Contents

Introduction 1

National Highlights 4

Findings
  Health Outcomes 6
  Social and Economic Factors 13
  Behaviors 17
  Clinical Care 21

State Rankings 23

National Summary 26

References 28
Introduction

The health of communities across the United States depends on the well-being of the country’s women and children. According to the U.S. Census Bureau, in 2020 there were 58.4 million women of reproductive age (18-44) and 72.8 million children in the United States, representing nearly 40% of the total population.

To better understand the health of women, infants and children, America’s Health Rankings® continues to collaborate with an advisory group of experts to develop the America’s Health Rankings Health of Women and Children Report. Since the first edition in 2016, the report has provided a comprehensive look at the health of infants, children and women of reproductive age across the nation and on a state-by-state basis. This report examines their health with data collected from the beginning of the COVID-19 pandemic in 2020 and 2021.

This year’s Health of Women and Children Report includes state rankings. Leaders and advocates can use this year’s report to tailor and target public health efforts in their states to address issues caused or exacerbated by the pandemic and, ultimately, build healthier communities.

The 6th edition of the Health of Women and Children Report finds that:

- Rates of mental and behavioral health challenges have increased broadly among women and children across the nation in recent years, though rates vary widely based on geography, race/ethnicity and socioeconomic factors.

- The overall mortality rate among women ages 20-44 increased dramatically during the first year of the COVID-19 pandemic, exacerbating existing disparities.

- The pandemic underscored the need to address long-standing disparities in mental health and other measures, including maternal mortality and morbidity, which continue to disproportionately affect Black and American Indian/Alaska Native women.

- In the first years of the COVID-19 pandemic, several socioeconomic and environmental conditions that shape health worsened. Women experienced record-high unemployment, and firearm deaths for children dramatically increased over the past decade. Also, markers of health related to children’s neighborhoods and home environments declined.

Impact of the COVID-19 Pandemic

Many children and women of reproductive age have been infected with the virus that causes COVID-19. According to the American Academy of Pediatrics, more than 14.4 million COVID-19 cases, representing 18.4% of all cases, have been reported among children as of August 25, 2022. There have been 1,430 deaths from COVID-19 among children and 26,133 among women ages 18-49, according to data from the Centers for Disease Control and Prevention (CDC) as of August 27, 2022.

While many people experience mild symptoms, some people are at particular risk for complications, including pregnant women. Research suggests that in 2020, pregnant women who contracted COVID-19 were at higher risk of severe outcomes, including being admitted to an intensive care unit, requiring ventilation, and death. The risk of preterm birth was also higher among pregnant women who had COVID-19 compared with those without COVID-19.

In addition, it is possible for individuals to experience long-term effects from COVID-19 infection. Post-COVID conditions, also referred to as long COVID, cover a wide range of symptoms that may last or appear at least four weeks after the initial COVID-19 infection. Research indicates that women are more likely to develop long COVID than men, and women with long COVID had higher odds of experiencing certain long COVID symptoms.
While COVID infections tend to be milder in children, they are still at risk for developing long COVID. One study found that the prevalence of long COVID was 25% among children and adolescents. The most common long COVID symptoms for children and adolescents in this study were mood changes, fatigue, sleep disorders, headaches and respiratory symptoms.

Vaccinations are safe and effective for preventing severe illness and death from COVID-19. Receiving a vaccination during pregnancy benefits the mother as well as the infant, whose risk of hospitalization from COVID-19 infection is significantly reduced. Despite common misconceptions, vaccinations are not associated with poor pregnancy outcomes, such as preterm birth or small-for-gestational age at birth. Among children and teens, vaccination reduces the risk of multisystem inflammatory syndrome in children, a rare but serious condition linked to COVID-19. Vaccination may also reduce the risk of developing long COVID.

Beyond the direct effects of COVID infection, the COVID-19 pandemic has presented unique challenges for women and children. As schools and businesses closed, households with children were left juggling work, child care and virtual schooling. The closing of schools and daycares disproportionately affected women, who still perform the majority of housework and child care. More than half of the 4.2 million Americans who left the labor force in the first year of the pandemic were women. Because 2 out of 3 caregivers are women, the pandemic has added additional stress to many women’s lives; caregivers are at higher risk for depression, anxiety and poor physical health.

Children and teenagers have also experienced disruptions to their school and home lives during the pandemic. During the first half of 2021, the CDC conducted the Adolescent Behaviors and Experiences Survey to determine some of the effects of the pandemic on students in grades 9-12 across the U.S. Two-thirds of students reported more difficulty completing their schoolwork during the pandemic. Almost 30% of students experienced a parent losing a job and more than 20% lost a job themselves. Nearly 1 in 4 students reported hunger. During the pandemic, less than half of high school students felt connected to people at their school. Students who felt close to those at school had a lower prevalence of poor mental health both during the pandemic and in the last 30 days.

Certain racial and ethnic groups have been disproportionately affected by COVID-19. Hispanic women had higher rates of COVID-19 infection during pregnancy, and non-Hispanic Black women experienced a disproportionately higher rate of death due to COVID-19. Higher rates of hospitalization from COVID-19 have been observed among Hispanic and Black children compared with white children. Children at greater risk for COVID-19 infection, including racial and ethnic minority groups, also face more barriers to receiving a COVID-19 vaccine.

The pandemic has had a disproportionate negative impact on the economic and mental well-being of minority groups as well. During the first year of the pandemic, Hispanic and Black women in particular faced a sharper decline in employment than other women. In a survey of 9th-12th grade students, parental job loss was higher among Asian, Hispanic and Latino students, and hunger was more prevalent among Black students. During the first half of 2021, the Adolescent Behaviors and Experiences Survey found that nearly 36% of students — largely Asian, Black and multiracial youth — reported experiencing racism during the pandemic.

The report is intended to encourage change and improve health by promoting data-driven discussions among individuals, community leaders, the media, policymakers and public health workers.
racism also reported a higher prevalence of poor mental health; not feeling close to people at school; and difficulties with concentration, memory or decision-making.\textsuperscript{23}

The COVID-19 pandemic continues to affect the health and well-being of America’s women and children, and the full extent and impact of the pandemic is still unknown. As we continue to navigate the pandemic and its impact, we must leverage the power of public health data to address disparities that affect women and children across the nation. We urge leaders to use the report’s data to inform solutions for narrowing these gaps and ensuring that all children, families and communities can thrive.

**Purpose**

The purpose of *America’s Health Rankings* is to inform; drive action to build healthier communities; and offer credible and comprehensive data for improving health and the elements that determine health at the state and national levels. Using 36 data sources, including the CDC’s Pregnancy Risk Assessment Monitoring System, the U.S. Census Bureau’s American Community Survey and the Maternal and Child Health Bureau’s National Survey of Children’s Health, the *Health of Women and Children Report* consists of:

- **121 measures** for tracking current and emerging health issues at the state and national levels, including four demographic measures.

- **Five categories** that encompass the *America’s Health Rankings* model: social and economic factors, physical environment, clinical care, behaviors and health outcomes.

In summary, the *Health of Women and Children Report* aims to improve population health of women and children by:

- **Providing a benchmark for states.** Each year the report presents trends, strengths, challenges and highlights for every state. Community leaders, public health workers and policymakers can examine health trends over time and compare their state with neighboring states and the nation.

- **Stimulating action.** The report is intended to encourage change and improve health by promoting data-driven discussions among individuals, community leaders, the media, policymakers and public health workers. States can use the report in their annual review of programs, and many organizations reference the report when assigning goals for health-improvement plans.

- **Highlighting disparities.** The report shows differences in health between states and among population groups at the state and national levels, with groupings based on age, race and ethnicity, educational attainment, income and metropolitan status. Health disparities must be addressed in order to achieve health equity.

**Model for Measuring America’s Health**

*America’s Health Rankings* is built upon the *World Health Organization* definition of health: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”\textsuperscript{24}
National Highlights

Health Outcomes

**BEHAVIORAL HEALTH | WOMEN**

**Frequent mental distress**

14% ↑

from 17.0% to 19.4% of women ages 18-44 between 2017-2018 and 2019-2020.

Source: CDC, Behavioral Risk Factor Surveillance System.

**BEHAVIORAL HEALTH | CHILDREN**

**Teen suicide**

29% ↑

from 8.4 to 10.8 deaths per 100,000 adolescents ages 15-19 between 2012-2014 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**BEHAVIORAL HEALTH | CHILDREN**

**Anxiety and depression**

9.2% and 4.2% of children ages 3-17, respectively, in 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children’s Health.

**SOCIAL SUPPORT AND ENGAGEMENT | CHILDREN**

**Neighborhood amenities**

8% ↓

from 38.7% to 35.5% of children ages 0-17 between 2018-2019 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children’s Health.

**SOCIAL SUPPORT AND ENGAGEMENT | CHILDREN**

**Unemployment**

131% ↑

from 3.6% to 8.3% of the female civilian workforce between 2019 and 2020.


**Frequent mental distress**

7% ↓

from 71.7% to 66.6% of children ages 6 months-17 years between 2018-2019 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children’s Health.

**Mortality**

21% ↑

from 97.2 to 117.3 deaths per 100,000 women ages 20-44 between 2019 and 2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**Mortality**

19.3 deaths per 100,000 live births in 2016-2020.

Source: HHS, HRSA, MCHB, Federally Available Data.

**Firearm deaths**

9% ↑

from 4.7 to 5.1 deaths per 100,000 women ages 20-44 between 2015-2017 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**Firearm deaths**

18% ↑

from 4.0 to 4.7 deaths per 100,000 children ages 1-19 between 2015-2017 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**Adverse childhood experiences**

14.0% of children ages 0-17 who reported ever experiencing two or more ACEs in 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children’s Health.

**MORTALITY | WOMEN**

**Maternal mortality**

9.2% to 4.2% of children ages 3-17, respectively, in 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children’s Health.

**COMMUNITY AND FAMILY SAFETY | WOMEN**

**Firearm deaths**

9% ↑

from 4.7 to 5.1 deaths per 100,000 women ages 20-44 between 2015-2017 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**COMMUNITY AND FAMILY SAFETY | CHILDREN**

**Firearm deaths**

18% ↑

from 4.0 to 4.7 deaths per 100,000 children ages 1-19 between 2015-2017 and 2018-2020.

Source: CDC WONDER, Multiple Cause of Death Files.

**Source:** CDC, Behavioral Risk Factor Surveillance System.
Behaviors

**Insufficient sleep**

7% ▼

from 36.1% to 33.4% of women ages 18-44 between 2018 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System.

**Smoking**

11% ▼

from 15.0% to 13.4% of women ages 18-44 between 2017-2018 and 2019-2020.

Source: CDC, Behavioral Risk Factor Surveillance System.

Nutrition and Physical Activity | Women

**Food sufficiency**

6% ▲

from 68.1% to 71.9% of children ages 0-17 between 2018-2019 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children's Health.

**Physical activity**

8% ▼

from 22.3% to 20.5% of children ages 6-17 between 2018-2019 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children's Health.

Sexual Health | Youth

**Teen births**

8% ▼

from 16.7 to 15.4 births per 1,000 females ages 15-19 between 2019 and 2020.

Source: CDC WONDER, Natality Public Use Files.

Clinical Care

Preventive Clinical Care | Women

**Cervical cancer screening**

4% ▼

from 79.9% to 77.1% of women ages 21-44 between 2018 and 2020.

Source: CDC, Behavioral Risk Factor Surveillance System.

**Flu vaccination**

26% ▲

from 30.8% to 38.9% of women ages 18-44 between 2017-2018 and 2019-2020.

Source: CDC, Behavioral Risk Factor Surveillance System.

Preventive Clinical Care | Children

**Preventive dental care**

6% ▼

from 79.6% to 75.1% of children ages 1-17 between 2018-2019 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children's Health.

**Well-child visit**

7% ▼

from 82.2% to 76.7% of children ages 0-17 between 2016-2017 and 2020-2021.

Source: HHS, HRSA, MCHB, National Survey of Children's Health.
Findings

Mental health worsened among women during the first year of the COVID-19 pandemic with disparities by race/ethnicity, income, education and age. Teen suicide, anxiety and depression among youth varied widely across states.

Women

Frequent Mental Distress

Frequent mental distress represents the population experiencing persistent, and likely severe, mental health issues, defined by 14 or more days of poor mental health a month. A strong relationship exists between the 14-day period and clinically diagnosed mental disorders, such as depression and anxiety.

Changes over time. Nationally, the percentage of women ages 18-44 who reported their mental health was not good 14 or more days in the past 30 days significantly increased 14% from 17.0% to 19.4% between 2017-2018 and 2019-2020. During 2019-2020, roughly 10.9 million women in the U.S. were affected, an increase of more than 1.2 million women since 2017-2018. Frequent mental distress significantly increased in eight states and the District of Columbia, led by 46% in the District of Columbia (12.5% to 18.3%) and 41% in Montana (15.8% to 22.2%). Most racial/ethnic, education, income and age subpopulations experienced significant increases in frequent mental distress. By group, the largest increases were: 54% among American Indian/Alaska Native women (17.3% to 26.6%), 32% among college graduates (10.2% to 13.5%), 30% among women with an annual household income of $75,000 or more (9.2% to 12.0%) and 18% among women ages 25-34 (16.2% to 19.1%).

Disparities. Frequent mental distress among women was highest in Arkansas (27.8%) and lowest in Hawaii (14.9%) in 2019-2020. The prevalence varied the most by race/ethnicity, and also significantly varied by income, education and age. It was 2.4 times higher among multiracial (26.7%) compared with Asian (11.3%) women; 2.1 times higher among women with an annual household income less than $25,000 (24.8%) compared with those with an income of $75,000 or more (12.0%); and 1.5 times higher among women with some post-high school education (20.8%) compared with college graduates (13.5%).
Depression

Changes over time. Nationally, the percentage of women ages 18-44 who reported being told by a health professional that they have a depressive disorder — including depression, major depression, minor depression or dysthymia — significantly increased 5% from 24.8% to 26.1% between 2017-2018 and 2019-2020. During 2019-2020, nearly 14.9 million women in the U.S. were affected by depression, an increase of roughly 624,000 women since 2017-2018. Some age subpopulations and white women experienced significant increases in depression.

Disparities. Depression among women was highest in West Virginia (39.7%) and lowest in Hawaii (16.9%) in 2019-2020. The prevalence varied the most by race/ethnicity, and also significantly varied by income, education, metropolitan status and age. It was 3.8 times higher among multiracial (37.1%) compared with Asian (9.7%) women; 1.5 times higher among women with an annual household income less than $25,000 (31.8%) compared with those with an income of $75,000 or more (21.1%); and 1.4 times higher among women with some post-high school education (30.2%) compared with college graduates (20.9%).

Postpartum Depression

Nationally, 13.6% of women with a recent live birth reported experiencing depressive symptoms in 2020, an increase of 14% (from 11.9%) since 2014. Out of the 41 states with data, postpartum depression was highest in Arkansas (23.2%) and lowest in Iowa (7.9%) in 2020.

Children

Teen Suicide

Suicide is a serious public health problem, especially among youth, as it exacts an enormous toll due to the years of potential life lost. In 2020, suicide was the second-leading cause of death among those ages 10-24 and 25-34.

Changes over time. Nationally, the teen suicide rate significantly increased 29% from 8.4 to 10.8 deaths per 100,000 adolescents ages 15-19 between 2012-2014 and 2018-2020. Teen suicide significantly increased in 10 states, led by 82% in Nevada (8.3 to 15.1), 67% in Colorado (12.9 to 21.5) and 55% in South Carolina (8.7 to 13.5). The rate significantly increased 28% among both females (4.0 to 5.1) and males (12.7 to 16.3).

Disparities. Teen suicide was highest in Alaska (40.4 deaths per 100,000 adolescents ages 15-19) and lowest in Massachusetts (5.0) in 2018-2020. The rate varied significantly by race/ethnicity and gender. It was 4.9 times higher among American Indian/Alaska Native teens (38.9) compared with Black teens (8.0), and 3.2 times higher among males (16.3) compared with females (5.1).
When I lost my brother Brian to suicide, like too many others in this country, I realized that “doing well” in school does not necessarily translate into fulfillment and well-being. As the past two-plus years of the pandemic have highlighted, there is much more than just academics and extracurricular activities that determine whether the youth in our lives are truly succeeding and flourishing; social connection and support play a crucial role in helping adolescents thrive.

Fortunately, today’s adolescents increasingly understand the importance of mental health and its connection to overall well-being, a generational shift that is leading to more open and destigmatized conversations. The clinical landscape is changing, too, as providers increasingly incorporate mental health into primary care, telehealth improves access to counseling and a recent explosion of scientific research and data gives us new tools and insights to guide evidence-based efforts to improve mental health.

However, not everyone has physical or emotional access to the help they need to survive and thrive. While mental health challenges do not discriminate, this lack of access does — disproportionately impacting Black, American Indian/Alaska Native and Hispanic youth. Additionally, historical trauma, stigma and a cultural narrative around fault and blame persists, coinciding with a lack of adequate representation in the clinical workforce for people of color and the LGBTQ community.

The striking findings in the 2022 Health of Women and Children Report reinforce years of reporting that depression, anxiety and suicidal thoughts are all concerningly prevalent among our nation’s youth and likely exacerbated by the COVID-19 pandemic. We must acknowledge the extraordinary, traumatic levels of loss by many young people as their lives were upended over the past two years — especially in underserved communities. However, we also must recognize that these longer-term challenges will not recede as the nation navigates today’s new pandemic realities.

At Active Minds, we aim to uplift the youth voices who are driving more open conversations in our society by embedding mental health into everyday peer-to-peer interactions. We provide resources, training and programs to teachers, students and families in over 1,000 high schools and colleges, with the goal of making young people more comfortable reaching out for help and ensuring they know where to find support. Having these conversations as early and often as possible is key to preventing adolescents’ mental health from worsening as they age, which is why our new partnership with the United Health Foundation builds on our evidence-based approach to reach middle schoolers for the first time across 50 urban, rural, suburban and underserved school districts.

As we seek to address resource gaps and cultural barriers to better mental health, public health data — especially when disaggregated by demographic factors — can target our efforts to the right issues, in the right populations, with the right interventions and messages. Together, we can reinforce the progress that America’s adolescents are making in changing the conversation and improve mental health and overall well-being across the nation.
Anxiety and Depression — Children

Occasional feelings of worry or sadness are normal from time to time. However, if children do not outgrow their fears and worries, or anxiety starts interfering with school and other activities, they might have an anxiety disorder. Or if they feel persistent sadness and hopelessness, they may have depression. If untreated, mental health disorders can interfere with a child’s development, causing problems in school and in forming friendships.

Changes over time. Nationally, among children ages 3-17, anxiety increased 23% from 7.5% to 9.2% (an increase of more than 1 million children), while depression increased 27% from 3.3% to 4.2% (an increase of 555,700) between 2017-2018 and 2020-2021. These conditions affected approximately 5.6 million children and 2.5 million children in 2020-2021, respectively.

Disparities. Anxiety was highest in Vermont (16.9%) and lowest in Hawaii (4.6%). Depression was highest in Kentucky (7.3%) and lowest in Hawaii (2.4%).

Flourishing

Flourishing measures children’s well-being and how well they function and thrive within their family and community. Flourishing in children is associated with higher levels of school engagement, and attributes of flourishing have been linked with fewer risky health behaviors during adolescence.

Changes over time. Nationally, flourishing among children significantly decreased 7% from 71.7% to 66.6% between 2018-2019 and 2020-2021, equaling roughly 4.7 million fewer children in 2020-2021. Flourishing is defined as the percentage of children ages 6 months to 5 years who show affection, resilience, interest and curiosity in learning, and smile and laugh a lot; and children ages 6-17 who show self-regulation, interest and curiosity in learning, and work to finish tasks, as reported by a caregiver. By age group, flourishing significantly decreased 3% (from 83.5% to 80.8%) among children ages 6 months to 5 years and 9% (66.5% to 60.4%) among children ages 6-17. Flourishing among children significantly decreased in 14 states, led by 14% in Maryland (75.1% to 64.5%) and South Carolina (76.6% to 66.0%).

Disparities. Flourishing among children was highest in Nebraska and Hawaii (both 71.6%) and lowest in Oregon (62.8%) in 2020-2021. The prevalence was significantly higher among children ages 6 months to 5 years (80.8%) compared with children ages 6-17 (60.4%).
The mortality rate among women significantly increased during the first year of the pandemic. Maternal mortality continued to be a major challenge for the U.S., with wide disparities by race/ethnicity.

**Women**

**Mortality Rate**

The mortality rate among women ages 20-44 held steady from 2016 to 2019 but increased significantly in 2020. The 10 leading causes of death among women ages 20-44 in 2020 were: unintentional injury, malignant neoplasm, heart disease, suicide, COVID-19, liver disease, homicide, diabetes mellitus, complicated pregnancy and cerebrovascular disease.

**Changes over time.** Nationally, the mortality rate among women significantly increased 21% from 97.2 to 117.3 deaths per 100,000 women ages 20-44 between 2019 and 2020. In 2020, 63,655 women in the U.S. died of any cause, an increase of 11,152 women since 2019. This increase was primarily driven by deaths from COVID-19, which became the fifth-leading cause of death nationwide among women. In addition to COVID-19, deaths from liver disease, unintentional injury, diabetes, homicide, pregnancy complications and heart disease all increased 14% or more in 2020. The mortality rate significantly increased in 32 states, led by 35% in Arizona (100.7 to 135.6 deaths per 100,000 women ages 20-44). Nearly all racial/ethnic subpopulations experienced significant increases in mortality.

**Disparities.** Mortality among women was highest in West Virginia (214.6 deaths per 100,000 women ages 20-44) and lowest in Hawaii (73.8) in 2020. The mortality rate was 9.5 times higher among American Indian/Alaska Native women (357.6), the group with the highest rate, compared with Asian women (37.6), the group with the lowest rate.
Drug Deaths

**Changes over time.** Nationally, the drug death rate — deaths due to drug injury (unintentional, suicide, homicide or undetermined) — among women significantly increased 19% from 18.9 to 22.4 deaths per 100,000 women ages 20-44 between 2015-2017 and 2018-2020. During 2018-2020, 36,358 women in the U.S. died from a drug overdose, an increase of 6,031 women since 2015-2017. The drug death rate significantly increased in 23 states, led by: 63% in Vermont (20.3 to 33.1 deaths per 100,000 women ages 20-44), 59% in Nebraska (7.0 to 11.1) and 49% in Louisiana (22.3 to 33.3). During the same time period, drug deaths among women significantly decreased 19% in Utah (23.9 to 19.4).

**Disparities.** Drug deaths among women were 7.8 times higher in West Virginia (72.2 deaths per 100,000 women ages 20-44), the state with the highest rate in 2018-2020, compared with Hawaii (9.3), the state with the lowest rate. The rate varied significantly by race/ethnicity and age. It was 15.9 times higher among American Indian/Alaska Native women (42.9) compared with Asian women (2.7), and 2.2 times higher among women ages 35-44 (27.0) compared with those ages 20-24 (12.2).

Drug deaths were nearly 16 times higher among American Indian/Alaska Native women compared with Asian women in 2018-2020.

Deaths per 100,000 women ages 20-44

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Deaths per 100,000 women ages 20-44</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>42.9</td>
</tr>
<tr>
<td>White</td>
<td>30.7</td>
</tr>
<tr>
<td>Black</td>
<td>19.2</td>
</tr>
<tr>
<td>Multiracial</td>
<td>15.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.2</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: CDC WONDER, Multiple Cause of Death Files, 2018-2020.

Note: The rate increase was not significant among Hawaiian/Pacific Islander women.
Maternal Mortality

The maternal mortality rate in the U.S. has been rising since 1990 and is higher than those of many other developed countries. Between April and December 2020, a substantial increase in maternal deaths was reported, coinciding with the COVID-19 pandemic.

Estimate in 2016-2020. The maternal mortality rate — deaths related to or aggravated by pregnancy (excluding accidental or incidental causes) occurring within 42 days of the end of a pregnancy — was 19.3 deaths per 100,000 live births, equating to 3,660 mothers in 2016-2020.

Disparities. Maternal mortality was highest in Alabama and Louisiana (both 38.7) and lowest in California (8.4). The rate varied significantly by race/ethnicity, age, and education. It was 3.9 times higher among Black mothers (52.0) compared with Hispanic mothers (13.4); 3.5 times higher among mothers ages 35 and older (40.8) compared with mothers ages 20-24 (11.8); and approximately 2.5 times higher among those with a high school diploma or GED degree (29.7) and those with less than a high school education (26.7) compared with college graduates (10.5).

Severe Maternal Morbidity

Changes over time. Nationally, severe maternal morbidity — the number of significant life-threatening maternal complications during delivery — significantly increased 5% from 77.5 to 81.0 complications per 10,000 delivery hospitalizations between 2018 and 2019, and 12% (from 72.1) since 2016. In 2019, 28,155 women experienced significant life-threatening complications during delivery. Severe maternal morbidity significantly increased in four states between 2018 and 2019: 29% in Nevada (65.2 to 84.4), 14% in Pennsylvania (77.0 to 87.8), 11% in Florida (73.4 to 81.8) and 9% in Texas (66.2 to 72.4).

Disparities. Out of the 48 states with data, severe maternal morbidity was highest in Rhode Island (111.3 complications per 10,000 delivery hospitalizations) and lowest in South Dakota (52.5) in 2019. The rate varied the most by race/ethnicity — it was 1.9 times higher among Black mothers (126.1) compared with white mothers (66.2) — but also significantly varied by age, income and metropolitan status.
Women and Children

Firearm Deaths

The U.S. has seen an uptick in firearm deaths over the last decade. In 2020, there were more than 45,000 deaths by gun violence, the highest number recorded. Additionally, firearm deaths surpassed motor vehicle accidents as the leading cause of death among children.

Changes over time. Nationally, the firearm death rate — deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 — among women ages 20-44 significantly increased 9% from 4.7 to 5.1 between 2015-2017 and 2018-2020, and 28% (from 4.0) since 2012-2014. Among children ages 1-19, the rate significantly increased 18% from 4.0 to 4.7 between 2015-2017 and 2018-2020, and 42% (from 3.3) since 2012-2014. In 2018-2020, 8,288 women and 11,070 children died by firearm.

Among women ages 20-44, the firearm death rate (deaths per 100,000) increased 34% in Missouri, from 8.5 to 11.4 since 2015-2017. Among children ages 1-19, the rate increased in 11 states, led by 71% in Mississippi (5.9 to 10.1).

Disparities. Among women and children, firearm death rates were highest in Alaska (13.8 deaths per 100,000 women ages 20-44 and 11.5 deaths per 100,000 children ages 1-19) and lowest in Massachusetts (0.9 and 1.2, respectively) in 2018-2020. Among children, the rate in the District of Columbia (14.8) was higher than the rate in any state. Rates among both women and children varied significantly by age and race/ethnicity. The rate was 24.5 times higher among children ages 15-19 (14.7) compared with children ages 1-4 (0.6). Firearm deaths were 12.4 times higher among Black children (14.9) compared with Asian children (1.2), 4.7 times higher compared with Hispanic and white children (both 3.2) and nearly twice as high compared with American Indian/Alaska Native children (7.7). The rate was 10.0 times higher among Black women (11.0) compared with Asian women (1.1).
Adverse childhood experiences impact millions of children. Access to neighborhood amenities worsened.

**Adverse Childhood Experiences**

Adverse childhood experiences (ACEs) are stressful or traumatic events that can impact children’s health and well-being throughout their lifespan. Early experiences have a broad and profound impact on an individual’s development and subsequent emotional, cognitive, social and biological functioning.

Estimates in 2020-2021. Nationally, 14.0% of children ages 0-17 experienced two or more of nine adverse childhood experiences (ACEs), as reported by a caregiver, equating to 9.9 million children. The prevalence of two or more adverse childhood experiences was 2.5 times higher in New Mexico (24.7%), the state with the highest value, compared with New York (9.8%), the state with the lowest value.

Changes over time. Between 2018-2019 and 2020-2021, the rate of being treated unfairly due to race or ethnicity significantly increased 19%, from 4.3% to 5.1%, and having a parent or guardian serve time in jail significantly decreased 13%, from 7.5% to 6.5%.

**Neighborhood Amenities**

Neighborhood amenities offer individuals opportunities to socialize, play, exercise and enjoy the neighborhood in which they live. There is evidence that safe neighborhoods with opportunities for and access to community engagement and healthy lifestyle habits contribute positively to physical and mental health.

Changes over time. Nationally, the percentage of children ages 0-17 whose caregiver reported that they had access to neighborhood amenities significantly decreased 8% from 38.7% to 35.5% between 2018-2019 and 2020-2021. Neighborhood amenities are defined as all of the following: a park or playground; recreation center, community center or boys’ and girls’ club; library or bookmobile; and sidewalks or walking paths. Access to neighborhood amenities significantly decreased 21% in Arizona (39.6% to 31.3%) and 17% in Washington (42.9% to 35.5%).

Disparities. Access to neighborhood amenities was 4.1 times higher in Colorado and Illinois (both 53.4%), the states with the highest values, compared with Mississippi (12.9%), the state with the lowest value. The prevalence in the District of Columbia (67.0%) was higher than in any state.

The most common ACE in 2020-2021 was parent or guardian divorce or separation.

<table>
<thead>
<tr>
<th>Percentage of children ages 0-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Divorce or Separation</td>
</tr>
<tr>
<td>Substance Misuse in Household</td>
</tr>
<tr>
<td>Mental Illness in Household</td>
</tr>
<tr>
<td>Parent or Guardian Time in Jail</td>
</tr>
<tr>
<td>Discrimination — Race or Ethnicity</td>
</tr>
<tr>
<td>Domestic Violence Witness</td>
</tr>
<tr>
<td>Neighborhood Violence Witness</td>
</tr>
<tr>
<td>Parent or Guardian Death</td>
</tr>
<tr>
<td>Discrimination — Sexual Orientation or Gender Identity*</td>
</tr>
</tbody>
</table>

*Percentage of children ages 12-17.
The unemployment rate spiked during the COVID pandemic, disproportionately affecting women.

### Women

#### Unemployment

A stable and well-paying job makes it possible for people to maintain [good health](#). Unemployment among women decreased between 2017 and 2019 but spiked in 2020 due to the COVID-19 pandemic. The rate among women peaked at 15.4% in April of 2020, higher than the overall unemployment rate of 14.7%. Working women composed the majority of the 4.2 million [Americans](#) who left the labor force in 2020, with Hispanic and Black women experiencing a sharper decline in employment. By August 2022, the unemployment rate among women had declined to 3.3%.

**Changes over time.** Nationally, the percentage of the female civilian workforce who were unemployed increased 131% nationally from 3.6% to 8.3%, an increase of about 3.5 million women between 2019 and 2020. Unemployment among women significantly increased in 41 states and the District of [Columbia](#), led by 480% in [Hawaii](#) (2.0% to 11.6%).

**Disparities.** The unemployment rate among women was 3.1 times higher in [Nevada](#) (13.2%), the state with the highest value in 2020, compared with [Nebraska](#) (4.2%), the state with the lowest value.

#### Concentrated Disadvantage

**Estimates in 2016-2020.** Nationally, 26.1% of households with children were located in areas of [concentrated disadvantage](#), affecting an estimated 9.8 million people. Households were identified as being in an area of concentrated disadvantage if the averaged z-score was above the 75th percentile for the following factors: percentage of family households below the poverty line; percentage of individuals receiving public assistance; percentage of female-headed households; percentage of unemployed population ages 16 and older; and percentage of [population younger than age 18](#).

The most common factor was receiving public assistance (24.4%), and the least common was being unemployed (5.4%).

**Disparities.** Concentrated disadvantage was 16.4 times higher in [New Mexico](#) (47.6%), the state with the highest value, compared with [Vermont](#) (2.9%), the state with the lowest value.

### College Graduate

**Estimates in 2020-2021.** Education is connected to employment, socioeconomic status and other factors that influence health. The disparities by race/ethnicity are striking. The percentage of [college graduates](#) was lowest among [Hispanic](#) (18.2%), [American Indian/Alaska Native](#) (20.2%) and [Hawaiian/Pacific Islander](#) (25.1%) women ages 25-44 and highest among [Asian](#) women (63.2%).
As a Lakota woman who grew up on my home reservation, the data in the Health of Women and Children Report about my people are heartbreaking to see — but completely consistent with my personal experience. Nearly every Native person has a loved one, friend or community member who has gone missing, been murdered, been incarcerated or lost a child. These grave disparities are foundational and rooted in history. Native people face a lack of access to food, housing, education and health services. This “lack of” is systemic, tied to loss of land, loss of loved ones and loss of family and community structure.

This profound and historic sense of loss, exacerbated anew by the COVID-19 pandemic, casts shadows on our overall health that are compounded by socioeconomic factors, lack of health resources and geographic barriers. While other populations in the United States may take basics like pap smears, prenatal care and breastfeeding support for granted, new and expecting mothers in tribal communities often must travel hours to receive many routine services and to deliver their babies.

The data on Native populations in reports like this one from America’s Health Rankings help tell our story and underscore the need for investment in practices and policies that can make progress towards a healthy, prosperous future for our children, grandchildren and great-grandchildren — a prospect that many of their ancestors and community members did not have.

This motivates my work at the American Indian College Fund, where we provide scholarships to Native students in an effort to diversify and strengthen the health profession, particularly in the rural areas where many tribal communities are located. We aim to give students the financial and cultural tools they need to attend and navigate college, thrive after graduation and achieve social and economic mobility. For Native students, mobility often does and should go beyond the ability to acquire basic necessities, but also to share resources with their communities and give access to restorative cultural practices that promote overall well-being and cultural identity for adolescents, mothers and whole extended families.

I strongly believe that our communities’ traditional knowledge holds power to reclaim the sense of wellness that we once had. However, we need the economic resources and stability to access these traditional teachings and relationships, complemented by routine and preventive health services, particularly for women and children. I hope that advocates and leaders across the country will take note of this report’s findings and use them to guide investments that can truly support my people.

Spotlighting Native Stories Through Data to Guide a Healthier Future

Cheryl Crazy Bull, Wacinyanpi Win (They Depend on Her), President and CEO, American Indian College Fund
BEHAVIORS | SLEEP HEALTH & SMOKING AND TOBACCO USE

Sleep health and cigarette smoking improved among women of reproductive age.

**Women**

**Insufficient Sleep**

Insufficient sleep has been recognized as a threat to public health. Sleep is critical to such basic functions as cognitive processing, mood regulation, blood sugar level and immune system response. Insufficient sleep can lead to serious health problems, including cancer, depression, diabetes, hypertension, obesity and heart attack.

*Changes over time.* Nationally, the percentage of women ages 18-44 who reported sleeping, on average, fewer than seven hours in a 24-hour period significantly decreased 7% from 36.1% to 33.4% between 2018 and 2020. In 2020, more than 19.2 million women in the U.S. reported insufficient sleep, a decrease of roughly 1.5 million women since 2018. Insufficient sleep significantly decreased 21% in Oregon (36.0% to 28.5%) and 13% in New York (39.0% to 33.9%). Some age, education, income and racial/ethnic subpopulations experienced significant decreases in insufficient sleep. The prevalence significantly decreased 14% among women ages 18-24 (33.5% to 28.7%), 11% among college graduates (31.5% to 28.1%), 9% among women with an annual household income of $75,000 or more (32.2% to 29.2%) and 5% among white women (34.3% to 32.5%).

*Disparities.* Insufficient sleep among women was highest in West Virginia (41.1%) and lowest in Alaska (25.3%) in 2020. The prevalence varied the most by race/ethnicity, with the prevalence among Black women (43.7%) 1.6 times higher compared with Asian women (26.7%). Insufficient sleep also significantly varied by education, income, age and metropolitan status.

---


**Smoking**

As the leading cause of preventable death in the U.S., cigarette smoking is responsible for the deaths of more than 480,000 Americans every year, including 201,770 women. Smoking damages nearly every organ and may affect reproductive health. Women who smoke are more likely to have reduced fertility, go through menopause at a younger age and experience adverse birth outcomes, including miscarriage and sudden infant death syndrome (SIDS).

*Changes over time.* Nationally, the percentage of women ages 18-44 who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days significantly decreased 11%, from 15.0% to 13.4%, between 2017-2018 and 2019-2020, and 23% (from 17.4%) since 2013-2014. In 2019-2020, nearly 7.2 million women in the U.S. reported smoking cigarettes, a decrease of more than 1 million since 2017-2018. Smoking significantly decreased 20% in West Virginia from 33.8% to 26.9% since 2017-2018. During this time, some age, racial/ethnic and education subpopulations...
experienced significant decreases in smoking. By group, the largest decreases were 21% among women ages 18-24 (10.0% to 7.9%), 12% among white women (19.0% to 16.7%) and 11% among women with some post-high school education (20.6% to 18.3%).

Disparities. Smoking among women was 4.1 times higher in West Virginia (26.9%), the state with the highest value in 2019-2020, compared with Utah (6.5%), the state with the lowest value. The prevalence varied the most by race/ethnicity, education and income and also significantly varied by age and metropolitan status. When considering groups with the highest versus the lowest prevalences, smoking was 5.9 times higher among American Indian/Alaska Native women (27.6%) compared with Asian women (4.7%); approximately 4.2 times higher among women with a high school diploma or GED degree (23.8%) and those with less than a high school education (22.9%) compared with college graduates (5.5%); and 3.5 times higher among women with an annual household income less than $25,000 (25.3%) compared with those with an income of $75,000 or more (7.3%).

Smoking During Pregnancy

Changes over time. Nationally, the percentage of live births in which the mother reported smoking cigarettes during pregnancy decreased 8% from 6.0% to 5.5% between 2019 and 2020, and 35% (from 8.4%) since 2014. In 2020, 199,584 women with a recent live birth in the U.S. reported smoking cigarettes during pregnancy, 22,504 fewer women than in 2019.

Disparities. Smoking during pregnancy was 21.4 times higher in West Virginia and lowest in California in 2020.

E-cigarette Use

Estimate in 2020. Nationally, 7.6% of women ages 18-44 reported using e-cigarettes or other electronic vaping products at least once in their lifetime and now use daily or some days.
Among children, food sufficiency improved and physical activity worsened. The teen birth rate continued to decrease, but large disparities persist by race/ethnicity and across states.

**Food Sufficiency**

Access to sufficient food is critical for proper nutrition and health. Children are particularly susceptible to the negative impacts of food insecurity because their brains and bodies are still developing. Food insecurity among children is associated with negative health outcomes such as asthma, anxiety and depression.

**Changes over time.** Nationally, the percentage of children ages 0-17 whose caregiver reported that their household could always afford to eat good nutritious meals in the past 12 months significantly increased 6% from 68.1% to 71.9% between 2018-2019 and 2020-2021. During 2020-2021, 50.5 million children were food-sufficient, an increase of 1.9 million children since 2018-2019. Food sufficiency significantly increased in seven states, led by 14% in both West Virginia (59.4% to 67.7%) and Montana (65.2% to 74.3%).

**Disparities.** Food sufficiency among children was highest in Massachusetts (81.5%) and lowest in Mississippi (59.9%) in 2020-2021.

**Children Physical Activity**

Regular physical activity in children and adolescents is associated with improved bone health, weight status, cognition, cardiovascular and muscular fitness, as well as reduced risk of depression. Exercise also increases the chances of living a longer and healthier life, and children who engage in regular physical activity are more likely to become physically active adults.

**Changes over time.** Nationally, the percentage of children ages 6-17 whose caregiver reported that they were physically active at least 60 minutes every day in the past week significantly decreased 8% from 22.3% to 20.5%, equating to a drop of nearly 1 million children between 2018-2019 and 2020-2021.

**Disparities.** Physical activity among children was highest in North Dakota (29.8%) and lowest in Nevada (13.9%).

**Related Health Outcome**

**Overweight or Obesity — Youth**

**Changes over time.** Nationally, the percentage of children ages 10-17 who were overweight or had obesity for their age based upon reported height and weight significantly increased 8% from 31.0% to 33.5%, affecting about 10.7 million youth in 2020-2021. This was an increase of nearly 830,000 since 2018-2019.

**Disparities.** Overweight or obesity among youth was highest in Mississippi (41.4%) and lowest in Wyoming (24.3%) in 2020-2021.
Teen Births

Substantial health, social and economic costs are associated with teen pregnancy and childrearing. Teen mothers are significantly more likely to drop out of high school and face unemployment.⁶⁰

Changes over time. Nationally, the teen birth rate decreased 8% from 16.7 to 15.4 births per 1,000 females ages 15-19 between 2019 and 2020, continuing a downward trend. In 2020, there were 158,043 births among teens in the U.S., equating to 13,631 fewer teen births since 2019. The teen birth rate decreased 10% or more in 18 states, led by 19% in Montana (16.3 to 13.2). During the same time period, the rate increased 16% in Maine (9.1 to 10.6).

Disparities. The teen birth rate was 4.6 times higher in Mississippi (27.9 births per 1,000 females ages 15-19), the state with the highest rate in 2020, compared with Massachusetts (6.1), the state with the lowest rate. The rate varied significantly by race/ethnicity.

Unintended Pregnancy

Changes over time. Nationally, the percentage of women with a recent live birth who did not want to become pregnant or wanted to become pregnant later decreased 7% from 30.6% to 28.5% between 2019 and 2020. Unintended pregnancy significantly decreased 19% in Mississippi from 47.1% to 38.3%.

Disparities. Unintended pregnancy was highest in Tennessee (41.0%) and lowest in Minnesota (19.4%) in 2020.
Use of many preventive care measures among women and children declined early on in the pandemic. However, flu vaccination among women improved, though large disparities persist by education, income and race/ethnicity.

### Women and Children

#### Cervical Cancer Screening

Cervical cancer is **preventable** and treatable due to the availability of screening tests and vaccines. Screening in the form of routine *Pap tests* has contributed to significant declines in cervical cancer mortality over the past 40 years.

**Changes over time.** Nationally, the percentage of women ages 21-44 who reported receiving a Pap smear within the past three years significantly decreased 4% from 79.9% to 77.1% between 2018 and 2020. In 2020, nearly 32.2 million women received a recommended cervical cancer screening. Cervical cancer screening significantly decreased in six states, led by 16% in *Alaska* (80.8% to 67.9%). All age groups and some racial/ethnic, education and income subpopulations experienced significant decreases in cervical cancer screening, led by 8% among *women ages 21-24* (62.5% to 57.7%).

**Disparities.** Cervical cancer screening among women was highest in *Mississippi* (85.2%) and lowest in *Alaska* (67.9%) in 2020. The prevalence significantly varied by age, race/ethnicity, education and income. It was 1.4 times higher among *women ages 25-34* (81.4%) and *35-44* (81.1%) compared with those ages 21-24 (57.7%). It was also 1.4 times higher among *Black women* (82.2%) compared with *Asian women* (60.5%).

### Children

#### Preventive Dental Care

Early preventive dental visits can preempt many oral health problems. Poor oral health during early childhood can impact health into adolescence and adulthood.

**Changes over time.** Nationally, the percentage of children ages 1-17 whose caregiver reported that they had one or more preventive dental care visits during the past 12 months significantly decreased 6% from 79.6% to 75.1% between 2018-2019 and 2020-2021. The prevalence of preventive dental care visits significantly decreased in seven states, led by 11% in both *New Jersey* (84.9% to 75.7%) and *Ohio* (78.4% to 69.6%).

**Disparities.** Preventive dental care among children was highest in *Hawaii* (84.9%) and lowest in *Florida* (69.5%) in 2020-2021.

#### Well-child Visit

It is **recommended** that all children receive routine preventive visits, known as well-child visits. During those visits, children receive important care such as routine immunizations, tracking of growth and development as well as screening for potential issues.

**Changes over time.** Nationally, the percentage of children ages 0-17 whose caregiver reported that they received one or more preventive visits in the past 12 months significantly decreased 7% from 82.2% to 76.7% between 2016-2017 and 2020-2021. The prevalence of well-child visits significantly decreased in 18 states, led by 13% in both *California* (79.0% to 68.7%) and *New Mexico* (80.9% to 70.6%). By age group, well-child visits significantly decreased 8% among *children ages 3-17* from 80.6% to 74.5%.

**Disparities.** Well-child visits among children were highest in *New Hampshire* (86.9%) and lowest in *Nevada* (67.4%) in 2020-2021. The prevalence was significantly higher among *children ages 0-2* (88.4%) compared with children ages 3-17 (74.5%).
Women

Flu Vaccination

The flu vaccine helps protect people against seasonal influenza (flu) viruses that may lead to severe complications.66 While all women are at risk of complications from influenza, pregnant women are at greater risk of severe illness, hospitalization and preterm delivery.67, 68 Getting the flu vaccine while pregnant also helps protect babies from flu illness in the first several months after birth when they are too young to get vaccinated.67

Changes over time. Nationally, the percentage of women ages 18-44 who reported receiving a seasonal flu vaccine in the past 12 months significantly increased 26% from 30.8% to 38.9% between 2017-2018 and 2019-2020, with more than 19.9 million women receiving flu vaccinations in 2019-2020. Flu vaccination significantly increased in 41 states and the District of Columbia, led by 51% in both New Hampshire (30.1% to 45.5%) and Oregon (25.8% to 39.0%). Nearly all age, racial/ethnic, education and income subpopulations experienced significant increases in flu vaccination. By group, the largest increases were: 32% among women ages 18-24 (28.3% to 37.4%); 31% among white women (32.2% to 42.1%); and 27% among both college graduates (40.9% to 52.1%) and women with an annual household income of $75,000 or more (40.6% to 51.6%).†

Disparities. The prevalence of flu vaccination among women was 2.1 times higher in South Dakota (53.3%), the state with the highest value in 2019-2020, compared with Nevada (25.9%), the state with the lowest value. The prevalence varied the most by education, and also significantly varied by income, race/ethnicity, age and metropolitan status.

<table>
<thead>
<tr>
<th>Education and income subpopulations</th>
<th>2017-2018</th>
<th>2019-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>College Graduate</td>
<td>26.6%</td>
<td>36.2%</td>
</tr>
<tr>
<td>Some Post-High School</td>
<td>29.5%</td>
<td></td>
</tr>
<tr>
<td>High School Grad/GED</td>
<td>52.1%</td>
<td></td>
</tr>
<tr>
<td>Less Than High School</td>
<td></td>
<td>36.2%</td>
</tr>
</tbody>
</table>

Flu vaccination was nearly 2 times higher among college graduates compared with women with less than a high school education in 2019-2020.

Percentage of women ages 25-44


Note: The prevalence did not significantly differ between women with less than a high school diploma and those with a high school diploma or GED degree.

* Education and income subpopulations are among women ages 25-44.
State Rankings

Women and children have faced unique challenges across the nation during the COVID-19 pandemic. The state of their health in the years leading up to the pandemic influenced the pandemic’s impact. The rankings included in this year’s Health of Women and Children Report — the first ranking analysis of this report since 2019 — are derived from 84 measures across five categories of health: social and economic factors, physical environment, behaviors, clinical care and health outcomes. For a detailed description of how the overall rank is calculated, visit AmericasHealthRankings.org.

The U.S. map displays the 2022 rankings shaded by quintile. The healthiest states for women and children are in the Northeast, West and Midwest. The states with the most health challenges are in the South and Southwest.

Minnesota Ranks No. 1

Minnesota is the healthiest state in this year’s report, and the healthiest for both women and children. It ranks among the top five states in social and economic factors (No. 3), physical environment (No. 5), behaviors (No. 1) and health outcomes (No. 3). Minnesota is No. 12 in clinical care.

- **Strengths:** High percentage of youth who are flourishing, high percentage of infants exclusively breastfed for six months and high percentage of female college graduates.
- **Challenges:** High prevalence of excessive drinking among women, high racial disparity between American Indian/Alaska Native and white children in poverty and low prevalence of dental care among children.

Massachusetts (No. 2), Vermont (No. 3), New Jersey (No. 4) and Utah (No. 5) complete the top five healthiest states.
Louisiana Ranks No. 50

Louisiana is the least healthy state in this year’s report, and for both women and children. It ranks in the bottom five states in social and economic factors (No. 50), physical environment (No. 48), behaviors (No. 50) and health outcomes (No. 49). Louisiana is No. 38 in clinical care.

- **Strengths:** Low prevalence of illicit drug use among youth, high prevalence of ADD/ADHD treatment and high prevalence of well-woman visits.

- **Challenges:** High infant mortality rate, low percentage of female college graduates and low prevalence of food sufficiency among children.

Arkansas (No. 49), Mississippi (No. 48), Oklahoma (No. 47) and Alabama (No. 46) complete the five least healthy states.
This graph displays the states in order of rank. The green bars represent states scoring healthier than the U.S. average (above zero), while gold bars represent states scoring less healthy than the U.S. average (below zero). The distance between bars indicates the difference between state scores. For example, Arkansas (No. 49) and Mississippi (No. 48) have a large difference in score, making it difficult for Arkansas to move up in the rankings. There is also a large gap in score between Vermont (No. 3) and the next highest state, Massachusetts (No. 2).

To further explore state-level data, visit [AmericasHealthRankings.org](http://AmericasHealthRankings.org). The website features a summary for each state and the District of Columbia that is available for download. Each summary describes state-specific strengths, challenges, trends and rankings for individual measures, allowing users to identify which measures positively or negatively influenced their state’s overall rank. This can be visualized using the Core Measure Impact graph by selecting a state in Explore Data. 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.

Source: *America’s Health Rankings* composite measure, 2022.

*Sum of weighted z-scores across all measures included in the rankings.*
National Summary
Health Department Website: hhs.gov

Summary

**TEEN BIRTHS**  
**▼42%**  
from 26.4 to 15.4 births per 1,000 females ages 15-19 between 2013 and 2020.

**FLU VACCINATION**  
**▲26%**  
from 30.8% to 38.9% of women ages 18-44 between 2017-2018 and 2019-2020.

**MORTALITY**  
**▲21%**  
from 97.2 to 117.3 deaths per 100,000 women ages 20-44 between 2019 and 2020.

**FIREARM DEATHS**  
**▲18%**  
from 4.0 to 4.7 deaths per 100,000 children ages 1-9 between 2015-2017 and 2018-2020.

**FREQUENT MENTAL DISTRESS**  
**▲14%**  
from 17.0% to 19.4% of women ages 18-44 between 2017-2018 and 2019-2020.

**SEVERE MATERNAL MORBIDITY**  
**▲12%**  
from 72.1 to 81.0 per 10,000 delivery hospitalizations between 2016 and 2019.

**FLOURISHING**  
**▼7%**  
from 71.7% to 66.6% of children ages 0-17 between 2018-2019 and 2020-2021.

**FOOD SUFFICIENCY**  
**▲6%**  
from 68.1% to 71.9% of children ages 0-17 between 2018-2019 and 2020-2021.

### Women

#### Measures  
<table>
<thead>
<tr>
<th>SOCIAL &amp; ECONOMIC FACTORS</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and Family Safety</td>
<td>5.1</td>
</tr>
<tr>
<td>Intimate Partner Violence Before Pregnancy</td>
<td>2.5</td>
</tr>
<tr>
<td>Violent Crime</td>
<td>3.7</td>
</tr>
<tr>
<td>Concentrated Disadvantage</td>
<td>26.1</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>10.7</td>
</tr>
<tr>
<td>Gender Pay Gap</td>
<td>8.0</td>
</tr>
<tr>
<td>Poverty</td>
<td>15.2</td>
</tr>
<tr>
<td>Unemployment</td>
<td>8.3</td>
</tr>
<tr>
<td>College Graduate</td>
<td>35.6</td>
</tr>
<tr>
<td>Infant Child Care Cost</td>
<td>12.0</td>
</tr>
<tr>
<td>Residential Segregation — Black/White</td>
<td>—</td>
</tr>
<tr>
<td>Voter Participation</td>
<td>61.7</td>
</tr>
<tr>
<td>Air Pollution</td>
<td>8.3</td>
</tr>
<tr>
<td>Drinking Water Violations</td>
<td>0.8</td>
</tr>
<tr>
<td>Household Smoke</td>
<td>13.8</td>
</tr>
<tr>
<td>Risk-screening Environmental Indicators Score</td>
<td>—</td>
</tr>
<tr>
<td>Water Fluoridation</td>
<td>73.0</td>
</tr>
<tr>
<td>Climate Change</td>
<td>—</td>
</tr>
<tr>
<td>Climate Change Policies</td>
<td>7.4</td>
</tr>
<tr>
<td>Transportation Energy Use</td>
<td>—</td>
</tr>
<tr>
<td>Drive Alone to Work</td>
<td>75.4</td>
</tr>
<tr>
<td>Housing With Lead Risk</td>
<td>17.6</td>
</tr>
<tr>
<td>Severe Housing Problems</td>
<td>17.3</td>
</tr>
</tbody>
</table>

### Children

#### Measures  
<table>
<thead>
<tr>
<th>SOCIAL &amp; ECONOMIC FACTORS</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and Family Safety</td>
<td>8.4</td>
</tr>
<tr>
<td>Child Victimization</td>
<td>4.7</td>
</tr>
<tr>
<td>Concentrated Disadvantage</td>
<td>16.8</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>3.0</td>
</tr>
<tr>
<td>Gender Pay Gap</td>
<td>92.6</td>
</tr>
<tr>
<td>Poverty</td>
<td>2.5</td>
</tr>
<tr>
<td>Unemployment</td>
<td>54.6</td>
</tr>
<tr>
<td>Early Childhood Education</td>
<td>48.9</td>
</tr>
<tr>
<td>Fourth Grade Reading Proficiency</td>
<td>34.3</td>
</tr>
<tr>
<td>High School Graduation</td>
<td>85.8</td>
</tr>
<tr>
<td>High School Graduation Racial Disparity</td>
<td>15.1</td>
</tr>
<tr>
<td>Adverse Childhood Experiences</td>
<td>14.0</td>
</tr>
<tr>
<td>Foster Care Instability</td>
<td>14.9</td>
</tr>
<tr>
<td>Neighborhood Amenities</td>
<td>35.5</td>
</tr>
<tr>
<td>Reading, Singing or Storytelling</td>
<td>57.2</td>
</tr>
</tbody>
</table>

---

Health Department Website: hhs.gov

---

2022 HEALTH OF WOMEN AND CHILDREN REPORT  America's Health Rankings.org
## Women

### Measures

#### CLINICAL CARE

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>74.7%</td>
</tr>
<tr>
<td>Adequate Prenatal Care</td>
<td>74.7%</td>
</tr>
<tr>
<td>Avoided Care Due to Cost</td>
<td>17.5%</td>
</tr>
<tr>
<td>Publicly-funded Women's Health Services</td>
<td>29.9%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>12.9%</td>
</tr>
<tr>
<td>Women’s Health Providers</td>
<td>49.5%</td>
</tr>
<tr>
<td>Preventive Clinical Care</td>
<td>77.1%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>77.1%</td>
</tr>
<tr>
<td>Dental Visit</td>
<td>65.5%</td>
</tr>
<tr>
<td>Flu Vaccination</td>
<td>38.9%</td>
</tr>
<tr>
<td>Postpartum Visit†</td>
<td>88.4%</td>
</tr>
<tr>
<td>Well-woman Visit</td>
<td>72.0%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>83.9%</td>
</tr>
<tr>
<td>Breastfeeding Initiation†</td>
<td>83.9%</td>
</tr>
<tr>
<td>Dedicated Health Care Provider</td>
<td>71.1%</td>
</tr>
<tr>
<td>Low-risk Cesarean Delivery</td>
<td>25.9%</td>
</tr>
<tr>
<td>Maternity Practices Score</td>
<td>81</td>
</tr>
</tbody>
</table>

#### BEHAVIORS

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition and Physical Activity</td>
<td>21.5%</td>
</tr>
<tr>
<td>Exercise</td>
<td>21.5%</td>
</tr>
<tr>
<td>Fruit and Vegetable Consumption</td>
<td>10.4%</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>22.3%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>1,552.8</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>1,552.8</td>
</tr>
<tr>
<td>High-risk HIV Behaviors</td>
<td>9.6%</td>
</tr>
<tr>
<td>Unintended Pregnancy‡</td>
<td>28.5%</td>
</tr>
<tr>
<td>Sleep Health</td>
<td>33.4%</td>
</tr>
<tr>
<td>Insufficient Sleep</td>
<td>33.4%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>7.6%</td>
</tr>
<tr>
<td>E-cigarette Use†</td>
<td>7.6%</td>
</tr>
<tr>
<td>Smoking</td>
<td>13.4%</td>
</tr>
<tr>
<td>Smoking During Pregnancy</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

#### HEALTH OUTCOMES

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>22.4</td>
</tr>
<tr>
<td>Drug Deaths‡</td>
<td>22.4</td>
</tr>
<tr>
<td>Excessive Drinking</td>
<td>19.4%</td>
</tr>
<tr>
<td>Frequent Mental Distress</td>
<td>19.4%</td>
</tr>
<tr>
<td>Illicit Drug Use</td>
<td>10.8%</td>
</tr>
<tr>
<td>Postpartum Depression‡</td>
<td>13.6%</td>
</tr>
<tr>
<td>Mortality</td>
<td>19.3</td>
</tr>
<tr>
<td>Maternal Mortality‡</td>
<td>19.3</td>
</tr>
<tr>
<td>Mortality Rate†</td>
<td>117.3</td>
</tr>
<tr>
<td>Physical Health</td>
<td>75.0%</td>
</tr>
<tr>
<td>Frequent Physical Distress</td>
<td>75.0%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>10.6%</td>
</tr>
<tr>
<td>High Health Status‡</td>
<td>57.4%</td>
</tr>
<tr>
<td>Multiple Chronic Conditions</td>
<td>4.1%</td>
</tr>
<tr>
<td>Obesity</td>
<td>30.4%</td>
</tr>
<tr>
<td>Severe Maternal Morbidity‡</td>
<td>81.0%</td>
</tr>
</tbody>
</table>

### Non-ranking measure.

— Indicates data missing or suppressed.

For measure descriptions, source details and methodology, visit AmericasHealthRankings.org.

## Children

### Measures

#### CLINICAL CARE

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>2.8%</td>
</tr>
<tr>
<td>ADD/ADHD Treatment</td>
<td>2.8%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>107.2</td>
</tr>
<tr>
<td>Uninsured</td>
<td>5.7%</td>
</tr>
<tr>
<td>Preventive Clinical Care</td>
<td>70.5%</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>70.5%</td>
</tr>
<tr>
<td>HPV Vaccination</td>
<td>58.6%</td>
</tr>
<tr>
<td>Preventive Dental Care</td>
<td>75.1%</td>
</tr>
<tr>
<td>Well-child Visit</td>
<td>76.7%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>68.2%</td>
</tr>
<tr>
<td>Adequate Insurance</td>
<td>68.2%</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>34.8%</td>
</tr>
<tr>
<td>Medical Home</td>
<td>46.0%</td>
</tr>
</tbody>
</table>

#### BEHAVIORS

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition and Physical Activity</td>
<td>24.9%</td>
</tr>
<tr>
<td>Breastfed</td>
<td>24.9%</td>
</tr>
<tr>
<td>Food Sufficiency</td>
<td>71.9%</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>20.5%</td>
</tr>
<tr>
<td>Soda Consumption — Youth‡</td>
<td>9.3%</td>
</tr>
<tr>
<td>Sexual Health — Youth</td>
<td>90.9%</td>
</tr>
<tr>
<td>Dual Contraceptive Nonuse‡</td>
<td>90.9%</td>
</tr>
<tr>
<td>Teen Births</td>
<td>15.4</td>
</tr>
<tr>
<td>Sleep Health</td>
<td>66.6%</td>
</tr>
<tr>
<td>Adequate Sleep</td>
<td>66.6%</td>
</tr>
<tr>
<td>Sleep Position‡</td>
<td>80.2%</td>
</tr>
<tr>
<td>Tobacco Use — Youth</td>
<td>32.7%</td>
</tr>
<tr>
<td>Electronic Vapor Product Use†</td>
<td>32.7%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

#### HEALTH OUTCOMES

<table>
<thead>
<tr>
<th>Measures</th>
<th>U.S. Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>8.8%</td>
</tr>
<tr>
<td>Alcohol Use — Youth</td>
<td>8.8%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>9.2%</td>
</tr>
<tr>
<td>Depression</td>
<td>4.2%</td>
</tr>
<tr>
<td>Flourishing</td>
<td>66.6%</td>
</tr>
<tr>
<td>Illicit Drug Use — Youth</td>
<td>7.7%</td>
</tr>
<tr>
<td>Teen Suicide†</td>
<td>10.8</td>
</tr>
<tr>
<td>Mortality</td>
<td>25.9</td>
</tr>
<tr>
<td>Child Mortality</td>
<td>25.9</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>5.6</td>
</tr>
<tr>
<td>Physical Health</td>
<td>6.9%</td>
</tr>
<tr>
<td>Asthma</td>
<td>6.9%</td>
</tr>
<tr>
<td>High Health Status‡</td>
<td>90.2%</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>8.2%</td>
</tr>
<tr>
<td>Low Birthweight Racial Disparity</td>
<td>2.0</td>
</tr>
<tr>
<td>Neonatal Abstinence Syndrome†</td>
<td>6.1</td>
</tr>
<tr>
<td>Overweight or Obesity — Youth</td>
<td>33.5%</td>
</tr>
</tbody>
</table>
References


REFERENCES


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 2022 America's Health Rankings 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 the design and selection of measures for this report.

Data contained within this report were obtained from and used with permission of:

- Center for Climate and Energy Solutions
- Child Care Aware
- Guttmacher Institute
- March of Dimes
- U.S. Department of Agriculture
  - Economic Research Service
- U.S. Census Bureau
  - American Community Survey
  - Current Population Survey, Voting and Registration Supplement
- U.S. Department of Education
  - National Center for Education Statistics
  - National Center for Homeless Education
- U.S. Department of Health and Human Services
  - Centers for Disease Control and Prevention
  - Centers for Medicare & Medicaid Services
  - Children's Bureau
  - Health Resources & Services Administration
    - Maternal and Child Health Bureau
  - Substance Abuse and Mental Health Services Administration
- U.S. Department of Housing and Urban Development
  - Office of Policy Development and Research
- U.S. Department of Justice
  - Federal Bureau of Investigation
- U.S. Department of Labor
  - Bureau of Labor Statistics
- U.S. Energy Information Administration
- U.S. Environmental Protection Agency

United Health Foundation encourages the distribution of information contained in this publication for non-commercial and charitable, educational or scientific purposes. Please acknowledge America's Health Rankings Health of Women and Children Report as the source and provide the following notice: ©2022 United Health Foundation. All Rights Reserved. Please acknowledge the original source of specific data as cited.

Arundel Metrics, Inc. of Saint Paul, Minnesota, conducted this project for and in cooperation with United Health Foundation, with design by Aldrich Design, Saint Paul, Minnesota.

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

Copyright ©2022 United Health Foundation
United Health Foundation

About the United Health Foundation

Through collaboration with community partners, grants and outreach efforts, the United Health Foundation works to improve our health system, build a diverse and dynamic health workforce and enhance the well-being of local communities. The United Health Foundation was established by UnitedHealth Group (NYSE: UNH) in 1999 as a not-for-profit, private foundation dedicated to improving health and health care. To date, the United Health Foundation has committed more than $700 million to programs and communities around the world. To learn more, visit UnitedHealthFoundation.org.

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