



MATERNAL CHILD HEALTH (MCH) COMMUNITY NEEDS ASSESSMENT

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Prepared for
Commonwealth of the Northern Mariana Islands (CNMI)
Commonwealth Health Care Corporation (CHCC)

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Executive Summary

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children, and youth – including children and youth with special health care needs – and their families. Every five years, states and jurisdictions are required to conduct a comprehensive needs assessment to receive Title V funding. The primary purpose of this needs assessment is to identify priority needs for the Commonwealth of the Northern Mariana Islands (CNMI) Maternal and Child Health (MCH) populations. The results will inform decisions related to program goals and objectives and to allocate state and local resources for the years 2025-2030.

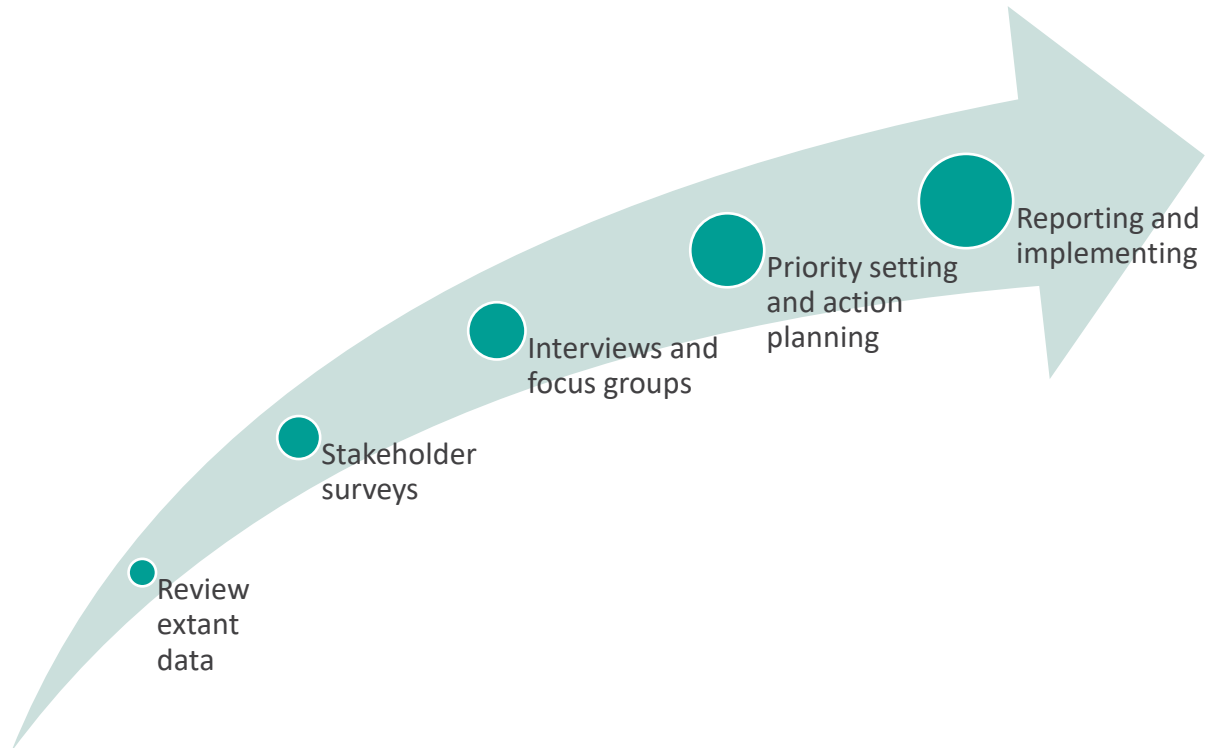
The multi-method needs assessment included:

- Scan of pre-existing sources which included needs assessments, program materials, reports, and administrative data
- Priority health issues surveys for youth and professionals garnering 2,900 responses across Saipan, Tinian, and Rota
- Interviews and focus groups on Saipan, Tinian, and Rota during which community members reviewed the priority health issues survey results and then discussed them in relation to their lived experiences.

Next, a priority setting meeting was held with 46 community members and public health decision-makers. These representatives were presented with an overview of the needs assessment process and data. They then self-selected into groups organized by the MCH domains. Employing an adapted strategy grid method, the groups identified the top three priorities based on their level of importance/urgency and feasibility.

In the final step of the needs assessment, the MCH Steering Committee, reviewed the priority needs and recommendations gathered with the surveys, interviews, focus groups, and strategy grid method. From these sources, the Steering Committee made a final selection of priorities deemed to be strategically sound, operationally viable, and likely to contribute to improved health outcomes for women, children, and families across the Commonwealth. The figure on the following page visually displays the needs assessment process. The table that follows summarizes the final set of priorities by MCH domain.

Figure A. Needs Assessment Process



The final set of priorities identified through the needs assessment is summarized in the table below.

Table A. Final Priorities by MCH Domain

Woman/Maternal
<ul style="list-style-type: none"> • Access to preventative medical visits • Access to mental health services
Perinatal/Infant
<ul style="list-style-type: none"> • Education and services to help prevent premature births and low birthweight • Education and support to help with breastfeeding
Child
<ul style="list-style-type: none"> • Access to healthy physical activities
Adolescent
<ul style="list-style-type: none"> • Bullying prevention and support • Access to teen pregnancy and sexually transmitted infection (STI) prevention services
Children with Special Health Care Needs
<ul style="list-style-type: none"> • Access to care coordination and navigation of healthcare and community programs • Parent training • Access to specialty healthcare services
Cross-Cutting
<ul style="list-style-type: none"> • Clear communication about health services and supports available in each area

Introduction

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children, and youth – including children and youth with special health care needs – and their families. Every five years, states are required to conduct a comprehensive needs assessment to receive Title V funding. **The primary purpose of the needs assessment is to identify priority needs for the CNMI's MCH populations. The results will inform decisions related to program goals and objectives and to allocate state and local resources from 2025-2030.**

MCH Population Health and Wellbeing

The Commonwealth of the Northern Mariana Islands is a unique setting for delivery of Title V services. Key contextual factors are described in the following sections.

The CNMI is a small, geographically isolated island jurisdiction. The Commonwealth of the Northern Mariana Islands (CNMI) is located in the northwestern Pacific Ocean approximately 3,700 miles west of Hawaii and 125 miles north of Guam. The CNMI consists of a chain of 14 islands with a total land area of 176.5 square miles spread out over 264,000 square miles of the Pacific Ocean. The CNMI's total area could be compared to two and a half times the size of Washington, D.C. The nearest U.S. tertiary medical center for referral is in Honolulu, Hawaii, which is over eight hours away by air. The population of the CNMI lives primarily on three islands, the major island being Saipan (population 43,385), followed by Tinian (2,044) and Rota (1,893).¹

The CNMI is comprised of a very ethnically and culturally diverse population. Single ethnic groups that accounted for the majority population in the CNMI were identified as Filipino (33%), followed by Chamorro (25%) and Chinese-except Taiwanese (7%). Carolinians make up about 5% of the total population. Asians were the largest group, representing nearly half of the total population. Native Hawaiian and Other Pacific Islanders made up about 14% and Caucasians less than 2%. About 7% of CNMI's population were of two or more ethnicities or races and "all others". In the CNMI, the Chamorro and Carolinian groups are Indigenous to the territory.²

The CNMI Medicaid program differs from the US mainland and publicly funded health insurance is inaccessible to many. The program is "capped" by the U.S. Federal Government and limited to a set dollar amount allotted to the CNMI. In addition, US territories are capped by legislation on the percentage of Federal Medical Assistance Program (FMAP) funding for the Medicaid program. Prior to the pandemic, this limited

¹ U.S. Census Bureau, 2020

² U.S. Census Bureau, 2020

funding severely affected access, cost, and quality of health care for residents of the CNMI, heavily influencing public perspectives about the availability of healthcare.³ Also of note, only US citizens qualify for Medicaid coverage and in 2013, CNMI Public Law 17-92 released employers from the responsibility of providing health insurance coverage to non-U.S. qualified workers (legally present-foreign workers). In the CNMI, approximately 40% of the population is comprised of foreign workers.⁴

The CNMI's economy has struggled to gain traction in recent decades. A variety of factors have undermined the CNMI's economy since the mid-2000s. The closing of the garment manufacturing industry and the implementation of federal Public Law 110-229 in 2008 which removed local control over immigration seriously hampered the manufacturing sector. Super Typhoon Yutu struck the CNMI in October 2018, exacting massive destruction to homes, businesses, and infrastructure. The COVID-19 pandemic followed, gutting the tourism industry. According to US Census 2020 data, 38% of people in the CNMI lived in poverty, nearly four times the poverty rate for the US overall (11.4%).

Title V Program Capacity

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children, and youth – including children and youth with special health care needs – and their families.

Organizational Structure

The Commonwealth Healthcare Corporation (CHCC) is the CNMI's healthcare system and primary provider of healthcare and related public health services in the CNMI, including management of federal health related grants. The CHCC Division of Public Health Services administers the Maternal, Infant, Child, and Adolescent Health (MICAH) Program, including MCH Title V services on Saipan, Tinian, and Rota. Organizational charts for the CHCC Department of Public Health Services and the Maternal, Infant, Child, and Adolescent Health Programs are provided on the following pages.

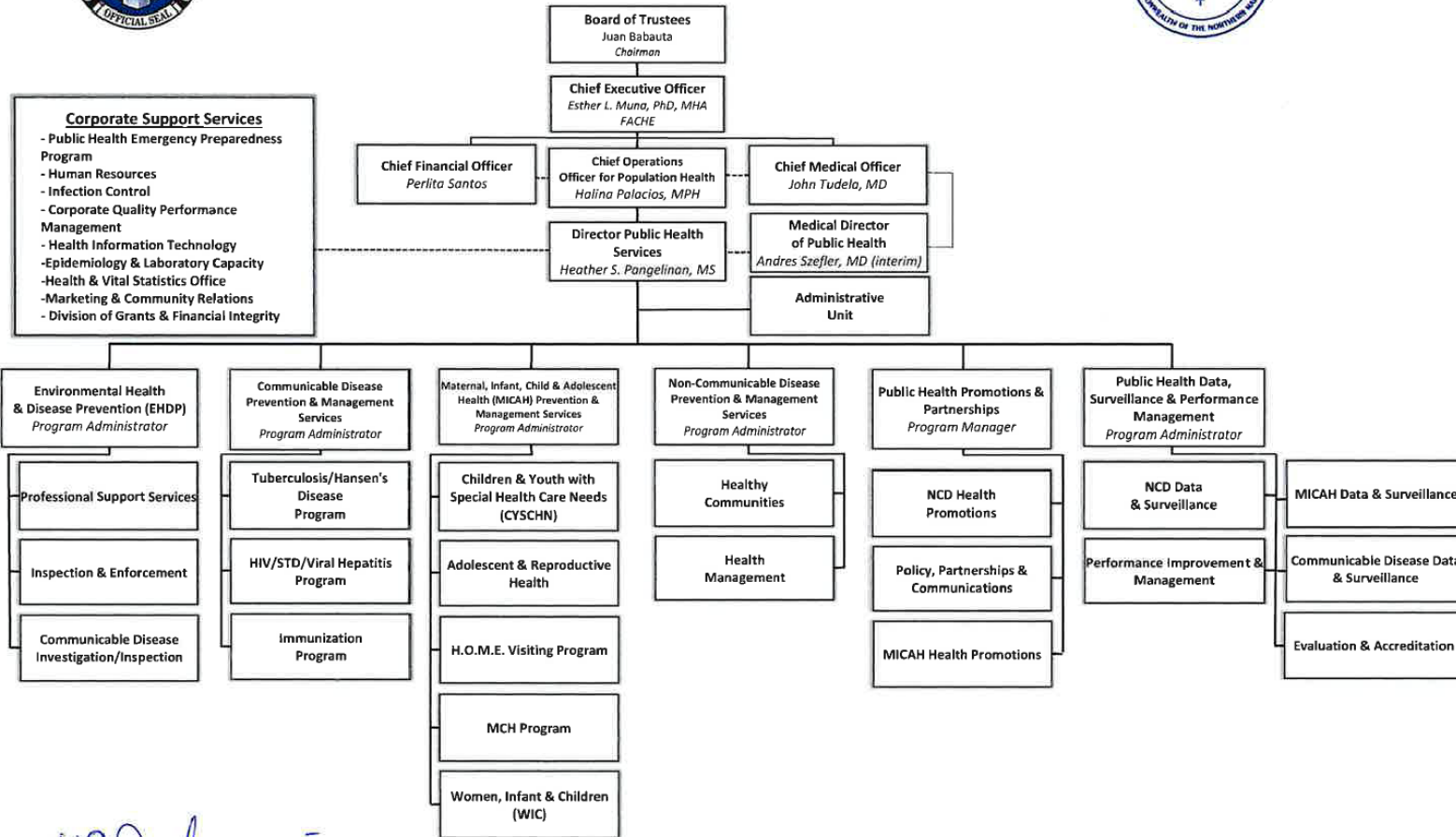
³ The CNMI is currently capped at 83% FMAP.

⁴ Government Accountability Office (2022). Commonwealth of the Northern Mariana Islands Recent Workforce Trends and Wage Distribution. Report to Congressional Committees.



Commonwealth Healthcare Corporation

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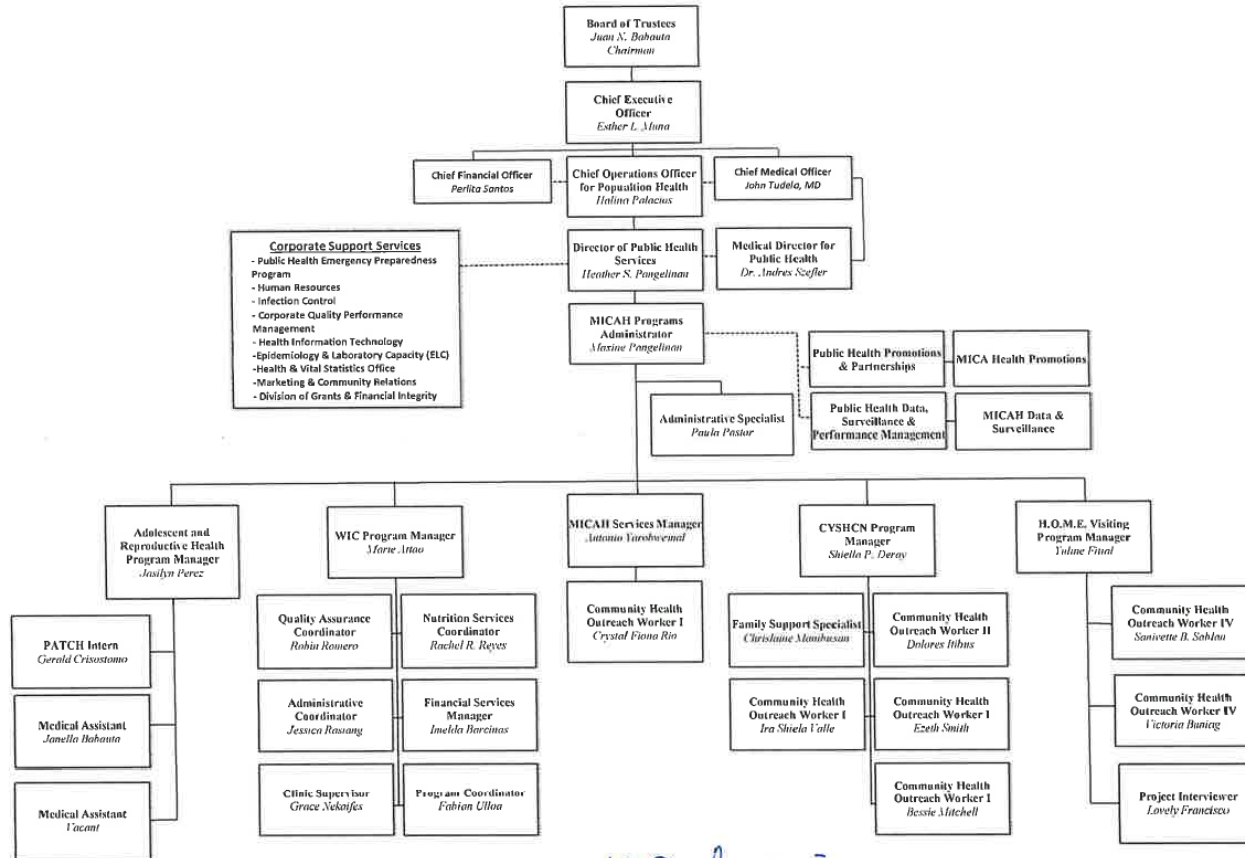
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Commonwealth Healthcare Corporation



Public Health Services Maternal, Infant, Children & Adolescent Health (MICA) Programs




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Agency Capacity

The CHCC, through its various divisions, including the Division of Public Health, Women and Children's Clinic and the Community Guidance Center, provides primary and preventive health services to the community. Services include medical, dental, mental health, substance abuse counseling, women's health, nutrition counseling, and family planning. Internal program collaboration and partnership with community organizations make it possible to bring health services out into the community, including through a mobile clinic. This work is supplemented by enabling services including outreach, case management, and health promotion efforts. Below is a description of capacity by domain.

Women/Maternal Health. Prenatal care is provided at the Women's Clinic located at the CHCC, and Rota and Tinian Health Centers. The services are based on standards of care aligned with US guidelines (e.g., American College of Obstetricians and Gynecologists). The Breast and Cervical Cancer Screening Program (BCSP) provides breast and cervical cancer screening services at no cost to women that meet the program's criteria. Eligibility assistance and transportation are provided to clients; transportation includes air fare for clients from Rota and Tinian to receive mammograms. In addition, the program conducts outreach presentations on early detection and prevention including risk factors. Supplemental activities include expanded outreach activities with partners such as through awareness months.

Comprehensive women's health and gynecological services are provided at the Women's Clinic and Rota and Tinian Health Centers. Health screenings such as blood sugar, blood pressure, weight, etc. are conducted during community events by the Division of Public Health as a mechanism for expanding access to preventive services and for early identification, treatment, and management of non-communicable diseases.

Perinatal/Infant Health and Child Health. Health services for infants include screenings, assessments, and education on a variety of health areas (e.g., growth monitoring, screening for health issues and developmental delays, breastfeeding, etc.). Services are aligned with US guidelines provided by the Centers for Disease Control, and American Academy of Pediatrics.

Well baby/child exams are provided at the Children's Clinic. Services include immunization, health education and counseling including nutrition, injury prevention, safety, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals for dental care, hearing screening, early intervention services, specialty clinics, and home visits are made based on assessment findings. These visits include breastfeeding promotion.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program serves to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. Programs within MICAH and across the Division of Public Health Services collaborate with WIC on many initiatives including breastfeeding support and encouraging prenatal care.

Newborn Hearing Screening is conducted for all newborns born at the CHCC before hospital discharge after birth and follow-up screenings and diagnostic audiological evaluations provided at the Children's Clinic.

The Immunization Program ensures availability and accessibility of vaccination services. Immunization is provided at through the Public Health Immunization Clinic and private clinic locations. The Public Health Clinic is open for walk-ins and open on Saturdays, improving accessibility. Programs within the MICAH unit work to provide awareness on the importance of immunization.

The Immunization Program also enforces the CNMI school health certificate requirement for all children enrolled in a CNMI school or licensed childcare facility. A school health certificate is an annual requirement and children who are entering the CNMI school system for the first time are required to complete a physical examination, including hearing and vision screening, and must receive vaccination in line with CDC immunization recommendations.

The School Dental Program administered through the CHCC Dental Clinic provides a full mouth examination, fluoride varnish and sealant application, and education at each Head Start facility. In addition to the Head Start Program, every school year children in first, fifth, and sixth grades in the public schools, including Rota and Tinian, are bussed to the Dental Clinic to receive dental services. Services include a full mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children receive report cards on their dental assessments so parents can make necessary appointments for further dental treatment and procedures.

Outside of the School Dental Program, the CHCC Dental Clinic provides general dentistry services such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. The Dental Clinic, along with four private dental clinics, accepts children enrolled in the Medicaid Program for their restorative treatment needs.

Adolescent Health. Preventive and primary health care services for adolescents are provided at the Women's Clinic, Children's Clinic, and through Mobile Clinic outreach. In

addition, much work for this population is done in collaboration with the Public School System (PSS). Mental health and social services are provided through the Community Guidance Center (CGC).

Efforts around adolescent health have been focused on the avoidance of risky health behaviors such as drugs, alcohol, and unsafe sex. The MICAH Programs work closely with the Family Planning Program. In addition, they collaborate with the Community Guidance Center (CGC) to promote positive youth behaviors. The CGC leads underage drinking prevention efforts. It also addresses injury and suicide, violence prevention, and has strong ties to the federal, state, and community agencies and programs that carry out risky behavior reduction activities.

Children with Special Healthcare Needs (CSHCN). Services are set up to promote an integrated service delivery system for CSHCN from birth to 21 years of age and their families. The CSHCN Program under MICAH works collaboratively and cooperatively with other CNMI agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. The CSHCN Program has been developed as an interagency effort among the MICAH program, the hospital, the Special Education Program, and the Early Intervention Services Program. The CSHCN Program employs care coordinators who oversee the coordination of specialty care that the children need. The program provides transportation, eligibility assistance, and activities such as parent events, health forums, and trainings to support CSHCN and their families. Contractual services, such as the audiologist, provide services that are not otherwise available. Specialty teams from Shriners Children's Hospital visit the CNMI 2 to 3 times a year. Shriners Hospital for Children's Hawai'i is part of an international pediatric healthcare system of hospitals, clinics, ambulatory surgery centers and global outreach. The CNMI also partners with Rady's Hospital for Children, San Diego through the CNMI's Health Network Program. This hospital provides comprehensive medical treatment and surgery from birth to 18 years old. This hospital has specialized groups that provide services in cardiology, neurology, gastroenterology, orthopedics, and select surgeries. The CNMI relies heavily on overseas contractors and medical referrals to meet the needs of this priority population off-island, which is very expensive.

Cross-cutting. The CHCC Dental Clinic described above provides services for all MICAH populations.

The MICAH Program works closely with the Medicaid office to promote eligibility and enrollment. A designated staff member helps with filling out Medicaid applications, assists with expediting application processing, and also provides translation assistance for those with limited English. MICAH receives referrals for uninsured people from the CHCC Women's and Children's clinics, Part C: Early Intervention Services Program, MIECHV Home

Visiting Program, and the Family Planning Program, among others. Screening for insurance is also conducted during Mobile Clinic outreach events in which community members seen during outreach are provided Medicaid application assistance as needed. The partnership between the MICAH program and the CNMI Medicaid program includes referrals, Medicaid reimbursement for services eligible under the Medicaid State Plan, data sharing, and training. The Medicaid program provides eligibility and enrollment information to the MICAH program on an annual basis or when requested. Additionally, the Medicaid program allows for the processing and expediting of MICAH client applications and provides training to MICAH program staff on Medicaid eligibility and application processing. In addition, MICAH has also devoted a staff member to assist clients with enrollment in the CHCC income-based sliding fee program to provide discounted services to those that qualify.

CHCC Division of Public Health Services continues to improve its data capacity to better serve the community's health needs. The CNMI MCH State Systems Development Initiative (SSDI) Project enhances the ability to collect, analyze, and utilize reliable data to support the CNMI Title V MCH Block Grant program. The SSDI Project continues to lead data collection and analysis efforts for MCH needs assessment, National Outcomes Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs), and Evidence-based or Informed Strategy Measures (ESMs). The SSDI project is committed to addressing health disparities, social determinants of health, and advancing access to health care services through an improved data management plan, removal of silos, and utilization of data analysis and business intelligence tools for better decision-making, resource allocation and improved health outcomes. The SSDI project is involved in the planning, development and implementation of Data Governance for setting internal standards to inform data policies and regulations, ensuring data quality and availability for informed-decision-making, including standard operating procedures for processing, sharing, storing, safeguarding, and disposing of data.

The MCH trend analysis dataset is developed by SSDI to collect data and monitor the health experiences of the MCH population by tracking encounters involving the National Performance and Outcome Measures, State Performance Measures, and Evidence-based or- Informed Strategy Measures for informed-decision-making. Surveillance efforts consist of identifying emerging or new cases affecting the MCH population through CNMI Syndromic Surveillance Report.

The CHCC's Health Information Technology (HIT) department continues to collaborate with the vendor Medsphere regarding upgrades to CareVue Electronic Health Record (EHR) and Revenue Cycle Management (RCM) system. Carevue is a centralized EHR system utilized throughout the CHCC system, including the Rota and Tinian sites. The system is utilized by SSDI to access healthcare encountered data to inform primary and preventive

care utilization analysis, types of conditions and diagnosis, and other performance and outcomes indicators collected and reported by the CNMI MCH Title V program.

Upgrades to Carevue included electronically transmitting drug prescription (eRx), improvements to the patient data displays for easy access to patient age, weight, height, BMI and BMI percentile, and firewall security updates. These upgrades provide CHCC clinicians with additional functionality including modern graphical user interfaces, automated clinical support, and a suite of pre-built interfaces to third-party applications and devices. With the addition of the RCM system, CHCC is able to significantly improve its overall revenue and expenditures tracking system. According to CHCC HIT, Electronic Case Reporting (eCR) is another priority function within the CareVue EHR that they are pursuing.

In August of 2022, the CNMI MICAH Programs applied and successfully obtained funding to support the CNMI SSDI efforts through 2027. Goals for this time period are provided below.

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming.

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.

Title V Workforce Capacity and Workforce Development

The MCH management and team are committed to promoting the strategic mission and values of the organization by developing a culturally competent and diverse workforce. To address the shifting demographic trends in the population served, each program works closely with key stakeholders and consumers to understand and manage the social and cultural differences of target groups.

Recruitment of all staff is handled through the CHCC Human Resource office and coordinated in accordance with CHCC Human Resource policies and procedures. The CNMI, as a whole, experiences difficulties in workforce recruitment as the shortage in local skilled workforce has forced organizations, both public and private, to recruit from other countries through a CNMI only workforce permit that is scheduled to phase out after 2029. Nursing positions are the most difficult to fill. The CNMI, like many US states and other jurisdictions and territories, recruits a large majority of its nursing workforce from the Philippines. However, due to the annual reduction in available CNMI conditional worker

permits until the program eventually phases out in 2029, the CNMI faces increasing challenges in recruiting and retaining nurses. Various industries compete for this limited number of permits and as such the healthcare field, and CHCC in particular, competes with both public and private agencies across the CNMI.

The CNMI also faces challenges in recruiting medical providers. Due to CMS Conditions for Participation, CNMI regulations require that medical providers be US trained or US board certified in order to be licensed providers in the CNMI, and this has limited recruitment to the US mainland. The CNMI's geographic location and distance from the US mainland poses as a challenge for recruiting medical providers and turnover is high.

Staffing for the Public Health programs, including Title V, is largely made up of a local workforce. Because of limited opportunity for post-secondary education locally, many community members move off-island to attend colleges and universities in the US mainland. While some eventually return to the CNMI, many do not return for various reasons. The CHCC has been working diligently in implementing strategies to support workforce retention focusing on staff engagement and team building activities.

Access to high quality training is a continuous challenge. While virtual learning sessions provide the MCH workforce in the CNMI the opportunity to interact with experts and other technical assistance that are not readily available on-island, the time difference between the CNMI and the US mainland makes it challenging for staff to participate as often times sessions are held early mornings, in some cases at 3 am.

Program Partnerships, Collaboration, and Coordination

The MICAH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Other strategies to strengthen the MICAH Program's capacity to promote and protect the health of the target population are: 1) work with schools to ensure children enrolled are up to date with their immunization; 2) work with partners during island-wide community events which strongly emphasize lifestyle behavioral changes including health care practices, diet, and physical fitness; 3) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; and 4) develop partnerships with other agencies to ensure continuity of care.

Much of the island-wide work accomplished by MICAH staff is done in collaboration with other state agency staff, particularly those who work within the Division of Public Health, and the Department of Education. MICAH personnel work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements.

The CNMI Public School System (PSS), in particular the Early Intervention Service, is an essential partner to the CSHCN Program. Together, the agencies offer services for children served by the CSHCN Program. A staff member represents the program and the department on the Interagency Coordinating Council, with membership requiring a governor appointment.

The PSS is an essential partner in activities relevant to early childhood state systems building efforts; the coordinated school health model; work with school counselors; and school-based activities. They also work with the CNMI Community Guidance Center, which leads underage drinking and suicide prevention efforts. The Community Guidance Center also addresses suicide and violence prevention and has strong ties to the federal, state, and community agencies and programs that carry out risky behavior reduction activities.

The MICAH Program works with the HRSA 330e-funded Kagman Community Health Center to improve accessibility and expand primary care services for low-income and vulnerable populations. These efforts include information sharing and referrals to care especially for those who are low-income and uninsured.

The CNMI WIC Program, a program within MICAH, is instrumental to current efforts focused on increasing breastfeeding rates, food security, and decreasing childhood overweight and obesity.

Family Planning services include efforts to address unintended pregnancy, preconception health, and preventing risky teen sexual behavior. Currently, MICAH funds are not used for direct family planning services, but rather, support procurement of pharmaceutical supplies such as contraceptives and population-based activities around unintended pregnancy prevention. This unit has strong ties to the programs that work on STD/HIV prevention and services.

The MICAH Program also works with the Immunization Program via interdepartmental activities, such as campaigns focused on increased routine childhood vaccination coverage and seasonal vaccines like influenza and RSV.

Relationships with the Public Health Non-Communicable Disease (NCD) Programs are strong and support work between MICAH projects and programs such as Diabetes, Cancer, Tobacco Control and other chronic disease prevention and health promotion. For example, the partnership has had a longstanding collaboration in addressing healthy weight among children.

The Health Vital Statistics Office (HVSO) is an established partner of the MICAH Program. This long-term relationship has led to the development of MICAH-specific data and

resources. The HVSO serves a critical role in providing CNMI birth and death data to Public Health, enabling programs, including MICAH Programs, to use the information to guide interventions, perform surveillance efforts, and evaluate efforts.

The MICAH Program has an established working partnership with Northern Marianas College (NMC) for training needs of both clinical and programmatic staff, conducting awareness activities in nutrition and physical activity and preventing and controlling non-communicable disease. The NMC School of Nursing provide volunteers during events such as school vaccination campaigns and health fairs. All Division programs conduct outreach activities at schools during their health fairs, science fairs, nutrition awareness events, etc.

Each unit manages on-going advisory groups and specific task forces that are made up of public and private partners that share concern and responsibility for addressing the needs of women, children, and families. Additionally, staff participates in partnerships led by colleagues within other state, federal, and community organizations.

Family and Community Partnerships

The MCH Program not only partners with CNMI organizations and agencies, but strives to involve families at all levels, individually, and at the decision-making level. Family/consumer engagement has taken place through advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, materials development, and advocacy. To ensure that services are effectively meeting the needs of the local population, programs under MICAH have taken a collective approach towards involving families in programmatic decision-making. A significant amount of family engagement activities is coordinated through the Family-to-Family Health Information Center (F2F HIC), a unit within the MICAH CSHCN Program. Since the implementation of the F2F HIC in the CNMI there has been an increased activity around building parents, caregivers, and family capacity around advocacy and empowerment. These are facilitated through informative learning sessions, recruitment of parent leaders to provide peer support, parent leadership training, establishing support groups and providing opportunities to attend national conferences. Additionally, through family engagement activities, CSHCN parent leaders have been recruited to be take part and be active members in committees such as the Disability Network Partners, Early Intervention Interagency Council, and the Developmental Disabilities Council.

The MCH Title V Program staff work closely with parent support groups, church leaders, women's groups, and community and traditional leaders. The Family-to-Family Health Information Center (F2F HIC) offers a peer support program for families with CSHCN. A Family Support Specialist and Parent Leaders provide guidance and peer support in addition to actively advocating for CSHCN. The MICAH programs are focused on continuing

to build parent/consumer partnerships to improve public input into the entire program and its policies and objectives.

Related advisory committees that MICAH programs are involved in which include family partners as members include the: Interagency Coordinating Council (ICC), CSHCN stakeholder group, H.O.M.E. Visiting Community Advisory Board, EHDI Advisory Board, Disabilities Network Partners, Governor's Council on Developmental Disabilities, Pediatric Mental Healthcare Access Program Advisory Council, and the Head Start Advisory Council. Families and community members also take active roles in the planning and coordinating of annual CNMI wide events, give feedback on annual reports and applications, and contribute in identification of strategies.

Most recently, the MICAH Program launched the Providers and Teens Communicating for Health ([PATCH](#)) Program which has recruited Teen Educators from all corners of Saipan to improve adolescent health care experiences for youth in our community. The program aims to improve the way adolescents receive, experience, and utilize health care. It complements existing adolescent health care quality initiatives by providing teen-centered education, awareness, and encouragement to youth and health care professionals.

The MICAH Program in collaboration with other programs under the Division of Public Health Services, maintains strong partnerships with CHCC medical providers in coordinating access to healthcare across the CNMI including Rota and Tinian and maximizing the utilization of the mobile clinic. These collaborative efforts bring vital health services directly to remote areas and assist in eliminating barriers such as transportation and limited provider access. In addition, we work closely to identify the unique health needs of our island community and address specific maternal and child health concerns while providing valuable clinical insights and responses. Through our partnerships, we aim to provide timely, quality care while reinforcing our shared commitment to accessible, community-driven healthcare solutions.

Regional Partnerships

At the regional level, the Division of Public Health has engaged with organizations such as the Pacific Island Health Officers' Association (PIHOA) and the Pacific Community (SPC). These partnerships facilitate shared learning, technical assistance, and capacity building across Pacific Island jurisdictions. Through these regional partnerships, the CNMI Public Health, inclusive of MICAH programs, participates in strategic planning and policy alignment with other island health systems, promoting regional consistency and evidence-based practices. The CNMI also receives direct support in workforce development, epidemiology training, and health system strengthening.

Additionally, the Division works closely with regional hospitals and public health agencies in Guam, American Samoa, and the Federated States of Micronesia to coordinate responses

to communicable disease outbreaks, exchange clinical expertise, and share data to support surveillance and contact tracing efforts.

National Partnerships

Nationally, the CNMI Division of Public Health partners with the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Association of State and Territorial Health Officials (ASTHO), the National Association of Chronic Disease Directors (NACDD), Association of Immunization Managers (AIM), and the Association of Maternal and Child Health Programs (AMCHP). These partnerships provide access to funding, technical guidance, policy support, and training that are instrumental in the development and implementation of public health programs.

With CDC support, CNMI has launched and sustained key programs in immunization, chronic disease prevention, emergency preparedness, and maternal and child health. CDC's regional project officers provide tailored support that accounts for the CNMI's unique context, ensuring grant activities are both feasible and impactful.

Through HRSA funding, the Division supports increasing access to preventive health services, primary care development, and the integration of behavioral health services in underserved communities. CNMI also participates in national learning collaboratives facilitated by ASTHO and the National Association of Chronic Disease Directors (NACDD) to adopt best practices and innovative approaches to local health priorities.

Impact of Partnerships

These partnerships have enabled CNMI MICAH Programs to:

- A. Implement data-driven health interventions tailored to the local population;
- B. Strengthen workforce capacity through technical assistance and training;
- C. Improve access to preventive and primary care services;
- D. Increase community engagement in public health initiatives;
- E. Respond more effectively to public health emergencies.

Needs Assessment Methods

The needs assessment applied a mixed method approach with quantitative and qualitative data to develop a holistic description of MICAH strengths and needs in the CNMI.

Scan of Pre-existing Sources

With the goal of minimizing the burden of the assessment by leveraging information the community already had, the needs assessment began with an inventory and scan of extant documents and data relevant to MCH in the CNMI. The review included needs assessments, program materials, reports, and administrative data. A summary of the sources reviewed is in **Appendix A**.

Priority Health Issues Surveys for Youth and Professionals

The scan of pre-existing sources demonstrated that multiple recent, rigorous, health-focused surveys had been conducted with parents, caregivers, and adult community members in the CNMI. Thus, the assessment limited new, project-specific surveying to: 1) paid professionals situated in relevant organizational and community settings (e.g., public education, community health programs), and 2) adolescents whose perspectives were not adequately reflected in the extant data. Survey response rates are reported in **Table 1** below. Detailed reports summarizing the results overall and by island are provided in **Appendix B**. The paid professionals survey report also displays points of data triangulation (i.e., common findings) with the sources reviewed in the scan. Triangulation demonstrated strong alignment between the results of the professionals survey and extant sources.

Table 1. Priority Health Issues Survey Response Rates

Survey	Overall	Saipan	Rota	Tinian
Professionals	140	118	12	10
Youth	2760	2492	213	55

Interviews and Focus Groups

To further enrich understanding of MICAH strengths and needs in the CNMI, interviews and focus groups were conducted on Saipan, Tinian, and Rota. During these discussions, priority health issues survey results pertinent to the person/group were presented. Participants were then asked to share if/how the results were reflective of their perspectives and experiences, *why* the priorities are important in the CNMI's current context, and to offer recommendations for *how* the priorities could be addressed. **Table 2** on the following page summarizes the qualitative data gathered for the assessment (n=74 participants). An example focus group protocol is provided in **Appendix C**. Data garnered from the interviews and focus groups were analyzed for key themes. A report with focus group results disaggregated by island is provided in **Appendix D**.⁵

⁵Adult participants over the age of 18 provided verbal consent. All PATCH Teens had parental consent to engage in the full scope of PATCH activities prior to joining the program. The teens were informed that their participation was voluntary, and their responses kept confidential. They also verbally consented to participate. Interview and focus group participants received gift cards for gas or groceries to thank them for their time.

Table 2. Summary of Qualitative Data Collected During the Site Visits

Island	Data Collection Type	Participant Type	Participant Count
Saipan	Intercept interviews	Women of childbearing age	17 women, collectively parenting 39 children
Saipan	Interviews	Health providers - nurses, doctor	3 providers
Saipan	Interviews	Community health workers - WIC provider, HOME Visitor, CGC outreach worker	3 CHW
Saipan	Focus group	Mental health providers and program administrators	5 staff members
Saipan	Focus group	Public school educators and administrators	4 staff members
Saipan	Focus group	Parents with CSHCN	7 parents
Saipan	Focus group	Faith community leaders	5 leaders
Saipan	Focus group	PATCH Program teens ages 15-18	10 teens
Rota	Focus group	Health providers (3) Health clinic resident director (1) HOME Visitor (1)	5 staff members
Rota	Focus group	Community members	5 adults
Tinian	Focus group	Health providers (2) Health clinic resident director (1) HOME Visitor (1) Public school counselor (1)	5 staff members
Tinian	Focus group	Community members	5 adults

Priority Setting Meeting

Finally, a priority setting meeting was held at the end of the site visit. At the meeting, 46 community members and decision-makers were presented with an overview of the needs assessment process and the quantitative and qualitative data sources and findings. Printed handouts with the quantitative and qualitative data sources and findings were also provided. Then they self-selected into groups organized by the MCH domains (see **Table 3** on the following page).

Table 3. MCH Title V Domains

Domain	Description
Women/maternal health	The health of women prior to, during, and between pregnancies
Perinatal/infant health	20 weeks gestation to <1 year
Child health	1-9 years old
Adolescent health	10-17 years old
Children with special healthcare needs (CSHCN)	Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount that goes beyond which is required by children generally
Cross-cutting/system building	Addresses program capacity and/or the systems-building needs of the CNMI.

Figure 1 on the following page displays an overview of the needs assessment methods as presented to stakeholder meeting attendees. The pink circle labeled “priority setting and action planning” indicated the present stage at which stakeholders were contributing to the assessment.

Stakeholder meeting attendees were then instructed to use an adapted strategy grid method⁶ to identify domain-specific priorities for the next five years and actions to execute them. Specifically, they were presented with a four-quadrant matrix structure in which the horizontal axis ranged from low to high *feasibility* and the vertical axis ranged from low to high *importance/urgency*. For each priority identified in the surveys and qualitative data, the domain-specific working groups used sticky notes to position the priority within the matrix and offer the logic underlying their selections (see **Figure 2**). After the first work session, the groups presented their top three priorities to the larger whole. Then they returned to their domain-specific groups for a second work session during which they identified concrete actions they believed should be implemented in the next five years to address the priorities. These priority actions were then presented to the larger whole.

⁶ Duttweiler, M. 2007. *Priority Setting Tools: Selected Background and Information and Techniques*. Cornell Cooperative Extension as cited in the National Association of County and City Health Officials Guide to Prioritization Techniques.

Figure 1. Needs Assessment Methods as Presented at the Stakeholder Meeting

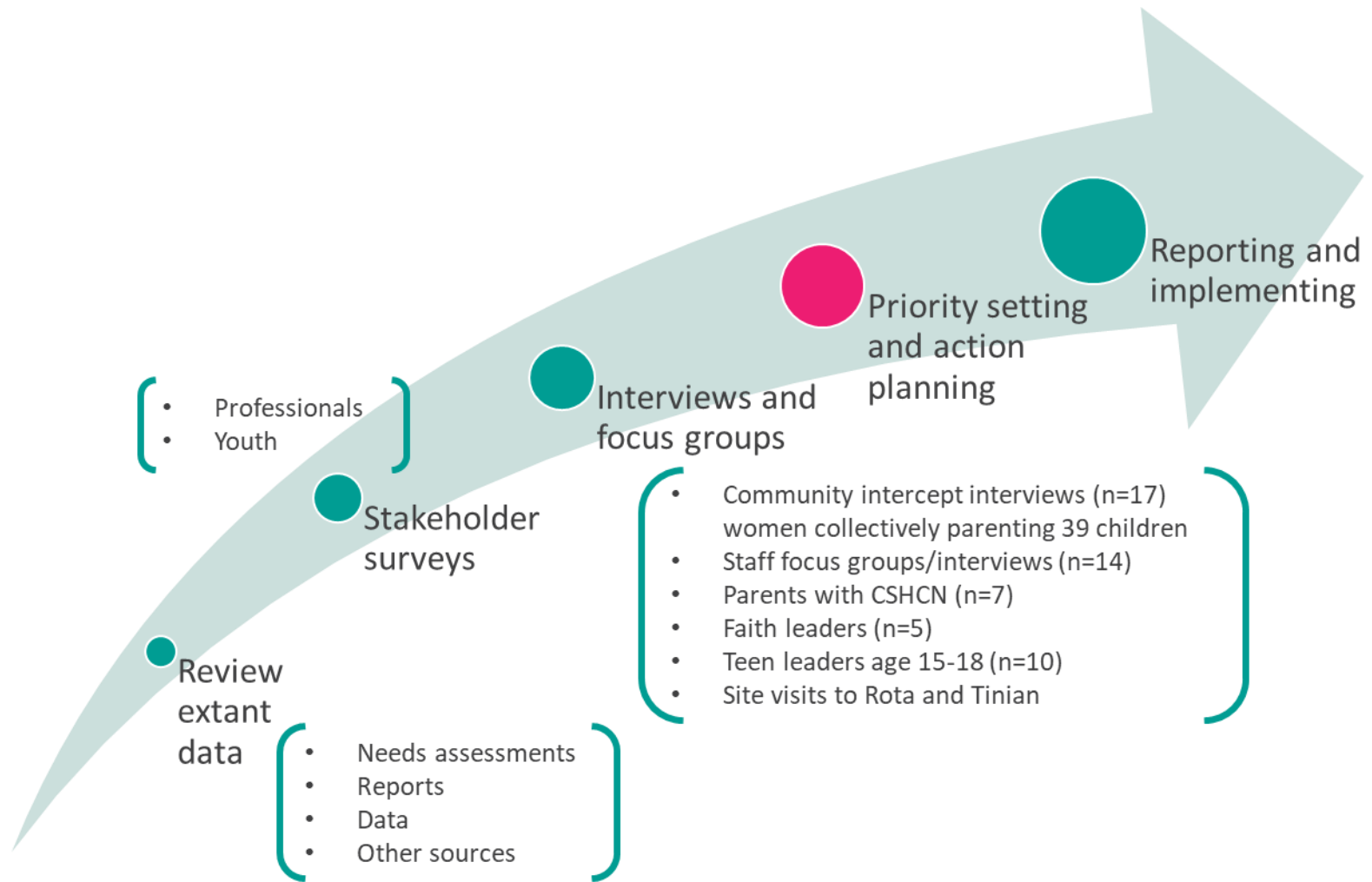
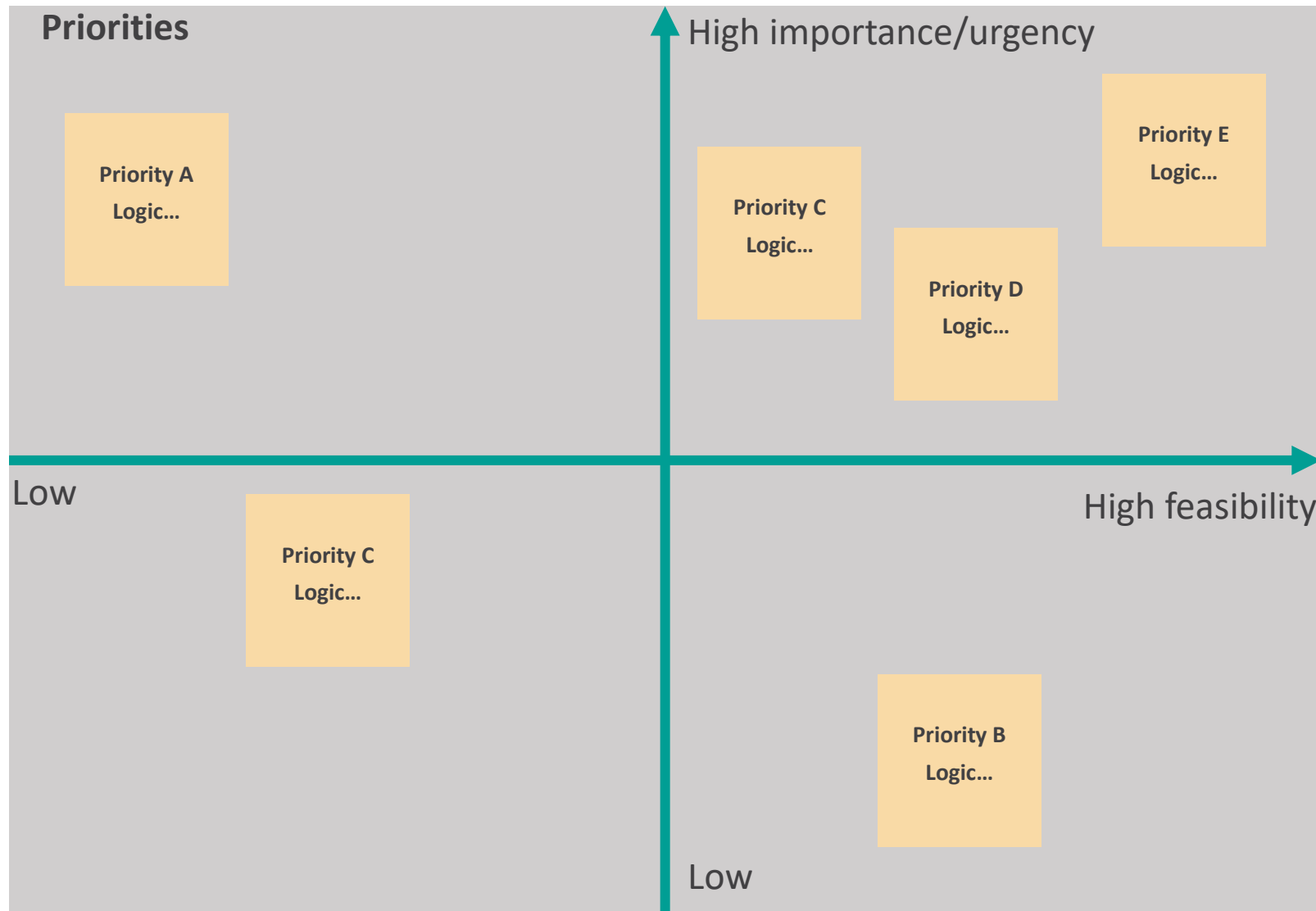


Figure 2. Strategy Grid Structure that Stakeholders Used to Prioritize Needs



MCH Needs Assessment Priority Recommendations by Steering Committee

The Steering Committee, consisting of both internal and external partners and stakeholders, plays an essential role in guiding and overseeing the 5-year needs assessment. The Steering Committee was tasked with making a final selection of priorities that are specific, measurable, achievable, relevant, and time bound.

Guided by the priority needs and recommendations gathered with the surveys, interviews, focus groups, and strategy grid priority setting process, the Steering Committee selected a final set of top priorities that are strategically sound, operationally viable, support efficient resource use, and align with the MCH Title V Block Grant application guidance. Perhaps most important, the Steering Committee believes the priorities are well-positioned to contribute to improved health outcomes for women, children, and families across the Commonwealth.

Findings

The following sections present detailed information for each MCH Title V Domain. **For the five domains reflecting age-based subpopulations (i.e., women/maternal, perinatal/infant, etc.), summary tables display the 2019-2023 NOM, NPM, ESM, and SPM data. Related Healthy People 2020 objectives are also included in the tables.**⁷ As available/relevant, additional quantitative data are also provided. A narrative description of health and wellbeing based on trends in the data precede each table.

Following the data tables, figures (i.e., bar charts) present the results from the priority health issues survey (i.e., professionals and/or adolescents) relevant to each domain. Top priorities identified during the strategy grid priority setting process are highlighted with blue bars. Direct quotations drawn from the qualitative methods (see **Table 2**, pg. 16) and which reflect the priorities are provided next to the blue bars in charts. Unless the speaker is identified as from Rota or Tinian, the quote is from Saipan.

Following the figures, the stakeholder-selected top priorities are listed again, along with the strategic actions meeting participants recommended to accomplish them. Healthy People 2030 objectives and current NOMs and NPMs relevant to the priorities are also shown.

Finally, the priorities determined by the Steering Committee are listed.

⁷ 2020 Healthy People objectives are presented in the tables because these were the objectives that guided public health practices in the CNMI during the 2020-2023 performance period. 2030 Healthy People objectives are presented along with the priorities identified for 2025-2030 following the data tables for each MCH domain.

Women/Maternal Health Domain

Women of childbearing age continue to face challenges meeting their healthcare needs. Medicaid applications are lengthy, with extensive documentation requirements. Non-citizen women – including those who live in poverty - do not qualify. Many women may feel hesitant to engage with the medical system due to previous challenging experiences with care, and in the CNMI, there are broader cultural and systemic factors that contribute to people delaying attention to their health needs. **Table 4** summarizes available 2019-2023 NOM, NPM, ESM, and SPM data and relevant Healthy People 2020 objectives for the CNMI Women/Maternal Health population. Trends are mixed, with some measures moving in the desired direction and others not. For example, while the percentage of women receiving first trimester prenatal care has increased since 2019, the proportion who attended a postpartum checkup has declined. The rate of postpartum depression remains high; in 2023 48% of women reported symptoms following a recent live birth. A highlight, no women have reported smoking during pregnancy since 2021.

Table 4. Women/Maternal Health Domain – Trend Data and Healthy People 2020 Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
NOM 1	PNC	% of live births with reported first prenatal visit during the first trimester	HVSO	38%	54%	67%	62%	58%
Healthy People 2020 Objective MICH-10.1: Relevant to NOM 1: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester. (Baseline: 77.1% of females delivering a live birth received prenatal care beginning in the first trimester in 2016, Target: 84.8%)								
Postpartum visit-B	PPV (B)	Percent of women who attended a postpartum checkup and received recommended care components	PRAMS	--	--	--	67%	
SPM 1	PNC	Percent of live births to <u>resident women</u> with first trimester prenatal care	HVSO	49%	56%	67%	62%	61%
NOM 2	SMM	Rate per 10,000 of deliveries hospitalizations with an indication of severe morbidity from ICD-10 diagnosis or procedure codes	HVSO	176	122	261	254	293

Healthy People 2020 Objective MICH-6: Relevant to NOM 2: Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery per 100 deliveries). (Baseline: 31.1 percent of pregnant females suffered complications during hospitalized labor and delivery in 2007, (Target: 28%)

NOM 3	MM	Rate per 100,000 of deaths related to or aggravated by pregnancy, but not due to accidental or incidental causes, and occurring within 42 days of the end of a pregnancy	HVSO	0	0	174	0	0
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Healthy People 2020 Objective MICH-5: Relevant to NOM 3: Reduce the rate of maternal mortality. (Baseline:12.7 maternal deaths per 100,000 live births in 2007, Target: 11.4 maternal deaths per 100,000 live births)

NOM 10	DPP-A	Percent of women who report drinking alcohol in the last 3 months of pregnancy	HVSO	--	1%	0%	1%	4%
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Healthy People 2020 Objective MICH-11.1: Relevant to NOM 10: Increase abstinence from alcohol among pregnant women. (Baseline: 89.4 percent of pregnant females ages15 to 44 years reported abstaining from alcohol in the past 30 days in 2007–08, Target: 98.3%)

NOM 24	PPD	Percent of women who report postpartum depressive symptoms following a recent live birth	MCHJ	*57%	--	*34%	--	*48%
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Healthy People 2020 Objective MICH-34: Relevant to NOM 24: Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms (Developmental)

Scan Source of Triangulation

Access to mental health services was a priority identified in the Community Health Assessment (2024)

NPM 1	WWV	Percent of women, ages 18-44, who had a preventative medical visit in the past year	MCHJ	*56%	--	57%	--	55%
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Healthy People 2020 Objective MICH-16.1: Relevant to NPM 1: Increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy

Scan Sources of Triangulation

- 37% of adult women ages 50-70 had an up-to-date colon cancer screening (Adult Hybrid Survey Non-Communicable Disease, 2023)

- Less than half have had received a mammogram or less than 65% had a pap smear (Adult Hybrid Survey Non-Communicable Disease, 2023)

NPM 13.1	PDV-Pregnancy	Percent of women who had a preventative dental visit during pregnancy	MCHJ	29%	--	28%	--	38%
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Healthy People 2020 Objective OH-7: Relevant to NPM 13.1: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year. (Baseline: 44.5%, Target: 49.0%)

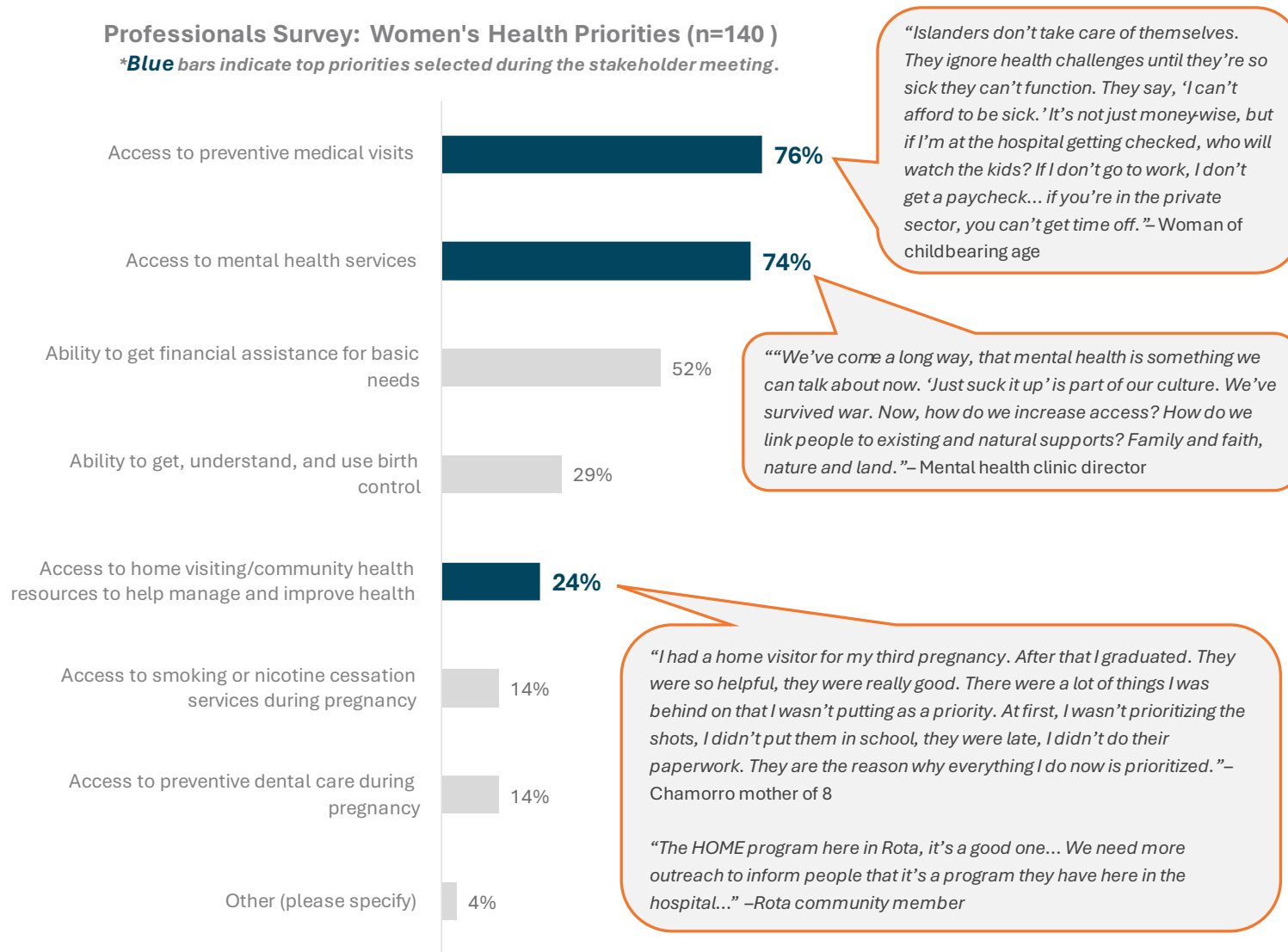
NPM 14.1	SMK-Pregnancy	Percent of women who report smoking during pregnancy	MCHJ	*56%	--	*0%	--	*0%
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Healthy People 2020 Objective TU-6: Relevant to NPM 14.1: Increase smoking cessation during pregnancy (Baseline: 11.3, Target: 30.0%) and related to Tobacco Use (**TU11.1**); Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke. (Baseline: 52.2%, Target 47%)

* Indicator has a confidence interval width > 20% points, > 1.2 times the estimate, or that it is inestimable and should be interpreted with caution.

Figure 3 on the following page presents the results of the priority health issues survey administered among paid professionals in the CNMI. **Blue bars identify women/maternal health priorities identified during the stakeholder meeting.** Quotes reflecting the top identified priorities are also provided. As shown, survey data offer additional support for prioritizing access to health and mental health services.

Figure 3. Women/Maternal Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews



Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting, along with the logic given for prioritizing each and the recommended actions to address them. The top two priorities are the same as those which were identified in the professionals' survey.

Priority 1. Access to preventative medical visits.

- *Logic:* Early detection will reduce healthcare costs.
- *Recommended Action(s):* Support funding for community health services (e.g., mobile clinic)

Priority 2. Access to mental health services.

- *Logic:* Mental health is just as important as physical health, contributing to improved productivity and quality of life.
- *Recommended Action(s):* Increase public service awareness and coverage (e.g., 988 crisis hotline, radio, social media, and community events)

Priority 3. Access to home visiting/community health resources to help manage and improve health.

- *Logic:* Home visitors connect families to community health resources to help manage and improve health.
- *Recommended Action(s):* Increase and support staffing capacity to serve the community. Improve and utilize the directory listing of community health resources.

Table 5 lists the top women/maternal health priorities along with the HRSA MCH Title V National Performance Measures (NPM) and Healthy People 2030 objectives they link to.

Table 5. Women/Maternal Health Priorities, NPMs, and Relevant Healthy People 2030 Objectives

Priorities	Relevant National Performance Measures	Relevant Healthy People 2030 Objectives
Access to preventative medical visits	Well-Woman Visit (WWV) – Percent of women, ages 18-44, with a preventative medical visit in the past year Preventative Dental Visit (PDV-Pregnancy) Percent of women who had a dental visit during pregnancy	AHS-08 – Increase the proportion of adults who get recommended evidence-based preventative health care OH-08 – Increase the proportion of adults who use the oral health care system OH-07 – Increase the proportion of oral and pharyngeal cancers detected at the earliest stage

Access to mental health services	Postpartum Visit (PPV -B) – Percent of women who attended a postpartum checkup and received recommended care components	MHMD-08 – Increase the proportion of primary care visits where adults are screened for depression MICH-D01 – Increase the proportion of women who get screened for postpartum depression
Access to home visiting/community health resources to help manage and improve health	Safe Sleep – A (SS-A) - Percent of infants placed to sleep only on their backs (not stomach or side) in the past two weeks.	MICH-14 - Increase the proportion of infants who are put to sleep on their backs

While none of the national measures or Healthy People 2030 objectives specifically focus on home visiting/community health resource access, increased access to resources to help manage and improve health through these pathways could influence a variety of national measures/Healthy People 203 Objectives. For example, women receiving home visiting services are encouraged by their visitors to complete recommended postpartum visits. Some Home Visiting programs align their services with National and Outcome measures such as safe sleep, postpartum attendance, and breastfeeding.

Final Priorities for Women/Maternal Health Domain Selected by the MCH Needs Assessment Steering Committee

Following the initial priority-setting meeting where stakeholders identified access to preventive medical visits, access to mental health services, and home visiting/community health resources as the top health priorities, the CNMI MCH Needs Assessment Steering Committee undertook a deeper prioritization process. This additional step was prompted by the need to align selected priorities with the current organizational capacity, availability of resources, and the practical feasibility of implementation for the Title V five-year funding cycle. The MCH Steering Committee selected the following two priorities for the next 5 years:

Priority 1. Access to preventative medical visits.

Access to preventative medical visits (Baseline: 55% (MCHJ), Target: 60%) continued to be ranked as the most critical health need for women in the CNMI. The priority of improving access to preventative medical visits aligns closely with the CNMI MCH agency’s existing infrastructure and capacity. The CHCC has a Mobile Clinic equipped to provide community-based outreach, health screenings, and preventative services. Leveraging this mobile clinic capacity will allow the MCH program to:

- Reach underserved populations in remote or hard-to-access areas.
- Provide early detection and intervention for common health conditions.
- Reduce long-term healthcare costs by addressing conditions before they worsen.

Priority 2. Access to mental health services.

Access to mental health services was selected as a priority for women diagnosed with postpartum depressive symptoms. Prioritizing postpartum mental health services will allow the MCH program to:

- Improve postpartum visits and deliver recommended treatment for women with mental health concerns (Baseline: 67% (PRAMS); Target 72%).
- Reduce suicide rates.
- Increase use of available prevention services.
- Increase public service awareness and coverage (e.g., 988 crisis hotline, radio, social media, and community events).

Considering these factors, the Steering Committee determined that access to preventive medical visits and access to mental health services are realistic and achievable priorities. They reflect clear community needs, offer opportunities for measurable impacts, and build on the MCH agency's current strengths which include mobile service delivery, inter-program referral, and cross-sector collaboration.

Perinatal/Infant Health Domain

Table 6 summarizes available MCH performance and outcomes data from 2019 to 2023, and the related Healthy People 2020 objectives.⁸ Similar to data trends for women, results are mixed. The percentage of low birthweight babies has increased since 2019, as has the rate of infant deaths. More positively, however, breastfeeding rates have increased steadily with 89% of infants having been breastfed in 2023. Safe sleep practices are also improving; 48% of mothers reported placing their babies to sleep on their backs only.

Table 6. Perinatal/Infant Health Domain – Trend Data and Healthy People 2020 Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
NOM 4	LBW	Percent of live births weighing less than 2,500 grams	HVSO	6%	11%	8%	11%	11%
Healthy People 2020 Objective MICH 8.1: Relevant to NOM 4: Reduce low birth weight (LBW). (Baseline 8.2 percent of live births were low birth weight in 2007, Target- 7.8%)								
NOM 5	PTB	Percent of live births before 37 weeks of complete gestation	HVSO	8%	11%	9%	12%	11%

⁸ There were no relevant sources of triangulation identified with the scan.

Healthy People 2020 Objective MICH-9.1: Relevant to NOM 5: Reduce total preterm births (PTB). (Baseline 10.4 percent of live births were preterm in 2007; Target - 9.4%)

NOM 6	ETB	Percent of live births born at 37, 38 weeks of completed gestation	HVSO	26%	28%	29%	28%	32%
NOM 8	PNM	Rate per 1,000 of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days	HVSO	13%	9%	16%	13%	12%

Healthy People 2020 Objective MICH 1.2: Relevant to NOM 8: Reduce the rate of fetal and infant deaths during the perinatal period (28 weeks of gestation to 7 days after birth). (Baseline: 6.6 fetal and infant deaths per 1,000 live births and fetal deaths occurred during the perinatal period, 28 weeks gestation to 7 days after birth, in 2005; Target: 5.9 perinatal deaths per 1,000 live births and fetal deaths)

NOM 9.1	IM	Rate per 1,000 of deaths of infants from birth through 364 days of age	HVSO	4%	8%	12%	13%	14%
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Healthy People 2020 Objective MICH-1.3: Relevant to NOM 9.1: Reduce the rate of all infant deaths (within 1 year). (Baseline: 6.7 infant deaths per 1,000 live births within the first year of life in 2006, Target: 6.0 infant deaths)

NOM 9.2	IM -Neonatal	Rate per 1,000 of deaths to infants under 28 days	HVSO	4%	8%	10%	4%	7%
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Healthy People 2020 Objective MICH 1.4: Relevant to NOM 9.2: Reduce the rate of neonatal deaths (within the first 28 days of life). (Baseline: 4.5 neonatal deaths per 1,000 live births occurred within the first 28 days of life in 2006, Target: 4.1 neonatal deaths per 1,000 live births)

NOM 9.3	IM - post-neonatal	Rate per 1,000 of deaths to infants from 28 through 364 days of age	HVSO	0%	0%	2%	9%	7%
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Healthy People 2020 Objective MICH 1.5: Relevant to NOM 9.3: Reduce the rate of post-neonatal deaths (between 28 days and 1 year). (Baseline 2.2 post neonatal deaths per 1,000 live births occurred between 28 days and 1 year of life in 2006; Target 2.0 post neonatal deaths per 1,000 live births)

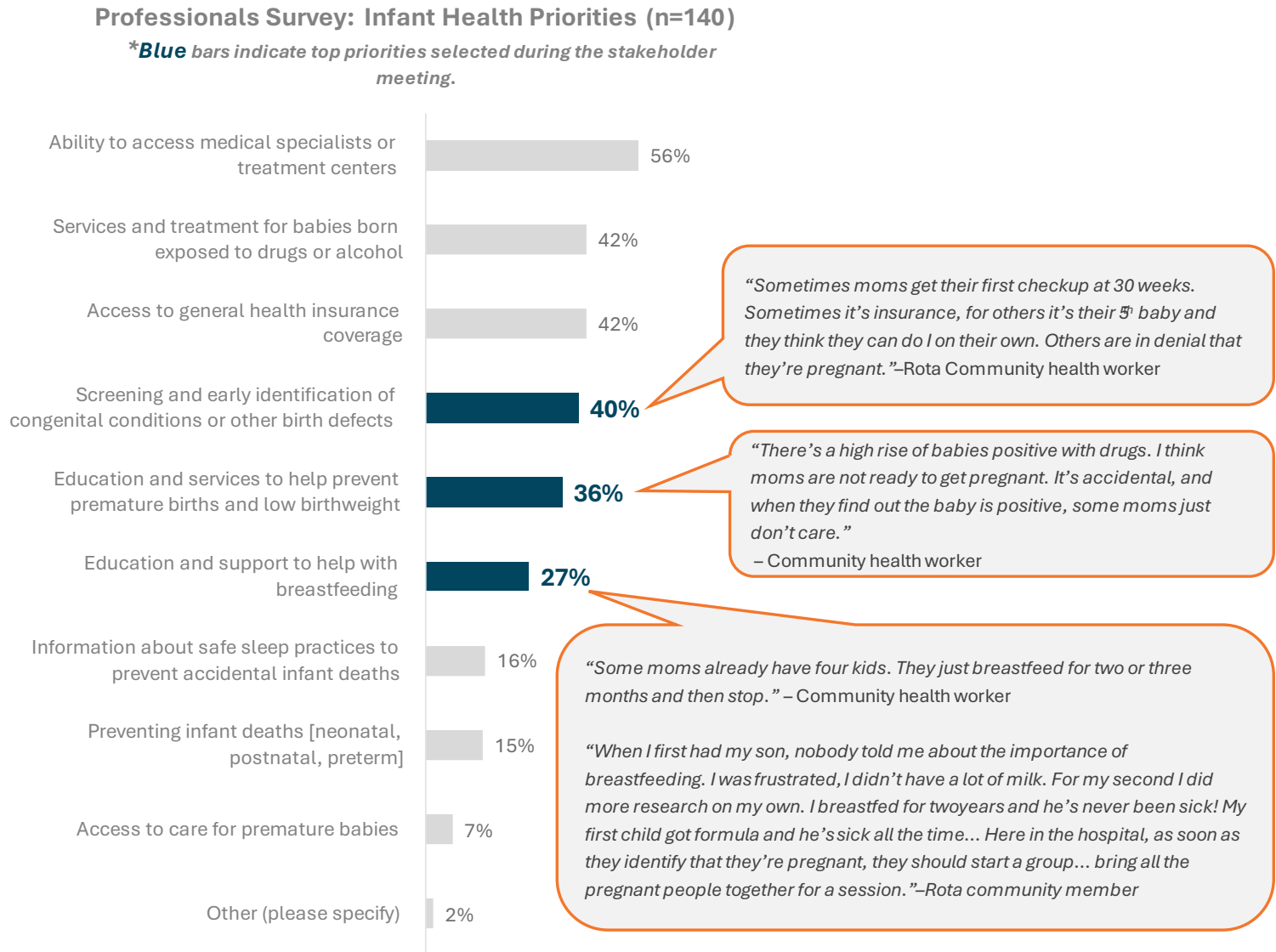
NOM 9.4	IM - Preterm-Related	Rate per 100,000 of infants born preterm with the underlying cause of death assigned to one	HVSO	220	306	696	0	344
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		of the flagged ICD-10 categories.						
Healthy People 2020 Objective MICH 1.3: Relevant to NOM 9.4: Reduce the rate of all infant deaths (within 1 year). (Baseline: 6.7 infant deaths per 1,000 live births within the first year of life in 2006, Target: 6.0 infant deaths per 1,000 live births)								
NPM 4A	BF-A	Percent of infants who are ever breastfed	CNMI WIC Program	96%	96%	97%	98%	96%
NPM 4B	BF-B	Percent of infants breastfed exclusively through 6 months	CNMI WIC Program	1%	.4%	0%	.5%	11%
Healthy People 2020 Objectives MICH 21.1, and MICH 21.4 Relevant to NPM 4A and 4B respectively: Increase the proportion of children who are ever breastfed (Baseline: 76.1 percent of infants born in 2009 were ever breastfed, as reported in 2011–12 , Target: 81.9%) and increase the proportion of children who are breastfed exclusively through 6 months (Baseline: 15.6 percent of infants born in 2009 were breastfed exclusively through 6 months, as reported in 2011–12 , Target: 25.5%).								
ESM 4.1	Breastfeeding	Percentage of WIC infants who were breastfed at 6 months.	CNMI WIC Program	37%	44%	45%	40%	43%
Healthy People 2020 Objectives MICH 21.2: Relevant to ESM 4.1: Increase the proportion of infants who are breastfed at 6 months (Baseline 46.6 percent of infants born in 2009 were breastfed at 6 months, as reported in 2011-12, Target 60.6%)								
NPM 5A	SS-A	Percent of mothers reporting that they most often place their baby to sleep on their back only	PRAMS	--	--	--	51%	--
NPM 5B	SS-B	Percent of mothers reporting that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing	PRAMS	--	--	--	15%	--
NPM 5C	SS-C	Percent of mothers reporting that their baby does not usually sleep with blankets, toys,	PRAMS	--	--	--	30%	--

		cushions, pillows, or crib bumper pads						
<p>Healthy People 2020 Objective MICH 20; Relevant to NPM 5A, 5B, and 5C: Increase the proportion of infants placed to sleep on their backs, separate approved sleep surface, and without soft object or loose bedding respectively. (Baseline 68.9 percent of infants were put to sleep on their backs in 2007, Target 75.8 %)</p>								

Figure 4 on the following page presents the results of the priority health issues survey administered among paid professionals in the CNMI. **Blue bars identify perinatal/infant health priorities identified during the stakeholder meeting.** Quotes reflecting the top identified priorities are also provided. Stakeholders’ top priorities are aligned with trends in national outcome measure data. However, just 16% of survey respondents identified information about safe sleep practices as a priority despite just 11% of mothers reporting that their baby always or often sleeps alone, usually in a crib, bassinet, or pack and play, and not usually in a standard bed, couch, sofa, armchair, car seat, or swing (NPM 5B in **Table 5** above).

Figure 4. Perinatal/Infant Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews



Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting, along with the logic given for prioritizing each and the recommended actions to address them.

Priority 1. Screening and early identification of congenital conditions/other birth defects.

- *Logic:* Screenings are available and are used to identify needed referrals for further treatment.
- *Recommended Action(s):* Train professionals in learning the signs and symptoms. Increase awareness through educational outreach (e.g., mobile clinic).

Priority 2. Education and services to help prevent premature births and low birthweight.

- *Logic:* Providing education is beneficial and improves partnerships among agencies.
- *Recommended Action(s):* Provide transportation assistance such as through gas and Commonwealth Office of Transit Authority (COTA) vouchers.

Priority 3. Education and support to help with breastfeeding.

- *Logic:* Providing education is beneficial and improves partnerships among agencies.
- *Recommended Action(s):* Deliver breastfeeding support through agency programs (e.g., HOME Visiting).

Table 7 lists the top perinatal/infant health priorities along with the HRSA MCH Title V National Performance Measures (NPM) and Healthy People 2030 objectives they link to.

Table 7. Perinatal/Infant Priorities, NPMs, and Relevant Healthy People 2030 Objectives

Priorities	Relevant National Performance Measures	Relevant Healthy People 2030 Objectives
Screening and early identification of congenital conditions/other birth defects.	NOM 12 (NBS): Percent of eligible newborns screened for heritable disorders with on time physician notification for out-of-range screens who are followed up in a timely manner. (DEVELOPMENTAL)	MICH-02 – Reduce the rate of infant deaths HOSCD-01 Increase the proportion of newborns who get screened for hearing loss by age 1 month
Education and services to help prevent premature births and low birth weight.	NOM 4 (LBW) - Percent of low-birth-weight deliveries (<2,500 grams) NOM 5 (PTB) - Percent of preterm births (<37 weeks)	MICH 07 – Reduce preterm births MICH-11 - Increase abstinence from illicit drugs among pregnant women

	Risk-Appropriate Perinatal Care (RAC) – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU)	MICH-33 - Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers
Education and support to help with breastfeeding.	NPM 4 A (BF-A) – Percent of infants who are ever breastfed NPM 4B (BF-B) – Percent of infants breastfed exclusively through 6 months	MICH 16 – Increase the proportion of infants who are breastfed at 1 year MICH 15 – Increase the proportion of infants who are breastfed exclusively through age 6 months
Not prioritized during the stakeholder meeting	REQUIRED NPM Medical Home (MH): Percent of children ages 0-17 who have a medical home	MICH-19 – Increase the proportion of children and adolescents who receive care in a medical home

Final Priorities for Perinatal/Infant Health Domain Selected by the MCH Needs Assessment Steering Committee

Following the stakeholder priority setting meeting, the CNMI MCH Needs Assessment Steering Committee recommended:

Priority 1. Education and services to help prevent premature births and low birth weight.

Premature births - baseline: 11%, Target 6%; premature births increased from 8% in 2019 to 11% in 2023 - HVSO

Low Birth weight - baseline: 11%, Target 10%; low birth weight increased from 6% in 2019 to 11% in 2023 - HVSO

The priority of education and services to help prevent premature births and low birth weight aligns with current emerging issues such as fetal and infant mortalities. Selecting this priority allows the MCH program to:

- Increase use of prenatal care.
- Decrease rates of fetal and infant mortality.
- Reduce rates of low birth weight and very low birth weight.
- Reduce rates of preterm birth.

Priority 2. Education and support to help with breastfeeding.

WIC breastfeeding rate: BF- B, Breastfed exclusively through 6 months (WIC: baseline: 11%, Target 16%). BF-B showed a positive trend from 1% in 2019 to 11% in 2023. The selection of the priority to educate and help with breastfeeding allows the MCH program to:

- Improve infant health outcomes.
- Improve maternal health outcomes.
- Increase breastfeeding initiation and duration.

Considering these factors, the Steering Committee determined that education and services to help prevent premature births and low birthweight and education and support to help with breastfeeding are realistic and achievable priorities. It reflects clear community needs, offers opportunity for measurable impacts, and builds on the MCH agency’s current strengths- including inter-program referral and cross-sector collaboration. By grounding the selections in both community and organizational feasibility, the CNMI MCH program aims to implement priorities that are both strategically sound and operationally viable, ensuring progress toward improving health outcomes for women, children, and families across the Commonwealth.

Child Health Domain

Table 8 summarizes available NOM, NPM, SPM, and ESM data from 2019 to 2023 and the related Healthy People 2020 objectives. Relevant sources of triangulation identified from the scan are also provided. Child health outcomes are improving in a number of areas including rates of physical activity, mental health service access, and vaccine completion. However, the percentage of children with caries has increased from 13% in 2019 to 25% in 2024 as measures with the maternal child health jurisdictional survey.

Table 8. Child Health Domain – Trend Data and Healthy People 2020 Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
NOM 14	TDC	Percent of children ages 1-17 who have decayed teeth or cavities in the past year ⁹	MCHJ	13%	--	17%	--	25%
Healthy People 2020 Objectives OH 1.1, OH 1.2 and OH 1.3 Relevant to NOM 14: OH 1.1 - Reduce the proportion of children ages 3-5 who have dental caries experience in their primary or permanent teeth (OH 1.1). (Baseline year 2020 :33.3 % (1999-2004), Target 49.0%) and OH 1.2 - Reduce the proportion of children ages 6-9 who have dental caries experience in their primary or permanent teeth (Baseline 54.4 percent of children aged 6 to 9 years had dental caries experience in at least one primary or permanent tooth in 1999-2004, Target 49.0%) and OH 1.3: Reduce the proportion of adolescents aged 13 to 15 years with dental caries experience in their permanent teeth (Baseline: 53.7%, Target: 48.3%).								
NPM 8.1	PA-Child	Percent of children, ages 6-11, who are physically active at least 60 minutes per day	MCHJ	*53%	--	*44%	--	*61%
Healthy People 2020 Objective PA 3 Relevant to NPM 8.1: Increase the proportion of the Nation’s public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%)								

⁹ NOMs 14, 15, 19, and 20, 21, 22.1, 22.2, and 25 include data for adolescents up to age 17.

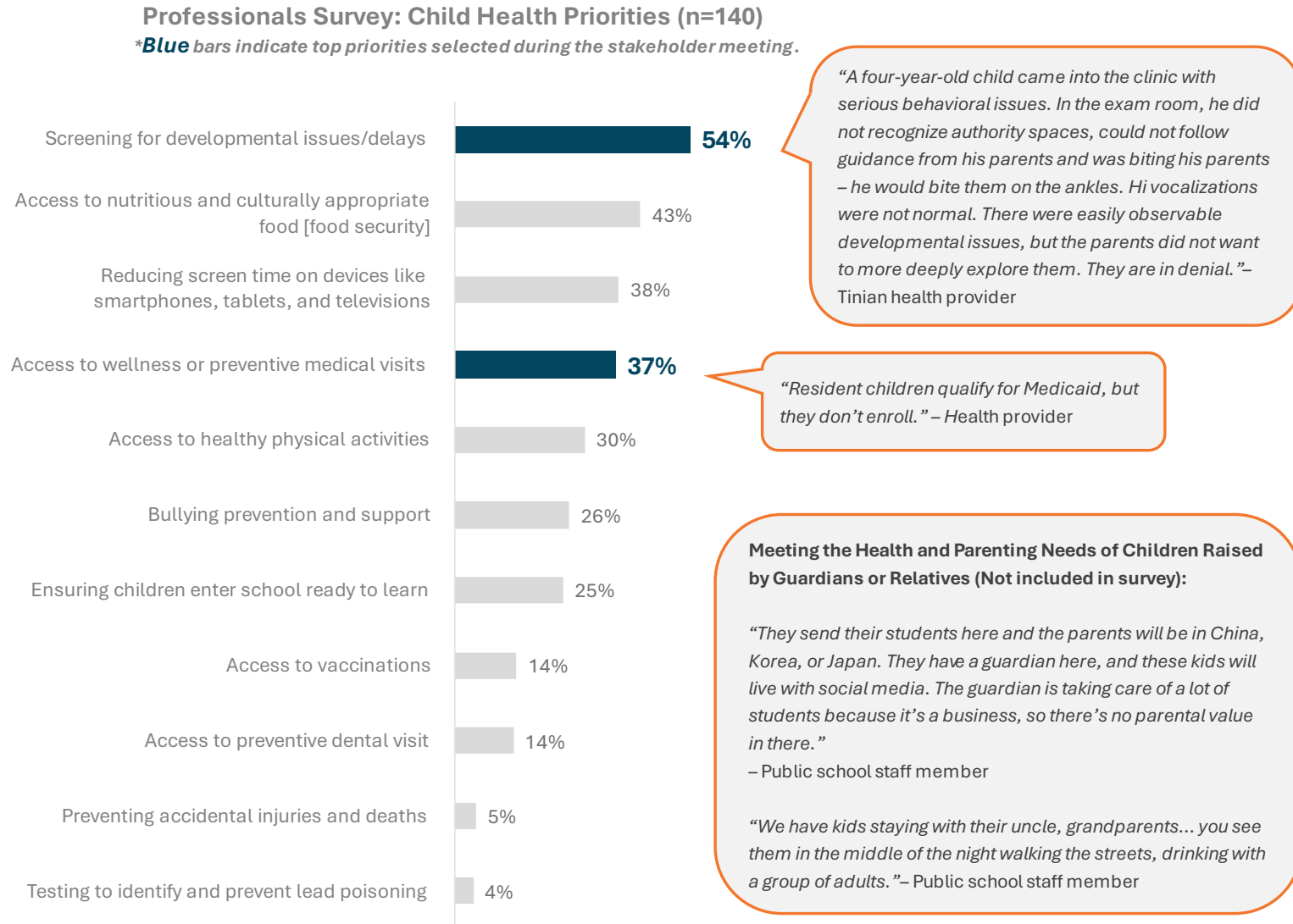
NPM 11	MH	Percent of children with special health care needs, ages 0-17, who have a medical home	MCHJ -CSHCN	*13%	--	*14%	--	*13%
Healthy People 2020 Objectives MICH 30.1 and MICH 30.2 Relevant to NPM 11: Increase the proportion of children who have access to a medical home. (Baseline: 57.5%, Target: 63.3%) and MICH 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%).								
NOM 15	CM	Child mortality rate ages 1-9 per 100,000	HVSO, US Census IDB	14	29	45	30	31
Healthy People 2020 Objective MICH 3.1 and MICH 3.2 Relevant to NOM 15: MICH 3.1 - Reduce the rate of child deaths aged 1-4 years. (Baseline 29.4 deaths among children aged 1 to 4 years per 100,000 population occurred in 2007, Target 26.5 deaths per 100,000 population) and MICH 3.2- Reduce the rate of deaths aged 5-9 years (Baseline 13.8 deaths among children aged 5 to 9 years per 100,000 population occurred in 2007, Target 12.4 deaths per 100,000 population)								
NOM 18	MHTX	Percent of children ages 3-17 with a mental/behavioral condition who receive treatment or counseling	MCHJ	*21%	--	* 8%	--	* 67%
Healthy People 2020 Objective MHMD 6 Relevant to NOM 18: Increase the proportion of children with mental health problems who receive treatment. (Baseline 68.9 Target 75.8)								
NOM 19	CHS	Percent of children ages 0-17 in excellent or very good health	MCHJ	81%	--	72%	--	78%
Healthy People 2020 Objective HRQOL/WB 1.1 Relevant to NOM 19: Increase the proportion of adults who self-report good or better physical health. (Base line 78.8, Target 79.8)								
NOM 20	OBS	Percent of adolescents ages 10-17 who are obese	MCH-JS	18%	--	24%	--	19%
NOM 20	OBS	Percent of students from grades 9 th through 12 who were obese	YRBS	22%	--	23%	--	--
Healthy People 2020 Objective NWS 10.4 Relevant to NOM 20: Reduce the proportion of children and adolescents aged 2-19 years who are considered obese. (Baseline: 16.1% in 2005-2008, Target: 14.5%).								
Scan Sources of Triangulation <ul style="list-style-type: none"> • Access to nutritious and culturally appropriate food [food security] is a CHA priority. • 56% of children aged 0-11 were in food-insecure households (MICH 2023) • 22% of 2-5 year olds enrolled in WIC are overweight or obese (WIC) 								

NOM 21	UI	Percent of children ages 0-17 without health insurance	MCHJ	22%	--	6%	--	20%
Healthy People 2020 Objective AHS 1.1 Relevant to NOM 21: Increase the proportion of persons with medical insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%)								
NOM 22.1	VAX-Child	Percent of children who have completed the combined 7-vaccine series by age 24 months	CHCC Immunization WebIZ	56%	72%	70%	73%	81%
Healthy People 2020 Objective IID 8.0 Relevant to NOM 22.1: Increase the percentage of children aged 19-35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV). (Baseline in 2009 of 44.3%, Target of 80.0%)								
NOM 22.2	VAX-Flu	Percent of children ages 6-17 who are vaccinated annually against seasonal influenza	CHCC Immunization WebIZ	51%	72%	28%	73%	81%
Healthy People 2020 Objective IID 12.11 Relevant to NOM 22.2: Increase the percentage of children aged 6 months through 17 years who are vaccinated annually against seasonal influenza. (Baseline of 46.9% in 2010-11 flu season, Target of 70%)								
NOM 25	FHC	Percent of children ages 0-17 who were unable to obtain needed health care in the past year	MCHJ	*6%	--	*6%	--	*3%
Healthy People 2020 Objective AHS 6.1 Relevant to NOM 25: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines. (Baseline 10% in 2007; Target 9%)								
Scan Source of Triangulation								
<ul style="list-style-type: none"> • Access to wellness or preventative medical visits is a CHA priority. 								

* Indicator has a confidence interval width > 20% points, > 1.2 times the estimate, or that it is inestimable and should be interpreted with caution.

Figure 5 on the following page presents the results of the priority health issues survey administered among paid professionals in the CNMI. **Blue bars identify health priorities identified during the stakeholder meeting.** Quotes reflecting the top identified priorities are also provided.

Figure 5. Child Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews



Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting, along with the logic given for prioritizing each and the recommended actions to address them. While the survey for professionals did not inquire about the health and parenting needs of children raised by guardians and relatives, this issue was surfaced by community members who contributed to the focus groups and selected as a top priority during the priority setting meeting.

Priority 1. Access to wellness or preventative medical visits.

- *Logic:* Existing systems are in place (i.e., mobile clinic, Family to Family program, and improved scheduling platforms).
- *Recommended Action(s):* Improve transportation.

Priority 2. Screening for developmental issues/delays.

- *Logic:* There are gaps and inconsistencies in implementation in clinical settings. Screenings are important to inform the level of care and services children need to support their development.
- *Recommended Action(s):* Create a developmental screening initiative that generates buy-in by delivering training and parent education in multiple languages. Deliver screenings across clinical and school settings including daycare.

Priority 3. Meeting the health and parenting needs of children raised by guardians and relatives. *NOTE:* This priority was not included in the health priorities survey.

- *Logic:* These children deserve attention and care.
- *Recommended Action(s):* Deliver guardian support legislation. Assist guardians to access notary, authorization, and education services.

Table 9 on the following page lists the top child health priorities along with the HRSA MCH Title V National Performance Measures (NPM) and Healthy People 2030 objectives they link to.

Table 9. Child Health Priorities, NPMs, and Relevant Healthy People 2030 Objectives

Priorities	Relevant National Performance Measures	Relevant Healthy People 2030 Objectives
Access to wellness or preventative medical visits.	<p>NPM-10 Adolescent Well-Visit (AWV) – Percent of adolescents ages 12-17 with preventative medical visit in the past year</p> <p>NPM 13.2 Preventative Dental Visit (PDV-Child) – Percent of children, ages 1-17, who had a preventative dental visit in the past year</p> <p>NPM-15 Adequate Insurance – Percent of children ages 0-17 who are continuously and adequately insured</p>	<p>AH-01 - Increase the proportion of adolescents who had a preventive health care visit in the past year</p> <p>OH-08 - Increase use of the oral health care system</p> <p>AHS-01 - Increase the proportion of people with health insurance</p>
Screening for developmental delays.	NPM-6 Developmental Screening (DS) – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.	<p>MICH-17 – Increase the proportion of children who receive a developmental screening</p> <p>EMC-D01 – Increase the proportion of children who are developmentally ready for school</p> <p>EMC-R01 – Increase the proportion of children with developmental delays who get intervention services by age 4 years</p>
Meeting the health and parenting needs of children raised by guardians and relatives.	NOM –19 Children Health Status (CHS) - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	EMC-01 - Increase the proportion of children and adolescents who communicate positively with their parents
Not prioritized during the stakeholder meeting	REQUIRED: NPM- 11A and NPM-11B (CSHCN) Medical Home (MH): Percent of children ages 0-17 who have a medical home	MICH-19 – Increase the proportion of children and adolescents who receive care in a medical home

Final Priorities for the Child Health Domain Selected by the MCH Needs Assessment Steering Committee

Based on the needs assessment priority selection results, the MCH Steering Committee selected one (1) priority measure for the child health domain: “Access to healthy physical activities”, which was selected by 30% of professionals who responded to the needs assessment survey. This measure aims to promote children’s physical activity and social well-being while reducing sedentary lifestyles, which can negatively impact physical and mental health.

Priority 1. Access to healthy physical activities

Aimed at increasing Child Physical Activity- PA-Child (MCHJ - Baseline: *61%; Target 66%

The MCHJ survey indicated an increase in children, ages 6-11, who are physically active at least 60 minutes per day from *53% in 2019 to *61% in 2023.

*Note: Indicator has a confidence interval width > 20% points, > 1.2 times the estimate, or that it is inestimable and should be interpreted with caution.

The priority of increasing access to healthy physical activities aligns with current issues such as non-communicable diseases (NCDs) and other related disorders. Selecting this priority allows the MCH program to:

- Lower risk of childhood obesity.
- Improve reported physical activity levels.
- Improve mental health and emotional well-being.

Considering these factors, the Steering Committee determined that addressing access to healthy physical activities is a realistic and achievable priority. It reflects clear community needs, offers opportunity for measurable impacts, and builds on the MCH agency's current strengths including program referral and cross-sector collaboration.

Adolescent Health Domain

Table 10 on the following page summarizes available NOM, NPM, SPM, and ESM data from 2019 to present and the related Healthy People 2020 objectives. Relevant sources of triangulation identified from the scan are also provided. Highlights include much increased access to mental health services and high vaccination rates. The teen birth rate has also decreased. However, preventative medical visit rates have dropped in recent years and a greater percentage of youth have dental issues.

Table 10. Adolescent Health Domain – Trend Data and Healthy People 2020 Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
NOM 14	TDC	Percent of children ages 1-17 who have decayed teeth or cavities in the past year ¹⁰	MCHJ	13%	--	17%	--	25%
<p>Healthy People 2020 Objective OH 1.1, OH 1.2, OH 1.3 Relevant to NOM 14: OH 1.1 Reduce the proportion of children ages 3-5 who have dental caries experience in their primary or permanent teeth, (Baseline: 33.3%, Target: 30.0%), OH 1.2 Reduce the proportion of children ages 6-9 who have dental caries experience in their primary or permanent teeth (Baseline: 54.4%, Target: 49.0%) and OH 1.3 Reduce the proportion of adolescents aged 13 to 15 years with dental caries experience in their permanent teeth (Baseline: 53.7%, Target: 48.3%).</p>								
<p>Scan Source of Triangulation</p> <ul style="list-style-type: none"> 37% of children ages 1-17 had a preventative dental visit (MCHJ) 								
NPM 10	AWV	Percent of adolescents, ages 12-17, with a preventative medical visit in the past year	MCHJ	*42%		39%		27%
<p>Healthy People 2020 Objective AH 1; Relevant to NPM 10: Increase the proportion of adolescents who have had a wellness checkup in the past 12 months. (Baseline: 68.7%, Target: 75.6%)</p>								
NPM 11A	MH	Percent of children with special health care needs, ages 0-17, who have a medical home	MCHJ -CSHCN	*13%	--	*14%	--	*13%
<p>Healthy People 2020 Objective MICH 30.2; Relevant to NPM 11A: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)</p>								
NPM 12 A	TR	Percent of adolescents with special health care needs, ages 12-17, who received services to prepare for the transition to adult health care	MCHJ-	*51%	--	*33%	--	*71%
NPM 12-B	TR	Percent of adolescents without special healthcare needs, ages 12-17, whose families report that they received services	MCHJ	*50%	--	*42%	--	40%

¹⁰ NOM 14 and 18 and NPM 11 include child data.

		necessary to make transitions into adult health care						
Healthy People 2020 Objective DH 5; Relevant to NPM 12-A: Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care. (Baseline: 41.2%, Target: 45.3%)								
Scan Source of Triangulation								
<ul style="list-style-type: none"> • 27% of adolescents had a check-up (MCHJ) • 20% of children 0-17 years were uninsured (MCHJ) 								
NOM 16.1	AM	Adolescent mortality rate ages 10-19 per 100,000	HVSO, US Census IDB	30	0	0	31	11
Healthy People 2020 Objective MICH 4.1 and 4.2; Relevant to NOM 16.1:								
MICH 4.1 - Reduce the rate of adolescent deaths aged 10 to 14 years. (Baseline: 16.5 deaths among adolescents aged 10 to 14 years per 100,000 population occurred in 2007, Target: 14.8 deaths per 100,000)								
MICH 4.2 - Reduce the rate of adolescent deaths aged 15 to 19 years. (Baseline: 60.3 deaths among adolescents aged 15 to 19 years per 100,000 population occurred in 2007, Target: 54.3 deaths per 100,000)								
NOM 16.2	AM-Motor Vehicle	Adolescent motor vehicle mortality rate, ages 15-19 per 100,000	HVSO, US Census IDB	0	0	0	40.8	0
Healthy People 2020 Objective IVP 13; Relevant to NOM 16.2: Reduce motor vehicle crash-related deaths. (Baseline: 13.8 motor vehicle traffic-related deaths per 100,000 population occurred in 2007, Target: 12.4 deaths per 100,000 population)								
NOM 16.3	AM – Suicide	Adolescent suicide rate, ages 15-19 per 100,000	HVSO, US Census IDB	44	0	0	0	0
Healthy People 2020 Objective MHMD 1; Relevant to NOM 16.3: Reduce suicide rate; (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000)								
NOM 18	MHTX	Percent of children ages 3-17 with a mental/behavioral condition who receive treatment or counseling	MCHJ	*21%	--	*8%	--	*67%
Healthy People 2020 Objective MHMD 6; Relevant to NOM 18: Increase the proportion of children with mental health problems who receive treatment. (Baseline: 68.9% in 2008, Target: 75.0%)								
Scan Source of Triangulation (NOM 16.3 and 18)								

- Mental health is a CHA priority.
- 2% of adolescents had received mental health services (MCHJ)

NOM 20	OBS	Percent of children ages 10-17 who are obese	MCHJ	18%	--	24%	--	19%
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Healthy People 2020 Objective NWS 10.4; Relevant to NOM 20: Reduce the proportion of children and adolescents aged 2-19 years who are considered obese. (Baseline: 16.1% in 2005-2008, Target: 14.5%).

Scan Source of Triangulation (NOM 16.3 and 18)

- 41% described themselves as slightly or very overweight and 22% were not physically active for 60 minutes in the past week (YRBS)
- Top risks to health include being overweight, poor eating habits, and lack of exercise (CHA)

NOM 21	UI	Percent of children ages 0-17 without health insurance	MCHJ	22%	--	6%	--	20%
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Healthy People 2020 Objective AHS 1; Relevant to NOM 21: Increase the proportion of persons with health insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%)

NOM 22.2	VAX-Flu	Percent of children ages 6-17 who are vaccinated annually against seasonal influenza	CHCC Immunization WebIZ	51%	30%	28%	73%	81%
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Healthy People 2020 Objective IID 12.11; Relevant to NOM 22.2: Increase the percentage of children aged 6 months through 17 years who are vaccinated annually against seasonal influenza. (Baseline of 46.9% in 2010-11 flu season, Target of 70%)

NOM 22.3	VAX-HPV	Percent of adolescents ages 13-17 who have received at least one dose of the HPV vaccine	CHCC Immunization WebIZ	89%	96%	96%	73%	96%
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Healthy People 2020 Objective IID 11.4; Relevant to NOM 22.3: Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females by age 13 to 15 years. (Baseline in 2008 of 16.6%, Target of 80%)

NOM 22.4	VAX-TDAP	Percent of adolescents ages 13-17 who have received at least one dose of the Tdap vaccine	CHCC Immunization WebIZ	95%	98%	98%	97%	98%
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Healthy People 2020 Objective IID 11.1; Relevant to NOM 22.4: Increase the vaccination coverage level of 1 dose of tetanus-diphtheria-acellular pertussis (Tdap) booster vaccine for adolescents age 13 to 15 years. (Baseline 46.7% in 2008; Target of 80%)

NOM 22.5	VAX-MEN	Percent of adolescents ages 13-17 who have received at least one dose of the meningococcal conjugate vaccine	CHCC Immunization WebIZ	95%	98%	98%	100%	98%
Healthy People 2020 Objective IID 11.3; Relevant to NOM 22.5: Increase the vaccination coverage level of 1 dose meningococcal conjugate vaccine for adolescents by age 13 to 15 years (Baseline 43.9% in 2008; Target 80%)								
NOM 23	TB	Teen birth rate ages 15-19 per 1,000 females	HVSO, US Census IDB	22	15	13	10	17
Healthy People 2020 Objective FP 8.1 and FP 8.2; Relevant to NOM 23: FP 8.1 - Reduce pregnancies among adolescent females aged 15 to 17 years (Baseline 40.2 per 1,000 in 2005; Target 36.2 per 1,000) and FP 8.2: Reduce pregnancies among adolescent females aged 17 to 19 years (Baseline 116.2 per 1,000 in 2005; Target 105.9 per 1,000)								
Scan Source of Triangulation								
<ul style="list-style-type: none"> • 29% had ever had sex and 25% did not use birth control (YRBS) 								
NOM 25	FHC	Percent of children ages 0-17 who were unable to obtain needed health care in the past year	MCHJ	*6%	--	*6%	--	*3%
Healthy People 2020 Objective AHS 6.1; Relevant to NOM 25: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines. (Baseline 10% in 2007; Target 9%)								

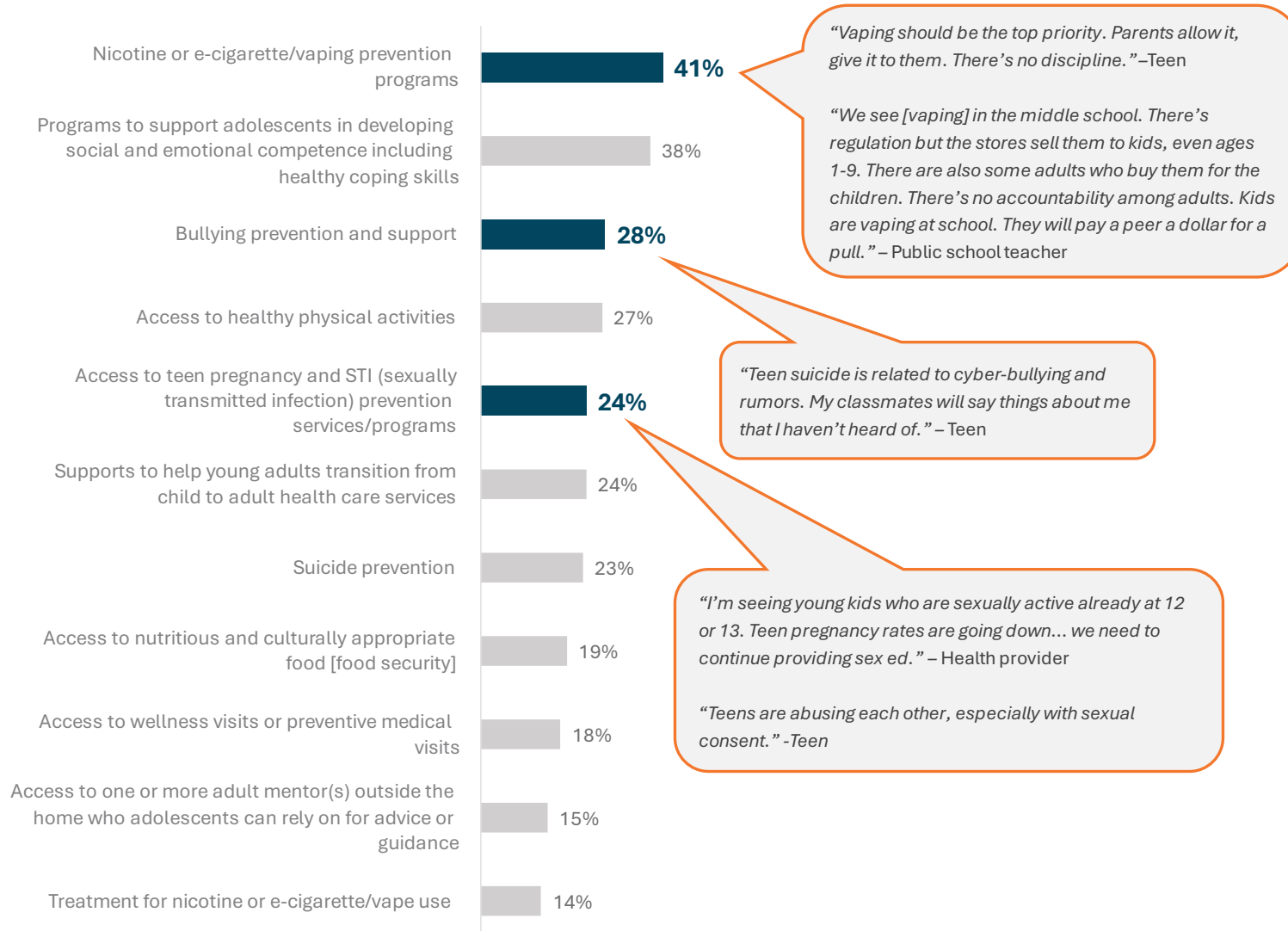
* Indicator has a confidence interval width > 20% points, > 1.2 times the estimate, or that it is inestimable and should be interpreted with caution.

Figure 6 on the following page presents the results of the priority health issues survey administered among paid professionals in the CNMI. The results of the adolescent health priority issues survey are contained in **Appendix B**. The results of the health priority issues survey completed by professionals are presented here. This is because the youth focus group participants' priorities were more strongly aligned with the results of the professionals survey. In the adolescent survey, nicotine or e-cigarette/vaping prevention programs was identified as a priority among 27% of respondents and bullying prevention and support was selected by 25%. Access to teen pregnancy and STI prevention services/programs was selected by just 16%; this may be the result of social desirability response bias. **Blue bars identify health priorities identified during the stakeholder meeting.** Quotes reflective of the top identified priorities are also provided. Top priorities identified in the survey were also strongly emphasized during qualitative data collection events with teens and educators.

Figure 6. Adolescent Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews

Professionals Survey: Adolescent Health Priorities (n=140)

**Blue bars indicate top priorities selected during the stakeholder meeting.*



Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting, along with the logic given for prioritizing each and the recommended actions to address them. Priorities selected during the priority setting meeting were aligned with the professionals survey results.

Priority 1. Bullying prevention and support.

- *Logic:* Cyberbullying and blackmail are common bullying tactics among adolescents in the CNMI.
- *Recommended Action(s):* Deliver (cyber)bullying and blackmail prevention ads online that model behavior adolescents can mimic. Through policymaking and law revision, establish accountability outside of school settings.

Priority 2. Access to teen pregnancy and sexually transmitted infection (STI) prevention services.

- *Logic:* The mobile clinic is available to be used for this purpose.
- *Recommended Action(s):* Increase availability/consistency of STI programs and services. Deliver a mentorship program similar to the Big Brother/Big Sister model.

Priority 3. Nicotine or e-cigarette/vaping prevention programs.

- *Logic:* Vaping is rampant, observed on school campuses and in the community.
- *Recommended Action(s):* Inform youth of the health harming effects. Make law/policy revisions to reduce access.

Table 11 lists the top adolescent health priorities along with the HRSA MCH Title V National Performance Measures (NPM) and Healthy People 2030 objectives they link to.

Table 11. Adolescent Health Priorities, NPMs, and Relevant Healthy People 2030 Objectives

Priorities	Relevant National Performance Measures	Relevant Healthy People 2030 Objectives
Bullying prevention and support.	NPM - 9 Bullying (BLY) – Percent of adolescents ages 12-17 who are bullied or who bully others.	EH-DO1 – Increase the proportion of schools with policies and practices that promote health and safety. AH-R09 – Increase the proportion of public schools with a counselor, social worker, and psychologist LGBT-05 – Reduce bullying of lesbian, gay, or bisexual high school students

		<p>LGBT-D01 – Reduce bullying of transgender students</p> <p>AH-03 – Increase the proportion of adolescents who have an adult they can talk to about serious problems.</p> <p>EMC-D06 – Increase the proportion of children and adolescents who get preventative mental health care in school</p> <p>EMC-D07 – Increase the proportion of children and adolescents who get show resilience to challenges and stress</p>
Access to teen pregnancy and sexually transmitted infection (STI) prevention services.	NPM-10 Adolescent Well-Visit (AWV) – Percent of adolescents, ages 12-17, with a preventative medical visit in the past year.	<p>FP-05 – Increase the proportion of adolescent females who used effective birth control the last time they had sex</p> <p>FP-06 - Increases the proportion of adolescent males who used a condom the last time they had sex</p> <p>FP-07 – Increase the proportion of adolescents who use birth control the first time they have sex</p> <p>FP-11 – Increase the proportion of adolescent females at risk for unintended pregnancy who use effective birth control</p> <p>HIV-01 – Reduce the number of new HIV infections</p> <p>STI-02 – Reduce gonorrhea rates in male adolescents and young men</p> <p>STI-07 – Reduce pelvic inflammatory disease in female adolescents and young women</p> <p>STI-01 – Increase the proportion of sexually active female adolescents and young women who get screened for chlamydia</p> <p>STI-D01 – reduce the proportion of adolescents and young adults with genital herpes</p>
Nicotine or e-cigarette/vaping prevention programs.	NPM 14.2 Smoking – Household (SMK-Household) – Percent of children, ages 0-17, who live in households where someone smokes.	<p>SU-R01 – Increase the proportion of adolescents who think substance abuse is risky</p> <p>TY-06 – Reduce current cigarette smoking in adolescents</p> <p>TU-08 – Reduce current use of smokeless tobacco products among adolescents</p> <p>T-07 – Reduce current cigar smoking in adolescents</p> <p>TU-10 – Eliminate cigarette smoking initiation in adolescents and young adults</p> <p>TU-05 – Reduce current e-cigarette use in adolescents</p> <p>TU-22 – Reduce the proportion of adolescents exposed to tobacco marketing</p> <p>TU-04 – Reduce current tobacco use in adolescents</p> <p>TU-09 – Reduce current use of flavored tobacco products in adolescents who use tobacco</p>
Not prioritized during the stakeholder meeting	REQUIRED NPM 11a and NPM 11b Medical Home (MH): Percent of children ages 0-17 with/without a medical home	MICH-19 – Increase the proportion of children and adolescents who receive care in a medical home

Final Priorities for the Adolescent Health Domain Selected by the MCH Needs Assessment Steering Committee

Based on the Needs Assessment results, the MCH Steering Committee selected the top two out of three Adolescent Health domain priorities to focus on for the next 5 years:

Priority 1. Access to teen pregnancy and sexually transmitted infection prevention programs.

- Teen Pregnancy TB - Teen birth rate, ages 15 through 19, per 1,000 females (Baseline: 17 per 1000; Target 16 per 1000)
Teen birth rates increase from 10 per 1,000 in 2022, to 17 per 1000 in 2023 for teens ages 15-19 years.
- Sexually transmitted Infections: - AH- 01 - Increase the proportion of adolescents who had a preventive health care visit in the past year (HP 2030 baseline: 69.6; Target – 82.6. According to the MCHJ survey, the percent of adolescents, ages 12-17, with a preventative medical visit in the past year, decreased from *42% in 2019, to 27% in 2023.

The selection of the priority to access to teen pregnancy and sexually transmitted infection (STI) prevention services allows the MCH program to:

- Reduce teen pregnancy rates.
- Reduce rates of STIs among adolescents.
- Improve use of contraception and prevention.
- Earlier and more consistent access to reproductive health care.
- Enhance adolescent health knowledge and autonomy.

Priority 2. Access to bullying prevention program.

The goal is to reduce the percentage of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY - (Baseline 9%; Target 8%). According to the Youth Risk Behavior Survey (YRBS) administered by the CNMI Public School System (YRBS), the percentage of high school teens reporting being bullied on school property in the past year increased from 9.9% in 2021 to 14.5% in 2023. There was also a slight increase in the percentage of high school students who reported being bullied electronically, at 16.9% in 2023 compared to 15.4% in 2021. The rates are even higher for youth in middle school with 35.7% reporting being bullied on school property and 33.7% reporting being bullied electronically.

The priority of bullying prevention and support aligns closely with the CNMI MCH agency's existing infrastructure and capacity. Selecting this priority allows the MCH program to:

- Support internal and external partners in their efforts to improve school climate and organizational culture.
- Increase reporting and help-seeking.
- Improve mental health outcomes.
- Reduce incidences of bullying including physical, verbal, and cyberbullying.

Considering these factors, the Steering Committee determined that bullying prevention and support and access to teen pregnancy and sexually transmitted infections (STIs) prevention services are realistic and achievable priorities. They reflect clear community needs, offer opportunities for measurable impacts, and build on the MCH agency's current strengths including mobile service delivery, inter-program referral, and cross-sector collaboration.

Children with Special Healthcare Needs (CSHCN) Domain

Table 12 summarizes available NOM, NPM, SPM, and ESM data from 2019 to present and the related Healthy People 2020 objectives. Relevant sources of triangulation identified from the scan are also provided. While the proportion of children in the CNMI with special health care needs appears to be increasing, medical service access as measured by the percentage of families served by the Family to Family Health Information Center who report having a medical home has decreased in recent years.

Table 12. CSHCN Health Domain – Trend Data and Healthy People 2020 Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
NOM 17.1	CSHCN	Percent of children with special health care needs, ages 0-17	MCHJ	6%	--	7%	--	8%
NOM 17.2	SOC	Percent of children with special health care needs ages 0-17 who receive care in a well-functioning system	MCHJ	*3%	--	*0%	--	*0%

Healthy People 2020 Objective MICH 19, 20, 30.1, and 30.2; Relevant to NOM 17.2:

MICH 19: Increase the proportion of children and adolescents who receive care in a medical home. (Baseline: 46.6%, Target: 53.6%) and
MICH 20: Increase the proportion of children and adolescents with special health care needs who have a system of care. (Baseline: 13.7%, Target 19.5%)
MICH 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and
MICH 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)

Scan Source of Triangulation

- 13% of CSHCN had a medical home and 6-% had a personal doctor or nurse (MCHJ)

NOM 17.3	ASD	Percent of children ages 3-17 diagnosed with autism spectrum disorder	MCHJ	*2%	--	*.2%	--	*2%
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Healthy People 2020 Objective MICH-29.1; Relevant to NOM 17.3: Increase the proportion of children (aged 10-35 months) who have been screened for Autism Spectrum Disorder (ASD) and other developmental delays. (Baseline 22.6 percent of children aged 10 to 35 months were screened for Autism Spectrum Disorder (ASD) and other developmental delays in the past year as reported in 2007; Target 24.9%.

NOM 17.4	ADHD	Percent of children ages 3-17 diagnosed with ADD/ADHD	MCHJ	*2%	--	*4%	--	*3%
----------	------	---	------	-----	----	-----	----	-----

Healthy People 2020 Objective MHMD 6; Relevant to NOM 17.4: MHMD 6 - Increase the proportion of children with mental health problems who receive treatment. (Baseline: 68.9 percent of children with mental health problems received treatment in 2008, Target 75.8%)

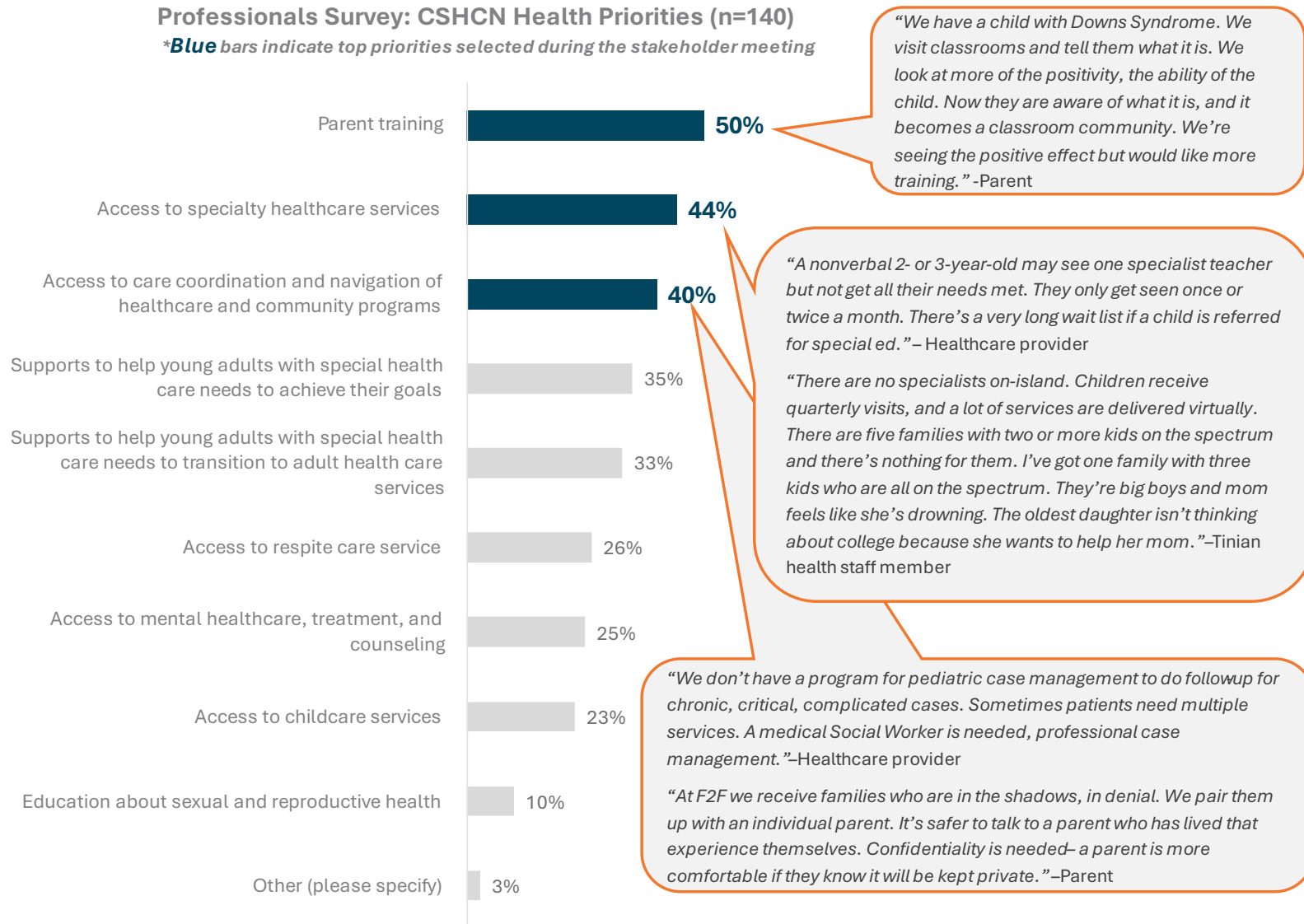
Scan Source of Triangulation

- 51% of CSHCN received services to make the transition to adult health care services (MCHJ)

** Indicator has a confidence interval width > 20% points, > 1.2 times the estimate, or that it is inestimable and should be interpreted with caution.*

Figure 7 on the following page presents the results of the priority health issues survey administered among paid professionals in the CNMI. **Blue bars identify health priorities identified during the stakeholder meeting.** Quotes reflective of the top identified priorities are also provided. Parent training surfaced as a top priority.

Figure 7. CSHCN Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews



Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting are listed, along with the logic given for prioritizing each and the recommended actions to address them. Priorities selected during the priority setting meeting were aligned with the professionals survey results.

Priority 1. Access to care coordination and navigation of healthcare and community programs.

- *Logic:* This will ensure families are able to navigate and find information and services, including insurance coverage and timely support with basic needs and essential services during emergencies.
- *Recommended Action(s):* Provide a directory of services for CSHCN.

Priority 2. Parent training.

- *Logic:* Parents of CSHCN identified American Sign Language and advocacy as training topic priorities during the focus group.
- *Recommended Action(s):* Assess the availability and feasibility of established program models for implementation in the CNMI.

Priority 3. Access to specialty healthcare services.

- *Logic:* Early identification and treatment will produce better outcomes.
- *Recommended Action(s):* Expand telehealth services. Improve recruitment and retention of specialists.

Table 13 lists the top adolescent health priorities along with the HRSA MCH Title V National Performance Measures (NPM) and Healthy People 2030 objectives they link to.

Table 13. CSHCN Priorities, NPMs, and Relevant Healthy People 2030 Objectives

Priorities	Relevant National Performance Measures	Relevant Healthy People 2030 Objectives
Access to care coordination and navigation of healthcare and community programs	NPM 11 A – increase the percent of children with special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for	MICH-19 - Increase the proportion of children and adolescents who receive care in a medical home

	care, and family-centered care; referrals or care coordination if needed)	
Parent training	NPM 12 A - increase the percent of adolescents with special health care needs who have received the services necessary to make transitions to adult health care.	AH-R01 - Increase the proportion of adolescents ages (12 to 17 years) who get support for their transition to adult health care
Access to specialty healthcare services	NPM 11 A - increase the percent of children with special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for care, and family-centered care; referrals or care coordination if needed)	AHS-R02 - Increase the use of telehealth to improve access to health services EMC-04 - Increase the proportion of children and adolescents with ADHD who get appropriate treatment MICH-18 - Increase the proportion of children with autism spectrum disorder who receive special services by age 4 years EMC-D05 - Increase the proportion of children and adolescents who get appropriate treatment for behavior problems. HOSCD-05 - Increase the proportion of children and adolescents with communication disorders who have seen a specialist in the past year. IMHMD-D01 - increase the number of children and adolescents with serious emotional disturbance who get treatment
Not prioritized during the stakeholder meeting	REQUIRED NPM Medical Home (MH): Percent of children ages 0-17 who have a medical home	MICH-19 - Increase the proportion of children and adolescents who receive care in a medical home

Final Priorities for the Children with Special Healthcare Needs (CSHCN) Health Domain Selected by the MCH Needs Assessment Steering Committee

The priorities and recommended actions gathered from the priority setting meeting are aligned with the priorities selected by the CNMI MCH Needs Assessment Steering Committee for the next 5 years.

Priority 1. Access to care coordination and navigation of healthcare and community programs.

The goal is to increase the percentage of CSHCN who report having a medical home. The MCHJ survey reported that the percentage of children with special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for care, and family-centered care; referrals or care coordination if needed) increased from *13% to *14% in 2019 and 2021 respectively. Likewise, the percentage of adolescents with special healthcare needs, ages 12-17, whose family reported that they

received the services necessary to transition to adult health care increased from 2019 at *51% to *71% in 2023. This priority will assist families in becoming proficient in navigating the healthcare system and accessing information and services, including insurance coverage and timely support with basic needs and essential services during emergencies; it is a key function of the medical home, where care coordination ensures patients receive necessary services in a timely manner.

Priority 2. Parent training.

One of the goals is to provide parent training on transition to adult health care services for the CSHCN population. Assessing readiness for transitioning to adult healthcare involves evaluating the young person's knowledge, skills, and overall preparedness for managing their health independently. Transition (TR) - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care (Transition, Formerly NPM 12). Baseline: *33% (2019), Target 23%. This priority allows the MCH program to:

- Increase care coordination and health management.
- Increase access to available services and support.
- Strengthen family resilience and function.
- Improve health literacy and self-advocacy.

Priority 3. Access to specialty healthcare services.

One of the recommended actions is to expand the telehealth and telemedicine platforms for accessing specialized healthcare services. MH – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling (Medical Home, Formerly NPM 11) - Relevant HP 2030 objective MICH-19 - Increase the proportion of children and adolescents who receive care in a medical home; Baseline: 46.6% (2020-21), Target 54%. This priority allows the MCH program to:

- Increase access to needed specialty care.
- Improve care coordination across providers.
- Increase use of telehealth and digital health tools.

Cross-Cutting/Systems Building Domain

Table 13 on the following page summarizes the state performance measure associated with system building in the CNMI. Trainings received by public health services staff members on MCH priorities and related topics has increased notably in recent years from 2% in 2021 to 49% in 2023.

Table 13. System Building Domain – Data and Healthy People Objectives

Measure	Indicator Name	Description	Data Source	2019	2020	2021	2022	2023
SPM 2	Cross-cutting / System Building	Percentage of CHCC Public Health Services (PHS) staff and MCH serving professionals who complete training on MCH priorities and related topics	CHCC Human Resources	--	--	2%	34%	49%

Cross-cutting public health issues impact multiple MCH population groups. Life course theory is a conceptual framework that helps explain health and disease patterns – particularly healthy disparities – across populations and over time. Instead of focusing on differences in health patterns based on one disease or condition at a time, life course theory points to broad social, economic, and environmental factors as underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups. Life course theory is population focused and firmly rooted in social determinants and social equity models. Though not often explicitly stated, life course theory is also community- or place-focused, since social, economic, and environmental patterns are closely linked to community and neighborhood settings. Systems building refers to activities involving the creation or enhancement of organizational infrastructure at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.¹¹ This section of the report includes professionals survey data for two sets of priorities – “life course” and “system building”. The cross-cutting/systems building domain was parsed in this way in the survey to support survey interpretability for respondents. **Figures 8 and 9** on the following pages present the results of the priority health issues survey administered among paid professionals in the CNMI. **Blue bars identify health priorities identified during the stakeholder meeting.** Quotes reflective of the top identified priorities are also provided. Across the life course, access to preventative healthcare was far and above other options as a priority for the next five years. For health system building, survey respondents identified awareness-raising about health service availability as the top priority for the next five years.

¹¹ US Department of Health and Human Services (2018). *Title V Maternal and Child Health Services Block Grant to States Program Guidance and Forms for the Title V Application/Annual Report.*

Figure 8. Life Course Health Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews

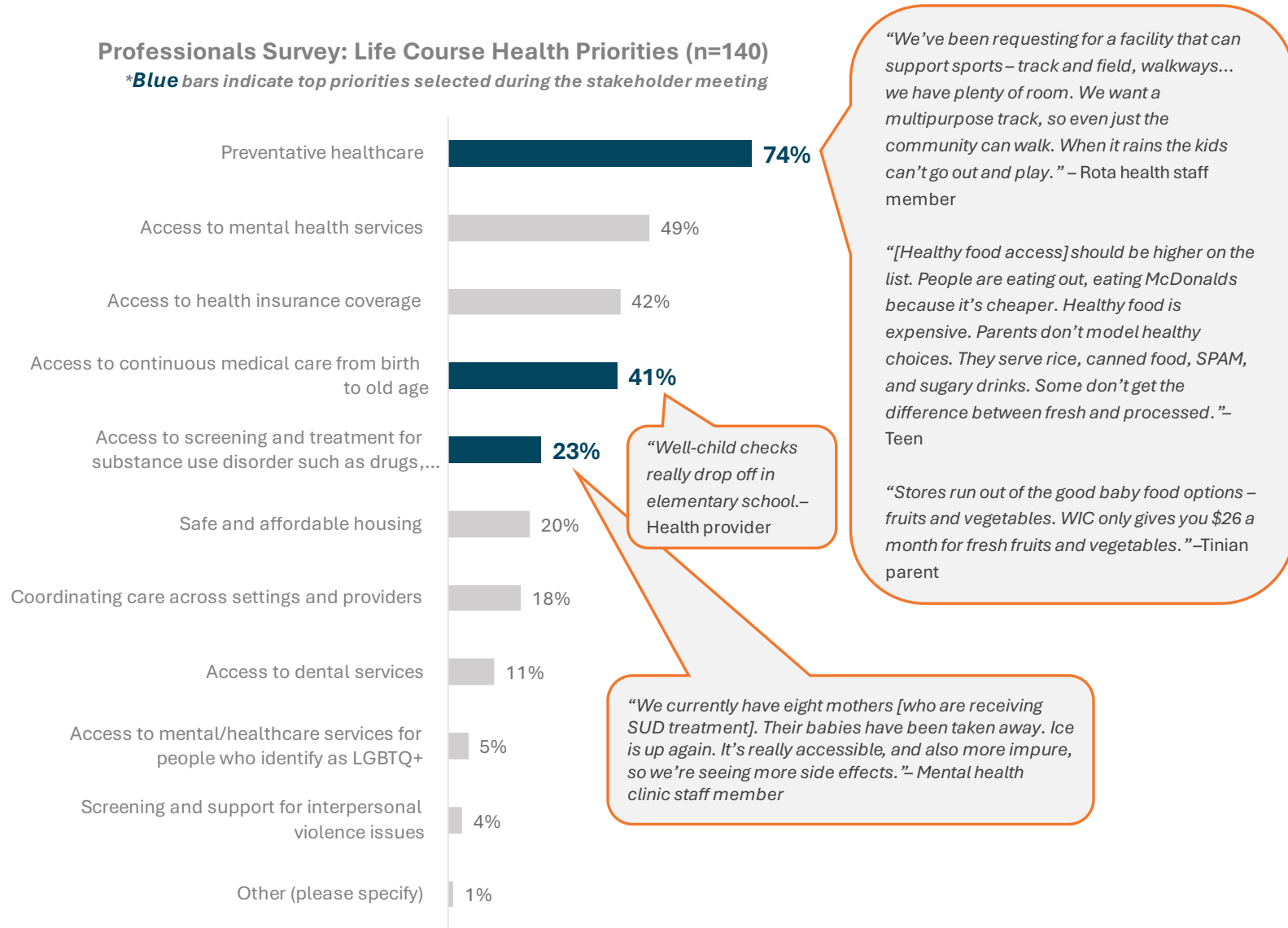
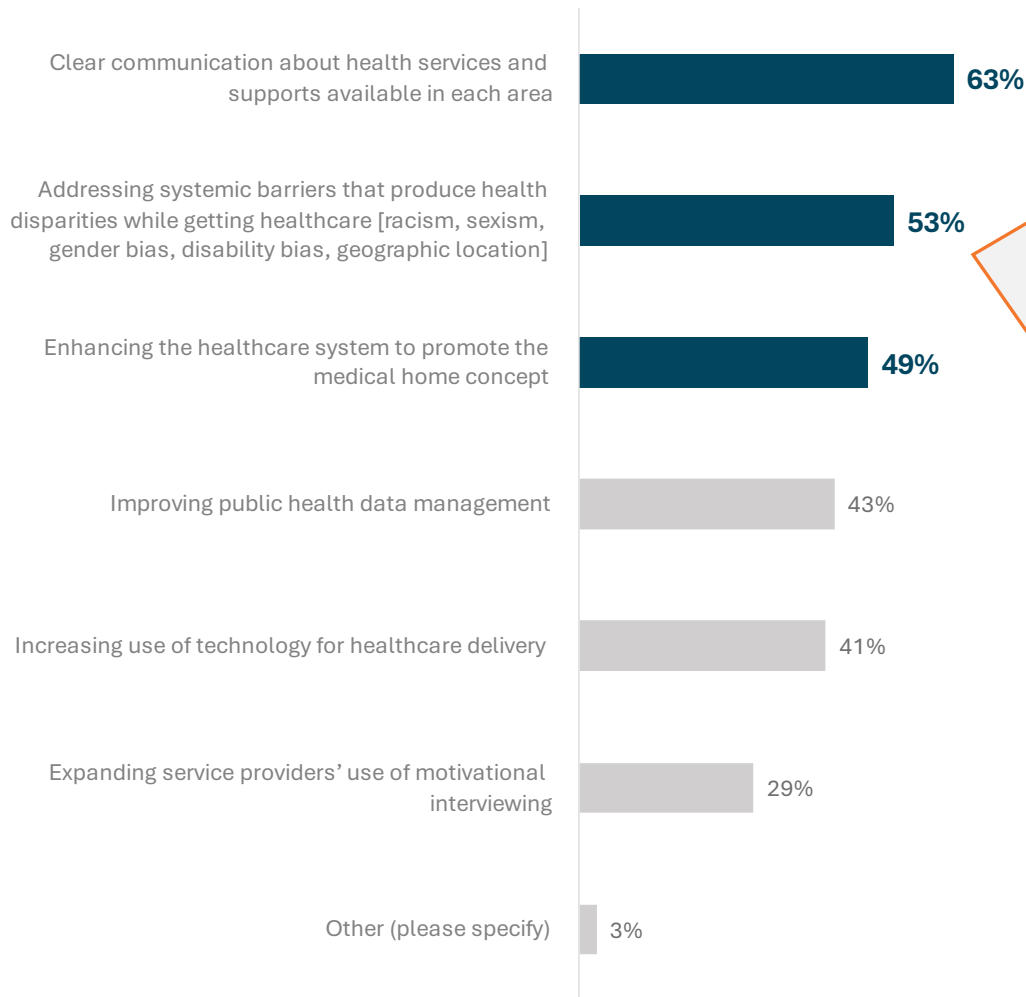


Figure 9. Health System Building Priorities Identified in the Professionals Survey with Representative Quotes from the Focus Groups/Interviews

Professionals Survey: Health System Building Priorities (n=140)

**Blue bars indicate top priorities selected during the stakeholder meeting.*



“We need to recognize that we need systemic thinking. No man is an island. We’re all interconnected. I think in the next five years, one of the things that really needs to happen within public health is if we collaborated with the community, faith-based leaders, and public school. A more intentional collaboration and application of holistic health. Mind, body and all that from the system and all the way to the nucleus. If we at least look at it in a bigger scale within the system, the next five years, that would be great.” – Faith leader

Life Course Health Priorities and Recommended Actions Gathered from the Priority Setting Meeting

During the stakeholder meeting, the cross-cutting/system building domain was also split between two separate work groups who identified priorities for the life course and system building. Below, the top three priorities identified during the health priorities setting meeting for the life course, along with the logic given for prioritizing each and recommended actions to address them, are provided. Sources of triangulation are also listed. Stakeholder meeting attendees agreed that preventative healthcare access should be prioritized.

Priority 1. Preventative healthcare.

- *Scan Source(s) of Triangulation:*
 - 33% of women had not had an annual exam (Adult Hybrid Survey Non-Communicable Disease, 2023)
 - 21% could not get health care because of cost, lack of transportation, or lack of childcare (Adult Hybrid Survey Non-Communicable Disease, 2023)
- *Logic:* It is connected to preventing all non-communicable diseases.
- *Recommended Action(s):* Incorporate “culture-based lifestyle” approaches in combatting non-communicable diseases (NCDs). Examples include high school presentations on STIs and NCDs, and community-based approaches such as the 500 Sails program.

Priority 2. Access to continuous medical care from birth to old age.

- *Scan Source(s) of Triangulation*
 - 30% experienced frustration/disappointment when trying to get health or medical service at CHCC. Reasons included appointment issues, bad customer service, unavailable specialty care (Women’s Health Survey, 2022).
 - Most significant health issues: Diabetes, high blood pressure, and cancer (Community Health Assessment, 2024)
 - Top risks to health include being overweight, poor eating habits, and lack of exercise (Community Health Assessment, 2024)
- *Logic:* New operators, upcoming new electronic health record system, and better referral communication.
- *Recommended Action(s):* Facilitate information sharing between agencies for referrals. Use the electronic health records (EHR) system’s continuous medical care prompts to notify providers and their patients when screenings are due. Use the EHR system to streamline preventative service referrals.

Priority 3. Access to screening and treatment for substance use disorder such as drugs, alcohol, betel nut/tobacco, and vaping.

- *Scan Source(s) of Triangulation*
 - 22% of women chew betel nut, 14% smoke cigarettes, and 7% vape (Adult Hybrid Survey Non-Communicable Disease, 2023)
 - 19% of women binge drink (Adult Hybrid Survey Non-Communicable Disease, 2023)
 - 11% use marijuana (Adult Hybrid Survey Non-Communicable Disease, 2023)
 - Priority identified in the Community Health Assessment (2024)
- *Logic:* None provided.
- *Recommended Action(s):* Increase marketing so community members are aware of available services.

System Building Priorities and Recommended Actions Gathered from the Priority Setting Meeting

Below, the top three priorities identified during the health priorities setting meeting for system building, along with the logic given for prioritizing each and recommended actions to address them, are provided. No sources of triangulation were identified in the scan. Those who contributed to priority setting during the stakeholder meeting agreed with the top priorities identified in the professionals survey.

Priority 1. Enhance the healthcare system to promote the medical home concept.

- *Logic:* Supports coordinated care.
- *Recommended Action(s):* Facilitate coordinated care through robust electronic case reporting. Use the electronic health record system to transfer medical records between agencies. Establish memoranda of understanding among providers to collectively commit to timely record/information sharing.

Priority 2. Address systemic barriers that produce health disparities while getting healthcare [racism, sexism, gender bias, disability bias, geographic location].

- *Logic:* Underserved communities deserve equitable health service access.
- *Recommended Action(s):* Work with COTA to arrange for transportation to health appointments. Provide childcare during health appointments.

Priority 3. Clear communication about health services and supports available in each area.

- *Logic:* This will increase awareness of available services and improve health literacy.
- *Recommended Action(s):* Increase awareness of available services by delivering Medicaid and other health information year-round through town halls, health fairs, media, and partner events. Obtain information from all providers regarding the services they offer and post the information online. This “information dashboard” will serve as a one-stop shop for health service information.

Final Priorities for the Cross-Cutting/Systems Building Domain Selected by the MCH Needs Assessment Steering Committee

Following the initial priority-setting meeting, the Professional Survey - Life Course indicated the top 3 priorities: 1) preventative healthcare; 2) access to continuous medical care from birth to old age; 3) access to screening and treatment for substance use disorder such as drugs, alcohol, betel nut/tobacco, and vaping; and the Professional Survey- Health Systems Building indicated the top 3 priorities: 1) Enhance the healthcare system to promote the medical home concept, 2) Address systemic barriers that produce health disparities while getting healthcare; and 3) Clear communication about health services and supports available in each area.

This additional step was prompted by the need to align selected priorities with the current organizational capacity, availability of resources, and the practical feasibility of implementation for the Title V five-year funding cycle. Based on the Needs Assessment results, the MCH Steering Committee selected the one out of six priorities identified to focus on and allocate MCH and Other resources for the next 5 years.

Priority 1. Clear communication about health services and support available in each area.

New Priority, Goal - develop a communication strategy involving multi-channel approach using websites, radio, or TV to reach diverse MCH population; it aligns more closely with the CNMI MCH agency's existing infrastructure and capacity. Selecting this priority allows the MCH program to:

- Increased awareness and use of available services and resources.
- Improved health literacy.
- Reduced missed appointments and delays in care.

Considering these factors, the Steering Committee determined that clear communication about health services and support available in each area is a realistic and achievable priority. It reflects clear community needs, offers opportunity for measurable impacts, and

builds on the MCH agency's current strengths- including leveraging resources, investing in program promotion, partnerships and education, inter-program referral, and cross-sector collaboration.

By grounding the selections in both community and organizational feasibility, the CNMI MCH program aims to implement priorities that are both strategically sound and operationally viable, ensuring progress toward improving health outcomes for women, children, and families across the Commonwealth.

Table 14 on the following page presents a snapshot of priorities identified through the needs assessment and previous priorities, by domain.

Table 14. Comparison of Current and Previous Priorities

Current Priorities - 2025	Previous Priority - 2020
Woman/Maternal	
<ul style="list-style-type: none"> • Access to preventative medical visits • Access to mental health services 	Ability to find and see a doctor when you need to [access to health services].
Perinatal/Infant	
<ul style="list-style-type: none"> • Education and services to help prevent premature births and low birthweight • Education and support to help with breastfeeding 	Education and support to help with breastfeeding. Prevention of premature births and infant mortality and prevention of alcohol and drug exposure and related developmental delays through prenatal care.
Child	
<ul style="list-style-type: none"> • Access to healthy physical activities 	Obesity related issues including nutrition/food security and safe school and neighborhood programs to promote physical activity.
Adolescent	
<ul style="list-style-type: none"> • Bullying prevention and support • Access to teen pregnancy and sexually transmitted infection (STI) prevention services 	Coping skills and suicide prevention. Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.
Children with Special Health Care Needs	
<ul style="list-style-type: none"> • Access to care coordination and navigation of healthcare and community programs • Parent training • Access to specialty healthcare services 	Helping parents/caregivers navigate the health care system for coordinated care. Support for individuals, families, and communities to make changes that will make it more likely for youth to be healthy and successful.
Cross-Cutting	
<ul style="list-style-type: none"> • Clear communication about health services and supports available in each area 	Home visiting/community health resources to help manage and improve health. Professionals have the knowledge and skills to address the needs of maternal and child health populations.

Conclusion

Drawing from their core values – respect, faith, love, and family – the CNMI has made progress on raising awareness of healthy sexual choices among adolescents, destigmatizing mental health challenges and help-seeking, and raising awareness of healthy lifestyle practices around diet and exercise. These successes warrant celebration and demonstrate that positive change is possible.

However, the CNMI also faces considerable challenges in its pursuit of maternal and child population health. Geographic isolation, systemic barriers to healthcare access, high rates of uninsured, and economic stagnation constrain what can be done to meet health needs.

This mixed method needs assessment gathered detailed information to guide the Commonwealth Healthcare Corporation to deliver high-priority, feasible, and relevant services in Saipan, Tinian, and Rota. The priorities identified through the scan of extant data sources, community surveys, qualitative methods, and priority setting process generated ambitious domain-specific priorities for the next five years. By continuing to leverage its strengths and successes, the public health system can support ever greater health and wellbeing for women and children.

Appendices

- **Appendix A.** List of documents and reports included in the quantitative data scan
- **Appendix B.** Priority health issues survey reports
- **Appendix C.** Example focus group protocol – PATCH Teens
- **Appendix D.** Qualitative data report

Appendix A. Extant Sources Included in the Assessment

Source	Description
Needs Assessments	<ul style="list-style-type: none"> • CNMI Community Health Assessment (2024) • CNMI Early Hearing Detection & Intervention Program Needs Assessment (2024) and Workplan (2024-2029) • CNMI Maternal Child Health Title V Block Grant Needs Assessment (2020) • CNMI HOME Visiting Program Needs Assessment (2020)
Reports	<ul style="list-style-type: none"> • CNMI Title X Annual Progress Report (2024) • CNMI Non-Communicable Disease Adult Hybrid Survey Report (2023) • US Government Accountability Office Recent Workforce Trends and Wage Distribution Report (2022) • US Economic Census Snapshot (2022) • CNMI Maternal and Child Health Needs Assessment (2020)
Data	<ul style="list-style-type: none"> • National outcome measures (NOMs), national performance measures (NPMs), state performance measures (SPMs), and evidence-based strategy measures (ESMs) data from (2019-2023/24) • CNMI Title X Data Submission Summary (2024) • NORC Jurisdictional Survey Data (2023) • CNMI Women’s Health Survey Data (2022) • CNMI Youth Risk Behavior Survey (YRBS) Data (2021) • US Census (2020)
Other Sources	<ul style="list-style-type: none"> • CNMI WIC Program Goals and Objectives (2025) • CNMI Maternal Mortality Workplan (2025) • CNMI Maternal, Infant, Child Home Visiting Workplan (2024) • CNMI Family-to-Family Health Information Center Grant Application Narrative (2022) and Workplan (2022-2027) • CNMI Title X Project Narrative (2022) • Commonwealth Utilities Corporation Web-based Electric Prepay Program FEQ (2017)

Appendix B. Priority health issues survey reports

- Professionals
- Youth
- Tinian
- Rota

MICAH Needs Assessment Stakeholder Survey **PROFESSIONALS**

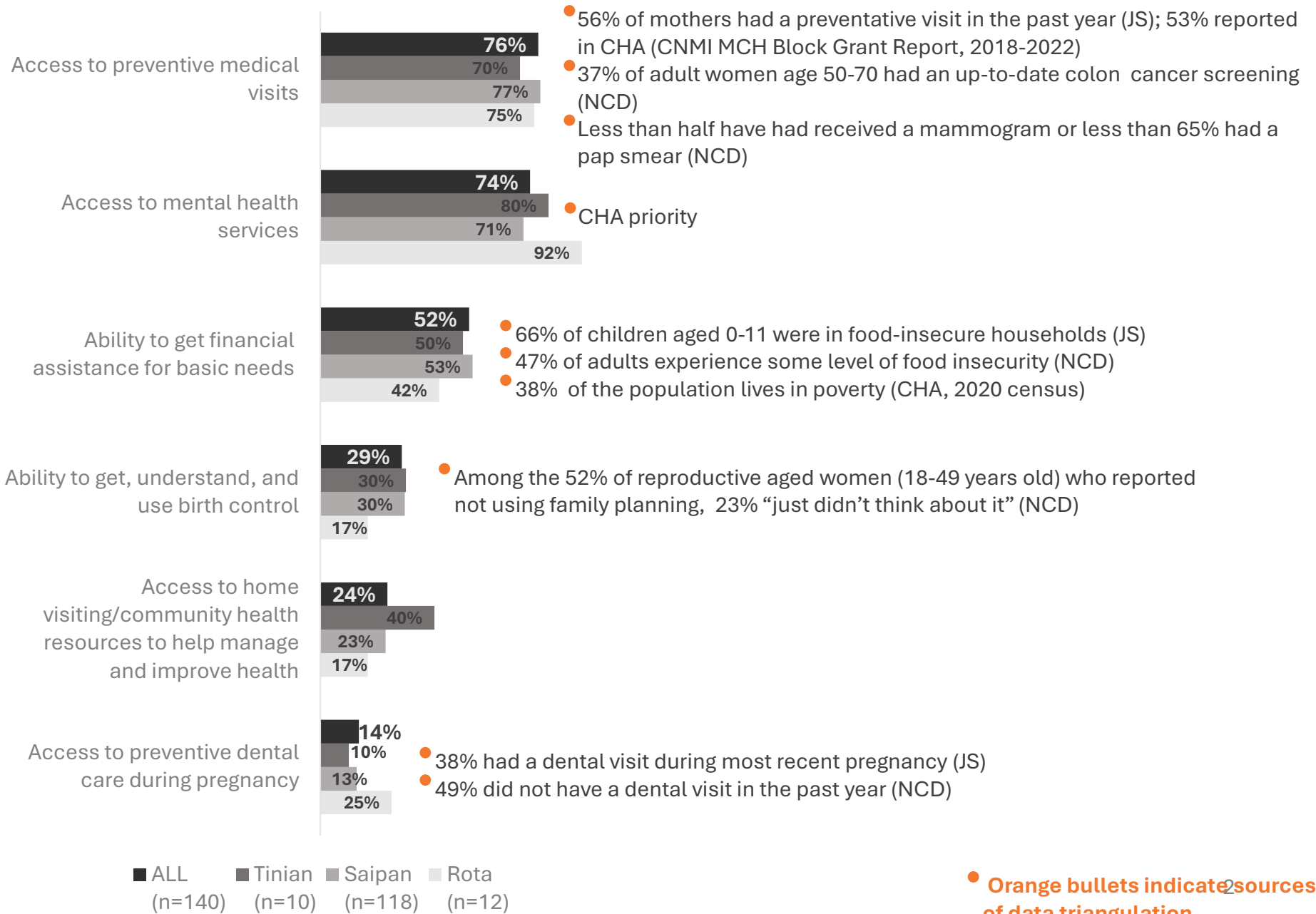
2025

May 20, 2021



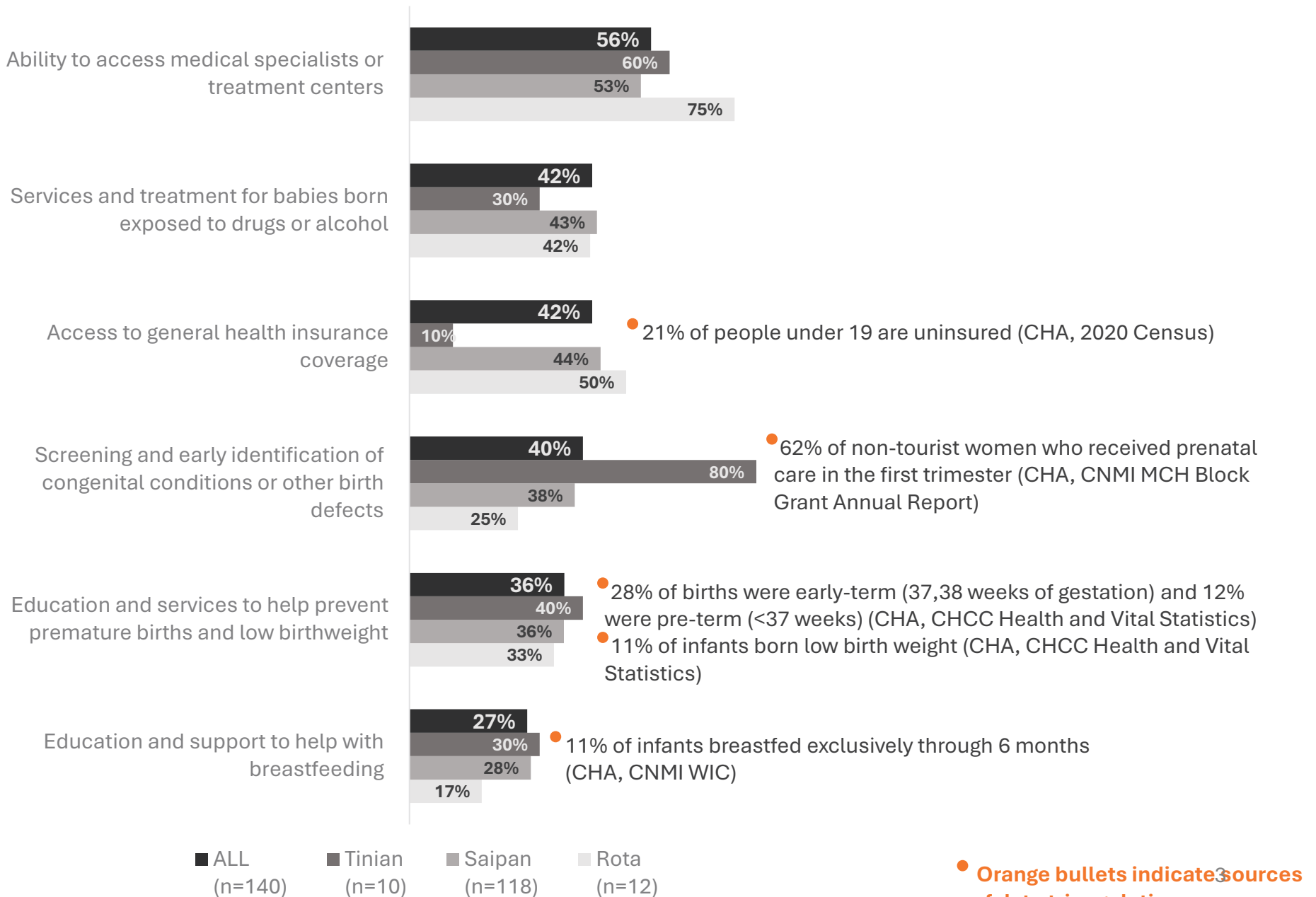
Stakeholder Survey - Professionals

Women's Health Priorities



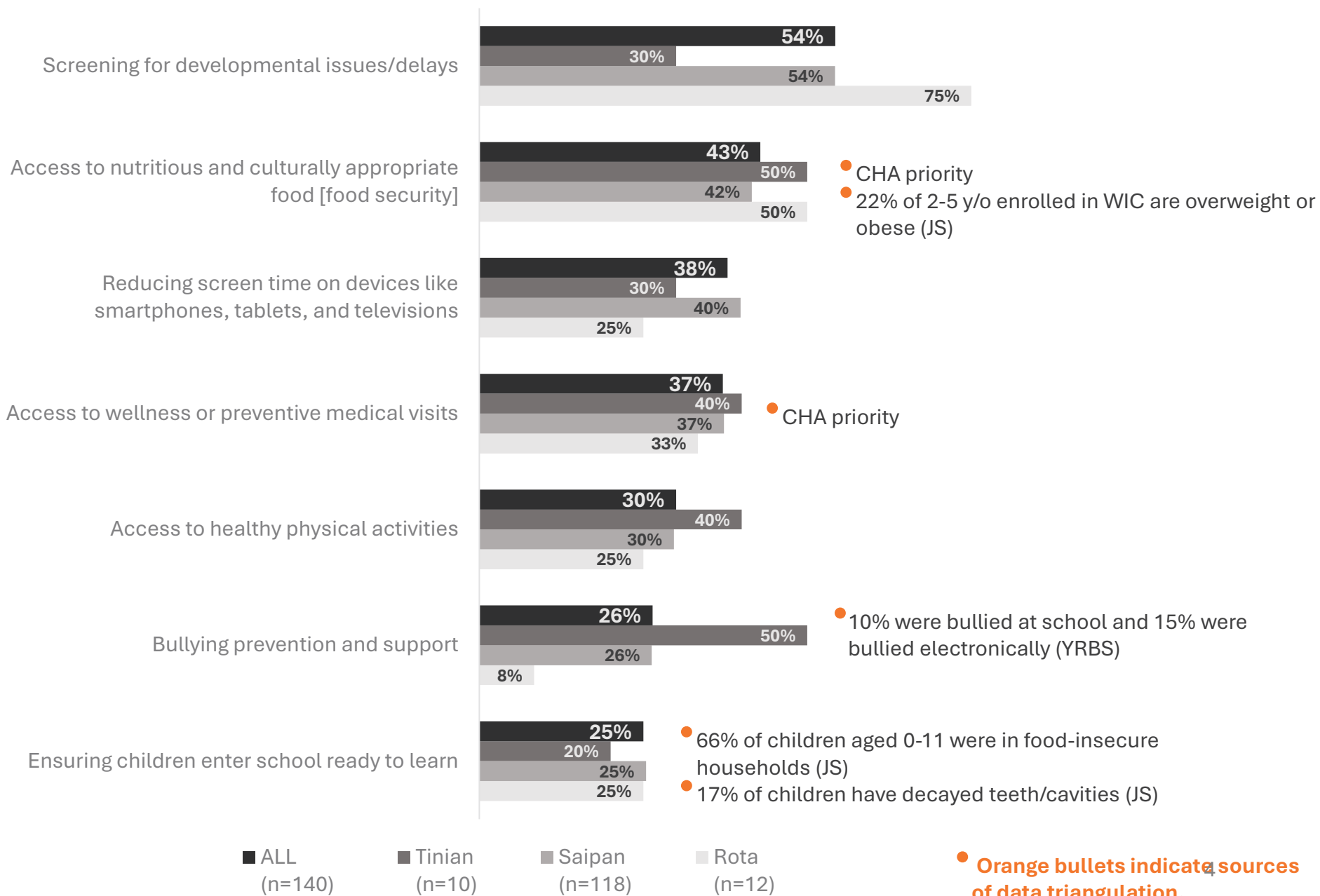
Stakeholder Survey - Professionals

Infant Health Priorities



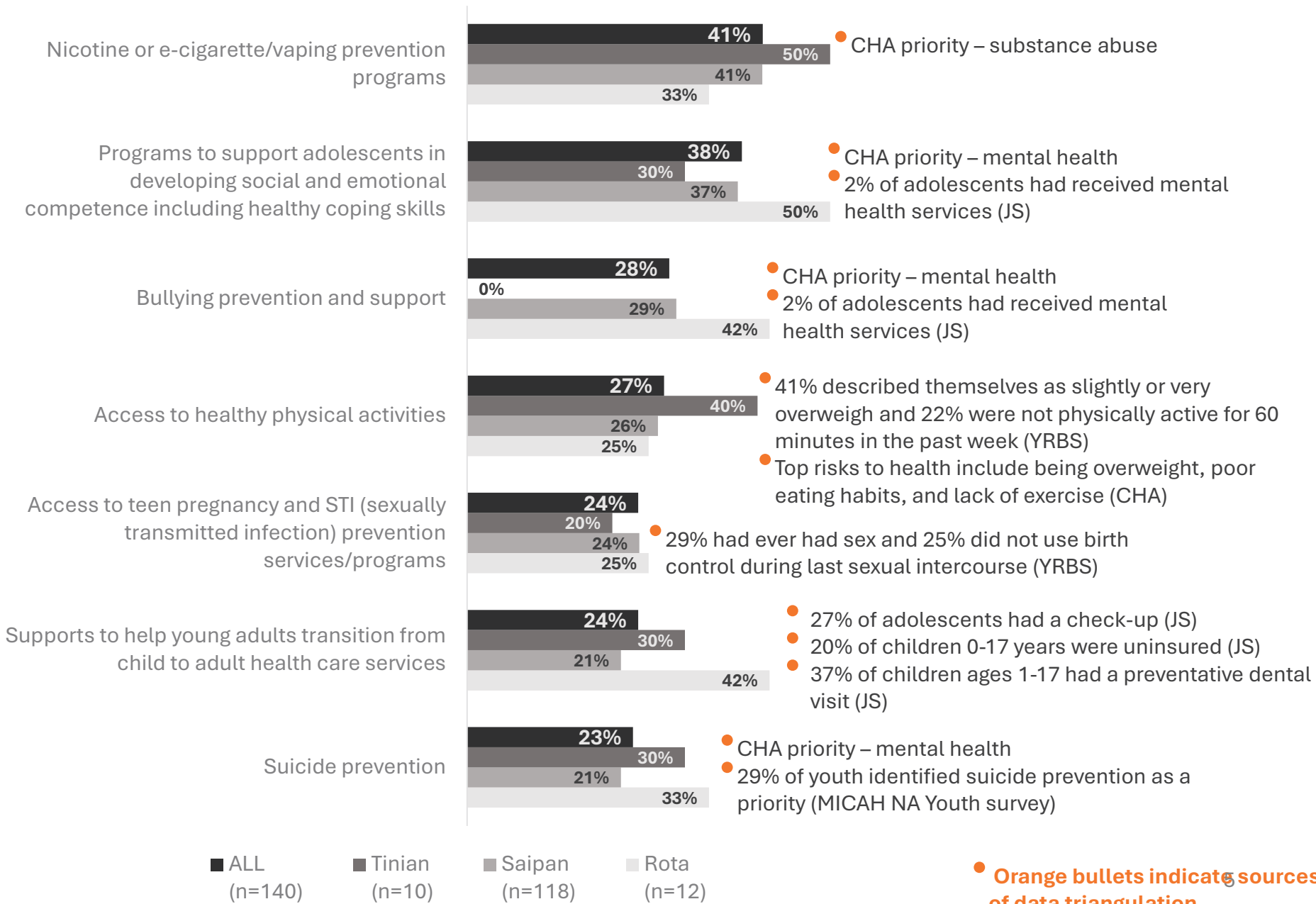
Stakeholder Survey - Professionals

Child Age 1-9 Health Priorities



Stakeholder Survey - Professionals

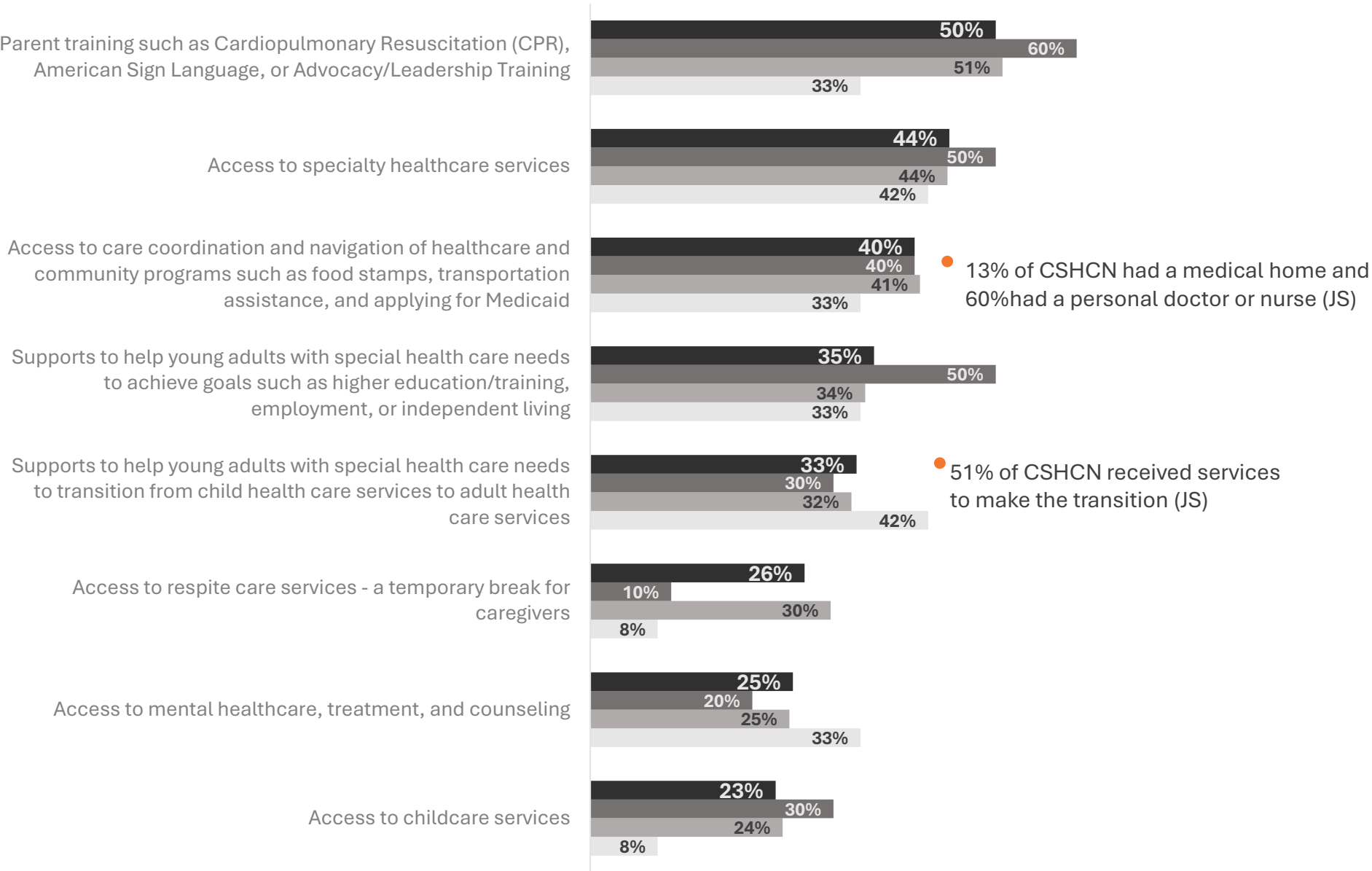
Adolescent Health Priorities



Orange bullets indicate sources of data triangulation.

Stakeholder Survey - Professionals

Children with Special Healthcare Needs (CSHCN) Health Priorities



ALL (n=140)
 Tinian (n=10)
 Saipan (n=118)
 Rota (n=12)

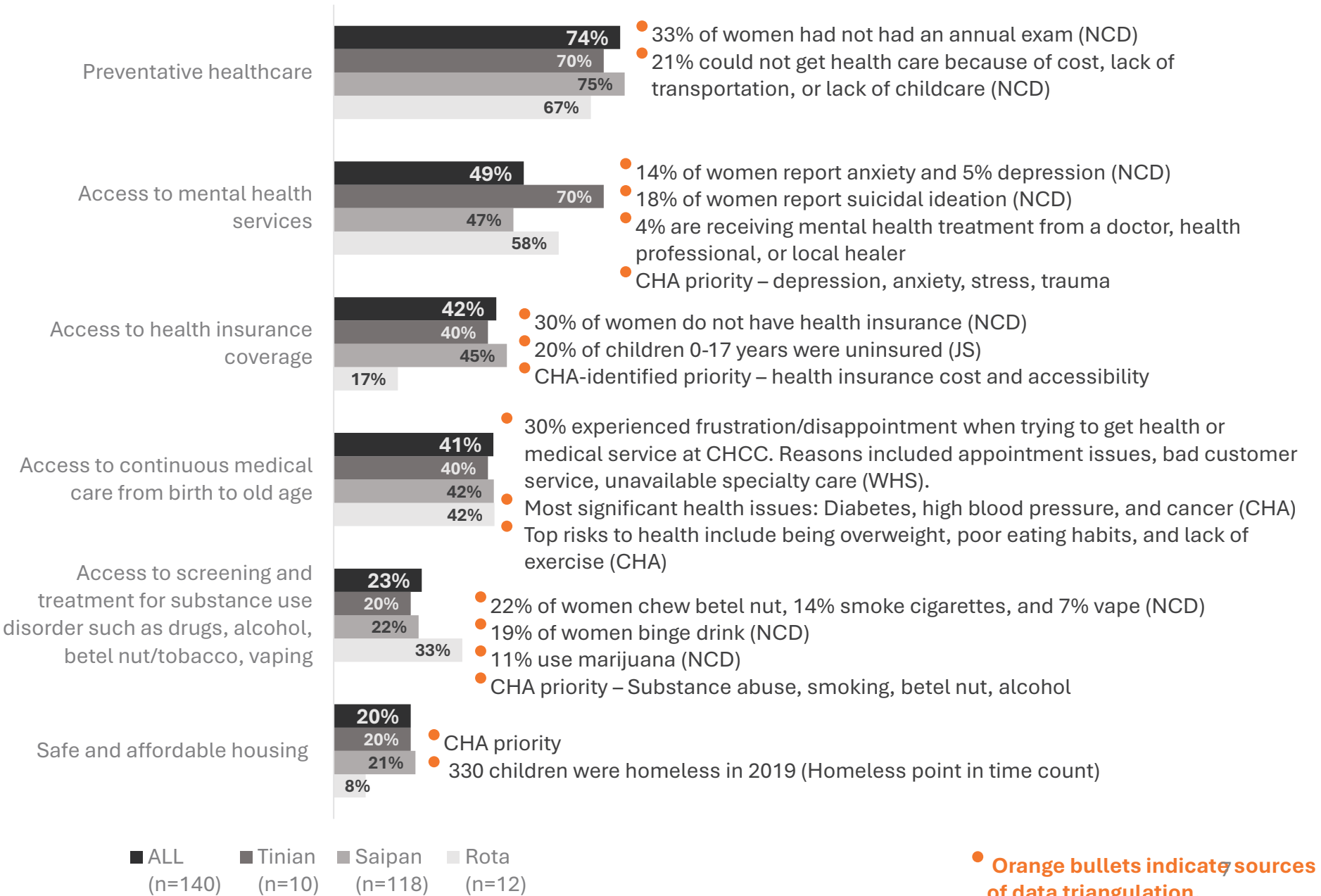
● 13% of CSHCN had a medical home and 60% had a personal doctor or nurse (JS)

● 51% of CSHCN received services to make the transition (JS)

● Orange bullets indicate sources of data triangulation.

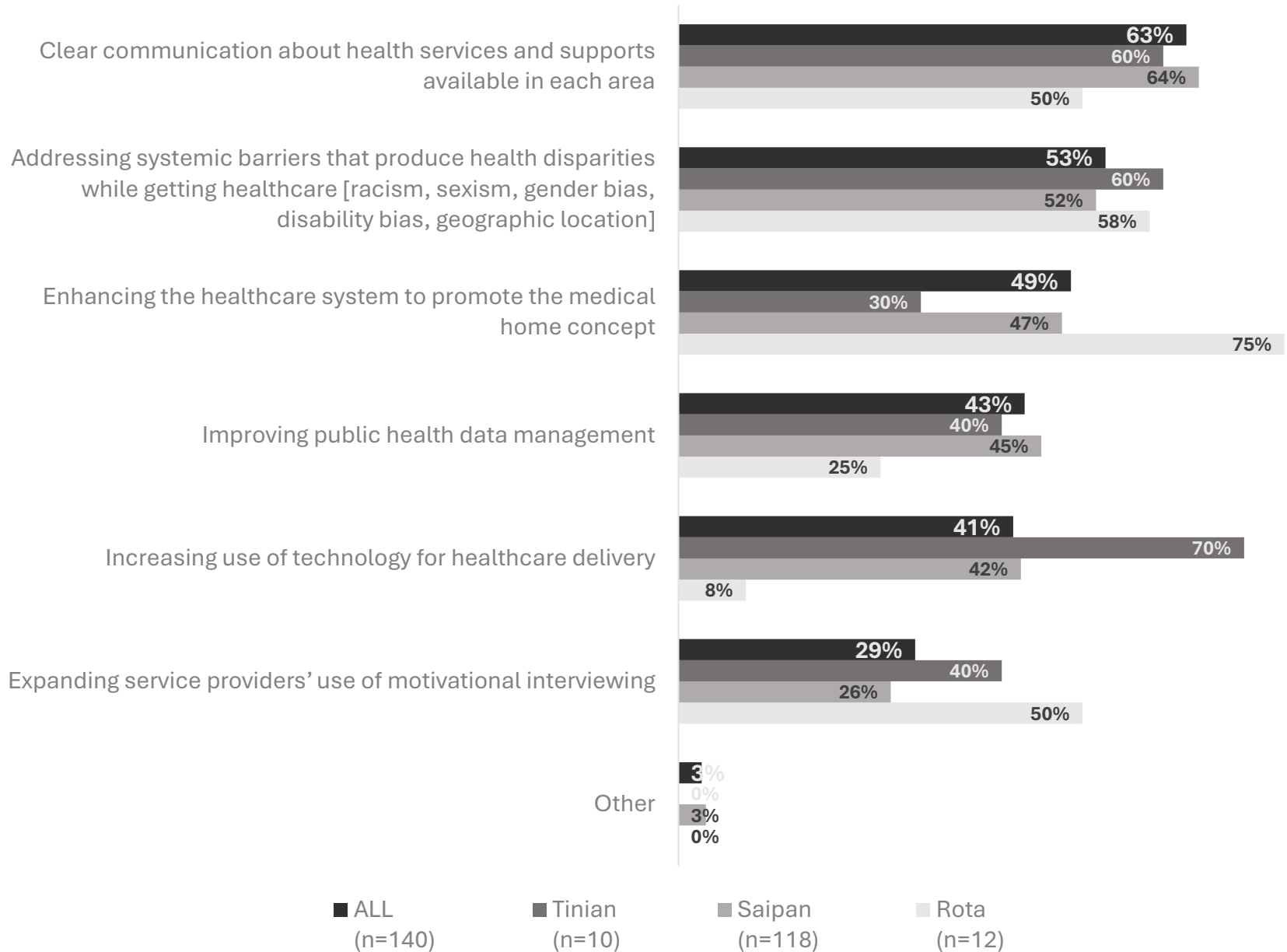
Stakeholder Survey - Professionals

Across the Lifespan Health Priorities



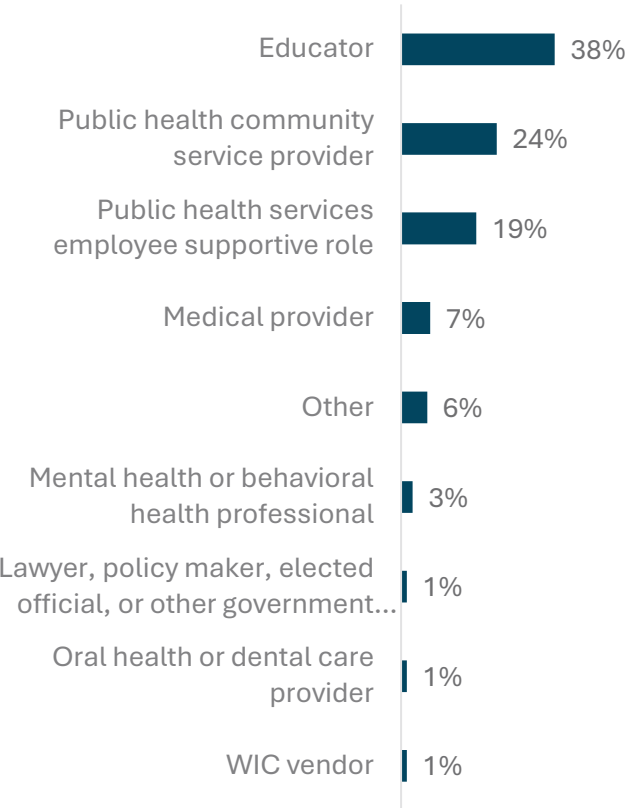
Stakeholder Survey - Professionals

Cross-Cutting Health Priorities

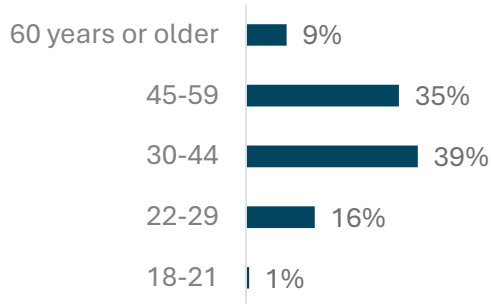


Demographics

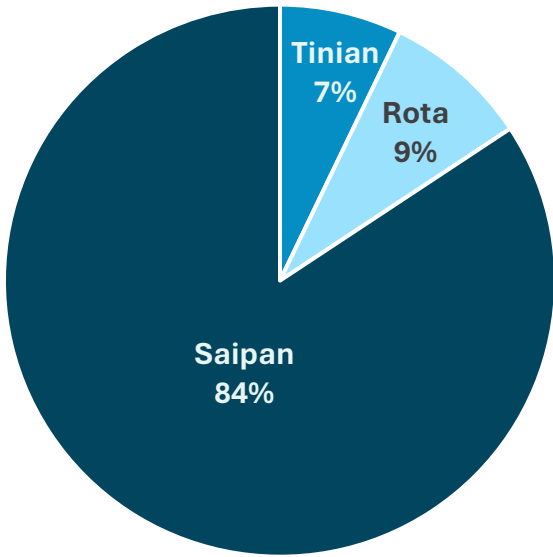
Professional Role (n=140)



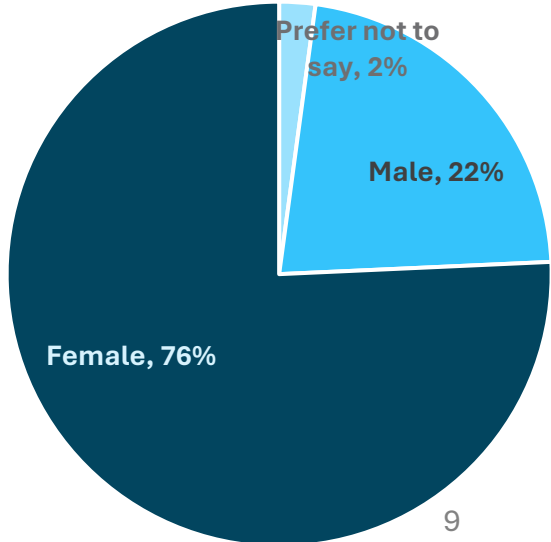
Survey Respondent Age (n=140)



Island of Residence (n=140)

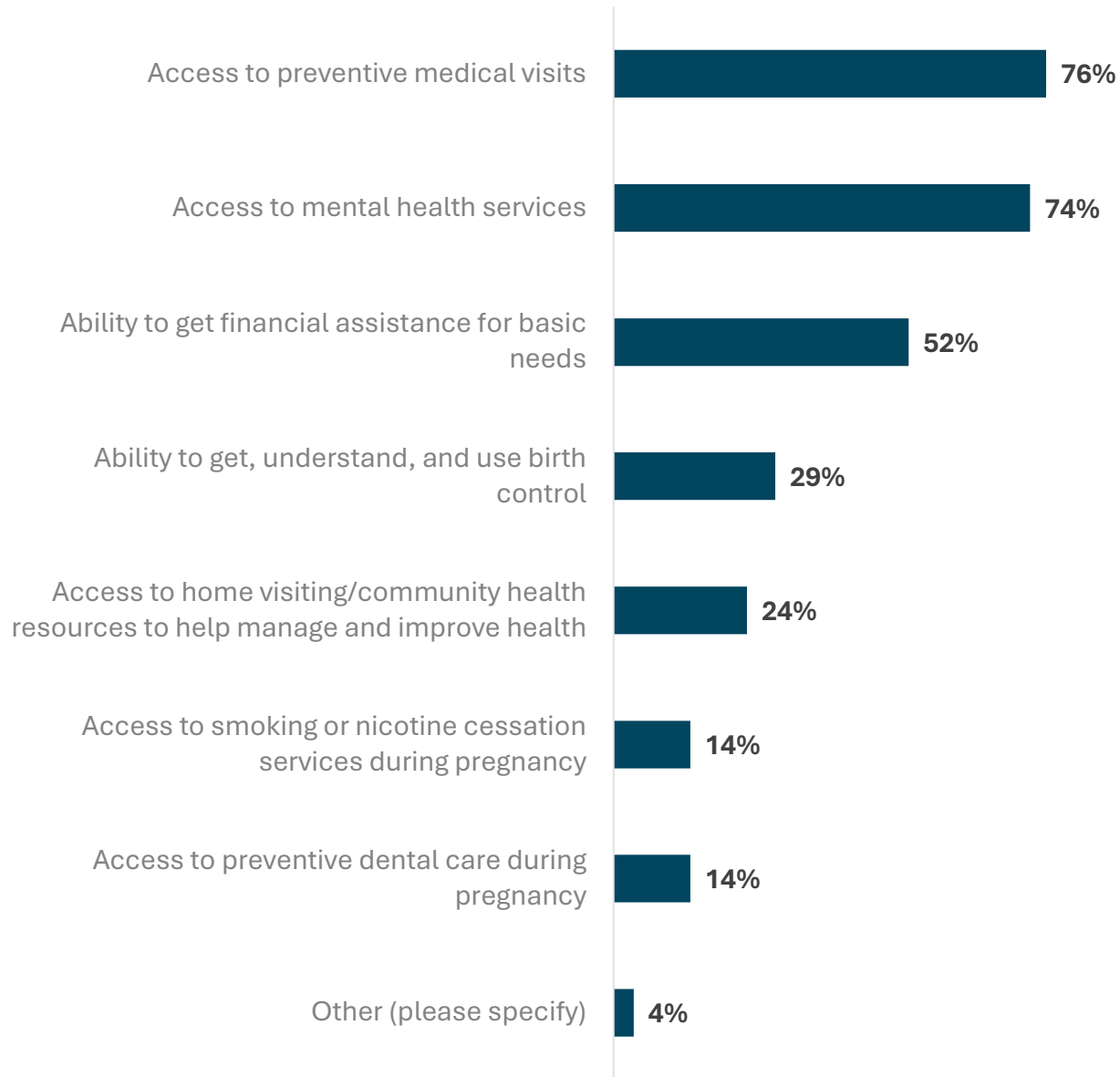


Gender

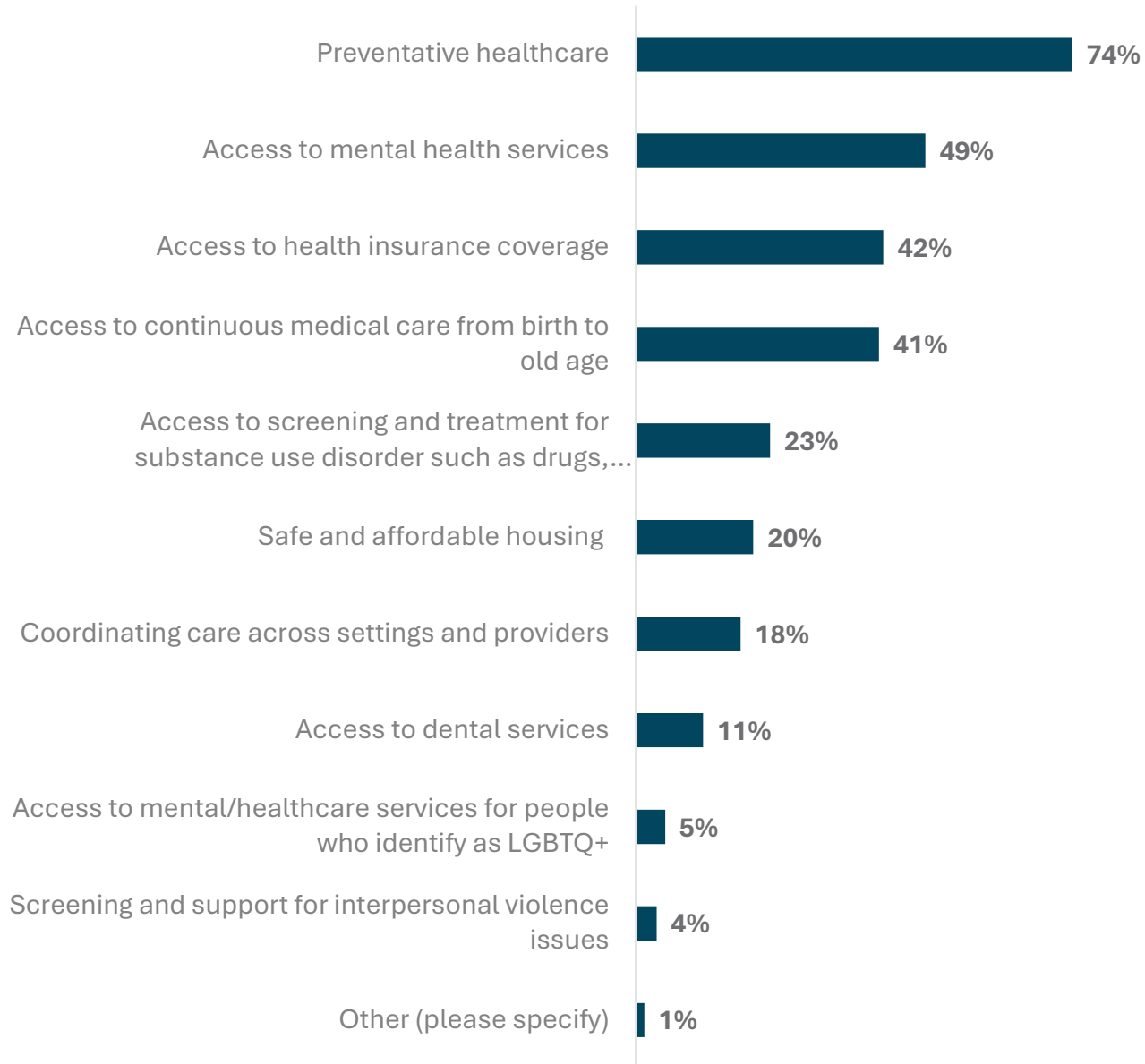


**MICAH Needs Assessment
Stakeholder Survey
PROFESSIONALS
2025
ALL Responses Combined**

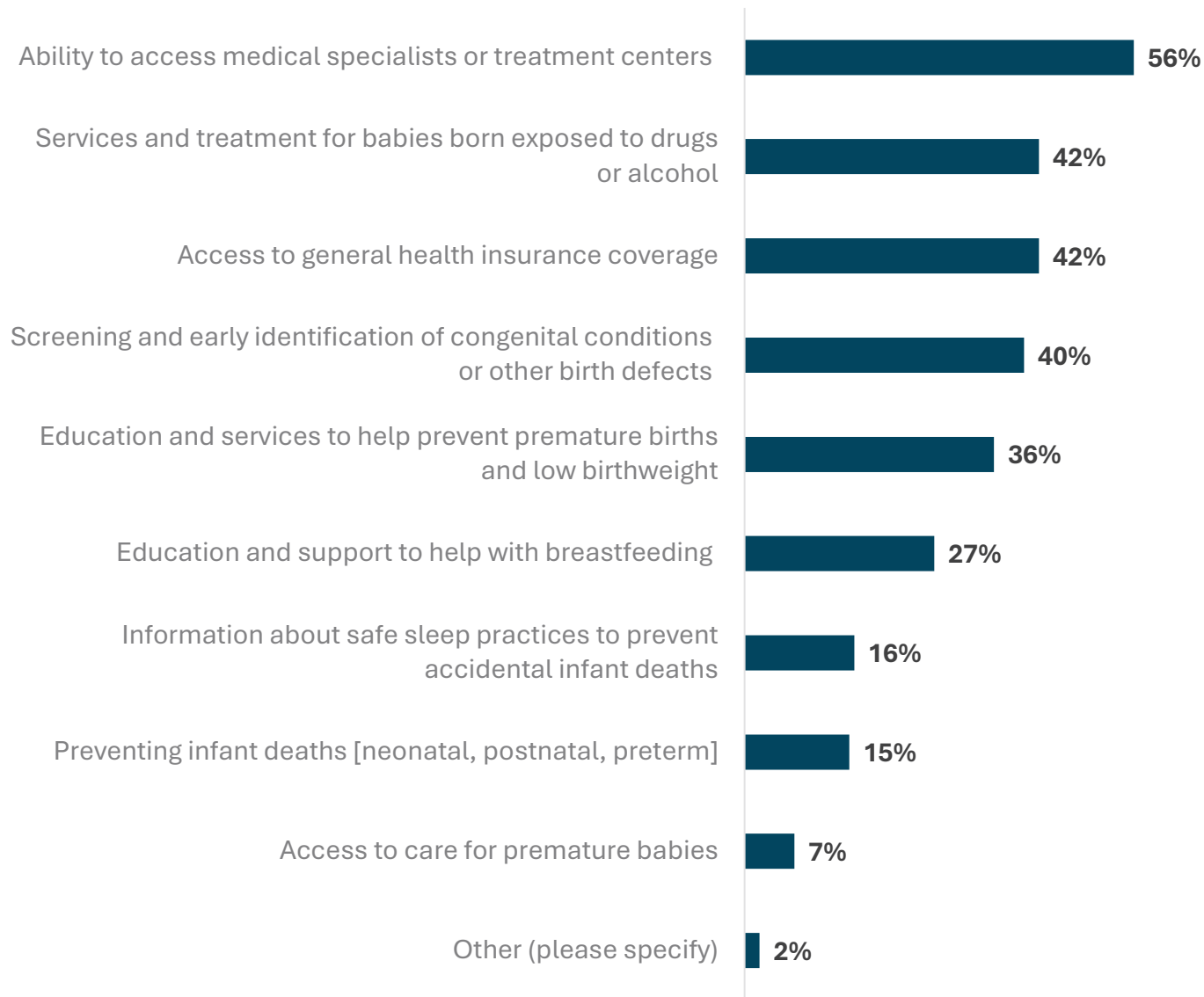
Women's Health Priorities (n=140)



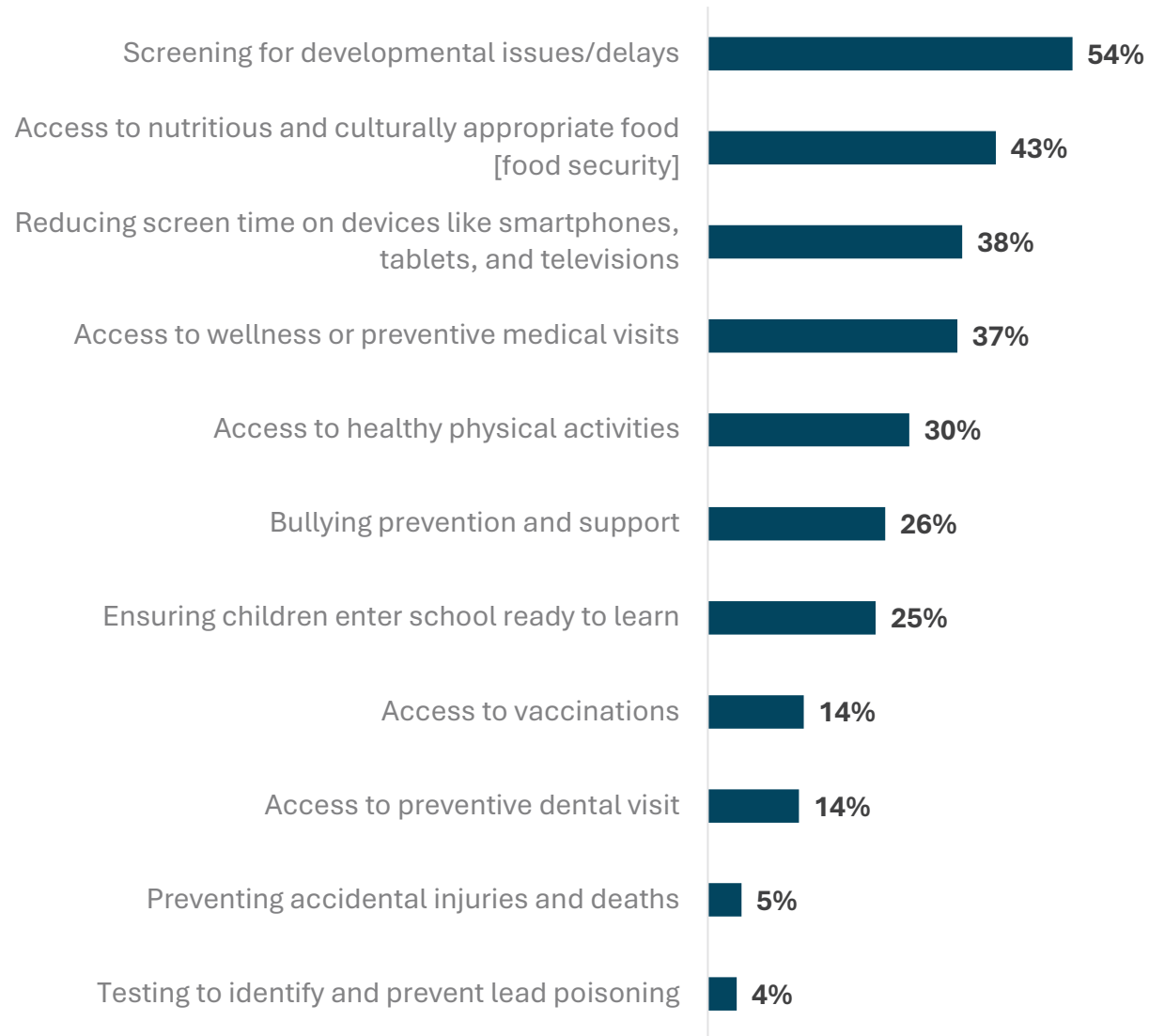
Health Priorities: **Across the Lifespan** (n=140)



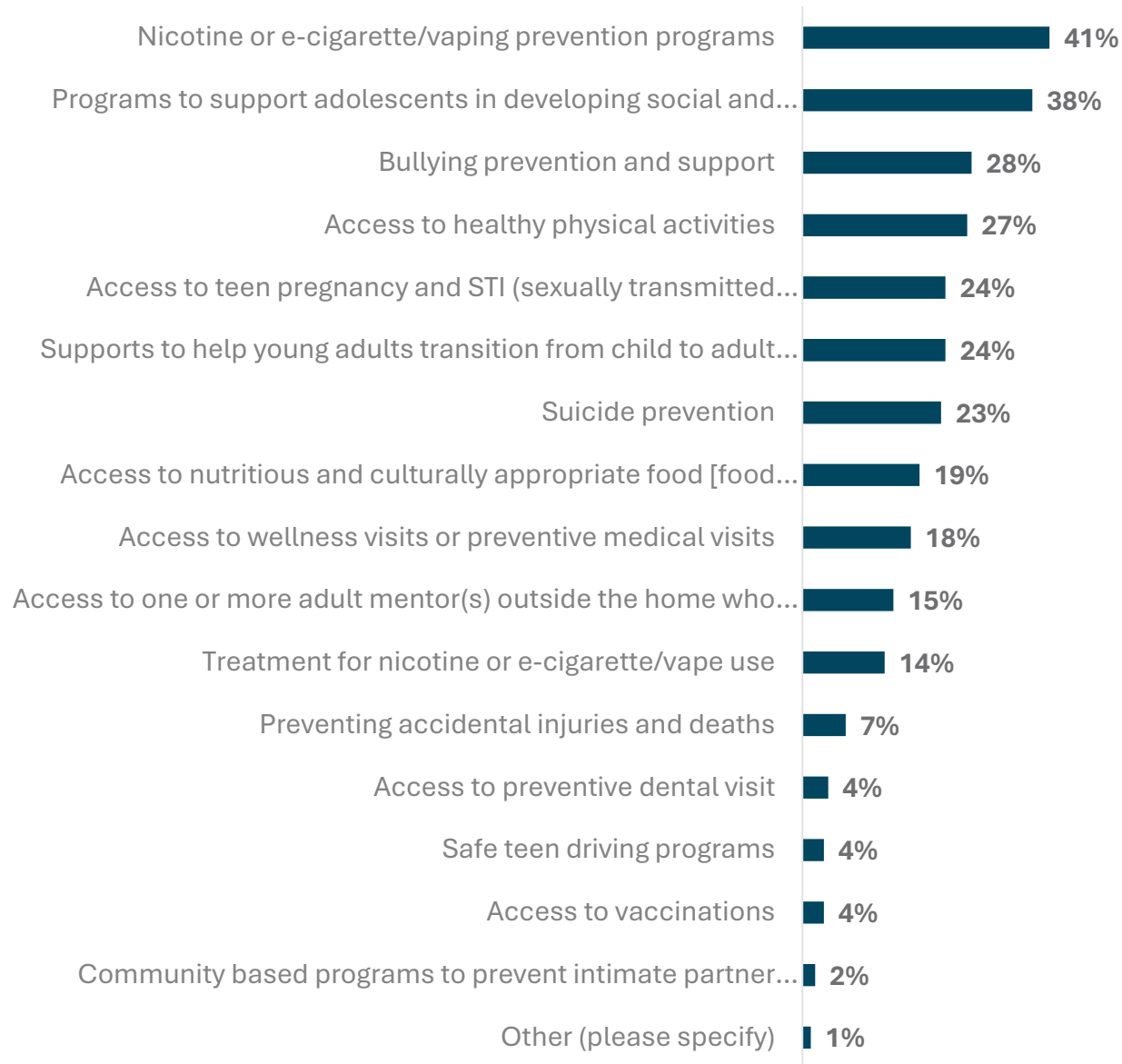
Infant Health Priorities (ages: 0-364 days old)
(n=140)



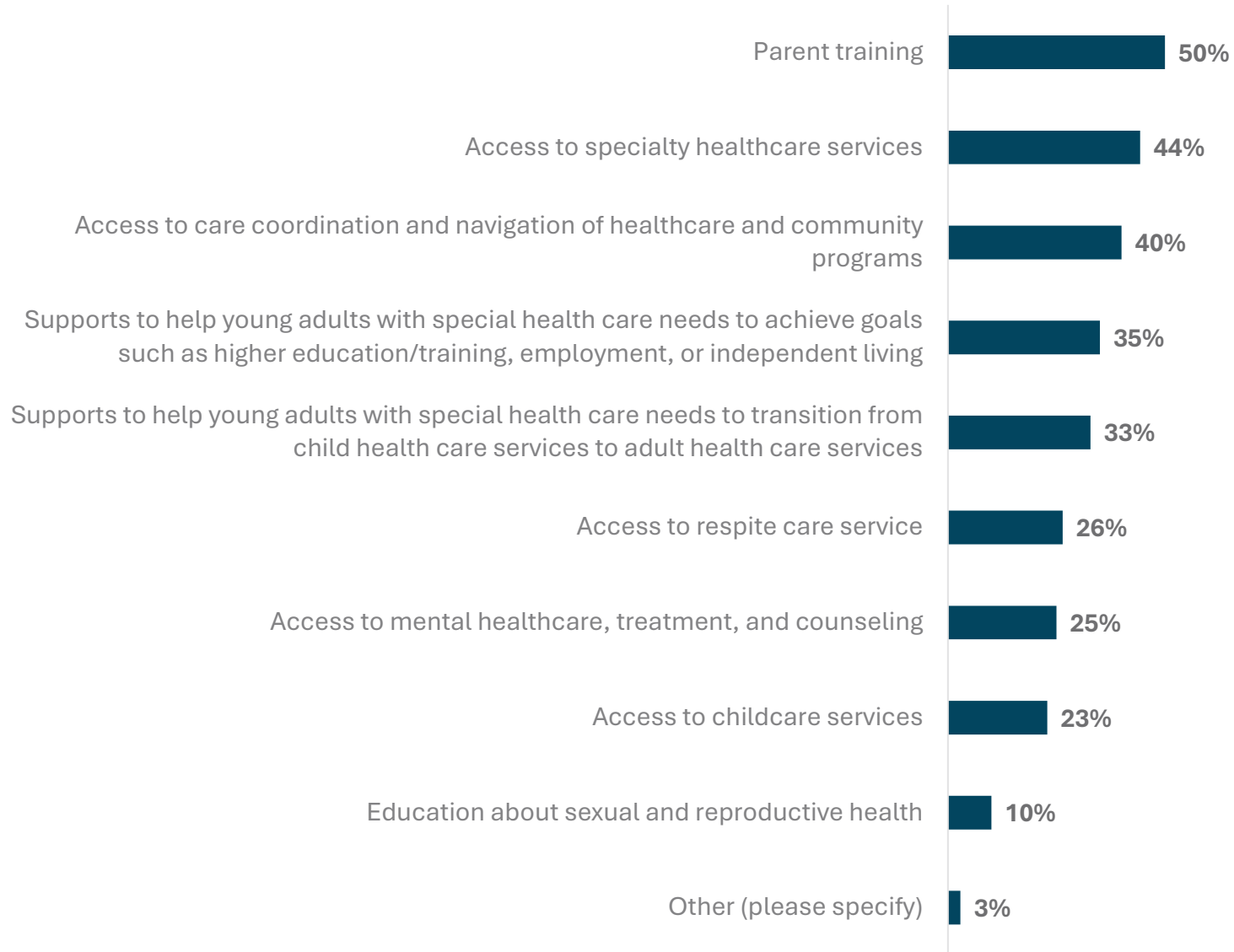
Child Health Priorities (**ages: 1 year - 9 years old**)
(n=140)



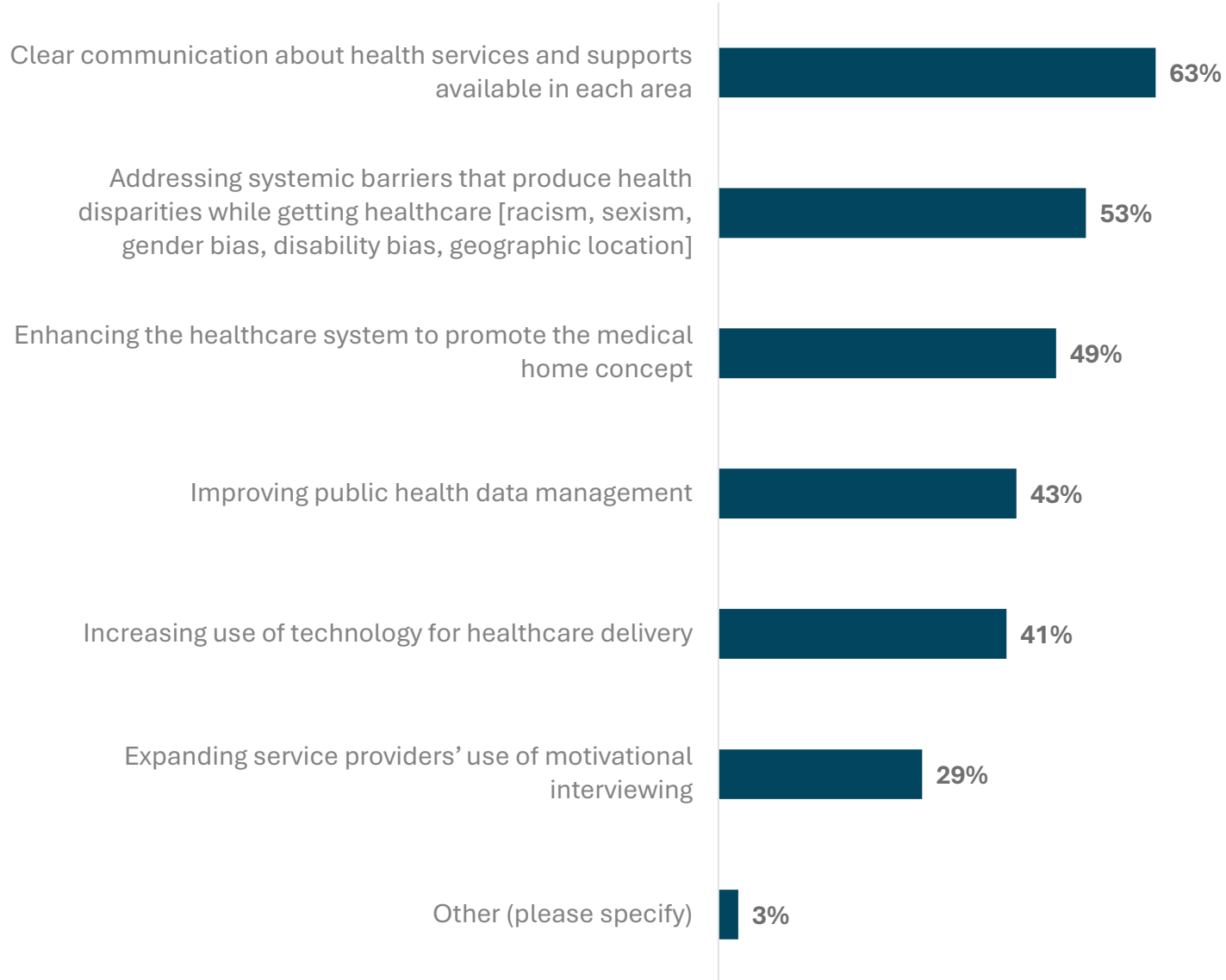
Adolescent Health Priorities (ages: 10-17 years old)
(n=140)



Health Priorities: **Children with Special Health Care Needs**
(n=140)



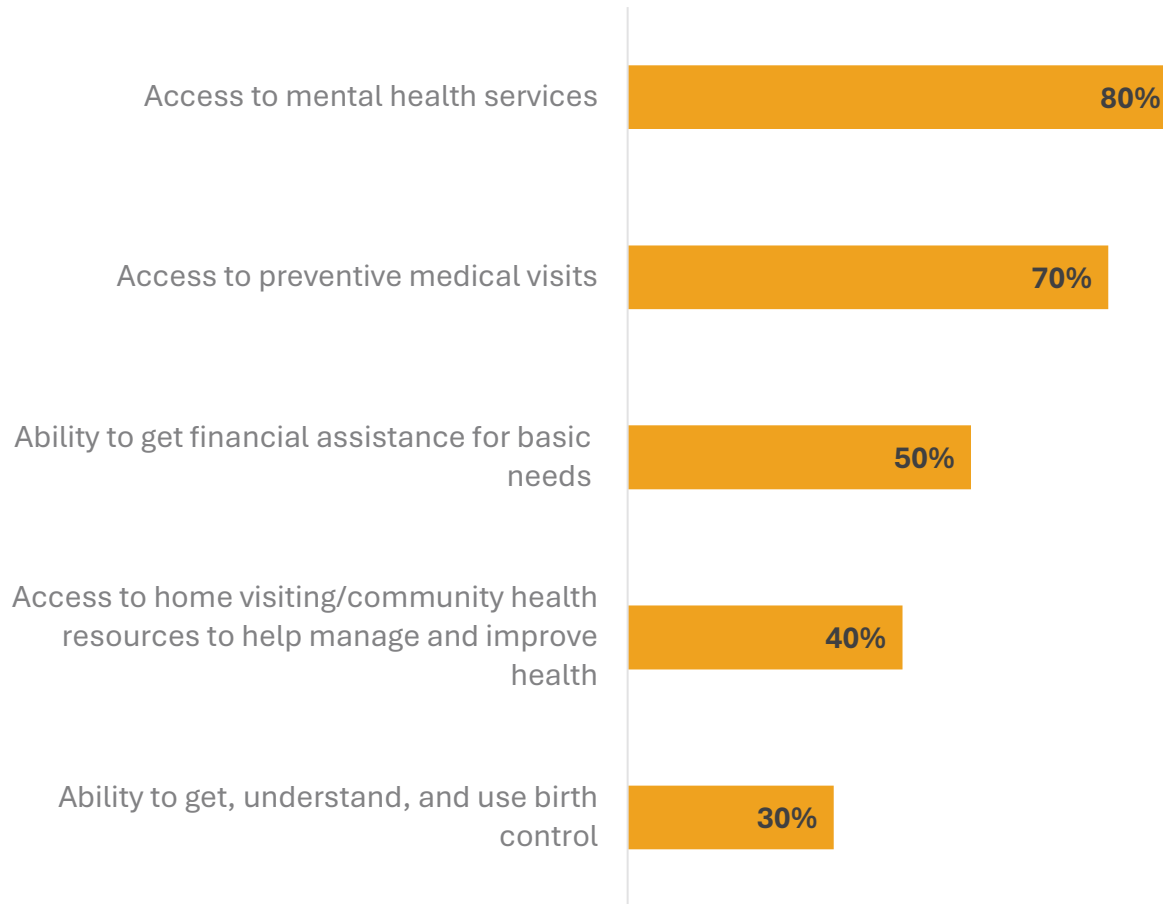
Cross-cutting/Systems Building Priorities (n=140)



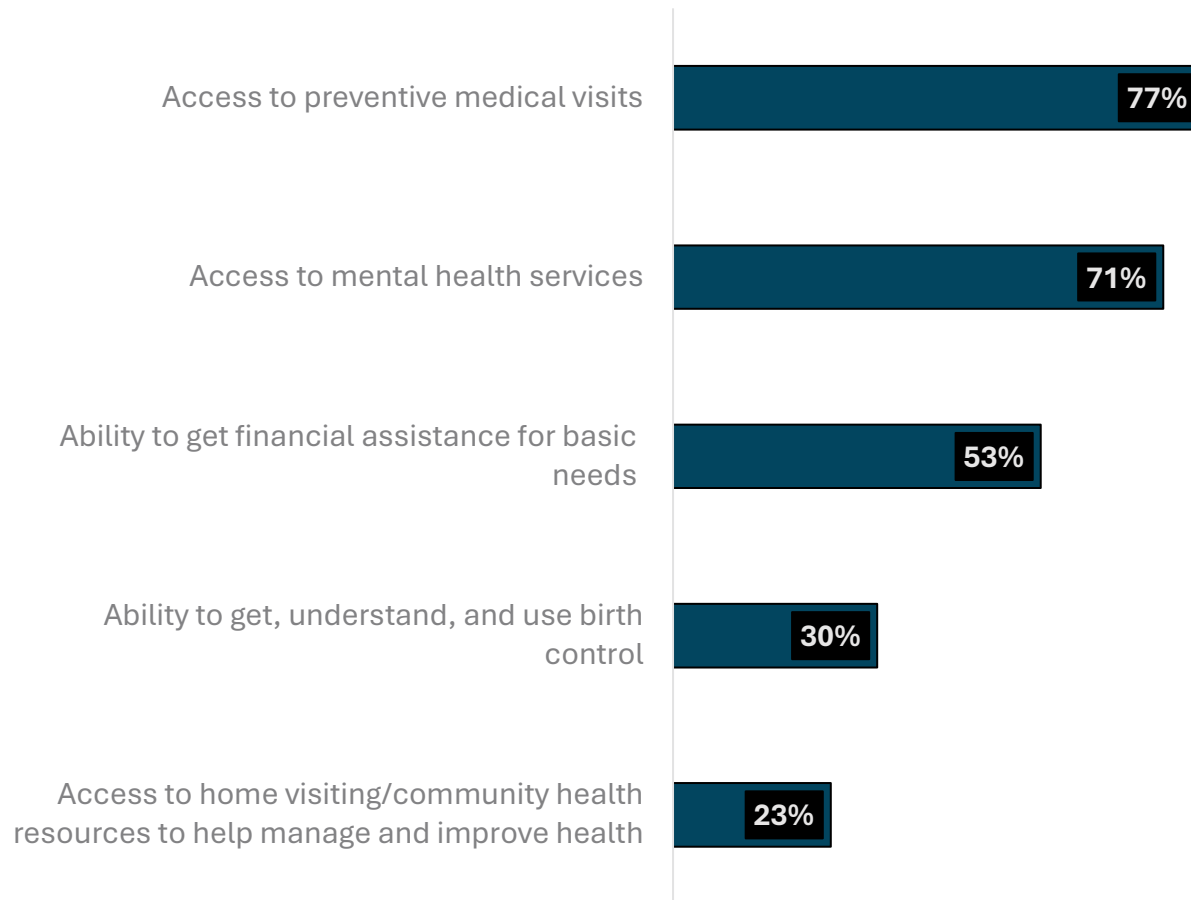
MICAH Needs Assessment
Stakeholder Survey
PROFESSIONALS - 2025

Results by Island
SAIPAN

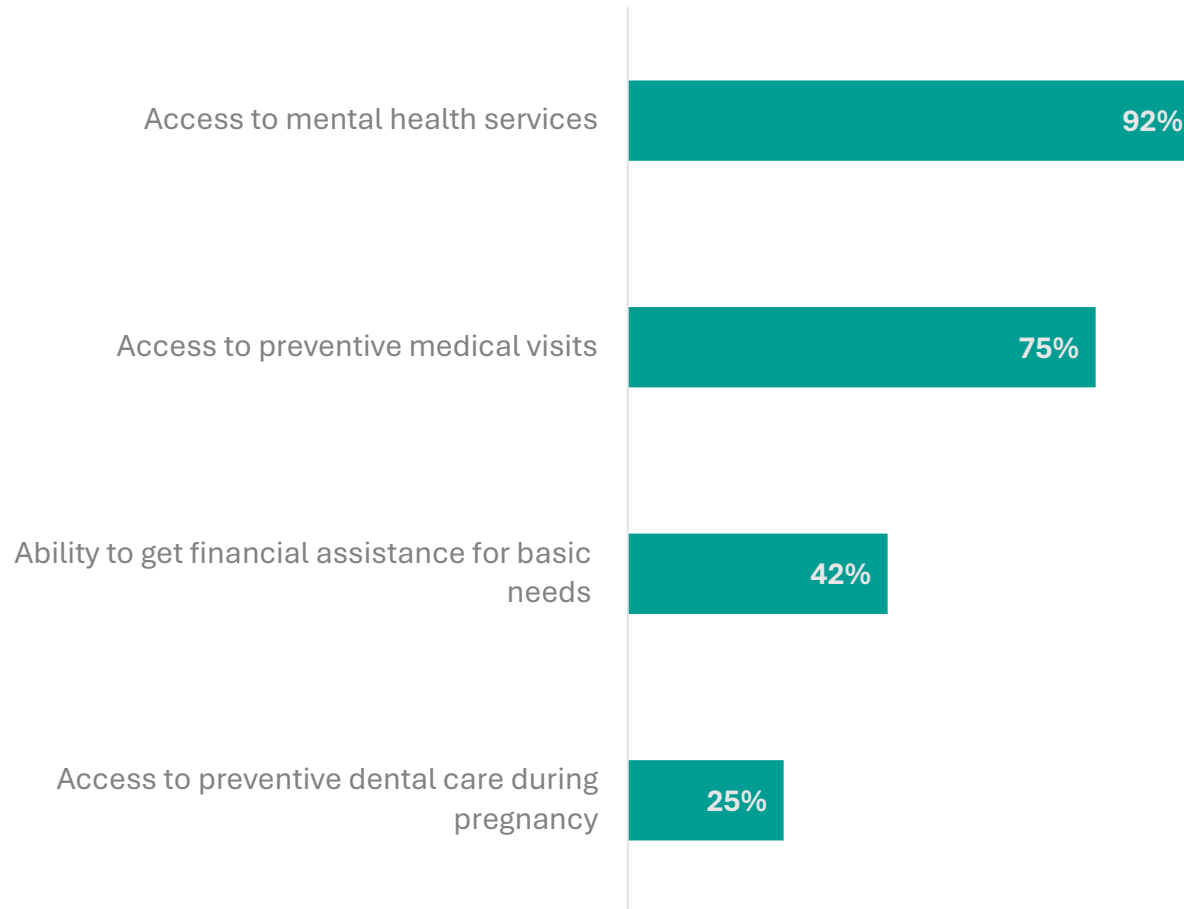
Tinian Professionals Survey:
Women's Health Priorities
(n=10)



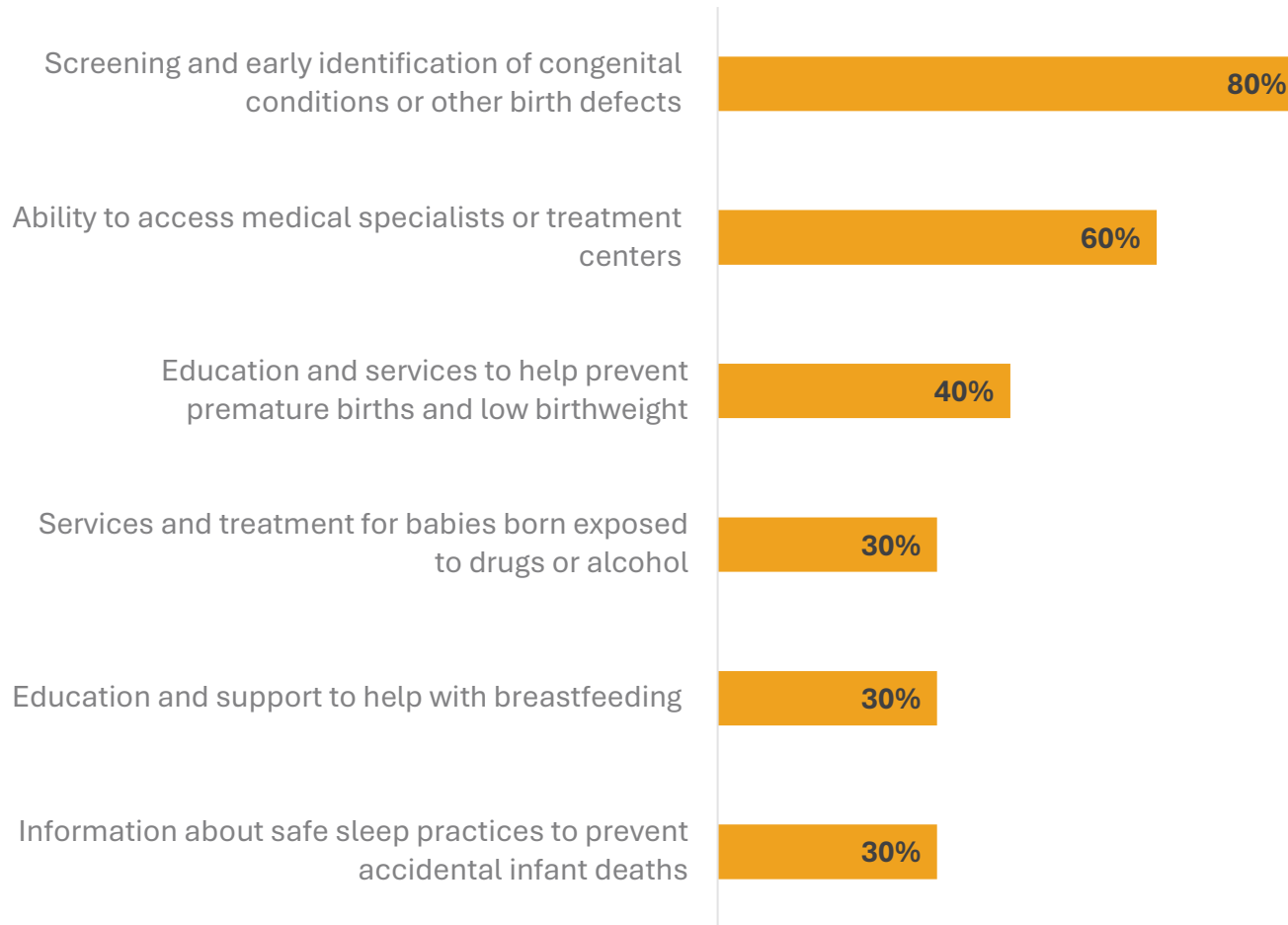
Saipan Professionals Survey:
Women's Health Priorities
(n=118)



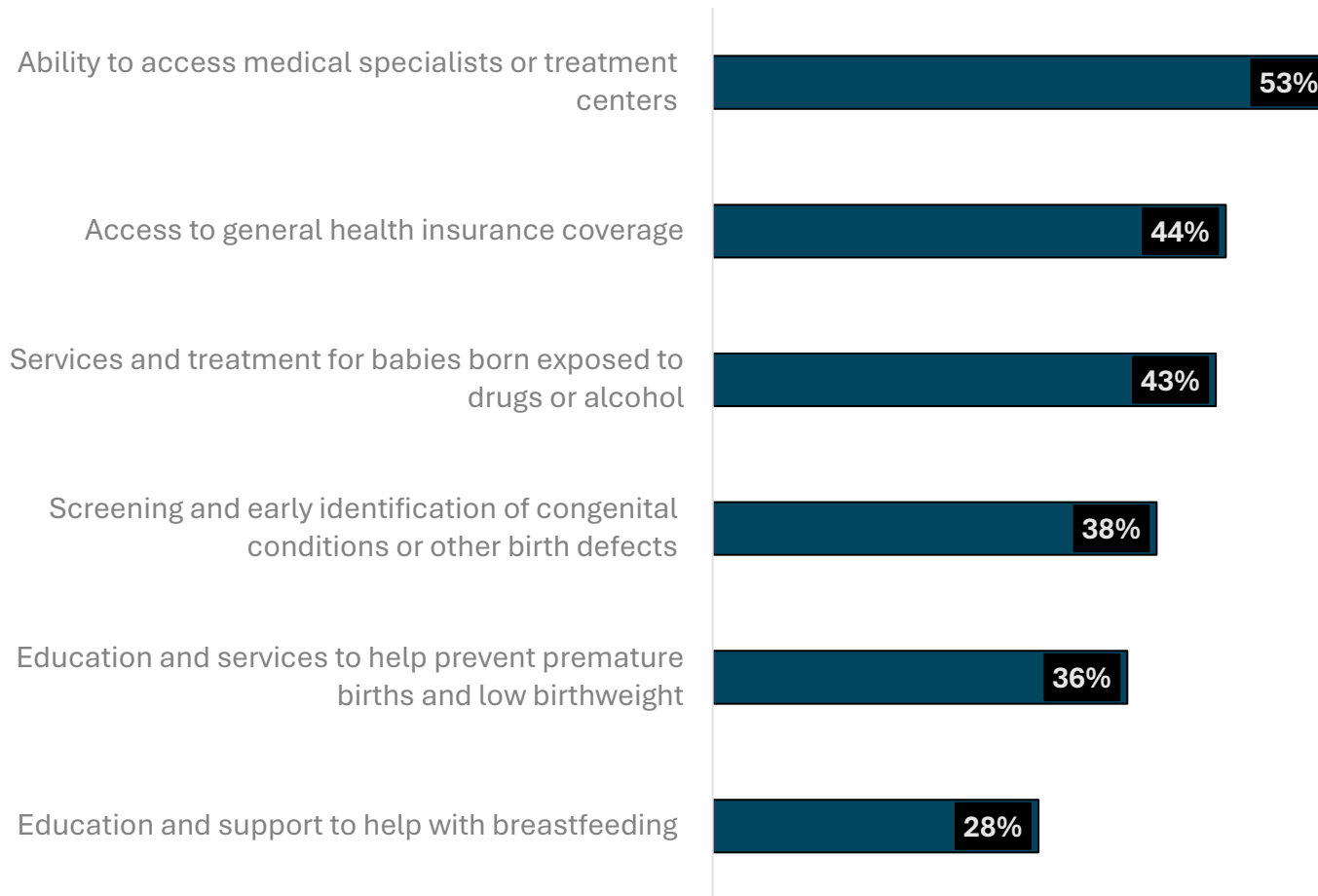
Rota Professionals Survey:
Women's Health Priorities
(n=12)



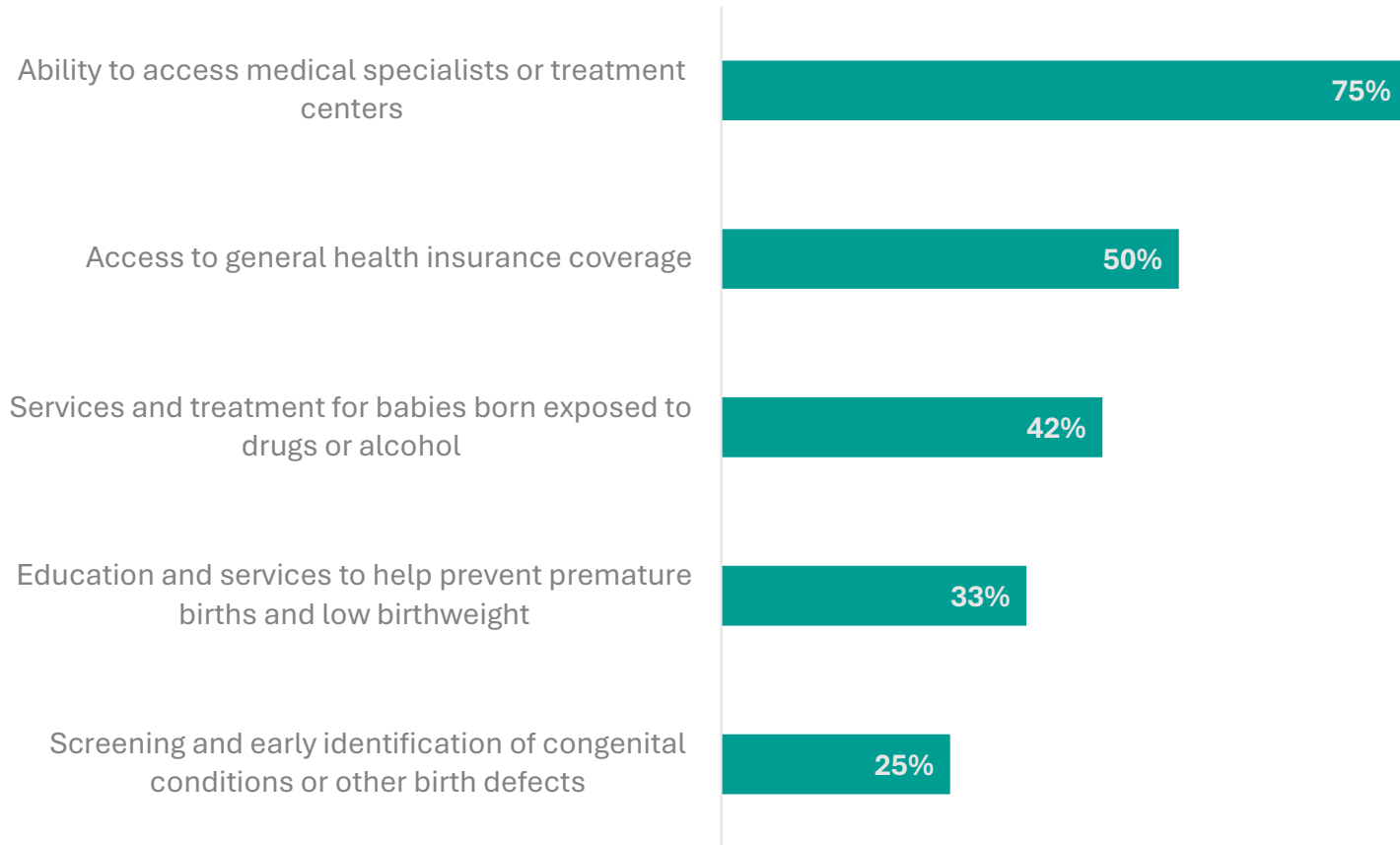
Tinian Professionals Survey:
Infant Health Priorities
(n=10)



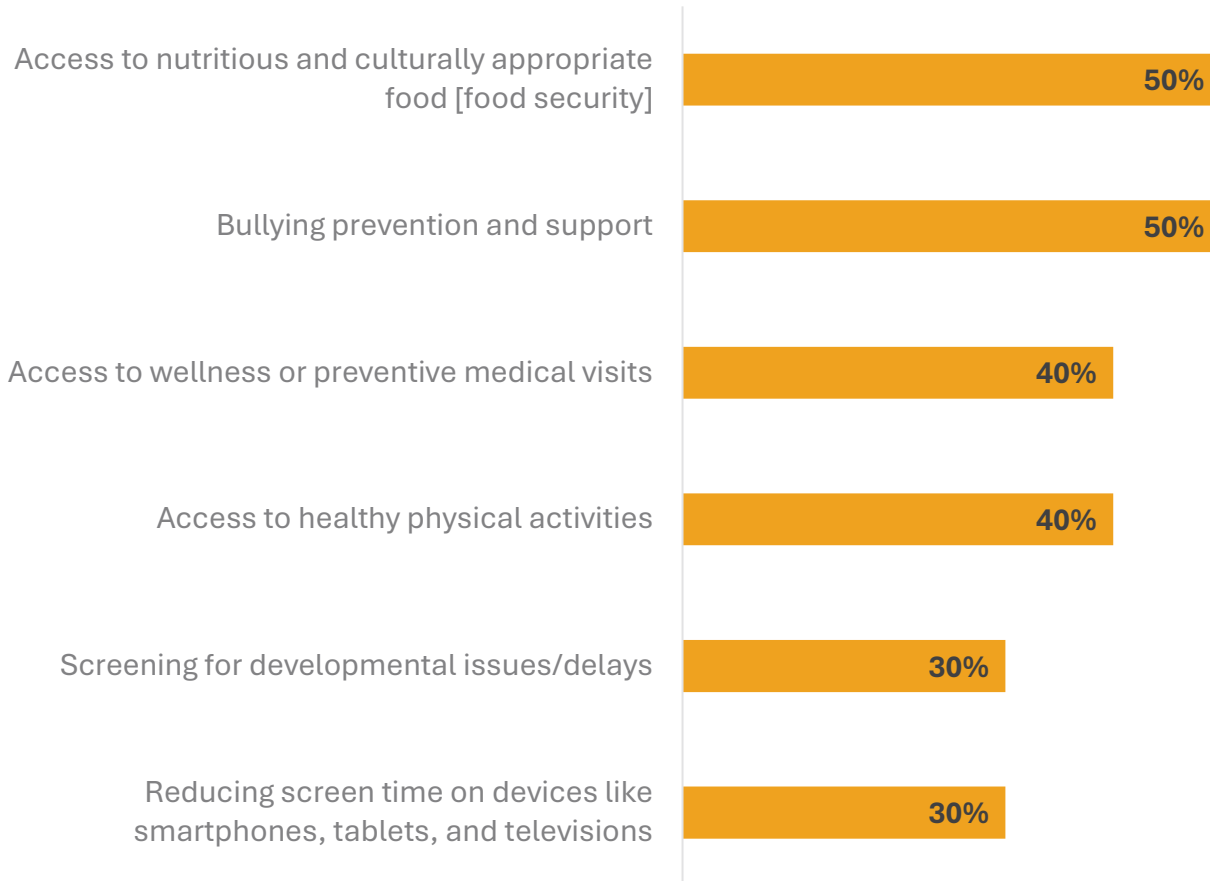
Saipan Professionals Survey:
Infant Health Priorities
(n=118)



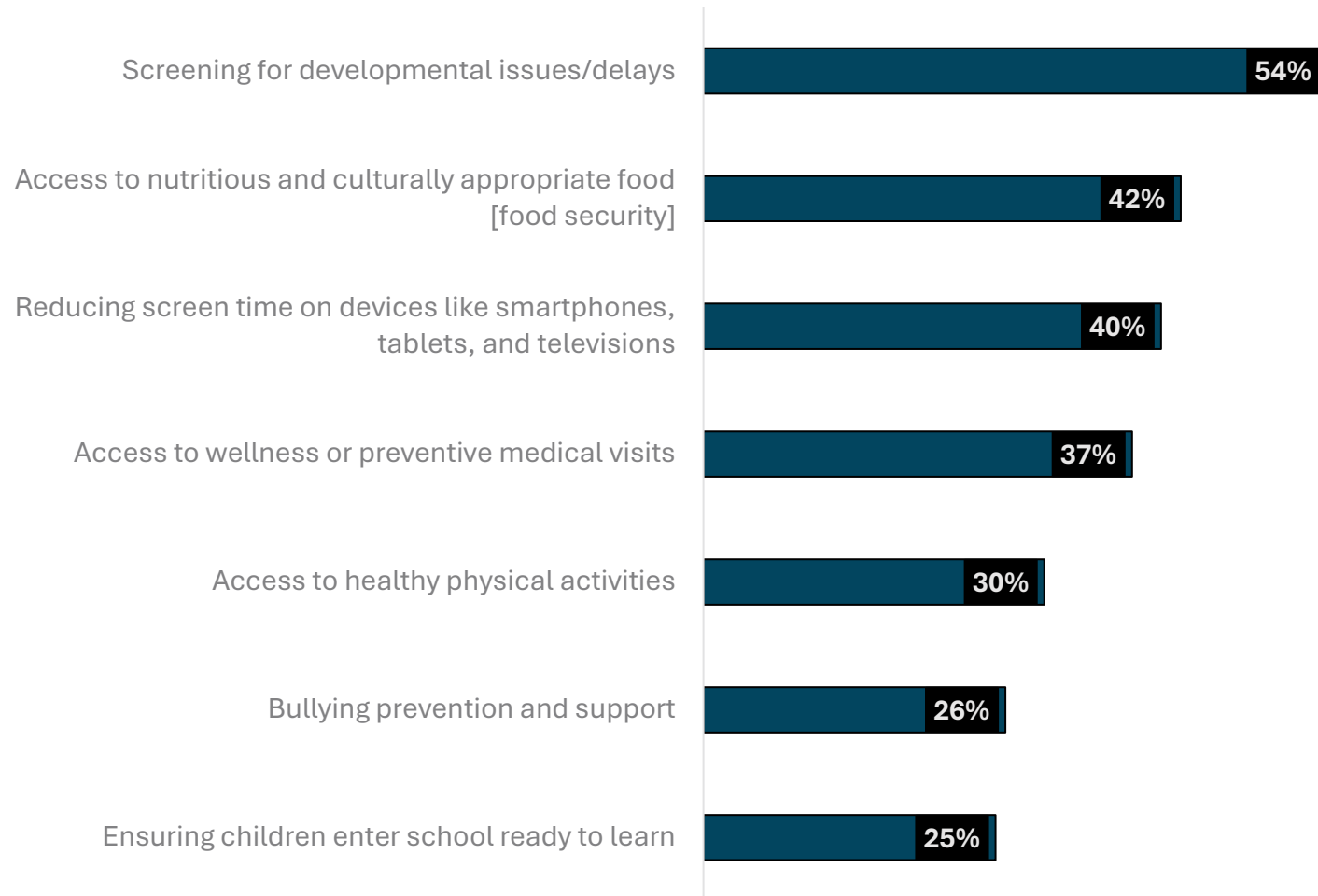
Rota Professionals Survey:
Infant Health Priorities
(n=12)



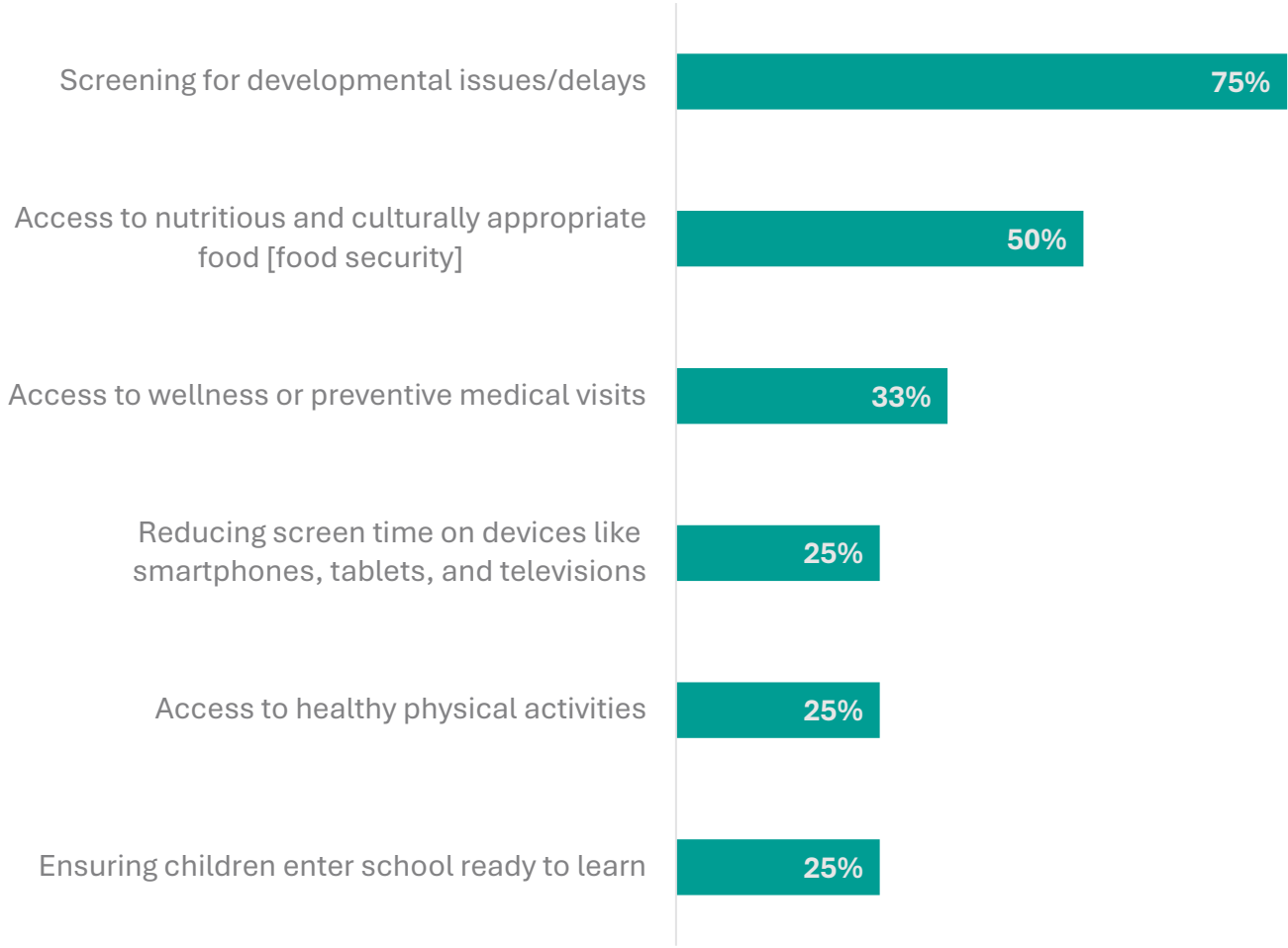
Tinian Professionals Survey:
Child Age 1-9 Health Priorities
(n=10)



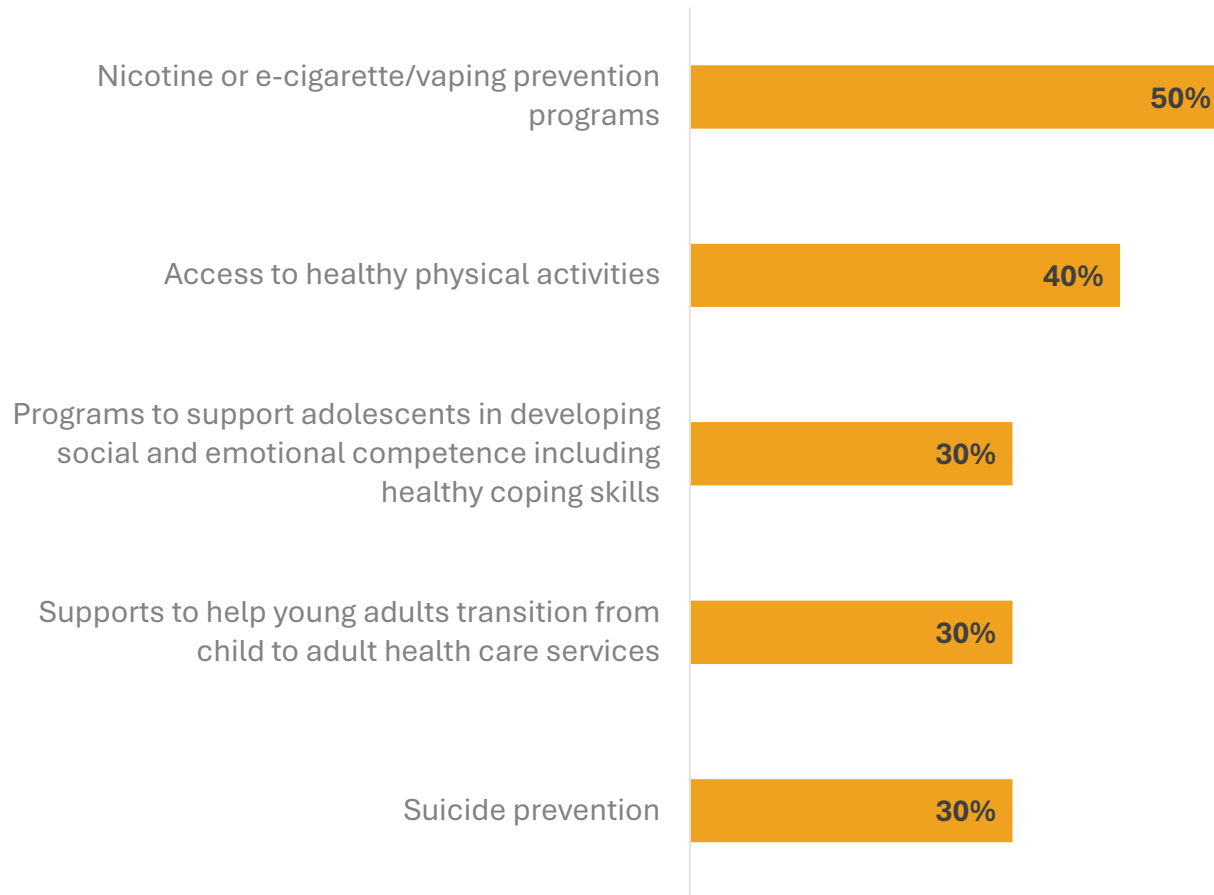
Saipan Professionals Survey:
Child Age 1-9 Health Priorities
(n=118)



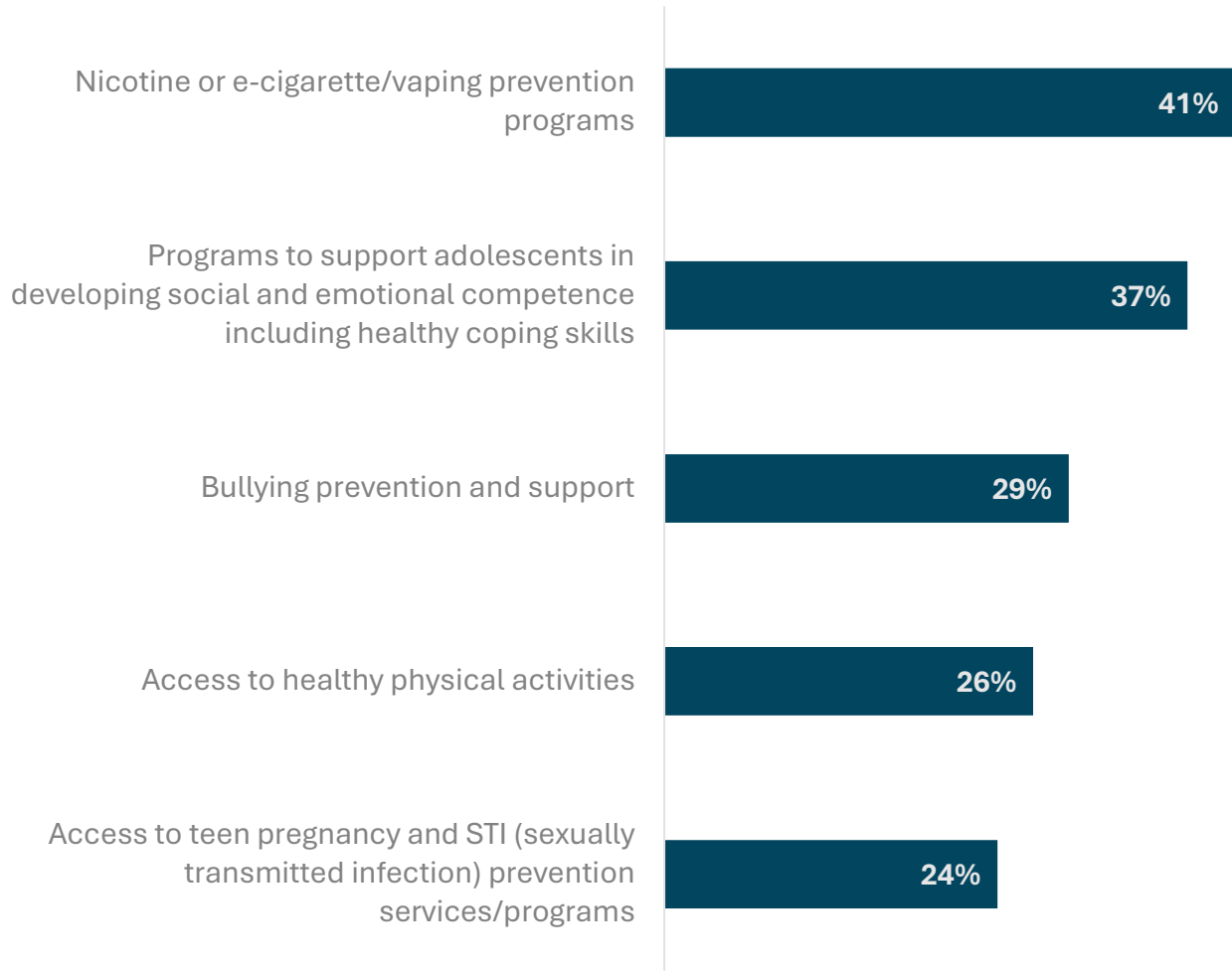
Rota Professionals Survey:
Child Age 1-9 Health Priorities
(n=12)



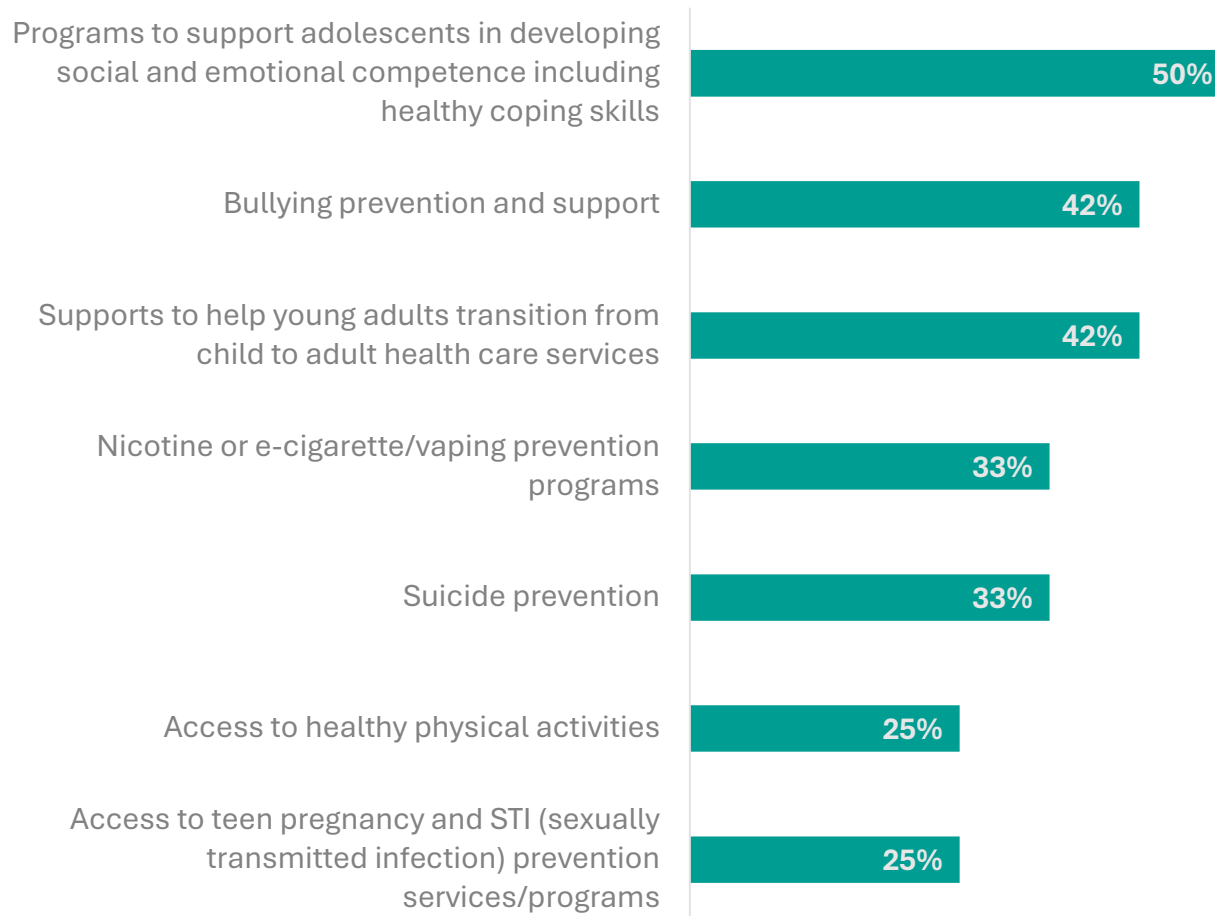
Tinian Professionals Survey:
Adolescent Health Priorities
(n=10)



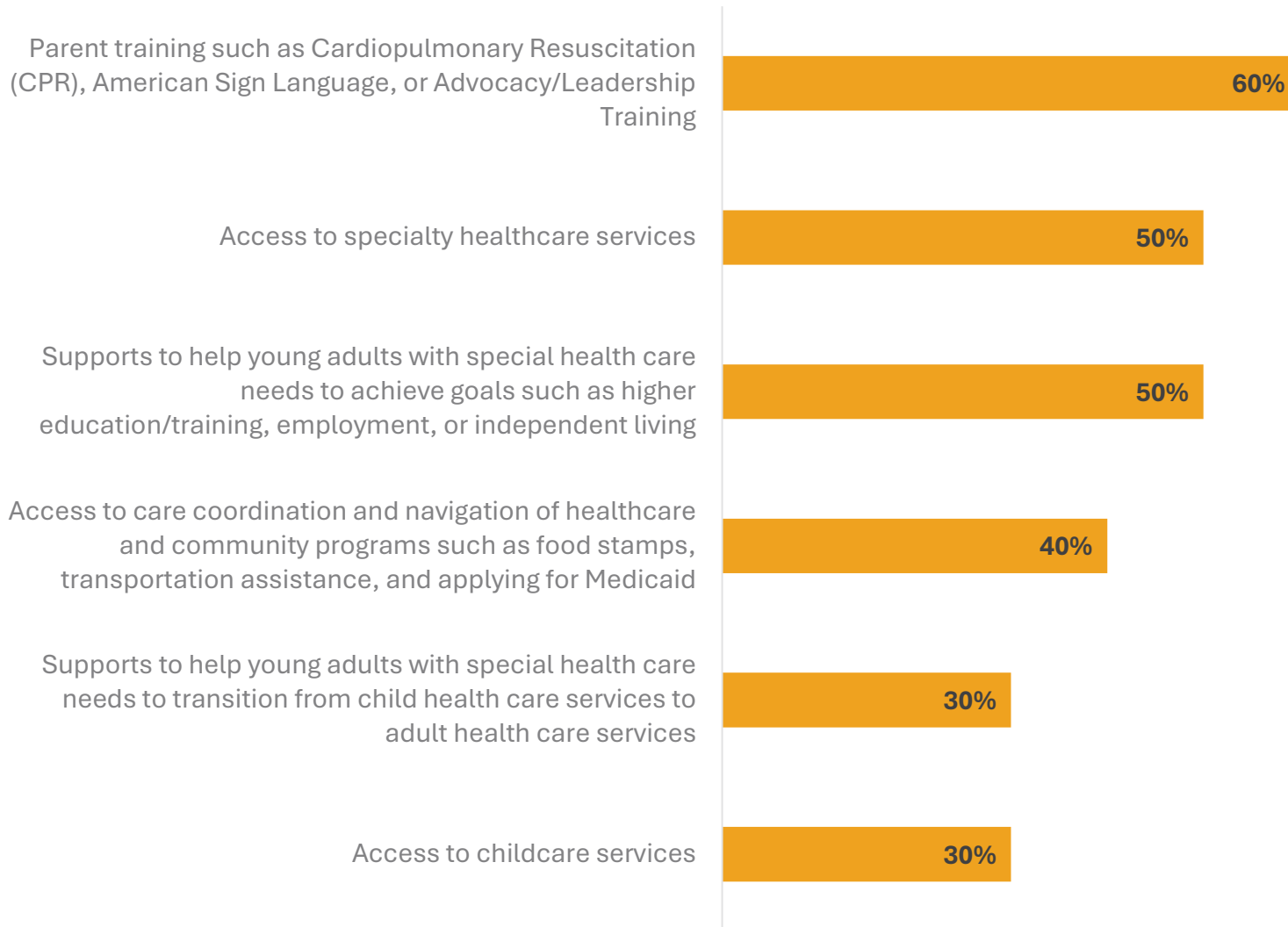
Saipan Professionals Survey:
Adolescent Health Priorities
(n=118)



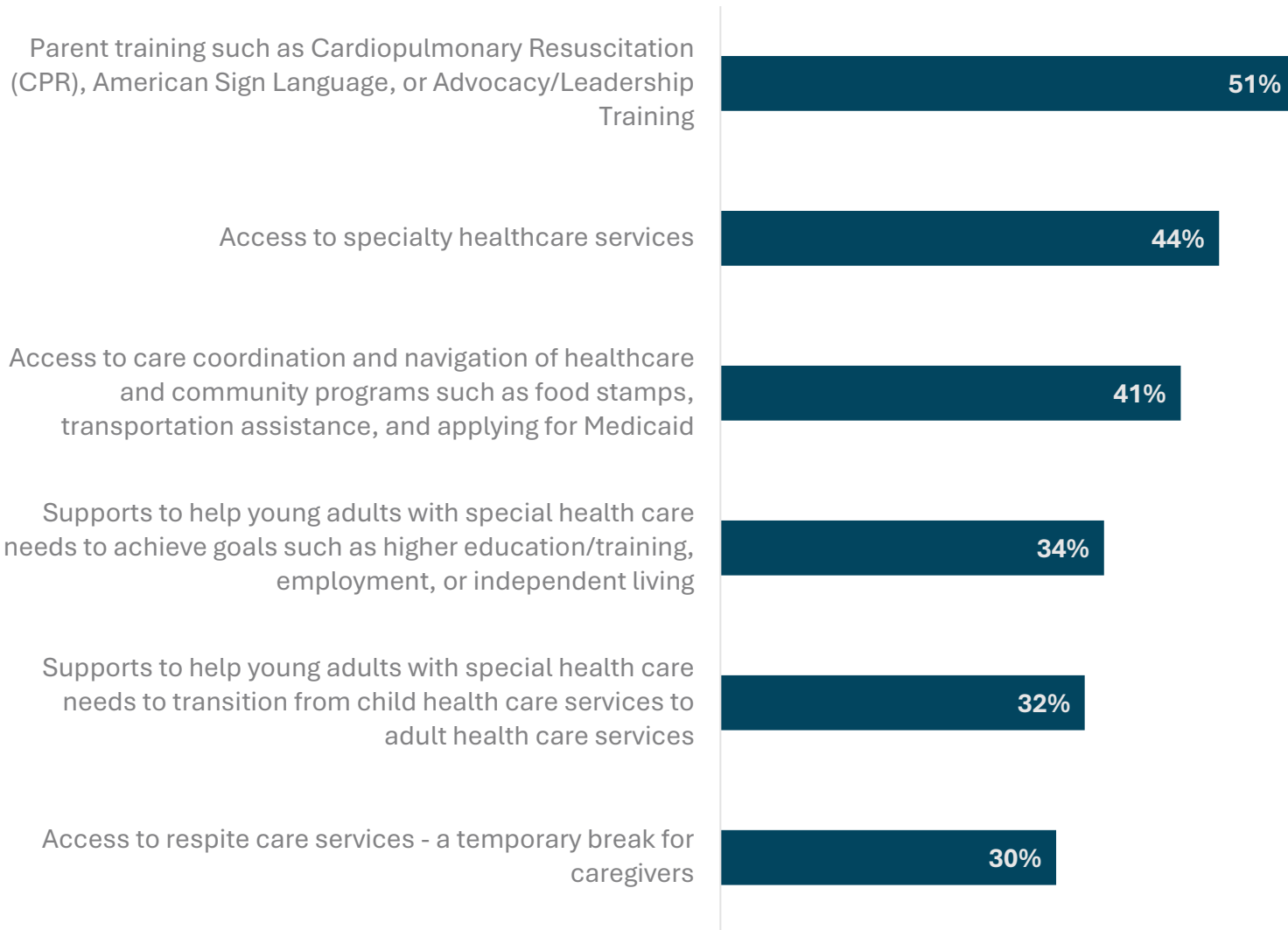
Rota Professionals Survey:
Adolescent Health Priorities
(n=12)



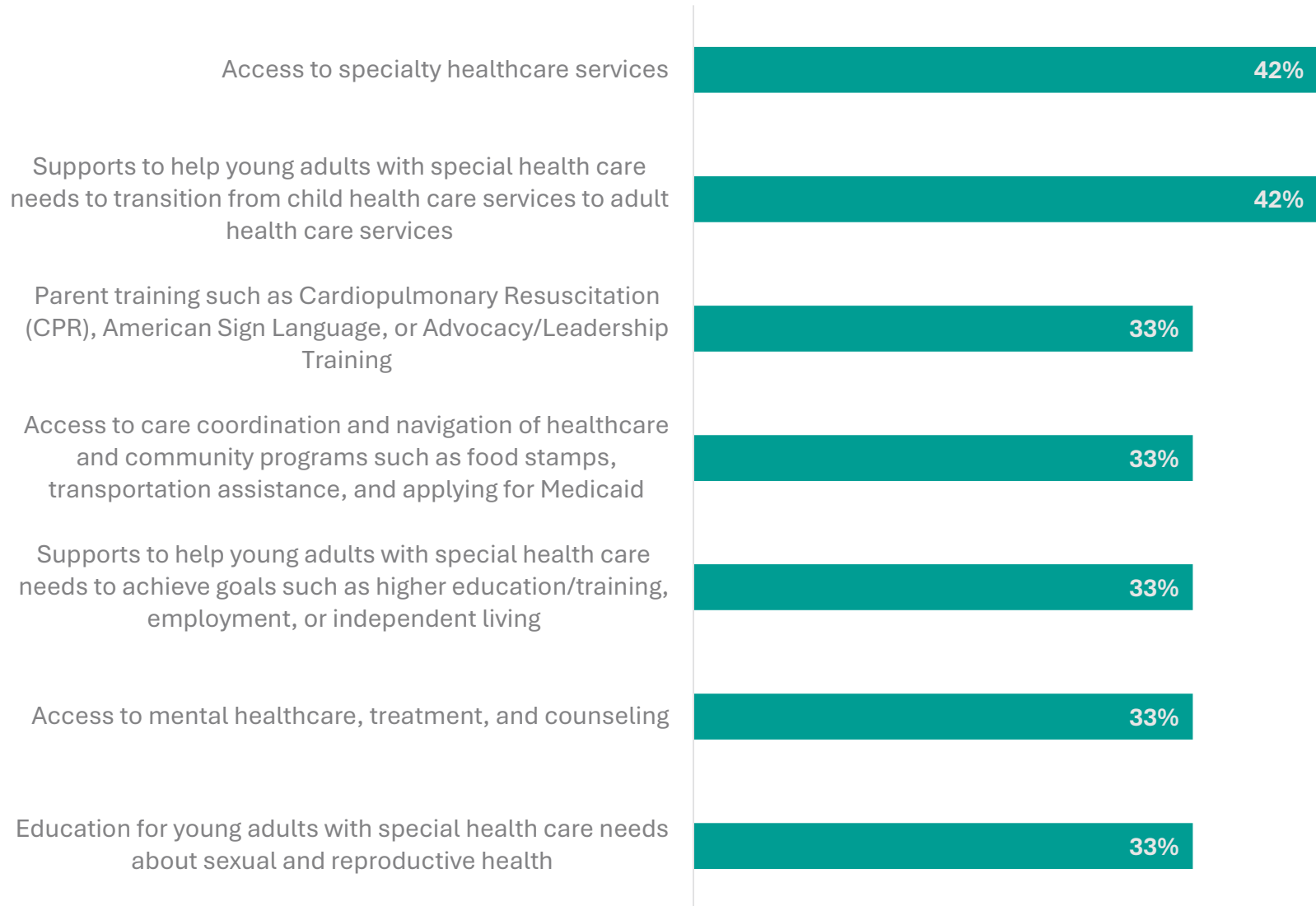
Tinian Professionals Survey:
Children with Special Healthcare Needs (CSHCN) Health Priorities
(n=10)



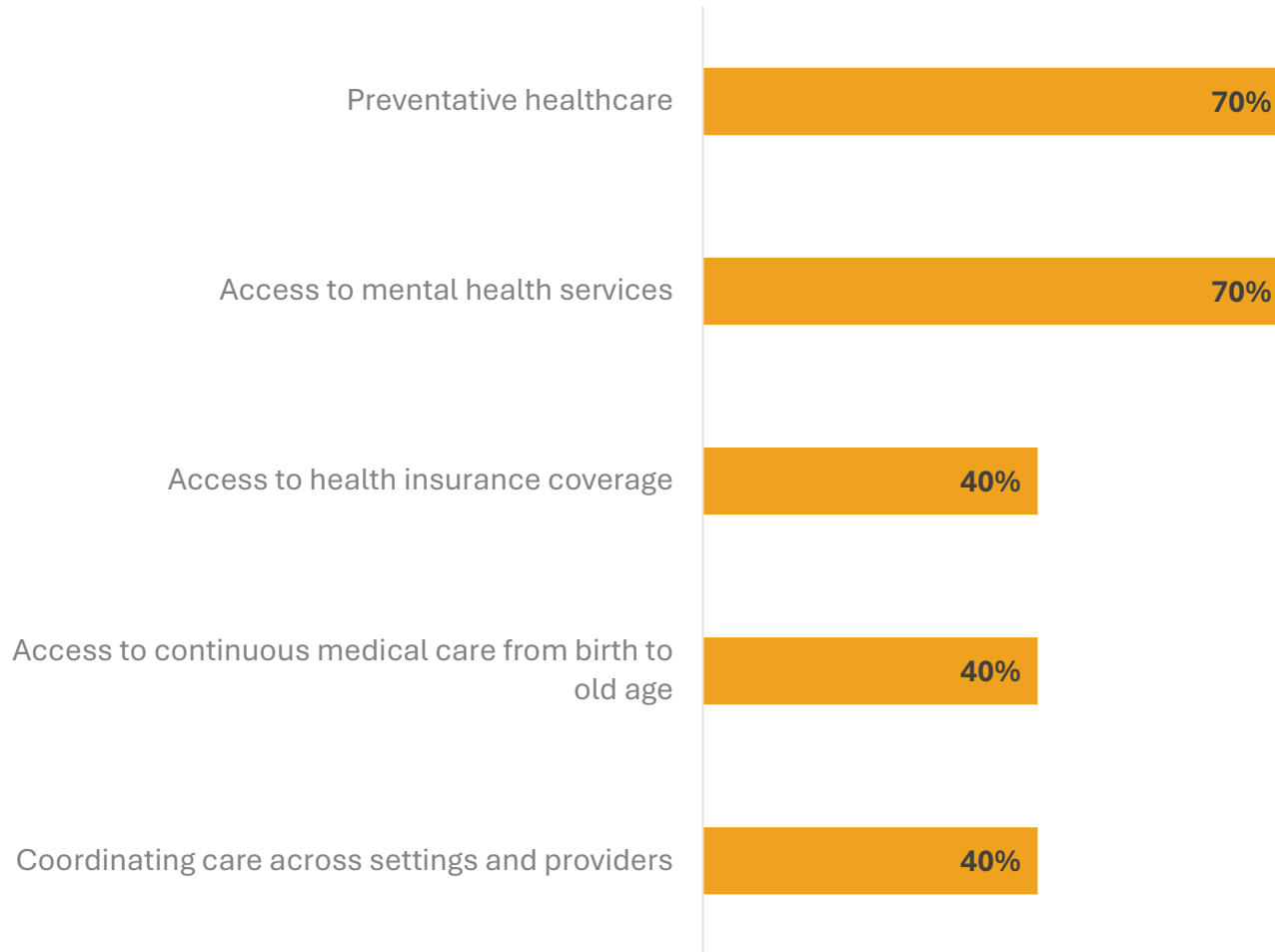
Saipan Professionals Survey:
Children with Special Healthcare Needs (CSHCN) Health Priorities
(n=118)



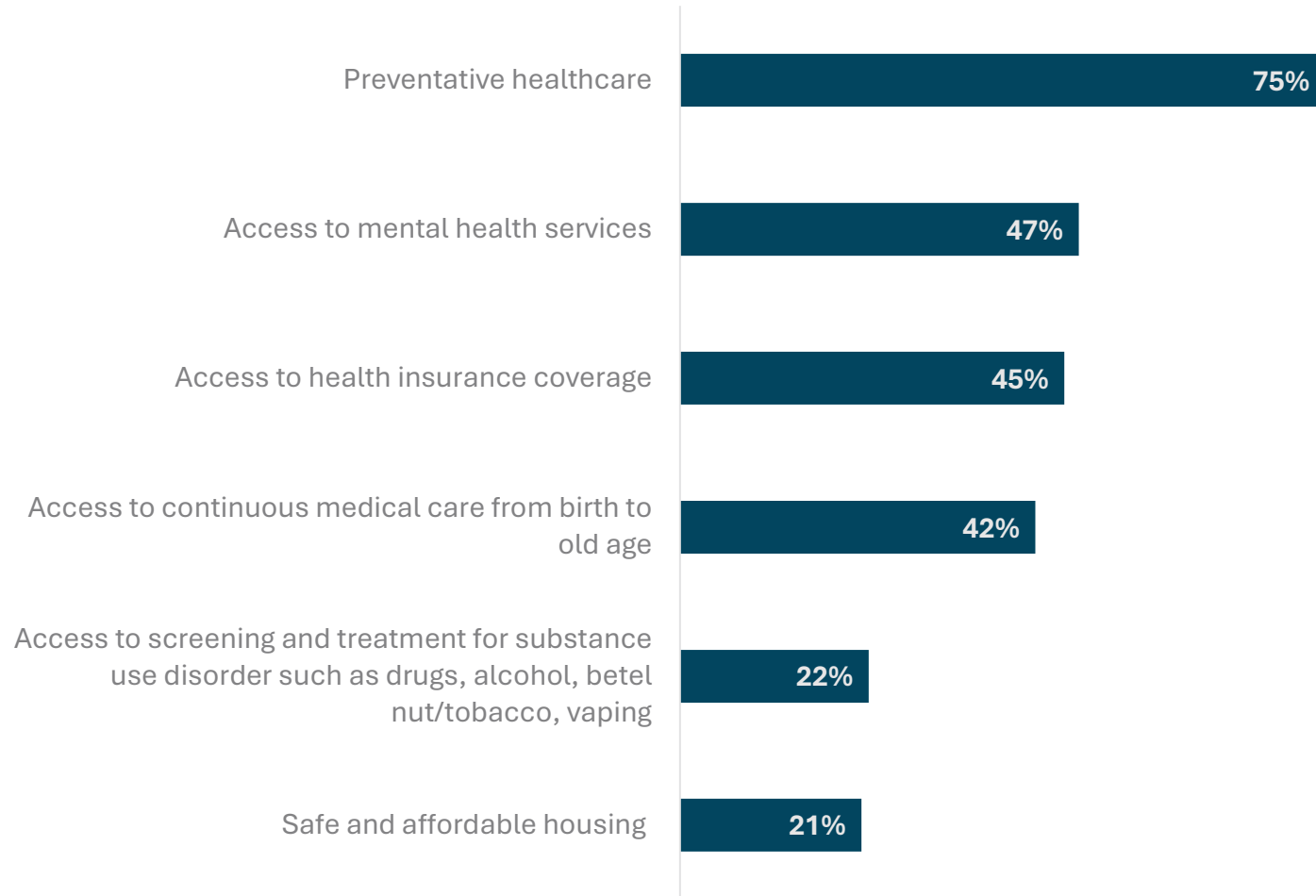
Rota Professionals Survey:
Children with Special Healthcare Needs (CSHCN) Health Priorities
(n=12)



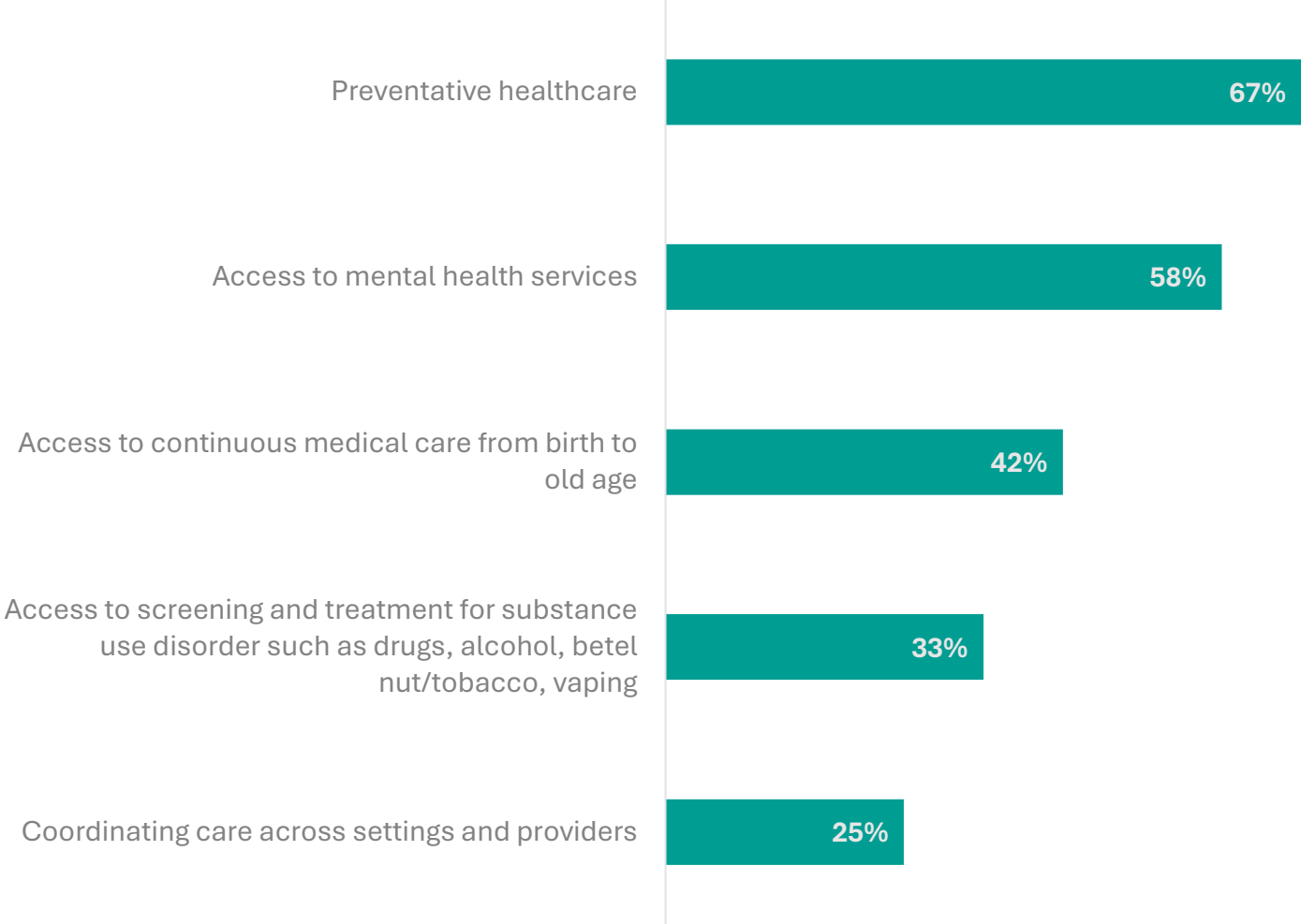
Tinian Professionals Survey:
Across the Lifespan Health Priorities
(n=10)



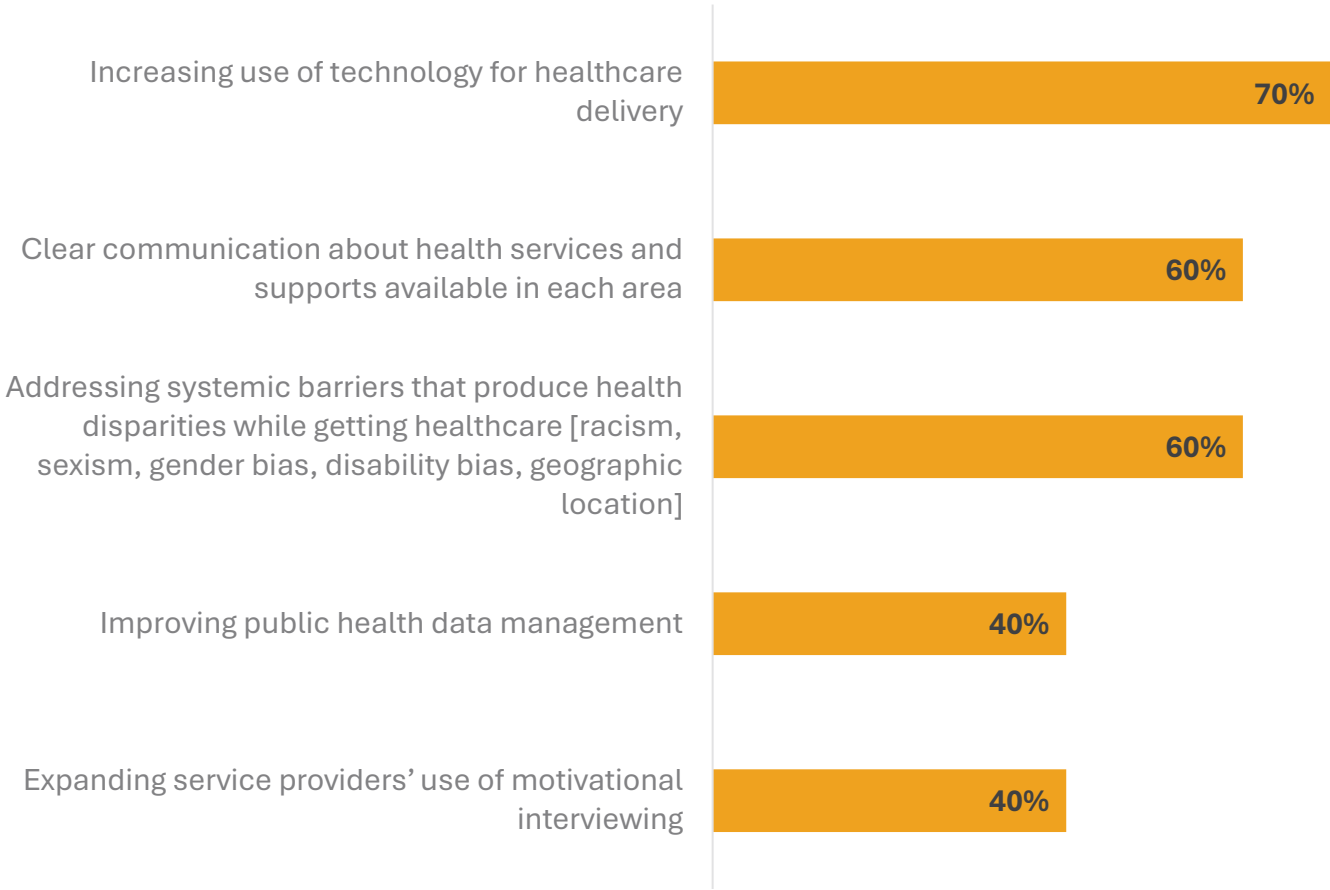
Saipan Professionals Survey:
Across the Lifespan Health Priorities
(n=118)



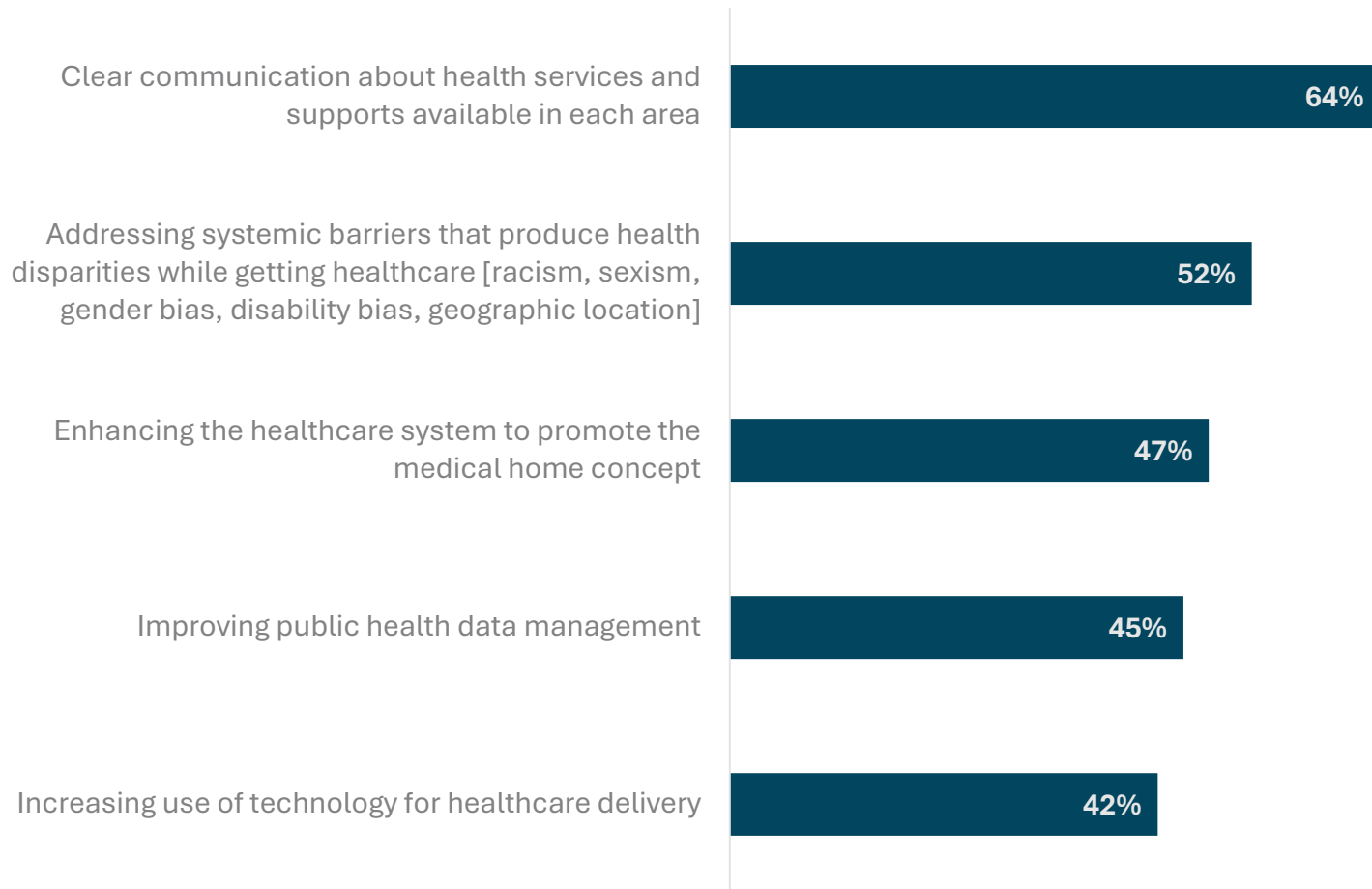
Rota Professionals Survey:
Across the Lifespan Health Priorities
(n=12)



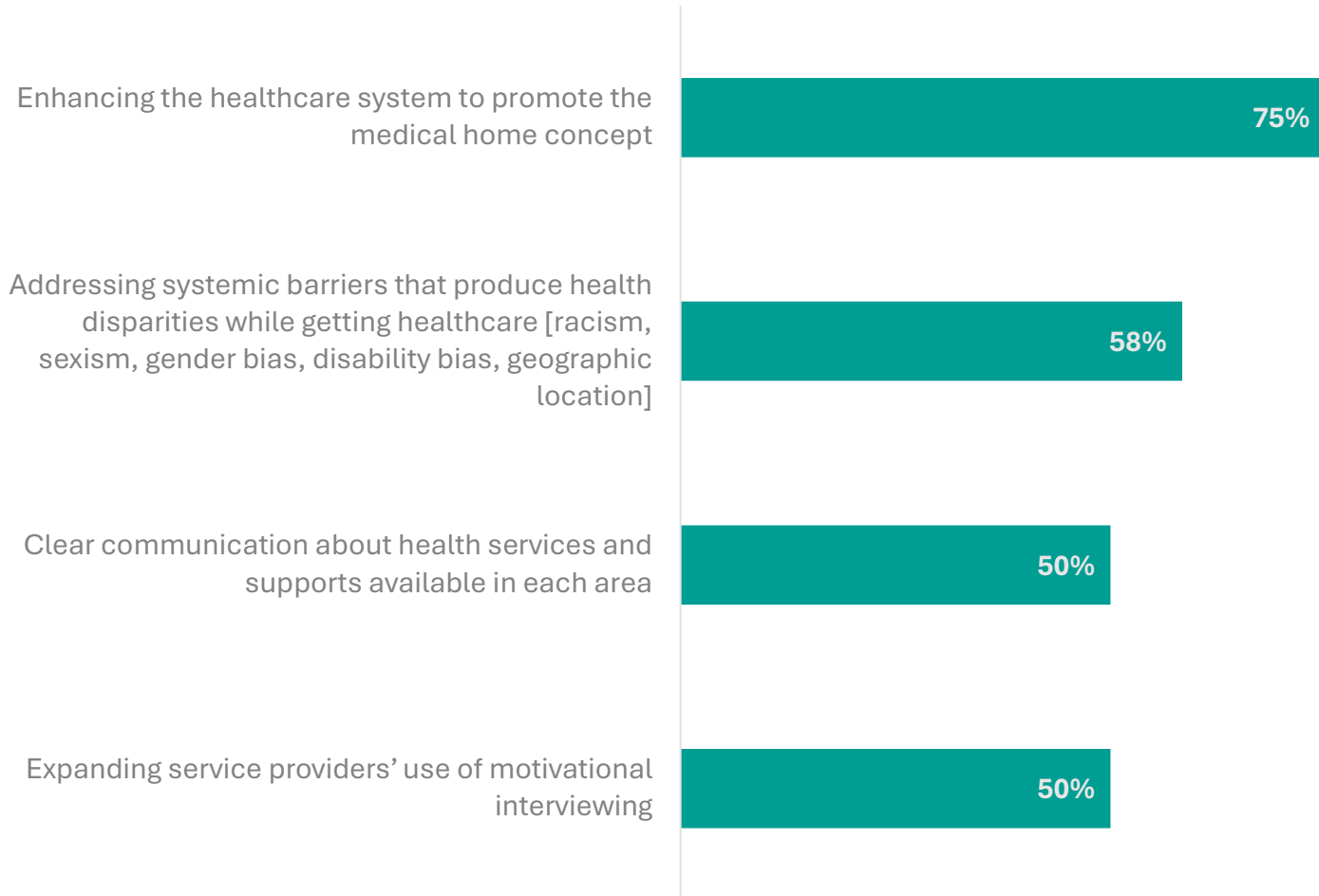
Tinian Professionals Survey:
Across the Lifespan Health Priorities
(n=10)



Saipan Professionals Survey:
Across the Lifespan Health Priorities
(n=118)



Rota Professionals Survey:
Across the Lifespan Health Priorities
(n=12)



MICAH Needs Assessment Stakeholder Survey

YOUTH

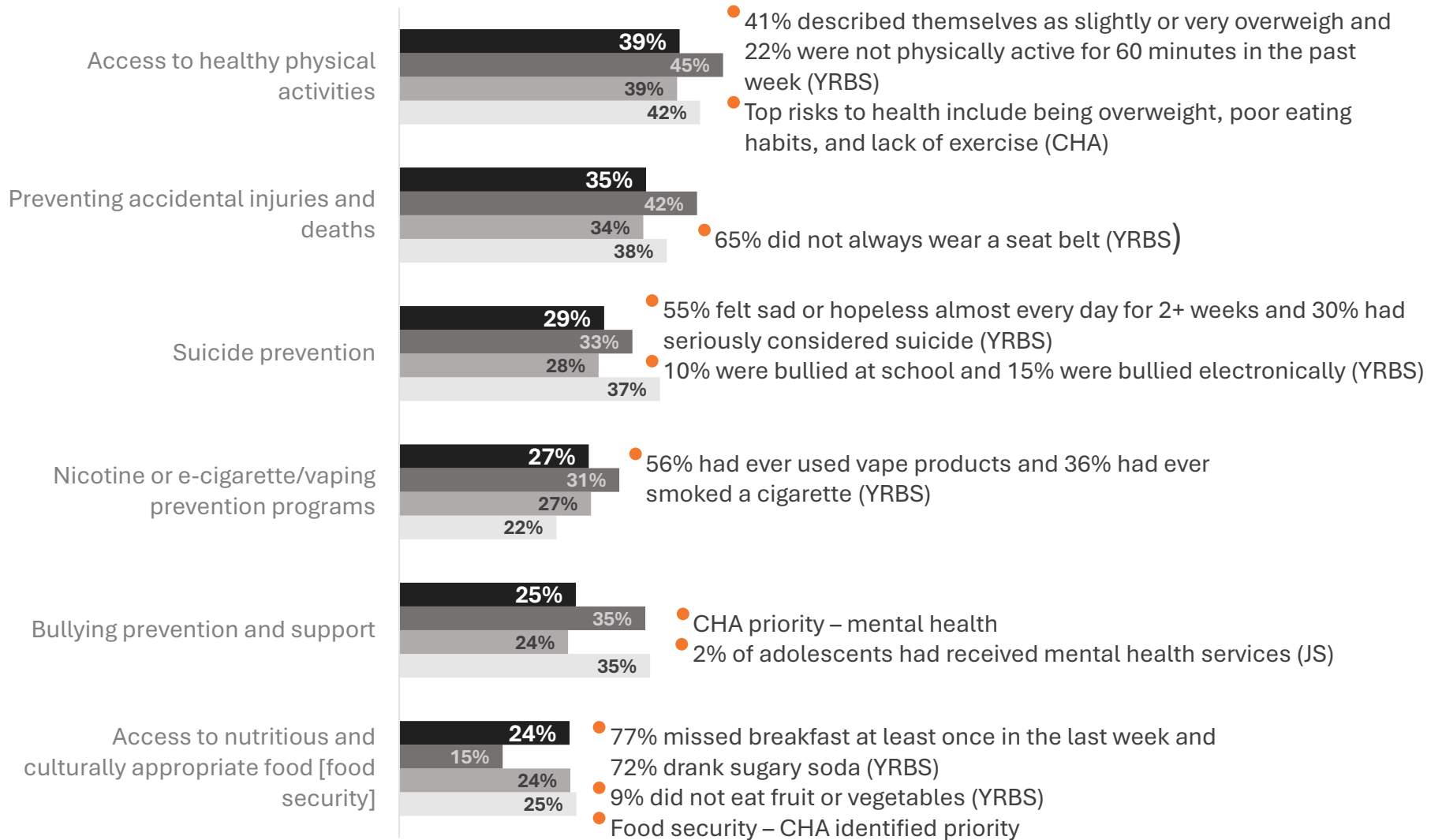
2025



May 20, 2021



Youth Survey: Adolescent Health Priorities - Overall and by Island

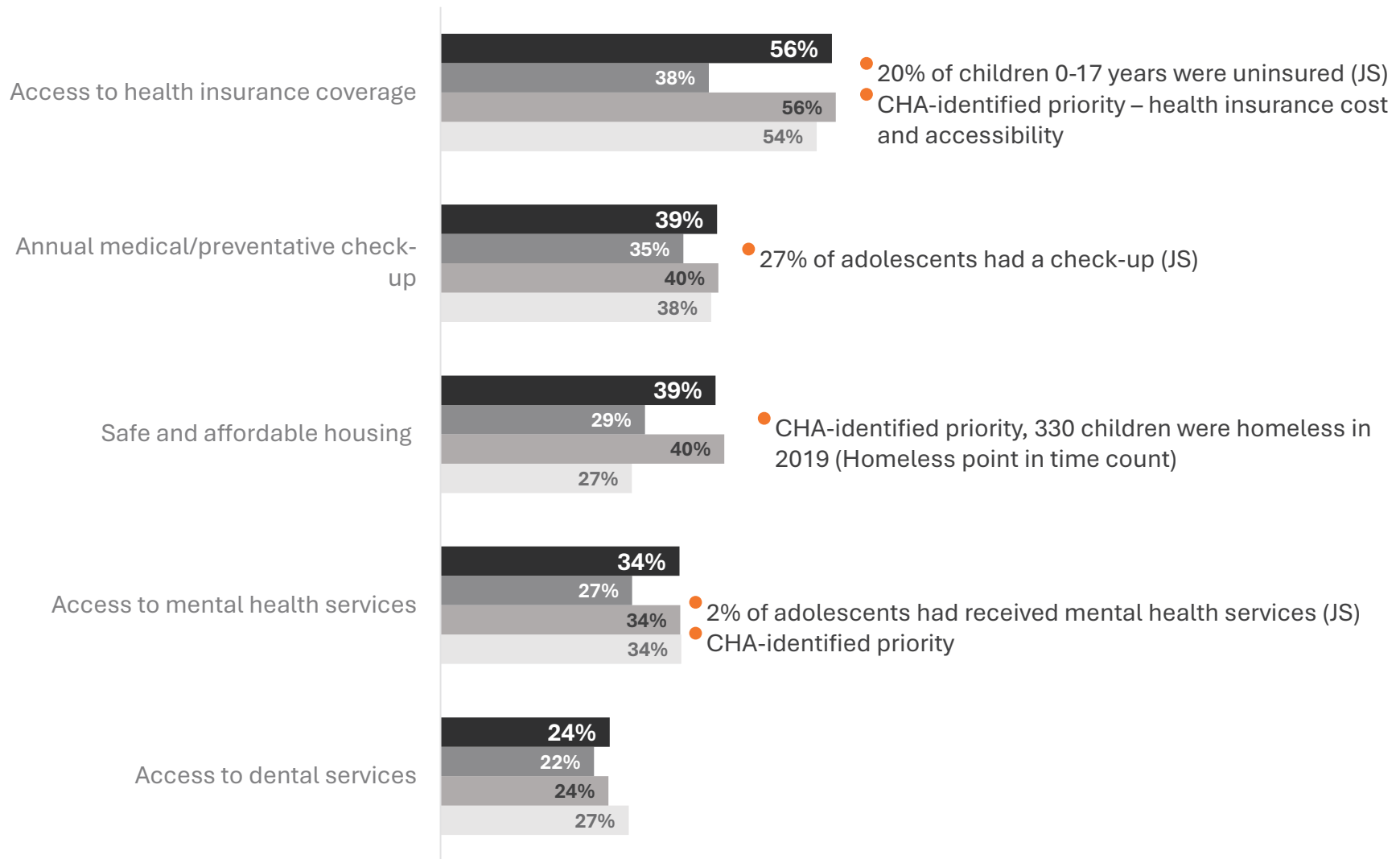


ALL (n=2760)
 Tinian (n=55)
 Saipan (n=2492)
 Rota (n=213)

● Orange bullets indicate sources of data triangulation.

Youth Survey: Health Priorities Across the Lifespan

Overall and by Island



- 20% of children 0-17 years were uninsured (JS)
- CHA-identified priority – health insurance cost and accessibility

- 27% of adolescents had a check-up (JS)

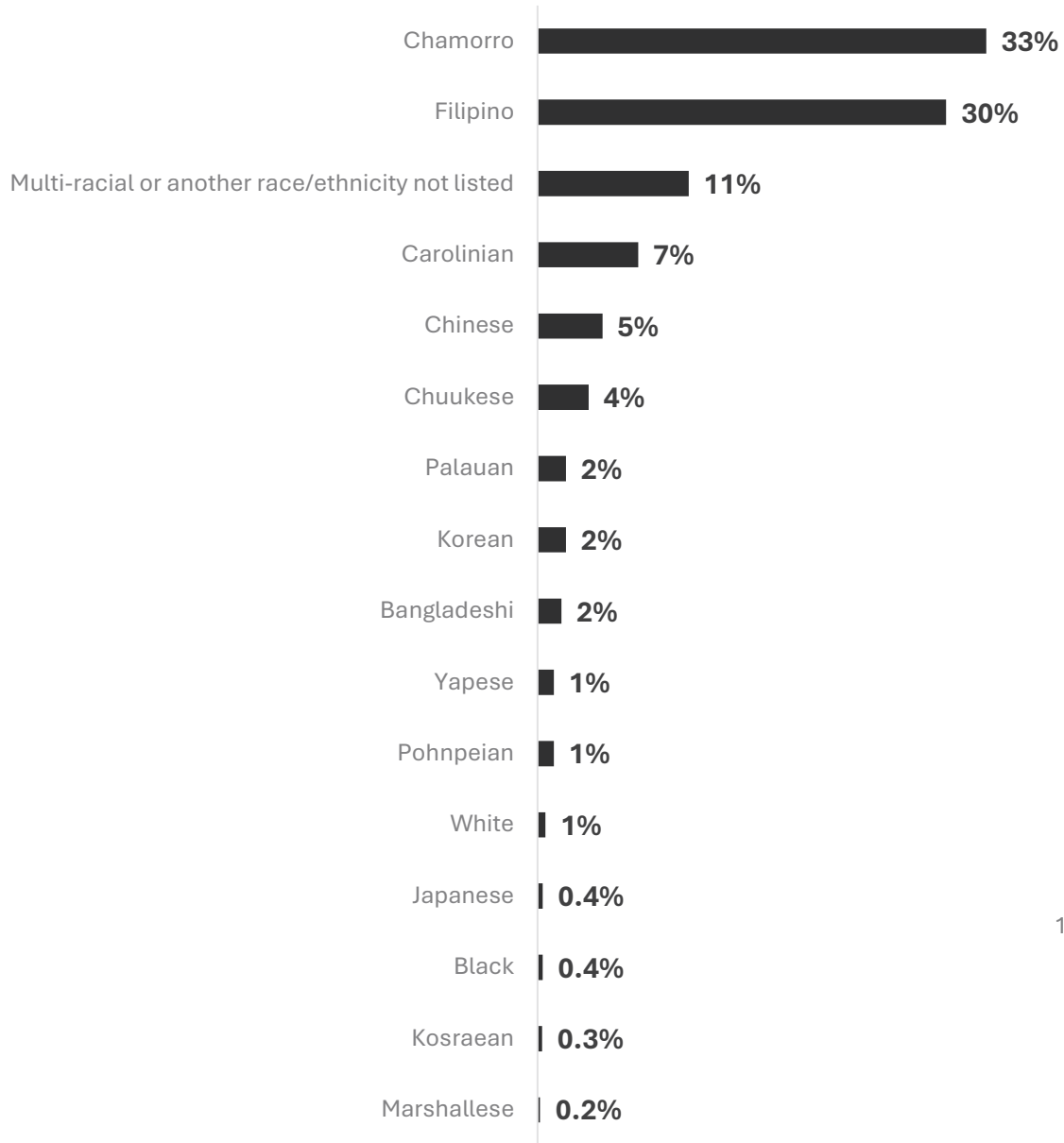
- CHA-identified priority, 330 children were homeless in 2019 (Homeless point in time count)

- 2% of adolescents had received mental health services (JS)
- CHA-identified priority

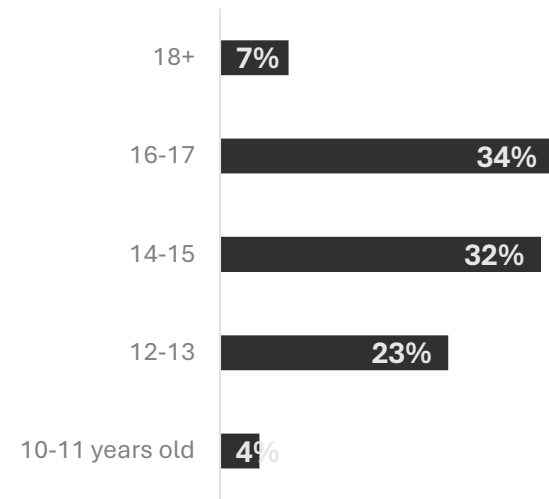
■ ALL (n=2760) ■ Tinian (n=55) ■ Saipan (n=2492) ■ Rota (n=213)

● Orange bullets indicate sources of data triangulation.

Youth Survey: Race/Ethnicity Overall (n=2751)



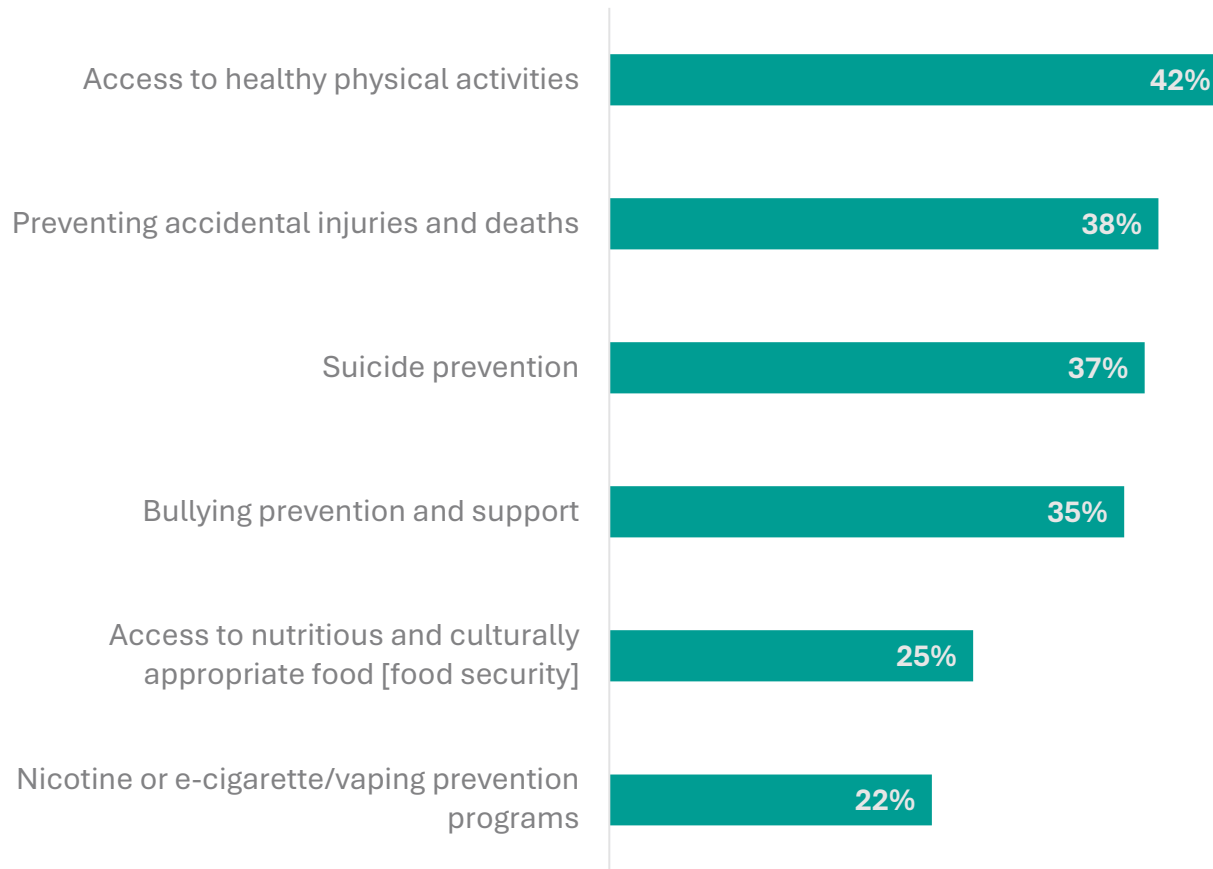
Youth Survey: Age Overall (n=2760)



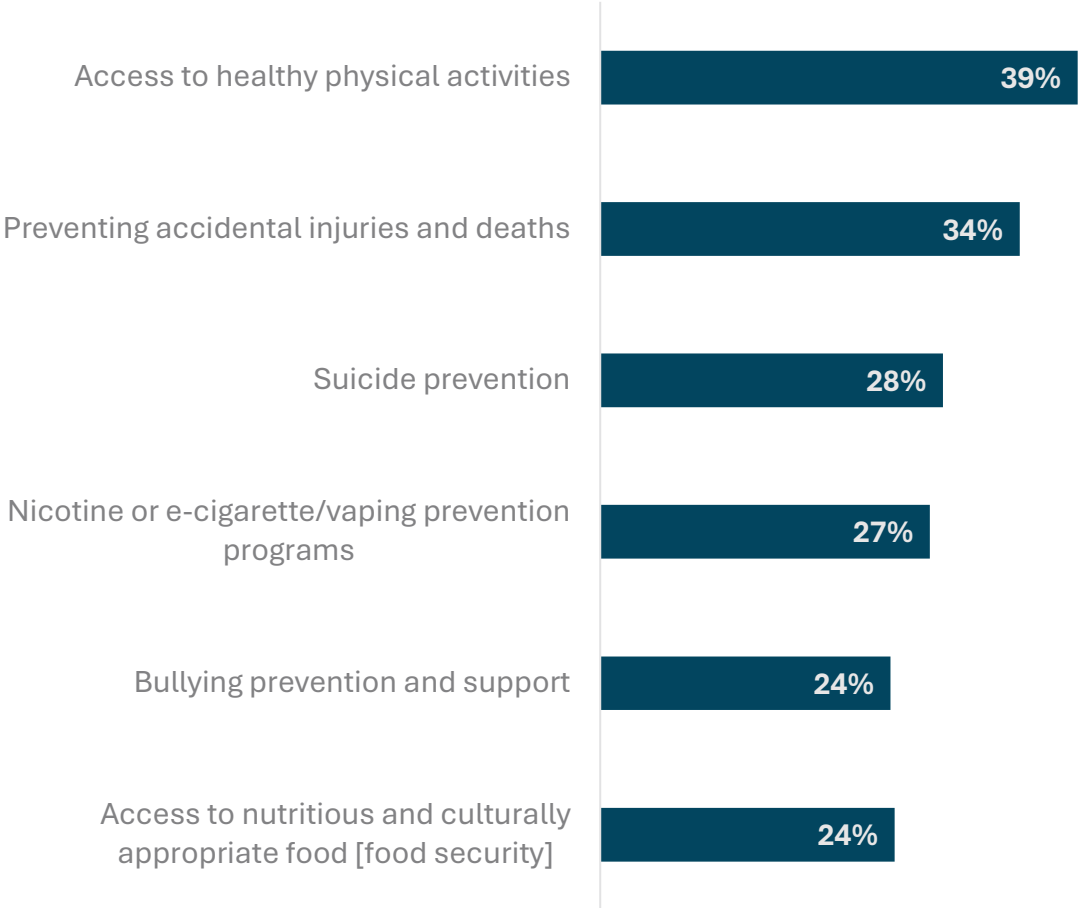
Results by Island



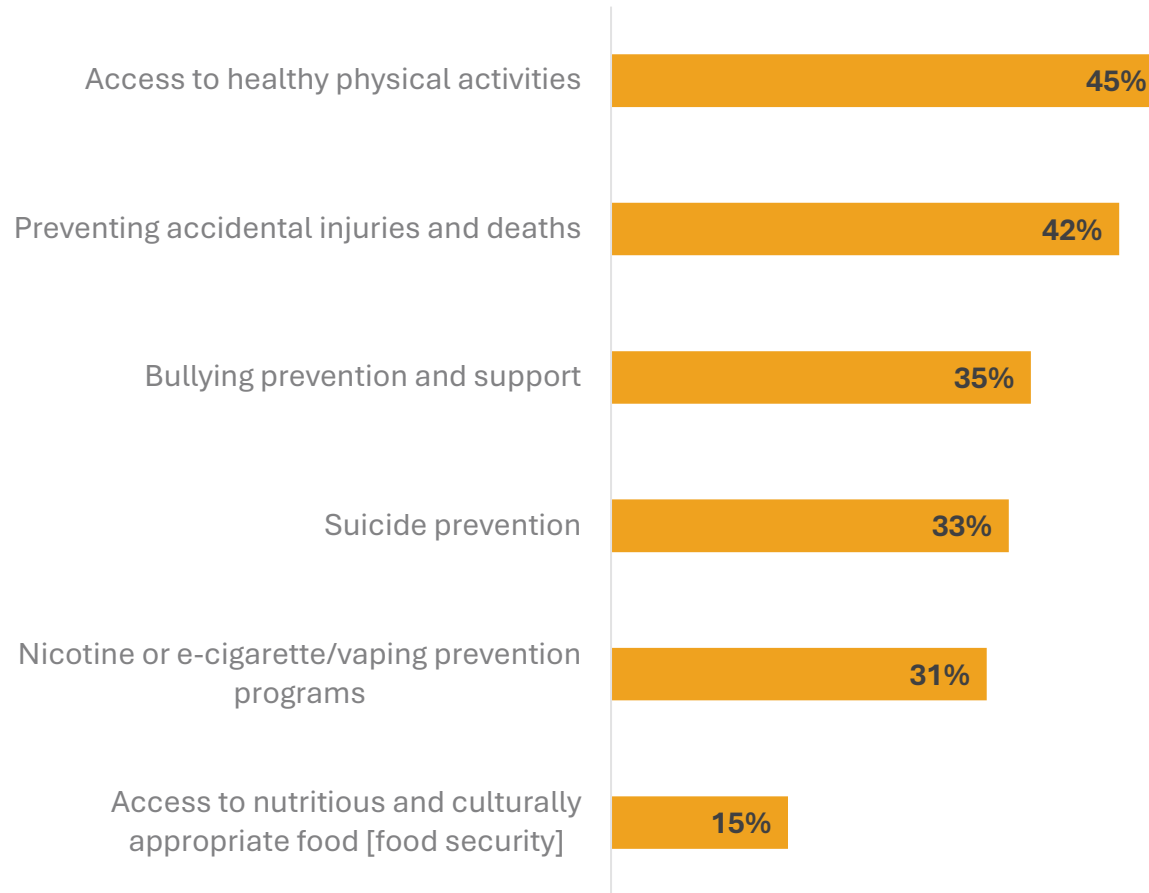
Rota Youth Survey: Adolescent Health Priorities
(n=213)



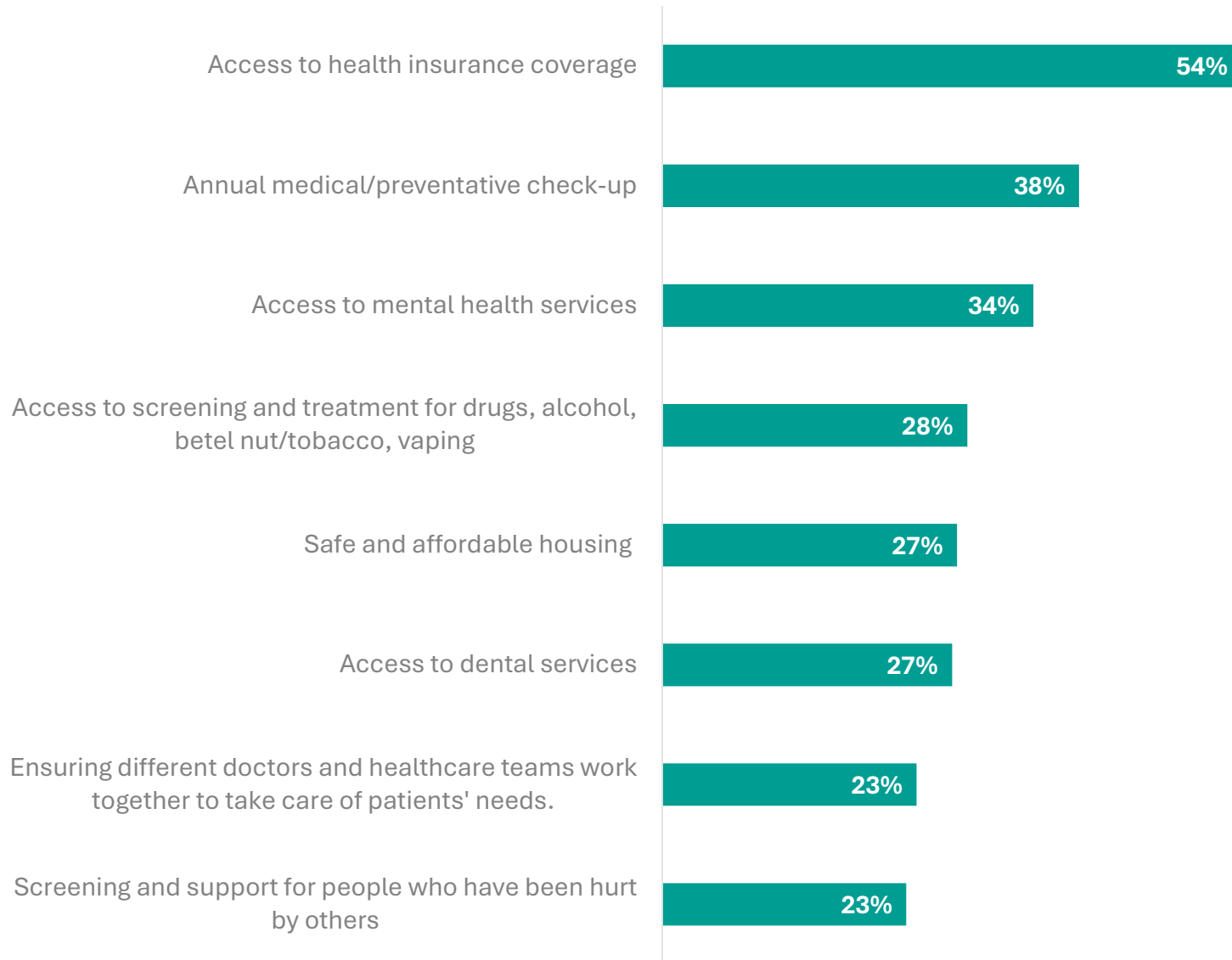
Saipan Youth Survey: Adolescent Health Priorities
(n=2492)



Tinian Youth Survey: Adolescent Health Priorities
(n=55)

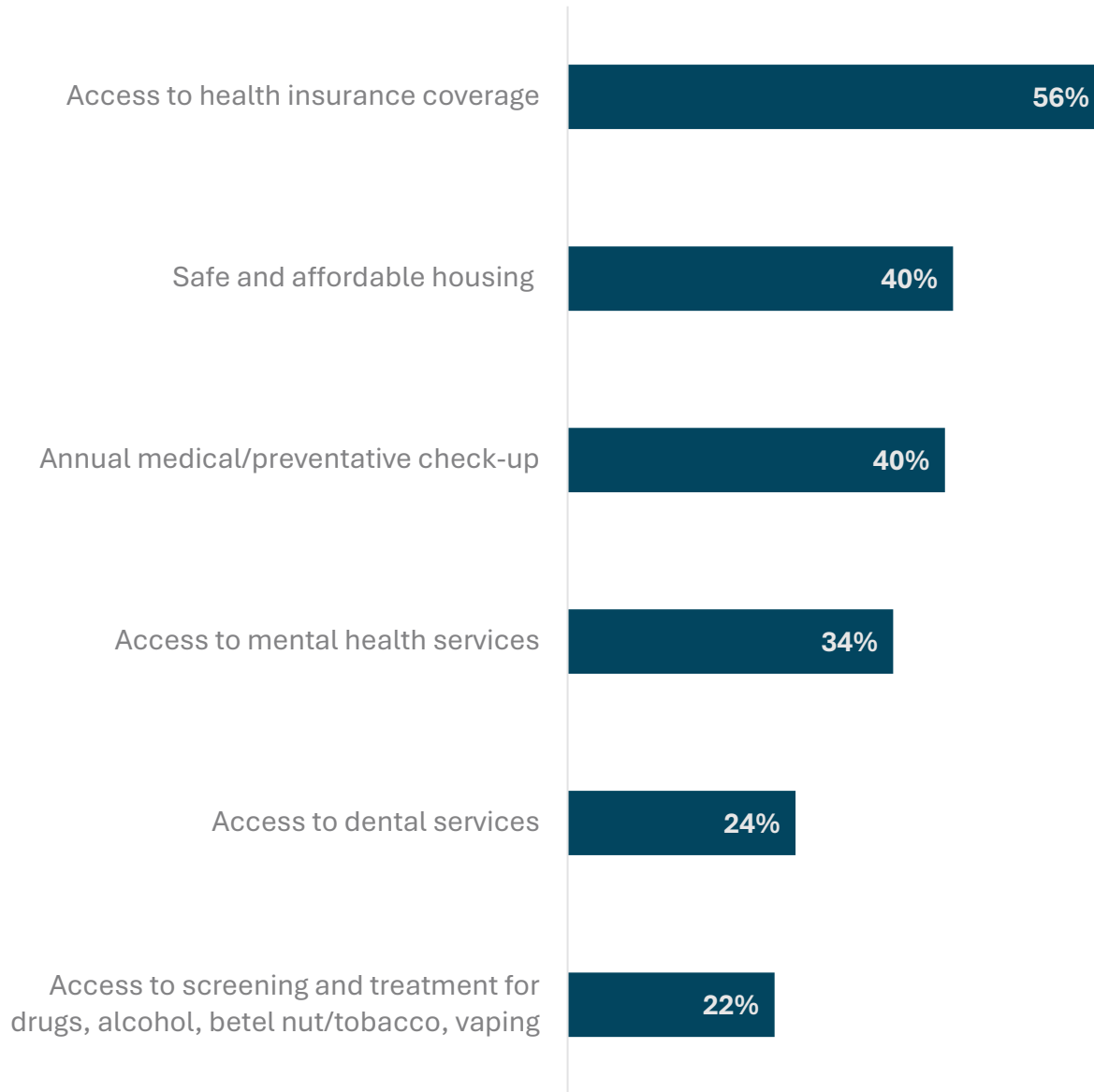


Rota Youth Survey: Health Priorities Across the Lifespan
Overall and by Island
(n=213)

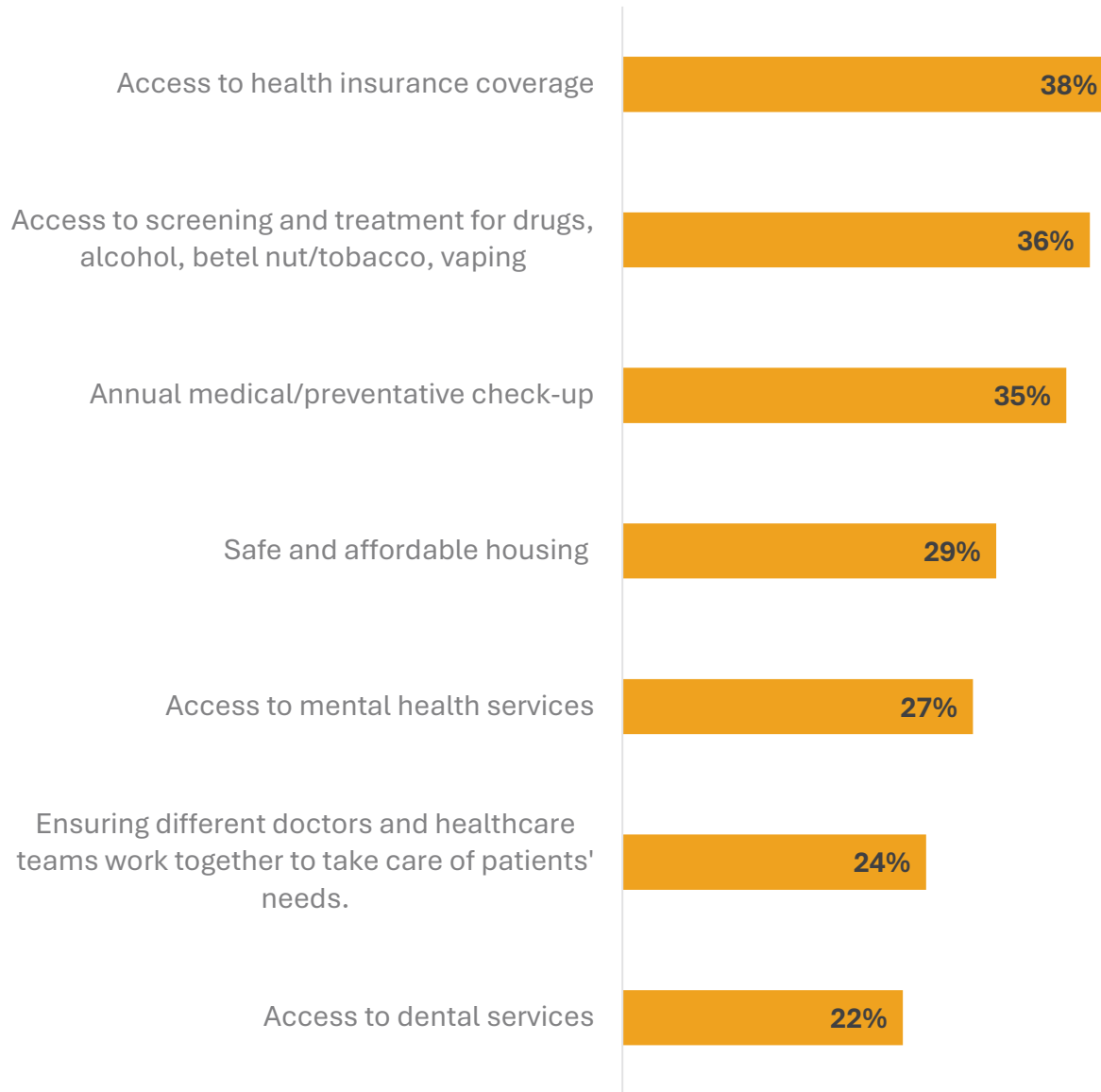


Saipan Youth Survey: Health Priorities Across the Lifespan Overall and by Island

(n=2492)



Tinian Youth Survey: Health Priorities Across the Lifespan
Overall and by Island
(n=55)



MICAH NEEDS ASSESSMENT 2025

Tinian

Survey Results

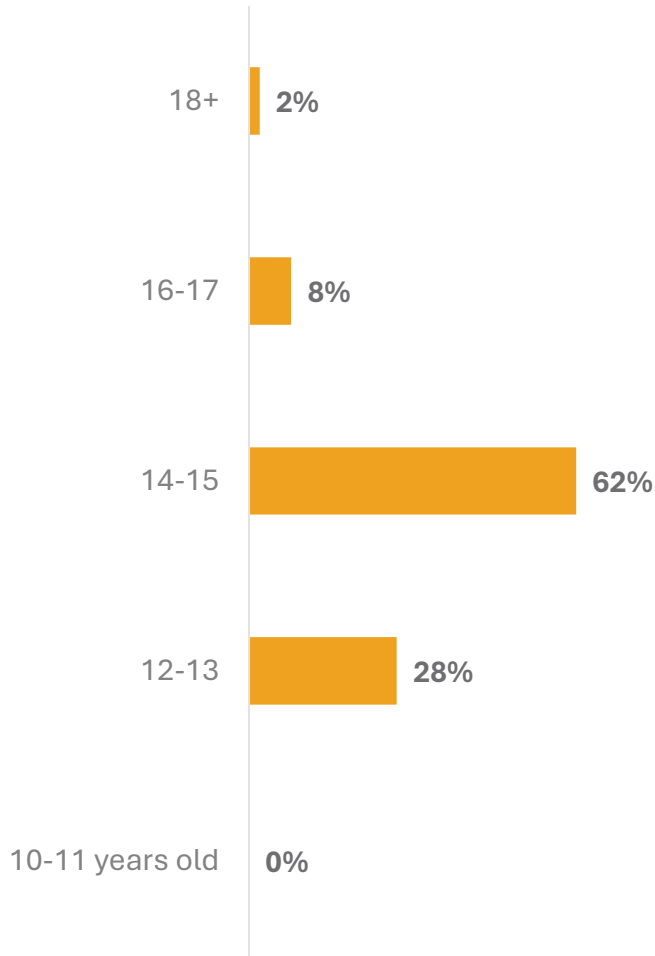


Every five years, the CNMI Division of Public Health, Maternal and Child Health Bureau (MCHB) is required to complete a **comprehensive needs assessment to assess community health**.

Health is a state of physical, social, and mental well-being and not merely the absence of disease. Health is created in the community through social, economic, and environmental factors as well as individual behaviors and biology.

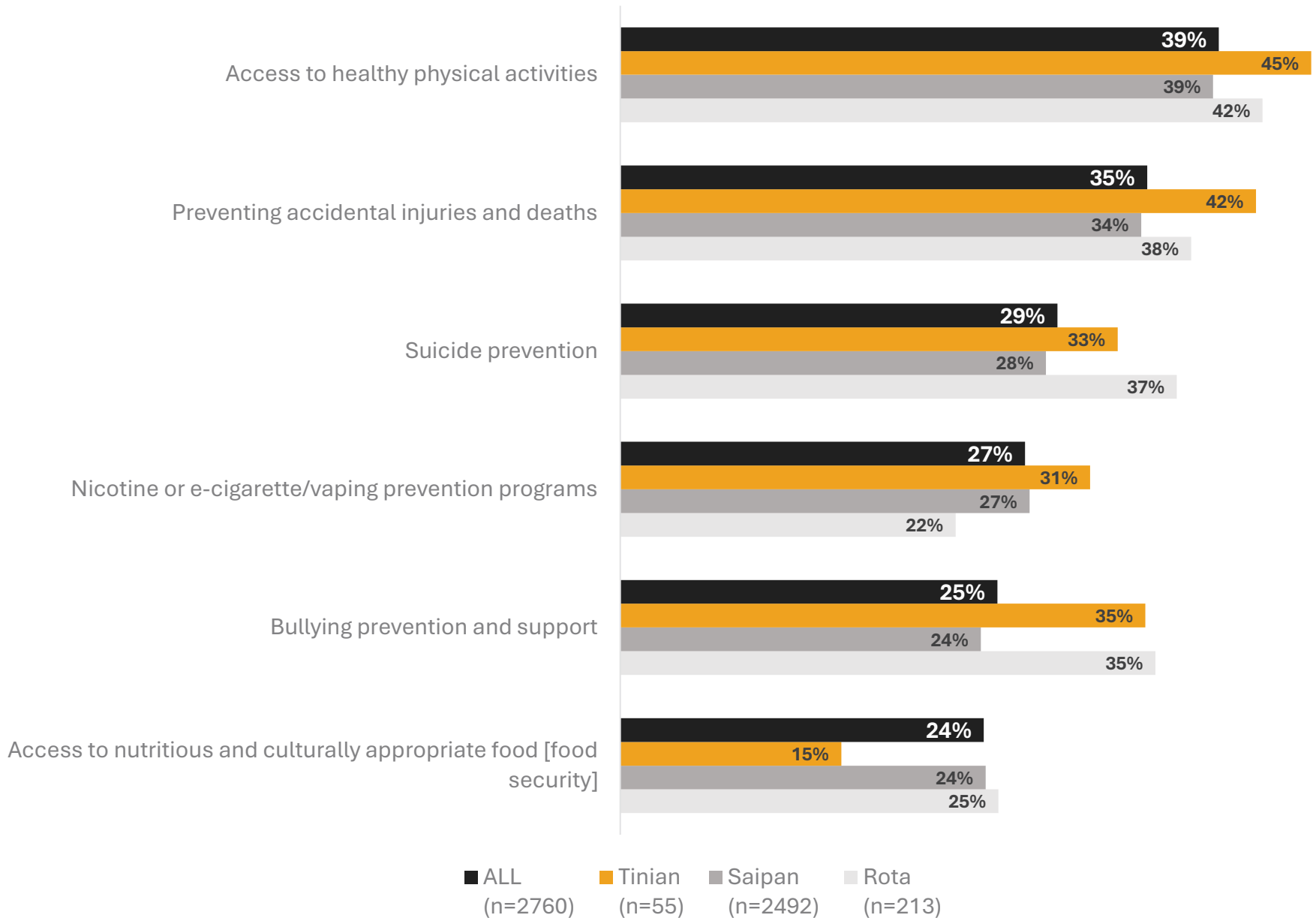
The needs assessment included surveys of professionals and youth to inform priority setting. Results for Tinian on its own and in relation to the other CNMI islands are shown on subsequent slides.

Tinian Middle School and High School
Survey Respondent Age
(n=50)

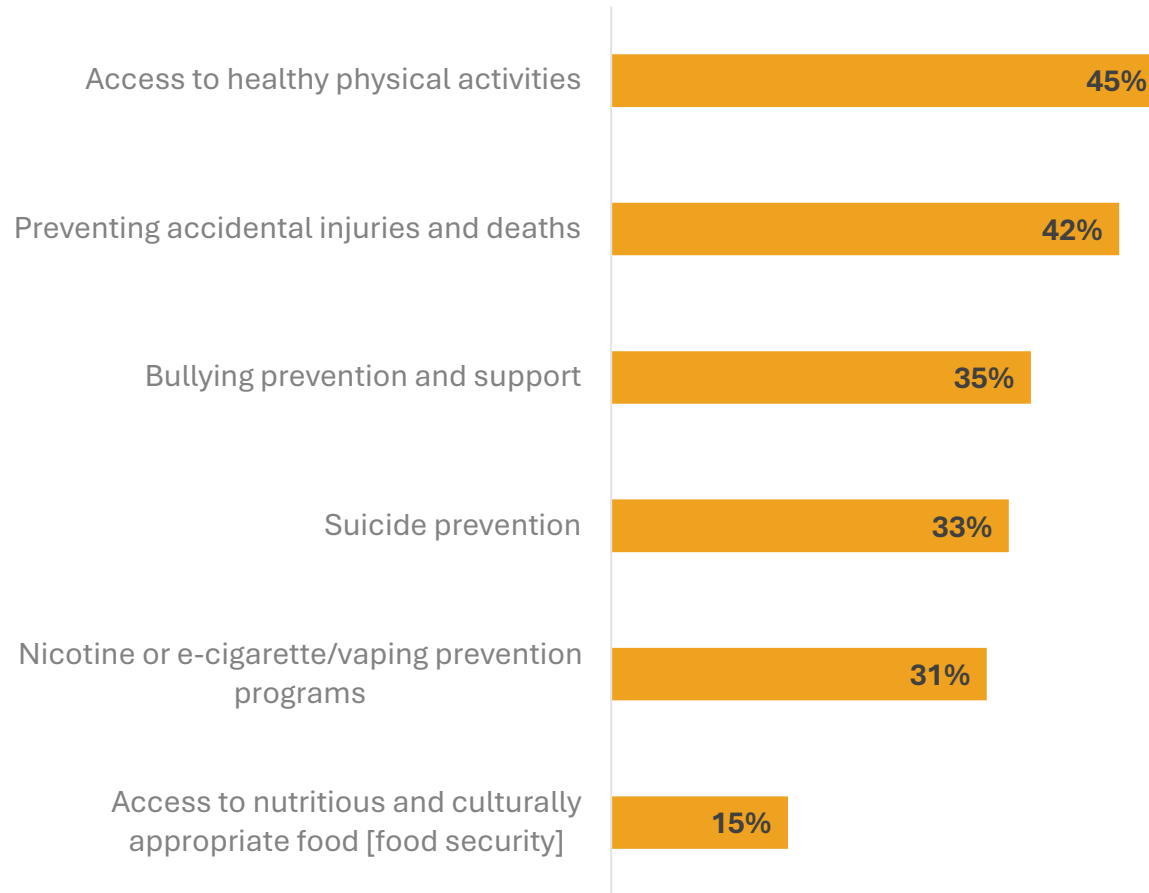


YOUTH SURVEY RESULTS (N=55)

Youth Survey: Adolescent Health Priorities - Overall and by Island

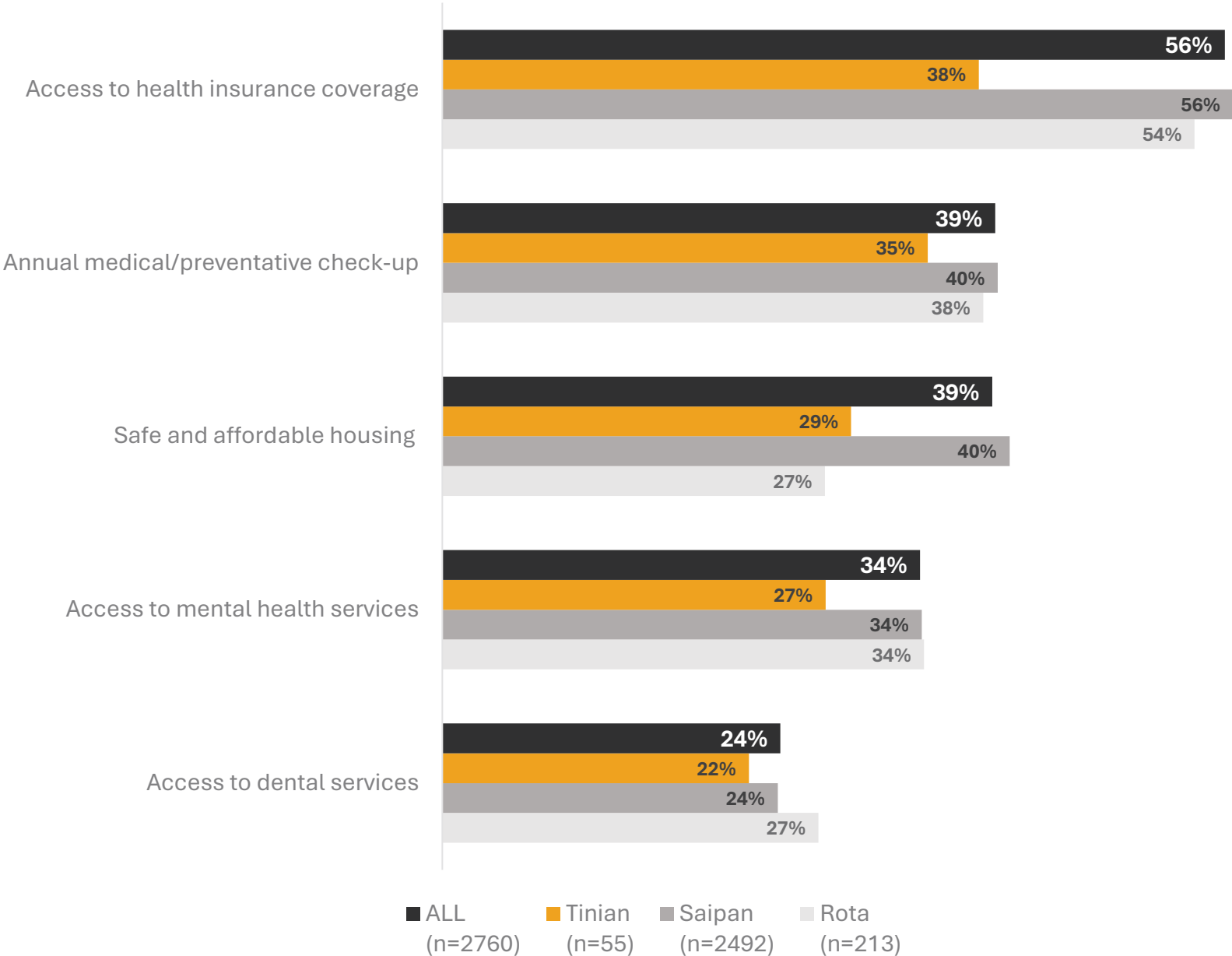


Tinian Youth Survey: **Adolescent** Health Priorities
(n=55)

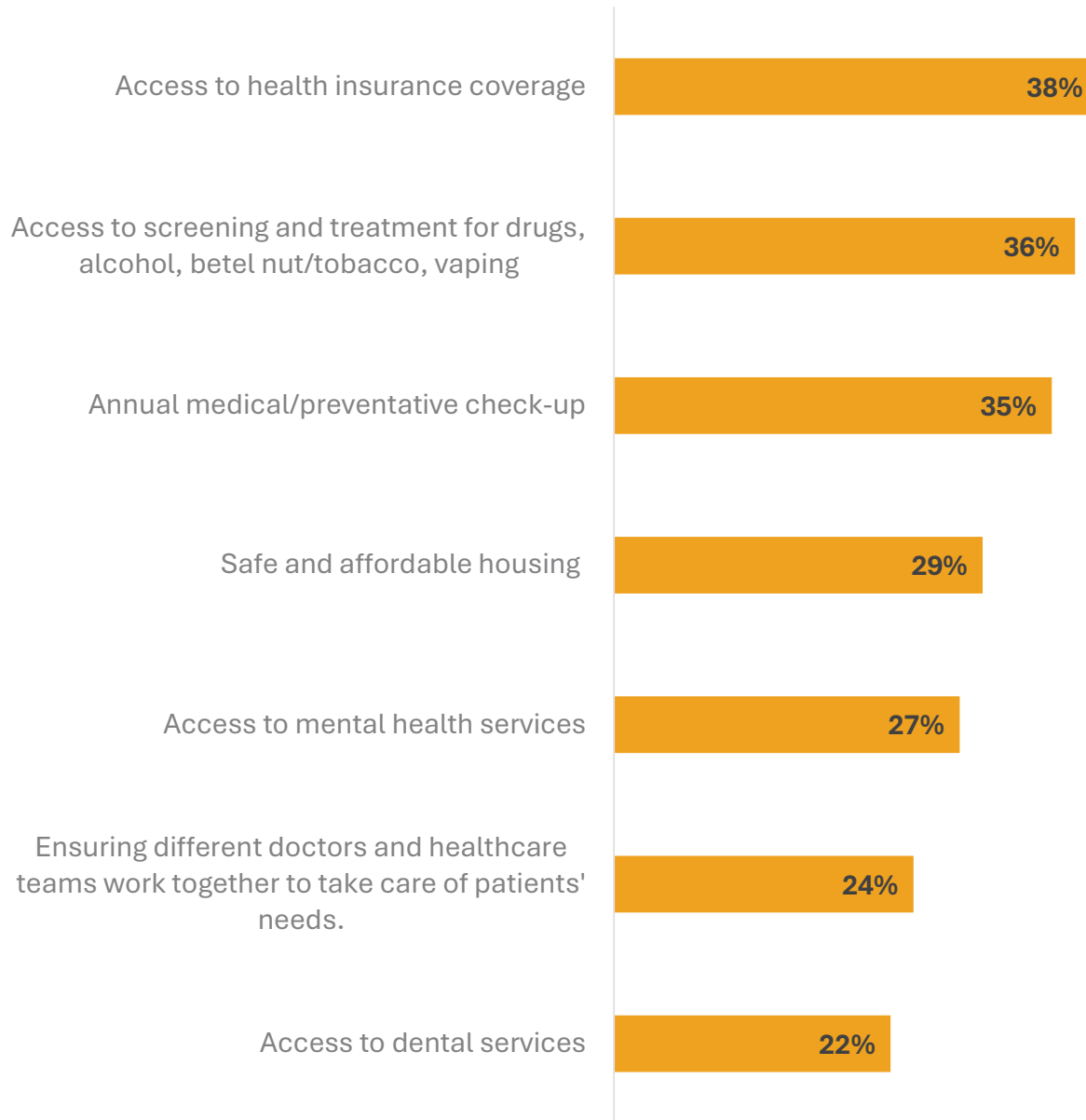


Youth Survey: Health Priorities Across the Lifespan

Overall and by Island

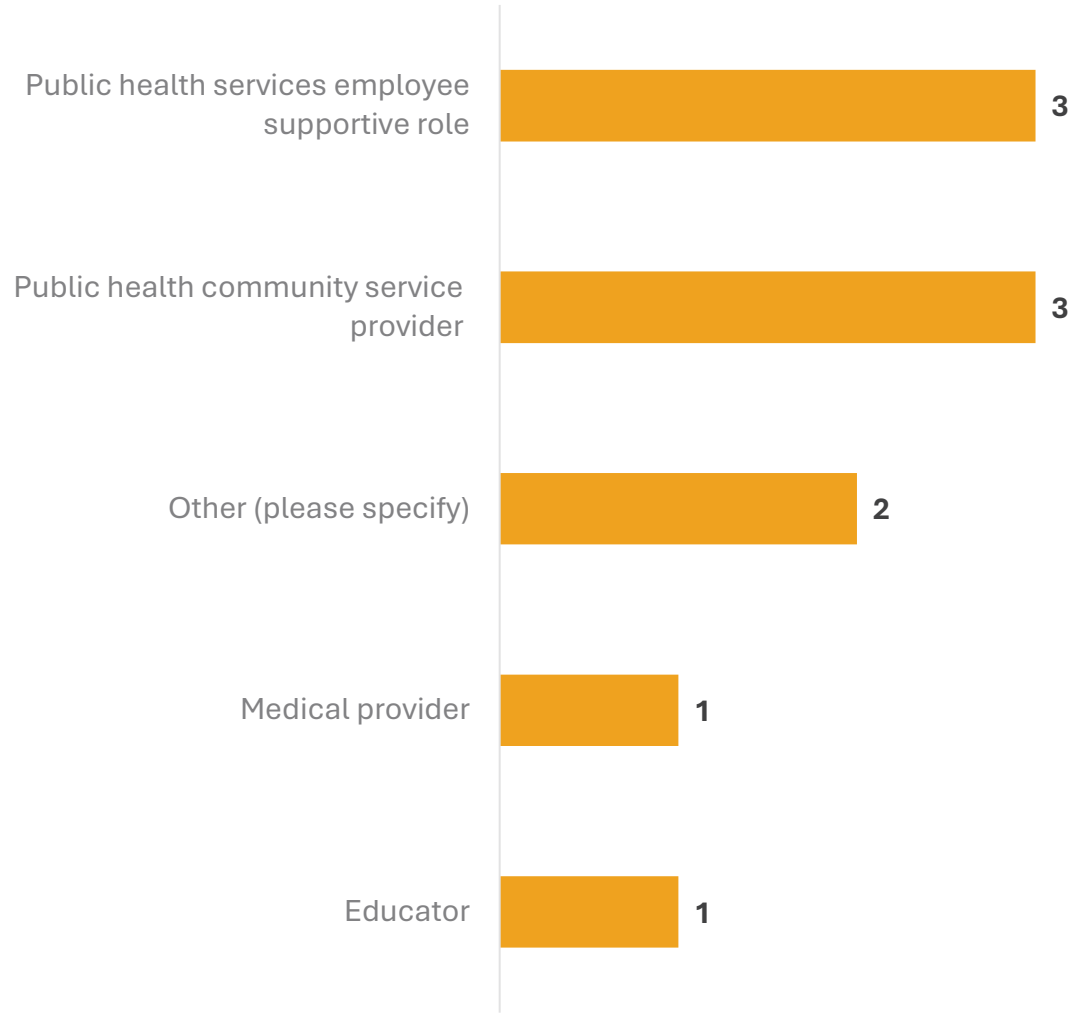


Tinian Youth Survey: Health Priorities **Across the Lifespan**
(n=55)



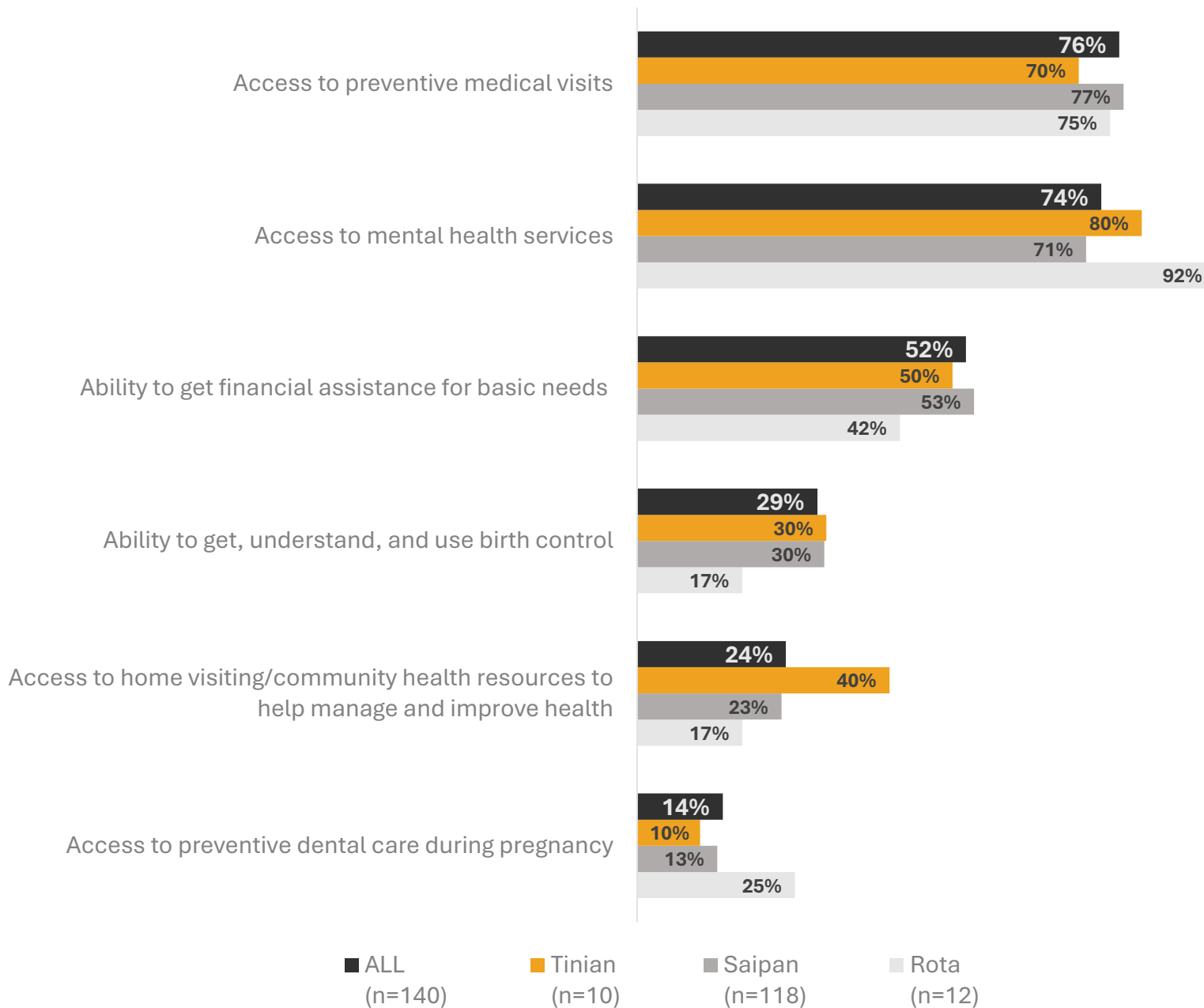
PROFESSIONALS SURVEY RESULTS (N=10)

Tinian Professionals Survey - Role (n=10)

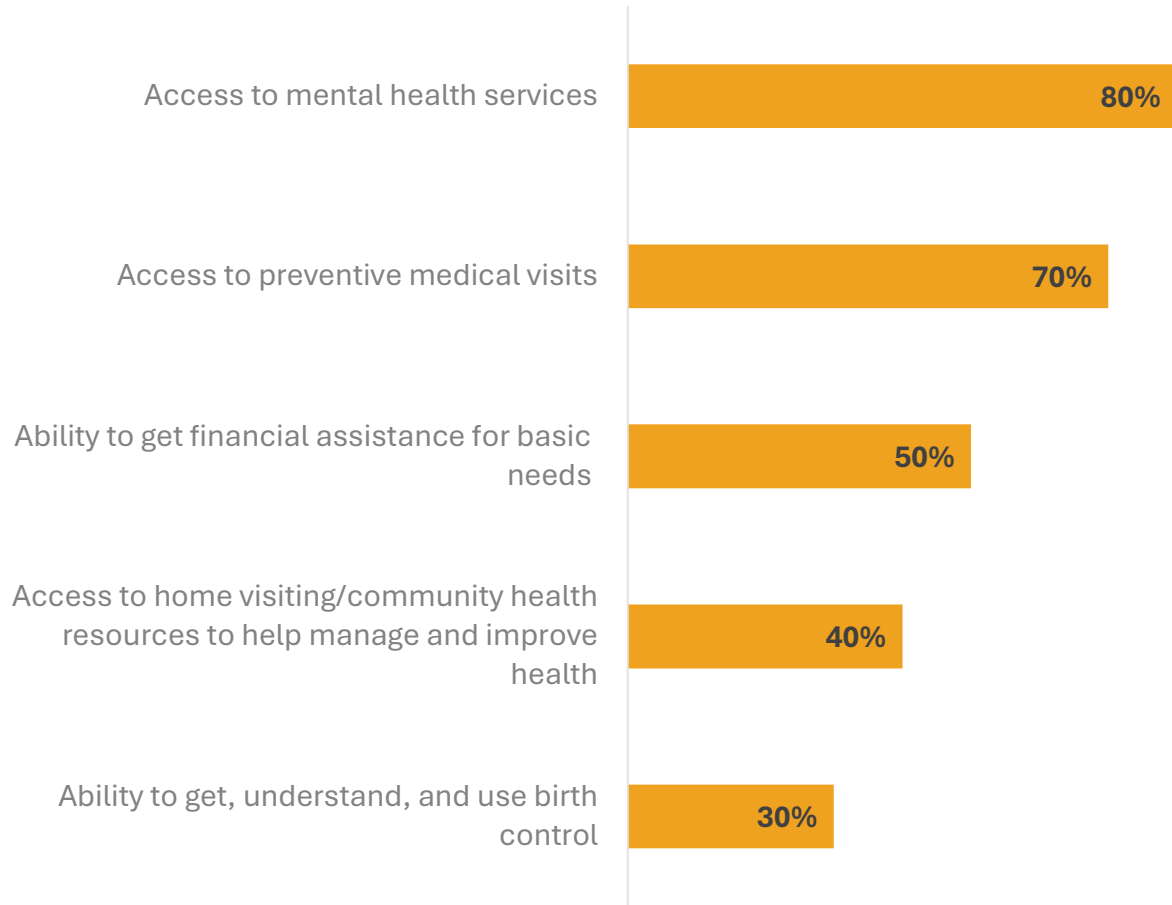


Stakeholder Survey - Professionals

Women's Health Priorities

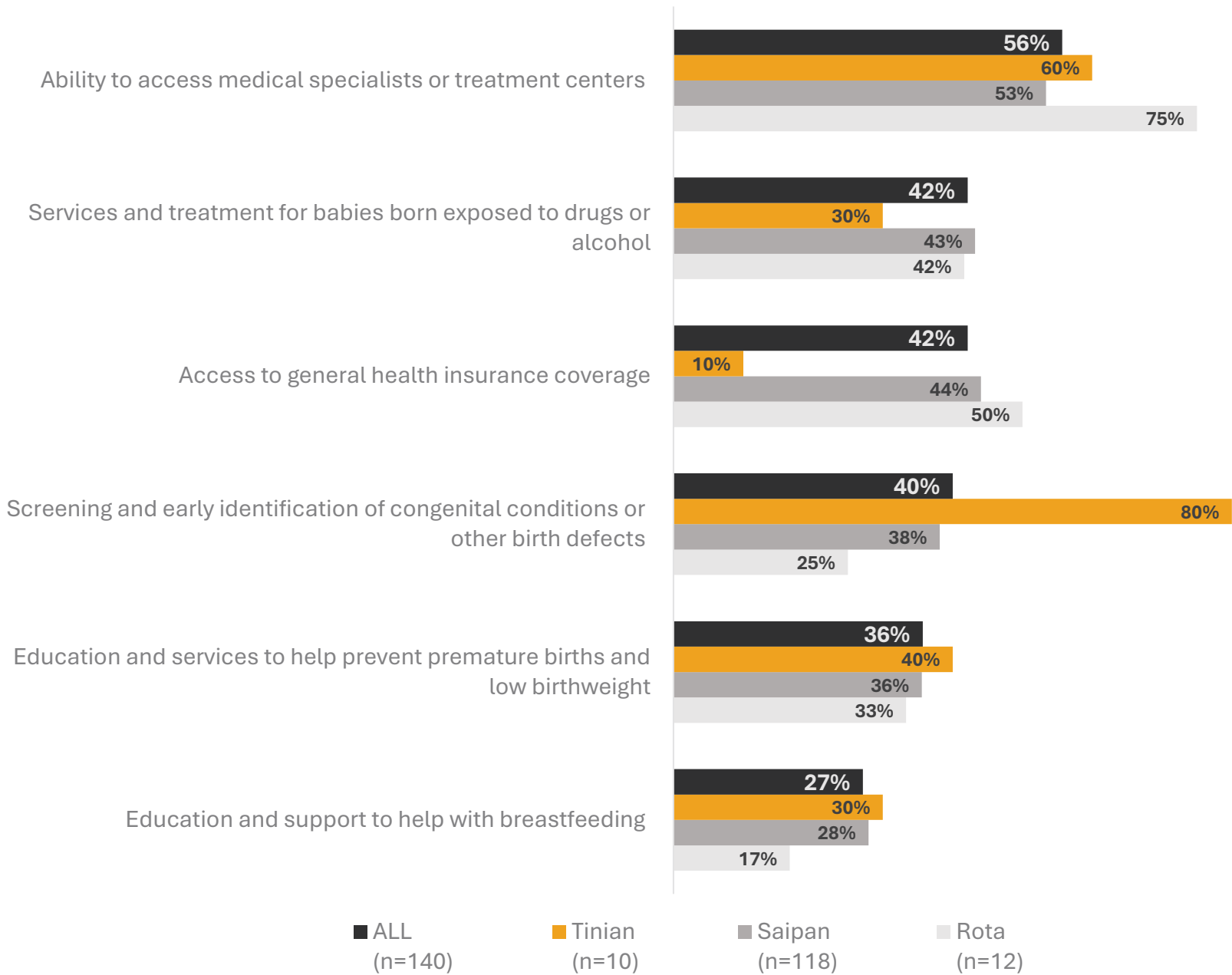


Tinian Professionals Survey:
Women's Health Priorities
(n=10)

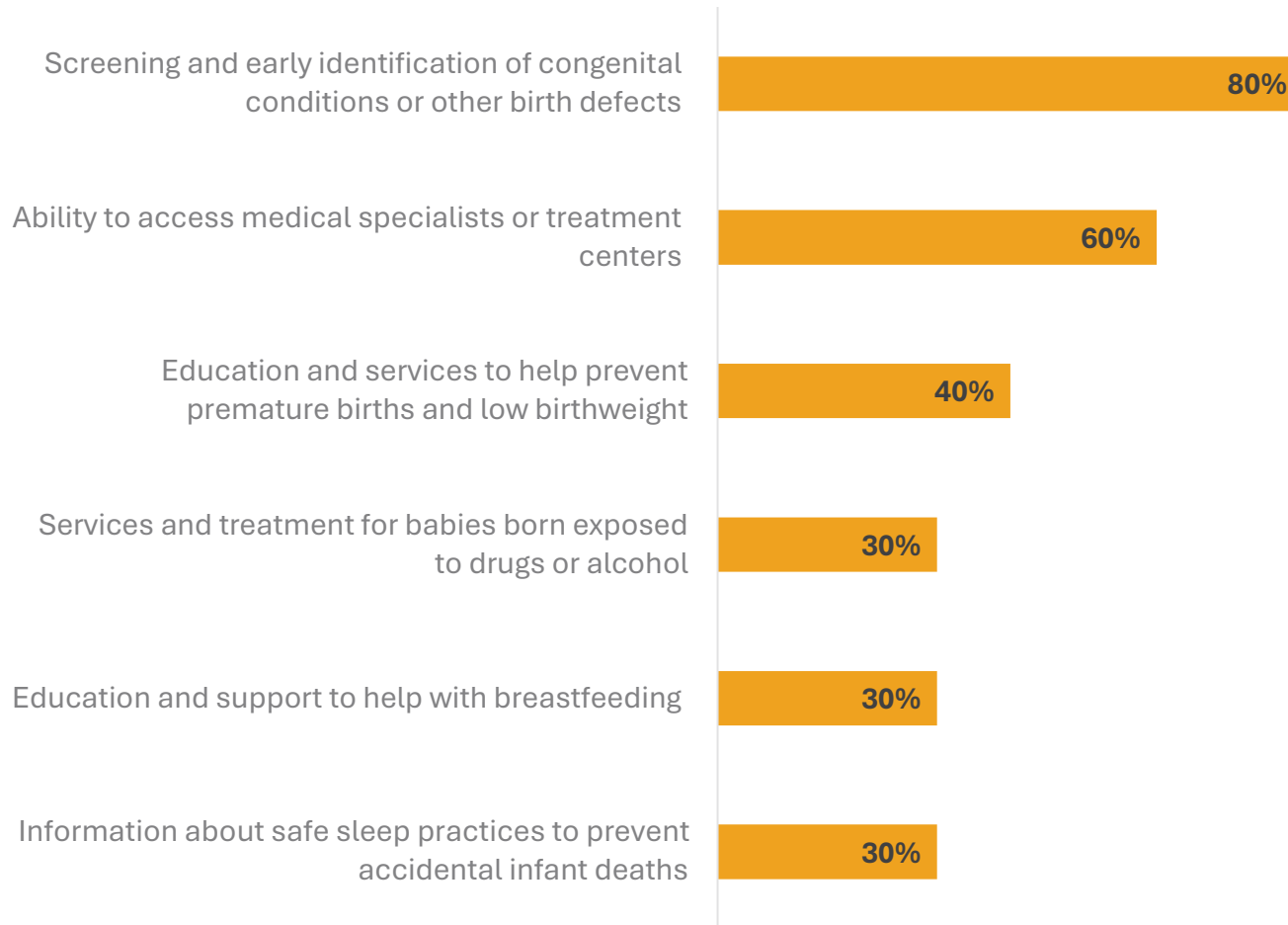


Stakeholder Survey - Professionals

Infant Health Priorities

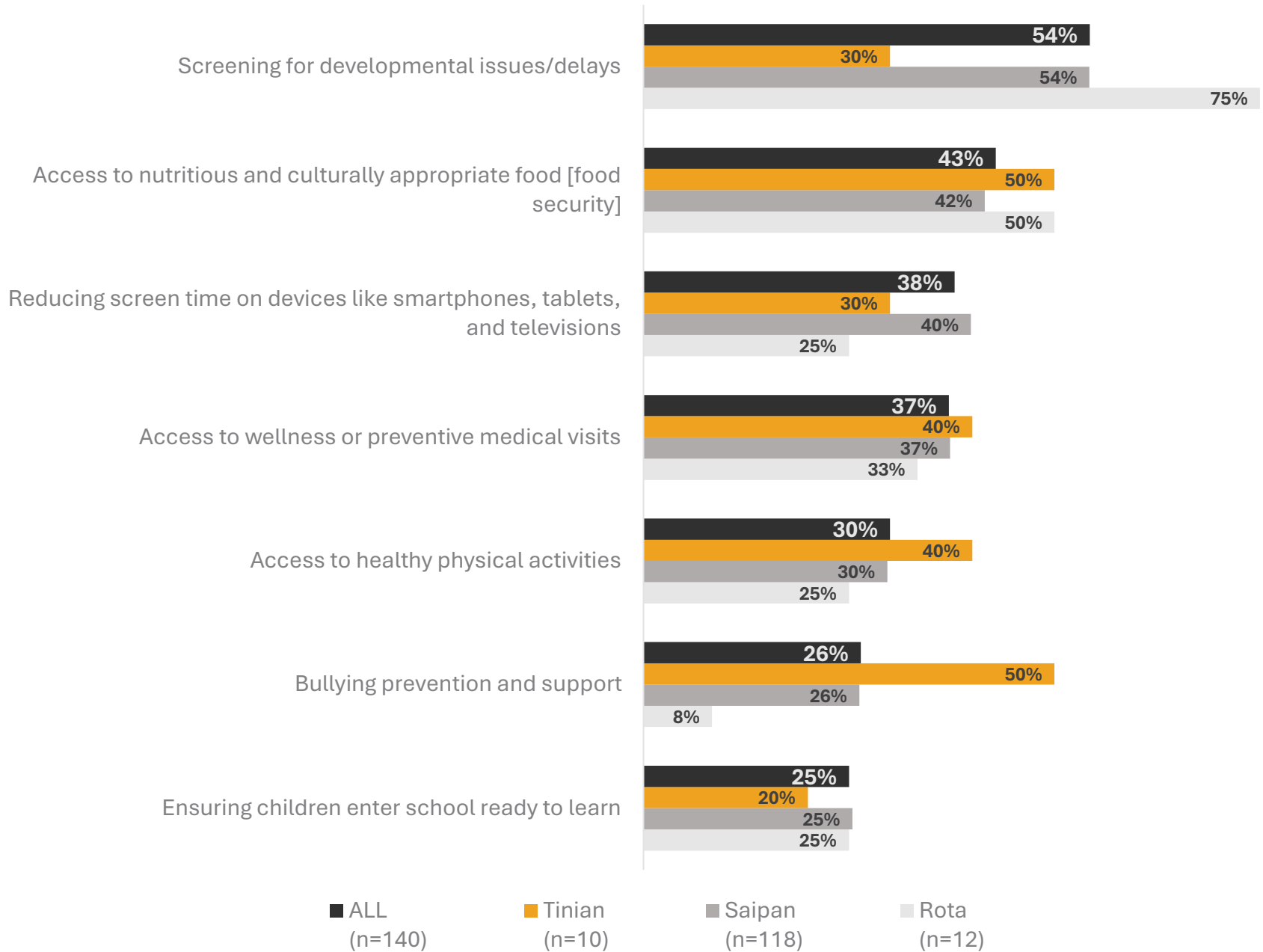


Tinian Professionals Survey:
Infant Health Priorities
(n=10)

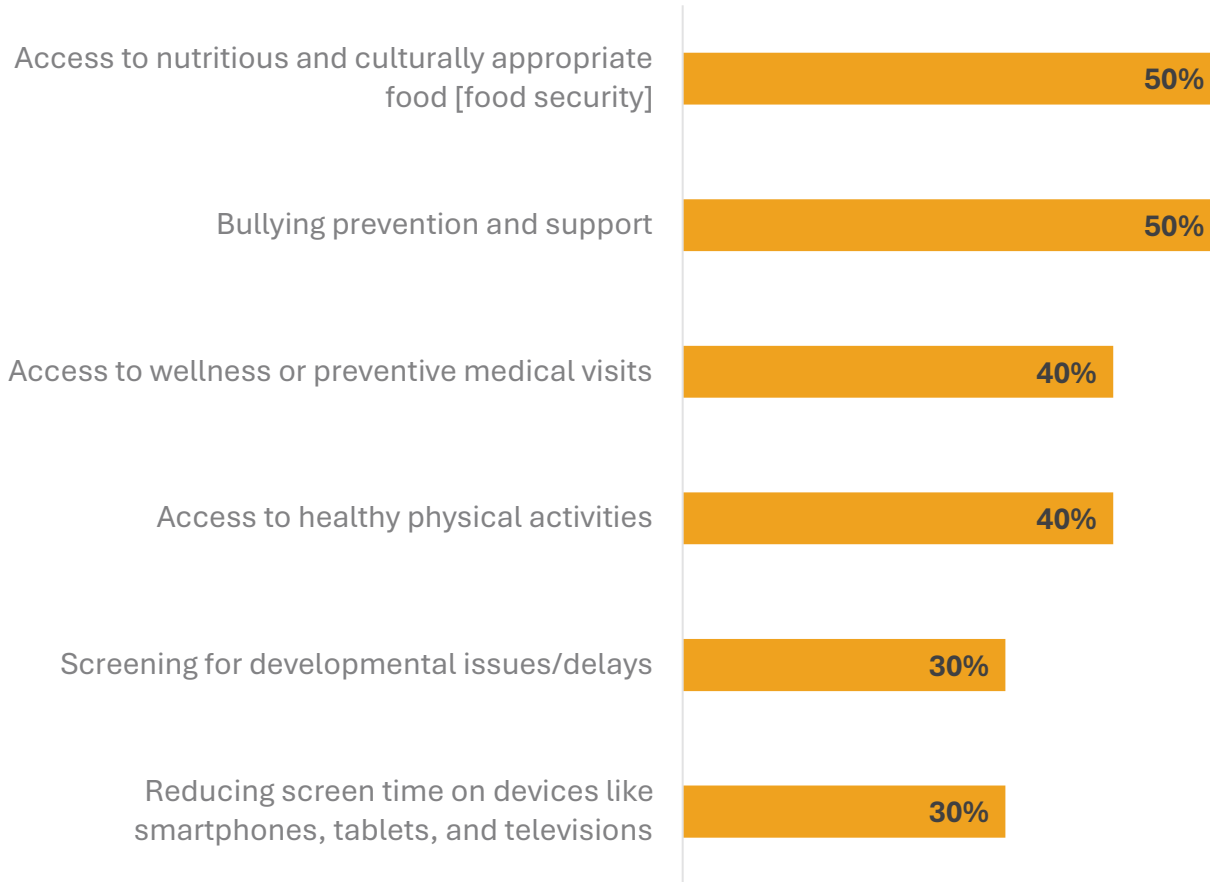


Stakeholder Survey - Professionals

Child Age 1-9 Health Priorities

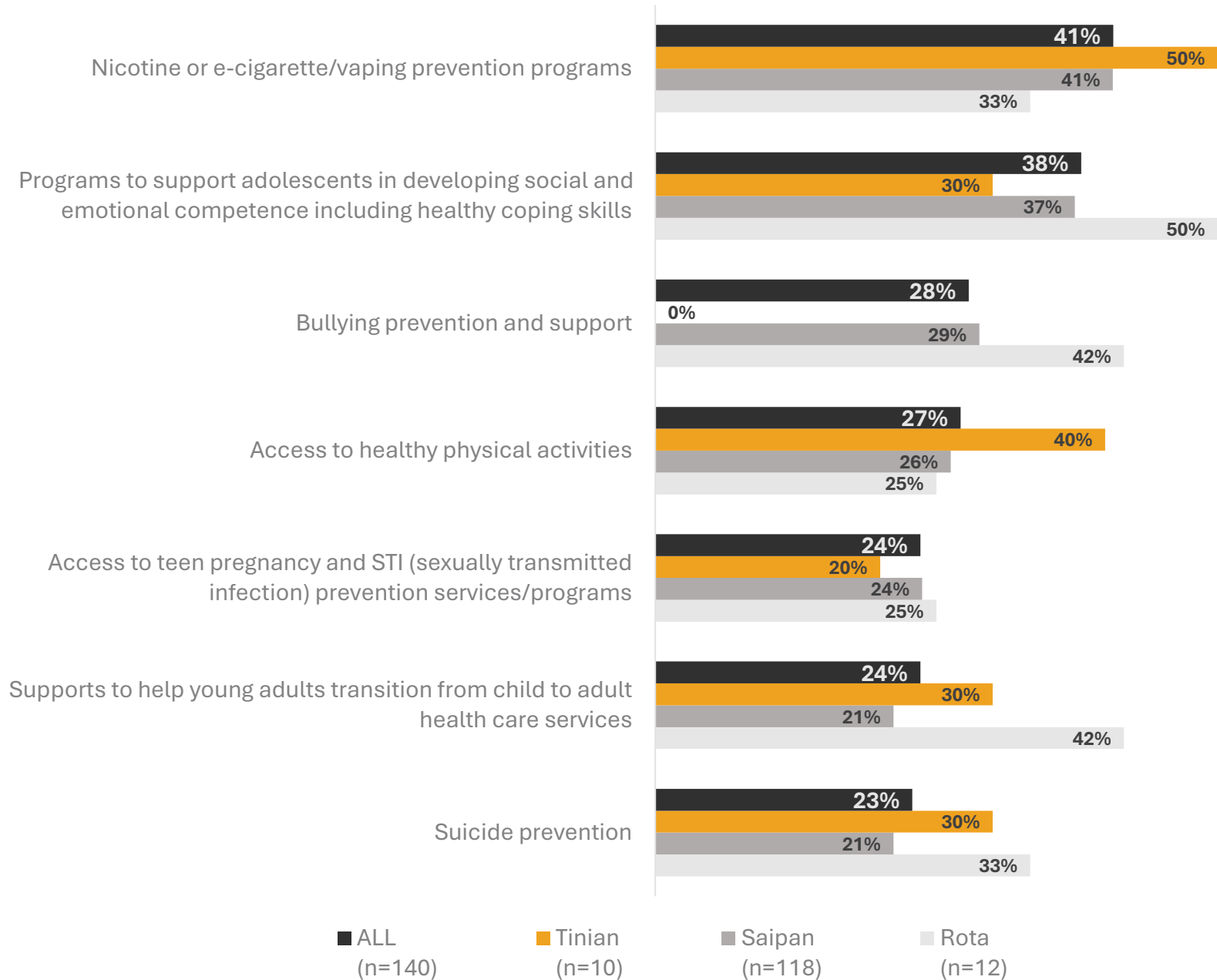


Tinian Professionals Survey:
Child Age 1-9 Health Priorities
(n=10)

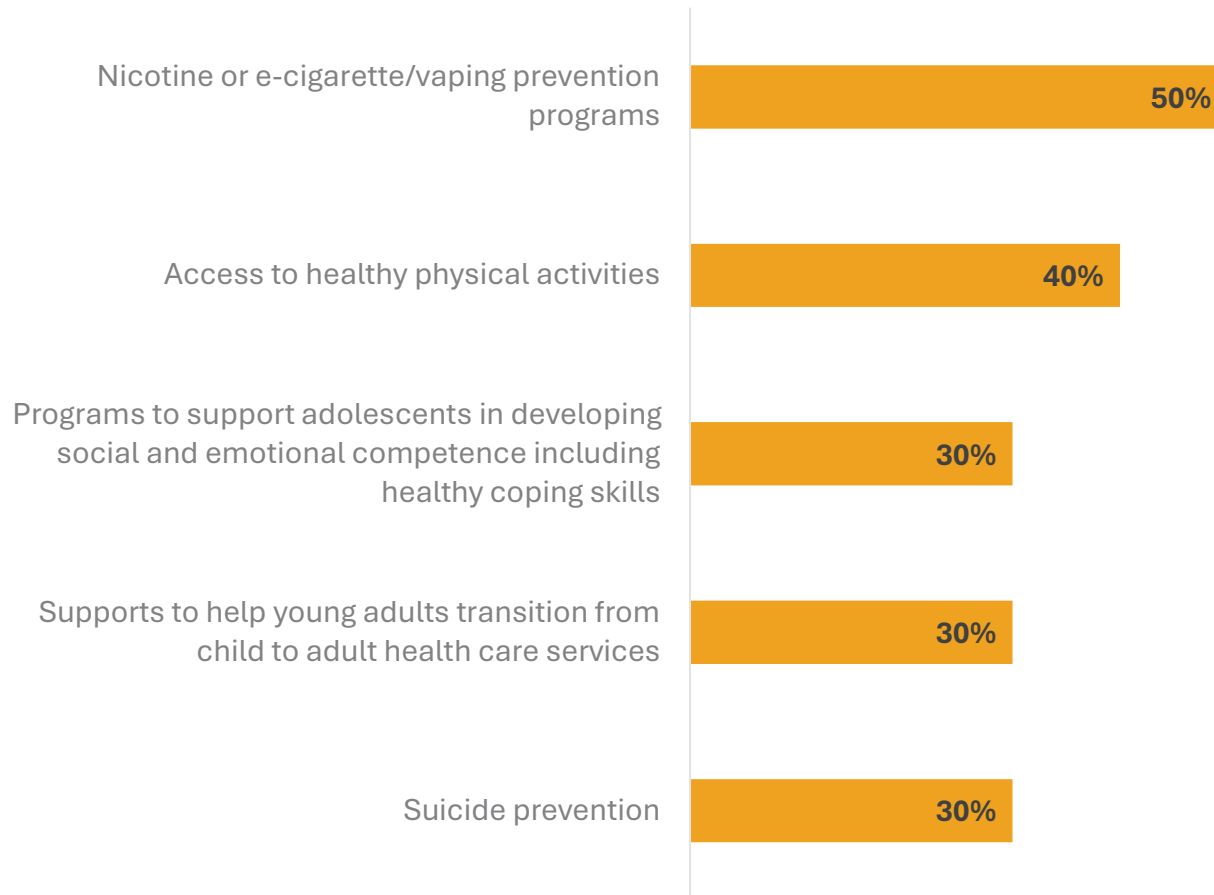


Stakeholder Survey - Professionals

Adolescent Health Priorities

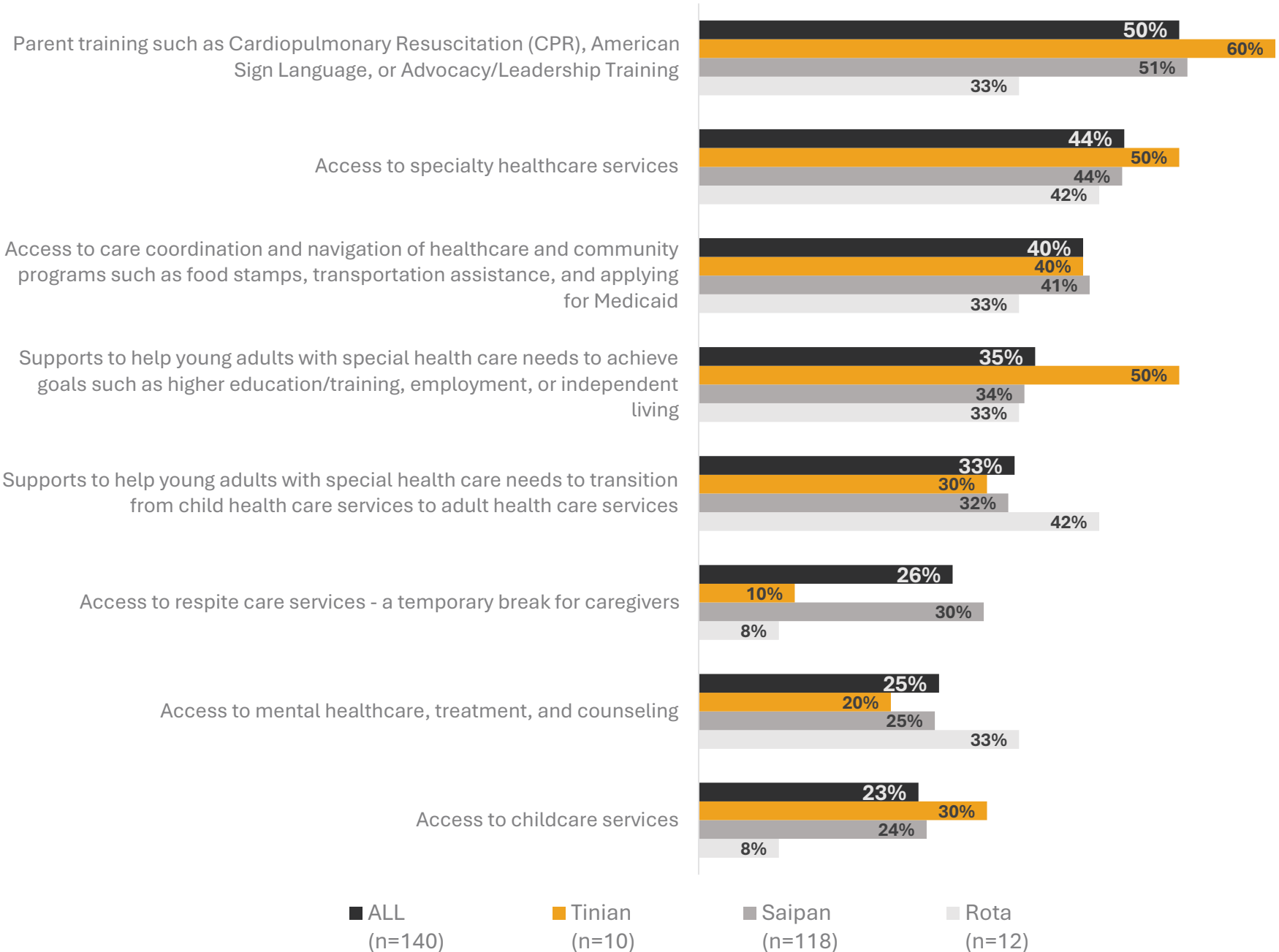


Tinian Professionals Survey:
Adolescent Health Priorities
(n=10)

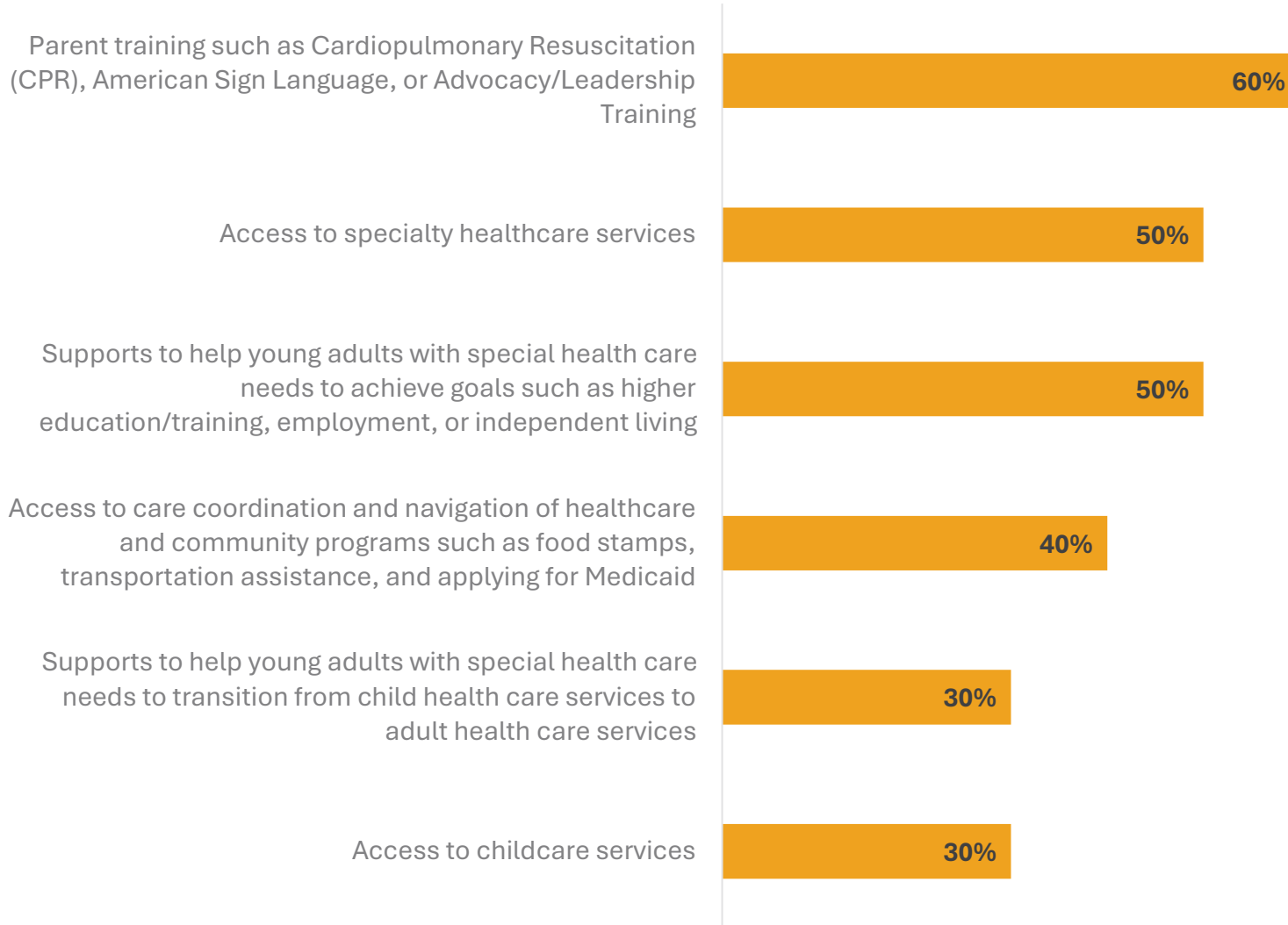


Stakeholder Survey - Professionals

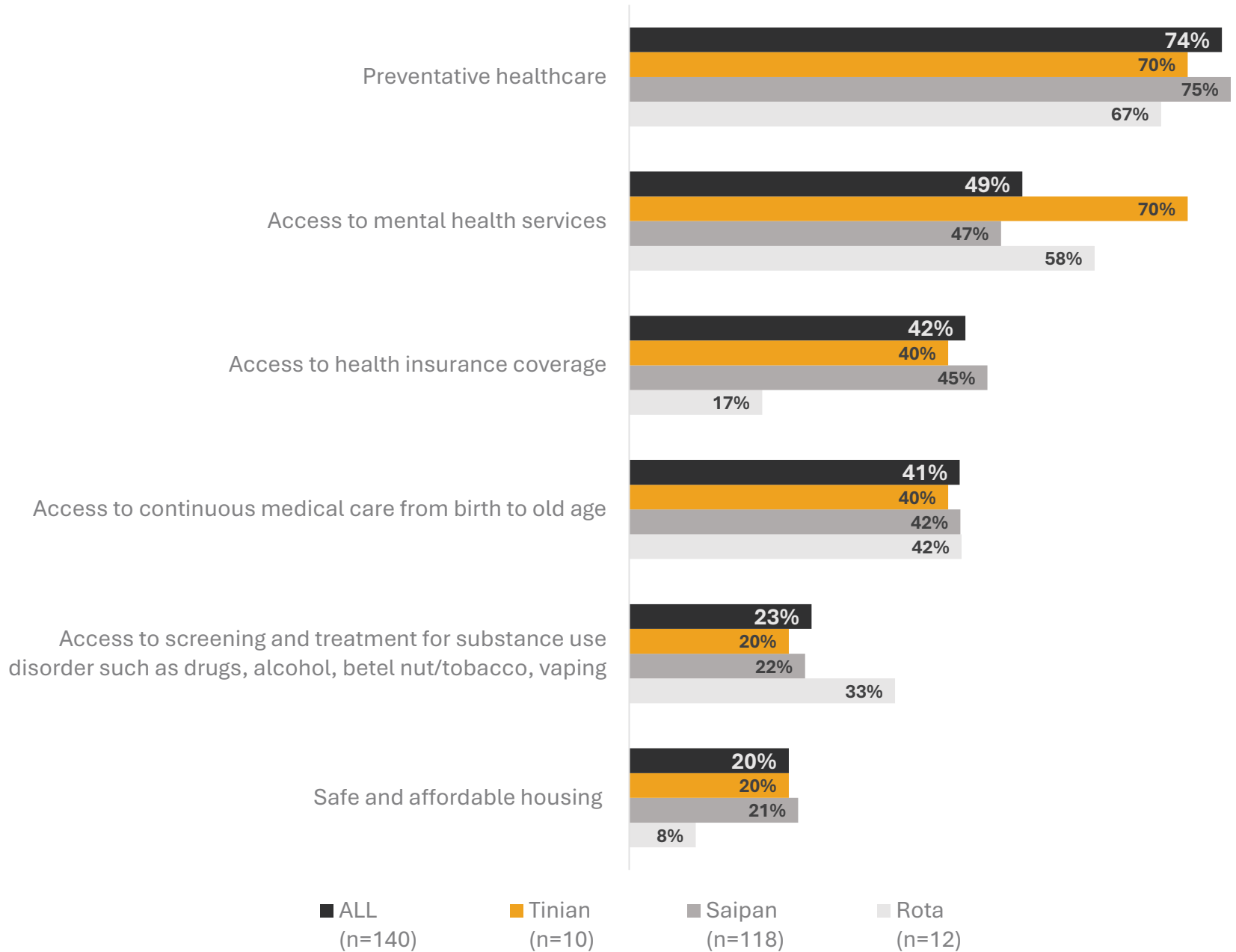
Children with Special Healthcare Needs (CSHCN) Health Priorities



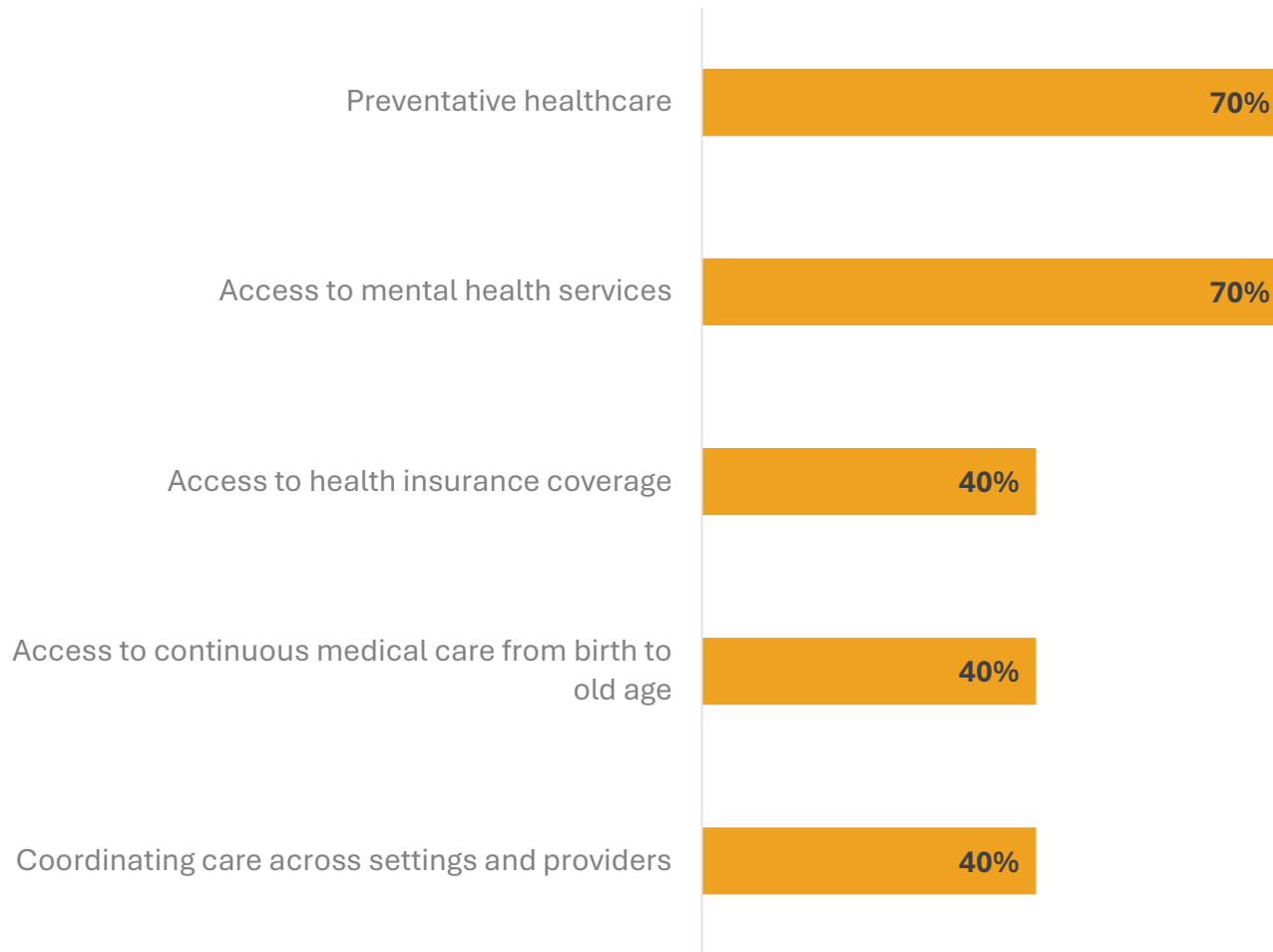
Tinian Professionals Survey:
Children with Special Healthcare Needs (CSHCN) Health Priorities
(n=10)



Stakeholder Survey - Professionals Across the Lifespan Health Priorities

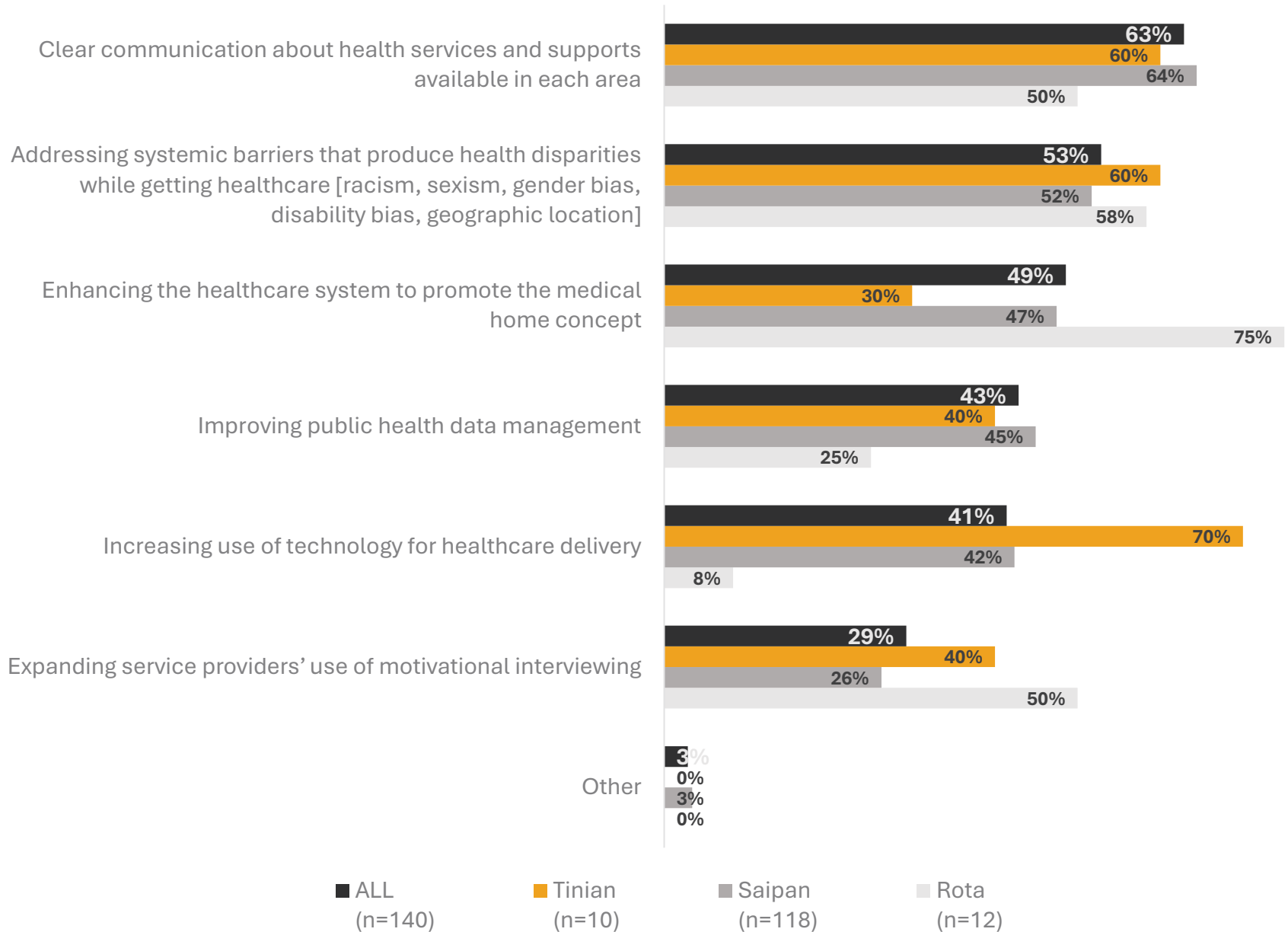


Tinian Professionals Survey:
Across the Lifespan Health Priorities
(n=10)

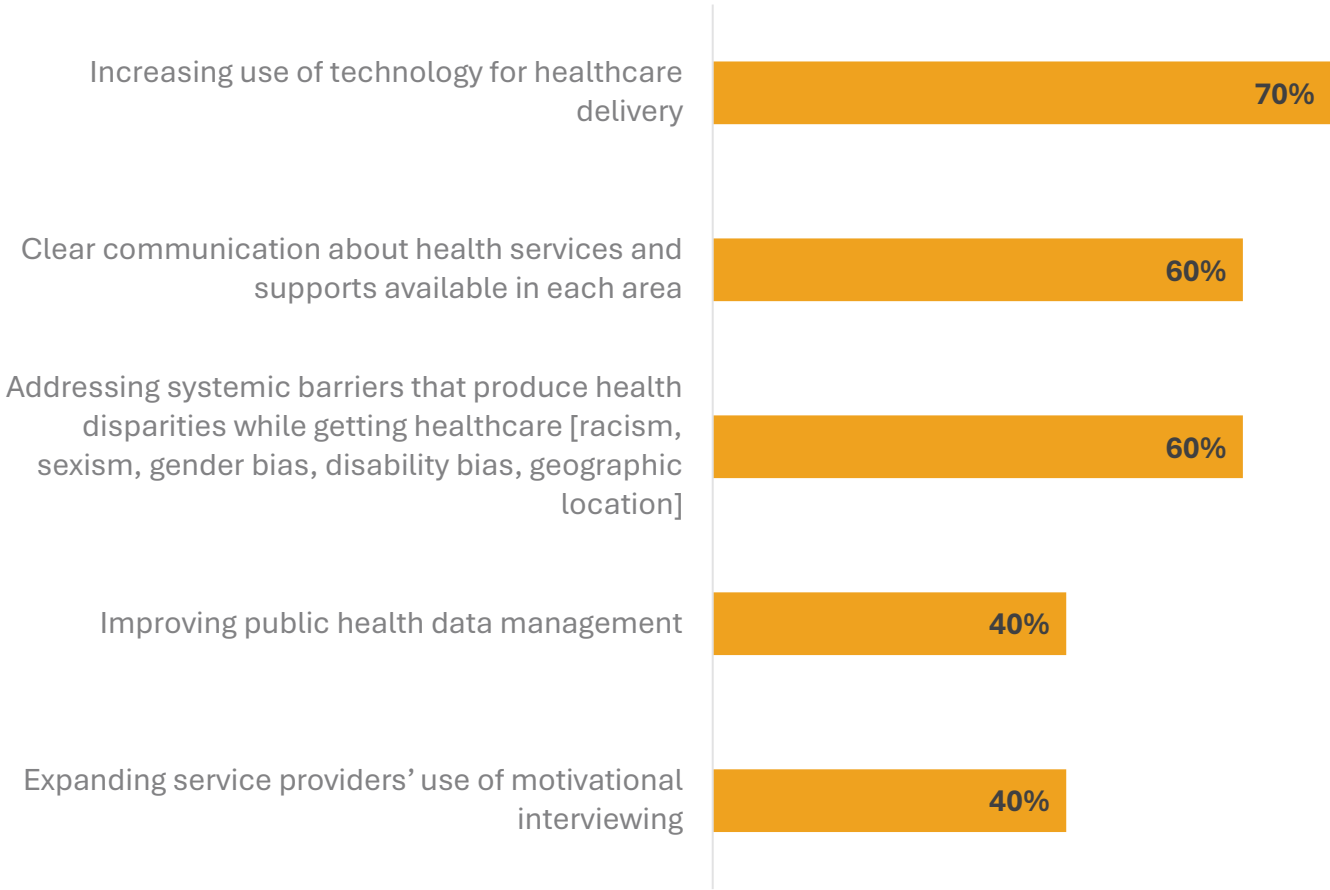


Stakeholder Survey - Professionals

Cross-Cutting Health Priorities



Tinian Professionals Survey:
Across the Lifespan Health Priorities
(n=10)





Prepared by Katie Winters, PhD
katie@insightforaction.net
(503) 956-6432

MICAH NEEDS ASSESSMENT 2025

Rota

Survey Results



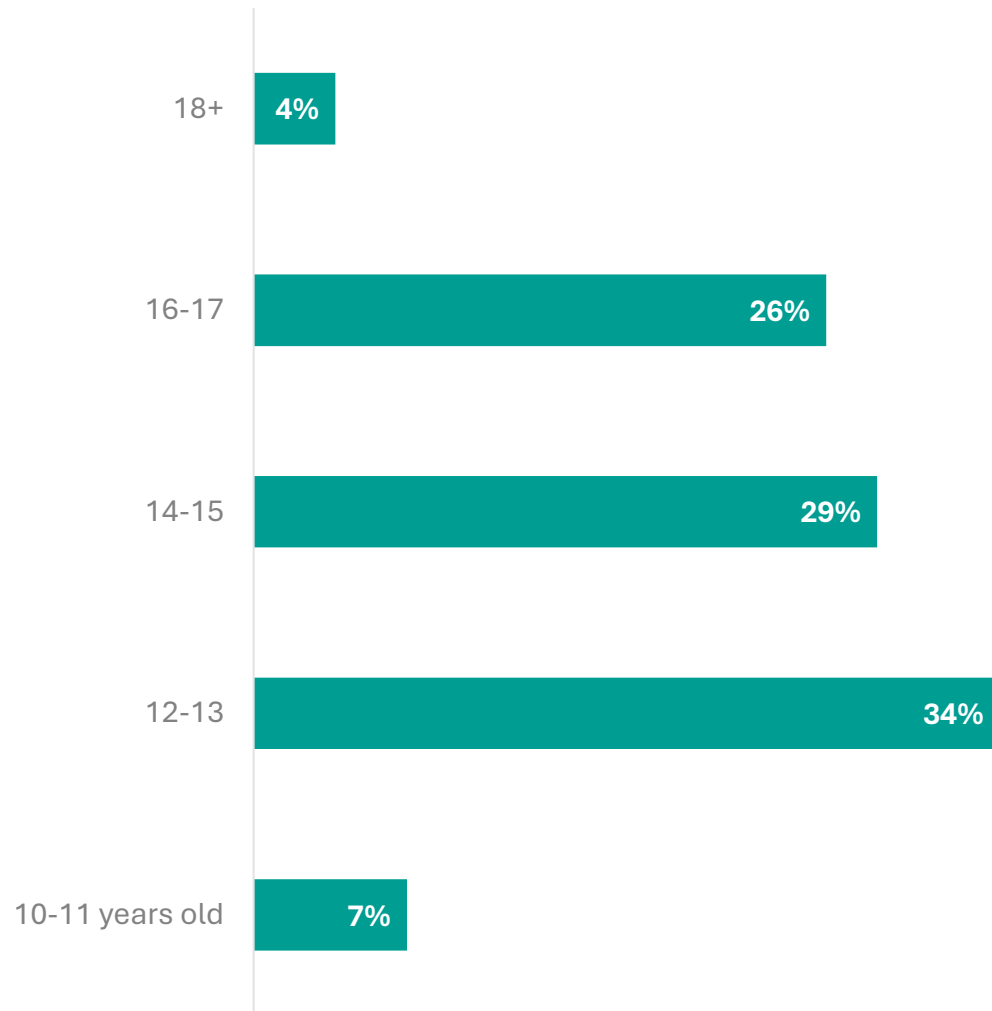
Every five years, the CNMI Division of Public Health, Maternal and Child Health Bureau (MCHB) is required to complete a **comprehensive needs assessment to assess community health**.

Health is a state of physical, social, and mental well-being and not merely the absence of disease. Health is created in the community through social, economic, and environmental factors as well as individual behaviors and biology.

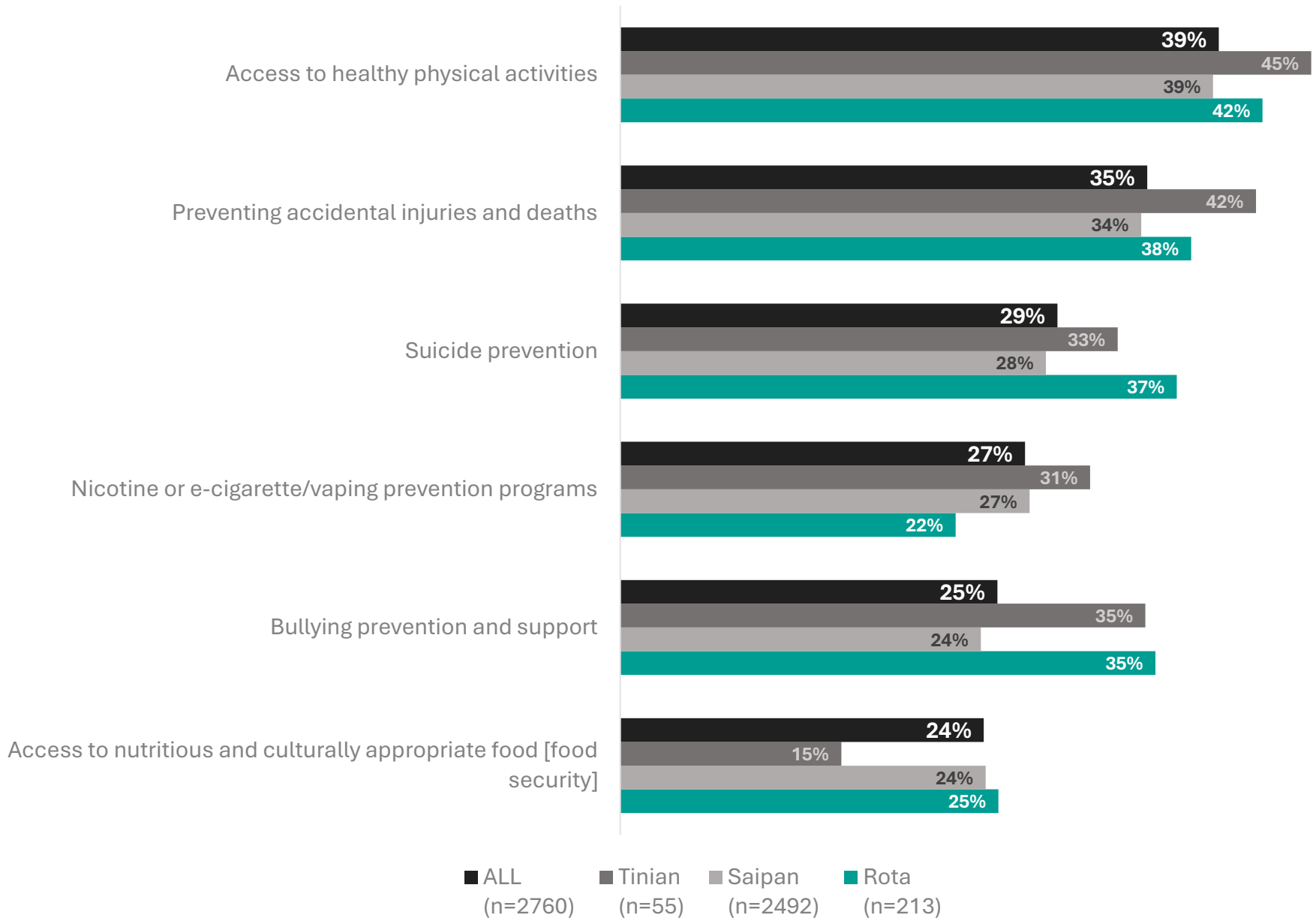
The needs assessment included surveys of professionals and youth to inform priority setting. Results for Rota on its own and in relation to the other CNMI islands are shown on subsequent slides.

YOUTH SURVEY RESULTS (N=213)

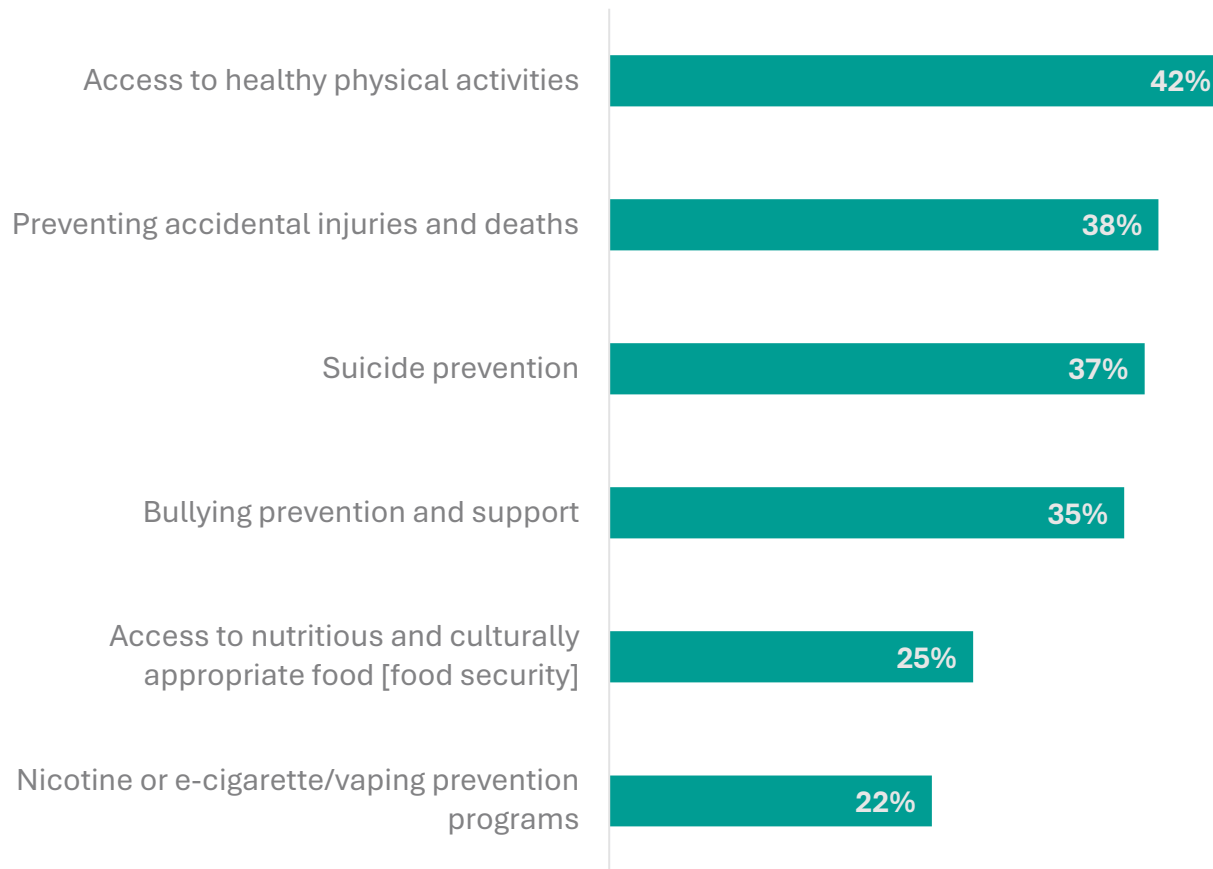
Rota Youth Survey Respondent Age



Youth Survey: Adolescent Health Priorities - Overall and by Island

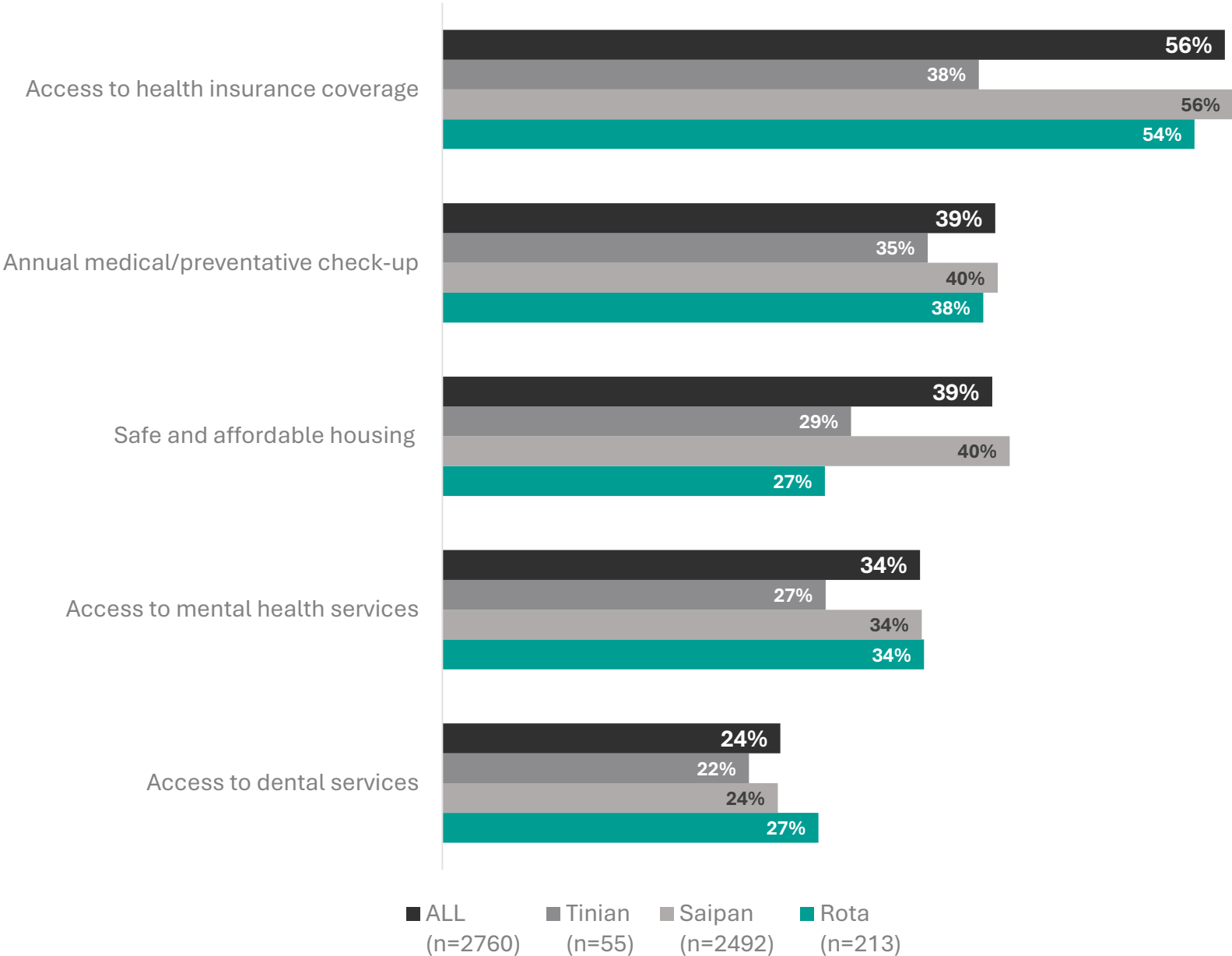


Rota Youth Survey: Adolescent Health Priorities
(n=213)

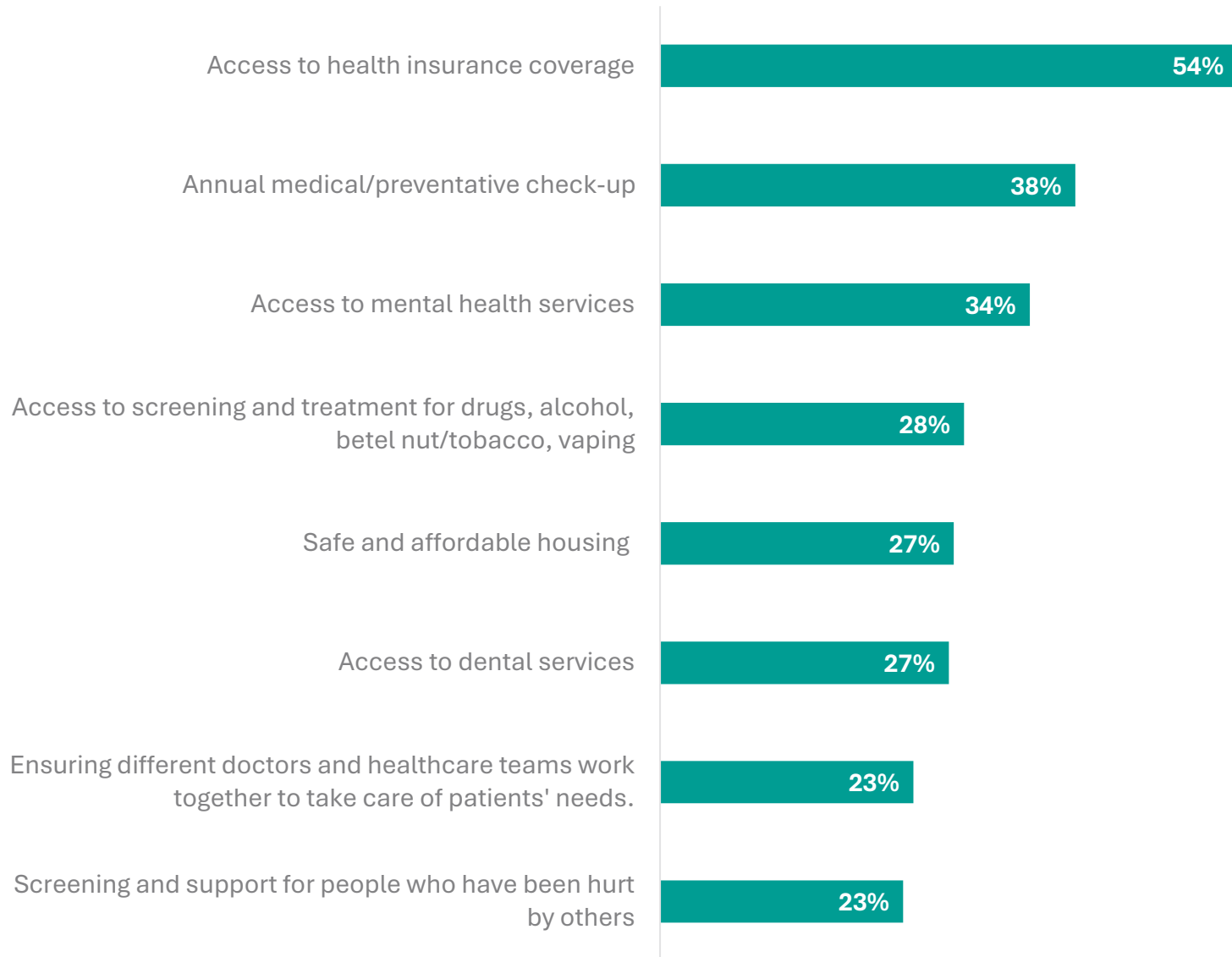


Youth Survey: Health Priorities Across the Lifespan

Overall and by Island

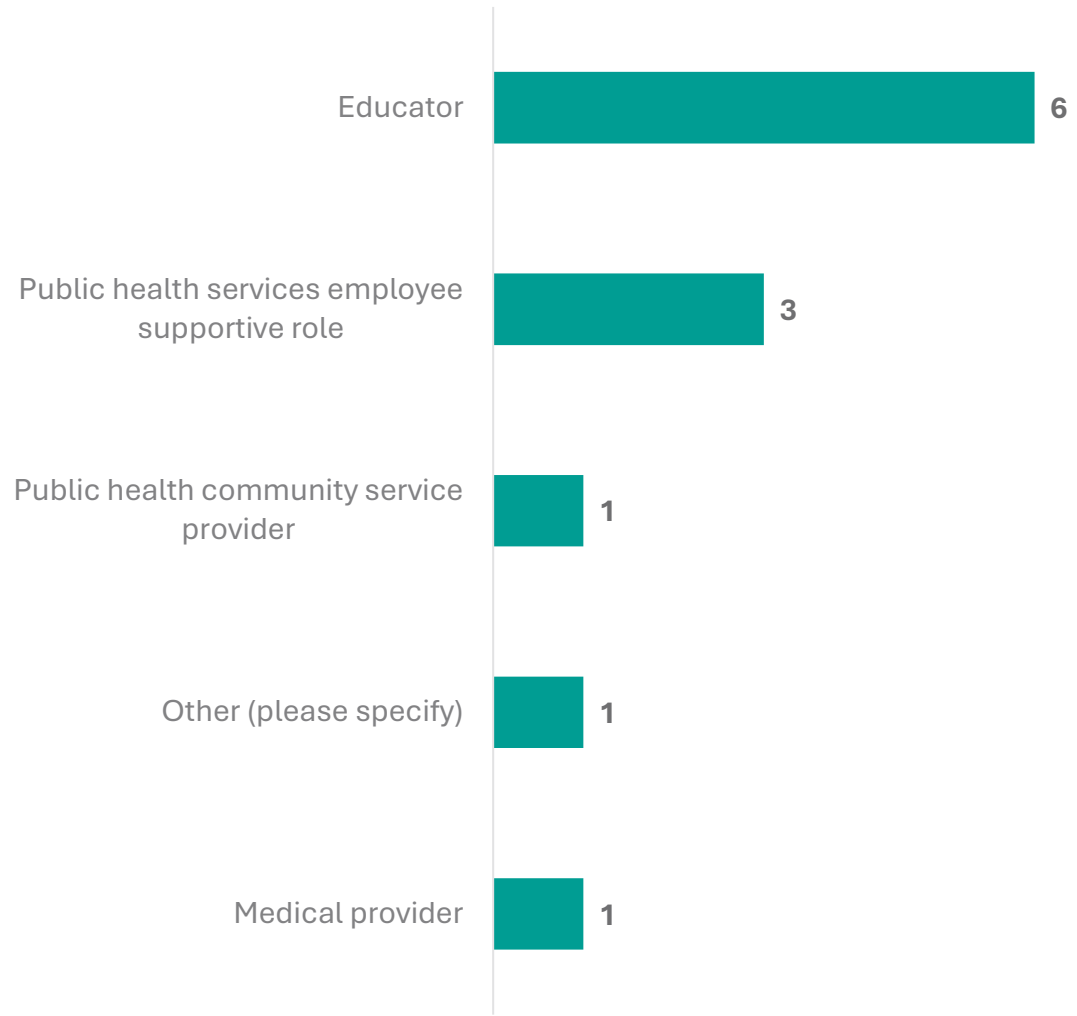


Rota Youth Survey: Health Priorities Across the Lifespan
Overall and by Island
(n=213)



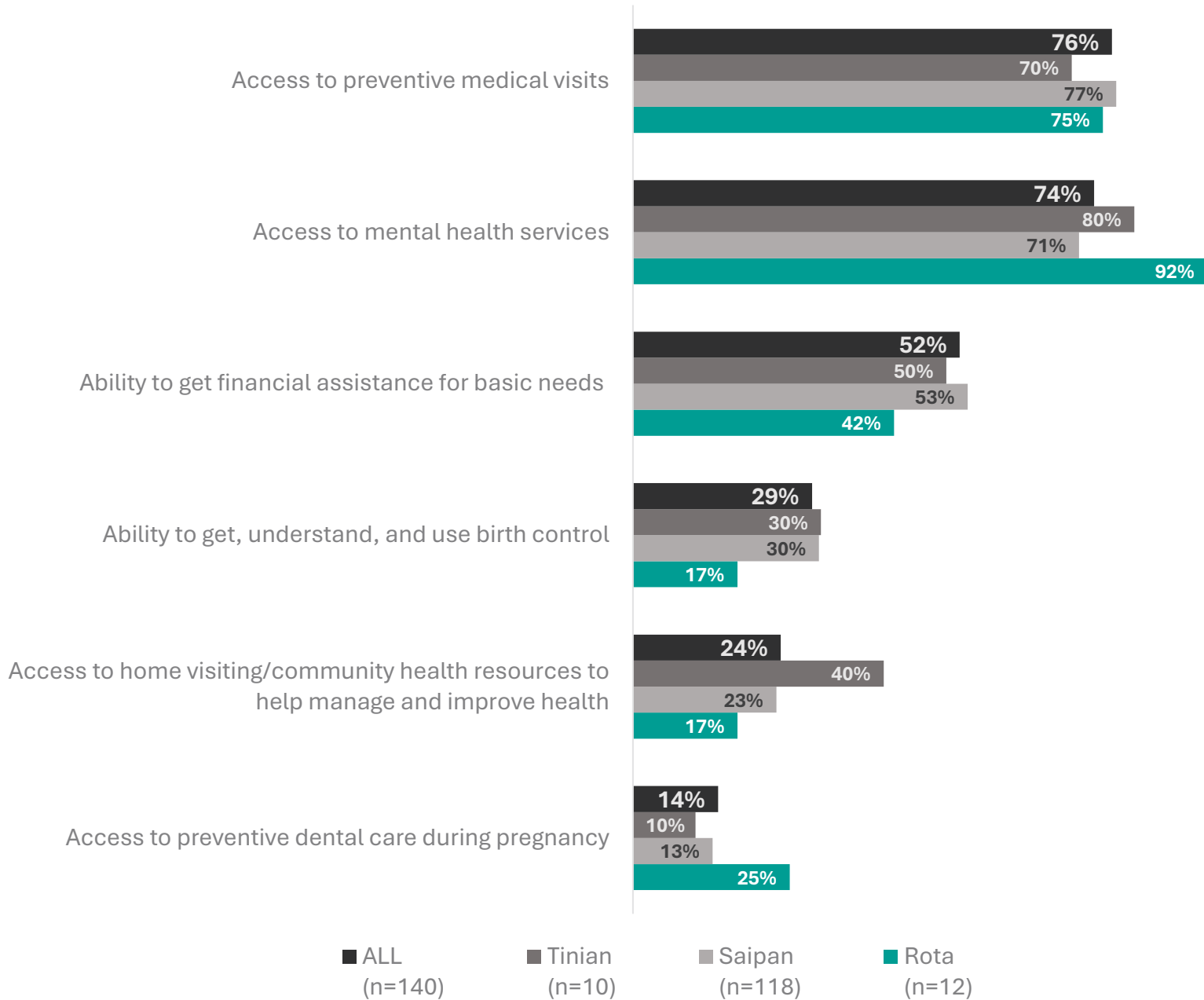
PROFESSIONALS SURVEY RESULTS (N=12)

Rota Professionals Survey - Role (n=12)

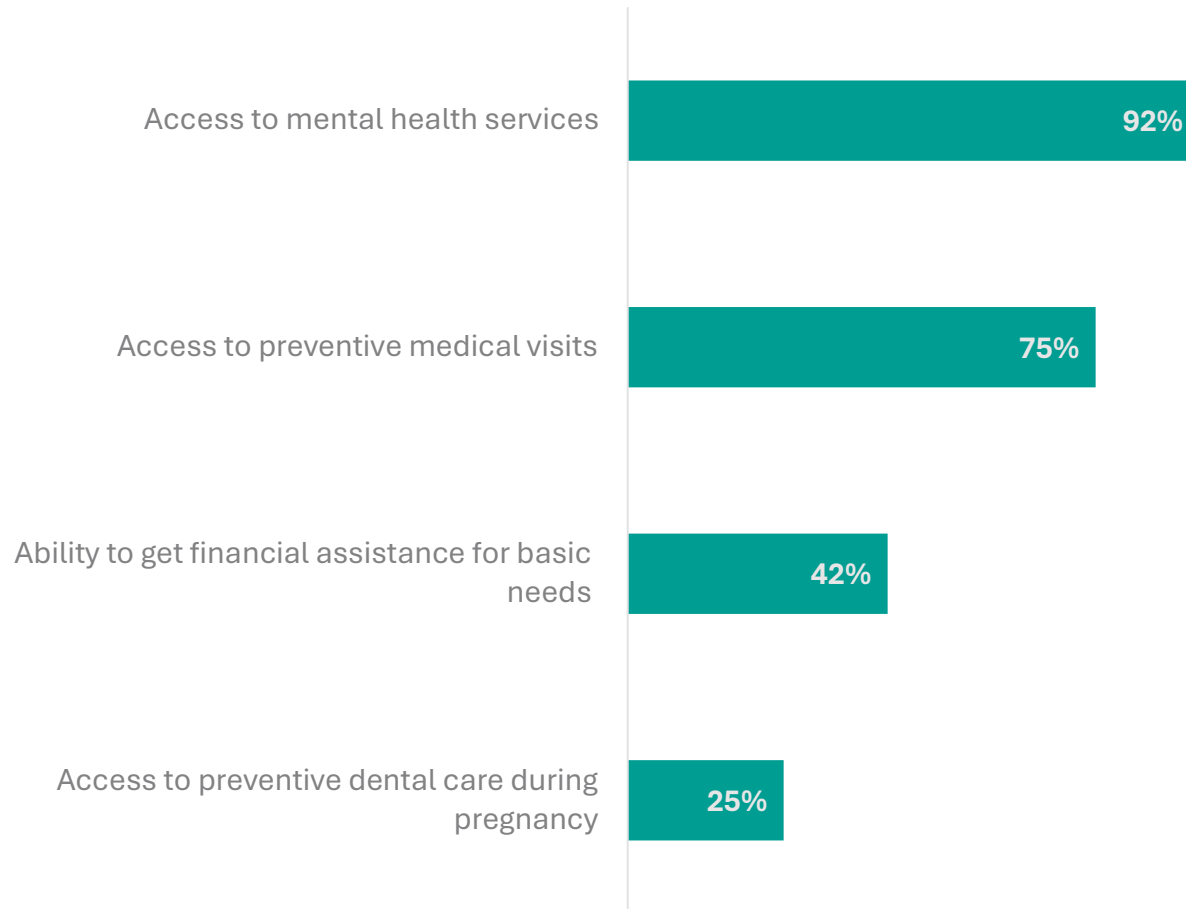


Stakeholder Survey - Professionals

Women's Health Priorities

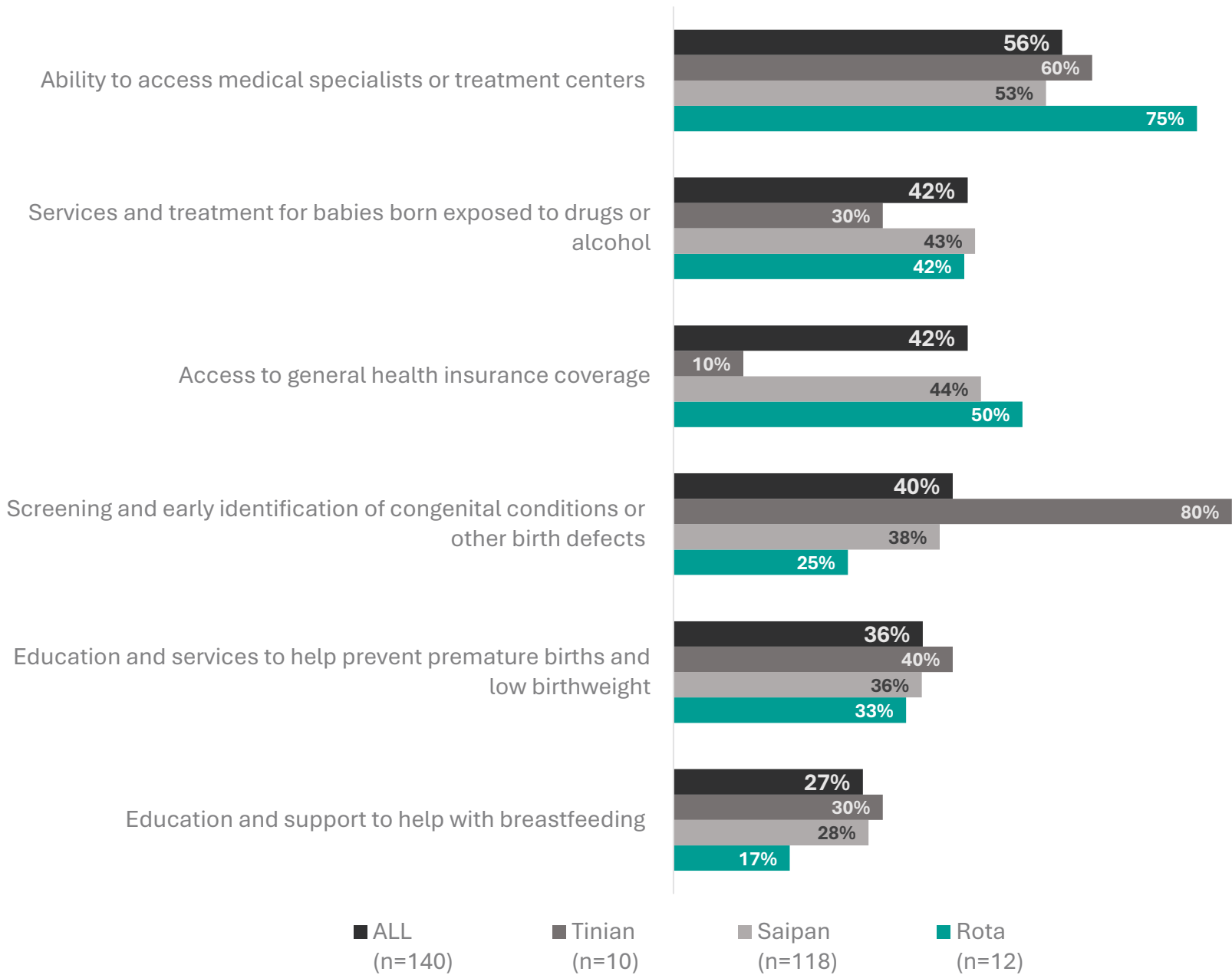


Rota Professionals Survey:
Women's Health Priorities
(n=12)

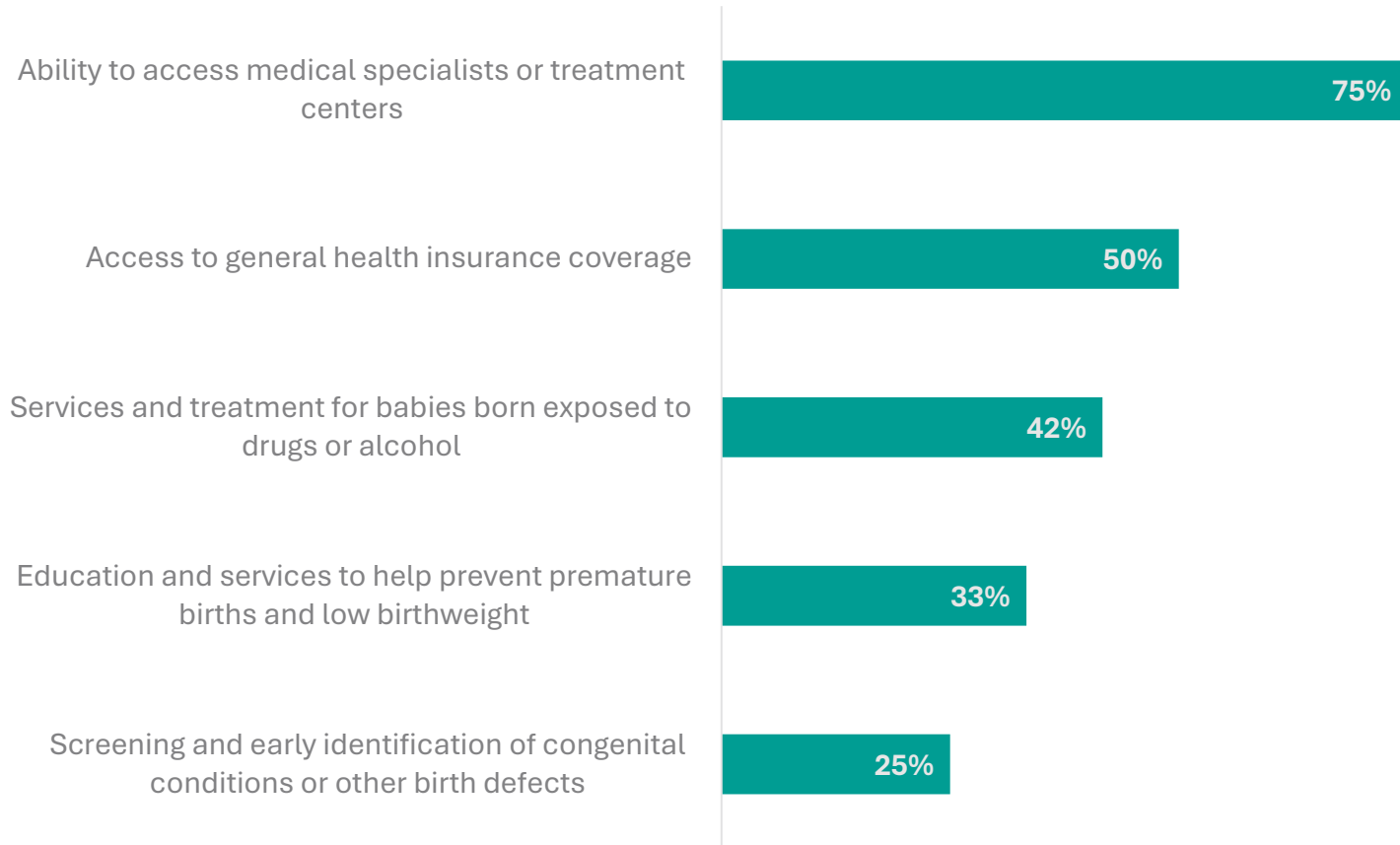


Stakeholder Survey - Professionals

Infant Health Priorities

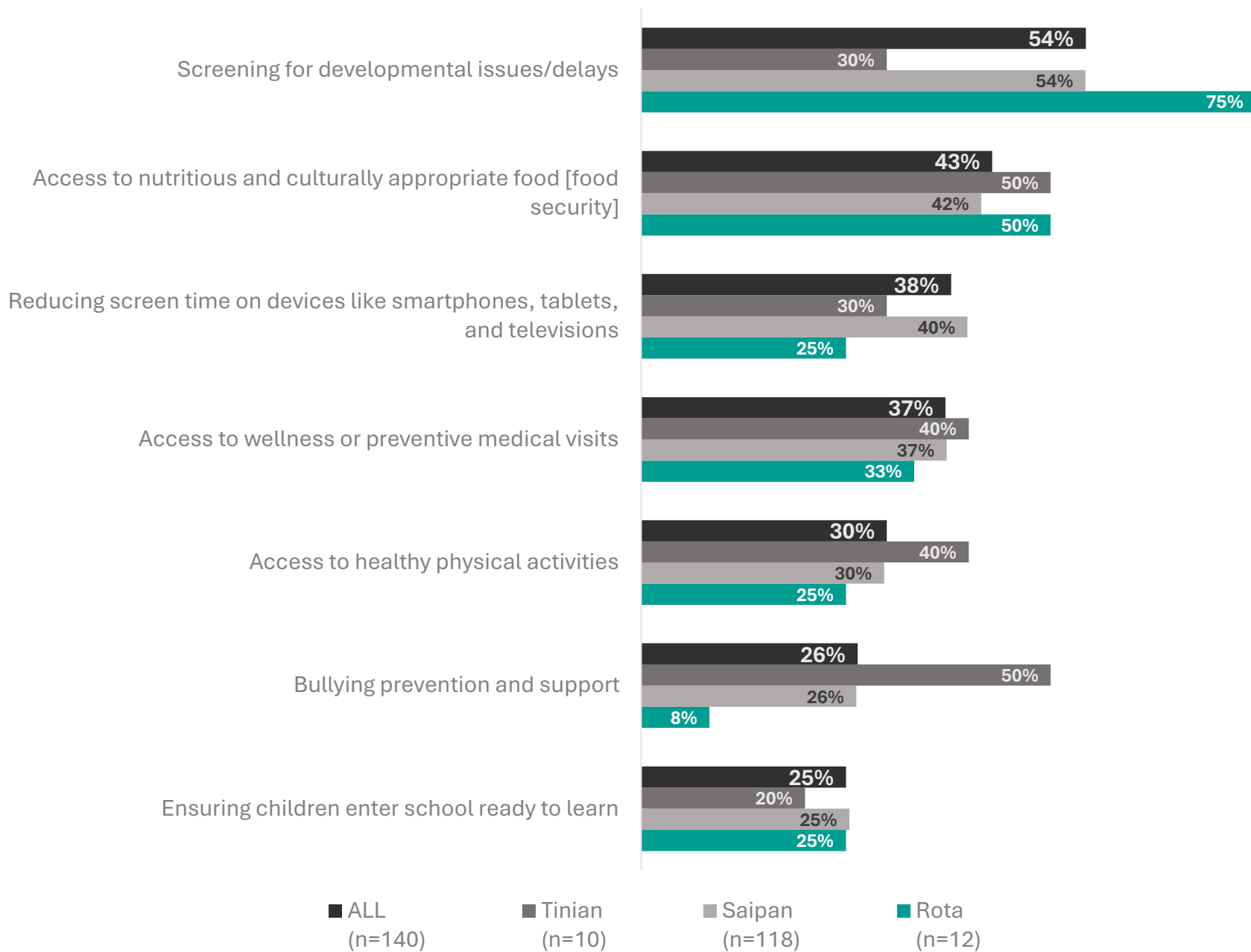


Rota Professionals Survey:
Infant Health Priorities
(n=12)

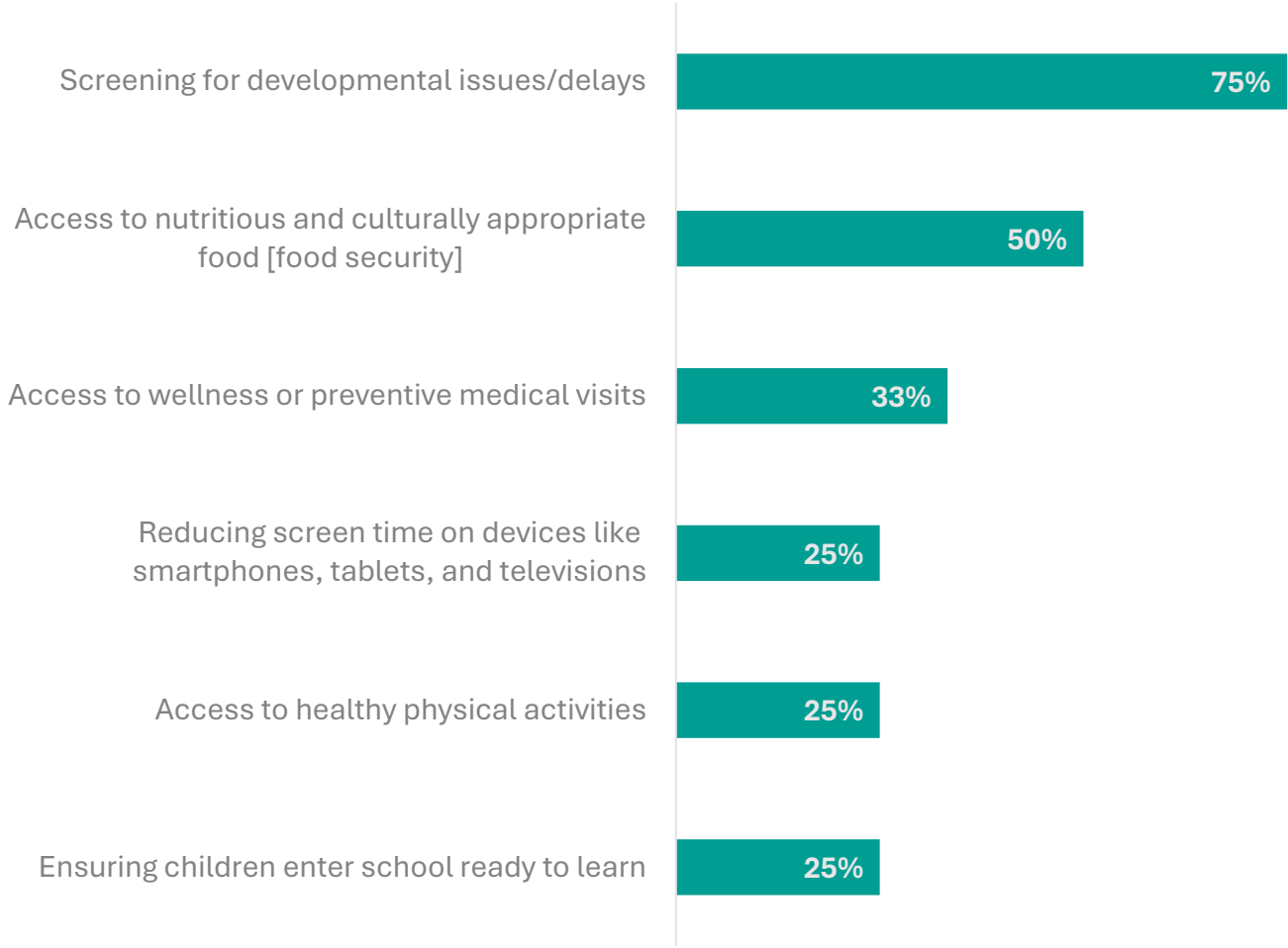


Stakeholder Survey - Professionals

Child Age 1-9 Health Priorities

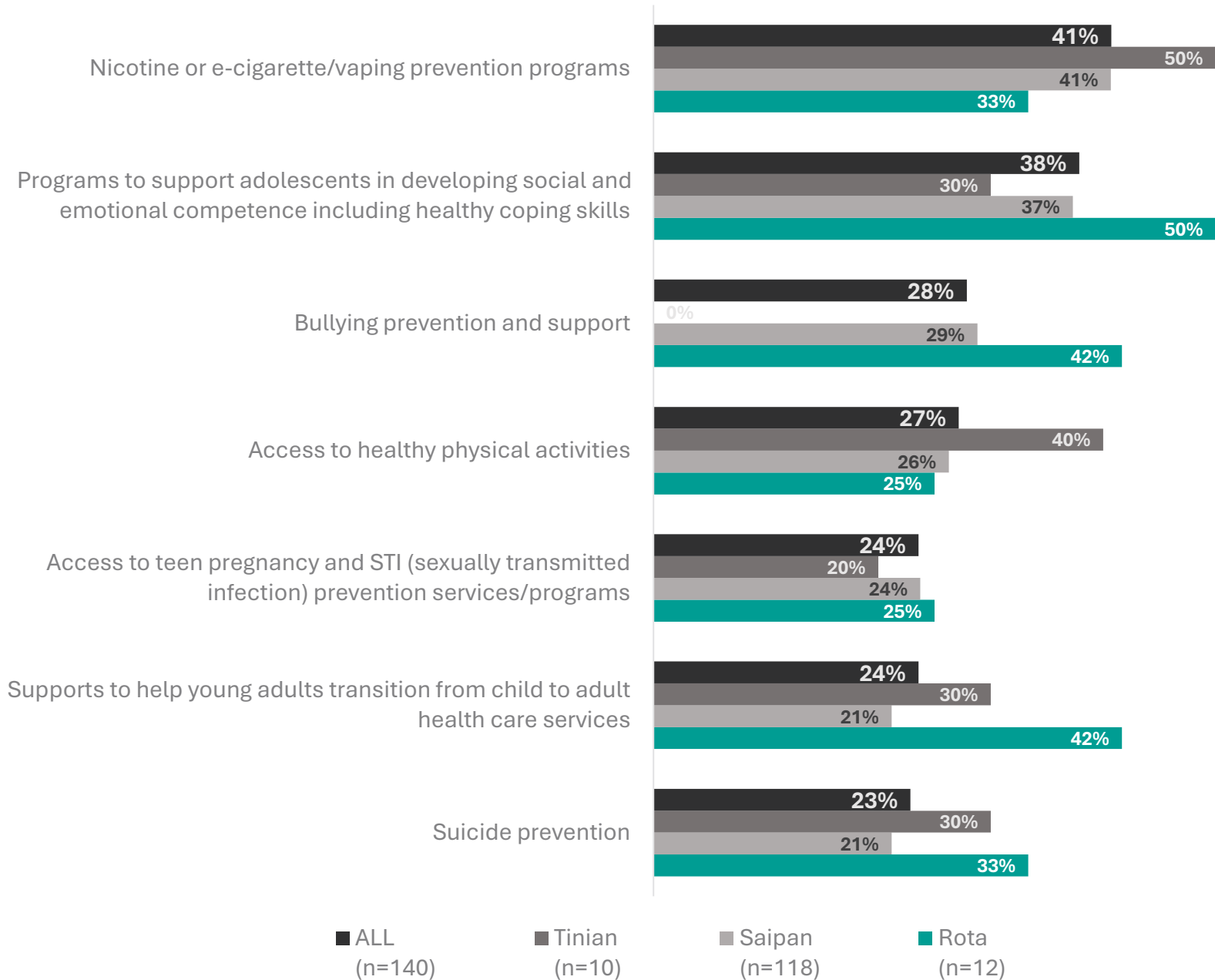


Rota Professionals Survey:
Child Age 1-9 Health Priorities
(n=12)

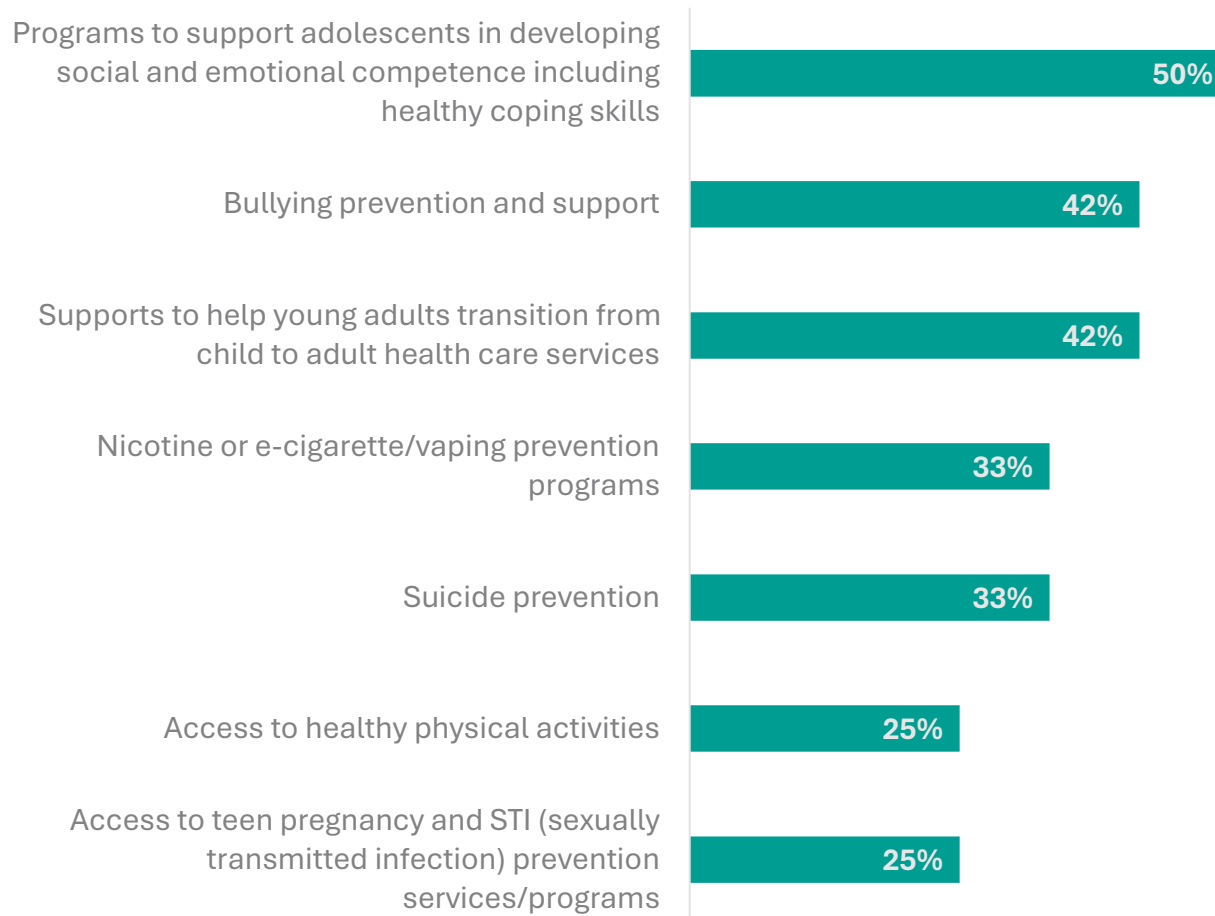


Stakeholder Survey - Professionals

Adolescent Health Priorities

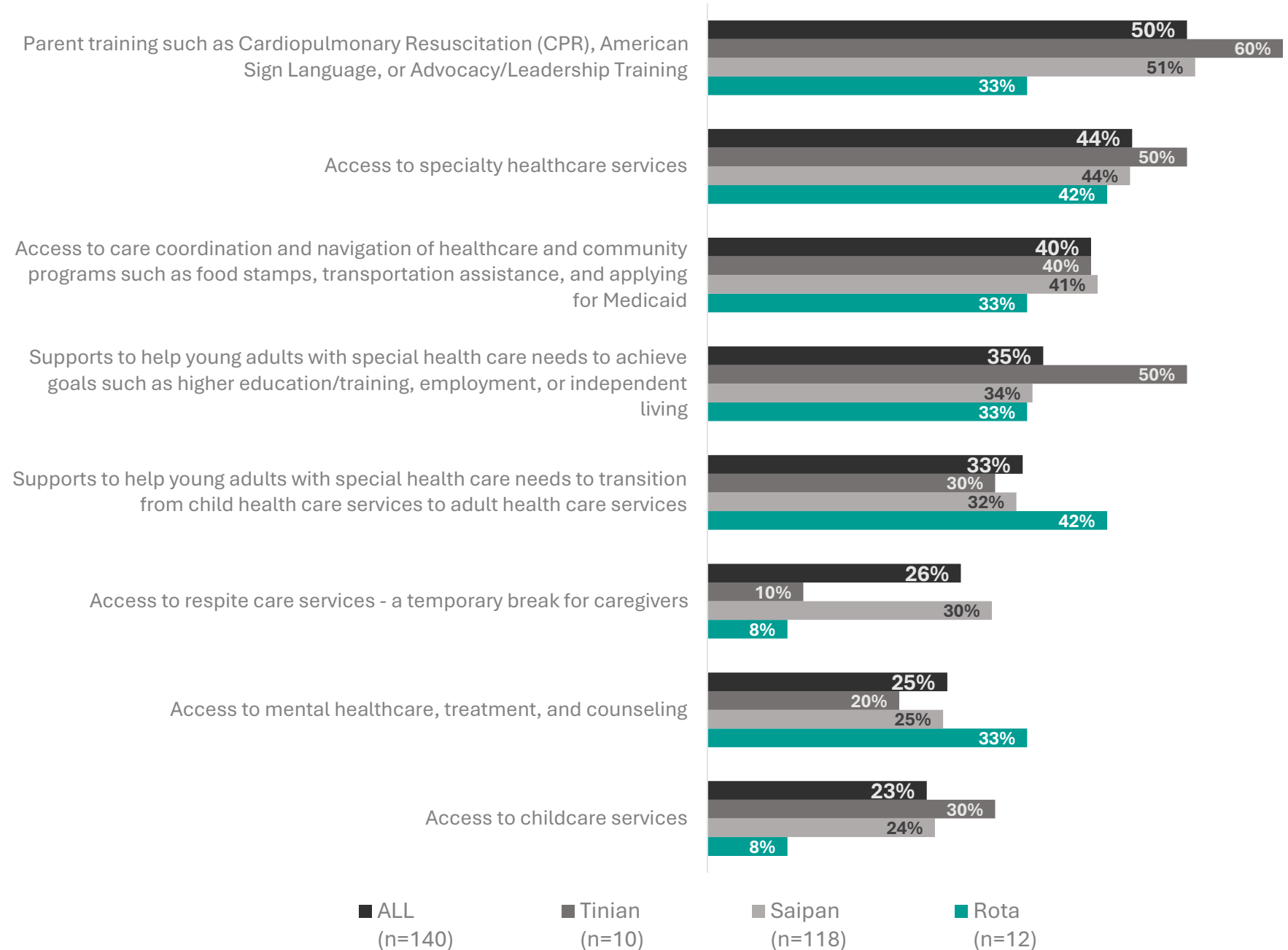


Rota Professionals Survey:
Adolescent Health Priorities
(n=12)

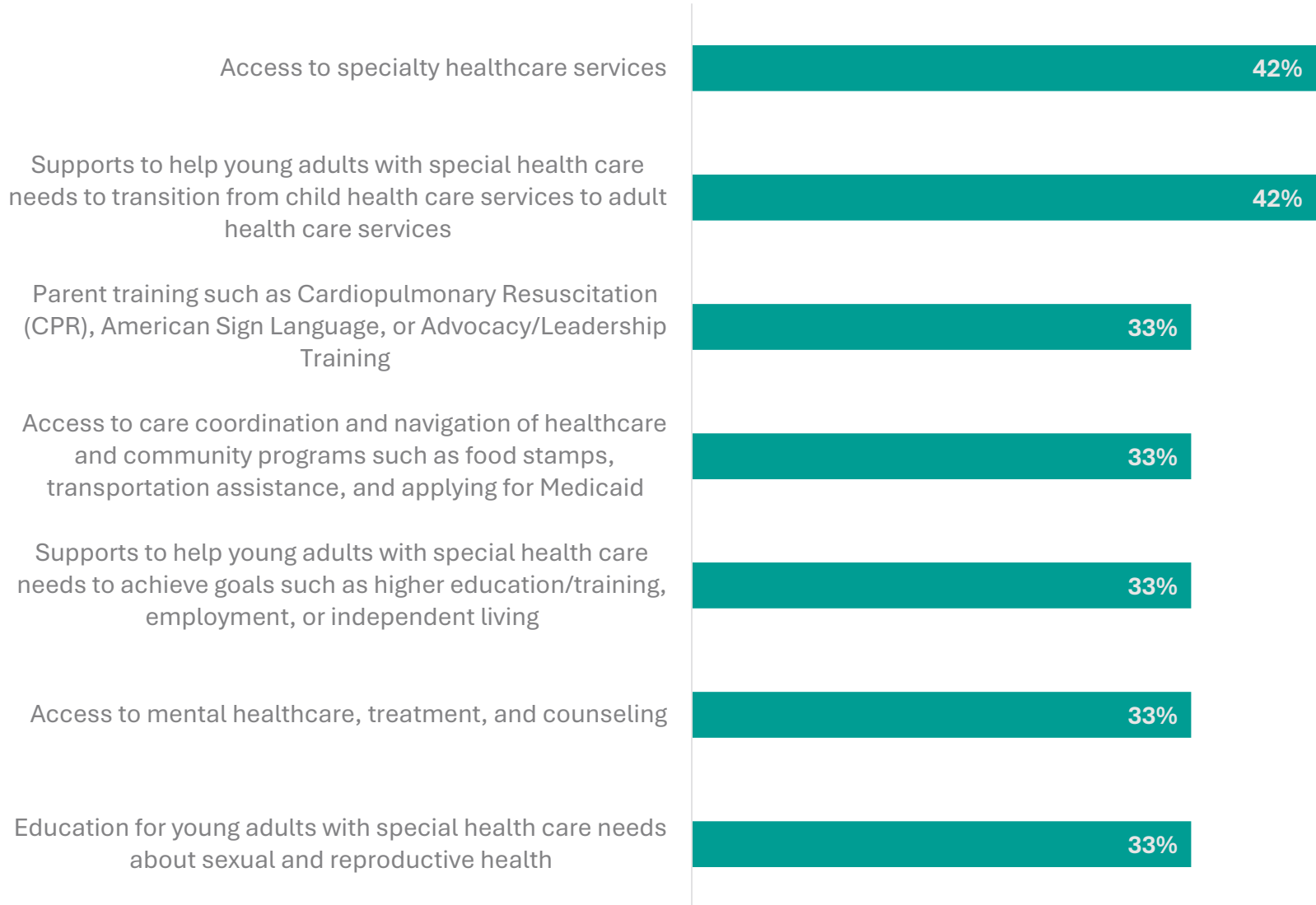


Stakeholder Survey - Professionals

Children with Special Healthcare Needs (CSHCN) Health Priorities

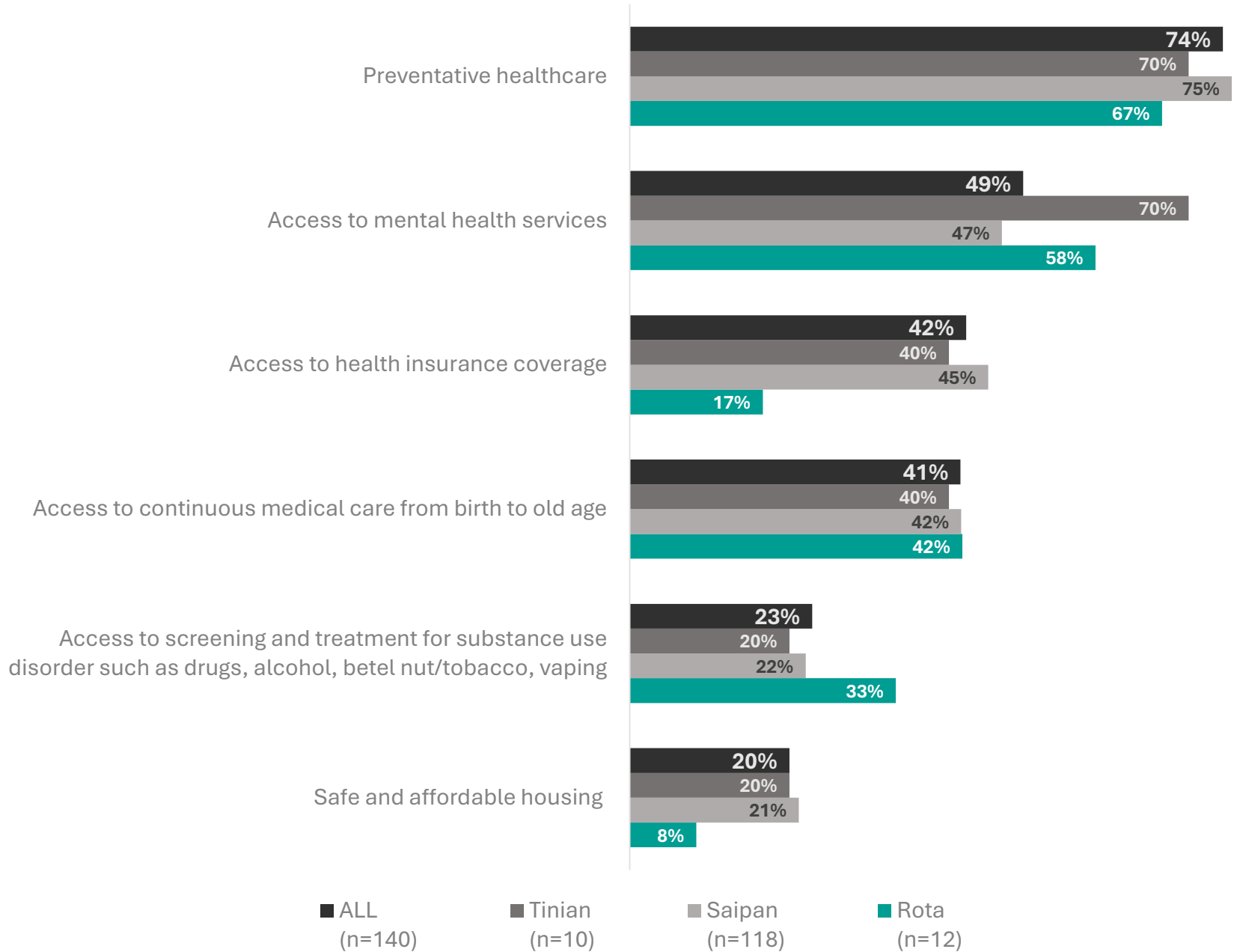


Rota Professionals Survey:
Children with Special Healthcare Needs (CSHCN) Health Priorities
(n=12)

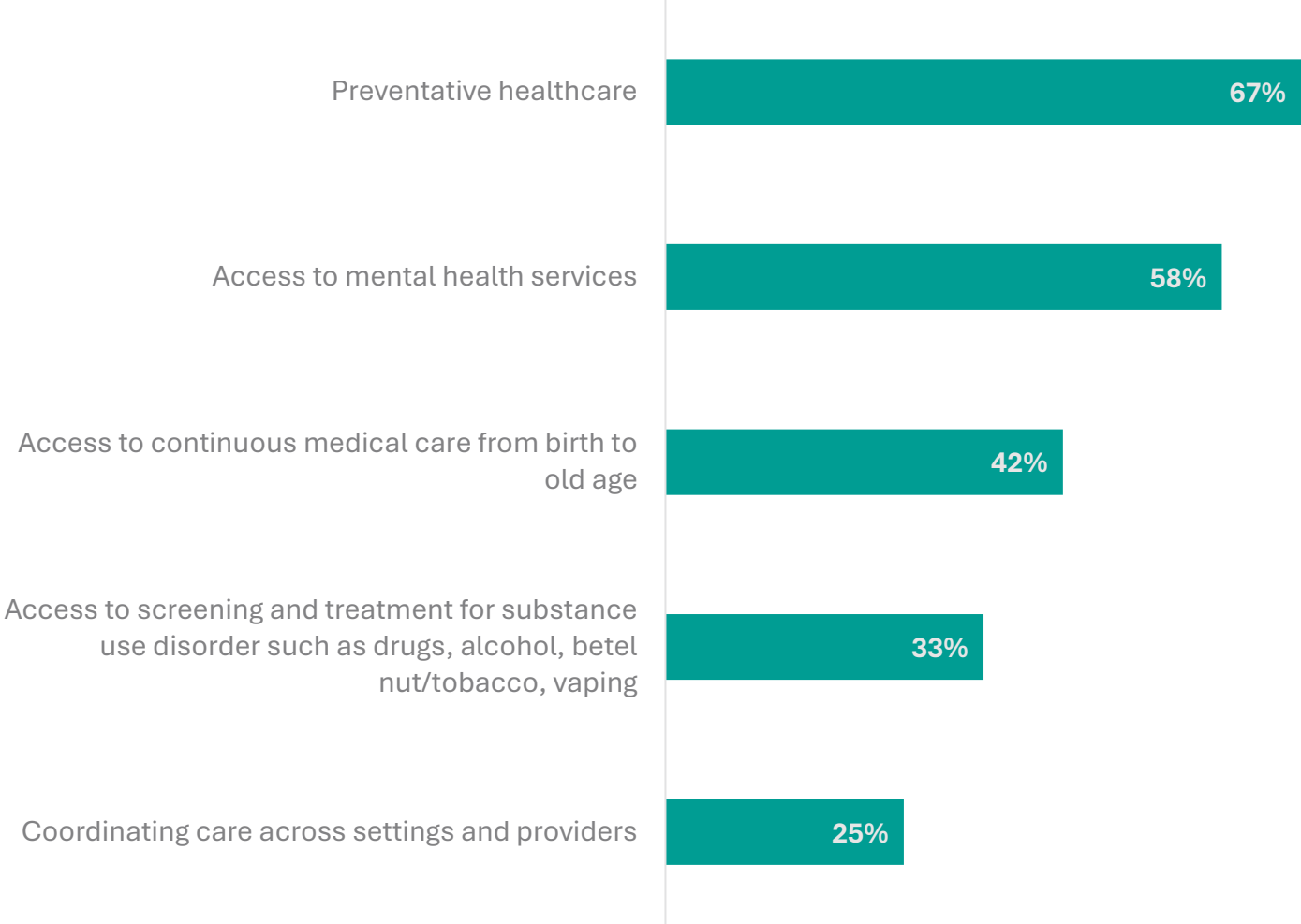


Stakeholder Survey - Professionals

Across the Lifespan Health Priorities

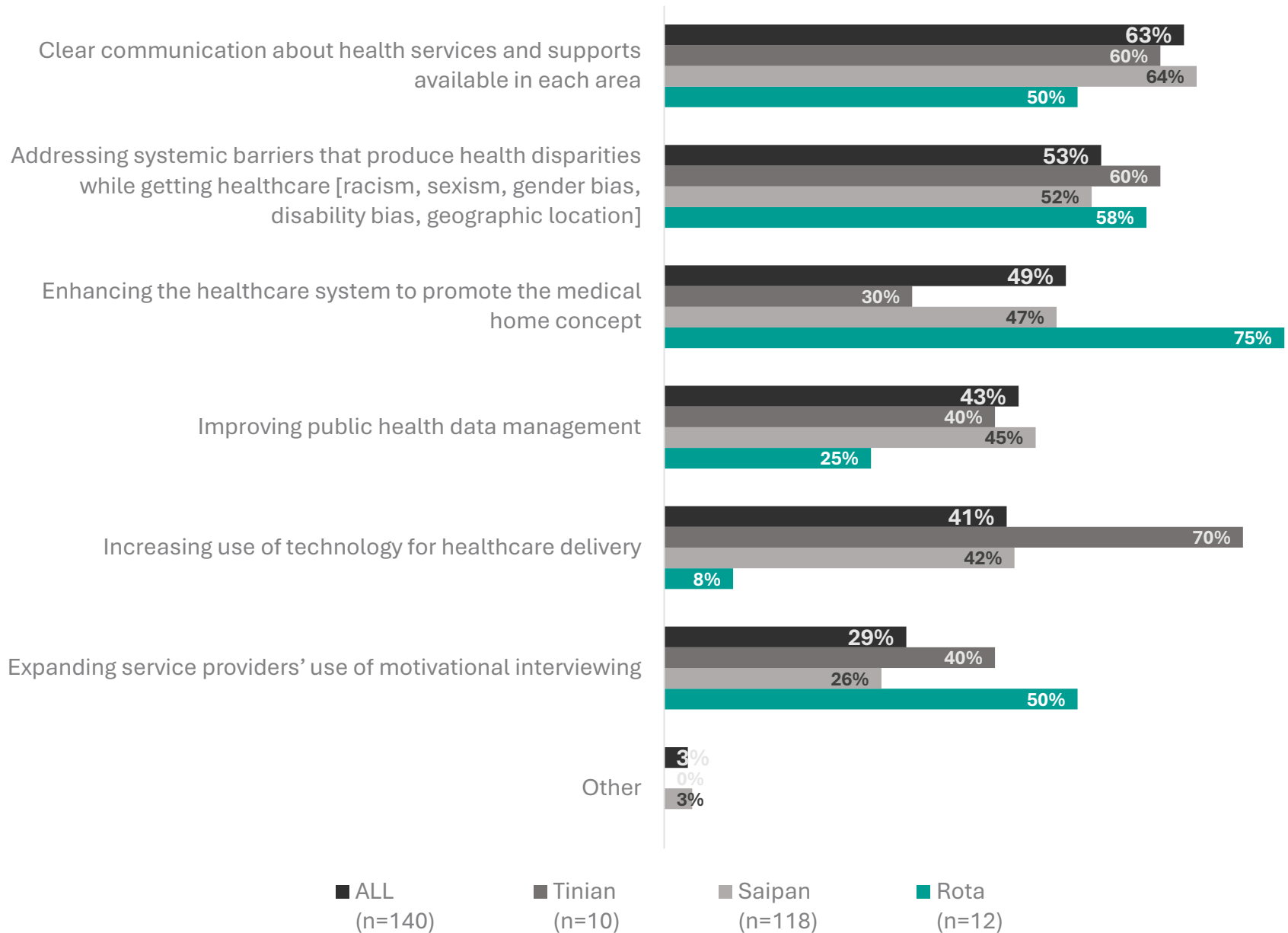


Rota Professionals Survey:
Across the Lifespan Health Priorities
(n=12)

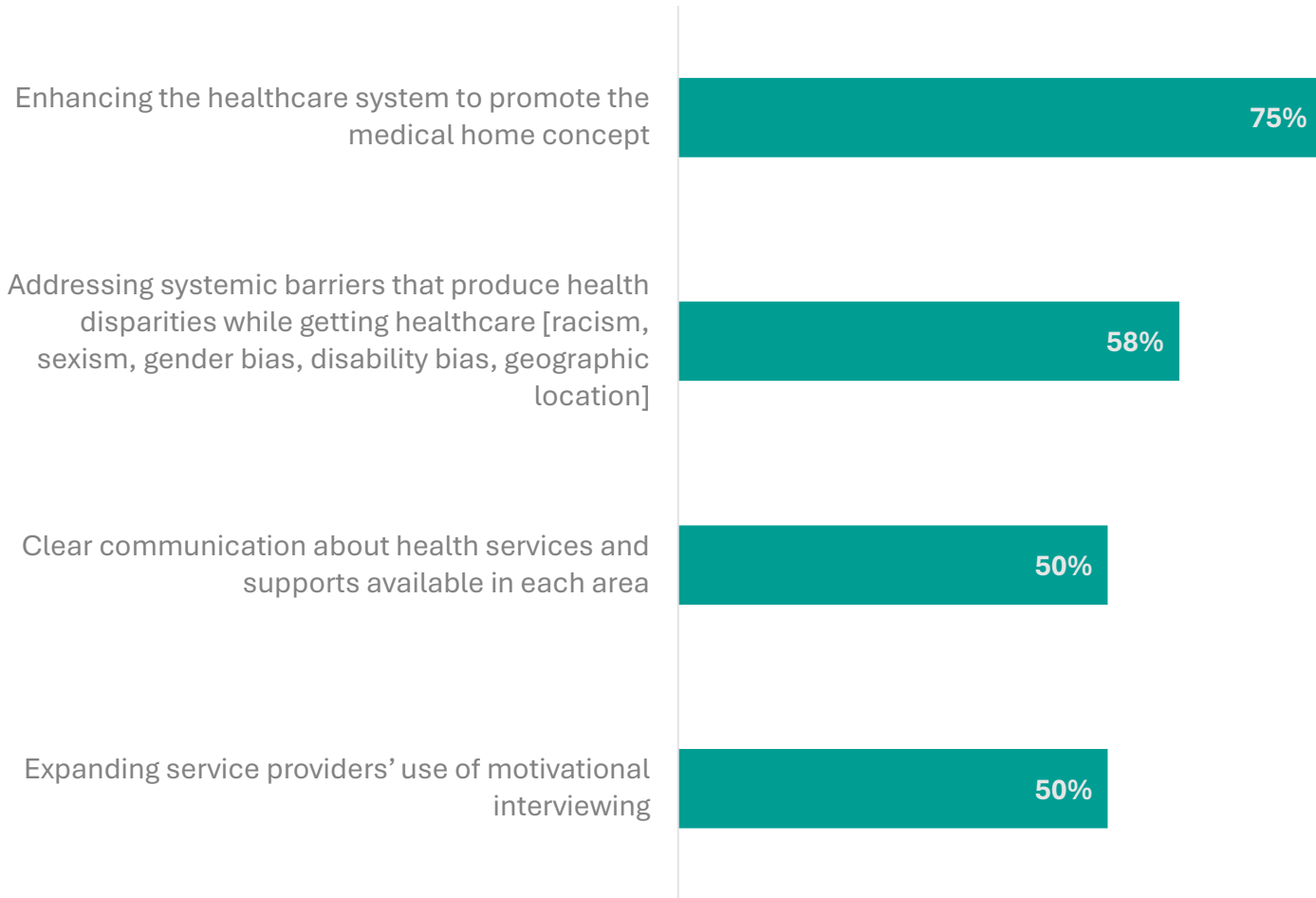


Stakeholder Survey - Professionals

Cross-Cutting Health Priorities



Rota Professionals Survey:
Across the Lifespan Health Priorities
(n=12)





Prepared by Katie Winters, PhD
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Appendix C. Example focus group protocol – PATCH Teens

MICAH Needs Assessment

Focus Group Protocol – YOUTH

Welcome

Hello! I'm Katie Winters. I'm with Insight for Action, a consulting firm located in Portland, Oregon. **I'm grateful to you for making the time to talk with me today.**

Why are we doing this?

Every five years, the CNMI Division of Public Health, Maternal and Child Health Bureau (MCHB) is required to complete a **comprehensive needs assessment to assess community health**. Your comments during this discussion will be used to **identify priorities for programs and services for the next 5 years**. In addition to talking with you all, I will also be facilitating groups with parents and community members, health and mental health providers, and faith community leaders.

Housekeeping & Participation Basics

Before we get going, I have a few basics to mention.

I ask that your cell phones are on **silent and away** during our discussion. This will help everyone to focus and for us to have a productive discussion!

We have a lot to cover, so we're going to go straight through. **If you need to step away** to use the restroom or for any other reason, you're welcome to do that. We'll be glad to have you join back with us when you're done.

There are no right or wrong answers to what we will talk about today. I want to hear thoughts and ideas from everybody who is here today. As the facilitator, it is my job to ask good questions, so that you all can have a lively conversation about the issues. I may invite you specifically to contribute if I haven't heard anything from you yet. Likewise, if you're someone who has a lot to share, please be mindful to allow space for others to offer their ideas. **[Describe pizza metaphor – everybody gets a slice]**. My hope is that this feels like a friendly and casual conversation.

Confidentiality and Permission to Record

Participating today is totally **voluntary**. You don't have to participate. You can also decide you want to stop participating midway through, after you've said you wanted to.

This conversation will be **confidential**. I won't tie any of your comments to your names in anything that I report. When I'm reporting, I will talk about the **themes and recommendations** that come from this conversation, and the conversations I'm having with other groups. I'd also like to ask that everybody in this group **agree to keep this conversation in the room**, and not talk about what's discussed in here outside of the group once it's over. **Does anybody have any questions about that? Does everybody agree to keep our conversation confidential?**

I would like to **record** the conversation to capture what we say accurately. This will help as I'm pulling together the many discussions over the week. *Does anyone have concerns about recording?*

- If you'd prefer not to be recorded, it's absolutely okay. I can take notes.
- [Agree not to record if any attendee prefers not –take notes in this case.]

Ok, here we go! *[START RECORDING]*

Rapport Building

Before we start, let's take a little time to talk about ourselves. Learning a little bit about you will help me to be a good facilitator. I'd like to go around the group and have each of us share a little bit about ourselves. A list of items is on the poster paper [point to where it is located].

- Name & Age
- Your school
- Favorite hobby and/or your superpower

Katie start, modeling introduction and then invite a member to share next. Continue until all in the group have introduced themselves.

Grounding in Our Definition of Health

First, I'd like to read the definition of health we're using for this project: ***Health is a state of physical, social, and mental well-being and not merely the absence of disease. Health is created in the community through social, economic, and environmental factors as well as individual behaviors and biology.***

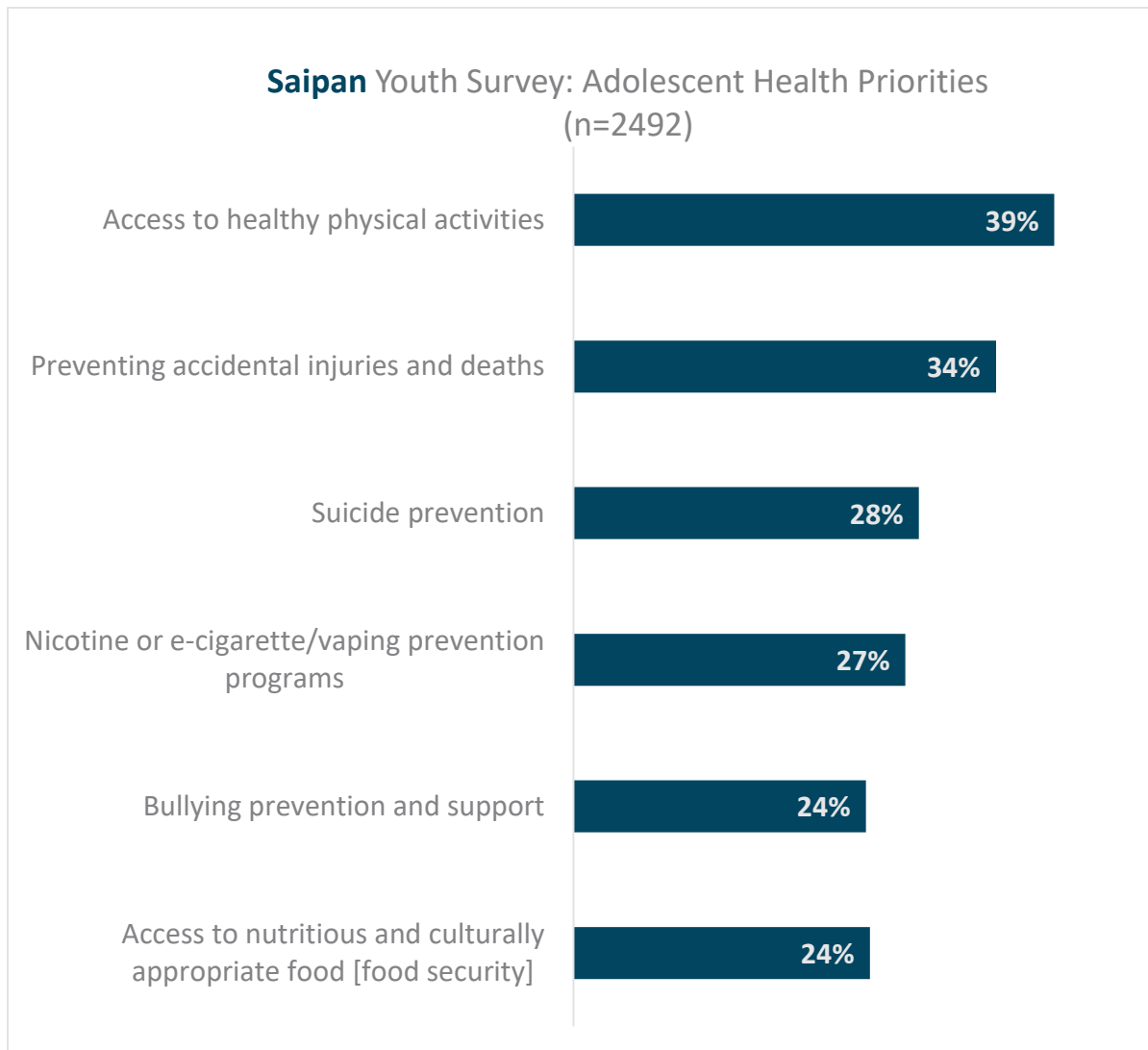
Youth Stakeholder Survey Results

Ok, now we're going to get into the priorities. A couple requests:

- The more **specific** you can be, the better, so do your best to really paint a picture as you share.
- We're interested in identifying **priorities for the CNMI overall**, so do your best to move beyond the experience that *you* have, or your close friends have, to talk about priorities for everybody, and **especially young people who have the most trouble being healthy.**

To help guide our conversation, I want to share the results of a youth survey we did a couple weeks ago. We were only able to survey public schools, so if you attend a private school, you didn't get a chance to fill it out. We got a really great response; 2,760 students filled it out and we have representation from all three islands.

This chart shows the adolescent health priorities students selected by a quarter(ish) or more of the survey respondents: [walk through chart, explaining how it's organized and reading the label in each bar].



Questions

Let's start by looking at the results all together. What are your initial reactions to these priorities?

- Do they match with what you think the priorities should be? Why or why not?
- Is anything in this list surprising?
- What is missing from this set of priorities?

Now I'd like to talk about individual priorities in a little more detail. For each priority, we'll discuss two things that are posted on the wall [point out two prompts].

WHY do you think students identified this as a priority?

- What's going on in the CNMI that makes this a priority?

HOW should this priority be addressed?

- Why do you think your suggestion would be helpful?
- How does it build from local culture or other community strengths?
- How could young people like you be involved?

Close and Next Steps

Okay, we've reached the finish line. **Thank you everybody, so SO much. This was fantastic!**

As far as next steps, I'll be summarizing the results of our conversation and the others happening in the CNMI and they will be used to set priorities for CHCC for the next 5 years.

Here is my business card. If you have any additional comments or ideas you'd like to share, please do reach out.

[If time allows, close the conversation by inviting each participant to share a one-word reflection about their experience.]

Okay, thanks again. Goodbye everybody.

Appendix D. Qualitative data report

MICAH Needs Assessment Qualitative Data Report

2025

May 20, 2021



Overview

Every five years, the CNMI Division of Public Health, Maternal and Child Health Bureau (MCHB) is required to complete a **comprehensive needs assessment to assess community health**.

Health is a state of physical, social, and mental well-being and not merely the absence of disease. Health is created in the community through social, economic, and environmental factors as well as individual behaviors and biology.

The needs assessment included interviews and focus groups conducted during site visits to Saipan, Tinian, and Rota. Participants discussed priority health issues in their communities, including *why* the priorities are important and *how* the priorities could be addressed.

Qualitative Data Sources

74 community members contributed to the interviews and focus groups

Island	Data Collection Type	Participant Type	Participant Count
Saipan	Community intercept interviews	Women of childbearing age	17 women, collectively parenting 39 children
Saipan	Focus groups/interviews	Health providers – nurses, doctor Mental health providers and program administrators Public school educators and administrators	3 staff members
Saipan	Interviews	Community health workers - WIC provider, HOME Visitor, CGC outreach worker	3 staff members
Saipan	Focus group	Mental health providers and program administrators	5 staff members
Saipan	Focus group	Public school educators and administrators	4 staff members
Saipan	Focus group	Parents with CSHCN	7 parents
Saipan	Focus group	Faith community leaders	5 leaders
Saipan	Focus group	PATCH Program teens ages 15-18	10 teens
Rota	Focus group	Health providers (3) Health clinic resident director (1) HOME Visitor (1)	5 staff members
Rota	Focus group	Community members	5 adults
Tinian	Focus group	Health providers (2) Health clinic resident director (1) HOME Visitor (1) Public school counselor (1)	5 staff members
Tinian	Focus group	Community members	5 adults

Results

Subsequent slides present the results of the interviews and focus groups. Health priorities and hindrances to achieving them are listed, along with quotes supportive of the findings.

Results are disaggregated by island.

For Saipan, results are further disaggregated by interview/focus group participant type:

- Women of childbearing age
- Medical providers
- Community health workers
- Mental health providers
- Public school staff
- Parents with children with special healthcare needs (CSHCN)
- Teens
- Faith community leaders

Women of Childbearing Age Saipan

Priorities

- Supporting women with post-partum depression
- Access to dermatology services on-island
- Addressing the health needs of guest workers and immigrants, including health insurance access
- Ensuring access to healthy, culturally-appropriate foods
- Family planning/birth control access for women and teens
- Healthy recreation opportunities for young people
- Maintaining Indigenous lifeways – culture, language
- Parenting education
- Access to quality education for youth and young adults

Hindrances

- Medicaid is inaccessible to non-citizens
- Medicaid applications are lengthy, with extensive documentation requirements.
- Mistrust of the medical system due to negative past experiences; providers not perceived as competent, or health issues were not resolved
- Much of the population identifies as Roman Catholic, a religion that does not support family planning or birth control
- Poor culture of health

Selected Quotes

“Access to health insurance should be the top priority. Some people don’t have access, so they don’t think about how they’re feeling and put it to the side until it gets worse. The contract worker coming here to have a life. They would always think that not having any health insurance, it’s expensive to go to the hospital, so that’s why they try not to think about it and just live day-by-day.”

“I was under Medicaid, but I have to renew it again. I know I can get it, but it’s harder for women. Who’s gonna watch my son? Who will come in and work for me while I’m doing that? I work from 7-5 doing childcare, and then I go home to parent my son.”

“I have a rash on my chest. The women’s clinic told me to put foot cream on it, but it didn’t work. Now I’m using Vaseline. We use our own remedies, and sometimes just go in the ocean since salt water is good for the skin. I wouldn’t go back to the clinic. They’d just tell me to try another cream. Medicaid won’t cover something to do with rash – you pay out of pocket.”

“90% of the people here are Catholic, so they’re not interested in birth control. There’s a perception that birth control is not covered by Medicaid. I bet if you made it free, women would accept it.”

“We used to have youth centers with games, activities. They were staffed – a safe space to do homework, get away from home. Those have been gone for 10 years.”

“If you’re active, you’re less likely to get pregnant.”

“Islanders don’t take care of themselves. They ignore health challenges until they’re so sick they can’t function. They say, ‘I can’t afford to be sick.’ It’s not just money-wise, but if I’m at the hospital getting checked, who will watch the kids? If I don’t go to work, I don’t get a paycheck... if you’re in the private sector, you can’t get time off.”

“It starts at home. Ultimately, it’s the parents who decide what kids can and cannot do.”

Medical Providers Saipan

Priorities

- Obesity prevention
- Nutrition specialist for underweight babies and overweight children
- Health insurance enrollment assistance
- Well-child check-ups
- Medical case management for high-need children, including psychiatric medication management
- Access to specialty care
- Contraception and sex education for adolescents

Hindrances

- Low health literacy among parents
- Low access to fitness activities
- Roman Catholicism does not support sex education for young people; encourages abstinence

Selected Quotes

“Fee-based recreation programs are out of reach for many.”

“Resident children qualify for Medicaid, but they don’t enroll.”

“Health insurance access is a huge challenge for families who don’t qualify for Medicaid. Even sliding fee is too expensive... Especially if the kid looks okay, the family will ignore it until it gets worse.”

“Well-child checks really drop off in elementary school.”

“Some parents are not intellectually ready to follow through with the care their child needs... We don’t have a pediatric case manage to do follow-up for chronic, critical, or complicated cases.”

“Most families don’t live in a place where you can go on a walk from your house. Dogs are a concern. You have to drive to get to a safe physical activity area, and many families don’t have access to a car.”

“I’m seeing young kids who are sexually active already at 12 or 13. Teen pregnancy rates are going down... we need to continue providing sex ed.”

Community Health Workers Saipan

Priorities

- Breastfeeding support
- Family planning and birth control access
- Building community awareness of healthy eating habits
- Health insurance enrollment assistance
- Non-communicable disease prevention
- Ensuring children receive vaccinations
- Preschool access, including transportation assistance

Hindrances

- Low nutrition literacy among parents and elders
- Increase in methamphetamine use in the CNMI
- Many families lack access to reliable transportation

Selected Quotes

“Some moms already have four kids. They just breastfeed for two or three months and then stop.”

“There’s a high rise of babies positive with drugs. I think moms are not ready to get pregnant. It’s accidental, and when they find out the baby is positive, some moms just don’t care.”

“It’s a small island and we have at least 200 dialysis patients. That is caused by uncontrolled hypertension and diabetes, which ties to obesity.”

“I’ve had parents who’ve said, ‘Oh yeah, I give them juice,’ but it’s Hi-C, sweetened iced tea. It’s important to target the older populations – grandparents who babysit the kids. They’re set in their thoughts. Talk about it on the local radio where people are speaking the language. I get young parents who say they’re trying but my mom said this is how I raised you! The emphasis should be on limiting, modifying, but not doing away with foods. People like to eat Spam.”

Mental Health Providers Saipan

Priorities

- Culturally-relevant services
- Services for children and adolescents with anxiety, depression, and who are using drugs/alcohol
- Peer support programs for adolescents
- Healthy recreation opportunities for young people
- Embed mental health staff in primary care clinics
- Screening for mental health challenges (SBRT)

Hindrances

- Stigma against receiving mental health services
- Substance use

Selected Quotes

“While our culture is heavy on spiritual and traditional practices, we prioritize the medical model here. We’ve always had our natural witch doctors... A good number of folks who come to see us have already been working with traditional healers. We’re the next option. I’ve been creatively pulling in their beliefs, blending them without disrespecting what’s valuable to them... The blended care often enhances what is being done.”

“We have to seriously look into identifying peer support champions for adolescents. Those who have gone through the system and can help out. A peer can be more helpful than a parental figure... let the kids who have gone through it be the ambassador to getting the help they need rather than throwing them into the system.”

“We currently have eight mothers [who are receiving SUD treatment]. Their babies have been taken away. Ice is up again. It’s really accessible, and also more impure, so we’re seeing more side effects.”

“We’ve come a long way, that mental health is something we can talk about now. ‘Just suck it up’ is part of our culture. We’ve survived war. Now, how do we increase access? How do we link people to existing and natural supports? Family and faith, nature and land.”

Public School Staff Saipan

Priorities

- Addressing vaping/tobacco use
- Ensuring adequate caretaking for children in guardian care
- Keeping children safe in the community
- Reducing social media, strengthening interpersonal social skills
- Preventing teen suicide
- Ensuring children attend school
- Building up programming/education in the trades and educate young people about these jobs
- Screening for vision, hearing, and developmental milestones
- Ensuring children who need glasses have them

Hindrances

- Lax parenting practices
- Lax enforcement of policies/laws (i.e., tobacco sales, curfew)
- School meals are not culturally appropriate or appetizing to young people

Selected Quotes

“We see [vaping] in the middle school. There’s regulation but the stores sell them to kids, even ages 1-9. There are also some adults who buy them for the children. There’s no accountability among adults. Kids are vaping at school. They will pay a peer a dollar for a pull.”

“I had one student express, ‘It’s okay for me to vape as long as I’m in front of [my mom]. They’re very lenient, there’s no discipline. Parents vaping with their high school student children. This generation parents differently, they want to be best friends.”

“Many students don’t know what’s possible, they have no idea what they’re going to do with their lives.”

“Those who don’t have food at home will eat the food at school. Those who have food at home will not.”

“They send their students here and the parents will be in China, Korea, or Japan. They have a guardian here, and these kids will live with social media. The guardian is taking care of a lot of students because it’s a business, so there’s no parental value in there.”

“We have kids staying with their uncle, grandparents... you see them in the middle of the night walking the streets, drinking with a group of adults.”

“Some parents have disclosed to me that they’re afraid of disciplining their children because the child might report them to DCFS. They’re also worried the child will harm themselves in response. Mental health is a big issue... they’re sensitive.”

“School has become optional. It’s becoming the norm... We need to educate the parents to help educate the kids.”

“A child in my class cried because he was too embarrassed to tell us his parents couldn’t afford to replace his broken glasses.”

Parents with Children with Special Healthcare Needs Saipan

Priorities

- Parent training
 - To learn and then teach American Sign Language
 - Advocacy and leadership
- Build up the Family-to-Family program, expand to Tinian and Rota
- Access to specialty care: OT, PT, speech therapy
- Access to assistive technology services and devices
- Free/low-cost legal services and referrals to reputable law offices
- Timely support with basic needs and essential services/medications during emergencies

Hindrances

- Processes and policies are not family-friendly
- Stigma/denial about neurodivergence and disabilities

Selected Quotes

“We have a child with Downs Syndrome. We visit classrooms and tell them what it is. We look at more of the positivity, the ability of the child. Now they are aware of what it is, and it becomes a classroom community. We’re seeing the positive effect but would like more training.”

“At F2F we receive families who are in the shadows, in denial. We pair them up with an individual parent. It’s safer to talk to a parent who has lived that experience themselves. Confidentiality is needed – a parent is more comfortable if they know it will be kept private.”

“They will lend [assistive technology] to you, but you have to return it. If you want a specialty app, you have to pay for it yourself. If you need mechanical assistive devices [such as to hold a pen] you can’t get it. I go to presentations, and they say it’s there, but then you go to use it and it’s not there. My son has an iPad from school that’s three years old and it’s kind of broken and that’s his way of communicating with the teachers. There was money to buy things during COVID but no longer...”

“When your child turns 18 you automatically lose legal guardianship and access to their medical records. We need referrals for qualified legal advice.”

“We’ve encountered two typhoons. In emergency situations we need a group to reach out and help. Special services, transportation, 5 gallons of water. Kids with special needs may need medications. We need to help them quickly. FEMA is for the general population.”

Priorities

- Addressing vaping
- Addressing (cyber) bullying and rumors
- Ensuring teens practice enthusiastic consent
- Addressing mental health and suicide
- Healthy/culturally appropriate food access/security

Hindrances

- Adults don't take teens seriously when they report issues
- Lax parenting practices

Selected Quotes

“They should be educating on how very harmful [vaping] is and giving more support to quit.”

“Vaping should be the top priority. Parents allow it, give it to them. There’s no discipline.”

“There are always a lot of rumors going around about sex, relationship factors.”

“Teens are abusing each other, especially with sexual consent. They are blackmailing each other by sending pictures of nudes over social media. Authorities [parents, adults, teachers, public safety] don’t take it seriously when youth report it.”

“Teen suicide is related to cyber-bullying and rumors. My classmates will say things about me that I haven’t heard of.”

“[Healthy food access] should be higher on the list. People are eating out, eating McDonalds because it’s cheaper. Healthy food is expensive. Parents don’t model healthy choices. They serve rice, canned food, SPAM, and sugary drinks. Some don’t get the difference between fresh and processed.”

Faith Leaders Saipan

Priorities

- Addressing youth vaping/tobacco use
- Non-communicable disease
- Healthy diet
- Applying systems thinking to community health challenges
- Health insurance and healthcare access

Hindrances

- Poverty
- Guest workers who don't qualify for Medicaid

Selected Quotes

“There’s a new birth in the area of tobacco and vape. [I heard from a teacher in the middle school, this is a big issue now.”

“It’s a small island and we have at least 200 dialysis patients. That is caused by uncontrolled hypertension and diabetes, which ties to obesity.”

“Our staple foods are rice and bread. Education is how to combat this.”

“We need to recognize that we need systemic thinking. No man is an island. We're all interconnected. I think in the next five years, one of the things that really needs to happen within public health is if we collaborated with the community, faith based leaders, and public school. A more intentional collaboration and application of holistic health. Mind, body and all that from the system and all the way to the nucleus. If we at least look at it in a bigger scale within the system, the next five years, that would be great.”

“Two, three years ago we had presumed insurance – you could go to the hospital and get checked for free... everybody’s coming in and getting checked, getting surgery, getting help, medicine, because it’s free. The moment that stopped a year ago, suddenly it declined big time. A lot of people here are contract workers... Especially if it’s cancer, it’s already stage four. They hold out until the last minute because they don’t have insurance... just one check-up will be one- or two-week’s salary... that is big because almost half the population is not US citizens. It’s sad, but that’s the reality.”

Rota

Priorities

- Addressing the health needs of non-local women and their children
- Health insurance enrollment assistance
- Ensuring adequate prenatal care
- Safe sleep practices
- Breastfeeding support
- Food access and nutrition education
- Access to fitness and leisure activities
- Youth education about development, healthy relationships, and safer sex
- Community safety
- Raising awareness of available services and supports

Hindrances

- Resistance to help-seeking
- Low privacy in healthcare settings
- Lack of on-island mental health services
- Lack of specialty care
- Catholicism advocates for sexual abstinence, does not support sex education for young people

Selected Quotes

“Insurance enrollment is a barrier – you have to put in bank statements. It makes people frustrated.”

“They won’t use the hospital because they’re worried they’ll have to pay. It would be great if a certain percentage of uninsured could get paid for. There’s nothing for undocumented people.”

“Babies co-sleeping is happening a lot.”

“Sometimes moms get their first checkup at 30 weeks. Sometimes it’s insurance, for others it’s their 5th baby and they think they can do it on their own. Others are in denial that they’re pregnant.”

“When I first had my son, nobody told me about the importance of breastfeeding. I was frustrated. I didn’t have a lot of milk. For my second I did more research on my own. I breastfed for two years and he’s never been sick! My first child got formula and he’s sick here all the time. No-one here in the hospital recommends breastfeeding. Here in the hospital, as soon as they identify that they’re pregnant, they should start a group. That’s the beginning of life for that citizen [baby]. I’ve never heard it, or heard it talked about it, that at the hospital they bring all the pregnant people together for a session.”

“Our eating habits are the worst. It’s gonna take time... My parents are in their 60s and we don’t agree. They say, ‘Give the kids Spam. I fed you Spam all your lives.’ Another attitude here, healthy food is expensive.”

“We’ve been requesting for a facility that can support sports – track and field, walkways... we have plenty of room. We want a multipurpose track, so even just the community can walk. When it rains the kids can’t go out and play.”

“When you’re jogging by yourself there’s a lot of wild dogs. You can hear them from inside the jungle. You have to bring a stick. People don’t go walking anymore because they’re afraid of the dogs.”

“The HOME program here in Rota, it’s a good one... We need more outreach to inform people that it’s a program they have here in the hospital... The information is everywhere and nowhere. Some people don’t have social media access. Before, we used to have town hall meetings. Public health should collaborate with the Mayor’s department. The best way to get things done here is with collaboration. Don’t make it a meeting – make it fun. A social gathering. A large amount of people don’t have smart phones, don’t have computers. Some others don’t care. I would like to see quarterly town hall meetings. Collaboration with the schools – they can disseminate it to all the parents.”

“Providers leave the door open a lot in the clinic when they’re meeting with patients. People will gawk in as they walk by – they’re not shy about it.”

“Our adolescent girls are reaching menstruation in 2nd, 3rd grade. Bringing health education into elementary is different now. Their bodies are maturing, so we’re trying to educate them and get them ready... We have to get parents’ consent. Most everybody here is Catholic, and some parents don’t want their children to be educated.”

“I think mothers should be given informed consent when it comes to vaccinating their kids... they have side effects. The vaccine requirement was set 20 years ago.... I don’t want to make people fear, so I just tell other moms to do their research.”

Tinian

Priorities

- Addressing the health needs of non-local women and their children
- Food access
- School readiness
- Access to learning materials and technology
- Addressing sexual abuse
- Parent education and support services
- Year-round access to playgrounds and recreation activities for children and adolescents
- Addressing school truancy and youth crimes like vandalism and vaping
- Meeting the needs of CSHCN, especially those with neurodivergence. Ensuring IEPs are transferred between elementary and middle school.

Hindrances

- Stigma around receiving help
- Lax parenting practices
- Costs of off-island healthcare, including birth
- Low on-island access to specialty care

Selected Quotes

“They entered the CNMI as guest workers or joined their husbands who are guest workers from Bangladesh and China. They speak little English, have no formal education, and don’t know how to address their children’s health needs. They could have just given their child Tylenol early on, but didn’t, so not it’s pneumonia.”

“It’s expensive to stay at the pregnancy guest house on Saipan before delivery. They don’t provide any transportation except for appointments, so you have to pay for car rental.”

“Stores run out of the good baby food options – fruits and vegetables. WIC only gives you \$26 a month for fresh fruits and vegetables.”

“A four-year-old child came into the clinic with serious behavioral issues. In the exam room, he did not recognize authority spaces, could not follow guidance from his parents and was biting his parents – he would bite them on the ankles. Hi vocalizations were not normal. There were easily observable developmental issues, but the parents did not want to more deeply explore them. They are in denial.”

“[Child sexual] abuse is undetected and unaddressed. It festers, leading to suicidal ideation in adolescence.”

“There’s not enough print copies of text books and they don’t provide digital. My kid gets messaged the pages from a friend through Instagram. They end up doing their homework at 11pm. Our kids are doing their homework on their phones. There’s not enough laptops for every student to have one.”

“Parents are just letting is slide, not just their own kids, but also in the community. It used to be okay to do ass whoopings at home, at school, and by the police. Now that’s changed, so there’s no enforcement, no discipline. Underage kids could be drinking by the beach, and the police don’t do anything. In my time, they would punch you out. That kind of punishment was built in during the Japanese occupation. That’s how they did it. Role call was at 6pm, and if anybody was late, they would beat the oldest person in the family, the grandma. Chamorro were basically slaves during the Japanese occupation, raising the sugar cane.”