

# Listening to Mothers:

## Transforming Maternity Care in the United States

---

**POLICY BRIEF**

October 2026

# Listening to Mothers to Solve the Maternal Health Crisis

The United States is the most dangerous place to give birth of any high-income country.<sup>1</sup> We have the highest maternal mortality rate, persistently high rates of severe complications and deep inequities that have persisted for decades.<sup>2</sup> Black, American Indian and Alaska Native (AIAN), Native Hawaiian and Pacific Islander (NHP), low-income, and rural communities bear a disproportionate share of this crisis. Current trends will likely deepen the crisis further, including maternity unit closures,<sup>3</sup> pervasive staffing shortages and expanding maternity care deserts,<sup>4</sup> substantial cuts to Medicaid,<sup>5</sup> and a political environment that is sharply constraining reproductive and maternal health services.<sup>6</sup> The vast majority of maternal deaths and severe complications are preventable.<sup>7</sup> Yet progress has been limited.

Many childbearing families\* struggle in a health care system that was not designed around their needs and often works against them. Communities face pressures that are physical, social, financial, and environmental. Too often, our health care system does not engage with individuals as whole persons living in specific socioeconomic circumstances. Instead, the system too often treats people as a collection of body parts and medical conditions, disconnected from their communities and broader lives. This overmedicalized approach does not consistently provide care based on the best evidence available — which is often less high-tech and more high-touch — and can fail to offer the holistic, person-centered care needed to support health and well-being. Rather than being structured around achieving the best possible health outcomes for the people it serves, the health care system is shaped by fiscal pressures and the interests of large corporate actors, including hospital systems, insurers, and pharmaceutical companies. The result can be a loss of agency and autonomy for mothers and families, with disrespect and mistreatment remaining all too common, whether intentional or not.

**And the human and economic costs are substantial.** When care fails to meet people's needs, mothers and families may experience preventable physical and emotional harm, unnecessary interventions, loss of trust, and greater financial burdens. These consequences extend beyond individual families, **contributing to higher health care costs** and broader social and economic impacts. Notably, the total economic impact of negative pregnancy-related outcomes was estimated at **\$165.3 billion** in 2020.<sup>8</sup>

These problems sit within a broader set of challenges in health care access, affordability, quality, and accountability driven by policy decisions that reduce insurance coverage, limit

\* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities and do not always identify as “women” or “mothers.”

access to necessary services, weaken protections for patients, and impair our ability to understand, protect, and promote the public's health. **This is happening on two fronts: the dismantling of the federal research and public health surveillance infrastructure, and attacks on the collection and use of disaggregated data that are indispensable to understanding who is experiencing poor outcomes, identifying disparities within and across communities, and developing policy solutions that actually improve health.** When data are aggregated in ways that obscure differences by race, ethnicity, geography, income, age, or other factors, policymakers and health systems can miss who is being left behind and what interventions are most needed. Without reliable, sufficiently detailed data, it becomes harder to hold systems accountable, target resources effectively, and measure whether efforts to improve health are working for all communities.

Deep funding cuts have decimated capacity at the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and offices within the Department of Health and Human Services (HHS), hampering our ability to identify and address public health threats and track outcomes. Even worse, the assault on disaggregated data not only intentionally obscures the realities of the maternal health crisis (and the human and economic costs of health disparities more broadly), it eliminates the most important tool we have to solve it: facts. Existing data disappeared from government sites, particularly data on women, people of color, LGBTQI+ people, and people with disabilities. Additionally, requirements to disaggregate new data were scrapped.

Lack of disaggregated data hobbles our ability to solve the maternal health crisis, which is multifaceted and complex. Generic, one-size-fits-all approaches will not work. It demands a clear understanding of exactly where and how our health care system is failing specific communities in order to tailor solutions to these gaps and barriers. Transforming our maternity care system so that it is high-functioning, high-quality, and affordable requires public and private actors to be able to direct resources and tailored solutions individualized to meet the specific needs of particular communities.

And even as public health experts, policymakers, and advocates sound the alarm on the lack of needed data, there are also deep concerns about what is happening to people's individual health information. From threats to medical data privacy to the collection and sale of personal health data, people are increasingly worried about how their health data is being used against them, especially in immigrant families and communities of color.



***Listening to Mothers IV*** is a nationwide initiative to hear directly from childbearing women and people about their experiences and views on pregnancy, birth, the postpartum period, and early parenting. Against the backdrop of a widely recognized maternal health crisis, marked by substandard and inequitable outcomes with significant implications for the nation's population health, we aimed to identify concrete opportunities for improvement. More than 3,800 respondents from all 50 states and the District of Columbia completed an in-depth questionnaire about their views and experiences of childbearing. The questionnaire was available in English or Spanish, and participants shared their experiences of 2023 and 2024 births. Results were carefully weighted by key demographic variables to create a nationally representative data set of new mothers, at least 18 years old at the time of the survey, who gave birth to single babies in U.S. hospitals. Since 2021, the initiative has been guided by the *Listening to Mothers* Advisory Council (LTMAC), which exclusively represents and brings maternal health expertise from the communities most affected by the maternal health crisis.

The findings from the Fourth National *Listening to Mothers (LTM IV)* survey underscore the importance of decisive action to address the maternal health crisis. The experiences of the nearly 4,000 mothers we surveyed point to fundamental systemic problems with maternity care, and the gaps in the infrastructure needed to support birthing families with the care they want and need, delivered with dignity and respect. These challenges were more pronounced for groups that face greater barriers and worse outcomes and experiences. Across many analyses, consistent patterns and inequities emerged including:

- American Indian/Alaska Native and Native Hawaiian/Pacific Islander respondents, Black respondents and Multiracial/Multiethnic respondents often fared worse than others.
- Participants covered by Medicaid frequently had worse results than those with private insurance.
- Younger respondents reported worse experiences and outcomes than older ones.
- Those who identified one or more disabilities often faced greater difficulties.

What is troubling is how little progress has been made since the first *LTM* survey more than 20 years ago. Mothers have told us clearly what needs to be fixed, and which positive experiences are worth scaling and building on. We know the solutions that work. We need to transform the maternity care system so that it sustainably pays for the services and supports that work and that childbearing families want and need, and extends them to the people with the greatest needs in the places where childbearing families live. It's time to listen to mothers and act accordingly.

## Mothers Described Their Top Concerns

*Listening to Mothers IV* respondents provided a vivid picture of their experiences being pregnant, giving birth, and being back home with their babies. Among all the challenges and issues they raised, five top concerns surfaced.

### ***Listening to Mothers: Their Top Concerns***

- 1** Disrespect, disempowerment, discrimination, and mistreatment
- 2** Too little access to the high-quality care and support providers they want and need
- 3** Extensive, untreated mental health needs
- 4** Too much counterproductive, low-quality care that does not align with the best evidence
- 5** Unaffordable, inaccessible care
- 6** Unmet social and economic needs that affected their health



## 1

## Women experienced disrespect, disempowerment, discrimination and mistreatment

Many birthing people reported being mistreated and treated disrespectfully during their hospital stay. Participants told us they felt:

- Their knowledge and experiences were not valued (43%) .
- Providers did not respond to requests for help in a timely manner (42%).
- Not heard and listened to by providers (41%) .
- They experienced some type of discrimination (6%).
- Their customs and culture were not respected (27%).

"My OB I started with was absolutely rude and denied my request for VBAC. I ran out of time to look for a provider who would support my decision so I stayed with her until I was able to switch to another OB in the same office."

"I was yelled at to shut up and told nobody needs to make noise during labor by the rude OB."

"I wanted to change positions while in labor and sit on a ball but was not allowed."

"Nothing went well, between poor treatment when being induced and breaking my water before they should've, sending me home when I was in danger only to call me back, incorrect epidural placement, emergency C-section then being ignored about concerns postpartum and extreme pain I was in, only to end up with my incision opening and with sepsis back in the hospital two weeks later."

Repeatedly, survey results revealed a troubling disregard for the individuals' dignity, agency, and desire to optimize outcomes and experiences for themselves and their babies:

- **Most experienced restrictions in labor.** Many who wanted to move, eat, or drink during the hard physical work of labor were prohibited from doing so:
  - 51% did not walk at all during labor.
  - 25% reported being prohibited from drinking and 31% from eating.
- **Most (68%) who had an episiotomy had no say in the decision,** despite the procedure being rarely beneficial and having clear risks.

## 2

### Limited options for the high-quality care, support, and workforce that women want and need.

Access to high-quality care remains far too limited. Missed opportunities to better support families include:

- **Midwives** — whose performance positively stood out repeatedly in the data both prenatally and during birth — were used by only a small percentage of respondents (8%).
- **The great majority had no doula support;** only a small fraction had doula support spanning pregnancy, birth, and the postpartum period.
  - 9% of respondents reported having had the support of a doula during pregnancy, led by Black (17%) women, followed by AIAN-NHPI and Asian (11% each), Latina (9%) and White women (6%).
- Many were unable to have an initial **prenatal visit** as early as they wanted, during a critical window when toxic exposures can harm developing embryos and fetuses, miscarriage risk is high, and people have many questions and concerns.
  - 25% were unable to have an initial prenatal visit as early as they wanted, most frequently citing that no earlier visit was available (45%) or that their provider would not see them that early (37%).
- Many did not feed their babies exclusively or any **breast milk** for as long as they wanted.

"They didn't have an opening for my first prenatal visit, so I had to wait like almost two months."

"I had the same midwife and doula for both pregnancies. They knew what I wanted. I felt heard and cared for."

### 3 They had extensive mental health needs that were not addressed.

Mothers reported high rates of symptoms of anxiety and depression before pregnancy, during pregnancy, and in the initial months after birth. But the majority received no treatment, either counseling or medication. Many reported experiencing symptoms of severe psychological distress while caring for a newborn and navigating the challenges of early parenthood.

"I got postpartum depression and didn't have any help."

- **Pre-pregnancy mental health:** 23% reported depression or sadness in the 3 months before pregnancy, while 43% reported anxiety, worry, or stress.
- **Mental health during pregnancy:** 21% of respondents reported having symptoms of depression during pregnancy, led by AIAN-NHPI (38%) and Black (35%) mothers, and 49% of mothers with one or more disabilities reported symptoms of depression.
- **Receiving mental health help.** More than half (53%) of those with symptoms of anxiety and/or depression in the 12 weeks after giving birth received no counseling or medication between their birth and when they took the survey. A lack of treatment for these treatable conditions was especially elevated among Asian respondents (64%), as well as those with Medicaid (59%) and in nonmetropolitan counties (59%).

"I wish there was more discussion about postpartum emotional support and resources, as I wasn't fully prepared for the emotional changes that came with motherhood."

"I wish there was more support for me and the depression I felt early on after delivery. I felt like my feelings and concerns were ignored and felt very alone."

"I felt unheard at my prenatal appointment. I was moderately depressed and the doctor said nothing about it and didn't supply me with any support."

## There was too much counterproductive, low-quality care they didn't want or need, and that didn't align with the best evidence.

Just a fraction (5%) of respondents experienced what is defined as physiologic childbirth. Respondents' births were overwhelmingly shaped by widely used medications, procedures, and interventions that started or accelerated labor, or surgically removed the baby. Most births were scheduled, and labor inductions and cesareans took place before signals of readiness from pregnant women caused the onset of labor.

- **Scheduled births:** The majority of births were scheduled before labor started on its own, either planned labor inductions or planned cesareans.
- **39% experienced labor induction.** Many were pushed to have elective inductions (and even cesareans) based on predictions of a large baby that turned out to be of normal or even low birth weight. The most common reason for a medical induction (49%) was an approaching due date.
- **Medical interventions:** 71% of all respondents experienced at least two and 32% at least three of the following major interventions in birth: medical induction of labor, epidural analgesia, labor augmentation, assisted vaginal birth, and cesarean birth.

"I only managed to avoid an unnecessary induction because I was working with the midwives and was well informed."

"When I was giving birth, they told me I would have to get a C-section but didn't say why."

"I don't feel like the doctor on call tried hard enough to stick to my plan of a vaginal birth and lied about me needing a C-section just so she could be done quicker. There was little to no communication from the doctors while the C-section was being performed, I got no updates on my baby once he was delivered. I got little to no instructions on C-section care after I left the hospital."

"I wanted an unmedicated vaginal birth and had a C-section.... I feel like I had surgery, not a birth experience. I felt rushed at the hospital and misunderstood."

## 5

## Insurance coverage didn't translate to affordable, accessible care.

Having insurance did not guarantee childbearing families could actually get the care and support they needed, from the providers they chose, without delay, and without financial strain. Many respondents, disproportionately those covered by Medicaid, described providers who would not accept their insurance, services their plans would not cover, and billing problems that added stress at an already demanding time.

- **Coverage gaps left support out of reach.** Even where evidence-based support services are available, insurance frequently did not cover them. Only 9% of respondents had a doula during pregnancy, and the cost and lack of insurance coverage were common reasons for why families did not use that support.
- **Providers wouldn't accept their coverage.** Participants described being unable to find providers who would accept Medicaid, effectively putting covered benefits out of reach or causing substantial delays in accessing them.
- **Needed services were not covered.** The gap between having coverage and receiving needed care is widest for those covered by Medicaid. Medicaid enrollees were less likely to receive postpartum mental health treatment and nearly three times as likely to report unresolved social needs.

"I wish that more insurance companies would pay for doulas for women who have to go through labor on their own. It was really lonely."

"Even on Medicaid I struggled with insurance paying for my regular visits. It was a billing nightmare and caused so much unnecessary stress on my pregnancy and postpartum self."

"My child stopped latching when he turned one month old and I couldn't get support from a lactation nurse as I was not able to find one. They wouldn't accept Medicaid."

## 6

## Unmet social needs affected their health.

The survey identified families facing a variety of challenges, and most reported that the social needs they had identified during pregnancy had not been resolved.

- **Social needs during pregnancy:** More than one-third of respondents identified one or more among nine social needs queried, including being unemployed or without a regular income (20%), having trouble paying utilities (14%), and childcare needs (11%).

- **Needs that continued postpartum:** 22% of respondents told us that at least one of these issues identified during pregnancy was not resolved by the time they completed the questionnaire (on average, 52 weeks after their births). Black respondents (31%) most frequently identified ongoing needs, and respondents with Medicaid (34%) were three times as likely as those with private insurance (11%) to report unresolved social needs.
- **Employment and pregnancy accommodations:** 67% of respondents were employed during their recent pregnancy by someone else (59%) or were self-employed (8%). More than one in three (35%) of respondents employed by someone else had no paid time off to attend prenatal visits, a rate that rose to 62% among those with Medicaid. Among those employed by someone else, 47% needed temporary changes in working conditions for a healthy pregnancy; of those, 9% received no adjustment and 35% received partial adjustment.

“[During] postpartum, I had no time off work, so I had to go without pay. I had to return [to work] earlier than you’re allowed.”

## Maternity Care System Transformation Priorities

**Listening to Mothers IV makes one fact unmistakably clear: Childbearing families know what they need.** They want a health care system that is centered on them, accountable to them, and designed to provide **safe, high-quality, respectful, whole-person care for every mother, every birth, every time**. Achieving that vision requires a maternity care system built on dignity, autonomy, and shared decision-making, and one that serves every family, regardless of income, race or ethnicity, geography, language, disability, citizenship or immigration status, gender identity, or sexual orientation.

**The solutions are within reach. What is missing is not evidence — it is the collective commitment to act.** *LTM* has consistently identified the policies, practices and system failures that stand between childbearing families and the care they deserve. Reversing the current trajectory will require bold leadership and coordinated action across every level of the maternity care system — from federal and state governments to hospitals, health plans, accrediting bodies, professional organizations, employers, and community partners.

## Listening to Mothers: Turning Women's Experiences into Priority Action Areas

For more than two decades, **Listening to Mothers** has provided one of the nation's most comprehensive and trusted assessments of women's experiences during pregnancy, childbirth, and the postpartum period. While many maternal health reports focus primarily on clinical outcomes or administrative data, *LTM* begins with a different premise:

**Women themselves are experts in their own health care experiences.**

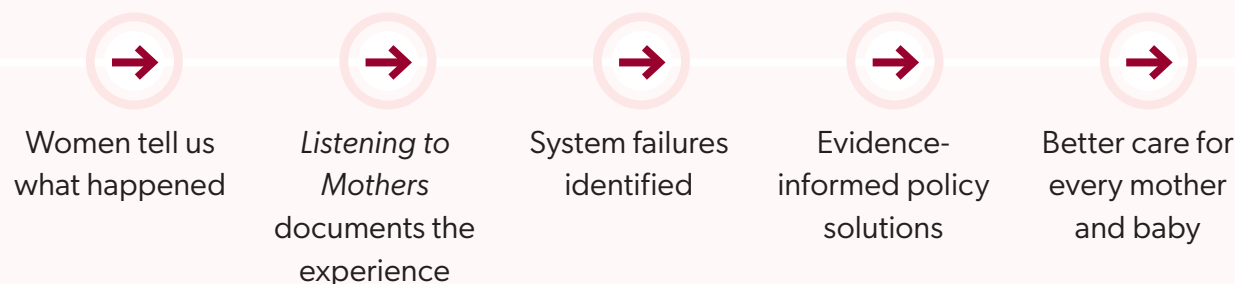
**Listening to Mothers has helped redefine what counts as evidence in maternity care, by not only measuring what happens to women during pregnancy and childbirth but also documenting what it feels like to experience the U.S. maternity care system.** By elevating women's voices alongside clinical and population health data, the survey has expanded how researchers, policymakers, health systems, and advocates understand quality, safety, equity, and accountability.

The survey captures dimensions of care that traditional quality measures often miss, including whether women felt heard, respected, involved in decisions, emotionally supported, able to access needed care, and treated equitably throughout pregnancy, birth, and the postpartum period. These experiences reveal not only how individual people experience care, but also how well the maternity care system is serving families.

Maternal health is shaped by far more than clinical care alone. People's experiences reflect the combined influence of health care delivery, insurance coverage, workforce capacity, behavioral health, workplace policies, family economic security, community resources, and the broader social and environmental conditions in which families live. **Listening to Mothers demonstrates that improving maternal health requires coordinated action across these systems, not isolated changes within them.**

### Listening to Mothers to Take Action

*Listening to Mothers* is more than a survey. It is the National Partnership for Women & Families' flagship vehicle for translating women's lived experiences into policies that improve maternity care, advance equity, and strengthen the health and well-being of women, infants, and families.



## Achieving Equity Must Be Central to Transforming Maternity Care

The experiences captured in *LTM IV* make clear that while every family deserves safe, respectful, and high-quality maternity care, not every family experiences it equally. Persistent disparities in maternal experiences and outcomes, particularly among Black and Indigenous women, remain one of the nation's most critical maternal health challenges, underscoring the urgent need to address the crises in these communities.

For decades, Black and Indigenous women have experienced disproportionately high rates of pregnancy-related complications, maternal mortality, mistreatment, and discrimination within the health care system. *LTM IV* reinforces that these inequities extend beyond clinical outcomes. Women of color are more likely to report feeling unheard, dismissed, disrespected, or unable to fully participate in decisions about their care. These experiences undermine trust, risk complications being overlooked, and contribute to poorer health outcomes. These disparities are not inevitable. They are the result of policies, systems, and practices, including structural racism, that have produced unequal access to resources, opportunities, and high-quality care.

Addressing the Black and Indigenous maternal health crisis therefore requires acknowledging the long history of harmful and discriminatory policies and practices by the federal government and many institutions and the need to build trust in light of the lasting impact of these failures. This is especially important for American Indian and Alaska Native people, whose welfare and safety the federal government has legal trust responsibility to protect under nation-to-nation treaty obligations that it has repeatedly failed to meet. Efforts to transform the maternity care system to respectfully and effectively serve all birthing people must encompass fulfilling federal trust responsibilities to AIAN people while honoring Tribal sovereignty and self-determination. Ultimately, it requires transforming the systems that shape women's experiences, from workforce diversity and respectful care to payment, accountability, coverage, community investment, and the social and economic conditions that support healthy families.

***Every maternal health system transformation action must be understood, developed, and implemented through a birth equity lens.*** Transforming maternity care requires not only improving care for all women, but also intentionally dismantling the barriers that have disproportionately harmed Black, Indigenous, and other historically marginalized communities. Building a maternity care system that is truly respectful, equitable, and accountable means ensuring that every childbearing family has the opportunity to experience a healthy pregnancy, a safe birth, and a strong start to building a family.

## System Transformation Priority Action Areas

The findings in this report reveal recurring patterns rather than isolated events that demand systemic solutions. Respondents describe challenges obtaining respectful care, participating in decisions, accessing behavioral health services, finding providers, maintaining insurance coverage, navigating fragmented systems, and balancing pregnancy and early parenthood with work, caregiving, and financial pressures. These are not individual failures — they are indicators of structural barriers that require structural solutions.

Guided by the top concerns expressed by the participants themselves, we identified six interconnected priority action areas for system transformation and translated them into specific goals for each priority area. **Together, these serve as the unified vision across systems for policymakers, industry leaders, health systems and providers, professional organizations, and community partners for what a maternity care system that centers women looks like.**

### *Listening to Mothers:* Priority Action Areas

- ① Guarantee respectful, holistic, culturally safe care for every mother, every birth, every time.
- ② Build, strengthen, and support the diverse workforce every mother needs.
- ③ Combat the maternal mental health crisis through integrated, culturally responsive systems of care.
- ④ Strengthen accountability for high-quality, evidence-based maternity care.
- ⑤ Expand and protect affordable, comprehensive health coverage.
- ⑥ Address the social, economic, and environmental conditions that shape maternal and infant health.



**These priorities are intentionally interconnected.** Respectful care depends on a well-supported workforce. High-quality care requires meaningful accountability. Coverage must translate into timely access to services. Mental health cannot be separated from maternity care, and health care alone cannot overcome the effects of poverty, unstable housing, food insecurity, transportation barriers, or inadequate paid leave. People do not experience these challenges in isolation, and neither should the policies designed to address them.

Recognizing that meaningful change requires coordinated action across many sectors, we have also developed a companion **Implementation Roadmap that translates the priority action areas' system transformation goals into detailed implementation strategies** for policymakers, health systems, health plans, employers, professional societies, accrediting bodies, community organizations, and other leaders responsible for improving maternity care. Together, these resources are intended to help move the field from evidence to action, and from action to measurable improvements in the health and well-being of women, infants, and families.

The system transformation priorities that follow are grounded in a simple but powerful principle: ***A maternity care system cannot be considered high quality unless it listens to women, respects their choices, responds to their needs, and is accountable for their experiences and outcomes.***



## **PRIORITY 1 | Guarantee respectful, holistic, culturally safe care for every mother, every birth, every time.**

**Respectful, person-centered maternity care is the foundation of safe, high-quality care — not an optional feature.** Every childbearing family deserves care that honors their dignity, autonomy, and lived experience. When women are ignored, coerced, discriminated against, or denied meaningful participation in decisions about their care, these are not simply poor patient experiences, they are failures of quality and patient safety.

*LTM IV* respondents repeatedly described not feeling heard, respected, or safe. These experiences were particularly pronounced among Black women, Indigenous women, and other historically marginalized communities, who continue to experience higher rates of discrimination, mistreatment, and preventable harm. **Respectful maternity care is both a quality imperative and a birth equity imperative.**

### **Systems Transformation Goals**

- **Make respectful maternity care a core patient safety and quality standard.** Federal and state policymakers, accrediting organizations, and health systems should recognize respectful, person-centered care as an essential component of quality, not a

secondary measure of patient experience. Mistreatment, discrimination, coercion, and failure to respond to patient concerns should be treated as preventable failures in care and incorporated into quality improvement and patient safety initiatives.

- **Measure, report, and act on people's experiences.** Health systems, payers, and policymakers should routinely measure respectful care, mistreatment, shared decision-making, and patient-reported experience across inpatient and outpatient settings using validated measures. Results should be publicly reported and used to drive quality improvement, payment reform, and accountability.
- **Build a maternity care workforce equipped to deliver culturally safe, trauma-informed care.** Health systems, professional societies, and educational institutions should ensure that both clinical and non-clinical staff receive ongoing education in trauma-informed care, anti-racism, cultural humility, disability justice, language access, privacy, LGBTQ+ affirming care, and effective communication. Respectful care must be embedded in organizational culture, professional standards, and clinical practice.
- **Protect bodily autonomy, civil rights, and shared decision-making.** Every individual should have the right to informed consent, informed refusal, shared decision-making, privacy, and evidence-based care, free from coercion, discrimination, criminalization, or unnecessary government interference. The post-*Dobbs* environment makes these protections even more essential to ensuring safe and ethical maternity care.
- **Create systems that respond when people raise concerns.** Hospitals and health systems should establish accessible processes for reporting mistreatment and discrimination, implement rapid response pathways when patient concerns are dismissed or symptoms are ignored, and ensure timely investigation and resolution of complaints. Women should know where to turn and trust that their concerns will be taken seriously.
- **Hold institutions accountable for delivering respectful care.** Accrediting organizations, regulators, payers, and health systems should align standards, payment, oversight, and public reporting to ensure respectful maternity care is consistently delivered and continuously improved. Accountability should extend beyond individual clinicians to the policies, organizational culture, and institutional practices that shape women's experiences.



**What accountability looks like:** Every person is treated with dignity, listened to without bias or judgment, actively involved in decisions about her care, and protected from discrimination, coercion, and preventable harm throughout pregnancy, birth, and the postpartum period.



## **PRIORITY 2 | Build, strengthen and support the diverse workforce every mother needs to have a healthy and safe pregnancy, birthing and postpartum, including mental health, and specialized care for high-risk, complex care, and social supports.**

**Every childbearing family deserves access to a coordinated, interdisciplinary maternity care team that can meet their clinical, behavioral health, and social support needs throughout pregnancy, birth, and the postpartum period.** Yet workforce shortages, maternity care deserts, hospital and maternity unit closures, and inadequate investment in community-based care continue to limit access to high-quality, culturally responsive, and risk-appropriate care.

*LTM IV* respondents consistently highlighted the value of midwives, doulas, lactation professionals, peer support workers, and culturally congruent providers while describing how difficult these supports were to access or afford. **Building and sustaining a diverse, community-rooted workforce that spans the full continuum of maternity care is essential to improving outcomes and advancing equity.**

### **Systems Transformation Goals**

- **Build the full continuum of the maternity care workforce.** Federal and state policymakers should invest in the full range of professionals who support maternal health, including community health workers, doulas, peer support specialists, lactation professionals, behavioral health providers, nurses, midwives, family physicians, obstetricians, maternal-fetal medicine specialists, and other clinicians caring for women with high-risk pregnancies and complex conditions. Every family should have timely access to the right provider at the right level of care.
- **Redesign maternity care around interdisciplinary, risk-appropriate teams.** Health systems and payers should support coordinated models of care that integrate clinical and non-clinical providers, strengthen continuity across pregnancy and the postpartum year, and ensure seamless access to specialty care, behavioral health services, and community supports when needs become more complex.
- **Transform payment to support workforce sustainability.** Payment policies should fairly compensate the full maternity care team, including non-clinical providers, and reward collaboration, continuity,



prevention, and whole-person care. Sustainable reimbursement is essential for recruitment, retention, workforce well-being, and expanding access to evidence-based models of care.

- **Rebuild maternity care infrastructure in underserved communities.** Federal and state investments should address maternity care deserts, hospital and maternity unit closures, and geographic workforce shortages by strengthening rural maternity services, community-based care, telehealth, and other innovative delivery models that improve access while preserving local capacity.
- **Develop and sustain a workforce that reflects and is rooted in the communities it serves.** Increasing racial, ethnic, cultural, linguistic, and geographic diversity across the maternity workforce — including expanding pathways for Black, Indigenous, and other underrepresented clinicians and community-based providers — is essential to advancing birth equity and improving trust in the health care system.
- **Expand evidence-based models that improve outcomes.** Policymakers, payers, and health systems should increase access to midwifery care, continuity models, doula integration, collaborative practice, peer support, behavioral health integration, and other evidence-based approaches that improve maternal outcomes, patient experience, and health equity.



**What action/accountability/results look like:** Every family has timely access to a coordinated maternity care team that reflects their community, is fairly supported, and provides the right care, in the right setting, throughout pregnancy and the postpartum period.



### **PRIORITY 3 | Combat the maternal mental health crisis through integrated, culturally responsive systems that ensure prevention, early identification, timely intervention, treatment, and sustained support across pregnancy and the postpartum year.**

**Maternal mental health is inseparable from maternal health.** Mental health conditions are among the leading preventable causes of maternal mortality, yet too many childbearing people continue to experience depression, anxiety, trauma, emotional isolation, and substance use disorders without timely access to appropriate care. Particular attention should be given to addressing inequities in access to culturally responsive maternal mental health care experienced by Black, Indigenous, rural, immigrant, and other underserved communities.

*LTM IV* respondents described unmet mental health needs across pregnancy and the postpartum year, often facing fragmented systems, stigma, and barriers to treatment.

**Every woman deserves access to a maternal mental health system that promotes well-being, identifies needs early, provides timely treatment, and supports long-term recovery for mothers, infants, and families.**

## Systems Transformation Goals

- **Build a comprehensive maternal mental health system.** Federal and state policymakers should support a continuum of care that includes promotion, prevention, early identification, timely intervention, treatment, recovery, and sustained support throughout pregnancy and well beyond the traditional postpartum period.
- **Fully integrate behavioral health into maternity care.** Health systems should embed behavioral health services within obstetric, primary care, pediatric, and community settings through collaborative care models, co-located services, and interdisciplinary teams so women receive care where they already access services.
- **Expand access to culturally responsive, community-based care.** Payment policies should support psychotherapy, psychiatric care, substance use treatment, peer support, community health workers, doulas, tele-behavioral health, and care navigation while strengthening partnerships with trusted community organizations. For AIAN communities, this should include supporting Tribal health systems, Indigenous providers, and culturally grounded models of care that reflect community priorities and traditions.
- **Address trauma and promote healing.** Maternity care systems should recognize the effects of prior trauma, birth trauma, and adverse experiences while expanding trauma-informed care, early relational health, dyadic models of care, and family-centered recovery services. This should also recognize the effects of historical and ongoing harms and support culturally grounded pathways to healing, resilience, and family well-being.
- **Measure outcomes — not simply screening.** Accountability should extend beyond screening rates to include timely follow-up, successful referrals, treatment initiation, continuity of care, patient-reported outcomes, and long-term maternal and family well-being.
- **Replace stigma and criminalization with compassionate care.** Policies should ensure people can seek mental health and substance use treatment without fear of judgment, surveillance, criminalization, family separation, or discrimination.



**What accountability looks like:** Every individual receives timely, culturally responsive mental health and substance use care that supports their well-being throughout pregnancy, postpartum, and beyond.



## **PRIORITY 4 | Strengthen accountability for high-quality, evidence-based maternity care and reduce practices that undermine maternal and infant health.**

**Too many women receive maternity care shaped by institutional routines rather than evidence or their own informed preferences.** *LTMIV* respondents described feeling pressured into interventions, receiving inadequate information, and experiencing care that too often prioritized convenience over evidence and partnership.

**High-quality maternity care requires changing what the health care system measures, rewards, and expects.**

### **Systems Transformation Goals**

- **Make evidence-based, person-centered care the standard.** Quality measurement, accreditation, payment, and regulatory systems should consistently promote respectful, evidence-based maternity care while reducing unwarranted variation in clinical practice.
- **Increase transparency and public accountability.** Health systems, payers, and policymakers should publicly report maternal outcomes, patient experience, intervention rates, disparities, and other quality measures that allow families and communities to understand how care is being delivered. Public reporting should stratify maternal outcomes and patient experiences by race, ethnicity, geography, disability, insurance status, and other demographic characteristics to identify disparities, promote transparency, and accelerate action to eliminate inequities.
- **Transform payment to reward quality rather than procedures.** Payment models should incentivize prevention, continuity, shared decision-making, physiologic birth when appropriate, interdisciplinary care, and improved maternal and infant outcomes rather than procedure volume.
- **Reduce unnecessary interventions through evidence-based guardrails.** Health systems should strengthen clinical review processes, require documentation of medical necessity when appropriate, and promote informed decision-making to reduce unnecessary inductions, cesareans, and other interventions.
- **Expand access to evidence-based models of care.** Policymakers and health systems should increase access to freestanding birth centers, continuity models, midwifery care, community-based maternity services, and other approaches associated with improved outcomes and patient experience.

- **Create continuous learning and accountability systems.** Maternal Mortality Review Committees, Perinatal Quality Collaboratives, health systems, and payers should translate maternal outcomes and patient experiences into measurable improvements in policy, payment, and clinical practice.



**What accountability looks like:** Every person receives evidence-based, respectful maternity care that is guided by science, informed by their preferences, and supported by payment and accountability systems that reward quality.



## **PRIORITY 5 | Expand and protect affordable, comprehensive health coverage, including Medicaid, that allows every family to access the care they need, where and when they need it.**

**Health coverage should guarantee access to care — not create barriers to it.** Every family deserves affordable, comprehensive coverage that allows them to receive the services they need, from the providers they choose, throughout pregnancy and the postpartum year.

*LTM IV* respondents repeatedly described insurance barriers, difficulty finding providers who accepted Medicaid, and financial obstacles that delayed or prevented care. **Coverage must support reproductive justice by ensuring every family can access whole-person maternity care, regardless of income, geography, or immigration status.**

### **Systems Transformation Goals**

- **Protect and strengthen Medicaid as the foundation of maternal health coverage.** Federal and state policymakers should preserve and expand Medicaid while ensuring continuous coverage throughout pregnancy and at least one year postpartum and eliminating unnecessary barriers to eligibility and enrollment.
- **Ensure comprehensive, whole-person benefits.** Coverage should include physical and behavioral health care, non-clinical supportive services, and the full spectrum of reproductive health services — including contraception, fertility care, miscarriage management, abortion care where legal, and preconception care.
- **Expand access to the providers and settings families choose.** Payment and coverage policies should support hospitals, community health centers, freestanding birth centers, home birth when appropriate, telehealth, mobile care, and community-based providers, including doulas and community health workers.

- **Remove barriers that limit meaningful access to care.** Health plans should strengthen provider networks, reduce unnecessary administrative burdens, improve directory accuracy, minimize inappropriate prior authorization, and ensure women can obtain timely appointments with qualified providers.
- **Advance equitable access for historically excluded communities.** Policymakers should eliminate structural barriers that disproportionately affect immigrant families, rural communities, people with disabilities, and other populations that continue to face inequitable access to maternity care.
- **Measure access by whether people receive care — not simply whether they have insurance.** Accountability should include continuity of care, provider availability, timely appointments, referral completion, affordability, and patient experience.



**What accountability looks like:** Every family has continuous, affordable coverage that provides timely access to the full range of maternity, reproductive, behavioral health, and supportive services they need.



## **PRIORITY 6 | Support birthing families by addressing their health-related social and economic needs.**

**Healthy pregnancies and healthy families require more than high-quality medical care.** Economic security is maternal health policy. Safe housing, paid family and medical leave, nutritious food, transportation, affordable child care, healthy workplaces, and strong communities all shape maternal and infant health and are among the strongest predictors of whether families can thrive before, during, and after pregnancy.

*LTM IV* respondents described the daily realities of navigating pregnancy while facing housing instability, food insecurity, transportation barriers, employment pressures, child care challenges, financial stress, and environmental risks. Their experiences make clear that **health care alone cannot overcome the structural conditions that undermine maternal health.** Improving maternal health requires a maternity care system that recognizes these realities, partners across sectors to address them, and invests in the social and economic conditions that allow every family to thrive.

## Systems Transformation Goals

- **Recognize health-related social and economic needs as an essential part of maternity care.** Health systems, Medicaid programs, and payers should routinely identify health-related social needs using culturally responsive, person-centered approaches and incorporate them into comprehensive care planning throughout pregnancy and the postpartum year. Addressing these needs should be considered a core component of high-quality maternity care, not an optional add-on.
- **Establish paid family and medical leave as a foundational maternal health policy.** Every family should have access to comprehensive, paid family and medical leave that supports healthy pregnancies, childbirth, postpartum recovery, caregiving, breastfeeding, parent-infant bonding, and maternal mental health without sacrificing economic security. *LTM IV* demonstrates that women cannot achieve optimal health outcomes when they are forced to choose between their health, their infant's well-being, and their paycheck. Paid leave should be recognized as an essential component of the nation's maternal health infrastructure, alongside health coverage and clinical care.
- **Build coordinated systems that connect families to meaningful support.** Health care organizations, Medicaid programs, and community partners should establish closed-loop referral systems, care navigation, and shared accountability to ensure families successfully access housing assistance, nutrition programs, transportation, legal services, behavioral health resources, home visiting, early childhood services, and other community supports. Measuring successful connection, not simply making referrals, should become the standard.
- **Invest in community organizations as essential partners in maternal health.** Governments, health systems, health plans, and philanthropy should provide sustained investment in community-based organizations that deliver trusted services, including doulas, community health workers, peer support, home visiting, parenting programs, legal



assistance, and care navigation. Community organizations should be recognized as integral members of the maternity care system and supported through sustainable financing and long-term partnerships. Governments, health systems, health plans, and philanthropy should provide sustained investment in community-based organizations, particularly those led by and serving Black, Indigenous, Tribal, and other historically marginalized communities.

- **Strengthen the economic and environmental conditions that allow families to thrive.** Policymakers should expand workplace protections for pregnant and postpartum workers while increasing access to affordable child care, stable housing, nutrition assistance, transportation, and other family economic supports. They should also reduce harmful environmental exposures, improve workplace safety, strengthen climate resilience, and protect pregnant and postpartum workers from preventable health risks. Maternal health policy should help create communities where families can not only survive pregnancy and childbirth but flourish afterward.
- **Create shared accountability across sectors for maternal and family well-being.** Improving maternal health requires coordinated leadership across health care, public health, housing, labor, education, transportation, nutrition, environmental protection, and early childhood systems. Policymakers should align financing, data sharing, performance measures, and cross-sector partnerships to address the root causes of inequities and ensure every family has the resources needed to thrive.



**What accountability looks like:** Every family has the economic security, including comprehensive paid family and medical leave, the community supports, and the healthy living conditions needed to experience a healthy pregnancy, recover after childbirth, bond with their infant and thrive throughout the critical first year postpartum.

# WE MUST ACT NOW

For more than two decades, the *LTM* surveys have elevated the voices and experiences of childbearing families, providing an unparalleled window into the realities of pregnancy, childbirth, and the postpartum period in the United States. The findings in this report make clear that while meaningful progress has been made, too many people continue to encounter barriers to safe, respectful, equitable, and high-quality maternity care.

The priorities outlined here provide a **blueprint for transforming maternity care** so that every woman and every family have the opportunity to thrive. Achieving this vision will require leadership and sustained commitment across government, health care, employers, payers, community organizations, and philanthropy. It will also require continued partnership with the people most affected — childbearing people, families, and communities — whose experiences must remain at the center of policy and practice.

**Listening is where change begins.** Acting on what women tell us is how lasting change happens. By working together to implement these systems transformations, we can build a maternity care system that is more respectful, equitable, accountable, and responsive to the needs of every family.

The National Partnership for Women & Families, Black Mamas Matter Alliance and MomsRising remain committed to partnering with policymakers, health systems, providers, community organizations, advocates, and families to translate the findings of *Listening to Mothers* into meaningful action that improves the health and well-being of women, infants, and families for generations to come.



# Acknowledgments

Collaboration is essential to successful policy change, and we are deeply grateful to the organizations and individuals that worked together to create this policy brief.

This brief was produced by the National Partnership for Women & Families in partnership with the Black Mamas Matter Alliance and MomsRising, and the members of the *Listening to Mothers* Advisory Council.

This policy brief was authored by Nima Sheth, Erin Mackay, Nan Strauss, and Sinsi Hernández-Cancio, of the National Partnership for Women & Families.

The National Partnership project team included: Stephanie Green, Lorena Bonet Velazquez, Amani Echols, Kimberly Pothemont, Danielle Hosein Johnson, Mona Papillon, Llenda Jackson-Leslie, Danielle Matthias, Amaya Smith, Mettabel Law, Tucker Ball, and Travis Hunter.

---

The brief was designed by Gratzner Graphics LLC.

Support for *Listening to Mothers* was generously provided by the California Health Care Foundation, Commonwealth Fund, Merck for Mothers, The David and Lucile Packard Foundation, Robert Wood Johnson Foundation, Skyline Foundation and W.K. Kellogg Foundation.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care, and policies that help all people meet the dual demands of work and family. More information is available at [NationalPartnership.org](https://NationalPartnership.org).

© 2026 National Partnership for Women & Families. All rights reserved.

# Listening to Mothers IV Advisory Council

**Nicolle L. Arthun, BSN, RN, MSN, CNM, FACNM**

CEO Transcending Strategies LLC; Founder, Changing Woman Initiative  
Albuquerque, NM and Washington, DC

**Lannesse Baker, MPH**

Executive Vice President, National Indian Health Board, Seattle/Pacific Northwest

**Nicole Deggins, CNM, MSN, MPH.**

Founder and CVO, Sista Midwife Production, New Orleans, LA

**Erin Gildner, MPA**

Disability and Maternal Health Expert, Public Administration Consultant, Gildner Project Solutions, Bryant, AR

**Whitney Hunter- Batteast**

Founder & Executive Director, Pickles & Popsicles, Inc, Jackson, MS

**Jennie Joseph, LM, CPM**

Founder and President, Commonsense Childbirth, Orlando, FL

**Leticia Knight, CPM**

Borderland Partera/Midwife, Changing Woman Initiative, El Paso, Texas/Ciudad Juárez, México

**Mashariki Kudumu, MPH**

Founder and Principal Consultant, Kudumu Partnerships or Equity and Justice/California Black Birth Summit, Los Angeles, CA

**Danielle Rivers, MPH**

Public Health Researcher, Black Mamas Matter Alliance; Research Associate, Atlanta, GA

**Frankie Robertson, MPA**

Founder and President of The Amandla Group, Founder and Doula, Black Joy, Baton Rouge, LA

**Ayanna Robinson, PhD, MPH**

Public Health Scientist, Director of Research and Evaluation, Atlanta, GA

**Diana Salas, MPA**

Trainer and Organizer for Latine and immigrant women, Senior Director, Community Engagement Programs, National Latina Institute for Reproductive Justice, New York City, Hudson Valley, NY and Ecuador

**Tina Sherman**

Birth Doula, Student Midwife and National Director of Maternal Justice, MomsRising, NC

**Sophia Tupuola**

Community Expert, Birth Justice Advocate for Black and Pasifika Mamas, Children's Book Author and illustrator, San Francisco, CA

## Endnotes

- <sup>1</sup> Gunja, M., Gumas, E., Masitha, R., & Zephyrin, L. (2024, June). *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*. Retrieved 1 May 2026, from The Commonwealth Fund website: <https://doi.org/10.26099/cthn-st75>
- <sup>2</sup> Hill, L., Rao, A., Artiga, S., & Ranji, U. (2025, December). *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues*. Retrieved 30 April 2026, from KFF website: <https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues>
- <sup>3</sup> Peters, C. & Chen, A. (2024, September). *Maternity Wing Closures in the U.S. South: Impetus and Impact*. Retrieved 18 June 2026 from the National Health Law Program website: <https://healthlaw.org/maternity-wing-closures-in-the-u-s-south-impetus-and-impact-2/> na
- <sup>4</sup> Gunja, M., Gumas, E., Masitha, R., & Zephyrin, L. (2024, June). *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*. Retrieved 1 May 2026 from The Commonwealth Fund website: <https://doi.org/10.26099/cthn-st75>
- <sup>5</sup> Health Affairs Forefront. *Medicaid Cuts Threaten Pregnancy and Postpartum Coverage, Access to Care, and Health*. (2025, 20 October) DOI: 10.1377/forefront.20251016.231218
- <sup>6</sup> Rosenthal, J., & Jones, K. (2025, 21 July) *The Trump Administration Is Endangering Women's Reproductive Health*. Retrieved 16 June 2026, from the Center for American Progress website: <https://www.americanprogress.org/article/the-trump-administration-is-endangering-womens-reproductive-health/>
- <sup>7</sup> Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A. (2022, September). *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019*. Retrieved 26 May 2026, from Centre for Suicide Prevention website: <https://www.suicideinfo.ca/wp-content/uploads/2024/03/Pregnancy-Related-Deaths.pdf>
- <sup>8</sup> Forati, A.M., Rodriguez-Alcala, M., Trolinger, W., Sigsworth, R. et al. (2024, May). *The Economic case for Investing in Maternal Health*. Retrieved 12 August 2026 from Heartland Forward website: [https://heartlandforward.org/wp-content/uploads/2026/03/Maternal-health-report\\_16.pdf](https://heartlandforward.org/wp-content/uploads/2026/03/Maternal-health-report_16.pdf)