

Protecting Moms and Babies in U.S. Disasters

Survey and Landscape Research Summary- 2026

Two Crises, One Population

Two national trends are converging on the same families: the United States has one of the highest maternal mortality rates of any developed nation, and climate-driven disasters are becoming more frequent and severe. Pregnant and postpartum women and their infants sit at the intersection of both crises, yet their unique needs are often overlooked in traditional disaster systems.

- **80%** of maternal deaths are estimated by the (CDC) to be preventable.
- **\$32.3B** societal cost of maternal morbidity across the 2019 U.S. birth cohort, through the child's fifth birthday.
- **23** billion-dollar disasters per year on average, 2020–2024 — 2.5x the long-term average.
- Evidence links climate disasters to adverse maternal and child health outcomes including severe maternal morbidity, stillbirth, pre-term birth, hypertensive disorders, and mental health disorders.

The Southeast (AL, FL, GA, LA, MS, NC, SC, TN, TX) **carries a disproportionate share of this risk.** It combines rising exposure to hurricanes, flooding, and extreme heat with the thinnest maternity care coverage in the country.

- **38.7%** of Southeastern counties are maternity care deserts.
- **23.8 vs 14.6** maternal deaths per 100,000 live births in rural vs. large metro counties.
- **\$769.5B** in disaster damages in the Southeast (2020–2024), vs. \$45B in the Northeast.

Recent storm-specific research reinforces the pattern:

- After hurricanes Laura and Ida in Louisiana, infant formula was the single most-requested item on a community hotline.
- After hurricanes Irma and Maria in Puerto Rico, 97% of postpartum women lost power for a week or more and 30% missed prenatal care.
- After Harvey in Texas, low-income pregnant respondents were far more likely to lose access to care than higher-income respondents.

What We Did and Learned

CARE led two complementary studies conducted March–August 2026: a practitioner survey and listening sessions engaging 50 maternal health and emergency response organizations and an Emory Rollins School of Public Health landscape analysis of 82 sources, including 17 peer-reviewed studies and 15 state and regional plans.

Cross-sector agreement that gaps exist

Both maternal health and emergency response organizations agree that current gaps leave pregnant and postpartum families vulnerable to preventable harm.

- **82%** of emergency organizations report no tailored plan for mom-and-baby needs.

“There’s a disconnect between the people [who] know emergencies and know disaster response, and the people that know how to help moms and babies.”

–**Emergency Response Org Survey Participant**

Limited, inconsistent cross-sector collaboration

Among organizations reporting cross-sector collaboration, that collaboration has largely focused on infant and young child feeding guidance rather than broader structural or systems change. This was reported by 42% of maternal health organizations and 33% of emergency response organizations.

Heat is an underrated hazard

Asked to name the greatest disaster risk to perinatal families, 70% of maternal health organizations chose extreme heat, while 48% of emergency organizations chose severe storms and hurricanes. Yet only 4 of 62 reviewed sources treat extreme heat as a primary hazard, despite a 16% increase in preterm births during heat waves.

Where the Gaps Are

Five structural gaps occur across coordination, data, definitions, guidance, and funding.

1. Two sectors, no bridge

Organizations closest to perinatal families are not routinely part of emergency management or VOAD (Voluntary Organizations Active in Disasters) structures.

- **42%** of emergency organizations have never collaborated with a maternal health organization.
- **33%** of maternal health organizations cite “no existing relationships” as their key barrier.

2. Missing from the plan and data

Pregnant and postpartum people and infants are often not named in official planning documents and are missing from disaster assessment tools. Evidence that disasters harm mothers and infants is strong. Evidence on which preparedness measures work is far more limited, and that gap inhibits investment.

“The biggest gap I see is data. All of the data sources used to inform our work are always lacking data on pregnant and postpartum populations.”

—**Emergency Response Org Survey Participant**

3. Definitional ambiguity leads to inaction

Perinatal families don’t fit neatly into standard disaster demographic categories, so responsibility often falls between the cracks. The federal CMIST access-and-functional-needs framework already lists pregnant women as an example, but the tool is under-utilized for this population.

4. Guidance doesn’t reach the ground

Federal agencies like the CDC and Administration for Strategic Preparedness and Response (ASPR) have built strong guidance documents, but they may not be reaching local practitioners.

- **93%** of maternal health organizations indicated a standardized preparedness toolkit would be helpful.
- **56%** of emergency organizations rely on rotating disaster volunteers with likely no perinatal training.

This traces to a structural cause: state plans align to federal guidance and local plans align to state guidance, so an omission at the federal level (e.g., the National Response Framework does not name perinatal populations; Emergency Support Function #8 names pediatric but not pregnant/postpartum populations) cascades down to the local level.

5. Funding inhibits progress

- **81%** of maternal health organizations cite lack of funding as a key barrier.
- **66%** of emergency response organizations agree.

Funding streams for maternal/child health and emergency preparedness rarely overlap. Title V, Public Health Emergency Preparedness Program, and the Hospital Preparedness Program each touch part of the problem but are limited in perinatal-specific disaster preparedness requirements and accountability mechanisms.

What States and Communities Can Do

Five sequenced actions, starting with low-cost moves that build the credibility and data needed for harder structural work.

1. Build the table before the storm

Identify and put maternal health representatives at the emergency planning table. Roughly 90% of maternal health organizations and emergency organizations rate a cross-sector model as valuable or highly valuable.

2. Name them in the plan

Name pregnant women, postpartum mothers, and infants separately in the at-risk sections of state emergency operations plans, since an unnamed population typically receives no allocated resources.

3. Improve data collection and assessment

Add perinatal and infant counts to rapid assessment tools and shelter intake forms, connect existing vital records and hospital data to disaster timelines, and consider integrating perinatal disaster preparedness experience into PRAMS.

4. Equip the frontline workforce

Invest in tailored emergency preparedness training for birth workers such as midwives, doulas, and community health workers as well as training for emergency response staff and volunteers on the unique needs of moms and babies in disasters.

- **93%** of maternal health organizations see real potential in doulas and community health workers being trusted partners in reaching families before, during, and after disasters.

“Trust infrastructure matters as much as physical infrastructure. Community health workers, doulas, and trusted local leaders are often the first line of response. Investing in them is not ‘nice to have’ — it is core emergency infrastructure.”

—**Maternal Health Org Survey Participant**

5. Build from what works

Five practices with some evidence of success:

1. Continuity of care (surge staffing, mobile services, referral systems)
2. Protected workforce (named plans for keeping birth workers and emergency responders trained and available)
3. Obstetric readiness (facility standards plus regional patient movement)

4. Infant feeding (private lactation space in shelter, safe formula distribution)
5. WIC/facility continuity (priority appointments, benefit replacement, cross-state transfers)

Some states already have adoptable models. The recommendation across the board is to adopt and adapt these tools rather than build new ones from scratch.

State Tools Ready to Adopt

State	Tool	What it Does
Florida	Neonatal/pediatric transport plan	Statewide transport organized around hurricane timing, with self-contained units.
Louisiana	Perinatal hotline & Infant Ready	A low-cost phone channel plus portable feeding kits and responder training.
North Carolina	Feeding Infants in a Disaster	Plain-language guidance a neighboring state could adapt within weeks.
South Carolina	EOP Annex 14	Named maternal and child health functions with a defined infant feeding supply chain.
Tennessee	EMS/ED guidelines	Standardized equipment, supplies, and training for obstetric and neonatal cases.
Texas	Regional Perinatal Care System Plan	Perinatal transport tied to a preparedness coalition, with triage and levels-of-care rules.

Bottom Line

The maternal mortality crisis and the rise in climate disasters are not separate stories — they compound for the same families. The solutions identified are largely low-cost and already exist in pockets across the Southeast; the primary barriers are coordination, naming, data, and accountable funding streams, not invention of new tools.

About CARE

Founded in 1945 when Americans rallied to send CARE PACKAGE® parcels to families in war-torn Europe, CARE has responded to every major crisis around the world for 80 years. In the U.S., CARE uniquely brings dual expertise in maternal health and humanitarian response and is the only national response organization focused on women- and family-centered recovery. This is because we know mothers and caregivers are family first-responders during crisis, and when they get the support they need, families can recover and communities are more resilient.

Responding to crises from Hurricane Ida to Spokane Wildfires, CARE partners with community-based organizations before, during, and after disasters to help families be safe, healthy, and thriving.

www.care.org/USPrograms