



Women's Reproductive Health Status in the United States:  
Women's Funds' Strategies to Improve Outcomes for Women



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## About This Report

This report was authored by the Institute for Women's Policy Research (IWPR) on behalf of Women's Funding Network with funding from The David and Lucille Packard Foundation. Drawing from IWPR's *Status of Women in the States: 2015*, the report provides an overview of the status of reproductive health rights in the United States today, discusses how expanding access to supports to help women delay pregnancy can improve young women's prospects for economic security in adulthood, and provides examples of how women's funds around the country are working to provide such support to women at the local and state levels. The report was written and compiled by Lindsey Reichlin, IWPR Research Associate and Program Manager, and Justine Augeri, former George Washington University/IWPR Fellow. The report is a part of IWPR's larger body of work, funded by the W.K. Kellogg Foundation, focused on improving access to two-generation supports for low-income women who are raising dependent children and pursuing postsecondary education. IWPR would also like to acknowledge the Ford Foundation for their support of *The Status of Women in the States: 2015* report, from which much of the data included in this report originates.

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**Institute for Women's Policy Research**  
1200 18th Street NW, Suite 301 Washington, DC 20036  
Tel: 202/785.5100 Fax: 202/833.4362  
[www.iwpr.org](http://www.iwpr.org)

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on behalf of

Women's Funding Network

Written and compiled by:

Lindsey Reichlin, M.A., and Justine Augeri, Ph.D.

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## Introduction

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Reproductive health outcomes and policies in the United States have substantially changed at the federal and state levels in recent years. The birth rate for teenagers has declined steadily (Hamilton et al. 2014) and the passage of the 2010 Patient Protection and Affordable Care Act (ACA) opened the door for millions of women to gain access to preventive women's health services and contraceptive methods and counseling. At the same time, however, the United States continues to have high rates of unplanned pregnancy among women (especially among young adults) and legal limitations on women's reproductive rights at the state level have increased across the country, making it harder for women to access the reproductive health services and information they need.

Ensuring that young adults have unencumbered access to contraception and reproductive health services and information has the potential to make a powerful, long-term difference in their lives (Kaye et al. 2014). Research suggests that contraception, as an effective and safe way for women to decide whether and when to have children, is linked to a wide range of socioeconomic and health benefits (Sonfield et al. 2013). In particular, the ability to control the timing and size of one's family is thought to have a significant effect on whether a young woman attends and completes college. With important economic premiums attached to the attainment of a postsecondary degree (Carnevale, Rose, and Cheah 2011; Gault, Reichlin, and Román 2014), contraception could mean the difference between a woman earning poverty-level wages and long-term financial security. Yet low-income women are less likely than their higher-income counterparts to have access to contraceptive methods and to information on how to use such methods effectively. Low-income women ages 15-44 who are not actively trying to get pregnant are much more likely than their higher income counterparts to experience unplanned pregnancy (Reeves and Venator 2015), which research suggests can have a detrimental effect on children's lifetime socioeconomic outcomes (Sawhill and Ventaor 2015).

This paper offers an overview of the significance and status of access to reproductive health rights and services in the United States today. It focuses particularly on how expanding access to family planning methods and information can improve young women's prospects for economic security in adulthood, largely through access to education. In addition to addressing the need for reproductive services to promote women's educational attainment, the report discusses how to support college students who already have children, and profiles the efforts of women's funds to ensure access to services that promote reproductive health and allow low-income parents to attend and succeed at postsecondary education.

## The Affordable Care Act and Access to Reproductive Rights and Services

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The Patient Protection and Affordable Care Act (ACA) dramatically expanded women's access to health insurance, as well as to preventive women's health services and affordable contraception. The ACA requires most health insurers to cover contraceptive counseling and services, and all FDA-approved

contraceptive methods, without any out-of-pocket costs to patients (U.S. Department of Health and Human Services 2014a).

The ACA also increased women's access to contraception by expanding the number of people with health insurance coverage. The ACA dramatically reduced rates of uninsurance among women aged 18 to 24 by allowing adult children to stay on their parents' health insurance plans until the age of 26. Between 2008 and 2014, the percentage of women aged 18 to 24 without health insurance decreased by more than a third, from 24.9 to 15.9 percent. During this period, uninsurance rates for women of all ages dropped about 18 percent, from 13.0 percent of women lacking insurance in 2008 to 10.6 percent in the first nine months of 2014 (Martinez and Cohen 2009 and 2015).

Expanded access to contraception is particularly significant for lower-income women who often struggle with the financial burden associated with purchasing contraception on a regular basis (Center for Reproductive Rights 2012). According to the Guttmacher Institute, the average cost of a year's supply of birth control pills is the equivalent of 51 hours of work for a woman making the federal minimum wage of \$7.25 an hour (Sonfield 2014). One national study estimates that for uninsured women, the average cost of these pills over a year (\$370) constitutes 68 percent of their annual out-of-pocket expenditures for health care services (Liang, Grossman, and Phillips 2011).

Research demonstrates that the ACA has significantly increased the proportion of women who have access to contraception at no cost: one study of approximately 900 women who had private health insurance and used a prescription contraceptive method found that between the fall of 2012 (before the ACA's contraceptive coverage requirement took effect for most women) and the spring of 2014, the percentage of women paying zero dollars out of pocket for oral contraception increased from 15 to 67 percent (Sonfield et al. 2015).

Prior to the ACA, state contraceptive equity laws were the only legal protections ensuring that women could access affordable contraceptives as easily as they could other prescription drugs (Guttmacher 2015a). These laws required state-regulated plans providing coverage for prescription medications to do the same for contraceptive drugs and devices (National Women's Law Center 2012). Only 28 states, however, required full or partial contraceptive coverage; the remaining states and the District of Columbia had no such legal protection safeguarding access to affordable contraception (Guttmacher 2015a).

The ACA's contraceptive requirement, however, has some notable exceptions. Some religious organizations, such as churches and other houses of worship, are exempt from the requirement to include birth control in their health insurance plans (National Women's Law Center 2015). Religiously-affiliated nonprofit organizations that certify their religious objections to birth control have an "accommodation" available to them if they certify their religious objections to the health insurance carrier or third party administrator, or notify the Department of Health and Human Services of their objection; those who qualify for the accommodation do not have to cover contraceptives for their female employees, but these employees can still get birth control coverage directly from the insurance company (National Women's Law Center 2015; Sobel, Salganicoff, and Kurani 2015). In addition, "grandfathered" health plans—those which existed prior to March 23, 2010 (the day the ACA became law) and have until 2017 to become ACA compliant (Obamacare n.d.)—are temporarily exempt from the requirement to provide

contraceptive coverage through employer-sponsored health plans, except in states with a contraceptive equity law that already requires coverage (although contraceptive equity laws do not require insurers to provide contraceptive coverage without cost sharing; National Women’s Law Center 2012).<sup>1</sup> A Supreme Court decision, *Burwell v. Hobby Lobby Stores, Inc.*, also expanded allowable exemptions to certain family-owned, “closely held” corporations with religious objections to contraception (Dreweke 2014; National Women’s Law Center 2015). The ruling does not supersede state contraceptive equity laws, but it does mean that employees of firms such as Hobby Lobby, which self-insures its employees and therefore is subject only to federal law, may lose their coverage of contraceptive drugs and services (Rovner 2014).

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

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<sup>1</sup> Women living in states without a contraceptive equity law must wait until their private health plan loses its grandfathered status to gain full access to no-cost contraceptive coverage (National Women’s Law Center 2012).

## Spotlight: Reproductive Health Rights and Women of Color

Women of color have historically encountered disproportional barriers in access to their full range of reproductive health rights. Relatively low socioeconomic status, and lower health insurance coverage rates, among other factors, contributed to limited access to reproductive health rights and resources. Black women experience higher rates of unintended pregnancy (Finer and Zolna 2014), breast cancer, heart disease (followed by white and Native American women), HIV/AIDS, chlamydia (followed by Native American women), and infant mortality (followed by Native American women), compared with women of other races/ethnicities (Institute for Women's Policy Research 2015). Women of color are more likely to live without health insurance coverage than their white counterparts (22 percent of black women and 36 percent of Hispanic women reported that they were uninsured at the end of 2013, compared with 13 percent of white women; Salganicoff et al. 2014). The ACA, in its expansion of health care access, Medicaid eligibility, and availability of affordable contraception and preventive health services, has taken important steps toward reducing the health disparities disproportionately experienced by women of color.

## Medicaid and Family Planning Expansion

The ACA has also increased the number of people with health insurance through changes to Medicaid, a public health coverage program for low-income individuals. To help those who may have struggled in the past to afford insurance, the ACA seeks to expand Medicaid eligibility to all individuals under age 65 who are not eligible for Medicare and have incomes up to 138 percent of the federal poverty line (individuals were previously eligible only if they were pregnant, the parent of a dependent child, 65 years of age or older, or disabled, in addition to meeting income requirements; the National Conference of State Legislatures 2011).<sup>2</sup> This change increases the number of women who are eligible to receive family planning services, along with other health care services. States, however, can opt out of this Medicaid expansion. As of September 2015, 31 states and the District Columbia had chosen to adopt the Medicaid expansion, and one was still in the process of deciding whether to do so (Kaiser Family Foundation 2015).

In addition to the overall Medicaid expansion, the ACA provides states with a new pathway to expand eligibility for family planning coverage through changes to their state Medicaid program. Before the ACA, states could expand their programs by obtaining a Section 1115 waiver of federal policy from the Centers for Medicare and Medicaid Services which would allow them to expand Medicaid eligibility to childless adults who, otherwise, would not have been qualified for Medicaid coverage under federal law (Rudowitz, Artiga, and Musumeci 2015; Guttmacher 2015b). States interested in expanding family planning through Medicaid can now either complete the process through a waiver from the federal government (which is a temporary solution), or through an expedited option of a State Plan Amendment, which is a permanent change to the state's Medicaid program (Guttmacher 2015b).

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<sup>2</sup> Federal law allows for the expansion of Medicaid to individuals with incomes at or below 133 percent of the federal poverty line. The law also includes a five percent "income disregard," which effectively makes the limit 138 percent of poverty (Center for Mississippi Health Policy 2012).



# The Status of Women's Reproductive Health in the United States

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The following data on women's reproductive health and rights are drawn from the Institute for Women's Policy Research's (IWPR) *The Status of Women in the States* national report (Institute for Women's Policy Research 2015). The report gives an in-depth overview of the status of women in all 50 states and the District of Columbia, highlighting obstacles facing women around the country. Since 1996, IWPR's *Status of Women in the States* project has worked to inform citizens about the progress of women in their state relative to women in other states, to men, and to the nation as a whole, as well as to encourage policy changes designed to improve women's status. The report provides state-by-state data on an array of issues related to women's reproductive health, including fertility, sex education, abortion access, and infant mortality, among other issues listed below. See Appendix A for the Reproductive Rights chapter Composite Index and Methodological Note.

## Teen Pregnancy and Fertility

With 26.5 live births per 1,000 teenagers aged 15-19 in 2013, the birth rate for teens was down 3 percent from 2012, the lowest seen in United States' history. The teen birth rate has steadily declined since the 1990's, and has dropped 35 percent since 1991. Among the states, rates ranged from 12.1 to 43.5 births per 1,000 teenagers aged 15-19 in 2013, with the lowest observed in Massachusetts and the highest in Arkansas (Martin et al. 2015). Teen birth rates vary among young women of different racial/ethnic backgrounds in the United States. Hispanic, black, and Native American teens aged 15-19 have much higher rates of teen pregnancy (41.7, 39.0, and 31.1 per 1,000, respectively) than Asian/Pacific Islander and white young women (8.7 and 18.6 per 1,000, respectively; Centers for Disease Control and Prevention 2014a).

In 2013, the overall fertility rate in the United States remained at an all-time low, at 62.5 live births per 1,000 women aged 15-44, down one percent from the year before. Between 2012 and 2013, declines were seen in the rates for non-Hispanic black women (down one percent) and Hispanic women (down two percent), though they rose slightly for non-Hispanic white women (by less than one percent). With 3.9 million registered births, the overall birth rate saw a 1 percent decrease in 2013 (Martin et al. 2015).

The 2013 fertility rate for women aged 15-44 ranged from a low of 50.8 births per 1,000 women in New Hampshire to 80.9 births per 1,000 in Utah. Between 2012 and 2013, rates declined in 19 states and the District of Columbia and remained relatively unchanged in 31. The five states with the highest fertility rates, Nebraska, North Dakota, Alaska, South Dakota, and Utah, have rates of 72.2 births per 1,000 women or higher. The five states with the lowest fertility rates (New Hampshire, Vermont, Rhode Island, Connecticut, and Massachusetts) all have rates of 52.8 births per 1,000 women or lower (Martin et al. 2015).

## Sex Education

A number of sex education programs that have proven effective in helping teens delay sex and use contraception more effectively when they become sexually active, and in reducing teen pregnancy (U.S. Department of Health and Human Services n.d.).<sup>3</sup> Less than half of all states (22 states) and the District of Columbia, however, require schools to provide sex education. In 20 of those states and the District of Columbia, HIV education is also required (Guttmacher Institute 2015d). Sex education curricula vary among states: 18 states and the District of Columbia require information about contraception in the curriculum while 37 states require information about abstinence (Guttmacher Institute 2015d).

## Abortion Access

Following the legalization of abortion with *Roe v. Wade* in 1973, the number of abortions conducted after the first trimester dropped significantly and induced abortion has become a safe procedure that rarely has medical complications that threaten the life of the mother (Boonstra et al. 2006).

Legislative efforts to limit access to abortion at the state level have become common. In 2013 and 2014, a broad range of legislation was introduced, seeking requirements that women seeking an abortion undergo invasive medical procedures, stringent regulatory measures targeting abortion providers, bans or restrictions preventing women from obtaining health insurance coverage for abortion, and bans on abortion at later stages of pregnancy (National Women's Law Center 2014a and 2014b).

As of January 2015, parental consent or notification laws were present in 44 states for minors seeking abortions, though in five of these states such laws were passed and subsequently challenged, resulting in the permanently enjoined status of these laws. Among the 38 states enforcing parental consent or notification laws, 21 states enforced parental consent, 12 enforced parental notification, and 5 states enforced both parental consent and notification laws (Guttmacher Institute 2015c).<sup>4</sup>

The share of women living in counties with an abortion provider ranges from a low of four percent in Wyoming to 100 percent in the District of Columbia and Hawaii. Fewer than a quarter of women live in counties with at least one provider in the bottom five states (South Dakota, Arkansas, West Virginia, Mississippi, and Wyoming), in the top eight jurisdictions at least 90 percent of women have such access (District of Columbia, Hawaii, California, Connecticut, Nevada, New Jersey, New York, and Massachusetts; Guttmacher Institute 2014).

Although federal funding cannot be used to fund abortions, most states have provisions that allow public funding of abortions for Medicaid-eligible women in certain instances. Seventeen states allow public funding of abortions for Medicaid-eligible women in all or most medically necessary circumstances, and

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<sup>3</sup> See the U.S. Department of Health's Teen Pregnancy Prevention Evidence Review for a searchable database of programs with evidence of effectiveness in reducing teen pregnancy, sexually transmitted diseases, and associated sexual risk behaviors. Visit the website at <http://tpevidencereview.aspe.hhs.gov/>.

<sup>4</sup> As of September 2015, 38 states had parental consent or notification laws for minors seeking abortions. Twenty-five of these states enforced parental consent, 13 enforced parental notification, and 5 enforced both parental consent and notification laws (Guttmacher Institute 2015c).

33 states and the District of Columbia allow it only under specific circumstances, such as rape or incest, to protect the woman's life or health, or fetal viability (Guttmacher Institute 2015c).

## Pro-Choice State Governments

The stance of state governments can be critically important to women's reproductive health rights, as demonstrated by the policy battles surrounding reproductive rights in recent years. There are only four states, as well as the District of Columbia where, as of January 2015 the position of the governor (mayor in the District of Columbia), state senate, and state assembly (city council for the District of Columbia) all do not support restrictions on women's reproductive rights (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 2015a).<sup>5</sup> In 21 states, all three state bodies are anti-choice; state governments are mixed in the remaining states (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 2015a).

## Access to Fertility Treatments

Infertility treatments can expand reproductive opportunities for women and men, but their high costs can make them inaccessible for many, if infertility treatments are not covered by insurance. As of June 2014, 11 states have laws mandating insurance companies to cover infertility treatments, and another two require that insurance companies offer at least one package with infertility coverage (National Conference of State Legislatures 2014).

## Infant Mortality

The national infant mortality rate in 2012 was 6.0 per 1,000 live births, down from 6.8 in 2001, and the national neonatal mortality rate was 4.04, both all-time lows for the United States. Alabama, Mississippi, South Dakota, and Louisiana saw the highest rates of infant mortality in 2012, ranging from 8.2 to 9.0 deaths of infants under age one per 1,000 live births. States with the lowest infant mortality rates, ranging from 4.2 to 4.4 per 1,000 births, include New Hampshire, Massachusetts, Vermont, and New Jersey (Centers for Disease Control and Prevention 2014b). Infant mortality rates differ substantially between women of different racial/ethnic backgrounds. Infant mortality is much higher among black and Native American women (at 11.2 and 8.4 per 1,000 live births, respectively) than among Asian/Pacific Islander women (4.1 per 1,000 live births), non-Hispanic white women (5.0 per 1,000 live births) and Hispanic women (5.1 per 1,000 live births; Centers for Disease Control and Prevention 2013).

## Low Birth Weight Babies

Nationally, eight percent of babies born in the United States in 2013 had low birth weights.<sup>6</sup> Among non-Hispanic black women 13.1 percent had low birth weight babies, compared with 8.3 percent of

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<sup>5</sup> As of September 2015, five states and the District of Columbia have pro-choice governments (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 2015b).

<sup>6</sup> Low birth weight is defined as less than five pounds, eight ounces (Martin et al. 2015).

Asian/Pacific Islander women, 7.5 percent of Native American women, 7.1 percent of Hispanic women, 7.0 percent of white women; Martin et al. 2015). The states with the highest rates of low birth weight babies were Mississippi, Louisiana, and Alabama (with rates of 10 percent or higher), while Alaska, Oregon, South Dakota, Minnesota, Nebraska, North Dakota, and Washington had the lowest rates (rates of 6.4 percent or lower; U.S. Department of Health and Human Services 2015).

## The Effect of Reproductive Health Services on Women's Educational and Economic Outcomes

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Contraception and other reproductive health services bring important socioeconomic benefits to women and families. A comprehensive report by Sonfield et al. (2013) summarizes literature examining the potential social and economic benefits of increased family planning abilities due to access to reliable contraception. Using both historical and contemporary research studies, the review suggests that greater access to contraception has contributed to improving women's well-being in a number of areas, including increased workforce participation, greater economic stability, as well as improved outcomes for children (Sonfield et al. 2013).

Access to reproductive health services, including contraception, can increase young women's chances of earning a college degree and achieving economic security. In a review of 66 studies, Sonfield et al. (2013) found that consistently both historical and contemporary research consistently suggest that the ability to postpone pregnancy until later in life can have positive effects on the likelihood of women's college attendance and attainment. Research suggests that women who have children at older ages are more likely to finish high school and to attend and complete postsecondary education. The younger a woman becomes a mother, the less likely she is to finish high school and the more likely it is that she does not enter college at all or she drops out before completing her degree (Sonfield et al. 2013).

Earning a degree or certificate is an important route to economic self-sufficiency (Hartmann and Hayes 2013; Carnevale, Rose, and Cheah 2011). Women with less than or only a high school diploma are significantly less likely than others to work for pay (Carnevale, Rose, and Cheah 2011), so a postsecondary degree or certificate can significantly increase the lifetime earnings of high school educated women. Women with an associate's degree earn \$217,000 more in their lifetimes than women who only have some college but no degree; they earn \$427,000 more than women with only a high school diploma. A four-year degree brings an even greater earnings premium: women with bachelor's degrees earn \$822,000 more in their lifetime than women with just a high school diploma (Carnevale, Rose, and Cheah 2011). Women with less than or only a high school diploma are significantly less likely to work for pay (Carnevale, Rose, and Cheah 2011), so a postsecondary degree or certificate can bring an important boost to the lifetime earnings of high school educated women. A woman's ability to delay pregnancy until she has completed postsecondary education, therefore, is significant for her ability to get a job that allows her to earn wages that will support herself and a family, should she decide to start one.

## Challenges Facing Students with Children

Women who already have dependent children while in college face significant challenges to their educational, and therefore long-term economic, success (Hess et al. 2014). Twenty six percent of the total college population, or 4.8 million undergraduate students, are balancing college and parenthood (Gault, Reichlin, and Román 2014). Nearly half of these student parents (45 percent or 2.1 million students) attend public two-year institutions. For student parents at any institution, 71 percent of whom are women and 43 percent of whom are single mothers, parenthood can threaten their ability to complete their degree program due to the time and financial demands associated with dependent care responsibilities, college classes and school work, and, often, a job (Gault, Reichlin, and Román 2014; Gault et al. 2014; Miller, Gault, and Thorman 2011).

The time required to care for children while in college poses a significant challenge to completion for student parents. More than a quarter of women (28 percent) attending community college say they spend 30 hours or more providing care to dependents, and 30 percent say that dependent care is likely or very likely to cause them to withdraw from class or from college altogether (Community College Survey of Student Engagement 2014). In a 2014 IWPR survey of female community college students in Mississippi, two in five respondents with dependent children reported having taken time off school one or more times. When asked the reasons for interrupting their college careers, 41 percent of these respondents cited caregiving demands, 38 percent cited becoming pregnant or having a baby, and 24 percent cited not having sufficient child care (Hess et al. 2014).

The costs of raising a child while in college compound low-income students' financial insecurity. Nearly 70 percent of community college students with children live at or below 200 percent of poverty, compared with 50 percent of community college students who are not parents. Parents who are raising a child without the support of a spouse or partner are even more likely to have low-incomes: 88 percent of single student parents at community colleges live at or below 200 percent of poverty (Gault, Reichlin, and Román 2014).

Debt levels are also higher for the students with children compared with their nonparent counterparts. For student mothers, average undergraduate debt amounts to approximately \$3,800 more than the debt experienced by female students without children, and nearly \$5,000 more than that of male students without children (Gault, Reichlin, and Román 2014).

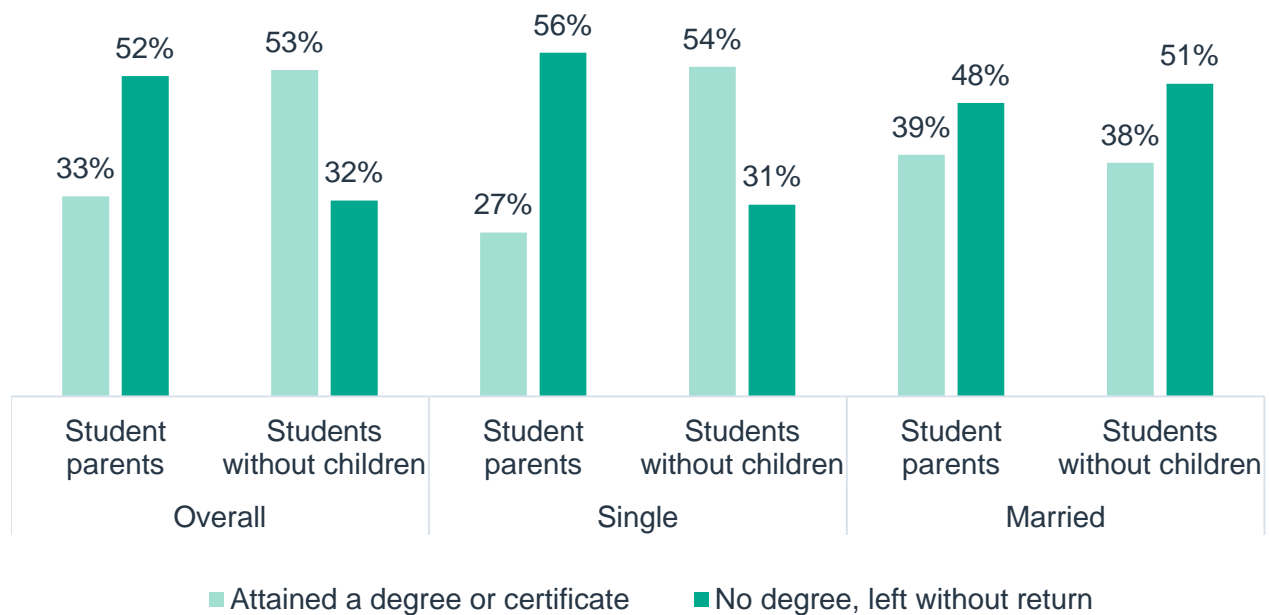
## Educational Attainment for Students with Children

Completion rates for students with children are lower than rates among nonparents. More than half of student parents (52 percent) drop out of college without a degree or certificate 6 years after enrollment, and only 33 percent successfully graduate with a degree or certificate (Figure 1). In comparison, students who are not parents are much more likely to graduate and much less likely to drop out without a degree:

53 percent graduate within 6 years of enrollment whereas 32 percent leave school in that time frame without attaining any degree or certificate (Figure 1).<sup>7</sup>

For both men and women, raising a child without the support of a partner can significantly decrease the likelihood of completing a degree or certificate program. As seen in Figure 1, only 27 percent of single student parents who began college in 2003 graduated with a degree or certificate by 2009, compared with 54 percent of their counterparts without children and 39 percent of married student parents; more than half (56 percent) dropped out without attaining a degree or certificate (Figure 1).<sup>8</sup> Given that 43 percent of all student parents are single mothers, such low completion rates and high dropout rates are particularly concerning for women trying to get the education they need to earn family-sustaining wages (Gault et al. 2014).

**Figure 1: Cumulative Persistence and Attainment by Parent and Marital Status, 2003-2009**



Note: Single is defined as single, divorced, widowed, or separated.

Source: IWPR analysis of data from the U.S. Department of Education, National Center for Education Statistics, 2003-04 Beginning Postsecondary Students Longitudinal Study, Second Follow-up (BPS:04/09).

<sup>7</sup> IWPR analysis of data from the U.S. Department of Education, National Center for Education Statistics, 2003-04 Beginning Postsecondary Students Longitudinal Study, Second Follow-up (BPS:04/09).

<sup>8</sup> Ibid.



## Addressing Unplanned Pregnancy to Increase College Completion

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Access to effective methods of avoiding an unplanned pregnancy is crucial to ensuring the success of women in college. Contrary to popular belief, however, young adults in college—like young adults overall—often do not know as much about contraceptive methods as they need to effectively avoid an unplanned pregnancy (Albert 2012; The National Campaign 2011).

### Gaps in Reproductive Health Knowledge among Community College Students

According to a qualitative study of community college students conducted by Child Trends for the National Campaign to Prevent Teen and Unplanned Pregnancy, while 82 percent of participants reported using birth control because they felt that having a child while in college would make their goals harder to accomplish, many reported doing so inconsistently and/or not using the most effective contraceptive methods. Participants also reported a lack of knowledge of how contraceptives work, how to use them correctly, and where to find them (The National Campaign 2011).

Another survey commissioned by The National Campaign using combined data from two national surveys, one of individuals ages 18-29 and another of individuals 18 and older, found that, while the large majority (94 percent) of survey respondents said they know everything they need to avoid an unplanned pregnancy, more than two in five reported knowing little or nothing about birth control pills and 11 percent said they know little or nothing about condoms. Far more student respondents had little to no knowledge about the most effective, low-maintenance methods of birth control, with 73 percent saying they knew little or nothing about intrauterine devices (IUDs). Although 84 percent of young adults surveyed felt that it is important to avoid an unplanned pregnancy, nearly 20 percent of respondents said they were likely to have sex without using any method of birth control within the next three months (Albert 2012).

### Promoting Reproductive Health and Awareness on Community College Campuses

The National Campaign has developed a series of recommendations for colleges to address gaps in reproductive health knowledge on their campuses, including incorporating educational material into college success courses and online resources, and connecting students with health services (The National Campaign 2015). For example, information on building a healthy relationship and avoiding an unplanned pregnancy can be integrated into credit-bearing courses, like English or sociology, or first year experience and/or orientation courses that all students are required to take when entering college (Prentice, Storin, and Robinson 2012). These strategies have the potential to play a key role in addressing gaps in knowledge of and improving access to contraception which can help college students avoid an unintended pregnancy and improve their chances of graduation. The National Campaign has many resources

available on its website that college faculty and staff can use to help students prevent unplanned pregnancy, including free [online lessons](#).<sup>9</sup>

## Spotlight: Student Parents at Community Colleges

Nearly half of all student parents in postsecondary education attending community colleges, the likelihood that they will persist and complete with a degree or certificate is particularly important. At public two-year institutions, only roughly one quarter (26 percent) of students with dependent children complete their programs within 6 years, while over half (56 percent) drop out without attaining any degree or certificate.<sup>1</sup>

Completion is even more challenging for the 42 percent of student mothers and 12 percent of student fathers attending community college and raising a child without a spouse or partner.<sup>2</sup> Only 14 percent of single student parents at community colleges finish their education with a degree or certificate, and 63 percent drop out altogether, compared with 35 percent and 51 percent of married student parents, respectively.<sup>3</sup>

<sup>1</sup> IWPR analysis of data from the U.S. Department of Education, National Center for Education Statistics, 2003-04 Beginning Postsecondary Students Longitudinal Study, Second Follow-up (BPS:04/09).

<sup>2</sup> IWPR analysis of data from the U.S. Department of Education, National Center for Education Statistics, 2012 National Postsecondary Student Aid Survey and 2011-12 Integrated Postsecondary Education Data System (IPEDS).

<sup>3</sup> IWPR analysis of data from the U.S. Department of Education, National Center for Education Statistics, 2003-04 Beginning Postsecondary Students Longitudinal Study, Second Follow-up (BPS:04/09).

## Addressing Unplanned Pregnancy and Supporting Low-Income Mothers' Educational Attainment: The Women's Funds Taking Leadership

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A number of women's foundations across the United States are taking leadership at the state and local levels to expand young women's access to supports that can help them delay pregnancy and attain the education or training needed to find a job with family-sustaining wages. These efforts including targeted grantmaking, advocacy, and program design. Examples of some of this work are described below. For a list of the women's funds included below, see Appendix B.

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<sup>9</sup> For more information on The National Campaign resources for colleges, visit <http://thenationalcampaign.org/featured-topics/colleges>. Online lessons can be found at <http://thenationalcampaign.org/resource/online-lessons-faculty-page>.

## The Women's Fund of Western Massachusetts: Supporting Local Pregnancy Prevention Initiatives

The [Women's Fund of Western Massachusetts](#) supports reproductive health as part of its mission to promote economic attainment and educational access and economic success for women. For example, the Fund has awarded a grant to the [Facts Teen Pregnancy Prevention Initiative](#), a coalition of teens and parents, local businesses, health care providers, and social service representatives, run by Berkshire United Way. With a goal of reducing teen pregnancy in Western Massachusetts by 50 percent among 15-19 year olds by the year 2020, the coalition advocates for comprehensive sex education, works to improve access to reproductive health care, and develops youth-friendly marketing materials to increase awareness of how to avoid teen pregnancy.

## The Women's Fund of Omaha: Grant Opportunities for Evidence-Based Reproductive Health Services

The [Adolescent Health Project](#) of the [Women's Fund of Omaha](#) works to improve the provision of evidence-based and results-oriented health services with a goal of decreasing the rates of sexually transmitted infections and teen pregnancy in Douglas County, Nebraska. The Women's Fund of Omaha, with support from the Sherwood Foundation, has hired an Adolescent Health Coordinator to create grant opportunities for community stakeholders promoting evidence-based approaches to reproductive health, support the development of evidence-based sex education materials, and improve youth access to contraception at the community level.

## The Women's Foundation of Arkansas: Research on Sex Education and Teen Pregnancy

The [Women's Foundation of Arkansas](#) sponsors education and research focused on improving the economic prospects of Arkansas women. In 2014, the Foundation published a report highlighting data on Arkansas' high rate of teen pregnancy, examining its educational and economic consequences for both young, low-income mothers and the larger state economy, and providing recommendations for steps that can improve outcomes for Arkansas teens moving forward. [\*Delivering Better Education: Impact of Teen Pregnancy & Birth on Education in Arkansas\*](#) advocates for medically-accurate, evidence-based sex education to be mandated in Arkansas schools (Jozkowski and D'Amico 2014). Arkansas does not currently require schools to provide sex education (Guttmacher Institute 2015d), and its teen birth rate was the highest in the country in 2013 (Martin et al. 2015).

## The Women's Fund of Greater Birmingham: Supporting Collaborations for Two-Generation Poverty Alleviation Strategies

The [Women's Foundation of Greater Birmingham](#) strives to support single mothers in Birmingham using a two-generation collaborative approach. The Foundation promotes the provision of supports that benefit

children and low-income mothers simultaneously, like child care, stable housing, higher education, and skills training. Basing their approach on work by Ascend at the Aspen Institute, and others, the Foundation's [Collaboration Institute](#) promotes formal collaborations among local organizations to help women and children achieve economic well-being. A nine-month curriculum provided by the Collaboration Institute guides organizations in forming collaborations and developing action plans for implementing two-generation approaches to poverty alleviation for low-income mothers.

## The Western New York Women's Foundation: Building Career Pathways for Mothers in Community College

The [Western New York \(WNY\) Women's Foundation](#) works to align job-focused higher education, life skills, career planning, and wraparound supports to improve the well-being of mothers living in poverty in the western New York community. The Foundation launched a pilot program for low-income, single parents who attend Niagara County Community College (NCCC) and are pursuing education or training that is targeted at jobs with a high demand for employees and has family-sustaining wages, such as jobs in health, tourism, and science, technology, engineering, and math (STEM). The [MOMS: From Education to Employment](#) initiative is an academic and support program that provides a range of services to participants, including child care through the NCCC Child Development Center, career and academic coaching, peer mentoring, financial aid and career planning workshops, and study groups. The WNY Women's Foundation reports that the *MOMS* program participants have higher retention and better academic outcomes in comparison with single mothers who did not participate, and is on track to serve more than 100 women over a three-year time period.

## The Women's Foundation of Mississippi: Comprehensive Strategies for Pregnancy Prevention and Supports for Mothers in College

The [Women's Foundation of Mississippi](#) (WFM) works to reduce unplanned pregnancies among Mississippi young women, in an effort to increase college completion and, ultimately, improve their chances of long-term economic success. WFM raises awareness of Mississippi's high teen pregnancy rate (the second highest of any state as of 2011, down from the highest rate in 2010; U.S. Department of Health and Human Services 2014b), and provides strategic recommendations to colleges seeking to address the issue of unintended pregnancy among their students. WFM also funds research and interventions focused on strategies to reduce rates of teen and unplanned pregnancies and to increase college attainment for women with and without dependent children.

WFM has played an important role in the efforts to pass and implement SB 2563, a bill that addresses Mississippi's unintended pregnancy rate among young adult women that took effect on June 1, 2014. The bill requires two- and four-year colleges and universities to develop a plan of action addressing unintended pregnancy amongst college students and is the first of its kind. SB 2563 acknowledges the link between unplanned pregnancy, college completion, and economic security, and seeks to engage colleges and universities in strategically addressing these issues on their campuses. WFM partnered with Senator Sally Doty (R-MS) and the National Campaign to Prevent Teen and Unplanned Pregnancy to

highlight to the need to reduce unplanned pregnancy rates among older teens ages 18-19, and has worked with other partners in Mississippi to provide the state legislature with recommendations on how to do so specifically in the context of SB 2563.

In addition to its work surrounding SB 2563, WFM awarded grants to four Mississippi community colleges in 2014 to implement recommendations identified in a report by IWPR, *Securing a Better Future: A Portrait of Female Students in Mississippi's Community Colleges* (Hess et al. 2014). The report, based on a survey of nearly 550 students from 13 of Mississippi's 15 community colleges, explored the motivations of, challenges faced by, and supports needed by women students attending community college. The report's recommendations highlight areas identified by survey respondents that could help them successfully complete community college, including, but not limited to, better career counseling on nontraditional and higher-paying jobs, improving student access to child care services, improving access to health care, and connecting female students to financial aid and public benefits.

WFM is collaborating with four community colleges located in high-need areas of Mississippi to develop a pilot program aimed at increasing access to health care for community college students, thereby decreasing rates of sexually transmitted infections and unplanned pregnancies. The pilot intervention will engage medical professionals from the University of Alabama at Birmingham to provide free training on reproductive health care to staff at community colleges' health centers and at clinics run by local Departments of Health. The training will focus on youth-friendly strategies for providing reproductive health care to young adults' use of health care services. WFM will offer grants to participating community colleges and their health centers to implement training recommendations, and is working to build a body of knowledge and lessons learned from the successes and challenges experienced during the pilot.

## Conclusion

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Organizations at the state and national levels have an important role to play in closing gaps in knowledge about safe sex and the economic and social benefits of delaying pregnancy, and improving access to reproductive health services and to supports for women pursuing a postsecondary education, including mothers. Several women's funds are taking leadership in establishing innovative programs at the state and local level to help women direct their own reproductive and economic success. Engaging community colleges in the effort to raise awareness of how to avoid an unplanned pregnancy holds particular promise for increasing the rate of college completion among community college students.

## Appendix A: Women’s Status on the Reproductive Rights Composite Index and Its Components

State	Does the State Require Parental Notification and/or Consent for Abortion Services for Minors? (as of March 2015)	Does the State Mandate a Waiting Period Prior to Abortion Services? (as of March 2015)	Does the State Provide Public Funding for Abortions? (as of March 2015)	What Percent of Women Live in Counties with an Abortion Provider? (2011)	Does the State Have a Pro-Choice Governor and Legislature? (as of January 2015)		Has the State Adopted the Medicaid Expansion (as of February 2015) or Expanded Eligibility for Medicaid Family Planning Services (as of April 2015)?	Does the State Require Health Insurers to Provide Coverage of Infertility Treatments? (as of June 2014)	Does the State Require Schools to Provide Sex Education? (as of March 2015)
	Yes/No	Yes/No	Yes/No	Percent	Yes/No	Mixed	Yes/No	Yes/No	Yes/No
Alabama	Yes	Yes	No	41%	No		Yes	No	No
Alaska	Yes	No	Yes	83%	No		No	No	No
Arizona	Yes	Yes	Yes	86%	No		Yes	No	No
Arkansas	Yes	Yes	No	22%	No		Yes	Yes	No
California	Yes	No	Yes	99%	Yes		Yes	Yes	No
Colorado	Yes	No	No	88%		X	Yes	No	No
Connecticut	No	No	Yes	95%	Yes		Yes	Yes	No
Delaware	Yes	Yes	No	82%		X	Yes	No	Yes
District of Columbia	No	No	No	100%	Yes		Yes	No	Yes
Florida	Yes	No	No	79%	No		Yes	No	No
Georgia	Yes	Yes	No	43%		X	Yes	No	Yes
Hawaii	No	No	Yes	100%	Yes		Yes	Yes	No
Idaho	Yes	Yes	No	31%	No		No	No	No
Illinois	Yes	No	Yes	61%		X	Yes	Yes	No
Indiana	Yes	Yes	No	39%	No		Yes	No	No
Iowa	Yes	No	No	50%		X	Yes	No	Yes
Kansas	Yes	Yes	No	26%	No		No	No	No
Kentucky	Yes	Yes	No	26%		X	Yes	No	Yes
Louisiana	Yes	Yes	No	37%	No		Yes	No	No
Maine	No	No	No	53%		X	No	No	Yes
Maryland	Yes	No	Yes	81%		X	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	91%		X	Yes	Yes	No
Michigan	Yes	Yes	No	66%	No		Yes	No	No
Minnesota	Yes	Yes	Yes	41%		X	Yes	No	Yes
Mississippi	Yes	Yes	No	9%	No		Yes	No	Yes
Missouri	Yes	Yes	No	26%		X	Yes	No	No
Montana	Yes	Yes	Yes	54%		X	Yes	Yes	Yes
Nebraska	Yes	Yes	No	59%	No		No	No	No
Nevada	Yes	No	No	94%		X	Yes	No	Yes



New Hampshire	Yes	No	No	88%		X	Yes	No	No
New Jersey	Yes	No	Yes	91%		X	Yes	Yes	Yes
New Mexico	Yes	No	Yes	52%		X	Yes	No	Yes
New York	No	No	Yes	92%		X	Yes	Yes	No
North Carolina	Yes	Yes	No	51%	No		Yes	No	Yes
North Dakota	Yes	Yes	No	27%	No		Yes	No	Yes
Ohio	Yes	Yes	No	49%	No		Yes	Yes	Yes
Oklahoma	Yes	Yes	No	45%	No		Yes	No	No
Oregon	No	No	Yes	78%	Yes		Yes	No	Yes
Pennsylvania	Yes	Yes	No	53%		X	Yes	No	No
Rhode Island	Yes	No	No	63%		X	Yes	Yes	Yes
South Carolina	Yes	Yes	No	40%		X	Yes	No	Yes
South Dakota	Yes	Yes	No	23%	No		No	No	No
Tennessee	Yes	Yes	No	42%	No		No	No	Yes
Texas	Yes	Yes	No	69%	No		Yes	Yes	No
Utah	Yes	Yes	No	66%	No		No	No	Yes
Vermont	No	No	Yes	65%	Yes		Yes	No	Yes
Virginia	Yes	Yes	No	41%		X	Yes	No	No
Washington	No	No	Yes	87%		X	Yes	No	No
West Virginia	Yes	Yes	Yes	18%		X	Yes	Yes	Yes
Wisconsin	Yes	Yes	No	40%	No		Yes	No	No
Wyoming	Yes	No	No	4%		X	Yes	No	No

## Methodological Note

**MANDATORY CONSENT:** States were described as having a mandatory consent law if they allow minors access to abortion without parental consent or notification. Mandatory consent laws require that minors gain the consent of one or both parents before a physician can perform the procedure, while notification laws require they notify one or both parents of the decision to have an abortion. Source: Guttmacher Institute 2015c

**WAITING PERIOD:** States were described as having a waiting period if they did not allow a woman to have an abortion without a waiting period. Waiting-period legislation mandates that a physician cannot perform an abortion until a certain number of hours after notifying the woman of her options in dealing with a pregnancy. Source: Guttmacher Institute 2015c.

**RESTRICTIONS ON PUBLIC FUNDING:** States were described as having restrictions on public funding for abortions if they do not provide public funding for all or most medically necessary abortions for women who meet income eligibility standards. Source: Guttmacher Institute 2015c.

**PERCENT OF WOMEN LIVING IN COUNTIES WITH AT LEAST ONE ABORTION PROVIDER:** Source: Guttmacher Institute 2014.

**PRO-CHOICE GOVERNOR OR LEGISLATURE:** This indicator is based on NARAL's assessment of whether governors and legislatures would support a ban or restrictions on abortion. Governors and legislatures who would support restrictions on abortion rights are considered anti-choice, and those who would oppose them are considered pro-choice. Legislatures with a majority that are neither anti- or pro-

choice are considered mixed. Source: NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 2015a and NARAL Pro-Choice America 2015.

**MEDICAID EXPANSION:** Whether a state had expanded Medicaid under the ACA or enacted a state Medicaid family planning eligibility expansion through either a waiver of federal policy from the Centers for Medicare and Medicaid Services or a state plan amendment: family planning eligibility expansions extend Medicaid coverage of family planning services to women who would be otherwise ineligible, and in some cases to women who are exiting the Medicaid program. Sources: Guttmacher Institute 2015b and Kaiser Family Foundation 2015.

**COVERAGE OF INFERTILITY TREATMENTS:** States mandating that insurance companies provide coverage of infertility treatments and states mandating that insurance companies offer policyholders coverage of infertility treatments were described as requiring health insurers to provide coverage of infertility treatments. Source: National Conference of State Legislatures 2014.

**MANDATORY SEX EDUCATION:** States were described as mandating schools to provide sex education if they require public schools (including K-12) to provide sex education classes. Source: Guttmacher Institute 2015d.

## Appendix B: List of Women’s Funds

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Name of Women’s Funds & Programs	Web Address
Women’s Fund of Western Massachusetts	<a href="http://www.womensfund.net/">www.womensfund.net/</a>
Facts Teen Pregnancy Prevention Initiative	<a href="http://www.berkshireunitedway.org/face-facts-reduce-teen-pregnancy">www.berkshireunitedway.org/face-facts-reduce-teen-pregnancy</a>
Women’s Fund of Omaha	<a href="http://www.omahawomensfund.org/">www.omahawomensfund.org/</a>
Adolescent Health Project	<a href="http://www.omahawomensfund.org/leading-change/adolescent-health-project/">www.omahawomensfund.org/leading-change/adolescent-health-project/</a>
Women’s Foundation of Arkansas	<a href="http://www.womensfoundationarkansas.org/">www.womensfoundationarkansas.org/</a>
Women’s Foundation of Greater Birmingham	<a href="http://www.womensfundbirmingham.org/">www.womensfundbirmingham.org/</a>
Collaboration Institute	<a href="http://www.womensfundbirmingham.org/#!/collaborationinstitute/c19ja">www.womensfundbirmingham.org/#!/collaborationinstitute/c19ja</a>
WNY Women’s Foundation	<a href="http://www.wnywomensfoundation.org/">www.wnywomensfoundation.org/</a>
MOMS: From Education to Employment	<a href="http://www.wnywomensfoundation.org/family-sustaining-jobs">www.wnywomensfoundation.org/family-sustaining-jobs</a>
Women’s Foundation of Mississippi	<a href="http://www.womensfoundationms.org/">www.womensfoundationms.org/</a>

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