# What are *perinatal cash transfers*?

Perinatal cash transfers are direct, flexible cash payments made to pregnant and postpartum people, typically starting during pregnancy and continuing into the first months (or year) of a child's life. Unlike many public benefits, they place no restrictions on how funds are spent — families decide whether the money goes toward rent, diapers, transportation to prenatal visits, or catching up on a utility bill.

THE BASICS

The pregnancy-through-infancy window is one of the highest-poverty, highest-stress periods across the entire life course. Income typically drops as parents reduce work hours or leave jobs, while expenses rise sharply.

That combination of income shock and increased need makes this window a uniquely high-leverage moment for direct investment — and one where existing safety-net programs (which are often means-tested, conditional, or slow to disburse) frequently fail to reach families in time.

## OUTCOMES PERINATAL CASH TRANSFERS MOVE

A growing evidence base links unconditional cash during pregnancy and infancy to measurable improvements across several domains:

### BIRTH OUTCOMES

Reductions in preterm birth, low birthweight, and NICU admissions.

### MATERNAL MENTAL HEALTH

Reduced rates of postpartum depression and anxiety, and lower parenting stress.

### FINANCIAL SECURITY & HOUSING STABILITY

Reduced material hardship and lower risk of eviction during pregnancy and the newborn period.

### PRENATAL CARE UTILIZATION

Increased likelihood of adequate, timely prenatal care.

### CHILD WELFARE

Early evidence associates cash receipt with reduced risk of child maltreatment investigations, plausibly through reduced financial and parenting stress.

## SUPPLEMENTAL PROGRAMMING ALONGSIDE CASH

Cash is powerful on its own, but the strongest programs typically pair it with wraparound supports that address needs cash alone can't fully solve. Common examples include:

*Doula & birth support*

Continuous, culturally congruent support through pregnancy, labor, and postpartum.

*Home visiting*

Regular check-ins on maternal and infant health, safety, and connection to care.

*Lactation support*

Lactation and infant feeding support.

*Financial coaching*

Helping families build credit, access other benefits, or plan around the cash.

*Peer support & case management*

Connecting families to community, mental health resources, and follow-up care.

# Key program *design decisions*

Programs vary along several dimensions, and each has real trade-offs.

## ELIGIBILITY

### Universal

Every pregnant resident in a defined geography qualifies, regardless of income. This maximizes reach, avoids stigma, and simplifies enrollment and administration, but costs more per capita served.

### Medicaid-eligible / means-tested

Eligibility is tied to enrollment in Medicaid or another income threshold. This concentrates limited dollars on lower-income families and can align with existing public financing streams (e.g., TANF, Medicaid), but adds administrative burden and can exclude families just above the cutoff.

## PAYMENT STRUCTURE

### One-time payment

A single lump sum, often at a fixed point (e.g., a "baby bonus" at birth). Simple to administer, but doesn't address ongoing, recurring hardship across pregnancy.

### Ongoing / recurring payments

Regular disbursements (monthly or biweekly) across pregnancy and/or infancy. More closely mirrors how income and expenses actually function for a household, smooths hardship over time, and allows families to plan.

## TIMING

Programs differ in whether payments begin at pregnancy confirmation, a specific trimester, or only after birth. Starting during pregnancy — rather than waiting for birth — reaches families during the window when income drops and prenatal care and stress-related outcomes are most sensitive to added resources.

## RECOMMENDED BEST PRACTICES

Based on the current evidence base and program experience to date, we recommend that perinatal cash transfer programs:

01

*Start payments during pregnancy*, not at or after birth, to capture the full window of financial and physiological vulnerability.

02

Use *repeat, recurring payments* across pregnancy (rather than a single lump sum), so support tracks ongoing need rather than a single moment in time.

03

*Pair cash with supplemental programming* — doula care, home visiting, lactation support, and care coordination — so families have both flexible resources and a connected support system, rather than cash operating in isolation.

Programs that combine these three elements are best positioned to move the full range of outcomes above: birth outcomes, maternal mental health, financial stability, and downstream child welfare and development outcomes.