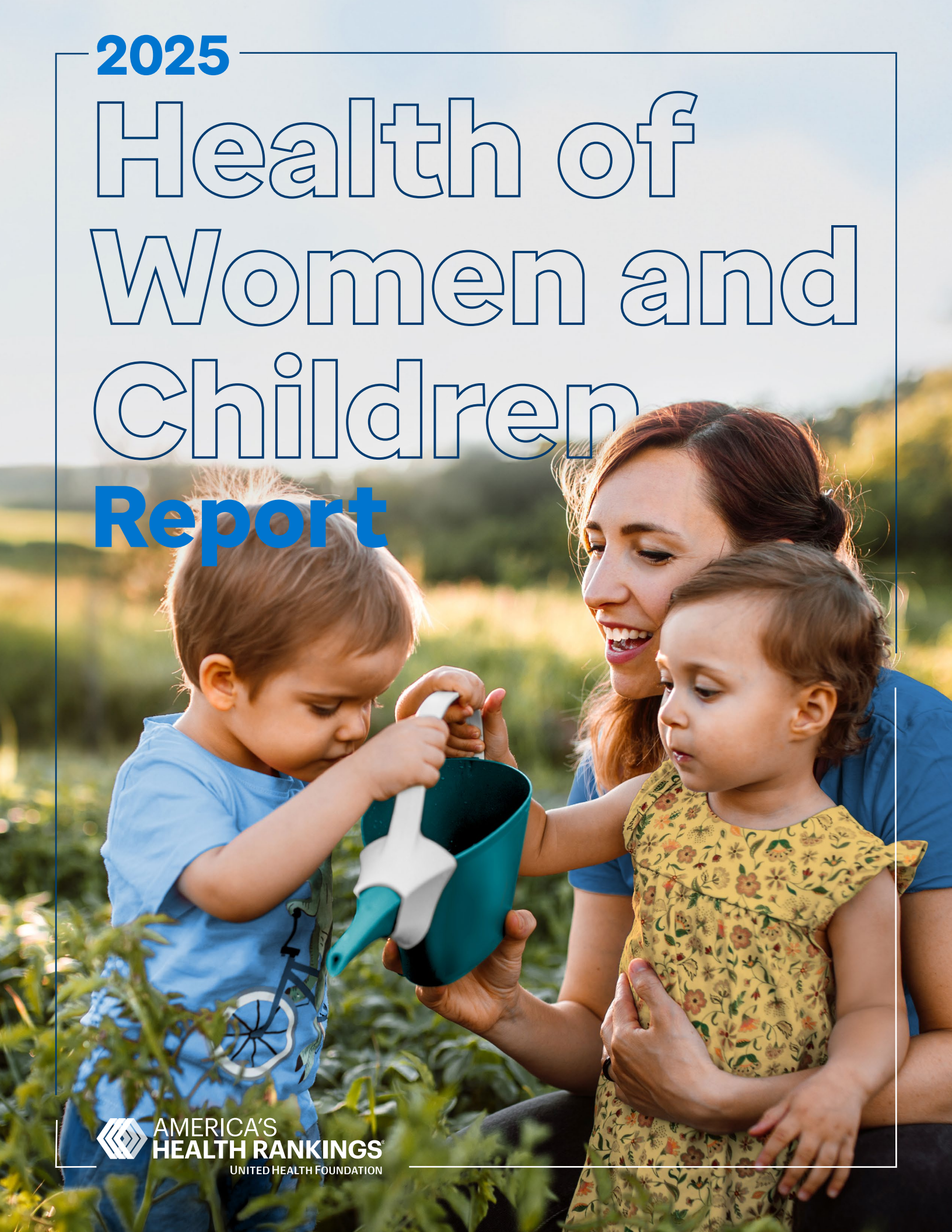
2025

Health of Women and Children

Report



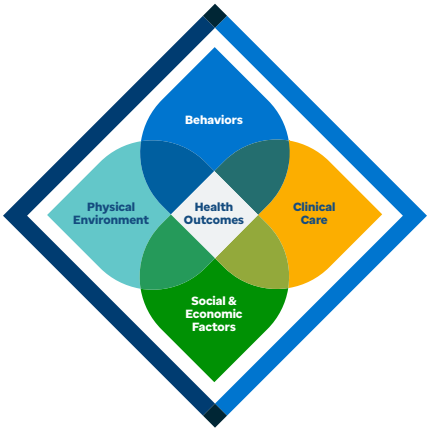
AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

Contents

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, particularly County Health Rankings & Roadmaps and Healthy People. The model serves as a framework across all *America's Health Rankings* reports for identifying and quantifying the drivers and outcomes that impact state and national population health.



Call to Action

While progress has been made, the data in the *2025 Health of Women and Children Report* show urgent challenges that cannot be ignored. Rising maternal and child mortality rates highlight the need for collaboration and coordinated action. These data can also foster interventions tailored to address communities' unique needs, like higher rates of chronic conditions among women in rural areas. Insights from *America's Health Rankings* data can help leaders target and prioritize strategies that advance the health of women and children and the nation as a whole.

The United Health Foundation® is proud to release the *America's Health Rankings 2025 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.

This report recognizes changes in mortality among women — including a historic plateauing of drug-related deaths — as well as other advances that strengthen long-term health and well-being, including a reduction in the prevalence of childhood overweight or obesity and increased early childhood education enrollment. Despite these successes, maternal, infant and child mortality increased and behavioral health issues rose among women and children.

In 2023, there were approximately 59.5 million women of reproductive age (18-44) and 72.8 million children younger than 18 in the United States. Together, these groups constitute a substantial share of the U.S. population, nearly 40%, whose health and well-being are essential to the strength and resilience of communities nationwide.

Women faced challenges across various health outcomes, including mortality, behavioral and physical health measures such as maternal mortality, depression and frequent physical distress. There were bright spots in children's health outcomes, including decreases in neonatal abstinence syndrome and overweight or obesity. These were offset in part by increases in child, infant and neonatal mortality. For the first time in the history of the *Health of Women and Children Report*, infant mortality increased.

The report also examines differences across communities, spotlighting challenges faced by women living in rural areas, who experience higher rates of chronic conditions and risk factors than their metropolitan counterparts. These differences underscore the need for solutions tailored to the unique needs of rural communities.

The *2025 Health of Women and Children Report* finds that:

- Child, infant and maternal mortality rates worsened, while the death rate among women of reproductive age continued to improve. This coincided with a plateau in drug deaths among women, which had been steadily increasing since 2014.
- The prevalence of depression and frequent mental distress among women continued to increase, as did diagnosed anxiety among children. However, the prevalence of children receiving needed treatment for attention-deficit/hyperactivity disorder (ADHD) improved.
- Some measures of women's physical health worsened, such as frequent physical distress and high health status, while obesity or overweight among children improved. Rates of severe maternal morbidity and neonatal abstinence syndrome also improved.
- The poverty rate among women of reproductive age improved, as did the percentage of eligible children receiving USDA's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Voter participation among women declined, while two measures of social support for children — neighborhood amenities and early childcare enrollment — improved.
- Fewer children were exposed to household smoke.
- More women avoided needed medical care due to cost, fewer women had a dedicated health care provider and fewer children had health insurance.
- The rate of preventive medical visits (well visits) improved among women and children, but vaccination rates declined.
- Fewer than 1 in 3 women met federal exercise guidelines.
- Chlamydia incidence among women decreased, and the teen birth rate continued to improve.
- Rates of smoking during pregnancy continued to improve.

New in 2025

This year, *America's Health Rankings* added chronic school absenteeism and postpartum anxiety to the report. Obesity among children (BMI in the 95th percentile or above) was also added as a component of the measure overweight or obesity among children (BMI in the 85th percentile and above). Also new this year is the ability to stratify measures sourced from the National Survey of Children's Health by special health care needs status. For a detailed description of this, and other demographic groups, see Methodology (page 54).

Users can explore population data by metropolitan and nonmetropolitan (rural) areas for a variety of measures. For further insights into differences by metropolitan status, look for this icon throughout the *Executive Brief* and *Comprehensive Report*.

For details on demographic group definitions and limitations, data sources and methodology, please refer to the Appendix on page 52 or visit AmericasHealthRankings.org.

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 *2025 Health of Women and Children Report* is based on:

- **One hundred and twenty-five measures.** These include 82 ranking and 43 unweighted measures (not included in a state's overall rank). For a complete list of measures, definitions and source details, see Measures Table – Women, Measures Table – Children and Data Source Descriptions (page 44).
- **Five categories of health.** These comprise Health Outcomes and four categories of health determinants: Social and Economic Factors, Physical Environment, Behaviors and Clinical Care.
- **Thirty-four sources.** Data are from multiple sources, including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance 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 determinants of health.
- **Providing a benchmark for states.** Since 2016, the report has presented strengths, challenges and key findings for every state and the District of Columbia. Public health leaders can monitor health trends over time and compare their state's health measures with those of other states and the nation. State Summaries are available on the *America's Health Rankings* website as separate downloads.
- **Highlighting differences.** The report shows differences in health between states and among demographic groups at state and national levels where data are available, with groupings based on race/ethnicity, gender, age, education, income, metropolitan status, disability status, special health care needs status among children, sexual orientation and veteran status.
- **Stimulating action.** The report aims to drive change and improve health by drawing attention to trends and promoting data-driven discussions among individuals, community leaders, public health workers, policymakers and the media. States can incorporate population insights into their annual review of programs, and many organizations use the report as a reference when assigning goals for health improvement plans.

Spotlight

Women in Rural Communities

Several chronic conditions were higher among women in rural areas compared with their metropolitan counterparts

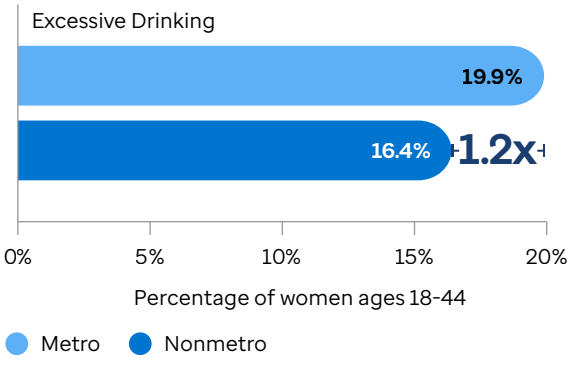
The *2025 Health of Women and Children Report* not only provides a national, comprehensive picture of women and children's health and well-being, but also sheds light on the distinct challenges faced by specific populations.

This year's report uses *America's Health Rankings'* depth of data to spotlight rural communities. It finds that women in rural areas had lower rates of excessive drinking, but higher rates of chronic conditions than those living in metropolitan areas.

These differences highlight how geographic location and access to resources can shape health outcomes and underscore the importance of tailored solutions to meet the needs of different populations across the United States.

Excessive Drinking Among Women

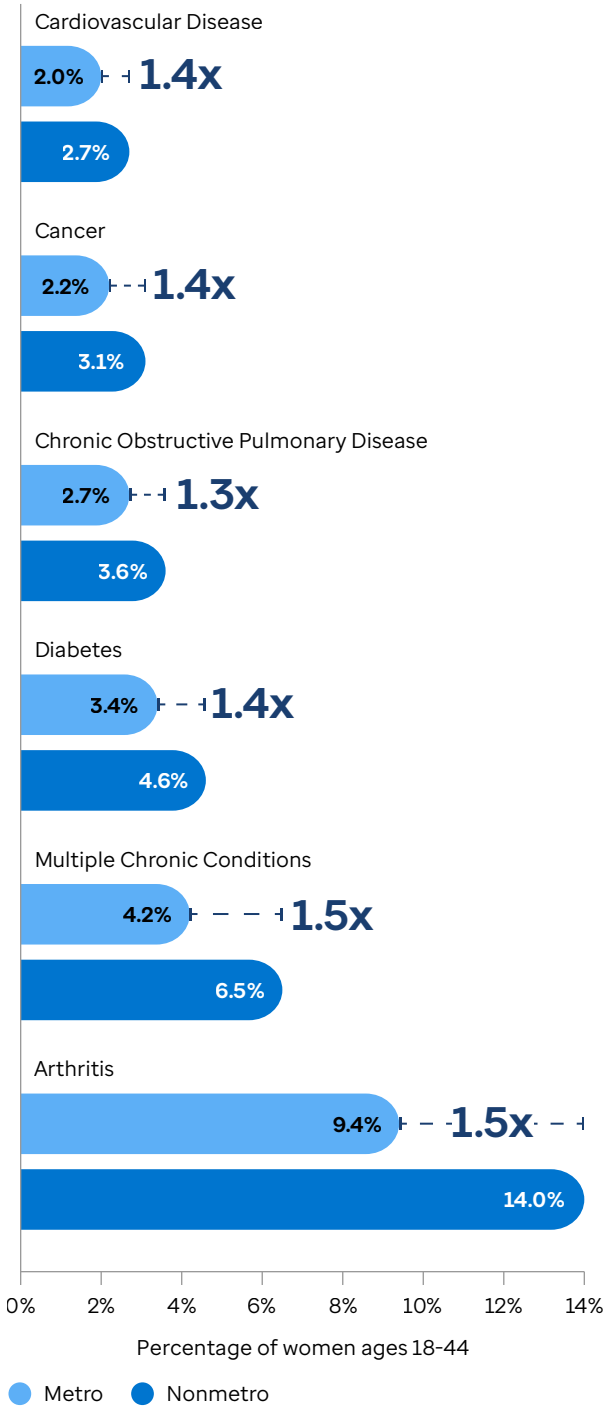
By Metropolitan Status in 2022-2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

Chronic Conditions Among Women

By Metropolitan Status in 2022-2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

National Snapshot

Rising Mortality Rates

Maternal Mortality*

36% ▲

increase from 17.3 to 23.5 deaths per 100,000 live births between 2014-2018 and 2019-2023.

Child Mortality**

14% ▲

increase from 25.9 to 29.6 deaths per 100,000 children ages 1-19 between 2018-2020 and 2021-2023.

Infant Mortality†

4% ▲

increase from 5.4 to 5.6 deaths before age 1 per 1,000 live births between 2020-2021 and 2022-2023.

Health Outcomes

37% ▲
Frequent Physical Distress Among Women††
increase from 7.1% to 9.7% of women ages 18-44 between 2020-2021 and 2022-2023.

13% ▼
High Health Status Among Women††
decrease from 59.0% to 51.6% of women ages 18-44 between 2020-2021 and 2022-2023.

11% ▲
Depression Among Women††
increase from 27.4% to 30.3% of women ages 18-44 between 2020-2021 and 2022-2023.

10% ▼
Neonatal Abstinence Syndrome*
decrease from 5.9 to 5.3 NAS hospitalizations per 1,000 birth hospitalizations between 2021 and 2022.

9% ▲
Mental Health Conditions Among Children‡
increase from 18.8% to 20.5% of children ages 3-17 between 2021-2022 and 2023-2024.

8% ▼
Mortality Rate Among Women**
decrease from 120.0 to 109.9 deaths per 100,000 women ages 20-44 between 2022 and 2023.

7% ▼
Overweight or Obesity Among Children‡
decrease from 33.8% to 31.3% of children ages 6-17 between 2021-2022 and 2023-2024.

6% ▼
Severe Maternal Morbidity*
decrease from 100.3 to 94.7 complications per 10,000 delivery hospitalizations between 2021 and 2022.

* Source: U.S. HHS, Maternal and Child Health Bureau, Federally Available Data.
** Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER.
† Source: U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER.
†† Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.
‡ Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health.

Social and Economic Factors

6% ▲
Neighborhood Amenities*
increase from 36.1% to 38.2% of children ages 0-17 between 2021-2022 and 2023-2024.

5% ▲
Reading, Singing or Storytelling*
increase from 57.1% to 59.7% of children ages 0-5 between 2021-2022 and 2023-2024.

5% ▼
Fourth Grade Reading Proficiency**
decrease from 32.1% to 30.5% of public school students between 2022 and 2024.

4% ▲
Early Childhood Education†
increase from 46.7% to 48.5% of children ages 3-4 between 2022 and 2023.

Clinical Care

21% ▲
ADD/ADHD Treatment Among Children*
increase from 2.8% to 3.4% of children ages 3-17 between 2021-2022 and 2023-2024.

19% ▲
Avoided Care Due to Cost Among Women††
increase from 14.6% to 17.4% of women ages 18-44 between 2021 and 2022-2023.

9% ▼
Flu Vaccination Among Women††
decrease from 38.9% to 35.5% of women ages 18-44 between 2020-2021 and 2022-2023.

6% ▲
Uninsured Children†
increase from 5.1% to 5.4% of children ages 0-18 between 2022 and 2023.

Behaviors

4% ▼
Chlamydia‡
decrease from 1,540.1 to 1,481.2 cases per 100,000 females ages 15-44 between 2022 and 2023.

4% ▼
Teen Births‡‡
decrease from 13.6 to 13.1 births per 1,000 females ages 15-19 between 2022 and 2023.

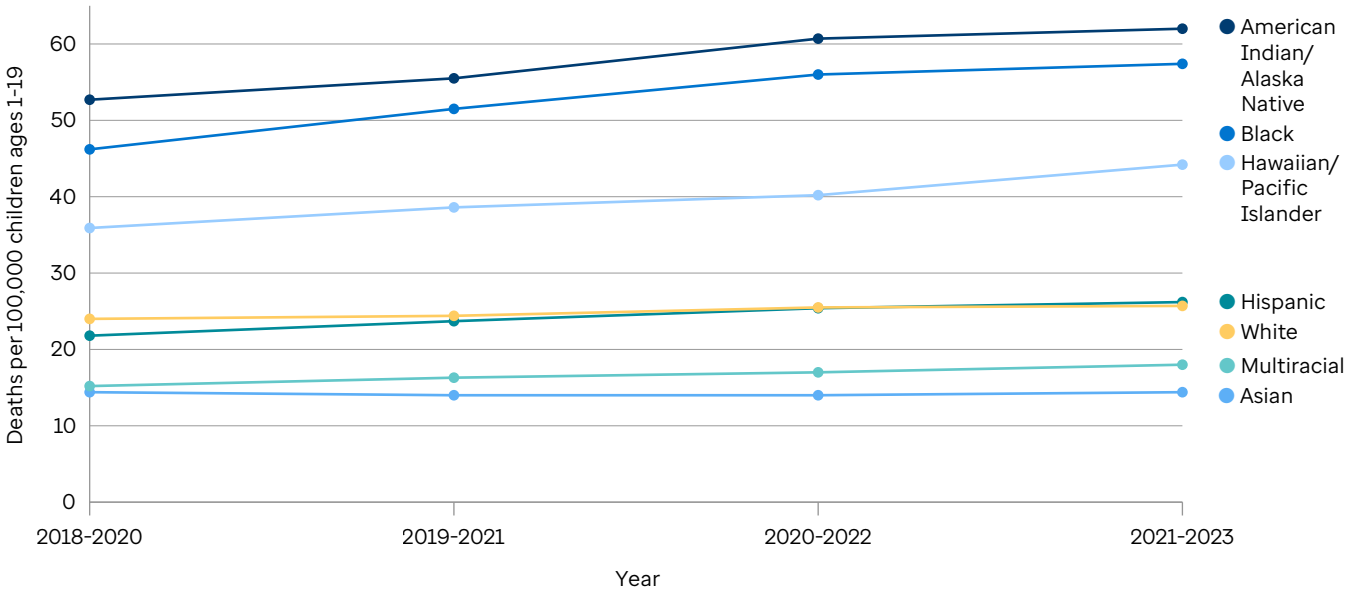
Household Smoke*
19% ▼
decrease from 12.7% to 10.3% of children ages 0-17 between 2021-2022 and 2023-2024.

Smoking During Pregnancy‡‡
19% ▼
decrease from 3.7% to 3.0% of live births between 2022 and 2023.

* Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health.
** Source: U.S. ED, National Center for Education Statistics, National Assessment of Educational Progress.
† Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset.
†† Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.
‡ Source: U.S. HHS, CDC, NCHHSTP AtlasPlus.
‡‡ Source: U.S. HHS, Natality Public Use Files via CDC WONDER.

Changes in Child Mortality

By Race/Ethnicity



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2018-2023.

HEALTH OUTCOMES | MORTALITY

Child Mortality

Most childhood deaths are preventable. In 2021-2023, the leading causes of death among children ages 1-19 in the United States were accidents (unintentional injuries), homicide, suicide, cancer and congenital abnormalities.[1] The leading mechanisms of injury deaths (intentional and unintentional) in 2021-2023 were firearms, followed by motor vehicle traffic accidents and poisoning.[2]

Changes over time. Nationally, the child mortality rate increased 14% between 2018-2020 and 2021-2023, from 25.9 to 29.6 deaths per 100,000 children ages 1-19. This rate exceeds the Healthy People 2030 target of 18.4 deaths among children and adolescents ages 1-19 per 100,000 population.[3] About 69,000 children died in the U.S. during 2021-2023, an increase of nearly 8,700 deaths from 2018-2020.

Between 2018-2020 and 2021-2023, the child mortality rate significantly increased:

- 24% among Black (46.2 to 57.4 deaths per 100,000 children ages 1-19), 20% among Hispanic (21.8 to 26.2), 18% among both American Indian/Alaska Native (52.7 to 62.0) and multiracial (15.2 to 18.0), and 7% among white (24.0 to 25.7) children.
- 15% among boys (33.2 to 38.1) and 13% among girls (18.3 to 20.7).
- 15% among children ages 1-4 (23.3 to 26.7), 14% among those ages 15-19 (52.2 to 59.6) and 9% among those ages 5-14 (13.5 to 14.7).

During the same period, the child mortality rate increased in 28 states. The largest increases were: 38% in Wyoming (30.1 to 41.5 deaths per 100,000 children ages 1-19), 30% in North Carolina (27.3 to 35.5) and 28% in Louisiana (38.1 to 48.9).

Differences. The child mortality rate varied significantly by race/ethnicity, age, geography and gender in 2021-2023. The rate was:

- 4.3 times higher among American Indian/Alaska Native (62.0 deaths per 100,000 children ages 1-19) compared with Asian (14.4) children.
- 4.1 times higher among children ages 15-19 (59.6) compared with those ages 5-14 (14.7).
- 3.1 times higher in Mississippi (51.6) than in Massachusetts (16.7).
- 1.8 times higher among boys (38.1) compared with girls (20.7).

Infant Mortality

Losing an infant is devastating for parents, families and communities. In 2023, the leading causes of infant death in the U.S. were congenital abnormalities, low birth weight, sudden infant death syndrome (SIDS), unintentional injuries and maternal complications.[4] The U.S. has a consistently and considerably higher infant mortality rate than other developed countries.[5]

Changes over time. Nationally, the infant mortality rate increased 4% between 2020-2021 and 2022-2023, from 5.4 to 5.6 infant deaths (before age 1) per 1,000 live births – the first increase in the history of the *Health of Women and Children Report*. This rate exceeds the Healthy People 2030 target of 5.0 infant deaths per 1,000 live births.[6] Reducing the rate of infant deaths is a Healthy People 2030 Leading Health Indicator.[7] Nearly 41,000 infants died in the U.S. during 2022-2023, an increase of more than 1,200 deaths compared with 2020-2021.

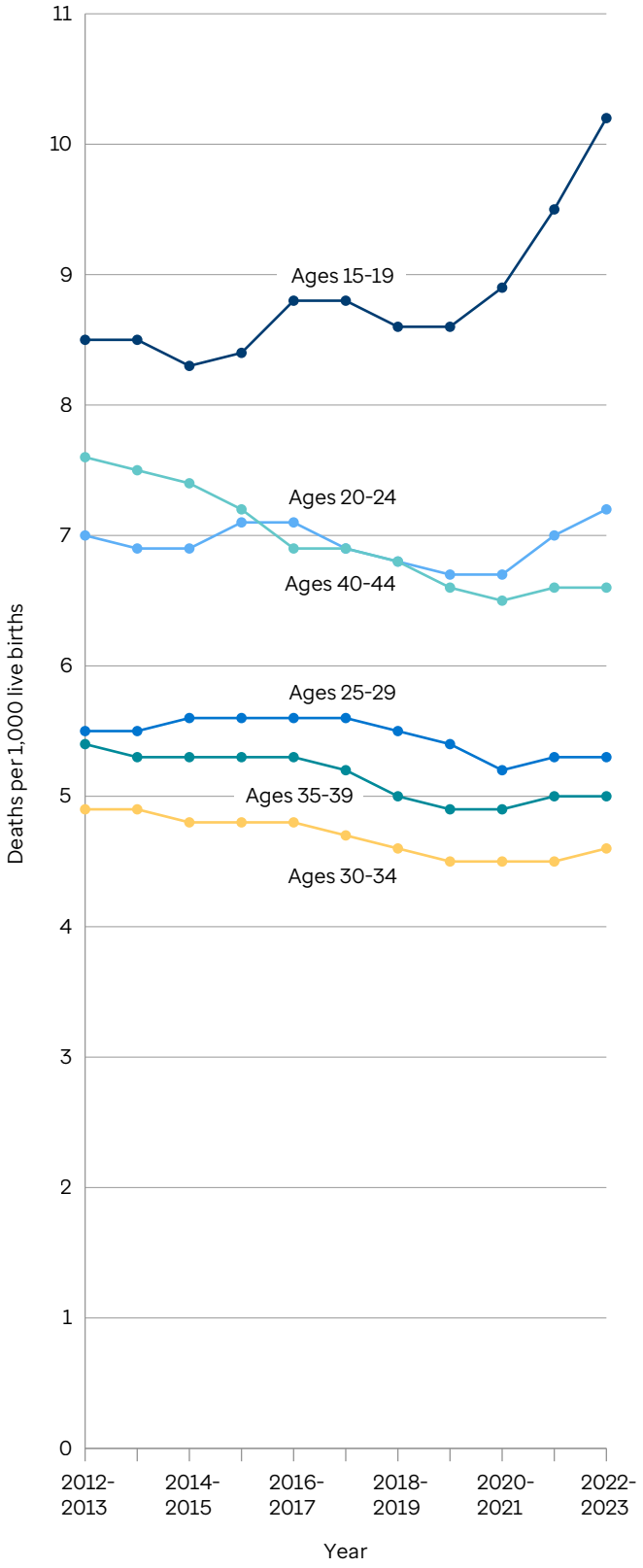
Between 2020-2021 and 2022-2023, the infant mortality rate significantly increased:

- 20% among infants born to American Indian/Alaska Native (7.6 to 9.1 deaths per 1,000 live births), 14% among infants born to Hawaiian/Pacific Islander (7.4 to 8.4), 6% among infants born to Hispanic (4.7 to 5.0), 4% among infants born to Black (10.5 to 10.9), 3% among infants born to Asian (3.4 to 3.5) and 2% among infants born to white (4.4 to 4.5) mothers.
- 15% among infants born to mothers ages 15-19 (8.9 to 10.2), 7% among infants born to mothers ages 20-24 (6.7 to 7.2) and 2% among infants born to mothers ages 25-29 (5.2 to 5.3), mothers ages 30-34 (4.5 to 4.6), mothers ages 35-39 (4.9 to 5.0) and mothers ages 40-44 (6.5 to 6.6).
- 3% among male (5.9 to 6.1) and 2% among female (5.0 to 5.1) infants.

During the same period, the infant mortality rate significantly changed in 40 states. Among the 26 states where it rose, the largest increases were: 39% in Delaware (4.9 to 6.8 deaths per 1,000 live births), 24% in Iowa (4.2 to 5.2) and 15% in Oregon (4.0 to 4.6). The rate also decreased in 14 states, led by: 24% in New Hampshire (4.2 to 3.2); and 8% in Colorado (4.9 to 4.5), Kansas (6.0 to 5.5), Massachusetts (3.6 to 3.3) and West Virginia (7.1 to 6.5).

Changes in Infant Mortality

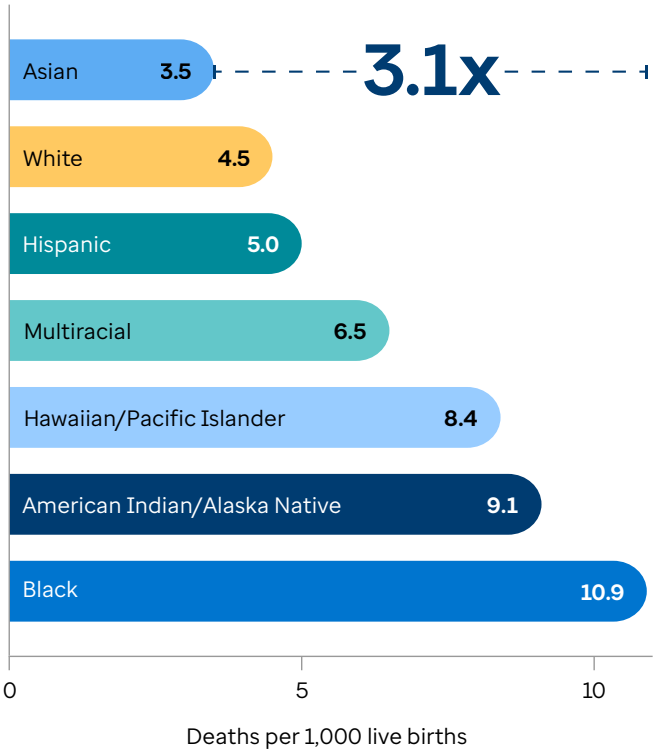
By Mother's Age



Source: U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER, 2012-2023.

Infant Mortality

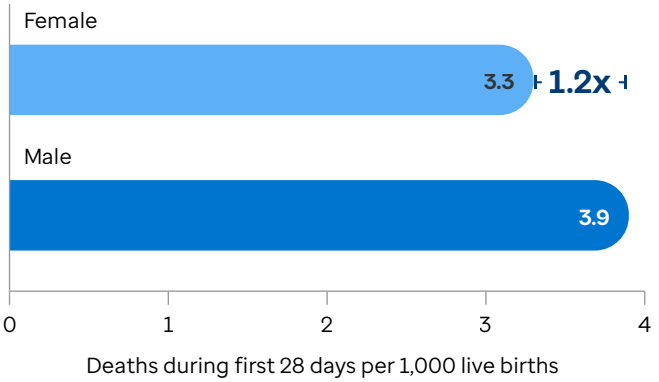
By Mother's Race/Ethnicity in 2022-2023



Source: U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER, 2022-2023.

Neonatal Mortality

By Gender in 2022-2023



Source: U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER, 2022-2023.

Differences. The infant mortality rate significantly varied by mother's race/ethnicity, geography, mother's age and infant gender. The rate was:

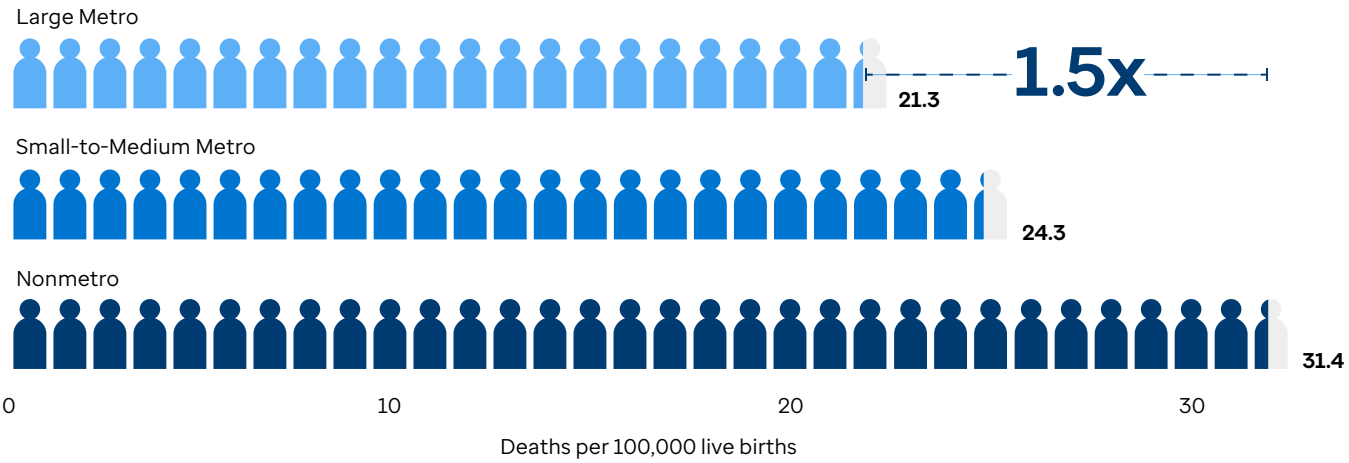
- 3.1 times higher among infants born to Black (10.9 deaths per 1,000 live births) compared with Asian (3.5) mothers.
- 2.8 times higher in Mississippi (9.0) than in New Hampshire (3.2).
- 2.2 times higher among infants born to mothers ages 15-19 (10.2) compared with mothers ages 30-34 (4.6).
- 1.2 times higher among male (6.1) compared with female (5.1) infants.

Related Measure: Neonatal Mortality

Nationally, the neonatal mortality rate increased 3% between 2020-2021 and 2022-2023, from 3.5 to 3.6 deaths during the first 28 days of life (0-27 days) per 1,000 live births. Approximately 26,300 neonatal deaths occurred in 2022-2023, about 600 more deaths than in 2020-2021. In 2022-2023, the rate was:

- 2.7 times higher in Mississippi (5.3 deaths per 1,000 live births) than in New Hampshire (2.0).
- 1.2 times higher among male (3.9) compared with female (3.3) infants.

Maternal Mortality
By Metropolitan Status in 2019-2023



Source: U.S. HHS, Maternal and Child Health Bureau, Federally Available Data, 2019-2023.
Note: The values for women who live in large metropolitan areas and those in small-to-medium metropolitan areas may not differ significantly based on overlapping 95% confidence intervals.

Maternal Mortality

The majority of maternal deaths resulting from pregnancy-related complications are preventable.[8] Despite this, the U.S. consistently has the highest rate of maternal mortality among high-income countries.[9]

Changes over time. Nationally, the maternal mortality rate increased 36% between 2014-2018 and 2019-2023, from 17.3 to 23.5 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. This rate exceeds the Healthy People 2030 target of 15.7 maternal deaths per 100,000 live births.[10] Reducing maternal deaths is a Healthy People 2030 Leading Health Indicator.[7] In 2019-2023, nearly 4,310 women died of pregnancy-related causes, an increase of more than 920 maternal deaths from 2014-2018.

Between 2014-2018 and 2019-2023, the maternal mortality rate significantly increased in 11 states. The largest increases were: 159% in Mississippi (15.3 to 39.7 deaths per 100,000 live births), 139% in Nevada (9.5 to 22.7) and 95% in Virginia (17.1 to 33.4).

Differences. The maternal mortality rate varied significantly by race/ethnicity, geography, age, educational attainment and metropolitan status in 2019-2023. The rate was:

- 4.8 times higher among American Indian/Alaska Native (60.8 deaths per 100,000 live births) compared with multiracial (12.7) women.
- 4.2 times higher in Tennessee (42.1) than in California (10.1).
- 3.2 times higher among women age 35 and older (46.1) than those ages 20-24 (14.3).
- 2.9 times higher among women who graduated from high school (35.9) compared with college graduates (12.2).
- 1.5 times higher among women living in nonmetropolitan areas (31.4) compared with those in large metropolitan areas (21.3).

Note: The values for American Indian/Alaska Native (60.8 deaths per 100,000 live births), Black (53.7) and Hawaiian/Pacific Islander (40.7) women may not differ significantly based on overlapping 95% confidence intervals. The same is true for multiracial (12.7), Asian (13.4) and Hispanic (17.5) women; women who are high school graduates (35.9) and women with less than a high school education (33.8); and women who live in large metropolitan areas (21.3) and small-to-medium metropolitan areas (24.3).

Significant Decreases in Mortality Among Women

Largest decreases in deaths per 100,000 women ages 20-44 between 2022 and 2023 by state.

Connecticut

20% ▼

decrease from 103.1 to 82.8.

Arkansas

19% ▼

decrease from 167.2 to 136.0.

Indiana

15% ▼

decrease from 147.3 to 125.9.

Missouri

15% ▼

decrease from 154.1 to 131.7.

Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2022-2023.

Mortality Among Women

In 2023, the leading causes of death for women ages 20-44 in the U.S. were unintentional injuries (led by poisoning and motor vehicle accidents), cancer, heart disease, suicide and chronic liver disease/cirrhosis.[11,12] Women in the United States have a higher rate of preventable deaths than women living in other high-income countries.[13]

Changes over time. Nationally, the mortality rate among women decreased 8% between 2022 and 2023, from 120.0 to 109.9 deaths per 100,000 women ages 20-44. Approximately 60,700 women ages 20-44 died in 2023, 5,300 fewer deaths than in 2022. Between 2022 and 2023, unintentional injuries decreased, and COVID-19 dropped out of the 10 leading causes of death among women for this age group.

Between 2022 and 2023, the mortality rate among women significantly decreased 10% among white (124.8 to 112.9 deaths per 100,000 women ages 20-44), 7% among Hispanic (81.0 to 75.1) and 6% among Black (192.3 to 179.9) women.

During this time, the mortality rate among women significantly decreased in 17 states, led by: 20% in Connecticut (103.1 to 82.8 deaths per 100,000 women ages 20-44), 19% in Arkansas (167.2 to 136.0), and 15% in both Indiana (147.3 to 125.9) and Missouri (154.1 to 131.7).

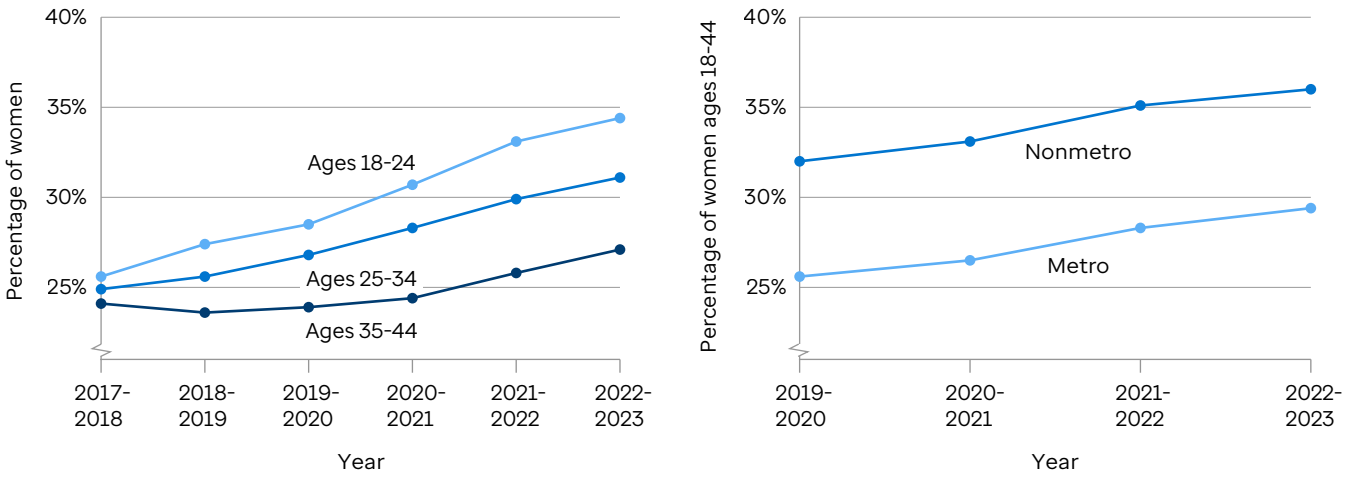
Differences. In 2023, the mortality rate among women was 9.4 times higher among American Indian/Alaska Native (343.2 deaths per 100,000 women ages 20-44) compared with Asian (36.4) women.

Related Measure: Drug Deaths Among Women

For the first time in the history of the *Health of Women and Children Report*, the drug death rate plateaued. In 2021-2023, the number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 women ages 20-44 remained at 28.6, the same as the period before. Racial/ethnic differences persisted; the drug death rate was 20.8 times higher among American Indian/Alaska Native (76.8) compared with Asian (3.7) women in 2021-2023. Provisional data from the CDC WONDER indicate that the drug death rate among women ages 20-44 continued to decrease between 2021-2023 and 2022-2024.[14]

Changes in Depression Among Women

By Age Group and Metropolitan Status



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2017-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023, Florida in 2021 or New Jersey in 2019.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Depression Among Women

Women in the U.S. experience a significantly higher prevalence of diagnosed depression than men.[15] Depression is a common mood disorder that can cause symptoms such as hopelessness, loss of interest and fatigue, all of which impact daily life and functioning.[16,17] Depression is a risk factor for attempting suicide.[18]

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 27.4% to 30.3% between 2020-2021 and 2022-2023. The prevalence has increased 22% (from 24.8%) since 2017-2018. In 2022-2023, more than 17.3 million women ages 18-44 in the U.S. had depression.

Between 2020-2021 and 2022-2023, the prevalence of depression significantly increased:

- 20% among women with an annual household income of $75,000 or more (21.6% to 26.0%), 11% among those with incomes of $50,000-$74,999 (29.3% to 32.6%) and 9% among those with incomes of $25,000-$49,999 (30.0% to 32.8%).
- 15% among college graduates (21.8% to 25.0%) and 10% among both high school graduates (27.0% to 29.7%) and women with some post-high school education (32.2% to 35.5%).
- 12% among women ages 18-24 (30.7% to 34.4%), 11% among those ages 35-44 (24.4% to 27.1%) and 10% among those ages 25-34 (28.3% to 31.1%).
- 11% among women living in metropolitan areas (26.5% to 29.4%) and 9% among those in nonmetropolitan areas (33.1% to 36.0%).
- 10% among white women (35.1% to 38.7%).

During this time, the prevalence of depression also significantly increased in 11 states. The largest increases were: 30% in Hawaii (15.9% to 20.7%) and 22% in both Tennessee (34.8% to 42.4%) and California (19.6% to 23.9%).

Differences. The prevalence of depression varied significantly by disability status, race/ethnicity, geography, sexual orientation, educational attainment, veteran status, age, household income and metropolitan status in 2022-2023. The prevalence was:

- 3.5 times higher among women with independent living difficulty (74.2%) than those without a disability (21.0%).
- 3.4 times higher among multiracial (45.3%) than Asian (13.3%) women.
- 2.1 times higher in Maine (43.3%) than in New Jersey (20.5%).
- 2.1 times higher among LGBQ+ (55.5%) than straight (26.2%) women.

Postpartum Anxiety

20.3%

of women with a recent live birth **(approximately 544,000 women)** reported experiencing anxiety symptoms in 2023.

Postpartum Depression

11.9%

of women with a recent live birth **(approximately 318,000 women)** reported experiencing depression symptoms in 2023.

Source: U.S. HHS, Maternal and Child Health Bureau, Federally Available Data, 2023.
Note: Data were not available for California, Idaho, North Carolina or Ohio.

- 1.5 times higher among women with some post-high school education (35.5%) than those with less than a high school education (23.0%).
- 1.4 times higher among women who have served in the U.S. armed forces (41.3%) than those who have not served (30.1%).
- 1.3 times higher among women ages 18-24 (34.4%) than those ages 35-44 (27.1%).
- 1.3 times higher among women with an annual household income less than $25,000 (34.5%) than those with incomes of $75,000 or more (26.0%).
- 1.2 times higher among women living in nonmetropolitan areas (36.0%) than those in metropolitan areas (29.4%).

Related Measures: Postpartum Depression and Anxiety

In 2023, 11.9% of women with a recent live birth (more than 318,000 women) reported experiencing depression symptoms. The prevalence of postpartum depression was highest in Mississippi (17.1%), Kansas (16.3%) and Alaska (15.9%). It was lowest in Louisiana (7.2%), New Jersey (8.3%) and Vermont (8.4%).

During the same year, 20.3% of women with a recent live birth (more than 544,000 women) reported experiencing anxiety symptoms. The prevalence of postpartum anxiety was highest in Mississippi (31.6%), Arkansas (29.1%) and Alabama (26.9%). It was lowest in Louisiana (12.8%), Florida (14.2%) and New Jersey (15.4%).

Related Measure: Frequent Mental Distress Among Women

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 12%, from 21.0% to 23.6% between 2020-2021 and 2022-2023. The prevalence significantly increased among women with annual household incomes of $50,000-$74,999, those with incomes less than $25,000 and those with incomes of $25,000-$49,999; high school graduates and women with some post-high school education; Hispanic women and white women; women ages 18-24, 25-34 and 35-44; and women living in both metropolitan and nonmetropolitan areas.

During this time, the prevalence of frequent mental distress significantly increased in six states. The largest increases were: 41% in Alaska (17.4% to 24.6%), 36% in Tennessee (24.3% to 33.0%) and 27% in Texas (18.1% to 23.0%).

Frequent mental distress significantly varied by disability status, race/ethnicity, sexual orientation, household income, geography, age, educational attainment, veteran status and metropolitan status in 2022-2023.

Note: Depression and frequent mental distress prevalence data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The value for women with independent living difficulty (74.2%) may not differ significantly from that of women who have difficulty with self-care (68.4%) based on overlapping 95% confidence intervals. The same is true for multiracial (45.3%) and American Indian/Alaska Native (38.8%) women; women with less than a high school education (23.0%) and women who are college graduates (25.0%); and women with incomes less than $25,000 (34.5%), incomes of $25,000-$49,999 (32.8%) and incomes of $50,000-$74,999 (32.6%). Data were not available for California, Idaho, North Carolina or Ohio for postpartum anxiety and depression.

Mental Health Conditions Among Children

While higher rates of diagnosis may reflect improved awareness and engagement with care, they could also indicate a growing burden of mental health challenges for youth.[19] Early diagnosis and treatment of mental health conditions in children is vital to preventing problems at home, in school or forming friendships.[20]

Changes over time. Nationally, the percentage of children ages 3-17 with a mental health condition increased 9%, from 18.8% to 20.5% between 2021-2022 and 2023-2024. This includes children who were told by a health care provider that they had ADHD, depression or anxiety problems; or were told by a doctor or educator that they had behavior or conduct problems. There were increases in the prevalence of ADHD (10%, from 10.1% to 11.1%) and anxiety (13%, from 9.9% to 11.2%). The prevalence of depression (4.2%) and behavioral problems (7.7%) did not significantly change.

Between 2021-2022 and 2023-2024, the prevalence of mental health conditions significantly increased:

- 14% among white children (21.3% to 24.2%).
- 13% among children with a caregiver who graduated from college (17.9% to 20.3%).
- 10% among girls (17.2% to 18.9%) and 8% among boys (20.3% to 22.0%).

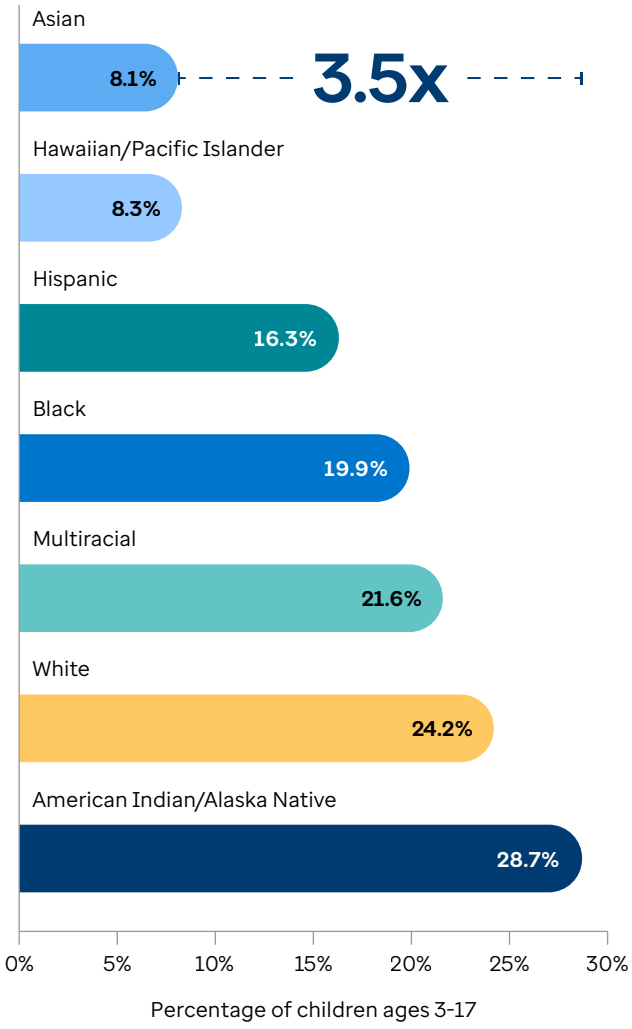
During this period, mental health conditions increased 32% in Iowa (18.6% to 24.5%), and 28% in both Oregon (20.3% to 26.0%) and California (12.7% to 16.2%).

Differences. Mental health conditions among children significantly varied by race/ethnicity, geography, caregiver educational attainment and gender in 2023-2024. The prevalence was:

- 3.5 times higher among American Indian/Alaska Native (28.7%) than Asian (8.1%) children.
- 2.2 times higher in Maine (28.5%) than in Hawaii (13.1%).
- 1.5 times higher among children who had a caregiver with some post-high school education (23.1%) than those whose caregivers had less than a high school education (15.9%).
- 1.2 times higher among boys (22.0%) than girls (18.9%).

Diagnosed Mental Health Conditions Among Children

By Race/Ethnicity in 2023-2024

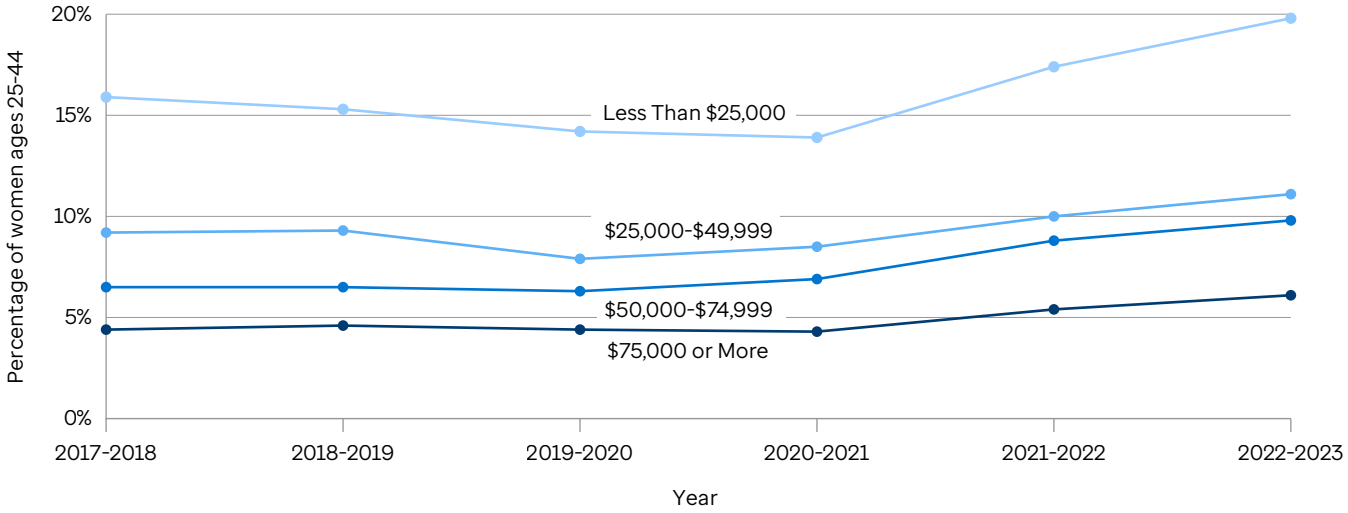


Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2023-2024.
Note: The values for American Indian/Alaska Native, white, multiracial and Black children may not significantly differ based on overlapping 95% confidence intervals. The same is true for Asian and Hawaiian/Pacific Islander children.

Note: The values for American Indian/Alaska Native (28.7%), white (24.2%), multiracial (21.6%) and Black (19.9%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian (8.1%) and Hawaiian/Pacific Islander (8.3%) children.

Changes in Frequent Physical Distress Among Women

By Income Group



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2017-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023, Florida in 2021 or New Jersey in 2019.

HEALTH OUTCOMES | PHYSICAL HEALTH

Frequent Physical Distress Among Women

Frequent physical distress measures the population experiencing persistent and likely severe physical health problems, which can significantly impact health-related quality of life and overall wellness.[21]

Changes over time. Nationally, the percentage of women ages 18-44 who reported their physical health was not good 14 or more days in the past 30 days increased 37%, from 7.1% to 9.7% between 2020-2021 and 2022-2023. In 2022-2023, more than 5.4 million women reported frequent physical distress. Between 2020-2021 and 2022-2023, the prevalence significantly increased:

- 133% among American Indian/Alaska Native (8.0% to 18.6%), and 42% among both Hispanic (6.6% to 9.4%) and white (7.7% to 10.9%) women.
- 63% among women ages 18-24 (5.1% to 8.3%), 31% among those ages 25-34 (7.0% to 9.2%) and 30% among those ages 35-44 (8.7% to 11.3%).
- 47% among college graduates (4.3% to 6.3%), 35% among high school graduates (8.9% to 12.0%), 33% among women with less than a high school education (11.9% to 15.8%) and 22% among those with some post-high school education (9.9% to 12.1%).
- 42% among women with an annual household income less than $25,000 (13.9% to 19.8%), those with incomes of $50,000-$74,999 (6.9% to 9.8%) and those with incomes of $75,000 or more (4.3% to 6.1%); and 31% among women with incomes of $25,000-$49,999 (8.5% to 11.1%).
- 39% among women living in nonmetropolitan areas (8.3% to 11.5%) and 38% among those in metropolitan areas (6.9% to 9.5%).

During the same period, the prevalence of frequent physical distress significantly increased in 18 states and the District of Columbia. The largest increases were: 81% in the District of Columbia (4.2% to 7.6%), 68% in New York (5.7% to 9.6%), 64% in Oregon (7.4% to 12.1%) and 62% in both Virginia (5.8% to 9.4%) and Vermont (6.5% to 10.5%).

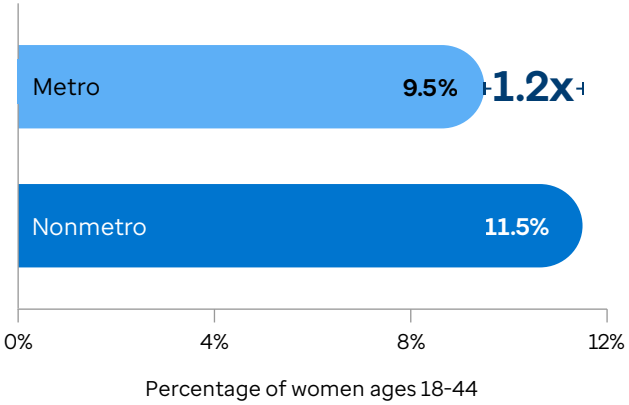
Differences. Frequent physical distress significantly varied by disability status, household income, race/ethnicity, educational attainment, geography, sexual orientation, veteran status, age and metropolitan status in 2022-2023. The prevalence was:

- 12.6 times higher among women who have difficulty with self-care (64.1%) than those without a disability (5.1%).
- 3.2 times higher among women with an annual household income less than $25,000 (19.8%) than those with incomes of $75,000 or more (6.1%).
- 2.7 times higher among American Indian/Alaska Native (18.6%) than Asian (6.8%) women.
- 2.5 times higher among women with less than a high school education (15.8%) than college graduates (6.3%).
- 2.1 times higher in Nevada (13.0%) than in Hawaii (6.3%).
- 1.8 times higher among LGBQ+ (15.3%) than straight (8.4%) women.
- 1.5 times higher among women who have served in the U.S. armed forces (14.0%) than those who have not served (9.6%).
- 1.4 times higher among women ages 35-44 (11.3%) than those ages 18-24 (8.3%).
- 1.2 times higher among women living in nonmetropolitan areas (11.5%) than those in metropolitan areas (9.5%).

Note: Data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The values for American Indian/Alaska Native (18.6%), other race (14.2%), multiracial (12.6%) and white (10.9%) women may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian (6.8%), Black (7.4%), Hispanic (9.4%), multiracial and other race women.

Frequent Physical Distress Among Women

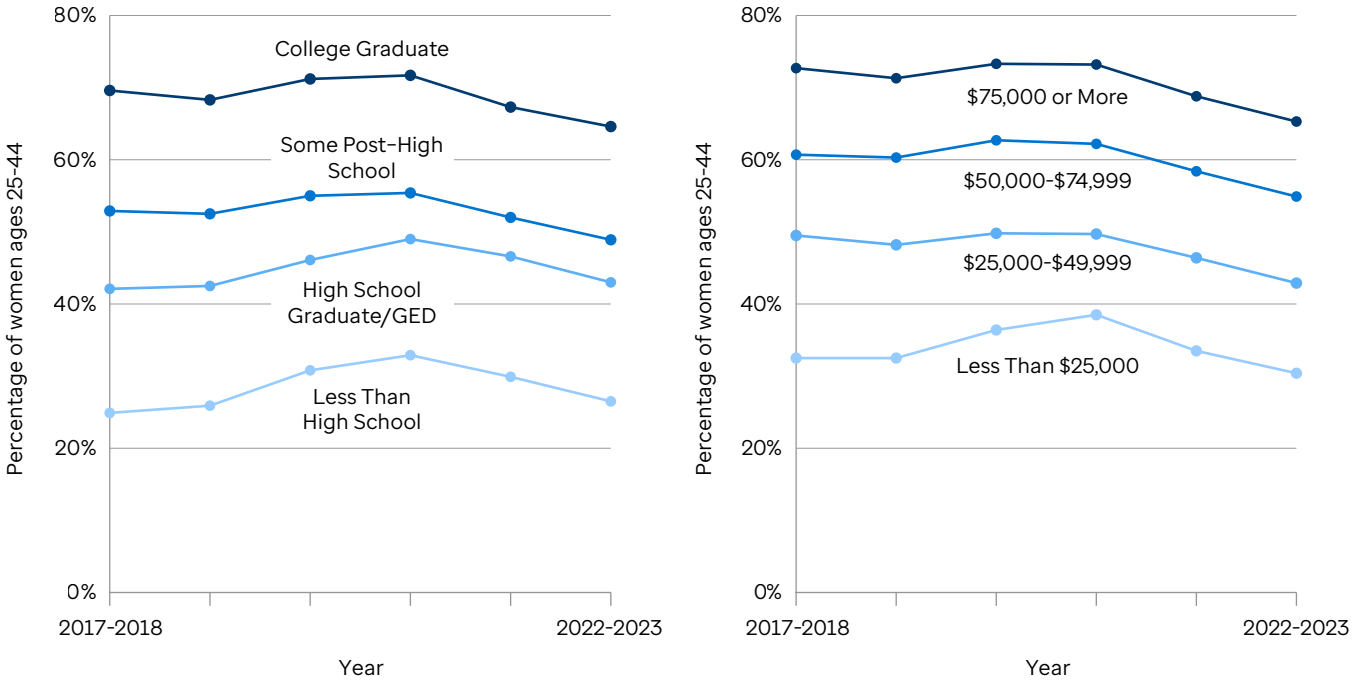
By Metropolitan Status in 2022-2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

Changes in High Health Status Among Women

By Educational Attainment and Income Group



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2017-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023, Florida in 2021 or New Jersey in 2019.

High Health Status Among Women

Self-reported health status is a subjective measure of health-related quality of life that encompasses not only specific health conditions or outcomes but also factors such as social support, ability and ease of functioning, and other socioeconomic, environmental and cultural components.[22] Research shows that those with "poor" self-reported health status have a mortality risk double that of those with "excellent" self-reported health status.[23]

Changes over time. Nationally, the percentage of women ages 18-44 who reported their health was very good or excellent decreased 13%, from 59.0% to 51.6% between 2020-2021 and 2022-2023. In 2022-2023, around 30 million women reported having very good or excellent health. Between 2020-2021 and 2022-2023, the prevalence significantly decreased:

- 21% among women with an annual household income less than $25,000 (38.5% to 30.4%), 14% among those with incomes of $25,000-$49,999 (49.7% to 42.9%), 12% among those with incomes of $50,000-$74,999 (62.2% to 54.9%) and 11% among those with incomes of $75,000 or more (73.2% to 65.3%).
- 19% among women with less than a high school education (32.9% to 26.5%), 12% among both high school graduates (49.0% to 43.0%) and women with some post-high school education (55.4% to 48.9%), and 10% among college graduates (71.7% to 64.6%).
- 18% among Hispanic (47.9% to 39.2%), 17% among multiracial (59.2% to 49.1%), 16% among Black (54.9% to 46.0%) and 14% among white (64.7% to 55.9%) women.
- 16% among women ages 18-24 (63.4% to 53.3%), 12% among those ages 25-34 (59.3% to 52.1%) and 10% among those ages 35-44 (55.6% to 50.2%).
- 13% among women living in metropolitan areas (59.3% to 51.8%) and 11% among those in nonmetropolitan areas (56.7% to 50.3%).

During this time, the prevalence of high health status significantly decreased in 37 states. The largest decreases were: 20% in both Oregon (59.0% to 47.3%) and Rhode Island (61.4% to 48.9%), 19% in both Hawaii (65.1% to 52.5%) and Tennessee (61.0% to 49.3%), and 18% in Maryland (62.3% to 51.3%).

Differences. The prevalence of high health status varied significantly by disability status, educational attainment, household income, race/ethnicity, sexual orientation, geography and age in 2022-2023. The prevalence was:

- 4.9 times higher among women without a disability (58.8%) compared with women who have difficulty with self-care (11.9%).
- 2.4 times higher among college graduates (64.6%) compared with women who have less than a high school education (26.5%).
- 2.1 times higher among women with an annual household income of $75,000 or more (65.3%) compared with those who have incomes less than $25,000 (30.4%).
- 1.4 times higher among Asian (56.6%) compared with Hispanic (39.2%) women.
- 1.3 times higher among straight (53.5%) compared with LGBQ+ (41.1%) women.
- 1.2 times higher in South Dakota (57.8%) than in Oregon and Texas (both 47.3%).
- 1.1 times higher among women ages 18-24 (53.3%) compared with those ages 35-44 (50.2%).

Note: Data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The values for women who have difficulty with self-care (11.9%) and those who have difficulty with mobility (14.1%) may not significantly differ based on overlapping 95% confidence intervals. The same is true for Asian (56.6%), white (55.9%), other race (50.7%), Hawaiian/Pacific Islander (50.2%) and multiracial (49.1%) women; Hispanic (39.2%), American Indian/Alaska Native (40.9%) and Hawaiian/Pacific Islander women; and women ages 18-24 (53.3%) and 25-34 (52.1%).

High Health Status Among Women

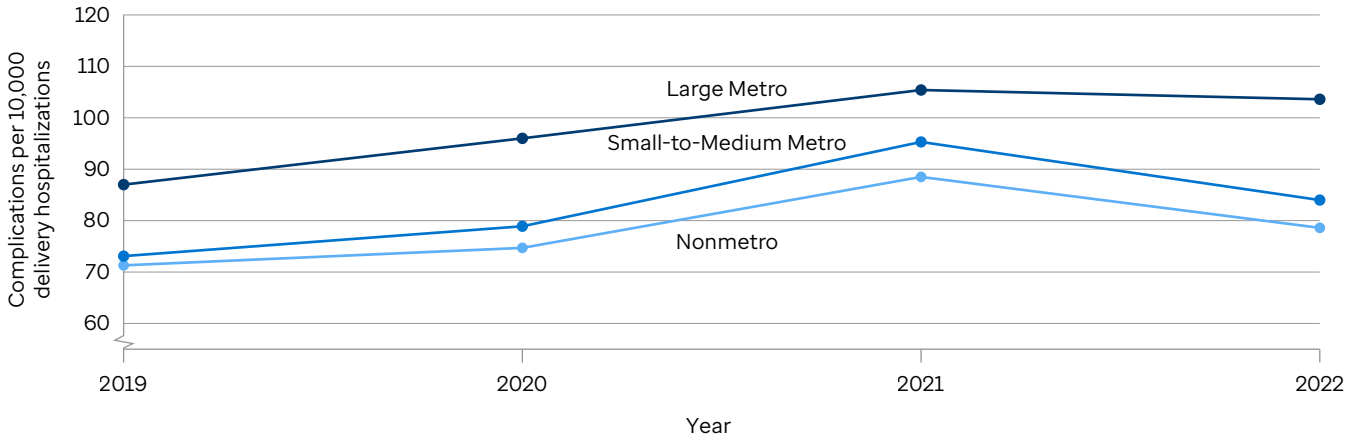
2.4x

higher among college graduates (64.6%) compared with women who have less than a high school education (26.5%) in 2022-2023.

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

Changes in Severe Maternal Morbidity

By Metropolitan Status



Source: U.S. HHS, Maternal and Child Health Bureau, Federally Available Data, 2019-2022.
Note: The values for women living in nonmetropolitan areas and small-to-medium metropolitan areas may not significantly differ in 2022 based on overlapping 95% confidence intervals.

Severe Maternal Morbidity

Severe maternal morbidity is a critical indicator for identifying preventable, severe complications in maternal health care.[24] As a population-level metric, it helps uncover the underlying causes of maternal health disparities, guides improvement efforts and supports the prevention of maternal mortality.

Changes over time. Nationally, the severe maternal morbidity rate decreased 6% between 2021 and 2022, from 100.3 to 94.7 significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations. In 2022, approximately 32,000 women experienced severe maternal morbidity, about 2,000 fewer than in 2021. Between 2020 and 2021, severe maternal morbidity significantly decreased:

- 12% among women living in small-to-medium metropolitan areas (95.3 to 84.0 complications per 10,000 delivery hospitalizations) and 11% among those living in nonmetropolitan areas (88.5 to 78.6).
- 9% among Hispanic (100.9 to 92.1) and 7% among white (83.4 to 77.4) women.
- 9% among women living in the least-wealthy ZIP code quartile (113.5 to 103.1) based on current-year median household income and 8% among those in the second least-wealthy ZIP code quartile (100.4 to 91.9).
- 8% among both women ages 20-24 (83.2 to 76.9) and those ages 25-29 (85.0 to 78.2), 6% among those ages 30-34 (97.8 to 92.4) and 4% among those age 35 and older (142.7 to 136.3).

During this time, the severe maternal morbidity rate significantly decreased 24% in Arizona (105.6 to 80.5 complications per 10,000 delivery hospitalizations), 22% in Mississippi (94.2 to 73.7), 14% in Texas (92.5 to 79.8) and 10% in Florida (114.7 to 102.7).

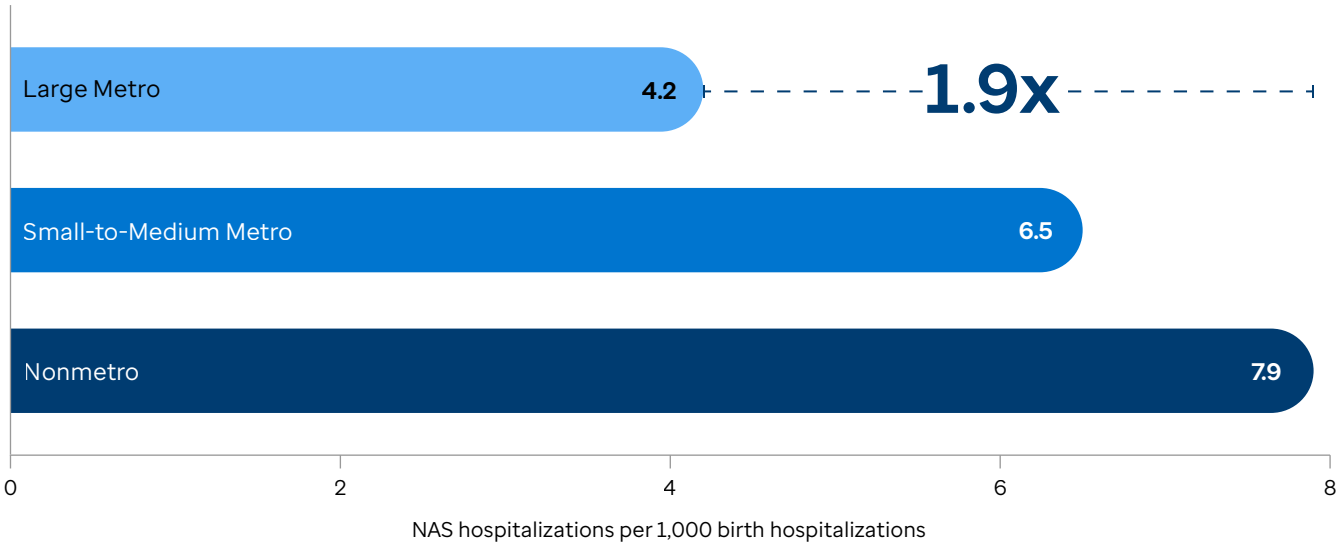
Differences. The prevalence of severe maternal morbidity significantly varied by geography, race/ethnicity, age, metropolitan status and household income. The prevalence was:

- 3.3 times higher in Vermont (144.2 complications per 10,000 delivery hospitalizations) than in South Dakota (43.6).
- 1.9 times higher among Black (150.3) compared with white (77.4) women.
- 1.8 times higher among women age 35 and older (136.3) compared with women ages 20-24 (76.9).
- 1.3 times higher among women living in large metropolitan areas (103.6) than those in nonmetropolitan areas (78.6).
- 1.1 times higher among women living in the least-wealthy ZIP code quartile (103.1) compared with those in the wealthiest ZIP code quartile (90.4).

Note: The values for women ages 20-24 (76.9) and women ages 25-29 (78.2) may not differ significantly based on overlapping 95% confidence intervals. The same is true for women living in the wealthiest (90.4), second least-wealthy (91.9) and second-wealthiest ZIP code quartiles (92.0).

Neonatal Abstinence Syndrome (NAS)

By Metropolitan Status in 2022



Source: U.S. HHS, Maternal and Child Health Bureau, Federally Available Data, 2022.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a drug withdrawal syndrome occurring in newborns, most commonly caused by fetal exposure to maternal opioid use.[25,26] Symptoms of NAS can include tremors, high-pitched crying, seizures and low birth weight, as well as long-term impacts such as developmental delays, growth problems and hearing and vision problems.[27-29]

Changes over time. Nationally, the rate of NAS decreased 10% between 2021 and 2022, from 5.9 to 5.3 birth hospitalizations with a diagnosis code of withdrawal symptoms due to prenatal exposure to illicit drugs per 1,000 birth hospitalizations. In 2022, there were approximately 18,000 NAS hospitalizations in the U.S., nearly 2,000 fewer hospitalizations than in 2021. Between 2021 and 2022, NAS hospitalization rates significantly decreased:

- 13% among infants living in nonmetropolitan areas (9.1 to 7.9 NAS hospitalizations per 1,000 birth hospitalizations) and 7% among infants living in both large metropolitan areas (4.5 to 4.2) and small-to-medium metropolitan areas (7.0 to 6.5).
- 12% among infants living in the least-wealthy ZIP code quartile (8.6 to 7.6) and 6% among both infants living in the second least-wealthy ZIP code quartile (6.5 to 6.1) and those in the second-wealthiest ZIP code quartile (4.9 to 4.6).
- 11% among white infants (8.4 to 7.5).

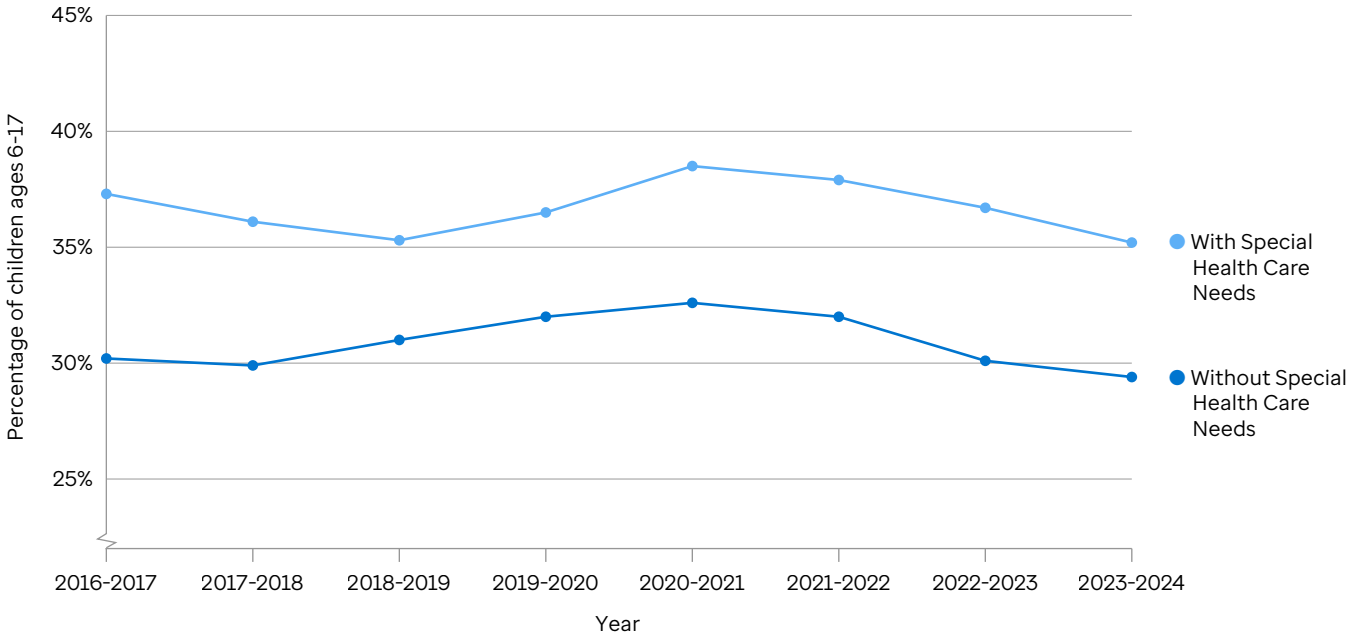
During this time, the rate significantly decreased in nine states. The largest decreases were: 26% in Maine (18.2 to 13.5 NAS hospitalizations per 1,000 birth hospitalizations), 25% in Kentucky (16.8 to 12.6), 21% in Massachusetts (7.8 to 6.2) and 20% in Pennsylvania (11.1 to 8.9). At the same time, the rate significantly increased in one state: 26% in Minnesota (5.0 to 6.3).

Differences. The prevalence of NAS hospitalizations significantly varied by geography, race/ethnicity, household income and metropolitan status in 2022. The rate was:

- 31.9 times higher in West Virginia (31.9 NAS hospitalizations per 1,000 birth hospitalizations) than in Hawaii (1.0).
- 23.5 times higher among American Indian/Alaska Native (14.1) compared with Asian/Pacific Islander (0.6) infants.
- 2.8 times higher among infants living in the least-wealthy ZIP code quartile (7.6) compared with infants living in the wealthiest ZIP code quartile (2.7).
- 1.9 times higher among infants living in nonmetropolitan areas (7.9) than those in large metropolitan areas (4.2).

Changes in Overweight or Obesity Among Children

By Special Health Care Need Status



Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2016-2024.

Overweight or Obesity Among Children

Childhood obesity is defined as a body mass index (BMI) value at or above the 95th percentile based on age and sex, while overweight is defined as a BMI value at or above the 85th percentile but below the 95th percentile.[30] Overweight and obesity in childhood are associated with physical, social and psychological health issues during adolescence and adulthood, including increased risk of substance misuse, disordered eating behaviors, chronic diseases and poor self-esteem.[31-35]

Changes over time. Nationally, the percentage of children ages 6-17 who had overweight or obesity for their age based on reported height and weight decreased 7%, from 33.8% to 31.3% between 2021-2022 and 2023-2024. In 2023-2024, approximately 14.7 million children had overweight or obesity, 1.1 million fewer than in 2021-2022. The prevalence of overweight and obesity significantly decreased:

- 11% among Hispanic children (42.3% to 37.7%).
- 10% among boys (36.4% to 32.7%).
- 8% among children without special health care needs (32.0% to 29.4%) and 7% among children with special health care needs (37.9% to 35.2%).

Differences. The prevalence of children who had overweight or obesity significantly varied by race/ethnicity, geography, caregiver educational attainment, special health care needs status and gender in 2023-2024. The prevalence was:

- 2.2 times higher among Hawaiian/Pacific Islander (47.8%) than Asian (21.3%) children.
- 1.8 times higher in Mississippi (41.8%) than in Colorado (23.1%).
- 1.7 times higher among children with a caregiver who has less than a high school education (41.2%) compared with those with a caregiver who graduated from college (24.4%).
- 1.2 times higher among children with special health care needs (35.2%) compared with children without special health care needs (29.4%).
- 1.1 times higher among boys (32.7%) than girls (29.8%).

Note: The values for children with caregivers who had less than a high school education (41.2%), children with a caregiver who graduated from high school (40.9%) and children with a caregiver who had some post-high school education (36.9%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for Hawaiian/Pacific Islander (47.8%), Black (39.3%), American Indian/Alaska Native (37.9%), Hispanic (37.7%) and multiracial (30.4%) children.

Concentrated Disadvantage

Concentrated disadvantage measures the percentage of households with children that are located in census tracts for which the averaged z-score of the following factors is above the 75th percentile: family households below the poverty line, female-headed households, individuals receiving public assistance, unemployed population age 16 and older and population younger than 18. It serves as an indicator of community well-being and projected socioeconomic needs.[36] Studies have found that living in areas of higher community socioeconomic disadvantage is associated with lack of access to healthy foods and recreational areas; environmental hazards, including lead exposure, poor air quality and substandard housing; and chronic conditions such as obesity, asthma, depression, anxiety and sexually transmitted infections.[36-38]

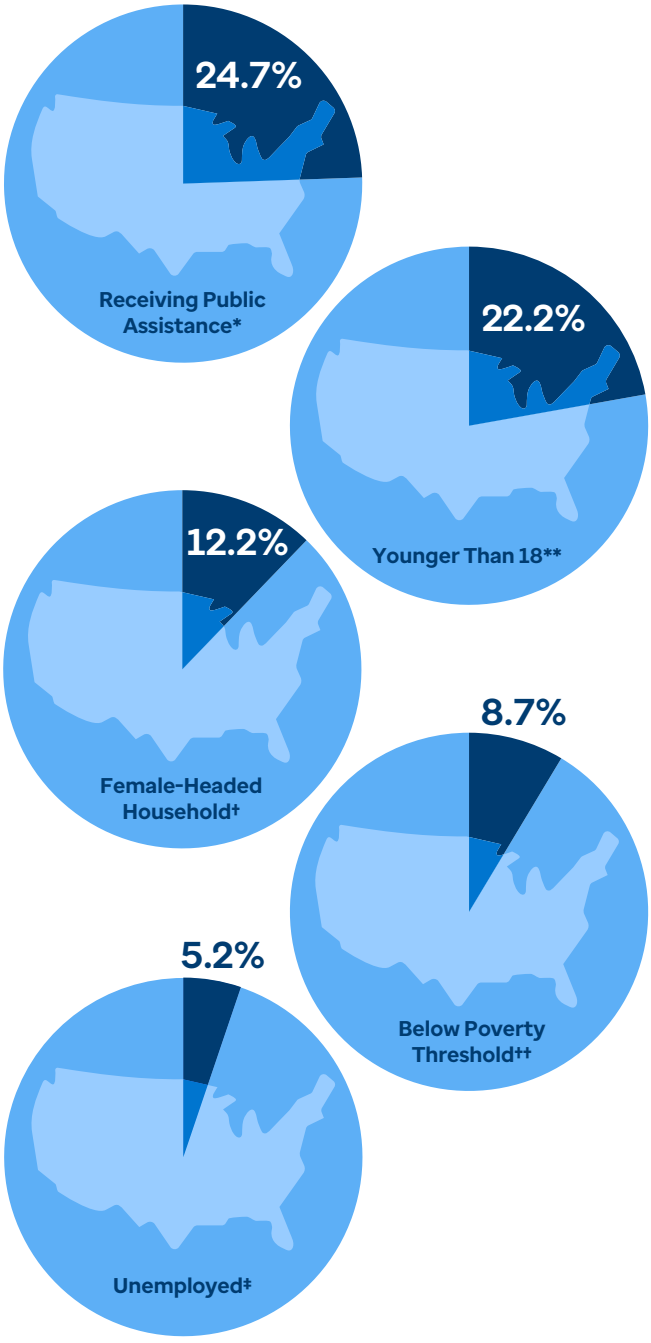
Changes over time. Concentrated disadvantage increased 10% or more in 12 states and simultaneously decreased 10% or more in seven states between 2015-2019 and 2019-2023. The largest increases were: 54% in North Dakota (4.8% to 7.4%), 43% in Wyoming (5.1% to 7.3%) and 39% in Hawaii (14.7% to 20.4%). The largest decreases were: 40% in Idaho (12.8% to 7.7%), 39% in Utah (10.8% to 6.6%) and 29% in South Dakota (15.0% to 10.6%).

During the same time, several components of concentrated disadvantage decreased. The prevalence of family households below the poverty threshold decreased 8% (9.5% to 8.7%), and the prevalence of female-headed households (12.4% to 12.2%), individuals receiving public assistance (25.2% to 24.7%) and unemployed individuals (5.3% to 5.2%) all decreased 2%.

Differences. During 2019-2023, concentrated disadvantage was 15.0 times higher in New Mexico (46.6%) than in Vermont (3.1%).

Concentrated Disadvantage Components

In 2019-2023



* Percentage of the population living in households that received supplemental security income (SSI), cash public assistance income or food stamps/SNAP in the past 12 months.
** Percentage of the population that is younger than age 18.
† Percentage of households that are female-headed.
†† Percentage of family households with income in the past 12 months below the poverty level.
‡ Percentage of the population ages 16 years and older who are in the civilian labor force (actively seeking work) but unemployed.

Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2019-2023.

Related Measure: Poverty Among Women

Nationally, the percentage of women ages 18-44 living below the poverty level decreased 2%, from 15.2% to 14.9% between 2022 and 2023. In 2023, more than 8.6 million women were living below the poverty level, a decrease of more than 100,000 women compared with 2022. Between 2022 and 2023, poverty among women significantly decreased 13% in Missouri (16.1% to 14.0%).

Differences. In 2023, the prevalence of poverty among women significantly varied by geography and race/ethnicity. The prevalence was:

- 2.9 times higher in Louisiana (24.0%) than in New Hampshire (8.4%).
- 2.1 times higher among American Indian/Alaska Native (21.9%) compared with Asian (10.3%) women.

The values for American Indian/Alaska Native (21.9%), Black (21.8%) and Hawaiian/Pacific Islander (18.2%) women may not differ significantly based on overlapping 95% confidence intervals.

WIC Coverage Among Children

Children who live in food-insecure households are at increased risk of adverse health outcomes such as asthma, depression and forgoing necessary medical care.[39] The federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has supported families across the United States for more than 50 years, providing health care referrals, breastfeeding support, nutrition education and additional food to low-income women and children at risk of hunger.[40]

Changes over time. Nationally, the percentage of children ages 0-4 eligible for WIC who received benefits in an average month increased 5%, from 49.9% to 52.2% between 2021 and 2022. During this time, WIC coverage increased 5% or more in 27 states. The largest increases were: 19% in both Delaware (46.8% to 55.6%) and Arkansas (32.1% to 38.3%), 13% in West Virginia (52.1% to 58.8%), and 12% in both New York (52.0% to 58.1%) and New Mexico (33.1% to 37.0%). The prevalence of WIC coverage also decreased 19% in the District of Columbia (56.9% to 46.0%) and 5% in New Hampshire (53.0% to 50.3%).

Differences. The prevalence of WIC coverage was 2.2 times higher in Vermont (72.9%) than in Louisiana (33.5%) in 2022.

SOCIAL AND ECONOMIC FACTORS | SOCIAL SUPPORT AND ENGAGEMENT

Voter Participation Among Women

Voting is associated with better individual and mental health, reduced community violence and lower unemployment rates.[41] Women gained the right to vote a century ago, and since 1980 they have consistently voted at significantly higher rates than men.[42,43] There is evidence that women have different policy priorities than men, focusing on issues such as funding for public health.[44]

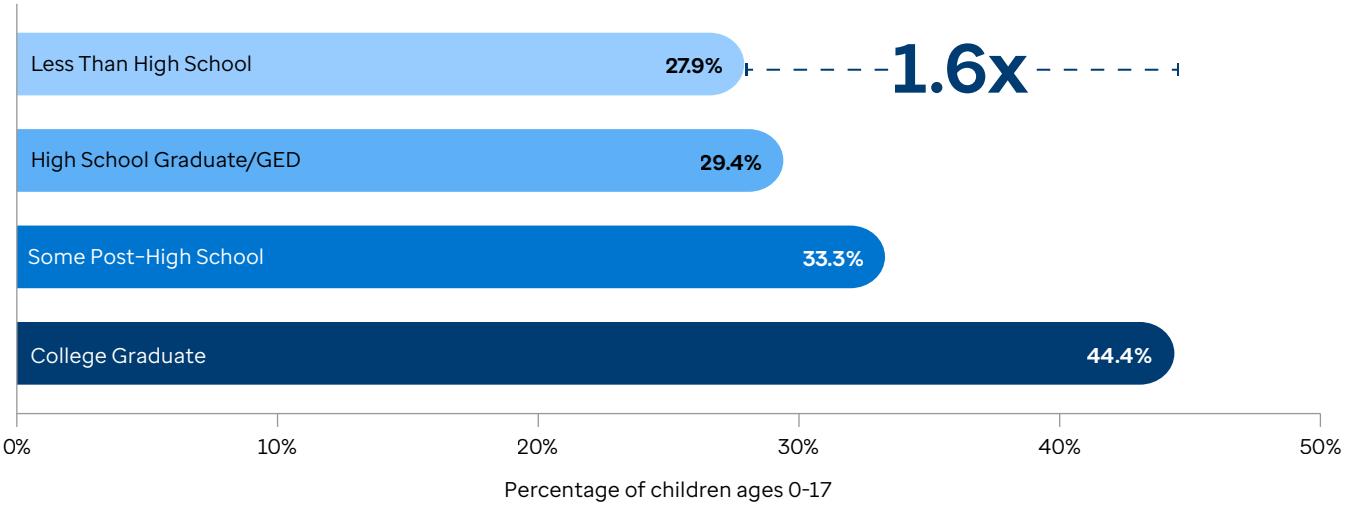
Changes over time. Nationally, the percentage of female U.S. citizens age 18 and older who voted in the last presidential election decreased 2%, from 68.4% to 66.9% between 2020 and 2024.

During this time, voter participation among women significantly decreased 17% in Arizona (76.5% to 63.3%) and 10% in Texas (66.3% to 59.9%).

Differences. Voter participation among women was 1.4 times higher in Minnesota (79.0%) than in Arkansas (54.6%) in 2024.

Neighborhood Amenities Among Children

By Caregiver Educational Attainment in 2023-2024



Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2023-2024.
Note: The values for children with caregivers who have less than a high school education and children with caregivers who are high school graduates may not differ significantly based on overlapping 95% confidence intervals.

Neighborhood Amenities Among Children

The health of individuals and communities is closely tied to the environment in which they live.[45] Neighborhood amenities, such as recreational facilities, libraries, playgrounds and sidewalks, offer opportunities to socialize, play, exercise and enjoy one's home.[46] There is evidence that safe neighborhoods with opportunities for and access to community engagement and healthy lifestyle habits contribute positively to physical and mental health.[47]

Changes over time. Nationally, the percentage of children ages 0-17 with access to neighborhood amenities (including all of the following: a park or playground; a recreation center, community center or boys' and girls' club; a library or bookmobile; and sidewalks or walking paths) increased 6%, from 36.1% to 38.2% between 2021-2022 and 2023-2024. In 2023-2024, 26.5 million children had access to all neighborhood amenities, an increase of 1.4 million children compared with 2021-2022.

Between 2021-2022 and 2023-2024, the prevalence of neighborhood amenities significantly increased:

- 9% among Hispanic children (35.6% to 38.7%).
- 7% among girls (36.0% to 38.4%) and 5% among boys (36.2% to 38.1%).
- 7% among children without special health care needs (36.8% to 39.2%).

During this time frame, neighborhood amenities increased 24% in North Dakota (33.6% to 41.6%) and 22% in Indiana (26.0% to 31.8%).

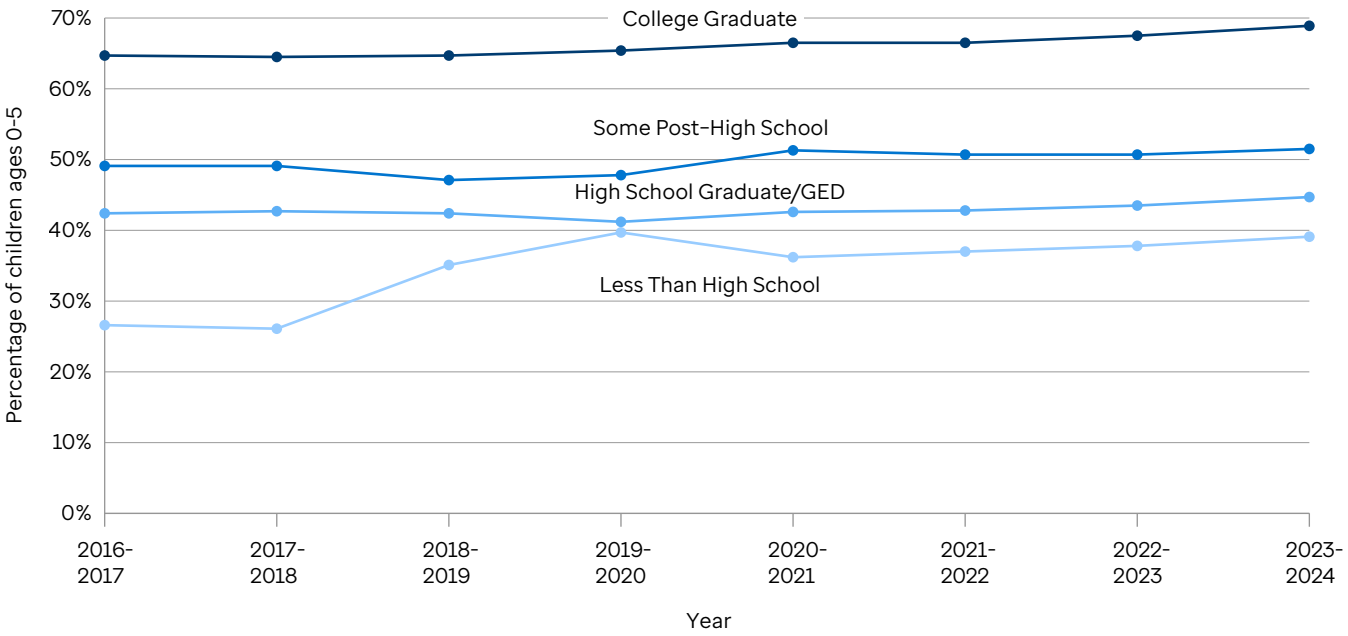
Differences. The prevalence of neighborhood amenities among children varied significantly by geography, race/ethnicity, caregiver educational attainment and special health care needs status in 2023-2024. The prevalence was:

- 5.3 times higher in the District of Columbia (73.5%) and 4.1 times higher in Colorado (56.7%) than in Mississippi (14.0%).
- 1.7 times higher among Asian (51.1%) compared with American Indian/Alaska Native (29.8%) children.
- 1.6 times higher among children with a caregiver who graduated from college (44.4%) compared with those who had caregivers with less than a high school education (27.9%).
- 1.1 times higher among children without special health care needs (39.2%) than those with special health care needs (35.6%).

Note: The values for Asian (51.1%) and Hawaiian/Pacific Islander (48.5%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for American Indian/Alaska Native (29.8%) and white (34.9%) children; and children with caregivers who had less than a high school education (27.9%) and children with a caregiver who graduated from high school (29.4%).

Changes in Reading, Singing or Storytelling Among Children

By Caregiver Educational Attainment



Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2016-2024.

Reading, Singing or Storytelling Among Children

Reading aloud to children was described as the most important factor in developing literacy by the Commission on Reading's 1985 landmark report *Becoming a Nation of Readers*.[48] Research has shown that regularly reading aloud to children stimulates patterns of brain development that strengthen language, literacy and social-emotional skills at a critical age.[49] Other language-rich experiences that benefit brain development and future school success include talking and singing to young children.[50]

Changes over time. Nationally, the percentage of children ages 0-5 whose family members read, sang or told stories to them every day during the past week increased 5%, from 57.1% to 59.7% between 2021-2022 and 2023-2024. In 2023-2024, nearly 12.9 million children had someone read, sing or tell stories to them every day, an increase of 157,800 children compared with 2021-2022.

Between 2021-2022 and 2023-2024, the prevalence of reading, singing or storytelling significantly increased 6% among girls (58.4% to 62.0%). During this time frame, reading, singing or storytelling increased 20% in Virginia (57.4% to 68.8%).

Differences. The prevalence of reading, singing or storytelling varied significantly by race/ethnicity, caregiver educational attainment, geography and gender in 2023-2024. The prevalence was:

- 1.9 times higher among white (67.6%) compared with Hawaiian/Pacific Islander (34.8%) children.
- 1.8 times higher among children with a caregiver who graduated from college (68.9%) compared with those whose caregivers had less than a high school education (39.1%).
- 1.6 times higher in Vermont (74.7%) than in Mississippi (47.8%).
- 1.1 times higher among girls (62.0%) compared with boys (57.6%).

Note: The values for white (67.6%) and multiracial (67.2%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Hawaiian/Pacific Islander (34.8%), American Indian/Alaska Native (43.7%), Black (46.5%), Asian (49.1%) and Hispanic (50.8%) children.

Early Childhood Education

Evidence suggests that early childhood education, combined with higher educational attainment, contributes to improved health and promotes health equity.[51] Typically, children who attend early childhood education programs have reduced rates of teen births and teen crime, improved standardized test scores and increased high school graduation rates.

Changes over time. Nationally, the percentage of children ages 3-4 who were enrolled in nursery school, preschool or kindergarten increased 4% from 46.7% to 48.5% between 2022 and 2023, returning to pre-pandemic levels. This means over 95,100 additional children ages 3 and 4 were enrolled in nursery school, preschool or kindergarten.

The rate of early childhood education enrollment increased in three states between 2022 and 2023: 19% in Arizona (33.7% to 40.0%), 10% in Texas (43.5% to 47.7%) and 7% in California (45.4% to 48.4%).

Differences. In 2023, early childhood education enrollment among children ages 3-4 was 3.4 times higher in the District of Columbia (90.1%) and 2.4 times higher in Connecticut and New Jersey (both 65.6%) than in North Dakota (26.8%).

Chronic School Absenteeism

Chronic absenteeism is defined as missing 10% or more of the school year, whether the absence is excused or unexcused.[52] Research has found that chronic absenteeism is strongly associated with falling behind academically, becoming socially disengaged and dropping out of school.[53]

Nationally, the percentage of public school students who missed 10% or more of their school days in an academic year was 27.8% in 2022-2023, representing approximately 13.4 million students.

Differences. Chronic school absenteeism was 2.8 times higher in the District of Columbia (46.7%) and 2.6 times higher in Oregon (43.8%) than in New Jersey (16.7%) in 2022-2023.

Significant Increases in Early Childhood Education

Change in the percentage of children ages 3-4 who are enrolled in nursery school, preschool or kindergarten between 2022 and 2023 by state.

Arizona

19% ▲

increase from 33.7% to 40.0%.

Texas

10% ▲

increase from 43.5% to 47.7%.

California

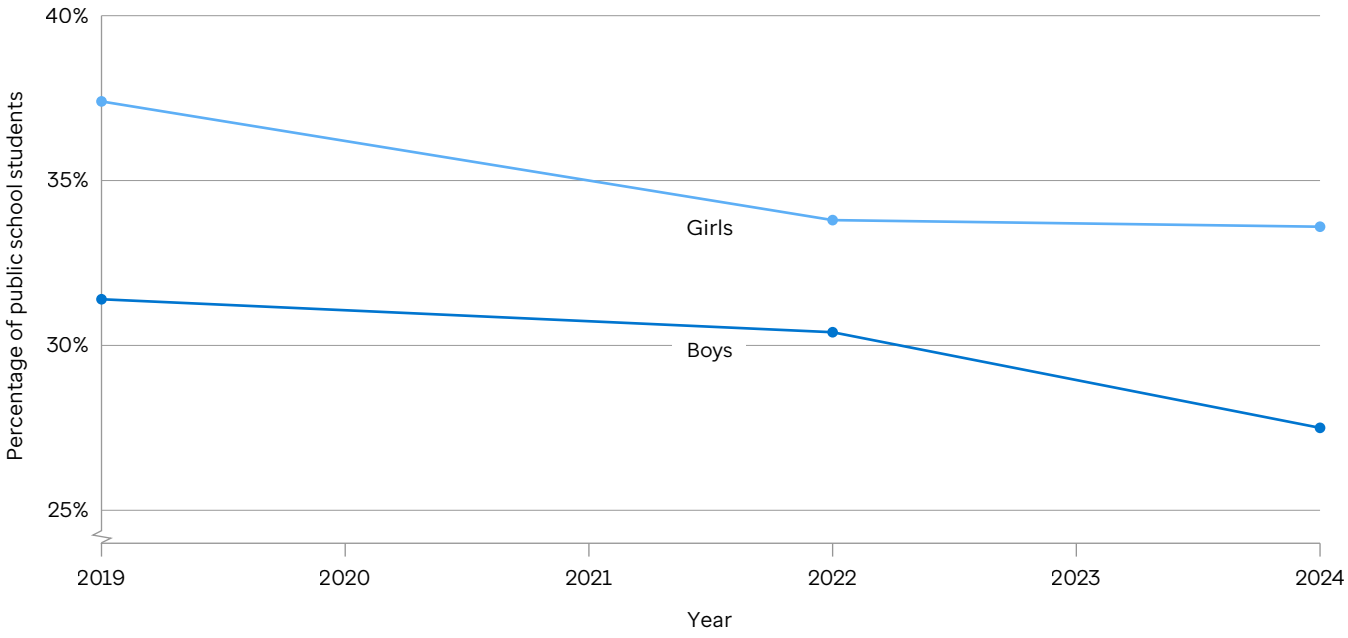
7% ▲

increase from 45.4% to 48.4%.

Source: U.S. Census Bureau, American Community Survey, 2022-2023.

Changes in Fourth Grade Reading Proficiency

By Gender



Source: U.S. ED, National Center for Education Statistics, National Assessment of Educational Progress, 2019-2024.

Fourth Grade Reading Proficiency

Fourth grade reading proficiency is an important indicator of adequate educational development.[54] By the time a child reaches fourth grade, they are expected to be able to read to learn other academic subjects.[55] If a child is not proficient in reading by this age, it becomes harder for them to succeed academically.

Changes over time. Nationally, the percentage of fourth grade public school students who scored proficient or above on the National Assessment of Educational Progress in reading comprehension decreased 5%, from 32.1% to 30.5% between 2022 and 2024.[56]

Between 2022 and 2024, fourth grade reading proficiency decreased:

- 17% among American Indian/Alaska Native (18.5% to 15.3%), 9% among Asian (57.7% to 52.3%), 6% among both multiracial (36.7% to 34.5%) and Hawaiian/Pacific Islander (21.4% to 20.2%), and 5% among white (41.0% to 38.9%) children.
- 10% among boys (30.4% to 27.5%).

During this time frame, fourth grade reading proficiency decreased by the national change (5%) or more in 27 states. The largest decreases were: 18% in Nebraska (34.0% to 28.0%), 16% in Arizona (31.4% to 26.4%) and 15% in Florida (39.0% to 33.0%).

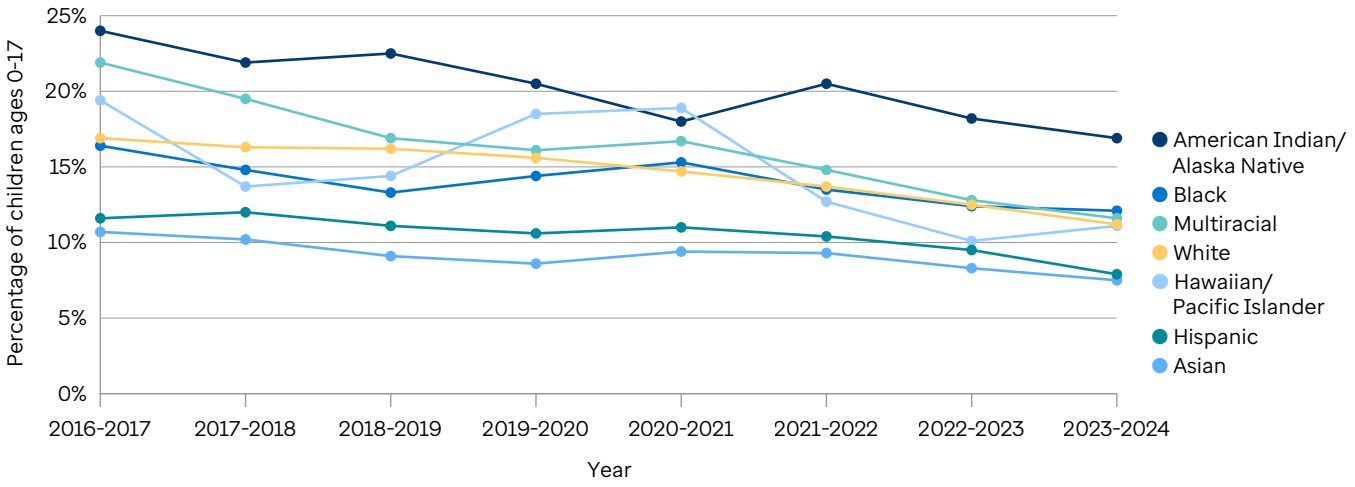
Over the same period, fourth grade reading proficiency increased 5% or more in 10 states and the District of Columbia, led by: 12% in the District of Columbia (26.5% to 29.6%), Nevada (26.9% to 30.0%) and Louisiana (28.3% to 31.8%); and 10% in both West Virginia (22.3% to 24.6%) and Maryland (30.6% to 33.6%).

Differences. In 2024, fourth grade reading proficiency varied by race/ethnicity, geography and gender. The prevalence was:

- 3.4 times higher among Asian (52.3%) compared with American Indian/Alaska Native (15.3%) children.
- 2.0 times higher in Massachusetts (40.4%) than in New Mexico (20.3%).
- 1.2 times higher among girls (33.6%) than boys (27.5%).

Changes in Household Smoke Among Children

By Race/Ethnicity



U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2016-2024.

PHYSICAL ENVIRONMENT | AIR AND WATER QUALITY

Household Smoke Among Children

The adverse impact of environmental tobacco smoke (secondhand smoke) on children's health is widely documented and recognized.[57] Secondhand smoke exposure is associated with numerous health problems in children, including respiratory infections, more frequent and severe asthma attacks, slower lung development, sudden infant death syndrome (SIDS) and premature death and disease from exposure to cancer-causing chemicals.[58,59]

Changes over time. Nationally, the percentage of children ages 0-17 living in households where someone used cigarettes, cigars or pipe tobacco decreased 19%, from 12.7% to 10.3% between 2021-2022 and 2023-2024. In 2023-2024, 7.2 million children lived in households where someone smoked, 1.7 million fewer than in 2021-2022.

Between 2021-2022 and 2023-2024, household smoke decreased:

- 24% among Hispanic (10.4% to 7.9%), 22% among multiracial (14.8% to 11.6%) and 18% among white (13.7% to 11.2%) children.
- 23% among boys (13.0% to 10.0%) and 14% among girls (12.3% to 10.6%).
- 21% among children with a caregiver who graduated from college (6.7% to 5.3%), and 15% among both children with a caregiver who graduated from high school (21.6% to 18.4%) and those who had a caregiver with some post-high school education (18.6% to 15.8%).

During this time, the prevalence significantly decreased: 38% in Texas (12.9% to 8.0%), 32% in North Dakota (17.1% to 11.6%), 28% in California (8.0% to 5.8%) and 25% in Tennessee (17.9% to 13.4%).

Differences. The prevalence of household smoke significantly varied by geography, caregiver educational attainment, race/ethnicity and special health care needs status in 2023-2024. The percentage was:

- 4.7 times higher in West Virginia (21.9%) than in Utah (4.7%).
- 3.5 times higher among children with a caregiver who graduated from high school (18.4%) compared with children with a caregiver who graduated from college (5.3%).
- 2.3 times higher among American Indian/Alaska Native (16.9%) compared with Asian (7.5%) children.
- 1.5 times higher among children with special health care needs (13.7%) than those without special health care needs (9.0%).

Note: The values for American Indian/Alaska Native (16.9%), Black (12.1%), multiracial (11.6%) and Hawaiian/Pacific Islander (11.2%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian (7.5%), Hispanic (7.9%) and Hawaiian/Pacific Islander children.

Avoided Care Due to Cost Among Women

In a 2022 survey, 59% of women in the U.S. reported that they would not be able to pay an unexpected $500 medical bill in full without going into debt, and among those, 19% would be unable to pay it at all.[60] Widespread lack of access to affordable, timely and high-quality primary care is associated with increased preventable hospitalizations, excess strain on emergency services and missed opportunities to prevent disease and manage chronic conditions, all of which can lead to worse and more expensive health outcomes.[61-64]

Changes over time. Nationally, the percentage of women ages 18-44 who reported a time in the past 12 months when they needed to see a doctor but could not because of cost increased 19%, from 14.6% to 17.4% between 2021 and 2022-2023. In 2022-2023, more than 10 million women were unable to afford care due to cost, representing an increase of 1.9 million women from 2021.

Between 2021 and 2022-2023, the percentage of women who could not afford care due to cost increased:

- 53% among women with an annual household income of $75,000 or more (5.5% to 8.4%), 29% among those with incomes of $50,000-$74,999 (14.1% to 18.2%) and 21% among those with incomes less than $25,000 (24.8% to 29.9%).
- 26% among white (12.9% to 16.2%) and 25% among Hispanic (19.2% to 24.0%) women.
- 26% among women with less than a high school education (23.9% to 30.1%), 23% among high school graduates (16.7% to 20.6%), 19% among college graduates (9.1% to 10.8%) and 16% among women with some post-high school education (16.4% to 19.1%).
- 19% among women living in metropolitan areas (14.7% to 17.5%) and 16% among those in nonmetropolitan areas (14.8% to 17.2%).

During this time frame, the prevalence of avoiding care due to cost increased 76% in the District of Columbia (6.6% to 11.6%), 48% in New Jersey (11.7% to 17.3%), 39% in New York (10.0% to 13.9%), 37% in Washington (11.0% to 15.1%) and 26% in Colorado (13.9% to 17.5%).

Differences. The prevalence of avoiding care due to cost varied significantly by household income, geography, disability status, educational attainment, race/ethnicity, sexual orientation and age in 2022-2023. The prevalence was:

- 3.6 times higher among women with an annual household income less than $25,000 (29.9%) compared with those with incomes of $75,000 or more (8.4%).
- 3.4 times higher in Texas (27.6%) than in Hawaii (8.1%).
- 3.0 times higher among women who have difficulty with self-care (38.5%) compared with women without a disability (12.7%).
- 2.8 times higher among women with less than a high school education (30.1%) compared with college graduates (10.8%).
- 2.6 times higher among Hispanic (24.0%) compared with Asian (9.3%) women.
- 1.6 times higher among LGBQ+ (24.7%) compared with straight (15.2%) women.
- 1.2 times higher among women ages 25-34 (19.4%) compared with those ages 35-44 (15.7%).

Note: Data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The values for women who have difficulty with self-care (38.5%), those with independent living difficulty (38.0%), those who have difficulty seeing (35.0%), those who have difficulty with mobility (34.3%), those who have difficulty with cognition (33.5%) and those who have difficulty hearing (31.7%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for Hispanic (24.0%), Hawaiian/Pacific Islander (22.3%), American Indian/Alaska Native (22.2%) and other race (20.7%) women; and women ages 35-44 (15.7%) and 18-24 (17.2%). 2020 data excluded due to methodological differences.

ADD/ADHD Treatment Among Children

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders in childhood.[65] (The term ADD is no longer an official diagnosis and is part of ADHD.) It is important to diagnose and treat ADHD early.[66] ADHD cannot be cured, but it can be managed and symptoms may improve as children age. If left untreated, ADHD can lead to significant problems in education, employment and personal relationships.[67]

Changes over time. Nationally, the percentage of children ages 3-17 who had ADD or ADHD, were taking medication and had received behavioral treatment increased 21%, from 2.8% to 3.4% between 2021-2022 and 2023-2024. In 2023-2024, nearly 2.1 million children had ADD/ADHD, were taking medication and had received behavioral treatment, an increase of 340,900 compared with 2021-2022.

Between 2021-2022 and 2023-2024, ADD/ADHD treatment significantly increased 30% among children with a caregiver who graduated from college (2.7% to 3.5%).

During the same time period, ADD/ADHD treatment increased 129% in Oregon (2.4% to 5.5%) and 90% in Illinois (2.1% to 4.0%).

Differences. ADD/ADHD treatment among children significantly varied by race/ethnicity, geography, caregiver educational attainment and gender in 2023-2024. The prevalence was:

- 11.3 times higher among American Indian/Alaska Native (7.9%) compared with Asian (0.7%) children.
- 4.8 times higher in Mississippi (6.3%) than in Hawaii (1.4%).
- 2.2 times higher among children with a caregiver who had some post-high school education (3.7%) compared with children whose caregivers had less than a high school education (1.7%).
- 1.7 times higher among boys (4.3%) than girls (2.5%).

Note: The values for American Indian/Alaska Native (7.9%), Black (4.3%), white (4.0%), multiracial (3.8%) and Hispanic (2.2%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian (0.7%) and Hawaiian/Pacific Islander (0.9%) children; and children with a caregiver who had some post-high school education (3.7%), children with a caregiver who graduated from high school (3.6%) and children with a caregiver who graduated from college (3.5%).

Uninsured Children

Maintaining continuous and adequate insurance is essential for everyone, and especially children, since there is rapid growth in the first months and years of life.[68] When compared with children who have health insurance, uninsured children experience more health disadvantages, including lower rates of vaccine coverage, more hospitalizations and higher in-hospital mortality rates.[69-71]

Changes over time. Nationally, the percentage of children younger than 19 years not covered by private or public health insurance increased 6%, from 5.1% to 5.4% between 2022 and 2023.

During this time frame, the percentage of uninsured children significantly increased 55% in New Mexico (3.8% to 5.9%), 30% in South Carolina (4.7% to 6.1%) and 9% in Texas (10.9% to 11.9%).

Differences. The prevalence of uninsured children was 7.9 times higher in Texas (11.9%) than in Massachusetts (1.5%) in 2023.

Childhood Immunizations

Early childhood immunizations are a safe and cost-effective way to protect children from potentially life-threatening preventable diseases during their most vulnerable years.[72]

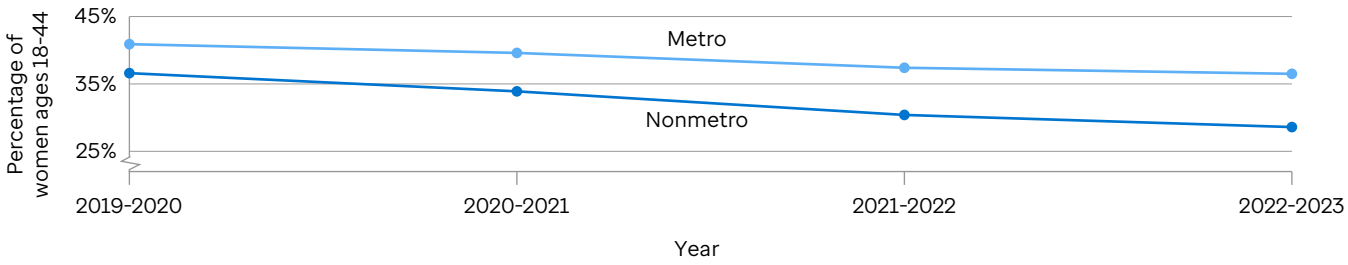
Changes over time. Nationally, the percentage of children who received all recommended doses of the combined seven-vaccine series by age 24 months decreased 4%, from 70.0% to 66.9% between the 2017-2018 and 2020-2021 birth cohorts.

During this time frame, childhood immunization rates significantly decreased 21% in Nebraska (77.3% to 61.2%) and 13% in Pennsylvania (76.7% to 67.1%).

Differences. The childhood immunization rate was 1.4 times higher in Massachusetts (83.1%) than in Montana (57.8%) in 2020-2021 birth cohorts.

Changes in Flu Vaccination Among Women

By Metropolitan Status



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2019-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023, Florida in 2021 or New Jersey in 2019.

Flu Vaccination Among Women

The flu vaccine helps protect people against seasonal influenza viruses (known as the flu) that may lead to severe complications.[73] Estimates suggest that during the 2022-2023 flu season, vaccines prevented 6 million flu-related illnesses and 65,000 hospitalizations associated with influenza in the U.S.[74]

Changes over time. Nationally, the percentage of women ages 18-44 who reported receiving a seasonal flu vaccine in the past 12 months decreased 9%, from 38.9% to 35.5% between 2020-2021 and 2022-2023. This remains below the Healthy People 2030 target of 70.0% of people age 6 months and older.[75] In 2022-2023, nearly 18.2 million women received a flu vaccine.

Between 2020-2021 and 2022-2023, the prevalence of flu vaccination significantly decreased:

- 26% among American Indian/Alaska Native (36.2% to 26.8%) and 14% among white (42.5% to 36.7%) women.
- 16% among women living in nonmetropolitan areas (33.9% to 28.6%) and 8% among those in metropolitan areas (39.6% to 36.5%).
- 15% among women with an annual household income of $25,000-$49,999 (33.0% to 28.2%), 11% among those with incomes of $50,000-$74,999 (39.4% to 34.9%) and 9% among those with incomes of $75,000 or more (51.8% to 47.0%).
- 12% among high school graduates (28.1% to 24.8%), 10% among women with some post-high school education (35.6% to 32.0%) and 6% among college graduates (53.2% to 50.0%).
- 11% among women ages 18-24 (37.1% to 33.0%), and 8% among both ages 25-34 (38.1% to 35.0%) and 35-44 (40.8% to 37.5%).

During this time frame, flu vaccination significantly decreased in 15 states. The largest decreases were: 27% in South Dakota (54.7% to 40.0%), 25% in Florida (30.3% to 22.7%) and 22% in Montana (41.5% to 32.2%).

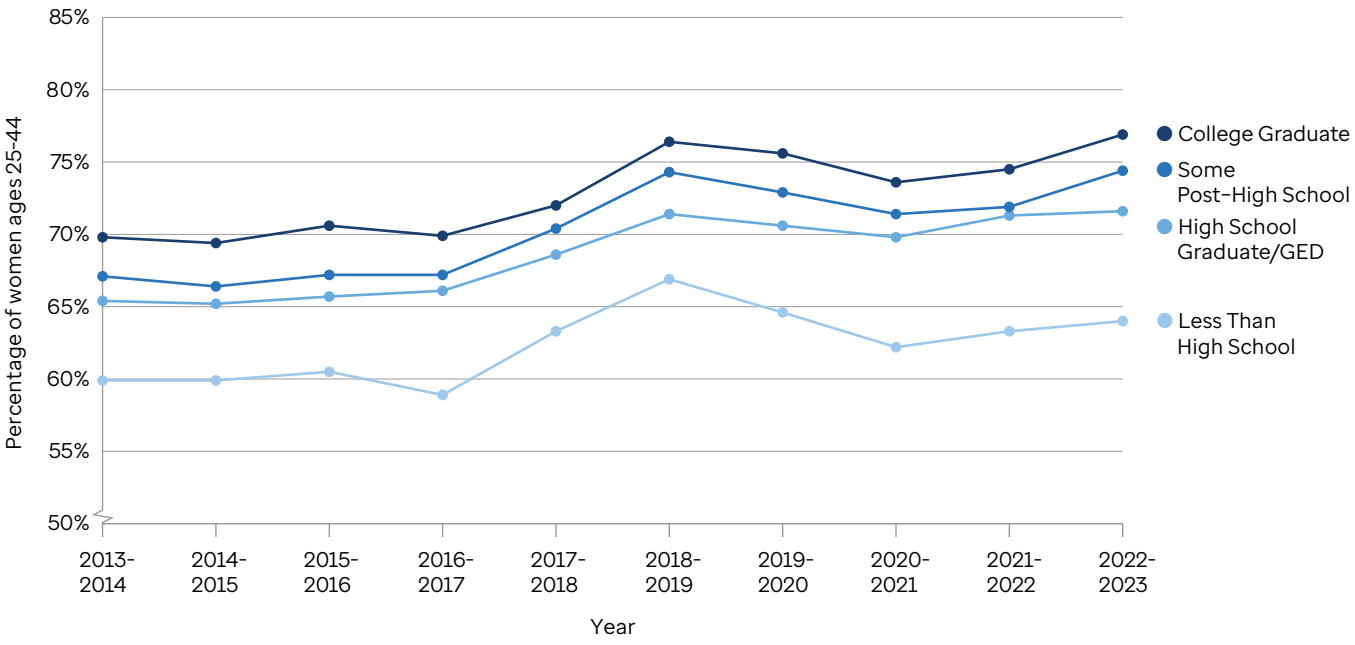
Differences. Flu vaccination rates varied significantly by geography, educational attainment, race/ethnicity, household income, disability status, veteran status, age and sexual orientation. In 2022-2023, the prevalence was:

- 2.4 times higher in the District of Columbia (53.9%) and 2.3 times higher in Massachusetts (52.5%) than in Florida (22.7%).
- 2.1 times higher among college graduates (50.0%) than women with less than a high school education (23.4%).
- 1.8 times higher among: Asian (47.0%) than American Indian/Alaska Native (26.8%) women; and women with an annual household income of $75,000 or more (47.0%) than those with incomes less than $25,000 (25.6%).
- 1.4 times higher among: women without a disability (37.2%) than those who have difficulty seeing (27.0%); and women who have served in the U.S. armed forces (48.2%) than those who have not served (35.2%).
- 1.1 times higher among: women ages 35-44 (37.5%) than those ages 18-24 (33.0%); and LGBQ+ (38.7%) than straight (36.2%) women.

Note: Data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The values for women with less than a high school education (23.4%) and high school graduates (24.8%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for American Indian/Alaska Native (26.8%), Black (28.4%), other race (29.2%), Hawaiian/Pacific Islander (30.1%) and Hispanic (30.7%) women; women with incomes less than $25,000 (25.6%) and incomes of $25,000-$49,999 (28.2%); women without a disability (37.2%) and those who have difficulty with self-care (34.9%); women with difficulty seeing (27.0%), those with independent living difficulty (29.5%), those with difficulty hearing (30.1%) and those who have difficulty with mobility (30.8%); and women ages 18-24 (33.0%) and 25-34 (35.0%).

Changes in Well-Woman Visits

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023, Florida in 2021 or New Jersey in 2019.

Well-Woman Visits

Annual health exams provide an opportunity for women to access preventive services such as vaccines and screening tests, which can help identify cancers and other conditions at an earlier stage when they are easier to treat.[76,77] Well-woman visits are also a great opportunity to discuss strategies for minimizing health risks and achieving a healthy lifestyle.[78]

Changes over time. Nationally, the percentage of women ages 18-44 who had a preventive medical visit in the past year increased 3%, from 70.5% to 72.7% between 2020-2021 and 2022-2023. In 2022-2023, 41.2 million women received a preventive visit.

Between 2020-2021 and 2022-2023, the prevalence of well-woman visits significantly increased:

- 12% among Asian (67.5% to 75.3%), 5% among Hispanic (66.3% to 69.9%) and 3% among white (70.3% to 72.1%) women.
- 6% among women with an annual household income of $25,000-$49,999 (67.6% to 71.4%) and 4% among those with incomes of $75,000 or more (74.3% to 77.6%).
- 4% among women ages 25-34 (68.9% to 71.9%) and 3% among those ages 35-44 (72.5% to 75.0%).
- 4% among both college graduates (73.6% to 76.9%) and women with some post-high school education (71.4% to 74.4%).
- 4% among women living in nonmetropolitan areas (69.9% to 72.5%) and 3% among those in metropolitan areas (70.6% to 72.7%).

During this time frame, well-woman visits significantly increased in seven states. The largest increases were: 16% in Vermont (64.7% to 74.9%), 14% in California (62.4% to 71.3%) and 11% in Alaska (63.9% to 70.7%).

Differences. Well-woman visits varied significantly by geography, race/ethnicity, educational attainment, disability status, age, household income, sexual orientation and veteran status in 2022-2023. The prevalence was:

- 1.3 times higher in Louisiana (80.3%) than in New Mexico (62.5%).
- 1.3 times higher among Black (82.0%) compared with Hawaiian/Pacific Islander (61.4%) women.
- 1.2 times higher among college graduates (76.9%) compared with women with less than a high school education (64.0%).

- 1.2 times higher among women who have difficulty with self-care (78.8%) than those with independent living difficulty (67.2%).
- 1.1 times higher among women ages 35-44 (75.0%) compared with those ages 18-24 (70.2%).
- 1.1 times higher among women with an annual household income of $75,000 or more (77.6%) compared with those with incomes less than $25,000 (69.7%).
- 1.1 times higher among straight (74.6%) compared with LGBQ+ (68.5%) women.
- 1.1 times higher among women who have served in the U.S. armed forces (79.6%) compared with those who have not served (72.5%).

Note: Well-woman visit data for Kentucky, Pennsylvania and all sexual orientation groups in Colorado are from 2022 only. Data for all racial and ethnic groups and all sexual orientation groups in Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only. The values for Hawaiian/Pacific Islander (61.4%), Hispanic (69.9%), multiracial (71.0%), white (72.1%), other race (72.7%), American Indian/Alaska Native (73.7%) and Asian (75.3%) women may not differ significantly based on overlapping 95% confidence intervals. The same is true for women who have difficulty with self-care (78.8%) and those with difficulty with mobility (77.1%); women with independent living difficulty (67.2%), those with difficulty with cognition (69.0%), those with difficulty seeing (70.2%) and those with difficulty hearing (71.5%); women ages 18-24 (70.2%) and 25-34 (71.9%); and women with incomes less than $25,000 (69.7%), incomes of $25,000-$49,999 (71.4%) and incomes of $50,000-$74,999 (72.6%).

Related Measure: Dedicated Health Care Provider Among Women

Nationally, the percentage of women ages 18-44 who reported having a personal doctor or health care provider decreased 2%, from 79.2% to 77.4% between 2021 and 2022-2023. This means roughly 403,800 fewer women had a personal doctor. During this period, the prevalence significantly decreased 8% in Nebraska (83.7% to 77.3%), South Carolina (79.2% to 72.8%) and Wisconsin (89.3% to 81.8%); and 7% in Iowa (86.5% to 80.3%). It also decreased 26% among women with an annual household income less than $25,000 (88.9% to 65.5%), 7% among Hispanic women (68.2% to 63.7%) and 5% among women ages 18-24 (75.4% to 71.6%). In contrast, the prevalence significantly increased 10% in Oregon (74.6% to 82.2%), 9% among women with incomes of $50,000-$74,999 (75.9% to 82.9%), 8% among women with incomes of $25,000-$49,999 (71.3% to 77.1%) and 4% among women with incomes of $75,000 or more (84.9% to 88.4%). Roughly 1.3 times more women in the highest income group (household incomes of $75,000 or more) had dedicated healthcare providers compared with the lowest income group (household income less than $25,000).

Note: Dedicated health care provider data for Kentucky and Pennsylvania are from 2022 only. Data for all racial and ethnic groups are from 2023 only. 2020 data excluded due to methodological differences.

Dedicated Health Care Provider

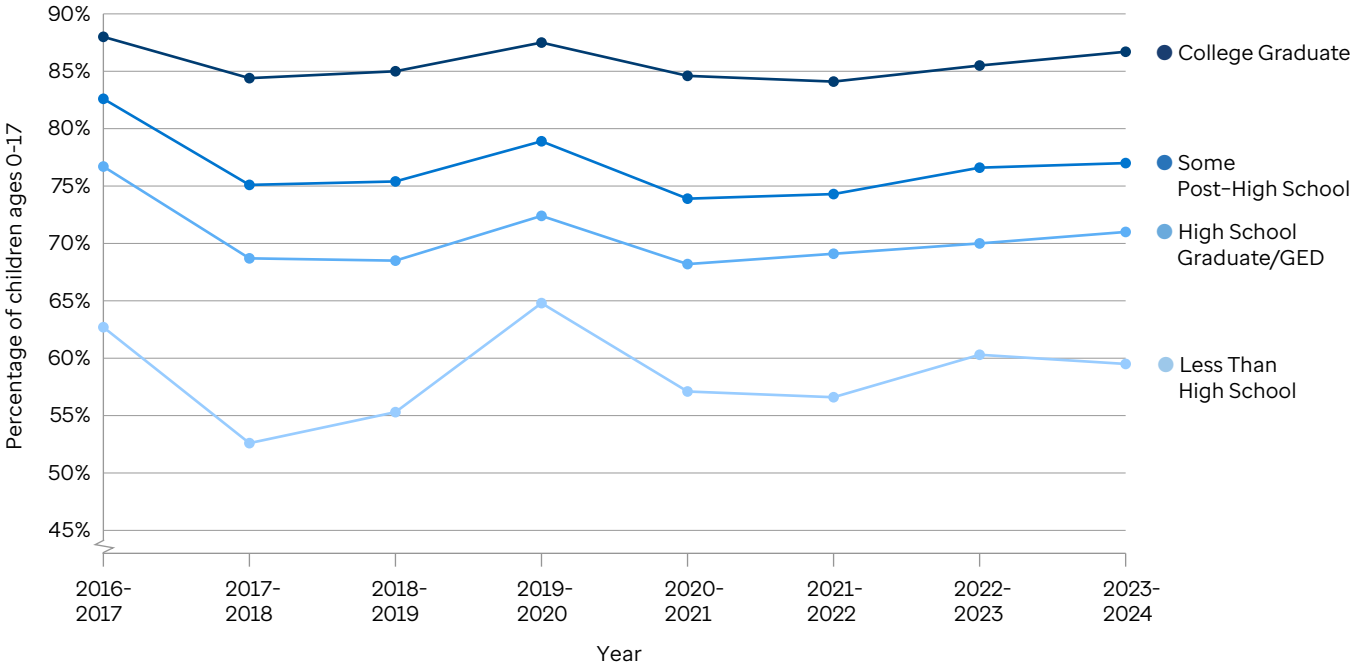
26%▼

decrease from 88.9% to 65.5% among women ages 25-44 with an annual household income less than $25,000 between 2021 and 2022-2023.

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2021-2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

Changes in Well-Child Visits

By Caregiver Educational Attainment



Source: U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health, 2016-2024.

Well-Child Visits

The American Academy of Pediatrics recommends that all infants, toddlers and children receive routine preventive visits, known as well-child visits.[79] Younger children require more frequent visits due to their rapid development.[80] As they enter adolescence, they experience several transitions that may require unique health care solutions and conversations. Social factors and behaviors that lead to morbidity and mortality are often initiated in adolescence, which makes it a critical time for education, prevention and early intervention.[81]

Changes over time. Nationally, the percentage of children ages 0-17 who received one or more preventive visits in the past 12 months increased 4%, from 76.8% to 79.6% between 2021-2022 and 2023-2024. In 2023-2024, 57.1 million children received a preventive visit, nearly 1.5 million more than in 2021-2022.

Between 2021-2022 and 2023-2024, the prevalence of well-child visits significantly increased:

- 13% among Asian (66.2% to 74.7%), 5% among Hispanic (70.3% to 73.8%) and 3% among white (81.4% to 83.6%) children.
- 4% among girls (76.9% to 80.0%) and 3% among boys (76.7% to 79.3%).
- 4% among children with a caregiver who had some post-high school education (74.3% to 77.0%) and 3% among children with a caregiver who graduated from college (84.1% to 86.7%).
- 4% among children without special health care needs (74.1% to 77.1%).

During this time frame, well-child visits significantly increased in six states. The largest increases were: 11% in New Mexico (69.8% to 77.5%), 10% in Vermont (83.8% to 92.0%) and 9% in California (68.4% to 74.8%).

Clinical Care Measures Continue to Fall Short of Healthy People 2030 Targets

Low-risk cesarean delivery and adequate prenatal care continued to fall short of 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 – slightly increased from 26.3% in 2022 to 26.6% in 2023, exceeding the Healthy People 2030 target of 23.6%.[82] 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 75.2% in 2023, short of the Healthy People 2030 target of 80.5% of pregnant females who received early and adequate prenatal care.[83]

Differences. Well-child visits varied significantly by educational attainment, race/ethnicity, geography, age and special health care needs status in 2023-2024. The prevalence was:

- 1.5 times higher among children with a caregiver who graduated from college (86.7%) compared with those who had caregivers with less than a high school education (59.5%).
- 1.3 times higher among multiracial (84.2%) compared with Hawaiian/Pacific Islander (64.9%) children.
- 1.3 times higher in Vermont (92.0%) than in Nevada (71.9%).
- 1.1 times higher among children ages 0-2 (88.4%) compared with children ages 3-17 (78.1%).
- 1.1 times higher among children with special health care needs (86.6%) compared with children without special health care needs (77.1%).

Note: The values for multiracial (84.2%) and white (83.6%) children may not differ significantly based on overlapping 95% confidence intervals. The same is true for Hawaiian/Pacific Islander (64.9%), American Indian/Alaska Native (71.8%), Hispanic (73.8%), Asian (74.7%) and Black (77.4%) children.

Exercise Among Women

Regular exercise is a vital component of a healthy lifestyle. Engaging in regular physical activity offers numerous benefits for both physical and mental health, including reduced risk of cardiovascular diseases, certain cancers, depression, sleep problems and anxiety.[84]

Nationally, in 2023, 27.6% of women ages 18-44 met the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days. The prevalence remained below the Healthy People 2030 national target of 29.7% of adults age 18 and older.[85]

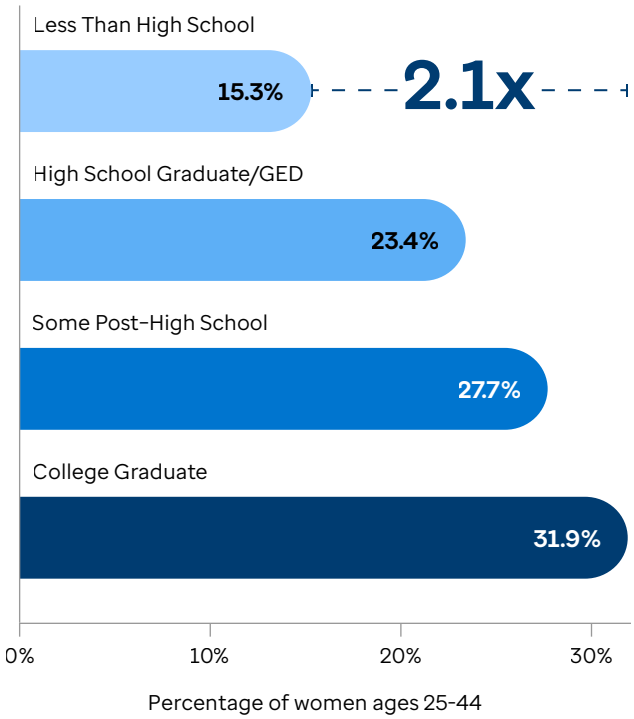
Differences. The prevalence of exercise among women varied significantly by educational attainment, disability status, household income, geography, race/ethnicity and veteran status. In 2023, the prevalence was:

- 2.1 times higher among college graduates (31.9%) than women with less than a high school education (15.3%).
- 1.8 times higher among women without a disability (29.2%) compared with women who have difficulty with self-care (15.9%).
- 1.7 times higher among women with an annual household income of $75,000 or more (32.4%) compared with those with incomes less than $25,000 (19.1%).
- 1.7 times higher in the District of Columbia (37.3%) and 1.6 times higher in Montana (34.2%) than in Mississippi (21.5%).
- 1.4 times higher among American Indian/Alaska Native (33.2%) compared with Hispanic (24.0%) women.
- 1.3 times higher among women who have served in the U.S. armed forces (34.7%) compared with those who have not served (27.4%).

Note: No data were available for Kentucky or Pennsylvania in 2023. The values for women who have difficulty with self-care (15.9%), women who have difficulty with mobility (19.3%), women with independent living difficulty (20.5%), women with difficulty hearing (21.9%) and women with difficulty seeing (22.3%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for American Indian/Alaska Native, multiracial (31.1%), other race (30.7%), white (29.8%), Asian (27.1%), Hawaiian/Pacific Islander (26.1%) and Black (24.6%) women; and Hispanic, Black, Hawaiian/Pacific Islander, white and multiracial women.

Exercise Among Women

By Educational Attainment in 2023



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023.
Note: No data were available for Kentucky or Pennsylvania in 2023.

Chlamydia

Chlamydia is the most commonly reported sexually transmitted infection in the United States.[86,87] The vast majority of reported chlamydia cases in the U.S. occur in women, particularly women of reproductive age.[88] In 2023, more than half of all reported chlamydia cases occurred in adolescents and young adults ages 15-24.[87]

Changes over time. Nationally, chlamydia incidence decreased 4% between 2022 and 2023, from 1,540.1 to 1,481.2 new cases per 100,000 females ages 15-44. In 2023, approximately 977,200 new cases of chlamydia were diagnosed among females ages 15-44, 32,300 fewer cases than in 2022.

Between 2022 and 2023, chlamydia incidence decreased 4% among white women (659.0 to 633.4 cases per 100,000) and 4% (the national change) or more in 26 states and the District of Columbia, led by: 51% in Maryland (1,555.9 to 766.5), 20% in Tennessee (1,723.2 to 1,375.3) and 13% in Montana (1,243.1 to 1,086.5). The incidence increased 4% or more in six states. The largest increases were: 26% in Maine (248.5 to 312.9), 10% in Hawaii (1,328.6 to 1,464.3) and 8% in Delaware (1,771.6 to 1,916.4).

Differences. Chlamydia incidence varied by race/ethnicity and geography in 2023. The rate was:

- 12.5 times higher among Black (3,031.3) compared with Asian (242.8) women.
- 8.2 times higher in Louisiana (2,572.4) than in Maine (312.9).

Teen Births

Substantial social, economic and health costs are associated with teen pregnancy and child-rearing. Teenage mothers are significantly more likely to drop out of high school and face unemployment.[89] The children of teen mothers also have a higher risk of mental health issues, aggression and behavior problems, academic difficulties, continuous delinquent behavior and becoming teen mothers themselves.[90,91]

Changes over time. Nationally, the teen birth rate decreased 4% between 2022 and 2023, from 13.6 to 13.1 births per 1,000 females ages 15-19. In 2023, nearly 141,000 teenagers gave birth, 2,800 fewer than in 2022.

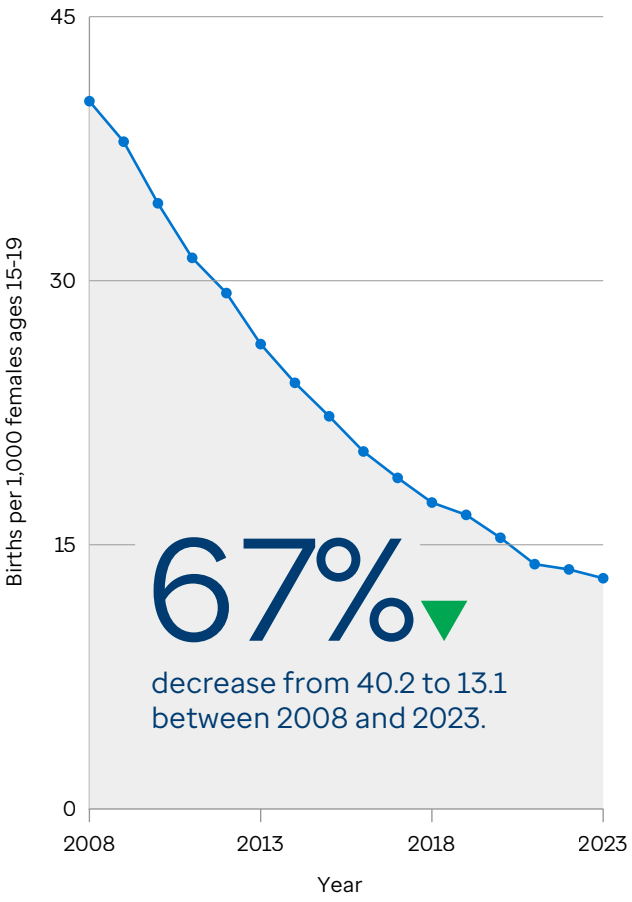
Between 2022 and 2023, the teen birth rate decreased 8% among white teenagers (9.0 to 8.3 births per 1,000 females ages 15-19), 7% among American Indian/Alaska Native teenagers (22.2 to 20.7), 6% among both Asian teenagers (1.7 to 1.6) and multiracial teenagers (13.5 to 12.7), and 5% among Black teenagers (20.2 to 19.2).

During this time frame, the teen birth rate decreased 4% (the national change) or more in 29 states, led by: 21% in Wyoming (16.0 to 12.6), 14% in Maine (8.4 to 7.2) and 10% in Rhode Island (8.3 to 7.5).

Differences. The teen birth rate varied by race/ethnicity and geography in 2023. The rate was:

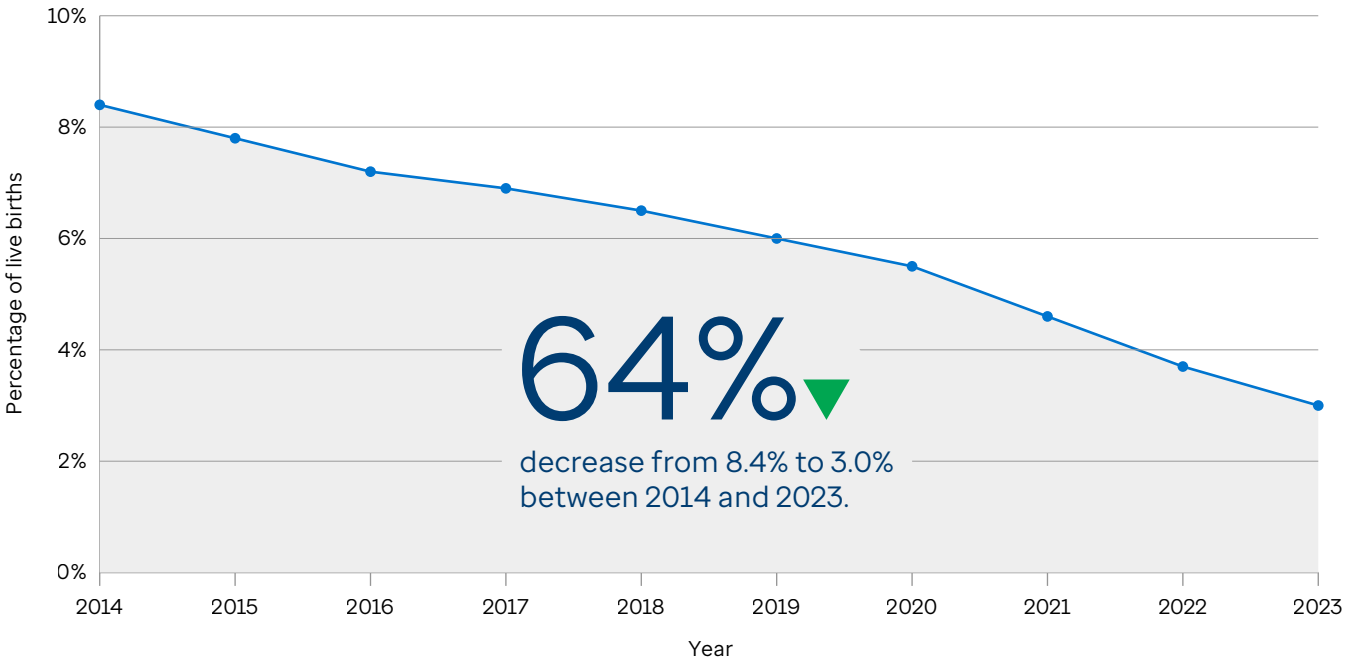
- 13.0 times higher among Hispanic (20.8 births per 1,000 females ages 15-19) compared with Asian (1.6) teenagers.
- 5.4 times higher in Mississippi (24.9) than in New Hampshire (4.6).

Changes in Teen Births



Source: U.S. HHS, Natality Public Use Files via CDC WONDER, 2008-2023.

Changes in Smoking During Pregnancy



Source: U.S. HHS, Natality Public Use Files via CDC WONDER, 2014-2023.

BEHAVIORS | SMOKING AND TOBACCO USE

Smoking During Pregnancy

Smoking cigarettes and using other tobacco products while pregnant is harmful to both mother and child, increasing risk of miscarriage, ectopic pregnancy, preterm birth, developmental damage and sudden infant death syndrome (SIDS).[92-95] A recent study estimates that quitting or reducing smoking during pregnancy has an economic benefit of more than half a billion dollars annually in the U.S., based on just the reduction of SIDS deaths.[96]

Changes over time. Nationally, the percentage of mothers who reported smoking cigarettes during pregnancy decreased 19%, from 3.7% to 3.0% of live births between 2022 and 2023. Over the long term, smoking during pregnancy has decreased 64% since 2014 (8.4%). In 2023, approximately 107,800 mothers smoked during pregnancy, 26,400 fewer mothers than in 2022.

Between 2022 and 2023, the prevalence of smoking during pregnancy decreased 19% or more (the national change) in 24 states, led by: 36% in Rhode Island (2.5% to 1.6% of live births), 27% in Mississippi (5.1% to 3.7%) and 26% in South Carolina (4.3% to 3.2%).

Differences. Smoking during pregnancy was 20.5 times higher in West Virginia (12.3%) than in California (0.6%) in 2023.

State Rankings

Rankings included in the *2025 Health of Women and Children Report* were derived from 82 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. The Methodology section (page 54) of the Appendix describes how overall ranks are calculated. Additional information can be found on the *America's Health Rankings* Methodology page.

Massachusetts Ranked No. 1

Massachusetts was the healthiest state in this year's report, ranking first for both women and children. It ranked among the top five states in Social and Economic Factors (No. 1), Clinical Care (No. 2) and Health Outcomes (No. 5). Massachusetts also ranked No. 9 in Behaviors and No. 14 in Physical Environment.

Strengths: Low prevalence of adverse childhood experiences (ACEs) among children, high percentage of women college graduates and high reading proficiency among fourth grade public school students.

Challenges: High prevalence of alcohol use among adolescents, high prevalence of multiple chronic conditions among women and high percentage of low-risk cesarean deliveries.

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

Louisiana Ranked No. 50

Louisiana was the least healthy state in this year's report, ranking No. 49 for women and No. 50 for children. It ranked in the bottom five states in Social and Economic Factors (No. 48), Physical Environment (No. 49), Behaviors (No. 49) and Health Outcomes (No. 50). In Clinical Care, Louisiana ranked No. 23.

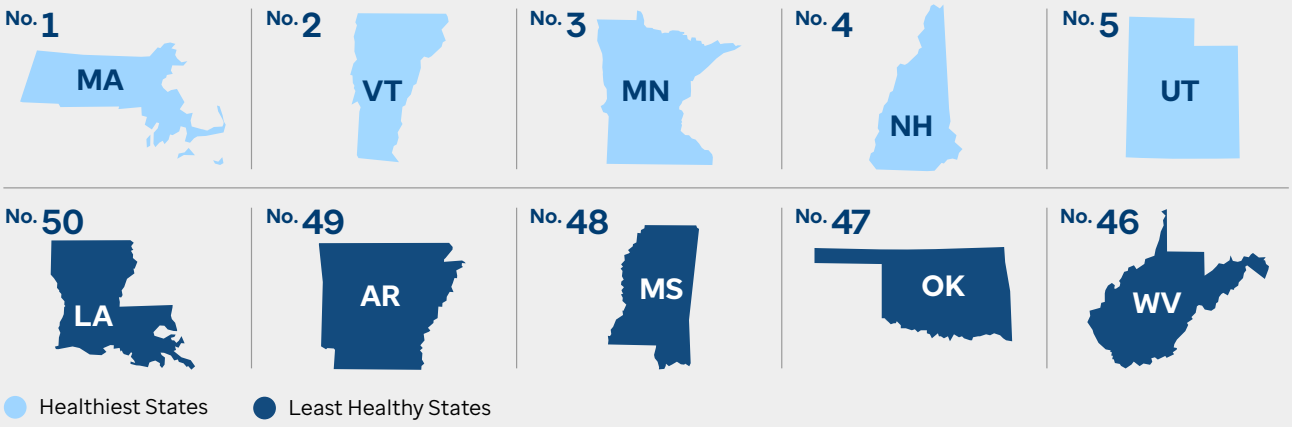
Strengths: High enrollment in early childhood education, high prevalence of women with a dedicated health care provider and high percentage of children with adequate and continuous health insurance.

Challenges: High child mortality rate, high percentage of children in poverty and high incidence of chlamydia among women.

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

Five Healthiest and Least Healthy States

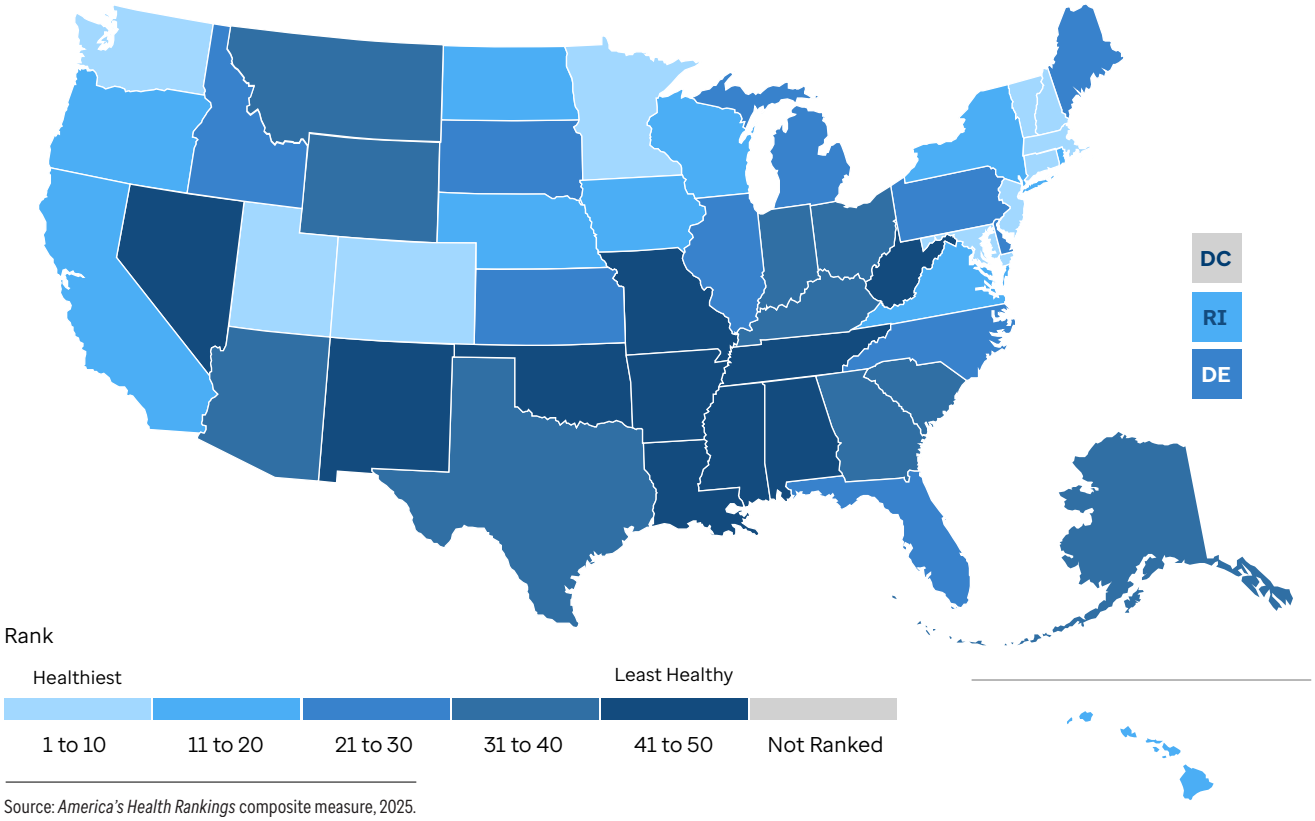
Healthiest and least healthy states for women and children ranked across Social and Economic Factors, Physical Environment, Clinical Care, Behaviors and Health Outcomes.



Source: *America's Health Rankings* composite measure, 2025.

State Rankings: Women and Children

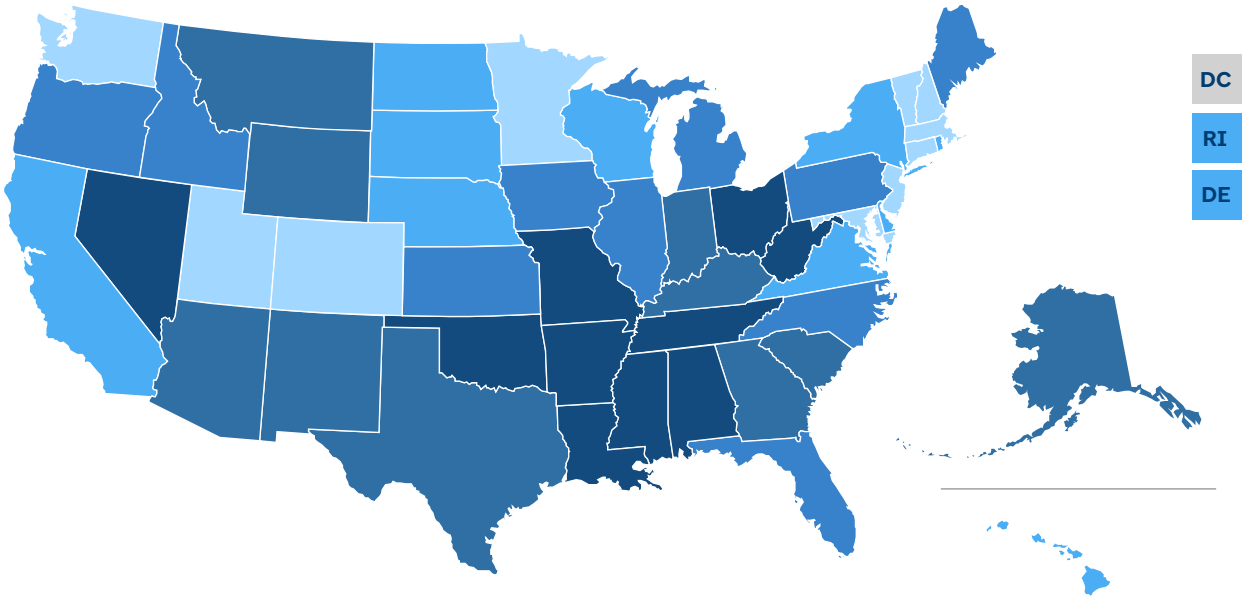
2025 Health of Women and Children Report



Source: *America's Health Rankings* composite measure, 2025.

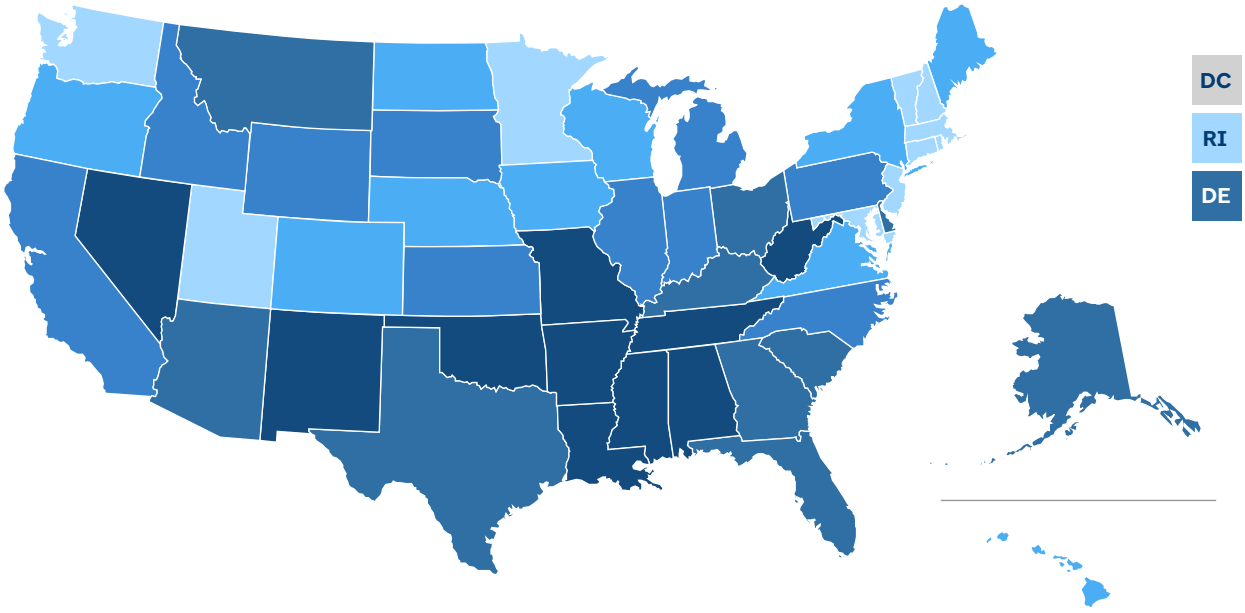
State Rankings: Women of Reproductive Age

2025 Health of Women and Children Report



State Rankings: Children

2025 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, 2025.

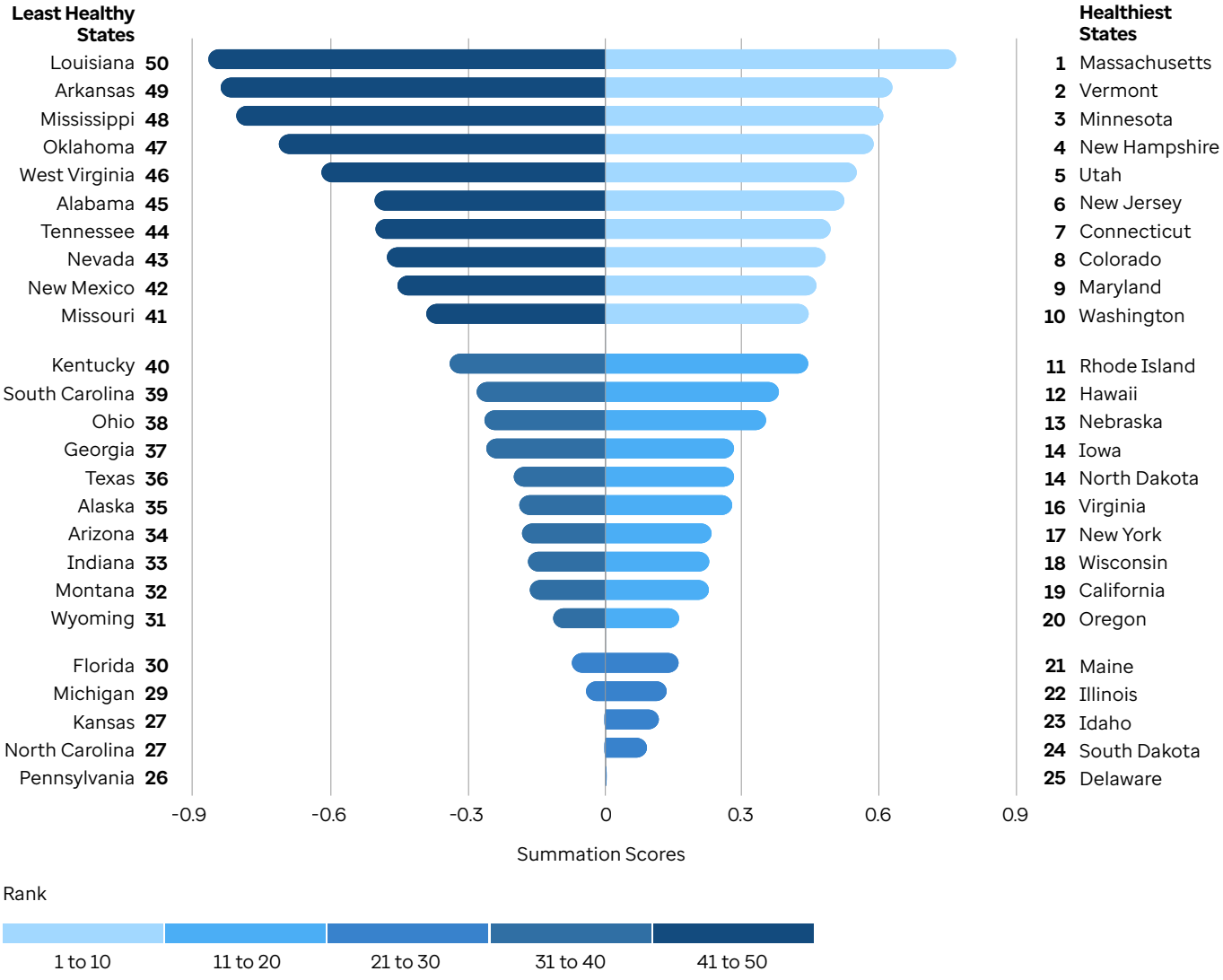
Measure Impact

This graph displays the state scores and ranks, 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, Massachusetts (No. 1) and Vermont (No. 2), although close in ranking, have a sizable difference in score, meaning Vermont would need to make improvements in many measures to improve its rank. There is also a large gap in score between Alabama (No. 45) and West Virginia (No. 46).

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, key findings 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, which indicate the relative difference between two groups within a demographic, are available for select measures in the website's State Summaries. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can impact a state's overall rank.

Overall State Rankings and Scores*

2025 Health of Women and Children Report



Source: *America's Health Rankings* composite measure, 2025.
*Sum of weighted z-scores of all ranked measures.

United States

Health Department Website: hhs.gov

Summary

Key Findings

Smoking During Pregnancy

64%▼

from 8.4% to 3.0% of women with a recent live birth between 2014 and 2023.

Frequent Physical Distress Among Women

37%▲

from 7.1% to 9.7% of women ages 18-44 between 2020-2021 and 2022-2023.

Maternal Mortality

36%▲

from 17.3 to 23.5 deaths per 100,000 live births between 2014-2018 and 2019-2023.

Child Mortality

14%▲

from 25.9 to 29.6 deaths per 100,000 children ages 1-19 between 2018-2020 and 2021-2023.

Fourth Grade Reading Proficiency

11%▼

from 34.3% to 30.5% of public school fourth graders between 2019 and 2024.

Overweight or Obesity Among Children

9%▼

from 34.3% to 31.3% of children ages 6-17 between 2020-2021 and 2023-2024.

Measures

Women

Social and Economic Factors		U.S. Value
Community and Family Safety	Firearm Deaths*	6.2
	Injury Deaths	51.9
	Intimate Partner Violence Before Pregnancy*	–
Economic Resources	Concentrated Disadvantage	25.9%
	Food Insecurity	12.2%
	Gender Pay Gap*	81.1%
	Poverty	14.9%
	Unemployment	3.5%
Education	College Graduate	37.8%
Social Support and Engagement	Infant Child Care Affordability*	12.1%
	Residential Segregation - Black/White	–
	Voter Participation	60.0%

Children

Social and Economic Factors		U.S. Value
Community and Family Safety	Child Victimization*	7.4
	Firearm Deaths *	5.9
	Injury Deaths	18.7
Economic Resources	Children in Poverty	16.0%
	Children in Poverty - Racial Disparity	3.0
	Food Sufficiency	66.6%
	Students Experiencing Homelessness	2.4%
	WIC Coverage	52.2%
Education	Early Childhood Education	48.5%
	Fourth Grade Reading Proficiency	30.5%
	High School Completion	89.8%
Social Support and Engagement	Adult Mentor*	88.0%
	Adverse Childhood Experiences	14.1%
	Foster Care Instability	15.2%
	High-Speed Internet	96.0%
	Neighborhood Amenities	38.2%
	Reading, Singing or Storytelling*	59.7%

Women and Children

Physical Environment		U.S. Value
Air and Water Quality	Air Pollution	8.6
	Drinking Water Violations	2.8
	Household Smoke	10.3%
	Water Fluoridation	72.3%
Climate and Health	Climate Policies	–
	Transportation Energy Use*	8.4
Housing and Transportation	Drive Alone to Work - Women	67.3%
	Housing Cost Burden - Households with Children	31.1%
	Housing with Lead Risk	16.4%

Measures

Women

		U.S. Value
Clinical Care		
Access to Care	Adequate Prenatal Care	75.2%
	Avoided Care Due to Cost	17.4%
	Maternity Care Desert*	3.7
	Uninsured	10.8%
	Women's Health Providers	47.8
Preventive Clinical Care	Cervical Cancer Screening	51.6%
	Dental Visit	64.1%
	Flu Vaccination	35.5%
	Postpartum Visit*	90.3%
	Well-Woman Visit	72.7%
Quality of Care	Breastfeeding Initiation	85.1%
	Dedicated Health Care Provider	77.4%
	Low-Risk Cesarean Delivery	26.6%
	Maternity Practices Score	82
Behaviors		
Nutrition and Physical Activity	Exercise	27.6%
	Fruit and Vegetable Consumption	9.8%
	Physical Inactivity	22.0%
Sexual Health	Chlamydia	1,481.2
	High-Risk HIV Behaviors	9.3%
	Unintended Pregnancy*	–
Sleep Health	Insufficient Sleep	36.5%
Smoking and Tobacco Use	E-Cigarette Use*	11.2%
	Smoking	9.9%
	Smoking During Pregnancy	3.0%
Health Outcomes		
Behavioral Health	Drug Deaths*	28.6
	Excessive Drinking	19.5%
	Frequent Mental Distress	23.6%
	Illicit Drug Use	10.5%
	Postpartum Anxiety*	20.3%
	Postpartum Depression*	11.9%
Mortality	Maternal Mortality*	23.5
	Mortality Rate	109.9
Physical Health	Depression*	30.3%
	Diabetes*	3.6%
	Frequent Physical Distress	9.7%
	High Blood Pressure	11.8%
	High Health Status*	51.6%
	Multiple Chronic Conditions	4.5%
	Obesity	32.5%
	Severe Maternal Morbidity*	94.7

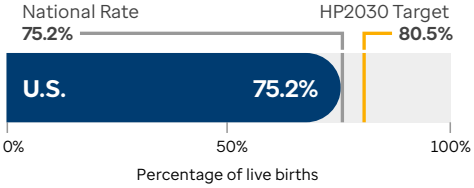
Children

		U.S. Value
Clinical Care		
Access to Care	ADD/ADHD Treatment	3.4%
	Mental Health Treatment*	83.3%
	Pediatricians	116.1
	Uninsured	5.4%
Preventive Clinical Care	Childhood Immunizations	66.9%
	HPV Vaccination	61.4%
	Preventive Dental Visit	80.2%
	Well-Child Visit	79.6%
Quality of Care	Adequate Insurance	64.6%
	Developmental Screening	36.5%
	Medical Home	45.5%
Behaviors		
Nutrition and Physical Activity	Breastfed	27.2%
	Physical Activity	19.7%
	Soda Consumption*	7.5%
Sexual Health	Dual Contraceptive Nonuse*	85.6%
	Teen Births	13.1
Sleep Health	Adequate Sleep	65.3%
	Sleep Position*	69.0%
Smoking and Tobacco Use	Electronic Vapor Product Use*	16.8%
	Tobacco Use	1.9%
Health Outcomes		
Behavioral Health	Alcohol Use	6.9%
	Flourishing	66.7%
	Illicit Drug Use	7.3%
	Mental Health Conditions	20.5%
	Teen Suicide*	10.2
Mortality	Child Mortality	29.6
	Infant Mortality	5.6
	Neonatal Mortality*	3.6
Physical Health	Asthma	6.8%
	Congenital Syphilis*	105.8
	High Health Status*	89.9%
	Low Birth Weight	8.6%
	Low Birth Weight - Racial Disparity	2.1
	Neonatal Abstinence Syndrome*	5.3
	Overweight or Obesity	31.3%

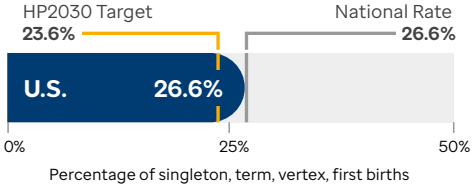
* Additional unweighted measure (not included in the overall score/rank).
– Data not available, missing or suppressed.

Healthy People 2030 (HP2030) Targets

Adequate Prenatal Care



Low-Risk Cesarean Delivery



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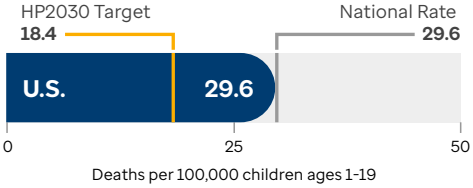

Visit **AmericasHealthRankings.org** for the full list of measures, source details and methodologies.

Measures Table

Social and Economic Factors – Women

Measure	Description	Source	Data Year(s)
Community and Family Safety			
Firearm Deaths*	Number of deaths among females ages 20-44 due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Injury Deaths	Number of deaths due to injury per 100,000 females ages 20-44	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Intimate Partner Violence Before Pregnancy*	Percentage of women with a recent live birth who experienced violence by a husband or partner (current or former) in the 12 months before pregnancy	U.S. HHS, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) or state equivalent	2023
Economic Resources			
Concentrated Disadvantage^	Percentage of households with children that are located in census tracts for which the averaged z-score of the following factors is above the 75th percentile: family households below the poverty line, female-headed households, individuals receiving public assistance, unemployed population age 16 and older and population younger than 18	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2019-2023
Food Insecurity	Percentage of households unable to provide adequate food for one or more household members due to lack of resources	USDA, Household Food Security in the United States Report Series	2021-2023
Gender Pay Gap*	Women's median annual earnings as a percentage of men's median annual earnings for full-time, year-round civilian workers age 16 and older	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Poverty	Percentage of females ages 18-44 who live below the poverty level	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Unemployment	Percentage of the female civilian workforce that is unemployed	U.S. DOL, Bureau of Labor Statistics, Local Area Unemployment Statistics Program	2023
Education			
College Graduate	Percentage of women ages 25-44 who graduated from a college or technical school	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Social Support and Engagement			
Infant Child Care Affordability*	Average price for center-based infant care as a percentage of married couples' median income	Child Care Aware of America, High Price of Child Care Report Series	2025 Publication
Residential Segregation – Black/White	Index of dissimilarity with higher values indicating greater segregation between Black and non-Hispanic white households, ranging from zero (complete integration) to 100 (complete segregation)	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2019-2023
Voter Participation (Average)^	Average of the percentage of female U.S. citizens age 18 and older who voted in the last presidential and national midterm elections	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2022/2024

Physical Environment – Women and Children

Measure	Description	Source	Data Year(s)
Air and Water Quality			
Air Pollution	Average exposure of the general public to particulate matter of 2.5 microns or less, measured in micrograms per cubic meter	U.S. EPA	2021-2023
Drinking Water Violations	Average number of health-based drinking water violations per community water system in a state	U.S. EPA, Safe Drinking Water Information System via ECHO	2023
Household Smoke	Percentage of children ages 0-17 who live in households where someone uses cigarettes, cigars or pipe tobacco	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Water Fluoridation	Percentage of the population served by community water systems that has fluoridated water	U.S. HHS, CDC, Water Fluoridation Reporting System	2022

Physical Environment – Women and Children (cont.)

Measure	Description	Source	Data Year(s)
Climate and Health			
Climate Policies	Number of the four following state policies in place: legally binding electricity portfolio standards; carbon pricing policies; climate change action plans; and economy-wide greenhouse gas emission targets	Center for Climate and Energy Solutions	2024
Transportation Energy Use*	Amount of energy in trillion British thermal units (BTUs) consumed by the transportation of people and goods per 100,000 population	U.S. EIA, State Energy Data System	2023
Housing and Transportation			
Drive Alone to Work	Percentage of female workers age 16 and older who drive alone to work	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Housing Cost Burden	Percentage of households with one or more children younger than 18 years for which housing costs are more than 30% of household income	U.S. Census Bureau, American Community Survey PUMS	2023
Housing With Lead Risk	Percentage of housing stock with potential elevated lead risk due to age of housing	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023

Clinical Care – Women

Measure	Description	Source	Data Year(s)
Access to Care			
Adequate Prenatal Care	Percentage of live births in which the mother received prenatal care beginning in the first four months of pregnancy with the appropriate number of visits for the infant's gestational age	March of Dimes	2023
Avoided Care Due to Cost	Percentage of women ages 18-44 who reported a time in the past 12 months when they needed to see a doctor but could not because of cost	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Maternity Care Desert†*	Percentage of females ages 15-44 living in a county with no birth centers, certified nurse midwives, family practice physicians, obstetricians or hospitals that provide obstetric care	March of Dimes	2024 Report
Uninsured Women	Percentage of women ages 19-44 not covered by private or public health insurance	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Women's Health Providers	Number of obstetricians, gynecologists and midwives per 100,000 females age 15 and older	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2024
Preventive Clinical Care			
Cervical Cancer Screening†	Percentage of women ages 25-44 who reported receiving cervical cancer screening consistent with the USPSTF guidelines	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Dental Visit†	Percentage of women ages 18-44 who reported visiting a dentist or dental clinic within the past year	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Flu Vaccination	Percentage of women ages 18-44 who reported receiving a seasonal flu vaccine in the past 12 months	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Postpartum Visit*	Percentage of women with a recent live birth who reported receiving a postpartum checkup	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2023
Well-Woman Visit	Percentage of women ages 18-44 with a preventive medical visit in the past year	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Quality of Care			
Breastfeeding Initiation	Percentage of infants who were breastfed between birth and discharge from the hospital	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Dedicated Health Care Provider	Percentage of women ages 18-44 who reported having a personal doctor or health care provider	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Low-Risk Cesarean Delivery	Percentage of singleton, head-first, term (37 or more completed weeks) first births that were cesarean deliveries	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Maternity Practices Score	Maternity Practices in Infant and Nutrition Care (mPINC) survey score based on seven birth facility policies and practices, with higher scores denoting better maternity care policies and practices	U.S. HHS, CDC, mPINC State Report Series	2024

Behaviors – Women

Measure	Description	Source	Data Year(s)
Nutrition and Physical Activity			
Exercise	Percentage of women ages 18-44 who met the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Fruit and Vegetable Consumption†	Percentage of women ages 18-44 who reported consuming two or more fruits and three or more vegetables daily	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2021
Physical Inactivity	Percentage of women ages 18-44 who reported doing no physical activity or exercise other than their regular job in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Sexual Health			
Chlamydia	Number of new cases of chlamydia per 100,000 females ages 15-44	U.S. HHS, CDC, NCHHSTP AtlasPlus	2023
High-Risk HIV Behaviors†	Percentage of women ages 18-44 who reported any of the following in the past year: injecting any drug other than those prescribed for them; being treated for a sexually transmitted disease or STD; or giving or receiving money or drugs in exchange for sex	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Unintended Pregnancy*	Percentage of women with a recent live birth who did not want to become pregnant or wanted to become pregnant later	U.S. HHS, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) or state equivalent	2023
Sleep Health			
Insufficient Sleep†	Percentage of women ages 18-44 who reported sleeping, on average, less than seven hours in a 24-hour period	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022
Smoking and Tobacco Use			
E-Cigarette Use*	Percentage of women ages 18-44 who reported using e-cigarettes or other electronic vaping products at least once in their lifetime and now use daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Smoking	Percentage of women ages 18-44 who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Smoking During Pregnancy	Percentage of mothers who reported smoking cigarettes during pregnancy	U.S. HHS, Natality Public Use Files via CDC WONDER	2023

Health Outcomes – Women

Measure	Description	Source	Data Year(s)
Behavioral Health			
Drug Deaths*	Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 females ages 20-44	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Excessive Drinking	Percentage of women ages 18-44 who reported binge drinking (four or more drinks on one occasion in the past 30 days) or heavy drinking (eight or more drinks per week)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Frequent Mental Distress	Percentage of women ages 18-44 who reported their mental health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Illicit Drug Use	Percentage of women ages 18-49 who reported misusing prescription psychotherapeutics (pain relievers, tranquilizers, stimulants or sedatives) or using cocaine (including crack), heroin, hallucinogens, inhalants or methamphetamine in the past year	U.S. HHS, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health	2022-2023
Postpartum Anxiety*	Percentage of women with a recent live birth who reported experiencing anxiety symptoms	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2023
Postpartum Depression*	Percentage of women with a recent live birth who reported experiencing depressive symptoms	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2023

Health Outcomes – Women (cont.)

Measure	Description	Source	Data Year(s)
Mortality			
Maternal Mortality*	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	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2019-2023
Mortality Rate	Number of deaths per 100,000 women ages 20-44	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Physical Health			
Frequent Physical Distress	Percentage of women ages 18-44 who reported their physical health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
High Blood Pressure	Percentage of women ages 18-44 who reported being told by a health professional that they have high blood pressure	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
High Health Status*	Percentage of women ages 18-44 who reported their health is very good or excellent	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Multiple Chronic Conditions	Percentage of women ages 18-44 who reported having three or more of the following chronic health conditions: arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease (heart disease, heart attack or stroke), cancer (excluding non-melanoma skin cancer), depression or diabetes	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Arthritis*	Percentage of women ages 18-44 who reported being told by a health professional that they have some form of arthritis	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Asthma*	Percentage of women ages 18-44 who reported ever being told by a health professional that they have asthma	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Cancer*	Percentage of women ages 18-44 who reported being told by a health professional that they had any type of cancer (excluding non-melanoma skin cancer)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Cardiovascular Diseases*	Percentage of women ages 18-44 who reported being told by a health professional that they had angina or coronary heart disease, a heart attack or myocardial infarction, or a stroke	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Chronic Kidney Disease*	Percentage of women ages 18-44 who reported being told by a health professional that they had kidney disease (excluding kidney stones, bladder infection and incontinence)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Chronic Obstructive Pulmonary Disease*	Percentage of women ages 18-44 who reported being told by a health professional that they had chronic obstructive pulmonary disease, emphysema or chronic bronchitis	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Depression*	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	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Diabetes*	Percentage of women ages 18-44 who reported being told by a health professional that they had diabetes (excluding prediabetes and gestational diabetes)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Obesity	Percentage of women ages 18-44 who have a body mass index of 30.0 or higher based on reported height and weight	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022-2023
Severe Maternal Morbidity*	Number of significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2022

Social and Economic Factors – Children

Measure	Description	Source	Data Year(s)
Community and Family Safety			
Child Victimization*	Number of children who were victims of substantiated or indicated maltreatment per 1,000 children	U.S. HHS, Children's Bureau, Child Maltreatment Report Series	2023
Firearm Deaths*	Number of deaths among children ages 1-19 due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Injury Deaths	Number of deaths due to injury per 100,000 children ages 1-19	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Economic Resources			
Children in Poverty	Percentage of children younger than 18 years who live in households below the poverty threshold	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Children in Poverty – Racial Disparity	Ratio of the childhood poverty rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2019-2023
Food Sufficiency	Percentage of children ages 0-17 whose household could always afford to eat good nutritious meals in the past 12 months	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Students Experiencing Homelessness†	Percentage of public school students who lack a fixed, regular and adequate nighttime residence	U.S. ED, National Center for Homeless Education, Student Homelessness in America Report Series	2021-2022 School Year
WIC Coverage	Percentage of children ages 0-4 eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) who received WIC benefits in an average month	USDA, National- and State-Level Estimates of WIC Eligibility and Program Reach Report Series	2022
Education			
Chronic School Absenteeism*	Percentage of public school students who miss 10% or more of school days in an academic year	U.S. ED, National Center for Education Statistics, EDFacts	2022-2023 School Year
Early Childhood Education	Percentage of children ages 3-4 who are enrolled in nursery school, preschool or kindergarten	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Fourth Grade Reading Proficiency	Percentage of fourth grade public school students who scored proficient or above on the National Assessment of Educational Progress in reading comprehension	U.S. ED, National Center for Education Statistics, National Assessment of Educational Progress	2024
High School Completion	Percentage of adults age 25 and older with at least a high school diploma or equivalent	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
High School Graduation†*	Percentage of high school students graduating with a regular high school diploma within four years of starting ninth grade	U.S. ED, National Center for Education Statistics, EDFacts	2021-2022 School Year
Social Support and Engagement			
Adult Mentor*	Percentage of children ages 12-17 who have at least one adult in their school, neighborhood or community who knows them well and whom they can rely on for advice or guidance	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Adverse Childhood Experiences^	Percentage of children ages 0-17 who have ever experienced two or more of the following adverse experiences: parental divorce or separation; household with an alcohol or drug problem; household with mental illness; neighborhood violence victim or witness; domestic violence witness; parent served jail time; treated or judged unfairly due to race/ethnicity; treated or judged unfairly due to a health condition or disability; or death of a parent	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Foster Care Instability†	Percentage of children in foster care with three or more placements within 12 months	U.S. HHS, Children's Bureau, Child Welfare Outcomes Report Series	2021
High-Speed Internet	Percentage of households with children under age 18 that have a broadband internet subscription and a computer, smartphone or tablet	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023

Social and Economic Factors – Children (cont.)

Measure	Description	Source	Data Year(s)
Neighborhood Amenities	Percentage of children ages 0-17 with access to all of the following: a park or playground; a recreation center, community center or boys' and girls' club; a library or bookmobile; and sidewalks or walking paths	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Reading, Singing or Storytelling*	Percentage of children ages 0-5 whose family members read, sang or told stories to them every day during the past week	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024

Clinical Care – Children

Measure	Description	Source	Data Year(s)
Access to Care			
ADD/ADHD Treatment^	Among all children ages 3-17, the percentage who currently have ADD or ADHD, are taking medication, and have received behavioral treatment in the last 12 months	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Mental Health Treatment*	Percentage of children ages 12-17 who receive needed mental health treatment or counseling	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Pediatricians	Number of pediatricians per 100,000 children ages 0-21	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2024
Uninsured Children	Percentage of children younger than 19 years not covered by private or public health insurance	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023
Preventive Clinical Services			
Childhood Immunizations	Percentage of children who received by age 24 months all recommended doses of the combined seven-vaccine series: diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; measles, mumps and rubella (MMR) vaccine; poliovirus vaccine; *Haemophilus influenzae* type b (Hib) vaccine; hepatitis B (HepB) vaccine; varicella vaccine; and pneumococcal conjugate vaccine (PCV)	U.S. HHS, CDC, NIS-Child	2020-2021 Birth Cohort
HPV Vaccination	Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine	U.S. HHS, CDC, NIS-Teen	2023
Preventive Dental Visit	Percentage of children ages 1-17 who had one or more preventive dental care visits during the past 12 months	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Well-Child Visit	Percentage of children ages 0-17 who received one or more preventive medical visits in the past 12 months	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Quality of Care			
Adequate Insurance	Percentage of children ages 0-17 who were continuously insured in the past year with adequate coverage based on the following criteria: benefits meet the child's needs; insurance allows the child to see needed providers; and insurance either has no or reasonable out-of-pocket expenses	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Developmental Screening	Percentage of children ages 9-35 months whose parent completed a standardized developmental screening tool for them in the past 12 months	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Medical Home^	Percentage of children ages 0-17 who received coordinated, ongoing and comprehensive medical care from a usual, nonemergency source where they had a personal doctor or nurse and access to family-centered care, referrals when needed, and effective care coordination	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024

Behaviors – Children

Measure	Description	Source	Data Year(s)
Nutrition and Physical Activity			
Breastfed	Percentage of infants exclusively breastfed for six months	U.S. HHS, CDC, NIS-Child	2021
Physical Activity	Percentage of children ages 6-17 who were physically active at least 60 minutes every day in the past week	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Soda Consumption*	Percentage of high school students who reported drinking a can, bottle or glass of soda or pop two or more times per day in the past week	U.S. HHS, CDC, Youth Risk Behavior Surveillance System	2023
Sexual Health			
Dual Contraceptive Nonuse*	Percentage of sexually active high school students who reported not using both: a condom during last sexual intercourse; and either birth control pills, an intrauterine device or implant, or a shot, patch or birth control ring before last sexual intercourse	U.S. HHS, CDC, Youth Risk Behavior Surveillance System	2023
Teen Births	Births per 1,000 females ages 15-19	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Sleep Health			
Adequate Sleep	Percentage of children ages 4 months to 17 years who sleep recommended age-appropriate hours on most weeknights	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Sleep Position*	Percentage of women with a recent live birth who reported their infants are usually placed on their backs to sleep	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2023
Smoking and Tobacco Use			
Electronic Vapor Product Use*	Percentage of high school students who reported using an electronic vapor product in the past 30 days	U.S. HHS, CDC, Youth Risk Behavior Surveillance System	2023
Tobacco Use	Percentage of children ages 12-17 who reported using a tobacco product (cigarettes, smokeless tobacco, cigars or pipe tobacco) in the past month	U.S. HHS, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health	2022-2023

Health Outcomes – Children

Measure	Description	Source	Data Year(s)
Behavioral Health			
Alcohol Use	Percentage of children ages 12-17 who reported drinking alcohol in the past month	U.S. HHS, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health	2022-2023
Flourishing^	Percentage of children ages 6 months to 5 years who show affection, resilience, interest and curiosity in learning, as well as smile and laugh a lot; and children ages 6-17 who show self-regulation, interest and curiosity in learning, as well as work to finish tasks	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Illicit Drug Use	Percentage of children ages 12-17 who reported using illicit drugs, including marijuana, in the past month	U.S. HHS, Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health	2022-2023
Mental Health Conditions^	Percentage of children ages 3-17 told by a health care provider that they currently have ADHD, depression or anxiety problems; or told by a doctor or educator that they have behavior or conduct problems	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Teen Suicide*	Number of deaths due to intentional self-harm per 100,000 adolescents ages 15-19	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023

Health Outcomes – Children (cont.)

Measure	Description	Source	Data Year(s)
Mortality			
Child Mortality	Number of deaths per 100,000 children ages 1-19	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births	U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER	2022-2023
Neonatal Mortality*	Number of deaths during first 28 days of life (0-27 days) per 1,000 live births	U.S. HHS, Linked Birth/Infant Death Records via CDC WONDER	2022-2023
Physical Health			
Asthma	Percentage of children ages 0-17 who currently have asthma	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Congenital Syphilis*	Number of new congenital syphilis cases per 100,000 live births	U.S. HHS, CDC, NCHHSTP AtlasPlus	2023
High Health Status*	Percentage of children ages 0-17 whose health is very good or excellent	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Low Birth Weight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Low Birth Weight – Racial Disparity	Ratio of the low birth weight rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate	U.S. HHS, Natality Public Use Files via CDC WONDER	2021-2023
Neonatal Abstinence Syndrome*	Number of birth hospitalizations with a diagnosis code of neonatal abstinence syndrome (withdrawal symptoms due to prenatal exposure to illicit drugs) per 1,000 birth hospitalizations	U.S. HHS, Maternal and Child Health Bureau, Federally Available Data	2022
Overweight or Obesity^	Percentage of children ages 6-17 who have overweight or obesity for their age based on reported height and weight	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024

Demographics

Children With Special Health Care Needs*	Percentage of children ages 0-17 with special health care needs	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
Population – Age <1*	Percentage of the population under age 1	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2023
Population – Age <18*	Percentage of the population younger than age 18	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2023
Population – Women – Ages 18-44*	Percentage of the population that is female, ages 18-44	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2023

* Additional measure, excluded from the Overall or category composite measures.
^ Data for each of the components are available in the Explore Data section.
† Data in this edition were repeated from the last edition.

Data Source Descriptions

The **American Community Survey** is an ongoing statistical survey coordinated by the United States Census Bureau that provides detailed information on U.S. population demographics. Data are derived from the bureau directly via its 1-year and 5-year datasets or using the public use microdata sample (PUMS) file.

The **Behavioral Risk Factor Surveillance System (BRFSS)** is the nation's largest phone-based population survey. The survey, coordinated by the Centers for Disease Control and Prevention (CDC) in collaboration with state, territory and federal agencies, provides information about health-related risk behaviors, chronic health conditions and use of preventive services. Data are accessed via the BRFSS website.

CDC WONDER is a query system for analyzing public-use data from the National Center for Health Statistics on births and deaths, as well as other topics. Data are obtained from the Multiple Cause of Death, Linked Birth/Infant Death, Natality and Single-Race Population Estimates files.

The **Center for Climate and Energy Solutions (C2ES)** is a nonprofit environmental policy think tank that produces data and reports on climate basics, solutions and policies. Data are obtained from the C2ES website.

Child Care Aware of America is a nonprofit organization that focuses on child care availability, quality and accessibility. Data on the cost of child care across states are published in the annual *The U.S. and the High Price of Child Care* report.

The ***Child Maltreatment*** report presents data about child abuse and neglect across the nation, collected from child protective service agencies. The report is published annually by the Children's Bureau, a federal office of the Administration for Children and Families dedicated to improving the health and well-being of children and families.

Child Welfare Outcomes report data are also produced by the Children's Bureau each year. These reports measure state performance across indicators of child safety and well-being, incorporating data from the Adoption and Foster Care Analysis and Reporting System and the National Child Abuse and Neglect Data System. Data are obtained from the Child Welfare Outcomes data site. Complete reports are also available on the Administration for Children and Families website.

EDFacts collects, analyzes and centralizes data from state education agencies and other data sources on district and school demographics, performance and participation for the Department of Education. Data are obtained using the ED Data Express tool.

The **Environmental Protection Agency** performs various federal research, monitoring, standard-setting and enforcement activities to ensure environmental protection. National Safe Drinking Water Act data are reported by states, compiled from the Safe Drinking Water Information System database for public water systems and downloaded from the Enforcement and Compliance History Online website. State-level air pollution data are obtained via a special request to the agency.

Federally Available Data (FAD) on measures of maternal and child health national outcomes and performance are collected and distributed by the Health Resources and Services Administration's Maternal and Child Health Bureau. Data are from various sources, including the Healthcare Cost and Utilization Project, the National Vital Statistics System and the Pregnancy Risk Assessment Monitoring System (PRAMS). All FAD data are available to download from the FAD resource documents.

The ***Household Food Security in the United States*** report provides national statistics on food security, household food spending and use of federal food and nutrition assistance by food-insecure households. The report is produced annually by the Economic Research Service of the Department of Agriculture (USDA), using data from the U.S. Census Bureau's Current Population Survey Food Security Supplements.

The **Local Area Unemployment Statistics (LAUS)** program produces monthly and annual employment, unemployment and labor force data by place of residence for the Department of Labor's Bureau of Labor Statistics. Data are obtained from the LAUS Expanded State Employment Status Demographic Dataset on the Bureau of Labor Statistics website.

March of Dimes is a long-standing nonprofit advocacy organization for maternal and infant health. Their Perinatal Data Center provides access to maternal and infant health data for the U.S. Data are obtained via a special request to the March of Dimes Perinatal Data Center.

Maternity Practices in Infant Nutrition and Care (mPINC) is a CDC-administered biennial survey of breastfeeding support and maternity care in U.S. hospitals. Data are obtained from the mPINC State Reports website.

The **National Assessment of Educational Progress** is the largest continuing and nationally representative assessment of student academic achievement and learning experiences in the U.S., administered by the Department of Education's National Center for Education Statistics. Results from the assessment, including reading proficiency data, are published in the Nation's Report Card.

The **National Plan and Provider Enumeration System (NPPES)** is a registry developed by the Centers for Medicare & Medicaid Services to improve the efficiency of electronic health information transmission. NPPES assigns a unique National Provider Identifier (NPI) number to covered health care providers and health plans to conduct all administrative and financial transactions under HIPAA, the Health Insurance Portability and Accountability Act. Data are accessed via the NPI files website.

The ***National- and State-Level Estimates of WIC Eligibility and Program Reach*** report is published annually by the USDA. The report provides statistical and visual information about the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The **National Survey of Children's Health** collects annual data on children's health and access to health care based on responses from a parent or guardian who knows about the child's health and health care needs. Data for this report are obtained from the Maternal and Child Health Bureau, which funds and directs the survey. Survey data are also published annually on the U.S. Census Bureau's website.

The **National Survey on Drug Use and Health** collects data on the use of illegal drugs, prescription drugs, alcohol and tobacco, as well as mental disorders, treatment and co-occurring substance use, at national, state and local levels. The survey is sponsored by the Substance Abuse and Mental Health Services Administration. Data are obtained from *State Estimates of Mental Health and Substance Use* reports and the 2-Year Restricted-Use Data Analysis System.

The **National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention (NCHHSTP) Atlas** allows users to create customized tables, maps and charts using more than 15 years of surveillance data on HIV/AIDS, viral hepatitis, sexually transmitted diseases, tuberculosis and social determinants of health. Data are obtained from the NCHHSTP AtlasPlus interactive website.

The **National Immunization Surveys (NIS)** are a set of ongoing phone surveys conducted by the CDC that collect information on vaccinations among children ages 6 months to 17 years. Breastfeeding information is also collected from households with children ages 19-35 months. NIS-Child and NIS-Teen data are obtained from the VaxView and Breastfeeding Rates websites.

The **Pregnancy Risk Assessment Monitoring System (PRAMS)**, formerly sponsored by the CDC in collaboration with state agencies, collected state-specific population-based data on maternal attitudes and experiences before, during and shortly after pregnancy. In April of 2025, the CDC PRAMS team received a reduction-in-force notice and the 2023 data were not published on the PRAMS Automated Research File (ARF) web portal as scheduled. The PRAMS data in this report were obtained directly from states or from FAD.

The **State Energy Data System (SEDS)**, maintained by the U.S. Energy Information Administration, produces comprehensive statistics on state energy consumption, prices and expenditures over time. Data are obtained from the SEDS website.

The ***Student Homelessness in America*** report series uses data from the Department of Education's EDFacts initiative to produce national and state-level information on the numbers of students experiencing homelessness each year and their characteristics and experiences. Report data are obtained from the National Center for Homeless Education.

Voting and Registration Supplement data from the Current Population Survey, an ongoing statistical survey sponsored jointly by the U.S. Census Bureau and the Bureau of Labor Statistics, are available every two years following national elections.

The **Water Fluoridation Reporting System** monitors community water systems receiving optimally fluoridated drinking water across the U.S. National and state-level data are obtained from the CDC's Fluoridation Statistics website.

The **Youth Risk Behavior Surveillance System (YRBSS)** surveys students in grades nine through 12 every two years about health-related behaviors that contribute to the leading causes of death and disability in the U.S. Data are accessed via the CDC's YRBSS Youth Online tool.

Methodology

How State Rankings Were Generated

This year, 125 measures (including 82 weighted and 43 additional unweighted measures) were analyzed for the *America's Health Rankings 2025 Health of Women and Children Report*, using the most recent data available as of August 18, 2025, with the exception of National Survey of Children's Health data, which were released on December 2, 2025. Data years varied by measure because of the variety of data sources. Multiple data years were combined for some measures to ensure reliable state-level estimates. Measure definitions, sources and data years are available in the Appendix: Measures Table – Women and Measures Table – Children (page 44). Measure changes were based on input from the *Health of Women and Children Report* Advisory Committee and are detailed on the *2025 Health of Women and Children Report* Measures Selection and Changes webpage.

Each state was ranked according to its value for each measure, with a rank of No. 1 assigned to the state with the healthiest value. Ties in value were assigned equal ranks. If a state value was unavailable for a measure in this edition, it was noted as missing, unavailable or suppressed. Composite scores were generated overall and by model category. The rankings show how a state compares with other states across all weighted measures.

Overall state rankings were based on 82 weighted measures that:

- Represented current population health issues.
- Had state-level data available.
- Maintained consistent measurement across all 50 states.
- Were current and regularly updated.
- Allowed for improvement over time.

The state value for each measure was normalized into a z-score, hereafter referred to as "score," using the following formula:

$$\text{Z-score} = \frac{\text{State value - National value}}{\text{Standard deviation of all state values}}$$

The score indicates the number of standard deviations a state value was above or below the U.S. value. Scores were capped at +/- 2.00 to prevent an extreme score from excessively influencing a state's overall score. If a U.S. value was unavailable from the original data source for a measure, the mean of all states and the District of Columbia was used. If a value was unavailable for a state, its value from the most recent available data year was used to generate a score.

Composite scores were calculated by adding the products of the score for each measure multiplied by that measure's assigned model weight and association with health. Measures positively associated with population health, such as adequate insurance and flu vaccination, were multiplied by 1. In contrast, measures with a negative association, such as smoking and maternal mortality, were multiplied by -1. A state that ranked No. 1 will have a higher composite score (e.g., 2.00), reflecting better health, whereas a state that ranked No. 50 will have a lower composite score (e.g., -2.00). The overall state ranks were calculated by ranking the Overall score, which included all weighted measures in the model (see Measures, Weights and Direction for model and measure weights).

Scores and ranks were not calculated for the District of Columbia because of its unique status as an entirely urban population with different governing and funding mechanisms than states. While the District of Columbia was not included in the overall state rankings, its data are available in this report and on the *America's Health Rankings* website.

For additional methodology information, submit an inquiry through the *America's Health Rankings* website.

Report

Findings. Data for all measures are analyzed and considered for inclusion in the report. Measures with updated data, measures with statistically significant national changes (based on nonoverlapping 95% confidence intervals, when available) and new measures on emerging topics were prioritized for selection.

Health Disparities. Health disparities highlight significant differences within measures based on age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation, special health care needs status among children (new in this report) and veteran status where data were available. Health disparities are presented as a ratio calculated by dividing the value of one group by the value of another. For example, the value of the group with the highest value may be divided by the value of the group with the lowest value. Only measures with significant differences, determined by nonoverlapping 95% confidence intervals, were considered. The groups with largest health disparities, considering relevant risk factors, were prioritized for inclusion, along with health disparities by metropolitan status, the subject of this year's report spotlight. Not all statistically significant differences are detailed in the report. Full demographic data are published on the *America's Health Rankings* website. For more information, see Disparity Measures Methodology.

State Summaries

Strengths and Challenges represent measures with the biggest impact on a state's overall ranking (from the 82 weighted measures). Measures with newly available data that span model categories and topic areas were given priority during selection. Unweighted measures were excluded from the ranking calculations, and the District of Columbia was assessed separately by comparing its values to those of the healthiest and least healthy states. The U.S. summary is a reference for calculating z-scores and overall rankings, so it does not include strengths and challenges.

Key Findings highlight notable trends, presented as percent changes between two time periods of interest, often capturing inflection points or describing short- or long-term trends. Only statistically significant changes, as determined by nonoverlapping 95% confidence intervals, were considered for measures with confidence intervals. Measures without confidence intervals were considered if the change was 5% or more between the two time periods. Findings were selected to include a mix of improving and worsening measures across model categories and topic areas. Measures that did not lend themselves to changes over time were excluded from the analysis.

Demographic Group Definitions

Analyses were performed to illuminate health disparities by age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation, special health care needs status among children (new in this report) and veteran status where data were available. 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 presented.

Age. Age data in this report were available for measures from the 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 females 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. Responses of yes to the question, "Are you deaf or do you have serious difficulty hearing?" were coded as "difficulty hearing." Responses of yes to the question, "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" were coded as "difficulty seeing." Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" were coded as "difficulty with cognition." Responses of yes to the question, "Do you have serious difficulty walking or climbing stairs?" were coded as "difficulty with mobility." Responses of yes to the question, "Do you have difficulty dressing or bathing?" were coded as "difficulty with self-care." Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" were coded as "independent living difficulty." 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, FAD/NVSS and the National Survey of Children's Health (NSCH). BRFSS groupings were limited to females ages 25-44 and based on responses to the question, "What is the highest grade or year of school you completed?" Responses of grades nine through 11 were classified as "less than high school." Responses of grade 12 or GED were classified as "high school/GED." Responses of college or technical school (1 year to 3 years) were classified as "some post-high school." Responses of college (4 years or more) were classified as "college graduate." FAD groupings were based on the education level that best described the highest degree or level of school completed at the time of death, grouped into four categories: less than high school (no diploma), high school graduate or GED completed, some college (no degree) and college or technical school (associate degree or higher). NSCH groupings were based on the highest education completed by an adult caregiver in the child's household, grouped into four categories: less than high school education, high school or GED, some college or technical school, and college degree or higher.

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." For BRFSS measures with 2022-2023 data years, the sexual orientation data for Alabama, Arizona, California, Idaho, New Jersey and Wyoming are from 2023 only, and Colorado are from 2022 only. See details in Measures Selection and Changes.

Income. Income data in this report were available for measures from BRFSS and FAD/HCUP. BRFSS groupings were limited to females ages 25-44 and based on responses to the question, "[What] is your annual household income from all sources?" Responses of less than $10,000, $10,000 to less than $15,000, $15,000 to less than $20,000 and $20,000 to less than $25,000 were summed and classified as "less than $25,000." Responses of $25,000 to less than $35,000 and $35,000 to less than $50,000 were summed and classified as "$25,000-$49,999." Responses of $50,000 to less than $75,000 were classified as "$50,000-$74,999." Responses of $75,000 or more were classified as "$75,000 or more." FAD groupings were based on current-year median ZIP code household income and grouped into quartiles, with Quartile 1 representing the wealthiest areas and Quartile 4 the least wealthy.

Metropolitan Status. Metropolitan status data in this report were available for measures from BRFSS and FAD/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 "nonmetro." 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, nonmetropolitan and nonmicropolitan areas were classified as "nonmetro."

Race/Ethnicity. Data were provided where available for the following aggregated 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. Racial and ethnic groups were defined differently across data sources (details below). In summary, BRFSS, CDC WONDER, FAD, National Center for Education Statistics and National Survey of Children's Health race groupings are all non-Hispanic, while American Community Survey data are presented as Hispanic-inclusive, except for white, which is non-Hispanic.

Racial and ethnic groups by source:

- American Community Survey: American Indian and Alaska Native; Asian; Black or African American; Hispanic or Latino Origin (any race); Native Hawaiian or Other Pacific Islander; white (non-Hispanic); two or more races; and some other race.

- BRFSS: American Indian/Alaskan Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic, Latino/a or Spanish origin (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and multiracial (non-Hispanic). For measures based 2022-2023 data years, the race data are from 2023 only. See details in Measures Selection and Changes.
- CDC WONDER: American Indian or Alaska Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and more than one race (non-Hispanic).
- FAD: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hispanic (any race); Native Hawaiian/Other Pacific Islander (non-Hispanic); and white (non-Hispanic). NVSS also included multiple race (non-Hispanic), while HCUP categorized multiple race and other race as Other (Hispanic inclusive).
- National Center for Education Statistics: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hispanic; Native Hawaiian/Pacific Islander (non-Hispanic); white (non-Hispanic); and multiracial (non-Hispanic).
- NSCH: American Indian/Alaskan Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and multiple race (non-Hispanic).

Special Health Care Needs Status Among Children. Children with special health care needs (CSHCN) status data in this report were available for measures from NSCH. CSHCN are grouped into two categories and classified as: "children with special health care needs" and "children without special health care needs." Children were considered CSHCN if they either: had at least one health condition and at least one functional difficulty (detailed in Measures Selection and Changes); and/or met the criteria from the Maternal and Child Health Bureau's CSHCN Screener – a five-item screening tool that identifies special health care needs based on the health consequences a child experiences due to an ongoing health condition, regardless of diagnosis. The screening criteria are categorized as: 1) need or use of prescription medications, 2) need or use of services, 3) need or use of specialized therapies, 4) functional difficulties and 5) emotional, developmental or behavioral problems for which treatment or counseling is needed.

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?" Responses of yes were summed and classified as "served." Responses of no were summed and classified as "not served."

Limitations

Rankings are a relative measure of health. Not all changes in rank translate into actual declines or improvements in health. 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. Values and ranks from prior years have been updated on the *America's Health Rankings* website to reflect known errors and updates from the reporting source.

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.

This report provides health disparity data on various demographic group characteristics alongside socioeconomic factors and environmental influences. Relying solely on health disparity data may lead to misinterpretations of health outcomes, as they do not account for the social drivers that significantly impact individuals' access to care, quality of life and overall well-being.[97]

Inclusivity in data collection is essential to documenting, analyzing and addressing the health disparities people experience. Equitable systems must accurately represent diverse populations throughout the data life cycle, from data collection through analysis to interpretation.[98]

Inadequate representation of populations may hinder the identification of trends and patterns within different demographic groups and limit the ability to tailor public health interventions and personalize care that empowers people to make better health choices.

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- National Center for Education Statistics
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- Centers for Medicare & Medicaid Services
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Questions and comments about the report should be directed to the United Health Foundation at unitedhealthfoundationinfo@uhg.com.

UNITED HEALTH FOUNDATION

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Through collaboration with community partners, grants and outreach efforts, the United Health Foundation works to improve the health system, advance and grow the health care workforce and enhance the well-being of local communities. The United Health Foundation was established by UnitedHealth Group in 1999 as a nonprofit, private foundation dedicated to improving health and health care. To date, the United Health Foundation has committed $845 million to programs and communities around the world, including a $100 million commitment to help support the health care workforce. To learn more, visit UnitedHealthFoundation.org.

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