HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

AMERICAN SAMOA

State Snapshot

FY2026 Application / FY2024 Annual Report

December 2025

Title V Federal-State Partnership - American Samoa

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY2026 Application / FY2024 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

MCH Director	CSHCN Director
Anaise Uso Title V Director anaise@doh.as (684) 731-3912	Ipuniuesea Eliapo-Unutoa CYSHCN Director ieliapo@doh.as (684) 770-9205

SSDI Project Director	State Family Leader
Anaise Uso SSDI Project Director anaise@doh.as (684) 770-9205	Melinda Peko Parent/State Family Leader

State Youth Leader
No Contact Information Provided

State Hotline: Toll-free hotline is not available

Funding by Source

Source	FY 2024 Expenditures
Federal Allocation	$516,923
State MCH Funds	$420,000
Local MCH Funds	$0
Other Funds	$0
Program Income	$0

Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$3,590	$0
Enabling Services	$231,440	$167,660
Public Health Services and Systems	$281,893	$155,000

FY 2024 Expenditures Federal

FY 2024 Expenditures Non-Federal

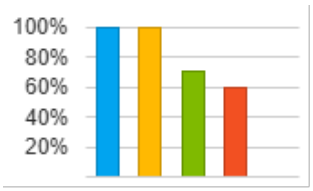
Percentage Served by Title V

Population Served	Percentage Served	FY 2024 Expenditures
Pregnant Women	100.0%	$45,915
Infants < 1 Year	100.0%	$70,192
Children 1 through 21 Years	70.0%	$275,849
CSHCN (Subset of all infants and children)	60.0%	$387,948
Others *	0.3%	$8,987

*Others– Women and men, over age 21.

FY 2024 Expenditures
Total: $788,891

FY 2024 Percentage Served



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2025 Needs Assessment reporting cycle. All states are also reporting on two Universal National Performance Measures, Postpartum Visit and Medical Home.

State Priorities and Associated Measures

Priority Needs and Associated Measures	Priority Need Type	Reporting Domain(s)
Improve care coordination for postpartum women. NPMs • A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV o ESM PPV.1: Percent of postpartum mom receiving a reminder call.	New	Women/Maternal Health

Improve infant feeding and nutrition.
 	
NPMs
• A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF
  o ESM BF.1: Percent of postpartum women who ever breastfed at discharge after birth.
  o ESM BF.2: Percentage of providers and health educators who were more confident in providing breastfeeding education to pregnant women after receiving breastfeeding TA training.
  o ESM BF.3: Percentage of postpartum women who received a home-visit from any DOH personnel that works closely with this population, providing breastfeeding reminders and support
  o ESM BF.4: Number of breastfeeding promotional translated materials disseminated throughout the community.
  o ESM BF.5: Percent of workplaces who received a talk on breastfeeding support and FLSA.
	Revised	Perinatal/Infant Health

Developmentally appropriate care and services are available for all children.
 	
NPMs
• Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS
  o ESM DS.1: Percent of providers serving children and families participating in learning collaborative.
  o ESM DS.2: Number of providers that initiated developmental screenings with parents during
	Continued	Child Health

medical/home visits after receiving developmental screening training. o ESM DS.3: Number of ASQ questionnaires disseminated to all Well Child Clinics (WCC). o ESM DS.4: Percentage of children ages 9 through 35 months completing an ASQ questionnaire in the past 12 months. o ESM DS.5: Translate the ASQ tools into the Samoan language. • Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH o ESM MH.1: Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population o ESM MH.2: The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots. o ESM MH.3: Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors. o ESM MH.4: Percent of children ages 3 through 14 years received a vision screening. o ESM MH.5: Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months. o ESM MH.6: Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting. o ESM MH.7: Percent of children ages 0 through 17 tested for Strep throat infections and treated. o ESM MH.8: Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year.		
Promote adolescent health through effective care coordination. NPMs • Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV o ESM AWV.1: Percent of adolescents who received a depression screening during a wellness visit annually. o ESM AWV.2: Percent of adolescents ages 12 through 17 receiving cardiology screening for Rheumatic Heart Disease in schools. o ESM AWV.3: Percent of children ages 12 through 17 receiving reproductive health talk in schools. o ESM AWV.4: Percentage of children ages 4 to 17 screened positive for RHD in schools.	New	Adolescent Health

Enhance System of Care for Children and Youth with Special Health Care Needs.
 	
NPMs
• Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH
  ○ ESM MH.1: Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population
  ○ ESM MH.2: The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots.
  ○ ESM MH.3: Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors.
  ○ ESM MH.4: Percent of children ages 3 through 14 years received a vision screening.
  ○ ESM MH.5: Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months.
  ○ ESM MH.6: Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting.
  ○ ESM MH.7: Percent of children ages 0 through 17 tested for Strep throat infections and treated.
  ○ ESM MH.8: Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year.
	Revised	Children with Special Health Care Needs

Mitigating and addressing rheumatic heart disease as a critical healthcare focus. SPMs • SPM 1: Rate per 1,000 of children, ages 3 through 17, diagnosed with Rheumatic Heart Disease. • SPM 2: Percent RHD patients ages 4 through 21 who are at least 80% compliant with their secondary prophylaxis in the past year.	Revised	Children with Special Health Care Needs
Refine the MCH database in SIILAS to capture all MCH reporting needs. SPMs • SPM 3: Percent of MCH data reports readily available in SILAS.	Revised	Cross-Cutting/Systems Building

Executive Summary

Program Overview

PROGRAM OVERVIEW:
MCH is currently under the leadership of Director Dr. Saipale Fuimaono, with direct supervision of Deputy Director for programs Fara Utu. An organizational chart is displayed in Figure 1.

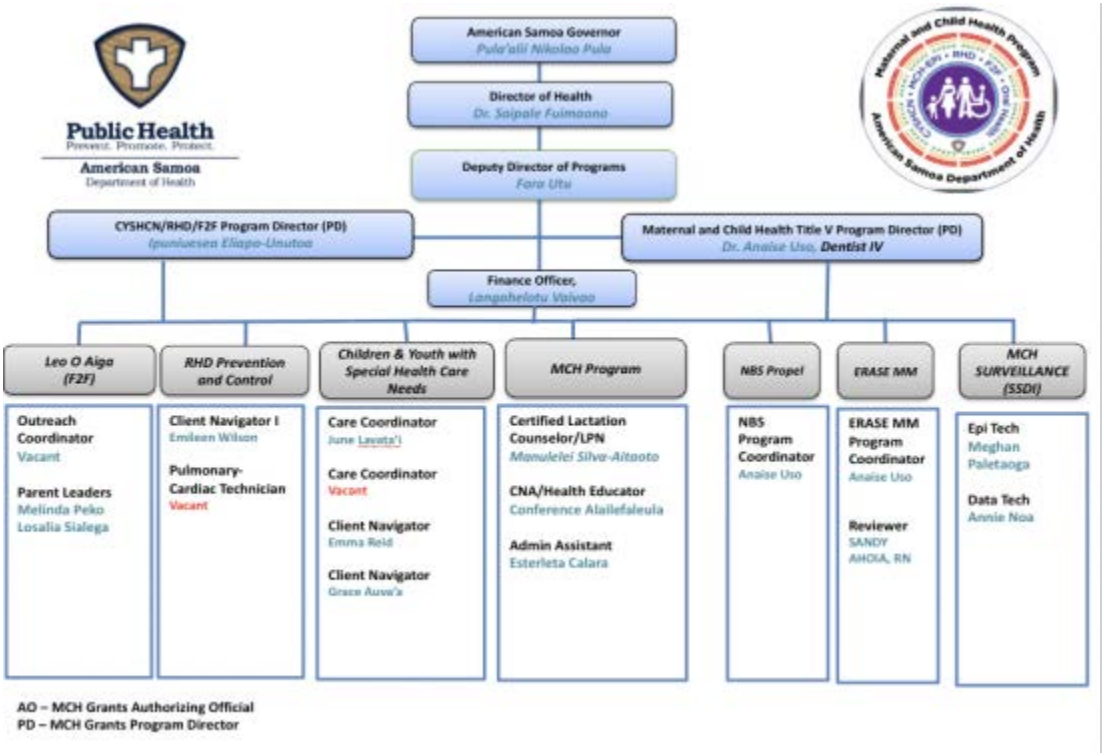


Figure 1: American Samoa MCH Program Organizational Chart:

In relation to Department wide activities, the MCH program is one of the many public health programs in DOH that help contribute to its overall vision and mission. MCH collaborates closely with Community Health Centers to assure families and their children are able to access, receive services in a timely and professional manner.

Needs Assessment Findings:
Internally, the MCH team has continually engaged in opportunities with partners to gather and review current community feedback on MCH priorities Such opportunities included community forums, advisory councils, community outreaches and school screening, continuing education sessions, and special projects. These opportunities also presented information that can be used to gauge changes and progress in the State Action Plan.

ASMCH Priority Needs and Emerging Needs:
Table 1: AS MCH Priority Needs 2024

POPULATION DOMAIN	ASMCH Priority Needs	NEW, REVISED OR CONTINUED PRIORITY NEED FOR THIS FIVE-YEAR REPORTING PERIOD		
		NEW	REVISED	CONTINUE
Women	1. Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.			X
Perinatal and Infants	2. Families are empowered to make educated choices about infant health and well-being.			X
Perinatal and Infants	3. Establish a Blood Spot Screening Program in American Samoa.			X
Children	4. Ensure early and periodic screening, diagnostic, and treatment services are available to all children. *		X	

Adolescent	5. Communities and providers support adolescents' physical, mental and emotional health.			X
CYSHCN	6. Improve Systems of care for CYSHCN			X
CYSHCN	7. Improve Rheumatic Heart Disease clients' compliance rate with secondary prophylaxis. *			X
Crosscutting	8. Build a functional RHD Registry in SILAS		X	

Six of the eight priority needs remain the same except for two. Priority Needs number 4 and 7 listed in table 1 were revised to better address more pressing needs identified through annual needs assessments. In addition, some activities and evidence-based strategy measures (ESM) have been revised to reflect collective efforts and improve health care services to MCH populations. Some activities and strategies being revised include how adolescents acquire a preventive visit at least once a year through efforts MCH can impact. Vision screening is another MCH led effort that is clearly becoming a priority for years to come. Additionally, another important revision to the strategies for CYCHSN is to capture and improve transitional services for adolescents who are needing preparation for adult based services with not just health, but also with vocation and educational purposes.

Population Domain: Women/Maternal Health

Priority Need: Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Five Year Objectives: By 2025, American Samoa will increase the percentage of women ages 18 to 44 with a preventive medical visit in the past year to 59%, an increase from the baseline of 47%.
Strategies: Promote women'' wellness through systems building efforts; Promote early prenatal care for all women by disseminating translated pamphlets and posters to all clinics, schools, churches, workplaces and major department stores etc. where most families frequently visit. Ensure regular reminders of opening hours for clinics are advertised through various media outlets such as radio, television and social media.
NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit)
Five Year Objectives: By 2025, American Samoa will increase the percentage of women receiving a postpartum visit within 12 weeks after giving birth from 9.8% in 2023 to 19%.
Strategies: Promote Postpartum care by supporting care coordination for postpartum women and reminder calls for all postpartum moms; Promote Maternal and Postpartum Depression Screening and referral for counseling and/or treatment; Collaborate with BHS to generate, translate and disseminate pamphlets to all sites most frequented by women across the territory; Promote preconception health and family planning support.

Population Domain: Perinatal/Infant Health

Priority Need: Families are empowered to make educated choices about infant health and well-being.
NPM: 4 A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Five Year Objectives: ●By 2025, increase the percentage of infants who ever breastfed in the past year to 87%, an increase from the baseline of 86%. ●By 2025, increase the percentage of infants who breastfeed exclusively through 6 months to 25% in the past year, an increase from the baseline of 17%.
Strategies: Acquire Breastfeeding related Training from Dietitians, WIC and AMCHP for services providers at least once a year; Disseminate translated posters and brochures on breastfeeding benefits in all clinics, workplaces, and other frequented areas; Promote awareness in workplaces to accommodate nursing mothers' rights to pump at work according to the Fair Labor Standards Act.

Population Domain: Perinatal/Infant Health

Priority Need: Establish a Newborn Bloodspot Screening Program in Am. Samoa
SPM 1: Percent of newborns receiving Blood Spot Screening

Objectives:

- By 2025, a comprehensive NBS Program is established to include screening for congenital hypothyroidism and critical congenital heart defects.

Strategies: Facilitate regular NBS Advisory Committee meetings; Develop a Birth Condition Surveillance reporting system; Partner with NBS Excel Awardee; Ensure all newborns receive BSS by year 2025; Establish MCH & Screening System to Support Individuals & Families Throughout the Lifespan

Population Domain: Child Health

Priority Need: Ensure early and periodic screening, diagnostic, and treatment services are available to all children.

NPM: 6 Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Five Year Objectives: By 2025, increase the percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 10%, an increase from the baseline of 7.1%.

Strategies: Disseminate ASQ screening tools to all Well Child Clinics and ensure current SOP is revised to include mandatory developmental screening for all age-appropriate individuals.

Population Domain: Child Health

Priority Need: Ensure early and periodic screening, diagnostic, and treatment services are available to all children.

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Objectives: By 2025, increase the percentage of children ages 1 through 17, who had a preventive dental visit in the past year to 35%, an increase from the baseline of 31%.

Strategies Promote Silver Diamine Fluoride treatment for children by disseminating translated brochures and posters in the community; Provide promotional oral hygiene kits including oral hygiene tips for all DOH dental clinics.

Population Domain: Child Health

Priority Need: Ensure early and periodic screening, diagnostic, and treatment services are available to all children.

SPM 2: Percent of children ages 3 who have completed their age-appropriate routine vaccinations.

Five Year Objectives: By 2025, increase immunization coverage of children ages 35 months who receive up to date routine vaccinations to 65%, an increase from the baseline of 32.8%.

Strategies: Support and promote vaccinations for MCH coordinated care services and community outreach activities.

Population Domain: Child Health

Priority Need: Ensure early and periodic screening, diagnostic, and treatment services are available to all children. **New**

NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. **New**

Five Year Objectives: By 2025, increase the percentage of children, ages 3 through 14 years, who received a vision screening in the past year to 10%, an increase from the baseline of 2.5%.

Strategies: Collaborate with DOE and private schools to establish an MOU supporting dissemination of consent forms for all medical screenings, including vision, heart and dental, in schools during school registration.

Population Domain: Adolescent Health

Priority Need: Communities and providers support adolescents' physical, mental and emotional health.

NPM 10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Five Years Objectives: By 2025, increase the percentage of adolescents ages 12 through 17, with a preventive medical visit in the past year from 48.2% in 2019 to 58.2%.

Strategies: Collaborate with BYU Rheumatic Relief Team to include BMI, blood pressure checks and depression screenings during heart screening in schools; Collaborate with DOE and private schools to implement an MOU that covers parental consent for all school screenings and health outreach including heart, eye and dental screenings in school by DOH and visiting specialists; Continue to collaborate with NGO Intersections Inc. to promote reproductive health and sexual risk avoidance education to support the decline in teenage pregnancy.

Population Domain: Children with Special Health Care Needs

Priority Need: Ensure early and periodic screening, diagnostic, and treatment services are available to all children. **New**

SPM: Rate per 1,000 of children ages 3 through 17 years with Rheumatic Heart Disease. **New**

Five Year Objectives: In 2025, increase the rate of children ages 3 through 17 years screened positive for RHD from 3.7 per 1,000 to 8 per 1,000.

Strategies

- Promote early detection of strep throat and treatment by ensuring there is sufficient Strep A rapid tests in the DOH laboratory.
- Coordinate annual screening and RHD health promotions in schools.
- Continue to promote care coordination for RHD clients accessing care at the DOH RHD clinic.

Population Domain: Children with Special Health Care Needs

Priority Need: Improve Rheumatic Heart Disease clients' compliance rate with secondary prophylaxis.

SPM 4: Percent of RHD patients ages 4 through 21 per 1,000 who are 90% compliant with their secondary prophylaxis in the past year.

Five Year Objectives: In 2025, increase the percentage of children with RHD ages 4 - 21 who are ≥80% compliant with their secondary prophylaxis to 60%, an increase from the baseline of 58.7%.

Strategies: Continue to promote care coordination for RHD clients accessing care at the DOH RHD clinic. Ensure all care coordination and clinical encounters are entered in the RHD Registry for tracking and monitoring.

Population Domain: Children with Special Health Care Needs

Priority Need: Improve Rheumatic Heart Disease clients' compliance rate with secondary prophylaxis.

SPM 4: Percent of RHD patients ages 4 through 21 per 1,000 who are 90% compliant with their secondary prophylaxis in the past year.

Five Year Objectives: In 2025, increase the percentage of children with RHD ages 4 - 21 who are ≥80% compliant with their secondary prophylaxis to 60%, an increase from the baseline of 58.7%.

Strategies: Continue to promote care coordination for RHD clients accessing care at the DOH RHD clinic. Ensure all care coordination and clinical encounters are entered in the RHD Registry for tracking and monitoring.

Population Domain: Cross-Cutting/Systems Building

Priority Need: Establish a functional RHD registry in the MCH centralized Database SILAS.

SPM 5. Build a functional RHD Registry in SILAS to capture all presumptive and confirmed cases of Rheumatic Fever and Rheumatic Heart Disease.

Objectives: Improve the Rheumatic Fever and Rheumatic Heart Disease (RHD) registry in SILAS to improve the monitoring, surveillance, and management of these conditions.

Strategies: Continue to update the RHD registry in SILAS and ensure easy access and reporting for service providers.

Program Evaluation:
MCH gathers input from stakeholders and community participants on the work that was provided throughout the interim years to measure progress. Implementing short surveys, and having parent/family group discussions to consider important issues that are significant to improving the lives of our populations are other means of connecting to the community. Another ways of evaluating progress is reviewing the growth of our program through data collection, the increase of enrollment from families. Utilizing social media also to spread information through program pages and reviewing numbers of followers, 'likes'' on posts, etc. Radio and TV mass media promotion of Title V and what it contributes to the health of the community in different aspects also highlights the program process throughout 2024

How Federal Title V Funds Complement State-Supported MCH Efforts

Title V funds

The ASDOH receives approximately $500,000.00 in Title V dollars annually to assure access to preventive and primary health care services for the required population groups of: (1) preventive and primary care services for pregnant women, mothers and infants; (2) preventive and primary care services for children; and (3) services for children with special health care needs (CSHCN). Title V allocates a minimum of 30 percent of available funds to services for children with special health care needs, and a minimum of 30 percent of available funds to services for children and adolescents. Other associated federal funds include but not limited to the following:

A. Medicaid
B. Federally Qualified Health Centers
C. Family to Family Health Information Center
D. Preventive Health & Health Services Funding
E. Public Health Emergency Preparedness
F. STD/HIV funding
G. Breast & Cervical Cancer Program
H. Comprehensive Cancer Control Program
I. Behavioral Health Services
J. Early Intervention Program *"Helping Hands"*
K. Early Hearing Detection & Intervention Program *"Helping Babies Hear"*
L. Maternal Infant Early Childhood Home-Visiting Program *"MIECHV"*
M. Department of Education Special Education
N. Administration for Native Americans funding
O. Pacific Center for Human Security (UCEDD)
P. Office of Vocational Rehabilitation
Q. Office for Protection & Advocacy for the Disabled
R. Department of Youth & Women Affairs (DYWA)
S. LBJ Tropical Medical Center (Title X)
T. American Samoa Comprehensive Cancer Coalition (ASCCC)- NGO
U. Intersections Inc -NGO
V. EPIC (Empowering Pacific Islanders and Communities) – NGO

The AS MCH Title V funds complement the State Plan in supporting healthcare for women and children by addressing gaps and priority needs which are not achieved by State funds or other federal dollars. Such examples include health education materials for women's health services, rheumatic heart disease clinical support, telehealth equipment support for satellite clinics in remote areas of American Samoa, school screenings and vaccination campaigns for tropical neglected diseases, and many other efforts that address health disparities among women and children locally.

MCH Success Story

2024 Success Story

In Samoan culture, the family is the heart of the community and plays a vital role in raising children and supporting their well-being. Children are seen as the promise of the future, and families are deeply involved in their growth and development. Recognizing this, the Maternal and Child Health (MCH) programs in American Samoa work closely with families to promote healthy lifestyles and ensure access to both preventative and primary care.

In 2024, we organized a variety of community outreach activities. One highlight was a collaborative event with Leo O Aiga held at Lions Park, a popular recreational space for families. To raise awareness about our services, we scooped over 300 free ice cream cones engaging both CYSHCN families and the wider public.

Throughout the year, we also hosted monthly Parent Support Group meetings. These gatherings provided a safe and supportive space for parents to connect, share their experiences, and hear from guest speakers, and reminded them that the MCH team is here to walk alongside them in helping their children reach their fullest potential.
One of our final events of the year was a joyful Christmas party, hosted in partnership with the Lions Club and Parents of Children with Special Needs Network(PCSN). Held at the American Samoa Community College (ASCC) Multipurpose Room, the event featured indoor games, face painting, free food, and Christmas gifts. It was a celebration not only for our clients but for their families, and a powerful way to close the year on a note of unity and gratitude.

Among the many lives touched by the program, we wish to highlight the story of a 12-year-old client with type 1 diabetes. He is not only active in attending his medical appointments but also participates in our Parent Support Group meetings. His grandmother, who is his primary caregiver, utilizes our Memorandum of Understanding (MOU) with LBJ to access critical services not covered by local Medicaid-including prescription medications and hospital fees. Every month, she visits our office to uplift an MOU and ensure her grandson receives the diabetic strips and medication he needs. This year she came in not to collect an MOU, but to thank the MCH team. She shared that while $10 per medication may seem small to some and additional $50+ for medical supplies, the MOU assistance has eased a major financial burden for her family-and for that, she is forever grateful. Stories like hers show the deep and lasting impact of Title V and the MCH programs on the lives of our clients and their families.
As we reflect on the year, we are proud of the work we've done and the partnerships we've built-with families always at the heart of it all.

Maternal and Child Health Bureau (MCHB) Discretionary Investments - American Samoa

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs, and their families. In addition, MCHB supports a range of other discretionary grants to help ensure that quality health care is available to the MCH population nationwide.

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2024.

List of MCHB Discretionary Grants

Please note: If you would like to view a list of more recently awarded MCHB discretionary investments, please refer to the Find Grants page that displays all HRSA awarded grants where you may filter by Maternal and Child Health.