The State of Reproductive Justice In Kentucky: A Social Justice Perspective on Reproductive Health

A report by the Kentucky Health Justice Network

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// Acknowledgment

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Executive Summary

An Integrated Approach

The State of Reproductive Justice in Kentucky: A Social Justice Perspective on Reproductive Health examines a broad range of interconnected issues that directly impact the health and wellbeing of women and families in the Commonwealth.

We believe in the power of policies and programs to bolster or negatively affect health outcomes. Viewing existing practices through the lens of current physical, social, and environmental conditions that influence outcomes can lead to the creation of effective, coordinated, and socially responsible evidence-based policies.

The report points out problems in the areas of data collection. In order to deal with inequities and uncover our areas of strength, we need current data broken down by categories of gender, race and ethnicity, as well as age and income level, on the county and regional level. A commitment to the collection of more detailed, relevant data will help Kentucky meet the health challenges of years to come.

We seek an integrated holistic view of the factors that influence reproductive health in order to build policies and programs that will meet the needs of the public, help build communities and strengthen our Commonwealth.

A Just, Healthy Kentucky

There is no disputing that poverty, education, race, gender, violence, pollution, unemployment, and discrimination each play a role in health outcomes. While Kentucky is a state rich in culture and natural resources with a history of resilience and a strong sense of community and family, we are challenged by systemic poverty, environmental

pollution and destruction, geographical isolation, and a dearth of locally-based economic opportunities.

We face formidable challenges in terms of health status and outcomes. Acknowledging the relationship between factors such as poverty, education and health is a first step. Changing policies to create a fairer distribution of resources and opportunities will help move us all forward. Speaking up about injustice and creating a health justice movement can change the lives of your friends, neighbors and co-workers.

The State of Reproductive Health in Kentucky

The following is snapshot of the state of women's health and related factors in Kentucky:

Education. In 2008, Kentucky had a smaller percentage of women graduating with a Bachelor's Degree or higher, 20%, compared to the national average of 27%.

Income. Kentucky had a lower per capita income ($27,625) than the national average ($33,689) in 2007. Looking at race and ethnicity, white women ($41,084) had a much higher household income in 2006 than women of color ($23,478). When examining wages by education and gender, women with an equivalent educational level suffer wage discrimination when compared to their male counterparts

Cancer. During 2000-2004, Kentucky accounted for the highest cancer mortality rates among women in the U.S. African American women in Kentucky had the highest mortality rates compared to African American women in other states

Teen Pregnancies. Kentucky has the 25th highest teenage pregnancy rate of any state. Of the 10,610 teenage pregnancies each year in Kentucky, 73% result in live births and 11% result in abortions.

Mental Health. In 2009, Kentucky ranked 50th regard to the number of poor mental health days and had a higher rate of frequent mental distress (14.1%) than the nation (9.9%). In addition women had higher rates of mental health issues (16.5%) than men (11.5%).

Infant Mortality, Low birth Weight, and Preterm Birth. Kentucky's infant mortality rates (6.7) are similar to the nation's (6.8). African Americans have the highest infant mortality rates in Kentucky, with 10.9 deaths per 1,000 births and account for the highest percentages of low birth weight births (14.6%) in the state.

Abortion Access and Emergency Contraception. Kentucky law restricts abortion coverage under private insurance plans and for public employees. There are only two clinics in Kentucky that provide the procedure. Emergency rooms and pharmacies are not required to dispense emergency contraception.

Health Reform and Reproductive Health

Recently passed health care reform legislation will greatly improve access to health care. Of the 12.4 million uninsured women of reproductive health age (15 to 44) in the United States, 94% would qualify for either Medicaid or federal subsidies to help them buy health insurance. Slightly more than half of these women (55% or 6.7 million) would qualify for Medicaid coverage. Another 4.8 million women of reproductive health age will qualify for federal subsidies to help them purchase private health coverage.

Almost $75 million per year will go to states over five years for a "personal responsibility education program" that will largely focus on preventing pregnancy and STIs through a combination of abstinence and contraceptive education. Community health centers,

where many low-income women and undocumented immigrant women receive primary and reproductive health care, will receive $11 billion in new funding.

However, there *still* will be no use of federal funds for abortion services (except in cases of rape, incest or threat to the life of the woman). Women on Medicaid and those who will become eligible for Medicaid in 2014 will not be able to use their coverage for abortion services in most cases, except in the circumstances stated above or if they live in one of the 17 states that use state dollars to provide abortion coverage under Medicaid. Low-income women receiving care at Community Health Centers still will not be able to receive federally-subsidized abortion services, making it more difficult for CHCs to provide this care.

What You Can Do to Make a Difference

Reproductive health affects all of us in profound and enduring ways. As we step back and view the bigger health picture, we see how every area of society is related and influenced by others.

You can use this report to: further public education on the health challenges we face; raise money to target specific areas related to reproductive justice; further advocate and lobby for social change; work with and for underserved communities; and build alliances and referrals among and between health and social service agencies that serve women in Kentucky.

We depend on one another for successful, healthy outcomes. All of us, personally and professionally, in the for-profit, nonprofit, academic, governmental or business arenas can become involved in creating a just and healthy environment for ourselves and our children.

Report Highlights

Education. In 2008, Kentucky had a smaller percentage of women graduating with a Bachelor's Degree or higher, 20%, compared to the national average of 27%.

Unemployment. African American and Latina women had the highest unemployment rate, 12% and 11%, respectively, among the female workforce in Kentucky by the end of 2008.

Income. Kentucky had a lower per capita income ($27,625) than the national average ($33,689) in 2007. Comparing the Kentucky counties with the lowest and highest per capita income a difference of almost $30,000 could be detected. Looking at race and ethnicity, White women ($41,084) had a much higher household income in 2006 than women of color ($23,478). When examining wages by education and gender, women with an equivalent educational level suffer wage discrimination when compared to their male counterparts.

Poverty. By the end of 2008, 57% of women were living below the poverty line in Kentucky. Almost half of the families below the poverty line had a female head of household.

Health Care Providers. In 2004, 36% of Kentucky's women were living in Health Care Provider Shortage Areas (HPSA); 26 counties were considered as HSPAs and medically underserved areas.

Health Insurance. Kentucky ranked 30th among all states in terms of women without health insurance in 2006. There is no state law against gender rating by private insurance providers. In addition, federal law restricts most legal immigrants from receiving public health insurance during their first five years of residence, and Kentucky has opted not to provide state coverage for this group.

Abortion Access, Emergency Contraception, and Sex Education. Kentucky law restricts abortion coverage under private insurance plans and for public employees. There are only two clinics in Kentucky that provide the procedure. Emergency rooms and pharmacies are not required to dispense emergency contraception. Sex education is focused on abstinence-only in Kentucky's school system. Schools are required to

teach abstinence, but not contraception. However, Congress recently made competitive grants available for evidence-based sex education programs.

Infant Mortality, Low birth Weight, and Preterm Birth. Kentucky's infant mortality rates (6.7) are similar to the nation's (6.8). African Americans have the highest infant mortality rates in Kentucky, with 10.9 deaths per 1,000 births and account for the highest percentages of low birth weight births (14.6%) in the state.

Prenatal Care. Kentucky fares better than the overall nation in prenatal care: 85% of Kentucky's women utilized prenatal care compared to 75% of women on a national level.

Fertility. Latinas had the highest rates of births within the past 12 months in 2008 with 93 live births per 1,000 women. Also, women living at 100% below the poverty level had high fertility rates with 92 live births per 1,000 women.

Unintended Pregnancies. Among the women who reported unintended pregnancies in 2008, African Americans accounted for the highest percentage at 65%.

Abortions. In 2005, women between 20 and 29 years had the highest percentages of abortion. Looking at total populations in 2005, abortions occurred among African American women at a higher rate than among White women: 480 African American women in every 100,000 had an abortion compared to 140 White women per 100,000.

Teen Pregnancies. Kentucky has the 25th highest teenage pregnancy rate of any state. Of the 10,610 teenage pregnancies each year in Kentucky, 73% result in live births and 11% result in abortions. The teen birth rate among the Kentucky Counties ranged from 17 per 1,000 in Oldham County to 90.5 per 1,000 in Knox County from 2003 to 2007.

Smoking. Kentucky is ranked 2nd in regard to the number of women smoking. Of women who were pregnant, 45% smoked during pregnancy.

Mental Health. In 2009, Kentucky ranked 50th in regard to the number of poor mental health days and had a higher rate of frequent mental distress (14.1%) than the nation (9.9%). In addition women had higher rates of mental health issues (16.5%) than men (11.5%).

Cancer. During 2000-2004, Kentucky accounted for the highest cancer mortality rates among women in the U.S. African American women in Kentucky had the highest mortality rates compared to African American women in other states.

HIV Infections. Among female children and adolescents, girls in the category *some other race* accounted for the highest proportions of HIV infections; whereas Latinas had the highest proportions among women in their 20s and 30s, and African Americans had the highest proportions among women in their 40s and older.

Data and Data Sources

This report includes data from various databases, such as the U.S. Census-- including the American Community Survey, the State Health Facts of the Kaiser Family Foundation, and the Kentucky Health Facts. When necessary, percentages were calculated using Excel 2008.

Information and data was also retrieved from various reports, issue briefs, fact sheets, and websites of different organizations, such as the Guttmacher Institute, the Kentucky Cabinet for Health and Family Services, the Behavior Risk Surveillance System, the Centers for Disease Control and Prevention, the Kaiser Family Foundation, the National Women's Law Center, etc.

In order to highlight specific issues, problems, and resources existing in Kentucky, various experts were interviewed for this report.

The focus of the report is on the state level; however, when possible, county level data was provided throughout the text or in separate tables.

It must be noted, that the information provided in this report is as current and complete as the information that was accessible at the time we collected it. For the most up-to-date information on programs and policies, please verify with the source of information cited in this report.

Many data sources did not segregate by gender or race and ethnicity, therefore, some of our data is limited in this manner. By not capturing data by gender, race, and ethnicity (as well as at county or regional level), it is more difficult to capture and understand disparities and inequities.

Reproductive Justice—Clarifying the Concept

Reproductive justice is a framework that allows us to address reproductive health from a social justice perspective. Reproductive justice looks at reproductive health as it intersects with all the other issues taking place in people's lives. It is related to the concepts of reproductive health and reproductive rights. Despite their interrelation, these three concepts vary in approach. The following conceptual distinction helps to clarify their relationship and the reproductive justice approach and framework.

Reproductive Health. The focus of reproductive health is the delivery of reproductive health services. This includes the assessment of the accessibility of reproductive health services, how information is distributed, and how accurately data is collected. Correspondingly, advocates for reproductive health work to improve and expand reproductive health research and service delivery, with a focus on prevention and cultural competency in underserved communities.[1]

Reproductive Rights. The reproductive rights framework focuses on a "woman's legal right to reproductive health care services with a focus on keeping abortion legal and increasing access to family planning services."[2] Women's reproductive rights are grounded in the fight for basic rights, such as the right to privacy, to make choices about sexuality and childbearing, to be free from discrimination, to access services and to social resources.[3]

Reproductive Justice. The concept of reproductive justice is grounded in the frameworks of social justice and human rights. This connection allows expansion of the analysis to address intersecting forces of oppression, such as racism, classism, and sexism that marginalize women and girls, especially in communities of color, and the right of women to make decisions about their own bodies, families, communities, and society. Reproductive justice focuses on three broad areas: the right to have children; the right to not have children; and the right to parent the children one has. Addressing these three pillars provides a basis for individual and community self-determination.

Further, because the reproductive justice framework addresses intersecting forces, it expands its focus to issues such as "sex trafficking, youth empowerment, family unification, educational justice, unsafe working conditions, domestic violence, discrimination of queer and transgendered communities, immigrant rights, economic and environmental justice, and globalization."[4]

Reproductive justice organizations have advocated for a comprehensive reproductive justice analysis, including the analysis of social determinants.[5] Health inequities between and within countries "are caused by the unequal distribution of power, income, goods, and services," existing living conditions, including lack of access to health care services, schools, education and employment, hazardous working conditions, housing, lack of leisure, and communities.[6] Health inequity emerges out of the intersection of these negative conditions. Therefore, structural determinants have to be addressed in order to affect the future health of populations.[7] Examining social determinants, such as educational attainment, income, housing, and employment, and their effect on health status and access requires viewing these factors through the lens of gender and race/ethnicity to detect injustices and gain a comprehensive understanding of the status of various populations in society.

These three distinct yet complimentary approaches lean on each other for effective analysis and policy/program development and implementation. While reproductive health and rights focus primarily on the individual level, reproductive justice applies to both the individual and the collective level, using more of a public health approach than a medical or legal model. Reproductive justice, through its recognition of the role that social determinants of health have in health outcomes, can support the reproductive health work by addressing the underlying health disparities persistent in terms of racial, ethnic, and socio-economic status. Reproductive justice can also work with the reproductive rights model to provide a social context for individuals, especially the political and historical context that shapes women's decision-making. By integrating immigration, racial, economic, and sexual identity issues in its analysis, reproductive justice can contribute to the dialogue about political rights and action led by the

reproductive rights movement. In effect, reproductive justice calls not only for a broader and more integrated analysis, but also for an approach that looks beyond the traditional view of reproductive health and rights by recognizing that reproductive health affects and is affected by multiple identities and contexts in individuals' and communities' social and physical environments. Bringing together the efforts and champions of these three movements can fortify the work towards a more just and healthy society.[8]

Kentucky Health Justice Network (KHJN) and Reproductive Justice

The purpose of the Kentucky Health Justice Network (KHJN) is to create broad-based and inclusive participation in a health justice movement in Kentucky to increase and improve access, quality, and scope of accurate and culturally-relevant health information and services, particularly those pertaining to comprehensive reproductive health, for communities across Kentucky.

KHJN recognizes the importance of addressing the role that culture, gender, race, income, geographic location, immigration status, sexuality, and educational attainment play in health status and health access for individuals and communities as a whole. We also understand that the issues addressed by social service, social justice, education, and health organizations are interconnected and affect each other in myriad ways. By working across disciplines and issues, KHJN works at the root causes of health, justice and equity as we build greater understanding and support for each other and each other's work. Health care services are one important element in attaining health and wellbeing, but health services alone cannot eliminate underlying inequities such as poverty, racism, and gender-based violence.

KHJN therefore embraces the reproductive justice approach as a way to integrate the social and physical realities in which Kentuckians live, both the strengths and challenges, into the work necessary to bring about equitable and just access to health and improved wellbeing. This requires working with individuals and organizations across disciplines to make connections between various social, economic, and political realities to enhance the health status of our communities. This also means working at

various levels, including policy analysis, program development and implementation, organizational capacity-building, and community-driven education and awareness.

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[1] Asian Communities for Reproductive Justice (2005). *A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice*. Retrieved October 30, 2009 from http://www.reproductivejustice.org/ACRJ_A_New_Vision_05.pdf

[2] Asian Communities for Reproductive Justice (2005). *A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice*. Retrieved October 30, 2009 from http://www.reproductivejustice.org/ACRJ_A_New_Vision_05.pdf, p. 2.

[3] Asian Communities for Reproductive Justice (2005). *A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice*. Retrieved October 30, 2009 from http://www.reproductivejustice.org/ACRJ_A_New_Vision_05.pdf

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Introduction

This report provides a snapshot of the state of reproductive health and rights in Kentucky from a reproductive justice perspective. The hope is that this report will expand the available base of knowledge about determinants of reproductive health to inform and strengthen current efforts affecting the reproductive health and lives of individuals and communities in Kentucky.

This report relies on secondary research data. While we hope to provide as complete a picture of reproductive justice in Kentucky as possible, this report is not exhaustive.

The premise of the report is that reproductive health outcomes are intricately intertwined with various biological, environmental, socio-political, cultural, and economic factors. An assessment of existing policies (legislative and administrative), programs and services, and health outcomes data within this broader social context will serve to provide a more complete picture of reproductive health status in Kentucky.

The report is laid out in a manner that follows the framework of social determinants of health. We begin by providing the general context within which individuals and communities exist in Kentucky: descriptive demographics, followed by socio-economic determinants such as educational attainment and employment. Then the report enters the world of policies and programs, which serve as intermediary determinants, by strengthening or undermining the options and resources available at the individual and community level based on socio-economic realities. Finally, we provide information on health outcomes. We place health outcomes as the last section as they are, in fact, a result of the interaction of the various socio-economic and environmental contexts that people live in, with policies and programs that either alleviate or exacerbate these conditions.

Most of the data available does not link health outcomes to the social context within which Kentuckians live. By analyzing and understanding health outcomes

independently of the neighborhood where a family lives, of the school that a child attends, and the stores and jobs available in their community, we fail to see the influence of these factors and we miss opportunities to intervene before health outcomes become manifest. We seek to provide an integrated view of the factors that influence health outcomes.

We hope that this report illustrates that health is integral to our ability to live full lives. This narrative also illuminates the roles that others play in determining the health of individuals, of families, and entire communities. These players seldom make an appearance in health reports but they are the ones who lay the path and make available (or not) the resources and opportunities necessary for good health and wellbeing. This narrative speaks of health, but it also speaks of poverty, education, race, gender, violence, pollution, unemployment, and discrimination. In the end, we hope that a vision for a more complete and sustainable form of prevention is developed. To prevent negative health outcomes we must start at the beginning of the problems, where individuals and communities are allotted differing levels of access and opportunity based on location, income, race, gender, and immigration status. We can use the tools we know—policies, programs, education, organizing, and others—to change the story's outcome.

Kentucky is a state rich in culture and natural resources, with a history of resilience and a strong sense of community and family. Kentucky's roots are deep and embedded in perseverance, creativity, and solidarity. KHJN believes that building on these assets is central to meeting the challenges facing Kentucky's communities in a respectful and sustainable way. With systemic poverty, environmental pollution and destruction, geographical isolation, and a dearth of locally-based economic opportunities, Kentucky faces formidable challenges in terms of health status and outcomes. KHJN believes creating a health justice movement can succeed in addressing these challenges.

M. Gabriela Alcalde, M.P.H.
KHJN, State Director

Demographic and Socioeconomic Conditions

Total Population

The 2006-2008 American Community Survey (ACS; 3-year estimate) reported 4,234,999 people living in Kentucky for the year 2008. Of these, 2,165,113 (51.1%) were female and 2,069,886 (48.9%) were male.[9] For all races and ethnicities, the population has grown during the last 8 years. Except for the populations represented by the categories Hispanic/Latina/o and *some other race*, there were more women than men in each race category (Table 1). The census data is limited in regard to the Latina/o immigrant population since data only capture a sample of women and men under a documented status and do not include those who live in the state under an undocumented status. Thus, only a fraction of the actual population is presented in following tables and charts.

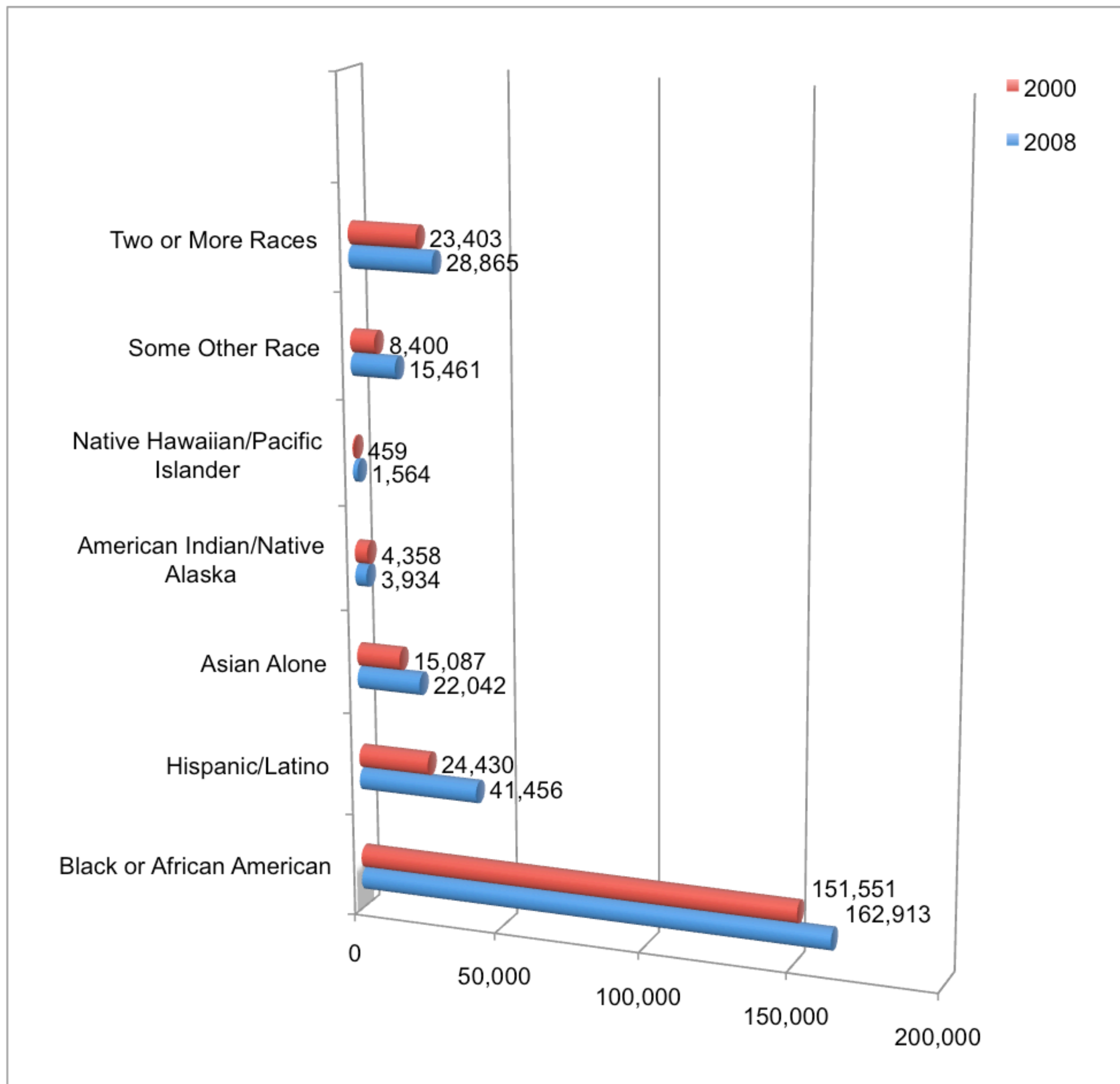
Table 1

Population Change 2000–2008 in Kentucky by Gender and Race/Ethnicity

	White Alone (Not Hispanic/Latino/a)		**Black or African American (Alone)**		**Asian (Alone)**		**Hispanic/ Latina/o**	
	Male	Female	Male	Female	Male	Female	Male	Female
2000	1,757,620	1,850,393	142,364	151,551	13,907	15,087	35,509	24,430
2008	1,816,242	1,906,782	153,630	162,913	18,642	22,042	52,720	41,456

Sources: 2000 Decennial Census; 2006-2008 American Community Survey, 3-year estimate[10]

Figure 1 shows the growth in the female population of color from 2000 to 2008 (except for the American Indian/Alaska Native population). Several populations grew considerably over this time period: the Asian female population grew by about 34%; the population represented by the category *some other race* increased by 46%; the Hispanic/Latina population increased significantly by 70%; and the Native Hawaiian/Pacific Islander population grew by about 71%.



Sources: 2000 Decennial Census; 2006-2008 American Community Survey, 3-year estimate

Figure 1. **The change in the female minority populations in Kentucky from 2000 to 2008 by race/ethnicity.**

Age

The median age in the year 2008 was estimated at 36.1 for men and 38.9 for women in general. Table 2 demonstrates the median age broken down by race/ethnicity and gender.[11]

Table 2

Median Age by Sex and Race/Ethnicity in Kentucky

	White Alone (Not Hispanic)	Black/African American Population (Alone)	American Indian, Alaska Native	Asian Alone	Native Hawaiian, other Pacific Islander	Hispanic or Latina/o
Total	**38.8**	**32.0**	**39.7**	**32.6**	**30.1**	**24.6**
Male	37.5	30.4	38.1	32.0	25.9	25.5
Female	40.2	33.4	42.1	33.1	32.9	23.1

Source: 2006-2008 American Community Survey, 3-year estimate

As Table 2 shows, the White and American Indian/Alaska Native female populations on average are older compared to other populations. Table 3 provides age-range distribution. Latina women had the highest percentage (44%) among women under 18 years old and at the same time accounted for the lowest percentage (52%) among women between 18 and 64. In contrast, White women had the highest percentage among women age 65 years and older.

Table 3

Female Population in Kentucky by Age

	White Alone (Not Hispanic)	Black or African American Population (Alone)	American Indian and Alaska Native	Asian Alone	Native Hawaiian and other Pacific Islander	Hispanic or Latina/
Total	**3,723,024**	**316,543**	**7,614**	**40,684**	**2,640**	**94,176**
Female	**1,906,782**	**162,913**	**3,934**	**22,042**	**1,564**	**41,456**
Under 18 years	407,449 or 21.00%	44,465 or 27.00%	665 or 17.00%	5,845 or 27.00%	271 or 17.00%	18,391 or 44.00%
18-64 years	1,200,536 or 63.00%	101,713 or 62.00%	2,874 or 73.00%	14,856 or 67.00%	1,223 or 78.00%	21,482 or 52.00%
65 years and older	298,797 or 16.00%	16,735 or 10.00%	395 or 10.00%	1,341 or 6.00%	70 or 4.00%	1,583 or 4.00%

Source: 2006-2008 American Community Survey, 3-year estimate

Number of women incarcerated in Kentucky. In 2009, a total of 2,266 women were incarcerated in Kentucky; of those 1,498 or 66.11% had children. Table 4 provides information about the races and ethnicities of the women, in general, and of those who have children.

Table 4

Counts of Women Incarcerated in Kentucky by Race/Ethnicity, 2009

	Women Overall	Women who have Children
American Indian/Alaskan Native	2	1
Asian/Pacific Islander	4	1
Bi-Racial	14	12
Black	355	218
Hispanic/Latina	8	5
White	1883	1261
Total	2266	1498

Source: Amanda Wilburn[12]

Immigration Status

The 2006-2008 ACS (3-year estimate) reported a total of 114,115 foreign-born men and women in Kentucky.[13] Since the ACS does not account for undocumented or mixed status families, it is estimated that between 149,115 and 174,115 immigrants reside in Kentucky.[14] In 2000, Kentucky ranked 37th in the foreign-born population and 48th in immigrant population.[15] The 2006-2008 ACS (3-year estimate) estimated that 53,428 women in Kentucky were foreign-born, which corresponds to 2.47% of the female population.[16] Of this population about 60.29% were not U.S. citizens and 39.70% were naturalized citizens. Since 2005, the foreign-born female population has increased by 15%. Among this population, the proportion of the non-U.S. citizens increased by 21%. In both years, the population of non-U.S. citizens accounted for a higher proportion of the foreign-born female population than the naturalized citizens.

In regard to the Latina/o population, Kentucky has seen an increase of 239% from the early nineties to 2004. This significant growth ranked Kentucky eighth in regards of the growth of the Latina/o population during the 1990s.[17]

Educational Attainment, Employment, and Income

Educational attainment. Education plays a major role in the context of health and reproductive health. Education is a key requisite to having access to jobs with higher income, healthy working conditions, and other benefits such as health insurance

coverage.[18] Nationally, Kentucky ranks 49th for women's educational attainment.[19] The 2006-2008 ACS (3-year estimate) reported that 18.42% of women in Kentucky did not finish high school and 34% reported having only a high school degree. In contrast, 20% had a Bachelor's degree or higher. Among communities of color, except among Asian women, the lowest percentages of their populations had a Bachelor's or higher level degree. On a national level, 30% of women had a high school degree and 27% had a Bachelors Degree or higher.[20]

Table 5
High School Graduation by County, State, and Nation (25 years and older; 2007)

County with lowest percentage: **Owsley**	49%
County with highest percentage: **Oldham**	87%
Kentucky	72%
United States	80%

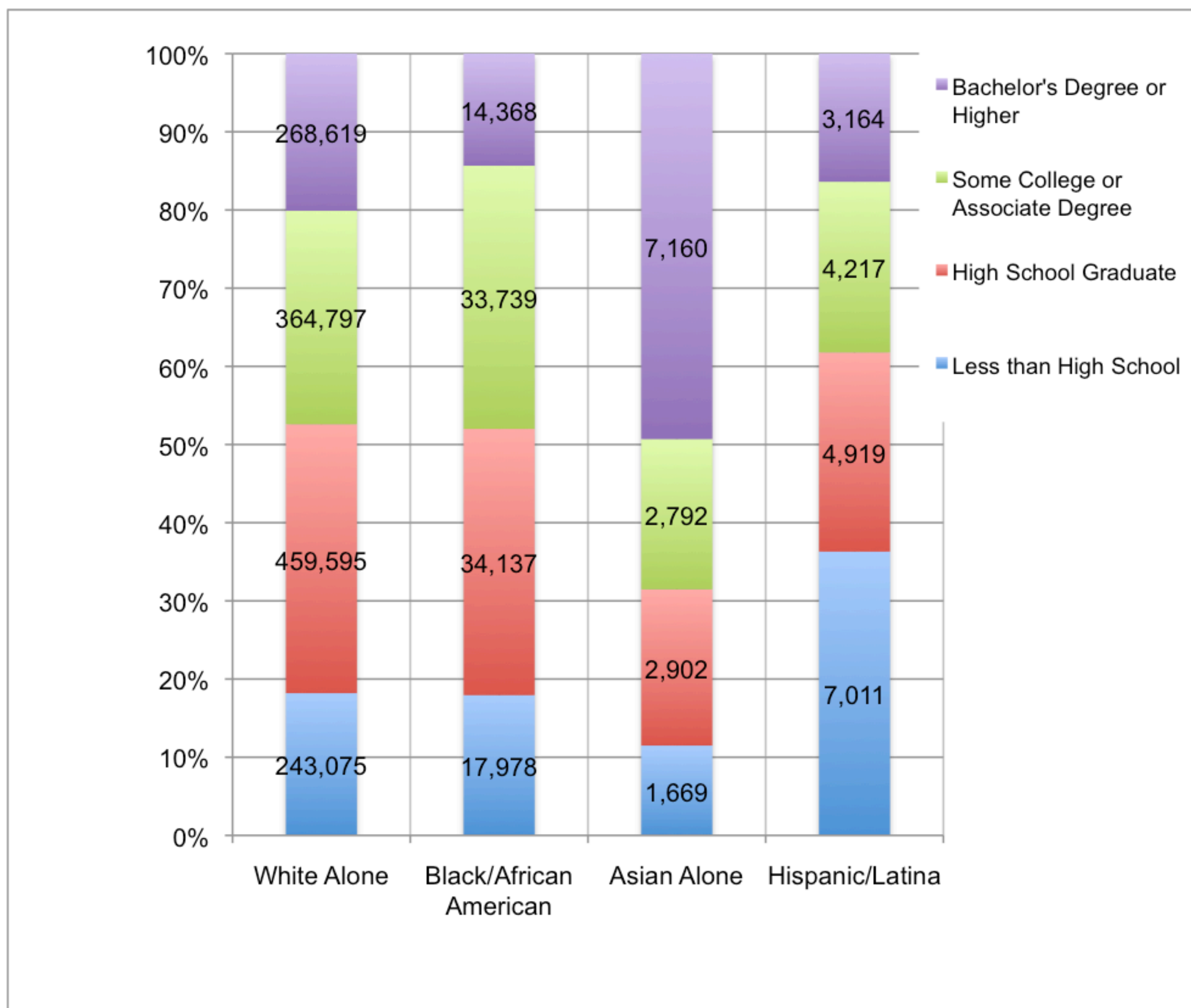
Source: Kentucky Health Facts,

Table 5 shows high school graduation rates by on a national and state level, as well as illustrating the range of graduate rates from the county with the high percentage of graduates to the county with the lowest percentage of graduates.

Figure 2 (below) demonstrates educational attainment by race and ethnicity in Kentucky. Almost 50% (7,160) of Asian women had a Bachelor's degree or higher and 11.49% (1,669) had less than a high school degree; among White women, 18.19% (243,675) were at the lowest and 20.10% (268,619) were at the highest educational levels. In contrast, Latinas and women categorized as *some other race* are over-represented at the lowest educational level (36% and 41%, respectively). African American women had the lowest percentages of the highest educational level, with 14.33% (14,368).[21]

On a national level, Asian women also accounted for the most highly educated group with 46% of women having a Bachelors Degree or higher. Women of *some other race* accounted for the lowest percentage (11%) of women having a Bachelors Degree or higher, followed by Latinas (13%) and American Indians/Alaska Natives (13%). Women of *some other race* also accounted for the highest proportion (41%) of women having less than a High School diploma, again followed by Latinas with 38%.[22]

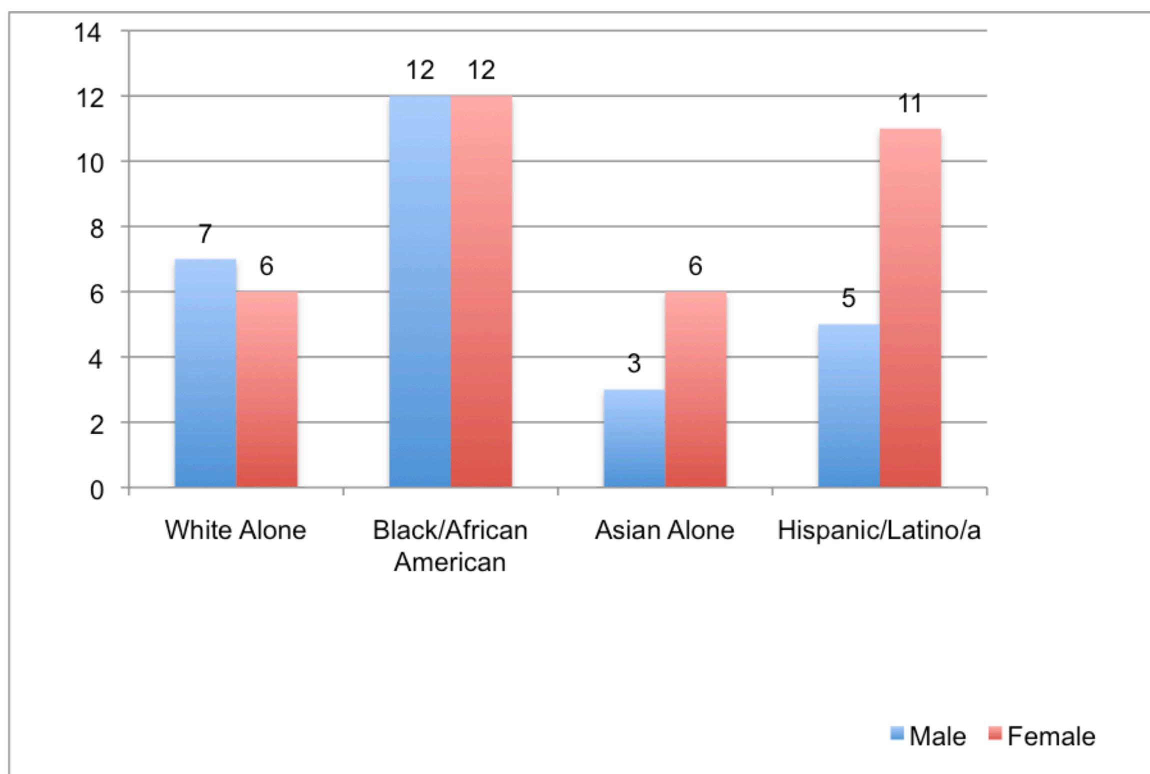
Research has linked education level to longer life expectancy and better health outcomes. The relationship between education and employment and income increases the chances of being able to afford more nutritious foods, to live in areas that provide possibilities for regular exercise, such as recreational facilities or parks and to have a regular source of health care. In effect, having access to better education translates into having access to better jobs with higher pay, safer working conditions, better benefits (including health insurance), and living in safer and less polluted neighborhoods.[23]



Source: 2006-2008 American Community Survey, 3-year estimate

Figure 2. **Educational attainment for female population 25 years and older by race/ethnicity.**

Unemployment. People with lower educational attainment and employed in lower income jobs are more likely to face unemployment due to economic fluctuations.[24] In Kentucky, the unemployment rate calculated in October 2009 was 11.2—1.7 points higher than in September 2009 (seasonally adjusted). In comparison, the national unemployment rate was at 10.2 in October 2009 (seasonally adjusted). Magoffin County in Eastern Kentucky experienced the highest rate of unemployment with 21.7, and Fayette County had the lowest rate with 7.8 (not seasonally adjusted).[25] Figure 3 (below) presents the percentage of civilian individuals between 16 and 64 years old, who were unemployed in Kentucky during the period 2006 to 2008. African American women and men had the highest percentage (12%) of unemployment, followed by Latinas with 11%. Associating educational attainment with unemployment in Kentucky among people ages 25 to 64 years, it can be concluded that, by the end of 2008, 2.08% of those who were among the civilian labor force and had a Bachelor's Degree or higher were unemployed compared to 11.71% of those who did not finish high school.[26]



Source: 2006-2008 American Community Survey, 3-year estimate

Figure 3. **Unemployment rates in percent for civilians between 16 and 64 years by race/ethnicity and gender.**

***Income and poverty (including SSI and food stamps)*.** Lower educational attainment is associated with lower income. A higher income is an indicator of greater economic security, greater ability to afford health care, healthier and more nutritious foods, and to live in safer areas that provide parks, recreational facilities, and grocery stores.[27] The median household income is an indicator in determining available resources to women and their families. In Kentucky, the median household income in 2006 (in inflation adjusted dollars) for all women was $39,880. White women had a median household income of $41,084, whereas all women of color had an income of $23,478.[28]

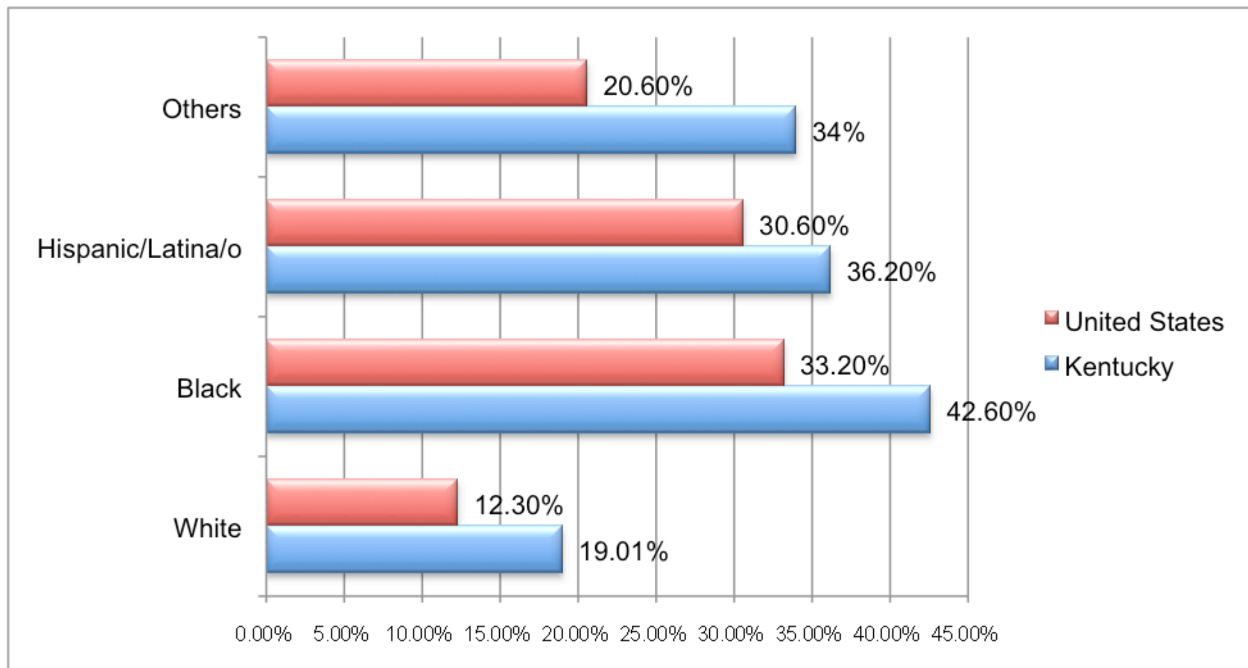
Table 6
Per Capita Personal Income by County, State, and Nation (2007)

County with lowest income: **Elliot**	$15,392
County with highest income: **Hickman**	$43,030
Kentucky	$27,625
United States	$33,689

Table Six presents per capita personal income at the national and state level, as well as showing the range of income by county.

Women living in poverty are less likely to have access to a regular source of health care, less likely to obtain regular screenings and checkups, and less likely to have health insurance coverage. This results in a greater chance of delaying care and of worse health outcomes.[29]

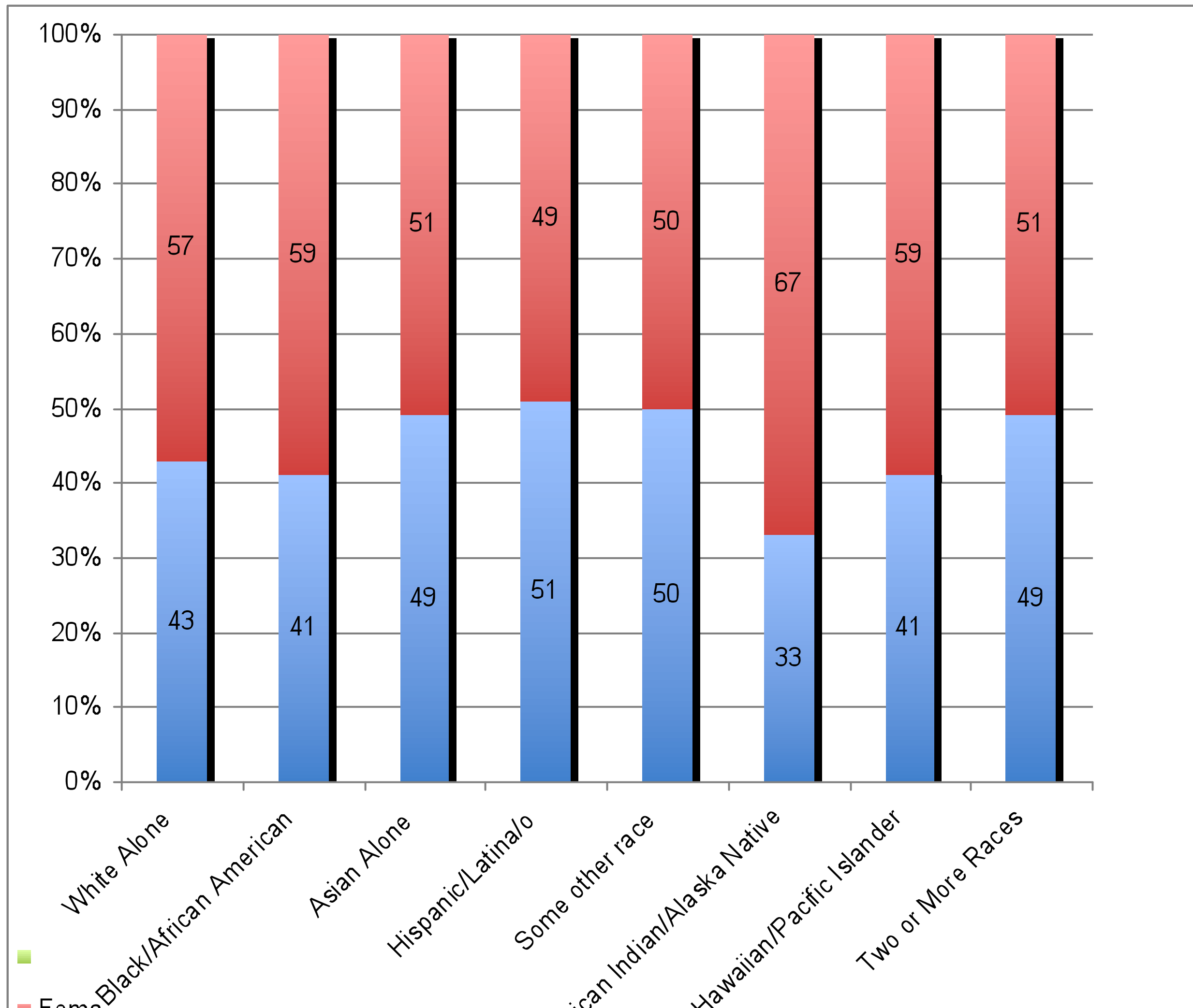
Figure 4 (next page) shows the poverty rate broken down by race and ethnicity in Kentucky for the time period of 2007 to 2008.



Source: The Kaiser Family Foundation State Health Facts

Figure 4. **Poverty rate by race and ethnicity in Kentucky for the time period 2007-2008.**

During the time period 2007-2008, the overall poverty rate in Kentucky was 21.6% compared to 18.3% on the national level.[30] In 2007, Owsley County had the highest percentage of people living in poverty at 44.4% and Oldham County the lowest percentage with 6.0%.[31] Comparing metropolitan and non-metropolitan areas in Kentucky, there was a1% difference. The poverty rate in metropolitan areas was at 21% and in non-metropolitan areas at 22%. Looking at race and ethnicity, the Black/African American population accounted for the highest percentage of people living in poverty during the time period 2007-2008 (Figure 5, next page).[32] In the previous year (2006), 18.7% of women in Kentucky were living in poverty. White women had a poverty rate of 17.5% and women of color had a rate of 28.9%.[33]



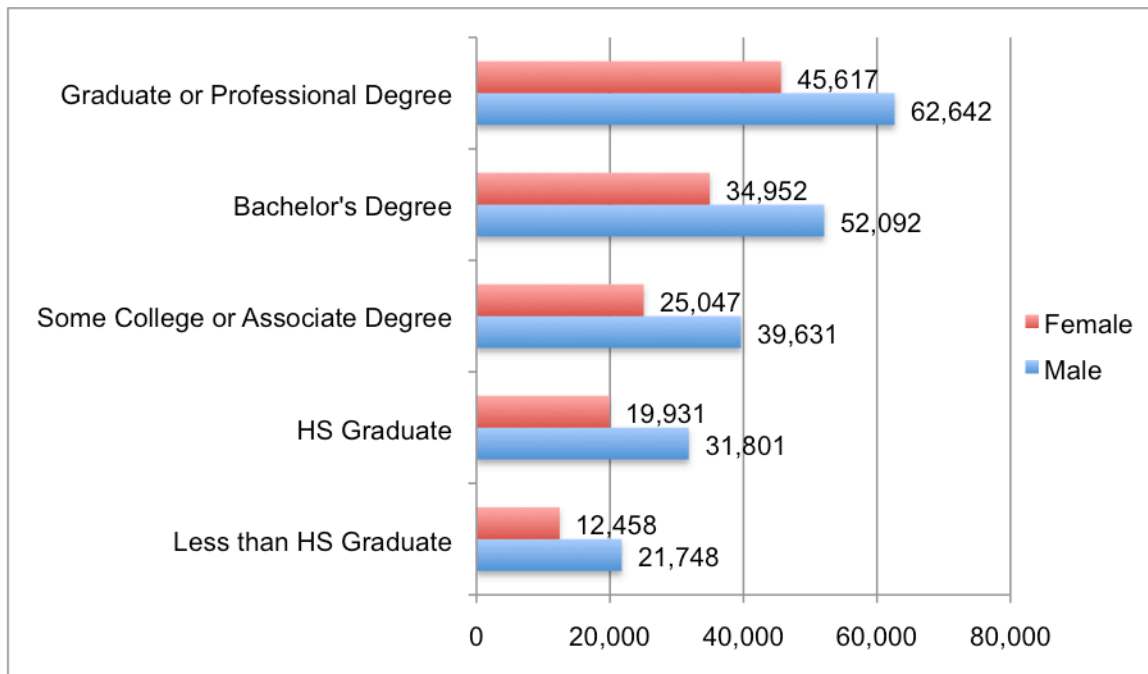
Source: 2006-2008 American Community Survey, 3-year estimate

***Figure 5*. Percentage of population living below the poverty level in the past 12 months by race/ethnicity and gender for the year 2008.**

The 2006-2008 American Community Survey (3-year estimate) counted the population that was living below the poverty level. Of the overall population whose poverty status was determined, 57% were women who lived below the poverty level. Figure 5 (above) shows the percentage of women and men living below the poverty level. With the exceptions of Latinas at 49%, more women than men lived below the poverty line; for example, within the American Indian/Alaska Native population, 67% women lived below the poverty line; in the Asian population, women accounted for 51% of those living below the poverty level. Thus, in Kentucky, women are, across race and ethnicity, more affected by poverty than men.[34]

In addition to household income and poverty, it is important to look at the wage gap. An increasing number of women live alone and have families without a partner; therefore, wages become even more critical to providing for basic needs, sustaining health, and to being able to afford health care for themselves and their families. Despite the Equal Pay Act of 1963, women earn less at all levels of education than men.[35] Figure 6 (below) demonstrates the various levels of education correlated with the median earnings of women and men in Kentucky in 2008.[36]

Figure 6 shows the increase of earnings in the higher educational attainment levels, and it also demonstrates the discrepancy between the genders. Research shows that there is also a wage gap within the female population. In 2006, female populations of color fared even worse than White women. James et al. reported a disparity score of 1.16 In regard to wages, with scores greater than 1.00 indicating that women of minority populations do worse economically. For every dollar White men earned, White women in Kentucky earned 75 cents and women of color (including Black/African American, Asian American, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and women of two or more races) earned 65 cents. The national average for all women was 73 cents.[37]



Source: 2006-2008 American Community Survey, 3-year estimate
***Figure 6.* Median earnings in the past 12 months (in 2008 inflation-adjusted dollars) by sex and educational attainment for the population 25 years and older.**

Motherhood and marriage also influence wages. A wage penalty, reduced earnings not explained by human capital or occupational factors, is often present when looking at the wages of women with children. A study based on the *National Longitudinal Survey of Youth* found that women who had one child did not have a wage penalty; however, having two, three, or four children indicated a wage penalty of 5%, 8%, and 4% respectively.[1,38] An earlier study reported that mothers of one child experienced a wage penalty of 3%.[39] Taking race and ethnicity into account, Glauber found that African American and Latinas pay less wage penalties. However, this may be accounted for by the fact that African American and Latina women earn less than White women to start with so there is less room for further decrease in wages. White mothers faced penalties of 6%, 10%, and 7% for two, three, and four or more children, respectively. Controlling for marriage, Glauber found that Latina mothers, regardless of their marital status and the number of children they had, did not face any wage penalties. Married African American women with one or two children also did not experience wage penalties;

[1] The sample used in this study was drawn from *The National Longitudinal Survey of Youth*: the timeframe was 1982-2004 and N = 5,929.

however, married White mothers with one child faced a 2% and with two children an 8% wage penalty. Married African American and White women with more than two children had similar wage penalties. While never-married White mothers paid wage penalties similar to their married counterparts, African American never-married mothers did not experience a wage penalty. Glauber states that reasons for racial and ethnic differences might lie in cultural perceptions of family, kinship support of the mother, and the fact that African American women earn less than White women and therefore their wages do not provide as much space for penalties as the ones of White women.[40]

Children in Poverty

By the end of 2008 in Kentucky, 268,105 children under age 18 (26.80%) were living in households that received Supplemental Security Income (SSI), cash public assistance income, or food stamps in the past 12 months. Of these, 48.22% lived with a female head of household (no husband or family present), 8% lived with a male head of household (no wife or family present), 42.32% lived in a married couple family, and 1.4% lived in nonfamily households. Among the 146,783 families with income below the poverty level, 73,260 or 49.9% had a female head of household with no husband present. Of those, 16.5% received Social Security Income in the past 12 months. Among the families at or above the poverty level (970,990), 13.6% had a female head of household with no husband present. Of those, roughly 31% had Social Security Income over the past 12 months.[41]

Comparing races and ethnicities of heads of household (gender specific data was not available in this case), it can be concluded that heads of households falling under the category *two or more races* have the highest percentages of people (24.16%) who received food stamps compared to the other races/ethnicities. African American households accounted for the second highest percentages at 22.9% (Table 7 below).

Table 7

Receipt of Food Stamps in the past 12 Months by Race/Ethnicity of Householder

	African American (Alone)	American Indian/ Alaska Native	Asian (Alone)	Native Hawaiian/ Other Pacific Islander	Some Other Race	Two or More Races	White Alone	Hispanic Latino
Total	124,873	3,550	13,339	906	7,920	13,716	1,488,593	23,072
Households that received food stamps	28,604 or 22.91%	631 or 17.77%	481 or 3.61%	40 or 4.42%	1,305 or 16.48%	3,314 or 24.16%	180,024 or 12.09%	3,498 or 15.16%

Source: 2006-2008 American Community Survey, 3-year estimate

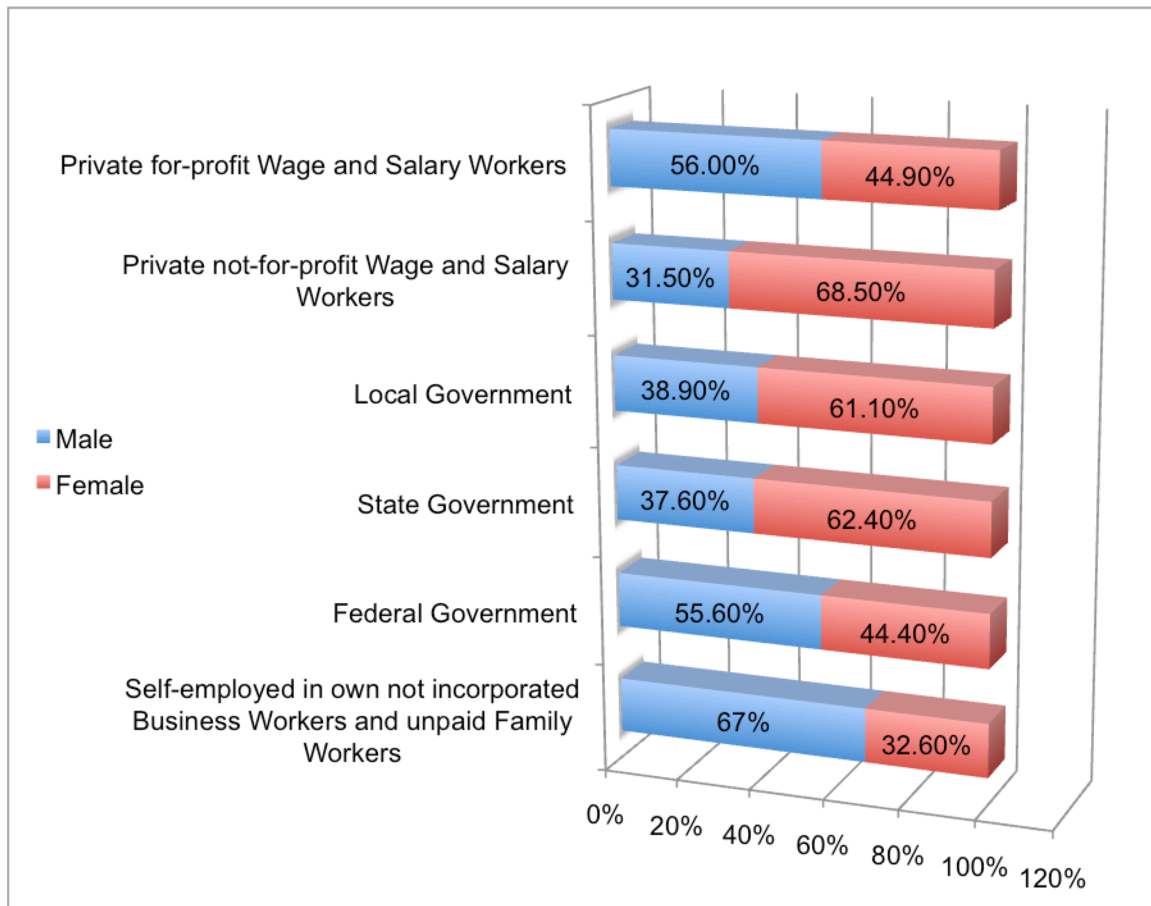
Women and Workforce

In 2002, Kentucky ranked 38th among all states in the percent of businesses owned by women. Women owned 26% of the companies in Kentucky that had sales and receipts over $9 billion.[42]

By the end of 2008, women accounted for 47.3% and men for 52.7% of the civilian employed population who were 16 years and older. Women in Kentucky accounted for lower proportions in private for-profit businesses and in the federal government. Figure 7 demonstrates the proportions of men and women (2006-2008 American Community Survey, 3-year estimate) distributed by the class of workers. As Figure 7 shows, women are overrepresented in state, local, and non-profit agencies. Among the private for-profit workers, women accounted for 44.9% of employees at private companies and for 25.7% of self-employed business workers.[43]

Women in Public Office

Kentucky ranks 47th in the U.S. in the number of women serving in elected office. Twenty-one women served in the state legislature in 2009. With a total of 138 seats, women account for only 15% of the body. About 16% of the senators and 15% of the representatives are female in KY. In comparison, nationally, 17.5% of the legislators are women. Among those, 17% are in the Senate and 17.7% in the House of Representatives. Of the 400 mayors in Kentucky, 18% are female. Only 25% of city council members are women. Women are significantly underrepresented in elected public office.[44]



Source: 2006-2008 American Community Survey, 3-year estimate

***Figure 7.* Class of workers by sex in the past 12 months.**

Homelessness, Housing, Neighborhood, and Workplace Conditions

Where we live impacts our daily lives and available options and resources. Having a home signifies safety, security and shelter and has a crucial influence on individuals' health.[45] Research finds that not having a home has severe consequences on individuals' physical and mental health, including respiratory and circulatory illnesses, skin problems, sexually transmitted diseases, HIV and AIDS, Hepatitis, tuberculosis and pneumonia, and cancer. In addition, individuals experiencing homelessness are at higher risk of having a drug or alcohol addiction and developing a mental illness. A lack of access to primary care providers and preventive services contributes to increased health risks.[46]

Homelessness. With the recent foreclosure crisis nationally, many families are under extreme and unprecedented financial stress. As of November 2009, one in 1,893 homes were foreclosed. Kentucky ranked 41 among the states in terms of foreclosures. Nationally one in 417 homes was foreclosed.[47] The *2009 Kentucky Statewide Point-In-Time Count* reported 5,999 homeless persons in Kentucky.[2] Of those 1,515 were in the Metro Louisville Region and 1,310 in the Lexington-Fayette area; 3,174 were in the remaining 118 counties. Of the 4,015 homeless households, 45% were female; 21% had dependent children; 68.5% self-identified as Caucasian/White, 24.8% as African American, 2.1% as multi-racial, 2.7% as *some other race*, 1.3% as American Indian/Alaska Native, 0.3% as Asian, and 0.2% as Native Hawaiian/Pacific Islander. Hispanic/Latinas/os accounted for 2.7%. The report states that among the more than 1,200 homeless individuals who self-identified severe mental illness, 57% were female. Over 1,100 respondents experienced domestic violence. Among those 90% were women.[48]

Housing and Neighborhood Conditions. In addition to the direct and indirect health impact of having a home, the quality of the home is of great health importance. Homes should be "free from physical hazards" that could potentially result in health problems, such as chronic diseases or injuries.[49] Inadequate housing can result in hazardous living conditions that affect health (Table 8). Affordability of housing determines an individuals' options of where and how they will live, putting low-income families at risk of living in unsafe neighborhoods that lack resources for health promotion[3]. Unaffordable housing also increases financial burden on families and individuals resulting in the need to pick and choose between basic needs, including health care and nutrition.

Neighborhood conditions contribute to the health and wellbeing of individuals. Research has shown that social, physical, and economic characteristics of

[2] The U.S. Department of Housing and Urban Development demands a so-called Point-In-Time Count, which means that the state counts homeless individuals staying in emergency shelters, transitional units, cars, under bridges, etc. during a 24-hour period. The count for 2009 happened during the ice storm in January, leading to an underrepresentation of the homeless in the count (Kathleen Meyer, personal communication, December 14, 2009; Kentucky Housing Corporation, 2009).
[3] Affordable housing is given "when a family spends less than 30% of its income to rent of buy a residence" (Pollack et al., 2008, p. 5).

neighborhoods have considerable effect on health quality and longevity. Having access to violence- and crime-free playgrounds and recreational areas and being able to shop at grocery stores that sell fresh food contribute to the overall wellbeing of individuals and families. The economic, social, and physical conditions of neighborhoods are also closely linked to the availability, accessibility, and quality of public services-- such as schools, health care services, and employment opportunities. Housing discrimination prevents many low-income and families of color from moving to healthy neighborhoods and restricts them to areas of concentrated substandard housing that include hazardous conditions, such as lead paint, mold, dust, poor air and water quality, and lack of access to healthy food stores, service providers, and recreational areas.[50]

Table 8

Health Hazards at Home

	Locations/Sources	Health Impacts
Asbestos	Floor, ceiling tiles, plasters, insulations, adhesives, wallboard, roofing material, fireproofing materials, cement products	Respiratory and lung diseases, such as lung cancer
Arsenic-Treated Wood	Anywhere outdoor lumber is utilized: Play sets, decks, picnic tables	Lung, skin, kidney, prostate, nasal passage cancer; nerve damage, dizziness, numbness, immune, cardiovascular diseases, diabetes, changes in hormone function
Carbon Monoxide	Cars, gas stoves, house fires, non-electric space heaters used indoors, furnaces with cracked heat exchangers or leaking chimneys	Flu-like symptoms, headaches, dizziness, problems to think clearly, visual impairment, reduced work capacity, poor learning ability etc.
Dust and Dust Mites	Tracked in from outdoors	Respiratory problems, asthma, allergic reaction, lead poisoning (if dust contains lead)
Lead	Dust and paint, soil, water, certain workplace	Toxic to pregnant women and women of childbearing age; children: reduced IQ and attention span, hyperactivity, impaired growth, reading and learning disabilities, hearing loss, insomnia; mental retardation, coma, convulsions, death
Mold	Moist environments: wallpaper, insulation, backing paper on drywall, dust and dirt	Allergens, irritants, respiratory problems
Pesticides	Used in households to fight insects; food, water, environment	Injury of nervous system, of reproductive system, birth defects, cancer; dizziness, vomiting, headaches, sweating, skin, eye, respiratory tract irritation
Radon	Since radon is a gas, can enter any home	Lung cancer
Rodents		Asthma, allergic symptoms

Source: Alliance for Healthy Homes[51]

Hollander stated that reproductive health is particularly dependent on an individual's environment. Working at a polluted workplace and being exposed to hazardous industries, or to toxic substances in homes are significant threats to reproductive health.

Table 9 provides examples of substances and other agents that put women and their children at substantial health risk.[52]

Table 9

Health Hazards at Work

Chemical and Physical Agents that are Reproductive Hazards at the Workplace		
Agent	**Observed Effects**	**Exposed Workers**
Cancer treatment drugs (e.g. methotrexate)	Infertility, miscarriage, birth defects, low birth weight	Health care workers, pharmacists
Certain ethylene glycol ethers (2-ethoxyethanol/2EE; 2 methoxyethanol/2MM)	Miscarriages	Electronic and semiconductor workers
Carbon disulfide (CS_2)	Menstrual cycle changes	Viscose rayon workers
Lead	Infertility, miscarriage, low birth weight, developmental disorders	Battery makers, solderers, welders, radiator repairers, bridge repainters, firing range workers, home remodelers
Ionizing radiation (e.g. x-rays, gamma rays)	Infertility, miscarriage, birth defects, low birth weight, developmental disorders, childhood cancers	Health care workers, dental personnel, atomic workers
Strenuous physical labor (prolonged standing, heavy lifting)	Miscarriage late in pregnancy, premature delivery	Many type of workers

Disease-causing Agents that are Reproductive Hazards for Women at the Workplace			
Agent	**Observed Effects**	**Exposed Workers**	**Prevention**
Cytomegalovirus (CMV)	Birth defects, low birth weight, developmental disorders	Health care workers, workers in contact with infants and children	Good hygienic practices such as hand-washing
Hepatitis B virus	Low birth weight	Health care workers	Vaccination
Human Immunodeficiency Virus (HIV)	Low birth weight, childhood cancer	Health care workers	Practice universal precautions
Human parvovirus B19	Miscarriage	Health care workers, workers in contact with infants and children	Good hygienic practices such as hand-washing
Rubella (German measles)	Birth defects, low birth weight	Health care workers, workers in contact with infants and children	Vaccination before pregnancy if no prior immunity
Toxoplasmosis	Miscarriage, birth defects, developmental disorders	Animal care workers, veterinarians	Good hygiene practice such as hand-washing
Varicella zoster virus (chicken pox)	Birth defects, low birth weight	Health care workers, workers in contact with infants and children	Vaccination before pregnancy if no prior immunity

Source: National Institute for Occupational Safety[53]

Environmental Impact on Women's Health. Our reproductive systems are vulnerable to toxic chemicals that are ubiquitous in the environment, indoors and outdoors, urban and rural, wherever we work, play, and live. Toxic chemicals are lurking in many products we use every day: cosmetics, health products, electronics, toys, building construction and maintenance materials, food and beverage containers and food itself.

Lax labeling regulations mean it is difficult to tell what products are harmful and what are the safer alternatives. The Toxic Substances Control Act and other federal regulations are not an effective means of protecting our health. Of the more than 80,000 chemicals on the market today, only 200 have been required by the government to be tested for safety. [54]

Here in Kentucky, people are exposed to harmful toxics from additional sources including coal mining and power plants, industrial facilities and agricultural pesticides. Coal mining practices result in emissions of coal dust and diesel fumes into the air, and toxic sludge that leaches out into the water. Coal burning power plants release soot, smog-forming chemicals and heavy metals into the air. These emissions are directly linked to asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases; heart disease; low birth weight and associated complications; and neurological and developmental disorders. The Rubbertown neighborhood in Louisville and communities near other manufacturing plants all over the state experience additional exposure to chemicals that are linked to cancers, respiratory and heart disease, birth defects and reproductive disorders. Communities of color and low-income communities bear a disproportionate burden of industrial chemical exposures. Waste incinerators and landfills are also more likely to be sited in disenfranchised communities. In rural communities, pesticide exposure from agricultural applications is also a public health concern. Pesticide drift can impact people living or recreating far from where the agri-chemicals are applied. In each situation, workers, whether inside a chemical plant or in the farm fields, are on the frontline of toxic exposure.[55]

According to the Mobilizing Action Towards Community Health (MATCH), a project of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, Jefferson County (followed by Oldham County) is the least healthy county in terms of physical environment in the state.[56]

In each case, scientists have established that there is no such thing as a safe level of toxic chemicals. Additionally, it is not always the dose that makes the poison toxic.

Exposure to small amounts of toxic chemicals at critical developmental stages can result in big health problems years after the exposures take place.[57]

Domestic Violence, Rape/Sexual Assault, and Family and Intimate Partner Violence

Violence against women is not only a major violation of human rights but it has serious consequences on women's physical, mental, sexual and reproductive health.[58] Family and Intimate Partner Violence (IPV) are widespread social issues with significant economic, legal, medical, and public health consequences. Women are disproportionately at risk for victimization by a current or former intimate partner. Women who have been physically and sexually abused during their childhood or adulthood are more at risk for negative health outcomes and unwanted pregnancy than other women.[59] IPV has numerous short- and long-term health consequences. These health effects persist even after a woman is no longer in an abusive situation. Table 10 lists the health consequences of intimate partner violence.

Table 10

Health Consequences of Intimate Partner Violence

Physical	Abdominal/thoracic injuries, bruises and welts, chronic pain syndrome, disability, fibromyalgia, fractures, gastrointestinal disorders, irritable bowel syndrome, laceration and abrasions, ocular damage, reduced physical functioning
Sexual and Reproductive	Gynecological disorders, infertility, pelvic inflammatory disease, pregnancy complications/miscarriage, sexual dysfunction, sexually transmitted diseases (including HIV/AIDS), unsafe abortion, unwanted pregnancy
Psychological and behavioral	Alcohol and drug abuse, depression and anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic disorders, physical inactivity, poor self-esteems, post-traumatic stress disorder, psychosomatic disorders, smoking, suicidal behavior and self-harm, unsafe sexual behavior
Fatal	AIDS-related mortality, maternal mortality, homicide, suicide

Source: World Report on Violence and Health[60]

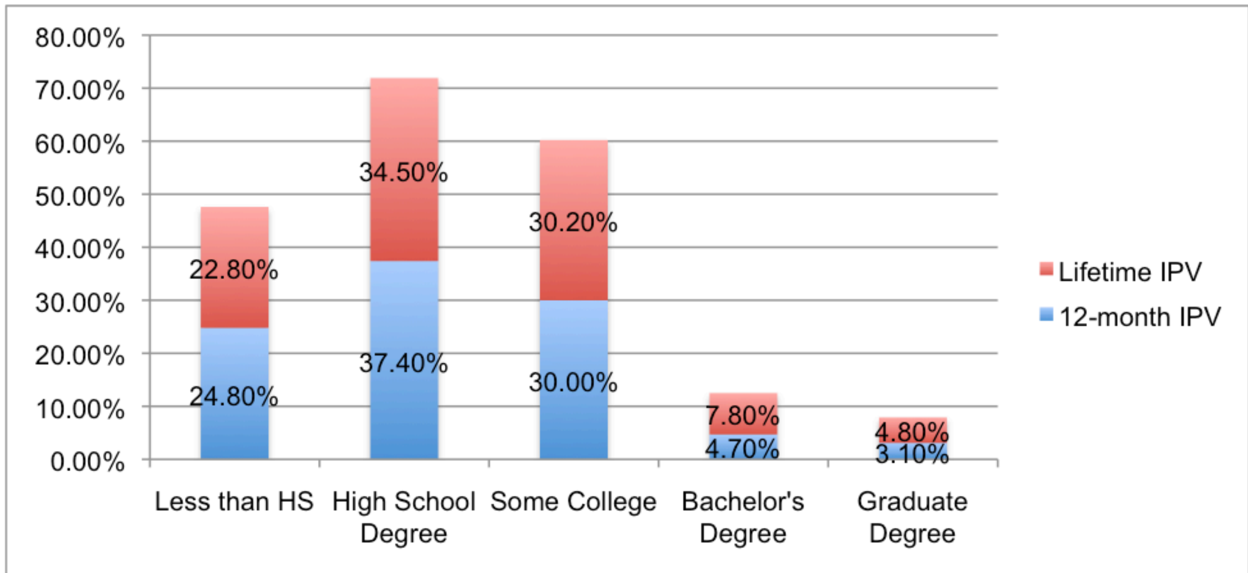
The effect of IPV on reproductive health is profound and far-reaching, from contraceptive sabotage, where the partner sabotages the woman's ability to use contraception through coercion, threats, damaging or throwing away the contraceptive, to forced pregnancy and/or forced abortion, to maternal homicide. Heise and Garcia Moreno reported that intimate partner violence could lead to delay of prenatal care,

stillbirth, premature labor and birth, fetal injury, and low birth weight. Furthermore, women in abusive relationships are at greater risk of repeat unintended pregnancy, sexually transmitted diseases including HIV and AIDS, and substance use during pregnancy.[61]

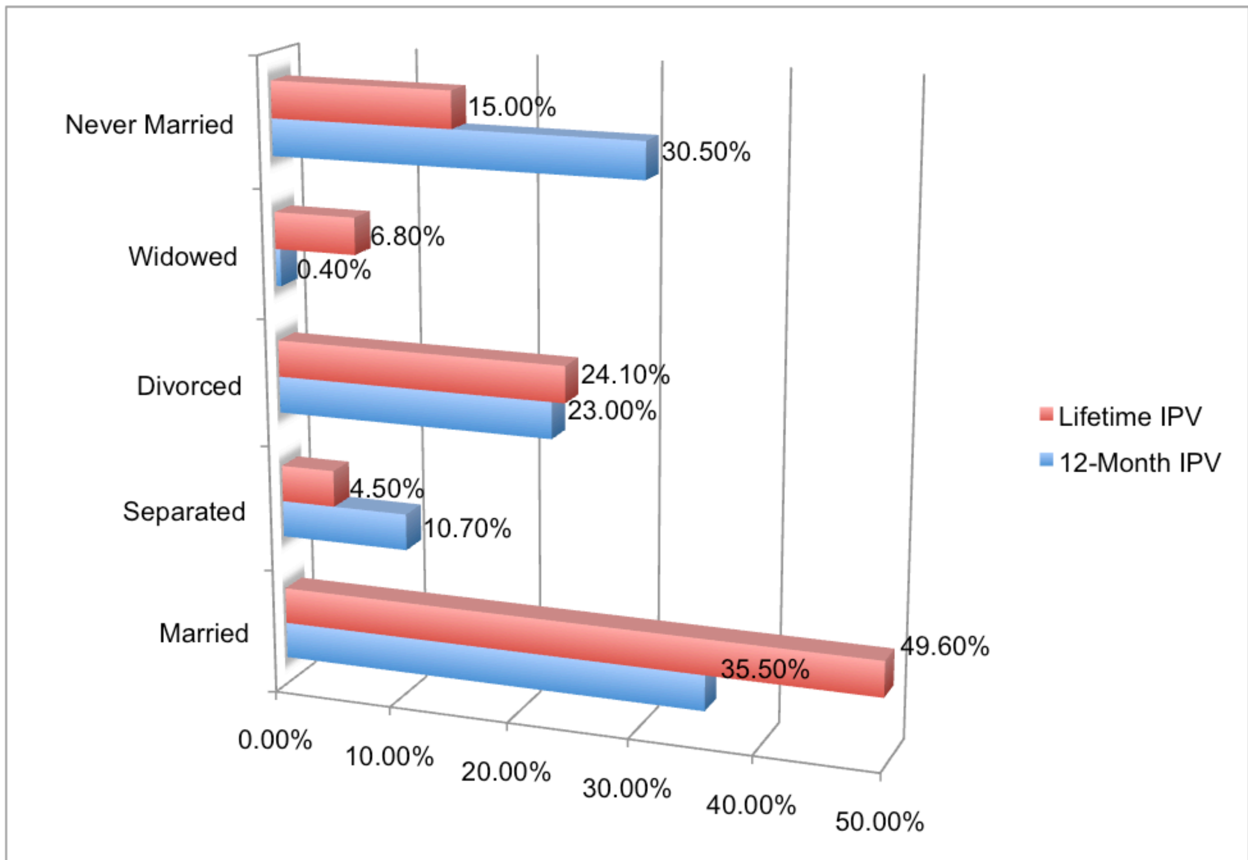
During July 1, 2008 and June 30, 2009, 2,413 women were admitted to domestic violence shelters in Kentucky. During the fiscal year 2003-2004, the highest proportion of women and children living in domestic violence shelters could be found in the Northern Kentucky region (11.6%).[62]

A study conducted among 4,059 women in Kentucky from 2002 to 2003, found that the majority of women (31.4%) who experienced abuse during a 12-month period were between 18 and 24 years old; 29.5% were between 25 and 34, and 23.1% were between 35 and 44 years old. Among the women who experienced lifetime abuse, 26.1% were between 35 and 44 years old; 22.9% were between 25 and 34; and 19.8% were between 45 and 54 years old. Of the 12-month IPV victims, 63.5% were employed and 33.7% were unemployed; while of the lifetime IPV victims, 60.2% were employed, 26.4% were unemployed and 13.3% were retired.[63]

As Figure 8 (below) demonstrates, the majority of the IPV victims had a high school degree, followed by those who went to college. The percentages declined drastically with the higher levels of educational attainment. This could be a product of lower reporting rates among higher-education (and possibly higher-income) individuals rather than an actual difference in incidence rates. Figure 9 (below) shows women who were IPV victims by their marital status. It demonstrates that a high percentage of victims were married. Among the women who were victims of IPV in the past 12-months a high number were never married.[64]



Source: Kentucky Injury Prevention Research Center, Intimate Partner Violence Surveillance Project
***Figure 8.* Female IPV victims in KY by educational attainment, 2002-2003.**



Source: Kentucky Injury Prevention Research Center, Intimate Partner Violence Surveillance Project
***Figure 9.* Female IPV victims in KY by marital status, 2002-2003.**

In regard to income, women who were 12-month IPV victims were fairly equally distributed along all income levels (Table 11). The majority of women who experienced lifetime IPV could be found along an income range of $25,000-$49,000 (Table 11).[65]

Table 11

Female IPV victims in Kentucky by Household Income, 2002-2003

	12-month IPV	Lifetime IPV
<$10,000	26.8%	17.0%
$10,000-$24,999	27.5%	26.2%
$25,000-$49,999	24.5%	31.5%
$50,000+	21.3%	25.2%

Source: Kentucky Injury Prevention Research Center, Intimate Partner Violence Surveillance Project

Pregnancy makes women particularly vulnerable to violence. Pregnancy is a time of particular and unique risks for abuse. Researchers have found maternal homicide (homicide within a year of the resolution of a pregnancy) to be the number one cause of death in the postpartum period.[66] Women experience forced pregnancy, forced pregnancy termination, delayed prenatal care, as well as physical and emotional abuse that adversely affect their health and the health of the pregnancy.

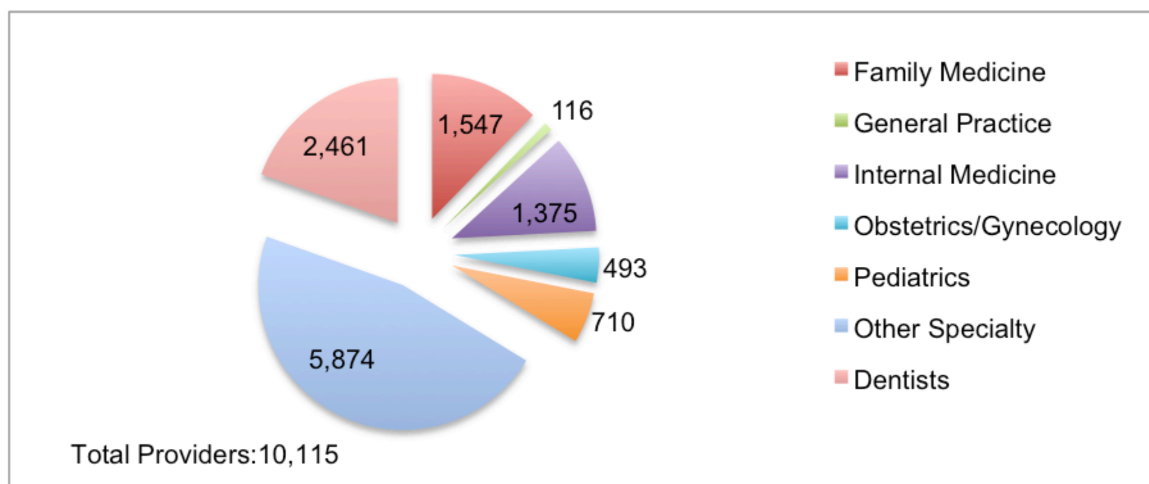
Another aspect of IPV and reproductive health is the lack of control that women experience in terms of family planning and contraception. Women and girls in abusive relationships report contraceptive sabotage, a partner preventing the effective use of contraception. Women are more exposed to sexually transmitted infections and unintended pregnancies when they are in an abusive relationship.[67]

Health Care Providers

Individuals with a regular source of care are more likely to have better access to health care services, to obtain preventive and necessary screenings and services, and to have medical support in case of chronic diseases. In addition, having a regular source of care also increases the chances of having support to successfully navigate the health care system. Whether individuals have a regular source of care relates to various factors, such as health insurance coverage and the physical availability of health care services where people live. In 2006, 15% of the female population in Kentucky did not

have a personal health care provider. Among those, 14.3% were white and 20.2% women of color, African American women accounted for 18.3% and Latinas for 25.1%.[68]

In November 2009, 10,115 physicians were practicing in Kentucky. Of those, 4,241 were primary care providers and 5,874 were other medical specialists. Figure 10 demonstrates the distribution of primary care providers, other specialists, and dentists in Kentucky.[69]



Source: Kentucky Health Facts
Figure 10. **Number of healthcare providers in Kentucky in 2006.**

Health Provider Shortage Areas (HPSA). The categories that define a HPSA are (a) primary care, (b) dental, (c) mental health, and (d) medically underserved area/population (MUA/P).[4] The scores for MUA/Ps range from 0, representing the highest need, to 100, representing the lowest need.[70] In 2009, of 120 counties in Kentucky, 26 showed a lack of health care providers in all three categories and were medically underserved areas or had medically underserved populations (yellow shaded in Table 12). Only two of 120 counties have an abortion provider. The majority of women in the state lack of access to comprehensive reproductive health services. Rural

[4] A medically underserved area could be "a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services" … "Medically underserved populations are groups of persons who face economic, cultural, or linguistic barriers to health care" (Health Resources and Service Administration, n.d.)

and low income women are disproportionately burdened due to transportation and other costs.

Table 12 (on page 46) demonstrates also all MUA/Ps and indicates the type of health care provider missing in a particular county (Primary Care = PC; Dental = D; Mental Health = MH). Not all of these areas reflect the same lack of health care providers. Some of them lack only one type of provider, some all three and others none. Elliot County (red shaded in Table 12), for example, is considered as the most medically underserved area in Kentucky, since residents face economic, cultural, or linguistic barriers to health care. Yet, Elliot County does not fall under the counties with the highest shortage of health care providers. James et al. reported that in 2004, 36% of women in Kentucky were living in HPSAs.[71]

Almost all counties represented in Table 12 lacked primary care providers, who are a primary resource for women to address health care needs and to navigate the health system. In addition to the above-mentioned counties, the following counties experience a lack of primary care providers but are not considered MUA/Ps: Allen County, Ballard County, Boone County, Carroll County, Clark County, Floyd County, Gallatin County, Hancock County, Henry County, Hopkins County, Laurel County, Nicholas County, Oldham County, Pendleton County, Russell County, Simpson County, and Whitley County.

Kentucky women also experience mental health provider shortages, with 60% of all women in the state living in an area shortage of mental health providers.[72]

Table 12

Health Provider Shortage Areas and Medically Underserved Areas/Populations in Kentucky in 2009

Counties	MUA	MUP	HPAS	Counties	MUA	MUP	HPAS
Adair	32.90		PC, MH	**Lewis**	60.00		PC, D, MH
Bath		58.90	PC, MH	**Lincoln**	39.50		PC, MH
Boyd	45.70		PC, D, MH	**Livingston**	60.60		PC, MH
Bracken		61.80	PC, MH	**Logan**	48.00		MH
Breathitt	51.20		PC, MH	**Lyon**	55.60		PC, MH
Breckenridge		57.20	PC, MH	**McCracken**	49.20		MH
Bullitt	55.50		PC, MH	**McCreary**	36.80		PC, D, MH
Butler	50.70		PC, MH	**McLean**	58.50		PC, MH
Caldwell	58.30		PC, MH	**Madison**	49.60		PC, D, MH
Campbell*	61.90 59.70		PC, D, MH	**Magoffin**	49.70		PC, MH
Carlisle	44.70		PC, MH	**Marion**	42.70		MH
Carter	60.60		PC, MH	**Marshall**		61.30	MH
Casey	55.40		PC, MH	**Martin**	49.30		PC, D, MH
Christian	60.30		MH	**Mason**	57.80		MH
Clay	32.50		PC, D, MH	**Meade**	60.90		PC, MH
Clinton	38.30		D, MH	**Menifee**	43.50		PC, D, MH
Crittenden	40.10		PC, MH	**Metcalfe**	42.20		PC, MH
Cumberland	61.60	41.60	PC, D, MH	**Monroe**	47.30		PC, MH
Edmonson	54.90		PC, D, MH	**Montgomery**	55.10		MH
Elliott	28.00		PC, MH	**Morgan**	50.60		PC, MH
Estill		51.70	PC, MH	**Muhlenberg**	61.90		PC, D, MH
Fayette	59.20		PC, D, MH	**Nelson**	54.40		MH
Garrard	60.50		PC, MH	**Ohio**	57.60		PC, MH
Graves	60.40		MH	**Owen**	57.70		PC, D, MH
Grayson		58.40	MH	**Owsley**	42.30		PC, MH
Green		49.40	PC	**Perry***	45.20	60.10	PC, D, MH
Greenup	59.00		MH	**Pike**	44.40		PC, MH
Hardin	53.30		MH	**Powell**	61.00		PC, MH
Harlan	50.40		PC, D, MH	**Pulaski**	58.00		D
Harrison	61.90		No HPAS	**Robertson**	39.10		PC, MH
Hart	57.60		PC, MH	**Rockcastle**	45.30		PC, MH
Henderson	55.30		No HPAS	**Scott**	55.80		MH
Hickman	32.60		PC, MH	**Spencer**	45.20		PC
Jackson	52.00		PC, D, MH	**Taylor**	55.90		No HPAS
Jefferson*	58.60 61.40 48.80 60.10		PC, D, MH	**Todd**	56.50		PC, D, MH
Kenton	52.20		MH	**Trigg**	54.40		PC, MH
Knott	56.00		PC, MH	**Trimble**	46.00		MH
Knox	53.30		PC, D, MH	**Union**	57.40		PC, MH
Larue		59.90	PC, D, MH	**Warren***	60.70 57.80 60.00		PC, D, MH
Lawrence	53.80		MH	**Washington**	51.30		PC, MH
Lee	37.00		PC, D, MH	**Wayne**	49.30		PC, D, MH
Leslie	30.30		PC, D, MH	**Webster**	48.60		MH
Letcher	48.20		PC, D, MH	**Wolfe**	47.70		PC, D, MH

Source: Kentucky Health Facts

* Campbell County: The first value refers to the Dayton Service Area and the second one to the Campbell Service Area.
* Jefferson County: The first three values represent the Jefferson Service Area and the fourth one the Central West Louisville service area.
* Perry County: The first value represents the low income Hazard Service Area and the second one Buckhorn Service Area
* Warren County: The first two values represent the Warren Service Area and the third one represents the Smiths Grove Service area.

Hospital Mergers. In late 2008, access to reproductive health services in Northern Kentucky was severely diminished due to the merger of two local hospitals: St. Elizabeth (a Catholic hospital) and St. Luke (religiously unaffiliated hospital). As a result of the merger, St. Luke Hospital discontinued a number of reproductive health services, such as vasectomies, in vitro fertilization, tubal ligations, and post-partum tubal ligations. While women who have access to insurance and transportation can travel to Cincinnati and Scott County to receive these services, low-income and rural women are largely without these vital health care services.[73]

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Policies and Programs

Health Insurance Coverage

Since an amendment of Title VII in 1978, the *Pregnancy Discrimination Act*, employers with 15 or more employees are prohibited from discriminating against women based on pregnancy, childbirth, or any other related medical condition when it comes to health insurance coverage. With the enactment of the *Health Insurance Portability and Accountability Act* (HIPAA) in 1996, employers are not allowed to charge "similar employees different premiums for health insurance based on age or health status."[74] In addition, health insurance cannot be denied based on health status. With the implementation of these policies, women having employer-based health insurance are protected during pregnancy, delivery and post care.

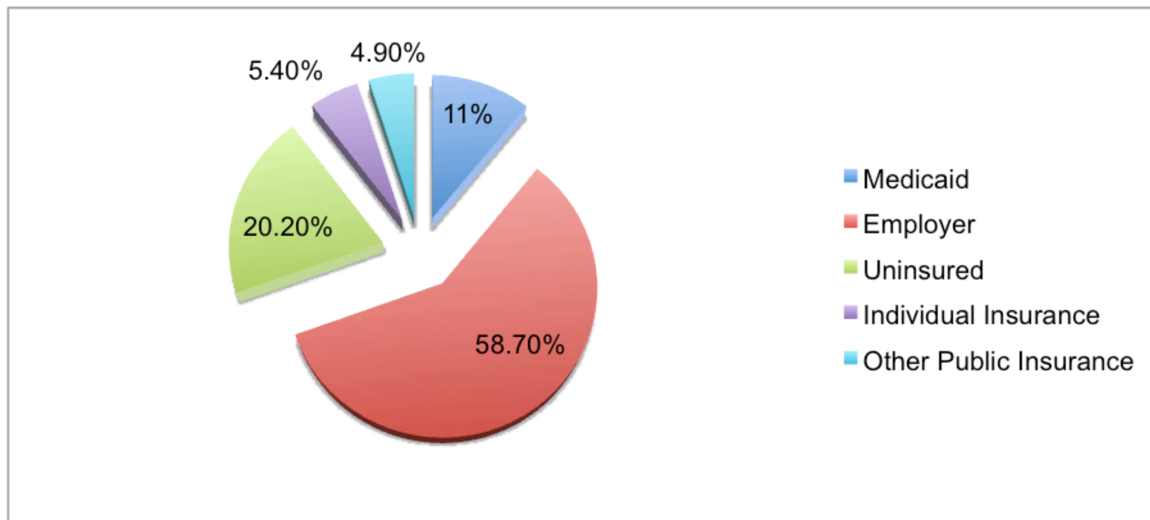
In 2008, most women (19-64 years) in Kentucky had health insurance provided by their employer (58.7%; Figure 11 on page 52). However, 20% of women were uninsured and 10.8% used Medicaid. Only 5.4% were individually insured and 4.9% had other types of public insurance.[75] The National Women's Law Center reported that in 2007, 16.6% White women (not Hispanic), over a quarter of African American women (not Hispanic), and nearly 50% of Latinas were uninsured in Kentucky (Figure 12, on page 49). Compared to other states, Kentucky ranked 30th In regard to women without health insurance in the year 2007 and was rated with an *F* (failed) by the National Women's Law Center.[76]

Table 13
Uninsured Population by County, State, and Nation (under 65 years; 2006)

County with lowest proportion: **Breathitt**	12%
County with highest proportion: **Calloway**	29%
Kentucky	18%
United States (2008)	17.4%

Source: Kentucky Health Facts, State Health Facts

Lack of insurance is associated with lower educational attainment and resulting lower income and jobs that do not provide health insurance coverage. In 2006, the Behavioral Risk Factor Surveillance Survey reported that the proportion of those who did not have health insurance in Kentucky was higher among those who had not finished high school (28.4%) compared to those who had a college degree (6.3%).[77]



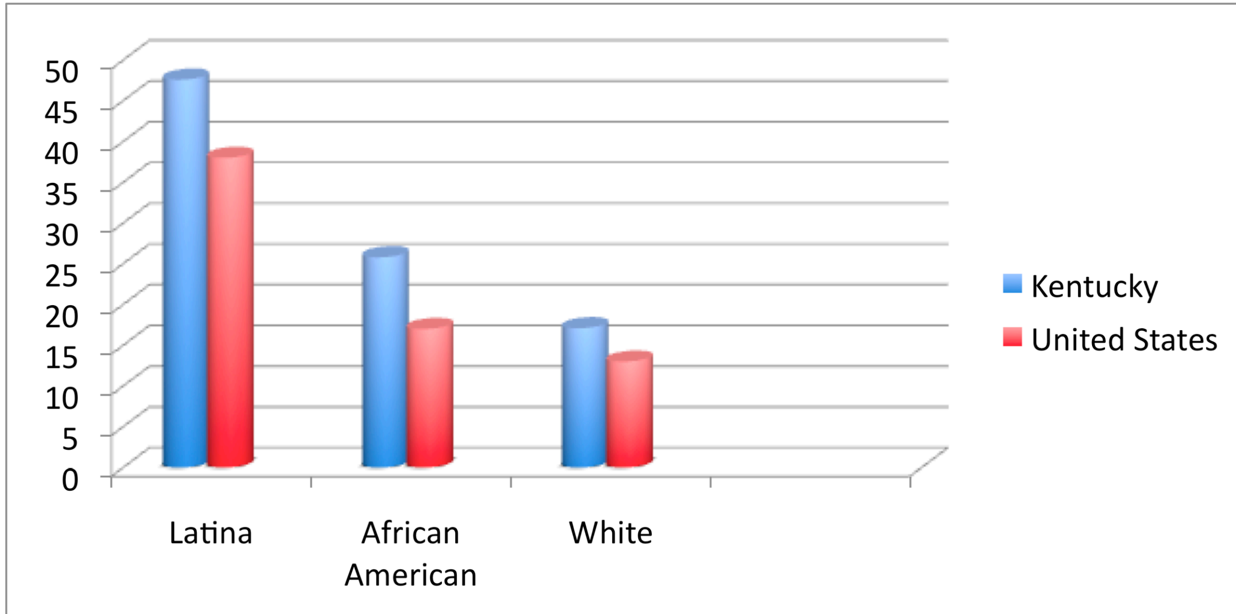
Source: Kaiser Family Foundation State Health Facts
Note: The percentages for Medicaid were rounded up in the chart.
***Figure 11.* Health insurance coverage for nonelderly adult female population (18-64 years) in Kentucky during the period 2007-2008.**

On the other hand, lack of health insurance coverage can also be related to the lack of regulation of the health insurance industry in most states. On the individual insurance market, no protection is provided for women unless there are specific state regulations. During the medical underwriting process, the time period in which the insurance company determines the premium to be paid, health insurance companies, if not restricted by law, can use health status and history, age, and gender as reasons for denying insurance coverage or for imposing higher premiums. For example, a woman who had a C-Section can experience higher premiums, exclusion of the coverage of another C-Section or overall rejection, unless she has been sterilized or is beyond childbearing age. Insurance companies can also use the history of prescription drug use, which is apparent more often for women than for men, to charge higher premiums or to refuse to insure. Age is also an important factor, meaning that younger women have more options when it comes to maternity benefits than older ones. Some states offer so-called riders that would provide coverage for maternity care. However, these often have long waiting periods, are very expensive and do not provide enough money for the care needed during pregnancy, labor and delivery, and post-delivery. Based on a study, conducted by Codispoti et al., Kentucky only offers one rider that costs $106.40 a month.[78]

Health Insurance and Gender

Another pervasive issue on the individual insurance market is *gender rating*. Gender rating means that insurers are free to charge women higher premiums than men—a method that limits women in obtaining individual health insurance plans. Gender rating is based on the argument that women, on average, have to go to the hospitals and doctors more often, and have higher health care costs. Thus, actuarially justified, women should have to pay more. Although the state provides some protection in regards to discrimination based on health status, Kentucky has not provided any protection to women in regards to this discriminative technique. Gender rating is often arbitrary, involving a wide range of premiums between women and men and between individual insurance plans within a single state.[79] Codispoti et al. compared similar sets of plans in all states and summarized them under Plan A and Plan B. In Kentucky, a 25-year-old woman pays 25%, a 40-year-old 38%, and a 55-year-old 4% more than men of the same ages. For Plan B, women of the two lower age groups would be charged 11%, 15% more (respectively) and women who are 55 years old 9% less than men of the same age. In the same study, Codispoti et al. reported that all plans under investigation were gender rated in Kentucky. Among these plans the percentage difference in premiums between 40-year-old women and men ranged from 15% to 48% higher charges for women.

Medicaid. Medicaid is a program, established by the federal government and administered by the states to provide medical benefits to low-income people who otherwise do not have health insurance or have insufficient health insurance. Based on federal guidelines, the eligibility criteria are appointed by the states.[80] Health care providers are willing to provide services to people under Medicaid coverage depending on the payments the providers obtain from the program. The Medicaid-to-Medicare fee index provides a measure for the “Medicaid fee-for-service physician fees relative to Medicare fees in the state.”[81] In Kentucky, overall Medicaid fees constituted 76% of the Medicare fees. Medicaid fees for primary care and obstetric care accounted for 63% and 111% of Medicare fees, respectively.



Source: National Women's Law Center (2009), National Institute for Reproductive Health (2006)
***Figure 12.* Percentage of uninsured females by race/ethnicity.**

In order to qualify for Medicaid, women have to meet certain criteria based on income and certain categories. The non-income categories differ from state to state and include pregnancy, age ranges, disability status, and immigration status. For example, for working parents in Kentucky, as of January 2008, the Medicaid Income Eligibility was 64% of the federal poverty level.[82]

As of January 2008, pregnant women with incomes up to 185% of the federal poverty level were eligible for Medicaid.[83] Medicaid also covers prenatal care, including doctors' visits and various supplements, such as vitamins, ultrasounds, and amniocentesis screenings, and the actual birth.[84] Family planning is mandated by federal Medicaid law and includes not only contraceptive services but also screening for cervical cancer and sexually transmitted diseases. Kentucky provides, on average, $359 per woman and thus is among the states with the highest funding for family planning.[85] Medicaid also covers women for treatment that were screened by a provider in the CDC (Center for Disease Control and Prevention) screening network or by a provider who receives CDC funds. Abortions are only covered in the cases of life endangerment of mother, rape, and incest, following the federal regulations. In all other cases, Medicaid does not cover

abortions.[86] States can also apply for a Family Planning waiver which allows states to cover counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals. However, as of November 2009, Kentucky has not secured a Family Planning waiver from the Centers for Medicare & Medicaid Services to cover services.[87]

Kentucky does provide for *Presumptive Eligibility* under Medicaid. This allows for Medicaid funds to be used for up to 90 days for women who fall under certain categories in order to improve prenatal care. In order to qualify for presumptive eligibility, a woman must (a) be pregnant, (b) a Kentucky resident, (c) meet certain income guidelines, (d) not currently have a pending Medicaid application, (e) not currently enrolled in Medicaid, (f) have not obtained previous presumptive eligibility for the current pregnancy, and (g) not an inmate of a public institution.[88]

On a positive note, a groundbreaking provision included in the recently enacted health care reform legislation gives states the option to expand Medicaid eligibility for family planning services without having to go through the cumbersome process of obtaining a federal waiver.

The measure is designed to give states the option of extending coverage for family planning services and supplies to individuals who are not pregnant and whose income does not exceed an eligibility level set by the state for pregnant women under either Medicaid or the Children's Health Insurance Program (CHIP). This provision is designed to enable state Medicaid programs to cover family planning services and supplies for any individual who would be eligible for Medicaid coverage of pregnancy-related care.

For purposes of this option, family planning services and supplies include medical diagnosis and treatment services provided pursuant to a family planning service in a

family planning setting (including, at state option, testing and treatment of sexually transmitted infections).

For states that already have a family planning waiver, the bill seeks to facilitate the conversion of that existing waiver into state plan amendments by allowing states to do so without modifying their existing eligibility policies. Specifically, the bill gives a state the ability to continue to use the eligibility standards and processes, including application procedures and practices, operational under a family planning waiver on or before January 1, 2007.

The bill specifically allows states to utilize presumptive eligibility in their programs[89].

Immigrants and Refugees. With the enactment of the Personal Responsibility and Work Opportunity Act (PRWORA) in 1996 federally guided programs, such as the Aid to Families with Dependent Children and the Job Opportunity and Basic Skills Program, were replaced with block grants under the program Temporary Assistance for Needy Families (TANF).[90] The implementation of PRWORA and TANF had devastating effects especially on immigrant populations. Before the enactment of PRWORA, many legal immigrants and some undocumented immigrants were eligible for federal public benefits. PRWORA drastically reduced the eligibility of many legal immigrants by creating a new category of "qualified alien" and barring most qualified aliens from receiving any non-emergency, means-tested, federally funded public benefits for a period of five years.[91] These barred benefits include Medicaid, food stamps, supplementary social security income (SSI) and TANF.[92] Later amendments restored food stamps for qualified aliens under 18, but otherwise the five year ban remains in place for most benefits. States can use their own funds to cover the five years, but Kentucky has not done so.[93]

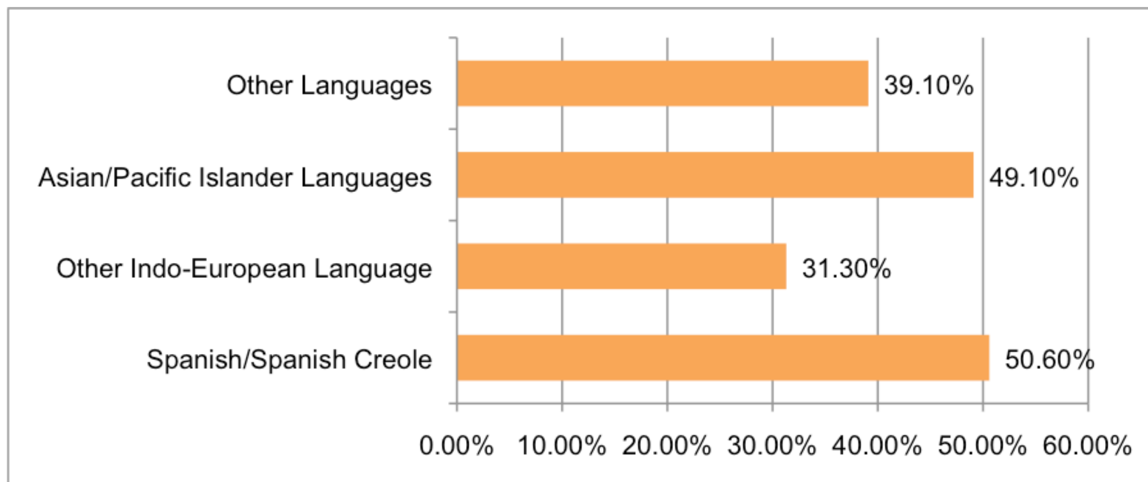
There are few programs still available for immigrants, independent from their status, such as Emergency Medicaid, and Women and Infants Care (WIC). Pregnant

immigrant women with documented or undocumented status fall under the above explained presumptive eligibility category.[94]

With the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states could implement coverage for documented immigrants who are pregnant women and children. Others still remain uncovered during these five years. Under current health reform proposals, undocumented immigrants would continue to be barred from receiving federal subsidies in order to purchase exchange coverage and would not be able to enroll in Medicaid. The Senate Bill also prohibits undocumented immigrants from purchasing the exchange with their own funds. Documented immigrants would be eligible for such federal subsidies by verifying their legal status. They would continue to be barred from Medicaid during their first five years, although states can allow access for children and pregnant women. However, these five years could be covered by the subsidized exchange.[95] Kentucky, as of January 2010, had not approved expansion of KCHIP (the Kentucky Children's Health Insurance Program) to immigrant children or pregnant women within the five-year waiting period.

Besides the lack of health insurance coverage, immigrants also face linguistic and cultural barriers. In 2000, then President Clinton signed the Executive Order 13166 of Title VI to ensure language access to all federally funded agencies for individuals with limited English proficiency. Language access requires that agencies provide meaningful access by assessing clients' language needs and offering interpretation services, effective telephone services, translation of vital documents, and staff trained on policies and procedures.[96] By the end of 2008, 4.2% of the population 5 years and older in Kentucky spoke a language other than English at home. Of those, 44.3% spoke English less than very well. The 2006-2008 American Community Survey (3-year estimate) investigated four different language groups: (a) Spanish/Spanish Creole, (b) other Indo-European languages, (c) Asian and Pacific Island languages, and (d) other languages.[97] Figure 12 represents the proportions of those who spoke English less than very well of each grouping, showing higher percentages for the Spanish speaking and Asian/Pacific Islander population. The ACS also examined linguistic isolation in

Kentucky and reported that among households speaking Spanish 20.8% felt linguistically isolated. Among the households speaking Asian/Pacific Island languages 27.8% felt linguistically isolated, and among the households speaking other languages 29.2% felt linguistically isolated.



Source: 2006-2008 American Community Survey, 3-year estimate

Figure 13. **Population 5 years and older, speaking a language other than English at home by speaking English less than *very well*.**

Kentucky has implemented policies that support specific programs related to language access that focus on HIV and AIDS prevention and treatment, Medicaid applications, Early Intervention Services, and Medicaid managed care organizations.[98] However, Kentucky still faces a lot of challenges when it comes to language access. In general, there is no organized network that represents a unified voice and is responsible to ensure language access. Service providers face many challenges when it comes to dealing effectively with foreign languages and cultures. Intake situations are problematic due to high staff turnover. This requires a constant and ongoing provision of language access training. However, standardized training and guidelines on how to effectively use interpreters, information about Title VI, and cultural competency are still lacking.[99]

Another challenge is “languages of lesser diffusion” that are spoken by refugees. Such languages include Burmese, Karan, and Karenni, spoken by people from Burma, or Mai Mai and Zigua, spoken by Somali Bantu. Interpreters for such languages are hard to

find and if an interpreter is offered they often speak the wrong language. Providers often assume that people coming from Burma speak Burmese when in fact they only speak Karenni, Karen, or Chin. Even the interpreter phones do not cover these languages. The Kentucky Cabinet for Health and Family Services started an agency, called the *Language Access Section* that oversees language access. It employs several Spanish interpreters/translators as staff and coordinates access to other languages through a phone service.

Regarding health care, interpreters are often not provided or the interpreter phone is utilized in very sensitive situations prone to miscommunication such as the delivery of a baby. Doctors often do not have the resources to actually provide language access due to the high costs of interpreters and interpreter phones. There is a lack of standardized training for interpreters.[100]

Local health departments, which provide reproductive health services through the Title X Family Planning Program throughout the state, have the responsibility to provide language access to their clients in abiding by the federal Title VI legislation. Each local health department can meet this requirement differently, from using a language line, to using interpreters, or bi-lingual staff. Currently, we do not know precisely what each local health department is doing in terms of language access. The state Office of Health Equity is looking into this issue in 2010.[101]

With regard to language access at other reproductive health facilities, Planned Parenthood of Kentucky reported that they provide interpreters and bilingual literature (Spanish and English). They also train staff on how to most effectively work with individuals who are not native English speakers.[102] Private clinics and providers of reproductive health services ask patients to bring their own interpreters, although some will provide some written information in Spanish.

Breastfeeding

Kentucky's breastfeeding legislation includes:

1. Ky. Rev. Stat. § 29A.100 (2007) directs judges at all levels of the court to excuse women who are breastfeeding or expressing breast milk from jury service until the child is no longer nursing. (SB 111)
2. Ky. Rev. Stat. § 211-755 (2006) permits a mother to breastfeed her baby or express breast milk in any public or private location. Requires that breastfeeding may not be considered an act of public indecency, indecent exposure, sexual conduct, lewd touching or obscenity. Prohibits a municipality from enacting an ordinance that prohibits or restricts breastfeeding in a public or private place. (SB 106)[103]

Legislation has been enacted in a patchwork manner in a number of states addressing various aspects of breastfeeding. Many states have enacted legislation that protects the rights of nursing mothers to nurse in public areas where they would otherwise be allowed to be or protect nursing mothers from being held to indecent exposure violations. A few states provide protection from discrimination at work due to the woman's need to breastfeed or pump breast milk during work hours. Florida was the first state to implement breastfeeding legislation in 1993. Currently, 44 states have some form of breastfeeding legislation.

The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) Baby Friendly Hospital Initiative was implemented in 1992 and hospitals can receive this designation by following the WHO's 10 Steps to Successful Breastfeeding guidelines. There are thousands of hospitals around the world that have achieved this designation with approximately 32 hospitals in the United States having attained the designation. One of these U.S. hospitals is in northern Kentucky—St. Elizabeth's Hospital.[104,105] This puts Kentucky ahead of the curve in terms of hospital support for breastfeeding. Hospitals that receive this designation have shown an increase in exclusive breastfeeding rates at time of discharge. For example, in a hospital in Boston, Massachusetts, the rate went up from 5 to 33 percent.[106]

Contraceptive Access

According to the Guttmacher Institute, almost half a million women in Kentucky are in need of contraceptives. About half of these women are low-income or adolescents and therefore would be eligible for publicly funded family planning services.[107] These women can seek services at one of the 191 publicly funded family planning clinics

throughout the state, with at least one clinic in each county. Title X (the federal program that provides for family planning services and supplies) services helped prevent 26,500 unintended pregnancies in Kentucky through provision of low-cost and free contraceptive services and supplies. Despite the widespread availability of family planning clinics, only about half of all women in need of "publicly supported contraceptive services" actually receive care from these clinics.[108] Cost-effectiveness studies have shown that for every public dollar spent on contraceptive services, three dollars are saved on prenatal and newborn costs in Medicaid.[109] The Guttmacher Institute has rated Kentucky as 34th in terms of family planning laws and policies. In Kentucky, only individual or small employer insurance plans are mandated to provide contraceptive coverage.[110] Other insurance plans may opt not to cover contraceptive services and supplies.

Abortion Access

With the establishment of the Hyde Amendment in 1976, the provision of federal funds for abortion is prohibited. Exempted from this are cases of pregnancy due to rape or incest, and if the pregnancy puts the life of the mother in danger. Kentucky is among the 32 states that follow these regulations, although states could provide abortion services under their own funding to Medicaid recipients in medically necessary cases. As of 2008, Kentucky restricts abortion coverage under private insurance plans and insurance plans for public employees under any circumstance.[111]

Kentucky has one abortion clinic in Louisville and one in Lexington (EMW Women's Surgical Centers). The state law in Kentucky requires women to wait for 24-hours after mandatory counseling until they can have an abortion. This is a regulation that puts low-income women who do not live in or near Louisville or Lexington at a particular disadvantage since they have to travel long distances, find childcare, take time off from work, and might not be able to afford a place to stay overnight.[112] James et al. reported that in 2008, 77% of women in Kentucky lived in counties with no abortion provider.[113] Kentucky state law also requires minors to obtain parental consent for abortions or obtain a judicial bypass. As of November 1, 2009, Kentucky also implemented a ban on

Partial Birth Abortion throughout pregnancy. This ban does not include a health exception. The state's *Later-Term Abortion Policies* prohibit some abortions after a certain point in pregnancy. The threshold for Later-Term Abortions is viability, and these are solely permitted when the mother's life and health is threatened by the pregnancy.[114] In March 2009, the State Senate approved that an ultrasound would be required prior to an abortion. The provider would have to explain the results of the ultrasound to the woman and would need to review the image with her. The woman would not have to look at the monitor during the review and would not experience any penalty for not looking at the image. However, these measures were not passed into law in 2009, but are being considered again in 2010 as this report goes to print.[115] According to a 2009 Kaiser Family Foundation report, Kentucky is one of 16 states considered as "most restrictive" in terms of abortion access policies. The authors of the report calculated a total abortion access score, where 0 is least restrictive and 1.00 is most restrictive. Kentucky was given as score of .92, whereas, Mississippi, the state with the most restrictive policies received a score of .97.[116]

Emergency Contraception Legislation

Since 2002, legislation has been proposed on the distribution of emergency contraception; however, it has never been passed. As of November 1, 2009, emergency rooms in Kentucky are not required to provide information about emergency contraception or to dispense emergency contraception upon request to the victims of sexual assault.[117] Pharmacies can sell emergency contraception without prescriptions to people 17 and older according to federal law. People 17 and younger can obtain emergency contraception only with a prescription from an advanced practical nurse, physician's assistant or physician. In Kentucky, pharmacies are not required to carry emergency contraception. If they do carry emergency contraception, it is legal for the pharmacist to refuse to dispense it. Pharmacies are not required to have someone available to dispense it. In other states, the law requires that if one person refuses to provide it, there must be someone available to dispense it.[118] Such conscience clauses are common, only not in Kentucky.

In 2006, the *American Civil Liberties Union of Kentucky* (ACLU) surveyed pharmacies in Kentucky about their willingness to provide Plan B emergency contraceptives. Although 57% stated that they would be willing to provide emergency contraception, they still faced the issue of ordering the medication and of receiving it in a timely manner. Only 13% of the surveyed pharmacies had Plan B in stock. In addition, 30% of the providers were in Louisville and thus not easily accessible for many women in Kentucky. Emergency contraception has not been considered as a mandatory recommendation for rape victims.[119] Table 14 (below) demonstrates a summary of the women's health services that can be refused by providers.

Many states have implemented policies that allow health care providers to refuse the provision of (or participation in) abortion, contraception, or sterilization. If the state does not explicitly provide refusal statutes, the health care professional who refuses services may still fall under the protection of policies that prohibit discrimination based on religious values. These policies can be either restricted to religious or private institutions or can include all institutions. In Kentucky, as of February 2010, all individual providers and institutions can refuse to provide abortions. In addition, all individual providers can refuse sterilization.[120]

Table 14

Refusal Policies for Health Services in Kentucky (as of November 1, 2009)

State allows individual providers to refuse services	**Yes**
Abortion	Yes
Contraception	No
Sterilization	Yes
State allows institutions to refuse services	**Yes**
Abortion	Yes
Contraception	No
Sterilization	No

Source: Kaiser Family Foundation, State Health Facts

Sex Education Legislation

Since 1981, the federal government has increased its support and promotion of abstinence-only-until-marriage programs, although the success of these programs is not evidence-based. Rigorous evaluations have demonstrated that such programs are not effective when it comes to changing teenagers' sexual behaviors. The federal

government implemented the *Adolescent Family Life Act* in 1981, followed by the *Title V Abstinence-Only-Until-Marriage Program* in 1996, and the *Community-Based Abstinence Education* in 2001—policies that channel funding into abstinence-only programs. Organizations that receive funds from these programs must comply with the definition of abstinence education by the federal government that includes the following points:[121]

For purposes of this section, the term "abstinence education" means an educational or motivational program which—

1. has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
2. teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
3. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
4. teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
5. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
6. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
7. teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
8. teaches the importance of attaining self-sufficiency before engaging in sexual activity.[5]

Despite evidence of ineffectiveness of these programs, Kentucky has been providing millions in tax-payers' money to organizations that provide abstinence-only education. Usually these organizations are Crisis Pregnancy Centers (CPC), overtly anti-choice agencies, and local health departments. In Kentucky, the CPCs are the only non-profit organizations that receive funds from the Title V abstinence-only programs. CPCs provide services that are based on a Christian, not medical, model and, ultimately, limit women's choices in reproductive health and services.[122]

Teen Pregnancy Prevention

Kentucky has the 25th highest teenage pregnancy rate of any state. Of the 10,610 teenage pregnancies each year in Kentucky, 73% result in live births and 11% result in abortions.[123]

In December 2009, the Consolidated Appropriations Act for the FY 2010 was passed by Congress. This Legislation includes $110 million in funding for a new Teen Pregnancy

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[5] For further information see also: http://www.ssa.gov/OP_Home/ssact/title05/0510.htm

Prevention Initiative. Public and private entities can apply for competitive grants by proposing evidence-based programs that reduce teen pregnancy. The $100 million provided for these grants are going to be split up into $75 million for programs that have been rigorously evaluated and have proven success and $25 million for innovative programs that have not yet been evaluated. The remaining $10 million will be provided for technical assistance, training, evaluation, outreach, and other program support. This initiative is considered to replace the Community Based Abstinence Education program.[124]

Public schools in Kentucky are mandated to provide sex and STI and HIV education. In both cases, the content needs to *cover* abstinence. However, teachers are not required to cover contraception.[125] The Kentucky Cabinet for Health and Family Services provides the following programs for the prevention of teen pregnancy (Table 15):

Table 15

Teen Pregnancy Prevention Initiatives in Kentucky

Community Work-Groups and Coalitions	Workgroups convened by local health departments, including social services, schools, youth service centers, clergy, elected offices, medical community, parents, teens to discuss strategies to reduce teen pregnancy
Direct Community Grants for Abstinence Education	Communities apply through local health department for projects that meet the abstinence education legislation priorities as stated in federal 1996 Welfare Law; purpose is to create strong partnerships among public and private community agencies, parents, schools, and the faith community to teach school-age children the value of sexual abstinence
Postponing Sexual Involvement (PSI)	School-based curriculum designed for junior high/middle school students; 5 sessions are taught by peer educators and trained high school students; PSI is abstinence-based and does not include any information about contraceptives
Reducing the Risk	School-based program (16 one-hour sessions) focusing on avoiding unprotected intercourse either through abstinence as the 100% safe method or with proper contraceptive use

Source: Kentucky Cabinet for Health and Family Services[126]

HIV and AIDS Programs, Legislation, and Regulations

There are a variety of services and programs in Kentucky in order to prevent, educate about, test for, and treat HIV and AIDS. The State provides funding for several prevention services through *The Department for Public Health Targeted HIV Prevention Program* that was established in 1992. The department collaborates with five local health departments, including Lexington/Fayette County, Louisville Metro, Barren River,

Northern Kentucky, and Purchase Region, in order to identify needs and individuals who do not obtain preventive services through programs funded by the Center for Disease Control and Prevention. The local health departments provide information and materials about HIV and AIDS. The program *HIV and AIDS Professional Education* involves the review, including approval or rejection, of all courses for individuals, health care providers, health education providers etc. that are proposed In regard to HIV and AIDS education, if they are eligible and appropriate for professional continuing education units. By state law, such courses need to contain information on epidemiology, transmission, medical treatment, legal, and appropriate attitudes and behaviors.[127]

The *Kentucky HIV Care Coordinator Program* takes on the coordination of services for people living with HIV/ and AIDS. The care coordinators inform about and assist with transmission prevention (safer sex and condom distribution). These services and their coordination are also done by a program called Comprehensive Risk Counseling Services. CRCS is a short-term (3-6 month) intervention which looks at the reasons behind heightened level of transmission risk for those infected and not infected with HIV and tries to help the client to address the primary issue(s) causing increased risk whether it is sexual practices, drug use, homelessness, unemployment or some other issue.[128] The *Care Coordinator Program* also assists in the provision of quality care and services to individuals with HIV and their families. The program receives federal funds; however, financial aid is not guaranteed.[129]

Local health departments offer on-site counseling, testing, condom distribution, and education for health care providers. The health departments also notify partners, but only if the client living with HIV requests this service and provides her/his consent. In addition, many health departments provide outreach services and one-to-one counseling through health educators. Health departments also offer the *Maternal Child Health* program, which includes a variety of services and programs, such as *Reducing*

the Risk, condom distribution, literature, and the *Prenatal 076 Protocol*.[6,130] It is important to note, that Kentucky is an *opt-out* state. Anyone who does not want an HIV test during pregnancy is not required to have one. Some women decline because they think there is additional cost; others decline because they do not see themselves as being at risk. This test is performed during the first trimester and may or may not be repeated during pregnancy at the discretion of the doctor. It is also important to note that any person aged 13 or older can have an HIV test in the Commonwealth of KY without parental consent.[131]

The Kentucky Cabinet for Health and Family Services lists three financial assistance programs: Kentucky AIDS Drug Assistances Program (KADAP), Kentucky Health Insurance Continuation Program (KHICP), and Kentucky Outpatient Health Care and Support Service Program. There are several conditions for eligibility: Those who apply for financial assistance must report a household income of no more than 300% of the federal poverty level, have case assets less than $10,000, be a Kentucky resident, provide medical documentation of their HIV positive status, and be ineligible for any third-party payers' financial assistance. KADAP provides financial assistance to low-income Kentuckians to purchase AIDS-related, FDA-approved medication. KHICP financially assists eligible individuals who are at risk to lose their employee health benefits or private insurance due to HIV-related illnesses. Eligibility is based on following criteria: (a) the individual must have health insurance for at least 6 months prior to her/his application; (b) the individual's health insurance policy must include a Medicare Part D or a prescription rider and the individual policies cover HIV positive status; and (c) if the participant is not able to pay the costs, Title II funds can be used to cover the premiums through an insurance continuation program. The outpatient programs provide support services (medical and non-medical) on a community basis.[132]

[6] The AIDS Clinical Trials Group Protocol 076 involves the daily intake of zidovudine (ZDV) of the pregnant woman, starting 14-34 weeks of gestation and continuing throughout pregnancy. A high dose is given during labor until delivery. The newborn is administered orally ZDV syrup during the first 6 weeks of life
Mofenson & Balsley, (1994). *Recommendations of the U.S. Public Health Service Task Force on the use of zidovudine to reduce perinatal transmission of Human Immunodeficiency Virus.* Retrieved December 12, 2009 from http://www.cdc.gov/mmwr/PDF/rr/rr4311.pdf

The *Kentucky Department of Education* expanded with the enactment of the *Kentucky Education Reform Act of 1990*, local curricula and their mandated content, including communicable diseases, communication strategies, peer pressure, decision-making, and abstinence. The state education and health departments, in collaboration with other prevention providers, sponsor prevention programs in and out of schools. The *Kentucky Department of Mental Health/Mental Retardation (Division of Substance Abuse)* educates at Kentucky schools about drug prevention and funds treatment facilities.

There are also programs that provide services to correction and detention centers in Kentucky: (a) the *Jefferson County Corrections* provide individual and group drug rehabilitation counseling, free literature, and free and confidential counseling services; (b) *Lexington-Fayette County Detention Center* offers its inmates weekly onsite HIV counseling and testing; (c) *Life Line Recovery* is a program that involves drug/alcohol rehabilitation for male inmates in Louisville, and currently provides free literature, group counseling, safer drug use education, AIDS 101, and safer sex instructions; (d) the *Federal Medical Center* in Lexington offers medical treatment and educational programs to staff and inmates (for more resources please see Appendix).[133] Despite being mentioned on the website of the Kentucky Cabinet of Health and Family Services not all of the programs mentioned for inmates still exist, accept large numbers of participants or are being duplicated across the state.

LGBT Legislation

Currently there are three bills under discussion in Kentucky that affect the LGBT community. The *Statewide Fairness Bill* (House Bill 117) "would prohibit discrimination on the basis of sexual orientation and gender identity throughout Kentucky in employment, housing, public accommodations, insurance coverage, and credit. The House bill also includes sexual orientation and gender identity provisions in the powers of state and local human rights commissions."[134,135]

Currently, residents of Metro Louisville, Lexington/Fayette County, and Covington are the only ones who are protected by city ordinances against discrimination.

The *Hospital Visitation Bill* (House Bill 118) would guarantee that any adult hospital patient could designate any other person to be considered and treated as family for purposes of visitation. Such a bill would ensure that same-sex couples would feel secure and respected in health care settings and could concentrate on their recovery without having to fear discrimination.[136]

With the *Dual Parent Adoption Bill* (House Bill 195), a non-relative adult, with the written consent of the legal parent, would be able to petition for adoption. The *Marriage Amendment Repeal* (House Bill 17) is a proposal for a constitutional amendment that would repeal the concept of marriage that defines it as between one man and one woman.[137]

The concept of *Divisive Child Welfare Shift* suggests that children are better off without a family rather than being raised by same-sex couples. In fact research has shown that sexual orientation has no relationship to parenting capabilities. If this bill passes, many children in the Kentucky foster care system would be displaced, solely because they are being raised by gay foster parents. The Kentucky Fairness Alliance reports that currently 1% of adopted children and 3% of fostered children are under the care of gay parents.[138]

Domestic Violence, Sexual Assault, and Child Abuse

The *Division of Violence Prevention Resources* (DVPR) works to increase public awareness regarding the effects of domestic violence, sexual assaults, and child abuse. It also aims at increasing efficiency and accountability of service providers on a state and local level. The DVPR is statutorily mandated to coordinate statewide victims' services. Among its tasks are (a) to oversee fund appropriations and contract for the Coalition of Rape Crisis Centers, Designated Child Sexual Abuse Coordinators, and the 15 regional Children's Advocacy Centers; (b) to partner with the state Department of

Corrections to assist with sexual assault offender treatment; or (c) to provide training to state agencies and community partners regarding domestic violence, child abuse, and sexual assault.[139]

In 2000, the General Assembly created the *Council on Domestic Violence and Sexual Assault* by statute. The council, which is currently inactive, consisted of 39 members, including government officials and gubernatorial appointees, such as legislators, judges, clerks, prosecutors, law enforcement, social workers, health and mental health professionals, etc. The council's tasks were "to plan and direct legal, protection and support services related to domestic violence and sexual assault and to increase public awareness of the prevalence and impact of these crimes."[140]

Specifically related to domestic violence, Kentucky currently provides 15 domestic violence shelters serving victims throughout the state. In addition, the Kentucky Domestic Violence Association advocates for women and children, coordinates services, and provides resources, technical assistance, and information services.[141] The Cabinet also provides the *Batterer Intervention Certification* that was established in 1996 by statute and administrative regulation. This program is aimed at mental health professionals who provide court-ordered interventions for batterers.[142] Kentucky has 13 rape crisis centers that are represented by the Kentucky Association of Sexual Assault Programs. The association also provides staff and other support to the centers and offers direct help to victims of rape and sexual assault.[143] In order to address and prevent child abuse, Kentucky established *Children's Advocacy Centers* in all 15 Area Development Districts. These centers investigate and prosecute child abuse cases and at the same time promote the well being of children.[144] Kentucky's laws regarding domestic violence protective orders currently do not apply to dating partners, despite efforts to pass the legislation in 2009 and 2010.

Immigrants. Kentucky is a new settlement state for many immigrants. Although Kentucky does not have a high number of immigrants, the percentage of immigrants has grown significantly over the past decade or two. The national atmosphere in terms

of immigration and immigrants has been a negative one in the recent past. This has, at times, resulted in anti-immigrant policies on the state and local level. Despite efforts to get local ordinances passed, Kentucky has not passed many ordinances that either directly cut off access to services or inadvertently create a climate of fear where victims stop seeking services. For example, Kentucky does not formally have a cooperative agreement between local police and Immigration and Customs Enforcement (ICE). However, unwritten practices and negative cultural attitudes exist in the state. These create a harmful environment for immigrant women, in general, and survivors of rape and domestic violence, specifically.[145]

Human Trafficking

Human trafficking has increasingly become a concern in Kentucky. In 2007, the University of Kentucky conducted a study that reported 67 cases in Kentucky that included sex trafficking and forced labor. Catholic Charities has reported 17 cases throughout the state between June 2008 and January 2009.[146] Human trafficking includes "the exploitation of an individual for labor or commercial sex, through the use of force, fraud or coercion."[147] Indicators of human trafficking include "being monitored and accompanied, having limited freedom and movement, physical abuse, health problems, fear of speaking to outsiders, and lack of possession of identity documents."[148]

Federal law in the United States has criminalized the treatment of individuals as property. However, the thirteenth amendment was found to be insufficient to address all forms of slavery. This resulted in the implementation of the statutes of involuntary servitude by Congress. The interpretation of these statutes, however, failed to address more subtle types of psychological coercion involved in human trafficking. In 2000, *The Victims of Trafficking and Violence Protection Act of 2000*, was enacted. This act included a more comprehensive "definition of the control that traffickers use to ensnare and imprison their victims."[149] With the passing of *The William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008* protection was expanded to, among others, U.S. citizen victims, domestic workers, and immigrant children. In 2007,

Kentucky addressed human trafficking by passing human trafficking state legislation that would make human trafficking a Class C felony or in cases of serious injury a Class B felony.[150]

Mental Health and Substance Abuse

The *Department of Reproductive Health and Research* of the *World Health Organization* describes intersections between mental and reproductive health on various levels:

> psychological issues related to pregnancy, childbirth and the postpartum period, and the mental health effects of violence, including sexual violence, adverse maternal outcomes, such as stillbirths and miscarriage, surgery or removal of reproductive organs, sterilization, premarital pregnancies in adolescents, HIV-infection and AIDS, menopause, and infertility.[151]

However, the idea of looking at mental and reproductive health as interconnected problems in society is still neglected due to, among other issues, a consistent idea of mind-body dualism, the focus on a small number of health conditions, such as postnatal depressions, and lack of data.[152]

Access to primary care and special mental health settings is crucial for women in order to prevent, recognize, and treat mental illness and to reduce fear and stigma.[153] However, as presented previously, many of Kentucky's counties are lacking in mental health services and primary care providers.

Women with substance abuse problems face different challenges than men, and often have different treatment needs. Women who are in substance abuse treatment show a higher prevalence of childhood sexual abuse, childhood and adult domestic violence, medical problems, unemployment, homelessness, mental health problems, primary caretaking responsibilities for children or other family members, and feelings of shame and guilt. Substance abuse during pregnancy not only exposes the mother to health risks but can also have severely negative health consequences for the child, such as mental, physical, and psychological impairments and problems. In 1997, about 10% of women taking a pregnancy test at a local health department in Kentucky were in need of substance abuse treatment. The age group below 18 needed treatment and

guidance the most. Thirty-one percent of girls between 11 and 17 years reported illicit drug use in the past month.[7,154]

In 1992 Kentucky became a leader in the nation when it enacted the Maternal Health Act of 1992 ("MHA"). This legislation created a comprehensive public health approach to issues concerning pregnant women and drug use. The legislature explicitly articulated its intent "to treat the problem of alcohol and drug use during pregnancy *solely* as a public health problem." The legislature stated in the statute's preamble that "*punitive actions taken against pregnant alcohol or substance abusers would create additional problems, including discouraging these individuals from seeking the essential prenatal care and substance abuse treatment necessary to deliver a healthy newborn.*"[155]

In the intervening years, the Commonwealth has, consistent with this approach, sought to meet some of the need for services by making substance abuse prevention and treatment services available for Medicaid eligible pregnant women. For example, the General Assembly funded two substance abuse treatment programs designed to address the health needs of pregnant women and allow them to remain eligible for state Medicaid.[156] In 1998, the Commonwealth reauthorized the Substance Abuse and Pregnancy Work Group for an additional four years (renamed the Substance Abuse, Pregnancy and Women of Childbearing Age Work Group, hereinafter "KWP").[157]

Furthermore, in 2000, Kentucky launched the KIDS NOW Substance Abuse and Pregnancy Initiative, designed to increase the number of pregnant women receiving substance abuse services through better identification and referral processes. The program includes coverage by Medicaid to pay for substance abuse prevention and treatment services for pregnant women and women who are up to 60 days postpartum.[158]

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[7] The data was collected in a Kentucky study on Substance Use and the Need for Treatment among Women of Childbearing Age.

In 2007, the Kentucky Cabinet for Health and Family Services announced major funding programs in counties across the Commonwealth to overcome addiction and strengthen families. In counties including Jefferson, Kenton and Martin, the Commonwealth initiated the Sobriety Treatment and Recovery Team (START).

The program is an intensive intervention model for substance abusing parents and families involved with the child welfare system that integrates addiction services, family preservation, community partnerships, and best practices in child welfare and substance abuse treatment. The program aims to address systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population.

It entails the pairing of a specially trained Child Protective Services (CPS) worker and a Family Mentor to share a caseload of families with the co-occurring issues of substance abuse and child maltreatment where at least one child is 3 or younger.[159]

These efforts demonstrate the Commonwealth's understanding that addiction is a medical condition appropriately addressed through the public health system. More specifically, it demonstrates the Commonwealth's steadfast commitment to the treatment, not the prosecution, of women who continue to term despite a drug addiction.[160]

In passing the MHA, the Kentucky Legislature sought to improve maternal and child health by making sure pregnant women who seek prenatal care could do so without fear of prosecution. Since the passage of the MHA, the Commonwealth has seen a steady and dramatic increase in the number of women receiving prenatal care. In 1990, Kentucky was ranked 26th out of 50 states for prenatal care, with 69.7 percent of women receiving prenatal care. In 2000, Kentucky improved its rank to 10th, with 80.7% of women receiving prenatal care. In 2009, Kentucky was still ranked 10th; however the percentage fell to 72.7%.[161] In addition, infant mortality rates fell 25% during that decade.[162] In 2001, Kentucky reported the lowest infant mortality rate since statistics were first recorded.[163,164]

Despite the progressive approach taken by the KY state legislature to address substance use during pregnancy as a health problem, legislation continues to be introduced in sessions of the General Assembly to criminalize substance use during pregnancy or to require all infants to be drug tested at delivery. This approach remains a concern as it can act as a deterrent to attending prenatal care and increase a woman's reluctance to seek help from their doctor due to fear of being arrested or reported to child protective services.

Despite the passage of the MHA several pregnant women have been arrested and charged in Kentucky related to their drug use during pregnancy. So far, these cases have been overturned by either the Kentucky Court of Appeals or the Kentucky Supreme Court.

In spite of Kentucky's progress and national leadership in efforts to increase access to prenatal care and drug treatment, however, both remain in short supply, especially in rural Kentucky. As Kentucky's Office of Women's Physical & Mental Health observed, "[o]nce women decide to seek treatment for substance abuse they find that in Kentucky, there is a large gap between the need for treatment and the availability of services, particularly gender-specific and sensitive treatment services."[165] According to the University of Kentucky Institute on Women and Substance Abuse, Kentucky has approximately 72,000 women in need of treatment for drug misuse.[166] Kentucky has roughly 270 residential beds that women can access for treatment, satisfying only about four percent of the treatment needs. Residential programs typically have waiting lists, often two months long or longer, particularly programs exclusively serving women.[167] The barriers to substance abuse treatment are much greater in rural Kentucky.[168,169]

Despite women's more frequent doctor visits, substance abuse often remains undetected due to a number of factors including a lack or inadequate training of health care providers, lack of employment or underemployment, and insufficient financial resources to pay for substance abuse treatment. With the exception of a handful of specialized treatment programs for women and their children, many substance abuse

treatment programs still lack comprehensive services including child care, which is a significant barrier to entering treatment. In addition to these external barriers, many women feel a greater amount of guilt and shame about their substance use due to the increased stigma associated with female substance abuse, especially during pregnancy.[170]

The Appendix includes an overview on state services and advocacy organizations in Kentucky. In regard to treatment services, Kentucky provides *Community Mental Health Centers* (CMHCs) for ambulatory care and hospitals for inpatient care. In addition to hospitals with psychiatric units, Kentucky provides seven psychiatric centers: Central State Hospital (Louisville, KY), Eastern State Hospital (Lexington, KY), Lincoln Trail Behavioral Health System (Radcliff, KY), Ridge Behavioral Health System (private hospital, Lexington, KY), Ten Broeck Hospital (Louisville, KY), and Western State Hospital (Hopkinsville, KY), and ARH Psychiatric Center (Hazard, KY).[171] Kentucky also has intermediate care facilities or nursing facilities that care for persons suffering from mental illness who need supervision or treatment. There are only two such facilities mentioned on the website of the Cabinet for Health and Human Services. They are located in Glasgow and Hopkinsville, Kentucky.

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Health Outcomes

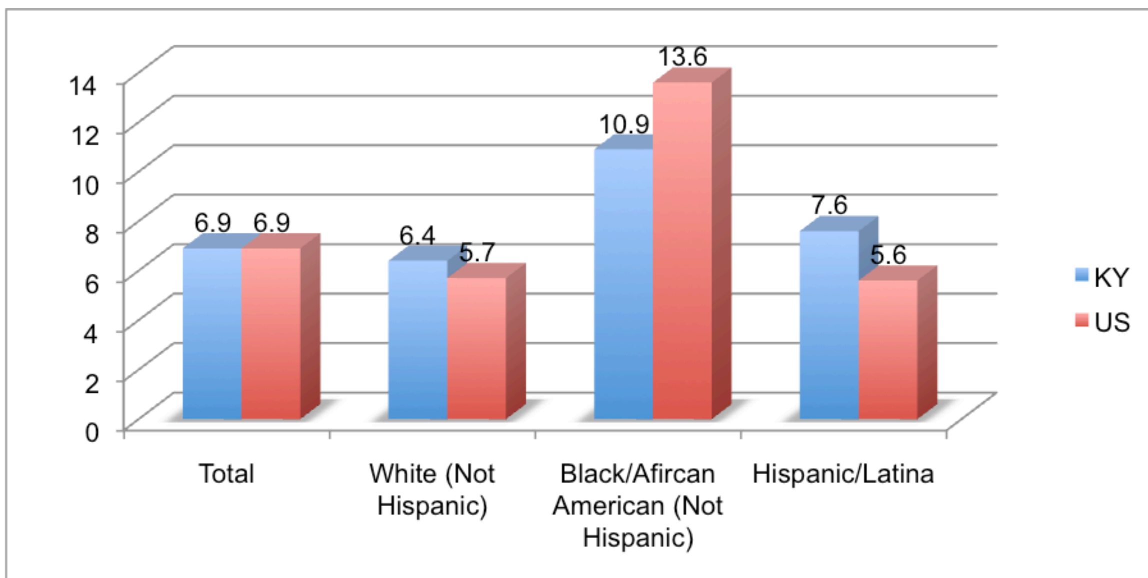
Infant Mortality, Low Birth Weight, and Preterm Births

The Kaiser Family Foundation noted that the infant mortality rate for Kentucky during the period of 2003-2005 was 6.9 deaths per 1,000 live births. White (not Hispanic) women had a rate of 6.4 deaths per 1,000 live births, African-American women 10.9 deaths per 1,000 live births, and Hispanic/Latina women 7.6 infant deaths per 1,000 live births.[172] Figure 14 (below) demonstrates the comparison of these numbers with the national level. White women and Latinas had higher rates in Kentucky than on a national level; while African American women in the state had a lower rate than the national average. However, African American women accounted for the highest rates of infant mortality both statewide at 10.9% and nationally at 13.6%. Latinas in Kentucky also had higher rates than White women. However, on a national level their rate was slightly below the infant mortality rate of White women.

Table 16
Infant Mortality by County, State, and Nation (per 1,000 life births; 2003-2007)

County with lowest rate: **Owsley and Robertson**	0.0
County with highest rate: **Jackson**	14.4
Kentucky	6.7
United States (2003-2005)	6.8

Source: Kentucky Health Facts, State Health Facts



Source: Kaiser Family Foundation, State health Facts
Note: Territories are not included on the national level.

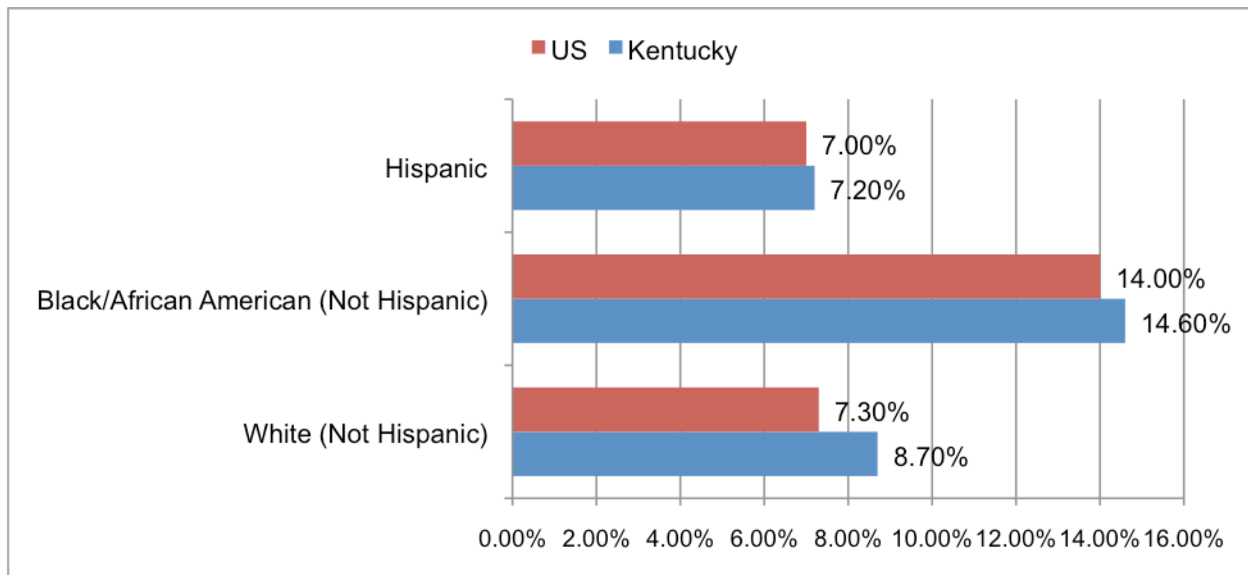
Figure 14. **Comparison of infant mortality rates between Kentucky and United States by race/ethnicity, 2003-2005.**

Low birth weight is a crucial indicator for infant mortality.[173] The low birth weight threshold lies at 2,500 grams or 5.5 lbs (and 1,500 grams for Very Low Birth Weight). Low birth weight is highly dependent on the mother's social and physical environment—smoking, drinking, young age of mother, and poor nutrition put mothers at an increased risk of having a low birth weight baby. Factors such as emotional and physical stress and abuse, and even low educational attainment, can have an impact on prenatal health and the baby's weight. Studies have shown that women with no high school degree are more at risk to deliver babies with low birth weight than those with higher educational attainment. In addition, the growing utilization of assisted reproductive technology contributes to an increase of the number of low birth weight babies.[174] In 2006, a total of 9.1% of all births in Kentucky were low birth weight births. As Figure 15 demonstrates, African American women accounted for the highest proportions of low birth weight births. The rates in Kentucky were higher overall than rates on a national level.[175]

Table 17
Low Birth Weight by County, State, and Nation (Under 2,500 Grams; per 100 total live births; 2003-2007)

County with lowest rate: **Hickman**	5%
County with highest rate: **Lawrence**	15%
Kentucky	9%
United States (2006)	8.3%

Source: Kentucky Health Facts, State Health Facts



Source: Kaiser Family Foundation, State Health Facts
Figure 15. **Low Birth weight births by race/ethnicity, 2006.**

Also in 2006, 15.1% of all births were preterm births compared to 12.8% on a national level. Again, African American (not Hispanic) women accounted for the highest proportion of preterm births in Kentucky with 20.3%; White (not Hispanic) women accounted for 14.6% and Hispanic/Latina women for 14.4%. These percentages were higher than those on a national level: in the United States, 11.7% White women, 18.5% African American women, 12.2% Latinas had preterm births.[176]

Prenatal Care

According to the State Health Facts of the Kaiser Family Foundation, 73.2% of pregnant women began prenatal care within the first trimester in 2006. Racial and ethnic disparities persisted, with 75.1% White (not Hispanic), 64.7% Black/African American, and 56.1 Latinas receiving prenatal care in the first trimester. About 85% women received adequate prenatal care in Kentucky; the lowest percentage of women received this care in Fulton County with 74%; whereas the highest percentage of women who received adequate prenatal care lived in Hancock with 95%.[177]

Table 18
Adequacy of Prenatal Care by County, State, and Nation (2007)

County with lowest proportion: **Fulton**	74%
County with highest proportion: **Hancock**	93%
Kentucky	85%
United States	75%

Source: Kentucky Health Facts

Breast Feeding

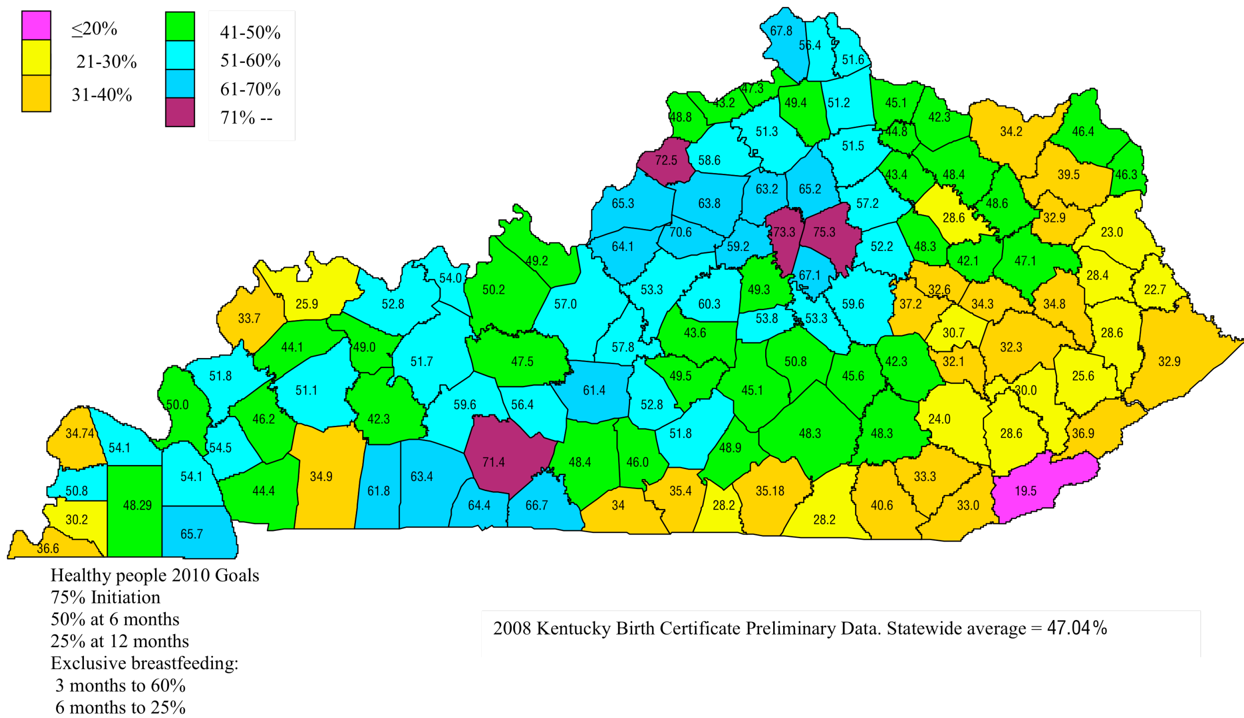
Breastfeeding is a health behavior that affects both infants and mothers, and has both short- and long-term health and economic impact at the individual and community level. According to the Healthy People 2010 initiative, "Breast milk is widely acknowledged to be the most complete form of nutrition for infants, with a range of benefits for infants' health, growth, immunity, and development."[8] Research has established and continues to identify ways in which breastfeeding is beneficial to both the infant and the mother. The benefits of breastfeeding outlast infancy and childhood, with research showing positive health impacts of having been breastfed well into adulthood. According to the

[8] Healthy People 2010 website, available at http://www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm#_Toc494699668

American Academy of Pediatrics, “Extensive research, especially in recent years, documents diverse and compelling advantages to infants, mothers, families, and society from breastfeeding and the use of human milk for infant feeding. These include health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits.”[178] Some of the most recent research confirms breastfeeding’s role in reducing the incidence of obesity in children. In Kentucky, were obesity and overweight are a major public health challenge, breastfeeding may represent a new tool in reducing obesity rates and hence the many serious health problems associated with being obese and overweight.

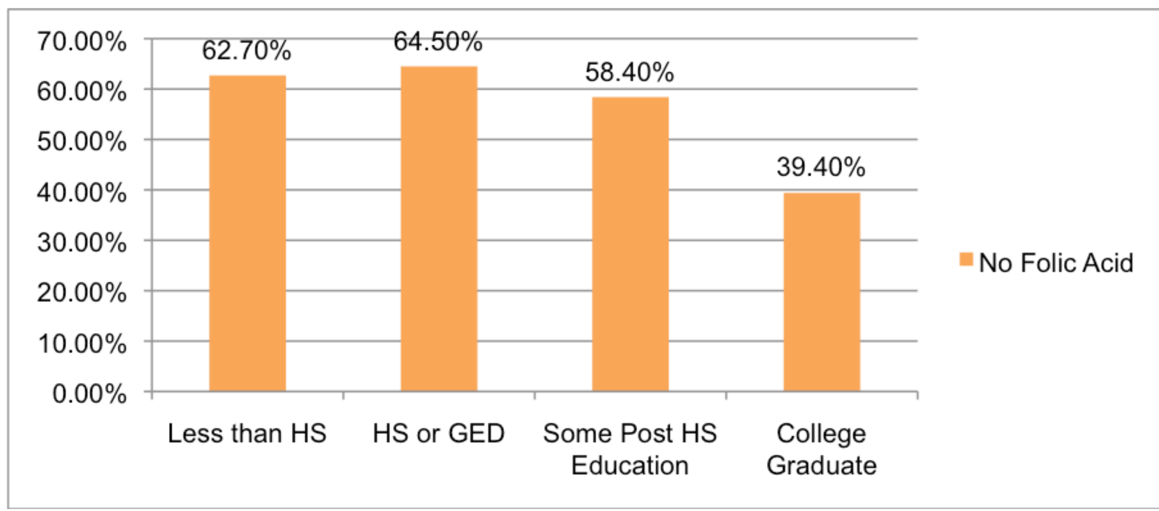
Breastfeeding Initiation by mother’s county of residence

2008 Birth Certificate Data



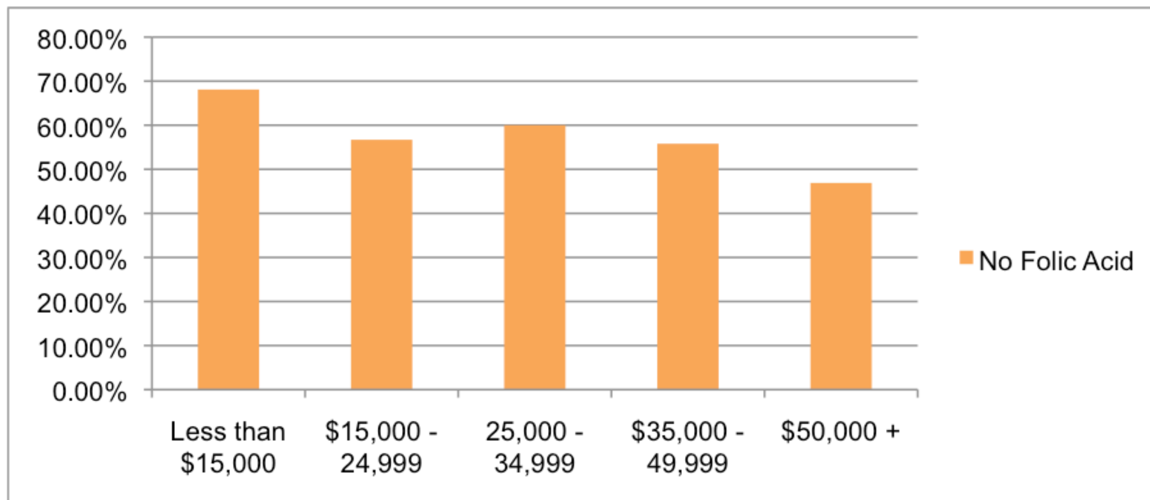
Source: 2008 Survey, Kentucky Department for Public Health

Folic acid. Folic acid is an essential B-vitamin that can minimize the risk for neural tube defects. These are defects in the baby's brain (anencephaly) or in the baby's spine (spina bifida). In order to prevent neural tube defects, women would have to consume necessary levels of folic acid very early in the pregnancy, before most women know that they are pregnant. According to the U.S. Public Health Service, women who could become pregnant should take 400 micrograms folic acid per day.[179] The Behavior Risk Factor Surveillance System (BRFSS) reported for 2006 that 55.8% of women between 18 and 44 did not take any vitamin supplements that included folic acid. There were major disparities in regard to race with 54.4% White women and 73.5% African American women not taking folic acid daily. It was shown that women with lower educational and income levels are generally more likely of not taking folic acid.[180] Figures 16 and 17 illustrate the percentage of women who did not take folic acid by educational attainment and income level.



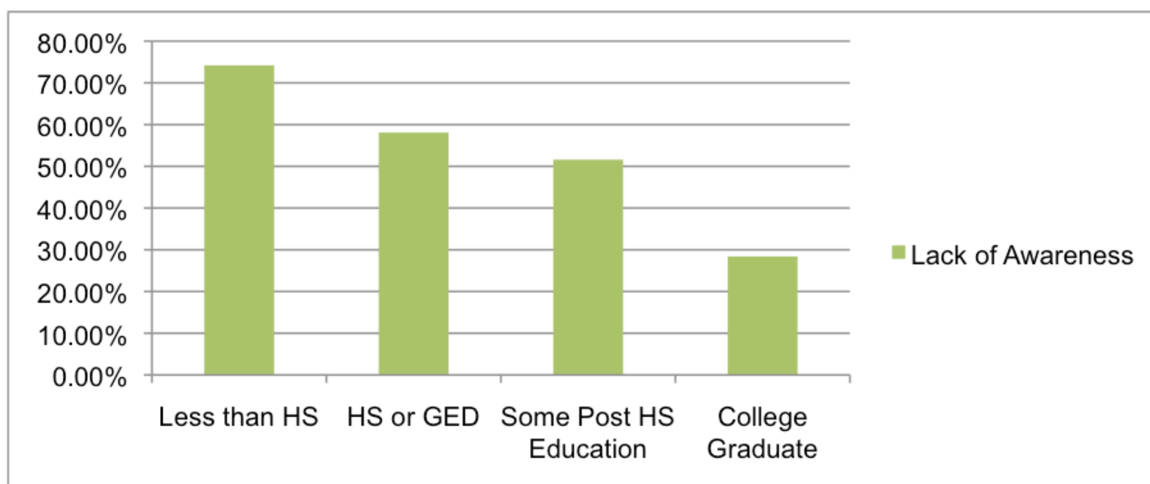
Source: The Kentucky Behavior Risk Factor Surveillance System, p.32

Figure 16. **Percentage of women who did not take folic acid by educational attainment.**

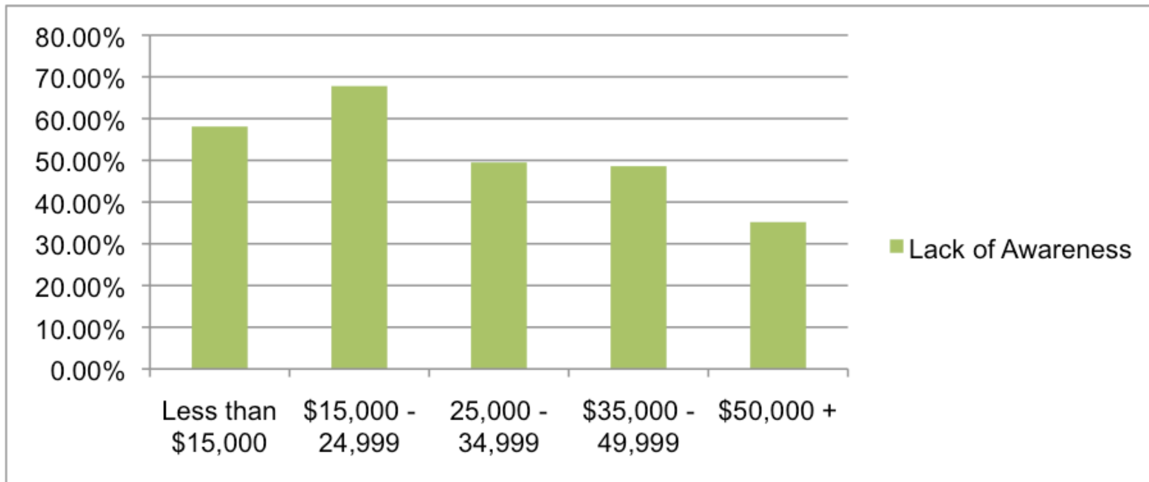


Source: The Kentucky Behavior Risk Factor Surveillance System, p.32
***Figure 17*. Percentage of women who did not take folic acid by income level.**

The 2006 BRFSS also reported that a total of 50% of women between the ages of 18 and 44 were not aware that folic acid prevents birth defects. Among those, 47.6% were White and 71.5% were African American. The majority (65%) of them were between the ages of 18 and 24. Again, disparities were noted in regard to educational attainment and income level: women with lower educational attainment accounted for higher percentages. Figure 18 and 19 demonstrate these disparities.[181]



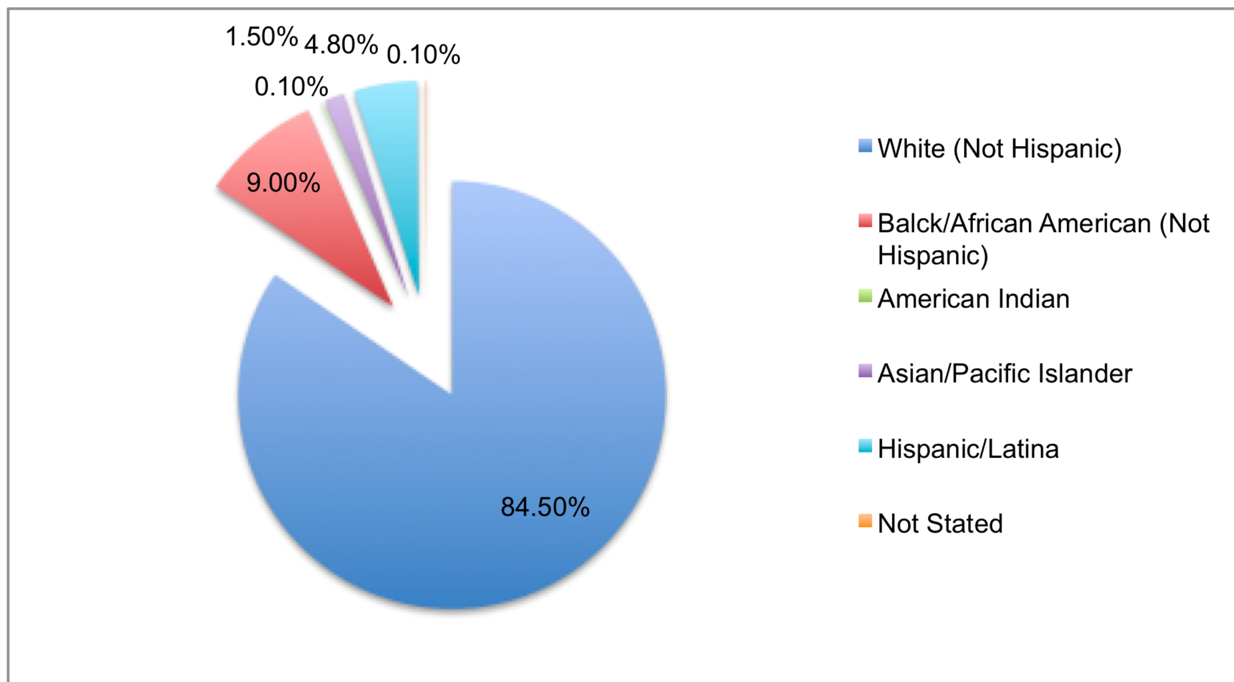
Source: The Kentucky Behavior Risk Factor Surveillance System, p.36
***Figure 18*. Percentage of women who were not aware of preventive effects of folic acid by educational attainment.**



Source: The Kentucky Behavior Risk Factor Surveillance System[182]
***Figure 19*. Percentage of women who were not aware of preventive effects of folic acid by income level.**

Fertility Rate

In 2006, the number of live births was 58,250.[183] Figure 19 demonstrates live births by race and ethnicity. In 2005, the highest rate of live births (crude rate per 1,000 people) was found in Christian County (20.8). Among unmarried women, Gallatin County accounted for the highest rate with 7.2.



Source: Kaiser Family Foundation, State Health Facts
***Figure 20.* Proportions of live birth by race/ethnicity in 2006.**

The 2006-2008 American Community Survey (3-year estimate) reported that by the end of 2008, 6% of the female population between 15 and 50 years had a birth over the past 12 months. Among those 3% were 15 to 19 years old; 11% were 20 to 34 years old; and 2% were 35 to 50 years old. Table 19 demonstrates a more detailed description of this population.[184] The highest proportion of births occurred among women ages 20 and 34 years.

Table 19

Fertility in Kentucky by Age, Race/Ethnicity, Foreign Born, Educational Attainment, Poverty Status

		Women with births in the past 12 months		
	Total	Number	Percentage*	Rate per 1,000
Women 15 to 50 years	**1,061,485**	**59,784**	**6.00%**	**56**
15 to 19 years	139,640	4,594	3.00%	33
20 to 34 years	421,743	46,677	11.00%	111
35 to 50 years	500,102	8,513	2.00%	17
Race and Hispanic/Latino Origin				
White Alone (Not Hispanic)	929,029	51,600	6.00%	56
Black/African American	86,330	4,894	6.00%	57
American Indian/Alaska Native	2,029	12	1.00%	6
Asian	12,679	746	6.00%	59
Native Hawaiian/Pacific Islander	N	N	N	N
Some Other Race	8,332	793	10.00%	95
Two or More Races	10,481	621	6.00%	59
Hispanic/Latina	20,374	1,898	9.00%	93
Foreign Born				
Native	1,026,938	57,059	6.00%	56
Foreign Born	34,547	2,725	8.00%	79
Educational Attainment				
Less than High School	199,255	9,811	5.00%	49
High School Graduate	311,572	17,098	5.00%	55
Some College/Associate's Degree	345,596	18,955	5.00%	55
Bachelor's Degree	135,512	9,015	7.00%	67
Graduate/Professional Degree	69,550	4,905	7.00%	71
Poverty Status in past 12 months				
Women 15 to 50 years, poverty status determined	**1,041,046**	**59,476**	**6.00%**	**57**
Below 100% of poverty level	206,226	19,068	9.00%	92
100 to 199% of poverty level	198,454	11,700	6.00%	59
200% or more above poverty level	636,366	28,708	5.00%	45

Source: 2006-2008 American Community Survey (3-year estimate)

* Percentages were rounded up.

Unintended Pregnancies and Abortions

The Pregnancy Risk Assessment Monitoring System (PRAMS) reported that 40.7% of pregnancies in Kentucky in 2008 were unintended. African American women accounted for the majority of unintended pregnancies among women with 65.8%. Women of younger age, with lower education, those who were unmarried, were uninsured or on Medicaid, and had lower incomes also reported higher rates of unintended pregnancies. Table 20 provides an overview on this socio-demographic data.[185]

Table 20

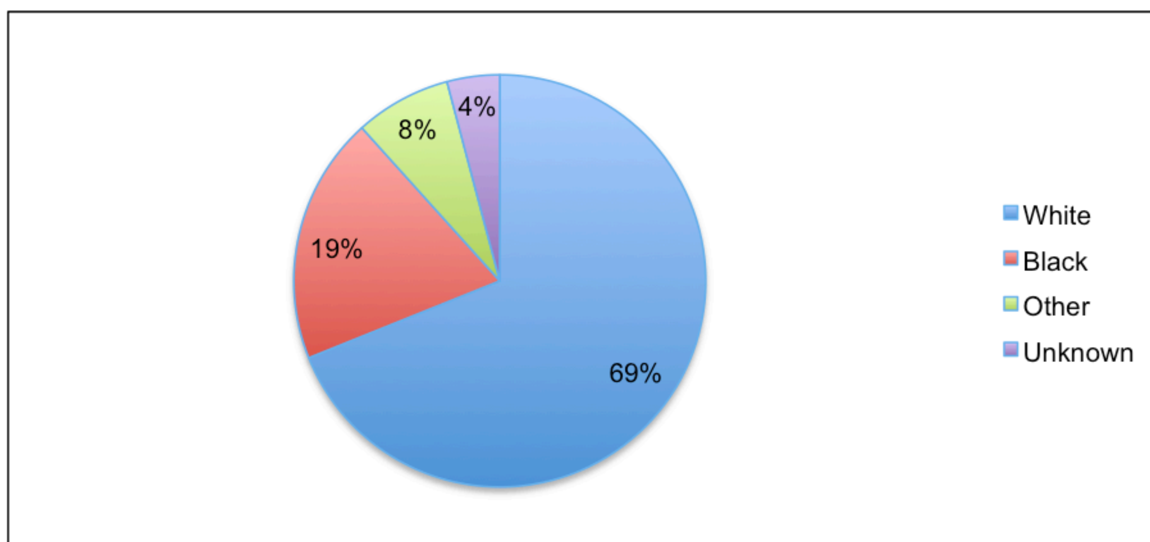
Unintended Pregnancies by Age, Education, Marital Status, Insurance Status, and Income

	% Intended	% Unintended
Age		
< 20	34.60	65.40
20-24	58.50	41.50
25-29	69.50	30.50
30-34	69.20	30.80
> 35	50.00	50.00
Education		
< High School	52.00	48.00
High School	52.20	47.80
> High School	67.40	32.60
Marital Status		
Married	74.50	25.50
Unmarried	42.30	57.70
Pre-Pregnancy Insurance Status		
Uninsured	44.80	55.20
Medicaid	40.10	59.90
Private	73.40	26.60
Income		
< $15,000	40.70	59.30
$15,000-$24,999	53.40	46.60
$25,000-$49,999	45.40	54.60
≥ $50,000	74.20	25.80

Source: Kentucky PRAMS, 2007-2008

In 2005, 3,776 abortions were performed in Kentucky. Of these 15% were performed on women under 19 years, 57% on women between 20 and 29, 24% on women between 30 and 39, and 3% on women of the age 40 and above. In regard to race, White women had the highest proportion of abortions with 68.9%, compared to Black women with 19.4% and others with 7.5%. For 4.1% of women, the race was unknown (Figure 20).[186] Looking at total populations in 2005, abortions occurred among African

American women at a higher rate than among White women: 480 African American women in every 100,000 had an abortion compared to 140 White women per 100,000.[9,187] While arguments have surfaced alleging that the higher abortion rates of African American and Latinas are due to abortion providers targeting communities of color, research finds that communities of color (particularly African Americans and Latinas) have higher abortion rates as a result of significantly higher unintended pregnancy rates, which, in turn, are related to various health care and socio-economic inequities.



Source: Kaiser Family Foundation State Health Facts

Figure 21. **Percentages of legal abortions in Kentucky by race, 2005.**

Teen Pregnancies (15-19 years)

The Census 2000 counted 141,027 females in the age group 15-19.[188] In 2000, Kentucky was ranked 25th on teenage pregnancy rate, 14th on teenage birth rate, and 47th on teenage abortion rate on a national level. Per 1,000 female teenagers between 15 and 19 years, 76

Table 21
Teen Births by County, State, and Nation (per 1,000 women ages 15-19; 2003-2007)

County with lowest rate: **Oldham**	17.0
County with highest rate: **Knox**	96.5
Kentucky	52.1
United States (2006)	41.9

Source: Kentucky Health Facts, State Health Facts

[9] This rate was calculated with the total female Black/White population of 2005 in Kentucky, presented by the 2005 American Community Survey and the abortion numbers presented by the *Abortion Surveillance—United States, 2005* of the Center of Disease Control.

were pregnant, 56 gave birth, and 8 had an abortion. In regard to race/ethnicity, African American teenagers had the highest pregnancy rate with 119 per 1,000 girls. White female teenagers accounted for 71 per 1,000 girls who were pregnant. Pregnancy rate data on Latina teenagers was not available. Per 1,000 girls, 53 White girls gave birth compared to 84 African American and 92 Latina girls. African American girls also had the highest abortion rate with 17, followed by White teenagers with 7 per 1,000. No abortion rate data was available for Latina teenagers.[189]

In 2006, the ACS reported 149,391 female teenagers between 15 and 19.[190] The Kaiser Family Foundation reported that in this year 54.6 per 1,000 teenagers of the age 15 to 19 in Kentucky were pregnant. From 1991 to 2006, the teen pregnancy rate declined by 21%.[191]

Substance Use

While substance use among women is a very serious health problem, it's taken society a longer time to acknowledge the problem and provide appropriately designed services. The University of Kentucky Institute on Women and Substance Abuse reported that an estimate of 72,000 women in Kentucky abused alcohol and/or other drugs. However, only 22% of them received treatment. Studies suggest that women, once introduced to substances, develop abuse problems faster than men.[192]

Smoking and Other Substance Use During Pregnancy. Smoking has negative effects on women's overall health, and also on their reproductive health, prenatal health, and on infants' and children's health. Cigarette smoking can cause increased primary and secondary infertility, delays in conceiving, higher risk of premature membrane rupture, tubal pregnancies, and preterm delivery. Smoking also increases risk for various cancers. The effects on prenatal health and infant health include low birth weight, learning disabilities, greater chance of stillbirth, and sudden infant death syndrome. Women who smoke are also less likely to breastfeed their infants. James et al. reported that, based on the BRFSS (2004-2006), a total of 31.4% women 18 years and older were smoking in Kentucky by the end of 2006. Among those 31.5% were

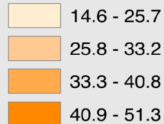
White, 25.9% were Black and 35.3% were Latina women. The proportion of Latina women who smoked was the highest compared to all other states. Compared with other states, Kentucky ranked second for women who were smoking.[193]

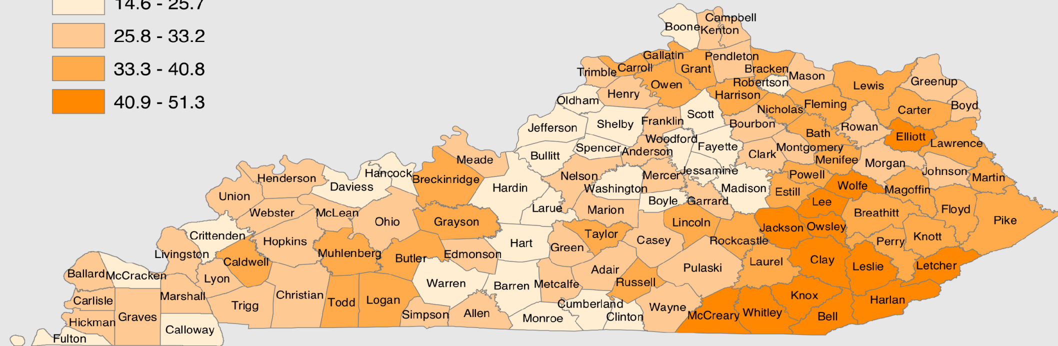
The PRAMS report found out that 45% of mothers interviewed did not quit smoking during pregnancy; 9.5% quit before they found out they were pregnant: 16% stopped smoking before they got pregnant; and 30% stopped smoking later in the pregnancy. Although 96.5% of the PRAMS mothers reported that they were asked by their prenatal care provider if they smoked or not, almost 60% stated that their health care provider did not take the time to discuss ways of quitting smoking.[194] The following map shows the distribution of pregnant women who smoke in Kentucky.

In addition to smoking, alcohol and drug abuse can have serious physical and mental health effects on both mother and child. In 2008, 9.9% of women between 18 and 44 years reported binge drinking in the past month in Kentucky. This rate is lower than the national one, which is at 14.8%; however, it is higher than the year before. In 2007, 6.2% of women in Kentucky reported binge drinking in the past month.[195] The PRAMS report found that 5% of the interviewed mothers were drinking during the last three months of pregnancy.[196]

In some states, health care professionals are required to report or test for prenatal drug exposure and the test results can be treated as evidence in child-welfare cases. Kentucky law allows health care professionals to test pregnant women when they suspect substance abuse. It states that if they do test, the attending individual must determine if abuse or neglect has occurred based on the findings of the toxicology test and determine whether or not the Cabinet should be contacted. It also states that the information garnered from the test cannot be used as prosecutorial evidence.

Smoking During Pregnancy in Kentucky, by County 2004





Kentucky: 26.7%

Kentucky data not comparable to US in 2004 due to a change in the format of tobacco use during pregnancy questions on the state's birth certificate. Other states still use previous format; data will not be comparable until most states' birth certificates are updated.

Source: Kentucky Department for Public Health Live Birth Files, 2004

Source: Kentucky Cabinet for Health and Human Services
Figure 22. **Smoking during pregnancy in Kentucky by county 2004.**

Mental Health

Mental health is critical to women's wellbeing. Women usually account for higher rates of mental illnesses than men, such as depression or related disorders. Various factors contribute to women's increased risk for poor mental health: women have lower incomes, experience stress related to family responsibilities, or are exposed to gender-based violence.[197] Communities of color are "less likely to receive services and less represented in mental health research."[198] In addition, there is the impact of social stigma on the identification, prevention and treatment of mental illness.

In 2009, Kentucky ranked 50th among all states In regard to poor mental health days. Over the past year the number of poor mental health days increased from 3.7 to 4.6 days in a 30-day period, an increase of 24%.[199] The BRFSS of 2006 reported that

Kentucky has a higher rate of frequent mental distress (14.1%) when compared to the nation (9.9%). Women accounted for higher rates of frequent mental distress (16.5%) than men (11.5%). The highest rates overall could be found in the Area Development Districts Big Sandy with 23.9%, Cumberland Valley with 23.3%, and Kentucky River with 21.7%.[200]

Breast and Female Genital System Cancer

Research on cancer prevention, detection, and treatment has progressed greatly over the past decades; however, more than 270,000 women in the U.S. are expected to die from cancer each year. It was shown that during the period of 2000-2004 Kentucky had the highest cancer mortality rate among women in the United States with 182.1 for every 100,000 women. In addition, African American women in Kentucky also accounted for the highest cancer mortality rates compared to the other states (221.5 for every 100,000 African American women). Cancer continues to be the number one cause of death for women between 18 and 64 years, despite an increase in survival time brought about by prevention and screening technology. Mortality rates have declined overall over the past three decades, yet they declined even more for men than for women. White women account for higher incidence rates overall in the United States; however, African American women and Latinas are more likely to be affected by certain type of cancers, such as cervical cancer. This is very disturbing since the risk of cervical cancer can be reduced by early detection through pap smears.[201] Latinas have an increased risk of reproductive cancers. On a national level, Latina cervical cancer rate is more than twice as high as the rate for White non-Hispanic women and they account for the second highest mortality rate after African American women.[202]

Breast cancer occurs when breast cells become abnormal. They "grow, divide, and create new cells that the body does not need and that do not function normally."[203] These cells establish a mass—a tumor—that can be benign, not causing big health problems, or that can be malignant.[204] The risk of breast cancer can be lowered by controlling body weight, limiting alcohol and exercising regularly; by knowing the history of breast cancer in the family; and by being aware of risks and benefits of hormone

replacement therapy. Regular breast cancer screenings can also impact outcomes related to breast cancer.[205]

Cancer in the female genital system has its origins in a woman's reproductive organs. These include the fallopian tubes, ovaries, cervix, vagina, and vulva. Each of the female genital system cancers shows different signs, symptoms and risk factors, and needs different prevention strategies.[206] For example, the HPV (human papilloma virus) vaccine helps to prevent some types of gynecological cancers. Cervical cancers can be detected early by a screening test, the Pap test. In general, female genital systems cancers that are detected earlier are more treatable.[207]

In Kentucky, more African American women had pap smears than White women: The Kaiser Family Foundation reported that 83.1% women in Kentucky received a pap smear in 2006. These rates were as follows: 83.2% of White and 86.7% of African American women. Among the women 40 years and above 75.1% and among women 50 years and above, 77% had a Mammogram in 2006.[208] Mammograms are considered critical to diagnosing breast cancer at an early stage. The U.S. Preventive Task Force Services suggests obtaining a Mammogram every 1-2 years starting at the age of 40.[209] There is no state data available on any other community of color. On a national level, American Indian/Alaska Native women accounted for the lowest proportion of women in 2006 that were over 50 and got a mammogram within the last two years (70%). Asian/Pacific Islanders accounted for 79.3% and Latinas for 80.6%. Also in 2006, among the women 18 years and older, Asian/Pacific Islanders had the lowest rate of women who had a pap smear within the last three years (75.6%), while American Indians/Alaska Natives and Latinas accounted for 80.5% and 81.6% respectively.[210]

Incidence rates of breast and female genital system cancer. During the period 2002-2006, 144.9 women (age-adjusted rate) for every 100,000 women were diagnosed with breast cancer (Figure 23). In terms of race and ethnicity, 141.63 per 100,000 were

White women and 152.29 were African American women.[10] Table 22 demonstrates the cancer incidence rates in Kentucky by county and race/ethnicity and the following map gives an overall idea of the counties mostly affected by breast cancer in Kentucky for all women.[11, 211]

Table 22

Incidence Rates for all Breast Cancer by County and Race, 2002-2006

	State	County with Highest Rate	County with Lowest Rate		
			# of Cases > 15	# of Cases < 15	# of Cases < 5
All Women	142.97	Robertson (218.95)	Elliott (77.41)	Owsley (61.62)	
White	141.63	Anderson (207.50)	Elliott (77.55)	Owsley (61.89)	
African American	152.29	Madison (216.58)	McCracken (111.05)	Hopkins (57.48)	Scott (34.63)

Source: Kentucky Cancer Registry
Note: The rates are age-adjusted. For the counties with cases < 15, there were too few counts to be able to calculate a stable age-adjusted rate; therefore the county with the lowest rate of the counties with cases >15 is also reported. In addition, counts were suppressed if there were fewer cases than 5 in order to protect identity.

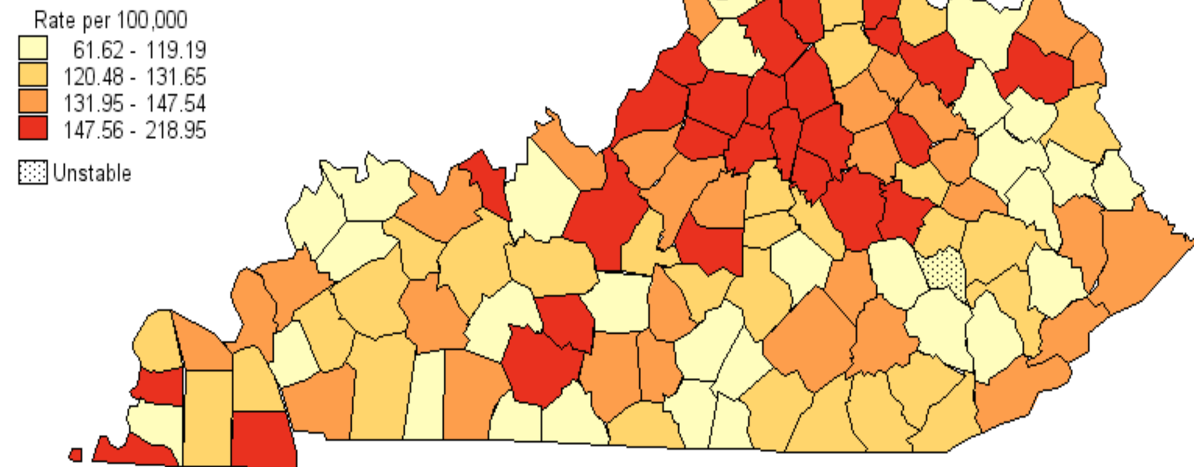


Figure 23. **Age-adjusted breast cancer incidence rate in KY by county, 2002-2006.**

During the same time period (2002-2006), the incidence for cancer in the female genital system stood at 57.07 for all women in Kentucky. White women had a rate of 56.89 for every 100,000 women and African American women had a rate of 51.68 per 100,000

[10] Data was only available for White and African American women.
[11] *Unstable* refers to rates in these counties.

women (Table 23). The following map again gives an impression of how female genital system cancers were distributed in Kentucky geographically.[212]

Table 23

Incidence Rates for all Cancer in the Female Genital System by County and Race, 2002-2006

	State	County with Highest Rate			County with Lowest Rate		
		# of Cases > 15	# of Cases < 15	# of Cases < 5	# of Cases > 15	# of Cases < 15	# of Cases < 5
All Women	57.07	Bath (95.20)			Henderson (30.06)		Crittenden (14.22)
White	56.89	Bath (94.46)			Henderson (26.76)		Crittenden (14.38)
African American	51.68	Fayette (54.02)	Boyle (99.64)	Scott (77.50)	Jefferson (52.97)	McCracken (26.92)	Franklin (23.02)

Source: Kentucky Cancer Registry
Note: The rates are age-adjusted. For the counties with cases < 15, there were too few counts to be able to calculate a stable age-adjusted rate; therefore the county with the lowest/highest rate of the counties with cases >15 is also reported. In addition, counts were suppressed if there were fewer cases than 5 in order to protect identity.

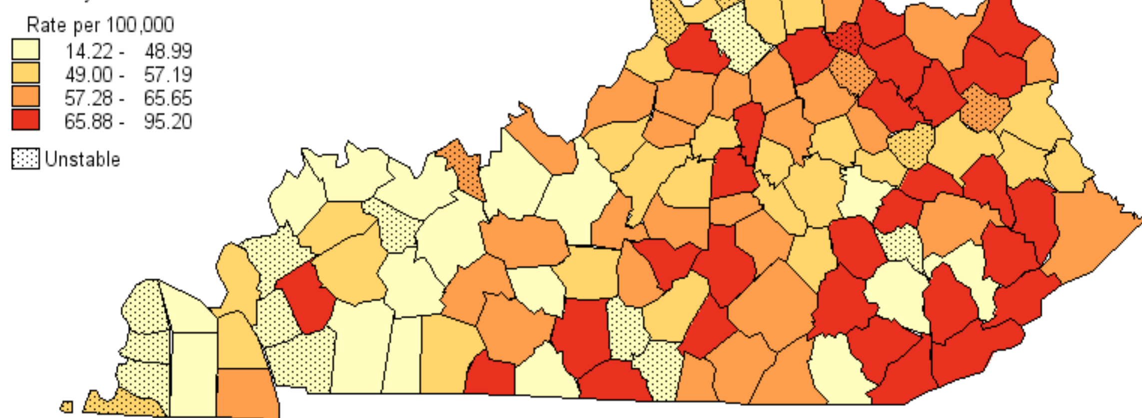


Figure 24. **Age-adjusted female genital system cancer incidence rate in KY by county, 2002-2006.**

Mortality rates of breast and female genital system cancer. From 2002 to 2006 24.61 of every 100,000 women died of breast cancer in Kentucky. White women had a rate of 24.16 per 100,000 and African American women had a rate of 33.35 per 100,000

(Table 24). The map demonstrates the distribution of all women who died from breast cancer in Kentucky between 2002 and 2006.[213]

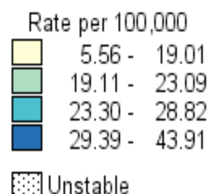
Table 24

Mortality Rates for all Breast Cancer by County and Race, 2002-2006

	State	County with Highest Rate			County with Lowest Rate		
		# of Cases > 15	# of Cases < 15	# of Cases < 5	# of Cases > 15	# of Cases < 15	# of Cases < 5
All Women	24.61	Estill (43.91)			Jessamine (15.95)	Henry (11.63)	Ballard (5.56)
White	24.16	Estill (44.04)			Jessamine (15.61)	Henry (12.23)	Ballard (5.72)
African American	33.35	Jefferson (35.34)	Madison (94.56)	Scott (57.24)	Fayette (27.68)	Boyle (0.00)	Warren (4.50)

Source: Kentucky Cancer Registry

Note: The rates are age-adjusted. For the counties with cases < 15, there were too few counts to be able to calculate a stable age-adjusted rate; therefore the county with the lowest/highest rate of the counties with cases >15 is also reported. In addition, counts were suppressed if there were fewer cases than 5 in order to protect identity.



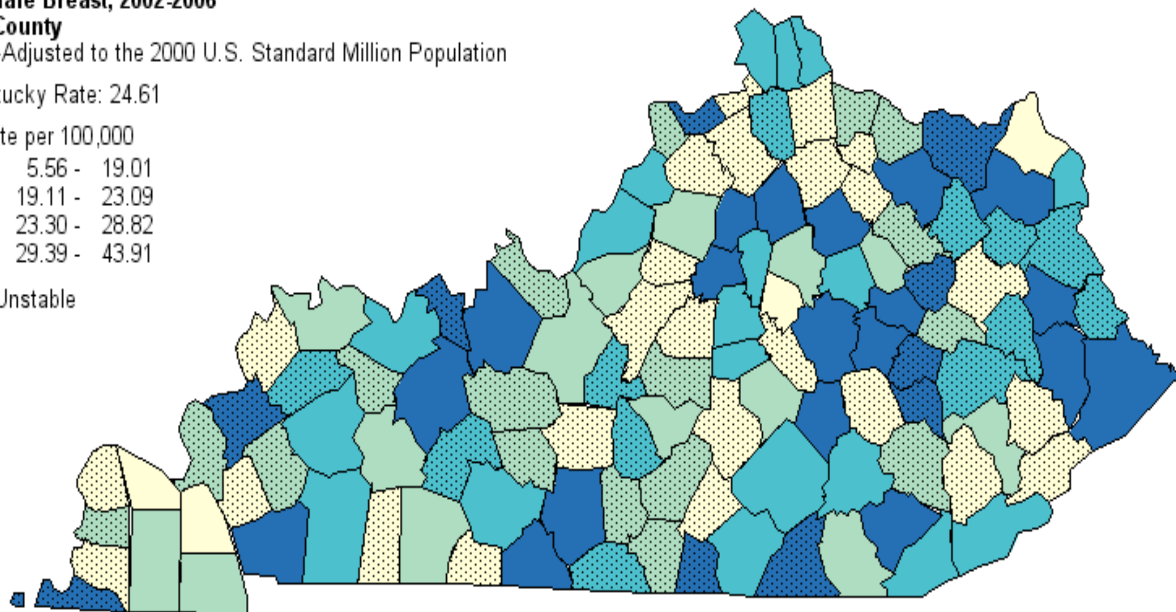


Figure 25. **Age-adjusted breast cancer mortality rate in KY by county, 2002-2006.**

Among women who had cancer in the genital system 15.63 per every 100,000 women died in Kentucky between 2002 and 2006. White women had a rate of 15.55 per 100,000 and African American women 18.08 per 100,000 women (Table 25). The map

demonstrates the distribution of women who died from cancer of the female genital system.[214]

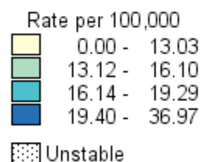
Table 25

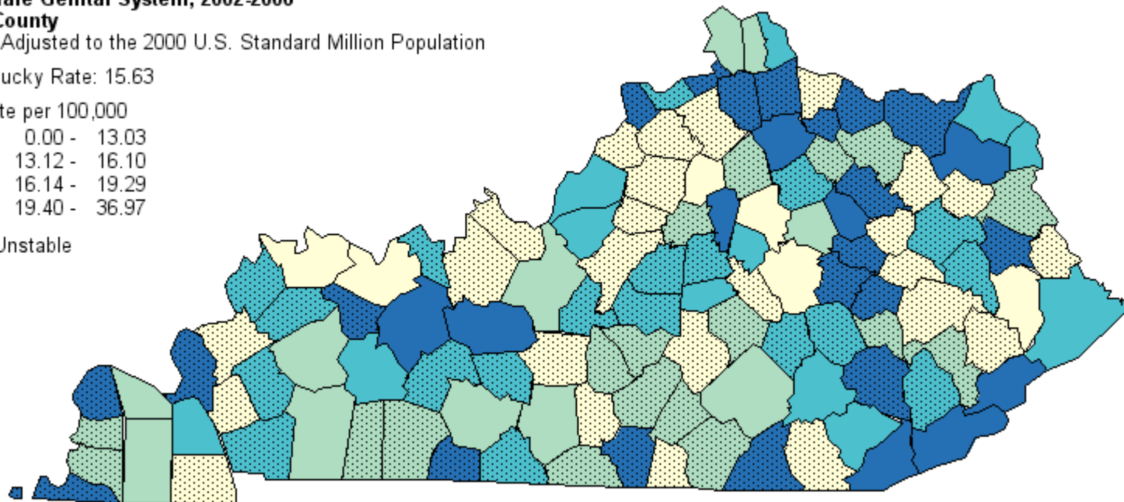
Mortality Rates for all Female Genital System Cancers by County and Race, 2002-2006

	State	County with Highest Rate			County with Lowest Rate		
		# of Cases > 15	# of Cases < 15	# of Cases < 5	# of Cases > 15	# of Cases < 15	# of Cases < 5
All Women	15.63	Harrison (27.49)	McLean (36.97)	Robertson (33.07)	Madison (8.35)	Crittenden (0.00)	Elliott (2.80)
White	15.55	Woodford (23.74)	McLean (37.37)	Robertson (33.23)	Madison (8.79)	Crittenden (0.00)	Elliott (2.82)
African American	18.08	Jefferson (19.10)	Hardin (37.16)	Logan (66.58)	N/A	Hopkins, Madison, Nelson, Henderson, Shelby, Scott (0.00)	Kenton (7.10)

Source: Kentucky Cancer Registry
Note: The rates are age-adjusted. For the counties with cases < 15, there were too few counts to be able to calculate a stable age-adjusted rate; therefore the county with the lowest/highest rate of the counties with cases >15 is also reported. In addition, counts were suppressed if there were fewer cases than 5 in order to protect identity.

Age-Adjusted Cancer Mortality Rates in Kentucky
Female Genital System, 2002-2006
By County
Age-Adjusted to the 2000 U.S. Standard Million Population





Created Nov 18, 2009
Copyright (C) 2009 Kentucky Cancer Registry

***Figure 26.* Age-adjusted female genital system cancer mortality rate in KY by county, 2002-2006.**

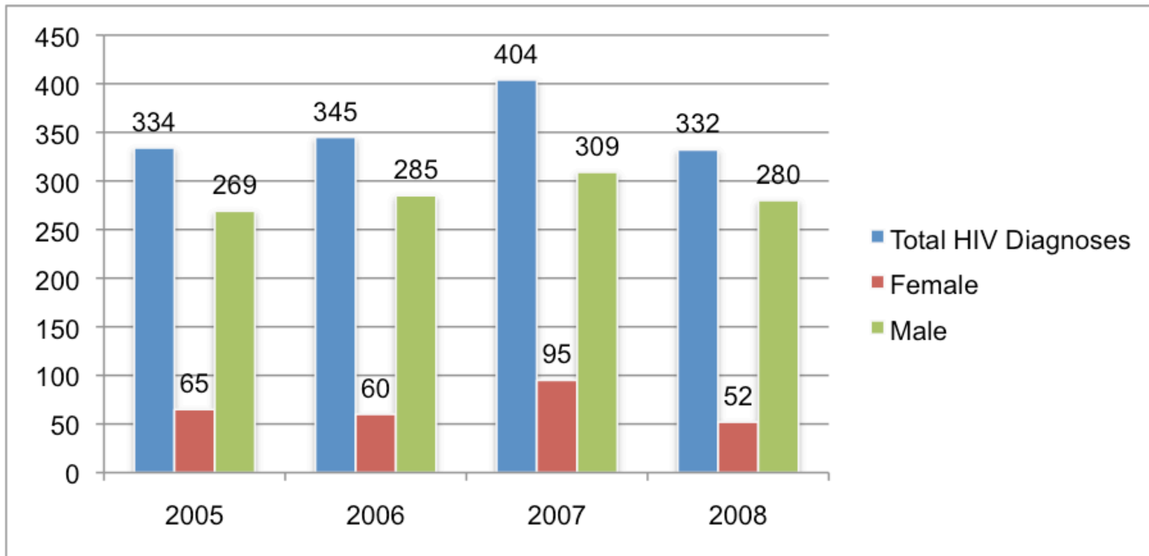
HIV and AIDS and Sexually Transmitted Infections

The human immunodeficiency virus (HIV) is a virus that attacks the human immune system by destroying certain white blood cells, the so called T cells or CD4 cells. These

cells are important for the immune system to fight diseases. HIV causes the acquired immunodeficiency syndrome (AIDS), which is considered as the final stage of HIV. This means that the immune system has been weakened by the virus to such an extent that it can hardly fight infection any more.[215]

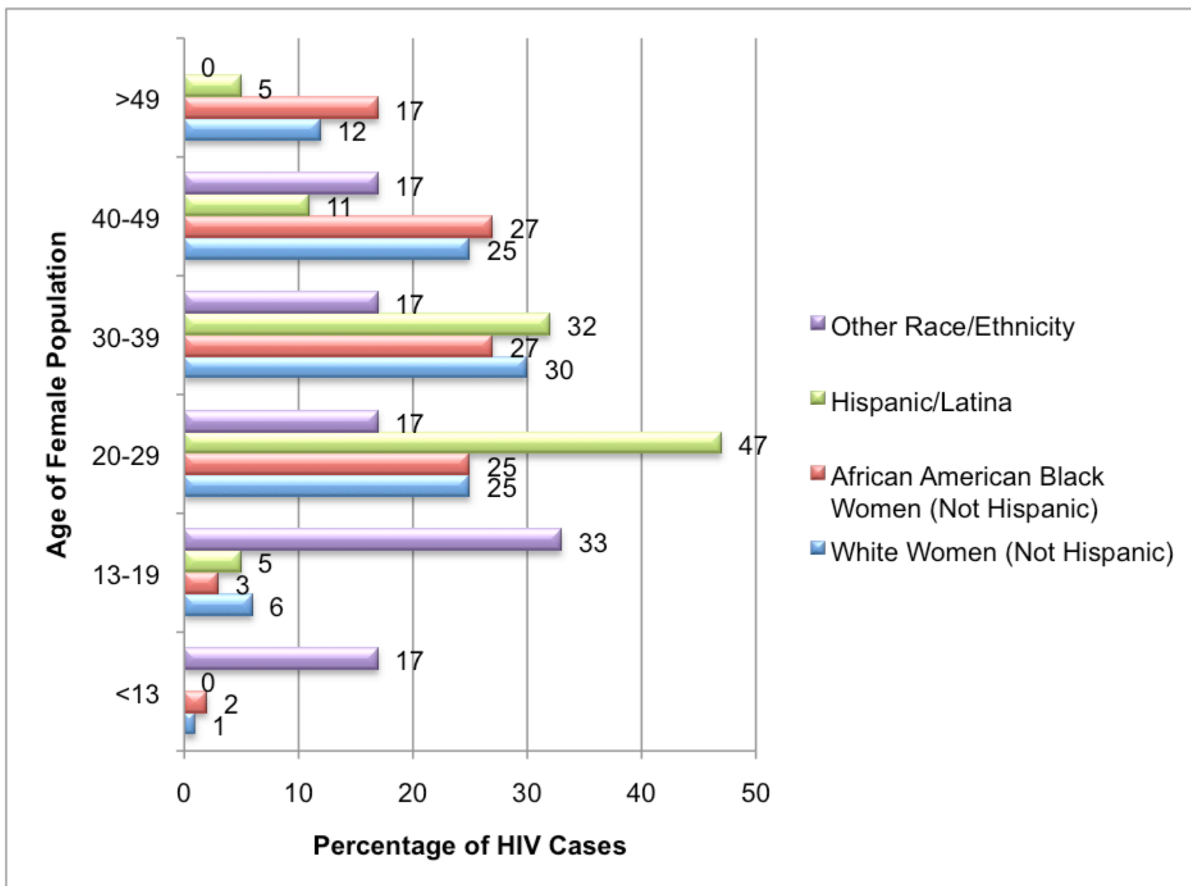
In 2005, AIDS was ranked 24th of all causes of death in Kentucky. Among women of all age groups, it was ranked 30th for White women (not Hispanic), 20th for African American women (not Hispanic), and 15th for Latinas (with this group, it was tied with two other causes of death). Among the female age group 25 to 44 years, it was ranked 12th for White (not Hispanic), 8th for African American, and 2nd for Latina women (here again tied with two other causes of death).[216]

HIV Infections in Kentucky. By December 31, 2008, 1,415 HIV infections have been reported since January 1, 2005. Among those 1,072 were diagnosed without AIDS, whereas 343 where concurrent with an AIDS diagnosis. Figure 27 demonstrates the total number of HIV diagnoses and the distribution of diagnoses among men and women in the time period from 2005 to 2008.[217] As it demonstrates, men have persistently higher numbers of new infections than women, with the peak of infections in 2007. However, when we look at proportions and compare the genders, women had higher percentages of new HIV infections than men in 2007. Women accounted for 35% of new cases, whereas men accounted for 27%. However, it reversed again in 2008, with 19% women and 24% men getting infected. Figure 28 demonstrates the proportions of new HIV cases of the female population by age and race/ethnicity during the time period 2005 to 2008.[218]



Source: Kentucky Cabinet for Health and Family Services, 2008

Figure 27. **Total HIV diagnoses from 2005 to 2008 in Kentucky by gender.**



Source: Kentucky Cabinet for Health and Family Services, 2008

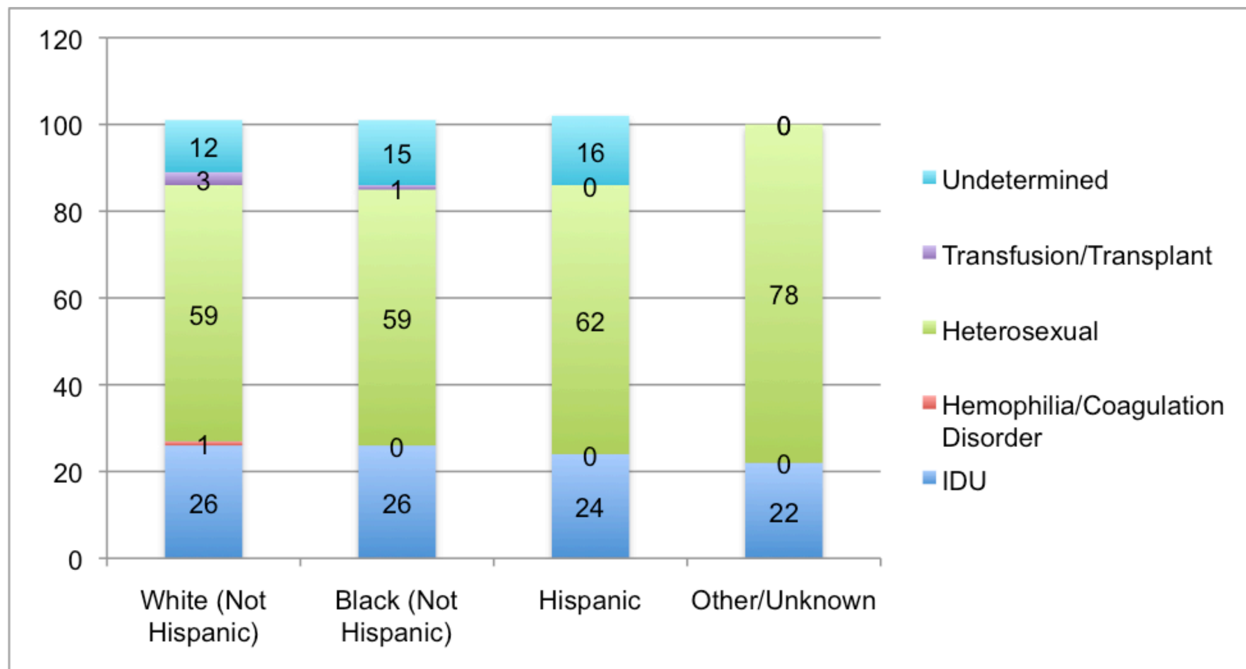
Figure 28. **Proportions of HIV cases among the female population between 2005 and 2008 by age, race/ethnicity.**

Figure 28 shows that among female children, teenagers, and adolescents, women falling under the category *other race/ethnicity* demonstrated the highest proportions; whereas Latinas accounted for the highest percentages of new HIV infections among women in their twenties and thirties. African American women, followed by White women, dominated the higher age categories.

AIDS cases in Kentucky. By the end of 2008, a total of 5,015 AIDS cases have been reported in Kentucky since 1982. Of those cases, 2,707 people are presumed to be alive now. Also in 2008, 216 new AIDS cases were reported in Kentucky—a slight decrease from the previous year, in which 247 were reported to the Kentucky HIV/AIDS Surveillance Program. Among the new identified AIDS cases by the end of 2008, 80% are men and 20% are women. The annual AIDS diagnosis rate has been fairly steady over the past two decades with a high rate of 8.4% new cases in 1995 and a low rate of 4.2% in 2005. In 2007, Kentucky ranked 27th of the Annual AIDS Diagnosis Rate in the United States: Kentucky had an annual rate of 6.9%, which lies below the overall rate of the United States of 12.4%. The highest number of AIDS cases were found in Jefferson County with 2,131, followed by Fayette County with 671, and Kenton County with 241. With zero AIDS cases, Robertson County accounted for the lowest numbers of cases.[219]

Among the cumulative adult/adolescent AIDS cases, the highest transmission rate among females was heterosexual contact with a person with HIV or at risk for HIV, followed by injection drug use. Among men, the category *men having sex with men* accounted for the highest percentages. As Figure 29 demonstrates, 59% of White and African American women, 62% of Latinas, and 78% of other/unknown races/ethnicities were infected through heterosexual contact. Taking age into account, the highest proportion of AIDS diagnoses was given in the thirties for White (40%) and African American (42%) women, whereas Latinas only accounted for 24% in the thirties, yet for 47% in the twenties. Women of other/unknown races/ethnicities had equal distribution in the twenties, thirties, and forties at 33%.[220] It is important to note that the state has only tracked HIV numbers for three years and will admit that its numbers may not be

completely accurate. In addition, as the western part of the state has a large migrant population, which may or may not access services due to issues of language, culture, documentation and accessibility, these numbers may be underreported.[221]



Source: Kentucky Cabinet for Health and Family Services, 2008

Figure 29. **Proportions of cumulative female adult/adolescent AIDS cases by transmission category, race/ethnicity.**

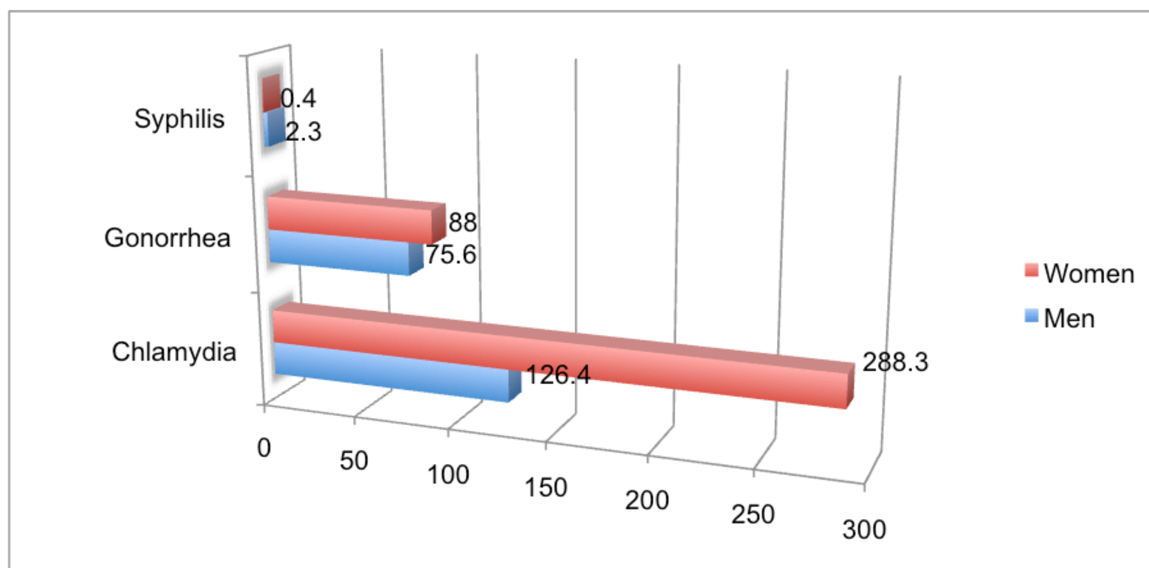
Sexually Transmitted Infections (STI). Sexually transmitted diseases or infections affect the population widely, with higher incidence among young adults age 15-24. Women have more severe and frequent health effects as a result of STDs/STIs, and can often have an STD/STI with no symptoms. STDs/STIs can lead to further health problems, including cancer, infertility, pregnancy complications, infections, organ damage, and death.[222]

There are various STIs; however, in this section only Chlamydia, Gonorrhea, and Syphilis are covered. Chlamydia is caused by the bacterium *Chlamydia trachomatis*. Although Chlamydia has very mild or absent symptoms, it can have damaging effects on a women's reproductive organs, causing irreversible damage, for example infertility. Gonorrhea is also caused by a bacterium, named *Neisseria gonorrhoeae*. This

bacterium grows in warm and moist areas, such as the reproductive tract in women, in the urinary tract in women and men, and in mouth, throat, eyes, and anus.[223]

Syphilis, caused by the bacterium *Treponema pallidum,* is transmitted "from person to person through direct contact with a syphilis sore."[224] These are usually located on lips and in the mouth or on external genitals, vagina, anus or in the rectum. Transmission happens during vaginal, anal, or oral sex. The disease can be passed on to the fetus during pregnancy. Condoms can help to prevent transmission only if the infected areas are covered.[225]

Figure 30 demonstrates that women have higher rates of Gonorrhea and Chlamydia cases than men. Chlamydia is for both genders the most prevalent sexually transmitted disease.



Source: Kaiser Family Foundation, State Health Facts

Figure 30. **Chlamydia, Gonorrhea, and Syphilis cases per 100,000 by gender in 2007**

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Concluding Thoughts

The process of conceptualizing, researching, and writing this report has brought to the surface certain issues and considerations. Our commitment to representing a holistic approach to health in this report is limited by the availability and specificity of the data. While information does not bring about change on its own, accurate and relevant information is integral to our ability to make informed decisions.

For example, in our experience, it is hard to find data by race, ethnicity and gender at the county or Area Development District level. This lack of data limits our understanding and ability to accurately represent underserved populations. It is hard to address health disparities and inequities without appropriate data collection. There was also inconsistency with the data available in terms of level (county, state). Some data has significant time lag and therefore limited our ability to present a current picture. Additionally, some data relevant to reproductive health and health inequity simply is not collected.

Better collection of data broken down by race/ethnicity and gender at the county or Area Development District level conducted more frequently would greatly enhance our ability to tackle the myriad health issues affecting Kentuckians.

Kentucky's population suffers from serious health problems that have been linked to the underlying, widespread inequities and unhealthy environments throughout the state. Research has shown the connection between poverty and negative health outcomes, and as a state historically affected by systemic poverty, we in Kentucky must address the root causes of our communities' ill health in order to bring about significant and sustainable change. For example, the county with the lowest high school graduation rate is also the third worst ranked county in terms of health outcomes, and 102 out of 120 in terms of health factors (including health behaviors, clinical care, social and economic factors, and physical environment). Further, the county with the lowest income is ranked 93 of 120 for health outcomes and 106 out of 120 for health factors.

This parallel between negative social determinants of health and health outcomes also holds true for rates of uninsured.[226]

While there is extensive research on the impact of poverty, education, and environmental toxicants on human health and quality of life, little of this research is applied in ways that involve or benefit vulnerable communities in a meaningful way. Given this reality, data reporting, collection, and application should be informed by the data's potential social impact.

As stated at the beginning of this report, policies and programs can help or undermine both determinants of health and health outcomes. Viewing existing state and local policies and programs through their potential to mitigate or exacerbate our physical and social environmental conditions can inform more coordinated, socially responsible, and evidence-based policies.

While we recognize and highlight the role and impact of policies and programs, as well as economic and political systems, we must also look at the role that cultural norms, practices, and expectations play in the opportunities, resources, and choices individuals and communities make and how these impact our overall health and well being.

Reproductive health is integral to overall health and well-being. It affects and is affected by multiple social, economic, and environmental factors interacting in complex ways in our communities. Reproductive justice offers us a lens through which we can view reproductive health as it plays out in real people's lives.

Reproductive health affects all of us in profound and long-lasting ways. As we step back and view the bigger picture, we see how every sector of society is related and influenced by others. We see that the roles and success of government, of non-profit, for-profit, volunteer, religious, academic, and community at large, depend on each other. This approach invites all of us, personally and professionally, to become involved in creating a just and healthy environment for today and tomorrow.

It is our hope that this report can be used to further public education, raise money to target specific areas related to reproductive justice, further advocate and lobby for social change, work with underserved communities, and build alliances and referrals among and between health and social service agencies that serve women in Kentucky.

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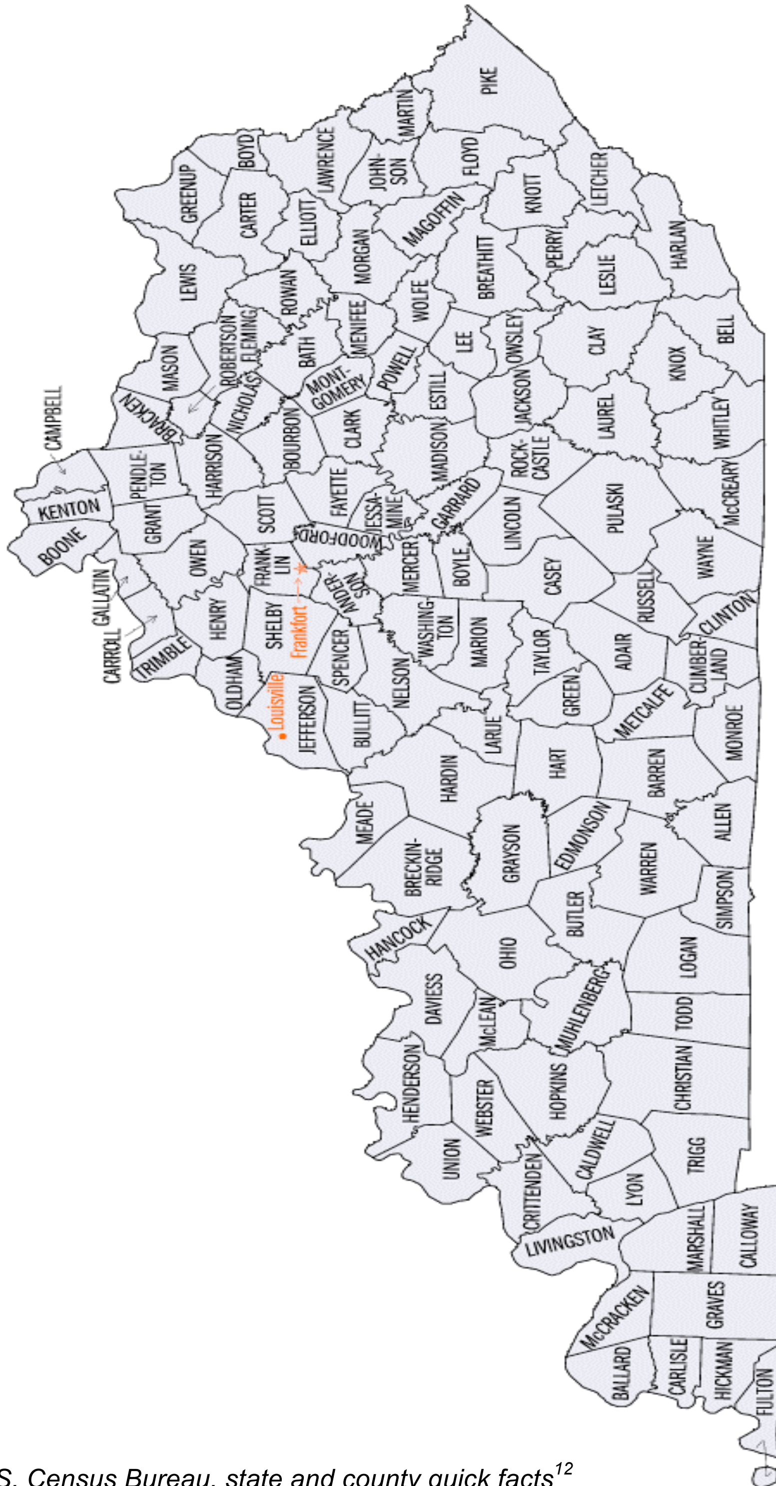
Appendix

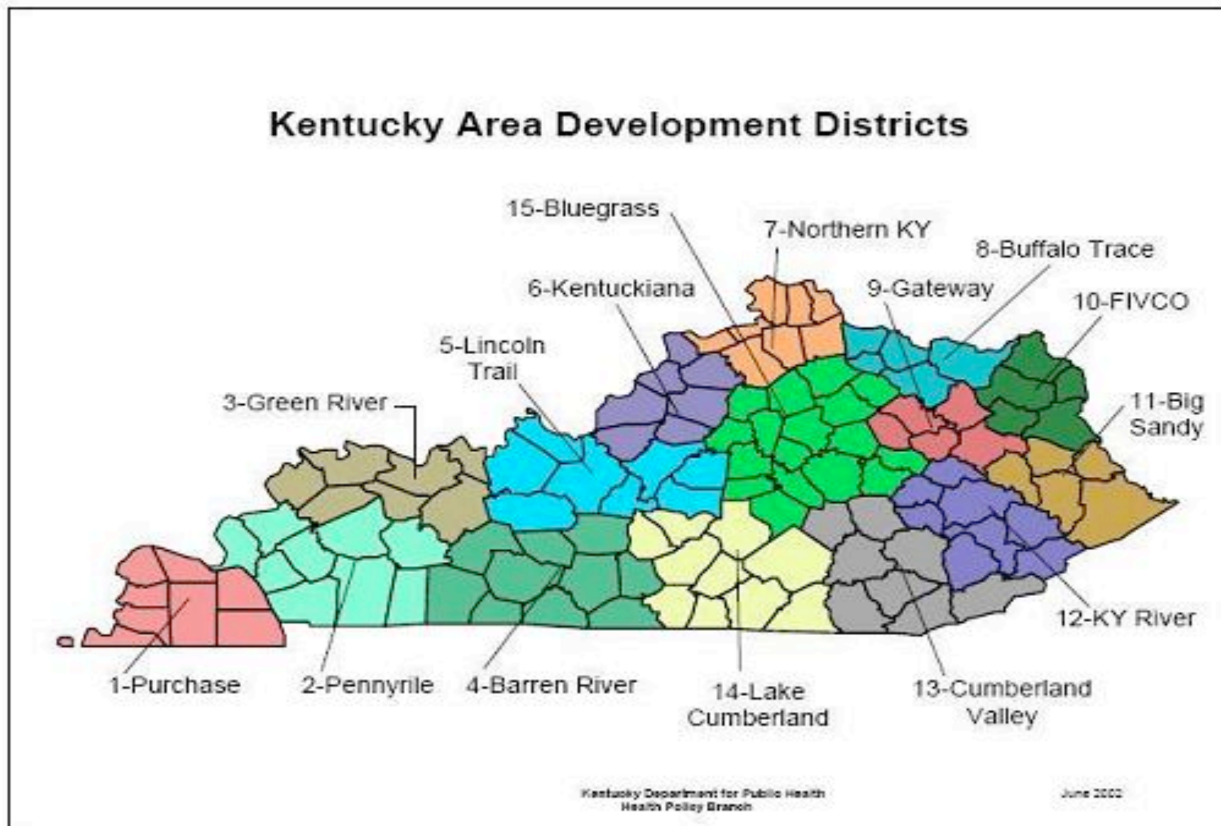
Kentucky County Map



Source: U.S. Census Bureau, state and county quick facts[12]

[12] For more information, please visit http://quickfacts.census.gov/qfd/maps/kentucky_map.html

Kentucky Area Development District Map



Source: Kentucky Cabinet for Health and Family Services, Kentucky Area Development Districts Map[13]

[13] For more information, please visit https://publicreports.chfs.ky.gov/healthdata/Kentucky%20Area%20Development%20Districts%20_Map.aspx

Table 1

Community Based HIV and AIDS Prevention Resources[14]

Name of Program	Service Areas/Location	Services
The Aids Project	Louisville (local bars, community fairs, special events)	HIV prevention, education, testing
AIDS Services Center Coalition (ASCC)		Provides direction to public to appropriate AIDS service agencies; literature, resource directory; volunteer network
AIDS Volunteers, INC. (AVOL)	Central & Eastern Kentucky	HIV/AIDS education, prevention initiatives, service programs, financial assistance for people living with or affected by HIV/AIDS
AIDS Volunteers of Northern Kentucky (AVNK)	Northern Kentucky	Addressing emotional, educational, social, spiritual, physical needs of people living with HIV/AIDS and their families, partners, friends, caregivers
The American Red Cross (ARC)	Kentucky-wide	Literature, AIDS 101 training, peer training for adolescents, African American, Hispanic AIDS 101 training, rural/church leaders AIDS 101 training, prison personnel training, AIDS in the Workplace
Bluegrass Care Clinic (BCC)	Central and Eastern Kentucky	Clinical and support services for HIV/AIDS patients and their families: harm reduction information, counseling about transmission
Bluegrass Farmworker Health Center (BFHC)	Fayette, Scott, Bourbon, Clark, Madison, Garrard, Jessamine, Woodford Counties	Primary and preventive health services, including service around HIV/AIDS to migrant/seasonal farm workers
Harlan Countians for a Healthier Community	Harlan County	Coalition of health care providers, consumers, other agencies to improve health care in Harlan County
Hazard Perry County Community Ministries	Hazard, Perry County	Supportive services, including case management and outreach, crisis aid, homeless shelter, transitional housing, and childcare
Heartland CARES, Inc.	Western Kentucky and Southern Illinois	Provision of various components of care to individuals infected by HIV/AIDS, of education, prevention to general public to stop spread of HIV/AIDS; medical service, Care Coordinator Program, Housing Opportunities for People with AIDS Grant Emergency Assistance, SAMSHA Grant, HOME Grant, KY Prevention Team
House of Ruth	Louisville/Jefferson County	Social, emotional, financial support to people living with HIV/AIDS
The I.N.D.Y (I'm not dead yet) project	Northern Kentucky	Enhancement of life for people with HIV/AIDS: picnics, movie nights, dinner, camping, art events, parties
Matthew 25 AIDS Services, Inc.	Daviess, Henderson, Union, Webster Counties	Medical case management, referrals, buddy program, literature, spiritual support, financial assistance, speaker's bureau, support groups, transportation, prevention education to community/medical professionals
Moveable Feast—Lexington (MFL)	Lexington/Fayette County	Nutritional support program: social support and free hot, freshly cooked dinner 5 days a week for individuals with HIV/AIDS and their dependent children; referral service to other CBOs
North Central AHEC/HETC	Northern and Central Kentucky	Educational support services to health profession students and health care providers, community health education, outreach to Hispanic and African American communities
Owensboro Area HIV/AIDS Task Force, Inc.	Owensboro area	Emergency financial assistance, transitional housing, advocate with property owners, utility companies, Social Security, HOPWA, and other community service agencies, community outreach services, including HIV prevention and risk reduction programs, support group, referrals
Sisters and Brothers Surviving AIDS (SABSA)	Louisville	Support group for HIV positive people, friends and families, including educational and emotional support
Stop AIDS	Cincinnati and Southwest Ohio, Northern Kentucky	Community outreach, prevention and education presentations, street outreach to women in underserved communities, testing, counseling, informational and referral hotline, speaker's bureau
The University of Cincinnati Emergency	Cincinnati	HIV testing counseling services to people seen in ER; referral to Holmes Clinic

[14] For more information to these service providers, please visit http://chfs.ky.gov/dph/epi/HIVAIDS/resources/CBOResources.htm
This list has not been updated recently. AVOL lost its state contract two years ago; we offer different services than those listed as we too for the last few years are a recognized site for rapid testing; it doesn't include either the Hispanic Alliance of Greater Owensboro or the Coalition for Community Health in Owensboro—both are coalitions of providers and consumers who advocate or provide healthcare in the greater Daviess county area (Christophre Woods, personal communication, January 30, 2009).

Room		
University of Cincinnati Hospital, Holmes Clinic	Cincinnati, Northern Kentucky	Medical services
Volunteers of America, inc. (VOA)	Louisville	Education, focus groups, risk reduction workshops to drug users, men, women, youth at risk; pre-test/post-test counseling, HIV testing, information about reduction of HIV risk factors, alcohol and drug abuse assessments, referrals, AIDS Housing Integration Project, case management for people with HIV
Westlake Primary Care	Located in Columbia	Information and educational AIDS materials, prevention kits with condoms, testing, and pre-/post-test counseling
WINGS Clinic	Located in Louisville	HIV counseling, testing; primary HIV medical service; client advocacy/financial eligibility services; mental health and substance abuse screening, assessment, treatment, referral, case management; nutritional assessment and referral; oral health care referrals; on-site consultation with pharmacist; referral to other specialty care; access to clinical drug trials

Source: Kentucky Cabinet for Health and Family Services, Department for Public Health, HIV/AIDS

Table 2

State Mental Health and Substance Abuse Agencies

	Resources
State Mental Health Agency	Information about admission, care, treatment, release, and patient follow-up in public or psychiatric residential facilities
State Substance Abuse Agency	Information about care and treatment of abuse disorders
State Protection and Advocacy Agency	Funded by Federal Center for Mental Health Services; protection of and advocacy for rights of people with mental illnesses; investigation of reports of abuse and neglect in (public or private) facilities, such as hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails, and prisons; investigation of issues that occur during transportation or admission to facilities, during residency, or within 90 days after discharge from facility
Family Support	The Center for Mental Health Services provides funding to family-run networks to support and inform families of children and adolescents with emotional, behavioral, or mental disorders
Centers for Medicare und Medicaid Services (CMS)	Investigation of some complaints about treatment facilities that receive Medicare and Medicaid funding
Advocacy Organizations	Local chapters of Mental Health America provide information about community services and advocacy on national and State level
The National Alliance of Mental Health	Helpline for information on mental illnesses and referrals to local groups; local self-help groups provide support and advocate and educate and inform about community services for families and individuals
Kentucky Consumer Advocacy Network	Statewide consumer organizations that are run by and for consumers of mental health services and promote consumer empowerment; information about mental health and support services at the State level; advocacy for mental health system issues
The National Mental Health Consumers' Self-Help Clearinghouse	Funded partly by the Center for Mental Health Services; promotion and development of consumer self-help groups across the country; technical assistance and materials available on organizing groups, fundraising, leadership development, public relations, advocacy, networking
The National Empowerment Center	Run by mental health consumers and survivors; represent recovery, empowerment, hope, and healing to people suffering from mental illness; information and referrals to consumer/survivor resources; provides technical assistance to individuals and groups that are active in consumer empowerment; distribution of publications and sponsors education and training activities
Consumer Organization & Networking Technical Assistance Center	Funded by the Center for Mental Health Services; resource center for consumers/survivors and consumer-run organizations; provides information materials, on-site training and skill-building curricula; electronic and other communication capabilities; networking and other activities promoting self-help, recovery, leadership, business management, and empowerment
Other Sources	For example mental health authority, branches of local government, family physician/area hospital, local bar association, local library and telephone yellow pages for lists of resources

Source: SAMHSA, National Mental Health Information Center[15]

[15] For more information http://mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/Kentucky01.asp

Table 3

Community Mental Health Centers in Kentucky

CMHC	Counties served
Adanta 259 Parkers Mill Road Somerset, KY 42502	Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne
Bluegrass 351 Newtown Pike Lexington, KY 40511	Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford
Communicare, Inc. 107 Cranes Roost Court Elizabethtown, KY 42701	Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington
Comprehend, Inc. 611 Forest Avenue Maysville, KY 41056	Bracken, Fleming, Lewis, Mason, Robertson
Cumberland River P.O. Box 568 Corbin, KY 40702-0568	Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
Four Rivers Behavior Health 425 Broadway Suite 201 Paducah, KY 42001	Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, Marshall, McCracken
Kentucky River Community Care, Inc 115 Rockwood Lane Hazard, KY 41701	Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe
Lifeskills, Inc P.O. Box 6499 Bowling Green, KY 42102-6499	Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren
Mountain Comp. Care Center 50 South Front Avenue Prestonsburg, KY 41653	Floyd, Johnson, Magoffin, Martin, Pike
NorthKey P.O. Box 2680 Covington, KY 41012	Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton
Pathways, Inc P.O. Box 790 Ashland, KY 41101	Bath, Boyd, Carter, Elliot, Greenup, Lawrence, Menifee, Montgomery, Morgan, Rowan
Pennyroyal Regional Center P.O. Box 614 Hopkinsville, KY 42241-0614	Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, Trigg
River Valley Behavior Health P.O. Box 1637 Owensboro, KY 42302-1637	Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster
Seven Counties Services, Inc. 101 W. Muhammad Ali Boulevard Louisville, KY 40202	Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble

Source: Kentucky Cabinet for Health and Family Services, Department of Behavioral Health, Developmental and Intellectual Disabilities[16]

[16] For more information, please visit http://mhmr.ky.gov/CMHC/cmhcinfo.asp