Skyline
FOUNDATION

BIRTH JUSTICE PROGRAM

Advancing Midwifery Care in the United States

TEN YEARS OF PROGRESS • 2015–2025

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Contents

Acknowledgments

We are deeply grateful to the grantees, leaders, advocates, and midwives whose vision and persistence define this field. Our grantees welcomed us as partners and taught us what this work actually demands. This report attempts to honor what they have built, and any limitations in how it captures their contributions are ours alone.

Practicing midwives are at the center of our work. Many gave time outside of already-full schedules to advise and educate funders, and to articulate what evidence-based, relationship-centered care looks like in practice. We are honored by their generosity and humbled by the weight of what they carry.

This work has also been strengthened through the collaboration of peer funders who share Skyline's belief that maternal health is inseparable from reproductive justice, racial equity, and economic power. Co-funding, joint learning, and honest conversation across foundations have made the field more coherent and better resourced than any one funder could have managed alone. We are grateful for those partnerships and look forward to deepening them in the work ahead.

A note for readers

Skyline recognizes that pregnant, birthing, postpartum, and parenting people have a range of gender identities, so this report gives preference to gender neutral terms. In referring to research or reports, we use the authors' gendered language.

Let's learn together

Collaboration is a throughline of midwifery and birth justice. At Skyline Foundation we're always learning. We welcome opportunities to share more about our grantees and find ways to partner with other areas of philanthropy. We invite other funders to **contact us** to learn more about our grantees and our work ahead.

A Letter from Skyline's Co-Founder

For the past decade I have had the honor of working alongside leaders whose vision is to make midwifery care available and affordable to any family in the United States who seeks it.

The seeds of Skyline Foundation's Birth Justice program were planted when I became pregnant with my first child. After five challenging years of hoping for a baby, the joy of the pregnancy grew with each visit to my obstetrician. Soon my mind turned to the matter of where and how I would give birth, a topic that I had barely given any thought in my thirty-seven years of life.

Like most people, before getting pregnant I had gone to the doctor only when I was sick or needed a checkup. Now I was interacting more with the health care system than I ever had before, but I wasn't sick, I was pregnant.

Around this time, I came across the documentary *The Business of Being Born*. As a feminist, I remember feeling both shocked and completely unsurprised to learn that our health care system is organized in a way that is far from ideal for supporting birth.

With many questions spinning in my head, I was fortunate to find Blossom Birth, a community organization in my town dedicated to educating women about childbirth. From their resources and events, I first learned what a doula was and where the midwives were in my community. Without these guides, I never would have understood my choices in childbirth.

Another eye-opener for me came when I learned about the concept of a birth plan. I had been accustomed to my doctors having a plan for me, but I discovered I might want to create a plan for myself that my providers would help me execute, rather than the other way around. Yes, there would be expert hands at the ready, but I was also allowed to have my own beliefs and preferences. And I would be better off putting those into writing and discussing them with my provider, before I was in the throes of contractions.

Halfway through my pregnancy, I made a hand-wringing decision to switch from the care of my beloved obstetrician to a midwife. I considered many factors, but most of all I chose a midwife because I knew she would be patiently by my side as my birth unfolded. She knew I wanted to avoid unnecessary medical interventions, and she did not judge me as careless or clueless for having that hope. She also taught her own childbirth education classes, an additional gift of time on top of her patient and thorough checkups. Importantly, she was well integrated into a team of doctors and specialists who could be on hand quickly if any issue arose.

I made the choice with eyes wide open. But even with plenty of personal resources, my path to this point felt surprisingly precarious. That journey is still fresh in my mind and drives my ongoing commitment to fund organizations expanding the midwifery model of care in America.

As this report makes abundantly clear, today too many women in this country face birth experiences that are swept along by a system not optimized for healthy birth. When our country's worsening birth outcomes and completely unacceptable racial inequities are discussed, rarely are important system-wide factors—including birth setting, provider type, and payment models—called into question. We fail to notice the water we are swimming in, missing simpler, often less expensive proven approaches like those offered by midwifery.

All of these years later, I am still in the care of midwives.

I am proud to support the midwifery organizations and leaders who are imagining what it would take for every birth in our country to be guided by education, choice, autonomy, and abiding respect for the utterly miraculous force of new life.

Together we can and will make the experience of childbirth in this country one that matches the beauty of being born.

Angela Filo
Skyline Foundation
Co-Founder & Board Member

Introduction

We've witnessed something remarkable:

A field that was long fragmented and underfunded has grown more coordinated and more powerful.

Midwifery is among the oldest forms of health care and today more necessary than ever. The midwifery model of care is built on trust in the inherent human capacity to give birth as well as a deep respect for the individual needs and choices of each person giving birth. Skyline Foundation believes that everyone deserves a healthy and empowering birth, and that midwives are crucial to achieving this vital goal. Integrating midwifery care has the power to directly address the US healthcare system's biggest failures simultaneously; in fact, it is the rare intervention that's been proven to move the needle on quality, disparities, access to care, and outcomes.

The United States spends more on childbirth than any other high-income country, while ranking among the worst in maternal and infant outcomes. Disparities persist across income, education, and insurance status, reflecting the racism and structural inequities embedded within the system. Half of US counties have no hospital with maternity services. Pregnancy and childbirth support too often are shaped by financial and institutional incentives that are not aligned with evidence-based care or with the needs, autonomy, and well-being of those giving birth.

Although the problems Skyline set out to address persist, we've witnessed something remarkable: a field that was long fragmented and underfunded has grown more coordinated and more powerful. New organizations have emerged, expanded their reach, and deepened their work; our grantees note that historically scattered work is increasingly coordinated. The number of practicing midwives is growing, many states have passed or improved enabling legislation, and the case for midwifery-led care has become significantly harder for policymakers, payers, and health systems to ignore.

This report describes where we have seen progress, what may have held the field back or been missed, and, most importantly, what we have learned. First, we provide an overview of Skyline's approach, including a summary of our grantmaking and how it has evolved. The reflections, learning, and thoughts about the future of the field are drawn from three primary sources: from the anonymous survey responses from our grantee partners, who are deep experts in their areas; from listening sessions; and from published reports and analyses. Despite the power differentials between grantee and funder, our grantees embraced this reflective work with candor and collaborative spirit. We strive to bring that same spirit to our own work. We conclude this report with suggestions for other funders and a list of Skyline's commitments to the field for the next decade and beyond.

1

The Promise of Midwifery

Midwifery is among the **oldest** health care practices and has developed over time into a rigorous professional discipline in the US. The United Nations acknowledges midwifery as "an intangible cultural heritage of humanity," and the International Confederation of Midwives states that universal access to midwifery care is a basic human right.

Midwives are trained specialists in the physiology of labor, birth, and the postpartum period, with a practice centered on the full experience of the birthing person and their family. Many midwives also are trained to provide care for the full spectrum of reproductive health needs, including contraception, abortion, and menopause.

There are **different types of midwives in the US**. Generally speaking, the majority of midwives trained in nursing attend births in hospitals, whereas "community midwives" attend births at independent birth centers or in homes and may be nurse-midwives or are specifically licensed or certified to practice outside of hospitals. The midwifery model is fundamentally relational: it builds trust, centers communication, and tailors care to the individual, with the explicit goal of fostering autonomy and self-determination. It reaches beyond clinical care to address the social conditions that shape birth outcomes and recognizes the profound, transformational nature of the childbearing experience itself.

Midwifery is built around a foundational belief that pregnancy and birth are normal physiological processes for the majority of people, and that care should support rather than routinely intervene in that process. Midwives provide comprehensive care during pregnancy, labor, birth, and the postpartum period. They intentionally attend to the whole person, their physical health, emotional well-being, social circumstances, and informed preferences, rather than treating birth as an isolated medical event requiring management.

Expanding access to midwifery-led prenatal and childbirth care is a data-supported strategy for improving outcomes, reducing unnecessary interventions, and enabling informed choice. A large systematic review of randomized trials comparing midwife-led models with other models of care found that people receiving midwifery-led care were less likely to have labor disturbed by interventions and less likely to have a cesarean birth, while reporting higher satisfaction with care.[1] The same review found no increase in adverse outcomes, affirming the safety of midwife-led models. Other US data similarly shows that integration of midwives into maternity care systems is associated with lower intervention

The midwifery model is fundamentally relational: it builds trust, centers communication, and tailors care to the individual, with the explicit goal of fostering autonomy and self-determination.

1 Jane Sandall et al., "Midwife Continuity of Care Models Versus Other Models of Care for Childbearing Women," *Cochrane Database of Systematic Reviews* no. 4 (2024).

rates and comparable or improved neonatal outcomes, particularly when midwives practice within collaborative, well-integrated systems.[2] [3] In addition, continuity-of-care models—central to midwifery practice—have been associated with reduced maternal anxiety and improved patient experience, reflecting the importance of relationship-based prenatal care.[4] [5]

Overall, the US is an outlier among high-income countries in its limited use of midwives, relying far more heavily on physician-led care despite the evidence that midwifery-centered systems achieve better outcomes.[6] [7] Physicians bring the necessary expertise in managing complications and surgical intervention; midwives' expertise is needed too. When midwives and physicians each practice at the top of their scope, low-risk patients can receive evidence-based, physiologic, relationship-centered care with fewer unnecessary interventions and higher satisfaction.[8] This also frees physicians to focus on higher-risk and more complex situations.[9] Clear team-based pathways for consultation, transfer, and co-management smooth the escalation process in emergencies.[10] The overall workforce is used more efficiently and accountably, strengthening prevention and postpartum support, and expanding access in underserved areas in ways that support more equitable outcomes. [11] This can lower total costs by reducing avoidable interventions and downstream complications.[12] [13] Additionally, midwifery models of care offer a viable, cost-effective way to expand access in maternity care deserts, where more than one-third of US counties lack obstetric clinicians and birthing facilities.[14]

The data clearly supports the potential for midwifery to improve outcomes and reduce disparities.[15] [16] A nationwide assessment and analysis, the Midwifery Integration Scoring Systems, showed significantly higher rates of physiologic birth, fewer interventions, and fewer adverse neonatal outcomes regardless of maternal age, prenatal care use, race, education, and marital status.[17]

When care and support during pregnancy, birth, and postpartum period are designed around these principles, the outcomes follow and promote lower cesarean rates, fewer unnecessary interventions, higher patient satisfaction, fewer preterm births, improved newborn outcomes, higher breastfeeding rates, better mental health outcomes for new mothers, and reduced disparities among birthing people across racial and socioeconomic groups.[18] [19] [20]

2 Saraswathi Vedam et al., "Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes," *PLOS One* 13, no. 2 (2018): e0192523.

3 Joan L. Combellick et al., "Midwifery Care During Labor and Birth in the United States," *American Journal of Obstetrics & Gynecology* 228, no. 5 (2023): S983–S993.

4 Sara Cibralic et al., "The Impact of Midwifery Continuity of Care on Maternal Mental Health: A Narrative Systematic Review," *Midwifery* 116 (2023): 103546.

5 Sue Kildea et al., "Continuity of Midwifery Carer Moderates the Effects of Prenatal Maternal Stress on Postnatal Maternal Wellbeing: The Queensland Flood Study," *Archives of Women's Mental Health* 21, no. 2 (2018), 203–214.

6 Combellick et al., "Midwifery Care During Labor and Birth in the United States."

7 Roosa Tikkanen et al., "Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries," *The Commonwealth Fund*, November 18, 2020.

8 Saraswathi Vedam et al., "Mapping Integration of Midwives Across the United States."

9 Saraswathi Vedam et al., "Mapping Integration of Midwives Across the United States."

10 Amy Romano et al., "Tools, Coaching, and Community to Support Interprofessional Emergency Transfer Drills: Results From a National Action Collaborative Focused on Birth Center to Hospital Transfer," *Journal of Midwifery & Women's Health* 70, no. 6 (2025): 952–959.

11 Shyamkumar Sriram et al., "Midwife-led Versus Obstetrician-Led Perinatal Care for Low-Risk Pregnancy: A Systematic Review and Meta-Analysis of 1.4 Million Pregnancies," *Journal of Clinical Medicine* 13, no. 22 (2024): 6629.

12 Kate A. McLean et al., "Expanding Midwifery Care in the United States: Implications for Clinical Outcomes and Cost," *Birth* 50, no. 4 (2023): 935–945.

13 Laura B. Attanasio et al., "Midwife-Led Care and Obstetrician-Led Care for Low-Risk Pregnancies: A Cost Comparison," *Birth* 47, no. 1 (2020): 57–66.

14 Isabella F. McNamara et al., "The Association Between Maternal Care Access and Term Stillbirth at the US County Level," *Pregnancy* 2, no. 2 (2026): e70225.

15 Madison Friesen et al., "Barriers to Rural Midwifery: An Integrative Review," *Journal of Advanced Nursing* 81, no. 10 (2025): 6120–6133.

16 Vedam et al., "Mapping Integration of Midwives Across the United States."

17 Vedam et al., "Mapping Integration of Midwives Across the United States."

18 Mary J. Renfrew et al., "Midwifery and Quality Care: Findings From a New Evidence-Informed Framework for Maternal and Newborn Care," *The Lancet* 384, no. 9948 (2014): 1129–1145.

19 Sandall et al., "Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women," 457.

20 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America: Outcomes, Quality, Access, and Choice* (Washington, DC: National Academies Press, 2020).

Midwifery Values: [21] [22] [23]

Dignity

Respect for human dignity and human rights.

Maternity care is grounded in respect for the fundamental rights of birthing people, including freedom from discrimination and mistreatment.

Autonomy

Self-determination and meaningful participation in decisions.

Birthing people are active participants and decisionmakers in their care, with authority supported rather than overridden.

Non-Coercion

Care that is respectful and free from coercion.

Quality care rejects authoritarian practice and emphasizes consent, trust, and the primacy of the patient's informed preference.

Equity

Equity and attention to structural injustice.

Maternity care quality is inseparable from equity, with explicit recognition that outcomes and experiences are shaped by historical and structural inequities.

Relationship

Person-centered, relationship-based care.

Care centers the person, their relationships, and lived experience, recognizing the importance of trust, continuity, and community.

Physiology

Birth as a physiological process.

Pregnancy, childbirth, and the postnatal period are usually normal physiological processes that do not require medical intervention in the absence of complications.

Midwifery Delivers: [24] [25]

Improved outcomes for low-risk pregnancies, reducing preterm birth, cesarean delivery, and instrumental birth rates

Reduced preventable intervention by applying physiologic care principles and shared decision-making.

Expanded access to maternal and child health care in rural and underserved areas where it can serve as a primary or anchor provider.

Strengthened continuity and trust, building the relationships that enable accurate risk assessment and responsive care.

Alignment with physiologic birth, counteracting the cascade effects of routine intervention.

Personal autonomy and culturally congruent care, directly addressing the disrespect, coercion, and bias that drive racial disparities.

21 International Confederation of Midwives, *Philosophy and Model of Midwifery Care* (The Hague: International Confederation of Midwives, 2025).

22 American College of Nurse-Midwives, *American College of Nurse-Midwives Philosophy of Midwifery* (Washington, DC: American College of Nurse-Midwives, 2024).

23 National Association of Certified Professional Midwives, "Professional Standards & Competencies," 2026.

24 P. Mimi Niles and Laurie Zephyrin, "How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis," *The Commonwealth Fund*, May 5, 2023.

25 Sandall et al., "Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women," 457.

2

The Context of Our Work

Just over ten years ago, Skyline Foundation began testing a hypothesis: could philanthropic support to the underinvested field of midwifery possibly help improve the experience of childbirth in the United States? This report looks back on what we have learned between 2015 and 2025 in partnership with the birth justice leaders and organizations we have funded.

Despite the great promise of midwifery, progress is slowed by a number of factors, most of which are linked to inequality. It is important to understand this context in order to fully appreciate the hard-won gains reflected in this report.

While birth is one of the most universal human experiences, it is also, in the United States, one of the most unequal.[26] [27] [28] Today, women are more likely to die from pregnancy-related causes than their own mothers—disproportionately so for Black and Indigenous birthing people.[29] [30]

Birth is one of the most stark examples of how gender inequity and limits on women's power is embedded in US systems—shaping care, access, outcomes, whose needs are centered, and whose are neglected.[31] [32] [33] The ability to meaningfully participate in one of the most transformational events in one's life has long-term physical, mental, and economic consequences on families that ripple out into society at large.[34] [35]

Health care is one of the core systems within our society, and pregnancy and childbirth sit at its center. Childbirth is the most common reason for hospitalization in the US, and cesarean delivery is the most common major surgery.[36] [37] For many otherwise healthy adults, pregnancy represents the first sustained engagement with the health care system, involving months of prenatal care, hospital delivery, and postpartum services. Today's maternity care system was built, in part, by layering a medical model onto a physiological one. What has emerged are practices designed for the most complex cases or rare events now becoming the norm and expectation, regardless of actual health risk.[38]

While birth is one of the most universal human experiences, it is also, in the US, one of the most unequal.

26 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

27 Latoya Hill et al., "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues," *Kaiser Family Foundation*, December 3, 2025.

28 Munira Z. Gunja et al., "Insights Into the US Maternal Mortality Crisis: An International Comparison," *The Commonwealth Fund*, June 4, 2024.

29 Eugene Declercq and Laurie Zephyrin, "Severe Maternal Morbidity in the United States: A Primer," *The Commonwealth Fund*, October 28, 2021.

30 Laura G. Fleszar et al., "Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States," *JAMA* 330, no. 1 (2023): 52–61.

31 Dorothy Shaw et al., "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centred Care?," *The Lancet* 388, no. 10057 (2016): 2282–2295.

32 P. Mimi Niles et al., "Examining Respect, Autonomy, and Mistreatment in Childbirth in the US: Do Provider Type and Place of Birth Matter?" *Reproductive Health* 20, no. 1 (2023): 67.

33 Chen Liu et al., "Disparities in Mistreatment During Childbirth," *JAMA Network Open* 7, no. 4 (2024): e244873.

34 Joshua P. Vogel et al., "Neglected Medium-Term and Long-Term Consequences of Labour and Childbirth: A Systematic Analysis of the Burden, Recommended Practices, and a Way Forward," *The Lancet* Global Health 12, no. 2 (2024): e317–e330.

35 Sasigant So O'Neil et al., "Societal Cost of Nine Selected Maternal Morbidities in the United States," *PLOS One* 17, no. 10 (2022): e0275656.

36 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

37 Annelee Boyle et al., "Primary Cesarean Delivery in the United States," *Obstetrics & Gynecology* 122, no. 1 (2013): 33–40.

38 American College of Nurse-Midwives, Midwives Alliance of North America, and National Association of Certified Professional Midwives, "Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM," *Journal of Perinatal Education* 22, no. 1 (2013): 14–18.

Autonomy and Choice

Gender norms play a powerful and often underacknowledged role in childbirth. Cultural expectations that women should endure pain, prioritize others over themselves, and defer to authority too often translate into clinical settings where institutions prioritize efficiency and cooperation over shared decision making.[39] [40] As a result, practices that might be considered unacceptable in other areas of medicine are expected and accepted in maternity care.[41] [42] This dynamic not only shapes individual interactions but also reinforces broader systemic patterns in which autonomy and dignity are unevenly upheld.[43] [44]

The choices most people assume they have about their birth have, in many cases, already been made for them.

Bodily autonomy is a human right and is not relinquished during pregnancy.[45] But the choices most people assume they have about their birth have, in many cases, already been made for them: by the hospital they walk into, their health insurance, and the institutional and financial incentives that drive how their care is delivered—systems influenced largely by race-based assumptions and biases.[46] [47] [48] [49]

Most people in the United States give birth in a way that is optimal for doctors and hospitals but that may or may not be for them or their babies.[50] [51] Whether someone has a surgical birth is more strongly predicted by which hospital they use than their medical risk factors.[52] These "choices" are the product of a system with incentives and norms driven by revenue, institutional convenience, liability management, and the use of medical technology and practices that are not always aligned with evidence.[53] [54] [55]

Access to reliable information about birth is an important condition for meaningful participation.[56] [57] In-person, hands-on childbirth education and postpartum support are no longer the norm for most pregnant new parents.[58] Instead, in isolation, they too often navigate conflicting, incomplete, misleading, and inaccurate information.[59]

39 Camille Kroll et al., "Cultivating the Ideal Obstetrical Patient: How Physicians-in-Training Describe Pain Associated with Childbirth," *Social Science & Medicine* 312 (2022): 115365.

40 Rachel Blankstein Breman, Alex Waddell, and Vanessa Watkins, "Shared Decision Making in Perinatal Care," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 53, no. 2 (2024): 96–100.

41 Saraswathi Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," *Reproductive Health* 16, no. 1 (2019): 77.

42 Chen Liu et al., "Disparities in Mistreatment During Childbirth," *JAMA Network Open* 7, no. 4 (2024): e244873.

43 Annie Glover, Carly Holman, and Patrick Boise, "Patient-Centered Respectful Maternity Care: A Factor Analysis Contextualizing Marginalized Identities, Trust, and Informed Choice," *BMC Pregnancy and Childbirth* 24, no. 1 (2024): 267.

44 Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," 77.

45 American College of Obstetricians and Gynecologists, "Informed Consent and Shared Decision Making in Obstetrics and Gynecology: ACOG Committee Opinion, Number 819," *Obstetrics & Gynecology* 137, no. 2 (2021): e34–e41.

46 Jamie R. Daw et al., "Women in the United States Experience High Rates of Coverage 'Churn' in Months Before and after Childbirth," *Health Affairs* 36, no. 4 (2017): 598–606.

47 Desalyn L. Johnson et al., "Health Insurance and Differences in Infant Mortality Rates in the US," *JAMA Network Open* 6, no. 10 (2023): e2337690.

48 Hill et al., "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

49 Rie Sakai-Bizmark et al., "Evaluation of Hospital Cesarean Delivery–Related Profits and Rates in the United States," *JAMA Network Open* 4, no. 3 (2021): e212235.

50 Hongyan Liu et al., "Effectiveness of Nulliparous Women's Different Childbirth Positions During the Second Stage of Labor: A Systematic Review and Network Meta-Analysis," *International Journal of Nursing Sciences* 12, no. 3 (2025): 268–275.

51 Katy B. Kozhimannil et al., "Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery: Analyses of a National US Hospital Discharge Database," *PLOS Medicine* 11, no. 10 (2014): e1001745.

52 Kozhimannil et al., "Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery."

53 Sakai-Bizmark et al., "Evaluation of Hospital Cesarean Delivery-Related Profits and Rates in the United States," e212235.

54 Carol Y. Sakala et al., "Maternity Care and Liability: Pressing Problems, Substantive Solutions," *Women's Health Issues* 23, no. 1 (2013): e7–e13.

55 American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine, "Safe Prevention of the Primary Cesarean Delivery," Obstetric Care Consensus No. 1. *American Journal of Obstetrics & Gynecology* (2014).

56 American College of Obstetricians and Gynecologists, Committee on Ethics, "Informed Consent and Shared Decision Making in Obstetrics and Gynecology."

57 American College of Obstetricians and Gynecologists, Committee on Ethics, "Informed Consent and Shared Decision Making in Obstetrics and Gynecology."

58 Jennifer Vanderlaan and Kristen Kjerulff, "Perinatal Education Participation: Description and Identification of Disparities," *The Journal of Perinatal Education* 31, no. 3 (2022): 161.

59 Carol Sakala et al., "Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report," *Washington, DC: National Partnership for Women & Families* (2018).

Access

The conditions that make meaningful choice possible during birth are profoundly unequal: Where someone lives determines when, how, and whether they can access maternity care.[60] More than 3.5 million people give birth each year in the US.[61] Yet, half of rural counties have no hospital with maternity services, and 35% of all counties have no birthing facility, physician, or midwife.[62] Hospital closures and hospital-based obstetric unit closures are widening these gaps, and are associated with increased travel for care, delayed or infrequent prenatal care visits, and higher rates of adverse outcomes.[63] [64] [65] The providers that remain, especially safety-net providers, operate under increasingly difficult financial pressure with low or negative margins, workforce shortages and a rising number of uninsured patients. [66] [67]

Half of rural counties have no hospital with maternity services, and 35% of all counties have no birthing facility, physician, or midwife.

By 2038, the US is projected to face a shortage of nearly 8,000 OB-GYN physicians across the maternal health ecosystem; in non-metropolitan areas, these physicians are projected to meet half of the demand for reproductive care.[68] State-level abortion restrictions are compounding this shortage.[69] Even where bans have not yet caused a dramatic drop in the total number of practicing OB-GYNs, they appear to be making restrictive states less attractive places to train and practice, intensifying existing workforce shortages in states that already have fewer clinicians, higher maternal health risks, and larger rural access gaps.[70] The result is an even more inequitable maternity care landscape. Pregnant women in those states may face longer travel distances, fewer clinicians willing or able to manage complex pregnancies, reduced access to miscarriage and emergency obstetric care, and greater strain on hospital-based maternity services.[71]

Additional barriers to accessing maternity care exist for many women, disproportionately so for Black, Indigenous, Latine, and some subgroups of Asian and Pacific Islander women.[72] Differences in health insurance coverage and other social drivers of health including income, immigration status, and racial discrimination are significant determinants of access to care.[73] [74]

60 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

61 Michelle J.K. Osterman et al., "Births: Final Data for 2023. National Vital Statistics Reports," *National Center for Health Statistics* 74, no. 1 (2025).

62 March of Dimes, "Nowhere to Go: Maternity Care Deserts Across the US," 2024.

63 U.S. Government Accountability Office, *Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas* (Washington, DC: U.S. Government Accountability Office, 2022).

64 Songyuan Deng et al., "The Association of Travel Burden with Prenatal Care Utilization, What Happens After Provider-Selection," *BMC Health Services Research* 24, no. 1 (2024): 781.

65 Katy B. Kozhimannil et al., "Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States," *JAMA* 319, no. 12 (2018): 1239–1247.

66 Clara E. Busse et al,. "Financial Challenges of Providing Obstetric Services at Rural US Hospitals," *The Journal of Rural Health* 41, no. 4 (2025): e70082.

67 Martha Heberlein, *Medicaid's Role in Financing Maternity Care* (Washington, DC: Medicaid and CHIP Payment and Access Commission, 2020).

68 U.S. Department of Health and Human Services, Health Resources and Services Administration, *State of the U.S. Maternal Health Workforce 2025* (Rockville, MD: National Center for Health Workforce Analysis, 2025).

69 Sara R. Collins et al., "2024 State Scorecard on Women's Health and Reproductive Care," *The Commonwealth Fund,* 2024.

70 Anisha P. Ganguly et al., "State-Level Disparities in Residency Applications after Dobbs v Jackson Women's Health Organization," *JAMA Network Open* 9, no. 3 (2026): e260286.

71 Maria I. Rodriguez et al., "Management of Spontaneous Abortion Among Commercially Insured Individuals in the United States after Dobbs v Jackson," *JAMA* (2026).

72 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

73 National Academies of Sciences, Engineering, and Medicine, *Communities in Action: Pathways to Health Equity* (Washington, DC: The National Academies Press, 2017).

74 Mara B. Greenberg et al., "Best Practices in Equitable Care Delivery–Addressing Systemic Racism and Other Social Determinants of Health as Causes of Obstetrical Disparities," *American Journal of Obstetrics and Gynecology* 227, no. 2 (2022): B44–B59.

More than 40% of births in recent years were covered by Medicaid.[75] As the single largest payer of maternity care, cuts to the program affect the accessibility and financial stability of the maternity care system overall.[76] The more than $900 billion in cuts to Medicaid and CHIP (Children's Health Insurance Program) enacted as part of H.R. 1 in 2025, as well as new eligibility restrictions and requirements, will dramatically decrease access to care. The Congressional Budget Office projects the number of uninsured will increase by ten million people by 2034.[77] New Medicaid work requirements alone threaten to eliminate Medicaid coverage for 2.1 million women of reproductive age, a disproportionate share of whom are Black and/or Latine.[78]

Quality of Care

Access to quality maternity care means access to evidence-based and person-centered care, and for far too many people in the United States, it is not a real choice.[79] The maternity care system routinely applies interventions to low-risk births that are not supported by evidence.[80] The medical interventions and procedures that are standard—labor induction, continuous electronic fetal monitoring, cesarean delivery, episiotomy—vary dramatically by institution and geography in ways that cannot be explained by health risk alone.[81] They are influenced by payment incentives, liability norms, and institutional practices that often prioritize intervention over physiology, autonomy, and shared decision-making, and are not always grounded in evidence.[82] [83] Continuous electronic fetal monitoring, for example, is used in more than 85% of hospital births, despite decades of research documenting it increases rates of interventions or surgical delivery without reducing infant mortality or other standard measures of neonatal well-being.[84] [85]

Medical interventions and procedures vary dramatically by institution and geography in ways that cannot be explained by health risk alone.

One in three babies in the US is born via cesarean—a major abdominal surgery—well above the rates in peer nations where midwife-led care is integrated into the system, and more than twice the rate at which the evidence shows is needed for reduction in maternal or newborn mortality.[86] [87] Among low-risk first-time mothers, the US cesarean rate exceeds both the Healthy People 2030 target and the rates in countries with better outcomes, suggesting a large proportion of these surgeries are

75 Joyce A. Martin et al., "Births in the United States, 2024," *NCHS Data Brief* 535 (2025).

76 Hill et al., "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

77 Alice Burns et al., "How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? Allocating CBO's Estimates of Additional Uninsured People Across the States," *Kaiser Family Foundation*, August 20, 2025.

78 Elizabeth Hinton et al., "A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law," *Kaiser Family Foundation*, July 30, 2025.

79 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

80 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

81 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

82 Rie Sakai-Bizmark et al., "Evaluation of Hospital Cesarean Delivery–Related Profits and Rates in the United States," *JAMA Network Open* 4, no. 3 (2021): e212235.

83 Sakala et al., "Maternity Care and Liability: Pressing Problems, Substantive Solutions."

84 Zarko Alfirevic et al., "Continuous Cardiotocography (CTG) as a Form of Electronic Fetal Monitoring (EFM) for Fetal Assessment During Labour," *Cochrane Database of Systematic Reviews* 5 (2013).

85 Raymond G. De Vries et al., "When Evidence Fails to Change Practice: Examining the Persistence of Continuous Fetal Monitoring," *Qualitative Health Research* (2025): 1–13.

86 Martin et al., "Births in the United States, 2024."

87 World Health Organization, *WHO Statement on Cesarean Section Rates* (Geneva: World Health Organization, 2015).

preventable.[88] When interventions are applied routinely rather than based on individual clinical need, they can disrupt the normal progression of labor, increase the likelihood of subsequent interventions and reduce the time and opportunity people have to understand and participate in their care.[89] [90] The recovery from surgery has cascading physical, emotional, and economic consequences: reduced capacity to care for a newborn, complications with breastfeeding, and delayed return to work.[91] For people without paid leave—especially low-wage workers, who are least likely to have access to paid leave or short-term disability benefits—an unnecessary surgery can also have significant financial impacts.[92]

Access to quality maternity care cannot be achieved by expanding access to a system that is not performing to the standard the evidence demands.[93] True access requires realigning that system, including its payment structures, training, and institutional incentives, around evidence and equity.[94]

The impact of being dismissed, coerced, or disrespected during birth does not end in the delivery room; it has lifelong consequences and can engender mistrust in the health care system for years, with negative and lasting ripple effects on the health of families.

Well-Being

Birth is not something simply to survive. It is a life transition with lasting physical, mental, and economic consequences.[95] Yet it is one of the few areas of healthcare where mistreatment—including violations of autonomy, respect, privacy, and informed consent—is now documented by the Centers for Disease Control and Prevention, in peer reviewed studies and nationally representative or multi-state surveys at substantial rates.[96] [97]

The impact of being dismissed, coerced, or disrespected during birth does not end in the delivery room; it has lifelong consequences and can engender mistrust in the health care system for years, with negative and lasting ripple effects on the health of families.[98] [99] Negative interpersonal experiences such as feeling powerless, ignored, or coerced are strongly associated with postpartum mental health conditions and are among the most common complications of childbirth for women.[100] [101]

88 U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, "Reduce Cesarean Births Among Low-Risk Women With no Prior Births," *Healthy People 2030.*

89 Michel Rossignol et al., "Interrelations Between Four Antepartum Obstetric Interventions and Cesarean Delivery in Women at Low Risk: A Systematic Review and Modeling of the Cascade of Interventions," *Birth* 41, no. 1 (2014): 70–78.

90 Eugene Declercqet al., "Women's Experience of Agency and Respect in Maternity Care by Type of Insurance in California," *PLOS One* 15, no. 7 (2020): e0235262.

91 Jane Sandall et al., "Short-Term and Long-Term Effects of Caesarean Section on the Health of Women and Children," *The Lancet* 392, no. 10155 (2018): 1349–1357.

92 U.S. Bureau of Labor Statistics, "National Compensation Survey: Employee Benefits in the United States," September 19, 2024.

93 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

94 Alan R. Weil and Alexandra J. Reichert, eds., *Reversing the U.S. Maternal Mortality Crisis: A Report of the Aspen Health Strategy Group* (Washington, DC: Aspen Institute, 2021).

95 Eugene R. Declercq et al., *Listening to Mothers III: New Mothers Speak Out* (New York: Childbirth Connection, 2013).

96 Liu et al., "Disparities in Mistreatment During Childbirth," e244873.

97 Yousra A. Mohamoud et al., "Vital Signs: Maternity Care Experiences — United States, August 2023," *MMWR Morbidity and Mortality Weekly Report* 72 (2023).

98 Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," 77.

99 Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," 77.

100 Claudia Susana Silva-Fernandez et al., "Factors Associated with Obstetric Violence Implicated in the Development of Postpartum Depression and Post-Traumatic Stress Disorder: A Systematic Review," *Nursing Reports* 13, no. 4 (2023): 1553-1576.

101 Sofie Van Sieleghem et al., "Childbirth Related PTSD and its Association With Infant Outcome: A Systematic Review," *Early Human Development* 174 (2022): 105667.

Joy in the birth experience is not a luxury. It is a meaningful part of health and dignity.[102] [103] Feeling safe, respected, and emotionally supported can help reduce stress and fear, support **physiologic** birth, and strengthen a sense of agency.[104] Joyful moments, including connection with care teams and loved ones, affirmation of identity, and early bonding, can also support mental well-being in the postpartum period and contribute to newborn well-being through responsive caregiving and attachment.[105] [106] [107]

In addition, the economic impact of the current system has significant and unequal consequences for millions of families just as they are starting off.[108] Pregnancy, childbirth, and postpartum care involve substantial total and out-of-pocket costs.[109] New mothers are more likely than similarly aged women who did not recently give birth to have medical debt.[110] [111] Deductibles, copays, coinsurance, and unexpected bills can add up quickly, and separate charges for prenatal visits, the delivery itself, hospital stays, anesthesia, newborn care, and postpartum follow-up can leave families with large medical debt at a moment when income may also drop due to unpaid leave.[112] As of 2023, 73% of US workers did not have access to paid family leave, and estimates suggest only 5% of low wage workers have paid time off to care for a new baby.[113] As a result many parents must return to work quickly or face financial strain. These are not incidental burdens; they are the predictable consequences of a maternity care system that has never been structured to support all women and birthing people.

Racial Disparities

The people most likely to be denied choice, access, and respectful treatment are also most likely to experience the worst outcomes.[114] [115] Race and ethnicity continue to impact both the quality of prenatal care and whether mothers or their babies survive birth or experience lasting harm.[116] [117] Black women in the United States face significantly higher risks of maternal mortality and severe morbidity than their peers—disparities that persist across income, education, and insurance status.[118] [119] These disparities reflect racism, bias, and unequal

102 Julia Leinweber et al., "Developing a Woman-Centered, Inclusive Definition of Positive Childbirth Experiences: A Discussion Paper," *Birth* 50, no. 2 (2023): 362–383.

103 World Health Organization, *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience* (Geneva: World Health Organization, 2018).

104 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

105 Meghan A. Bohren et al., "Continuous Support for Women During Childbirth," *Cochrane Database of Systematic Reviews* 7 (2017).

106 Elizabeth R. Moore et al., "Early Skin to Skin Contact for Mothers and their Healthy Newborn Infants," *Cochrane Database of Systematic Reviews* 11 (2016).

107 Erja Rusanen et al., "Maternal Postnatal Bonding and Its Risk Factors: A Longitudinal Study," *Child and Adolescent Psychiatry and Mental Health* 19, no. 1 (2025): 140.

108 Heidi Allen et al., "When the Bough Breaks: The Financial Burden of Childbirth and Postpartum Care by Insurance Type," *The Milbank Quarterly* 102, no. 4 (2024): 868–895.

109 Aubrey Winger et al., "Health Costs Associated with Pregnancy, Childbirth, and Infant Care," *Peterson-KFF Health System Tracker*, June 26, 2024.

110 Cynthia Cox and Gary Claxton, "Medical Debt Among New Mothers," *Peterson-KFF Health System Tracker*, May 9, 2024.

111 Jordan Cahn et al., "The Association of Childbirth With Medical Debt in the USA, 2019–2020," *Journal of General Internal Medicine* 38, no. 10 (2023): 2340–2346.

112 Winger et al., "Health Costs Associated with Pregnancy, Childbirth, and Infant Care."

113 U.S. Bureau of Labor Statistics, "What Data Does the BLS Publish on Family Leave?" September 21, 2023.

114 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

115 Sakala et al., "Listening to Mothers in California."

116 Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2023," *NCHS Health E-Stats*, February 5, 2025.

117 P. Mimi Niles et al., "Examining Respect, Autonomy, and Mistreatment in Childbirth in the US: Do Provider Type and Place of Birth Matter?," *Reproductive Health* 20, no. 1 (2023): 67.

118 Hoyert, "Maternal Mortality Rates in the United States, 2023."

119 Hill et al., "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

treatment embedded within maternity care systems. Black and Indigenous birthing people consistently experience higher rates of mistreatment, disrespect, dismissal, and lack of agency during childbirth.[120] [121] Cultural mismatches and the absence of concordant providers erode trust.[122]

Black women in the US face significantly higher risks of maternal mortality and severe morbidity than their peers, disparities that persist across income, education, and insurance status.

While disparities for Black and Indigenous people are most severe, inequities in maternal health extend across other communities of color and are often masked by aggregated data. Outcomes for Asian Americans and Pacific Islanders vary significantly by subgroup, with worse outcomes among Southeast Asian and Pacific Islander communities.[123] [124] Latine people face persistent barriers including delayed prenatal care, language access challenges, and insurance gaps, alongside rising maternal mortality over time.[125]

Barriers to Midwifery

Access to midwifery care in the United States is severely constrained by policy, financing, and health system design, in contrast to comparable countries where midwifery is fully integrated into the reproductive healthcare system.[126] Medicaid reimbursement rates for midwifery services are often set below the cost of care, and in many states certified nurse-midwives are reimbursed below the physician rate for the same services, while certified professional midwives and licensed midwives may not be covered at all.[127] Rates in the commercial market are often misaligned with the midwifery model of care, and in some cases birth centers, midwifery practices, and planned home births are excluded from networks.[128] These payment gaps make it difficult for midwifery practices to remain financially viable, particularly those serving low-income and rural communities where Medicaid is the dominant payer.[129] [130]

The varied state landscape for licensure and scope-of-practice laws compounds the problem.[131] In a significant number of states, nurse-midwives are required to practice under physician supervision or collaborative agreements that are often difficult to secure because physicians face liability concerns or institutional opposition.[132] Where these agreements are required but unavailable, midwives may be unable to practice independently or within the full scope of their training. States and national certifying bodies use several terms for midwives who enter

120 Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States," 77.

121 Joia Crear-Perry et al., "Social and Structural Determinants of Health Inequities in Maternal Health," *Journal of Women's Health* 30, no. 2 (2021): 230–235.

122 Katy B. Kozhimannil, "Indigenous Maternal Health—A Crisis Demanding Attention," *JAMA Health Forum* 1, no. 5, (2020): e200517–e200517.

123 Janice Hata and Adam Burke, "A Systematic Review of Racial and Ethnic Disparities in Maternal Health Outcomes Among Asians/Pacific Islanders," *Asian/Pacific Island Nursing Journal* 5, no. 3 (2020): 139–152.

124 Stephanie Glover and Dawn Godbolt, *Listening to Asian and Pacific Islander Mothers in California,* (Washington, DC: National Partnership for Women & Families, 2018).

125 Stephanie Glover and Dawn Godbolt, *Listening to Latina Mothers in California* (Washington, DC: National Partnership for Women & Families, 2018).

126 Munira Z. Gunja et al., "Insights into the US Maternal Mortality Crisis: An International Comparison," *The Commonwealth Fund*, June 4, 2024.

127 Dakota Staren et al., *State Medicaid Coverage of Certified Nurse Midwives* (Washington, DC: National Academy for State Health Policy, 2026).

128 Staren et al., *State Medicaid Coverage of Certified Nurse Midwives*.

129 Medicaid and CHIP Payment and Access Commission, *Access to Maternity Providers: Midwives and Birth Centers* (Washington, DC: Medicaid and CHIP Payment and Access Commission, 2023).

130 North American Registry of Midwives, *Direct Entry Midwifery State-by-State Legal Status,* September 30, 2023.

131 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

132 American College of Nurse-Midwives, *State Practice Environment for Certified Nurse-Midwives*, March 2026.

the profession through non-nursing pathways, including the national credential of certified professional midwife (CPM), licensed midwife, direct-entry midwife, licensed lay midwife, certified midwife (CM), and traditional midwife.[133] The regulatory landscape for CPMs varies widely by state, and in some cases it is illegal to practice midwifery without a nursing license or other state-recognized credential.

Birth centers face their own set of structural obstacles.[134] Licensing requirements vary significantly by state and are in many cases designed around hospital standards that do not fit the evidence of what is needed in the community-based setting.[135] Certificate-of-need laws in some states require birth centers to demonstrate that the public needs their services before they can open, a threshold that is difficult for a small practice to prove and that reinforces existing gaps in access.[136] Reimbursement for birth center care is often inadequate, inconsistent, and routinely paid months after care is provided, making it hard for centers to cover operating costs let alone expand.[137]

The midwifery workforce itself remains insufficient in both size and diversity to meet the need...

The result is a limited workforce that does not reflect the communities where expanded access is most urgent, and that cannot grow fast enough even when and where policy and payment conditions improve.

Integration of midwifery-led care into hospital systems presents additional barriers.[138] Midwives seeking hospital privileges frequently encounter resistance from medical staff and administration, limiting their autonomy and ability to provide the midwifery model of care or continuity of care when clients require transfer.[139] Professional hierarchies and liability concerns can make collaboration between midwives and physicians difficult even where both parties are willing, and hospital policies often default to physician-only protocols regardless of clinical evidence.[140] This lack of integration means that even clients who begin care with a midwife may lose that relationship at the moment of birth, undermining one of the core benefits of midwifery-led care: continuity.[141]

Finally, the midwifery workforce itself remains insufficient in both size and diversity to meet the need.[142] [143] Training programs are limited in number and capacity, pathways into the profession are narrow for students from low-income backgrounds, and midwives of color face additional barriers in accessing both the didactic and clinical education and necessary credentialing.[144] The result is a limited workforce that does not reflect the communities where expanded access is most urgent, and that cannot grow fast enough even when and where policy and payment conditions improve.[145]

133 North American Registry of Midwives, *Direct Entry Midwifery State-by-State Legal Status*.

134 Medicaid and CHIP Payment and Access Commission, *Access to Maternity Providers: Midwives and Birth Centers*.

135 National Partnership for Women & Families, *Improving Access to and Payment for Maternity Care in Community Settings*, May 2023.

136 National Partnership for Women & Families, *Improving Access to and Payment for Maternity Care in Community Settings*.

137 American Association of Birth Centers, *Getting Payment Right: An Action Plan for Birth Centers*, white paper (2021).

138 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America*.

139 American College of Nurse-Midwives, *Removing Barriers to Midwifery Care: Hospital Privileges,* September 2024.

140 American College of Nurse-Midwives, *Collaborative Agreement Between Certified Nurse-Midwives/Certified Midwives and Physicians or Other Health Care Providers,* position statement, 2023.

141 Birth Place Lab, University of British Columbia, *Best Practice Guidelines for Transfer and Collaboration*, 2026.

142 U.S. Government Accountability Office, *Midwives: Information on Births, Workforce, and Midwifery Education*, GAO-23-105861 (Washington, DC: U.S. Government Accountability Office, 2023).

143 American Midwifery Certification Board, *2024 Demographic Report*, 2024.

144 Renee Mehra et al., "Racism Is a Motivator and a Barrier for People of Color Aspiring to Become Midwives in the United States," *Health Services Research* 58, no. 1 (2023): 40–50.

145 P. Mimi Niles and Laurie Zephyrin, "How Expanding the Role of Midwives in US Health Care Could Help Address the Maternal Health Crisis," *The Commonwealth Fund*, May 5, 2023.

3

Skyline's Work Toward Birth Justice

Skyline Foundation's work is grounded in the belief that everyone deserves a healthy and empowering birth, and that midwives are essential to achieving this goal. Integrating midwifery care has the power to directly address the system's biggest failures simultaneously; in fact, it is the rare intervention that's been proven to improve quality, reduce disparities, expand access to providers, and strengthen outcomes.[146] [147] [148] [149]

Community-based care such as midwifery is often treated as peripheral rather than a high-impact, evidence-based investment. Funding for birth justice requires moving money to historically underfunded and disparate communities of advocates, providers, and scholars who have been working for decades with almost no philanthropic investment.

Skyline Foundation's Birth Justice funding is grounded in the recognition that the US maternity care system is not consistently organized around the needs, autonomy, or well-being of birthing people and their families. We work to create a system in which people can meaningfully participate in decisions about their pregnancy, birth, and postpartum care, and ensure that access is equitable across communities. To us, it means people are able to move through pregnancy, birth, and the postpartum period with dignity, agency, and the kind of care that fits their needs. This includes not only clinical excellence, but also continuity, respect, and support for the well-being of those giving birth, their babies, and their families.

Skyline recognizes that there are powerful economic and political forces determining the conditions under which babies are born. We believe the scientific evidence and experience of other nations demonstrate midwifery is the intervention most likely to move the needle on the most intractable problems in maternity care today. When the principles and practices of skilled midwives are seamlessly part of our maternity system, we can expect to see maternal and infant outcomes improve, disparities diminish, and women experience greater autonomy and well-being in their pregnancy, birth, and postpartum.

We support building the field infrastructure, policy conditions, and workforce capacity that determine whether women can exercise genuine authority over one of the most consequential experiences of their lives.

THE BIRTH JUSTICE MOVEMENT

The Birth Justice movement emerged from the reproductive justice framework developed by Black women activists working to end preventable maternal mortality and morbidity. Their goal was creating conditions for all people to give birth with dignity, joy, and support to address the root causes of maternal health disparities—including racism, economic exploitation, gender oppression, and colonialism. It calls for transforming the conditions that determine who has access to safe, respectful, culturally affirming care and who has the power to make decisions about their own bodies, pregnancies, and families.

Birth justice occurs when everyone is equally capable of self-determination during the perinatal period and their self-determination is supported and amplified.

146 Vedam et al., "Mapping Integration of Midwives Across the United States."

147 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America.*

148 Sandall et al., "Midwife Continuity of Care Models Versus Other Models of Care for Childbearing Women."

149 Mary J. Renfrew et al. "Midwifery and Quality Care: Findings From a New Evidence-Informed Framework for Maternal and Newborn Care," *The Lancet* 384, no. 9948 (2014): 1129–1145.

We fund organizations advancing one or more of these strategic priorities:

1 Data, Quality, and Accountability Systems

2 Education, Organizing, and Evidence-Building

3 Payment Reform, Legislation, and Policy

4 Workforce Expansion and Diversification

Grantmaking Approach

Skyline's grantmaking is structured to support both organizational resilience and systemic change. Grants are made in two forms: general operating support, which gives organizations the flexibility to respond to a changing environment and invest in institutional capacity; and project support, which funds specific initiatives, research, and advocacy efforts tied to defined outcomes.

Over the decade, the vast majority of grants spanned two or more years. Of all grants awarded, 45% have funded general operating support and 55% have funded project grants, a ratio that has shifted toward general operating support in recent years. This reflects a deliberate philosophy: organizations doing systems-change work need the stability that multi-year general operating support provides, and strategic project funding can accelerate specific areas of work and promote cross-stakeholder collaboration. Of the organizations who have received a grant from Skyline in the past, 75% remain in the portfolio, reflecting our commitment to provide the long-term funding needed to strengthen organizations and our knowledge that complex issues require patient capital. Of the organizations no longer in the portfolio, more than half were engaged in time-limited projects. In a small number of cases, organizations moved out of the portfolio as Skyline refined its focus, prioritizing work most directly aligned with midwifery or reflecting individual organizations' circumstances or capacity.

Grant sizes have grown substantially over the decade, reflecting the maturation of the field and Skyline's increasing confidence in the organizations it funds. This growth is grounded in a **trust-based approach**:

THE HISTORICAL SIDELINING OF MIDWIFERY PRACTICE

While it is a practice with deep historic roots, midwifery in the United States was sidelined as medicine professionalized and physicians consolidated authority through licensing systems and hospital expansion.[1] Organized campaigns framed midwives as unsafe and "unscientific." These efforts were deeply racialized: Black "granny midwives," immigrant midwives, and rural practitioners were disproportionately targeted through stereotypes and regulatory barriers.[2] Training and supervision of midwives became a surrogate for surveillance and, eventually, elimination of this practice, shifting power away from communities and toward often segregated institutions.[3] Anti-abortion politics strengthened the broader project of state control over reproduction by elevating physician authority.[4] Expanded regulatory policing and reporting frameworks have increasingly restricted what midwives are allowed to do, contributing to a highly medicalized maternity system and persistent inequities in care and outcomes.[5]

1 Weil and Reichert, eds., *Reversing the U.S. Maternal Mortality Crisis.*

2 Michele Goodwin, "The Racist History of Abortion and Midwifery Bans," *American Civil Liberties Union*, July 1, 2020.

3 Sheena Morrison, "Called to Practice: African American 'Grannies,' *Midwives, & Health Reform* (Bethesda, MD: National Library of Medicine, 2010).

4 Goodwin, *The Racist History of Abortion and Midwifery Bans.*

5 Goodwin, *The Racist History of Abortion and Midwifery Bans.*

Ten Years of Grantmaking 2015–2025

$33.6M Total granted	**101** Grants made	**39** Grantees *(29 active)*	**10** Grantees funded 5+ years
48% BIPOC-led grantees	**83%** Multi-year grants	**55%** Project support *(by number of grants)*	**45%** General support *(by number of grants)*

Skyline prioritizes multi-year relationships, minimizes administrative burden, and centers grantee expertise in shaping strategy and learning. By providing flexible funding, and engaging in ongoing dialogue designed for shared learning rather than one-way evaluation, Skyline seeks to shift power toward the organizations closest to the work, while strengthening our own understanding of the issues and the conditions for long-term systems change. Skyline's Birth Justice portfolio reflects a strategy that balances broad support for the field, with targeted investments in key levers of systems change. Most grantees are advancing work in two or more of our strategic priorities and 14% work across all four. More than half of the portfolio grantees focus on policy advocacy, underscoring Skyline's belief that durable improvements in maternal health require changes to the policies, regulations, and payment systems that shape how care is delivered. Grantees work to expand and improve Medicaid coverage, reform reimbursement structures, advance licensure and scope-of-practice policies for midwives, remove regulatory barriers to birth center care, and elevate community-informed policy solutions at the state and federal levels. Skyline also directs support to a wide range of grantees engaged in efforts to expand access to community-based maternity care, support leadership development across the Birth Justice movement, and strengthen the operational capacity of organizations working directly with pregnant and postpartum people.

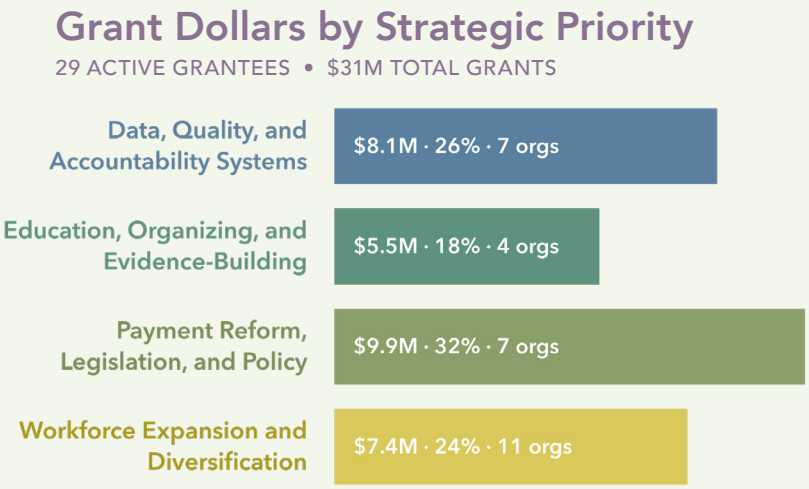
Grant sizes have grown substantially over the decade, reflecting the maturation of the field and Skyline's increasing confidence in the organizations it funds.

A smaller share of grantees focused on payment and financing receive a larger share of grant funding, reflecting the complexity and capital intensity of developing new payment models, financing mechanisms, and care-delivery innovations. These efforts include designing sustainable financing for birth centers, developing value-based payment models for maternity care, and piloting new approaches to integrating community-based midwives into health systems. Research initiatives complement this work by generating the evidence needed to inform policy reform, demonstrate the impact of community-based care models, and strengthen the data available to advocates and policymakers.

Collaboratives and other organizations focused on their own grantmaking play an important role in the Skyline portfolio as well. They have their finger on the pulse of the field across multiple geographies, provide essential field infrastructure and coordinating

functions, and expertly move resources to grassroots and community-led organizations that are less visible to funders but central to advancing birth justice. **Groundswell Fund** and **Birth Center Equity** each fall among the top 25% of Skyline grantees as measured by total funds received.

The portfolio also includes health care providers and community-based organizations delivering care directly to pregnant and postpartum people including **CHOICES Center for Reproductive Health (CHOICES)**, **PCC Community Wellness Center**, and **Community of Hope**. These organizations not only provide high quality integrated midwifery care in underserved communities but are also advancing the field with innovative models addressing workforce development and payment reform. By supporting organizations working at the policy and systems level and those delivering care, Skyline's grantmaking reflects an understanding that improving maternal health outcomes requires change across multiple layers of the ecosystem—from workforce development and care delivery models to financing systems, policy reform, and community power.



Many grantees combine research, design, and implementation and conduct analysis, develop new models of care, and work directly with health systems and policymakers to translate ideas into practice. Advocacy and power-building organizations are also a central component of the portfolio, mobilizing communities, advancing policy agendas, and ensuring that the voices of historically marginalized communities are shaping maternal health reform.

Professional associations play a distinct role by representing the interests of midwives, birth centers, and other maternity care providers, setting standards for practice, supporting workforce development, and advancing policies that expand access to midwifery care. Skyline's grantee partners represent each of the national midwifery professional membership bodies, including the **American Association of Birth Centers**, the **American College of Nurse-Midwives**, the **National Association of Certified Professional Midwives**, and state-level professional associations or membership groups, including the **Californians for the Advancement of Midwifery** and the **California Nurse-Midwives Foundation**.

Geographic Reach

Our grantmaking is focused on the United States and includes national, state, and local level. The majority of grant dollars, 60%, fund support organizations working at the national level including the **Institute for Medicaid Innovation**, the **National Association to Advance Black Birth**, and **National Partnership for Women & Families**. These organizations play a critical role in shaping federal policy debates, advancing national standards for maternity care, building the evidence base for community-based models, and coordinating advocacy efforts across states. National organizations including **Elephant Circle** and the **National Academy for State Health Policy** also help translate lessons from local innovation into broader policy and systems change.

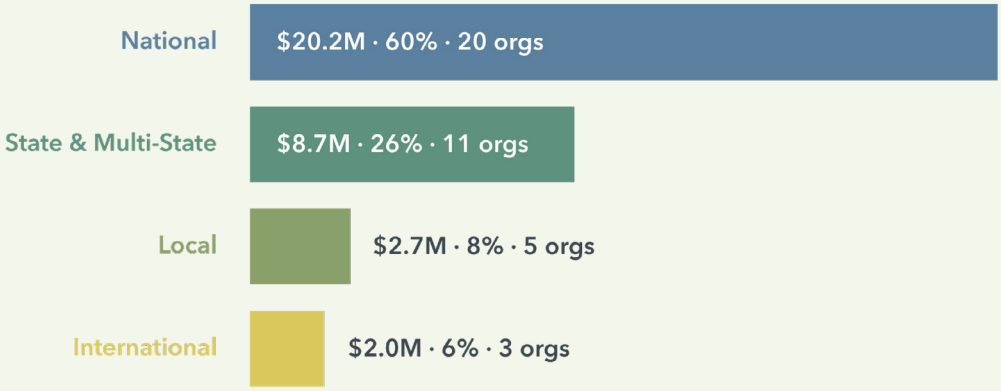
Skyline also supports organizations working at the state and local levels, where many of the most consequential decisions affecting maternal health are made. Our grantees working at the state level focus on advancing Medicaid policy reforms, expanding licensure and scope of practice for

midwives, and strengthening state-level advocacy coalitions; **Midwifery Access California** is one example. Local and multi-state organizations such as **Asociación de Parteras de Puerto Rico**, **Sisters in Birth**, and **Black Midwifery Collective** together represent 17% of portfolio funding—and frequently support community-based care models, birth centers, and grassroots organizing efforts that are closely connected to the needs of pregnant and postpartum people.

Additionally, the three international organizations —**Birth Place Lab**, **Every Mother Counts**, and **Quality Maternal and Newborn Care Research Alliance**—have received grants because their work contributes to global learning, research, and cross-national exchange relevant to advancing birth justice in the United States.

Grant Dollars by Geographic Focus

39 ACTIVE & PAST GRANTEES • $33.6M TOTAL GRANTS



Emerging Organizations and Growth

The Birth Justice portfolio includes eight organizations founded in the last ten years, each of them developing innovative models of care, policy solutions, and community-based strategies that address longstanding inequities in maternal health.

One grantee, Ariadne Labs, designed, tested, and implemented **TeamBirth**, a hospital-based care model that reflects many of the core principles of midwifery care: centering the birthing person's voice, strengthening communication across the team of providers, supporting informed decision-making, and aligning the care team around the patient's priorities. Peer-reviewed studies have found that TeamBirth is associated with improved structured communication and higher patient-reported trust and autonomy during childbirth.[150] Now adopted by more than 300 hospitals, the model's strong uptake led to the launch of **Unravel Healthcare**, a new organization created to support broader TeamBirth implementation, an example of how early philanthropic support can help promising models move from proof of concept toward field-level infrastructure.

Grantees in the portfolio for more than three years have seen median budget increases of approximately 200% over that time. Smaller and emerging organizations experienced the most rapid growth, suggesting that early-stage support can help promising organizations stabilize, expand their work, and build the track record needed to attract additional philanthropic and public funding.

150 Isabel Griffith et al., "Effect of Teambirth on Patient Trust and Autonomy During Childbirth in Oklahoma," *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 54, no. 5 (2025): 501–515.

The Evolution of Skyline Strategy

2015–2017 LISTENING AND LEARNING

5 GRANTS • $1.38M

Skyline's entry into birth justice began with an overarching question: where and how could philanthropic support address the lack of information, autonomy, and dignity during birth?

Early grants were intended to understand and elevate pregnant women's experiences, and assess the windows of opportunity with input from a range of stakeholders including maternity care providers, purchasers, employers, and hospitals. The first grants were focused on California, where Skyline (then known as Yellow Chair Foundation) is based.

Skyline and the California Health Care Foundation co-funded the National Partnership for Women & Families to design and implement **Listening to Mothers (LTM) in CA**, a population-based survey designed to capture mothers' experiences of pregnancy, birth, and postpartum care with unusually rich detail—including care practices, decision-making, outcomes, and experiences of respect or mistreatment—so the findings could inform both policy and quality improvement. It was also the first national survey intentionally designed to produce meaningfully sized samples of multiple racial/ethnic groups, enabling robust comparisons across groups rather than treating race as an afterthought. Among the rich data, the survey found that 54% of women expressed interest in using a midwife for their next birth, but most did not have access to one. Skyline went on to fund the most recent national fielding of the survey as well, and together the set of Listening to Mothers surveys remain one of the only comprehensive, representative sources capturing how pregnancy and birth care are experienced in the US. The National Partnership for Women & Families continues to be a core Skyline partner and essential resource for **advocates**, **policymakers**, and **consumers**. Listening to Mothers surveys have shaped the US maternity care field by making childbearing people's experiences visible at national scale—impacting how researchers, advocates, and policymakers define and measure maternity care quality, including respectful care and patient experience.

Another early grantee, **Purchaser Business Group on Health (PBGH)**, received funding for a multi-year effort to engage a broad range of stakeholders from birth centers, hospitals, large employers, maternal health providers and advocates, and health plans to develop a blueprint for integrating midwifery. As a result, there are now **several tools available for medical groups, hospitals, and employers** to increase access to midwifery-led care in their organizations. Today, there is **a shared standard** to define comprehensive maternity care and the first-ever **Comprehensive Maternity Care Measure Set**, which informed the development of the **PBGH Comprehensive Maternity Care Common Purchasing Agreement**. The agreement has now been implemented by multiple large purchasers and provides benefit design and purchasing recommendations for employers and public purchasers, health plans, and providers.

Skyline also made a grant to the **California Maternal Quality Care Collaborative** (CMQCC) to work on hospital-based quality improvement efforts to reduce unnecessary cesareans and other interventions using data, reporting, and accountability. CMQCC's work contributed to California's significant decline in unnecessary C-sections (from 26% to 22.8%) and surpassing national goals (Healthy People 2020) ahead of schedule. Currently, CMQCC has a grant from Skyline to support their **Community Birth Partnership Initiative**, designed to improve safety of transfers between community births and hospitals.

2018–2019 REFINING A STRATEGY

13 GRANTS • $2.89M

By 2018, Skyline defined its grantmaking around two interconnected goals:

- Expand access to the midwifery model of care by increasing demand among consumers, purchasers, payers, and providers; promoting the scale and spread of birth centers; and increasing the size and diversity of the midwifery workforce.
- Reduce unnecessary cesareans and other medical interventions in hospitals among first-time low-risk pregnancies in California and other states, and shifting incentives among consumers, purchasers, payers, and providers.

New grantees added in this period reflected a deepening of work to expand access. This is when Ariadne Labs joined the portfolio to develop **TeamBirth**, a model that has helped shift the narrative around childbirth toward respect, dignity, and shared decision-making. March for Moms also received its first grant in 2018.

Skyline supported **Groundswell Fund's** Birth Justice Initiative, which brought a reproductive justice frame to bear by funding midwives, doulas, and birth workers of color who were leading innovative direct service delivery, advocacy, and organizing efforts. Skyline provided the initial funding for the University of California San Francisco Midwifery Mentoring & Belonging Program, designed to address the underrepresentation of BIPOC midwives and the barriers they face during training. After the program launched at Cal State Fullerton, the model was made available to nurse midwifery programs nationally.

The **American Association of Birth Centers**, the **Institute for Medicaid Innovation**, and **Black Mamas Matter Alliance** joined the portfolio during 2019, reflecting a deliberate effort to bolster the birth center and midwifery representation in national policy work and resource small organizations lacking resources to disseminate their work.

2020–2022 BRINGING IN COMMUNITY MIDWIVES

41 GRANTS • $9.9M

In this phase, Skyline sharpened its focus on equity and expansion to include initiatives squarely focused on midwives trained for birth center and home births. The foundation supported the Foundation for Health Care Quality's **Community Birth Data Registry**, as well as the development of safety and transfer protocols, training for emergency services, and agreements between hospitals and birth centers or home-birth midwives.

Response to the COVID-19 pandemic helped shape grantmaking in 2020. The California Birth Worker Relief Fund received emergency COVID-related support for BIPOC midwives facing a sudden financial crisis when demand for out-of-hospital births increased.

In 2021, Skyline updated its portfolio description to make the equity focus more explicit by adding "to make birth equitable and just for all" to reflect grantmaking

COVID RESPONSE GRANT: UCSF / UCLA PRIORITY STUDY

The UCSF/UCLA PRIORITY Study helped curb early over-treatment in pregnancy by showing most COVID-19 cases were mild and didn't require routine hospitalization or intervention.[1]

The findings also supported moving away from automatic mother–infant separation, helping shift guidance toward rooming-in and breastfeeding with precautions rather than default separation.[2]

1 Yalda Afshar et al., "Clinical Presentation of Coronavirus Disease 2019 (COVID-19) in Pregnant and Recently Pregnant People," *Obstetrics & Gynecology* 136, no. 6 (2020): 1117–1125.

2 Valerie J. Flaherman et al., "Infant Outcomes Following Maternal Infection with Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2): First Report From the Pregnancy Coronavirus Outcomes Registry (PRIORITY) Study," *Clinical Infectious Diseases* 73, no. 9 (2021): e2810–e2813.

priorities and a recognition that the structural failures of the maternity care system fell most heavily on Black and other historically marginalized communities.

During this period, grants were given for the first time to American College of Nurse Midwives, the California Nurse-Midwives Foundation, and National Birth Equity Collaborative. Skyline also became an early funder of the Birth Center Equity and the **Quality Maternal and Newborn Care Research Alliance**. In 2022, additional first-time grants were given to the National Association of Certified Professional Midwives. Skyline co-funded **Jamaa Birth Village** with Merck for Mothers, and the **Funders for Birth Justice and Equity** formally launched.

2023–2025 ADVANCING EQUITY IN MATERNAL HEALTH

26 GRANTS • $10.06M

In 2023, the foundation launched its first public website across all of its work, giving the portfolio a more visible presence in the field. At that time the portfolio, previously described as "Maternal Health," was renamed "Birth Justice" to align the foundation's language with its approach to grantmaking and to make explicit the values driving the work. The portfolio grew significantly in this phase to include: **Birth Place Lab**, Elephant Circle, CHOICES, the **Midwifery Education Accreditation Council**, the National Association to Advance Black Birth, and PCC Community Wellness Center.

The portfolio aim was updated with greater clarity of focus; the foundation now sought to improve the birth experience in the United States by working toward the full integration of midwifery into the health care system, addressing systemic failures to provide equitable, accessible, respectful, safe, and affordable care to all families.

New grantees added in 2024 and 2025 reflected this sharpened focus: Asociación de Parteras de Puerto Rico, the Black Midwifery Collective, Californians for the Advancement of Midwifery, Midwifery Access California, Sisters in Birth, **University of Washington's H.E.A.L.I.N.G. Midwifery Together**, the National Academy for State Health Policy, and Community of Hope.

As an example of supporting local providers who are innovating new models of care, the foundation supports Community of Hope in Washington, DC as they partnered with DC's Department of Health Care Finance (one of the Centers for Medicaid and Medicare Services's fifteen state awardees) to develop a sustainable payment model for midwifery-led birth center care housed within a federally qualified health center (FQHC). Locating a birth center within an FQHC strengthens access and continuity for Medicaid and underserved patients by pairing the birth center's evidence-based, low-intervention model with the FQHC's comprehensive primary and reproductive health services. This enables integrated prenatal-to-postpartum care, stronger wraparound supports, and a stable safety-net infrastructure that can sustain high-quality maternity care over time.

During this time period, there was greater recognition that advancing equity included support for the midwifery-led systems of quality improvement and accountability. Existing systems have focused predominantly on improving hospital-based care and excluding planned community births. This **exclusion of community birth** from perinatal data collection and **quality improvement systems** yields an incomplete picture of US birth outcomes, and limits efforts to promote greater integration of midwifery care.

Skyline also began funding **Uplift Lab** at Oregon State University to convene the field to pursue a ten-year goal of an accountability and quality infrastructure for community births that includes a comprehensive data system to support pattern detection, quality improvement, and ultimately a federally recognized system for community birth data.

Grantee Spotlights

DATA, QUALITY, AND ACCOUNTABILITY SYSTEMS

Community birth outcomes data has historically been fragmented and under-resourced. To change this, midwifery and birth-center leaders are building durable, privacy-conscious systems that can capture outcomes across care settings, support continuous quality improvement, and make community birth data usable for research, policy, and accountability.

The **Think Big Initiative** is a two-year, collaborative process led by the National Association of Certified Professional Midwives and Uplift Lab that brings midwives and partners together to envision and design the national infrastructure upgrades needed to expand universal access to community midwifery care. Through structured, peer-driven workgroups and broader community input, the initiative is building a shared blueprint for what it will take to strengthen and scale community birth—centering the practical systems, supports, and coordination needed for midwives and families to thrive. This work will build upon existing data collection systems including the **Community Birth Data Registry**, the **Perinatal Data Registry**, and other national and local perinatal data sources.

EDUCATION, ORGANIZING, AND EVIDENCE-BUILDING

The **Birth Place Lab (BPL)**, based at the University of British Columbia, advances the integration of the midwifery model of care in the US by producing practical, policy-relevant evidence about what high-quality maternity care looks like across birth settings, and by translating that evidence into tools that US health systems and decision-makers can use.

Through its essential and widely used Midwifery Integration Scoring System (MISS) and related state-level report card, BPL has shown that states with stronger integration of midwives tend to have better maternal-newborn outcomes including higher rates of physiologic birth and lower rates of adverse neonatal outcomes across all racial groups. Their analysis helps shift integration from an abstract goal into concrete levers: regulation, scope of practice, prescribing authority, payment and coverage, as well as smoother collaboration and transfer pathways when higher acuity care is needed. The **recently released updated state rankings** reflect the current landscape of midwifery integration across the United States, and captures significant policy changes, new licensure frameworks, expanded scope-of-practice legislation, and shifts in Medicaid coverage.

BPL has developed three of the primary validated instruments now used across the field: the Mothers on Respect index, which measures the quality of respectful maternity care; the Mothers Autonomy in Decision-Making scale, which measures patient agency in clinical decision-making during maternity care; and the Mistreatment by Care Providers in Childbirth indicators.

PAYMENT REFORM, LEGISLATION, AND POLICY

The **Institute for Medicaid Innovation (IMI)** has advanced midwifery as a high-value, evidence-based maternal model of care within Medicaid by convening state Medicaid agencies, Medicaid managed care plans, and provider and community partners to work on the changes required to make midwifery-led care accessible and sustainable. IMI's work focuses on persistent barriers such as financing and reimbursement, limited access for people with low incomes from culturally diverse communities, low public and stakeholder awareness of midwifery benefits, and fragmentation between health systems, payers, and clinicians.

A centerpiece of that effort has been IMI's multi-state learning agenda. After publishing a report for Medicaid stakeholders on opportunities to improve maternal outcomes, IMI launched an 8-part virtual learning series with national experts and cross-state Medicaid stakeholders, and then moved into a more intensive Midwifery and Medicaid Learning Collaborative phase. This "midwifery business learning" emphasis helps states and plans move from general interest to implementation by surfacing real-world operational questions like how midwifery and birth center models are financed, how Medicaid coverage and contracting can work across settings, and what it takes to align incentives and accountability in a fragmented maternity care system.

California was one of five state-based teams selected to receive technical assistance and guidance from IMI and a national advisory committee. When the IMI-facilitated learning collaborative concluded, the California team chose to continue as an ongoing coalition, and the momentum from this work and the cross-sector relationships that were built led to the founding of a new organization. Midwifery Access California (MACa) is a multi-stakeholder collaboration that brings together midwifery practices, Medi-Cal health plans, community advocacy organizations, and state and local agencies to expand access to midwife-led care across California. MACa's work focuses on two linked strategies: integrating midwife-led care more fully into existing clinical settings such as clinics and hospitals, and strengthening community midwifery capacity in homes and freestanding birth centers. MACa has an explicit focus on communities most impacted by social, economic, and geographic inequities and racial disparities.

WORKFORCE EXPANSION AND DIVERSIFICATION

The **Black Midwifery Collective** works to improve outcomes for Black birthing people by advancing racially concordant, community midwifery care and confronting racism in the OB-GYN sector. Their workforce strategy focuses on growing and re-diversifying the midwifery pipeline through efforts like partnering with Kennedy-King College, a community college in Chicago, to expand access to midwifery education in the communities most impacted by poor maternal outcomes. The first cohort of students is anticipated this fall. A community college pathway to midwifery promises to reduce many of the structural barriers to workforce diversification. Also in Chicago, the Birth Center at PCC Community Wellness Center advances this strategy as one of the few freestanding birth centers embedded within a Federally Qualified Health Center, serving those who face the steepest barriers to care within a comprehensive safety-net system. In partnership with the Black Midwifery Collective, PCC Birth Center also functions as an equity-centered clinical training site critical to building culturally responsive maternity care; the training site provides supervised clinical placements required for licensure while ensuring BIPOC midwives can develop skills and a durable sense of belonging in a community-based setting.

4

Progress in the Field

Over the past ten years, we've witnessed several ways in which midwifery has moved from the margins of health care towards full integration. Through leadership, innovation, and collective action, our grantees have delivered progress and notched significant gains nationally.

Increased Receptivity and Demand for Midwifery Care

47%
Increase in community births
2019–2022

78,000
Community births
(Home + Birth Center)
2022

2.1%
Share of US births outside hospitals
2022

"We no longer have to explain the difference between midwives and doulas as frequently to health plans, and federal and state agency representatives… we've been able to shift our work towards facilitating at a higher and more nuanced level."

—Skyline Grantee

Among the most striking changes of the past decade is the growth in public awareness of midwifery-led care—most clearly reflected in its prevalence. In 2015, 9.3% of births were attended by midwives; according to CDC data, by 2024 this number had risen to 13.3%.[151] By 2025, expanding access to midwives had become part of a broader public conversation about maternal health, birth equity, and the failures of a system that spends more on maternity care than any comparable country while producing worse outcomes.

The COVID pandemic contributed to a demand for out-of-hospital births, as hospital visitation restrictions took effect in early 2020 and fears of infection raised interest in birth outside of hospitals. Awareness of the maternal health crisis deepened in the same period, offering new opportunities for families to experience care models that prioritize agency, continuity, and culturally aligned support. The safety concerns spotlighted by the pandemic were instrumental in challenging the widespread assumption that doctors and hospitals are the only option during birth, or always the safest option.

Alongside rising numbers, the nature of demand shifted. Interest in midwifery intersected with concerns about racism and mistreatment in maternity care. Advocacy efforts led by Black midwives, scholars, and community organizers reframed midwifery not as a lifestyle preference but as a structural response to inequity as a model of care built around dignity, autonomy, and cultural alignment that the dominant system had failed to provide. This reframing, supported by a growing body of evidence, broadened the constituency for midwifery and deepened the policy rationale for reform.

A clear sign of this broadening support came in May 2024 when the Purchaser Business Group on Health released its Comprehensive Maternity Care Common Purchasing Agreement, the first collective effort by large employers and public purchasers to define and demand high-quality, equitable maternity care.

151 Centers for Disease Control and Prevention, National Center for Health Statistics, "Natality Data, 2015–2021," *CDC WONDER Online Database.*

Growing Recognition, Integration, and Access to the Midwifery Model of Care

32%
Increase in birth centers, US
2015–2025
395 Birth Centers (2025)

60%
Increase in home births, US
2015–2021
1.4% of total births (2021)

32%
Increase in certified nurse midwives, US
2015–2025
14,832 total CNMs/CMs (2025)

"We now have countless examples of hospitals and midwives working together in a collaborative way.

We regularly hear providers say 'I've been in this a long time, and this once felt impossible.'"

—Skyline Grantee

GRANTEE HIGHLIGHT

Birth Center Equity (BCE) was founded in 2020 to make birth center care an option for every person who wants it, by growing and sustaining birth centers led by Black, Indigenous and other people of color. By investing in and standing alongside birth center leaders, BCE is helping build the kind of care infrastructure that makes safe, culturally reverent, midwifery-led birth more accessible and sustainable

Since its founding, the BCE network has grown from fourteen BIPOC-led birth centers to over sixty-four established and developing birth centers nationwide. BCE is growing a community of operational and emerging sites working to shift what's possible for families across the country. Their **Beloved Birth 50 by 50** campaign sets forth a shared vision that 50% of births in the US will be attended by midwives in 2050.

The past decade also produced meaningful structural integration of midwifery into the health care system. Professional relationships and formal recognition between midwives and obstetric medicine improved in ways that would have been hard to predict a decade earlier. The American College of Nurse Midwives, the American Association of Birth Centers, the National Association of Certified Professional Midwives, and many other grantees played critical roles in moving this work forward.

Examples of milestones over the decade include:

ACNM-ACOG Joint Statement (2018)

The American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG)—the two leading national professional bodies for midwives and OB physicians respectively—issued **a joint statement** affirming that certified nurse-midwives and certified midwives are independent clinicians and endorsing team-based care. Coming from the nation's foremost obstetric physician organization, this formal recognition that midwives are peers rather than subordinates carries significant weight in shifting hospital culture, credentialing practices, and collaborative agreements at the institutional level.

Levels of Maternal Care (2019)

The Levels of Maternal Care framework, developed jointly by ACOG and the Society for Maternal-Fetal Medicine to standardize and guide how maternity facilities are designated and resourced, was **updated in 2019** to formally recognize birth centers accredited by the American Association of Birth Centers as "an integral part of regionalized care systems" and names certified nurse midwives as a core provider type. Embedding birth centers and midwives into this official classification system makes it substantially harder for payers, regulators, and health systems to treat them as peripheral or optional.

NASEM Report, Birth Settings in America (2020)
The National Academies of Sciences, Engineering, and Medicine, the country's preeminent independent scientific advisory body, convened a multidisciplinary committee that concluded in their **consensus report** that birth centers and home births are safe options for low-risk pregnancies when integrated into the broader care system. It pointed to lack of integration—rather than the birth setting or provider—as a key driver of poor outcomes, reframing the policy conversation and providing a credible reference point for advocates, payers, and legislators.

AIM Community Birth Transfer Resource Kit (2024)
The Alliance for Innovation on Maternal Health, a national patient safety program funded by the Health Resources and Services Administration, released a **Community Birth Transfer Resource Kit** that provides standardized best practices for safe and timely transfers from home and birth center settings to hospitals. Building on key elements of the **Step Up Together** transfer protocol work created by Primary Maternity Care, the kit gives quality improvement teams, community birth providers, hospitals, and emergency responders a shared framework for interprofessional coordination.

Growth of the Evidence Base, and Steps Toward Valuing Quality and Safety

A growing body of rigorous, nationally recognized evidence—alongside shifts in how quality is defined and measured—significantly strengthened the legitimacy of midwifery-led care and its role in improving maternal health outcomes. This has had a ripple effect, impacting broader institutional recognition of the value of integrating midwives into health care settings. The federally funded Strong Start Initiative tested enhanced prenatal care models for people with Medicaid coverage, and the results for birth center care were positive. A subsequent analysis found that after controlling for medical risk factors, outcomes were similar to privately insured people. In 2018 the Centers for Medicare & Medicaid Services (CMS) published the final evaluation of the Strong Start Initiative, finding that people who received prenatal care in Strong Start birth centers had better outcomes and lower costs, including lower rates of preterm birth, low birthweight, and cesarean birth.

GRANTEE HIGHLIGHT

The Community Birth Data Registry was created in 2019 by the Foundation for Healthcare Quality (FHCQ) to provide an ongoing view of outcomes across maternity care settings (hospital, birth center, and home) and is now available nationwide. In parallel, the American Association of Birth Centers (AABC) maintains the Perinatal Data Registry and related infrastructure for birth centers.

Collaboration between AABC and FHCQ ensures that there are mechanisms for integration of the data from both platforms to be available for research and quality improvement efforts across the country. Both systems have faced coverage and capacity constraints due to cost and the time required for data entry, mostly by midwives.

The two registries are integrated through ongoing collaboration and in coordination with the **Think Big Initiative**.

At the same time, national quality and accountability frameworks have worked to improve low-risk cesarean rates, patient experience, prenatal and postpartum depression, and equity. Primary factors in advancing these outcomes include the Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP, the "Birthing-Friendly" hospital designation program from CMS, and the Joint Commission's perinatal certification. The National Committee for Quality Assurance (NCQA) has also made contributions—by adopting prenatal and postpartum depression screenings.

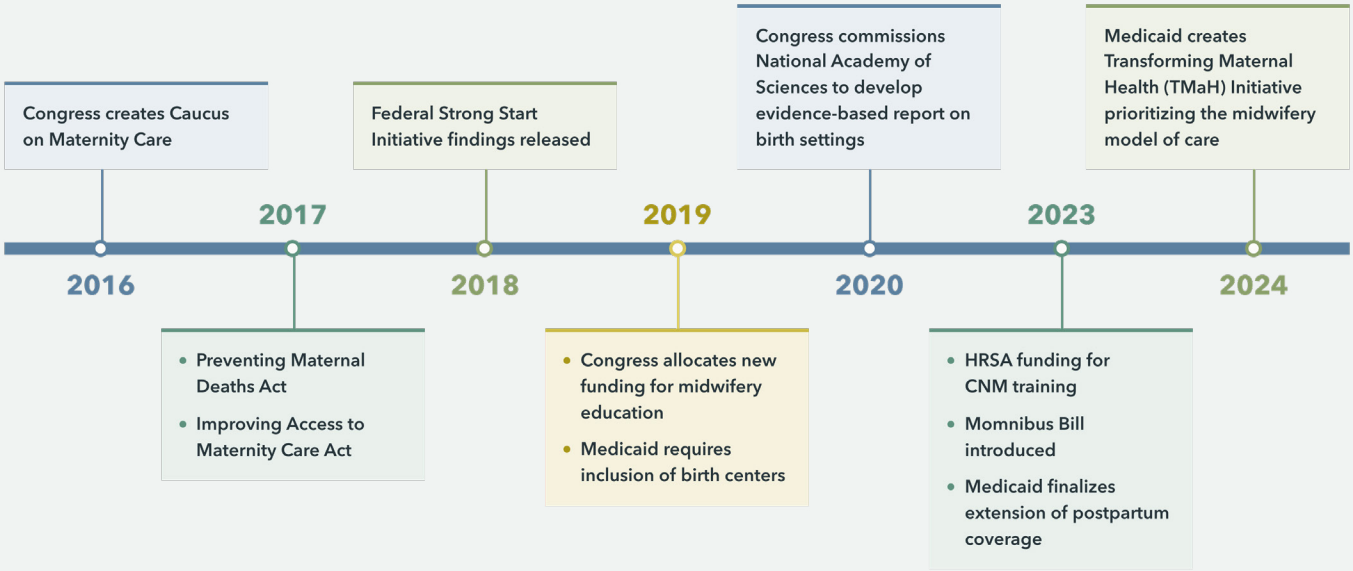
Advances in Legislation, Policy, and Litigation

Federal Action on Maternal Health

Skyline grantees and many other allied organizations helped to secure significant legislation, policy change, and funding for birth justice, maternal health, and midwifery. Just a few of these include the extension of Medicaid postpartum coverage to twelve months, championing of the Black Maternal Health Momnibus, the BABIES Act (H.R. 5189), and the Protecting Moms Who Served Act.

Other signs of federal prioritization of maternal health, birth justice, and midwifery included the creation in 2022 of the White House Blueprint for Addressing the Maternal Health Crisis, calling for expanded access to freestanding birth centers, licensed midwives, and doulas. The Health Resources and Services Administration (HRSA) directed more than $60 million toward maternal health, including the first ever federal scholarships for midwifery students. In perhaps the strongest signal of the promise and recognition of midwifery by the federal government, in 2025 the Centers for Medicare and Medicaid Innovation announced the selection of fifteen states to participate in the Transforming Maternal Health Model (TMaH) which includes among its top priorities the expansion of access to midwifery care through payment reform. TMaH is a multi-year initiative designed to improve maternal health outcomes by supporting state Medicaid agencies in testing and scaling whole-person, equity-centered approaches to pregnancy, birth, and postpartum care.

Key Federal Legislative and Policy Changes



The environment shifted dramatically in 2025, and progress is being reversed or threatened as a result of congressional or executive action. Funding for the technical assistance to states participating in the Transforming Maternal Health Initiative has been cut, and HRSA funding for midwifery training approved by congress is at risk.

State-Level Midwifery Reform

At the state level, the past decade produced a meaningful set of legislative and regulatory wins, although the pace and scope varied widely. The proportion of births attended by midwives in 2021 ranged from 1% in Arkansas to 32% in Alaska. In New Hampshire, where midwives can practice independently without physician supervision, they attended 26% of births. In Louisiana, where midwives face a limited scope of practice and mandatory physician collaboration requirements, they attended 3.6%.[152]

12
States created CPM licensure
2016–2024

6
States expanded CNM authority
2016–2025

13
States passed momnibus bills
2016–2025

Incremental improvements in Medicaid reimbursement for midwifery occurred in a few states. New York raised its midwifery rate to 95% of the physician fee schedule in 2023, and more incremental increases were seen in Louisiana and New Jersey.

The Certified Midwife credential is currently recognized in Colorado, Delaware, Hawai'i, Maine, Maryland, Minnesota, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia. Several other states are currently pursuing licensure of CMs.

STATE WINS: CPM LICENSURE

- 2016: Maine, Michigan
- 2017: Alabama, South Dakota
- 2019: Hawai'i, Kentucky
- 2020: Oklahoma, District of Columbia
- 2021: Illinois
- 2023: Iowa
- 2024: Massachusetts, Virginia (LCM)
- 2025: Six states introduced bills for initial licensure (GA, NE, NY, NC, OH, WV)

STATE WINS: CNM EXPANDED AUTHORITY

- 2016: Virginia
- 2017: Illinois
- 2018: Oregon
- 2020: Minnesota, California
- 2025: Massachusetts

At the state level, the past decade produced a meaningful set of legislative and regulatory wins, although the pace and scope varied widely.

152 U.S. Government Accountability Office, *Midwives: Information on Births, Workforce, and Midwifery Education*.

Litigation

Litigation has increasingly become an important lever for policy change in midwifery, with advocates using equal protection, economic liberty, and public health arguments to challenge restrictive state laws governing scope of practice, birth settings, and licensure. Recent successes—including the decriminalization of Indigenous midwifery **in Hawai'i** and early wins in challenges to certain restrictions on midwifery **in Alabama** and **Mississippi**—demonstrate the effectiveness of strategies that focus on barriers to care, are culturally discriminatory, or are internally inconsistent.

Several grantees have supported this work including Elephant Circle, Sisters in Birth, and the American College of Nurse Midwives.

GRANTEE HIGHLIGHT

Elephant Circle advances birth justice through an intersectional reproductive justice and design-thinking approach, centering historically marginalized communities. Through its Michigan-focused State of Birth Justice work, it has supported the Michigan Momnibus Package and Birth Center Bill and backed field-building efforts such as the Detroit Midwifery School. Learning is captured in their **State of Birth Justice Workbook**.

Emergence of a Coordinated Ecosystem

Perhaps the most consequential shift of the decade—and the least visible from the outside—was the emergence of a more coordinated field. In 2015, midwifery advocacy was fragmented across credentials, settings, regions, and philosophies. Professional associations did not routinely collaborate. Research organizations worked in silos. Advocates in different states pursued incompatible strategies without awareness of what was working elsewhere.

Over the past decade, organizations that once operated independently began aligning around common standards, shared messaging, and joint reform priorities. Highlights of this collaboration include joint policy agendas across CNM and CPM credentials, shared quality improvement initiatives, multi-state Medicaid strategy, and research-practice partnerships that link data generation with implementation work.

> Perhaps the most consequential shift of the decade—*and the least visible from the outside*—was the emergence of a more coordinated field.

This coordination has strengthened the field's capacity to respond to federal opportunities and presents a coherent case to policymakers who had historically struggled to navigate an internally divided professional landscape. Internal tensions did not disappear—differences in training pathways, scope, and regulation across credential types continued to create complexity—but the baseline shifted from fragmentation toward functional alignment in key areas.

In 2022, a multi-organization coalition led by the National Partnership for Women & Families (in collaboration with American Association of Birth Centers, the American College of Nurse-Midwives, Birth Center Equity, National Association of Certified Professional Midwives, and the National Black Midwives Alliance) released "**Improving Our Maternity Care Now**." The report synthesized evidence regarding the effectiveness and safety of birth centers and planned home births, and recommended that decision makers in the public and private sector increase access to healthcare in community settings.

In 2025, the Institute for Medicaid Innovation's Maternal Health Policy Equity Summit brought together state and federal Medicaid leaders, Medicaid managed care plans, maternal health policy and research leaders, community-based birth workers and people with lived experience. From the Summit, the National Strategic Medicaid Maternal Health Coalition was convened as a collaborative, multi-stakeholder table to bring together national and state maternal health organizations, Medicaid leaders, and other partners. The goal is to align strategies and drive Medicaid policy reforms that improve maternal health and expand access to community-based models of care. Elephant Circle co-leads this work to ensure that it is grounded in reproductive justice and community power-building, bringing community-based expertise, including legal and policy insight, to help shape a shared agenda that centers equity and lived experience alongside system-level Medicaid change.

Increased Philanthropic Investment in Midwifery

When Skyline entered this field in 2015, there were only a handful of funders making any grants to midwifery or birth justice. Since then, there has been an exciting shift in philanthropy toward a recognition of midwifery integration as essential health system infrastructure, not a niche or peripheral investment. More foundations have entered the space, and many are backing multi-year initiatives that explicitly focus on expanding and integrating midwifery care through policy, payment, workforce, and care delivery change. Additionally innovative new financing structures blending philanthropic and private investment have been created to fund birth centers and the midwifery ecosystem.

There has been an exciting shift in philanthropy toward a recognition of midwifery integration as essential health system infrastructure, not a niche or peripheral investment.

Funders have begun to build the connective tissue needed to learn together and align investments, including the **Funders for Birth Justice and Equity** learning community, the **State Exchange for Maternal Health** and its midwifery-focused learning community, and a funders affinity group connected to the National Medicaid Maternal Health Coalition led by the Institute for Medicaid Innovation and Elephant Circle. At the same time, philanthropy has strengthened field partnerships with state government leaders to help translate policy wins into real implementation.

Philanthropy is filling longstanding gaps in maternal health data at a moment when the need for rigorous, population-level evidence has never been greater. A coalition of funders—including the Commonwealth Fund, the Robert Wood Johnson Foundation, and Skyline Foundation—has come together to support **Listening to Mothers IV**. Led by the National Partnership for Women & Families in partnership with Black Mamas Matter Alliance and MomsRising, this national survey oversampled Indigenous and Asian childbearing people, in addition to capturing the experiences of Black and Latine women. Results were released in June 2026, and a full dataset is available to researchers for secondary analyses.

Today, an additional funder coalition including the David and Lucille Packard Foundation, the Pritzker Children's Initiative, and the W.K. Kellogg Foundation are leading the development of a national philanthropic strategy to accelerate midwifery integration. This will be achieved by mapping current grantmaking portfolios, identifying the most urgent needs and highest-leverage opportunities, and creating a shared framework that helps coordinate existing and future investments while bringing new funders into the work. This effort will be completed by late summer 2026.

5

Challenges that Remain

"We are still in a fragile ecosystem."

—Skyline Grantee

The lessons, reflections, and learnings in this report draw from our grantee leaders. In late 2025, Skyline invited grantees to complete an anonymous survey with open-ended questions focused on their priorities, persistent barriers, and new headwinds. Their responses were supplemented by a listening session, as well as their reports, analyses, and other research.

We have grouped the challenges surfaced by our grantees as follows:

1. Payment Structures, Rates, and Regulation Prevent Birth Center Growth
2. Division Slows Collective Advocacy
3. Doula Expansion May Displace Deeper Systems Work
4. Structural Barriers Prevent Workforce Growth Where It Is Most Needed
5. Underinvestment in Field Infrastructure
6. Limited Access to Meaningful Data

1. PAYMENT STRUCTURES, RATES, AND REGULATION PREVENT BIRTH CENTER GROWTH

Medicaid reimbursement rules determine which providers can practice sustainably, what is covered, and how much care is worth. When those rules do not adequately cover midwifery services, particularly for Certified Professional Midwives and birth center care, consumer demand alone cannot create sustainable access. Grantees across our portfolio concur: no state has yet achieved Medicaid reimbursement rates sufficient to ensure the financial viability of community birth models. Additionally, facility payments are often tied to state licensure, but not all states license birth centers; those that do have complex and onerous regulations.

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In addition to low reimbursements, payments can be slow, and the billing and credentialing requirements add significant administrative overhead. As a result, many birth centers cannot cover the cost of midwifery-led, longer-visit care within Medicaid payment levels and choose not to enroll. Many of the centers that do participate in Medicaid are led by people of color

Many proponents of midwifery focus on the model's potential for cost savings. While tactically useful in some policy conversations, this approach may also create challenges when advocating for adequate payment and can further embed the assumption that midwifery care should be cheaper, rather than fairly priced.

in communities most affected by birth inequities, and they prioritize access even when it is financially and operationally challenging.

Although there is significant variation across states, and a few states received incremental increases in Medicaid rates, most have remained insufficient to support community birth models. Payment is the least standardized for birth centers as they can be paid via fee-for-service, global professional fees, or facility fees, and range from 15% to 70% of hospital rates.

Birth centers operate in precarious financial conditions and are perennially at risk of closure; twenty-four centers closed in 2025 alone. Many others reduced services or stopped accepting Medicaid. Midwifery practices serving Medicaid populations—the families most in need of community-based, culturally aligned care—faced the most severe reimbursement gaps and sustainability challenges.

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2. DIVISION SLOWS COLLECTIVE ADVOCACY

Many grantees identified the ongoing division among midwifery credentials as one area that has set the field back. Some people identify as traditional midwives and intentionally operate outside the formal education, training, and licensure systems. This may be driven by distrust, experiences of racism, religious or philosophical reasons, or lack of access to formal training. Within the Birth Justice field, this division is widely understood to be rooted in the displacement of Black, Immigrant, and Indigenous midwives by a largely white public health nurse workforce from which the modern nurse midwife emerged.

Differences in training pathways, scope of practice, and regulatory frameworks across different midwifery credentials have created divisions within the field and hindered collective action on policymaking and payment reform.

Differences in training pathways, scope of practice, and regulatory frameworks across different midwifery credentials (CNMs, CPMs, CMs, LMs) have created divisions within the field of midwifery and hindered collective action on policymaking and payment reform. Policymakers and payers struggle to distinguish roles—which dilutes messaging, creates confusion, and prevents coalition-building. Tensions within the field sometimes mean that energy is periodically directed inward rather than at the systemic barriers both credential pathways face.

3. DOULA EXPANSION MAY DISPLACE DEEPER SYSTEMS WORK

The expansion of doula coverage over the past few years through state Medicaid programs increased access to birth support. However, nearly one-third of grantees surveyed, raised concerns that advocacy efforts to expand access to doulas might also limit deeper systems change. Capacity that could have gone to payment reform, licensure expansion, and community birth infrastructure was instead focused on doulas during a critical window when maternal health disparities could have been addressed. The progress on one intervention may have left policymakers, health plans, and administrators with the false impression that doulas alone had the power to solve some of the significant problems in maternity care today.

4. STRUCTURAL BARRIERS PREVENT WORKFORCE GROWTH WHERE IT IS MOST NEEDED

While the overall number of midwives increased over the past decade, the workforce pipeline remains insufficient to meet increasing demand, address the existing needs of underserved areas, and provide culturally concordant care. Geographic distribution is uneven with midwives concentrated in urban and suburban areas, while rural communities—where maternity care deserts are most severe and where hospital obstetric unit closures have been most rapid—have among the fewest practicing midwives.

The current midwifery workforce also does not yet reflect the communities it serves. The cost of midwifery education, availability of training placements, and the absence of state and community college pathways have limited access to low-income and historically excluded students. When formal educational and credentialing pathways remain financially and structurally out of reach, some aspiring midwives have sought routes outside the licensure system; this risks personal criminalization and, for the communities they intended to serve, increases confusion and safety gaps. Expanding the pipeline is not only about growing the workforce—it is about making the formal pathways more accessible, anti-racist, and representative of Black and Indigenous communities most impacted by disparities.

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The growth of the workforce is constrained by a clogged training-to-practice pipeline, exacerbated by long-standing federal underinvestment in midwifery education and training infrastructure. Educational capacity is limited by a shortage of faculty and clinical preceptors, uneven access to high-quality clinical sites, and high out-of-pocket costs for students—all of which are harder to address without sustained federal support for programs, clinical training sites, and scholarships. Entry pathways are also fragmented: scope of practice, licensure categories, and supervision requirements vary widely by state, so a credential that supports full practice in one place may not translate elsewhere. These factors slow recruitment, delay graduation and licensure, and make it

harder for programs to scale or for midwives to move to communities with the greatest need. Midwifery burnout further blocks the pipeline by driving experienced clinicians and preceptors out of practice, and reducing the capacity to train and mentor the next cohort.

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Workplace and market conditions further restrict growth by making midwifery roles hard to sustain. In many hospital settings, physician-led protocols, restrictions on midwifery practice, and productivity metrics that favor medical procedures can limit midwives' autonomy and continuity of care, which increases burnout and turnover. Outside hospitals, birth centers and community practices face low and slow reimbursement, especially from Medicaid, plus heavy billing, credentialing, compliance, and liability burdens that small teams struggle to absorb. Weak referral and transfer relationships, insurer network exclusions, and structural racism and underinvestment in community-rooted care models can make midwifery practices fragile. Additionally staffing losses or contract and credentialing disputes can trigger abrupt closures and further narrow training and employment opportunities.

5. UNDERINVESTMENT IN FIELD INFRASTRUCTURE

Decades of underinvestment in field coordination and infrastructure has meant the emerging field could not act on significant windows of opportunity. Despite the fact that the field was working at the intersection of seismic and historic issues—the COVID19 pandemic, the Black Lives Matter movement, #MeToo, and the Supreme Court's overturning of Roe v. Wade—the ecosystem was not prepared to respond strategically. Our grantees were upfront about not having the mandate, staffing, or capacity to capture philanthropic and public funding when opportunities arose.

The same limitations shaped the field's impact in policy and movement building at the national level. While there was incremental progress at the federal level, the absence of a unified field strategy and coordinating mechanism limited the field's ability to maximize political opportunities—for example, when Congress was attuned to the maternal health crisis and the administration had elevated these issues in its domestic policy agenda. Without the infrastructure to move cohesively, the field could not fully capitalize on a rare moment of alignment between public urgency and political will.

A field with stronger policy infrastructure and a unified voice in the deliberations could have pushed for code structures and reimbursement rates that account for out-of-hospital care.

Another window of opportunity missed due to lack of resources was the restructuring of the way all maternity care is reimbursed. Conversations at the federal and state level rarely included midwifery advocacy or analysis of the value of the model. In January 2027, the entire maternity care reimbursement system in the US will move away from the "global" bundled payment model—where prenatal, delivery, and postpartum care are reimbursed as a single fee—toward a system in which providers bill separately for increments of service. A field with stronger policy

infrastructure and a unified voice in the deliberations could have pushed for code structures and reimbursement rates that account for out-of-hospital care.

6. LIMITED ACCESS TO MEANINGFUL DATA

Despite a decade of unprecedented access to information in the United States—where people can now compare consumer products, schools, and many other domains of their lives—there is no access to the outcome data, quality measures, or demographic comparisons that would make decisions about childbirth truly informed. What exists instead are fragmented systems that are not connected across home, birth center, and hospital settings, and that rarely disaggregate outcomes in ways that would allow a birthing person to understand how care differs for someone who looks like them, lives where they live, or shares their clinical profile. Decades of underinvestment in midwifery has contributed to this fragmentation, and most community midwives have limited access to efficient data systems.

This shift has coincided with a broader erosion of trust in health care institutions and in science, leaving many without reliable sources of guidance at a moment in their lives when the stakes are high and the decisions are consequential.

The challenges tracking maternal health outcomes is now further impacted by the Trump Administration's dismantling of the national data collection infrastructure that is essential to addressing maternal and child health disparities. A 2025 **blog** by Skyline Foundation's Birth Justice program documented these setbacks to progress and issued a call to funders to support field-led data collection to advance equity and health outcomes.

Over the past decade, the way people seek information about childbirth has shifted significantly. In-person childbirth education has declined, replaced by an enormous and largely unregulated information environment—online communities, social media, and direct-to-consumer sales content of widely varying quality and accuracy. The American College of Obstetricians and Gynecologists has identified misinformation in obstetrics and gynecology—particularly on social media platforms—as a major and growing threat to patient understanding and safety, noting the rapid spread of inaccurate or misleading content related to pregnancy and birth.

This shift has coincided with a broader erosion of trust in health care institutions and in science, leaving many without reliable sources of guidance at a moment in their lives when the stakes are high and the decisions are consequential. Despite wide variation in outcomes and substantial evidence documenting mistreatment, disrespect, coercion, and harm—disproportionately affecting Black women—there is very little transparency or accountability. In some cases, existing data systems and oversight mechanisms are being weakened or dismantled at the federal and state levels.

Fully integrating midwifery and out-of-hospital birth into the health care system will require standardized data systems that link outcomes across settings, capture the demographic detail necessary to identify disparities, and produce information that is transparent, comparable, and accessible to the public.

6

Looking Ahead

Sustaining the Momentum Grantees Have Built

The progress in the field that our grantees and their allies have made over the past ten years is precarious. The emerging ecosystem exists within the most challenging environments for gender, reproductive, and birth justice in a generation. Our grantees are navigating severe headwinds, yet through that they see opportunity not only to push back but to rethink and redesign systems that meet everyone's needs.

"As a midwife you have to be hopeful; We're far enough along that we're not stopping."

—Skyline Grantee

"People are so ready for a change."

—Skyline Grantee

Our grantees are very clear about what is needed to sustain and advance their momentum:

1. Create Financial Conditions and Infrastructure for Midwives and Birth Centers to Thrive
2. Division Slows Focus on States as the Primary Arenas for Change
3. Bolster the Workforce Pipeline
4. Use All Levers

1. CREATE FINANCIAL CONDITIONS AND INFRASTRUCTURE FOR MIDWIVES AND BIRTH CENTERS TO THRIVE

Most reimbursement rates are not sufficient to ensure the long-term financial viability of community birth models or even hospital-based midwifery practices. This is especially true for most state reimbursement systems. Additionally, facility payments are often tied to state licensure, but not all states license birth centers; those that do have complex and onerous regulations. For hospitals, reimbursement systems make inequitable and often inadequate payments to cover the true costs of midwifery care.

With most rural hospitals no longer delivering babies, birth centers offer critical care that may not otherwise be available.153 However, many—in both rural and urban settings—face closure without sustainable reimbursement. Practices serving Medicaid populations will not be able to hire, retain, or expand their workforce. Workforce pipeline investments alone don't solve the problem; they produce trained midwives who cannot find economically viable places to practice. Policy wins on scope of practice do not translate into access if payment rates remain inadequate. Payment reform is the crucial work that determines whether everything else survives.

Alternative payment models including maternity episode payment and maternity care home programs are **promising and under-used approaches**. Grantees identified the Centers for Medicare & Medicaid Service's

153 Katy B. Kozhimannil et al., "Obstetric Care Access at Rural and Urban Hospitals in the United States," *JAMA* 333, no. 2 (2025): 166–169.

Transforming Maternal Health (TMaH) initiative as a potential blueprint for aligning financing with whole-person, equitable maternity care, and called for continued implementation support for the current states and others. Including midwifery in TMaH models will be essential to each state's successful implementation.

All maternity providers shift to a new way of billing for maternity care in 2027, into four phases—antepartum, labor management, delivery, and postpartum—each now requiring separate documentation and billing using individual encounter codes. For birth centers and home-birth midwives, who already operate on narrow margins with less administrative infrastructure, a more complex billing environment is likely to compound existing financial strain.

Our grantees identified data infrastructure—including interoperable systems that track outcomes across birth settings—as among the greatest needs in the field. They also emphasize the need for resources to plan, develop, and implement a range of systems, including billing and patient health records. They highlighted the need and opportunity for shared administrative services for birth centers and small birth justice organizations.

Our grantees identified three key areas for action:

1. **Midwifery inclusion and leadership in public and private efforts to change or improve payment models and care pathways**
2. **Support for birth centers within Federally Qualified Health Centers**
3. **Increases in Medicaid reimbursement rates and birth center facility fees**

2. DIVISION SLOWS FOCUS ON STATES AS THE PRIMARY ARENAS FOR CHANGE

Severe policy headwinds at the national level intensify the responsibility and burden on states to protect and expand care for pregnant women and birthing people. Despite the political threats to birth justice, our grantees see opportunity. They are intensely focused on state-level policy change and see it as the most promising platform for both protecting and advancing birth justice. States have the responsibility, and administrative burden, to implement sweeping federal changes to Medicaid, the single largest payor of maternity care. State choices about rate-setting, managed care contracting, licensure enforcement, and quality measurement have outsized influence on midwifery's viability. Several states have demonstrated that meaningful reform is achievable within existing legal and fiscal frameworks. Seventeen states have introduced **maternal health legislation** omnibus bills; of those, thirteen were partially or fully passed, ten prioritized equity and centering communities most affected by the maternal health crisis through the policy development process, eight included expanding access to birth centers and midwifery care.

Our grantees identified two key areas for action:

1. **Support implementation efforts to ensure policy wins translate to change**
2. **Train and equip lawyers, policy advocates, and health system leaders in midwifery-specific regulatory, financing, and legal issues, as well as birth rights.**

"There are some very hopeful signs, at least at the organizational levels, that midwives who have joined the profession through various routes (direct entry, nursing, apprentice, etc.) see the value of joining forces, supporting one another in a more unified way."

—Skyline Grantee

3. BOLSTER THE WORKFORCE PIPELINE

The midwifery workforce has not grown sufficiently to meet demand, and the distribution remains deeply unequal. Rural communities, communities of color, and regions where hospital closures have been most widespread are precisely where midwives are scarcest.

Midwives are needed now more than ever given the widespread rollback in access to reproductive health. With more than twenty states banning or severely restricting abortion care, midwives provide urgently needed counseling that increases continuation and satisfaction with contraception. Abortion bans correlate with delayed prenatal care and increased maternal risk, and midwives are equipped to manage early pregnancy loss/miscarriage and reduce ER utilization for non-emergent postpartum concerns. As clinicians become more hesitant to provide abortions in states where they are banned, midwives often remain accessible as first points of contact for patients experiencing delays and confusion.

Innovation among midwifery clinics is driving the kind of change needed to meet the growing demands and a more robust workforce. CHOICES birth center provides a key example of efforts to strengthen the midwifery workforce pipeline. By housing its midwifery fellowship and birth center within a full scope reproductive health clinic, the organization offers a rare, community-rooted training environment where new midwives can gain full-scope experience. This model builds and retains talent—especially Black midwives—through a tiered education-to-fellowship pathway.

Our grantees identified two key areas for action:

1 **Consensus on a minimum set of competencies and standards for midwifery practice, providing a common foundation for licensure, credentialing, and quality assurance across credential types**

2 **Create and expand midwifery training programs and clinical preceptorships at high-quality sites**

4. USE ALL LEVERS

"None of these things can happen before the other, or we will arrive without the things we need...

We have to move them all forward at approximately the same time."

—Skyline Grantee

One of the clearest messages to emerge from grantee partners is that any single area is fragile without progress in all others. When Skyline asked grantees to rank the needs in the field by urgency and importance, sustainable payment for midwives and an enabling policy environment rose to the top. However, all grantees indicated that workforce expansion and diversification are necessary—and that data, evidence, and public education are important drivers of any advancement in the field, especially in policy change.

Our grantees emphasized the need to accelerate progress across the ecosystem. Policy wins on scope of practice do not translate into access if payment rates remain inadequate. Workforce pipeline investments alone don't solve the problem; they produce trained midwives who cannot find economically viable places to practice. Progress over the past decade has been possible when organizations worked collaboratively and across levers, with flexible multi-year support from philanthropy.

Our grantees identified four key areas for action:

1 **Creation of a field-wide strategic plan to create shared goals across types of midwifery, settings, and regions**

2 **Reliable and accessible public information about birth, midwives, and birth outcomes**

3 **An accountability system for rights-based, equitable, and person-centered care that sets measurable standards for respectful treatment, informed consent, and culturally aligned practice**

4 **Greater participation and trust from philanthropy**

Lessons for Funders

The field has demonstrated it can use philanthropic resources effectively, but the ecosystem is very fragile. We asked grantees anonymously what they want funders to know and where funders can play a greater role.

Here's what we heard:

1. Change is possible, though often incremental
2. Long-term, flexible funding is often the most valuable thing a funder can provide
3. Funders play a unique and underutilized role in field coordination
4. Support the reimagining of systems, including public norms and expectations

> "Listening to midwives who are connected to their communities—have practiced in their communities and have deep relationships—
>
> is key to understanding midwifery and developing a funding approach."
>
> *—Skyline Grantee*

1. CHANGE IS POSSIBLE, THOUGH OFTEN INCREMENTAL

Skyline grantees expressed concern that the very areas that most need funding are for work that is not "bright and shiny." Support for infrastructure, data and quality systems, technical assistance, payment and regulatory reform can be the most challenging areas for which to fundraise. This sustained work takes time and coordination on the part of funders. Similarly, supportive legislation is insufficient without equally strong investment in the nuts and bolts of implementation. Our grantees emphasized that this type of work is foundational to any real change. We also heard that clinical outcome data—particularly data comparing community birth outcomes to hospital outcomes for low-risk pregnancies—are among the most powerful tools for changing the minds of policymakers and private payers.

For the historically under-resourced field of midwifery, efforts like upgrading data systems, implementing quality improvement plans, and publishing outcomes data can be daunting without support and coordination. Large

system-wide investment is necessary to build the data infrastructure that birth centers and home-birth midwives need to be seamlessly integrated into the broader health care system. Grantees emphasized that philanthropy is uniquely positioned to fund the coordination and consensus on systems that cut across birth settings.

2. LONG-TERM, FLEXIBLE FUNDING IS OFTEN THE MOST VALUABLE THING A FUNDER CAN PROVIDE

Grantees consistently cited multi-year unrestricted grants as being essential to their work in a rapidly changing world, not just to survive and respond, but to learn and lead. Early and sustained commitment from the small group of funders helped to signal the legitimacy of midwives and attract other funders, building credibility with policymakers. This synergy created the conditions for the federal funding and attention that followed. Relationships derived from long-term commitments build trust, transparency, and increase a funders' ability to deploy funds in the most effective ways.

EQUITY AND URGENCY

On the question of urgency, *enabling legislation and policy* and *expanding and diversifying the workforce* emerged as our grantees' top priorities. They stressed *centering equity* and *funding BIPOC leadership* as well.

Making maternity care in the US more equitable requires a system that is built for everyone's individual needs and life circumstances. As we learn alongside our grantees, we continue to see leaders from the communities most impacted by disparities designing and implementing durable ways to advance progress, in part because they bring specific expertise. Funders need to actively work to direct resources in ways that do not reproduce the very inequities their strategies may seek to address. For guidance, we encourage funders to see Elephant Circle's **Funders Field Guide to Birth Justice**.

3. FUNDERS PLAY A UNIQUE AND UNDER-UTILIZED ROLE IN FIELD COORDINATION

Grantees urged funders to use their power as conveners to bring together organizations or interests, and in particular to encourage a conversation across midwifery credentials. We also have a role as translators, attracting peer funders working in intersecting areas like education, economic mobility, climate resilience, early childhood, and other parts of health care and public health. We have seen other funders do this well and bring their influence to bear—and midwives need this contribution too. Almost a quarter of survey respondents (24%) explicitly identified the power of funder organizing as a strategic lever in the field.

4. SUPPORT THE REIMAGINING OF SYSTEMS, INCLUDING PUBLIC NORMS AND EXPECTATIONS

As the legal and political landscape for reproductive rights has shifted following the Dobbs decision, many funders concentrated primarily on abortion access are increasingly examining the broader reproductive health ecosystem. Reproductive justice advocates have long argued against siloed approaches that separate reproductive rights from maternal care and economic justice. This moment represents a historic opportunity for alignment between Birth Justice philanthropy and a larger pool of funders who are rethinking where and how to have an impact. Many of our grantees are well ahead of funders in working collaboratively and breaking down silos. Funders can play a part by not only bringing peer funders to the table but by creating new spaces that center power-building. This also includes providing resources for inclusive design and implementation and testing of "unproven" things knowing that learning from what didn't work contributes to progress.

7

Skyline's Strategic Commitments

Skyline is committed to shifting midwifery from the margins to the mainstream and reshaping how our nation approaches and supports birth. We aim to remove structural barriers to equitable care by addressing payment, policy, workforce, and systems infrastructures that determine whether midwifery can take root and be sustainable.

Our Approach

A decade of partnership with grantees informs not only what we fund, but also how we approach our work going forward. Skyline will:

- Provide multi-year, flexible funding grounded in trust-based grantmaking practices, recognizing that field-building work requires stability, organizational strength, and resources to learn from setbacks as well as wins
- Support catalytic work where grantee efforts and collective progress exceed what any individual grant could achieve by focusing on the four strategic priorities that anchor our approach and grantmaking
- Prioritize the sustainability and strength of current grantee partners' initiatives, amplifying their accomplishments, and creating opportunities for convening, shared learning, and field alignment
- Welcome new grantee partners, including individual birth centers, who value collaboration across midwifery and the maternity care system, as well as building the next generation of midwives who can meet the needs of all pregnant people
- Seek opportunities to co-fund or align our efforts with peer funders to maximize impact through coordination that frees grantees to focus more fully on their work
- Partner with other funders to support the entire birth justice ecosystem through funder education, organization, and collaboration
- Deepen our understanding of how philanthropy can shift narratives and norms around knowledge, rights, and expectations during pregnancy, birth, and postpartum recovery, recognizing the role that culture plays in women's power during this time

Our Vision

We stand alongside our grantees in working toward a future in which:

- Every state has a pathway to midwifery licensure.
- Midwives are able to practice the midwifery model of care to their full scope.
- Midwives are respected and compensated equitably—through pay and reimbursement rates that reflect their clinical responsibility and the value of the care they provide, comparable to other maternity care clinicians (including physicians).
- Standardized and seamless systems are in place for consultation, collaboration, and transfer of care between community midwives, physicians and hospitals.
- Universal data collection and reporting of birth outcomes data is established across all birth settings.

Our Strategic Priorities, Goals, and Focus Areas

1 Data, Quality, and Accountability Systems

Build the data infrastructure needed to measure outcomes across birth settings, demonstrate the value of midwifery-led care, and hold systems accountable for safety, equity, and respectful treatment.

- Implementing comprehensive data systems to collect information on midwifery services, patient outcomes, and safety metrics
- Developing standardized quality measures and benchmarks specific to midwifery practice to ensure consistent, high-quality care across different settings
- Establishing clear performance indicators that document the impact of midwifery care on maternal and infant health outcomes, cost-effectiveness, and patient satisfaction
- Creating transparent reporting systems that hold health-care facilities and providers accountable for midwifery integration and outcomes

2 Education, Organizing, and Evidence-Building

Build awareness, advocacy capacity, and the evidence base for the midwifery model of care.

- Building coalitions for a unified voice for midwifery integration with the skills and tools needed to effectively advocate for policy changes and system reforms
- Addressing gaps in the evidence base
- Raising awareness among patients, families, and communities about the benefits of midwifery care
- Educating other healthcare providers, administrators, and policymakers about how to effectively integrate midwives into healthcare teams
- Sharing stories and experiences that highlight the positive impact of midwifery care on pregnant people and families

3 Payment Reform, Legislation, and Policy

Reform the payment, policy, and regulatory environment to address the financial and regulatory barriers to access and integrate midwifery into the healthcare system.

- Equitable coverage and reimbursement rates in Medicaid and private markets
- Passage and implementation of laws that support midwifery and birth center practice and integration into healthcare systems
- Transitioning from fee-for-service to value-based payment models
- Ensuring midwives can practice to the full extent of their training and licensure, maximizing their contribution to healthcare delivery

4 Workforce Expansion and Diversification

Expand the number and diversity of midwives to meet demand and reflect the communities served, ensuring improved health outcomes across all populations.

- Expanding access to midwifery education programs and support for students from diverse backgrounds as well as building support for a diverse midwifery workforce that reflects the communities served
- Creating supportive practice environments to retain midwives in the healthcare system

Our Active Grantees

We are a proud funder of the following organizations:

click an organization's name to visit its website

In 2026, Skyline will make the largest single-year investment in its portfolio—

giving more than $7 million in grants to advance Birth Justice and midwifery.

American Association of Birth Centers

American College of Nurse-Midwives

Asociación de Parteras de Puerto Rico

Birth Center Equity

Birth Place Lab

Black Midwifery Collective

California Maternal Quality Care Collaborative

California Nurse-Midwives Foundation

Californians for the Advancement of Midwifery

CHOICES Center for Reproductive Health / Birth Center

Community of Hope

Elephant Circle

Foundation for Health Care Quality

Funders for Birth Justice and Equity

Groundswell Fund's Birth Justice Initiatives

HEALING Midwifery Together
University of Washington Department of Child, Family, Population Health Nursing

Institute for Medicaid Innovation

Midwifery Access California

Midwifery Education Accreditation Council

National Academy for State Health Policy

National Association for Certified Professional Midwives

National Association to Advance Black Birth

National Partnership for Women & Families

PCC Community Wellness Center

Purchaser Business Group on Health

Quality Maternal and Newborn Care Research Alliance

Sisters in Birth

Unravel Health

Uplift Lab at Oregon State University

Collaboration is a throughline of midwifery and birth justice. We're always learning. We welcome opportunities to share more about our grantees and find ways to partner with other areas of philanthropy. We invite other funders to **contact us** to learn more about our grantees and our work ahead.

Authors

Valerie Lewis

Valerie Lewis is a philanthropic advisor and strategist who helps funders and organizations advance women's health, power, and self-determination. Drawing on a background in public health, policy, and Medicaid, Valerie is dedicated to shifting resources toward communities most impacted by systemic racism and discrimination, with a particular focus on maternal and reproductive health. She led Skyline Foundation's birth justice work from its inception in 2015 until 2022. She holds a Master of Public Health and a Master of Public Administration from Columbia University. Valerie is also the mother of two daughters, and her own experiences with the failures of the maternity care system continue to inform her commitment to birth justice.

Tanya Khemet Taiwo

A social justice activist, researcher, and midwife with over twenty-five years of experience, Tanya is dedicated to eliminating the disparities in maternal and infant health outcomes, expanding access to the midwifery model of care, and the field's ability to successfully reach those who need support most. Since 2022, Tanya has been the program lead for Skyline's Birth Justice program. She is a Certified Professional Midwife (CPM) and holds a Master of Public Health from San Jose State University and a PhD in Epidemiology from UC Davis. Born in Kingston, Jamaica, Tanya is the descendant of at least two generations of midwives and the mother of three beautiful daughters who were born at home into the hands of midwives.

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