The United Health Foundation is proud to release the America’s Health Rankings® 2023 Health of Women and Children Report, which continues to provide a comprehensive look at the health of these populations.

This report highlights the rising rates of mortality among women of reproductive age and children across the nation and on a state-by-state basis, as well as the stark disparities that exist by geography and race/ethnicity.

Monitoring the health and well-being of women of reproductive age and children is a fundamental aspect of public health. Ensuring the health of these two groups by preventing disease, improving access to care, encouraging healthy behaviors and promoting equity by addressing the social determinants of health can have a significant impact on the overall well-being of individuals, families and communities. According to the U.S. Census Bureau, in 2021 there were 58.7 million women of reproductive age (18-44) and 73.6 million children in the United States, representing roughly 40% of the total population. These populations have continued to grow and diversify in the past several years; however, many of the challenges affecting their health and well-being have remained consistent, and new challenges have emerged.

For the second consecutive year, the mortality rate among both women and children continued to increase, reaching new highs in America’s Health Rankings’ history. This report highlights the rising rates of maternal mortality and drug deaths among women and introduces two new community and family safety measures that are on the rise: injury deaths among both women and children. Within these measures of mortality, stark disparities exist by geography and race/ethnicity.

Despite negative trends in mortality, the percentage of women who reported their own health was very good or excellent improved, reaching the highest level recorded by America’s Health Rankings.

The data also highlight several changes that occurred during the COVID-19 pandemic. In some cases, long-term improvements like the reduction in teen births continued; however, other measures shifted. For example, there was an encouraging decrease in the prevalence of electronic vapor product use among high schoolers, while there was a discouraging drop in the percentage of 3- and 4-year-olds enrolled in early childhood education.
The 2023 Health of Women and Children Report finds that:

- Mortality rates, including maternal mortality, continued to increase among women of reproductive age and children, while the infant mortality rate declined. All mortality measures had wide disparities by race/ethnicity and geography.

- Women's mental and behavioral health challenges continued to grow, with increases in the drug death rate and prevalences of frequent mental distress and depression, all with disparities by age, race/ethnicity and geography.

- Despite troubling trends in women's mortality measures and mental health, the percentage of women who reported their own health was very good or excellent improved, along with the percentage who reported frequent physical distress. However, severe maternal morbidity and the percentage of infants born with a low birth weight significantly worsened.

- Injury deaths, an indicator of community and family safety, have been increasing among women of reproductive age and children.

- During the COVID-19 pandemic, early childhood education enrollment declined substantially between 2019 and 2021.

- Many measures of individuals’ access to care improved while the number of women's health providers declined.

- Among women of reproductive age, fruit and vegetable intake decreased and the percentage of physically inactive women declined.

- The long-term successes in reducing smoking and teen birth rates have continued.

We encourage policymakers, advocates, community leaders and individuals to use these findings to help target and tailor public health interventions that address these concerning trends and their upstream causes.
Objective

America’s Health Rankings aims to inform and drive action to build healthier communities by offering credible, trusted data that can guide efforts to improve population health and health care. To achieve this, America’s Health Rankings continues to collaborate with an advisory group to determine the selection of a comprehensive set of measures. The 2023 Health of Women and Children Report is based on:

- **122 measures.** These include 83 ranking and 39 additional measures (not included in overall rank). Five new measures are introduced this year including high school completion, injury deaths among women, injury deaths among children, housing cost burden in households with children and maternity care desert. For a full list of measures, definitions and source details, see the Measures Table.

- **Five categories of health.** These include health outcomes and four other categories that are determinants of health: social and economic factors, physical environment, behaviors and clinical care.

- **34 data sources.** Data are from many sources, including CDC’s Behavioral Risk Factor Surveillance System and Pregnancy Risk Assessment Monitoring System, the March of Dimes and the U.S. Census Bureau’s American Community Survey.

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

- **Presenting a holistic view of health.** This report goes beyond measures of clinical care and health behaviors by considering social, economic and physical environment measures, reflecting the impact of social determinants of health.

- **Providing a benchmark for states.** Each year the report presents strengths, challenges and highlights for every state using data dating back to the first Health of Women and Children Report. Public health advocates can monitor health trends over time and compare their state with other states or the nation. State summaries containing data on all 83 ranking measures are available on the website as a separate download.

- **Highlighting disparities.** The report shows differences in health between states and among population groups at state and national levels, with groupings based on race/ethnicity, gender, age, educational attainment, income level and metropolitan status. These analyses often reveal differences among groups that national or state aggregate data may mask.

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

Model for Measuring America’s Health

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

Health Outcomes

16% ▲ Mortality — Women
increased from 117.3 to 136.4 deaths per 100,000 women ages 20-44 between 2020 and 2021.
Source: CDC WONDER, Multiple Cause of Death Files.

16% ▲ Frequent Mental Distress
increased from 18.1% to 21.0% between 2018-2019 and 2020-2021.
Source: CDC, Behavioral Risk Factor Surveillance System.

7% ▲ Child Mortality
increased from 25.7 to 27.4 deaths per 100,000 children ages 1-19 between 2016-2018 and 2019-2021.
Source: CDC WONDER, Multiple Cause of Death Files.

10% ▲ High Health Status
increased from 53.8% to 59.0% of women ages 18-44 between 2018-2019 and 2020-2021.

4% ▼ Infant Mortality
decreased from 5.7 to 5.5 deaths per 1,000 live births between 2017-2018 and 2019-2020.
Source: CDC WONDER, Linked Birth/Infant Death Files.

9% ▲ Severe Maternal Morbidity
increased from 8.1 to 8.83 complications per 10,000 delivery hospitalizations between 2019 and 2020.
Source: Federally Available Data, Maternal and Child Health Bureau, Health Resources and Services Administration.

27% ▲ Drug Deaths
increased from 20.3 to 25.7 deaths per 100,000 females ages 20-44 between 2016-2018 and 2019-2021.
Source: CDC WONDER, Multiple Cause of Death Files.

Social and Economic Factors

17% ▲ Injury Deaths — Women
increased from 41.0 to 48.1 deaths per 100,000 females ages 20-44 between 2016-2018 and 2019-2021.
Source: CDC WONDER, Multiple Cause of Death Files.

11% ▲ Injury Deaths — Children
increased from 15.7 to 17.4 deaths per 100,000 children ages 1-19 between 2016-2018 and 2019-2021.
Source: CDC WONDER, Multiple Cause of Death Files.

Recent notable shifts in key health indicators

Maternal Mortality
22.4 deaths per 100,000 live births in 2017-2021.

High Health Status
59.0% of women ages 18-44 reported that their health was very good or excellent in 2020-2021.
Clinical Care

9%▼
Uninsured Women
decreased from 12.9% to 11.8% among women ages 19-44 between 2019 and 2021.
Source: U.S. Census Bureau, American Community Survey.

5%▼
Uninsured Children
decreased from 5.7% to 5.4% among children ages 0-19 between 2019 and 2021.
Source: U.S. Census Bureau, American Community Survey.

7%▼
Women’s Health Providers
decreased from 12.9% to 11.8% among women ages 19-44 between 2019 and 2021.
Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.

Behaviors

20%▼
Fruit and Vegetable Consumption
decreased from 12.2% to 9.8% of women ages 18-44 between 2017 and 2021.
Source: CDC, Behavioral Risk Factor Surveillance System.

7%▼
Physical Inactivity
decreased from 22.6% to 21.1% of women ages 18-44 between 2018-2019 and 2020-2021.
Source: CDC, Behavioral Risk Factor Surveillance System.

15%▼
Smoking
decreased from 14.3% to 12.1% of women ages 18-44 between 2018-2019 and 2020-2021.
Source: CDC, Behavioral Risk Factor Surveillance System.

10%▼
Teen Births
decreased from 15.4 to 13.9 births per 1,000 females ages 15-19 between 2020 and 2021.
Source: CDC WONDER, Natality Public Use Files.

Early Childhood Education

18%▼
decreased from 48.9% to 40.2% of children ages 3-4 between 2019 and 2021.

Fruit and Vegetable Consumption

1 in 10
women ages 18-44 reported consuming two or more fruits and three or more vegetables daily in 2021.

Electronic Vapor Product Use — Youth

45%▼
decreased from 32.7% to 18.0% of high school students between 2019 and 2021.
Mortality rates, including maternal mortality, continued to increase among women of reproductive age and children, while the infant mortality rate declined. All mortality measures had distressing disparities by race/ethnicity and geography.

**Mortality Among Women**

The death rate among women of reproductive age has **risen** since 2011 after declining between 2003 and 2011. Between 2020 and 2021, the number of deaths from accidents and COVID-19 increased, and COVID-19 moved from the fifth to the second leading cause of death. In 2021, the leading causes of death among women ages 20-44 were accidents (unintentional injuries), COVID-19, cancer, heart disease and suicide. In addition, the maternal mortality rate in the U.S. has **risen** steadily since 1990, and the U.S. had the **highest rate** among high-income countries.²³

**Increases in Mortality Among Women Between 2020 and 2021**

Data show concerning trends and disparities in mortality, rising mental health challenges among women — with gains in some other health measures.
Significant changes over time. Nationally, the mortality rate increased 16% from 117.3 to 136.4 deaths per 100,000 women ages 20-44 between 2020 and 2021, a smaller increase than the 21% increase between 2019 and 2020. In 2021, about 74,400 U.S. women died, an increase of nearly 10,800 women compared with 2020. The mortality rate increased in 27 states, led by 32% in Georgia (126.7 to 167.1), 29% in Nevada (117.7 to 152.0) and 28% in Nebraska (86.7 to 111.0). The rate increased among every racial/ethnic group, led by 43% among Hawaiian/Pacific Islander (168.9 to 240.9), 21% among Hispanic (80.5 to 97.3) and 18% among American Indian/Alaska Native (357.6 to 423.4) women.

Disparities. The mortality rate significantly varied by race/ethnicity and geography in 2021. The rate was:

- 9.9 times higher among American Indian/Alaska Native (423.4 deaths per 100,000 women ages 20-44) than Asian (42.6) women.
- 3.0 times higher in West Virginia (266.3) than Hawaii (87.5).

Related Measure: Maternal Mortality

Nationally, the maternal mortality rate increased 29% from 17.3 to 22.4 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 between 2014-2018 and 2017-2021. The rate exceeded the Healthy People 2030 national target of 15.7 per 100,000. During this period, the maternal mortality rate increased in eight states, led by 148% in Mississippi (15.3 to 38.0 deaths per 100,000 live births), 136% in Nevada (9.5 to 22.4) and 70% in California (5.6 to 9.5). The rate varied by race/ethnicity, geography, age and educational attainment in 2017-2021. The rate was:

- 4.5 times higher among American Indian/Alaska Native (60.6) than multiracial (13.6), 4.3 times higher than Asian (14.0), 3.4 times higher than Hispanic (17.7) and 3.1 times higher than white (19.6) women.
- Notably, the maternal mortality rate was also 2.6 times higher among Black (51.3) compared with white women.
- 4.4 times higher in Alabama (41.9) than California (9.5).
- 3.5 times higher among women ages 35 and older (46.7) than women ages 20-24 (13.4).
- 2.9 times higher among women who graduated from high school (34.4) than college graduates (11.9).

Note: The 2014-2018 and 2017-2021 comparison contains overlapping 5-year estimates. Because of the overlapping data years, the comparison is largely between the non-overlapping years (2014-2016 and 2019-2021). The estimates for women ages 20-24 and women less than 20 years (14.3) and the estimates for high school graduates and women with less than a high school education (31.7) were not significantly different based on non-overlapping 95% confidence intervals.
Child Mortality

Most deaths among children are preventable. Among children ages 1-19, the top causes of death in 2019-2020 were accidents (unintentional injury), homicide, suicide, cancer and congenital abnormalities. Since 2016-2018, homicide has surpassed suicide as the second-leading cause of death among children.

Significant changes over time. Nationally, the mortality rate increased 7% from 25.7 to 27.4 deaths per 100,000 children ages 1-19 between 2016-2018 and 2019-2021. That rate exceeded the Healthy People 2030 target of 18.4 deaths per 100,000. In 2019-2021, nearly 64,100 U.S. children died, an increase of 3,700 children compared with 2016-2018. The mortality rate increased in seven states, led by 19% in Arizona (28.8 to 34.3 deaths per 100,000 children ages 1-19), 18% in Mississippi (40.6 to 48.0) and 16% in Louisiana (37.7 to 43.7). Significant increases occurred among the oldest age group and by gender. The mortality rate increased 12% among children ages 15-19 (50.6 to 56.5), 8% among boys (32.7 to 35.3) and 3% among girls (18.5 to 19.1).

Disparities. The mortality rate significantly varied by age, race/ethnicity, geography and gender in 2019-2021. The rate was:

- 4.1 times higher among children ages 15-19 (56.5 deaths per 100,000 children ages 1-19) than children ages 5-14 (13.8).
- 4.0 times higher among American Indian/Alaska Native (55.5) than Asian (14.0) children.
- 3.3 times higher in Mississippi (48.0) than Massachusetts (14.7).
- 1.8 times higher among boys (35.3) than girls (19.1).

Note: The estimates for American Indian/Alaska Native and Black (51.5) children were not significantly different from each other based on non-overlapping 95% confidence intervals.

Source: CDC WONDER, Multiple Cause of Death Files, 2016-2021.

Child Mortality


Source: CDC WONDER, Multiple Cause of Death Files, 2019-2021.
Infant Mortality

The infant mortality rate is consistently higher in the U.S. than in other developed countries.6,7 Around two-thirds of infant deaths occur during the neonatal period, birth to 27 days old.8 Research shows that socioeconomic inequality in the U.S. is a primary contributor to its higher infant mortality rate.9

Significant changes over time. Nationally, the infant mortality rate decreased 4% from 5.7 to 5.5 deaths before age 1 per 1,000 live births between 2017-2018 and 2019-2020, moving closer to the Healthy People 2030 target of 5.0 per 1,000.10 In 2019-2020, approximately 40,500 U.S. infants died, a decrease of about 3,300 infants compared with 2017-2018. The infant mortality rate decreased in 33 states and the District of Columbia, led by 35% in the District of Columbia (7.8 to 5.1 deaths per 1,000 live births), 18% in Hawaii (6.1 to 5.0) and 13% in both Nevada (6.0 to 5.2) and Rhode Island (5.6 to 4.9). During the same period, the infant mortality rate increased in seven states, led by 30% in North Dakota (5.0 to 6.5), 5% in Louisiana (7.4 to 7.8) and 4% in both South Dakota (6.8 to 7.1) and Colorado (4.6 to 4.8). The rate decreased among every racial/ethnic and age group. By group, the largest decreases were 11% among infants born to Hawaiian/Pacific Islander women (8.5 to 7.6) and Asian women (3.7 to 3.3) and 6% among infants born to women ages 35-39 (5.2 to 4.9).

Disparities. The infant mortality rate varied significantly by race/ethnicity, geography, age and metropolitan status in 2019-2020. The rate was:

- 3.2 times higher among infants born to Black (10.5 deaths per 1,000 live births) than Asian (3.3) women.
- 2.7 times higher in Mississippi (8.4) than Vermont (3.1).
- 1.9 times higher among infants born to women ages 15-19 (8.6) than women ages 30-34 (4.5).
- Higher among infants born to women in non-metropolitan (6.3) areas than metropolitan (5.4) areas.

Related Measure: Neonatal Mortality

Nationally, between 2017-2018 and 2019-2020 the neonatal mortality rate significantly decreased 5% from 3.8 to 3.6 deaths during the first 28 days of life per 1,000 live births. During this timeframe, the rate significantly decreased in 30 states and the District of Columbia, led by 41% in the District of Columbia (5.1 to 3.0), 21% in Hawaii (3.9 to 3.1) and 17% in both Indiana (4.7 to 3.9) and Oklahoma (4.7 to 3.9). During the same period, the rate significantly increased in Louisiana, Washington, Michigan, North Carolina, West Virginia and Wisconsin. The rate of neonatal mortality was 2.6 times higher in Mississippi (5.0) than Vermont (1.9) and higher among male (3.9) than female (3.3) neonates.
At Any Baby Can, we work with clients in central Texas to build stability in families. We help parents develop skills to navigate complex systems, advocate for themselves and reach their full potential, one family and one child at a time. We work on the ground with parents and children who face medical, educational and financial obstacles.

The Health of Women and Children Report’s findings are not a surprise to me, unfortunately. In fact, I see it as confirmation of the urgency of our work. The challenges it outlines — high maternal mortality rates, rising mental health concerns among women, and increasing health disparities among underserved populations — are what we seek to improve daily.

As a mom and grandma, I know children don’t come with instructions. Our Nurse-Family Partnership program — supported in part by a grant from the United Health Foundation — pairs each client with a clinician to walk beside them through the journey of motherhood, from 28 weeks to age 2, or longer. Together we help achieve a mentally and physically healthy pregnancy, birth and postpartum period. As a result of this grant, we implemented innovations in maternal health to our home visiting program. All clients are now screened to identify mental health needs, and women at risk for preeclampsia are provided with and trained on using blood pressure monitors.

This report also reinforces the need for approaching maternal and child health with a prevention lens. We empower women with knowledge and self-confidence to understand their own needs and act, and build awareness of risk factors for negative health outcomes. Our population of lower-income, first-time pregnant mothers often face higher risk for pregnancy complications, pre-term labor, low birth weight babies and maternal mortality. This includes preeclampsia, characterized by high blood pressure and can potentially lead to organ failure and maternal mortality. First-time pregnant women may not know their likelihood of developing preeclampsia or the early symptoms, so to reduce risk, we provide clients with blood pressure cuffs and training on how to monitor at home. We help mothers know their baseline metrics, advocate for their own health and understand what to do if something changes. Through these and other programs, we seek to meet each family where they are — including physically meeting directly in their homes — and equip them with the tools they need.

We know that a child’s ability to have a healthy and happy future is based on the well-being of the whole family and those surrounding them. At Any Baby Can, we provide holistic programming to help address stressors, including case management, mental health care and support for a family’s everyday needs. If you’re focusing on keeping a roof over your head and food on the table, it’s hard to be fully present for the joys and challenges of parenting.

While the report’s findings are tragic, the positive outcomes I see among the families we serve gives me hope. They have hope for a better future, and we hold that hope with them. I’ve had countless mothers over decades tell me how our work has been valuable to them, the humans behind the worrisome data in the report.

I’m also heartened by the high rates of healthy birth weight babies, moms initiating breastfeeding and immunization rates among our families. We are extremely proud, too, that according to our surveyed clients, 99% are more knowledgeable about child development, 94% more prepared to plan their families’ futures and 98% better able to handle stress.

To improve maternal and childhood health outcomes, there is much work to be done to address barriers to care and services. My hope is that we all reflect on and use this data; that we link arms and join together to help transform lives — because healthy families raise healthy children, and that leads to healthier communities for everyone.
Women’s mental and behavioral health challenges continued to grow, with increases in drug deaths, frequent mental distress and depression, all with disparities by age, race/ethnicity and geography.

**Drug Deaths**

Drug overdose deaths have risen steadily in the U.S. over the past two decades, becoming a leading cause of injury death and contributing to the decline in life expectancy.\(^1\)

**Significant changes over time.** Nationally, the drug death rate — deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 females ages 20-44 — increased 27% from 20.3 to 25.7 between 2016-2018 and 2019-2021. This increase was larger than the 19% increase in the 2022 *Health of Women and Children Report*. The rate exceeded the Healthy People 2030 target of 20.7 deaths per 100,000.\(^1\)\(^2\) In 2019-2021, nearly 41,900 women in the U.S. died from a drug overdose, an increase of slightly more than 9,200 women since 2016-2018. The drug death rate increased in 30 states and the District of Columbia, led by 90% in North Dakota (10.7 to 20.3 deaths per 100,000 females ages 20-44), 89% in Mississippi (12.0 to 22.7), 82% in the District of Columbia (9.2 to 16.7) and 77% in Louisiana (24.2 to 42.8).

**Disparities.** The drug death rate significantly varied by race/ethnicity, geography and age in 2019-2021; all disparities were larger than those in the 2022 *Health of Women and Children Report*. The rate was:

- 18.1 times higher among American Indian/Alaska Native (56.0 deaths per 100,000 females ages 20-44) than Asian (3.1) women.
- 8.8 times higher in West Virginia (84.6) than Hawaii (9.6).
- 2.3 times higher among women ages 35-44 (31.3) than women ages 20-24 (13.9).
Frequent Mental Distress

21.0%

of women ages 18-44 reported their mental health was not good 14 or more days in the past 30 days in 2020-2021.


Frequent Mental Distress

Frequent mental distress is a self-reported measure that captures the population experiencing persistent and severe mental health issues.

Significant changes over time. Nationally, the percentage of women ages 18-44 who reported their mental health was not good 14 or more days in the past 30 days increased 16% from 18.1% to 21.0% between 2018-2019 and 2020-2021, a larger increase than seen in last year’s report. During this timeframe, the prevalence of frequent mental distress increased in 12 states, led by 38% in Colorado (16.0% to 22.1%), 32% in Iowa (18.0% to 23.7%) and 30% in Connecticut (15.1% to 19.6%). The prevalence increased across all income and age groups and among some educational attainment and racial/ethnic groups during this timeframe. By group, the largest increases were 42% among women with a household income of $75,000 or more (9.9% to 14.1%), 40% among college graduates (11.1% to 15.5%), 21% among women ages 35-44 (14.6% to 17.6%) and 19% among white women (20.7% to 24.7%).

Disparities. Frequent mental distress significantly varied by race/ethnicity, geography, income, educational attainment, age and metropolitan status in 2019-2021. The prevalence among women ages 18-44 was:

- 2.3 times higher among multiracial (28.9%) than Asian (12.7%) women.
- 1.9 times higher in Arkansas (28.7%) than Hawaii (15.5%) and 1.9 times higher among women with an annual household income less than $25,000 (26.3%) than women with an income of $75,000 or more (14.1%).
- 1.5 times higher among women with some post-high school education (23.4%) than college graduates (15.5%) and 1.5 times higher among women ages 18-24 (26.1%) than women ages 35-44 (17.6%).
- Higher among women living in non-metropolitan (23.6%) than metropolitan (20.7%) areas.

Note: The estimates for multiracial women, women who identify their race as other (28.2%) and American Indian/Alaska Native women (25.4%) were not significantly different from each other based on non-overlapping 95% confidence intervals; the same was true for estimates for Asian, Hispanic (15.5%) and Hawaiian/Pacific Islander (16.4%) women.

Related Measures: Depression and Postpartum Depression

Nationally, the percentage of women ages 18-44 who reported being told by a health professional that they had a depressive disorder — including depression, major depression, minor depression or dysthymia — significantly increased 8% from 25.3% to 27.4% between 2018-2019 and 2020-2021; this exceeded the 5% increase in the 2022 Health of Women and Children Report. During this timeframe, the prevalence significantly increased 36% in Connecticut (20.9% to 28.4%), 30% in Colorado (23.1% to 30.1%), 26% in Indiana (28.5% to 35.9%) and 17% in Virginia (23.8% to 27.9%). The prevalence increased among some income, age, racial/ethnic and educational attainment groups. It was 2.4 times higher in New Hampshire (38.7%) than Hawaii (15.9%) and significantly varied by race/ethnicity, income, educational attainment, age and metropolitan status.

Nationally, the prevalence of postpartum depression among women with a recent live birth was 12.7% in 2021. Evaluating the 34 states with data, the prevalence was 2.9 times higher in Idaho (25.4%) than Vermont (8.7%).
The percentage of women who reported their own health was very good or excellent improved, along with the percentage who reported frequent physical distress. However, severe maternal morbidity and the percentage of infants born with a low birth weight significantly worsened.

High Health Status

Self-reported health status is a measure of how individuals perceive their health.\(^{13}\) It is a subjective measure of health-related quality of life that is not limited to specific health conditions or outcomes but also factors in social support, ability and ease of functioning, and other socioeconomic, environmental and cultural aspects.\(^{14}\)

**Significant changes over time.** Nationally, the percentage of women ages 18-44 who reported their health is very good or excellent increased 10% from 53.8% to 59.0% between 2018-2019 and 2020-2021. During this timeframe, the prevalence of high health status increased in 20 states, led by 22% in both New Mexico (46.0% to 56.3%) and Hawaii (53.5% to 65.1%) and 21% in Nevada (47.8% to 57.7%). The prevalence increased among most racial/ethnic, all educational attainment, some income and all age groups. By group, the largest increases were 29% among Hawaiian/Pacific Islander women (46.9% to 60.5%), 27% among women with less than a high school education (25.9% to 32.9%), 18% among women with an annual income less than $25,000 (32.5% to 38.5%) and 12% among women ages 18-24 (56.7% to 63.4%).

**Disparities.** The prevalence of high health status among women significantly varied by educational attainment, income, race/ethnicity, geography, age and metropolitan status in 2020-2021. It was:

- 2.2 times higher among college graduates (71.7%) than women with less than a high school education (32.9%).
- 1.9 times higher among women with an annual income of $75,000 or more (73.2%) than women with an income less than $25,000 (38.5%).
- Higher among white (64.7%) compared with American Indian/Alaska Native (47.2%) women, higher in South Dakota (65.5%) than Mississippi (53.4%), higher among women ages 18-24 (63.4%) than women ages 35-44 (55.6%) and higher among women living in metropolitan (59.3%) compared with non-metropolitan (56.7%) areas.

**Note:** The estimates for white, Asian (62.3%) and Hawaiian/Pacific Islander women were not significantly different from each other based on non-overlapping 95% confidence intervals; the same was true for American Indian/Alaska Native and Hispanic (47.9%) women.

**Related Measure: Frequent Physical Distress**

Nationally, the percentage of women ages 18-44 who reported their physical health was not good 14 or more days in the past 30 days significantly decreased 15% from 8.4% to 7.1% between 2018-2019 and 2020-2021. Frequent physical distress significantly decreased 40% in Oregon (12.3% to 7.4%), 32% in Arizona (10.7% to 7.3%), 28% in Virginia (8.1% to 5.8%) and 24% in New York (7.5% to 5.7%). The prevalence significantly decreased among some racial/ethnic, age and educational attainment groups. It was 2.1 times higher in Kentucky (11.0%) than Hawaii (5.2%) and varied significantly by income, race/ethnicity, educational attainment, age and metropolitan status.
Severe Maternal Morbidity

Severe maternal morbidity includes serious and potentially life-threatening events and outcomes, such as hemorrhage, eclampsia or hysterectomy.\textsuperscript{15,16}

Significant changes over time. Nationally, severe maternal morbidity — life-threatening maternal complications during delivery — increased 9% from 81.0 to 88.3 complications per 10,000 delivery hospitalizations between 2019 and 2020. This is larger than the increase between 2018 and 2019 and exceeded the Healthy People 2030 target of 64.4 per 10,000.\textsuperscript{17} In 2020, approximately 29,600 women experienced significant life-threatening complications during delivery, an increase of about 1,400 women compared with 2019. Severe maternal morbidity increased 22% in New York (92.2 to 112.1 complications during delivery per 10,000 delivery hospitalizations), 21% in Tennessee (73.1 to 88.6), 15% in both Michigan (78.3 to 89.9) and Florida (81.8 to 94.1) and 10% in Texas (72.4 to 79.5). The rate increased among some racial/ethnic groups and all age and income groups. By group, the largest increases were 15% among Hispanic women (82.2 to 94.6), 12% among both women younger than 20 (77.8 to 86.9) and women in the poorest income quartile (89.6 to 100.6) and 10% among women in metropolitan (87.0 to 96.0) areas.

Disparities. Severe maternal morbidity varied significantly by geography, race/ethnicity, age, income and metropolitan status in 2020. The rate was:

- 2.8 times higher in New York (112.1 complications per 10,000 delivery hospitalizations) than Wyoming (40.3).
- 2.0 times higher among Black (139.0) than white (69.9) women.
- 1.8 times higher among women ages 35 and older (127.9) compared with women ages 20-24 (72.3).
- Higher among women in the poorest income quartile (100.6) compared with women in the wealthiest income quartile (79.8), and higher among women in metropolitan (96.0) than non-metropolitan (74.7) areas.

Note: Data are missing for Alabama and Idaho. The estimates for women ages 20-24 and women ages 25-29 (75.7) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Low Birth Weight

Low birth weight infants (weighing less than 2,500 grams at birth) are at increased risk of several short- and long-term complications.\textsuperscript{18} Low birth weight and preterm birth are leading causes of infant mortality.\textsuperscript{6}
Injury deaths, an indicator of community and family safety, have been increasing among women of reproductive age and children. During the COVID-19 pandemic, early childhood education enrollment declined substantially.

**Injury Deaths — Women**

Injuries are the leading cause of death among women ages 20-44. In 2021, the top causes of injury death among women of reproductive age were poisoning (including drug deaths), motor vehicle traffic accidents and firearms. Firearm violence is a serious and deadly public health issue, especially for women. Women in the U.S. are 21 times more likely to die by firearm than women in comparable countries.¹⁹ Most injury deaths were accidents (unintentional), followed by suicide and homicide.

**Significant changes over time.** Nationally, the percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth increased 4% from 8.2% to 8.5% between 2020 and 2021. In 2021, approximately 311,900 infants were born with a low birth weight, an increase of about 14,300 infants compared with 2020. The low birth weight rate increased in eight states, led by 8% in Nevada (9.0% to 9.7%) and 7% in Minnesota (6.7% to 7.2%), Kentucky (8.5% to 9.1%), Georgia (9.9% to 10.6%) and Arizona (7.4% to 7.9%). The prevalence increased among some racial/ethnic, all age and some educational attainment groups. By group, the largest increases were 8% among infants born to Asian women (8.5% to 9.2%), 5% among infants born to both women ages 20-24 (8.6% to 9.0%) and women ages 40-44 (10.5% to 11.0%) and 4% among infants born to women with a high school diploma or GED (9.4% to 9.8%).

**Disparities.** Low birth weight varied significantly by race/ethnicity, geography, educational attainment and age in 2021. It was:

- 2.1 times higher among infants born to Black (14.7%) than white (7.0%) women.
- 1.9 times higher in Mississippi (12.3%) than North Dakota (6.6%).
- Higher among infants born to women with less than a high school education (10.1%) compared with college graduates (7.0%) and higher among infants born to women ages 40-44 (11%) compared with women ages 30-34 (7.9%).

**Note:** The estimates for women ages 30-34 and women ages 25-29 (8.0%) were not significantly different from each other based on non-overlapping 95% confidence intervals.

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**Source:** CDC WONDER, Multiple Cause of Death Files, 2012-2021.
Disparities. The injury death rate among women significantly varied by race/ethnicity, geography and age in 2019-2021. The rate was:

- 12.1 times higher among American Indian/Alaska Native (137.4 deaths per 100,000 females ages 20-44) than Asian (11.4) women.
- 4.3 times higher in West Virginia (116.1) than Hawaii (27.3).
- Higher among women ages 35-44 (53.2) than women ages 20-24 (36.9).

Related Measure: Firearm Deaths — Women

Nationally, firearm deaths among women significantly increased 14% from 4.9 to 5.6 deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 females ages 20-44 between 2016-2018 and 2019-2021. This increase is larger than the increase in the 2022 Health of Women and Children Report. In 2019-2021, 9,100 women died from firearms, an increase of approximately 1,300 women compared with 2016-2018. Between 2016-2018 and 2019-2021, the rate significantly increased 47% in Maryland (3.6 to 5.3 deaths per 100,000 females ages 20-44), 39% in Mississippi (10.8 to 15.0), 33% in Tennessee (7.5 to 10.0) and 25% in Georgia (6.8 to 8.5). The rate of firearm deaths among women varied significantly by geography, race/ethnicity and age in 2019-2021. It was 13.6 times higher in Mississippi (15.0) than Massachusetts (1.1), 10.1 times higher among Black (13.1) than Asian (1.3) women and higher among women ages 20-24 (5.9) and 25-34 (5.8) compared with women ages 35-44 (5.2).

Note: Data for Hawaii, Rhode Island and Vermont were suppressed because 20 or fewer deaths were recorded. The estimates for women ages 20-24 and women ages 25-34 were not significantly different from each other based on non-overlapping 95% confidence intervals.

Injury Deaths — Children

Accidents (unintentional injuries) are the leading cause of death among U.S. children ages 1-19, followed by homicide and suicide, all of which are considered injury deaths. In 2019-2021, the leading cause of injury deaths was firearms, followed by motor vehicle accidents and poisoning. The U.S. is the only nation among its peers where firearms are the leading cause of child mortality.

Significant changes over time. Nationally, injury deaths among children increased 11% from 15.7 to 17.4 deaths due to injury per 100,000 children ages 1-19 between 2016-2018 and 2019-2021. In 2019-2021, approximately 40,600 U.S. children died because of injury, an increase of 3,800 children compared with 2016-2018. Injury deaths among children increased in nine states and the District of Columbia, led by 71% in the District of Columbia (15.0 to 25.6 deaths per 100,000 children ages 1-19), 25% in Arizona (18.7 to 23.4) and 23% in both Mississippi (25.6 to 31.6) and Minnesota (12.1 to 14.9) between 2016-2018 and 2019-2021. The rate also increased among the following age groups and by gender: 13% among children ages 15-19 (38.7 to 43.7), 10% among children ages 5-14 (5.9 to 6.5), 12% among boys (21.7 to 24.4) and 5% among girls (9.5 to 10.0).

Significant Changes in Injury Deaths Among Children

Source: CDC WONDER, Multiple Cause of Death Files, 2016-2021.
Disparities. Injury deaths among children significantly varied by age, race/ethnicity, geography and gender in 2019-2021. The rate was:

- 6.7 times higher among children ages 15-19 (43.7 deaths per 100,000 children ages 1-19) than children ages 5-14 (6.5).
- 5.9 times higher among American Indian/Alaska Native (40.8) than Asian (6.9) children.
- 4.4 times higher in Alaska (32.9) than Massachusetts (7.5).
- 2.4 times higher among boys (24.4) than girls (10.0).

Related Measure: Firearm Deaths — Children

Nationally, firearm deaths among children significantly increased 26% from 4.2 to 5.3 deaths due to firearm injury per 100,000 children ages 1-19 between 2016-2018 and 2019-2021. This is a larger increase than the increase in last year’s report. In 2019-2021, approximately 12,500 U.S. children died by firearm, about 2,600 more deaths than in 2016-2018. Between 2016-2018 and 2019-2021, the rate significantly increased in 14 states, led by 61% in Kansas (4.9 to 7.9 per 100,000 children ages 1-19) and 55% in both North Carolina (4.4 to 6.8) and Louisiana (8.6 to 13.3). The rate of firearm deaths among children varied significantly by age, race/ethnicity and geography in 2019-2021. It was 23.4 times higher among children ages 15-19 (16.4) than children ages 1-4 (0.7), 15.0 times higher among Black (18.0) than Asian (1.2) children and 12.1 times higher in Louisiana (13.3) than Massachusetts (1.1).

Related Measure: Teen Suicide

Nationally, the teen suicide rate was 10.6 deaths per 100,000 adolescents ages 15-19 in 2019-2021, or approximately 6,800 deaths. The rate did not significantly differ from the 2016-2018 rate. However, the teen suicide rate significantly decreased 27% in Missouri (17.2 to 12.5 deaths per 100,000 adolescents ages 15-19) between 2016-2018 and 2019-2021. In 2019-2021, the teen suicide rate was 8.6 times higher in Alaska (41.3) than in Massachusetts (4.8) and 5.0 times higher among American Indian/Alaska Native (39.9) than Hispanic (8.0) teens.

Note: Teen suicide data for Delaware, Rhode Island and Vermont were suppressed because 20 or fewer deaths were recorded.

Early Childhood Education

The COVID-19 pandemic severely disrupted early childhood education and exacerbated already present disparities.21 For many, the path to higher educational attainment starts with early childhood education. There is sound evidence that early childhood education leads not only to higher educational attainment but also contributes to better health and promotes health equity.22

Significant changes over time. Nationally, the percentage of children ages 3-4 who are enrolled in nursery school, preschool or kindergarten decreased 18% from 48.9% to 40.2% between 2019 and 2021. In 2021, approximately 3,150,000 U.S. children were enrolled in early childhood education, a decrease of 838,000 compared with 2019. Early childhood education enrollment decreased in 28 states, led by 44% in New Mexico (46.1% to 25.6%), 34% in Mississippi (60.4% to 39.9%) and 31% in New Hampshire (58.2% to 40.1%).

Disparities. Early childhood education was 2.4 times higher in Connecticut (55.5%) than West Virginia (23.5%) in 2021.
Many measures of individuals’ access to care improved, while the number of women’s health providers declined.

Uninsured Women and Children

Health insurance is a critical factor in ensuring women and children receive the preventive and medical care they need to achieve and maintain good health. Benefits of health insurance coverage among children include increased access to and use of preventive, primary and specialty health care, as well as higher quality of care and improved health outcomes.

Significant changes over time. Nationally, the percentage of women ages 19-44 not covered by private or public health insurance decreased 9% from 12.9% to 11.8% between 2019 and 2021. In 2021, approximately 6,641,000 U.S. women were uninsured, a decrease of 550,000 compared with 2019. The uninsured rate among women decreased in 12 states, led by 49% in Vermont (5.7% to 2.9%), 41% in Idaho (18.3% to 10.8%) and 36% in Maine (10.7% to 6.9%).

Uninsured Women

The uninsured rate among women was highest in Texas and lowest in Massachusetts and Vermont.

Uninsured Children

The uninsured rate among children was highest in Texas and lowest in Massachusetts.

Nationally, the percentage of children younger than 19 years not covered by private or public health insurance decreased 5% from 5.7% to 5.4% between 2019 and 2021. The uninsured rate among children decreased 20% in Illinois (4.0% to 3.2%) and 7% in Texas (12.7% to 11.8%). During this same period, the uninsured rate among children increased 40% in Idaho (5.0% to 7.0%).

Disparities. In 2021, the uninsured rate among women was 8.8 times higher in Texas (25.6%) than Massachusetts and Vermont (both 2.9%) and the rate among children was 9.1 times higher in Texas (11.8%) than Massachusetts (1.3%).

Source: U.S. Census Bureau, American Community Survey, 2021.
Women’s Health Providers

Women’s health providers — such as obstetricians, gynecologists and midwives — specialize in reproductive topics including pregnancy, contraception (birth control) and menopause. They also advise on long-term health and wellness as well as provide important preventive services for women like cancer screening, contraception counseling and well-woman visits.

Changes over time. Nationally, the number of obstetricians, gynecologists and midwives per 100,000 females ages 15 and older decreased 7% from 49.5 to 46.0 between September 2021 and September 2022, the first decline since this measure was added to the report in 2020. As of September 2022, there were approximately 63,500 women’s health providers in the U.S., a decrease of 4,600 compared with September 2021. The supply of women’s health providers decreased at a rate greater than or equal to the nation in 20 states, led by 16% in Rhode Island (72.2 to 60.4 providers per 100,000 females ages 15 and older) and 13% in both Nebraska (46.8 to 40.6) and New Jersey (52.2 to 45.5).

Disparities. The supply of women’s health providers was 3.8 times higher in Alaska (103.8 providers per 100,000 females ages 15 and older) than Alabama (27.5) in September 2022. The supply was highest in the District of Columbia (107.0).

Pediatricians

Pediatricians are physicians who specialize in treating mental and physical illness in children from birth through young adulthood. They also monitor the development of children and provide preventive care, including vaccinations, through wellness exams.

Changes over time. Nationally, the number of pediatricians per 100,000 children ages 0-21 increased 2% from 107.2 to 109.3 between September 2021 and September 2022. As of September 2022, there were approximately 99,300 pediatricians in the U.S., an increase of 2,900 compared with September 2021. The supply of pediatricians increased at a rate greater than or equal to the nation in 30 states and the District of Columbia, led by 8% in Oklahoma (67.6 to 72.9 providers per 100,000 children ages 0-21), Alaska (86.6 to 93.7) and the District of Columbia (524.2 to 564.4) between 2021 and 2022. During this same period the supply decreased 4% in Rhode Island (191.9 to 183.3) and 2% in Delaware (176.5 to 172.1), New Jersey (123.3 to 120.6), Vermont (145.1 to 142.4) and Wisconsin (104.5 to 102.9).

Disparities. The supply of pediatricians was 4.7 times higher in Massachusetts (214.0) than Wyoming (45.6). The number, however, was highest in the District of Columbia (564.4).
Among women of reproductive age, fruit and vegetable intake decreased and the percentage of physically inactive women declined. The long-term successes in reducing smoking and teen birth rates have continued.

**Fruit and Vegetable Consumption**

Diets high in fruits and vegetables reduce the risk of many chronic diseases such as Type 2 diabetes, obesity, heart disease and stroke. Consuming fruits and vegetables three or more times daily is associated with a lower overall mortality risk.

**Significant changes over time.** Nationally, the percentage of women ages 18-44 who reported consuming two or more fruits and three or more vegetables daily decreased 20% from 12.2% to 9.8% between 2017 and 2021. Fruit and vegetable consumption decreased in nine states, led by 60% in Mississippi (9.5% to 3.8%), 59% in Oregon (15.7% to 6.5%) and 56% in Idaho (16.0% to 7.0%). The prevalence decreased among some income, educational attainment, racial/ethnic and age groups. By group, the largest decreases were 39% among women with an income of $50,000-$74,999 (14.5% to 8.8%), 31% among college graduates (15.7% to 10.9%), 23% among white women (12.8% to 9.9%) and 21% among women ages 35-44 (13.5% to 10.7%).

**Disparities.** Fruit and vegetable consumption varied significantly by geography, age and income in 2021. The prevalence was:

- 4.4 times higher in Vermont (16.8%) than Mississippi (3.8%).
- Higher among women ages 35-44 (10.7%) than women ages 18-24 (8.1%) and higher among women with an annual income of $75,000 or more (11.7%) than women with an income of $50,000-$74,999 (8.8%).

**Note:** Data were not available for Florida. The estimates for women ages 25-34 (10.1%) were not significantly different from the other age groups based on non-overlapping 95% confidence intervals; the same was true for the three lowest annual household income groups.

**Physical Inactivity**

Physical inactivity, or a sedentary lifestyle, can increase the risk of several health consequences such as cardiovascular disease, hypertension, cancer, obesity, diabetes and premature death.

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**Disparities in Physical Inactivity by State**

Physical inactivity was highest in Mississippi and lowest in Vermont.
Significant changes over time. Nationally, 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 decreased 7% from 22.6% to 21.1% between 2018-2019 and 2020-2021. The prevalence decreased among some educational attainment, racial/ethnic and age groups. By group, the largest decreases were 14% among college graduates (13.2% to 11.4%), 12% among white women (17.8% to 15.7%) and 8% among women ages 35-44 (24.2% to 22.2%).

Disparities. Physical inactivity varied by educational attainment, income, geography, race/ethnicity and age group in 2020-2021. The prevalence was:

- 3.6 times higher among women with less than a high school education (41.0%) than college graduates (11.4%).
- 3.0 times higher among women with an annual income less than $25,000 (34.9%) than women with an income of $75,000 or more (11.6%).
- 2.0 times higher in Mississippi (27.4%) than Vermont (13.6%).
- 1.9 times higher among Hispanic (29.5%) than white (15.7%) women.
- Higher among women ages 35-44 (22.2%) than women ages 18-24 (19.5%).

Note: The estimates for Hispanic and Black (28.2%) women were not significantly different from each other based on non-overlapping 95% confidence intervals; the same was true for white, multiracial (16.4%) and Hawaiian/Pacific Islander (21.5%) women. The estimates for women ages 25-34 (21.2%) were not significantly different from the estimates for women ages 18-24 or ages 35-44.

Smoking

Smoking cigarettes is the leading cause of preventable death in the U.S. It is responsible for more than 480,000 American deaths yearly, including nearly 201,800 women.

Significant 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 decreased 15% from 14.3% to 12.1% between 2018-2019 and 2020-2021, exceeding the decrease in last year’s report. Despite this progress, the current prevalence remains higher than the Healthy People 2030 target of 6.1%. The prevalence of smoking decreased in

Despite large declines in smoking among women of reproductive age, the 12.1% prevalence is still nearly double Healthy People 2030’s goal to reduce current smoking among adults to 6.1%.
six states, led by 32% in Maryland (11.6% to 7.9%) and 31% in both Delaware (17.8% to 12.2%) and Oregon (16.6% to 11.5%). The prevalence decreased among some age, educational attainment and one racial/ethnic group. By group the largest decreases were 34% among women ages 18-24 (9.2% to 6.1%), 19% among college graduates (5.9% to 4.8%) and 14% among white women (18.0% to 15.4%).

Disparities. The prevalence of smoking varied significantly by race/ethnicity, educational attainment, geography, income, age and metropolitan status in 2020-2021. The prevalence was:

- 7.7 times higher among American Indian/Alaska Native (25.3%) than Asian (3.3%) women.
- 4.7 times higher among women with less than a high school education (22.5%) than college graduates (4.8%).
- 4.4 times higher in West Virginia (26.2%) than California (5.9%).
- 3.5 times higher among women with an annual income less than $25,000 (24.0%) than women with an income of $75,000 or more (6.9%).
- 2.5 times higher among women ages 35-44 (15.4%) than women ages 18-24 (6.1%).
- 1.9 times higher among women living in non-metropolitan (20.2%) areas than metropolitan (10.9%) areas.

Note: The estimates for women with less than a high school education and high school graduates (22.3%) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Related Measure: Smoking During Pregnancy

Nationally, the percentage of women who reported smoking cigarettes during pregnancy decreased 16% from 5.5% to 4.6% between 2020 and 2021, exceeding the decrease in the 2022 Health of Women and Children Report. In 2021, approximately 168,100 U.S. women reported smoking during pregnancy, a decrease of 31,500 women compared with 2020. Smoking during pregnancy decreased at a rate greater than or equal to the nation in 33 states and the District of Columbia, led by 28% in Vermont (13.1% to 9.4%), 27% in Connecticut (3.3% to 2.4%) and 26% in Delaware (7.0% to 5.2%). Smoking during pregnancy was 22.8 times higher in West Virginia (18.2%) than California (0.8%).

Related Measure: E-Cigarette Use

Nationally, 8.8% of women ages 18-44 reported that they had used e-cigarettes or other electronic vaping products at least once in their lifetime and currently use daily or some days in 2020-2021. The prevalence was 2.7 times higher in Kentucky (15.5%) than California and Maryland (both 5.8%). The District of Columbia (4.0%) had the lowest prevalence. It also varied significantly by age, educational attainment, race/ethnicity, income and metropolitan status.

Related Measure: Electronic Vapor Product Use — Youth

Nationally, the percentage of high school students who reported using an electronic vapor product in the past 30 days significantly decreased 45% from 32.7% to 18.0% between 2019 and 2021. In 2021, approximately 161,000 high school students reported using an electronic vapor product, a decrease of 3,300 students compared with before the COVID-19 pandemic in 2019. Electronic vapor use decreased significantly in 16 states, led by 61% in Connecticut (27.0% to 10.6%) and 52% in both Hawaii (30.6% to 14.8%) and New Hampshire (33.8% to 16.2%). Assessing the 43 states with data, electronic vapor use was 2.8 times higher in West Virginia (27.5%) than Utah (9.7%).

Note: Minnesota, Oregon, Washington, Wyoming and D.C. did not participate in the 2019 or 2021 Youth Risk Behavior Surveillance System. In addition, data were missing for Alaska, California and Florida in 2021 and Delaware, Florida and Indiana in 2019.
Teen Births

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

Changes over time. Nationally, the teen birth rate decreased 10% from 15.4 to 13.9 births per 1,000 females ages 15-19 between 2020 and 2021, continuing a long-term downward trend and exceeding the decrease between 2019 and 2020. In 2021, there were approximately 147,000 births among U.S. teens, a decrease of 11,100 births compared with 2020.

The teen birth rate decreased 10% or more in 19 states and the District of Columbia, led by 26% in Maine (10.6 to 7.8 births per 1,000 females ages 15-19) and 18% in Idaho (14.6 to 12.0), Illinois (13.6 to 11.1) and New Hampshire (6.6 to 5.4). During the same period, the rate decreased 15% among Asian teens (2.0 to 1.7) and 10% among Black (24.2 to 21.7), Hispanic (23.5 to 21.1) and white (10.3 to 9.3) teens.

Disparities. The teen birth rate varied by race/ethnicity and geography in 2021. The rate was:

- 14.1 times higher among American Indian/Alaska Native (23.9 births per 1,000 females ages 15-19) than Asian (1.7) teens.
- 4.9 times higher in Arkansas (26.5) than New Hampshire (5.4).

Source: CDC WONDER, Natality Public Use Files, 2008-2021.
State Rankings

Rankings included in the 2023 Health of Women and Children Report are derived from 83 measures across five categories of health: social and economic factors, physical environment, behaviors, clinical care and health outcomes. For a more detailed description of how the overall rank is calculated, visit the America’s Health Rankings Methodology page.

Comprehensive State Rankings

2023 Health of Women and Children Report

Ranking
1-10 11-20 21-30 31-40 41-50
Source: America’s Health Rankings composite measure, 2023.
Minnesota Ranks No. 1

Minnesota is the healthiest state in this year’s report for both women and children. It ranks among the top five states in social and economic factors (No. 1), physical environment (No. 4), behaviors (No. 2) and health outcomes (No. 3). Minnesota is number 15 in clinical care.

**Strengths:** Low infant mortality rate, high prevalence of high school completion and high voter participation among women.

**Challenges:** High prevalence of excessive drinking among women, high racial disparity among children in poverty and low prevalence of well-woman visits.

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

Mississippi Ranks No. 50

Mississippi is the least healthy state in this year’s report, ranking number 50 for children and number 48 for women. It ranks in the bottom five states in social and economic factors (No. 46), physical environment (No. 50), behaviors (No. 49) and health outcomes (No. 47). Mississippi is number 41 in clinical care.

**Strengths:** High enrollment in early childhood education, high prevalence of well-woman visits and low prevalence of excessive drinking among women.

**Challenges:** High infant mortality rate, high mortality rate among women ages 20-44 and high percentage of children in poverty.

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

Women’s State Rankings

2023 Health of Women and Children Report

Children’s State Rankings

2023 Health of Women and Children Report
Measure Impact

This graph displays the state scores in order of rank, with the least healthy states on the left and the healthiest states on the right. The distance between bars shows the difference between state scores. For example, Louisiana (No. 48) and Oklahoma (No. 47), while close in ranking, have a sizable difference in score, meaning a lot of progress would need to be made in order for Louisiana to improve its score and move up in the rankings. There is also a large gap in score between Illinois (No. 15) and the next highest state, Virginia (No. 14).

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

Comprehensive State Rankings and Scores*
2023 Health of Women and Children Report

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<thead>
<tr>
<th>Least Healthy States</th>
<th>Healthiest States</th>
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<tr>
<td>Mississippi 50</td>
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<td></td>
<td>25 Kansas</td>
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<td></td>
<td>26 South Dakota</td>
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Source: America’s Health Rankings composite measure, 2023.

*Sum of weighted z-scores of all ranked measures.
## United States

### Summary

#### Highlights

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<tr>
<th>Category</th>
<th>Percentage</th>
<th>Change</th>
<th>Description</th>
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<tbody>
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<td>Mortality</td>
<td>40%</td>
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<td>from 97.2 to 136.4 deaths per 100,000 women ages 20-44 between 2019 and 2021.</td>
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<td>Early Childhood Education</td>
<td>18%</td>
<td>↓</td>
<td>from 48.9% to 40.2% of children ages 3-4 between 2019 and 2021.</td>
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<td>Frequent Mental Distress</td>
<td>16%</td>
<td>↑</td>
<td>from 18.1% to 21.0% of women ages 18-44 between 2018-2019 and 2020-2021.</td>
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<td>Teen Births</td>
<td>10%</td>
<td>↓</td>
<td>from 15.4 to 13.9 births per 1,000 females ages 15-19 between 2020 and 2021.</td>
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<td>High Health Status</td>
<td>10%</td>
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<td>from 53.8% to 59.0% of women ages 18-44 between 2018-2019 and 2020-2021.</td>
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<td>Injury Deaths</td>
<td>11%</td>
<td>↑</td>
<td>from 15.7 to 17.4 deaths per 100,000 children ages 1-19 between 2016-2018 and 2019-2021.</td>
</tr>
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#### Measures

##### Women

**Social & Economic Factors**

<table>
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<tr>
<td>Firearm Deaths</td>
<td>5.6</td>
</tr>
<tr>
<td>Injury Deaths</td>
<td>48.1</td>
</tr>
<tr>
<td>Intimate Partner Violence Before Pregnancy</td>
<td>2.6</td>
</tr>
<tr>
<td>Economic Resources</td>
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</tr>
<tr>
<td>Concentrated Disadvantage</td>
<td>25.9%</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>10.4%</td>
</tr>
<tr>
<td>Gender Pay Gap</td>
<td>81.5%</td>
</tr>
<tr>
<td>Poverty</td>
<td>15.5%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>5.2%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>College Graduate</td>
<td>36.8%</td>
</tr>
<tr>
<td>Social Support and Engagement</td>
<td></td>
</tr>
<tr>
<td>Infant Child Care Cost</td>
<td>11.7%</td>
</tr>
<tr>
<td>Residential Segregation – Black/White</td>
<td>60.7%</td>
</tr>
<tr>
<td>Voter Participation</td>
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</tr>
<tr>
<td>Physical Environment*</td>
<td></td>
</tr>
<tr>
<td>Air and Water Quality</td>
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<tr>
<td>Air Pollution</td>
<td>78%</td>
</tr>
<tr>
<td>Drinking Water Violations</td>
<td>0.8%</td>
</tr>
<tr>
<td>Household Smoke</td>
<td>13.8%</td>
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<tr>
<td>Water Fluoridation</td>
<td>72.7%</td>
</tr>
<tr>
<td>Climate and Health</td>
<td></td>
</tr>
<tr>
<td>Climate Change Policies</td>
<td></td>
</tr>
<tr>
<td>Transportation Energy Use</td>
<td>8.2</td>
</tr>
<tr>
<td>Housing and Transportation</td>
<td></td>
</tr>
<tr>
<td>Drive Alone to Work</td>
<td>66.0%</td>
</tr>
<tr>
<td>Housing Cost Burden (households with children)</td>
<td>31.2%</td>
</tr>
<tr>
<td>Housing With Lead Risk</td>
<td>16.9%</td>
</tr>
<tr>
<td>Severe Housing Problems</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

**Children**

<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></td>
</tr>
<tr>
<td>Child Victimization</td>
<td>81%</td>
</tr>
<tr>
<td>Firearm Deaths</td>
<td>5.3</td>
</tr>
<tr>
<td>Injury Deaths</td>
<td>17.4</td>
</tr>
<tr>
<td>Economic Resources</td>
<td></td>
</tr>
<tr>
<td>Children in Poverty</td>
<td>16.9%</td>
</tr>
<tr>
<td>Children in Poverty Racial Disparity</td>
<td>3.0</td>
</tr>
<tr>
<td>High-Speed Internet</td>
<td>95.3%</td>
</tr>
<tr>
<td>Students Experiencing Homelessness</td>
<td>2.2%</td>
</tr>
<tr>
<td>WIC Coverage</td>
<td>48.3%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Education</td>
<td>40.2%</td>
</tr>
<tr>
<td>Fourth Grade Reading Proficiency</td>
<td>32.1%</td>
</tr>
<tr>
<td>High School Completion</td>
<td>89.4%</td>
</tr>
<tr>
<td>Social Support and Engagement</td>
<td></td>
</tr>
<tr>
<td>Adverse Childhood Experiences</td>
<td>14.0%</td>
</tr>
<tr>
<td>Foster Care Instability</td>
<td>15.2%</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>

### Appendix

Health Department Website: [hhs.gov](http://hhs.gov)

---

2023 Health of Women and Children Report  AmericasHealthRankings.org  28
# United States

Health Department Website: hhs.gov

## Measures

<table>
<thead>
<tr>
<th><strong>Women</strong></th>
<th><strong>U.S. Value</strong></th>
<th><strong>Children</strong></th>
<th><strong>U.S. Value</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Access to Care</td>
<td>Adequate Prenatal Care</td>
<td>74.7%</td>
<td>ADD/ADHD Treatment</td>
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<tr>
<td></td>
<td>Avoided Care Due to Cost</td>
<td>14.6%</td>
<td>Physicians</td>
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<tr>
<td></td>
<td>Maternity Care Desert†</td>
<td>3.1</td>
<td>Uninsured</td>
</tr>
<tr>
<td></td>
<td>Uninsured</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women’s Health Providers</td>
<td>46.0</td>
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</tr>
<tr>
<td>Preventive Clinical Services</td>
<td>Cervical Cancer Screening</td>
<td>77.1%</td>
<td>Childhood Immunizations</td>
</tr>
<tr>
<td></td>
<td>Dental Visit</td>
<td>65.5%</td>
<td>HPV Vaccination</td>
</tr>
<tr>
<td></td>
<td>Flu Vaccination</td>
<td>38.9%</td>
<td>Preventive Dental Care</td>
</tr>
<tr>
<td></td>
<td>Postpartum Visit†</td>
<td>90.9%</td>
<td>Well-Child Visit</td>
</tr>
<tr>
<td></td>
<td>Well-Woman Visit</td>
<td>70.5%</td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Breastfeeding Initiation‡</td>
<td>83.7%</td>
<td>Adequate Insurance</td>
</tr>
<tr>
<td></td>
<td>Dedicated Health Care Provider</td>
<td>79.2%</td>
<td>Developmental Screening</td>
</tr>
<tr>
<td></td>
<td>Low-Risk Cesarean Delivery</td>
<td>26.3%</td>
<td>Medical Home</td>
</tr>
<tr>
<td></td>
<td>Maternity Practices Score</td>
<td>81</td>
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<tr>
<td><strong>Behaviors</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition and Physical Activity</td>
<td>Exercise</td>
<td>21.5%</td>
<td>Breastfed</td>
</tr>
<tr>
<td></td>
<td>Fruit and Vegetable Consumption</td>
<td>9.8%</td>
<td>Food Sufficiency</td>
</tr>
<tr>
<td></td>
<td>Physical Inactivity</td>
<td>21.1%</td>
<td>Physical Activity</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>Chlamydia</td>
<td>1.5631</td>
<td>Soda Consumption – Youth†</td>
</tr>
<tr>
<td></td>
<td>High-Risk HIV Behaviors</td>
<td>9.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unintended Pregnancy‡</td>
<td>25.5%</td>
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</tr>
<tr>
<td>Sleep Health</td>
<td>Insufficient Sleep</td>
<td>33.4%</td>
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</tr>
<tr>
<td>Smoking and Tobacco Use</td>
<td>E-Cigarette Use†</td>
<td>8.8%</td>
<td>Dual Contraceptive Nonuse†</td>
</tr>
<tr>
<td></td>
<td>Smoking</td>
<td>12.1%</td>
<td>Teen Births</td>
</tr>
<tr>
<td></td>
<td>Smoking During Pregnancy</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Health Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Behavioral Health</td>
<td>Drug Deaths†</td>
<td>25.7</td>
<td>Alcohol Use – Youth</td>
</tr>
<tr>
<td></td>
<td>Excessive Drinking</td>
<td>18.8%</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Frequent Mental Distress</td>
<td>210%</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Illicit Drug Use</td>
<td>10.6%</td>
<td>Flurishing</td>
</tr>
<tr>
<td></td>
<td>Postpartum Depression†</td>
<td>12.7%</td>
<td>Illicit Drug Use – Youth</td>
</tr>
<tr>
<td>Mortality</td>
<td>Maternal Mortality‡</td>
<td>22.4</td>
<td>Teen Suicide‡</td>
</tr>
<tr>
<td></td>
<td>Mortality Rate</td>
<td>136.4</td>
<td></td>
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<tr>
<td>Physical Health</td>
<td>Depression‡</td>
<td>274%</td>
<td>Asthma</td>
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<tr>
<td></td>
<td>Frequent Physical Distress</td>
<td>7.1%</td>
<td>High Health Status†</td>
</tr>
<tr>
<td></td>
<td>High Blood Pressure</td>
<td>10.8%</td>
<td>Low Birth Weight</td>
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<tr>
<td></td>
<td>High Health Status‡</td>
<td>59.0%</td>
<td>Low Birth Weight Racial Disparity</td>
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<td></td>
<td>Multiple Chronic Conditions</td>
<td>4.2%</td>
<td>Neonatal Abstinence Syndrome†</td>
</tr>
<tr>
<td></td>
<td>Obesity</td>
<td>31.5%</td>
<td>Overweight or Obesity – Youth</td>
</tr>
<tr>
<td></td>
<td>Severe Maternal Morbidity‡</td>
<td>88.3</td>
<td></td>
</tr>
</tbody>
</table>

* The value assigned to a summation score is a sum of weighted, ranking measure z-scores (the number of standard deviations a state value was above or below the U.S. value).

† Additional measures

‡ Data not available, missing or suppressed.

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

Ranks are calculated for each measure, ordered by the states’ values, with 1 corresponding to the healthiest value and 50 the least healthy value. Ties in value are assigned equal ranks.
Subpopulation analyses were performed to illuminate disparities by gender, race/ethnicity, education, income and metropolitan status. Not all subpopulations were available for all data sources and measures. Individual estimates were suppressed if they did not meet the reliability criteria laid out by the data source or by internally established criteria. Some values had wide confidence intervals, meaning the true value may be far from the estimate listed.

**Gender.** This report highlights data on women and includes gender stratification as female and male 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 limited the ability to describe the health of transgender or gender nonbinary individuals.

**Age.** Age data in this report were available for measures from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and the Maternal and Child Health Bureau’s Federally Available Data (FAD), which were sourced from the National Vital Statistics System (NVSS) and the Healthcare Cost Utilization Project (HCUP). BRFSS groupings in this report were limited to females of childbearing 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.

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

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

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

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

**Limitations**

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

Caution is suggested when interpreting data on certain health and behavioral measures. Many were self-reported and relied on an individual’s perception of health and behaviors. Additionally, some health outcome measures were based on respondents being told by a health care professional that they had a disease and may have excluded those who have not received a diagnosis or sought or obtained treatment.
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 America's Health Rankings 2023 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.

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- Center for Climate and Energy Solutions
- Child Care Aware
- 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 Labor
  - Bureau of Labor Statistics
- U.S. Energy Information Administration
- U.S. Environmental Protection Agency

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