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- LHD Regions 1-10: Resources for Birthing Families
- Key Informant Interview Guide
- Social Listening Military/Veteran Sources
- Social Listening Hispanic/Latine Sources

Durham County:
Bridging the Gap in Maternal Health Through Nurse Navigation

Durham County has taken a proactive step to improve maternal and child health outcomes by creating a **Nurse Navigator** position that bridges critical gaps in care for pregnant and postpartum women. This innovative role goes beyond traditional referrals — it provides **personalized education, compassionate support, and consistent follow-up** to ensure women receive the care they need when they need it most.

The Nurse Navigator connects women to vital community resources, including medical, behavioral health, and social support services. Just as importantly, she helps women understand the **importance of ongoing health maintenance** beyond the postpartum period — empowering them to manage fertility, chronic conditions, and overall wellness. Recognizing that many women lose contact with the health system after delivery, the Navigator also assists in establishing connections with **primary care providers**, ensuring continuity of care long after the baby's first birthday.

Mental health is a cornerstone of this approach. The Nurse Navigator prioritizes early identification and linkage to **culturally responsive mental health services**, particularly for women at higher risk for postpartum depression and anxiety. By meeting women "where they are" — in both readiness and understanding — the Navigator fosters trust, provides education in real time, and promotes self-advocacy in navigating the health care system.

This initiative is already making a measurable difference. Women report feeling **more supported, informed, and connected** to care during one of the most vulnerable times in their lives. Providers have seen improvements in appointment follow-through and early intervention for complications.

Ultimately, the Nurse Navigator program reflects Durham County's commitment to **building healthier futures for mothers, children, and families — one connection at a time.**

Social Listening: Military/Veteran Population

Background

Because traditional secondary data sources did not offer sufficient detail on military and veteran issues, we used social listening to conduct a review of media coverage from January 2024 through March 2025 (Appendix E). This review helped identify key themes, trends, and emerging concerns for this population.

Summary

North Carolina is one of the most militarily significant states in the nation — home to large installations like Fort Bragg and Camp Lejeune, a vibrant defense economy, with over 615,000 veterans residing within the state. The military sector generates over $66 billion annually and supports 11% of statewide employment. With approximately 20,000 service members transitioning to civilian life in North Carolina each year, the state benefits from a continuous infusion of skilled workers and veteran leadership. A comprehensive network of Veterans Administration (VA) medical centers and outpatient clinics helps meet the diverse health care needs of this population, underscoring the importance of integrated support systems that serve those who have served.

Syracuse University is home to the National Veterans Resource Center and the D'Aniello Institute for Veterans and Military Families. The institute hosts the Veterans Strategic Analysis & Research Tool (V-SMART), a data visualization platform that brings together veteran demographic, education, socioeconomic, and employment data in a user-friendly interface. It enables users to quickly explore geographic trends and make informed decisions about veteran programs and services.

V-SMART supports transitioning service members, veterans, and military families in making informed post-service choices, and provides corporations, foundations, nonprofits, and government agencies with data to guide initiatives that benefit veterans and their families (D'Aniello Institute for Veterans and Military Families).

FOUR THEMES EMERGED:

- Veteran Homelessness
- Environmental Health Concerns
- Health Care Access
- Workforce Development

Veteran Homelessness

Homelessness and housing insecurity remain significant challenges for North Carolina veterans. According to the 2024 Point-in-Time (PIT) Count, 688 veterans were experiencing homelessness, representing 5.9% of the state's total homeless population. This reflects an 11% decrease from 2023, when 777 veterans (7.9%) were counted (North Carolina Department of Military & Veterans Affairs [NCDMVA], 2024). While encouraging, this downward trend underscores the need for continued statewide efforts to address housing instability among veterans.

The PIT Count may underestimate the full scope of veteran homelessness, as some individuals do not report their living situation or experience housing insecurity without meeting HUD's definition of homelessness. Data from the 2023–2024 NCServes Annual Report highlight the ongoing demand for housing support: *Housing & Shelter* was the most commonly requested service category, accounting for 25,435 cases (30.3%) (Veterans Services of the Carolinas, 2024). Rising housing costs across North Carolina may further intensify future need.

Local initiatives are working to address these challenges. For example, the City of Raleigh launched the Addressing Crises through Outreach, Referrals, Networking, and Service (ACORNS) program in 2024 to connect veterans experiencing homelessness with housing and mental health services (City of Raleigh, 2024).

Environmental Health Concerns

The Honoring Our PACT Act, signed in 2024, expanded health care and benefits for veterans exposed to toxic substances during military service. As of 2024, approximately 74,000 North Carolina veterans had submitted PACT-related claims, and 45,000 had been approved (U.S. Department of Veterans Affairs, 2024).

Veterans in western North Carolina also experienced significant impacts from Hurricane Helene. Medically vulnerable veterans — including those with disabilities and chronic conditions — faced disruptions when local VA clinics closed or modified services due to power outages and building damage. Clinics shifted to emergency-only operations, diverting routine care to neighboring VA facilities (U.S. Department of Veterans Affairs, 2024). While intended to maintain continuity of care, many veterans struggled with accessibility during regional recovery efforts. The VA deployed clinical teams to local emergency shelters to support displaced veterans, while ongoing home-visiting and social support programs have assisted those rebuilding their homes and lives (Governor's Office of North Carolina, 2024).

Health Care Access

There is growing concern about the potential impacts of federal VA staffing reductions on service delivery in North Carolina. Staff losses at VA facilities in Asheville, Fayetteville, and Durham have raised questions about the long-term implications of budget cuts and future staffing constraints for veterans' access to timely and comprehensive care (U.S. Office of Personnel Management, 2024).

Workforce Development

Veteran workforce development is a rising priority for Governor Josh Stein and leaders in the North Carolina Department of Commerce and Department of Military & Veterans Affairs. Recent statewide roundtables emphasized veterans' economic contributions, the importance of translating military skills into civilian employment, and the role of NCWorks in providing veteran-centered career services (NCDMVA, 2024). These discussions highlight North Carolina's commitment to strengthening pathways to employment for transitioning service members and veterans.

Social Listening: Hispanic/Latine Population

Background

Because traditional secondary data sources did not provide enough detail on Hispanic/Latine issues, we used social listening to review media coverage from January 2024 through March 2025. This approach helped identify key themes, trends, and emerging concerns affecting this population.

Summary

Since we were not able to conduct focus groups or community listening sessions with the Hispanic/Latine population, we reviewed media sources from May 2020 through November 2024. We looked for recurring themes, trends, and emerging issues. Appendix F contains a detailed summary of the media sources reviewed.

FOUR THEMES EMERGED:

- Access to Health Care and Services
- COVID-19 Response
- Environmental Health Concerns
- Hurricane Helene and Long-Term Impacts

Access to Health Care and Services

Hispanic/Latine individuals in North Carolina face significant disparities in accessing health care. Adults and children in this population are more likely to be uninsured than their non-Hispanic peers and the national average. Lack of insurance limits choices and discourages the use of preventive services. Local health departments (LHDs) are the only safety net provider in all 100 counties. While Federally Qualified Health Centers (FQHCs) and free clinics provide essential support for uninsured individuals, many health care settings do not deliver culturally, linguistically, or socially responsive care that meets the diverse needs of Hispanic/Latine communities.

Medicaid expansion has improved access to care, and by July 2024 more than 45,000 Hispanic/Latine individuals had enrolled. Local enrollment navigators have been central to this progress by building trust, dispelling misinformation, and assisting with eligibility and enrollment.

Despite increased coverage, Hispanic/Latine individuals remain less likely to engage with the health care system. Many health care providers lack Spanish-speaking staff and do not offer culturally competent care, which can create confusion and discourage engagement — especially when navigating health insurance. Changes in immigration policy and national discourse about immigration and immigrant rights have also created fear and uncertainty. These concerns may deter individuals from seeking care, particularly from government-funded services, unless they are facing an emergency. These challenges contribute to delayed care, increased health risks, and higher costs over time.

Mental health access is also a growing concern. Community members report increasing anxiety, depression, and social stressors related to discrimination, isolation, economic hardship, and immigration-related fears. Barriers such as stigma, cost, lack of insurance, and a shortage of Spanish-speaking mental health providers make it difficult for Hispanic/Latine people to receive timely support. In response,

the North Carolina Farmworker Health Program is working with community partners to expand behavioral health services, particularly in areas with large migrant and seasonal farmworker populations.

COVID-19 Response

The COVID-19 pandemic disproportionately affected Hispanic/Latine communities in North Carolina but also demonstrated the effectiveness of culturally informed public health outreach. As of November 2021, 67% of Hispanic/Latine individuals ages 12 and older had been vaccinated — a rate 10 percentage points higher than the non-Hispanic population.

This success is credited to community-driven engagement, including the use of trusted ambassadors, local leaders, and bilingual community health workers who served as effective messengers. The state also provided direct compensation to grassroots organizations and community networks to support outreach and relationship-building, laying the groundwork for more inclusive partnerships between government agencies and Hispanic/Latine communities.

Environmental Health Concerns

Environmental exposures and occupational health risks continue to disproportionately affect Hispanic/Latine communities. Research from the University of Virginia found that ammonia levels were 35% higher in areas with significant Hispanic/Latine populations in eastern North Carolina, particularly near industrial hog operations. Many people in these communities are also employed by these facilities, compounding exposure risks and related health outcomes.

Agricultural worker — many of whom are Hispanic/Latine — face additional environmental and occupational hazards. In response, organizations such as El Futuro es Nuestro, the NC Environmental Justice Network, and the Farmworker Defense Fund advocate for stronger worker protections, especially given North Carolina's severe weather conditions, including extreme heat. These efforts include the "Not One More Life" campaign, launched after the death of Jose Arturo Gonzalez Mendoza, a farmworker from Nash County.

Hurricane Helene and Long-Term Impacts

The aftermath of Hurricane Helene in western North Carolina highlighted the vulnerability of Hispanic/Latine communities to natural disasters. An estimated 60,000 Hispanic/Latine individuals live in this region, many in high-risk flood zones or in housing especially susceptible to damage, such as mobile homes.

Although the hurricane affected the entire region, some Hispanic/Latine people were hesitant to seek recovery assistance due to concerns about immigration status and federal requirements (e.g., Social Security numbers for FEMA applications). Language barriers also created challenges throughout the response and recovery periods. In the absence of formal assistance, many people relied on faith communities, neighbors, and grassroots organizations for support. Hispanic/Latine construction workers also played a visible and essential role in local recovery efforts, using their skills to repair homes and rebuild community infrastructure.

Summary Statement

Hispanic/Latine people are an integral and growing part of North Carolina's population, yet they continue to face persistent barriers to health care access, mental health services, and environmental safety. While Medicaid expansion has improved coverage for tens of thousands of Hispanic/Latine individuals, challenges such as limited cultural and linguistic responsiveness in health care, fear stemming from immigration policy, and environmental exposures remain significant. Community-led strategies — especially those rooted in trusted relationships — have proven essential in promoting vaccine uptake, expanding Medicaid enrollment, and navigating disaster response. Continued investment in culturally tailored services, environmental justice, and inclusive disaster recovery is vital to advancing health outcomes for Hispanic/Latine communities across the state.

Key Informant Interviews:

Maternal Child Health Nurses and Social Workers

Community and Social Factors Affecting Maternal Health

Poverty, Food Insecurity, and Economic Stress

Respondents across regions described poverty and related economic pressures as fundamental barriers shaping maternal health. These pressures influence maternal nutrition, economic and social stability, and women's ability to prioritize care.

Persistent poverty. Respondents cited poverty as an underlying driver of poor maternal health. Respondents described it as deep and generational in many areas, shaping women's overall circumstances — from limited access to stable housing and healthy food to higher rates of chronic conditions that complicate pregnancy. In rural counties, limited employment opportunities further constrain economic stability, while in urban areas, rising costs of living have outpaced wages, leaving many families strained. Respondents emphasized that persistent poverty is a long-standing barrier that health services alone cannot resolve.

> "If you're lower income, you don't have access to transportation, you don't have paid leave to take time off for your visits, you don't have support to help with child care or other basic needs. You may not have anyone you can call on to help in a pinch. Or even steady access to food. All of those things affect [whether you can get the care you need.]"

Economic trade-offs. Poverty translates into difficult daily choices. Women often have to weigh the costs of housing, food, transportation, or medical care against one another. Respondents described women skipping prenatal appointments or medications because they couldn't afford gas, child care, or time off from hourly jobs. These pressures have become more acute as costs rise faster than wages.

Food insecurity. Families often struggle to afford or access healthy foods. Some counties are designated as food deserts with very few grocery stores, compelling families to rely on small convenience shops which typically lack fresh produce. Respondents said food insecurity directly affects maternal health through poor nutrition during pregnancy and reliance on stopgap supports. Families frequently turn to WIC for supplemental foods, but benefits are limited and do not cover all household needs. Many women also enroll only after the first trimester, missing an opportunity for early nutrition support. Families depend heavily on food pantries, church distributions, and similar programs, which provide critical short-term relief but are limited in frequency and availability, leaving many families without steady access to nutritious food.

Housing Instability and Cost

Housing was one of the most universally cited barriers to maternal health, with respondents across nearly all counties and regions pointing to high costs, poor-quality stock, storm damage, and the loss of supports that once helped families stay housed.

Rising housing costs in high-growth areas. Rapid population growth in coastal, metro, and some mountain communities has driven steep increases in rent and home prices, fueled in part by in-migration and outside investment. Families with low or moderate incomes are being priced out of traditional neighborhoods and pushed farther from services, lengthening trips to prenatal and postpartum care. Respondents emphasized that these pressures have worsened in recent years as rents rise faster

than wages, forcing many families into neighboring counties or temporary, unstable housing.

Homelessness and poor-quality housing in rural regions. In smaller rural counties, poverty combines with limited housing stock to leave families in precarious living situations. Some described rising homelessness, families doubling up in unsafe housing, or waiting lists for subsidized housing programs that stretch indefinitely. Storm damage has also reduced the supply of safe housing in both eastern and western parts of the state, from hurricane-related flooding in coastal counties to the destruction caused by Hurricane Helene in 2024 in the mountains.

Impact of program cuts. Several respondents emphasized the end of the Healthy Opportunities Pilots (HOP) in July 2025 as a major setback. Launched in 2022, HOP operated in selected eastern, southeastern, and western counties, providing Medicaid-funded support for essential needs such as housing deposits, repairs, furnishings, utilities, food, and transportation. Respondents said the program helped families stabilize their living situations and address barriers that directly affect health. When funding ended, needs remained, but the safety net disappeared, leaving health departments and care managers unable to fill the gap.

> "I think [social determinants of health] are buzzwords that people latch onto and say, "Oh, we really need to work on transportation."... But when it comes down to it, nobody is willing to pay. ... A great [example] is HOP, the Healthy Opportunities Pilot. It was going in North Carolina. They were showing, hey, by providing food to those who are experiencing food insecurity, there is a positive impact. And then it was written out of the budget. ... So, I think it's very easy to identify and say these are the issues that are impacting maternal health, but I don't see anybody who really wants to fund it."

Family and Social Stressors

Respondents emphasized that maternal health is shaped not only by poverty and housing but also by family and social conditions that create instability and stress.

Substance use and its ripple effects. Many respondents linked maternal health challenges to high rates of substance use in their communities — especially opioids and, increasingly, methamphetamines. They emphasized that substance use affects far more than individual health: it contributes to family instability, financial strain, and heightened stress during pregnancy and postpartum. Partners' substance use and related domestic conflict can exacerbate these pressures, sometimes leading to involvement with child protective services. Respondents said that fear of custody loss or judgment often discourages women from seeking help, compounding isolation and stress.

Domestic violence and partner conflict. A few respondents noted that women sometimes face violence or conflict in their relationships, which compounds stress during pregnancy and limits their ability to seek help. These risks were said to be especially visible in counties also struggling with poverty and substance use, where services for women in abusive situations are limited.

Fear of child protective services involvement. Respondents said that fear of child protective services looms large for many families, discouraging women from disclosing needs or accepting help. This fear extends to many situations, such as behavioral health struggles or housing instability, where women worry that seeking help could draw scrutiny from the agency.

> "A challenge is people understanding who you are and that you're here for them, that you're not there to judge them. A lot of times care management gets mixed up with Department of Social Services, and [thinking] that we're going to take their children."

Social isolation and lack of support networks. Respondents noted that some women lack strong family or community support, leaving them more vulnerable during pregnancy and postpartum. Without partners, extended family, or reliable community ties, mothers may struggle with child care, transportation, and emotional support, making it harder to engage with health services. These issues of social isolation may be especially pronounced in counties with large military installations, where the transience of the population limits opportunities to build and sustain local support networks.

Community Strengths & Partnerships

Respondents emphasized that health departments are not working in isolation. Families benefit from various community-based organizations and informal networks that supplement public health services. These partnerships provide material support, education, and trusted relationships that help families navigate pregnancy and postpartum challenges.

Faith-based and nonprofit supports. Churches, sororities and fraternities, local businesses, and nonprofits often step in to provide resources that health departments cannot. These supports include diaper banks, food pantries, baby supplies, transportation, and parenting education. Pregnancy resource centers also play a role, offering classes and distributing items such as car seats, formula, and Pack 'N Plays. Most of these programs operate on church or nonprofit funding rather than public dollars and are concentrated in urban areas where larger populations sustain them. In smaller or rural communities, support networks are often more informal — rooted in churches, civic groups, and personal relationships. Respondents described these local networks as vital but less consistent, relying on individual initiative and limited resources rather than formal funding or structure.

> "For a lot of …our communities, because we're so tight knit and we know everybody, our communities come together and they rally and they help. We've got two separate food banks here. We have [a church program]. Every Saturday, it's open. It doesn't matter who you are, you just come and get your groceries. And they have diapers and they have clothes and they have over-the-counter medication. They have so many things. So our local churches and our community "rally' together."

Community coalitions and networks. Formal coalitions and partnerships help align efforts across agencies. Respondents described coalitions that bring together hospitals, DSS, nonprofits, and schools to coordinate referrals, reduce duplication, and ensure families get connected to the right services. These partnerships are especially important in smaller counties, where no single agency has the resources to meet all needs.

Peer and group supports. In some counties, group prenatal care models such as CenteringPregnancy, as well as childbirth classes and support groups, provide education and emotional support. Respondents described these peer-based programs as valuable for reducing isolation and helping women build networks of support during pregnancy.

Factors Affecting Access to Maternal Health Care

Transportation Challenges

Transportation was raised by nearly all counties and consultants as a barrier to maternal health. Distance, geography, and cost make access to care difficult and unreliable, even when women ultimately find ways to reach appointments.

Long travel distances and geographic barriers. Respondents shared that in many rural and mountainous areas, women must drive long distances for prenatal care, childbirth facilities, or specialty services — sometimes traveling up to two hours on winding roads which can be especially hazardous in winter. Even within metropolitan counties, families in outlying areas often face long commutes or lack convenient transit routes connecting them to services.

Referrals far from home. Women with high-risk pregnancies are increasingly referred to tertiary hospitals for specialized services such as maternal-fetal medicine or neonatal intensive care. This occurs even in areas that still have delivery hospitals, as local providers become more cautious about managing complicated cases or lose the capacity to do so. While referrals facilitate access to advanced care, they often involve increased travel times, additional transportation and child care costs, and greater potential for fragmented care across multiple providers.

Medicaid transport. Respondents emphasized that Medicaid transportation is a critical resource for addressing transportation challenges. The program provides rides to medical appointments for eligible enrollees who have no other means of transportation, facilitating access to prenatal, postpartum, and other essential care. This service makes it possible for many women to obtain care they would otherwise have to forgo, particularly in rural areas where travel distances are long and public transit is limited.

Limitations of Medicaid transport. Despite its value, Medicaid transportation has practical limitations. Rides often must be scheduled several days in advance, making the service unsuitable for urgent visits. The service also poses challenges for mothers with young children: under traditional Medicaid, children generally could not accompany their mothers, and car seat requirements further restricted who could be transported. Some managed care plans now allow children to ride along and offer more flexible scheduling. However, differences across plans have also increased administrative complexity. Each plan operates its own transportation system with different vendors, rules, and procedures, requiring care managers to master multiple processes and devote considerable time to helping families arrange rides — time that could otherwise be spent on direct support.

> "It's particularly difficult with last-minute appointments, if they would need to be seen quickly, because a lot of the transportation providers through the Medicaid plans require at least 48 hours advance notice for a ride reservation."

Public transit and navigation barriers. Where public transportation exists, it does not always align well with families' needs. Rural areas often have no fixed-route service at all, while urban systems may not extend into outlying neighborhoods or may require long, multi-transfer trips. Even when routes are available, language barriers, low literacy, or complex scheduling can make them difficult to navigate for some patients. These issues particularly affect low-income and immigrant families who depend on public systems but often lack the time, flexibility, or support — such as child care or time off work — to manage lengthy or complicated trips.

Broader impacts on care. Transportation challenges compound other maternal obstacles such as child care, work schedules, and associated costs. Lengthy or unreliable travel can delay the start of prenatal care, lead to missed appointments, or discourage follow-up after delivery — factors that contribute to worse maternal health outcomes across the state.

Provider & System Capacity

Respondents consistently described provider shortages as a central barrier to maternal health. These shortages shape whether counties continue offering prenatal services themselves or shift to an assurance model in which hospitals or private providers deliver care.

Loss of delivery providers. Many communities have lost local obstetricians or delivery hospitals, forcing increased reliance on external providers. Hospital closures, staff retirements, and persistent challenges recruiting obstetricians to rural areas have accelerated this trend. Nurse consultants noted that younger providers are often reluctant to practice in small counties, and in some areas the number of births is too low to sustain a practice. Midwives remain limited in number and unevenly distributed across the state, particularly in rural areas. Respondents cited state supervision requirements, restrictive practice regulations, and hospital privileging policies as barriers to expanding the role of midwives. Moreover, some remaining providers do not accept Medicaid, thus further limiting access for low-income women.

> "One of the biggest challenges we have right now is the loss of providers and not having enough, so patients are waiting way too long to get appointments. Like, we have one patient right now that's going back to her home county, which is three hours away, for prenatal care, because it was going to take her two months to get an appointment here."

Limited availability of doulas. Several respondents noted that doula services are largely unavailable across much of the state. Even in some urban counties, respondents said there are few or no practicing doulas, and those who are available may not be covered by insurance or accessible to low-income families. Some health plans have begun reimbursing doula services, but respondents described the benefit as difficult to obtain because families must find their own providers and navigate complex plan requirements.

Reliance on assurance arrangements. North Carolina requires every county health department to either provide maternal health services directly or to "assure" that people have access to them. Assurance can include partnering with or contracting through another provider rather than offering services in-house. In many rural counties, assurance is used after repeated struggles to recruit or retain obstetricians or because birth volumes are too low to sustain a practice. In other counties, assurance is viewed as a way to connect families with hospital-based care that can offer a broader range of services than the health department alone. One respondent noted that a factor driving the shift to assurance was that more private practices began accepting Medicaid patients during the 2009–2010 economic downturn, leading to a reduction in the number of women served in health department clinics. Respondents said the model works well in those places where hospitals provide nearby care. However, in places where hospitals are more remote, health departments must often depend on external partners whose capacity and priorities are beyond their control. When those partners reduce services, reach capacity, or are located far from where women live, the health department has limited ability to intervene or fill the gap.

Limited local capacity for high-risk pregnancies. Respondents said the growing number of referrals for complicated pregnancies reflects deeper capacity constraints within local systems. Smaller hospitals are increasingly unable, or unwilling, to manage high-risk cases, leading to reliance on tertiary centers for maternal-fetal medicine and neonatal intensive care. This broader contraction of local capacity stems from maternity-unit closures and provider shortages. While referrals improve access to specialized care, they underscore the shrinking ability of local systems to manage high-risk pregnancies close to home.

> "We lost our high risk clinic here for maternity patients at the health department. And so that meant that a lot of people had to go to private practices. Patients that did not have Medicaid or a source of income were affected by that because they … couldn't afford the prices of going to a private clinic."

Uneven distribution of resources. Provider shortages are a statewide issue. Urban centers have more clinicians than rural areas, but demand still outpaces supply, leading to long wait times even in well-resourced counties. However, rural areas continue to experience the greatest deficits, in some cases with no local providers, and respondents said this disparity is widening as more clinicians cluster in metro areas as rural capacity declines.

Insurance Coverage

Respondents consistently described health insurance as one of the most important determinants of maternal health in North Carolina. Medicaid is the primary coverage source for low-income pregnant and postpartum women, and several recent policy changes have expanded its reach. These expansions have brought important gains, yet gaps and barriers to access and affordability remain.

Coverage and Services Available

Medicaid eligibility during pregnancy. Most low-income pregnant women in North Carolina qualify for Medicaid, which provides eligibility at higher income levels during pregnancy than for non-pregnant adults. A key feature is presumptive eligibility: local health departments (LHDs) and hospitals can grant immediate, temporary coverage so that prenatal care can begin while a full application is being processed. This ensures that women who will ultimately qualify can start care right away rather than waiting weeks. Respondents also emphasized the importance of presumptive eligibility for immigrant women who do not qualify for full Medicaid, because it allows them to receive a limited amount of prenatal care — typically an initial visit and some follow-up services — even if they cannot remain enrolled long term.

Postpartum extension. Effective April 2022, North Carolina extended Medicaid postpartum coverage from 60 days to 12 months. Respondents described this change as a critical improvement, ensuring that women continue to receive medical, behavioral health, and family planning services during a period when many complications and maternal deaths can occur.

Impact of Medicaid expansion. In December 2023, North Carolina expanded Medicaid to all low-income adults. Respondents highlighted its value for women's health not just during pregnancy but before conception. Continuous coverage allows earlier detection and management of conditions such as hypertension or diabetes, improving outcomes once women become pregnant. Expansion also reduces gaps in coverage between pregnancies, creating more stability across the reproductive years. At the same time, respondents emphasized that coverage alone does not guarantee access — some newly eligible adults remain unaware of their eligibility, and provider participation is still uneven, particularly for mental health and specialty services. Several respondents also expressed concern about future policy changes and funding stability. They noted that ongoing debates at the state level could alter how expansion is implemented or maintained, creating uncertainty about whether these recent gains will be sustained.

"There are pending policy changes that we're concerned about... [regarding] Medicaid expansion. We don't yet know how that's going to affect people receiving Medicaid and getting the care that they need."

Care management. Medicaid funds the Care Management for High-Risk Pregnancies (CMHRP) program, a statewide Medicaid care management program delivered by registered nurses and social workers through local health departments. The program is available at no cost to Medicaid-enrolled pregnant women in North Carolina. The program is available at no cost to Medicaid-enrolled pregnant women in North Carolina. Women are eligible if they are enrolled in Medicaid and identified as high-risk through a standardized screening tool used by prenatal care providers. Qualifying factors can include chronic health conditions (such as hypertension or diabetes), behavioral health concerns, history of preterm birth, multifetal pregnancies, substance use, late entry into care, or unsafe living environments. A limited number of uninsured women may also be enrolled when capacity allows.

Care managers provide one-on-one support — coordinating appointments, offering health education, and linking families to resources for food, housing, and behavioral health services. Respondents consistently praised these services as invaluable for helping women navigate a complex health system and address needs that extend beyond medical care. They emphasized that in-person, ongoing relationships are central to the program's effectiveness. For many women without family support, their care manager may be the one consistent person they can rely on, and this trust was described as key to improving outcomes.

"[The care manager] doing those regular in-person visits makes a huge difference in the birth outcomes. A lot of the members that we see, they don't have family support and they just feel like we're the one person they can truly rely on and trust."

Exclusion of undocumented women. Respondents stressed that immigrant women without eligible status remain excluded from full Medicaid coverage. While presumptive eligibility may allow an initial visit and limited follow-up, most prenatal and postpartum care remains out of reach. Undocumented women often depend on charity clinics or other safety-net services. Even for documented immigrant families, language barriers, confusion about eligibility, and fear of sharing personal information can delay enrollment and limit access to needed services.

Financial strain despite coverage. Even insured women face significant out-of-pocket costs to access care. Co-pays for visits, prescription expenses, and uncovered services — such as certain tests, procedures, or postpartum supports — can still pose barriers to receiving recommended care. Too often, families must weigh these expenses against essentials like rent, utilities, and food, and respondents said such trade-offs sometimes lead women to delay or skip appointments, forego medications, or avoid follow-up after delivery.

Provider participation and limitations. Coverage does not always equal access. Some providers only accept certain Medicaid plans, while others decline to serve high-risk pregnancies or limit the number of Medicaid patients they see. Respondents said this can force women to switch providers mid-pregnancy or travel long distances for care, disrupting continuity and eroding trust in the system.

Coverage awareness and administrative complexity. Families often struggle to understand what is included in their coverage or which providers participate in their plan. Respondents said this leads to missed services, unexpected bills, and stress. Some care managers also reported that families remain unaware of recent coverage expansions or how to enroll, particularly those without internet access or English proficiency.

Medicaid Transformation

North Carolina implemented Medicaid Transformation in July 2021, shifting most beneficiaries from fee-for-service to managed care plans administered by private insurance companies. Five commercial plans now operate statewide. In July 2024, the state also launched separate tailored plans to serve individuals with behavioral health or intellectual and developmental disability needs. Local health departments continue providing CMHRP, while health plans employ their own case managers, creating both new opportunities for coordination and added layers of complexity.

Added supports under managed care. Respondents said managed care has expanded some supports for families — such as more flexible transportation policies and plan-based case managers who can help coordinate care and connect families to needed services. When collaboration works well, these additional touchpoints strengthen engagement and reduce missed appointments.

Coordination challenges. In many counties, however, overlapping responsibilities between CMHRP and plan case managers have led to confusion for families and fragmented follow-up. The complexity of multiple care-management systems contributes to duplication and gaps in communication. Several care managers also reported that navigating multiple systems and plan-specific requirements consumes significant time, diverting attention from direct support to families.

Importance of local, in-person relationships. Nearly all respondents emphasized that telephonic case management cannot replace the community-based connections that local care managers provide. In-person engagement allows care managers to build trust, understand local resources, and identify social or behavioral health needs that families might not disclose otherwise.

> "I would like to see care management remain in the communities versus an insurance company taking it over. Telephonic care management when needed is great, but we really need care managers in the community who can see members face-to-face, who understand the resources that are available, the resources that are not available."

Health-plan incentives and value-added benefits. Respondents described a range of incentives and supplemental benefits offered through Medicaid managed care plans. These include gift cards, Pack 'N Plays, and other baby items for completing prenatal or postpartum visits, as well as "value-added" benefits such as gym memberships and doula support. Several respondents said these benefits help families with limited resources and encourage attendance at key appointments. Respondents said availability varies by plan and region but is often viewed as a meaningful way to meet basic needs.

> "'[With Medicaid transformation], I think the patient gets lost in all the bureaucracy of it all. [Before], it was less complicated, because Medicaid paid for services directly. And as care managers, all we had to do was just understand the Medicaid policy.... Now, you've got five different health plans involved. So if you're having a struggle getting something covered or making sure the patient has access to a particular service that should be covered, you've got to try to navigate that health plan. ... So everything is just not as simple because there's more room for misinterpretation and more people involved to say, 'No, that's not covered.'"

Variation in hospital plan acceptance. Respondents said that not all hospitals accept every Medicaid managed care plan, creating barriers for women who rely on specific plans for maternity care. In counties with only one delivery hospital, this can leave women with no local option that aligns with their insurance. When hospitals or health systems choose not to contract with certain plans, women may have to travel long distances or give birth outside their established provider network, disrupting continuity of care and delaying access to services.

Concentration of provider networks. Respondents also expressed concern that provider networks under the Medicaid managed care plans are concentrated in urban areas, leaving rural counties with fewer participating providers and less capacity for coordination.

Uncertain impacts. Respondents said it is too soon to fully assess the long-term effects of Medicaid Transformation. Some respondents expressed optimism that additional resources and flexibility could ultimately strengthen maternal health care. Others worried that Medicaid Transformation's shift in responsibilities to health plans could erode the role of health departments, create inequities between counties, and destabilize programs like CMHRP.

Language, Cultural, and Immigration Factors

Respondents described language access and cultural differences as persistent barriers to care for immigrant and minority populations. These barriers often intersect with health care coverage exclusions, challenges, and mistrust, compounding the difficulty of accessing consistent maternal health services. Language access and interpretation. Spanish is the primary language need beyond English for families served by local health departments, and most departments are well equipped to meet it. Many have bilingual staff or in-house interpreters who provide consistent support for Spanish-speaking clients. For languages other than Spanish, health departments often rely on phone- or tablet-based interpretation systems, which respondents said are useful but can feel impersonal during clinical visits. Language barriers become even more challenging after referral to specialty services, since many outside providers have fewer interpreter resources, leaving families to rely on relatives or health department staff to bridge communication barriers.

Cultural responsiveness and inclusion. Respondents said that while cultural differences can sometimes pose challenges in maternal health services, health departments make strong efforts to address them. Most departments have bilingual or bicultural staff and work to ensure that care is respectful of families' beliefs and practices. Several respondents highlighted examples of culturally responsive practices, such as employing a community outreach worker to help care managers better understand the expectations of Haitian families. Even so, families from immigrant or minority communities at times feel misunderstood or judged, which can lead them to disengage from services. One respondent noted that ongoing attention to cultural humility and representation in staffing remains important for building trust and sustaining engagement.

> "I think that the health departments have really been dedicated to making sure that they serve clients in as culturally appropriate a way as they are capable of doing. So, I applaud our rural health departments for doing what they do."

Availability of written materials. Most health departments provide written materials in both English and Spanish, but materials in other languages are less common. Health departments that serve multiple immigrant or refugee groups said it is difficult to keep information current across the range of languages spoken in their communities. Even when translations are available, respondents noted that some materials are overly technical or not adapted to local context or literacy levels, limiting their usefulness for families with different educational backgrounds or health beliefs.

Immigration enforcement fears. Respondents said concerns about immigration enforcement have made some immigrant families — particularly those who are undocumented — more hesitant to engage with public health services. Some health departments have not yet seen a clear decline in participation, while others reported an increase in missed appointments or greater reluctance to come in for care. Fear of entering government buildings or sharing personal information has led some women to delay or avoid prenatal or home-visiting services. In response, staff are emphasizing education and reassurance — explaining that services are available regardless of immigration status, clarifying what information is collected and why, and stressing confidentiality. One department is also taking services out into the community, using a mobile unit and partnering with trusted organizations — such as local food pantries — to offer classes and screenings in familiar settings where families feel comfortable receiving care.

> "With our Haitian Creole and Spanish-speaking immigrants, it is challenging getting them in the building in this climate that we're in politically. We have seen a decline in those populations coming to receive services, or just a lot more hesitation."

Community Perceptions of Public Health Services

Respondents described how community perceptions and social attitudes can shape whether families seek out or avoid public health programs. These dynamics sometimes limit engagement even when services are available.

Pandemic-related trust shifts. Several respondents reported that the COVID-19 pandemic affected public trust in health departments. In some communities, health departments were closely associated with the implementation of public health mitigation strategies, including mask requirements and vaccination campaigns. Respondents noted that, in certain areas, this association contributed to lingering hesitancy or reduced engagement with public health services. less willing to engage with public health services. One respondent noted, however, that their department had regained considerable trust after Hurricane Helene through its active role in recovery efforts.

Preferences of younger mothers. Respondents noted that younger mothers increasingly rely on online information and social media for health guidance, shaping how they seek and engage with services. This shift toward digital communication and preference for flexible or virtual options may reduce participation in in-person postpartum visits or public health programs. Respondents also highlighted the spread of misinformation on social media as a growing barrier to effective engagement.

> "'Pre-pandemic, I would have 17-,18- and 19-year-old moms that just delivered that would be ringing my phone off the hook, needing visits. And those are some of the ones that really need the education that I provide. And I call them up now and they're like, 'Nope, I don't need that.'"

Perceptions and awareness of public care. Many families have limited awareness of the range of services local health departments provide, especially beyond prenatal care. In one urban county, respondents said families also view health department services as lower quality than those offered in hospitals or private clinics. Both misperceptions and lack of awareness can prevent eligible women from accessing public health services.

Health Department Capacity

Local health departments remain the backbone of maternal health infrastructure across North Carolina, yet respondents said they operate under increasing strain. Counties vary in how they organize and deliver services, but most face similar staffing, funding, and system-level pressures.

Staffing

Staff shortages and turnover. Health departments across the state struggle to recruit and retain qualified staff — particularly nurses, social workers, and pregnancy care managers. Obstetricians are especially difficult to hire in rural areas, where salaries are lower and professional isolation greater. Vacancies that last for months leave remaining staff stretched thin, reducing both the number of families served and the intensity of support provided.

Community-rooted staff and cohesive teams. Many departments benefit from long-serving employees who are locally known and trusted. Their personal relationships help families feel comfortable engaging with care, especially in small counties where informal networks matter as much as formal systems. Several respondents said that close-knit, stable teams also help maintain morale and continuity despite limited resources.

> "You get to know the people, and people know you. Sometimes I'm driving through the streets, I'll hear somebody yell [my name], and they're waving. You know what I mean? You make an impression when you're local."

Qualification changes for care managers. The state's recent decision to lower educational requirements for pregnancy care managers has helped some counties fill vacancies. However, several respondents expressed concern that the change weakens case management skills that are vital for effectively serving high-risk populations.

Funding and Resources

Inadequate and stagnant budgets. Several respondents said that health department budgets cover only the most basic services, leaving little capacity for innovation, staff development, or program expansion, and limiting the ability to offer competitive salaries. Furthermore, funding has not kept pace with rising costs — for example, the per-month rate for care management has remained unchanged since 2011.

Variation in local support. Some county boards of commissioners actively champion maternal and child health, while others provide minimal attention or funding. This variability contributes to unequal capacity and resources across counties.

Instability of grant support. Many departments rely on categorical or short-term grants to sustain maternal health programs and staff positions. This reliance creates cycles of expansion and contraction, as programs grow during grant periods but must scale back or end when funding ends. These shifts disrupt services for families and eliminate positions for experienced staff whose roles depend on temporary funding.

> "This grant is supposed to address X, Y and Z. We might have it for five years and let's say it's up and running. It's doing great. But the grant is only for five years, so once it's over, then what? I think that's where we have kind of done a bad job towards the community because it has built distrust. Because it's like, 'Hey, you keep promising us these things and you keep coming in our community offering these great services. But two years later, that program is completely gone.'"

Trust and Public Perception

Lingering distrust of public health. Distrust not only acts as a barrier to care but also poses a challenge for health departments. The pandemic-related trust shifts left some families viewing health departments as punitive or political actors rather than service providers. This reputation has made outreach and engagement more difficult, particularly in rural and conservative counties, and has contributed to burnout among staff who feel their efforts are undervalued or misunderstood.

Rebuilding trust. Respondents said that trust can be rebuilt through direct relationships and visible engagement in the community. Familiar, long-serving staff who are known locally can overcome skepticism through steady, personal connection. Families' trust in their care managers often extends to other providers, since care managers are located on site and serve as consistent, trusted points of contact. Several respondents said that these long-term relationships — sometimes spanning multiple pregnancies — help families feel understood and supported even when other systems feel impersonal. Respondents from one county said trust improved after Hurricane Helene, when people saw the central role the health department played in recovery efforts.

Care Management and Postpartum Support

Care management. Health departments' CMHRP teams were consistently described as a major strength. Care managers are embedded in the community and work across clinical and social domains. Respondents emphasized that in-person, ongoing relationships with care managers help families feel supported and improve birth outcomes. The program was often described as one of the most effective tools local health departments have for promoting maternal health.

Postpartum support. Postpartum support is another key service provided by health departments to support women after birth. Through check-ins and home visits, staff help identify emerging concerns such as depression, hypertension, or family stressors and connect women with appropriate care. In most counties, this work is carried out through CMHRP care managers, but limited staffing and high caseloads make it difficult to reach all women or provide multiple contacts. Some counties have expanded their postpartum outreach by adding nurse-navigator or care-management roles focused specifically on follow-up for behavioral health and other postpartum concerns. One county reported using grant funding to support dedicated staff for home visits, allowing them to reach more women after delivery than would otherwise be possible.

Partnerships and Collaboration

Cross-sector partnerships. Collaboration with hospitals, local departments of social services (DSS), private practices, and behavioral-health providers helps coordinate referrals, fill service gaps, and maintain continuity of care. Counties often collaborate with nearby universities to expand clinical, mental health, and research capacity.

Variation in partnership strength. Larger health departments often have formal referral networks and shared records, while smaller counties rely on personal relationships and informal communication. Despite these differences, respondents consistently described partnerships as essential for sustaining maternal health services amid limited resources.

Behavioral Health

Respondents emphasized that behavioral health is a critical but under-resourced dimension of maternal health. Needs are diverse, ranging from common postpartum mental health concerns to severe substance use disorders.

Behavioral Health Needs

Perinatal depression and anxiety. Depression and anxiety during pregnancy and postpartum were described as widespread. While many health departments screen for depression, most do not provide ongoing treatment. Women are typically referred to external counseling or therapy, but availability is limited — especially in rural counties where there are few or no local mental health providers. Urban counties also reported challenges: Even where providers are more numerous, wait times are long and many practices do not accept Medicaid or uninsured patients. Long wait times and lack of specialized perinatal services mean many women go without timely care.

Serious mental illness. A smaller but important group of women experience conditions such as bipolar disorder, schizophrenia, or severe anxiety that require psychiatric management. Health departments generally lack in-house capacity to serve these women, and rely on referrals to community mental health centers or tailored Medicaid plans. This leads to gaps in medication management and follow-up.

Substance use. Respondents identified substance use — particularly opioids and methamphetamines — as one of the most pressing behavioral health concerns affecting maternal health. Several noted that while opioid misuse remains widespread, methamphetamine use appears to be increasing, a pattern consistent with broader statewide data. In addition, one respondent observed a growing normalization of marijuana or THC use, particularly among younger populations, with limited awareness of potential risks during pregnancy. Access to medications for opioid use disorder (MOUD) for pregnant and postpartum women is limited, especially in rural counties, and many must travel long distances for care or go without treatment because few programs accept pregnant clients.

Factors Affecting Behavioral Health Care

Stigma and barriers to disclosure. Across all types of behavioral health needs, stigma was described as a major obstacle to behavioral health care. Women feared being judged, losing custody of their children, or being reported to DSS. Respondents said this discourages disclosure, even when screenings indicate a need for further support.

Role of care managers. Pregnancy care managers often serve as the first point of identification for behavioral health needs. Their ongoing relationships allow them to recognize depression, anxiety, or substance use and encourage disclosure. They make referrals to specialty services, but their effectiveness depends on whether those services exist and are accessible. Respondents stressed that in counties with few providers, care managers have limited options to connect women with the help they need.

> "We do a lot of screenings for mental health concerns, particularly depression and anxiety... I think that has helped get a lot of people help who may not have otherwise known that they needed that help or that that help was available."

Availability and adequacy of services. Respondents consistently described behavioral health services for pregnant and postpartum women as limited and difficult to access. Even where community providers or programs exist, many are unable or unwilling to treat pregnant women, and few have expertise in perinatal mental health. Others limit eligibility based on diagnosis, insurance, or pregnancy status, further

constraining access. A few respondents mentioned the state's NC MATTERS program — which provides consultation and referral support to clinicians caring for patients with perinatal mental-health needs — as a valuable resource, but emphasized that it does not substitute for local treatment capacity.

> "Access to mental health care is almost non-existent out in the far west. That's been a big issue... And that's one thing that our care managers can help assist with. If they have to go out of county or out of state, we can help arrange transportation to get them to and from."

Tailored Medicaid plans. Respondents in one health department commented that most of their clients with behavioral health issues who qualify for Medicaid are in a tailored Medicaid plan serving members with serious mental health, substance use, or developmental conditions. These plans have their own care management team, and the respondents felt that they provide relatively robust services in connecting members with mental health or substance abuse services.

Emerging health department responses. While most health departments do not provide behavioral health treatment directly, several offer limited counseling or short-term support services and refer clients elsewhere for ongoing therapy or medication management. One county reported prioritizing behavioral health and hiring staff to address these needs more directly, though this position depends on short-term grant funding. Some larger counties are exploring integrated or co-located behavioral health staff within maternal health programs to improve access and reduce stigma. Respondents said these efforts are still uncommon, and most health departments continue to rely on external providers, leaving significant gaps in availability.

Disparities

Respondents said disparities are evident across multiple dimensions of maternal health in North Carolina. They most often highlighted racial and ethnic inequities, but also pointed to geographic, economic, and immigration-related differences that shape women's access to care and health outcomes.

Racial and ethnic inequities. Black women were most often identified as experiencing the greatest burden of poor outcomes, including higher rates of preterm birth, infant mortality, and pregnancy complications. Respondents emphasized that these gaps persist even when income and education are similar, reflecting the cumulative effects of racism, chronic stress, and differential treatment within health care. Racial disparities are evident in both rural and urban settings and remain a central challenge for improving maternal health statewide.

Geographic and economic inequities. Access to care varies sharply by location and income. Rural areas face shortages of providers and delivery hospitals, while urban areas contend with long wait times and affordability pressures. Notably, even health departments that include urban or suburban centers often have outlying areas that lack providers and transportation. Low-income women across settings encounter persistent obstacles related to cost, transportation, and child care — even when insured through Medicaid. Respondents described these geographic and economic divides as reinforcing one another: Families with fewer financial resources are often those who must travel the farthest or navigate the most fragmented systems to obtain care.

Immigration-related inequities. Immigrant women — particularly those who are undocumented — face overlapping barriers of language, cultural differences, and restricted eligibility for insurance coverage. Limited interpreter availability and fear of immigration enforcement further discourage engagement with care.

Respondents said these challenges affect both rural and urban communities, where growing immigrant populations often outpace available bilingual staff and culturally responsive services.

Intersecting vulnerabilities. Respondents emphasized that these disparities rarely occur in isolation. Women who are simultaneously affected by racial inequities, geographic isolation, and economic hardship face the greatest challenges in accessing care and achieving healthy outcomes. Many noted that health department programs mitigate some barriers but cannot fully overcome the structural inequities that underlie them.

Recommendations from Respondents

Respondents offered ideas for strengthening maternal health in North Carolina, reflecting both immediate operational needs and broader system changes. These suggestions highlight areas that county and state partners may wish to explore further; they do not represent an exhaustive or consensus set of recommendations. Continued analysis and stakeholder input will be needed to develop a comprehensive action plan informed by these findings.

Strengthen System Capacity and Stability

Invest in the workforce. Respondents emphasized improving recruitment and retention of obstetric, nursing, and social work staff through competitive salaries, loan repayment, and incentives for rural service. One consultant also expressed concern that recent reductions in qualification requirements for pregnancy care managers could affect case-management skills and recommended restoring higher standards for that role. Others underscored the need to expand training pipelines for behavioral-health and bilingual staff.

Stabilize funding. Participants recommended establishing longer-term, predictable funding streams to reduce staff turnover and service interruptions caused by short-term grants. They also suggested updating the per-member, per-month rate for care management, which has remained unchanged for more than a decade.

Expand Access and Continuity of Care

Address rural service gaps. Respondents recommended incentives for providers to practice in underserved counties, expansion of telehealth where feasible, and stronger support for overcoming transportation and mobility barriers. Other respondents proposed the development of regional approaches to share provider networks and specialty services.

Enhance insurance coverage. Participants emphasized maintaining recent gains from Medicaid expansion and postpartum extension and exploring ways to improve continuity of care for immigrant women who are currently ineligible for full coverage — such as extending presumptive eligibility or strengthening safety-net supports.

Expand access to doula services. Several respondents expressed interest in expanding access to doula support as a way to improve women's experiences during pregnancy, delivery, and postpartum care. One respondent suggested that state or grant funding could help establish community-based doula programs and raise awareness among both families and hospital systems about the value of doula care.

Advancing Community Engagement

Increase cultural and language support. Respondents urged greater investment in interpreters, translated materials, and culturally responsive care to better serve immigrant and minority populations. In one county, participants also noted that increasing staff diversity and improving the health department's community presence could help strengthen trust among underrepresented groups.

Deepen partnerships and local engagement. Some respondents emphasized expanding coalitions and collaborations with trusted community organizations — such as churches, sororities, and nonprofits — to extend the reach of maternal health programs and build trust with families who may be hesitant to engage with public health systems.

Taken together, these recommendations point to the need for sustained investment in the maternal health workforce, reliable program funding, and equitable access to care across all communities. They also underscore the importance of community-rooted approaches that rebuild trust and extend the reach of maternal health services beyond traditional systems.

Structured Web Search: Resource for Birthing Families

Background

This section describes the process used to collect and analyze primary data on maternal and infant health (MIH) resources in all North Carolina counties. Prior to the initiation of the NC SHA process, stakeholders identified limited public awareness of available (MIH) as an ongoing concern. Given that many individuals rely on social media and online sources for health information, the SHA team worked with maternal health staff in local health departments to confirm the accuracy and availability of identified resources.

The goal of this effort was to create a comprehensive, up-to-date inventory of publicly available services that support birthing families from pregnancy through the postpartum period. A transparent, systematic, and consistent approach was essential to accurately identify resource gaps and guide public health planning.

Findings from many local health department community health assessments show that community members are often unaware of available resources in their own area. Developing a centralized database of MIH services is an important first step toward improving visibility, maintaining accurate information, and promoting web-based resources for birthing families.

Appendix B provides a detailed summary of MIH resources by local health department region.

Search Criteria and Approach

To guide the data collection process, the following criteria and parameters were established:

Geographic Scope

All 100 counties in North Carolina were included.

Focus Areas

Services related to maternity and postpartum care were prioritized, including but not limited to:

- Breastfeeding and lactation support
- WIC programs
- Medicaid enrollment offices
- Doulas and perinatal support providers
- Transportation services for medical care
- Parenting education and family support resources

Sources Consulted

Information was gathered from:

- Official state and county government websites
- Local health departments
- Nonprofit and community-based organizations
- Faith-based service providers
- Verified online community directories

Inclusion Criteria

Services were included if they were:

- Currently active and publicly accessible
- Clearly relevant to maternity, infant, or family health

Exclusion Criteria

Services were excluded if they:

- Were duplicative
- Lacked public contact information
- Appeared inactive or outdated
- Did not directly serve the target population

Data Collection Timeframe

Data were collected from **February through June 2025,** with all final entries completed by **June 30, 2025.**

Limitations

While significant effort was made to ensure the completeness and accuracy of the inventory, several limitations should be noted

- **Availability of Information:** Some counties had outdated websites or limited online presence, which may have affected the comprehensiveness of the findings.
- **Lack of Standardization:** Service descriptions varied widely across counties, requiring interpretation and standardization of terminology.
- **Geographic Variability:** Some services operate regionally or across multiple counties, while others are limited to a single locality.
- **Time-Bound Accuracy:** Information reflects service availability as of mid-2025; some listings may have changed since data collection.
- **Time Constraints:** Given the limited data collection window, some services may have been unintentionally omitted and may require future validation or outreach.

Definitions of Key Terms

The following definitions were used to ensure clarity and consistency during the data collection and classification process

Governmental: Services operated or directly funded by federal, state, or local governments.

NGO (Non-Governmental Organization): Independent nonprofit or community-based organizations.

Faith-Based: Services provided by or affiliated with religious organizations.

Other: Includes hospital systems and private providers offering public-facing maternal or family services.

Maternity Care Deserts: Areas lacking adequate access to maternity care providers and facilities.

WIC (Women, Infants, and Children): A supplemental federal nutrition program for low-income pregnant/postpartum individuals and children under age five.

Doula: A trained professional offering non-medical support during pregnancy, birth, and the postpartum period.

Perinatal Services: Programs supporting pregnant and postpartum individuals from conception through one year after birth.

Postpartum Care: Services addressing health, recovery, and mental well-being following childbirth.

Smart Start: A key initiative with focus on early care and education, family support, literacy, and the health and development of children ages 0–5.

Medicaid (Maternal Care): Public insurance for low-income individuals that covers prenatal, delivery, and postpartum services.

Transportation Services: Government-supported programs that help individuals access medical or WIC appointments.

Lactation Consultant: Certified professionals who provide breastfeeding and infant feeding support.

Parenting Classes: Educational programs that promote child development and strengthen caregiver skills.

Early Intervention Programs: A program under the Individuals with Disabilities Education Act (IDEA) that provides services for children with developmental delays or disabilities, including screenings and therapy.

Family Resource Centers: Community hubs offering wraparound services and referrals for families.

Home Visiting Programs: Voluntary in-home education and support for families during pregnancy and postpartum.

Lactation Support Groups: Group-based programs offering breastfeeding education, support, and peer connection.