



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Public Health

Request for Applications

RFA # A430

Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Program

FUNDING AGENCY: North Carolina Department of Health and Human Services
Division of Public Health
Women, Infant, and Community Wellness Section
Infant and Community Health Branch

ISSUE DATE: 9/30/2026

DEADLINE DATE: 11/6/2026

INQUIRIES and DELIVERY INFORMATION:

Direct inquiries concerning this RFA to:

Shelby.Weeks@dhhs.nc.gov

919-707-5707 (office) or 919-218-2359 (cell)

Applications will be received until 5:00pm on 11/6/2026.

Electronic copies of the application and all required forms are available for download at
<https://wicws.dph.ncdhhs.gov/>.

Send all applications electronically as indicated below:

Email Address: Shelby.Weeks@dhhs.nc.gov

IMPORTANT NOTE: Indicate Applicant name and RFA number in the subject line of the email.

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I. INTRODUCTION

The North Carolina Division of Public Health (NC DPH) Women, Infant, and Community Wellness Section WICWS) develops and promotes programs and services that protect the health and well-being of infants and women during their childbearing years. Section goals are to improve the overall health of women, reduce infant sickness and death, and strengthen families and communities. The Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Program was established in 2015 to provide funding to local health departments (LHDs) to improve birth outcomes, reduce infant mortality, and improve health among children ages birth to five. Grants will be awarded for a three-year period and will be administered by the Division of Public Health-Women, Infant, and Community Wellness Section-Infant and Community Health Branch.

The health of individuals of reproductive age (14-44 years) and children ages 0-5 is critical to the health of communities. ICO4MCH program efforts will focus on several key indicators which provide information on the health of women and young children as outlined in following paragraphs below.

Infant Mortality

In 2024, the infant mortality rate in North Carolina (NC) returned to a historic low of 6.3 infant deaths per 1,000 live births, accounting for 770 infants who died before reaching their first birthday. The infant mortality disparity ratio between non-Hispanic White and non-Hispanic Black births remained greater than two-fold at 2.74.¹ The national infant mortality rate was 5.5 per 1,000 live births in 2024. Significant variance in rates among racial/ethnic groups continues to exist in NC. Thirty-five counties had a disparity ratio higher than the state ratio.

Child Poverty

The percent of children under five years of age living in poverty in NC decreased from 26.4% in 2015 to 17.4% in 2024, according to the U.S. Census Small Area Income and Poverty Estimates. NC continues to have higher rates of poverty than the national rate, which decreased from 22.8% in 2015 to 16.5% in 2024. NC ranked eighteenth highest among all states for poverty rates of children under five years of age in 2024. County-level data estimates for the percent of children under the age of five are available from the US Census Bureau 2020-2024 American Community Survey (ACS). While the state estimate from this survey period is 18.9%, the estimated poverty levels ranged from 3.6% to 42.0% among NC counties.

Child Health Insurance

According to U.S. Census Small Area Health Insurance Estimates (SAHIE), 94.6% of children under the age of 19 in NC had health insurance in 2024, which remains virtually unchanged from the 2014 estimate of 94.5%. However, disparities exist among racial/ethnic groups. Per 2024 American Community Survey (ACS) data for NC, 90.6% of American Indian and 87.4% of Hispanic children had health insurance compared to 95.6% of African American, 98.1% of Asian, and 96.3% of NH white children. According to 2024 ACS data, 45.1% of all children under the age of 19 in NC are covered by public health insurance.

¹North Carolina infant mortality disparity ratios are based on disparities between infant deaths reported among non-Hispanic White and non-Hispanic African American births. Counties whose infant mortality rates are based on 10 deaths or less are excluded from this list. The State Center for Health Statistics considers rates that are less than 10 deaths unstable. Source: NC Department of Health & Human Services, Title V Office in Collaboration with the State Center for Health Statistics, 14 August 2026.

1. Eligibility

Only Local Health Departments and Districts are eligible to apply to this RFA if they meet the criteria outlined below. Given the amount of funding available, this RFA process will be competitive. DPH encourages and will accept applications from single or multi-county local health departments (LHDs) that meet eligibility criteria. For a multi-county application that includes different local health departments/districts, one county must take the lead in submitting the application and be responsible for ensuring completion and compliance with all required deliverables and reporting requirements outlined under this RFA.

Eligibility criteria are:

1,000 or more births in 2024 in the county or counties that the single or multi-county local health departments will implement the selected evidence-based strategies (EBS) in

AND

1. At least **ONE** of the following:

- Combined 2022-2024 infant mortality rate must be 10.1 or higher per 1,000 live births and 20 or more infant deaths
- Combined 2022-2024 infant mortality disparity ratio must be 2.0 or higher
- Percent of children <5 years of age living in poverty must be 28.4% or higher (ACS 2020-2024 data) or
- Percent of children <19 years of age who are uninsured must be 8.0% or higher (2023 SAHIE)

LHDs should determine their eligibility, either as a single county or multi-county project, by assessing the data above using the tool provided by DPH in September 2026. The eligibility tool can be found online: <https://wicws.dph.ncdhhs.gov>.

2. Subawards

Per 09 NCAC 03M .0801, NCDHHS cannot disburse any state financial assistance Subaward to an entity that is on the North Carolina [Suspension of Funding List](#). Nor can NCDHHS contract with entities on the North Carolina [Debarred Vendors List](#) (01 NCAC 05B .1520) or the [Federal Exclusions List](#) (Sections 1128 and 1156 of the Social Security Act (Act)).

Awarded Subrecipients must adhere to all required terms and conditions of the Subaward, including terms and conditions regarding access to persons and records resulting from all contracts or grants.

3. Funding

Up to five (5) ICO4MCH projects will be funded at an award level of \$400,000-\$475,000 annually. Funds will be awarded for a three-year period, contingent upon contract compliance, program performance, and the availability of funding. The project period for agreement addendums awarded through this competitive application process will begin June 1, 2027, and end May 31, 2030.

Funding Source

Agreement Addenda resulting from this RFA will be funded with State Appropriations.

Number of Awards

Up to 5 local health departments/districts will be awarded grant funding through this RFA.

Funding Periods

Please see chart for funding timeline information under this RFA.

Year	Agreement Addenda Performance Period	Agreement Addendum Payment Period
1	June 1, 2027 – May 31, 2028	July 1, 2027 – June 30, 2028
2	June 1, 2028 – May 31, 2029	July 1, 2028 – June 30, 2029
3	June 1, 2029 – May 31, 2030	July 1, 2029 – June 30, 2030

4. Definitions

Below is a list of definitions for programmatic words or phrases used specifically in this RFA. Terms listed in alphabetical order:

Agreement Addendum: a financial assistance contract which is processed as an addendum to the Consolidated Agreement.

Consolidated Agreement: a master contract executed annually between the LHD and NCDHHS Divisions, DPH and DCFW which governs subsequent Agreement Addenda.

DCFW: North Carolina Division of Child and Family Well-Being.

DPH: North Carolina Division of Public Health or Division.

Grantee (also “Subrecipient”): An entity that receives a subaward from a pass-through entity to carry out part of a federal award. Successful applicants to this RFA will be Grantees of the State.

Grantee Award Period (GAP): The period of time for which the State’s subaward contracts to its Grantees are funded.

NCDHHS: North Carolina Department of Health and Human Services.

Parents As Teachers (PAT): Parent as Teachers is an evidence-based home visiting program model designed to teach positive parenting skills, improve developmental outcomes and support strong parent-child relationships. There are four dynamic components to the Parents as Teachers model: home visits, group connections (educational sessions), resource network (referrals to local services) and child development screening.

Pass-through Entity: A Grantee that provides a subaward to a Subrecipient (including lower-tier subrecipients) to carry out part of a federal program. In subawarding these funds, NCDHHS is a Pass-through Entity.

Subaward: An award provided by a Pass-through Entity to a Subrecipient for the Subrecipient to contribute to the goals and objectives of the Project by carrying out part of the federal program awarded to the Pass-through Entity. NCDHHS provides its Subawards by executing a financial assistance contract in the form of an Agreement Addendum with the awarded Subrecipient.

Suspension of Funding List: a database maintained and distributed by the North Carolina Office of State Budget and Management in consultation with State agencies designating grantees or subgrantees in a state of non-compliance with grant agreement requirements in accordance with 09 NCAC 03M .0801.

Triple P-The Positive Parenting Program: Triple P is a parenting program designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.

II. BACKGROUND

Session Law 2026-41 (SB257), Section 9H.1.(a)-(d) continues funding to the Division to award competitive grants to local health departments for the improvement of maternal and child health based on maternal and infant health indicators and the county's detailed proposal to invest in evidence-based programs to achieve the following program aims:

1. Improve North Carolina's birth outcomes
2. Improve the overall health status of children in this State from birth to age 5.
3. Lower the State's infant mortality rate

The session law requires that a Request For Applications (RFA) process be implemented to award grants to local health departments to carry out evidence-based strategies to achieve the three aims. The session law requires that the DPH complete the following as part of the RFA process:

- prioritize grant awards to local health departments that are able to leverage non-State funds in addition to the grant award
- award grants to local health departments that are dedicated to providing services on a county-wide basis
- require that local health departments participate in evaluation, including measurable impact or outcomes, and
- ensure that local health department sites that receive ICO4MCH funds will supplement and not supplant existing funds for health and wellness programs and initiatives.

This multi-factorial, comprehensive, population-level maternal and child health initiative addresses three aims: (1) improve birth outcomes, (2) reduce infant mortality, and (3) improve the health status of children ages 0–5.

The following long-term (3–5 years) outcomes will measure the achievement of the three aims for all racial and ethnic groups:

- the rate of infant mortality
- the rate of unintended pregnancy
- birth spacing rates
- preterm birth rates (babies born <37 weeks)
- low (<2500 grams) and very low (<1500 grams) birthweight rates
- the rate of child death, among children ages 1–5
- the rate of substantiated child abuse and neglect cases
- the rate of out-of-home placements for children ages 0–5

III. SCOPE OF SERVICES

The ICO4MCH Program aims are to improve birth outcomes, reduce infant mortality, and improve the health status of children, ages 0 – 5. The table below outlines each program aim and the evidence-based programs that can assist LHDs to achieve each program aim.

Applicants must address all three (3) program aims and select one (1) evidence-based strategy for each aim.

Evidence-Based Strategies

PROGRAM AIMS	EVIDENCE-BASED STRATEGIES
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A. Improved Birth Outcomes	Reproductive Justice (RJ)/Reproductive Life Planning (RLP) Improving Preconception and Interconception Health a. Mothers and Babies Program b. Preconception Peer Educator Model Doula Services
B. Reduced Infant Mortality	10 Successful Steps for Breastfeeding, with a specific focus on Step 3 and Step 10 a. Making It Work-Empowering Employers and Mothers b. Baby-Friendly City Program c. Shared Decision Making/Using Patient Decision Aids d. Implement Prenatal Breastfeeding Education e. Establish Public Lactation Rooms Community Health Worker (CHW) Model
C. Improved Health Status of Children Ages 0-5	Positive Parenting Program (Triple P) Family Connects Newborn Home Visiting Parents As Teachers (PAT)

Appendix A contains detailed program descriptions of each evidence-based strategy. This includes scope of services, performance measures, and reporting requirements.

To address the aims listed above, each funded site should implement the project using the required and optional components described below. Each funded site is required to use the Collective Impact framework and address the social drivers of health and the gaps that result for each of their selected evidence-based strategies.

COLLECTIVE IMPACT

The complexity and challenges facing communities to improve the health of individuals of reproductive age and children ages 0-5 can be overwhelming. Collaboration between community-based organizations, local health departments, and other key stakeholders can lead to long-term systematic change. Collective impact is an effective means of collaboration and a proven approach for helping organizations work together. Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. <https://collectiveimpactforum.org/>.

Each funded ICO4MCH project is required to infuse the collective impact framework into the implementation of each evidence-based strategy (EBS). Within the collective impact framework, the development and maintenance of a Community Action Team (CAT) is critical and required. The CAT is composed of local health department representatives (including management), current and former program participants, community members, caretakers, and other representatives including hospital administrators, faith leaders, other public and private maternal and child health providers, and additional partners who work to improve the health and well-being of women, infants, children, and families residing in the implementation county or counties. Each CAT shall convene at least quarterly during each year of the funding period. The CAT will provide guidance and expertise to the local health department responsible for managing the ICO4MCH grant during the planning, implementation, and evaluation of the project.

Social Drivers of Health

Social Drivers Of Health (SDOH)² are defined as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors that can be addressed to close the gaps in socioeconomic and health status or risk between different population groups. Disparities in infant mortality rates, birth outcomes, and child health indicators exist in North Carolina, reflecting the inequities between population groups in our state. Each funded ICO4MCH project should utilize stratified local and state data to identify the health disparities among the impacted population(s) within each aim to address the root causes of the socioeconomic and health inequities that exist.

Community Health Impact Assessment (CHIA) Tool and Process

Each funded ICO4MCH project is also required to integrate the use of a Community Health Impact Assessment (CHIA) tool into Community Action Team efforts. This tool is used by ICO4MCH sites as a framework to guide discussions led by the local ICO4MCH Program Manager, in collaboration with input and feedback from Community Action Team (CAT) members.

The Community Health Impact Assessment (CHIA) tool was previously developed by #impactEQUITYNC, a collaboration between NC Child, the NC Division of Public Health Women, Infant and Community Wellness Section, the NC Office of Minority Health and Health Disparities, and NC Chapter of the March of Dimes. This assessment was modeled after a planning tool created by the Washington State Department of Public Health and the City of Seattle.

The CHIA tool encourages ICO4MCH funded sites to focus on one of the evidence-based strategies to be or already being implemented and its impact on social drivers of health and gaps identified and experienced by local populations and communities at large. The CHIA tool encourages a team to think outside the box and consider all factors that could potentially impact the health of populations at risk. The tool and process help ICO4MCH CATs facilitate conversations around factors that support or weaken health, including the root causes of gaps and differences. Information gathered throughout this process will provide community perspective and guide your team in strategic planning to modify an existing or proposed evidence-based strategy. The CHIA tool will help ICO4MCH sites develop concrete methods and action steps aimed at improving policies/programs in the hope of reducing disparities and addressing gaps within the impacted population(s).

Newly funded ICO4MCH sites, in Year 1, will be required to participate in an orientation session with the DPH Contract Administrator and a representative from the University of North Carolina at Chapel Hill's National Maternal Child Health (MCH) Workforce Development Center to learn foundational information about the CHIA tool and process. Following participation in the session, new ICO4MCH sites will then work collaboratively with their Community Action Team (CAT) to develop a plan in preparation for CHIA tool completion and implementation in Years 2 and 3. Currently funded ICO4MCH sites will be recommended to collaborate with the DPH Contract Administrator, a representative from the University of North Carolina at Chapel Hill's National MCH Workforce Development Center and their CAT to plan and complete at least 2 CHIA tools/processes during the three-year RFA cycle.

² <https://www.cms.gov/priorities-innovation-key-concepts-social-drivers-health-health-related-social-needs>

IMPLEMENTATION SCIENCE

Lead local health departments receiving ICO4MCH funds for the first time will be required to work with an Implementation Coach from the National MCH Workforce Development Center (<https://mchwdc.unc.edu>) during the 1st year of the project period to:

1. increase their understanding of and capacity to use effective implementation science practices
2. support the implementation of the project, using relevant tools, assessments, and methods
3. provide technical assistance and guidance as projects evolve
4. support projects to measure and improve implementation processes

Newly funded ICO4MCH projects' CAT leadership and members should participate in implementation capacity building activities facilitated by implementation coaches. Each newly funded ICO4MCH project should expect to work with an implementation coach at a minimum of two days per month during the 1st year of the project period. The local ICO4MCH Program Manager shall serve as the primary contact for the implementation coach. Applicants who plan to work with National MCH Workforce Development Center should budget \$3,000 per month for the Implementation Coach.

If a currently funded ICO4MCH project is selected to be funded, working with the National MCH Workforce Development Center is optional. ICO4MCH sites whose funding is renewed under this RFA funding cycle that would like to work with the National MCH Workforce Development Center during the project period can negotiate a contract and scope of work based on their needs and goals for the consultation and an estimate of how many days of coaching is required. Sites should budget \$600/day based on the number of days of coaching and technical assistance desired.

IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. Award or Rejection

All qualified applications will be evaluated, and award made to that entity whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest.

2. Cost of Application Preparation

Any cost incurred by an entity in preparing or submitting an application is the entity's sole responsibility; the funding agency will not reimburse any entity for any pre-award costs incurred.

3. Elaborate Applications

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

4. Oral Explanations

The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the grant.

5. Reference to Other Data

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

6. Titles

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

7. Form of Application

Each application must be submitted on the form provided by the funding agency and will be incorporated into the funding agency's Subaward (contract).

8. Exceptions

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any entity may be grounds for rejection of that entity's application. Funded entities specifically agree to the conditions set forth in the Subaward (contract).

9. Advertising

In submitting its application, entities agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

10. Right to Submitted Material

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the entity will become the property of the funding agency when received.

11. Applying Entity's Representative

Each entity shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the entity and answer questions or provide clarification concerning the application.

12. Subcontracting

Entities may propose to subcontract or subgrant portions of work provided that their applications clearly indicate the scope of the work to be subcontracted or passed through, and to whom.

Subcontractors are vendors hired by the entity via a contract to provide a good or service required by the entity to perform or accomplish specific work outlined in the entity's executed contract with the State.

Subgrantees of the entity are awardees chosen by the entity to receive a portion of the State's pass-through funding to carry out all or a portion of the programmatic responsibilities outlined in the entity's executed contract with the State.

Entities may refer to [2 CFR 200.331](#) to assist in making the determination.

Each is subject to the State's approval prior to being awarded a contract or agreement from the entity. All Subcontractors and Subgrantees are subject to the funding restrictions and applicable terms and conditions of the Federal award and the State award to the entity. The entity is required to execute written agreements with all Subcontractors and Subgrantees prior to the commencement of any work.

Entities must also ensure that subcontractors are not on the North Carolina [Suspension of Funding List](#), [Debarred Vendors List](#), or [Federal Exclusions List](#).

In accordance with 09 NC Administrative Code 03M.0703 – Required Contract Provisions, information is required for each proposed subgrantee and subcontractor. See *Section VII. Application for Subcontractor/Subgrantee Information Form*.

13. Proprietary Information

Trade secrets or similar proprietary data which the entity does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

14. Agreement Addendum

The Division will issue a financial assistance contract ("Subaward") also known as an Agreement Addendum to the Consolidated Agreement between the LHD and DPH to the awarded entity(ies) ("Grantee") of the RFA funding.

15. Reimbursement

Financial assistance funding operates on a reimbursement basis. This requires the awarded entity to pay for program expenses upfront using their own funds and subsequently request payment from NCDHHS via the Aid-to-Counties payment subsystem for approved costs.

V. APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW

The following is a general description of the process by which applicants will be selected for this project.

1. Announcement of the Request for Applications (RFA)

The announcement of the RFA and instructions for receiving the RFA will be posted at the following DHHS website on 9/30/2026:

<http://www.ncdhhs.gov/about/grant-opportunities/public-health-grant-opportunities> and may be sent to prospective applicants via email and/or the Program's website.

2. Distribution of the RFA

RFAs will be posted on the following website <https://wicws.dph.ncdhhs.gov/> and may be sent via email to interested applicant entities beginning 09/30/2026.

3. Applicant Conference / Teleconference / Question & Answer Period

All prospective applicants are encouraged to attend an Applicant Conference on 10/9/2026 at 10:00 a.m. via Zoom.

Zoom meeting link: <https://www.zoomgov.com/j/1651112905> Meeting ID: 165 111 2905

Questions must be submitted in writing to the email address listed on this RFA cover page no later than 5:00 p.m. on 10/14/2026.

As an addendum to this RFA, a summary of all questions and answers asked in the Conference will be posted on 10/21/2026 at 5:00 p.m. on the following website: <https://wicws.dph.ncdhhs.gov/>.

Questions directed to any other DPH staff or email will not be addressed.

4. Notice of Intent

Any entity that plans to submit an application shall submit a Notice of Intent no later than 5:00 p.m. on 10/14/2026 to the email address listed on this RFA cover page. Please include the following information in the Notice of Intent:

- The legal name of the entity.
- The name, title, phone number, mailing address, and email address of the person who will coordinate the application submission.

5. Applications

Applicants shall email a PDF version of their full application to the email address listed on the cover sheet of this RFA. The subject line must contain the applicant's legal name, RFA number and RFA title. In addition to their application response, applicants should email the Excel worksheet of the application budget. Faxed and hand-delivered applications will not be accepted. DPH can only accept email attachments less than 30MB. If necessary, break the application into separate PDFs and emails, noting the number and total, i.e., 1 of 3, 2 of 3, 3 of 3.

6. Format

The application should be single-spaced with 1" margins. Arial, Times New Roman, Calibri, or similar font; 12 pt (10 pt for tables/charts).

7. Space Allowance

Page limits are clearly marked in each section of the application. Attachments do not count toward page limit. Examples include: Organizational chart, board list, job descriptions, financial statements, letters of commitment.

8. Application Deadline

All applications must be received by the date and time on the cover sheet of this RFA. Faxed or hard copies of applications will not be accepted in lieu of the emailed PDF version.

9. Receipt of Applications

Applications from each responding entity will be timestamped with the date and time received in by DPH's email application. Entities will receive an email that the application has been received.

10. Review of Applications

Applications are reviewed by a multi-disciplinary committee of public and private health and human services subject matter specialists. Staff from applicant entities may not participate as reviewers.

Applications will be evaluated by the committee for completeness, content, experience with similar projects, ability of the entity's staff, benefit to the State, etc. The State reserves the right to conduct site visits as part of the application review and award process. The award of a grant to one entity does not mean that the other applications lacked merit, but that, all facts considered, the selected application was deemed to provide the best service to the State. Entities are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

11. Request for Additional Information

At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, applicant entities are cautioned that the reviewers are not required to request clarification. Therefore, all applications should be complete and reflect the most favorable terms available from the entity.

12. Audit

[N.C.G.S. 159-34](#) states that each unit of local government and public authority must have its accounts audited as soon as possible after the close of each fiscal year.

13. Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement

The Grantee shall complete and submit to the Division, the Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement Form within 10 State Business Days upon request by the Division when awarded \$25,000 or more in federal funds. The form is attached for reference in Appendix A of this RFA.

14. Application Process Summary Dates

- 09/30/2026: Request for Applications released to eligible applicants.
- 10/09/2026: Bidder's Conference / Teleconference.
- 10/14/2026: Notice of Intent due.
- 10/14/2026: End of Q&A period. All questions due in writing by 5pm.
- 10/21/2026: Answers to Questions posted as an addendum to the RFA.
- 11/06/2026: Applications due by 5pm.
- 11/25/2026: Successful applicants will be notified.
- 06/01/2027: Estimated Contract Start Date.

VI. EVALUATION CRITERIA

SCORING OF APPLICATIONS

Applications shall be scored based on the responses to the four application content areas. Each content area shall be scored on a scale of 1 to 4 based on the scale below:

- | | | |
|---|-----------|--|
| 1 | POOR | Applicant only marginally addressed the application area. |
| 2 | AVERAGE | Applicant adequately addressed the application area. |
| 3 | GOOD | Applicant did a thorough job of addressing the application area. |
| 4 | EXCELLENT | Applicant provided a superior response to the application area. |

The highest total score is 100 points. The scoring procedure is described below:

1. Needs Assessment:

Total maximum points = 15

2. Program Plan:

Total maximum points = 30

3. Data Collection and Evaluation:

Total maximum points = 10

4. Agency Ability:

Total maximum points = 15

5. Collective Impact and Community Involvement:

Total maximum points = 15

6. Project Budget:

Total maximum points = 15

Each of the content areas will be scored according to the numerical values stated above.

VII. APPLICATION

Application Checklist

The following items must be included in the application. Please assemble the application in the following order:

1. **Cover Letter**
2. **Application Face Sheet**
3. **Applicant's Statement of Work**
4. **Project Budget**
Include a budget in the format provided.
5. **Indirect Cost Rate Approval Letter** (if applicable)
6. **Subcontractor/Subgrantee Information** (if applicable)
7. **IRS Letter Documenting Your Organization's Tax Identification Number** (public agencies)

Attachment A: Agency Information

Attachment B: Community Involvement / Collective Impact

Attachment C: Letters of Agreement

1. Cover Letter

The application must include a cover letter, on the entity's letterhead, signed and dated by an individual authorized to legally bind the Applicant. The letter must include:

- Legal name of the Applicant entity
- RFA number
- Applicant entity's federal tax identification number
- Applicant entity's Unique Entity Identifier (UEI)

Please address the following items in the letter:

- Entity mission
- Related/relevant services/programs provided in North Carolina within the last three (3) years.
- How this proposed work fits within your entity mission

There is no page limit for the cover letter.

2. Application Face Sheet

This form provides basic information about the applicant and the proposed project, including the signature of the individual authorized to sign “official documents” for the entity. This form is the application’s cover page. Signature affirms that the facts contained in the applicant’s response to RFA #A430 are truthful, and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

1. Legal Name of Entity:	
2. Name of individual with Signature Authority:	
3. Mailing Address (include zip code+4):	
4. Address to which checks will be mailed:	
5. Street Address:	
6. Contract Administrator: Name: Title:	Telephone Number: Email Address
7. Entity Status: ☐ Local Health Department/District	
8. Entity Federal Tax ID Number:	9. Entity UEI:
10. Entity’s URL (website):	
11. Entity’s Financial Reporting Year:	
12. Current Service Delivery Areas (county(ies) and communities):	
13. Proposed Area(s) To Be Served with Funding (county(ies) and communities):	
14. Amount of Funding Requested:	
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document, and I am authorized to represent the applicant. “I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812.”	
15. Signature of Authorized Representative:	16. Date

3. Applicant’s Statement of Work

Social Drivers of Health

Social drivers of health (SDOH)³, as previously noted, are defined as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are community-level factors that can be addressed to close the gaps in socioeconomic and health status or risk between different population groups. Difference in infant mortality rates, birth outcomes, and child health indicators exist in North Carolina, reflecting the inequities between population groups in our state.

Throughout the application response, the Applicant must outline how they will ensure the three evidence-based strategies (EBSs) selected will address the social drivers of health that impact the population in the service area(s) and exacerbate differences in health that have been identified. Each program aim and EBS should clearly identify how the Applicant will use resources, materials, program planning, implementation, and evaluation to ensure their EBSs are addressing the root causes of the differences within infant mortality, birth outcomes, and infant/child health outcomes.

Community Health Impact Assessment Tool/Process

Newly funded ICO4MCH sites in Year 1 will be required to participate in an orientation session with the DPH Contract Administrator and a representative from the University of North Carolina at Chapel Hill's National MCH Workforce Development Center to learn foundational information about the CHIA tool and process. Following participation in the session, new ICO4MCH sites will then work collaboratively with their CAT to develop a plan in preparation for CHIA tool completion and implementation in Years 2 and 3.

Currently funded ICO4MCH sites will be recommended to collaborate with the DPH Contract Administrator, a representative from the University of North Carolina at Chapel Hill's National MCH Workforce Development Center and their CAT to plan and complete at least 2 CHIA tools/processes during the three-year RFA cycle.

Section 1 Needs Assessment

**Total Point Value:
15**

**Page Limit:
8 single-spaced, not including citation page(s)**

Do not delete the question headers.

³ <https://www.cms.gov/priorities-innovation-key-concepts-social-drivers-health-health-related-social-needs>

Please provide your response to each question under the heading.

- 1-1. Define the specific area that will be served by the ICO4MCH project. An area may be a county or a multi-county area. (1 point)
- 1-2. For each EBS, provide recent data to demonstrate the need for the ICO4MCH project in the county or multi-county area you propose to serve. For each EBS, describe the impacted population(s) to be served. Data should be stratified at the county and state level, and, when possible, by race and ethnicity. Data should be compared to other counties and the state. Data provided should be associated with the EBSs selected by the agency. Additional information about birth outcomes, infant mortality, and early childhood health may be included beyond these suggestions, including qualitative data (i.e., from focus groups, key informant interviews, etc.) (5 points)
- 1-3. Applicants are encouraged to present data in tables or graphs with a detailed narrative analysis of data (4 points).
 - a. Demographic statistics for individuals who gave birth (i.e., age, education level, health status, pre-pregnancy body mass index, marital status)
 - b. Infant mortality and disparity rates
 - c. Birth outcomes (i.e., low and very low birth weight rates, preterm birth rates, etc.)
 - d. Prenatal care (i.e., initiation rates, adequate prenatal care rates, etc.)
 - e. Child poverty rate (children <5 years of age)
 - f. Uninsured child rate (children <19 years of age)
 - g. Number of providers in the county or multi-county area that offer long-acting reversible contraceptive (LARC)
 - h. Breastfeeding initiation rates among individuals
 - i. Description of businesses/organizations that accommodate breastfeeding individuals
- 1-4. Describe the availability and accessibility of health services and other support services in the community that impact the three aims. Describe strengths, barriers, and gaps in services. Services should include both internal and external health and other support services available to the LHD. (2 points)
- 1-5. Applicants are required to state which three EBSs they are selecting for each of the three program aims. Applicants must provide a rationale for how these EBSs and priority population(s) were selected or identified. The EBSs must be addressed to meet the needs of the population to be served within the entire county or multi-county area. (2 points)
- 1-6. Appropriate data sources must be cited in the needs assessment. The citation list can be included on a separate page and will not count against the page limit for this section. (1 point).

Section 2

Program Plan

Total Point Value:

30

Page Limit:

12 single-spaced

Do not delete the question headers.

Please provide your response to each question under the heading.

Applicants will be required to describe in detail their program and implementation plan for the three EBSs chosen to address the three program aims: reduce infant mortality, improve birth outcomes, and improve health status of children ages birth to five. Applicants should describe their experience with implementing the selected EBSs. Applicants will describe how their program will meet or exceed the program service deliverables, and describe the activities involved to meet the deliverables. Applicants will describe how their program will meet each of the program performance outcome measures. Please provide your response to each question under the heading.

- 2-1. For each EBS, describe how the Applicant will implement and potentially exceed the scope of services, performance measures, and reporting requirements. In the description, include detailed activities for each EBS. Information such as who will oversee each EBS and the activities, what activities will take place, where and when activities will be implemented, etc. Applicants are encouraged to use tables to clearly identify each EBS, scope of service, performance measure, activities, etc. (15 points)
- 2-2. For each EBS, describe how the impacted/priority population(s) has been or will be involved in the program planning, implementation, and evaluation. (5 points)
- 2-3. Describe your experience implementing maternal and child health EBSs. In the description, include how your agency has collaborated with other organizations; how your agency will partner with other organizations to implement the three EBSs chosen for the ICO4MCH project. (5 points)
- 2-4. For each EBS, what change do you expect to see because of the implemented strategies? (5 points)

Section 3

Data Collection and Evaluation

Total Point Value:

10

Page Limit:

9 single-spaced

Do not delete the question headers.

Please provide your response to each question under the heading.

Applicants must describe how data will be collected and what tools will be used to track successful implementation of each EBS based upon the scope of services and performance measures listed for each EBS. Applicants will detail how they will track activities and outcomes provided in the proposed program plan, and the type of tools used and their participation in evaluation activities in collaboration with the UNC evaluation team. Applicants will describe their policies and procedures for maintaining client confidentiality. Applicants can refer to Appendix E for additional information regarding the data that will be provided by the Applicant and by DPH.

- 3-1. For each EBS, describe how your agency will monitor and track performance measures. Include past experiences monitoring and evaluating similar maternal and child health programs. (4 points)
- 3-2. For each EBS, describe the evaluation tools that will be used to monitor and track each activity described in your program plan (e.g., assessments, pre/post-tests, data tracking methods/tools, reports). Refer to Appendix E, that identifies the data that can be provided by the DPH. (4 points)
- 3-3. Describe how you will maintain client confidentiality for each of the selected three EBSs. (2 points)

Section 4

Agency Ability

Total Point Value:

15

Page Limit:

3 single-spaced

Do not delete the question headers.

Please provide your response to each question under the heading.

Applicants must indicate experience that program staff has with the chosen EBSs and training they have received or plan to receive if awarded funding. Required trainings are described in the Scope of Services Section for each EBS.

- 4-1. Describe your agency's mission, background, and services and how these relate to the program aims for ICO4MCH. Applicants should include their experience working with and implementing maternal and child health programs in the community. Include the agency's organizational chart in Attachment A. (5 points)
- 4-2. Describe the agency's staff that will oversee grant funds (budgeting, billing, sub-contracts, contract expenditure reports, etc.), if awarded. (5 points)
- 4-3. Use the chart below to list the current and/or new staff positions that will be necessary to implement and support the three EBSs. For each staff listed, please highlight their qualifications, FTE, or percent effort on the ICO4MCH project and which EBSs they will be working with. Administrative, management staff, or in-kind staffing should be accounted for in the chart below. Please insert additional rows, if needed. Include copies of job descriptions of future staff and/or resumes of current staff in Attachment A. (5 points)

Staff Position/Name	FTE or Percent Time	Qualifications	EBS

Section 5
Collective Impact and Community Involvement

Total Point Value:

15

Page Limit:

3 single-spaced

Do not delete the question headers.

Please provide your response to each question under the heading.

- 5-1. Describe how the Community Action Team (CAT) or other stakeholders from the community were involved in the selection of the evidence-based strategies (EBS), the program and implementation plans. Include information on how the CAT or other stakeholders from the community with maternal and child health programs will be involved in the ICO4MCH project. (3 points)
- 5-2. Describe how the agency will collaborate with community members, consumers, advocates, content experts, other health and human service agencies, and community or faith-based organizations to implement the three EBSs. The Collective Impact framework should be addressed when describing this collaboration. (3 points)
- 5-3. Use the chart below to identify the CAT members currently collaborating with the LHD. Identify their name, role, and how long they have been involved with the CAT. Roles include community members, content experts, health care providers, local health department staff, impacted groups, community leaders, or advocates. Provide a letter of commitment (LOC) from each member in Attachment B. (3 points)
- 5-4. If the agency does not have a CAT or similar team, use the chart below to identify potential stakeholders from the county/community and what their role will be in implementation of the EBSs. Include LOC in Attachment B. (3 points)

Participant Name	Role & Affiliation	Length of participation (months/years)	LOC Attached?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

- 5-5. Use the chart below to list the other health and human service agencies, and community or faith-based organizations that will assist with implementing the EBSs. Organizations may include those that will sub-contract with the Applicant to provide services associated with the EBS, assist in services such as referrals, transportation, childcare, programming, training, etc. Include a Letter of Agreement (LOA) from each agency/organization describing their contribution to the specific EBS. Include the LOA in Attachment C. Please insert additional rows if needed. (3 points)

Organization	Services Provided	EBS Focus	Subcontract?
			☐ Yes ☐ No

			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable. Identify in the chart where the LOC or LOA can be found.

4. Project Budget

Total Point Value:

15

Page Limit: Not Applicable

Applicants must provide budget and narrative justification for the following anticipated Grantee Award Period: 06/01/2027 – 05/31/2028 (Year 1).

Budget and Justification Form (5 points)

Applicants must complete the *Budget and Justification Form*, which requires a line-item budget and narrative justification for the period of funding outlined above.

Budgets must align clearly with proposed activities and resources.

The Budget form and instructions on how to use the form will be posted along with this RFA and can be downloaded by the Applicant for editing.

Narrative Justification for Expenses (5 points)

A narrative justification must be included for every expense listed in the budget. Each justification should show how the amount on the line-item budget was calculated, and it should be clear how the expense relates to the project. Ensure all subtotals equal the total amount entered on the row for that line item.

Staffing (5 points)

Each Applicant must adhere to the following guidelines for staffing the ICO4MCH project, unless otherwise noted in the scope of services: 1.0 FTE Program Manager, and at least one 0.50 FTE per EBS which are paid staff positions. Note: Triple P, Family Connects Newborn Home Visiting and Parents as Teachers Programs have specific staffing requirements that must be followed. In addition, staff hired to implement the project can be contract employees and/or salaried employees with this state funding. All applicants should follow county guidelines for hiring.

Implementation Science Costs

As described in the Scope of Services Section of this RFA, each newly funded ICO4MCH project will be required to budget funds for an Implementation Coach from the National MCH Workforce Development Center for at least the first year of the grant period. Re-funded Applicants are not required to budget funds for an Implementation Coach. The monthly cost for the Implementation Coach is \$3,000 which must be included in the project budget(s). Each project should expect to work with the Implementation Coach for a minimum of two days per month in the early stages of the project.

If an existing ICO4MCH project is selected and decides to work with the National MCH Workforce Development Center during the project period, they can negotiate a contract based on their goals for the consultation and an estimate how many days of coaching is required. In this case, the scope of work and budget must be tailored to the site's needs. Currently funded sites should budget for \$600/day based on the number of days of coaching desired.

Travel Reimbursement Rates

Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the "Change in IRS Mileage Rate" memorandum to be found on OSBM's website

when there is a change in this rate. The current state mileage reimbursement rate is **\$0.760** cents per mile.

For other travel-related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. NCDHHS will only reimburse for rates authorized in North Carolina Department of Health and Human Services Travel Policy. NCDHHS utilizes GSA State/City Standard Travel Per Diems as the maximum allowable statutory rate for meals and lodging (subsistence). The following is the current NCDHHS schedule which shall be used for reporting allowable subsistence expenses incurred while traveling on official state business:

Current Rates for Travel and Lodging

Meals	In State	Out of State
Breakfast	\$16.00	\$16.00
Lunch	\$19.00	\$19.00
Dinner	\$28.00	\$28.00
<i>Total Meals Per Diem Per Day</i>	<i>\$63.00</i>	<i>\$63.00</i>
Lodging <i>(Maximum rate per person, excludes taxes and fees)</i>	\$110.00 + taxes/fees	\$110.00 + taxes fees
Total Travel Allowance Per Day	\$173.00	\$173.00
Mileage	\$0.76 per mile/regardless of distance	

Additional Funding Restrictions

All project budgets must adhere to these requirements:

The legislation authorizing this program requires “that the Division prioritize grant awards to those local health departments that are able to leverage non-State funds in addition to the grant award.”

Applicants should describe how they plan to leverage non-state funds in their budget narrative. This should include an approximate amount of funding and source in the narrative as they relate to the program plan. This is not a match requirement, but a statement of local support for the services to be carried out.

Indirect Cost

Indirect cost is the cost incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. Indirect Cost may not exceed restrictions or limits placed on it by the funding source.

Per NC Session Law 2023-65: For Grantees, including nonprofit grantees, that (i) are receiving financial assistance and do not have a federally approved indirect cost rate from a federal agency or (ii) have a previously negotiated but expired rate, the Department may allow the grantee, in accordance with 2 C.F.R. § 200.332(a)(4) or 2 C.F.R. § 200.414(f), to use the de minimis rate of modified total direct costs. Alternatively, the grantee may negotiate or waive an indirect cost rate with the Department. If State or federal law or regulations establish a limitation on the amount of funds the grantee may use for administrative purposes, then that limitation controls, in accordance with 2 C.F.R. § 200.414(c)(3).

The funding source(s) of this RFA and its subsequent awards has NO Indirect / Administrative Cost Restrictions

Indirect cost is allowed on 100% of the sub-award.

Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR), the applicant entity may request up to the federally negotiated rate. The total modified direct cost identified in the applicant's FNICR shall be applied. A copy of the FNICR must be included with the applicant's budget.

If the applicant does not have an FNICR, then the applicant may claim the *de minimis* indirect cost rate of 15% with no additional documentation required, per the federal Uniform Guidance.

The applicant may elect to claim a lesser portion of the allowed indirect cost rate. If claiming the *de minimis* or some portion thereof, it may not exceed the limit of the modified total direct costs in the proposed budget as defined by [2 CFR 200.1 "Modified Total Direct Cost \(MTDC\)"](#). Applicants must indicate in the budget narrative that they wish to use the *de minimis* rate, or some part thereof.

Applicants who do not wish to claim any indirect cost must enter "No indirect cost requested" in the indirect cost line item of the budget narrative.

5. Indirect Cost Rate Approval Letter

Local Health Departments or Districts that 1) have a Federally Negotiated Indirect Cost Rate (FNICR) and 2) have included more than the 15% *de minimis* rate in their budget should attach that document here in their application.

6. SubContractor/SubGrantee Information

In accordance with 09 N.C. Administrative Code 03M.0703, Required Contract Provisions, the Applicant must provide the required information for every subcontractor and subgrantee included in the Project Budget. If the Applicant has no subcontractor and subgrantee, indicate that in the first line under "Name." If the Applicant plans to have subcontractors or subgrantees but they are unknown at this time, that must be indicated in the first line under "Name" for as many as are planned. When they are known, this information shall be submitted to the Division for review prior to the Applicant contracting with the entity. Attach additional pages as necessary.

NOTE: If awarded federal pass-through funds, subgrantees must certify to the Applicant whenever applying for funds, requesting payment, and submitting financial reports:

"I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812."

SubContractor/SubGrantee Name:

Position Title (if applicable):

EIN or Tax ID:

Street Address or PO Box:

City, State and ZIP Code:

Contact Name:

Contact Email:

Contact Telephone:

Fiscal Year End Date (for organizations):

Is this organization functioning as a pass-through entity "SubGrantee" of the Applicant?

Is this organization functioning as a vendor "SubContractor" of the Applicant?

7. IRS Letter Documenting Your Organization's Tax Identification Number

Provide a copy of a letter from the IRS which documents your organization's tax identification number. The organization's name and address on the letter must match your current organization's name and address.

Attachment A: Agency Information

This attachment must include each of the following:

1. Organizational chart of the applying agency.
2. Job descriptions of new staff and/or resumes of current staff, including in-kind staff.

Attachment B: Community Involvement/Collective Impact

This attachment must include each of the following:

1. Letters of Commitment from existing or potential Community Action Team (CAT) members or stakeholders
2. Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable.

Attachment C: Letters of Agreement

This attachment must include LOA from agencies that are committed to assisting with implementation and/or serve as a referral agency for services provided to clients. Each LOA should specify the agency's contribution to the selected evidence-based strategy. An LOA should also be included for any agency that the Applicant will sub-contract with for this project.

Appendix A: Evidence-Based Strategies:

Evidence-Based Strategy Scope of Services, Performance Measures, and Report Requirements

PROGRAM AIM 1: Improve Birth Outcomes
I. Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP)
Reproductive Justice is a framework built on the belief in the “complete physical, mental, spiritual, political, economic, and social well-being of women and girls”.¹ It is also the recognition that historically, women, girls, and individuals have experienced reproductive abuses based on “race, ability, class, gender, sexuality, age, and immigration status”.² These abuses have resulted in harmful outcomes that have lasting community effects.¹ Reproductive Life Planning (RLP) is a strategy that aims to encourage both women and men to reflect on their reproductive intentions and to find family planning strategies that function for them.¹ The guidelines associated with RLP seek to develop a set of standardized questions to guide conversations with patients that would support a life course perspective.⁵ The Centers for Disease Control and Prevention (CDC) recommend the use of RLP questions with all clients “receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted disease and preconception health services...”⁶ Paired with the RLP strategy, the Reproductive Justice framework will provide additional resources to health care professionals (clinical and non-clinical) as well as men and women of reproductive age to engage in decisions about their reproductive future. Based on this framework all women should 1) have access to their contraception method of choice, 2) be able to decline a contraception method without judgement or pressure and 3) have access to contraception removal services when they desire.^{3,4} Long-acting reversible contraception (LARC) methods are effective for three to 10 years, and do not require any action on the part of the user after insertion. LARCs include hormonal intrauterine devices (IUDs) such as Mirena®, Skyla®, Liletta® and Kyleena®; the non-hormonal IUD known as ParaGard®; and the implant known as Nexplanon®. Research shows that more patients opt to use a LARC when it is in stock and available for same-day insertion.⁷ Tiered contraceptive counseling is a recommended best practice per the Providing Quality Family Planning Services guidelines, developed by the CDC and the U.S. Office of Population Affairs.⁸ The evidence supports increased use of LARCs and a substantial reduction in unintended pregnancy when the tiered approach to contraceptive counseling is utilized.^{8,9} The Oregon Foundation for Reproductive Health developed and tested the One Key Question® for primary care providers.¹⁰ Asking “Would you like to become pregnant in the next year” opens a discussion with patients to begin assessing their RLP as part of their overall life plan. For same-day insertion to be viable, health care practices/clinics/local health departments must have sufficient numbers of trained health care providers and staff to facilitate clinic flow, and must stock LARC devices in advance rather than purchasing a particular device for a particular patient. Programs for the uninsured, such as Access and Resources in Contraceptive Health (ARCH) Patient Assistant Program, supply Bayer brand IUDs at no cost for specific patients who apply. Health care practices may opt to order devices for specific patients under their pharmacy benefit,

which can create barriers for the patient, since this practice generally requires more than one provider visit. Patients that receive Medicaid can have LARC devices provided from stock and the providers can bill Medicaid for reimbursement. For more information, visit: Obstetrics and Gynecology Clinical Coverage Policies (1E-7): <https://medicaid.ncdhhs.gov/blog/2023/01/30/update-changes-pharmacy-professional-dispensing-fee-and-340b-long-acting-reversible-contraception>.

A. Scope of Services

Offer educational workshops and trainings, within the LHD and at other public/private health care facilities to educate women and men of reproductive age about family planning methods, such as LARCs, using the reproductive justice approach and evidence-based and evidence-informed protocols, such as reproductive life planning (RLP), which may include One Key Question® and a tiered approach to contraceptive counseling. Topics for participants include the principles and application of Reproductive Justice, patient centered and culturally sensitive counseling, learning how access to family planning methods, such as LARCs; potential side effects; informed consent and confidentiality.

Involve consumers of service (men and women of reproductive age) in developing and implementing educational materials, protocols, policies, and strategies to increase access to RLP and family planning methods, including LARCs.

Provide outreach and awareness to members of the community-at-large about the benefits, potential side effects, and informed consent surrounding family planning methods, including LARCs, within the framework of reproductive justice, using the principles of RLP.

Collaborate with other entities, such as your regional Area Health Education Center (AHEC) and Upstream NC, to educate and train health care providers, staff at the LHD, and other public/private health care facilities. Education and training may include the utilization of reproductive justice framework and evidence-informed principles of RLP, utilization of the One Key Question® as well as a tiered approach, implicit bias, and patient centered and culturally sensitive counseling to all patients of reproductive age.

Provide same-day availability and insertion (when applicable) for LARC methods at the local health department.

Provide training, resources, and technical assistance to increase access to same-day insertion of LARC and the availability of full range birth control methods at the LHD, community health clinics, and private healthcare facilities. Training can include insertion and removal of IUDs/implants, tiered counseling, informed consent, and possible side effects for a full range of birth control methods. Reimbursement/billing procedures and the Be Smart Family Planning Program should also be included. Furthermore, encouraging collaboration is highly recommended to provide or assist with trainings. Potential collaborators include AHEC and Upstream NC (www.upstream.org).

B. Performance Measures

Conduct education with a minimum of 300 women and men of reproductive age, using a reproductive justice framework, about family planning methods, including LARCs, reproductive life planning (RLP), and a tiered approach to contraceptive counseling.

Conduct outreach and awareness based on the reproductive justice framework, to a minimum of 1,000 members of the community-at-large about the benefits, potential side effects, and informed consent of family planning methods, specifically, LARCs.

Increase the number of trainings offered to LHD providers and other public/private health care providers. Topics include insertion/ removal of IUDs/implants, billing and reimbursement, tiered contraceptive counseling, postpartum IUD/implant insertion, clinic flow, and other topics as relevant.

Increase the percent of LHD providers who provide consistent and regular same-day insertion of LARCs when requested.

C. Reporting/Monitoring Requirements

Funded local health departments shall document and submit data on the following requirements:

The number of women and men of reproductive age educated during workshops/trainings. Data should include topic of the workshop/training, location, basic demographic information (name, age, race, ethnicity), and resources distributed.

The number of community members who receive outreach and awareness. Data should include topics discussed, location, basic demographics, and resources shared.

The number of LHD and other public/private health care providers who participate in an in-person or webinar training or technical assistance with regards to any of the following topics: insertion/removal of IUDs/implants, tiered contraceptive counseling, motivational interviewing, postpartum IUD/implant insertion, reproductive justice or implicit bias.

NOTE: Other private/public health care providers or facilities include, but are not limited to federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.

2. Preconception and Interconception Health

Most efforts to reduce infant and maternal mortality have historically focused on prenatal care and interventions during labor and delivery. Unfortunately, after several decades of emphasis in this area, birth outcomes are not improving as much as expected. The importance of prenatal care and delivery management cannot be overstated, but there remain many additional ways to make a great impact on improving birth outcomes for mothers and babies. However, these supports, and services needs to happen prior to pregnancy. (<http://beforeandbeyond.org/wp-content/uploads/2017/01/Zero-to-Three-Article-for-Dr.-Frayne.pdf>)

Preconception health refers to the health of women and men during their reproductive years, which are years they can have a child. It focuses on taking steps now to protect the health of a baby they might have sometime in the future. Preconception care is aimed at identifying and modifying physical, behavioral and social risks through preventive and management interventions (<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>).

Common modifiable risk factors in women that influence birth outcomes for themselves and the baby include: pregnancy intention, interpregnancy interval, maternal age, folic acid supplementation and other nutritional factors, exposure to substances, chronic disease control and toxic stress. For men, preconception health interventions should be focused on reproductive planning and contraception, infection/immunizations, genetics/family history, social and behavioral issues and interpersonal violence. Engaging men during the preconception period is an excellent opportunity to discuss their important role in parenting.

A. Scope of Services

Implement a community-based health education and outreach program for women of reproductive age and/or women during the interconception period in partnership with a community partner. The program should provide opportunities for women to build social support, learn health information,

adopt healthy life skills, become knowledgeable of resources and increase motivation to adopt health improving behaviors. To address issues prevalent during the preconception and/or interconception periods, program content should include, but limited to 1) Healthy Eating/Active Living, 2) Mental Health and Wellness, and 3) Healthy Relationships

Implement the **Mothers and Babies Program** designed to promote healthy mood management while teaching pregnant women and new moms how to effectively respond to stress in their lives through increasing the frequency of thoughts and behaviors that lead to positive mood states. Mothers and Babies offers a “toolkit” of approaches for women to observe their mood, note factors affecting their mood, and make changes in their daily lives to impact these areas.
(<http://www.mothersandbabiesprogram.org/mothers-clients/>)

Utilize social media, along with radio, television, billboards, web banners or newspapers to increase public awareness of preconception and interconception health. Campaigns should promote information and behaviors that can improve birth outcomes, such as reducing tobacco use, starting prenatal care within first trimester, responsible use of alcohol, healthy diet and optimal weight, value of postpartum visit, resources that support maternal and paternal mental wellness, breastfeeding support, and reproductive life planning (RLP).

Select one (1) of the following Scope of Services to implement in addition to the above listed activities:

1. Establish a partnership with local community colleges, four-year universities or agencies that serve women and men of reproductive age to implement a **Preconception Health Peer Educator program (PPE)**. The PPE program was initiated by the U.S. DHHS Office of Minority Health to train and raise awareness among college students about healthy behaviors that can impact birth outcomes and the social determinants of health that impact health disparities. The PPE program aims to reach college-aged students with targeted health messages emphasizing preconception health and care.

These PPE student groups are led by a college/university faculty member or staff. The goals of the PPE program are to:

- a. Train college students as peer educators
- b. Arm the peer educators with materials, activities and exercises to train their peers in college and in the community at large.
- c. Reach the college-age population with targeted health messages emphasizing preconception health and healthcare
- d. Provide focused health messages to and activities for non-college women and men, ages 18 – 30 years old, within the funded county(ies).

2. Enhance efforts in promoting and increasing utilization of pre-pregnancy services by women and men of reproductive age, including under- and un-insured, to reinforce the importance of pregnancy planning and preparedness among women and men in the Local Health Department Family Planning clinic or within other primary care practices. This visit should include: physical assessment, completion of the reproductive life plan tool/assessment and provide education and/or referral on folic acid supplementation, oral health, healthy diet and optimal weight, family and genetic history, social and behavioral history, chronic disease management, physical/sexual/emotional abuse and importance of early prenatal care. Funds may support the provision of pre-pregnancy services for women and men of reproductive age, including under- and un-insured clients, or funds may be used to implement strategies to identify individuals in the community who would benefit from these services and raise awareness of pre-pregnancy services available.

(Source: <https://www.aafp.org/about/policies/all/preconception-care.html>)

B. Performance Measures

Increase the number of unduplicated men and women of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness.
Increase the number of women and men of reproductive age who complete a reproductive life plan assessment.
Facilitate a minimum of 25 Mothers and Babies sessions with women and/or men of reproductive age
Increase the presence of social media messages that provide information about issues related to preconception and interconception health.
Select the appropriate performance measure to match the selected scope of service above:
1a. Coordinate with the DPH Program Manager or designee to plan and conduct two PPE trainings.
1b. Develop a written agreement with a minimum of 2 partnering community colleges, universities and/or organizations that serve women and men of reproductive age to implement the PPE program. Agreement components shall include: a. Identify a PPE advisor at each community college, university and/or agency. The PPE advisor will oversee student PPE outreach on their campus. b. Recruit and maintain a minimum of 10 PPE students each academic year. These PPE students will serve as peer educators to reach their peers with targeted health messages emphasizing preconception health and healthcare. c. Develop and carry out a PPE workplan consisting of at least two on-campus and two community activities each academic year.
2. Increase the percent of LHDs providing a pre-pregnancy visit for women and men of reproductive age.
C. Reporting Requirements
Funded local health departments shall document and submit data on the following requirements: a. The number of unduplicated women of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness. b. Number of RLP assessments/tool completed by program participants c. The number of women and men of reproductive age reached through the Mothers and Babies program. Data should include format (one-on-one or group); basic demographic information, and resources/referrals made.
Select appropriate reporting requirements to match the selected scope of service above:

3. Doula Services

A doula is a trained professional that provides physical, emotional, and informational support to a woman before, during and after childbirth, including continuous labor support. Evidence supports those women who use a birth doula are less likely to have a cesarean birth; less likely to use Pitocin during labor; and more likely to rate greater satisfaction with her birth experience. Studies also show that doula support can improve preterm birth and low birthweight rates among non-Hispanic Black women and play a role in reducing racial/ethnic disparities in birth outcomes.

A. Scope of Services

1. Program activities shall include: developing policy and procedures for the program; developing educational and advertising materials for the program; establishing collaborative relationships with local birth facilities; conducting outreach and recruitment of community members to be trained as doulas; coordinating the trainings required for community members to serve as doulas; purchasing training and educational materials, and incentive items; conducting community outreach and education; educating local hospitals, LHD staff and maternity patients on the program; providing supervision and support to contracted doulas; matching doulas with pregnant women; conducting three-month follow-up contacts with program participants and completing birth satisfaction surveys; and tracking program data and completing program reports.
2. Coordinate two (2) required trainings for the community members recruited to be trained as doulas. The required trainings include a one (1) day introduction to childbirth education for doulas course and a two (2) day birth doula workshop. Program budgets must include the cost for both trainings. The estimated cost for both required trainings is \$600 per person.
3. Develop a written doula services agreement with each trained doula that will include: the responsibilities of both parties, the stipend amount to be paid for providing doula services before, during and after childbirth, and the doula's required time commitment to the program.
4. Provide complete doula services for each enrolled participant, which includes a minimum of one (1) prenatal visit, the provision of childbirth education, continuous onsite labor support at the hospital, at least one (1) postpartum visit either in the hospital or within one (1) week after birth, and at least one (1) telephone contact within 30 days after birth.
5. Collect data on program participants and report on a biannual basis. Program participant data shall include demographic information, prenatal care visits, breastfeeding initiation and duration, delivery outcomes, and birth outcomes.
6. Administer a birth satisfaction survey to each Doula Services program participant. All birth satisfaction survey responses shall be entered into an online survey provided by the DPH Contract Administrator. A copy of the Doula Services birth satisfaction survey can be found in Appendix G.
7. Develop and administer a program participant satisfaction survey to evaluate program services and submit an annual satisfaction survey summary report.

B. Performance Measures

1. At least four (4) community members shall be trained as doulas.
2. At least 40 unduplicated pregnant women shall receive complete doula services, at least 50% shall represent a minority population.
3. At least 75% of program participants shall complete a birth satisfaction survey.
4. At least 80% of program participants shall report a positive birth experience.
5. At least two (2) community outreach and education activities shall be conducted by the Program Coordinator.

C Reporting Requirements

Funded local health departments shall document and submit data on the following requirements:

1. The number of persons who successfully completed doula training.
2. The number of unduplicated pregnant women who received doula services.
3. The number of program participants by age, race and ethnicity who receive doula services.
4. The number of program participants who completed a survey reporting a positive birth experience with their doula.
5. The number of community and educational activities carried out

PROGRAM AIM 2: Reduce Infant Mortality

1. Ten Steps for Successful Breastfeeding, with a focus on Steps 3 & 10

Exclusive breastfeeding is considered one of the most effective preventative health measures to reduce child morbidity and mortality in the US and globally.¹¹ Infants who received any breastmilk were found to have a 60% lower risk of dying from Sudden Infant Death Syndrome (SIDS) and an overall lower risk of dying in their first year of life.^(12,13,14) North Carolina (NC) has a lower rate of ever breastfeeding (83.8%) compared to the US (86.1%).¹⁴ Breastfeeding at six and 12 months drops dramatically in both the US and in NC. In 2023, the rate of breastfeeding at six and 12 months was 63.9% and 41.9%, respectively.¹⁴ In the US, the rates were 62.8% and 40.8% in 2023.¹⁴ Although breastfeeding rates have increased in the US and NC, racial/ethnic disparities exist. According to the National Immunization Survey (2023), non-Hispanic (NH) whites had higher rates of breastfeeding at initiation (86.6%), six months (61.5%), and 12 months (39.6%) compared to NH-African Americans who had the lowest rates: (initiation, 74.0%; six months, 48.6%; and 12 months, 27.1%). NH-Asians had the highest overall rates of breastfeeding at initiation (88.2%), six months (72.1%), and 12 months (51.6%).¹⁵ Racial/ethnic disparities in NC mirror those of the US. At discharge, 87.6% of NH-white women reported initiating breastfeeding compared to 73.1% of NH-African Americans, 95.2% of non-Hispanic Other, 94.7% of Latina.¹⁶

The Ten Steps for Successful Breastfeeding is an evidence-based protocol used by Baby-Friendly USA to encourage and promote breastfeeding.¹⁷ This evidence-based protocol is best implemented by hospitals; however, Steps 3 and 10 focuses on broader strategies to increase initiation, duration, and support of breastfeeding. Step 3 of the Ten Steps for Successful Breastfeeding states to *“Inform all pregnant women about the benefits of and management of breastfeeding.”* Step 10 of the Ten Steps for Successful Breastfeeding states to *“Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.”*

To address the racial/ethnic disparities in breastfeeding initiation and duration in North Carolina, this strategy will target minority-women and their social networks to increase support, access, knowledge, and resources. In NC, NH African American, NH-Native American/American Indian, and Hispanic women have the lowest rates of breastfeeding.

A. Scope of Services

Provide culturally and linguistically appropriate education to men and women of reproductive age to increase the initiation and continuation of breastfeeding. Educational opportunities may include community outreach events; educational workshops; distribution of educational materials; or preconception, prenatal, and postnatal counseling.

Provide education and training on breastfeeding guidelines as recommended by the American Academy of Pediatrics (AAP) to all clinical and non-clinical staff in the local health department and other public/private health care practices* who interact with women of reproductive age or infants to recognize that breastfeeding is a normal physiologic process that has short- and long-term benefits for the mother-baby dyad.

Implement and enhance connections with community-based and faith-based organizations to promote the normalcy of breastfeeding within the social support systems (fathers, partners, grandmothers, church members, & neighbors) for women of reproductive age. This includes but is not limited to implementing or enhancing breastfeeding support groups, breastfeeding classes, breastfeeding rooms, or education for family and social networks.
Maintain a designated group to manage breastfeeding policy development and review LHD staff orientation, and education in the service area(s).
Strengthen partnerships between the local health department and Title V program providers, WIC, maternity care/perinatal care, quality improvement partners, state and local breastfeeding coalitions, and faith-based and community-based organizations. Partnerships should focus on increasing the access to peer support groups within the community.
Utilize social media, including radio, television, the internet, billboards, or newspaper, to increase the awareness of breastfeeding for the mom-baby dyad.
Select one (1) of the following Scope of Services to implement in addition to the above listed activities:
Making it Work: Empowering Employers and Mothers: Utilize approved resources for the increasing the number of breastfeeding friendly businesses/work sites in the service area. LHDs should provide education, consultation, and information to the businesses/work sites. Resources include the adapted Making It Work Toolkit (https://www.workwellnc.com/NCMakingItWork.php) and the Businesses Leading the Way: (http://www.nutritionnc.com/breastfeeding/index.htm)
Breastfeeding Friendly City Program: Collaborate with communities in the service area(s) to increase the support for the breastfeeding family through the implementation of the Breastfeeding Friendly City program, which includes implementing some of the following strategies within designated communities: 1. Developing or enhancing a local breastfeeding coalition; 2. Developing community-based peer support groups, such as La Leche League or similar mother-to-mother groups; 3. Working with at least one community hospital to apply for the North Carolina Maternity Center Breastfeeding Designation or to pursue designation as a Baby Friendly Hospital; 4. One public establishment for every 1000 community citizens or 25 (whichever is less) participate in the “Breastfeeding Welcomed Here” program; and 5. One employer for every 5000 community residents or 10 (whichever is less) to receive the “Breastfeeding Employee Support Award” from the Making It Work initiative. For more information, review: AMCHP Communities Supporting Breastfeeding Carolina Global Breastfeeding Institute (CGBI): Breastfeeding Friendly Community Designation
Shared Decision-Making using Patient Decision Aids: Implement a shared decision-making process with the use of patient decision aids that will promote the best clinical evidence for breastfeeding. Patient decision aids must be integrated into the clinical workflow to assist with the patient’s “decision journey”. This strategy will allow patients to contemplate options, gather additional information, consult with family and friends, consider individual preferences, and address their personal concerns. The shared decision-making process will increase provider-patient engagement and allow health care providers and patients to make informed, explicit decisions together. Patient decision aids can be in the following formats: written, video, or web-based. Breastfeeding decision aids will include evidence-based information & practices; present information objectively; be written in appropriate reading and literacy level; and allow patients to clarify their preferences/values. LHDs selecting this strategy will incorporate breastfeeding-focused decision aids at specific prenatal care visits as well as targeted decision aids

for the support systems of patients. After patient or family member reviews the decision aid, the provider will follow up with a targeted discussion to engage the patient in dialogue about the content just reviewed. Additional information about Patient Decision Aids can be found:

<https://decisionaid.ohri.ca/implement.html> or

http://familiesusa.org/sites/default/files/product_documents/Shared-Decision-Making.pdf

Implement Prenatal Breastfeeding Education:

The LHD shall provide prenatal breastfeeding education that follows the Carolina Global Breastfeeding Institute's (CGBI) Ready, Set, BABY curriculum (or similar curriculum that adheres to Baby-Friendly, USA's requirements for prenatal breastfeeding education) for increasing pregnant families access to prenatal breastfeeding education. This may include the development of free prenatal breastfeeding classes offered on a consistent schedule and advertised to the community, partnering with external entities (breastfeeding support groups, medical providers, maternity care centers, and retailers) to develop or enhance prenatal breastfeeding support. CGBI's Ready, Set, BABY curriculum can be found at: <https://sph.unc.edu/cgbi/resources-ready-set-baby/>.

Establish Public Lactation Rooms:

The LHD shall provide a lactation room for the public in accordance with the "Fairness For Breastfeeding Mothers Act of 2019". The LHD should work with other "Covered Public Buildings" to establish the required Lactation Room. Additional information about the requirements of the "Fairness For Breastfeeding Mothers Act of 2019" can be found at <https://www.congress.gov/bill/116th-congress/senate-bill/528/text>.

B. Performance Measures

Increase the percentage of infants who are breastfeeding at discharge from the hospital.

Increase the percentage of WIC-eligible infants who are breastfeeding at six and 12 months.

Increase the number of unduplicated men and women of reproductive age, and members of their social support who received education, support, and information to increase the initiation and continuation of breastfeeding.

Increase the number of staff and health care providers from the local health department and other public/private health care practices* that receive training to support the initiation and continuation of breastfeeding women.

Increase the number of collaborations with partner organizations, community-based and faith-based organizations that support breastfeeding women and their families.

Increase the presence of social media messages that provide information about the importance of breastfeeding.

Select appropriate performance measure(s) to match the selected scope of service above:

Increase the number of businesses/worksites that are breastfeeding-friendly for patrons and/or employees.

The number of organizations, businesses, hospitals, day care/childcare centers, etc. that are engaged in working towards the Breastfeeding Friendly City Program.

Increase the number of staff and health care providers from the LHD and other public/private health care practices* who are trained and implementing Patient Decision Aid practices.

Engage 100% of women during their prenatal care visit in one or more targeted decision aids followed by prompted discussion with provider about breastfeeding during their prenatal visit at the LHD and other public/private health care practices.

Increase the number of public lactation rooms in the service area.

C. Reporting/Monitoring Requirements

Funded local health departments shall document and submit data on the following requirements:

The number and type of breastfeeding education training that staff and health care providers in the local health department and at other public/private health care practices* participate.

The number of community-based and faith-based organizations that support breastfeeding women and their families with breastfeeding support groups, breastfeeding education classes, breastfeeding rooms, etc.

The number and type of partnerships that have developed in the service area with stakeholders and other programs.

Select the appropriate reporting requirement(s) to match the selected scope of services

The number of businesses/worksites that are engaged in becoming breastfeeding-friendly for patrons and/or employees.

Provide information on the initiation and progress of counties/ communities/etc. that begin the process to becoming a Breastfeeding Friendly City Program.

The number of staff and health care providers who are trained and implementing Patient Decision Aid method.

The number of women who have been engaged with one or more of the patient decision aids during their prenatal visit in the local health department and other public/private health care practices.

The number of public lactation rooms available in the service area.

*Other private/public health care providers or facilities include, but are not limited to federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.

2. Integration of Community Health Workers

North Carolina public health leaders agree that coordinating efforts to address population health is even more critical than ever. One intervention that is associated with promoting improved health outcomes is the use of community health workers (CHW). The American Public Health Association (APHA) defines a community health worker as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy”

(<https://www.apha.org/apha-communities/member-sections/community-health-workers>). CHWs are uniquely qualified to work with women and men of reproductive age, their children, and families to implement evidence-based efforts to improve population health outcomes focused on maternal and child health.

A. Scope of Work

The ICO4MCH Program recognizes the value and strengths that CHWs, especially those who reside in the communities that they serve, what they bring to this work and the importance of their role as liaison, patient navigator, health and wellness promoter and advocate for individuals, families and communities at large. Applicant agencies that select this EBS shall:

1. Hire at least 1.0 full time equivalent (FTE) Community Health Worker to conduct outreach, education and support activities to the identified county/counties to be served.

2. Upon successful completion of the foundational CHW training, the CHW's may opt to enroll and complete additional specialized CHW training. Information about the NC CHW SCCT training can be found here: <https://ncchwa.org/services/training/>. Funds should be allocated in the program budget to cover for CHW training registration, internet (for online only training options) and/or associated travel costs for classroom-based trainings. The WICWS will provide maternal and child health specific training.

3. Conduct outreach (i.e., participate in “tabling” events, health fairs, etc.) and complete follow up efforts to identify, recruit and connect with preconception, pregnant and interconception women and/or men who have missed family planning, prenatal care and/or postpartum visits or otherwise are not connected with the local health department for care.

4. Complete a brief assessment of needs with each preconception, pregnant or interconception woman or male reached via outreach. The DPH contract administrator will provide tool options to local health departments that select this EBS.
5. Complete a brief assessment of need with each preconception, pregnant or interconception woman or male reached during outreach or via self-referral.
6. Refer each preconception, prenatal or postpartum woman or man to an internal local health department program or external agency resource based on results of brief individualized assessment.
7. Conduct individualized and group-based education using evidence-based and/or evidence-informed curriculum or resource materials to preconception, pregnant and/or postpartum women or males.

B. Performance Measures

1. Number of Community Health Workers who successfully completed CHW foundational training.
2. Number of preconception, prenatal and interconception women and men reached via outreach
3. Number of preconception, prenatal and interconception women and men that completed a brief assessment
4. Percent of program participants that completed a referral
5. Percent of preconception, prenatal and interconception women and men that completed at least 3 group-based education sessions

C. Reporting Requirements

1. Number of CHWs who completed foundational training
2. Number of outreach events that CHWs participated in
3. Number of preconception, prenatal and interconception women and men reached via outreach
4. Number of assessments completed
5. Number of referrals made
6. Number of group-based education sessions conducted

PROGRAM AIM 3: Improved Health Status of Children Ages 0-5

1. Positive Parenting Program (Triple P)

The overarching goals of Triple P are:

- a. To promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency.
- b. To promote the development of non-violent, protective, and nurturing environments for children.
- c. To promote the development, growth, health, and social competence of young children; and
- d. To reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence.
- e. To reduce out-of-home placements.
- f. To reduce emergency department visits related to abuse and neglect.
- g. To reduce out of childcare/school suspensions related to behavioral issues.

There are five levels of Triple P, from conducting a media-based parent information campaign, to providing brief group and individual sessions, to providing intensive individually tailored programs. The level of intervention is based upon the needs of the parents and family. A Triple P provider must receive training to become an accredited provider in each Triple P level of services. The five Triple P levels are:

1. Level One – conduct a media-based parent information campaign.

2. Level Two – provide specific advice to parents on solving common child developmental issues and minor behavioral problems.
3. Level Three – provide brief programs (60 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage discrete child problem behaviors.
4. Level Four – provide a broad-focus program (about 10 hours over 8 to 10 sessions) for parents requiring intensive training in positive parenting skills, generalization enhancement strategies and application of parenting skills to a range of target behaviors.
5. Level Five – provide intensive individually tailored programs (up to 11 sessions) for families with child behavior problems and family dysfunction. Program modules include practice sessions, mood management strategies, stress coping skills, partner support skills, attribution retraining and anger management.

A. Scope of Services

1. Adhere to the standards set by Triple P America, as described in the Triple P Implementation Manual, to ensure that the project is implemented with model fidelity.
2. Hire and maintain a 1.0 FTE local Triple P Implementation Specialist (Coordinator) to oversee the expansion of Triple P under this Agreement Addendum. This person will participate in quarterly North Carolina Triple P State Learning Collaboratives, work collaboratively with the Division of Child and Family Well-Being's (DCFV) Triple P Program Manager, and participate on other local community advisory boards to assure integration of Triple P into the system of care as applicable.
3. Develop by August 31, 2024, an implementation plan for the service area and submit it to the DCFV Triple P Program Manager for review and approval using the template provided by Triple P America with guidance from the DCFV Triple P Program Manager and Triple P America. The implementation plan is to include:
4. Create a training schedule for practitioners to access the various levels of Triple P to be implemented in the service area.
5. Develop a plan for peer-to-peer coaching sessions for trained practitioners;
6. Create a plan for data collection across the service area;
7. Formulate a community outreach plan that includes media strategies for both caregivers (families) and practitioners (those providing services to families);
8. Develop an annualized budget;
9. Create a practitioner/child-serving agency support plan, including the use of parent support materials, refresher and attrition training, Peer Assisted Supervision and Support (PASS), Triple P integration into the child-serving agency, and practitioner service delivery plan;
10. Develop job descriptions and work plans for key staff; and
11. Note-only one implementation plan for both Title V and ICO4MCH Triple P activities needed.
12. Maintain membership and participation in the service area - Triple P Implementation Team that includes representatives from the other partner counties in the service region. The Triple P Implementation Team will meet quarterly and will advocate for the implementation or continuation of Triple P in the county or counties and support strategies for sustainability. They will also develop, maintain, and update, as needed, Memoranda of Agreements (MOAs) with local child serving agencies and practitioners to engage them in participation in Triple P provider training courses (inclusive of pre-accreditation, accreditation, and workshops), delivery of Triple P, and support (peer coaching and data reporting) for the local Triple P efforts.
13. Develop, maintain, and update as needed a Memoranda of Agreement (MOA) with local agencies participating in the coordinating council that support the local Triple P efforts. Develop and maintain an agreement with Triple P America for ongoing technical assistance and support.

14. Participate in the North Carolina Triple P State Learning Collaborative (Collaborative). The Collaborative will share best practices, provide peer support, monitor data collection, and develop quality improvement strategies, share social marketing strategies, establish a network of open enrollment trainings, and participate in professional development opportunities. Coordinate with the Triple P Online State Coordinator to provide local support for families in the service area(s) who are accessing Triple P via the online modules.

B. Performance Measures

1. Increase the number of families/caregivers with children ages 0–5 served.
2. Increase the number of children ages 0–5 served.
3. Increase satisfaction among families/caregivers with children ages 0–5 within the pre-test and post-test intervention surveys.
4. Increase the number of Triple P Online users who have children ages 0–5.
5. Increase the number of practitioners (child serving agencies and other practitioners) where children ages 0–5 are served who receive accreditation by Triple P America, including child care centers, day care centers, home visiting programs, pediatric and family practice clinics, faith-based facilities, etc.
6. Decrease the number of childcare suspension or expulsions due to behavioral issues for children ages 0–5 served.
7. Increase outreach and educational activities among parents/caregivers of children, ages 0 – 5, for the Triple P Online program and Triple P programs.

C. Reporting/Monitoring Requirements

Funded local health departments shall document and submit data on the following requirements:

1. The number of children, 0–5 served.
2. The number of practitioners who provide services for families with children ages 0 – 5, who are trained and accredited.
3. The number of outreach and educational events for Triple P online programming and Triple P in the service area(s) for parents/caregivers.

Local Health Departments that are interested in selecting Triple P (Positive Parenting Program) as one of its evidence-based programs must contact Triple P America before responding to this RFA. The contact for Triple P America is Ashley Lindsay, Implementation Consultant, Triple P America at 803.661.4711.

Family Connects Newborn Home Visiting Program

The overarching goal of the Family Connects Newborn Home Visiting program is to reduce emergency medical care costs through improvement in parenting and infant well-being. All parents of newborns 2–12 weeks old born in the service area are eligible for this service. Family Connects Newborn Home Visiting provides the following services:

- a. One home visit by a registered nurse to all parents of newborns living in service area and
- b. Two additional home visits are available from the nurse home visitor for families who need additional support.
- c. The grantee will sub-contract with the Center for Child and Family Health (CCFH) for technical assistance, data management, and model implementation.

Scope of Services

1. Hire and maintain a home visiting staff composed of 1.0 FTE Nurse Home Visitor for every 200 births in the service area (total FTE will depend on the total number of births in the service area).
2. For each active family, utilize the required service delivery and assessment forms collected and stored in the CCFH database.

3. Contact the families of at least 70% of all resident births within the service area by telephone.
4. Conduct an initial home visit with the families of at least 75% of the resident births who received an initial phone call inquiry.
5. Utilizing the Family Support Matrix, nurses will maintain an inter-rater agreement of at least 75%. The nurse home visitor rating for each factor reflects the level of family needs and risk of future problems. The Family Support Matrix includes four domains known to predict parent and child well-being and to prevent child maltreatment. These include four domains (health care, caring for an infant, safe home and parent support) with three questions in each domain (a total of 12 factors). The following scores indicate the level of risk and subsequent action:
 - a. A score of 1 is identified as “no or low risk” and receives no subsequent intervention;
 - b. A score of 2 is identified as “mild to moderate risk” and receives short-term nurse-delivered intervention on a topic over 1 -3 sessions;
 - c. A score of 3 is identified as “high risk” and receives a connection or referral to a community resource tailored to address the specific family need; and
 - d. A score of 4 is identified as “immediate danger” and receives immediate emergency intervention.
 - e. The inter-rater agreement metric is the cumulative rate of agreement between nurse home visitors and the nursing supervisor in rating the family risk during the Quality Assurance checks conducted quarterly by the nursing supervisor.
6. Maintain nurse fidelity to the home visit model protocol of at least 75%. The metric is a cumulative rate of overall nurse home visitor adherence to the manualized protocol as measured by the Quality Assurance checks conducted quarterly by the nurse supervisor. The nurse fidelity checklist contains 62 individual model components which are covered in each integrated home visit. The components cover the following domains:
 - a. Introduction by the nurse (a total of 4 components);
 - b. Support for health care with supportive guidance (a total of 17 components);
 - c. Support for caring for the infant with supportive guidance (a total of 8 components);
 - d. Support for a safe home with supportive guidance (a total of 15 components);
 - e. Support for parents with supportive guidance (a total of 8 components);
 - f. Written screeners (a total of 2 components); and
 - g. Planning (a total of 8 components).
 - h. Deliver all program services based on the Family Connects Implementation and Policies Manual.

B. Performance Measures

1. Complete home visits in the service area with 60–70% of all births in the service area.
2. Complete an integrated home visit (IHV) with at least 75% of all families who agreed to participate in the program.
3. Complete successful home visits with families who require one or more visits after the completion of the initial integrated home visit with at least 75% of all families.
4. Complete successful follow-up phone calls with families who require one or more substantive phone calls after completion of the initial integrated home visit.
5. Complete successful referral linkages with parents who received one or more referrals for long term support.
6. Have observed fidelity to the home visitor model protocol in at least 75% of home visits.
7. Have nurse inter-rater reliability agreement with the Family Status Index in at least 75% of home visits
8. Participate in weekly case conference meetings at the Center for Child and Family Health.
9. Complete documentation of family demographics on all families participating in the program.

C. Reporting Requirements

The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor. Data shall be submitted from the monthly-quarterly reports provided by the purveyor, when available.

1. Number of infants born in the service area to residents.
2. The number of home visits scheduled.
3. The number of in-home visits completed.
4. The number of families receiving one or more follow-up in-home visits or telephone calls after completion of initial integrated home visit (IHV).
6. The number of families receiving one or more referrals for long-term support.
7. The number of referrals resulting in successful connections with community agency/resource.
8. The percentage of nurse fidelity to the home visit model protocol.
9. The percentage of nurse inter-rater agreement the rating family risk using the Family Support Matrix.
10. Documentation and summary of case review meetings as required by Center for Child and Family Health (CCFH) and the Local Health Department.
11. Family demographics which include maternal and child characteristics collected on all families participating in the program.

Local Health Departments that are interested in selecting the Family Connects program as one of its evidence-based programs must contact the Center for Child and Family Health (CCFH) in Durham, North Carolina before responding to this RFA. The contact at the CCFH is at 919-491-9883.

Parents As Teachers

Parent as Teachers is an evidence-based home visiting program model designed to teach positive parenting skills, improve developmental outcomes and support strong parent-child relationships.

There are four components to the PAT model:

- a. Personal Visits
- b. Group Connections
- c. Resource Network
- d. Child and Caregiver Screening

These components create an all-encompassing set of services to accomplish seven goals:

- a. Increase parent knowledge of early childhood development and parenting practices
- b. Provide early detection of developmental delays and connection to services
- c. Improve parent, child, and family health and well-being
- d. Prevent child abuse and neglect
- e. Increase children's school readiness and success
- f. Improve family economic well-being
- g. Strengthen community capacity and connectedness

Scope of Services

1. Hire and maintain a home visiting staff composed of a supervisor (at least .20 FTE or more) and at least 2.0 FTE Home Visitors.
2. Serve at least 50 families per home visitor per year
3. Schedule and complete an initial home visit with the families referred to the program within 30 days of receipt of the referral to the PAT program.
4. Conduct the following screenings and assessments through the utilization of the following forms and questionnaires listed during the outlined time periods; use the results to identify target interventions and refer participants for further services:

5. Administer the Edinburgh Postnatal Depression Screening (EPDS) or Patient Health Questionnaire (PHQ)-9 at enrollment, again within 60 days after birth, and then repeat as often as necessary. The template and training shall be provided by the ICO4MCH program.
6. Develop an individualized service plan within 45 days of enrollment into the PAT program with each program participant and enter it into Visit Tracker. This service plan outlines the steps to be taken (e.g., information to be gathered, referrals to be made to local programs and service providers, visits conducted, prenatal, interconception/parenting and health promotion education to be offered) to address each family's identified needs.
7. For each active family, complete the required screening and assessment tools and service delivery and related forms collected and stored in the Parents As Teachers (PAT) Visit Tracker database within seven (7 days) of visit completion.
8. Conduct home or virtual visits (defined as the participant's place of residence, designated location, or virtual consultation, if necessary) and case management/care coordination contacts with each family. Frequency of home visits and other contacts is determined by the service delivery level, gestation of pregnancy, and age of the child. A medium and high service delivery level will dictate more frequent home visits, regardless of the gestation of pregnancy and age of the child, until crisis related concerns can be resolved.
9. Once crisis related concerns are stabilized, home visits can be reduced to the required minimum number of visits according to the program participant's gestation of pregnancy or child's age as noted below:

Program Participant	Age of Child	Home Visit Interval	Other Additional Case Management Contacts Interval
Prenatal	—	At least once a month	As needed or requested
Parenting	0–12 months	Monthly	Monthly
Interconception	12-24 months	Bimonthly	Bimonthly
Interconception	24–60 months	Quarterly	Quarterly

10. This home visiting and case management/care coordination contact schedule can be altered if the program participant requires services on a more frequent basis. Documentation of home visits and case management contacts must be completed within 7 business days of contact with each program participant.
11. Facilitate at least 10 group education sessions in Year 1 using Parents As Teachers' *Born to Learn* curriculum as the foundation for core education topics. Documentation of all education sessions conducted, and participant attendance information shall be entered into the Visit Tracker and/or other tools (attendance sheets, etc.).
12. Conduct supervisor-home visitor reflective supervision case conference sessions at least monthly with each home visitor.

B. Performance Measures

1. Complete monthly home visits with 85% of families enrolled in the PAT program.
2. Complete successful referral linkages with parents who received one or more referrals for resources based on individual action plan.
3. Participate in monthly webinars/meetings with Parents As Teachers State Director.
4. Complete documentation of family demographics on all families participating in the program in the Visit Tracker online platform.

C. Reporting Requirements

The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor. Data shall be entered into the Visit Tracker database by LHD staff.

1. Number of infants and parents enrolled in program services.
2. The number of visits completed.
3. The number of families receiving one or more referrals for resources based on individualized case management plan.
4. The number of referrals resulting in successful connections with community agency/resource.
5. Number of completed supervisor-home visitor reflective supervision/case review meetings.

Local Health Departments interested in selecting the Parents As Teachers program as one of its evidence-based programs are encouraged to reach out to the PAT State Director at Positive Childhood Alliance at 336-207-7042.

Appendix B: Online County-Level Data Sources

A. STATE CENTER FOR HEALTH STATISTICS (SCHS) WEBSITE

1. [Basic Automated Birth Yearbook \(BABYBOOK\)](#)
This annual report contains tables showing statewide and county counts for resident live births classified by selected infant and maternal characteristics.
2. [BRFSS Survey Results](#) (not county specific, but state and regional data available)
3. [Child Deaths in NC](#) (grouped by cause and also by age group)
4. [County Health Data Book](#)

This website has links to county data related to the topics of Pregnancy and Live Births, Life Expectancy, Mortality, and Morbidity. The most recent book is displayed; to find book for other years, scroll to bottom of page and select a specific year. Perhaps one of the most helpful data tables on this website is the *Birth Indicators Tables by State and County* which is found as the last bullet under the Pregnancy and Live Births section. Use the dropdown menu to select the county of interest to find information by racial/ethnic population group about births and birth outcomes (gestational age; birthweight; prenatal care; etc.).

5. [Detailed Mortality Statistics](#)
6. [Infant Mortality Statistics](#)
7. [NC Reported Pregnancies](#)
8. [NC Vital Statistics, Volume 1: Population, Births, Deaths, Marriages, Divorces](#)
9. [NC Vital Statistics, Volume 2: Leading Causes of Death](#)
10. [Life Expectancy - State & County Estimates](#)
11. [N.C. Maternal and Infant Health Data Dashboard | Division of Public Health](#)

B. DATA AVAILABLE ON NC CHILD WEBSITE/KIDS COUNT NC

1. [NC Child County Data](#)
This website provides "the latest data for key indicators in five areas of children's well-being: A Strong Start, Family Economic Security, Nurturing Homes and Communities, Health and Wellness, and High-Quality Education" for all counties in NC. Links to the County Data Dashboard, downloadable county data cards, the most recent NC Child Health Report Card, the KIDS COUNT Data Center, and the KIDS COUNT Data book are all found on this webpage.

Appendix C: Training Resources

Compiled by the Women, Infant, and Community Wellness Section

Reproductive Justice:

- **APHA: A Path to Reproductive Justice: Research, Practice and Policies**
 - o <https://apha.org/Events-and-Meetings/APHA-Calendar/Webinar-Events/2020/Racial-Equity-Part-2>
- **Region V Public Health Training: Reproductive Justice 101**
 - o <https://www.mittrainingcenter.org/courses/rj101a0719noce>

Community Engagement:

- **Association of Maternal & Child Health Programs (AMCHP): Shifting Power in Practice: Strategies for Centering People with Lived Experience When Making Evidence-Based Decisions**
 - o <https://amchp.org/courses/shifting-power-in-practice/>

Policy:

- **#impactEQUITYNC: North Carolina Community Health Impact Assessment**
 - o <https://ncchild.org/health-equity-impact-assessment/>

Social Drivers of Health:

- **Region V Public Health Training Center: Determinants of Health**
 - o <https://www.mittrainingcenter.org/courses/dohes0720noce>
- **Public Health Foundation: What Are Social Determinants of Health?**
 - o <https://www.train.org/main/search?query=social%20determinants%20of%20health&type=course>

Trauma-Informed Care:

- **Reproductive Health Branch, WICWS: Trauma-Informed Reproductive Health Care – Practical Pearls and Pitfalls**
 - o [Link to recorded Zoom meeting for Trauma-Informed Reproductive Health Care](https://www.zoomgov.com/rec/play/8NfSABs8_Br7GH3ulKlrIUy3wopbicNUECP8qmQmZWeuSWFMzn5SCcJPw1ZvT-DCbF3xblylFCglOWd.JNm4lItpnD8upTtc?continueMode=true) or https://www.zoomgov.com/rec/play/8NfSABs8_Br7GH3ulKlrIUy3wopbicNUECP8qmQmZWeuSWFMzn5SCcJPw1ZvT-DCbF3xblylFCglOWd.JNm4lItpnD8upTtc?continueMode=true
- **RHNTC: Understanding Trauma and the Six Core Principles of a Trauma-Informed Approach**
 - o <https://rhntc.org/resources/understanding-trauma-six-core-principles-trauma-informed-approach-video>

Appendix D: Community Health Impact Assessment

Tool

Differences in health status are complex and often highlight longstanding problems that affect our communities. These outcomes are further impacted by policies and programs created with the intention of improving quality of life. By acknowledging the factors that contribute to health differences and associated gaps in accessing health care and related services, we can be inclusive and strategic in our approach to address the inequities that negatively impact the health of certain populations. The Community Health Impact Assessment tool (CHIA) encourages focus on a particular policy/program and its impact on health disparities and health inequities. The tool allows a team to think outside the box and consider all factors that could potentially impact the health of populations at risk.

The CHIA helps facilitate conversations about factors that support or weaken health, including the root causes of disparities and inequities. Information gathered throughout this process will provide community perspective and guide your team in strategic planning to modify an existing or proposed policy/program. The CHIA will help to develop concrete methods and action steps aimed at improving policies/programs in the hope of reducing health disparities and inequities within the impacted population(s). In addition, the CHIA will:

- **Analyze Data** to determine potential impact of policies/programs.
- **Involve Stakeholders and Impacted Populations.** Effective community health impact assessments require early and continued involvement of members of impacted populations. It is important to have knowledge of the community (resources, contacts, and partners) and to gain their perspective on current policies and programs as well as understand the potential impacts on the community, both positive and negative.
- **Identify** ways to modify current or proposed policies or programs to ensure they reduce health disparities and inequities; **NOT** make them worse.
- **Provide information** on uneven impacts on various populations or communities.
- **Recommend** modifications to policies or programs that promote equity and ease negative impacts.

The CHIA consists of three pre-work steps, team-building activities, four implementation steps, a glossary, and worksheets. To access a full copy of the CHIA, contact the DPH Contract Administrator.

Appendix E: Data Elements Provided by DPH

The table below indicates additional data elements that will be provided to the funded Local Health Department (LHD) by DPH. Data will be provided on a quarterly, bi-annual, or annual basis, depending on the evidence-based strategy (EBS). Data not listed will be provided by the funded LHD. This rubric is subject to change.

Evidence-based strategy	Data element	Procedure
Using a Reproductive Justice Framework to improve the utilization of Reproductive Life Planning (RLP).	-Unique monthly users of long-acting reversible contraception (LARC) services in the LHDs	-DPH will provide the LHD-HSA data quarterly to the LHDs.
Ten Steps for Successful Breastfeeding	-Breastfeeding initiation rates -Breastfeeding duration at 6 and 12 months	-NC State Birth Certificate data, annually. -Division of Child and Family Well-Being Nutrition Services Branch, Crossroads data system, annually
Positive Parenting Program (Triple P)	-Triple P online data	-DPH will provide data quarterly to the LHDs
Collective Impact	-Focus group/key informant interview data.	-Evaluators, contracted with DPH, will provide site specific summaries to DPH and each LHD.
Parents As Teachers (PAT)	PAT online data	DPH will provide data quarterly to the LHDs

Appendix F: Citations

1. North Carolina State Center for Health Statistics
2. Small Area Health Insurance Estimates
3. U.S. Census Small Area Income and Poverty Estimates (SAIPE) Data and Mapping Tool. 2021 Available: <https://www.census.gov/library/publications/2025/demo/p30-10.html>
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15. CDC Breastfeeding Rates: cdc.gov/breastfeeding-data/modules/2023-rates-any-exclusive-bf-state.html
16. Office of Disease Prevention and Health Promotion. (n.d.). Increase the proportion of infants who are breastfed exclusively through age 6 months. Healthy People 2030. U.S. Department of Health and Human Services. <https://health.gov/healthypeople/objectives-and-data/browse->

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24. North Carolina State Center for Health Statistics. Available: [2024 North Carolina Infant Mortality Report: Risk Factors and Characteristics for North Carolina Resident Live Births: 2024](#)

Appendix G: Doula Services Satisfaction Survey

1. In partnership with your doula, did you prepare a birth plan/wish list to share with your doctor or midwife and nurse?	☐ YES ☐ NO
2. Did you feel that you were involved in the decision-making process and felt listened to during your labor and birth - a. By your doctor/midwife? b. By your nurse?	☐ NEVER ☐ SOMETIMES ☐ ALWAYS ☐ NEVER ☐ SOMETIMES ☐ ALWAYS
3. What comfort measures and coping techniques did you find to be the most helpful while you labored at home and in the hospital? (Check all that apply)	☐ Birth ball ☐ Breathing techniques ☐ Massage ☐ Music ☐ Position changes ☐ Shower ☐ Tub ☐ Walking ☐ Other (please specify) _____
4. What comfort measures or coping techniques were not helpful to you in labor? (Check all that apply)	☐ Birth ball ☐ Breathing techniques ☐ Massage ☐ Music ☐ Position changes ☐ Shower ☐ Tub ☐ Walking ☐ Other (please specify) _____
5. a. Did you use any of these pain medications during your labor? b. Did the medication work as you expected?	☐ Epidural ☐ Nitrous oxide ☐ IV medication ☐ None ☐ YES ☐ NO
6. Please describe what happened after your baby was born. a. Did you hold your baby directly on your chest (skin-to-skin) for at least 1 hour immediately after birth? b. Did you start nursing your baby within the first hour?	☐ YES ☐ NO ☐ If no, please explain _____ ☐ YES ☐ NO ☐ If no, please explain _____
8. What did you feed your baby while in the hospital?	☐ Only their breastmilk ☐ A mix of their breastmilk and formula ☐ Only formula ☐ Other (please specify) _____
9. What are you currently feeding your baby?	☐ Only their breastmilk ☐ A mix of their breastmilk and formula ☐ Only formula ☐ Other (please specify) _____
10. If you are feeding your baby breastmilk, what has been the most helpful to get you started and/or to continue breastfeeding? (Check all that apply)	☐ In-hospital support (nurse/lactation consultant) ☐ Professional support (lactation consultant/counselor) ☐ Local Health Department support (WIC Breastfeeding Peer Counselor) ☐ Community support (support groups) ☐ Family/Friends ☐ Other (please specify) _____
11. Please describe your birth experience in 2-3 descriptive words.	
12. Describe how your doula contributed to your birth experience in 1-2 ways.	_____ _____ _____
13. Would you recommend that other women use a doula during their birth?	☐ YES Please tell us why? _____ ☐ NO Please tell us why? _____ ☐ OTHER Please specify _____

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