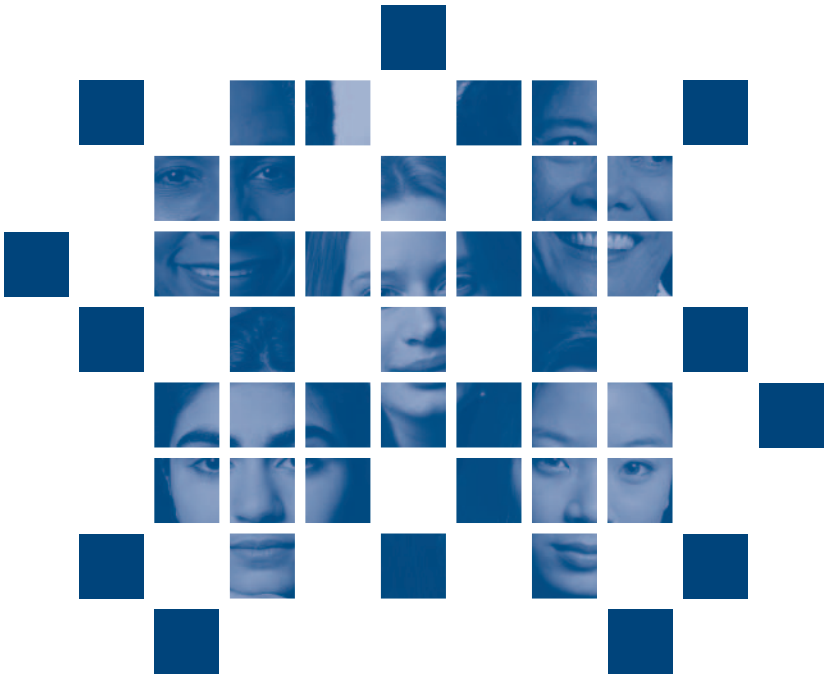

METHODOLOGY

This section describes the criteria for status and policy indicator selection, data sources and limitations, grading and ranking, and modifications from the 2001 *Report Card*, along with information about the demographic data sources.

Status Indicator Methodology

Criteria for Indicator Selection

Health status indicators were selected based primarily on whether they had a significant impact on women's quality of life, functioning and well-being, and whether they affected a large number of women generally or a large number of women in a specific population and/or age group. Additional criteria were whether the indicator could be affected through intervention, prevention or improvement; was potentially measurable; was commonly used or there existed consensus on use; or reflected an emerging important issue where the problem was increasing in prevalence, incidence, or severity.

Women's health status varies by ethnic and racial groups as well as by age. Wherever possible, the state data for the status indicators are presented within these categories. In many cases, data on these specific populations of women were not available or available only at the national or state level. The available information is presented on the national and state report cards in Chapter I and in the discussion of key health disparities among special populations of women in Chapter IV.

Data Sources and Limitations

The *Report Card* uses the best data available for each indicator and uses published information when available. There are some status indicators for which data runs were made specifically for the *Report Card*, as noted in the data source notes. Wherever possible, the *Report Card* uses data sets that are comparable for the states and the nation. Thus for certain indicators, while more recent data might be available for the nation, the *Report Card* uses older national data that is comparable with state-level data, as noted in the data source notes in Chapter II. With few exceptions, the information presented in the *Report Card* is based upon data collected at the state level and reported by sex. Exceptions include a few indicators based on data not reported by sex, but where general population data were viewed as a reliable

reflection of women's health status (such as the number of people living in medically underserved areas). More detailed information for individual indicators, including data sources and explanations, is included in the indicator description pages in Chapter II. Some national data on key measures of women's health are included, even though no reliable state data are available for these state indicators (i.e., osteoporosis, unintended pregnancies and violence against women), given their importance to women's health. Data are also presented by race, by ethnicity and by age, but these data are collected inconsistently by states and national surveys (see also the Demographic Data Sources section that follows for more on race and ethnicity data). Although reporting data by income level also would have been desirable, time and data constraints precluded doing so in this *Report Card*. Data collection for the status indicators ended in February 2004.

Because published National Center for Health Statistics mortality data are currently age-adjusted to the 2000 standard population, the data in this *Report Card* are not comparable to the mortality data used in the 2000 or 2001 *Report Cards* (which are age-adjusted to the 1940 standard population). While the newer data better reflect the current state of the health of U.S. women, this change precludes comparison of status indicator mortality data in this *Report Card* with the status indicator mortality data in the previous *Report Cards*.

Grading and Ranking

In devising the grading process, *Report Card* staff and advisors endeavored to find the best benchmarks available for each indicator. For most indicators, the *Report Card* grades the nation and states against benchmarks drawn primarily from the health objectives set for the nation by the U.S. Department of Health and Human Services' Healthy People 2010 agenda, which provides a roadmap for where the nation's health should be by the year 2010. The Healthy People 2010 benchmarks for three disease indicators—namely the death rates for coronary heart disease, stroke, and lung cancer—were modified to address concerns that the Healthy People 2010 benchmarks for these indicators are based on data for men and women combined. The timing of trends in these diseases has historically been different for men and women, so the use of benchmarks based on men and women combined could be misleading about the current status of women specifically. For example, the lung cancer epidemic appeared in men well before the 1950s but began to reverse by the late 1980s. In women, however, it appeared later and continued to climb in most states into the 1990s; only now is the lung cancer epidemic slowing in women, at least in some states.[1] For these reasons, the *Report Card* employs benchmarks more applicable to women for these three disease indicators, using the same principles as the Healthy People 2010 target-setting standard of "better than the best." Using this Healthy People 2010 standard, the benchmark for each disease is set as the rate in the state that currently has the lowest death rate. For example, Utah had the lowest death rate of lung cancer among women (16.6 per 100,000); this rate became the lung cancer benchmark for all other states and the nation. Similarly, Hawaii's 84.5 per 100,000 death rate for heart disease, and New York's 38.8 per 100,000 death rate for stroke serve as benchmarks for those respective diseases.

In cases where there is no Healthy People benchmark, states are graded against another benchmark decided upon by the *Report Card* authors with the input of experts. For example, in the case of life expectancy, the Healthy People 2010 goal is to increase life expectancy, but no specific target is provided. The *Report Card* adopted Japan's life expectancy for women as a benchmark, since it is a highly industrialized nation with the highest life expectancy for women. In some cases, no appropriate benchmark was found and the states are ranked and not graded.

The nation and states are graded as follows. First, the raw data for each indicator is expressed as a percentage difference from the benchmark for that indicator. Next, the percentage differences from the benchmarks are scaled to range between 0 and 100, in order to account for the differences in the magnitude and the range of each indicator. For example, the Healthy People 2010 benchmark for increasing the consumption of fruits and vegetables is 50 percent, while the benchmark for increasing blood cholesterol testing is 80 percent. The range for each of these indicators is markedly different; for example, the consumption of fruits and vegetables indicator has a range that is 33 percent larger than the range for the blood cholesterol testing indicator. Scaling the percentage differences from a given benchmark addresses this problem (further information on how raw data was converted to scaled scores is available at this note).[2]

Once the states are assigned scaled scores, they are graded based on those scores. A state that meets the benchmark receives a score of 100 and a grade of "Satisfactory." A state that receives a score of between 70 and 99 receives a "Satisfactory Minus," a state that receives a score of between 50 and 69 receives an "Unsatisfactory," and a state that receives a score of below 50 receives a "Fail." The worst state receives a score of 0. A score of 50 means that a state's performance is halfway between the worst state and the benchmark. The 70 and 50 cutoff scores were determined by a panel of experts and were chosen to reflect how far

2004 *Report Card* Status Indicator Benchmarks

Indicator	Objective Source	Benchmark
Women without Health Insurance*	HP2010 Objective 1-1	Increase the proportion of persons with health insurance to 100%
People in Medically Underserved Areas	No applicable benchmark	
First Trimester Prenatal Care	HP2010 Objective 16-6a	Increase the proportion of pregnant women who receive care beginning in the first trimester of pregnancy to 90%
Women in County without Abortion Provider	*Report Card*	Reduce the percent of women living in a county without access to an abortion provider to 0%
Pap Smears	HP2010 Objective 3-11b	Increase the proportion of women age 18 and older who received a Pap test within the preceding 3 years to 90%
Mammograms	HP2010 Objective 3-13	Increase the proportion of women age 40 and older who have received a mammogram within the preceding 2 years to 70%
Colorectal Cancer Screening	HP2010 Objective 3-12b	Increase the proportion of adults age 50 and older who have ever received a sigmoidoscopy to 50%
Cholesterol Screening	HP2010 Objective 12-15	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years to 80%
No Leisure-Time Physical Activity	HP2010 Objective 22-1	Reduce the proportion of adults who engage in no leisure-time physical activity to 20%
Obesity	HP2010 Objective 19-2	Reduce the proportion of adults who are obese (having a body mass index of 30 or more) to 15%
Eating Five Fruits & Vegetables a Day	Adapted HP2010 Objective 19-5 & 19-6**	Increase the proportion of women who are consuming at least five or more servings of fruits and vegetables a day to 50%
Smoking	HP2010 Objective 27-1a	Reduce cigarette smoking among adults age 18 and older to 12%
Binge Drinking	HP2010 Objective 26-11c	Reduce the proportion of adults age 18 and older engaging in binge drinking during the past month to 6%
Annual Dental Visits	HP2010 Objective 21-10	Increase the proportion of children and adults who use the oral health care system each year to 56%
Coronary Heart Disease Death Rate	Adapted HP2010 Objective 12-1***	Reduce the coronary heart disease death rate to 84.5 deaths per 100,000 population (Hawaii)
Stroke Death Rate	Adapted HP2010 Objective 12-7***	Reduce the stroke death rate to 38.8 deaths per 100,000 population (New York)
Lung Cancer Death Rate	Adapted HP2010 Objective 3-2***	Reduce the lung cancer death rate to 16.6 deaths per 100,000 population (Utah)
Breast Cancer Death Rate	HP2010 Objective 3-3	Reduce the breast cancer death rate to 22.3 deaths per 100,000 population
High Blood Pressure	HP2010 Objective 12-9	Reduce the proportion of adults with high blood pressure to 16%
Diabetes	HP2010 Objective 5-3	Reduce the overall rate of diabetes that is clinically diagnosed to 25 overall cases per 1,000 population (2.5%)
AIDS Rate	HP2010 Objective 13-1	Reduce AIDS among adolescents and adults to 1.0 new case per 100,000 persons
Arthritis	No applicable benchmark	
Osteoporosis	HP2010 Objective 2-9	Reduce the proportion of adults with osteoporosis to 8%
Chlamydia	HP2010 Objective 25-1a	Reduce *chlamydia trachomatis* infections among females ages 15-24 attending family planning clinics to 3%
Maternal Mortality Rate	HP2010 Objective 16-4	Reduce maternal deaths to 3.3 maternal deaths per 100,000 live births
Unintended Pregnancies	HP2010 Objective 9-1	Increase the proportion of pregnancies that are intended to 70%
Mental Health Days	No applicable benchmark	
Violence Experienced Over Lifetime	No applicable benchmark	
Life Expectancy	*Report Card*	Increase the life expectancy of women in America to that of women in Japan, 82.9 years
Activity Limitation Days	No applicable benchmark	
Infant Mortality Rate	HP2010 Objective 16-1c	Reduce infant deaths to 4.5 infant deaths per 1,000 live births
Poverty	*Report Card*	Reduce the percentage of women living in poverty to 0%
Wage Gap	*Report Card*	Increase the earnings ratio between women and men to 100%
High School Completion	HP2010 Objective 7-1	Increase the high school completion rate to 90%

* For this indicator, the complementary data are presented.

** Healthy People 2010 contains separate objectives and benchmarks for fruits and for vegetables – HP2010 Objective 19-5 is to increase the proportion of persons age two and older who consume at least two daily servings of fruit to 75% and HP2010 objective 19-6 is to increase the proportion of persons age two and older who consume at least three daily servings of vegetables to 50%. The data are published as one grouping for fruits and vegetables. Therefore, the benchmark is adapted from these two and is 50%.

*** The benchmarks for these indicators were adapted to be more applicable to women, as explained on the previous page. The Healthy People 2010 benchmarks for men and women combined for these indicators are as follows: coronary heart disease—reduce deaths to 166 per 100,000; stroke—reduce deaths to 48 per 100,000; lung cancer—reduce deaths to 44.9 per 100,000.

states are from the benchmarks, recognizing that states still have several years to achieve the Healthy People 2010 benchmarks. Nonetheless, a few states are already meeting these standards. A state's overall score was computed by averaging the scores on 27 individual indicators. Each state's overall score was then used to determine both the overall grade and the rank for the state. Each status indicator grade is given equal weight in calculating the total grade. The nation is graded in the same manner.

Minimum Performance on Each Indicator Necessary to Receive Each Grade

	Minimum performance required		
Grade:	S	S-	U
Scaled Score:	100	70	50
Indicator			
Women without Health Insurance*	0.0	8.5	14.1
People in Medically Underserved Areas	N/A	N/A	N/A
First Trimester Prenatal Care	90.0	83.7**	79.5**
Women in County without Abortion Provider	0.0	26.0	44.0
Pap Smears	90.0	87.0	85.1
Mammograms	70.0	69.1	68.5
Colorectal Cancer Screening	50.0	46.9	44.8
Cholesterol Screening	80.0	76.2	73.6
No Leisure-Time Physical Activity	20.0	25.0	28.3
Obese	15.0	18.9	21.5**
Eating Five Fruits and Vegetables a Day	50.0	40.0	33.4
Smoking	12.0	17.5	21.2
Binge Drinking	6.0	8.4	10.0
Annual Dental Visits	56.0	57.2	58.0
Coronary Heart Disease Death Rate	84.5	122.3	147.6
Stroke Death Rate	38.8	50.3	57.9
Lung Cancer Death Rate	16.6	27.9	35.5
Breast Cancer Death Rate	22.3	26.0**	28.4
High Blood Pressure	16.0	21.3	24.8
Diabetes	2.5	4.7	6.1
AIDS Rate	1.0	28.3	46.5
Arthritis	N/A	N/A	N/A
Osteoporosis	N/A	N/A	N/A
Chlamydia	3.0	5.7	7.5
Maternal Mortality Rate	3.3	9.2	13.1
Unintended Pregnancies	N/A	N/A	N/A
Days Mental Health was "Not Good" in Past 30 Days	N/A	N/A	N/A
Violence Experienced over Lifetime	N/A	N/A	N/A
Life Expectancy	82.90	80.30	78.57
Days Activities were Limited in Past 30 Days	N/A	N/A	N/A
Infant Mortality Rate	4.5	7.1**	8.8
Poverty	0.0	6.1	10.2
Wage Gap	100.0	89.3	82.2
High School Completion	90.0	86.5	84.1

* For this indicator, the complementary data were used for grading in order to be consistent with the relevant benchmark listed in the benchmark chart above.

** Discrepancies apparent between the minimum performance value and states' grades are due to rounding.

Modifications from previous Report Cards

The 2004 *Report Card* employs a new methodology for grading and ranking as described above. Because this methodology is based on the states' performance on each indicator, there are some status indicators with an appropriate benchmark but data at the national level only that can no longer be graded. These are noted in the data source notes in Chapter II. Furthermore, the 2004 *Report Card* now employs the Healthy People 2010 health objectives as its benchmarks, except as noted; the 2001 *Report Card* used a mixture of Healthy People 2000, Healthy People 2010 and other health objectives as its benchmarks.

One new health status indicator has been added for the 2004 *Report Card*. While the 2001 *Report Card* discussed the need for cholesterol screening in the special chapter on cardiovascular disease, the 2004 *Report Card* adds this important health status indicator to the national and state report cards. This indicator was factored into the calculations of the overall national grade and the overall grades and ranks at the state level. In addition, for the 2001 *Report Card*, data for the arthritis status indicator were available at the national level only, but such data are now available at the state level and are included.

This *Report Card* generally uses the same data sources for indicator grading and ranking that the 2000 and 2001 *Report Cards* used, wherever possible using the most recent data available. However, for a few indicators that have been updated at the national level but not at the state level (i.e., life expectancy, maternal mortality), the *Report Card* uses the older data to be consistent at both the national and state levels. In addition, there are a few indicators for which updated data were not available and this *Report Card* has reprinted the data used in the 2001 *Report Card*. More specifically, for osteoporosis, unintended pregnancies, and violence against women, for which data are available at the national level only, updated data were not available. For these indicators, this *Report Card* uses the same data published in the 2001 *Report Card*.

As mentioned before, where possible, the *Report Card* includes data by race/ethnicity and age. Although these data are generally from the same data source as the overall data, there may be differences in methodologies and data years, which are explained in the data source notes in Chapter II.

Policy Indicator Methodology

The policy indicators examine state policies and programs important to women's health—whether statutes, regulations, executive orders, or other manifestations of state policies and programs. This section briefly describes the criteria for policy indicator selection, the data sources and their limitations, the way in which state policies were evaluated and any modifications from the 2001 *Report Card*.

Criteria for Indicator Selection
The criteria used to select the indicators for state health policies are similar to those used to select the health status indicators. State policy indicators were selected based on whether they addressed and could have a significant positive impact on the critical women's health issues reflected in the status indicators and whether they were measurable and comparable across states.

While the status and policy indicators are closely connected, some state policy indicators are included even though there is no status indicator that correlates directly to those policies. In cases where there were no reliable data for every state describing the extent of a major women's health problem, such as domestic violence, the *Report Card* included state policies that address that problem.

Data Sources and Limitations
Data sources follow each policy indicator description in the policy chapter and explanations of the data's evaluation are provided where necessary. Generally, the *Report Card* includes state health policy information that was collected from published or online sources.

Adopting the policies covered by the indicators can improve women's health, but the states' actual implementation is a crucial component in determining whether and how much the policies impact women's health. Generally, the *Report Card* does not explore the effectiveness of state implementation efforts or subsequent judicial actions because such data are not routinely or consistently available. Sources did not always note delayed effective dates of policies (e.g., a statute was passed in 2001, but not effective until 2002). Since it could not be reasonably determined that sources identified delayed effective dates uniformly (e.g., that some states with delayed effective dates were not identified) and since the adoption of the relevant policy still demonstrates some state commitment, the 2004 *Report Card* considers a state to be in the relevant category regardless of effective date. Data collection for the policy indicators ended in February 2004.

Evaluating the Policies
States are compared, but not graded, on the policy indicators. In contrast to the status indicators—where basic data were available, although with serious gaps—the absence of consistently collected policy data precluded meaningful comparisons of the states in key policies areas, such as health program budget expenditures. For all the policy indicators, the strength of each state's policy is indicated on the state report card pages by the designations "Meets Policy," "Limited Policy," "Weak Policy" and "No/Harmful Policy." With certain indicators, the 2004 *Report Card's* lowest category is called "Harmful Policy" in order to recognize that states can adopt policies which are just as harmful (and in some cases more so) as having no policy at all.

The *Report Card* authors determined the categorizations for each of the policies after research and input from experts. Some policies have all four categories, others have three or two categories depending most often on the scope of the policy. Each state's performance in the 2004 *Report Card* is compared to its performance in the 2001 *Report Card* on every indicator, except where noted.

Modifications from the 2001 *Report Card*
Whenever possible, this third *Report Card* uses updated information from the same source or sources that were used for the indicators in the 2001 *Report Card*. If those sources were not available, the 2004 *Report Card* uses other reliable sources. When no such updates were available, the 2004 *Report Card* either eliminated the indicator entirely or, when the data could still be meaningful, included the indicator data from the 2001 *Report Card*. Comparisons between data in the 2001 and 2004 *Report Cards* reflect 2001 information with any corrections to the 2001 data as noted.

In an effort to highlight several additional policy issues important to women, this *Report Card* includes three new indicators that were not in the 2001 *Report Card*. These indicators are state regulation of the individual health insurance market, access to emergency contraception and private insurance mandates for coverage of smoking cessation treatments. Additionally, nine indicators have been eliminated, seven of which are due to a lack of recent data that could still be meaningful. These indicators are the 100 hour rule for two-parent families, state funding of comprehensive primary medical care practice programs, adults per 1,000 receiving medicaid home and community based care services, diabetes control programs, osteoporosis

education programs, percent of income poor paid in state and local taxes, and per capita (urban resident) spending on public transport. Two indicators were eliminated for more substantive reasons. Due to recent changes in the reimbursement procedure for federally qualified health centers (FQHC), the *Report Card* no longer evaluates Medicaid reimbursement for FQHC. The recently passed Medicare Prescription Drug, Improvement, and Modernization Act of 2003[3] raises significant questions about how one indicator—non-Medicaid pharmaceutical programs—will evolve in the future.

Demographic Data Sources

The demographic profile for each state and the nation as a whole includes data that provide the context for the *Report Card* status and policy indicators. Most of the demographic data presented here are based on data from the most recent two years (2002 and 2003) of the U.S. Census Bureau's *Current Population Survey* (CPS) as described below. The most recent two years of CPS data are used to increase the sample of women in the analysis and to improve accuracy, especially for smaller states. Although the source of the basic CPS data is the U.S. Census Bureau, the *Report Card* authors, in cooperation with Decision Demographics, the demographic data consultant for this project, developed the specifications for the demographic measures in this publication. Two tabulations are based on data from Census 2000, since the data are not collected in the CPS: "Linguistically Isolated Households" and "Women Residing in Urban and Rural Areas," as noted below.

Demographic Data Sources

Listed below are the sources for the specific demographic data on the national and state report card pages.

Population of Females by Race, by Age, and Total (% and #), 2002 and 2003.

EXPLANATION: This measure includes females of all ages as a percentage of the total civilian, non-institutionalized[4] population of the state. Data by race and ethnicity are in the following categories: White (non-Hispanic), Black[5] (non-Hispanic), Native American/Alaskan Native (non-Hispanic), Asian/Pacific Islander (non-Hispanic), and Hispanic. Data by age reflect the percentage of females in the following age categories: 18-44, 45-64, 65 and older.

SOURCE: U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey*, "Annual Demographic Survey March Supplement" (Washington: U.S. Census Bureau, 2002, 2003) (databases) (unpublished data analyzed by Decision Demographics) [hereinafter CPS].

The concepts of race and ethnicity are in transition in American society and in the statistics that measure it. Starting with Census 2000 and 2003 CPS, the Census Bureau has followed guidelines that allow respondents to specify multiple races in collecting and issuing data.[6] Since this report draws upon a combination of the 2002 and 2003 CPS, some adjustments were needed to combine data incorporating distinct race concepts. There is no perfect way to use these concepts together. In order to combine the two data sets, the 2003 race concepts were adapted to be compatible with the 2002 concepts. People who report only one race in 2003 are categorized with that same race group in 2002. Those respondents for whom two or more races were reported in 2003 were allocated in equal proportions to those races. That is, if one respondent reported White, Black, and Hawaiian races, then one-third of that respondent was allocated to each of the three races.

The statistical and health reporting agencies that provide data for this report vary widely in their collection and reporting of race and Hispanic identity. Hispanic identification is considered to be an ethnicity rather than a race, and the Census Bureau asks separate race and Hispanic questions. In processing the CPS demographic data for this report, Hispanic identity is given priority in determining respondents' race and ethnicity. That is, anyone who reported himself or herself as Hispanic was counted as Hispanic regardless of what race he or she reported. Thus a Black Hispanic would be reported only as Hispanic. The *Report Card* presents parallel sets of columns that apply to race and Hispanic origin. Columns marked as "non-Hispanic" omit all Hispanics regardless of race. Columns that lack that label include Hispanics with whatever race that they report. The "White" column, for example, includes everyone who reported White as a race. The "White non-Hispanic" column omits Hispanics.

Households Headed by Single Women (% and #), 2002 and 2003.

EXPLANATION: This measure includes households headed by a woman with no spouse present.

SOURCE: CPS (see Population of Females data source note).

Lesbian-Headed Households (% and #), 2000.

EXPLANATION: Lesbian-Headed Households are households where the householder is female and there is another female whose relationship to the householder is reported as "unmarried partner." Since Census 2000 asks no direct question about sexual orientation, this household relationship item has been used to estimate lesbian-headed households. This estimate represents a count of households headed by women who have same-sex partners, cohabit, report one of the couple as the household head, and report the other as an unmarried partner. Women in this group are distinguished by their willingness to report these combined characteristics in the Census and may not represent all women living in this status.[7] It is estimated that 44.1 percent of lesbians live as cohabiting partners like this respondent group.[8] Applying that rate to the U.S. total of lesbian-headed households implies that there were at least 1.3 million lesbians in the U.S. as of 2000. If the assumption is made that four percent of U.S. women age 18 and older are lesbians,[9] then there were up to 4.3 million lesbians in 2000.

SOURCE: CPS 2000 (see Population of Females data source note).

Median Earnings for Women ($), 2002 and 2003.

EXPLANATION: This measure includes wages, salaries, self-employment income, and farm income for civilian, non-institutionalized women age 17 and older who reported full-time, full-year employment. The median income divides the income distribution into two equal parts; half fall above the median and half fall below.

SOURCE: CPS (see Population of Females data source note).

Women with Disabilities Affecting Workforce Participation (% and #), 2002 and 2003.

EXPLANATION: This measure includes civilian, non-institutionalized women ages 18 to 64: (a) who are not in the labor force because they are disabled or (b) whose labor force participation in the past year has been limited by disability or illness and who also receive Social Security or Supplemental Security Income.

SOURCE: Decision Demographics/CPS (see Population of Females data source note).

Linguistically Isolated Households (% and #), 2000.

EXPLANATION: A household living in "linguistic isolation," as defined by the Census, is a household in which no person age 14 and older speaks only English, and no person age 14 and older who speaks a language other than English speaks English "very well." In other words, all members age 14 and older have at least some difficulty with English. This measure includes all linguistically isolated households as a percentage of the total number of households in a state.

SOURCE: Census 2000 (Washington: U.S. Census Bureau, 2000).

Births Attended by Midwife (%), 2001.

EXPLANATION: This measure includes the percentage of live births attended by a midwife using data reported on birth certificates. Although the percentage of birth records that contains missing information for the attendant is very small (less than one percent), there is some evidence that midwife-attended births are under-reported on the birth certificates.[10]

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, "Birth Attendant by State of Residence of Mother, United States, Live Births, 2001" (unpublished data analysis by Decision Demographics).

Women Residing in Urban and Rural Areas (% and #), 2000.

EXPLANATION: Urban women include females of all ages who live in urban areas. Urban areas are densely settled, contiguous areas delineated by the Census Bureau that exceed specified size and density criteria. "Urban clusters" have 2,500 to 49,999 people and a core that exceeds 1,000 people per square mile. "Urbanized areas" have at least 50,000 people in a densely settled area. Women who live in urban clusters and urbanized areas are classified as urban, while all other women are classified as rural.

SOURCE: Census 2000 (Washington: U.S. Census Bureau, 2000).

Women with Some College or Associate Degree (% and #), 2002 and 2003.

EXPLANATION: This measure includes the percentage of civilian, non-institutionalized women age 25 and older who have one or more years of college but no degree, and civilian, non-institutionalized women age 25 and older who have attained an Associate degree.

SOURCE: CPS (see Population of Females data source note).

Women with a Bachelor's Degree or Higher (% and #), 2002 and 2003.

EXPLANATION: This measure includes the percentage of civilian, non-institutionalized women age 25 and older who have attained a bachelor's, master's, doctorate, or professional degree.

SOURCE: CPS (see Population of Females data source note).