



2026 Health of Women and Children Report



Supporting Healthy People 2030

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

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



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Definitions, Limitations and Methodology

For details on demographic group definitions and limitations, data sources and methodology, please refer to the Appendix on [page 52](#) and visit AmericasHealthRankings.org.



A Decade of Insights on Women's Health Across the Lifespan

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“Ten years of data give us a clearer picture of where improvements are taking hold, where gaps persist and where action is needed. By continuing to follow the evidence, listen to communities and build on the work underway, we can help more women and children live healthier lives.”

I want to thank you for taking the time to explore this edition of the *America's Health Rankings Health of Women and Children Report*. A decade after the report's first publication, this milestone offers an opportunity to reflect on where sustained efforts are making a difference in the health of these populations that form the cornerstone of our communities – and where challenges remain.

Over the course of my career as a maternal fetal medicine specialist, I have seen how sustained attention can gradually improve the health of women and infants. I am encouraged that more women are receiving preventive care and breastfeeding, while fewer women use tobacco products during pregnancy and fewer babies are born with neonatal abstinence syndrome. The progress documented in this report reflects decades of work by health care providers, public health leaders, community organizations and individuals. Yet, these achievements over the past decade stand in contrast to the fact that maternal morbidity and mortality increased dramatically over the same time period.

This raises an important question: Why hasn't the progress we've made translated into better maternal health outcomes? In reflecting on the data, a few perspectives come to mind.

First, changes in behaviors and socioeconomic conditions that shape women's health may take years to translate into better outcomes. Improvements in education and poverty rates, for example, can strengthen women's health over time, but their effects may not immediately appear in measures such as mortality, chronic disease or mental health. The findings reinforce the need to sustain the efforts driving progress, even when their full impact is not yet visible.

Second, women's health cannot be viewed as a series of isolated moments. Pregnancy, childbirth, menopause and individual diagnoses are important points in a woman's life, but they are part of a much larger story. A woman's health is shaped throughout their everyday life, with effects that

can extend to children, families and communities. Rising rates of obesity, diabetes, depression and frequent mental distress help illustrate why improving maternal outcomes requires attention to women's health long before pregnancy begins and well after it ends.

Creating healthier communities takes more than any single investment or action – it requires sustained coordination among health care leaders, local community partners and families. The United Health Foundation is helping scale community-led programs that respond to local needs and improve care for women and families across the country. In New Mexico, our partnership with [La Clinica de Familia](#) has served 1,240 patients through expanded prenatal and well-woman care, with 95% of babies born through the program at or above a healthy birth weight. In Wisconsin, we are working with [Meta House](#) to provide specialized care for pregnant, postpartum and parenting women experiencing substance use disorder. Every baby born to a participant who entered residential treatment at least one month before delivery was born substance-free.

Expanding access and supporting women and families will also require us to further build the capacity of the health care workforce and strengthen community-based care. We are optimistic that the Foundation's [10-year, \\$100 million commitment](#) to support current and future health care professionals can help do that, alongside our doula partnerships, which have supported more than 200 new doulas in enrolling in programs, and more than 470 in continuing education or professional development.

The challenges identified in this report are significant, but the progress of the past decade shows that change is possible. Ten years of data give us a clearer picture of where improvements are taking hold, where gaps persist and where action is needed. By continuing to follow the evidence, listen to communities and build on the work underway, we can help more women and children live healthier lives.

The United Health Foundation is proud to release the *America's Health Rankings® 2026 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.

A decade of progress in behaviors, care and socioeconomic conditions did not consistently translate into better health outcomes for women and children.

This edition marks the 10th anniversary of the *America's Health Rankings Health of Women and Children Report*, providing a decade of insights into the health and well-being of women and children across the United States. By analyzing trends over the past 10 years, the report features long-term data to provide a holistic view of key factors shaping health and well-being.

Between 2014 and 2024, the number of women ages 18-44 in the United States grew 6%, from 57.2 million to 60.9 million, while the number of children younger than 18 decreased 1%, from 73.6 million to 73.1 million. Together, children and women of reproductive age made up nearly 40% of the U.S. population in 2024.

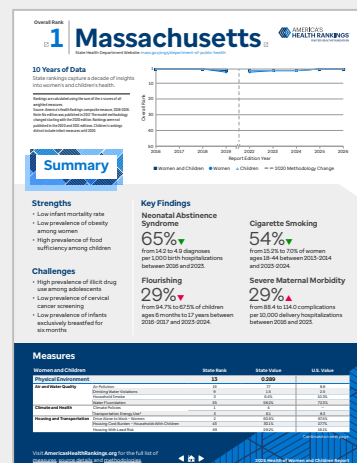
The findings reveal a complex landscape for women and children, where significant advancements in economic resources and educational attainment are contrasted by urgent and persistent challenges in mental and physical health – and uneven access to clinical care.

In the past decade:

- The prevalence of frequent mental distress and depression among women increased, while measures of children's mental health worsened, marked by a decline in flourishing and rising rates of teen suicide. Overall, the prevalence of diagnosed mental health conditions among children has risen.
- Rates of maternal mortality, severe maternal morbidity and low birth weight worsened, while teen births decreased and infant well-being measures such as infant mortality and breastfeeding improved.
- Substance use trends were also mixed. While drug deaths among women increased, rates of neonatal abstinence syndrome improved.
- Several measures of physical health among women worsened, including the prevalence of obesity and diabetes; overall, self-perceived high health status declined. Levels of physical inactivity among women remained unchanged, while physical activity decreased among children.
- Injury and firearm death rates increased among both women and children over the past decade.
- Poverty rates among both women and children improved, as did high school and college graduation rates. Additional improvements included a reduced housing cost burden among households with children and long-term decreases in household food insecurity, though these trends have begun to reverse in recent years.
- Several clinical care measures of access and prevention improved for women but have moved in the opposite direction for children. The rate of uninsured women and prevalence of well-woman visits improved, but the rate of uninsured children and prevalence of well-child visits worsened, despite an increase in the supply of pediatricians. Fewer children also had adequate insurance coverage or a medical home.
- Smoking patterns have shifted. Cigarette smoking among women, cigarette smoking during pregnancy and household smoke exposure among children decreased, while e-cigarette use among women rose.

State Summaries

State Summaries provide tailored data and insights about the demographics and health of women and children in specific states to guide local action. Visit [State Summaries](#) to explore the data.



Call to Action

Ten years of *America's Health Rankings* analysis shows that meaningful progress in women's and children's health requires sustained focus. Long-term improvements in health behaviors, access to care and socioeconomic conditions reflect public health and clinical efforts, while persistent and emerging challenges reinforce the need for purposeful collaboration in a changing landscape. Leaders can use state data to target action where it is most needed, maintain momentum in areas showing improvement and help foster better health and well-being for women and children across their lifespan.

Objective

America's Health Rankings aims to inform and drive action 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 *2026 Health of Women and Children Report* is based on:

- **One hundred and twenty-five measures.** These include 83 ranking and 42 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](#).
- **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.
- **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.

The *America's Health Rankings 2026 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.

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."¹

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.



National Snapshot

A Decade of Data

Health Outcomes

Drug Deaths Among Women*

50% ▲

from 16.7 to 25.0 deaths per 100,000 women ages 20-44 between 2014-2016 and 2022-2024.

Maternal Mortality††

34% ▲

from 17.3 to 23.1 deaths per 100,000 live births between 2014-2018 and 2020-2024.

Neonatal Abstinence Syndrome‡

25% ▼

from 6.8 to 5.1 diagnoses per 1,000 birth hospitalizations between 2016 and 2023.

Frequent Mental Distress Among Women**

62% ▲

from 14.3% to 23.2% of women ages 18-44 between 2013-2014 and 2023-2024.

Mental Health Conditions Among Children‡

32% ▲

from 15.5% to 20.5% of children ages 3-17 between 2016-2017 and 2023-2024.

Obesity Among Women**

26% ▲

from 25.9% to 32.6% of women ages 18-44 between 2013-2014 and 2023-2024.

Infant Mortality††

7% ▼

from 6.0 to 5.6 deaths per 1,000 live births between 2012-2013 and 2022-2023.

Severe Maternal Morbidity†

36% ▲

from 72.1 to 97.8 complications per 10,000 delivery hospitalizations between 2016 and 2023.

Flourishing Among Children‡

28% ▼

from 92.8% to 66.7% of children ages 6 months to 17 years between 2016-2017 and 2023-2024.

Diabetes Among Women**

16% ▲

from 3.1% to 3.6% of women ages 18-44 between 2013-2014 and 2023-2024.

Low Birth Weight§

6% ▲

from 8.0% to 8.5% of live births between 2014 and 2024.

* Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER.

** Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.

† Source: U.S. HHS, AHRQ, HCUP, State Inpatient Database via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD).

†† Source: U.S. HHS, CDC, NCHS, NVSS via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD).

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

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

§ Source: U.S. HHS, Natality Public Use Files via CDC WONDER.

Social and Economic Factors

Injury Deaths Among Women*

47%▲

from 31.9 to 47.0 deaths per 100,000 women ages 20-44 between 2012-2014 and 2022-2024.

Children in Poverty**

29%▼

from 21.7% to 15.5% of children ages 0-17 between 2014 and 2024.

Injury Deaths Among Children*

25%▲

from 14.2 to 17.8 deaths per 100,000 children ages 1-19 between 2012-2014 and 2022-2024.

Poverty Among Women**

12%▼

from 16.3% to 14.4% of women ages 18-44 between 2018 and 2024.

College Graduation Among Women†

9%▲

from 35.7% to 39.0% of women ages 25-44 between 2017-2018 and 2023-2024.

High School Graduation††

7%▲

from 81.4% to 86.7% of students between the 2012-2013 and 2022-2023 school years.

Clinical Care

Uninsured Children**

20%▲

from 5.0% to 6.0% of children ages 0-18 between 2017 and 2024.

Uninsured Women**

10%▼

from 12.4% to 11.2% of women ages 19-44 between 2017 and 2024.

Well-Woman Visits†

10%▲

from 66.5% to 73.4% of women ages 18-44 between 2013-2014 and 2023-2024.

Medical Home Among Children‡

6%▼

from 48.5% to 45.5% of children ages 0-17 between 2016-2017 and 2023-2024.

Adequate Insurance Among Children‡

5%▼

from 68.3% to 64.6% of children ages 0-17 between 2016-2017 and 2023-2024.

Well-Child Visits‡

3%▼

from 82.1% to 79.6% of children ages 0-17 between 2016-2017 and 2023-2024.

Behaviors

E-Cigarette Use Among Women†

121%▲

from 5.3% to 11.7% of women ages 18-44 between 2018 and 2023-2024.

Cigarette Smoking Among Women†

52%▼

from 17.4% to 8.4% of women ages 18-44 between 2013-2014 and 2023-2024.

* Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER.

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

† Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.

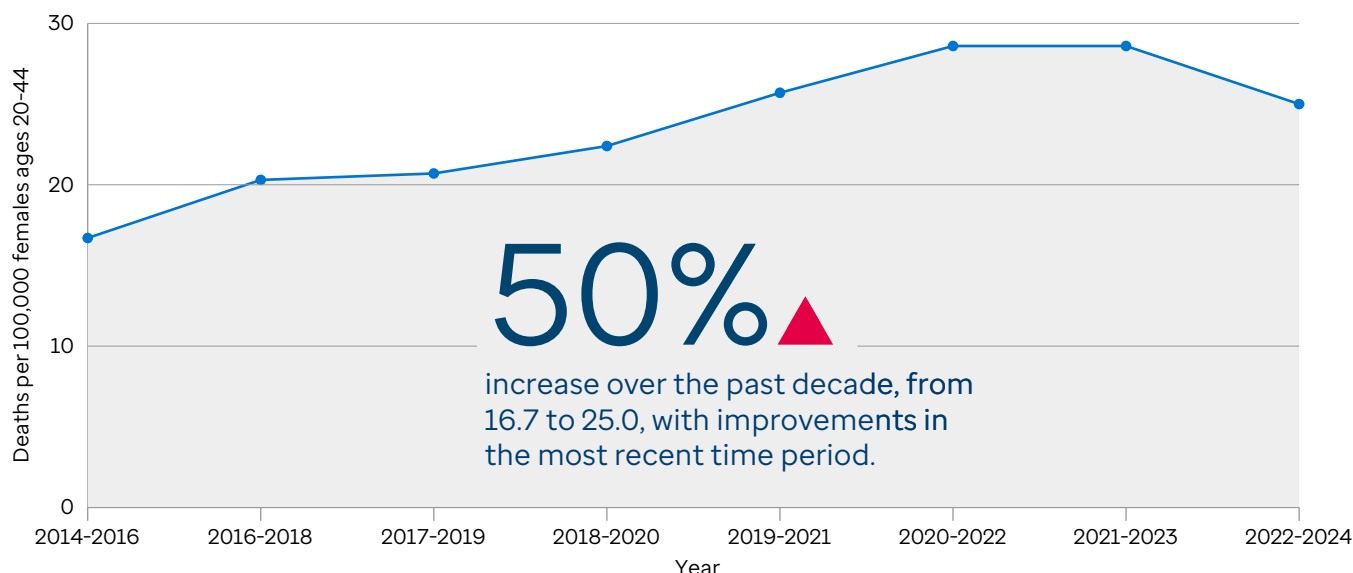
†† Source: U.S. ED, National Center for Education Statistics, EDFacts.

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

Findings



Drug Deaths Among Women



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2014-2024.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Drug Deaths Among Women

Drug overdose deaths in the United States [decreased](#) between 2022 and 2024, after two decades of near-continuous increases.² According to *America's Health Rankings* analysis of CDC data, [unintentional drug poisonings have remained the leading cause of injury deaths](#) among women of reproductive age for the past decade.³

Changes over the last decade. Nationally, the drug death rate – the number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 women ages 20-44 – increased 50% from 16.7 to 25.0 between 2014-2016 and 2022-2024. However, for the first time in a decade, the rate decreased 3% (from 25.7 deaths per 100,000 women ages 20-44) between 2019-2021 and 2022-2024. Despite this decrease, the rate remains above the [Healthy People 2030 target of 20.7 drug overdose deaths per 100,000 population](#).⁴ Reducing drug overdose deaths is a Healthy People 2030 [Leading Health Indicator](#).⁵ In 2022-2024, 41,700 women ages 20-44 in the U.S. died from a drug overdose, an increase of 15,000 deaths compared with 2014-2016.

In the decade between 2014-2016 and 2022-2024, the drug death rate significantly decreased 26% in Utah

(23.9 to 17.7 deaths per 100,000 women ages 20-44) and increased in 38 states and the District of Columbia. The largest increases were 360% in the District of Columbia (4.3 to 19.8), 185% in North Dakota (9.2 to 26.2), 170% in Alaska (19.6 to 53.0) and 132% in Oregon (11.4 to 26.5).

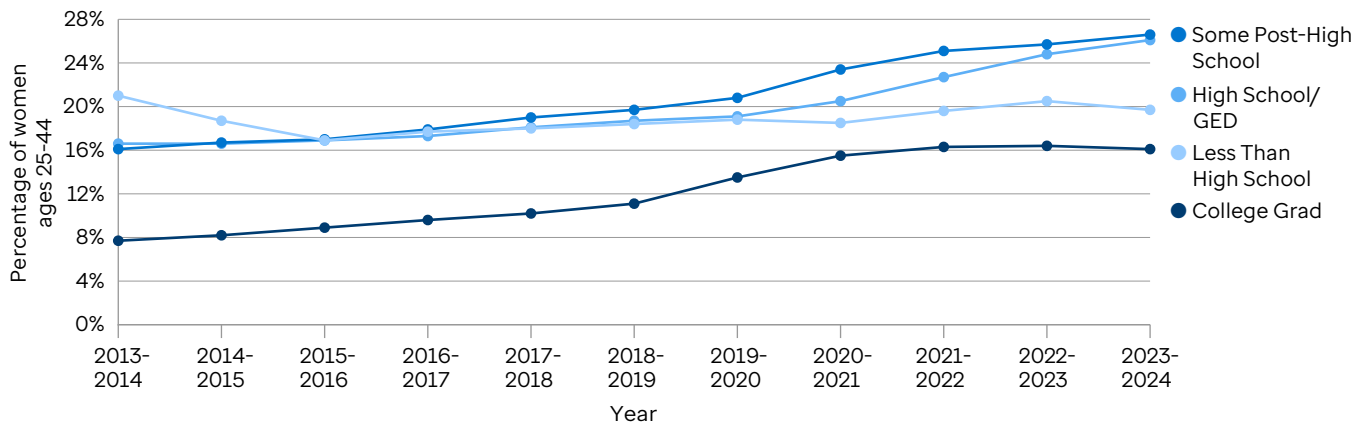
In the period between 2018-2020 and 2022-2024, the drug death rate significantly increased 75% among American Indian/Alaska Native (42.9 to 74.9 deaths per 100,000 women ages 20-44), 57% among Black (19.2 to 30.2), 40% among Hispanic (9.2 to 12.9), 36% among multiracial (15.2 to 20.7) and 26% among Asian (2.7 to 3.4) women but remained stable among white women (30.7 to 30.9).

Recent differences. The drug death rate varied by race/ethnicity, geography and age. In 2022-2024, the rate was:

- 22.0 times higher among American Indian/Alaska Native (74.9 deaths per 100,000 women ages 20-44) compared with Asian (3.4) women.
- 7.4 times higher in West Virginia (75.2) than in Nebraska (10.2).
- 2.7 times higher among women ages 35-44 (32.7) compared with women ages 20-24 (11.9).

Frequent Mental Distress Among Women

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Frequent Mental Distress Among Women

Although occasional short periods of mental distress and a few bad mental health days may be unavoidable, more prolonged and severe episodes are treatable and potentially [preventable](#) through early intervention.⁶

Changes over the last decade. Nationally, the prevalence of frequent mental distress – 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 62% from 14.3% to 23.2% between 2013-2014 and 2023-2024. In 2023-2024, 13.3 million women ages 18-44 experienced frequent mental distress, an increase of 5.2 million women compared with 2013-2014.

In the decade between 2013-2014 and 2023-2024, frequent mental distress among women ages 18-44 significantly increased:

- 154% among women with an annual household income of \$50,000 to \$74,999 (9.7% to 24.6%), 90% among women with an income of \$25,000 to \$49,999 (14.0% to 26.6%) and 26% among women with an income less than \$25,000 (22.5% to 28.3%).
- 109% among college graduates (7.7% to 16.1%), 65% among women with some post-high school education (16.1% to 26.6%) and 57% among high school graduates (16.6% to 26.1%).
- 83% among women ages 18-24 (15.1% to 27.7%), 64% among women ages 25-34 (14.3% to 23.4%) and 43% among women ages 35-44 (13.8% to 19.8%).
- 72% among white (15.3% to 26.3%) and 50% among Hispanic (12.5% to 18.7%) women.

During the same time period, the prevalence of frequent mental distress significantly increased in 49 states and the District of Columbia. The largest increases were 146% in North Dakota (9.4% to 23.1%), 145% in Montana (12.1% to 29.7%) and 117% in Nevada (13.2% to 28.6%).

Recent differences. The prevalence of frequent mental distress significantly varied by disability status, income, race/ethnicity, sexual orientation, geography, educational attainment, age, veteran status and metropolitan status. In 2023-2024, the prevalence among women ages 18-44 was:

- 4.2 times higher among women who have independent living difficulty (62.0%) compared with women without a disability (14.8%).
- 2.3 times higher among multiracial (32.4%) compared with Asian (14.4%) women.
- 2.2 times higher among women with an annual household income less than \$25,000 (28.3%) compared with women who have an income of \$150,000 or more (12.6%).
- 2.1 times higher among lesbian, gay, bisexual or otherwise nonheterosexual (LGBQ+) women (40.7%) compared with straight women (19.7%).
- 1.9 times and 1.8 times higher in Maine (31.2%) than in the District of Columbia (16.2%) and Hawaii (17.8%), respectively.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain disability, income, race/ethnicity and educational attainment groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [frequent mental distress data for women](#) on the *America's Health Rankings* website.

- 1.7 times higher among women with some post-high school education (26.6%) compared with college graduates (16.1%).
- 1.4 times higher among women ages 18-24 (27.7%) than women ages 35-44 (19.8%).
- 1.2 times higher among women who have served in the U.S. armed forces (28.5%) than women who have not served (23.1%).
- 1.1 times higher among women living in nonmetropolitan areas (26.3%) compared with women in metropolitan areas (22.9%).

Related Measures:

Depression Among Women

Nationally, the prevalence of depression – 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 23% from 24.8% to 30.6% between 2017-2018 and 2023-2024. In the more recent period between 2021-2022 and 2023-2024, the prevalence of depression increased 5% (from 29.1%). In 2023-2024, 17.7 million women ages 18-44 reported having depression.

Between 2017-2018 and 2023-2024, the prevalence of depression among women ages 18-44 significantly increased in 32 states and the District of Columbia. The largest increases were 51% in Texas (20.0% to 30.1%), 49% in Nevada (18.1% to 26.9%) and 41% in Colorado (24.1% to 34.0%). In 2023-2024, the prevalence among women ages 18-44 was 2.4 times higher in West Virginia (47.4%) than in New Jersey (19.4%). The prevalence of depression also significantly varied by disability status, race/ethnicity, sexual orientation, education, income, age, metropolitan status and veteran status. For more information, view [depression data for women](#) on the *America's Health Rankings* website.

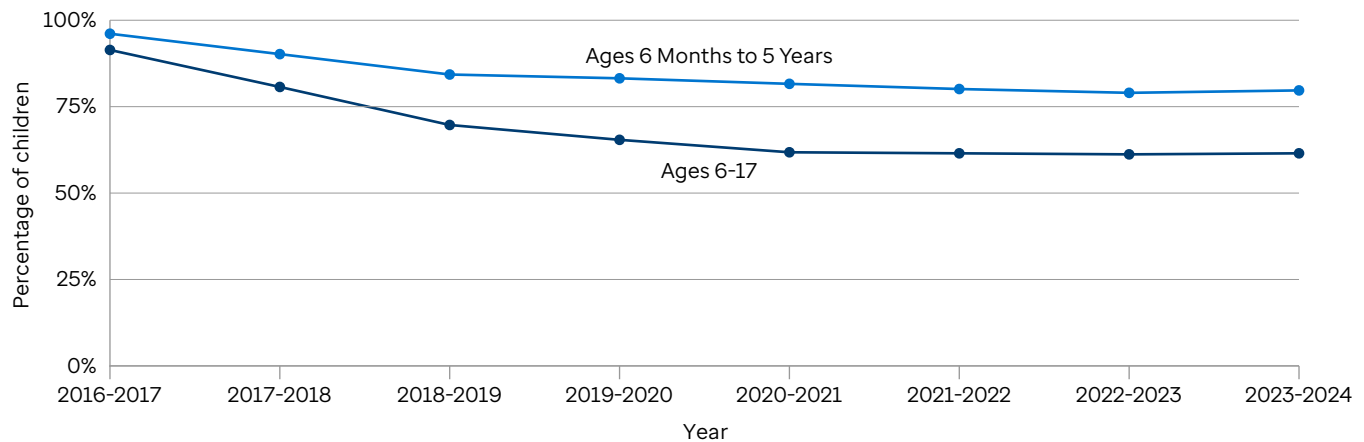
Postpartum Anxiety and Depression

In 2023, 11.9% of women with a recent live birth (more than 318,000 women) reported experiencing depression symptoms, or postpartum depression. During the same year, 20.3% of women with a recent live birth (more than 544,000 women) reported experiencing anxiety symptoms, or postpartum anxiety.

Note: No depression data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. No postpartum anxiety or postpartum depression data were available for California, Idaho, North Carolina or Ohio in 2023.

Flourishing Among Children

By Age



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

Flourishing Among Children

Flourishing measures how well children are thriving within their family and community.⁷ It represents socialization, curiosity, resilience and self-regulation.

Changes over time. Nationally, flourishing – the 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 – decreased 28% from 92.8% to 66.7% between 2016-2017 and 2023-2024. In 2023-2024, 46.6 million children were flourishing, nearly 20 million fewer than in 2016-2017.

Between 2016-2017 and 2023-2024, flourishing significantly decreased:

- 47% among children with special health care needs (81.0% to 43.2%) and 22% among those without special health care needs (96.8% to 75.7%).
- 33% among children ages 6-17 (91.4% to 61.5%) and 17% among those ages 6 months to 5 years (96.1% to 79.7%).
- 33% among Hawaiian/Pacific Islander (91.3% to 61.3%), 32% among multiracial (94.2% to 64.2%), 29% among American Indian/Alaska Native (91.5% to 65.1%), 29% among Black (90.0% to 64.0%), 28% among Hispanic (92.1% to 66.3%), 28% among white (93.7% to 67.5%) and 22% among Asian (94.5% to 73.3%) children.
- 31% among children whose caregivers have less than a high school education (88.8% to 61.1%), 30% among

those with a caregiver who graduated from high school (90.1% to 63.2%), 30% among those with a caregiver who has some post-high school education (91.8% to 64.4%) and 27% among those with a caregiver who graduated from college (95.2% to 69.7%).

- 30% among boys (91.8% to 64.5%) and 26% among girls (93.9% to 69.1%).

During the same time period, flourishing significantly decreased in all states and the District of Columbia. The largest decreases were 33% in Maine (94.0% to 62.9%), Oregon (92.7% to 62.0%) and South Dakota (94.0% to 62.9%).

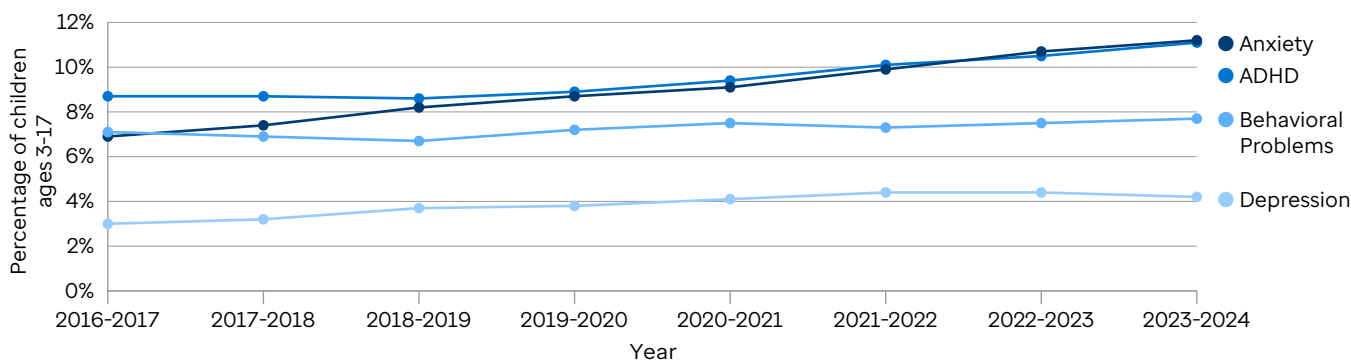
Recent differences. In 2023-2024, flourishing was:

- 1.8 times higher among children without special health care needs (75.7%) than those with special health care needs (43.2%).
- 1.3 times higher among children ages 6 months to 5 years (79.7%) than those ages 6-17 (61.5%).
- 1.1 times higher in Nebraska (70.1%) than in Oregon (62.0%); among girls (69.1%) than boys (64.5%); among Asian (73.3%) than Black (64.0%) children; and among children with a caregiver who graduated from college (69.7%) compared with those whose caregivers have less than a high school education (61.1%).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity and educational attainment groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [flourishing data](#) on the *America's Health Rankings* website.

Mental Health Conditions Among Children

By Diagnosed Condition



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

Mental Health Conditions Among Children

Mental health is an essential [component of overall health](#) and well-being.⁸ [Early diagnosis](#) of mental health conditions among children is important for preventing problems at home, in school or in forming friendships.⁹ Common [mental health conditions](#) among children include anxiety, depression and behavioral disorders.⁹

Changes over time. Nationally, the prevalence of mental health conditions – the percentage of children ages 3-17 with a diagnosed mental health condition – increased 32% from 15.5% to 20.5% between 2016-2017 and 2023-2024. This includes children who received diagnoses from a health care provider for attention-deficit/hyperactivity disorder (ADHD), depression or anxiety problems, as well as those who were told by a doctor or educator that they had behavior or conduct problems. There were increases in the prevalence of ADHD (28%, from 8.7% to 11.1%), anxiety (62%, from 6.9% to 11.2%) and depression (40%, from 3.0% to 4.2%). The prevalence of behavioral problems (7.7%) did not significantly change. In 2023-2024, nearly 12.4 million children were diagnosed with a mental health condition, an increase of 3 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of mental health conditions among children ages 3-17 significantly increased:

- 52% among girls (12.4% to 18.9%) and 20% among boys (18.4% to 22.0%).
- 43% among children with a caregiver who graduated from college (14.2% to 20.3%), 40% among children with a caregiver who has some post-high school education (16.5% to 23.1%) and 23% among children with a caregiver who graduated from high school (16.8% to 20.7%).

- 40% among white (17.3% to 24.2%), 34% among Hispanic (12.2% to 16.3%) and 26% among multiracial (17.2% to 21.6%) children.
- 38% among children without special health care needs (3.9% to 5.4%) and 18% among children with special health care needs (47.1% to 55.6%).

During the same time period, the prevalence of mental health conditions significantly increased in 18 states. The largest increases were 71% in New York (11.5% to 19.7%), 63% in Oregon (16.0% to 26.0%) and 61% in South Dakota (13.0% to 20.9%).

Recent differences. The prevalence of mental health conditions significantly varied by special health care needs status, race/ethnicity, geography, caregiver educational attainment and gender. In 2023-2024, the prevalence among children ages 3-17 was:

- 10.3 times higher among children with special health care needs (55.6%) compared with children without special health care needs (5.4%).
- 3.5 times higher among American Indian/Alaska Native (28.7%) compared with Asian (8.1%) children.
- 2.2 times higher in Maine (28.5%) than in Hawaii (13.1%).
- 1.5 times higher among children whose caregivers have some post-high school education (23.1%) compared with children whose caregivers have less than a high school education (15.9%).
- 1.2 times higher among boys (22.0%) compared with girls (18.9%).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [mental health conditions data for children](#) on the America's Health Rankings website.

Related Measure: Teen Suicide

Nationally, the teen suicide rate – the number of deaths due to intentional self-harm per 100,000 adolescents ages 15-19 – increased 15% from 8.4 to 9.7 in the 10 years between 2012-2014 and 2022-2024. However, the teen suicide rate improved 8% in 2022-2024 (down from 10.6 in 2019-2021).

In the decade between 2012-2014 and 2022-2024, the teen suicide rate significantly increased in three states: 62% in Georgia (6.8 to 11.0 deaths per 100,000 adolescents ages 15-19), 41% in Ohio (7.4 to 10.4) and 30% in Texas (8.7 to 11.3). In 2022-2024, the rate was 6.5 times higher in Alaska (29.7) than in Massachusetts (4.6). The teen suicide rate also significantly varied by race/ethnicity and gender. For more information, view [teen suicide data](#) on the *America's Health Rankings* website.



Michael Warren, MD, MPH, FAAP
Chief Medical and Health Officer,
March of Dimes

“Improving maternal and infant health requires both ensuring women can access high-quality clinical care when they need it *and* strengthening the supports that shape health beyond the clinic or hospital.”

Data-Driven Collaboration Between Public Health Leaders and Clinicians Can Support Moms and Babies

Over the course of my career in maternal and child health, I have worked with and on behalf of women, children and families across the health care continuum. As a clinician, a state and federal public health leader for over 15 years, and now Chief Medical and Health Officer with [March of Dimes](#), these roles have shown me the importance of coordinated and sustained action between public health, providers and families.

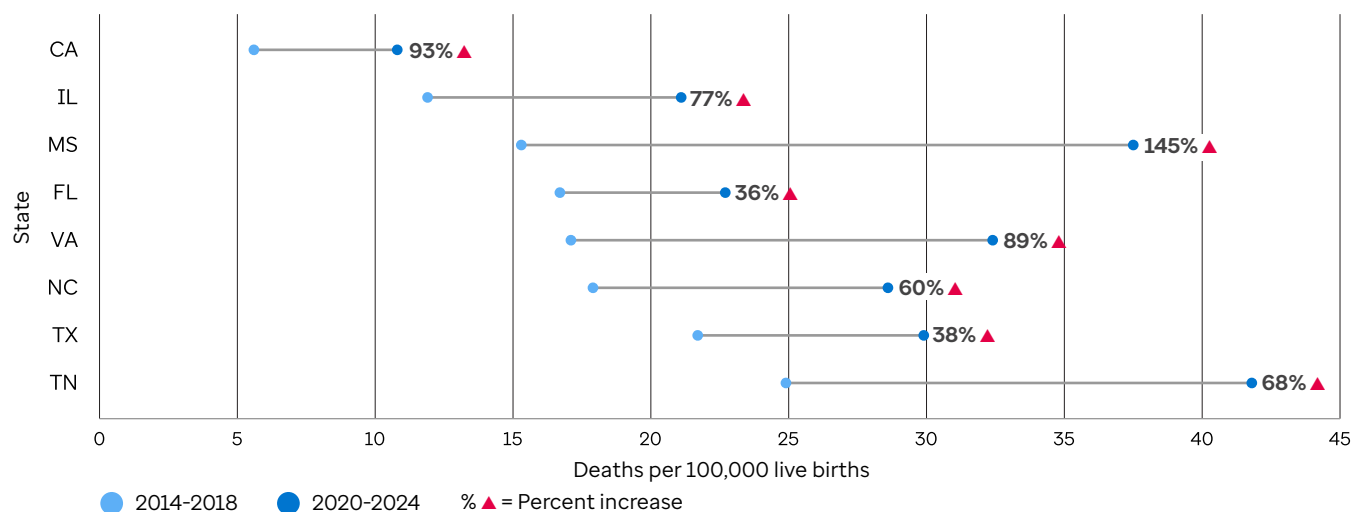
The need for this critical action is reflected in the findings of the *2026 Health of Women and Children Report*. Its examination of long-term trends shows meaningful gains in infant health: reductions in infant mortality over the long term, while the low birth weight rate is beginning to improve after years of worsening. These represent real progress in our efforts to give every baby a healthy start. However, this progress is uneven: The data reveal concerning trends over the decade for pregnant women, including long-term increases in severe maternal morbidity and maternal mortality.

These findings reinforce the reality that we at March of Dimes know all too well: Too many women continue to face [gaps in access](#) to the care that they need. Although some socioeconomic factors have improved, other findings like rising rates of chronic conditions and mental health challenges among women jeopardize the future health of women, their babies and their communities.

The data reinforce what my career has taught me: that clinicians cannot shoulder all of these outcomes alone. Improving maternal and infant health requires both ensuring women can access high-quality clinical care when they need it *and* strengthening the supports that shape health beyond the clinic or hospital. Clinical providers, public health professionals, community-based workers and other trusted partners can help identify risks early, and support women and infants with the care and resources they need. It takes all of us working together as a country to improve outcomes.

Significant Increases in Maternal Mortality

By State Between 2014-2018 and 2020-2024



Source: U.S. HHS, CDC, NCHS, NVSS via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD), 2014-2024.

HEALTH OUTCOMES | MORTALITY

Maternal Mortality

The majority of maternal deaths resulting from pregnancy-related complications are [preventable](#).¹⁰ Despite this, the U.S. consistently has the [highest rate](#) of maternal mortality among high-income countries.¹¹ The [leading causes of pregnancy-related deaths](#) in the U.S. in 2024 according to death records were cardiovascular conditions, other noncardiovascular medical conditions (endocrine, hematologic, immunologic and renal), and infection or sepsis.¹² Maternal Mortality Review Committees, which have access to clinical and nonclinical data, have identified [mental health conditions](#) as a leading cause of pregnancy-related deaths.¹³

Changes over the last decade. Nationally, the maternal mortality rate increased 34% between 2014-2018 and 2020-2024, from 17.3 to 23.1 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](#).¹⁴ Reducing maternal deaths is a Healthy People 2030 [Leading Health Indicator](#).⁵ In 2020-2024, approximately 4,200 women died of pregnancy-related causes, an increase of nearly 820 maternal deaths compared with 2014-2018.

In the decade between 2014-2018 and 2020-2024, the maternal mortality rate significantly increased in eight states. The largest increases were 145% in Mississippi (15.3 to 37.5 deaths per 100,000 live births), 93% in California (5.6 to 10.8) and 89% in Virginia (17.1 to 32.4).

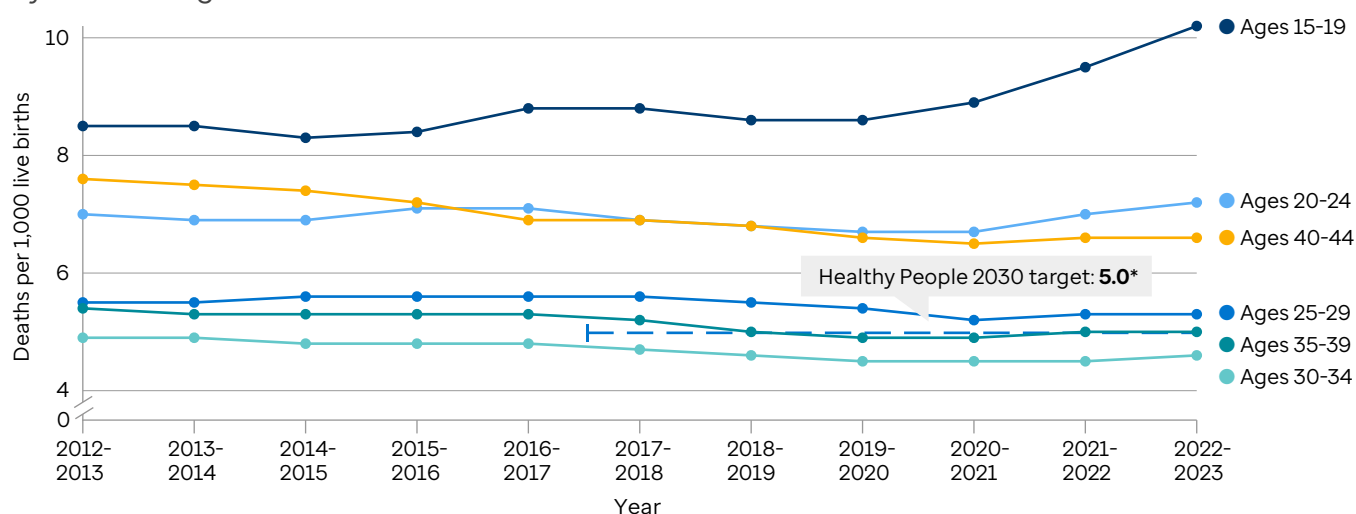
Recent differences. The maternal mortality rate varied significantly by race/ethnicity, geography, age, educational attainment and metropolitan status in 2020-2024. The rate was:

- 4.1 times higher among American Indian/Alaska Native (58.9 deaths per 100,000 live births) compared with Asian and multiracial (both 14.3) women.
- 3.9 times higher in Tennessee (41.8) than in California (10.8).
- 3.0 times higher among women age 35 and older (44.2) than women ages 20-24 (14.6).
- 2.8 times higher among women who graduated from high school (35.3) compared with college graduates (12.5).
- 1.4 times higher among women living in nonmetropolitan areas (30.4) compared with women in large metropolitan areas (21.1).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity, age, educational attainment and metropolitan status groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [maternal mortality data](#) on the America's Health Rankings website.

Infant Mortality

By Mother's Age



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

*Source: Healthy People 2030. The Healthy People 2030 target specifically applies to the baseline year of 2017 and onward.

Infant Mortality

The U.S. has a consistently and considerably [higher infant mortality rate](#) than other developed countries.¹⁵ In 2024, the [leading causes of infant death](#) in the U.S. were congenital abnormalities, low birth weight and sudden infant death syndrome (SIDS).¹⁶

Changes over the last decade. Nationally, the infant mortality rate improved 7% between 2012-2013 and 2022-2023, from 6.0 to 5.6 infant deaths per 1,000 live births, approaching the [Healthy People 2030 target to reduce the rate of infant deaths to 5.0 per 1,000 live births](#).¹⁷ Reducing the rate of infant deaths is a Healthy People 2030 [Leading Health Indicator](#).⁵ Nearly 41,000 infants died in the U.S. during 2022-2023, a decrease of nearly 6,400 deaths compared with 2012-2013.

In the decade between 2012-2013 and 2022-2023, the infant mortality rate decreased 13% among infants born to mothers ages 40-44 (7.6 to 6.6 deaths per 1,000 live births), 7% among infants born to mothers ages 35-39 (5.4 to 5.0), 6% among infants born to mothers ages 30-34 (4.9 to 4.6) and 4% among infants born to mothers ages 25-29 (5.5 to 5.3). However, it also increased 20% among infants born to mothers ages 15-19 (8.5 to 10.2) and 3% among infants born to mothers ages 20-24 (7.0 to 7.2).

Between 2017-2018 and 2022-2023, the infant mortality rate significantly decreased:

- 6% among infants born to multiracial (6.9 to 6.5), 5% among infants born to Asian (3.7 to 3.5) and 4% among infants born to white (4.7 to 4.5) mothers.

- 3% among male (6.3 to 6.1) and 2% among female (5.2 to 5.1) infants.

Between 2017-2018 and 2022-2023, the infant mortality rate significantly increased 5% among infants born to American Indian/Alaska Native mothers (8.7 to 9.1).

In the decade between 2012-2013 and 2022-2023, the infant mortality rate decreased 7% or more in 23 states and the District of Columbia, while increasing in five states. The largest decreases were 35% in New Hampshire (4.9 to 3.2 deaths per 1,000 live births), 34% in Rhode Island (6.5 to 4.3) and 26% in North Dakota (6.2 to 4.6). The largest increases were 28% in Alaska (5.4 to 6.9), 24% in Nebraska (4.9 to 6.1) and 8% in Iowa (4.8 to 5.2).

Recent differences. The infant mortality rate significantly varied by mother's race/ethnicity, geography, mother's age and infant gender. In 2022-2023, 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 those born to mothers ages 30-34 (4.6).
- 1.2 times higher among male (6.1) compared with female (5.1) infants.

HEALTH OUTCOMES | PHYSICAL HEALTH

Severe Maternal Morbidity

Severe maternal morbidity encompasses [unanticipated labor and delivery outcomes](#) and results in short- or long-term health effects.¹⁸ Tracking severe maternal morbidity is important for [monitoring population-level maternal health](#), understanding the root causes of perinatal complications and ultimately preventing maternal mortality.¹⁹

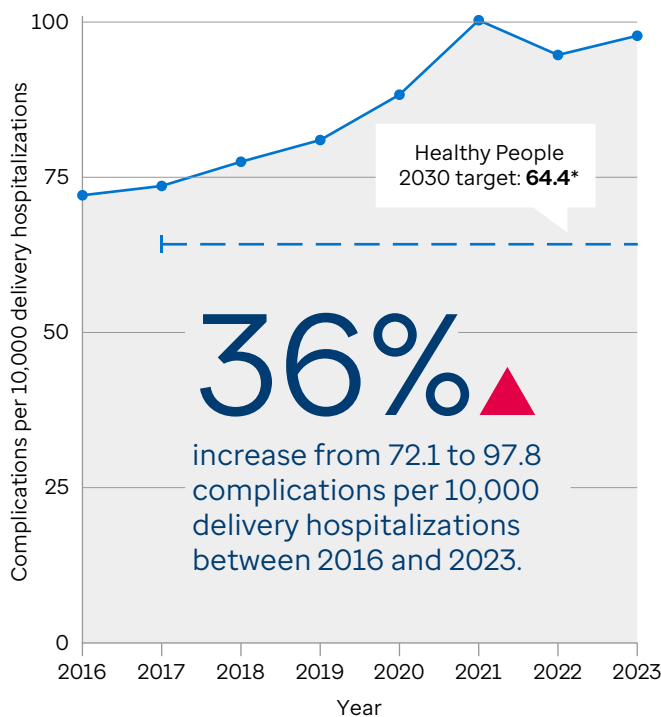
Changes over time. Nationally, the severe maternal morbidity rate increased 36% between 2016 and 2023, from 72.1 to 97.8 significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations. The current rate is much higher than the [Healthy People 2030 target of 64.4 hospital discharges per 10,000 delivery hospitalizations](#).²⁰ In 2023, nearly 28,300 women experienced severe maternal morbidity, approximately 2,000 more than in 2016.

Between 2016 and 2023, severe maternal morbidity significantly increased in 29 states and the District of Columbia. The largest increases were 105% in both Maine (52.9 to 108.6 complications per 10,000 delivery hospitalizations) and Delaware (63.1 to 129.3), 99% in the District of Columbia (88.4 to 176.1) and 97% in Minnesota (61.6 to 121.2).

In the period between 2019 and 2023, severe maternal morbidity significantly increased:

- 30% among Asian/Pacific Islander (88.5 to 115.4), 23% among Black (126.1 to 155.5), 22% among white (66.2 to 81.0), 20% among other race (90.7 to 108.8) and 14% among Hispanic (82.2 to 94.0) women.
- 25% among women living in the most wealthy ZIP code quartile (75.1 to 94.1), 22% among women living in the second most wealthy ZIP code quartile (77.0 to 93.7), 20% among women living in the least wealthy ZIP code quartile (89.6 to 107.7) and 17% among women living in the second least wealthy ZIP code quartile (80.0 to 93.8).
- 23% among women living in large metropolitan areas (87.0 to 106.7), 22% among women in small-to-medium metropolitan areas (73.1 to 89.3) and 14% among women in nonmetropolitan areas (71.3 to 81.3).
- 21% among women younger than 20 (77.8 to 94.3), 21% among women ages 30–34 (78.8 to 95.6), 19% among women ages 25–29 (68.6 to 81.6), 19% among women age 35 and older (119.5 to 142.5) and 17% among women ages 20–24 (65.7 to 77.0).

Severe Maternal Morbidity



Source: U.S. HHS, AHRQ, HCUP, State Inpatient Database via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD), 2016–2023.

*Source: Healthy People 2030. The Healthy People 2030 target specifically applies to the baseline year of 2017 and onward.

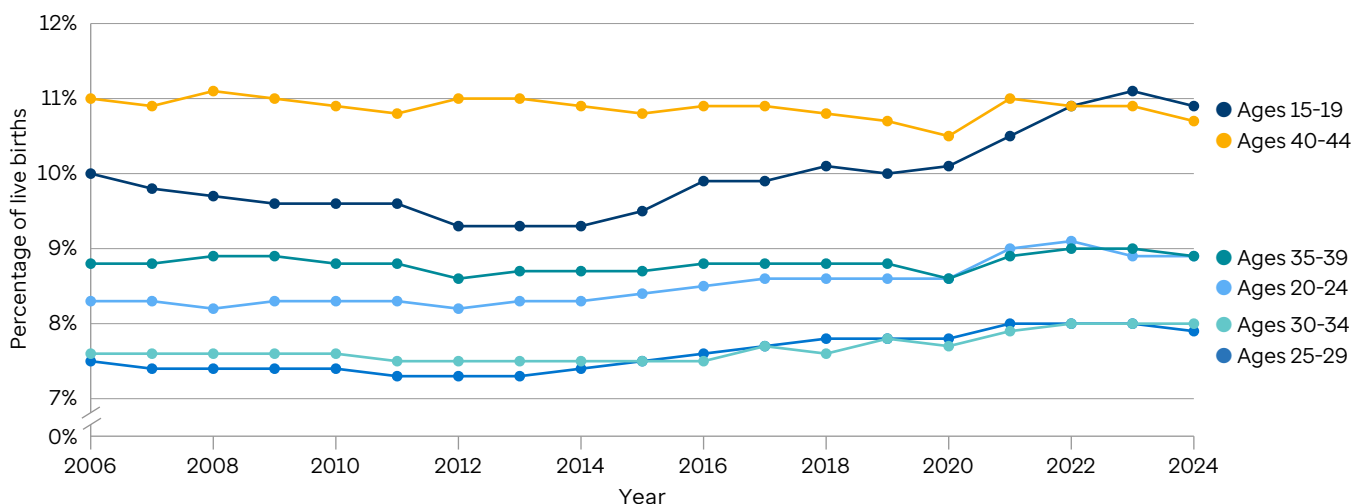
Recent differences. The rate of severe maternal morbidity significantly varied by geography, race/ethnicity, age, metropolitan status and median ZIP code income. The prevalence was:

- 3.1 times higher in the District of Columbia (176.1 complications per 10,000 delivery hospitalizations) and 2.6 times higher in Alaska (147.2) than in Nebraska (56.8).
- 1.9 times higher among Black (155.5) compared with white (81.0) women.
- 1.9 times higher among women age 35 and older (142.5) compared with women ages 20–24 (77.0).
- 1.3 times higher among women living in large metropolitan areas (106.7) than women in nonmetropolitan areas (81.3).
- 1.1 times higher among women living in the least wealthy ZIP code quartile (107.7) compared with women in the second-wealthiest ZIP code quartile (93.7).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain income groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [severe maternal morbidity data](#) on the *America's Health Rankings* website.

Low Birth Weight

By Mother's Age



Source: U.S. HHS, Natality Public Use Files via CDC WONDER, 2006-2024.

Low Birth Weight

Low birth weight infants are at increased risk of several [short- and long-term complications](#).²¹ Low birth weight and preterm birth are leading causes of [infant mortality](#).²²

Changes over the last decade. Nationally, the prevalence of low birth weight – the percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth – increased 6% from 8.0% to 8.5% between 2014 and 2024. However, low birth weight decreased 1% in the most recent period between 2023 (8.6%) and 2024. In 2024, approximately 309,000 infants were born with low birth weight, nearly 10,000 fewer than in 2014.

In the decade between 2014 and 2024, low birth weight increased:

- 17% among infants born to mothers ages 15-19 (9.3% to 10.9%), 7% among infants born to mothers ages 20-24 (8.3% to 8.9%), 7% among infants born to mothers ages 25-29 (7.4% to 7.9%), 7% among infants born to mothers ages 30-34 (7.5% to 8.0%) and 2% among infants born to mothers ages 35-39 (8.7% to 8.9%).
- 11% among infants born to mothers who graduated from high school (8.9% to 9.9%), 11% among infants born to mothers with some post-high school education (8.1% to 9.0%), 9% among infants born to mothers with less than a high school education (9.2% to 10.0%) and 4% among infants born to mothers who graduated from college (6.8% to 7.1%).

During the same time period, low birth weight increased 6% or more in 29 states and the District of Columbia. The largest increases were 21% in Nebraska (6.6% to 8.0%), 17% in both Nevada (8.3% to 9.7%) and Alaska (5.9% to 6.9%), and 15% in both Oregon (6.2% to 7.1%) and North Dakota (6.2% to 7.1%).

Recent differences. Low birth weight significantly varied by race/ethnicity, geography, age and educational attainment. In 2024, it was:

- 2.1 times higher among infants born to Black (15.0%) compared with white (7.0%) mothers.
- 1.9 times higher in Mississippi (12.7%) than in New Hampshire (6.6%).
- 1.4 times higher among infants born to mothers ages 15-19 (10.9%) compared with mothers ages 25-29 (7.9%).
- 1.4 times higher among infants born to mothers with less than a high school education (10.0%) compared with mothers who graduated from college (7.1%).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain age and educational attainment groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [low birth weight data](#) on the America's Health Rankings website.

Related Measures:

Low Birth Weight Racial Disparity

Nationally, the racial disparity in low birth weight – the ratio of the low birth weight rate of the racial/ethnic group with the highest rate to the non-Hispanic white rate – increased 5% from 2.0 (14.1% of Black infants versus 6.9% of white infants) to 2.1 (14.9% of Black infants versus 7.0% of white infants) between 2018-2020 and 2022-2024.

Breastfed

Nationally, breastfeeding prevalence – the percentage of infants exclusively breastfed for six months – increased 27% from 21.9% to 27.9% between the 2012 and 2022 birth cohorts, remaining lower than the [Healthy People 2030 target of 42.4% of infants](#).²³ During the same period, breastfeeding significantly increased in seven states. The largest increases were 140% in Mississippi (10.0% to 24.0%), 136% in Alabama (11.2% to 26.4%) and 132% in Louisiana (11.8% to 27.4%). In the 2022 birth cohort, the percentage of infants exclusively breastfed for six months was 1.9 times higher in Nebraska (36.7%) than in Georgia (19.5%).

Cigarette Smoking During Pregnancy

Nationally, cigarette smoking during pregnancy decreased 71% from 8.4% to 2.4% of live births between 2014 and 2024. In 2024, almost 87,000 mothers reported smoking cigarettes during pregnancy – 228,000 fewer mothers than in 2014.

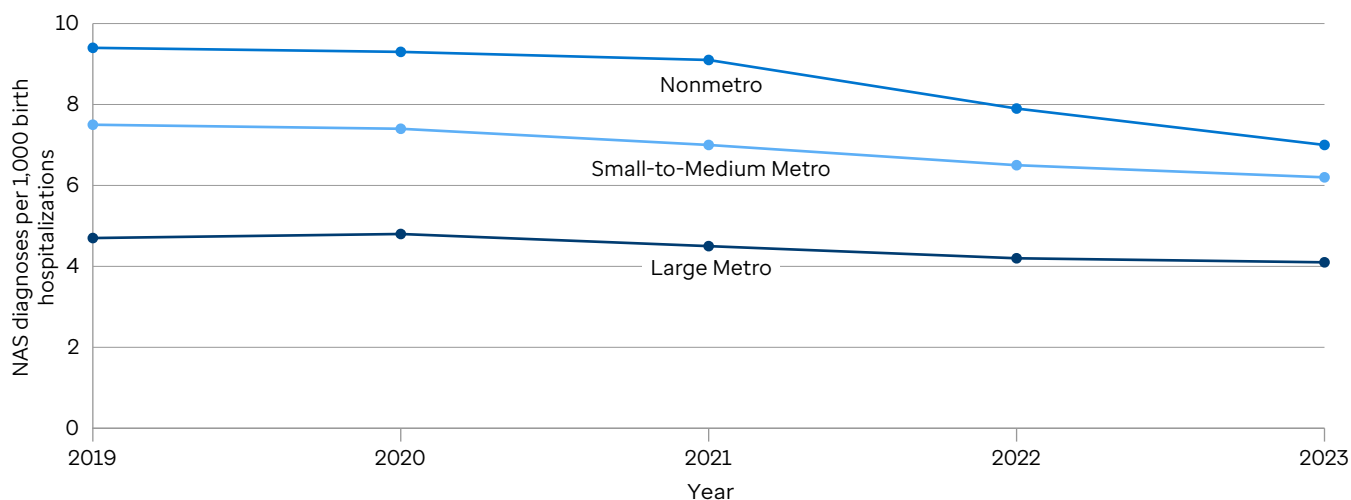
During the same time period, the percentage of mothers who reported smoking cigarettes during pregnancy decreased 71% or more in 17 states and the District of Columbia. The largest decreases were 80% in Idaho (10.7% of live births to 2.1%) and 79% in both Massachusetts (6.2% to 1.3%) and Texas (3.9% to 0.8%). In 2024, the prevalence was 26.2 times higher in West Virginia (10.5%) than in California (0.4%) and 3.1 times higher among mothers in nonmetropolitan areas (5.8%) compared with mothers in metropolitan areas (1.9%).

Teen Births

Nationally, the teen birth rate decreased 48% from 24.2 to 12.6 births per 1,000 females ages 15-19 between 2014 and 2024, meeting the [Healthy People 2030 target of 31.4 pregnancies per 1,000 females ages 15-19](#).²⁴ During the same time period, the teen birth rate decreased 48% or more in 27 states. The largest decreases were 59% in California (21.1 to 8.7 births per 1,000 females ages 15-19) and 58% in Montana (26.4 to 11.1), New Hampshire (11.0 to 4.6) and Utah (19.4 to 8.2). In 2024, the teen birth rate was 5.0 times higher in Mississippi (22.8) than in New Hampshire (4.6). The rate was 13.3 times higher among Hispanic (20.0) than Asian (1.5) teenagers.

Neonatal Abstinence Syndrome (NAS)

By Metropolitan Status



Source: U.S. HHS, AHRQ, HCUP, State Inpatient Database via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD), 2019-2023.

Note: No data were available for Alabama, California, Idaho, Nevada or Vermont in 2023, nor for Alabama, Idaho or New Hampshire in 2016.

Neonatal Abstinence Syndrome

Newborns experiencing [drug withdrawal](#) may be diagnosed with neonatal abstinence syndrome (NAS), a condition most commonly caused by [fetal exposure to maternal opioid use](#).^{25,26} [Long-term impacts](#) include developmental delays, growth problems and hearing and vision problems.²⁷

Changes over time. Nationally, the rate of NAS decreased 25% between 2016 and 2023, from 6.8 to 5.1 birth hospitalizations with a diagnosis code of withdrawal symptoms due to prenatal exposure to illicit drugs per 1,000 birth hospitalizations. In 2023, there were approximately 14,800 NAS diagnoses in the U.S., about 10,000 fewer diagnoses than in 2016.

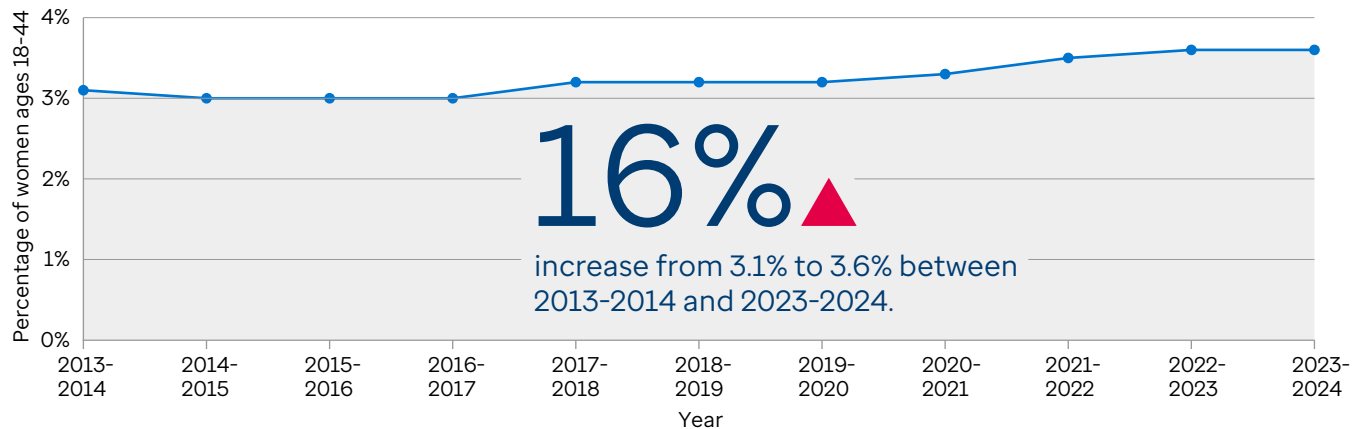
Between 2016 and 2023, the NAS hospitalization rate significantly decreased in 19 states. The largest decreases were 67% in Delaware (26.8 to 8.9 NAS diagnoses per 1,000 birth hospitalizations), 65% in Massachusetts (14.2 to 4.9) and 58% in Tennessee (18.0 to 7.6). During the same time period, the NAS hospitalization rate significantly increased in three states: 42% in Arizona (7.2 to 10.2), 30% in Oregon (6.3 to 8.2) and 29% in South Carolina (4.2 to 5.4).

Recent differences. The NAS hospitalization rate significantly varied by geography, race/ethnicity, median ZIP code income and metropolitan status in 2023. The rate was:

- 16.9 times higher in West Virginia (25.3 NAS diagnoses per 1,000 birth hospitalizations) than in Nebraska (1.5).
- 21.6 times higher among American Indian/Alaska Native (17.3) compared with Asian/Pacific Islander (0.8) infants.
- 2.7 times higher among infants living in the least wealthy ZIP code quartile (7.1) compared with infants living in the wealthiest ZIP code quartile (2.6).
- 1.7 times higher among infants living in nonmetropolitan areas (7.0) than infants in large metropolitan areas (4.1).

Note: No data were available for Alabama, California, Idaho, Nevada or Vermont in 2023, nor for Alabama, Idaho or New Hampshire in 2016.

Diabetes Among Women



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Diabetes Among Women

Diabetes is a [chronic health condition](#) that disrupts the body's ability to use or make insulin and can lead to serious health problems like heart disease, vision loss and kidney disease.²⁸ Diabetes was the [seventh-leading cause of death](#) among women ages 20-44 in 2023 and 2024.¹⁶

Changes over the last decade. Nationally, the prevalence of diabetes – the percentage of women ages 18-44 who reported being told by a health professional that they had diabetes – increased 16% from 3.1% to 3.6% between 2013-2014 and 2023-2024. In 2023-2024, nearly 2.1 million women ages 18-44 reported having diabetes, an increase of 336,100 women compared with 2013-2014.

In the decade between 2013-2014 and 2023-2024, the prevalence of diabetes among women ages 18-44 significantly increased:

- 71% among women with an annual household income of \$50,000 to \$74,999 (2.4% to 4.1%) and 51% among women with an income of \$25,000 to \$49,999 (3.7% to 5.6%).
- 32% among college graduates (1.9% to 2.5%) and 28% among women with some post-high school education (4.0% to 5.1%).

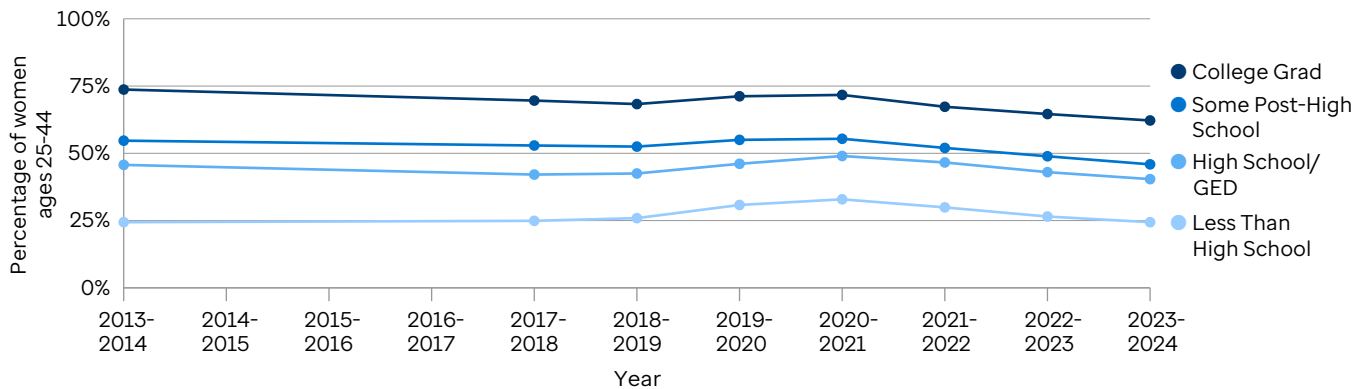
Recent differences. The prevalence of diabetes significantly varied by disability status, income, geography, age, educational attainment, race/ethnicity and metropolitan status. In 2023-2024, the prevalence among women ages 18-44 was:

- 5.0 times higher among women who have difficulty with mobility (13.4%) compared with women without a disability (2.7%).
- 4.0 times higher among women with an annual household income less than \$25,000 (6.8%) compared with women who have an income of \$150,000 or more (1.7%).
- 3.5 times and 2.8 times higher in West Virginia (6.7%) than in the District of Columbia (1.9%) and New Hampshire (2.4%), respectively.
- 3.4 times higher among women ages 35-44 (5.7%) compared with women ages 18-24 (1.7%).
- 2.4 times higher among women with less than a high school education (5.9%) compared with college graduates (2.5%).
- 2.0 times higher among Black (5.3%) compared with Asian (2.7%) women.
- 1.4 times higher among women living in nonmetropolitan areas (4.8%) compared with women in metropolitan areas (3.4%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain disability, income, educational attainment and race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [diabetes data for women](#) on the America's Health Rankings website.

High Health Status Among Women

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

High Health Status Among Women

Self-reported health status measures how individuals [perceive](#) their health.²⁹ Those with “poor” self-reported health status have a higher [mortality risk](#) than those with “excellent” self-reported health status.³⁰

Changes over the last decade. Nationally, high health status – the percentage of women ages 18-44 who reported their health is very good or excellent – decreased 12% from 56.0% to 49.4% between 2013-2014 and 2023-2024. Notably, 10% of this decline occurred recently, between 2021-2022 and 2023-2024. In 2023-2024, 28.7 million women reported having high health status, 2.9 million fewer women than in 2013-2014.

Between 2013-2014 and 2023-2024, high health status among women ages 18-44 significantly decreased:

- 28% among women with an annual household income of \$25,000 to \$49,999 (54.6% to 39.5%), 23% among women with an income of \$50,000 to \$74,999 (65.9% to 50.8%) and 14% among women with an income less than \$25,000 (34.4% to 29.5%).
- 16% among both college graduates (73.7% to 62.2%) and women with some post-high school education (54.7% to 45.9%) and 12% among high school graduates (45.7% to 40.4%).
- 13% among women ages 18-24 (59.4% to 51.4%), 11% among women ages 25-34 (55.8% to 49.6%) and 10% among women ages 35-44 (53.5% to 48.0%).
- 13% among white women (63.3% to 55.2%).

During the same time, high health status significantly decreased in 35 states. The largest decreases were 23% in Iowa (62.7% to 48.3%), 22% in Oregon (59.6% to 46.5%) and 20% in Pennsylvania (59.8% to 48.1%).

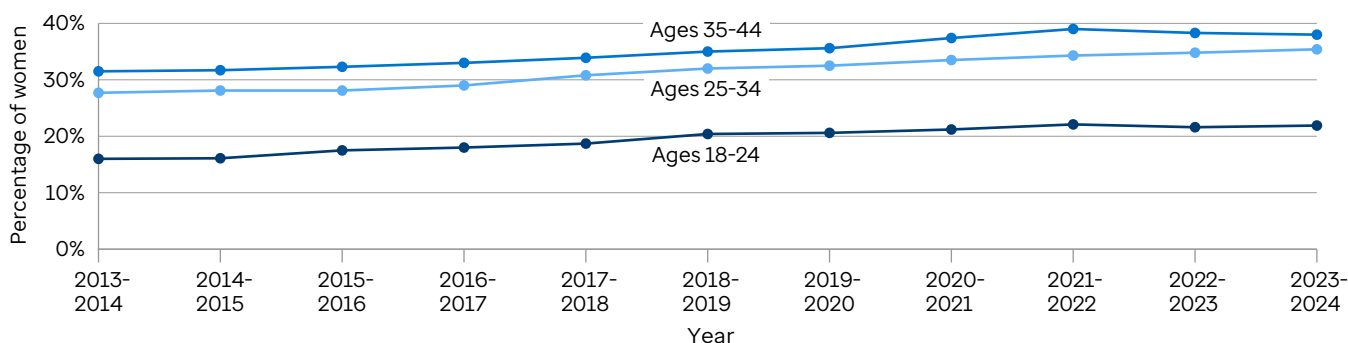
Recent differences. In 2023-2024, high health status among women ages 18-44 was:

- 5.9 times higher among women without a disability (56.5%) than women who have difficulty with self-care (9.6%).
- 2.5 times higher among college graduates (62.2%) than women with less than a high school education (24.4%).
- 2.4 times higher among women with an annual household income of \$150,000 or more (69.8%) than women with an income less than \$25,000 (29.5%).
- 1.5 times higher in the District of Columbia (65.7%), and 1.3 times higher in Vermont (58.8%), than in West Virginia and Arkansas (both 44.6%).
- 1.4 times higher among white (55.2%) and Asian (54.5%) than American Indian/Alaska Native (38.6%) women.
- 1.3 times higher among straight women (51.8%) than LGBTQ+ women (39.1%).
- 1.1 times higher among women ages 18-24 (51.4%) than women ages 35-44 (48.0%); and among women who have served in the U.S. armed forces (54.7%) than women who have not served (49.2%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain disability, race/ethnicity and age groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [high health status data for women](#) on the America's Health Rankings website.

Obesity Among Women

By Age



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Obesity Among Women

Obesity is a [complex health condition](#) with biological, economic, environmental, individual and societal causes.³¹ Women with obesity are at an increased risk of developing [serious health conditions](#).³²

Changes over the last decade. Nationally, obesity – the percentage of women ages 18-44 who have a body mass index (BMI) of 30.0 or higher based on reported height and weight – increased 26% from 25.9% to 32.6% between 2013-2014 and 2023-2024. In 2023-2024, 16 million women ages 18-44 had obesity, nearly 3.2 million more women than in 2013-2014.

Between 2013-2014 and 2023-2024, obesity among women ages 18-44 significantly increased:

- 53% among women with an annual household income of \$50,000 to \$74,999 (26.5% to 40.6%), 30% among women with an income of \$25,000 to \$49,999 (33.8% to 44.1%) and 13% among women with an income less than \$25,000 (39.5% to 44.8%).
- 51% among Asian (8.0% to 12.1%), 35% among white (23.3% to 31.5%), 20% among Hispanic (29.1% to 34.8%) and 14% among Black (39.5% to 45.2%) women.
- 50% among college graduates (18.2% to 27.3%), 26% among women with some post-high school education (33.4% to 42.0%), 20% among high school graduates (36.2% to 43.4%) and 12% among women with less than a high school education (39.8% to 44.6%).
- 37% among women ages 18-24 (16.0% to 21.9%), 28% among women ages 25-34 (27.7% to 35.4%) and 21% among women ages 35-44 (31.5% to 38.0%).

During the same time period, the prevalence of obesity significantly increased in 40 states. The largest increases

were 45% in Minnesota (21.7% to 31.4%), 40% in Nebraska (25.8% to 36.1%), and 39% in both South Dakota (25.5% to 35.4%) and Alabama (31.0% to 43.1%).

Recent differences. In 2023-2024, obesity among women ages 18-44 was:

- 3.7 times higher among Black (45.2%) than Asian (12.1%) women.
- 2.1 times higher among both women with an annual household income less than \$25,000 (44.8%) and women with an income of \$25,000 to \$49,999 (44.1%) than women with an income of \$150,000 or more (21.2%).
- 1.8 times higher in West Virginia (43.4%) than in the District of Columbia and Massachusetts (both 24.3%); and among women who have difficulty with mobility (53.3%) than women without a disability (30.3%).
- 1.7 times higher among women ages 35-44 (38.0%) than women ages 18-24 (21.9%).
- 1.6 times higher among both women with less than a high school education (44.6%) and high school graduates (43.4%) than college graduates (27.3%).
- 1.3 times higher among women living in nonmetropolitan areas (39.8%) than women in metropolitan areas (31.5%).
- 1.1 times higher among LGBTQ+ (36.9%) than straight women (33.7%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity, income, disability status and educational attainment groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [obesity data for women](#) on the America's Health Rankings website.

Related Measures:

Physical Inactivity Among Women

Nationally, the prevalence of physical inactivity – the percentage of women ages 18-44 who reported doing no physical activity or exercise other than their regular job in the past 30 days – remained unchanged over the last 10 years (22.5% in 2013-2014 to 22.0% in 2023-2024). In 2023-2024, 12.8 million women ages 18-44 reported being physically inactive.

In the decade between 2013-2014 and 2023-2024, the prevalence of physical inactivity among women ages 18-44 significantly decreased 34% in the District of Columbia (19.4% to 12.9%), 17% in Utah (16.9% to 14.0%) and 16% in Indiana (25.0% to 21.0%). In 2023-2024, the prevalence among women ages 18-44 was 2.4 times and 2.2 times higher in Mississippi (30.8%) than in the District of Columbia (12.9%) and Utah (14.0%). The prevalence of physical inactivity also significantly varied by income, education, disability status, race/ethnicity, veteran status, age and sexual orientation. For more information, view [physical inactivity data for women](#) on the *America's Health Rankings* website.

Physical Activity Among Children

Nationally, the prevalence of physical activity – the percentage of children ages 6-17 who were physically active at least 60 minutes every day in the past week – decreased 14% from 23.0% to 19.7% between 2016-2017 and 2023-2024. In 2023-2024, 9.7 million children engaged in sufficient physical activity, a decrease of nearly 1.5 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of physical activity among children ages 6-17 significantly decreased 49% in Nevada (25.3% to 12.9%), 31% in California (25.5% to 17.6%) and 30% in Oklahoma (28.9% to 20.1%). In 2023-2024, the prevalence was 2.1 times higher in Maine (26.6%) than in Nevada (12.9%). The prevalence of physical activity also significantly varied by race/ethnicity, gender, caregiver educational attainment and special health care needs status. For more information, view [physical activity data for children](#) on the *America's Health Rankings* website.

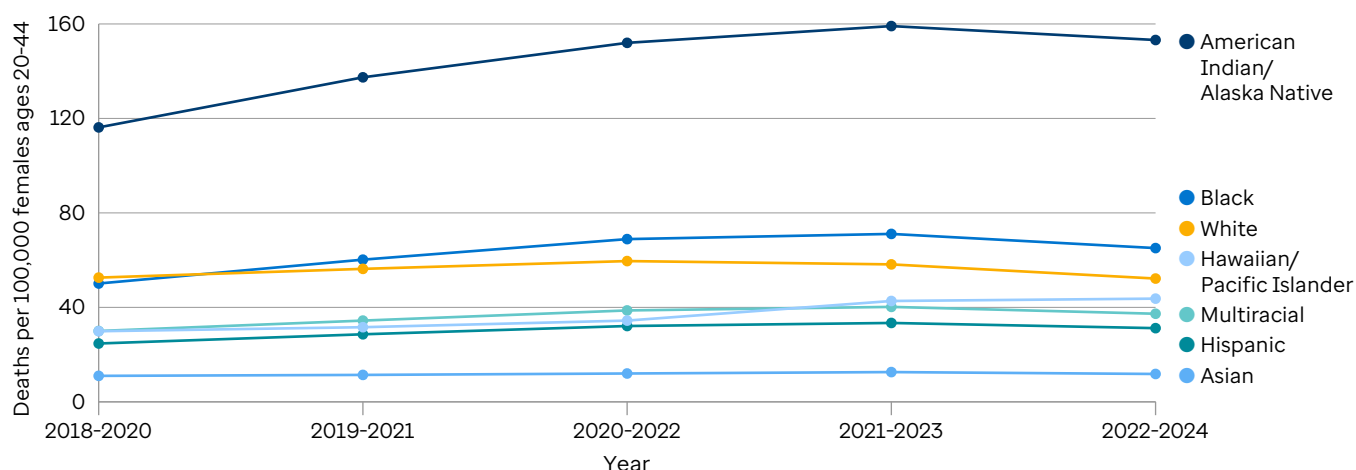
Overweight or Obesity Among Children

Nationally, the prevalence of overweight or obesity – the percentage of children ages 6-17 who have overweight or obesity for their age based on reported height and weight – remained unchanged between 2016-2017 (32.3%) and 2023-2024 (31.3%). In 2023-2024, 14.7 million children were overweight or obese.

In 2023-2024, the prevalence of overweight or obesity among children ages 6-17 was 1.8 times higher in Mississippi (41.8%) than in Colorado (23.1%). The prevalence of overweight or obesity also significantly varied by race/ethnicity, caregiver's educational attainment, special health care needs status and gender. For more information, view [overweight or obesity data for children](#) on the *America's Health Rankings* website.

Injury Deaths Among Women

By Race/Ethnicity



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2018-2024.

Note: Race groupings are all non-Hispanic.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

Injury Deaths Among Women

According to *America's Health Rankings* analysis of CDC data, between 2022 and 2024, the [leading causes of injury deaths among women](#) ages 20-44 were unintentional poisoning, unintentional motor vehicle traffic incidents, homicide by firearm and suicide by firearm.³ [Unintentional injuries have been the leading cause of death](#) among women between the ages of 20 and 44 for the past decade (2014-2024).³

Changes over the last decade. Nationally, the injury death rate – the number of deaths due to injury per 100,000 females ages 20-44 – increased 47%, from 31.9 to 47.0 between 2012-2014 and 2022-2024. In the most recent period of 2022-2024, the rate decreased 2% (from 48.1 in 2019-2021). In 2022-2024, there were approximately 78,300 injury deaths among women of reproductive age in the U.S., nearly 28,000 more deaths than in 2012-2014.

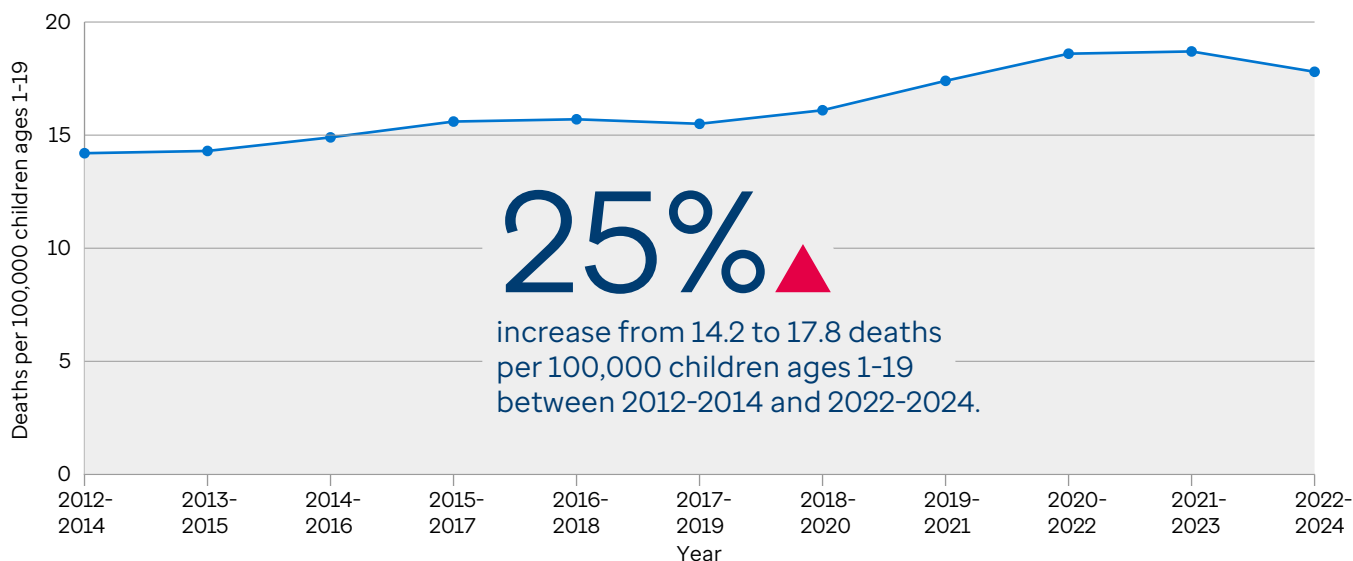
In the decade between 2012-2014 and 2022-2024, injury deaths among women significantly decreased in one state: 17% in Utah (42.2 to 35.2 deaths per 100,000 females ages

20-44). During the same period, the rate significantly increased in 44 states and the District of Columbia. The largest increases were 106% in Alaska (54.1 to 111.7), 103% in the District of Columbia (17.8 to 36.1), 84% in Maine (33.3 to 61.2) and 81% in both Delaware (37.4 to 67.7) and North Dakota (28.0 to 50.7).

Recent differences. The injury death rate significantly varied by race/ethnicity, geography and age. In 2022-2024, the rate among women ages 20-44 was:

- 13.0 times higher among American Indian/Alaska Native (153.2 deaths per 100,000 women ages 20-44) compared with Asian (11.8) women.
- 3.8 times higher in Alaska (111.7) than in New Jersey (29.4).
- 1.7 times higher among women ages 35-44 (54.9) than women ages 20-24 (33.2).

Injury Deaths Among Children



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2012-2024.

Injury Deaths Among Children

Injury death, including accidents or unintentional injuries, homicide and suicide, has been the [leading cause of death](#) among children ages 1-19 in the U.S. for the last decade, according to *America's Health Rankings* analysis of CDC data.³ Unintentional motor vehicle accidents remained the [leading cause of injury death](#) for children ages 1-19 from 2014 to 2024, followed by homicide by firearm.³ Other prevalent causes of injury death throughout the decade include suicide and unintentional drowning.

Changes over the last decade. Nationally, the injury death rate – the number of deaths due to injury per 100,000 children ages 1-19 – increased 25% from 14.2 to 17.8 between 2012-2014 and 2022-2024. In 2022-2024, there were approximately 41,600 injury deaths among children in the U.S., nearly 8,200 more deaths than in 2012-2014.

In the decade between 2012-2014 and 2022-2024, injury deaths among children significantly increased in 26 states and the District of Columbia. The largest increases were

134% in the District of Columbia (14.1 to 33.0 deaths per 100,000 children ages 1-19), 53% in New Mexico (20.0 to 30.6), 49% in Tennessee (17.4 to 26.0) and 48% in both Mississippi (23.6 to 34.9) and Colorado (14.9 to 22.0).

Recent differences. The injury death rate significantly varied by age, race/ethnicity, geography and gender. In 2022-2024, the rate was:

- 6.6 times higher among children ages 15-19 (43.2 deaths per 100,000 children ages 1-19) compared with children ages 5-14 (6.5).
- 6.2 times higher among American Indian/Alaska Native (43.5) than Asian (7.0) children.
- 4.4 times higher in Mississippi (34.9) than in Rhode Island (7.9).
- 2.4 times higher among boys (25.0) compared with girls (10.3).



Child Mortality

18%▲

increase from 24.3 to 28.7 deaths per 100,000 children ages 1-19 between 2012-2014 and 2022-2024.

Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2012-2024.

Related Measures: Child Mortality

Nationally, the child mortality rate – the number of deaths per 100,000 children ages 1-19 – increased 18% from 24.3 to 28.7 deaths per 100,000 children ages 1-19 between 2012-2014 and 2022-2024. The current rate exceeds the [Healthy People 2030 target of 18.4 deaths among children and adolescents ages 1-19 per 100,000 population](#).³⁵

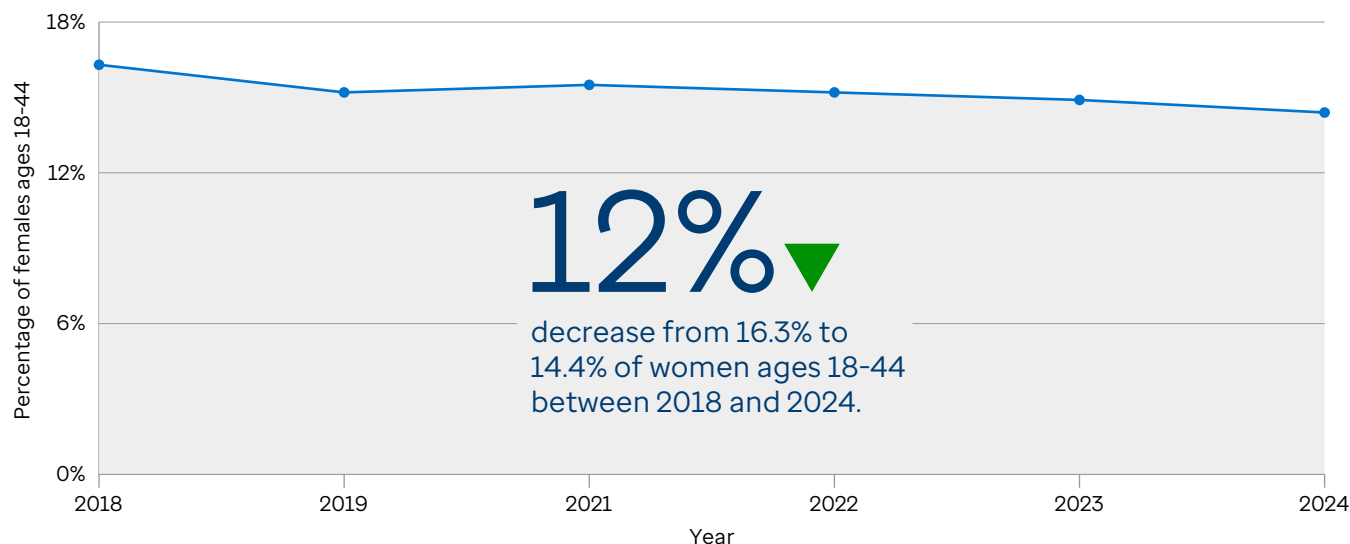
In 2022-2024, 67,000 children died, 10,000 more deaths than in 2012-2014. In the decade between 2012-2014 and 2022-2024, the child mortality rate significantly increased in 27 states and the District of Columbia. The largest increases were 67% in the District of Columbia (26.3 to 43.8 deaths per 100,000 children ages 1-19), 36% in both North Carolina (25.8 to 35.1) and Mississippi (36.7 to 49.9), and 33% in New Mexico (30.8 to 41.1). In 2022-2024, the child mortality rate was 3.0 times higher in Mississippi (49.9) than in Massachusetts (16.6). The child mortality rate also significantly varied by race/ethnicity, age and gender. For more information, view [child mortality data](#) on the *America's Health Rankings* website.

Firearm Deaths Among Children

Nationally, the firearm death rate – the number of deaths among children ages 1-19 due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population – increased 67% from 3.3 to 5.5 between 2012-2014 and 2022-2024. In 2022-2024, nearly 13,000 children died due to firearm injury, 5,000 more than in 2012-2014.

During the same time period, the firearm death rate significantly increased in 26 states and the District of Columbia. The largest increases were 267% in the District of Columbia (5.8 to 21.3 deaths per 100,000 children ages 1-19), 198% in Mississippi (4.9 to 14.6), 189% in New Mexico (3.8 to 11.0) and 147% in Georgia (3.6 to 8.9). In 2022-2024, the firearm death rate among children ages 1-19 was 14.2 times higher in the District of Columbia (21.3) and 9.7 times higher in Mississippi (14.6) than in Massachusetts (1.5). The firearm death rate also significantly varied by age and race/ethnicity. For more information, view [child firearm deaths data](#) on the *America's Health Rankings* website.

Poverty Among Women



Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2018-2024.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Poverty Among Women

Poverty is associated with many [adverse health outcomes](#).³⁴ Women with household incomes below the federal poverty level frequently face barriers to affording [essential needs](#) such as stable housing, health insurance and food.³⁵

Changes over time. Nationally, the poverty rate – the percentage of women ages 18-44 who live below the poverty level – decreased 12% from 16.3% to 14.4% between 2018 and 2024. Despite this improvement, the rate remains higher than the [Healthy People 2030 goal to reduce the proportion of people living in poverty to 8.0%](#).³⁶ In 2024, 8.5 million women were living below the poverty level, a decrease of 660,000 women compared with 2018.

Between 2018 and 2024, the poverty rate significantly decreased in 24 states. The largest decreases were 34% in Montana (17.1% to 11.3%), 26% in New Mexico (23.9% to 17.6%) and 20% in Arizona (16.8% to 13.4%).

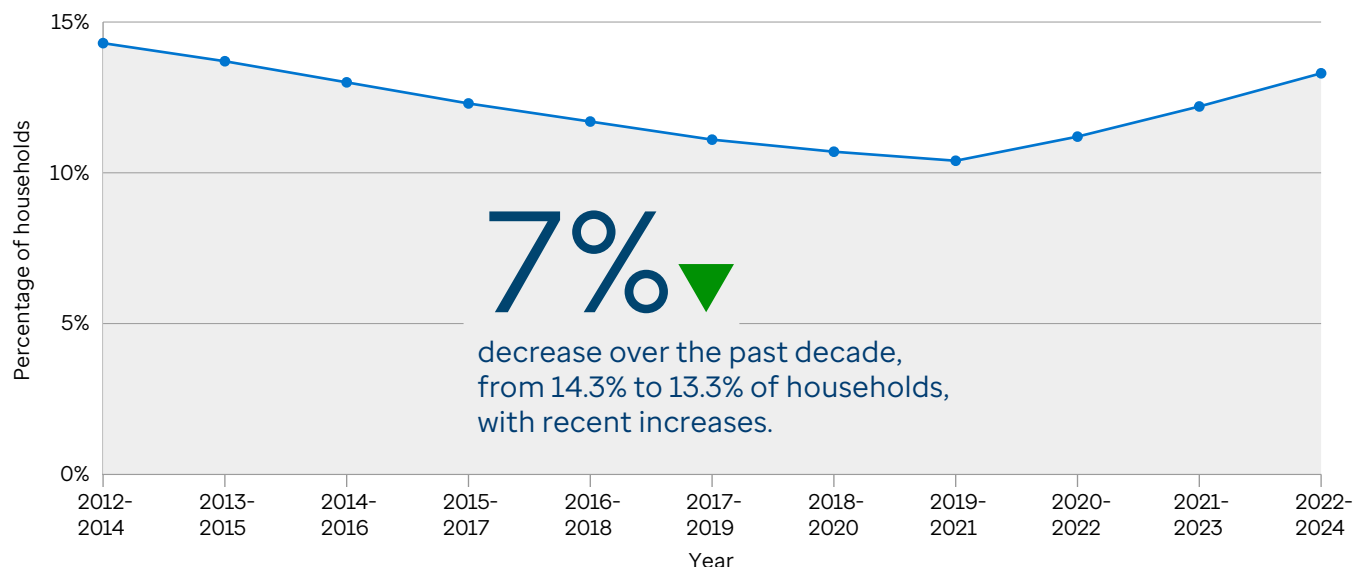
Between 2019 and 2024, poverty decreased 19% among American Indian/Alaska Native (25.3% to 20.5%), 6% among white (12.4% to 11.6%), 5% among Black (22.1% to 21.1%) and 4% among Hispanic (18.7% to 17.9%) women.

Recent differences. The poverty rate significantly varied by geography and race/ethnicity. In 2024, the prevalence among women ages 18-44 was:

- 2.4 times higher in Mississippi (22.2%) than in New Hampshire (9.1%).
- 2.0 times higher among Black (21.1%) compared with Asian (10.6%) women.

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [poverty data for women](#) on the America's Health Rankings website.

Food Insecurity



Source: USDA, Household Food Security in the United States Report Series, 2012-2024.

Related Measure: Food Insecurity

Nationally, the prevalence of food insecurity – the percentage of households unable to provide adequate food for one or more household members due to lack of resources – decreased 7% from 14.3% to 13.3% in the 10 years between 2012-2014 and 2022-2024, but increased 28% between 2019-2021 and 2022-2024 (from 10.4%). Despite the improvement, the prevalence remains higher than the [Healthy People 2030 target to reduce household food insecurity and hunger to 6.0% of households](#).³⁷ Reducing household food insecurity and hunger is a Healthy People 2030 [Leading Health Indicator](#).⁵

In the decade between 2012-2014 and 2022-2024, the prevalence of food insecurity decreased in two states: 29% in North Carolina (16.7% to 11.8% of households) and 21% in Mississippi (22.0% to 17.3%). In 2022-2024, the prevalence of food-insecure households was 2.2 times higher in Arkansas (19.4%) than in North Dakota (9.0%).

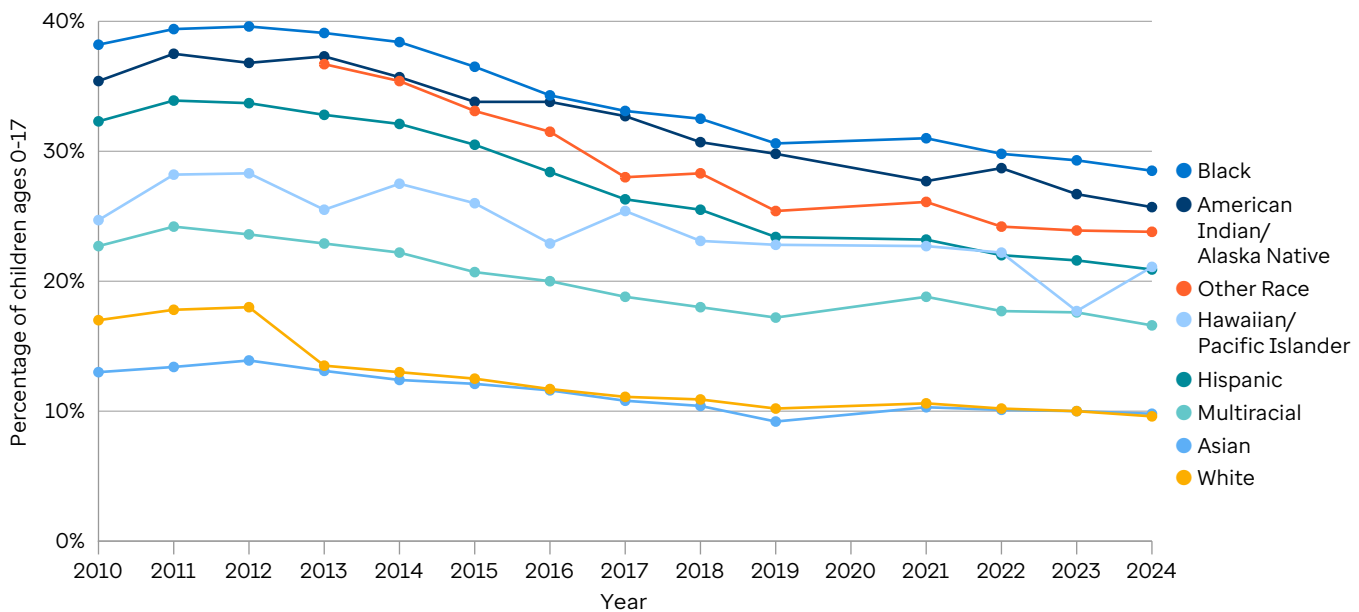


Traci Causey, PhD, MBA, MCHES
CEO of the Alliance for a Healthier Generation

“When health care providers, schools, families and communities reinforce one another, guidance can become action, and consistent healthy behaviors can become part of children’s everyday lives and help them thrive as they grow up.”

Children in Poverty

By Race/Ethnicity



Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2010-2024.
Note: Data are presented as Hispanic-inclusive, except for white, which is non-Hispanic.

Children in Poverty

Living and growing up in poverty can have [negative effects](#) on the physical health, development and [educational achievement](#) of children.^{38,39} Children who come from low-income families or neighborhoods are [more likely](#) to have health problems such as low birth weight and asthma.⁴⁰

Changes over the last decade. Nationally, the rate of children in poverty – the percentage of children ages 0-17 living in households below the poverty threshold – decreased 29% from 21.7% to 15.5% between 2014 and 2024. The prevalence of children in poverty peaked in 2012 at 22.6%, followed by a 31% decrease between 2012 and 2024.

In the decade between 2014 and 2024, the rate of children in poverty decreased 35% among Hispanic (32.1% to 20.9%), 33% among other race (35.4% to 23.8%), 28% among American Indian/Alaska Native (35.7% to 25.7%), 26% among Black (38.4% to 28.5%), 26% among white (13.0% to 9.6%), 25% among multiracial (22.2% to 16.6%) and 21% among Asian (12.4% to 9.8%) children.

During the same time period, the rate of children in poverty decreased in 43 states. The largest decreases were 49% in New Hampshire (13.0% to 6.6%), 43% in Arizona (25.6% to 14.6%) and 42% in Vermont (15.8% to 9.1%).

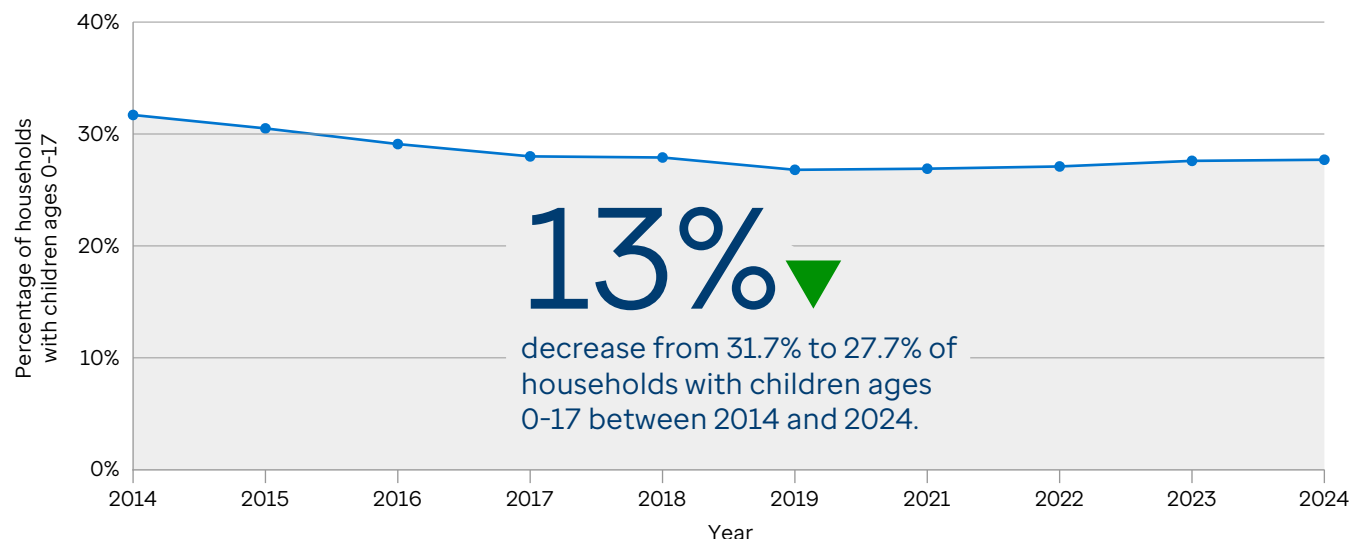
Recent differences. The children in poverty rate significantly varied by geography and race/ethnicity. In 2024, the prevalence among children was:

- 4.3 times higher in the District of Columbia (28.3%) and 3.8 times higher in Louisiana and Mississippi (both 25.2%) than in New Hampshire (6.6%).
- 3.0 times higher among Black (28.5%) compared with white (9.6%) children.

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [poverty data for children](#) on the America's Health Rankings website.

Housing Cost Burden

Among Households With Children



Source: U.S. Census Bureau, American Community Survey PUMS, 2014-2024.

Related Measures: Children in Poverty Racial Disparity

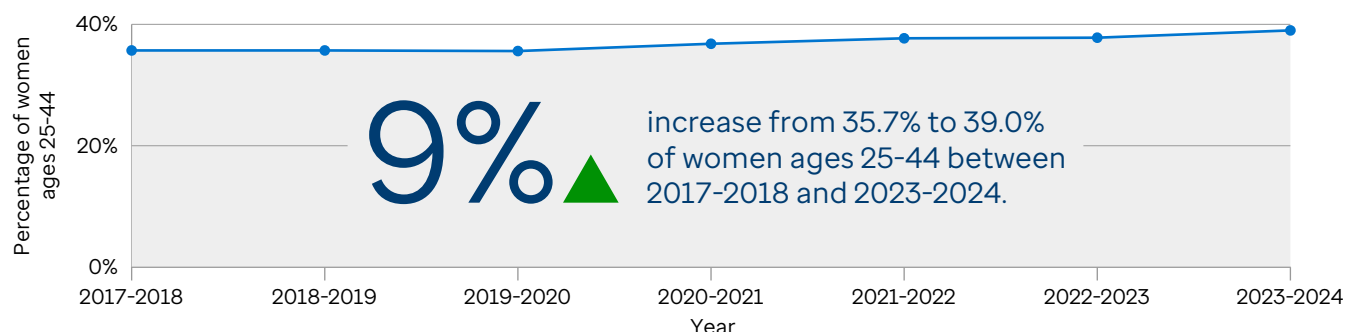
Nationally, the racial disparity among children in poverty – the ratio of the childhood poverty rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate – did not change between 2015-2019 (33.2% of Black children versus 11.1% of white children) and 2022-2024 (29.9% of Black children versus 9.9% of white children) and remains 3.0.

Housing Cost Burden

Nationally, housing cost burden – the percentage of households with one or more children ages 0-17 with housing costs more than 30% of household income – decreased 13% from 31.7% to 27.7% in the 10 years between 2014 and 2024. However, the percentage of cost burdened households with children increased 3% since 2019 (from 26.8%). In 2024, nearly 10.0 million households with children were cost burdened, a decrease of over 1.2 million households compared with 2014.

In the decade between 2014 and 2024, housing cost burden decreased in 29 states. The largest decreases were 39% in Maine (32.9% of households with children ages 0-17 to 20.1%), 39% in Vermont (30.8% to 18.8%) and 27% in Wisconsin (27.4% to 20.0%). In 2024, housing cost burden was 2.2 times higher in Hawaii (38.8%) than in West Virginia (18.0%).

College Graduation Among Women



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2017-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

SOCIAL AND ECONOMIC FACTORS | EDUCATION

College Graduation Among Women

Income differences between those with a college degree and those with only a high school diploma in the U.S. have remained prevalent for decades, [persisting into 2025](#).⁴¹ Women with a bachelor's degree earn a median of [\\$2.4 million](#) over their lifetime compared with \$1.3 million for high school graduates.⁴²

Changes over time. Nationally, the rate of college graduates – the percentage of women ages 25-44 who have graduated from a college or technical school – increased 9% from 35.7% to 39.0% between 2017-2018 and 2023-2024. In 2023-2024, 16.6 million women were college graduates, an increase of nearly 1.5 million women compared with 2017-2018.

Between 2017-2018 and 2023-2024, women college graduates ages 25-44 significantly increased:

- 26% among Hispanic (16.9% to 21.3%), 15% among Black (29.1% to 33.4%) and 9% among white (41.5% to 45.4%) women.
- 10% among women ages 25-34 (33.9% to 37.2%) and 8% among women ages 35-44 (37.6% to 40.6%).

During the same time period, the rate of women college graduates significantly decreased 20% among those with an annual household income of \$25,000 to \$49,999 (24.6% to 19.7%) and 9% among those with an income of \$50,000 to \$74,999 (43.3% to 39.4%).

Between 2017-2018 and 2023-2024, the rate of women college graduates ages 25-44 increased in 12 states and the District of Columbia. The largest increases were 30% in Idaho (27.2% to 35.4%), 23% in Arizona (28.3% to 34.8%) and 22% in both New Hampshire (37.8% to 46.1%) and the District of Columbia (61.3% to 75.0%).

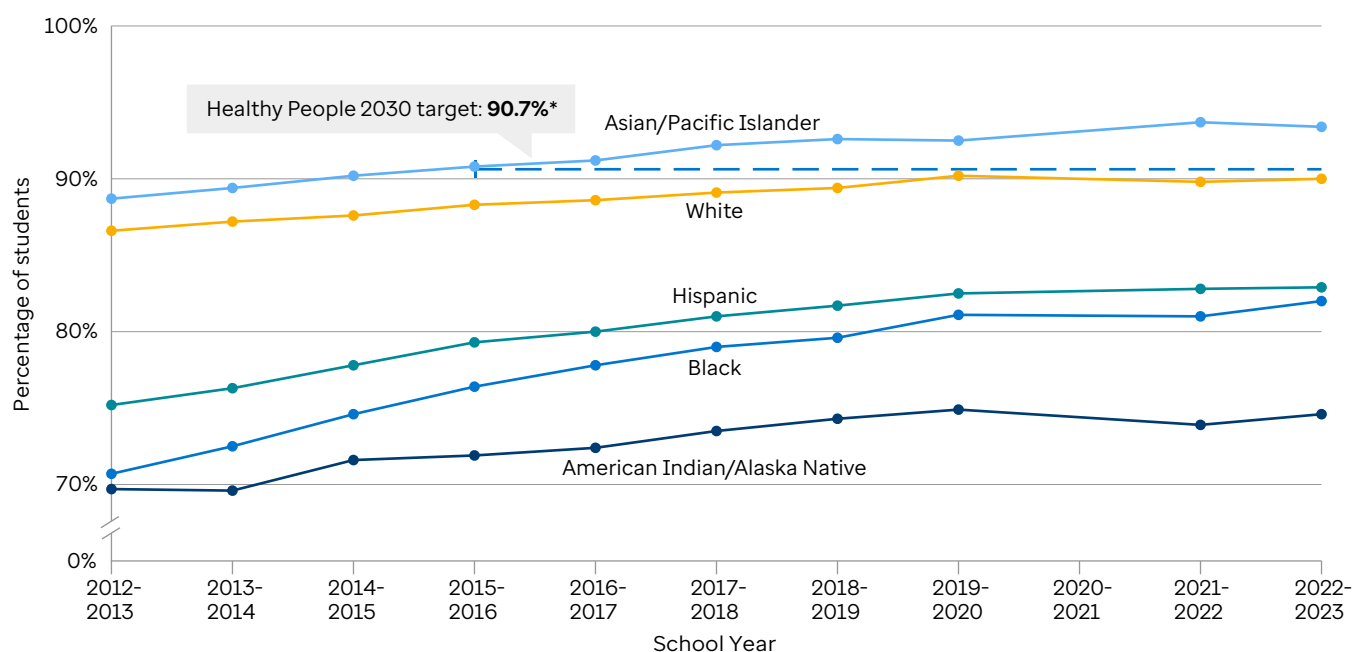
Recent differences. The rate of women college graduates significantly varied by income, race/ethnicity, disability status, geography, metropolitan status, age and sexual orientation. In 2023-2024, the percentage among women ages 25-44 was:

- 7.3 times higher among women with an annual household income of \$150,000 or more (77.1%) compared with women with an income less than \$25,000 (10.6%).
- 3.3 times higher among Asian (70.5%) compared with Hispanic (21.3%) women.
- 2.8 times higher among women without a disability (44.5%) compared with women who have difficulty with mobility (16.1%).
- 2.8 times higher in the District of Columbia (75.0%) and 2.1 times higher in Massachusetts (55.5%) than in West Virginia (26.5%).
- 1.6 times higher among women living in metropolitan areas (40.9%) compared with women in nonmetropolitan areas (25.8%).
- 1.1 times higher among women ages 35-44 (40.6%) compared with women ages 25-34 (37.2%).
- 1.1 times higher among straight women (39.0%) than LGBTQ+ women (36.1%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain disability and race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [college graduate data for women](#) on the *America's Health Rankings* website.

High School Graduation

By Race/Ethnicity



Source: U.S. ED, National Center for Education Statistics, EDData, 2012-2013 School Year-2022-2023 School Year.

Note: Race groupings are all non-Hispanic.

*Source: Healthy People 2030. The Healthy People 2030 target specifically applies to the baseline year of 2015-2016 and onward.

High School Graduation

The connection between education and health is [well-documented](#).⁴³ Higher educational attainment is associated with [higher earnings](#), [increased health literacy](#) and [higher life expectancy](#).⁴⁴⁻⁴⁶ Individuals with lower educational attainment are at greater risk of [adverse health outcomes](#) such as [cardiovascular disease](#).^{47,48}

Changes over the last decade. Nationally, the high school graduation rate – the percentage of students graduating with a regular high school diploma within four years of starting ninth grade – increased 7% from 81.4% to 86.7% between the 2012-2013 and 2022-2023 school years. The current rate still falls short of the [Healthy People 2030 target to increase the proportion of high school students who graduate in four years to 90.7%](#).⁴⁹

In the decade between the 2012-2013 and 2022-2023 school years, the rate of high school graduation increased 16% among Black (70.7% to 82.0%), 10% among Hispanic (75.2% to 82.9%), 7% among American Indian/Alaska Native

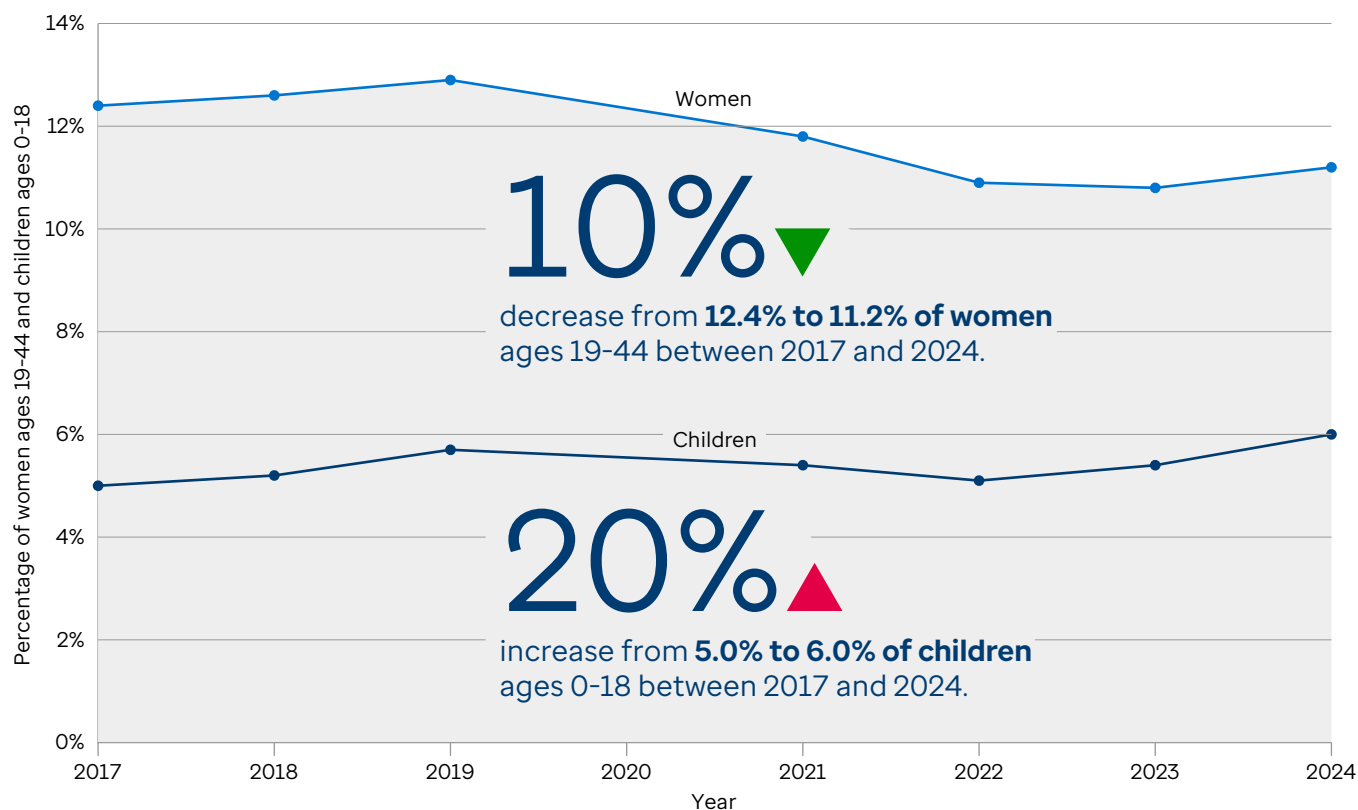
(69.7% to 74.6%), 5% among Asian/Pacific Islander (88.7% to 93.4%) and 4% among white (86.6% to 90.0%) students.

During the same time period, the rate of high school graduation increased 7% or more in 16 states and the District of Columbia. The largest increases were 23% in the District of Columbia (62.3% to 76.5%) and 18% in Oregon (68.7% to 81.3%), Mississippi (75.5% to 89.4%) and Georgia (71.7% to 84.4%).

Recent differences. The high school graduation rate varied by race/ethnicity and geography. In the 2022-2023 school year, the rate was:

- 1.3 times higher among Asian/Pacific Islander (93.4% of students) compared with American Indian/Alaska Native (74.6%) students.
- 1.2 times higher in West Virginia (92.6%) than in the District of Columbia (76.5%) and New Mexico (76.5%).

Uninsured Women and Children



Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2017-2024.

CLINICAL CARE | ACCESS TO CARE

Uninsured Women

[Health insurance](#) is crucial for ensuring women receive the preventive and acute medical care they need to achieve and maintain good health.⁵⁰ Coverage also offers [financial protection](#) against high medical expenses.⁵¹

Changes over time. Nationally, the uninsured rate – the percentage of women ages 19-44 not covered by private or public health insurance – decreased 10% from 12.4% to 11.2% between 2017 and 2024. However, the rate of uninsured women increased 4% in 2024 (from 10.8% in 2023). In 2024, 6.5 million women were uninsured, a decrease of 300,000 women compared with 2017.

Between 2017 and 2024, the uninsured rate among women increased in five states and decreased in 17 states. The largest increases were 31% in Minnesota (5.4% to 7.1%), 28% in Connecticut (7.1% to 9.1%) and 22% in Arkansas (11.6% to 14.2%). The largest decreases were 34% in Maine (12.0% to 7.9%), 30% in Idaho (16.8% to 11.8%) and 29% in Oregon (9.4% to 6.7%).

Recent differences. In 2024, the rate among women ages 19-44 was 6.7 times higher in Texas (22.7%) than in Massachusetts (3.4%).

Related Measure: Avoided Care Due to Cost Among Women

Nationally, the prevalence of avoided care due to cost – 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 27% from 14.6% to 18.5% between 2021 and 2023-2024. In 2023-2024, 10.7 million women ages 18-44 avoided medical care due to cost.

Between 2021 and 2023-2024, the prevalence of avoiding care due to cost among women ages 18-44 significantly increased in 12 states. The largest increases were 69% in New Jersey (11.7% to 19.8%), 60% in Montana (12.3% to 19.7%) and 57% in Nevada (16.1% to 25.2%). In 2023-2024, the prevalence was 2.9 times higher in Texas (26.7%) than in Hawaii (9.2%). The prevalence of avoiding care due to cost also significantly varied by income, disability status, race/ethnicity, education, sexual orientation, veteran status and age. For more information, view [avoided care due to cost data for women](#) on the America's Health Rankings website.

Uninsured Children

Health insurance is critical for ensuring that children receive the medical care they need to achieve and [maintain good health](#).⁵² Children with [health insurance coverage](#) are more likely to have a usual source of care and less likely to delay or forgo necessary medical care because of cost.⁵³

Changes over time. Nationally, the uninsured rate – the percentage of children younger than 19 years not covered by private or public health insurance – increased 20% from 5.0% to 6.0% between 2017 and 2024. Notably, 11% of this increase occurred during the most recent period, between 2023 (5.4%) and 2024. In 2024, 4.6 million children were uninsured, an increase of more than 700,000 children compared with 2017.

Between 2017 and 2024, the uninsured rate among children increased in 15 states. The largest increases were 76% in Idaho (4.6% to 8.1%), 75% in Arkansas (4.4% to 7.7%) and 50% in Washington (2.6% to 3.9%).

Recent differences. In 2024, the uninsured rate among children was 6.5 times higher in Texas (13.6%) than in Massachusetts (2.1%).



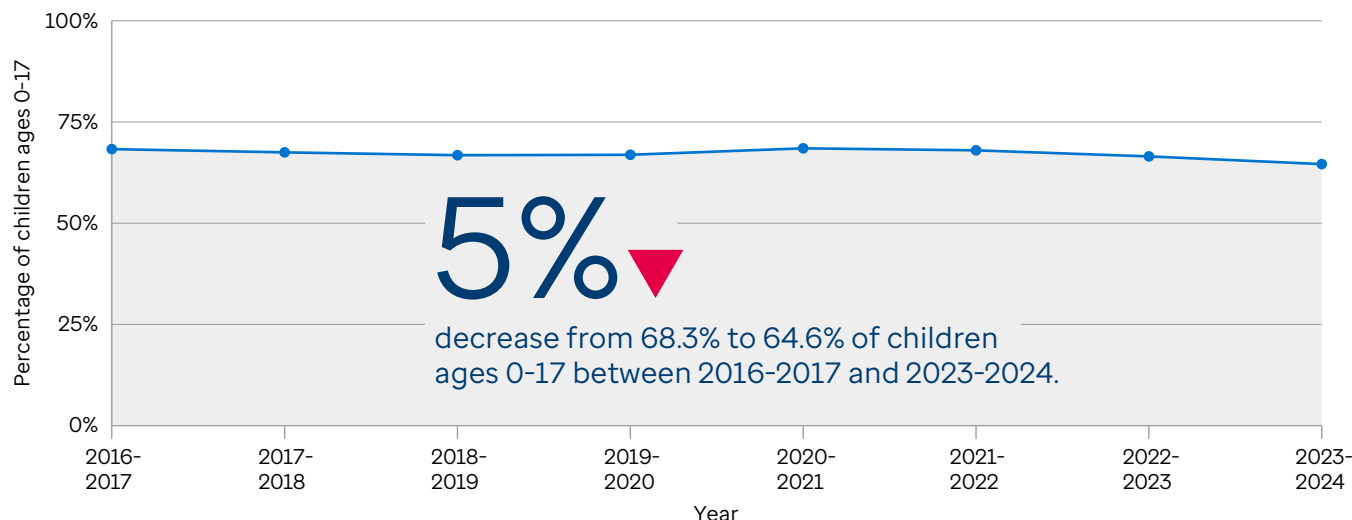
Avoided Care Due to Cost

27%▲

increase from 14.6% to 18.5%
of women ages 18-44 between
2021 and 2023-2024.

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2021-2024.

Adequate Insurance Among Children



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

CLINICAL CARE | QUALITY OF CARE

Adequate Insurance Among Children

Nearly [one-third of children](#) in the United States are underinsured – meaning their health insurance does not adequately cover a sufficient portion of their care or health expenses.⁵² Compared with adequately insured children, those who are underinsured have more [health care disadvantages](#), including delayed or forgone care, lack of a personal doctor and difficulty obtaining needed specialist care.⁵²

Changes over time. Nationally, the prevalence of adequate insurance – the 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 – decreased 5% from 68.3% to 64.6% between 2016-2017 and 2023-2024. In 2023-2024, 46.3 million children had adequate insurance, a decrease of 3.5 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of adequate insurance among children ages 0-17 significantly decreased:

- 9% among Asian (69.6% to 63.6%) and 7% among white (67.8% to 63.2%) children.
- 6% among girls (68.5% to 64.7%) and 5% among boys (68.2% to 64.6%).
- 6% among children with a caregiver who graduated from college (67.9% to 63.6%).

- 6% among children with special health care needs (63.4% to 59.8%) and 5% among children without special health care needs (70.0% to 66.4%).

During the same time period, the prevalence of adequate insurance significantly decreased in eight states and the District of Columbia. The largest decreases were 14% in the District of Columbia (77.2% to 66.6%), 12% in both Idaho (70.5% to 62.1%) and Pennsylvania (72.2% to 63.7%), and 11% in both Indiana (68.7% to 61.0%) and Nebraska (65.1% to 58.2%).

Recent differences. The prevalence of adequate insurance significantly varied by geography, special health care needs status and caregiver educational attainment. In 2023-2024, the prevalence among children ages 0-17 was:

- 1.4 times higher in Hawaii (78.7%) than in Texas (56.7%).
- 1.1 times higher among children without special health care needs (66.4%) compared with children with special health care needs (59.8%).
- 1.1 times higher among children with a caregiver who graduated from high school (68.6%) compared with children whose caregivers have less than a high school education (61.2%).

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain educational attainment groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [adequate insurance data for children](#) on the America's Health Rankings website.



Medical Home Among Children

6% ▼

decrease from 48.5% to 45.5%
of children ages 0-17 between
2016-2017 and 2023-2024.

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

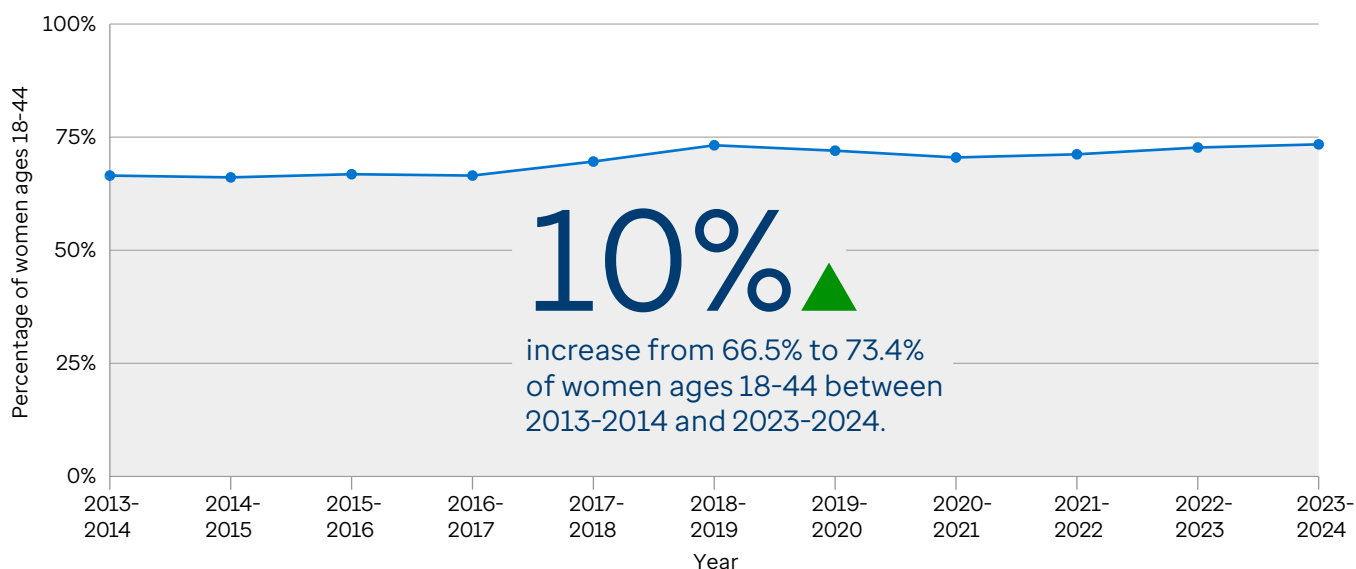
Definition: The percentage of children ages 0-17 who received coordinated, ongoing and comprehensive medical care from a usual, nonemergency source where they had a personal doctor or nurse and access to family-centered care, referrals when needed, and effective care coordination.

Related Measure: Medical Home Among Children

Nationally, medical home – the 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 – decreased 6% from 48.5% to 45.5% between 2016-2017 and 2023-2024. This falls short of the [Healthy People 2030 target to increase the proportion of children and adolescents who receive care in a medical home to 53.5%](#).⁵⁴ In 2023-2024, 32.8 million children ages 0-17 had a medical home, a decrease of 2.6 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of medical home care among children ages 0-17 significantly decreased in four states: 19% in Maryland (56.2% to 45.7%), 18% in Connecticut (56.1% to 46.2%), 16% in Massachusetts (58.7% to 49.2%) and 15% in Washington (52.6% to 44.6%). In 2023-2024, the prevalence among children ages 0-17 was 1.6 times higher in Vermont (57.8%) than in Nevada (35.6%). The prevalence of medical home care also significantly varied across race/ethnicity, education and children with special health care needs. For more information, view [medical home data for children](#) on the *America's Health Rankings* website.

Well-Woman Visit



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

CLINICAL CARE | PREVENTIVE CLINICAL SERVICES

Well-Woman Visit

[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.^{55,56}

Well-woman visits also provide an opportunity to [discuss strategies](#) for minimizing health risks and achieving a healthy lifestyle.⁵⁷

Changes over the last decade. Nationally, well-woman visits – the percentage of women ages 18-44 with a preventive medical visit in the past year – increased 10% from 66.5% to 73.4% between 2013-2014 and 2023-2024. In 2023-2024, 42.0 million women reported having a preventive medical visit in the past year, an increase of nearly 5.5 million women compared with 2013-2014.

In the decade between 2013-2014 and 2023-2024, well-woman visits significantly increased:

- 16% among women with an annual household income less than \$25,000 (61.4% to 71.1%) and 9% among women with an income of \$25,000 to \$49,999 (65.1% to 71.0%).

- 16% among Asian (64.6% to 74.7%), 12% among white (64.9% to 72.6%), 11% among Hispanic (64.0% to 70.9%) and 5% among Black (77.6% to 81.5%) women.
- 12% among women ages 25-34 (64.5% to 72.5%), 10% among women ages 35-44 (68.8% to 75.9%) and 7% among women ages 18-24 (66.0% to 70.9%).
- 12% among college graduates (69.8% to 78.2%), 11% among women with some post-high school education (67.1% to 74.3%), 10% among high school graduates (65.4% to 71.7%) and 9% among women with less than a high school education (59.9% to 65.4%).

During the same time period, the prevalence significantly increased in 34 states. The largest increases were 36% in Idaho (53.3% to 72.5%), 32% in Indiana (58.9% to 77.7%) and 28% in Alaska (55.0% to 70.4%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity, age, disability and income groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [well-woman visit data](#) on the *America's Health Rankings* website.

Recent differences. The prevalence of well-woman visits significantly varied by educational attainment, race/ethnicity, age, disability status, income, sexual orientation and veteran status. In 2023-2024, the prevalence among women ages 18-44 was:

- 1.2 times higher among college graduates (78.2%) compared with women with less than a high school education (65.4%).
- 1.2 times higher among Black (81.5%) compared with Hawaiian/Pacific Islander (68.9%) women.
- 1.1 times higher among women ages 35-44 (75.9%) compared with women ages 18-24 (70.9%).
- 1.1 times higher among women with difficulty with mobility (76.6%) compared with women with independent living difficulty (67.1%).
- 1.1 times higher among women with an annual household income of \$150,000 or more (80.0%) compared with women with an income of \$25,000 to \$49,999 (71.0%).
- 1.1 times higher among straight women (74.7%) compared with LGBTQ+ women (70.4%).
- 1.1 times higher among women who have served in the U.S. armed forces (77.8%) compared with women who have not served (73.3%).

Related Measure: Flu Vaccination Among Women

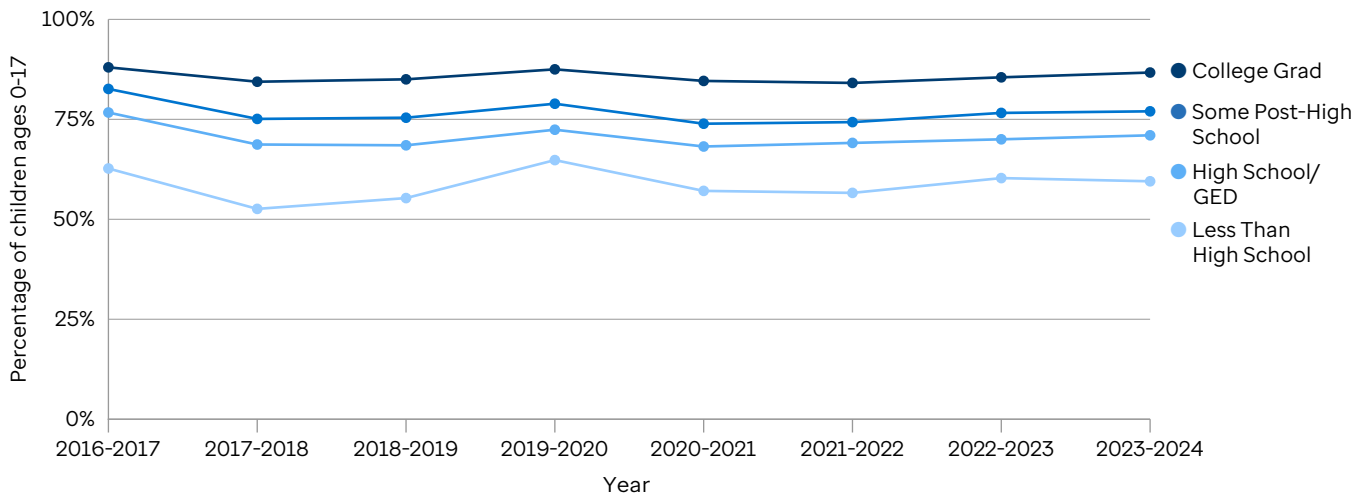
Nationally, the flu vaccination rate – the percentage of women ages 18-44 who reported receiving a seasonal flu vaccine in the past 12 months – increased 3% from 32.8% to 33.9% in the 10 years between 2013-2014 and 2023-2024. However, flu vaccinations decreased 7% (from 36.4% to 33.9%) between 2021-2022 and 2023-2024. In 2023-2024, nearly 17.6 million women reported receiving the flu vaccine, an increase of 1.0 million women compared with 2013-2014.

In the decade between 2013-2014 and 2023-2024, the flu vaccination rate among women ages 18-44 significantly increased in seven states and the District of Columbia, while decreasing in eight states. The largest increases were 52% in the District of Columbia (35.5% to 53.8% of women ages 18-44), 28% in New Jersey (30.2% to 38.6%) and 26% in both Vermont (38.5% to 48.5%) and California (30.4% to 38.4%). The largest decreases were 25% in Tennessee (35.1% to 26.5%), 22% in Oklahoma (35.7% to 27.8%) and 21% in Arkansas (36.2% to 28.7%). In 2023-2024, the rate among women ages 18-44 was 2.4 times higher in the District of Columbia (53.8%) and 2.3 times higher in Massachusetts (51.0%) than in Florida (22.1%). The flu vaccination rate also significantly varied by income, education, race/ethnicity, veteran status, disability status, metropolitan status, age and sexual orientation. For more information, view [flu vaccination data for women](#) on the *America's Health Rankings* website.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Well-Child Visit

By Caregiver's Educational Attainment



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

Well-Child Visit

The American Academy of Pediatrics [recommends](#) that all infants, toddlers and children receive routine preventive visits, known as well-child visits.⁵⁸ Some of the [benefits of well-child visits](#) include preventing illness through routine vaccinations, tracking growth and development and having opportunities to discuss parental concerns about child development, behavior, sleep and eating.⁵⁸

Changes over time. Nationally, the prevalence of well-child visits – the percentage of children ages 0-17 who received one or more preventive medical visits in the past 12 months – decreased 3% from 82.1% to 79.6% between 2016-2017 and 2023-2024. In 2023-2024, 57.1 million children received a well-child visit, a decrease of 2.6 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of well-child visits significantly decreased:

- 7% among children with a caregiver who graduated from high school (76.7% to 71.0% of children ages 0-17), 7% among children with a caregiver who has some post-high school education (82.6% to 77.0%) and 1% among children with a caregiver who graduated from college (88.0% to 86.7%).
- 6% among Black (82.3% to 77.4%) and 2% among white (85.4% to 83.6%) children.
- 4% among boys (82.3% to 79.3%).
- 4% among children without special health care needs (80.4% to 77.1%).

- 3% among children ages 0-2 (91.2% to 88.4%) and 3% among those ages 3-17 (80.3% to 78.1%).

During the same time period, the prevalence of well-child visits significantly decreased in three states: 9% in Delaware (87.1% to 79.2%), 8% in Rhode Island (88.9% to 82.2%) and 7% in New Jersey (88.7% to 82.3%).

Recent differences. The prevalence of well-child visits significantly varied by caregiver educational attainment, geography, race/ethnicity, special health care needs status and age. In 2023-2024, the prevalence among children was:

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

Note: Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [well-child visit data](#) on the America's Health Rankings website.

Related Measure: Pediatricians

Nationally, the number of pediatricians increased 18% from 100.1 to 118.2 per 100,000 children ages 0-21 between September 2019 and September 2025. In September 2025, there were nearly 110,000 pediatricians in the U.S.

Between September 2019 and September 2025, the number of pediatricians increased 18% or more in 33 states and the District of Columbia. The largest increases were 31% in Oklahoma (61.8 to 81.2 per 100,000 children ages 0-21), 29% in both Hawaii (113.2 to 146.3) and Arkansas (68.4 to 88.3), and 26% in Utah (69.2 to 87.3). In September 2025, the number of pediatricians was 4.4 times higher in Massachusetts (224.2) than in Idaho (51.3).



Pediatricians

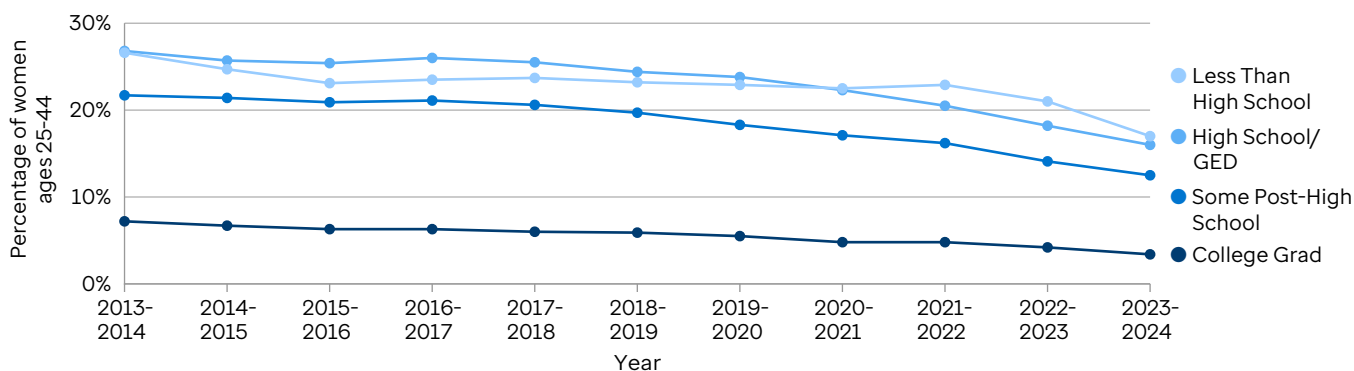
18%

increase from 100.1 to 118.2 providers
per 100,000 children ages 0-21 between
September 2019 and September 2025.

Source: U.S. HHS, CMS, National Plan and Provider Enumeration System,
September 2019-September 2025.

Cigarette Smoking Among Women

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2013-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

BEHAVIORS | SMOKING AND TOBACCO USE

Cigarette Smoking Among Women

As the [leading cause of preventable death](#) in the U.S., cigarette smoking is responsible for the deaths of more than 470,000 Americans every year, including 196,200 women.⁵⁹ Smoking affects [nearly every organ](#) and can cause cancer, heart disease, stroke, diabetes and respiratory conditions such as chronic obstructive pulmonary disease (COPD).⁶⁰

Changes over the last decade. Nationally, the prevalence of cigarette smoking – the percentage of women ages 18-44 who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days – decreased 52% from 17.4% to 8.4% between 2013-2014 and 2023-2024. The current rate remains above the [Healthy People 2030 target to reduce current cigarette smoking in adults to 6.1%](#).⁶¹ Reducing current cigarette smoking in adults is a Healthy People 2030 [Leading Health Indicator](#).⁵ In 2023-2024, nearly 4.5 million women reported smoking, a decrease of 4.8 million women compared with 2013-2014.

In the decade between 2013-2014 and 2023-2024, cigarette smoking significantly decreased:

- 74% among women ages 18-24 (14.4% to 3.7%), 60% among women ages 25-34 (19.7% to 7.9%) and 28% among women ages 35-44 (17.3% to 12.4%).
- 53% among white (21.9% to 10.4%), 52% among Asian (4.8% to 2.3%), 48% among Black (15.7% to 8.1%), 44% among American Indian/Alaska Native (33.1% to 18.7%) and 42% among Hispanic (8.8% to 5.1%) women.

- 53% among college graduates (7.2% to 3.4%), 42% among women with some post-high school education (21.7% to 12.5%), 40% among high school graduates (26.8% to 16.0%) and 36% among women with less than a high school education (26.6% to 17.0%).
- 33% among women with an annual household income less than \$25,000 (28.4% to 18.9%), 32% among women with an income of \$50,000 to \$74,999 (14.6% to 10.0%) and 29% among women with an income of \$25,000 to \$49,999 (19.9% to 14.1%).

During the same time period, the prevalence significantly decreased in 49 states and the District of Columbia. The largest decreases were 69% in the District of Columbia (14.0% to 4.3%), 65% in Connecticut (15.6% to 5.5%) and 64% in Rhode Island (18.1% to 6.6%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity, education and disability groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [cigarette smoking data for women](#) on the America's Health Rankings website.



Household Smoke

34% ▾

decrease from 15.5% to 10.3%
of children ages 0-17 between
2016-2017 and 2023-2024.

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

Recent differences. The prevalence of cigarette smoking significantly varied by race/ethnicity, geography, income, educational attainment, disability status, age, metropolitan status and sexual orientation. In 2023-2024, the prevalence among women ages 18-44 was:

- 8.1 times higher among American Indian/Alaska Native (18.7%) compared with Asian (2.3%) women.
- 6.1 times higher in West Virginia (22.7%) than in Utah (3.7%).
- 5.9 times higher among women with an annual household income less than \$25,000 (18.9%) compared with women with an income of \$150,000 or more (3.2%).
- 5.0 times higher among women with less than a high school education (17.0%) compared with college graduates (3.4%).
- 3.9 times higher among women with difficulty with self-care (23.6%) compared with women without a disability (6.0%).
- 3.4 times higher among women ages 35-44 (12.4%) compared with women ages 18-24 (3.7%).
- 1.9 times higher among women living in nonmetropolitan areas (14.4%) compared with women in metropolitan areas (7.5%).
- 1.3 times higher among LGBTQ+ women (11.1%) compared with straight women (8.4%).

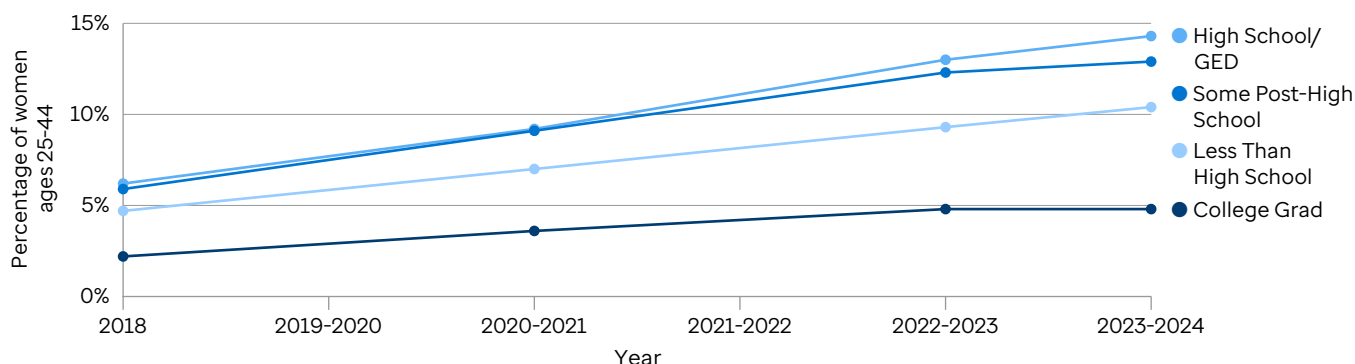
Related Measure: Household Smoke

Nationally, the prevalence of household smoke – the percentage of children ages 0-17 who live in households where someone uses cigarettes, cigars or pipe tobacco – decreased 34% from 15.5% to 10.3% between 2016-2017 and 2023-2024. In 2023-2024, 7.2 million children ages 0-17 lived in a household with smoke, a decrease of 3.9 million children compared with 2016-2017.

Between 2016-2017 and 2023-2024, the prevalence of household smoke among children ages 0-17 significantly decreased in 26 states. The largest decreases were 47% in California (11.0% to 5.8%), 46% in Colorado (14.3% to 7.7%) and 45% in Nebraska (18.4% to 10.2%). In 2023-2024, the prevalence was 4.7 times higher in West Virginia (21.9%) than in Utah (4.7%). The prevalence of household smoke also significantly varied by education, race/ethnicity and children with special health care needs. For more information, view [household smoke data for children](#) on the *America's Health Rankings* website.

E-Cigarette Use Among Women

By Educational Attainment



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2018-2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

E-Cigarette Use Among Women

Electronic cigarettes, also called [e-cigarettes](#), vapes or vape pens, are electronic devices that use heat to make an aerosol that the user inhales.⁶² The aerosol produced by e-cigarettes contains [toxic substances](#) that can cause cancer and serious lung disease.⁶²

Changes over time. Nationally, the prevalence of e-cigarette use – the 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 – increased 121% from 5.3% to 11.7% between 2018 and 2023-2024. In 2023-2024, 6.2 million women reported using e-cigarettes, an increase of nearly 4.1 million women compared with 2018.

Between 2018 and 2023-2024, e-cigarette use among women ages 18-44 significantly increased:

- 298% among Hawaiian/Pacific Islander (5.4% to 21.5%), 272% among Asian (1.8% to 6.7%), 143% among American Indian/Alaska Native (6.0% to 14.6%), 134% among Hispanic (3.2% to 7.5%), 131% among Black (3.5% to 8.1%), 116% among white (6.9% to 14.9%) and 97% among multiracial (9.5% to 18.7%) women.
- 205% among women with an annual household income of \$50,000 to \$74,999 (3.8% to 11.6%), 157% among women with an income of \$25,000 to \$49,999 (5.1%

to 13.1%) and 84% among women with an income less than \$25,000 (6.4% to 11.8%).

- 131% among high school graduates (6.2% to 14.3%), 121% among women with less than a high school education (4.7% to 10.4%), 119% among women with some post-high school education (5.9% to 12.9%) and 118% among college graduates (2.2% to 4.8%).
- 130% among women ages 25-34 (5.0% to 11.5%), 125% among women ages 18-24 (7.6% to 17.1%) and 100% among women ages 35-44 (4.0% to 8.0%).

During the same time period, the prevalence significantly increased in 48 states. The largest increases were 218% in Pennsylvania (3.9% to 12.4%), 216% in Louisiana (5.6% to 17.7%) and 209% in Kansas (4.7% to 14.5%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. Differences highlight the groups with the highest and lowest values. However, the values for certain race/ethnicity, educational attainment, disability and income groups may not differ significantly based on overlapping 95% confidence intervals. For more information, view [e-cigarette use data for women](#) on the America's Health Rankings website.

Recent differences. The prevalence of e-cigarette use significantly varied by race/ethnicity, educational attainment, disability status, geography, income, age, sexual orientation, metropolitan status, and veteran status. In 2023-2024, the prevalence among women ages 18-44 was:

- 3.2 times higher among Hawaiian/Pacific Islander (21.5%) compared with Asian (6.7%) women.
- 3.0 times higher among high school graduates (14.3%) compared with college graduates (4.8%).
- 2.9 times higher among women with independent living difficulty (25.0%) compared with women without a disability (8.5%).
- 2.6 times higher in West Virginia (19.5%) than in Maryland (7.6%).
- 2.5 times higher among women with an annual household income of \$25,000 to \$49,999 (13.1%) compared with women who have an income of \$150,000 or more (5.2%).
- 2.1 times higher among women ages 18-24 (17.1%) compared with women ages 35-44 (8.0%).
- 2.0 times higher among LGBTQ+ women (20.1%) compared with straight women (9.9%).
- 1.5 times higher among women living in nonmetropolitan areas (16.7%) compared with women in metropolitan areas (11.0%).
- 1.3 times higher among women who have served in the U.S. armed forces (15.0%) compared with women who have not served (11.6%).

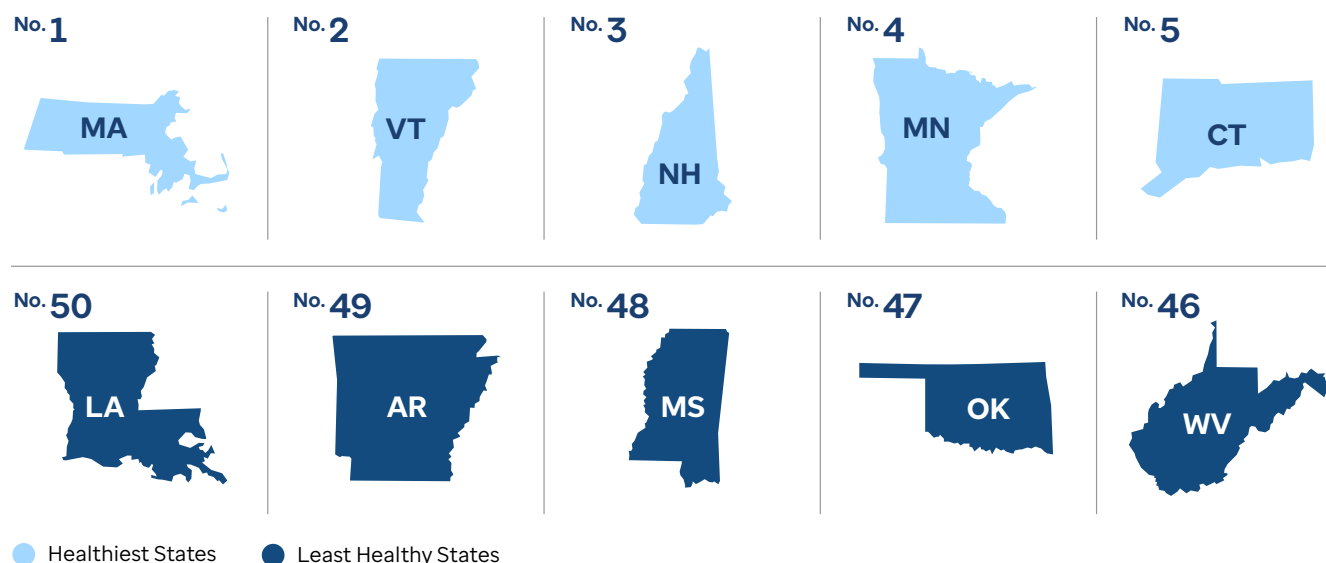
Related Measure: Electronic Vapor Product Use Among Youth

Nationally, the prevalence of electronic vapor product use – the percentage of high school students who reported using an electronic vapor product in the past 30 days – decreased 49% from 32.7% to 16.8% between 2019 and 2023. During the same time period, electronic vapor product use decreased in 15 states. The largest decreases were 60% in Nebraska (17.1% to 6.9%), 59% in Virginia (19.9% to 8.1%) and 57% in Hawaii (30.6% to 13.2%). In 2023, the prevalence among high school students was 4.3 times higher in Montana (24.3%) than in Utah (5.7%).

State Rankings

2026 Health of Women and Children Overall State Rankings

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, 2026.

State Rankings

The overall state rankings are based on 83 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. 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 No. 1 in both women's and children's health as well as ranking No. 1 overall for the second consecutive year. Massachusetts also ranked among the top five in nearly every category: No. 1 in Social and Economic Factors, No. 2 in Clinical Care, No. 3 in Health Outcomes and No. 4 in Behaviors. It ranked No. 13 in Physical Environment.

Strengths: Low infant mortality rate, low prevalence of obesity among women and high prevalence of food sufficiency among children.

Challenges: High prevalence of illicit drug use among adolescents, low prevalence of cervical cancer screening and low prevalence of infants exclusively breastfed for six months.

Rounding out the top five healthiest states in this report are Vermont (No. 2), New Hampshire (No. 3), Minnesota (No. 4) and Connecticut (No. 5).

Louisiana ranked No. 50

Louisiana was the least healthy state in this year's report, ranking No. 50 overall for the second consecutive year. It ranked No. 50 for women as well and No. 49 for children. Louisiana ranked in the bottom two states in nearly every category: No. 49 in Social and Economic Factors, No. 50 in Physical Environment, No. 49 in Behaviors and No. 50 in Health Outcomes. In Clinical Care, Louisiana ranked No. 29.

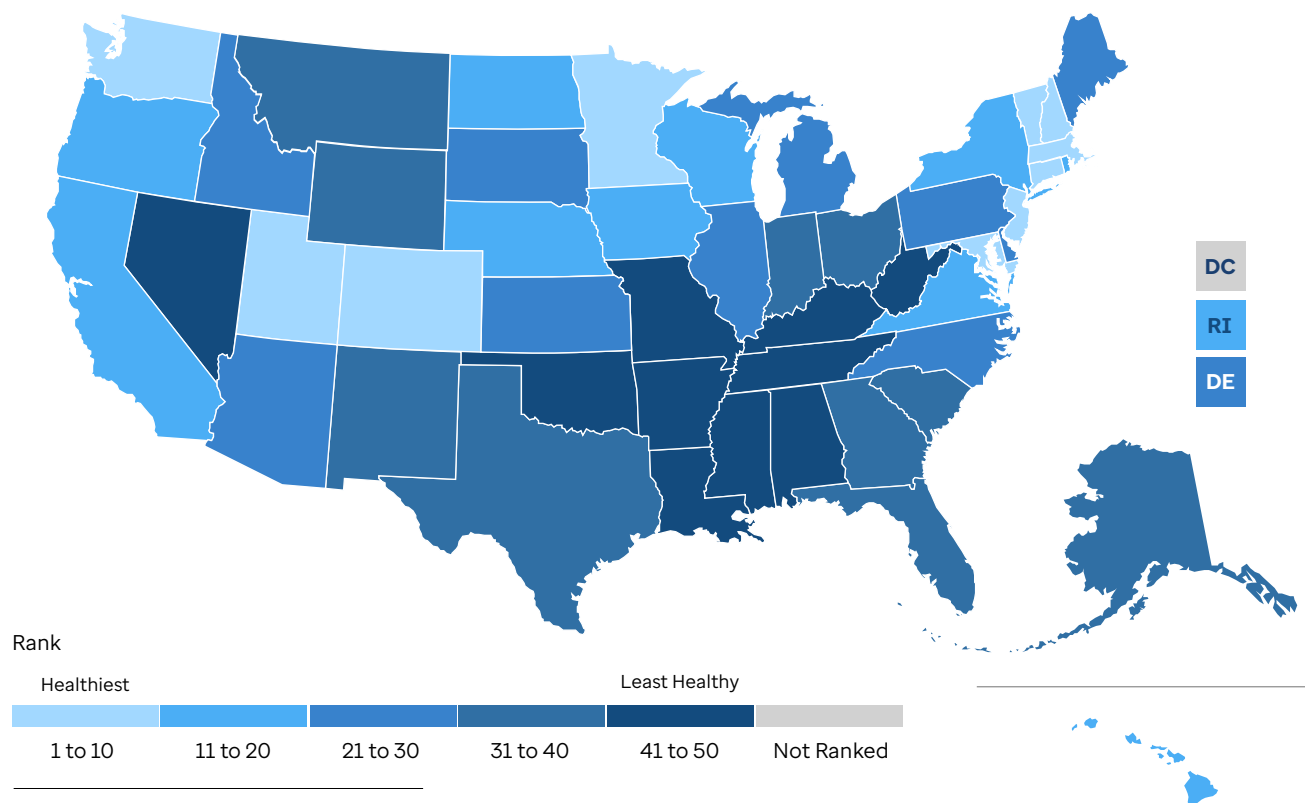
Strengths: High enrollment in early childhood education, low prevalence of uninsured children and high prevalence of well-woman visits.

Challenges: High child mortality rate, high prevalence of women in poverty and high prevalence of e-cigarette use among women.

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

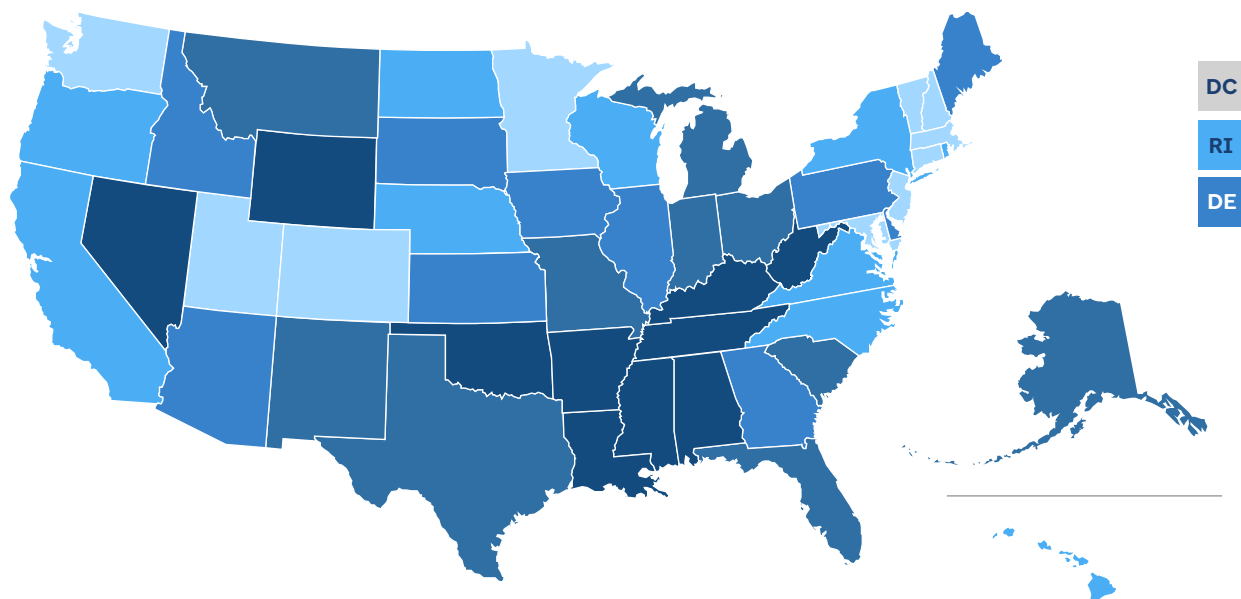
State Rankings: Overall Women and Children

2026 Health of Women and Children Report



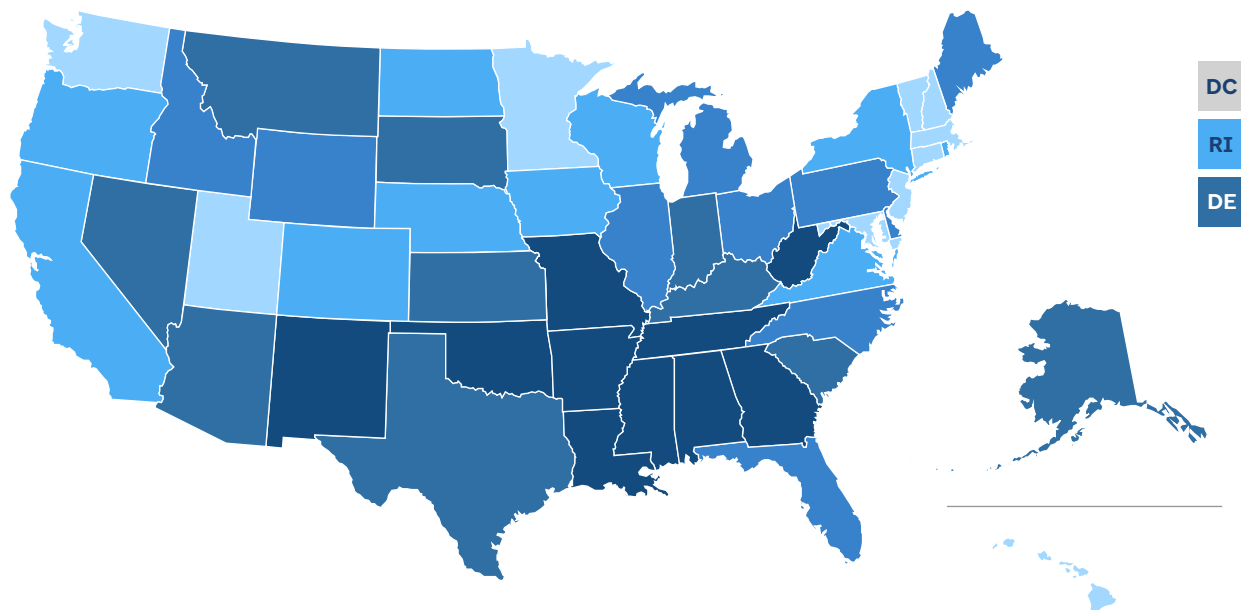
State Rankings: Women of Reproductive Age

2026 Health of Women and Children Report

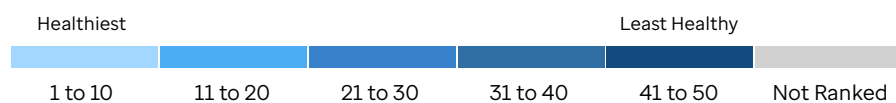


State Rankings: Children

2026 Health of Women and Children Report



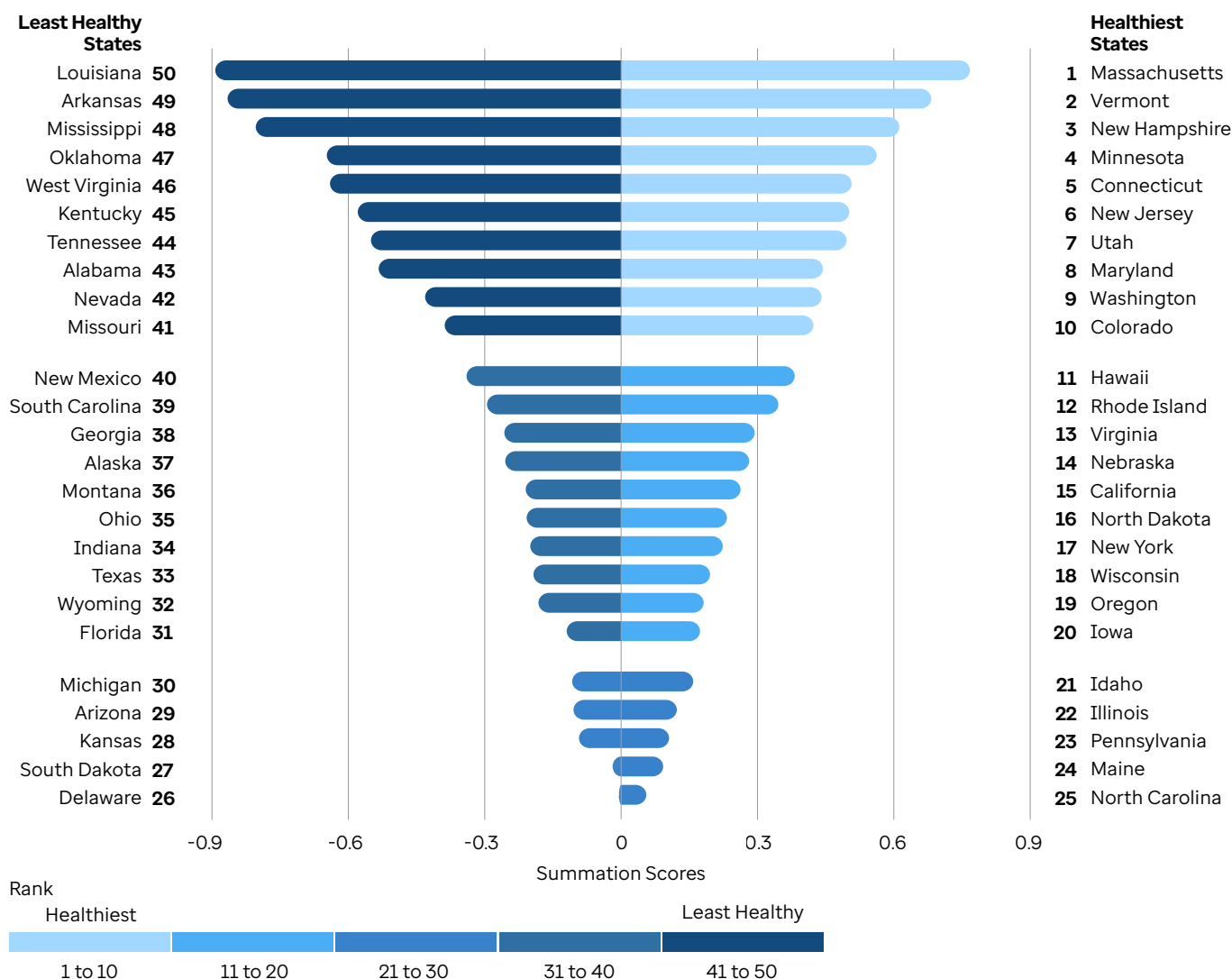
Rank



Source: America's Health Rankings composite measure, 2026.

Overall State Rankings and Scores*

2026 Health of Women and Children Report



Source: America's Health Rankings composite measure, 2026.

*Scores are the sum of weighted z-scores of all weighted measures.

The graph above displays state scores and ranks, with the least healthy states on the left and the healthiest on the right. The distance between bars shows the difference between state scores. For example, while Oklahoma (No. 47) and Mississippi (No. 48) are adjacent in the rankings, there is a sizable difference in their overall scores. This indicates that Mississippi would need to show significant improvement across multiple measures to move up in the rankings. There is also a large gap in score between Nevada (No. 42) and Alabama (No. 43).

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 show 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.

State Rankings Over a Decade

Since the publication of the first *America's Health Rankings Health of Women and Children Report* in 2016, Massachusetts, Vermont, New Hampshire, Minnesota and Connecticut have consistently remained in the top 10 healthiest states, while Louisiana, Arkansas, Mississippi and Oklahoma have consistently ranked among the 10 least healthy states.

Three states improved more than 10 places between 2016 and 2026:

- Maryland's rank improved 15 places (No. 23 to No. 8).
- Arizona's rank improved 14 places (No. 43 to No. 29).
- New Jersey's rank improved 13 places (No. 19 to No. 6).

Eight additional states improved in rank by at least five places:

- Florida (No. 40 to No. 31) improved nine places.
- Oregon (No. 27 to No. 19) and Texas (No. 41 to No. 33) improved eight places.
- Washington (No. 16 to No. 9) and Georgia (No. 45 to No. 38) improved seven places.
- Idaho (No. 26 to No. 21), North Carolina (No. 30 to No. 25) and Nevada (No. 47 to No. 42) improved five places.

On the other hand, three states worsened 10 or more places between 2016 and 2026:

- Maine's rank declined 13 places (No. 11 to No. 24).
- Iowa's rank declined 12 places (No. 8 to No. 20).
- Kentucky's rank declined 11 places (No. 34 to No. 45).

The ranks of six additional states worsened five or more places between 2016 and 2026:

- Alaska (No. 28 to No. 37) and South Dakota (No. 18 to No. 27) declined nine places.
- West Virginia (No. 38 to No. 46) declined eight places.
- Missouri (No. 35 to No. 41) declined six places.
- California (No. 10 to No. 15) and Montana (No. 31 to No. 36) declined five places.

Note: This report presents these long-term comparisons, noting that the underlying measures and methodologies have evolved over the last decade. The model methodology changed starting with the 2020 edition, rankings were not published in the 2020 and 2021 editions, and children's rankings did not include infant measures prior to 2020.

Overall - Women and Children State Rankings

State Rankings Over a Decade

2016	2018	2019	2022	2023	2024	2025	2026	
1	1	2	2	2	2	1	1	Massachusetts
2	4	4	3	3	5	2	2	Vermont
3	2	3	7	4	1	4	3	New Hampshire
5	5	6	1	1	3	3	4	Minnesota
4	6	5	6	8	7	7	5	Connecticut
19	12	8	4	7	4	6	6	New Jersey
6	8	9	5	6	6	5	7	Utah
23	16	12	9	11	12	9	8	Maryland
16	11	17	10	10	10	10	9	Washington
14	10	10	11	9	9	8	10	Colorado
7	13	14	8	5	8	12	11	Hawaii
9	3	1	13	12	11	11	12	Rhode Island
12	15	18	14	14	15	16	13	Virginia
17	22	28	12	12	17	13	14	Nebraska
10	7	7	17	17	14	19	15	California
13	17	15	15	19	19	14	16	North Dakota
20	19	13	21	18	21	17	17	New York
15	14	19	22	22	18	18	18	Wisconsin
27	18	20	19	20	20	20	19	Oregon
8	9	10	17	16	13	14	20	Iowa
26	25	22	23	24	24	23	21	Idaho
21	26	26	20	15	23	22	22	Illinois
24	23	23	25	23	25	26	23	Pennsylvania
11	21	16	16	21	16	21	24	Maine
30	30	30	30	30	28	27	25	North Carolina
22	20	21	24	29	27	25	26	Delaware
18	24	23	28	26	22	24	27	South Dakota
25	27	25	26	25	29	27	28	Kansas
43	39	37	35	34	33	34	29	Arizona
32	29	29	33	28	30	29	30	Michigan
40	34	39	27	27	26	30	31	Florida
29	31	33	32	33	31	31	32	Wyoming
41	44	43	34	36	35	36	33	Texas
36	35	35	39	39	34	33	34	Indiana
33	32	32	38	37	39	38	35	Ohio
31	28	27	29	31	32	32	36	Montana
28	33	31	31	32	37	35	37	Alaska
45	37	40	36	35	36	37	38	Georgia
39	36	36	43	42	38	39	39	South Carolina
37	37	34	44	43	40	42	40	New Mexico
35	41	37	37	38	42	41	41	Missouri
47	45	46	41	40	41	43	42	Nevada
44	46	45	46	45	45	45	43	Alabama
42	43	41	40	41	43	44	44	Tennessee
34	42	44	42	44	44	40	45	Kentucky
38	40	42	45	46	46	46	46	West Virginia
46	47	48	47	47	47	47	47	Oklahoma
50	50	50	48	50	49	48	48	Mississippi
49	49	49	49	49	50	49	49	Arkansas
48	48	47	50	48	48	50	50	Louisiana

Ranking

● 1-10 ● 11-20 ● 21-30 ● 31-40 ● 41-50

Source: *America's Health Rankings* composite measure, 2016-2026.

Note: No edition was published in 2017. The model methodology changed starting with the 2020 edition. Rankings were not published in the 2020 and 2021 editions. Children's rankings did not include infant measures until 2020.

Appendix



United States

Health Department Website: hhs.gov

Summary

Key Findings

E-Cigarette Use

121%▲

from 5.3% to 11.7% of women
ages 18-44 between 2018
and 2023-2024.

Frequent Mental Distress

62%▲

from 14.3% to 23.2% of women
ages 18-44 between 2013-2014
and 2023-2024.

Cigarette Smoking

52%▼

from 17.4% to 8.4% of women
ages 18-44 between 2013-2014
and 2023-2024.

Teen Births

48%▼

from 24.2 to 12.6 births per
1,000 females ages 15-19
between 2014 and 2024.

Injury Deaths

47%▲

from 31.9 to 47.0 deaths per
100,000 women ages 20-44
between 2012-2014 and 2022-2024.

Severe Maternal Morbidity

36%▲

from 72.1 to 97.8 complications
per 10,000 delivery hospitalizations
between 2016 and 2023.

Children in Poverty

29%▼

from 21.7% to 15.5% of children
ages 0-17 between 2014 and 2024.

Flourishing

28%▼

from 92.8% to 66.7% of children
ages 6 months to 17 years between
2016-2017 and 2023-2024.

Neonatal Abstinence Syndrome

25%▼

from 6.8 to 5.1 diagnoses per
1,000 birth hospitalizations
between 2016 and 2023.

Measures

Women and Children

U.S. Value

Physical Environment		
Air and Water Quality	Air Pollution	8.8
	Drinking Water Violations	2.5
	Household Smoke	10.3%
	Water Fluoridation	72.3%
Climate and Health	Climate Policies	—
	Transportation Energy Use*	8.3
Housing and Transportation	Drive Alone to Work - Women	67.4%
	Housing Cost Burden - Households With Children	27.7%
	Housing With Lead Risk	16.1%

Continued on next page.

Measures (cont.)

Women		U.S. Value
Social and Economic Factors		
Community and Family Safety	Firearm Deaths*	5.9
	Injury Deaths	47.0
	Intimate Partner Violence Before Pregnancy*	—
Economic Resources	Concentrated Disadvantage	25.8%
	Food Insecurity	13.3%
	Gender Pay Gap*	83.0%
	Poverty	14.4%
	Unemployment	3.9%
Education	College Graduate	39.0%
Social Support and Engagement	Infant Child Care Affordability*	12%
	Residential Segregation – Black/White	—
	Voter Participation	60.0%
Clinical Care		
Access to Care	Adequate Prenatal Care	75.0%
	Avoided Care Due to Cost	18.5%
	Maternity Care Desert*	3.5
	Uninsured	11.2%
	Women's Health Providers	48.1
Preventive Clinical Care	Cervical Cancer Screening	69.7%
	Dental Visit	65.6%
	Flu Vaccination	33.9%
	Postpartum Visit*	90.3%
	Well-Woman Visit	73.4%
Quality of Care	Breastfeeding Initiation	85.4%
	Dedicated Health Care Provider	77.9%
	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	8.5%
	Unintended Pregnancy*	—
Sleep Health	Insufficient Sleep	36.5%
Smoking and Tobacco Use	Cigarette Smoking	8.4%
	Cigarette Smoking During Pregnancy	2.4%
	E-Cigarette Use	11.7%
Health Outcomes		
Behavioral Health	Drug Deaths*	25.0
	Excessive Drinking	18.1%
	Frequent Mental Distress	23.2%
	Illicit Drug Use	10.5%
	Postpartum Anxiety*	20.3%
	Postpartum Depression*	11.9%
Mortality	Maternal Mortality*	23.1
	Mortality Rate	98.0
Physical Health	Depression*	30.6%
	Diabetes*	3.6%
	Frequent Physical Distress	10.1%
	High Blood Pressure	11.8%
	High Health Status*	49.4%
	Multiple Chronic Conditions	4.5%
	Obesity	32.6%
	Severe Maternal Morbidity*	97.8

Children		U.S. Value
Social and Economic Factors		
Community and Family Safety	Child Victimization*	7.2
	Firearm Deaths*	5.5
	Injury Deaths	17.8
Economic Resources	Children in Poverty	15.5%
	Children in Poverty – Racial Disparity	3.0
	Food Sufficiency	66.6%
	Students Experiencing Homelessness	3.2%
	WIC Coverage	54.5%
Education	Early Childhood Education	49.3%
	Fourth Grade Reading Proficiency	30.5%
	High School Completion	89.9%
Social Support and Engagement	Adult Mentor*	88.0%
	Adverse Childhood Experiences	14.1%
	Foster Care Instability	18.7%
	High-Speed Internet	96.6%
	Neighborhood Amenities	38.2%
	Reading, Singing or Storytelling*	59.7%
Clinical Care		
Access to Care	ADD/ADHD Treatment	3.4%
	Mental Health Treatment*	83.3%
	Pediatricians	118.2
	Uninsured	6.0%
Preventive Clinical Care	Childhood Immunizations	68.0%
	HPV Vaccination	62.9%
	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	27.9%
	Physical Activity	19.7%
	Soda Consumption*	7.5%
Sexual Health	Dual Contraceptive Nonuse*	85.6%
	Teen Births	12.6
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	6.8%
	Flourishing	66.7%
	Illicit Drug Use	7.4%
	Mental Health Conditions	20.5%
	Teen Suicide*	9.7
Mortality	Child Mortality	28.7
	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	8.5%
	Low Birth Weight – Racial Disparity	2.1
	Neonatal Abstinence Syndrome*	5.1
	Overweight or Obesity	31.3%

* Unweighted measure that does not contribute to a state's overall rank.

— Data not available, missing or suppressed.

Measures Table

Social and Economic Factors – Women			
Measure	Description	Source(s)	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	2022–2024
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	2022–2024
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 under age 18	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2020–2024
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	2022–2024
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	2024
Poverty	Percentage of females ages 18–44 who live below the poverty level	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Unemployment	Percentage of the female civilian workforce that is unemployed	U.S. DOL, Bureau of Labor Statistics, Local Area Unemployment Statistics Program	2024
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	2023–2024
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	2026 Publication
Residential Segregation – Black/White	Index of segregation between Black and non-Hispanic white households measured by the proportion of a state's population that would need to move in order to achieve complete integration, ranging from zero (the proportion of each racial/ethnic group in each census tract is the same as their proportion to the population as a whole) to 100 (each tract contains only one racial/ethnic group)	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2020–2024
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†

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

† Data in this edition were repeated from the last edition.

Physical Environment – Women and Children

Measure	Description	Source(s)	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	2022-2024
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	2024
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 [†]
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	2024
Housing and Transit			
Drive Alone to Work - Women	Percentage of female workers age 16 and older who drive alone to work	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Housing Cost Burden - Households With Children	Percentage of households with one or more children ages 0-17 for which housing costs are 30% or more of household income	U.S. Census Bureau, American Community Survey PUMS	2024
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	2024

Clinical Care – Women

Measure	Description	Source(s)	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	2024
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	2023-2024
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	2026 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	2024
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 2025

* Unweighted measure, excluded from the Overall and category composite measures.

* Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

† Data in this edition were repeated from the last edition.

Preventive Clinical Services

Cervical Cancer Screening	Percentage of women ages 25-44 who reported receiving cervical cancer screening consistent with U.S. Preventive Services Task Force guidelines	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
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	2024
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	2023-2024
Postpartum Visit*	Percentage of women with a recent live birth who reported receiving a postpartum checkup	U.S. HHS, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	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	2023-2024

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	2024
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	2023-2024
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(s)	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 fruit two or more times a day and vegetables three or more times a day	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	2023-2024

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 giving or receiving money or drugs in exchange for sex	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
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 [†]

* Unweighted measure, excluded from the Overall and category composite measures.

[^] Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

[†] Data in this edition were repeated from the last edition.

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†
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Smoking and Tobacco Use

Cigarette 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	2023-2024
Cigarette Smoking During Pregnancy	Percentage of live births where the mother reported smoking cigarettes during pregnancy	U.S. HHS, Natality Public Use Files via CDC WONDER	2024
E-Cigarette Use	Percentage of women ages 18-44 who reported using e-cigarettes or other electronic vaping products daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023-2024

Health Outcomes – Women

Measure	Description	Source(s)	Data Year(s)
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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	2022-2024
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	2023-2024
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	2023-2024
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, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	2023†
Postpartum Depression*	Percentage of women with a recent live birth who reported experiencing depressive symptoms	U.S. HHS, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	2023†

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, CDC, NCHS, NVSS via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	2020-2024
Mortality Rate	Number of deaths per 100,000 women ages 20-44	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2024

* Unweighted measure, excluded from the Overall and category composite measures.

† Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

† Data in this edition were repeated from the last edition.

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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
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	2023-2024
Severe Maternal Morbidity** [^]	Number of significant life-threatening maternal complications during delivery per 10,000 delivery hospitalizations	U.S. HHS, AHRQ, HCUP, State Inpatient Database via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	2023

* Unweighted measure, excluded from the Overall and category composite measures.

[^] Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

[†] Data in this edition were repeated from the last edition.

Social and Economic Factors – Children

Measure	Description	Source(s)	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	2024
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	2022-2024
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	2022-2024
Economic Resources			
Children in Poverty	Percentage of children ages 0-17 who live in households below the poverty threshold	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
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	2020-2024
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	2023-2024 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	2023
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	2024
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	2024
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	2022-2023 School Year

* Unweighted measure, excluded from the Overall and category composite measures.

† Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

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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	2024
High-Speed Internet	Percentage of households with children ages 0-17 that have a broadband internet subscription and a computer, smartphone or tablet	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
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(s)	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 2025
Uninsured Children	Percentage of children ages 0-18 not covered by private or public health insurance	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024

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	2021-2022 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	2024
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 had 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†

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

† Data in this edition were repeated from the last edition.

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(s)	Data Year(s)
Nutrition and Physical Activity			
Breastfed	Percentage of infants exclusively breastfed for six months	U.S. HHS, CDC, NIS-Child	2022 Birth Cohort
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	2024

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 placed on their backs to sleep	U.S. HHS, CDC, Pregnancy Risk Assessment Monitoring System (PRAMS) via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	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	2023-2024

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

† Data in this edition were repeated from the last edition.

Health Outcomes – Children

Measure	Description	Source(s)	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	2023-2024
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	2023-2024
Mental Health Conditions (Diagnosed) [^]	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	2022-2024
Mortality			
Child Mortality	Number of deaths per 100,000 children ages 1-19	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2022-2024
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	2024
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	2022-2024
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, AHRQ, HCUP, State Inpatient Database via HRSA, Maternal and Child Health Bureau, Federally Available Data (FAD)	2023
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 [†]

^{*} Unweighted measure, excluded from the Overall and category composite measures.

[^] Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through the [Explore Data](#) section.

[†] Data in this edition were repeated from the last edition.

Demographics

Measure	Description	Source(s)	Data Year(s)
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 that is under age 1	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Population - Age <18*	Percentage of the population that is under age 18	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
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	2024

* Unweighted measure, excluded from the Overall and category composite measures.

^ Multicomponent measure. Data for each subcomponent are published on their respective measure pages, which can be found through 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 national population demographics. The survey collects and produces information about social, economic, housing and demographic characteristics from the nation's civilian noninstitutionalized population each year. Data are derived from the bureau directly via its [1-year](#) and [5-year](#) datasets or from 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. Annual [BRFSS survey data](#) are available on the CDC website.

[CDC WONDER](#) is a query system for analyzing public-use data from the CDC's [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 are obtained from [annual reports on the price of child care](#) across the U.S.

The [Child Maltreatment](#) report series presents data about child abuse and neglect collected from child protective service agencies across the nation. Reports are 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](#).

[EDFacts](#) collects, analyzes and centralizes data from state education agencies and other data sources on district and school demographics, performance and participation for the [U.S. Department of Education \(ED\)](#). 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 \(ECHO\)](#) 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 series provides national statistics on food security, household food spending and use of federal food and nutrition assistance by food-insecure households. Reports are produced annually by the [Economic Research Service](#) of the [U.S. Department of Agriculture \(USDA\)](#) using data from the 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 [U.S. Department of Labor's Bureau of Labor Statistics](#). Data are obtained from [LAUS Expanded State Employment Status Demographic Data](#) published on the bureau's 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 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 Center for HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention (NCHHSTP) AtlasPlus** 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 **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.

National- and State-Level Estimates of WIC Eligibility and Program Reach reports are published annually by the USDA's [Food and Nutrition Administration](#). This report series 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 [Census Bureau](#) 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 \(SAMHSA\)](#). Data are obtained from [State Estimates of Mental Health and Substance Use](#) reports and the [SAMHSA Data Analysis System](#).

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 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 future of PRAMS is currently unknown.

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 are released by the Census Bureau 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 83 weighted and 42 additional unweighted measures) were analyzed for the *America's Health Rankings 2026 Health of Women and Children Report*, using the most recent data available as of August 19, 2026. 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. Measure changes were based on input from the *Health of Women and Children Report Advisory Committee* and are detailed on the *2026 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 83 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:

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

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 cigarette 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.

This report presents long-term ranking comparisons, noting that the underlying measures and methodologies have evolved over the last decade. The model methodology changed starting with the 2020 edition, rankings were not published in the 2020 and 2021 editions, and children's rankings did not include infant measures prior to 2020.

For additional methodology information, [submit an inquiry](#).

Report

Findings. A decade after its first publication, this edition features long-term trends. Data for all measures were analyzed and considered for inclusion in the report. Measures with long-term trends were selected, with priority to those with updated data and/or statistically significant national changes (based on nonoverlapping 95% confidence intervals, when available). Of note, long-term trend analyses were not available for all demographic groups due to changes in methodology and/or data availability over time. Notably, income groups \$75,000 and above are excluded from long-term trend comparisons.

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 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 the largest health disparities, considering relevant risk factors, were prioritized for inclusion. 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

This year's State Summaries highlight ranking history over the past decade. The underlying measures and methodologies have evolved over this period. In 2020, *America's Health Rankings* introduced a [new rankings model](#) to reflect a growing understanding of the impact of social determinants on health. Rankings were not published in the 2020 and 2021 editions, and children's rankings did not include infant measures prior to 2020.

Strengths and Challenges represent measures with the biggest impact on a state's overall ranking (from the 83 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 long-term trends, presented as percent changes between two time periods of interest. Only statistically significant changes 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, as well as a mix of women's and children's measures.

Demographic Group Definitions

Age. Age data in this report were available for measures from the Behavioral Risk Factor Surveillance System (BRFSS), 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 and Utilization Project (HCUP), and USDA's National and State-Level Estimates of WIC Eligibility and Program Reach report series. 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. WIC groupings included infants age <1 and children ages 1-4.

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. Disability groups are not mutually exclusive.

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 (NVSS) 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 diploma, some college education or an associate degree, and bachelor's 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 LGBTQ+. Responses of straight – that is, not gay – were summed and classified as straight. For BRFSS measures with 2023-2024 data years, sexual orientation data for Pennsylvania are from 2024 only, while California, Ohio, Vermont and Wyoming data are from 2023 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 were classified as less than \$25,000, \$25,000 to \$49,999, \$50,000 to \$74,999, \$75,000 to \$99,999, \$100,000 to \$149,999 and \$150,000 or more. FAD (HCUP) groupings were based on current-year ZIP code median 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 metropolitan, and identification as micropolitan or noncore was classified as nonmetropolitan. FAD (HCUP) 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 categories 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).
- 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 status data in this report were available for measures from NSCH. For this demographic, children were grouped into two categories and classified as children with special health care needs (CSHCN) or children without special health care needs. Children were defined as having special health care needs if they either had at least one functional difficulty and one health condition (detailed in Measures Selection and Changes) and/or met one or more of the criteria outlined in the [Children with Special Health Care Needs \(CSHCN\) Screener®](#), which [characterizes special health care needs](#) based on the health challenges a child experiences due to an ongoing health condition, regardless of diagnosis.^{63,64} The screener has five criteria: needing or using prescription medications; needing or using medical, mental health or educational services more than average; having functional limitations compared with children of the same age; using or needing specialized therapies, such as speech therapy or occupational therapy; or receiving treatment or counseling for emotional, behavioral or developmental problems.

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.⁶⁵

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.⁶⁶

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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The *America's Health Rankings® Health of Women and Children Report* is available in its entirety at AmericasHealthRankings.org. Visit the site to request or download additional copies. The *America's Health Rankings 2026 Health of Women and Children Report* is funded entirely by the United Health Foundation, a recognized 501(c)(3) organization. An [advisory committee](#) provided expertise and guidance in selecting measures and designing this report.

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American Community Survey

Current Population Survey, Voting and Registration Supplement

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Children's Bureau

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Substance Abuse and Mental Health Services Administration

U.S. Department of Housing and Urban Development

Office of Policy Development and Research

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U.S. Energy Information Administration

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Data Maven of Minneapolis, Minnesota, conducted this project for and in cooperation with the United Health Foundation, with design by VML.

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