. Health insurance coverage was also worse for individuals who identify as some other race in Montgomery County at 49%, compared to 72.8% in the U.S. and 78.1% in Pennsylvania.

Figure 3.3. Health Insurance Coverage by Race (Age 18-64) in the United States, 2016



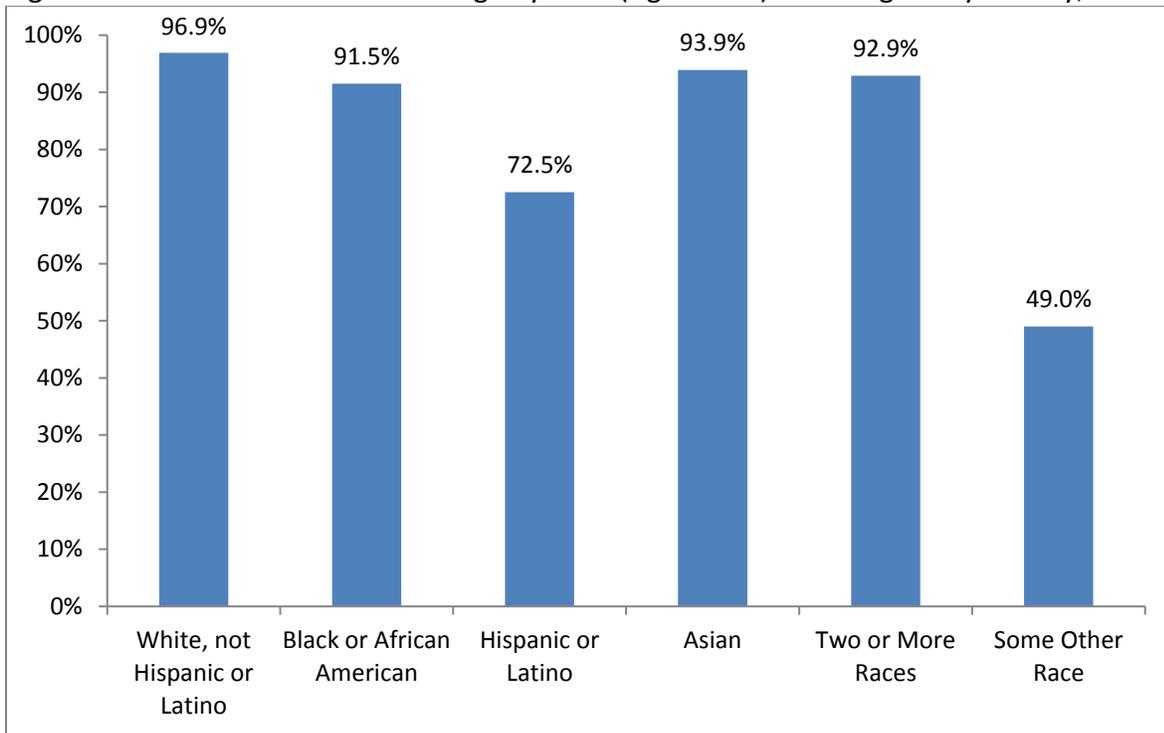
Source: Compiled by the author from the U.S. Census, American Community Survey, 1-Year Estimates, 2016

Figure 3.4. Health Insurance Coverage by Race (Age 18-64) in Pennsylvania, 2016



Source: Compiled by the author from the U.S. Census, American Community Survey, 1-Year Estimates, 2016

Figure 3.5. Health Insurance Coverage by Race (Age 18-64) in Montgomery County, 2016

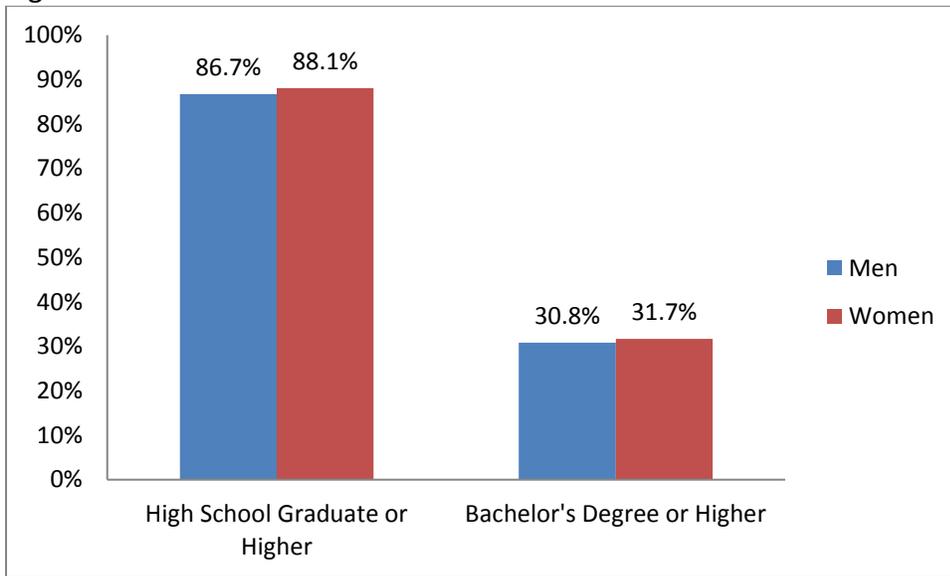


Source: Compiled by the author from the U.S. Census, American Community Survey, 1-Year Estimates, 2016

Education

Women's educational attainment has increased dramatically over the past several decades. In 1970, 34% of women did not have a high school diploma, compared to 6% in 2016 (U.S. Bureau of Labor Statistics 2017). Since 1970, the number of women earning bachelor's degrees has also risen considerably. In 1970, 11% of women in the workforce (ages 25-64) had a bachelor's degree, while 42% of women in 2016 did (DeWolf 2017). Title IX of the Educational Amendments of 1972 has been one of the contributing factors to women's rising education levels because it prohibits sex discrimination in educational institutions that receive federal funding (U.S. Department of Education 2018). In 2016, the Institute for Women's Policy ranked Pennsylvania 28th among 50 states and Washington, DC in the percent of women who earned a bachelor's degree or higher (IWPR #532, 2018).

Figure 3.6. Educational Attainment of Men & Women in the United States, 2016

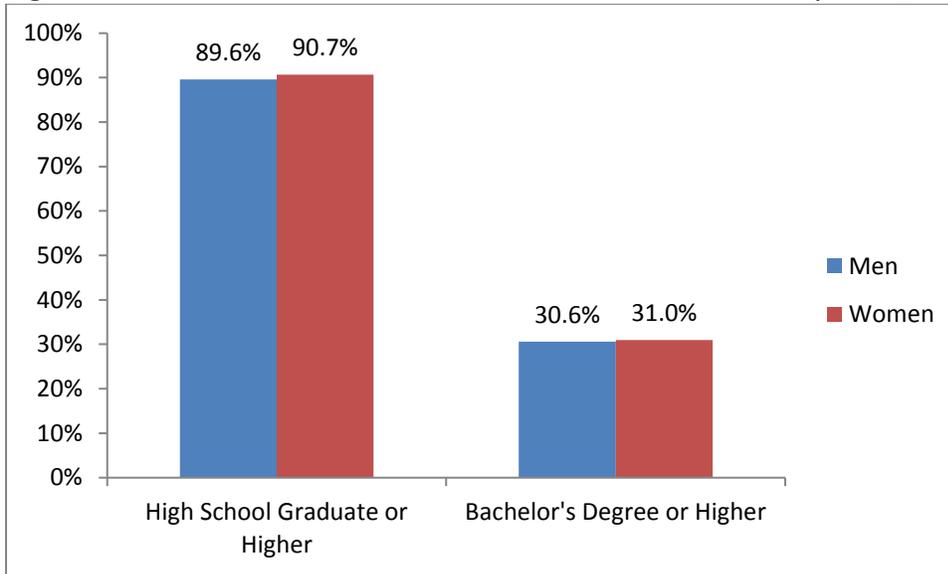


Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Selected Population Profile in the United States, 2016

Notes: Population 25 Years and Older

In 2016, women in the U.S. were slightly more likely to graduate high school and to attain a bachelor's degree than men (Figure 3.6). The likelihood of having a high school degree or higher was better in Pennsylvania than in the United States, with 89.6% of men and 90.7% of women having a high school degree or higher (Figure 3.6). The likelihood of earning a bachelor's degree or higher was nearly the same in the United States and Pennsylvania, with 30.8% of men and 31.7% of women having a bachelor's in the U.S. and 30.6% of men and 31% of women having a bachelor's degree or higher in Pennsylvania. Women were slightly more likely to have a bachelor's degree or higher in the United States and Pennsylvania.

Figure 3.6. Educational Attainment of Men & Women in Pennsylvania, 2016

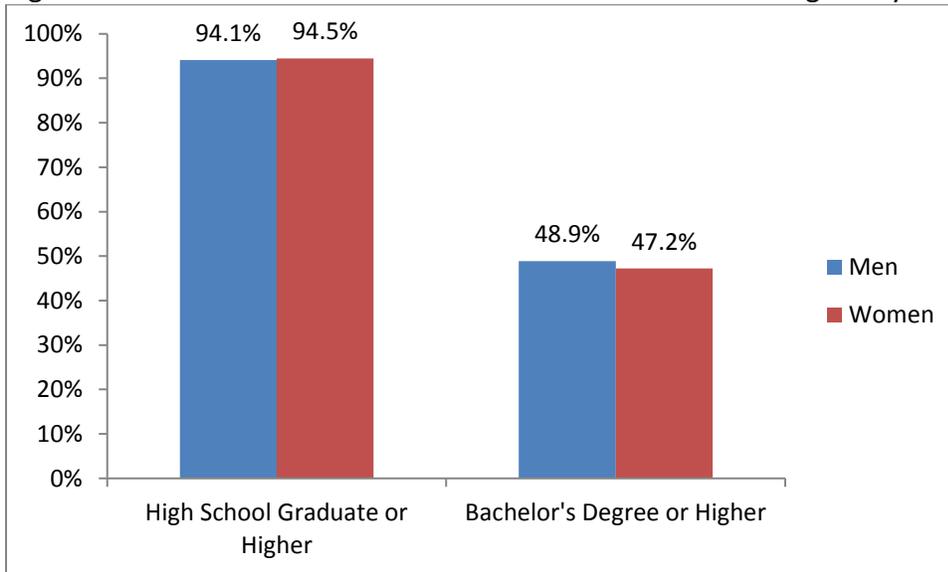


Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Selected Population Profile in the United States, 2016

Notes: Population 25 Years and Older

Levels of educational attainment were much higher in Montgomery County than in the U.S. or Pennsylvania with 94.1% of men and 94.5% of women earning a high school diploma or higher in Montgomery County (Figure 3.7). Unlike in the U.S. and Pennsylvania, the percent of men with bachelor's degrees or higher (48.9%) was slightly higher than that of women (47.2%).

Figure 3.7. Educational Attainment of Men & Women in Montgomery County, 2016



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Selected Population Profile in the United States, 2016

Notes: Population 25 Years and Older

Educational Achievement by Race and Ethnicity

Educational levels also vary by race and ethnicity. Tables 3.2, 3.3, and 3.4 show the different educational levels of women based on the 2016 U.S. Census categories of race and ethnicity. Overall, Asian women had the highest levels of educational attainment in the U.S. (Table 3.2). Asian women were more likely to have a bachelor’s degree (30.9%) and a graduate or professional degree (20.2%). Hispanic or Latino women were the least likely to have a bachelor’s degree (11.5%) and graduate or professional degree (5.3%) aside from women who identified as “some other race.”

Table 3.2. Educational Attainment for Women by Race & Ethnicity in the United States, 2016

Educational Level	White, Not Hispanic or Latino	Black or African American	Hispanic or Latino	Asian	Some Other Race	Two or More Races
High School Diploma	23.6%	24.9%	22.7%	14.3%	23.6%	16.4%
Bachelor's Degree	21.5%	14.0%	11.5%	30.9%	8.8%	20.5%
Graduate or Professional Degree	13.4%	9.1%	5.3%	20.2%	3.5%	11.8%

Source: Compiled by author from the U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016
Notes: Population 25 Years and Older. Racial and ethnic categories based on the 2016 American Community Survey. Percentages do not equal 100%. Not enough data was available for American Indian and Alaskan Native Alone or Native Hawaiian and Other Pacific Islander Alone at the county and/or state level, so they were excluded.

In Pennsylvania, White women were more likely to have a bachelor’s degree (35.9%), and Asian women were most likely to have a graduate or professional degree (23.9%) (Table 3.3). Black women and Hispanic or Latino women were less likely to have a bachelor’s degree at 12.9% and 11.5% respectively. Again, women who identified as “some other race” had the lowest levels of educational attainment.

Table 3.3. Educational Attainment for Women by Race & Ethnicity in Pennsylvania, 2016

Educational Level	White, Not Hispanic or Latino	Black or African American	Hispanic or Latino	Asian	Some Other Race	Two or More Races
High School Diploma	32.8%	28.1%	24.2%	16.3%	28.2%	18.5%
Bachelor's Degree	35.9%	12.9%	11.5%	27.1%	6.9%	22.2%
Graduate or Professional Degree	12.7%	8.6%	5.9%	23.9%	3.3%	10.7%

Source: Compiled by author from the U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016
 Notes: Population 25 Years and Older. Racial and ethnic categories based on the 2016 American Community Survey. Percentages do not equal 100%. Not enough data was available for American Indian and Alaskan Native Alone or Native Hawaiian and Other Pacific Islander Alone at the county and/or state level.

Overall, educational attainment levels were higher for women in Montgomery County in 2016. Asian women had higher levels of educational attainment than other groups, with 36.2% having a bachelor’s degree and 24.2% having a graduate or professional degree (Table 3.4). White women had the next highest levels of educational attainment, with 27.4% having a bachelor’s degree, and 20.7% having a graduate or professional degree. Hispanic and Latino women were again less likely to have a bachelor’s (16.9%) and/or a graduate or professional degree (10.4%). Again, women who identified as “some other race” were least likely to have a bachelor’s (2.3%) and/or a graduate or professional degree (9.2%).

Table 3.4. Educational Attainment for Women by Race & Ethnicity in Montgomery County, 2016

Educational Level	White, Not Hispanic or Latino	Black or African American	Hispanic or Latino	Asian	Some Other Race	Two or More Races
High School Diploma	23.4%	20.4%	22.9%	16.5%	19.7%	15.4%
Bachelor's Degree	27.4%	19.6%	16.9%	36.2%	2.3%	23.2%
Graduate or Professional Degree	20.7%	17.6%	10.4%	24.2%	9.2%	16.3%

Source: Compiled by author from the U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016
 Notes: Population 25 Years and Older. Racial and ethnic categories based on the 2016 American Community Survey. Percentages do not equal 100%. Not enough data was available for American Indian and Alaskan Native Alone or Native Hawaiian and Other Pacific Islander Alone at the county and/or state level.

Even though women’s educational attainment has improved, female students have been disadvantaged in other ways such as student loan debt. In 2016, women comprised 56% of students enrolled in American universities and colleges, and they also took out more student loans than men did (Miller 2017). About 44% of female undergraduates took out student loans

in one year, compared to 39% of male undergraduates (Miller 2017). In fact, women were more likely to take out student loans at almost every degree level and type of institution. Women's student loan balances were approximately 14% greater than men's in any given year (Miller 2017). Black women took out more student loans than any other racial/ethnic group (Miller 2017). Once women graduated, they paid their student loans back more slowly than men due to the gender wage gap. The impact of the gender wage gap for Black women exaggerated the pace of payback even more.

Gender Differences in Fields of Study

One of the factors in the gender wage gap is occupational segregation that can be traced back to the college majors of female and male students. Among the majors that are high paying and male-dominated are Mechanical Engineering (89% male), Civil Engineering (83% male), Physics (81% male), Computer Science and Engineering (74% male), and Electrical Engineering (74% male) (Chamberlain and Jayaraman 2017). Female students are more likely to major in the social sciences and liberal arts, which are typically much lower-paying. Among the majors that are female dominated are Social Work (85% female), Healthcare Administration (84% female), Anthropology (80% female), Nursing (80% female) and Human Resources (80% female) (Chamberlain and Jayaraman 2017). Out of the ten highest paying majors, nine were male-dominated, and six out of ten of the lowest paying majors were female-dominated. The underrepresentation of women in science, technology, engineering, and mathematics (STEM) fields has a significant impact on the earning potential of women.

Women Business Owners

Over the past several decades, the number of women-owned businesses has increased considerably. The most recent Survey of Business Owners was performed by the U.S. Census in 2012. At that time, women were the majority owners (51% or more) of 9.9 million business and co-owners (equally with men) of 2.5 million businesses. Nearly all (99.9%) of women-owned businesses were small businesses (McManus 2017). Women-owned businesses were more likely to have lower profits and fewer employees than male-owned businesses, but women-owned businesses contributed \$1.4 trillion in sales to the economy and employed over 8.4 million people in 2012 (McManus 2017). In the 2012 Census Survey of Business Owners, Pennsylvania ranked 42nd in the percent of businesses owned by women at 31.2% (IWPR #R532, 2018).

Women of color were more likely to own a business in their demographic group. For example, 59% of Black or African American owned businesses were owned by Black women. White women owned a lower percentage of businesses (32%) in their demographic group than any other group. American Indian women owned 48% of businesses in their demographic group, compared to 39% for Asian women, 46% for Native Hawaiian women, and 44% for Hispanic or Latino women in their respective demographic groups (McManus 2017).

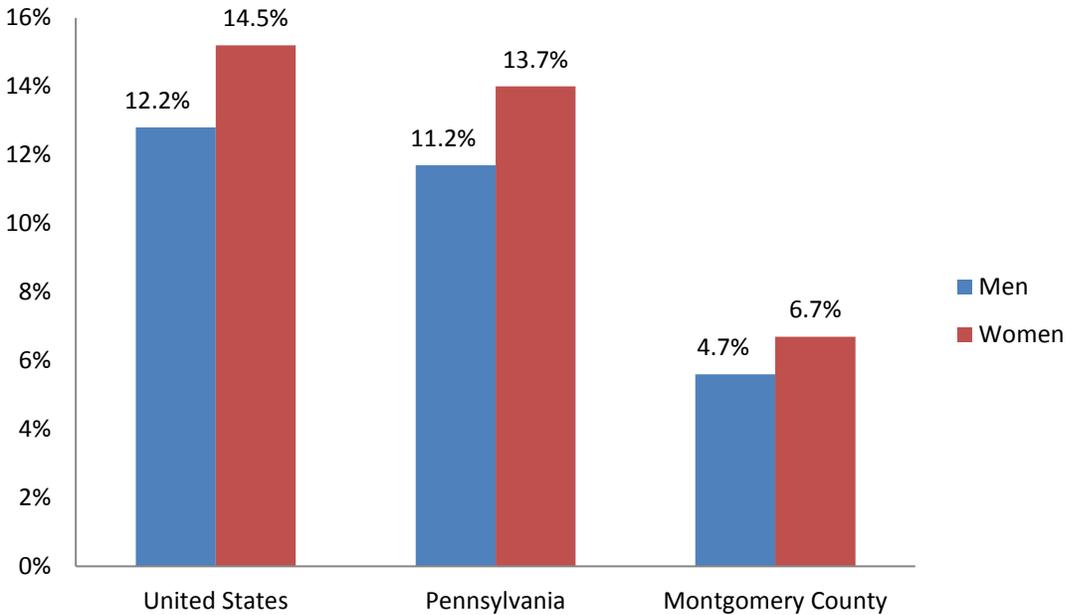
The 2017 State of Women-Owned Businesses Report projected that women-owned businesses have grown 114% from 1997 to 2017, compared to an overall growth rate of 44% for all businesses (American Express 2017). The growth rate for the number of employees in women-owned businesses (27%) was also greater than the national average (13%). Revenues were the one area where women-owned businesses did not outpace national growth rate patterns. Over the past twenty years, revenues in women-owned businesses increased 103%, compared to the national growth rate of 114%.

There are a variety of government and nonprofit organizations dedicated to assisting women entrepreneurs. At the national level, one such organization is the Office of Women's Business Ownership (OWBU) within the U.S. Small Business Administration. The OWBU supervises Women's Business Centers in numerous locations nationwide. These centers provide educational resources for female entrepreneurs (U.S. Small Business Administration 2018). Pennsylvania offers Small Business Development Centers that offer some resources specifically for female business owners. In 1998, the Amber Grant Foundation was established, and it provides grants to female entrepreneurs. The Women's Business Enterprise Council provides procurement resources and serves southeastern Pennsylvania (as well as Delaware and southern New Jersey).

Women's Poverty and Economic Security

Women are more likely to live in poverty than men. In the United States, 12.2% of men and 14.5% of women lived below the poverty level in 2017 (Figure 3.9). Statistics in Pennsylvania were similar, with 11.2% of men and 13.7% of women living below the poverty level. Overall, fewer men (4.7%) than women (6.7%) lived in poverty in Montgomery County.

Figure 3.9. Percent of Women & Men Living Below Poverty Level in the United States, Pennsylvania, & Montgomery County, 2017



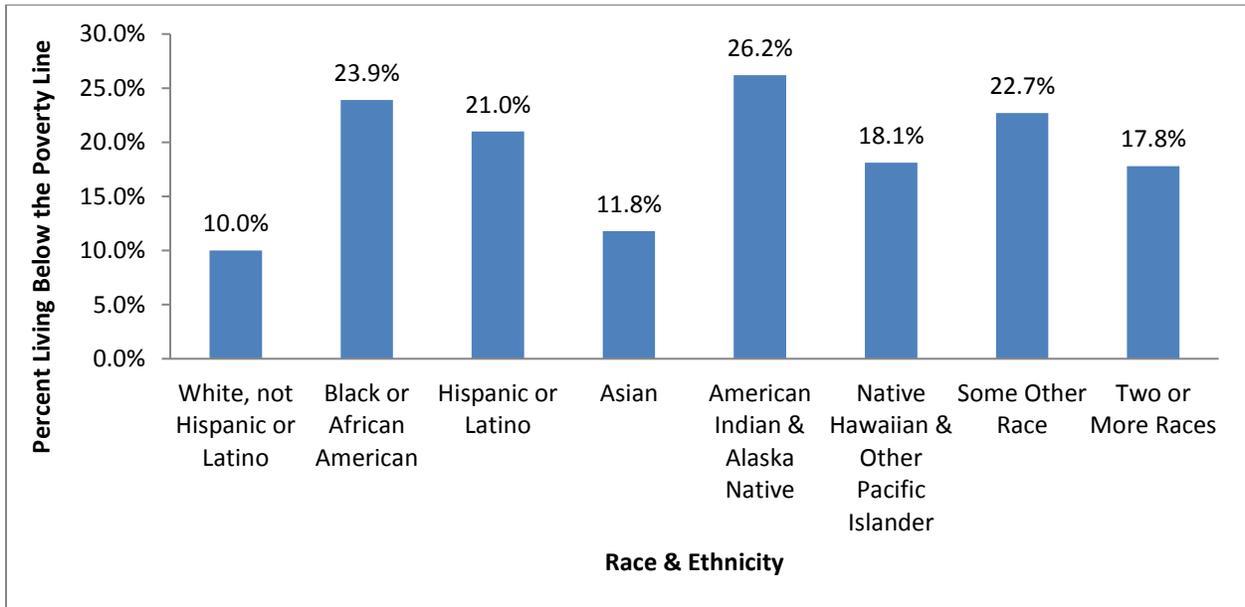
Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Poverty Status in the Past 12 Months, 2017

Notes: Poverty level refers to the Federal Poverty Line.

Poverty by Race and Ethnicity

In the United States, both female and male American Indians and Alaska Natives were the most likely to live in poverty at 26.2%, with Blacks and African Americans not far behind at 23.9% (Figure 3.10). Only 10% of Whites and 11.8% of Asians lived below the poverty level in comparison. Although these figures do not show a gendered breakdown of poverty by race and ethnicity, they provide an overall picture of how inequity varies.

Figure 3.10. Percent Living Below the Poverty Level by Race & Ethnicity in the United States, 2016

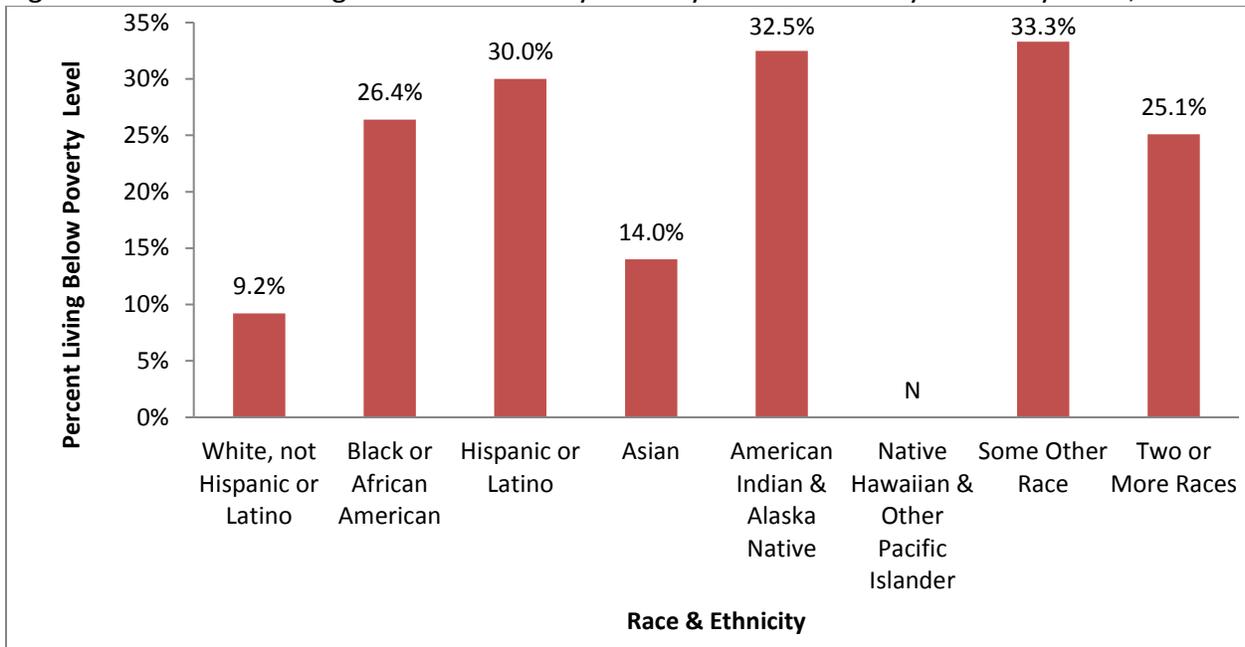


Source: U.S. Census Bureau, American Community Survey 1-Year Estimates, Poverty Status in the Past 12 Months, 2016

Notes: Poverty level refers to the Federal Poverty Line. Racial and ethnic categories based on the 2016 American Community Survey.

In Pennsylvania, 32.5% of American Indians and Alaska Natives and 30% of Hispanics or Latinos lived in poverty in 2016 (Figure 3.11). The poverty rate for both of these groups was higher in Pennsylvania than in the U.S. Individuals who identified as “some other race” had the highest levels of poverty in the state at 33.3%. Similar to the United States, Whites and Asians had the lowest percentage of people in poverty at 9.2% and 14% respectively.

Figure 3.11. Percent Living Below the Poverty Level by Race & Ethnicity in Pennsylvania, 2016

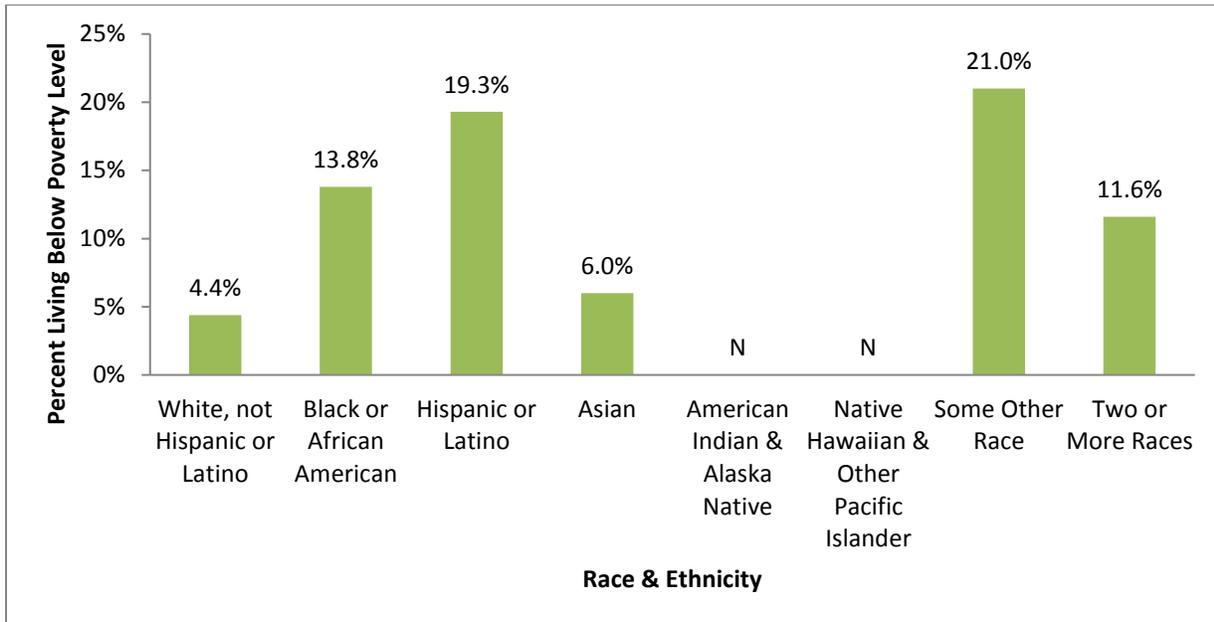


Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Poverty Status in the Past 12 Months, 2016

Notes: Poverty level refers to the Federal Poverty Line. Racial and ethnic categories based on the 2016 American Community Survey. N means that the number of cases was too small for Native Hawaiian and Other Pacific Islander.

In Montgomery County, the percent of people living below the poverty level was less than in the U.S. or Pennsylvania. Hispanics or Latinos and those who identified as “some other race” had the highest poverty levels at 19.3% and 21% respectively. Whites were the least likely to live in poverty at 4.4%, followed by Asians at 6%. (Figure 3.12).

Figure 3.12. Percent Living Below the Poverty Level by Race & Ethnicity in Montgomery County, 2016



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Poverty Status in the Past 12 Months, 2016

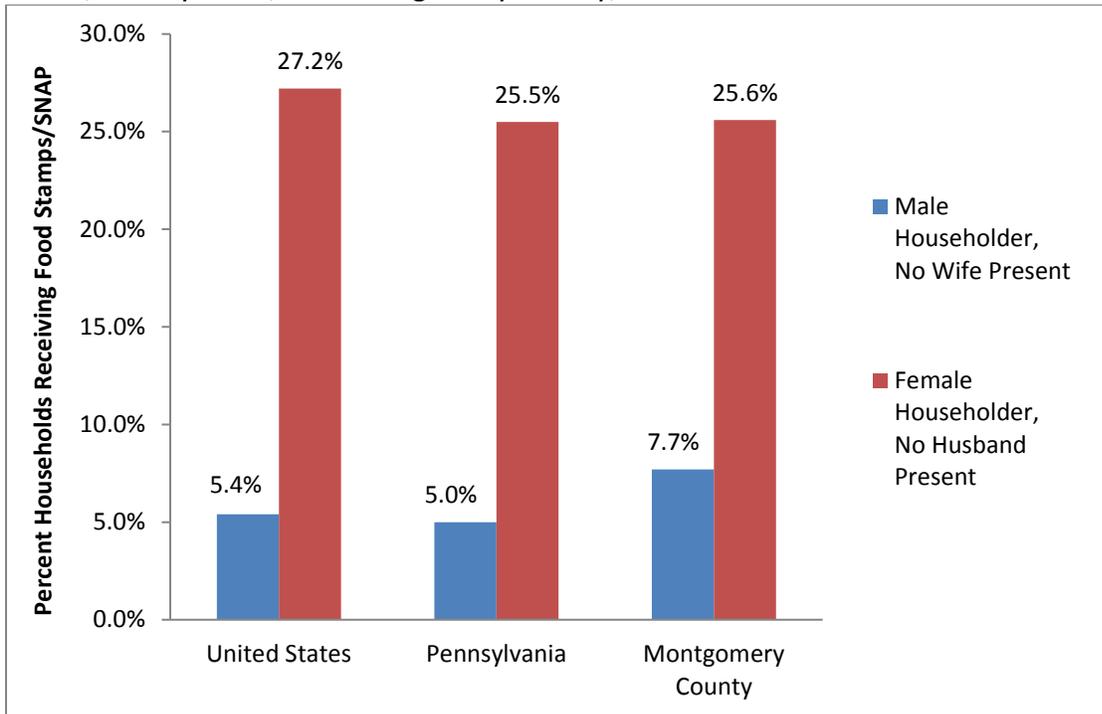
Notes: Poverty level refers to the Federal Poverty Line. Racial and ethnic categories based on the 2016 American Community Survey. N means that the number of cases was too small for American Indian & Alaska Native and Native Hawaiian and Other Pacific Islander.

Social Safety Net

Public assistance programs like the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid are particularly important for women given their more economically vulnerable position due to the gender wage gap and the greater likelihood of facing poverty.

In households that have children under 18 years old, mothers were much more likely to receive SNAP than fathers. In 2016, 27.2% of female householders (with no husband present) and 5.4% of male householders (with no wife present) received SNAP benefits in the United States (Figure 3.13). The percent of female and male householders receiving SNAP was similar in Pennsylvania, with 25.5% for women and 5% for men. Although the general pattern in Montgomery County was the same, the percent of male householders receiving SNAP was higher than in the U.S. or Pennsylvania at 7.7%, but was similar for women at 25.6%.

Figure 3.13. Percent of Male & Female Households Receiving Food Stamps/SNAP in the United States, Pennsylvania, and Montgomery County, 2016



Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, Food Stamps/Supplemental Nutrition Assistance Program (SNAP), 2016

Notes: Based on households with children under 18.

Conclusion

Overall, women’s economic well-being has improved in many areas of measurement including health insurance coverage, education, and women-owned businesses. Despite these advancements, however, women are still more likely to live in poverty than men – particularly women of color. This overall progress also hides the disadvantages women face. For example, even though educational levels between men and women are much closer among younger people, women over 65 are less likely than their male counterparts to have a bachelor’s degree (Hess et al. 2015). Although men and women over 65 are covered by Medicare, women have higher out-of-pocket expenses. Poverty rates are also higher for women (11.3%) over 65 than for men (7.4%) (Hess et al. 2015). Even in areas of improvement like health insurance and education, women of color have not experienced benefits at the same rate as non-Hispanic White women. This suggests that maintaining women’s health insurance coverage and educational levels for all women is important for the future.

HEALTH & WELL-BEING

Introduction

There are many facets to women’s health and well-being that range from physical to mental health. Women’s health can be an important part of their financial well-being or vice versa. Access to health care regardless of socioeconomic status is a key component to maintaining women’s health. Historically, women’s health has been under studied. The Centers for Disease Control and Prevention (CDC) currently have a commitment to make sure they work with a diverse group of human subjects that include women and minorities.

Women’s Health and Well-Being in the United States, Pennsylvania, and Montgomery County (2015)

The Institute for Women’s Policy Research created the Health and Well-Being Composite Index to compare the performance of different states on indicators related to women’s health. The index is composed of nine different indicators: heart disease mortality, lung cancer mortality, breast cancer mortality, incidence of diabetes, chlamydia, incidence of AIDS, suicide mortality, poor mental health days, and limited activities (Hess et al. 2015). In 2015, composite scores ranged from a low of 1.20 to a high of 2.81, with higher scores meaning better health outcomes and higher letter grades. Minnesota ranked the highest, and Mississippi ranked the lowest (Hess et al. 2015).

In 2015, Pennsylvania ranked 31st among 50 states and the District of Columbia on the Health and Well-Being Composite Index (Table 4.1). Its composite score was 2.02, and it had a grade of a C-. This rank placed Pennsylvania in the middle third of states. Overall, states in the South and parts of the Midwest were the worst in regard to women’s health, while states in the Northeast, West, and other parts of the Midwest were the best for women’s health.

Table 4.1. Women’s Status on Health & Well-Being Composite Index, Pennsylvania, 2013

Composite Score			
	Score	Rank	Grade
Pennsylvania	2.02	31	C-

Source: Hess et al. 2015, *Status of Women in the States*, Institute for Women’s Policy Research

Table 4.2 shows the individual components that comprise the composite index, as well as indicator scores for the U.S. and Pennsylvania. In 2015, Pennsylvania’s scores on individual indicators were worse than the national average when it came to heart disease mortality (143.6), lung cancer mortality (37.4), breast cancer mortality (22.5), the incidence of diabetes (10.1%), the incidence of AIDS (5.6), and poor mental health days (4.6). Pennsylvania’s scores were better than the national average when it came to reported cases of chlamydia (546), suicide mortality (5.2), and limited activities (4.6).

Table 4.2. Women’s Status on Components of Health & Well-Being Composite Index, United States & Pennsylvania, 2013

	Heart Disease Mortality		Lung Cancer Mortality		Breast Cancer Mortality		Incidence of Diabetes		Reported Cases of Chlamydia		Incidence of AIDS		Poor Mental Health		Suicide Mortality		Limited Activities	
	Score	Rank	Rate	Rank	Rate	Rank	Percent	Rank	Rate	Rank	Rate	Rank	Days	Rank	Rate	Rank	Days	Rank
U.S.	136.1	n/a	36.3	n/a	21.3	n/a	10.0%	n/a	623	n/a	4.8	n/a	4.3	n/a	5.4	n/a	4.8	n/a
PA	143.6	35	37.4	25	22.5	39	10.1%	30	546	18	5.6	37	4.6	36	5.2	15	4.6	23

Source: Hess et al. 2015, *Status of Women in the States*, Institute for Women’s Policy Research

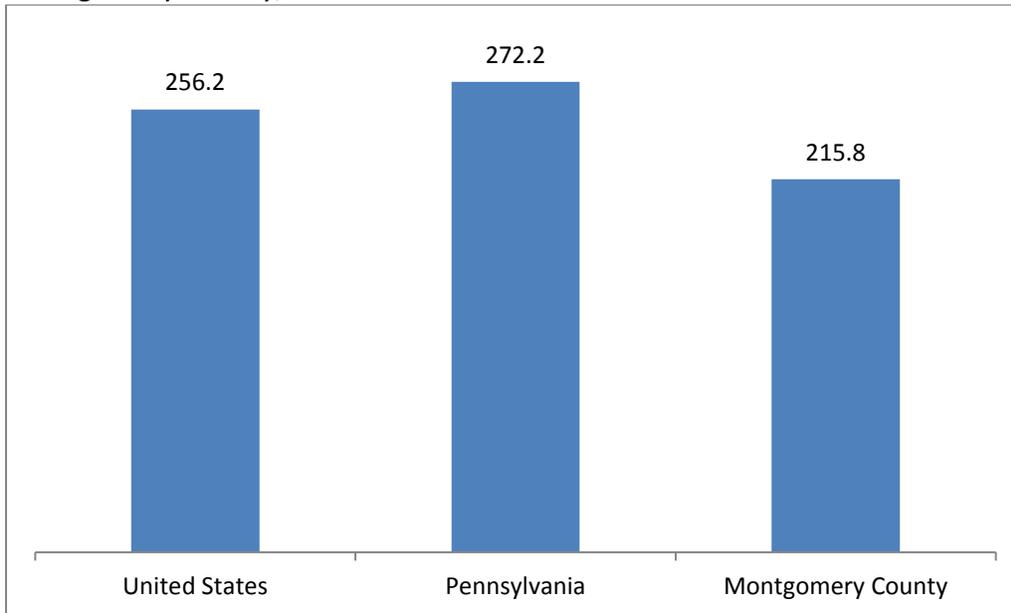
Chronic Disease

Heart Disease

In the U.S., heart disease is the leading cause of death, with approximately 610,000 people dying every year (Centers for Disease Control and Prevention, n.d.). Heart disease is the leading cause of death for both women and men. The most common type of heart disease is coronary heart disease, and it kills about 370,000 people a year. Heart disease is typically associated with men, and only 54% of women even realize that heart disease is their leading cause of death. The overall death rate due to heart disease from 2014-2016 for both women and men was 324.3 (Centers for Disease Control and Prevention, n.d.). Women are more likely than men to be affected by chest pain, cardiac syndrome, and broken heart syndrome (stress-induced cardiomyopathy where stress hormones stun the heart and enlarge portions of the heart, typically without leaving permanent damage) (Office of Women’s Health, n.d.).

Approximately one in four women die from heart disease every year (Centers for Disease Control and Prevention, n.d.). In the U.S., the rate of death for heart disease for women was 256.2 from 2014 to 2016 (Figure 4.1). In Pennsylvania, the heart disease death rate was higher than the U.S. at 272.2. The death rate was considerably less for women in Montgomery County (215.8) than in the United States or Pennsylvania. In fact, Montgomery County had the second lowest death rate among all counties in Pennsylvania (Centers for Disease Control and Prevention, n.d.).

Figure 4.1. Heart Disease Death Rates for Women in the United States, Pennsylvania, & Montgomery County, 2014-2016

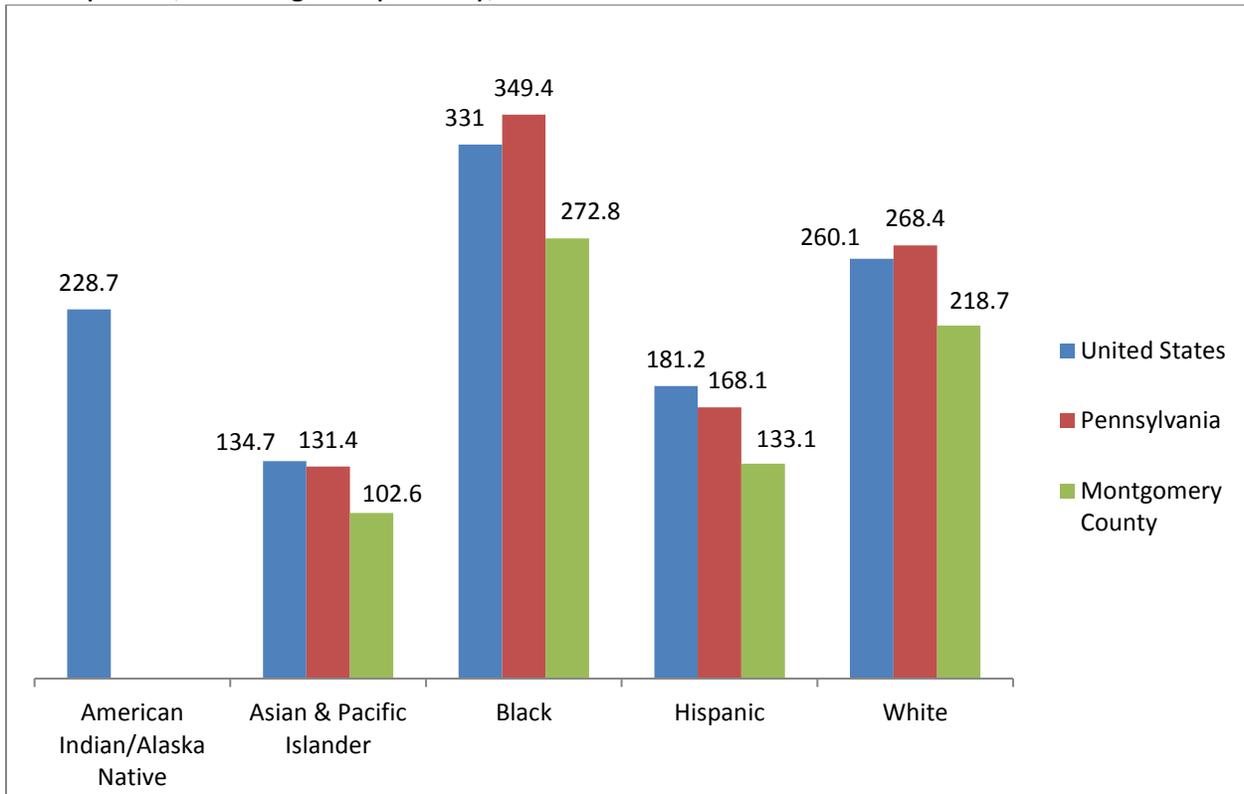


Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014-2016

Notes: Death rate is per 100,000 for those 35 years and older.

Figure 4.2 shows how heart disease death rates vary by race and ethnicity. Black women have the highest heart disease death rates among all racial and ethnic groups. The death rate for Black women was 333 in the U.S., 349.4 in Pennsylvania, and 272.8 in Montgomery County. White women had the next highest death rates: 260.1 in the U.S., 268.4 in Pennsylvania, and 218.7 in Montgomery County. Heart disease death rates were also high for American Indians and Alaska Natives in the U.S., but there was not enough data available at the state or county level to compare. Asian/Pacific Islander women had the lowest rates of heart disease, but it is important to note that there was considerable variation in this group – with Asian Indian women having the highest rates among Asian/Pacific Islanders (Hastings et al. 2015).

Figure 4.2. Heart Disease Death Rates for Women by Race/Ethnicity in the United States, Pennsylvania, & Montgomery County, 2014-2016



Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014-2016

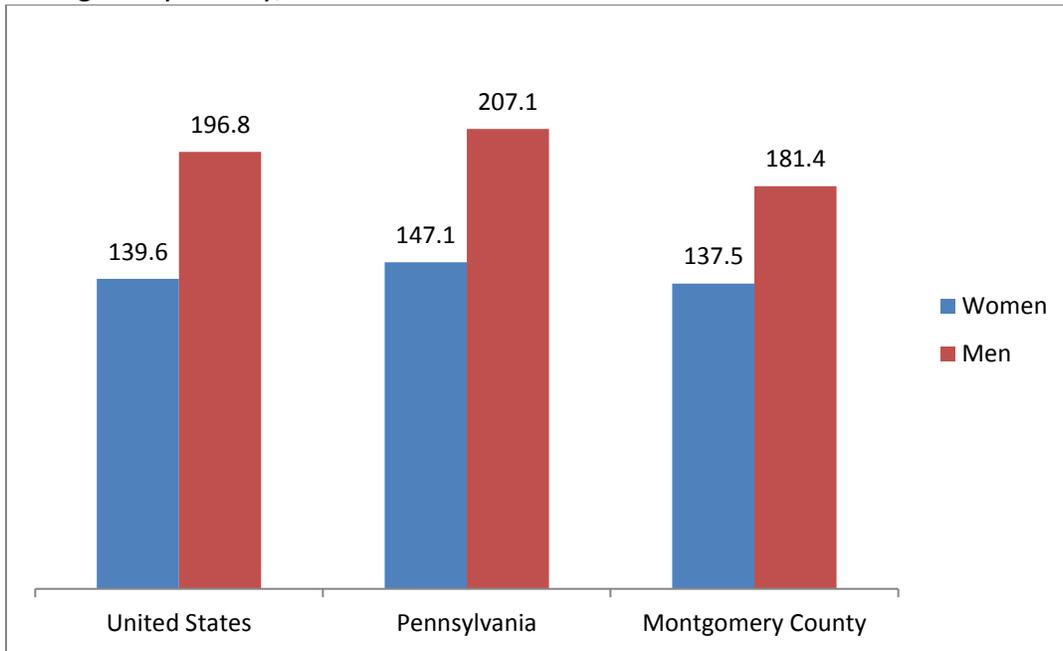
Notes: Death rate is per 100,000 for those 35 years and older. Not enough data was available at the state and county level for American Indians and Alaska Natives.

Cancer

Cancer is the second leading cause of death in the U.S. (United States Cancer Statistics: Data Visualizations, n.d.). According to the American Cancer Society, estimated deaths due to all types of cancer in 2018 were 609,640. Of those deaths, an estimated 286,010 were women (American Cancer Society 2018). In Pennsylvania, estimated deaths of women and men due to cancer in 2018 were 28,620.

The most common types of cancer among women are skin, breast, lung, colorectal, and uterine. In 2015, there were 816,453 new cases of cancer, and 282,107 women died in the U.S. (United States Cancer Statistics: Data Visualizations, n.d.). Figure 4.3 compares cancer death rates for women and men in the U.S., Pennsylvania, and Montgomery County. From 2011 to 2015, the death rate due to cancer for women was 139.6 in the U.S., 147.1 in Pennsylvania, and 137.5 in Montgomery County. For men, the cancer death rate was 196.8 in the U.S., 207.1 in Pennsylvania, and 181.4 in Montgomery County.

Figure 4.3. Cancer Death Rates for Women & Men in the United States, Pennsylvania, & Montgomery County, 2011-2015

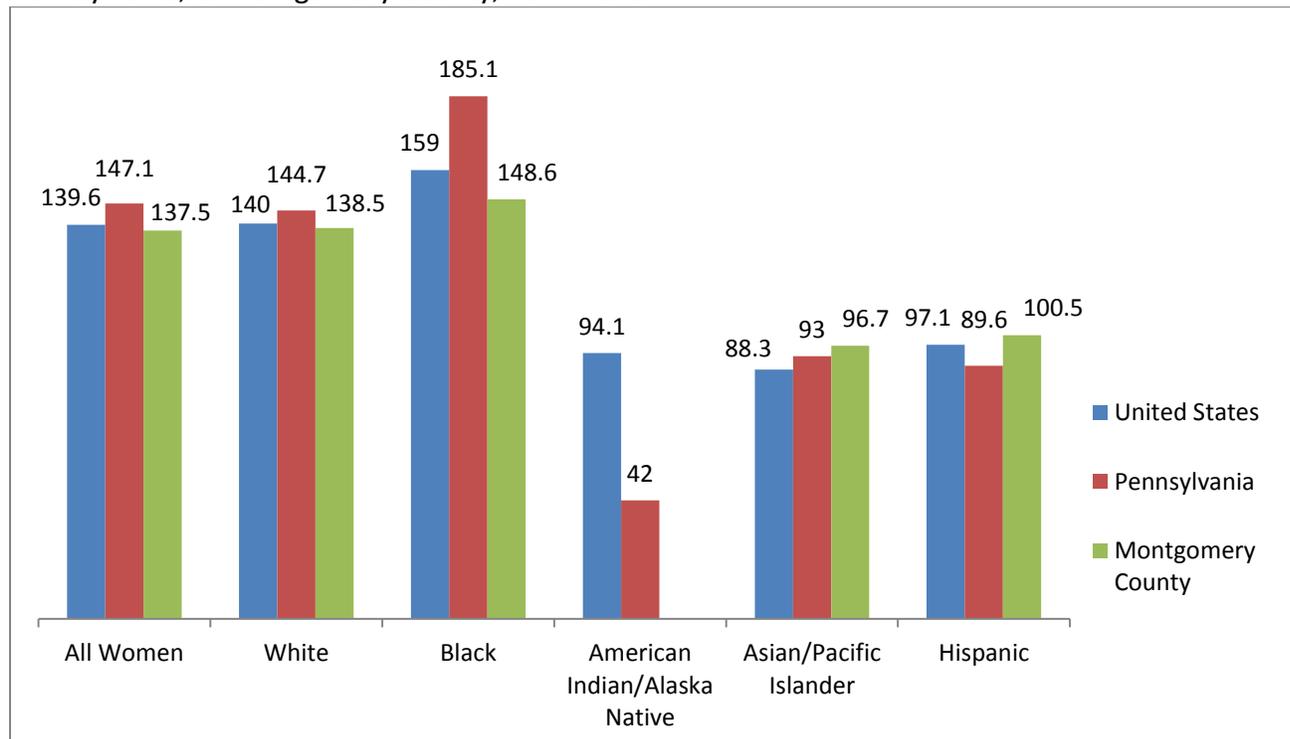


Source: *United States Cancer Statistics: Data Visualizations Tool*, Centers for Disease Control and Prevention

Notes: Death rate is per 100,000 for those 35 years and older.

As Figure 4.4 shows, Black women have the highest cancer death rates in the U.S., Pennsylvania, and Montgomery County. Cancer death rates were higher for Black women in Pennsylvania (185.1) than in the U.S. (159). Rates were lowest for Black women in Montgomery County at 148.6. Cancer death rates for White women were the second highest and were the lowest for Hispanic and Asian/Pacific Islander women.

Figure 4.4. Cancer Death Rates for Women by Race & Ethnicity in the United States, Pennsylvania, & Montgomery County, 2011-2015



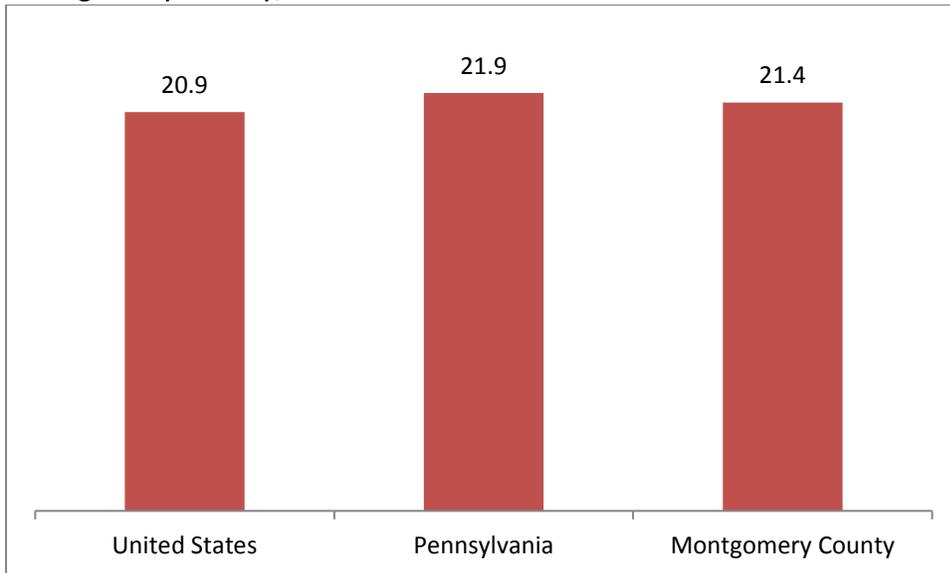
Source: *United States Cancer Statistics: Data Visualization Tool, Centers for Disease Control and Prevention*
 Notes: Death rate is per 100,000 for those 35 years and older. Data for American Indian/Alaska Native women in Montgomery County was not available.

Female breast cancer is the fastest growing type of cancer, with a rate of 124.7 per 100,000 women from 2011 to 2015. Among cancer deaths for women, female breast cancer ranks second highest with a rate of 20.9 (U.S. Cancer Statistics Data Visualizations, n.d).

The mortality rate for female breast cancer was slightly higher in Pennsylvania and Montgomery County than it was nationwide (Table 4.5). Death rates were 21.9 in Pennsylvania, 21.4 in Montgomery County, and 20.9 in the U.S. In Pennsylvania, there were 54,672 new cases of female breast cancer from 2011-2015, and 10,054 women died.

In Montgomery County from 2011 to 2015, there were 3,777 new cases of female breast cancer (U.S. Cancer Statistics Data Visualizations, n.d.). This means that for every 100,000 women, there were 142 female breast cancer cases reported. During this same time frame, 632 women died of female breast cancer. This is a rate of 21.4 - meaning that for every 100,000 women in Montgomery County, 21 women died.

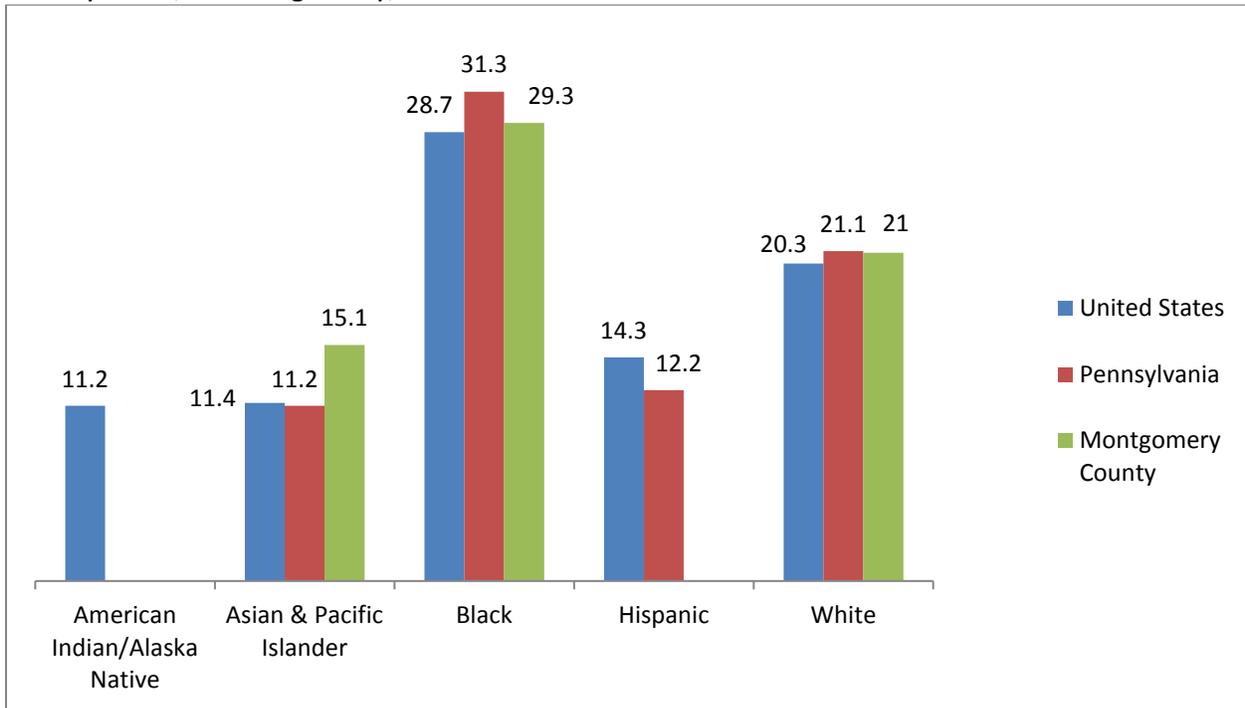
Figure 4.5. Cancer Death Rates for Female Breast Cancer, United States, Pennsylvania, & Montgomery County, 2011-2015



Source: *United States Cancer Statistics: Data Visualization Tool*, Centers for Disease Control and Prevention
Notes: Death rate is per 100,000 for those 35 years and older.

Breast cancer affects women differently depending on their racial or ethnic background. Black women are affected by breast cancer at a much greater rate than all other racial and ethnic groups (Figure 4.6). From 2011-2015, breast cancer death rates for Black women were 31.3 in Pennsylvania, 29.3 in Montgomery County, and 28.7 in the U.S. Breast cancer mortality rates were also disproportionately high for White women at 20.3 in the U.S., 21.1 in Pennsylvania, and 21 in Montgomery County. Mortality rates were lowest among American Indian/Alaska Native women, but there was not enough data available at the county or state level. Hispanic women and Asian/Pacific Islander women had much lower mortality rates due to breast cancer than Black or White women.

Figure 4.6. Female Breast Cancer Death Rates by Race/Ethnicity in the United States, Pennsylvania, & Montgomery, 2011-2015

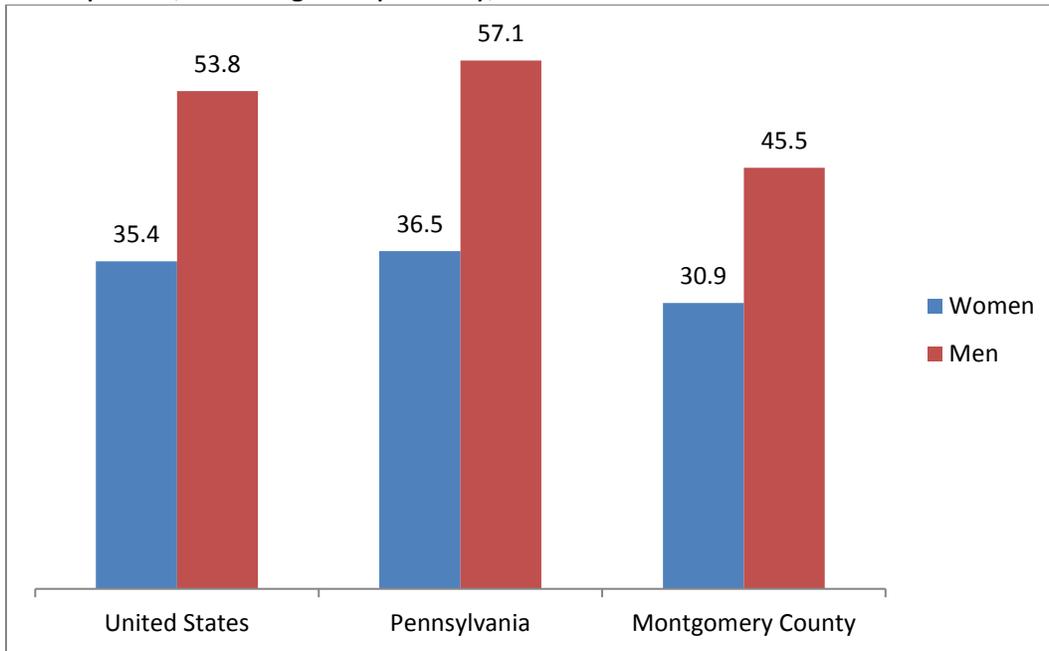


Source: *United States Cancer Statistics: Data Visualization Tool, Centers for Disease Control and Prevention*
 Notes: Death rate is per 100,000 for those 35 years and older. Not enough data was available for all racial/ethnic groups in Montgomery County.

Among women and men, lung and bronchus cancer had the highest rate of cancer deaths in the U.S. There were 515,208 new cases of lung and bronchus cancer reported for women from 2011-2015, and 352,209 women died. Among men during the same time period, there were 572,602 new cases of lung and bronchus cancer, and 427,587 men died (U.S. Cancer Statistics Data Visualizations, n.d.).

From 2011-2015, lung cancer mortality rates were higher among men than women (Figure 4.7). The rate of death for women with lung and bronchus cancer in the U.S. was 35.4. From 2011-2015, there were 53,600 new cases of lung and bronchus cancer in Pennsylvania, and 37,772 people died (U.S. Cancer Statistics Data Visualizations, n.d.). The rate of death for women with lung and bronchus cancer in Pennsylvania was slightly higher than the U.S. at 36.5. From 2011-2015, there were 2,823 new cases of lung and bronchus cancer in Montgomery County, and 1,949 people died (U.S. Cancer Statistics, n.d.). Lung cancer mortality rates for women in Montgomery County were 30.9, slightly lower than in the U.S. or Pennsylvania.

Figure 4.7. Lung & Bronchus Cancer Death Rates for Women & Men, United States, Pennsylvania, & Montgomery County, 2011-2015

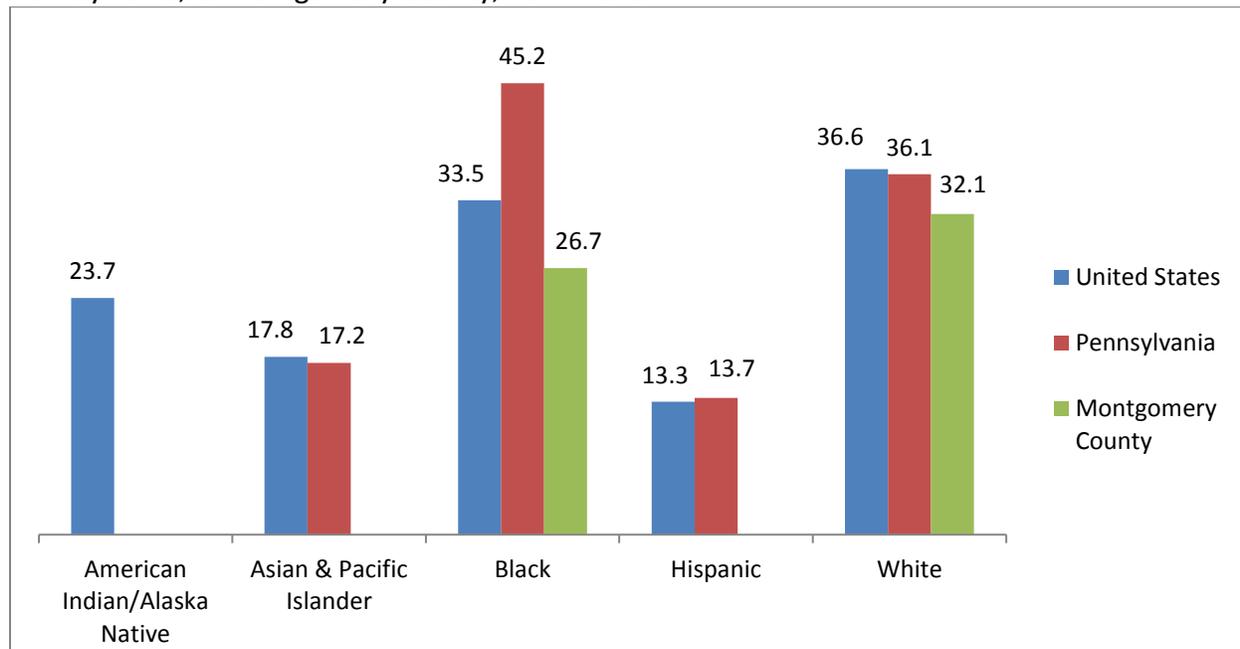


Source: *United States Cancer Statistics: Data Visualization Tool*, Centers for Disease Control and Prevention

Notes: Death rate is per 100,000 for those 35 years and older.

As shown in Figure 4.8, lung and bronchus cancer mortality rates are highest among Black women in Pennsylvania at 45.2. In the U.S. mortality rates are highest among White women at 36.6, followed by Black women at 33.5. In Montgomery County, mortality rates are highest for White women at 32.1, followed by Black women at 26.7. Lung and bronchus cancer mortality rates were lowest for Hispanic women at the national and state level, but there was not enough data available at the county level to make a determination.

Figure 4.8. Female Lung & Bronchus Cancer Death Rates by Race/Ethnicity in the United States, Pennsylvania, & Montgomery County, 2011-2015



Source: *United States Cancer Statistics: Data Visualizations Tool, Centers for Disease Control and Prevention*
 Notes: Death rate is per 100,000 for those 35 years and older. Not enough data was available for all racial/ethnic groups in Montgomery County.

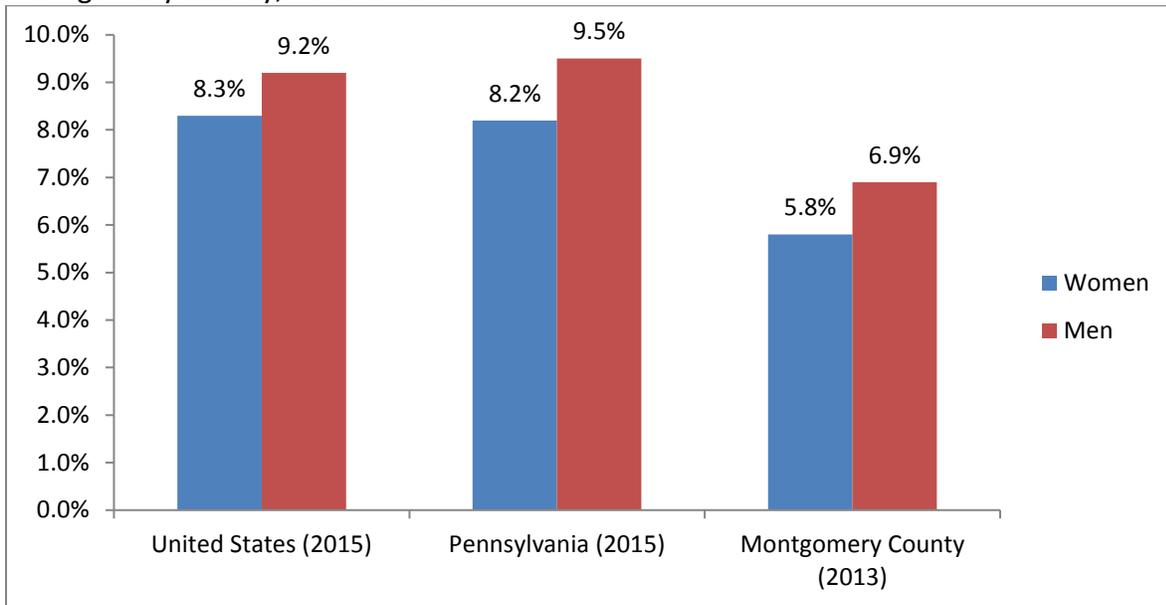
Diabetes

Diabetes increases the likelihood of heart disease, stroke, kidney disease, and blindness (Hess et al. 2015). Since 1980, the rates of diagnosed diabetes in the U.S. have increased dramatically. Prior to 1997, the rates of diagnosed diabetes among women and men were relatively similar, with women’s rates slightly higher at times. Since 1997, men’s rates of diabetes have increased more rapidly than women’s rates. In 2015, 8.3% of women and 9.2% of men were diagnosed with diabetes nationwide.

In Pennsylvania, 8.2% of women and 9.5% of men were diagnosed with diabetes in 2015. Among all states, the median percentage of women diagnosed with diabetes was 8.6%, so Pennsylvania was below the median. The median for men was 9.7%, so Pennsylvania was also below the median for men as well (U.S. Diabetes Surveillance System, 2015).

In 2013, Montgomery County had the lowest percentage of people with diagnosed diabetes out of all the counties in Pennsylvania, with 6.3% of all adults having been diagnosed with diabetes (United States Diabetes Interactive Surveillance System, n.d.). The rate of diagnosed diabetes in 2013 was 5.8% for women and 6.9% for men in Montgomery County (Figure 4.9). This was also the lowest percentage in Pennsylvania for both women and men as individual groups. In Montgomery County, diagnosed diabetes rates were substantially lower than the national and state rates for both women and men.

Figure 4.9. Diagnosed Diabetes for Women & Men, United States, Pennsylvania, & Montgomery County, 2013 & 2015

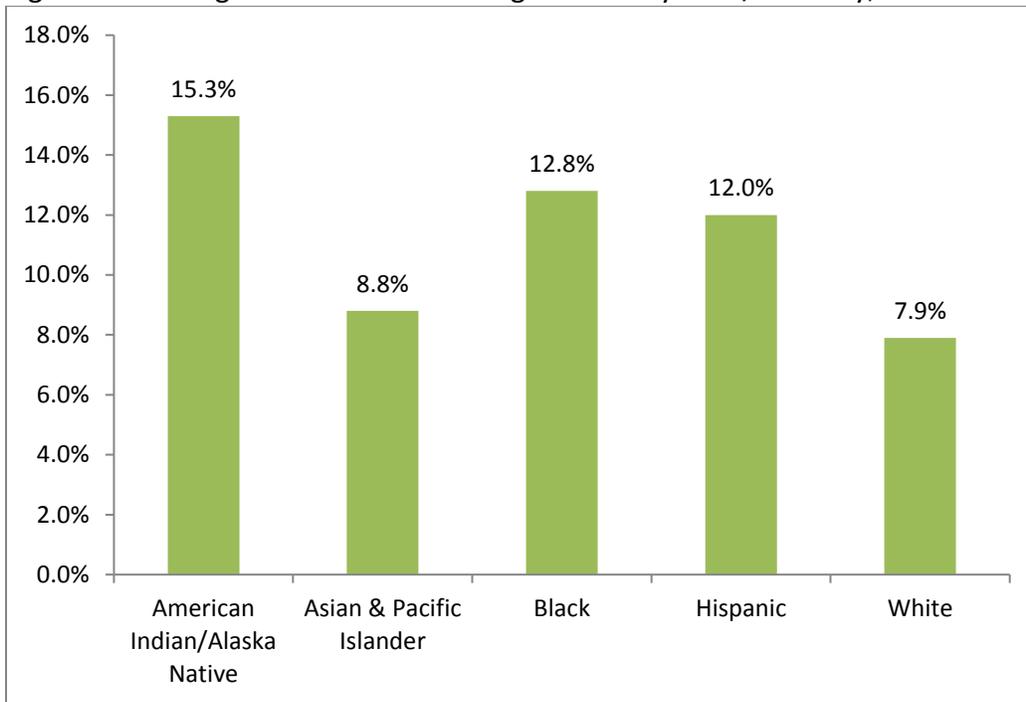


Source: *United States Diabetes Interactive Surveillance System (Interactive)*, Centers for Disease Control and Prevention

Notes: *Diagnosed diabetes means that a person has been told they have diabetes by a health care provider. Data for Pennsylvania and the United States are from 2015. Data for Montgomery County are from 2013.*

Figure 4.10 shows how diabetes varies for different racial and ethnic groups. Of all women, American Indian and Alaska Native women had the highest percentage of women diagnosed with diabetes at 15.3%. American Indian and Alaska Native men were also the most likely to be diagnosed with diabetes at 14.9%. Prevalence was higher among American Indians in portions of the Southwest U.S. (National Diabetes Statistics Report 2017). Black women had the next highest levels of diabetes at 12.8%, followed by Hispanic women at 12% (Figure 4.10). In comparison only 7.9% of White women had diabetes.

Figure 4.10. Diagnosed Diabetes among Women by Race/Ethnicity, United States, 2015

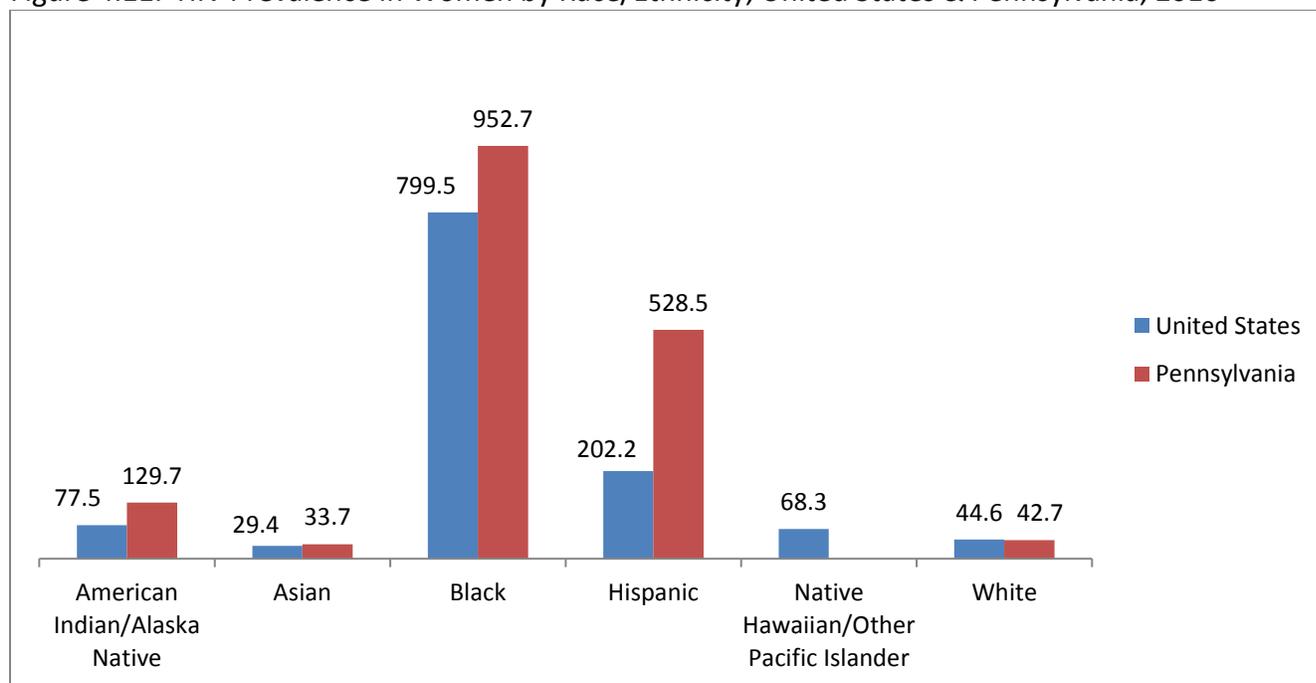


Source: *United States Diabetes Surveillance System (Interactive)*, Centers for Disease Control and Prevention
Notes: *Diagnosed diabetes means that a person has been told they have diabetes by a health care provider.*

HIV/AIDS

In 2015, there were an estimated 38,500 new cases of HIV in the U.S. From 2008 to 2015, the estimated number of infections declined by 8% (Centers for Disease Control and Prevention 2018a). Rates of HIV prevalence are higher in men than women, but HIV rates vary a great deal among women by race and ethnicity. Black women, in particular, are disproportionately affected by HIV/AIDS. In 2016, the HIV prevalence rate for Black women was 799.5 in the U.S. and 952.7 in Pennsylvania (Figure 4.11). HIV prevalence rates were considerably higher for Black and Hispanic women in Pennsylvania than in the U.S. The prevalence rate of HIV was 202.2 for Hispanic women nationwide, but was considerably higher at 528.5 in Pennsylvania. There is no cure for HIV, but it can be managed with medication.

Figure 4.11. HIV Prevalence in Women by Race/Ethnicity, United States & Pennsylvania, 2016



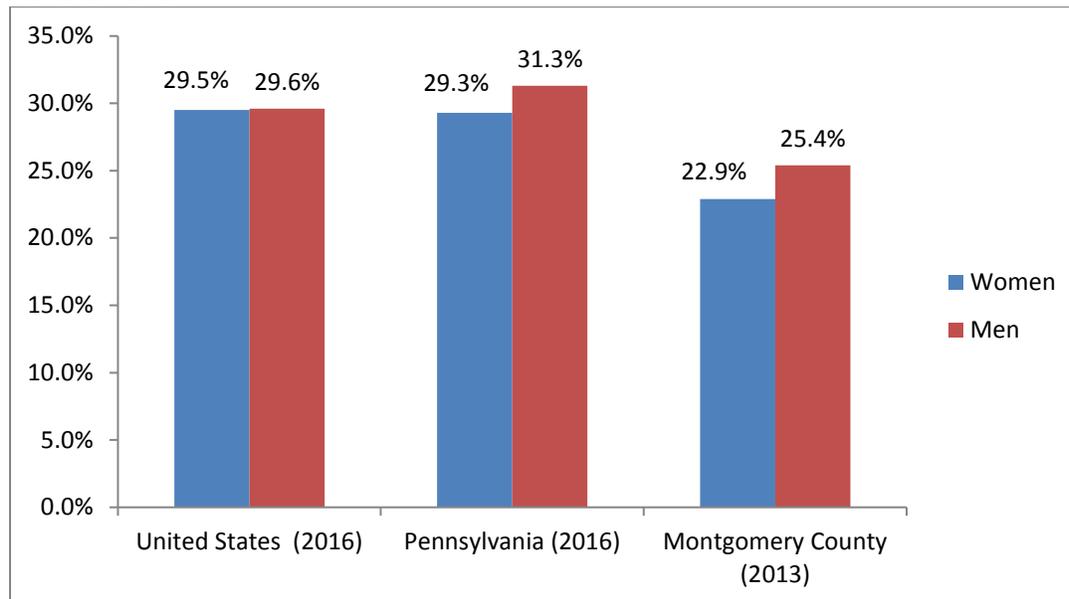
Source: NCHHSTP AtlasPlus Interactive Tool, Updated 2017, Centers for Disease Control and Prevention
 Notes: Numbers include all age groups and all transmission categories. Rate is per 100,000. Not enough data available for all racial/ethnic groups.

Obesity and Healthy Weight

Obesity has become a serious health concern for Americans nationwide. It is defined as body mass index (BMI) greater than or equal to 30.0. Obesity is associated with heart disease, stroke, type 2 diabetes, and some types of cancer. According to the Behavioral Risk Factor Surveillance System (BRFSS), 29.6% of Americans had obesity in 2016 (Division of Nutrition, Physical Activity, and Obesity Data, Trends, and Maps Interactive Database). Estimates from the National Health and Nutrition Examination Surveys were even higher – suggesting that 39.8% of American adults were obese from 2015 to 2016 (Hales et al. 2017). In the U.S., the prevalence of obesity is similar among women and men. Both women and men aged 40-59 had the highest levels of obesity compared to all other age groups (Hales et al. 2017).

In 2016, the rates of obesity for women and men were almost exactly the same nationwide – 29.5% for women and 29.6% for men (Figure 4.12). While the percentage of obese women in Pennsylvania was almost the same (29.3%), the percent of obese men was slightly higher (31.3%). Rates of obesity were somewhat lower for both women and men in Montgomery County, compared to the state and national averages. For women, the percent of women with obesity was 22.9%. For men, it was 25.4%.

Figure 4.12. Obesity in Women & Men, United States, Pennsylvania, & Montgomery County, 2013 & 2016



Source: Division of Nutrition, Physical Activity, and Obesity Data, Trends, and Maps (Interactive Database), National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
 Notes: Obese is defined as body mass index (BMI) greater than or equal to 30.0. BMI was calculated from self-reported weight and height for adults aged 18 years and older.

Although obesity affects women and men equally, it has a disproportionate effect on some racial and ethnic groups. The prevalence of obesity was lowest among Asian women and men, compared to all other racial and ethnic groups. According to the BRFSS, Black and American Indian/Alaska Native women and men had the highest rates of obesity. In 2016, 38.3% of Blacks, 38.1% of American Indians/Alaska Natives, and 33.1% of Hispanics were obese – compared to 9.8% of Asians.

Sexual Health

According to the Centers for Disease Control and Prevention (CDC), sexually transmitted diseases (STDs) and sexually transmitted infections (STIs) are on the rise in the U.S. From 2013 to 2017, the overall number of diagnosed STDs increased from 1.8 million to 2.3 million – a 31% increase (Centers for Disease Control and Prevention 2018b). These numbers only represent a small portion of the actual cases of STDs because most cases go undiagnosed

STDs disproportionately affect women over the course of their lives. Women are at greater risk than men to contract STDs and STIs because their anatomy makes it is easier for bacteria and viruses to penetrate the lining of the vagina (Centers for Disease Control and Prevention 2011). Women are less likely than men to have symptoms from STDs, and/or they may not be able to see symptoms like genital ulcers. STDs can also cause other health complications such as pelvic inflammatory disease that can cause infertility and ectopic pregnancy. Untreated STDs cause approximately 24,000 women each year to become infertile. Pregnant women can also pass on

STDs such as syphilis and genital herpes to their babies. Untreated syphilis in pregnant women can cause infant death in up to 40% of cases. In addition, untreated STDs can cause brain damage, blindness, deafness, low birth weight, and stillbirths in babies. The most common STD in women is the human papillomavirus (HPV), which can cause cervical cancer. Even though HPV is also common in men, most of them will not have serious health problems as a result (Centers for Disease Control and Prevention 2011).

STD education and screening are always important, but especially now because of the increase in STDs. Women who are sexually active and less than 25 years old should have annual chlamydia and gonorrhea tests. Pregnant women should be checked early in their pregnancy for chlamydia, syphilis, HIV, and hepatitis (CDC Fact Sheet 2017).

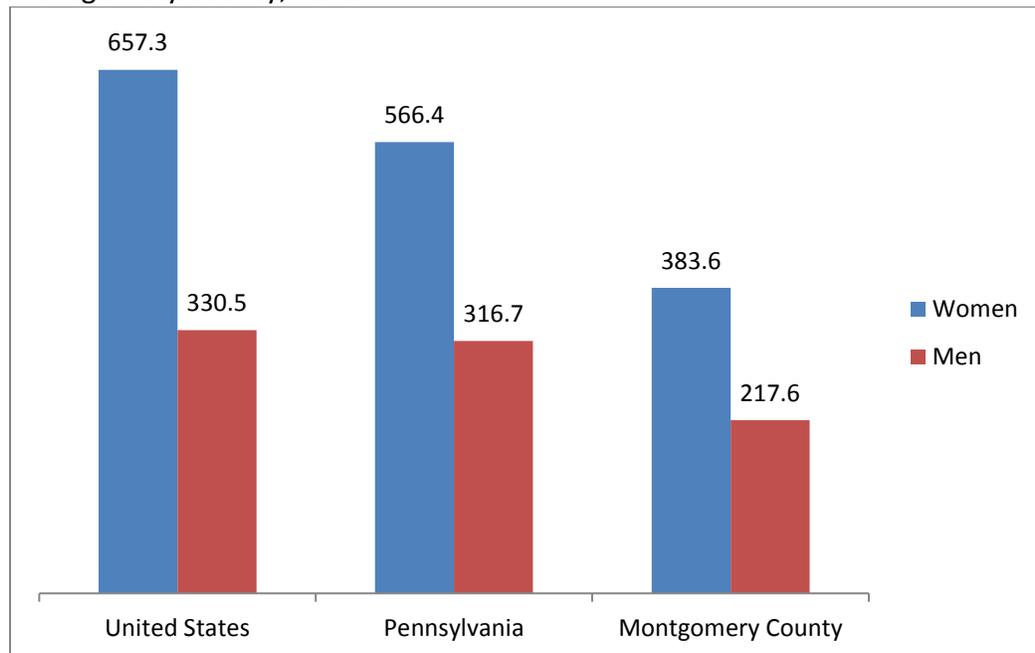
Chlamydia

Chlamydia is the most common STD in the U.S. Preliminary data from the CDC estimates that 1.7 million Americans were diagnosed with chlamydia in 2017 (Centers for Disease Control and Prevention 2018b). Of those diagnosed with chlamydia, 45% were young women between 15 and 24 years old. Undiagnosed or untreated chlamydia can cause infertility, ectopic pregnancy, and stillbirth in women, but seldom causes complications for men (Centers for Disease Control and Prevention 2011).

As Figure 4.13 shows, rates of chlamydia were higher for women than men nationwide in 2016. In the U.S. women's rates of chlamydia were 657.3, compared to 330.5 for men. Although chlamydia rates for women were lower in Pennsylvania at 566.4, they were still considerably higher than men's rates at 316.7.

In Montgomery County, the overall rate of chlamydia was 304.4 in 2016 - well below the national and state averages. However, Montgomery County had the 20th highest rate of chlamydia among all counties in Pennsylvania. In Montgomery County, women's rates of chlamydia (383.6) were roughly half of women's rates nationwide (657.3), but were almost double that of Montgomery County men (217.6).

Figure 4.13. Rates of Chlamydia in Women & Men in the United States, Pennsylvania, & Montgomery County, 2016



Source: Compiled from EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health and NCHHSTP AtlasPlus Interactive Tool, Updated 2017, Centers for Disease Control and Prevention.

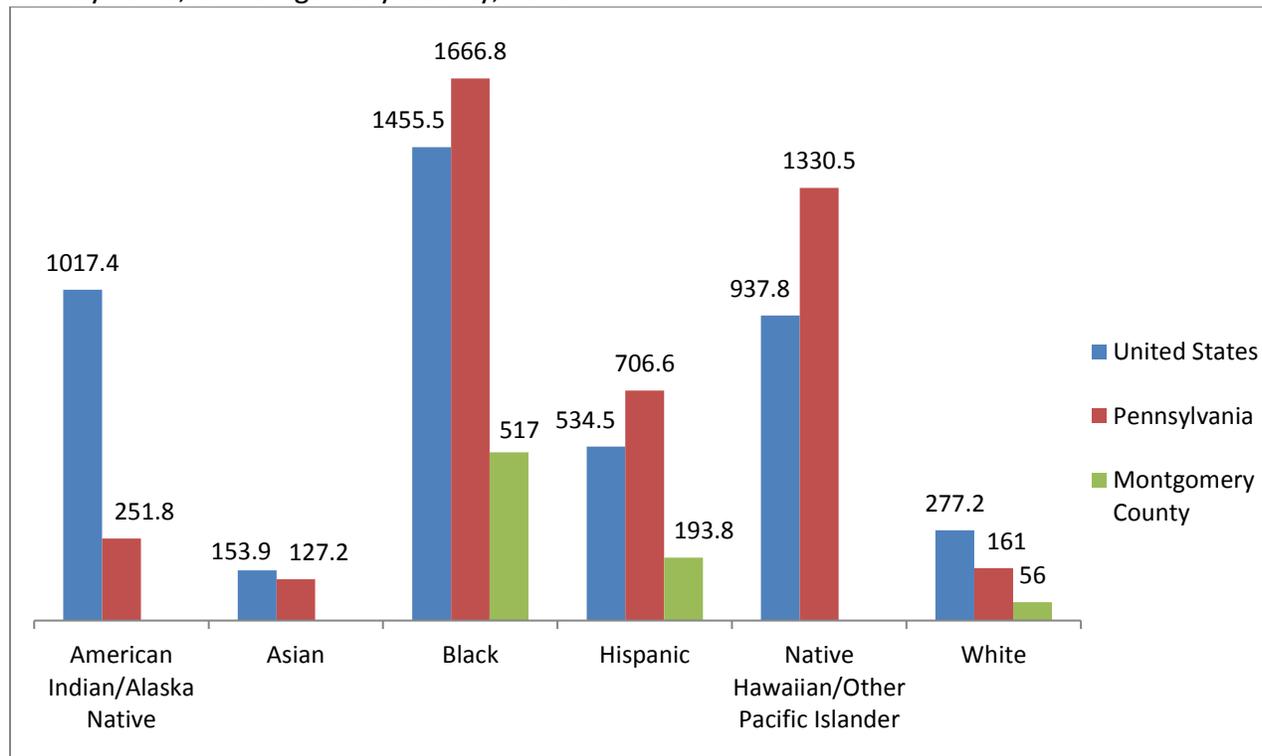
Notes: Numbers include all age groups and all transmission categories. Rate is per 100,000.

Figure 4.14 shows how chlamydia affects Black women disproportionately. Nationwide in 2016, Black women had the highest rates of diagnosed chlamydia at 1455.5, followed by American Indian/Alaska Native women at 1017.4 and Native Hawaiian/Other Pacific Islander women at 937.8. Rates of chlamydia then decreased substantially among Hispanic, White, and Asian women – with Asian women having the lowest rates at 153.0.

In Pennsylvania, chlamydia was also most prevalent among Black women and Native Hawaiian/Pacific Islander women and was much higher than the national rate of 1666.8 and 1330.5, respectively (Figure 4.14). Hispanic women ranked third in chlamydia rates in Pennsylvania, though their rates were significantly lower at 706.6. Asian women and White women had the lowest rates of 127.2 and 161, respectively.

In Montgomery County, all chlamydia rates were considerably lower than state and national rates in every racial and ethnic group for which data was available. Although Black women’s rates were still the highest, they were only about a third (517) of the national (1455.5) and state (1666.8) rates (Figure 4.14). Hispanic women had the second highest rates (193.8), and White women had the lowest rates (56).

Figure 4.14. Rates of Chlamydia in Women by Race/Ethnicity in the United States, Pennsylvania, & Montgomery County, 2016



Source: Compiled from EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health and NCHHSTP AtlasPlus Interactive Tool, Updated 2017, Centers for Disease Control and Prevention.

Notes: Numbers include all age groups and all transmission categories. Rate is per 100,000. Data was not available for all racial/ethnic groups in Montgomery County. For data obtained through EDDIE: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Gonorrhea

Overall, the diagnosed cases of gonorrhea increased 67% from 2013 to 2017 (Centers for Disease Control and Prevention 2018b). The raw numbers of new cases have increased from 333,004 to 555,608. Although gonorrhea is more common in men, the speed at which new cases have emerged among women is particularly concerning. Diagnosed gonorrhea has increased among women for the third year in a row. Although antibiotics have historically been used to treat gonorrhea, it has become resistant to almost every class of antibiotics used previously. Ceftriaxone is the last highly effective antibiotic left in the U.S. to treat gonorrhea. This makes prevention and screening even more important.

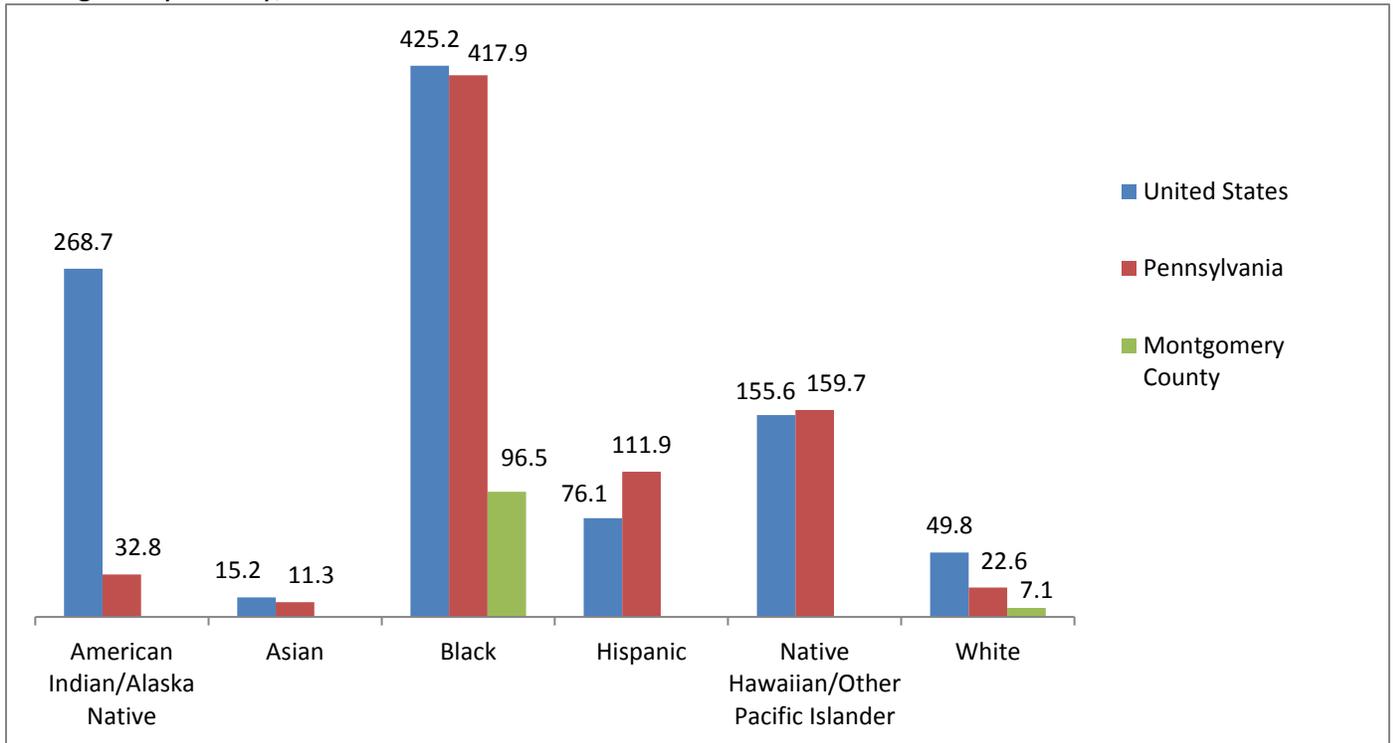
As Figure 4.15 shows, Black women and American Indian/Alaska Native women were disproportionately affected by gonorrhea nationwide in 2016, with rates of 425.2 and 268.7 respectively. There was a massive gap between the gonorrhea rates for Black and American Indian/Alaska Native women and all other racial and ethnic groups. Nationwide, rates of

gonorrhoea were 155.6 for Native Hawaiian/Pacific Islander women, 76.1 for Hispanic women, and 49.8 for White women. Asian women had the lowest rates at 15.2.

In Pennsylvania, Black women had the highest rates of gonorrhoea at 417.9, followed by Native Hawaiian/Pacific Islander women at 159.7 and Hispanic women at 111.9 (Figure 4.15). White women and Asian women had the lowest rates of 22.6 and 11.3, respectively. Rates were lower in Pennsylvania for Black, White, Asian, and American Indian/Alaska Native women.

Rates of gonorrhoea were considerably lower for women in Montgomery County, but not enough data was available for all racial and ethnic groups. Although Black women’s rates of gonorrhoea were still the highest, they were much lower at 96.5, compared to the national rate of 425.2. White women’s rate of gonorrhoea was 7.1, which was the lowest rate in Montgomery County.

Figure 4.15. Gonorrhoea in Women by Race/Ethnicity in the United States, Pennsylvania, & Montgomery County, 2016



Source: Compiled from EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health and NCHHSTP AtlasPlus Interactive Tool, Updated 2017, Centers for Disease Control and Prevention.

Notes: Numbers include all age groups and all transmission categories. Rate is per 100,000. Not enough data was available for all racial/ethnic groups in Montgomery County. For data obtained through EDDIE: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Syphilis

Although syphilis was nearly eradicated a decade ago, it is currently on the rise. Although men are more likely to contract syphilis, there are serious health consequences for women. From 2015 to 2016, the rate of syphilis increased 36% among women (CDC Fact Sheet 2017). Pregnant women can pass on syphilis to their baby, a condition called congenital syphilis. From 2015 to 2016, the rate of congenital syphilis increased by 28% and to a rate of 16 cases per 100,000 from 12 per 100,000 (CDC Fact Sheet 2017). Congenital syphilis can lead to infant death and other health complications. Syphilis can also increase the risk of developing HIV.

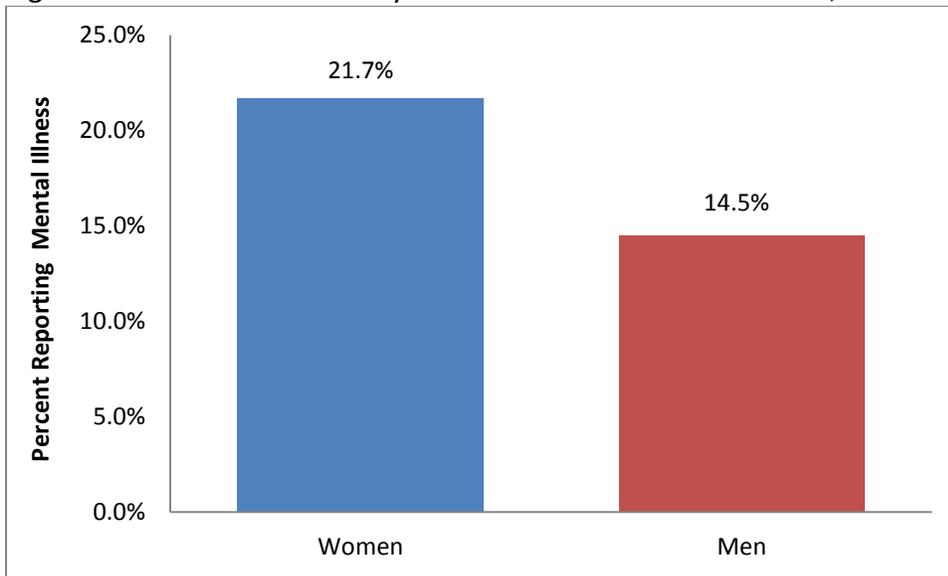
Mental Health

Approximately one in five adults has a mental health condition in the U.S. Mental illness can affect women and men differently. Women are more prone to depression and anxiety than men. Due to hormonal changes, they may also experience perinatal depression, premenstrual dysphoric disorder, and perimenopause related depression (National Institute of Mental Health, n.d). Men, on the other hand, are more likely to have substance abuse and antisocial personality disorders (Eaton et al. 2012). Approximately 56% of American women and men with a mental illness have not received treatment (Nguyen et al. 2018). Overall, Pennsylvania ranked 16th out of all 50 states and D.C. in terms of prevalence of mental illness and access to care. Pennsylvania ranked 21st in the prevalence of mental illness. The lower the ranking, the higher the prevalence of mental illness (Nguyen et al. 2018).

Rates of Mental Illness by Gender and Race/Ethnicity

In the U.S., about 18.3% of all adults, aged 18 or older, experienced some type of mental illness in 2016 (National Institute of Mental Health, 2016). The National Institute of Mental Health has identified two broad categories: any mental illness (AMI) and serious mental illness (SMI). Serious mental illness is a subcategory of any mental illness. In 2016, the prevalence of any mental illness was higher among women at 21.7% than men at 14.5% (Table 4.16).

Figure 4.16. Prevalence of Any Mental Illness in Women & Men, United States, 2016

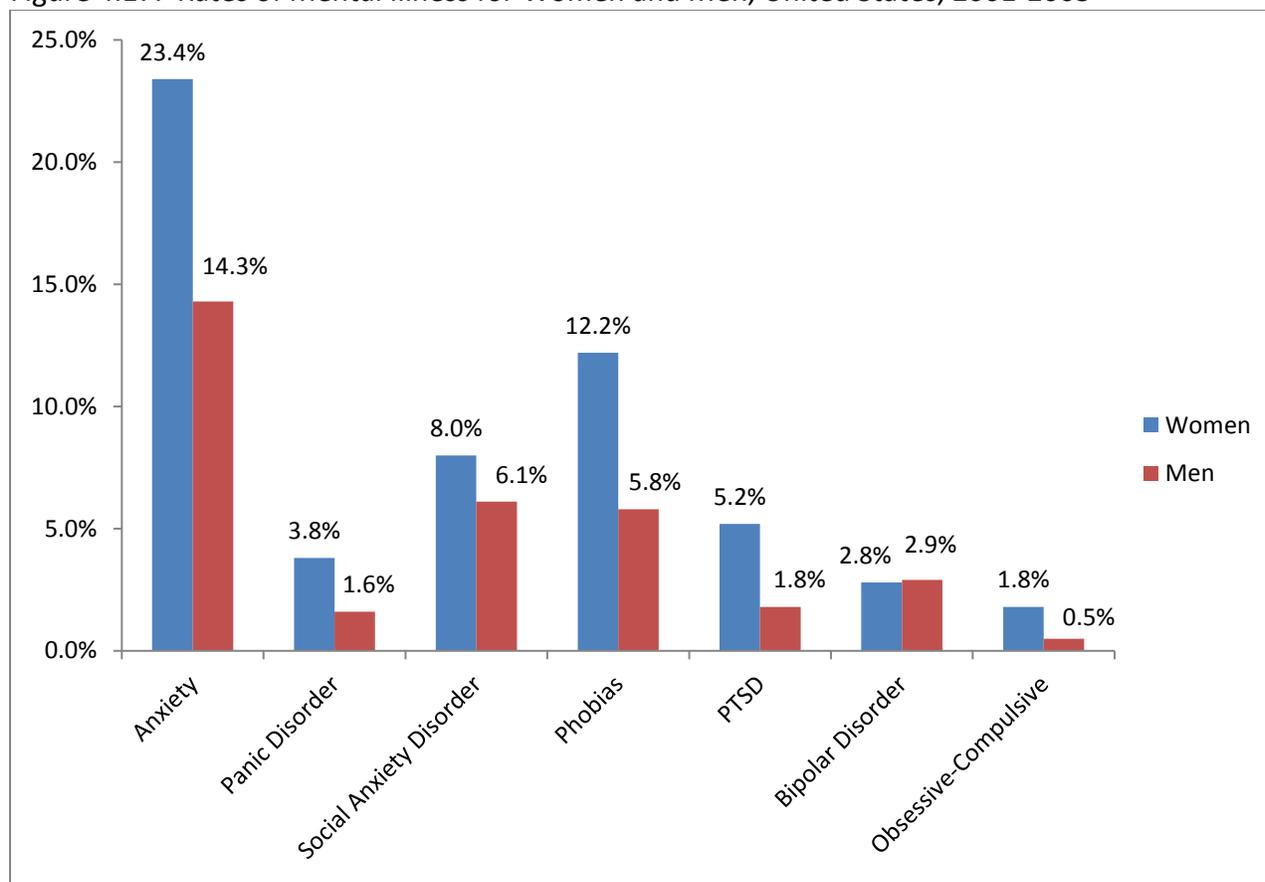


Source: National Institute for Mental Health, Centers for Disease Control and Prevention
Notes: Numbers include all age groups.

Among all racial and ethnic groups, the prevalence of AMI was highest among American Indians/Alaska Natives (22.8%) and Whites (19.9%) and was lowest among Asian Americans (12.1%) (National Institute of Mental Health 2016). Prevalence of AMI was also highest among young adults aged 18-25, both male and female (National Institute of Mental Health 2016). Of those with any mental illness in Pennsylvania, an average of 49% of adults aged 18 or older received mental health treatment or counseling from 2010 to 2014 (Behavioral Health Barometer 2015).

As Figure 4.17 shows, American women were more likely to experience anxiety, panic disorder, social anxiety disorder, specific phobias, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder. Women and men experience bipolar disorder and schizophrenia at about the same rates. Gender differences were most noticeable in regard to anxiety disorder, with 23.4% of women reporting anxiety compared to 14.3% of men. The percent of women who experienced some sort of phobia (12.1%) was twice the percent of men (5.8%) who experienced a phobia.

Figure 4.17. Rates of Mental Illness for Women and Men, United States, 2001-2003



Source: National Institute of Mental Health Statistics

Notes: Data from the National Institute of Mental Health were originally sourced from the National Comorbidity Survey Replication (2001-2003).

In the U.S., the percent of women who reported having PTSD (5.2%) was more than double that of men (1.8%) (Figure 4.17). PTSD may develop after a traumatic event or stressor. This event is frequently violent or dangerous, but does not have to be. It could be triggered by a non-violent event like the sudden death of a loved one. PTSD is typically associated with military veterans, but is actually more widespread in the population. Women are disproportionately exposed to specific types of trauma such as intimate partner violence and sexual violence that can lead to PTSD.

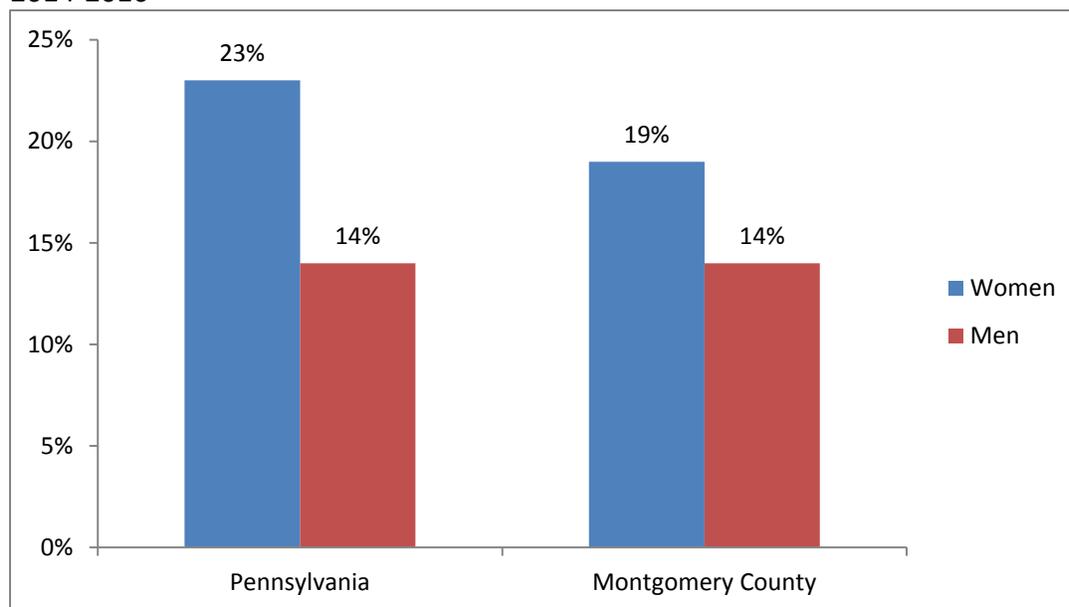
Depression

Depression is one of the most common forms of mental illness in the U.S. Depression can be debilitating and interfere with a person's ability to perform major life activities (National Institute of Mental Health 2016). In 2016, 17.4% of Americans reported they had been told at some point in their lifetime they have a depressive disorder - including depression, major depression, minor depression, or dysthymia (Behavioral Risk Factor Surveillance System 2016). In Pennsylvania, 19% of all adults reported they had been told they have some form of depressive disorder in 2016 (Behavioral Risk Factor Surveillance System 2016). Major

depressive episodes (two weeks or longer of depressed mood) affected an estimated 16.2 million adults in 2016 (National Institute of Mental Health 2016). Women (8.5%) were almost twice as likely as men (4.8%) to experience major depression. Multiracial individuals had the highest rates of major depression at 10.5% compared to other racial and ethnic groups.

Figure 4.18 shows the rates of depression among women and men in Pennsylvania and Montgomery County. Women were more likely to experience depression than men. From 2014 to 2016, 23% of women and 14% of men in Pennsylvania had (ever) been told they have some form of depressive disorder. While rates of depression were lower for women in Montgomery County than in Pennsylvania, women were still more likely to report depression than men. In Montgomery County, 19% of women and 14% of men reported they had been told they have some form of depression (Figure 4.18). There was no change in the percent of men who reported depression in Pennsylvania and Montgomery County.

Figure 4.18. Rates of Depression among Women & Men, Pennsylvania & Montgomery County, 2014-2016



Source: EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health
Notes: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.
Data obtained from the Pennsylvania Department of Health are based on the CDC's Behavioral Risk Factor Surveillance System (BRFSS) Survey.

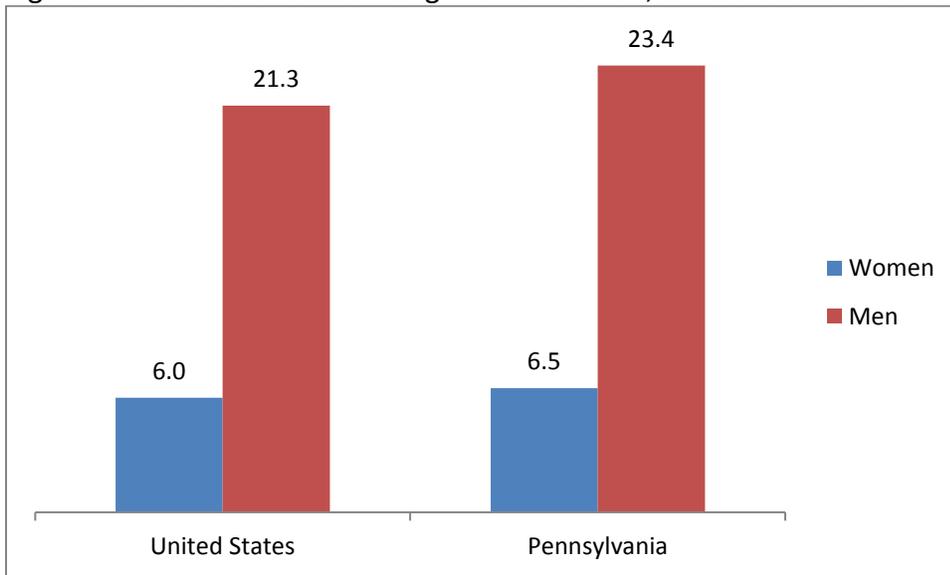
Suicide

From 1999 to 2016, suicide rates in the U.S. have increased from 10.5 to 13.4, or 28% (National Institute of Mental Health 2016). In 2016, suicide was the tenth leading cause of death. Almost 45,000 Americans died from suicide, which was more than twice the number who died from homicide (19,362). Suicide was the second leading cause of death for Americans between 10 and 34 years old. Even though overall rates of mental illness are higher among women, rates of

suicide are almost four times higher among men. For men, the most common method of suicide was a firearm. For women, the most common method was poison (National Institute of Mental Health 2016).

In 2016, the suicide rate was 6.0 for women and 21.31 for men in the U.S. (Figure 4.19). The overall suicide rate in Pennsylvania was 14.7 in 2016 (WISQARS, n.d.). In Pennsylvania, the suicide rate for men was slightly higher than the national average of 21.31. The suicide rate was 6.5 for women and 23.4 for men in Pennsylvania (Figure 4.19). Across the U.S., the suicide rate was highest for women aged 45 to 54. For men, the suicide rate was highest among those aged 65 and older (National Institute of Mental Health 2016).

Figure 4.19. Suicide Rates among Women & Men, United States & Pennsylvania, 2016



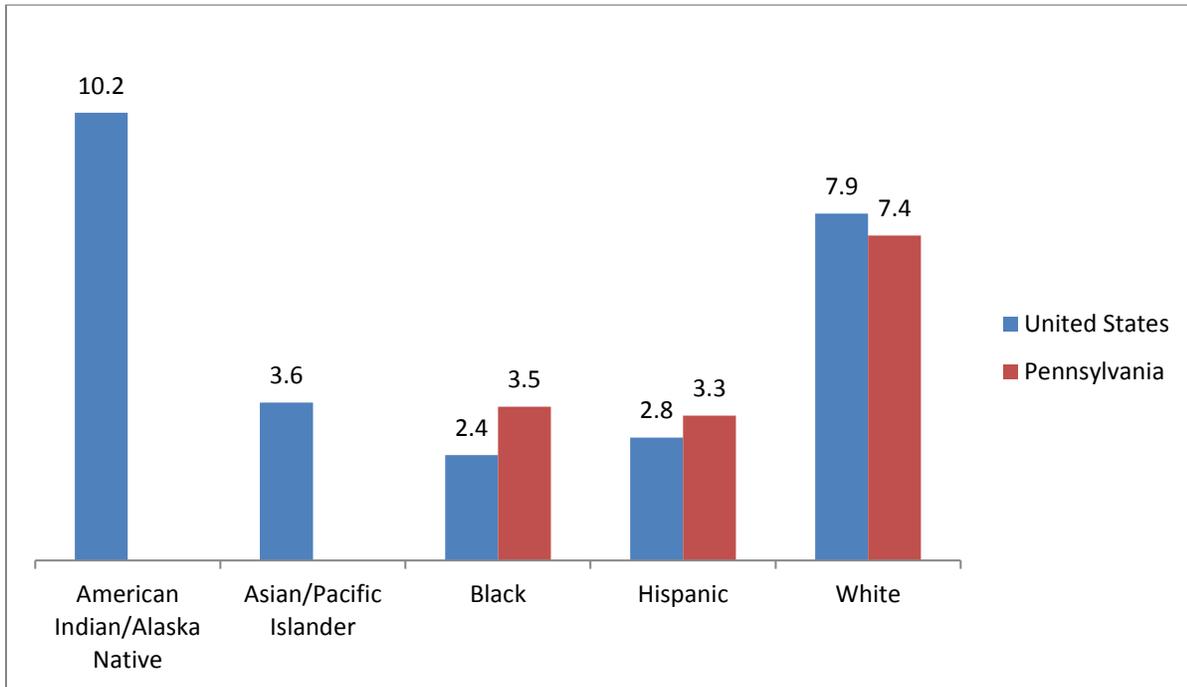
Source: WISQARS (Web-Based Injury Statistics Query and Reporting System) Interactive Database, Centers for Disease Control and Prevention

Notes: Suicide rates are based on the number of people who have died by suicide per 100,000 people. Rates are age-adjusted and include all age groups.

Suicide rates also vary by race and ethnicity. For both women and men, suicide rates are highest for American Indians and Alaska Natives. In 2016, the suicide rate for male American Indians and Alaska Natives was 32.8, and the suicide rate for females was 10.2 (National Institute of Mental Health 2016).

Figure 4.20 shows female suicide rates for different racial and ethnic groups. Among women in the U.S., the suicide rate was 10.2 for American Indians and Alaska Natives in 2016. The next highest rate was 7.9 among White, non-Hispanic women. Suicide rates dropped off noticeably for Asian/Pacific Islanders (3.6) and Hispanic (2.8) women. Black women had the lowest suicide rate of 2.4.

Figure 4.20. Suicide Rates among Women by Race/Ethnicity, United States & Pennsylvania, 2016



Source: WISQARS (Web-based Injury Statistics Query and Reporting System) Interactive Database, Centers for Disease Control and Prevention.

Notes: Suicide rates are based on the number of people who have died by suicide per 100,000 people. Rates are age-adjusted and include all age groups.

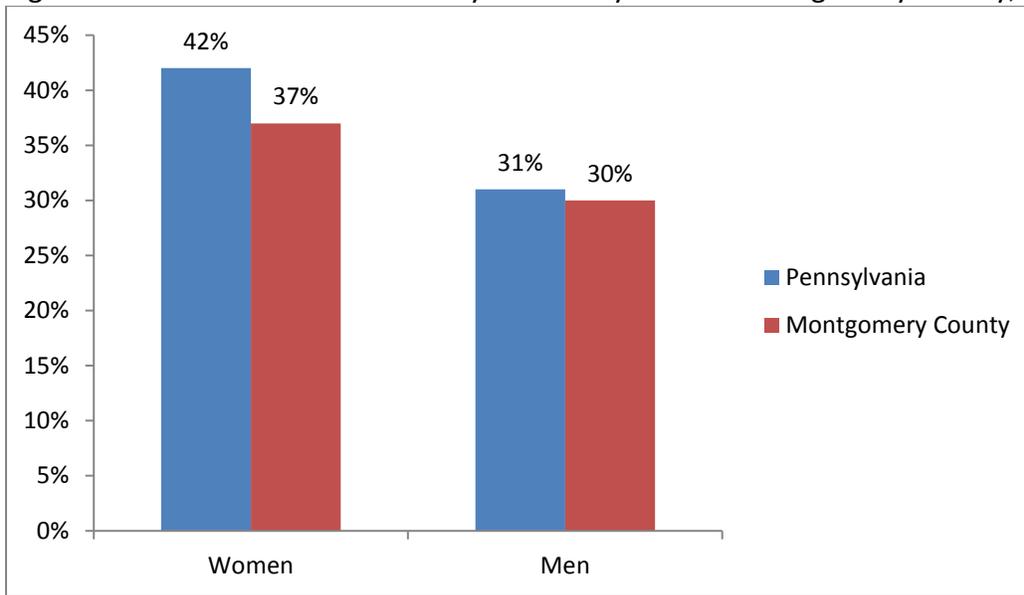
In 2015, the overall suicide rate was 11.4 in Montgomery County. This is slightly lower than the overall national rate of 13.42 and the overall state rate of 14.7. Of all suicides between 2008 and 2014, 73.4% were committed by men, and 26.6% were committed by women (Montgomery County Department of Health and Human Services, n.d.). In Montgomery County, 81% of suicides were committed by Whites.

Effects of Poor Mental Health

Mental illness can affect a person’s ability to complete day-to-day tasks. The effects vary depending on the type of mental illness, but can range from problems sleeping, to interfering with relationships and job/school performance, to disability (National Institute for Mental Health, n.d). Effects can also vary by person with the same illness because people experience mental illness differently (National Alliance on Mental Illness, n.d.). Unfortunately, mental health services can be difficult to access because of cost and a shortage of mental health care professionals (Nguyen 2018).

Figure 4.21 shows the differences in the percent of women and men who identified that their mental health was not good one or more days in the past month. Women were somewhat more likely to experience one or more poor mental health days.

Figure 4.21. Poor Mental Health Days in Pennsylvania & Montgomery County, 2014-2016



Source: EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health
Notes: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Data obtained from the Pennsylvania Department of Health are based on the CDC's Behavioral Risk Factor Surveillance System (BRFSS) Survey.

Mental Illness and Insurance

Before the Affordable Care Act, millions of people in the individual market did not have access to mental health services because of preexisting conditions. Although states had the authority to require individual market plans to cover mental health services, only five states required insurers to offer mental health coverage. Coverage was also frequently limited to serious medical illness or biologically-based mental illness. Ten states had broad mandates that required insurers to cover mental health (Palanker et al. 2018). The Affordable Care Act did not allow insurance companies to deny coverage to individuals with preexisting conditions. With the future of the Affordable Care Act uncertain, the recent gains in mental health care coverage could be lost.

Health-Related Risk Behaviors and Preventive Services

The causes of chronic diseases and mental illness are complicated and are generally a combination of genetics, environment, and behaviors. Preventive care and behavioral changes can have a positive impact on overall health and well-being. Nationwide, Americans use preventive services at half of the recommended rate (U.S. Preventive Services, n.d.) Chronic disease can be prevented or treated with proper screening. Americans can be healthier if they exercise, eat healthy, avoid smoking, and have regular preventive screenings and immunizations.

As Table 4.3 shows, women in Montgomery County are engaging in healthy behaviors overall. Only 11% of women smoke; only 12% binge drink, and only 1% fail to use seatbelts regularly. Of women aged 50-64, 70% reported having a mammogram in the past two years. Of women aged 18 to 64, 45% received an HIV/AIDS test. According to the most current data, nearly half of Montgomery County women (49%) also engaged in healthy behaviors like physical activity for five or more days a week for 30 minutes or more a session. While 31% of women eat at least five servings of fruits and vegetables a day in Montgomery County, 28% of women eat their fruits and vegetables in Pennsylvania (Enterprise Data Dissemination Informatics Interactive Tool).

Table 4.3. Behavioral Risk Factors for Women in Montgomery County

Type of Behavioral Risk	Percent
Tobacco Use (2014-2016)	
-Current Smoker (Smokes Every Day or Some Days)	11%
Physical Activity (2005-2007)	
-Engaged in Moderate Physical Activity 5 or More Days a Week for 30 Minutes or More a Session	49%
Fruits & Vegetables (2005-2007)	
-Consume at least 5 servings of fruits/vegetables every day	31%
Alcohol Consumption (2014-2016)	
- Binge Drinkers (Females Having 4 or More Drinks on One Occasion)	12%
Women's Health (2002-2004)	
-Women Who Had a Mammogram & Clinical Breast Exam in the Past 2 years, Ages 50-64	70%
HIV/AIDS (2014-2016)	
-Ever Tested for HIV (Except Blood Donation), Ages 18-64	45%
Injury (2014-2016)	
-Seldom or Never Uses Seatbelts When Riding in a Car	1%

Source: EDDIE (Enterprise Data Dissemination Informatics) Interactive Tool, Pennsylvania Department of Health

Notes: These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Data obtained from the Pennsylvania Department of Health are based on the CDC's Behavioral Risk Factor Surveillance System (BRFSS) Survey.

Opioid Use Disorder

Over the past twenty years, opioid use disorder has increased significantly in the U.S. and may be affecting women disproportionately. From 1999-2015, the rate of deaths from prescription opioid overdose increased 471% among women and 218% among men in the United States (Office of Women's Health 2017).

Women use opioids differently than men, and new evidence suggests that opioids affect women differently as well – although the causes are not well known. Women are more likely than men to experience chronic pain (Centers for Disease Control and Prevention 2017b). As a result, women are also more likely to be prescribed opioid and narcotic pain killers. Further, women are more likely to be prescribed higher doses, and they tend to use painkillers for longer periods of time than men. Some studies have shown that women become dependent on opioids more quickly and have more cravings than men (Office of Women’s Health 2017). In addition, psychological and emotional distress may contribute to opioid misuse or overuse among women, but not men.

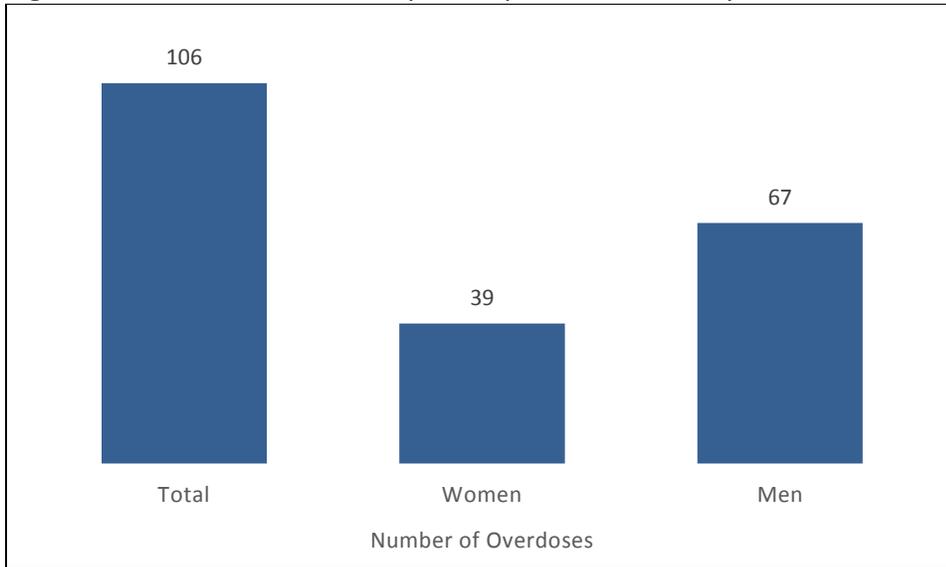
A variety of factors contribute to opioid use disorder for women, including biological and social factors, geography, demographic characteristics, and past experiences. Women’s physiology may put them at greater risk for substance use disorders. Women develop lung damage more quickly than male smokers and cirrhosis more quickly than male heavy drinkers. In other studies, women have been more sensitive to cravings for cocaine and cigarettes than men. Potential reasons may have to do with women’s higher proportion of body fat and lower proportion of water, but research is lacking (Office of Women’s Health 2017).

For women, psychological and emotional distress are risk factors for prescription opioid misuse. Physical and sexual abuse are correlated with substance abuse disorders for women, and studies have found that rates of childhood and adult sexual abuse are higher for women than men. This means that among all individuals with substance use disorders, a higher proportion of women have a history of trauma that frequently includes sexual and physical abuse. Childhood abuse is also associated with chronic pain later in life (Office of Women’s Health 2017).

Opioid prescription rates are highest among women in the South between the ages of 15 and 44. Mortality rates from a drug overdose are higher in the rural South and Midwest and lowest in the Northeast (Office of Women’s Health 2017). American Indian or Alaska Native women are at the greatest risk of dying from a prescription opioid overdose. The overdose death rate is also significantly higher among White, non-Hispanic women than other racial and ethnic groups – with the exception of American Indian or Alaska Native women. This is probably due to the lower opioid prescription rates among women of color that is likely a result of prescriber bias.

According to the Montgomery County Department of Public Safety, the number of prescription opioid overdoses has increased since 2013. In 2017, there were 106 prescription opioid overdoses in Montgomery County. Of those opioid overdoses, 67 occurred among men, and 39 occurred among women (Figure 4.22).

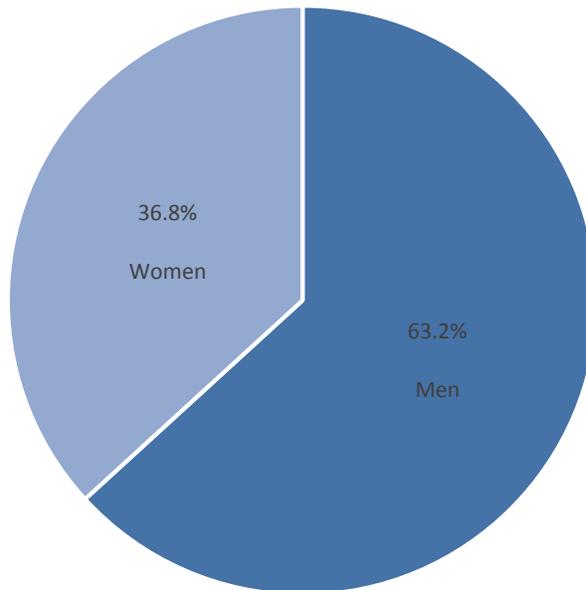
Figure 4.22. Number of Prescription Opioid Overdoses by Gender in Montgomery County, 2017



Source: Montgomery County, Department of Public Safety, 2017

In Montgomery County, 63.2% of men overdosed on prescription opioids compared to 36.8% of women in 2017 (Figure 4.23). The average age for prescription opioid overdose victims was 42 (Pasquale 2017).

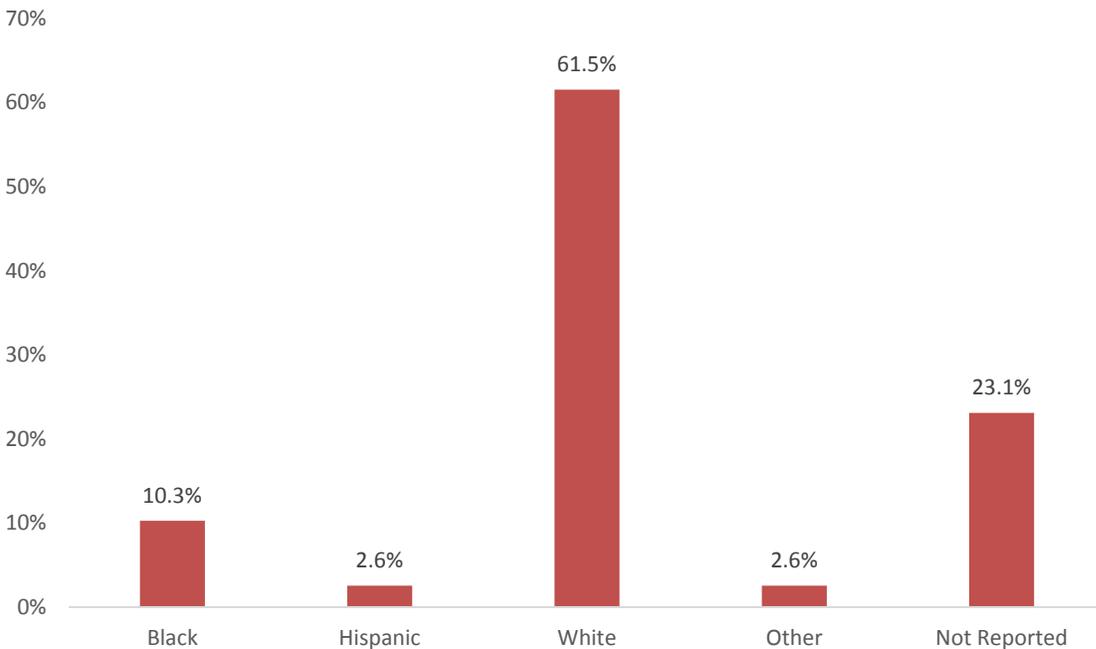
Figure. 4.23. Percentage of Prescription Opioid Overdoses by Gender in Montgomery County, 2017



Source: Montgomery County, Department of Public Safety, 2017

Of the prescription opioid overdose incidents among women in Montgomery County in 2017, the vast majority occurred among White women at 62.5% (Figure 4.23), which is similar to national trends that show higher overdose rates among White women. Black women only comprised 10.3% of prescription opioid overdose incidents, while Hispanic women comprised even less at 2.6%. In 23.1% of prescription opioid overdoses incidents in Montgomery County, the race or ethnicity was not reported.

Figure 4.23. Percentage of Prescription Opioid Overdoses by Race & Ethnicity Among Women in Montgomery County, 2017



Source: Montgomery County, Department of Public Safety, 2017

Conclusion

Since 2000, some aspects of women’s health have improved while others have worsened. Women are less likely to die from heart disease, breast cancer, and lung cancer, but heart disease and cancer are still the leading causes of death among women (Hess et al. 2015). Heart disease and cancer also disproportionately affect Black women. Other measures of women’s health have grown worse. Diabetes and obesity have increased as have rates of chlamydia and gonorrhea. Suicide mortality and poor mental health have also increased. In the United States, opioid use disorder is a growing public health concern that affects women disproportionately. Death rates have increased faster for women, and not enough is known about why women are more susceptible. Although the Affordable Health Care has helped to provide women with more access to preventive care, the future of the ACA is uncertain.

VIOLENCE & SAFETY

Introduction

According to the Center for Disease Control and Prevention (CDC), sexual violence and intimate partner violence pose a serious public health problem. Victims of sexual violence suffer both physical and psychological trauma. Being a victim of violence as a child also increases the odds of being victimized as an adult. The CDC estimates that the cost of rape is \$122,461 per victim in lost wages, medical costs, and court costs (Centers for Disease Control and Prevention 2017a). About 40% of female murder victims are killed by an intimate partner (Smith et al. 2018). In 2015, 266 women were shot or killed in the middle of an argument by a spouse or intimate partner (Violence Policy Center 2017).

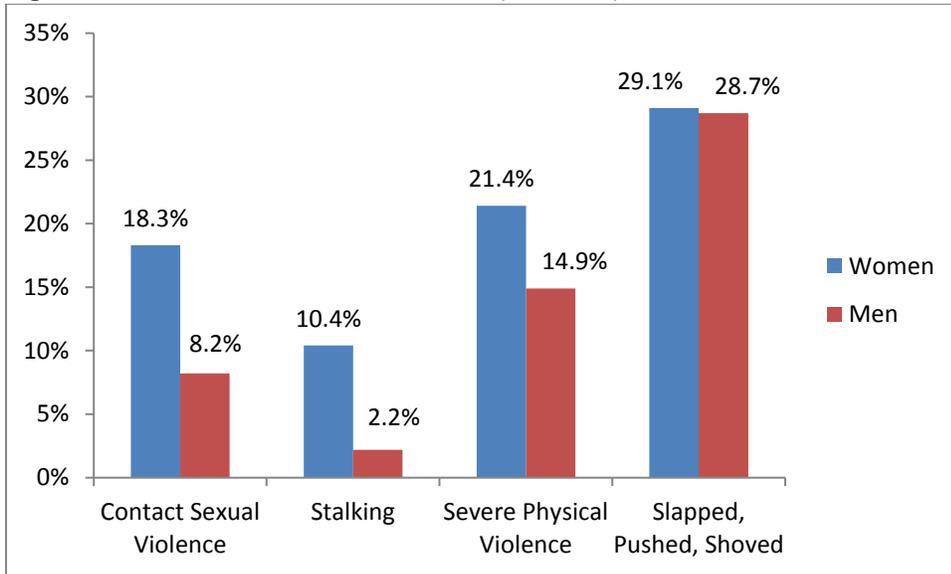
Intimate Partner Violence and Abuse

Intimate partner violence involves violence or aggression in a close relationship with a current or former dating partner or spouse. It includes sexual violence, stalking, physical violence, and psychological aggression. These categories are not mutually exclusive and can occur simultaneously. Nearly 1 in 4 women and 1 in 10 men experience some sort of intimate partner violence during the course of their lifetime (Smith et al. 2018).

Sexual violence includes the following: rape (completed or attempted), unwanted sexual contact, sexual coercion, or being made to penetrate someone else. Stalking is a pattern of unwanted threatening and/or harassing behaviors used to make victims afraid and concerned about their safety. Physical violence includes a variety of behaviors ranging from hitting and shoving to using a knife or gun on a victim. Psychological aggression can include coercive control or expressive aggression such as name calling and humiliation (Smith et al. 2018). Both women and men can be the victims of intimate partner violence, but women are more likely to face most forms of violence.

In 2015, 18.3% of women in the U.S. reported instances of contact sexual violence during their lifetime, compared to 8.2% of men (Figure 5.1). Women were much more likely to be stalked, with 10.4% of women reporting stalking behaviors, compared to 2.2% of men. Almost a quarter of women (21.4%) reported severe physical violence during their lifetime, compared to 14.9% of men. Women and men reported almost the same likelihood that they had been slapped, shoved, or pushed, with 29.1% of women and 28.7% of men reporting this.

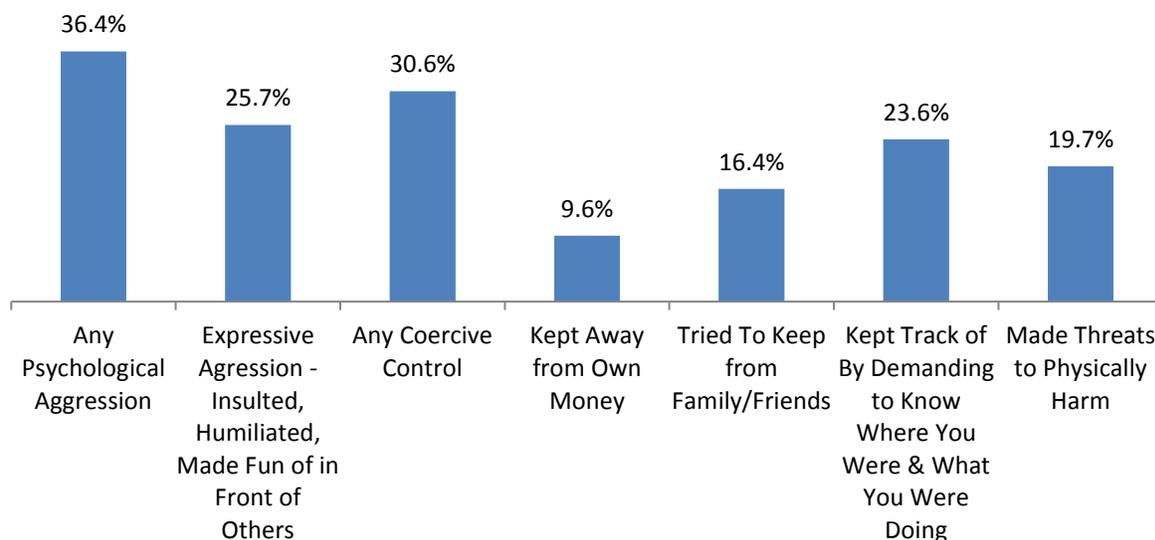
Figure 5.1. Intimate Partner Violence (Lifetime), Female & Male Victims, United States, 2015



Source: National Intimate Partner and Sexual Violence Survey: 2015 Data Brief

Psychological aggression and coercive control can be used to threaten an intimate partner. In 2015, 36.4% of women in the U.S. reported that they had experienced some form of psychological aggression, while 30.6% reported that they had experienced some form of coercive control during their lifetime (Figure 5.2). The most common form of coercive control (23.6%) was demanding to know where the intimate partner was. About 25.7% of women reported that they had been insulted, humiliated, or made fun of in front of others.

Figure 5.2. Lifetime Psychological Aggression by an Intimate Partner, Female Victims, United States, 2015



Source: National Intimate Partner and Sexual Violence Survey: 2015 Data Brief

Intimate Partner Violence by Race and Ethnicity

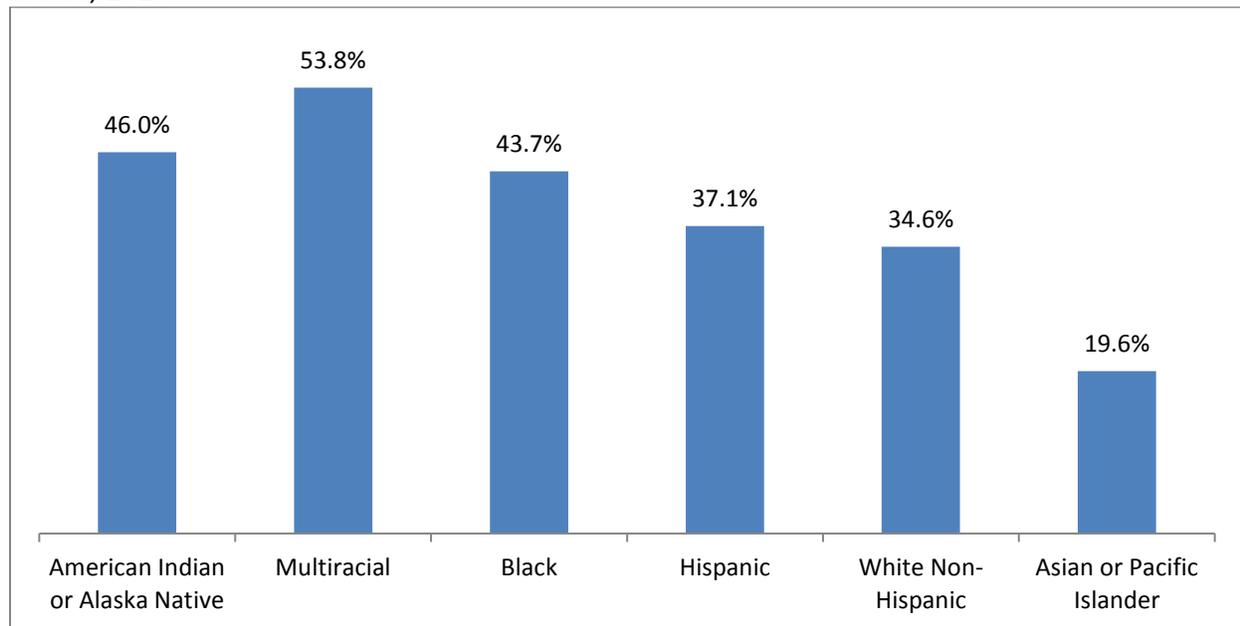
Intimate partner violence varies considerably by race and ethnicity. According to the Rape, Abuse, and Incest National Network (RAINN), American Indian women are the most likely to face sexual assault. Over 84% of Native women have experienced assault or domestic violence at some point during their lifetime (NCADV, n.d.). They are twice as likely as women in any other demographic group to experience rape or sexual assault (RAINN 2018). About 46% of American Indian or Alaska Native women have experienced physical violence, rape, or stalking. Over 50% of Native women have reported sexual assault specifically, and about 66% have experienced psychological abuse (NCADV, n.d.). There are over 566 Native tribes in the U.S. but only 26 shelters across the country that offer culturally specific services to Native women. Compared to other racial/ethnic groups, American Indian women experience more interracial violence than other racial/ethnic groups. About 2/3 of Native women who are sexually assaulted are attacked by non-Native men. Over half (59%) of Native women were in relationships with non-Native men (NCADV, n.d.).

Black women and multiracial women are also more likely to have been a victim of rape, physical violence, or stalking by an intimate partner. About 43.7% of Black women and 53.8% of multiracial women experienced physical violence, rape, or stalking, in comparison to 34.6% of White women and 19.6% of Asian or Pacific Islander women (Breiding et al. 2014).

Figure 5.3 shows the prevalence of rape, physical violence, or stalking by race and ethnicity in the United States in 2010. American Indian or Alaska native women (46%) and multiracial women (53.8%) were most likely to report an instance of rape, physical violence, or stalking.

Black women (43.7%) and Hispanic women (37.1%) were the next most likely to experience one of these forms of intimate partner violence. In comparison, Asian or Pacific Islander women (19.6%) were the least likely to experience intimate partner violence.

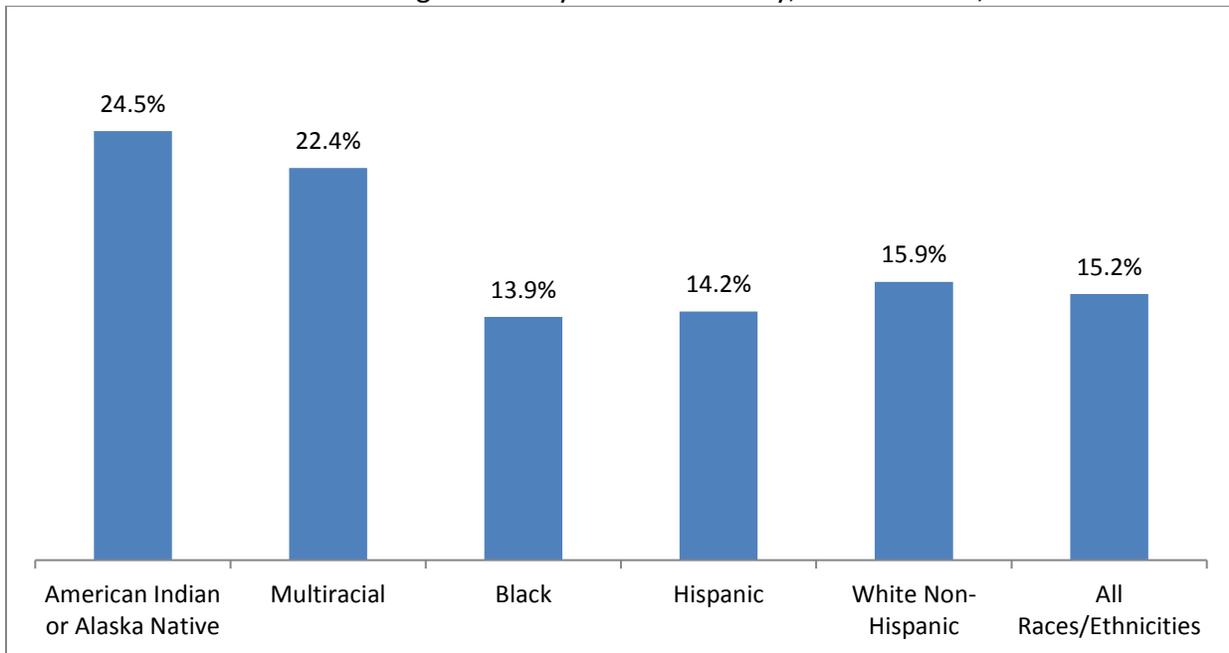
Figure 5.3. Lifetime Prevalence of Rape, Physical Violence, or Stalking by Race/Ethnicity, United States, 2010



Source: Breiding et al. 2014 (*Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization-National Intimate Partner and Sexual Violence Survey, United States, 2011*)

American Indian/Alaska Native women and multiracial women are also both more likely to have experienced stalking at some point in their lives. Nearly 25% of American/Alaskan women and nearly 23% of multiracial women have been stalked (Figure 5.4). In comparison, only 13.9% of Black women, 14.2% of Hispanic women, and 15.9% of White woman have been victims of stalking (Figure 5.4).

Table 5.4. Prevalence of Stalking Victims by Race & Ethnicity, United States, 2011



Source: Breiding et al. 2014 (*Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization-National Intimate Partner and Sexual Violence Survey, United States, 2011*)

Note: There is not enough data available on Asian/Pacific Islander women.

The Cost of Intimate Partner Violence

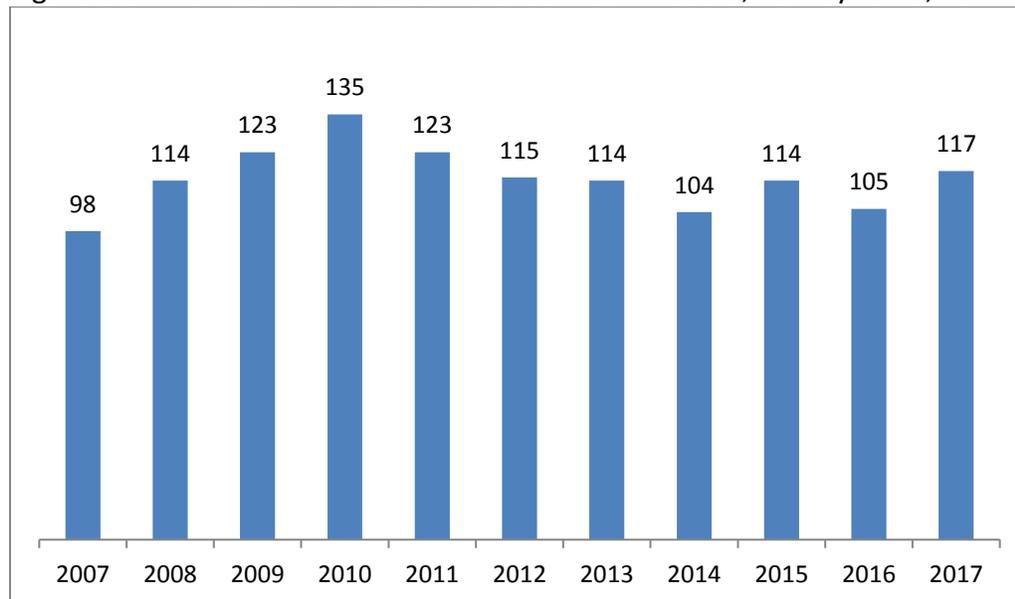
In the U.S., the costs of physical assault, intimate partner rape, and stalking amount to over \$5.8 billion a year (National Center for Injury Prevention & Control 2003). Almost \$4.1 billion of that is for direct medical care and mental health care services. Other costs include about \$.9 billion in lost productivity from paid work and household chores and about \$.9 billion in lifetime earnings (National Center for Injury Prevention & Control 2003).

Domestic Violence Deaths

In a study from 2003 to 2015, over half (55.5%) of female victim homicides were instances of intimate partner violence. Male perpetrators (98.2%) were overwhelming responsible for female homicides (Petrosky et al. 2017). Black women were murdered by men at a rate twice as high as that of White females. The murder rate for Black women was 2.43 per 100,000, compared to .96 per 100,000 for White females. American Indian and Alaskan Native women were murdered by men at a rate of 1.46 per 100,000. Asian and Pacific Islander females had the lowest homicide rate of .51 per 100,000 (Violence Policy Center 2017).

More than 1,600 victims and perpetrators have died in domestic violence-related deaths in Pennsylvania over the last ten years (PCADV 2017). In 2017, 117 victims died due to domestic violence-related causes in Pennsylvania (Figure 5.5). An additional 47 perpetrators died (PCADV 2017).

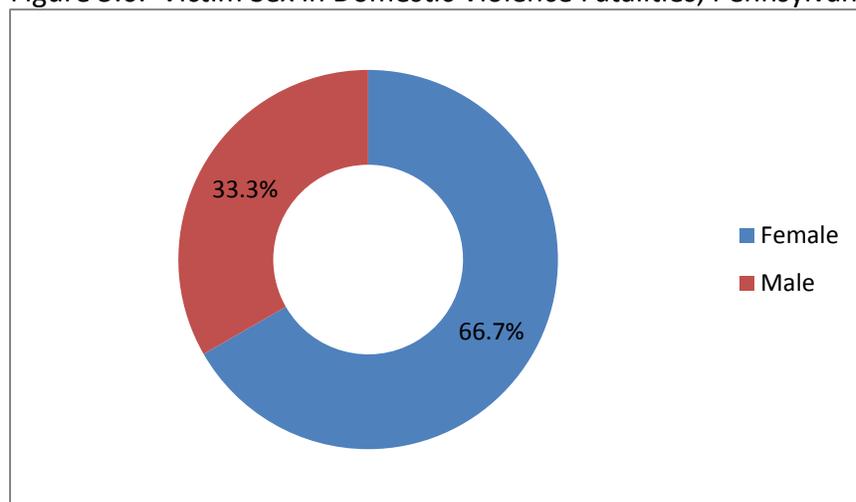
Figure 5.5. Number of Domestic Violence Victim Deaths, Pennsylvania, 2017



Source: PCADV 2017 Domestic Violence Fatality Report

In 2017, 66.7% of the victims who died in domestic violence incidents were women, and 33.3% were men (Figure 5.6). There were 100 victims between the ages of 18 and 25, 9 victims over age 65, 6 victims aged 1-12, and 2 victims between the ages of 13 and 17 (PCADV 2017). Of the 117 deaths in 2017, 60% of victims were killed by a current or former intimate partner. Of the 78 women who were killed, 58 were killed by a current or former intimate partner. Of the 39 men who were killed, 13 were killed by a current or former intimate partner (PCADV 2017). The most common method of killing victims was with a firearm. Of the 117 victims who were killed, 78 were shot (PCADV 2017).

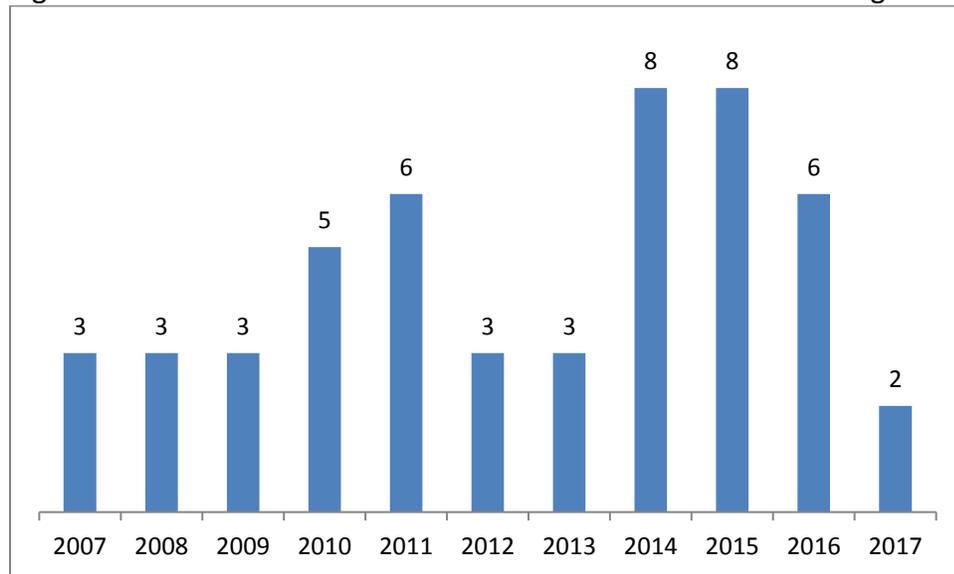
Figure 5.6. Victim Sex in Domestic Violence Fatalities, Pennsylvania, 2007-2017



Source: PCADV 2017 Domestic Violence Fatality Report

Over the past eleven years, there have been 50 victim deaths due to domestic violence incidents in Montgomery County. Victim fatalities reached a high point in 2014 and 2015 when there were 8 each year (Figure 5.7). Victim fatalities decreased to 6 in 2016 and to 2 in 2017 (Figure 5.7). In Pennsylvania, the number of victim fatalities per county ranged from 0 to 13 in 2017 and were highest in Philadelphia County at 13 and Allegheny County at 10 (PCADV 2017).

Figure 5.7. Number of Domestic Violence Victim Fatalities in Montgomery County, 2007-2017



Source: PCADV 2007-2017 Domestic Violence Fatality Reports

Lethality Assessment Program

In 2012, Pennsylvania implemented the Lethality Assessment Program, which helps connect domestic violence victims with services. As part of this program, police officers ask victims a series of screening questions to assess whether or not the victim has a high risk of being killed. Police will immediately put victims in touch with advocates from local domestic violence centers depending on the victim’s answers. Pennsylvania’s program is modeled after Maryland’s, which is a nationally ranked evidence-based program. Because studies have shown that only 4% of victims who were killed contacted a hotline, program, or shelter prior to their death, programs like this are critical (PCADV 2017). Since 2012, there have been 14,227 lethality assessment screenings in Pennsylvania, and 9,761 of those were deemed “high-danger.” As a result of the program, 6,183 spoke with a hotline advocate at the scene, and 63% of “high-danger” victims accessed local shelter or program resources (PCADV 2017). The following townships in Montgomery County participated in the Lethality Assessment Program as of 2015:

- Abington Township
- Lower Merion Township
- North Wales Borough
- Pottstown Borough

Telford Borough
Upper Dublin Township
Upper Merion Township
Upper Moreland Township
Hatfield Township
Lower Pottsgrove Township
Upper Gwynedd Township

Domestic Violence Fatality Review Teams

Because domestic violence can be fatal, domestic violence fatality review teams are important. The National Domestic Violence Fatality Review Initiative provides support to organizations and agencies that review information related to domestic violence deaths in order to understand the factors that contribute to intimate partner violence and death. The initiative is funded by the Office of Violence Against Women (OVW), which is part of the U.S. Department of Justice. Domestic violence fatality review teams are composed of relevant stakeholders from a variety of fields including education, health, social services, and criminal justice. Along with most other states, Pennsylvania has created a domestic violence fatality review team, the Pennsylvania Coalition Against Domestic Violence. The teams produce annual reports on domestic violence-related deaths and review the circumstances to see how these deaths could have been avoided (National Domestic Violence Fatality Review Initiative, n.d.). In 2018, Montgomery County was one of five other counties in Pennsylvania that had a domestic fatality review team according to the National Domestic Violence Fatality Review Initiative.

Montgomery County is also home to the Domestic Violence Legal Network (DVLN), which facilitates communication between law enforcement, government agencies, and community organizations in order to provide services to victims of domestic violence (Montgomery County, n.d.). According to the by-laws of DVLN, representatives from the following organizations are invited to become core members:

Laurel House
The Women's Center of Montgomery County
Montgomery Bar Association
Prothonotary's Office
Board of Judges
Court Administration
Magisterial District Judges
MDJ Administration
Legal Aid
Montgomery County Correctional Facility
Local Law Enforcement
Sheriff's Office
Adult Probation Office
Domestic Relations Office

Children & Youth Services
Pennsylvania State Policy
Victims Services Center of Montgomery County
Batterer's Treatment Providers

Unmet Need for Services and Supports

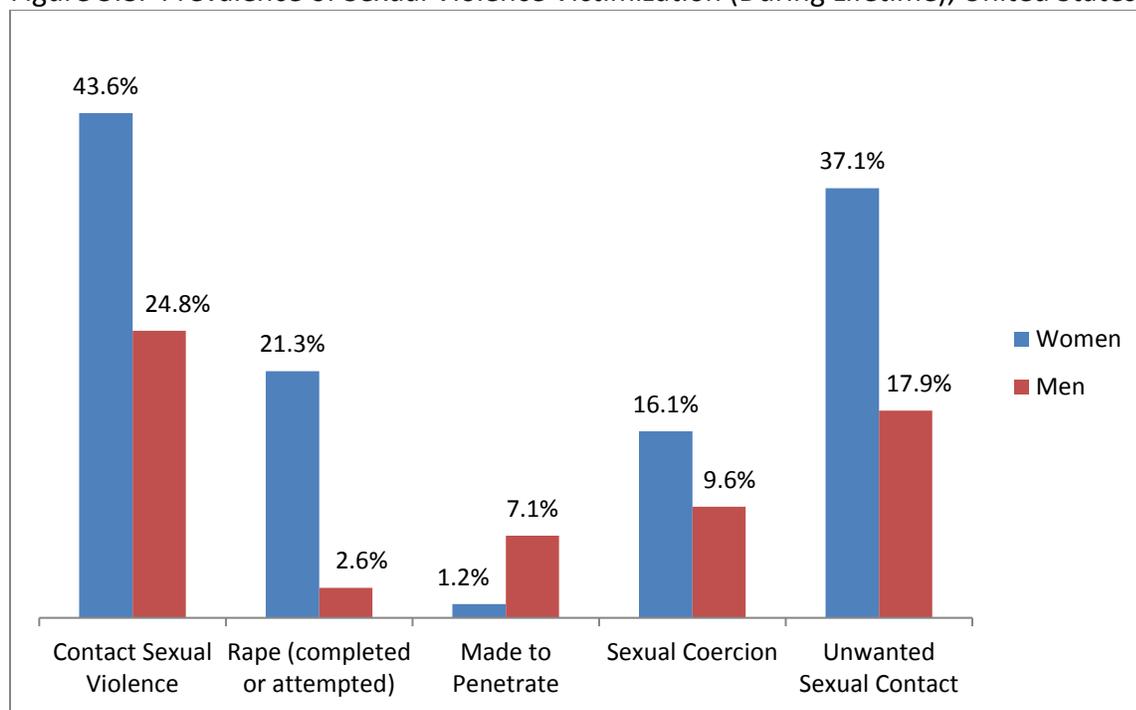
Unfortunately, the demand for domestic violence services in the U.S. cannot be fully met. The National Network to End Domestic Violence has conducted a survey called the National Census of Domestic Violence Services every year since 2006. This survey provides a 24-hour snapshot of domestic violence programs in the U.S. On September 12, 2017, 90% of domestic violence programs participated in the National Census of Domestic Violence Services. On that day 72,245 adult and child victims were served, 20,352 domestic violence hotline calls were answered, and 24,030 people attended prevention and education trainings. There were also 11,441 unmet requests for services in one day (National Network to End Domestic Violence 2018). Of those requests, 65% were for housing.

In Pennsylvania, 100% of the 60 domestic violence programs participated in the National Census of Domestic Violence Services. On that day, 2,486 adult and child victims of domestic violence were served, 760 domestic violence hotline calls were answered, and 1,831 people attended prevention and education trainings. There were 1,003 unmet requests for services, and 81% of those were for housing. During 2017, 20 local programs either laid off or did not fill 44 staff positions. Of those positions not filled, 44% were direct service providers such as legal advocates or shelter staff. Ultimately, this means there were fewer employees to provide services or provide legal advocacy (National Network to End Domestic Violence 2018).

Rape and Sexual Violence

In 2015, 43.6% of women reported that they had experienced some sort of contact sexual violence during their lifetime (Figure 5.8). This translates to 52.2 million women across the U.S. Of those women who reported contact sexual violence, 4.7% of them reported that it had occurred in the 12 months before the survey (Smith et al. 2018). In comparison, 24.8% of men reported that they had experienced some sort of contact sexual violence (Figure 5.8). About 1 in 5 women (21.3%) reported completed or attempted rape during their lifetime. Of those women who reported completed or attempted rape, 13.5% reported forced penetration, 6.3% reported an attempt at forced penetration, and 11% reported completed alcohol or drug-facilitated penetration (Smith et al. 2018). About 1.5 million women, or 1.2%, reported that the completed or attempted rape had occurred in the 12 months before the survey. In comparison, 2.6% of men reported completed or attempted rape during their lifetime.

Figure 5.8. Prevalence of Sexual Violence Victimization (During Lifetime), United States, 2015



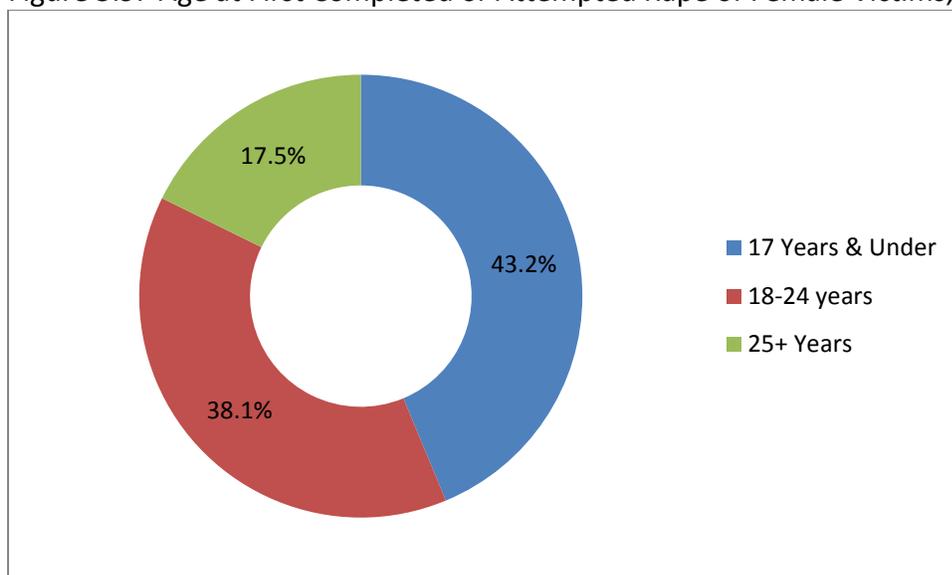
Source: National Intimate Partner and Sexual Violence Survey: 2015 Data Brief

Notes: Contact sexual violence includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.

About 16.1% of women and 9.6% of men reported sexual coercion at some point in their life. Sexual coercion can be repeated requests for sex until a person gives in, or pressure from someone in a position of power or authority (Smith et al. 2018). Over a third of women (37.1%) reported unwanted sexual contact such as groping during their lifetime, while 17.9% of men reported the same. Almost 1.4 million women (1.2%) and 7.9 million men (7.1%) reported they were forced to penetrate someone else during their lifetime.

Figure 5.9 shows how old women were when they were raped (completed or attempted) for the first time. The majority of female victims (81.3%) reported completed or attempted rape before the age of 25. Almost 11 million female victims (43.2%) were under the age 18 when they were raped (completed or attempted) for the first time (Smith et al. 2018). Of those female victims under 18, 30.5% reported they were raped between the ages of 11 and 17, while 12.7% reported that they were raped at the age of 10 or younger (Smith et al. 2018).

Figure 5.9. Age at First Completed or Attempted Rape of Female Victims, United States, 2015



Source: *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief*

Campus Sexual Assault

Sexual assault is a common problem on college campuses, and it frequently goes unreported. One in five women is sexually assaulted at some point while attending college (Krebs et al. 2016). Sexual assault includes “any unwanted sexual activity, from unwanted touching to rape” (Office of Women’s Health, n.d.). Students are at a greater risk for sexual assault during the first few months at college. More than half of sexual assaults in college occur in September, October, and November (RAINN, n.d.). It is estimated that only about 20% of female student victims (aged 18-24) report the crime to law enforcement (Sinozich and Langton 2014). Sexual assault is common across all racial and ethnic groups, but is more prevalent among female students who identify as lesbian, gay, or bisexual (Krebs et al. 2016). Alcohol and/or drugs are often involved in instances of campus rape and sexual assault. It is estimated that about 15% of female student victims were incapacitated when they were raped during their first year of college (Office of Women’s Health, n.d.).

Any college that receives federal funding is required to report crime statistics and security information per the 1990 Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act) (AAUW 2017). This information must be reported to the U.S. Department of Education every year. Statistics on rape, fondling, incest, and statutory rape are included in the annual crime statistics that must be reported. In 2013, Congress added amendments to the Clery Act when it reauthorized the Violence Against Women Act (VAWA). These amendments require schools to collect and report instances of domestic violence, dating violence, and stalking (AAUW 2014). Title IX of the Educational Amendments of 1972 also helps to protect women against sexual assault on college campuses. Although Title IX is typically associated with sports, it actually prohibits sex discrimination more broadly in any educational institution that receives federal funding (U.S. Department of Labor 1972). This applies to a

variety of campus experiences from housing to sexual harassment and assault. Title IX is also a mechanism by which students can file a complaint related to sexual harassment or assault.

Table 5.1 shows the number and types of sexual assaults on college and university campuses in Montgomery County (or on the border of Montgomery County). The following colleges and universities were included in the calculations below in Table 5.1: Arcadia University, Bryn Mawr College, Gwynedd Mercy College, Haverford College, Rosemont College, Ursinus College, and Villanova University. All statistics were obtained from the U.S. Department of Education. Offenses included the following: rape, fondling, domestic violence, dating violence, and stalking. These numbers are incidents reported to campus security and/or local police and represent a total over a three-year period from 2014 to 2016.

Overall, there were 89 reported incidents of rape at colleges and universities in Montgomery County (Table 5.1). Further, there were 53 reported incidents of fondling, 142 incidents of domestic violence, 43 incidents of dating violence, and 49 stalking incidents. All local colleges and universities reported incidents of fondling, ranging from 1 incident to 17. All local colleges and universities also reported incidents of dating violence, ranging from 1 incident to 22. Six out of seven local colleges and universities had reports of rape, ranging from a low of 2 and a high of 31. Six local colleges and universities also reported incidents of stalking, ranking from 2 incidents to 30. The least reported offense was domestic violence, with five local colleges and universities reporting incidents ranging from 1 to 5.

Table 5.1. Number & Type of Sexual Assault & Offenses at Colleges & Universities, Montgomery County, 2014-2016 (3 Year Totals)

Offense	Total
Rape	89
Fondling	53
Domestic Violence	142
Dating Violence	43
Stalking	49

Source: Campus Safety & Security Data Analysis Cutting Tool, Campus Safety & Security, U.S. Department of Education

Note: Not all of the colleges and universities have a mailing address in Montgomery County. Many of these colleges and universities straddle physical County boundaries, and part of the campus may be in Montgomery County or on the border. Only main campus locations and on-campus incidents are reported here.

A study of college-age females from 1995 to 2013 found that the offender had a weapon in 1 out of 10 instances of rape and sexual assault both on and off college campuses. Female college students were less likely to report the incident than college-aged females who did not attend school. Only 16% of female student victims received any support services after the incident. Seventy-eight percent of female student victims knew their attacker. Among female student victims, 97% of the offenders were male (Sinozich and Langton 2014).

In 2011, the Obama administration issued new guidelines in regard to sexual violence cases that applied to college campuses. These new guidelines recommended that the standard for evidence be changed from a “clear and convincing standard” (it is highly probable) to a “preponderance of evidence standard” (it is more likely than not). This standard made it easier for victims to prove sexual assault. On September 22, 2017, the U.S. Department of Education announced that the Obama era guidelines were no longer in effect. The Department will undergo official rulemaking procedure, but has issued temporary guidelines. According to these guidelines, a school may use the “clear and convincing standard” or the “preponderance of evidence standard,” but the standard must be the same for all disciplinary cases (U.S. Department of Education 2017).

Stalking

In the United States, approximately 7.5 million people are stalked in one year (National Center for Victims of Crime 2015). Stalking refers to “harassing or threatening tactics used by a perpetrator that is both unwanted and causes fear or safety concerns” (Smith et al. 2018). Common stalking tactics include the following (as measured by the National Intimate Partner and Sexual Violence Survey):

- Unwanted phone calls, voice or text messages, hang-ups
- Unwanted emails, instant messages, messages through social media
- Unwanted cards, letter, flowers, or presents
- Watching or following from a distance, spying with a listening device, camera, or global positioning system
- Approaching or showing up in places such as the victim’s home, workplace, or school when it was unwanted
- Leaving strange or potentially threatening items for the victim to find
- Sneaking into victim’s home or car and doing things to scare the victim or let the victim know the perpetrator had been there
- Damaged personal property or belongings, such as in their home or car
- Made threats of physical harm (Smith et al. 2018)

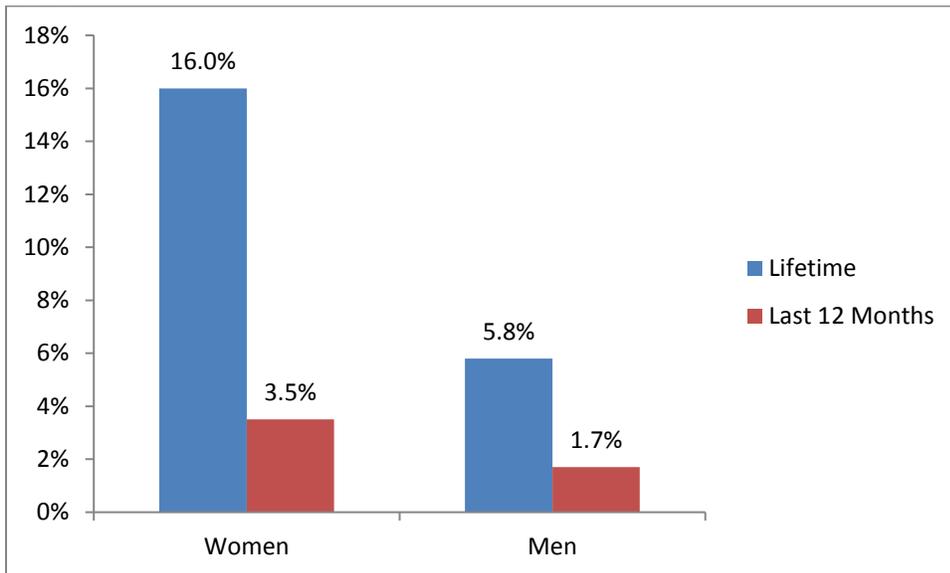
Most stalking victims are stalked by someone they know. In fact, 61% of female victims and 41% of male victims are stalked by a current or former intimate partner, and 25% of female victims and 32% of male victims are stalked by an acquaintance (National Center for Victims of Crime 2015). About 46% of stalking victims have at least one unwanted form of contact a week, and 11% have been stalked for five or more years (National Center for Victims of Crime 2015).

Nearly 1/3 of stalkers have previously stalked someone, and 1 in 5 use weapons to threaten their victims. About 2/3 of stalkers harass their victims at least once a week using more than one method (National Center for Victims of Crime 2015). About 76% of intimate partner

femicide victims reported that they had been stalked before they were killed. Over half of intimate partner femicides reported stalking behaviors to the police before they were killed.

Almost 19.1 million women (16%) reported that they had been stalked during their lifetime (Figure 5.10). The female victims reported being fearful or believing they would be harmed. About 3.5% of women reported they had been stalked in the 12 months prior to the survey. In comparison, 5.8% of men reported that they had been a victim of stalking during their lifetime, and 1.7% reported that they had been a victim of stalking in the 12 months prior to the survey.

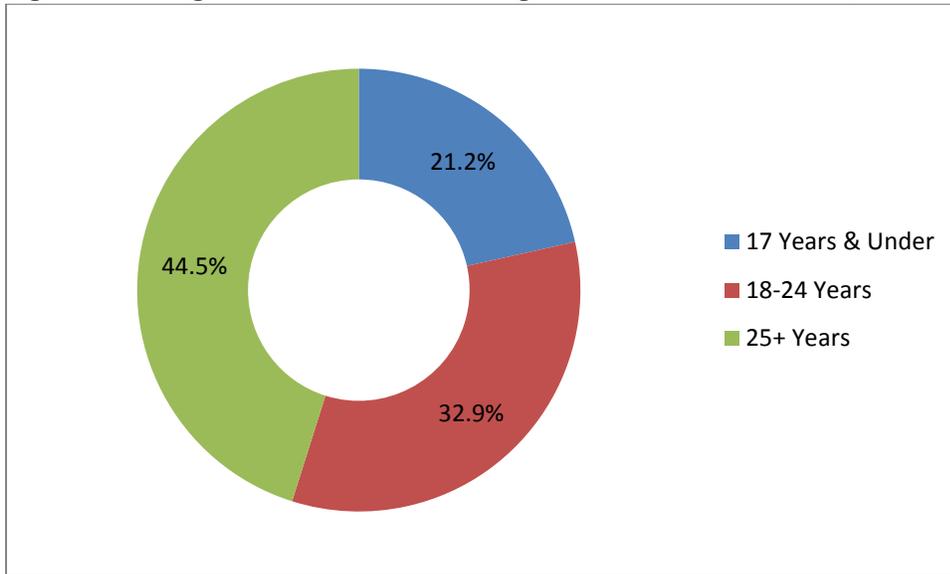
Figure 5.10. Female & Male Victims of Stalking in Lifetime & in Last 12 Months, United States, 2015



Source: *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief*

The majority (54.1%) of female stalking victims reported that they had been stalked before the age of 25 (Figure 5.11). About 21.2% of women reported they had been stalked for the first time before they turned 18 years old. About 8.5 million (44.5%) women reported that they were stalked for the first time when they were 25 years or older.

Figure 5.11. Age at Time of First Stalking Victimization in Lifetime, United States, 2015



Source: *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief*

Stalking has a variety of negative consequences. Victims of stalking typically experience anxiety, severe depression, insomnia, and social dysfunction at higher rates than the general population. About 1 in 8 will miss work, and about 1 in 7 will move as a result of their victimization (National Center for Victims of Crime 2015).

Stalking Statutes

Stalking is a crime in all 50 states and the District of Columbia. Stalking is also a crime under federal law and the U.S. Territories. Below is a summary of different stalking laws (National Center for Victims of Crime 2015):

- 13 states allow a victim to file a civil suit against a stalker
- Nearly a third of states classify stalking as a felony on the first offense
- About half of states classify stalking as a felony if there are aggravating factors (such as possession of deadly weapon) or if it is a repeat offense

In 2003, Pennsylvania passed a stalking law. Stalking is defined as (1) a course of conduct that is designed to cause fear of bodily injury or to cause emotional distress (This includes following another person without the proper authority.) and (2) repeated contact or communication that causes fear or emotional distress. A first offense is considered a first-degree misdemeanor, and a second or subsequent offense is considered a third-degree felony (PA General Assembly 2003).

A victim of stalking in Pennsylvania can also file a Protection from Abuse Order (PFA) for themselves or for children under the age of 18. The process to obtain a PFA varies by county. In Montgomery County, a victim must go to court in person sometime between 8:30 a.m. and

1:30 p.m., Monday through Friday. In order to be eligible for a PFA, a victim must have a family relationship or intimate relationship with the person from whom they are seeking protection. A PFA can be implemented for any length of time up to three years, and there is no charge to file a PFA.

In Pennsylvania, a victim of stalking may also file a Victim/Witness Protection Order if a criminal complaint is filed against the stalker. This type of order may be used in any criminal case, including stalking. Three conditions must be met: there must be criminal complaint filed, (2) the prosecutor has to request the protection from the court, and (3) there must be substantial evidence that a victim or witness will be or has been intimidated. A Victim/Witness Protection Order is difficult to get, but will allow the police to arrest a stalker more quickly and allow the court to order a stalker to stay away from the victim's home, work, neighborhood, or school (PCADV 2018).

Civil Protection Orders

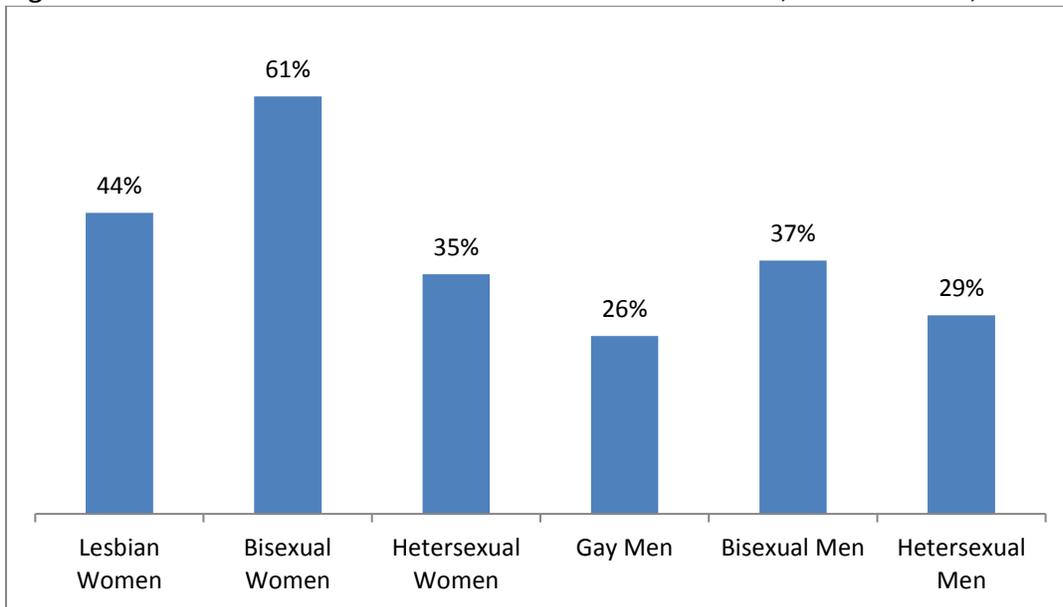
In Pennsylvania, there are three options for Civil Protection Orders: Protection from Abuse Order, Sexual Violence Protection Order, and Protection from Intimidation Order (Pennsylvania Coalition Against Rape 2017). As previously mentioned, the Protection from Abuse Order (PFA) can be filed by stalking victims. The PFA is most appropriate when there is physical, sexual, or psychological abuse involving current or former spouses or intimate partners as well as for family members. The Protection from Intimidation Order is appropriate in stalking and harassment cases when the victim and perpetrator do not currently have or have never had a family, household, or intimate partner relationship and the victim is under 18 years old, and the perpetrator is over 18 years old. The Sexual Violence Protection Order can be filed in instances of sexual violence when the victim and perpetrator are not intimate partners or family. This could be relationships with strangers, friends, acquaintances, co-workers, and neighbors (Pennsylvania Coalition Against Rape 2017). The process to obtain these orders can be intimidating and difficult for a victim.

Violence and Safety among LGBT Women and Youth

According to the National Intimate Partner and Sexual Violence Survey (NISVS), LGBT individuals in the U.S. were more likely than heterosexual individuals to have experienced intimate partner violence, sexual violence, and stalking (NISVS 2010). The Centers for Disease Control and Prevention issued the first report on Victimization by Sexual Orientation in 2010.

Figure 5.12 illustrates how sexual orientation interacts with reports of intimate partner violence. Among women, bisexual women (61%) reported instances of intimate partner in their lifetime, compared to 44% of lesbian women and 35% of heterosexual women. Among men, bisexual men also had the highest reports of intimate partner violence at 37%, compared to 26% for gay men and 29% for heterosexual men.

Figure 5.12. Intimate Partner Violence & Sexual Orientation, United States, 2010



Source: NISVS: An Overview of 2010 Findings on Victimization by Sexual Orientation

Note: Intimate partner violence includes rape, physical violence, and/or stalking.

Women who identify as bisexual, in particular, are disproportionately affected by intimate partner violence. About 1 in 5 bisexual women have been raped by an intimate partner, compared to 1 in 10 heterosexual women (NISVS 2013). Bisexual women have experienced stalking at a rate more than double the rate for heterosexual women. About 37% of bisexual women have been stalked, compared to 16% of heterosexual women. Thirty-seven percent of bisexual women have also been injured as a consequence of rape, stalking, or physical violence, compared to 16% of heterosexual women (NISVS 2013).

Conclusion

Intimate partner violence and other sexual violence pose a serious threat to public health. The most serious threat is death, of course, but other consequences are serious as well. Intimate partner violence and other sexual violence can cause negative physical health problems, ranging from chronic cardiovascular, gastrointestinal, reproductive, musculoskeletal, and nervous system issues (Centers for Disease Control and Prevention 2017b). There are negative mental health consequences such as depression, and posttraumatic stress disorder. Survivors are also at a greater risk of engaging in risky behaviors such as binge drinking, smoking, and HIV risk behaviors. Ways to reduce and/or stop intimate partner violence and sexual violence include providing education about healthy relationships, promoting societal norms that discourage violence, promoting health sexuality, and encouraging bystanders to speak up when they see something inappropriate.

REPRODUCTIVE RIGHTS & INFANT HEALTH

Introduction

Reproductive health is an important facet of women's health and well-being. Public policy can be a valuable tool to promote women's reproductive health. According to the United Nations' (UN) Committee on the Elimination of Discrimination Against Women (CEDAW), a women's right to health includes her reproductive and sexual health (UN 1995). At the Fourth World Conference on Women in Beijing, the Platform for Action acknowledges the "basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (UN 1995). In the United States, unintended pregnancies can lead to greater levels of poverty, the potential need for public assistance, and poor health outcomes for women and children (Women's Law Project 2018b).

Reproductive Rights Composite Index

The Institute for Women's Policy Research has developed a composite index of reproductive rights, which is composed of several indicators including: (1) access to abortion services without mandatory parental consent or notification laws for minors, (2) public funding for abortion services (if a woman is income eligible), (3) access to abortion services without a mandatory waiting period, (4) the percent of women living in counties with at least one abortion provider, (5) the presence of a pro-choice governor or state legislature, (6) state adoption of the Medicaid expansion under the Affordable Care Act or expanded eligibility for Medicaid expansion family planning services, (7) state mandated insurance policies for coverage of infertility treatments, (8) policies that allow for second parent adoption in same sex couples, and mandatory sex education in public schools. Higher scores indicate more reproductive rights and lead to higher letter grades as well.

In 2015, Pennsylvania's score on the Reproductive Rights Composite Index was 2.53, and its grade was a C. This score put Pennsylvania at the bottom of the middle third of states in regard to women's reproductive rights with a rank of 31. Pennsylvania has a variety of restrictions on abortion and a limited number of abortion providers. Only 53% of women in Pennsylvania lived in a county with an abortion provider in 2011 (Hess et al. 2015). While the governor of Pennsylvania in 2018 is pro-choice, the majority party in the State Senate and House are not.

Access to Abortion

In 1973, the Supreme Court of the United States (SCOTUS) established a legal right to abortion in *Roe v. Wade* that falls under the right to privacy. Before *Roe v. Wade*, it was up to the individual states to allow abortion or not. According to *Roe*, abortion could not be restricted in the first trimester. In the second and third trimesters, however, the state could intervene. Since the *Roe* decision, many states have passed numerous restrictions on abortion. Some restrictions have been upheld by SCOTUS while others have not. In 1989, SCOTUS upheld the

constitutionality of several restrictions of a Missouri law. In *Webster v. Reproductive Health Services*, SCOTUS upheld restrictions on the use of public facilities and/or public funds for abortion unless the woman's life was in danger as well as a viability test of the fetus in the 20th week of pregnancy. In *Planned Parenthood v. Casey* (1992), SCOTUS upheld the constitutionality of informed consent for minors seeking an abortion and a 24-hour waiting period requirement. SCOTUS also created a new standard for judging the constitutionality of state restrictions on abortions called the "undue burden" standard, which means that restrictions are allowable as long as they do not place an undue burden on a woman trying to receive an abortion. In *Gonzales v. Carhart* (2007), SCOTUS upheld the constitutionality of a federal law that specifically bans a late term abortion procedure called dilation and extraction. In *Whole Woman's Health v. Hellerstedt* (2016), SCOTUS ruled that medical benefits must be considered when reviewing the undue burden standard. Since *Roe* was decided in 1973, states have passed 1,142 restrictions on abortion (Guttmacher 2018a).

Below is an overview of abortion related restrictions in the U.S. as of July 1, 2018 (Guttmacher 2018a):

- 27 states have mandatory waiting periods
- 37 states require parental consent or notification for minors
- 18 states require mandatory counseling
- 45 states allow individual health care providers to refuse to participate in abortion procedures
- 42 states allow institutions to refuse to perform abortions
- 11 states prohibit private insurance plans from covering abortion except in cases of life endangerment
- 20 states prohibit "partial-birth" abortion

In 2014, there were 42 facilities that provided abortions in Pennsylvania, and 20 of those were clinics. This was an 11% decline in the number of overall providers from 2011 when there were 47 facilities that provided abortions. In 2014, about 85% of the counties in Pennsylvania had no facilities that provided abortions (Guttmacher 2018a). In 2018, Montgomery County had at least two clinics that offered abortion services.

As of May 1, 2018, the following restrictions on abortion were in effect in Pennsylvania (Guttmacher 2018a):

- mandated counseling and a 24-hour waiting period before a woman can obtain an abortion
- the state health exchange under the ACA only pays for abortion if the woman's life is in jeopardy or in instances of incest or rape
- minors must obtain permission from a guardian or parent
- insurance for public employees does not cover abortion except in cases of incest, rape, and if the woman's life is in danger
- there is no public funding available for abortion except in cases of rape, incest, or life endangerment

- no abortions can be performed at 24 weeks or more after a women’s last menstrual period unless a woman’s life or health is in danger

In 2018, a bill was introduced in the Pennsylvania House of Representatives that would ban and criminalize abortion if a fetal heartbeat is detected (which can be as early as six or seven weeks), but the bill remains in committee (Women’s Law Project 2018a).

In the U.S., 652,639 abortions were reported to the CDC in 2014. The highest abortion rates were for women in their 20s (CDC 2017). In Pennsylvania, there were 30,881 abortions in 2016, and 30.8% of those were performed on women between the ages of 20 and 24 (Pennsylvania Department of Health 2016). The majority of abortions performed in Pennsylvania occurred in four counties: Allegheny, Dauphin, Northampton, and Philadelphia. In Montgomery County, there were 1,649 abortions performed in 2016 (Pennsylvania Department of Health 2016).

The Affordable Care Act and the Future of Contraceptive Coverage

Under the Patient Protection and Affordable Care Act (ACA) of 2010, women’s access to contraceptives was increased. The ACA required health insurance companies to cover contraceptive counseling and all FDA approved methods of contraception with no out-of-pocket expenses. Since the cost of contraception can be prohibitive, this was a great victory for women and for low-income women, in particular. Before the passage of the ACA, contraceptive coverage was widespread but not universal, and there were out-of-pocket expenses. Before implementation of the ACA, approximately 30-44% of women’s out-of-pocket medical expenses were on contraception (Sobel 2017a). Out-of-pocket expenses for all prescriptions were reduced significantly by the ACA, and most of that reduction was related to reduced out-of-pocket expenses for contraception (Sobel 2017a).

Beginning in 2012 when provisions about contraception under the ACA were implemented, the only employers that were exempt from the mandate were classified as a “house of worship” (Sobel et al. 2018). Several nonprofits and some businesses challenged the mandatory contraceptive coverage on religious or moral grounds. Hobby Lobby was a for-profit business that challenged mandatory contraception coverage, arguing that their first amendment rights to free exercise of religion were violated, and the case went to the Supreme Court. In a 5-4 decision, the Court ruled that Hobby Lobby could obtain an exception under the Freedom and Religious Restoration Act since they are a “closely held” corporation (*Burwell v. Hobby Lobby* 2014). Thus, any for-profit corporation that is family owned can refuse to cover women’s contraception if they have sincere religious beliefs that do not support the use of contraception. Under the current ACA regulations post-*Hobby Lobby*, religiously affiliated nonprofits and closely held for-profits are not exempt per say, but can receive an accommodation – meaning that the employer can opt out of paying the costs of contraception. The cost shifts to the insurance company primarily and to the woman in the form of a co-payment.

Since the 2016 election, many of the regulations around contraceptive coverage under the ACA may change, but these new regulations were blocked by the courts during litigation. In October, 2017, the number and types of employers considered to be exempt from the contraceptive mandate increased (HHS 2017). Because the new regulations were issued without the typical notice and comment period per the Administrative Procedure Act, there were four lawsuits filed challenging the regulations under the 1st and 5th amendments. In December 2017, the new regulations were blocked by Pennsylvania and California courts pending outcomes of the litigation (Sobel et al. 2018). If the regulations go into effect, the following types of organizations could refuse contraceptive coverage to women on the basis of “religious beliefs or moral convictions”: publicly traded for-profit companies, nonprofits, and private universities and colleges that provide student health plans. Basically, any employer with a religious or moral objection can claim an exemption and refuse to cover contraception. The accommodations would no longer be required and would be optional. If these new regulations are implemented, employers who are eligible for a federal exception would still have to comply with state law. Thus, the affordability and access to contraception would vary considerably depending on the employer and state in which a woman lives. As of March 2018, nine states do not allow any exemptions to employers: Colorado, Georgia, Iowa, Montana, Nevada, Vermont, Washington, and Wisconsin. Three states allow an exemption for employers with a moral objection: Illinois, Missouri, and West Virginia. The remaining states have narrowly defined exemptions for religious employers such as houses of worship and religious groups (Sobel et al. 2018). In a survey done by the Kaiser Family Foundation and the *Washington Post*, 71% of respondents said that they supported laws that required insurance plans to cover the full cost of birth control (Sobel et al. 2017b).

Title X

Title X is a federally funded family planning program created in 1970 that provides low income women with preventative reproductive health services and affordable contraception. At the time, Title X received bi-partisan support. In 2016, about 4,000 clinics received Title X funding. The program serves approximately 4 million low-income, uninsured women a year (Kaiser Foundation 2018b). Services include pelvic exams, pregnancy testing, contraceptive counseling and services, infertility services, health education, screening for cervical and breast cancer, high blood pressure, anemia, diabetes, sexually transmitted diseases, and HIV/AIDS (Women’s Law Project 2018b). Current regulations stipulate that no Title X funds may be used for abortion services. In May 2018, the current administration issued a new rule that would withhold Title X funding to any healthcare provider that provides abortion services or makes referrals to abortion clinics. The new regulations are being challenged in court by Planned Parenthood and the National Family Planning and Reproductive Health Association for lack of proper rulemaking procedures (Kaiser Foundation 2018b). The case is currently on appeal.

In Pennsylvania, 36% of patients who relied on Title X services used Planned Parenthood in 2017 (Women’s Law Project 2018b). In fact, Pennsylvania had the third largest patient population that qualified for Title X funding in the U.S. The unintended pregnancy rate in Pennsylvania is higher than the national average. About 53% of pregnancies are unintended in

Pennsylvania, but the national average is 45%. If implemented, the new regulations would disproportionately affect low-income women and women of color. About 21% of Title X patients identified as Black or African American, and 32% identified as Hispanic or Latino (Women’s Law Project 2018b).

Emergency Contraception

Emergency contraception (EC) is a secondary form of birth control that can be taken several days after contraceptive failure, unprotected intercourse, or sexual assault. EC is a “concentrated dose of progestin, a hormone found in many birth control pills, which inhibits or delays ovulation” (NCLS 2012). Unlike RU-486 (which induces an abortion), EC will not work if a woman is already pregnant. Depending on the type of EC used, effectiveness rates range from 75% to 99% (for a copper intrauterine device), and it can be taken within 75 to 120 hours after intercourse or inserted within five days after unprotected intercourse in the case of the copper intrauterine device (Kaiser Foundation 2016).

Accessing EC can still be difficult for women. Before 2006, women had to have a prescription to access EC. Between 2006 and 2014, women over 17 could obtain Plan B (a type of EC) and its generic counterpart without a prescription. Women under 17 still needed a prescription. In 2014, the age requirements for EC were removed by the FDA. Some forms of EC such as ella still require a prescription for all women regardless of age. Even though women can access many forms of EC without a prescription, they must pay retail price without a prescription in most states (Kaiser Foundation 2016).

Under the Affordable Care Act (ACA), most private insurance companies are required to cover contraceptive drugs and devices without a co-pay (Kaiser Foundation 2016). This would include the insertion and removal of copper IUDs. Women who receive Medicaid are entitled to family planning services – meaning that any FDA approved contraceptive is approved so long as there is a prescription.

Although there has been progress in accessing emergency contraception, challenges remain. One study has shown that EC is not always stocked consistently and may be in a locked display or behind the counter because of the high cost. American Indian women, in particular, lack consistent access to EC through Indian Health Services (IHS). A study found that 9% of IHS clinics did not stock Plan B; 11% required a prescription, and 72% had an improper age restriction on Plan B (Kaiser Foundation 2016).

Below are laws that expand access to emergency contraception:

- 18 states require hospital emergency rooms to provide information about EC to female victims of sexual assault (Kaiser Foundation 2018)
- 15 states require hospital emergency rooms to dispense EC upon request to sexual assault victims (Kaiser Foundation 2018)
- 7 states allow pharmacists to prescribe EC if they are working with a physician or have had EC training (Kaiser Foundation 2018)

- 4 states require pharmacies or pharmacists to fill valid prescriptions (Guttmacher 2018b)

Below are laws that restrict access to emergency contraception:

- 7 states have laws that allow pharmacies and/or pharmacists to refuse to fill prescriptions for EC on moral or ethical grounds (Kaiser Foundation 2016)
- 2 states exclude EC from their contraceptive coverage mandate (Guttmacher 2018b)
- 1 state excludes EC from the state’s family planning program (Guttmacher 2018b)

In 2008, Pennsylvania adopted an administrative code that requires hospitals to provide “emergency medical care to victims of sexual assault” and “to supply written information about emergency contraception, orally inform victims of the availability of emergency contraception and administration emergency contraception onsite upon the victim’s request” (NCSL 2012). A hospital can claim a moral or religious exemption, but still has to provide written information about EC and must transport a victim who requests EC to a facility that will administer it.

Other Family Planning Policies and Resources

Access to Infertility Treatments

Infertility is a term generally used after a year of regular, unprotected sexual intercourse that does not result in a pregnancy. About 10% of women in the U.S. of childbearing age have received infertility treatments, which can include insemination and hormone therapy in order to increase egg production (NCSL 2018). Assisted reproductive technology is when eggs are fertilized outside of a women’s womb and then put into her uterus through in vitro fertilization (IVF). In 2015, 72,913 babies were born this way (NCSL 2018). Infertility treatments are expensive. For example, one cycle of IVF is estimated to cost between \$12,000 and \$17,000 (NCLS 2018). As of 2018, 15 states have passed laws that either require an insurance provider to cover or to offer coverage for infertility diagnosis and treatment (Table 6.1).

Table 6.1. States with Laws that Require Insurance Providers to Either Cover or Offer Coverage for Infertility Diagnosis & Treatment

Arkansas	Louisiana	New York
California	Maryland	Ohio
Connecticut	Massachusetts	Rhode Island
Hawaii	Montana	Texas
Illinois	New Jersey	West Virginia

Source: National Conference of State Legislatures, *State Laws Related to Insurance Coverage for Infertility Treatments*

California and Texas have laws that require insurance providers to offer coverage for infertility treatment.

Mandatory Sex-Education in Schools

Sex education can help to prevent unplanned pregnancies and to avoid sexually transmitted diseases. As of August 1, 2018, 24 states and the District of Columbia mandated sex education in public schools (Guttmacher 2018c). Of the states that mandate sex education, 13 require that the instruction be medically accurate, 8 require that it must be culturally appropriate, 2 prohibit it from promoting religion, 18 require that information on contraception must be provided, and 12 states require a discussion about sexual orientation (3 of those are negative, while 6 are inclusive). Thirty-seven states require that information on abstinence be provided. Several states also require HIV education in conjunction with sex education or on its own. To that end, 20 states require information on condoms be provided, while 39 states require that abstinence be covered. In Pennsylvania, only HIV education is mandated. Parents must be notified, and there is an opt-out option (Guttmacher 2018c).

Same-Sex Marriage and Second-Parent Adoption

Since the 2015 Supreme Court decision in *Obergefell*, same-sex couples have had the right to marry anywhere in the U.S. and are entitled to same benefits. Historically, same-sex couples were often denied the right to legally adopt children. As a result of *Obergefell*, same-sex couples now have the right to stepparent adoption and joint adoption for married couples (Movement Advancement Project 2018). Some states have provided additional protections against discrimination in fostering and adoption. Nine states have passed nondiscrimination laws on the basis of sexual orientation and/or gender identity. There are ten states, however, that allow a religious exemption – meaning that an agency can refuse to place a child with a same-sex couple or LGBT individual on the basis of religious beliefs (Movement Advancement Project 2018). In Pennsylvania, LGBT individuals comprise 3.6% of the population, and 27% of the LGBT population is raising children. There are no anti-discrimination laws for same sex couples in reference to fostering or adoption in Pennsylvania (Movement Advancement Project 2018).

Fertility, Low Birth Weights, Prenatal Care, and Infant Mortality

Depending on how it is measured, the fertility rate for women reached a historic low of 62 births per 1000 women, aged 15-44 (Martin et al. 2018). This form of measurement is called the general fertility rate, and this was down 1% from 2015. Birth rates (using the general fertility rate) increased for women aged 30 to 34 and decreased for women under the age of 30. The average age of a mother's first birth was 26.6, up from 26.4 in 2015 (Martin et al. 2018).

In 2016, the general fertility rate (ages 15 to 44) was 58.5% in Montgomery County and Pennsylvania (Pennsylvania Department of Health 2016). Table 6.2 shows reported pregnancies in Pennsylvania and Montgomery County by age group and outcome (live birth, fetal death, or induced abortion). There were 174,100 reported pregnancies in Pennsylvania

and 10,610 in Montgomery County during 2014 (Table 6.2). Of those pregnancies, 142,113 resulted in live births in Pennsylvania and 8,845 in Montgomery County. Only 76 pregnancies (less than 1%) resulted in fetal deaths in Montgomery County, and 1,223 (less than 1%) resulted in fetal death in Pennsylvania. There were more pregnancies and live births for 20-29 year olds in Pennsylvania than any other age group, but in Montgomery County, there were more pregnancies and live births among women 30 years or older.

Table 6.2. Reported Pregnancies & Outcomes by Age in Pennsylvania (PA) & Montgomery County, 2014

Age of Woman	Reported Pregnancies		Outcome					
			Live Births		Fetal Deaths		Induced Abortions	
	PA	Montgomery County	PA	Montgomery County	PA	Montgomery County	PA	Montgomery County
All Ages	174,100	10,610	142,113	8,845	1,223	76	30,764	1,689
Under 15	201	7	95	3	1	0	105	4
15-17	3,035	88	2,080	52	27	0	928	36
18-19	8,082	271	5,752	159	63	2	2,267	110
20-29	90,168	4,090	70,814	3,134	589	30	18,765	926
30+	72,243	6,139	63,003	5,482	541	44	8,699	613

Source: Pennsylvania Department of Health, Pennsylvania and County Health Profiles 2016 Report

Table 6.3 shows the number of women with births in the past 12 months in the United States, Pennsylvania, and Montgomery County by age group. In 2016, there were no births in the 15 to 19 age category in Montgomery County, while 2.8% of births fell in that category in Pennsylvania, and 3.8% in the U.S. Most women gave birth between the ages of 20 and 34: 74.2% in the U.S., 74.7% in Pennsylvania, and 70.3% in Montgomery County. The percent of women giving birth aged 35 to 50 was slightly higher in Montgomery County at 29.7%, compared to 22% in the U.S. and 22.5% in Pennsylvania.

Table 6.3. Women with Births in the Past 12 Months in the United States, Pennsylvania, & Montgomery County, 2016

Age	United States		Pennsylvania		Montgomery County	
	Number	Percent	Number	Percent	Number	Percent
15 to 19	148,036	3.8%	4,061	2.8%	0	0.0%
20 to 34	2,930,214	74.2%	108,179	74.7%	6,666	70.3%
35 to 50	868,653	22.0%	32,528	22.5%	2,815	29.7%

Source: U.S. Census Bureau, 2016c, American Community Survey, 1-Year Estimates, Fertility

The number of births by race and ethnicity can be seen in Table 6.4. In 2016, approximately 70% of births were to White women in Pennsylvania and Montgomery County. The percent of babies born to Black women was significant lower in Montgomery County at 9.1%, compared to 13.7% in Pennsylvania. The percent of babies born to Hispanic or Latino women was also lower in Montgomery County at 8.8%, compared to 11% in Pennsylvania.

Table 6.4. Live Births by Race in Pennsylvania & Montgomery County, 2016

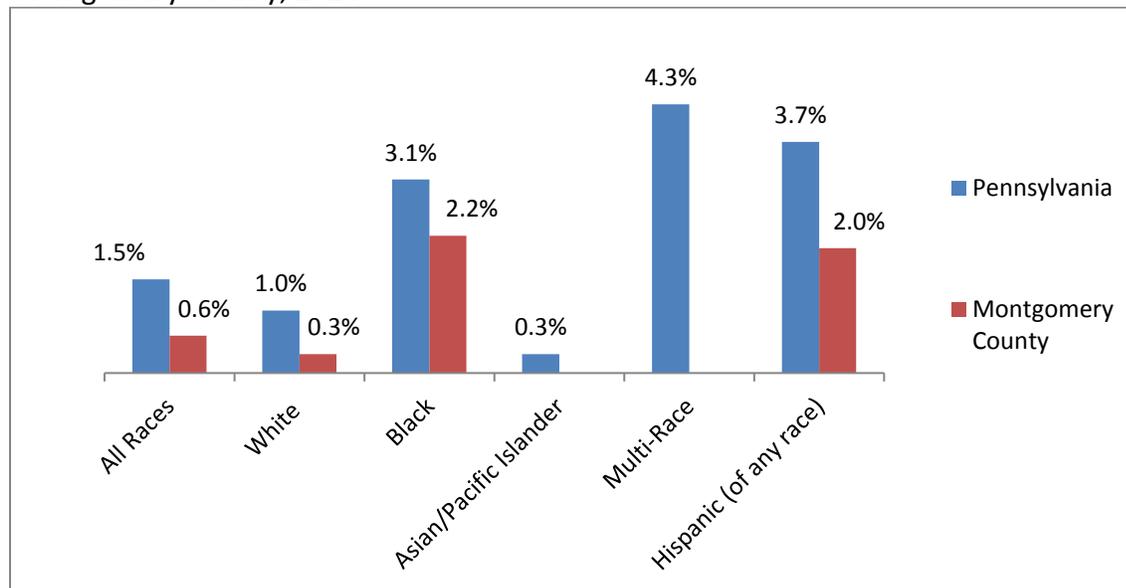
	Pennsylvania		Montgomery County	
	Number	Percent	Number	Percent
All Races	139,356		8,694	
White	97,939	70.3%	6,152	70.8%
Black	19,033	13.7%	789	9.1%
Other	18,838	13.5%	1,637	18.8%
Hispanic	15,323	11.0%	765	8.8%
Unknown	3,546	2.5%	116	1.3%

Source: Pennsylvania Department of Health, Birth Statistics, Division of Health Informatics, Resident Live Births by Age and Race of Mother by Year of Birth

Note: Racial categories were taken directly from the Pennsylvania Department of Health report.

Overall, the percent of births to mothers who are younger than 18 is lower in Montgomery County than in Pennsylvania (Figure 6.1). In 2016, most of these births were to women of a multiracial background (4.3%) in Pennsylvania. In Montgomery County, 2.2% of these births were to Black women and 2.0% were to Hispanic or Latino women. There was not enough data available on all demographic groups in Montgomery County.

Figure 6.1. Percent of Births to Mothers Under 18 by Race & Ethnicity in Pennsylvania & Montgomery County, 2014



Source: Pennsylvania Department of Health, Pennsylvania and County Health Profiles 2016 Report

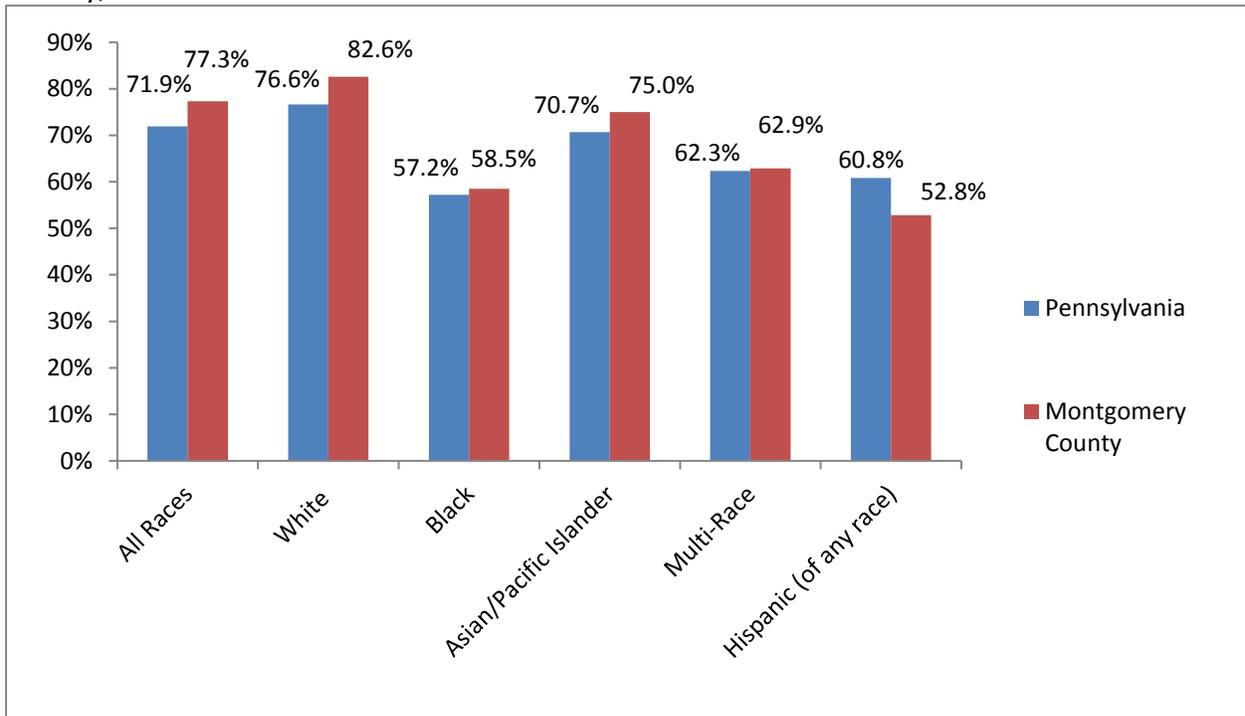
Note: Racial categories were taken directly from the Pennsylvania Department of Health report.

Prenatal Care

From 2012-2016, the percent of mothers with prenatal care in the first trimester was 78.2% in Montgomery County and 72.5% in Pennsylvania (Pennsylvania Department of Health 2016). This is up from 2014 when the percent of mothers with prenatal care in the first trimester was 77.3% in Montgomery County and 71.9% in Pennsylvania (Figure 6.2).

Figure 6.2 also shows the percent of women with prenatal care by race and ethnicity in 2014. White women were the mostly likely to have received prenatal care in Pennsylvania (76.6%) and Montgomery County (82.6%). Only 57.2% of Black or African American women received prenatal care in Pennsylvania during the first trimester, and only 52.8% of Hispanic or Latino women received prenatal care in Montgomery County during the first trimester.

Figure 6.2. Percent of Prenatal Care by Race & Ethnicity in Pennsylvania & Montgomery County, 2014



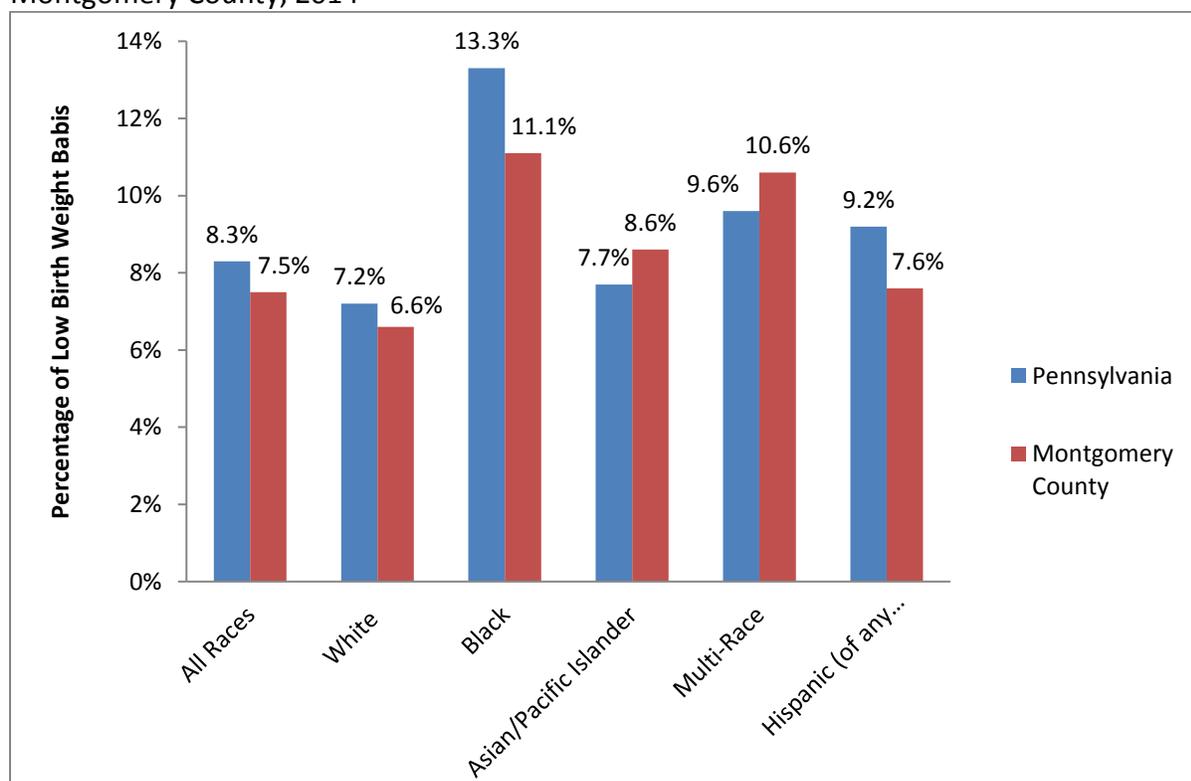
Source: Pennsylvania Department of Health, Pennsylvania and County Health Profiles 2016 Report

Low Birth Weight

In 2016, the low birth weight rate in both the United States and Pennsylvania was 8.2 (CDC 2016). This placed Pennsylvania at a rank of 24th (tied) among the 50 states and Washington DC. Pre-term birth rates were 9.3 in Pennsylvania, slightly less than the national rate of 9.9 (CDC 2016).

From 2012-2016, the percent of low birth births was 8.2 in Pennsylvania and 7.4 in Montgomery County (Pennsylvania Department of Health 2016). Figure 6.3 shows a distribution of low birth weight by race and ethnicity in Pennsylvania and Montgomery County in 2014. The percentage of low birth rates was typically higher in Pennsylvania than Montgomery County, except for those who identified as multiracial or Asian/Pacific Islander. Low birth rates were 10.6% among multiracial women in Montgomery County and 9.6% in Pennsylvania. Low birth rates were most common among Black or African American women in Pennsylvania (13.3%) and Montgomery County (11.1%). In both Pennsylvania and Montgomery County, White women are the least likely to give birth to low birth weight babies at 7.2% and 6.6%, respectively.

Figure 6.3. Percent of Low Birth Weight Babies by Race & Ethnicity in Pennsylvania & Montgomery County, 2014

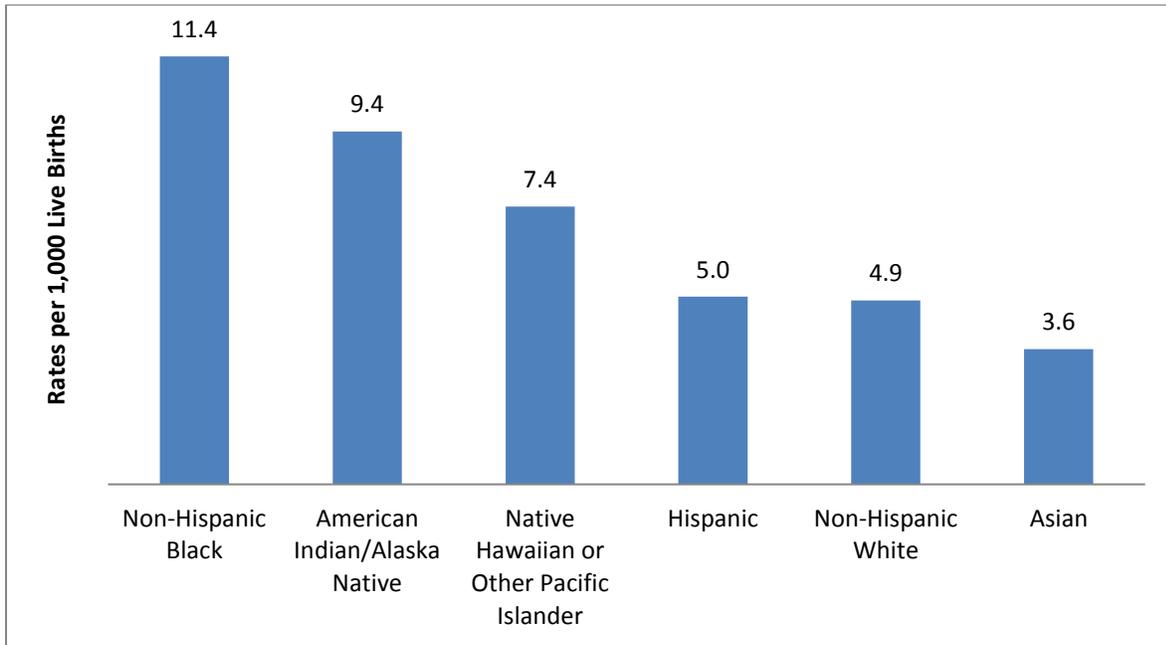


Source: Pennsylvania Department of Health, Pennsylvania and County Health Profiles 2016 Report

Infant Mortality

The infant mortality rate refers to the number of infant deaths per 1,000 live births. In 2016, the infant mortality rate was 5.9 in the United States and was higher at 6.1 in Pennsylvania (CDC 2016). Figure 6.4 shows infant mortality rates by race and ethnicity in the U.S. Infant mortality rates were highest among Black or African women (11.4) and lowest among Asian women (3.6).

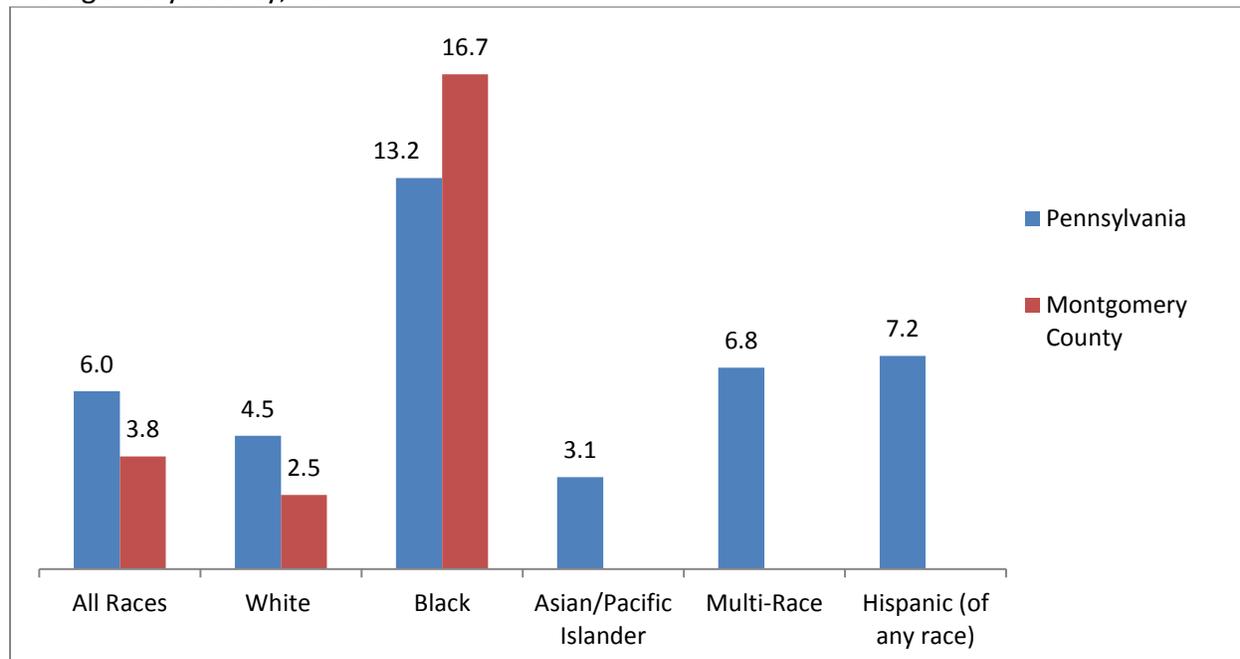
Figure 6.4. Infant Mortality Rate (per 1,000 Live Births) by Race & Ethnicity in the United States, 2016



Source: Center for Disease Control and Prevention, *Infant Mortality Rates, 2016*

Infant mortality rates for Black women were higher in Pennsylvania and Montgomery County than in the U.S. Infant mortality rates for Black women were 11.4 in the U.S., 13.2 in Pennsylvania, and 16.7 in Montgomery County (Figure 6.5). For White women, infant mortality rates were lower in Pennsylvania and Montgomery County than the U.S. Not enough data was available on other racial groups in Montgomery County.

Figure 6.5. Infant Mortality Rate (per1,000 Live Births) by Race & Ethnicity in Pennsylvania & Montgomery County, 2014



Source: Pennsylvania Department of Health, Pennsylvania and County Health Profiles 2016 Report

Note: There is enough data available for the following racial/ethnic groups in Montgomery County: Asian/Pacific Islander, Multi-Race, and Hispanic (of any race).

Conclusion

Birth rates in the U.S. are down. Women are waiting until they are older to have children and are having fewer children. Even though infant mortality rates have improved overall, women of color have considerably higher infant mortality rates than White women. Women of color are also less likely to have access to prenatal care during the first trimester. In Montgomery County, infant mortality among Black women is concerning as the rate is much higher than other racial groups and considerably higher than national and state averages.

Although the United States has made considerable progress in terms of women’s reproductive rights over the years, women’s reproductive rights are under siege in 2018. Under the Affordable Care Act (ACA), women’s access and use of contraception increased, but expanded access to contraception is currently being threatened by the proposed expansion of exemptions granted on the basis of religious and moral objections by any employer – religious or not. Title X funding that provides reproductive health care to low-income women received bipartisan support in 1970, but it is also being threatened in the current political climate. Proposed rule changes would withhold Title X funds to any healthcare provider that provides abortion or abortion referral services. In 2015, 60% of women used health care providers funded by Title X as their usual healthcare provider (Women’s Law Project 2018b). Access to emergency contraception and abortion is also being restricted on a state-by-state basis.

POLITICAL PARTICIPATION

Introduction

Historically, women have not been as active in public life as men. Women did not even receive the right to vote until 1920 with the passage of the 19th amendment, so it is no wonder that women's political participation has lagged behind men's in the United States. However, women's political participation in the form of voting has increased considerably since women received the right to vote, and women currently vote at greater rates than men. Unfortunately, women are severely underrepresented in elected office at all levels: federal, state, and local. In 2018, only 20% of the U.S. Congress was comprised of women, and only 7.1% of Congress was made up of women of color. The main reason for women's lack of representation currently is because women are less likely to express an interest in running for political office than men, which is related to gender socialization and gender stereotypes. In fact, women's perceptions about running for office often hold them back (Fox and Lawless 2011). Women tend to think that they will lose an election even though they are just as likely as men to win. Despite the fact that women who run for office face numerous stereotypes in experiments about vote choice (Huddy and Terkildsen 1993), women are just as likely to win elections as men in the real world (Dolan 2014). Further, women tend to think that they cannot raise enough money even though they are just as successful as men at fundraising. Women also tend to underestimate their qualifications for elected office and are less likely than men to be asked to run for office.

Political Participation Composite Index

The Political Participation Composite Index, created by the Institute for Women's Policy Research (IWPR), consists of four different elements: percent of women registered to vote, percent of women who voted, a composite score of women in elected office, and an index that measures women's institutional resources (Hess et al. 2015). The composite score of women in elected office is comprised of the proportion of women holding office at the following levels: state representatives, state senators, statewide elected executive officials and U.S. representatives, and U.S. senators and governors (Hess et al. 2015). Women's institutional resources are measured with an index, and this index is comprised of a commission for women (created by executive order or legislation), a campaign training program for women, a women's political action committee, and a state chapter of the National Women's Political Caucus (NWPC). The IWPR then ranked all states and the District of Columbia (DC) on the basis of the Political Participation Composite Index. Scores ranged from a low of -8.12 to a high of 14.40. New Hampshire received the high score for women's political participation, while Utah received the low score.

According to IWPR, Pennsylvania ranked 45th out of all the states in 2015 (Table 7.1). This put Pennsylvania in the bottom third of states in terms of women's political participation. The IWPR gave Pennsylvania a composite score of -5.29 and a letter grade of a D-. Of the components that made up the composite score, Pennsylvania scored the lowest on the number

of women in elected office, with a rank of 48. Pennsylvania scored the highest in terms of women’s institutional resources, where it ranked 11th.

Table 7.1. Women's Status on the Political Participation Composite Index and Its Components, Pennsylvania, 2015

	Composite Score			Women In Elected Office Index		Percent of Women Registered to Vote, 2010/2012 Average		Percent of Women Who Voted, 2010/2012 Average		Women's Institutional Resources Index	
	Score	Rank	Grade	Score	Rank	Percent	Rank	Percent	Rank	Score	Rank
Pennsylvania	-5.29	45	D-	1.02	48	66.9%	27	51.4%	32	1.5	11

Source: Hess et al. 2015, *Status of Women in the States*, Institute for Women's Policy Research

Voter Registration and Turnout in the United States and Pennsylvania

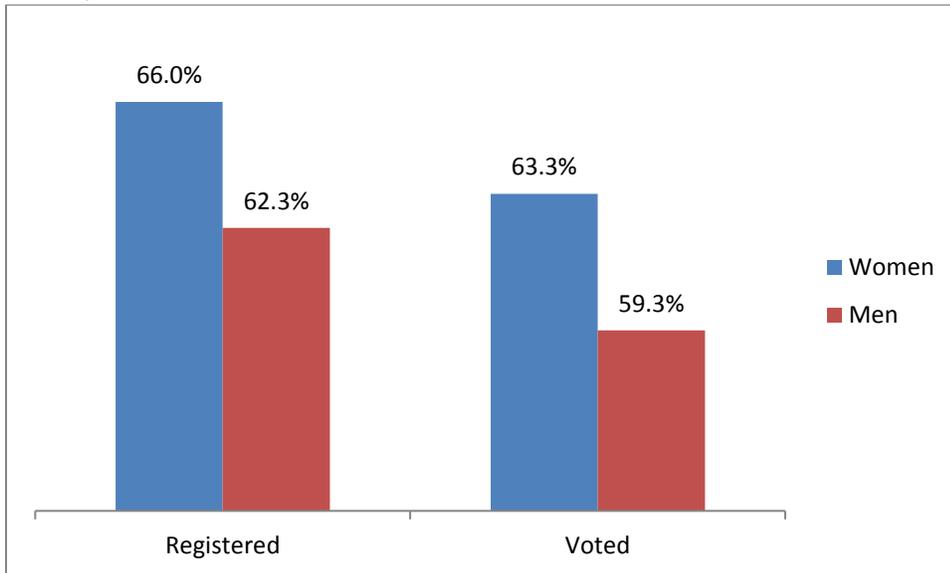
In the November election of 2016, 70.3% of U.S. citizens were registered to vote, and 61.4% turned out to vote. Age, gender, race, ethnicity, and education all influence the likelihood of voting. For example, older individuals are more likely to vote than younger individuals. In 2016, 43% of 18 to 24 year olds voted, compared to 70.9% of people over 65 years old (U.S. Census Bureau 2017a). Women are also more likely to vote. In 2016, 63.3% of women voted, compared to 59.3% of men. Education is also correlated with voting. In 2016, only 34.3% of people who did not earn a high school diploma voted, compared to 76.3% for those who earned a bachelor’s degree. Race and ethnicity also impact the likelihood of voting. The voting rate was highest among non-Hispanic Whites at 65.3%, compared to 59.4% for Blacks, and 47.6% for Hispanics (U.S. Census Bureau 2017a).

In Pennsylvania, 72% of citizens were registered to vote, and 62.6% turned out to vote (U.S. Census Bureau 2017b). Young people were more likely to vote in Pennsylvania than in the U.S., with 51.4% of 18 to 24 year olds voting (compared to 43% at the national level). Only 31% of those who did not complete high school voted, compared to 76.8% of those who earned a bachelor’s degree. In 2016, 63% of Whites and Blacks voted in Pennsylvania, compared to 52% of Hispanics (U.S. Census Bureau 2017b).

Voter Registration, Voter Turnout, and Gender in the United States and Pennsylvania

Figure 7.1 shows the percent of women and men registered to vote and then the percentage that voted in the United States during the 2016 Presidential election. Voter registration rates are higher among women. In 2016, 66% of women registered to vote in the U.S., compared to 62.3% of men. Voter turnout rates were higher among women as well. While 63.3% of women turned out to vote, 59.3% of men did.

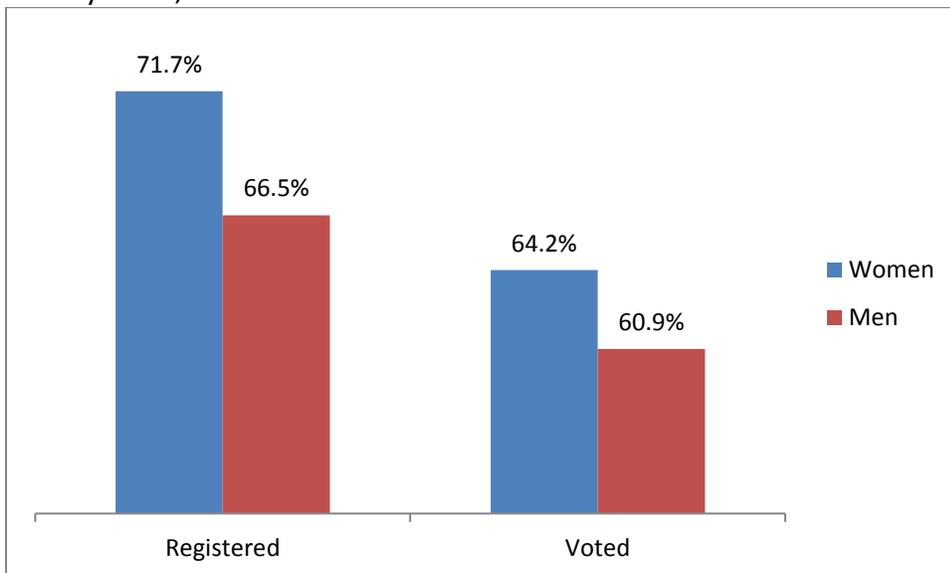
Table 7.1. Voter Registration & Turnout by Gender for the November 2016 Election, United States, 2016



Source: U.S. Census Bureau, Current Population Survey, November 2016

Trends for voter registration and turnout were similar in Pennsylvania (Figure 7.2), but even more exaggerated because registration rates, in particular, were higher in Pennsylvania than in the U.S. In 2016, 71.7% of women in Pennsylvania were registered to vote, compared to 66.5% of men. Voter turnout rates were more similar to national trends. While 64.2% of women voted in 2016, 60.9% of men did.

Table 7.2. Voter Registration & Turnout by Gender for the November 2016 Election, Pennsylvania, 2016

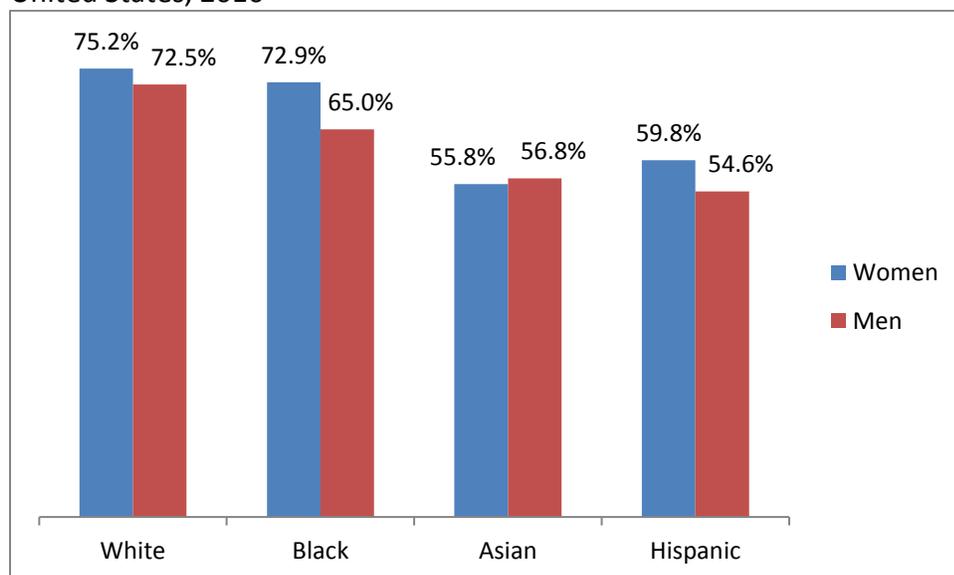


Source: U.S. Census Bureau, Current Population Survey, November 2016

Voter Registration and Voter Turnout by Gender, Race, & Ethnicity in the United States

Voting is also influenced by demographic characteristics such as race and ethnicity in addition to gender (Figure 7.3). Non-Hispanic Whites are most likely to be registered to vote. Overall, voter registration rates were noticeably higher among White and Black women and men, compared to Asian and Hispanic women and men. In 2016, 75.2% of White women and 72.5% of White men were registered to vote. Voter registration rates were 72.9% among Black women and 65% among Black men. While 59.8% of Hispanic women were registered to vote, 54.6% of Hispanic men were. Among women, Asians had the lowest voter registration rates at 55.8% and the smallest difference between male and female registration rates. Asian American men were registered at a similar rate of 56.8%.

Table 7.3. Voter Registration by Gender & Race/Ethnicity for the November 2016 Election, United States, 2016

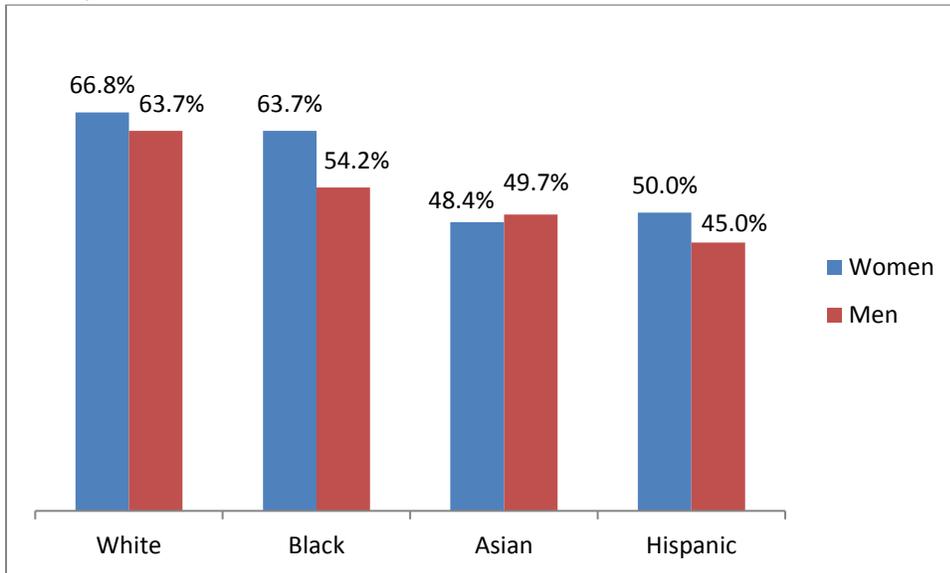


Source: U.S. Census Bureau, Current Population Survey, November 2016

Note: Percentages represent totals for 18 years and older. Racial categories are non-Hispanic White Alone, Black Alone, Asian Alone, and Hispanic.

Voter turnout rates demonstrate a similar trend as registration rates, but it is less pronounced. In 2016, voter turnout was higher among White and Black women and men than among Hispanic and Asian women and men (Figure 7.4). Voter turnout rates were highest among White women at 66.8%. White men and Black women turned out to vote at the same rate, 63.7%, while 54% of Black men turned out to vote. Hispanic women were slightly more likely to vote at 50% than Asian men at 49.7%. Voter turnout among Asian women was the lowest among women and similar to that of Asian men at 48.4%. Hispanic men were the least likely to vote, with only 45% turning out to vote.

Table 7.4. Voter Turnout by Gender & Race/Ethnicity for the November 2016 Election, United States, 2016



Source: U.S. Census Bureau, Current Population Survey, November 2016

Note: Percentages represent totals for 18 years and older. Racial categories are non-Hispanic White Alone, Black Alone, Asian Alone, and Hispanic.

Women in Elected Office in the United States & Pennsylvania

Table 7.2 shows the number and percent of women in elected office in the U.S. Congress, statewide executive offices, and state legislatures prior to the November 2018 election. In 2018, 20% of the U.S. Congress was comprised of women, and 7.1% of Congress was made up of women of color. Women made up 23% of the U.S. Senate and 19.3% of the House of Representatives. Women of color made up 4% of the Senate and 7.8% of the House. There were no female Congressional representatives or senators from Pennsylvania prior to the November 2018 election, and it was 1 of only 12 states with no female members of Congress in 2018 (Center for American Women and Politics 2018). Pennsylvania has never had a female senator, but has had seven Representatives.

In 2018, women made up 23.4% of all elected statewide executive offices, and 2.6% of those offices were comprised of women of color (Table 7.2). In Pennsylvania, women did not hold any elected statewide executive offices. Historically, 10 women have served in statewide elective executive positions in Pennsylvania (Center for American Women and Politics 2018). Pennsylvania has never had a female governor and is 1 of 23 states that have never had a female governor.

Table 7.2. Women in U.S. Congress, Statewide Elected Executive Office, & State Legislatures, United States & Pennsylvania, 2018

	Women in U.S. Congress		Women in Pennsylvania Congressional Delegation	
	Number	Percent	Number	Percent
U.S. Congress (Total)	107/535	20.0%	0	0%
Women of Color	38	7.1%	0	0%
U.S. Senate	23/100	23.0%	0	0%
Women of Color	4	4.0%	0	0%
U.S. House of Representatives	84/435	19.3%	0	0%
Women of Color	34	7.8%	0	0%

	Women in All Statewide Executive Offices		Women in PA Statewide Executive Offices	
Statewide Executive Office (Elected)	73/312	23.4%	0/5	0%
Women of Color	8	2.6%	0	0.0%

	Women in All State Legislatures		Women in Pennsylvania State Legislature	
State Legislatures (Total)	1,874/7,383	25.4%	48/253	19.0%
Women of Color (Total)	456	6.2%	1	0.004%
State Senate	450/1,972	22.8%	7/50	14.0%
Women of Color	111	5.6%	0	0.0%
State House of Representatives	1,424/5,411	26.3%	41/203	20.2%
Women of Color	345	6.3%	1	0.005%
State Legislative Leaders (Total)	70	-	0	0.0%

Source: Compiled from Center for American Women in Politics 2018, National Conference of State Legislatures 2018b, Pennsylvania State Senate 2018, and Pennsylvania House of Representatives 2018.

Note: State legislative leaders include Speaker of the House, President of the Senate, Speaker Pro Tem, Majority Leader, or Minority Leader. These statistics were compiled prior to the November 2018 election.

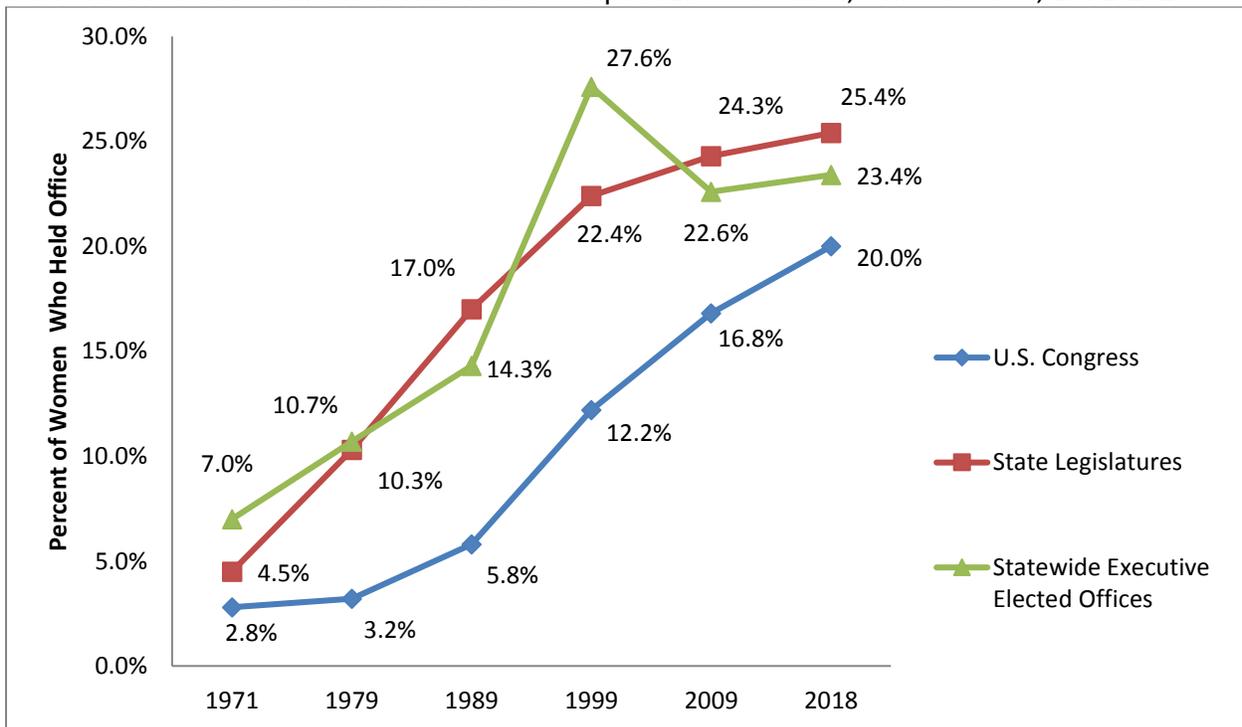
Almost one-fourth (25.4%) of state legislatures were comprised of women in 2018 (Table 7.5). Women of color made up 6.2% of state legislative offices. Women made up 22.8% of state senators. Women were best represented in state houses at 26.3%. Women of color made up 5.6% of state senators and 6.3% of state house representatives. There were 70 women in positions of leadership in state legislatures nationwide.

In Pennsylvania, women made up 19% of the state legislature in 2018 prior to the November election (Table 7.5). Women made up 14% of the State Senate and 20.2% of the House. There

were no women of color in the State Senate and only one woman of color in the State House. There were also no women in leadership positions in the Pennsylvania General Assembly. The Center for Women and American Politics ranked Pennsylvania 37th out of 50 states in terms of the proportion of women in state legislatures in 2018.

Figure 7.5 shows how the percent of women who have occupied elected office has changed over time. Women have gradually won more seats in U.S. Congress and statewide legislatures, but the progress in statewide legislatures was more rapid than that of Congress. In 1971, 2.8% of Congress, 4.5% of state legislatures, and 7% of statewide elected executive offices were made up of women. Women’s representation in state legislatures reached its height in 2018 at 25.4%. Women’s representation in state legislatures increased more rapidly, but has stalled since 2009. From 2009 to 2018, women’s share of seats in state legislatures has only varied about one percentage point. Women’s representation in Congress was slow in the 1980s and 1990s, but picked up considerably in the 1990s and early 2000s. Progress for women in statewide elected executive positions has been more sporadic over time, but was higher at 7% than representation in Congress or state legislatures in 1971. Women’s representation in statewide elected executive offices reached its height in 2000, but dropped off to 22.6% in 2009 and then rebounded somewhat to 23.4% in 2018.

Table 7.5. Percent of Women Who Have Occupied Elected Office, United States, 1971-2018



Source: Compiled by author from the Center for American Women and Politics
 Note: The first year that there is data for all three types of elected office is 1971.

Women in Elected Office: Montgomery County

Prior to the November 2018 election, there were no women from Montgomery County serving in the Pennsylvania State Senate. This is considerably lower than women’s overall representation in the state senate, which is 14% (Table 7.3). Of the 18 state representatives that have jurisdiction in Montgomery County, 5 (27.8%) are women. This is actually higher than women’s representation as a whole in the state house, which is 20.2%.

There is one female Montgomery County Commissioner, which means women’s representation is 33.3% (Table 7.3). Women also make up 33.3% of the Montgomery County Row offices, which are comprised of the Controller, Clerk of Courts, Coroner, District Attorney, Prothonotary, Recorder of Deeds, Register of Wills, Sheriff, and Treasurer.

Table 7.3. Women in Elected Office, Montgomery County, 2018

Montgomery County Elected Officials in the Pennsylvania General Assembly	Number	Percent
Pennsylvania State Senate	0/6	0.0%
Pennsylvania House of Representatives	5/18	27.8%

Montgomery County Elected Officials	Number	Percent
County Commissioners	1/3	33.3%
County Row Offices	3/9	33.3%

Municipal Elected Governing Bodies in Montgomery County	Number	Percent
Mayor	4/24	16.7%
President/Chair of Board/Council	10/61	16.4%
Commissioner/Council Member/Supervisor	113/377	30.0%

Source: Compilation from the Montgomery County website and all municipality websites in Montgomery County

Note: Green Lane Borough did not have a website, so the composition of the council is unknown. These statistics were compiled prior to the November 2018 election.

There are 61 municipalities in Montgomery County. Each municipality has a governing body. The types of governing bodies include a Board of Supervisors, a Board of Commissioners, or a Council. There are 377 total seats on these governing bodies, and women occupy 113 (30%) of those seats. The leader of the governing body is called a president or chair. Women comprise 16.4% (10) of those chair or president positions. There are 24 boroughs in Montgomery County that have mayors. Women make up 16.7% (4) of mayors in boroughs across the county.

Women's Institutional Resources

In terms of women's institutional resources, the Institute for Women's Policy Research (IWPR) ranked Pennsylvania 11th with several other states. Pennsylvania had three of the four indicators that composed the women's institutional resource index: campaign training for women, women's political action committees, and a women's commission. Pennsylvania did not have the fourth indicator measured by the IWPR, a national women's political caucus state chapter.

Because women are less likely to run for political office, having access to institutional resources can help women to run for office. Such programs work to prepare women for political campaigns and to serve a networking function to connect them to other women. Campaign training is critical for increasing women's pipeline to political office and for encouraging women to run for office in the first place.

The Governor of Pennsylvania created a statewide Commission for Women by executive order in 2017 (Table 7.4). The Commission is responsible for advising the Governor about legislation and policies that affect women. It also supports economic and civic opportunities for women, encourages mentoring programs for girls and young women, identifies opportunities and programs that benefit and advance women, and serves as a resource for all women in Pennsylvania (Pennsylvania Commission for Women, n.d.). One State Representative from Montgomery County serves as a member of the Women's Commission.

Montgomery County also has a Commission on Women and Families created by the Montgomery County Commissioners (Table 7.4). The Commission is composed of 13-26 members who serve a four-year term. Members may be reappointed for an additional term. The goals of the Commission are "to foster leadership, provide awareness of existing series, promote the development of resources and advocate equal access to such resources in order to enhance the lives of women and families" (Commission on Women and Families n.d.).

In Pennsylvania, there are 19 different statewide resources for leadership and campaign training, but not all of these are targeted specifically to women. Table 7.4 shows the campaign and leadership training programs available specifically to women in Pennsylvania.

There are five campaign programs designed specifically for women: Emerge Pennsylvania, Ready to Run Northeastern Pennsylvania, Ready to Run Pennsylvania, She Can Win, and the Anne Anstine Excellence in Public Service Series. Three of these are nonpartisan, while one caters to Republicans, and the other caters to Democrats (CAWP, n.d.). Emerge Pennsylvania is the state affiliate of Emerge America, which recruits and trains Democratic women for elected office across the state of Pennsylvania. Each state has autonomy over its local training program. Emerge Pennsylvania has a six-month training program designed to prepare women to run for office (Emerge Pennsylvania, n.d.). One of the co-founders of Emerge Pennsylvania is a state representative, who serves part of Montgomery County, and one of the board members is the assistant director of the Montgomery County Democratic Committee (Emerge

Pennsylvania, n.d). The Anne Anstine Excellence in Public Service Series is an annual nine month training leadership program for Republican women across Pennsylvania. It is designed to engage more women in the Republican Party as voters, donors, and leaders and to prepare women to become party leaders, community leaders, and elected or appointed officials (Anne Anstine Excellence in Public Service Series, n.d.). Ready to Run Pennsylvania is a part of the Ready to Run National Training Network, sponsored by the Center for Women and American Politics and Rutgers University. It is a nonpartisan training program to prepare women to run for office. There are several affiliated programs, including Ready to Run Northeastern Pennsylvania at the University of Scranton. Although Ready to Run Pennsylvania is based at Chatham University in Pittsburgh, there are programs in both Pittsburgh and Philadelphia (Ready to Run, n.d.). She Can Win is a nonpartisan organization founded in 2013 by a woman from Pennsylvania, and it works to elect women at the local, state, and federal level. It promotes women in civic leadership through training, mentorship, and professional development programs (She Can Win, n.d.).

There are two leadership training programs for women in Pennsylvania, both nonpartisan: New Leadership Pennsylvania and Women in Leadership program. New Leadership Pennsylvania is a week-long residential leadership program held at Chatham University in Pittsburgh for young women. The Women in Leadership program is a 12-week, part-time leadership training program offered in the evenings in southwestern Pennsylvania (CAWP, n.d.).

There are two political action committees (PACs) that financially support women candidates: Represent! PAC and Women for the Future of Pittsburgh. Represent! PAC is a political action committee founded in 2014 and based in Philadelphia, which raises money from women donors and fundraisers in order to financially support the campaigns of progressive women candidates across Pennsylvania (Represent!, n.d). Women for the Future of Pittsburgh also fundraises for progressive women candidates, but in Western Pennsylvania specifically (Women for the Future of Pittsburgh, n.d).

Table 7.4. Political & Leadership Resources for Women in Pennsylvania & Montgomery County

Women's Commissions

Pennsylvania Commission for Women

Montgomery County Commission on Women and Families

Campaign Training for Women

Emerge Pennsylvania

Ready to Run Northeastern Pennsylvania

Ready to Run Pennsylvania

She Can Win

The Anne Anstine Excellence in Public Service Series

Leadership Training for Women

New Leadership Pennsylvania
Women in Leadership Program

Women's PACs

Represent! PAC
Women for the Future of Pittsburgh

Organizations for Political Parity

Pennsylvania Center for Women & Politics at Chatham University
Pennsylvania Federation of Democratic Women
Pennsylvania Federation of Republican Women
Pennsylvania NOW

Source: Center for American Women and Politics

Four organizations work towards gender parity in politics in general: Pennsylvania Center for Women and Politics at Chatham University, Pennsylvania Federation of Democratic Women, Pennsylvania Federation of Republican Women, and Pennsylvania National Organizations for Women (NOW). The Pennsylvania Center for Women and Politics is housed at Chatham University in Pittsburgh and is a nonpartisan organization that supports women's leadership in public service through education and empowerment (Pennsylvania Center for Women and Politics, n.d.). Both the Pennsylvania Federation of Democratic Women and the Pennsylvania Federation of Republican Women encourage women to run in their respective political parties. Pennsylvania NOW's mission is to achieve gender equality, not only in elected office, but in public policy as well.

Conclusion

Having active or even symbolic representation is critical in a democracy, which is why it is so important that women occupy elected political offices. Even though women of color are grossly underrepresented as candidates and officeholders, there were some important political wins for them in 2016. Black women did particularly well in state legislatures and actually represented the net increase of women in state legislatures from 2016 to 2017 (Higher Heights 2017).

Although women have made great progress in registering to vote and turning out to vote, they have had less success in elected office. Part of that is due to women's own reluctance to run for office, which is influenced by gendered expectations at home and work. There are more institutional resources than ever for women, but the access to these resources varies according to geographic region. Typically, there are more of these resources present in the Northeast and West than in the South and Midwest.

In Montgomery County, women occupy one-third of the County Row Offices and one-third of the County Commissioners. Women have also had some success in Montgomery County at the local level in elected municipal offices such as supervisor or council member where women represented 30% of the seats on these elected bodies. Women have had less success with mayoral representation, where they only make up 16.7% of positions. Women also only make up 16.4% of council or board presidents or chairs.

WOMEN VETERANS

Introduction

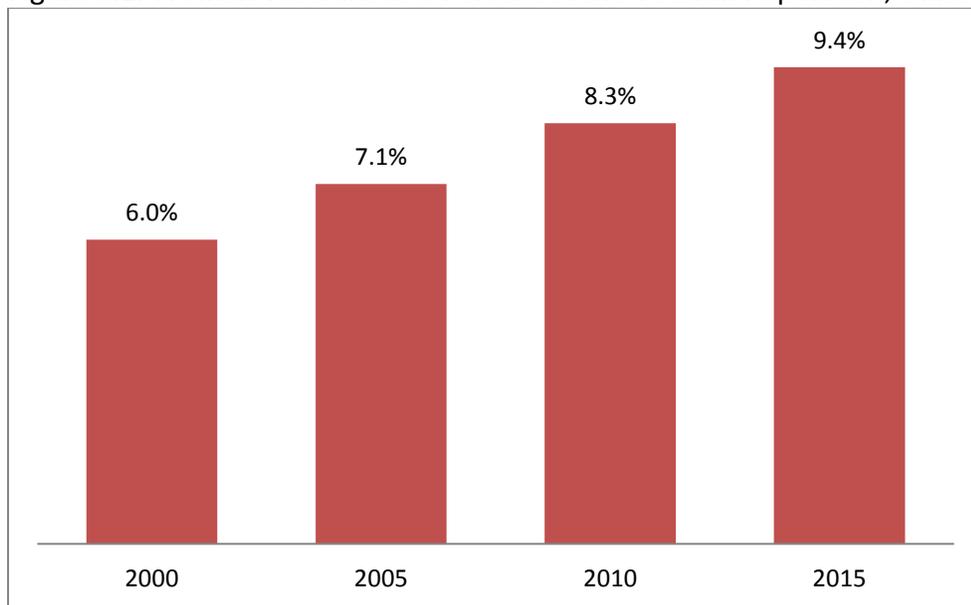
Although women have served unofficially in the U.S. military since its inception, women have been an official part of the U.S. military since 1901 with the creation of the Army Nurse Corps. In 1948, Congress passed the Women's Armed Services Integration Act, which allowed women to serve as permanent members of all military branches including the Army, Navy, Marine Corps, and Air Force (National Center for Veteran Analytics and Statistics 2017). The law limited women to 2% of the enlisted force and 10% of officers. In 1967, the limit was repealed. When military conscription and the draft were ended in 1973, the opportunities for women to serve in the military increased. In 2014, women comprised 16.5% of those in both active and reserve duty in the armed forces and the National Guard (National Center for Veteran Analysis and Statistics 2017).

Women as Veterans

Historically, women have not always been recognized officially as veterans, meaning they were denied benefits that veterans received such as the G.I. Bill and health care. Veterans eligible for the G.I. Bill received a variety of benefits including financial support for education and vocational training, unemployment compensation, and home and business loans. It was not until the late 1970s and early 1980s when women who served in World War II would be granted official veteran status. In the 1980s and 1990s, the federal government performed studies to find out how they could serve women veterans better. In 1983, the Advisory Committee on Women Veterans was formed to ascertain the needs of women veterans. In 1994, Congress approved the Center for Women Veterans to supervise Veteran Affairs (VA) health care administration for women. In 2000, the VA provided funding to support programs specifically for homeless women veterans (National Center for Veterans Analysis and Statistics 2017).

In 2015, women veterans constituted 9.4% of the veteran population (Figure 8.1), and that is expected to increase to 16.3% by 2042. While the number of women veterans is projected to increase, the overall number of veterans is projected to decrease (National Center for Veterans Analysis and Statistics 2017).

Figure 8.1. Women Veterans as a Percent of the Veteran Population, United States, 2015



Source: National Center for Veterans Analysis and Statistics, 2018

Most women veterans who are alive today served post-9/11. About 27.7% of women veterans served during Gulf War 2, and 27.6% served during peacetime. In 2011, 9% of women veterans had served as an officer, compared to 6% of men (Women’s Bureau 2014).

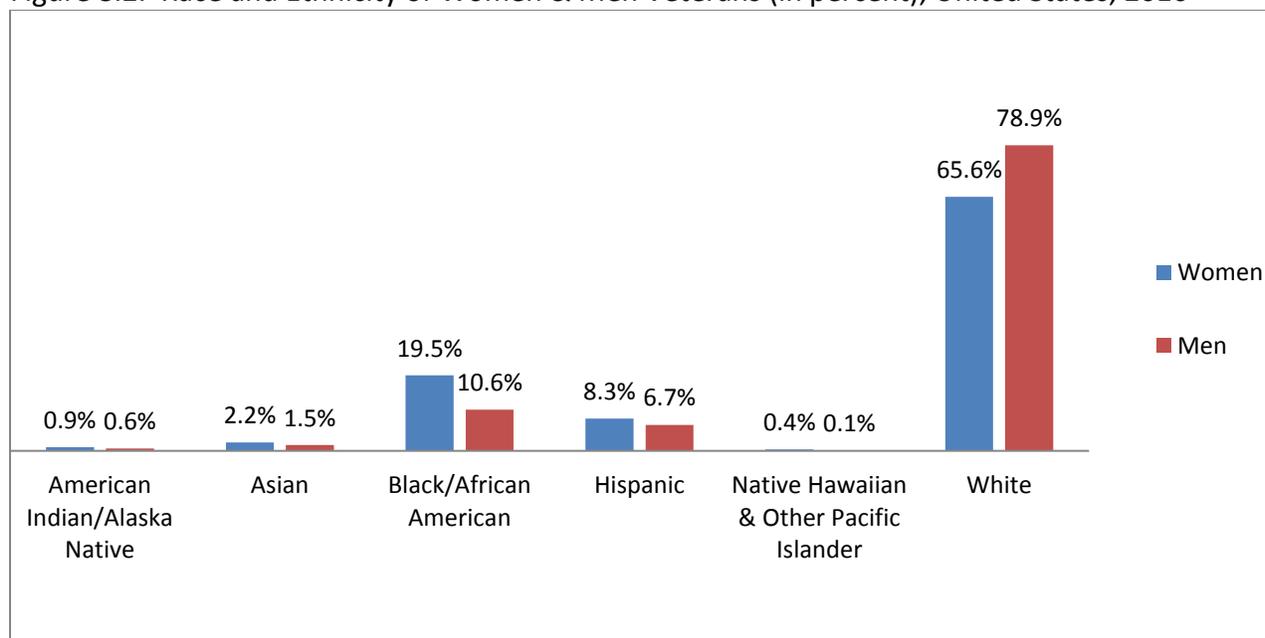
Age

Women veterans are more likely to be younger than male veterans and older than their female nonveteran counterparts. In 2016, the median age for women veterans was 50, compared to 65 for men veterans (National Center for Veterans Analysis and Statistics 2018). In 2016, the median age was 47 for nonveteran women and 41 for nonveteran men (National Center for Veterans Analysis and Statistics).

Race and Ethnicity

Women veterans are more racially and ethnically diverse than men veterans. As Figure 8.2 shows, 78.9% of male veterans are White compared to 65.6% of women veterans in 2016. In every other racial or ethnic group, the percent of women was higher in comparison to men. For example, Black women comprised 19.5% of women veterans (Figure 8.2). In comparison, Black men made up 10.6% of male veterans. Hispanic women veterans comprised 8.3% of female veterans in comparison to Hispanic men, who made up 6.7% of male veterans. Asian women were 2.2% of the female veteran population in comparison to Asian men who were 1.5% of the male veteran population. American Indian/Alaska Native women were only .9% of women veterans, but this was still slightly higher than American Indian/Alaska men, who were only .6% of the male veteran population.

Figure 8.2. Race and Ethnicity of Women & Men Veterans (in percent), United States, 2016



Source: National Center for Veterans Analysis and Statistics, 2018

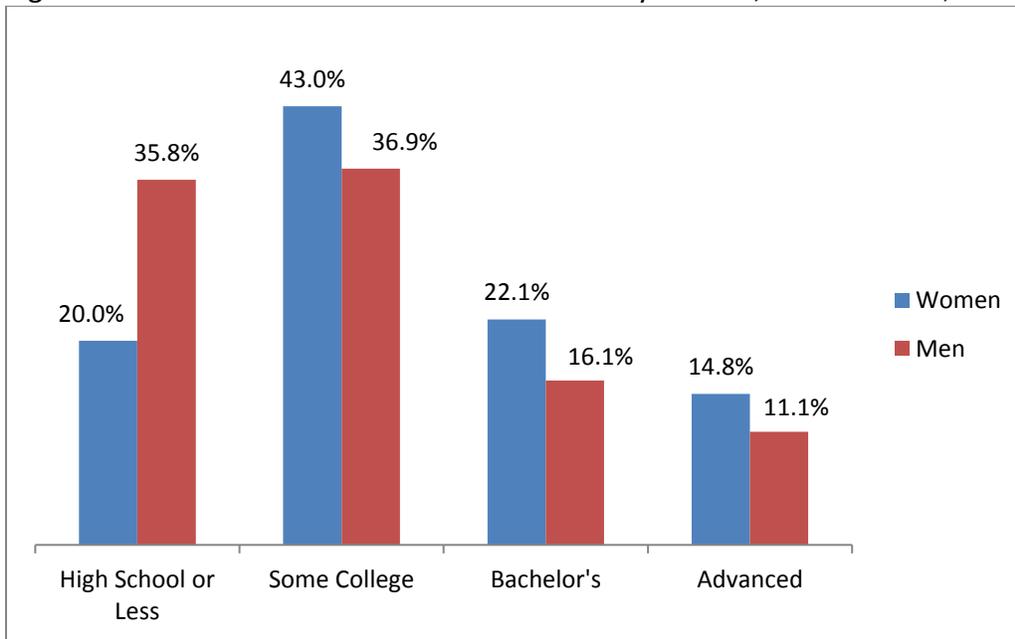
Note: Race categories are shown for the non-Hispanic population. Hispanics can be of any race.

Although not shown in Figure 8.2, Black women and White women are the most overrepresented as women veterans when compared to their demographics in the larger population, but American Indian/Alaska Native women and Native Hawaiian/Pacific Islander women are also overrepresented in comparison to their representation in the larger population. Hispanic and Asian women are the only two demographic groups that are underrepresented as women veterans in comparison to their representation in the population as a whole (National Center for Veterans Analysis and Statistics 2017).

Education

As with the general population, women's educational attainment is higher than men's in the military. In 2016, women veterans were more likely to have completed some college or to have earned a bachelor's or master's degree. Of veterans who had attended some college, 43% were women, and 36.9% were men (Figure 8.3). About 22.1% of women veterans had earned bachelor's degrees compared to 16.1% of men. The smallest difference was in earning advanced degrees – 14.8% of women veterans earned master's degrees compared to 11.1% of men.

Figure 8.3. Educational Attainment of Veterans by Gender, United States, 2016



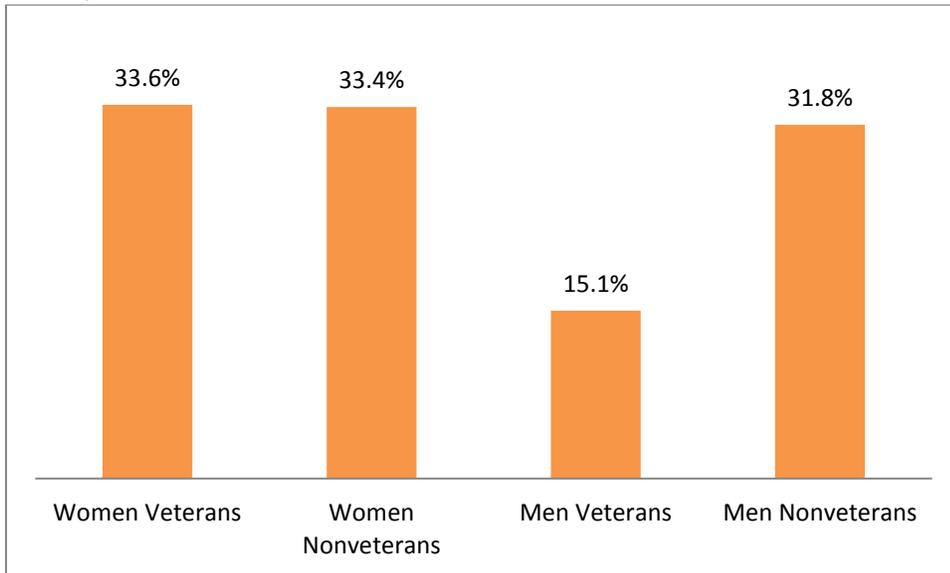
Source: National Center for Veterans Analysis and Statistics, 2018

In 2015, women veterans also had higher educational attainment than nonveteran women. While 44.3% of women veterans had some college, only 31.7% of nonveteran women had the same. The difference in bachelor's and advanced degrees was smaller. In 2015, 20.7% of women veterans had a bachelor's degree and 13.8% had an advanced degree, compared to 31.7% and 10.1% of nonveteran women respectively (National Center for Veterans Analysis and Statistics 2017).

Children in Household

One area where women veterans differ significantly from men veterans is having children in the household. In 2016, 33.6% of women veterans had children in the household, compared to 15.1% of men veterans (Figure 8.4). Women veterans and women nonveterans were just as likely to have children. There was no statistically significant difference between the two groups, with 33.4% of nonveteran women having children in the household. There was a significant difference between men veterans and men nonveterans. While only 15.1% of men veterans had children in the household, 31.8% of men nonveterans did – which is comparable with women regardless of veteran status.

Figure 8.4. Percent of Women & Men with Children in the Household by Veteran Status, United States, 2016



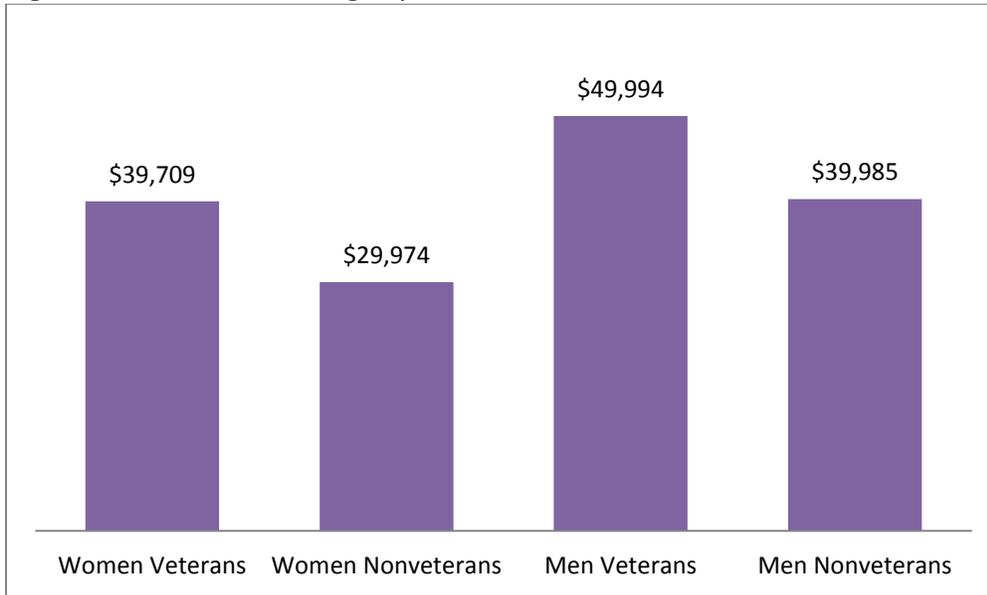
Source: National Center for Veterans Analysis and Statistics, 2018

Income, Unemployment, Occupation, and Poverty

Income

In 2016, there were 1.2 million women veterans in the labor force, which was about 12% of the total veteran population in the labor force. As Figure 8.5 shows, veteran men had higher median earnings than nonveteran men, and veteran women had higher median earnings than nonveteran women. In 2016, veteran men had the highest median earnings at \$49,994. Nonveteran men had the next highest salaries at \$39,985. Veteran women made almost the same as nonveteran men at \$39,705, but were approximately \$10,000 below that of median salaries for veteran men. This means women veterans earned approximately 79% of what their male veteran counterparts did. Female nonveterans made the least of all groups at \$29,974.

Figure 8.5. Median Earnings by Gender & Veteran Status, United States, 2016

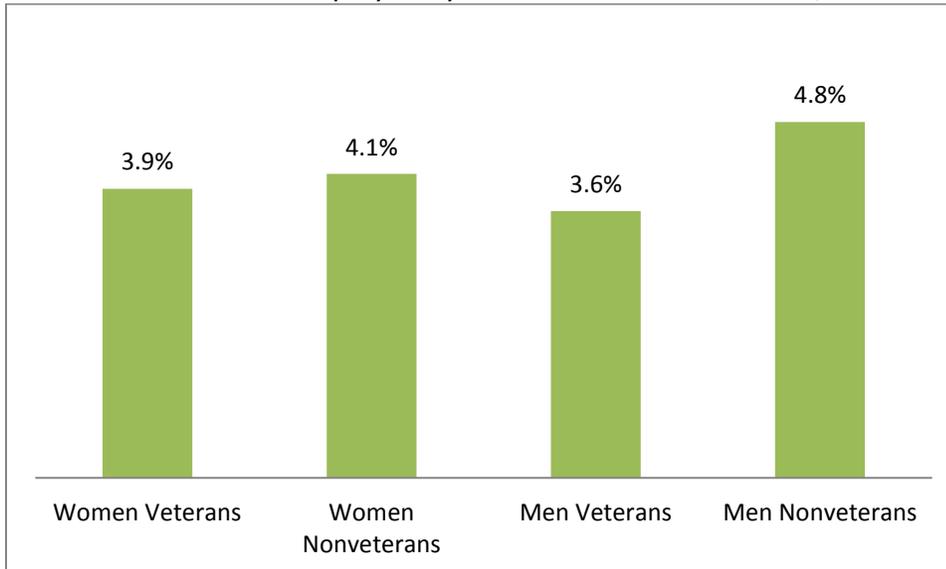


Source: National Center for Veterans Analysis and Statistics, 2018

Note: For year-round full-time workers.

Unemployment rates are slightly higher for women veterans than men veterans. In 2016, the unemployment rate was 3.9% for women veterans and 3.6% for men veterans (Figure 8.6). Unemployment rates were better for men veterans compared to nonveteran men (4.8%), but were about the same for women veterans and nonveterans (4.1%).

Table 8.6. Percent Unemployed by Veteran Status and Gender, United States, 2016

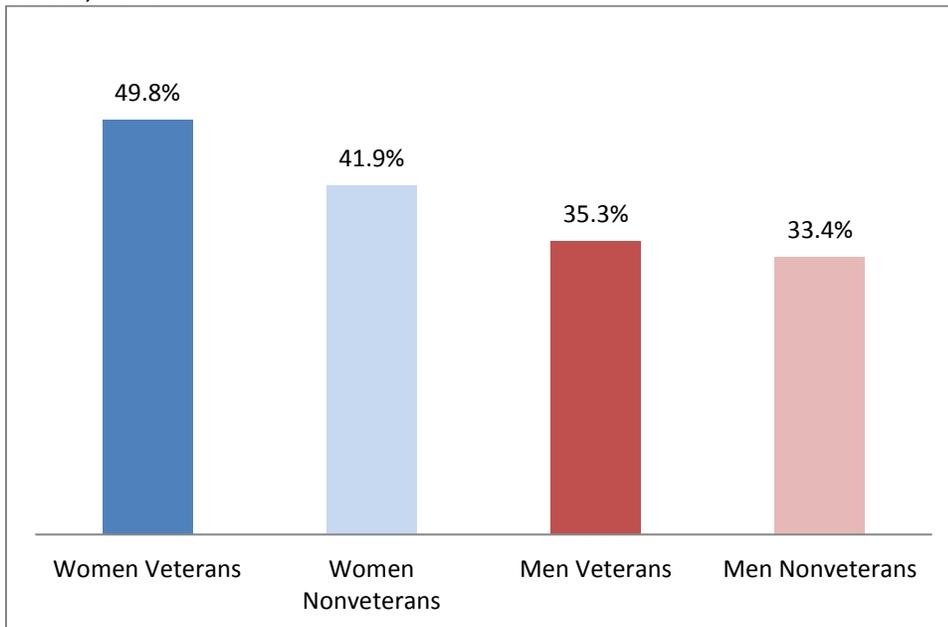


Source: National Center for Veterans Analysis and Statistics, 2018

Employment Occupation and Industry

In 2016, more women veterans worked in management and professional occupations than their male counterparts. Regardless of veteran status, men are less likely to work in management and professional occupations. Roughly 49.8% of women veterans worked in management and professional occupations, compared to 35.3% of men veterans and 33.4% of nonveteran men (Figure 8.7). Women veterans were also more likely than nonveteran women to work in management and professional occupations, with only 41.9% of nonveteran women working in those fields.

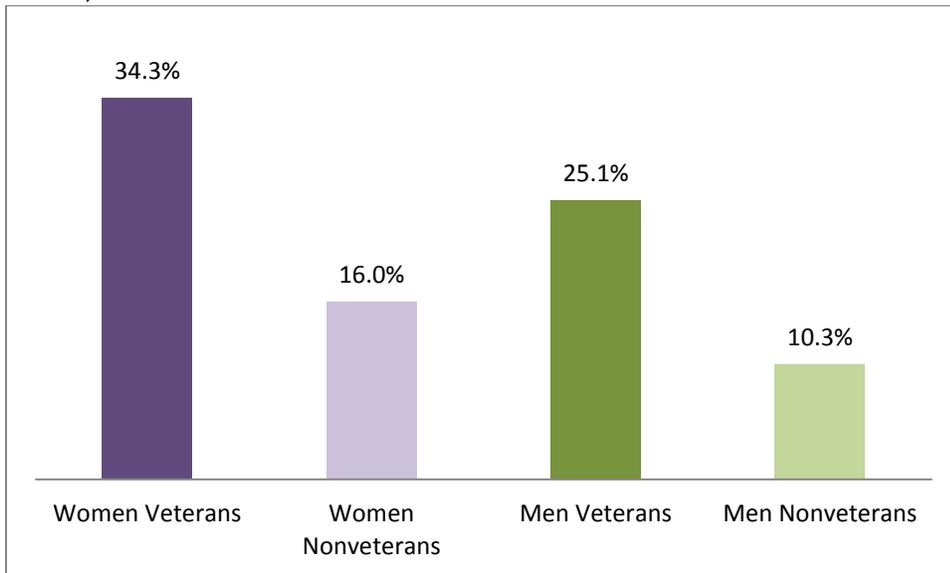
Figure 8.7. Management and Professional Occupations by Veteran Status and Gender, United States, 2013



Source: National Center for Veterans Analysis and Statistics, 2018

Figure 8.8 shows that women veterans were more likely to work in government than women nonveterans, men veterans, and men nonveterans. Both women (34.3%) and men (25.1%) veterans were more likely to work in government than nonveteran women (16%) and men (10.3%). Although not illustrated in the figure below, nonveteran women were much more likely to work in the private sector (77.1%), compared to veteran women (60.5%) (National Center for Veteran Analysis and Statistics 2017).

Figure 8.8. Percent of Women & Men Working in Government by Veteran Status, United States, 2016

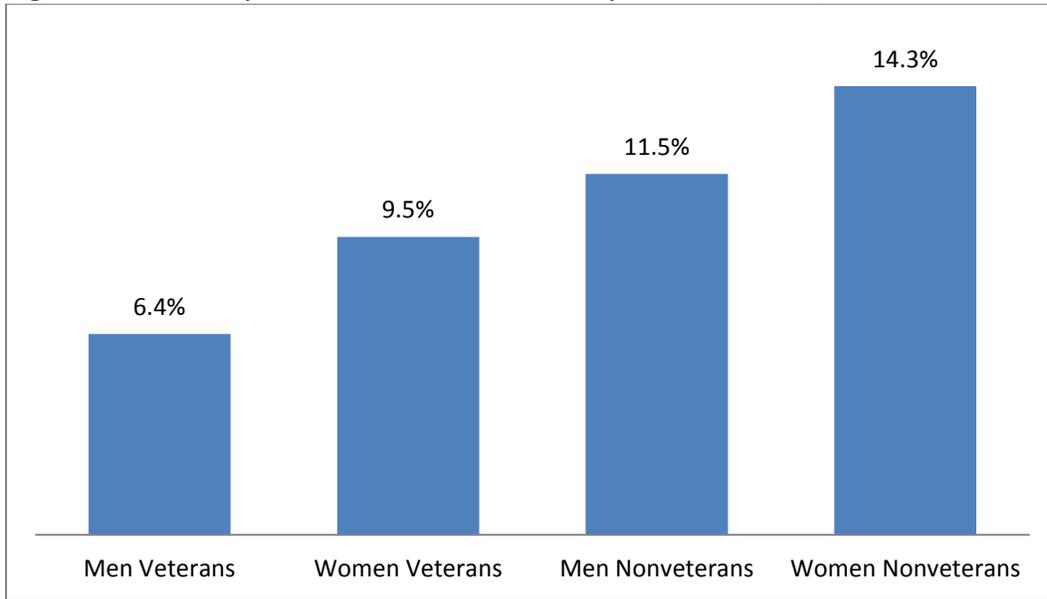


Source: National Center for Veterans Analysis and Statistics, 2018

Poverty

Poverty levels were higher for women veterans than men veterans. In 2016, 9.5% of women veterans were below the poverty threshold, compared to 6.4% of men veterans (Figure 8.9). Overall, poverty levels for both women and men were less for veterans than nonveterans. In 2016, 14.3% of nonveteran women and 11.5% of nonveteran men lived below the poverty threshold (Women's Bureau 2015).

Figure 8.9. Poverty Levels of Women & Men by Veteran Status, 2016

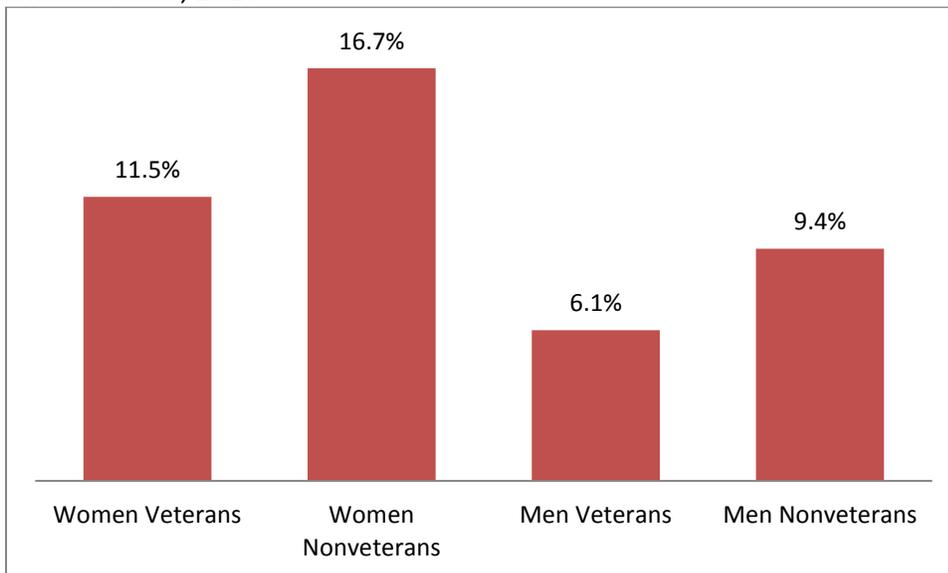


Source: National Center for Veterans Analysis and Statistics, 2018

Food Stamps

Regardless of veteran status, women are far more likely to receive food stamps than men. In 2016, 11.5% of women veterans received food stamps compared to 6.5% of men veterans (Figure 8.10). This was also higher than the percent of nonveteran men who received food stamps, which was 9.4%. Nonveteran women were the most likely to receive food stamps (16.7%).

Figure 8.10. Percent of Women & Men Working Receiving Food Stamps by Veteran Status, United States, 2016

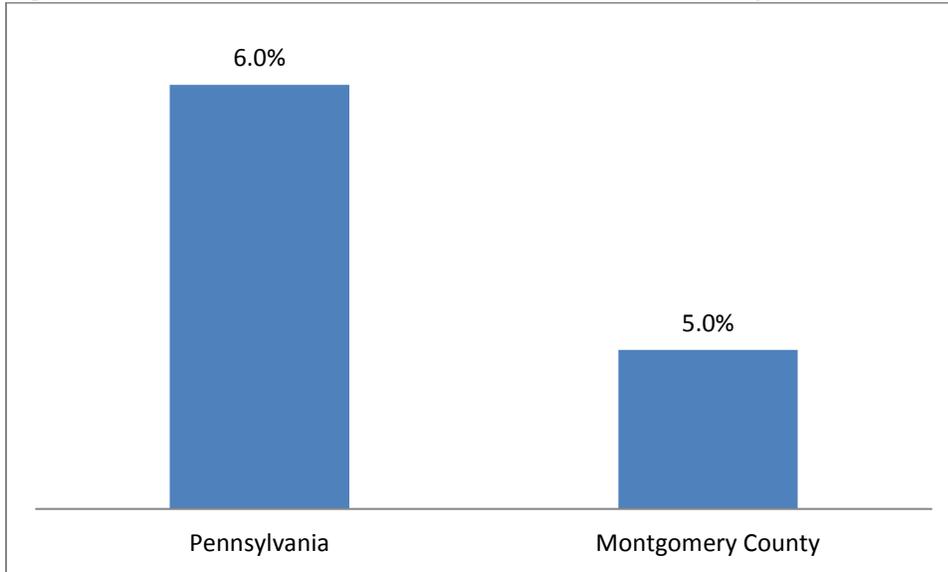


Source: National Center for Veterans Analysis and Statistics, 2018

Veterans in Pennsylvania & Montgomery County

Figure 8.11 shows the percent of veterans who are women in Pennsylvania and Montgomery County. According to the U.S. Census, 6% of veterans in Pennsylvania were women, and 5% of veterans in Montgomery County were women in 2016 (Figure 8.11).

Figure 8.11. Percent of Women & Men Veterans in Pennsylvania & Montgomery County, 2016

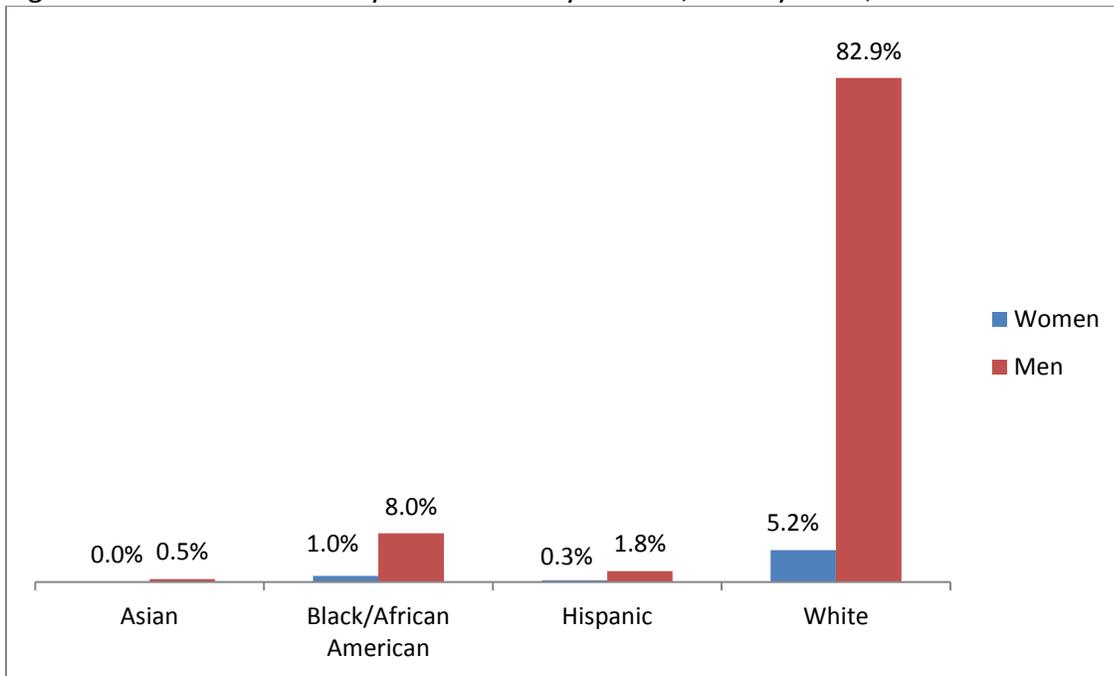


Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Notes: All racial groups are non-Hispanic. Hispanics can be any racial group.

Table 8.12 shows the racial and ethnic distribution of veterans in Pennsylvania in 2016. Of veterans in Pennsylvania, 82.9% were White males, and 5.2% were women veterans. Black men comprised 8% of the Pennsylvania veteran population, and Black women comprised 1%. Asian women comprised .004% of the veteran population in Pennsylvania, and Asian men comprised .5% of the veteran population. Hispanic women and men made up .3% and 1.8%, respectively, of the state's veteran population.

Figure 8.12. Race & Ethnicity of Veterans by Gender, Pennsylvania, 2016

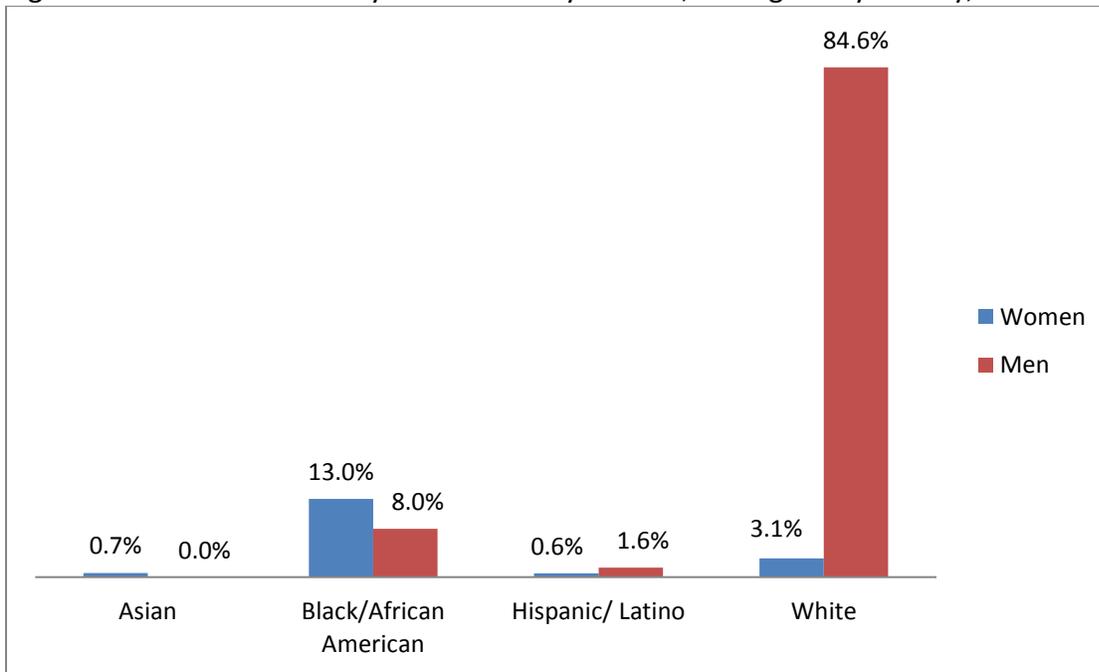


Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Notes: All racial groups are non-Hispanic. Hispanics can be any racial group. Data was not available for all racial and ethnic groups.

In 2016, White men made up 84.6% of the veteran population in Montgomery County, followed by Black women, who made up 13% of the veteran population (Figure 8.13). Black men had the third highest representation among Montgomery County veterans at 8%. White women comprised 3.1% of the county's veterans. Hispanic women and men constituted .6% and 1.6%, respectively, of the Montgomery County veteran population. There were no Asian women in the county's veteran population, but Asian men made up .7% of the veteran population.

Figure 8.13. Race & Ethnicity of Veterans by Gender, Montgomery County, 2016



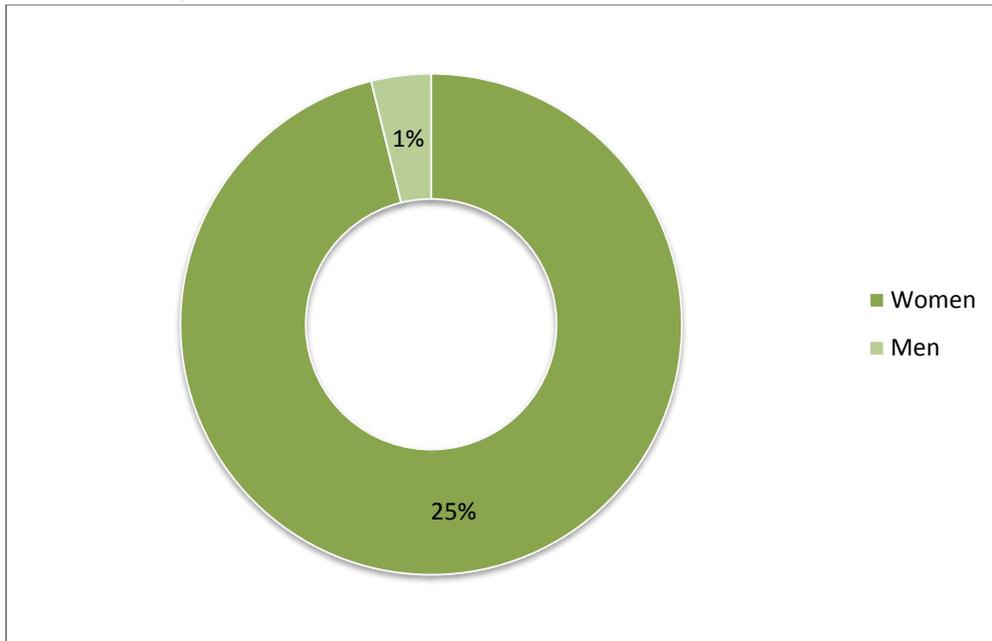
Source: U.S. Census Bureau, American Community Survey, 1-Year Estimates, 2016

Notes: All racial groups are non-Hispanic. Hispanics can be any racial group. Data was not available for all racial and ethnic groups.

Military Sexual Trauma

According to the U.S. Department of Veteran Affairs, the term military sexual trauma (MST) refers to sexual assault or repeated experiences of threatening sexual harassment during military service (U.S. Department of Veteran Affairs 2015). Veteran Affairs (VA) healthcare providers have implemented a screening program where they ask all of their patients if they have experienced MST. Data from this screening program reveal that 25% of women veterans seen at these healthcare providers have experienced MST, in comparison to 1% of men veterans.

Table 8.14. Percent of Women & Men Veterans Who Have Experienced Military Sexual Trauma, United States, 2015



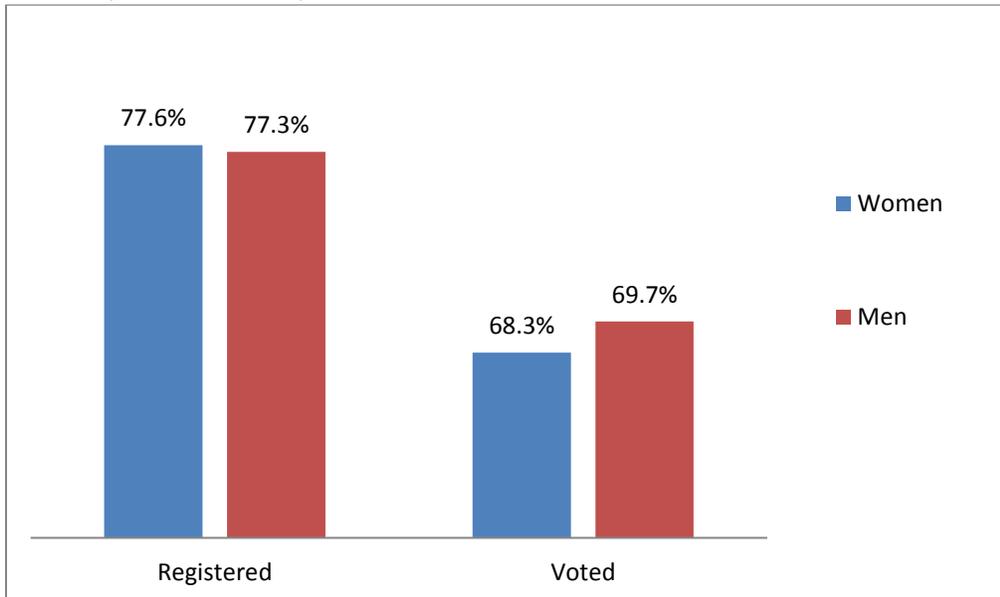
Source: U.S. Department of Veteran Affairs

Note: Data are obtained from veterans during health care screenings at VA health care providers. These data cannot be used to make estimates of sexual assault and/or harassment beyond VA health care providers.

Voter Registration and Turnout

Veterans are registered to vote at greater rates than nonveterans (Voting and Registration Supplement 2016). Although women in the general population are more likely to be registered to vote than men, women and men veterans are registered to vote at similar rates. In 2016, 77.6% of women veterans were registered to vote, and nearly the same percentage of men veterans were registered to vote at 77.3% (Figure 8.15). Veterans are also more likely than nonveterans to turn out to vote (Voting and Registration Supplement 2016). Voting turnout rates were slightly higher among men veterans at 69.7% compared to women veterans at 68.3%. This is different than the general population because women are more likely to vote than men overall.

Figure 8.15. Voter Turnout & Registration Rates for Veterans by Gender in the November 2016 Election, United States, 2016



Source: *Voting and Registration Supplement, November 2016, Current Population Survey, U.S. Census Bureau*

Conclusion

In 2015, women made 15% of active duty military and 19% of National Guard and reserve forces. Even though there are many similarities among women and men in the military, the differences often necessitate special interventions during active duty and veteran status. There are currently several initiatives underway to assist women veterans. For example, the Department of Labor has adopted the “Trauma-Informed Care for Women Veterans Experiencing Homelessness” guide to assist homeless women veterans with children. Since women veterans are more likely to be homeless and have children, it is important to study the contributing factors: unemployment, disability, low income, military sexual trauma, poor health, medical conditions, anxiety disorder, PTSD, and tobacco use. These services have not always been provided in ways that are women friendly since they have additional childcare responsibilities. Overall, veteran status increases earnings and reduces unemployment for both women and men, but a gender gap is still evident.

PRIMARY DATA SUMMARY: SURVEYS, FOCUS GROUPS, & INTERVIEWS

As previously mentioned, primary data were gathered from a survey, focus groups, and interviews to determine the resources available to women in Montgomery County as well as the needs and barriers to service. Each method is described in more detail in the introduction. This section will focus on the information and themes that emerged from these three sources of data.

Nonprofit Provider “Snapshot” Survey

The Center for Social and Economic Policy Research at West Chester University distributed a Nonprofit Provider “Snapshot” Survey to nonprofit organizations and government agencies that provide social and health services within Montgomery County. Survey recipients were identified by The Montgomery County Foundation, Inc. and through the Montgomery County Resource Guide, available through the Pennsylvania Department of Health. The survey was distributed via email through Qualtrics, a software platform for survey distribution and data analysis. A full list of survey questions is available in Appendix A.

Of those organizations that responded to the survey, 94.87% were nonprofits, and 5.13% were government agencies. About 90% of respondents provided services throughout the county. The services provided by the responding organizations varied considerably and included each category available in the survey. The top three services provided by survey respondents were education, information and referral, and parent support/parent education.

When asked what services women had difficulty accessing in Montgomery County, respondents indicated child care (27%) as the most frequently occurring response. Other services that were considered difficult to access were housing (7.24%), legal assistance (7.24%), and mental health services (6.9%). For individuals receiving health care assistance, it was difficult for them to receive gynecological care, dental care, and therapy.

Survey respondents were also asked how difficult services were to access in Montgomery County. The services that were considered “very difficult” were financial assistance, housing, and child care: 47.83% of respondents said getting financial assistance for women was very difficult; 42.31% of respondents said getting housing was very difficult; and 41.38% of respondents said getting child care was very difficult.

Respondent organizations/agencies were asked if they were unable to provide services during the past *month* and *year*. The three primary reasons for not providing services in the past month (prior to taking the survey) were: lack of capacity - such as staffing or other resources (20.29%), service was unavailable (20.29%), and insufficient funding for program (15.94%). The three top responses were the same for the past year although the percentages were slightly different. Although these unserved clients lived in boroughs and townships scattered throughout Montgomery County, they were somewhat more concentrated in Norristown, Lansdale, and Limerick.

The most common service gaps identified by respondents were in the areas of child care, housing, employment, mental health, and transportation. Respondents identified other service gaps in an open-ended question where the most common responses were about specific health care concerns. Respondents felt the issues deserving the most attention are affordable housing/subsidies, child care support/subsidies, and physical or mental health care.

When asked what community leaders should focus on in regard to women in Montgomery County, respondents had a variety of responses, but the most common responses were affordable and/or subsidized housing and child care support, particularly for single women.

When asked if people from different races and ethnicities get along, respondents were divided in their responses: 38.46% said things were “getting worse,” 33.33% said things “stayed the same,” 20.51% said they were “not sure,” and 7.69% said things were “improving.”

When it comes to “making a living over the past year” in Montgomery County, a plurality of respondents felt things were getting worse, compared to 26.32% who felt things were improving, and 26.32% who felt things had stayed the same.

Most providers in Montgomery County were not sure how the county’s growth was affecting their service area, and most felt crime had stayed the same.

Focus Groups & Interview Themes

The Center for Social and Economy Policy Research conducted five focus groups in different locations throughout Montgomery County. Focus groups involved the following participants who were recruited for their diverse perspectives on issues affecting women in the county: nonprofit executives, community leaders, nonprofit staff, and nonprofit clients. There were two client groups, which were held at a women’s resource organization and at a Latino family center. Translation was provided at the Latino family center to garner the greatest levels of participation possible. Although the Center for Economic Policy Research and The Montgomery County Foundation, Inc. were present at the focus group, it was conducted by a bilingual speaker. A second bilingual speaker working for the family center translated notes into English for the researcher. All focus groups were asked the same questions, which centered on the needs of women in Montgomery County and the barriers to service. The questions overlapped somewhat to provide a comprehensive assessment. An exact list of questions is available in Appendix B.

Because of the overlapping nature of the questions, themes have been divided into three broad categories: barriers to accessing resources, needs of women in Montgomery County, and needs of women veterans. The five focus groups and two interviews have been consolidated into one section in order to protect the confidentiality of participants. Interviewees were asked the same questions that focus groups participants were, but in-depth interviews provided ample time for participants to voice their concerns in a one-on-one environment. Interviewees

were recruited after the focus groups to provide a voice for those underrepresented in focus groups. The primary themes from the focus groups and interviews are listed below.

Barriers to Accessing Resources:

- Transportation
- Hours of operation (of nonprofits and government agencies)
- Immigration status/citizenship
- Language
- Stigma related to mental health in general and related to PTSD for women veterans
- Cultural norms that discourage reporting of domestic violence or abuse
- Limited access to online/digital resources
- Cultural fear of government and/or police
- Getting time off from work to obtain services
- Discrimination based on race/ethnicity or language

Needs of Women:

- Transportation
- Affordable housing
- Medical care
- Birth control
- Child care
- Mental health services
- Food security
- Cultural competency from providers
- Legal and financial assistance for divorce
- Limited periods for assistance
- Cultural education about the U.S., particularly as it relates to child abuse
- Living wage
- Greater political representation of women
- English classes and/or translation services

Needs of Women Veterans:

- Housing
- Trauma/PTSD care
- Living wages
- Child care in general
- Child care in order to seek in-patient substance abuse treatment

This list is not all inclusive, but summarizes the main responses from all five focus groups. Transportation was one of the most common themes mentioned in focus groups and the nonprofit provider survey. It is listed as a barrier and a need in the focus groups because women need transportation, yet lack of transportation is also the barrier that often prevents

them from accessing services. Another common theme was affordable housing. Given the high costs of rent in Montgomery County, less affluent and single women have difficulty finding housing that they can afford.

RECOMMENDATIONS & CONCLUSION

Recommendations

The recommendations provided here are for policy makers, community organizations, and community leaders from a wide spectrum of sectors to consider. Recommendations have been divided into two categories. The first set of recommendations includes more localized, programmatic recommendations that could be implemented by community leaders, nonprofits, and a diverse representation of stakeholders throughout Montgomery County to make an immediate impact. The second set of recommendations focuses on broad based public policy solutions at the county, state, and/or federal level as appropriate.

Programmatic Recommendations:

- Create best practices for - and teach - cultural competency across nonprofit and government service providers in order to promote cultural competency in services.
- Promote cultural competency throughout Montgomery County in all sectors of employment to improve workplace environments.
- Maintain a searchable database of vacancies on county and/or municipal boards, commissions, and committees in order to motivate women in Montgomery County to become more involved in public life. Then recruit women to fill these vacancies. These positions could be elected or volunteer.
- Recruit women to run for political office and connect women who want to run for office with nonpartisan campaign training programs like Ready to Run.
- Support and/or create leadership programs for women and for women of color, in particular.
- Promote and expand child care subsidies for those in need of support.
- Support and/or create vocational programs to train women in occupations that are in high demand and that do not necessarily require a college degree.
- Expand the marketing of Montgomery County social service resources available through local nonprofits and government agencies. Make marketing materials available in multiple languages and larger fonts for senior citizens.
- Support and expand programs that assist immigrants with legal challenges and language barriers.
- Gather detailed data on women veterans in Montgomery County in cooperation with Montgomery County Veteran Affairs. Create a database that is easily searchable and can produce reports.
- Create and/or support programs to assist women veterans who need in-patient substance abuse treatment by providing childcare given that most in-patient programs do not allow women to bring their children.
- Develop a program to provide education about healthy relationships to young women in middle school, high school, and/or college.
- Support transit oriented development in Montgomery County because lack of transportation is a key challenge for disadvantaged women.

- Support and/or create a nonprofit program to provide low-income individuals with used, but reliable, automobiles. Locations in the county with fewer public transportation options could be prioritized.
- Explore rideshare programs to make transportation more accessible.

Public Policy Recommendations:

- Support strengthening state and federal equal pay act laws by adding provisions that promote transparency in salary and promotion decisions, expand the population protected by the law, and prohibit pay secrecy. Employers should also pay particular attention to the structure of merit pay to avoid discrimination against women and minorities. Keep job descriptions up-to-date, use performance evaluations, and document all pay and promotion decisions.
- Support laws to raise the minimum wage.
- Support laws to reduce sexual harassment by mandating that employers provide sexual harassment training and create policies and procedures for sexual harassment complaints.
- Support laws that promote paid medical and family leave, paid sick days, and schedule predictability.
- Support laws that protect the social safety net, including Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Supplemental Security Income (SSI).
- Support policies that provide funding for child care subsidies for low-income families.
- Support employer policies for flexible spending plans that can be used for child care expenses.
- Oppose the repeal of the Affordable Care Act because it has expanded access to health care, mental services, and contraception for women.
- Support policies that promote prenatal and infant care.
- Protect women's safety by passing laws that protect women from violence, stalking, harassment, and abuse.
- Support laws that expand employment anti-discrimination protections to sexual orientation, gender identity, and gender expression.

Conclusion

Over the past 50 years, women have made significant progress toward social equity and have gained many legal protections. Since the passage of the Civil Rights Act of 1964, sex-based discrimination has been prohibited in hiring, firing, and promotion decisions. Unfortunately, women are still the victims of sex-based discrimination and still earn less than men despite the passage of the Equal Pay Act in 1963. Economic equality has been elusive as women are also more likely to live in poverty than men. Although women's educational levels now equal and/or exceed those of men, this has not translated to greater earnings than men due to occupational segregation and family responsibilities. Since women still bear more caregiving responsibilities and a greater proportion of household tasks, they often work part-time and

earn less money. Of particular concern are the health outcomes for women of color. Black women and American Indian/Alaska Native women are disproportionately affected by a number of health conditions that are often related to a lack of access to health care. Women are more likely to be victims of rape and sexual abuse, and there are still cultural norms against women speaking up about these crimes. Further, women veterans are far more likely to have experienced military sexual trauma than men veterans. In the political realm, women are still underrepresented in elected office at all levels of government. While there has been considerable progress, there are still substantial challenges that need to be addressed.

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APPENDIX A: Nonprofit Provider Snapshot Survey

Note: The following survey was distributed via Qualtrics. The text for each question is below.

Provider Snapshot Survey

The Center for Social and Economic Policy Research at West Chester University has been contracted by The Montgomery County Foundation, Inc. to perform a comprehensive and objective needs assessment of women in Montgomery County, Pennsylvania. One of the methodologies being used to inform the report is a Provider Snapshot. The purpose of the Provider Snapshot is to help us understand the availability of health and human services available to women in Montgomery County and to identify any gaps in services that may exist. In order to understand the needs of women in the county better, we need your assistance in answering the following questions.

The study should take you around 12-16 minutes to complete. Your participation in this research is voluntary. Please note that all responses are confidential and that each agency or nonprofit organization should only submit one survey.

1. Which choice best describes your provider?

- Nonprofit Organization
- Government Entity
- Other

2. Indicate the type of nonprofit organization or provider you work for (ex: health, housing, education, etc...)

3. Please provide the following information regarding your agency:

- Agency name
- Street number
- Street name
- City
- State
- Zip code
- Municipality
- Email address
- Executive Director's name
- Number of sites your agency operates in Montgomery County
- Number of programs your agency operates in Montgomery County

4. Does your agency provide services county-wide?

- Yes
- No

5. Please check below the services provided by your agency (check all that apply):

- After school youth activities
- Aging
- Arts and cultural
- Child care
- Educational
- Employment
- Food/clothing assistance
- Health care
- Housing
- Information and referral
- Intellectual disability
- Legal assistance
- Literacy/ESL
- Mental health
- Parent support/parent education
- Prenatal care
- Recreation
- Substance abuse
- Transportation
- Youth activities
- Leadership development
- Financial assistance
- Wholeness/wellness
- Domestic violence
- Safety
- Veteran services
- Immigrant services
- Other

6. Please describe the “other” services provided by your agency:

7. Please check below the services you feel women have difficulty accessing in Montgomery County (check all that apply):

- After school youth activities
- Aging
- Arts and cultural
- Child care
- Educational
- Employment
- Food/clothing assistance
- Health care
- Housing

Information and referral
 Intellectual disability
 Legal assistance
 Literacy/ESL
 Mental health
 Parent support/parent education
 Prenatal care
 Recreation
 Substance abuse
 Transportation
 Youth activities
 Leadership development
 Financial assistance
 Wholeness/wellness
 Domestic violence
 Safety
 Veteran services
 Immigrant services
 Other

8. Please indicate the “other” services that you feel women have a difficult time accessing in Montgomery County.

9. Please indicate the degree of difficulty women have in accessing these services in Montgomery County (check one):

Somewhat Difficult Difficult Very Difficult

After school youth activities
 Aging
 Arts and cultural
 Child care
 Educational
 Employment
 Food/clothing assistance
 Health care
 Housing
 Information and referral
 Intellectual disability
 Legal assistance
 Literacy/ESL
 Mental health
 Parent support/parent education

Prenatal care
Recreation
Substance abuse
Transportation
Youth activities
Leadership development
Financial assistance
Wholeness/wellness
Domestic violence
Safety
Veteran services
Immigrant services
Other

10. Please indicate the number of women your agency was unable to provide services to in the past month (for each applicable service).

After school youth activities
Aging
Arts and cultural
Child care
Educational
Employment
Food/clothing assistance
Health care
Housing
Information and referral
Intellectual disability
Legal assistance
Literacy/ESL
Mental health
Parent support/parent education
Prenatal care
Recreation
Substance abuse
Transportation
Youth activities
Leadership development
Financial assistance
Wholeness/wellness
Domestic violence
Safety
Veteran services
Immigrant services
Other

11. Please describe "other" services that were unable to be provided within the past month.

12. Why was your agency unable to provide services in these identified instances? (Please select all that apply.)

- Client refused services
- Client unable to pay
- Insurance did not cover requested services
- Lack of capacity (staffing)
- Language barrier
- Service not available at this agency
- Insufficient funding for program
- Lack of physical space
- Other

13. Please describe "other" reasons that your agency was unable to provide services within the past month.

14. Please indicate the number of women your agency was unable to provide services to in the past year (for each applicable service):

- After school youth activities
- Aging
- Arts and cultural
- Child care
- Educational
- Employment
- Food/clothing assistance
- Health care
- Housing
- Information and referral
- Intellectual disability
- Legal assistance
- Literacy/ESL
- Mental health
- Parent support/parent education
- Prenatal care
- Recreation
- Substance abuse
- Transportation
- Youth activities
- Leadership development
- Financial assistance

Wholeness/wellness
Domestic violence
Safety
Veteran services
Immigrant services
Other

15. Please describe “other” services that were unable to be provided within the past year.

16. Why was your agency unable to provide services in these identified instances (Please select all that apply)?

Client refused services
Client unable to pay
Insurance did not cover requested services
Lack of capacity (staffing)
Language barrier
Service not available at this agency
Insufficient funding for program
Lack of physical space
Other

17. Please describe “other” reasons that your agency was unable to provide services within the past year.

18. Of those your agency was unable to serve, please indicate the municipality in which the majority of the people lived (please indicate no more than three):

Abington Township
Ambler Borough
Bridgeport Borough
Bryn Athyn Borough
Cheltenham Township
Collegeville Borough
Conshohocken Borough
Douglass Township
East Greenville Borough
East Norriton Township
Franconia Township
Green Lane Borough
Hatboro Borough
Hatfield Borough
Hatfield Township

Horsham Township
Jenkintown Borough
Lansdale Borough
Limerick Township
Lower Frederick Township
Lower Gwynedd Township
Lower Merion Township
Lower Moreland Township
Lower Pottsgrove Township
Lower Providence Township
Lower Salford Township
Marlborough Township
Montgomery Township
Narberth Borough
New Hanover Township
Norristown Borough
North Wales Borough
Pennsburg Borough
Perkiomen Township
Plymouth Township
Pottstown Borough
Red Hill Borough
Rockledge Borough
Royersford Borough
Salford Township
Schwenksville Borough
Skipack Township
Souderton Borough
Springfield Township
Telford Borough
Towamencin Township
Trappe Borough
Upper Dublin Township
Upper Frederick Township
Upper Gwynedd Township
Upper Hanover Township
Upper Merion Township
Upper Moreland Township
Upper Pottsgrove Township
Upper Providence Township
Upper Salford Township
West Conshohocken Borough
West Norriton Township
West Pottsgrove Township

Whitemarsh Township
Whitpain Township
Worcester Township

19. Please indicate the areas where you feel service gaps exist in Montgomery County by checking the boxes. (Select all that apply)

- After school youth activities
- Aging
- Arts and cultural
- Child care
- Educational
- Employment
- Food/clothing assistance
- Health care
- Housing
- Information and referral
- Intellectual disability
- Legal assistance
- Literacy/ESL
- Mental health
- Parent support/parent education
- Prenatal care
- Recreation
- Substance abuse
- Transportation
- Youth activities
- Leadership development
- Financial assistance
- Wholeness/wellness
- Domestic violence
- Safety
- Veteran services
- Immigrant services
- Other

20. Please describe "other" service gaps indicated in the previous question.

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

22. Thinking about the future of women in Montgomery County, what do you think community leaders should focus on?

23. Is the growth Montgomery County is experiencing improving your service area, making it worse, or does it have no effect?

- Improving
- Making it worse
- No effect
- Not sure

24. Thinking about the past year, when it comes to how people from different races and ethnicities get along, would you say things are getting better, getting worse, or have stayed the same in your service area?

- Improving
- Getting worse
- Stayed the same
- Not sure

25. Thinking about the past year, when it comes to crime in Montgomery County, would you say things are getting better, getting worse, or have stayed the same?

- Improving (less crime)
- Getting worse
- Stayed the same
- Not sure

26. In terms of making a living over the past year, do you think things in Montgomery County are getting better for families, getting worse, or have they stayed the same?

- Improving
- Getting worse
- Stayed the same
- Not sure

27. Please provide the following information regarding your agency:

- Number of full-time staff
- Number of part-time staff
- Number of volunteer hours annually

28. Please provide the following information for *each program* provided by your agency

- Program name
- Program capacity (number of individuals served) each year
- Percent of time the program operates at capacity each year

29. Please indicate the following percentages for the identified program on a scale from 1-100%.

Percent of time the program operates at capacity each year

Of the total persons served annually in this program, what percent is uninsured?

Of the total persons served annually in this program, what percent require bilingual services?

30. People served in this program must be a certain age/age group.

Yes

No

31. If yes, indicate age group(s) below

0-5

6-13

14-21

22-59

60 and above

32. People served in this program must be citizens of the United States.

Yes

No

33. If yes, people served in this program must live in a specific area of the county.

Yes

No

34. Indicate area(s) below:

Abington Township

Ambler Borough

Bridgeport Borough

Bryn Athyn Borough

Cheltenham Township

Collegeville Borough

Conshohocken Borough

Douglass Township

East Greenville Borough

East Norriton Township

Franconia Township

Green Lane Borough

Hatboro Borough

Hatfield Borough

Hatfield Township

Horsham Township

Jenkintown Borough

Lansdale Borough

Limerick Township
Lower Frederick Township
Lower Gwynedd Township
Lower Merion Township
Lower Moreland Township
Lower Pottsgrove Township
Lower Providence Township
Lower Salford Township
Marlborough Township
Montgomery Township
Narberth Borough
New Hanover Township
Norristown Borough
North Wales Borough
Pennsburg Borough
Perkiomen Township
Plymouth Township
Pottstown Borough
Red Hill Borough
Rockledge Borough
Royersford Borough
Salford Township
Schwenksville Borough
Skipack Township
Souderton Borough
Springfield Township
Telford Borough
Towamencin Township
Trappe Borough
Upper Dublin Township
Upper Frederick Township
Upper Gwynedd Township
Upper Hanover Township
Upper Merion Township
Upper Moreland Township
Upper Pottsgrove Township
Upper Providence Township
Upper Salford Township
West Conshohocken Borough
West Norriton Township
West Pottsgrove Township
Whitemarsh Township
Whitpain Township
Worcester Township

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

36. Please provide the following information for *each program* provided by your agency (You will have an opportunity to provide information for multiple programs if applicable. Please begin with the first program you would like to discuss.)

Program name

Program capacity (number of individuals served) each year

Percentage of time the program operates at capacity each year

37. Please indicate the following percentages for the identified program on a scale from 1-100%.

Percent of time the program operates at capacity each year

Of the total persons served annually in this program, what percent is uninsured?

Of the total persons served annually in this program, what percent require bilingual services?

38. People served in this program must be a certain age/age group.

Yes

No

39. If yes, indicate age group(s) below

0-5

6-13

14-21

22-59

60 and above

40. People served in this program must be citizens of the United States.

Yes

No

41. People served in this program must live in a specific area of the county.

Yes

No

42. If yes, indicate area(s) below:

Abington Township

Ambler Borough

Bridgeport Borough

Bryn Athyn Borough

Cheltenham Township

Collegeville Borough

Conshohocken Borough
Douglass Township
East Greenville Borough
East Norriton Township
Franconia Township
Green Lane Borough
Hatboro Borough
Hatfield Borough
Hatfield Township
Horsham Township
Jenkintown Borough
Lansdale Borough
Limerick Township
Lower Frederick Township
Lower Gwynedd Township
Lower Merion Township
Lower Moreland Township
Lower Pottsgrove Township
Lower Providence Township
Lower Salford Township
Marlborough Township
Montgomery Township
Narberth Borough
New Hanover Township
Norristown Borough
North Wales Borough
Pennsburg Borough
Perkiomen Township
Plymouth Township
Pottstown Borough
Red Hill Borough
Rockledge Borough
Royersford Borough
Salford Township
Schwenksville Borough
Skipack Township
Souderton Borough
Springfield Township
Telford Borough
Towamencin Township
Trappe Borough
Upper Dublin Township
Upper Frederick Township
Upper Gwynedd Township

Upper Hanover Township
Upper Merion Township
Upper Moreland Township
Upper Pottsgrove Township
Upper Providence Township
Upper Salford Township
West Conshohocken Borough
West Norriton Township
West Pottsgrove Township
Whitemarsh Township
Whitpain Township
Worcester Township

43. How many additional programs do you need to report? Provide number.

Survey loop for each additional program starts over at #36.

APPENDIX B: Focus Group and Interview Questions

Focus Group & Interview Questions

1. What is the status of women in Montgomery County? How has this changed over time?
2. What are the needs of women in Montgomery County?
3. Are there needs specific to women in Montgomery County?
4. What are the resources available to women in Montgomery County?
5. What barriers exist for women in Montgomery County?
6. Are there any gaps in service to women in Montgomery County?
7. Of the things we discussed, what is the most important to you?
8. Is there anything else you would like to add?