



Alabama Title V

Maternal and Child Health

2025 Comprehensive Needs Assessment



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Introduction & Purpose

The Alabama Department of Public Health (ADPH) serves as the lead agency for the state's Title V Maternal and Child Health (MCH) Block Grant, a federally mandated initiative requiring annual applications and a comprehensive statewide needs assessment every five years. The administration of Alabama's Title V MCH Block Grant program is unique in that ADPH's Bureau of Family Health Services division oversees four of the five MCH population domains (groups established through the federal legislation). These are the Women/Maternal, Perinatal/Infant, Child, and Adolescent domains. Children's Rehabilitation Service (CRS), a division of the Alabama Department of Rehabilitation Services, oversees the fifth domain, Children and Youth with Special Health Care Needs (CYSHCN).

The purpose of the statewide needs assessment is to identify priority MCH issues and guide strategic planning efforts. The primary goal is to improve MCH outcomes and to strengthen state, local, and community partnerships in addressing the needs of Alabama's MCH population. The findings from this statewide assessment, together with prioritized needs and aligned measures, provide a framework against which progress can be assessed during the 2025-2030 Title V MCH Block Grant reporting period.

Based on the needs assessment, states must prioritize seven to ten MCH needs, aligning at least one to each of the MCH population domains. From a national list, states must select at least one National Performance Measures (NPM) for each MCH population domain, assuring that the selected NPM aligns with making progress toward addressing the prioritized need. States may also develop State Performance Measures (SPMs) to address any prioritized need that does not adequately align with NPMs. Alabama's 2025 Title V MCH Needs Assessment culminated in the selection of **eight (8) state priority needs**, which are addressed through **five (5) NPMs** and **three (3) SPMs**.

Needs Assessment Process & Methods

Overview

The FY 2025 Title V MCH Needs Assessment was collaboratively conducted by ADPH and CRS. Due to the organizational structure of Title V MCH in the state, there were two separate, but related processes for the needs assessment. Both ADPH and CRS entered into contractual agreements with the UAB School of Public Health's Applied Evaluation and Assessment Collaborative (AEAC) to facilitate the implementation of the needs assessment process. UAB AEAC also partnered with community-based organizations to support community engagement during the assessment. These organizations included the

Alabama Network of Family Resource Centers (ANFRC), Family Voices of Alabama (FVA), United Ability (UA), and United Cerebral Palsy of Huntsville (UCP-H).

Both ADPH and CRS established Needs Assessment Leadership Teams and convened Advisory Committees to support planning and implementation of the needs assessment, as well as responding to the findings to support prioritization and strategic planning. Staff from ADPH and CRS participated on each other's committees and there was some overlap of key partners and community representatives on the advisory groups.

Community, Family, and Stakeholder Engagement

Engaging community members, families, and other stakeholders from the outset, as well as maintaining their involvement throughout the needs assessment process, is essential to accurately identifying and addressing the needs of a state's MCH population. As such, both the ADPH and CRS needs assessment processes included strategies for ongoing stakeholder engagement and to assure equitable opportunities for participation. These included:

- Convening needs assessment leadership teams and advisory committees
- Partnering with local, trusted community-based organizations for recruitment and awareness efforts
- Using social media and press releases to encourage participation in needs assessment data collection methods
- Distributing marketing materials in English and Spanish
- Collaborating with agency local staff, parent consultants, and partners to promote distribution of data collection methods and encourage participation
- Partnering with community-based organizations to support community participation in focus groups
- Facilitating diverse focus groups that included representation based on geography, race, ethnicity, language, income, age, and disability status
- Using translation and interpreter services for focus groups (Spanish and American Sign Language, ASL)
- Fielding mobile-friendly online surveys in English and Spanish
- Assuring accessibility of online surveys for screen reading software

Data Collection Methods and Sources

While there were some differences in approach, both ADPH and CRS worked with UAB AEAC to review and summarize Federally Available Data (FAD), key MCH indicators, and trend analyses that are provided to states annually based on national, population-based surveys. FAD represent national priority areas that are important MCH health outcome and systems measures. The most recently available data were reviewed and synthesized for each MCH population domain, comparing Alabama performance to U.S. averages and

Alabama trends over time. When possible, these data were reviewed to identify any differences in outcomes based on common sociodemographic characteristics.

Additionally, UAB AEAC supplemented FAD with new data gathered through community, family, and stakeholder engagement. These quantitative (numbers) and qualitative (stories, experiences) data were synthesized to identify potential priority need topics. As discussed below, all needs that emerged were considered through a two-phase process to finalize the state’s priority need list and guide state action planning.

ADPH

In addition to FAD, ADPH also included the following data collection methods and sources:

- Web-based survey for healthcare providers, families, and adolescents
- Newly convened community focus groups
- Key informant interviews (partner and community organizations)
- Transcripts from related projects, including:
 - *Maternal Health Taskforce* listening sessions
 - *ALL Babies* evaluation focus groups

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	
Key MCH indicators provided to states.	936 Responses (Online, English & Spanish) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups (1 in Spanish) Data Access: 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups (1 in Spanish)	

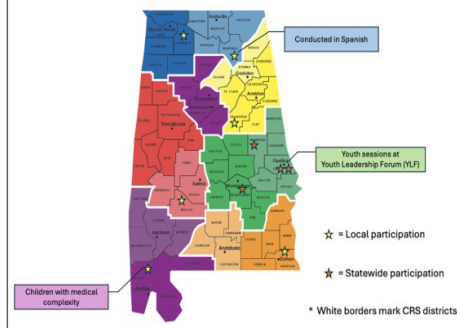
CRS

In addition to FAD, CRS also included the following data collection methods and sources:

- Three years of data from two CRS client and caregiver surveys focused on:
 - Transition to adulthood and adult health care services
 - Care coordination services
- Consensus scoring documents from three years of the *Family Engagement in Systems Assessment Tool (FESAT)*
- Web-based survey for healthcare providers, families, and adolescents

- Community focus groups
- Listening sessions held during existing events and convenings
 - Key informant interviews (representatives from local and state agencies and public and private organizations serving CYSHCN and their families)

Federally Available Data (FAD)	Survey	Focus Groups & Listening Sessions	Key Informants	Other Existing Information
Key MCH indicators provided to states (specific to CYSHCN) These are National Performance Measures	427 Responses (Online, English & Spanish) • Parent/Caregiver of CYSHCN = 225 • YSHCN = 58 • Health Care/Health-Related Care Provider = 86 • Teacher/Childcare Provider = 59 • Advocacy or Community Support Organization = 36 • State Agency Employee = 35	8 Focus Groups & 2 Listening Sessions Focus Groups: <ul style="list-style-type: none"> • Parents/ Caregivers of CYSHCN – English = 5 • Parents/ Caregivers of CYSHCN – Spanish = 1 • Youth/ Young Adult with SHCN = 2 Listening Sessions: <ul style="list-style-type: none"> • Alabama Hands and Voices (40+ families of children 18 months - teens) • CRS State Parent Advisory Committee (20+ Local Parent Consultants and Local Parent Advisory Committee Members) 	9 Participants • Health and Health-Related Care Providers (rural pediatrician, nurse practitioner, school therapists) • Rural Teacher, Secondary Grades • Health Care Equipment Vendors • Advocacy & Community Organization Staff	• CRS Transition Survey • CRS Care Coordination Survey • CRS FESAT Consensus Scoring



Description of Prioritization Process

UAB collaborated closely with ADPH and CRS to co-facilitate a two-phase process to prioritize identified needs. Phase one involved advisory committee members, partners, and staff reviewing synthesized data and potential priority needs to provide feedback using criteria that ADPH and CRS established as important for final decision-making related to the identification of a priority need list. Phase two incorporated the broader phase one feedback with additional decision criteria to allow the ADPH and CRS leadership teams to finalize the selection of priority needs for further action.

ADPH and CRS

Both groups used similar processes and the same decision-making criteria for both Phase One and Phase Two of the prioritization process.

Phase One: UAB AEAC presented synthesized data and identified needs to each organization’s broader advisory group or committee. These groups then reviewed the data and potential priority needs and rated each need using a 5-point Likert scale of 1 (low) to 5 (high) based on three decision-making criteria:

- **Importance based on data**
 - Importance of addressing need based on all data presented, including numbers (quantitative) and themes from experiences and opinions shared by families, youth, and providers (qualitative).

- Includes consideration of comparisons to national outcomes, state trends over time, and disparities in outcomes (unequal outcomes for some groups).
- **Alignment with other state priorities and efforts**
 - The extent to which the issue/need aligns with other priorities and efforts in the state.
 - The extent to which the issue/need has “momentum” in the state or is a “hot topic” that others are talking about and working on.
 - The extent to which working on the issue/need would create opportunities to partner with other groups to expand efforts to address the topic.
- **Potential for effective approaches or solutions**
 - The extent to which potential solutions or approaches exist to address the issue/need.
 - Based on your professional knowledge and experiences, the extent to which there are strategies that work or can work with appropriate leadership, funding, and attention.

Using a QR code, attendees entered ratings into a form hosted on the Qualtrics survey platform which calculated the average ratings for each need on each decision criterion, as well as the sum of all three. This information was used to establish the preliminary rank order of the identified needs for each MCH population domain.

Phase Two: UAB AEAC facilitated a full-day session with each organization’s needs assessment leadership team to review synthesized data and preliminary rankings of needs from Phase One and to determine the final priority needs list for all MCH population domains. This final list was established via consensus through discussion guided by the following decision criteria:

- **Importance based on data**
 - Based on all data (qualitative and quantitative)
 - Considering comparisons to nation/region, trends over time, and unequal outcomes
 - Considering family and provider stories
 - Considering advisory group ratings and preliminary rankings
- **Effective interventions or potential solutions**
 - Are there evidence-based or evidence-informed solutions/interventions?
- **Feasibility**
 - How feasible is it to address the need?
 - Based on cost, expertise, time, resources, political will, existence of solutions, and whether addressing the need is within agency scope and control
- **Alignment with other priorities and initiatives in the agency**
 - Is there alignment with other agency priorities?

- **Opportunities to collaborate with national, state, and/or community partners**
 - Are there opportunities to work with others at national, state, and/or community levels?
- **Data/Method to assess availability**
 - Do we have (or can we get) data to measure and monitor progress on addressing the need?

Slight nuances in the prioritization process for each organization are described below.

ADPH

Phase One: UAB AEAC presented synthesized data and identified needs to the MCH Needs Assessment Advisory Group to facilitate preliminary selection of priority needs. Through two full-day meetings, more than 50 individuals representing a broad spectrum of stakeholders—including state and community organizations, ADPH and CRS staff, and ADPH regional MCH coordinators—reviewed the data and potential priority needs. Participants rated each need based on three decision-making criteria and 5-point Likert scale as described above.

Phase Two: UAB AEAC facilitated a full-day session with the ADPH Needs Assessment Leadership Team to review synthesized data and preliminary rankings of needs from Phase One and to determine the final priority need list for all MCH population domains except CYSHCN (to be determined by CRS separately). This final list was established via consensus through discussion guided by the decision criteria as described above.

CRS

Phase One: UAB AEAC presented synthesized data and identified needs to the CRS Needs Assessment Advisory Committee and partners to facilitate preliminary selection of priority needs. Through a full-day meeting, more than 60 individuals with an interest in CYSHCN participated, representing state and community organizations, family-led groups and family leaders, advisory committee members, and key CRS staff, including parent consultants. The meeting featured both large and small group discussions, which fostered deeper engagement and generated valuable strategic ideas and partnership opportunities to support the next five-year Title V MCH Block Grant cycle. Participants rated each need based on three decision-making criteria and 5-point Likert scale as described above.

Phase Two: UAB AEAC facilitated a half-day session with the CRS State Office Leadership Team to review synthesized data and preliminary rankings of needs from Phase One and to determine the final priority need list for the CYSHCN domain. This final list was established via consensus through discussion guided by the decision criteria as described above.

Final List of Priority Needs

Using the previously described process, ADPH and CRS selected a total of eight priority needs and then aligned them with performance measures to guide improvement efforts, serving as the foundation for developing Alabama’s State Action Plan over the 2026-2030 MCH Block Grant cycle. The following table presents the state priority needs aligned with selected measures and specific MCH population domain.

Priority Need	National or State Performance Measure	MCH Population Domain
Comprehensive Postpartum Care and Education	NPM: Postpartum Visit	Women/Maternal
	SPM: Trusted Birth Control Method	Women/Maternal
Infant Mortality	NPM: Safe Sleep	Perinatal/Infant
Access to Comprehensive Health Care	NPM: Medical Home, all children	Child
Adolescent Safety and Wellness	NPM: Bullying	Adolescent
Comprehensive Care Coordination and Supports for System Navigation	NPM: Medical Home, CYSHCN	CYSHCN
Transition to Adulthood	NPM: Transition to Adult Health Care	CYSHCN
Family and Youth Peer Supports	SPM: Emotional Support with Parenting	CYSHCN
Access to Comprehensive Oral Health Education and Services for all MCH Populations	SPM: Dental Health Kit Usage	Cross-cutting

Although the additional identified needs for each domain were not included in the final list, ADPH and CRS leadership believed that addressing the selected priority needs would indirectly address many of these other needs through comprehensive strategies aligned under the selected NPMs and newly developed SPMs. Synthesized data summaries and all identified needs are shared in the Appendices of this report with the intention that partner organizations and other groups can use the information to guide their work. Both ADPH and CRS identified broader systems and community factors that influence health. While these were not directly included in prioritization, they are recognized as foundational considerations in the development of strategies that will support outcome improvements for all of Alabama’s MCH populations.

Appendices: MCH Population Domain Reports

This section includes the comprehensive MCH domain-specific reports that guided the need prioritization and selection process. These reports contain a synthesis of all data – previously existing and newly gathered – that were included in the 2025 Title V MCH Needs Assessment. Based on these data, need topics were identified for each MCH population domain.

Women/Maternal Health

The table below presents the **need topics** that were identified for women/maternal health in Alabama presented in rank-order based on the average score from all raters during Phase One of the prioritization process.

Rank	Need Topic	Average Phase One Score
1	Access to Health and Dental Care Services	11.78
2	Access to Prenatal Care and Labor and Delivery Hospitals	11.70
3	Comprehensive Mental Health and Wellness Treatment and Supports	11.67
4	Comprehensive Postpartum Care and Education	10.89
5	Birthing Choices and Access to Alternative Providers	8.07

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **Women/Maternal Health-specific report**, which begins on the next page.

Selected State Priority Need and Aligned Measures

During Phase Two of the prioritization process, “**Comprehensive Postpartum Care and Education**” was selected as the state priority need for the Women/Maternal Population Health Domain for the 2025-2030 Title V MCH Block Grant cycle.

Two measures were aligned to track performance in addressing this need.

National Performance Measure: A) Percent of women who attended a **postpartum checkup** within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and **received recommended care components**

State Performance Measure: Percent of survey respondents ages 15 to 55 eligible to enroll into Well Woman program who report having a **trusted birth control method** and are not planning for a pregnancy within the next 12 months.

Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State’s public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

The Alabama Department of Public Health partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. The Alabama Network of Family Resource Centers partnered to support focus groups.

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	
Key MCH indicators provided to states	936 Responses (Online, English & Spanish) Role (Respondents could select all that apply.) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups (1 in Spanish) <u>Data Access:</u> 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups (1 in Spanish)	

WOMEN/MATERNAL HEALTH

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topics	Key Findings	Statewide Survey ¹	Focus Groups, Listening Sessions, & Key Informant Interviews	Federally Available Data ²
Access to Health and Dental Care Services	<ul style="list-style-type: none"> • Lack of or unequal access to comprehensive, respectful health care services, including primary care, preventive screenings, family planning/contraception, care for chronic conditions, and dental care, especially in rural areas and for those with Medicaid insurance. • Lack of or unequal access to preventive dental visits during pregnancy, especially in rural areas and for those with Medicaid insurance. 	X	X	X
Comprehensive Mental Health and Wellness Treatment and Supports	<ul style="list-style-type: none"> • Lack of, lack of awareness of, or unequal access to comprehensive mental health treatment and wellness supports, including postpartum depression screening and care. 	X	X	X
Access to Prenatal Care and Labor and Delivery Hospitals	<ul style="list-style-type: none"> • Lack of or unequal access to respectful prenatal care and labor and delivery hospitals, especially in rural areas. • Lack of or unequal access to supports for women receiving care for high-risk pregnancies or emergency transport for high-risk deliveries. 	X	X	No FAD indicator
Comprehensive Postpartum Care and Education	<ul style="list-style-type: none"> • Lack of or unequal access to comprehensive, respectful postpartum care that includes all recommended components of care. • Lack of, lack of awareness of, or unequal access to postpartum education, assistance programs, and community supports. 		X	X
Birthing Choices and Access to Alternative Providers	<ul style="list-style-type: none"> • Lack of or unequal access to alternative birth attendants and supports, including certified nurse midwives and doulas. 	Write-in comments	X	No FAD indicator

¹Ranking in Top 5 issue list for any respondent role group.

² A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

WOMEN/MATERNAL HEALTH

Statewide Survey

Out of 760 responses to this section of the survey, the following issues were ranked as concerns affecting women/maternal health in Alabama. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³			
	ADPH Employee	Family/ Individual	Partner	Medical Provider
Access to a Labor and Delivery Hospital	3 rd	4 th	5 th	4 th (tie)
Access to Contraceptives and Family Planning Services	6 th	6 th	6 th	6 th
Chronic Health Conditions	1 st	2 nd	2 nd	1 st (tie)
Doctor Visits After Pregnancy (postpartum health visits)	11 th	8 th	9 th	8 th
Family/Partner Violence and Neglect	13 th	11 th	11 th	13 th
Mental Health/Behavioral Issues and Treatment	5 th	3 rd	4 th	4 th (tie)
Postpartum Mental Health/ Depression Screenings after Pregnancy	4 th	1 st	1 st	1 st (tie)
Prenatal Care	2 nd	5 th	3 rd	3 rd
Regular Dental Visits	12 th	12 th	12 th	11 th (tie)
Regular Health Screenings (Pap tests, breast exams, etc.)	7 th	7 th	7 th	7 th
Risky Sexual Behaviors	8 th	13 th	10 th	10 th
Staying Active/Physical Activity	10 th	9 th	13 th	11 th (tie)
Substance Use (alcohol, drugs)	9 th	10 th	8 th	9 th
Tobacco and Vaping	14 th	14 th	14 th	14 th

³Based on number and percentage of respondents who selected issue as one of top five concerns.

Write-In Concerns: Medicaid coverage of dental services; Medicaid expansion; midwifery and doula services; paid parental leave; reproductive rights, choices, and education

Federally Available Data

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures			
Postpartum Visit – Attendance ⁴	92.3% ⁱⁱ	Comparable	Stable
Postpartum Visit - Recommended Components ⁴	74.4% ⁱⁱ	Worse (lower)	Stable
Postpartum Mental Health Screening ⁴	76.2% ⁱⁱ	Worse (lower)	Not available
Postpartum Contraception Use ⁴	56.3% ⁱⁱ	Better (higher)	Decreasing (worsening)
Preventive Dental Visit – Pregnancy ⁵	41.1% ⁱⁱ	Worse (lower)	Stable
Standardized Measures			
Well-Woman Visit ⁶	74.5% ⁱⁱⁱ	Comparable	Stable
Low-Risk Cesarean Delivery ⁷	28.3% ^{iv}	Worse (higher)	Decreasing (improving)
Smoking – Pregnancy ⁸	3.9% ^{iv}	Worse (higher)	Decreasing (improving)
National Outcome Measures			
Maternal Mortality ⁹	35.1 ^{iv} per 100,000	Worse (higher)	Increasing (worsening)
Postpartum Depression ⁶	15.8% ⁱⁱ	Worse (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes
4	Data not available
5	Less than college graduate
6	None in available data
7	30+ years
8	Less than HS graduate; Medicaid; White; Non-Metro
9	Less than HS graduate; 35+ years; Black

ⁱData and analyses provided to states by Maternal and Child Health Bureau (<https://mchb.tvisdata.hrsa.gov/Home/FADDocuments>)

ⁱⁱPregnancy Risk Assessment Monitoring System (PRAMS 2023)

ⁱⁱⁱBehavioral Risk Factor Surveillance System (BRFSS 2023)

^{iv}National Vital Statistics System (2023, 2019-2022 for maternal mortality)

Focus Groups, Listening Sessions, Key Informant Interviews, and Survey Write-In Comments

Themes	Summary
<p>Access to Health and Dental Care</p>	<p><u>Access to Care and Barriers</u></p> <ul style="list-style-type: none"> • Lack of providers or limited provider choices, including for primary health care, specialty care, and dental care, especially for rural areas, low-income families, or those with Medicaid. • Transportation challenges, geographic isolation, and insurance limitations. • Lack of providers in rural areas and/or the feeling that local, high quality providers were unavailable created needs for lengthy travel to larger cities to access care, causing challenges with reliable transportation, cost, missing time from work, and childcare or school issues. • Insurance limitations in coverage (example, lack of Medicaid coverage for adult dental care) and out-of-pocket expenses for procedures and medications (insulin, antidepressants) caused budget challenges or required people to make difficult choices about filling prescriptions and other household needs. • Mixed experiences with telehealth services. Some appreciated the convenience, being able to avoid a long drive, and not having to sit in waiting rooms, especially for basic questions and check-ins. Others preferred in-person visits, especially for some services and needs, or felt it was easier to explain things in person. <p><u>Emergency Transport Services</u></p> <ul style="list-style-type: none"> • In rural areas, ambulance response times were reported as dangerously slow, sometimes over an hour. This led to families driving themselves to hospitals, even in emergencies.
<p>Access to Comprehensive Reproductive Health Services</p>	<p><u>Access to Care and Barriers</u></p> <ul style="list-style-type: none"> • Limited access to OB/GYN services, especially in rural areas. • Mixed experiences in accessing routine women’s health screenings (pap smears, mammograms). • Some reported receiving these services through providers, while others noted difficulties due to lack of providers, cost, or lack of comprehensive and culturally inclusive services. <p><u>Access to Contraception</u></p> <ul style="list-style-type: none"> • Mixed experiences in accessing family planning and contraception services. • Some reported receiving these without challenges through their provider or the health department, while other had challenges in accessing this care.

Access to Pregnancy Care

Pregnancy and Prenatal Care

Access to Care:

- Limited availability of OB/GYN services and prenatal care, especially in rural areas.
- Long travel distances for prenatal appointments or high-risk pregnancy care, which created challenges with reliable transportation, cost, missing time from work, and childcare or school issues.
- Delays in scheduling and long wait times for appointments. Delays in receiving Medicaid cards and appointments hindered timely care.
- Some women were denied ultrasounds unless they paid out-of-pocket.

Continuity of Care and Communication:

- Expressed frustration about seeing different providers at each visit, especially in teaching hospitals or clinics with rotating staff. This lack of continuity led to repeated explanations, discomfort, and a sense of being unheard.

Respectful Care:

- Some women described feeling dismissed or judged by providers, especially those on Medicaid or from minority race/ethnic backgrounds.
- Emphasized the importance of being listened to and respected during pregnancy.

Labor and Delivery

- Lack of access to labor and delivery hospitals, especially in rural areas.
- High-risk deliveries require treatment in larger cities, which creates challenges for transportation and being away from home.
- Emergency high-risk deliveries that require transport often created additional challenges for women being in unfamiliar cities, away from their provider team, and without emotional supports from partner, family, and friends.
- Receiving postpartum education immediately post-delivery when women were still recovering or waking from anesthesia created challenges for retaining information.
- Lack of nursery services in some delivery hospitals made recovery and breastfeeding more difficult.
- Some women mentioned the presence of student observers during recovery without their consent.

	<ul style="list-style-type: none"> Some women described dismissive, disrespectful care from staY, including lack of pain management or being ignored, especially those on Medicaid or from minority race/ethnic backgrounds. <p>Postpartum Care</p> <ul style="list-style-type: none"> Postpartum care was seen as inadequate, often feeling superficial or rushed, and limited to a single follow-up visit. These visits were noted as lacking comprehensive physical and mental health assessments. Participants described examples where postpartum depression screenings were inconsistent or incomplete, such as the use of paper forms for screening without any follow-up or referrals. Some women saw new providers postpartum, which limited continuity of care and hindered trust and follow-through. Some women expressed that they experienced disrespect or dismissal by providers, particularly those on Medicaid, recent immigrants, and those from minority race/ethnic backgrounds. DiYiculty changing providers due to insurance limitations, even when they felt uncomfortable or unheard. <p>Father Involvement</p> <ul style="list-style-type: none"> Father participants expressed a strong desire to be involved in the postpartum process but felt under-informed. Participants advocated for father-inclusive education during prenatal care to better prepare for postpartum challenges.
<p>Birth Choices and Access to Alternative Providers</p>	<ul style="list-style-type: none"> Some women expressed desire for choices in birth attendants and supports, including nurse midwives and doulas.
<p>Comprehensive Mental Health Treatment and Care</p>	<p>Access to Mental Health Care in General</p> <ul style="list-style-type: none"> Lack of or limited providers, with long waitlists and long wait times for appointments throughout the state, and especially in rural areas. Rural participants noted having to travel long distances for both basic and emergency care. Additional challenges in small and rural areas where “everybody knows everybody” and local providers may be known outside of treatment. This may be a conflict of interest or privacy concern. Mixed experiences with telehealth. Some appreciated the convenience, especially for mental health check-ins or prescription refills. Others preferred to be in person with a therapist.

- Some participants reported being prescribed medications without thorough evaluation, therapy, or support strategies to address issues.

Postpartum Mental Health, Depression Screening, and Treatment

- Many women discussed feeling overwhelmed and having issues with postpartum depression, anxiety, or rage.
- Many women also noted having pre-existing depression and anxiety, which worsened during pregnancy and the postpartum period.
- Lack of mental health screening and support for postpartum depression and anxiety.
- Participants described examples where postpartum depression screenings were inconsistent or incomplete, such as the use of paper forms for screening without any follow-up or referrals.
- Few were referred to mental health services after traumatic births or complications.
- Some mothers described being dismissed, not taken seriously, or feeling stigmatized when disclosing postpartum depression or anxiety.
- Issues were compounded for new mothers in unhealthy relationships with their partner or who felt unsupported by their partner.
- Stigma and the fear of child protective services was a deterrent from seeking help.

Peer and Community Support

- Peer support and community-based emotional support are highly valued, including creating spaces and opportunities for new mothers to connect, share experiences, and decompress.
- Strong desire for more support groups, including “Mommy and Me” activities and informal gatherings.

Father Involvement

- Father participants expressed they were unaware of postpartum mental health issues until witnessing them firsthand in their families.
- They shared they were unprepared for the emotional toll of the postpartum period on their partners and themselves and called for education during pregnancy to raise awareness.

“Yeah, I think I had a little bit of depression with my first. I cried a lot. I had more rage with my second. I remember saying to my husband that I was envisioning myself throwing her across the room. [*Crying*] It was really shameful. I would have never told my doctor. Of course, I knew enough to put her down and walk away. You just don't know that a lot of people have those thoughts. I was fortunate I have friends that I can talk to about it that validated those feelings. I imagine women without a support system wouldn't know what to do with that. My husband was supportive, but I remember he said like, 'No, you psycho.' I was like, 'I'm not a psycho.' It was a bad time. It wasn't great.”

“I will say, I had a high-risk pregnancy 'cause she was small, so they sent me to Mobile, really, for no reason, ... I don't have a car, transportation, or anything. It was kinda hard finding transportation. ... It was almost four hours. ... Transportation was really hard to getThey gave me information to a bus that will take me – and it was free. It was stressful having to go to appointments in [*City*], then Mobile. I went to Mobile four times..... They told me the same thing every time, just that she was below percentile. It was stressful. ... I felt that they didn't hear me. I changed doctors towards the end of my pregnancy.”

“A lot of times when I was pregnant with her, I didn't want to be pregnant yet. That was my biggest thing – I did not want to be pregnant yet. That was a huge toll on me. I was sitting there telling them 'I don't want to do this. I don't want to be pregnant. I don't know how to handle this.' ... With him [*my partner*], I was constantly waking up 'cause I had claustrophobia, I was getting sick all the time. It was awful. I never knew that I was getting sick because I was so badly depressed. It was every night. I was waking up 'cause I couldn't breathe. I was feeling like everything was closing in. I tried to talk to him about it, and he just wanted to go back to sleep 'cause he was workin'. He didn't know it was that bad until I was at the [*hospital facility name*]. They looked at me and they're like, 'Well, has anything crossed your mind about hurting yourself?' I said, 'Yeah. Yeah, I really want to hurt myself.' ”

“I think also, it's [*mental health treatment*] not even always accessibility, but as moms, you're not – people will say they're encouraging you to seek out help, especially for mental health with anxiety and depression. There's always that stigma of, 'Is DHR about to get involved? Are my kids about to be taken from me? What can I say that's not gonna cost me my kids?' If we seek that help, if we say, 'OK, look, I'm at a point where I can't anymore,' are my kids gonna be home when I get there? Or are they gonna be with strangers? It's very stigmatized, the mental health situation for women.”

“Well, on one my children [*I*] did not have a good experience because the doctor that I had, he was strict. It was basically like, 'Take the pain. You laid there and did it.' That's what he say. 'If you laid there and did it, gonna have to take the pain.' ”

“Like she said, we were already diagnosed with depression. Then when you have a baby, they automatically are like, 'Oh, it's postpartum.' It's like, 'No, it's not. I've already had depression, I'm sad. This is not just helping. This is making it 10 times more enhanced.' ”

Perinatal/Infant Health

The table below presents the **need topics** that were identified for perinatal/infant health in Alabama presented in rank-order based on the summed average score from all raters during Phase One of the prioritization process.

Rank	Need Topic	Average Phase One Score
1	Safe Sleep Environment	13.04
2	Infant Mortality	12.48
3	Access to Comprehensive Health Care	11.67
(tie)	Access to Labor and Delivery Hospitals	11.67
5	Breastfeeding Education and Supports	11.48
6	Affordable, Quality Childcare	10.48

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **Perinatal/Infant Health-specific report**, which begins on the next page.

Selected State Priority Need and Aligned Measure

During Phase Two of the prioritization process, “**Infant Mortality**” was selected as the state priority need for the Perinatal/Infant Population Health Domain for the 2025-2030 Title V MCH Block Grant cycle.

One measure was aligned to track performance in addressing this need.

National Performance Measure: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep

Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State’s public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

The Alabama Department of Public Health partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. The Alabama Network of Family Resource Centers partnered to support focus groups.

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	
Key MCH indicators provided to states.	936 Responses (Online, English & Spanish) Role (Respondents could select all that apply.) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups (1 in Spanish) <u>Data Access:</u> 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups (1 in Spanish)	

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topic	Key Findings	Statewide Survey ¹	Focus Groups, Listening Sessions, & Key Informant Interviews	Federally Available Data ²
Breastfeeding Education and Supports	<ul style="list-style-type: none"> • Lack of, lack of awareness of, or unequal access to breastfeeding education and supports. • Inconsistent breastfeeding supports immediately following delivery. 	X	X	X
Access to Comprehensive Health Care	<ul style="list-style-type: none"> • Lack of or unequal access to comprehensive, respectful healthcare, including well visits, developmental screening, and specialty care. 	X	X	No FAD indicator
Access to Labor and Delivery Hospitals	<ul style="list-style-type: none"> • Lack of or unequal access to labor and delivery hospitals. 	X	X	No FAD indicator
Affordable, Quality Childcare	<ul style="list-style-type: none"> • Lack of or unequal access to affordable, quality childcare. 	X	X	No FAD indicator
Infant Mortality	<ul style="list-style-type: none"> • Concerning levels, trends, and unequal outcomes related to infant mortality, including associated conditions (pre-term birth, low birth weight). 	X		X
Safe Sleep Environment	<ul style="list-style-type: none"> • Undesirably low levels of infants being placed in a safe sleep environment, with unequal observance among groups. • Increased difficulty in meeting some measures of safe sleep environment, including separate sleep surface without soft objects/loose bedding, with unequal observance among groups. • Concerning levels and unequal outcomes related to SUID mortality. 			X

¹ Ranking in Top 5 issue list for any respondent role group.

² A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

Statewide Survey

Out of 484 responses to this section of the survey, the following issues were ranked as concerns affecting perinatal/infant health in Alabama. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³			
	ADPH Employee	Family	Partner	Medical Provider
Access to a Labor and Delivery Hospital	5 th	6 th	5 th	8 th
Affordable Day-Care Providers	1 st	1 st	1 st	1 st
Breastfeeding	7 th	4 th	7 th	5 th
Family Violence and Neglect	8 th	9 th	8 th	9 th
Having a Doctor or Provider Who Knows You (Medical Home)	9 th	7 th	9 th	6 th
Infant Mortality/Death	3 rd	5 th	4 th	4 th
Qualified Day-Care Providers	4 th	3 rd	3 rd	3 rd
Regular Doctor Well-Visits/Developmental Screening	2 nd	2 nd	2 nd	2 nd
Safe Sleep	6 th	8 th	6 th	7 th

³Based on number and percentage of respondents who selected issue as one of top five concerns.

Write-In Concerns: Assistance (financial and mental health) for families with infants in NICU, car seat safety, infant development education, mental health and crisis supports for parents, midwifery and doula services, paid parental leave, postpartum education and supports, reproductive rights and choices, substance use

Federally Available Data

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures			
Breastfeeding – Initiation ⁴	75.0% ⁱⁱ	Worse (lower)	Increasing (improving)
Breastfeeding - Exclusive to 6 Months ⁵	26.8% ⁱⁱⁱ	Comparable	Increasing (improving)
Safe Sleep - Back Sleep Position ⁶	74.5% ^{iv}	Worse (lower)	Increasing (improving)
Safe Sleep - Separate Approved Sleep Surface ⁷	28.1% ^{iv}	Worse (lower)	Increasing (improving)
Safe Sleep - No Soft Bedding ⁸	65.9% ^{iv}	Worse (lower)	Increasing (improving)
Developmental Screening (9-35 months) ⁹	29.1% ⁱⁱⁱ	Comparable	Increasing (improving)
Childhood Vaccination (combined 7 series) ¹⁰	63.7% ^v	Worse (lower)	Decreasing (worsening)
Risk-Appropriate Perinatal Care ¹¹	87.5% ⁱⁱ	Not available	Stable
Standardized Measures			
Early Prenatal Care ¹²	71.3% ⁱⁱ	Worse (lower)	Decreasing (worsening)
National Outcome Measures			
Low Birth Weight ¹³	10.4% ⁱⁱ	Worse (higher)	Stable
Preterm Birth ¹⁴	12.9% ⁱⁱ	Worse (higher)	Stable
Infant Mortality ¹⁵	7.8 per 1,000	Worse (higher)	Increasing (worsening)
SUID Mortality ¹⁶	175.4 per 100,000	Worse (higher)	Stable

Color Key: ■ = statistically worse ■ = statistically better ■ = concerning trend

ⁱData and analyses provided to states by Maternal and Child Health Bureau (<https://mchb.tvisdata.hrsa.gov/Home/FADDdocuments>)

ⁱⁱNational Vital Statistics System (NVSS 2022, 2023)

ⁱⁱⁱNational Survey of Children’s Health (NSCH 2022-2023)

^{iv}Pregnancy Risk Assessment Monitoring System (PRAMS 2023)

^vNational Immunization Survey supplemented with CDC ChildVaxView (2021); <https://www.cdc.gov/childvaxview/about/interactive-reports.html>

Federally Available Data (continued)

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes
4	HS graduate or less; Medicaid, uninsured; <25 years; Black, Hispanic; WIC participant (proxy for lower income)
5	Less than college graduate; Medicaid; <100% Federal Poverty Level (FPL)
6	Less than college graduate; Medicaid; Black, Hispanic
7	Less than HS graduate; Medicaid; <20 years; Black, Hispanic; WIC participant
8	Less than HS graduate; Medicaid; <25 years; Black, Hispanic; WIC participant
9	Less than HS graduate; Medicaid; Black; <200% FPL
10	Medicaid; Black, Hispanic; <100% FPL
11	Data not available
12	Less than college graduate; Medicaid; Uninsured; <25 years; Black; Hispanic; Non-Metro
13	Less than college graduate; Medicaid; <20 years; 35+ years; Black
14	Less than college graduate; Medicaid; 35+ years; Black
15	Medicaid; Black; Hispanic
16	Less than college graduate; Medicaid; <25 years

Focus Groups, Listening Sessions, Key Informant Interviews, and Survey Write-In Comments

Themes	Summary
Access to Pediatric Healthcare	<ul style="list-style-type: none"> • Lack of pediatric specialists, especially in rural areas. • Long wait lists and delays in getting appointments and care. • Many services, especially specialty care, required long travel distances to access in larger cities, which created challenges with transportation and time away from work and school.
Breastfeeding Experiences and Supports	<p>Breastfeeding Experiences</p> <ul style="list-style-type: none"> • Breastfeeding was described as physically painful and emotionally exhausting, especially without support. • Women discussed the emotional and physical toll of breastfeeding without adequate support. • Some described being “terrified” or being afraid about breastfeeding, and many said they felt unprepared for breastfeeding challenges. • Women also expressed feeling guilty or anxious if they struggled or chose to stop breastfeeding. • Lack of nursery services in hospitals was seen as a barrier to successful breastfeeding, as new mothers were expected to care for newborns immediately and continuously, even when exhausted post-delivery. This contributed to fatigue and stress, making breastfeeding more difficult. • Women described inconsistent access to lactation consultants and mixed experiences.

	<ul style="list-style-type: none"> • Some women felt that they received helpful lactation support at bedside with follow-up instruction and support. • Some women shared that the supports received from lactation consultants felt rushed or poorly timed, often happening when they were immediately post-delivery and potentially waking from anesthesia. • Some women shared that they felt pressured by hospital staff to breastfeed, which created stress and discomfort. • Some felt unsupported in their attempts to breastfeed, both in the hospital and when they returned home. Some did not have family members who had ever breastfed and were unaware of or unable to access breastfeeding supports. • Women shared that lack of paid family leave and needing to go back to work soon after delivery were barriers to breastfeeding. <p><u>Breastfeeding Education and Supports</u></p> <ul style="list-style-type: none"> • During many focus groups, women who had previously breastfed shared resources, tips, and ideas with other women in the group who were pregnant or attempting to breastfeed. This was a naturally occurring conversation and support within the group, even among women who were not familiar with each other. • Women shared that they wanted more <i>prenatal</i> education about what to expect related to breastfeeding. Having this education prior to delivery was seen as a way to prepare ahead. • Tools like the WIC Pacify app and breast pumps from health departments were appreciated but not universally available or women were not aware of them. • Some women were unaware of available resources, such as lactation consultants or WIC support. • Access to these resources was inconsistent and often discovered through word-of-mouth rather than proactive outreach.
<p>Childcare</p>	<ul style="list-style-type: none"> • Women and father participants described a lack of affordable, flexible, and quality childcare options in general. • Many described the lack of or limited choices for childcare options, with limited slots, long waitlists, limited hours, and high costs. • Participants discussed a lack of flexible childcare, especially for non-traditional hours/night shifts and irregular work schedules. • Many noted increased difficulty in finding childcare for infants and toddlers. • Many also had lack of trust in the quality and safety of available childcare providers, especially for infants and young toddlers who are not yet verbal.

	<ul style="list-style-type: none"> • Participants described relying on an informal network of family members, older children, or neighbors for childcare. While helpful, these arrangements were often unreliable or unsustainable, especially for working parents or those without extended family nearby. • Participants shared that lack of childcare prevented or limited parents from working or created a barrier to employment and economic stability. • They also shared that lack of childcare prevented or limited their ability to attend health appointments and participate in education and support groups.
<p>Safe Sleep</p>	<ul style="list-style-type: none"> • This topic did not naturally emerge in discussions. • When prompted, one young mother mentioned her child’s pediatrician teaching her about safe sleep. • One focus group site shared that an interested physician (from another large city where local women went for pregnancy care) led an education session on safe sleep one time per year and cribs were made available at this time.

Quotes

“It's no childcare facility in this area. It's pretty hard for the young generation, or anybody, that's lookin' for employment or anything. We don't have resources for childcare. If it's not your auntie, grandma, mama watchin' 'em and you payin' them, it's not any childcare resources out there in this area. It's hard for childcare.”

“You want to be able to trust the person that's with your baby in your home. It's so diYicult because my husband doesn't want him to go to daycare until he can talk. I'm OK with that. OK, that's fine Once he goes to daycare, well, then that's an additional cost that's comin' out of our pocket to try to make sure – what's the point of me even working? 'Cause my paycheck's going to daycare. Yeah, well, I might as well be a stay-at-home mom because now my money that I'm making means nothing because it's going to daycare. So, what's the point?....Not only do we need more aYordable daycare, because obviously, but also the daycare workers need to get paid more because you need good people at the daycare.”

“I had an emergency C-section 'cause his heart rate was dropping. I planned to breastfeed. He had to go to the NICU because he had some stuY goin' on. My husband was with me, but my mom had passed at this point. ...They take me after I had a C-section..... I'm still loopy. It's like two hours after, the breastfeeding lady came in, and I was falling asleep while she's talking to me. She keeps telling me stuY, and I'm like, 'I don't know what's happening. I'm falling asleep.' Nobody's in the room with me 'cause they're down with [son's name]. I'm not able to stay awake, or nobody else is there to listen on what is being said. With him being in the NICU, I didn't even try because I don't know what she said. I don't know what happened. When got down in the NICU, there was no place for me to breastfeed privately in the NICU, and so I just pumped. I pumped for about six to eight weeks. I should have done that longer, but the reason I couldn't is because, once again, my mom's not there. I'm having to deal with a newborn while also trying to pump. I really should have breastfed, but I was like, 'I don't even know how to start, 'cause I don't remember what that woman said.' There was so much happening at once that I wish that I could have done – I wish I could have breastfed. Just the circumstances, I was too overwhelmed to even try.”

I think there's somewhat of a generational diYerence – at least in my experience. I remember having the same experience as she did. I wanted my first oY of me. She touched me all the time. I dealt with post-partum rage with both of mine. Also with the breastfeeding experience, my mom didn't breastfeed. She took formula. I remember feeling very pressured because I'm more of a Type A person. I wanted to breastfeed, and I was gonna make it work. Even though she was supportive, I felt like any time I tried to talk about why I was struggling it and the emotions I was having about it, not knowing what to do, I was uneducated 'bout it as well. Everybody was just like, 'Why do you really want to breastfeed? Why not just give it up? This isn't working.' ”

“Yes, they had one [*lactation consultant*] come in, and I'm still on the table getting fixed up here. The lady's comin' in there and showin' me how to breastfeed. I'm like, 'Lady, I'm not even in the world, really.' Yes, just had her, and they're coming in there tryin' to show me how to pump. I'm like, 'That's the least of my worries right now.' She did come back later. I was like, 'Can you get her to come back?' 'Cause I wasn't really there, explaining. She explained it good. When I got home, it didn't do what it was supposed to do. I think I called the doctor or the nurse that was online – or on call or whatever. She tried to walk me through it. It just wasn't for me.”

“I went to a lactation class in Birmingham at six weeks. That was the first time that I felt like I was doing it right. Because I went to the class where they weighed. I fed her, and in my mind, I was like, 'I know she's not drinking enough. I'm not producing what I'm supposed to. Everybody else produces more.' Then she weighed her, and I was so mesmerized that she had eaten three ounces. I was like, 'There's no way.' That was exactly the amount that she needed. I just didn't under – it's exactly what you said. What your body is supposed to do, it's doing what it needs to do. You just have to give it time. If I hadn't gone to that class, I probably would have given it up.

Child Health

The table below presents the **need topics** that were identified for child health in Alabama presented in rank-order based on the summed average score from all raters during Phase One of the prioritization process.

Rank	Need Topic	Average Phase One Score
1	Food SuAiciency	12.33
2	Childhood Vaccinations	11.83
3	Mental Health and Behavioral Treatment and Supports	11.67
4	Access to Preventive Dental Visits for Children and Adolescents	11.00
5	Child Mortality	10.83
(tie)	Housing Instability	10.83
7	AAordable, Quality Childcare	10.50
(tie)	Bullying and School Safety	10.50
9	Access to Comprehensive Health Care	10.00
10	Cell Phone/Social Media Usage	9.83
11	Exposure to Smoking in Household	9.67
(tie)	Obesity	9.67

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **Child Health-specific report**, which begins on the next page.

Selected State Priority Need and Aligned Measure

During Phase Two of the prioritization process, “**Access to Comprehensive Health Care**” was selected as the state priority need for the Child Population Domain for the 2025-2030 Title V MCH Block Grant cycle.

One measure was aligned to track performance in addressing this need.

National Performance Measure: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

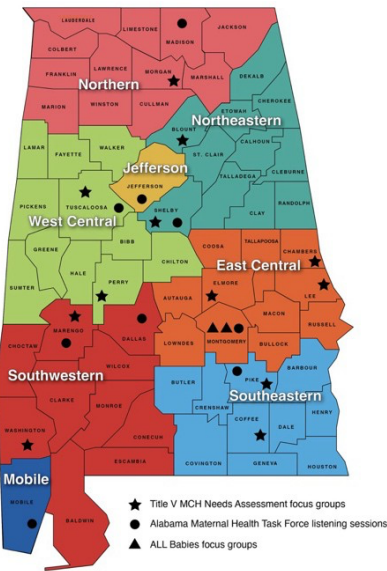
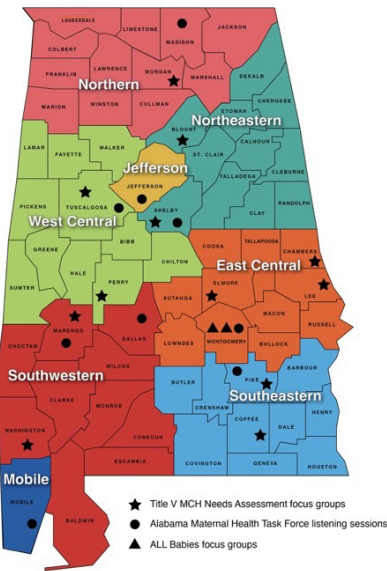
Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation's families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State's public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

The Alabama Department of Public Health partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. The Alabama Network of Family Resource Centers partnered to support focus groups.

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	 <p> ★ Title V MCH Needs Assessment focus groups ● Alabama Maternal Health Task Force listening sessions ▲ ALL Babies focus groups </p>
Key MCH indicators provided to states.	936 Responses (Online, English & Spanish) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups <u>Data Access:</u> 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups	 <p> ★ Title V MCH Needs Assessment focus groups ● Alabama Maternal Health Task Force listening sessions ▲ ALL Babies focus groups </p>

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topic	Key Findings	Statewide Survey ¹	Focus Groups & Listening Sessions	Federally Available Data ²
Food Sufficiency	Concerning and unequal levels of food sufficiency for children.		X	X
Housing Instability	Concerning and unequal levels of housing insufficiency for children.		X	X
Childhood Vaccinations	Decreasing (worsening) and unequal levels of childhood vaccinations.		X	X
Access to Preventive Dental Visits for Children and Adolescents	Lack of or unequal access to preventive dental visits for children and adolescents, especially in rural areas and for those with Medicaid insurance.			X
Child Mortality	Concerning levels, trends, and unequal outcomes related to child mortality.			X
Obesity	Concerning levels and unequal outcomes related to child and adolescent obesity.	X		X
Bullying and School Safety	Increased concerns about experiences of bullying, including in school settings.	X		No FAD indicator
Mental Health and Behavioral Treatment and Supports	Lack of, lack of awareness of, or unequal access to comprehensive mental health and behavioral health treatment and supports for children.	X	X	No FAD indicator
Affordable, Quality Childcare	Lack of or unequal access to affordable, quality childcare.	X	X	No FAD indicator
Access to Comprehensive Health Care	Lack of or unequal access to comprehensive health care, including well visits and developmental screening.	X	X	No FAD indicator
Cell Phone/Social Media Usage	Excessive use of cell phones and social media.	X	X	No FAD indicator
Exposure to Smoking in Household	Concerning levels and unequal outcomes related to exposure to smoking in the household for children and adolescents.			X

¹Ranking in Top 5 issue list for any respondent role group.

² A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

Statewide Survey

Out of 534 responses to this section of the survey, the following issues were ranked as concerns affecting child health in Alabama. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³			
	ADPH Employee	Family	Partner	Medical Provider
Bullying	2 nd	2 nd	2 nd	2 nd
Family Violence and Neglect	10 th	8 th	9 th	12 th
Gun Violence	15 th	11 th	12 th	10 th
Having a Doctor or Provider Who Knows You (Medical Home)	14 th	10 th	11 th	9 th
Mental Health/Behavioral Issues and Treatment	1 st	1 st	1 st	1 st
Obesity/Overweight	3 rd	9 th	7 th	3 rd
Qualified Child-Care/Day-Care Providers	7 th	3 rd	3 rd	4 th
Regular Dental Visits	6 th	7 th	6 th	8 th
Regular Doctor Well-Visits/Developmental Screening	5 th	5 th	5 th	6 th
Risky Sexual Behaviors (unprotected sex, multiple sex partners, STD/STIs, etc.)	12 th	14 th	14 th	15 th
School Safety	8 th	4 th	8 th	7 th
Staying Active/Physical Activity	9 th	12 th	10 th	11 th
Substance Use (alcohol, drugs, etc.)	11 th	13 th	13 th	13 th
Tobacco and Vaping	13 th	15 th	15 th	14 th
Use of Cell Phone/Social Media	4 th	6 th	4 th	5 th

³Based on number and percentage of respondents who selected issue as one of top five concerns.

Write-In Concerns: Community supports; health and sexual health education; early intervention services; educational services and specialty supports for children with special needs; nutrition

Federally Available Data

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures			
Food Sufficiency – 0-11 years ⁴	61.8% ⁱⁱ	Worse (lower)	Decreasing (worsening)
Housing Instability – 0-11 years ⁵	20.5% ⁱⁱ	Worse (higher)	Increasing (worsening)
Developmental Screening (9-35 months) ⁶	29.1% ⁱⁱ	Comparable	Increasing (improving)
Childhood Vaccination (combined 7 series) ⁷	63.7% ⁱⁱⁱ	Worse (lower)	Decreasing (worsening)
Preventive Dental Visit – Child ⁸	80.5% ⁱⁱ	Comparable	Stable
Physical Activity – Child ⁹	30.6% ⁱⁱ	Better (higher)	Decreasing (worsening)
Medical Home – All Children ¹⁰	50.9% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children Care coordination ¹¹	71.9% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children Personal doctor or nurse ¹¹	73.6% ⁱⁱ	Comparable	Stable
Medical Home – All Children Usual source of sick care ¹¹	79.2% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children Family-centered care ¹¹	84.7% ⁱⁱ	Comparable	Stable
Medical Home – All Children Referrals ¹¹	78.6% ⁱⁱ	Comparable	Stable
Standardized Measures			
Smoking – Household ¹²	13.9% ⁱⁱ	Worse (higher)	Decreasing (improving)
Adequate Insurance – 0-17 years ¹³	74.6% ⁱⁱ	Better (higher)	Stable
MMR Vaccination ⁶	93.8% ⁱⁱⁱ	Comparable	Stable
Flu Vaccination ⁶	43.0% ⁱⁱⁱ	Worse (lower)	Decreasing (worsening)
National Outcome Measures			
Child Mortality ¹⁴	24.8 ^{iv} per 100,000	Worse (higher)	Increasing (worsening)
Obesity – 6-17 years ¹⁵	22.8% ⁱⁱ	Worse (higher)	Stable

Federally Available Data (continued)

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes
4	6-11 years; Black; 0-199% Federal Poverty Level (FPL); less than college graduate; CSHCN; Medicaid
5	Black; 0-199% FPL; less than college graduate; CSHCN; Medicaid
6	Data not available
7	Medicaid; Hispanic; <100% FPL
8	1-5 years; Medicaid; uninsured; 0-199% FPL
9	None in available data
10	Medical Home: Black; Hispanic; language other than English; 0-199% FPL; HS graduate or less; CSHCN; CSHCN with more complex health needs; Medicaid; uninsured
11	Limited data; none or unable to determine
12	HS graduate or less; Medicaid; uninsured; less than 400% FPL
13	12-17 years; CSHCN; private insurance
14	1-4 years; Black; male
15	6-11 years; Black; 0-199% FPL; less than college graduate; Medicaid

Color Key: ■ = statistically worse ■ = statistically better ■ = concerning trend

ⁱData and analyses provided to states by Maternal and Child Health Bureau (<https://mchb.tvisdata.hrsa.gov/Home/FADDdocuments>)

ⁱⁱNational Survey of Children's Health (NSCH 2022-2023)

ⁱⁱⁱNational Immunization Survey supplemented with CDC ChildVaxView (2021; <https://www.cdc.gov/childvaxview/about/interactive-reports.html>)

^{iv}National Vital Statistics System (NVSS 2022, 2023)

Focus Groups, Listening Sessions, and Survey Write-In Comments

Themes	Summary
Access to Comprehensive Health Care	<ul style="list-style-type: none"> • Lack of pediatricians, dentists, and specialty care providers, specifically in rural areas, requiring travel to larger cities in Alabama, such as Birmingham and Montgomery. • Participants expressed concern about rushed visits, inconsistent providers, long wait lists for appointments, and lack of trust in urgent care settings. • Some parents reported being denied care or receiving substandard treatment based on insurance type or immigration issues. • Some were told their children were “too young” for autism screening despite clear concerns. • Some families mentioned challenges in accessing specialty care providers and related services for children with health concerns or special health care needs.
Childhood Vaccinations	<ul style="list-style-type: none"> • Pediatricians were generally proactive with reminders for well-child visits and vaccinations. • Some parents reported confusion or concern about duplicate vaccinations or rushed procedures.
Mental Health and Behavioral Treatment and Supports	<ul style="list-style-type: none"> • Lack of access to developmental evaluations or behavioral health screenings for young children. • Unequal access to early intervention programs and IEP support in school-based settings. • Emphasis on the need for trauma-informed care and culturally competent mental health and behavioral health providers.
Affordable, Quality Childcare	<ul style="list-style-type: none"> • Lack of affordable, quality, flexible childcare is considered a major challenge for parents. • Waitlist and limited hours prevent parents from working or attending their own health appointments. • Women and father participants discussed challenges in accessing childcare for people who work non-traditional hours, nightshifts, or have irregular work schedules. • Many noted increased difficulty in finding childcare for infants and toddlers. • Many also had a lack of trust in the quality and safety of available childcare providers, especially for younger children and children who are not yet verbal. • Participants called for more inclusive, accessible early childhood programs.

Quotes

“*[Pediatric clinic name]* ... referred me to specialists in Birmingham, Mobile, even Atlanta ... they'll put in multiple references to see who gets there first.”

“My son had an appointment in November ... no transportation with Kid One ... we had to wait two months.”

“My four-year-old, ... I tried to go to the *[pediatric clinic name]* to get her diagnosed because I believe she's autistic. They're saying that she's too young. I'm like, 'No, she's 4 years old. The way she throws them tantrums, it's crazy. Runnin' into the walls and hittin' herself and everything.' They said, 'No, she's perfectly fine.' I'm like, 'No, no. It's weird. She does this 24/7 every day around the clock.' It's hard because she's only 4, and I'm tryin' to teach her the best way I can, and it's like I'm not getting enough help. I don't know what to do.”

“My child was feeling suicidal at 5 years old ... we were able to get somebody to talk to.”

“They questioned that I was the mother of my child and tried to force me to produce paperwork proving that I was his mother, and I refused. They weren't gonna treat him just because they doubted it. It's none of their business. It doesn't affect his health.”

“I don't think mental health is taken seriously enough for women and for people in poverty and lower-income households and in children. I think there is this idea that kids don't have mental health issues until they're older, and that's just not true.”

Adolescent Health

The table below presents the **need topics** that were identified for adolescent health in Alabama presented in rank-order based on the summed average score from all raters during Phase One of the prioritization process.

Rank	Need Topic	Average Phase One Score
1	Adolescent Mortality	11.83
(tie)	Mental Health and Behavioral Treatment and Supports	11.83
3	Substance Use	11.67
4	Comprehensive Sexual Health Education and Risk Reduction	11.42
5	Physical Activity and Safe Social and Recreational Opportunities	11.17
6	Bullying	10.67
7	Adolescent Well-Visit	10.33
8	Cell Phone/Social Media Usage	10.17
(tie)	Flu Vaccination	10.17
10	Obesity	10.00
11	Transition to Adulthood	9.90
12	Adult Mentor	9.33
13	Exposure to Smoking in Household	8.67

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **Adolescent Health-specific report**, which begins on the next page.

Selected State Priority Need and Aligned Measure

During Phase Two of the prioritization process, a revised need topic “**Adolescent Safety and Wellness,**” was selected as the state priority need for the Adolescent Population Domain for the 2025-2030 Title V MCH Block Grant cycle. This revised need topic combines several of the identified need topics into a broader priority need for adolescents, allowing for a wide range of strategies that address across multiple areas identified for adolescents during the needs assessment.

One measure was aligned to track performance in addressing this need.

National Performance Measure: Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others

Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State’s public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

The Alabama Department of Public Health partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. The Alabama Network of Family Resource Centers partnered to support focus groups.

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	
<p>Key MCH indicators provided to states.</p>	<p>936 Responses (Online, English & Spanish)</p> <p>Role (Respondents could select all that apply.)</p> <p>Families & Individuals = 634</p> <p>Health Care/Health-Related Care Providers = 262</p> <p>Organizational Partners = 399</p> <p>ADPH employees = 298</p>	<p>8 Participants</p> <p>Representatives from multiple partner organizations</p>	<p>12 Focus Groups</p> <p><u>Data Access:</u></p> <p>9 Maternal Task Force Listening Sessions</p> <p>2 ALL-Babies Evaluation Project Focus Groups</p>	

ADOLESCENT

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topic	Key Findings	Statewide Survey ¹	Focus Groups & Listening Sessions	Federally Available Data ²
Comprehensive Sexual Health Education and Risk Reduction	<ul style="list-style-type: none"> Lack of, lack of awareness of, or unequal access to comprehensive sexual health education, including birth control options and family planning services. Concerning levels and unequal outcomes related to teen births. Increased concerns about risky sexual behaviors among youth. 	X	X	X
Mental Health and Behavioral Treatment and Supports	<ul style="list-style-type: none"> Lack of, lack of awareness of, or unequal access to comprehensive mental health and behavioral health treatment and supports for adolescents. 	X	X	X
Adult Mentor	<ul style="list-style-type: none"> Unequal outcomes for youth having adult mentors and positive role models. 		X	X
Cell Phone/Social Media Usage	<ul style="list-style-type: none"> Excessive use of cell phones and social media. 	X	X	No FAD indicator
Physical Activity and Safe Social and Recreational Opportunities	<ul style="list-style-type: none"> Lack of or unequal access to safe social and recreational opportunities, including options for physical activity. 		X	X
Substance Use	<ul style="list-style-type: none"> Increased concerns about youth substance use, including alcohol, drugs, and vapes. 	X	X	No FAD indicator
Adolescent Mortality	<ul style="list-style-type: none"> Concerning levels and unequal outcomes related to adolescent mortality, including motor vehicle death. 			X
Adolescent Well-Visit	<ul style="list-style-type: none"> Worsening trend and unequal outcomes related to receipt of adolescent well-visit. 			X
Bullying	<ul style="list-style-type: none"> Increased concerns about experiences of bullying, including in school settings and for specific groups of youth. 	X		X
Exposure to Smoking in Household	<ul style="list-style-type: none"> Concerning levels and unequal outcomes related to exposure to smoking in the household for children and adolescents. 			X
Flu Vaccination	<ul style="list-style-type: none"> Concerning levels and worsening trends for receipt of flu vaccination. 			X
Obesity	<ul style="list-style-type: none"> Concerning levels and unequal outcomes related to child and adolescent obesity. 			X
Transition to Adulthood	<ul style="list-style-type: none"> Lack of education and support for adolescents transitioning from pediatric care to adult health care. Lack of education and support for adolescents to prepare for transitioning to adulthood and independence in general. 		X	X

¹ Ranking in Top 5 issue list for any respondent role group.

² A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

Statewide Survey

Out of 450 responses to this section of the survey, the following issues were ranked as concerns affecting adolescent health in Alabama. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³			
	ADPH Employee	Family	Partner	Medical Provider
Access to Adult Mentor/Positive Role Model	9 th	10 th	9 th	8 th (tie)
Access to Contraceptives	10 th	9 th	10 th	10 th
Bullying	5 th	4 th	6 th	6 th
Education About Birth Control Options/Family Planning Services	2 nd	2 nd	3 rd	3 rd
Family/Partner Violence and Neglect	18 th	18 th	17 th	18 th
Gun Violence	8 th	7 th	7 th	8 th (tie)
Having a Doctor or Provider Who Knows You (Medical Home)	17 th	17 th	18 th	14 th
Mental Health/Behavioral Issues and Treatment	3 rd (tie)	1 st	1 st	1 st
Obesity/Overweight	11 th	14 th	13 th	11 th
Regular Dental Visits	12 th (tie)	12 th	12 th	12 th
Regular Doctor Well-Visits/Developmental Screening	12 th (tie)	15 th	15 th	16 th
Risky Sexual Behaviors (unprotected sex, multiple sex partners, STD/STIs, etc.)	1 st	6 th	5 th	5 th
School Safety	12 th (tie)	11 th	11 th	13 th
Staying Active/Physical Activity	15 th	16 th	16 th	17 th
Substance Use (alcohol, drugs, etc.)	3 rd (tie)	5 th	2 nd	2 nd
Tobacco and Vaping	7 th	8 th	8 th	7 th
Transition to Adult Health Care	16 th	13 th	14 th	15 th
Use of Cell Phone/Social Media	6 th	3 rd	4 th	4 th

³Based on number and percentage of respondents who selected issue as one of top five concerns.

Write-In Concerns: Affordable family-friendly activities; anger management; autonomy in healthcare decisions; comprehensive sexual health education; eating disorders and treatment options; gun safety; guidance on how to research and interpret information to make healthy choices; life skills education (money management, self-care); recreational activities and social engagement; transgender health/mental health supports

Federally Available Data

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures			
Adolescent Well-Visit ⁴	70.0% ⁱⁱ	Comparable	Decreasing (worsening)
Adult Mentor ⁵	90.0% ⁱⁱ	Comparable	Stable
Mental Health Treatment, if needed ⁵	81.6% ⁱⁱ	Comparable	Decreasing (worsening)
Bullying – Victimization ⁶	33.5% ⁱⁱ	Comparable	Stable
Transition to Adult Healthcare ⁷	17.2% ⁱⁱ	Comparable	Increasing (improving)
Medical Home – All Children ⁸	50.9% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children ⁹ Care Coordination	71.9% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children Personal doctor or nurse ⁹	73.6% ⁱⁱ	Comparable	Stable
Medical Home – All Children Usual source of sick care ⁹	79.2% ⁱⁱ	Better (higher)	Stable
Medical Home – All Children Family-centered care ⁹	84.7% ⁱⁱ	Comparable	Stable
Medical Home – All Children Referrals ⁹	78.6% ⁱⁱ	Comparable	Stable
Standardized Measures			
Physical Activity – Adolescent ¹⁰	11.1% ⁱⁱ	Comparable	Decreasing (worsening)
Smoking – Household ¹¹	13.9% ⁱⁱ	Worse (higher)	Decreasing (improving)
Adequate Insurance – 0-17 years ¹²	74.6% ⁱⁱ	Better (higher)	Stable
HPV Vaccination ¹³	79.0% ⁱⁱⁱ	Comparable	Increasing (improving)
Flu Vaccination ¹⁴	43.0% ⁱⁱⁱ	Worse (lower)	Decreasing (worsening)

Color Key: = statistically worse = statistically better = concerning trend

Federally Available Data (continued)

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Outcome Measures			
Adolescent Mortality ¹⁵	53.7 ^{iv} per 100,000	Worse (higher)	Mixed
Adolescent Motor Vehicle Death ¹⁶	19.8 ^{iv} per 100,000	Worse (higher)	Decreasing (improving)
Adolescent Suicide ¹⁷	7.3 ^{iv} per 100,000	Comparable	Increasing (worsening)
Teen Births ¹⁸	24.8 ^{iv} per 1,000	Worse (higher)	Decreasing (improving)
Adolescent Depression/Anxiety ¹⁹	15.8% ⁱⁱ	Better (lower)	Increasing (worsening)
Obesity – 6-17 years ²⁰	22.8% ⁱⁱ	Worse (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes
4	Hispanic; <100% Federal Poverty Level (FPL); less than college graduate; non-CSHCN; Medicaid
5	Less than 400% FPL; born outside U.S.; female
6	Female; LGB; CSHCN
7	Female; Medicaid
8	Medical Home: Black; Hispanic; language other than English; 0-199% FPL; HS graduate or less; CSHCN; CSHCN with more complex health needs; Medicaid; uninsured
9	Limited data; none or unable to determine
10	Female
11	HS graduate or less; Medicaid; uninsured; less than 400% FPL
12	12-17 years; CSHCN; private insurance
13	White; private insurance
14	Data not available
15	15-19 years; Black; male
16	Male
17	White; male
18	18-19 years; Black; Hispanic
19	White; female; <400% FPL
20	6-11 years; Black; 0-199% FPL; less than college graduate; Medicaid

ⁱData and analyses provided to states by Maternal and Child Health Bureau (<https://mchb.tvisdata.hrsa.gov/Home/FADDdocuments>)

ⁱⁱNational Survey of Children’s Health (NSCH 2022-2023)

ⁱⁱⁱNational Immunization Survey supplemented with CDC ChildVaxView (2021; <https://www.cdc.gov/childvaxview/about/interactive-reports.html>)

^{iv}National Vital Statistics System (NVSS 2022, 2023, 2021-2023)

Focus Groups, Listening Sessions, and Survey Write-In Comments

<p>Transition to Adulthood</p>	<ul style="list-style-type: none"> • Participants expressed difficulty finding adult providers who accept Medicaid once children age out of pediatric care. • Lack of education and awareness about health insurance, specifically about the importance of health insurance, how to apply, and how to determine the necessary coverage. • Lack of access to dental care after age 19, creating a gap for young adults. • Participants emphasized the need for smoother transitions and continued support for adolescents moving to adulthood. • Participants discussed the need for education and supports to help adolescents prepare for adulthood and independence in general, including financial literacy, managing budgets, finding health insurance, and caring for a home.
<p>Mental Health and Behavioral Treatment and Supports</p>	<ul style="list-style-type: none"> • Lack of access to mental or behavioral health providers for adolescents with behavioral and emotional needs. • Inconsistent support from schools for students who require an IEP or behavioral health plan. • Parents reported feeling “dismissed” or “blamed” for their child’s behavior rather than supported.
<p>Comprehensive Sexual Health Education and Risk Reduction</p>	<ul style="list-style-type: none"> • Lack of comprehensive education on sexual health, personal hygiene, and life skills. • Mentorship programs were seen as critical to helping teens navigate peer pressure and risky behaviors, including sexual choices and substance use. • Parents emphasized the importance of early, honest conversations about mental health, substance use, and relationships. • Some participants suggested having more comprehensive health classes in school and having representatives from the health department teach about sexual health.
<p>Physical Activity and Safe Social and Recreational Opportunities</p>	<ul style="list-style-type: none"> • Lack of safe, affordable activities for teens contributed to boredom, isolation, and risky behavior. • Participants requested more community-based programs, youth centers, and peer support groups. • Fathers and mothers alike stressed the need for spaces where teens can be mentored and supported.
<p>Access to Comprehensive Health Care</p>	<ul style="list-style-type: none"> • Lack of pediatric/adolescent primary care and specialty care providers, specifically in rural areas, requiring travel to other major cities in Alabama, such as Birmingham and Montgomery. • Some youth felt that they were not taken seriously by providers and experienced challenges in getting needed services and prescriptions.

Quotes

“I feel like the most pressing thing is stuV for the kids to do, because especially durin’ the summer. They gettin’ into summer – everything, because there’s nothing aimed towards kids, and when we were – when I was a kid, every weekend, we would go to the skatin’ rink and hang out with other kids, and it was always stuV to do – go to the mall with your friend, go to the movies with your – it’s nothing for kids to do, so kids around grown people doin’ stuV that grown people do – and now they’re into stuV earlier than they should be because there’s nothin’ aimed towards children.”

“I think when I was in school, they never talked about consent, and I think that’s a big thing that they should talk about because a lot of people don’t realize how far it goes. If I have to – if you have to ask somebody eight times, they’re not consenting. If they say ‘Yeah’ by the eighth time, that’s still not consent because you forced – not force, but you – They just tryin’ to get you out they face. I feel like it could be taught to kids. You doesn’t have to be around sex to teach consent. You can teach consent in other ways. Like touchin’ and huggin’ and stuV like that and askin’ permission for things before you just snatch somethin’. I feel like people don’t focus on consent enough.”

“I think havin’ a plan as far as someone comin’ in and talkin’ to the young or educate young people more on their bodies and how their body changes and as they get older, how to protect themselves, and not bein’ afraid to talk about these things and ask the right questions. Havin’ more of those conversations – I think just bein’ educated on those things for our young people so that they’re more aware of those things.”

“For teens and young adults, it’s getting diVicult to get the prescriptions and getting some care that you do need. ‘Cause sometimes the doctors won’t take you serious. I’ve had to deal with that most throughout my middle school year, all the way up still to me being a young adult. I’m still dealing with all that.”

“Once you get past 18, you’re just thrown to the wolves.”

“There’s nothing for families to do. They’re doing drugs, getting pregnant because they don’t have anything else.”

CYSHCN

The table below presents the **need topics** that were identified for CYSHCN in Alabama presented in rank-order based on the summed average score from all raters during Phase One of the prioritization process.

Rank	Need Topic	Average Phase One Score
1	Comprehensive Care Coordination and Supports for System Navigation	12.03
2	Access to Health and Health-Related Services and Equipment	12.00
3	Transition to Adulthood	11.57
4	Access to Community Services and Supports	11.26
5	Medical Home	11.16
6	Adequate Insurance and Financial Supports	11.14
7	Special Education Services and Integration into School Systems	11.10
8	Health Teaching and Information Needs	10.71
9	Family and Youth Peer Supports	10.69
10	Transportation and Geographic Isolation	10.38
11	Family and Youth Engagement	10.22
12	Community Factors that Influence Health Outcomes	9.64

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **CYSHCN-specific report**, which begins on the next page.

Selected State Priority Needs and Aligned Measures

During Phase Two of the prioritization process, three state priority needs were selected for the CYSHCN Population Domain for the 2025-2030 Title V MCH Block Grant cycle:

- **“Comprehensive Care Coordination and Supports for System Navigation”**
- **“Transition to Adulthood”**
- **“Family and Youth Peer Supports”**

Three measures were aligned to track performance in addressing these needs.

National Performance Measure: Percent of children with (and without) special health care needs, ages 0 through 17, who have a medical home

National Performance Measure: Percent of adolescents with (and without) special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

State Performance Measure: Percent of children with special health care needs, ages 0-17, whose parent receives emotional support with parenting

Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State’s public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

Children’s Rehabilitation Service partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. Family Voices of Alabama, United Ability, and United Cerebral Palsy-Huntsville partnered to support focus groups.

Federally Available Data (FAD)	Survey	Focus Groups & Listening Sessions	Key Informants	Other Existing Information	Map of Alabama showing survey locations and participation types.
<p>Key MCH indicators provided to states</p> <p>These are National Performance Measures</p>	<p>427 Responses (Online, English & Spanish)</p> <p>Role (Respondents could select all that apply.)</p> <ul style="list-style-type: none"> Parent/Caregiver of CYSHCN = 225 YSHCN = 58 Health Care/Health-Related Care Provider = 86 Teacher/Childcare Provider = 59 Advocacy or Community Support Organization = 36 State Agency Employee = 35 	<p>8 Focus Groups & 2 Listening Sessions</p> <p><u>Focus Groups:</u></p> <ul style="list-style-type: none"> Parents/ Caregivers of CYSHCN – English = 5 Parents/ Caregivers of CYSHCN – Spanish = 1 Youth/ Young Adult with SHCN = 2 <p><u>Listening Sessions:</u></p> <ul style="list-style-type: none"> Alabama Hands and Voices (40+ families of children and teens) CRS State Parent Advisory Committee (20+ Local Parent Consultants and Local Parent Advisory Committee Members) 	<p>9 Participants</p> <ul style="list-style-type: none"> Health and Health-Related Care Providers (rural pediatrician, nurse practitioner, school therapists) Rural Teacher, Secondary Grades Health Care Equipment Vendors Advocacy & Community Organization Sta_ 	<ul style="list-style-type: none"> CRS Transition Survey CRS Care Coordination Survey CRS FESAT Consensus Scoring 	<p>Conducted in Spanish</p> <p>Youth sessions at Youth Leadership Forum (YLF)</p> <p>★ = Local participation</p> <p>★ = Statewide participation</p> <p>* White borders mark CRS districts</p> <p>Children with medical complexity</p>

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topic	Key Findings	Statewide CYSHCN Survey ¹	Focus Groups & Listening Sessions	Key Informant Interviews	Federally Available Data ²	CRS Programmatic Data
Access to Community Services and Supports	<ul style="list-style-type: none"> Inadequate and unequal access to and availability of community services and supports, especially in rural areas. These are services and supports that foster quality of life and engagement in daily activities outside of addressing medical or health care needs, including respite care, recreational opportunities, and childcare programs that are trained to support CYSHCN and willing to accept them. 	X	X	X	No FAD indicator	X
Access to Health and Health-Related Services and Equipment	<ul style="list-style-type: none"> Inadequate and unequal access to and availability of health and health-related services, in-home supports, medical equipment, and supplies, especially in rural areas and for people whose first language is not English. 	X	X	X	No FAD indicator	X
Adequate Insurance and Financial Supports	<ul style="list-style-type: none"> Inadequate insurance, including financial strain from out-of-pocket costs, benefit limits, non-covered items, and complicated processes for approvals and waivers. 	X	X	X	X	
Community Factors that Influence Health Outcomes	<ul style="list-style-type: none"> Unequal experiences of community factors that influence health outcomes, overall and specifically for families of CYSHCN. These are system and community issues that influence health and well-being, including high cost of living, unsuitable housing, lack of housing modifications and accessible homes, financial strain and difficulty maintaining employment, and food insecurity. 		X	X	X	X
Comprehensive Care Coordination and Supports for System Navigation	<ul style="list-style-type: none"> Inadequate or unequal assistance to help families navigate the system of care, including identifying providers, programs, family supports, and community resources. Inconsistent comprehensive care coordination that includes topics beyond health medical needs, including services/supports that address quality of life, engagement in daily activities, and the non-medical drivers of health. 	X	X	X	X	X
Family and Youth Engagement	<ul style="list-style-type: none"> Inconsistent opportunities for families and youth to engage in policymaking and the design, delivery, and evaluation of programs and policies. 		X		No FAD indicator	X

CYSHCN

Family and Youth Peer Supports	<ul style="list-style-type: none"> • Lack of opportunities to create “community” for families, caregivers, and youth. • Lack of peer support – including coping, mental health, and emotional support – and opportunities to learn from each other and share resources. 		X	X	No FAD indicator	
Health Teaching and Information Needs	<ul style="list-style-type: none"> • Lack of (accurate) information about specific conditions and disabilities. Lack of awareness of policies, rights, and processes. • Lack of preparation for families to engage in partnerships with professionals who work with their children/youth and to participate in shared decision-making about their care. 		X	X	No FAD indicator	
Medical Home	<ul style="list-style-type: none"> • Lack of or inadequate access to comprehensive medical homes, including comprehensive care coordination, streamlined referrals, and communication across systems/between providers. • Inconsistent medical provider knowledge about CYSHCN and specific conditions. Inconsistent provision of health care that focuses on overall well-being and quality of life versus clinical care only. • Lack of preparation of the medical provider workforce to provide family-centered care, engage in partnerships with families, and participate in shared decision-making with them about the care of their children. 		X	X	X	
Special Education Services and Integration into School Systems	<ul style="list-style-type: none"> • Insufficient special education services and integration into school systems, including before- and after-school programs, teacher and para-teacher training, unequal accommodations, and truancy/absenteeism policies. 	X	X	X	No FAD indicator	X
Transition to Adulthood	<ul style="list-style-type: none"> • Inadequate supports for transition to all aspects of adulthood, including health care, education, employment, community programs, and independent/supported living. 	X	X	X	X	X
Transportation and Geographic Isolation	<ul style="list-style-type: none"> • Lack of or unequal ability to access health and community services due to lack of transportation and/or geographic location. 		X	X	No FAD indicator	X

¹Ranking in Top 5 issue list for any respondent role group.

²A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

Statewide Survey

Out of 427 total responses, the following issues were ranked as challenges affecting Alabama CYSHCN, their families, and the providers who serve them. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³						
	Overall	Parent/ Caregiver of CYSHCN (n=220)	Youth with SHCN (n=56)	Health Care or Health- Related Care Provider (n=83)	Teacher or Childcare Provider (n=59)	Advocacy or Community Support Organization (n=35)	State Agency Employee (n=35)
Access to community services and supports	1 st	1 st	1 st	2 nd	1 st (tie)	1 st (tie)	1 st (tie)
Quality early childhood programs that are safe and affordable, especially for children with disabilities	2 nd	3 rd	2 nd	1 st	1 st (tie)	1 st (tie)	3 rd (tie)
Help for families to navigate the system of care	3 rd	2 nd	3 rd	3 rd	3 rd	3 rd	1 st (tie)
Special education services	4 th	4 th	6 th	4 th	5 th	8 th	3 rd (tie)
Access to health and related services	5 th	5 th	4 th (tie)	6 th	4 th	4 th	9 th
Transition to adulthood	6 th	6 th (tie)	4 th (tie)	7 th	7 th (tie)	5 th	6 th (tie)
Adequacy of insurance	7 th	8 th	8 th (tie)	5 th	6 th	6 th	10 th (tie)
Accessibility and accommodation supports	8 th	6 th (tie)	7 th	10 th	9 th	7 th	6 th (tie)
Provider workforce that is knowledgeable about CYSHCN	9 th	9 th	8 th (tie)	8 th	7 th (tie)	9 th (tie)	3 rd (tie)
Transportation	10 th	12 th (tie)	11 th (tie)	9 th	10 th	9 th (tie)	6 th (tie)
Integrated technology, medical records, and data to support continuity of care and data-informed decision-making for program planning and evaluation	11 th	10 th	11 th (tie)	12 th	11 th	13 th	10 th (tie)
Shared decision-making and partnerships between families and health-related professionals	12 th	11 th	10 th	14 th	12 th	12 th	12 th
Family and youth involvement and participation in advisory groups, program development, policymaking, and systems-building activities	13 th	12 th (tie)	11 th (tie)	13 th	13 th (tie)	9 th (tie)	13 th (tie)
Comprehensive medical homes	14 th	14 th	11 th (tie)	11 th	15 th	15 th	13 th (tie)
Youth with SHCN not meeting physical activity and nutrition guidelines	15 th	15 th	15 th	15 th	13 th (tie)	14 th	15 th

*Issue list based on needs identified in previous 2020 needs assessment and do not directly match need topics identified in current 2025 needs assessment.

³Based on number and percentage of respondents who selected issue as one of their top five concerns. Yellow highlight identifies Top 5 issue for respondent group.

Federally Available Data

Indicator		Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures				
Food Sufficiency ⁴ (0-11 years)	All	61.8%	Worse (lower)	Decreasing (worsening)
	CYSHCN	54.8%	Worse (lower)	Decreasing (worsening)
Housing Instability ⁵ (0-11 years)	All	20.5%	Worse (higher)	Unavailable
	CYSHCN	29.9%	Worse (higher)	Unavailable
Bullying – Victimization ⁶	All	33.5%	Comparable	Stable
	CYSHCN	47.8%	Comparable	Decreasing (improving)
Transition to Adult Healthcare ⁷	All	15.5%	Comparable	Stable
	CYSHCN	23.2%	Comparable	Increasing (improving)
Medical Home ⁸	All	50.9%	Better (higher)	Stable
	CYSHCN	46.5%	Better (higher)	Increasing (improving)
Medical Home – CYSHCN Personal doctor or nurse ⁹		78.0%	Comparable	Decreasing (worsening)
Medical Home – CYSHCN Usual source of sick care ¹⁰		78.3%	Worse (lower)	Decreasing (worsening)
Medical Home – CYSHCN Family-centered care ¹¹		78.7%	Worse (lower)	Increasing (improving)
Medical Home – CYSHCN Referrals ¹²		75.1%	Better (higher)	Increasing (improving)
Medical Home – CYSHCN Care coordination ¹³		66.0%	Better (higher)	Increasing (improving)
Standardized Measure				
Adequate Insurance ¹⁴ (0-17 years)	All	74.6%	Better (higher)	Stable
	CYSHCN	72.1%	Better (higher)	Stable

Color Key: = statistically worse = statistically better = concerning trend

ⁱData and analyses provided to states by Maternal and Child Health Bureau (<https://mchb.twisdata.hrsa.gov/Home/FADDdocuments>) from the National Survey of Children’s Health (NSCH 2022-2023)

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes ⁱⁱ
4	ALL: 6-11 years; CYSHCN; household education less than college graduate; Medicaid, uninsured; <400% Federal Poverty Level (FPL); Black
5	ALL: 6-11 years; CYSHCN; household education less than college graduate; Medicaid, uninsured; <400% FPL; Black, Hispanic
6	ALL: CYSHCN; household education high school graduate; Medicaid; <100% FPL; female CYSHCN: Medicaid; female
7	ALL: Non-CYSHCN; Medicaid; <100% FPL CYSHCN: Medicaid; <100% FPL (limited data due to sample size)
8	ALL: 0-5 years; CYSHCN; CYSHCN with more complex health needs; household education high school graduate or less; Medicaid; uninsured; <100% FPL; Black, Asian, Hispanic; language other than English CYSHCN: 0-5 years; CYSHCN with more complex health needs; Medicaid; <100% FPL; Black (limited data due to sample size)
9	CYSHCN: Medicaid; <100% FPL; Black (limited data due to sample size)
10	CYSHCN: 0-5 years; Medicaid; <100% FPL; Black (limited data due to sample size)
11	CYSHCN: <100% FPL; Black (limited data due to sample size)
12	CYSHCN: Private insurance; 200-399% FPL (limited data due to sample size)
13	CYSHCN: 0-5 years; private insurance; 200-399% FPL (limited data due to sample size)
14	ALL: 12-17 years; CYSHCN; private insurance

ⁱⁱAnalyses for unequal outcomes for CYSHCN are limited by small sample size in the national dataset. Not all listed outcome differences are statistically significant. All differences are reported to show concerning trends.

Focus Groups and Listening Sessions

<p>Access to Care</p>	<ul style="list-style-type: none"> • <u>Health-Related Services and Equipment</u> <ul style="list-style-type: none"> ○ Access to Health Care Services: Difficulties accessing specialty care (neurologists, nephrologists, adult physicians), therapies (PT, OT, SP, ABA), dental care (especially for children with Medicaid), and autism diagnostic services. ○ Access to Medical Equipment (wheelchairs, gait trainers, assistive communication devices) and Therapies: Frustrating, slow, bureaucratic process, which often requires multiple trips to providers resulting in additional copays and leads to delays in receiving essential services; importance of loaner medical equipment. ○ Access to Medical Supplies: Complex, time-consuming, and inefficient process to obtain monthly supplies creates risk for gaps in essential care. ○ Mental and Behavioral Health Services for CYSHCN: <ul style="list-style-type: none"> ■ CYSHCN often faced additional mental and behavioral health challenges, such as managing emotions, coping with stress, and dealing with social interactions. ■ Inefficient services, long wait lists, and limited availability of specialized care, with limited services outside of crisis care. ○ Mental and Behavioral Health Services and Support for Caregivers: Caregiving burden and financial strain can lead to depression, stress, and feelings of isolation. Need for respite care or breaks for caregivers to care for themselves too. ○ Challenges in Obtaining Services, Equipment, and Supplies: <ul style="list-style-type: none"> ■ Limited providers, long wait times, travel distances, geographic barriers. ■ Copays, insurance coverage issues/lack of coverage, frequent insurance denials, complex paperwork, slow approval processes. ■ Lack of provider awareness. ○ Language Access: Importance of accommodating language needs to support access to care; inconsistent or inadequate interpreter services and translated materials. • <u>Community Services and Supports</u> <ul style="list-style-type: none"> ○ Childcare Challenges: <ul style="list-style-type: none"> ■ Lack of childcare options for CYSHCN – especially with older children – including after-school, summer, and school closure/e-learning days. ■ Lack of training for childcare providers to care for CYSHCN, including tube-feeding, behavioral issues, basic care.
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	<ul style="list-style-type: none"> ■ Some programs are unwilling to take CYSHCN or require paying for a full week to get one day of care. ■ Reliance on individual sitters to provide childcare. ■ Challenges keeping a job due to lack of childcare. ○ Respite Care Needs: Families with medically fragile children struggle to find adequate and affordable respite care options. ○ Limited Recreational Activities: Lack of local recreational activities for CYSHCN to keep children engaged and active.
<p>Adequate Insurance and Financial Supports</p>	<ul style="list-style-type: none"> • Financial Burden: Out-of-pocket expenses for uncovered medical supplies, equipment, therapies, and medicines cause stress, financial strain, and challenges with cost of living. There is a lack of expendable income to purchase what public and private insurance doesn't cover. • Access and Usability Issues: Gaps and barriers to essential care are created by complex paperwork/application processes; insufficient coverage; claim denials (even with accompanying letters of medical necessity); slow approval processes; and delays in receiving services, supplies (including monthly/recurring supplies), and equipment. • Medicaid Challenges: Application for Medicaid waiver and financial assistance programs is complex and time-consuming, requiring extensive paperwork. Medicaid reimbursement rates have not increased since 2012, causing financial strain for providers.
<p>Community Factors that Influence Health</p>	<ul style="list-style-type: none"> • Financial Burden: Families face financial strain and stress due to overall cost of living, made worse by high cost of care, out-of-pocket medical expenses, copays, and items not covered by Medicaid or private health insurance. Despite available assistance, many families still face significant financial burdens. • Work Limitations: Difficulty maintaining employment due to the demands of caring for their children, further impacting financial stability. Limited flexible work options and employers who understand that caring for a CYSHCN often requires parents to take time off work for appointments and illness. • Housing Challenges: Concerns about inadequate housing conditions, long waiting lists for accessible housing, difficulties affording better housing options, and lack of affordability with long waiting lists for housing modifications.
<p>Comprehensive Care Coordination and Supports for System Navigation</p>	<ul style="list-style-type: none"> • Challenges for Families: <ul style="list-style-type: none"> ○ Difficulty coordinating care, navigating complex systems, and ensuring continuity of services. ○ Greater challenges in receiving comprehensive care coordination for children with more medical complexity. <p>(continued on next page)</p>

	<ul style="list-style-type: none"> • System Navigation Issues: <ul style="list-style-type: none"> ○ Lack of clear and timely information, uncertainty about where to seek support, and concerns about knowing what to ask to access services. ○ Concerns about having to “know about” services and resources or “know what to ask” to access services and resources or have questions answered. ○ Concerns about lack of referrals and/or information between programs or resources CYSHCN might qualify for (CRS, EI, VRS, school systems, therapies), which results in “missed opportunities.” • Needs for Improvement: <ul style="list-style-type: none"> ○ Better communication and collaboration among providers, agencies, and community organizations to support families and improve care coordination. ○ Lack of continuity in care and support once students age out of the school system.
<p>Family and Youth Peer Supports and Engagement in Policy</p>	<ul style="list-style-type: none"> • Support for Parents and Caregivers: Emotional and mental health support, community support groups, and peer networks are crucial for parents and caregivers. <ul style="list-style-type: none"> ○ Feelings of isolation and stress and the need for breaks. ○ Struggles with managing their own mental health while caring for their children. ○ Comfort in sharing experiences with others who understand parent/caregiver challenges. ○ Importance of providing resources, education, information, training, and peer support to parents and caregivers to help them navigate the challenges of caring for their CYSHCN. • Needs of CYSHCN: Quality of life includes access to recreational activities, peer relationships, and community involvement. <ul style="list-style-type: none"> ○ Need for building community connections, more opportunities for social interaction, and inclusive programs and activities. ○ Importance of opportunities for CYSHCN to be around other CYSHCN like them, including those who use sign language. ○ Older CYSHCN face difficulties in forming friendships and finding appropriate peer activities. • Family and Youth Engagement in Policy: Parents/caregivers want to be aware of rights, rules, and laws and have experiences to share with policymakers to support policy change/improvement. <ul style="list-style-type: none"> ○ Parents/caregivers are leaders at many levels and have valuable experiences and ideas to share with lawmakers and systems that serve CYSHCN. ○ Parents/caregivers advocate for policy change in communities, including inclusion in school systems, childcare programs, and recreational opportunities.
<p>Health Teaching and Information Needs</p>	<ul style="list-style-type: none"> • Information Gap: Caregivers may be unaware of Early Intervention services, CRS, and other available programs and resources. Caregivers may lack knowledge of specific therapies and treatments and how

	<p>they could benefit their children. Some words and terms that are used may be confusing and hard to understand, limiting caregivers’ ability to choose services that best fit their child's needs.</p> <ul style="list-style-type: none"> • Need for Education and Outreach: More education and outreach are needed for families and providers about available resources, services, and rights. • Advocacy Challenges: Families often need to advocate strongly for their children, sometimes facing resistance from schools and institutions.
<p>Medical Home</p>	<ul style="list-style-type: none"> • Healthcare Provider Challenges: <ul style="list-style-type: none"> ○ Difficulty finding doctors familiar with CYSHCN conditions and disabilities, as well as the therapies and services they may need. ○ Providers are often unfamiliar with the available resources, services, programs, and other supports that may benefit CYSHCN and their families. ○ Not enough time in appointments to ask questions and receive detailed explanations. ○ Need for consistent healthcare provider who understands child's medical history and needs. ○ Need for healthcare providers who consider the overall quality of life for CYSHCN, not just their medical needs. ○ Importance of hospitals and healthcare providers directing families to programs like CRS and Early Intervention when they first suspect an issue with children. • Information and Support Gaps: Lack of information for new parents about available resources and programs, often forcing them to rely on word of mouth. • Need for Coordinated Care: <ul style="list-style-type: none"> ○ Many families experience difficulties in coordinating care, navigating complex systems, and ensuring continuity of services. ○ Need for a central healthcare provider to manage and coordinate various services (therapies, specialist care, equipment), ensuring continuity and considering the overall quality of life for CYSHCN. ○ Need for better communication and collaboration among providers and agencies to support families more effectively.
<p>Special Education Services</p>	<ul style="list-style-type: none"> • Quality and Access: <ul style="list-style-type: none"> ○ Concerns about the quality and accessibility of special education services. ○ Complicated IEP processes, feelings of being overwhelmed in meetings, and having to fight for services and inclusion. • Teacher Needs: Teachers need to be knowledgeable, approachable, and supportive. Lack of training for teachers and childcare providers to care for CYSHCN.

	<ul style="list-style-type: none"> • School Supports: Schools need to provide adequate support and accommodations, consistent curricula, and opportunities for socialization. Concerns related to inconsistencies in how well schools integrated CYSHCN. • Resource Needs: Increased funding is needed for special education, including teachers, therapists, paraeducators (especially in rural areas), and ABA services. <ul style="list-style-type: none"> ○ Not enough school system therapists, with low frequency of visits, group sessions, and summer skill loss. Lack of school therapists and services, gap in services for children who do not qualify for school therapy but still need support.
<p>Transition to Adulthood</p>	<ul style="list-style-type: none"> • Transition Challenges: Lack of residential options, community supports, and appropriate services for young adults with SHCN after leaving the school system. Lack of local activities and day programs to keep youth engaged and learning once they transition out of school systems. • Healthcare Concerns: Challenges finding suitable adult doctors familiar with CYSHCN diagnoses and conditions. • Legal Issues: Concerns about preparing youth for lifelong care, including issues such as guardianships, wills, and trusts. • Life Skills and Independence: Importance of learning life skills like managing finances, finding housing, managing a household (cooking, cleaning), basic hygiene care, and achieving career goals, along with the need for support and motivation.
<p>Transportation and Geographic Isolation</p>	<ul style="list-style-type: none"> • Transportation Barriers: <ul style="list-style-type: none"> ○ Transportation is a major barrier for some families, particularly in rural areas, due to the need to travel to larger cities to access the services and providers their children need. ○ Difficulties in finding reliable and flexible transportation, impacting healthcare access and regular attendance for appointments and therapy sessions. ○ Frustration with the difficulty of booking transportation services in advance with no immediate options available. ○ Difficulty using gas cards and lengthy approval for Medicaid travel reimbursement. • Financial Burden and Scheduling Issues: <ul style="list-style-type: none"> ○ Expenses related to long-distance travel for healthcare, including gas and time away from work. ○ Challenges in getting appointments after school and work, with the drive time causing children to miss school. • Accessibility Issues: <ul style="list-style-type: none"> ○ Lack of wheelchair-accessible transportation options (vans, public transit) hinders access to essential services. ○ Purchasing personal accessible vehicles is often cost-prohibitive.

Quotes

“I wish it was not so hard – as a new parent, I didn’t really know what I was doing, but I felt like it was a mistake and there were many IEP meetings that I went to and I just felt like – I don’t know. I felt like if I really – I wish that I could go back and fight harder for her to be in a regular classroom, but why should I have to fight so hard? Why can’t our children be given the same opportunity to learn and not be – I don’t know.”

“I just want to say that things like this are important [speaking about the focus group session]. Prior to COVID, our school used to host a coVee and chat, and we would get together the special needs parents because you might be going through potty training a special needs child that might have physical or emotional or mental handicaps that are creating a little bit diVerent of an issue than maybe a typical child. Being able to talk to someone that has been through it before. Having this, being able to sit and just discuss it and find out about other resources but also connect to families, I think is definitely beneficial and would also help get some of that information out if they could host more events and more things like that.”

“If I could make a blanket rule of, “Don't ask me my child's diagnosis. Ask me what symptoms we need to be seen for.” Because the moment they hear the diagnosis. ... ‘Oh, it's just she's disabled.’ She's a human being with emotions ... Or, if you don't have a specific diagnosis, they won't see you. If we could take that diagnosis oV and go by symptoms – that's my magic wand moment.”

“Most families are already under stress because of inflation, health insurance/healthcare cost concerns, and work-life balance. When you add CYSHCN, the stress can be a breaking point for families. Families need holistic support that takes into consideration an array of variables that aVect whole families.”

“Well, my daughter, she has a feeding tube, so we was having to go to Birmingham to get it changed because they didn’t have the right person down here at (location), so it was constantly goin’ to Birmingham ‘cause her tube comes out so much, like once a month or maybe two times a month.”

"It is a little bit challenging to obtain all of the supplies that she needs. Her supplies are G-tube-related diapers, wipes, underpads, and then suction supplies, oxygen supplies. That, then there's medications. Then there's doctor visits, appointments, all that. It just at times becomes very overwhelming just to have to coordinate all of it every month. Some of those, if you miss a day or a deadline, you're going into a weekend – potentially a holiday weekend – without things that (she) cannot live without. That is a challenge."

"I recently found out this week that I have to go and apply through the court system for guardianship for medical care for my 18-year-old. He's turning 19. I understand the law, but I was told I need to come up with \$2,800 and go have a conversation so I can go in front of a judge. I have two kids that I'm gonna to have to do this for. I don't think any of us have the money sitting around just to walk up and be like, 'Hey, let's go do this.' "

"Our boys go to therapy once a week. They are having to miss – what, five weeks? Because their insurance won't cover their last five weeks. For us to do it, it's like – For us to pay for their five weeks, it's \$399 per kid a week. We have five weeks that we're not gonna have any therapy whatsoever. It's gonna be like starting all over with our oldest."

"Another thing that was resonating with the panel here is our kids' self-esteem and their mental health. We focus so much on their physical stuff and their accommodations that we are not conscientious about how things are going emotionally and mentally and that's something that we're leaving on the table and not addressing that as much as we're addressing the (condition)."

Cross-Cutting All Domains; Systems and Community Factors that Influence Health

Selected State Priority Need and Aligned Measure

During Phase Two of the prioritization process, “**Access to Comprehensive Oral Health Education and Services for all MCH Populations**” was developed as a state priority need in a Cross-Cutting Population Domain for the 2025-2030 Title V MCH Block Grant cycle. This need applies to all MCH population domains.

One measure was aligned to track performance in addressing this need.

State Performance Measure: Percent of dental health kit survey respondents who plans to use the dental health kit, which includes age-appropriate toothbrush, educational materials, dental floss, timer, and toothpaste

The table below presents **need topics** that were identified for all MCH population domains in Alabama. These are presented in alphabetical order as they were not rated or ranked but are recognized as foundational considerations in the development of strategies that will support outcome improvements for all of Alabama’s MCH populations.

Need Topic
Adequate Insurance for All
Community Health Factors
Culturally and Linguistically Appropriate and Respectful Providers and Care
Food Sufficiency
Housing Instability
MCH Workforce
Recreational Opportunities and Safe, Affordable Options for Physical Activity
Systems of Support and Resources for Families

More detailed descriptions for these need topics and synthesized data aligned with them are presented in the **Cross-Cutting Systems and Community Factors that Influence Health-specific report**, which begins on the next page.

Title V Maternal and Child Health Services Block Grant and Needs Assessment Overview

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s families, including women, adolescents, infants, children, and children and youth with special health care needs. One requirement for funding is that every five years states must conduct a comprehensive needs assessment to identify priority issues of the MCH population.

The needs assessment is a systematic process to collect information about the State’s public health system and service provision to women, pregnant women, mothers, infants, children, adolescents, and children and youth with special health care needs. The information collected is used to identify statewide priorities, drive strategic planning, and allocate funds. The goal is to improve MCH outcomes by aligning evidence-based strategies with the identified priority needs of the MCH population.

Needs Assessment Methods

The Alabama Department of Public Health partnered with the Applied Evaluation and Assessment Collaborative at the University of Alabama at Birmingham School of Public Health to conduct the 2025 needs assessment. The Alabama Network of Family Resource Centers partnered to support focus groups.

Federally Available Data (FAD)	Community Survey	Key Informant Interviews	Focus Groups & Listening Sessions	
Key MCH indicators provided to states.	936 Responses (Online, English & Spanish) Role (Respondents could select all that apply.) Families & Individuals = 634 Health Care/Health-Related Care Providers = 262 Organizational Partners = 399 ADPH employees = 298	8 Participants Representatives from multiple partner organizations	12 Focus Groups (1 in Spanish) <u>Data Access:</u> 9 Maternal Task Force Listening Sessions 2 ALL-Babies Evaluation Project Focus Groups (1 in Spanish)	

CROSS-CUTTING SYSTEMS AND COMMUNITY FACTORS THAT INFLUENCE HEALTH

Domain Summary (Need topics and key findings synthesized based on all data sources.)

Need Topic	Key Findings	Statewide Survey ¹	Focus Groups, Listening Sessions, & Key Informant Interviews	Federally Available Data ²
Food SuBiciency	<ul style="list-style-type: none"> Concerning and unequal levels of food su2iciency for children. Increased concern about food security for all MCH populations. Increased concern about lack of or unequal access to healthy and fresh foods, fruits, and vegetables. 	X	X	X
MCH Workforce	<ul style="list-style-type: none"> Inadequate and unequal distribution of critical MCH providers to support access to health/medical, mental health, and dental services. 	X	X	X
Adequate Insurance for All	<ul style="list-style-type: none"> Increased concerns about access to a2ordable health insurance that meets needs for all MCH populations. 	X	X	No FAD indicator
Community Health Factors	<ul style="list-style-type: none"> Increased concerns related to community health factors, including cost of living, jobs, wages, and transportation. 	X	X	No FAD indicator
Housing Instability	<ul style="list-style-type: none"> Concerning and unequal levels of housing insu2iciency for children. Increased concerns about lack of or unequal access to safe and a2ordable housing. 		X	X
Systems of Support and Resources for Families	<ul style="list-style-type: none"> Lack of, lack of awareness of, or unequal access to systems of support for families, including resources and education. Lack of father-inclusive programs and resources 	X	X	No FAD indicator
Culturally and Linguistically Appropriate and Respectful Providers and Care	<ul style="list-style-type: none"> Increased concerns related to insu2icient or unequal language access for some groups. Increased concerns related to lack of respectful, non-judgmental providers and care, especially for those with Medicaid and people from minority races or ethnicities. 		X	No FAD indicator
Recreational Opportunities and Safe, ABordable Options for Physical Activity	<ul style="list-style-type: none"> Lack of or unequal access to safe, a2ordable recreational opportunities and options for physical activity for people of all ages. 		X	No FAD indicator

¹ Ranking in Top 5 issue list for any respondent role group.

² A FAD indicator related to this topic has a value that is worse compared to U.S., a worsening state trend, and/or unequal outcomes.

CROSS-CUTTING SYSTEMS AND COMMUNITY FACTORS THAT INFLUENCE HEALTH

Statewide Survey

Out of 534 responses to this section of the survey, the following issues were ranked as concerns affecting the Alabama MCH population in general. Responses are broken down by respondent role group. Respondents could select all role groups that apply to them.

Issue	Rank ³			
	ADPH Employee	Family/ Individual	Partner	Medical Provider
Access to a Medical Provider	4 th	5 th	6 th	2 nd
Access to Affordable Health Insurance that Meets Needs	1 st	1 st	1 st	1 st
Cost of Living	2 nd	2 nd	3 rd	3 rd
Culturally Appropriate Services, including Language Access	11 th	11 th	10 th	10 th
Disaster Readiness	12 th	12 th	12 th	12 th
Food Security/Hunger/Not Having Enough Food	3 rd	3 rd	5 th	4 th
Non-Judgmental Services and Providers	10 th	8 th	8 th (tie)	9 th
Safe and Affordable Housing	7 th	6 th	7 th	7 th
Safe Communities	8 th	9 th	8 th (tie)	8 th
Systems of Support for Families (adults with disabilities, help raising children, etc.)	6 th	4 th	2 nd	6 th
Transportation to Activities of Daily Living (healthcare, grocery, etc.)	5 th	7 th	4 th	5 th
Vaccinations	9 th	10 th	11 th	11 th

³Based on number and percentage of respondents who selected issue as one of top five concerns.

Federally Available Data

Indicator	Value ⁱ	Comparison to U.S.	State Trend
National Performance Measures			
Food Sufficiency – 0-11 years ⁴	61.8%	Worse (lower)	Decreasing (worsening)
Housing Instability – 0-11 years ⁵	20.5%	Worse (higher)	Increasing (worsening)
Housing Instability – during pregnancy	Not available yet		
Standardized Measures			
Adequate Insurance – 0-17 years ⁶	74.6%	Better (higher)	Stable

Indicator Note	Groups Experiencing Unequal (Worse) Outcomes
4	6-11 years; Black; 0-199% Federal Poverty Level (FPL); less than college graduate; CSHCN; Medicaid
5	Black; 0-199% FPL; less than college graduate; CSHCN; Medicaid
6	CSHCN; private insurance

MCH Workforce (per 100,000) ⁱⁱ	U.S.	Alabama
Obstetricians and Gynecologists ⁱⁱⁱ	5.9	2.3
Certified Nurse Midwives ^{iv}	2.1	1.3
Family Medicine Physicians ⁱⁱⁱ	33.4	9.6
Pediatricians ⁱⁱⁱ	10.4	8.8
Practicing Dentists ^v	61.0	41.7
Mental Health Providers ^{vi}	344.9	152.2

Color Key: ■ = statistically worse ■ = statistically better ■ = concerning trend

ⁱ Data and analyses provided to states by Maternal and Child Health Bureau from the National Survey of Children’s Health 2022-2023 (<https://mchb.tvisdata.hrsa.gov/Home/FADDocuments>).

ⁱⁱⁱ Data and analyses provided to states by Maternal and Child Health Bureau from Form 11 (<https://mchb.tvisdata.hrsa.gov/Home/FADDocuments>). There is substantial variation by county; rural areas are of particular concern.

^{iv} Alabama value from https://www.amcbmidwife.org/docs/default-source/reports/number-of-cnm-cm-by-state---february-2019-present607d50819fd7410f84b748c059e9a2d9.pdf?sfvrsn=cce5f80_6

^v American Dental Association, Health Policy Institute analysis of ADA masterfile; <https://www.al.com/news/2024/10/alabamas-decaying-dental-care-necessitates-immediate-attention.html>

^{vi} includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care; <https://www.americashealthrankings.org/explore/measures/MHP/AL>

Focus Groups, Listening Sessions, Key Informant Interviews, and Survey Write-In Comments

Themes	Summary
<p>Family Strengthening Policies and Legislation</p>	<ul style="list-style-type: none"> • Participants discussed policies and legislation that they believed should be developed to support and strengthen families. • These included broader childcare support, development and expansion of paid parental leave, expanding Medicaid and Medicaid benefits, and creating an app or portal to show Medicaid-covered services, providers, and copays. • Some participants felt that income qualifications for support programs such as Medicaid, WIC, and childcare subsidies are too low, excluding families who make just above the cut point, but still struggle financially. • Fathers specifically noted the lack of paternity leave, legal support, and father-specific programs as creating barriers for their participation in raising their children and supporting their partner. • Fathers also felt that single fathers face bias in accessing Medicaid, childcare, and housing support.
<p>Adequate Health Insurance</p>	<ul style="list-style-type: none"> • Participants discussed inadequacies of health insurance, including high copays, high out-of-pocket costs, and lack of medication affordability. • They also mentioned insurance gaps, including non-covered services and providers (dental, mental health, some specialty care) based on age and/or insurance type.
<p>Cost of Living and Employment</p>	<ul style="list-style-type: none"> • Participants shared concerns about lack of jobs and job opportunities, especially in rural areas. • They also worried about the high cost of living in general and having to choose between paying for medication or other basic needs like food or utilities.
<p>Recreational Opportunities and Safe, Affordable Options for Physical Activity</p>	<ul style="list-style-type: none"> • People described a lack of options for safe, affordable recreational activities for individuals, adolescents, and families. • Gym and recreation centers that were available often required expensive monthly fees. • Walking trails, parks, and other outdoor options for physical activity were not equally distributed and required travel or reliable transportation to access. • The lack of recreational options for adolescents specifically was mentioned as reasons that they might engage in what were deemed unhealthy or inappropriate behaviors.
<p>Cultural Sensitivity, Language Access, and Respect</p>	<ul style="list-style-type: none"> • Some participants shared that they felt they had unequal access to care or had received dismissive and disrespectful treatment based on their race, ethnicity, immigration status, or insurance type. • Some shared stories of being dismissed or judged, which discouraged future care-seeking. • Immigrant mothers reported being treated with suspicion or disrespect during labor and delivery.

CROSS-CUTTING SYSTEMS AND COMMUNITY FACTORS THAT INFLUENCE HEALTH

	<ul style="list-style-type: none"> • Some parents reported being asked to show proof of citizenship or parentage prior to their children receiving treatment, even in emergency rooms. • Spanish-language participants reported language and cultural barriers as significantly impacting their families' care, including a lack of interpreters and culturally sensitive care. • Participants often needed to rely on their children or community members for translation.
<p>Education, Resources, and Community Support Systems for Families</p>	<ul style="list-style-type: none"> • Many participants said they didn't know where to start when seeking care, especially for prenatal or pediatric services, or for community resources and support programs. • Many participants expressed a need for navigators or liaisons to help them with understanding and accessing available services, and many were unaware of available services until referred by a care coordinator or peer. • Participants relied on word-of-mouth and online reviews for healthcare information. • Churches, schools, and pediatricians were also key sources of referrals. • Participants emphasized the need for better outreach and centralized directories. • Many participants expressed confusion about Medicaid eligibility, covered services, and providers. • They also expressed challenges in knowing how to navigate referrals and insurance paperwork. • Additionally, they shared challenges in understanding medical terminology and treatment plans. • There was a strong desire for local parenting groups and support activities.
<p>Housing and Food Access</p>	<ul style="list-style-type: none"> • Some participants noted a lack of affordable housing in their areas, stating that rent is unaffordable, even in subsidized housing. • Concerns were shared about poor living conditions and lack of housing maintenance. • Some participants felt there was a lack of access to fresh foods, fruits, and vegetables in their areas. They shared that healthy food is unaffordable, and fast food is cheaper and easier to get. • Food banks may be difficult to access due to documentation requirements and limited hours. • Participants requested more local food assistance and education on infant nutrition.
<p>Transportation</p>	<ul style="list-style-type: none"> • Many participants described long travel times to larger cities for specialty, dental, and mental health care. This created challenges due to a lack of reliable transportation and cost of travel. • Participants noted a lack of public transportation in rural areas. • Participants shared that Medicaid transportation reimbursement is slow, and Medicaid services are inconsistent.
<p>MCH Workforce Investments</p>	<ul style="list-style-type: none"> • Many participants mentioned a lack of healthcare, pregnancy care, mental health, and dental care providers for all ages and throughout the state, especially in rural areas. • They specifically suggested training more pediatricians and OB/GYN's to serve rural areas. • They also suggested supporting students pursuing healthcare careers with scholarships and incentives.

Quotes

“When it comes to the point where a parent has a toothache or somethin' like that, and the dentist and stuY is so backed up, and they ain't take Medicaid, there ain't no services in the area because they so far backed up. We ain't got no resources around here 'cause they so backed up. Mental health farther than that.”

“Today's been a good day 'cause I got a new car today. That's the only good thing I've had in the last five months because I'm pretty much homeless when I'm not with my kids. We have to split our house. I don't have any money besides the job that I get, and it ain't much. Yeah, it's definitely hard.”

“You can get healthcare with low income, but you're not gonna get quality healthcare. You're gonna get whatever they can scrape up for you. That's a huge issue with the public health system nationwide, is they're getting bottom-of-the-barrel care.”

[speaking of “mic drop” issue]

“One thing that I've noticed too about people that receive Medicaid: They don't get treated the same way that someone with Blue Cross Blue Shield does. They are treated very diYerently. That goes down to the nurse, the doctor. It's not fair. They're getting paid either way. Everybody deserves the same quality of care and not meaning because you're on Medicaid, you're less than.”

“We're in our 30's now. That's great and wonderful, but [*name of county*] has a lot of young teen moms. They don't have support. We live in a very Bible-belted area where, ‘You had a baby at 16!’ They need somewhere that they're confident, where they can talk to us older moms who can reassure 'em and be like, ‘Look, babe, I get it.’ ”

“The whole ‘support moms’ to me, I just see a lot of people that are just hungry and thirsty for people that might care about them, that physically sit down, ... and just be like, ‘What do you need? What are you feeling like today?’ I'm glad that y'all have done this because it's even opened my eyes. That's what I told my husband that's a pastor here in town. I was like, ‘I just wanna go and see how we can help.’ Even talkin' to y'all, but also just hearing how everybody feels. Like she said, you can read through scripture all day, but are you there for 'em? Your actions speak so much louder than words, that Bibles really go by. It's our lesson plans; it's our instruction manual. ‘What are you doing beyond that? How are you caring for each other and how are you talkin' to each other?’ ”

“I'm just done. The daycare thing, that's really annoying. We can't say that we're supporting mothers and then not actually support mothers. Lord, I'm gonna get political. All these people want to do be down in Montgomery and be like, 'We support mothers and babies. We love 'em.' Then after they're born, they're like, 'Good luck.' OK. Give us something but do something. I would gladly pay an extra tax every time I get a paycheck to make sure that we have daycare that's affordable for kids and their moms. It just makes sense. OK, I'm done. ... Yes, so we can't say that we love moms and we love babies, and then after they're born, they don't do anything for us.”

“She also shared that she has had some struggles when she goes to WIC where they don't have translators available for them. She'll have to take her daughter out of school sometimes, but she tries not to do that. She tries to use her phone as much as possible to do the translations, but it seems like the people there just look at her funny or won't even make an effort to understand her or use any of their translation service, so she's had some struggles with that.”

[speaking through interpreter]

“She's sharing that she had an experience where her son had to go to an emergency room. When they were gonna attend to him, they wouldn't take care of him. They had to show proof of his Social Security just for him to be taken care of. She had to call her husband to come and bring his information just to get him checked out, and so that was very difficult.”

[speaking through interpreter]

“... Some of 'em, it's just because you have second insurance, but sometimes it's not just about the insurance. It's about your ethnicity. Because if they see you, that you look Latino or another race, even though my kids, my two first kids, they had double insurance, and they would always get treated different because they're Latino, even though they were born here.”

[speaking through interpreter]