CHAPTER 5 | Reproductive Rights

Introduction

Reproductive rights, which protect women's ability to decide whether and when to have children, are vitally important to women's overall health and socioeconomic well-being. Being able to make decisions about one's own reproductive life and the timing of one's entry into parenthood is associated with greater relationship stability and satisfaction (National Campaign to Prevent Teen and Unplanned Pregnancy 2008), more work experience among women (Buckles 2008), and increased wages and average career earnings (Miller 2009). In addition, the ability to control the timing and size of one's family can have a significant effect on whether a young woman attends and completes college (Buckles 2008; Hock 2007). While reproductive freedom is a right that should belong to all women, the denial of this right is felt hardest by poor and minority women (Roberts 1992). Women of color, especially black women, often face particular barriers due to racial biases when attempting to access reproductive care (Roberts 1997).

As this chapter will show, though there have been some advancements in the area of reproductive rights, women in the South continue to face numerous barriers when it comes to accessing reproductive health services.[1] Women in the South are less likely to live in a state with a governor or state legislature that is pro-choice—resulting in more mandatory waiting periods for abortions and harsher restrictions when it comes to parental consent or notification of abortions for minors—and many live in a county with no abortion provider. The reproductive health of women in the South also varies greatly by race and ethnicity. For example, while black women in the South have some of the highest infant and maternal mortality rates, Hispanic women have some of the lowest rates of infant mortality and babies born with low birth weights. Both black and Hispanic women are more likely to receive inadequate prenatal care when compared with other women in the South. Women in the South, however, are experiencing an increase in access to much needed reproductive health services with the implementation of the Affordable Care Act (ACA) and the expansion of Medicaid.

This chapter provides information on a range of policies related to women's reproductive health and rights in the South. It examines abortion, contraception, infertility, and sex education. It also presents data on fertility and natality—including infant mortality—and highlights disparities in women's reproductive health by race and ethnicity. In addition, the chapter details recent shifts in federal and state policies related to reproductive rights. It explores the decision of some

[1] In this report, southern states include Alabama, Arkansas, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Throughout the report, the District of Columbia is referred to as a state, although it is technically a jurisdiction.

states to expand Medicaid coverage under the ACA, as well as state policies to extend eligibility for Medicaid family planning services.

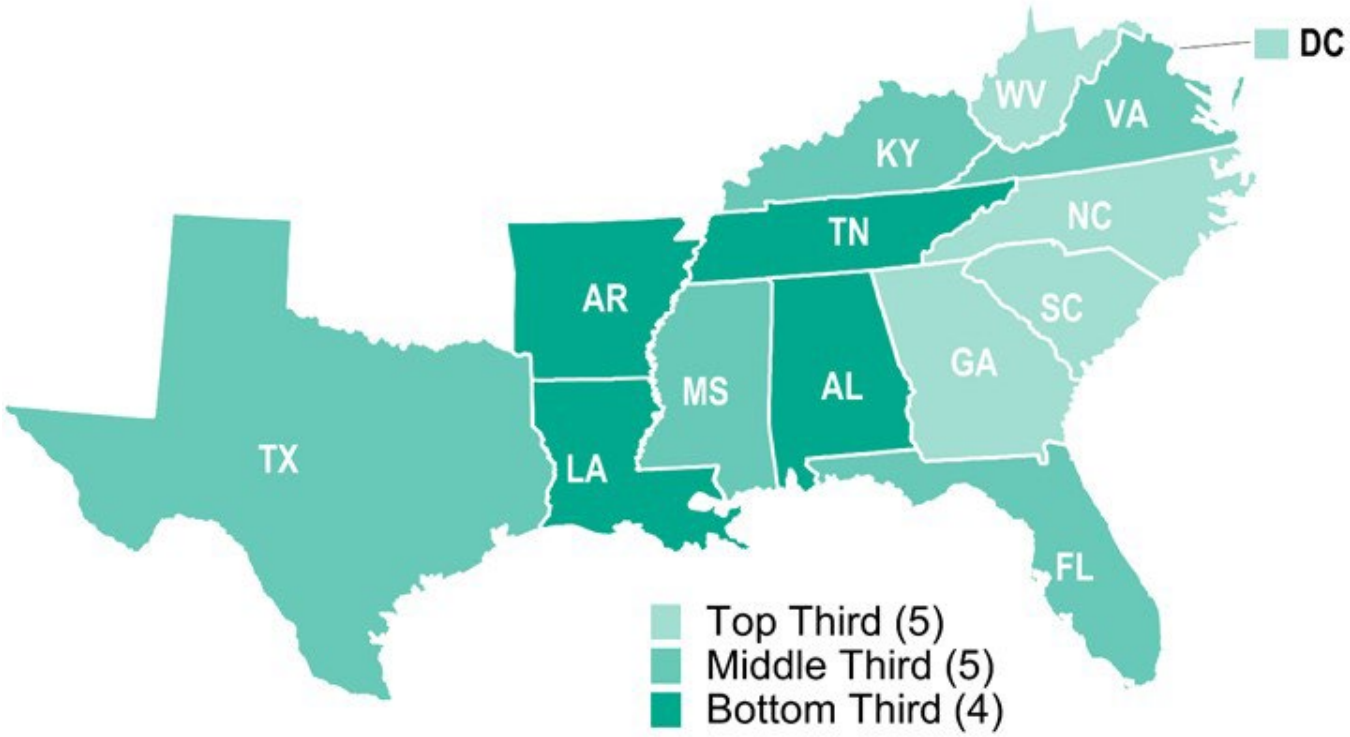
The Reproductive Rights Composite Score

The Reproductive Rights Composite Index includes eight component indicators of women's reproductive rights: mandatory parental consent or notification laws for minors receiving abortions, waiting periods for abortions, restrictions on public funding for abortions, the percent of women living in counties with at least one abortion provider, pro-choice governors or legislatures, Medicaid expansion or state Medicaid family planning eligibility expansions, coverage of infertility treatments, and mandatory sex education.[2] States receive composite scores and corresponding grades based on their combined performance on these indicators, with higher scores reflecting a stronger performance and receiving higher letter grades (Table 5.1; Map 5.1). For information on how composite scores and grades were determined, see Appendix A5.

- The District of Columbia has the highest score on the Reproductive Rights Composite Index for the South. It is the only place in the South that does not require parental consent or notification for abortions or require a waiting period. In addition, 100 percent of women living in the District live in a county with an abortion provider. The District also has a pro-choice mayor and city council, has adopted the expansion of Medicaid coverage under the ACA, and requires schools to provide sex education. The District of Columbia does not, however, provide public funding to poor women for abortions or require insurance companies to cover infertility treatments. The District of Colum-

Map 5.1.

Reproductive Rights Composite Index—South



Note: For methodology and sources, see Appendix A5.
Calculated by the Institute for Women's Policy Research.

[2] This composite represents a slight break from previous IWPR Reproductive Rights composites in that it no longer includes an indicator on same-sex marriage or second parent adoption for individuals in a same-sex relationship. The Supreme Court ruling on June 26, 2015 legalizing same-sex marriage for all LGBT couples in the U.S. eliminated the need for a composite indicator on this topic. See Appendix A5 for the methodology on how the composite was re-weighted to account for this change.

bia was awarded an A- and is ranked 8th overall nationally.

- The worst-ranking state for reproductive rights in the South is Louisiana. It requires parental consent or notification and waiting periods for abortions, does not provide public funding to poor women for abortions, has just 37 percent of women living in counties with abortion providers, does not have a pro-choice state government, does not require insurance companies to cover infertility treatments, and does not require schools to provide mandatory sex education. Louisiana does, however, have state Medicaid family planning eligibility expansions and has also opted to expand Medicaid through the ACA. Louisiana is ranked 47th nationally and receives a D.

In general, the South does fair on the Reproductive Rights Composite Index when compared with the nation as a whole, with seven of the 14 southern states ranked in the middle third nationally. There is still room for improvement on the Reproductive Rights Composite Index in the South: only the District of Columbia ranks in the top third nationally and six of the southern states rank in the bottom third nationally.

Table 5.1.

How the South Measures Up: Women's Status on the Reproductive Rights Composite Index and Its Components, 2014

	Composite Index				Parental Consent/ Notification	Waiting Period	Public Funding	Percent of Women Living in Counties with a Provider	Pro-Choice Governor and Legislature	Medicaid Expansion or Medicaid Family Planning Expansion	Coverage of Infertility Treatments	Mandatory Sex Education
State	Score	National Rank	Regional Rank	Grade	Score	Score	Score	Percent	Score	Score	Score	Score
Alabama	1.52	44	13	D	0	0	0	41%	0.00	1	0.0	0
Arkansas	1.85	37	11	D+	0	0	0	22%	0.00	1[a]	1.0	0
District of Columbia	5.38	8	1	A–	1	1	0	100%	1.00	1	0.0	1
Florida	1.93	35	9	C–	0	0	0	79%	0.00	1	0.0	0
Georgia	2.80	27	3	C	0	0	0	43%	0.17	1	0.0	1
Kentucky	2.61	30	6	C	0	0	0	26%	0.17	1	0.0	1
Louisiana	1.48	47	14	D	0	0	0	37%	0.00	1	0.0	0
Mississippi	2.25	32	7	C–	0	0	0	9%	0.00	1	0.0	1
North Carolina	2.70	29	5	C	0	0	0	51%	0.00	1	0.0	1
South Carolina	2.76	28	4	C	0	0	0	40%	0.17	1	0.0	1
Tennessee	1.53	43	12	D	0	0	0	42%	0.00	0	0.0	1[c]
Texas	2.09	34	8	C–	0	0	0	69%	0.00	1[b]	0.5	0
Virginia	1.88	36	10	C–	0	0	0	41%	0.33	1	0.0	0
West Virginia	4.14	18	2	B	0	0	1	18%	0.17	1	1.0	1
United States					**8 (count)**	**20 (count)**	**17 (count)**			**44 (count)**		**23 (count)**

Notes: [a]Arkansas has not enacted a state Medicaid family planning eligibility expansion, however they have approved Section 1115 waivers for Medicaid expansion. [b]Texas operates its own state-funded family planning program; women aged 18 and older with family income up to 185% of the federal poverty line are eligible. [c]Tennessee requires sex education if the teen pregnancy rate for 15-17 year-olds is 19.5 per 1,000 or higher.
See Appendix A5 for methodology and sources.

FOCUS ON PROGRESS: Same-Sex Marriage and Second-Parent Adoption

Previously, the Reproductive Rights Composite Index included an indicator on same-sex marriage or second parent adoption for individuals in a same-sex relationship (see Appendix A5 for methodology changes). After a long and impassioned fight for marriage equality, on June 26, 2015 the Supreme Court of the United States asserted the fundamental right of same-sex partners to legally marry. The Court wrote that as long as same-sex marriages are not recognized, "same-sex couples are denied the constellation of benefits that the States have linked to marriage," and further that "it is demeaning to lock same-sex couples out of a central institution of the Nation's society, for they too may aspire to the transcendent purpose of marriage" (Obergefell v. Hodges 2015). This landmark victory means equal access to the more than 1,100 benefits tied to marriage, including hospital visitations, child custody, adoption, parenting rights, medical decision-making power, automatic inheritance, divorce protections, social security benefits, and domestic violence protections, among many others (Revel & Riot 2015).

LGBT people, however, still face a slew of legal barriers to equality as many states do not protect LGBT people from being unfairly fired or discriminated against in the workplace, evicted or denied a home loan, and denied health coverage on the basis of their identities (Culp-Ressler 2015). These barriers have significant financial costs for LGBT individuals, leaving them more likely to be poor than non-LGBT individuals: 20.7 percent of LGBT individuals living alone have extremely low wages, while 4.3 percent of male same-sex couples and 7.6 percent of female same-sex couples live in poverty (Center for American Progress and Movement Advancement Project 2014). Yet, the Supreme Court decision could herald further rulings from the Supreme Court regarding gay rights. For example, the Mississippi law specifically prohibiting second-parent adoption for same-sex couples is currently being challenged in court, and there is much hope that the recent Supreme Court ruling will influence the ruling for this case (Lewin 2015). Thus, marriage equality not only means increased access to benefits for same-sex couples and their children, it also brings with it the hope of future gains through legal precedent for equal treatment under the law.

Access to Abortion

The 1973 Supreme Court case of Roe v. Wade established the legal right to abortion in the United States. However, state legislatures and executive bodies continue to battle over legislation related to access to abortion, including parental consent and notification and mandatory waiting periods (Guttmacher Institute 2015a), and public funding for abortions remains a contested issue in many states even though the use of federal funds for most abortions has been banned since 1977 (Boonstra 2013).[3]

Efforts to limit women's access to abortion have increased exponentially in recent years, with more abortion restrictions enacted since 2010 than in the previous decade (231 new restrictions; Guttmacher Institute 2014; Guttmacher Institute 2015b). In 2015 alone, 514 provisions aimed at restricting access to abortion were introduced in state legislatures, leading to 57 new abortion restrictions in 17 states (Nash et al. 2016). Legislative measures include bills requiring women to have an ultrasound before obtaining an abortion, bans on obtaining abortions later in a pregnancy, bans or restrictions preventing women from using health insurance to cover abortions, and stringent regulations on abortion providers including legislation that will result in the closure of multiple abortion clinics (Culp-Ressler 2015).

While legislative attacks on reproductive rights are occurring throughout the United States, they are particularly concentrated in the South. The Guttmacher Institute has been tracking abortion restrictions and uses these to identify states that they consider to be 'hostile' to abortion rights.[4] According to Guttmacher, in 2000 only 13 states were considered 'hostile' to abortion rights, of which 5 were southern states (Guttmacher Institute 2015b). By 2014 the number of 'hostile' states had grown to 27, of which 18 are labeled 'extremely hostile' to abortion rights. Of the 14 southern states, five are labeled 'hostile' and seven are

[3] Federal funds can be used for abortion if the pregnancy resulted from rape or incest or the woman's life is in danger (Boonstra 2013).

[4] According to Guttmacher, supportive states have no more than one type of major abortion restriction, middle ground states have 2-3 types of major restrictions, hostile states have 4-5, and extremely hostile states have 6-10 (Guttmacher Institute 2015b).

considered 'extremely hostile' to abortion rights. Only two southern states—West Virginia and the District of Columbia—have not been labeled 'hostile' to abortion as of 2014 (Guttmacher Institute 2015b).

In fact, many southern states have passed laws specifically targeted at regulating abortion providers (Guttmacher Institute 2015c), with Alabama, Louisiana, Mississippi, Tennessee, and Texas all passing laws requiring that clinicians have admitting privileges at a local hospital. While the laws in Alabama, Louisiana, and Mississippi are being challenged in the courts and have yet to take effect,[5] the law in Texas has already lead to the closure of numerous clinics (Culp-Ressler 2014; Guttmacher Institute 2015c). The closure of these clinics not only limits women's access to abortions, it also limits their access to other essential reproductive health services—health services that are essential for poor, rural, and minority women who may not have access to these services elsewhere. For example, abortion services at Planned Parenthood account for only three percent of all services. Planned Parenthood clinics also provide STI/STD testing and treatment (41 percent of services), contraception (34 percent of services), and cancer screening and prevention (10 percent of services), among others (Planned Parenthood Federation of America 2014).

Though abortion rates overall have fallen in recent years, the abortion rate for women of color is still much higher than that for white women: the abortion rate for Hispanic women is double the rate for white women and the rate for black women is almost five times that for white women (Cohen 2008). Much of this has to do with the fact that women of color have less access to contraceptives and reproductive health care, which leads to more unintended pregnancies (Cohen 2008). The lack of access to contraceptives and reproductive health care will only continue to increase as legislative measures result in the closure of more abortion clinics in the South, clinics that provide much needed family planning services to low-income women (Culp-Ressler 2014; Redden 2015).

- As of December 2015, 13 states in the South had statutes requiring mandatory waiting periods for obtaining an abortion and enforced these statutes, with waiting periods ranging from 24 to 72 hours (Guttmacher Institute 2015a).
- Thirteen southern states had parental consent or notification laws as of December 2015, which require parents of a minor seeking an abortion to consent to the procedure or be notified. Among these southern states eight enforced parental consent (with Mississippi requiring consent from both parents) and three enforced the notification of parents (Florida, Georgia, and West Virginia). Texas and Virginia enforced both parental consent and notification for minors seeking to undergo an abortion procedure (Guttmacher Institute 2015a).
- While, as of December 2015, 17 states nationally fund abortions for low-income women who were eligible for Medicaid in all or most medically necessary circumstances, West Virginia was the only southern state to do so. In all the other southern states, state Medicaid funds can be used only in situations where the woman's life is in danger or the pregnancy resulted from rape or incest. In Mississippi and Virginia there is an additional exception when there is a fetal anomaly (Guttmacher Institute 2015a).
- As of 2011—the most recent year for which data are available—the percentage of women aged 15-44 who lived in counties with an abortion provider ranged across the South from a low of nine percent in Mississippi to 100 percent in the District of Columbia. However, in the vast majority of southern states (ten out of 14) fewer than half the women lived in counties with at least one provider and in North Carolina only 51 percent of women lived in a county with at least one provider. Only Texas, Florida, and the District of Columbia have more than this (69, 79, and 100 percent respectively; Guttmacher Institute 2015d).
- As of December 2014, the governor and majority of state legislators in eight southern states were anti-choice (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 2015). Only the District of Columbia had a mayor and a majority of the city council who were pro-choice and would not support restrictions on abortion rights. In the remaining southern states, the government was mixed.

[5] The laws are temporarily enjoined pending final decision in the courts.

FOCUS ON: The Legacy of Forced Sterilization in the South

Forced sterilization has a long history in the United States, going as far back as 1907 when the U.S. enacted policy giving the government the right to sterilize those deemed incapable—mainly the "insane," "feebleminded," or "diseased"—of managing their own reproductive lives (Krase 2014). Thirty states, including Alabama, Georgia, Mississippi, North Carolina, South Carolina, Virginia, and West Virginia, followed suit in the following decades, passing their own laws legitimizing forced sterilization of certain groups (Kaelber 2011; Schoen 2006). The states with the most cases of state-sanctioned sterilizations between the 1920s and the mid-1970s were California (20,000), North Carolina (over 8,000), and Virginia (over 7,000; Kaelber 2011). While most state-ordered sterilizations slowed or ceased completely by the late 1940s, this was countered by the expansion of these same programs in Georgia, North Carolina, and Virginia, whose state-sanctioned sterilizations accounted for 76 percent of all sterilizations nationally by 1958 (Schoen 2006).

With the "diagnosis" of feeblemindedness including social symptoms such as poverty, promiscuity, alcoholism, and illegitimacy, forced sterilization became a tool for limiting the number of poor people who would be dependent on welfare programs (Schoen 2006). As a result, poor women and women of color were most often the targets of forced sterilization efforts. For example, 84 percent of sterilizations in North Carolina were performed on women (Schoen 2006) and 65 percent of these over 8,000 sterilizations were performed on black women, which is notable since black women account for only 25 percent of North Carolina's female population (Krase 2014). North Carolina, though the most egregious of the southern states, was not alone, as most southern states with state-sanctioned sterilization performed more sterilizations on women than on men (Kaelber 2011).

As sterilization became a tool for curbing reliance on government benefits, many women were threatened with the loss of government benefits for themselves or their families if they did not comply with sterilization. North Carolina even went so far as to allow social workers to designate candidates for sterilization and submit sterilization petitions to the state Eugenics Board (Murdock 2013; Schoen 2006). Other abuses included sterilization of young women and girls without their families' knowledge or approval. The most notable case occurred in Alabama in 1973 and involved the Relf sisters, ages 17, 14, and 12, whose family never consented to or received notice of the tubal sterilizations for the younger two, the early and experimental Depo-Provera shots for all three, and an intrauterine device for the eldest (Krase 2014; Volscho 2010).

The effects of state-sanctioned forced sterilization in the South are still being felt today, as states begin to face this history of marginalization and abuse. In 2003 the governors of North Carolina, South Carolina, and Virginia issued apologies for their states' programs (Schoen 2006). In 2013 North Carolina became the first state to pass legislation approving the compensation of its sterilization victims, though the program has already encountered complications as some victims have been deemed ineligible since their sterilizations were not officially approved by the central state Board, but rather by local authorities (Mennel 2014). As a result, the South will most likely continue to grapple with this legacy for years to come.

Medicaid Expansion and State Medicaid Family Planning Eligibility Expansions

The Affordable Care Act (ACA) has increased the number of people with access to health insurance coverage through changes to Medicaid, a public health coverage program for low-income individuals. To help those who may have struggled in the past to afford insurance, the ACA seeks to expand Medicaid eligibility to all individuals under age 65 who are not eligible for Medicare and have incomes up to 138 percent of the federal poverty line (individuals were previously eligible only if they were pregnant, the parent of a dependent child, 65 years of age or older, or disabled, in addition to meeting income requirements; National Conference of State Legislatures 2011).[6] While this change increases the number of women who are eligible to receive family planning services, along with other health care services, states can opt out of this Medicaid expansion. As of January 2016, 32 states—including Arkansas, Kentucky, Louisiana, and West Virginia—and the District of Columbia had chosen to adopt the Medicaid expansion, with three in the process of deciding whether to do so (including Virginia; Kaiser Family Foundation 2016).

In addition to Medicaid expansion through the ACA, states interested in expanding Medicaid family planning services to individuals who would otherwise not be eligible for Medicaid can now expand their programs either through a waiver from the federal government—which is temporary—or through an expedited option of a State Plan Amendment, which is a permanent change to the state's Medicaid program (Guttmacher Institute 2016).

- As of January 2016, nine southern states had extended family planning services to individuals who were otherwise ineligible, either through a waiver or through a State Plan Amendment (including Texas, which had an expansion funded solely by the state). The income ceiling among these states ranged from a low of 138 percent of the federal poverty line in Louisiana, to a high of 205 percent of the federal poverty line in Virginia (where the expansion includes those losing postpartum coverage; Guttmacher Institute 2016).
- Of these nine states, Florida is the only state that provided these benefits to women who lose Medicaid coverage for any reason, rather than basing eligibility only on income. The remaining eight southern states all provide family planning benefits to individuals based on income, with most of the states having an income ceiling near 200 percent of the federal poverty line (Guttmacher Institute 2016).
- Five states defined the eligible population for Medicaid coverage of family planning services to include individuals who are younger than 19 years old. Georgia included individuals who are 18 years old but not those who are younger than 18 (Guttmacher Institute 2016).
- As of January 2016, three southern states—Arkansas, Kentucky, and West Virginia—and the District of Columbia had expanded the Medicaid program overall but did not have a family planning eligibility expansion. Virginia, one of the nine southern states with family planning eligibility expansions, is currently discussing the adoption of the Medicaid expansion. While Louisiana was the only southern state to both adopt the Medicaid expansion and have a family planning eligibility expansion (Guttmacher Institute 2016; Kaiser Family Foundation 2016), Tennessee is the only southern state that had neither expanded Medicaid overall nor enacted a state family planning expansion (Table 5.1).

Other Family Planning Policies and Resources

Access to Fertility Treatments

Infertility treatments can improve the reproductive choices of women and men, but they are often prohibitively expensive, especially when they are not covered

[6] 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).

by insurance. As of June 2014, only Arkansas and West Virginia had passed measures requiring insurance companies to cover infertility treatments.[7] In Texas, insurance companies had to offer infertility coverage to their policy holders (National Conference of State Legislatures 2014).[8]

Mandatory Sex Education in Schools

Research has shown that sex education is critical to ensuring that young women and men have the knowledge they need to make informed decisions about sexual activity and avoiding unwanted pregnancy and disease (Douglas 2007). In eight southern states—the District of Columbia, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and West Virginia—schools are required to provide sex education and of these eight, all except Mississippi also require HIV education.[9] Five states and the District of Columbia require that information about contraception be included in the curricula when sex education is taught. Additionally, while 13 states require that information regarding abstinence be included in sex education curricula, 10 of these states require that information on abstinence be stressed and it must include information on the importance of sex only within marriage (Guttmacher Institute 2015e).[10]

Fertility, Natality, and Infant Health

Key to women's reproductive health is access to quality health care services. Unfortunately, women in the South and women of color have worse outcomes when looking at pregnancy and birth outcomes, which are not only linked to their access to prenatal care, but also can often be linked to complications arising from the presence of preventable chronic and obesity related conditions (see Health & Wellbeing chapter; Black Women's Roundtable 2015; Mason 2015). In fact, the maternal mortality rate for women in the United States has hit a record high, with the number of reported pregnancy-related deaths increasing from 7.2 deaths per 100,000 live births in 1987 to 17.8 deaths per 100,000 live births in 2011 (Centers for Disease Control and Prevention 2015). The maternal mortality rate for black women is even higher, with black women 3.4 times more likely to die due to pregnancy and childbirth than white women (42.8 deaths per 100,000 live births for black women versus 12.5 deaths per 100,000 live births for white women; Centers for Disease Control and Prevention 2015). Maternal mortality is also alarmingly high in the South. For example, Mississippi has one of the highest rates of pregnancy-related deaths in the United States at 39.7 deaths per 100,000 live births, with the rate for black women even higher, at 54.7 deaths per 100,000 live births (Graham and Collier 2013).[11] While the exact reasons for the high rate of maternal mortality in the South are still unknown, many of the factors attributed to this high rate of death are linked to women entering pregnancy unhealthier overall (Mason 2015; Morello 2014; Paquette 2015). Some believe racial discrimination also plays a large part in the overall health and well-being of women of color, impacting not only their reproductive health and maternal mortality rates (Center for Reproductive Rights 2014; Paquette 2015; Roberts 1997), but also their fertility and infant health.

Women's Fertility

The fertility rate for women in the United States overall has declined in recent years, which is partly due to women giving birth later in life. In 2013, the median age for women at the time of their first birth was 26.0 years, compared with 22.7 years in 1980 (Martin et al. 2015b). In 2014, the fertility rate was 62.9 live births per 1,000 women aged 15-44 in the United States. While this is a significant decline since 1960, when the fertility rate was 118.0 births per 1,000 women (Martin et al. 2015a), this is an increase from the birth rate in 2013 (62.5 births per 1,000 women), which is the first increase in the fertility rate since 2007 (Hamilton et al. 2015).

[7] Louisiana prohibits the exclusion of coverage for a medical condition that would otherwise be covered solely because the condition results in infertility.

[8] A mandate to cover infertility treatments requires health insurance plans sold by licensed insurers to include coverage for these treatments. A mandate to offer coverage means that the plans must provide this coverage, but the person buying the policy does not have to elect coverage for this benefit (Kaiser Family Foundation 2015).

[9] Tennessee requires schools to provide sex education if the pregnancy rate among 15- to 17-year-olds is 19.5 per 1,000 or higher (Guttmacher Institute 2015e).

[10] The District of Columbia does not require that sex education must include information on abstinence (Guttmacher Institute 2015e).

[11] The Mississippi rates are three year averages (2010-2012) and the data is collected by the Mississippi State Department of Health, office of Health Data and Research.

- In 2013, the District of Columbia had the lowest fertility rate in the South among women aged 15-44 at 53.3 live births per 1,000 women, followed by Florida at 59.3 per 1,000, North Carolina at 60.4 per 1,000, and Alabama and South Carolina both at 60.6 per 1,000 women (Martin et al. 2015a).

- Texas had the highest fertility rate in the South in 2013 at 69.9 live births per 1,000 women, followed by Louisiana (67.3 per 1,000), Arkansas (65.9 per 1,000), Kentucky (65.3 per 1,000), and Mississippi (64.2 per 1,000). These are also the southern states with higher fertility rates than the national average of 62.9 live births per 1,000 women (Martin et al. 2015a).

Prenatal Care

Women who receive prenatal care throughout their pregnancy are, in general, more likely to deliver healthy babies (U.S. Department of Health and Human Services 2012). In the United States in 2011, 84 percent of women began receiving prenatal care in the first trimester of pregnancy (Centers for Disease Control and Prevention 2012). Unfortunately, prenatal care is not the same across racial and ethnic groups. According to one study, while black women tend to have more positive perceptions of their health and well-being during pregnancy and after birth, they and their babies are more than twice as likely to be re-hospitalized in the months following birth (Childbirth Connection, National Partnership for Women and Families 2015). Black and Hispanic women are also more likely to experience group prenatal care[12] and about one in five black and Hispanic women reported poor treatment from hospital staff as a result of race, ethnicity, cultural background, or language (Childbirth Connection, National Partnership for Women and Families 2015).

In the South, women are most likely to receive inadequate prenatal care in the District of Columbia (23.8 percent), Texas (23.7 percent), and South Carolina (19.2 percent). Women are least likely to receive inadequate prenatal care in Virginia (10.3 percent), Mississippi (10.6 percent), and West Virginia (10.8 percent; Appendix Table B5.3). [13] However, inadequate prenatal care is not a problem that is uniformly prevalent across all racial and ethnic groups. As can be seen in Appendix Table B5.3 and in Figure 5.1, women of color are far more likely to receive inadequate prenatal care than white women in the South (March of Dimes 2015).

- White women are the least likely to experience inadequate prenatal care in every southern state except Florida—where a slightly higher percentage of white women have inadequate care (14 percent) compared with Asian/Pacific Islander women (13.4 percent).

- In Alabama, Hispanic women are almost five times as likely as white women and more than twice as likely as black women to receive inadequate prenatal care. Hispanic women in Tennessee and South Carolina closely follow at 34.8 percent and 34.4 percent respectively, which are the highest rates of inadequate care for any racial/ethnic group of women in the southern states. West Virginia and Florida have the lowest percent of Hispanic women who receive inadequate prenatal care (15.1 and 16 percent respectively).

- The highest percent of black women who receive inadequate prenatal care can be found in the District of Columbia (33.5 percent) and Texas (32.5 percent). Black women in Virginia and Mississippi are the least likely to receive inadequate prenatal care of all black women in the South (13.4 and 14.9 percent respectively).

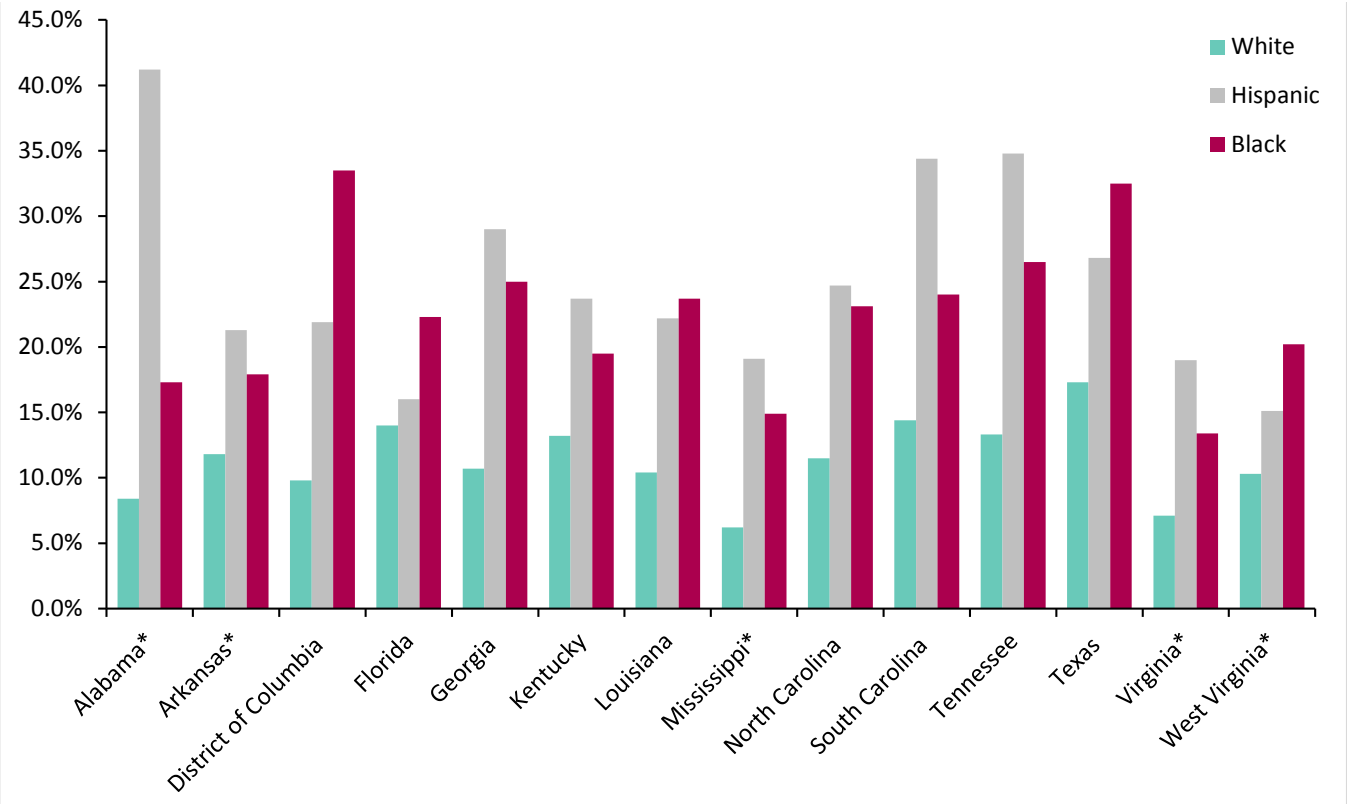
- Though generally lower than Hispanic and black women, Native American and Asian/Pacific Islander women also have relatively high rates of inadequate prenatal care in certain states (Appendix Table B5.3). Texas and South Carolina have both the highest proportions of Native American women (24.5 and 23 percent respectively) and Asian/Pacific Islander women (20 and 21 percent respectively) who receive inadequate prenatal care. Mississippi and Virginia have the lowest percent of Native American women (10.3 and 9.1 percent respectively) and Asian/Pacific Islander women (7.2

12 Group prenatal care is as at least one prenatal visit happening in a group setting with other pregnant women.

13 Inadequate prenatal care is defined as care begun after the 4th month of pregnancy or less than 50 percent of recommended visits received. See Appendix Table B5.3 for full March of Dimes methodology.

Figure 5.1.

Percent of Women in the South with Inadequate Prenatal Care by Race/Ethnicity and State



Note: *Denotes 2008-2010 prenatal care data, which are based on the 1989 Revision of the U.S. Standard Certificate of Live Birth and are not available after 2010. Prenatal care data for all other states are 2011-2013 data. Inadequate prenatal care is defined as care begun after the 4th month of pregnancy or less than 50 percent of recommended visits received. See Appendix Table B5.3 for full March of Dimes methodology. State data compiled by the Institute for Women's Policy Research from the March of Dimes peristats website.
Source: March of Dimes 2015.

and 9.6 percent respectively) receiving inadequate prenatal care.

Low Birth Weight

While low birth weight can be caused by numerous factors, poverty is strongly associated with low birth weight (Paneth 1995). Low birth weight is a concern in the South since, in general, the states in the South have comparatively high proportions of babies born with low birth weights (less than five pounds, eight ounces). In fact, the percent of low birth weight babies in each southern state is equal to or higher than the percent of babies with low birth weight nationally (8 percent; Martin et al. 2015b). However, the southern states differ in their proportions of babies born with low birth weight by race:

- Virginia has the lowest proportion of babies born with low birth weight at 8.0 percent, closely followed by Texas (8.3 percent), Florida (8.5 percent), Kentucky (8.7 percent), and North Carolina and Arkansas (8.8 percent). Mississippi has the largest proportion of babies born with low birth weight at 11.5 percent and is followed by Louisiana at 10.9 percent (Appendix Table B5.1).
- Within each state, Hispanic women generally have proportions of low birth weight babies that are equal to or less than white woman, with the exception of the District of Columbia where 5.8 percent of babies born to white women have low birth weights compared with 7.5 percent of babies with Hispanic mothers. In fact, the percent of low birth weight babies born to Hispanic women is lower in each southern state than the national average of 8 percent—Texas has the highest proportion at 7.7 percent (Appendix Table B5.1).
- In the southern states, black women have the highest proportion of babies born with low birth weights. Black women in Virginia and the District of Columbia have the lowest proportion of ba-

bies born with low birth weights at 12.3 percent, while black women in Mississippi have the highest proportion at 16.1 percent, which is double the national average (Appendix Table B5.1).

Infant Morality

In the United States overall, infant deaths occur at a rate of 6.0 per 1,000 live births. The southern states, however, generally have much higher infant mortality rates than the national average—the only state to have a lower rate is Texas (5.8 per 1,000 live births). In fact, for the South overall, infant deaths occur at a rate of 7.2 per 1,000 live births, compared with the much lower rate of 5.6 per 1,000 live births for all other states. Mississippi has the highest infant mortality rate at 9.3 per 1,000 live births, well above the national average, followed by Alabama (8.6 per 1,000 per live births) and Louisiana (8.4 per 1,000 per live births). The southern states to join Texas with the lowest infant mortality rates are Florida (6.2 per 1,000 live births) and Virginia (6.5 per 1,000 live births; Mathews, MacDorman, and Thoma 2015).

Among women of the largest racial and ethnic groups, Asian/Pacific Islander women (4.2 per 1,000 live births) and white and Hispanic women (5.1 per 1,000) have the lowest rates of infant mortality nationally, while Native American women and black women have the highest rates (8.1 and 11.3 per 1,000 live births respectively; Mathews, MacDorman, and Thoma 2015). In fact, the higher than average infant mortality rates in the South have much to do with the high infant mortality rates among black women, though infant mortality rates do vary by race and ethnicity across the southern states:

- White women have the lowest infant mortality rates in Virginia at 4.8 per 1,000 live births, closely followed by Florida (5.0 per 1,000 live births) and Georgia and Texas (5.1 per 1,000 live births). West Virginia has the highest infant mortality rate for white women at 7.0 per 1,000 live births, closely followed by white women in Alabama and Mississippi (6.9 and 6.8 per 1,000 live births respectively), all of which are below the average infant mortality rate for the southern states (Appendix Table B5.2).
- Hispanic women have the lowest infant mortality rates in Florida, Georgia, and Louisiana (4.6, 4.7, and 4.8 per 1,000 live births respectively), all of which are well below both the southern and national averages. In fact, Hispanic women have mortality rates that are lower than the national average in every southern state except Arkansas (6.2 per 1,000 live births), Mississippi (6.4 per 1,000 live births), and Kentucky (6.8 per 1,000 live births; Appendix Table B5.2).
- Black women have the lowest infant mortality rate in Kentucky, at 9.8 per 1,000 live births, which is still more than twice the lowest infant mortality rates for white and Hispanic women in the South. Black women in Alabama have the highest infant mortality rate, at 12.9 per 1,000 live births, which is well above the southern average and more than double the national average (Appendix Table B5.2).

Conclusion

Though southern women have seen some gains in the area of reproductive rights, there are still major barriers that need to be overcome before women in the South see advancement on this issue. Women, especially women of color, in the South are generally doing worse than the nation as a whole when it comes to accessing prenatal care, leading to some of the highest rates of maternal and infant mortality in the nation. Women of color in the South are also still struggling with the legacy of forced sterilization and are continuing to fight the stigma that they are less able to make their own reproductive choices. At the same time, southern women's options for affordable reproductive health care are being limited with the closure of health clinics that also provide abortion services. While there has been increased access to much needed reproductive health services for women in the South with the implementation of the Affordable Care Act and the expansion of Medicaid, women still face many barriers to obtaining the services they need, and these services will only continue to be harder to come by as efforts to limit women's reproductive rights continue in the South.

Appendix A5:

Methodology

To analyze the status of women in the South, IWPR selected indicators that prior research and experience have shown illuminate issues that are integral to women's lives and that allow for comparisons between each state and the United States as a whole. The data in IWPR's *Status of Women in the South* report come from federal government agencies and other sources; much of the data in this chapter rely on analysis from the Centers for Disease Control and Prevention and organizations such as the Guttmacher Institute, NARAL Pro-Choice America, and the March of Dimes. The tables present data for individuals, in some cases disaggregated by race and ethnicity. In the data tables on prenatal care and low birthweight, racial categories are non-Hispanic; Hispanics may be of any race or two or more races. In the data on infant mortality, only whites and blacks are non-Hispanic.

The Reproductive Rights Composite Index reflects a variety of indicators of women's reproductive rights. These include access to abortion services without mandatory parental consent or notification laws for minors, access to abortion services without a waiting period, public funding for abortions if a woman is income eligible, the percent of women living in counties with at least one abortion provider, whether the governor and state legislature are pro-choice, whether states have adopted the Medicaid expansion under the ACA and/or expanded eligibility for Medicaid family planning services, policies that mandate insurance coverage of infertility treatments, and mandatory sex education for children in the public school system. These indicators reflect one major change from IWPR's 2015 *Status of Women in the States* report that takes into account a recent policy development: the indicator on same-sex marriage or second parent adoption has been removed as a result of the Supreme Court ruling on June 26, 2015 legalizing same-sex marriage for all LGBT couples in the United States. With same-sex marriage now legal in all 50 states and the District of Columbia, and Mississippi having the only law specifically prohibiting second parent adoption by LGBT partners, which is currently being challenged in the courts (Lewin 2015), the need for this indicator has been effectively eliminated.

Calculating the Composite Index

To construct this Composite Index, each component indicator was rated on a scale of 0 to 1 and assigned a weight. The notification/consent and waiting-period indicators were each given a weight of 0.5. The indicators of public funding for abortions, pro-choice government, women living in counties with an abortion provider, and Medicaid expansion and/or Medicaid family planning eligibility expansions were each given a weight of 1.0. The infertility coverage law was also given a weight of 0.5. Finally, states were given 1.0 point if they mandate sex education for students. The weighted scores for each component indicator were summed to arrive at the value of the composite index score for each state. In order to maintain a composite score that is roughly comparable to the historical composites so as to be able to see how women's reproductive rights have changed over time, while also preserving the relative importance of each indicator, IWPR used a simple multiplier (of 7/6.5) for each composite index score to get back to values similar to those in previous years. The states were then ranked from the highest to the lowest score.

To grade the states on this Composite Index, values for each of the components were set at desired levels to produce an "ideal score." An ideal state was assumed to have no notification/consent or waiting period policies, public funding for abortion, a pro-choice government, 100 percent of women living in counties with an abortion provider, a Medicaid expansion or state Medicaid family planning eligibility expansion, infertility coverage, and mandatory sex education for students. Each state's score was then compared with the resulting ideal score to determine its grade.

MANDATORY CONSENT: States received a score of 1.0 if they allow minors access to abortion without parental consent or notification. Mandatory consent laws require that minors gain the consent of one or both parents before a physician can perform the procedure, while notification laws require they notify one or both parents of the decision to have an abortion. Source: Guttmacher Institute 2015a.

WAITING PERIOD: States received a score of 1.0 if they 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 2015a.

RESTRICTIONS ON PUBLIC FUNDING: If a state provides public funding for all or most medically necessary abortions, exceeding federal requirements, for women who meet income eligibility standards, it received a score of 1.0. Source: Guttmacher Institute 2015a.

PERCENT OF WOMEN LIVING IN COUNTIES WITH AT LEAST ONE ABORTION PROVIDER: States were given a scaled score ranging from 0 to 1, with states with 100 percent of women living in counties with abortion providers receiving a 1. Source: Guttmacher Institute 2015d.

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. Each state received 0.33 points per pro-choice governmental body—governor, upper house, and lower house—up to a maximum of 1.0 point. Those governors and legislatures with mixed assessments received half credit. Source: NARAL Pro-Choice America and NARAL Pro-Choice America Foundation 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. States received a score of 1.0 if they have adopted the Medicaid expansion under the ACA or enacted a state Medicaid family planning eligibility expansion. Sources: Guttmacher Institute 2016; Kaiser Family Foundation 2015.

COVERAGE OF INFERTILITY TREATMENTS: As of June 2014, states mandating that insurance companies provide coverage of infertility treatments received a score of 1.0, while states mandating that insurance companies offer policyholders coverage of infertility treatments received a score of 0.5. Louisiana, which enacted a statute that prohibits the exclusion of coverage for a medical condition that would otherwise be covered solely because it results in infertility, received a score of 0.0. Source: National Conference of State Legislatures 2014.

MANDATORY SEX EDUCATION: States received a score of 1.0 if they require public schools (including K-12) to provide sex education classes. Source: Guttmacher Institute 2015e.

Appendix B5:

Reproductive Rights Tables

Appendix Table B5.1.

Percent of Low Birth-Weight Babies in the South by Race and Ethnicity, 2013

State	All Women	White	Hispanic	Black
Alabama	10.0%	8.1%	6.5%	14.6%
Arkansas	8.8%	7.7%	5.9%	14.0%
District of Columbia	9.4%	5.8%	7.5%	12.3%
Florida	8.5%	7.2%	7.1%	12.8%
Georgia	9.5%	7.3%	6.8%	13.4%
Kentucky	8.7%	8.4%	6.3%	13.1%
Louisiana	10.9%	8.1%	7.3%	15.6%
Mississippi	11.5%	8.2%	7.5%	16.1%
North Carolina	8.8%	7.3%	6.8%	13.2%
South Carolina	9.7%	7.6%	6.8%	14.3%
Tennessee	9.1%	7.9%	6.9%	14.0%
Texas	8.3%	7.4%	7.7%	13.1%
Virginia	8.0%	6.7%	6.7%	12.3%
West Virginia	9.4%	9.2%	N/A	15.3%

Note: Low birth weight is less than 5 lbs., 8 oz. Racial categories are non-Hispanic. Hispanics may be of any race or two or more races. Data are not available for Asian/Pacific Islanders, Native American, or those who identify with another race or two or more races. N/A=not available.
Source: IWPR compilation of data from Martin et al. 2015b.

Appendix Table B5.2.

Infant Mortality Rates in the South, by Race and Ethnicity and South/Non-South, 2013

State	All Women	White	Hispanic	Black	Asian/ Pacific Islander	Native American
Alabama	8.6	6.9	5.0	12.9	N/A	N/A
Arkansas	7.4	6.7	6.2	10.9	N/A	N/A
District of Columbia	7.3	N/A	5.5	11.1	N/A	N/A
Florida	6.2	5.0	4.6	10.8	3.7	N/A
Georgia	6.7	5.1	4.7	10.0	3.9	N/A
Kentucky	6.7	6.4	6.8	9.8	N/A	N/A
Louisiana	8.4	6.2	4.8	12.0	6.4	N/A
Mississippi	9.3	6.8	6.4	12.4	N/A	N/A
North Carolina	7.2	5.4	5.6	12.6	4.3	10.6
South Carolina	7.2	5.3	5.0	11.5	N/A	N/A
Tennessee	7.2	6.1	5.3	11.7	3.9	N/A
Texas	5.8	5.1	5.3	10.7	3.8	N/A
Virginia	6.5	4.8	5.8	11.7	5.0	N/A
West Virginia	7.1	7.0	N/A	12.0	N/A	N/A
Southern States	**7.2**	**0.0**	**0.0**	**0.0**	**0.0**	**N/A**
All Other States	**5.6**	**4.8**	**5.6**	**10.7**	**4.4**	**N/A**
United States	**6.0**	**5.1**	**5.1**	**11.3**	**4.2**	**8.1**

Notes: Infant mortality rates include deaths of infants under age one per 1,000 live births. Whites and blacks are non-Hispanic; other racial categories include Hispanics. Hispanics may be of any race or two or more races. N/A=not available.
Source: IWPR compilation of data from Mathews, MacDorman, and Thoma 2015.

Appendix Table B5.3.

Inadequate Prenatal Care in the South by Race and Ethnicity

State	All Women	White	Hispanic	Black	Asian/ Pacific Islander	Native American
Alabama*	13.9%	8.4%	41.2%	17.3%	10.2%	11.5%
Arkansas*	14.1%	11.8%	21.3%	17.9%	12.9%	19.7%
District of Columbia	23.8%	9.8%	21.9%	33.5%	14.8%	N/A
Florida	16.4%	14.0%	16.0%	22.3%	13.4%	20.1%
Georgia	18.4%	10.7%	29.0%	25.0%	15.3%	17.8%
Kentucky	14.4%	13.2%	23.7%	19.5%	18.1%	21.5%
Louisiana	16.2%	10.4%	22.2%	23.7%	15.7%	12.2%
Mississippi*	10.6%	6.2%	19.1%	14.9%	7.2%	10.3%
North Carolina	16.6%	11.5%	24.7%	23.1%	17.2%	21.3%
South Carolina	19.2%	14.4%	34.4%	24.0%	21.0%	23.0%
Tennessee	18.1%	13.3%	34.8%	26.5%	19.0%	19.5%
Texas	23.7%	17.3%	26.8%	32.5%	20.0%	24.5%
Virginia*	10.3%	7.1%	19.0%	13.4%	9.6%	9.1%
West Virginia*	10.8%	10.3%	15.1%	20.2%	12.0%	N/A

Notes: *Denotes 2008-2010 prenatal care data, which are based on the 1989 Revision of the U.S. Standard Certificate of Live Birth and are not available after 2010. Prenatal care data for all other states are 2011-2013 data. Timing of prenatal care calculations stratify the timing of the mother's entry into prenatal care into three categories. These categories include: "Early prenatal care," which is care started in the 1st trimester (1-3 months); "Second trimester care" (4-6 months); and "Late/no prenatal care," which is care started in the 3rd trimester (7-9 months) or no care received. Calculations are based on the number of live births to mothers in a specific prenatal care category divided by all live births excluding those missing data on prenatal care, multiplied by 100. Adequacy of prenatal care calculations are based on the Adequacy of Prenatal Care Utilization Index (APNCU), which measures the utilization of prenatal care on two dimensions. The first dimension, adequacy of initiation of prenatal care, measures the timing of initiation using the month prenatal care began reported on the birth certificate. The second dimension, adequacy of received services, is measured by taking the ratio of the actual number of visits reported on the birth certificate to the expected number of visits. The expected number of visits is based on the American College of Obstetrics and Gynecology prenatal care visitations standards for uncomplicated pregnancies and is adjusted for the gestational age at initiation of care and for the gestational age at delivery. The two dimensions are combined into a single summary index, and grouped into four categories: Adequate Plus, Adequate, Intermediate, and Inadequate. Inadequate prenatal care is care begun after the 4th month of pregnancy or less than 50 percent of recommended visits received. Racial categories are non-Hispanic. Hispanics may be of any race or two or more races. N/A=not available.
Source: IWPR compilation from March of Dimes 2015.

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LGBT Women

In June of 2015, the Supreme Court of the United States found bans on marriage equality to be unconstitutional, sending a message of hope to many LGBT women across the country. Despite this progress, LGBT women still experience a variety of inequalities compared with other women, and more progress is needed in the areas of employment and earnings, poverty, health, and safety in order to reduce these inequities. In the South particularly there is a lack of state laws to prohibit employment discrimination based on sexual orientation (Hasenbush et al. 2014), jeopardizing the economic stability of LGBT women.

In addition to inequalities in employment security, LGBT women across the country experience health disparities compared with other women that may stem from a variety of factors, including the stresses of being part of a sexual minority, societal stigma toward the LGBT community, barriers to accessing health insurance, and the outright denial of care due to sexual orientation or gender noncomforming behavior (Grant, Mottet, and Tanis 2011; Institute of Medicine 2011; Lick, Durso, and Johnson 2013; Ranji et al. 2015).

One survey found that 53.4 percent of gay or lesbian women and 55.5 percent of bisexual women report their health as excellent or very good, compared with 59.8 percent of straight women (Ward et al. 2014). Transgender adults also face specific barriers to maintaining good health (Ranji et al. 2015); according to one study in Massachusetts, transgender individuals were least likely among all LGBT individuals to report their health as excellent or very good (Landers and Gilsanz 2009).

LGBT individuals have a much higher lifetime prevalence of suicide attempts than the U.S. population overall; for the population overall, the prevalence is 4.6 percent, while for lesbian, gay, and bisexual adults it is 10-20 percent and for transgender and gender non-conforming individuals it is 41 percent (Haas, Rodgers, and Herman 2014).

LGBT women experience a heightened risk of violence and abuse (Walters, Chen, and Breiding 2013).

- Bisexual women have a much higher lifetime prevalence of rape (46.1 percent) and other sexual violence (74.9 percent) compared with lesbian and heterosexual women. They are also twice as likely as heterosexual women to experience stalking in their lifetime (36.6 percent and 15.5 percent, respectively).

- Over one half of bisexual women (57.4 percent) and one third of lesbian women (33.5 percent) who survive rape, violence, or stalking by an intimate partner report a negative impact such as missing one or more day of school or work, being fearful, worrying about their safety, and/or experiencing at least one symptom of post-traumatic stress.

Same-Sex Households

Women living with a same-sex partner comprise 0.3 percent of households in the southern states, as well as the country overall.[1] Differences across a variety of indicators of women's status, including employment, earnings, health insurance coverage, educational attainment, and poverty, exist between women living with a same-sex partner in the South compared with southern women in other types of households, as well as compared with same-sex women in other parts of the country.[2]

- In the South, 72.9 percent of women aged 16 and older living with a same-sex partner participate in the labor force, while 77.2 percent of women living with a same-sex partner in other states are in the labor force. In comparison, 56.9 percent of southern women married to men are in the workforce.

[1] In this report, southern states include Alabama, Arkansas, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Same-sex couples include those who are married and unmarried partners. For the number of female same-sex partner households in the South, see Appendix Table 8.1.

[2] IWPR calculations based on 2014 American Community Survey microdata, except for the percent of households that are same-sex which are three-year (2012-2014) averages. Data are restricted to heads of households and their spouses/partners.

- Women in the South living with a same-sex partner and working full-time year-round have higher median annual earnings ($42,000) than women in the South in other types of households.[3] However, they earn substantially less than women in same-sex households living in other states ($50,000).

- A higher proportion of southern women living with a same-sex partner are employed in managerial or professional occupations (48.6 percent) compared with southern women overall (44.0 percent). A similar percentage of women (48.2 percent) in heterosexual married households are also employed in managerial or professional occupations.

- Fewer southern women aged 18-64 in all household types carry health insurance than their counterparts in all other states (83.1 percent compared with 89.6 percent). This is also true among women living with a same-sex partner; only 82.7 percent of same-sex women in the South are insured, compared with 91.4 percent in all other states and 86.4 percent of southern women in heterosexual marriages.

- Women aged 25 and older living with a same-sex partner in the South are much more likely to have a bachelor's degree or higher (41.5 percent), compared with 29.6 percent of southern women overall.

- Among women in the South aged 18 and older, women living with a same-sex partner have relatively low rates of poverty (7.6 percent) compared with single women (26.6 percent) and unmarried women living with a male partner (14.6 percent), although there are more same-sex women in the South living in poverty than same-sex women in other states (4.9 percent).

Southern women in same-sex households have higher rates of labor force participation relative to southern women married to men and to single women; they have higher earnings than southern women in other household types; and they also have higher rates of college education than southern women in other household types. Yet, the disparities when compared with women in same-sex households in other states raise concerns and support the need to extend legal and social protections against discrimination based on sexual orientation.

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[3] Including women in heterosexual marriages, women living with male partners, and single women.

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