



2026



Sonoma County Maternal Health Needs Assessment

FIRST 5 SONOMA COUNTY

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Executive Summary

The Sonoma County Maternal Health Needs Assessment reveals a community with meaningful health assets alongside pronounced disparities in access, support, and experience. Aggregate data show that women in Sonoma County often fare as well as or better than their counterparts across California—initiating prenatal care earlier, breastfeeding at higher rates, and receiving perinatal mental health care more reliably. Yet this surface-level view masks a more difficult reality for women living on the margins. Maternal health experiences in Sonoma County diverge sharply along lines of income, race and ethnicity, language, and immigration status. Women with financial stability and racial, cultural, and linguistic alignment with the healthcare system can generally access the care and support they need. Women navigating economic insecurity, language barriers, immigration fear, or the absence of a support network face substantial and compounding obstacles—often during the period when they need support most.

Some challenges, however, transcend demographic boundaries. A high baseline of psychological distress, the intensity of the perinatal mental health burden, and the withdrawal of support after birth emerged as concerns affecting women across the county, regardless of background. These are not the struggles of a single community—they are systemic features of how maternal health is experienced in Sonoma County.

This assessment draws on a community survey completed by 623 women in English and Spanish, 19 key informant interviews, 8 focus groups, and secondary public health data to describe the maternal health experiences and needs of women across the perinatal continuum. The findings are nuanced and wide-ranging, reflecting the diversity of women's experiences across Sonoma County. Five key findings are highlighted here.



DATA SOURCES

- 623** Women surveyed in English & Spanish
- 19** Key informant interviews
- 8** Focus groups across the county
- +** Secondary public health data sets

THE FIVE FINDINGS: What Matters Most for Women & Families

01

Perinatal Mental Health

02

Severe Maternal Morbidity

03

The Postpartum Cliff

04

Concordant Care

05

Economic Insecurity

01

Perinatal mental health emerged as the most pervasive and consistently named need.

Women in Sonoma County enter pregnancy with a higher baseline of psychological distress than women statewide, and the perinatal period intensifies it. Half of survey participants rated their postpartum mental health as fair or poor, and nearly three in four reported experiencing mental health challenges during the perinatal period. Anxiety—not depression—was the most consistently described experience, yet screening may not be capturing the full burden. Even when women recognized they were struggling, many could not reach care: nearly one in five who experienced challenges could not access support at all, with the steepest barriers among Spanish-speaking, immigrant, and lower-income women. A shortage of specialized and Spanish-speaking providers, fragmented referral pathways, and limited care formats compounded the gap.

02

Severe maternal morbidity has risen sharply—and faster than California.

The physical risk of pregnancy and birth in Sonoma County is worsening. Severe maternal morbidity—a composite measure of life-threatening complications during delivery—rose 74% between 2016–2018 and 2022–2024, reaching a rate significantly above the California average, and the share of births involving at least one maternal risk factor climbed by more than half (51%) over the same period. These trends carry pronounced racial disparities: severe morbidity falls heaviest on Asian and Hispanic women, and Black women now experience preterm birth at nearly double their rate of a decade ago—a rate significantly higher than that of any other group in the county. This worsening clinical picture does not arise in isolation—it is shaped by the conditions women carry into pregnancy, including elevated rates of chronic disease, psychological distress, and economic insecurity.

03

The postpartum period is where women need the most support and receive the least.

Women described a structured system of care during pregnancy and birth that largely disappears after delivery, with only a single six-week visit to check on them. Nearly three in four survey participants (74.8%) named at least one postpartum phase among the most challenging of their perinatal experience. Compounding the loss of formal care was the absence of informal support—many women described navigating postpartum largely alone, without the 'village' that once surrounded new mothers.

04

Racially, culturally, and linguistically concordant care is frequently unavailable, with significant consequences for women's experiences.

Women felt more supported and heard, and described more positive experiences, when their providers reflected their racial, cultural, or linguistic background. When that concordance was absent, women more often felt dismissed or misunderstood—and for some women of color, the absence of concordance crossed into experiences of racial bias, including having their pain or concerns minimized. Language access was an especially acute concern during birth, where reliance on interpreter machines and family members in place of professional interpreters was described as inadequate and, at times, traumatic. Yet the perinatal workforce does not mirror the county's childbearing population. Doulas and birth workers—among the most valued supports identified in the assessment—illustrate both the promise and the gap: Medi-Cal now covers doula care, but too few Spanish-speaking, Indigenous, and culturally concordant doulas exist to meet demand, and utilization remains concentrated among white and English-speaking women.

05

Economic insecurity is a foundational driver of maternal health and wellbeing.

Financial stress shaped who could afford to stay home after birth, who could pay for therapy or childcare, and who could prioritize their own health. The burden fell hardest on the lowest-income families—and on a “squeezed middle” earning too much to qualify for public supports but too little to afford private ones. Housing instability, inadequate paid leave, and the financial pressures tied to documentation status compounded these challenges for immigrant, Latine, and Spanish-speaking families.

Together, these findings describe a county with valuable assets alongside persistent gaps that fall hardest on the women already navigating the most. The sections that follow document these experiences in depth across pregnancy, birth, and the postpartum period.

Background



First 5 Sonoma County is a public agency dedicated to improving the health, development, and well-being of children from prenatal through age five and their families. Funded through Proposition 10 tobacco tax revenues and Measure I—the Sonoma County Child Care and Children's Health Initiative—First 5 administers a coordinated network of services, programs, and partnerships supporting children and families across the county. Measure I, passed by Sonoma County voters in November 2024, is funded by a quarter-cent sales tax dedicated to expanding access to childcare and children's health services. Forty percent of Measure I revenue is allocated to children's physical and mental health, developmental screenings, perinatal mental health, and early childhood trauma recovery.

First 5 Sonoma County's 2026–2031 Strategic Plan

reflects an expanded and deepened commitment to maternal and perinatal health. The plan's Healthy Children priority area establishes that children's physical, emotional, and developmental needs are met starting prenatally, and identifies a set of investments aimed at expanding access to culturally concordant perinatal mental health services, building a diverse doula and lactation support workforce, and delivering care where families live, work, and play. These commitments reflect a growing body of evidence that the conditions of pregnancy, birth, and the postpartum period shape children's developmental trajectories from the earliest moments of life—and that disparities in maternal health are among the most consequential drivers of inequity in child health outcomes.

With the passage of Measure I came a significant expansion of First 5 Sonoma County's resources and capacity to invest in maternal health. First 5 Sonoma County commissioned the Sonoma County Maternal Health Needs Assessment (MHNA) to ensure that future investments are strategic, evidence-based, and responsive to the needs of Sonoma County women—particularly those facing the greatest disparities. The goal of the assessment is to describe the diverse maternal health experiences and needs of women across Sonoma County and identify supports for improving maternal health. Findings are organized by community experience across the perinatal continuum, providing an evidence base that can inform but is not predetermined by First 5's investment framework.

The MHNA was conducted by KFH Strategic Impact between December 2025 and May 2026 and draws on focus groups, key informant interviews, a bilingual community survey, and secondary public health data. Methods are described in full in the following section.

VISION

Children in Sonoma County, from the prenatal stage to age five, will develop to their fullest potential.

MISSION STATEMENT

To maximize the healthy development of every child in Sonoma County from the prenatal stage through age five by providing equitable support, education, and advocacy.

Methods

Maternal Health Framework

This assessment is grounded in an understanding that maternal health outcomes are shaped by more than the clinical care a woman receives during pregnancy, birth, and postpartum. The conditions in which women live, work, and seek care—including access to transportation, social support networks, neighborhood resources, and economic stability—are powerful determinants of whether pregnancy is healthy and whether complications arise or go unaddressed.

To anchor this perspective, the assessment draws on **Kramer et al.'s (2019)** community determinants of maternal mortality framework, which situates the pregnant woman at the intersection of two dimensions: her life course health trajectory, beginning at conception and shaped by accumulated exposures over time, and the multilevel social and environmental factors acting on her health from conception through the postpartum period. The framework distinguishes between biomedical processes and the community environments that regulate risk: the general health environment, reproductive health environment, behavioral health environment, transportation environment, and social support environment. Overlaying all of these are fundamental social determinants, including structural racism, residential segregation, and poverty concentration, which systematically shape the opportunities and exposures available to women across their life course. These dimensions reflect the broader social determinants of health—the conditions in which people are born, grow, live, work, and age—which are well established as primary drivers of health equity and disparities.

Language & Terminology

Two key terminology choices are explained below to provide context for language used throughout this report.

Latine

Throughout this report, Latine is used as an inclusive term for people of Latin American descent. This gender-neutral alternative to Latino/a acknowledges non-binary and gender-diverse individuals within Latin American communities while remaining accessible across Spanish and English. The use of Latine was recommended by Latino Service Providers, who served as a key community partner in this assessment. When reporting figures drawn from secondary data sources, this report uses the exact racial and ethnic terminology of the original source; Latine is used for findings from this assessment's own survey and qualitative data. Because these terms reflect different population definitions, comparisons between survey and secondary data are interpreted with appropriate caution.

Woman & Mother

Throughout this report, the terms woman and mother are used as the primary language to describe people in the perinatal period. In consultation with First 5 Sonoma County, these terms were selected because they are more commonly understood by the general public than alternatives such as birthing person. The decision also reflects the language used by participants themselves across focus groups, interviews, and the community survey—neither community members nor providers used alternative terminology when describing their experiences. This report recognizes that perinatal experiences are more diverse than these terms capture, and this choice is not intended to exclude or diminish the experiences of those who do not identify as women or mothers. The limitations of this approach are further addressed in the data collection and limitations sections that follow.

Secondary Data Analysis

Secondary data were drawn from multiple publicly available sources to characterize maternal and perinatal health in Sonoma County. Data sources included the California Department of Public Health (CDPH) Maternal, Child, and Adolescent Health (MCAH) Data Dashboards; the California Maternal and Infant Health Assessment (MIHA); the California Health Interview Survey (CHIS); the CDC WONDER Natality Database; the American Community Survey (ACS); the California Overdose Surveillance Dashboard; the California Department of Justice Crimes Dashboard; and Medi-Cal enrollment data from the California Health and Human Services Open Data Portal.

Sonoma County estimates were compared to California state-level benchmarks whenever data were available at both levels to contextualize local trends. Data were disaggregated by race and ethnicity, age, insurance type, and income where available to identify disparities across populations. Trend information was reviewed for all indicators with multiyear comparison data. Some indicators are reported as rolling three-year averages due to small sample sizes at the county level. Data availability and disaggregation varied by source and indicator; limitations in secondary data are noted where relevant throughout the report.

Secondary data findings are summarized in the Sonoma County Maternal Health Profile section that follows the Methods. That section provides an overview of key population health indicators, demographic context, and disparities relevant to maternal health in Sonoma County. The full secondary data analysis, including detailed data tables and source documentation, is presented in **Appendix B**.

Community Survey

The community maternal health survey used a non-probability convenience sample of people living in Sonoma County who gave birth in 2023 or later. As a convenience sample, findings reflect the experiences of participants and are not statistically generalizable to all county residents who gave birth in this period.

The survey was available online in English and Spanish from January through May 2026, was designed to take approximately five minutes, and was administered through Typeform. To protect data quality, no gift card or other incentive was offered for online survey completion. The online survey included two spam-prevention measures: honeypot fields (hidden form fields that legitimate respondents leave blank) and an eligibility screen that prevented respondents from advancing if they had not given birth in 2023 or later. Completed responses were reviewed for completion time and zip code validity; seven responses from adjacent counties were retained given that residents of neighboring communities may access maternal health services in Sonoma County. A total of 623 valid responses were included in the analysis. All data are self-reported.

The survey was promoted broadly through radio, social media, and partner networks, with additional targeted outreach to reach lower-income mothers and Black women. Virtual outreach included First 5 Sonoma County and partner email distribution, paid and unpaid social media posts on Facebook and Instagram, and geofenced mobile display advertising. Radio advertisements aired on nine local radio stations in English and Spanish between February and March 2026. In-person outreach was conducted at Child Parent Institute (CPI) Diaper Drives, the Children's Museum of Sonoma County, and the Corazón Healdsburg Preschool Fair, where participants who completed the survey received a \$10 gift card; partner organizations serving low-income families also distributed flyers to promote the survey among their clients. Additional targeted outreach was conducted through Black doulas to reach more Black women.

The survey collected data on experiences, needs, and supports across the perinatal continuum, including pregnancy, birth, and the postpartum period. Not all respondents answered every question; item-level denominators therefore vary, and all percentages reported in this assessment are based on the number of participants who responded to the relevant question. Responses were disaggregated by race/ethnicity, income, home language, and immigration status. Subgroup results are reported only where a group reached 30 or more responses ($n \geq 30$) for the specific question being analyzed. Because not all respondents answered every question, a subgroup may meet this threshold for some measures but not others; in those cases, results are reported for the measures that meet the threshold and suppressed for those that do not.

Race and ethnicity were collected using a single combined select-all-that-apply question, consistent with the 2024 revisions to the U.S. Office of Management and Budget's Statistical Policy Directive No. 15 (OMB SPD 15, 2024). “Hispanic or Latino/a/e”: is offered as one response category (referred to as Latine in this report; see [Language and Terminology](#)) rather than asked separately, and participants who selected more than one identity are counted in each category and may appear in more than one group.



References to “English-speaking” and “Spanish-speaking” participants refer to those who identified English or Spanish as the main language spoken in their home; participants who identified other home languages (n=20) fell below the n≥30 threshold and are not included in language-based disaggregations. Survey data tables are presented in [Appendix A](#).

SURVEY DEMOGRAPHICS: Community Survey Snapshot

623

Community members participated

18-48

Age range of survey participants

34

Median age of participants
(n=599)

109 (17%)

Participants who identify as immigrants
(n=623)

Participants could select more than one race or ethnicity; categories are not mutually exclusive and percentages do not sum to 100%. Race and ethnicity were reported by 450 of 623 participants; percentages reflect the share of those who responded.

Race / Ethnicity (n=450)	n	%
Latine	217	48.2%
White	201	44.7%
Asian	30	6.7%
Black or African American	20	4.4%
American Indian or Alaska Native	6	1.3%
Native Hawaiian or Other Pacific Islander	2	0.4%
Other	8	1.8%

Main Language Spoken at Home (n=600)	n	%
English	377	62.8%
Spanish	203	33.8%
Other	20	3.3%

Annual Household Income (n=600)	n	%
Less than \$43,000	164	27.3%
\$43,000–\$61,999	67	11.2%
\$62,000–\$92,999	49	8.2%
\$93,000–\$124,999	62	10.3%
\$125,000 or more	185	30.8%
Don't know	73	12.2%

Health Insurance Type During Pregnancy (n=609)	n	%
Private or employer-based	306	50.2%
Medi-Cal	264	43.3%
Covered California	28	4.6%
No health insurance	7	1.1%
Don't know	4	0.7%

Key Informant Interviews

Nineteen (19) key informant interviews were conducted with 25 stakeholders who offered diverse perspectives on maternal health needs in Sonoma County. All interviews were conducted virtually. Stakeholders represented both clinical and community-based settings and included obstetricians, family physicians, perinatal mental health providers, Comprehensive Perinatal Services Program (CPSP) coordinators, family support specialists, perinatal group facilitators, public health nurses, midwives, doulas, and birth workers, including independent practitioners. Participating organizations included:

- Humanidad Therapy and Education Services
- Santa Rosa Community Health
- Sonoma Community Action Network
- Sonoma County Department of Health Services
- Sonoma County Indian Health Project
- Sonoma Valley Health Center
- West County Health Center
- Better Beginnings
- Child Parent Institute
- Common Ground Society
- Corazon Healdsburg
- Kaiser Permanente
- Mothers Care
- Petaluma Health Center

Focus Groups

Focus group priority populations were selected using two complementary frameworks. **Place-based focus groups** were conducted in geographic areas identified in *A Portrait of Sonoma County* as having the lowest Human Development Index (HDI) scores, reflecting concentrated socioeconomic disadvantage and health disparities. **Affinity-based focus groups** were organized around shared identities or experiences—including race and ethnicity, immigration status, and occupation—to surface the distinct maternal health experiences of communities defined by those characteristics. Groups in this latter category included Black, Native American, undocumented, and farmworker women. Focus groups were designed to capture the maternal health experiences of populations that face the greatest disparities and whose perspectives are often underrepresented in quantitative data because sample sizes are too small to yield statistically meaningful estimates.

Eight focus groups were conducted across Sonoma County in English and Spanish, in-person and virtually. Latino Service Providers conducted focus groups in Spanish to ensure a culturally inclusive and welcoming environment for Spanish-speaking participants. The language, modality, and recruitment partners for each group are detailed in the Focus Group Overview table below.

Despite targeted outreach, several priority populations could not be engaged. Recruitment efforts targeting Pacific Islander and Southeast Asian women did not achieve sufficient participation for either group, and perspectives from these communities are therefore not represented in the qualitative findings. Outreach to recruit birthing people who do not identify as women was conducted in partnership with trusted local LGBTQIA+ organizations; however, no participants were successfully recruited. As a result, the experiences of transgender, nonbinary, and gender-

expansive birthing people are also absent from the qualitative findings. This assessment should not be interpreted as a complete account of maternal health experiences for any of these communities, and dedicated engagement strategies are recommended to ensure their perspectives inform future planning.

Focus Group Overview

Population	n	Modality	Language	Recruitment Partner
Affinity-Based Groups				
Black mothers	8	Virtual	English	Health Equity Rising; NAACP Santa Rosa–Sonoma; North Bay Black Chamber of Commerce
Farmworker mothers	3	Virtual	Spanish	First 5 Sonoma County
Native American mothers	5	Virtual	English	Sonoma County Indian Health Project WIC
Undocumented mothers	6	In-person	Spanish	La Plaza
Place-Based Groups				
Low-income mothers in Cloverdale	6	In-person	English	Head Start / Early Head Start
Low-income mothers in Santa Rosa	5	In-person	English	Head Start / Early Head Start
Low-income mothers in Sonoma Valley	5	In-person	Spanish	La Luz Center; Sonoma Valley Health Center
Mothers in or near Monte Rio	10	In-person	English	River to Coast Children’s Services; West County Health Centers
TOTAL	48			

FOCUS GROUP DEMOGRAPHICS

48

Focus group participants

8

Total focus groups

21-44

Age range of participants

34

Median age of participants

Insurance and race / ethnicity were multi-select; all other questions were single-select. Percentages for single-select items are calculated among participants who provided a response. Participants could select more than one race or ethnicity; categories are not mutually exclusive and percentages do not sum to 100%.

Race / Ethnicity (n=42)	n	%
American Indian or Alaska Native	5	10%
Asian	0	—
Black or African American	9	19%
Hispanic or Latine	24	50%
Middle Eastern or North African (MENA)	0	—
Native Hawaiian or Other Pacific Islander	0	—
White	10	21%

Health Insurance During Most Recent Pregnancy (n=48)	n	%
Medi-Cal	33	68.8%
Private or employer-based	15	31.2%
Covered California	1	2.1%

Note: Multiple selections allowed; one participant selected two insurance types, so totals exceed n (n=48).

Annual Household Income (n=47)	n	%
Less than \$43,000	15	31.9%
\$43,000–\$61,999	14	29.8%
\$62,000–\$92,999	6	12.8%
\$93,000–\$124,999	7	14.9%
\$125,000 or more	1	2.1%
Don't know	4	8.5%

Highest Education Completed (n=47)	n	%
Less than high school	7	15%
High school diploma or GED	11	23%
Some college or technical school	17	36%
Associate degree	2	4%
Bachelor's degree	10	21%
Graduate or professional degree	0	—

Qualitative Analysis

Focus group sessions and key informant interviews were recorded and transcribed. Focus groups conducted in Spanish were translated to English prior to analysis. All transcripts were imported into Dedoose, a mixed-methods analysis platform, for systematic coding and analysis. A structured codebook was developed around the perinatal continuum—organizing themes across pregnancy, birth and delivery, and the postpartum period—with additional codes capturing cross-cutting themes such as access to care, cultural responsiveness, and systemic barriers, as well as emergent themes that arose from the data. Qualitative data from focus groups and key informant interviews are the primary basis for the thematic structure of this report because they are best positioned to capture the experiences of priority populations—including Black, Latine, Native American, farmworker, and undocumented women across the county—whose perspectives are often too small in number to surface meaningfully in quantitative data alone. Low-income women were also prioritized given the significant disparities they face across the perinatal continuum. Community survey data are incorporated throughout to add breadth and quantitative context, and

are noted where they diverge from or add nuance to qualitative themes. Secondary data are referenced where they corroborate or contextualize primary findings.

Limitations

This assessment has several limitations that should be considered when interpreting findings.

Recruitment relied primarily on community organizations to identify and invite focus group and survey participants. While this approach effectively reached women connected to community-based services, it likely underrepresented those who are most isolated or disconnected from formal support systems—who may also face the greatest barriers to care. Outreach and data collection were conducted in English and Spanish only, meaning the perspectives of women who speak other languages are not represented. Digital survey distribution methods may have further limited participation among those with limited technological access or internet connectivity.

Despite targeted outreach, focus groups with Pacific Islander and Southeast Asian women were not successfully convened, and survey responses for both groups fell below the threshold for standalone quantitative reporting ($n < 30$). These communities face documented maternal health disparities and are frequently underrepresented in administrative data; their absence is a meaningful gap in this assessment. Similarly, research documents elevated rates of mental health challenges and trauma among transgender men and nonbinary individuals in the perinatal period, reflecting distinct needs that this assessment was not designed to capture. Outreach conducted in partnership with local LGBTQIA+ organizations did not result in participation from transgender, nonbinary, or gender-expansive birthing people, and no survey participants indicated they were transgender or nonbinary. This report is therefore unable to speak to the maternal health experiences or service needs of these populations. Dedicated engagement strategies are recommended to ensure these perspectives inform future planning and investment decisions.

Among survey participants, white and Latine participants reached sufficient numbers ($n \geq 30$) for race/ethnicity-based comparisons across measures, and Asian participants did so for selected measures. Other racial and ethnic groups did not reach the threshold for quantitative comparison; their experiences are described qualitatively where possible.

Sonoma County Maternal Health Profile

Public Health Indicators & Trends

This profile draws on secondary public health data to establish a baseline portrait of maternal health in Sonoma County—the demographic, clinical, and social landscape against which the community experiences documented in this report unfold. It highlights the indicators most central to this assessment; complete data tables and source documentation, including disaggregation by race and ethnicity, income, and insurance type where possible, are presented in [Appendix B](#).



Sonoma County is home to approximately 247,000 women, nearly a third of whom (31%) are eligible for Medi-Cal. Among women of reproductive age (15–50), the uninsured rate has declined substantially over the past decade, falling from 19.2% in 2013 to 4.9% in 2023—a positive indicator of expanded coverage access (ACS, 2013–2023). Despite this progress, significant disparities in maternal health outcomes persist across race and ethnicity, income, health insurance type, and geography. These opportunities for improvement are described below.

Baseline Health of Women of Reproductive Age

Understanding maternal health outcomes requires attention not only to what happens during and after pregnancy, but to the health that women have prior to pregnancy. In Sonoma County, a substantial share of women of reproductive age are navigating elevated rates of chronic disease, economic insecurity, psychological distress, and substance use before they become pregnant—conditions that shape their capacity to access prenatal care, navigate pregnancy and birth, and recover in the postpartum period.

Physical Health

According to the California Health Interview Survey (CHIS, 2020–2024), 18.5% of Sonoma County women aged 18–49 report fair or poor health—higher than the California rate of 14.0%. More than half of Sonoma County women (55.8%) have a BMI of 25 or higher, a rate consistent with the state overall but with pronounced disparities by ethnicity and income: 76.3% of Hispanic women and 75.4% of women below 200% of the federal poverty level fall into this category—both significantly higher than other groups.

Economic Insecurity & Food Access

Economic stress is a defining feature of the reproductive-age landscape in Sonoma County. Nearly 26% of county households spend 50% or more of their income on rent (ACS, 2023), and among women aged 18–49 living at or below 200% of the federal poverty level, 61.9% report being unable to afford enough food—a food insecurity rate that significantly exceeds California's rate of 51.9% (CHIS 2022–2024).

Substance Use

Drug overdose death rates among Sonoma County women rose sharply over the past decade, peaking at 18.7 per 100,000 in 2020 before declining to 11.8 in 2024. Emergency department visits for opioid overdoses among Sonoma County women stand at 27.2 per 100,000 (2024), above the California rate of 23.8.

Psychological Distress

The mental health burden among Sonoma County women of reproductive age is among the most striking findings in the baseline data. According to CHIS (2022–2024), 44.4% of women aged 18–50 in the county reported needing help for an emotional or mental health problem or substance use, compared to 37.8% statewide. More than a third (34.2%) are estimated to have experienced serious psychological distress in the past year, a rate significantly higher than California's 24.8%. Among Latine women of reproductive age, the serious psychological distress rate reaches 44.0%. Lifetime suicidal ideation was reported by 38.6% of Sonoma County women in this age group, compared to 26.8% statewide.

34%

of reproductive-age women in Sonoma County experienced serious psychological distress in the past year

44%

among Hispanic/Latino women of reproductive age

| vs 25% statewide

Source: CHIS 2022-2024

Who Is Having Babies in Sonoma County?

The overall birth rate in Sonoma County has declined modestly over the past decade, from 9.9 births per 1,000 residents in 2016 to 9.0 in 2024 — a pattern consistent with statewide and national trends. Hispanic/Latino women have consistently higher birth rates than white, non-Hispanic women in the county (12.9 vs. 6.5 per 1,000 in 2024), reflecting the younger median age of the Hispanic/Latino population and the demographic composition of the county's childbearing population. The county's teen birth rate (6.7 per 1,000 females aged 15–19 in 2024) is below the California rate (8.7). Though Hispanic/Latino teens in Sonoma County continue to give birth at substantially higher rates than their white, non-Hispanic peers (10.6 vs. 2.6 per 1,000 in 2024), this gap has narrowed considerably over the past decade.



Physical Health in Pregnancy

Sonoma County performs well on several prenatal health indicators relative to California as a whole. Nearly 90% of women in the county initiated prenatal care in the first trimester (2021–2023), compared to 86.5% statewide (CDPH MCAH, 2021–2023). Tdap vaccination during pregnancy is also notably higher in Sonoma County (80.2%) than in California (65.8%), suggesting strong engagement with prenatal care systems among those who access them (MIHA, 2020–2022).

However, prenatal care entry rates are not equitable across the county's population. White women initiated first-trimester care at a rate of 92.4% in the most recent period, compared to 87.3% for Hispanic women, 83.6% for Black women, and 62.5% for Native Hawaiian and Pacific Islander women. Women without insurance (self-pay) entered prenatal care in the first trimester at a rate of just 71.0%, compared to 94.2% for those with private insurance (CDPH MCAH, 2021–2023).

Rates of gestational diabetes (11.9%) and pregnancy-associated hypertension (15.0%) are rising across Sonoma County and remain above California averages, with hypertension during delivery having risen by roughly 60% since 2016–2018. These trends carry particular concern for Black women, whose rates of pregnancy-associated hypertension (20.6 per 100 deliveries) are higher than those of Hispanic (13.5) and white (16.2) women in the county (CDPH MCAH, 2021–2023).

Excessive weight gain during pregnancy is more common in Sonoma County (48.0% of deliveries, 2021–2023) than in California (43.7%), and has remained elevated over time. Rates of substance use during pregnancy are also higher locally than statewide: cannabis use during pregnancy

Hispanic / Latino Birth Rates Remain Nearly Twice Those of White Residents

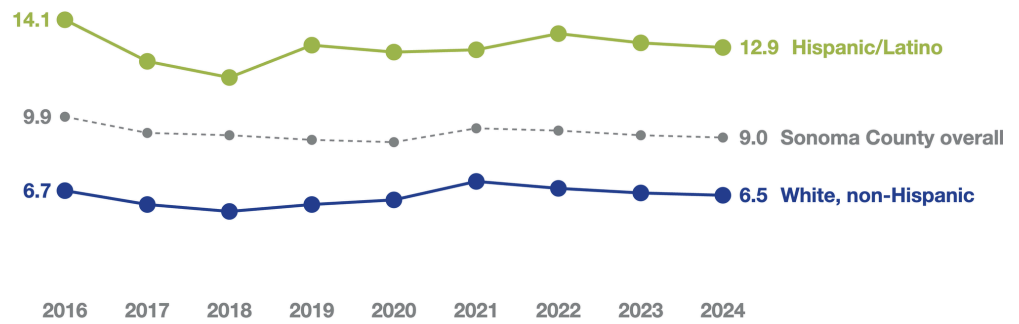


Figure 1. Overall Birth Rates by Race / Ethnicity, Sonoma County, 2016–2024
Births per 1,000 residents. Source: CDC WONDER.

Hispanic / Latino Teens Give Birth at Higher Rates Than White Teens—But the Gap is Closing

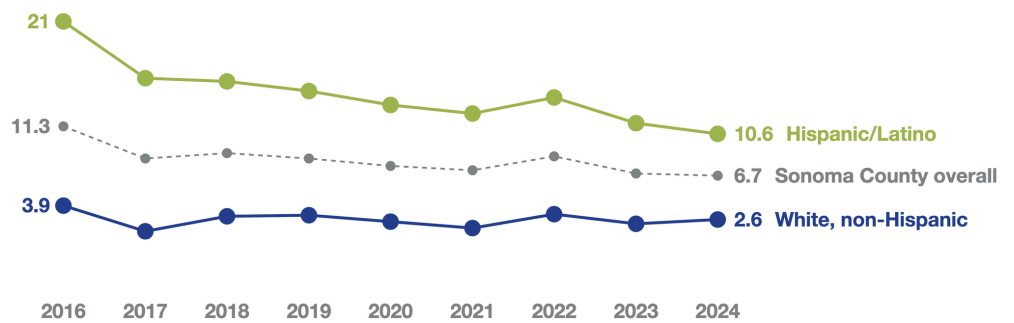


Figure 2. Teen Birth Rates by Race / Ethnicity, Sonoma County, 2016–2024
Births per 1,000 females ages 15–19. Source: CDC WONDER.

(9.1%) and alcohol use in the third trimester (10.3%) both significantly exceed California averages, with cannabis use particularly elevated among women aged 20–34 and those with lower incomes (CDPH MCAH, 2021–2023).

Intimate partner violence (IPV) during pregnancy affects an estimated 6.0% of Sonoma County women, comparable to the California rate of 5.4%, with notably elevated rates among women living at or below the federal poverty level (10.6%) (MIHA, 2020–2022).

Physical Health in Birth

The physical risk profile of birth in Sonoma County is worsening. The share of births involving at least one maternal risk factor has risen from 24.0% in 2016 to 36.3% in 2024, a 51% increase—outpacing California's already-rising rate (26.2% to 33.6% over the same period) (CDPH MCAH, 2016–2024). Rates of severe maternal morbidity—a composite indicator of serious, life-threatening complications during delivery—reflect this trajectory: Sonoma County's rate rose from 111.0 per 10,000 births (2016–2018) to 193.4 per 10,000 births (2022–2024), a 74% increase that is significantly higher than California's rate of 113.0 per 10,000. Disparities by race and ethnicity are pronounced: Asian women experience the highest rates (247.3 per 10,000), followed by Hispanic women (177.1) and white women (161.9).

Sonoma County's Severe Maternal Morbidity Rate Rose 74% Since 2016-2018—Now Significantly Above California

Rate per 10,000 Births, Rolling 3-Year Average

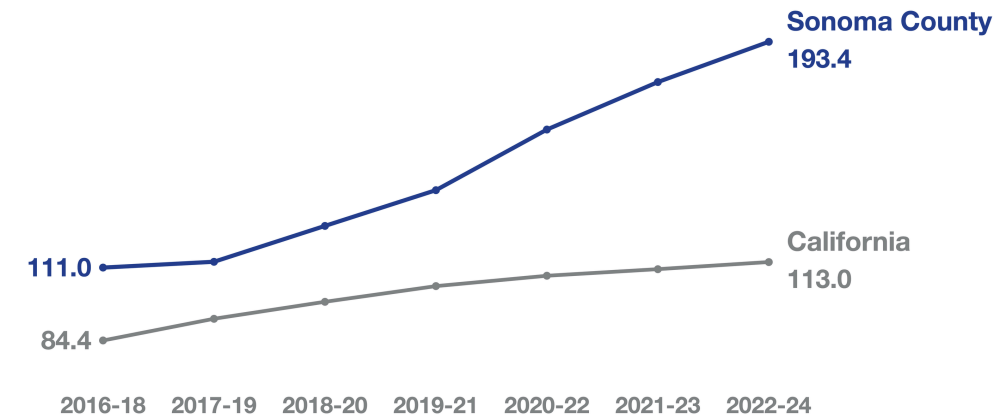


Figure 3. Severe Maternal Morbidity, Sonoma County vs. California, 2016-2018 to 2022-2024. Rates per 10,000 births, rolling 3-year average. Source: CDPH MCAH Dashboard.

Cesarean delivery rates in Sonoma County have also risen—from 26.4% of births (2017–2019) to 28.4% (2021–2023), though the county remains below California's rate of 31.1%. Increases have been sharpest among American Indian and Alaska Native women (30.4% to 38.2%) and Asian women (31.1% to 35.7%), groups already facing elevated morbidity risk.

Preterm birth rates in Sonoma County (7.9%) remain below the California rate (9.1%) (CDPH MCAH, 2016–2018 to 2022–2024). However, racial disparities in preterm birth are an area of



concern, particularly for Black women, whose rate has nearly doubled since 2016–2018 (6.6% to 12.8%) and is significantly higher than that of other racial and ethnic groups in the county.

The experience of birth in Sonoma County is not only physically riskier—it is also marked by gaps in respectful care. More than one in ten Sonoma County women (11.3%) reported rarely or never feeling heard or listened to by providers during delivery, slightly above the California rate of 10.2%. Among women living below 100% of the federal poverty level, that figure rises to 25.5%.

The physical consequences of the county's elevated substance use rates are also visible at birth. Rates of neonatal abstinence syndrome (NAS)—a marker of in-utero substance exposure—have increased in Sonoma County (5.6 per 1,000 births, 2021–2023) and are significantly higher than in California (2.8). NAS rates are particularly elevated among Medi-Cal-covered births (12.1 per 1,000) and white women (9.4 per 1,000) (CDPH MCAH Dashboards).

Perinatal Mental Health

Mental health represents one of the most significant dimensions of maternal health in Sonoma County. According to the California Maternal and Infant Health Assessment (MIHA), 41.1% of Sonoma County women reported anxiety or depression symptoms before, during, or after pregnancy (2020–2022), a rate significantly higher than the California average of 35.4%. This county-level figure reflects a substantially broader burden than is captured by postpartum depression screening alone: Sonoma County's postpartum depression symptom rate (14.9%) is comparable to the state rate. The approximately 26 percentage point difference between the anxiety-or-depression rate and the postpartum depression rate alone represents a large population of women experiencing perinatal anxiety and other mood disorders that standard screening protocols may miss.

Notably, while 38.8% of Sonoma County women reported a perceived need for mental health care during the perinatal period (higher than the state rate of 31.6%), 69.9% of those who needed care reported receiving it, a rate significantly higher than in California (53.9%) (MIHA, 2020–2022). This suggests that when women can access perinatal mental health care, Sonoma County's system performs relatively well.

2 in 5 Sonoma County Women Experience Perinatal Anxiety or Depression, with Higher Rates Among Asian and Black Women

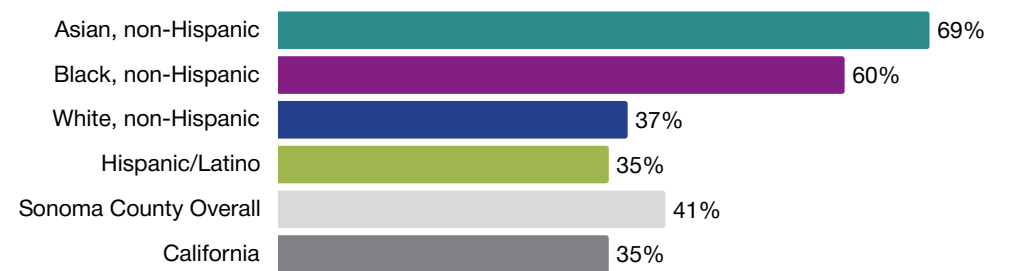


Figure 4. Perinatal Anxiety or Depression Symptoms by Race / Ethnicity, Sonoma County. Source: MIHA 2020-2022.



Rates of anxiety or depression symptoms are highest among Asian, non-Hispanic (69.1%) and Black, non-Hispanic (60.3%) women in the county. Additionally, women living in higher-poverty neighborhoods (20–29% neighborhood poverty rate) reported anxiety or depression symptoms at a rate of 52.7%, compared to 38.3% in lower-poverty neighborhoods (MIHA, 2020–2022).

Postpartum Health

Postpartum medical visit rates in Sonoma County (91.7%) exceed the California average (88.2%) (MIHA, 2020–2022), indicating that most women do re-engage with care after delivery. Sonoma County also leads California in postpartum contraceptive use, with 36.6% of postpartum women using the most effective methods—well above the state rate of 25.8%.

Breastfeeding initiation in Sonoma County is a notable strength: 96.8% of women initiated any breastfeeding at the hospital (2022–2024), above the California rate of 93.6%. Exclusive breastfeeding initiation (85.5%) also far exceeds the state rate (68.8%) (CDPH MCAH, 2022–2024). At one month, 92.3% of Sonoma County mothers were still breastfeeding, compared to 85.7% statewide. However, continuation rates decline over time and are unevenly distributed, with lower continuation among Hispanic mothers and mothers at lower income levels (MIHA, 2020–2022).

These indicators represent the extent of population-level postpartum data available for Sonoma County through existing public health surveillance systems. Notably absent are measures of physical recovery, anxiety and other mental health conditions beyond depression symptoms, and social support and isolation. This gap is itself a finding: the postpartum period remains the least monitored phase of the perinatal continuum, despite being the period in which women need the most support. The qualitative and survey findings in the sections that follow give voice to postpartum experiences that public data do not capture.

Community Experiences & Provider Perspectives

Survey, Focus Group & Interview Findings

The sections that follow draw on all three primary data sources—the community survey, focus groups, and key informant interviews—to give depth and context to what public health data alone can capture. Qualitative findings from focus groups and interviews drive the overall thematic structure; survey data are woven throughout to add breadth and quantitative context, and are noted where they diverge from or add nuance to qualitative themes. Secondary data are referenced throughout where they corroborate or contextualize primary findings.



Pregnancy

Experiences

Most women in Sonoma County described feeling supported during pregnancy (77.6%). However, women with lower incomes, who primarily speak Spanish at home, or who identified as Latine reported feeling less supported during pregnancy than their white, English-speaking, and higher-income counterparts. White and Asian participants reported feeling well-supported at similar rates (89.1% and 86.7%, respectively), compared to 72.7% among Latine participants. Feeling supported during pregnancy increased steadily with household income, ranging from 68.7% among the lowest-income participants to 90.8% among those earning \$125,000 or more. Participants who primarily speak Spanish at home reported feeling well-supported at 69.3%, compared to 82.9% of those who primarily speak English at home. Higher-income participants were more than twice as likely to report no unmet needs during pregnancy as those at the lowest income tier (45.9% among those earning \$125,000 or more vs. 22.0% among those earning under \$43,000).

When women named what helped them most during pregnancy, family and friend support was most prominent—named by 46.0% of participants as a helpful support. Access to healthy food (36.1%) and regular prenatal care appointments (33.3%) were the second and third most cited helpful supports. When they named what was missing, connection with other parents topped the list (22.1%). The family and friends finding carried distinct disparities: white participants were nearly twice as likely as Latine participants to name family and friends as a helpful support (62.2%

vs. 34.5%), and English-speaking participants were more than twice as likely as Spanish-speaking participants (55.9% vs. 30.2%). Overall, 65.8% of survey participants reported at least one unmet need during pregnancy—a figure that rises to 78.0% among the lowest-income respondents.

Two-Thirds of Pregnant Women Reported An Unmet Need

Top 5 Unmet Needs During Pregnancy

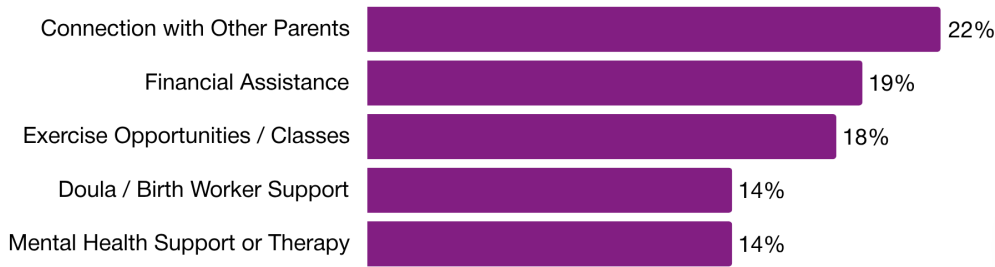


Figure 5. Unmet Needs During Pregnancy; top five shown. Full results in Appendix A. % of all participants, multiple selections allowed; Community Survey, n=603.



Mental Health

Mental health emerged as the most significant theme across the qualitative analysis and was identified as the top pregnancy challenge in the community survey. Mothers and providers described experiences of prenatal anxiety, depression, fear, grief associated with pregnancy loss, and isolation.

2 in 5
pregnant women rated
their mental health as fair
or poor

Source: Community Survey, n=478

In the survey, nearly four in ten participants (39.1%) rated their mental health during pregnancy as fair or poor, compared to 30.0% who said the same about their physical health. This burden was not evenly distributed: Latine participants reported fair or poor mental health at 44.1%, compared to 37.0% among white participants. MIHA data—detailed in the Maternal Health Profile—show perinatal anxiety or depression rates significantly elevated among Asian (69.1%) and Black (60.3%) women relative to white (37.4%) and Latine (35.1%) women (2020–2022). The gap between the MIHA rate of prenatal depression symptoms (14.1%) and the 39.1% of participants reporting fair or poor mental health reflects a broader burden that standard screening tools may not fully capture.

Providers described isolation as a primary driver of mental distress. Isolation arises from different factors, including being geographically far from family support, especially if a recent immigrant. Isolation can also come from being in a geographically isolated or distant location in the county.

As one perinatal group facilitator described it, mothers are isolated “not just from not having their abuelitas and their tías and family members nearby, but also from the actual town.”

Fear—about what was happening in their bodies, about the healthcare system, about their circumstances—ran as an undercurrent through many pregnancy narratives, with sources ranging from past experiences with the healthcare system to immigration status to prior pregnancy loss.

“What I see through my groups is definitely isolation. These are moms who are home all day, doing their pregnancy by themselves ... It is a cry of help that they want spaces where they can meet other moms—that they're not doing it alone.”

— Perinatal Group Facilitator



“I think people feel very alone in their experience of pregnancy and very fearful. There's a lot of fear and anxiety around what is happening in the body. There's not a lot of understanding.”

— Family Physician

“At the doctor's office they told me I was already too old to have babies. I'm 42. That scared me with this baby—instead of feeling excited and happy, I felt a lot of depression, anxiety, and anguish.”

— Undocumented Focus Group Participant

Pregnancy loss and grief surfaced as a distinct, under-supported experience. Providers consistently named the absence of formal grief support — including doula care for miscarriages and terminations — as a significant gap, while mothers who had experienced prior loss described carrying that grief into subsequent pregnancies with little acknowledgment from the systems around them.

“Grief support for pregnancy loss would be great. If we had doula care for miscarriages or terminations — another thing we're thinking about but haven't figured out.”

— Certified Nurse-Midwife

“I was very fortunate, especially because in a previous pregnancy I had a miscarriage and received no support at all.”

— Undocumented Focus Group Participant

Physical Health

Three in ten survey participants (30.0%) rated their physical health during pregnancy as fair or poor—a significant burden, though lower than the 39.1% who rated their mental health the same way. Physical health challenges during pregnancy are real and unevenly distributed, but they do not dominate women's experience of pregnancy the way mental health does.

Income shapes physical health experience. Participants earning under \$62,000 reported fair or poor physical health at 37.4%, compared to 23.6% among those earning \$62,000 or more. Race and ethnicity compound this: Latine women reported fair or poor physical health at 41.2%, compared to 22.9% among white women and 16.7% among Asian women.

When women named their physical challenges, nausea and severe morning sickness emerged most prominently as the second most common pregnancy challenge (21.9%), following mental health. Weight management (17.7%), high blood pressure or preeclampsia (12.5%), gestational diabetes (11.6%), and dental pain or needs (8.2%) rounded out the most commonly cited conditions.

County-level data add important context to the physical health picture, particularly for Black women, who experience pregnancy-associated hypertension at 20.6 per 100 deliveries—higher than Hispanic (13.5) and white (16.2) women in the county (CDPH MCAH, 2021–2023). As detailed in the Maternal Health Profile, rates of gestational diabetes and pregnancy-associated hypertension are rising across Sonoma County and remain above California averages—trends of particular concern in a county where severe maternal morbidity is already significantly above the state rate and rising.

“My second [pregnancy] was miserable—I was exhausted and nauseous 24/7, and I had a toddler. It was go, go, go.”

— Monte Rio Focus Group Participant

Clinicians consistently flagged hypertension and diabetes as the most medically significant and increasingly prevalent complications they manage—one family physician described them as “increasingly common” because “people's baseline health is deteriorated”—yet these conditions ranked below nausea in women's own accounts of what made pregnancy physically hard. Notably, the conditions that carry the greatest clinical risk are not always the ones women experience as their most significant physical burden.

Prenatal Care

As described in the Sonoma County Maternal Health Profile section, Sonoma County outperforms California in prenatal care in the first trimester, dental care during pregnancy, and Tdap vaccination. The survey reported consistent findings, with only 7.1% of participants reporting that accessing prenatal care was difficult or very difficult. However, those barriers were not evenly distributed: participants who primarily speak Spanish at home were more than twice as likely to report difficulty as those who primarily speak English at home (10.4% vs. 4.5%), Latine participants were more than twice as likely as white participants (8.3% vs. 3.5%), and lower-income participants (under \$62,000) were more than twice as likely as those earning \$62,000 or more (9.6% vs. 4.4%). County-level vital statistics data

“Diabetes is a really big thing. The requirements on diabetic mamas are enormous—the responsibilities, the things they are asked to do for their own health.”

— Family Physician

reveal a more striking disparity: Native Hawaiian and Pacific Islander women initiated prenatal care in the first trimester at a rate of just 62.5%—the lowest of any racial or ethnic group in Sonoma County and 30 percentage points below the rate for white women (92.4%).

For Latine and Spanish-speaking families, WIC also plays a critical role alongside clinical prenatal care—nearly one in four Latine survey participants named WIC as a top helpful support during pregnancy, compared to just 2.4% of White participants. County-level data, however, reveal a concerning trend: WIC participation during pregnancy in Sonoma County has declined from 41.9% in 2013–2015 to 31.4% in 2020–2022—even as California's rate has risen from 42.1% to 53.4% over the same period. Participation remains highest among Medi-Cal recipients (65.5%), Hispanic women (57.3%), and women with less than a high school education (81.9%).

The experience of prenatal care varies and the particular provider can have a significant impact on women during pregnancy. Most notably, women appreciated having the same care provider throughout their pregnancy and very much disliked when they had different providers at different prenatal visits.

“Something I really didn't like about [my healthcare provider] is that every time I went, it was a different person. It was horrible to have to explain everything again and again, and they didn't know me.”

— Santa Rosa Focus Group Participant

“With my second child—the first was born in Mexico—yes, the whole process had one doctor who saw me every month and was there when I delivered. And with my youngest too, the doctor was consistent throughout and was there to deliver the baby. There's trust. But when it keeps changing every visit, it's like ... you have to explain everything again.”

— La Plaza Focus Group Participant

Some women experienced judgment or dismissiveness from providers when expressing their preferences for care. When women connected with providers they trusted, they described a markedly more positive prenatal care experience.

“I just had a really bad experience with my OB. She was just so unsupportive. I felt like she treated me negatively—almost like maybe something about me, whether it was that I was a younger mother or that I was low income, or a combination of factors. It was just like absolutely no sensitivity, just going through the appointments, rushing through and being really unfriendly to me.”

— Black Focus Group Participant

A recurring concern across both focus groups and provider interviews was that many women left prenatal visits without fully understanding what they had been told—leaving confused, with questions unasked, and wanting more from the interaction. These barriers to comprehension and communication are documented in depth in the Barriers to Care section of this report.

“I even had a birth plan form that the doula gave me, but I felt uncomfortable handing it to the doctor—I was afraid he would scold me.”

— Sonoma Valley Focus Group Participant

Prenatal Education

Prenatal education and classes emerged as a valued support when available and a significant gap when absent. Mothers frequently expressed that they did not know what to expect across the perinatal period and would have appreciated more opportunities to increase their knowledge. Mothers and interviewees also identified the need for more education for fathers, who often lack the knowledge and skills to be the supportive partners mothers need.

“It's important to offer these support groups or classes to dads, because sometimes they don't know how to be that supportive person. I mean, they're not very supportive, but I don't think that they do it on purpose. I think they do it because they're afraid.”

— Perinatal Group Facilitator

“I wish there were more options for prenatal and postnatal classes for ALL insurance types. Everything is free or low cost for Medi-Cal patients, but I was struggling hard to pay for basic needs and couldn't afford extra classes that could have really benefited me and my child.”

— Survey Participant

“People are either really educated and informed about what they want, or they have no idea what to expect.”

— Certified Nurse-Midwife

Assets • Pregnancy Support

The following assets support women during pregnancy in Sonoma County:

WIC

A primary institutional anchor for Latine and low-income families during pregnancy, providing nutritional support, peer breastfeeding counseling, and connection to resources; named as a helpful support by 24.6% of Latine participants and 28.1% of Spanish-speaking participants. Immigration-related fears and awareness gaps may be limiting enrollment among eligible families, representing an opportunity to strengthen outreach and ensure more women receive the support they qualify for.

Prenatal Education and Classes

Where offered through hospital systems and community clinics, prenatal education was named as a meaningful support, with some systems providing robust prenatal preparation including hospital tours, birth preparation classes, and partner education. Access is uneven across insurance types and geographies, and women who do not qualify for Medi-Cal but cannot afford private classes face a particular gap. Education for fathers and partners is largely absent. Women described arriving at birth feeling unprepared for the realities of labor—not knowing what to ask for or what was optional—and partners frequently arrived equally unprepared to provide effective support. Expanding access to low-cost, community-based, and culturally relevant prenatal education that includes non-birthing partners represents a meaningful opportunity.

Gaps • Pregnancy Support

The following systemic gaps in pregnancy support were identified across the assessment:

Perinatal Mental Health Support

Prenatal mental health screening tools may be missing the broader anxiety burden experienced during pregnancy; mental health support during pregnancy is unevenly available and concentrated at higher income levels. Grief support for pregnancy loss is largely absent. These gaps point to an opportunity to expand both screening approaches and available support options across the continuum of need.

Continuity of Prenatal Care Providers

Rotating provider schedules in larger health systems mean many women see a different provider at every visit, losing the relationship continuity that meaningfully shapes the care

experience. Women described this as disorienting and named knowing your provider as something they wished for.

Knowledge of Resources and Benefits During Pregnancy

Many women leave prenatal appointments without knowing what programs they are eligible for, including benefits such as Medi-Cal doula coverage, WIC, and home visiting programs. Providers do not consistently connect women to available resources. This gap is addressed in greater depth in the Cross-Cutting Themes Assets and Gaps section.

Doula Access and Awareness

Despite Medi-Cal coverage since January 2023, awareness of the doula benefit during pregnancy remains low among both patients and providers, and referrals often come too late in pregnancy to allow a meaningful relationship to develop before birth. This gap is addressed in greater depth in the Cross-Cutting Themes Assets and Gaps section.

Peer Connection and Community

Connection with other parents was the single largest unmet need identified during pregnancy, named by 22.1% of participants. Structured opportunities for pregnant women to connect with peers are limited, particularly in formats that are flexible, low-cost, and geographically accessible. This is addressed in greater depth in the Cross-Cutting Themes Assets and Gaps section.



Experiences

Most women in Sonoma County felt supported during birth (81.0%). However, the same patterns of disparity seen during pregnancy carried into birth—women with lower incomes, who primarily speak Spanish at home, or who identified as Latine reported feeling less supported than their higher-income, English-speaking, and white counterparts. White participants reported feeling well-supported at 86.5%, compared to 79.0% among Latine participants. By income, 85.2% of participants earning \$62,000 or more reported feeling well-supported, compared to 75.0% of those earning under \$62,000. Participants who primarily speak Spanish at home reported feeling well-supported at 74.2%, compared to 86.1% of those who primarily speak English at home.

“I think most people are pretty stunned by their first birthing experience. I would say I have more people tell me that they felt their birth was traumatic than people tell me they had a great birthing experience.”

— Family Physician

Having a partner or support person present was the single most helpful factor women named at birth—identified by 66.1% of participants. Clear communication about what was happening (41.0%), providers listening to and respecting their preferences (36.4%), and knowing what to expect (27.3%) followed. When they named what was missing, the same themes inverted: clearer communication (20.3%) and better listening and respect from providers (17.7%) topped the list of what would have made the experience better, followed by doula support (15.8%). Preparation shaped experience as well—particularly for first-time mothers, who often described not knowing what to expect, a gap consistent with the need for prenatal and birth education described in the **Pregnancy** section.

Birth outcomes data for Sonoma County reveal a worsening clinical picture, with significant disparities in who bears the greatest risk. As detailed in the Maternal Health Profile, severe maternal morbidity rose 74% between 2016–2018 and 2022–2024, reaching a rate well above the California average, with Asian and Hispanic women experiencing the highest burden. Cesarean delivery rates have also risen, with the sharpest increases among American Indian and Alaska Native and Asian women.

Unmet Needs at Birth Centered on Communication and Respect

Top 5 Unmet Needs During Labor and Delivery

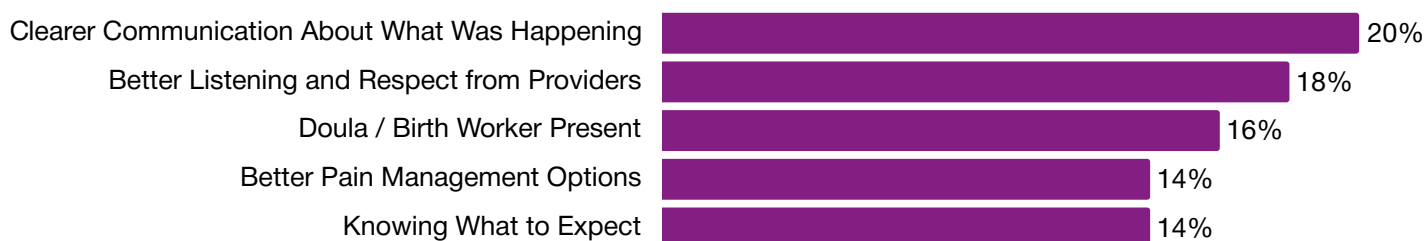


Figure 6. Unmet Needs During Labor and Delivery; top five shown. Full results in Appendix A. % of all participants, multiple selections allowed; Community Survey, n=601.

Communication & Agency

The experience of birth is shaped by several interconnected factors that are much more about how a woman feels she was treated than about which specific procedures occurred. Women have different preferences for procedures—some prefer a vaginal birth after Cesarean (VBAC) while others strongly prefer a cesarean delivery; some want a scheduled induction while others feel strongly about not being induced. What shapes the birth experience is less the procedure itself and more whether women feel heard, informed, and given a meaningful sense of agency over their own care.

26%

of women below 100% of the federal poverty level rarely or never felt heard during delivery

| vs 11% overall

Source: MIHA 2020-2022

As one perinatal therapist described it, birth experiences were a “mixed bag—one person can have a C-section and it's traumatic, another it's what they wanted.” What she emphasized mattered most was whether a woman was “kept abreast of what was happening”—and whether she felt she mattered. “If someone feels like they didn't matter, that matters.”

The way providers listen—or fail to listen—emerged as one of the most consequential factors in how women experienced birth. When providers listened to and respected preferences, women named it as one of the most helpful aspects of their birth (36.4% overall). It also ranked as the second highest unmet need during birth (17.7%), reflecting how much its absence matters. These experiences were not evenly distributed: white participants were more than twice as likely as Latine participants to name providers listening to and respecting preferences as a helpful factor at birth (59.6% vs. 24.7%), and English-speaking participants were four times as likely as Spanish-speaking participants to name it as helpful (51.5% vs. 12.8%). MIHA data show that 11.3% of Sonoma County mothers rarely or never felt heard during delivery—a figure that rises to 25.5% among women living below the federal poverty level (2020–2022).

Providers and birth workers described the same pattern from the care side. What is often missing, one nurse midwife explained, is true shared decision-making between the patient and care team—even when patient and provider disagree.



“People want all the information. They want to be engaged in decision making. They want to understand why things are being recommended, so they are participating in the process and not having things done to them. People want to feel listened to, that their preferences are respected.”

— Certified Nurse-Midwife

Lower-Income Women Were Less Likely to Report Providers Listening To and Respecting Their Preferences During Birth

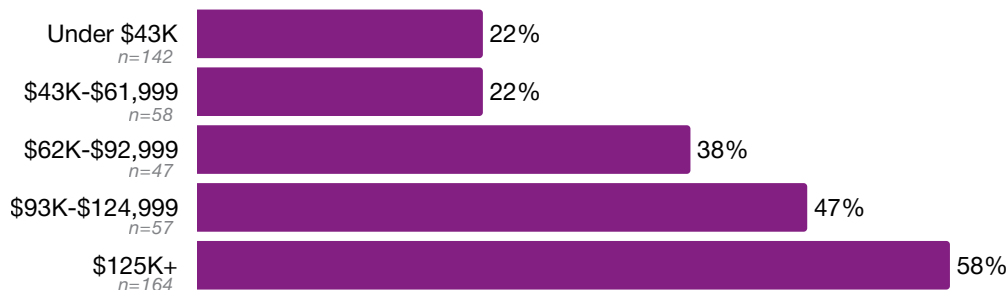


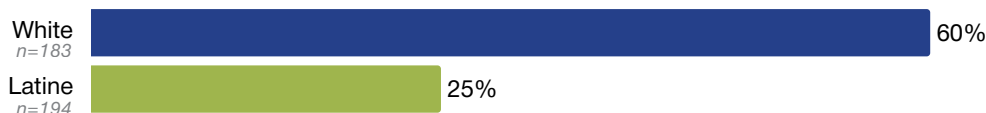
Figure 7. Providers Listening To and Respecting Preferences During Birth, by household income. Community Survey, n=468.

“Providers need to communicate more about what they're doing and why. They just come in, do things to your body, and don't explain what's happening. You're left confused and sometimes scared.”

— Cloverdale Focus Group Participant

Latine and Spanish-Speaking Women Were Less Likely to Report Providers Listening To and Respecting Their Preferences During Birth

Race / Ethnicity



Survey Language



Figure 8. Providers Listening To and Respecting Preferences During Birth, by race / ethnicity and home language. Community Survey, n=546.

Consent and being informed of processes and procedures were also important components—when absent, they negatively influenced the birth experience. Women described feeling that procedures were “done to them” rather than with them—a phrase that recurred across multiple focus groups. The challenges with communication and consent become particularly acute during emergency procedures like an unplanned cesarean delivery, when speed and stress compound the gap between what providers know and what women are told. A public health nurse noted that when this happens, “families don't feel like they were totally prepared or informed.” One birth worker described providers treating patients “like a car to be worked on” rather than as a person.

“I had a horrible experience when it came to labor and delivery. Things were being done without my consent.”

— Survey Participant

“The nurses were not listening to anything I was saying, even after the birth.”

— Native American Focus Group Participant

“I don't remember them explaining anything about how the C-section would go.”

— Farmworker Focus Group Participant



“They even restarted my labor without telling me what they were doing. It was a very disorienting experience.”

— Cloverdale Focus Group Participant

Choice and shared decision-making emerged as a related theme—particularly around procedures women had strong feelings about. Many women wanted to attempt a VBAC but were told they could not. Others wanted to avoid an induction but felt they had no real choice in the matter. A perinatal group facilitator described seeing a pattern in how “doctors want us to have C-sections, doctors want us to be induced.” One survey participant described “lots of frustration with push to induce and not feeling heard in labor/delivery.” When women were given a choice—about birthing position, about whether to follow a recommendation, about how to use their bodies in labor—the experience was markedly different.



“I’ve always wanted to give birth in a position that felt right for my body—sitting, squatting, holding on to something. But the staff insisted I stay on my back. That frustrated me deeply. When I was allowed to use the birthing ball or move around, I felt much better.”

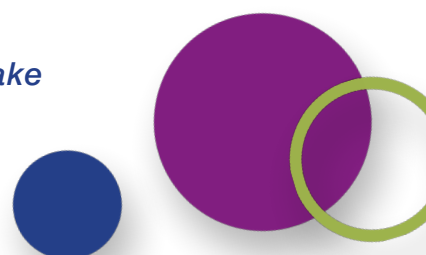
— Sonoma Valley Focus Group Participant

The disparity in who experiences this kind of agency during birth is notable. Lower-income participants were significantly less likely to name providers listening as a helpful factor (22.0% among those earning under \$62,000 vs. 52.2% among those earning \$62,000 or more).

Language

Language plays a significant role in communication and consent during labor and delivery, and women who do not speak English are at a substantial disadvantage in their birth experience. The survey data confirm what the qualitative data showed: participants who primarily speak Spanish at home were much more likely than those who primarily speak English at home to name a provider who spoke their language as something missing from their birth experience (9.6% vs. 0.3%). One in four Spanish-speaking participants (25.0%) named care that respected their culture and traditions as one of the most helpful factors at birth, compared to 9.5% of English-speaking participants.

Language barriers also extend beyond Spanish. One Spanish-language survey participant captured the gap directly:



“I just want there to be more services and for service providers to take into account those of us who speak diverse Indigenous languages.”

— Survey Participant

Her response is a reminder that women who speak Indigenous languages face compounded barriers in a healthcare system that, when it offers translation at all, typically offers only Spanish.

Providers described the consequences of these gaps in stark terms. One family physician/obstetric provider characterized the care that women who primarily speak languages other than English receive as “absolutely substandard,” explaining that “the type of care that makes a birthing person feel welcomed, heard, and respected is absolutely diminished.” Interpreter machines were widely described as inadequate. Translations are often delivered at an educational level above what some women could understand even in their primary language—the medical terminology, once translated, still reflecting the more highly educated language that healthcare providers typically use.

Family members translating in place of a professional interpreter posed problems as well, leaving women without reliable, impartial communication at a critical moment. A birth worker described women who cannot speak English and do not have providers who speak their language as “flying blind” and “having to place blind faith in someone who may or may not be acting in their best interest.”

“Even if there's translation services available, I don't feel that they get the same amount of care or the same level of detail in conversation, because they're just trying to do the bare minimum with the translation services rather than fully explaining all the procedures and fully explaining their choices.”

— Doula

These gaps become most dangerous during complications and emergencies, when speed and stress widen the distance between what providers know and what women understand. In some situations, women face the added burden of translating for partners who do not speak English—even while navigating an emergency themselves. A family support specialist shared one such account:

“I had a client that delivered early at 26 weeks, and her partner didn't speak any English. She had to translate while they were trying to prep her for the emergency surgery, for C-section. And then they just left him in the visiting room because nobody would tell him what's happening. And she felt destroyed. She felt so sad, because she's like, ‘I didn't have the support.’”

— Family Support Specialist

Language as a cross-cutting barrier across prenatal care, postpartum support, and mental health access is documented further in the **Barriers to Care** section of this report.

Support Persons

Whether a woman feels heard, informed, and supported during birth depends not only on her providers but on who else is in the room. Support persons—partners, family members, doulas, and birth workers—shape the birth experience in unique ways. Across both survey and qualitative data, having the right people present emerged as one of the most consistent themes in what makes a birth experience positive or difficult.

2 in 3

women said having a partner or support person present was the most helpful part of their birth

more than any provider, procedure, or service

Source: Community Survey, n=546

Partners

Having a partner or support person present was the single most-cited helpful factor at birth (66.1%). However, many women described partners who were physically present but unable to provide the kind of support they needed: scared, unprepared, or unsure how to engage with medical staff. Key informants consistently described this as a matter of preparation, pointing to the need for more partner support and education.

“I think partners can be very scared during labor and not prepared. I don't think there's enough emphasis on partners and partner support.”

— Doula

“They're not very supportive, but I don't think that they do it on purpose. I think they do it because they're afraid.”

— Perinatal Group Facilitator



Equipping fathers and partners to engage more effectively in pregnancy, labor, and the postpartum period—rather than arriving at birth unprepared—was named as one of the most direct ways to strengthen the support network women rely on. The **Prenatal Education** section identifies this as a key opportunity.

Doulas

Doulas were among the most consistently named supports across the qualitative data—and among the most inequitably distributed. The survey ranked doula presence as a helpful factor at birth for 20.9% of participants and as the third most-cited unmet need (15.8%). What doulas offer at birth extends beyond physical labor support—they bring relational continuity, knowledge of

the birthing person's history and preferences, and an ability to advocate that is distinct from both a partner's support and a clinical provider's role.

“As doulas, we're able to build that relationship and that trust earlier on. We may have information that the hospital staff may not—they may have just disclosed that they did have sexual trauma in the past, or a history of abuse that the hospital may not know about.”

— Doula

“I was pressured to have a C-section by the midwife delivering my baby, but with the support of a doula we were able to have a successful vaginal birth.”

— Survey Participant

“My birth experience was great thanks to my doula.”

— Survey Participant

The doula access gap, workforce shortage, and Medi-Cal coverage policy are documented in depth in the **Cross-Cutting Themes** section of this report.

Midwives

Midwives appeared primarily in the qualitative data among English-language participants. For women who had access to them, the experience was distinctive. Midwives were described as “invaluable” and bringing a different kind of presence into the birth room—more attentive to the experiential dimension of birth, more inclined to remind women of their options, and more able to manage the dynamics of the room.

“What really helped me was my midwife managing the room. When my in-laws were getting in the way, she was the one who got them to leave. She'd read the situation and act on it. I'd whisper things to her, and she'd handle it.”

— Monte Rio Focus Group Participant

“What I loved about the midwives was that they reminded me I had choices. Instead of feeling like you have to do what you're told, they'd come in and say, ‘Hey, you have options here.’”

— Monte Rio Focus Group Participant

For women of color especially, finding a midwife who shared their background was meaningful. But access is sharply limited: as one traditional birth worker noted, there are “zero practicing midwives of color in Sonoma County.” The broader need for racial and cultural concordance across the perinatal workforce is documented in depth in the **Cross-Cutting Themes** section.

A Familiar Provider

The desire to be attended by a familiar provider—someone who had already seen them through pregnancy—surfaced repeatedly in birth narratives. Arriving in labor to be met by a stranger was a consistently named negative aspect of birth.

“If the provider that they are comfortable with is in attendance—someone who they actually have met and seen before, rather than someone on call they've never met—they have a much better experience, because they have that connection with them.”

— Doula

“It's hard when the doctor who delivers your baby isn't the one you've been seeing all pregnancy. In the delivery room, whoever happens to be on call walks in—someone you've never met. You lose that connection and trust you've built over nine months.”

— Cloverdale Focus Group Participant



Assets • Birth Support

The following assets support women during birth in Sonoma County:

Doulas & Birth Workers

When present and culturally concordant, doulas were repeatedly described as transformative for birth experience, agency, and mental health outcomes. Medi-Cal doula coverage, in place since January 2023, has meaningfully expanded access for lower-income families. This asset is addressed in greater depth in the **Cross-Cutting Assets and Gaps** section.

Certified Nurse Midwifery Services

Available within some Sonoma County health systems, midwifery care was described by women who accessed it as meaningfully different from physician-only care: more attentive to the experiential dimension of birth, more likely to present options rather than directives, and more actively supportive of patient autonomy and choice. Access to midwifery care is uneven across health systems, representing an opportunity to expand what women in Sonoma County can access regardless of where they give birth.

The following systemic gaps in birth support were identified across the assessment:

Healthcare Culture Around Listening, Consent, and Shared Decision-Making

Inconsistently practiced across birth settings; women across communities described procedures being done to them rather than with them, feeling unheard, and lacking meaningful choice in the management of their births. The disparity in who receives respectful, patient-centered care falls hardest on Latine, Spanish-speaking, and lower-income women.

High-Quality Language Access At Birth

In-person interpretation is rarely available during labor and delivery; machine and video translation were widely described as inadequate, particularly during emergencies or moments requiring nuanced communication. The absence of linguistically concordant providers shapes both the quality and safety of birth care in ways that fall disproportionately on women who do not speak English. Expanding in-person interpretation and increasing the pipeline of bilingual birth providers represent meaningful opportunities.

Father & Partner Preparation

Partners frequently arrive at birth unprepared to provide effective support; education and preparation for partners is largely absent from prenatal care systems. Integrating partner preparation into prenatal education represents a low-cost opportunity with meaningful potential impact on birth experience.

Perinatal Care Teams That Reflect the Diversity of Communities They Serve

The shortage of healthcare providers, doulas, and birth workers who are of diverse racial and ethnic backgrounds, speak Spanish, and bring cultural knowledge to their work is a significant gap across birth settings; documented in depth in the **Cross-Cutting Themes** section of this report.

Continuity From Prenatal Care Provider to Birth Attendant

Large health systems and rotating provider schedules make consistent continuity difficult to achieve; women who arrive in labor to meet a stranger lose the trust built across nine months of prenatal care, a loss that was named as disorienting and that shapes the birth experience in ways that are difficult to recover from in the moment.

Birth Location Options

The closure of labor and delivery units in Petaluma and Sonoma Valley has contracted the

geography of accessible birth care, compounding existing transportation and geographic barriers. Home birth and birth center options remain largely inaccessible for Medi-Cal recipients. Expanding birth location options represents an opportunity to improve both access and experience.

*Additional assets and gaps that cut across pregnancy, birth, and postpartum are documented in the **Cross-Cutting Themes** section of this report.*

Postpartum

Experiences

Women in Sonoma County felt least supported during the postpartum period. While 77.6% felt supported during pregnancy and 81.0% during birth, that figure fell to 65.6% in the first six weeks after birth and remained low through the first year (67.8%). Women described feeling forgotten the moment they delivered—without a system to meet their needs during what many named as the hardest period of the entire perinatal experience.

Postpartum disparities shifted from those observed during pregnancy and birth. The gap between Latine and white participants—which was notable during pregnancy—narrowed in the postpartum period, with both groups reporting similar rates of support. Spanish-speaking participants followed a similar pattern. The income gradient, clear during pregnancy, was less predictable postpartum—participants earning \$43,000–\$61,999 reported the lowest support rate of any income group at one year (52.5%), lower even than the lowest income bracket, suggesting that this middle-lower income group—too financially stable to qualify for many formal supports but too resource-constrained to purchase private services—may be particularly vulnerable during the postpartum year.

When women named what helped them most postpartum, paid maternity leave (36.4%) and family and friend support (34.2%) were cited most often, followed by lactation support (27.5%) and peer connection (21.5%). When asked what was missing, the most commonly named postpartum unmet needs were financial assistance (20.0%), infant sleep support (17.0%), home visits (16.6%), childcare (16.5%), and connecting with other parents (15.3%).

3 in 4

survey participants named a postpartum phase as their most challenging overall

more than named labor and delivery (35%) or pregnancy (26%)

Source: Community Survey, n=442

4 in 5 Postpartum Women Reported At Least One Unmet Need

Top 5 Unmet Needs in the Postpartum Period



Figure 9. Unmet Needs in the Postpartum Period; top five shown. Full results in Appendix A. % of all participants, multiple selections allowed; Community Survey, n=601.



The Postpartum Cliff

Women and providers described a consistent pattern: during pregnancy and birth, there is a structured system of care—frequent prenatal visits, a care team, a clinical environment organized around the mother’s wellbeing. After birth, that system largely disappears. Most women have one six-week postpartum visit, sometimes conducted virtually, at the moment when their needs are greatest. The postpartum support cliff—the abrupt withdrawal of formal care after birth—was described as the most significant structural gap in the entire maternal health system.

“We spend all of this time preparing for the birth—and we completely neglect the next six months that comes, which is really the most important part.”

— Certified Nurse-Midwife

“Once the baby is born, it’s like the mom doesn’t exist anymore. Baby has checkups at two weeks, one month, two months—but for the mom, they have that six-week visit, and it’s been reduced to almost nothing.”

— Perinatal Home Visitor

The survey data confirm that postpartum is where the weight of the perinatal experience falls most heavily: 48.9% of participants identified the first six weeks postpartum as among their most challenging phases, followed by the six weeks to six months period (39.7%). Labor and delivery was named by 33.5% and pregnancy by 26.1%. Nearly three in four participants (74.8%) identified at least one postpartum phase as among their most challenging overall.

“I was hugely supported during pregnancy and as soon as my baby was born, I felt forgotten.”

— Survey Participant

“I felt almost abandoned by the system after birth.”

— Survey Participant

Where women located their hardest phase differed by language. Spanish-speaking and immigrant participants were the most likely of any subgroup to name labor and delivery itself (39.9% and 42.9%, compared to 30.7% of English-speaking participants), consistent with the communication and language barriers documented in the Birth section. English-speaking, white, and higher-income participants concentrated difficulty in the extended postpartum period. Half of English-speaking participants (50.3%) named six weeks to six months among their hardest phases, compared to one in five Spanish-speaking participants (20.3%).

The absence of a formal care structure is compounded for women who also lack informal support. Women who had family nearby, a supportive partner, or access to community resources described meaningfully better postpartum experiences. Those without—immigrants whose families are far away, single mothers, women in geographically isolated areas—described navigating the hardest period of the perinatal continuum entirely alone.

Immediate Postpartum Was Hardest Overall

But Challenges Clustered Around Birth for **Spanish-Speaking** Women, and Stretched Across the First Year for **English-Speaking** Women

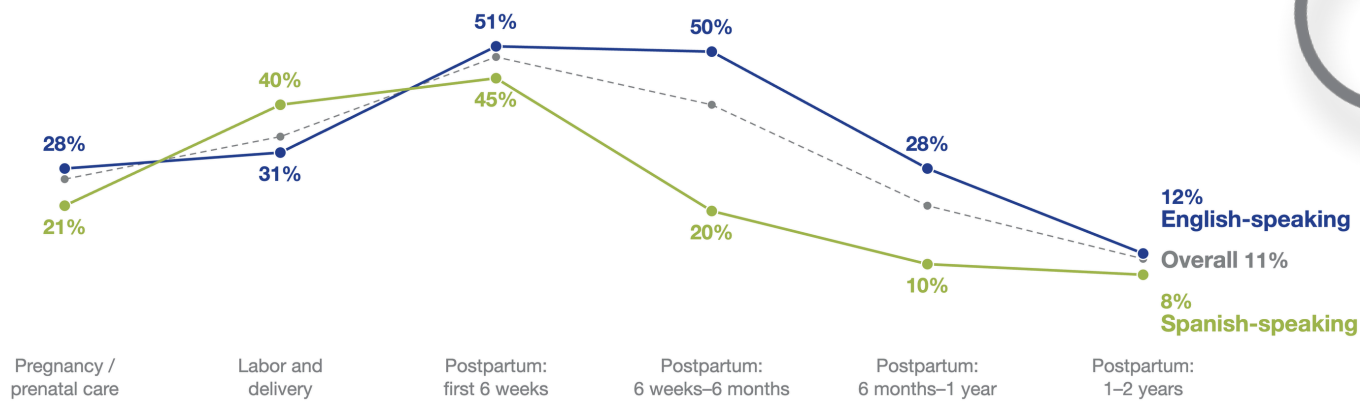


Figure 10. Most Challenging Perinatal Phase, by home language. Community Survey, overall n=468 (English-speaking n=296, Spanish-speaking n=148); participants could select multiple phases.

“What I needed was a support person—someone who would be with me and understand me and just be there. It was also very hard for me because I was in a two-story apartment, alone. With other children to care for I had to go up and down 16 stairs to feed them or get to any appointment—by myself. My husband went to work. I cried a lot from exhaustion and desperation.”

— Undocumented Focus Group Participant

“Support is everything in postpartum—it is both the greatest challenge and the most significant protective factor. Women need at least one support, and that alone can make a huge difference. The absence of support can be the trigger for mental health issues and concerns.”

— Bilingual Perinatal Therapist

The Postpartum Cliff: Support Falls After Birth

Latine Women Felt Least Supported During Pregnancy, but Most Supported by One Year

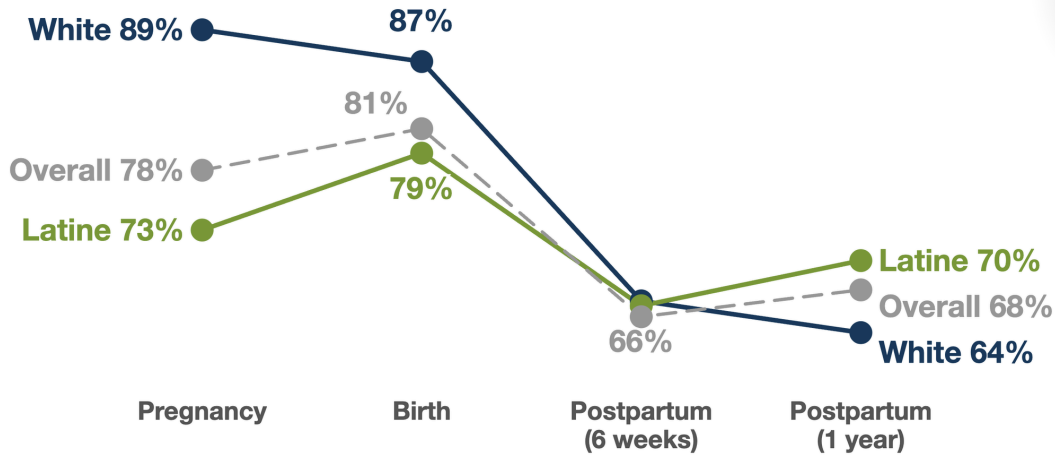


Figure 11. Share Who Felt Very or Somewhat Supported, by perinatal stage and race/ ethnicity. Community Survey; n varies by stage (see Appendix A). Stages shown at equal intervals; time between stages is not uniform.



Mental Health

Mental health emerged as the dominant theme of the postpartum period—in both the weight of qualitative evidence and the survey data. Half of all participants (50.1%) rated their postpartum mental health as fair or poor—up from 39.1% during pregnancy—and the share reporting poor mental health specifically nearly doubled, from 8.6% during pregnancy to 16.8% postpartum. When asked directly whether they experienced mental health challenges, the proportion was even higher: nearly three in four participants (74.7%) reported experiencing challenges postpartum, suggesting that many women who rated their mental health as good or excellent still recognized they were struggling in meaningful ways.

1 in 2

women rated their postpartum mental health as fair or poor

Source: Community Survey, n=493

Anxiety

Providers and mothers in interviews and focus groups consistently described anxiety as prevalent, underdiagnosed, and underaddressed relative to depression. Women described their anxiety not as sadness or loss of interest, but in concrete physical and emotional terms — hypervigilance, intrusive thoughts, relentless worry, and a nervous system that never fully rests — experiences that may not be fully captured by standard perinatal mental health screening.

“The screening tools mostly focus on postpartum depression, but I don’t really feel depressed. I feel anxious about everything. Those are different things, and I don’t think the standard screenings capture it.”

— Monte Rio Focus Group Participant

“I was feeling bad—short of breath, afraid to go into the bathroom, afraid to shower with the curtain closed. I would shower with the door open because I was so scared. They told me it was postpartum anxiety—something I’d never experienced before.”

— Farmworker Focus Group Participant



“My nervous system needs a hug. I’m always in fight-or-flight. I sleep lightly—alert for any sound from the baby. When she doesn’t nap and I was really counting on that break, I completely fall apart.”

— Monte Rio Focus Group Participant

Perinatal mental health providers confirmed that anxiety presentations—including obsessive compulsive disorder (OCD)—are common but frequently misdiagnosed, and that clinical approaches for anxiety and OCD differ meaningfully from those used for depression, with some standard treatments contraindicated during the perinatal period.

Screening & Referrals

A recurring theme across both survey and qualitative data was that women did not feel adequately screened or supported to connect with mental health care during the postpartum period. Many described receiving little or no mental health check-in beyond the six-week visit—with no follow-up in the months that followed, precisely when symptoms often emerge or intensify.

“I felt ok initially but for me my PPD / PPA didn’t hit until 4 months later—I think there should be another check in after that point.”

— Survey Participant

“I wish there was more support 6–24 months post birth, when things actually can be harder for mental health.”

— Survey Participant

Women also described being told about postpartum depression broadly but not being helped to understand what to look for, when to seek support, or how to navigate the steps to access it. The result was that many women recognized something was wrong but could not find their way to care—or found the pathway so difficult that they gave up.

“Everyone should receive care and info on postpartum depression and anxiety. It’s too hard to access when you’re sleep-deprived, depressed, and feeling all alone.”

— Monte Rio Focus Group Participant

“They mention postpartum depression but they don’t talk about it or how to get resources for it.”

— Survey Participant

“Making sure moms don’t have to take a thousand steps to get the help they need. It is already a rough year. Most moms seek help when they are at their breaking point.”

— Monte Rio Focus Group Participant

Providers described the same gap from the clinical side—noting that a single check-in is insufficient for a condition that presents differently across individuals and can intensify over months.

“I almost feel like everybody should have a mental health consultation after they gave birth. This huge thing, this life-changing, forever-altering-who-you-are thing—I can’t imagine that not affecting your mental health in some way.”

— Public Health Nurse

“The most important thing is that every person who is pregnant and postpartum is checked in with multiple times. Their needs change from early postpartum to late postpartum. Professionals need to be checking in, assessing, and providing referrals throughout.”

— Perinatal Therapist

Access

County surveillance data show that 69.9% of Sonoma County women who perceived a need for perinatal mental health care received it—significantly higher than California's 53.9% (MIHA, 2020–2022). The survey suggests this does not tell the full story: of the 432 participants who reported experiencing mental health challenges, only 48.1% felt they received adequate support; 32.9% received some that wasn't enough, and 19.0% could not find or access support at all—meaning more than half of those who needed it either could not get it or found it insufficient.

Access barriers were not evenly distributed: Spanish-speaking participants were more likely to be unable to access support than English-speaking participants (23.5% vs. 15.6%). Income patterns were less consistent, though participants in the \$43,000–\$61,999 range reported the highest rate of being unable to access support (25.9%) and those earning \$125,000 or more the lowest (12.8%).

More than half of women who experienced postpartum mental health challenges did not receive sufficient support

32.9% received some care that wasn't enough—19% could not find or access support at all

Source: Community Survey, n=432

The most fundamental barrier is a shortage of providers who specialize in perinatal mental health. Perinatal mental health requires specialized clinical knowledge that is not common among general providers—anxiety, OCD, and postpartum depression each present differently during the perinatal period and require providers who understand those distinctions. A general therapist unfamiliar with perinatal presentations may miss symptoms, misdiagnose, or apply approaches that are contraindicated—exposure therapy, a standard OCD treatment, can be harmful during the perinatal period. The result is that even women who successfully navigate the system may not receive adequately specialized care. The shortage is particularly acute for Spanish-speaking providers: Spanish-speaking therapists who accept Medi-Cal and have perinatal specialization are extremely scarce, and mothers who do connect are often referred out after only a few sessions.

“We have a paucity of people who are able to see people in the perinatal period. Long wait times for psychiatrists. Minimal therapists who accept Medi-Cal, and who are specially trained in perinatal mental health issues.”

— Certified Nurse-Midwife & Lactation Consultant

“I called everywhere for help and couldn't find any.”

— Survey Participant

“I have a couple clients that were in real need of support after the baby was born, that became really anxious and depressive, and there was nothing available for them. They really wanted to talk to a therapist, and there was nothing available. And still, six months after, she just started therapy because she was on the waitlist.”

— Family Support Specialist

Even when providers are available, secondary barriers compound the challenge—cost, transportation, childcare, and the logistical demands of scheduling care while in survival mode. Therapy is often deprioritized when rides are limited—medical appointments and lactation support take precedence, leaving mental health care without a reliable pathway to access. Women described the compounding effect of these barriers clearly.



“I was not able to afford to continue with my therapist post-birth because of all the out-of-pocket costs associated with my children's care. Some free or low-cost sessions would have been helpful.”

— Survey Participant

Access is also shaped by format and modality. Different mothers need different things—individual therapy or group support, telehealth or in-person, clinical settings or informal community connection. Telehealth, while reducing transportation barriers, is not universally accessible—for women living with extended family or multiple households, there may be no private space to speak openly, and the presence of family members who are unsupportive or judgmental about seeking therapy can make even a virtual session impossible. For women with more severe presentations such as OCD or intrusive thoughts, group settings may not be appropriate at all. A system that offers only one or two modalities will inevitably fail the women whose needs or circumstances do not fit those options.

“Different things are helpful for different people, which is how perinatal mental health is so different from physical health. Services have to be responsive—some people want groups, others want individual support, others want to connect informally with other mothers.”

— Perinatal Therapist

Stigma & Fear

Focus group participants and providers shared that among Latine women—particularly those who have immigrated more recently—postpartum mental health challenges are often framed as something that does not exist or should be endured rather than treated. Family members may dismiss what a woman is experiencing as normal, exaggerated, or not real, creating a stigma that discourages disclosure and help-seeking.

“Postpartum depression is not real to them—it’s not a thing. Instead of helping, they’re judging you, and it makes it harder. My mom would say, ‘Why are you doing this? We’re all tired. I still get up every day.’ And I was like, ‘No, I’m not myself, and you’re not seeing that.’”

— Santa Rosa Focus Group Participant

“Culturally, it’s just a thing that doesn’t exist—postpartum depression or anxiety in that culture is just not a real thing in a way.”

— CPSP Coordinator

“How do you have time for depression? Just stay busy and you’re not going to have depression. Absolutely, 100% there is that present.”

— Perinatal Group Facilitator

For some mothers, fear extended beyond social judgment to fear of the system itself. Fear of Child Protective Services (CPS) added a compounding barrier, particularly for Native, undocumented, and substance-using mothers. A persistent fear that disclosing mental health symptoms could lead to child removal keeps some mothers from asking for help when needed.

Isolation and the Absence of a Village

Isolation emerged as both a cause and a consequence of postpartum mental health struggles—and as an experience that cuts across income, race, and geography, though it falls hardest on those who are newer to the country and farthest from their family and support network.



“Moms are alone really early.”

— Family Physician

“Postpartum depression can really incubate in those containers of isolation. Big time.”

— Birth Worker

“Early motherhood is extraordinarily isolating, even if you have all the support in the world. Isolation is a big issue.”

— Public Health Nurse

For many women, the isolation is structural—the product of living far from extended family, having a partner who returns to work within days, and being home alone with a newborn without a community around them.

“After my baby, I was so lonely. I felt like I was lost. I was kind of sick of my partner. At some point, I wanted to be in a community where I had people who were going through the same situation as me.”

— Black Focus Group Participant

“In Mexico, there’s always an older neighbor lady who brings you a plate of food when you’re sick or going through something hard. Here in the United States, everyone lives their own individual life and that sense of caring community doesn’t exist in the same way.”

— Undocumented Focus Group Participant

“When people were living in the village, the village was the support. Now we’re so disconnected we don’t even know our next-door neighbors. Women are doing everything on their own, and it’s so impossible.”

— Perinatal Group Facilitator

For Latine women, isolation carries a specific cultural dimension. La cuarentena—the traditional 40-day postpartum rest period in which support comes to the mother—represents a practice that many Latine women value and identify with, but that is difficult or impossible to practice when family is far away, work demands continue, and other children need care. As one perinatal therapist described it, some women feel connected to the tradition but do not have the support to carry it out—and there is a sense of loss about what they are not getting.

Sleep and Mental Health

Sleep deprivation was named consistently across focus groups as one of the most immediate and destabilizing aspects of the postpartum experience—and one with direct mental health consequences. Providers named it explicitly as a driver of postpartum mental health struggles, particularly in the early weeks when support is most absent and women are most vulnerable.

“It doesn't matter how much support you have, people are still just totally shocked by how hard it is to not sleep.”

— Family Physician

“Sleep deprivation plays into mental health. Folks are typically really struggling by the time they reach out.”

— Certified Nurse-Midwife

The survey data reflect the scale of this need: infant sleep support was named as an unmet postpartum need by 17.0% of participants—the second most commonly named unmet need after financial assistance.

Support Groups and Peer Connection

Across all data sources—interviews, focus groups, and the community survey—peer connection and support groups emerged as one of the most consistently and powerfully named themes in the postpartum period. Women described the absence of peer connection as one of the hardest aspects of early motherhood, and those who found it described it as transformative.

The survey data confirm the scale of this need. Peer connection with other parents was the top unmet need during pregnancy (22.1%) and remained a significant gap postpartum (15.3%). White and English-speaking participants were more likely to name connecting with other parents as a helpful postpartum resource (29.9% and 27.7% respectively) than Latine and Spanish-speaking participants (16.3% and 10.5%). Immigrant participants named peer connection as an unmet need at nearly the same rate as the overall population (16.2%) despite naming it as a helpful resource far less often—suggesting a gap between need and access for this group.

Women described what they were looking for in concrete terms: free or low-cost, drop-in, flexible in timing, close to home, offering childcare, and led by someone with relevant training or lived experience. Many described the simple act of being with other mothers who were going through the same thing as more meaningful than any formal intervention.

“I think I would have really loved the mom's group—a group, maybe online or even in person, with moms like myself. That would be wonderful—having people with similar experiences, someone to talk to that actually understands.”

— Black Focus Group Participant

“Better Beginnings support group at the Sebastopol Library was invaluable and the only connection to community I had for a long time.”

— Survey participant

“Mom communities/support groups saved me—I couldn’t have done it without my village.”

— Survey participant

When groups exist and are accessible, providers described them as highly effective—not just as social connection but as a meaningful mental health intervention.

“It wasn’t until recently that I found the La Plaza group, and that has helped me a lot. My doctor wanted to put me on medication for depression, but I told her I wanted to try the group first. Thank God, it has helped me significantly.”

— Undocumented Focus Group Participant

“The groups are extremely successful in the people connecting with each other and having a sense of belonging and connection.”

— Perinatal Group Facilitator

“Drop-in support groups saved my life.”

— Survey Participant

Providers also described barriers that prevent women from accessing groups even when they exist—transportation, childcare, and inflexible timing. Women named two specific formats as particularly important: drop-in windows that accommodate the unpredictability of life with a newborn, and peer connection with mothers who are slightly further along in the journey.

“More parenting classes or support groups later in the day. It’s hard to make it to them when you have to work.”

— Survey Participant

“Everything should have a drop-in window. When you have a baby, you can’t always commit to a scheduled time. A flexible window—come anytime between 10 and noon—would remove a lot of the anxiety and pressure.”

— Monte Rio Focus Group Participant

“Talking to moms who have already had kids gives me more insight, because they have so much experience. They have raised babies and know different remedies, hacks, and what works. So having access to moms at various stages of their motherhood journey is helpful.”

— Native American Focus Group Participant



For Spanish-speaking women, the need for groups that are Spanish-language and culturally informed—not just translated—was named as a specific barrier. For women in rural and geographically isolated communities, informal formats such as park meetups and neighborhood walking groups were named as more viable alternatives than traveling to a clinic-based group.

“Online postpartum depression support group in Spanish for moms who can’t travel or don’t have someone to take care of their children.”

— Survey Participant

“I would love something like walking circles—meeting up at a park and going on a walk.”

— Native American Focus Group Participant

Breastfeeding

Breastfeeding initiation rates in Sonoma County were high—91.5% of survey participants breastfed their youngest child, with no meaningful disparity by home language and only modest variation by race. Initiation did rise with household income, from 85.4% among participants earning under \$43,000 to 96.2% among those earning \$125,000 or more. High initiation, however, does not mean breastfeeding was easy—providers and mothers consistently described it as one of the hardest aspects of the postpartum period.

“Breastfeeding is really, really hard.”

— Family Physician

“Lactation is so complex. Lactation is not black and white.”

— CPSP Coordinator

Among survey participants who breastfed, 77.5% said they breastfed as long as they wanted to. Population-level data, detailed in the Maternal Health Profile, confirm strong initiation rates but declining continuation over time, with lower rates among Hispanic and lower-income mothers. Among those who reported a reason for stopping earlier than desired, the most common were returning to work or school (40.2%), insufficient milk supply (39.1%), and difficulty latching (25.3%). Of the 8.5% who did not breastfeed at all, more than half of those reporting a reason cited latch difficulties (51.1%) and 44.7% cited milk supply challenges—suggesting that many non-breastfeeding women wanted to breastfeed but faced barriers.

Providers described a consistent pattern: early challenges quickly overwhelm mothers who lack immediate, accessible support—and by the time a lactation consultant appointment becomes available, many have already given up.

“They might be able to get an appointment with a lactation consultant, but it’s three days from now, and they have to pick up and drive to the clinic or the hospital to do that. By then, things have gotten so bad that they’ve just given up, or their pain level is just off the charts.”

— Public Health Nurse

40%

of women who stopped breastfeeding earlier than desired did so because they returned to work

the single most common reason for stopping breastfeeding earlier than desired

Source: Community Survey—among participants who stopped breastfeeding earlier than desired and reported a reason, n=87

“More than half of the families I work with were frustrated with breastfeeding, and so they just switched to formula. They didn’t have the knowledge or the encouragement or the support to try and continue it.”

— Family Support Specialist

When participants wrote about lactation support in open-ended responses, in-home delivery was the recurring theme. Women described in-home visits as transformative precisely because they remove the barrier of having to travel while physically recovering, sleep-deprived, and caring for a newborn.

“It would be amazing if additional support with breastfeeding was available during the first week after birth. The quick, one-time consultation at the hospital just didn’t feel like enough, and the disappointment with not being able to feed my baby the way I’d hoped to was so hard.”

— Survey Participant

“I hired a lactation consultant who came to my house, which I was very fortunate enough to do, and it very much changed my breastfeeding experience from my first to second son. Having someone come into my space took a lot of pressure off and made it easier to digest the information.”

— Survey Participant

Access gaps are compounded for Spanish-speaking families, who face additional barriers in finding Spanish-language lactation consultants. Providers also noted that lactation support tends to be oriented toward crisis rather than prevention, and that earlier, proactive access—before problems escalate—would better support breastfeeding continuation. Mothers also navigated conflicting social pressures—judged for breastfeeding, judged for not breastfeeding, and often left without practical guidance when milk did not come in as expected.

“There are so many ways to feed a baby—breastfeeding, pumping, formula, combination—and people judge you whatever you do.”

— Monte Rio Focus Group Participant

“Less pressure around breastfeeding. It was so painful and an awful experience and I felt pressured to do more than I felt mentally capable of.”

— Survey Participant

Providers noted that breastfeeding struggles carry real mental health consequences—shaping how mothers see themselves at a vulnerable moment and contributing to the broader postpartum mental health burden documented throughout this section.

“If someone is having a struggle feeding their child, it’s primal—it impacts their view of themselves, and you can see where anxiety starts to form around this.”

— Perinatal Therapist



Physical Health

While mental health dominated postpartum experiences in both the qualitative and survey data, postpartum physical health was a significant and often unaddressed burden. Nearly four in ten participants (40.9%) rated their physical health in the first year after birth as fair or poor—higher than during pregnancy (30.0%), and falling disproportionately on Latine participants (48.1% vs. 37.3% for white participants and 30.0% for Asian participants) and immigrant participants (52.8%).

Physical recovery challenges included cesarean recovery, diastasis recti, incontinence, and pelvic floor dysfunction. Women described being largely uninformed about what to expect and left to rely on internet searches when they were not sure if what they were experiencing was normal.

“The physical aspects of recovery were really challenging for me, because I feel like my doctor didn’t explain it to me at all. She just kind of explained up until birth, and then I had a ton of knowledge on caring for my baby, but not really on how long postpartum would take, how I would care for myself, what type of pain was normal or what was not. Waiting for the six-week appointment—which didn’t end up being very informational or thorough at all—I just didn’t know what was normal healing.”

— Black Focus Group Participant

Providers described a disparity in who receives postpartum physical care—with lower-income and Medi-Cal-covered women often receiving no guidance and accepting physical limitations as permanent.

“These moms are having awful tears and not feeling like they’re healing. They’re having diastasis recti on their third child in three years, and their abdominal wall has never closed. They’re having incontinence issues and think that’s just their life now. There is not proper postpartum care for women here.”

— Perinatal Home Visitor

“English-speaking white women are going to get the support they need and be able to get their body back, because they know what to ask and where to look. But if you are a low-income woman on Medi-Cal, it just doesn’t happen.”

— Perinatal Home Visitor



Assets • Postpartum Support

The following assets support women during the postpartum period in Sonoma County:

Specialized Perinatal Mental Health Programs and Peer Support Groups

A small but meaningful infrastructure of perinatal-specific mental health support and peer connection exists in the county, including bilingual bicultural therapy, community health worker pairing, and culturally responsive peer groups. These programs are addressed in greater depth in the **Cross-Cutting Assets and Gaps** section.

Group Well-Child Visit Model

West County Health Center's centering approach combines developmental care with facilitated peer connection, offering a promising model for integrating clinical and community support during the postpartum period. Expanding this model to additional sites and health systems represents an opportunity to address both clinical and social postpartum needs in a single setting.

WIC Postpartum Breastfeeding Support

WIC provides lactation counseling, peer breastfeeding support, and formula access postpartum. The peer counseling model was specifically named as valuable by providers.

The following systemic gaps in postpartum support were identified across the assessment:

A Comprehensive Postpartum System of Care

The current standard of a single six-week visit is widely insufficient to identify or address the full range of postpartum physical and mental health needs. Multiple follow-up contacts across the first year—including early home-based check-ins, breastfeeding support, and mental health screening at clinically meaningful intervals—represent a significant opportunity to close what providers and mothers consistently named as a critical gap in postpartum care.

In-Home Postpartum Support

Home-based delivery of support is largely absent at scale for the general postpartum population. Women named in-home visits as critical, particularly in the early weeks when travel is physically difficult and logistically overwhelming. Home visiting programs serve eligible lower-income families but do not reach the broader postpartum population. Expanding home-based postpartum support—including lactation, mental health, and basic needs check-ins—represents a meaningful opportunity, especially for families who fall just above program eligibility thresholds.

Perinatal Mental Health Screening and Referral

Current screening tools may be missing the broader anxiety burden documented throughout this assessment, and screening concentrated at the six-week visit fails to capture conditions that often emerge or intensify over subsequent months. Referral pathways from positive screening to actual care are fragmented and difficult to navigate, and the gap between identifying a need and receiving adequate support is wide. This gap is addressed in greater depth in the **Cross-Cutting Assets and Gaps** section.

Accessible Perinatal Mental Health Care

The shortage of perinatal mental health specialists who accept Medi-Cal, speak Spanish, and offer flexible formats—individual therapy, groups, virtual, in-person, free or low-cost—leaves many postpartum women without care that meets them where they are. This gap is addressed in greater depth in the **Cross-Cutting Assets and Gaps** section.

Postpartum Mental Health Stigma in Latine Communities

Cultural norms that frame postpartum mental health challenges as something to be endured rather than treated are a significant barrier to help-seeking, compounded by fear of judgment, immigration-related concerns, and the absence of culturally concordant care options. Efforts to reduce stigma and increase awareness of mental health support within Latine communities represent a meaningful opportunity.

Infant Sleep Support

Named as an unmet postpartum need by 17.0% of survey participants. Sleep deprivation was consistently named by providers and mothers as a primary driver of postpartum mental health struggles, yet practical sleep support and education are largely absent from postpartum care. Integrating sleep support into postpartum follow-up represents an opportunity with meaningful potential impact.

Peer Support Groups and Community Connection Postpartum

Existing peer support programs are insufficient to meet documented demand. Accessible, low-cost, drop-in options with childcare and flexible hours are needed in more locations across the county. Spanish-language and culturally informed groups are especially scarce, and rural and geographically isolated communities are particularly underserved. Expanding the availability, format diversity, and geographic reach of postpartum peer support represents a significant opportunity.

Lactation Support

Breastfeeding support exists through WIC and clinic-based lactation consultants but requires women to travel at a time when physical recovery, sleep deprivation, and newborn care make leaving home difficult. Expanding in-home and quick-response lactation support represents a clear opportunity.

Postpartum Physical Recovery Support

Pelvic floor therapy, cesarean recovery support, and guidance on normal postpartum physical healing are needed by many but are almost entirely inaccessible for lower-income and Medi-Cal-covered women. Providers named this as a significant and underrecognized gap. Expanding access to postpartum physical recovery support—particularly for Medi-Cal recipients—represents a meaningful opportunity.

*Additional assets and gaps that cut across pregnancy, birth, and postpartum are documented in the **Cross-Cutting Themes** section of this report.*

Cross-Cutting Themes

Several themes cut across pregnancy, birth, and postpartum. This section examines three such themes:

1

Economic Insecurity

Economic insecurity cuts across every phase of the perinatal continuum — not as a background condition, but as a primary determinant of the experiences documented throughout this report.

2

Barriers to Care

Multiple and compounding obstacles prevent women from accessing the services that exist.

3

Doulas & Birth Workers

The unique capacity of doulas and birth workers to span the perinatal continuum makes them one of the most consistently valued resources in this assessment — and one where the gap between need and access is most acute, driven by a shortage of Spanish-speaking and racially and culturally concordant providers.

Economic Insecurity

Financial stress and economic insecurity significantly shape the experience of pregnancy, birth, and postpartum—impacting who can access prenatal care, who can stay home after birth, who can afford therapy, childcare, or other supports. Women and providers described families navigating difficult tradeoffs: between rent and food, between staying home with a newborn and returning to work, between their own health needs and their family's basic material survival. Economic insecurity is not a peripheral concern in maternal health—it is a foundational driver of the disparities documented throughout this report.

The burden falls hardest on the lowest-income families — but a consistent pattern across the survey data points to a second group at elevated risk: middle-lower income families earning roughly \$43,000–\$62,000 annually. Across multiple measures, this group showed notably poor outcomes: they had the highest rate of fair or poor postpartum mental health of any income bracket (61.1%), the lowest rate of feeling well-supported at one year postpartum (52.5%), and the highest rate of being unable to access mental health support at all (25.9%) — higher even than the lowest-income group. These findings suggest that families just above the lowest income tier may fall into a gap between eligibility for public supports and the financial resources to access private ones. Survey participants named this directly:

“Financial assistance for FMLA time—especially for lower middle class—often don't qualify for certain supports due to being just over the income threshold. This is felt extra during maternity leave when you want to be home with baby but can't afford to.”

— Survey Participant

“The cost of living is hitting so hard. My mental health would be better if we could afford childcare, housing, and other basic needs.”

— Survey Participant

Financial assistance was one of the most consistently named unmet needs across the assessment—cited by 19.2% of participants during pregnancy and 20.0% postpartum. Immigrant participants named it at higher rates during both pregnancy (32.4%) and postpartum (33.3%). Spanish-speaking participants named it at higher rates than English-speaking participants during both pregnancy (21.9% vs. 16.5%) and postpartum (24.0% vs. 16.4%).

“Right after I had the baby, I started looking for work but couldn't find anything. Things are really difficult right now. Even now we're still affected—some days I work, some days I don't. Sometimes we can pay the rent, sometimes we can't.”

— Farmworker Focus Group Participant

“I think families right now are so stressed out financially—with the economy, with immigration, with just a generalized fear in the air. Babies are being born into a very stressful and toxic environment, and just making ends meet every day is a struggle for a lot of these families—with mental health, with any health problems, or financial or food or just any kind of needs. They're struggling a lot nowadays.”

— Family Support Specialist

Housing

Providers frequently identified stable housing as the single most important support they wanted for their clients—naming it ahead of clinical services, mental health support, and financial assistance. They described families navigating profound housing instability during pregnancy and the postpartum period: sharing multi-generational homes in configurations they would not otherwise choose, living in makeshift converted sheds, and separating from partners simply to access more affordable housing options.

“If every one of our clients had stable housing that was safe to live in, that they weren't at risk of losing, that they could afford to stay in, we'd just solve so many problems.”

— Public Health Nurse

“I have people living in what I would call a shed in people's backyards—they've put insulation and drywall in them and got little generators. I have families sharing multi-generational housing when they wouldn't normally. I have one couple where the father is not living with the rest of the family just because he can rent a room and make more money working in another community.”

— Certified Nurse-Midwife & Lactation Consultant

The survey confirms housing instability as a significant and inequitably distributed unmet need. Housing assistance was named as an unmet need in pregnancy by 8.1% of participants overall — rising to 16.7% among immigrant participants, 12.4% among Latine participants, and 12.2% among Spanish-speaking participants, compared to 4.0% of white participants and 5.4% of English-speaking participants. These disparities were even more pronounced postpartum, with immigrant participants (19.0%), Spanish-speaking participants (15.1%), and Latine participants (14.4%) identifying housing as an unmet need at rates well above white (2.5%) and English-speaking (3.5%) participants.

Paid Leave

Paid maternity leave was the single most-cited helpful postpartum support overall — named by 36.4% of survey participants — yet 13.8% named it as something they needed but did not have. White participants were more than twice as likely as Latine participants to name paid leave as helpful (55.1% vs. 25.0%), and English-speaking participants were more than four times as likely as Spanish-speaking participants (51.2% vs. 11.6%). Among immigrant participants, only 19.1% named paid leave as a helpful resource. The majority of participants earning \$125,000 or more (59.2%) identified paid leave as helpful, compared to 14.2% of those earning under \$43,000—likely reflecting that formal paid leave benefits are concentrated among higher-wage employment and largely inaccessible to low-wage, part-time, and informal workers.

4x

Highest-income women were more than four times as likely to name paid leave as a helpful postpartum support.

59% among those earning \$125,000+ vs. 14% among those earning under \$43,000

Source: Community Survey, n=549

Paid leave also emerged as a prominent theme in open-ended survey responses, where participants consistently called for longer duration and broader eligibility.

“More financial support so we can stay home longer—the money runs out and is barely enough to support maternity leave.”

— Family Support Specialist

“Longer paid leave!! The baby is still so little when job protection runs out.”

— Survey Participant

Providers echoed this concern, pointing to both the inadequacy of current leave policies and the downstream consequences of early return to work. The consequences are tangible: returning to work was the single most commonly cited reason for stopping breastfeeding earlier than desired, named by 40.2% of survey participants who stopped before they wanted to.

For many participants, the challenge was not only the duration of leave but navigating the process of accessing it. California's paid family leave and state disability programs do not automatically cover self-employed, informal, or undocumented workers, and eligibility requires sufficient wage history — leaving many low-wage and informal workers without access.

“I wish someone had helped me navigate the benefits I was entitled to. I was working part-time and know I missed out on things I could have received—I just didn't know how to find and apply for them.”

— Monte Rio Focus Group Participant

“Maybe clearer instructions if you qualify for maternity leave. I have 2 part-time jobs so I didn't meet the hours for leave so I didn't get any help for my 4 children while pregnant.”

— Survey Participant

“Support with filing for disability, paid family leave, and baby bonding.”

— Survey Participant, when asked what one service or resource they would add

“Disability is not enough. So people go back to work early.”

— Family Physician

“The amount of time people get off is 100% not enough.”

— Perinatal Therapist

A CPSP coordinator shared that she frequently helps patients navigate state disability questions even though it falls outside her formal scope—underscoring both the depth of the need and the absence of a dedicated navigation resource.

Barriers to Care

For many women navigating pregnancy, birth, and postpartum in Sonoma County, barriers to care are multiple and compounding. Providers working with mothers living on the margins described how even a single barrier can make care effectively inaccessible.

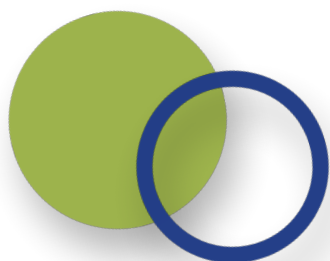
Knowledge of Resources and System Navigation

Across provider interviews, focus groups, and open-ended survey responses, one of the most consistently named barriers is not the absence of services—but the absence of knowledge that those services exist, and the difficulty of navigating to them once you know. Women described

leaving prenatal appointments without knowing what programs they were eligible for, postpartum without knowing where to find mental health support, and the entire perinatal period without a clear guide to what was available to them.

“Why are these OB/GYNs and doctors not telling them about the resources that are available to them as soon as they find out they're pregnant? Why am I getting these moms so late in the game?”

— Perinatal Group Facilitator



“The neediest of the neediest have literally a thousand different things in all different directions, and they don't have the capacity to do them alone. The system has really good things that exist, but the people who need them most have the most difficult time attaining them.”

— Perinatal Home Visitor

Health insurance is a specific and significant knowledge gap within this broader picture. More than four in ten survey participants (43.3%) were covered by Medi-Cal during pregnancy—rising to 62.5% of Latine participants, 79.0% of Spanish-speaking participants, and 71.0% of immigrant participants. Despite this coverage, many women do not know what their insurance entitles them to. Providers described patients being surprised to learn they could access breast pumps, belly bands, and other supplies through their coverage. Women discover Medi-Cal eligibility sometimes only weeks before their due date. And for those already enrolled, Medi-Cal navigation itself creates barriers—county-to-county assignment delays, managed care transitions, and referral gaps that delay care access even for women who are technically covered.

“Insurance was also a challenge. Even though I had coverage through my employer, when it came time for delivery they told me I would have to pay \$6,000. That's when I reached out and was told that since I was pregnant, I could apply for Medicaid. With about a month left—40 days before my due date—I was approved.”

— Undocumented Focus Group Participant

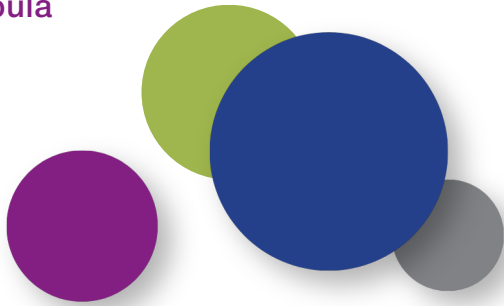
“Getting your Medi-Cal switched to this county, assigned to the right clinic, getting a referral—it shouldn't be this hard. Lots of phone calls and delays. We have to reschedule patients because they're still assigned to Lake County.”

— Family Physician

Beyond insurance, the fragmentation of the broader care and social services system creates navigation burdens that many families—particularly those with the greatest needs—cannot manage alone. The referral system between programs is weak, services are siloed, and the paperwork and bureaucratic requirements of accessing support fall disproportionately on families least equipped to absorb them. Providers and women alike described the aspiration for a more coordinated, wraparound model of care.

“A lot of folks have the same dream of having a one stop shop where people can go under one roof and get care from a medical provider, a mental health provider, a lactation provider, a doula, a social worker—everything under one roof.”

— Doula



“If they need housing support, food support, childcare support, any other resources—it's quite segmented. Trying to find those resources, the referral system is not great. The programs are impacted, and there's a lot of paperwork and bureaucracy. Many people don't have the skills or the time to do that.”

— Doula

Transportation and Geographic Access

Transportation was one of the most consistently named barriers across key informant interviews—cited by providers in clinical settings, home visiting programs, and community organizations. Women in focus groups who lacked transportation also described the significant impact it had on their ability to access care. However, it ranked low among unmet needs in the community survey. Together, these findings suggest that transportation is not a universal barrier—but for women with the fewest resources, it is a meaningful one.

The challenge is not only the absence of a car. It is the planning required to use public transit while pregnant or postpartum, the timing constraints of bus schedules, the physical difficulty of navigating transit with a stroller and other children, and the reality that transportation assistance—when it exists—typically covers medical appointments but not childcare, therapy, or support group attendance. Providers also described how the cognitive and emotional load of pregnancy and the postpartum period compound this barrier—getting to an appointment via public transit requires planning far in advance, and for women under significant stress, that planning capacity may not be available.

“For therapy specifically, lack of transportation is a major barrier. A few clients take the bus but miss the bus and miss appointments. The organization tried offering telehealth to reduce this barrier, but many clients do not have privacy at home—sometimes they are living with multiple families. Telehealth is not an option because they do not have a sense of safety at home.”

— Bilingual Prenatal Therapist

“I did not have any personal transportation ... Having a toddler and navigating the bus system—I recall being very pregnant, having a stroller, having to take my toddler out of the stroller so he could sit on the bus. They cannot be in the car seat on the bus. It was really challenging.”

— Native American Focus Group Participant

Transportation surfaced as a barrier more often among Spanish-speaking participants than English-speaking participants in both pregnancy and postpartum, though survey numbers were small. For women in outlying areas—West County, Cloverdale, and the northern parts of the county—transportation barriers are compounded by geographic isolation. Services are concentrated in Santa Rosa, satellite clinic hours are limited, and specialty care may require travel as far as San Francisco. As labor and delivery units have closed in Petaluma and Sonoma Valley, hospital-based labor and delivery care is now limited to Santa Rosa.

“For me and my rural area, we do not have any services. We have a satellite clinic from Sonoma County Indian Health, but they are only open certain days and it is more of a clinic—there are no additional services being brought there. The resources just are not there.”

— Native American Focus Group Participant

“Our anatomy ultrasound has to be outsourced all the way to San Francisco because the UCSF satellite in Santa Rosa closed. That’s a huge barrier.”

— CPSP Coordinator



Childcare

The absence of reliable childcare shaped women's perinatal experiences across the entire continuum—from prenatal appointments through birth and into the postpartum period. As appointment frequency increases during pregnancy, childcare for older children becomes an increasingly acute logistical challenge. Providers named it consistently as a structural barrier to attendance.

During labor and delivery, the absence of childcare influenced clinical decisions and care quality directly. Providers described women scheduling inductions at known times specifically to arrange care for older children in advance. When childcare falls through in these situations, the consequences are immediate.

In the postpartum period, the absence of childcare became a barrier to accessing nearly every form of support—therapy, support groups, appointments, and simple recovery. The logistics of arranging childcare—whether it falls through, runs long, or creates family judgment—shape whether women can access care at all.

“Childcare for other children during birth is a huge unmet need, driving unnecessary inductions. I once had to read a book to a three-year-old while mom was in labor because grandma didn't arrive.”

— Doula

“If a provider is running an hour behind and you have a newborn or arranged childcare with a neighbor, those time limitations are real barriers.”

— CPSP Coordinator

“Even accessing therapy requires childcare. If you have to explain to your family why you need them to watch your kids, that opens up a whole set of uncomfortable questions and judgments. A drop-in childcare option connected to therapy would remove a huge barrier.”

— Cloverdale Focus Group Participant

Language, Health Literacy, and Patient Confidence

A consistent pattern across focus groups and provider interviews was that many women leave clinical encounters without fully understanding what they were told, without having asked the questions they needed to ask, and without a clear sense of what to do next. For some women the barrier is primarily language—care delivered in English they do not fully understand, or through interpretation services that flatten nuance and miss context. For others it is confidence and health literacy—a cultural or personal deference toward providers, unfamiliarity with how to navigate clinical settings, or a sense that asking questions is not their place. For many women, both are present at once, compounding each other in ways that make full participation in their own care difficult.

“A common pattern is that a client will have a visit at the clinic and then meet with a home visitor, and it will turn out they have a lot of questions they didn't ask during the clinical visit. They feel unsure.”

— Public Health Nurse

“People coming from a less privileged position don't have the confidence or the information to challenge any of that, or to ask any questions. Just that mentality of—you just go into the clinic, you do as you're told.”

— Public Health Nurse

“There's processes that we don't know and we don't understand, and sometimes we're afraid to ask. A lot of these moms fully trust doctors because they are educated, and a lot of these moms have lower schooling for whatever reason. We trust that doctors know best.”

— Perinatal Group Facilitator

The language dimension of this barrier extends beyond the presence or absence of an interpreter. Medical terminology, health literacy levels, and educational background create comprehension gaps even when the surface language matches—a challenge that affects Spanish-speaking women navigating medical Spanish as much as English-speaking women with lower education levels navigating clinical jargon.



“They are speaking medical Spanish to a patient who is from a tiny little pueblo who has a fourth-grade education and has no idea what this person is saying. It doesn't matter that they're speaking Spanish—it's the same problem as if a doctor were using all doctor-speak with someone who didn't graduate high school here.”

— Perinatal Home Visitor

“We come out of the appointment and I ask, 'Did you understand everything?' And they say, 'I don't know what they were talking about. What am I supposed to do?' In some cases, they're walking out with narcotics in their hands and don't know what they're for.”

— Perinatal Home Visitor

The consequences of unaddressed language barriers extend beyond a single appointment. Women who cannot communicate effectively with their providers are dismissed, misunderstood, and left without care they need—sometimes repeatedly.

“She'd been to the clinic 10 times and the ER five times, and everyone had dismissed her because of the language barrier. But there was actually a real issue.”

— Perinatal Home Visitor

Fear of the System and Provider Distrust

For many women—particularly those navigating substance use, mental health challenges, or prior negative experiences with the healthcare system—the decision to seek care is not straightforward. A pervasive fear of being judged, dismissed, or reported shaped whether and how women engaged with providers across every phase of the perinatal period. Providers described the challenge of building trust with populations who have had prior negative experiences with the healthcare system, or who carry justified fears about what disclosure might trigger.

“A lot of these families have multiple reasons for experiencing discrimination—education, race, language, substance use, or mental health history. Judgment from providers is an issue. Finding a care team that makes them feel safe is a challenge.”

— Bilingual Prenatal Therapist

“I was offered in-home support—someone who could come to the house and help—but I turned it down. Part of why I said no was fear of being judged—having strangers in my home, especially if it felt like a government-connected program.”

— Native American Focus Group Participant

For women with substance use histories, fear of judgment carries an additional and acute dimension: fear of child removal. Providers described women delaying or avoiding care—not because they didn't want support, but because disclosing a struggle felt too dangerous. The fear

of CPS involvement kept some women from seeking mental health support, engaging with home visiting programs, or being honest with their providers about what they were experiencing.

“If you're using substances—shame and fear of stigma, feeling like you need to get your substance use under control before seeking care, or fear that your child will be removed. A lot of people prioritize 'I'll get this under control first, then also do care.'”

— Addiction Medicine Physician

“I find this so incredibly sad and remarkably still very pervasive—a fear that your baby will be taken away if you are mentally ill. I don't know how to change that narrative.”

— Family Physician

Substance Use

As described in the community health profile, Sonoma County's rates of substance use during pregnancy exceed state averages—a pattern that shapes the clinical landscape providers navigate. Beyond the fear of judgment and CPS involvement discussed above, women who use substances or are in recovery face barriers rooted in the care system itself.

One addiction medicine physician raised concerns about clinically inaccurate guidance, noting that well-meaning providers unfamiliar with addiction medicine sometimes advise patients to discontinue or reduce medication-assisted treatment during pregnancy, without recognizing that pregnancy-related metabolism changes may actually require dose increases—advice that puts patients “at risk of returning to illicit use or becoming medically destabilized.” The same physician described a shortage of treatment infrastructure for pregnant women locally, with no medically managed detox program and few pathways for a pregnant woman seeking immediate help to be admitted for care. Providers also noted a gap in preventive services for women who are already sober: proactive, non-punitive support is limited, leaving those in recovery without a clear pathway to support that is not tied to crisis or enforcement.

This dynamic extends across the perinatal period. Providers described the immediate postpartum as especially fraught for women with substance use histories, when a positive toxicology screen at delivery can prompt CPS involvement and, in some cases, infant removal—a risk that shapes how women engage with care well before they reach it.

Among the 86 survey participants who indicated using alcohol, marijuana, or other drugs during pregnancy, the supports most commonly identified as potentially helpful were financial assistance, childcare, a supportive person in their life, and therapy or counseling.

Documentation Status & Immigration Fear

For undocumented women and recent immigrants, fear of immigration enforcement was named by providers as one of the most significant—and worsening—barriers to perinatal care access in Sonoma County. The consequences are concrete and measurable: women delaying prenatal care until the third trimester, avoiding emergency department visits, declining home visiting programs, and withholding information from providers out of fear that it will be recorded in a permanent medical record.

“With ICE activity, patients don't want to leave comfortable areas, especially for appointments in San Francisco.”

— CPSP Coordinator

“Hands down, the number one barrier is the financial insecurity and safety concern around immigration. Patients aren't opening up because they know what they say goes in their medical record permanently. They're not coming in for first or second trimester care because of that fear. We're getting tons of patients who stayed home for 20, 26 weeks and are coming in during the third trimester. Some started prenatal care at 35 weeks. They're reserving their last appointments just for delivery. It's too much, too fast for them to gather any of the education they truly need.”

— CPSP Coordinator

The financial consequences of documentation status compound the fear. Undocumented women often cannot access paid family leave, state disability benefits, or many publicly funded support programs—leaving them with fewer resources and greater financial pressure to return to work quickly after birth, regardless of their physical or mental health. The survey data reflect this burden: immigrant participants were more likely than the overall population to name financial assistance as an unmet need (32.4% vs. 19.2%).

“When you have papers, you can collect unemployment. And when you don't have papers, sometimes you don't even know that you might still qualify for certain benefits, because the doctors don't tell you and the clinics don't give you that information. Someone with documentation can take more time to be with their baby, whereas someone without papers has to go back to work right away because there's no money coming in. You have to leave a tiny baby to go back to work.”

— Farmworker Focus Group Participant

Racial & Cultural Concordance in Care

Access to care is not only shaped by logistics, language, and knowledge—it is shaped by whether women feel seen, understood, and respected by the providers they encounter. Cultural concordance—the degree to which a provider shares or deeply understands a patient's cultural background, values, and lived experience—emerged across the assessment as a meaningful determinant of whether women engaged openly with care, disclosed their true concerns, and felt safe enough to ask for what they needed.

“Knowing there's a Spanish speaker and someone that can reflect back to them their culture. It's a buy-in. This is someone that will 'get me.' They can be more at ease. Feel more comfortable.”

— Bilingual Perinatal Therapist

“People are just going to feel safer if their nurse and the person they go see in the clinic knows something about their culture, speaks their language.”

— Public Health Nurse

“My midwife was the one that delivered my baby, and she was a woman of color, so that even felt more comfortable for me.”

— Monte Rio Focus Group Participant

The value of cultural concordance is not simply about comfort. Providers described how a culturally concordant relationship changes the clinical encounter fundamentally—patients disclose more, trust more, and engage more consistently with care. The inverse is equally true: when women do not feel culturally understood, they disengage, withhold information, and avoid care.

“I think one thing that would have made my experience better would be if there were actually staff that were more culturally aware.”

— Black Focus Group Participant

Despite its documented value, culturally concordant care is unevenly distributed. The perinatal workforce in Sonoma County does not reflect the diversity of the communities it serves. Public health nurses described racial discrimination and racial identification as significant barriers—noting that women of color often struggle to find providers they identify with, and that this difficulty shapes their willingness to engage with care. Providers named the particular scarcity of midwives and providers of color across clinical settings—a gap that community members named independently in the survey.

“There are ZERO midwives of color in Sonoma County and not nearly enough indigenous birthworkers (doulas) who can provide culturally relevant care. This was a major gap for me in feeling like I had the best care possible and someone who understood my experience.”

— Survey Participant

At the most acute end of this spectrum, the absence of cultural concordance at times reflects racial bias—providers making clinical assumptions based on race rather than individual patient presentation. This is distinct from a cultural mismatch. It reflects failures of clinical judgment rooted in racial stereotyping—with direct consequences for patient safety.

“When I'd talk about having pain—concerns about pains—it would usually not get taken seriously or just get dismissed. Because I remember one of the healthcare team members told me that I'm a Black woman and I am strong enough.”

— Black Focus Group Participant

“There were moments where I felt my concerns weren't taken as seriously, and it kind of made me wonder if it was because of my color. When I asked questions about my care or pain management, I felt rushed, or like I wasn't really fully listened to.”

— Black Focus Group Participant

A doula named the systemic dimension directly: the lack of provider diversity is not incidental—it reflects policies and institutional structures that have historically excluded providers of color from the perinatal workforce, with consequences that compound across every clinical encounter.

“Systemic racism: lack of provider diversity, implicit bias, and policies rooted in racism like universal drug testing. People of color don't feel safe accessing care.”

— Doula

The **Doulas & Birth Workers** section of this report describes one avenue for addressing both the cultural concordance gap and the workforce diversity gap—and the specific barriers that prevent this avenue from being fully realized.

For some women—particularly within Latine and Native communities—the desire for culturally concordant care extends beyond provider identity to healing practices rooted in cultural tradition. Providers and community members described the integration of traditional and somatic healing alongside clinical care as meaningful and largely absent from Sonoma County's perinatal landscape. For Native women, this extended to traditional knowledge about pregnancy and birth, naming ceremonies, and the presence of community elders—practices that clinical care cannot provide and that many described searching for on their own.

“The ideal would include having access to supportive somatic practitioners and traditional healers. A place where women could meet with a curandera, or a woman who offers healing through massage during pregnancy, or who teaches about the right teas to take during pregnancy and postpartum.”

— Bilingual Perinatal Therapist

Doulas & Birth Workers

Doulas and birth workers occupy a unique position in the perinatal care landscape—neither clinical providers nor family members, but trusted advocates who span pregnancy, birth, and the postpartum period in ways that no other role does. Providers and community members described doulas as filling a role that clinical providers are too time-constrained to fill and that partners are often too unprepared to fill on their own: continuous labor support, advocacy for the family's goals in clinical settings, and practical knowledge that nurses and physicians typically do not have time to provide. Across this assessment, doulas and birth workers were named as among the most valuable—and most underutilized—supports available to Sonoma County mothers.

“For most people, when you actually talk to them about what a doula is—that it’s a person there to help them identify what their goals are and then to help them advocate for those goals in the hospital—for most people, that’s something they want.”

— Certified Nurse-Midwife

The survey data confirm meaningful impact: 20.9% of participants named a doula as a helpful support during birth—and 15.8% named doula support as something they wished they had but did not.

Medi-Cal doula coverage is a breakthrough—but coverage alone does not meet the need.

The expansion of Medi-Cal coverage theoretically makes doula support available at no cost to the county’s lowest-income mothers. But realizing that promise depends on more than coverage: mothers knowing what a doula is and the value one brings, knowing the benefit is covered, and being able to find a Spanish-speaking, Indigenous, or culturally-concordant doula when they want one.

Medi-Cal Doula Coverage

The expansion of Medi-Cal coverage for doula services represents one of the most significant perinatal policy advances in recent years—making doula support theoretically available to the county’s lowest-income mothers at no cost. Providers described the coverage as a genuine breakthrough that has already made a difference for mothers who access it.

“Now that Medi-Cal funds doulas, that’s been a tremendous help.”

— Perinatal Home Visitor

“People don’t realize that there is a huge Medi-Cal benefit that covers doulas. Often, once I say, ‘Your Medi-Cal pays for it in full,’ the eyes come open, the light bulbs come on.”

— Certified Nurse-Midwife

But awareness of the benefit remains low—particularly among the mothers most likely to be eligible and most likely to benefit. Across multiple focus groups, participants had never been told doula support was covered under their insurance—in some groups, participants didn’t know what a doula was until the facilitator explained it. The survey data reinforce that many Medi-Cal recipients may be unaware the benefit exists: Medi-Cal recipients were nearly half as likely as those with private insurance to name doula support as an unmet need at birth (10.0% vs. 20.1%)—likely reflecting not lower need but lower expectation or knowledge of the resource.

“I would have liked to have a doula, but no one offered it and I didn’t know.”

— Undocumented Focus Group Participant

“I actually didn’t know I could request a doula through my insurance.”

— Santa Rosa Focus Group Participant

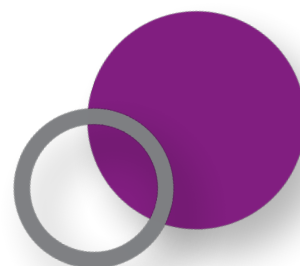
“I was surprised that my doctor never offered me information about doulas. I only knew about it because [my perinatal home visitor] told me. I had to pursue it on my own.”

— Santa Rosa Focus Group Participant

Provider culture also emerged as a barrier. Some providers actively discouraged doulas—questioning why a patient wanted one, making women feel ashamed for asking, or telling laboring women not to call their doula.

“Why do you want a doula? You don’t need that. And I told [my CPSP coordinator] that I felt scolded, and it really hit me hard.”

— Sonoma Valley Focus Group Participant, describing a provider’s response to her request for a doula



Doula Access

Despite universal Medi-Cal coverage and broad interest across communities, doula utilization in Sonoma County is deeply unequal. White participants were more than twice as likely as Spanish-speaking participants to name a doula as helpful at birth (28.4% vs. 11.7%), and almost twice as likely to name doula support as an unmet need (20.6% vs. 10.6%). Spanish-speaking and immigrant participants reported the lowest rates of naming it as an unmet need, suggesting that for many in these communities, doula support may not be an expectation.

“The nurse says, ‘Oh, don’t call your doula. You don’t need a doula right now.’”

— Doula

“Historically, it’s always been women of wealth who had access and were interested in having a doula—higher income and maybe higher education level. It’s culturally normative in those spaces.”

— Family Physician

“I primarily only see white people with doulas ... It’s universally covered, why isn’t it universally accepted?”

— Midwife

Hesitancy in immigrant and Spanish-speaking communities may reflect a combination of unfamiliarity with the doula role and distrust of outside support—particularly for mothers navigating immigration fear or reluctant to invite strangers into an intimate setting.

“I think there is anxiety around strangers in the Latinx community. If someone is not coming from the clinic directly, patients decline referrals—even when they would so benefit.”

— Family Physician

“The immigrant population fears outside support especially now. Having doulas from all backgrounds is essential.”

— Doula

“They don’t speak Spanish, so it’s harder [to find] a doula or birth worker. I tried to contact them, and I wasn’t feeling comfortable.”

— Santa Rosa Focus Group Participant

Partners also emerged as a consideration. When doula support is framed as additional support rather than a replacement for the partner, acceptance increases significantly.

“Most of the single clients are open to doulas. The ones with partners are initially hesitant because they think it’s a replacement. Once I explain it’s additional support, the moms get on board, but the partners can still be resistant.”

— Perinatal Home Visitor

The single most significant barrier to equitable doula access is the absence of doulas and birth workers who reflect the communities most in need of support. The county has doulas, but not enough who speak Spanish, who share Indigenous backgrounds, or who bring cultural knowledge and community trust alongside their skills. Birth workers and community members named the workforce gap directly:

“There’s plenty of doulas in Sonoma County, but in terms of cultural competency, cultural relevancy, it’s two. I’ve gone to Meet the Doula groups ... and I’ve been the only Spanish-speaking one. I’ve been the only Indigenous one.”

— Birth Worker

“Not nearly enough indigenous birthworkers who can provide culturally relevant care. This was a major gap for me in feeling like I had the best care possible and someone who understood my experience.”

— Survey Participant

“Having doulas from all backgrounds is helpful so that anyone who wants a doula can find someone they feel comfortable with. Having someone in the room that looks like you is really important—so that you feel like you’re not the only one of color or the only one of whatever cultural ethnicity in that room.”

— Doula

The following assets span the full perinatal continuum:

Federally-Qualified Health Centers (FQHCs)

Sonoma County's FQHCs provide perinatal care for predominantly low-income mothers. Salient features include bilingual providers, integrated behavioral health and substance use support, warm handoffs to home visiting and social services, and a mission-driven commitment to serving the most underserved mothers regardless of ability to pay.

Comprehensive Perinatal Services Program (CPSP)

CPSP is a statewide Medi-Cal benefit providing psychosocial support, nutrition counseling, care navigation, and resource connection from conception through the postpartum period. CPSP coordinators serve as an embedded source of perinatal knowledge within the clinical setting, ensuring women understand what they are entitled to—including benefits many would not otherwise know about, such as Medi-Cal doula coverage—and following up on questions that went unasked during the clinical visit itself. California expanded Medi-Cal postpartum coverage from 60 days to 12 months in 2022, extending the window during which CPSP-enrolled women can receive continued support.

Home Visiting Programs

Home visiting programs provide intensive, individualized support to lower-income and higher-risk mothers across pregnancy and the postpartum period. Like CPSP coordinators, home visitors serve as a consistent, trusted presence who can follow up after clinical encounters, surface the questions women did not ask, connect mothers to resources they did not know they had access to, and accompany them through processes that are difficult to navigate alone. Expanding in-home programs of this kind—including to mothers just above income eligibility thresholds—represents a meaningful opportunity to extend this level of support to a broader population of women.

WIC Across the Perinatal Continuum

WIC serves as a primary institutional anchor for Latine and low-income families across pregnancy and postpartum, providing nutritional support, peer breastfeeding counseling, and connection to resources. Ensuring consistent referral and enrollment—particularly early in pregnancy—would extend WIC's reach to more women who would benefit from it.

Specialized Perinatal Mental Health Programs

A small number of organizations provide perinatal-specific mental health support, including bilingual bicultural therapy, community health worker pairing, and provider training in Latine cultural context. These programs represent a meaningful foundation of

culturally-concordant care and an opportunity for expansion to meet a need that currently far exceeds available capacity.

Community-Based Perinatal Programs and Peer Support Groups

A network of community-based organizations across the county provides perinatal education and peer connection, with some programs described by participants as meaningful in reducing isolation and building confidence during pregnancy and postpartum. These programs exist in various formats and locations but are not fully meeting demand, representing an opportunity for expansion in reach, format, and geographic availability.

Medi-Cal Transportation Benefit

Transportation to medical appointments is a covered benefit for all Medi-Cal managed care members in Sonoma County, providing rides to prenatal, birth, and postpartum appointments at no cost. Awareness of the benefit and ease of scheduling vary across plans.

Medi-Cal Doula Coverage

Since January 2023, doula services are covered across prenatal visits, labor and delivery, and postpartum visits, a meaningful policy win that has opened access for lower-income mothers across the perinatal continuum. Uptake remains uneven, with awareness gaps among both patients and providers, late referrals, and a shortage of racially and culturally concordant and Spanish-speaking doulas limiting reach to the mothers who stand to benefit most. Strengthening provider and patient awareness of the benefit, supporting earlier referrals, and growing the pipeline of concordant doulas represent opportunities to close the gap between coverage and uptake.

The following systemic gaps span the full perinatal continuum:

Financial Support for Families

Financial assistance was named as an unmet need by nearly one in five survey participants during both pregnancy and postpartum; concentrated at the lowest income tier and among immigrant families, including those who fall just above Medi-Cal eligibility thresholds and lack access to safety net supports.

Housing Instability

Housing was named by multiple providers as among the single most urgent unmet needs during the perinatal period. Challenges include overcrowding, shelter time limits that can expire during postpartum recovery, and eligibility requirements that place stable housing effectively out of reach.

Inadequate Paid Leave

Paid leave shapes who can stay home after birth and for how long. This is a concern for lower-wage workers and those in informal employment who lack access to or knowledge of state disability and paid family leave benefits.

Coordinated Care and Navigation Support

Perinatal health and social services remain largely fragmented, requiring women with multiple needs to navigate multiple systems independently. The absence of coordinated, well-connected care and dedicated navigation support is felt most acutely by women facing overlapping challenges across housing, mental health, and economic insecurity—precisely the women for whom the navigation burden is greatest. Greater integration across systems and more consistent access to someone who can help women find and access what they need represents a significant opportunity to reduce that burden.

Awareness Of and Connection To Available Resources

Women across all phases described leaving clinical encounters without knowing what they were eligible for or that certain programs and benefits existed. When awareness is present, navigating fragmented systems to actually access resources remains a significant burden that falls disproportionately on families with the greatest needs and the least capacity to manage it.

Access to Intensive Perinatal Support for Women Outside Program Eligibility

Home visiting and CPSP provide the most intensive navigational and relational support available to perinatal women in Sonoma County, but eligibility requirements mean that

women who fall just outside income thresholds or are not connected to qualifying clinics may have no access to this level of support despite having significant need.

Transportation and Geographic Access

Transportation barriers and the concentration of services in Santa Rosa create significant access gaps for women in outlying areas. Bringing services closer to where women live—through in-home support, mobile or pop-up clinical presence, and community-based programming in geographically isolated areas—represents a meaningful opportunity to reduce these barriers.

Accessible Perinatal Mental Health Care

The shortage of perinatal mental health specialists who accept Medi-Cal, speak Spanish, and offer flexible, affordable formats is a significant gap across pregnancy and postpartum. Expanding culturally concordant programs, reducing barriers to access, and broadening the range of available formats represent a significant opportunity to meet women where they are.

Accessible Substance Use Care Across the Perinatal Period

Local treatment pathways for substance-using and recovering women are limited, and fear of CPS involvement deters disclosure and care-seeking from pregnancy through postpartum. Few supports exist for women working to sustain recovery. Improving substance use treatment knowledge among local providers who care for pregnant women, including accurate guidance on medication during pregnancy, would improve care for this population.

Culturally, Racially, and Linguistically Concordant Providers, Doulas, and Birth Workers

The perinatal workforce does not reflect the racial, ethnic, or linguistic diversity of Sonoma County's childbearing population. Building a more diverse pipeline of providers, doulas, and birth workers—particularly those who are Spanish-speaking, culturally concordant, and racially representative of the communities they serve—represents a structural opportunity to improve quality, safety, and accessibility of care across all phases.

Conclusion

Sonoma County has genuine assets in maternal health—committed providers, established programs, and communities with deep reserves of care and resilience. It also has serious and well-documented gaps: in mental health access, in culturally concordant care, in economic support, and in the coordinated wraparound services that would allow women to navigate the perinatal period without falling through the cracks. These gaps are not evenly distributed. They fall hardest on women who are already navigating the most—and they cut across pregnancy, birth, and postpartum in ways that require equally cross-cutting responses.

This report is intended as a foundation for that work. The findings it contains are most meaningful when reviewed in partnership with the community members, providers, and organizations whose experiences and expertise shaped them. First 5 Sonoma County and its partners are encouraged to engage with these results collaboratively—centering the voices of women of color, immigrant women, low-income women, and other underserved communities—to determine the priorities, strategies, and investments that will make the most meaningful difference for women and families across the perinatal continuum in Sonoma County.



Appendices

Appendix A: Community Survey Results

Table A-1. Fair or Poor Health Ratings, by Subgroup

Group	Mental Health — Pregnancy (n=478)	Mental Health — Postpartum (n=493)	Physical Health — Pregnancy (n=620)	Physical Health — Postpartum (n=619)
Overall	39.1%	50.1%	30.0%	40.9%
<i>By race/ethnicity</i>				
Asian	—	—	16.7%	30.0%
Latine	44.1%	47.6%	41.2%	48.1%
White	37.0%	52.9%	22.9%	37.3%
<i>By language and immigration status</i>				
English home language	40.2%	57.6%	25.5%	41.4%
Spanish home language	35.7%	38.8%	36.9%	42.1%
Immigrant	42.3%	44.3%	40.7%	52.8%
<i>By household income</i>				
Under \$43K	39.5%	43.4%	36.8%	42.1%
\$43K–\$61,999	50.9%	61.1%	38.8%	53.8%
\$62K–\$92,999	48.7%	48.8%	18.4%	30.6%
\$93K–\$124,999	46.0%	71.7%	29.0%	48.4%
\$125K+	32.6%	52.3%	23.2%	36.8%

Note: Column denominators reflect respondents who answered each health rating question. Each cell reflects the percentage of respondents within that subgroup who rated their health as fair or poor; columns do not sum to 100. Asian responses did not meet the reporting threshold of $n \geq 30$ for mental health measures.

Table A-2. Felt Well-Supported During the Perinatal Period, by Subgroup

	Pregnancy Well Supported (n=617)	Birth Well Supported (n=500)	Postpartum (6 weeks) Well Supported (n=535)	Postpartum (1 year) Well Supported (n=562)
Overall	77.6%	81.0%	65.6%	67.8%
<i>By race/ethnicity</i>				
Asian	86.7%	—	—	—
Latine	72.7%	79.0%	66.5%	70.2%
White	89.1%	86.5%	66.9%	64.3%

	Pregnancy Well Supported (n=617)	Birth Well Supported (n=500)	Postpartum (6 weeks) Well Supported (n=535)	Postpartum (1 year) Well Supported (n=562)
By language and immigration status				
English home language	82.9%	86.1%	63.7%	66.8%
Spanish home language	69.3%	74.2%	70.6%	72.0%
Immigrant	68.8%	75.0%	66.7%	65.3%
By household income				
Under \$43K	68.7%	73.2%	64.2%	69.5%
\$43K–\$61,999	73.1%	78.9%	62.1%	52.5%
\$62K–\$92,999	73.5%	79.5%	79.5%	78.0%
\$93K–\$124,999	79.0%	77.8%	57.4%	64.9%
\$125K+	90.8%	88.7%	67.9%	69.0%

Note: Column denominators reflect respondents who answered the support question for each perinatal phase. Percentages reflect the share of respondents who reported feeling well-supported during each phase of the perinatal period. Cells marked — indicate subgroups with fewer than 30 respondents for that phase; estimates are not reported. Asian respondents met the reporting threshold for pregnancy only (n=30).

Table A-3. Most Challenging Phases of the Perinatal Experience, by Subgroup

Group	Pregnancy /prenatal care	Labor and delivery	Postpartum				No significant challenges
			First 6 weeks	6 weeks - 6 months	6 months to 1 year	1–2 years	
Overall (n=468)	26.1%	33.5%	48.9%	39.7%	21.2%	10.5%	5.8%
By race/ethnicity							
Latine (n=173)	25.4%	37.0%	46.2%	31.8%	17.9%	13.3%	5.8%
White (n=169)	28.4%	27.8%	52.7%	52.7%	26.6%	10.7%	6.5%
By language and immigration status							
English home language (n=296)	27.7%	30.7%	51.4%	50.3%	27.7%	12.2%	4.4%
Spanish home language (n=148)	20.9%	39.9%	45.3%	20.3%	9.5%	8.1%	9.5%
Immigrant (n=77)	24.7%	42.9%	44.2%	29.9%	13.0%	7.8%	1.3%
By household income							
Under \$43K (n=116)	25.0%	32.8%	43.1%	25.9%	14.7%	8.6%	9.5%

Group	Pregnancy /prenatal care	Labor and delivery	Postpartum				No significant challenges
			First 6 weeks	6 weeks - 6 months	6 months to 1 year	1–2 years	
\$43K–\$61,999 (n=56)	21.4%	37.5%	50.0%	42.9%	23.2%	7.1%	5.4%
\$62K–\$92,999 (n=41)	31.7%	36.6%	58.5%	41.5%	24.4%	17.1%	2.4%
\$93K–\$124,999 (n=52)	30.8%	32.7%	57.7%	44.2%	26.9%	13.5%	1.9%
\$125K+ (n=139)	27.3%	28.1%	51.8%	55.4%	25.9%	10.8%	5.0%

Note: Percentages reflect the share of respondents who selected each phase from a multi-select question (“Which phases of your perinatal experience were most challenging?”); respondents could select multiple phases, and percentages may exceed 100%. Denominators reflect only those who selected at least one response.

Table A-4. Postpartum Mental Health Challenges and Support Access, by Subgroup

	Did not experience a challenge (% of all respondents)	Received adequate support (% of those with challenge)	Support was not enough (% of those with challenge)	Could not find/access support (% of those with challenge)
Overall (n=578)	25.3%	48.1%	32.9%	19.0%
By race/ethnicity				
Latine (n=205)	24.9%	53.9%	26.6%	19.5%
White (n=190)	22.1%	44.6%	40.5%	14.9%
By language and immigration status				
English (n=352)	19.9%	45.4%	39.0%	15.6%
Spanish (n=189)	37.0%	57.1%	19.3%	23.5%
Immigrant (n=101)	26.7%	51.4%	24.3%	24.3%
By household income				
Under \$43K (n=147)	30.6%	52.0%	25.5%	22.5%
\$43K–\$61,999 (n=67)	19.4%	38.9%	35.2%	25.9%
\$62K–\$92,999 (n=45)	24.4%	61.8%	23.5%	14.7%
\$93K–\$124,999 (n=58)	25.9%	39.5%	39.5%	20.9%
\$125K+ (n=173)	18.5%	45.4%	41.8%	12.8%

Note: “Did not experience a challenge” is calculated as a percentage of all respondents who answered this question. The three support response columns are calculated as a percentage of those who reported experiencing a mental health challenge.

Table A-5. Pregnancy — Most Helpful Supports, by Subgroup

	Overall (n=457)	Latine (n=171)	White (n=164)	English (n=295)	Spanish (n=139)	Immigrant (n=76)	Under \$43K (n=114)	\$43K– \$61,999 (n=49)	\$62K– \$92,999 (n=42)	\$93K– \$124,999 (n=46)	\$125K+ (n=147)
Support from family or friends	46.0%	34.5%	62.2%	55.9%	30.2%	22.4%	27.2%	40.8%	50.0%	65.2%	61.9%
Access to healthy food	36.1%	33.9%	37.2%	36.6%	33.1%	35.5%	41.2%	32.7%	42.9%	32.6%	35.4%
Regular prenatal care appointments	33.3%	27.5%	44.5%	40.3%	22.3%	25.0%	18.4%	32.7%	28.6%	41.3%	47.6%
Mental health support or therapy	18.4%	14.6%	23.8%	21.7%	12.9%	17.1%	8.8%	22.4%	23.8%	26.1%	23.8%
Exercise opportunities/ classes	16.6%	10.5%	25.6%	21.4%	7.2%	6.6%	7.0%	8.2%	16.7%	15.2%	30.6%
Doula/birth worker support	16.4%	14.6%	20.7%	19.3%	10.1%	15.8%	16.7%	14.3%	21.4%	17.4%	18.4%
Prenatal classes or education	14.9%	11.1%	15.9%	16.9%	12.2%	13.2%	8.8%	22.4%	21.4%	17.4%	14.3%
WIC	13.1%	24.6%	2.4%	6.1%	28.1%	23.7%	28.1%	22.4%	11.9%	4.3%	0.0%
Financial assistance	9.2%	11.1%	7.9%	10.2%	7.2%	9.2%	15.8%	22.4%	7.1%	6.5%	2.0%
Support groups or peer connections	6.1%	5.3%	7.9%	7.8%	2.9%	3.9%	2.6%	4.1%	11.9%	8.7%	8.8%
Online resources	4.8%	5.8%	5.5%	6.4%	2.2%	5.3%	1.8%	0.0%	4.8%	13.0%	8.2%
Culturally appropriate care	3.9%	3.5%	1.8%	3.7%	3.6%	2.6%	5.3%	4.1%	4.8%	0.0%	4.1%
Home visiting programs	2.6%	2.3%	1.2%	2.0%	3.6%	7.9%	5.3%	2.0%	2.4%	2.2%	1.4%
Housing assistance	1.5%	1.8%	1.8%	1.7%	1.4%	1.3%	4.4%	4.1%	0.0%	0.0%	0.0%
Transportation	0.7%	1.2%	0.6%	0.3%	1.4%	0.0%	1.8%	0.0%	2.4%	0.0%	0.0%
Nothing was particularly helpful	1.8%	2.3%	0.6%	1.7%	1.4%	1.3%	1.8%	4.1%	0.0%	2.2%	1.4%
Other	1.3%	1.2%	2.4%	1.0%	1.4%	1.3%	1.8%	0.0%	0.0%	2.2%	2.0%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Table A-6. Pregnancy — Unmet Needs, by Subgroup

	Overall (n=603)	Latine (n=209)	White (n=198)	English (n=369)	Spanish (n=196)	Immigrant (n=108)	Under \$43K (n=159)	\$43K– \$61,999 (n=65)	\$62K– \$92,999 (n=48)	\$93K– \$124,999 (n=60)	\$125K+ (n=183)
Connection with other parents	22.1%	23.4%	20.2%	22.5%	20.4%	29.6%	24.5%	20.0%	29.2%	23.3%	20.8%
Financial assistance	19.2%	22.5%	13.1%	16.5%	21.9%	32.4%	28.3%	21.5%	27.1%	23.3%	8.2%
Exercise opportunities/ classes	17.6%	16.7%	17.2%	17.1%	18.4%	18.5%	23.3%	13.8%	16.7%	15.0%	15.3%
Doula/birth worker support	14.3%	11.5%	16.2%	16.3%	10.7%	14.8%	13.8%	15.4%	18.8%	15.0%	15.8%
Mental health support or therapy	13.6%	12.4%	14.1%	15.2%	8.7%	14.8%	13.2%	16.9%	6.2%	18.3%	15.8%
Support from family or friends	11.3%	12.4%	7.6%	11.1%	10.7%	14.8%	17.0%	10.8%	4.2%	11.7%	10.4%
Dental care	8.5%	8.1%	6.6%	7.6%	8.7%	12.0%	12.6%	18.5%	10.4%	8.3%	1.6%
Housing assistance	8.1%	12.4%	4.0%	5.4%	12.2%	16.7%	17.6%	12.3%	6.2%	1.7%	0.5%
Prenatal classes/education	7.0%	7.7%	8.6%	7.6%	6.6%	7.4%	6.9%	10.8%	4.2%	11.7%	6.6%
Access to healthy food	5.8%	6.7%	2.5%	4.6%	7.7%	12.0%	10.7%	7.7%	4.2%	1.7%	2.2%
Care that respected my culture/traditions	5.8%	8.1%	1.5%	5.1%	4.6%	12.0%	9.4%	1.5%	8.3%	5.0%	5.5%
Transportation	3.3%	4.3%	1.5%	2.2%	5.6%	1.9%	7.5%	4.6%	0.0%	1.7%	0.5%
Health insurance	2.8%	2.9%	0.5%	1.6%	3.1%	3.7%	3.1%	4.6%	6.2%	0.0%	0.5%
Regular prenatal care appointments	0.8%	0.5%	1.0%	0.8%	0.5%	1.9%	0.6%	1.5%	0.0%	1.7%	1.1%
None — I had adequate support	34.2%	29.2%	44.9%	38.5%	29.1%	23.1%	22.0%	27.7%	43.8%	38.3%	45.9%
Other	3.0%	3.3%	4.0%	3.5%	2.0%	0.0%	1.9%	0.0%	4.2%	6.7%	3.8%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Table A-7. Birth — Most Helpful Supports, by Subgroup

	Overall (n=546)	Latine (n=194)	White (n=183)	English (n=336)	Spanish (n=180)	Immigrant (n=94)	Under \$43K (n=142)	\$43K– \$61,999 (n=58)	\$62K– \$92,999 (n=47)	\$93K– \$124,999 (n=57)	\$125K+ (n=164)
Partner or support person present	66.1%	60.3%	76.5%	72.6%	58.3%	61.7%	58.5%	62.1%	74.5%	68.4%	78.0%
Clear communication about what was happening	41.0%	33.0%	56.8%	50.6%	25.6%	29.8%	28.9%	31.0%	53.2%	42.1%	57.3%
Providers listening to and respecting preferences	36.4%	24.7%	59.6%	51.5%	12.8%	24.5%	21.8%	22.4%	38.3%	47.4%	57.9%
Knowing what to expect	27.3%	16.0%	41.0%	38.7%	8.9%	18.1%	13.4%	17.2%	36.2%	28.1%	46.3%
Effective pain management	23.3%	16.0%	35.5%	32.4%	8.9%	10.6%	13.4%	10.3%	25.5%	40.4%	37.8%
Doula/birth worker present	20.9%	16.5%	28.4%	26.5%	11.7%	14.9%	17.6%	24.1%	21.3%	26.3%	27.4%
Care that respected my culture/traditions	15.2%	18.6%	6.6%	9.5%	25.0%	18.1%	25.4%	17.2%	8.5%	5.3%	7.9%
Provider who spoke my language	13.2%	15.5%	12.6%	10.7%	19.4%	16.0%	16.9%	22.4%	6.4%	8.8%	10.4%
Language interpretation services	2.4%	3.6%	0.0%	0.0%	6.1%	5.3%	5.6%	3.4%	2.1%	0.0%	0.0%
I did not feel well-supported during birth	4.8%	3.6%	4.9%	5.4%	4.4%	5.3%	2.1%	10.3%	6.4%	7.0%	4.3%
Other	2.0%	1.0%	1.6%	2.4%	1.7%	0.0%	2.8%	1.7%	0.0%	3.5%	1.8%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Table A-8. Birth — Unmet Needs, by Subgroup

	Overall (n=600)	Latine (n=209)	White (n=199)	English (n=372)	Spanish (n=188)	Immigrant (n=105)	Under \$43K (n=153)	\$43K– \$61,999 (n=66)	\$62K– \$92,999 (n=48)	\$93K– \$124,999 (n=61)	\$125K+ (n=183)
Clearer communication about what was happening	20.3%	19.6%	20.6%	20.7%	20.7%	24.8%	19.0%	27.3%	25.0%	19.7%	19.1%
Better listening and respect from providers	17.7%	15.3%	15.6%	19.9%	12.8%	16.2%	17.0%	19.7%	16.7%	11.5%	18.6%
Doula/birth worker present	15.8%	14.4%	20.6%	19.1%	10.6%	13.3%	13.1%	10.6%	22.9%	13.1%	23.0%
Better pain management options	13.8%	17.7%	9.0%	12.6%	14.4%	25.7%	14.4%	10.6%	14.6%	18.0%	11.5%
Knowing what to expect	13.5%	15.3%	15.6%	15.1%	12.2%	13.3%	8.5%	16.7%	25.0%	18.0%	14.2%
Care that respected my culture/traditions	5.7%	8.6%	1.0%	2.4%	10.1%	16.2%	9.2%	4.5%	6.2%	4.9%	3.3%
Partner or support person present	5.7%	8.6%	1.5%	4.3%	9.0%	7.6%	7.8%	13.6%	2.1%	1.6%	2.7%
Provider who spoke my language	4.0%	3.8%	0.0%	0.3%	9.6%	13.3%	7.8%	4.5%	4.2%	3.3%	0.0%
Language interpretation services	3.0%	5.3%	0.0%	0.0%	8.0%	6.7%	7.2%	1.5%	4.2%	0.0%	0.0%
Nothing — my experience was positive	37.8%	32.5%	45.7%	41.7%	34.0%	21.9%	36.6%	28.8%	39.6%	49.2%	43.2%
Other	3.2%	2.9%	4.0%	4.8%	0.5%	1.0%	1.3%	1.5%	4.2%	4.9%	4.9%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Table A-9. Postpartum — Most Helpful Supports, by Subgroup

	Overall (n=549)	Latine (n=196)	White (n=187)	English (n=344)	Spanish (n=172)	Immigrant (n=94)	Under \$43K (n=141)	\$43K– \$61,999 (n=58)	\$62K– \$92,999 (n=43)	\$93K– \$124,999 (n=57)	\$125K+ (n=174)
Paid maternity leave	36.4%	25.0%	55.1%	51.2%	11.6%	19.1%	14.2%	22.4%	53.5%	52.6%	59.2%
Support from family or friends	34.2%	21.4%	50.3%	42.2%	22.7%	18.1%	18.4%	31.0%	34.9%	43.9%	48.9%
Lactation/breastfeeding support	27.5%	24.5%	34.8%	31.7%	21.5%	26.6%	21.3%	32.8%	30.2%	24.6%	33.3%
Access to healthy food	21.7%	19.4%	20.3%	21.2%	19.8%	22.3%	25.5%	19.0%	18.6%	19.3%	21.8%
Connecting with other parents	21.5%	16.3%	29.9%	27.6%	10.5%	13.8%	13.5%	15.5%	20.9%	31.6%	29.9%
Mental health support or therapy	17.1%	14.8%	23.0%	20.3%	11.0%	10.6%	11.3%	10.3%	25.6%	24.6%	22.4%
WIC	16.0%	29.1%	2.7%	7.3%	34.9%	29.8%	31.9%	34.5%	14.0%	5.3%	2.3%
Childcare	15.1%	14.8%	15.5%	16.9%	11.0%	13.8%	13.5%	15.5%	16.3%	17.5%	17.2%
Home visits from health workers	6.6%	5.1%	8.6%	5.8%	7.0%	11.7%	10.6%	3.4%	2.3%	7.0%	4.0%
Financial assistance	5.8%	7.7%	3.7%	5.8%	5.2%	8.5%	11.3%	8.6%	4.7%	3.5%	2.3%
Infant sleep support/resources	5.3%	3.6%	5.9%	7.3%	1.7%	3.2%	2.1%	5.2%	7.0%	8.8%	6.3%
Housing assistance	2.4%	2.6%	1.6%	2.3%	1.7%	6.4%	5.0%	5.2%	2.3%	0.0%	0.6%
Parenting classes	1.6%	1.5%	0.5%	1.2%	2.3%	1.1%	1.4%	1.7%	0.0%	1.8%	1.1%
Transportation	0.5%	1.5%	0.0%	0.0%	1.7%	0.0%	1.4%	0.0%	0.0%	0.0%	0.6%
I did not receive any helpful supports	3.5%	4.1%	2.1%	2.9%	5.2%	2.1%	4.3%	3.4%	2.3%	3.5%	1.7%
Other	0.5%	0.5%	0.5%	0.9%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.6%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Table A-10. Postpartum — Unmet Needs, by Subgroup

	Overall (n=601)	Latine (n=208)	White (n=200)	English (n=371)	Spanish (n=192)	Immigrant (n=105)	Under \$43K (n=157)	\$43K– \$61,999 (n=65)	\$62K– \$92,999 (n=48)	\$93K– \$124,999 (n=62)	\$125K+ (n=183)
Financial assistance	20.0%	22.6%	14.5%	16.4%	24.0%	33.3%	29.9%	26.2%	25.0%	27.4%	4.4%
Infant sleep support/resources	17.0%	11.1%	20.0%	22.4%	6.8%	9.5%	10.8%	15.4%	14.6%	22.6%	21.9%
Home visits from health workers	16.6%	15.4%	20.5%	22.4%	7.8%	15.2%	10.2%	10.8%	22.9%	16.1%	27.9%
Childcare	16.5%	15.9%	20.0%	17.8%	16.1%	12.4%	16.6%	16.9%	20.8%	19.4%	18.6%
Connecting with other parents	15.3%	15.9%	18.0%	17.5%	13.0%	16.2%	10.8%	15.4%	20.8%	9.7%	19.1%
Paid maternity leave	13.8%	8.2%	20.5%	18.1%	5.7%	8.6%	9.6%	12.3%	25.0%	11.3%	18.6%
Mental health support or therapy	12.1%	11.1%	16.5%	14.3%	7.3%	10.5%	7.6%	26.2%	6.2%	17.7%	13.1%
Support from family or friends	9.3%	7.7%	9.5%	12.4%	4.2%	4.8%	6.4%	10.8%	6.2%	11.3%	14.2%
Lactation support	8.2%	6.2%	9.0%	9.7%	6.2%	5.7%	5.1%	4.6%	8.3%	11.3%	10.9%
Housing assistance	8.0%	14.4%	2.5%	3.5%	15.1%	19.0%	17.8%	12.3%	6.2%	3.2%	0.0%
Parenting classes	7.0%	6.7%	7.5%	7.8%	6.2%	8.6%	8.3%	4.6%	8.3%	9.7%	6.6%
Access to healthy food	5.8%	10.1%	3.0%	3.8%	7.3%	6.7%	9.6%	10.8%	2.1%	4.8%	2.2%
WIC	4.0%	5.3%	2.5%	3.8%	4.7%	2.9%	4.5%	3.1%	8.3%	3.2%	2.7%
Transportation	1.8%	2.9%	1.0%	0.8%	4.2%	1.9%	5.7%	1.5%	0.0%	0.0%	0.5%
None — I had adequate support	20.1%	20.7%	22.0%	19.9%	22.9%	15.2%	19.7%	16.9%	16.7%	16.1%	23.0%
Other	1.5%	0.0%	3.5%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	4.8%	3.3%

Note: Responses are ordered by overall prevalence, descending. Percentages reflect the share of respondents who selected each option from a multi-select question. Denominators reflect only those who selected at least one response.

Appendix B: Secondary Data Tables

Section 1: Population Profile - Women of Reproductive Age in Sonoma County

Table B-1. Poverty — Sonoma County vs. California

Group	Sonoma County	California
<i>Overall (% population below Federal Poverty Level)</i>		
All	10.4%	15.3%
<i>Female-headed households with children under 18 below FPL</i>		
Sonoma County	27.5%	—
California	—	38.1%

Source: ACS, 2023 5-Year Estimates; Table S1701 data.census.gov (S1701) and data.census.gov (S1702)

Table B-2. Educational Attainment — Females 25 Years and Older

Attainment Level	California	Sonoma County	Cloverdale–Geyserville	Healdsburg	Petaluma	Santa Rosa	Sebastopol
Less than 9th grade	8.8%	5.4%	5.8%	5.3%	3.6%	7.4%	2.3%
9th–12th grade, no diploma	6.1%	4.1%	5.1%	3.4%	3.5%	5.4%	3.2%
High school graduate	19.4%	16.9%	16.0%	15.9%	17.7%	18.3%	13.2%
Some college, no degree	19.7%	22.8%	27.2%	22.5%	23.5%	22.7%	21.3%
Associate's degree	8.6%	10.7%	11.0%	11.0%	10.6%	10.7%	8.8%
Bachelor's degree	23.0%	25.0%	22.3%	28.9%	26.7%	22.5%	26.5%
Graduate or professional degree	14.2%	15.1%	12.7%	13.1%	14.4%	12.9%	24.7%
HS graduate or higher	85.1%	90.5%	89.2%	91.3%	92.9%	87.2%	94.4%

Source: ACS, 2023 5-Year Estimates Table S1501 data.census.gov

Table B-3. Rent Burden — Percent of Households by Share of Income Spent on Rent

Gross Rent as % of Household Income	California	Sonoma County	Cloverdale–Geyserville	Healdsburg	Petaluma	Santa Rosa	Sebastopol	Sonoma
Spending ≥50% of income on rent	28.3%	25.9%	14.4%	25.1%	26.0%	26.2%	28.6%	29.1%
Spending 30–49% of income on rent	26.9%	27.6%	26.9%	27.7%	28.0%	26.9%	26.8%	28.4%
Spending <30% of income on rent	44.8%	46.5%	58.7%	47.2%	46.0%	46.9%	44.6%	42.5%

Source: ACS, 2023 5-Year Estimates, Table B25070; data.census.gov

Table B-4. Single Parent Households and Marital Status – Females

Household Type / Marital Status	California	Sonoma County	Cloverdale–Geyserville	Healdsburg	Petaluma	Russian River–Sonoma Coast	Santa Rosa	Sonoma
<i>Female householder, no spouse/partner present</i>								
All female-headed households	26.1%	26.7%	17.9%	24.0%	26.6%	24.1%	28.2%	28.0%
With children under 18	4.5%	3.8%	3.6%	4.3%	3.4%	2.0%	4.4%	2.2%
<i>Marital status – females 15 years and over</i>								
Never married	34.7%	29.8%	24.9%	27.9%	33.3%	24.4%	30.5%	24.0%
Now married (except separated)	45.1%	46.5%	54.5%	50.3%	46.0%	49.8%	44.9%	45.2%
Separated	2.1%	1.4%	0.8%	0.9%	0.8%	2.1%	2.0%	1.4%
Widowed	7.3%	7.8%	7.0%	6.1%	6.5%	10.2%	8.5%	9.6%
Divorced	10.7%	14.4%	12.7%	14.7%	13.4%	13.4%	14.0%	19.8%

Source: ACS, 2023 5-Year Estimates

Table B-5. Medi-Cal Eligibility – Sonoma County Females, 2025

Age Group	Total Eligibles	Total Population	% of Population
<19 years	23,521	48,818	48.2%
19–44 years	28,782	75,855	37.9%
45–64 years	15,768	61,634	25.6%
65+ years	8,575	60,587	14.2%
Total	76,646	246,894	31.0%

Source: CHHS Medi-Cal Certified Eligibles with Demographics by Month; data.chhs.ca.gov

Table B-6. Insurance Status – Women Ages 15–50, Sonoma County

Coverage	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Uninsured	19.2%	13.1%	8.6%	7.0%	8.7%	9.6%	9.4%	8.4%	8.7%	6.4%	4.9%
Private insurance	69.4%	72.1%	70.2%	74.9%	74.4%	73.9%	74.4%	77.0%	73.0%	73.4%	74.9%
Public insurance	13.1%	16.9%	24.1%	21.4%	20.8%	18.4%	18.5%	16.4%	21.9%	23.7%	23.6%

** Categories not mutually exclusive; individuals may have both private and public coverage. Source: American Community Survey (ACS), 1-Year Estimates, Table B27001; data.census.gov

Table B-7. Food Access — Females 18–49 at ≤200% FPL

Group	Sonoma County	California
% of females 18–49 at ≤200% FPL who could not afford enough food		
Sonoma County	61.9%	—
California	—	51.9%
By race/ethnicity (Sonoma County)		
Hispanic/Latino	50.8%	—
White	52.6%	—

Source: CHIS, 2020/2022–2024 pooled estimates; healthpolicy.ucla.edu

Table B-8. Self-Reported Health Status — Women 18–49

Group	Sonoma County	California
Overall (% reporting fair or poor health, women 18–49)		
All women	18.5%	14.0%
By race/ethnicity		
Hispanic	30.3% *	—
White, non-Hispanic	12.0%	—
By income		
200%+ FPL	14.5%	—

* Estimate is unstable. Source: California Health Interview Survey (CHIS), 2020–2024 pooled estimates; healthpolicy.ucla.edu

Table B-9. Overweight or Obese (BMI ≥25) — Women 18–49

Group	Sonoma County	California
Overall (% overweight or obese, BMI ≥25, women 18–49)		
All women	55.8%	55.8%
By race/ethnicity		
Hispanic	76.3% ^^	—
White, non-Hispanic	45.1%	—
Multiracial	31.6%	—
By income		
<200% FPL	75.4% ^^	—
200%+ FPL	49.9%	—

^^ Significantly greater than other values in this category Source: CHIS, 2020–2024 pooled estimates; healthpolicy.ucla.edu

Table B-10. Mental Health Status — Women 18–50

Group	Needed Help for Mental Health / SUD (%)	Likely Serious Psychological Distress (%)	Ever Seriously Thought About Dying by Suicide (%)
Overall (women 18–50)			
Sonoma County	44.4%	34.2% ^	38.6%
California	37.8%	24.8%	26.8%
By race/ethnicity (Sonoma County)			
Hispanic/Latino	—	44.0%	38.1%
White, non-Hispanic	—	30.8%	42.7%
By income (Sonoma County)			
200%+ FPL	—	—	44.5%

^ Significantly greater than California measure Source: California Health Interview Survey, 2022–2024; healthpolicy.ucla.edu

Table B-11. Maternal Mental Health Status

Group	Anxiety or Depression Symptoms Prenatal or Postpartum (%)	Perceived Need for Mental Health Care (%)	Receipt of Mental Health Care When Needed (%)	Prenatal Depression Symptoms (%)	Postpartum Depression Symptoms (%)
Overall					
Sonoma County	41.1%	38.8% ^	69.9% ^	14.1%	14.9%
California	35.4%	31.6%	53.9%	14.8%	14.1%
By age group (Sonoma County)					
20–34 years	43.6%	38.5%	69.6%	15.5%	17.1%
35+ years	37.4%	39.7%	71.9%	11.1%	10.2%
By race/ethnicity (Sonoma County)					
Asian, non-Hispanic	69.1%	53.7%	—	—	—
Black, non-Hispanic	60.3%	—	—	—	—
Hispanic/Latino	35.1%	32.9%	75.9%	14.5%	13.2%
White, non-Hispanic	37.4%	40.7%	72.4%	8.4%	16.3%
By income (Sonoma County)					
0–100% of poverty	44.5%	39.4%	64.2%	23.2%	12.1%
101–200% of poverty	39.5%	34.9%	75.6%	18.7%	12.5%
200%+ of poverty	40.4%	39.4%	68.7%	8.1%	16.6%
By neighborhood poverty (Sonoma County)					
<10% neighborhood poverty	38.3%	39.1%	70.1%	13.1%	13.4%
10–19% neighborhood poverty	45.1%	38.9%	65.6%	14.0%	18.7%
20–29% neighborhood poverty	52.7%	34.3%	100.0%	—	—

^ Significantly greater than California measure Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov; CHIS, 2022–2024; healthpolicy.ucla.edu

Table B-12. Drug Overdose Death Rate — Sonoma County Females (per 100,000)

Group	2016	2017	2018	2019	2020	2021	2022	2023	2024
Sonoma County	5.4	10.4	10.5	14.4	18.7	18.1	9.4	16.8	11.8
California	7.7	7.5	7.9	8.4	11.2	13.2	12.7	13.9	11.4

Source: California Overdose Surveillance Dashboard, CDPH Substance and Addiction Prevention Branch; skylab.cdph.ca.gov

Table B-13. Emergency Department Visits for Opioid Overdoses — Sonoma County Females (per 100,000)

Group	2016	2017	2018	2019	2020	2021	2022	2023	2024
Sonoma County	21.9 ^	25.1 ^	26.7 ^	26.6 ^	35.4	32.5	34.1	26.2	27.2
California	15.7	14.9	14.6	16.4	21.8	28.5	28.4	30.1	23.8

^ Significantly greater than California Source: California Overdose Surveillance Dashboard, CDPH Substance and Addiction Prevention Branch; skylab.cdph.ca.gov

Table B-14. Count of Crimes — Sonoma County

Crime Type	2016	2017	2018	2019	2020	2021	2022	2023	2024	% Change Since 2020
Violent crimes	1,868	2,025	1,985	2,016	2,212	1,946	1,682	1,400	1,350	−39.0%
Homicide	10	12	9	9	10	9	22	15	6	−40.0%
Rape (forcible)	282	298	312	277	239	302	319	266	285	+19.2%
Rape	275	297	306	267	230	294	308	249	272	+18.3%
Attempted rape	7	1	6	10	9	8	11	17	13	+44.4%

Source: California Department of Justice, Crimes Dashboard; openjustice.doj.ca.gov

Section 2: Perinatal Substance Use

Table B-15. Any Cigarette Use During Pregnancy (%)

Group / Timing	2013–15	2016–18	2019–21	2020–22
3 months before pregnancy				
Sonoma County	13.7%	9.1%	8.0%	6.0%
California	10.8%	8.6%	6.2%	5.7%
3rd trimester				
Sonoma County	3.1%	1.3%	1.9%	—
California	2.7%	2.5%	1.6%	1.7%
Postpartum				
Sonoma County	5.3%	2.9%	3.5%	2.8%
California	5.4%	4.3%	2.8%	2.5%

Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-16. Any Cannabis Use During Pregnancy (%)

Group	2016–18	2019–21	2020–22
Overall			
Sonoma County	6.3%	9.6% ^	9.1% ^
California	4.7%	5.1%	5.2%
By age group (Sonoma County)			
20–34 years	7.3%	11.5%	11.4% ^^
35+ years	4.1%	5.6%	3.2%
By race/ethnicity (Sonoma County)			
Hispanic	6.5%	4.3%	6.3%
White	6.9%	9.6%	8.4%
By income (Sonoma County)			
0–100% of poverty	11.9%	20.2%	16.6%
101–200% of poverty	7.5%	9.1%	10.1%
200%+ of poverty	3.8%	4.7%	5.2%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: MIHA, 2016–2018 to 2020–2022; cdph.ca.gov

Table B-17. Any Alcohol Use — 3rd Trimester (%)

Group	2013–15	2016–18	2019–21	2020–22
Overall (any alcohol use, 3rd trimester)				
Sonoma County	10.0%	9.1%	11.7% ^	10.3% ^
California	7.3%	7.5%	7.4%	7.3%
By age group (Sonoma County)				
20–34 years	9.0%	8.2%	9.7%	9.3%
35+ years	14.2%	11.9%	17.5%	13.4%
By race/ethnicity (Sonoma County)				
Hispanic	3.0%	7.6%	7.9%	5.7%
White	16.5% ^^	11.3%	15.0%	15.1% ^^

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-18. Any Substance Use Disorder at Delivery (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall (% with any substance use disorder at delivery)							
Sonoma County	3.1% ^	2.8% ^	2.8% ^	2.8% ^	2.8% ^	2.6% ^	–16.5%
California	1.8%	1.8%	1.8%	1.8%	1.7%	1.6%	–9.9%
By race/ethnicity (Sonoma County)							
Black	8.2% ^^	7.1% ^^	7.8% ^^	8.1% ^^	8.2% ^^	8.7% ^^	+6.3%
Hispanic	1.8%	1.6%	1.6%	1.6%	1.4%	1.3%	–25.9%
White	4.0% ^^	3.7% ^^	3.8% ^^	3.9% ^^	4.0% ^^	3.6% ^^	–9.7%
By insurance type (Sonoma County)							
Medi-Cal	4.9% ^^	4.6% ^^	4.7% ^^	5.2% ^^	5.1% ^^	4.6% ^^	–5.2%
Private	1.7%	1.5%	1.5%	1.4%	1.5%	1.3%	–20.7%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: CDPH, MCAH Data Dashboards; cdph.ca.gov

Table B-19. Neonatal Abstinence Syndrome (rate per 1,000 births)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall (rate per 1,000 births)							
Sonoma County	4.1 ^	4.1 ^	4.0	5.3	5.7	5.6 ^	+36.8%
California	2.3	2.4	2.4	2.5	2.6	2.8	+21.2%
By insurance type (Sonoma County)							
Medi-Cal	8.0	8.7	8.1	10.8 ^^	12.2 ^^	12.1 ^^	+50.6%
Private	—	—	—	2.1	2.2	2.0	—
By race/ethnicity (Sonoma County)							
Hispanic	—	—	—	—	—	2.1	—
White	6.1	6.3	6.3	8.8	9.5	9.4 ^^	+53.7%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: CDPH, MCAH Data Dashboards; cdph.ca.gov

Section 3: Prenatal Care and Access

Table B-20. Births with Prenatal Care Initiated in the First Trimester (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall							
Sonoma County	87.9%	89.1%	90.4%	91.5%	90.7%	89.5%	+1.8%
California	83.9%	85.1%	86.5%	87.9%	87.6%	86.5%	+3.1%
By age group (Sonoma County)							
<20 years	73.6%	74.6%	76.2%	77.1%	79.0%	76.7% ^^	+4.2%
20–24 years	82.2%	84.1%	86.2%	87.5%	86.3%	84.5%	+2.8%
25–29 years	87.3%	87.5%	88.6%	89.9%	89.6%	88.8%	+1.7%
30–34 years	90.2%	91.8%	92.8%	93.5%	92.5%	91.4%	+1.3%
35–39 years	90.5%	92.1%	93.0%	93.3%	92.3%	91.0%	+0.6%
40+ years	87.7%	88.5%	91.4%	93.4%	92.6%	90.6%	+3.3%
By race/ethnicity (Sonoma County)							
American Indian and Alaska Native alone	78.7%	82.1%	89.6%	88.5%	82.4%	83.1% ^^	+5.6%
Asian alone	85.7%	87.8%	90.0%	91.8%	91.8%	90.8%	+6.0%
Black alone	81.3%	86.1%	86.0%	86.9%	85.4%	83.6% ^^	+2.8%
Hispanic of any race	86.6%	87.7%	89.2%	90.3%	89.0%	87.3%	+0.8%
Multiracial alone	87.8%	89.2%	90.2%	92.6%	91.2%	89.6%	+2.1%
Native Hawaiian and Pacific Islander alone	61.5%	73.5%	78.0%	86.7%	70.0%	62.5% ^^	+1.6%
White alone	90.2%	91.5%	92.6%	93.2%	93.2%	92.4%	+2.4%
By insurance type (Sonoma County)							
Medi-Cal	83.1%	84.7%	86.5%	87.8%	86.3%	83.9%	+1.0%
Private	92.0%	92.9%	93.8%	94.8%	94.7%	94.2%	+2.4%
Self-pay	75.1%	77.3%	75.1%	74.9%	72.9%	71.0% ^^	–5.5%
Other	62.5%	75.9%	83.6%	91.1%	86.8%	89.9%	43.8%
By education (Sonoma County)							
Less than high school	83.4%	83.6%	85.5%	86.7%	84.4%	81.3% ^^	–2.5%
High school graduate	86.1%	87.7%	88.8%	89.8%	88.6%	87.1%	+1.2%
Some college	89.5%	90.4%	91.9%	92.6%	92.5%	91.3%	+2.0%
College graduate	92.2%	93.7%	94.5%	94.8%	94.1%	93.5%	+1.4%

^^ Significantly less than other values in this category Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-21. Uninsured Before Pregnancy (%)

Group	2013–15	2016–18	2019–21	2020–22
Overall				
Sonoma County	24.4%	12.9%	10.4%	9.7%
California	21.6%	10.8%	10.1%	9.4%
By race/ethnicity (Sonoma County)				
Hispanic	44.8% ^^	25.8% ^^	17.2% ^^	16.4% ^^
White	14.4%	5.4%	4.7%	3.7%
By education (Sonoma County)				
Less than high school	40.2% ^^	27.6%	23.4%	27.8% ^^
College graduate	7.2%	5.6%	3.9%	—

^^ Significantly higher than other values in this category Source: CA Maternal and Infant Health Assessment (MIHA), 2013–2015 to 2020–2022; cdph.ca.gov

Table B-22. Received Dental Care During Pregnancy (%)

Group	2016–18	2019–21	2020–22
Overall			
Sonoma County	66.6% ^	59.2% ^	58.8% ^
California	44.3%	42.3%	41.9%
By age group (Sonoma County)			
15–19 years	54.2%	52.7%	—
20–34 years	65.0%	54.7%	53.6%
35+ years	72.9%	71.1%	74.5% ^^
By race/ethnicity (Sonoma County)			
Asian/Pacific Islander	44.8%	65.4%	55.2%
Black	—	—	68.5%
Hispanic	74.9%	65.6%	60.8%
White	67.9%	51.7%	55.0%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: MIHA, 2016–2018 to 2020–2022; cdph.ca.gov

Table B-23. Received Tdap Vaccine During Pregnancy (%)

Group	2016–18	2019–21	2020–22
Overall			
Sonoma County	72.1%	80.2%	80.2% ^
California	55.8%	65.0%	65.8%
By age group (Sonoma County)			
15–19 years	47.2%	48.3%	47.0%
20–34 years	72.4%	83.2%	83.3%
35+ years	73.9%	75.4%	75.5%
By insurance type (Sonoma County)			
Medi-Cal	64.9%	74.2%	69.4%
Private insurance	77.1%	84.1%	86.8% ^^
By race/ethnicity (Sonoma County)			
Hispanic	71.1%	74.0%	73.2%
White	74.5%	83.7%	84.3%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Section 4: Pregnancy

Table B-24. Pre-Pregnancy Weight Status (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Sonoma County							
Underweight	2.2%	2.1%	1.9%	1.8%	1.8%	1.8%	–18.2%
Normal weight	43.5%	42.9%	41.7%	40.5%	39.0%	38.2%	–12.2%
Overweight	29.5%	29.0%	29.3%	29.7%	30.1%	29.9%	+1.4%
Obese	24.8%	26.0%	27.1%	28.1%	29.1%	30.1%	+21.4%
California							
Underweight	3.7%	3.5%	3.2%	3.0%	2.7%	2.7%	–27.0%
Normal weight	45.1%	44.0%	42.9%	41.7%	40.5%	39.5%	–12.4%
Overweight	26.8%	27.1%	27.5%	27.9%	28.2%	28.4%	+6.0%
Obese	24.4%	25.4%	26.4%	27.4%	28.6%	29.4%	+20.5%

Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-25. Excessive Weight Gain During Pregnancy (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall							
Sonoma County	47.5 ^	47.1 ^	47.5 ^	48.2 ^	48.6 ^	48.0 ^	+1.1%
California	42.0	42.0	42.6	43.6	43.7	43.7	+4.1%
By age group (Sonoma County)							
<20 years	52.0	58.1	58.2	56.8	53.5	55.6 ^^	+6.9%
20–24 years	51.8	52.3	51.9	52.5	51.2	51.9	+0.2%
25–29 years	48.7	47.0	47.8	48.6	50.0	49.8	+2.3%
30–34 years	46.8	46.8	47.2	47.9	48.3	47.0	+0.4%
35–39 years	44.8	44.2	44.8	46.1	46.4	45.5	+1.6%
40+ years	42.5	41.9	43.2	43.9	45.2	45.2	+6.4%
By race/ethnicity (Sonoma County)							
American Indian and Alaska Native alone	58.6	59.8	51.3	60.0	59.7	65.6 ^^	+11.9%
Asian alone	32.5	30.1	30.6	34.4	34.6	35.2	+8.3%
Black alone	48.6	50.0	47.1	40.1	43.6	41.5	–14.6%
Hispanic of any race	44.6	44.7	45.4	45.6	45.8	45.0	+0.9%
White alone	51.0	50.0	50.8	51.7	52.1	51.4	+0.8%
By insurance type (Sonoma County)							
Medi-Cal	49.0	49.3	49.4	49.6	48.8	48.0	–2.0%
Private	46.4	45.8	46.4	47.5	48.5	48.3	+4.1%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: CDPH, MCAH Data Dashboards; cdph.ca.gov

Table B-26. Physical, Psychological, or Sexual Intimate Partner Violence During Pregnancy (%)

Group	2016–18	2019–21	2020–22
Overall (% experiencing physical, psychological, or sexual IPV during pregnancy)			
Sonoma County	7.0%	6.3%	6.0%
California	5.8%	5.6%	5.4%
By age group (Sonoma County)			
20–34 years	—	7.8%	—
35+ years	—	5.4%	7.5%
By race/ethnicity (Sonoma County)			
Hispanic	10.1%	8.0%	6.1%
White	3.8%	4.0%	—
By income (Sonoma County)			
0–100% of poverty	20.5%	11.2%	10.6%
101–200% of poverty	8.0%	8.2%	3.8%
200%+ of poverty	—	3.9%	4.7%

Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-27. WIC Participation During Pregnancy — Sonoma County (Count of Participants)

Measure	2019	2020	2021	2022	2023	2024
Number of certified participants	645	551	493	551	575	620
Number of issued participants	546	492	451	507	536	582

Certified participants = enrolled and eligible. Issued participants = received WIC food benefits.

Source: CDPH WIC Participants by County; data.chhs.ca.gov

Table B-28. WIC Participation During Pregnancy (%)

Group	2013–15	2016–18	2019–21	2020–22
Overall (% of pregnant women participating in WIC)				
Sonoma County	41.9% ^^	32.8% ^^	29.3% ^^	31.4%
California	42.1%	42.2%	48.2%	53.4%
By age group (Sonoma County)				
15–19 years	—	57.9% ^^	60.8% ^^	66.4% ^^
20–34 years	42.8%	32.5%	28.8%	30.8%
35+ years	31.9%	30.6%	27.9%	29.7%
By education (Sonoma County)				
Less than high school	81.6%	71.2%	81.3%	81.9%
High school graduate	63.9%	65.8%	55.1%	65.3%
Some college	39.4%	28.2%	20.5%	21.0%
College graduate	10.0%	7.7%	8.1%	8.5%
By race/ethnicity (Sonoma County)				
Asian	—	—	—	58.7%
Hispanic	81.3%	65.5%	54.5%	57.3%
White	18.0%	10.6%	8.7%	9.2%
By insurance type (Sonoma County)				
Medi-Cal	79.1% ^^	61.4% ^^	62.1% ^^	65.5% ^^
Private insurance	7.8%	8.0%	4.9%	4.5%
By birth order (Sonoma County)				
First birth	33.9%	20.5%	22.9%	24.0%
Second birth or higher	47.6%	41.4%	33.9%	36.8%

^^ Significantly lower/greater than California or other values in this category Source: MIHA Snapshots, 2013–2015 to 2020–2022; cdph.ca.gov

Section 5: Birth and Delivery

Table B-29. Birth Rate per 1,000 — Sonoma County vs. California

Group	2016	2017	2018	2019	2020	2021	2022	2023	2024	% Change 2016–2024
Overall										
Sonoma County	9.9	9.2	9.1	8.9	8.8	9.4	9.3	9.1	9.0	–8.8%
California	12.5	11.9	11.5	11.3	10.7	10.7	10.7	10.3	10.2	–18.1%
By age group (Sonoma County)										
15–19 years	11.3	8.3	8.8	8.3	7.6	7.2	8.5	6.9	6.7	–40.9%
20–24 years	47.3	42.5	40.8	38.5	39.7	39.8	40.8	38.8	40.0	–15.5%
25–29 years	79.1	74.3	71.8	73.0	74.2	74.5	79.4	79.7	73.9	–6.6%
30–34 years	104.8	98.5	96.1	95.6	89.2	103.0	94.4	93.6	94.7	–9.7%
35–39 years	59.4	57.8	58.2	58.9	60.9	63.5	64.4	63.3	64.0	+7.8%
40–44 years	13.7	13.2	16.2	14.0	14.4	17.6	16.5	16.8	17.3	+26.4%
By race/ethnicity (Sonoma County)										
American Indian and Alaska Native, non-Hispanic	7.1	11.2	11.4	9.7	7.5	7.0	9.1	7.8	7.7	+9.3%
Asian, non-Hispanic	10.4	9.4	8.9	9.3	10.8	9.8	8.8	9.5	9.3	–10.7%
Black or African American, non-Hispanic	6.3	8.6	6.5	5.7	7.7	8.7	10.8	9.1	8.6	+36.5%
Hispanic/Latino	14.1	12.3	11.6	13.0	12.7	12.8	13.5	13.1	12.9	–9.1%
White, non-Hispanic	6.7	6.1	5.8	6.1	6.3	7.1	6.8	6.6	6.5	–1.7%

Source: CDC WONDER, Births, 2016–2024; wonder.cdc.gov

Table B-30. Teen Birth Rate (per 1,000 females ages 15–19)

Group	2016	2017	2018	2019	2020	2021	2022	2023	2024
Overall (rate per 1,000 females ages 15–19)									
Sonoma County	11.3 ^	8.3 ^	8.8	8.3	7.6	7.2	8.5	6.9	6.7
California	17.0	15.1	13.6	12.4	11.0	9.9	9.8	9.1	8.7
By age group (Sonoma County)									
15–17 years	5.4	5.0	2.9	3.1	3.0	2.9	2.8	3.4	2.3
18–19 years	19.4 ^^	12.5 ^^	17.4 ^^	14.1 ^^	13.7 ^^	13.3 ^^	17.4 ^^	12.2 ^^	12.6 ^^
By race/ethnicity (Sonoma County)									
Hispanic/Latino	21.1 ^^	15.8 ^^	15.5 ^^	14.6 ^^	13.3 ^^	12.5 ^^	14.0 ^^	11.6 ^^	10.6 ^^
White, non-Hispanic	3.9	1.5	2.9	3.0	2.4	1.8	3.1	2.2	2.6

^ Significantly less than California rate | ^^ Significantly greater than other values in this category Source: CDC WONDER, Natality Records, 2016–2024; wonder.cdc.gov

Table B-31. Repeat Teen Births — Percent of Teen Births That Were Repeat Births

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	2022–24
Sonoma County	16.1%	14.4%	17.4%	15.5%	17.3%	13.9%	13.3%
California	20.2%	19.6%	18.7%	18.4%	17.9%	17.5%	16.9%

Source: CDC WONDER, Natality Records, 2016–2024; wonder.cdc.gov

Table B-32. Births with at Least One Maternal Risk Factor (%)

Group	2016	2017	2018	2019	2020	2021	2022	2023	2024	% Change 2016–2024
Overall (% births with at least one maternal risk factor)										
Sonoma County	24.0%	24.2%	26.2%	28.3%	30.1%	33.1%	31.4%	33.6%	36.3%	+51.2%
California	26.2%	27.2%	28.1%	29.1%	30.5%	31.2%	32.2%	32.9%	33.6%	+28.3%
By age group (Sonoma County)										
15–19 years	7.1%	12.2%	9.9%	—	16.4%	15.2%	14.2%	10.1%	20.8%	+191.7%
20–24 years	13.3%	15.2%	17.8%	17.0%	21.2%	22.1%	21.5%	18.5%	24.4%	+84.0%
25–29 years	19.4%	19.6%	21.1%	23.5%	27.0%	28.3%	28.2%	30.6%	32.9%	+69.1%
30–34 years	27.1%	26.4%	27.4%	30.2%	29.9%	33.1%	30.8%	34.4%	36.8%	+35.8%
35–39 years	31.2%	30.2%	33.0%	35.9%	38.0%	39.7%	37.6%	41.7%	40.6%	+30.3%
40–44 years	42.9%	40.4%	38.8%	41.7%	38.5%	52.9% ^^	48.1%	45.6%	53.5%	+24.7%
By race/ethnicity (Sonoma County)										
Asian, non-Hispanic	25.9%	28.9%	33.3%	32.3%	36.4%	42.5%	36.4%	35.5%	40.5%	+55.9%
Black or African American, non-Hispanic	35.4%	—	19.2%	45.7%	24.2%	34.3%	35.2%	46.6%	42.3%	+19.3%
Hispanic/Latino	25.8%	25.9%	27.3%	29.6%	30.2%	34.5%	33.2%	33.6%	35.8%	+38.6%
White, non-Hispanic	21.7%	21.9%	24.4%	26.0%	29.4%	31.3%	28.4%	33.0%	35.2%	+62.6%
By insurance type (Sonoma County)										
Medi-Cal	23.6%	26.0%	26.7%	28.7%	28.4%	32.6%	29.8%	31.8%	36.2%	+53.0%
Private	24.9%	23.6%	26.4%	28.9%	31.8%	34.6%	33.4%	35.9%	37.3%	+49.6%

*This field indicates whether any pregnancy risk factors were reported for 1) diabetes (pre-pregnancy or gestational); 2) hypertension (pre-pregnancy or gestational); 3) eclampsia; 4) previous preterm births; 5) pregnancy resulted from infertility treatment; and 6) mother had a previous cesarean delivery. For more information, refer to page 66 in the NCHS guide to 2017 birth records data. ^^ Significantly greater than other values in this category Source: CDC WONDER, Births, 2016–2024; wonder.cdc.gov

Table B-33. Preterm Births — Less Than 37 Weeks Gestation (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	2022–24	% Change 2016–18 to 2022– 24
Overall (% of births <37 weeks gestation)								
Sonoma County	7.4%	7.4%	7.7%	7.8%	7.9%	8.0%	7.9% ^	+6.2%
California	8.7%	8.8%	8.8%	9.0%	9.0%	9.1%	9.1%	+4.8%
By age group (Sonoma County)								
<20 years	9.4%	9.8%	9.1%	6.3%	5.7%	5.6%	5.1%	–46.2%
20–24 years	7.5%	7.3%	7.4%	7.5%	7.7%	7.8%	7.4%	–2.0%
25–29 years	7.0%	6.3%	6.6%	6.5%	7.4%	7.8%	7.7%	+10.6%
30–34 years	6.9%	7.2%	7.9%	7.9%	7.9%	7.5%	7.4%	+6.7%
35–39 years	8.2%	7.9%	7.7%	8.3%	8.1%	8.6%	8.3%	+1.3%
40+ years	8.1%	9.8%	11.5%	11.9%	9.6%	10.2%	11.1%	+36.7%
By race/ethnicity (Sonoma County)								
Asian	9.3%	7.5%	8.4%	8.7%	10.2%	10.1%	8.6%	–7.8%
Black	6.6%	6.7%	6.4%	8.0%	10.7%	13.8%	12.8% **	+92.8%
Hispanic	8.2%	8.3%	7.9%	7.7%	7.7%	8.1%	8.0%	–2.7%
Multi-Race	6.6%	8.2%	7.6%	7.6%	6.9%	8.1%	8.6%	+30.8%
White	6.7%	6.7%	7.2%	7.3%	7.3%	7.0%	7.1% ^^	+5.1%
By insurance type (Sonoma County)								
Medi-Cal	7.9%	8.0%	8.6%	8.5%	8.1%	8.2%	7.9%	0.0%
Private insurance	7.2%	7.2%	7.4%	7.6%	7.9%	8.1%	8.0%	+11.6%
By education (Sonoma County)								
Less than high school	8.5%	8.4%	8.9%	9.1%	8.8%	8.8%	7.9%	–8.0%
High school graduate	7.7%	8.0%	8.7%	8.7%	9.0%	8.7%	8.2%	+5.7%
Some college	8.2%	8.2%	7.6%	7.2%	7.2%	7.6%	7.6%	–7.3%
College graduate	6.8%	6.4%	6.5%	6.6%	6.9%	7.2%	7.2%	+5.3%

^ Significantly less than California | ^^ Significantly lower than other values in this category | **Significantly higher than other values in this category. Source: CDPH MCAH Dashboards; cdph.ca.gov

Table B-34. Births by Cesarean Section (%)

Group	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2017–19 to 2021– 23
Overall						
Sonoma County	26.4%	26.2%	27.0%	27.2%	28.4%	+7.6%
California	31.0%	30.7%	30.7%	30.7%	31.1%	+0.3%
By age group (Sonoma County)						
<20 years	14.0%	15.9%	15.6%	14.4%	12.1%	–13.6%
20–24 years	18.8%	19.9%	20.7%	20.5%	20.7%	+10.1%
25–29 years	22.6%	22.5%	23.2%	23.4%	24.3%	+7.5%
30–34 years	27.5%	26.3%	26.8%	27.2%	28.8%	+4.7%
35–39 years	32.5%	32.1%	32.8%	32.7%	33.5%	+3.1%
40+ years	38.5%	36.9%	39.2%	39.9%	43.3% ^^	+12.5%
By race/ethnicity (Sonoma County)						
American Indian and Alaska Native	30.4%	28.1%	34.2%	31.6%	38.2%	+25.7%
Asian	31.1%	30.6%	32.6%	34.5%	35.7%	+14.8%
Black	31.5%	30.6%	32.6%	29.2%	32.1%	+1.9%
Hispanic	25.8%	25.5%	26.6%	27.5%	28.7%	+11.2%
White	26.0%	25.6%	26.5%	26.2%	27.3%	+5.0%

^^ Significantly greater than other values in this category Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-35. Rarely or Never Felt Heard or Listened to by Providers During Delivery (%) – 2020–22

Group	Sonoma County	California
Overall (% who rarely or never felt heard/listened to by providers during delivery, 2020–22)		
All	11.3%	10.2%
By age group		
20–34 years	10.6%	—
35+ years	13.9%	—
By insurance type		
Medi-Cal	10.7%	—
Private	9.7%	—
By race/ethnicity		
Hispanic	9.5%	—
By income		
0–100% of poverty	25.5%	—
101–200% of poverty	12.7%	—
200%+ of poverty	6.9%	—

Source: MIHA, 2020–2022; cdph.ca.gov

Table B-36. Severe Maternal Morbidity (rate per 10,000 births)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	2022–24	% Change 2016–18 to 2022–24
Overall (rate per 10,000 births)								
Sonoma County	111.0	113.1	126.2	139.2	161.4	178.7	193.4 ^	+74.2%
California	84.4	92.3	98.5	104.2	108.0	110.4	113.0	+33.9%
By age group (Sonoma County)								
20–24 years	162.0	161.7	158.4	125.7	143.0	157.8	170.5	+5.2%
25–29 years	84.1	85.6	101.3	136.2	166.8	183.6	176.4	+109.8%
30–34 years	95.6	95.7	115.7	123.6	156.3	179.5	206.3	+115.8%
35–39 years	116.2	119.0	132.9	152.5	166.8	166.0	189.7	+63.3%
40+ years	179.4	192.0	200.0	187.9	161.1	223.0	273.3 ^^	+52.3%
By race/ethnicity (Sonoma County)								
Asian alone	—	—	—	339.3	243.9	333.3	247.3 ^^	—
Hispanic of any race	108.6	102.4	109.3	159.4	143.6	161.9	177.1	+63.1%
White alone	107.6	110.3	113.3	201.1	115.1	129.3	161.9	+50.5%
By insurance type (Sonoma County)								
Medi-Cal	116.1	124.6	151.3	158.1	158.6	162.2	135.7	+16.9%
Private	105.2	104.0	112.3	128.2	163.0	188.2	229.1 ^^	+117.8%
Specific indicators (Sonoma County, rate per 10,000 births)								
Acute renal failure	34.8	33.3	30.4	34.4	52.5	70.8	79.6 ^^	+128.7%
Sepsis	37.8	35.6	40.8	36.8	36.6	37.0	43.8	+15.9%
Disseminated intravascular coagulation	25.9	28.7	36.0	42.4	42.9	37.0	36.6	+41.3%
Hysterectomy	9.6	13.2	12.8	12.8	9.5	12.6	15.1	+57.3%

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-37. Deliveries with Gestational Diabetes (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall (% of deliveries with gestational diabetes)							
Sonoma County	10.8%	11.5%	11.4%	12.0%	11.9%	11.9%	+10.4%
California	9.7%	10.0%	10.3%	10.9%	11.2%	11.4%	+17.6%
By race/ethnicity (Sonoma County)							
Asian/Pacific Islander	17.3%	18.4%	19.8%	19.7%	18.3%	17.1%	–1.4%
Black	7.3%	8.5%	8.3%	11.2%	12.3%	13.8%	+88.5%
Hispanic	13.9%	14.2%	14.2%	14.9%	15.1%	15.3%	+10.0%
White	8.0%	8.7%	8.3%	8.9%	8.6%	8.4%	+5.0%
By insurance type (Sonoma County)							
Medi-Cal	13.0%	13.5%	13.1%	14.0%	14.1%	14.7%	+13.0%
Private	9.4%	10.1%	10.3%	10.7%	10.5%	10.2%	+8.3%

Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-38. Deliveries with Chronic Hypertension (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021– 23
Overall (% of deliveries with chronic hypertension)							
Sonoma County	2.7%	2.6%	2.4%	2.4%	2.7%	3.2%	+18.4%
California	2.2%	2.3%	2.4%	2.7%	3.0%	3.2%	+47.5%
By race/ethnicity (Sonoma County)							
Asian/Pacific Islander	4.3%	3.6%	2.6%	2.2%	3.2%	3.4%	–20.7%
Black	4.9%	—	—	—	—	6.9%	+40.4%
Hispanic	1.8%	2.0%	2.1%	2.5%	2.6%	3.0%	+68.3%
White	3.1%	2.9%	2.5%	2.2%	2.7%	3.2%	+2.8%

Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-39. Deliveries with Pregnancy-Associated Hypertension (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021– 23
Overall (% of deliveries with pregnancy-associated hypertension)							
Sonoma County	9.4%	10.3%	11.6%	12.6%	13.7%	15.0%	+60.0%
California	8.3%	9.3%	10.4%	11.5%	12.5%	13.4%	+61.7%
By age group (Sonoma County)							
<20 years	11.8%	10.7%	11.5%	14.4%	16.6%	14.9%	+26.0%
20–24 years	10.2%	11.5%	12.3%	12.4%	12.7%	13.2%	+29.6%
25–29 years	9.0%	10.0%	11.0%	11.9%	13.9%	15.7%	+74.9%
30–34 years	9.4%	9.8%	10.8%	11.9%	13.6%	15.7%	+66.8%
35–39 years	8.4%	10.2%	12.7%	13.1%	13.2%	13.6%	+61.9%
40+ years	12.2%	12.6%	14.0%	16.5%	16.5%	17.6%	+44.2%
By race/ethnicity (Sonoma County)							
American Indian and Alaska Native	18.8%	22.5%	20.2%	—	17.2%	23.5%	+25.2%
Asian/Pacific Islander	8.6%	9.9%	10.3%	10.6%	11.0%	13.5%	+56.8%
Black	8.2%	10.3%	11.2%	16.8%	16.4%	20.6%	+151.7%
Hispanic	8.5%	9.6%	10.2%	10.9%	12.3%	13.5%	+59.3%
White	10.0%	10.7%	12.8%	14.1%	15.2%	16.2%	+61.9%
By insurance type (Sonoma County)							
Medi-Cal	9.2%	9.3%	9.8%	10.5%	11.5%	12.3%	+33.9%
Private	9.6%	11.0%	12.8%	13.7%	15.1%	16.7%	+73.5%

Source: CDPH, MCAH Dashboards; cdph.ca.gov

Table B-40. Births with Short Interpregnancy Interval — Less Than 18 Months (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	% Change 2016–18 to 2021–23
Overall (% of births with short interpregnancy interval <18 months)							
Sonoma County	23.2%	23.5%	23.3%	23.3%	24.3%	25.0%	+7.8%
California	26.5%	26.2%	26.1%	26.2%	26.5%	27.0%	+1.9%
By race/ethnicity (Sonoma County)							
American Indian and Alaska Native	36.5%	40.3%	44.1%	40.0%	32.1%	29.4%	–19.4%
Black	28.9%	29.2%	35.8%	25.8%	26.4%	25.0%	–13.5%
Hispanic	17.9%	18.2%	17.7%	18.0%	19.2%	20.0%	+11.6%
White	27.8%	27.8%	27.8%	27.4%	29.0%	29.8%	+7.1%

Source: CDPH, MCAH Dashboards; cdph.ca.gov

Section 6: Postpartum

Table B-41. Postpartum Visit and Contraception Use

Group	Sonoma County	California
<i>Had a postpartum medical visit (2020–22)</i>		
All	91.7% ^	88.2%
<i>Using most effective contraception method postpartum (2020–22)</i>		
All	36.6% ^	25.8%
Medi-Cal	50.2% ^^	—
Private insurance	29.6%	—
Less than high school	59.7% ^^	—
College graduate	26.6%	—

^ Significantly greater than California | ^^ Significantly greater than other values in this category Source: MIHA, 2020–2022; cdph.ca.gov

Table B-42. Any Breastfeeding Initiation at Hospital (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	2022–24	% Change 2016–18 to 2022–24
<i>Overall</i>								
Sonoma County	97.2%	96.8%	96.7%	96.7%	96.7%	96.6%	96.8%	–0.3%
California	93.9%	93.9%	93.8%	93.6%	93.6%	93.6%	93.6%	–0.4%
<i>By race/ethnicity (Sonoma County)</i>								
American Indian and Alaska Native	98.2%	96.3%	97.8%	97.4%	97.7%	98.1%	93.0%	–5.3%
Asian	97.6%	98.0%	97.7%	98.1%	97.6%	96.8%	97.1%	–0.5%
Black	97.7%	98.4%	98.3%	97.4%	97.8%	95.7%	97.1%	–0.6%
Hispanic	97.0%	96.4%	96.0%	95.9%	96.0%	96.2%	96.7%	–0.3%
Multi-Race	96.5%	96.3%	97.5%	97.1%	97.2%	96.6%	97.3%	+0.9%
White	97.3%	97.1%	97.2%	97.2%	97.3%	97.2%	97.2%	–0.1%
<i>By birthweight (Sonoma County)</i>								
Low (<2,500 g)	93.7%	93.8%	92.9%	95.5%	95.4%	96.5%	94.7%	+1.1%
Normal (2,500–3,999 g)	97.2%	96.8%	96.8%	96.6%	96.7%	96.7%	97.0%	–0.2%
High (4,000+ g)	97.8%	97.5%	97.7%	97.4%	96.8%	95.8%	96.1%	–1.8%

Age group and gestational age breakdowns available for 2022–24 only. Source: CDPH MCAH Dashboards; cdph.ca.gov

Table B-43. Exclusive Breastfeeding Initiation at Hospital (%)

Group	2016–18	2017–19	2018–20	2019–21	2020–22	2021–23	2022–24	% Change 2016–18 to 2022–24
Overall								
Sonoma County	85.2%	83.9%	83.3%	83.8%	83.4%	83.5%	85.5%	+0.3%
California	69.9%	70.1%	70.1%	69.7%	69.2%	68.9%	68.8%	–1.6%
By race/ethnicity (Sonoma County)								
American Indian and Alaska Native	87.3%	83.3%	78.3%	76.9%	67.4%	79.6%	81.8%	–6.2%
Asian	80.9%	81.3%	82.1%	84.0%	82.7%	79.9%	88.4%	+9.3%
Black	84.5%	85.3%	79.7%	83.6%	79.3%	80.7%	80.1%	–5.2%
Hispanic	81.0%	79.0%	78.2%	78.9%	78.5%	78.9%	78.9%	–2.5%
Multi-Race	84.7%	83.9%	84.3%	84.5%	84.2%	84.9%	80.4%	–5.1%
White	89.3%	88.5%	88.1%	88.4%	88.6%	88.9%	90.4%	+1.3%
By birthweight (Sonoma County)								
Low (<2,500 g)	51.7%	51.0%	46.6%	48.8%	52.0%	58.6%	65.4%	+26.6%
Normal (2,500–3,999 g)	86.9%	85.6%	85.1%	85.3%	84.8%	84.6%	86.4%	–0.6%
High (4,000+ g)	81.3%	79.4%	78.6%	80.1%	79.8%	80.7%	83.2%	+2.4%

Age group and gestational age breakdowns available for 2022–24 only. Source: CDPH MCAH Dashboards; cdph.ca.gov

Table B-44. Any Breastfeeding at 1 Month (%)

Group	2013–15	2016–18	2019–21	2020–22
Overall				
Sonoma County	88.4% ^^	89.3% ^^	95.2% ^^	92.3% ^^
California	83.8%	86.0%	85.9%	85.7%
By age group (Sonoma County)				
15–19 years	82.2%	—	—	—
20–24 years	93.2%	96.1%	89.2%	88.5%
35+ years	91.1%	93.6%	90.4%	89.8%
By race/ethnicity (Sonoma County)				
Hispanic	82.6%	82.3%	94.0%	92.5%
White	93.1%	95.8%	96.0%	92.6%
By insurance type (Sonoma County)				
Medi-Cal	84.3%	84.1%	95.2%	90.3%
Private insurance	91.2%	92.6%	95.2%	95.2%
By education (Sonoma County)				
Less than high school	78.9%	81.7%	93.8%	86.3%
High school graduate	81.0%	84.9%	94.2%	91.3%
Some college	89.9%	90.0%	97.2%	92.7%
College graduate	92.6%	92.7%	94.6%	94.9% ^^
By income (Sonoma County)				
0–100% FPL	79.9%	83.8%	94.7%	89.5%
100–199% FPL	88.0%	85.7%	95.7%	92.1%
200%+ FPL	93.2%	94.4%	97.0%	94.5%
By birth order (Sonoma County)				
First birth	89.1%	89.4%	96.9%	92.9%
Second birth or more	87.9%	89.3%	94.0%	91.9%

^^ Significantly greater than California or other values in this category Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-45. Exclusive Breastfeeding at 1 Month (%)

Group	2013–15	2016–18	2019–21	2020–22
Overall				
Sonoma County	52.8% ^^	56.4% ^^	65.6% ^^	63.5% ^^
California	41.3%	43.7%	47.8%	44.2%
By age group (Sonoma County)				
15–19 years	—	—	69.0%	56.9%
20–24 years	55.4%	58.4%	67.3%	63.1%
35+ years	49.1%	54.1%	59.6%	66.1%
By race/ethnicity (Sonoma County)				
Asian	—	—	—	46.5%
Hispanic	45.8%	44.9%	65.4%	59.1%
White	56.8%	64.3%	67.1%	70.4% ^^
By insurance type (Sonoma County)				
Medi-Cal	51.6%	47.9%	62.6%	60.5%
Private insurance	54.0%	63.3%	65.7%	67.4%
By education (Sonoma County)				
Less than high school	49.2%	45.7%	49.7%	52.2%
High school graduate	45.8%	43.7%	73.2%	60.2%
Some college	53.4%	56.9%	64.9%	62.6%
College graduate	56.2%	64.1%	69.0%	70.1% ^^
By income (Sonoma County)				
0–100% FPL	46.3%	44.9%	56.1%	59.9%
100–199% FPL	55.7%	50.9%	70.5%	64.3%
200%+ FPL	56.6%	66.7%	68.0%	66.7%
By birth order (Sonoma County)				
First birth	50.0%	54.9%	64.8%	60.4%
Second birth or more	54.8%	57.6%	66.1%	65.7%

^^ Significantly greater than California or other values in this category Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-46. Exclusive Breastfeeding at 3 Months (%)

Group	2013–15	2014–16	2015–17	2016–18	2017–19	2018–20	2019–21	2020–22	% Change 2013–15 to 2020– 22
Overall									
Sonoma County	49.0% ^^	52.8% ^^	51.8% ^^	53.7% ^^	53.3%	51.5%	45.5%	39.4%	–19.6%
California	29.1%	31.1%	33.2%	33.5%	34.0%	33.2%	32.0%	30.8%	+5.8%
By age group (Sonoma County)									
20–24 years	48.1%	53.3%	52.8%	54.0%	51.9%	48.9%	45.6%	40.2%	–16.4%
35+ years	53.0%	55.2%	53.4%	55.5%	57.8%	56.7%	47.2%	39.3%	–25.8%
By race/ethnicity (Sonoma County)									
Hispanic	43.9%	47.3%	46.5%	52.1%	47.9%	41.9%	31.8%	32.2%	–26.7%
White	55.2%	58.6%	58.5%	55.4%	59.7%	57.4%	58.1%	47.1%	–14.7%
By insurance type (Sonoma County)									
Medi-Cal	45.5%	52.5%	49.0%	49.6%	42.7%	41.1%	35.2%	34.8%	–23.5%
Private insurance	53.6%	53.0%	53.4%	55.5%	61.1%	59.5%	54.9%	45.1%	–15.9%
By education (Sonoma County)									
Less than high school	38.2%	35.8%	29.8%	34.3%	35.9%	43.0%	35.8%	39.9% ^^	+4.5%
High school graduate	44.2%	50.5%	49.3%	58.0%	49.4%	36.5%	27.1%	23.5%	–46.8%
Some college	47.7%	53.7%	57.7%	50.5%	49.8%	47.6%	42.9%	37.2%	–22.0%
College graduate	56.0%	59.6%	56.6%	66.0%	67.3%	64.1%	58.8%	48.0%	–14.3%
By income (Sonoma County)									
0–100% FPL	40.6%	43.9%	36.7%	41.2%	39.0%	40.0%	32.3%	28.0%	–31.0%
100–199% FPL	52.4%	59.4%	59.1%	60.2%	52.4%	49.6%	41.8%	45.7%	–12.8%
200%+ FPL	54.3%	55.4%	56.9%	58.4%	64.1%	61.5%	56.9%	44.2%	–18.6%
By birth order (Sonoma County)									
First birth	49.2%	52.1%	54.8%	55.8%	57.4%	50.9%	43.6%	34.6%	–29.7%
Second birth or more	48.7%	53.2%	49.8%	52.3%	50.6%	51.8%	46.9%	42.7%	–12.3%

^^ Significantly greater than California or other values in this category Note: apparent decline in 2017–19 reflects a change in question wording in MIHA; interpret trend with caution across this break. Source: MIHA, 2013–2015 to 2020–2022; cdph.ca.gov

Table B-47. WIC Participation Postpartum – Sonoma County (Count of Participants)

Measure	2019	2020	2021	2022	2023	2024
<i>Breastfeeding participants</i>						
Number of certified participants	836	816	782	843	971	988
Number of issued participants	687	673	688	749	892	914
<i>Non-breastfeeding participants</i>						
Number of certified participants	260	249	231	231	216	219
Number of issued participants	240	228	219	222	207	207

Certified participants = enrolled and eligible. Issued participants = received WIC food benefits.

Source: CDPH WIC Participants by County; data.chhs.ca.gov

Appendix C: Data Sources

The secondary data presented in this assessment draw on the following sources:

ACS

U.S. Census Bureau, American Community Survey, 5-Year and 1-Year Estimates. Available at data.census.gov.

CDC WONDER

Centers for Disease Control and Prevention, WONDER Natality Database. Available at wonder.cdc.gov.

CDPH WIC Participants by County

California Department of Public Health, Women, Infants and Children Program. Available at data.chhs.ca.gov.

CHHS Open Data

California Health and Human Services Agency Open Data Portal (WIC participation; Medi-Cal certified eligibles). Available at data.chhs.ca.gov.

CHIS

UCLA Center for Health Policy Research, California Health Interview Survey. Available at healthpolicy.ucla.edu/chis.

California DOJ Crimes Dashboard

California Department of Justice, OpenJustice Crime Data. Available at openjustice.doj.ca.gov.

California Overdose Surveillance Dashboard

California Department of Public Health, Substance and Addiction Prevention Branch. Available at skylab.cdph.ca.gov.

Maternal Health Framework

Kramer MR et al. Changing the conversation: applying a health equity framework to maternal mortality reviews. Am J Obstet Gynecol. 2019;221(6):609.e1–609.e9. Available at doi.org/10.1016/j.ajog.2019.08.057.

MCAH Dashboards

California Department of Public Health, Maternal, Child, and Adolescent Health Division Data Dashboards. Available at cdph.ca.gov.

MIHA

California Department of Public Health, California Maternal and Infant Health Assessment.
Available at cdph.ca.gov.

OMB SPD 15 (2024)

U.S. Office of Management and Budget, Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (2024). Available at [federalregister.gov](https://www.federalregister.gov).