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social impact
partners

Maternal and Child Health Systems Landscape: A Three-County Study in California

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Section 1

Introduction

The David and Lucile Packard Foundation (the Foundation) partners with communities and leaders to support long-lasting solutions that advance equity and environmental sustainability. As part of its broader commitment to fostering thriving communities, the Foundation launched the 10-year Children and Families Initiative (CFI) in 2024. The initiative aims to improve maternal and infant health and promote healthy child development from birth to age three, with a focus on supporting Black, Indigenous, and Latino families.

In the United States, Black, Indigenous, and Latino families face significant inequities in maternal health and child development outcomes, with pregnancy-related mortality rates for Black and American Indian and Alaska Native women more than three times higher than those of their White peers.[1] In California, Black babies are twice as likely to die before their first birthday as White babies.[2] These disparities stem from racial biases within the very systems intended to provide support and create barriers that prevent many families from accessing the tools and resources essential for giving their children a strong and healthy start.

Recognizing that families' lives are complex and that parents must often navigate health care, child care, housing, and food needs simultaneously, the Foundation understands that better alignment across systems is essential. CFI embraces a systems of care model, which emphasizes collaboration across sectors to more effectively meet families' interconnected needs. This work is grounded in the belief that if health care, child care, and financial supports are strengthened and connected through equitable systems, maternal and child health outcomes will improve, and disparities by race and ethnicity will be reduced.

In California, to bring this vision to life, the CFI is making targeted investments in Fresno, Alameda, and Monterey Counties to pilot and refine promising practices in improving maternal and child health outcomes. These efforts aim to build proof points for what connected, effective systems can look like, and to inform policy at the local, state, and federal levels.

Section 2

About the Landscape Assessment

In 2024, the Foundation engaged VIVA Social Impact Partners (VIVA) to conduct a landscape assessment in Alameda, Fresno, and Monterey Counties. The goal of this work was to document how publicly funded health care, child care, and financial support systems related to maternal and child health are structured and connected, and to identify opportunities to build a more aligned and effective system of care for pregnant people and families with children from birth to age three.[3]

Rather than attempting to catalog every locally funded program, the research prioritized state and federally funded programs and explored how they function at the county level. Special attention was given to how these systems are experienced and navigated by both system leaders and families, particularly those interacting with all three systems at once.

In some cases, locally funded programs and initiatives are individually mentioned because they play a critical role in connecting or supplementing public programs, helping families access and coordinate care across the broader system.

The desired outcomes of this report are as follows:

1. Document how publicly funded health care, child care, and financial support systems related to maternal and child health are structured in each county, including how they are connected within and across systems that serve pregnant people and families with children under age three.
2. Elevate the voices and lived expertise of families, particularly those navigating all three systems simultaneously, to illuminate barriers, gaps, and opportunities for greater coordination.
3. Identify county-specific strengths and unmet needs, as well as common strengths and challenges across the three counties, to inform strategies for building more connected, responsive, and equitable systems of care.
4. Highlight actionable opportunities for philanthropic investment that can accelerate systems alignment, fill critical service gaps, and support community-driven solutions.

METHODOLOGY

VIVA conducted this landscape assessment using a multifaceted approach, including co-creation with a Design Team, desk research, interviews with county-level systems leaders, parent interviews, and county-specific sensemaking meetings with local stakeholders. Each is described in Appendix A, Methodology.

LIMITATIONS

While conducting this landscape assessment, the research team encountered the following limitations:

- **Timing of research:** Data collection concluded in Spring 2025, during a time of significant uncertainty regarding federal and state policy and funding. The rapidly changing policy and fiscal environment likely influenced participants' perspectives and may have affected how they described current conditions. There are several shifts in the landscape expected due to changes in federal and state funding that will not be captured in this assessment.
- **Limitations of a point-in-time assessment:** As a snapshot of systems at a single point in time, this assessment cannot establish causality or determine the extent to which any specific factor directly influenced the findings.
- **Trouble reaching monolingual Spanish-speaking parents:** The parents who were referred to the research team were not monolingual Spanish-speaking. Although parents who identify as Latino and bilingual Spanish-English were interviewed, they may have different experiences navigating systems and supports than those who do not speak English. For this reason, those populations are not represented in our interview sample, despite being key target populations for this assessment.

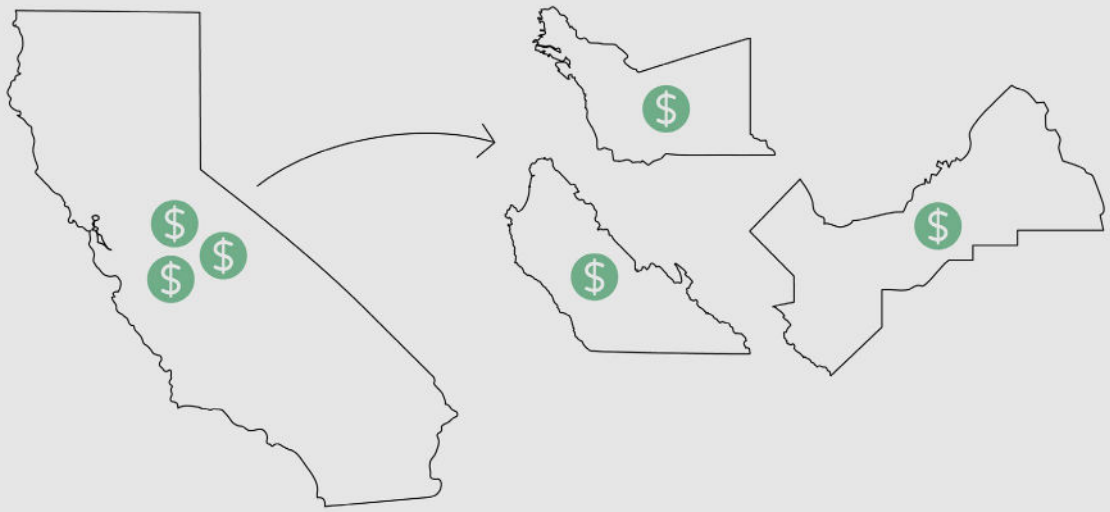
In addition to these limitations, it is important to note that the systems of focus for this report are extremely complex. Findings should be used as a starting point for further inquiry.

Section 3

Realignment in California

The history of California's realignment policies is key to understanding the differences in system structures and family experiences across counties in California. These realignment policies, enacted through major legislation in 1991 and 2011, shifted administrative and financial responsibility for significant health and social service programs from the state to county governments. These changes aimed to enhance efficiency, promote local innovation, and better address the unique needs of individual communities.

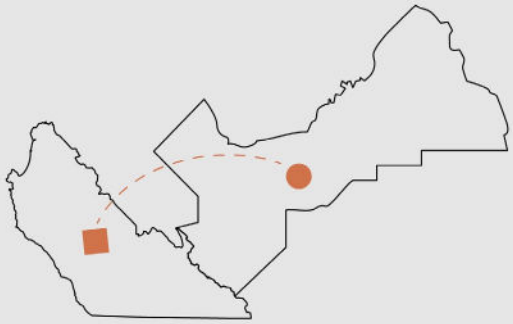
Realignment policies shifted administrative and financial responsibility for significant health and social service programs from the state to county governments.



To support county-level administration, the state allocates a portion of sales tax and vehicle license fee (VLF) revenues to counties, allowing them discretion over spending within state-defined parameters. California's 1991 realignment dedicated a half-cent sales tax and a 0.65 percent increase in the VLF to counties, with the sales tax providing about two-thirds ($4.9 billion) and the VLF about one-third ($2.8 billion) of annual revenues in 2025–26. The 2011 realignment added a 1.0625-cent portion of the state sales tax and redirected part of the same 0.65 percent VLF base rate, generating roughly $10.7 billion annually. These allocations represent major, but not exclusive, sources of funding that support county-administered health and human service programs.[4]

California remains the only state in the United States where counties fully administer many federally funded safety net programs. Nevertheless, counties do not have full autonomy in administration because most program requirements are still governed by state and federal laws. While realignment has increased local flexibility and, in some instances, expanded eligibility, it has also led to variation in program implementation across counties and heightened administrative complexity. Parents interviewed for this landscape study provided several examples of loss of coverage and gaps in coverage due to moving across county lines.

The majority of families interviewed for this report who had moved to a different California county reported experiencing temporary benefit loss and delays in coverage, including during pregnancy.



One example of how California counties offered different benefits can be seen in how Alameda, Fresno, and Monterey Counties implemented Medi-Cal under the 2010 federal Section 1115 "Bridge to Reform" waiver approved by the Centers for Medicare & Medicaid Services. Due to California's 1991 Realignment, counties gained broad authority to design and finance health care systems for low-income and uninsured residents. This decentralized structure produced wide variation in the scope and accessibility of county safety nets. When the Bridge to Reform waiver introduced the Low Income Health Program (LIHP) as a temporary bridge to the Affordable Care Act's Medi-Cal expansion, counties were given flexibility to decide whether and how to participate. Under the waiver, counties could set income thresholds (up to 133% or 200% of the federal poverty level), define benefit packages, and determine eligibility standards. As a result, Alameda, Fresno, and Monterey Counties implemented—or declined to implement—the waiver in markedly different ways, reflecting both their fiscal capacity and administrative priorities.[5,6]

Alameda County was an early adopter and implemented a comprehensive LIHP that offered preventive, primary, and behavioral health services for adults up to 200% of the federal poverty level. Monterey County launched its LIHP later with more limited eligibility (up to 133% of poverty) and required a current medical need for enrollment. Fresno County, by contrast, declined to implement an LIHP altogether, maintaining only a minimal indigent care program and forgoing the federal matching funds available through the waiver.[7]

In addition to these programmatic differences, the counties diverged significantly in their treatment of residents without legal immigration status. Federal rules restricted LIHP participation to citizens and lawfully present immigrants, but Alameda County created a parallel, county-funded program that extended full LIHP-equivalent benefits to undocumented adults using local dollars (known locally as HealthPAC). Monterey County, in contrast, limited eligibility to citizens and legal residents, and Fresno County provided only limited emergency or episodic care. These differences illustrate how county discretion under realignment, combined with the flexibility of the Bridge to Reform waiver, resulted in uneven access to Medi-Cal–like coverage across California, with eligibility and benefits varying sharply based on county of residence and immigration status.[8,9]

California's current Section 1115 waiver, California Advancing & Innovating Medi-Cal (CalAIM), is set to expire December 31, 2026.

County variation is also evident in how Temporary Assistance for Needy Families (TANF) funds are used through the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Under realignment, counties receive a CalWORKs Single Allocation that combines funding for three main components: Eligibility and Administration, Employment Services (including welfare-

to-work), and Cal-Learn for pregnant and parenting teens.[10] Within this allocation, counties have discretion to shift resources among components based on local priorities and caseload needs.[11] Core eligibility rules for TANF/CalWORKs are set at the state level, but counties may supplement benefits and support services with their allocations or through additional realignment and TANF-related funds.[12] As a result, some counties emphasize expanded vocational training and assessments within their employment programs, while others invest in wraparound services for teen parents or home visiting programs for pregnant and parenting families.[13]

While realignment has positive impacts for people living in counties that expand coverage, individuals moving from one county to another often do not understand that all public benefits are not the same in each county. Additionally, the decentralized nature of program administration often necessitates reapplication or transfer paperwork and can cause temporary service disruptions despite efforts to maintain continuity under federal guidance.

In the event of potential significant federal budget reductions to TANF and Medicaid in upcoming years, it is unknown to what extent California's state budget will be leveraged to stabilize counties or provide guidance on service reductions.

"At one point, I was switching counties and I had to go to do a hearing because my Medi-Cal had frozen because of the process of switching the county. I don't know what happened, but for a long time, I didn't have coverage due to my Medi-Cal being frozen. And so that kind of delayed some of the visits I went to for prenatal care.

I was just very stressed, not knowing that, you know, not having the health care, not being able to get the medicine. Not being able to get an ultrasound when I'm supposed to just to make sure that, you know, everything was going well in there. I was supposed to be receiving some type of aid, but since like my case was frozen, I wasn't able to."

Parent interview, Alameda County

Section 4

The Landscape: Findings

This section provides a comprehensive analysis of the health, child care, and financial support systems serving pregnant individuals and families with children from birth to age three in Alameda, Fresno, and Monterey Counties. Drawing upon quantitative data, interviews with system leaders, and the lived expertise of parents, the findings illustrate both the strengths and limitations of existing systems, as well as the disparities that disproportionately affect Black, Indigenous, and Latino families.

The findings begin with an overview of maternal and infant health outcomes to establish the current state of need and highlight persistent inequities. Next, it describes the organization and administration of each system, identifies programs designed to serve historically marginalized populations, and describes programs at risk due to funding instability. The analysis also highlights systemic strengths, persistent challenges, and opportunities for cross-system collaboration.

Together, these findings provide an integrated view of the landscape, offering critical insight into where systems are functioning effectively, where they are falling short, and where targeted investment and alignment efforts may yield the greatest impact.

MATERNAL AND INFANT HEALTH OUTCOMES

This section presents a series of maternal and infant health indicators for Alameda, Fresno, and Monterey Counties. It begins with countywide outcomes benchmarked against California averages. These initial tables offer an overall picture of each county's performance but do not disaggregate results by race or other demographic factors.

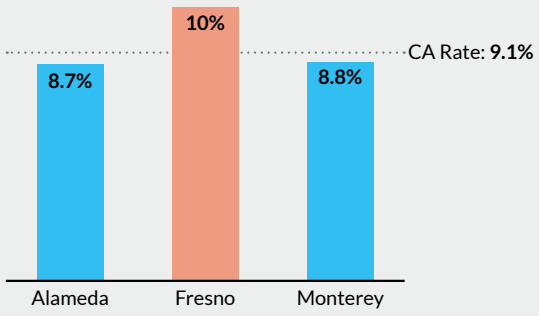
The pages that follow provide a disaggregated table for each county that breaks outcomes down by race and other factors. In these disaggregated views, patterns of inequity become visible. This contrast between countywide averages and stratified data highlights how aggregate measures can mask significant disparities.

Taken together, these indicators establish a foundational understanding of maternal and infant health across the three counties and underscore the need for equity-focused strategies that address persistent gaps in access, outcomes, and systemic conditions.

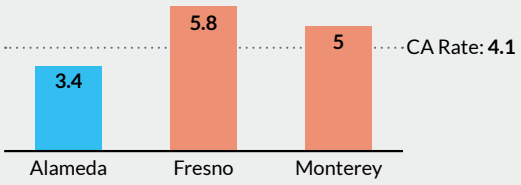
COUNTY COMPARISON: MATERNAL AND INFANT HEALTH OUTCOMES

Blue bars represent outcomes that are better than the California average. Orange bars represent outcomes that are worse than the California average.

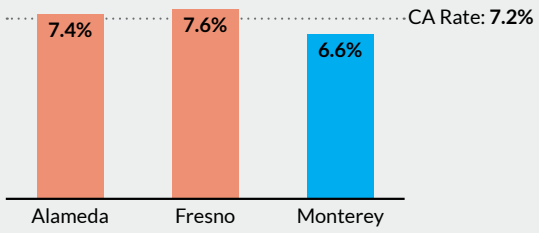
PRETERM BIRTH RATE



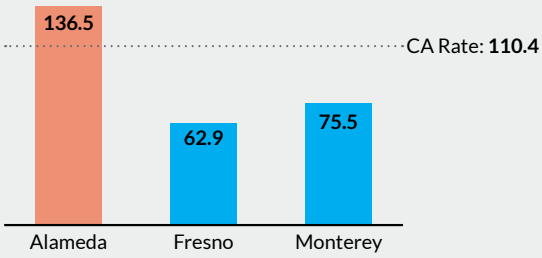
INFANT MORTALITY RATE
(rate per 1,000)



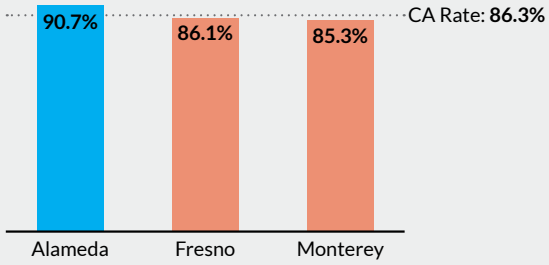
LOW BIRTHWEIGHT RATE



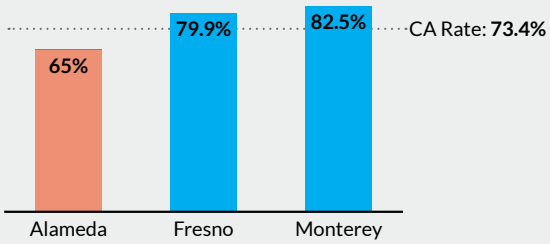
SEVERE MATERNAL MORBIDITY RATE
(rate per 10,000)



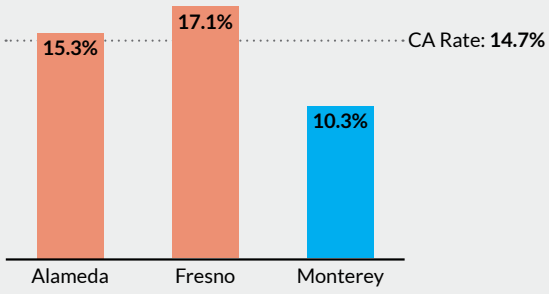
EARLY PRENATAL CARE ACCESS



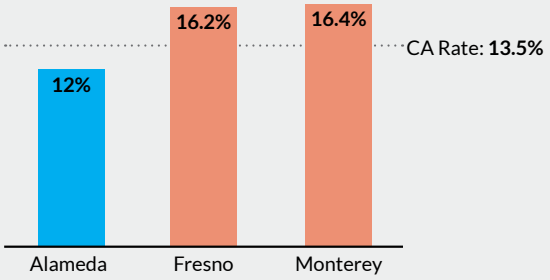
ADEQUATE PRENATAL CARE ACCESS



PRENATAL DEPRESSION SYMPTOMS RATE



POSTPARTUM DEPRESSION SYMPTOMS RATE

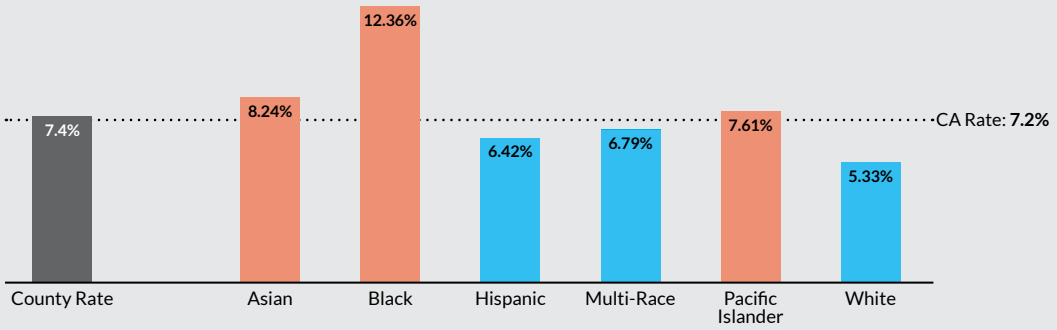


ALAMEDA COUNTY

Maternal and infant health outcomes in Alameda County present a mixed picture. While the county performs better than the state average on indicators such as preterm birth, infant mortality, access to early prenatal care, and postpartum depression, it lags behind in areas like low birthweight, severe maternal morbidity, access to adequate prenatal care, and prenatal depression.[14,15,16,17,18,19] Stark racial disparities persist: **Black birthing parents and infants experience the worst outcomes across nearly all indicators,** followed by Native Hawaiian/Pacific Islander and American Indian/Alaska Native populations, who face particularly high rates of preterm birth and low access to adequate prenatal care. Additionally, people using Medi-Cal, except in early and adequate prenatal care, experience poorer outcomes than those with other insurance types.[20]

ALAMEDA COUNTY: LOW BIRTHWEIGHT RATES

*Countywide rate and disaggregated rates by **race***

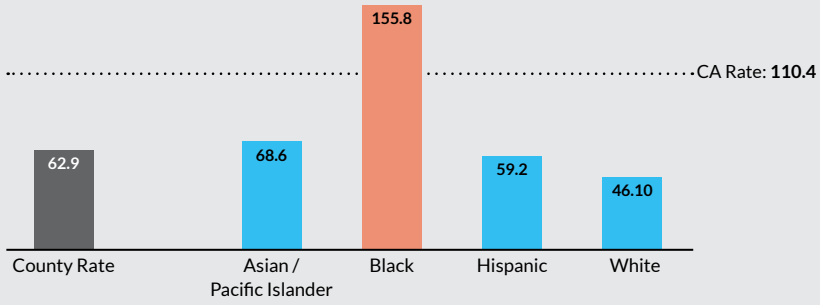


FRESNO COUNTY

Fresno County also demonstrates mixed outcomes, with lower rates of severe maternal morbidity and higher access to adequate prenatal care compared to statewide averages. These are offset by higher infant mortality and elevated rates of prenatal and postpartum depression.[21,22,23,24,25] **Black birthing parents and infants are the most adversely affected, with severe maternal morbidity rates 3.4 times higher than those of White birthing people.** Native Hawaiian/Pacific Islander and American Indian/Alaska Native communities also experience significant disparities in preterm birth, prenatal care access, and postpartum depression. Outcomes are worse across nearly all indicators for individuals using Medi-Cal, and people born outside the U.S. have lower rates of early and adequate prenatal care.[26]

FRESNO COUNTY: SEVERE MATERNAL MORBIDITY RATES (RATE PER 10,000)

*Countywide rate and disaggregated rates by **race***

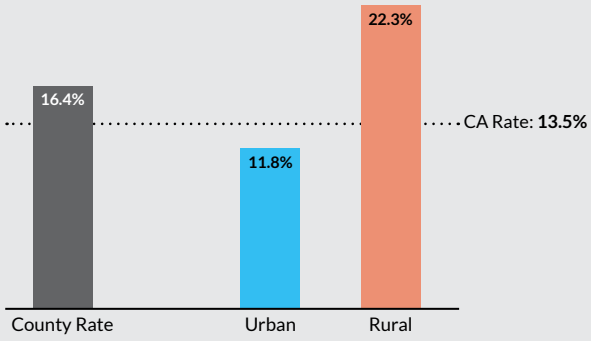


MONTEREY COUNTY

In Monterey County, birthing parents and infants generally experience outcomes comparable to or better than state averages, though postpartum depression symptoms are notably more common.[27,28,29,30,31] Racial disparities are evident[32]: Asian and Pacific Islander birthing parents report high rates of preterm birth and low birthweight, while Black, Hispanic, and American Indian/Alaska Native birthing parents access early and adequate prenatal care at some of the lowest rates. People using Medi-Cal experience higher rates of severe maternal morbidity and prenatal depression, and non-U.S.-born birthing parents face elevated infant mortality and lower prenatal care access. **Notably, birthing parents in rural settings experienced a 10.5 percentage point higher rate of postpartum depression compared to those in urban settings.**[33]

MONTEREY COUNTY: POSTPARTUM DEPRESSION SYMPTOM RATES

*Countywide rate and disaggregated rates by **population density***



See Appendix B for maternal and child health outcome data in each county.

SUMMARY OF LANDSCAPE FINDINGS

A. ORGANIZATION AND ADMINISTRATION OF EACH SYSTEM'S SERVICES

Across Alameda, Fresno, and Monterey Counties, health, child care, and financial assistance programs are primarily administered by county social services agencies, with differences shaped by California's realignment and local partnerships. Health programs such as the CalWORKs Home Visiting Program are county-run, while administration of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) varies: through Federally Qualified Health Centers (FQHCs) in Alameda, the Economic Opportunities Commission (EOC) in Fresno, and the Public Health Department in Monterey. Child care programs are divided between county- and state-administered components. CalWORKs Stage 1 is managed by county social services agencies, with Alameda subcontracting implementation to two R&R's, while Fresno and Monterey administer Stage 1 directly. In contrast, CalWORKs Stages 2 and 3 and the California Alternative Payment Program (CAPP) are state-funded programs administered through direct contracts with local R&R agencies and CBOs, with Alameda being the exception for CAPP, as the county receives the state contract and then subcontracts it to R&R partners. Core benefits such as CalFresh and CalWORKs cash aid are consistent across counties, though CalWORKs employment and training services differ based on local funding and partnerships.

B. PROGRAMS FOCUSED ON BLACK, INDIGENOUS, AND LATINO POPULATIONS

All three counties have implemented culturally tailored strategies to address inequities for historically marginalized families. Cross-county efforts include culturally specific home visiting and case management, group prenatal care for Black birthing parents, participatory program design, and enhanced language access.

C. PROGRAMS AT RISK OF LOSING FUNDING

Across counties, stakeholders interviewed as a part of this landscape study voiced significant concerns about the potential loss of funding for core health and social service programs. For example, stakeholders cited anticipated changes to eligibility for programs such as CalWORKs, CalFresh, and Medi-Cal, including questions about whether undocumented families will retain Medi-Cal access. Additionally, some wondered whether CalAIM reforms, such as Enhanced Care Management (ECM), would be sustained for high-need birth populations. These concerns reflect broader uncertainty about how state and federal budget decisions will affect access to essential supports for vulnerable communities.

D. STRENGTHS OF SYSTEMS

Across Alameda, Fresno, and Monterey Counties, stakeholders and parents identified strong community partnerships, coordinated service delivery, and a shared commitment to equity as key system strengths. Counties were praised for culturally responsive programs serving Black, Indigenous, Latino, immigrant, and disabled families, as well as for collaborative efforts that align services and elevate family voice. Parents highlighted WIC for its accessibility, supportive staff, and practical benefits, while system leaders cited Medi-Cal improvements under CalAIM as advancing maternal and infant health. In child care, Family Friend and Neighbor and Family Child Care Home providers were valued for their essential role, supported by Resource & Referral agencies that help families navigate and access services.

E. CHALLENGES OF SYSTEMS

Across Alameda, Fresno, and Monterey Counties, families and system leaders pointed to complex eligibility rules, administrative burdens, and fragmented systems as major barriers to accessing health, child care, and financial supports. Redundant documentation, long wait times, and staff turnover often disrupted benefits, while families called for more integrated digital enrollment tools. Community-based organizations were seen as essential partners, but often lack the administrative infrastructure needed to partner with county agencies. Coordination challenges, especially in data sharing and perinatal and mental health services, further hindered access. Additional barriers included language and immigration concerns, shortages in maternal and behavioral health care, and insufficient, unaffordable child care options.

COMPREHENSIVE CROSS-COUNTY LANDSCAPE FINDINGS

A. ORGANIZATION AND ADMINISTRATION OF EACH SYSTEM'S SERVICES

Across Alameda, Fresno, and Monterey Counties, health, child care, and financial programs are primarily administered by county social services agencies, with some responsibilities subcontracted to community partners. Variation in administration stems from California's realignment, which provides counties with flexibility in how programs are organized and delivered, often through a mix of subcontracted community-based partners, creating county-specific differences in how families access and navigate these systems. The following systems-specific sections describe these differences, with visual system maps for Alameda, Fresno, and Monterey Counties (see Appendix D) illustrating how programs are administered across agencies and partners.

Health Systems Administration:
Across counties, key health programs that support maternal, child, and family well-being share many structural similarities. CalWORKs Home Visiting, CalWORKs Family Stabilization, and Medi-Cal enrollment are all administered by each county's social services agency. Similarly, Early Start, which provides early intervention programs for children with developmental delays, is administered by Regional Centers. Maternal and child health programs, including SIDS Prevention, Home Visiting models such as Nurse Family Partnership and Healthy Families America, and the Black Infant Health Program, are primarily operated by county public health agencies, with local partners supporting implementation.

Some health programs differ due to administrative flexibility under realignment. For instance, the WIC program is administered differently in all three counties:

- In Alameda, WIC is delivered through both the Public Health Department and several FQHCs.
- In Monterey, WIC is managed solely by the Public Health Department.
- In Fresno, the program is administered by a local community action agency, Fresno EOC.

Child Care System Administration:
While all three counties manage early learning and child care supports through a mix of social services agencies and contracted community organizations, administrative responsibility varies most notably for CalWORKs and subsidized child care programs.

- CalWORKs Stage 1 Child Care is administered directly by social services in Fresno and Monterey, while Alameda contracts with Child Care Resource and Referral (R&R) agencies to manage Stage 1 services.
- CalWORKs Stages 2 and 3, along with the California Alternative Payment Program (CAPP), are administered by local R&R agencies and community partners in each county. In Alameda, the Social Services Agency receives the CAPP contract from the state and subcontracts it to R&R agencies, whereas in Fresno and Monterey Counties, both CAPP and CalWORKs Stages 2 and 3 flow directly from the state to local R&R and CBO partners.
- Early Head Start and related federal programs are operated through direct federal

contracts with local agencies that vary by county.

- Fresno County and Monterey County offer Migrant Seasonal Head Start.
- Fresno is the only county to offer Migrant Alternative Payment Program.

Financial Support:
Core benefits, such as CalFresh (SNAP), CalWORKs cash aid, and CalWORKs Homelessness Assistance Programs, are consistently administered by each county's social services agency, following statewide eligibility and benefit rules.

However, differences emerge in how counties structure supportive employment and training services under CalFresh Employment & Training (E&T) and CalWORKs Welfare-to-Work.

- Alameda County delivers E&T through a hybrid model that combines county-led services with contracts to community-based providers, offering job training and navigation support.
- Fresno County integrates E&T services through nonprofit partners and community initiatives, leveraging voluntary participation given its designation as a Labor Surplus Area.
- Monterey County administers E&T primarily through its Department of Social Services, coordinating referrals through the Workforce Development Board and other partners.

Counties also vary in local investment levels, with some using county funds or co-located service models to expand navigation, financial coaching, or short-term assistance. These investments influence families' experiences of timeliness, access, and support beyond the core benefit structure.

See the **Alameda County System Map**, **Fresno County System Map**, and **Monterey County System Map** for visual representations of health program administration, child care program administration, and financial support program administration.

B. PROGRAMS FOCUSED ON BLACK, INDIGENOUS, AND LATINO POPULATIONS

For this report, strategies are considered cross-county findings when they were described by stakeholders in at least two of the three focus counties — Alameda, Fresno, and Monterey. These efforts include culturally specific home visiting and case management, participatory program design and decision-making, tailored language and cultural supports, and group prenatal care models for Black birthing parents. The examples provided below are illustrative, not exhaustive, and are intended to highlight the range of approaches counties are using to advance equity and improve maternal, child, and family outcomes.

1. **Culturally specific home visiting and case management programs**
   In Alameda County, First 5 Alameda County partners with TLC Consulting, which provides community support groups to address inequities in lactation support and breastfeeding rates for Black mothers and birthing people. This entity also offers home visiting for Black parents needing additional lactation support. A tribal-serving health clinic similarly

provides home visiting and case management for Native families with children under age five.

In Fresno County, home visiting and family support services have been developed to reflect the needs of predominantly Latino communities. For example, the Family Connections program is embedded within a low-income, primarily Latino neighborhood to ensure services are culturally and geographically aligned with the community.

In Monterey County, the Maternal, Child, and Adolescent Health (MCAH) home visiting program prioritizes meeting clients where they are, both geographically and culturally. This includes providing navigation and advocacy support to ensure Indigenous clients receive appropriate interpretation during medical appointments. Parents also reported receiving culturally grounded support through the Parents as Teachers program, which offered bilingual home visits, parenting guidance, and essential supplies such as a crib, car seat, and high chair.

2. **Participatory program design and decision-making**
A common strategy across counties is the intentional inclusion of community members, particularly those with lived expertise, in program design and governance.

In Fresno County, the Early Matters Fresno initiative supports Network Improvement Communities that engage local residents in identifying challenges and shaping solutions.

In Alameda County, the Maternal, Child, and Adolescent Health (MCAH) unit has established a Steering Committee that includes parents currently or formerly enrolled in public health programs. This committee plays an active role in guiding initiatives and providing feedback to ensure services are relevant and effective. In addition, the Blue Skies: Mental Health and Wellness Team program, which provides mental health services for pregnant people and parents enrolled in home visiting programs, was developed in direct response to community feedback, including input from community-based organizations and advisory bodies that identified significant barriers to accessing mental health care.

3. **Tailored supports, including language access, for specific populations**
Across all three counties, programs have been designed to meet the cultural and linguistic needs of diverse communities.

In Alameda County, the Public Health Department is actively engaging the Pacific Islander community through efforts that build on the former Health Advancements for Pacific Islanders program, which focused on improving access to prenatal care and health insurance. The county is also developing a Spanish-language group prenatal care model designed for the Latino population.

In Fresno County, parents expressed deep appreciation for culturally and linguistically aligned programs, noting that services offered by organizations such as Centro Binacional Para el Desarrollo Indígena Oxaqueño, and the presence of staff who speak Mixteco or Spanish, made them feel understood and supported. Parents also highlighted the value of the Black Infant Health program, which provided sustained encouragement even after formal services ended, and praised the Celebrating Families parenting group, which included mental health sessions for parents and was offered through a CalWORKs referral.

In Monterey County, the Health Department uses interpreters and visual materials to make health information more accessible, and WIC parenting classes are offered in

Spanish to support Latina mothers with child development and nutrition education. Language access is a priority across the county, with 40% of children ages 0–5 served by First 5 Monterey County partners speaking an Indigenous language at home. In addition to language efforts, doula programs and the Maternal Mental Health Task Force are working to strengthen engagement with the Black community, though decision makers acknowledged that more intentional outreach is still needed.

4. **Group prenatal care models for Black birthing parents**
Both Alameda and Fresno Counties offer evidence-based group prenatal care models designed specifically for Black birthing parents.

   In Fresno County, First 5 Fresno County partners with a Black-led maternal health organization to deliver an adapted group prenatal care model. This program is culturally responsive and coordinated with county health initiatives that support Black parents, ensuring comprehensive and connected care throughout pregnancy and the postpartum period.

   In Alameda County, a community-based group prenatal care initiative offers culturally tailored support for Black birthing parents. The program was developed in direct response to disproportionately poor maternal and infant health outcomes among Black families in the county.

See Appendix E, County-Specific Landscape Findings, for additional county-specific programs focused on Black, Indigenous, and Latino populations.

C. PROGRAMS AT RISK

Across counties, system stakeholders expressed concern about changes to eligibility for public safety net programs and loss of funding. In Fresno and Monterey Counties, system decision makers expressed concerns about anticipated changes to program eligibility due to potential funding reductions affecting key entitlement programs, including CalWORKs, CalFresh, and Medi-Cal. In particular, decision makers questioned whether undocumented families would continue to have access to Medi-Cal coverage under emerging funding and policy shifts. There was also uncertainty about the sustainability of benefits introduced through CalAIM, California's Medi-Cal reform initiative, including the continuation of ECM services for high-need birth populations.

These concerns reflect broader anxieties about how evolving state and federal policies may impact access to critical health and social support for vulnerable communities. See Appendix E: County-Specific Landscape Findings for a summary of programs identified as at risk in each county.

D. STRENGTHS OF SYSTEMS

Across Alameda, Fresno, and Monterey Counties, decision makers and parents emphasized the strengths of the health, child care, and financial systems in meeting the needs of families with young children. The following surfaced as strengths across counties:

1. **Strong community partnerships and collaborative culture**
A collaborative approach enables stakeholders to collectively identify service gaps and develop coordinated responses. In Alameda County, leaders noted that system collaboratives play a vital role in elevating the voices of families, ensuring that individuals with lived expertise are included in decision-making and program improvement efforts. In

Fresno County, the Economic Opportunities Commission partners with a range of agencies to implement programs and offers a wide array of services directly to families. In addition, the Home Visiting Network allows for collaboration and coordination of home visiting services, and community clinics and school districts coordinate to refer families to services. In Monterey County, collaboratives such as the Central Coast Early Childhood Advocacy Network, Perinatal Task Force, and the Children's Council were noted as examples of collaborative efforts in system implementation. At the same time, decision makers acknowledged the need to balance collaboration with efficiency, as one Fresno leader pointed out the risk of duplicative efforts and stakeholder fatigue due to participation in multiple collaboratives.

2. **Coordination of services within the Departments of Social Services (DSS)**
In Fresno and Monterey Counties, service coordination within DSS was cited as a strength, with an emphasis on holistic, whole-family approaches to service delivery for families who qualify for multiple services administered by the agency. However, Fresno County system stakeholders noted challenges in establishing partnerships between DSS and key community-based organizations operating outside the agency, who have established trust in target communities and would impact access to key services for families with young children.

3. **Focus on historically marginalized communities, including people of color, immigrants, and people with disabilities**
System decision makers from all counties noted a commitment to design programs for specific populations, including those described in the Black, Indigenous, and Latino populations section listed above.

In Alameda County, hospitals and community health partners offer targeted programs that address the diverse needs of families and children. These include initiatives designed to support Black families with young children and comprehensive programs that provide medical and developmental care for children and adolescents with Down syndrome.

In Fresno County, there are several programs for children with disabilities, and system decision makers shared that the health system is focused on offering services for low-income and Black, Indigenous, and People of Color (BIPOC) communities.

One decision-maker from Monterey County noted the Health Department's focus on developing resources and programs designed specifically for different target populations, including Indigenous and Latino communities.

"I feel like they [Resource and Referral] understand how hard it is for parents to find daycare…As a single parent, I feel like they come up with different ways for us to excel."

Alameda County parent testimonial about BANANAS, a supportive organization, particularly for single or working parents.

4. **Vital support offered through WIC**
Parents across all three counties highlighted the value and support offered through WIC. It was frequently praised for having respectful staff and for providing crucial support to breastfeeding services and food access. Two parents from Alameda County described the helpful lactation support provided by WIC, including access to breast pump equipment, lactation counseling, and nutritional guidance. Parents noted the ease of the WIC App application process, with one parent appreciating the ability to track benefits, scan documents, and receive timely communication and reminders. Three out of five parents interviewed from Fresno County specifically highlighted WIC as the most helpful and accessible program, citing clear communication, supportive staff, and useful referrals and parenting classes. Four out of five parents interviewed from Monterey County reported receiving same-day approval for WIC services. They described the online application process as easy and efficient, highlighting the convenience of uploading required documents from home without needing to visit an office in-person.

5. **Medi-Cal enhancements under CalAIM**
System decision makers noted the importance of CalAIM (Medi-Cal Reform) benefits in providing wraparound services and filling gaps in access to health care. They highlighted the importance of ECM and the ability to leverage Medi-Cal billing for community health workers (CHWs) to provide home visiting to pregnant people and new parents. One interviewee shared that they have received positive feedback about the availability of the Dyadic Care Medi-Cal benefit, as it allows parents to ensure that their needs are met as they care for their children. Recent Medi-Cal policy enhancements for perinatal care also include extended Medi-Cal coverage to 12 months postpartum, improved payment for Medi-Cal providers, doula services, Birth Equity Population of Focus, and Community Supports.[34] However, one Fresno stakeholder noted that, for community-based organizations implementing CalAIM benefits, support is limited and the need for administrative coordination is significant.

6. **Family Friend and Neighbor (FFN) and Family Child Care Home (FCC) providers**
These providers, who often serve Latino and African American families and offer care during nontraditional hours, are recognized as essential contributors to the child care system. While they are seen as an essential part of the child care delivery system, the support for these providers and the number of FCCs is insufficient to meet the needs of families in each county.

THE ROLE OF CHILD CARE RESOURCE & REFERRAL AGENCIES

Resource and Referral agencies are charged with supporting families in understanding their child care options and selecting the care that works best for their family. They also support providers, including working with providers to obtain licensing, expanding the availability and support of FCC providers.

The support offered to families and providers was noted as a strength, particularly in Monterey County, where system decision makers also noted an increased awareness across sectors about the importance of child care to a thriving economy.

In addition to the strengths described above, maternal health initiatives, such as Maternal Child Adolescent Health (MCAH), Fetal Infant Mortality Review (FIMR), and Sudden Infant Death Syndrome (SIDS) programs, that are funded through both state and federal sources, were noted by system decision makers as initiatives designed to improve maternal health outcomes through coordinated policy efforts.

For additional detail, see Appendix E, County-Specific Landscape Findings, which highlights system strengths unique to each county.

E. CHALLENGES OF SYSTEMS

System leaders and parents shared challenges of the health, child care, and financial systems in meeting the needs of families with young children. The following challenges are present across counties and systems:

1. **Eligibility complexity and administrative burden**
   Parents across counties consistently described how complex eligibility rules, redundant documentation requirements, and administrative inefficiencies create barriers to accessing and sustaining benefits such as subsidized child care, Medi-Cal, CalWORKs, and CalFresh. This includes stringent residency verification, which particularly affects Indigenous, migrant, and housing-insecure families. A common frustration across all three counties was the need to resubmit the same documents, such as proof of income, residency, or pregnancy, often due to poor coordination, system errors, or miscommunication. Parents reported that these burdens, exacerbated by system errors and high caseworker staff turnover, caused stress, discouraged some from applying, and in some cases resulted in missed care or financial hardship during critical periods. System decision makers emphasized that these administrative burdens disproportionately impact families most in need.

> **"If you apply for WIC, for Medi-Cal, for whatever you applied for first, it would be easier for them to tell you in the same application what else you qualify for, what more help you could get, what more benefits ... because sometimes you don't know about certain benefits, without having to look for them or without having to make another application."**
>
> *Monterey County Parent explaining how she wishes the application process for benefits was integrated*

THE NEED FOR STREAMLINED APPLICATIONS FOR PUBLIC PROGRAMS

Parents across counties emphasized how the lack of integration and coordination during the application process often led to repeated storytelling, income verification, and multiple follow-ups to ensure services were maintained. The cumulative administrative burden sometimes led families to delay or abandon applications altogether.

In contrast, parents in all counties, especially Monterey, expressed appreciation for WIC's online document upload and phone-based application processes. In Fresno, parents appreciated Medi-Cal's online application. These tools made services more accessible and user-friendly, reducing the need for in-person visits and helping families navigate the system more easily. Online applications are particularly helpful given that in Fresno County, nearly two-thirds of calls to Medi-Cal result in being put on hold, 29% of calls are ended due to high call volume, and 50% have hold times of over 2 hours. In Alameda County, an even higher percentage (44%) of calls were ended due to high call volume.[35]

2. **Partnering with community-based organizations (CBOs)**
CBOs are viewed as critical partners in meeting the needs of historically underserved communities, due to their deep-rooted trust and cultural competence. However, systems decision makers across all three counties reported that these organizations often lack the funding and infrastructure necessary to scale their services. Administrative requirements of funders, as well as limited capacity to manage the complex application and reporting requirements associated with public funding sources, prevent many CBOs from accessing sustainable financial support and entering into effective partnerships with public agencies.

3. **Braiding funding sources**
In both Alameda and Fresno Counties, efforts to braid funding across programs have been hampered by incompatible reporting requirements and administrative complexity. In Fresno, systems decision makers expressed a desire to streamline multiple home visiting programs under a single, better-coordinated model, but were unable to do so due to constraints tied to disparate funding streams. A decision maker from Alameda County Public Health echoed this concern, noting that aligned or blended funding would reduce inefficiencies, but is currently difficult to achieve given the fragmented structure of fiscal and reporting systems.

4. **Coordination gaps**
Decision makers across counties emphasized the need for stronger coordination within the health care, child care, and financial support systems. The size and complexity of these systems, and the need for alignment in priorities and operations, present challenges. For example, Fresno County Public Health reported persistent barriers to data sharing with the Department of Social Services, as well as challenges in obtaining timely information from Medi-Cal managed care plans to coordinate outreach and services for pregnant and postpartum families. In Alameda, decision makers described the challenge of balancing day-to-day program implementation with the broader goal of systems change, noting that additional resources are needed to effectively manage both.

Hospitals often lack strong connections to community-based primary care providers and operate in silos, leading to inconsistent care and limited coordination among providers. These internal silos within the broader health care system make it difficult for families to navigate care and for providers to deliver it in a unified manner. Monterey County decision makers noted that coordination between perinatal mental health, doula services, and prenatal care providers could be strengthened for holistic coverage.

5. **Access to services for immigrant communities**
Decision makers across all three counties raised concerns about the accessibility of services for immigrant families, particularly those who are undocumented and in mixed-status households. Stakeholders described a prevalent climate of fear that discourages many families from seeking services, including providing personal information or data, due to concerns about exposure to immigration enforcement or other related risks. This fear further isolates families from support systems and contributes to the underutilization of critical health care, child care, and financial support programs. Additionally, stakeholders in Fresno and Monterey Counties noted a need for increased interpretation and access to in-language services for immigrant communities. Language access in key systems is a statewide issue, as noted in a statewide study on Medi-Cal call wait times, which found insufficient menu options available for languages other than English.[36]

6. **Insufficient access to maternal mental health and behavioral health services**
System decision makers and stakeholders in Alameda and Monterey Counties noted capacity challenges in mental and behavioral health services. Accessing perinatal mental health services is challenging, as the health system tends to focus on chronic and severe mental health issues. Those with perinatal mental health challenges, such as postpartum depression, have a hard time accessing support. Blue Skies, the primary maternal mental health initiative within the Alameda County Public Health Department, was developed in response to the difficulty of referring clients to external mental health providers. However, access to this program is limited to individuals already enrolled in another county program, and overall capacity continues to fall short of community need.

   Monterey County is facing a shortage of mental and behavioral health professionals. In Behavioral Health, there are several very qualified providers; however, many skilled staff are retiring or leaving, presenting a need to increase the number of skilled behavioral and mental health providers in the county.

   Further, both Fresno and Monterey Counties are considered Health Professional Shortage Areas for child and adolescent psychiatrists, with only 10 psychiatrists per 100,000 children.[37] System stakeholders also noted that there is a need for more providers who accept Medi-Cal and other forms of insurance, especially in behavioral health.

PARENT EMOTIONAL AND MENTAL HEALTH NEEDS

Multiple parents described needing emotional support during postpartum recovery or after fleeing domestic violence. One parent in Fresno County described receiving support from the Marjaree Mason Center to escape domestic violence, including therapy, parenting classes, and safety group meetings. Parenting groups, therapy, and community referrals are seen as critical to emotional healing.

7. **Gaps in outreach and awareness**
System decision makers and parents in Fresno and Alameda counties emphasized the need for increased communication and outreach to raise awareness of available programs and services. Parents from Fresno County expressed interest in receiving information through modern outreach channels, such as social media advertising. One parent noted a lack of accessible public information on eligibility criteria and the application process. This aligns with statewide findings that Medi-Cal members do not understand the benefits and services available to them during pregnancy and postpartum.[38]

8. **Data sharing between different agencies/programs in the same system**
System stakeholders in Monterey and Alameda counties emphasized that restrictive information-sharing policies and complex data systems impede effective collaboration within systems. One system decision maker shared, *"Most of these data systems do not belong solely to the County of Monterey… They are state systems. So there are policies around who can have access to data in that sense. And then, because there are so many different data systems… it's very hard to match the data between those different data systems."*

9. **The need for in-person offices and extended hours of support**
Parents in both Monterey and Fresno emphasized the continued need for more physical office locations. For some families, technology is a barrier to accessing services. Long wait times and limited in-person access created additional barriers for those who preferred or required face-to-face assistance to complete applications, ask questions, or receive timely support. In addition, system stakeholders note that services are not offered at hours that work for working parents.

10. **Child care access and affordability**
Access to child care remains a significant challenge for families in all counties. Systems decision makers noted that, due to limited availability and affordability, it is common for siblings or extended family members to provide care. In addition, insufficient wages for providers are a challenge in building a workforce. In Fresno County, the Central Valley Children's Services Network shared that this dynamic underscores the critical need for additional support for FFN care providers. While these caregivers often share cultural and linguistic backgrounds with the families they serve, an asset in delivering culturally and linguistically competent care, they frequently lack access to early childhood development resources and professional support.

    In Alameda County, there is a substantial unmet need for child care vouchers, with only 10% of eligible families with infants and toddlers receiving vouchers. In Monterey County, there are only enough licensed child care spaces for about one quarter of children ages 0-5, and most children who qualify for subsidized care are not able to access it.[39] In Fresno County, only 9% of eligible children are enrolled in subsidized child care.[40]

    In addition to insufficient numbers of providers and subsidized care, another challenge with accessing child care is that many families need child care during nontraditional hours due to inconsistent or nontraditional work schedules. Existing providers have a hard time meeting these needs, leaving families without critical care for their children.

For additional detail, see Appendix E, County-Specific Landscape Findings, which highlights system challenges unique to each county.

SYSTEMS SUMMARY: STRENGTHS AND CHALLENGES EXPERIENCED WITHIN & ACROSS COUNTIES

As demonstrated in the preceding two sections, system strengths and challenges often overlap. For example, Monterey County identified its commitment to building mental health capacity across sectors as a strength; yet, families continue to experience limited access to mental health services due to provider shortages. In addition, family child care programs are viewed as a strength, yet families continue to face long waitlists and limited availability, underscoring how progress in one area can coexist with persistent barriers in another. The findings should be considered with the understanding that system-building work is highly complex and nuanced.

"I had to apply for everything; nothing was automatic... A separate application has to be submitted for each one. I had to provide my information multiple times for each program, sometimes because some of the benefits can't always be received, and they want more information... It was challenging to have transportation to go to the places to apply for the programs. Sometimes we go to apply and it's not done correctly, and then we have to go back to do it again, like for Medi-Cal or any documents from the Department of Social Services that they ask for, looking for transportation to find someone to help me fill out the forms... It was all confusing, you have to go back and forth many times, and we don't have a car to go... I tried to transfer my Medi-Cal benefits from San Luis Obispo County to Fresno County. I went again to the Social Services office in Paso Robles to make the change, but it couldn't be done. I had to apply for Medi-Cal again in Fresno County. I'm still not sure if my case has been transferred. It took about 30-60 days for the case to transfer to Fresno County. But when we went to Selma [DSS], they said our case still hadn't been transferred. I'm still not sure if my case was transferred, but since I've tried going to the doctor and they haven't charged me, I think maybe it has."

Parent interview, Fresno County

CROSS-SYSTEM COLLABORATION: APPROACHES & CHALLENGES

This section examines how Alameda, Fresno, and Monterey Counties coordinate health, child care, and financial support systems to better serve families with young children. The summary below highlights key themes, with additional detail provided in the subsections that follow.

SUMMARY: CROSS-SYSTEM EXPERIENCES

- **Collective Impact and Cross-Sector Partnerships Supporting Families Across Systems:** Counties are implementing collective impact initiatives, cross-sector partnerships, and data-sharing pilots to improve coordination and align services.
- **Barriers to Collaboration:** Persistent challenges include restrictive data-sharing policies, complex funding requirements, limited staff capacity, and insufficient representation of people with lived expertise in decision-making.
- **Family Experiences:** Parents reported fragmented services, disruptions when moving between counties, and housing and transportation barriers that complicate access across multiple systems.
- **Role of Community-Based Organizations:** CBOs serve as trusted connectors and provide critical care coordination and home visiting services, helping families navigate complex systems, access essential resources, and build relationships with providers in ways that are culturally and linguistically responsive.

A. COLLECTIVE IMPACT AND CROSS-SECTOR PARTNERSHIPS SUPPORTING FAMILIES ACROSS SYSTEMS

Across Alameda, Fresno, and Monterey counties, system leaders are implementing strategies to align services across systems to better support families with young children:

1. **Collective impact initiatives supporting families across systems**
   Examples of those include the following:

   Alameda
   Pre-5 Collaborative works to address the holistic needs of families by fostering agency collaboration and systems thinking. Participants explore how decisions in one agency may unintentionally affect families involved with other systems and are developing a shared electronic health record framework that incorporates social determinants of health.

   Fresno
   Early Matters Fresno is a collective impact initiative addressing early childhood needs through multiple strategic efforts. One component, the Community Information Exchange, facilitates early childhood data sharing among home visiting providers. Another, Network Improvement Communities, creatively leverages community school funding to serve children ages 0-3 by connecting local schools with community-based organizations.

   Monterey
   The Maternal Mental Health Task Force supports early childhood educators by building

capacity around maternal health topics. This task force includes early childhood providers, behavioral health professionals, and community-based organizations working together to ensure providers can better support families' mental health needs.

2. **Cross-sector partnerships to meet the needs of different populations, including pregnant and postpartum parents, young children, and children with special needs**
System decision makers noted specific partnerships that are helping to bridge systems. For example, in Monterey County, the Department of Social Services has established a partnership with WIC to facilitate a warm handoff and streamline services for families. There is also a growing partnership between County Behavioral Health and the County Office of Education.

   In Alameda County, when Public Health was conducting the maternal and child health (MCH) needs assessment, they engaged the Pre-5 collaborative as well as other cross-sector groups. Through those partnerships, Public Health was able to identify meaningful gaps in the system. As a result, they are focusing on building adolescent health resources and resources for children with special health care needs.

   In Fresno, Central Valley Children's Services Network, the Child Care Resource & Referral agency and administrator of Alternative Payment Program, partnered with Exceptional Parents Unlimited (EPU) and Central Valley Regional Center (CVRC) to support children with special needs. In addition, Head Start partners with the Fresno Unified School District, which helps provide wraparound services for children.

   For additional examples, see Appendix E, County-Specific Landscape Findings, which highlights collective impact efforts and cross-sector partnerships that support families across systems in each county.

B. BARRIERS TO CROSS-SYSTEM COLLABORATION FACED BY SYSTEM DECISION MAKERS

System decision makers highlighted significant barriers to cross-system collaboration. The following highlights challenges faced across counties:

1. **Challenges with cross-system communication and data sharing**
Stakeholders shared that restrictive data-sharing policies and incompatible data systems often hinder effective collaboration between agencies. Even when information sharing is permitted, agencies frequently use different data collection methods and definitions, creating practical challenges in aligning or integrating information. One interviewee described the situation as "systems speaking different languages even if the goals are the same."

   Beyond data challenges, systems decision makers shared that systems and agencies often operate within silos, making it difficult to collaborate across systems. One interviewee acknowledged that the systems are hundreds of years old, and to undo the system structures is very difficult, even when operating from within the system.

2. **Funding requirements and bureaucratic hurdles**
While braiding multiple funding sources is often necessary for cross-system coordination of services, it introduces intensive administrative burdens and challenges. Additionally,

limited flexibility in categorical funding impedes agencies' ability to act responsively and to use existing funding to support innovative programs or initiatives.

Bureaucratic hurdles and internal county processes also pose significant barriers. For example, Fresno County Public Health representatives noted that internal policies require multiple layers of approval before subcontracting with external agencies can proceed. These administrative delays are particularly challenging when a rapid response or collaboration with multiple agencies is needed to meet community needs. The requirement to conduct a Request for Proposals (RFP) process, which usually takes three to nine months, can outlast the available funding window, jeopardizing program compliance with funding requirements.

3. **Limited staff capacity and turnover**
Interviewees across all counties noted limited capacity to collaborate across systems. For example, one agency may be going through a leadership change or focusing on hiring new staff, which requires time and focus that otherwise might be spent on collaboration. One interviewee noted that participation in cross-county collaboration is not funded work. Leaders choose to engage in this work because they understand it to be important, but it is often done on their own time and on top of their other daily responsibilities. Agency staff, already stretched thin, often lack the time or infrastructure to engage meaningfully in collaborative efforts. Interviewees stressed the need for dedicated resources, training, and long-term investment to build the capacity required for sustainable cross-system work.

4. **Lack of decision-making power for people with lived expertise**
System decision makers in Alameda and Monterey Counties observed that community members with direct experience of public systems are often underrepresented at decision-making tables. Although Alameda County has made progress in elevating community voices (see System Strengths), most systems continue to operate without consistently sharing decision-making power with those most affected. Increasing the influence of parents and community members would help ensure that decisions prioritize the needs of families navigating these systems rather than reinforcing existing institutional priorities.

In addition, system decision makers in Monterey County noted that power dynamics, a lack of a shared belief in race being at the core of the inequities, and not centering healing-centered approaches are also barriers to cross-system collaboration.

C. EXPERIENCES OF FAMILIES NAVIGATING ACROSS SYSTEMS

In the Challenges of Systems section above, the discussion primarily highlights decision makers' and parents' experiences within individual systems. For families navigating multiple systems simultaneously, these challenges do not exist in isolation; rather, they layer on top of one another, compounding barriers and making it even more difficult to secure consistent support.

Parents shared the following experiences specific to accessing services across systems:

1. **Service fragmentation and lack of coordination across programs**
Parents consistently reported challenges stemming from fragmented service systems and a lack of coordination across programs. Many described the burden of submitting separate applications and documentation for each service, such as WIC, Medi-Cal, and CalWORKs,

even when those services were housed in the same physical location. Data was not shared between programs, and staff did not appear to communicate across departments or agencies. This siloed approach created significant obstacles, particularly for families facing time constraints, limited access to transportation, or language and literacy barriers. These experiences highlight the impact of the challenges with cross-system communication and data sharing described by system decision makers in the Barriers to Cross-System Collaboration Faced by System Leaders section above.

THE NEED FOR STREAMLINED SERVICES

Parents in Alameda County expressed a strong desire for more streamlined and coordinated service delivery. Specifically, they recommended that agencies offer in-person, one-stop services where multiple benefits could be applied for and processed during a single visit. This approach, they noted, would provide immediate clarity and peace of mind, reducing the stress of navigating multiple systems separately.

2. **Housing instability**

In Alameda, Fresno, and Monterey Counties, parents commonly raised housing instability as a barrier to health and well-being. Some lived in unsafe or overcrowded conditions, while others were on long waitlists or struggled to qualify for subsidies. Housing needs often intersect with transportation and access to services, and create added stress during pregnancy. This is a widespread issue across counties, with the rates of rent-burdened households reaching 49%, 54%, and 55% in Alameda, Fresno, and Monterey counties, respectively.[41]

Parents in Alameda also described challenges navigating housing assistance:

"Well, I did always try to apply for Section 8, like over and over again, but I never got it. [I] never got any low-income housing, anything to that nature. I mean, I pretty much [have] always lived paycheck to paycheck." - Alameda County parent

"I feel like they put you on the list…you get on the list and then you don't get an update until like maybe a year or two later. I need these services right now. So I feel like [there] is delayed time of receiving the services for housing." - Alameda County parent

3. **County-to-county moves and disrupted services**

Of the fifteen parents interviewed across the three counties, four reported moving to a different county during pregnancy or shortly after giving birth. T**hree of these four parents experienced delays or disruptions in accessing public services, most notably Medi-Cal, following the move.** In two cases, one parent who moved from San Mateo County to Alameda County and another who moved from San Luis Obispo to Fresno went without coverage for two months of pregnancy. One had to completely reapply, and the other had to attend a hearing to reinstate benefits, despite remaining eligible.

These experiences highlight the administrative complexity that can occur under California's realignment structure, in which counties are responsible for program administration and may have differing processes and systems. Parents described frozen accounts, delayed re-enrollment, and missed prenatal care as impacts of these county-to-

county transfers. One parent who moved received navigation support from a community-based organization and was able to complete the transfer more quickly, suggesting that additional navigation support and clearer transfer procedures could help promote continuity of care for mobile families.

4. **Transportation and distance to services**
Transportation challenges were particularly acute in both Fresno and Monterey Counties, where **three parents out of five interviewed in each county described difficulties traveling to and from in-person service locations.** These experiences underscored the need for more accessible and community-centered service delivery. They expressed a preference for having services brought directly to neighborhoods, such as through local resource centers, rather than needing to travel long distances and wait at central offices like the county welfare office. They also suggested expanding virtual service options, including online meetings, to reduce transportation barriers and improve convenience.

One Fresno parent explained how even short distances became burdensome when relying on public transportation:

"The transportation - just getting to the appointment for me to turn in the papers [for] my CalWORKs. [The bus] usually charges us a dollar…so it's not that much. The only thing is the travel. It takes a while. If I were to get to my CalWORKs [office], it's like a 15-minute drive, but with the bus it's like 1 hour and 30 minutes since it has a lot of stops." – Fresno County parent

D. ROLE OF COMMUNITY-BASED ORGANIZATIONS IN SUPPORTING SYSTEM NAVIGATION

Community-based organizations (CBOs) play a vital role in helping families navigate complex health, child care, and financial support systems. Across all three counties, stakeholders described the role of CBOs as trusted connectors and critical for care coordination.

1. **Trusted organizations.**
CBOs are seen as trusted entities with deep-rooted relationships in the communities they serve, including among Black, Indigenous, and Latino populations. Their cultural competence and close community ties position them as effective connectors between families and public systems.

Government agencies frequently partner with CBOs to reach families more effectively. These partnerships are viewed as crucial for ensuring that services are responsive to community needs, particularly when public systems may be perceived as bureaucratic or inaccessible. By leveraging the relationships and cultural knowledge that CBOs bring, government partners can extend their reach and improve service coordination and delivery. However, as noted in the "Challenges of Systems" section, while government partnering with CBOs is desired, it is not always possible due to the limited administrative infrastructure of CBOs and the challenges in

navigating the often complex and bureaucratic partnership development process.

In Fresno, two large CBOs, Central Valley Children's Services Network (CVCSN) and the EOC, underscored the importance of warm handoffs and ongoing trust-building with public agencies. They developed strong relationships with public programs, enabling them to refer families effectively when their needs exceeded the services offered by their own organizations.

2. **Care coordination.**
CBOs provide critical navigation services. Home visitors contribute significantly to system navigation by offering direct, in-home support that connects families to needed services. The Fresno County Department of Public Health collaborates with numerous CBOs to provide non-clinical home visitation services, particularly for families who do not require a public health nurse. These partnerships are operationalized through initiatives such as the HOPE Pathways Community Hub, a home visiting program, which is managed by the Fresno Community Health Improvement Partnership and leverages community health workers to connect families to a wide range of supports, including medical, food, and mental health services.

First 5 Monterey County shared that care coordinators, navigators, or connectors are essential in supporting families through complicated processes. While funding is limited for this type of support, these individuals provide critical guidance and advocacy as families move through various systems, including health, early education, and social services.

THE ROLE OF FAMILY RESOURCE CENTERS (FRCS) IN MONTEREY COUNTY

FRCs were highlighted as a key access point for families to receive direct services and referrals to broader supports. According to the Monterey County Health Department, most school districts in the county operate an FRC or similar hub. These centers serve as community anchors, helping families connect to services, particularly those with children ages 0-3 and school-aged children. In addition to providing basic resources, FRCs often host office hours for staff from other public agencies. For example, health department staff are available at select FRC locations, allowing families to access public health services within their neighborhoods and reducing transportation or scheduling barriers. The Mexican American Opportunity Foundation (MAOF) also highlighted the importance of FRCs, sharing that some families bring their documents to these centers for assistance with service applications, including child care enrollment. While MAOF offers this support with applications as well, they noted that FRCs have established trusted relationships, resulting in community members leveraging their support in this area.

Section 5

Parent Recommendations for System Strengthening

Across all three counties, parents pointed to clear opportunities to strengthen system supports for families during pregnancy, birth, and early parenthood. These recommendations emerged from discussion questions that asked parents to imagine changes from their perspective. For example, "If you were in charge, what do you think would be an ideal way to receive the services you needed?" and "If you could wave a magic wand and change one thing to make this process easier or better for families like yours, what would it be?"

Their responses generated the following recommendations:

1. **Develop Community-Based Eligibility Hubs**
   Parents consistently described public systems as fragmented and duplicative, making it difficult to access multiple benefits at once. They recommended creating neighborhood-based hubs where families can access multiple programs in one location. These hubs would allow families to apply for benefits across systems (health, child care, and financial) in a single visit, reducing administrative burden, minimizing missed benefits, and improving trust by offering face-to-face support in convenient, community-centered settings.

2. **Invest in Technology to Streamline Eligibility and Verification**
   Parents emphasized the need for digital solutions, such as apps modeled after WIC's user-friendly platform, that would allow families to submit common eligibility documentation (e.g., proof of income, residency) once and have it accepted across all public programs. Such tools would improve efficiency, reduce duplicative paperwork, and provide families with timely updates on application status.

3. **Enhance Communication and Caseworker Responsiveness**
   Timely, consistent communication was described as essential to sustaining benefits. Parents cited long wait times, unresponsive caseworkers, and unclear information about eligibility as major barriers. They recommended proactive follow-up, direct lines to caseworkers, and real-time updates through phone calls or text messaging.

4. **Embed Service Referrals Earlier, Beginning in Pregnancy**
   Parents expressed a strong desire for services and information to be introduced earlier, ideally during pregnancy rather than postpartum. Many reported missing support because they learned about programs only after their child was born. Embedding referrals and enrollment support into prenatal care visits and hospital discharge processes was a priority recommendation.

5. **Advocate for More Realistic Eligibility and Documentation Requirements**
   Parents noted that current income thresholds, time limits, and documentation requirements often do not reflect the true cost of living or the realities of raising young

children. They recommended revisiting eligibility rules and streamlining documentation processes to make services more inclusive and accessible for families who are struggling financially but whose income may be just over program cutoffs.

6. **Fund Flexible, Family-Centered Service Models**
Parents emphasized the need for service delivery models that accommodate their schedules, transportation challenges, and caregiving responsibilities. This includes extending service hours beyond standard business times, co-locating services where possible, and providing supports like transportation assistance or virtual options to make participation feasible for working families.

7. **Expand Culturally and Linguistically Responsive Services**
Language access and cultural relevance were described as critical to equitable service delivery, particularly for Spanish- and Mixteco-speaking families in Fresno and Monterey Counties. Parents emphasized the need for more bilingual and Indigenous-language staff, as well as culturally grounded approaches that reflect the values and lived expertise of the communities served.

Section 6

Stakeholder Recommendations for Philanthropy

In interviews, system decision makers were asked to describe how philanthropy could help improve maternal and child health outcomes in their county. Specifically, they were asked: The David and Lucile Packard Foundation is using this landscape assessment to inform investments over the next nine years. Given your experience, what would you recommend they consider to improve maternal and child health outcomes, particularly for Black, Indigenous, and Latino families?

Their responses generated the following recommendations:

CROSS-COUNTY

1. **Build System and Community Capacity for Cross-Sector Collaboration**
Philanthropy can play a catalytic role in strengthening the capacity of both systems and communities to work together toward shared goals. Investments should focus on:
    - Creating Spaces for Collaboration: Fund convenings and collaborative infrastructure where leaders, agencies, and community-based organizations can align priorities, share data, and co-create solutions.
    - Supporting Dedicated Staff Time: Provide resources for system and community leaders to engage in cross-system work without sacrificing their core responsibilities.
    - Investing in Training and Skill-Building: Support capacity-building in facilitation, participatory process design, data system development, and equity-centered leadership.
    - Resourcing Community Participation: Offer stipends, leadership development opportunities, and facilitation support to ensure that those most impacted by systems, families, service providers, and grassroots leaders, can meaningfully shape decisions.

2. **Support Community-Based Organizations (CBOs) to Expand Capacity**
Provide flexible, multi-year funding for CBOs so they can:
    - Maintain and expand culturally responsive direct services.
    - Participate fully in systems-change initiatives.

3. **Fund Targeted Research and Parent Outreach**
Invest in outreach campaigns and research that help systems better understand and serve under-reached populations. For example:
    - Research to understand the needs of growing Indigenous communities.
    - Designing outreach campaigns for populations with emerging poor birth outcomes (e.g., Filipino communities in Alameda County) and underenrolled programs like Black Infant Health.

4. **Protect and Sustain Critical Programs at Risk of Funding Loss**
Stakeholders expressed concern about losing key programs due to time-limited grants and expected federal and state funding reductions. Philanthropy can:

   - Fill Gaps Left by State Funding Changes: Support programs affected by reductions, such as those tied to Proposition 1 Behavioral Health Services Act (BHSA) funding, for example Monterey's Infant-Family and Early Childhood Mental Health Training Program (BHSA-funded).
   - Stabilize Proven Local Programs: Provide stopgap funding for programs with demonstrated impact that face uncertain futures, such as Alameda County's EmbraceHer program (Healthy Start grant).

5. **Invest in Child Care Access for Children Ages 0–3**
Expand the availability of infant and toddler care by:

   - Supporting family child care providers to offer care during nontraditional hours.
   - Funding training, start-up costs, and facility improvements to increase the number of licensed providers.

6. **Sustain and Scale Guaranteed Income Programs**
Philanthropy can play a key role in expanding guaranteed income programs that stabilize families and reduce trade-offs between basic needs. Foundations are uniquely positioned to:

   - Fund pilots that demonstrate the impact of guaranteed income on family stability Support counties and partners in seeking waivers or policy clarifications so participation does not interfere with eligibility for public programs.
   - Partner with counties to align guaranteed income efforts with other family support programs.

RECOMMENDED APPROACHES FOR PHILANTHROPY

In addition to the priority investment areas listed above, stakeholders emphasized several approaches that are essential for ensuring long-term impact:

1. **Build Trust and Take a Long-Term View.**
Recognize that relationship-building and systems-change work take time and require sustained funding commitments.

2. **Use Data to Inform Investments.**
Partner with counties and CBOs to analyze data, identify priority populations, and measure progress over time.

3. **Build on Existing Collaborations and Investments.**
Rather than creating new structures and initiative-specific collaboration tables, philanthropy can maximize impact by strengthening and scaling existing cross-system

initiatives that already have community buy-in and demonstrated momentum. Examples include:

- **Alameda County:** The Pre-5 Collaborative and Oakland Starting Smart and Strong, which convene cross-sector partners to identify system gaps, address disparities, and advance early childhood equity.
- **Fresno County:** Early Matters Fresno and the Community Information Exchange, which coordinate home visiting services and improve data sharing across systems.
- **Monterey County:** Bright Beginnings Early Childhood Initiative and the Maternal Mental Health Task Force, which align stakeholders around prenatal-to-early-childhood goals and build capacity to support family mental health needs.

COUNTY-SPECIFIC RECOMMENDATIONS

Alameda County
All system decision maker recommendations are captured above.

Fresno County
In addition to the cross-county recommendations above, the following recommendations were made specific to Fresno County:

- **Support Case Management and Home Visiting.**
  Acknowledging the impact that these programs have on participants, one decision maker raised a need for additional investment to expand these programs, including evidence-based short- and long-term home visiting.

Monterey County
In addition to the cross-county recommendations above, the following recommendations were made specific to Monterey County:

- **Increase the number of service providers and build provider capacity, including cultural responsiveness skills.**
  Interviewees in Monterey County noted a need for additional health and child care service providers to meet community needs. One decision maker noted a need to build a health care provider pipeline, where providers can pursue a career pathway from high school to college and beyond, resulting in more providers who are known and trusted in the community. In addition, there is a need to build the capacity of providers, including offering services in multiple languages and in a culturally responsive manner.

Section 7

Conclusion

The The David and Lucile Packard Foundation's Children and Families Initiative comes at a pivotal moment, as communities across California work to strengthen maternal health, early childhood development, and family well-being. Findings from this landscape assessment underscore both the promise and the challenges of building more equitable systems of care.

System stakeholders emphasized the difficulty of collaborating effectively across agencies and organizations due to outdated agency and program level data systems and limited ability to share information, underscoring the need for more coordinated, family-centered approaches. Parents interviewed across all three counties echoed these concerns, describing siloed and antiquated public benefit systems and interruptions in services when moving from one California county to another.

Statewide efforts such as the Birthing Care Pathway and the Transforming Maternal Health Model demonstrate a growing commitment to improving maternal and child health outcomes. Nevertheless, this report was developed during a time of significant uncertainty due to ongoing shifts in the federal funding and policy landscape. Meeting the needs of families across Alameda, Fresno, and Monterey Counties will require ongoing assessment of the landscape and discussion with communities. Insights in this report serve as a starting point for coordinated, community-driven solutions that reduce disparities and create healthier futures for children and families.

Section 8

Acknowledgments

VIVA Social Impact Partners extends sincere gratitude to the David and Lucile Packard Foundation for funding this project, and to Katie Harkin, Children and Families Program Officer, for her vision, guidance, and steadfast commitment to supporting birthing mothers, expectant parents, and young children. Their leadership and investment were instrumental in shaping this work.

Appreciation is also extended to the Design Team, comprised of system leaders from the health, child care, and financial support sectors across Alameda, Fresno, and Monterey Counties. The Design Team played a central role in refining research questions and methods, developing the Assessment Plan, and remaining actively engaged throughout the process. Their insight and collaboration ensured that this report reflects the realities of local systems and provides a strong foundation for collective action.

This project also benefited from the perspectives of numerous community-based organization leaders and public agency representatives who participated in interviews and provided valuable context about service delivery, partnerships, and opportunities for improvement. Their contributions helped illuminate both the strengths and challenges within and across county systems.

VIVA is especially grateful to the fifteen parents who generously shared their time and experiences for this report. Through in-depth interviews, they offered thoughtful reflections on the health, child care, and financial support systems, as well as their hopes and ideas for the future. The strength of the findings and recommendations reflects their depth of experience and lived expertise.

The project team at VIVA feels both humbled and proud to have contributed to such an important effort. We look forward to following the developments in each county.

SUGGESTED CITATION

VIVA Social Impact Partners. Maternal and Child Health Systems Landscape: A Three-County Study in California. The David and Lucile Packard Foundation. November 2025.

ABOUT VIVA SOCIAL IMPACT PARTNERS

VIVA Social Impact Partners is a woman-owned consulting firm dedicated to strengthening early childhood, maternal health, and family well-being systems through research, strategic planning, community engagement, systems design, impact measurement, and communications. Since 2011, VIVA has partnered with counties, foundations, public agencies, and statewide initiatives across California and the U.S. to design more equitable, coordinated, and community-centered systems.

VIVA's approach integrates multi-method research, cross-system mapping, strategic facilitation, and lived-experience insights to illuminate how programs function on the ground and where systems can improve. We combine rigorous analysis with community engagement and equity-centered design, ensuring that strategies are informed by data, shaped by community voice, and communicated through compelling narratives that inspire action.

To move findings into sustained change, VIVA partners with clients from design through implementation, supporting collaborative planning, strengthening systems for greater equity and effectiveness, measuring impact, and developing communications that help partners tell their story and mobilize support.

Learn more at www.vivasocialimpact.com.

APPENDIX

The appendix includes supplemental materials that provide additional context and detail to support the findings of this report. It is organized as follows:

A. Methodology: Outlines the mixed-methods approach used to conduct the landscape assessment and details how these methods informed a comprehensive analysis of maternal and child health systems across Alameda, Fresno, and Monterey Counties.

B. Maternal & Infant Health Outcomes Table: County-level data highlighting key indicators of maternal and infant health.

C. Parent Interview Summary Report: A synthesis of themes and perspectives gathered through parent interviews across the three counties.

D. System Maps: Visual representations of the health, child care, and financial service systems in each county. The system maps are included as links to an external interactive interface. These Include:

a. Alameda County System Map
b. Fresno County System Map
c. Monterey County System Map

D. Comprehensive County-Specific Landscape Findings: Presents detailed findings for Alameda, Fresno, and Monterey Counties, organized by key themes to highlight local system strengths, challenges, and culturally responsive efforts, offering deeper insight into how maternal and child health systems operate within each county context.

APPENDIX A: METHODOLOGY

VIVA conducted this landscape assessment using a multifaceted approach, including co-creation with a Design Team, desk research, interviews, and other engagement with county-level systems leaders, parent interviews, and county-specific sensemaking meetings with local stakeholders.

1. Design Team

The Design Team included system leaders from all three sectors (health, child care, and financial support) with representation across the three counties. Their participation in the planning process included meetings and correspondence to review and refine the landscape research questions and methods, ultimately resulting in a finalized Assessment Plan. The Design Team was actively engaged throughout the research process, offering feedback, recommending interview participants or intermediaries, and participating in interviews themselves. This included reviewing and providing feedback on the accuracy of system maps for each county, identification of program funding sources, and other content areas included in this report. Organizations represented in the Design Team are noted in the table below:

County	Design Team Members
Alameda	Noha Aboelata, MD - Founding Chief Executive Officer, Roots Community Health Anna Gruver - Family Health Services Division Director, Alameda County Public Health Department Kym Johnson - Chief Executive Officer, BANANAS, Inc.
Fresno	Shantay R. Davies-Balch - Chief Executive Officer & President, BLACK Wellness & Prosperity Center Matilda Soria, EdD - Executive Director, Child and Family Success, Fresno County Superintendent of Schools Kendra Devejian – Chief Executive Officer, Heartland Compass
Monterey	Erika Librado – Programs Manager, Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) Francine Rodd – Executive Director, First 5 Monterey County Lori Medina – Retired, Director, Monterey County Department of Social Services

2. Desk Research

VIVA began documenting system structures through in-depth desk research, focusing on key programs within the health, child care, and financial support systems across Alameda, Fresno, and Monterey Counties. The research prioritized programs related to maternal and child health that are funded by state or federal sources. This included gathering information on program descriptions, eligibility criteria, administering agencies, and funding streams.

The findings were reviewed by the Design Team and other system decision makers and were used

to develop system maps for each county that highlight key programs, lead agencies, and funding sources (see Appendices B–D).

In addition, VIVA conducted desk research to review related reports, datasets, and indicators of maternal and child health outcomes in each county.

3. Engagement with System Decision Makers

In addition, a total of fifteen system decision makers representing health, financial support, and child care systems across the three counties were interviewed to provide insight into the existing systems' and cross-system strengths, challenges, and opportunities. Decision makers were identified through collaboration with Design Team members, who recommended local leaders and organizations with deep expertise and active involvement in their respective systems, ensuring that the perspectives gathered were both informed and representative. Outreach and coordination were led by VIVA Social Impact Partners with the support of Design Team members from each county, who referred selected representatives from their county. Interviews took place from March to June 2025, each lasting 45-90 minutes. See below for a table of interviews conducted.

In addition to the formal interviews, several decision makers were consulted through email and phone to provide supplemental information and ongoing feedback throughout the research process.

County	Number of interviews	Agencies Represented by Interviewees
Alameda	4	Alameda County Social Services Agency, Department of Children and Family Services Alameda County Public Health Department, Family Health Services BANANAS First 5 Alameda County
Fresno	6	Central Valley Children's Services Network County of Fresno Department of Public Health, Maternal Child and Adolescent Health First 5 Fresno County Fresno County Department of Social Services, CALWORKS Fresno Economic Opportunities Commission
Monterey	5	First 5 Monterey County Mexican American Opportunity Foundation Monterey County Department of Social Services Monterey County Health Department, Home Visiting Programs

4. Parent Interviews

Parent interviews were conducted across Fresno, Monterey, and Alameda Counties between March and April 2025 to gather firsthand perspectives on navigating health, child care, and financial support systems. A total of fifteen interviews were completed, five in each county. Participants were selected based on specific eligibility criteria aligned with the focus of the landscape assessment to ensure that the perspectives gathered reflected the experiences of the families and communities with direct experience with the systems being studied.

Eligible participants met the following criteria:

1. Were birthing parents of children from birth up to age three.
2. Resided in Fresno, Monterey, or Alameda County.
3. Identified as Black, Indigenous, and/or Latino.
4. Were fluent in English, Spanish, or an Indigenous language.
5. Had accessed services from at least two of the following systems.
    - Health (e.g., Medi-Cal, home visiting, doula services)
    - Financial support (e.g., WIC, CalFresh, CalWORKs)
    - Child care (e.g., Alternative Payment Vouchers, First 5 services, Early Head Start)

Of the fifteen interviews, eight were conducted in English, four in Spanish and three interviews were conducted in Indigenous languages.

6. Sensemaking Meetings

In July and August 2025, preliminary findings were shared with system decision makers and community partners representing the health, child care, and financial support systems across Alameda, Fresno, and Monterey Counties. One sensemaking meeting was held in each county, providing an opportunity for local stakeholders to reflect on the preliminary findings and provide critical insights. Given the limitations of desk research and a small number of interviews, these county-specific discussions played a key role in identifying gaps, validating what resonated, and building VIVA's understanding of each county's unique systems landscape.

Together, these elements informed a robust analysis of system structures, offering a diverse perspective on how state and federally funded health care, child care, and financial assistance systems related to maternal and child health operate within and across Alameda, Fresno, and Monterey Counties.

APPENDIX B: MATERNAL & INFANT HEALTH OUTCOMES TABLE

David and Lucile Packard Foundation
Children and Families Initiative Landscape Assessment
Maternal and Infant Health Outcomes

The data in the table below was extracted from the California Department of Public Health, Maternal, Child & Adolescent Health Division website.

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
U.S.	Aggregate	N/A	10.41%	5.44						
California	Aggregate	N/A	9.12%	4.1	7.21%	110.4	86.30%	73.40%	14.70%	13.50%
California	By delivery payment source	Medi-Cal	9.95%	5.23	7.96%	113.60	80.60%	73.60%	18.10%	13.60%
California	By delivery payment source	Private	8.72%	3.21	7.12%	110.70	92.40%	74.50%	11.40%	13.20%
California	By delivery payment source	Self-Pay	4.69%	2.49	4.27%		72.10%	66.20%		
California	By delivery payment source	Other Public				131.10				
California	By delivery payment source	Uninsured				70.00				
California	By delivery payment source	Other	8.53%	4.26	7.05%		89.30%	78.60%		
California	By delivery payment source	Born in U.S.	9.21%	4.22	7.41%		87.50%	73.50%		
California	By delivery payment source	Born out-side U.S.	9.04%	3.58	7.36%		84.10%	73.50%		
California	By popula-tion density	Urban	9.14%	4.01	7.46%		87.20%	73.50%	14.70%	13.40%
California	By popula-tion density	Rural/Fron-tier							14.80%	13.80%
California	By popula-tion density	Rural	9.03%	4.64	6.96%		81.70%	73.80%		
California	By popula-tion density	Frontier	8.86%		7.94%		77.50%	72.20%		

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
California	By race (alone or in combina-tion and ethnicity)	AIAN	10.59%		7.73%		76.20%	67.80%		
California	By race (alone or in combina-tion and ethnicity)	Asian	8.66%	2.75	8.67%	128.40	91.00%	75.50%		
California	By race (alone or in combina-tion and ethnicity)	Asian/Pacific Islander							15.30%	15.20%
California	By race (alone or in combina-tion and ethnicity)	Black	12.57%	7.91	12.14%	184.30	81.50%	66.00%	23.50%	18.40%
California	By race (alone or in combina-tion and ethnicity)	Hispanic	9.47%	4.32	7.12%	106.30	83.60%	71.90%	15.60%	12.70%
California	By race (alone or in combina-tion and ethnicity)	Multiracial		3.20	7.85%	136.80	87.50%	71.70%		
California	By race (alone or in combina-tion and ethnicity)	NHPI	10.87%							
California	By race (alone or in combina-tion and ethnicity)	Pacific Islander		8.76	6.72%	185.10	76.60%	62.40%		
California	By race (alone or in combina-tion and ethnicity)	White	8.71%	3.10	6.09%	94.10	90.00%	76.80%	11.50%	12.70%
Alameda	Aggregate	N/A	8.74%	3.36	7.38%	136.5	90.70%	65%	15.30%	12.00%
Alameda	By delivery payment source	Medi-Cal	9.93%	4.55	8.75%	148.50	80.90%	74.30%	23.30%	17.30%
Alameda	By delivery payment source	Private	8.47%	3.03	6.95%	131.20	94.30%	60.70%	11.60%	9.60%
Alameda	By delivery payment source	Self-Pay	5.70%		6.47%		76.00%	66.30%		

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
Alameda	By delivery payment source	Other	8.10%		7.72%		97.80%	91.50%		
Alameda	By nativity	Born in U.S.	9.00%	3.50	7.42%		91.50%	61.70%		
Alameda	By nativity	Born out-side U.S.	8.44%	3.03	7.32%		90.10%	68.60%		
Alameda	By popula-tion density	Urban	8.66%	3.38	7.37%		90.80%	64.90%	15.70%	12.00%
Alameda	By popula-tion density	Rural	10.65%		6.56%		92.80%	69.00%		
Alameda	By popula-tion density	Frontier								
Alameda	By race (alone or in combina-tion and ethnicity)	AIAN	10.27%				78.00%	62.70%		
Alameda	By race (alone or in combina-tion and ethnicity)	Asian	8.58%	3.07	8.24%		94.60%	67.60%		
Alameda	By race (alone or in combina-tion and ethnicity)	Asian/Pacific Islander				108.20			15.80%	12.10%
Alameda	By race (alone or in combina-tion and ethnicity)	Black	11.67%	7.16	12.36%	224.10	85.50%	64.10%	29.30%	15.20%
Alameda	By race (alone or in combina-tion and ethnicity)	Hispanic	9.02%	2.61	6.42%	152.30	87.10%	63.90%	14.00%	13.60%
Alameda	By race (alone or in combina-tion and ethnicity)	NHPI	10.70%							
Alameda	By race (alone or in combina-tion and ethnicity)	Multi-Race			6.79%		91.10%	60.00%		
Alameda	By race (alone or in combina-tion and ethnicity)	Pacific Islander			7.61%		77.50%	53.30%		

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
Alameda	By race (alone or in combina-tion and ethnicity)	White	7.87%	2.99	5.33%	120.40	91.90%	62.20%	11.00%	8.60%
Fresno	Aggregate	N/A	10.04	5.8	7.62%	62.9	86.10%	79.90%	17.10%	16.20%
Fresno	By delivery payment source	Medi-Cal	10.49%	6.50	8.01%	66.10	84.00%	77.90%	22.40%	17.80%
Fresno	By delivery payment source	Private	9.17%	4.21	6.74%	55.55	92.10%	85.40%	6.10%	12.00%
Fresno	By delivery payment source	Self-Pay	10.00%		11.48%		69.30%	63.60%		
Fresno	By delivery payment source	Other	11.83%		8.96%		85.80%	85.70%		
Fresno	By nativity	Born in U.S.	10.27%	5.92	7.69%		86.90%	80.80%		
Fresno	By nativity	Born out-side U.S.	9.43%	5.05	7.40%		83.80%	77.60%		
Fresno	By popula-tion density	Urban	10.17%	6.14	7.86%		85.80%	79.50%	16.20%	16.90%
Fresno	By popula-tion density	Rural	9.82%	5.26	7.15%		86.80%	80.70%		
Fresno	By popula-tion density	Rural/Fron-tier							19.60%	15.50%
Fresno	By popula-tion density	Frontier								
Fresno	By race (alone or in combina-tion and ethnicity)	AIAN	11.38%				74.10%	76.50%		
Fresno	By race (alone or in combina-tion and ethnicity)	Asian	10.25%	4.35	8.98%		86.40%	79.80%		
Fresno	By race (alone or in combina-tion and ethnicity)	Asian/Pacific Islander				68.60			11.10%	22.90%
Fresno	By race (alone or in combina-tion and ethnicity)	Black	13.21%	10.56	13.74%	155.80	80.50%	72.10%	30.00%	25.00%

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
Fresno	By race (alone or in combina-tion and ethnicity)	Hispanic	10.00%	5.74	7.24%	59.20	85.50%	78.80%	21.30%	14.50%
Fresno	By race (alone or in combina-tion and ethnicity)	Multi-Race			8.19%		88.50%	82.70%		
Fresno	By race (alone or in combina-tion and ethnicity)	NHPI	12.88%							
Fresno	By race (alone or in combina-tion and ethnicity)	Pacific Islander					76.80%	78.60%		
Fresno	By race (alone or in combina-tion and ethnicity)	White	10.08%	4.96	6.52%	46.10	89.30%	83.80%	5.50%	10.30%
Monterey	Aggregate	N/A	8.79%	5.02	6.56%	75.5	85.30%	82.50%	10.30%	16.40%
Monterey	By delivery payment source	Medi-Cal	9.26%	6.01	7.17%	81.10	81.20%	79.80%	12.30%	14.70%
Monterey	By delivery payment source	Private	9.54%	4.50	6.35%	69.20	93.30%	90.30%	5.80%	16.10%
Monterey	By delivery payment source	Self-Pay	6.47%				68.40%	73.50%		
Monterey	By delivery payment source	Other	6.45%		5.58%		84.70%	75.30%		
Monterey	By nativity	Born in U.S.	8.85%	4.19	6.48%		89.90%	86.40%		
Monterey	By nativity	Born out-side U.S.	8.71%	5.80	6.67%		79.80%	77.70%		
Monterey	By popula-tion density	Urban	8.88%	4.90	6.61%		86.40%	83.10%	10.50%	11.80%
Monterey	By popula-tion density	Rural	8.71%	5.04	6.53%		84.20%	81.80%		
Monterey	By popula-tion density	Rural/Fron-tier							10.40%	22.30%
Monterey	By popula-tion density	Frontier					82.70%	75.80%		

Geography	Data broken down by	Category	Preterm Birth	Infant mortality rate (rate per 1,000)	Low birth-weight	Severe Maternal Morbidity (rate per 10,000)	Early prena-tal care	Adequate prenatal care	Maternal mental health: prenatal depression symptoms	Maternal mental health: postpartum depression symptoms
Monterey	By race (alone or in combina-tion and ethnicity)	AIAN					64.00%	68.00%		
Monterey	By race (alone or in combina-tion and ethnicity)	Asian	9.84%		7.69%		91.30%	88.10%		
Monterey	By race (alone or in combina-tion and ethnicity)	Black	8.33%				81.60%	76.30%		
Monterey	By race (alone or in combina-tion and ethnicity)	Hispanic	8.62%	5.04	6.56%	71.70	83.40%	80.50%	10.80%	16.10%
Monterey	By race (alone or in combina-tion and ethnicity)	Multi-Race			6.93%		91.30%	90.70%		
Monterey	By race (alone or in combina-tion and ethnicity)	Pacific Islander					86.70%	75.60%		
Monterey	By race (alone or in combina-tion and ethnicity)	NHPI	11.50%							
Monterey	By race (alone or in combina-tion and ethnicity)	White	8.26%		4.97%	73.90	92.80%	89.60%	9.60%	19.20%

Citations for Maternal and Infant Health Outcomes Table

Indicator	Citation
Preterm Birth	California Department of Public Health. (n.d.). *Preterm birth*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Preterm-Birth.aspx
Infant mortality rate	California Department of Public Health. (n.d.). *Infant mortality*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Infant-Mortality.aspx
Low birthweight	California Department of Public Health. (n.d.). *Low birthweight*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Low-Birthweight.aspx

Severe Maternal Morbidity	California Department of Public Health. (n.d.). *Severe maternal morbidity*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Severe-Maternal-Morbidity.aspx
Early Prenatal Care	California Department of Public Health. (n.d.). *Prenatal care*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Prenatal-Care.aspx
Adequate Prenatal Care	California Department of Public Health. (n.d.). *Prenatal care*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Prenatal-Care.aspx
Maternal Mental Health (Prenatal depression symptoms; Postpartum depression symptoms)	California Department of Public Health. (n.d.). *Maternal mental health*. Maternal, Child and Adolescent Health Division. Retrieved April 17, 2025, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Maternal-Mental-Health.aspx

APPENDIX C: PARENT INTERVIEW SUMMARY REPORT

The David and Lucile Packard Foundation Children and Families Initiative (CFI)
Landscape Assessment of Maternal and Child Health Systems
Parent Interviews: Themes & Key Learnings
August 2025

Introduction

In 2024, the Foundation engaged VIVA Social Impact Partners (VIVA) and Lucile Packard Foundation to conduct a landscape assessment in Alameda, Fresno, and Monterey Counties. The goal of this work was to document how publicly funded health care, child care, and financial support systems related to maternal health are structured and connected. It aimed to identify opportunities to build a more aligned and effective system of care for pregnant people and families with children from birth to age three.

As part of this work, conducted from March to April 2025, VIVA conducted fifteen interviews (five in each county) with parents navigating public support systems.[42] Of the fifteen interviews, eight were conducted in English, four in Spanish, and three in Indigenous languages. Each interview lasted 75 minutes and followed a structured protocol to ensure consistency. Participants were selected according to eligibility criteria designed to align with the focus of the landscape assessment:

- Were birthing parents of children under age three
- Resided in one of the three study counties
- Identified as Black, Indigenous, and/or Latino
- Spoke English, Spanish, or an Indigenous language
- Had accessed services from at least two of the following systems: Health (e.g., Medi-Cal, doula care, home visiting); financial support (e.g., WIC, CalFresh, CalWORKs); and child care (e.g., Alternative Payment vouchers, Early Head Start)

Findings & Insights

The themes that emerged from the interviews are organized into three overarching areas:

1) Strengths in Service Delivery, 2) Persistent Barriers to Access, and 3) Opportunities for System Strengthening. For clarity, terms such as "a few," "several," and "the majority" are used to indicate the frequency of responses across the 15 interviews conducted in the counties.[43]

Topic: Strengths in Service Delivery

Across the three counties, parents pointed to several programs and services that effectively met their needs. These strengths included culturally relevant supports, accessible enrollment, and respectful interactions with staff.

1. Use of Core Public Benefits: Across Alameda, Fresno, and Monterey Counties, the majority of parents consistently relied on programs such as Women, Infants, and Children (WIC Program), CalFresh, Medi-Cal, and CalWORKs during pregnancy and early parenting. Each program addressed a critical need: WIC provided access to food and breastfeeding education, CalFresh addressed ongoing food insecurity, Medi-Cal ensured access to prenatal and postpartum healthcare, and CalWORKs provided essential cash assistance, often paired with child care and

job training. Families typically combined these benefits, using them together as the foundation of their well-being.

2. Culturally Relevant Parenting and Education Programs: Several parents emphasized the importance of programs that reflected their cultural and linguistic identities. Across all three counties, parents cited home visiting and parenting programs, such as Parents as Teachers, for providing linguistically responsive support in Spanish, as well as mental health resources, parenting education, and material assistance. These services were valued for reducing feelings of isolation and strengthening parents' confidence.

Parents who identified as Indigenous Mexican highlighted the trusted role of Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) in providing navigation support in both Mixteco and Spanish. When organizations like CBDIO offered culturally aligned services and staff who spoke Indigenous or home languages, parents reported feeling more comfortable and understood. Two parents noted that CBDIO supported them with Medi-Cal, CalFresh, and WIC applications, describing staff as patient, knowledgeable, and trustworthy.

African American mothers, one in Fresno County and one in Alameda County, also spoke about the value of culturally affirming support. In Alameda, a parent highlighted the Coco Doula Program in neighboring Contra Costa County as a vital prenatal, birth, and postpartum resource, noting its advocacy and emotional support for Black birthing people. Similarly, a Fresno parent praised the Black Infant Health program for its ongoing encouragement and follow-up, even after formal services had ended, an example of sustained, culturally responsive care. In addition, a Latina mother in Fresno shared a positive experience with Celebrating Families, a culturally responsive parenting group offered through a CalWORKs referral that included in-person sessions focused on mental health for both her and her partner.

While most parents appreciated respectful treatment across programs, many noted a lack of cultural tailoring in the broader systems they navigated. The majority reported that while services were generally respectful, they often felt generic and not designed with their specific cultural backgrounds in mind. However, several services were viewed as respectful and supportive, even if not explicitly culturally or linguistically tailored. These included: BANANAS (Alameda County), Marjaree Mason Center (Fresno County), Medi-Cal (Fresno and Monterey Counties), and WIC (Alameda, Fresno, and Monterey Counties).

3. Online and Phone-Based Accessible Access: Several parents across counties described online application systems and phone-based case management as more efficient and accessible than in-person visits, particularly for those without transportation or limited mobility in the postpartum period. Parents appreciated being able to upload documents digitally and receive follow-up by phone.

Access to online and phone-based systems varied by county. Two parents in Fresno and two parents in Monterey counties reported using online applications for programs such as WIC, Medi-Cal, and CalFresh. In contrast, three out of five parents in Alameda County applied for Medi-Cal in person through lengthy paper forms, describing frustrating experiences with lost paperwork, repeated application steps, multiple in-office visits, and extended wait times.

In contrast, WIC was a notable exception across all counties. Whether applications were submitted online or in person, most parents found the WIC enrollment process to be

straightforward and timely. Some reported receiving same-day approval, while others were enrolled within a few weeks. Parents frequently described WIC staff as respectful, helpful, and kind, with many noting that services were offered in Spanish and provided critical support for both nutrition and breastfeeding.

Topic: Persistent Barriers to Access
Despite accessing various programs, parents described numerous barriers that complicated their efforts to apply, maintain, or transfer benefits. These challenges often created added stress during pregnancy and early parenting, and in some cases, resulted in missed care or delayed access to essential supports.

1. Service fragmentation and lack of coordination across programs: Across counties, most parents described siloed systems that required separate applications and documentation for each program, even when housed in the same office. The lack of data sharing further created inefficiencies and added burdens.

- In Alameda County, a parent described having to apply separately to each service, even when referred through the same agency. In Fresno County, a parent recounted repeatedly calling and verifying information multiple times due to a lack of cross-program coordination. Similarly, in Monterey County, a parent noted that although WIC and Medi-Cal requested similar information, the programs did not appear to communicate, requiring her to submit separate forms.

2. Eligibility complexity and administrative burden: Across counties, several parents described how complex eligibility rules, redundant documentation requirements, and administrative inefficiencies created barriers to accessing and sustaining benefits. A common frustration across all three counties was the need to resubmit the same documents - proof of income, residency, or pregnancy - often due to poor coordination, system errors, or miscommunication.

- In Alameda County, parents described confusion navigating various service systems' eligibility steps, combined with long wait times, and lack of follow-up, which at times led to abandoned applications and missed essential program opportunities.

- Across counties, parents were often assigned agency or program-specific case workers to help with the administrative processes of the public services they received. However, in Fresno County, four of five parents reported frequent caseworker turnover, resulting in inconsistent support.

3. County-to-county moves and disrupted services: Of the fifteen parents interviewed across the three counties, four reported moving to a different county during pregnancy or shortly after giving birth. Three of these four parents experienced delays or disruptions in accessing public services, most notably Medi-Cal, following the move. In two cases, one parent who moved from San Mateo County to Oakland (Alameda County) and another who moved from San Luis Obispo to Fresno went without coverage for two months of pregnancy. One had to reapply completely, and the other had to attend a hearing to reinstate benefits, despite remaining eligible.

These experiences highlight the administrative complexity that can occur under California's realignment structure, in which counties are responsible for program administration and may have differing processes and systems. Parents described frozen accounts, delayed re-enrollment, and missed prenatal care as impacts of these county-to-county transfers. One parent who received

navigation support from a community-based organization was able to complete the transfer more quickly, suggesting that additional navigation support and clearer transfer procedures could help promote continuity of care for mobile families.

4. Housing instability: In both Fresno and Monterey Counties, parents raised housing instability as a barrier to their health and overall well-being. Parents described being on waitlists for subsidized housing for several years, often forced to find other options. Some also recounted living in unsafe or overcrowded conditions while waiting for housing support.

5. Transportation barriers: Transportation challenges were particularly acute in both Fresno and Monterey Counties. In Fresno, three out of five parents described difficulties traveling to and from in-person service locations. During one parent's pregnancy, it took more than an hour by bus to reach a clinic that would have been just a 15-minute drive by car. She suggested that bus passes, more flexible transportation options, and neighborhood-based service sites could ease access for families without personal vehicles.

In Monterey, three of five parents described similar experiences, emphasizing that transportation and distance to services were major obstacles. One mother shared that WIC appointments required travel to Soledad and Medi-Cal appointments to King City, with neither conveniently located near bus routes. Without a car, she often had to walk long distances to bus stops with her children, and when her husband was unable to drive her, she sometimes missed or delayed appointments. Another parent explained that even with navigation support from a local community-based organization, the requirement for in-person visits remained difficult without reliable transportation.

6. Child care access gaps: Across counties, parents noted that child care access remained one of the most uncertain and challenging parts of their journey. Several described year-long waitlists, mismatches between available child care hours and their work or school schedules, and incomplete information about provider quality and licensing status. For some, applications for child care assistance were met with slow responses or no follow-up, leading to reliance on relatives or informal care arrangements. Parents also emphasized that pursuing education and vocational goals was difficult without timely and reliable child care. These experiences underscored that child care availability is central to a family's ability to achieve stability and meet long-term goals.

Topic: Opportunities for System Strengthening

Across all three counties, parents identified tangible opportunities to improve how systems support families during pregnancy, birth, and the early years of parenting.

1. Develop Community-Based Eligibility Hubs: Parents consistently described public systems as fragmented and duplicative, making it difficult to access multiple benefits at once. They recommended creating neighborhood-based hubs where families can access multiple programs in one location. These hubs would allow families to apply for benefits across systems (health, child care, financial) in a single visit, reducing administrative burden, minimizing missed benefits, and improving trust by offering face-to-face support in convenient, community-centered settings.

2. Invest in Technology to Streamline Eligibility and Verification: Parents emphasized the need for digital solutions, such as apps modeled after WIC's user-friendly platform, that would allow families to submit common eligibility documentation (e.g., proof of income, residency) once and have it accepted across all public programs. Such tools would improve efficiency, reduce

duplicative paperwork, and provide families with timely updates on application status.

3. Enhance Communication and Caseworker Responsiveness: Timely, consistent communication was described as essential to sustaining benefits. Parents cited long wait times, unresponsive caseworkers, and unclear information about eligibility as major barriers. They recommended proactive follow-up, direct lines to caseworkers, and real-time updates through phone calls or text messaging.

4. Embed Service Referrals Earlier, Beginning in Pregnancy: Parents expressed a strong desire for services and information to be introduced earlier, ideally during pregnancy rather than postpartum. Many reported missing support because they learned about programs only after their child was born. Embedding referrals and enrollment support into prenatal care visits and hospital discharge processes was a priority recommendation.

5. Advocate for More Realistic Eligibility and Documentation Requirements: Parents noted that current income thresholds, time limits, and documentation requirements often do not reflect the true cost of living or the realities of raising young children. They recommended revisiting eligibility rules and streamlining documentation processes to make services more inclusive and accessible for families who are struggling but may be just over program cutoffs.

6. Fund Flexible, Family-Centered Service Models: Parents emphasized the need for service delivery models that accommodate their schedules, transportation challenges, and caregiving responsibilities. This includes extending service hours beyond standard business times, co-locating services where possible, and providing supports like transportation assistance or virtual options to make participation feasible for working families.

7. Expand Culturally and Linguistically Responsive Services: Language access and cultural relevance were described as critical to equitable service delivery, particularly for Spanish- and Mixteco-speaking families in Fresno and Monterey Counties. Parents emphasized the need for more bilingual and Indigenous-language staff, as well as culturally grounded approaches that reflect the values and lived expertise of the communities served.

APPENDIX D: SYSTEM MAPS

System Maps: Visual representations of the health, child care, and financial service systems in each county. The system maps are included as links to an external interactive interface. These include:

1. Alameda County System Map
2. Fresno County System Map
3. Monterey County System Map

APPENDIX E: COUNTY-SPECIFIC LANDSCAPE FINDINGS

This appendix presents detailed county-level findings for Alameda, Fresno, and Monterey Counties. These sections build on the cross-county analysis provided earlier in the report and are organized consistently across four themes: Programs Focused on Black, Indigenous, and Latino Populations; Programs at Risk; Strengths of Systems; and Challenges of Systems. This means the programs, strengths and challenges listed here are not comprehensive - they are supplemental to cross county findings in the main body of the report.

The inclusion of county-specific data is intended to highlight local context, programmatic nuances, and the lived expertise of families and system leaders that may not be fully captured in the cross-county findings. Together, these details provide a more complete understanding of how maternal and child health systems are structured and experienced in each county. *Nevertheless, county-specific findings are framed by the research questions, which focused on state and federal funding sources. As a result, many locally funded programs likely exist but are not included in this report unless they were explicitly mentioned during data collection.*

A. Alameda County

Programs Focus on Black, Indigenous, and Latino Populations
Stakeholders in Alameda County highlighted the following effort aimed at meeting the needs of Black, Indigenous, and Latino families:

- Building the Black Birthing Workforce: Interviewees highlighted the B.L.A.C.K. (Birth, Lactation, Accommodation, Culture, Kinship) Course program as a key initiative, offering provider training in lactation education with pathways to becoming an International Board Certified Lactation Consultant or a Lactation Peer Educator. The B.L.A.C.K. Course is an independent organization supported by First 5 Alameda County.

Parents interviewed from Alameda County reported mixed experiences regarding whether the programs they leveraged were culturally tailored to their needs and identities. Three parents said they did not perceive the programs they used as culturally specific, such as Medi-Cal, CalWORKs, and the County's Housing Authority among others, but emphasized that they nonetheless felt respected in their interactions with service providers. One parent explained, "No, I think…the services or things I received, I feel like it's for everybody. It doesn't really matter about your race or ethnicity."

Other parents pointed to examples of cultural or contextual responsiveness. One highlighted Coco Doula, a program based in neighboring Contra Costa County, describing, "It was free for Black women…It was definitely nice to have that because doula services are expensive and this program provided like over $3,000 worth of doula services for free…to help combat the disproportionate maternal mortality rate for Black women." Another parent referenced classes offered through Kaiser, noting, "I wouldn't say [the classes are] specifically for Black women, but specifically for a pregnant woman. I did attend a lot of the different classes that Kaiser offered, like breastfeeding class, newborn care, postpartum."

A parent also identified BANANAS as a supportive organization, particularly for single or working parents. One mother shared, "I feel like they understand how hard it is for parents to find daycare…As a single parent, I feel like they come up with different ways for us to excel."

Across all experiences, parents consistently underscored the importance of respectful treatment, regardless of whether services felt culturally tailored. As one parent affirmed, "Yes, for the most part, I felt like I was respected." Respectful and empathetic interactions were described as essential for building trust and encouraging families to remain engaged with services.

Programs at Risk

Stakeholders voiced significant concerns about the potential loss of funding for core health and social service programs. The following table summarizes specific programs identified by decision makers as at risk due to potential elimination or decline in funding:

County	Program at Risk	Reason for Risk	Lead Agency
Alameda	EmbraceHer	Fully funded by a federal Healthy Start grant; sustainability concerns due to uncertain funding	Alameda County Department of Public Health

Strengths of Systems

In Alameda County, stakeholders noted that a progressive culture in the county leads those in leadership positions to be more apt to explore root causes of disparities and to focus on prevention. Additional strengths of each system are outlined below:

Health:

- Data-driven and evidence-based practices: One decision-maker highlighted the focus on data and evidence-based practices in driving decisions made in the health system in the county.

Child Care:

- Experienced and diverse early childhood workforce: The Alameda County early childhood educators are very experienced. They have been doing this work for a long time and have a high level of dedication to the work. There is also diversity in terms of language, culture, and pedagogies offered through different child care programs in the county.
- Support for families seeking child care: One parent positively mentioned Head Start, citing the timely intake process and responsive staff. Another shared that BANANAS provided a broad range of supports, including diapers, gift cards, financial assistance, mental health resources, and reliable child care.
- Measure C funding: This local measure, the Children's Health and Child Care Initiative, will raise approximately $150 million annually through 2040. First 5 Alameda County is the administrator and will leverage funding to fill gaps in access and quality of child care, including through additional child care vouchers, family navigation supports, and professional development and wage enhancements for providers.[44]

Financial Support:

- Limited flexible funding to meet the unique needs of families: The Department of Social Services provides funding for Child Abuse Prevention, Intervention, and Treatment providers (CAPIT) contractors to serve families who fall through all eligibility cracks for public services. The providers include BANANAS, East Bay Agency for Children, and the American Indian Child Resource Center, among others. While this is an effective way to use flexible funding to meet the needs of families, the funding is extremely limited (about

$90,000 per year for each contractor).

Challenges of Systems
Parents and system leaders identified significant barriers that limit families' access to health, child care, and financial supports. The following outlines challenges specific to Alameda County systems:

- Insufficient wages for frontline providers. One system decision maker noted that those providing vital community services often are not earning livable wages. For example, the reimbursement rate for doulas offering services through Medi-Cal is not high enough for providers in Alameda County, which makes it challenging to grow the workforce and increase access to services.
- Inadequate funding for innovation: Many programs face inadequate government funding and insufficient capacity to innovate or implement new models of care.

Opportunity for health system alignment:

Acknowledging challenges within the health system in the county, one interviewee noted an opportunity for the Public Health Department to work more closely with managed care plans to work towards shared goals. They shared an example of the department partnering with the local managed care plan (MCP) in the development of their Community Health Improvement Plan.

Collective Impact and Cross-Sector Partnerships Supporting Families Across Systems
System leaders in Alameda County leverage collaborative strategies to align services across systems to better support families with young children.

Examples of collective impact initiatives supporting families across systems include:

- Rise East is a collective impact collaborative supporting a community in a 40x40 block in East Oakland through a 10-year comprehensive investment and community development plan. Using a targeted universalism approach with a focus on uplifting the Black community, the plan includes strategies to strengthen education (including early education and care and early literacy), reduce violence, increase access to housing and employment, and improve health (including a focus on maternal and child health).[45]
- Oakland Starting Smart and Strong is a citywide collaborative that advances racial justice, develops and amplifies community-driven solutions, and advocates for changes in policy and resources to create an early childhood ecosystem that effectively serves children 0-5, their families, caregivers, and educators. One initiative of this collaborative is the Boys of Color Workgroup, which developed best practices for supporting boys of color in early care and education.

Additional local efforts include:

- Guaranteed income programs: Programs such as the Abundant Birth Project, which is offered in Alameda, Contra Costa, Los Angeles, and Riverside counties and provides monthly unconditional income supplements to pregnant individuals at the highest risk

of preterm birth, provides families with the resources they need to meet their needs and navigate complex systems. Another program being offered by BANANAS is a pilot CARE Collaborative Guaranteed Income Program called Steady Steps. This is a program for families with young children in Northern Alameda County (Oakland, Alameda, Albany, Berkeley, Emeryville, and Piedmont) and is limited to a few CARE Collaborative Partners to provide short-term financial stability for eligible families who are not currently receiving a child care subsidy. One interviewee noted that while these programs do not simplify cross-system navigation for families, they provide crucial financial resources so that families are better equipped to navigate the systems. Importantly, due to partnerships with programs offering other social services, participation in these programs does not disqualify families from accessing other programs, such as Medi-Cal or CalFresh, with income eligibility criteria.

B. Fresno County

Programs Focused on Black, Indigenous, and Latino Populations

Fresno County has implemented culturally tailored strategies to address inequities for historically marginalized families. Stakeholders in Fresno County highlighted the following efforts aimed at meeting the needs of Black, Indigenous, and Latino families:

- Strategic Location of Offices & Service Provision: The Department of Social Services has strategically located an office in a predominantly Black neighborhood in West Fresno to improve access. In addition, Fresno's Economic Opportunities Commission (EOC) food distribution programs are tailored to meet the needs of Hispanic communities, including rural distributions that primarily serve Hispanic migrant farm workers.
- Partnerships with the BLACK Wellness and Prosperity Center (BWPC): This was cited as instrumental in centering the needs of the Black community. In addition to First 5 Fresno County's collaboration on the GLOW group prenatal care program, EOC noted a partnership with BWPC to implement a meal distribution program for families with newborn babies.
- Early Matters Fresno (EMF): This collective impact initiative focuses on aligning experts in maternal and child health as well as early childhood care and education to strengthen maternal and child outcomes. The initiative includes a focus on Black, Indigenous, and people of color (BIPOC) communities. EMF was built from the Preconception to Age 5 Blueprint for Funding and Advocacy, which was informed by community feedback and engagement through focus groups and surveys conducted by First 5 Fresno County.

Parents interviewed from Fresno County generally reported feeling their culture and needs were respected in their interactions with service providers. One parent reflected, "I felt very comfortable and respected with Black Infant Health."

Another parent, who identified as Mixteco, described more complex experiences. They noted that staff at a local community-based organization that supports indigenous communities, CBDIO, were consistently respectful and supportive: "Yes, they do respect me. For example, here (CBDIO), they are respectful, but there are (other) places where they don't help or get angry... In Fresno, I haven't had to pay to fill out documents to receive services." This parent also pointed to challenges at the Department of Social Services office in Selma, explaining, "Sometimes they help, and

sometimes they don't want to fill out documents or explain things to me. They only speak English."

Overall, while interviewed Fresno parents generally felt respected, the Mixteco parents' account underscores how experiences could vary greatly across agencies and highlights the importance of culturally and linguistically responsive organizations that provide navigation support.

Programs at Risk
Stakeholders voiced significant concerns about the potential loss of funding for core health and social service programs. The following table summarizes specific programs identified by decision makers as at risk due to potential elimination or decline in funding:

County	Program at Risk	Reason for Risk	Lead Agency
Fresno	Food Distribution Programs	USDA funding cuts are reducing services and food bank partnerships	Fresno Economic Opportunities Commission
Fresno	CalWORKS Cal-Learn Program	Anticipated cuts from federal and state funding	Fresno Department of Social Services
Fresno	Home Visiting and Housing Support Programs	Anticipated cuts from federal and state funding	Fresno Department of Social Services
Fresno	Head Start and Early Head Start Regional Offices	Closure of regional offices due to funding cuts	Fresno Regional Head Start

Strengths of Systems
Additional strengths of the Fresno County systems include:

Child Care:

- Head Start and Early Head Start: These programs are celebrated as a place to meet the comprehensive needs of young children and their families, including mental health services. In Fresno County, the majority of Head Start participants are Black, Indigenous, and Latino.

Financial Support:

- Funding flexibility for housing support programs: The Department of Social Services (DSS) combines CalWORKs Housing Support Program and Housing Assistance Program funds to extend transitional housing support for families, avoiding unnecessary moves and disruptions by strategically counting eligible days across the two funding streams.

- Food services offered through Fresno Economic Opportunities Commission: The Commission is partnering with Head Start, schools, and other community organizations to ensure that all children and pregnant people's nutritional needs are met.

Challenges of Systems
Parents and system leaders identified significant barriers that limit families' access to health, child care, and financial supports. The following outlines challenges specific to Fresno County systems:

- Challenges in enrolling target populations. System decision makers noted the stigma

associated with some services and reported challenges with enrollment for services such as Head Start, WIC, and programs offered through the Department of Social Services. Leaders from the Economic Opportunities Commission noted that WIC participants often are unaware that they are eligible for services during pregnancy and for more than a year after giving birth (see Gaps in Outreach and Awareness in the cross-system findings above). They also noted that WIC participants are not accessing additional services because they lack the case management support needed to navigate and access those services.

- FQHCs are not meeting community/partner needs. Multiple system decision makers shared challenges partnering with FQHCs. They also noted that FQHCs are not incentivized to provide comprehensive care to community members, leading to multiple visits and long wait times.

Collective Impact and Cross-Sector Partnerships Supporting Families Across Systems
System leaders in Fresno County leverage collaborative strategies to align services across systems to better support families with young children.

Examples of collective impact initiatives supporting families across systems include:

- Map Point is another innovative Fresno initiative, a partnership among the Departments of Public Health, Behavioral Health, and Social Services. These agencies collaboratively fund three community-based organizations, each focused on supporting a different population: Hispanic residents, individuals experiencing homelessness, and people with behavioral health needs. Through a braided funding model and a single master agreement, Map Point offers comprehensive services, ranging from immigration and housing support to mental health and social services, under one roof, with closed-loop referrals to ensure continuity of care.

- First 5 Fresno County and Fresno County Cradle to Career have partnered to strengthen countywide cradle to career efforts.

Additional local efforts include:

- Community Information Exchange (CIE): CIE is a joint project with Fresno County, the Office of the Fresno County Superintendent of Schools, and Fresno Cradle to Career through which efforts are underway to address the legal, policy, and technical challenges of data sharing across health, education, and social service systems. Early Matters Fresno is leveraging the CIE for a pilot project focused on coordinating countywide home visiting services and collecting data to assess the impact of home visiting on rates of preterm birth and maternal depression.[46]

- First 5 Fresno County's Lighthouse for Children is a physical hub where families can access services: Through this space, developed and owned by First 5, where community partners such as Fresno Superintendent of Schools have offices, families can directly access resources such as child care and parent education classes. Families are also connected to programs such as Help Me Grow, which is operated by Exceptional Parents Unlimited, and provides support to parents with concerns about their child's development.

C. Monterey County

Programs Focused on Black, Indigenous, and Latino Populations
Monterey County has implemented culturally tailored strategies to address inequities for historically marginalized families. Stakeholders in Monterey County highlighted the following effort aimed at meeting the needs of Black, Indigenous, and Latino families:

- Cultural training for providers: The Mexican American Opportunity Foundation (MAOF), which serves a community with a significant Hispanic population, shared its efforts to support dual language learners and launch culturally tailored programming. In addition, First 5 Monterey County offers Infant-Family and Early Childhood Mental Health training for providers across several different sectors, including those in health, behavioral health, social services, nonprofits/community-based organizations, child care, and education. The training is offered in English and Spanish and is focused on building a reflective practice and supporting capacity building across sectors. The Spanish training is rooted in Latino culture and understanding, and the curriculum focuses on integrating history and culture.

Parents interviewed from Monterey County reported limited experiences with services that felt culturally tailored. Most parents reported that they had not received support tailored specifically to their cultural background.

Some parents pointed to WIC classes as helpful, including one mother who appreciated that classes were offered in Spanish: "Just the WIC mothering classes where they taught me." Another parent highlighted Parents as Teachers as a program that provided meaningful support in Spanish.

When asked whether they felt respected and whether their culture was honored in applying for and receiving services, most parents described positive interactions. One explained, "WIC treated me well. The Medi-Cal people treated me well." Another parent noted, "Yeah, for the most part. Like, there's not much representation [in the] people that work in the benefits office [such as] African Americans…Most times, it's people who are of Caucasian or visibly Latina descent. But I haven't received any discrimination."

Despite these generally respectful experiences, parents emphasized that services were not always aligned with their cultural or linguistic needs. In particular, parents from Indigenous backgrounds highlighted that programs often lacked visibility and accessibility for Indigenous-language speakers. When asked if they felt treated differently because of their race or ethnicity, parents largely said no, though one observed, "Personally no, but have seen sometimes ... that when we talk our languages the workers just stare and look rude."

Programs at Risk
Stakeholders voiced significant concerns about the potential loss of funding for core health and social service programs. The following table summarizes specific programs identified by decision makers as at risk due to potential elimination or decline in funding:

County	Program at Risk	Reason for Risk	Lead Agency
Monterey	CalWORKs Home Visiting Program	Expected reductions in the state budget	Monterey County Department of Social Services

County	Program at Risk	Reason for Risk	Lead Agency
Monterey	Infant-Family and Early Childhood Mental Health Training Program	Behavioral Health Services Act funding for this program is only guaranteed for one more year	First 5 Monterey County

Strengths of Systems
Additional strengths of the Monterey County systems include:

Health:

- Focus on building staff capacity in cultural awareness and responsiveness: There is a strong focus on building staff capacity in this area, particularly within health-related services, to ensure families are understood and respected. This includes efforts to focus on Black birthing needs. However, across systems, meeting the needs of Black communities is seen as a challenge (see the Challenges of Systems section below).

- Building mental health resources and capacity: Through programs like the Infant-Family and Early Childhood Mental Health Training Program, providers across sectors are building capacity and awareness of mental health resources for families and young children. In 2023-24, 132 total practitioners participated in the training program, with 72% reporting that they learned new information and directly applied it to their work.[47] System decision makers noted a widespread increased focus on maternal mental health, on providing interventions at an earlier stage, and on looking at prevention and early screening related to mental health.

Challenges of Systems
Parents and system leaders identified significant barriers that limit families' access to health, child care, and financial supports. The following challenges are specific to Monterey County systems:

- Geographic inequities. The southern region of the county, where many Indigenous and Latino families reside, has limited health care infrastructure and continues to face significant access barriers. While recent efforts to expand access represent progress, including the approval of a mobile clinic, additional investment is needed. The absence of a local birthing hospital forces families to travel to Salinas for labor and delivery, creating substantial challenges to safe, timely, and equitable birth experiences.

- Need for increased capacity for health providers. System decision makers noted a need to build a larger and more diverse health care workforce, including providers who speak multiple languages. In addition, there is an ongoing need to build the health care provider capacity in cultural responsiveness and awareness, as well as family-centered care. Stakeholders identified multiple challenges related to doula care. First, providers' immigration status can be a barrier for doulas who aim to become certified and provide culturally congruent services. Second, even as more doulas are credentialed through Medi-Cal/Central California Alliance for Health, stakeholders in Monterey County noted that coverage does not extend to more traditional and culturally rooted supports, particularly for Latino and Indigenous communities. In addition, there is a need to increase mental health supports that providers can access so that they are at their best when supporting families.

- Reaching and serving the Black community. In the health system, stakeholders emphasized

the need to strengthen services for the Black community, including through efforts like expanding doula access to support birthing equity.

- Insufficient navigation support for families. System decision makers noted that there is a need for additional support for families navigating within and across systems to ensure that they are able to access the services they need. This would help to address the confusion around program eligibility and enrollment reported by parents interviewed. Parents interviewed shared inconsistent experiences with case workers; while some parents praised workers who provided clear, helpful guidance, others struggled with unresponsive staff or conflicting information.

Collective Impact and Cross-Sector Partnerships Supporting Families Across Systems
System leaders in Monterey County leverage collaborative strategies to align services across systems to better support families with young children.

Examples of collective impact initiatives supporting families across systems include:

- *Bright Beginnings Early Childhood Initiative*: A collective impact initiative focused on young children and their families, ages prenatal to 8 years old. The Initiative works together with the Bright Futures Education Partnership for a cradle-to-career approach.
- *Roadmap to Child Well-being* (ended in 2018): A notable early initiative, the Roadmap to Child Well-Being (2016–2018) was led by the Monterey County Department of Social Services and brought together diverse stakeholders, including health, education, law enforcement, and faith-based organizations to promote cross-sector coordination and community-centered navigation services. However, it ended in 2018 due to a lack of funding to sustain the work.

Additional local efforts include:

- Individual care coordination within programs: In partnership with First 5 Monterey County, the Monterey County Health Department implements home visiting services funded through CalWORKs. Together, they are working to strengthen the local home visiting system by expanding program capacity and aligning services across agencies. Families enrolled in home visiting are supported in navigating services. Decision makers also noted that Enhanced Care Management, offered through CalAIM, also provides comprehensive case management and care coordination support for specific populations.
- The Aging and Disability Resource Center (ADRC) program model addresses multi-generational needs within households: While the ADRC is not explicitly focused on meeting the needs of families with young children, the program, administered by the Department of Social Services, is an innovative model focused on meeting the holistic needs of all members of a household, including young children and parents.
- Smart Referral Network: A project led by United Way of Monterey County, the Smart Referral Network is an online closed-loop referral tool. While still in the early stages, county agencies such as the Health Department are interested in participating in using this tool, which has the potential to simplify and streamline referral processes across systems.

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