2024

Health of Women and Children Report

AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

This report is complemented by the *2024 Maternal and Infant Health Disparities Data Brief*, which sought to more deeply understand disparities in several of the key outcome measures included in this report, such as maternal mortality and severe maternal morbidity. The brief provides detailed State Profiles which include disparities and trends over time in these and other measures.

For the first time, the *Health of Women and Children Report* examines health disparities among women by disability status, sexual orientation and veteran status. The report also includes four new measures: congenital syphilis, mental health conditions and mental health treatment among children, and mentorship of children.

Supporting Healthy People 2030: Measuring Health Disparities and Health Equity

Healthy People 2030 is a program led by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services (HHS) that sets data-driven national objectives for the nation's health and well-being over the next decade, with a key focus on addressing the social determinants of health and working toward health equity. For nearly five decades, Healthy People's national-level objectives have served as valuable benchmarks for advancing health and well-being at the state level. It also provides data to track the nation's progress toward achieving those goals, as well as tools that help guide individuals, organizations and communities to do so.

As a long-standing champion of public health and the HHS Healthy People 2030 goals, the United Health Foundation is honored to be recognized as a Healthy People 2030 Champion.

Contents

Call to Action

The *2024 Health of Women and Children Report* spotlights the various factors that influence the health of women and children, underscoring the importance of the social drivers of health to the well-being of our communities. By taking a proactive and preventive approach to health, supporting the health care workforce and ensuring everyone has access to the resources and care they need to thrive, we can address health challenges before they worsen. We encourage policymakers, advocates, community leaders and individuals to use these findings to advance better health and well-being for all women and children nationwide.

The United Health Foundation is proud to release the *America's Health Rankings® 2024 Health of Women and Children Report*, which provides a comprehensive look at the health of women of reproductive age and children nationwide and on a state-by-state basis

Monitoring and supporting the health and well-being of women of reproductive age and children is a cornerstone of public health. By promoting a proactive and preventive approach to health, addressing persistent and emerging challenges and supporting the health care workforce, the nation can improve the health of these two populations and the well-being of individuals, families and communities. In 2022, there were approximately 59.2 million women of reproductive age (18-44) and 72.5 million children younger than 18 in the United States, together making up around 40% of the population.

Women faced challenges across various health outcomes, including behavioral and physical health measures such as rising rates of drug deaths and obesity. There were several bright spots in children's health, including decreases in the teen suicide rate and overweight and obesity prevalence among youth. These were offset in part by continued challenges like the child mortality rate, which increased for the third consecutive year – reaching a new high in the history of the *Health of Women and Children Report*.

The data also highlight several measures returning toward pre-pandemic levels after worsening or improving during the COVID-19 pandemic. These include unemployment, frequent physical distress, insufficient sleep and flu vaccination among women, and early education enrollment and neighborhood amenities among children. Additionally, the mortality rate for women improved between 2021 and 2022 after rising due to COVID-19.

The *2024 Health of Women and Children Report* finds that:

- Child and maternal mortality both worsened, while the overall mortality rate among women improved. All mortality measures had significant disparities by race/ethnicity and geography. Firearm deaths, an indicator of community and family safety, have been increasing among women of reproductive age and children.
- Behavioral and mental health challenges among women continued to grow, with increases in the drug death rate and the prevalence of depression and frequent mental distress.
- The prevalence of mental health conditions among children increased, while mental health treatment among children remained stable and the teen suicide rate improved.
- Some physical health measures improved while others worsened. Rates of severe maternal morbidity, asthma and obesity among women rose. However, the prevalence of youth who are overweight or have obesity improved. Among newborns, cases of congenital syphilis increased, but cases of neonatal abstinence syndrome decreased.
- Cigarette smoking among women, smoking during pregnancy and household smoke exposure among children improved.
- Early childhood education enrollment increased after having declined substantially between 2019 and 2021 during the COVID-19 pandemic. However, food sufficiency among children worsened.
- Several measures of access to care improved. The uninsured rate among women and children decreased, and the number of pediatricians per 100,000 children increased. However, other clinical care measures, including low-risk cesarean delivery, adequate prenatal care and well-woman visit, did not significantly change.

Objective

America's Health Rankings aims to inform and drive action to build healthier communities by offering credible, trusted data that can guide efforts to improve population health and health care. To achieve this, *America's Health Rankings* collaborates with an advisory committee to determine the selection of a comprehensive set of measures. The *2024 Health of Women and Children Report* is based on:

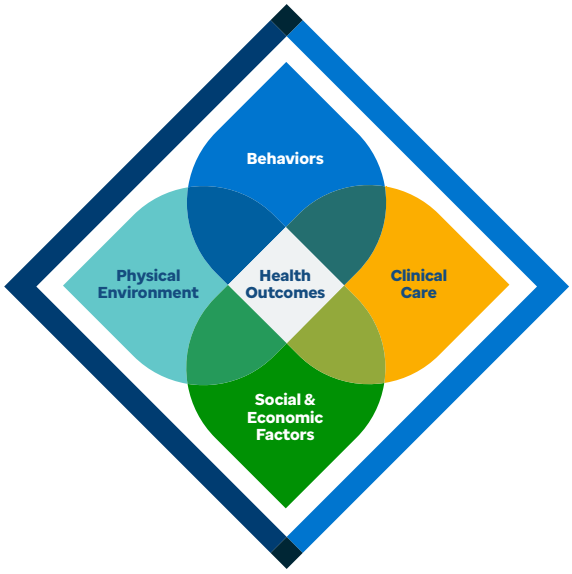
- **Measures: 123.** These include 82 measures included in the state ranking calculation and 41 additional (unweighted) measures not included in the state rankings. For a complete list of measures, definitions and source details, see the Measures Table.
- **Categories of health: five.** The report analyzes health and well-being holistically through measures of Health Outcomes and four categories of drivers of health: Social and Economic Factors, Physical Environment, Behaviors and Clinical Care.
- **Data sources: 33.** Data are from many sources, including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and Pregnancy Risk Assessment Monitoring System, March of Dimes, the National Survey of Children's Health and the U.S. Census Bureau's American Community Survey.

The *America's Health Rankings Health of Women and Children Report* aims to improve population health by:

- **Presenting a holistic view of health.** This report goes beyond measures of clinical care and health behaviors by considering social, economic and physical environment measures, reflecting the impact of social drivers of health.
- **Providing a benchmark for states.** Each year since its first publication, the report has presented strengths, challenges and key findings for each state and the District of Columbia. Public health advocates can monitor health trends over time and compare their state with other states or the nation. State Summaries containing data on all 82 ranking and 41 unweighted measures are available on the website as a separate download.
- **Highlighting disparities.** The report shows differences in health between states and among demographic groups at state and national levels, with groupings based on race/ethnicity, gender, age, disability status, educational attainment, income level, metropolitan status, sexual orientation and veteran status. These analyses often reveal differences among groups that national or state aggregate data may mask.
- **Stimulating action.** The report aims to drive change and improve health by promoting data-driven discussions among individuals, community leaders, public health workers, policymakers and the media. States can incorporate the report into their annual review of programs, and many organizations use it as a reference when assigning goals for health improvement plans.

Model for Measuring America's Health

America's Health Rankings is built upon the World Health Organization's definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The model was developed under the guidance of the *America's Health Rankings'* advisory council and committees, with insights from other rankings and health models, namely County Health Rankings & Roadmaps and Healthy People 2030. The model serves as a framework across all *America's Health Rankings* reports for identifying and quantifying health drivers and outcomes that impact state and national population health.



National Snapshot

Returning Toward Pre-Pandemic (2019) Levels

Unemployment Among Women*

31%▼

decrease from 5.2% to 3.6% of the female civilian workforce between 2021 and 2022.

Frequent Physical Distress Among Women**

15%▲

increase from 7.5% to 8.6% of women ages 18-44 between 2019-2020 and 2021-2022.

Health Outcomes

14%▲

Mortality Among Children†

increase from 25.4 to 29.0 deaths per 100,000 children ages 1-19 between 2017-2019 and 2020-2022.

12%▼

Mortality Among Women†

decrease from 136.4 to 120.0 deaths per 100,000 women ages 20-44 between 2021 and 2022.

34%▲

Maternal Mortality††

increase from 17.3 to 23.2 deaths per 100,000 live births between 2014-2018 and 2018-2022.

11%▲

Depression Among Women**

increase from 26.1% to 29.1% of women ages 18-44 between 2019-2020 and 2021-2022.

6%▼

Teen Suicide†

decrease from 11.2 to 10.5 deaths per 100,000 adolescents ages 15-19 between 2017-2019 and 2020-2022.

12%▲

Mental Health Conditions Among Children‡

increase from 17.7% to 19.9% of children ages 6-17 between 2020-2021 and 2022-2023.

8%▲

Obesity Among Women**

increase from 30.4% to 32.7% of women ages 18-44 between 2019-2020 and 2021-2022.

6%▼

Overweight or Obesity Among Youth‡

decrease from 33.2% to 31.1% of youth ages 10-17 between 2020-2021 and 2022-2023.

* Source: U.S. Department of Labor, Bureau of Labor Statistics.
** Source: CDC, Behavioral Risk Factor Surveillance System.
† Source: CDC WONDER, Multiple Cause of Death Files.
†† Source: HHS, HRSA MCHB, Federally Available Data.
‡ Source: HHS, HRSA MCHB, National Survey of Children's Health.
‡‡ Source: U.S. Census Bureau, American Community Survey.
§ Source: CDC WONDER, Natality Public Use Files.

Social and Economic Factors

37%▲
Firearm Deaths Among Children†
increase from 4.3 to 5.9 deaths per 100,000 children ages 1-19 between 2017-2019 and 2020-2022.

27%▲
Firearm Deaths Among Women†
increase from 4.8 to 6.1 deaths per 100,000 women ages 20-44 between 2017-2019 and 2020-2022.

16%▲
Early Childhood Education‡‡
increase from 40.2% to 46.7% of children ages 3-4 between 2021 and 2022.

6%▼
Food Sufficiency Among Children‡
decrease from 71.9% to 67.3% of children ages 0-17 between 2020-2021 and 2022-2023.

Behaviors

20%▼
Smoking During Pregnancy§
decrease from 4.6% to 3.7% of women with a recent live birth between 2021 and 2022.

16%▼
Smoking Among Women**
decrease from 13.4% to 11.2% of women ages 18-44 between 2019-2020 and 2021-2022.

Clinical Care

8%▼
Uninsured Women‡‡
decrease from 11.8% to 10.9% of women ages 19-44 between 2021 and 2022.

6%▼
Uninsured Children‡‡
decrease from 5.4% to 5.1% of children younger than 19 between 2021 and 2022.

Returning Toward Pre-Pandemic (2019) Levels

Insufficient Sleep Among Women**

9%▲

increase from 33.4% to 36.5% of women ages 18-44 between 2020 and 2022.

Neighborhood Amenities Among Children‡

6%▲

increase from 35.9% to 38.0% of children ages 0-17 between 2020-2021 and 2022-2023.

** Source: CDC, Behavioral Risk Factor Surveillance System.
† Source: CDC WONDER, Multiple Cause of Death Files.
†† Source: HHS, HRSA MCHB, Federally Available Data.
‡ Source: HHS, HRSA MCHB, National Survey of Children's Health.
‡‡ Source: U.S. Census Bureau, American Community Survey.
§ Source: CDC WONDER, Natality Public Use Files.

Findings

Several measures of behavioral and physical health among women worsened, like depression and severe maternal morbidity. Mortality among children also worsened. However, several other measures of children's health improved, including teen suicide and the prevalence of youth who are overweight or have obesity.

HEALTH OUTCOMES | MORTALITY

Overall mortality improved among women of reproductive age. In contrast, rates of maternal mortality and mortality among children worsened.

Mortality Among Women

Women in the United States have a higher rate of preventable deaths than women living in other high-income countries.[1] In 2022, the 10 leading causes of death for women ages 20-44 were unintentional injuries (led by poisoning and motor vehicle accidents), cancer, heart disease, suicide, chronic liver disease/cirrhosis, homicide, COVID-19, diabetes, cerebrovascular diseases and deaths associated with pregnancy and childbirth.[2,3] The number of COVID-19 deaths among women ages 20-44 dropped from approximately 8,700 to 2,300 between 2021 and 2022, shifting the disease from the second to the seventh most common cause of death.

Changes over time. Nationally, mortality among women – the number of deaths per 100,000 females ages 20-44 – decreased 12%, from 136.4 to 120.0 between 2021 and 2022, after increasing 16% between 2020 and 2021. In 2022, about 66,000 women of reproductive age died in the U.S., a decrease of 8,400 deaths compared with 2021. Rates decreased 26% among Hawaiian/Pacific Islander (240.9 to 178.0 deaths per 100,000 women ages 20-44), 17% among Hispanic (97.3 to 81.0), 14% among Black (222.7 to 192.3), 12% among American Indian/Alaska Native (423.4 to 370.5) and 10% among white (138.8 to 124.8) women.

The mortality rate decreased in 20 states, led by: 23% in Alabama (212.3 to 163.1 deaths per 100,000 women ages 20-44), 22% in Mississippi (244.4 to 189.9) and 21% in Florida (159.4 to 125.4).

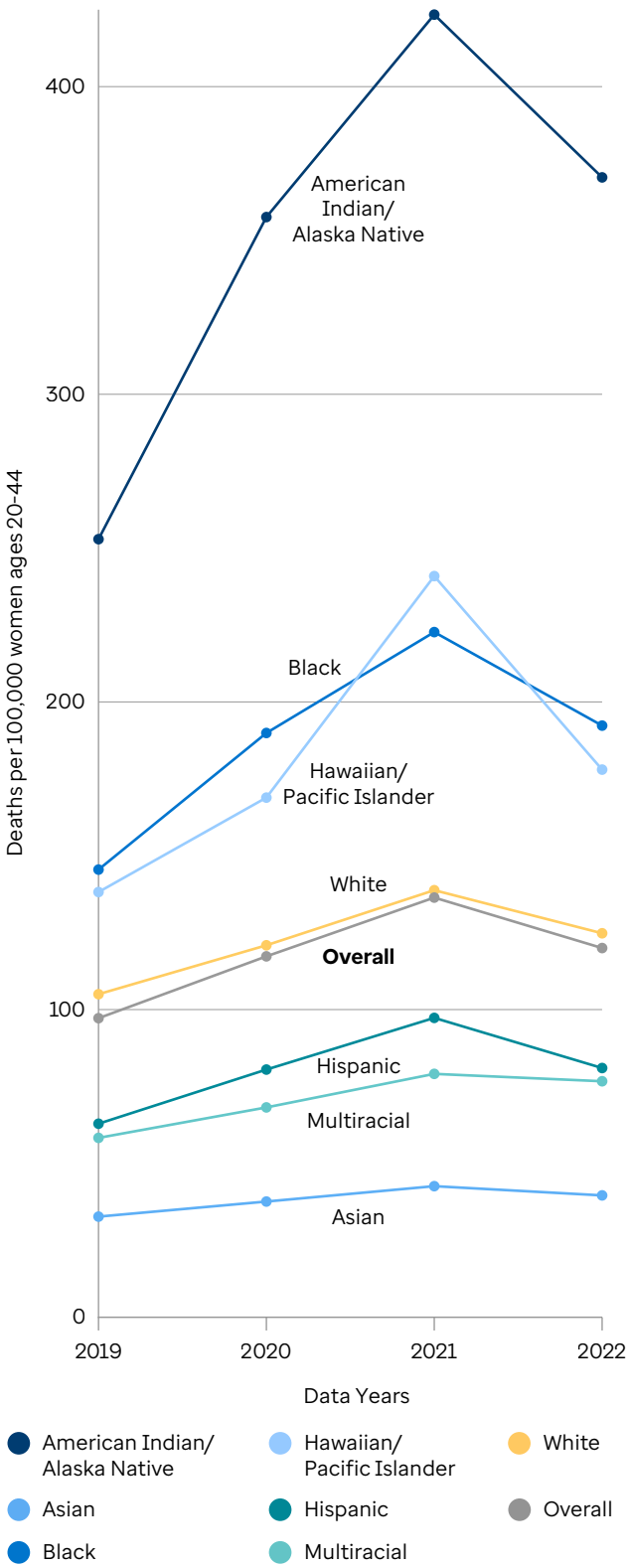
Disparities. The mortality rate significantly varied by race/ethnicity and geography in 2022. The rate was:

- 9.4 times higher among American Indian/Alaska Native (370.5 deaths per 100,000 women ages 20-44) than Asian (39.6) women. The disparity between these two groups was wider in 2022 than in 2019 (7.7).
- 2.9 times higher in West Virginia (224.8) than Hawaii (78.7).

Note: The maternal mortality 2014-2018 and 2018-2022 comparison contains an overlapping data year (2018); thus, the comparison is mainly between the non-overlapping years (2014-2017 and 2019-2022). The values for American Indian/Alaska Native, Black and Hawaiian/Pacific Islander women may not differ significantly based on overlapping 95% confidence intervals. The same is true for multiracial, Asian and Hispanic women; women younger than 20, women ages 20-24 and women ages 25-29; and women with less than a high school education and high school graduates.

Changes in Mortality Among Women

By Race/Ethnicity Between 2019 and 2022



Source: CDC WONDER, Multiple Cause of Death Files, 2019-2022.

Related Measure: Maternal Mortality

Nationally, maternal mortality – the number of deaths related to or aggravated by pregnancy (excluding accidental or incidental causes) occurring within 42 days of the end of a pregnancy per 100,000 live births – increased 34%, from 17.3 to 23.2 between 2014-2018 and 2018-2022. The rate exceeds the Healthy People 2030 national target of 15.7 deaths per 100,000. Approximately 4,300 maternal deaths occurred in 2018-2022, about 900 more deaths than in 2014-2018.

Disparities. The maternal mortality rate significantly varied by race/ethnicity, geography, age and educational attainment in 2018-2022. The rate was:

- 4.4 times higher among American Indian/Alaska Native (58.0 deaths per 100,000 live births) than multiracial (13.1) women.
- 3.9 times higher in Tennessee (41.1) than California (10.5).
- 3.4 times higher among women age 35 and older (48.1) than those ages 20-24 (14.0).
- 3.0 times higher among women who graduated from high school (36.2) than college graduates (12.2).

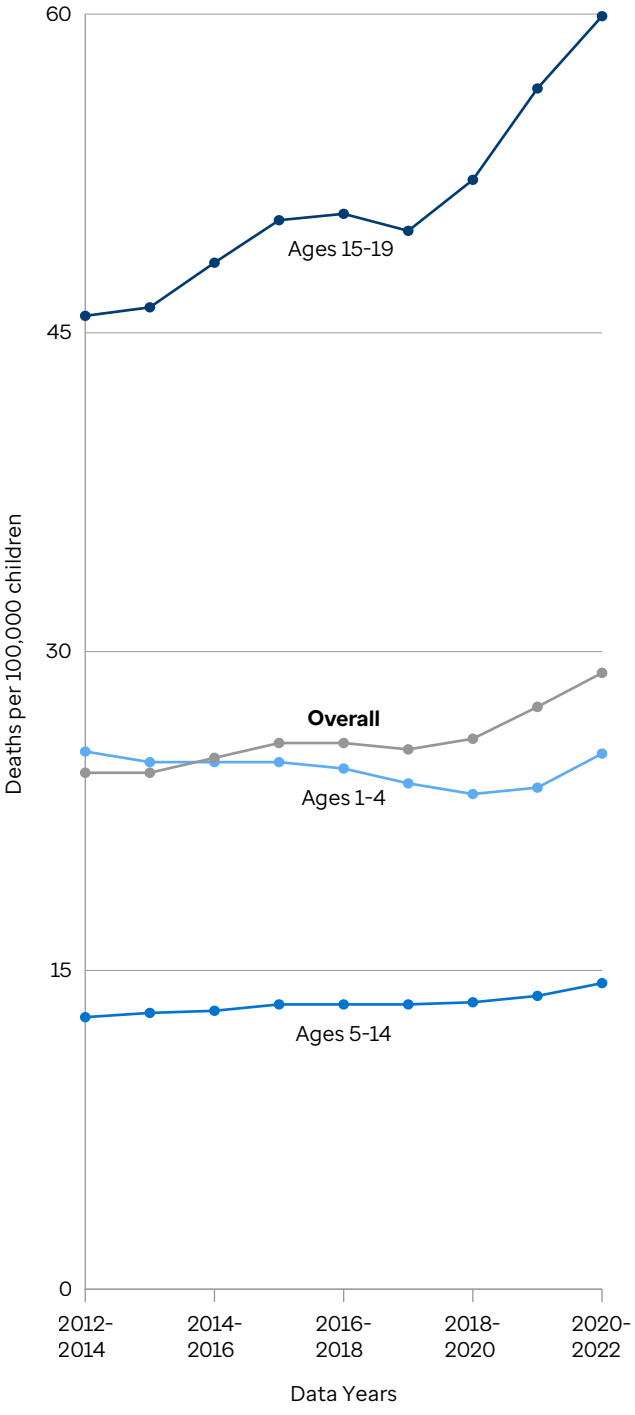
I always knew I wanted to work with children. I realized that providing the best outcomes for them starts with taking care of moms. That's why I focus on postpartum care as a mental health nurse right now. I've seen too many moms suffering in silence, afraid to speak up about the challenges they face. Midwifery training allows me to really listen to these patients, ensuring they get care so moms and babies can thrive.

Yamilee, RN, a Diversity in Health Care scholar pursuing a DNP in midwifery

United Health Foundation Diversity in Health Care Scholar

Changes in Mortality Among Children

By Age Between 2012-2014 and 2020-2022



Source: CDC WONDER, Multiple Cause of Death Files, 2012-2022.

Mortality Among Children

In 2020-2022, the leading causes of death among children ages 1-19 in the U.S. were accidents (unintentional injuries), homicide, suicide, cancer and congenital abnormalities. Many of these types of deaths are often preventable.[4] The leading causes of injury death (both intentional and unintentional) among children in 2020-2022 were firearms, followed by motor vehicle traffic accidents and poisoning.[5] The U.S. is the only nation among its economic peers where firearms are the leading cause of child mortality.[6]

Changes over time. Nationally, child mortality – the number of deaths per 100,000 children ages 1-19 – increased 14%, from 25.4 to 29.0 between 2017-2019 and 2020-2022. This increase is larger than the increase featured in the *2023 Health of Women and Children Report* and exceeds the Healthy People 2030 target of 18.4 deaths per 100,000 population. About 68,000 children died in the U.S. during 2020-2022, an increase of 8,000 deaths since 2017-2019. Rates increased among all age and gender groups. By group, the largest increases between 2017-2019 and 2020-2022 were:

- 20% among children ages 15-19 (49.8 to 59.9 deaths per 100,000 children), 7% among children ages 5-14 (13.4 to 14.4) and 6% among children ages 1-4 (23.8 to 25.2).
- 16% among boys (32.3 to 37.5) and 12% among girls (18.1 to 20.2).

During the same period, the child mortality rate increased in 22 states. The largest increases were: 37% in Montana (33.4 to 45.7 deaths per 100,000 children ages 1-19), 29% in Louisiana (36.8 to 47.3) and 25% in North Carolina (26.7 to 33.4).

Disparities. The child mortality rate significantly varied by race/ethnicity, age and geography in 2020-2022. The rate was:

- 4.3 times higher among American Indian/Alaska Native (60.7 deaths per 100,000 children ages 1-19) compared with Asian (14.0) children.
- 4.2 times higher among children ages 15-19 (59.9) than those ages 5-14 (14.4).
- 3.1 times higher in Mississippi (49.4) than Massachusetts (15.8).

Note: The values for American Indian/Alaska Native and Black children may not differ significantly based on overlapping 95% confidence intervals.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Many behavioral health measures worsened for women. Among children, diagnoses of mental health conditions increased and teen suicide rates improved.

Drug Deaths Among Women

Heavy drug use and overdoses are costly to society, burdening individuals, families, the health care system and the economy.[7] The opioid epidemic has contributed to a decline in overall life expectancy in the U.S.[8] Though this measure includes deaths from all drug deaths, opioids – fentanyl in particular – are the most significant contributor.[9] More than 76% of drug deaths in 2022 involved an opioid.[10]

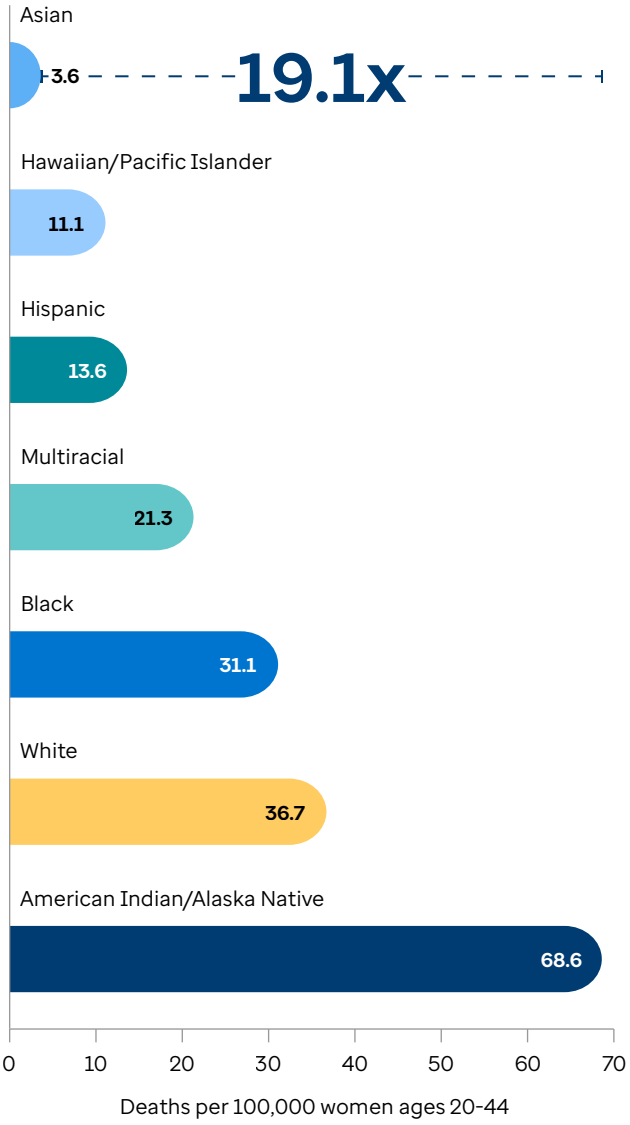
Changes over time. Nationally, the drug death rate – death due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 females ages 20-44 – increased 38%, from 20.7 to 28.6 between 2017-2019 and 2020-2022. This increase exceeded the 27% increase featured in last year's report. The rate is higher than the Healthy People 2030 target of 20.7 deaths per 100,000 population. In 2020-2022, nearly 46,900 women of reproductive age died in the U.S. from a drug overdose, an increase of 13,500 deaths since 2017-2019. The drug death rate increased in 35 states and the District of Columbia. The largest increases were: 113% in Mississippi (12.6 to 26.9 deaths per 100,000 women ages 20-44), 111% in North Dakota (12.3 to 26.0) and 101% in Oregon (11.0 to 22.1).

Disparities. The drug death rate significantly varied by race/ethnicity, geography and age in 2020-2022; all disparities were wider than they were in 2019-2021. The rate was:

- 19.1 times higher among American Indian/Alaska Native (68.6 deaths per 100,000 women ages 20-44) compared with Asian women (3.6).
- 10.2 times higher in West Virginia (91.2) than Hawaii (8.9).
- 2.4 times higher among women ages 35-44 (35.5) than those ages 20-24 (15.0).

Drug Deaths Among Women

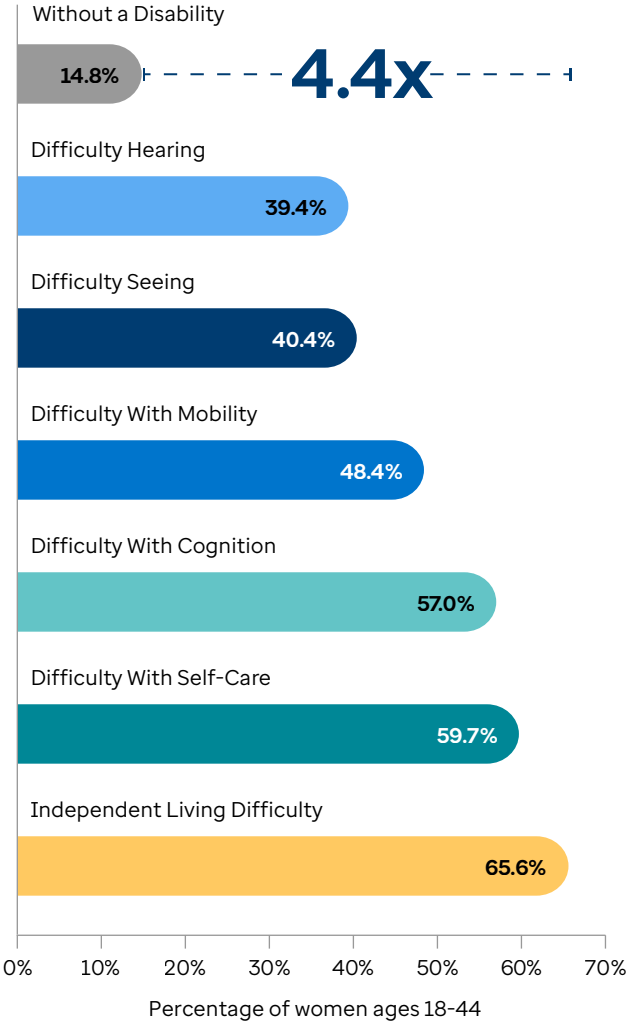
By Race/Ethnicity in 2020-2022



Source: CDC WONDER, Multiple Cause of Death Files, 2020-2022.

Frequent Mental Distress Among Women

By Disability Status in 2021-2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2021-2022.

Frequent Mental Distress Among Women

Chronic stressors like housing insecurity, food insecurity and insufficient sleep are associated with frequent mental distress, a self-reported measure representing the population experiencing persistent and severe mental health issues.[11] In severe cases, poor mental health can lead to suicide, one of the leading causes of death in the U.S.[12,13]

Changes over time. Nationally, the percentage of women ages 18-44 who reported their mental health was not good 14 or more days in the past 30 days increased 18%, from 19.4% to 22.9% between 2019-2020 and 2021-2022, larger than the 16% increase featured in last year's report. The prevalence increased across all income and age groups and some educational attainment groups, as well as among women living in both metropolitan and non-metropolitan areas during this time frame. By group, the largest increases were:

- 38% among women with an annual household income of $50,000-$74,999 (16.7% to 23.1%), 26% among women with incomes of $75,000 or more (12.0% to 15.1%), 20% among women with incomes of $25,000-$49,999 (20.3% to 24.4%) and 17% among women with incomes less than $25,000 (24.8% to 28.9%).
- 20% among women ages 18-24 (24.5% to 29.4%), 19% among women ages 25-34 (19.1% to 22.8%) and 17% among women ages 35-44 (16.0% to 18.7%).
- 21% among women who graduated from college (13.5% to 16.3%) and women with some post-high school education (20.8% to 25.1%), and 19% among women who graduated from high school (19.1% to 22.7%).
- 17% among women living in non-metropolitan areas (21.9% to 25.6%) and 15% among women living in metropolitan areas (19.6% to 22.6%).

During this time frame, the prevalence of frequent mental distress increased in 20 states. The largest increases were: 46% in Alaska (15.8% to 23.0%), 43% in Wisconsin (18.5% to 26.4%) and 37% in Idaho (19.3% to 26.5%).

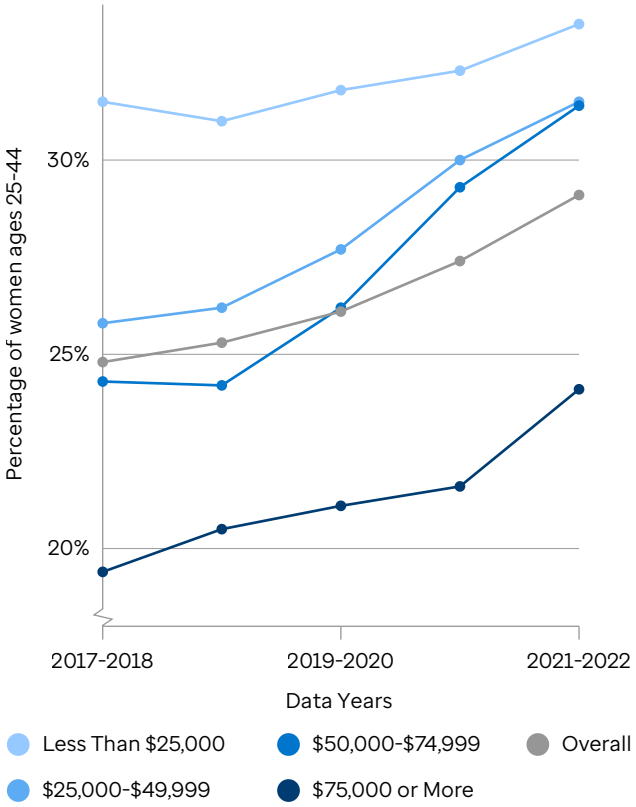
Disparities. Frequent mental distress significantly varied by disability, sexual orientation, race/ethnicity, income, geography, age and educational attainment in 2021-2022. The prevalence was:

- 4.4 times higher among women with independent living difficulty (65.6%) than those without a disability (14.8%).
- 2.2 times higher among LGBQ+ (43.0%) than straight (19.3%) women.
- 2.2 times higher among multiracial (33.2%) compared with Asian (15.1%) women.
- 1.9 times higher among women with an annual household income less than $25,000 (28.9%) than those with incomes of $75,000 or more (15.1%).
- 1.8 times higher in Tennessee (30.5%) than Hawaii (16.6%).
- 1.6 times higher among women ages 18-24 (29.4%) than those ages 35-44 (18.7%).
- 1.5 times higher among women with some post-high school education (25.1%) than college graduates (16.3%).

Note: The values for women with independent living difficulty and those who have difficulty with self-care may not differ significantly based on overlapping 95% confidence intervals. The same is true for multiracial and American Indian/Alaska Native women; as well as Asian, Hispanic and Hawaiian/Pacific Islander women.

Changes in Depression Among Women

By Income Between 2017-2018 and 2021-2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2017-2022.

Note: The values for women with incomes less than $25,000, incomes of $25,000-$49,999 and incomes of $50,000-$74,999 in 2021-2022 may not differ significantly based on overlapping 95% confidence intervals.

Depression Among Women

Depression is a serious mood disorder that is more common among women than men.[14,15] The symptoms of depression – such as hopelessness, fatigue and loss of interest in activities – can interfere with daily life.[14]

Changes over time. Nationally, the percentage of women ages 18-44 who reported being told by a health professional that they had a depressive disorder – including depression, major depression, minor depression or dysthymia – increased 11%, from 26.1% to 29.1% between 2019-2020 and 2021-2022, higher than the 8% increase featured in the *2023 report*. In 2021-2022, depression affected nearly 17.1 million women ages 18-44 in the U.S., 2.2 million more than in 2019-2020. The prevalence increased among the following population groups between 2019-2020 and 2021-2022:

- 20% among women with an annual household income of $50,000-$74,999 (26.2% to 31.4%) and 14% among both women with incomes of $75,000 or more (21.1% to 24.1%) and women with incomes of $25,000-$49,999 (27.7% to 31.5%).
- 16% among women ages 18-24 (28.5% to 33.1%), 12% among women ages 25-34 (26.8% to 29.9%) and 8% among women ages 35-44 (23.9% to 25.8%).
- 15% among women with some post-high school education (30.2% to 34.6%) and 13% among college graduates (20.9% to 23.7%).
- 11% among women living in metropolitan areas (25.6% to 28.3%) and 10% among women living in non-metropolitan areas (32.0% to 35.1%).

During this time, the prevalence of depression increased in 16 states. The largest increases were: 32% in New Mexico (21.9% to 28.8%), 28% in Colorado (25.2% to 32.3%) and 26% in Wyoming (29.9% to 37.7%).

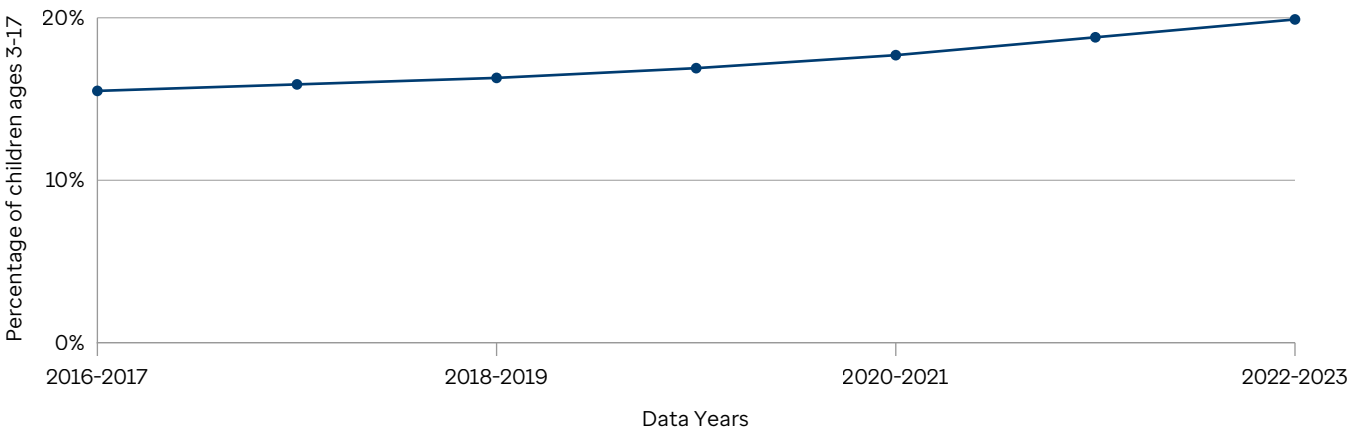
Disparities. The prevalence of depression varied significantly by disability, race/ethnicity, geography, sexual orientation, educational attainment, income, age, veteran status and metropolitan status in 2021-2022. The prevalence was:

- 3.7 times higher among women with independent living difficulty (74.1%) than those without a disability (20.3%).
- 2.6 times higher among multiracial (42.1%) than Asian (16.0%) women.
- 2.4 times higher in Maine (41.0%) than Hawaii (17.2%).
- 2.1 times higher among LGBQ+ (55.9%) than straight (26.3%) women.
- 1.5 times higher among women with some post-high school education (34.6%) than those with less than a high school education (22.8%).
- 1.4 times higher among women with an annual household income less than $25,000 (33.5%) than those with incomes of $75,000 or more (24.1%).
- 1.3 times higher among women ages 18-24 (33.1%) than those ages 35-44 (25.8%).
- 1.3 times higher among women who have served in the U.S. armed forces (37.8%) than those who have not served (29.0%).
- 1.2 times higher among women living in non-metropolitan (35.1%) than metropolitan (28.3%) areas.

Note: The values for multiracial and white women as well as Asian and Hawaiian/Pacific Islander women may not differ significantly based on overlapping 95% confidence intervals. The same is true for women with less than a high school education and college graduates; as well as for women with incomes less than $25,000, incomes of $25,000-$49,999 and incomes of $50,000-$74,999.

Changes in Mental Health Conditions Among Children

Between 2016-2017 and 2022-2023



Source: U.S. HHS, HRSA MCHB National Survey of Children's Health, 2016-2023.

Mental Health Conditions Among Children

Early diagnosis of mental health conditions among children is vital to provide adequate care and support and reduce problems at home, in school and in forming friendships.[16] Common mental health conditions among children include anxiety, depression and attention deficit/hyperactivity disorder (ADHD).[17]

Changes over time. Nationally, the percentage of children ages 3-17 told by a health care provider they currently have ADHD, depression or anxiety problems, or told by a doctor or educator they have behavior or conduct problems, increased 12%, from 17.7% to 19.9% between 2020-2021 and 2022-2023. In 2022-2023, around 12.1 million children had a diagnosis, about 1.4 million more children than in 2020-2021. ADHD increased 12% (9.4% to 10.5%) and anxiety increased 18% (9.1% to 10.7%). The prevalence of depression (4.4%) and behavior problems (7.5%) did not significantly change in this period. It is possible that the rise in diagnosed mental health conditions reflects an increase in diagnoses rather than the underlying conditions.

During this period, the prevalence of mental health conditions increased among the following populations:

- 16% among girls (15.7% to 18.2%) and 10% among boys (19.6% to 21.5%).
- 15% among white children (19.9% to 22.9%).
- 14% among children with a caregiver who graduated from college (16.9% to 19.3%).

Between 2020-2021 and 2022-2023, mental health conditions among children increased 47% in Minnesota (15.8% to 23.2%), 39% in Missouri (16.3% to 22.7%) and 33% in Utah (17.9% to 23.8%).

Disparities. Mental health conditions among children significantly varied by race/ethnicity, geography, caregiver educational attainment and gender in 2022-2023. The prevalence was:

- 3.8 times higher among American Indian/Alaska Native (24.9%) than Hawaiian/Pacific Islander (6.6%) children.
- 2.1 times higher in Maine (28.9%) than Hawaii (14.0%).
- 1.6 times higher among children who have a caregiver with some post-high school education (22.8%) than those whose caregivers have less than a high school education (14.2%).
- 1.2 times higher among boys (21.5%) than girls (18.2%).

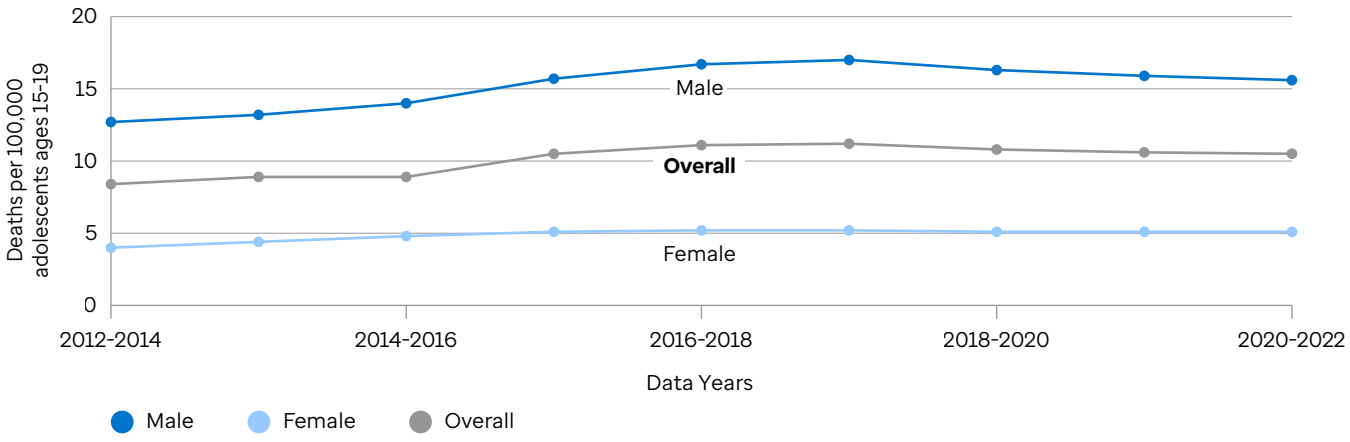
Related Measure: Mental Health Treatment

The surgeon general has issued an advisory on the state of mental health among youth in the U.S.[18] In 2022-2023, 82.5% of children ages 12-17 (nearly 4.5 million) received needed mental health treatment or counseling. The percentage of children receiving treatment ranged from 95.9% in Iowa to 69.0% in Florida, and has not significantly changed in recent years.

Note: The values for American Indian/Alaska Native, white, multiracial and Black children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian and Hawaiian/Pacific Islander children; and children who have a caregiver with some post-high school education and those with a caregiver who graduated from high school.

Changes in Teen Suicide

By Gender Between 2012-2014 and 2020-2022



Source: CDC WONDER, Multiple Cause of Death Files, 2012-2022.

Teen Suicide

In 2022, suicide was the second-leading cause of death for children ages 10-14 in the U.S.[13]

Changes over time. Nationally, the teen suicide rate decreased 6%, from 11.2 to 10.5 deaths per 100,000 adolescents ages 15-19 between 2017-2019 and 2020-2022. However, the rate remains significantly higher than in 2014-2016 (8.9), when it started to increase. In 2020-2022, about 7,000 teens died of suicide in the U.S., 380 fewer deaths than in 2017-2019. Between 2017-2019 and 2020-2022, the rate among teenage boys decreased 8% (17.0 to 15.6 deaths per 100,000 adolescents ages 15-19) but is still 11% higher than in 2014-2016 (14.0).

Teen suicide decreased 24% in Ohio (12.6 to 9.6) during the same period.

Disparities. The teen suicide rate significantly varied by geography, race/ethnicity and gender in 2020-2022. The rate was:

- 7.1 times higher in Montana (36.3 deaths per 100,000 adolescents ages 15-19) than New York (5.1). South Dakota (33.7) and Alaska (30.2) also had high rates, and New Jersey (5.3) and Connecticut (5.8) also had low rates.
- 4.7 times higher among American Indian/Alaska Native (37.2) than Hispanic (7.9) teens.
- 3.1 times higher among teenage boys (15.6) than teenage girls (5.1).

Note: The values for Hispanic, multiracial and Asian adolescents may not differ significantly based on overlapping 95% confidence intervals.

Transforming Mental Health Care Through Data and Technology

Dr. Sy Saeed
Founding Executive Director, North Carolina Statewide Telepsychiatry Program, and Professor and Chair Emeritus, Department of Psychiatry and Behavioral Medicine, Brody School of Medicine at East Carolina University

I've always viewed data as one of our most powerful tools — not just for understanding the challenges we face, but for driving real change. Data can guide us in designing programs, securing funding and advocating for policy changes that address disparities, especially in mental health. I've used data to advocate for communities that are too often overlooked, and I've focused on how we can harness technology to close gaps in care.

I've also learned that statistics represent averages, but people don't live in averages; I see that those communities are actually living different experiences. The science behind treating mental illness is more effective than ever and it might look like things are "getting better" overall. But, we cannot feel satisfied as too many people don't have access to these life-saving treatments. Here in North Carolina, as in many other states across the nation, rural regions are falling through the cracks.

More detailed data can help us expand access for the people who are in need through efforts, like the NC Statewide Telepsychiatry Program's (NC-STeP), that provide access to evidence-based psychiatric services to those who otherwise may not have access to this care. The most recent expansion of this program, funded through a grant from the United Health Foundation, connects underserved children and adolescents in rural areas with psychiatric care through telehealth (NC-STeP-Peds). This eliminates the need for travel and significantly reduces wait times. Before NC-STeP-Peds, children in rural regions often had to wait months for a psychiatry appointment. Now, through video conferencing and telehealth infrastructure, we've cut wait times to just a few weeks.

While NC-STeP helps us bring psychiatric care directly to rural communities through telehealth, we recognize that mental health is only one part of the solution. That's why, in addition to NC-STeP, we've also focused on lowering geographic and transportation barriers to other critical services, such as care coordination, clinical care, education/knowledge dissemination and social work. By physically bringing these resources into centralized locations, we've reduced the need for long drives and helped patients access comprehensive care locally.

Throughout all of this work, one critical resource that has helped us identify and address these needs is *America's Health Rankings*. By tracking health trends over time, the platform also helps us predict future needs. For me, it's more than just a collection of numbers — it's a tool for shaping policy and advocating for change.

> **By continuing to use data to identify gaps, advocate for policy changes and push for innovations that make care more efficient and accessible, I believe we can close the mental health care gap.**

I remain optimistic because we have the tools to get people the mental health care they deserve. We know what works — we just need to ensure that these solutions are reaching everyone. By continuing to use data to identify gaps, advocate for policy changes and push for innovations that make care more efficient and accessible, I believe we can close the mental health care gap. And that's what keeps me motivated: the knowledge that we can, and must, do better.

HEALTH OUTCOMES | PHYSICAL HEALTH

Among women, rates of severe maternal morbidity, asthma and obesity worsened. However, the prevalence of youth who are overweight or have obesity improved. Among newborns, congenital syphilis increased, but neonatal abstinence syndrome decreased.

Severe Maternal Morbidity

Severe maternal morbidity includes serious and potentially life-threatening events and outcomes, such as eclampsia or hysterectomy.[19,20] It is estimated that for every pregnancy-related death, 20-30 people experience unexpected outcomes of pregnancy, labor or delivery that lead to short- or long-term health consequences.[21]

Changes over time. Nationally, severe maternal morbidity – the number of significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations – increased 14%, from 88.3 to 100.3 complications between 2020 and 2021. In 2021, about 33,600 women in the U.S. experienced severe maternal morbidity, about 4,000 more than in 2020. Between 2020 and 2021, severe maternal morbidity increased among the following populations:

- 35% among American Indian/Alaska Native (99.6 to 134.7 complications per 10,000 delivery hospitalizations), 19% among white (69.9 to 83.4), 16% among Asian/Pacific Islander (98.4 to 114.1), 13% among Black (139.0 to 156.8) and 7% among Hispanic (94.6 to 100.9) women.
- 17% among women living in the second-least wealthy ZIP code quartile (85.9 to 100.4), 14% among women living in the wealthiest ZIP code quartile (79.8 to 90.6), 13% among women living in the least wealthy ZIP code quartile (100.6 to 113.5) and 12% among women living in the second-wealthiest ZIP code quartile (84.5 to 94.8).
- 15% among women ages 20-24 (72.3 to 83.2) and women ages 30-34 (84.8 to 97.8), and 12% among women ages 25-29 (75.7 to 85.0) and women age 35 and older (127.9 to 142.7).

The severe maternal morbidity rate increased in 14 states. The largest increases were: 41% in Oregon (63.9 to 89.9 complications per 10,000 delivery hospitalizations), 35% in Mississippi (69.9 to 94.2), and 32% in both Washington (77.9 to 102.8) and South Carolina (75.3 to 99.3).

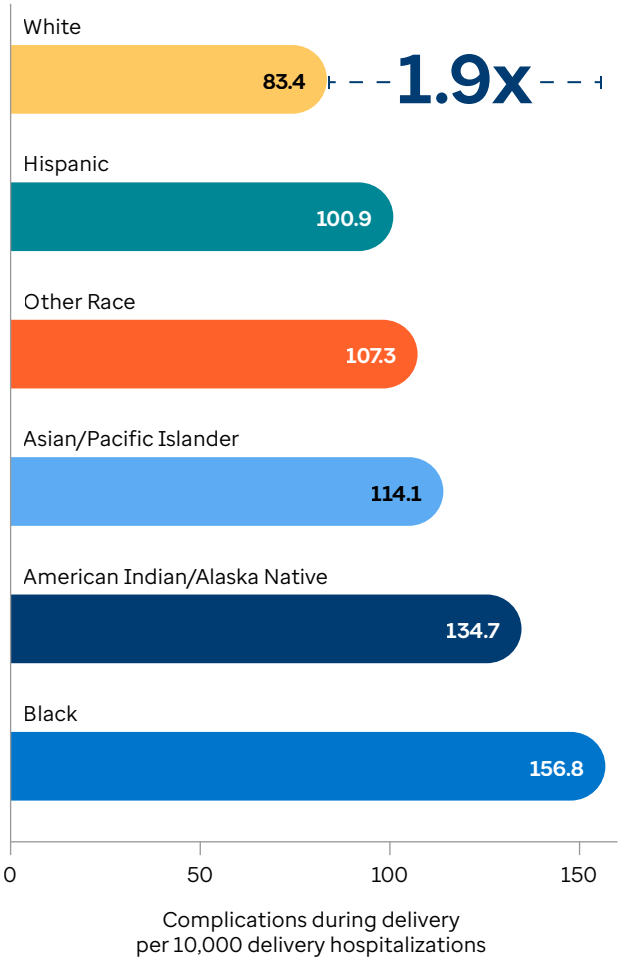
Disparities. Severe maternal morbidity was:

- 2.2 times higher in Alaska (131.1) than Nebraska (60.1).
- 1.9 times higher among Black (156.8) than white (83.4) women.
- 1.7 times higher among women age 35 and older (142.7) than those ages 20-24 (83.2).
- 1.3 times higher among women living in the least-wealthy ZIP code quartile (113.5) than those in the wealthiest income ZIP code quartile (90.6).

Note: The values for women ages 20-24 and ages 25-29 may not differ significantly based on overlapping 95% confidence intervals. The same is true for women living in the wealthiest and second-least wealthy ZIP code quartiles.

Severe Maternal Morbidity

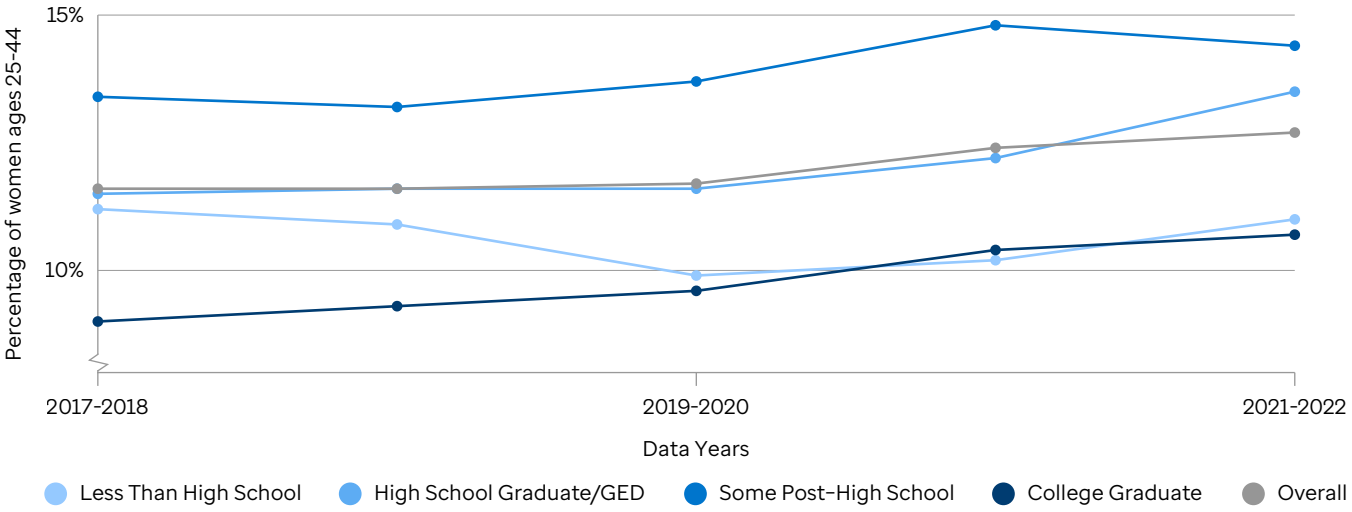
By Race/Ethnicity in 2021



Source: U.S. HHS, HRSA MCHB, Federally Available Data, 2021.

Changes in Asthma Among Women

By Educational Attainment Between 2017-2018 and 2021-2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2017-2022.

Asthma Among Women

Asthma is a chronic disease that affects the lungs and can cause wheezing, breathing difficulty and coughing.[22] Risk factors for asthma include: having allergies, frequent respiratory infections or a family history of asthma, as well as exposure to common triggers such as tobacco smoke, air pollution, dust and mold.[23,24]

Changes over time. Nationally, the prevalence of asthma – the percentage of women ages 18-44 who reported ever being told by a health professional that they currently have asthma – increased 9%, from 11.7% to 12.7% between 2019-2020 and 2021-2022. In 2021-2022, about 7.4 million women reported having asthma, an increase of 743,800 women compared with 2019-2020. The prevalence increased among the following population groups:

- 20% among women with an annual household income of $25,000-$49,999 (11.6% to 13.9%).
- 16% among women who graduated from high school (11.6% to 13.5%) and 11% among college graduates (9.6% to 10.7%).
- 10% among women ages 35-44 (11.5% to 12.7%).

One state had a significant increase. Asthma prevalence increased 41% in Georgia (10.0% to 14.1%).

Disparities. The prevalence of asthma among women significantly varied by disability, race/ethnicity, geography, sexual orientation, income and educational attainment. The prevalence was:

- 3.6 times higher among women who have difficulty with self-care (35.7%) than women without a disability (9.8%).
- 3.1 times higher among multiracial (17.0%) compared with Asian (5.5%) women.
- 2.1 times higher in Maine (19.3%) than South Dakota (9.3%).
- 1.5 times higher among LGBQ+ (18.5%) than straight (12.2%) women.
- 1.5 times higher among women with an annual household income less than $25,000 (16.0%) than those with incomes of $75,000 or more (10.7%).
- 1.3 times higher among women with some post-high school education (14.4%) than college graduates (10.7%).

Note: The values for women who have difficulty with self-care and those who have difficulty with mobility may not differ significantly based on overlapping 95% confidence intervals. The same is true for multiracial, American Indian/Alaska Native, Black, white and Hawaiian/Pacific Islander women; women with incomes less than $25,000 and those with incomes of $25,000-$49,999; women with incomes of $75,000 or more and those with incomes of $50,000-$74,999; women with some post-high school education and high school graduates; women who graduated from college and those with less than a high school education; and women ages 25-34 and those ages 35-44.

Obesity Among Women

8% ▲

increase from 30.4% to 32.7% of women ages 18-44 between 2019-2020 and 2021-2022.

Overweight or Obesity Among Youth

6% ▼

decrease from 33.2% to 31.1% of youth ages 10-17 between 2020-2021 and 2022-2023.

Source: CDC, Behavioral Risk Factor Surveillance System, 2019-2022; U.S. HHS, HRSA MCHB, National Survey of Children's Health, 2020-2023.

Obesity Among Women

Obesity is a complex health condition with biological, economic, environmental, individual and societal causes.[25] Contributing factors to obesity include social and physical environment, genetics, prenatal and early life influences and behaviors such as poor diet and physical inactivity.[26,27] Adults with obesity are at an increased risk of developing serious health conditions, including hypertension, Type 2 diabetes, heart disease and stroke, sleep apnea and breathing problems, some cancers and mental illnesses like depression and anxiety.[28]

Changes over time. Nationally, the prevalence of obesity — the percentage of women ages 18-44 who have a body mass index (BMI) of 30.0 or higher based on reported height and weight — increased 8%, from 30.4% to 32.7% between 2019-2020 and 2021-2022. In 2021-2022, about 16 million American women had obesity, an increase of nearly 1.3 million women compared with 2019-2020. The prevalence increased among some income, educational attainment and age groups, as well as among women living in metropolitan areas:

- 13% among women with an annual household income of $25,000-$49,999 (39.0% to 43.9%) and women with incomes of $75,000 or more (25.0% to 28.2%).
- 12% among women who graduated from college (23.7% to 26.5%) and 11% among women with some post-high school education (37.7% to 41.8%).
- 10% among women ages 35-44 (35.6% to 39.0%).
- 8% among women living in metropolitan areas (29.5% to 31.8%).

The prevalence of obesity increased in six states. The largest increases were: 37% in Alaska (25.5% to 34.9%), 34% in Nevada (25.8% to 34.6%) and 21% in Maine (28.0% to 33.8%).

Disparities. The prevalence of obesity among women significantly varied by race/ethnicity, geography, age group, disability status, educational attainment, income, veteran status, metropolitan status and sexual orientation in 2021-2022. The prevalence was:

- 4.0 times higher among Black (47.9%) compared with Asian (12.1%) women.
- 1.8 times higher in Mississippi (42.0%) than Colorado (23.1%).
- 1.8 times higher among women ages 35-44 (39.0%) than those ages 18-24 (22.1%).
- 1.8 times higher among women who have difficulty with mobility (53.8%) than those without a disability (30.6%).
- 1.7 times higher among women with less than a high school education (45.4%) than college graduates (26.5%).
- 1.7 times higher among women with an annual household income less than $25,000 (46.7%) than those with incomes of $75,000 or more (28.2%).
- 1.3 times higher among women who have not served in the U.S. armed forces (33.0%) than those who have served (26.1%).
- 1.2 times higher among women living in non-metropolitan (39.1%) than metropolitan (31.8%) areas.
- 1.1 times higher among LGBQ+ (37.3%) than straight (34.0%) women.

Note: The values for Black and American Indian/Alaska Native women may not differ significantly based on overlapping 95% confidence intervals. The same is true for women who have difficulty with mobility and those who have difficulty with self-care; women with less than a high school education, high school graduates and those with some post-high school education; and women with incomes less than $25,000 and those with incomes of $25,000-$49,999.

Overweight or Obesity Among Youth

According to the National Center for Health Statistics, the prevalence of childhood obesity has more than tripled since the 1970s.[29] BMI-for-age percentiles are used to define healthy weight, overweight and obesity in children ages 2-19.[30] The healthy weight range is the 5th to less than the 85th percentile; overweight is the 85th to less than the 95th percentile; and obesity is the 95th percentile or higher. It should be noted that weight stigma, also known as weight-based discrimination or weight bias, can lead to negative impacts such as mood and anxiety disorders and health care avoidance.[31]

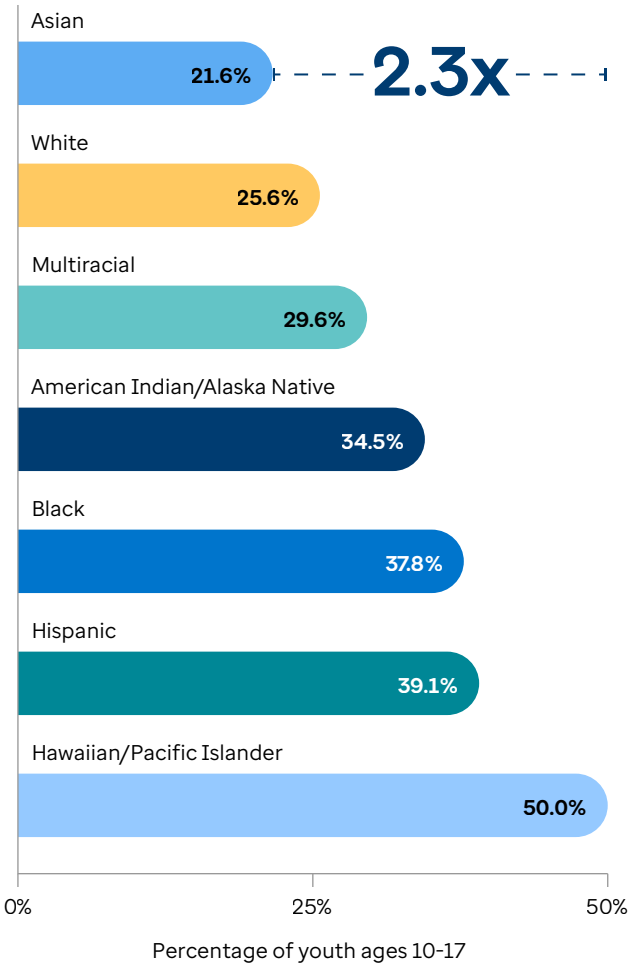
Changes over time. Nationally, the percentage of children ages 10-17 who have overweight or obesity for their age based on reported height and weight decreased 6.0%, from 33.2% to 31.1% between 2020-2021 and 2022-2023. In 2022-2023, approximately 10.2 million American youth had obesity or were overweight, 428,000 fewer than in 2020-2021. The prevalence of youth who were overweight or had obesity decreased 34% in South Dakota (37.2% to 24.4%) between 2020-2021 and 2022-2023.

Disparities. The prevalence of youth who were overweight or had obesity significantly varied by race/ethnicity, geography, caregiver educational attainment and gender in 2022-2023. The prevalence was:

- 2.3 times higher among Hawaiian/Pacific Islander (50.0%) compared with Asian (21.6%) youth.
- 1.9 times higher in Mississippi (42.0%) than New Hampshire (21.6%).
- 1.8 times higher among youth with a caregiver who graduated from high school (41.0%) than those with a caregiver who graduated from college (23.1%).
- 1.2 times higher among boys (33.8%) than girls (28.2%).

Overweight or Obesity Among Youth

By Race/Ethnicity in 2022-2023

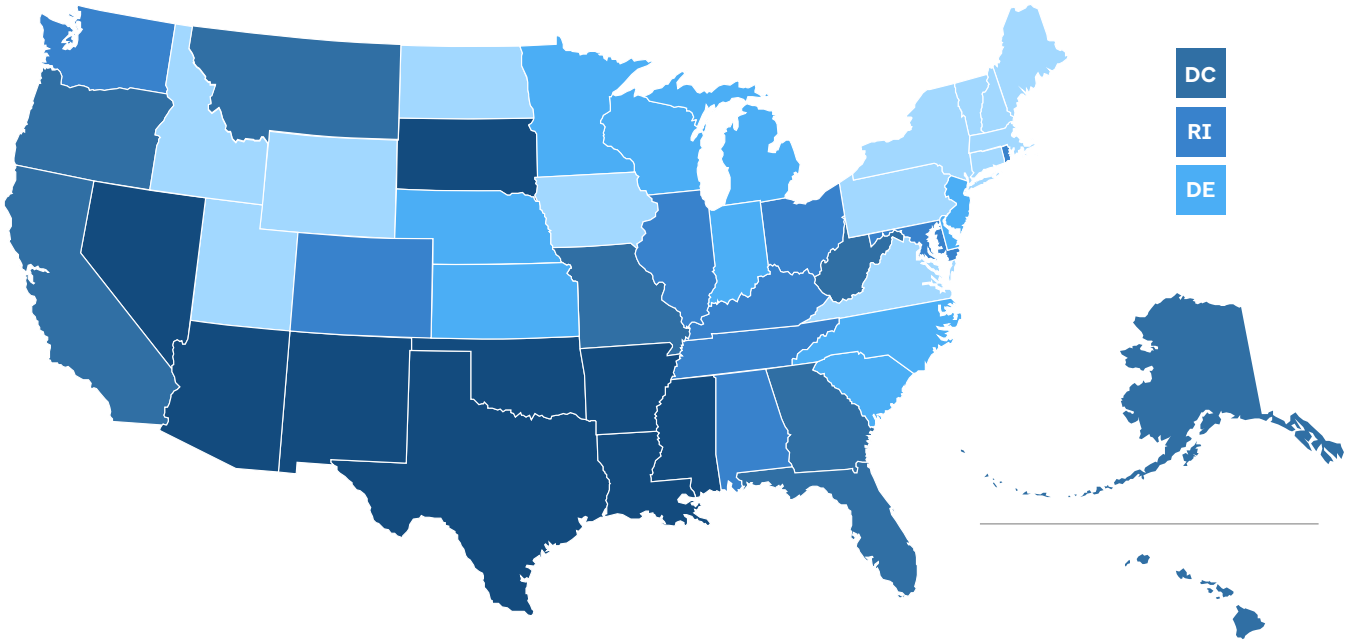


Source: U.S. HHS, HRSA MCHB, National Survey of Children's Health, 2022-2023.

Note: The values for Hawaiian/Pacific Islander, Hispanic, Black, American Indian/Alaska Native and multiracial youth may not significantly differ based on overlapping 95% confidence intervals.

Note: The values for Hawaiian/Pacific Islander, Hispanic, Black, American Indian/Alaska Native and multiracial youth may not differ significantly based on overlapping 95% confidence intervals. The same is true for youth with a caregiver who graduated from high school, youth with a caregiver who has some post-high school education and youth with caregivers whose educational attainment is less than high school.

Congenital Syphilis by State in 2022



Cases per 100,000 live births

0.0 - 29.4	29.5 - 47.5	47.6 - 74.6	74.7 - 172.9	173.0 - 355.3

Source: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Atlas, 2022.

Congenital Syphilis

Complications from congenital syphilis during pregnancy include miscarriage, preterm birth and stillbirth.[32] It may cause neonatal death, anemia or meningitis. The number of congenital syphilis cases in the U.S. has increased in recent years, with more than 10 times as many babies born with syphilis in 2022 as in 2012.[33]

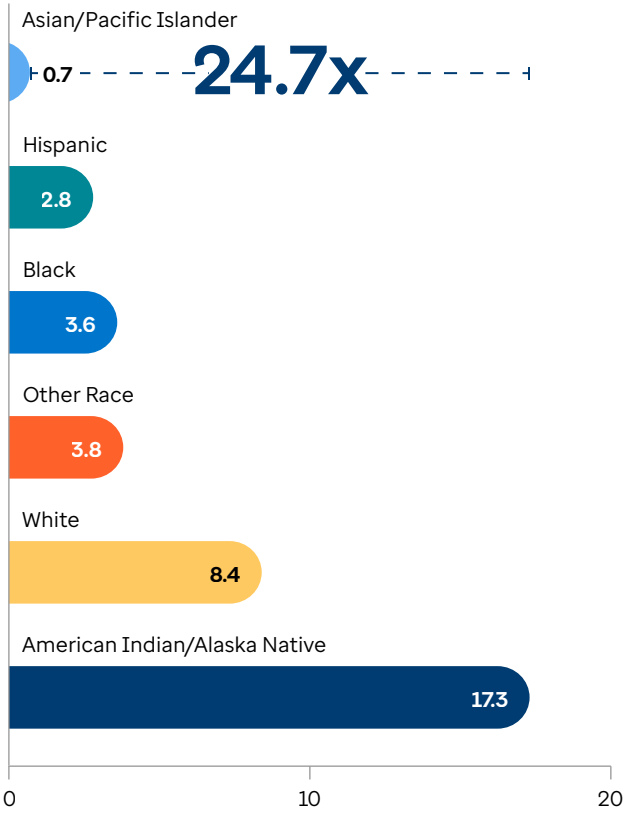
Changes over time. Nationally, congenital syphilis – the number of new cases per 100,000 live births – increased 31%, from 78.5 to 102.5 between 2021 and 2022. In 2022, about 3,800 cases were reported in the U.S., an increase of nearly 900 cases since 2021. Between 2018 and 2022, congenital syphilis cases increased 194%, from 34.9 to 102.5 cases per 100,000 live births.

Twenty-five states and the District of Columbia had increases greater than or equal to the national change. The largest increases were: 302% in Delaware (9.5 to 38.2 cases per 100,000 live births), 249% in Utah (4.3 to 15.0) and 177% in Pennsylvania (10.6 to 29.4).

Disparities. The congenital syphilis rate varied by geography in 2022. Among states with cases, the rate was 23.7 times higher in New Mexico (355.3) than Utah (15.0). Idaho, Vermont and Wyoming had no reported cases.

Neonatal Abstinence Syndrome

By Race/Ethnicity in 2021



Source: U.S. HHS, HRSA MCHB, Federally Available Data, 2021.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome is a drug withdrawal syndrome occurring in newborns.[34] It is most commonly caused by fetal exposure to maternal opioid use, and is also associated with benzodiazepine, barbiturate and alcohol use.[35] Between 55% and 94% of infants exposed to opioids during gestation experience withdrawal symptoms.[35] Opioid use during pregnancy has increased in the U.S. in the last 20 years, with corresponding increases in neonatal abstinence syndrome.[36,37]

Changes over time. Nationally, neonatal abstinence syndrome – the number of birth hospitalizations with a diagnosis code of withdrawal symptoms due to prenatal exposure to illicit drugs per 1,000 birth hospitalizations – decreased 5%, from 6.2 to 5.9 between 2020 and 2021. In 2021, there were about 19,600 neonatal abstinence syndrome hospitalizations in the U.S., a decrease of almost 1,000 hospitalizations from 2020. Hospitalization rates decreased among the following population groups:

- 9% among white infants (9.2 to 8.4 hospitalizations per 1,000 birth hospitalizations).
- 9% among infants living in the second-wealthiest ZIP code quartile (5.4 to 4.9).
- 6% among infants living in large metropolitan areas with at least one million residents (4.8 to 4.5) and 5% among infants living in small to medium metropolitan areas with less than one million residents (7.4 to 7.0).

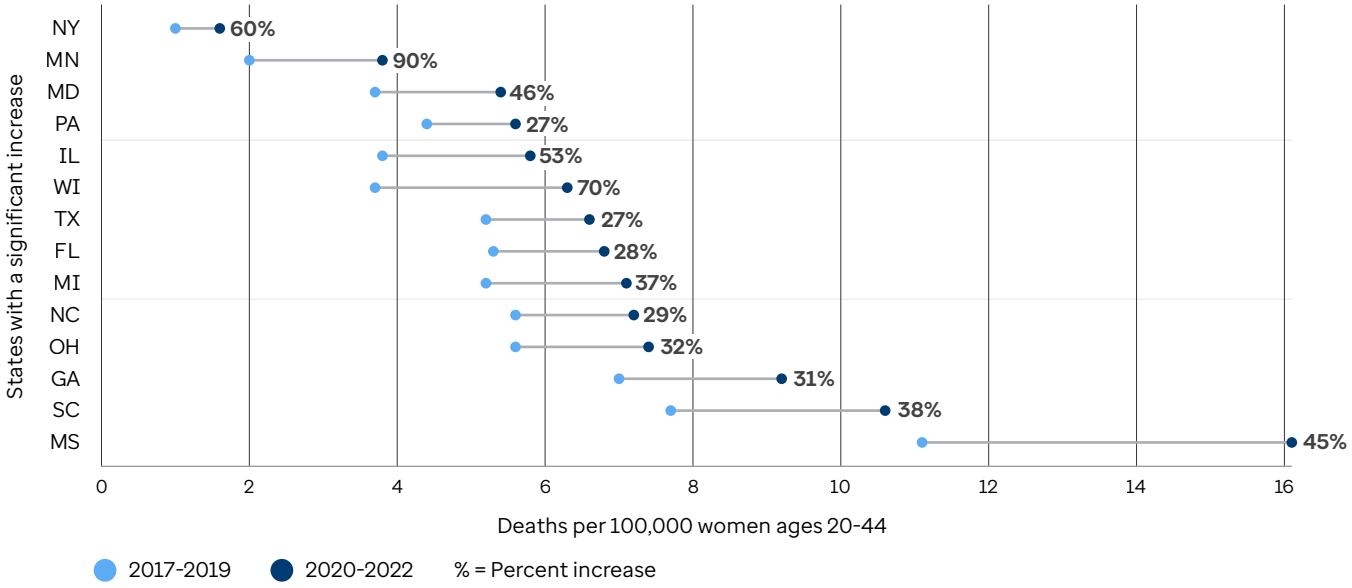
The rate increased 17% in Arizona (10.3 to 12.1 hospitalizations per 1,000 birth hospitalizations) and decreased in six states, led by: 31% in Delaware (20.9 to 14.4), 23% in Connecticut (8.8 to 6.8) and 19% in New Jersey (5.7 to 4.6).

Disparities. The prevalence of neonatal abstinence syndrome hospitalizations significantly varied by race/ethnicity and geography in 2021. The prevalence was:

- 24.7 times higher among American Indian/Alaska Native (17.3 per 1,000 birth hospitalizations) compared with Asian/Pacific Islander (0.7) infants.
- 22.6 times higher in West Virginia (38.4) than Nebraska (1.7).

Percent Increase in Firearm Deaths Among Women

By State Between 2017-2019 and 2020-2022



Source: CDC WONDER, Multiple Cause of Death Files, 2017-2022.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

Firearm and injury mortality rates increased among women and children.

Firearm Deaths Among Women

Firearm violence is a severe and deadly public health issue in the U.S.[38] Women in the U.S. are far more likely to die by firearm than women in other high-income countries – the firearm death rate in the U.S. is nearly five times higher than in France, the country with the second-highest rate.[39]

Changes over time. Nationally, firearm deaths – the number of deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 females ages 20-44 – increased 27%, from 4.8 to 6.1 between 2017-2019 and 2020-2022. In 2020-2022, approximately 10,000 women in the U.S. died by firearm, an increase of more than 2,200 deaths since 2017-2019. Between 2018-2020 and 2020-2022, rates among some racial/ethnic and all age groups significantly increased:

- 36% among Black (11.0 to 15.0 deaths per 100,000 women ages 20-44), 26% among Hispanic (3.1 to 3.9) and 8% among white (4.9 to 5.3) women.
- 23% among women ages 25-34 (5.2 to 6.4), 20% among women ages 20-24 (5.4 to 6.5) and 17% among women ages 35-44 (4.8 to 5.6).

Rates of firearm deaths increased in 14 states between 2017-2019 and 2020-2022. The largest increases were: 90% in Minnesota (2.0 to 3.8 deaths per 100,000 women ages 20-44), 70% in Wisconsin (3.7 to 6.3) and 60% in New York (1.0 to 1.6).

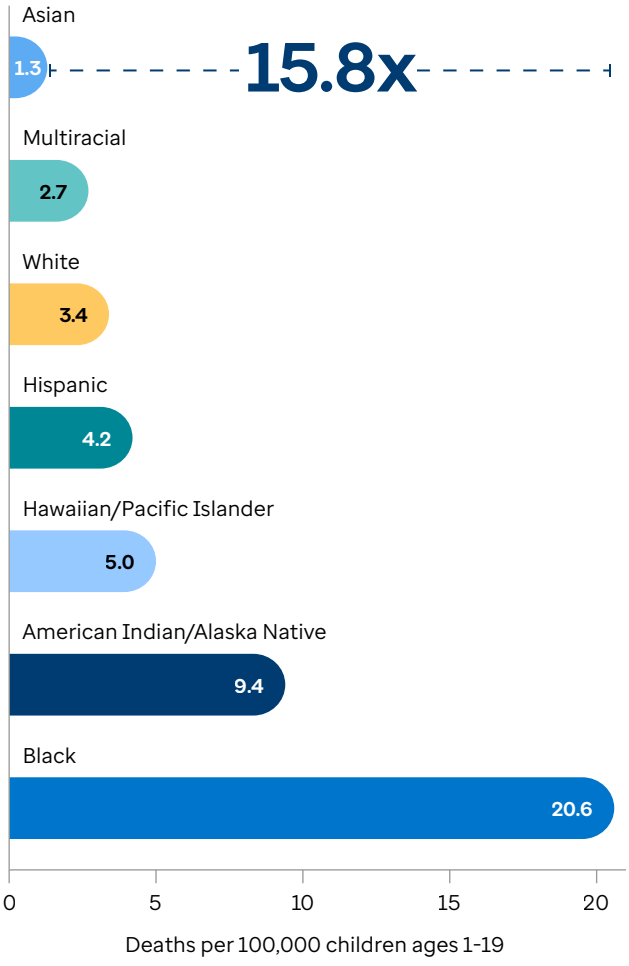
Disparities. Firearm deaths significantly varied by geography, race/ethnicity and age in 2020-2022. The rate was:

- 13.4 times higher in Mississippi (16.1 deaths per 100,000 women ages 20-44) than Massachusetts (1.2).
- 10.7 times higher among Black (15.0) compared with Asian (1.4) women.
- 1.2 times higher among women ages 20-24 (6.5) than those ages 35-44 (5.6).

Note: The values for women ages 20-24 and those ages 25-34 may not differ significantly based on overlapping 95% confidence intervals.

Firearm Deaths Among Children

By Race/Ethnicity in 2020-2022



Source: CDC WONDER, Multiple Cause of Death Files, 2020-2022.

Firearm Deaths Among Children

The U.S. is the only nation among Organization for Economic Co-operation and Development (OECD) countries similar in size and wealth where firearms are the leading cause of child mortality.[6] In 2020, firearm deaths among children surpassed deaths due to motor vehicles, which had previously been the leading cause of death for children.[6]

Changes over time. Nationally, firearm deaths – the number of deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 children ages 1-19 – increased 37%, from 4.3 to 5.9 between 2017-2019 and 2020-2022. This is a larger increase than the 26% increase cited in the *2023 Health of Women and Children Report*. In 2020-2022, approximately 14,000 children in the U.S. died by firearm injury, about 3,500 more deaths than in 2017-2019. Between 2017-2019 and 2020-2022, the rate significantly increased in 23 states. The largest increases were: 84% in both North Carolina (4.3 to 7.9 deaths per 100,000 children ages 1-19) and Montana (5.5 to 10.1), and 70% in Wisconsin (3.3 to 5.6). Rates increased among all age and some race/ethnicity groups between 2018-2020 and 2020-2022:

- 50% among children ages 1-4 (0.6 to 0.9 deaths per 100,000 children), 25% among children ages 5-14 (1.2 to 1.5) and 20% among children ages 15-19 (14.7 to 17.7).
- 38% among Black (14.9 to 20.6) and 31% among Hispanic (3.2 to 4.2) children.

Disparities. The rate of firearm deaths among children varied significantly by age and race/ethnicity in 2020-2022. The rate was:

- 19.7 times higher among children ages 15-19 (17.7 deaths per 100,000 children) than those ages 1-4 (0.9).
- 15.8 times higher among Black (20.6) compared with Asian (1.3) children.

Note: The 2018-2020 and 2020-2022 comparison contains an overlapping data year (2020). Thus, the comparison is mainly between the non-overlapping years (2018-2019 and 2021-2022).

Injury Deaths Among Women

26%▲

increase from 41.2 to 52.0 deaths per 100,000 women ages 20-44 between 2017-2019 and 2020-2022.

Injury Deaths Among Children

20%▲

increase from 15.5 to 18.6 deaths per 100,000 children ages 1-19 between 2017-2019 and 2020-2022.

Source: CDC WONDER, Multiple Cause of Death Files, 2017-2022.

Related Measure: Injury Deaths Among Women

Nationally, injury deaths – the number of deaths due to injury per 100,000 females ages 20-44 – increased 26%, from 41.2 to 52.0 between 2017-2019 and 2020-2022. In 2020-2022, there were approximately 85,000 injury deaths among women of reproductive age in the U.S., an increase of more than 18,600 deaths since 2017-2019. Rates significantly increased among all age groups between 2017-2019 and 2020-2022: 30% among women ages 35-44 (44.9 to 58.4 deaths per 100,000), 25% among women ages 25-34 (41.8 to 52.4) and 18% among women ages 20-24 (32.8 to 38.6).

The injury death rate also increased in 35 states and the District of Columbia during this period. The largest increases were: 69% in the District of Columbia (23.6 to 40.0 deaths per 100,000 women ages 20-44), 51% in Louisiana (55.8 to 84.2) and 47% in Mississippi (51.4 to 75.7).

Disparities. The injury death rate significantly varied by race/ethnicity, geography and age. The rate was:

- 12.7 times higher among American Indian/Alaska Native (152.0 deaths per 100,000 women ages 20-44) than Asian (12.0) women.
- 4.3 times higher in West Virginia (120.0) than Hawaii (27.9).
- 1.5 times higher among women ages 35-44 (58.4) than those ages 20-24 (38.6).

Related Measure: Injury Deaths Among Children

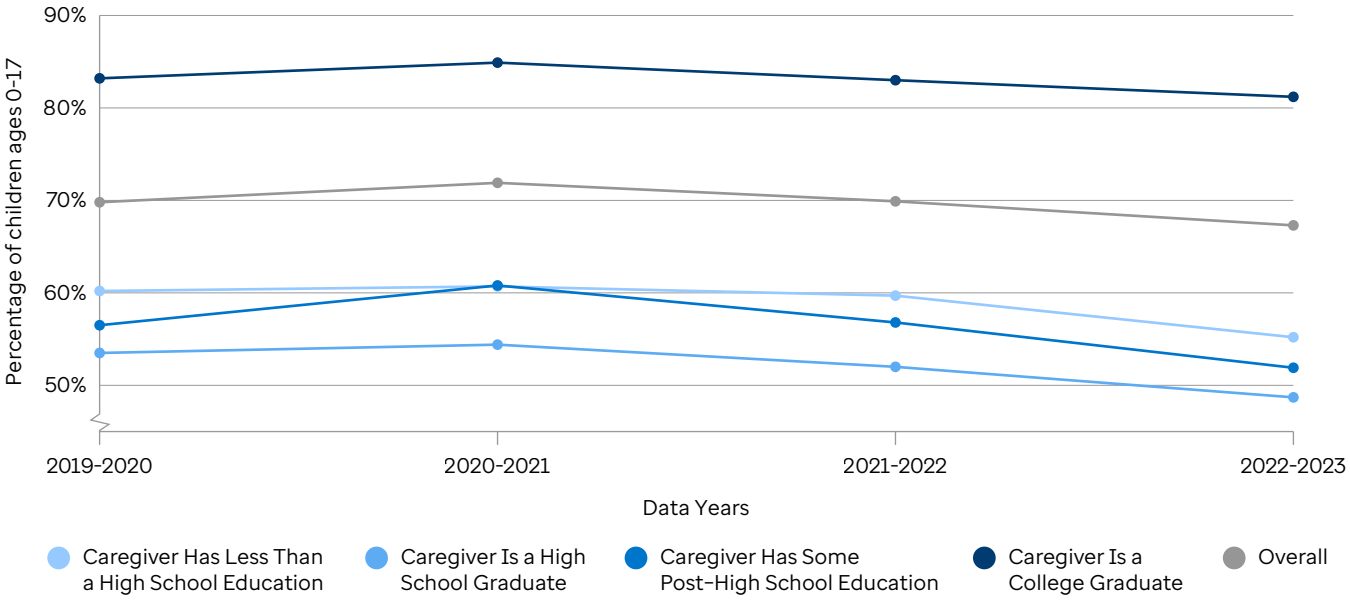
Nationally, injury deaths – the number of deaths due to injury per 100,000 children ages 1-19 – increased 20%, from 15.5 to 18.6 between 2017-2019 and 2020-2022. Approximately 43,000 children in the U.S. died due to fatal injury in 2020-2022, an increase of roughly 7,000 deaths compared with 2017-2019. The rate of injury deaths among children increased in 23 states between 2017-2019 and 2020-2022. The largest increases were: 41% in Montana (24.3 to 34.3 deaths per 100,000 children ages 1-19), 37% in North Carolina (16.1 to 22.1) and 33% in Louisiana (24.7 to 32.9). Rates of injury death also increased 22% among adolescents ages 15-19 (38.1 to 46.6), 13% among children ages 5-14 (6.0 to 6.8), 10% among children ages 1-4 (10.0 to 11.0), 21% among boys (21.5 to 26.1) and 16% among girls (9.2 to 10.7) during the same period.

Disparities. Injury deaths among children significantly varied by age, race/ethnicity, geography and gender in 2020-2022. The rate was:

- 6.9 times higher among children ages 15-19 (46.6 deaths per 100,000 children ages 1-19) than those ages 5-14 (6.8).
- 6.4 times higher among American Indian/Alaska Native (44.5) than Asian (6.9) children.
- 4.1 times higher in Montana (34.3) than Massachusetts (8.3).
- 2.4 times higher among boys (26.1) than girls (10.7).

Changes in Food Sufficiency Among Children

By Caregiver Educational Attainment Between 2019-2020 and 2022-2023



Source: U.S. HHS, HRSA MCHB, National Survey of Children's Health, 2019-2023.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Food sufficiency among children worsened.

Food Sufficiency Among Children

Children should consume a variety of nutrients to maintain a healthy lifestyle.[40] Consistent access to nutritious food is essential to promote health throughout development and prevent diet-related chronic diseases in adulthood.[40] Healthy eating patterns during childhood development look different at each stage of life and can change based on activity level.[41]

Changes over time. Nationally, food sufficiency – the percentage of children ages 0-17 whose household could always afford to eat good nutritious meals in the past 12 months – decreased 6%, from 71.9% to 67.3% between 2020-2021 and 2022-2023. The prevalence among children in most caregiver educational attainment and some racial/ethnic groups significantly decreased:

- 15% among children with a caregiver who has some post-high school education (60.8% to 51.9%), 10% among children with a caregiver who graduated from high school (54.4% to 48.7%) and 4% among children with a caregiver who graduated from college (84.9% to 81.2%).
- 9% among Hispanic (65.1% to 59.3%) and 6% among white (77.6% to 73.1%) children.

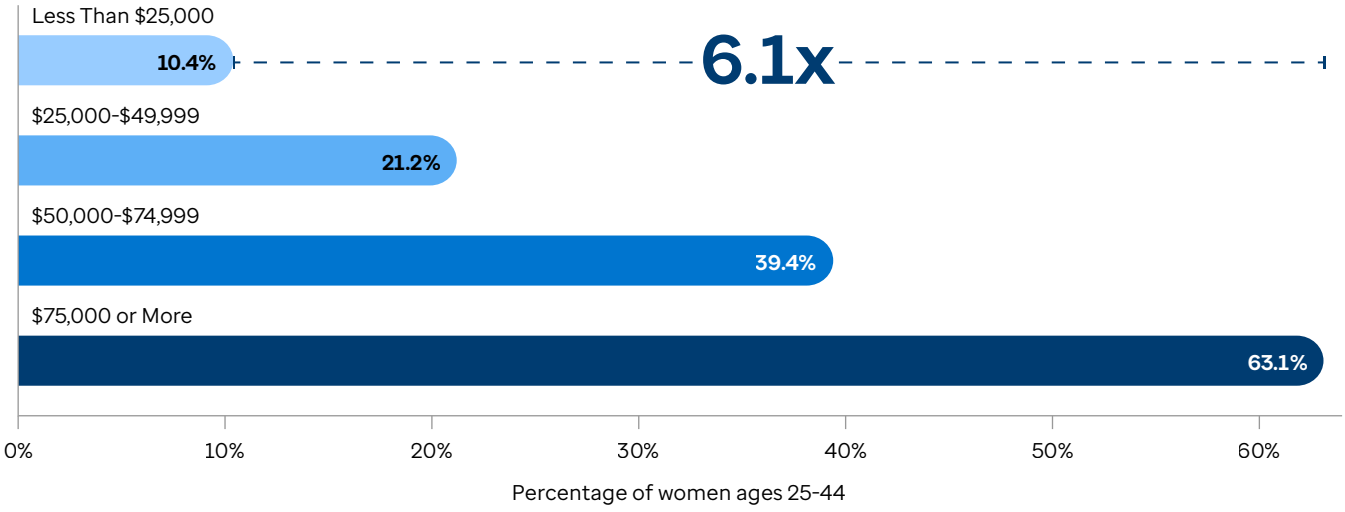
Disparities. The prevalence of food sufficiency varied significantly by caregiver educational attainment, race/ethnicity and geography in 2022-2023. It was:

- 1.7 times higher among children with a caregiver who graduated from college (81.2%) compared with those with a caregiver who graduated from high school (48.7%).
- 1.6 times higher among Asian (81.1%) compared with Hawaiian/Pacific Islander (51.6%) children.
- 1.5 times higher in Massachusetts (79.2%) than Mississippi (54.6%).

Note: The values for Hawaiian/Pacific Islander, American Indian/Alaska Native, Black and Hispanic children may not differ significantly based on overlapping 95% confidence intervals.

College Graduates Among Women

By Income Group in 2021-2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2021-2022.

SOCIAL AND ECONOMIC FACTORS | EDUCATION

The percentage of women ages 25-44 who graduated from college improved, and early childhood education enrollment started to return to the pre-pandemic rate.

College Graduates Among Women

Income differences between college graduates and those with a high school diploma in the U.S. have widened since 1965, persisting into 2024.[42,43] People who earn a college degree have access to a wider variety of employment opportunities and are compensated more on average than those without a college degree.[44,45]

Changes over time. Nationally, college graduates – the percentage of women ages 25-44 who graduated from a college or technical school – increased 6%, from 35.6% to 37.7% between 2019-2020 and 2021-2022. In 2021-2022, there were approximately 16.5 million women of reproductive age who were college graduates in the U.S., an increase of more than 1.4 million women since 2019-2020. The percentage increased among both age groups and women living in metropolitan areas:

- 6% among women ages 25-34 (34.1% to 36.0%) and women ages 35-44 (37.1% to 39.2%).
- 5% among women living in metropolitan areas (37.7% to 39.4%).

On the other hand, college graduates decreased 9% among women with an annual household income of $25,000-$49,999 (23.4% to 21.2%). The percentage increased 26% in Rhode Island (34.4% to 43.2%), 21% in Louisiana (26.6% to 32.3%), 12% in the District of Columbia (62.9% to 70.5%) and 10% in Colorado (43.5% to 48.0%).

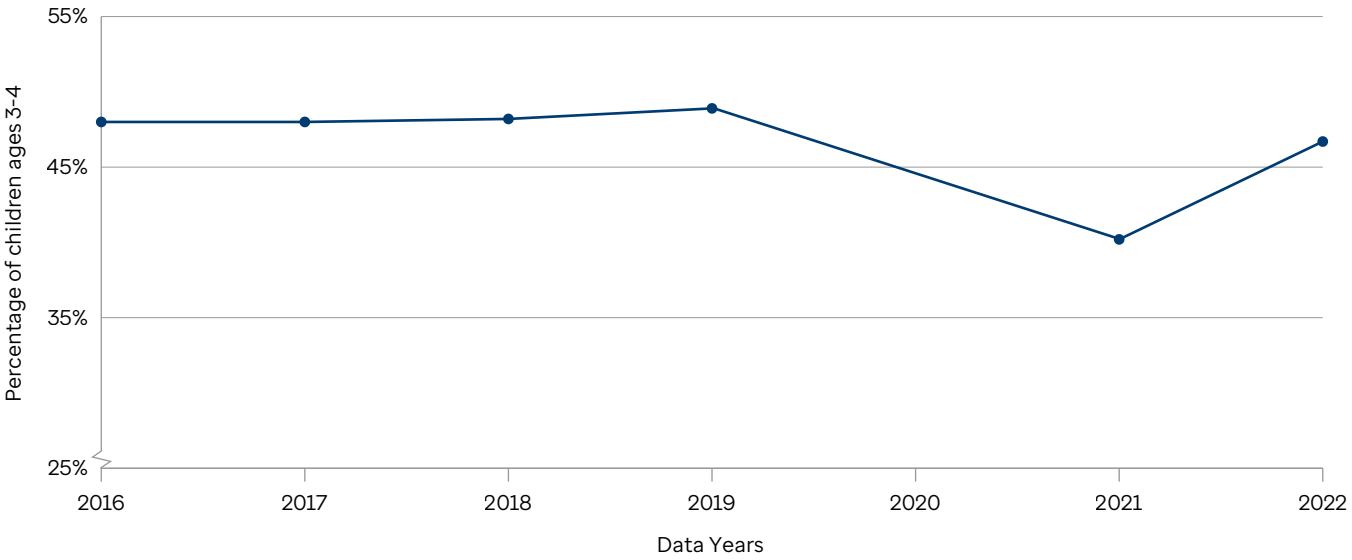
Disparities. The percentage of women ages 25-44 who graduated from college significantly varied by income, race/ethnicity, disability and geography in 2021-2022. The percentage was:

- 6.1 times higher among women with an annual household income of $75,000 or more (63.1%) than those with incomes less than $25,000 (10.4%).
- 2.9 times higher among Asian (65.7%) compared with Hispanic (22.9%) women.
- 2.7 times higher among women without a disability (42.6%) than those who have difficulty with self-care (15.6%).
- 1.9 times higher in Massachusetts (49.4%) than Nevada (26.0%).

Note: The values for women who have difficulty with self-care and those with independent living difficulty, difficulty with mobility, difficulty seeing and difficulty hearing may not differ significantly based on overlapping 95% confidence intervals.

Changes in Early Childhood Education

Between 2016 and 2022



Source: U.S. Census Bureau American Community Survey, 2016-2022.

Early Childhood Education

Evidence shows that early childhood education leads to higher educational attainment, improves health and promotes health equity.[46] Typically, children who attend early childhood education programs have reduced special education use, lower rates of teen births and crime, improved standardized test scores and increased high school graduation rates compared with those who did not have an early childhood education.[46]

Changes over time. Nationally, the percentage of children ages 3-4 enrolled in nursery school, preschool or kindergarten increased 16%, from 40.2% to 46.7% between 2021 and 2022. Despite this improvement, the rate is still lower than in 2019 (48.9%) before enrollment dropped during the COVID-19 pandemic.

The rate of early childhood education increased in 19 states between 2021 and 2022, led by: 46% in New Mexico (25.6% to 37.5%), 43% in Oregon (31.9% to 45.6%) and 40% in New Hampshire (40.1% to 56.0%).

Disparities. The percentage of early childhood education among children ages 3-4 significantly varied by geography in 2022. It was 2.3 times higher in New Jersey (67.0%) than North Dakota (29.1%).

CLINICAL CARE | ACCESS TO CARE

The percentage of uninsured women and children improved, as did the number of pediatricians per 100,000 children.

Uninsured Women and Children

Health insurance coverage promotes positive health outcomes, increases appropriate use of health care services and offers financial protection against high medical expenses.[47] People without insurance are more likely to delay or forgo necessary medical care because of cost and are less likely to have seen a doctor in the past year compared with people with insurance.[48] Those without insurance often rely on emergency departments to receive care, which costs more and is less efficient than preventive care.[47]

Changes over time. Nationally, the percentage of women ages 19-44 not covered by private or public health insurance decreased 8%, from 11.8% to 10.9% between 2021 and 2022. In 2022, nearly 6.2 million American women did not have health insurance, 482,000 fewer women than in 2021. The uninsured rate among women decreased in nine states, led by: 30% in South Dakota (14.7% to 10.3%), 20% in Oklahoma (20.5% to 16.3%) and 17% in Ohio (8.4% to 7.0%).

Nationally, the percentage of children younger than 19 not covered by private or public health insurance decreased 6%, from 5.4% to 5.1% between 2021 and 2022. The uninsured rate among children decreased 41% in New Mexico (6.4% to 3.8%).

Disparities. The percentage of uninsured women and children significantly varied by geography in 2022. The percentage of uninsured women was 8.5 times higher in Texas (23.0%) than in Massachusetts and the District of Columbia (both 2.7%). The percentage of uninsured children was 7.3 times higher in Texas (10.9%) than Massachusetts (1.5%).

Uninsured Women

10.9%

of women ages 19-44 were not covered by private or public health insurance in 2022.

Uninsured Children

5.1%

of children ages 0-18 were not covered by private or public health insurance in 2022.

Source: U.S. Census Bureau American Community Survey, 2022.

Pediatricians

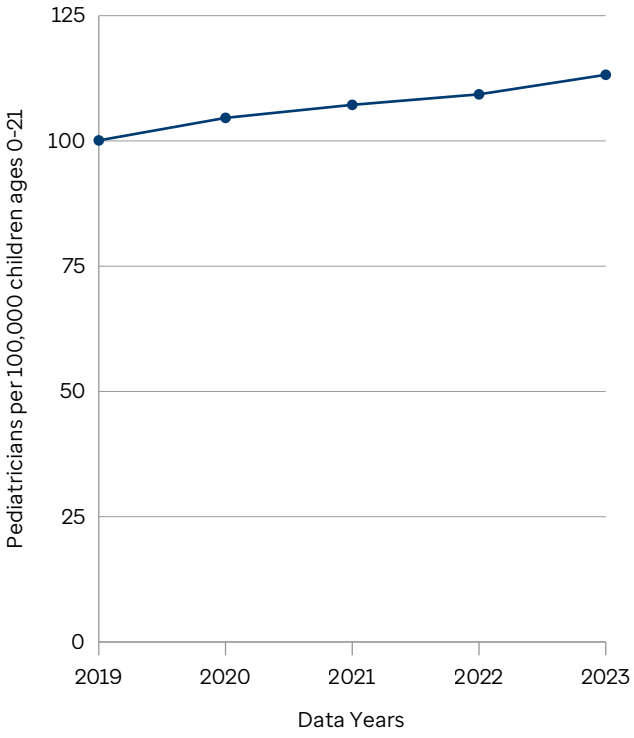
There is currently a shortage of pediatric specialists — such as those who specialize in developmental pediatrics or child psychiatry — in the U.S., and the uneven geographical distribution of pediatricians and family physicians has left many rural communities and other underserved areas with insufficient child health care options.[49,50] In addition to treating illnesses, pediatricians monitor childhood development and provide crucial preventive care, including administering vaccinations and tracking development, through wellness exams.[51,52]

Changes over time. Nationally, the number of pediatricians increased 4%, from 109.3 to 113.2 per 100,000 children ages 0-21 between September 2022 and September 2023. In September 2023, there were approximately 100,000 pediatricians in the U.S., an increase of almost 3,000 pediatricians since September 2022. Twenty-five states and the District of Columbia had increases greater than or equal to the national change, led by: 7% in both South Dakota (73.6 to 78.5 per 100,000 children ages 0-21) and Arkansas (78.0 to 83.7), and 6% in both Wisconsin (102.9 to 108.8) and Nevada (59.4 to 62.7).

Disparities. The number of pediatricians per 100,000 children varied by geography. The rate was 4.7 times higher in Massachusetts (221.0 per 100,000 children ages 0-21) than Idaho (46.9).

Increases in Pediatricians

Between 2019 and 2023



Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System, 2019-2023.

Clinical Care Measures Fall Short of Healthy People 2030 Targets

Low-risk cesarean delivery and **adequate prenatal care** did not improve between 2021 and 2022 and have not met national public health goals. Low-risk cesarean delivery — the percentage of singleton, head-first, term (37 or more weeks) first births that were cesarean deliveries — remained at 26.3% in both 2021 and 2022, exceeding the Healthy People 2030 target of 23.6%. Meanwhile, adequate prenatal care — the percentage of live births in which the mother received appropriate prenatal care in the first four months of pregnancy — was 74.9% in 2022, short of the Healthy People 2030 target of 80.5%.

While the percentage of **well-woman visits** did not change significantly between 2019-2020 and 2021-2022, the most recent prevalence was significantly higher than it was in 2013-2014, representing an improvement over time.

BEHAVIORS | SMOKING AND TOBACCO USE

E-cigarette use among women ages 18-44 exceeded 10%, while rates of smoking among women decreased.

E-Cigarette Use Among Women

Electronic cigarettes, also called e-cigarettes, vapes or vape pens, are devices that use heat to make an aerosol that users inhale.[53] E-cigarettes may contain additives such as ultrafine particles that can go deep into the lungs, cancer-causing chemicals and flavoring chemicals linked to lung disease and injury.[54,53,55]

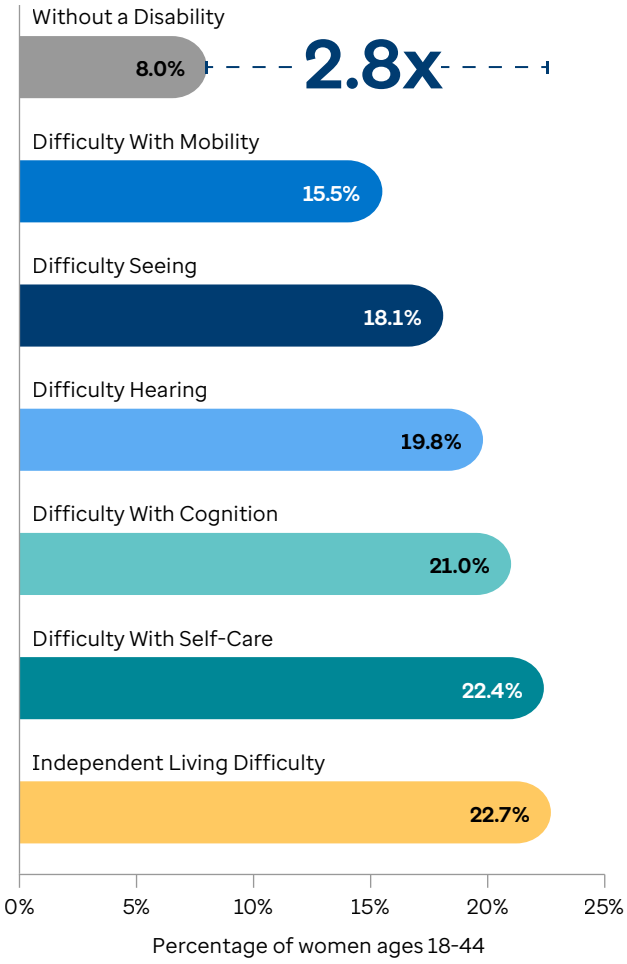
Nationally, 10.8% of women ages 18-44 – 5.8 million women – reported using e-cigarettes or other electronic vaping products at least once in their lifetime and now use daily or some days in 2022.

Disparities. E-cigarette use significantly varied by geography, disability, race/ethnicity, education, age, sexual orientation, income, veteran status and metropolitan status in 2022. The prevalence was:

- 2.8 times higher in Arkansas (18.8%) than Maryland (6.6%).
- 2.8 times higher among women with independent living difficulty (22.7%) and women who have difficulty with self-care (22.4%) compared with those who do not have a disability (8.0%).
- 2.7 times higher among multiracial (16.7%) compared with Asian (6.2%) women.
- 2.4 times higher among high school graduates (12.2%) and women with some post-high school education (12.2%) compared with college graduates (5.0%).
- 2.2 times higher among women ages 18-24 (15.7%) than those ages 35-44 (7.2%).
- 2.0 times higher among LGBQ+ women (18.2%) than straight women (9.0%).
- 1.8 times higher among women with an annual household income less than $25,000 (11.5%) than those with incomes of $75,000 or more (6.4%).
- 1.5 times higher among women who have served in the U.S. armed forces (15.9%) compared with those who have not served (10.7%).
- 1.3 times higher among women living in non-metropolitan areas (13.4%) than those in metropolitan areas (10.5%).

E-Cigarette Use Among Women

By Disability Status in 2022



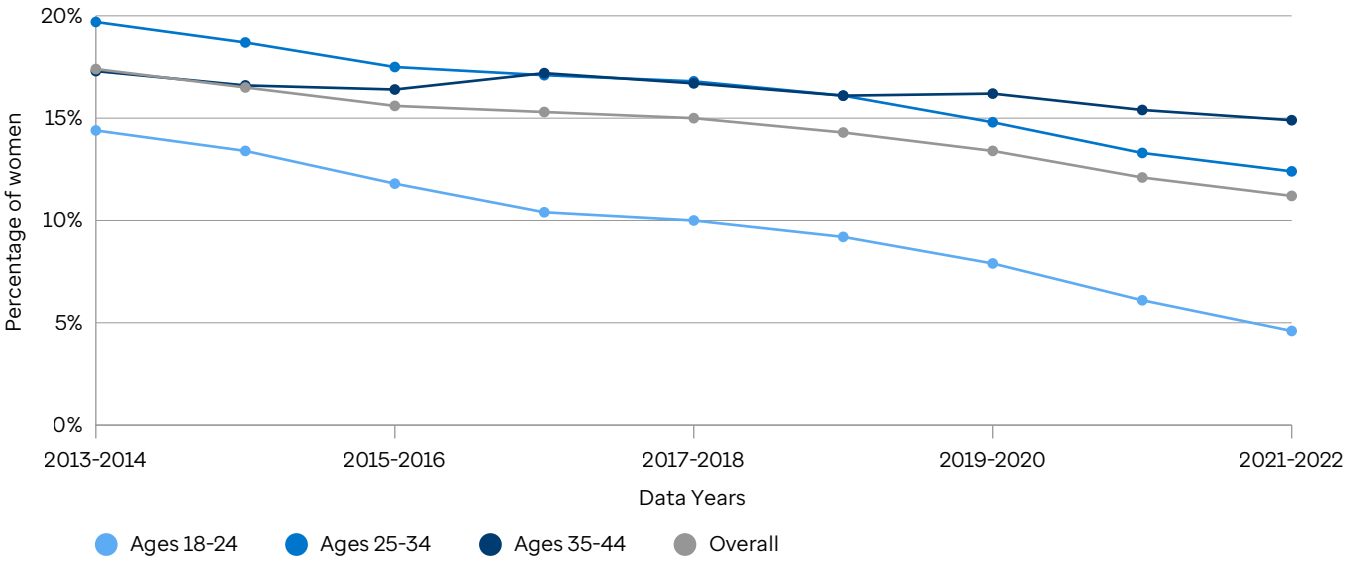
Source: CDC, Behavioral Risk Factor Surveillance System, 2022.

Note: The value for women who have difficulty with independent living may not be significantly different from the values for women who have difficulty with cognition, difficulty with self-care, difficulty seeing or difficulty hearing based on overlapping 95% confidence intervals.

Note: The value for women with independent living difficulty may not differ significantly from the values for those who have difficulty with cognition, those who have difficulty with self-care, those who have difficulty seeing and those who have difficulty with hearing based on overlapping 95% confidence intervals. The same is true for multiracial, Hawaiian/Pacific Islander and American Indian/Alaska Native women; and Asian, Black and Hispanic women; as well as women with incomes less than $25,000, women with incomes of $25,000-$49,999 and women with incomes of $50,000-$74,999.

Changes in Smoking Among Women

By Age Group Between 2013-2014 and 2021-2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2013-2022.

Smoking Among Women

As the leading cause of preventable death in the U.S., cigarette smoking is responsible for the deaths of more than 480,000 Americans every year, including 201,770 women.[56] One study estimated the probability of female smokers living to age 80 to be 38%, compared with 70% for female nonsmokers.[57]

Changes over time. Nationally, smoking – the percentage of women ages 18-44 who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days – decreased 16%, from 13.4% to 11.2% between 2019-2020 and 2021-2022. In 2021-2022, about 6 million women in the U.S. were active smokers, 1.1 million fewer women than in 2019-2020. The prevalence decreased among all ages and some educational attainment groups, as well as among women living in metropolitan areas. By group, the largest decreases were:

- 42% among women ages 18-24 (7.9% to 4.6%), 16% among women ages 25-34 (14.8% to 12.4%) and 8% among women ages 35-44 (16.2% to 14.9%).
- 14% among women who graduated from high school (23.8% to 20.5%) and 11% among women with some post-high school education (18.3% to 16.2%).
- 11% among women living in metropolitan areas (11.4% to 10.2%).

Smoking among women decreased in seven states, led by: 31% in both Hawaii (12.4% to 8.6%) and Kentucky (25.5% to 17.6%), and 30% in Connecticut (11.4% to 8.0%).

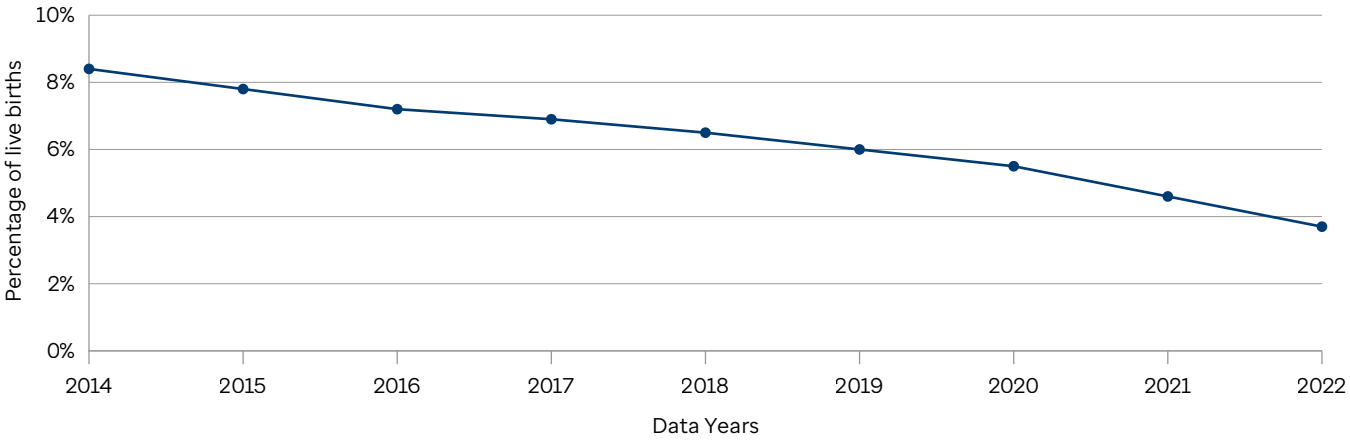
Disparities. Smoking among women significantly varied by race/ethnicity, educational attainment, geography, income, disability and age in 2021-2022. The rate was:

- 7.4 times higher among multiracial (18.5%) compared with Asian (2.5%) women.
- 4.8 times higher among women with less than a high school education (22.9%) than college graduates (4.8%).
- 4.7 times higher in West Virginia (25.6%) than California (5.4%).
- 3.5 times higher among women with an annual household income less than $25,000 (24.1%) than those with incomes of $75,000 or more (6.9%).
- 3.4 times higher among women who have difficulty with self-care (29.0%) than those without a disability (8.5%).
- 3.2 times higher among women ages 35-44 (14.9%) than those ages 18-24 (4.6%).

Note: The values for multiracial, American Indian/Alaska Native and Hawaiian/Pacific Islander women may not differ significantly based on overlapping confidence intervals. The same is true for women with less than a high school education and high school graduates. It is also true for women who have difficulty with self-care, those who have difficulty with mobility, those with independent living difficulty and those who have difficulty hearing.

Changes in Smoking During Pregnancy

Between 2014 and 2022



Source: CDC WONDER, Natality Public Use Files, 2014-2022.

Smoking During Pregnancy

Tobacco use during pregnancy has been linked to serious health problems, including: miscarriage and ectopic pregnancy; preterm birth and low birth weight; birth defects of the mouth and lip; abnormal bleeding during pregnancy and delivery; damage to a baby's developing lungs and brain that can last through childhood and adolescence; and increased risk of sudden infant death syndrome (SIDS).[58-62]

Changes over time. Nationally, smoking during pregnancy – the percentage of mothers who reported smoking cigarettes during pregnancy – decreased 20%, from 4.6% to 3.7% between 2021 and 2022, and 56% (from 8.4%), between 2014 and 2022. In 2022, about 134,000 mothers smoked during pregnancy, 34,000 fewer than in 2021.

Thirty states and the District of Columbia had decreases greater than or equal to the national change, led by: 44% in the District of Columbia (1.6% to 0.9% of live births), 38% in Delaware (5.2% to 3.2%) and 31% in Idaho (5.5% to 3.8%).

Disparities. Smoking during pregnancy varied by geography. In 2022, the rate was 21.9 times higher in West Virginia (15.3%) than California (0.7%).

Related Measure: Household Smoke Among Children

Changes over time. Household smoke – the percentage of children ages 0-17 who live in households where someone used cigarettes, cigars or pipe tobacco – decreased 16%, from 13.7% to 11.5% of U.S. children between 2020-2021 and 2022-2023.

The prevalence decreased among some racial/ethnic and educational attainment groups. By group, the largest decreases were:

- 23% among multiracial (16.7% to 12.8%), 19% among Black (15.3% to 12.4%) and 15% among white (14.7% to 12.5%) children.
- 20% among children whose caregiver has some post-high school education (21.0% to 16.9%) and 14% among children with a caregiver who graduated from college (7.0% to 6.0%).

The percentage decreased in two states: 33% in Texas (15.7% to 10.5%) and 29% in Indiana (19.7% to 14.0%).

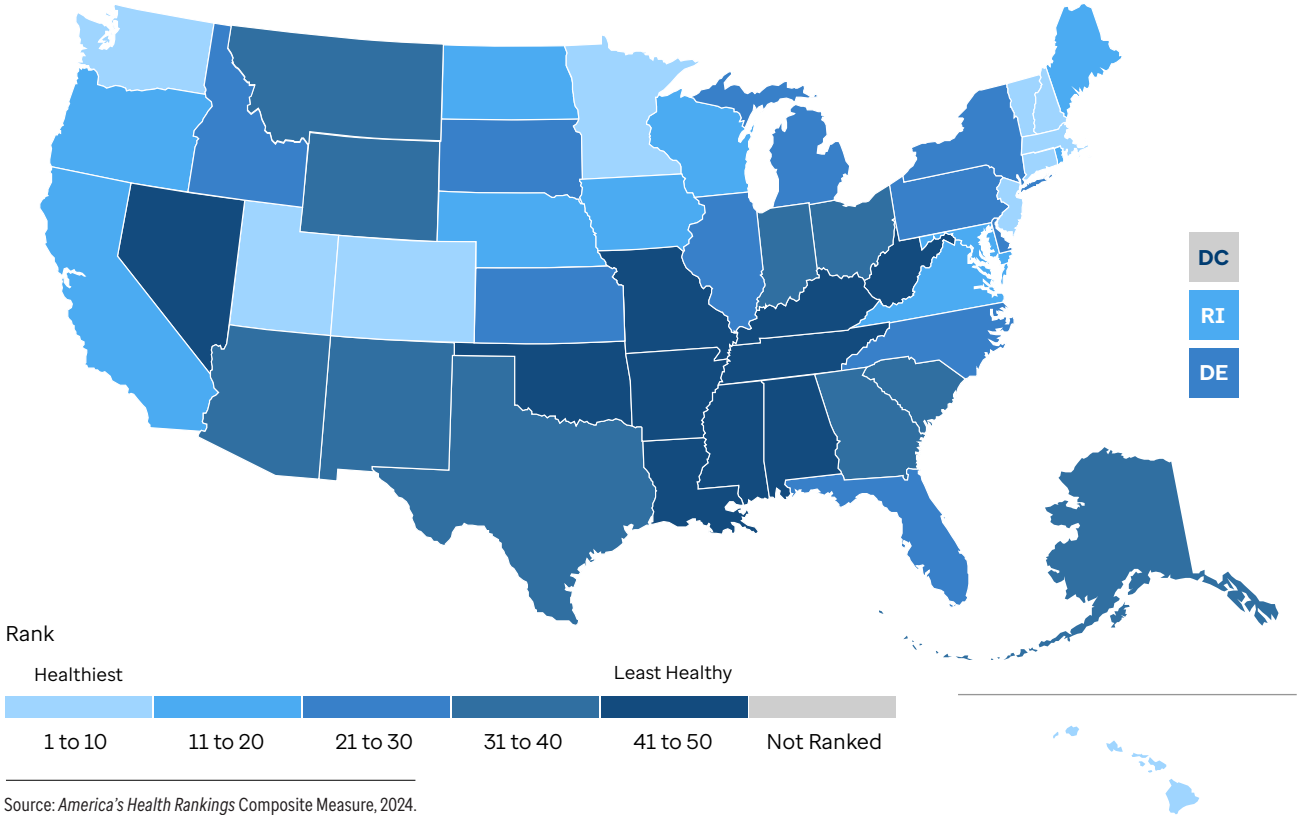
Disparities. The prevalence of household smoke significantly varied by geography, caregiver educational attainment and race/ethnicity in 2022-2023. The percentage was:

- 4.7 times higher in West Virginia (24.9%) than Utah (5.3%).
- 3.4 times higher among children with a caregiver who graduated from high school (20.6%) than those with a caregiver who graduated from college (6.0%).
- 2.2 times higher among American Indian/Alaska Native (18.2%) compared with Asian (8.3%) children.

Note: The values among American Indian/Alaska Native, multiracial, Black and Hawaiian/Pacific Islander children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian, Hispanic and Hawaiian/Pacific Islander children.

State Rankings: Women and Children

2024 Health of Women and Children Report



Source: *America's Health Rankings* Composite Measure, 2024.

State Rankings

Rankings included in the *2024 Health of Women and Children Report* are derived from 82 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. Visit the *America's Health Rankings* Methodology page for a more detailed description of how the overall rank is calculated.

New Hampshire Ranks No. 1

New Hampshire is the healthiest state in this year's report, ranking first for children and sixth for women. It ranks among the top five states in Social and Economic Factors (No. 2), Behaviors (No. 2) and Clinical Care (No. 4). New Hampshire is No. 13 in Physical Environment and No. 15 in Health Outcomes.

Strengths: Low percentage of women in poverty, high prevalence of high school completion and low percentage of children in poverty.

Challenges: Low percentage of children who are flourishing, high prevalence of frequent mental distress among women and high prevalence of multiple chronic conditions among women.

Massachusetts (No. 2), Minnesota (No. 3), New Jersey (No. 4) and Vermont (No. 5) complete the top five healthiest states.

Arkansas Ranks No. 50

Arkansas is the least healthy state in this year's report, ranking No. 49 for children and last for women. It ranks in the bottom five states in Social and Economic Factors (No. 50), Physical Environment (No. 47), Behaviors (No. 48) and Health Outcomes (No. 49). Arkansas is No. 44 in Clinical Care.

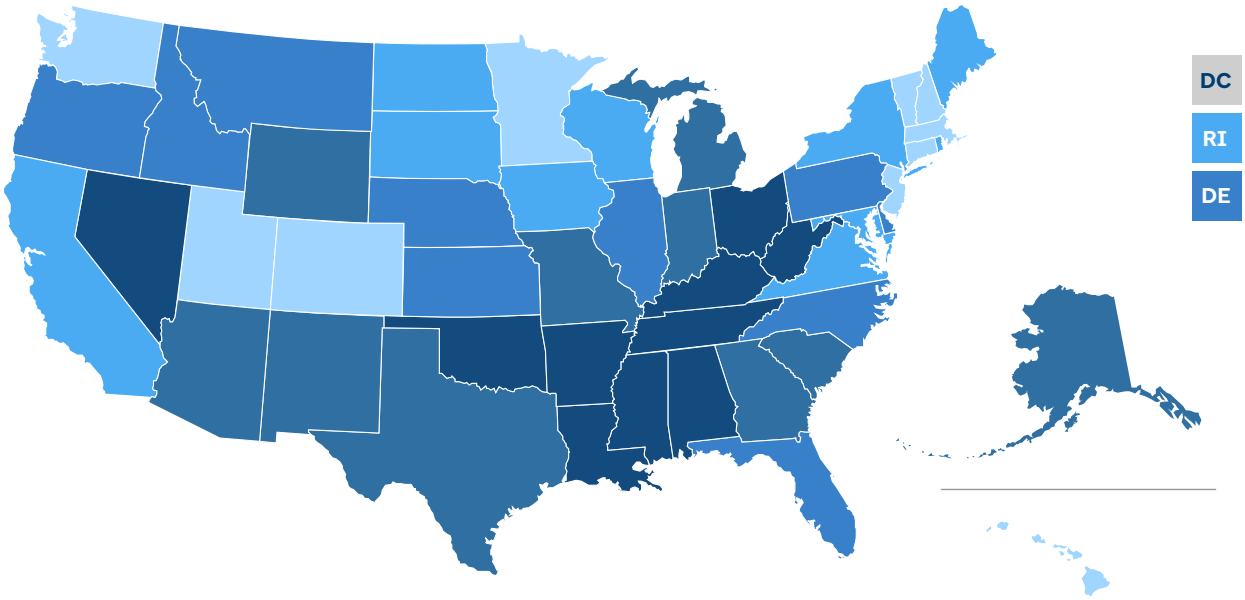
Strengths: Low prevalence of illicit drug use among adolescents, high prevalence of well-woman visits and low housing cost burden among households with children.

Challenges: High prevalence of adverse childhood experiences (ACEs) among children, high teen birth rate and high prevalence of cigarette smoking among women.

Mississippi (No. 49), Louisiana (No. 48), Oklahoma (No. 47) and West Virginia (No. 46) complete the five least healthy states.

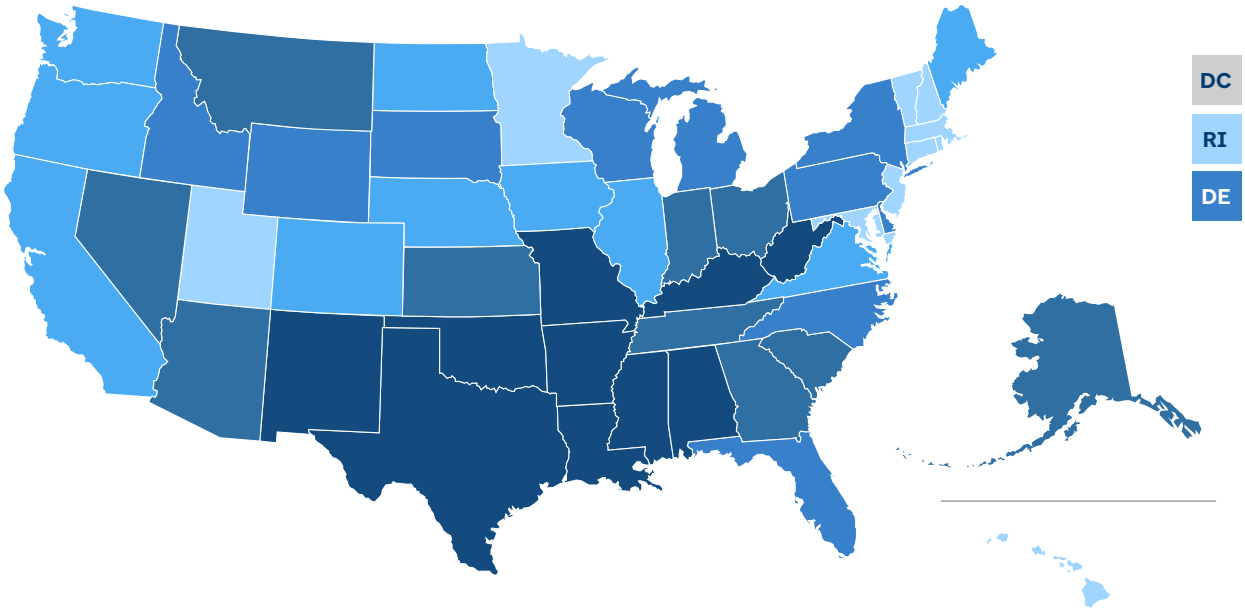
State Rankings: Women of Reproductive Age

2024 Health of Women and Children Report



State Rankings: Children

2024 Health of Women and Children Report



Rank

Healthiest — Least Healthy

1 to 10	11 to 20	21 to 30	31 to 40	41 to 50	Not Ranked

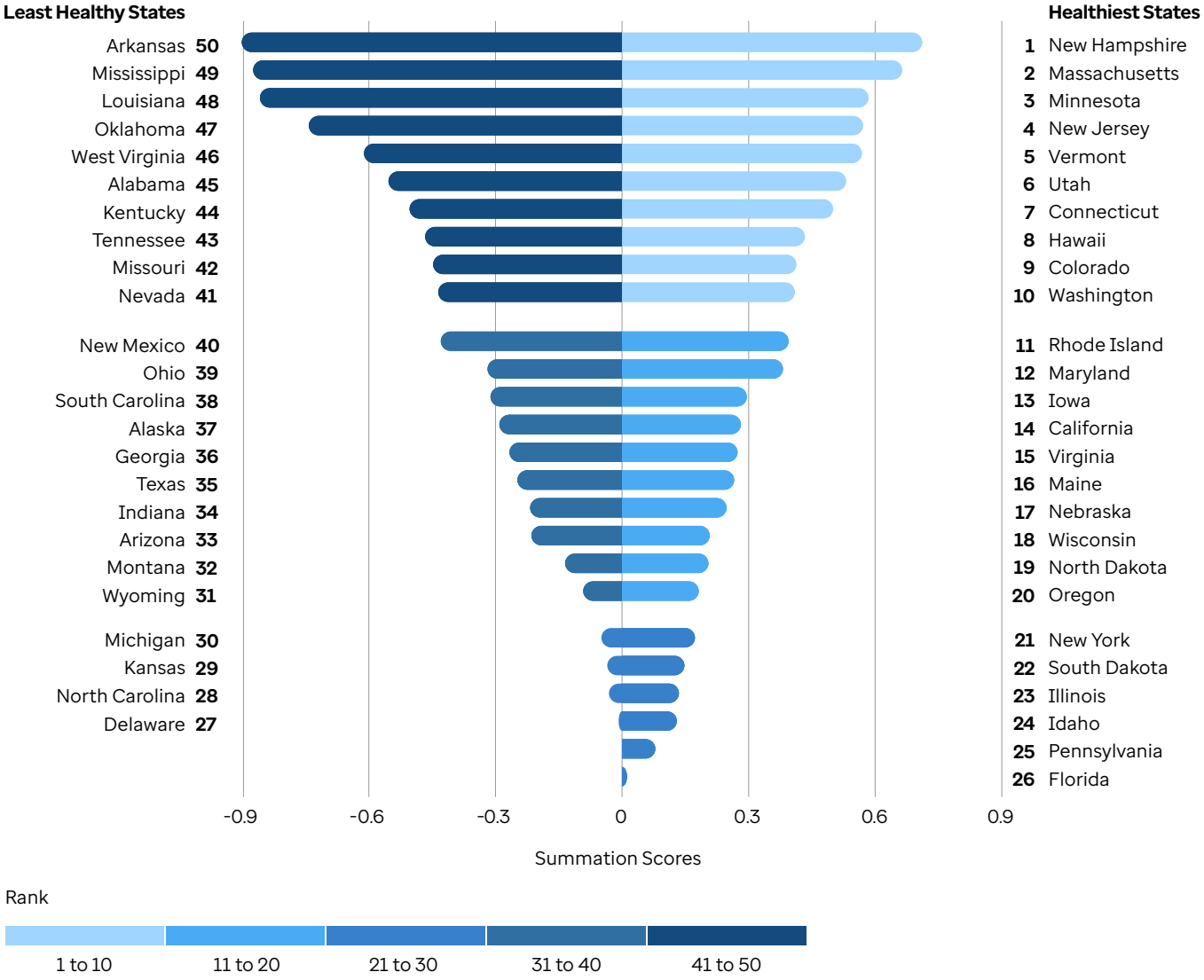
Source: *America's Health Rankings* Composite Measure, 2024.

This graph displays the state scores and rank with the least healthy states on the top left and the healthiest states on the top right. The distance between bars shows the difference between state scores. For example, Oklahoma (No. 47) and West Virginia (No. 46), while close in ranking, have a sizable difference in score, meaning Oklahoma would need to make improvements in many measures to improve its rank. There is also a large gap in score between Oklahoma and Louisiana (No. 48).

To further explore state-level data, see Explore Data. The website features downloadable State Summaries for each state and the District of Columbia. Each summary describes state-specific strengths, challenges, trends and rankings for individual measures, allowing users to identify which measures positively or negatively influenced each state's overall rank. This can be visualized by selecting a state in the Explore Data section. Disparity ratios, the relative difference between two groups within a demographic, have been added to the State Summaries on the website this year. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can affect a state's overall rank.

Overall State Rankings and Scores*

2024 Health of Women and Children Report



Source: *America's Health Rankings* Composite Measure, 2024.
*Sum of weighted z-scores of all ranked measures.

United States

National Health Department Website: hhs.gov

Summary

Key Findings

Firearm Deaths Among Children
37%▲
from 4.3 to 5.9 deaths per 100,000 children ages 1-19 between 2017-2019 and 2020-2022.

Smoking During Pregnancy
20%▼
from 4.6% to 3.7% of women with a recent live birth between 2021 and 2022.

Mortality Among Children
14%▲
from 25.4 to 29.0 deaths per 100,000 children ages 1-19 between 2017-2019 and 2020-2022.

Mental Health Conditions Among Children
12%▲
from 17.7% to 19.9% of children ages 3-17 between 2020-2021 and 2022-2023.

Mortality Among Women
12%▼
from 136.4 to 120.0 deaths per 100,000 women ages 20-44 between 2021 and 2022.

Teen Suicide
6%▼
from 11.2 to 10.5 deaths per 100,000 adolescents ages 15-19 between 2017-2019 and 2020-2022.

Measures

Women		U.S. Value
Social & Economic Factors		
Community and Family Safety	Firearm Deaths*	6.1
	Injury Deaths	52.0
	Intimate Partner Violence Before Pregnancy*	–
Economic Resources	Concentrated Disadvantage	25.9%
	Food Insecurity	11.2%
	Gender Pay Gap*	82.0%
	Poverty	15.2%
	Unemployment	3.6%
Education	College Graduate	37.7%
Social Support and Engagement	Infant Child Care Affordability*	11.7%
	Residential Segregation - Black/White	–
	Voter Participation	60.7%

Children		U.S. Value
Social & Economic Factors		
Community and Family Safety	Child Victimization*	7.7
	Firearm Deaths*	5.9
	Injury Deaths	18.6
Economic Resources	Children in Poverty	16.3%
	Children in Poverty - Racial Disparity	3.0
	Food Sufficiency	67.3%
	Students Experiencing Homelessness	2.4%
	WIC Coverage	49.9%
Education	Early Childhood Education	46.7%
	Fourth Grade Reading Proficiency	32.1%
	High School Completion	89.6%
Social Support and Engagement	Adult Mentor*	86.8%
	Adverse Childhood Experiences	14.5%
	Foster Care Instability	15.2%
	High-Speed Internet	95.4%
	Neighborhood Amenities	38.0%
	Reading, Singing or Storytelling*	58.4%

Women and Children		U.S. Value
Physical Environment		
Air and Water Quality	Air Pollution	8.6
	Drinking Water Violations	2.7
	Household Smoke	11.5%
	Water Fluoridation	72.7%
Climate and Health	Climate Policies	–
	Transportation Energy Use*	8.3
Housing and Transportation	Drive Alone to Work	66.9%
	Housing Cost Burden - Households With Children	30.6%
	Housing with Lead Risk	16.5%

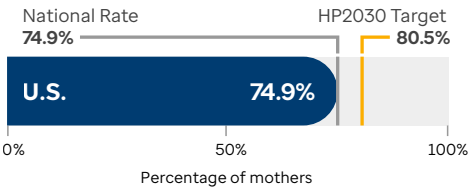
Measures

Women		U.S. Value
Clinical Care		
Access to Care	Adequate Prenatal Care	74.9%
	Avoided Care Due to Cost	16.0%
	Maternity Care Desert*	3.7
	Uninsured	10.9%
	Women's Health Providers	46.9
Preventive Clinical Care	Cervical Cancer Screening	51.6%
	Dental Visit	64.1%
	Flu Vaccination	36.4%
	Postpartum Visit*	–
	Well-Woman Visit	71.2%
Quality of Care	Breastfeeding Initiation	85.5%
	Dedicated Health Care Provider	78.1%
	Low-Risk Cesarean Delivery	26.3%
	Maternity Practices Score	81
Behaviors		
Nutrition and Physical Activity	Exercise	21.5%
	Fruit and Vegetable Consumption	9.8%
	Physical Inactivity	21.6%
Sexual Health	Chlamydia	1,540.1
	High-Risk HIV Behaviors	9.3%
	Unintended Pregnancy*	–
Sleep Health	Insufficient Sleep	36.5%
Smoking and Tobacco Use	E-Cigarette Use*	10.8%
	Smoking	11.2%
	Smoking During Pregnancy	3.7%
Health Outcomes		
Behavioral Health	Drug Deaths*	28.6
	Excessive Drinking	19.5%
	Frequent Mental Distress	22.9%
	Illicit Drug Use	10.4%
	Postpartum Depression*	–
Mortality	Maternal Mortality*	23.2
	Mortality Rate	120.0
Physical Health	Depression*	29.1%
	Diabetes*	3.5%
	Frequent Physical Distress	8.6%
	High Blood Pressure	10.8%
	High Health Status*	55.1%
	Multiple Chronic Conditions	4.6%
	Obesity	32.7%
	Severe Maternal Morbidity*	100.3

Children		U.S. Value
Clinical Care		
Access to Care	ADD/ADHD Treatment	3.1%
	Mental Health Treatment*	82.5%
	Pediatricians	113.2
	Uninsured	5.1%
Preventive Clinical Care	Childhood Immunizations	69.1%
	HPV Vaccination	62.6%
	Preventive Dental Visit	79.2%
	Well-Child Visit	78.8%
Quality of Care	Adequate Insurance	66.5%
	Developmental Screening	35.6%
	Medical Home	45.5%
Behaviors		
Nutrition and Physical Activity	Breastfed	25.4%
	Physical Activity	19.5%
	Soda Consumption*	8.5%
Sexual Health	Dual Contraceptive Nonuse*	89.8%
	Teen Births	13.6
Sleep Health	Adequate Sleep	64.8%
	Sleep Position*	–
Smoking and Tobacco Use	Electronic Vapor Product Use*	18.0%
	Tobacco Use	2.4%
Health Outcomes		
Behavioral Health	Alcohol Use	7.0%
	Flourishing	65.6%
	Illicit Drug Use	7.4%
	Mental Health Conditions	19.9%
	Teen Suicide*	10.5
Mortality	Child Mortality	29.0
	Infant Mortality	5.5
	Neonatal Mortality*	3.5
Physical Health	Asthma	6.6%
	Congenital Syphilis*	102.5
	High Health Status*	90.0%
	Low Birth Weight	8.6%
	Low Birth Weight - Racial Disparity	2.1
	Neonatal Abstinence Syndrome*	5.9
	Overweight or Obesity	31.1%

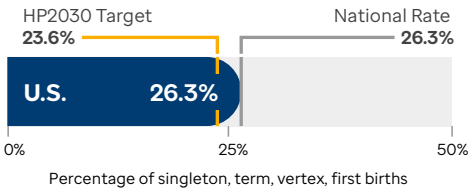
Healthy People 2030 (HP2030) Targets

Adequate Prenatal Care



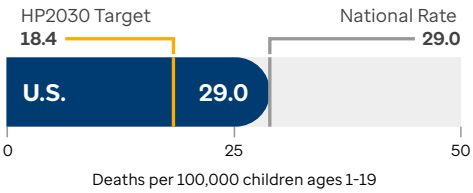
Percentage of mothers

Low-Risk Cesarean Delivery



Percentage of singleton, term, vertex, first births

Child Mortality



Deaths per 100,000 children ages 1-19

Visit **AmericasHealthRankings.org** for additional information, including measure definitions, source details and methodologies.

* Additional unweighted measure (not included in the overall score/rank).
– Data not available, missing or suppressed.

Demographic Group Definitions

Analyses were performed to illuminate disparities by age, disability status, education, gender, sexual orientation, income, metropolitan status, race/ethnicity and veteran status. Not all groups were available for all data sources and measures. Individual estimates were suppressed if they did not meet the reliability criteria laid out by the data source or internally established criteria. Some values had wide 95% confidence intervals, meaning the true value may be far from the estimate listed.

Age. Age data in this report were available for measures from the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System (BRFSS) and the Maternal and Child Health Bureau's Federally Available Data (FAD), which were sourced from the National Vital Statistics System (NVSS) and the Healthcare Cost Utilization Project (HCUP). BRFSS groupings in this report were limited to women of reproductive age and included the following self-reported age ranges: 18-24, 25-34 and 35-44. FAD groupings were based on maternal age and were grouped into five age ranges: <20, 20-24, 25-29, 30-34 and ≥35.

Disability Status. Disability status data in this report were available for measures from BRFSS. Groupings were based on responses to the questions in the core disability section: "Are you deaf or do you have serious difficulty hearing?"; "Are you blind or do you have serious difficulty seeing, even when wearing glasses?"; "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?"; "Do you have serious difficulty walking or climbing stairs?"; "Do you have difficulty dressing or bathing?"; and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" Responses of no or missing to all questions, with at least one response being no, were coded as without a disability.

Education. Education data in this report were available for measures from BRFSS and FAD data sourced from NVSS. BRFSS groupings were based on responses to the question, "What is the highest grade or year of school you completed?" FAD groupings were based on the education level that best described the highest degree or level of school completed at the time of death.

Gender. This report highlights data on women and includes gender stratification (girls, boys) for youth and children's measures as available through public data sources – even though not all people identified with these two categories. Data did not differentiate between assigned sex at birth and current gender identity. While sex and gender influence health, the current data collection practices of many national surveys limit the ability to describe the health of transgender and nonbinary individuals, especially at the state level.

Sexual Orientation. Sexual orientation data in this report were available for measures from BRFSS. Groupings were based on responses to the question, "Which of the following best represents how you think of yourself?" Responses of lesbian or gay, gay, bisexual or something else were summed and classified as LGBQ+. Responses of straight, that is, not gay, were summed and classified as straight.

Income. Income data in this report were available for measures from BRFSS and FAD data sourced from HCUP. BRFSS groupings were based on responses to the question, "[What] is your annual household income from all sources?" FAD groupings were based on quartiles (poorest to wealthiest) of current-year median ZIP code household income obtained from Claritas, a data-driven marketing company.

Metropolitan Status. Metropolitan status data in this report were available for measures from BRFSS and FAD data sourced from HCUP. BRFSS groupings were coded based on the respondent's residence. Identification as large central metro, large fringe metro, medium metro or small metro was classified as metro, and identification as micropolitan or noncore was classified as non-metro. FAD groupings were based on the 2013 National Center for Health Statistics Urban-Rural Classification Scheme for Counties. Metropolitan areas with at least 1 million residents were classified as large metro. Metropolitan areas of fewer than 1 million residents were classified as small to medium metro. Micropolitan, non-metropolitan and non-micropolitan areas were classified as non-metro.

Race/Ethnicity. Data were provided where available for the following racial and ethnic groups: American Indian/Alaska Native, Asian, Black or African American (classified in this report as "Black"), Hispanic or Latino/a (classified as "Hispanic"), Native Hawaiian or Other Pacific Islander (classified as "Hawaiian/Pacific Islander"), white, multiracial and those who identify as other race. Hispanic ethnicity includes members of all racial groups. Racial/ethnic groups were defined differently across data sources. In summary, BRFSS, CDC WONDER and FAD race groupings are all non-Hispanic, while the American Community Survey data are Hispanic-inclusive, except for white, which is non-Hispanic.

Veteran Status. Veteran status data in this report were available for measures from BRFSS. Groupings were based on responses to the question, "Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?"

Language

This report uses language aligned with the *AP Style Guide* when labeling women and children, due to the complexity of having similar measures for women and children and the many referenced sources. The report uses women instead of females, except for in measure definitions, which use language consistent with the underlying data sources to ensure accuracy. BRFSS is the exception and uses women rather than females in measure definitions to differentiate BRFSS measures in the *Health of Women and Children Report* from measures in the *Annual Report*. The report uses boys and girls instead of males and females when describing gender demographic groups for children's measures. It also uses teens or adolescents for measures that exclude younger children (teen suicide, teen births). Youth represents the population that excludes younger children but includes tweens (overweight or obesity - youth, tobacco use - youth).

Limitations

Data presented in this report were aggregated at the state level and cannot be used to make inferences at the individual level. Additionally, estimates cannot be extrapolated beyond the population upon which they were created.

While the sampling methods used by the data sources ensure estimates are representative at the state and national levels, limitations exist. Not all demographic groups were available for all data sources and measures. Additionally, at times sample sizes were too small to create reliable estimates.

Use caution when interpreting data, as many measures are self-reported and rely on an individual's perception of health and behaviors. Additionally, some health outcome measures are based on respondents being told by a health care professional that they have a disease and may exclude those who have not received a diagnosis or sought or obtained treatment.

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Child Care Aware

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- National Center for Education Statistics
- National Center for Homeless Education

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- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Children's Bureau
- Health Resources & Services Administration
  - Maternal and Child Health Bureau
- Substance Abuse and Mental Health Services Administration

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Questions and comments on the report should be directed to the United Health Foundation at unitedhealthfoundationinfo@uhg.com.

UNITED HEALTH FOUNDATION®

About the United Health Foundation

Through collaboration with community partners, grants and outreach efforts, the United Health Foundation works to improve our health system, build a diverse and dynamic health workforce and enhance the well-being of local communities. The United Health Foundation was established by UnitedHealth Group (NYSE: UNH) in 1999 as a not-for-profit, private foundation dedicated to improving health and health care. To date, the United Health Foundation has committed nearly $800 million to programs and communities around the world, including a $100 million commitment to help diversify the health workforce. To learn more, visit UnitedHealthFoundation.org.

AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

For more information, contact:
The United Health Foundation
Jenifer McCormick
jenifer_mccormick@uhg.com
(952) 936-1917

AmericasHealthRankings.org