HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

AMERICAN SAMOA

State Snapshot

FY2025 Application / FY2023 Annual Report

November 2024

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 FY2025 Application / FY2023 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

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SSDI Project Director	State Family Leader
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State Youth Leader
No Contact Information Provided

State Hotline: (684) 633-5871

Funding by Source

Source	FY 2023 Expenditures
Federal Allocation	$519,096
State MCH Funds	$390,760
Local MCH Funds	$0
Other Funds	$0
Program Income	$0

Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$3,850	$0
Enabling Services	$408,115	$293,725
Public Health Services and Systems	$107,131	$98,155

FY 2023 Expenditures Federal

FY 2023 Expenditures Non-Federal

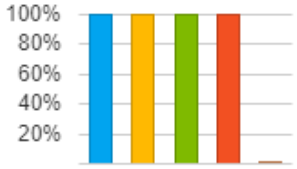
Percentage Served by Title V

Population Served	Percentage Served	FY 2023 Expenditures
Pregnant Women	100.0%	$58,333
Infants < 1 Year	100.0%	$83,109
Children 1 through 21 Years	100.0%	$370,509
CSHCN (Subset of all infants and children)	100.0%	$316,985
Others *	1.0%	$30,331

*Others– Women and men, over age 21.

FY 2023 Expenditures
Total: $859,267

FY 2023 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 2020 Needs Assessment reporting cycle. Beginning with the FY 2025 Application, 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	Reporting Domain(s)

Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.
 	
NPMs
• Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
  ○ ESM WWV.1: Percent of women who report scheduling a preventive visit based on information obtained through various media outlets.
  ○ ESM WWV.2: Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.
  ○ ESM WWV.3: Percent of postpartum women who received a depression screening in the past 12 months.
  ○ ESM WWV.4: Percent of pregnant women who receive at least one preventive dental service in the past year.
  ○ ESM WWV.5: Percentage of women who received the COVID-19 vaccine during a wellness visit.
  ○ ESM WWV.6: Number of translated materials disseminated to clinics and the community to promote early and adequate prenatal care.
  ○ ESM WWV.7: Percent of women ages 18 through 44 served through the CHC women's clinics.
• 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) - PPV
  ○ ESM PPV.1: Percent of postpartum mom receiving a reminder call.
	Women/Maternal Health

Establish a Newborn Metabolic Screening Program in American Samoa SPMs • SPM 1: Percent of newborns receiving Blood Spot Screening	Perinatal/Infant Health
Families are empowered to make educated choices about infant health and well-being. NPMs • A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	Perinatal/Infant Health

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM BF.1: Percent of postpartum women who ever breastfed at discharge after birth. ○ 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. ○ ESM BF.3: Percentage of BF women who access the virtual chat room for lactation and peer counseling. ○ ESM BF.4: Percentage of postpartum women who received a home-visit from any DOH personnel that works closely with this population, providing breastfeeding reminders and support ○ ESM BF.5: Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year ○ ESM BF.6: Percent of House and Senate who are aware of the importance of paid Maternity Leave. ○ ESM BF.7: Number of breastfeeding promotional translated materials disseminated throughout the community. ○ ESM BF.8: Percent of workplaces who received a talk on breastfeeding support and FLSA.	
Ensure early and periodic screening, diagnostic, and treatment services are available to 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 (Developmental Screening, Formerly NPM 6) - DS ○ ESM DS.1: Percent of providers serving children and families participating in learning collaborative. ○ ESM DS.2: Number of providers that initiated developmental screenings with parents during medical/home visits after receiving developmental screening training. ○ ESM DS.3: Number of ASQ questionnaires disseminated to all Well Child Clinics (WCC). ○ ESM DS.4: Percentage of children ages 9 through 35 months completing an ASQ questionnaire in the past 12 months. ○ 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 (Medical Home, Formerly NPM 11) - 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: Percent of providers that reported they were more confident using the MCHAT screener after receiving autism screening training ○ ESM MH.3: Percent of CSHCN families receive transition training. ○ ESM MH.4: The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots. ○ ESM MH.5: Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors. ○ ESM MH.6: Percent of children ages 3 through 14 years received a vision screening.	Child Health

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM MH.7: Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months. ○ ESM MH.8: Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting. ○ ESM MH.9: Percent of children ages 0 through 17 tested for Strep throat infections and treated. ○ ESM MH.10: Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year. ● Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child ○ ESM PDV-Child.1: Percent of children 0-3 years receiving fluoride varnish at least twice a year. ○ ESM PDV-Child.2: Percent of dental providers receiving Silver Diamine Fluoride training, annually. ○ ESM PDV-Child.3: Percent of children ages 0 through 3 receiving promotional oral hygiene kits. SPMs ● SPM 2: Percent of children ages 3 who have completed their age-appropriate routine vaccinations.	
Communities and providers support adolescents' physical, mental and emotional health. NPMs ● Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV ○ ESM AWV.1: Percent of adolescents who have a wellness check-up passport. ○ ESM AWV.2: Percent of adolescents who received a depression screening during a wellness visit annually. ○ ESM AWV.3: Percent of adolescents that scheduled a wellness checkup after hearing/reading the importance of an annual checkup through mass media campaigns. ○ ESM AWV.4: Percent of adolescents ages 12 through 17 receiving cardiology screening for Rheumatic Heart Disease in schools. ○ ESM AWV.5: Percent of children ages 12 through 17 receiving reproductive health talk in schools. ○ ESM AWV.6: Percentage of children ages 4 to 17 screened positive for RHD in schools.	Adolescent Health
Improve 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 (Medical Home, Formerly NPM 11) - MH	Children with Special Health Care Needs

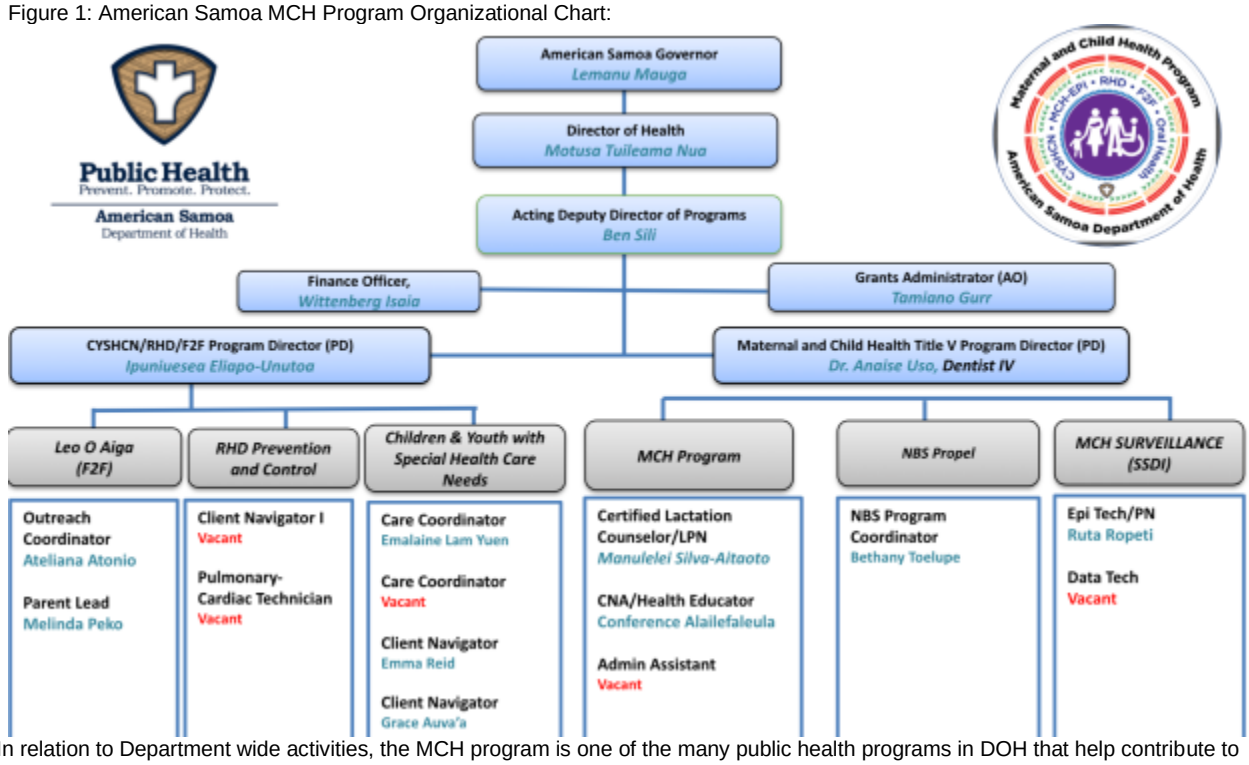
Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM MH.1: Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population ○ ESM MH.2: Percent of providers that reported they were more confident using the MCHAT screener after receiving autism screening training ○ ESM MH.3: Percent of CSHCN families receive transition training. ○ ESM MH.4: The percentage of children ages 4 - 17 years of age who attends at least 90% of their appointed Bicillin shots. ○ ESM MH.5: Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors. ○ ESM MH.6: Percent of children ages 3 through 14 years received a vision screening. ○ ESM MH.7: Percentage of active CYSHCN clients who completed an annual medical check-up in the past 12 months. ○ ESM MH.8: Percent of CYSHCN ages 33-36 months, and ages 14 to 17 engaging in at least 1 transition meeting. ○ ESM MH.9: Percent of children ages 0 through 17 tested for Strep throat infections and treated. ○ ESM MH.10: Percentage of children ages 3 through 17 screened for RHD using echocardiography in the past year. SPMs ● SPM 3: Rate per 1,000 of children, ages 3 through 17, diagnosed with Rheumatic Heart Disease.	
Establish a functional RHD registry in the MCH centralized Database SILAS. SPMs ● SPM 4: Build a functional RHD Registry in SILAS to capture all presumptive and confirmed cases of Rheumatic Fever and Rheumatic Heart Disease.	Cross-Cutting/Systems Building
Improve Rheumatic Heart Disease clients' compliance rate with secondary prophylaxis. SPMs ● SPM 5: Percent RHD patients ages 4 through 21 who are at least 80% compliant with their secondary prophylaxis in the past year.	Children with Special Health Care Needs

Executive Summary

Program Overview

PROGRAM OVERVIEW:
MCH is currently under the leadership of Director Motusa Tuileama Nua, with the assistance of Acting Deputy for programs Ben Sili. 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 works across the lines with Community Health Centers to assure families and their children who are referred for services as well as women receive these services in a timely and professional manner.

Needs Assessment Findings:
Internally, the MCH team has continually engaged in opportunities with partners to collect, review, and compare current community feedback on MCH priorities to the initial needs assessment of the five-year cycle and the State Action Plan. Such opportunities included community forums, advisory councils, outreaches and school screening, continuing education sessions, and special projects. MCH utilized these opportunities to also obtain 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

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	

In its continued review of the Strategic Action Plan, six of the 8 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 mothers, children and youth, including CYSHCN. Some activities and strategies being revised include how adolescents receive or acquire a preventive visit at least once a year through efforts MCH can impact. Another strategy revised is the availability of preventive health screening for children such as with vision, to assure corrective eye care is applied early on in life. Vision screening has revealed a significant number of young children in American Samoa in need of corrective mechanisms for their vision, and MCH has been the lead in initiating and implementing this project. 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.

ESM; 1. Percent of women ages 18 through 44 served through the CHC women's clinics. **New**
2. Number of translated materials disseminated to clinics and the community to promote early prenatal care.

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.

ESM

1. Percent of postpartum mom receiving a reminder call
2. Percent of postpartum women who received a depression screening and were referred to a behavior health counselor/psychologist.
3. Percent of Providers receiving Technical Assistance Training in Prenatal Care Standards of Care and Provider Competencies.

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.

ESMs

1. Percentage of service providers who were more confident in providing breastfeeding education to pregnant women after receiving breastfeeding TA training. **Active**
2. Number of translated breastfeeding promotional materials disseminated throughout the community. **New**
3. Number of workplaces who received a talk on breastfeeding support and the updated FLSA. **New**

Population Domain: Perinatal/Infant Health

Priority Need: Establish a Newborn Bloodspot Screening Program in American 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.

ESMs: **New-** Number of ASQ questionnaires disseminated to all Well Child Clinics (WCC)
New: Translate the ASQ tools into Samoan and other languages.
New: Percentage of children ages 9 through 35 months completing an ASQ questionnaire in the past 12 month.

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.

ESM: **New:** Percent of dental providers receiving SDF training.
New: Percent of children receiving promotional oral hygiene kits.

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.

ESMs:

New 1. Official MOU for preventive medical screenings in school to include vision is endorsed by governing directors. **New** 2. Percent of children ages 3 through 14 years received a vision screening using a PlusOptix screener.

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.

ESMs:

New 1 Percent of school children ages 12 through 17 receiving cardiology screening
Active 2.Percent of adolescents who received a depression screening during a wellness visit annually
New 3. Percent of children ages 12 through 17 receiving reproductive health talk in schools.

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.

ESM

New 1. Percentage of children ages 0 through 17 tested for streptococcal pharyngitis with rapid tests.
New 2. Percentage of children ages 3 through 17 screened for RHD using an echocardiography machine in the past year.
New 3. Percentage of new RHD cases who established a medical home.

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.

ESM:

New Percentage of RHD clients receiving monthly call reminders and care coordination services, including appointment reminders at least every 3 weeks.

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.
ESM: **New** Percentage of RHD clients receiving monthly call reminders and care coordination services, including appointment reminders at least every 3 weeks.

6. 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 means 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 within 2023.

How Federal Title V Funds Complement State-Supported MCH Efforts

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). American Samoa 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. Together with State funds, and other additional federal funds, as well as non-governmental organizations, the Title V MCH block grant is used to address American Samoa's MCH priority needs, improve performance related to targeted MCH outcomes through evidence-based practices, and expand systems of care for the MCH and CYSHCN populations. 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

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, and many other efforts that address health disparities among women and children locally.

MCH Success Story

2023 Success Story

Family involvement in a child's wellbeing and care is a huge component to the success of the work MCH provides in the community. Without it, the continuity of recommendations and follow up care would be difficult. In the past years, we've closely worked with existing families already in the program but we knew we had many other families who needed to know Title V the support they can receive to help their child(ren).
Title V worked closely with the Leo o Aiga Center (F2FHIC) and other internal partners such as the Helping Babies Hear Program (Hearing Screening) and the Early Intervention Helping Hands Program to create a space for families in the community to be heard and to receive answers about the services provided for their CYSHCN. A forum was created during the Developmental Disability Month which not only invited all parents & legal guardians for CYSHCN but also offered a monetary stipend for attendees. There were more than 400 parents & family members who came to this forum. A variety of sessions were offered spanning from healthcare, to vocational support, to special education services, to understanding federal funds dedicated to supporting existing services for CYSHCN in the community. MCH lead the Healthcare session along with its partners and received many questions from parents and families who attended regarding affording care for their chronically ill child, extra support in equipment and medication, as well as mental and behavioral health support. Families took this opportunity to connect, not just to service providers in the building, but also amongst each other.
Many expressed their gratitude for the information that was shared, but also other parents continued to express their frustration with the existing system and requested for specialized services to help them better care for their child. Parents felt empowered to speak up because there were many other parents sharing the same issues and knew they were not alone.
Since this forum, an estimated 28% increase in the number of families enrolled into the Family Center as well as Title V services. Many families requested financial assistance to help cover expenses when visiting the LBJ hospital for medication, supplies such as feeding tubes and suction machines. Title V already has an MOU in place with the local hospital to cover expenses that Medicaid funding would not be able to take care for these families and still allow them access to the care they need.
We have seen more new families join our monthly Autism Support Group, reporting they found out about our center from radio advertisements that were actual parents talking about connecting and advocating for a better healthcare system for the children. This group continues to meet and share information, resources, ideas with each other, and parents claiming they leave each meeting with new information that will help them and their child.
Title V understands the work continues with families, and we may not meet all the specific needs for each family the program comes in contact with, but the engagement with families empower MCH to continue to improve the services we support for women and children, including CYSHCN, to advocate for their needs, and to prioritize and address these needs towards and thriving healthy community.

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 2023.

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.