

Health of Women and Children Report 2022



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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, 2022.¹ 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.^{2,3}

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.⁴ The [risk of preterm birth](#) was also higher among pregnant women who had COVID-19 compared with those without COVID-19.⁵

In addition, it is possible for individuals to experience [long-term effects](#) from COVID-19 infection.⁶ 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.⁷

While COVID infections tend to be milder in children, they are still at risk for [developing long COVID](#).⁸ One study found that the [prevalence of long COVID](#) was 25% among children and adolescents.⁹ 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.^{10,11} Receiving a [vaccination during pregnancy](#) benefits the mother as well as the infant, whose risk of hospitalization from COVID-19 infection is significantly reduced.¹² Despite common misconceptions, vaccinations are [not associated with poor pregnancy outcomes](#), such as preterm birth or small-for-gestational age at birth.¹³ Among children and teens, vaccination reduces the risk of [multisystem inflammatory syndrome in children](#), a rare but serious condition linked to COVID-19.¹⁴ Vaccination may also [reduce the risk](#) of developing long COVID.⁶

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.^{15,16} More than half of the [4.2 million Americans](#) who left the labor force in the first year of the pandemic were women.¹⁷ 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.¹⁸

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.¹⁸ Two-thirds of students [reported](#) more difficulty completing their schoolwork during the pandemic.¹⁹ 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.²⁰ 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-19.⁴ [Higher rates of hospitalization](#) from COVID-19 have been observed among Hispanic and Black children compared with white children.²¹ Children at greater risk for COVID-19 infection, including racial and ethnic minority groups, also face [more barriers](#) to receiving a COVID-19 vaccine.²²

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.¹⁷ 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.¹⁹ 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.^{18,23} Students who experienced

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.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.

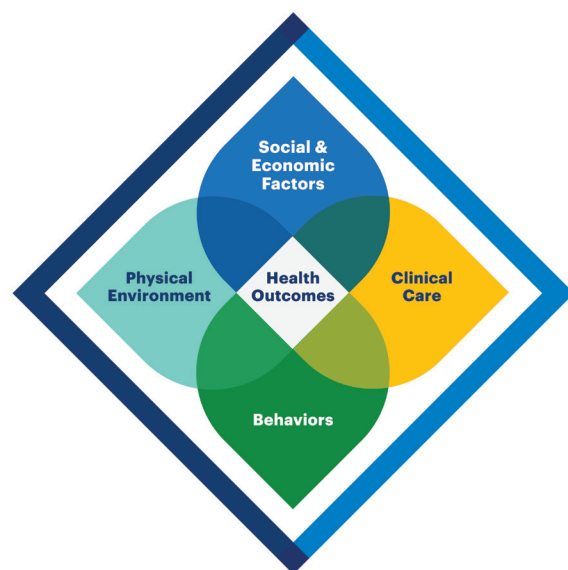
In summary, the *Health of Women and Children Report* aims to improve population health of women and children by:

- **Presenting a holistic view of health.** The report goes beyond measures of clinical care and considers many social, economic and physical environment measures that reflect our growing understanding of the impact of social determinants on health.

- **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."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.

BEHAVIORAL HEALTH | CHILDREN

Flourishing

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 | WOMEN

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 | WOMEN

Maternal mortality

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

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

Social and Economic Factors

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.

SOCIAL SUPPORT AND ENGAGEMENT | CHILDREN

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.

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.

ECONOMIC RESOURCES | WOMEN

Unemployment

131% ▲

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

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Behaviors

SLEEP HEALTH | WOMEN

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 AND TOBACCO USE | WOMEN

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 | CHILDREN

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.

NUTRITION AND PHYSICAL ACTIVITY | CHILDREN

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.

PREVENTIVE CLINICAL CARE | WOMEN

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.

PREVENTIVE CLINICAL CARE | CHILDREN

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

HEALTH OUTCOMES | BEHAVIORAL HEALTH

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

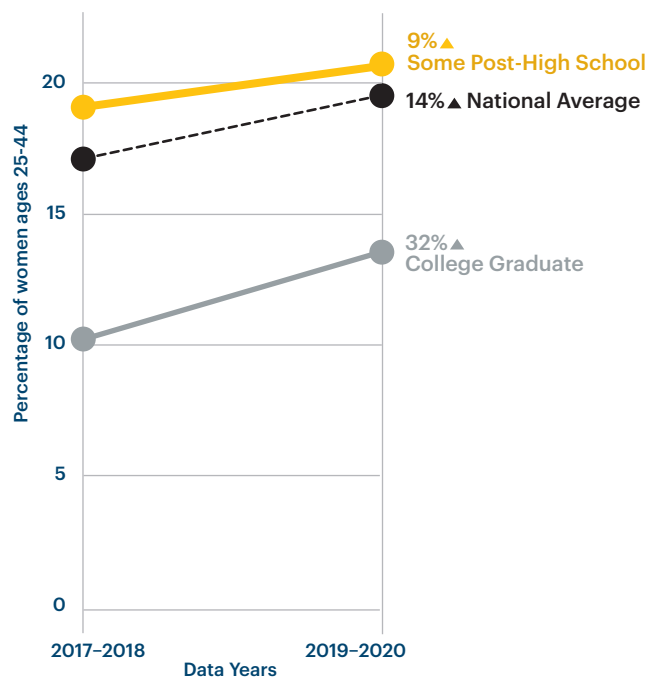
Frequent Mental Distress

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.²⁵ 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

Frequent mental distress increased significantly among college graduates and women with some post-high school education.



Source: CDC, Behavioral Risk Factor Surveillance System, 2017-2018, 2019-2020.

Note: Frequent mental distress increases were not significant among women with less than high school education and those with a high school diploma or GED degree.

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%).*

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

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%).[‡]

[‡] Education and income subpopulations are among women ages 25-44.

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

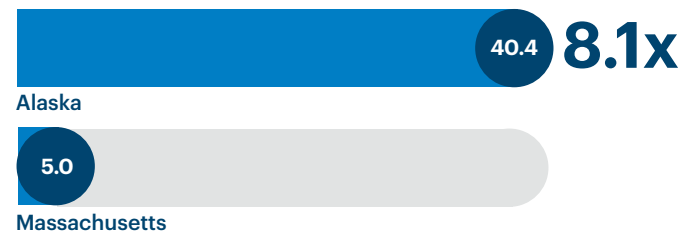
Teen Suicide

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 25-34.²⁶

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).

Teen suicide was highest in Alaska and lowest in Massachusetts in 2018-2020.

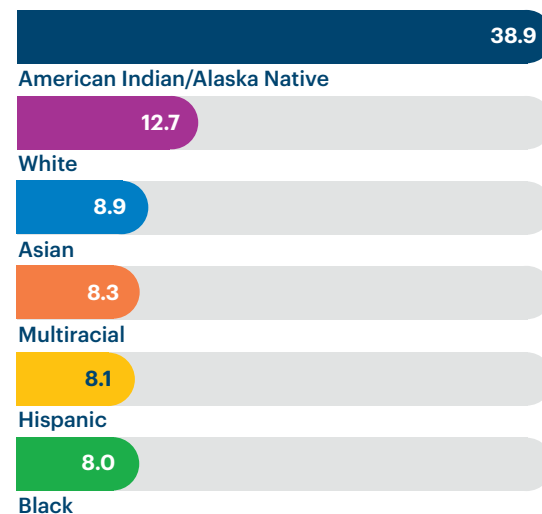
Deaths per 100,000 adolescents ages 15-19



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

Teen suicide was nearly 5 times higher among American Indian/Alaska Native teens compared with Black teens in 2018-2020.

Deaths per 100,000 adolescents ages 15-19



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

Note: The rate did not significantly differ among Black, Hispanic, multiracial and Asian teens.

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).



Data-driven Approaches Can Build on a Generational Shift to Address Youth Mental Health Challenges

Alison Malmon, Founder and Executive Director, Active Minds

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](#).²⁷ Or if they feel persistent sadness and hopelessness, they may have [depression](#).²⁸ If untreated, mental health disorders can [interfere](#) with a child's development, causing problems in school and in forming friendships.²⁹

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

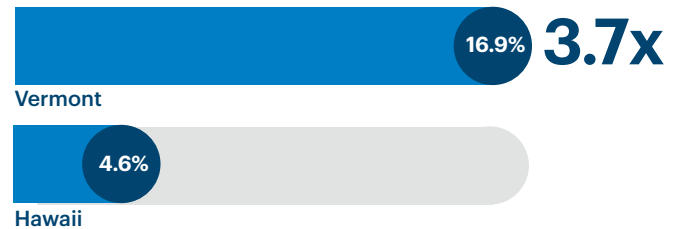
[Flourishing](#) measures children's well-being and how well they function and thrive within their family and community.³⁰ Flourishing in children is associated with higher levels of school [engagement](#), and attributes of flourishing have been [linked](#) with fewer risky health behaviors during adolescence.^{31, 32}

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%).

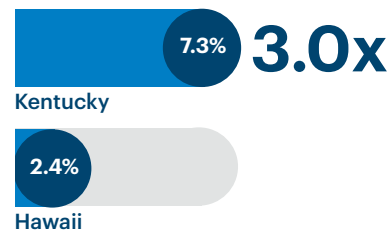
Anxiety was highest in Vermont and lowest in Hawaii, and depression was highest in Kentucky and lowest in Hawaii in 2020-2021.

Percentage of children ages 3-17

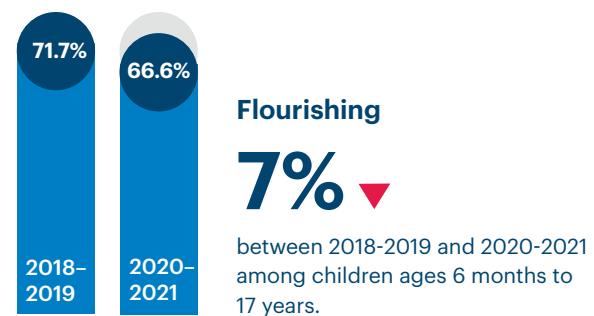
Anxiety



Depression



Source: HHS, HRSA, MCHB, National Survey of Children's Health, 2020-2021.



Source: HHS, HRSA, MCHB, National Survey of Children's Health, 2018-2019, 2020-2021.

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%).

HEALTH OUTCOMES | MORTALITY

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.

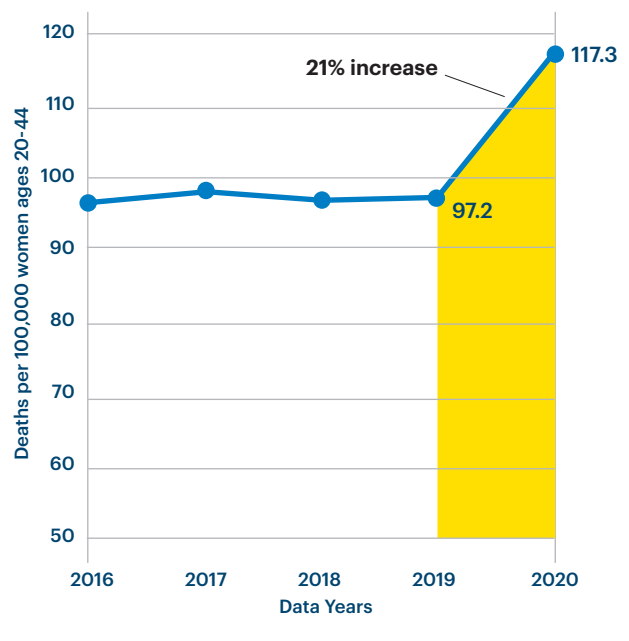
Women Mortality Rate

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.

Mortality among women increased sharply between 2019 and 2020.



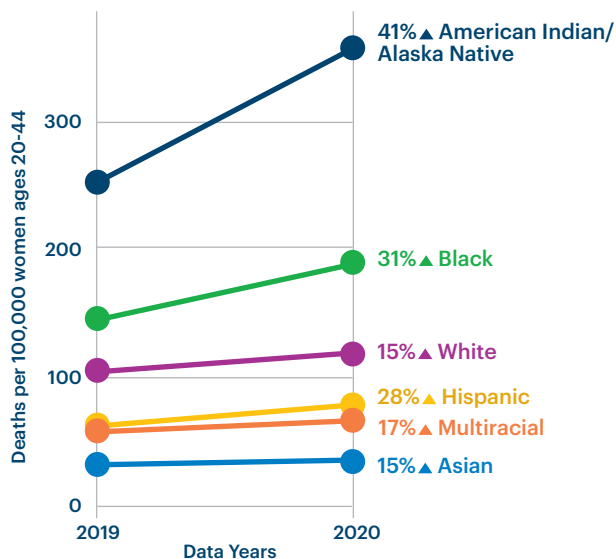
Source: CDC WONDER, Multiple Cause of Death Files.

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).

Mortality among women increased significantly across most racial/ethnic groups.

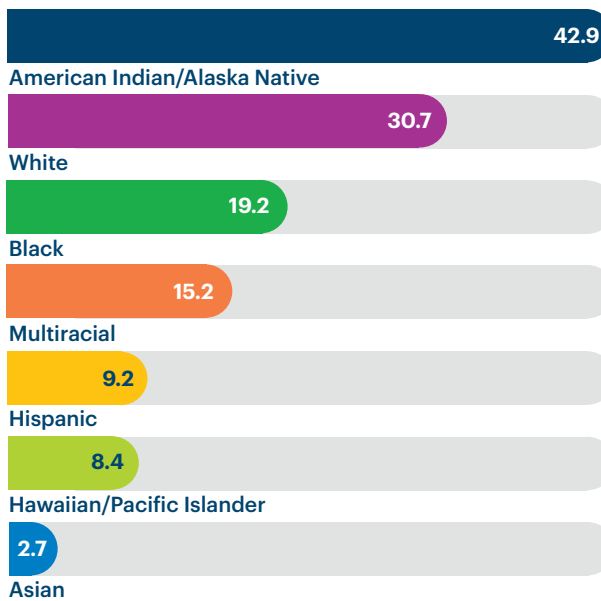


Source: CDC WONDER, Multiple Cause of Death Files, 2019, 2020.

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

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



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

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.^{33, 34} Between April and December 2020, a [substantial increase](#) in maternal deaths was reported, coinciding with the COVID-19 pandemic.³⁵

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.

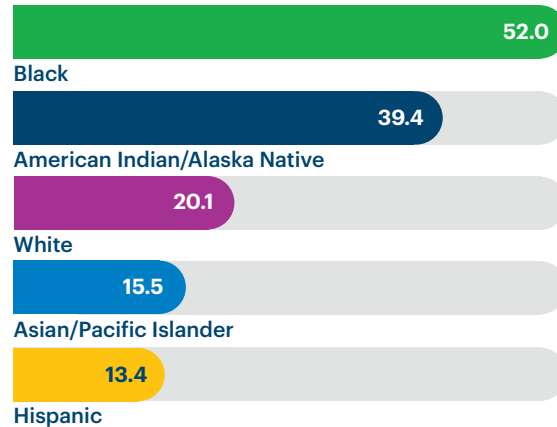
Disparities. Maternal mortality was highest in [Alabama](#) and [Louisiana](#) (both 38.7) and lowest in [California](#) (8.4). The rate varied significantly by race/ethnicity, age and education. It was 3.9 times higher among [Black mothers](#) (52.0) compared with [Hispanic mothers](#) (13.4); 3.5 times 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).

Maternal mortality was nearly 4 times higher among Black mothers compared with Hispanic mothers in 2016-2020.

Deaths per 100,000 live births



Source: HHS, HRSA, MCHB, Federally Available Data, 2016-2020.

Note: The rate did not significantly differ between Black and American Indian/Alaska Native mothers. It also did not differ between Hispanic and Asian/Pacific Islander mothers.

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.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

The firearm death rate among both women and children continued to rise.

Women and Children

Firearm Deaths

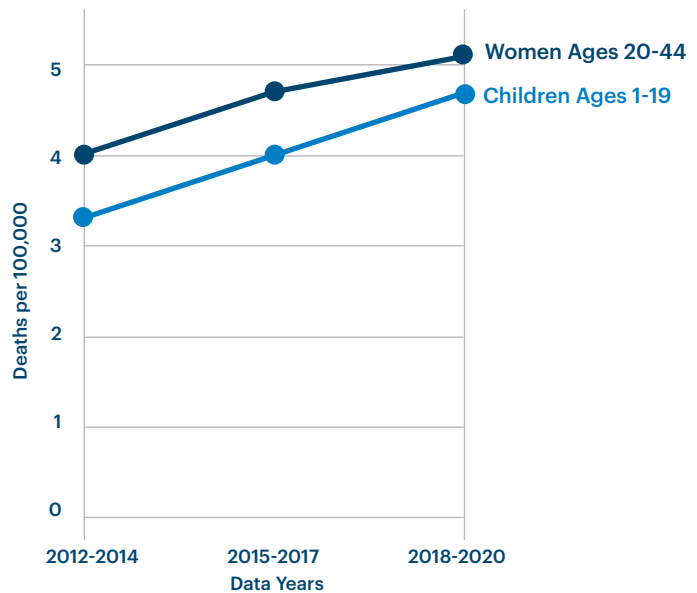
The U.S. has seen an uptick in [firearm deaths](#) over the last decade.³⁶ In 2020, there were more than 45,000 deaths by gun violence, the [highest number](#) recorded.³⁶ Additionally, firearm deaths surpassed motor vehicle accidents as the [leading cause](#) of death among children.³⁷

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).

Firearm deaths are on the rise among both women and children.



Source: CDC WONDER, Multiple Cause of Death Files.

Firearm deaths among women and children were highest in Alaska and lowest in Massachusetts in 2018-2020.

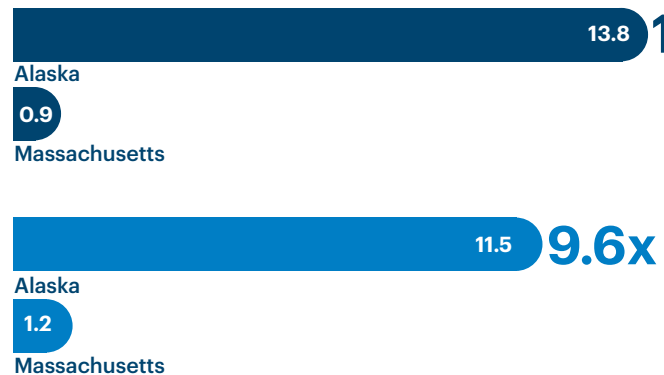
Women

Deaths per 100,000 women ages 20-44



Children

Deaths per 100,000 children ages 1-19



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

SOCIAL AND ECONOMIC FACTORS | SOCIAL SUPPORT AND ENGAGEMENT

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.³⁸ Early experiences have a broad and profound impact on an individual’s development and subsequent emotional, cognitive, social and biological functioning.³⁹

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%.

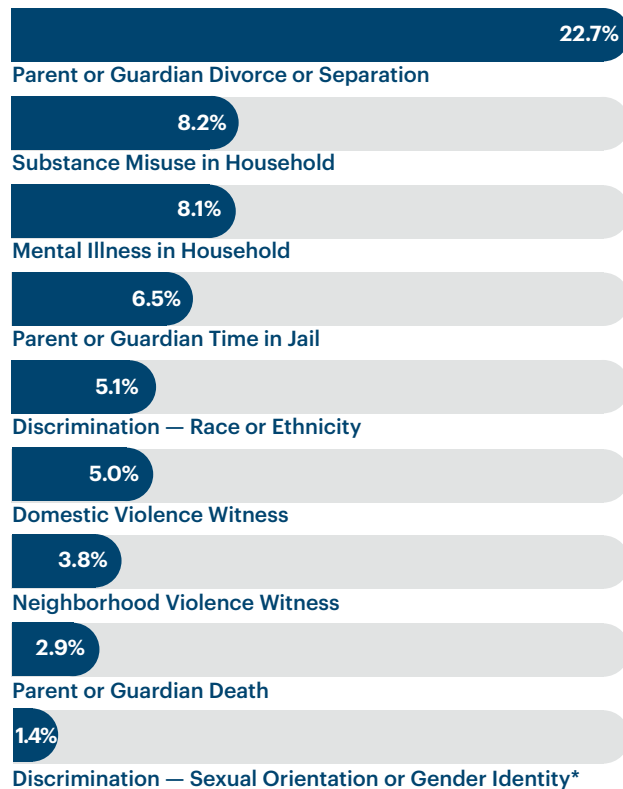
Neighborhood Amenities

Neighborhood amenities offer individuals opportunities to socialize, play, exercise and enjoy the neighborhood in which they live.⁴⁰ 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.⁴¹

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

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

Percentage of children ages 0-17



Source: HHS, HRSA, MCHB, National Survey of Children’s Health, 2020-2021.

*Percentage of children ages 12-17.

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.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

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](#).⁴² 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%.⁴³ 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.¹⁷ By August 2022, the unemployment rate among women [had declined](#) to 3.3%.⁴³

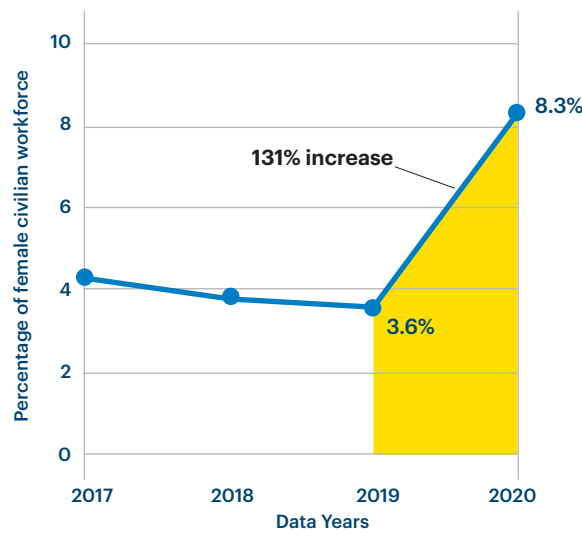
Changes over time. Nationally, the percentage of the female civilian workforce who were unemployed increased 131% nationally from 3.6% to 8.3%, an increase of about 3.5 million women between 2019 and 2020. [Unemployment](#) among women significantly increased in 41 states and the [District of Columbia](#),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

Unemployment among women increased sharply between 2019 and 2020.



Source: U.S. Department of Labor, Bureau of Labor Statistics.

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%).



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

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.

BEHAVIORS | SLEEP HEALTH & SMOKING AND TOBACCO USE

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

Women

Insufficient Sleep

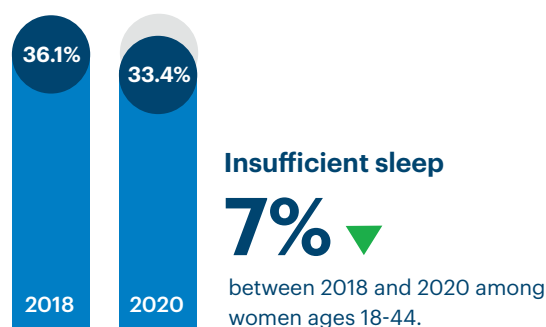
Insufficient sleep has been recognized as a [threat to public health](#).⁴⁴ Sleep is critical to such basic [functions](#) as cognitive processing, mood regulation, blood sugar level and immune system response.⁴⁵ Insufficient sleep can lead to serious [health problems](#), including cancer, [depression](#), [diabetes](#), [hypertension](#), [obesity](#) and [heart attack](#).⁴⁶⁻⁵¹

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.

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

[‡]The prevalence did not significantly differ among Black, Hawaiian/Pacific Islander (40.1%), other race and American Indian/Alaska Native (both 37.4%) women. It also did not differ among Asian, Hispanic (30.5%) and other race women.



Source: CDC, Behavioral Risk Factor Surveillance System, 2018, 2020.

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.⁵² 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).⁵²⁻⁵⁴

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](#) (21.4%), the state with the highest value in 2020, compared with [California](#) (1.0%), the state with the lowest value.

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.

Smoking was highest in West Virginia and lowest in Utah in 2019-2020.

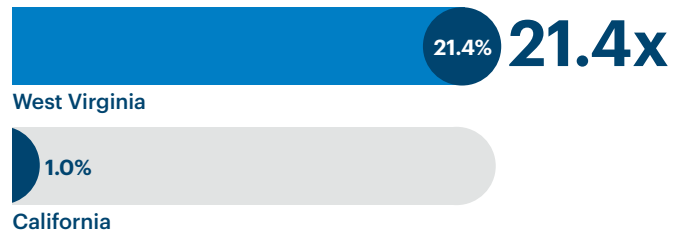
Percentage of women ages 18-44



Source: CDC, Behavioral Risk Factor Surveillance System, 2019-2020.

Smoking during pregnancy was highest in West Virginia and lowest in California in 2020.

Percentage of live births



Source: CDC WONDER, Natality Public Use Files, 2020.

Disparities. Out of the 38 states with data, [e-cigarette use](#) among women was highest in [Kentucky](#) (12.6%) and lowest in [Illinois](#) (4.3%) in 2020. The prevalence varied the most by race/ethnicity;^{*} it was 3.3 times higher among [white women](#) (10.4%) compared with [Asian women](#) (3.2%). The prevalence also significantly varied by age, education and income.

[‡] Education and income subpopulations are among women ages 25-44.

^{*}The prevalence did not significantly differ among white, American Indian/Alaska Native (10.3%) and multiracial (8.6%) women. It also did not differ among Asian, Hispanic (3.5%), Black (4.6%) and American Indian/Alaska Native women.

BEHAVIORS | NUTRITION AND PHYSICAL ACTIVITY & SEXUAL HEALTH

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](#).⁵⁵ 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.⁵⁶

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

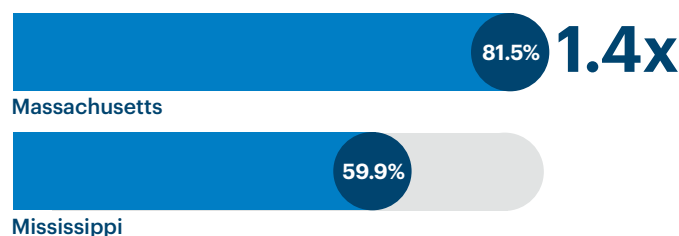
Regular physical activity in children and adolescents is [associated](#) with improved bone health, weight status, cognition, cardiovascular and muscular fitness, as well as reduced risk of depression.⁵⁷ Exercise also [increases](#) the chances of living a longer and healthier life, and children who engage in regular physical activity are [more likely](#) to become physically active adults.^{58, 59}

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%).

Food sufficiency was highest in Massachusetts and lowest in Mississippi in 2020-2021.

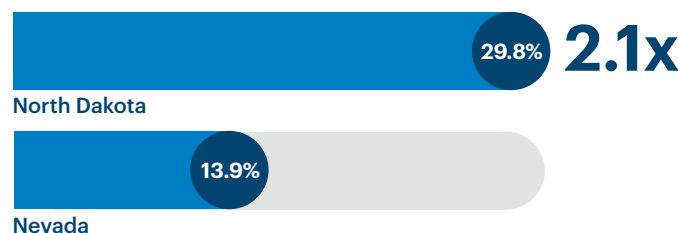
Percentage of children ages 0-17



Source: HHS, HRSA, MCHB, National Survey of Children's Health, 2020-2021.

Physical activity was highest in North Dakota and lowest in Nevada in 2020-2021.

Percentage of children ages 6-17



Source: HHS, HRSA, MCHB, National Survey of Children's Health, 2020-2021.

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).

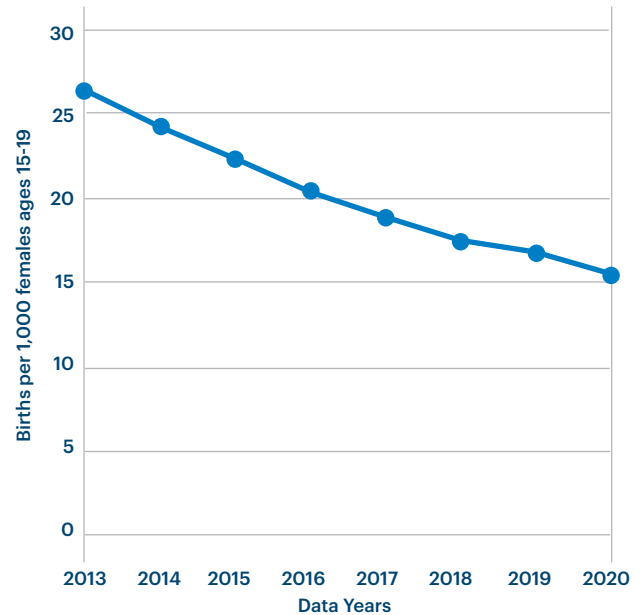
Disparities. The teen birth rate was 4.6 times higher in [Mississippi](#) (27.9 births per 1,000 females ages 15-19), the state with the highest rate in 2020, compared with [Massachusetts](#) (6.1), the state with the lowest rate. The rate varied significantly by race/ethnicity.

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.

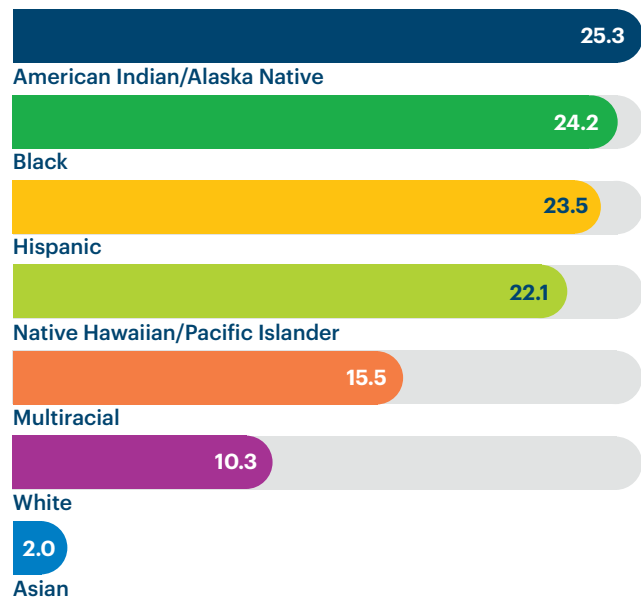
Teen births have continued to decrease.



Source: CDC WONDER, Natality Public Use Files.

Teen births were 12.7 times higher among American Indian/Alaska Native teens compared with Asian teens in 2020.

Births per 1,000 females ages 15-19



Source: CDC WONDER, Natality Public Use Files, 2020.

CLINICAL CARE | PREVENTIVE CLINICAL CARE

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.⁶¹ Screening in the form of routine [Pap tests](#) has contributed to significant declines in cervical cancer mortality over the past 40 years.⁶²

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](#).^{63, 64}

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.⁶⁵ 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

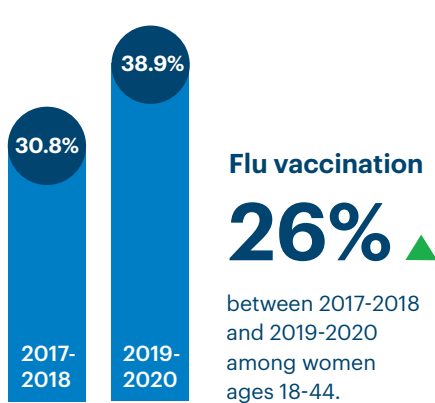
The [flu vaccine](#) helps protect people against seasonal influenza (flu) viruses that may lead to severe complications.⁶⁶ While all women are at risk of complications from influenza, pregnant women are at [greater risk](#) of severe illness, hospitalization and [preterm delivery](#).^{67, 68} Getting 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%).[‡]

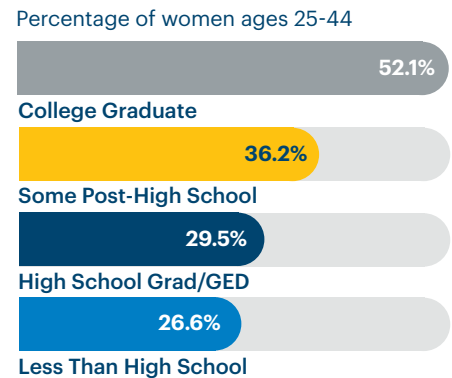
Disparities. The prevalence of flu vaccination among women was 2.1 times higher in [South Dakota](#) (53.3%), the state with the highest value in 2019-2020, compared with [Nevada](#) (25.9%), the state with the lowest value. The prevalence varied the most by education, and also significantly varied by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

[‡] Education and income subpopulations are among women ages 25-44.



Source: CDC, Behavioral Risk Factor Surveillance System, 2017-2018, 2019-2020.

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



Source: CDC, Behavioral Risk Factor Surveillance System, 2019-2020.

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

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.

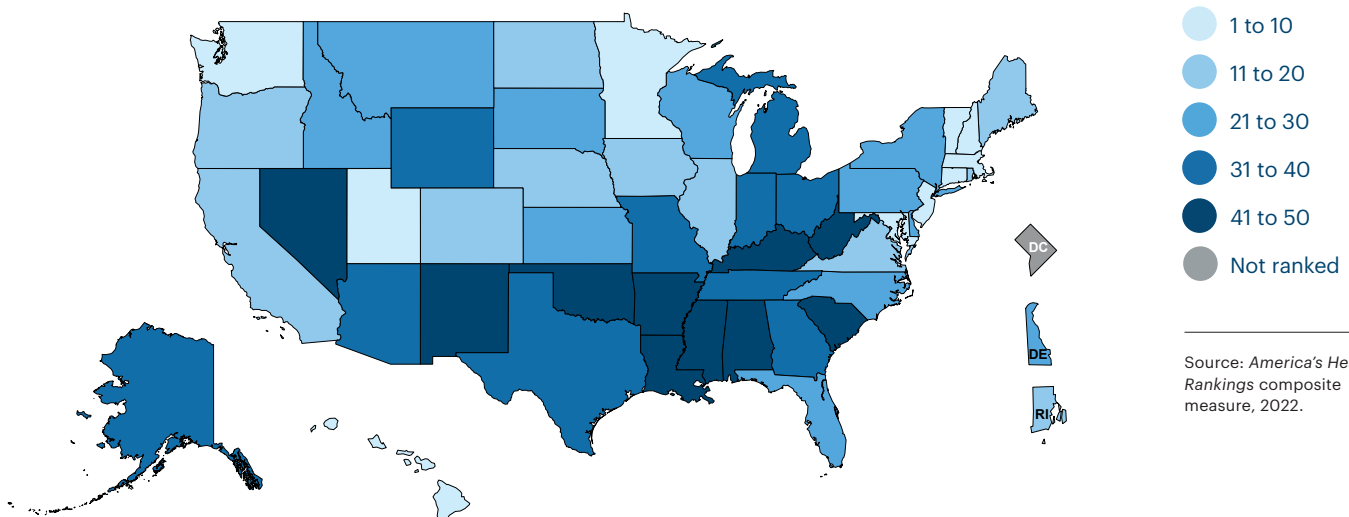
Minnesota Ranks No. 1

[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.

2022 Health of Women and Children Report State Rankings



Louisiana Ranks No. 50

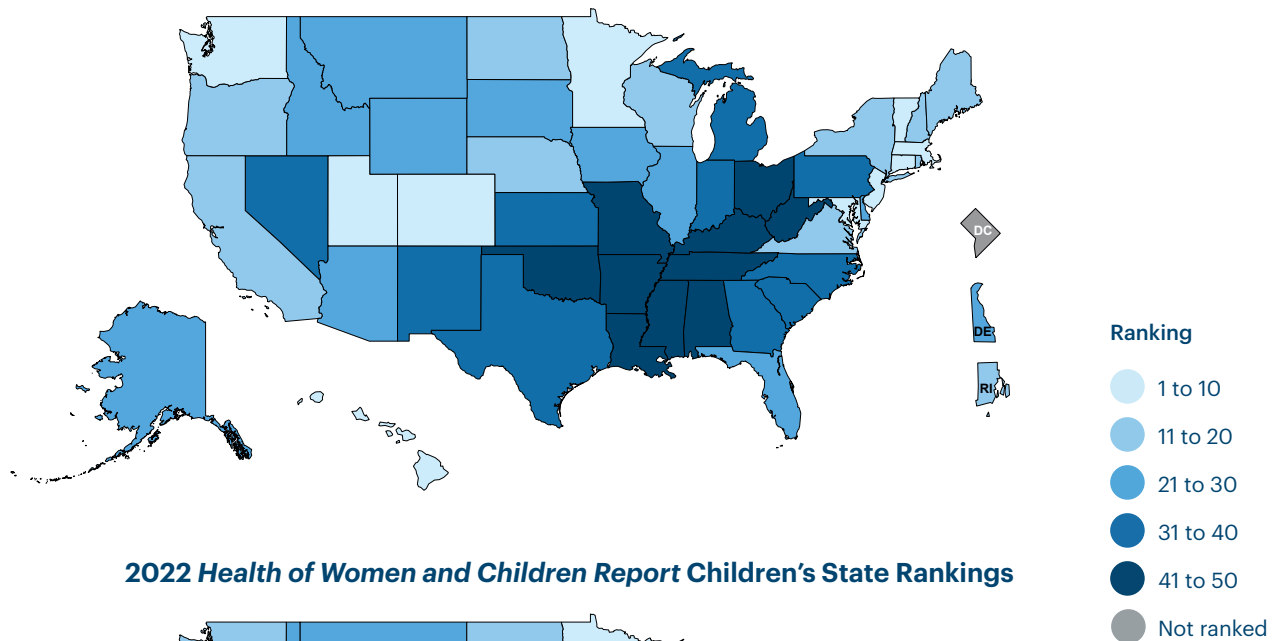
[Louisiana](#) is the least healthy state in this year’s report, and for both women and children. It ranks in the bottom five states in social and economic factors (No. 50), physical environment (No. 48), behaviors (No. 50) and health outcomes (No. 49). Louisiana is No. 38 in clinical care.

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

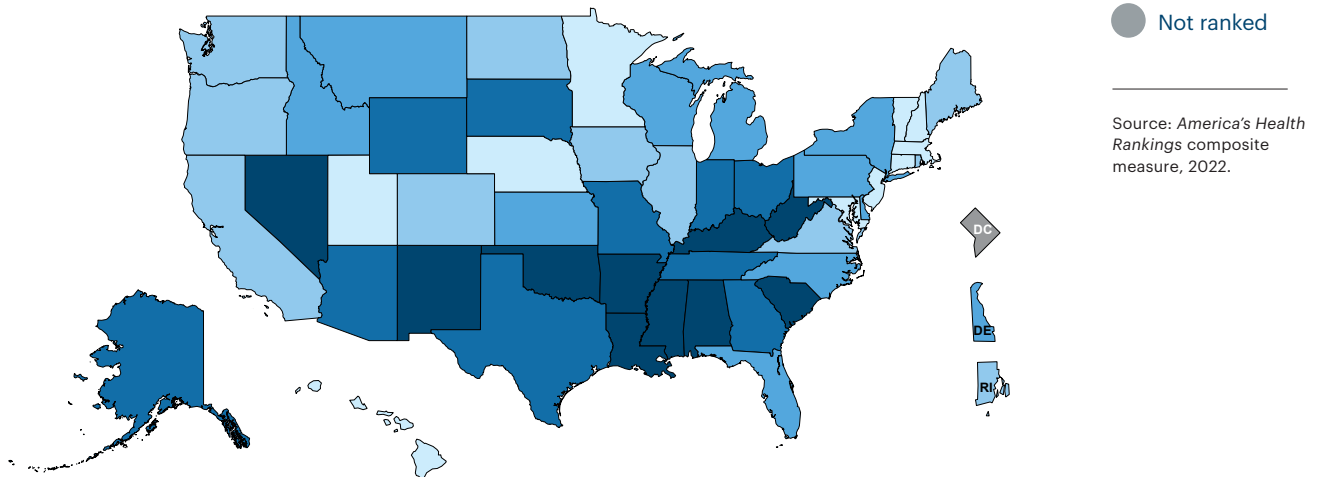
• **Challenges:** High infant mortality rate, low percentage of female college graduates and low prevalence of food sufficiency among children.

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

2022 Health of Women and Children Report Women’s State Rankings



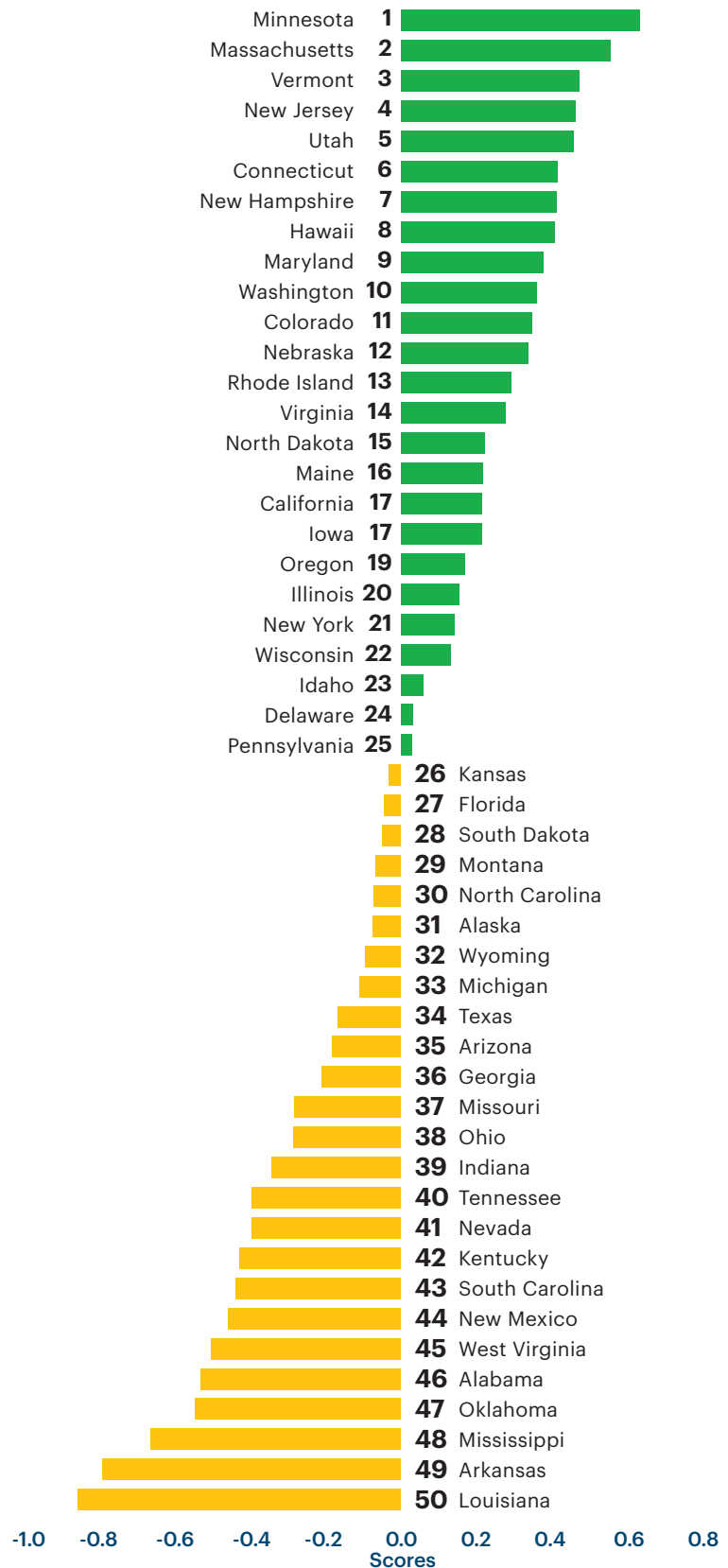
2022 Health of Women and Children Report Children’s State Rankings



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. 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.

2022 Health of Women and Children Report State Rankings and Scores*



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 1-19 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	U.S. Value
SOCIAL & ECONOMIC FACTORS	
Community and Family Safety	
Firearm Deaths*	5.1
Intimate Partner Violence Before Pregnancy*	2.5%
Violent Crime	379
Economic Resources	
Concentrated Disadvantage	26.1%
Food Insecurity	10.7%
Gender Pay Gap*	81.0%
Poverty	15.2%
Unemployment	8.3%
Education	
College Graduate	35.6%
Social Support and Engagement	
Infant Child Care Cost*	12.0%
Residential Segregation — Black/White	—
Voter Participation	61.7%
PHYSICAL ENVIRONMENT	
Air and Water Quality	
Air Pollution	8.3
Drinking Water Violations	0.8%
Household Smoke	13.8%
Risk-screening Environmental Indicators Score	—
Water Fluoridation	73.0%
Climate Change	
Climate Change Policies*	—
Transportation Energy Use*	7.4
Housing and Transportation	
Drive Alone to Work	75.4%
Housing With Lead Risk	17.6%
Severe Housing Problems	17.3%

Children

Measures	U.S. Value
SOCIAL & ECONOMIC FACTORS	
Community and Family Safety	
Child Victimization*	8.4%
Firearm Deaths*	4.7
Economic Resources	
Children in Poverty	16.8%
Children in Poverty Racial Disparity	3.0
High-speed Internet	92.6%
Students Experiencing Homelessness	2.5%
WIC Coverage	54.6%
Education	
Early Childhood Education	48.9%
Fourth Grade Reading Proficiency	34.3%
High School Graduation	85.8%
High School Graduation Racial Disparity	15.1
Social Support and Engagement	
Adverse Childhood Experiences	14.0%
Foster Care Instability	14.9%
Neighborhood Amenities	35.5%
Reading, Singing or Storytelling	57.2%

Women

Measures	U.S. Value
CLINICAL CARE	
Access to Care	
Adequate Prenatal Care	74.7%
Avoided Care Due to Cost	17.5%
Publicly-funded Women's Health Services	29%
Uninsured	12.9%
Women's Health Providers	49.5
Preventive Clinical Care	
Cervical Cancer Screening	77.1%
Dental Visit	65.5%
Flu Vaccination	38.9%
Postpartum Visit*	88.4%
Well-woman Visit	72.0%
Quality of Care	
Breastfeeding Initiation*	83.9%
Dedicated Health Care Provider	71.1%
Low-risk Cesarean Delivery	25.9%
Maternity Practices Score	81
BEHAVIORS	
Nutrition and Physical Activity	
Exercise	21.5%
Fruit and Vegetable Consumption	10.4%
Physical Inactivity	22.3%
Sexual Health	
Chlamydia	1,552.8
High-risk HIV Behaviors	9.6%
Unintended Pregnancy*	28.5%
Sleep Health	
Insufficient Sleep	33.4%
Tobacco Use	
E-cigarette Use*	7.6%
Smoking	13.4%
Smoking During Pregnancy	5.5%
HEALTH OUTCOMES	
Behavioral Health	
Drug Deaths*	22.4
Excessive Drinking	19.4%
Frequent Mental Distress	19.4%
Illicit Drug Use	10.8%
Postpartum Depression*	13.6%
Mortality	
Maternal Mortality*	19.3
Mortality Rate	117.3
Physical Health	
Frequent Physical Distress	7.5%
High Blood Pressure	10.6%
High Health Status*	57.4%
Multiple Chronic Conditions	4.1%
Obesity	30.4%
Severe Maternal Morbidity*	81.0

Children

Measures	U.S. Value
CLINICAL CARE	
Access to Care	
ADD/ADHD Treatment	2.8%
Pediatricians	107.2
Uninsured	5.7%
Preventive Clinical Care	
Childhood Immunizations	70.5%
HPV Vaccination	58.6%
Preventive Dental Care	75.1%
Well-child Visit	76.7%
Quality of Care	
Adequate Insurance	68.2%
Developmental Screening	34.8%
Medical Home	46.0%
BEHAVIORS	
Nutrition and Physical Activity	
Breastfed	24.9%
Food Sufficiency	71.9%
Physical Activity	20.5%
Soda Consumption — Youth*	9.3%
Sexual Health — Youth	
Dual Contraceptive Nonuse*	90.9%
Teen Births	15.4
Sleep Health	
Adequate Sleep	66.6%
Sleep Position*	80.2%
Tobacco Use — Youth	
Electronic Vapor Product Use*	32.7%
Tobacco Use	3.1%
HEALTH OUTCOMES	
Behavioral Health	
Alcohol Use — Youth	8.8%
Anxiety	9.2%
Depression	4.2%
Flourishing	66.6%
Illicit Drug Use — Youth	7.7%
Teen Suicide*	10.8
Mortality	
Child Mortality	25.9
Infant Mortality	5.6
Physical Health	
Asthma	6.9%
High Health Status*	90.2%
Low Birthweight	8.2%
Low Birthweight Racial Disparity	2.0
Neonatal Abstinence Syndrome*	6.1
Overweight or Obesity — Youth	33.5%

* Non-ranking measure.

— Indicates data missing or suppressed.

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

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