Fiscal Year 25 Annual Report

Improving Community Outcomes for Maternal and Child Health (ICO4MCH)

Working together to improve maternal and child health in North Carolina

Report prepared by the UNC Evaluation team:

Laura Page
Rebecca Pulliam
Alicia Reynolds Reddi
Christine Tucker

Fiscal Year 25 Annual Report

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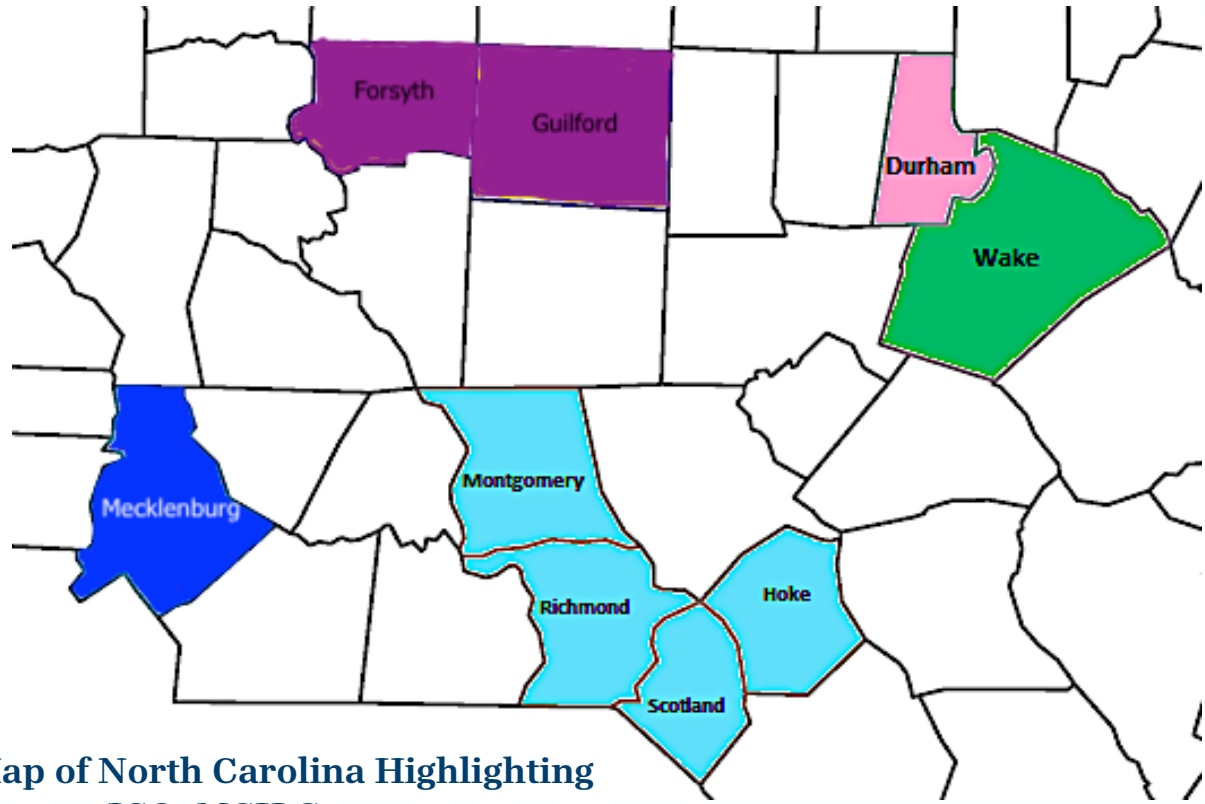
ICO4MCH
Improving Community Outcomes for Maternal and Child Health

UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

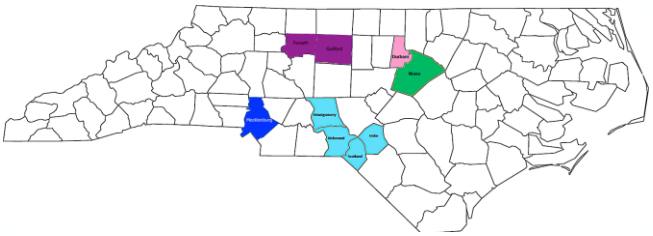
ICO4MCH Overview

In Session Law 2015-241, the North Carolina General Assembly allocated funding to be distributed to Local Health Departments (LHD) to implement evidence-based strategies (EBS) with the following aims: 1) Improving birth outcomes, 2) Reducing infant mortality, and 3) Improving child health ages 0 to 5. In June 2016, the NC Division of Public Health (DPH), Women, Infant, and Community Wellness Section funded five grantee LHDs to implement three evidence-informed strategies for two years. In June 2018, funding was renewed for the initial five grantee LHDs and Scotland County joined as a partner with Robeson County, increasing the reach of ICO4MCH from 13 to 14 counties. In June 2020, funding was renewed for four initial grantees, and a new grantee, Wake County, was added; 13 counties were funded for Fiscal Year (FY) 21-22. In June 2022, funding was renewed for four continuing grantees, and a new grantee, Guilford County was added; 9 counties were funded for FY23-24. In June 2024, funding was renewed for five continuing grantees; 9 counties were funded for FY24-25. Two of these grantees changed county composition: Mecklenburg Collaborative was previously composed of Mecklenburg and Union counties; Forsyth County joined Guilford County to create the Guilford-Forsyth Collaborative.

FY25-26 ICO4MCH Grantees (9 Counties)



Map of North Carolina Highlighting ICO4MCH Grantees



ICO4MCH Overview

Grantee	Counties	Improve birth outcomes	Reduce infant mortality	Improve child health, ages 0-5
Durham County: *Family Matters Durham**	Durham	Preconception Health	Breastfeeding	Family Connects
Guilford-Forsyth Collaborative: *Every Baby Guilford**	Guilford, Forsyth	Preconception Health	Breastfeeding	Triple P
Mecklenburg Collaborative	Mecklenburg	Preconception Health	Breastfeeding	Triple P
Sandhills Collaborative	Hoke, Montgomery, Richmond, Scotland	Doula Services	Breastfeeding	Triple P
Wake County: *Best Baby Wake**	Wake	Doula Services	Breastfeeding	Triple P

ICO4MCH Grantee full local health department names: Durham County Department of Public Health, Guilford-Forsyth Collaborative (Guilford County Department of Health and Human Services – Division of Public Health and Forsyth County Department of Public Health), Mecklenburg County Health Department, Sandhills Collaborative (Hoke County Health Department, Montgomery County Health Department, Richmond County Health and Human Services Department, and Scotland County Health Department), and Wake County Health and Human Services.

* Note: Some grantees have re-branded their collaboratives to increase community awareness and recognition of programming, services, and initiatives.

Evaluation and Data Measures: Performance measures for each EBS are collected from grantees quarterly in REDCap: Q1 (June, July, August), Q2 (September, October, November), Q3 (December, January, February), and Q4 (March, April, May) to document progress in the short-tern (one year) and intermediate outcomes (1-3 years). Existing evaluation tools and additional data are provided by partners including Triple P data from the Division of Child and Family Well-Being (DCFW)-Whole Child Health Section, UNC Implementation Coaches, and Family Connects International. The UNC Evaluation team holds meetings with an Evaluation Advisory Committee including grantees, implementation coaches, and DPH and DCFW content experts bi-annually to review data and improve evaluation protocols.

Collective Impact, FY25

ICO4MCH uses a Collective Impact Framework. Implementing sites maintain a Community Action Team (CAT) that meets regularly with the goal of providing partner and community input on ICO4MCH activities. CATs are made up of local health department (LHD) staff, community health workers (CHW), and external community organizations and experts.

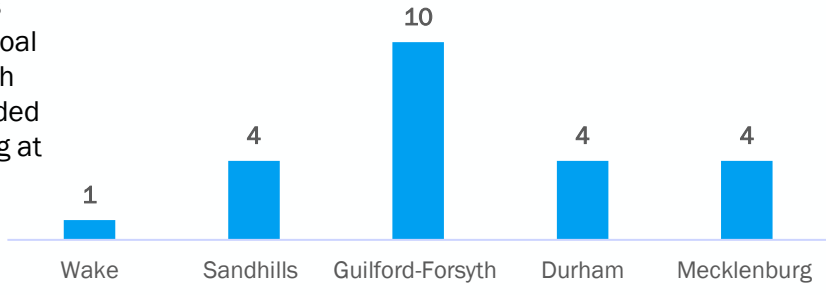
The Five Conditions for Collective Impact

Community Action Teams collaborate with the **backbone organization,** the LHD, to implement evidence-based strategies (EBS) through various initiatives. For example, the **Mecklenburg Collaborative** CAT provided ongoing, community-informed feedback that shaped EBS adaptation and delivery to be culturally relevant, accessible, and responsive to the lived experiences of local families. CATs implement a **common agenda** to align efforts to improve birth and child health outcomes; in **Durham County**, the CAT worked throughout the fiscal year to finalize the Durham County Human Milk Feeding Strategic Plan, which will guide the **agenda** and **mutually-reinforcing activities** across organizations and evidence-based strategies in Durham County. In **Guilford County,** their CAT, *Community Action for Healthy Babies* employs **mutually-reinforcing activities** by ensuring that different community partners contribute to shared health outcomes, such as improving transportation, housing, and food security. They sent surveys to organizations and community members to identify assets and challenges that partners can address in complementary ways through **mutually-reinforcing activities.** CATs facilitate **continuous communication** across evidence-based strategies. For example, **Wake County** implemented a new program newsletter in Quarter 2 (Q2) and launched a new website in Q3. **Guilford-Forsyth Collaborative** utilizes regular meetings to maintain continuous communication; the Forsyth County Infant Mortality Reduction Coalition meets quarterly. CATs utilize **shared data measurement systems** to inform decision-making, such as in **Durham County**, where an UNC evaluator presented long-term outcome data at the Q1 CAT meeting. This presentation allowed for insights as to long-term progress and impact, leading to an asset mapping activity at the Q2 CAT meeting and interest from CAT members in viewing additional data on the county map, especially Geographic Information System (GIS) data. Another contribution towards **shared measurement** for **Sandhills Collaborative** was their Triple P Coordinator being appointed to a statewide Data Optimization Committee to support the standardization of data reporting and address data-related challenges at the state level in Q4.

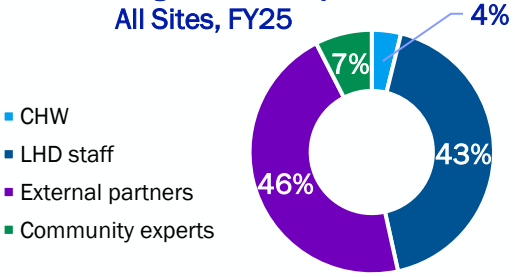
Community Action Teams

In FY25, **23 CAT meetings** were held across sites with almost **500 attendees.** Most sites met the goal of meeting at least quarterly, as seen in the graph to the right. Guilford-Forsyth Collaborative exceeded this goal. Guilford-Forsyth has two CATs operating at the county level: Community Action for Healthy Babies (Guilford County) and the Forsyth County Infant Mortality Reduction Coalition. Each CAT hosted 5 meetings throughout FY25.

CAT meetings throughout FY25



CAT Meeting Attendees by Role
All Sites, FY25



Of the **492 total CAT members** who attended a meeting in FY25, most were LHD staff (43%, n = 210) or external partners (46%, n = 226). A breakdown of CAT members' roles is pictured on the left. Only Forsyth County met the goal for 25% of CAT members to be community members, including community experts and CHWs. The proportion of community experts varied by grantee from 4% to 26%. Forsyth County had the greatest number of community experts (n = 25) and Guilford County had the greatest number of CHWs (n = 5) across grantees.

Implementation Coaching, FY25

Fiscal Year (FY) 25 Coaching Highlights

In FY25, **ICO4MCH implementation coaches continued to support Durham and Wake Counties, and Guilford-Forsyth Collaborative,** as they onboarded new staff and implemented plans for the new fiscal year. Coaches reviewed Durham County's workplan and strategized with team members about how to support a growing collaborative. Coaches also provided additional technical assistance (TA) to grantees including planning Community Action Team (CAT) meetings, working with grantees to problem solve specific challenges that affect relationships with partners, and managing internal messaging to health department staff and leaders.

- **Durham County** most appreciated coaches' support in strengthening team coordination, improving meeting efficiency, and enhancing the team's ability to navigate complex discussions.
- **Guilford-Forsyth Collaborative** most appreciated the coaches regularly meeting with team members, listening to challenges, and helping identify growth opportunities aligned with collective impact goals. Their timely and practical guidance strengthened systems change efforts, improved implementation strategies, and kept the team focused, connected, and equipped to advance the work. Looking ahead, the implementation coach will provide technical assistance in FY26 for the joint Guilford and Forsyth CAT meeting in March 2026, as well as for implementation efforts in Forsyth County.
- **Wake County** most appreciated the coaches' involvement in the Maternal and Infant Mortality Workgroup as a facilitator. The county shared that the implementation coaches' mentorship extends beyond ICO4MCH, making them an indispensable resource as the team prepares for the next fiscal year and grant cycle.

ICO4MCH Learning Collaborative

In addition to directly supporting these three grantees, the implementation coaches, in collaboration with the ICO4MCH Program Manager and UNC Evaluation Team, also hosted an annual ICO4MCH full-day in-person spring learning collaborative for all grantees on April 24, 2025 in Greensboro, NC. About 25 ICO4MCH staff and partners attended in Greensboro. The primary objectives of the learning collaborative were to help grantee staff and partners:

- Learn more about engaging fathers in MCH
- Utilize an action planning tool for ICO4MCH activities
- Navigate changes in the federal MCH landscape

The Learning Collaborative sessions included:

- A Welcome, Resiliency Bingo, and Overview
- Fathers in Maternal and Child Health Keynote by Lorenzo Hopper
- Panel Discussion on Examples of Fatherhood Engagement in NC
- Team Time with Action Planning Tool
- Discussion on Navigating Changes in the Federal Maternal and Child Health Landscape

Of the 22 participants who completed the learning collaborative evaluation survey, **81% strongly agreed** that the Learning Collaborative format was effective. Participants also shared additional resources and information that would be helpful for them, such as a self-care tips list; strategic planning resources; and panel discussions at future learning collaboratives.

Community Health, FY25

ICO4MCH supports the attainment of the highest level of health for all people. Each grantee examines the social determinants of health within each evidence-based strategy (EBS) to understand and support community health in their county(ies).

Accomplishments

- **Durham County** continued to advance their Human Milk Feeding Strategic Plan by developing an addendum focused on Infant and Young Child Feeding in Emergencies (IYCF-E).
- **Guilford-Forsyth Collaborative** conducted a landscape analysis on breastfeeding, gathering valuable feedback from their CAHB (Community Action for Healthy Babies) meetings.
- **Mecklenburg Collaborative** met with faith community partners and designated community members to present on messaging and upcoming training opportunities (Preconception Peer Educator Program, Triple P and Mothers and Babies). Mecklenburg trained four community-based health ambassadors in Triple P Discussion Group and three were trained in Mothers & Babies.
- **Wake County** worked with the Board of Commissioners to reconvene the Infant Mortality Workgroup, with an additional focus on maternal mortality. They also focused on intentional relationship-building across Health and Human Services and with external partners to support data collection, increase access to breastfeeding resources and doula care, and provide technical support for Triple P providers.
- **Sandhills Collaborative** launched targeted efforts across the four-county region, including distributing informational materials, increasing social media engagement, participating in community events, and partnering with local health departments. They onboarded a new bilingual doula to improve inclusivity, and a doula portfolio is currently in development to help clients choose the doula most compatible with their needs and preferences.

Community Health Impact Assessments (CHIA)

CHIAs are used to evaluate the impact of programs, policies, or initiatives on the health of the population. In Fiscal Year (FY) 25:

- **Durham County** completed CHIAs on Breastfeeding in Q2 and Family Connects in Q4. In Q2, Durham County held a Community Action Team (CAT) meeting to collaborate on the breastfeeding CHIA modifications through an asset mapping activity. One modification focused on increasing outreach to Durham zip codes with the highest infant mortality, aiming to rebuild trust and engagement. County maps of infant mortality rates were used during the activity to track progress toward this goal.
- **Guilford-Forsyth Collaborative** completed CHIAs on Breastfeeding in Q3 and Preconception and Interconception Health and Triple P in Q4. In follow up to the Breastfeeding CHIA, in Q4, they conducted a series of virtual sessions with partners and community members focused on the breastfeeding landscape in Guilford County. These sessions marked a significant step toward strengthening lactation supports.
- **Mecklenburg Collaborative** completed a CHIA on Preconception and Interconception Health in Q4.
- **Wake County** completed a CHIA at the end of FY24 on their Doula Services which they used throughout FY25 in the planning and roll out of this new evidence-based strategy.
- **Sandhills Collaborative** completed a CHIA in Q3 for their Doula Services where they detailed their goals of recruiting bilingual doulas to provide culturally and linguistically appropriate support for community members. They plan to promote culturally responsive care among healthcare providers and increase compensation for their doulas in the doula services program.

Preconception & Interconception, FY25

ICO4MCH funding was awarded to **Mecklenburg Collaborative, Guilford-Forsyth Collaborative, and Durham County** in Fiscal Year 25 (FY25) to establish Preconception and Interconception Health programs for individuals of reproductive age with the goal of improving birth outcomes. To accomplish this, the Local Health Department (LHD) is implementing Northwestern University's Mothers and Babies program to enhance perinatal mood support. They will also implement a community-based outreach program for women of reproductive age and utilize social media to expand public awareness of preconception and interconception health. Preconception implementing sites also chose to partner with a local community college or four-year university to reach students through a Preconception Health Peer Educator (PPE) program.

Throughout FY25, **major accomplishments** included:

- **All implementing sites** hosted outreach events, Mothers & Babies (M&B) trainings, M&B group and individual sessions, and on-campus and community (off-campus) PPE events. **All sites** additionally facilitated Reproductive Life Planning (RLP) assessments.
- **Mecklenburg Collaborative** received positive feedback from M&B participants and hosted **14 educational and outreach events** throughout the year, including a healthy relationships workshop, mental health workshop for teen parents, and safe sleep classes.
- **Guilford-Forsyth Collaborative** continued to promote their RLP Assessment: "Are You Thinking Ahead?" through community events and on social media. Their Community Health Worker (CHW) is planning a new health education component to work with home visiting program partners to offer RLP educational sessions.
- **Durham County** completed the Mothers & Babies (M&B) training requirements in Q1 and partnered with MAAME to offer M&B sessions in Q3. In Q4, they updated and translated their RLP guides into Spanish.

Outreach & Education

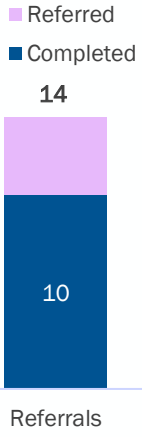
Throughout FY25, sites hosted educational events on preconception and interconception health to increase the awareness and adoption of healthy eating, active listening skills, enhanced mental wellness, or reproductive life planning.

66 *Outreach or educational events on preconception and interconception health held*

2,562 *Individuals reached at educational events*

Mothers & Babies

In FY25, **37 staff** participated in trainings on how to deliver M&B across sites. A major accomplishment was that all sites offered individual and group sessions throughout FY25; **53 individual sessions** and **22 group sessions** were offered across sites, serving a total of **50 unique women**. **Durham County exceeded the performance measure to facilitate at least 25 M&B sessions, hosting 33 sessions across FY25.** All sites also received and completed referrals, with an overall completion rate of **71%** (depicted in the graph to the right).



Preconception Health Peer Educator (PPE) Program

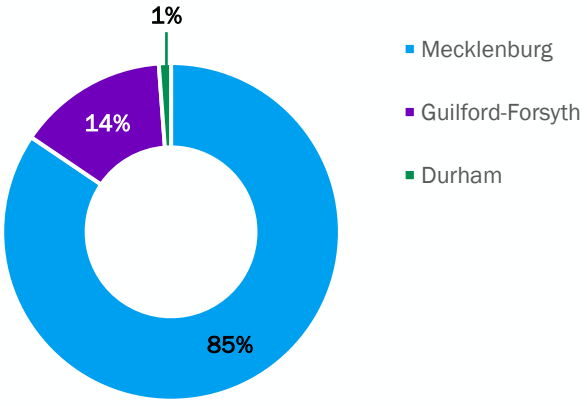
During FY25, all sites neared or met the performance measure of hosting at least **two** on-campus events and **two** off-campus community events. **Guilford-Forsyth Collaborative** hosted the most events, holding **16 events** with North Carolina A&T, reaching over **800 students.** These events included STI/HIV testing, health and wellness workshops, and a spirituality workshop. Mecklenburg Collaborative participated in UNC Charlotte's annual Wellness Block Party during Q4 and Durham County hosted a campus outreach event at North Carolina Central University. **All sites met the performance measure of maintaining 10 active PPE students; Durham County had the most with 16 active PPE students in FY25**. All sites additionally hosted community events off-campus; Guilford hosted a community baby shower in Q2, Mecklenburg participated in two Black Maternal Health Week events in Q4, and Durham hosted a produce giveaway in Q4.

Preconception & Interconception, FY25 *(cont.)*

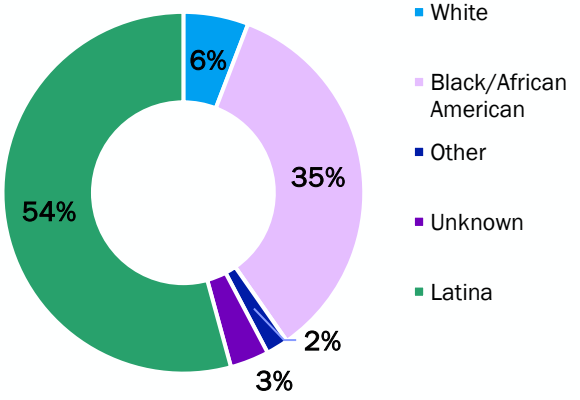
Reproductive Life Planning (RLP)

- In FY25, **140 individuals** received training on Reproductive Justice and counseling related to RLP. Most were LHD staff (n = 120) or from Mecklenburg Collaborative (n = 98).
- **Across sites, 3,432 unique women of reproductive age created an RLP assessment.** Most of these women were from Mecklenburg Collaborative; the participant breakdown by site is shown to the right. A participant breakdown by race and ethnicity can be found below. **Also, 156 unique men of reproductive age created an RLP assessment.** All were from the Guilford-Forsyth Collaborative. Most of these men identified as Black or African American.

Unique women who completed an RLP assessment by site



Unique women who completed an RLP assessment by race/ethnicity



Spotlight on Guilford County: RLP Assessment

ARE YOU THINKING AHEAD?

Reproductive Life Planning Guide: Birthing or Child-Free People

The graph to the left depicts the race and ethnicity breakdown of women who completed an RLP assessment during FY25 across sites. Over half of women completing an RLP assessment in FY25 were Latina and approximately one third were Black or African American. These metrics were not provided by every individual, potentially resulting in discrepancies between subgroup totals and the total number of participants. Additionally, race and ethnicity categories that represented less than 1% of total women were suppressed and combined into "Other," including Asian, American Indian, and Native Hawaiian and Other Pacific Islander categories.

Doula Services, FY25

ICO4MCH funding was awarded to implementing sites, **Sandhills Collaborative** and **Wake County,** with the goal of improving birth outcomes by providing doula services. A doula is a trained professional that provides physical, emotional, and informational support to a woman and their partner before, during, and after childbirth, including continuous labor support, to help them achieve the healthiest, most satisfying birth experience as possible. The birth doula serves as the liaison and advocate to the birthing woman and her family, but specifically in the contexts of prenatal care, labor, birth and postpartum care. Birth doulas are an evidence-based intervention to reduce the likelihood of Cesarean birth, reduce the likelihood of using Pitocin during labor, and increasing the likelihood of a high satisfaction birth for mothers. To accomplish this, Local Health Departments (LHDs) are conducting community outreach and education on doula services, recruiting and training community members as doulas, establishing a collaborative relationship with at least 1 birth facility, and providing clients with doula services. Complete doula services include a minimum of 1 prenatal visit, the provision of childbirth education, continuous onsite labor support at the hospital, at least 1 postpartum visit either in the hospital or within 1 week after birth, and at least 1 telephone contact within 30 days after birth. **Fiscal Year 2025 (FY25) was the inaugural year of the Doula Services evidence-based strategy (EBS) for ICO4MCH.**

Major Accomplishments

- In FY25, both grantees successfully started implementing the Doula Services strategy. Major accomplishments included hiring a Doula Services Coordinator, developing a written doula services agreement, establishing relationships with birthing facilities, recruiting and training community members as doulas, and starting to serve clients.
- In **Sandhills Collaborative**, a major success was marketing services using Facebook, a billboard, and advertisements through Beasley Media Group.
- In **Wake County**, a major success was utilizing community input from the previous Community Health Impact Assessment (CHIA) centered on Doula Services to guide program development and implementation.

Outreach & Education

Grantees provided outreach and education on Doula Services at **15** total events in FY25. At these events, grantees shared information about doulas and gathered interest from potential doulas and clients. Both grantees exceeded the goal of two events, with **Wake County** hosting **two** events and **Sandhills Collaborative** hosting **13.** Almost **two thousand attendees** were reached at these events.

15 *Community and educational events held*

1,985 *Individuals who received education and/or outreach related to doula services*

Recruitment & Training

- In FY25, over 100 community members were **recruited** to be trained as doulas.
- **Sandhills Collaborative** trained **four community members** as doulas.
- **Wake County** trained **three community members** and **seven LHD staff** as doulas.
- **11 doulas actively provided services in FY25, 8 in Wake County and 3 in Sandhills Collaborative.**

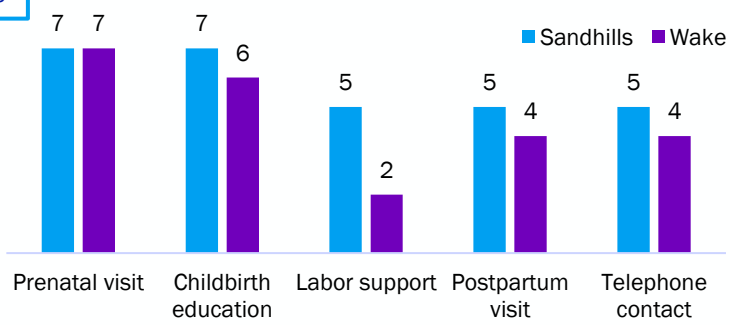
Program Participants

15 women received *any* doula services

8 women received *complete* doula services

7 / 7 women who received complete doula services reported a ***positive*** **birth experience** and ***positive*** **experience with their doula** on their Birth Satisfaction Survey

Number and Type of Doula Services Visits in FY25

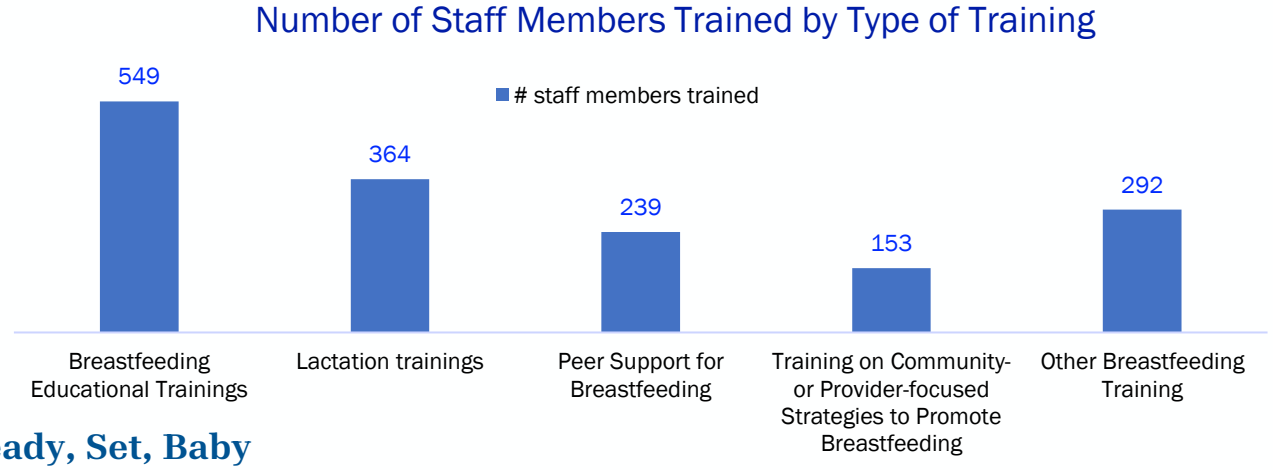


Ten Steps for Successful Breastfeeding, FY25

ICO4MCH funding was awarded to **Guilford-Forsyth Collaborative, Sandhills Collaborative, and Durham, Mecklenburg, and Wake Counties** with the goal of reducing infant mortality by encouraging and promoting breastfeeding. The Ten Steps for Successful Breastfeeding is an evidence-based protocol used by Baby-Friendly USA. Steps 3 and 10, to "*inform all pregnant women about the benefits of and management of breastfeeding*" and "*foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center*" are areas that grantees can support as they focus on broader strategies to increase initiation, duration, and support of breastfeeding. To accomplish this, Local Health Departments (LHDs) are training and collaborating with health care providers, community-based and faith-based organizations to increase the knowledge and skills to support breastfeeding women; and increasing social media messaging. Additionally, grantees chose to implement 1) the Making It Work: Empowering Employers and Mothers, 2) Breastfeeding-Friendly City Program, 3) Shared Decision-Making Using Patient Decision Aids, 4) Prenatal Breastfeeding Education: Ready, Set, BABY, or 5) Establish Public Lactation Rooms.

Trainings

In FY25, the counties and collaboratives held 313 trainings with 1,555 staff members trained. Most trainings were on breastfeeding education and lactation.



Ready, Set, Baby

In FY25, **Durham County** educated 15 pregnant community members using the Ready, Set, Baby curriculum and offered 14 free prenatal breastfeeding classes.

Public Lactation Rooms

In FY25, **Mecklenburg Collaborative** expanded public lactation spaces by identifying five new sites—including libraries, childcare centers, and a health clinic— and partnered with three faith-based institutions and with recreation centers and county government buildings to install resources. **Wake County** partnered with three new organizations to outfit seven public lactation room spaces.

Making It Work

In FY25, **Guilford-Forsyth Collaborative** established four promising breastfeeding-friendly sites—including UNCG's Jackson Library and Cone Health Sagewell Center—and began preparing policy guidance, wish-list items, and toolkit delivery, while also training staff at Atrium Health and initiating outreach to additional organizations like YMCA and Authoracare. **Sandhills Collaborative** actively used the Making It Work toolkit to educate childcare facilities and businesses on lactating rights, integrates it into staff trainings, ensures access in all lactation spaces, and recently leveraged it to engage Richmond NASCAR Speedway in creating a public lactation space. **Mecklenburg County** connected with 14 business/worksites and 4 designated as breastfeeding friendly.

Ten Steps for Successful Breastfeeding, FY25 *(cont.)*

Outreach & Collaboration

ICO4MCH grantees aim to increase partner organizations, education events, and people reached each year. Across all grantee sites in FY25:

95	*New partner organizations*
4,028	*Educational events held*
11,578	*People of childbearing age reached at educational events*

Social Media Campaigns

Grantees also set a goal to increase the presence of social media messages that provide information on breastfeeding. Across all grantee sites in FY25:

4	*Counties/collaboratives worked on a social media campaign*
9,856	*People reached across social media campaigns*

Accomplishments

- **Durham County's** key initiatives included observing centering sessions at the Women's Health Clinic, planning support groups with Welcome Baby, and participating in community events like the Triangle Area Parenting Support (TAPS) Baby Shower. Community partners also helped establish lactation spaces, distributed breastfeeding materials, and formed collaborations with over 35 organizations, including schools, childcare centers, libraries, and local businesses. These efforts focused on increasing access to culturally appropriate breastfeeding resources, supporting Spanish-speaking families, and providing direct services such as breast pump deliveries and education. The social media campaign saw growth primarily Instagram, where both post impressions and engagement rates increased dramatically: one Instagram post reached 618 followers.
- **Guilford-Forsyth Collaborative** completed a breastfeeding landscape analysis and launched a media campaign featuring billboards and ads to raise awareness. The county also expanded the Making It Work initiative by onboarding two new businesses and continues to see strong engagement at both Baby Cafés. During a collaborative meeting, **Guilford County** gathered feedback on a provider survey to identify gaps in lactation services and prepared for its third Community Health Impact Assessment (CHIA) focused on breastfeeding. **Forsyth County** strengthened partnerships, hosted lunch and learn sessions, and enhanced WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) outreach with new laptops funded by ICO4MCH, which will improve data collection and reporting for the next fiscal year.
- **Mecklenburg County** continued to expand breastfeeding support through educational classes, peer groups, and strategic partnerships with Novant Health and Atrium Hospitals, offering quick access to breast pumps and supplies. Their collaboration with local organizations and healthcare providers strengthened referral pathways, increased engagement through support groups, and enhanced access to breastfeeding resources for moms with babies in the neonatal intensive care unit (NICU) and other community members.
- **Sandhills Collaborative** supported the establishment of breastfeeding-friendly spaces at local pregnancy and community centers, along with staff training and program referrals. They installed a Mamava lactation pod at Richmond County Speedway, new lactation spaces at Richmond County Partnership for Children and Montgomery County Head Start and maintained ongoing coordination with WIC offices and local partnerships to expand access and support for lactating mothers.
- **Wake County** expanded breastfeeding support by partnering with local businesses, faith communities, and health organizations, while continuing to outfit lactation spaces and launch a postpartum support group. They trained three community doulas and seven staff in breastfeeding education, initiated one-on-one consultations with their community health workers for families who were not eligible for WIC, and launched quarterly Breastfeeding 101 classes and community-led support groups with partners like Enjoy the Baby and Triangle Area Parenting Support.

Positive Parenting Program (Triple P), FY25

ICO4MCH funding was awarded to four grantees, **Sandhills Collaborative, Mecklenburg Collaborative, Guilford-Forsyth Collaborative,** and **Wake County,** with the goal of improving the health status of children ages 0 to 5 by enhancing parents' knowledge, skills, confidence, and self-sufficiency; promoting the development of non-violent, protective, and nurturing environments for children; promoting development, growth, health, and social competence of young children; and reducing the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence. Local Health Departments (LHDs) are increasing access to Triple P programming in daycare/childcare centers for both caregivers and parents and targeting faith-based organizations, and other agencies that serve children ages 0 to 5 as ways to expand availability of and access to the various levels of Triple P programming including the Positive Early Childhood Education program (PECE), Triple P for Baby, and Triple P Online (TPOL).

Accomplishments

Sandhills Collaborative is spearheading the planning and launch of Statewide Virtual Seminars to expand access to Triple P services. These seminars will establish a statewide schedule to enable parent referrals from across North Carolina, addressing access barriers both within and beyond the Sandhills region. Additionally, it will allow the Collaborative to engage Spanish-speaking seminar providers from other regions, further enhancing accessibility and cultural responsiveness. In recognition of their expertise, the Sandhills Triple P Coordinator was appointed to the Statewide Data Optimization Committee. This role supports efforts to standardize data reporting and resolve data-related challenges across the state. Their Triple P Coordinator worked to help plan the monthly NC Learning Collaboratives, offering suggestions to help the group address and discuss root causes of Triple P topic issues. The Triple P Coordinator is also working with the Cumberland Lead Implementing Agency to plan a Triple P practitioner conference and to have previously trained providers be trained in brief primary care after Triple P America announced all trained providers could administer the program through brief primary care. Sandhills Collaborative successfully secured approval from the North Carolina Division of Child Development and Early Education to offer contact hours for select Triple P trainings delivered during the recent practitioner conference in hopes of enhancing provider attendance and engagement.

Mecklenburg Collaborative's Triple P team hosted the 4th Annual Triple P Practitioner conference in Quarter 3 (Q3). Nearly 150 attendees enjoyed refresher sessions and information sessions, with topics including self-care, engaging the faith-based community, and more. Several practitioners attended and were reengaged as a result. Mecklenburg Collaborative is excited about a new partnership with their county Parks and Recreation Department, in which Triple P signs were placed in designated parks with parenting tips and a QR code for additional information.

Guilford-Forsyth Collaborative established a partnership with Parenting Path of Forsyth to begin reporting Title V Triple P data. Additionally, they partnered with the Kelin Foundation and will launch Level 4 group sessions in Guilford following the state training held in January. Forsyth County sent several staff to the Triple P Northwest NC Region (Service Area 2) 1st Annual Workshop.

Wake County made great progress on their data with technical assistance from Durham's Region 3 Triple P team. Wake's Triple P Coordinator has nurtured new connections, including with two community partners who are now hosting recurring parent education sessions supported by Best Baby Wake and in collaboration with their other evidence-based strategies.

Outreach & Education

By reaching a combined total of **5,960 staff and parents** in FY25, ICO4MCH grantees surpassed the FY25 goal to expand outreach from the FY24 total of 3,933 individuals.

ICO4MCH grantees provided outreach and education to 1,808 staff and 4,152 parents in Fiscal Year (FY) 25.

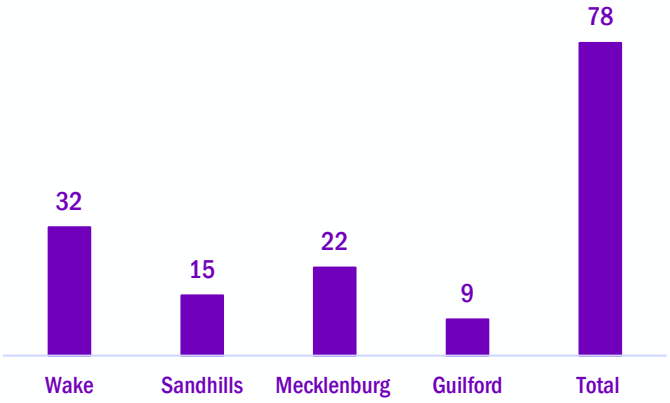
1,808 *Staff* **4,152** *Parents*

Positive Parenting Program (Triple P), FY25 *(cont.)*

Trainings for Accreditation

The performance measure is to increase the number of practitioners who are trained and accredited each year. Thus, for FY25, the goal to train 60 new practitioners across all ICO4MCH grantees was surpassed. Most staff were trained in Level 3 (50 staff), followed by Triple P for Baby (14 staff) focused on prenatal through 12 months.

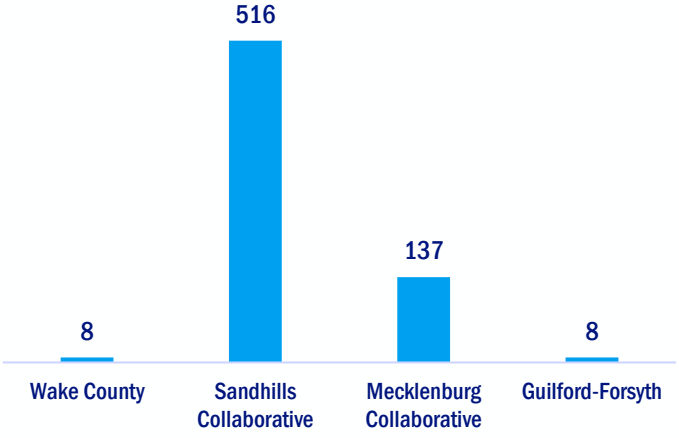
ICO4MCH Grantees trained 78 staff to become accredited Triple P practitioners in FY25.



Coaching and Peer Support

In FY25, ICO4MCH grantees conducted **669 coaching contacts**, a slight decrease from FY24 in which 810 coaching contacts were completed. ICO4MCH grantees held 29 Peer Assisted Supervision and Support (PASS) events, attended by 165 practitioners. To surpass FY24 numbers, the goal was to host 41 PASS events and reach 161 practitioners (practitioner goal met).

ICO4MCH grantees had 669 Coaching contacts in FY25 with Triple P practitioners.



Community Health Workers (CHW)

Several sites utilized Community Health Workers in the planning and delivery of the Triple P evidence-based strategy. Wake County's CHW supported their Triple P Coordinator with trainings, PASS sessions and community outreach. In FY25, Mecklenburg Collaborative's CHW completed the Triple P for Baby training.

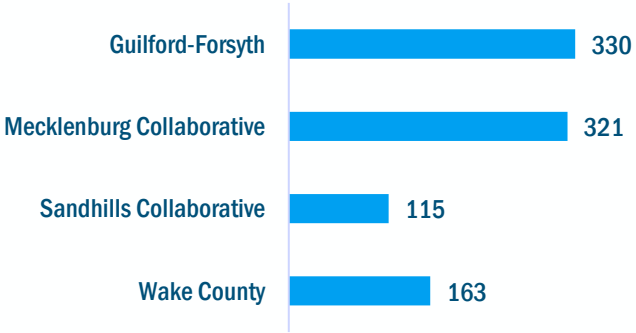
Triple P Online (TPOL)

The Triple P Online data is also undergoing a data transition from calendar year to fiscal year. Thus, data in the figure to the right do not totally align with the state fiscal year. It includes July, 2024 - May, 2025 (it excludes June 2024). Also, now TPOL includes any caregivers with children ages 0-5 completing Module 1 of TPOL English 0-12, English Teen, Fear-less, and BABY.

Data Note

The Title V Triple P program is undergoing a data transition from calendar year to fiscal year. Thus, data from Title V on practitioners accredited and caregivers and children served was not available in time for this report and therefore is not included in this report. The Triple P Online data is also transitioning so April-May was considered the transition quarter and only included two months.

Over 900 parents of children ages (0-5) completed Module 1 of Triple P Online from July 2024 to May 2025.



Family Connects Newborn Home Visiting Program, FY25

ICO4MCH funding was awarded to **Durham County** for the Family Connects International (FCI) Nurse Home Visiting Program to increase child well-being by bridging the gap between parent needs and community resources. Utilizing the Family Support Matrix, home visiting nurses ask questions pertaining to the well-being of the mother, father, and infant in the following domains: health (parental and infant), infant care, safe home (including safe sleep), and social and emotional support for the parents, as well as other needs. Nurses make referrals to resources for the family as indicated by the score on the Family Support Matrix. Activities include: one integrated home visit (IHV) by a registered nurse to all parents of newborns 2 – 12 weeks old born in the service area; two additional home visits from the nurse home visitor for families who need additional support; and referrals to resources and services for the parents or infant.

Mothers Served in FY25

- Of mothers whose ethnicity was assessed, 50% were Hispanic or Latina.
- Of mothers whose racial identity was assessed, 29% were Black or African American.
- Nearly 56% of mothers with insurance assessed have Medicaid.

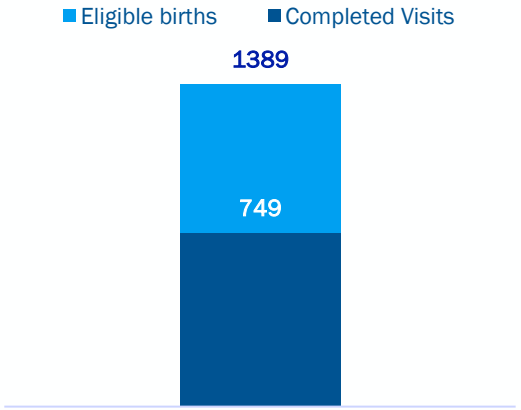
Accomplishments

- Family Connects Durham continued offering Mothers and Babies groups for interested parents, starting a Spanish-speaking group and completing an English-speaking group and launching a new one in Quarter 3.
- In Quarter 4, they completed a Health Equity Impact Assessment on Family Connects.

FY25 Family Connects Activity

Family Connects Program Activity	N/%
Eligible Birth Population	1,389
Scheduled Integrated Home Visits (IHV)	749
Integrated Home Visits Completed	577
Population Reach (IHV Completed out of Eligible)	41.5%
Completion Rate (IHV Completed out of Scheduled)	77%
Follow-up and Referrals	**N/%**
Families Receiving Follow-up Visit	18
Families Receiving Referrals for Long Term Support	27
Families with Referrals Completed	26
Successful Linkage Rate (Families with Referrals Completed out of Families Receiving Referrals)	96%

In FY25, Durham reached 41.5% of all eligible births with home visits, up from 37% in FY24.



In FY25, Durham surpassed their goal of completing 75% of scheduled home and completed 77% of all scheduled home visits.

In FY25, Durham was close to their goal of linking all families who were referred to Family Connects. 96% of all families with referrals had successful referral linkages, up from 90% of families in FY24.

Challenges

The new database makes it difficult to capture the number of referral linkages. Only the referrals that nurses mark as complete prior to closing the case are captured. Additionally, there are challenges with collecting patient demographics with about 40% of patients not having race assessed and 30% not having ethnicity assessed.