American Samoa State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	By 2025, American Samoa will increase the percentage of women ages 18 to 44 with a preventive medical visit in the past year to 58%, an increase from the baseline of 47%. (Data Source: MCH Jurisdictional Survey 2019, 2021, 2024).	Promote early prenatal care for all women. Disseminate translated pamphlets and posters to all clinics, schools, churches, workplaces and major department stores etc. which families frequently visit.	***Inactive -*** *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. ***Inactive -*** *ESM WWV.4 - Percent of pregnant women who receive at least one preventive dental service in the past year.*	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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			Inactive - *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.		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Women have access to and receive coordinated, comprehensive services before, during and after pregnancy.	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 12%.	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 in all women's health clinics.	ESM PPV.1 - Percent of postpartum mom receiving a reminder call.	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) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Families are empowered to make educated choices about infant health and well-being.	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%.	Acquire Breastfeeding related Training from Dietitians, WIC and AMCHP for service 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.	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. ***Inactive -*** *ESM BF.3 - Percentage of BF women who access the virtual chat room for lactation and peer counseling.*	NPM - 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	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			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 ***Inactive -*** *ESM BF.5 - Percentage of Breastfeeding Feeding Coalition Members who report they meet at least 6 times a year* ***Inactive -*** *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		

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			breastfeeding support and FLSA.		
Establish a Newborn Metabolic Screening Program in American Samoa	By 2025, a comprehensive NBS Program is established to include screening for congenital hypothyroidism and critical congenital heart defects.	Collaborate with the HBH program to 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		SPM 1: Percent of newborns receiving Blood Spot Screening	
Child Health					
Ensure early and periodic screening, diagnostic, and treatment services are available to all children.	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%.	Support and promote vaccinations for MCH coordinated care services and community outreach activities.		SPM 2: Percent of children ages 3 who have completed their age-appropriate routine vaccinations.	
Ensure early and periodic screening, diagnostic, and treatment services are available to all children.	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%.	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 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	NPM - 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	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very

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			ages 0 through 3 receiving promotional oral hygiene kits.		good health (Children's Health Status, Formerly NOM 19) - CHS
Ensure early and periodic screening, diagnostic, and treatment services are available to all children.	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%.	Translate the ASQ tools and disseminate them to all Well Child Clinics. Ensure current Well Child Check SOP is revised to include mandatory developmental screening for all age appropriate individuals.	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	NPM - 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	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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			language.		
Ensure early and periodic screening, diagnostic, and treatment services are available to all children.	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%.	Collaborate with DOE and private schools to establish an MOU supporting dissemination of consent forms for all medical screenings, including vision, heart and oral health, in schools during school registration.	ESM MH.1 - Percent of Providers Serving Children with Special Health Care Needs report they are confident in providing services for this population ***Inactive -*** *ESM MH.2 - Percent of providers that reported they were more confident using the MCHAT screener after receiving autism screening training* ***Inactive -*** *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.	NPM - 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	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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			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.		
Adolescent Health					
Communities and providers	By 2025, increase the percentage of adolescents ages 12 through	Collaborate with BYU Rheumatic Relief Team to include BMI, blood pressure checks and depression screenings during heart screening in	***Inactive -*** *ESM AWV.1 - Percent of*	NPM - Percent of adolescents, ages 12	NOM - Adolescent mortality rate ages 10 through 19, per 100,000

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support adolescents' physical, mental and emotional health.	17, with a preventive medical visit in the past year from 48.2% in 2019 to 58.2%.	schools and refer to the Community Health Center if needed for further monitoring and care. 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.	*adolescents who have a wellness check-up passport.* ESM AWV.2 - Percent of adolescents who received a depression screening during a wellness visit annually. ***Inactive -*** *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	through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	(Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

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			screened positive for RHD in schools.		NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Improve System of Care for Children and Youth with	By 2025, increase the percentage of CSHCN who report having a medical home to 10%, an increase from a baseline percentage of 0%.	Strategically provide training for providers (medical, educational, vocational) and families. Ensure all CYSHCN receive an annual preventive medical and dental visit.	ESM MH.1 - Percent of Providers Serving Children with Special Health Care Needs report they are	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care,

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Special Health Care Needs.		Collaborate with Leo O Aiga (F2FHIC) to promote community outreach programs for families of CYSHCN to increase enrollment and active participation. Promote transition services for all CYSHCN ages 33-36 months, and ages 14 through 21 years of age.	confident in providing services for this population ***Inactive -*** *ESM MH.2 - Percent of providers that reported they were more confident using the MCHAT screener after receiving autism screening training* ***Inactive -*** *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.	Home, Formerly NPM 11) - MH	Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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			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.		
Improve System of Care for Children and Youth with Special Health Care Needs.	In 2025, increase the rate of children ages 3 through 17 years screened for RHD from 13.3% to 16%.	Promote early detection of strep throat and treatment by ensuring there is sufficient Strep A rapid tests in the DOH laboratory. Provide annual screening and RHD health promotions in schools. 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		SPM 3: Rate per 1,000 of children, ages 3 through 17, diagnosed with Rheumatic Heart Disease.	
Improve	In 2025, increase the percentage	Continue to promote care coordination for RHD clients accessing care at		SPM 5: Percent RHD	

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Rheumatic Heart Disease clients' compliance rate with secondary prophylaxis.	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%.	the DOH RHD clinic. Ensure all care coordination and clinical encounters are entered in the RHD Registry for tracking and monitoring.		patients ages 4 through 21 who are at least 80% compliant with their secondary prophylaxis in the past year.	
Cross-Cutting/Systems Building					
Establish a functional RHD registry in the MCH centralized Database SILAS.	Improve the Rheumatic Fever and Rheumatic Heart Disease (RHD) registry in SILAS to improve the monitoring, surveillance, and management of these conditions.	Continue to update the RHD registry in SILAS and ensure easy access and reporting for service providers.		SPM 4: Build a functional RHD Registry in SILAS to capture all presumptive and confirmed cases of Rheumatic Fever and Rheumatic Heart Disease.	