Birth in Massachusetts: Falling rates, rising risks, and racial divides

Despite years of investment by the state, maternal health disparities continue to grow.

By Sarah Rahal Globe Staff, Updated April 3, 2026, 38 minutes ago

Brianna Smith-Thomson, a 35-year-old mother of three, played with her 5-month-old daughter, Serenity, on the couch as her other daughter, Heavyn, 4, watched television in the family's living room in Lynn. JESSICA RINALDI/GLOBE STAFF

For all the money and glory associated with the Massachusetts medical world, one of the oldest and most fundamental aspects of it is going in the wrong direction: giving birth.

Maternity units and birthing centers are closing. Too many low-risk pregnancies end up with deliveries by C-section, and too many patients, especially women of color, have disproportionately high numbers of complications and adverse outcomes.

Dr. Wendy Barr, a family physician who provides pregnancy care and conducts research, said maternal health too often receives intensive medical or surgical treatment.

“In the urban Northeast, we’re very good at caring for the sick and finding cures for acute rare diseases, and because we do that so well, we use a very specialized disease-oriented approach and apply it to the birth process, which does better with a holistic approach,” said Barr, who practiced in Massachusetts for 15 years and now helps run a family medicine residency at Yale School of Medicine.

Severe maternal complications among Massachusetts births are 16 percent higher than the national average and the rate nearly doubled between 2011 and 2020. Racial disparities in complication rates, C-section rates, and birth outcomes are widening, and patients with disabilities and those on MassHealth are seeing worse outcomes, too, particularly in Greater Boston.

These are all the more confounding given the big picture of health care in Massachusetts: Nearly 98 percent of the population has health insurance — the highest in the nation — and the state ranks in the top 10 for lowest rates of infant mortality, maternal mortality, and pre-term births, according to the March of Dimes 2025 report.

One development that has likely triggered a domino effect is the closure of 13 maternity units, totaling more than 100 beds, over the past decade, many of which were located in distant, rural areas far from Boston and its wealthy, celebrated medical centers.

As hospitals close their labor and delivery units, prenatal care declines, making it easier for doctors to miss high-risk conditions like high blood pressure. That can set the stage for more serious complications such as the blood pressure disorder pre-eclampsia, which increases the likelihood of C-sections — procedures with serious risks of their own.

Low-risk driving C-sections

The number of C-sections in Massachusetts is a particularly telling statistic: They are on the rise, with more than one-third of all births in the state being surgical. That's higher than the national average and, more important, is nearly double the optimal rate of 15 to 19 percent, according to the World Health Organization.

Maybe most shocking is that a sizable share of those — nearly 40 percent — occur in what are initially deemed low-risk pregnancies.

An incubator sat near a window inside the neonatal intensive care unit at Mount Auburn Hospital in Cambridge. ERIN CLARK/GLOBE STAFF

Erin Yang had at first seemed a low-risk, “stress-free” pregnancy and was preparing for an uncomplicated vaginal birth by staying active, following pre-natal exercise, and working with a doula. She ran, swam, and even hiked the Alps until week 34.

But then a placental complication convinced her doctors to induce her labor in November. After 26 hours, her baby turned sideways, and doctors recommended a C-section, which she had hoped to avoid.

“I had done everything to prepare for a smooth vaginal birth,” said Yang, a biotech engineer. “Part of me was sad, but part of me was relieved. They said I’d meet my baby in 10 minutes.”

C-sections are major surgeries that carry risks, including infection, blood clots, longer recovery times, and more complicated future pregnancies.

They have also been linked to disruptions in babies’ immune and gut development, leading to higher risks of allergies and metabolic conditions later in life, as well as to maternal stress and anxiety.

Yang said her care team “saved my life and my baby,” but the experience was harrowing: A painful second IV triggered panic before surgery, and she later developed an infection in her incision. In the weeks after, she wondered whether the surgery might have been avoidable. “If labor were spontaneous, maybe it would have been preventable,” she said. “I’m reconciling that induction meant my baby wasn’t ready.”

By one national standard, no more than 23.6 percent of women with low-risk pregnancies should deliver via C-section. But a review by the state several years ago found that only five of 32 reporting hospitals met that standard: Beth Israel Deaconess Hospital, Plymouth; Beverly Hospital; Cape Cod Hospital; Lowell General Hospital; and Mount Auburn Hospital.

The differences in C-section rates among hospitals are striking. For example, patients at Holy Family Hospital in Methuen, then owned by the for-profit Steward Health Care, were 14 percent more likely to have a C-section than those at Mount Auburn Hospital in Cambridge, despite each having similar numbers of low-risk births, according to data from the Massachusetts Health Policy Commission covering 2016 to 2024. Holy Family has since been acquired out of Steward's bankruptcy by Lawrence General and on Wednesday announced it will close its maternity unit as part of a consolidation.

Erin Yang with her daughter at her home in Somerville. JESSICA RINALDI/GLOBE STAFF

While complications such as those Yang experienced explain some number of C-sections, some specialists say there are many other factors that are less obvious to determine if all the surgical births are justified.

"The right number of C-sections isn't zero," said Dr. Neel Shah, chief medical officer of Maven Clinic, the world's largest virtual clinic for women's and family health.

"Sometimes they are necessary to save lives. But even on a case basis, inevitability isn't always clear, even if we know from zooming out that the majority of C-sections performed today should be avoidable."

One possible explanation that he and other specialists point to is the hospital itself, its culture and policies, from routines and financial incentives to staffing patterns, and risk tolerance that shape how labor units operate.

In many hospitals, C-sections are faster, easier to schedule, and reimbursed at higher rates, while a vaginal birth can require staffing a labor and delivery unit around the clock, often costing hospitals more.

Shah said if he could change one thing about maternal health, it would be for insurance companies to pay more for vaginal births than C-sections.

"If we want to fix problems, we have to financially support them with resources. Hospitals can bill insurance more for C-section deliveries, but a vaginal delivery costs more due to the need to staff a labor and delivery unit through an 18- [to] 24-hour labor," he said.

Through research, Shah's team found that a shortage of hospital beds can lead to a higher rate of C-sections.

He called the loss of 100 obstetric beds in Massachusetts over the last decade substantial. Among the hospitals that have shut their labor and delivery wards are North Adams, Harrington Memorial, Morton in Taunton, UMass Memorial Health Alliance Clinton–Leominster, and Holyoke Medical Center — many of which served low-income communities and those of color.

"I understand the economics that lead to hospitals closing maternity units for financial reasons, but if you look at where maternity units close, it disproportionately affects areas

outside Boston, particularly rural areas of the Commonwealth like Western Massachusetts," he said.

'Two complementary lenses'

Nurses worked at computer stations inside the neonatal intensive care unit at Mount Auburn Hospital in Cambridge. The hospital integrates midwives and obstetricians in its maternity care model, emphasizing patient-centered care and maintaining one of the lowest Cesarean section rates in the state. ERIN CLARK/GLOBE STAFF

One hospital that can show visible progress is Mount Auburn in Cambridge, which has one of the state's lowest C-section rates. Its leaders credit a strong patient-centered approach, where midwives make up more than half of its 34 providers. The hospital delivers about 220 babies each month and invests in hydrotherapy, video translation, and team-based simulation training — efforts clinicians said help reduce unnecessary C-sections while maintaining safety.

"You create a culture that sees birth through two complementary lenses," said Julie Mann, a midwife who leads Mount Auburn's simulation training program. "Midwifery

training views it as a natural, physiologic process. Physician training focuses on identifying and managing medical complications. When you bring those approaches together, you get care that's both safe and deeply centered on the individual."

Certified nurse-midwife Julie Mann (left) and Dr. Brette Young posed for a portrait inside a labor and delivery room at Mount Auburn Hospital in Cambridge. ERIN CLARK/GLOBE STAFF

A third of Mount Auburn's patients are on MassHealth, and doula Cheyenne Bell regularly transfers her clients there because midwives and OB/GYNs "take the time to support vaginal births," including breech deliveries that default to surgery elsewhere.

"They're not perfect, but Mount Auburn is almost like a birthing center inside a hospital," Bell said.

In 2024, Governor Maura Healey signed the Maternal Health Law, which creates licensing opportunities for birth workers, expands postpartum home visits, and extends MassHealth coverage to doulas. A nine-member maternal health task force created by the law is expected to deliver additional recommendations this spring.

One fact before them: the large differences in outcomes between white patients and Black, Hispanic, Asian, and publicly insured patients, said Kara Vidal, director of the Health Policy Commission, who presented findings on the disparities to the task force last fall.

“Even on measures where Massachusetts overall performs favorably compared to the US, we see these disparities,” Vidal said.

Indeed, Black women consistently have the highest C-section rates in Massachusetts, at 39 percent in 2024, up from 31 percent in 2019.

Diana Louis of Somerville had an unplanned C-section at 33 weeks after a routine ultrasound revealed a drop in her baby’s heart rate and blood flow through the umbilical cord. Louis later learned there was a problem with her placenta and questioned whether it could have been caught and addressed earlier.

“I do wonder if I needed this and why it was overlooked in my prenatal care,” she said.

Half of all births of Black children in Massachusetts occur at just five hospitals — Boston Medical Center, Brigham and Women’s Hospital, UMass Memorial Medical Center, Beth Israel Deaconess Medical Center, and Baystate Medical Center. Some of these hospitals have elevated C-section rates, “but location alone does not fully explain the racial division,” state health experts say.

Bell, a Boston-area doula and UMass Lowell undergraduate studying premed to become an OB/GYN, said much of her work involves educating clients and fiercely advocating for vaginal births in people who previously had C-sections when they’re safe. As a Black doula, she is especially vigilant, given the higher rates of complications faced by many Black women.

“I warn all of my clients about places where doulas consistently report poor care,” said Bell, 30, some of which she points to a “history of racism.”

More often, Bell sees rushed inductions including overuse of the induction drug Pitocin, relying too heavily on monitors and other machines, which can cascade into what she believes are avoidable C-sections. She said external fetal monitoring feeds this trend.

“Doctors err on the side of caution. If a baby’s heart rate dips for seven minutes, they’re already rushing to surgery. But by the time you get to the OR, the baby’s usually fine. It wasn’t truly necessary.”

Some in the industry say there are broader societal issues at play that contribute to these disparities.

For example, a highly dangerous form of blood disorder known as preeclampsia, said Dr. Chenchen Sun, an obstetrician who teaches at Tufts University School of Medicine, “disproportionately affects Black patients and those with lower socioeconomic status — not because of biology, but because of health care disparities.”

“From a systems standpoint, we have to train providers to recognize their biases and deliver culturally competent, trauma-informed care, especially for our most vulnerable patients.”

‘The risk doesn’t end when the baby is born’

Dr. Allison Bryant, an obstetrician and associate chief health equity officer at Mass General Brigham worked in the Labor and Delivery Unit at Massachusetts General Hospital on Feb. 17. SUZANNE KREITER/GLOBE STAFF

For some mothers, the danger doesn't end with delivery.

Experts say substance use disorder and mental health are now the leading drivers of the death of new mothers in Massachusetts.

Many of those deaths happen months after delivery, said Dr. Allison Bryant, an obstetrician and associate chief health equity officer at Mass General Brigham.

"They reveal how vulnerable the postpartum period is, especially when support systems fall away," she said.

A recent study by Massachusetts General Brigham also found that patients who undergo an unscheduled C-section face a much higher risk of stress in the weeks after birth.

“Substance use is the leading cause of death among young people, so it’s also the leading cause among pregnant and postpartum individuals,” Bryant said. “During pregnancy, we monitor people closely, but six months later, they may be disconnected from care. That’s when relapse, withdrawal, or mental health crises can occur.”

For Brianna Smith-Thomson, a 35-year-old mother of three girls who lives on the North Shore, the loss of follow-up care was devastating. She remembers that after her first daughter, Kennedy, was born, the baby was jaundiced, and instead of having her stay in the hospital overnight, they were discharged and told to return the next day for an appointment.

“I remember not having transportation, taking my newborn baby on the T as a first-time mom, and as I was standing there, I started crying and didn’t know what to do next or what was wrong with her,” Smith-Thomson said. “I knew I needed professional help when I started to get overwhelmed, crying for no reason.”

She is in therapy for postpartum anxiety and grief and wishes there had been more hands-on support — transportation, group care, practical help — beyond the standard six-week visit.

Brianna Smith-Thomson, a 35-year-old mother of three, reached out as her daughter Kennedy, 10, passed her sister 5-month-old Serenity back to her mom as Heavyn, 4, watched television in the family's living room in Lynn. JESSICA RINALDI/GLOBE STAFF

Brianna Smith-Thomson's daughter Serenity looked up from her crib. JESSICA RINALDI/GLOBE STAFF

More than 80 percent of pregnancy-related deaths are preventable, state data show. Reviewers found discrimination and mental health conditions in 44 percent of cases, substance use in more than half, and care-coordination failures in nearly as many, according to a 2024 report.

"We know half of maternal deaths occur postpartum, and one in five is tied to mental health," said Tufts' Dr. Sun. "The key is identifying risks early and putting the right supports in place before and after birth."

Postpartum depression figures heavily in a painfully public tragedy with the trial of Lindsay Clancy of Duxbury for the deaths of her three children in 2023 before attempting to take her own life. Clancy had repeatedly sought help for severe postpartum illness and her attorney has indicated he will cite extreme mental distress in her defense.

Maternal health providers say that improving outcomes will require confronting racism and other forms of discrimination in care, including to those with disabilities, and strengthening the economic and community supports that shape a person's health long before pregnancy.

"Maternal outcomes aren't determined by health care alone," Bryant said. "They're shaped by nutrition, housing, transportation, social support, and by lifetime stress and inequity. Even with excellent care, those factors matter."

Sarah Rahal can be reached at sarah.rahal@globe.com. Follow her on X @SarahRahal_ or Instagram @sarah.rahal.