

Moving Upstream: Perinatal Cash Transfers as a Tool to Address Inequities in Birth Outcomes

Kamaria Taylor, MD,¹ Yuan He, MD, MPH, MSHP,^{1,2,3} Zea Malawa, MD, MPH^{4,5}

The United States has an exceptionally high preterm birth rate, which features inequities that impact many Black, Indigenous, and Pacific Islander families. Unconditional perinatal cash transfers, which offer cash assistance to pregnant and postpartum women with no strings attached, are a promising tool to address disparate birth outcomes. Canada and the United States both have an emerging evidence base that supports the impact of perinatal cash transfers on birth outcomes for all groups, but especially for those who are from under-resourced communities. We review the evidence supporting the use of perinatal cash transfers in Canada and the United States, discuss the distinct advantages of perinatal cash transfers, and highlight examples of growing momentum and support for this type of intervention. Although there are still challenges to their widespread expansion and adoption, we argue that perinatal cash transfers should be included as an essential tool in the US public health toolbox to advance health and financial equity while optimizing dignity, autonomy, and flexibility for families in a changing policy landscape.

PRETERM BIRTHS ARE INCREASING IN THE UNITED STATES, WITH STARK RACIAL INEQUITIES

The US preterm birth rate is exceptionally high and worsening. From 2014 to 2024, the preterm birth rate increased from 9.6% to 10.4%.¹ Stark inequities are pervasive within this trend,² likely due to systemic racism embedded within political, legal, economic, health care, school, and criminal justice systems, which perpetuates differential access to housing, education, and economic opportunity.³ In particular, Black, American Indian and Alaska Native, and Pacific Islander infants are at higher risk of preterm birth, with rates of 14.7%, 12.5%, and 12.3%, respectively, whereas white infants have a preterm birth rate of 9.5%.¹ Because race is a social construct, rather than a biological reality,⁴ we attribute these inequities to racism, not race itself. A multidisciplinary scientific workgroup convened by the March of Dimes to describe and analyze causes of Black-white inequities in preterm birth concluded that although the etiology of preterm birth is likely multifactorial and complex, racism in many forms has repeatedly been linked with many of the plausible midstream and downstream mechanisms. In particular, concentrated poverty and increased exposure to neighborhood environmental hazards are direct consequences of structurally racist policies such as redlining and racialized segregation, whereas

abstract

¹Children's Hospital of Philadelphia, Philadelphia, Pennsylvania; ²Division of General Pediatrics, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, Pennsylvania; ³Philadelphia Department of Public Health, Division of Reproductive, Adolescent, and Child Health, Philadelphia, Pennsylvania; ⁴The California Abundant Birth Project, San Francisco, California; and ⁵University of California, San Francisco, San Francisco, California

Address correspondence to: K. Taylor, Pediatrics Residency Program, Children's Hospital of Philadelphia, 3401 Civic Center Blvd M985, Philadelphia, PA, 19104. taylorlk14@chop.edu

K Taylor conceptualized the article, drafted the initial manuscript, and critically reviewed and revised the manuscript. Y He and Z Malawa conceptualized the article and critically reviewed and revised the manuscript. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

CONFLICT OF INTEREST DISCLOSURES: The authors have no conflicts of interest to disclose.

FUNDING: No funding was secured for this manuscript.

Accepted for Publication Date: June 17, 2026

<https://doi.org/10.1542/peds.2025-075073>

Copyright © 2026 by the American Academy of Pediatrics

To cite: Taylor K, He Y, and Malawa Z. Moving Upstream: Perinatal Cash Transfers as a Tool to Address Inequities in Birth Outcomes. *Pediatrics*. 2026;158(3):e2025075073

ongoing racial discrimination in employment, housing, policing, and sentencing exacerbate chronic stress experienced by Black women.² Consistent with this analysis, studies have demonstrated that compared with Black mothers born outside the United States, US-born Black mothers are more likely to deliver preterm or low birth weight (LBW) infants,⁵ and African-born Black women experience preterm birth at similar rates as US-born white women.⁶ Ultimately, a bounty of evidence supports the distinct role of individual, institutional, and structural racism within the United States underlying inequitable birth outcomes.

Although the multifactorial impacts of racism influence disproportionate preterm birth rates, it remains challenging to isolate a singular cause for increasing prematurity rates across all groups. Still, the consequences of preterm birth are clear. Preterm births are a leading cause of infant mortality, and premature infants who do survive are at increased risk for developmental delays, chronic conditions, and long-term disabilities.⁷ For Black and Indigenous populations already subject to adversity secondary to structural racism, preterm birth presents intergenerational human and financial costs because it can perpetuate hardship and poor health outcomes across subsequent generations. These harms underscore the reality that US infants need protection from racism and poverty before they are even born, in turn posing the question of how we can buffer their negative impacts on birthing parents and their pregnancies. In light of recent research indicating worsening birth outcomes experienced by low-income families,⁸ who are disproportionately Black and other racial and ethnic minorities,³ there is a growing need for targeted financial support during the perinatal period.

PERINATAL CASH TRANSFERS IMPROVE BIRTH OUTCOMES

Unconditional cash transfers during pregnancy and infancy are an emerging health intervention that can reduce preterm births and address inequitable infant health outcomes. Rather than imposing burdens such as documentation of work and other administrative requirements, cash transfers are disbursed regularly with no strings attached, typically beginning in the second trimester of pregnancy and continuing through the first year of life to reduce the financial stressors of the perinatal period. For Black and Indigenous families who have experienced centuries of racialized segregation of resources and economic exclusion, direct cash payments may also symbolize intentional investment in previously disinvested communities, prioritizing dignity and autonomy in their implementation.

Population studies like the Healthy Baby Prenatal Benefit (HBPB) in Manitoba, Canada, demonstrate the promise of unconditional cash interventions. Low-income women who received a small monthly cash benefit (approximately \$81 per month) during the second and third trimester of pregnancy had a 17.5% reduction in preterm births and a

21% reduction in LBW rates compared with low-income peers who did not receive the cash benefit.⁹ Similar findings of reduced preterm and LBW rates were demonstrated when evaluating the HBPB among Manitoba's First Nations families.¹⁰ However, the most recent updates from the program found that with no change to the cash benefit amount in nearly 20 years, the improved birth outcomes were nearly eliminated, suggesting the importance of a cash payment that is adjusted for inflation and cost of living.¹¹ Although Canada has a vastly different social safety net than the United States, the HBPB highlights the potential of direct cash payments on birth outcomes.

The United States also offers compelling data regarding perinatal cash transfers. The Alaska Permanent Fund Dividend (Alaska PFD) is one of the first longstanding, public income supplementation programs in the country. All Alaska residents are eligible for annual cash disbursements that are derived from a state fund of oil profits. Studies show that an additional \$1000 from the Alaska PFD distributed at any time during pregnancy increased birthweight by an average of 17.7 g and significantly decreased the likelihood of a LBW outcome. It is notable that the greatest gains were among those with lower levels of educational attainment; mothers with a high school diploma or lower experienced an increase of 30.8 to 41.5 g in birthweight. The same study found a statistically significant increase of one-tenth of a week in gestational age, which could explain between 34% and 57% of the birthweight increase.¹² The Alaska PFD is also theorized to improve the in-utero environment and promote fetal development. Male twin survival rates, which typically decline in times of economic adversity, increased following Alaska PFD payment, suggesting a reduction of in-utero selection against male twin fetuses. The total amount of Alaska PFD payments appears to be a driver of this finding,¹³ indicating that even 1-time cash transfers have the potential to impact birth outcomes.

RxKids is one example of a US perinatal unconditional cash transfer program. It is a population-level intervention based in Flint, Michigan that provides \$1500 during mid-pregnancy (as early as 16 weeks gestation) and \$500 per month starting after delivery for 12 months postpartum. In recently published findings, RxKids was linked with a 2.7% reduction in the preterm birth rate, a 4.2% reduction in the LBW rate, and a 4.4% reduction in neonatal intensive care unit hospitalizations for families receiving cash prescriptions when compared with a group of matched cities.¹⁴ In addition, researchers found significant reductions in infant maltreatment investigations during the first 6 months of life,¹⁵ a promising indication that the impacts of perinatal cash transfers extend beyond just birth outcomes.

Programs like RxKids and Alaska PFD provide evidence to support various mechanisms by which perinatal cash may improve birth outcomes. Studies indicate that known portions of the inequity in preterm birth rates between

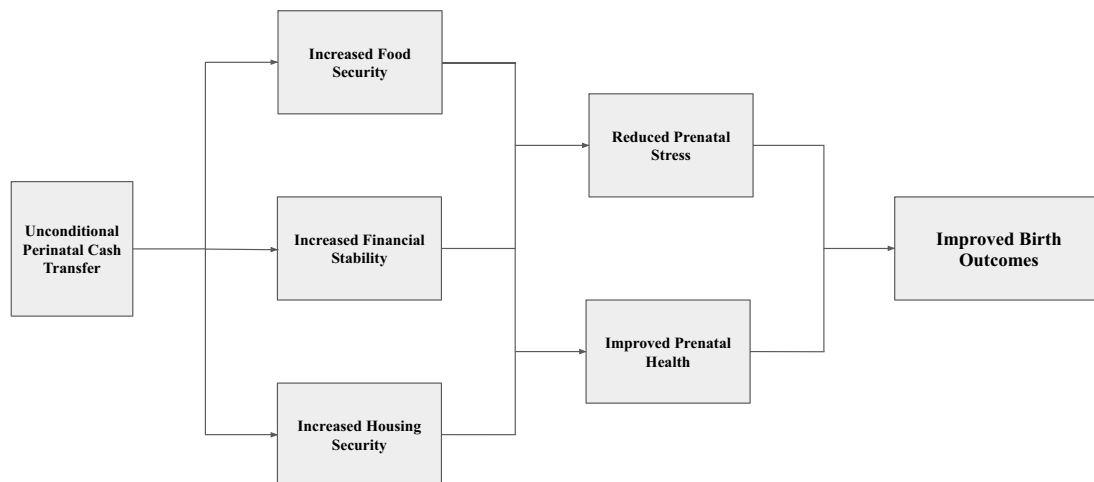


FIGURE 1.

Our hypothetical mechanistic framework shares pathways through which perinatal cash transfers may improve birth outcomes. Cash gives families flexibility and may improve food and housing security and overall financial stability. These factors contribute to both prenatal stress and general prenatal health, which we hypothesize improves birth outcomes.

Black and white families can be attributed to social and economic factors, as well as preconception and prenatal care.¹⁶ These findings suggest that perinatal cash transfers may be able to help address the racial gap in preterm birth rates, perhaps by addressing economic hardship and increasing access to needed supports. The mechanisms by which cash promotes healthier pregnancies are undoubtedly complex (Figure 1), but findings from RxKids support our conceptual framework. The program has demonstrated that cash payments are associated with reduced likelihood of eviction and postpartum depression,¹⁷ as well as reduced postpartum parenting stress.¹⁸ They have also shown increased prenatal care use when receiving cash prescriptions, positing that financial support allows families to cover the direct and indirect costs of accessing care.¹⁹ Taken together, these early findings from RxKids demonstrate how maternal gains may translate to infant outcomes.

PERINATAL CASH TRANSFERS ARE FEASIBLE, FLEXIBLE, AND EQUITABLE

Programs like the Alaska PFD and Flint's RxKids demonstrate that publicly funded cash transfer programs are both feasible and effective. In cities and counties across the country, perinatal cash transfer programs are spreading and gaining momentum, with at least 39 programs currently offering unconditional cash transfers during pregnancy and infancy. These initiatives have been implemented through a range of private-public partnerships, with some receiving millions in public funding.²⁰ For example, the Abundant Birth Project in California received millions in state funding to expand to multiple counties across the state, and New York City's Bridge Project received both city and state funds to expand to specific populations across

New York and other states. The aforementioned RxKids is funded by a combination of philanthropic and state dollars, including funding from the federal cash assistance program Temporary Assistance for Needy Families (TANF).²¹ The number and scale of these programs, including public funds granted to disburse as direct cash payments, is an early testament to the interest and critical need for new and bold interventions to address poor perinatal health outcomes in this country, especially among racialized and low-income families. Importantly, these individual programs have flourished in part because of organizing efforts of the Mother and Infant Cash Coalition (MICC). MICC is a coalition of program practitioners, researchers, and advocates who share learnings to advance the evidence base and support federal policy for perinatal cash transfer legislation.²⁰ The number and reach of perinatal cash transfer programs across the country demonstrate their political feasibility on both local and state levels, posing the question of how programs can be scaled more broadly.

Reimagining perinatal cash transfers as a health intervention also acknowledges where our existing social safety net falls short. Although targeted benefits like Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) play critical roles in providing health coverage and food access, they are administratively burdensome for participants to apply and for governments to administer.²² Furthermore, they do not flexibly address other social determinants of health, such as financial, housing, and utility insecurity. Perinatal cash transfers can work together with existing in-kind benefits to fill crucial gaps as family needs, incomes, and benefit eligibility statuses change in the

perinatal period. Families benefit from the dignity and autonomy to identify their unique financial needs, contrasting with the stigmatizing work requirements and benefit cliffs that currently plague our social safety net.

Perinatal cash transfers offer the opportunity to build a more equitable and just social safety net. Beyond the benefits seen in all groups, income supplementation may address inequitable birth outcomes for under-resourced communities. For example, Canada's HBPB for low-income women ultimately reduced population-level birth inequities between those receiving the supplement and women with higher incomes.²³ Similarly, the US Earned Income Tax Credit (EITC), notably a conditional cash transfer structurally different from programs previously discussed, has been shown to ameliorate birth inequities. Specifically, although mothers in all groups receiving the EITC during pregnancy had improvements in LBW and gestational age, these gains were most profound for Black families.²⁴ Perinatal cash transfer programs like RxKids and Abundant Birth Project are already prioritizing equity in their implementation. RxKids started in Flint, Michigan, where there are high levels of child poverty and inequitable birth outcomes disproportionately affecting the city's Black population,¹⁷ and have since expanded to cities and counties across the state. Similarly, the Abundant Birth Project centered its intervention specifically around the groups facing the highest risk of adverse birth outcomes, including Black and Pacific Islander pregnant people.²⁵ These programs suggest that when designed and implemented with a lens toward equity to address communities of highest need, there is potential to begin closing racial and economic health gaps.

Community-centered design has also been a defining feature of many perinatal cash transfer programs, ensuring that those who are most impacted help guide effective and efficient implementation. The Abundant Birth Project and Philly Joy Bank, another perinatal cash transfer program that was created to address inequities in infant mortality and prematurity, have made community voice and expertise a central pillar of program design, implementation, and evaluation.²⁶ This approach ensures that those who have been most impacted by adverse birth outcomes have a seat at the table and are actively involved in decision-making around how best to design, evaluate, and scale programs meant to support them. Community co-design not only ensures improved trust and uptake of perinatal cash transfers but also strengthens the efficacy and impact of services provided. In addition, Abundant Birth Project and Philly Joy Bank both started as programs implemented by local health departments, presenting an opportunity to support participants with direct cash payments in a way that may increase parents' trust in local institutions.

NEXT STEPS FOR PERINATAL CASH TRANSFERS

Despite the emerging promise of perinatal cash transfers, significant barriers remain for policy expansion across the US. Key knowledge gaps persist, and large-scale, population-level interventions similar to Canada's HBPB are needed to examine rarer outcomes such as preterm birth and infant mortality. Stigma around the need for cash assistance is also a major barrier. Although cash benefits have long existed as part of our country's social safety net, harmful and often racist narratives persist with regards to poverty and welfare programs, which hinder advancement and expansion of these policies.²⁷ Recent legislation, including HR-1, which was signed into federal law in 2025 with numerous tax and spending provisions,²⁸ has significantly reduced federal funding and further increased administrative requirements for key social safety net programs such as Medicaid and SNAP. Although these policies present as race-neutral, not explicitly mentioning race or ethnicity, their emphasis on factors like work requirements, which are steeped in racist and discriminatory practices,²⁹ and immigration status both disproportionately impact racial and ethnic minorities.³⁰ Policy changes like HR-1 present a major barrier not only because they threaten the prospect of perinatal health equity as is,³¹ but also because they make budgetary choices even more difficult for local and state leaders who must consider how to support new initiatives, such as perinatal cash transfer programs, while receiving fewer federal dollars.

Still, programs like RxKids, Bridge Project, and Abundant Birth Project that have successfully scaled using public dollars offer optimism for perinatal cash transfer programs.²⁰ These programs have demonstrated the power of public-private partnerships to fund and scale innovative strategies to overcome entrenched health disparities, garner more robust evidence to support perinatal cash transfers in the United States, and generate broad-based political and public support. As pediatricians, we have an opportunity both as practitioners and advocates to support these efforts. At the individual and family level, we can provide information and referrals for free tax preparation services that empower families to access tax credits—another form of cash transfers—that are beginning to scale and spread nationally. At the community and local level, we can leverage resources like MICC to identify and connect with local perinatal cash transfer initiatives or learn how best to support thoughtful design and implementation of new programs. At the policy level, we can join local coalitions that work together to advocate for economic security initiatives that prioritize dignity instead of stigma and flexibility instead of administrative burden. As champions of child health, all pediatricians can support perinatal cash transfer policy advancement by reframing it as a preventive health intervention to improve birth outcomes and promote long-term well-being for all families.

ABBREVIATIONS

Alaska PFD: Alaska Permanent Fund Dividend
 EITC: Earned Income Tax Credit
 HBPB: Healthy Baby Prenatal Benefit
 LBW: low birth weight
 MICC: Mother Infant Cash Coalition
 SNAP: Supplemental Nutrition Assistance Program
 TANF: Temporary Assistance for Needy Families
 WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

REFERENCES

1. March of Dimes. 2025 March of Dimes report card for United States. PeriStats. Accessed December 12, 2025. <https://www.marchofdimes.org/peristats/reports/united-states/report-card>
2. Braveman P, Dominguez TP, Burke W, et al. Explaining the black-white disparity in preterm birth: a consensus statement from a multi-disciplinary scientific work group convened by the March of Dimes. *Front Reprod Health*. 2021;3:684207. PubMed doi: 10.3389/frph.2021.684207
3. Braveman PA, Arkin E, Proctor D, Kauh T, Holm N. Systemic and structural racism: definitions, examples, health damages, and approaches to dismantling. *Health Aff (Millwood)*. 2022;41(2):171–178. PubMed doi: 10.1377/hlthaff.2021.01394
4. Smedley A, Smedley BD. Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *Am Psychol*. 2005;60(1):16–26. PubMed doi: 10.1037/0003-066X.60.1.16
5. Montoya-Williams D, Barreto A, Fuentes-Afflick E, Collins JW Jr. Nativity and perinatal outcome disparities in the United States: beyond the immigrant paradox. *Semin Perinatol*. 2022;46(8):151658. PubMed doi: 10.1016/j.semperi.2022.151658
6. Braveman P, Heck K, Dominguez TP, Marchi K, Burke W, Holm N. African immigrants' favorable preterm birth rates challenge genetic etiology of the Black-White disparity in preterm birth. *Front Public Health*. 2024;11:1321331. PubMed doi: 10.3389/fpubh.2023.1321331
7. Waitzman NJ, Jalali A, Grosse SD. Preterm birth lifetime costs in the United States in 2016: an update. *Semin Perinatol*. 2021;45(3):151390. PubMed doi: 10.1016/j.semperi.2021.151390
8. Dore EC, Reynolds MM, Collin DF, Hamad R. Trends in poverty and birth outcomes in the US. *JAMA Pediatr*. 2026;180(5):583-585. PubMed doi: 10.1001/jamapediatrics.2026.0004
9. Brownell MD, Chartier MJ, Nickel NC, et al; PATHS Equity for Children Team. Unconditional prenatal income supplement and birth outcomes. *Pediatrics*. 2016;137(6):e20152992. PubMed doi: 10.1542/peds.2015-2992
10. Enns JE, Nickel NC, Chartier M, et al. An unconditional prenatal income supplement is associated with improved birth and early childhood outcomes among First Nations children in Manitoba, Canada: a population-based cohort study. *BMC Pregnancy Childbirth*. 2021;21(1):312. PubMed doi: 10.1186/s12884-021-03782-w
11. Enns JE, Brownell M, Nickel NC, et al. Birth and early childhood outcomes in families receiving an unconditional prenatal cash benefit. *JAMA Netw Open*. 2025;8(8):e2526996. PubMed doi: 10.1001/jamanetworkopen.2025.26996
12. Chung W, Ha H, Kim B. Money transfer and birth weight: evidence from the Alaska Permanent Fund Dividend. *Econ Inq*. 2016;54(1):576–590. doi: 10.1111/ecin.12235
13. Singh P, Mark N, Cowan S. Male twin live births following unconditional cash transfers in Alaska: a time-series analysis. *Twin Res Hum Genet*. 2025;28(1):34–41. doi: 10.1017/thg.2024.50
14. Agarwal S, Shaefer HL, Zamani-Hank Y, Finegood E, LaChance J, Hanna M. The effects of the Rx Kids unconditional cash prescription programme during pregnancy and infancy on birth outcomes in the USA: a population-based, quasi-experimental study. *Lancet Public Health*. 2026;11(6):e355–e363. PubMed doi: 10.1016/S2468-2667(26)00055-1
15. Agarwal S, Shaefer HL, Jubaed S, Schneider W, Finegood ED, Hanna M. Cash transfers in the perinatal period and investigations of infant maltreatment. *JAMA Pediatr*. Published online May 7, 2026. PubMed doi: 10.1001/jamapediatrics.2026.1602
16. Thoma ME, Drew LB, Hirai AH, Kim TY, Fenelon A, Shenassa ED. Black-white disparities in preterm birth: geographic, social, and health determinants. *Am J Prev Med*. 2019;57(5):675–686. PubMed doi: 10.1016/j.amepre.2019.07.007
17. Hanna M, Shaefer HL, Finegood E, Agarwal S, Zamani-Hank Y, LaChance J. Hardship and hope: the relationship between unconditional prenatal and infant cash transfers, economic stability, and maternal mental health and well-being. *Am J Public Health*. 2025;115(12):2020–2029. PubMed doi: 10.2105/AJPH.2025.308244
18. Finegood ED, Shaefer HL, Zamani-Hank Y, et al. Quasi-experimental impacts of unconditional prenatal and infant cash transfers on postpartum parenting stress. *J Fam Psychol*. Published online April 27, 2026. doi: 10.1037/fam0001471
19. Hanna M, Agarwal S, Shaefer HL. Unconditional cash transfers and prenatal care utilization in Flint, Michigan. *JAMA Netw Open*. 2025;8(10):e2538406. PubMed doi: 10.1001/jamanetworkopen.2025.38406
20. Espinoza S, Goodman M, Towne C. *Unconditional Cash Transfer Programs as a Promising Reproductive and Racial Justice Policy Intervention*. Center on Reproductive Health, Law, and Policy, UCLA School of Law; February 2025. Accessed December 12, 2025. https://law.ucla.edu/sites/default/files/PDFs/Center_on_Reproductive_Health/2502%20UCT%20%283%29.pdf
21. Shaefer HL, Hanna M, Harris D, Richardson D, Laker M. Protecting the health of children with universal child cash benefits. *Lancet*. 2024;404(10469):2380–2391. PubMed doi: 10.1016/S0140-6736(24)02366-3
22. Negro D, Yazdani M, Benitez L, Kenyon CC, Fiks AG, Vasan A. Caregiver perspectives on improving government nutrition benefit programs. *Pediatrics*. 2024;154(5):e2024067012. PubMed doi: 10.1542/peds.2024-067012
23. Brownell M, Nickel NC, Chartier M, et al. An unconditional prenatal income supplement reduces population inequities in birth

- outcomes. *Health Aff (Millwood)*. 2018;37(3):447–455. PubMed doi: 10.1377/hlthaff.2017.1290
24. Komro KA, Markowitz S, Livingston MD, Wagenaar AC. Effects of state-level earned income tax credit laws on birth outcomes by race and ethnicity. *Health Equity*. 2019;3(1):61–67. PubMed doi: 10.1089/heq.2018.0061
 25. Karasek D, Williams JC, Taylor MA, et al. Designing the first pregnancy guaranteed income program in the United States: qualitative needs assessment and human-centered design to develop the Abundant Birth Project. *JMIR Form Res*. 2025;9(1):e60829. PubMed doi: 10.2196/60829
 26. Groves AK, Coaxum N, Sokale A, et al. Going beyond participation: community-led design and evaluation of the Philly Joy Bank. *Front Public Health*. 2026;14:1725812. PubMed doi: 10.3389/fpubh.2026.1725812
 27. Floyd I, Pavetti L, Meyer L, Safawi A. *TANF Policies Reflect Racist Legacy of Cash Assistance*. Center on Budget and Policy Priorities; 2021. Accessed March 8, 2026. <https://www.cbpp.org/research/income-security/tanf-policies-reflect-racist-legacy-of-cash-assistance>
 28. An Act to Provide for Reconciliation Pursuant to Title II of H Con Res 14, HR 1, 119th Cong (2025-2026). Accessed March 18, 2026. <https://www.congress.gov/bill/119th-congress/house-bill/1>
 29. Minoff E. *The Racist Roots of Work Requirements*. Center for the Study of Social Policy; 2020. Accessed March 19, 2026. <https://cssp.org/resource/racist-roots-of-work-requirements/>
 30. Ku L. Medicaid and SNAP advance equity but sometimes have hidden racial and ethnic barriers. *Health Aff (Millwood)*. 2023;42(10):1347–1350. PubMed doi: 10.1377/hlthaff.2023.00994
 31. Reese A, Edwardson N, Ruyak S, Tinkle MB. Federal policy changes endanger Medicaid's critical role in perinatal care and health equity. *J Obstet Gynecol Neonatal Nurs*. 2026;55(2):130–142. PubMed doi: 10.1016/j.jogn.2026.01.002