



**HEALTHY
MOMS.
STRONG
BABIES.**

Nowhere to Go: Maternity Care Deserts Across the U.S.

2026 REPORT



The Bell family

For Latasha Bell, living in Lowndes County, Alabama, meant a 45-minute drive to the nearest hospital when she was ready to give birth. The county is one of roughly 1 in 3 U.S. counties classified as a maternity care desert, with no birthing hospital or obstetric clinician.

When she went into labor with her youngest daughter, Kylen, doctors determined she was not yet in active labor and sent her home. Rather than risk the long drive again, she and her husband, Karl, rented a nearby hotel room. An hour later, they returned to the hospital. Kylen was born with breathing complications and rushed to the neonatal intensive care unit (NICU).

“If I had delivered at home, would I even have her here with me right now?” Latasha said.

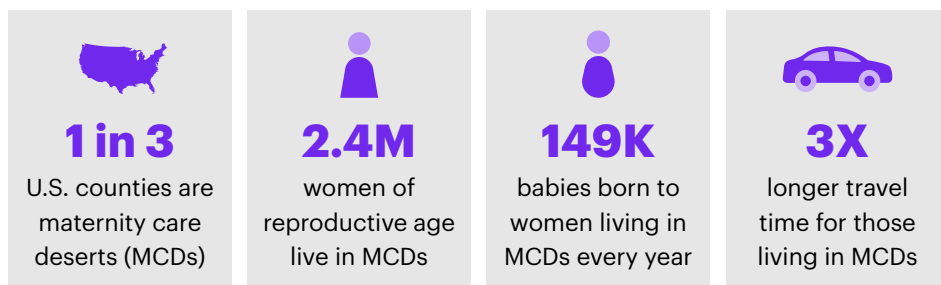
A nurse, maternal mortality prevention advocate, and mother of four, Latasha is now helping bring solutions to her community, including a March of Dimes Mom & Baby Mobile Health Center®. She hopes future generations have maternity care closer to home.

Executive Summary

Across the United States, access to maternity care continues to be a significant challenge, leaving millions of moms and babies with fewer opportunities to receive high-quality care.

What the report shows

The “Nowhere to Go: Maternity Care Deserts Across the U.S.” (2026 report) examines access to maternity care using county-level analyses of obstetric clinicians, birthing facilities, insurance coverage, and travel burden. The report highlights national trends, identifies populations most affected, and explores how workforce shortages, hospital closures, and policy changes are reshaping the maternity care landscape.



Why it matters

Over half of U.S. counties lack a hospital with labor and delivery services. At the same time, labor and delivery unit closures are continuing nationwide, with nearly 100 recently reported closures. In many affected communities, the closed unit was the only local birthing facility, placing additional strain on families and healthcare systems. Rural communities and under-resourced areas continue to face the greatest challenges.

Maternity care deserts are not naturally occurring, nor are they inevitable. They are the result of policy decisions and longstanding underinvestment in maternity care infrastructure. Individuals in these communities are increasingly required to navigate pregnancy and childbirth with fewer local resources and greater travel burdens.

Our commitment

March of Dimes remains committed to advancing data-driven solutions that address maternity care access challenges nationwide. We will continue working with our partners and communities to improve access for moms and babies. Efforts such as March of Dimes Mom & Baby Mobile Health Centers and PeriStats demonstrate how community-based care delivery and publicly accessible data can help expand access and inform decision-making. Continued investment and action will be critical to ensuring all women can access high-quality maternity care.

Leadership perspectives



Cindy Rahman, MBA
President and Chief Executive Officer

“Every family deserves access to high-quality maternity care, no matter where they live.”



Michael Warren, MD MPH FAAP
Chief Medical and Health Officer

“Data helps us see the gaps and drive solutions that bring care closer to families.”

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Acknowledgments

Thanks to Motoko Oinuma, Tamara Currin, Danielle Procopio, Dr. Michael Warren, Kelly Ernst, and Stacey Brayboy for reviewing and editing the report. March of Dimes would also like to thank Rachelle Marina Johnson for her help with report design.

Suggested citation: Stoneburner A, Chestnut JF, Lucas R, Jones EE, DeMaria AL. "Nowhere to Go: Maternity Care Deserts Across the U.S." Report No. 5. March of Dimes, 2026. <https://www.marchofdimes.org/maternity-care-deserts-report>



National support for this report is provided by Ob Hospitalist Group (OBHG).

As the nation's largest employer of OB-GYNs, OBHG partners with hospitals and community clinicians to expand access to maternal healthcare, building a new standard of care that is connected, equitable, and always within reach. Their sponsorship reflects a shared commitment to improving outcomes for moms and babies nationwide.

Introduction

Too many families in the U.S. continue to face barriers to accessing timely and appropriate maternity care. Maternal and infant outcomes are shaped by systems, policies, and access to care, highlighting the critical need for continued investment in maternity care infrastructure to improve outcomes for moms and babies.

March of Dimes envisions a maternity care system in which trained obstetric clinicians are available, birthing facilities are accessible, and care is high-quality and affordable. Across the U.S., access varies widely, particularly in rural and under-resourced communities facing clinician shortages, labor and delivery unit closures, long travel distances, and financial barriers to care.

“Nowhere to Go: Maternity Care Deserts Across the U.S.” examines access to maternity care across the country, highlighting geographic disparities and recent trends in access to care. The findings are intended to inform public health planning, support policy and systems change, and elevate strategies that improve access and outcomes for moms and babies.

For more information about definitions, data sources, and analytical methods, see our [technical notes](#).



What is a maternity care desert?



March of Dimes uses the term “maternity care deserts” to describe locations in the U.S. where there are no hospitals or birth centers offering obstetric care and no obstetric clinicians. It is important to note that maternity care deserts are not naturally occurring; rather, they are the result of deliberate policy decisions and resource allocations.

Key findings

1 in 3 U.S. counties (34.6%) are maternity care deserts, with no obstetric clinicians or birthing facilities.

- These counties are home to **2.4 million women** of reproductive age and **149,000 infants** born each year.

An additional **3.4 million women** and **209,000 infants** live in counties with low or moderate access to maternity care.

- In total, **5.8 million women** and **358,000 infants** have limited access to maternity care.

Obstetric clinician shortages are more severe in rural areas, where nearly **58% of counties** lack obstetric clinicians, compared to about **19% of urban counties**.

More than half of U.S. counties lack a hospital with labor and delivery services, affecting nearly **370,000 births** annually.

Labor and delivery unit closures are ongoing nationwide, with at least **96** publicly reported **closures** across 35 states between 2024 and early 2026.

- In nearly **60%** of affected counties, the closed unit was the only local birthing facility.
- Recent closures have **increased travel times** to maternity care by an average of **25 minutes** in affected communities.

Residents of maternity care deserts travel about **3 times longer**, on average, to reach labor and delivery services than residents of full-access counties.

About **1 in 9 women** of reproductive age are uninsured nationally, with the highest rates concentrated in the South, rural areas, and maternity care deserts.

Policies such as **Medicaid expansion** and **postpartum Medicaid extension** have improved access to care, but recent and proposed policy changes threaten to reverse progress.

What is healthcare access and why does it matter?

Access to healthcare means being able to find qualified clinicians and receive timely, appropriate medical services. Maternity care access functions as a structural determinant of maternal and infant health.

Limited access to maternity care is associated with inadequate prenatal care and higher risks of maternal and infant morbidity and mortality.¹⁻³ Barriers to quality maternity care can have cascading effects across the pregnancy journey, contributing to delayed care, unmanaged conditions, and increased risk of complications.

Access to comprehensive maternity care across the pregnancy journey supports:⁴

Before pregnancy	During pregnancy	After pregnancy
Reproductive planning	Timely initiation of prenatal care	Postpartum follow-up care
Identification and management of chronic conditions	Recommended screenings and vaccinations	Monitoring for postpartum complications
Mental health screening and treatment	Mental health screening and treatment	Management of chronic conditions
Optimal health before pregnancy begins	Monitoring and management of pregnancy complications	Mental health screening and treatment
	Risk-appropriate care at delivery	Newborn care education

What factors can impact access to maternity care?



Clinician availability: Availability of obstetric and subspecialty clinicians, wait times for appointments, and acceptance of insurance plans



Birthing facilities: Physical access to services, proximity of hospital labor and delivery units, availability of higher-level care when appropriate



Financial access: Access to health insurance, affordability of transportation and childcare



Policy: State, federal, and facility-level policies that shape coverage, access, and care delivery

Maternity care access in the U.S.

Key insights

- 1 in 3 counties (34.6%) in the U.S. are maternity care deserts, with no obstetric clinicians or birthing facilities.
- 5.8 million women and 358,000 infants live in counties without full access to care.
- In some states, up to 1 in 5 women and infants live in maternity care deserts.
- Living in a maternity care desert is associated with elevated risk of infant mortality, pregnancy-associated mortality, and inadequate prenatal care.⁵
- From 2016 to 2024, the share of U.S. counties designated as maternity care deserts remained largely unchanged (34.7% to 34.6%).

Definitions for maternity care access designations

March of Dimes defines maternity care access at the county level using three factors: obstetric clinician availability, birthing facility availability, and insurance coverage among women of ages 19 to 54. Counties are classified into four designations: full access, moderate access, low access, or maternity care desert (Table 1).

Table 1. Maternity care access designations

Indicator	Maternity care desert	Low access	Moderate access	Full access
 Birthing facilities (hospitals or birth centers)	zero	<2	<2	≥2
 Obstetric clinicians per 10,000 births*	zero	<60	<60	≥60
 Proportion of women 19-54 without health insurance	any	≥10%	<10%	any

Note: Obstetric clinicians include obstetrician gynecologists (OB-GYNs), certified nurse midwives/certified midwives (CNMs/CMs), and family physicians who reported delivering babies. A county is classified as full access if it meets at least one criterion.

1 in 3 U.S. counties (34.6%) is designated as a maternity care desert, defined as an area with no birthing facilities or obstetric clinicians (Figure 1). These counties are home to more than 2.4 million women of reproductive age (ages 15 to 44), who gave birth to nearly 149,000 infants in 2024 (Figure 2). An additional 3.4 million women and 209,000 infants live in low- and moderate-access counties.

1 in 3 U.S. counties (34.6%) are maternity care deserts, areas with no birthing facilities or obstetric clinicians

Figure 1. Maternity care access designations by county, U.S. and Puerto Rico

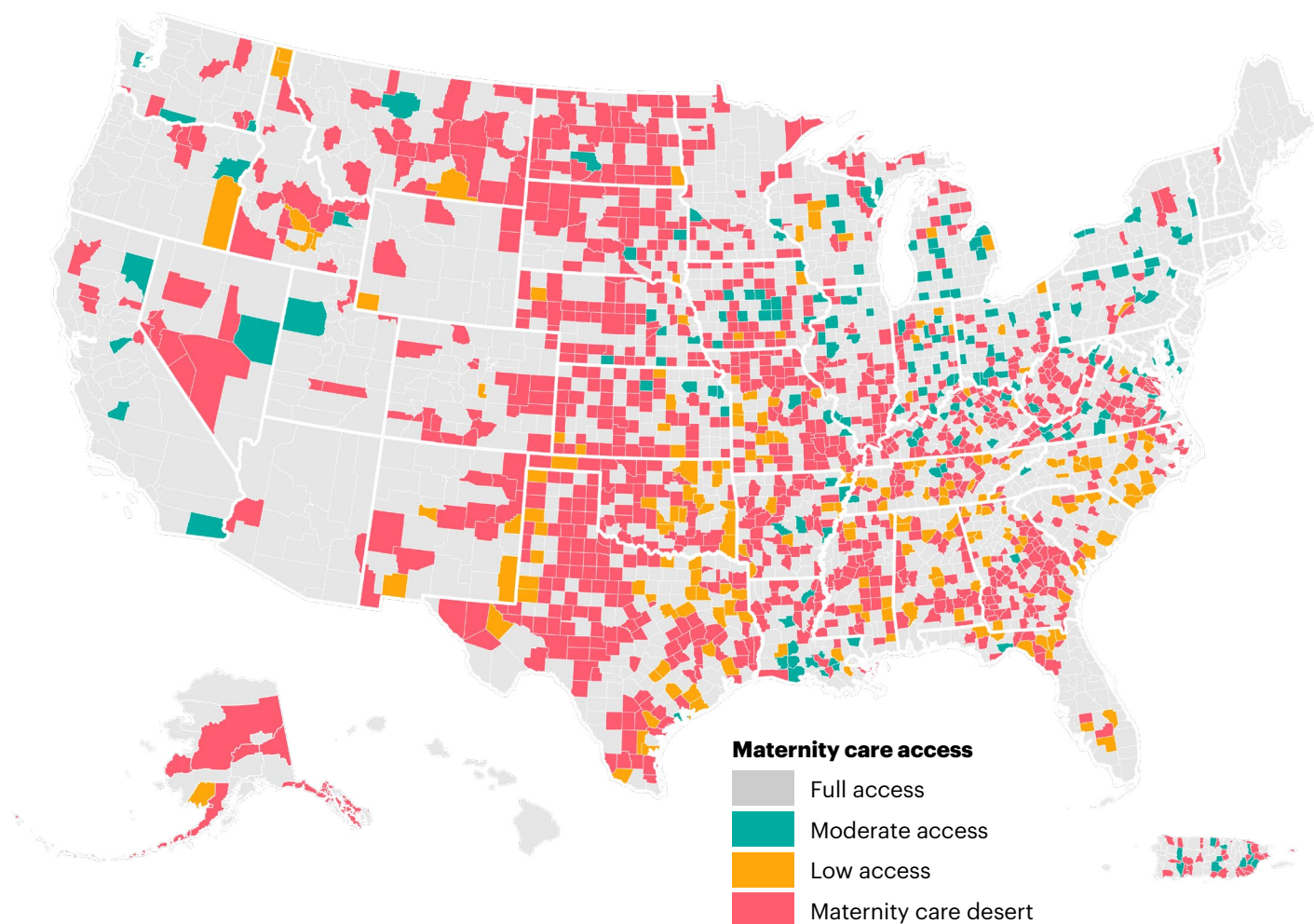
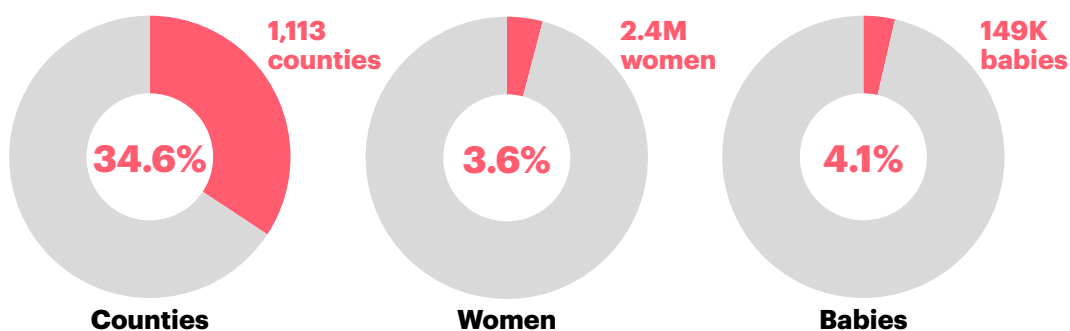


Figure 2. Number and percentage of U.S. counties designated as maternity care deserts and the reproductive-aged women (ages 15 to 44) and babies living in these counties



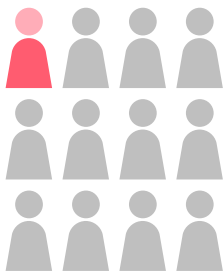
Note: Percentages are calculated from the following totals: 3,219 U.S. counties, including 78 Puerto Rico municipalities, 66.6 million reproductive-aged women, and 3.6 million babies born in 2024.

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2024-2025 file; American Board of Family Medicine, 2021-2024; American Association of Birth Centers, 2024; Centers for Medicare and Medicaid Services (CMS), National Plan and Provider Enumeration System (NPPES), November 2024 file; National Center for Health Statistics, 2024 final natality data; U.S. Census Bureau, 2024 American Community Survey 5-Year Estimates; American Hospital Association, 2024; CMS Provider of Services File, 2024.

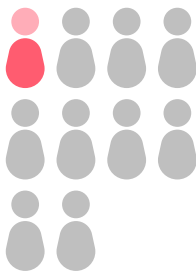
5.8 million women and 358,000 infants live in counties without full access to care

This translates to:

1 in 12 women



1 in 10 infants

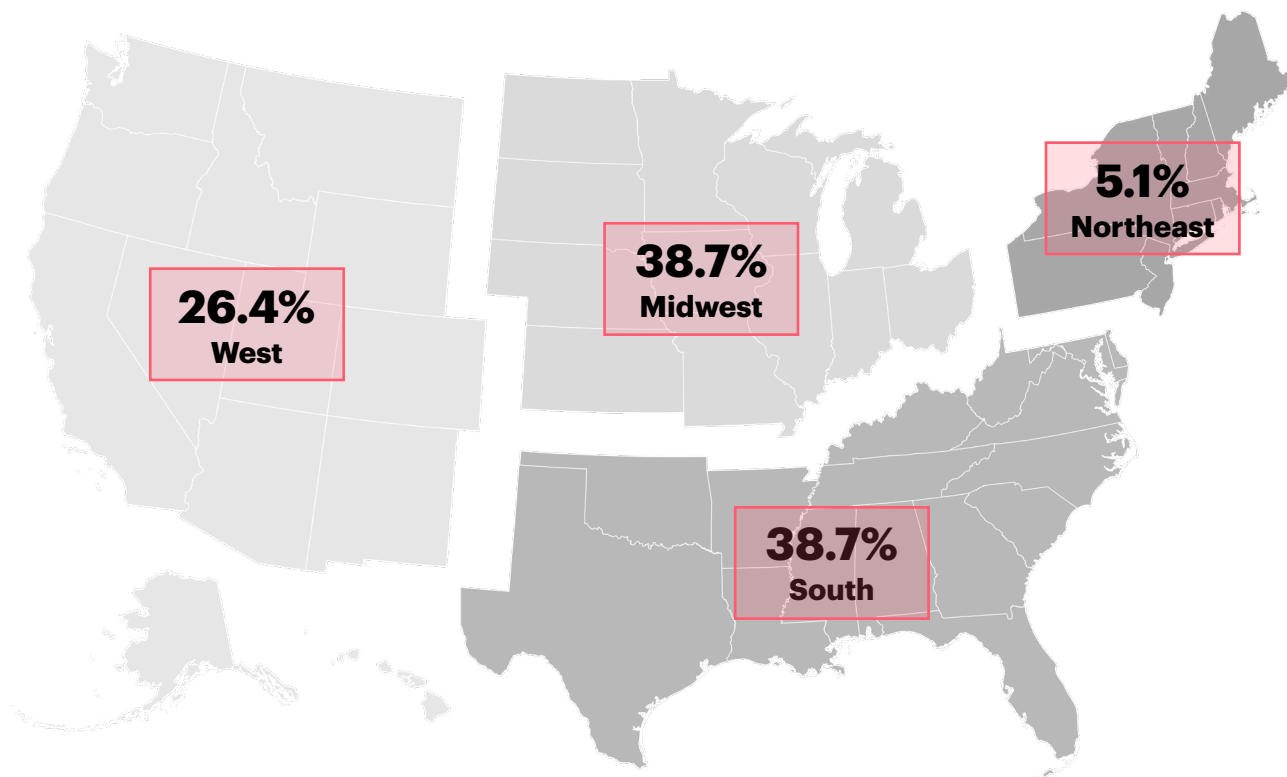


Geographic patterns vary across regions. The South and Midwest have the greatest proportion of counties designated as maternity care deserts (38.7%; Figure 3), though a smaller share (5-6%) of women and infants in these regions live in maternity care deserts overall. However, in some states, such as Mississippi, West Virginia, and North Dakota, as many as 1 in 5 women and infants live in maternity care deserts, increasing to 1 in 4 when including low- and moderate-access counties.

States with the largest number of women and infants impacted include North Carolina, Texas, and Tennessee, which together account for more than 1.2 million women and 82,000 infants living in areas with limited access to maternity care.

The South and Midwest regions have a greater proportion of maternity care deserts

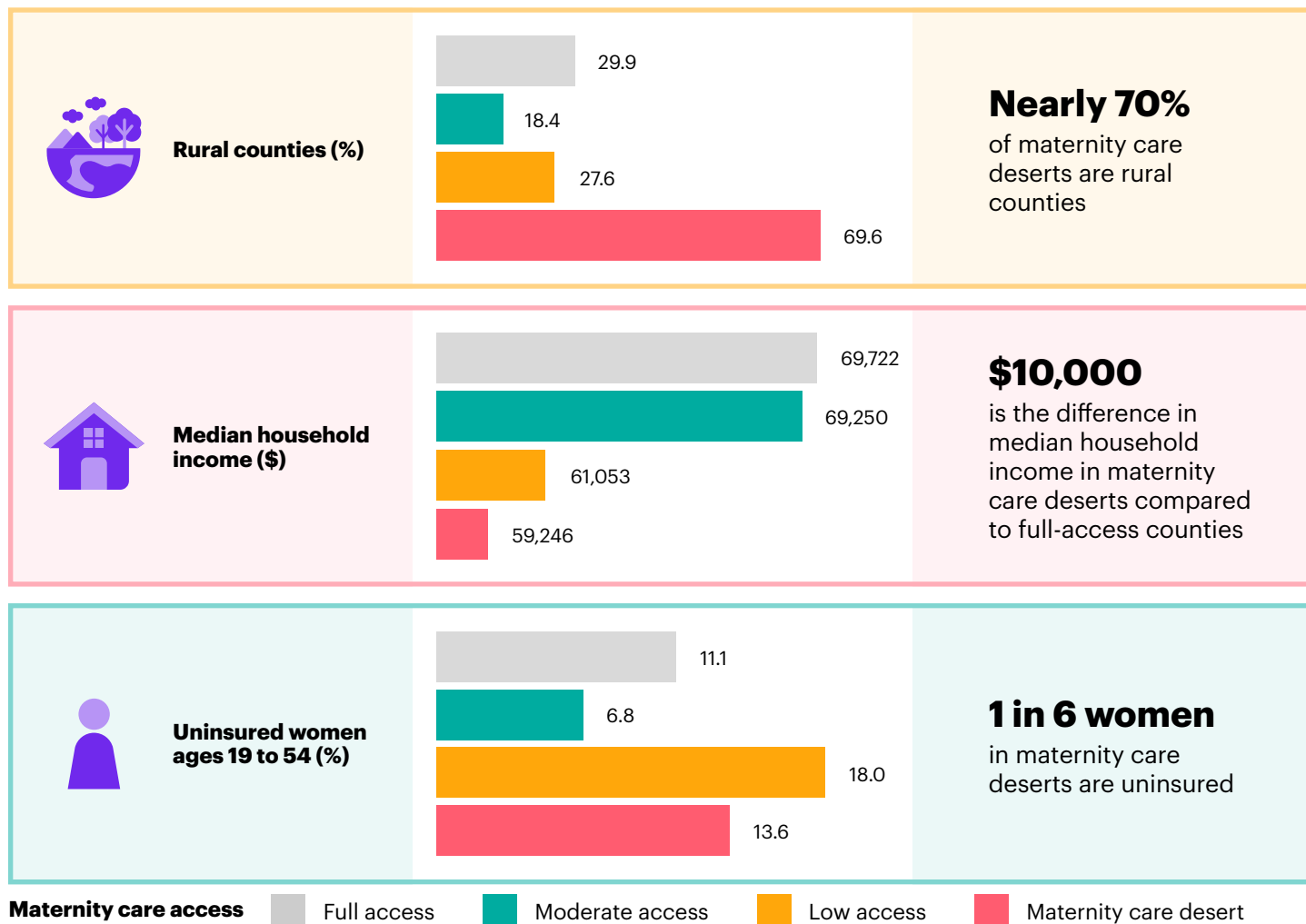
Figure 3. Percentage of counties designated as maternity care deserts, by U.S. region



Maternity care deserts are not only defined by a lack of clinicians and facilities, but they also share demographic and economic characteristics that further limit access to care.

Maternity care deserts are more often rural, have lower median incomes, and higher uninsured rates among women

Figure 4. County demographics by maternity care access designation



Maternity care deserts in the literature

Research consistently shows that living in a maternity care desert is associated with worse outcomes for moms and babies, compared to individuals in full-access counties:



Infants face a **higher risk** of mortality.⁶



Women face a **higher risk** of pregnancy-associated mortality.^{5,7}



Medicaid recipients are **less likely** to receive timely prenatal and postpartum care, and infants are less likely to be vaccinated.⁸



Have **fewer** mental health clinicians and pediatricians.⁸

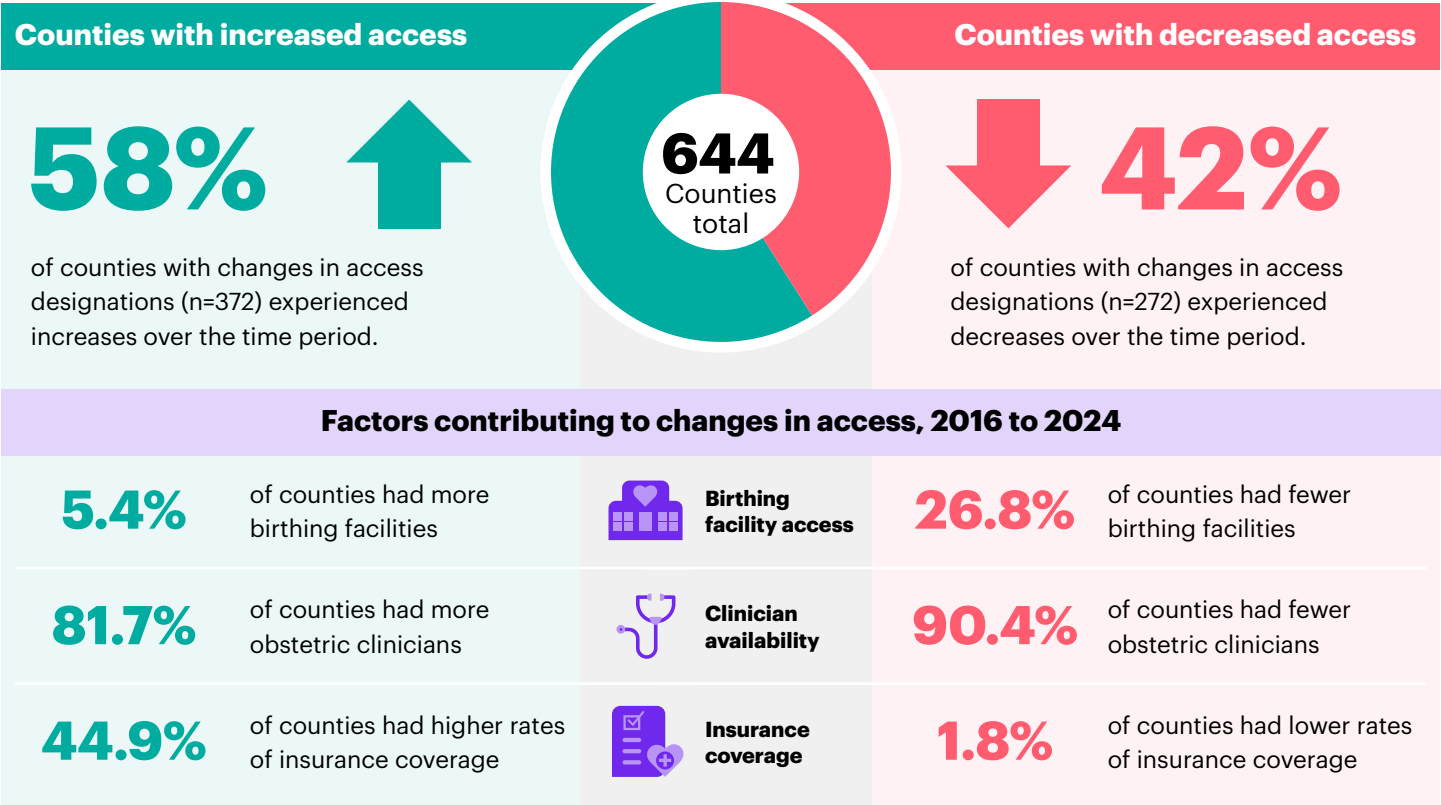
Changes in maternity care access, 2016-2024

For nearly a decade, March of Dimes has tracked county-level maternity care access across the U.S. Over time, the measures used have evolved through enhanced data sources, more rigorous methodologies, and expanded metrics. Using current methods, historical designations have been reassessed to measure how access has changed since 2016. Maternity care deserts remained relatively stable from 2016 to 2024, accounting for about one-third of U.S. counties (34.7% in 2016 and 34.6% in 2024). During the same period, the proportion of full access counties increased slightly from 52.0% to 53.2%.

Overall, 372 counties improved in access, resulting in 153 fewer maternity care desert counties nationwide. At the same time, 272 counties experienced a decrease in access, including 150 counties that became new maternity care deserts. Together, these shifts affected nearly 1 in 5 U.S. counties, reflecting a broader transformation in the U.S. maternity care system.

Clinician availability was the primary driver of changing access designations. In counties with increased access, more than 80% experienced a gain of clinicians; in counties with decreased access, more than 90% experienced a loss of clinicians. Between 2016 and 2024, the number of family physicians delivering babies declined by 7.3%, while the supply of doctors of medicine (MD) obstetrician-gynecologists (OB-GYNs) remained relatively stable nationally, but declined in rural areas. In contrast, the number of doctors of osteopathic medicine (DO) OB-GYNs and certified nurse-midwives/certified midwives (CNMs/CMs) increased by 31.8% and 41.8%, respectively, with smaller gains in rural areas.

Among counties that lost access, reductions in birthing facility availability were also a key contributor, reflecting ongoing labor and delivery unit closures and regionalization of maternity services. In contrast, improvements in insurance coverage were more common than declines and contributed to access gains over the same period.



State-level changes in access, 2016 to 2024



Louisiana showed meaningful gains in access. 6 counties moved out of maternity care desert status.



Nevada demonstrated notable improvements in access. 2 counties moved out of maternity care desert status.



Montana saw rural access recovery in select counties. 5 counties moved out of maternity care desert status.



Texas saw the largest expansion of maternity care deserts. 16 counties became maternity care deserts.



Iowa experienced a steady decline in access. 5 counties became maternity care deserts.



Nebraska also saw measurable declines in access. 5 counties became maternity care deserts.

Collectively, these patterns point to a broader restructuring of the U.S. maternity care system. While some communities have benefited from growth in the maternity care workforce, particularly among DO OB-GYNs and CNMs/CMs, others have experienced labor and delivery unit closures and reductions in the obstetric clinicians, especially family physicians. Consequently, access is increasingly shaped by the intersection of workforce availability, birthing facility access, and insurance coverage. These shifts have occurred unevenly across the country, leaving many rural counties with persistent gaps in both workforce capacity and facility availability.



Scan to learn more about Madison's experience in a low-access area.

“We need more places like this model.”

Madison Dickerson, expectant mother and medical assistant, Cahaba Medical Care, Centreville, Alabama

Madison has seen how access to maternity care can transform a community. At Cahaba Medical Care in Centreville, she works alongside a team that provides prenatal care close to home while helping patients overcome barriers to care.

During her current pregnancy, an unexpected finding on an ultrasound meant she would deliver more than an hour away at a higher-level hospital. With prenatal care available in her own community, she was able to build trusted relationships with the providers who guided her pregnancy and recognized when she needed specialized care.

Her experience reflects how investments in clinicians, healthcare infrastructure, and local maternity services can strengthen access while ensuring patients receive the right level of care when complications arise.

“We need more places like this model. If we were maybe a little bit better funded, we would be able to help get these patients more of the help that they need.”

Obstetric clinicians

Key insights

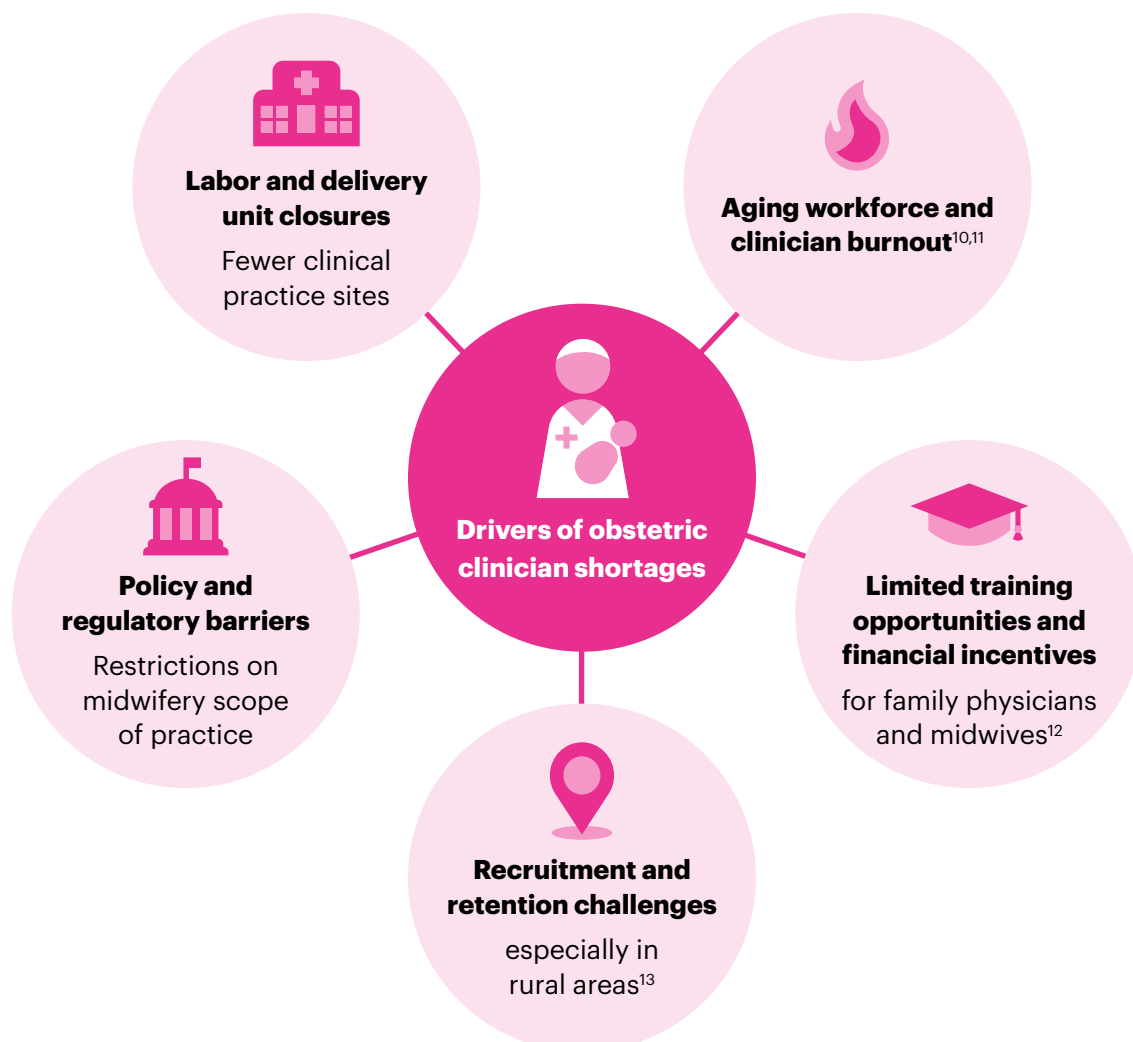
Over one-third (35.9%) of U.S. counties lack a practicing obstetric clinician.

In rural counties, 57.9% lack an obstetric clinician, compared to 19.4% of urban counties.

More than 1 in 10 counties have only one obstetric clinician.

Comprehensive policy actions in 16 states have expanded midwifery practice, including independent practice, prescribing authority, admitting privileges, and pay parity for CNMs.

The shortage of obstetric clinicians remains a major barrier for equitable maternity care access in the U.S. A 2026 Health Resources and Services Administration (HRSA) report projects that by 2035, all but 6 states will have an inadequate OB-GYN supply, particularly in rural communities.⁹



Over one-third (35.9%) of U.S. counties lack an obstetric clinician and over 10% of counties have just one

Figure 5. Distribution of obstetric clinicians by county, U.S. and Puerto Rico

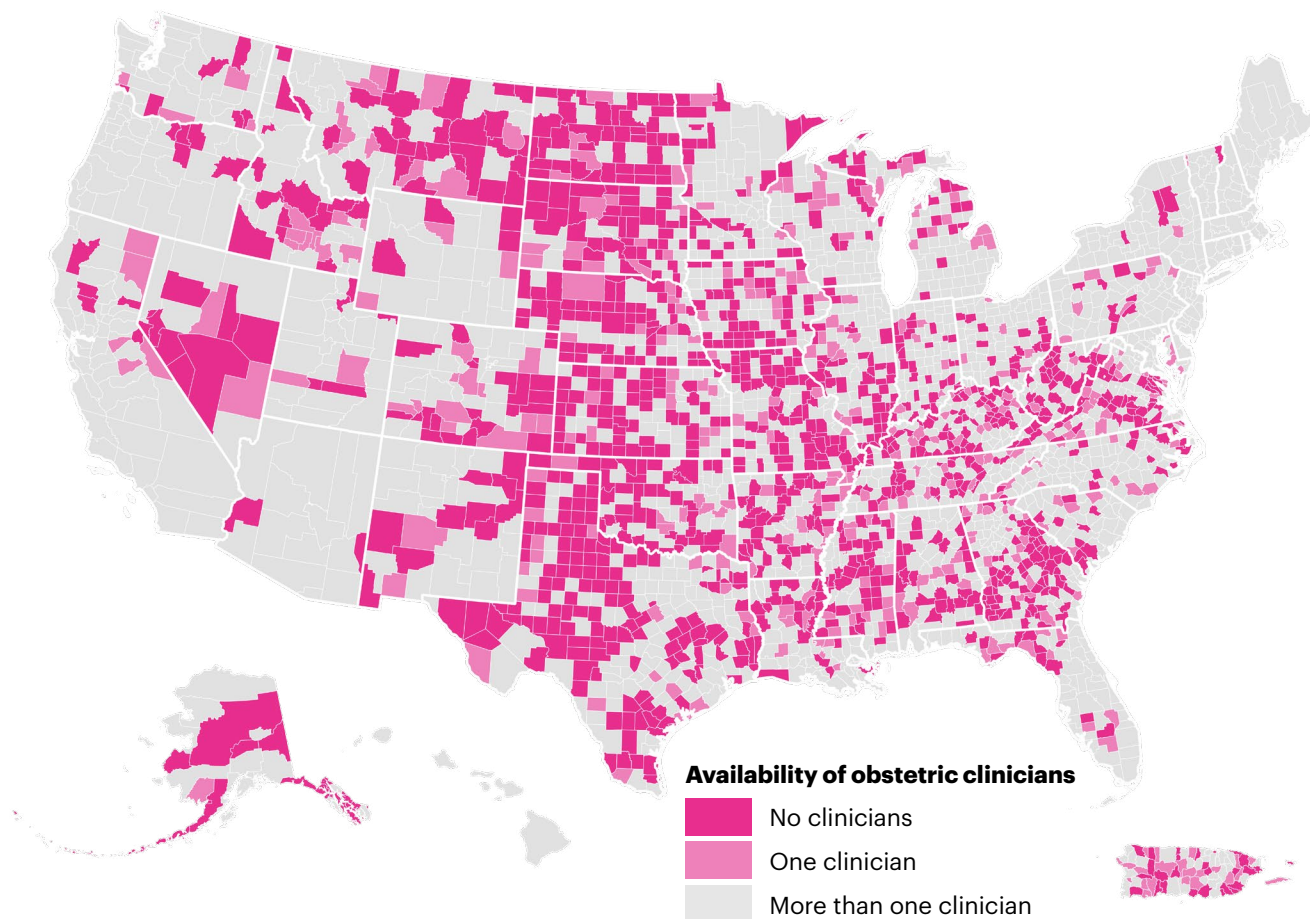
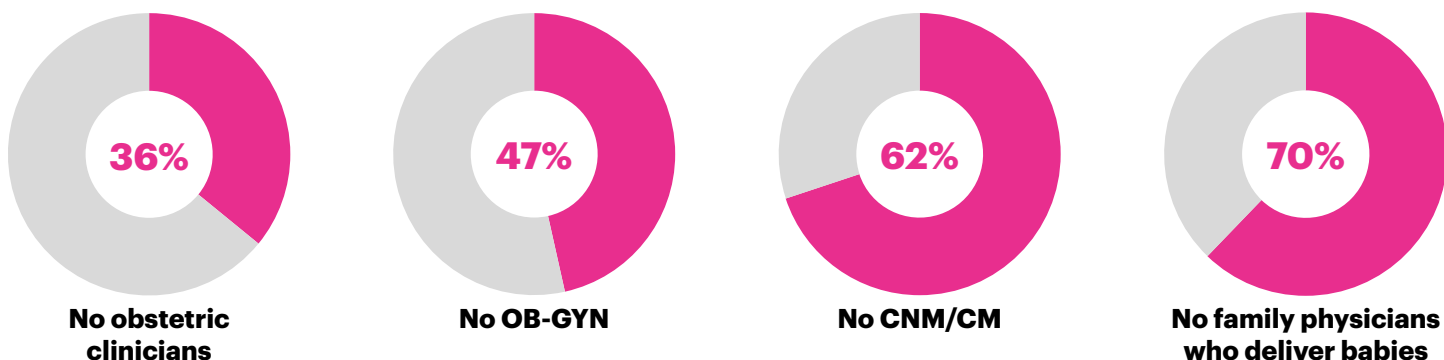


Figure 6. Percentage of counties without obstetric clinicians, by type



Half of U.S. counties lack each major type of obstetric clinician, including OB-GYNs, midwives, and family physicians, with over one-third having none, leaving many communities without access to any consistent source of maternity care.

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2024-2025 file; American Board of Family Medicine, 2021-2024; Centers for Medicare and Medicaid Services (CMS), National Plan and Provider Enumeration System (NPPES), November 2024 file.

Challenges for rural communities

Rural communities in the U.S. face significant gaps in access to obstetric care, driven by workforce shortages. In rural counties, 57.9% lack an obstetric clinician, compared to 19.4% of urban counties. Although 5.3% of women of reproductive age live in rural counties, 2.6% of OB-GYNs and 4.8% of CNMs/CMs practice there.

Family physicians play a critical role in addressing these gaps. While they represent just 5.6% of the overall obstetric workforce, they account for 26.8% of obstetric clinicians in rural counties. Family physicians face fewer opportunities for obstetric training during residency and increasing barriers to maintaining obstetric practice. Hospital credentialing requirements further limit their ability to retain privileges, reducing access in communities where alternative clinicians are already scarce.

Recruiting and retaining clinicians in rural areas is further challenged by professional isolation, heavy workloads, frequent on-call demands, and family considerations including limited employment opportunities for spouses, housing availability, and long travel distances.¹³⁻¹⁵ Evidence suggests that medical students who complete rural training are more likely to practice in those settings, especially if they come from rural backgrounds.¹⁶

Strengthening rural training pipelines and recruitment is critical to addressing long-term workforce shortages. Additional strategies include expanding rural training programs, offering loan repayment incentives, and leveraging telehealth to support collaboration and complex care management.



Scan to learn more about Dr. Bishop's experience as a clinician in a low-access area.

“It’s scary to think that if our clinic were not there, where would they go?”

Dr. Jamie Bishop, family physician,
Cahaba Medical Care, Centreville, Alabama

Dr. Jamie Bishop delivers babies and provides prenatal care in rural Alabama, where maternity services have become increasingly difficult to access. Many of her patients travel long distances for specialty care, struggle with transportation, or face financial barriers that can delay treatment during pregnancy.

A graduate of the Cahaba-UAB Family Medicine Residency, Bishop believes rural training programs are essential to building the workforce communities need. Physicians trained in rural settings gain experience managing complex situations while working with limited resources and fewer specialists nearby.

For Bishop, the issue is personal. She was raised in a rural area herself, a fact she regards as preparation more than coincidence. She sees firsthand what happens when access to care disappears.

“Families in rural communities deserve the same opportunity for healthy pregnancies and healthy babies as anyone else,” she said. “If local maternity care continues to disappear, many patients won’t know where to turn.”

Filling the gap: opportunities for midwives

Midwives play a critical role in expanding access to maternity care, particularly in rural and under-resourced communities. Midwifery care is associated with higher rates of spontaneous vaginal delivery and lower use of interventions such as Cesarean delivery, instrumental delivery, and episiotomy. Individuals receiving midwifery care also report higher satisfaction.¹²

Despite these benefits, midwives attend a relatively small share of births in the U.S. In 2024, 11.6% of hospital births were attended by midwives, up from 8.4% in 2016 (Figure 7). While this represents meaningful growth and mirrors the trend of an increasing workforce, access to midwifery care remains uneven across states and communities.

Expanding and fully integrating midwives into the maternity care workforce represents a cost-effective strategy to improve access. However, regulatory and institutional barriers continue to limit their impact. Addressing these barriers, along with supporting the integration of midwives into hospitals and care teams, can strengthen midwives' roles and expand access to care.

Midwives are essential to expanding access to high-quality maternity care, especially in communities with limited access

Sources: National Center for Health Statistics, final natality data, 2016; National Center for Health Statistics, final natality data, 2024.

In 2024, 11.6% of hospital births were attended by midwives, up from 8.4% in 2016



Figure 7. Percentage of hospital births attended by midwives, 2016 and 2024



Remove requirements for physician supervision or contractual agreements, allowing midwives to practice within their full scope of training.

Authorize midwives to prescribe medication to manage patient care directly.

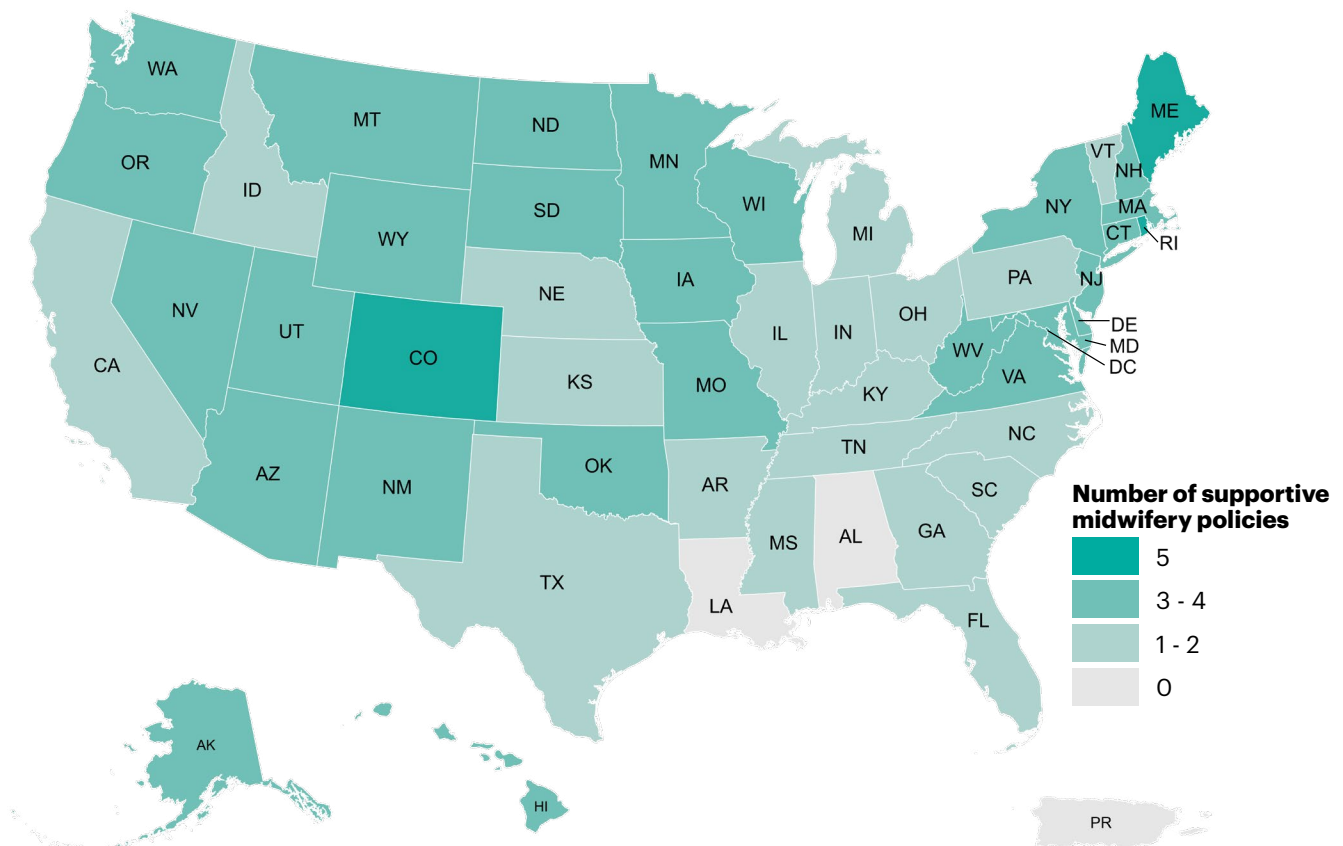
Enable midwives to admit and discharge patients to ensure continuity of care across settings.

Align reimbursement rates so midwives are paid at 100% of physician rates for comparable services, supporting sustainable practice.

Expand licensure for CMs, which is currently available in 11 states, to increase workforce capacity.

Colorado, D.C., Maine, and Rhode Island lead in adopting all 5 supportive midwifery policies

Figure 8. Supportive midwifery policies by state, U.S. and Puerto Rico



Source: American College of Nurse Midwives, 2026.

Strengthening access to maternity care will require expanding obstetric training and practice opportunities for family physicians, reducing barriers to midwifery integration, and addressing OB-GYN workforce challenges such as burnout, particularly in rural and under-resourced communities.

It takes a team: the full spectrum of maternity care

This report focuses on clinicians who attend hospital deliveries in the U.S.; however, many professionals support healthy pregnancies and births across the care continuum.

Provide support



Doulas
Community
health workers

Provide medical care



Family physicians
trained in obstetrics

OB-GYNs

Maternal fetal
medicine specialist

CNMs/CMs

Women's health
nurse practitioner

Certified professional
midwives (CPMs)

Note: CNMs/CMs, family physicians trained in obstetrics, and OB-GYNs are licensed to deliver babies in hospital settings.



“What gives me hope is that there is a new generation of physicians who want to care for families in rural communities.”

Dr. John Waits, co-founder and CEO,
Cahaba Medical Care, Alabama

For more than 20 years, Dr. John Waits has worked to improve access to maternity care in rural Alabama. When he arrived in Bibb County, the local labor and delivery unit had been closed for more than a decade, forcing families to travel outside their community for care.

Through Cahaba Medical Care and the Cahaba Family Medicine Residency, Waits has helped train physicians for rural practice while building partnerships to strengthen local maternity services. In 2015, those efforts helped reopen the county's labor and delivery unit, restoring access to care for local families.

His experience demonstrates that addressing maternity care deserts requires long-term investment in workforce development, community collaboration, and sustainable healthcare infrastructure.



Scan to learn more about
Dr. Waits' experience as a
clinician in a low-access area.



Addressing implementation challenges for doulas

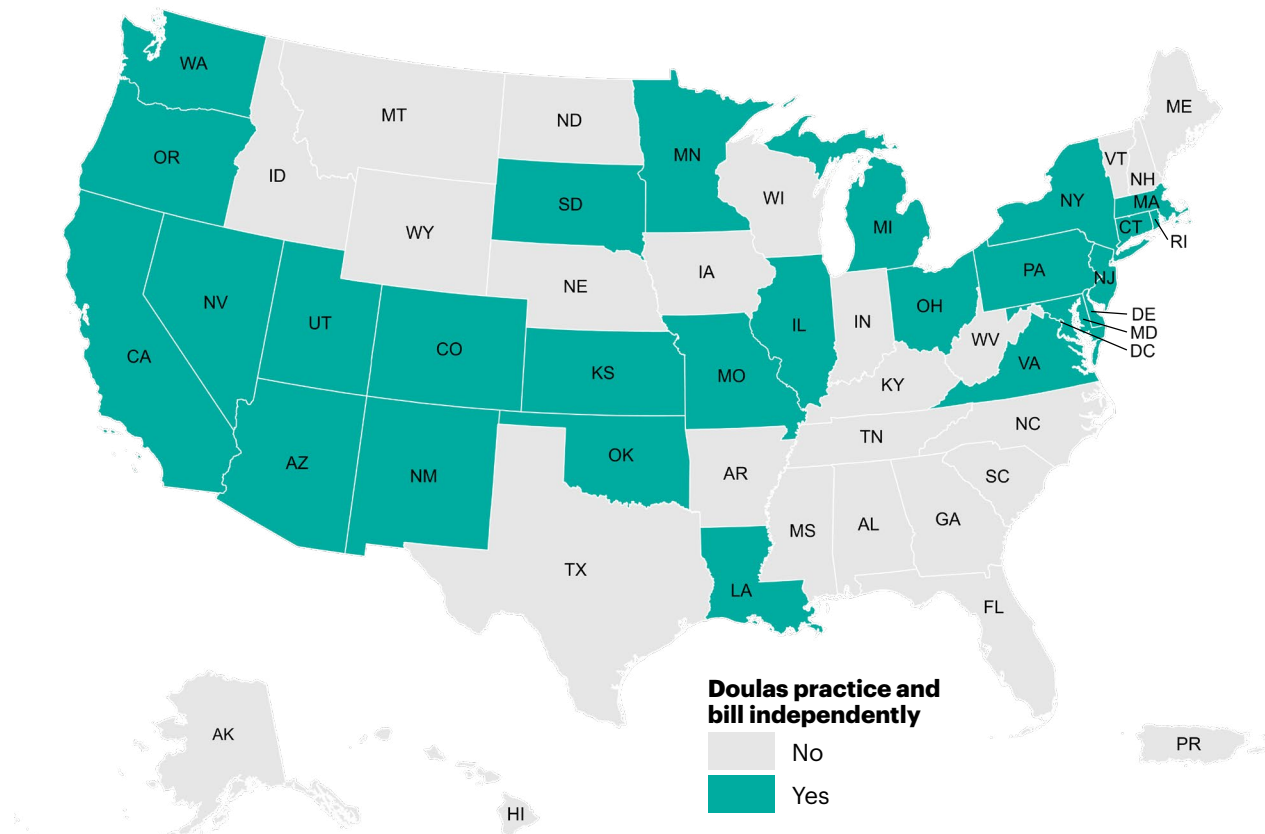
Doulas are trained, non-clinical professionals who provide emotional, physical, and educational support before, during, and after childbirth.¹⁷ Rooted in longstanding cultural and community traditions of birth support, they help individuals navigate pregnancy, childbirth, and the postpartum period.¹⁸ Although they do not provide medical care, doulas play an important role in helping families navigate complex maternity care systems.¹⁹ In communities with limited access to obstetric clinicians or hospital-based maternity services, doulas may also help bridge gaps in care coordination, education, and support.²⁰

Research links continuous doula support to improved maternal and infant outcomes, including lower intervention rates, shorter labor duration, improved patient satisfaction, and reduced risk of preterm birth.^{21,22}

Policy efforts to recognize doulas within the maternity care system have accelerated in recent years, particularly through Medicaid programs.^{23,24} These efforts commonly include reimbursement for prenatal, labor and delivery, and postpartum support, as well as policies allowing doulas to enroll as independent Medicaid providers.

26 states and D.C. allow doulas to enroll as Medicaid providers and bill Medicaid independently

Figure 9. States allowing independent doula practice and billing under Medicaid



Source: National Academy for State Health Policy, 2026.



Addressing implementation challenges for doulas

States are also addressing implementation challenges, including low reimbursement rates, administrative barriers, and workforce sustainability

Addressing implementation challenges



Oregon has worked to strengthen Medicaid reimbursement structures and expand provider participation.²⁵



Minnesota has developed standardized certification pathways to support workforce participation and sustainability.²⁶



California and **New Jersey** have advanced community-based doula models that emphasize culturally responsive care and partnerships with community organizations.^{27,28}



In **New York**, recent legislation would require insurance coverage of doula services as part of standard maternity care.²⁹

As efforts to expand access to and reimbursement for doula services continue, doulas are increasingly recognized as a practical strategy to improve continuity of care and support families in communities with limited access to maternity services.

Hospital-based labor and delivery services

Key insights

More than half of U.S. counties lack a hospital with a labor and delivery unit, affecting nearly 370,000 births annually.

Residents of maternity care deserts travel three times longer, on average, to reach their nearest labor and delivery hospital.

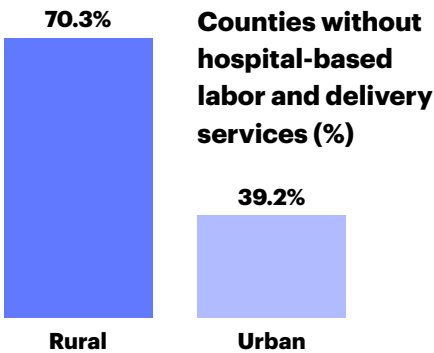
Out-of-hospital births have increased since 2016, with home birth rates nearly twice as high in maternity care deserts compared to full-access counties.

Access to birth centers remains limited and uneven, shaped by geography, policy environments, and socioeconomic factors.

Access to hospital-based labor and delivery services

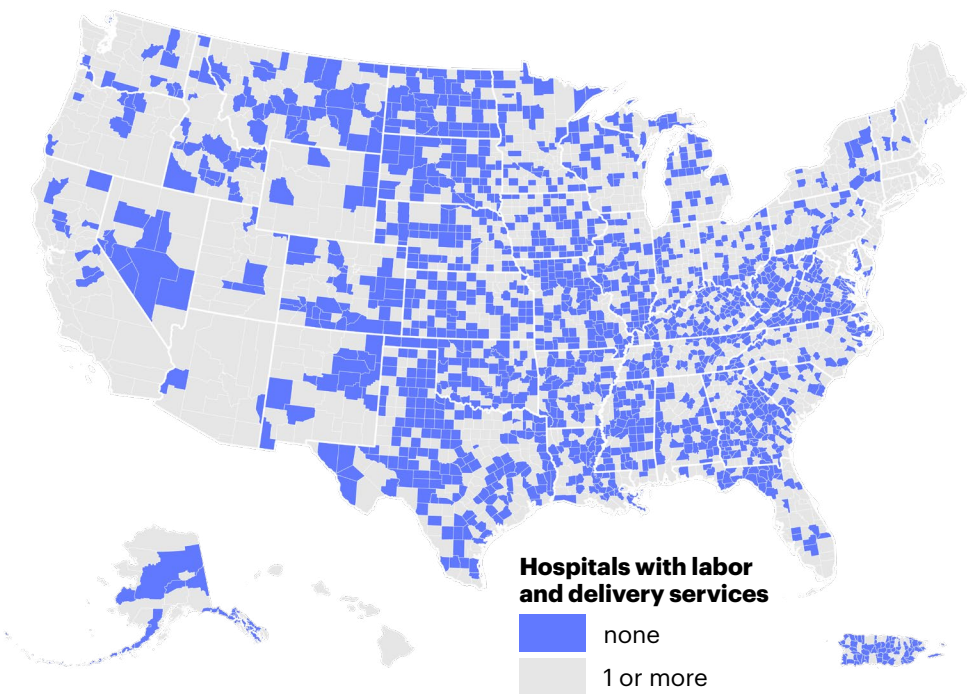
More than half of U.S. counties (52.5%) lack a hospital with a labor and delivery unit, limiting care for millions of families, affecting nearly 370,000 births annually (Figure 10).

Geographic disparities are substantial: 70.3% of rural counties lack a hospital with labor and delivery services, compared to 39.2% of urban counties, leaving many families without nearby options for giving birth.



52.5% of all U.S. counties do not have hospital-based labor and delivery services

Figure 10. Hospitals with labor and delivery services by county, U.S. and Puerto Rico, 2024

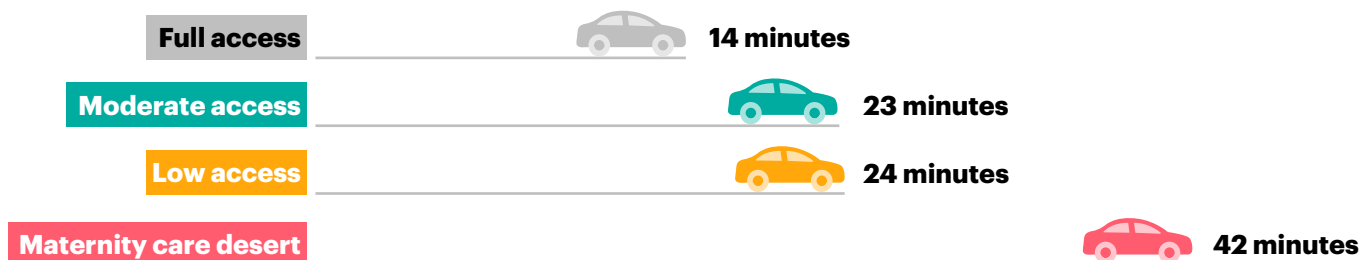


Sources: American Hospital Association, 2024; Centers for Medicare and Medicaid Services Provider of Services File, 2024.

On average, pregnant women travel 16 minutes by car to their nearest labor and delivery unit. However, access varies substantially by location. Geographic disparities are particularly pronounced in rural counties, where average travel time is 33 minutes, more than twice that of urban counties (15 minutes). In several states, including North Dakota, West Virginia, and Montana, average travel times are 25 minutes or more. Residents of maternity care deserts travel an average of 42 minutes to reach labor and delivery services, three times longer than those traveling 14 minutes in full-access counties (Figure 11).

Women living in maternity care deserts travel three times longer, on average, to reach the nearest hospital with labor and delivery services

Figure 11: Travel time by maternity care access designation



Longer travel distances are associated with delayed entry into prenatal care, increased likelihood of unplanned out-of-hospital deliveries, higher rates of maternal morbidity, and greater neonatal intensive care unit (NICU) admissions.^{2,30,31} Longer travel distances also increase indirect costs for families, including transportation, childcare, missed work, and temporary lodging.



Scan to learn more about Latasha's experience in a low-access area.

“If labor happened, the drive was always on our minds.”

Latasha Bell, RN, maternal mortality prevention professional and mother, Lowndes County, Alabama

For Latasha, living in a maternity care desert meant planning every pregnancy around distance. As a teenager expecting her first child, and years later as a registered nurse preparing to deliver her fourth, the nearest labor and delivery hospital was more than 45 minutes away. Every appointment, every contraction, and every decision began with one question: How long will it take to get there?

Even with health insurance, reliable transportation, and medical knowledge, Latasha understood that geography alone could shape pregnancy outcomes. She knows many families in rural Alabama face even greater barriers, forcing them to delay care or travel long distances for routine prenatal visits, labor and delivery, and emergency care.

“I wish people understood how much access to care matters. Sometimes it's as simple as being able to get to a provider.”

Closures across the nation: the search for a place to give birth

Key insights

Hospital labor and delivery unit closures have accelerated across the U.S. and are associated with negative impacts on maternal and infant health.

96 publicly reported labor and delivery unit closures were identified across 91 counties in 35 states between 2024 to early 2026.

Across all affected counties, unit closures increased travel time by an average of 25.0 minutes, with increases up to 77 additional minutes to reach the nearest labor and delivery unit.

Across the U.S., an increasing number of women of reproductive age are losing access to local birthing facilities. As labor and delivery units close, access to maternity care can shift across entire regions, often requiring families to travel farther for care. Research shows that the loss of local labor and delivery services is associated with longer travel distances, delays in accessing care during emergencies, increased risk of out-of-hospital births, and adverse maternal and infant outcomes, particularly among those living in rural communities.^{2,32-34} For many families, these changes can delay care during pregnancy and childbirth and add stress while navigating already complex health systems. At the same time, some hospitals report that consolidating maternity services can allow remaining facilities to concentrate specialized staff and resources, potentially improving quality and safety in higher-volume centers.^{32,25}

Because national hospital datasets are lagged, we analyzed publicly reported closures occurring between 2024 and early 2026 using Becker's Hospital reviews, data from the Center for Healthcare Quality and Payment Reform, online news reports, and hospital announcements. This approach captures publicly reported closures and may not represent all closures during this period.

During the study period, 96 labor and delivery unit closures were identified across 91 counties in 35 states. Nearly two-thirds of closures occurred in rural hospitals, and more than half involved the county's only birthing facility.

Reported drivers of labor and delivery unit closures included declining birth volume, workforce shortages, and financial pressures. Declining birth volume was the most frequently cited factor, reflecting reduced patient demand that challenges hospitals' ability to sustain staffing, maintain financial viability, and support continuous obstetric services. Workforce shortages were reported in approximately half of closures and most commonly involved shortages of obstetric clinicians, labor and delivery nurses, and anesthesia providers, limiting hospitals' ability to maintain safe, 24-hour coverage. Financial pressures were reported in approximately one-third of closures and included rising operating costs, low Medicaid reimbursement, and persistent financial losses associated with maintaining labor and delivery services.

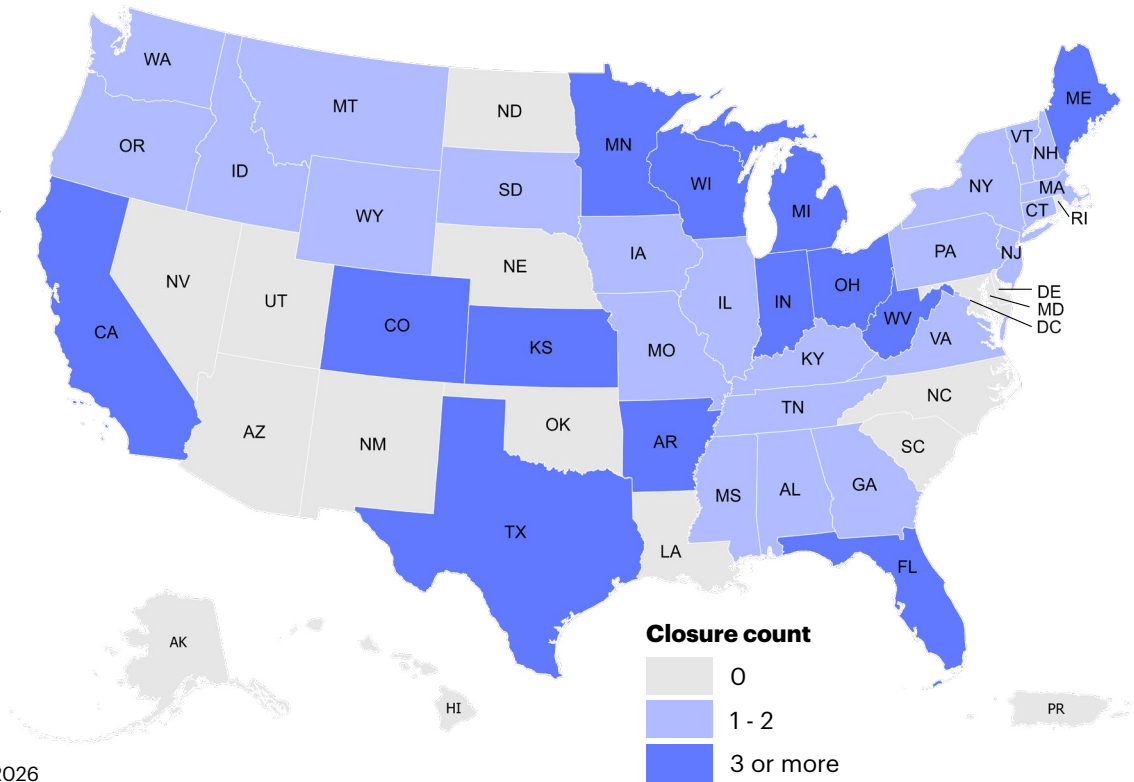
Reported reasons for closure also differed by hospital location. Rural hospitals more frequently cited workforce shortages as a primary contributing factor, whereas urban hospitals more often reported declining birth volume.



This report is based on publicly reported labor and delivery unit closures and may not capture every closure. Help us keep this resource current by reporting any closures you are aware of through the March of Dimes closure reporting survey: <https://www.marchofdimes.org/L&Dclosure>

Labor and delivery unit closures across the U.S.

96
labor and delivery
unit closures
occurred across
35 states and 91
counties*



*From January 1, 2024, to May 1, 2026

Who is affected?



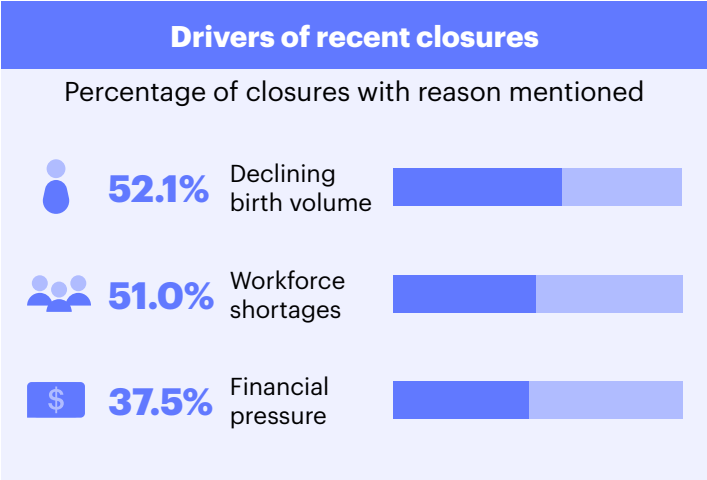
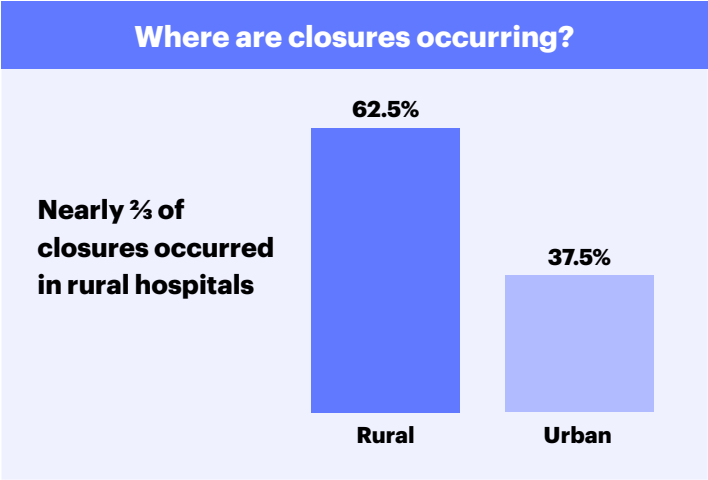
9.2 million
women of reproductive age live in counties with recent closures.



465K births
occur annually in these counties, representing 13% of live births.



58.3%
of closures were a county's sole birthing facility.



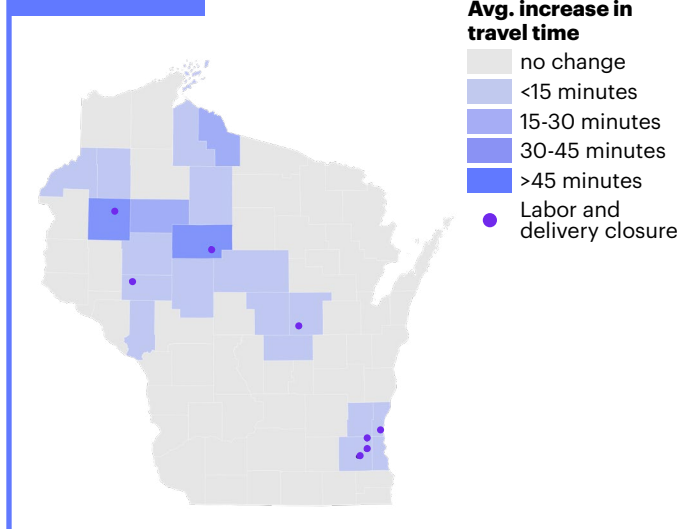
The impact of labor and delivery unit closures on travel time

Recent labor and delivery unit closures have increased travel times to maternity care by an average of 25 minutes in affected communities. While some states, including California, Wisconsin, Indiana, and Minnesota, experienced a higher number of closures, the greatest relative increases in travel burden occurred in more rural states, including Wyoming (12.8% increase in travel time), West Virginia (10.6%), Maine (7.4%), and Wisconsin (6.6%).

State spotlight: local impacts of labor and delivery unit closures

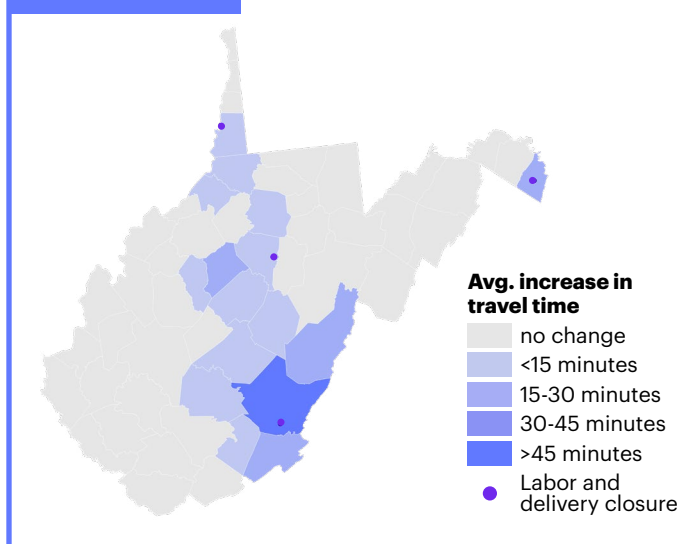
While labor and delivery unit closures are occurring nationwide, their impact varies considerably across states. In some areas, closures are concentrated geographically, further limiting already constrained systems. In others, even a single closure can substantially alter access because few alternative facilities exist. West Virginia and Wisconsin demonstrate how quickly access to maternity care can shift when local birthing services are lost.

Wisconsin



In Wisconsin, recent closures have further strained maternity care systems, particularly in rural communities. Staffing shortages contributed to multiple labor and delivery unit closures, including in Barron and Taylor counties, where travel times to the nearest unit tripled for residents. The effects also extended into surrounding counties such as Rusk and Price, where travel times were already nearly one hour and increased by 46% and 19%, respectively. While rural communities are disproportionately affected, similar challenges are occurring in metropolitan and suburban areas. In the Milwaukee region, for example, hospital consolidations and labor and delivery service changes have shifted where families seek obstetric care, reflecting broader financial and workforce pressures affecting hospitals across Wisconsin.

West Virginia



In West Virginia, the impact of closures is intensified by a long-standing shortage of birthing facilities. Because the state has one of the lowest densities of labor and delivery hospitals in the country, even a single closure can significantly alter access to care. In Greenbrier County, the closure of the only unit serving several surrounding counties increased travel times across the region, particularly in the Southeast. Families in multiple rural counties now travel two to three times longer to reach obstetric services, with many communities requiring at least one hour of travel after accounting for the increase in travel time due to a nearby closure. Together, the affected counties in southeastern West Virginia are home to more than 17,000 women of reproductive age and over 1,000 births annually, highlighting how the loss of a single facility can quickly create widespread geographic barriers to care.



Strategies to address or mitigate the impact of hospital closures

States and health systems are implementing a range of strategies to mitigate the impact of labor and delivery unit closures. These strategies range from advanced planning requirements to new funding and care delivery models.



Maine

Maine enacted legislation requiring hospitals to provide 120 days' advance notice before closing labor and delivery units or making significant changes to maternity or newborn care services.^{36–38}



California

California SB 669, enacted in 2025, established a new “standby perinatal services” model for rural hospitals unable to sustain traditional 24/7 labor and delivery units.



Oregon

In 2026, Oregon launched a statewide rural stabilization initiative in response to the increasing number of labor and delivery unit closures. The initiative allocated \$25 million to support rural maternity care services.

In communities where maintaining full obstetric services is no longer feasible, hospitals are also strengthening emergency department capacity to respond to obstetric emergencies³⁹ and training emergency medical service personnel to stabilize patients during longer maternal and infant transport times. Continued evaluation will be important to understand which strategies most effectively preserve access while maintaining quality and safety.

Value-based payments: alternative payment methods for maternity care

Traditionally, healthcare providers in the U.S. have been reimbursed through a fee-for-service (FFS) model, in which payment is tied to each individual service delivered. In contrast, value-based payment (VBP) models incentivize high-quality, coordinated, and cost-efficient care.

Efforts to expand VBP in maternity care include pay-for-performance models, episode-based bundles, maternity care homes, population-based models, and total cost of care approaches. Strengthening and scaling value-based maternity care models may improve access, quality, and cost-efficiency. Some value-based models also create opportunities to better integrate midwives, doulas, care coordination, and postpartum support into maternity care systems.

Shifts in birth settings

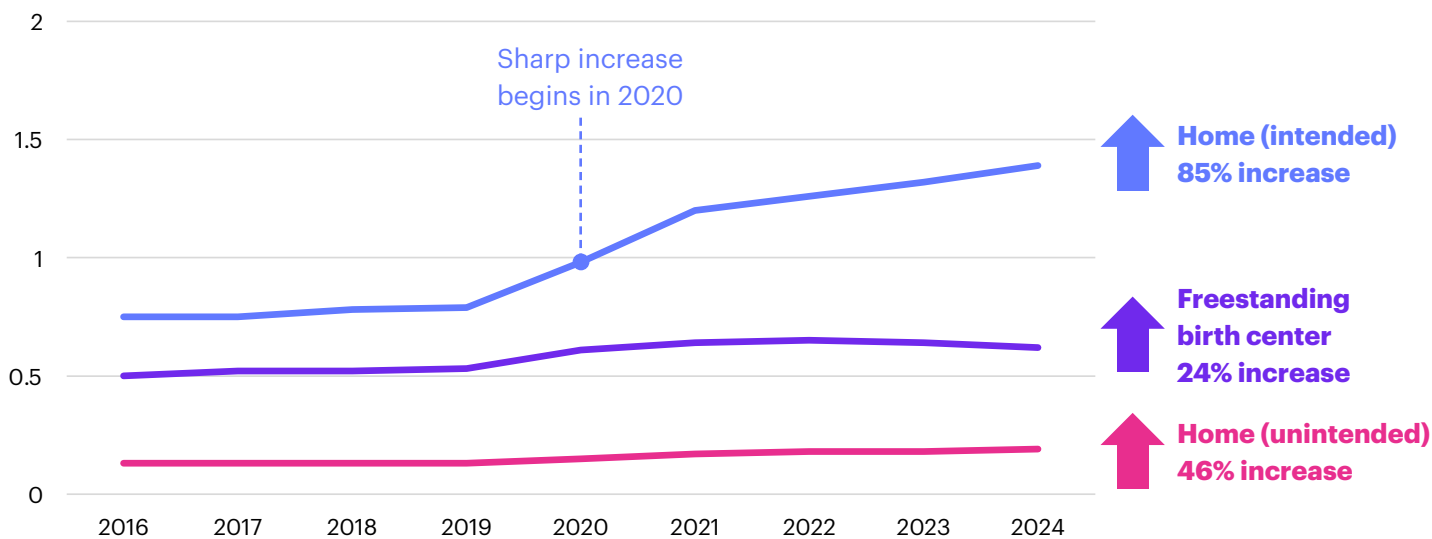
As access to hospital-based labor and delivery care becomes more limited, particularly in counties with long travel times and fewer labor and delivery services, birth patterns are shifting. In these areas, decisions about birth setting may reflect access constraints, with choices shaped in part by the local options available.

Out-of-hospital births increased by 50% since 2016, and home birth rates are 1.9 times higher in maternity care deserts than in full-access counties

While hospitals remain the primary setting for childbirth, accounting for nearly 98% of all births, this pattern is changing. Between 2016 and 2024, the proportion of counties without a labor and delivery hospital increased from 47.5% to 52.5%. Over the same period, births occurring outside hospital settings increased by 50%, reaching 2.3% of all births in 2024.

Home births have increased from 1.0% of all births in 2016 to 1.6% in 2024, a 65.3% relative increase (Figure 12). This trend has been linked to the loss of hospital-based birthing services and is more pronounced in areas with limited or no access to maternity care.⁴⁰ In maternity care deserts, home birth rates are nearly twice as high as in full-access counties. Among home births in maternity care deserts, 92.3% are reported as intended, suggesting birth setting decisions may reflect limited local hospital access.

Figure 12. Percentage of out-of-hospital births by setting, 2024



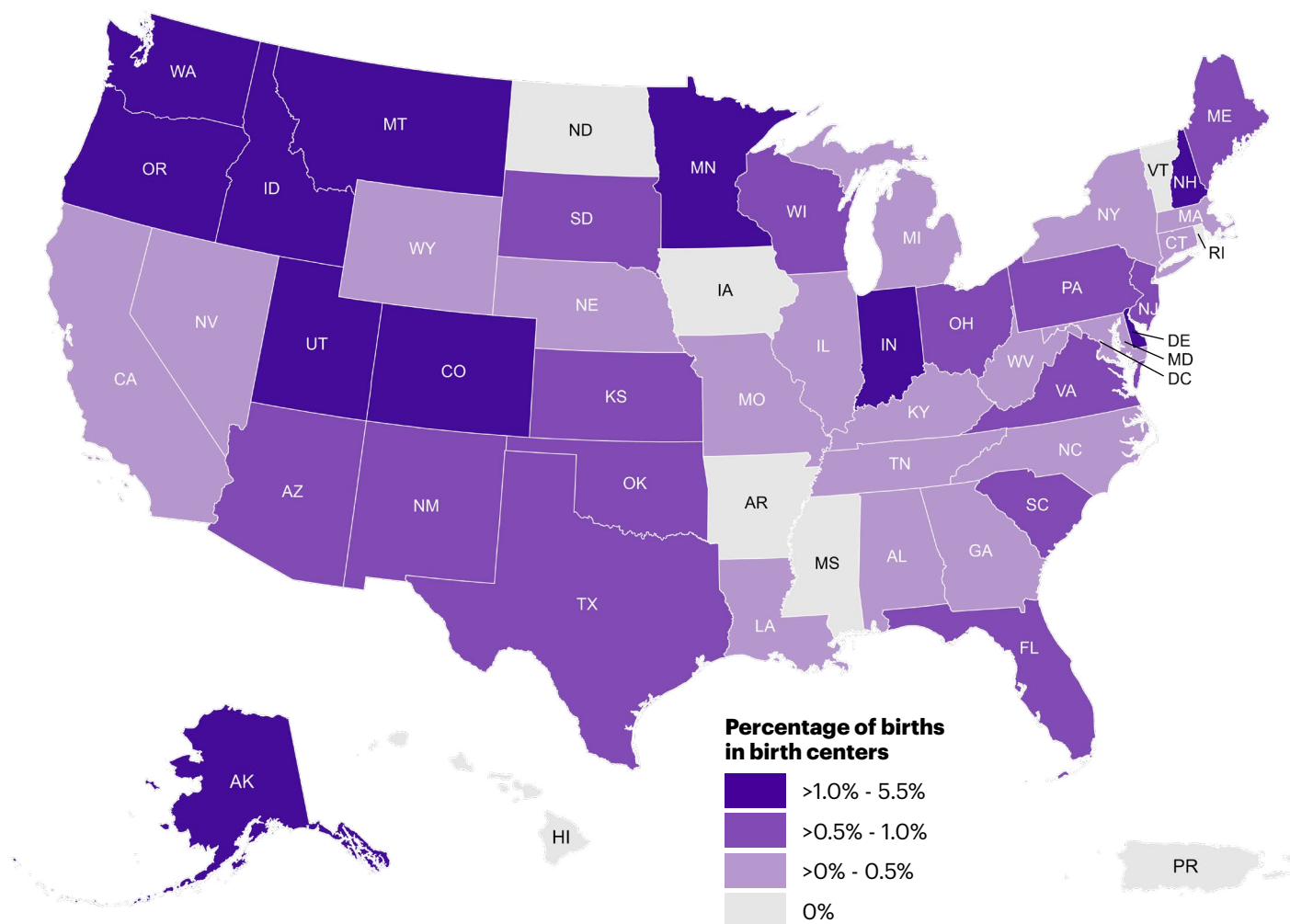
Source: National Center for Health Statistics, final natality data, 2016-2024.

Birth centers

Birth centers offer an alternative to hospital birth, emphasizing the midwifery model of care for low-risk pregnancies.⁴¹ There are 421 birth centers nationwide, yet only 8.4% of counties have at least one. Birth center access remains highly uneven, with just 1.3% of rural counties having one, compared to 13.7% of urban counties. Nearly 70% of all birth centers are concentrated in just 10 states, with the largest shares in Texas, California, Florida, Washington, and Virginia. Birth centers accounted for 0.6% of U.S. births in 2024, up from 0.5% in 2016, a 24.0% relative increase (Figure 13).

Birth centers are associated with improved outcomes and lower-cost, patient-centered care.⁴¹ Low reimbursement rates, administrative burdens, and payment delays create significant operational challenges. In addition, variation in state licensure requirements and the absence of clear pathways in some states further restrict where birth centers can operate and expand.

Figure 13. Percent of total births in birth centers by state, U.S. and Puerto Rico, 2024



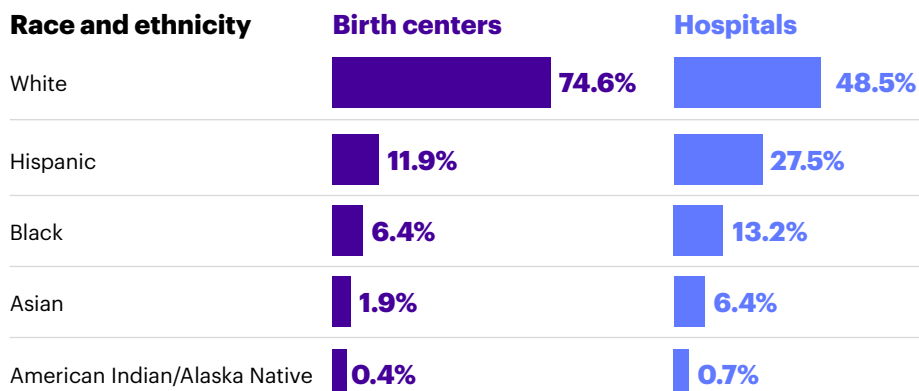
Source: National Center for Health Statistics, final natality data, 2024.

Birth centers are not accessed equally

Geography, income, insurance coverage, race, and ethnicity all can shape women's options and outcomes during pregnancy, childbirth, and the postpartum period.

Birth center utilization by race and ethnicity

Percentage of births that occur in birth centers versus hospitals.



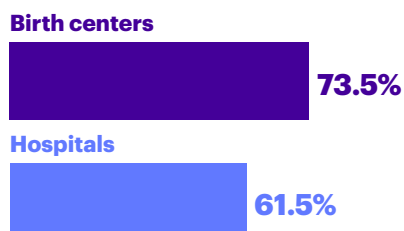
The takeaway



Birth center utilization varies substantially by race/ethnicity, education, insurance coverage, and geography. **Addressing these disparities is critical to ensuring equitable access to birth center care.**

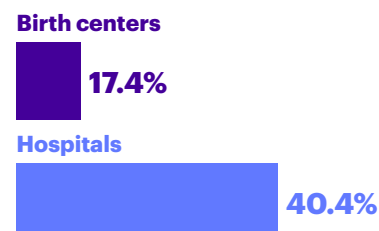
Education level

Percentage of individuals with at least some college.



Insurance coverage

Percentage of births covered by Medicaid.



Expanding access to accredited birth centers

Expanding access to accredited birth centers is a critical strategy for addressing gaps in maternity care access, particularly in under-resourced and rural communities. Key policy actions include:

Remove regulatory barriers:

Exempt birth centers from certificate of need (CON) requirements that can delay or prevent new facilities from opening.

Improve financial sustainability:

Establish equitable Medicaid reimbursement rates (at 100% of the fee schedule) and reduce administrative burdens, including payment delays.

Standardize quality measures:

Align state regulations with Commission for the Accreditation of Birth Centers (CABC) standards.

Integrate into care systems:

Support standardized coding, contracting mechanisms, and inclusion in provider networks to ensure coordinated care.

Plan for emergencies:

Require transfer agreements and documented protocols for responding to obstetric or neonatal emergencies.

Health insurance coverage

Key insights

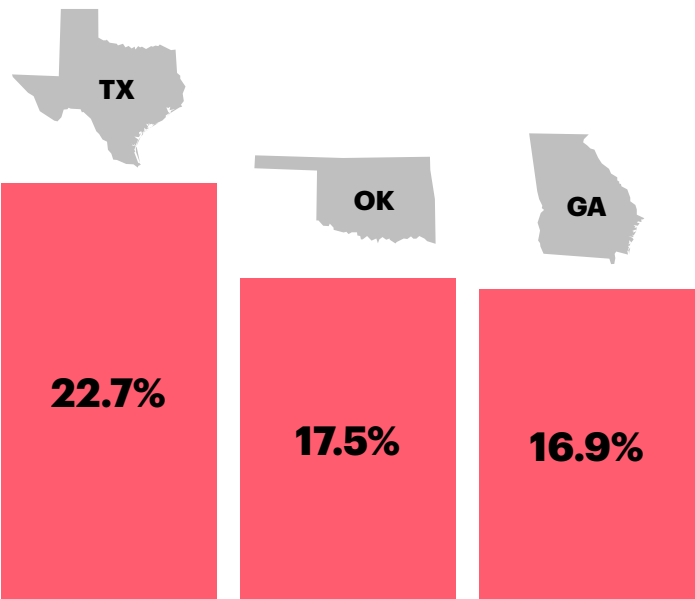
Nationally, about 1 in 9 (10.9%) women ages 19 to 54 were uninsured in 2024, with substantial variation across states and counties.

Since the passing of the Affordable Care Act in 2010, which expanded Medicaid income-eligibility thresholds, uninsured rates among women ages 19 to 54 have decreased 45% nationally, but to a lesser extent (just 35%) in states that have not expanded Medicaid.

Recent federal policy could result in increases in uninsured rates nationwide, leading to decreased financial access to care.

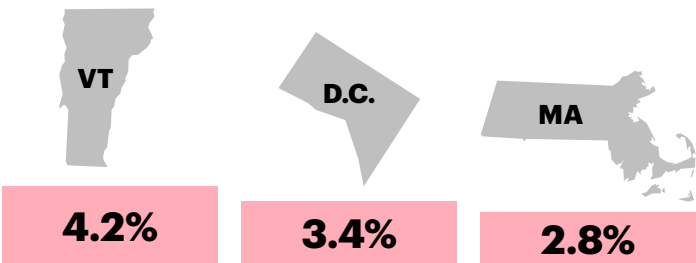
Access to affordable, comprehensive health insurance is critical for healthy pregnancies and positive outcomes for moms and babies.⁴² Without stable coverage, women are more likely to enter pregnancy with unmanaged conditions, delay prenatal care, and face barriers to specialty and high-risk services. Access to care before pregnancy influences maternal and infant outcomes long before prenatal care begins. Coverage gaps increase the risk of delayed prenatal care and preventable complications.

**1 in 9 women
ages 19 to 54 years
are uninsured**



States with highest uninsured rates

**Insurance coverage rates among
reproductive-aged women vary
widely across states**

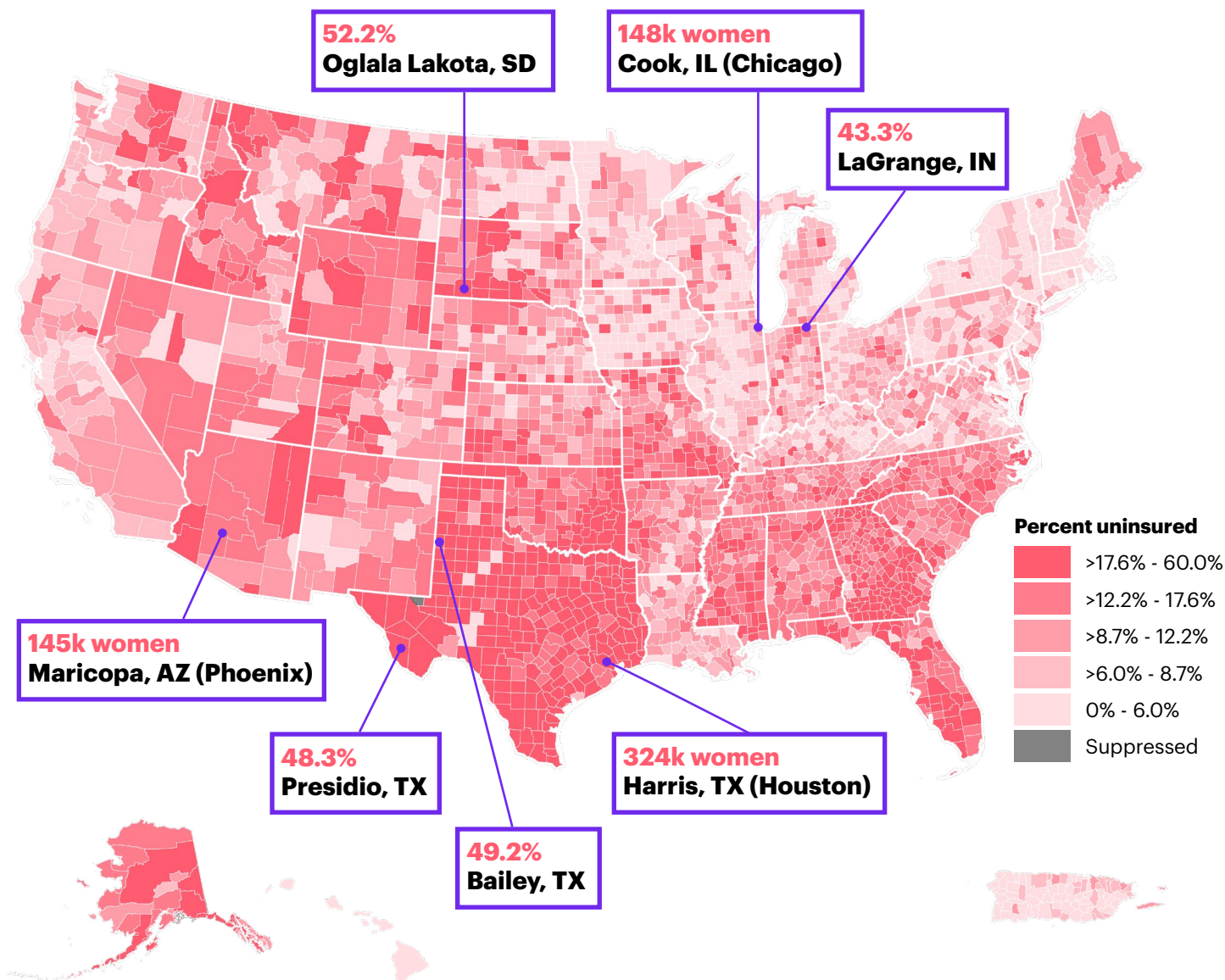


States with lowest uninsured rates

County-level variation in insurance coverage is even more pronounced. In approximately 3% of counties, as many as 1 in every 3 women are uninsured, with clusters in Texas, Georgia, Oklahoma, Alaska, and South Dakota. Uninsured rates are highest in maternity care deserts, as well as in rural, border, and tribal counties, while several large urban counties also experience both high rates and large numbers of uninsured women (Figure 14).

High uninsured rates persist across U.S. counties

Figure 14. Percentage of uninsured women ages 19 to 54 by county, U.S. and Puerto Rico, 2024



Source: U.S. Census Bureau, 2024 American Community Survey 5-Year Estimates.

Note: Individual callouts represent cities or counties with high rates or numbers of uninsured women.

Landmark health insurance policy and changes in access

Access to health insurance and coverage for women and families in the U.S. has been shaped by federal policy since the introduction of Medicaid in 1965. The Affordable Care Act (ACA) marked a major turning point by allowing states to expand Medicaid income eligibility (adopted in all but 10 states as of 2026) and providing insurance premium tax credits.⁴³

Medicaid expansion, implemented in 2014, has led to substantial declines in uninsured rates overall and among women ages 19 to 54. While research on the impacts of Medicaid expansion on overall maternal and infant outcomes is mixed, some studies suggest that expansion may be associated with timely initiation of prenatal care and improved management of high-risk conditions such as hypertensive disorders of pregnancy, progress toward reducing racial and ethnic disparities, and reductions in maternal mortality.⁴⁴⁻⁴⁷

More recent policies, including extension of postpartum Medicaid coverage through 12 months (adopted in 49 states and D.C. as of July 2026),⁴³ have further strengthened access to care. However, proposed or enacted changes following the passage of House Resolution 1 (H.R. 1), also referred to as the One Big Beautiful Bill Act, including Medicaid funding cuts and work requirements, and the expiration of insurance premium tax credits, threaten to reverse these gains and increase the number of uninsured families.

In maternity care deserts, where clinician and facility shortages already limit access, loss of coverage compounds existing barriers to care, making it more difficult for women to receive timely prenatal, delivery, and postpartum services.

Health insurance policy shapes who can access care, when they receive it, and whether coverage is continuous across pregnancy and postpartum



“I had to jump through three hoops with fire on them just to obtain insurance.”

Savannah Yax, mother, Elmore County, Alabama

After moving to Alabama early in her pregnancy, Savannah spent five months navigating the state's Medicaid enrollment process before she could establish prenatal care. Even after gaining coverage, every appointment required a 40-minute trip to the nearest obstetric provider and reliable transportation she often didn't have.

Throughout her pregnancy and postpartum recovery, Savannah faced delays in receiving treatment because of transportation challenges, provider availability, and the limits of her coverage. Now, as her Medicaid eligibility comes to an end, she worries about losing access to the mental healthcare and other services she still needs as a new mother.

Throughout her experience, Savannah learned that getting insurance alone wasn't enough. Finding providers, arranging transportation, and keeping coverage were ongoing challenges that affected every stage of her pregnancy and recovery.

“Make healthcare and prenatal and postpartum care easily accessible for mothers and children all over.”



Scan to learn more about Savannah's experience in a low-access area.

Legislative milestones in health insurance policy for pregnant women and children

Over time, federal policies have expanded eligibility, increased affordability, and improved continuity of coverage for pregnant women and children.⁴⁸⁻⁵¹

Early and Periodic Screening, Diagnosis and Treatment Program

Required all states to provide Medicaid-enrolled infants and children with appropriate and necessary pediatric services.

1967

Pediatric services coverage for children

1965

Medicaid program established

Social Security Act

Required all states, D.C., and U.S. territories to provide health coverage for low-income individuals.

1970

Coverage for family planning

Family Planning Act

Established federal funding and authority for family planning programs, expanding access to contraception and reproductive health services. Required that all services be provided on a voluntary basis.

1984

Medicaid coverage for children under 5

Deficit Reduction Act of 1984

Required states to provide Medicaid coverage to eligible children under age 5 and income qualifying pregnant women (single parents or single earner households) and granted automatic one-year Medicaid eligibility to infants born to mothers covered by Medicaid.

1985-1990

Expanded coverage for pregnant women and presumptive eligibility

Omnibus Budget Reconciliation Acts

Required Medicaid coverage during pregnancy through 60 days postpartum, regardless of employment or marital status, and gradually broadened eligibility to higher income levels (up to 133% FPL required, with options up to 185% FPL).

Introduced presumptive eligibility to allow states the option to provide temporary prenatal care access while formal Medicaid eligibility is determined.



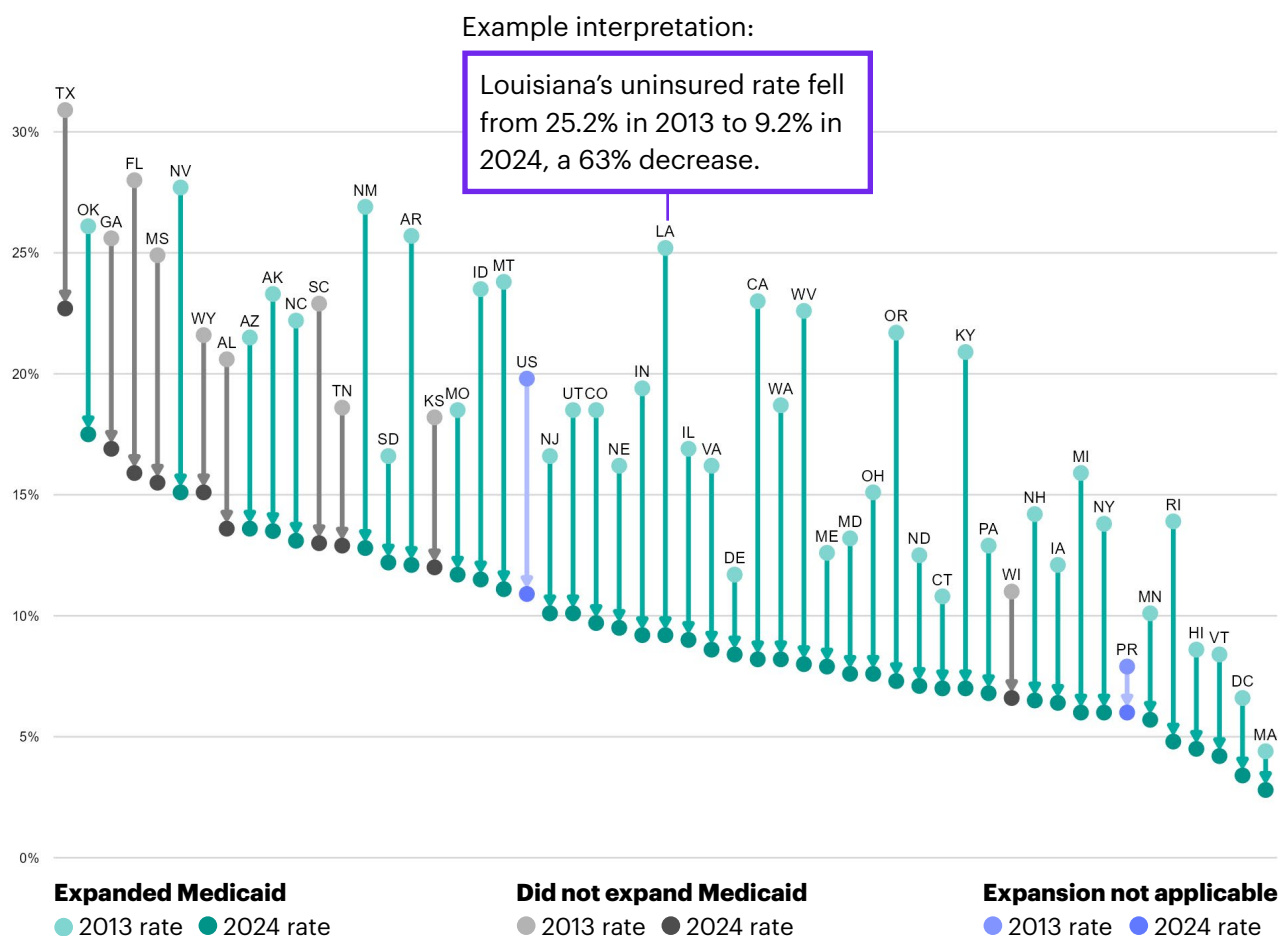


Changes in uninsured rates since ACA implementation

Since the implementation of the ACA, uninsured rates among women ages 19 to 54 have declined nationally, from 19.7% in 2013 to 10.9% in 2024, and across all states and most counties. At the state level, average rates decreased from 18.0% to 9.8%, representing a 45.1% reduction (Figure 15).

Uninsured rates among women decreased across all states, though progress varies

Figure 15. Percentage of uninsured women ages 19 to 54 by U.S. state, 2013 and 2024



Key insights

Kentucky and Oregon demonstrated the largest improvements, each reducing uninsured rates by 66%.

Even states with the smallest improvements, including Puerto Rico and Texas, achieved reductions of roughly 25%.

Despite state-level progress, about 1 in 20 counties did not experience declines.

The average reduction in states that had expanded Medicaid by 2024 was 48%, compared to just 35% in non-expansion states.

Medicaid expansion and other policies implemented through the passing of the ACA have been one of the strongest drivers of coverage gains among women of reproductive age. States that expanded Medicaid experienced larger reductions in uninsured rates, demonstrating the impact of policy decisions on access to care. Variation across states and counties

highlights the need for targeted strategies and supportive policies to ensure that gains in health insurance coverage are equitable and sustained over time. Maintaining and expanding access to continuous coverage before, during, and after pregnancy will be critical to sustaining gains and preventing further erosion of maternity care access.



Advocacy can help drive meaningful change. Join the **March of Dimes Advocacy Network to support policies that improve access to care for moms and babies.**



Discover Sen. Katie Britt's work to improve access to maternity care.

“We have a lot of work to do because there are so many moms and babies counting on us.”

Sen. Katie Britt, U.S. Senator, Alabama

As Alabama continues to face one of the nation's highest maternal mortality rates, Sen. Katie Britt has made improving maternal health a priority in Congress. Growing up in rural Alabama and raising two children of her own, Britt understands the importance of ensuring families can access quality care before, during, and after pregnancy.

Recognizing that many rural communities are far from labor and delivery services, Britt has championed efforts to better prepare rural hospitals and first responders to care for women experiencing obstetric emergencies. She also supports expanding research into the causes of maternal mortality and improving access to resources that help women navigate pregnancy and early parenthood.

For Britt, improving maternal health requires strengthening both the healthcare system and the support available to families, particularly in rural communities where access to care remains limited.

“We have a lot of work to do. There are many of us rolling up our sleeves because we know there are so many moms and babies counting on us.”

Increasing access to prenatal care

Early prenatal care is critical to improving maternal and infant health outcomes. Timely care supports risk identification, chronic disease management, and delivery of recommended preventative services, including mental health screenings, substance use treatment, vaccinations, and infectious disease screening.⁴

More than 1 in 4 women covered by Medicaid during pregnancy reported being uninsured prior to conception, increasing to more than 1 in 3 in non-expansion states.⁵² Gaps in pre-pregnancy coverage can delay prenatal care initiation as women navigate Medicaid enrollment early in pregnancy. Presumptive eligibility (PE) policies help reduce this barrier by allowing immediate access to care while eligibility is determined.

Many states have long-standing PE policies for pregnant women, while recent actions in Alabama and Arkansas expanded PE beginning in 2025.^{53,54} These policies may be particularly impactful in non-expansion states, where women are more likely to be uninsured before pregnancy and experience delays in accessing prenatal care.

Although research suggests PE policies may improve prenatal care initiation, findings have not consistently demonstrated improvements in birth outcomes.^{55,56} These findings suggest that insurance coverage alone does not eliminate barriers to prenatal care.

Additional barriers to prenatal care include:⁵⁷



Socioeconomic and logistical barriers

- Transportation challenges and long travel distances
- Work, school, childcare, and paid leave constraints
- Limited access to broadband internet and digital tools in rural and under-resourced communities



Health system barriers

- Understaffed clinics and long wait times
- Limited clinician availability or participation in Medicaid and other insurance plans



Population-specific barriers

- Language barriers
- Immigration-related concerns that may deter seeking care

In 2024, 1 in 4 women did not receive prenatal care during the first trimester of pregnancy



Rates of early prenatal care are slightly lower among women living in maternity care deserts (74.8%) and low-access counties (71.3%) compared to full-access counties (75.6%).

Evidence-based strategies to improve prenatal care utilization:⁵⁸



Providing financial incentives



Expanding telehealth services



Deploying mobile health clinics in underserved communities

Broader investments in maternity care infrastructure and workforce capacity are also needed to improve timely access to prenatal care in under-resourced areas.

Digital technologies and mobile health centers: meeting families where they are

Telehealth, remote patient monitoring (RPM), mobile health applications, and mobile health centers can expand access to maternity care in under-resourced communities by helping overcome geographic, transportation, and workforce barriers. Reliable broadband access is increasingly essential healthcare infrastructure for maternity care access.

Studies suggest that mobile health centers can improve early and adequate prenatal care utilization, increase patient satisfaction, support the identification of maternal hypertension, and reduce preterm birth rates. While not a substitute for sustainable local

maternity care infrastructure, these approaches may be particularly beneficial for high-risk pregnancies and postpartum monitoring, including for hypertensive, cardiac, and mental health conditions.

Postpartum care remains especially important, as most pregnancy-related deaths occur after delivery and the majority are preventable.⁵⁹ Yet many women do not receive the recommended postpartum care.⁶⁰ Mobile health centers and digital tools may help improve timely follow-up care and reduce barriers to accessing postpartum care.



Advancing digital innovation in maternal healthcare

To expand equitable access to technology-enabled maternity care, policymakers should prioritize the following:



Payment and insurance reform:

Establish permanent reimbursement parity for telehealth services across Medicaid and private insurance plans. Expand coverage for RPM tools, including blood pressure cuffs and glucose monitors, and reimburse audio-only visits when video access is not feasible.



Broadband and technology access:

Invest in broadband expansion in rural and under-resourced communities. Support digital literacy initiatives and programs that improve access to smartphones, tablets, and data plans for patients and clinicians.



Licensure and regulatory flexibility:

Expand interstate licensure contracts to allow obstetric clinicians, midwives, doulas, and mental health professionals to provide care across state lines, particularly in areas with limited access to specialty care.

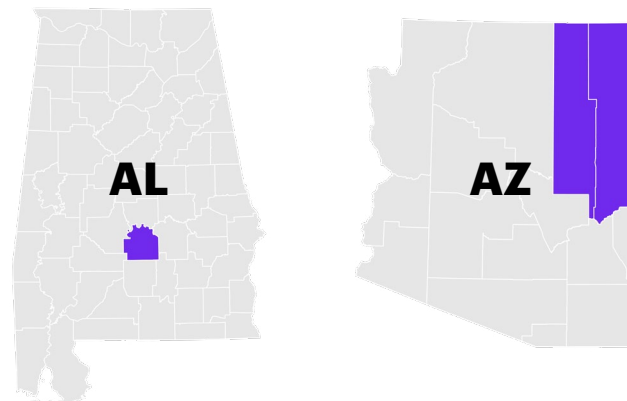
By addressing these policy priorities, digital health technologies may help reduce barriers to care and improve maternal health outcomes, particularly in under-resourced communities.

March of Dimes Mom & Baby Mobile Health Centers

March of Dimes partners with local organizations and healthcare systems to bring maternity care services directly to communities with limited access through the Mom & Baby Mobile Health Centers program. The program currently operates seven mobile health centers across Ohio, New York, Arizona, Washington, D.C., and Texas, with additional sites launching in 2026.⁶¹ These mobile clinics provide services spanning pre-pregnancy, prenatal, postpartum, and newborn care.

In 2026, new Mom & Baby Mobile Health Centers will launch in:

- Navajo and Apache counties in Arizona, two rural counties
- Lowndes County, Alabama, a maternity care desert



The Rural Health Transformation Program: state approaches to address maternity care access⁶²

The Rural Health Transformation Program (RHTP), created through H.R. 1, will distribute \$50 billion over 10 years to strengthen healthcare delivery in rural communities. The initiative presents an opportunity for states to modernize health systems, improve access to maternity care, and test innovative models of care delivery.

Because states will implement different strategies and receive varying levels of funding, continued evaluation will be important to identify which approaches most effectively improve access and outcomes.

Promising state initiatives:



Regional care networks

Alabama, California, Pennsylvania, and South Dakota are implementing hub-and-spoke models to expand specialty care access in rural communities.



Addressing labor and delivery unit closures

Indiana is training rural emergency departments to manage obstetric emergencies, Ohio is pursuing policies to expand delivery at birth centers, and Washington is exploring new hospital financing approaches to help sustain maternity services.



Telehealth

Alaska and Maine are expanding behavioral telehealth services, remote fetal monitoring, and cloud-based technologies to support perinatal care in tribal and rural communities.



Workforce development

States including Illinois, Missouri, Nevada, and New Jersey are investing in scholarships and training opportunities for doulas, midwives, family physicians, community health workers, lactation consultants, and home visitors.



Value based payment

Tennessee and Colorado are incorporating maternal health into new rural value-based payment initiatives.

Conclusion

Maternity care deserts are not inevitable.

Every family deserves access to high-quality maternity care—no matter where they live. With coordinated action and sustained investment, we can build a future where all families can access the care and support they need.

The challenge

Access to maternity care in the U.S. remains uneven, with millions of families living in communities facing shortages of obstetric clinicians, limited access to birthing facilities, long travel distances, and financial barriers to care. In many rural and under-resourced communities, these challenges are compounded by hospital labor and delivery unit closures and persistent workforce shortages.

The path forward

Improving access to maternity care will require coordinated action across healthcare systems, policymakers, payors, public health agencies, community organizations, and maternal and child health advocates. The absence of maternity care results from interlocking challenges, which means there is no single solution; it also means there are multiple opportunities for action.

Essential investments

Expanding the maternity care workforce, strengthening hospital and birth center infrastructure, improving insurance coverage, integrating midwives and doulas into care teams, and investing in telehealth and mobile health models are all important strategies to improve access and outcomes for moms and babies.

March of Dimes' role

Organizations like March of Dimes play an important role in advancing data-driven solutions, supporting communities, elevating evidence-based policy and systems change, and bringing partners together to address gaps in care. Continued collaboration and investment will be critical to ensuring all families can access the care and support they need.

Explore the data

To explore additional national, state, and county-level maternal and infant health data, visit March of Dimes [PeriStats](#), a public data resource designed to support research, policy, and community action.

Limitations

This report measures maternity care access at the county level using available national data on obstetric clinicians, birthing facilities, and insurance coverage. County-level designations may not fully reflect local variation in care access, including transportation barriers, appointment availability, or differences in quality of care. In addition, national datasets may contain reporting delays or incomplete information on clinicians and facilities, and the designations do not capture all professionals who support pregnancy and birth, such as doulas or community health workers.

Despite these limitations, these measures provide an important national view of geographic patterns and trends in maternity care access across the U.S.

For more information about definitions, data sources, and methods, see our [technical notes](#).

"Nowhere to Go: Maternity Care Access Across the U.S." was produced by March of Dimes. Lead sponsorship for this report was provided by Ob Hospitalist Group (OBHG). OBHG has no role in the research design, data analysis, interpretation of findings, or development of conclusions presented in this report. March of Dimes retains sole editorial control over the content and any reference to the sponsor is limited to acknowledgement of its participation and support.

Abbreviations and definitions

AABC – American Association of Birth Centers

ABFM – American Board of Family Medicine

ACA – Affordable Care Act

ACNM – American College of Nurse Midwives

ACS – American Community Survey, Census Bureau

AHA – American Hospital Association

AI/AN – American Indian/Alaska Native

CABC – Commission for the Accreditation of Birth Centers

CDC – Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CM – Certified midwife

CMS – Centers for Medicare & Medicaid Services

CNM – Certified nurse midwife

CON – Certificate of need

DO – Doctor of osteopathic medicine

FPL – Federal poverty level

HRSA – Health Resources and Services Administration

MCD – Maternity care desert

MD – Doctor of medicine

NCHS – National Center for Health Statistics

NICU – Neonatal intensive care unit

NPPES – National Plan and Provider Enumeration System

OB-GYN – Obstetrician-gynecologist

PNC – Prenatal care

Topic	Definition	Associated data source
Birth center	A healthcare facility that follows the midwifery model of care and provides maternity care to low-risk birthing people.	American Association of Birth Centers
Doula	A non-clinical professional who provides physical, emotional, and informational support before, during, and after childbirth.	National Academy for State Health Policy
Certified nurse midwife	A registered nurse with additional training in midwifery, providing care to women throughout pregnancy, childbirth, and the postpartum period.	Centers for Medicare and Medicaid Services, National Provider Identifier file
Certified midwife	A midwife who meets specific educational and certification requirements to provide care to women during pregnancy, childbirth, and the postpartum period.	Centers for Medicare and Medicaid Services, National Provider Identifier file
Family physician	A doctor trained to care for common and chronic illnesses among both children and adults with an emphasis on person-centered care and general well-being.	American Board of Family Medicine
Federal poverty level	Measure used by the federal government to determine eligibility for certain programs and benefits based on income.	US Census Bureau, American Community Survey
Maternity care desert	A county with no birthing facilities or obstetric clinicians.	March of Dimes
Obstetrician-gynecologist	A physician (MD or DO) specializing in women's health, particularly in pregnancy, childbirth, and disorders of the reproductive system.	Health Resources and Services Administration, Area Health Resources File
Obstetric hospital	A hospital with a dedicated maternity ward or labor and delivery unit.	American Hospital Association, Annual Survey
Prenatal care	Healthcare services provided to pregnant individuals to monitor pregnancy and ensure the health of mom and baby.	National Center for Health Statistics, Natality file

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