EVALUATING PRIORITIES

Measuring Women's and Children's Health and Well-being against Abortion Restrictions in the States

VOLUME II

Ibis Reproductive Health

CENTER FOR REPRODUCTIVE RIGHTS

Acknowledgements

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Executive Summary

Sometimes working in reproductive health, rights, and justice can feel like taking two steps forward and one step back. While the U.S. Supreme Court's historic decision reaffirming a woman's constitutional right to abortion in ***Whole Woman's Health v. Hellerstedt*** *in June 2016 was cause for celebration, the recent election has signaled a changing landscape for abortion access that threatens the progress we've worked so hard to gain. Today, it feels like the need for action is more urgent than ever.*

And it is. The *What If Roe Fell* report from the Center for Reproductive Rights **(www.whatifroefell.org)** details the troubling consequences for the health and safety of American women if *Roe v. Wade,* the landmark Supreme Court case establishing access to abortion as a constitutional right, were overturned — a frightening new reality under the Trump administration. The report found that more than 37 million women in 33 states are at risk of living in a state where abortion could become illegal if *Roe* were reversed. Twenty-two states, nearly all of which are situated in the central and southern most part of the country, could immediately ban abortion outright, while women in an additional 11 states (plus the District of Columbia) would also face losing their right to abortion.

But that isn't the whole story. While hundreds of abortion restrictions have been introduced at the state level throughout 2017, many often resulting in barriers for people in need of abortion care, hundreds of proactive measures to improve women's reproductive health and rights have also been introduced. These attempts by state legislators to preemptively fill the gaps that will inevitably be created by an administration determined to roll back progress on abortion access are promising. State advocates are also becoming more savvy and innovative in mobilizing supporters and garnering press to raise awareness about the impact of these relentless anti-abortion bills designed to restrict women's rights while shaming and stigmatizing their decisions.

To brave the changing national landscape, we also have the *Whole Woman's Health v. Hellerstedt* decision at our disposal. In the decision, the Supreme Court declared that abortion restrictions must be struck down if the burdens they will impose on women exceed the benefits they will provide; it furthermore requires that the benefits and burdens that derive from an abortion restriction must be judged by credible evidence, not speculation or junk science, and that a law's real-life impact, like the quality of a woman's abortion experience, must factor into the benefits and burdens analysis. This historic ruling will help activists continue to fight back against deceptive anti-choice laws now and well into the future.

Evaluating Priorities: Then and Now

The 2014 release of *Evaluating Priorities* aimed to evaluate whether policymakers who claim to care about health and safety when restricting abortion access also direct their energies towards passing evidence-based policies that support women, their pregnancies, and their families, and whether that concern actually translates into improved health and well-being outcomes in the states. Unsurprisingly, the report found that the more abortion restrictions a state has, the worse women and children fare when it comes to their health outcomes, and the fewer evidence-based policies that support women's well-being a state has. We worked with state advocates across the country to use this data to defend against abortion restrictions and push for proactive reproductive health policies in their states.

Now, with the Supreme Court's decision in *Whole Woman's Health v. Hellerstedt* underscoring the importance of real data – and not fake news – in reproductive health policy, our opponents are abandoning their guise of caring about women's health and shifting their policy strategy to privilege an embryo or fetus above a woman.

As we see this emerging trend of anti-abortion policies that prioritize an embryo or fetus over a woman's health, rights, and dignity, it is even more important to investigate a legislator's efforts to improve children's health and well-being in their states. This research

collaboration designed to update the 2014 issue of *Evaluating Priorities* asks the question: if "potential life" is a priority for legislators, is a child's well-being also a priority? What about maternal health and supporting pregnant women?

The answer is evident. In the last year alone, anti-abortion policymakers in states such as Texas, Indiana, and Louisiana have spent a great deal of energy passing laws and regulations requiring embryonic and fetal tissue to be buried or cremated and yet they all rank among the lowest in children's health and well-being outcomes. Pregnant women don't fare any better. In 2017, Arkansas enacted a law that requires doctors to investigate the pregnancy history of a woman seeking an abortion to make sure they are not using the procedure as a way to select the sex of their child – an outrageous policing of women's decision-making in a state that ranks last on indicators of women's health in this very report.

This 2017 *Evaluating Priorities* report finds once again that the more abortion restrictions a state has passed, the fewer evidence-based supportive policies exist, and the poorer the health and well-being outcomes for women and children. The updated research also identified two categories of states: those that have passed seven or fewer abortion restrictions and those that have passed 10 or more. States in the latter category appear to account for a disproportionately large number of the more than 330 abortion restrictions passed in states since 2011. We posit that this reflects the overwhelming influence of anti-abortion organizations that push one-size-fits-all policies to state legislators that do nothing to actually help the women and children they claim to be protecting.

The message of Evaluating Priorities is clear: evidence matters. Women's stories and experiences, in every facet of their lives, matter. Legislators should be taking their cues from public health data and their constituents to address the real health concerns in their states, and stop playing politics with women's reproductive rights and health.

RESEARCH REPORT

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BACKGROUND

Since abortion was legalized in the United States (US) in 1973, states have enacted hundreds of laws limiting whether, when, and under what circumstances a woman may obtain an abortion.[1] In recent years, abortion restrictions have begun passing at an alarming rate; from 2010 to mid-2016 states enacted over 344 abortion restrictions.[2] These restrictions take many forms, including prohibiting insurance coverage of abortion, mandating involvement of parents in minors' abortion decisions, and requiring women to undergo counseling or ultrasound procedures prior to an abortion.

When enacting abortion restrictions, policymakers sometimes claim that such laws are necessary to protect the health and well-being of women, their pregnancies, and children. Such claims have become the bedrock of numerous abortion restrictions.[3,4,5] Further, anti-choice groups such as The National Right to Life Committee and Americans United for Life use this framing for model legislative proposals to increase the chances that such bills will pass.[6,7] Some scholars attribute, in part, the passage of bills modeled after these proposals to the successful framing of abortion restrictions as necessary for the health and well-being of women, their pregnancies, and their children.[8]

Given that these claims of concern for health and well-being have proven successful for facilitating the passage of abortion restrictions, in 2014, Ibis Reproductive Health (Ibis) and the Center for Reproductive Rights (the Center) collaborated to gain a better understanding of policymakers' health-related priorities. We sought to determine whether policymakers' legislative actions are aligned with concerns regarding women and children's health and well-being. To understand how policymakers use their legislative time, we assessed both the number of abortion policies in a state and the number of policies that were supportive of women's and children's well-being (throughout their life course, including during pregnancy). To provide context for health status in each state, we assessed women's and children's health outcomes. Furthermore, in keeping with our broad perspective on women's and children's well-being, we examined the association between the number of abortion restrictions in a state with social determinants of health (i.e., social, economic, and environmental factors that have been documented to affect well-being).[9]

Since 2014, legislators' have continued to voice concerns for women's health and well-being when proposing abortion restrictions. Such concerns played a prominent role in *Whole Women's Health v. Hellerstedt*, however, the Supreme Court ultimately favored scientific evidence regarding the impact of abortion restrictions over legislators' claims. Given the ongoing threats to abortion access across the U.S., we have updated our analyses to reflect the current state-level landscape. In this report, we aimed to determine if reported concern for women, their pregnancies, and their children translates into

the passage of state policies known to improve the health and well-being of women and children. We highlight changes in abortion restrictions and supportive policies at the state level since 2014 and their association with one another.

METHODS

To describe abortion restrictions, supportive policies, women's and children's health, and social determinants of health in each state and their associations, we: 1) selected indicators[i] of abortion restrictions, policies supportive of women's and children's well-being, and women's and children's health outcomes; 2) created a scoring system to evaluate the number of selected state restrictions, policies, women's and children's health outcomes, and social determinants of health to create composite outcomes for each state; and 3) examined the association between abortion restrictions and these composite outcomes.

Indicator selection

We collected data on both state-level abortion restrictions and state-level policies and outcomes related to the well-being of women and children to create composite scores in each of five topic areas: abortion restrictions, policies supportive of women's and children's well-being, women's health outcomes, children's health outcomes, and social determinants of health. Our definition of well-being is broad and encompasses health, social, and economic status.

Within each of the topic areas, we included indicators of women's and children's health and well-being that were: reported at the state-level, publicly available, regularly updated, easy to understand, and evidence-based.

We consulted experts, public health literature, and prior policy analyses to determine the appropriate indicators for inclusion. A large pool of potential indicators was narrowed down to ensure our scoring system was consumable, easy to update, and balanced in its representation of women's and maternal and child health. All indicators included in the 2014 Evaluating Priorities report[10] were included in this report. Additional supportive policies not included in 2014 were included if they met all of the criteria listed above.

[i] "Indicator" refers to the presence or absence of a policy (either an abortion restriction or a policy to support women and children) or a health outcome statistic (e.g., infant mortality rate, prevalence of asthma, etc.).

The final indicator list included 78 indicators in the five topic areas: abortion restrictions (14), women's health outcomes (15), children's health outcomes (15), social determinants of health (10), and policies supportive of women's and children's health (24). Two additional supportive policy indicators were included that were not in the 2014 report. The full list of indicators and evidence supporting each indicator's impact on well-being is documented in the Appendix.

Data collection

Data were collected from government and nonprofit organizations with expertise in women's and children's health, such as the Guttmacher Institute, the Kaiser Family Foundation, the Centers for Disease Control and Prevention, the National Women's Law Center, and the Annie E. Casey Foundation. The data source for each indicator is included in the Appendix. For indicators included in the 2014 report, updated data were included where available. Data were updated through January 2017. For one supportive policy indicator, establishment of a maternal mortality review board, additional review of publicly-available government records was conducted to update the indicator.

Variable construction

For each state, we calculated six composite scores, one each for: abortion restrictions, policies supportive of women's and children's well-being, women's health outcomes, children's health outcomes, social determinants of health, and overall women's and children's well-being.

Abortion Restrictions

For abortion restrictions, each state was scored 0-14 to reflect the total number (14) of possible abortion restrictions in place in that state. Any law was counted, including those that were currently not enforced due to court challenges and/or rulings. Higher scores indicate more abortion restrictions.

Supportive Policies

For policies supportive of women's and children's well-being, each state was scored 0-24 to reflect the total number (24) of possible supportive policies. Higher scores indicate more policies supporting women's and children's well-being.

Non-Policy Categories

For the three non-policy categories (women's health, children's health, and social determinants of health), the standard deviation across states was calculated. As in the 2014 report, a benchmark was

set equal to the national average plus or minus one half of the standard deviation across states for each indicator; for indicators where a lower number was better, one half of a standard deviation was subtracted and vice versa for indicators where a higher number was better. This benchmark was set to be moderately but meaningfully better than the national average. A state received a score of 1 if it met or exceeded the benchmark and a 0 if it did not. Because the US average for the selected indicators is often poor relative to other developed countries, the pre-determined benchmarks do not necessarily reflect an "ideal," but rather are meant to be attainable goals for states. Across all three categories, higher scores indicate better performance on women's or children's health outcomes or social determinants of health.

For women's health outcomes, each state was scored 0-15 to reflect the total number (15) of benchmarks met for women's health outcomes. For children's health outcomes, each state was scored 0-15 to reflect the total number (15) of benchmarks met for children's health outcomes. For social determinants of health, each state was scored 0-10 to reflect the total number (10) of benchmarks met for social determinants of health.

Overall Score

For overall women's and children's well-being, the scores for supportive policies, women's health, children's health, and social determinants of health well-being were summed, for a total score of 0-64.

Analysis

Changes in number of abortion restrictions and supportive policies in each state between 2014 and 2017 were assessed. To examine the association between abortion restrictions and women's and children's health and well-being, we created a series of scatter plots, comparing states' abortion restriction scores against their total scores on: supportive policies, women's health, children's health, social determinants of health, and overall women's and children's well-being.

RESULTS

Data on the selected abortion restrictions were available for all 50 states and the District of Columbia. For health and well-being indicators, in the cases where data were not available, as a conservative estimate, the indicator was set to 0. A total of 20 (0.5%) data points were missing. Three women's health, five children's health, and five supportive policy indicators were not updated from the 2014 report as more recent data were not available.

Abortion restrictions

Selected abortion restrictions are presented in Table 1.

Table 1. Abortion restrictions

Mandatory parental involvement before a minor obtains an abortion
Mandatory waiting periods between time of first appointment and abortion
Mandatory counseling prior to abortion
Requirement to have or be offered an ultrasound
Restrictions on abortion coverage in private health insurance plans
Restrictions on abortion coverage in public employee health insurance plans
Restrictions on abortion coverage in Medicaid
Restrictions on which health care providers may perform abortions
Ambulatory surgical center standards imposed on facilities providing abortion
Hospital privileges or alternative arrangement required for abortion providers
Refusal to provide abortion services allowed
Gestational age limit for abortion set by law
Restrictions on provision of medication abortion
Below average number of providers (per 100,000 women aged 15-44)

The median number of state abortion restrictions was 11 as compared to 10 in 2014. As in 2014, only one state, Vermont, had zero restrictions; however, in 2017 five states, Indiana, Kansas, Mississippi, Oklahoma, and South Carolina, had the maximum 14 restrictions as compared to three in 2014 (Table 2). Interestingly, few states (n=3) had between seven and 10 restrictions; most states had either fewer than seven (n=22) or greater than 10 restrictions (n=26) in place.

Table 2. Number of abortion restrictions by state

Number of restrictions	State(s), 2014	State(s), 2017
0	Vermont	Vermont
1	District of Columbia, Oregon, Washington	District of Columbia, Oregon, Washington
2	Hawaii, New Hampshire, New York	Hawaii, New Hampshire, New York
3	California, Connecticut, Montana, New Jersey, New Mexico	California, Colorado, Connecticut, Montana, New Jersey, New Mexico
4	Maine, Maryland, Wyoming	Alaska, Illinois, Maine, Maryland, Wyoming
5	Alaska, Colorado, West Virginia	N/A
6	Delaware, Illinois, Iowa, Massachusetts, Minnesota	Delaware, Massachusetts, Minnesota, West Virginia
7	Nevada	Nevada
8	-none-	Iowa
9	Rhode Island	Rhode Island
10	Kentucky	-none-
11	Arkansas, Florida, Georgia, Idaho, Michigan, Pennsylvania, Tennessee, Wisconsin	Georgia, Pennsylvania, Tennessee, Texas
12	Alabama, Ohio, South Dakota, Texas, Utah, Virginia	Alabama, Florida, Idaho, Kentucky, Michigan, Nebraska, Ohio, South Dakota, Utah, Virginia, Wisconsin
13	Arizona, Indiana, Louisiana, Missouri, Nebraska, North Carolina, North Dakota, South Carolina	Arizona, Arkansas, Louisiana, Missouri, North Carolina, North Dakota
14	Kansas, Mississippi, Oklahoma	Indiana, Kansas, Mississippi, Oklahoma, South Carolina

Overall, there are six more abortion restrictions in place in 2017 than there were in 2014. While many more than six restrictions were enacted between 2014 and 2017, some of these new laws fall into categories (e.g. mandatory counseling) where there was already an existing restriction in that state. Since 2014, 36 states (71%) have not enacted or repealed any abortion restrictions included in our indicator.

Supportive Policies

Selected supportive policies are presented in Table 3.

Table 3. Supportive policies

Expanded Medicaid under the Affordable Care Act
Allows telephone, online, and/or administrative renewal of Medicaid/CHIP
Requires domestic violence protocols, training, or screening for health care providers
Does not have a family cap policy or flat cash assistance grant
Requires worksites, restaurants, and bars to be smoke free
Medicaid income limit for pregnant women is at least 200% of the federal poverty line
Has expanded family/medical leave beyond the FMLA
Provides temporary disability insurance
Maternal mortality review board has been established
Requires reasonable accommodations for pregnant workers
Prohibits or restricts shackling pregnant prisoners
Allows children to enroll in CHIP with no waiting period
Requires physical education for elementary, middle, and high school
Mandates sex education
Mandates HIV education
Has broad eligibility criteria for Early Intervention services for children at risk of developmental delay
Initiative(s) to expand Early Head Start in place
Requires districts to provide full-day kindergarten without tuition
Has firearm safety law(s) designed to protect children
Allows families receiving TANF to keep child support collected on their behalf
State minimum wage is above the federal minimum
Income limit for child care assistance is greater than 55% of state median income
Has above average Title X Family Planning Funding
Has contraceptive parity laws in place

Note: Italicized supportive policies were not included in the 2014 Evaluating Priorities report.

As in 2014, none of the states had all supportive policies in place; however all states had at least four supportive policies in place in 2017. California and Hawaii had the greatest number of supportive policies in place (18), while Wyoming had the fewest (4) (Table 4).

Table 4. Number of supportive policies by state

Number of supportive policies	State(s), 2014	State(s), 2017
0	-none-	-none-
1	-none-	-none-
2	-none-	-none-
3	Idaho, South Dakota, Wyoming	-none-
4	Indiana, North Dakota	Wyoming
5	Nebraska	-none-
6	Alabama, Arizona, Kansas, Kentucky, Mississippi, Missouri, Tennessee	Idaho, Kansas
7	Arkansas, Georgia, Virginia	Alabama, Nebraska, South Dakota
8	Florida, Louisiana, Montana, Oklahoma, Utah	Florida, Kentucky, Mississippi, North Dakota, Virginia
9	Colorado, South Carolina	Arizona, Arkansas, Georgia, Indiana
10	Nevada, Texas	South Carolina, Tennessee, Utah
11	Alaska, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, Wisconsin	Alaska, Louisiana, Missouri, North Carolina, Oklahoma
12	Connecticut, Delaware, Ohio, Oregon, Pennsylvania	Michigan, Nevada, New Hampshire, Texas
13	Hawaii, Iowa, Maine, Maryland, West Virginia	Iowa, Ohio, Oregon, Wisconsin
14	District of Columbia, New Mexico, New York, Rhode Island, Vermont, Washington	Colorado, Connecticut, Maine, Montana, Pennsylvania
15	New Jersey	Delaware, Massachusetts, New Mexico, Washington, West Virginia
16	California	Illinois, Vermont
17	Illinois	District of Columbia, Maryland, Minnesota, New Jersey, New York, Rhode Island
18	-none-	California, Hawaii
19 - 22	-none-	-none-
23 - 24	N/A	-none-

Note: In 2017, two additional supportive policies were included. In 2014, the maximum possible score was 22 and in 2017 it was 23.

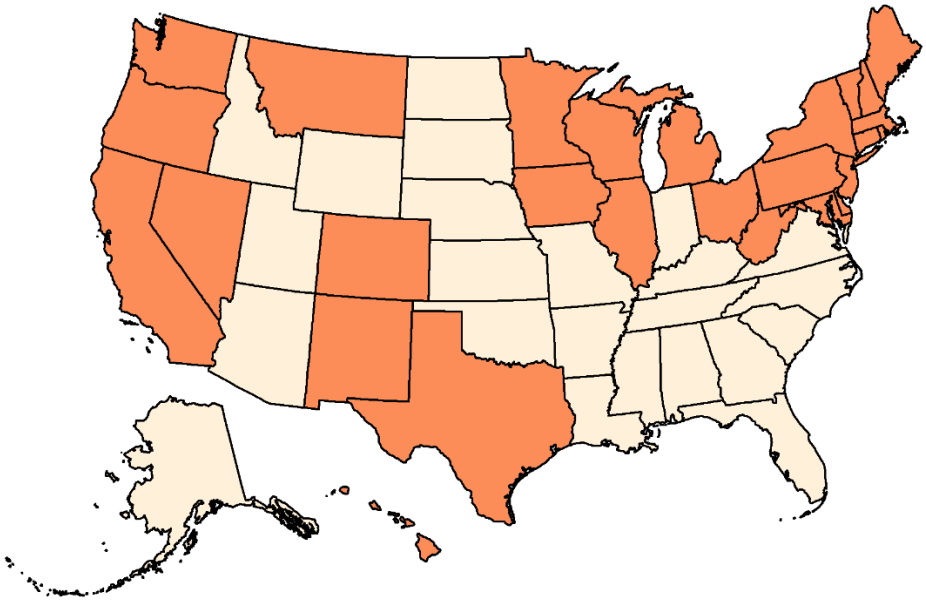
Of the policies examined in both 2014 and 2017, 66 more supportive policies were in place in 2017 than in 2014; 35 states have enacted 74 policies, and eight laws in seven states are no longer in place, while the majority of states (65%) had the same number of supportive policies or had added one or two policies (Figure 2).

Figure 2. Change in number of supportive policies by state, 2014 to 2017

Note: Count only includes those supportive policies that were considered in both 2014 and 2017.

Despite the addition of two indicators, the median number of supportive policies was 12 (range: 4 to 18), as compared to 11 in 2014. Twenty-eight states were at or above the median (Figure 3).

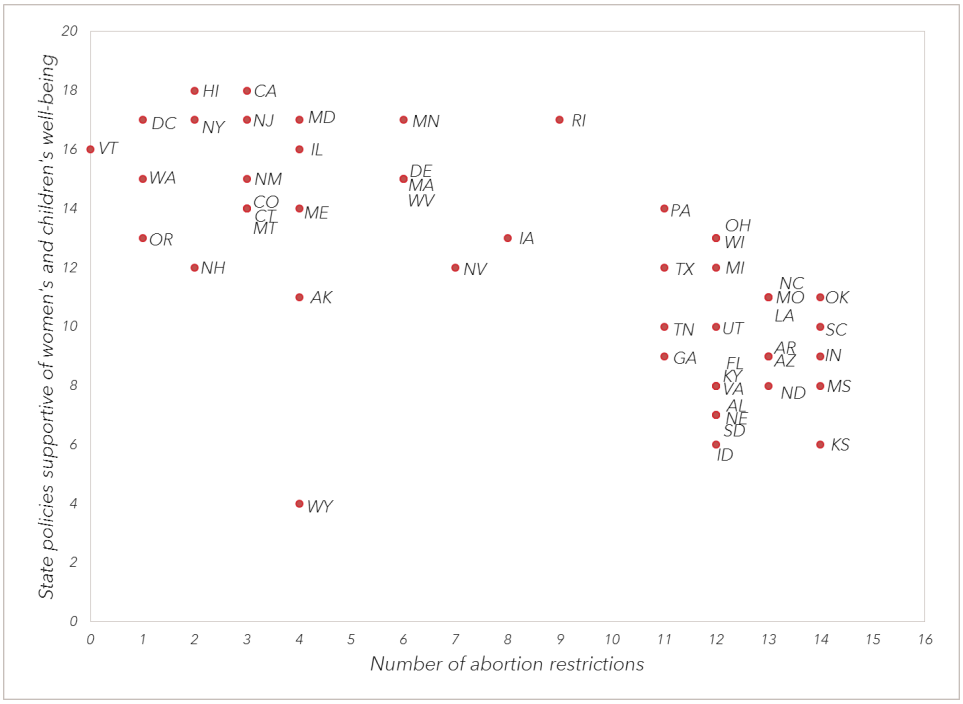
Figure 3. States' number of supportive policies



Note: Orange (darker) indicates states above the median (12) supportive policies score, while the lighter color indicates states below the median supportive policies score.

In general, states that have passed multiple abortion restrictions have passed fewer evidence-based policies to support women's and children's well-being, compared to states with fewer restrictions on abortion (Figure 4). The scatterplot shows two clusters of states, one with a higher number of supportive policies and fewer than seven restrictions and another with fewer supportive policies and more than ten restrictions. Among the states with 12 or more supportive policies in place, the number of abortion restrictions in place ranged from 0 to 12 (median=4). Conversely, in states with 11 or fewer supportive policies in place, the number of abortion restrictions in place ranged from 2 to 14 (median=12). Wyoming was an outlier with relatively few abortion restrictions (4) and the lowest number of supportive policies (4).

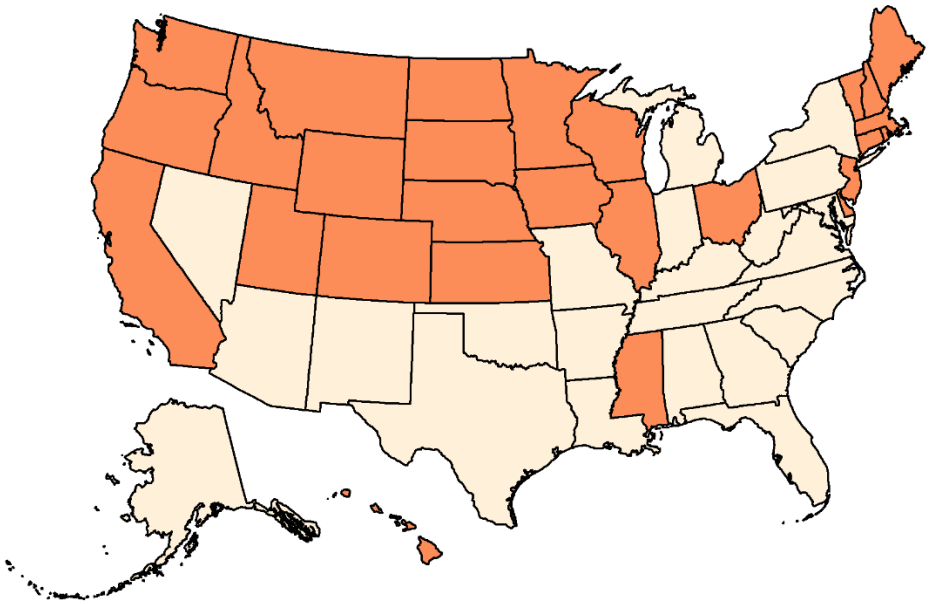
Figure 4. State abortion restrictions and supportive policies



Women's health outcomes

The median number of women's health benchmarks met was 5 (range: 0 to 11). Twenty-seven states were at or above the median. Arkansas and Nevada met none of the benchmarks, while Minnesota met the most (11) (Figure 5).

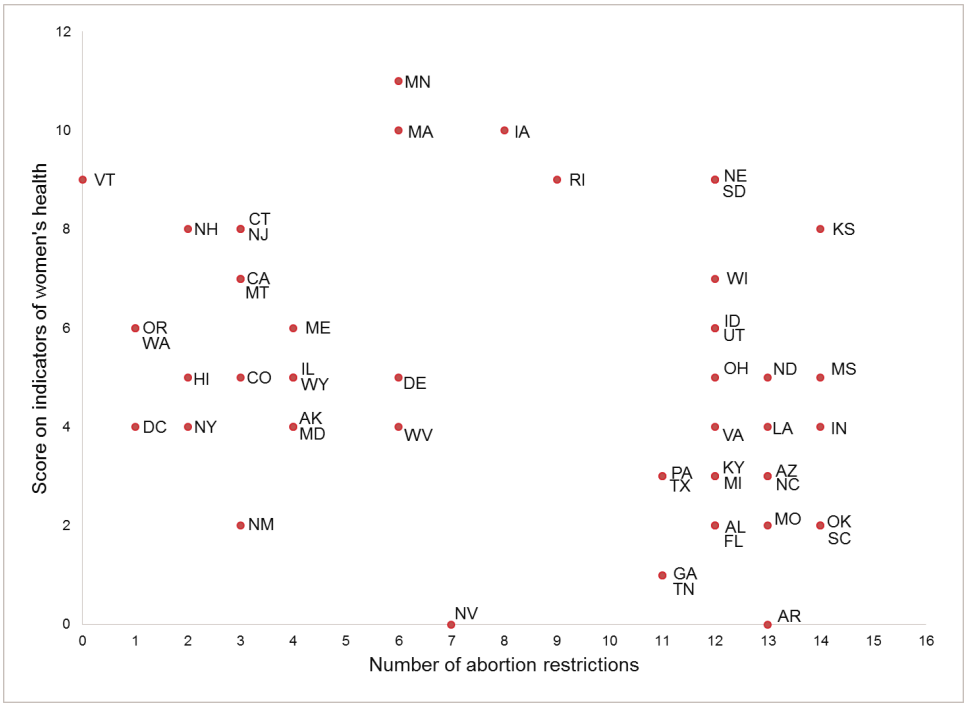
Figure 5. States' score on women's health



Note: Orange (darker) indicates states above the median (5) women's health score, while the lighter color indicates states below the median women's health score.

The trend between number of abortion restrictions and women's health was less striking than for supportive policies (Figure 6); however, there was some evidence of an inverse association between number of abortion restrictions and number of women's health benchmarks met. Among the states that met five or more women's health benchmarks, the number of abortion restrictions in place ranged from 0 to 14 (median=6). Conversely, in states that met four or fewer benchmarks, the number of abortion restrictions in place ranged from 1 to 13 (median=12).

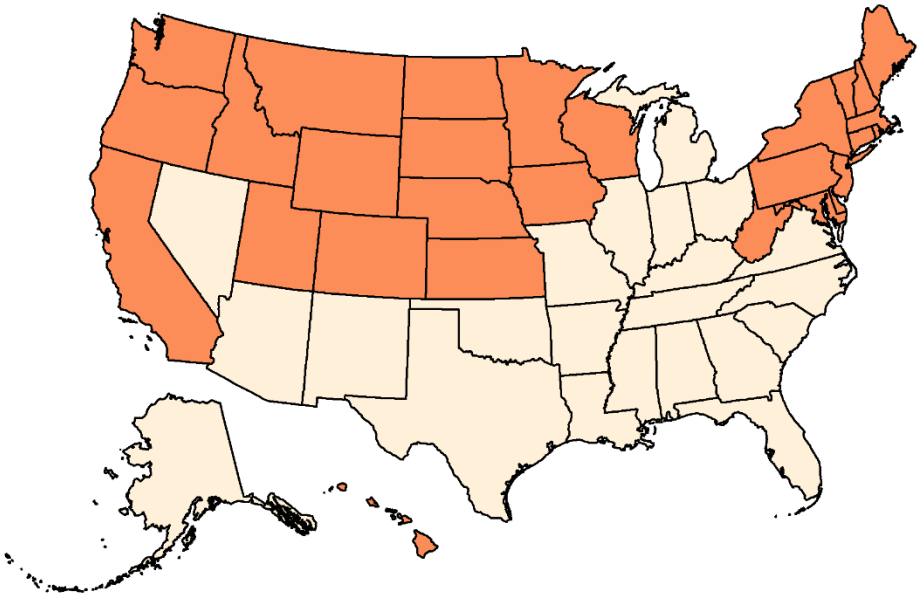
Figure 6. State abortion restrictions and women's health



Children's health outcomes

The median number of children's health benchmarks met was four (range: 0 to 11). Twenty-eight states were at or above the median. Mississippi, New Mexico, South Carolina, and Texas met none of the benchmarks, while New Hampshire, New Jersey, Vermont, and Washington met the most (11) (Figure 7).

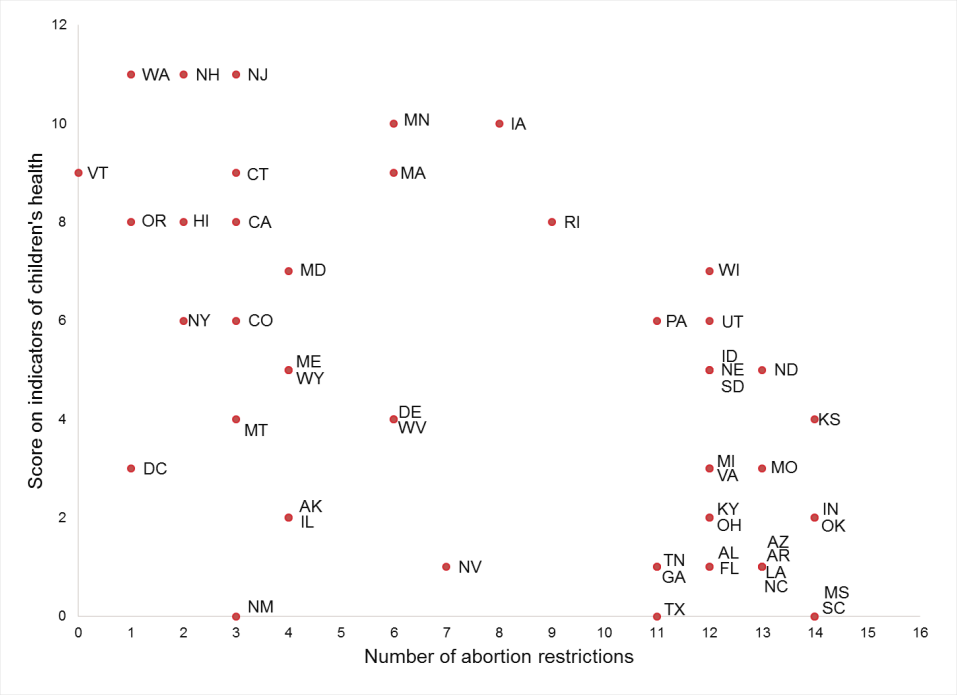
Figure 7. States' score on children's health



Note: Orange (darker) indicates states above the median (4) children's health score, while the lighter color indicates states below the median children's health score.

The trend between number of abortion restrictions and children's health was also less pronounced than for supportive policies, but indicated an inverse relationship (Figure 8). Among the states that met four or more children's health benchmarks, the number of abortion restrictions in place ranged from 0 to 14 (median=5). Conversely, in states that met three or fewer benchmarks, the number of abortion restrictions in place ranged from 1 to 14 (median=12).

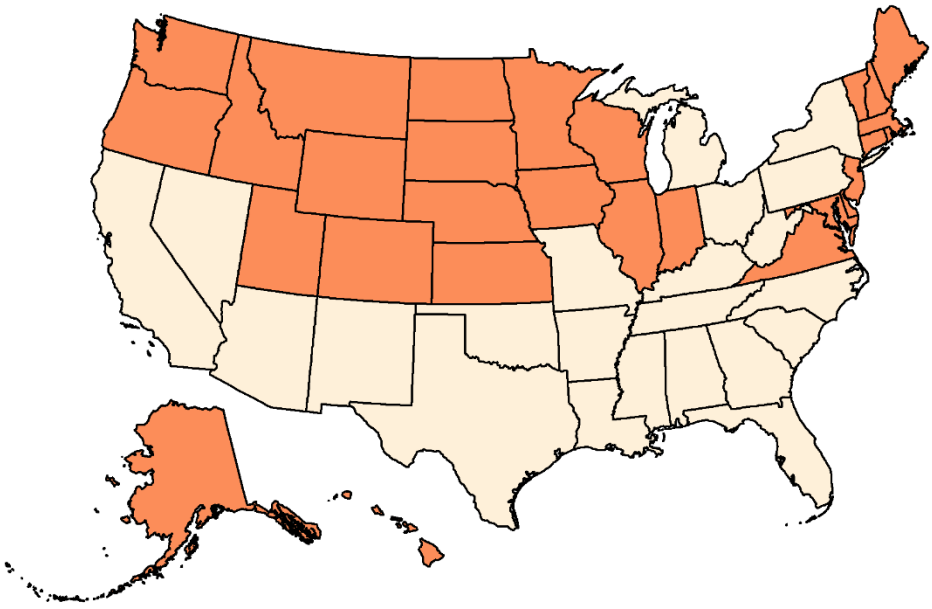
Figure 8. State abortion restrictions and children's health



Social determinants of health

The median number of social determinants of health met was three (range: 0 to 9). Twenty-nine states were at or above the median. Michigan, Oklahoma, and South Carolina met none of the benchmarks, while Vermont met the most (9) (Figure 9).

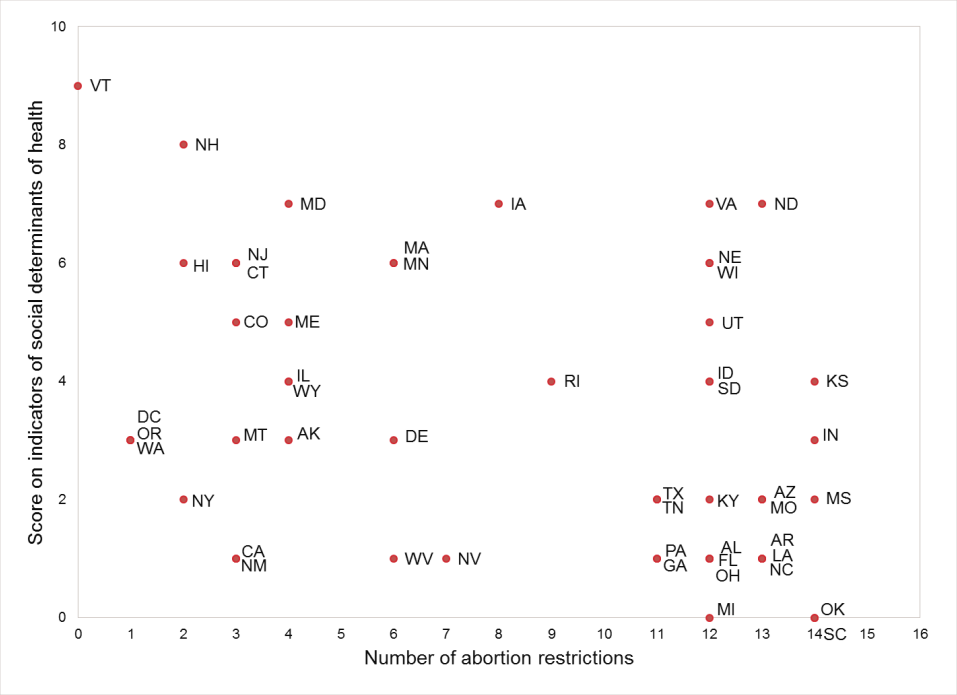
Figure 9. States' score on social determinants of health



Note: Orange (darker) indicates states above the median (3) social determinants of health score, while the lighter color indicates states below the median social determinants of health score.

Again, the scatter plot suggests inverse association between number of abortion restrictions and social determinants of health (Figure 10). Among the states that met three or more social determinants of health benchmarks, the number of abortion restrictions in place ranged from 0 to 14 (median=4). Conversely, in states that met two or fewer benchmarks, the number of abortion restrictions in place ranged from 2 to 14 (median=12).

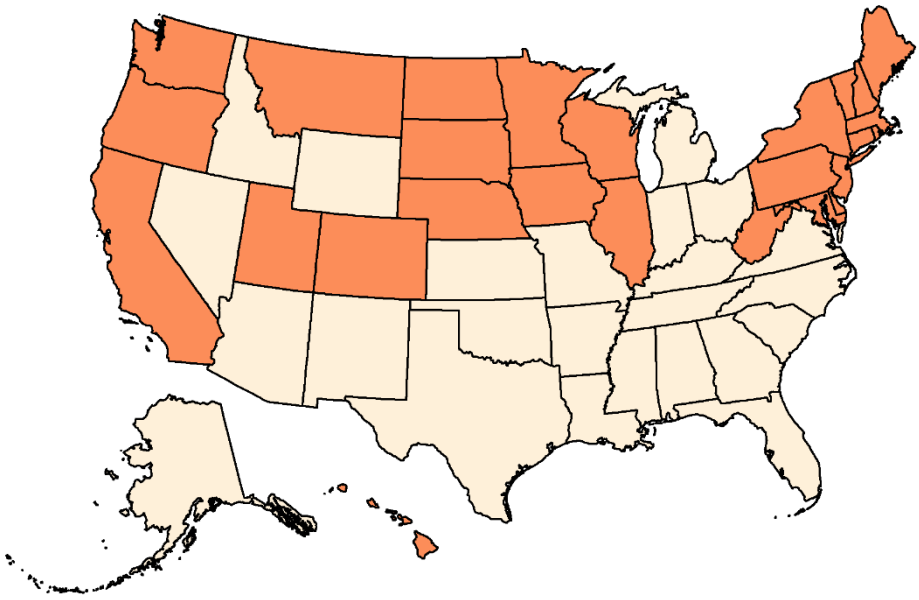
Figure 10. State abortion restrictions and social determinants of health



Overall well-being

States' median overall score was 24 (range: 11 to 44). Twenty-seven states were at or above the median. Alabama and Arkansas had the lowest score (11), while Minnesota had the highest (44) (Figure 11).

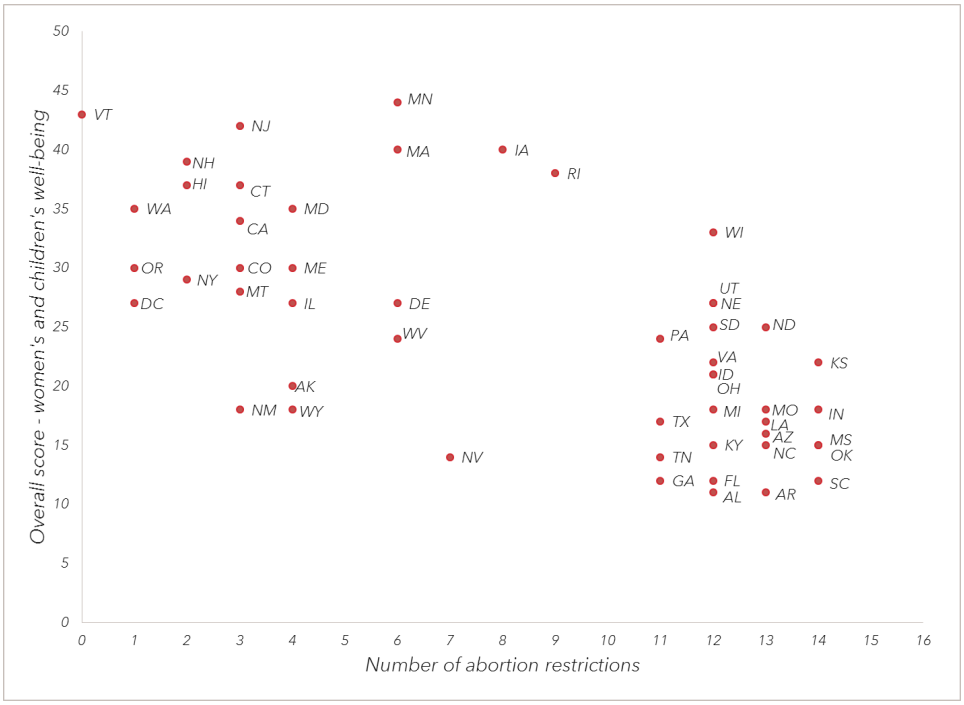
Figure 11. States' score on overall well-being



Note: Orange (darker) indicates states above the median (24) overall score, while the lighter color indicates states below the median overall score.

Similar to between number of abortion restrictions and number of supportive policies, there appeared to be an inverse association between number of abortion restrictions and overall well-being score (Figure 12). Among the states with an overall score greater than or equal to 24, the number of abortion restrictions in place ranged from 0 to 13 (median=4). Conversely, in states with an overall score less than 24, the number of abortion restrictions in place ranged from 3 to 14 (median=12).

Figure 12. State abortion restrictions and overall score on indicators of well-being



DISCUSSION

We found that many states continue to impede abortion access through the implementation of abortion restrictions. Compared with 2014, 13 additional abortion restrictions were identified in 10 states. Furthermore, we found that compared with those that have few restrictions, states with the most abortion restrictions tend to have implemented fewer policies known to support women's and children's well-being. This analysis also found some evidence that a state's number of abortion restrictions and its performance on indicators of women's health, children's health, and social determinants of health were inversely associated. These data show that policymakers in states with fewer abortion policies have been more successful in enacting policies supportive of women, their pregnancies, and their children. Conversely, in states with more abortion restrictions, fewer supportive policies have been enacted.

These findings are troubling, as ample scientific evidence makes clear that restricting abortion is detrimental, while supportive policies are beneficial to women. Abortion restrictions can delay or make access to care more difficult, contributing to poor emotional and financial well-being as women try to navigate abortion care hurdles.[9, 11, 12, 13, 14, 15, 16, 17] Other restrictions block access to abortion all together,

interfering with women's abilities to make their own reproductive decisions and preventing the achievement of life plans and goals. Women denied abortion care are at increased risk of experiencing poverty, physical health impairments, and intimate partner violence[8, 11, 14, 18, 19, 20, 21, 22, 23, 24, 25, 26] In contrast, supportive policies can lead to improved health and safety, lower poverty rates, and better developmental and educational outcomes for children.[27] See the Appendix for further details on the impacts of the abortion restrictions and supportive policies on well-being measures included in this analysis. Additionally, the observed associations between number of supportive policies and number of abortion restrictions is particularly concerning, as restrictions are often disproportionately felt[28] by populations that may derive the greatest benefit from supportive policies.

Our abortion restriction indicator is consistent with other scoring systems. All of the states that had nine or more restrictions on our scale, had "severely restricted access" according to NARAL's level of abortion access measure.[1] States with four or fewer restrictions had either "protected access" or "strongly protected access" except for: Colorado ("some access"), District of Columbia (no level given) New Hampshire ("some access"), and Wyoming ("restricted access"). Furthermore, the majority (65%) of states that scored 10 or higher were in the top third of the Institute for Women's Policy Research's Reproductive Rights Composite Index (higher composite score indicates more reproductive rights restrictions).[29] Prior research has linked reproductive rights and other indicators of women's status with better outcomes for children, such as lower infant mortality.[30] One study found that between 1964 and 1977, the single most important factor in the reduction of infant mortality was the increase in abortion legalization.[31] More recently, investigators found that a state-level composite score for reproductive rights was associated with adverse birth outcomes.[32]

Limitations

These analyses are limited by their reliance on cross-sectional data. As such, we cannot make inferences about causality or the direction of relationships between abortion restrictions and the examined indicators. For example, it is possible that state policymakers implemented abortion restrictions in response to poor health outcomes, rather than poor health outcomes being effects of abortion restrictions.

Furthermore, because these analyses were unadjusted, they ignore potential confounders of the relationship between the explored measures. These analyses did not directly adjust for poverty, which has been shown to play a major role in women's and children's well-being,[33] and is associated with other social issues that may play a role in our findings, such as racism[34] and sexism.[35] However, the data suggest that proportion of women in poverty, while included as an indicator, does not explain all

observed differences between states. For example, in New Mexico 18% of women were in poverty (minimum proportion in poverty was 8% and maximum was 19%) and there were 15 supportive policies in place, while in Wyoming 9% of women were in poverty and there were only four supportive policies in place.

Additionally, we relied on publicly-available secondary data, rather than primary data collection. Our efforts were limited by the available data; while we attempted to select the most meaningful, evidence-based indicators, the composite scores we constructed are a simplified measure of women's and children's well-being. We were reliant on data that were available at the state-level across the country, therefore we could not evaluate all potentially relevant markers of well-being. For example, measures of experienced racism and voting rights were not available systematically across states; however, this does not mean that these indicators do not play a role in the health of communities. Furthermore, state-level measures may mask within-state heterogeneity in outcomes and disparities in health, which can result in certain populations bearing a greater burden of poor health outcomes. Those disparities cannot be examined using these data. Additionally, for some indicators included in the 2014 report, updated data were not available.

Finally, our dichotomous scoring methodology is limited in its ability to detect variation between states since states are classified as either meeting the benchmark or not, without any accounting for the degree of difference, nor did we account for differences in specific policies across states (e.g., 24-hour vs. 72-hour waiting periods prior to an abortion). Nevertheless, we feel this simple approach is also a strength in that it facilitates understanding and replicability of our analysis, and makes the information accessible.[36]

Conclusion

These findings mirror those from the 2014 Evaluating Priorities report, demonstrating that states with many abortion restrictions tend to have fewer supportive policies in place. This finding indicates that state policymakers may focus more effort or attention on policies that restrict abortion access compared with those known to promote the health and well-being of women and children.

Given these associational findings, future work should aim to better understand the relationship between number of abortion restrictions and number of supportive policies at the state-level through the collection of qualitative data from policymakers and other key stakeholders. In particular, we should work to understand the observed divide between states with fewer than seven abortion restrictions and those with greater than 10, as well as the pattern of restriction across states. Lastly, future research should expand on these findings to understand whether the effects of number of supportive policies is

modified by pre-existing health and social conditions. In states with both few supportive policies and many restrictions, there may be particularly adverse outcomes.

In order to truly protect women and children's well-being, state policymakers must promote legislation that improves the well-being of women and children, rather than restricting access to needed health care services, such as abortion. These findings support the continued need for ongoing research to to better understand how and which legislative policies are being prioritized.

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Appendix: Indicators, evidence of impact, and sources

ABORTION RESTRICTIONS

Below average number of abortion providers

Description: Number of abortion providers per 100,000 women aged 15-44 is below the national average, 2014.
Data source(s):

- Guttmacher Institute. State data center, create a table: Number of abortion providers, 2014. Available at: https://data.guttmacher.org/states. Accessed Feb 7, 2017.
- Guttmacher Institute. State data center, create a table: Total number of women aged 15-44, 2014. Available at: https://data.guttmacher.org/states. Accessed Feb 7, 2017.

Impact: The quality and functionality of any health care delivery system depends on the availability of medical personnel. A limited number of abortion providers likely impedes access to health care and disproportionately impacts those living in medically underserved areas.
Impact source(s):

- Agency for Healthcare Research and Quality. Health system infrastructure: National healthcare disparities report, 2010. *Agency for Healthcare Research and Quality*; 2011. Available at: http://1.usa.gov/1rpXvY6. Accessed June 25, 2014.
- Henshaw SK. Factors hindering access to abortion services. *Family Planning Perspectives.* 1995;27(2):54-87.

Ambulatory surgical center standards imposed on facilities providing abortion

Description: Facilities providing abortion must meet standards intended for ambulatory surgical centers, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Targeted regulation of abortion providers. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/LzzolX. Accessed Feb 7, 2017.

Impact: Imposing ambulatory surgical standards on facilities providing abortion can reduce the number of providers able to stay open and offer care, limiting women's access to care. These standards also increase the cost of care, which can further impede access.
Impact source(s):

- The University of Texas at Austin. The Texas Policy Evaluation Project: How abortion restrictions would impact five areas of Texas. *The University of Texas at Austin*; August 2013. Available at: http://bit.ly/1hj0Xzx. Accessed June 25, 2014.
- Jones BS, Wietz TA. Legal barriers to second-trimester abortion provision and public health consequences. *American Journal of Public Health.* 2009; 99(4):623-630.

Gestational age limit for abortion set by law

Description: Abortion is restricted beyond a specified gestational age, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: State policies on later abortions. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1isGcj3. Accessed Feb 7, 2017.

Impact: Gestational age limits for abortion set by law can prevent women from being able to access care and force them to continue unwanted pregnancies. Not being able to access care because of gestational age limits can also reduce women's self-esteem and life satisfaction, and increase regret and anger.
Impact source(s):

- Upadhyay UD, Weitz TA, Jones RK, Barar RK, Foster DG. Denial of abortion because of provider gestational age limit in the United States. *American Journal of Public Health*. 2014;104(9):1687-94.
- Biggs MA, Upadhyay UD, Steinberg JR, Foster DG. Does abortion reduce self-esteem and life satisfaction? *Quality of Life Research*. 2014;23(9):2505-13.
- Rocca CH, Kimport K, Gould H, Foster DG. Women's emotions one week after receiving or being denied an abortion in the United States. *Perspective on Sexual and Reproductive Health.* 2013;45(3):122-31.
- Jones BS, Wietz TA, Legal barriers to second-trimester abortion provision and public health consequences. *American Journal of Public Health.* 2009;99(4):623-630.

Hospital privileges or alternative arrangement required for abortion providers

Description: Abortion providers are required to be affiliated with a local hospital, through admitting privileges or an alternative arrangement, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Targeted regulation of abortion providers. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/LzzolX. Accessed Feb 7, 2017.

Impact: Requiring abortion providers to have hospital privileges or alternative arrangements reduces access to care without improving patient safety.
Impact source(s):

- The University of Texas at Austin. The Texas Policy Evaluation Project: Abortion restrictions in context. *The University of Texas at Austin;* August 2013. Available at: http://bit.ly/1lr0mLp. Accessed June 25, 2014.
- Nash E, Gold RB. TRAP laws gain political traction while abortion clinics – and the women they serve – pay the price. *Guttmacher Policy Review*. 2013;16(2):7-12.

Mandatory counseling prior to abortion

Description: Women seeking an abortion must undergo counseling before obtaining the procedure, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Counseling and waiting periods for abortion. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/U17fJC. Accessed Feb 7, 2017.

Impact: Mandatory counseling laws can postpone the timing of some abortions, particularly when counseling must be received in person or when a woman must wait a state-specified amount of time between the time she obtains counseling and the time of the abortion. Delays increase the risks and costs of abortion.
Impact source(s):

- Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard K. The impact of state mandatory counseling and waiting period laws on abortion: A literature review. *Guttmacher Institute;* April 2009. Available at: http://bit.ly/1pFcVmG. Accessed June 25, 2014.

Parental involvement required before a minor obtains an abortion

Description: Minors seeking an abortion must notify and/or obtain consent from one or both parents, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: An overview of abortion laws. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1iAuL5u. Accessed Feb 9, 2017.

Impact: There is no evidence to suggest that parental involvement laws deter minors from engaging in sexual activity (as is the often-stated thinking behind the laws). However, some minors do try to circumnavigate the laws by obtaining a judicial bypass or traveling outside of their home state to obtain an abortion in a state without parental involvement laws. The laws can delay access to the procedure, which increases the risks and costs of abortion.
Impact source(s):

- Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard K.. The impact of laws requiring parental involvement for abortion: A literature review. *Guttmacher Institute*; April 2009. Available at: http://bit.ly/1pFcVmG. Accessed June 25, 2014.
- Colman S, Dee TS, Joyce T. Do parental involvement laws deter risky teen sex? *Journal of Health Economics*. 2013; 32(5):873-80.
- Colman S, Joyce T. Minors' behavioral responses to parental involvement laws: Delaying abortion until age 18. *Perspectives on Sexual and Reproductive Health*. 2009;41(2):119-26.

Restriction on which health care providers may perform abortions

Description: Restrictions on which type of health care provider may perform abortions, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: An overview of abortion laws. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1iAuL5u. Accessed Feb 9, 2017.

Impact: Limiting the types of health care providers able to perform abortions likely impedes or delays access to abortion care as the health care delivery system depends on the availability of medical personnel to function. This may disproportionally impact women living outside of urban areas.

Impact source(s):

- Agency for Healthcare Research and Quality. Health system infrastructure: National healthcare disparities report, 2010. *Agency for Healthcare Research and Quality*; 2011. Available at: http://1.usa.gov/1rpXvY6. Accessed June 25, 2014.
- Dunn JT, Parham L. After the choice: Challenging California's physician-only abortion restriction under the state constitution. *UCLA Law Review Discourse*. 2013;61(5):22-42.

Medication abortion restrictions

Description: Medication abortion is required to be administered in accordance with the outdated FDA labeling and/or is required to be provided by a clinician who is physically present during the procedure, 2017.

Data source(s):

- Guttmacher Institute. State policies in brief: Medication abortion. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1ke23vY. Accessed Feb 9, 2017.

Impact: Requiring medication abortion to be administrated in accordance with outdated FDA protocols forces health care providers to administer medication in a way that counters best practice of medicine, denies women access to evidence-based regimens for care, and reduces the number of providers able to offer medication abortion. Requiring a clinician to be physically present during the procedure limits access to abortion, particularly for women living in remote areas. It may also delay access to care and increase women's travel time to care.

Impact source(s):

- The University of Texas at Austin. The Texas Policy Evaluation Project: Abortion restrictions in context. *The University of Texas at Austin;* August 2013. Available at: http://bit.ly/1lr0mLp. Accessed June 25, 2014.
- Linnane R. Wisconsin law increases abortion delays, risk. *WisconsinWatch.org*; 2013. Available at: http://bit.ly/1o7LfFS. Accessed June 25, 2014.
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Refusal to provide abortion services allowed

Description: Health care providers are allowed to refuse to provide abortion services, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Refusing to provide health services. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1IsohM6. Accessed Feb 9, 2017.

Impact: Allowing health care providers to refuse to provide abortion services violates standards of medical care and reduces accessibility of abortion. This likely disproportionally impacts women living outside of urban areas.
Impact source(s):

- NARAL Pro-Choice America. Refusal laws: Dangerous for women's health. *NARAL Pro-Choice America;* 2014. Available at: http://bit.ly/2oGqMRF. Accessed June 25, 2014.
- Harries J, Stinson K, Orner P. Health care providers' attitudes toward termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*. 2009; 9(296).

Restrictions on abortion coverage in Medicaid

Description: Restrictions on abortion coverage in Medicaid, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: An overview of abortion laws. *Guttmacher Institute;* Feb 2017. Available at: http://bit.ly/1iAuL5u. Accessed Feb 9, 2017.

Impact: Restrictions on abortion coverage in Medicaid can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women's personal medical decisions, undermine women's autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, force women and their families to endure financial hardships to afford care, and force women who cannot afford abortion care to continue unwanted pregnancies.
Impact source(s):

- Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid funding for abortions: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1aIMlcA. Accessed June 26, 2014.
- Dennis A, Blanchard K. A mystery caller evaluation of Medicaid staff responses about state coverage of abortion. *Women's Health Issues.* 2012;22(2): e143-e148.
- Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study. *Health Services Research.* 2013;48(1): 236-252.
- Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for Poor and Underserved*. 2014;25(4):1571-85.

Restrictions on abortion coverage in private health insurance plans

Description: Restrictions on abortion coverage in all private health plans or in health plans offered through the health insurance exchanges, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Restricting insurance coverage of abortion. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1mRToyW. Accessed Feb 9, 2017.

Impact: Though little research has documented the specific impacts of restricting abortion coverage in private health insurance plans, there is ample data showing the harms of limiting public insurance coverage of the procedure. Such restrictions can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women's personal medical decisions, undermine women's autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, and force women and their families to endure financial hardships to afford care.
Impact source(s):

- Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid funding for abortions: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1alMlcA. Accessed June 25, 2014.
- Dennis A, Blanchard K. A mystery caller evaluation of Medicaid staff responses about state coverage of abortion. *Women's Health Issues.* 2012;22(2): e143-e148.
- Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study. *Health Services Research.* 2013;48(1):236-252.
- Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for Poor and Underserved*. 2014;25(4):1571-85.

Restrictions on abortion coverage in public employee health insurance plans

Description: Restrictions on abortion coverage in state employee health plans, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Restricting insurance coverage of abortion. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1mRToyW. Accessed Feb 9, 2017.

Impact: Though little research has documented the specific impacts of restricting abortion coverage in public employee health insurance plans, there is ample data showing the harms of limiting public insurance coverage of the procedure. Such restrictions can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women's personal medical decisions, undermine women's autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, and force women and their families to endure financial hardships to afford care.

Impact source(s):

- Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid funding for abortions: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1alMlcA. Accessed June 25, 2014.
- Dennis A, Blanchard K. A mystery caller evaluation of Medicaid staff responses about state coverage of abortion. *Women's Health Issues.* 2012;22(2):e143-e148.
- Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study. *Health Services Research.* 2013;48(1):236-252.
- Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for Poor and Underserved*. 2014;25(4):1571-85.

Requirement to have or be offered an ultrasound

Description: Women seeking an abortion must either undergo or be offered an ultrasound procedure, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: Requirements for ultrasound. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1d9Qi2P. Accessed Feb 13, 2017.

Impact: Viewing an ultrasound generally does not impact women's abortion decision making (though that is the reasoning behind the law).
Impact source(s):

- The University of Texas at Austin. The Texas Policy Evaluation Project: How abortion restrictions would impact five areas of texas. *The University of Texas at Austin;* August 2013. Available at: http://bit.ly/1hj0Xzx. Accessed June 25, 2014.
- Gatter M, Kimport K, Foster DG, Weitz TA, Upadhyay UD. Relationship between ultrasound viewing and proceeding to abortion. *Obstetrics and Gynecology*. 2014;123(1):81-7.

Waiting periods required between time of first appointment and abortion

Description: Women seeking an abortion must wait a specified period of time between required counseling and obtaining the procedure, 2017.
Data source(s):

- Guttmacher Institute. State policies in brief: An overview of abortion laws. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1iAuL5u. Accessed Feb 13, 2017.

Impact: Mandatory waiting periods can postpone the timing of abortions, increase the proportion of second-trimester abortions occurring in a state, and increase the number of women traveling out of state for an abortion. They can also negatively impact women's emotional well-being.

Impact source(s):

- Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard, K.. The impact of state mandatory counseling and waiting period laws on abortion: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1pFcVmG. Accessed June 25, 2014.
- Jones RK, Jerman J. How far did US women travel for abortion services in 2008? *Journal of Women's Health*. 2013;22(8):706-713.
- The University of Texas at Austin. The Texas Policy Evaluation Project: Impact of abortion restrictions in Texas. *The University of Texas at Austin*; August 2013. Available at: http://bit.ly/1o6r8Ic. Accessed June 25, 2014.

POLICIES SUPPORTIVE OF WOMEN AND CHILDREN

Improving access to health care

Moving forward with the Affordable Care Act's Medicaid expansion

Description: State is implementing the Medicaid expansion under the Affordable Care Act in 2017, as of Jan 1, 2017.
Data source(s):

- The Kaiser Family Foundation. State health facts: Status of state action on the Medicaid expansion decision. Available at: http://bit.ly/1fxs2KU. Accessed Feb 13, 2017.

Impact: In states that do not expand Medicaid, many women will fall into a coverage gap, making too much to qualify for Medicaid but not enough to qualify for subsidized health coverage through the exchanges. Low-income women without health insurance are more likely to report going without needed care, are less likely to have a regular health care provider, and are less likely to access preventive services than low-income women with health insurance.
Impact source(s):

- National Women's Law Center. Mind the gap: Low-income women in dire need of health insurance. Available at: http://bit.ly/KZWq5f. Accessed June 25, 2014.

Allows telephone, online, and/or administrative renewal of Medicaid/CHIP

Description: State facilitates renewal of Medicaid and/or CHIP by allowing enrollees to use an automated renewal process, 2017.
Data source(s):

- The Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey.. Available at: http://kaiserf.am/2kjNDBL. Accessed Feb 13, 2017.

Impact: Streamlined renewal processes for Medicaid/CHIP helps prevent lapses in health care coverage for enrolled women and children, and reduces the administrative burden for both states and enrolled families.
Impact source(s):

- The Kaiser Family Foundation. Getting into gear for 2014: Findings from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, 2012–2013. Available at: http://bit.ly/1mXgK4u. Accessed June 25, 2014.

Requires domestic violence protocols, training, or screening for health care providers

Description: State has attempted to reduce the impact of domestic violence by requiring health care protocols, training, and screening for domestic violence for health care providers, 2010.
Data source(s):

- National Women's Law Center. Health care report card: Domestic violence. Available at: http://bit.ly/ThWHVT. Accessed Feb 13, 2017.

Impact: Routine screening for intimate partner violence can increase early detection and intervention and reduce violence, abuse, and physical or mental harms. Routine screening is recommended by the United States Preventive Services Task Force, the American Congress of Obstetricians and Gynecologists, and the American Medical Association.
Impact source(s):

- US Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults. Available at: http://bit.ly/1mePTPR. Accessed June 25, 2014.
- The American College of Obstetricians and Gynecologists. Committee opinion: Intimate partner violence. Available at: http://bit.ly/1j2FkOS. Accessed June 25, 2014.

Has above average Title X funding per patient

Description: State has above average levels of Title X funding per patient, 2017.
Data Source(s):

- National Family Planning & Reproductive Health Association. Title X in Your State (Interactive Map), 2017. Available at http://bit.ly/2n7aIYt. Accessed March 20, 2017.

Impact: Funding for Title X provides states with the support to build an infrastructure to ensure access to family planning services for low-income women, which can decrease unintended pregnancy rates and lead to associated negative health outcomes.
Impact Source(s):

- Cohen A. The numbers tell the story: the reach and impact of Title X. *Guttmacher Policy Review*. 2011;14(2).

Contraceptive parity law in place

Description: Has a law or ruling in place that requires insurers that cover prescription drugs to also provide coverage for any FDA-approved contraceptive.
Data Source(s):

- National Conference of State Legislators. Insurance Coverage for Contraception Laws, 2012. Available at: http://bit.ly/Oc8K3Q. Accessed March 20, 2017.

Impact: States that have in place contraceptive parity laws protect access to contraception for insured women should the parity provision in the Affordable Care Act be affected. These laws ensure that women are able to access effective, more affordable contraceptives through their insurance and avoid unintended pregnancy and the associated poor health outcomes.
Impact Source(s):

- National Conference of State Legislators. Insurance Coverage for Contraception Laws, 2012. Available at: http://bit.ly/Oc8K3Q. Accessed March 20, 2017.
- National Women's Law Center. The Affordable Care Act's Birth Control Benefit is Working for Women. Available at: http://bit.ly/2pK6uVa. Access April 10, 2017.

Supporting pregnant women

Medicaid income limit for pregnant women is at least 200% of the federal poverty line

Description: State Medicaid eligibility criteria for pregnant women includes an income limit of 200% of the federal poverty line or higher, 2016.
Data source(s):

- Center for Medicaid & CHIP Services. State Medicaid and CHIP income eligibility standards. Available at: http://bit.ly/1um6TK7. Accessed Feb 13, 2017.

Impact: Increased Medicaid eligibility limits for pregnant women has been shown to increase health care coverage of pregnant women and to reduce infant mortality and low birth weight.
Impact source(s):

- Currie J, Gruber J. Saving Babies: The efficacy and cost of recent expansions of Medicaid eligibility for pregnant women. *National Bureau for Economic Research*; 1994. Available at: http://bit.ly/1hfKdc0. Accessed June 25, 2014.

Has expanded family/medical leave beyond the FMLA

Description: State has set standards that are more expansive than the federal Family Medical Leave Act (for example, expanding either the amount of leave available or the classes of persons for whom leave may be taken), 2016.
Data source(s):

- National Conference of State Legislatures. State family medical leave and parental leave laws. Available at: http://bit.ly/1mXjWgB. Accessed Feb 13, 2017.

Impact: Parental leave has been associated with numerous positive outcomes, including lower rates of premature birth, increased birth weight, higher rates of breastfeeding and well-baby care, stronger labor force attachment, positive changes in wages, and lower levels of public assistance receipt.
Impact source(s):

- Houser L, Vartananian T. Pay matters: The positive economic impacts of paid family leave for families, business and the public. *The Center for Women and Work, Rutgers University*; 2012. Available at: http://bit.ly/SbUBpt. Accessed June 25, 2014.

Provides temporary disability insurance

Description: State has a social insurance program that partially compensates for the loss of wages caused by temporary nonoccupational disability or maternity, 2013.
Data source(s):

- Social Security Administration. Annual statistical supplement: Temporary disability insurance. Available at: http://1.usa.gov/1qONDpi. Accessed Feb 13, 2017.

Impact: Temporary disability insurance programs allow more mothers to take paid leave following the birth of a child. Parental leave has been associated with numerous positive outcomes, including lower rates of premature birth, increased birth weight, higher rates of breastfeeding and

well-baby care, stronger labor force attachment, positive changes in wages, and lower levels of public assistance receipt.
Impact source(s):

- Houser L, Vartanian T. Policy Matters: Public policy, paid leave for new parents, and economic security for US workers. *The Center for Women and Work, Rutgers University*; 2012. Available at: http://bit.ly/1jVrygD. Accessed June 25, 2014.
- Houser L, Vartananian T. Pay Matters: The positive economic impacts of paid family leave for families, business and the public. *The Center for Women and Work, Rutgers University*; 2012. Available at: http://bit.ly/SbUBpt. Accessed June 25, 2014.

Maternal mortality review board established

Description: State has established a maternal mortality review committee to track maternal health patterns and develop effective solutions to address maternal mortality, 2017.
Data source(s):

- **Excl. HI, MT, NH, TN, TX, VT**: Amnesty International. Deadly delivery: The maternal health care crisis in the USA. Available at: http://bit.ly/2kQmK7i. Accessed Feb 13, 2017.
- **GA**: Senate Bill 273, 2013-2014 Leg., Reg. Session (Ga. 2014). Available at: http://bit.ly/2pGyglD. Accessed May 9, 2017.
- **HI**: Senate Bill 2317, 2016 Leg., Reg. Session (Haw 2016). Available at: http://bit.ly/2q84YPx. Accessed May 9, 2017.
- **MT**: House Bill 28, 2013 Leg., Reg. Session (Mont. 2013). Available at: http://bit.ly/2q9ldcp. Accessed May 9, 2017.
- **NH**: House Bill 1553, 2010 Leg., Reg. Session (N.H. 2010). Available at: http://bit.ly/2r57wf3. Accessed May 9, 2017.
- **TN**: Senate Bill 2303, 2015-2016 Leg., Reg. Session (Tenn. 2016). Available at: http://bit.ly/2q6KqaK. Accessed May 9, 2017.
- **TX**: Texas Legislature Online. Senate Bill 495: Relating to the creation of a task force to study maternal mortality and severe maternal morbidity, 2013. Available at: http://bit.ly/VtE0QD. Accessed Feb 13, 2017.
- **VT**: Senate Bill 15: Midwifery insurance coverage, 2011-2012 Leg., Reg. Session (Vt. 2011). Available at: http://bit.ly/2r6Sgiu. Accessed May 9, 2017.

Impact: Maternal mortality review boards monitor and analyze maternal deaths and propose recommendations to improve maternal health. Maternal mortality review boards are recommended by Amnesty International and the American Public Health Association.
Impact source(s):

- Amnesty International. Deadly delivery: The maternal health care crisis in the USA. Available at: http://bit.ly/1mCPqv8 . Accessed June 25, 2014.
- American Public Health Association. Reducing US maternal mortality as a human right. Available at: http://bit.ly/2oG9bJC. Accessed June 25, 2014.

Requires reasonable accommodations for pregnant workers

Description: State has a law requiring some employers to provide reasonable accommodations to pregnant workers, 2016.
Data source(s):

- National Partnership for Women and Families. Reasonable accommodations for pregnant workers: State laws. Available at: http://bit.ly/1jyedyx. Accessed Feb 13, 2017.

Impact: Despite the federal Pregnancy Discrimination Act, many pregnant workers are at risk of losing their jobs or being forced to take unpaid leave due to their pregnancy.
Impact source(s):

- National Women's Law Center. It shouldn't be a heavy lift: Fair treatment for pregnant women. Available at: http://bit.ly/Uf54lR. Accessed June 25, 2014.

Prohibits or restricts shackling pregnant prisoners

Description: State has a law prohibiting or restricting the shackling of pregnant prisoners, 2011.
Data source(s):

- American Civil Liberties Union. ACLU briefing paper: The shackling of pregnant women and girls in US prisons, jails & youth detention centers. *American Civil Liberties Union*; 2012. Available at: http://bit.ly/1mXmT0H. Accessed Feb 13, 2017.

Impact: Restraining pregnant women increases the risk of injury to the woman and the fetus and can interfere with medical care during labor, delivery, and recovery. The American Congress of Obstetricians and Gynecologists, the American Medical Association, and the American Public Health Association oppose shackling pregnant women.
Impact source(s):

- American Civil Liberties Union. ACLU briefing paper: The shackling of pregnant women and girls in US prisons, jails & youth detention centers. *American Civil Liberties Union*; 2012. Available at: http://bit.ly/1mXmT0H. Accessed June 25, 2014.

Promoting children's and adolescents' health, education, and safety

Allows children to enroll in CHIP with no waiting period

Description: State does not require children to be without health insurance for a minimum amount of time prior to being considered eligible for CHIP, 2015.
Data source(s):

- Brooks T, Making Kids Wait for Coverage Makes No Sense in a Reformed Health System. Georgetown University Health Policy Institute Center for Children and Families. Available at http://bit.ly/2kkiuOX. Accessed Feb 13, 2017.

Impact: Requiring children to be uninsured before enrolling in CHIP disrupts continuity of care and affects children's ability to access needed health care; 23 organizations, including the American Academy of Pediatrics, Children's Defense Fund, and March of Dimes, have signed onto a letter calling on the United States Department of Health and Human Services to eliminate waiting periods.

Impact source(s):

- AIDS Alliance for Women, Infants, Children, Youth & Families et al. RE: CHIP waiting periods in proposed rule pertaining to Medicaid, children's health insurance programs, and exchanges. Available at: http://bit.ly/1umcgJe. Accessed June 25, 2014.

Requires physical education for elementary, middle, and high school

Description: State mandates, elementary, middle/junior high, and high school physical education, 2016.
Data source(s):

- National Association for Sport and Physical Education and American Heart Association. 2016 Shape of the Nation. Status of physical education in the USA. Available at: http://bit.ly/1UWf7ZI. Accessed Feb 13, 2017.

Impact: Physical activity among children and adolescents can improve bone health, cardiorespiratory and muscular fitness, and decrease body fat and symptoms of depression; increasing the proportion of schools requiring physical education is a Healthy People 2020 objective.
Impact source(s):

- Healthypeople.gov. 2020 topics & objectives: Physical activity. Available at: http://1.usa.gov/1tLGfIH. Accessed June 25, 2014.

Mandates sex education

Description: State requires sex education in schools. Content requirements vary between states, 2017.
Data source(s):

- Guttmacher Institute. State Policies in brief: Sex and HIV education. *Guttmacher Institute;* Feb 2017. Available at: http://bit.ly/1xddadJ. Accessed Feb 13, 2017.

Impact: Comprehensive sex education programs have been shown to result in lower rates of teen pregnancy, later sexual initiation, fewer sexual partners, and increased use of condoms and contraception.
Impact source(s):

- Advocates for Youth. Comprehensive sex education: Research and results. Available at: http://bit.ly/SxVqcv. Accessed June 25, 2014.

Mandates HIV education

Description: State requires HIV education in schools. Content requirements vary between states, 2017.
Data source(s):

- Guttmacher Institute. State Policies in brief: Sex and HIV education. *Guttmacher Institute*; Feb 2017. Available at: http://bit.ly/1xddadJ. Accessed Feb 13, 2017.

Impact: Comprehensive sex education programs have been shown to reduce transmission of HIV and other STIs.

Impact source(s):

- Advocates for Youth. Comprehensive sex education: Research and results. Available at: http://bit.ly/SxVqcv. Accessed June 25, 2014.

Has broad eligibility criteria for Early Intervention services for children at risk of developmental delay

Description: State Early Intervention eligibility criteria are defined as broad, moderate, or narrow based on the degree of developmental delay required to receive services, 2015.
Data source(s):

- The Early Childhood Technical Assistance (ECTA) Center. States' and territories' definitions of/criteria for IDEA Part C eligibility. March 2015. Available at http://bit.ly/2l8tmik. Accessed Feb 13, 2017.

Impact: Early Intervention services for children who have or are at risk of development delay have been shown to improve children's outcomes in language and cognitive and social development, reduce the need for special education, and improve parents' skills and confidence.
Impact source(s):

- The National Early Childhood Technical Assistance Center. The outcomes of early intervention for infants and toddlers with disabilities and their families. *The National Early Childhood Technical Assistance Center*; 2011. Available at: http://bit.ly/1og3bzX. Accessed June 25, 2014.

Initiative(s) to expand Early Head Start in place

Description: State has adopted one or more initiatives to expand access to Early Head Start, 2012.
Data source(s):

- Colvard J, Schmit S. Expanding access to Early Head Start: State initiatives for infants and toddlers at risk. *The Center for Law and Social Policy* and *Zero to Three*; 2012. Available at: http://bit.ly/Uf6YCX. Accessed Feb 14, 2017.

Impact: Early Head Start has been shown to improve children's cognitive, language, and social-emotional development; and to improve parenting outcomes.
Impact source(s):

- Mathematica Policy Research. Making a difference in the lives of infants and toddlers and their families: The impacts of early head start. Available at: http://bit.ly/2oPsvnY. Accessed June 25, 2014.

Requires districts to provide full-day kindergarten without tuition

Description: Full-day kindergarten is provided at no charge to all children per state statute and funding, 2016.
Data source(s):

- Education Commission of the States. Full Day Kindergarten: A Look Across the States. 2016. Available at http://bit.ly/2cXzMdT. Accessed Feb 14, 2017.

Impact: Children who attend full-day kindergarten have better educational outcomes than children who attend half-day kindergarten, including a smoother transition to first grade and better

academic achievement and attendance in later grades. The National Association for the Education of Young Children supports full-day kindergarten being available and affordable to all children.
Impact source(s):

- Children's Defense Fund. The facts about full-day kindergarten. Available at: http://bit.ly/1kEK4yK. Accessed June 25, 2014.
- Kagan S, Kauerz K. Making the most of kindergarten—trends and policy issues. *The National Association for the Education of Young Children*;2006. Available at: http://bit.ly/1hfTIrU. Accessed June 25, 2014.

Has firearm safety law(s) designed to protect children

Description: State has one or more of the following firearm laws: safe storage requirement, trigger locks required to be sold or offered at point of gun sales, assault weapons ban, 2014.
Data source(s):

- The Kaiser Family Foundation. State health facts: States with firearm laws designed to protect children. Available at: http://bit.ly/1oxq407. Accessed Feb 14, 2017.

Impact: In 2010, more than 2,500 children and teens were killed by guns. Gun safety laws have been shown to reduce accidental shootings, suicides, and mass shootings. The American Academy of Pediatrics supports gun safety regulation, including an assault weapons ban, safe storage requirements, and trigger locks.
Impact source(s):

- Children's Defense Fund. Protect children, not guns 2013. *Children's Defense Fund*; 2013. Available at: http://bit.ly/2oGbqfR. Accessed June 25, 2014.
- American Academy of Pediatrics. American Academy of Pediatrics gun violence policy recommendations. *American Academy of Pediatrics*; 2013. Available at: http://bit.ly/1l4d1T5. Accessed June 25, 2014.

Supporting families' financial health

Allows families receiving TANF to keep child support collected on their behalf

Description: Under federal law, families receiving income assistance, known as Temporary Assistance for Needy Families (TANF), must assign their rights to child support payments to the state. States, however, have the option of allowing some of the child support payment to be passed through to the parent and child, 2016.
Data source(s):

- National Conference of State Legislators. Child Support Pass-Through and Disregard Policies for Public Assistance Recipients. 2016. Available at http://bit.ly/2kPY7aH. Accessed Feb 14, 2017.

Impact: Receipt of child support reduces families' need for public assistance programs, and has other economic, social, and academic benefits to children and families.

Impact source(s):

- Turetsky, V. In everybody's best interests: Why reforming child support distribution makes sense for government and families. *Center for Legal and Social Policy*; 2005. Available at: http://bit.ly/1umflt2. Accessed June 25, 2014.

State minimum wage is above the federal minimum

Description: State law requires a minimum wage that is higher than the federal minimum wage, 2017.
Data source(s):

- Department of Labor, Wage and Hour Division. Minimum wage laws in the states – January 1, 2017. Available at: http://bit.ly/1T5AzJV. Accessed Feb 14, 2017.

Impact: Increases in the minimum wage can increase family earnings, reduce enrollment in public assistance programs (such as food stamps), and bring families out of poverty.
Impact source(s):

- Reich M, West R. The effects of minimum wages on SNAP enrollments and expenditures. *Institute for Research on Labor and Employment, Center for American Progress*; 2014. Available at: http://bit.ly/1nSzNSR. Accessed June 25, 2014.

Income limit for child care assistance is greater than 55% of state median income

Description: The federal limit for income eligibility is 85% of the state median income, but no state has adopted a limit that high. The 55% benchmark comes from the average across states, which is 55.9%, 2015.
Data source(s):

- National Women's Law Center. Building Blocks: State child care assistance policies 2015. Available at: http://bit.ly/2kQ7Yxo. Accessed Feb 14, 2017.

Impact: Child care assistance helps low-income parents participate in the workforce, helps keep families out of poverty, and increases children's access to high-quality child care and early education programs.
Impact source(s):

- Matthews H. Child care assistance: A program that works. *Center for Law and Social Policy*; 2009. Available at: http://bit.ly/1pIwltx. Accessed June 25, 2014.

Does not have a family cap policy or flat cash assistance grant

Description: Welfare benefits are most often calculated based on family size. Many states passed family cap policies, which deny additional benefits or reduce the cash grant to families who have additional children while on assistance, 2015.
Data source(s):

- Welfare Rules Database. Custom Search. Available at http://urbn.is/2pJAv7u. Accessed Feb 14, 2017.

Impact: Family cap policies have no effect on their stated goal of reducing childbearing among women receiving welfare. Family caps result in higher poverty rates among mothers and children.

Impact source(s):

- Levin-Epstein J. Lifting the lid off the family cap: States revisit problematic policy for welfare mothers. *Center for Law and Social Policy*; 2003. Available at: http://bit.ly/1hBMija. Accessed June 25, 2014.
- McKernan SM, Ratcliffe C. The effect of specific welfare policies on poverty. *The Urban Institute*; 2006. Available at: http://urbn.is/2pajR4y. Accessed June 25, 2014.

Promoting a healthy environment

Requires worksites, restaurants, and bars to be smoke free

Description: Data are for state-wide laws that apply to private-sector worksites, restaurants, and bars. States without statewide smoking restrictions may have local smoke-free laws. Private-sector worksites are places of work other than a building leased, owned, or operated by the state, 2015.
Data source(s):

- The Kaiser Family Foundation. State health facts: State smoking restrictions for worksites, restaurants, and bars. Available at: http://bit.ly/1xdtlaP. Accessed Feb 14, 2017.

Impact: Exposure to secondhand smoke has numerous negative health consequences, including increased risk of asthma and other respiratory problems in children as well as lung cancer and heart disease in adults. The World Health Organization recommends all indoor workplaces and all indoor public spaces be 100% smoke free.
Impact source(s):

- Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke. *Department of Health and Human Services*; 2006. Available at: http://1.usa.gov/1hBOGpU. Accessed June 25, 2014.

- World Health Organization. WHO framework convention on tobacco control: Guidelines for implementation. *World Health Organization;* 2013. Available at: http://bit.ly/1rOKKXd. Accessed June 25, 2014.

WOMEN'S HEALTH OUTCOMES

Asthma prevalence

Description: Percentage of women aged 18 and older reporting current asthma, 2015.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Adult Self-Reported Current Asthma Prevalence Rate by Gender. Available at: http://bit.ly/1pFQ4dp. Accessed Dec 1, 2016.

Impact: Asthma causes adults to miss days of work, interferes with daily activities, and can lead to hospitalizations and even death. Women are more likely to have asthma, and more women than men die from asthma. Healthy People 2020 includes a number of objectives related to decreasing the impact of asthma.
Impact source(s):

- Centers for Disease Control and Prevention. Asthma's impact on the nation. Available at: http://1.usa.gov/U1sR8M. Accessed June 25, 2014.
- HealthyPeople2020.gov. 2020 topics & objectives: Respiratory diseases. Available at: http://1.usa.gov/1kShAgv. Accessed June 25, 2014.

Cervical cancer screening

Description: Percentage of women aged 18-64 who report having had a pap smear within the past 3 years, 2014.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of Women Ages 18-64 who Report Having Had a Pap Smear Within the Past Three Years. Available at: http://kaiserf.am/2gNc7hY. Accessed Dec 1, 2016.

Impact: Having cervical cancer increases the risks of medical, psychological, social, and relational concerns, as well as mortality. Women of color, women with low incomes, and women with low educational attainment disproportionally experience cervical cancer. However, when found early, it is highly treatable and associated with long survival and good quality of life. The US Preventive Services Task Force recommends screening for cervical cancer every three years. Increasing the proportion of women who receive recommended cervical cancer screenings is a Healthy People 2020 objective.
Impact source(s):

- Ashing-Giwa KT, Kagawa-Singer M, Padilla GV et al. The impact of cervical cancer and dysplasia: a qualitative, multiethnic study. *Psychooncology*. 2004;13(10):709-728.
- Singh GK, Miller BA, Hankey BF, Edwards BK. Persistent area socioeconomic disparities in U.S. incidence of cervical cancer, mortality, stage, and survival, 1975–2000. *Cancer*. 2004;101(5):1051-1057.
- Centers for Disease Control and Prevention. Gynecological cancers, cervical cancer. Available at: http://1.usa.gov/1d3LeLV. Accessed June 25, 2014.
- U.S. Preventive Services Task Force. Screening for cervical cancer. Available at: http://bit.ly/1qigMqw. Accessed June 25, 2014.

- HealthyPeople2020.gov. 2020 topics & objectives: Cancer. Available at: http://1.usa.gov/1vYzmXo. Accessed June 25, 2014.

Chlamydia incidence

Description: Number of new chlamydia infections among women per 100,000 women, 2014.
Data source(s):

- Centers for Disease Control and Prevention. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. Available at: http://bit.ly/2fWWhm9. Accessed Dec 1, 2016.

Impact: Chlamydia is strongly associated with ectopic pregnancy, infertility, and chronic pelvic pain. Maternal chlamydia may result in fetal death or substantial physical and developmental disabilities for a child, including mental retardation and blindness. Reducing chlamydia infections among adolescents and young adults is a Healthy People 2020 objective.
Impact source(s):

- Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report: Recommendations to improve preconception health and health care. Available at: http://1.usa.gov/1psJu9U. Accessed June 25, 2014.
- HealthyPeople.gov. 2020 topics & objectives: Sexually transmitted diseases. Available at: http://1.usa.gov/1oL5G05. Accessed June 25, 2014.

HIV incidence

Description: Number of new HIV diagnoses among women per 100,000 women, 2014.
Data source(s):

- Centers for Disease Control and Prevention. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. Available at: http://1.usa.gov/1fVVBtd. Accessed Dec 1, 2016.

Impact: Among women ever diagnosed with AIDS, an estimated 4,014 died during 2010, and by the end of 2010, an estimated 111,940 had died since the beginning of the epidemic. HIV affects the immune system, and, for women, this can cause specific gynecological issues, including cervical dysplasia, anal/rectal dysplasia, invasive cervical cancer, extensive herpes simplex 2, recurrent yeast infections, and recurrent genital warts. HIV can also potentially lead to other related health problems (such as opportunistic infections, Hepatitis, tuberculosis, oral health issues, cancer, cardiovascular problems, diabetes, kidney disease, and dementia), which can lead to increased morbidity and mortality.
Impact source(s):

- Centers for Disease Control and Prevention. HIV among women. Available at: http://bit.ly/2oPjEmm. Accessed April 10, 2017.
- Aids.gov. Staying healthy with HIV/AIDS: Taking care of yourself: Women's health. Available at: http://1.usa.gov/1iXbgnU. Accessed June 25, 2014.

Lifetime prevalence of sexual violence

Description: Percentage of women who reported ever experiencing sexual assault other than rape by any perpetrator, 2010.
Data source(s):

- Centers for Disease Control and Prevention. National Intimate Partner and Sexual Violence Survey. Available at: http://1.usa.gov/1tv5wqg. Accessed on Dec 1, 2016.

Impact**:** Sexual violence can cause long-term physical consequences such as chronic pelvic pain, premenstrual syndrome, gastrointestinal disorders, gynecological and pregnancy complications, migraines and other frequent headaches, back pain, facial pain, and disability that prevents work. Sexual violence can also cause psychological consequences such as shock, anxiety, symptoms of PTSD (including flashbacks, emotional detachment, and sleep disturbances), depression, and attempted or completed suicide, among others.
Impact source(s)**:**

- Centers for Disease Control and Prevention. Injury prevention & control, sexual violence: Consequences. Available at: http://1.usa.gov/1hkaFBE. Accessed on June 25, 2014.

Low birth weight

Description: Percentage of infants born weighing less than 2,500 grams/5.5lbs, 2014.
Data source(s):

- Hamilton BE, Martin JA, Osterman, M, et al. National Vital Statistics Reports: Births: Final data for 2014. *Center for Disease Control and Prevention*; 2014. Available at: http://bit.ly/1QOvc1v. Accessed December 1, 2016.

Impact: Low birth weight can lead to lifelong disabilities for a child (including visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe).
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Maternal, infant, and child health. Available at: http://bit.ly/2pr4lAX. Accessed April 20, 2017.

Maternal mortality ratio

Description: Number of maternal deaths per 100,000 live births, 2001-2006.
Data source(s):

- National Women's Law Center. Health care report card: Maternal mortality rate (per 100,000). Available at: http://bit.ly/1rqvGPh. Accessed Dec 2, 2016.

Impact: Many women still die in childbirth or of pregnancy related causes. Maternal mortality can negatively impact the health of a woman's baby, the health of her other children, and the social and economic standing of her family. Reducing the maternal mortality ratio is a Millennium Development Goal Indicator.

Impact source(s):

- Koblonsky M, Chowdhury EM, Moran A, Ronsmans C. Maternal morbidity and disability and their consequences: Neglected agenda in maternal health. *Journal of Health, Population and Nutrition*. 2012;30(2):124-130.

Overweight/obesity prevalence

Description: Percentage of women aged 18 and older with BMI ≥ 25.0, 2015.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Overweight and Obesity Rates for Adults by Gender (2015). Available at: http://bit.ly/1hkcHSk. Accessed Dec 2, 2016.

Impact: Obesity-related conditions include heart disease, stroke, and type 2 diabetes, which are among the leading causes of death. Also, obesity at the beginning of pregnancy places women at a higher risk of high blood pressure and diabetes during pregnancy. Adults who are obese is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Maternal, infant, and child health. Available at: http://bit.ly/2pr4lAX. Accessed April 10, 2017.
- HealthyPeople.gov. Healthy People 2020 topics & objectives: Nutrition, physical activity, and obesity. Available at: http://bit.ly/2oigFzR. Accessed April 10, 2017.

Poor mental health status

Description: Percentage of women aged 18 and over who reported their mental health was "not good" between one to 30 days over the past 30 days, 2015.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of Adults Reporting Poor Mental Health Status, by Gender (2015). Available at: http://bit.ly/1pRGvp8. Accessed Dec 2, 2016.

Impact: People with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including substance abuse, violent or self-destructive behavior, and suicide. Also, mental health disorders (most often depression) are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions, including diabetes, hypertension, stroke, heart disease, and cancer.
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Mental health and mental disorders. Available at: http://bit.ly/2on7zB4. Accessed April 10, 2017.

Preterm birth

Description: Percentage of infants born at less than 37 weeks completed gestation, 2015.

Data source(s):

- Hamilton BE, Martin JA, Osterman MJK. National Vital Statistics Reports, Births: Preliminary data for 2015. Available at: http://bit.ly/1r3IcoX. Accessed Dec 2, 2016.

Impact: Preterm birth can lead to lifelong disabilities for a child (including visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe). Preterm birth is a Healthy People 2020 leading health indicator.

Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Maternal, infant, and child health. Available at: http://bit.ly/2pr4IAX. Accessed April 10, 2017.

Proportion of pregnancies unintended

Description: Percentage of all pregnancies that were unintended, 2015.

Data source(s):

- Kost K. Unintended pregnancy rates at the state level: Estimates for 2012 and Trends Since 2002. *Guttmacher Institute*; 2015. Available at: http://bit.ly/2gIQqirhttps://ibisreproductivehealthorg-2.sharepoint.microsoftonline.com/Group/Shared Documents/Projects/Dire States (CRR)/Publications/National report/Available at: http:/bit.ly/1joNy46. Accessed Dec 2, 2016.
- Unintended Pregnancy in the United States Fact Sheet, Sept 2016. Guttmacher Institute. Available at http://bit.ly/2gQFIwi. Accessed Dec 2, 2016

Impact: Risks associated with unintended pregnancy include low birth weight, postpartum depression, delays in receiving prenatal care, and family stress.

Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Reproductive and sexual health. Available at: http://bit.ly/2pawCvQ. Accessed April 10, 2017.

Smoking prevalence

Description: Percentage of women aged 18 and older that report currently smoking, 2015.

Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of Adults Who Smoke by Gender. Available at: http://bit.ly/1hkdDWK. Accessed Dec 2, 2016.

Impact: Tobacco use causes several diseases and health problems, including several kinds of cancer (lung, bladder, kidney, pancreas, mouth, and throat), heart disease and stroke, lung diseases (emphysema, bronchitis, and chronic obstructive pulmonary disease), pregnancy complications (preterm birth, low birth weight, and birth defects), gum disease, and vision problems. Adults who are current cigarette smokers is a Healthy People 2020 leading health indicator.

Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Tobacco use. Available at: http://bit.ly/2pawSuO. Accessed April 10, 2017.

Suicide deaths

Description: Number of suicide deaths among women per 100,000 women, 2012-2014.
Data source(s):

- Centers for Disease Control and Prevention. Compressed mortality file 1999-2014. Available at: http://1.usa.gov/1iB1843. Accessed Dec 6, 2016.

Impact: Suicide results in the death for the individual and has impacts on families such as decreases in cohesion and adaptability and feelings of guilt and blaming. Adolescents who have experienced a suicide death in the family are more likely to engage in risky behaviors and experience emotional distress. Suicide is a Healthy People 2020 leading health indicator.
Impact source(s):

- Cerel J, Jordan JR, Duberstein PR. The impact of suicide on the family. *Crisis.* 2008;29(1):38-44.
- HealthyPeople.gov. Healthy People 2020 topics & objectives: Mental health and mental disorders. Available at: http://1.usa.gov/1uGrbMG. Accessed June 25, 2014.

Women without health insurance

Description: Percentage of women aged 15-44 uninsured, 2015.
Data source(s):

- Guttmacher Institute. State data center: Demographics: Percentage of women uninsured. Available at: http://bit.ly/2owk6W5. Accessed April 13, 2017.

Impact: People without health insurance are more likely than the insured to skip routine medical care, which increases the risk of serious and disabling health conditions. They are also often burdened with large medical bills and out-of-pocket expense. Persons with medical insurance is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Access to health services. Available at: http://bit.ly/2oPs0dN. Accessed April 10, 2017.

Women with no personal health care provider

Description: Percentage of women aged 18 and older who report having no personal doctor or health care provider, 2012-2014.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of women with no personal doctor or health care provider. Available at: http://bit.ly/1wBJerg. Accessed Dec 6, 2016.

Impact: Having a usual personal health care provider increases patient trust in the provider, patient-provider communication, and the likelihood that patients will receive appropriate care. Persons with a usual provider is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Access to health services. Available at: http://bit.ly/2oPs0dN. Accessed April 10, 2017.

CHILDREN'S HEALTH OUTCOMES

Child mortality rate

Description: Number of deaths per 100,000 children aged 1-14(excl. DC, RI, VT), 2014
Data source(s)

- The Henry J Kaiser Family Foundation. State health facts: Rate of child deaths (1-14) per 100,000. Available at: http://bit.ly/1tXGWjR. Accessed Dec 7, 2016.

Impact: Parents who experience the loss of a child experience more depressive symptoms, poorer well-being, and cardiovascular health problems than comparison parents. Parents who lose a child are also more likely to experience marital disruption. Bereaved parents have significantly worse health-related quality of life than comparison group parents.
Impact source(s):

- Rogers CH, Floyd FJ, Seltzer MM, Greenberg J, Hong J. Long-term effects of the death of a child on parents' adjustment in midlife,. *Journal of Family Psychology*. 2008;22(2):203-211.
- Song J, Floyd FJ, Seltzer MM, Greenberg J, Hong J. Long-term effects of child death on parents' health-related quality of life: A dyadic analysis. *Family Relations*. 2010; 59(3):269-282.

Children receiving medical and dental preventive care

Description: Percentage of children aged 0-17 who had both a medical and dental preventive care visit in the past 12 months, 2011.
Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of children (0-17) who had both a medical and dental preventive care visit in the past 12 months. Available at: http://bit.ly/1kudGih. Accessed Dec 7, 2016.

Impact: Clinical preventive services prevent and detect illnesses and diseases in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs. Regular visits to the dentist can help prevent oral diseases including cavities and oral cancers. A growing body of evidence has also linked oral health, particularly periodontal disease, to several chronic diseases, including diabetes, heart disease, and stroke. Persons aged two or older who used the oral health care system in the past 12 months is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Leading health indicators: Clinical preventive services overview & impact. Available at: http://bit.ly/2nVJrKo. Accessed April 10, 2017.
- HealthyPeople.gov. Leading health indicators: Oral health overview & impact. Available at: http://bit.ly/2oimop6. Accessed April 10, 2017.

Children receiving needed mental health care

Description: Percentage of children aged 2-17 with emotional, developmental, or behavioral problems that received mental health care, 2011.

Data source(s):

- The Henry J Kaiser Family Foundation. State health facts: Percent of children (ages 2-17) with emotional, developmental, or behavioral problems that received mental health care. Available at: http://bit.ly/1lYJ30P. Accessed Dec 7, 2016.

Impact:

Compared to children without developmental problems, children with developmental problems are more likely to have lower self-esteem, depression and anxiety, problems with learning, missed school days, and less involvement in sports and other community activities. Families of children with emotional, developmental, or behavioral problems are more likely to experience difficulty in the areas of childcare, employment, parent-child relationships, and caregiver burden. Receiving needed mental health care can help ameliorate some of these outcomes. Increasing the proportion of children with mental health problems who receive treatment is a Healthy People 2020 objective.

Impact source(s):

- Blanchard L, Gurka M, Blackman J. Emotional, developmental, and behavioral health of American children and their families: A report from the 2003 National Survey of Children's Health. *American Academy of Pediatrics Journal*. 2006;117(6):e1202-e1212.
- Blackorby J, Cameto R. Special Education Elementary Longitudinal Study: Wave 1 wave 2 overview: Changes in school engagement and academic performance of students with disabilities. *SRI International*; 2004. Available at: http://bit.ly/1ISIDgc. Accessed June 25, 2014.
- HealthyPeople2020.gov. 2020 topics & objectives: Mental health and mental disorders. Available at: http://1.usa.gov/1pntYuJ. Accessed June 25, 2014.

Complete vaccination (children 19-35 months)

Description: Percentage of children aged 19-35 months that received the full combined vaccination series, 2015.

Data source(s):

- Centers for Disease Control and Prevention. National, state, and local area vaccination coverage among children aged 19-35 months, United States, 2015 CDC Morbidity and Mortality Weekly Report. Available at: http://bit.ly/2hgLtB1. Accessed Dec 7, 2016.

Impact: Immunizations can protect children and adolescents from serious and potentially fatal diseases, including mumps, tetanus, and chicken pox. Children's vaccination rates are a Healthy People 2020 leading health indicator.

Impact source(s):

- HealthyPeople.gov. Leading health indicators: Clinical preventive services overview & impact. Available at: http://1.usa.gov/1psP0cB. Accessed June 25, 2014.

Confirmed child maltreatment

Description: Number of children reported to be victimized per 1,000 children less than 18 years old, confirmed by child protective services, 2014 .

Data source(s)
Excl. NC and OK: Annie E Casey Foundation. Kids count data center, 2014. Available at: http://datacenter.kidscount.org/. Accessed Dec 7, 2016.
Impact: A history of exposure to childhood maltreatment is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problem. Reducing fatal injuries and homicide (which can be related to child maltreatment) is a Healthy People 2020 leading health indicator.
Impact source(s):

- National Prevention Council, Office of the Surgeon General, U.S. Department of Health and Human Services. National prevention strategy. Available at: http://bit.ly/2pJPRsD. Accessed April 10, 2017.
- HealthyPeople.gov. Leading health indicators: Injuries and violence overview & impact. Available at: http://bit.ly/2pK3sjo. Accessed April 10, 2017.

Exclusive breastfeeding for 6 months

Description: Percentage of children fed only breast milk and no additional food, water, or other fluids. Exceptions are made for necessary medicines and vitamins, 2014.
Data source(s):

- National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Breastfeeding report card. Available at: http://bit.ly/2gJo5Is. Accessed Dec 9, 2016.

Impact: Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness.
Impact source(s):

- World Health Organization. Programmes: Nutrition, exclusive breastfeeding. Available at: http://bit.ly/Kg8OO7. Accessed June 25, 2014.

Infant mortality rate

Description: Number of infant deaths (aged 0-364 days) per 100,000 live births, 2014.
Data source(s):

- Kochanek K, Murphy S, Xu J, Tejada-Vera B. National Vital Statistics Report: Deaths: Final Data for 2014. Table 22. *Centers for Disease Control and Prevention* Available at: http://bit.ly/29y2d2o. Accessed Dec 9, 2016.

Impact: Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. The U.S. infant mortality rate is higher than those in most other developed countries. Infant mortality rates are above the U.S. average for non-

Hispanic black, Puerto Rican, and American Indian or Alaska Native women. Reducing infant mortality is a Healthy People 2020 leading health indicator.
Impact source(s):

- Centers for Disease Control and Prevention. National Center for Health Statistics data brief: Recent trends in infant mortality in the United States. Available at: http://bit.ly/1tIBJuq. Accessed June 25, 2014.
- HealthyPeople.gov. Healthy People 2020 topics & objectives: Maternal, infant, and child health. Available at: http://bit.ly/2pr4IAX. Accessed April 20, 2017.

Percentage of children aged 10-17 who are overweight or obese

Description: Calculated using BMI for children, which is age and gender specific. A child is considered overweight if their BMI is at or above the 85th percentile of the CDC growth charts for age and gender, 2011.
Data source(s):

- The Kaiser Family Foundation. *2011 National Survey of Children's Health*. Available at: http://bit.ly/1iHUbga. Accessed Dec 9, 2016.

Impact: Obesity-related conditions include heart disease, stroke, and type 2 diabetes, which are among the leading causes of death. Reducing the percentage of children or adolescents who are considered obese is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Healthy People 2020 topics & objectives: Nutrition, physical activity, and obesity. Available at: http://bit.ly/2oigFzR. Accessed April 10, 2017.

Percentage of children living in a home with someone who smokes

Description: Percentage of children aged 0-17 whose household includes someone who smokes tobacco, 2011.
Data source(s):

- Data Resource Center for Child and Adolescent Health. 2011 National Survey of Children's Health. Available at: http://bit.ly/1nPbqFx. Accessed Dec 9, 2016.

Impact: Secondhand smoke exposure contributes to heart disease and lung cancer. Children may be more vulnerable to smoke exposure than adults because their bodily systems are still developing and their behavior can expose them more to chemicals and organisms. Reducing the percentage of children living in a home with someone who smokes Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Leading health indicators: Environmental quality overview & impact. Available at: http://bit.ly/2oEy2f4. Accessed April 10, 2017.

Percentage of children with health insurance

Description: Health insurance coverage of children under age 18, 2015.

Data source(s):

- US Census Bureau. American Community Survey Tables for Health Insurance Coverage: Table HI05: Health insurance coverage status and type of coverage by state and age for all people. Available at: http://bit.ly/2oa1jgM. Access April 13, 2017.

Impact: Children without health insurance are more likely to have unaddressed health needs, including delayed care, unmet medical care, and unfilled prescriptions. The risk of going without a usual source of care, which is higher among children without insurance, is associated with decreased use of preventive care and increased use of emergency departments for nonemergency conditions. Persons with medical insurance is a Healthy People 2020 leading health indicator.
Impact source(s):

- Olson L, Tang SS, Newacheck PW. Children in the United States with discontinuous health insurance coverage. *The New England Journal of Medicine*. 2005; 353:382-391.

Percentage of children with a medical home

Description: Children aged 0-17 who received health care that meets criteria of having a medical home: child had a personal doctor/nurse; had a usual source for sick care; received family-centered care from all health care providers; had no problems getting needed referrals; and received effective care coordination when needed, 2011.
Data source(s):

- The Kaiser Family Foundation. State health facts: Child and adolescent health measurement initiative: 2011 National Survey of Children's Health. Available at: http://bit.ly/Te4qnS. Accessed Dec 9, 2016.

Impact: Having a usual personal health care provider increases patient trust in the provider, patient-provider communication, and the likelihood that patients will receive appropriate care. Increasing the proportion of children and youth aged 17 years and under who have a specific source of ongoing care is a Healthy People 2020 objective.
Impact source(s):

- HealthyPeople.gov. 2020 topics & objectives: Access to health services. Available at: http://1.usa.gov/1rcjIFa. Accessed June 25, 2014.

Percentage of children with asthma problems

Description: Children under 18 who have been diagnosed with asthma by a doctor or health professional and still have asthma, 2011-2012.
Data source(s):

- Annie E Casey Foundation. Kids count data center. Available at: http://datacenter.kidscount.org. Accessed Dec 14, 2016.

Impact: Children with asthma miss more days of school, and experience more limitation in activity and hospitalizations than children without asthma. Asthma is the third ranking cause of non-injury-related hospitalization among children age 14 and younger.

Impact source(s):

- Taylor W, Newacheck P. Impact of childhood asthma on health. *Official Journal of the American Academy of Pediatrics*. 1992;90(5):657-662.
- HealthyPeople.gov. Leading health indicators: Environmental quality life stages & determinants. Available at: http://1.usa.gov/1kCTCds. Accessed June 25, 2014.

Teen alcohol or drug abuse

Description: Children aged 12 to 17 who reported dependence on or abuse of illicit drugs or alcohol in the past year, 2013-2014.
Data source(s):

- Annie E Casey Foundation. Kids count data center. Teens Ages 12 to 17 Who Abused Alcohol or Drugs in the Past Year. Available at: http://datacenter.kidscount.org. Accessed Dec 14, 2016.

Impact: Alcohol and drug abuse is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Substance abuse also contributes to a number of negative health outcomes including cardiovascular conditions, pregnancy complications, HIV, STIs, motor vehicle crashes, homicide, and suicide. Also, reducing adolescent use of alcohol or any illicit drugs is a Healthy People 2020 leading health indicator.
Impact source(s):

- HealthyPeople.gov. Leading health indicators: Substance abuse overview & impact. Available at: http://bit.ly/2pJH61K. Accessed April 10, 2017.

Teen birth rate

Description: Number of live births to 15-19 year olds per 1,000 female persons, 2014.
Data source(s):

- HHS.gov Trends in teen pregnancy and childbearing. Available at: http://bit.ly/2nJWpuK. Accessed April 13, 2017.

Impact: Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.
Impact source(s):

- HealthyPeople.gov. 2020 topics & objectives: Family planning overview. Available at: http://1.usa.gov/1haPkdC. Accessed June 25, 2014.

Teen mortality rate

Description: Number of deaths per 100,000 teens aged 15-19, 2014 (excl. DC, RI, VT).
Data source(s):

- The Kaiser Family Foundation. State health facts: Health status. Available at: http://bit.ly/1i1rRGM. Accessed Dec 14, 2016.

Impact: Parents who experience the loss of a child experience more depressive symptoms, poorer well-being, and cardiovascular health problems than comparison parents. Parents who lose a child are also more likely to experience marital disruption. Bereaved parents have significantly worse health-related quality of life than comparison group parents.
Impact source(s):

- Rogers CH, Floyd FJ, Seltzer MM, Greenberg J, Hong J. Long-term effects of the death of a child on parents' adjustment in midlife. *Journal of Family Psychology*. 2008; 22(2):203-211.
- Song J, Floyd FJ, Seltzer MM, Greenberg JS, Hong J. Long-term effects of child death on parents' health-related quality of life: A dyadic analysis. *Family Relations*. 2010; 59(3):269-282.

SOCIAL DETERMINANTS OF HEALTH

Children aged 3-4 not enrolled in nursery school, preschool, or kindergarten

Description: Percentage of children aged 3-4 not enrolled in nursery school, preschool, or kindergarten during the previous three months, 2013-2015.
Data source(s):

- Kids count data center. National Kids Count. Available at: http://bit.ly/1ufZwlG. Accessed Feb 1, 2017.

Impact: High-quality child care before age five is related to higher levels of school readiness, academic achievement, educational attainment, and behavioral/emotional functioning during elementary, middle, and high school.
Impact source(s):

- Vandell DL, Belsky J, Burchinal M, Steinberg L, Vandergrift N, NICHD Early Child Care Research Network. Do effects of early child care extend to age 15 years? Results from the NICHD study of early child care and youth development. *Child Development*. 2010;81(3):737-756.
- HealthyPeople.gov. 2020 topics & objectives: Early and middle childhood. Available at: http://1.usa.gov/SGK9Gz. Accessed June 25, 2014.

Gender wage gap

Description: Median annual earnings ratio between full-time, year-round employed women and men, 2013.
Data source(s):

- Institute for Women's Policy Research. Median Annual Earnings and the Gender Earnings Ratio by State. Available at: http://bit.ly/2lhsGo3. Accessed Feb 6, 2017.

Impact: Women who work full time still earn, on average, 77 cents for every dollar men earn, which increases women's risk of falling into poverty. The wage gap exists for almost every occupation. The gap is worst for women of color. Increases in education do not account for the wage gap. Women's loss of wages reduces their families' income, a loss which accumulates greatly over time.
Impact source(s):

- American Association of University Women. The simple truth about the gender pay gap. *American Association of University Women*; 2014. Available at: http://bit.ly/1d16nHL. Accessed June 25, 2014.

Homelessness

Description: Rate of homelessness per 10,000 population, 2015 (includes several subpopulations such as: chronic, veterans, family households, people in families, individuals, unsheltered, and sheltered).

Data source(s):

- National Alliance to End Homelessness. The state of homelessness in America 2016. *Homelessness Research Institute*; 2016. Available at http://bit.ly/1qJMXo1. Accessed Feb 6, 2017.

Impact: People experiencing homelessness experience higher levels of poverty and the associated risk factors. They often lack ready access to certain medical services and have a high occurrence of conditions that increase the risk of Tuberculosis, including substance abuse, HIV infection, and congregation in crowded shelters.

Impact source(s):

- Centers for Disease Control and Prevention. TB in the homeless population. Available at: http://1.usa.gov/1xVuRyA. Accessed June 25, 2014.
- Centers for Disease Control and Prevention. Podcasts at the CDC: Homelessness and health – part 1. Available at: http://1.usa.gov/1li8Hwt. Accessed June 25, 2014.

On-time high school graduation rates

Description: The percentage of all students who graduated from high school based on an average freshman graduation rate defined by the National Center for Education Statistics (NCES), 2014-2015.

Data source(s):

- United States Department of Education. ED Data Express: Averaged freshman graduation rate. Available at: http://bit.ly/2kAD6iK . Accessed Feb 6, 2017.

Impact: Not graduating from high school on time can lead to poor academic skills and limited employment opportunities and earning potential, which in turn increases the risk of experiencing poverty. Additionally, education level, and high school graduation in particular, is a strong predictor of health. The more schooling people have, the lower their levels of risky health behaviors such as smoking, being overweight, or having low levels of physical activity.

Impact source(s):

- Rumberger RW. High school dropouts: A review of issues and evidence. *Review of Educational Research*. 1987;57(2):101-121.
- Freudenberg N, Ruglis J. Reframing school dropout rates as a public health issue. *Preventing Chronic Disease*. 2007;4(4):1-11.

Percentage of children living in poverty

Description: Children under the age of 18 who live in families with incomes below the national poverty line, 2015.

Data source(s):

- Kids count data center. National Kids Count. Available at: http://bit.ly/1ufZwlG. Accessed Feb 6, 2017.

Impact: Children living in poverty are more likely than children not in poverty to experience food insecurity, have frequent emergency room visits, and go without health insurance coverage.

Impact source(s):

- Centers for Disease Control and Prevention. Health, United States, 2000. Available at: http://1.usa.gov/1p2CAoL. Accessed June 25, 2014.
- Black M. Household food insecurities: Threats to children's well-being. Available at: http://bit.ly/1oYtqeO. Accessed June 25, 2014.

Percentage of women aged 19-64 living in poverty

Description: Persons in poverty are defined here as those living in "health insurance units" with incomes less than 100% of the Federal Poverty Level (FPL) as measured by the U.S. Department of Health and Human Services' (HHS) poverty guidelines, 2015.
Data source(s):

- The Kaiser Family Foundation. State health facts: Nonelderly Adult Poverty Rate by Gender. Available at: http://bit.ly/1sY7hid. Accessed Feb 6, 2017.

Impact: From 2011-2012, 20% of women aged 12-44 were living in poverty, compared to 18% of men. Women of color are more likely to be poor than white women. Compared to women not in poverty, women living in poverty are three times more likely to be in poor health; poverty is associated with numerous chronic diseases (such as HIV, asthma, diabetes, and coronary heart disease), poor mental health, and exposure to violence. Women in poverty also have diminished access to nutritious food and high-quality health care. Compared to women with higher incomes, they are also at a higher risk of having children with higher infant mortality rates and post-neonatal mortality rates.
Impact source(s):

- The Henry J Kaiser Family Foundation. State health facts: Adult poverty rate by gender. Available at: http://bit.ly/1qHPsSd. Accessed June 25, 2014.
- Centers for Disease Control and Prevention. Poverty and infant mortality – United States, 1988. *Centers for Disease Control and Prevention*; 1995. Available at: http://1.usa.gov/1iuCDFW. Accessed June 25, 2014.
- Black M. Household food insecurities: Threats to children's well-being. Available at: http://bit.ly/1oYtqeO. Accessed June 25, 2014.

Prevalence of household food insecurity

Description: Food insecurity occurs when households do not have access at all times to enough food for an active, healthy life for all household members. In households with very low food security, the food intake of one or more household members was reduced and their eating patterns were disrupted at times during the year because the household lacked money and other resources for food, 2013-2015.
Data source(s):

- Coleman-Jenson A, Rabbitt M, Gregory C, Singh A. Household food security in the United States in 2015. *U.S. Department of Agriculture, Economic Research Service*; 2016. Available at: http://bit.ly/2jVzPgI. Accessed Feb 6, 2017.

Impact: With limited resources, food insecure families often resort to low-cost, low nutrient-dense food. Individuals living in food insecure households may be at greater risk for malnutrition, diabetes, obesity, hospitalizations, poor health, iron deficiency, and developmental risk and behavior problems (such as aggression, anxiety, depression, and attention deficit disorder), compared to individuals living in food secure households.
Impact source(s):

- Seligman HK, Laraia BA, Kushel MB. Food insecurity is associated with chronic disease among low-income NHANES participants. *The Journal of Nutrition*. 2011;141(3):542.
- Black M. Household food insecurities: Threats to children's well-being. Available at: http://bit.ly/1oYtqeO. Accessed June 25, 2014.

Unemployment

Description: Rates as a percentage of the labor force, 2017.
Data source(s):

- Bureau of Labor Statistics. Local area unemployment statistics: Unemployment rates for states. Available at: http://1.usa.gov/1cd7rXA. Accessed Feb 7, 2017
- Bureau of Labor Statistics. National Unemployment Monthly Updates. Available at http://bit.ly/1p8bMEj. Accessed Feb 7, 2017.

Impact: The unemployed tend to have higher annual illness rates, lack health insurance and access to health care, and have an increased risk of mortality.
Impact source(s):

- Athar H, Chang MH, Hahn RA, Walker E, Yoon P. Unemployment – United States, 2006 and 2010. *Centers for Disease Control and Prevention*; 2014. Available at: http://1.usa.gov/SGL3CZ. Accessed June 25, 2014.

Violent crime rate

Description: Rates are per 100,000 inhabitants, 2014.
Data source(s):

- The Federal Bureau of Investigations. Uniform Crime Reporting Statistics. Available at: http://bit.ly/2kJxViK. Accessed Feb 7, 2017.

Impact: Violent crime increases the risk of injury, disability, and mortality. Also, victims of violent crime, families and friends of victims of violent crime, and witnesses of violent crime experience long-term physical, social, and emotional consequences. Healthy People 2020 includes fatal injuries and homicides (which are related to violent crime) as leading health indicators.
Impact source(s):

- HealthyPeople.gov. Leading health indicators: Injuries and violence overview & impact. Available at: http://bit.ly/2pK3sjo. Accessed April 10, 2017.

Women's participation in the labor force

Description: Percentage of women aged 16 or older with earnings, 2013.

Data source(s):

- Institute for Women's Policy Research. State-by-State Data and Rankings on the Employment and Earnings Composite and Its Components, 2013. Available at: http://bit.ly/2lkyTPg. Accessed Feb 7, 2017.

Impact: Over the last 50-75 years, women's participation in the labor force has increased greatly. Women's labor force participation increases gender equity and the available workforce, and reduces the risk of poverty. It also increases women's purchasing power, and their access to employee-sponsored benefits, such as health insurance.

Impact source(s):

- Centers for Disease Control and Prevention. Vital and Health Statistics: Women: Work and Health. *Centers for Disease Control and Prevention*; December 1997. Available at: http://1.usa.gov/1jRKcXr. Accessed June 25, 2014.
- Jaumotte F. Labour force participation of women: Empirical evidence on the role of policy and other determinants in OECD countries. *Organisation for Economic Co-operation and Development*; June 2014. Available at: http://bit.ly/1nI1NDL. Accessed June 25, 2014.

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